## OVERVIEW

We are a clinical-stage biotechnology company established in 2018 with an integrated drug pipeline comprising three clinical-stage drug candidates (ECC4703, ECC5004 (also known as elecoglipron), and ECC0509) and three preclinical-stage drug programs (GIP program, Amylin program, and UPA program). Our Core Product, ECC4703, is a self-discovered and developed, oral small molecule liver-targeting THR-β full agonist being developed as both a monotherapy and a combination therapy with one of our Key Products, ECC0509, a SSAO inhibitor, to treat MASH, and also as an adjunct to an approved and commercialized GLP-1RA for treating obesity/overweight. ECC4703 would be classified as a NCE drug in the United States and a Class 1 Innovative Drug in China if approved. The intended indications of ECC4703 are closely correlated with those of other drug candidates in our cardiometabolic portfolio. Because effective MASH treatment typically requires combining agents with different mechanisms of action, and THR-β full agonist represents one such key mechanism, ECC4703 may be used, if supported by clinical data and regulatory approvals, in combination with other drug candidates in our pipeline that address complementary pathways. Another Key Product, ECC5004, is an oral small molecule GLP-1RA designed to treat obesity/overweight and T2D, for which we entered into an exclusive collaboration and license agreement with AstraZeneca in November 2023, granting AstraZeneca exclusive rights to develop and commercialize ECC5004 outside Greater China and retaining co-development and co-commercialization rights in Greater China. In addition to being developed as both a monotherapy and a combination therapy with ECC4703 for MASH, ECC0509 is also being developed as a monotherapy for OA pain. **There is no assurance that we will ultimately be able to develop and market our Core Product successfully.**

In addition to our Core Product, ECC4703, our broader pipeline includes ECC5004 and ECC0509, along with three self-developed preclinical programs of oral small molecules and peptide, which are aimed at treating a range of metabolic diseases. Each of our clinical assets is purposely engineered to deliver targeted treatment while unlocking broad therapeutic opportunities across cardiometabolic diseases and inflammatory disorders. Moreover, our therapies can be combined in different ways to tackle the multifaceted challenges of cardiometabolic diseases and inflammatory disorders.

Under the AstraZeneca Agreement, we granted AstraZeneca the exclusive global rights for the development and commercialization of ECC5004 for any indication in all territories except the Greater China, where we retained co-development and co-commercialization rights. The agreement includes a US$185 million upfront payment (which has been paid to us), and up to US$1.825 billion in development and commercial milestone payments (of which US$60 million has been paid to us), as well as high-single to mid-teens tiered royalties on annual net sales outside of Greater China, making it the largest licensing transaction in the oral GLP-1RA space globally in terms of upfront payment, according to Frost & Sullivan. By joining forces with AstraZeneca, we intend to accelerate the worldwide development of ECC5004 and promote broad patient access. Our development strategy is centered on maximizing the self-discovery and self-development of our pipeline drug candidates, leveraging our in-house R&D capabilities to advance our product candidates from discovery through clinical development. While self-development remains our primary focus, we also remain open to pursuing selective collaboration opportunities with global pharmaceutical companies, including in-licensing, out-licensing and co-development arrangements, where such partnerships are expected to accelerate development timelines, expand patient access, and enhance capital efficiency, while enabling us to retain regional rights. To date, we have not in-licensed any programs and, apart from ECC5004, have not out-licensed any programs.

## Our Approach

We aim to become a global leader in developing oral small molecule therapies targeting cardiometabolic diseases and inflammatory disorders. Addressing the high prevalence and overlap of obesity, T2D, MASH, and related conditions, we focus on "weight loss 2.0 solutions" that deliver superior weight loss, improved tolerability, minimized lean mass loss, and targeted comorbidity management through multiple mechanisms as illustrated in the diagram below. Our integrated pipeline includes oral small molecules with complementary mechanisms, such as ECC4703 (THR-β full agonist) and ECC0509 (SSAO inhibitor), which could be combined with GLP-1RA to enhance potential benefits. In addition, we also developed an oral small molecule GLP-1RA, ECC5004, as a monotherapy and a backbone that can be combined with other oral therapeutic agents.


*Source: Company*

Oral small molecules provide the following advantages: solutions potentially no food effect, the ability to engage targets that other modalities cannot easily reach, broad accessibility without cold-chain supply issues, co-formulation and combination therapy opportunities, and stronger adherence. We adopt both monotherapy and combination therapy approaches to fully realize the potential of GLP-1 based therapy.

### *Our Product Pipeline*

Our product development strategy is designed to deliver meaningful impact for broad patient populations while capturing strong commercial potential. This strategy is guided by four key principles: (i) we are dedicated to developing best-in-class or first-in-class oral medicines for cardiometabolic diseases and inflammatory disorders, including obesity/overweight, T2D, MASH, and associated comorbidities, where unmet medical needs and rising global prevalence create significant opportunities for impactful innovation; (ii) our pipeline emphasizes oral therapeutics to improve long-term patient adherence and accessibility, addressing the challenges of managing chronic conditions and supporting sustained treatment outcomes; (iii) we leverage our proprietary TRANDD workflow system to guide the development of target product profiles, ensuring that each asset is distinguished by differentiated efficacy, safety, and modality selection; and (iv) each of our programs is developed as both a monotherapy and in combination therapy, establishing a pipeline within a pipeline that supports treatment strategies to target multiple aspects of cardiometabolic diseases and inflammatory disorders, reflecting the strength of our programs designed to drive synergy, enable innovative combinations, and expand therapeutic opportunities. Based on the four key principles discussed above, we are advancing a competitive pipeline of clinical and preclinical assets.

The following pipeline chart provides an overview of our current programs as of the Latest Practicable Date.

| Program | Modality | Target | R&D Model | Lead Indications | Regimen | Preclinical | Phase I/Ib | Phase II/IIb | Phase III | Trial Sponsor | Trial Location | Current Status/Upcoming Milestones | Commercial Rights | Partner |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Clinical-stage Programs** | | | | | | | | | | | | | | |
| ★ **ECC4703**(1) | Oral small molecule | THR-β | Self-discovered and developed | MASH ▲ | Mono/ Combo with ECC0509 | | US (FDA) | | | ECCOGENE | U.S. | US Phase II initiation with first patient enrolled in Dec 2025; expected to complete in 2027 | Global | / |
| | | | | Obesity/ overweight ▲ | + GLP-1RA | | US (FDA)(2) | | | ECCOGENE | U.S. | US Phase II initiation with first patient enrolled in March 2026; expected to complete in 2027 | | |
| | | | | Metabolic diseases | Mono | | China (NMPA) | | | ECCOGENE | China | Completed Phase I China trial in healthy participants | | |
| ☆ **ECC5004** | Oral small molecule | GLP-1R | Collaboration(3) | T2D ▲ | Mono | | US (FDA), EU (EMA) | | | AstraZeneca | Global | Phase IIb trial (SOLSTICE); completed in December 2025, with data expected to be presented at a scientific congress in June 2026 | Co-commercial in Greater China | AstraZeneca(4) |
| | | | | Obesity/ overweight ▲ | Mono | | US (FDA), EU (EMA) | | | AstraZeneca | Global | Phase IIb trial (VISTA); completed in November 2025, with data expected to be presented at a scientific congress in June 2026 | | |
| | | | | | Mono | | China (NMPA)(5) | | | ECCOGENE | China | Phase Ib bridging trial in China completed in November 2025, with data expected to be presented at a scientific congress in June 2026 | | |
| ☆ **ECC0509** | Oral small molecule | SSAO (VAP-1) | Self-discovered and developed | OA pain ▲ | Mono | | US (FDA) | | | ECCOGENE | U.S. | US IND approved in Apr 2025; Phase II initiation in 2027 | Global | / |
| | | | | MASH ▲ | Mono/ Combo with ECC4703 | | US (FDA) | | | ECCOGENE | U.S. | US Phase II initiation with first patient enrolled in Dec 2025; expected to complete in 2027 | | |
| **Preclinical Programs** | | | | | | | | | | | | | | |
| **GIP Program** | Oral small molecule | GIPR | Self-discovered | Metabolic diseases | Mono/ Combo | | | | | ECCOGENE | / | IND submission by 2028 | Global | / |
| **Amylin Program** | Oral small molecule | AmylinR | Self-discovered | Metabolic diseases | Mono/ Combo | | | | | ECCOGENE | / | IND submission by 2028 | Global | / |
| **UPA Program** | Peptide | GLP-1R, GIPR, AmylinR | Self-discovered | Metabolic diseases | UPA | | | | | ECCOGENE | / | IND submission by 2028 | Global | / |

★ Core Product ☆ Key Product ▲ Lead Indication

*Notes:*

(1) ECC4703 has completed Phase I trials in China and the United States, with data from both reviewed by the FDA in connection with our IND submissions for Phase IIa trial of ECC4703 and ECC0509 for the treatment of MASH as monotherapy and in combination therapy in the U.S., as well as the Phase IIa trial of ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight in the U.S. The Phase IIa trial for the treatment of MASH includes six parallel treatment arms: placebo (QD); ECC4703 monotherapy (20 mg or 40 mg, QD); ECC0509 monotherapy (10 mg or 30 mg, QD); and ECC4703 40 mg plus ECC0509 30 mg combination therapy (QD), all arms are conducted under a single U.S. IND within the same Phase IIa trial pursuant to one protocol, and do not constitute separate clinical trials. We will continue to advance ECC4703 for MASH and obesity/overweight through Phase IIa and subsequent U.S. trials, subject to results and regulatory guidance.

(2) We have initiated Phase IIa trial of ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight.

(3) On November 8, 2023, we entered into the AstraZeneca Agreement, under which we granted AstraZeneca exclusive rights to develop and commercialize ECC5004 for any indication in all territories except Greater China, where we retained the right to co-develop and co-commercialize ECC5004. **We have the final decision-making power with respect to the research and development activities of ECC5004 in Greater China subject to limited exceptions, while AstraZeneca has the final decision-making power with respect to the research and development activities of ECC5004 in all other territories in the world.** See "Business — Our Collaboration and Licensing Agreement" for more details.

(4) ECC5004 may be developed with AstraZeneca's SGLT2 inhibitor and oral PCSK9 inhibitor in the future. For the avoidance of doubt, such development is not currently specified or mandated under the AstraZeneca Agreement.

(5) This Phase Ib bridging trial in China was completed in November 2025, with topline results announced in February 2026, and Phase Ib data to be presented at a scientific congress in June 2026, which may support Phase III MRCT program with inclusion of investigational sites in China (subject to final clinical results and regulatory approval).

*Our R&D Workflow System*

We have self-developed our proprietary TRANDD workflow system, focused on guiding decision-making and prioritization across key elements of preclinical and clinical development programs targeting cardiometabolic diseases and inflammatory disorders. Our TRANDD workflow system was developed internally by our R&D team to facilitate decision making during drug discovery and development. These include determining whether and how a product candidate will benefit patients; identifying how the compound will differentiate from existing and emerging therapies and establishing the development path to achieve a clinical meaningful and competitive product profile. To meet these objectives, our R&D team designed the workflow system to facilitate the designation of a target product profile ("**TPP**") at the outset of each program, create customized assays aligned to that TPP, and formulate and implement a governance process to support evidence-based decision-making based on our internal data and analysis of publicly available information. For clarity, the discovery and development of the TRANDD workflow system was conducted solely by our R&D team, with guidance from our management, without contributions from any third-party contributions except for the use of publicly available research and data.

Our TRANDD workflow system takes a disciplined approach to building differentiated therapies. We select targets with strong translational relevance in cardiometabolic diseases, refining target product profiles using translational insights and real-world evidence. We prioritize chemical scaffolds with optimal drug-like properties while pursuing novel indications through mechanism-based reasoning and biomarkers. Our clinical trials incorporate biomarker endpoints to test proof-of-mechanism and differentiation, enabling biomarker-driven patient stratification strategies that support target engagement, de-risk translation, and inform go/no-go decisions. See "— Our Workflow System " below for more details on the design and capabilities of our TRANDD workflow system. As of the Latest Practicable Date, we had not obtained any patents for our TRANDD workflow system, but we had registered the TRANDD trademark in Switzerland, an U.S. trademark application and a PRC trademark application were in process.

Beyond our TRANDD workflow system, our medicinal chemistry capabilities focus on rationally designing drug molecules optimized for potency, selectivity, safety, pharmacokinetics, and manufacturability suitable for long-term use in broad populations. Leveraging these combined strengths, we have advanced an integrated pipeline of therapeutics for cardiometabolic diseases and inflammatory disorders, including three quality clinical programs with differentiated profiles that address unmet medical needs.

## OUR STRENGTHS

### A Clinical-Stage Biotech Company Advancing the Next-Generation Oral Small Molecule Solutions for Cardiometabolic Diseases and Inflammatory Disorders

We are advancing an integrated pipeline of next-generation oral small molecules targeting cardiometabolic diseases and inflammatory disorders, including obesity/overweight, T2D, MASH and their associated comorbidities. Within just four years of beginning our oral small molecule programs, we have advanced three drug candidates into clinical development, reflecting our rapid innovation and execution capabilities supported by our TRANDD workflow system and strong medicinal chemistry expertise.

GLP-1 based therapies, particularly GLP-1RAs, have transformed T2D and obesity/overweight and are rapidly evolving from monotherapy to combinations with complementary mechanisms, expanding into broader cardiometabolic disease. The GLP-1 based therapy market increased from US$13.2 billion in 2020 to US$72.1 billion in 2024 and is expected to US$246.5 billion in 2029 and US$415.8 billion by 2034. The existing approved GLP-1RAs face a number of limitations, including usage and handling requirements, and cold-chain logistics limiting uptake and adherence. Within oral options, small molecules offer distinct advantages over peptides, such as higher bioavailability, no strict food-related dosing constraints, less supply chain

constraints, and easier co-formulation. Oral GLP-1RAs are poised to capture over 30% of the market by 2034 compared to approximately 6% in 2024, according to Frost & Sullivan, positioning ECC5004 to capitalize on this shift and support future oral combination regimens across cardiometabolic diseases.

We believe we are well positioned in this vast and fast-growing market, led by our advanced oral small molecule GLP-1RA, ECC5004, which as of the Latest Practicable Date is expected to be potentially best-in-class and second to global market, according to Frost & Sullivan. Our careful selection of a superior chemical scaffold through our TRANDD workflow system has resulted in a molecule with good drug-like properties. Through our vision, technical strength, and strategic partnerships, we are developing oral small molecule solutions to potentially address the evolving needs of patients with cardiometabolic diseases and inflammatory disorders worldwide.

**A Competitive Pipeline for Mono and Combination Therapies to Enhance Potential Benefits of GLP-1 Based Therapy**

With extensive expertise in disease biology and translational research, we have built a robust and diverse pipeline, including both clinical and preclinical assets. In addition to developing monotherapies, we are dedicated to creating innovative combination therapies to address the complex nature of cardiometabolic diseases and inflammatory disorders and deliver meaningful outcomes for patients worldwide. To date, we have successfully discovered and developed three clinical-stage oral small molecule assets, namely, ECC4703, ECC5004 and ECC0509, each designed to address key unmet needs in cardiometabolic diseases and/or inflammatory disorders, and each with significant potential for use in combination regimens.

- ***ECC4703: Our Core Product, oral small molecule THR-β full agonist with potential to be best-in-class and second to global market for MASH and first-in-class for obesity/overweight.*** ECC4703 is our Core Product, a self-discovered and independently developed oral small molecule liver-targeting, selective THR-β full agonist. Unlike partial THR-β agonists which demonstrate only moderate effects on lipid lowering, hepatic fat reduction and fibrosis improvement, ECC4703 is a THR-β full agonist. This confers enhanced pharmacological potency, supporting potentially greater efficacy in reducing circulating atherogenic lipids and improving hepatic steatosis, inflammation, and fibrosis in MASH. According to Frost & Sullivan, ECC4703 has the potential to become best-in-class and second-to-global market for MASH and first-in-class for obesity/overweight. In the completed Phase I trial of ECC4703 as a monotherapy in healthy volunteers and participants with treatment-unnecessary LDL-C under 160 mg/dL in the United States, it has shown robust pharmacodynamic changes, including a 30% to 45% placebo-adjusted reduction in LDL-C, at 40 mg and 80 mg doses, substantially outperforming other agents in its class, including Rezdiffra, VK2809 (Phase IIb dose), and Tern-501, which achieved only 15-27%, based on reported data and not head-to-head trial results, according to Frost & Sullivan. In the same Phase I trial, ECC4703 has shown a favorable safety and tolerability profile, with no Grade ≥3 treatment-related adverse events ("**TRAE**"), limited gastrointestinal or cardiac side effects, and no pruritus, supporting its suitability for combination use. We obtained the IND approval for Phase IIa trial of ECC4703 and ECC0509 for the treatment of MASH as monotherapy and in combination therapy from the FDA in October 2025. We initiated the trial in December 2025. Additionally, ECC4703 can be combined with GLP-1RAs for obesity/overweight, where preclinical models have shown greater weight loss than GLP-1RAs alone, driven primarily by fat mass reduction with minimized lean mass loss. We have submitted the IND application to the FDA for Phase IIa trial of ECC4703 as an adjunct to GLP-1RA for the treatment of obesity/overweight in December 2025 and received the IND approval from the FDA in January 2026. Subsequently, we have initiated the trial in March 2026.

- ***ECC5004, Our Key Product, highly differentiated oral small molecule GLP-1RA with best-in-class and second to global market potential.*** ECC5004 represents a differentiated oral small molecule GLP-1RA with the potential to set a new standard in its class. ECC5004's pharmacokinetic profile is optimized for convenient, once-daily dosing, with an extended half-life that supports this regimen and no clinically meaningful food effect, as demonstrated in its Phase I trial, allowing administration with or without regard to meals. See "— Our Pipeline — ECC5004, Our Key Product — Summary of Clinical Trials — Completed Phase I First-in-Human Trial of ECC5004 as Monotherapy in Healthy Participants and in Patients with T2D in the United States" for more details.

  ECC5004's small molecule modality enables flexible co-formulation with other oral agents, such as SGLT2 inhibitors and oral PCSK9 inhibitors. Additionally, ECC5004's oral route of administration eliminates the need for injections and offers greater patient convenience, adherence and access.

  According to Frost & Sullivan, the current scaffold types for oral GLP-1RAs can be generally categorized into two classes, Scaffold A and Scaffold B. ECC5004 belongs Scaffold A class of oral GLP-1RAs, which is more amenable to the design and creation of drug molecules with favorable safety profile and good drug-like properties, offering a lower risk of toxicity issues compared to Scaffold B, according to Frost & Sullivan. In contrast, compounds from Scaffold B class, such as Danuglipron and Lotiglipron, were discontinued due to liver-related safety concerns, in April 2025, and June 2023, respectively.

  Pursuant to the AstraZeneca Agreement, we granted AstraZeneca the global rights (excluding Greater China) to develop and commercialize ECC5004. We retained the right of co-development and co-commercialization in Greater China. See "Business — Our Collaboration and Licensing Agreement" for more details. ECC5004 has completed two global IIb trials in T2D and in obesity/overweight, with data readout expected around June 2026.

- ***ECC0509: Our Key Product, an oral inhibitor of SSAO with first-in-class potential.*** ECC0509 is an oral small molecule SSAO inhibitor with first-in-class potential for OA pain, according to Frost & Sullivan. It has demonstrated dose-dependent pain relief in OA models and robust pharmacodynamic effects in humans, including sustained SSAO inhibition and methylamine accumulation. ECC0509's versatile combination potential is being explored in MASH in combination with ECC4703 to address both metabolic and inflammatory drivers of disease, and ECC0509 could treat OA pain as monotherapy or in combination with GLP-1RA for enhanced efficacy in patients with obesity/overweight with joint pain.

Our clinical development strategy emphasizes phase-appropriate evaluation of combination potential. By leveraging the complementary mechanisms of our assets, we aim to address the complex biology underlying cardiometabolic diseases and inflammatory disorders. Key potential combination regimens include:

- ***THR-β agonist (ECC4703) + SSAO inhibitor (ECC0509) for MASH***. This combination aims to address both the metabolic and fibrotic components of MASH. ECC4703, a THR-β full agonist, targets hepatic lipid metabolism and fibrosis, while ECC0509, an SSAO inhibitor, targets inflammation and fibrosis. The combination is designed to unite complementary mechanisms — THR-β-driven reductions in hepatic steatosis and atherogenic lipids with ECC0509's inhibition of SSAO-mediated leukocyte trafficking and oxidative injury — to target the inflammation-fibrosis axis that persists despite metabolic correction;

- ***THR-β agonist (ECC4703) + GLP-1RA for obesity/overweight***. Combining a THR-β agonist with a GLP-1RA leverages complementary mechanisms to potentially deliver better weight loss. ECC4703 is aimed at fat mass reduction and improvement of lipid metabolism, while GLP-1RA act via appetite suppression and delayed gastric emptying, leading to improved glycemic control and sustained weight loss. Preclinical data suggest this combination may result in greater weight loss, minimized lean mass loss and improved metabolic parameters than GLP-1RA monotherapy alone, addressing the complex needs of patients with cardiometabolic diseases;

- ***SSAO inhibitor (ECC0509) + GLP-1RA for OA pain***. ECC0509, as an SSAO inhibitor, has demonstrated efficacy in reducing OA pain in preclinical models. A GLP-1RA has shown benefits for the treatment of OA pain. The combination of SSAO inhibitor (ECC0509) with GLP-1RA may provide synergistic effects, offering enhanced pain relief, particularly in patients with obesity or are overweight with joint pain; and

- ***GLP-1RA (ECC5004) in combination with SGLT2 inhibitor or oral PCSK9 inhibitor***. ECC5004 has the potential to be combined with other oral therapies such as SGLT2 inhibitors and PCSK9 inhibitors. This approach targets glycemic control, weight management and lipid lowering, addressing a broader spectrum of cardiometabolic risk factors. In partnership with AstraZeneca, we aim to develop combination regimens that can be tailored to individual patient profiles, potentially improving outcomes and expanding the therapeutic reach of oral GLP-1RA based treatments.

Beyond our clinical-stage assets, we have developed a competitive pipeline of preclinical programs, including oral small molecule GIPR modulator, Amylin receptor agonist and peptide UPA.

**An Innovative R&D Powerhouse Anchored by Deep Expertise in Translational Research and Proven Execution Capabilities**

Our TRANDD workflow system sits at the core of our discovery and development efforts, linking target biology with clinical translation. Drawing on our expertise in translational medicine and cardiometabolic biology, this workflow system enabled us to conceive, design, and progress three key assets within four years, providing compelling proof of the system's productivity. Our TRANDD workflow system integrates a comprehensive set of translational research capabilities built on core strengths in the following:

- ***Target selection and validation.*** We prioritize mechanisms with strong human genetic evidence or clinical precedent, such as GLP-1 receptor and THR-β, which have already demonstrated therapeutic utility in cardiometabolic diseases and inflammatory disorders. By grounding our discovery decisions in targets that possess clear, translatable biology, we lower scientific risk while retaining ample room for pharmacological differentiation.

- ***Refinement and development of TPP.*** We view the disciplined determination and refinement of TPP as equally important. At the inception of programs, cross-functional teams benchmark the current standard of care, quantify unmet medical needs, and integrate physician, payer and regulatory insights to define clinical and commercial objectives. These TPPs provide pragmatic guidance for medicine-chemistry optimization, non-clinical strategy and early-phase design.

- ***Analysis and prioritization of chemical scaffold.*** Our translational understanding allows us to compare different chemical scaffolds and select those with optimal drug-like properties and potential to achieve desirable product profiles. For oral small molecule GLP-1RA program, we deliberately selected a chemical scaffold that is more amenable to the design and creation of drug molecules with a favorable safety profile and drug-like properties, offering a lower risk of toxicity issues.

- ***Novel indication selection.*** Our indication selection is grounded in deep understanding of disease biology and mechanistic relevance, leveraging preclinical models to generate therapeutic hypotheses with focus on translation to human diseases, which inform our clinical trial design and indication expansion strategy. For example, the combination of GLP-1RA and THR-β full agonist (ECC4703) has demonstrated profound additional weight loss and muscle-sparing effects compared to GLP-1RA monotherapies in animal models, informing an important therapeutic opportunity for obesity/overweight and supporting our clinical trial design and indication expansion strategy.

- ***Design of early clinical trials.*** We design adaptive, biomarker-enriched protocols that generate quality pharmacokinetic and pharmacodynamic data, including dose-ranging insights for later-phase trials. Developed in collaboration with biostatisticians and in accordance with GCP, our approach integrates preclinical insights into clinical trial design, enabling seamless bench-to-bedside transition. Coupled with rapid go/no-go decision points, this supports efficient resource allocation while maintaining scientific rigor.

- ***Determination of biomarkers and patient stratification.*** For each asset, we prospectively nominate translational biomarkers — such as body weight, glucose, and LDL-C — that confirm target engagement, elucidate mechanisms in humans, and serve as predictors of downstream clinical benefit. These readouts provide early proof-of-concept, refine patient selection strategies, and increase confidence that later-phase trials are designed for improved likelihood of success, ultimately helping to shorten the path to pivotal studies. In addition, our translational research enables us to pinpoint patient subgroups most likely to benefit from specific mechanisms of action.

Additionally, the intellectual property rights generated from the various programs supported by our TRANDD workflow system and medicinal chemistry expertise are protected. Our Core Product, ECC4703, and Key Products, ECC5004 and ECC0509, are protected by issued patents whose terms extend to 2040 and beyond, covering the United States, China and other major markets.

**Strategic Global Partnership to Advance Development and Commercialization Efforts**

In November 2023, we entered into the AstraZeneca Agreement for our internally developed oral small molecule GLP-1RA, ECC5004. This collaboration represents a major validation of our TRANDD workflow system and highlights the significant potential of ECC5004 to treat obesity/overweight and related cardiometabolic diseases. Under the agreement, we granted AstraZeneca exclusive global rights to develop and commercialize ECC5004, except in the Greater China (including mainland China, Hong Kong, Macau and Taiwan). In Greater China, we retain co-development and co-commercialization rights. This structure in Greater China provides us with the opportunity to participate directly in the development and commercialization of ECC5004. The agreement includes a US$185 million upfront payment and up to US$1.825 billion in development and commercial milestone payments, making it the largest licensing transaction in the oral GLP-1RA space globally by upfront payment, according to Frost & Sullivan. We are eligible to receive tiered royalties of high-single to mid-teens percentage of annual net sales outside of Greater China. To date, we have received the US$185 million upfront payment and US$60 million in milestone payments from AstraZeneca. We also entered into a side letter with AstraZeneca in March 2026, pursuant to which AstraZeneca will provide a total credit of $75 million toward our share of development expenses for a global Phase III MRCT program of ECC5004, starting in the third quarter of 2026.

Since inception of our partnership, two global Phase IIb trials (VISTA for obesity/overweight and SOLSTICE for T2D) have been completed. In China, we were sole sponsor of the completed Phase Ib bridging trial and plan to participate in the global Phase III trial as part of a MRCT program, supporting regulatory alignment with Chinese authorities and facilitating integration of China-specific data into the global development program. This strategy allows comprehensive evaluation of ECC5004 across diverse populations and supports potential regulatory submissions in both China and other major markets.

### Experienced Management with Deep Scientific Expertise and Industry Insight

We are built on a foundation of experienced founders and propelled by a seasoned executive management team. Our leadership brings a combination of scientific excellence, entrepreneurial execution, and global development insight, empowering us to advance meaningful oral small molecule therapies for cardiometabolic and inflammatory disorders. Our management team is led by:

Our co-founder and CEO, Dr. Jingye Zhou, a distinguished scientist and biotech entrepreneur with deep expertise in translational research and small molecule drug discovery. Prior to founding the Company, Dr. Zhou served as the Head of Chemistry at Eli Lilly's China R&D Center, where he led project teams to identify clinical candidates for the treatment of diabetes and its complications. Under his leadership, Eccogene has built an integrated pipeline of cardiometabolic candidates;

Our scientific research is led by co-founder and CSO, Dr. Jianfeng Xu, who has extensive experience in metabolic disease biology and translational research. Dr. Xu has played a central role in the discovery and development of our three clinical stage assets;

Our clinical development is overseen by our CMO, Dr. Jaikrishna Patel, a seasoned clinical leader with deep expertise in global drug development. Dr. Patel is responsible for the design and execution of our clinical programs, ensuring scientific rigor and regulatory alignment across all stages of development; and

Our financial and strategic planning efforts are led by our CFO, Mr. Ting Xiao, chartered financial analyst, a partner and founding member of Delos Capital with extensive experience in life sciences advisory and investments. Mr. Xiao oversees our financial strategy and capital planning, ensuring strong fiscal discipline and alignment with our long-term growth objectives.

Our management team is supported by a research and development organization, which included 15 Ph.D. and M.D. holders as of December 31, 2025, with great expertise spanning discovery biology, medicinal chemistry, CMC, non-clinical development, clinical operations and regulatory affairs. This breadth of talent enables us to maintain a wide range of capabilities from early research through clinical development. In addition, we have also established a distinguished Scientific Advisory Board and a Liver Disease Advisory Board, composed of leading experts in cardiometabolic and liver diseases. These boards provide critical guidance on translational research and clinical development across our pipeline programs. In addition, we regularly engage with KOLs and external experts to further strengthen our strategy and decision-making, supporting continued progress in scientific and clinical innovation.

## OUR STRATEGIES

### Strategically Advance Our Pipeline Programs and Capture Market Opportunities via Indication Expansion and Combination Therapies

We are actively investing in innovative therapeutics designed to expand treatment options and further improve clinical outcomes. At the heart of our strategy, each of our assets is versatile and designed for monotherapy and/or combination therapy, we aim to deliver more effective, durable solutions for patients with complex, overlapping conditions. Following this strategy, our competitive pipeline includes three clinical-stage programs and three preclinical assets, all designed to address cardiometabolic diseases and inflammatory disorders through differentiated mechanisms. Each program is purpose-built to deliver superior outcomes with optionality for monotherapy and/or combination therapies that address the needs of diverse patient populations. Our agile clinical execution enables customized development strategies for each molecule, maximizing therapeutic impact and accelerating our path to leadership in next-generation oral small molecule therapeutics. For ECC4703, we initiated the Phase IIa trial of ECC4703 as a monotherapy and in combination with ECC0509 for MASH in December 2025. We also believe ECC4703 can be combined with GLP-1RAs. We have submitted the IND application to the FDA for Phase IIa trial of ECC4703 as

an adjunct to GLP-1RA for the treatment of obesity/overweight in December 2025, with IND approval from the FDA in January 2026, we have initiated the trial in March 2026. For ECC5004, we believe it has the potential to serve as a monotherapy and a backbone therapy for combination regimens, including those with SGLT2 inhibitors and oral PCSK9 inhibitors. For ECC0509, we initiated the Phase IIa trial of the ECC0509 in combination with ECC4703 as discussed above, and plan to conduct a Phase II trial as a monotherapy for OA pain in 2027.

For our small molecule GIPR modulator, which is currently in preclinical development, we are strategically exploring its use in combination with other weight loss agents for the treatment of obesity/overweight and its associated comorbidities. In parallel, our Amylin receptor agonist program is currently in preclinical development and has the potential to be used both as a monotherapy and in combination regimens. Building on this foundation, our preclinical UPA program is advancing a peptide agonist that is aiming to deliver durable weight loss and cardiometabolic benefits as a single molecule.

We intend to develop these assets to broaden our therapeutic reach and explore combination therapies, leveraging our translational research expertise to continuously deliver innovative therapies.

**Continue to Strengthen Our Proprietary TRANDD Workflow System and Enhance Our R&D Capabilities**

We believe next-generation oral therapeutics have the potential to redefine the treatment landscape for cardiometabolic and inflammatory disorders. We are committed to advancing our proprietary TRANDD workflow system and strengthening our R&D capabilities. The TRANDD workflow system was developed solely by our R&D team, with guidance from our management, without any third-party contributions except for the use of publicly available research and data.

We aim to advance our pipeline through measured, data-informed execution by leveraging our TRANDD workflow system. We will continue to draw on our experience in cardiometabolic and inflammatory biology to prioritize mechanism with patient evidence and clinical relevance, grounding our programs in translational principles. Building on our approach to animal models and assay selection, we plan to invest in translational research to support steady progression from preclinical studies to early clinical evaluation and to enable more timely decision-making. In medicinal chemistry, we will continue to refine oral small molecule and UPA programs for potency, selectivity, safety and manufacturability. We also plan to incorporate technology tools, including biomarker analytics, to support our discovery and development efforts. While our primary focus remains cardiometabolic disease, we will evaluate adjacent opportunities in cardiovascular and immunological disorders where the underlying biology may be applicable. We will also continue to develop and protect our intellectual property, seeking appropriate patent coverage for our drug candidates to support our portfolio over time. Through these initiatives, we aim to further strengthen our TRANDD workflow system, enhance our R&D capabilities, and expand the reach of our innovative therapies, ultimately disrupting the current treatment paradigm and delivering meaningful benefits to patients worldwide.

**Maximize the Value of Our Assets Through Accretive Partnerships**

We have established a proven track record of forging successful global partnership. Building on this foundation, we will continue to pursue value-accretive collaborations worldwide to accelerate clinical development and enable earlier market entry for our next-generation therapeutics, with the goal of delivering innovative treatments to patients globally more rapidly and efficiently. In parallel, we remain committed to leveraging our internally built TRANDD workflow system to developing our in-house pipeline.

We apply a resource-optimization lens when considering any third-party collaborations, prioritizing partnerships that could help accelerate development timelines, expand patient reach, and enhance capital efficiency. Our primary focus is on engaging with partners whose strengths complement our own, enabling us to leverage their expertise and infrastructure to optimize

development strategies, accelerate worldwide development, and expand patient access globally. Our strategic collaboration reflects this approach, targeting broader market access, particularly in large-population geographies outside of China, thereby enhancing patient access and expanding our global reach, while enhancing the overall realization of our assets through broader reach and operational leverage. We may retain regional rights, and partner with global pharmaceutical companies to capitalize on their established presence and accelerate our commercial scale-up in the region. This partnership-driven model enables us to rapidly build a meaningful commercial footprint efficiently, while maintaining strategic flexibility and focusing on delivering innovative oral therapies to patients at scale. However, we are disciplined in our selection process. To date, we have not in-licensed any programs and, apart from ECC5004, have not out-licensed any programs.

**Attract, Train and Retain Talents Across Regions to Drive Global Innovation**

Since our inception, we have built a globally integrated organization with offices in the United States and China, enabling our team to collaborate across geographies throughout the drug development continuum — from early discovery and preclinical research to clinical trial design and execution. By integrating capabilities and leveraging regional strengths, we accelerate development and generate quality data to support the development of our innovative therapies globally. We will continue to attract, develop, and retain talent across discovery, translational medicine, non-clinical development, and regulatory affairs to sustain our competitive position and advance next-generation therapies for cardiometabolic diseases and inflammatory disorders.

## OUR PIPELINE

Since our inception, we have executed our research and development programs with precision, harnessing the TRANDD workflow system to build an integrated pipeline of three clinical-stage assets and three preclinical programs.

The following pipeline chart summarizes the development status of these candidates and preclinical programs as of the Latest Practicable Date:

| Program | Modality | Target | R&D Model | Lead Indications | Regimen | Preclinical | Phase I/Ib | Phase II/IIb | Phase III | Trial Sponsor | Trial Location | Current Status/Upcoming Milestones | Commercial Rights | Partner |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Clinical-stage Programs** | | | | | | | | | | | | | | |
| ★ **ECC4703**(1) | Oral small molecule | THR-β | Self-discovered and developed | MASH ▲ | Mono/ Combo with ECC0509 | | US (FDA) | | | ECCOGENE | U.S. | US Phase II initiation with first patient enrolled in Dec 2025; expected to complete in 2027 | Global | / |
| | | | | Obesity/ overweight ▲ | + GLP-1RA | | US (FDA)(2) | | | ECCOGENE | U.S. | US Phase II initiation with first patient enrolled in March 2026; expected to complete in 2027 | | |
| | | | | Metabolic diseases | Mono | | China (NMPA) | | | ECCOGENE | China | Completed Phase I China trial in healthy participants | | |
| ☆ **ECC5004** | Oral small molecule | GLP-1R | Collaboration(3) | T2D ▲ | Mono | | US (FDA), EU (EMA) | | | AstraZeneca | Global | Phase IIb trial (SOLSTICE); completed in December 2025, with data expected to be presented at a scientific congress in June 2026 | Co-commercial in Greater China | AstraZeneca(4) |
| | | | | Obesity/ overweight ▲ | Mono | | US (FDA), EU (EMA) | | | AstraZeneca | Global | Phase IIb trial (VISTA); completed in November 2025, with data expected to be presented at a scientific congress in June 2026 | | |
| | | | | | Mono | | China (NMPA)(5) | | | ECCOGENE | China | Phase Ib bridging trial in China completed in November 2025, with data expected to be presented at a scientific congress in June 2026 | | |
| ☆ **ECC0509** | Oral small molecule | SSAO (VAP-1) | Self-discovered and developed | OA pain ▲ | Mono | | US (FDA) | | | ECCOGENE | U.S. | US IND approved in Apr 2025; Phase II initiation in 2027 | Global | / |
| | | | | MASH ▲ | Mono/ Combo with ECC4703 | | US (FDA) | | | ECCOGENE | U.S. | US Phase II initiation with first patient enrolled in Dec 2025; expected to complete in 2027 | | |
| **Preclinical Programs** | | | | | | | | | | | | | | |
| **GIP Program** | Oral small molecule | GIPR | Self-discovered | Metabolic diseases | Mono/ Combo | | | | | ECCOGENE | / | IND submission by 2028 | Global | / |
| **Amylin Program** | Oral small molecule | AmylinR | Self-discovered | Metabolic diseases | Mono/ Combo | | | | | ECCOGENE | / | IND submission by 2028 | Global | / |
| **UPA Program** | Peptide | GLP-1R, GIPR, AmylinR | Self-discovered | Metabolic diseases | UPA | | | | | ECCOGENE | / | IND submission by 2028 | Global | / |

★ Core Product ☆ Key Product ▲ Lead Indication

*Notes:*

(1) ECC4703 has completed Phase I trials in China and the United States, with data from both reviewed by the FDA in connection with our IND submissions for Phase IIa trial of ECC4703 and ECC0509 for the treatment of MASH as monotherapy and in combination therapy in the U.S., as well as the Phase IIa trial of ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight in the U.S. The Phase IIa trial for the treatment of MASH includes six parallel treatment arms: placebo (QD); ECC4703 monotherapy (20 mg or 40 mg, QD); ECC0509 monotherapy (10 mg or 30 mg, QD); and ECC4703 40 mg plus ECC0509 30 mg combination therapy (QD), all arms are conducted under a single U.S. IND within the same Phase IIa trial pursuant to one protocol, and do not constitute separate clinical trials. We will continue to advance ECC4703 for MASH and obesity/overweight through Phase IIa and subsequent U.S. trials, subject to results and regulatory guidance.

(2) We have initiated Phase IIa trial of ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight, not ECC5004.

(3) On November 8, 2023, we entered into the AstraZeneca Agreement, under which we granted AstraZeneca exclusive rights to develop and commercialize ECC5004 for any indication in all territories except Greater China, where we retained the right to co-develop and co-commercialize ECC5004. **We have the final decision-making power with respect to the research and development activities of ECC5004 in Greater China with certain exceptions, while AstraZeneca has the final decision-making power with respect to the research and development activities of ECC5004 in all other territories in the world.** See "Business — Our Collaboration and Licensing Agreement" for more details.

(4) ECC5004 may be developed with AstraZeneca's SGLT2 inhibitor and oral PCSK9 inhibitor in the future. For the avoidance of doubt, such development is not currently specified or mandated under the AstraZeneca Agreement and remains subject to further discussion and mutual agreement between the parties.

(5) This Phase Ib bridging trial in China was completed in November 2025, with topline results announced in February 2026, and Phase Ib data to be presented at a scientific congress in June 2026, which may support Phase III MRCT program with inclusion of investigational sites in China (subject to final clinical results and regulatory approval).

## ECC4703, our Core Product

### *Overview*

ECC4703, our Core Product, is a our self-discovered and independently developed liver targeting, oral small-molecule THR-β full agonist in development for MASH and obesity/overweight, with potential expansion into other metabolic diseases. THR-β is predominantly expressed in the liver, where its activation lowers lipids without the cardiac or skeletal safety liabilities associated with extrahepatic THR-α activation. It remains one of the few mechanisms with strong human validation in MASH. As a THR-β full agonist, ECC4703 is expected to achieve more consistent and pronounced reductions in hepatic fat, circulating atherogenic lipids, and liver fibrosis compared to partial agonists. In the Phase I trial in healthy volunteers and participants with treatment-unnecessary LDL-C under 160 mg/dL in the United States, ECC4703 showed a favorable safety and tolerability profile, a pharmacokinetic profile compatible with once-daily dosing, and biomarker changes consistent with robust target engagement and clinically relevant decreases in circulating atherogenic lipids.

As of the Latest Practicable Date, we had completed two Phase I clinical trials of ECC4703, including one trial conducted in the U.S. and one trial conducted in China. We are also conducting two Phase IIa clinical trials in the U.S. to evaluate ECC4703 for the treatment of MASH and obesity/overweight, respectively.

### *Drug Design and Mechanism of Action*

ECC4703 is our self-discovered and independently developed, liver-targeted, selective THR-β full agonist, designed through our TRANDD workflow system to maximize the therapeutically relevant thyroid hormone receptor signaling in the liver while limiting activation in non-liver tissues. See "Our Workflow System — Translational Research-Aided Drug Discovery and Development Workflow System" for more details. The program was initiated in July 2018 with the goal of identifying a molecule with full THR-β agonism, high THR-β/THR-α selectivity, and liver-preferential exposure. Through our internal R&D efforts, we identified the ECC4703 molecule in December 2019, and in October 2021 nominated it as our preclinical candidate after it had met our internal criteria for advancement into IND-enabling preclinical development. We completed the IND-enabling package, comprising the requisite preclinical pharmacology, pharmacokinetic, and other supporting studies and documentation for the first-inhuman trial, in June 2022. Since completing the IND-enabling package, we have continued to advance ECC4703 through our own development activities and have publicly presented data relating to ECC4703 at a number of scientific conferences, including a pre-clinical study of ECC4703 for MASH at the European Association for the Study of the Liver ("**EASL**") meeting in June 2022, Phase I results of ECC4703 in the United States at the American Association for the Study of Liver Diseases ("**AASLD**") meeting in November 2024, a pre-clinical study of ECC4703 in combination with Semaglutide or Tirzepatide for obesity/overweight at the American Diabetes Association meeting in June 2025, and a pre-clinical study of ECC4703 in combination with ECC0509 or Semaglutide for MASH at the AASLD meeting in November 2025.

Its discovery and development have been led by Dr. Zhou, together with our CSO, Dr. Xu, and our CMO, Dr. Patel, whose prior experience in drug discovery, translational science and clinical development has informed the design and advancement of the program. The design of ECC4703 focused not only on the biological role of THR-β, but also on optimizing the molecular and pharmacokinetic properties of the compound itself. We believe ECC4703 incorporates three key design features that collectively underpin its pharmacological profile: (i) full agonist activity at THR-β, (ii) receptor subtype selectivity, and (iii) liver-preferential exposure.

- **Full agonist activity to induce a robust and durable hepatic pharmacodynamic response.**

  ECC4703 is designed to function as a full agonist at THR-β in hepatocytes, thereby activating liver-selective transcriptional programs involved in lipid utilization, fatty acid oxidation and lipoprotein metabolism. Full receptor activation is mechanistically important: unlike partial agonists, which occupy the receptor but elicit a submaximal transcriptional response, a full agonist drives complete conformational change of the receptor, enabling recruitment of the full complement of co-activator complexes and robust downstream gene expression. In preclinical head-to-head studies, ECC4703

achieved an 80% response at the highest dose level compared to 32% for Resmetirom, an FDA-approved THR-β partial agonist for MASH. Consistent with this profile, in the Phase I trial, ECC4703 demonstrated robust, placebo-adjusted pharmacodynamic effects after 14 days of once-daily dosing, including a significant increase in sex hormone binding globulin ("**SHBG**"), a sensitive hepatic biomarker of THR-β engagement, and a robust reduction LDL-C, confirming meaningful target engagement in humans. This full agonist profile, together with liver-directed exposure, may support a stronger pharmacodynamic effect in the liver than compounds with lower potency, partial efficacy or less favorable tissue selectivity. This may support reductions in liver fat and improvements in metabolic dysfunction and MASH disease activity.

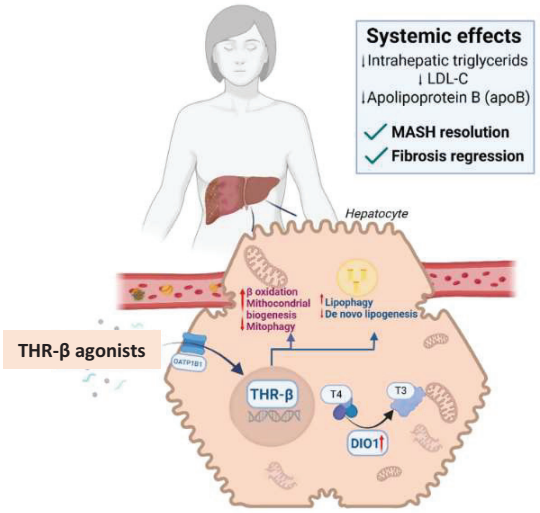
- **Receptor subtype selectivity to prioritize THR-β activation.**

  THR-α and THR-β have highly similar ligand-binding pockets, making receptor subtype selectivity difficult to achieve. THR-α is broadly expressed in the heart, bone, and skeletal muscle, and its activation is associated with adverse effects including tachycardia, cardiac arrhythmia, bone loss, and muscle wasting, which is the principal safety liabilities that have historically limited the therapeutic utility of non-selective thyroid hormone receptor agonists. THR-β, by contrast, is predominantly expressed in the liver, making it the therapeutically relevant isoform for hepatic metabolic diseases such as MASH and dyslipidemia. ECC4703 was identified from a large number of compounds through iterative structure-activity relationship optimization based on our internal know-how. In this process, we applied both THR-α and THR-β transcriptional activation assays to identify compounds that combined strong THR-β activation, low THR-α activity and full agonist efficacy. This design enables ECC4703 to retain potent activity at the intended receptor while reducing the likelihood of undesired pharmacology associated with less selective compounds.

- **Liver-preferential exposure to support efficacy in the target organ while limiting extrahepatic activity.**

  Because thyroid hormone receptors are broadly distributed across tissues, receptor selectivity alone may not be sufficient to optimize therapeutic performance. ECC4703 was therefore further designed with balanced physicochemical and pharmacokinetic properties intended to favor liver exposure over extrahepatic distribution. In selecting ECC4703, we optimized parameters including lipophilicity ("**LogP**"), pKa, membrane permeability, transporter-mediated uptake and drug metabolism and pharmacokinetic, or DMPK, characteristics because these properties are key determinants of tissue distribution, hepatocyte access and duration of exposure. Balancing these parameters is important to achieving preferential liver exposure, sufficient intracellular activity in hepatocytes and limited exposure in extrahepatic tissues. In turn, this optimization is intended to enhance efficacy-relevant THR-β signaling in the liver while reducing the risk of adverse effects associated with thyroid hormone receptor activation outside the liver. This liver-preferential distribution profile is intended to enhance efficacy-relevant THR-β signaling in the liver while reducing the risk of adverse effects associated with thyroid hormone receptor activation in non-target tissues. Importantly, ECC4703 is designed not to form reactive metabolic intermediates, further supporting its safety and tolerability profile.

The differentiated profile of ECC4703 arises from the coordinated optimization of all three design features, i.e. full agonist efficacy, receptor subtype selectivity, and liver-preferential pharmacokinetics, rather than from any single property in isolation. In our *in vitro* studies, ECC4703 demonstrated higher potency, efficacy and receptor isoform selectivity than Resmetirom (MGL-3196), an FDA-approved treatment for MASH, and showed greater effects on liver-selective gene transcription. This profile reflects the combined effect of receptor-binding optimization and liver-targeting pharmacokinetic design and is intended to support therapeutic activity at clinically relevant exposure levels. The following diagram demonstrates mechanism of action of ECC4703.




*Source: Literature review, Frost & Sullivan*

***Market Opportunity and Competition***

MASH. MASH is a progressive, inflammatory liver disease. Closely associated with obesity/overweight and T2D, MASH is increasing worldwide and can advance to cirrhosis, cardiovascular disease, chronic kidney disease, or hepatocellular carcinoma if left untreated.

Traditional management of MASH centers on lifestyle modification — caloric restriction, weight loss, and increased physical activity — along with control of metabolic risk factors using agents such as statins, antihypertensives, and anti-diabetic therapies. Although Semaglutide and Resmetirom have been approved for MASH, limitations such as tolerability issues and limited efficacy indicate that there is still a significant need for novel therapies.

As of the Latest Practicable Date, Resmetirom, a THR-β partial agonist and Semaglutide, a GLP-1RA were approved for the treatment of MASH and four THR-β candidates entered Phase II clinical development globally. For more details, please refer to "Industry Overview — Overview of Cardiometabolic and Inflammatory Diseases Drug Market — MASH Drug Market — Competitive Landscape of Small Molecule THR-β Drug Market."

Obesity/overweight. Obesity and overweight, defined as abnormal or excessive fat accumulation that may impair health, are commonly measured using the BMI. According to the World Health Organization ("**WHO**"), a BMI $\geq$ 25 is considered overweight, while a BMI $\geq$ 30 qualifies as obesity. Obesity/overweight presents significant challenges, particularly with respect to lifestyle interventions. Besides lifestyle modification, GLP-1 based therapies have become the first-line treatment for obesity/overweight, but limitations in weight-loss magnitude, tolerability, and loss of lean mass constrain broader adoption, whereas adding a THR-β agonist offers clear advantages by enhancing weight loss and minimize lean mass loss and potentially improving metabolic parameter.

As of the Latest Practicable Date, no THR-β drug have been approved globally for the treatment of obesity/overweight. For more details, please refer to "Industry Overview — Overview of Cardiometabolic and Inflammatory Diseases Drug Market — Obesity/Overweight Drug Market — Competitive Landscape of THR-β Drug in Obesity/Overweight Drug Market."

Beyond MASH and obesity/overweight, ECC4703 also presents significant market opportunities in dyslipidemia, a chronic metabolic disorder characterized by abnormal blood lipid profiles. While acknowledging an active and evolving competitive landscape, including potential

competition from lower-cost generic drugs or biosimilars, and relying on broad market expansion, the strategy emphasizes differentiation on clinically meaningful measures (including atherogenic lipid subfractions, cardiometabolic risk markers, and tolerability), targeted penetration of defined patient segments (such as mixed dyslipidemia and statin-intolerant populations), and potential use in combination with standard of care. This approach is intended to address competitive intensity in a measured way, supporting sustainable adoption and growth aligned with clinical practice evolution. Such generic or biosimilar competition could intensify pricing pressure, influence payer coverage and reimbursement decisions, affect physician and patient preferences, and limit market share, pricing flexibility and overall commercial potential.

***Key Advantages***

- **Stronger Target Engagement and Potentially More Robust Lipid Lowering and MASH Efficacy than Partial Agonists.** ECC4703 as THR-β full agonist can potentially drive a more completely receptor activation, which may lead to robust PD effect than a partial agonist. Enhanced efficacy and reduced undesirable effects associated with THR-α activation are achieved with ECC4703, which demonstrates strong potency and full-agonist activity on THR-β while maintaining high selectivity over THR-α in preclinical study.

  Significant improvements in liver disease and lipid profiles were observed with ECC4703, with further fibrosis reduction under combination therapy. In preclinical models, treatment with ECC4703 resulted in significantly lowering in both the NAFLD Activity Score (NAS) and fibrosis scores relative to vehicle. In addition, the combination of ECC4703 and ECC0509 further reduced liver fibrosis, highlighting the potential of combination therapy for MASH. Moreover, in a hyperlipidemia model, ECC4703 significantly lowered circulating LDL cholesterol and total cholesterol.

  Superior *in vivo* efficacy versus MGL-3196 was achieved while preserving high selectivity and a clear liver-preferential profile. In preclinical model, ECC4703 demonstrated stronger *in vivo* efficacy versus MGL-3196 while preserving high selectivity and a clear liver-preferential profile. As illustrated in the chart below, in a head-to-head preclinical study, ECC4703 achieved an 80% response at the highest dose level, while MGL-3196 achieved 32%. ECC4703 is purpose-built to maximize the potential to hepatic benefit and limit systemic exposure without forming reactive intermediates.

- **Promising PD Changes in Early Study.** In the Phase I trial, ECC4703 showed robust, placebo-adjusted pharmacodynamic effects after 14 days of once-daily dosing. Notably, we observed a significant increase in sex hormone binding globulin ("**SHBG**") and a robust reduction in LDL-C, indicating clear targeted engagement in humans.

- **Favorable Safety and Tolerability Profile in Humans.** In the first-in-human Phase I trial of ECC4703, no serious adverse events were observed, and all observed side effects were mild. Notably, limited GI effects, no pruritus, and no clinically meaningful changes in Thyroid-Stimulating Hormone ("**TSH**") or Triiodothyronine ("**T3**") levels were observed, suggesting that ECC4703 may support improved patient adherence, lower discontinuation risk, and reduced safety monitoring burden, particularly in chronic treatment settings.

- **Promising Candidate for Combination Therapies in Cardiometabolic and Inflammatory Diseases.** Building on ECC4703's superior profile, we are actively advancing research on combinations of ECC4703 with SSAO inhibitor and GLP-1RA, and we are exploring opportunities for indication expansion.

  - *Potentially enhanced efficacy in MASH.* In preclinical studies, the combination of ECC4703 with ECC0509 for the treatment of MASH, achieved greater improvements in fibrosis scores which is associated with liver benefits.

- *Indication expansion in obesity/overweight.* Combining ECC4703 with GLP-1RAs has the potential to enhance weight loss, minimize lean mass loss, and improve overall outcomes.

In preclinical studies, ECC4703 potentiated total weight loss without additional reductions in food intake in combination with GLP-1RAs. In addition, ECC4703 in combination with GLP-1RAs demonstrated reduction in lean mass loss. It was hypothesized the synergistic weight loss effect may be derived from the remobilization of fatty acid to the liver under the energy deficient state, followed by lipid oxidation from THR-β agonism.

***Clinical Development Plan***

ECC4703 is being clinically developed for the treatment of MASH and obesity/overweight. We may also evaluate ECC4703 in additional metabolic disease indication in the future based on emerging clinical data. As of the Latest Practicable Date, our clinical development for ECC4703 Phase II trials is U.S.-focused, although ECC4703 has also been studied in a Phase I trial in China to support its overall development. As of the Latest Practicable Date, the ECC4703 clinical program consists of: (i) two completed Phase I trials, one conducted in the U.S. and one in China; (ii) one ongoing U.S. Phase IIa proof-of-concept ("**PoC**") trial for the treatment of MASH, conducted under a single protocol encompassing ECC4703 monotherapy, ECC0509 monotherapy and their combination as separate treatment arms; and (iii) one separate ongoing U.S. Phase IIa PoC trial evaluating ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight.

We elected to design the Phase IIa trial of ECC4703 and ECC0509 for the treatment of MASH as monotherapy and in combination therapy as PoC studies, which are exploratory clinical studies intended to establish early evidence of pharmacologic activity, clinical benefit, safety, tolerability, and dose-related effects to inform subsequent development decisions, because this approach generally requires a smaller patient population and a shorter study duration than later-stage trials, thereby enabling a more efficient early assessment of pharmacologic activity, clinical benefit, safety, tolerability, and dose-related effects. In particular, for a novel metabolic therapy such as ECC4703, a Phase IIa PoC design is intended to provide an early indication of whether the observed data are consistent with the proposed mechanism of action, while also informing dose selection, patient population selection and refinement of clinically relevant endpoints for subsequent development.

- **Phase I Trial of ECC4703 in the U.S. (IND 161573)**

  We initiated the Phase I clinical trial of ECC4703 in the United States in September 2022 and completed the trial in October 2023. This study provided the initial U.S. clinical safety and pharmacokinetics data for ECC4703 and formed a key component of the early development package supporting the subsequent advancement of ECC4703 into U.S. Phase II trials. Its primary objective was to evaluate safety and tolerability, with secondary objectives assessing PK and PD, and the trial met these objectives.

- **Phase I Trial of ECC4703 in China (CTR20230786)**

  We have initiated the Phase I clinical trial of ECC4703 in China in April 2023 and completed the trial in November 2023. The China Phase I trial was conducted to complement the overall clinical package for ECC4703 and to expand our early clinical dataset in a Chinese population, and provide initial clinical safety and pharmacokinetic data of ECC4703 in Chinese patients. Data from this study, together with data from the U.S. Phase I trial, have informed our understanding of the safety and pharmacologic profile of ECC4703 and have been included in materials reviewed by the FDA in connection with subsequent U.S. Phase II IND submissions. As of the Latest Practicable Date, the China Phase I trial serves a supportive role within our overall development program and does not form part of our current primary registrational pathway. Our

determination as to whether to pursue later-stage standalone clinical development of ECC4703 in China will depend on a number of factors, including the results of our ongoing and planned U.S. studies, the target indication, our global development strategy and applicable regulatory requirements in China. Its primary objective was to evaluate safety and tolerability, with secondary objectives assessing PK and PD, and the trial met these objectives.

- **Phase IIa PoC Trial of ECC4703 and ECC0509 for the Treatment of MASH as Monotherapy and in Combination Therapy (IND 176762)**

  We have initiated the Phase IIa clinical trial in December 2025 and expect to complete by 2027. This study is designed to evaluate ECC4703 as monotherapy, ECC0509 as monotherapy and their combination in adults with presumed MASH. The study includes six parallel treatment arms: placebo (QD); ECC4703 monotherapy (20 mg or 40 mg, QD); ECC0509 monotherapy (10 mg or 30 mg, QD); and ECC4703 40 mg plus ECC0509 30 mg combination therapy (QD). All arms are conducted under a single IND within the same Phase IIa trial pursuant to one protocol, and do not constitute separate clinical trials.

  Accordingly, ECC4703 monotherapy, ECC0509 monotherapy and the combination of ECC4703 and ECC0509 for the treatment of MASH are not separate ongoing clinical trials, but rather distinct treatment arms within the same Phase IIa trial conducted under a single protocol and a single U.S. IND. Participants across these treatment arms are enrolled under the same core eligibility criteria and follow the same overall visit schedule and study procedures, enabling controlled comparison of the relative contributions of ECC4703, ECC0509 and their combination within a comparable patient population. The trial design reflects the distinct and potentially complementary mechanisms of action of ECC4703 and ECC0509. ECC4703 targets THR-β pathway, which is a clinically validated therapeutic target in MASH, while ECC0509 inhibits SSAO, a pathway implicated in inflammation, metabolic dysfunction and fibrogenesis. By evaluating ECC4703 and ECC0509 both as individual monotherapy arms and in combination, the study is designed to characterize the treatment effect attributable to ECC4703, assess the activity of ECC0509 as a monotherapy, and determine whether the addition of SSAO inhibition to THR-β pathway modulation may provide incremental benefit through two parallel mechanisms. In this context, the ECC0509 monotherapy arms also serve as internal comparator arms to facilitate interpretation of the treatment effects observed with ECC4703 and the combination regimen.

  Further, the trial is designed to establish early PoC in MASH by evaluating noninvasive endpoints, including liver fat reduction as measured by MRI-PDFF at Week 12, together with additional assessments of liver function biomarkers, fibrosis and inflammation biomarkers, metabolic parameters, pharmacokinetics and safety. The results of this trial are intended to inform subsequent decisions regarding dose selection, combination strategy and later-stage development planning in MASH.

- **Phase IIa Trial of ECC4703 as an Adjunct to Semaglutide for the Treatment of Obesity/Overweight in the U.S. (IND 179857)**

  We have also submitted the IND application to the FDA in December 2025 and received the IND approval from the FDA for the Phase IIa clinical trial in January 2026 to evaluate ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight. We subsequently initiated the trial in March 2026 and expect to complete by 2027. This study is intended to evaluate ECC4703 as an oral adjunctive therapy to GLP-1RA treatment in adults with obesity BMI $\geq$30 kg/$m^2$ and to evaluate whether ECC4703 may contribute incremental weight loss and favorable metabolic effects beyond background Semaglutide therapy.

The following table sets forth an overview of the completed, ongoing and planned clinical studies of ECC4703:

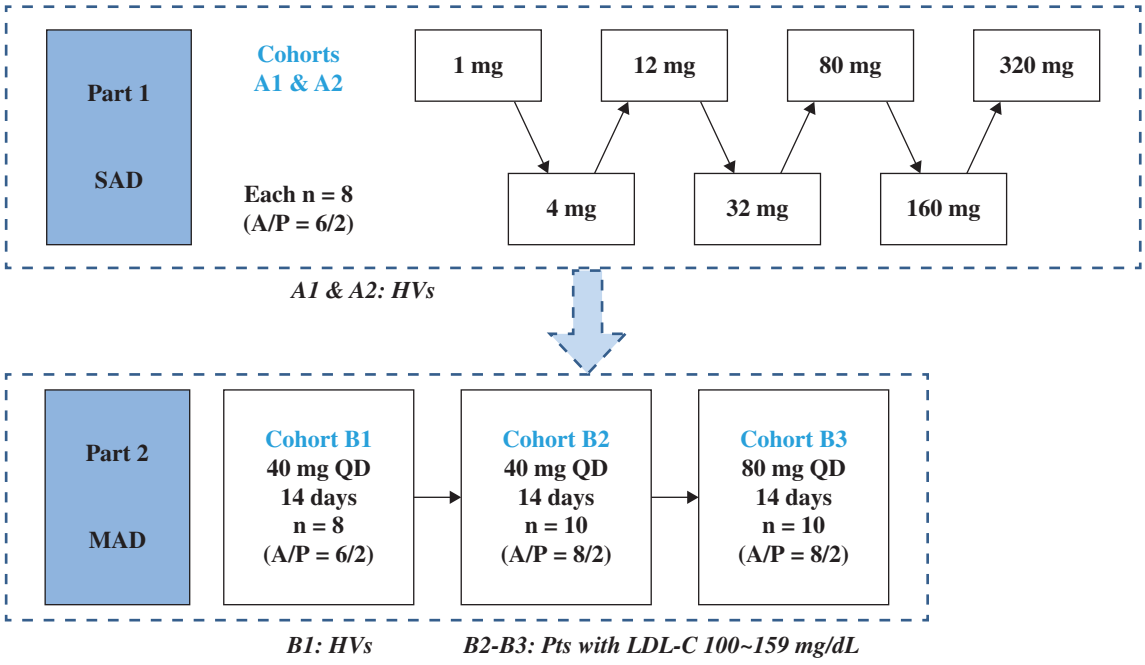
| Indication | Trial Phase | Study Population | Regimens | Trial Status | Jurisdiction | (Expected) Trial Initiation Date | (Expected) Trial Completion Date | Trial Design |
|---|---|---|---|---|---|---|---|---|
| MASH Obesity/overweight . | Phase I | Healthy volunteers and participants with treatment unnecessary LDL-C under 160 mg/dL | Mono | Completed | United States | September 2022 | October 2023 | Randomized, double-blind, placebo-controlled, first-in-human study evaluating the safety, tolerability, pharmacokinetics, and pharmacodynamics of ECC4703 in healthy volunteers and participants with treatment-unnecessary LDL-C below 160 mg/dL. |
| MASH Obesity/overweight . | Phase I | Healthy participants | Mono | Completed | China | April 2023 | November 2023 | Randomized, double-blind, placebo-controlled trial designed to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ECC4703 in healthy volunteers. |
| MASH . . . . . | Phase IIa | Presumed MASH patients | Mono Combo with ECC0509 | Ongoing | United States | December 2025 | 2027 | U.S.-based, multicenter, randomized, double-blind, placebo-controlled Phase IIa trial that will evaluate the efficacy, safety, PK, and PD of ECC4703, ECC0509 as monotherapy and the combination of ECC4703 and ECC0509 in presumed MASH patients. |
| Obesity/overweight . . | Phase IIa | Obese patient | As an adjunct to Semaglutide | Ongoing | United States | March 2026 | 2027 | U.S. based, multicenter, randomized, double-blind, placebo-controlled trial to evaluate the efficacy, safety, and tolerability of ECC4703 as an adjunct to Semaglutide in adults with obesity. |

***Summary of Clinical Trial Results***

*Completed Phase I First-in-Human Trial of ECC4703 in Healthy Volunteers and Participants with Treatment-Unnecessary LDL-C under 160 mg/dL in the United States*

Trial Design. The study was a Phase I, double-blind, randomized, placebo-controlled, single and multiple ascending dose study of ECC4703, designed to investigate single ascending dose ("**SAD**") part of ECC4703 in healthy volunteers and multiple ascending dose ("**MAD**") part of ECC4703 for 14 days first in 1 cohort of healthy volunteers and then in 2 cohort of treatment-unnecessary LDL-C under 160 mg/dL. 38 healthy participants were enrolled in Part 1 SAD, and 8 healthy participants and 21 participants with treatment-unnecessary LDL-C under 160 mg/dL were enrolled in Part 2 MAD.

See the diagram below for an illustration of the Phase I trial design.




*Source: "Safety, Tolerability, Pharmacokinetics and Pharmacodynamics of ECC4703, a Highly Selective Liver Targeting Thyroid Hormone Receptor-beta (THR-β) Full Agonist for MASH in a Phase I Trial" by Samuel Pak. M.D., et all, The Liver Meeting, AASLD, Nov. 15-19, 2024.*

The SAD portion enrolled healthy adults aged 18-65 years. Eligible participants were required to be in good general health, BMI 18-32 kg/m$^2$ with no clinically significant findings on medical history, physical exam, 12-lead ECG, vital signs, or laboratory evaluations. Individuals with a history of liver or thyroid disease, or other conditions that could confound results or increase risk, were excluded. Participants were randomized to receive single oral doses of ECC4703 (1, 4, 12, 32, 80, 160, or 320 mg) or placebo in two sequential interlocking cohorts. The primary objective was to assess safety and tolerability, with secondary objectives including characterization of pharmacokinetic parameters such as area under the curve ("**AUC**"), Cmax, Tmax and apparent terminal half-life ("**t1/2**").

The MAD portion enrolled adults aged 18-65 years with BMI 18-32 kg/m$^2$, including generally healthy participants and those with fasting LDL-C 100-159 mg/dL. Participants were randomized to receive once-daily oral ECC4703 (40 mg or 80 mg) or placebo for 14 days across three sequential cohorts: B1 (40 mg in healthy volunteers), B2 (40 mg in participants with mild LDL-C elevation), and B3 (80 mg in participants with mild LDL-C elevation). Eligibility required meeting the general inclusion criteria from SAD; for B2 and B3, additional requirements included

fasting LDL-C 100-159 mg/dL without indication for lipid-lowering therapy, being otherwise generally healthy, use of stable concomitant medications not affecting lipid metabolism or thyroid axis, and normal baseline liver and thyroid function tests. The primary objective was to evaluate safety and tolerability with repeated dosing, while secondary and exploratory objectives included pharmacokinetics and pharmacodynamic biomarkers such as SHBG and lipid panel. All dosing was conducted under fasted conditions to reduce PK variability.

Trial Status. We submitted the IND application in June 2022 and received the IND approval from the FDA in July 2022. Subsequently, we dosed the first participant in September 2022 and completed the trial in October 2023. As of August 20, 2024, we enrolled 75 adult participants in this trial. We did not encounter obstacles or practical challenges in recruiting participants who met the requisite patient selection criteria. All objectives had been met, the FDA has completed the review and indicated no objection.

Safety Results. ECC4703 was generally well tolerated by the study participants, no deaths or SAEs were reported in the study and no drug-related adverse events ("**AEs**") of Grade 3 or higher.

Overall, in the MAD portion of the study, the most frequently reported TEAEs were mild elevations of alanine aminotransferase ("**ALT**") which were all asymptomatic. ALT increase occurred in one participant at 40 mg and one participant at 80 mg. The most common treatment-related AE was mild elevation of ALT, which were all asymptomatic. The ALT increases were not accompanied by changes in bilirubin and returned to normal by the end of the study. Notably, the approved THR-β agonist Resmetirom shows a similar profile, with mild ALT elevations typically observed within the first 4 weeks of treatment that return to baseline by around 8 weeks. In addition, GGT increase occurred in one participant at 40 mg, and pain in extremity occurred in two participants at 80 mg. All TEAEs were mild in severity and managed if needed, and all TEAEs resolved without any intervention by the end of the study. One participant with mild AEs of chest pain and increased blood pressure was discontinued from the study due to a TEAE, but it was determined to be not related to the study treatment.

Across the MAD cohorts, there were no clinically meaningful changes in blood pressure, heart rate, T3, or TSH. Hematology, urinalysis, 12-lead ECGs, and physical examination findings were unremarkable, with no abnormalities considered clinically significant or reported as TEAEs. No participant experienced clinically meaningful arrhythmias or QTc prolongations. Across all dose levels, laboratory results showed no clinically significant trends or symptom-associated abnormalities, and thyroid function measurements revealed no treatment-related changes. Modest reductions of approximately 20-30% in total and free Thyroxine ("**T4**") were observed at Day 14, similar to those reported with Resmetirom and were not associated with clinically meaningful impact. No diarrhea or pruritus was observed in the MAD portion of the trial.

Pharmacokinetics results.

Following single oral doses of ECC4703, the terminal half-life was approximately 10-16 hours, supporting once-daily administration.

Pharmacodynamic results.

SHBG and LDL-C are established PD markers of hepatic THR-β activation. SHBG is synthesized in the liver in response to THR-β stimulation and serves as a sensitive indicator of target engagement, while LDL-C reduction reflects downstream effects on lipid metabolism. After 14 days oral administration of once-daily ECC4703, robust biomarker changes were observed. LDL-C was significantly reduced: at 40 mg, LDL-C fell by 37% in B1 and 21% in B2; the pooled 40 mg reduction was 28%. At 80 mg (B3), LDL-C declined by 27%, while placebo showed an 8% increase. These parallel changes — marked SHBG elevation with substantial LDL-C lowering — underscore strong and selective THR-β engagement by ECC4703. ECC4703 effectively lowered a panel of atherogenic lipids over 14 days of treatment.

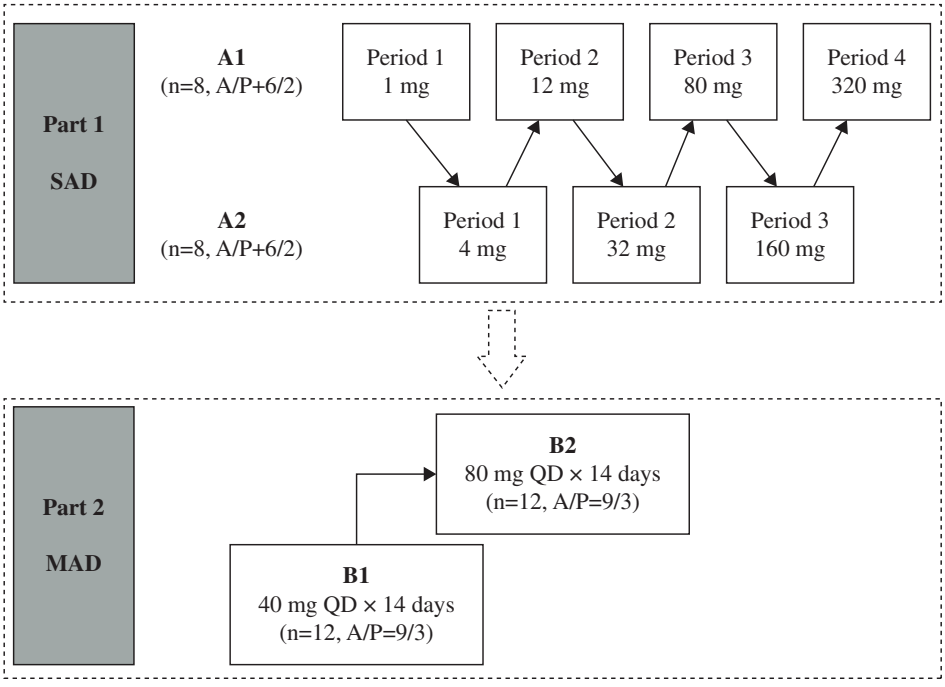
Conclusion. ECC4703 was safe and well tolerated following single and repeated daily dosing in healthy volunteers and in participants with treatment-unnecessary LDL-C <160 mg/dL. Its pharmacokinetic profile supports a once-daily regimen. ECC4703 produced effect across a panel of atherogenic lipids, with significant LDL-C lowering over 14 days. Collectively, these findings support continued development of ECC4703 as a potential oral therapy for patients with MASH and obesity/overweight.

*Completed Phase I trial of ECC4703 in Healthy Volunteers in China*

Trial Design.

This Phase I double-blind, randomized, placebo-controlled trial of ECC4703 included both SAD and MAD parts. In the SAD arm, 17 healthy adults received a single oral dose of 1-320 mg or placebo under fasting, with safety monitored for 48 hours and follow-up through Day 8. In the MAD arm, 26 participants received 40 mg, 80 mg, once daily for 14 days or placebo, with monitoring through 48 hours post-dose and follow-up to Day 21. The primary objective was safety and tolerability, with pharmacokinetics as a secondary objective.

See the diagram below for an illustration of the Phase I trial design.




*Source: Company Data*

The SAD portion enrolled healthy adults aged 18 to 65 years, with a BMI of 18 to 32 kg/m$^2$ and body weight of at least 50 kg for men and at least 45 kg for women. Major exclusions: pregnancy, recent illness or vaccination, substance use, recent trial participation, infectious disease, significant blood loss, prohibited meds, or abnormal ECG. The MAD portion enrolled adults aged 18 to 65 years with a BMI of 18 to 32 kg/m$^2$, including generally healthy participants with mildly elevated LDL-C. Eligibility mirrored SAD with similar key exclusions.

Trial Status. We submitted the IND application in October 2022 and received the IND approval from the NMPA in January 2023. Subsequently, we initiated the trial in April 2023 and completed the trial in November 2023. As of November 22, 2023, we enrolled 43 participants in this trial. We did not encounter obstacles or practical challenges in recruiting participants who met the requisite patient selection criteria. All primary and secondary endpoints had been met.

Safety Results.

ECC4703 was safe and well tolerated, with no deaths, serious adverse events. Most adverse events were mild and not dose related.

Conclusion. ECC4703 demonstrated a generally acceptable safety and tolerability profile.

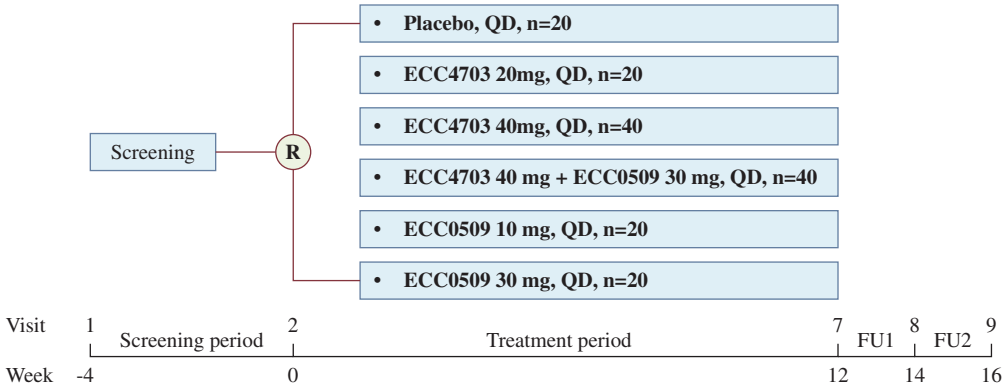
*Ongoing Phase IIa trial of ECC4703 and ECC0509 for the Treatment of MASH as Monotherapy and in Combination Therapy in the United States*

Trial Design.

This is designed as multicenter, randomized, double-blind, placebo-controlled Phase IIa trial of ECC4703 and ECC0509 as monotherapy and the combination of ECC4703 and ECC0509 for the treatment of MASH. Approximately 160 participants are randomized into six arms. The study includes six parallel treatment arms: placebo (QD); ECC4703 monotherapy (20 mg or 40 mg, QD); ECC0509 monotherapy (10 mg or 30 mg, QD); and ECC4703 40 mg plus ECC0509 30 mg combination therapy (QD). All arms are conducted under a single IND within the same Phase IIa trial pursuant to one protocol, and do not constitute separate clinical trials.

The six-arm design prospectively isolates the contribution of each mechanism (THR-β agonism with ECC4703; SSAO inhibition with ECC0509) and quantifies any incremental benefit when both mechanisms act in parallel. Monotherapy arms establish each agent's effect size on the same endpoints, in the same population and time frame. The combination arm, at fixed doses, is then compared head-to-head with each component on identical primary and secondary endpoints (magnetic resonance imaging-proton density fat fraction ("**MRI-PDFF**"), a noninvasive imaging measure that quantifies liver fat burden and is commonly used to monitor treatment response) and ALT-anchored measures, plus noninvasive fibrosis scores.

See the diagram below for an illustration of the Phase IIa trial design.




*Abbreviation: FU = follow-up; QD = once daily; R = randomization.*

*Source: Company Data*

Eligible participants are ≥18 years with presumed MASH, hepatic steatosis confirmed by imaging, and features of metabolic syndrome or biopsy evidence of active disease, able to comply with fasting and MRI procedures, and willing to use required contraception where applicable. Key exclusions include other chronic liver diseases, advanced/decompensated cirrhosis, heavy alcohol use, prior THR-β therapy, use of prohibited concomitant medications with relevant drug-drug interaction risk, recent major weight change or bariatric surgery, uncontrolled diabetes or significant cardiovascular disease, pregnancy or breastfeeding, and standard contraindications to MRI and conditions likely to confound efficacy or safety assessments.

The 12-week treatment phase will measure change in liver fat by MRI-PDFF as the primary endpoint. Safety will be monitored through adverse events, liver function, DILI signals, ECGs, and labs. The primary efficacy endpoint was the change from baseline in liver fat at Week 12 measured by MRI-PDFF, comparing ECC4703 dose groups with placebo under prespecified multiplicity control. Secondary endpoints included additional MRI-PDFF measures for ECC0509 and for the combination versus components, the proportion of participants achieving prespecified liver fat reduction thresholds and fat normalization, change in ALT and a composite of ALT and MRI-PDFF response, noninvasive liver fibrosis and inflammation scores, imaging-based liver stiffness, metabolic measures (lipids, glucose control, weight), and patient-reported outcomes. Population pharmacokinetics were characterized with intensive sampling after the first dose and prespecified sampling at later visits.

Safety was monitored throughout via adverse event collection, examinations, vital signs, ECGs, and laboratory testing, with predefined procedures for treatment-emergent events. Management included close monitoring and protocol-defined stop rules for liver-related laboratory changes or symptoms, real-time blinded adjudication of potential drug-induced liver injury, evaluation and discontinuation for confirmed adrenal injury, protocol-directed evaluation for clinically significant cardiovascular events with discontinuation for confirmed major adverse cardiac events, creatine kinase-based pause/stop rules for muscle safety with urgent evaluation for suspected rhabdomyolysis, and monitoring for histamine/tyramine-related intolerance with dietary counseling and treatment interruption as indicated. An independent data monitoring committee oversaw unblinded safety with prespecified stopping rules, serious adverse events were reported within 24 hours, and pregnancies led to treatment discontinuation with follow-up of outcomes.

Trial Status. We submitted the IND application in August 2025 and have received the IND approval from the FDA in October 2025. We initiated the trial in December 2025.

*Ongoing Phase IIa Trial of ECC4703 as an Adjunct to Semaglutide for the Treatment of Obesity/Overweight in the United States*

Trial design. This is a Phase IIa randomized double blind placebo controlled U.S. study at about fifteen sites tests ECC4703 added to once weekly subcutaneous Semaglutide in adults with obesity who do not have diabetes. Primary objectives are to evaluate effects on body weight and on liver fat content in an MRI PDFF imaging subgroup with hepatic steatosis. Key primary endpoints are percent change in body weight, the proportion achieving at least five percent weight loss, absolute and percent change in liver fat, and the proportion with at least thirty percent relative reduction in liver fat. Secondary objectives include body composition by DXA, metabolic biomarkers such as glycemic and lipid measures, additional weight outcomes, and liver enzymes. Approximately 160 participants are randomized into two arms. See the table below for an illustration of the Phase IIa trial design.

**Study Phase** Phase IIa

**Study Design:** Randomized; Parallel Assignment

Patient Inclusion Criteria: Obese with BMI ≥30 kg/m$^2$
Duration: 20 weeks

| **Interventions** | **Study Arms** | |
|---|---|---|
| • ECC4703 orally QD<br>• Placebo orally QD<br>• Semaglutide SC once weekly | **Arm 1: ECC4703 + Semaglutide**<br>• ECC4703 orally QD plus Semaglutide SC once weekly | **Arm 2: Placebo + Semaglutide**<br>• Placebo orally QD plus Semaglutide SC once weekly |

Trial Status. We have submitted the IND application in December 2025 to the FDA and have received the IND approval in January 2026. Subsequently, we have initiated the trial in March 2026 and expect to complete the trial by 2027.

***License, Rights and Obligations***

We are developing ECC4703 in-house and own the global rights to develop and commercialize ECC4703. We have not licensed in, acquired or outsourced the core R&D ownership or proprietary technology relating to ECC4703 from any third party, no third party has any ownership, development, commercialization, royalty, milestone payment or other economic rights in relation to ECC4703.

***Material Communications with Competent Authorities***

Below is a summary of our material communications with the competent authorities regarding ECC4703 from IND/pre-IND interactions as of the Latest Practicable Date.

*FDA*

In April 2022, we submitted a pre-IND meeting request to the FDA in relation to ECC4703 for the treatment MASH. In its written responses dated May 26, 2022, the FDA indicated that the completed nonclinical studies described in the meeting package appeared adequate to support the proposed Phase I clinical trial, subject to the FDA's review of the full study reports. The FDA also indicated that the chemistry, manufacturing and controls package provided at that stage appeared reasonable to support initiation of the proposed Phase I clinical study.

In June 2022, we submitted the IND application for the Phase I trial of ECC4703 as a monotherapy to the FDA (IND 161573). The IND covered a Phase I clinical trial, the objective of which was to evaluate the safety, tolerability and pharmacokinetic profile of ECC4703. On July 25, 2022, the FDA granted the IND approval for IND 161573. The FDA's comments were non-hold comments and included certain nonclinical recommendations. The FDA did not impose a clinical hold on IND 161573.

In April 2025, we submitted a pre-IND meeting request to the FDA in connection with a proposed Phase IIa clinical trial for ECC4703 as monotherapy, ECC0509 as monotherapy and their combination for the treatment of MASH. In its written responses dated June 27, 2025, the FDA stated that the comprehensive nonclinical package for ECC4703 as monotherapy, ECC0509 as monotherapy and the combination therapy for the treatment of MASH was sufficient to support the proposed Phase IIa clinical trial, and agreed with our proposed plan to submit a new IND for the combination therapy development program. In response to the our question on whether ECC4703 and ECC0509 could be advanced into the proposed Phase IIa trial based on the Phase I safety and pharmacokinetic profiles together with the nonclinical combination toxicology package, the FDA stated that the submitted pharmacokinetic and safety data of ECC4703 and ECC0509 from their respective Phase I trials, and nonclinical combination toxicology package, were adequate to evaluate the combination for the proposed trial. The FDA also provided preliminary comments on the proposed study design, including comments relating to the fixed-combination rule, sample size, eligibility criteria, safety monitoring, drug-drug interaction exclusions, pharmacokinetic sampling duration and statistical methodology.

In August 2025, we submitted the IND application for the Phase IIa trial of ECC4703 and, ECC0509 for the treatment of MASH as monotherapy and their combination in adults with presumed MASH (IND 176762) to the FDA. On October 2, 2025, the FDA granted the IND approval for IND 176762. The FDA stated that it had completed its safety review and concluded that the proposed clinical investigation may proceed. The FDA's comments were non-hold comments and primarily to clinical pharmacology, eligibility criteria, baseline cirrhosis exclusion criteria, statistical analysis, handling of intercurrent events and missing data, and submission of a statistical analysis plan prior to unblinding. The FDA did not impose a clinical hold on IND 176762.

In December 2025, we submitted the IND application to the FDA for the Phase IIa trial of ECC4703 as an adjunct to Semaglutide for the treatment of obesity/overweight to evaluate the efficacy, safety and tolerability. On January 21, 2026, the FDA granted the IND approval (IND 179857). The FDA stated that it had completed its safety review of the application and concluded that we may proceed with the proposed clinical investigation. The FDA also provided comments and requests for additional information, while expressly noting that such requests were not clinical hold issues. These comments related primarily to clinical pharmacology, including potential drug-drug interactions, and clinical considerations relating to trial design, Semaglutide dosing, follow-up duration, tolerability management, eligibility criteria and body composition endpoints. The FDA did not impose a clinical hold on IND 179857.

As of the Latest Practicable Date, ECC4703 had not been placed on clinical hold by the FDA in connection with the foregoing clinical development.

*NMPA*

In October 2022, we submitted the Phase I IND application to the NMPA for ECC4703 as monotherapy. On January 13, 2023, the NMPA approved the application, permitting the trial to proceed in China. The NMPA did not object to the conduct of the Phase I trial, and the trial was approved without a clinical hold.

The following table sets forth a summary of our material communications with regulatory authorities regarding ECC4703:

| Clinical Trial | Jurisdiction | IND Application | IND Approval Date | Material Reviewed by the FDA | Material Reviewed by the NMPA | Scope of IND Approval | Proposed or Recommended Revision to the Study Protocol by the FDA/NMPA |
|---|---|---|---|---|---|---|---|
| Phase I (IND 161573) | United States | June 2022 | July 2022 | IND application for IND161573 | N/A | Approval with non-hold comments | No |
| Phase I (CTR20230786) | China | October 2022 | January 2023 | N/A | IND application for CTR20230786 | Unconditional approval | No |
| Phase IIa (IND 176762) | United States | August 2025 | October 2025 | PK, safety and tolerability results from preclinical results, study results of Phase I trials (IND 161573 and CTR20230786), study protocol of Phase IIa trial (IND 176762) | N/A | Approval with non-hold comments | No |
| Phase IIa (IND 179857) | United States | December 2025 | January 2026 | PK, safety and tolerability results from preclinical results, study results of Phase I trials (IND 161573 and CTR20230786), study protocol of Phase IIa trial (IND 179857) | N/A | Approval with non-hold comments | No |

As of the Latest Practicable Date, ECC4703 had not received any major concerns or objections from the above-mentioned regulatory authorities to its clinical development plans.

## WE MAY NOT BE ABLE TO ULTIMATELY DEVELOP AND MARKET ECC4703 SUCCESSFULLY

### ECC5004, our Key Product

#### *Overview*

ECC5004 (also known as elecoglipron/AZD5004) is an once-daily, oral small molecule GLP-1RA that is being developed for two lead indications with T2D and obesity/overweight.

#### *Drug Design and Mechanism of Action*

ECC5004 is an oral small molecule GLP-1RA designed to combine efficacy-relevant GLP-1 receptor signaling with the exposure and pharmacokinetic properties required for convenient daily administration. In designing ECC5004, we deliberately selected a molecular scaffold with strong *in vivo* potency and favorable drug-like properties, while deprioritizing an alternative scaffold that, according to Frost & Sullivan, is more prone to off-target liabilities that have resulted in program termination for other drug candidates in that scaffold class. We believe ECC5004 incorporates three key design features that collectively underpin its pharmacological profile:

- **G-protein biased cAMP signaling supporting sustained receptor responsiveness.** ECC5004 was specifically engineered to selectively activate cAMP signaling, the principal downstream pathway that could be responsible for the established clinical benefits of GLP-1 receptor agonism, including enhanced insulin secretion, reduced glucagon, delayed gastric emptying, greater satiety and improved glycemic control. In our *in vitro* assays, ECC5004 demonstrated potent cAMP activation while β-arrestin-2 recruitment and receptor internalization were not observed under the assay conditions tested. In cellular assays, ECC5004 acts as a full agonist in HEK-293 cells and a partial agonist in CHO-K1 cells, confirming effective downstream receptor activation across different cellular contexts. By avoiding β-arrestin engagement, ECC5004 is designed to keep receptors available on the cell surface, supporting consistent pharmacological activity.

- **Potent GLP-1 receptor engagement and demonstrated *in vivo* efficacy.** In receptor binding and functional assays, ECC5004 bound with high affinity to the human GLP-1 receptor and exhibited potent agonist activity, supporting robust target occupancy at clinically relevant exposures. ECC5004 also potentiates glucose-stimulated insulin secretion in human pancreatic β cells in a dose-dependent manner, demonstrating that receptor activation translates into enhanced insulin secretion in response to glucose, a key mechanism for glycemic control in T2D and an important feature of effective GLP-1 receptor agonism. In non-human primate studies, ECC5004 administration resulted in dose-dependent increases in insulin secretion and significant reductions in body weight, confirming potent GLP-1 receptor engagement in *vivo*. The observed metabolic benefits support the translational potential of ECC5004 for glycemic control in patients with T2D and weight management issues

- **Oral drug-like properties enabling once-daily dosing.** The medicinal chemistry strategy of ECC5004 was focused on optimizing oral absorption and metabolic stability. Key structural modifications included careful engineering of the core scaffold, which forms the structural backbone of the molecule, and optimizing the side-chain design, leading to approximately 90% oral bioavailability, good metabolic stability and pharmacokinetics suitable for once-daily dosing. By contrast, based on published data, Rybelsus (oral Semaglutide) has oral bioavailability of approximately 0.4% to 1.0%, and orforglipron has been reported to show oral bioavailability of approximately 20% to 40% in preclinical animal models.

*Market Opportunity and Competition*

The global market of GLP-1RAs is experiencing unprecedented growth, with market size valued at US$55.5 billion in 2024 and projections indicating that the market could reach US$185.1 billion worldwide by 2034, according to Frost & Sullivan. However, the penetration rate of GLP-1RA therapies among eligible patients with T2D and obesity/overweight issues remains relatively low, creating a meaningful opportunity for more convenient and accessible treatment options. While the current competitive landscape is dominated by injectable GLP-1RAs, there remains a substantial need for oral therapies that combine efficacy, convenience and flexibility. ECC5004's differentiated profile positions it to potentially drive greater market penetration and serve as a foundation for future combination products.

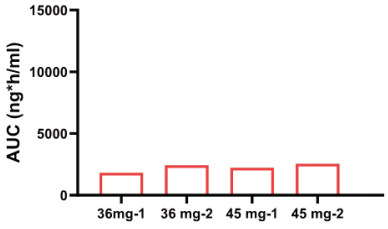
ECC5004 is being developed for two lead indications: T2D and obesity/overweight. T2D arises from insulin resistance combined with gradual decline in insulin production. GLP-1RAs are an established therapeutic class in the treatment of T2D, enhancing glucose-dependent insulin secretion, minimizing hypoglycemia risk, promoting satiety, and offering end organ protection. With many GLP-1RAs now approved for use in T2D, these benefits have been demonstrated in clinical practice. However, the growing number of approved GLP-1RAs has also led to an increasingly competitive landscape, with multiple established and emerging therapies vying for market share across both injectable and oral formulations. Oral therapeutics like ECC5004 may provide greater convenience, improved adherence, and eliminate injection-related discomfort. As of the Latest Practicable Date, one oral small molecule GLP-1RA has been approved. For market details and competitive landscape, "Industry Overview — Overview of Cardiometabolic and Inflammatory Diseases Drug Market — T2D Drug Market" and "Industry Overview — Overview Of Cardiometabolic and Inflammatory Diseases Drug Market — Competitive Landscape of Small Molecule GLP-1RAs in Obesity/Overweight Drug Market and T2D Drug Market."

*Key Advantages*

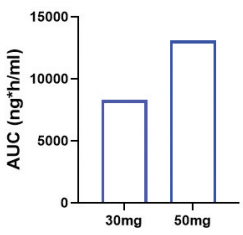
- **Strong Potency in Preclinical Studies**. ECC5004 demonstrates strong in vitro potency, binding with high affinity to the human GLP-1 receptor and effectively activating cAMP signaling as a full agonist in HEK-293 cells and partial agonist in CHO-K1 cells. It has G-protein biased signaling without triggering the β-arrestin pathway. ECC5004 also enhances insulin release from human pancreatic beta cells at low concentrations (EC50 = 5.9 nM). In non-human primate studies, ECC5004 demonstrated dose-dependent increases in insulin secretion and reductions in body weight, confirming potent GLP-1 receptor engagement in vivo.

- **Dose-dependent Increase in Exposure**. In the Phase I SAD and MAD portions of the first-in-human trial, ECC5004 showed dose-dependent increases in concentration. For the purpose of understanding exposure profiles across different compounds, orforglipron demonstrated a plateau in steady-state exposure (AUC) of approximately 2,550 h*ng/mL in its Phase IIb trial.

**Steady State AUC**
orforglipron Ph2b




**Steady State AUC**
ECC5004 MAD D28




*Source: Clinicaltrials.gov, Company data*

Although the data are derived from two distinct clinical studies, which precludes direct comparison, and recognizing that greater exposure is not inherently associated with better efficacy, ECC5004 achieved steady-state exposure ($AUC_{0\text{-last}}$) of 8,310 h*ng/mL at 30 mg and 13,105 h*ng/mL at 50 mg, respectively, in the MAD portion of its first-in-human trial. Importantly, clinically meaningful reductions in both blood glucose and body weight were observed in the 50 mg cohort.

- **Extended Half-life and Low Peak-to-Trough Ratio**. The half-life of ECC5004 in the fasted state at 50 mg is approximately 21.2 hours, which is comparable to the same in the fed state at approximately 20.7 hours, supporting once-daily dosing. In addition, ECC5004 exhibited a low peak-to-trough ratio in the completed first-in-human Phase I trial. This may help minimize peak-related gastrointestinal side effects and contribute to improved tolerability.

- **No food effect**. Based on the completed Phase I trial, ECC5004 demonstrated no clinically meaningful food effect on its pharmacokinetic profile. A single 50 mg dose of ECC5004 under both fed and fasted conditions resulted in comparable plasma exposure. This supports the flexible dosing of ECC5004 with or without regard to meals, offering greater convenience for patients.

- **Clinically Meaningful Glucose and Weight Reductions**. In the completed first-in-human Phase I trial, ECC5004 demonstrated dose-dependent improvements in glycemic control and body weight in patients with T2D. In the SAD portion of the completed Phase I trial, ECC5004 demonstrated strong engagement of GLP-1 receptor across different doses. In the MAD portion of the completed Phase I trial, ECC5004 demonstrated improvements in glycemic control, as well as meaningful weight loss.

- **Favorable Safety and Tolerability Profile**. ECC5004 demonstrates a favorable safety and tolerability profile, as evidenced by the results of Phase I clinical trial in both healthy volunteers and patients with T2D as discussed in more detail below.

- **Flexible Combination and Broad Applicability Potential**. We believe that ECC5004 has broad clinical potential for obesity/overweight and related comorbidities, potentially functioning as a monotherapy and in combination with other cardiometabolic agents. Mechanistically, the combination of ECC5004 with agents such as SGLT2 inhibitors, which lower blood glucose by promoting urinary glucose excretion and offer cardiovascular and renal protection, and oral PCSK9 inhibitors, which provide robust LDL-cholesterol reduction, could target the multifaceted pathophysiology of cardiometabolic diseases and enhance overall clinical outcomes.

***Clinical Development Plan***

We self-discovered ECC5004 and initiated preliminary discussions with AstraZeneca to explore potential partnership opportunities during the preclinical research and development stages. As the clinical and commercial potential for GLP-1RAs continued to expand across large chronic indications, we determined that advancing ECC5004 into late-stage development and through global commercialization would require additional resources, scale and infrastructure beyond what we could efficiently deploy on a standalone basis. These discussions advanced through 2023 as both parties evaluated strategic alignment and the potential for value creation, culminating in a collaboration agreement executed in November 2023. With a global-oriented clinical development strategy in place, ECC5004 is being rapidly advanced with the goal of entering into a global Phase III MRCT program in 2026, among the first wave in its class.

With the IND approval from the FDA in November 2022, we initiated a Phase I clinical trial of ECC5004 in healthy participants and patients with T2D in the United States in December 2022 and completed the trial with the final clinical study report in March 2024. ECC5004 was

investigated in two Phase IIb trials, one involving adults with T2D and the other involving participants with obesity/overweight with at least one comorbidity. The global Phase IIb trials are mid-stage trials designed to evaluate the efficacy and safety of ECC5004 in larger and more diverse patient populations. These trials are intended to provide data to support the design of pivotal Phase III trial(s) and to inform regulatory submissions in multiple jurisdictions. The global Phase IIb trials are generally equivalent to conventional Phase II trials. Both trials commenced in October 2024. The Phase IIb trial for adults with T2D was completed in December 2025 and the Phase IIb trial for adults with obesity/overweight was completed in November 2025. The data for both trials is expected to be presented at a scientific congress in June 2026. ECC5004 is expected to enter into a global Phase III MRCT program in 2026, which will include investigator sites in Greater China.

To further support the global advancement of ECC5004, we initiated a Phase Ib clinical trial in Greater China in June 2025 to evaluate ECC5004 in Chinese participants with obesity/overweight, with or without T2D. A Phase Ib bridging trial is an early-stage clinical trial conducted in a specific population. The results would help to evaluate whether the results observed in global trials are applicable to the local population, and to identify any population-specific considerations that may impact subsequent clinical development or regulatory approval in China. The Phase Ib bridging trial is not strictly equivalent to a conventional Phase I trial, such as first-in-human trial, as it not only evaluates key elements of Phase I trial (such as safety and pharmacokinetics), but also examines whether there are specific differences between different ethnic groups. The global Phase IIb trials and the Phase Ib bridging trial were conducted independently, each with its own protocols and patient populations. They are all important to the global development of ECC5004. The data generated from the Phase Ib bridging trial will complement the findings from the global Phase IIb trials by providing critical information on ECC5004's performance in the Chinese population. The result of Phase Ib bridging trial may also facilitate the inclusion of China in future global Phase III MRCT(s). This approach is designed to support regulatory alignment with Chinese authorities and to enable the integration of China-specific data into the global development and registration for ECC5004. Through this approach, we aim to support a compliant development pathway in Greater China. This Phase Ib bridging trial was completed in November 2025, with topline results announced in February 2026 and Phase Ib data to be presented at a scientific congress in June 2026.

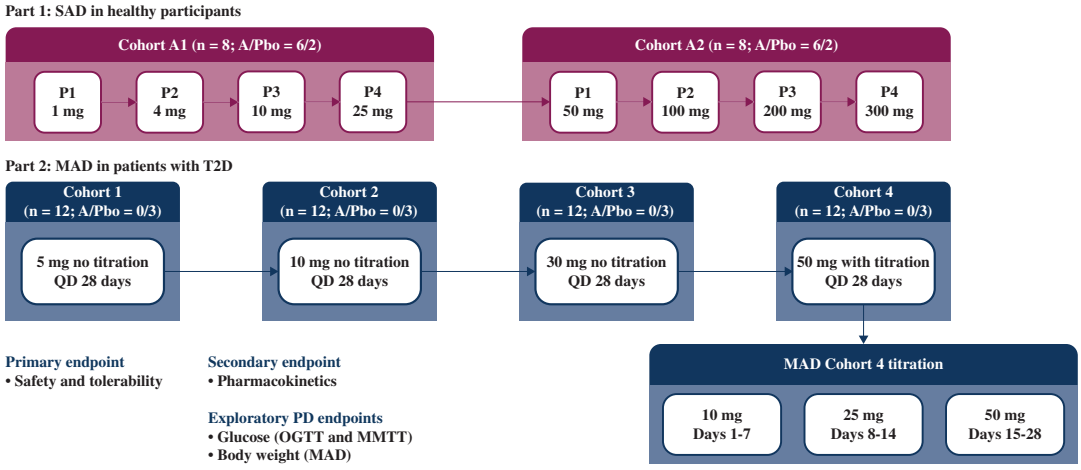
***Summary of Clinical Trials***

*Completed Phase I First-In-Human Trial of ECC5004 as Monotherapy in Healthy Participants and in Patients with T2D in the United States*

Trial design. This is a randomized, double-blind, placebo-controlled, single and multiple ascending doses, first-in-human study designed to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ECC5004 as monotherapy in both healthy participants and patients with T2D conducted in the United States. The trial consisted of two parts and both SAD and MAD parts were conducted in an in-patient setting: (i) the SAD part involved healthy adults between the aged 18 to 65 years, with a BMI between 18.0 and 32.0 $kg/m^2$ were randomized to receive single oral doses of ECC5004 (1 mg to 300 mg) or placebo in two sequential cohorts, and the primary objective was to assess safety and tolerability, with secondary objectives being the evaluation of pharmacokinetic and/or pharmacodynamic parameters. 19 participants participated in the SAD part of the trial; and (ii) the MAD part involved patients with T2D aged 18 to 70 years, with BMI of 24.0 to 40.0 $kg/m^2$ on lifestyle modification or stable metformin were randomized to receive once-daily oral ECC5004 or placebo for 28 days in four sequential cohorts, and the primary objective was to assess the safety and tolerability over repeated dosing, and the secondary and exploratory objectives were to assess pharmacokinetic profile and pharmacodynamic parameters. Participants were required to fast for at least 14 hours each day to minimize variability in pharmacokinetic assessments. 48 patients participated in the MAD part of the trial.

The primary endpoints were to assess the safety using the number of participants with AEs, with abnormal laboratory test results, abnormal electrocardiograms ("**ECGs**"), abnormal vital signs and abnormal physical examinations up to Day 8 for SAD portion and up to Day 35 for MAD portion of the trial. The secondary endpoints were: (i) to assess AUC from time 0 to 24 hour dosing interval up to Day 3 for SAD portion and up to Day 30 for MAD portion; (ii) to assess AUC from time 0 to the time of quantifiable non-zero concentration up to Day 3 for SAD portion; (iii) assess AUC over a dosing interval from time 0 to time of last quantifiable concentration up to Day 30 for MAD portion; (iv) to assess AUC from time 0 extrapolated to infinity up to Day 3 for SAD portion; (v) to assess maximum observed plasma concentration up to Day 3 for SAD portion and Day 30 for MAD portion; (vi) to assess observed concentration at 24 hours post dose up to Day 3 for SAD portion and up to Day 30 for MAD portion; (vii) observed concentration at the end of dosing internal up to Day 30 for MAD portion; (viii) to assess time of maximum observed plasma concentration up to Day 3 for SAD portion and up to Day 30 for MAD portion; (ix) to assess lag time up to Day 3 for SAD portion and up to Day 30 for MAD portion; (x) to assess apparent terminal elimination half-life up to Day 3 for SAD portion and up to Day 30 for MAD portion; (xi) to assess last measurable non-zero concentration up to Day 3 for SAD portion; (xii) to assess apparent clearance up to Day 3 for SAD portion and up to Day 30 for MAD portion; (xiii) to assess AUC for glucose, insulin, glucagon and C-peptide from time 0 to 4 hour dosing internal up to Day 30 for MAD portion; (xiv) to assess change from baseline using fasting plasma glucose, mean daily glucose and body weight and waist circumference up to Day 30 for MAD portion; and (xv) to assess fasting plasma glucose homeostatic model assessment using fasting plasma glucose and insulin up to Day 30 for MAD portion.

See the diagram below for an illustration of the Phase I trial design.




*Source: "Safety, Tolerability and Pharmacokinetics of AZD/ECC5004, an Oral Small Molecule GLP-1 Receptor Agonist" by Haggag, M.D., et all, presentation at Obesity Week, 2024.*

Trial status. We submitted the IND application in September 2022 and received the IND approval from the FDA in November 2022. We initiated the trial in December 2022 and completed the trial with the clinical study report in March 2024.

Safety results.

*SAD in healthy participants*. ECC5004 was generally well tolerated across single doses from 1 to 300 mg. There were no SAEs or deaths. Two participants discontinued due to TEAEs: one case of oral candidiasis and one COVID-19 infection. Overall, TEAE frequency increased with dose, and events were predominantly GI and mild to moderate in severity. In the higher-dose cohort (50-300 mg), TEAEs occurred in 66.7% at 50 mg and in 100% of participants at 100, 200, and 300 mg. Nausea, and vomiting were the most common TEAEs. In the lower-dose cohort (1-25 mg), TEAEs

were infrequent, and GI events were uncommon. Most events were Grade 1 or 2; one Grade 3 event occurred at 300 mg. No clinically relevant treatment-emergent abnormalities were observed in laboratory assessments, 12-lead electrocardiogram, or vital signs.

*MAD in patients with T2D*. Across once-daily dosing for up to 28 days (5, 10, 30 mg without titration; 50 mg with weekly up-titration 10 to 25, 25 to 50 mg), ECC5004 was generally well tolerated. There were no SAEs or deaths. Two participants discontinued due to TEAEs, both of which resolved without intervention. TEAEs were predominantly GI- related. Common GI events included nausea, constipation, diarrhea, dyspepsia, and vomiting. Most events were Grade 1; one Grade 3 event (transient liver enzyme elevation) occurred at 50 mg, leading to discontinuation. The table below summarizes TEAEs over 28 days.

| | | ECC504 | | | | |
|---|---|---|---|---|---|---|
| *Variables, n (%)* | Placebo (n=13) | 5mg (n=9) | 10mg (n=9) | 30mg (n=9) | 50mg* (n=9) | Total (n=51) |
| **TEAEs** | **8 (61.5%)** | **7 (77.8%)** | **3 (33.3%)** | **10 (100%)** | **9 (90%)** | **37 (72.5%)** |
| Leading to Study Discontinuation | 0 | 0 | 0 | 1 (10.0%) | 1 (10.0%) | 2 (3.9%) |
| **Gastrointestinal AEs** | **7 (53.8%)** | **3 (33.3%)** | **3 (33.3%)** | **9 (90.0%)** | **7 (70.0%)** | **29 (56.9%)** |
| Nausea | 1 (7.7%) | 1 (11.1%) | 1 (11.1%) | 6 (60.0%) | 6 (60.0%) | 15 (29.4%) |
| Diarrhea | 3 (23.1%) | 3 (33.3%) | 0 | 2 (20.0%) | 2 (20.0%) | 10 (19.6%) |
| Vomiting | 0 | 0 | 0 | 1 (10.0%) | 2 (20.0%) | 3 (5.9%) |

*Source: "Non-clinical and first-in-human characterization of ECC5004/AZD5004, a novel once-daily, oral small-molecule GLP-1 receptor agonist" by Haggag, M.D., et all, 2024.*
*Note:* * uptitrated

In addition, ECC5004 at therapeutic doses (5 mg, 10 mg and 30 mg) was well tolerated when administered without stepwise dose escalation. For the 50 mg cohort, a simple titration schedule was implemented: participants received 10 mg for the first seven days, 25 mg for the next seven days and 50 mg for the remaining two weeks. Across the MAD portion of the trial, an acceptable tolerability profile was observed with either no titration (5 mg, 10 mg and 30 mg) or this straightforward titration schedule (50 mg).

Pharmacokinetics results. In both SAD and MAD portion of the trial, ECC5004 showed dose-dependent increases in plasma concentration. The pharmacokinetic profile observed in the MAD study was shown in the table below.

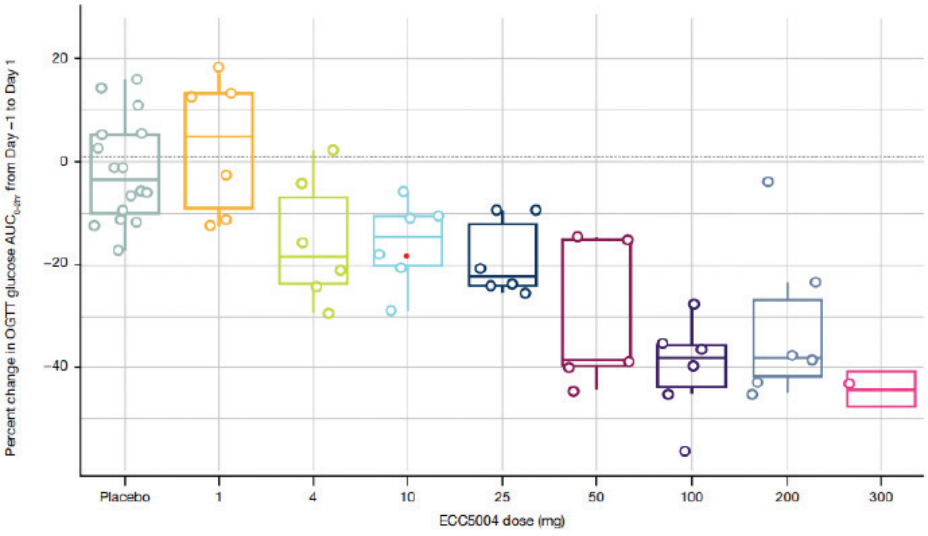
| | ECC5004 | | | |
|---|---|---|---|---|
| | **5 mg n = 9** | **10 mg n = 9** | **30 mg n = 9** | **50 mg n = 10** |
| $C_{max}$, ng/mL, GM (gCV%) | 27.31 (45.4) | 80.28 (64.6) | 373.66 (47.9) | 682.66 (92.8) |
| Tmax, hr, GM (gCV%) | 5.69 (60.3) | 3.67 (77.7) | 7.18 (36.9) | 6.61 (41.6) |
| $AUC_{0\text{-last}}$, h·ng/mL, GM (gCV%) | 666.49 (40.2) | 1,801.64 (60.2) | 8,310.03 (66.3) | 13,104.95 (143.3) |
| CL/F, L/h | 11.31 (37.4) | 8.19 (59.3) | 5.07 (57.5) | 4.34 (90.7) |
| *$t_{1/2}$, hr, GM (gCV%)** | *22.83 (27.0)* | *21.07 (25.3)* | *14.95 (29.9)* | *11.37 (20.8)* |

*Notes:*
* PK estimates are limited in their interpretation as the elimination phase was not well captured at 48 hours; for detailed PK characterization, refer to Haggag A, et al. *AZD5004/ECC5004, a Small Molecule GLP-1 Receptor Agonist May be Administered Once Daily Under Fed/Fasted Conditions*. Presented at Obesity Week, Nov 4, 2024.

*Abbreviation: $AUC_{0\text{-}last}$ = area under the plasma concentration-time curve from time zero to the last measurable non-zero concentration; CL/F = oral clearance; gCV% = geometric coefficient of variation; $C_{max}$ = maximum concentration; GM = geometric mean; MAD = multiple-ascending dose; PK = pharmacokinetics; $t_{1/2}$ = elimination half-life time; Tmax = time to maximum concentration*
*Source: "Safety, Tolerability and Pharmacokinetics of AZD/ECC5004, an Oral Small Molecule GLP-1 Receptor Agonist" by Haggag, M.D., et all, presentation at Obesity Week, 2024.*

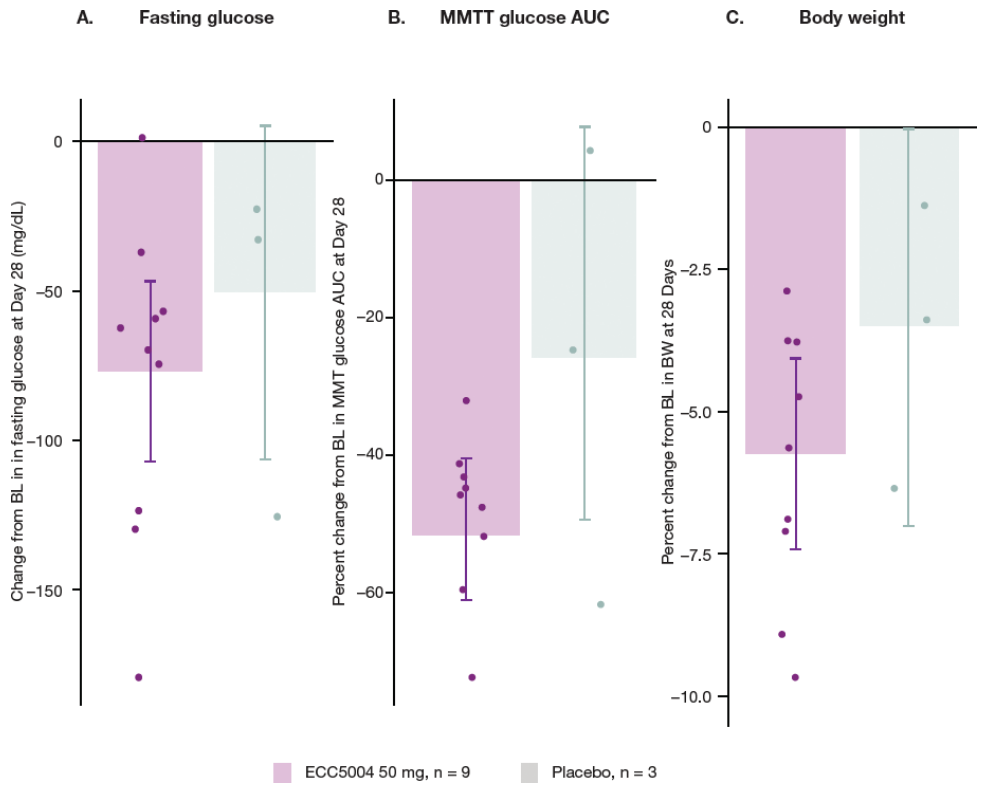
In addition, ECC5004 also demonstrated a low peak-to-trough ratio across therapeutic dose levels in the first-in-human Phase I trial, with values of 2.03 at 5 mg, 2.37 at 10 mg, 2.27 at 30 mg, and 3.07 at 50 mg, respectively. A low peak-to-trough ratio indicates relatively stable plasma drug concentrations, which may help minimize peak-related gastrointestinal side effects and contribute to improved tolerability. Together, ECC5004 displays dose-dependent pharmacokinetics and its profile supports once-daily oral dosing.

Pharmacodynamic results. In the SAD portion of the trial, ECC5004 demonstrated dose-dependent improvements in glucose tolerance as assessed by the oral glucose tolerance test ("**OGTT**"). Reductions in glucose AUC from baseline to post-dose were observed at doses 4 mg and above as shown in the graph below, indicating target engagement of the GLP-1 receptor. The effect was more pronounced at higher doses. These findings provide early clinical evidence of the glucose-lowering potential of ECC5004.




*Source: "Safety, Tolerability and Pharmacokinetics of AZD/ECC5004, an Oral Small Molecule GLP-1 Receptor Agonist" by Haggag, M.D., et all, presentation at Obesity Week, 2024.*
*Notes: Dots represent individual % change; box plot is of median, 25th & 75th percentiles.*
*During the OGTT, participants fasted for 10 hrs and blood was collected for plasma glucose at 0.25, 0.5, 1.0, 1.5, and 2 hours post oral intake of 75 g glucose at baseline (Day -1) and Day 1 post treatment.*

In the MAD portion of the trial, ECC5004 demonstrated clinically meaningful, dose-dependent improvements in both glycemic control and body weight in patients with T2D. The patients in the MAD portion of the trial experienced reductions in fasting and postprandial glucose, as well as clinically significant body weight loss at 50 mg.




*Source: "Safety, Tolerability and Pharmacokinetics of AZD/ECC5004, an Oral Small Molecule GLP-1 Receptor Agonist" by Haggag, M.D., et all, presentation at Obesity Week, 2024.*

*Note: Titration: 10mg 7 days, 25 mg 7 days, 50 mg 14 days. Error bars together with boxes show 95% confidence interval ("CI") and LS means (LS geometric means for MMTT AUC) from the linear mixed effect analysis. Dots are individual data points.*

In the 50 mg cohort, ECC5004 produced an least square ("**LS**") mean reduction from the baseline in fasting plasma glucose of 76.6 mg/dL at Day 28. In addition, the AUC for glucose during a mixed-meal tolerance test ("**MMTT**") decreased by 51.7% from the baseline, indicating robust improvements in both fasting and postprandial glucose levels. ECC5004 treatment resulted in a mean body weight reduction of 5.76% from the baseline at Day 28 for subjects in the 50 mg cohort.

Conclusion. In the Phase I trial, ECC5004 was generally well tolerated with no serious adverse events. AEs were predominantly mild gastrointestinal events typical of the class.

*Completed Phase I Trial of ECC5004 in Healthy Participants under Fasted and Fed Conditions in the United States*

Trial design. The Phase I trial was an open-label, randomized, single-dose trial designed to evaluate the effect of food on the pharmacokinetics of ECC5004 in healthy participants. The trial included 14 healthy participants and was a crossover design. The study was conducted under fasted (> 10 hours) conditions, or fed condition. For the fed condition, ECC5004 was administered within 30 minutes of the start of the meal. The trial included healthy male and female participants of non-childbearing potential, aged 18 to 65 years, with BMI of 18.0 to 32.0 $kg/m^2$.

The primary objective was to assess the pharmacokinetic profile using serial plasma concentrations of ECC5004 for 120 hours after a single dose of 50 mg ECC5004. The primary endpoints were pharmacokinetic parameters. The secondary endpoints were to assess the safety and tolerability profile, $AUC_{0\text{-}tau}$, AUC from time 0 to 24 hours post-dose, lag time, apparent terminal

elimination half-life, apparent clearance, and AUC from the first measured concentration value back extrapolated to the concentration value at time 0 as a percentage of the AUC extrapolated to infinity using the predicted value of the last non-zero concentration.

Trial status. The existing IND for ECC5004 received from the FDA in November 2022 encompasses all Phase I trials of the compound in the United States. We submitted protocol to the existing IND in December 2023 and received approval in the same month. We subsequently initiated the trial in February 2024 and completed the trial in March 2024.

Safety and tolerability results. There were no SAEs, deaths or discontinuations due to TEAEs. The overall frequency of AEs was 64.3% in the fed state and 50% in the fasted state. The most common AEs were nausea, dyspepsia, abdominal discomfort and vomiting. There were no clinically relevant treatment-emergent abnormalities on laboratory assessments or ECGs.

Pharmacokinetics results. ECC5004 demonstrated a favorable elimination half-life, where serial plasma concentrations were measured for up to 120 hours following a single 50 mg dose for an assessment of the elimination phase. The estimated half-life was 21.2 hours in the fasted state and 20.7 hours in the fed state as shown in the table below, supporting the feasibility of once-daily dosing. While half-life estimates were also derived from the MAD portion of the completed first-in-human trial, interpretation is limited due to the pharmacokinetic sampling only up to 48 hours post-dose, which may not fully capture the elimination phase, whereas the half-life results from the food effect study are considered more accurate and support the suitability of ECC5004 for convenience, once-daily oral administration.

| Arms | $AUC_{last}$, ng hr/mL GM (CV%) | $C_{max}$, ng/mL GM (CV%) | $t_{max}$, hr GM (CV%) | $t_{1/2}$, hr GM (CV%) |
|---|---|---|---|---|
| 50 mg fasted (n = 14) | 11,443.21 (56.22) | 374.5 (53.6) | 8.8 (42.2) | 21.2 (19.1) |
| 50 mg fed (n = 14) | 12,054.39 (65.48) | 326.9 (51.1) | 10.7 (54.3) | 20.7 (14.7) |

*Abbreviation: $CV_1$ = coefficient of variation; $C_{max}$ = maximum concentration; GM = geometric mean; $t_{1/2}$ = elimination half-life time; Tmax = time to maximum concentration*

*Source: "AZD5004/ECC5004, a Small Molecule GLP-1 Receptor Agonist May Be Administered Once Daily Under Fed/Fasted Conditions" by Haggag, M.D., et all, presentation at Obesity Week, 2024.*

Food effect analysis. The results demonstrated that concomitant food intake does not materially alter the pharmacokinetic profile of ECC5004. Following a single 50 mg dose, the geometric mean ratios (fed versus fasted) for $AUC_{0\text{-last}}$ and Cmax were 1.05 (90% CI: 0.90-1.23) and 0.87 (90% CI: 0.69-1.04). These findings provide that ECC5004 can be administered with or without food, offering a level of dosing flexibility and patient convenience not achievable with oral peptide-based GLP-1RAs that mandate strict fasting conditions.

Conclusion. ECC5004 exhibited a pharmacokinetic profile supportive of once-daily dosing that was not significantly different between fed and fasted states.

*Completed Global Phase IIb Trial of ECC5004 as Monotherapy in Patients with T2D (SOLSTICE)*

Trial design. The Phase IIb trial (SOLSTICE) is designed to evaluate the efficacy, safety and tolerability of ECC5004 in patients with T2D. It is a randomized, global, double-blind, parallel-group, placebo-controlled trial with an open-label active comparator, which is Rybelsus titrated from a starting dose of 3 mg up to 14 mg.

This trial included patients with T2D patients aged 18 or older with an hemoglobin A1c ("**HbA1c**") 7.0-10.5%, BMI ≥ 23 kg/m$^2$, stable body weight (±5% for three months), and managed with diet/exercise or stable metformin or SGLT2 inhibitor. Key exclusions include type 1 or secondary diabetes, severe diabetic complications, recent severe hypoglycemia, recent weight loss medication, significant gastrointestinal conditions, bariatric surgery (previous or planned), and history of pancreatitis.

The primary objective was to evaluate the effect of ECC5004 versus placebo on glycemic control. The primary endpoints are the change in HbA1c at baseline to Week 26. The secondary objectives and endpoints were: (i) to evaluate the effect of ECC5004 versus placebo on fasting glucose by measuring the change in fasting glucose at baseline to Weeks 4, 12, 16 and 26; (ii) to evaluate the effect of ECC5004 versus placebo on HbA1c by measuring the achievement of HbA1c ≤ 6.5% at Week 26; (iii) to evaluate the effect of ECC5004 versus placebo on HbA1c by measuring baseline HbA1c ≥ 7.0% and achieved HbA1c < 7.0% at Week 26; (iv) to evaluate the effect of ECC5004 versus placebo on weight loss by measuring the percent change in body weight at baseline to Week 26; (v) to evaluate the effect of ECC5004 versus placebo on weight loss by measuring the absolute change in body weight at baseline to Week 26; and (vi) to evaluate the effect of ECC5004 versus placebo on weight loss by measuring the achievement of ≥ 5%, ≥ 10%, and ≥ 15% weight reduction at baseline to Week 26.

Trial status. The trial was initiated in October 2024. The enrollment was fully completed in June 2025, with a total of 406 patients enrolled. The trial was completed in December 2025, with data expected to be presented at a scientific congress in June 2026.

*Completed Global Phase IIb Trial of ECC5004 as Monotherapy in Participants with Obesity/Overweight with at Least One Comorbidity (VISTA)*

Trial design. The Phase IIb trial (VISTA) was designed to assess the efficacy and safety of five different dose arms of ECC5004 compared to a placebo for adults with obesity/overweight with at least one comorbidity. This is a randomized, global, double-blind, parallel-group, placebo-controlled, multi-center study with 36-week treatment duration. The trial was designed to have approximately 304 participants who were 18 years or older and have a BMI of 30 kg/m$^2$ or higher (obesity), or BMI of 27 kg/m$^2$ or higher (overweight) plus at least one comorbidity. Exclusions include obesity from other endocrine disorders, recent weight loss medication use, prior or planned bariatric surgery, history of T1D or T2D, significant gastrointestinal conditions, and history of pancreatitis.

This trial included patients who were (i) 18 years or older; (ii) have a BMI of (a) ≥ 30 kg/m2, or (b) ≥ 27 kg/m2 and have a current diagnosis of at least 1 of the following weight-related comorbidities (treated or untreated): (x) hypertension, (y) dyslipidemia or hyperlipidemia, (z) cardiovascular disease or (xx) obstructive sleep apnea; and (iii) have a stable body weight for three months prior to screening (+/- 5% body weight change).

The primary objectives and endpoints of the trial were: (i) to determine whether ECC5004 is superior to placebo for weight loss by measuring the percentage change in body weight from baseline for 26 weeks, and (ii) to determine whether ECC5004 is superior to placebo on the proportion of participants with weight loss ≥ 5% from baseline by measuring the proportion of participants with weight loss ≥ 5% from baseline weight for 26 weeks. The secondary objectives and endpoints of the trial were: (i) to determine whether ECC5004 is superior to placebo for weight loss by measuring the percent change in body weight from baseline for 36 weeks; (ii) to determine whether ECC5004 is superior to placebo on the proportion of participants with weight loss ≥ 5% from baseline by measuring proportion of participants with weight loss ≥ 5% for 36 weeks; (iii) to determine whether ECC5004 is superior to placebo for absolute weight loss by measuring absolute change from baseline in body weight at Week 26 and Week 36; and (iv) to assess the effect of ECC5004 versus placebo on the proportion of participants with weight loss ≥ 10% as well as ≥ 15% by measuring the proportion of participants with weight loss ≥ 10% as well as ≥ 15% at Week 26 and Week 36.

Trial status. The trial was initiated in October 2024. The enrollment was fully completed in March 2025, with a total of 310 participants enrolled. This trial was completed in November 2025, with data expected to be presented at a scientific congress in June 2026.

*Completed Phase Ib Bridging Trial of ECC5004 in Chinese Participants With Obesity or Were Overweight, With or Without T2D in China*

Trial design. This was a two-cohort, placebo-controlled trial designed to evaluate the safety, tolerability and pharmacokinetics of ECC5004 compared with placebo in Chinese participants with obesity/overweight with or without T2D. This trial was a randomized, parallel-group, double-blind, placebo-controlled, multicenter, two-arm treatment trial.

The trial included participants aged between 18 to 74 years and have stable self-reported body weight for three months prior to screening. For cohort A, the participants included have 27 $kg/m^2 \leq$ BMI $\leq$ 35 $kg/m^2$ and weigh at least 60 kg at screening. For cohort B, the participants included were: (i) diagnosed with T2D for at least two months prior to the signing of informed consent for the trial; (ii) have HbA1c value at screening of $\geq$ 7.0% and $\leq$ 10.5%; and (iii) BMI of $\geq$ 24 $kg/m^2$ at screening. Exclusions include conditions affecting trial participation or interpretation, gastric emptying abnormalities, significant hepatic or renal disease, history of pancreatitis or gallstones, and uncontrolled thyroid disease.

The primary objective and endpoints were to evaluate the safety and tolerability of ECC5004 compared with placebo in the qualified Chinese participants by measuring the number of participants with AEs, SAEs, adverse events leading to the discontinuation of study intervention, death, and adverse events of special interest from baseline to week 16. The secondary objective is to characterize the pharmacokinetics profile following repeated administration by measuring the following at Week 16: (i) ECC5004 concentrations in plasma, (ii) AUC-time curve over a dosing interval, (iii) Cmax, (iv) half-life, (v) tmax, and (vi) trough concentration.

Trial status. We received the IND approval from the NMPA in November 2024. The trial was initiated in June 2025. The enrollment was completed in July 2025, with 45 participants enrolled. We completed the trial in November 2025 and announced the topline results in February 2026.

*Safety results.* Based on the topline results, ECC5004 was generally well-tolerated in the 45 Chinese participants living with obesity/overweight, with or without T2D in the randomized, double-blind, placebo-controlled trial evaluating ECC5004 administered once daily over a 16-week treatment period. The topline safety profile observed was consistent with the established profile of the GLP-1 RA class. The majority of AEs reported were mild-to-moderate in severity, with the most commonly observed AEs being gastrointestinal in nature, including nausea and vomiting. Notably, no TEAEs results in treatment discontinuation across either cohort, and no liver safety signals were identified during the treatment period. These topline safety results are subject to final data review and verification.

*Pharmacokinetics results.* Based on the topline data, the pharmacokinetics profile of ECC5004 observed in Chinese participants enrolled in the Phase 1b trial was broadly comparable with prior pharmacokinetics data generated from global Phase I clinical trials conducted in non-Chinese populations. The topline results suggest that the absorption, distribution, and exposure characteristics of ECC5004 in Chinese adults are consistent with those previously established in the global clinical development program. These findings support the potential use of a consistent dose level and once-daily dosing regimen for Chinese participants in future global clinical development stages. Additionally, exploratory pharmacodynamic assessments, based on topline data and subject to final confirmation, demonstrated clinically meaningful reductions in body weight at week 16 in participants in cohort A compared with placebo, as well as clinically meaningful reductions in mean HbA1c at week 16 in participants in cohort B compared with placebo, indicating confirmed target engagement consistent with the intended mechanism of action of ECC5004.

*Conclusion.* The topline data from the Phase 1b trial, subject to final data confirmation and the final data from the global Phase IIb trials, could provide a clinical foundation supporting the advancement of ECC5004 into global Phase III development, with the potential for China's inclusion pending relevant regulatory approvals.

***License, Rights and Obligations***

In November 2023, we entered into an exclusive collaboration and license agreement with AstraZeneca for the development, manufacturing and commercialization of ECC5004, under which we granted AstraZeneca exclusive global rights, excluding Greater China, to develop and commercialize ECC5004. We retained co-development and co-commercialization rights in Greater China. Pursuant to the agreement, we received a US$185 million upfront payment in November 2023 and are eligible to receive up to US$1.825 billion in development, regulatory and commercial milestone payments, of which US$60 million had been paid to us in October 2024 for achieving development milestones relating to ECC5004, including the first patient dosed in the Phase IIb program. We are also eligible to receive tiered royalties ranging from high-single-digit to mid-teen percentages of annual net sales of ECC5004 outside Greater China. In March 2026, we entered into a side letter with AstraZeneca providing for a US$75.0 million credit against our share of development expenses for multiple anticipated global Phase III trials of ECC5004. For further details, see "Business — Our Collaboration and Licensing Agreement."

***Material Communications with Competent Authorities***

The IND application for ECC5004, which encompasses all Phase I clinical trials for the compound in the United States, was approved by the FDA in November 2022. Acting pursuant to that IND, the Phase I trial of ECC5004 in healthy participants and patients was initiated in December 2022. The trial was completed with the clinical study report in March 2024.

The protocol for an additional Phase I trial of ECC5004 in healthy participants under fed and fasted conditions in the United States was submitted to the existing IND and approved in December 2023. The trial was initiated in February 2024 and completed in March 2024.

The global Phase IIb trial of ECC5004 in patients with T2D (SOLSTICE) and global Phase IIb trial of ECC5004 of participants with obesity/overweight with at least one comorbidity (VISTA) were initiated in October 2024. The SOLSTICE trial was completed in December 2025 and the VISTA trial was completed in November 2025.

The IND approval from NMPA for the Phase Ib bridging trial of ECC5004 in Chinese participants with obesity/overweight, with or without T2D in China was received in November 2024. The trial was initiated in June 2025 and completed in November 2025.

ECC5004 did not receive any major concerns or objections from the above-mentioned regulatory authorities to its clinical development plans. We and AstraZeneca plan to maintain close communication with the competent authorities at key milestones of ECC5004's clinical development from time to time.

## WE MAY NOT BE ABLE TO ULTIMATELY DEVELOP AND MARKET ECC5004 SUCCESSFULLY

### ECC0509, our Key Product

***Overview***

ECC0509 is an oral, once-daily, peripherally distributed, highly selective small-molecule inhibitor of SSAO (also known as vascular adhesion protein-1 ("**VAP-1**") being advanced as a first-in-class therapy for OA pain and as a combination agent for MASH. We are advancing ECC0509 as a non-opioid, non-steroidal oral analgesic for OA pain. ECC0509 may also be evaluated in combination with GLP-1RA in patients with obesity or are overweight with joint pain.

In parallel, we are further exploring ECC0509 in combination with ECC4703 for the treatment of MASH, where SSAO inhibition's immuno-vascular biology may unlock additional clinical benefit. This combination is designed to unite complementary mechanisms — THR-β-driven reductions in hepatic steatosis and atherogenic lipids with ECC0509's inhibition of SSAO-mediated leukocyte trafficking and oxidative injury — to target the inflammation-fibrosis axis that persists despite metabolic correction.

***Drug Design and Mechanism of Action***

ECC0509 was intentionally designed to achieve potent, mechanism-based inhibition of semicarbazide-sensitive amine oxidase, or SSAO, in peripheral tissues with minimal brain exposure. Guided by our TRANDD workflow system, ECC0509 was optimized to preserve robust target engagement in plasma and liver while reducing central nervous system-related amine oxidase drug-drug interaction risk.

- **Peripheral tissue distribution with minimal brain exposure.**

  ECC0509 was designed to achieve robust target engagement in plasma and liver, the primary sites of SSAO-mediated pathology, while minimizing exposure in the brain. This peripheral distributing profile is designed to address a key limitation of an earlier SSAO inhibitor, which was associated with monoamine oxidase-related drug interaction risk arising from central amine oxidase inhibition. By restricting brain penetration, ECC0509 is intended to preserve pharmacological activity in peripheral target tissues while substantially reducing the risk of clinically significant drug interaction risks.

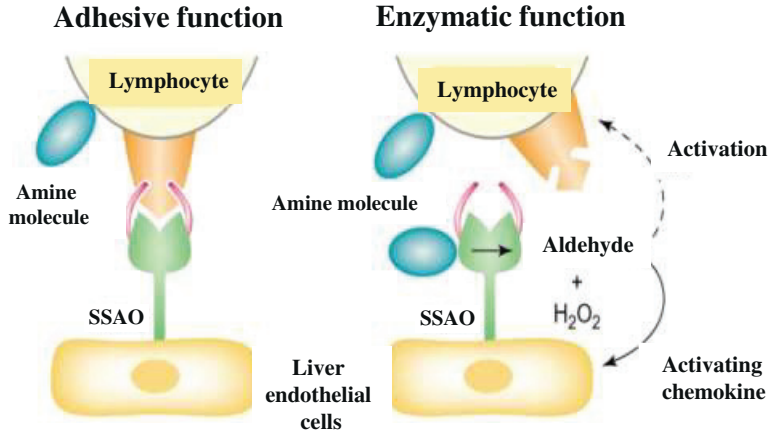
- **Potent and selective mechanism-based SSAO inhibition.**

  ECC0509 was designed as a potent, mechanism-based SSAO inhibitor with good selectivity and *in vivo* potency to achieve sustained inhibition of SSAO activity in peripheral tissues. By inhibiting SSAO, ECC0509 reduces the formation of SSAO-derived toxic byproducts that are believed to contribute to oxidative tissue injury and disease progression in conditions such as OA pain and MASH. The mechanism-based nature of inhibition is intended to confer durable target coverage, supporting once-daily oral dosing regimen.

- **Downstream modulation of inflammatory and fibrotic pathways.**

  Beyond its enzymatic inhibitory activity, ECC0509 is designed to exploit the dual functionality of SSAO/VAP-1 as both an enzyme and a cell-adhesion molecule. By inhibiting VAP-1-mediated leukocyte tethering and extravasation, ECC0509 is intended to attenuate the downstream inflammatory cascade, including chemotaxis, endothelial activation, and profibrotic signaling in hepatic stellate cells and synovial fibroblasts, which drives tissue injury and fibrosis progression.

The following diagram illustrates such mechanism of action of ECC0509.




*Source: Literature Review, Frost & Sullivan*

*Market Opportunity and Competition*

OA Pain. OA pain typically worsens with activity and eases with rest, in severe cases it can become constant due to cartilage breakdown in the knees, hips, and hands. Management of OA pain focuses on symptom control with physical therapy and obesity/overweight alongside medications such as NSAIDs, though chronic use of NSAIDs might lead to increased risks of gastrointestinal bleeding, renal impairment, and cardiovascular events.

SSAO, is an upstream target that integrates oxidative injury and leukocyte trafficking, key drivers of OA pain and damage. This combined anti-inflammatory and antioxidative strategy offers a new opportunity to relieve OA pain.

MASH. SSAO protein expression is upregulated in MASH patients and correlates with fibrosis stage and disease progression. Recent research suggests the potential for enhanced efficacy in the treatment of MASH when SSAO inhibitor is combined with THR-β agonist.

As of the Latest Practicable Date, there was no approved SSAO inhibitor for the treatment of OA pain and MASH, ECC0509 remains the only clinical stage SSAO candidate targeted for the treatment of OA pain and MASH. For more details, please refer to "Industry Overview — Overview of Cardiometabolic and Inflammatory Diseases Drug Market — OA Pain Drug Market — Competitive Landscape of Small Molecule SSAO Drug Market."

*Key Advantages*

- **High Selectivity and Peripheral Distribution Profile to Mitigate Drug to Drug Interaction ("DDI") Concern Associated with Monoamine Oxidases.** Across *in vitro* and *in vivo* evaluations, ECC0509 demonstrates excellent SSAO selectivity and minimal brain distribution to mitigate the DDI risk associated with monoamine oxidases, supporting its continued development as a clinically differentiated SSAO inhibitor.

- **Robust and Sustained Target Engagement Demonstrated in Humans.** In the Phase I trial, ECC0509 produced rapid onset and near-complete suppression of plasma SSAO activity and sustained this effect over time, indicating durable target coverage at clinically feasible doses. A dose-dependent increase in plasma methylamine was also observed, these pharmacodynamic effects can guide the dose selection of subsequent clinical trials.

- **First-in-Class Opportunity in OA Pain.** ECC0509 stands out as potential first-in-class candidate with robust and rapid pain relief in two distinct OA animal models as shown below, with clear efficacy observed at doses as low as ~0.4 mpk.

*Clinical Development Plan*

Following acknowledgment from the Therapeutic Goods Administration (the "**TGA**"), we commenced a Phase I clinical trial for ECC0509 in healthy volunteers in Australia in July 2021 and completed the trial in July 2023.

The table below sets forth details of ECC0509's clinical development plan:

| Indication | Trial Phase | Study Population | Regimens | Trial Status | Jurisdiction | (Expected) Trial Start Date | (Expected) Trial Completion Date |
|---|---|---|---|---|---|---|---|
| MASH<br>OA Pain | Phase I | Healthy participants | Mono | Completed | Australia | July 2021 | July 2023 |
| OA Pain | Phase IIa | OA Pain | Mono | IND approved by the FDA | United States | 2027 | To be determined |
| MASH | Phase IIa | Presumed MASH | Mono<br>Combo with ECC4703 | Ongoing | United States | December 2025 | 2027 |

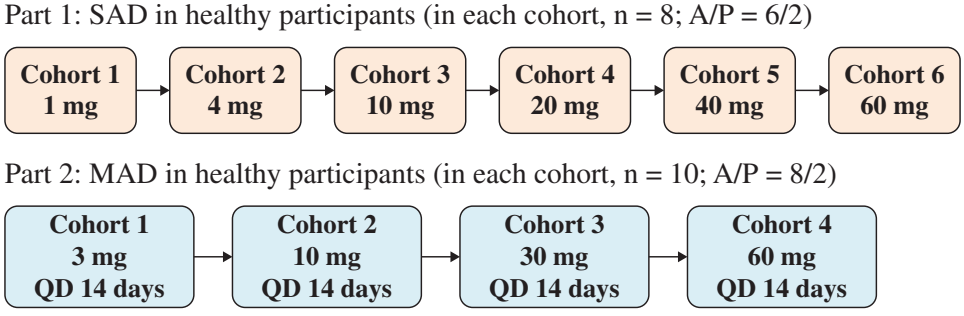
***Summary of Clinical Trial Results***

*Completed Phase I First-in-Human Trial of ECC0509 in Healthy Volunteers*

Trial Design. This was a single-center, Phase I, randomized, double-blind, placebo-controlled trial of ECC0509 in healthy subjects, including sequential SAD and MAD parts with a food-effect assessment. The primary objective was to evaluate the safety and tolerability of ECC0509 following oral administration of single and multiple ascending doses of ECC0509. The secondary objectives were to characterize the PK and PD profiles of ECC0509 following single and multiple dose administrations.

The SAD portion of the Phase I trial evaluated six dose levels of ECC0509 (1-60 mg) in healthy volunteers. A total of 48 participants were enrolled and completed the SAD part. The MAD portion evaluated ECC0509 at 3, 10, 30, and 60 mg once daily for 14 days in cohorts of 10 participants (8 active, 2 placebo), enrolling a total of 41 healthy adults.

See the diagram below for an illustration of the Phase I trial design.




*Source: "Safety, Tolerability, Pharmacokinetics and Pharmacodynamics of ECC0509, an SSAO Inhibitor for MASH, in a Phase I trial" by Angela Rowland, et all, The Liver Meeting, AASLD, Nov. 15-19, 2024.*

Primary endpoints assessed safety, including TEAEs/SAEs and clinically significant changes in labs, ECGs, vitals, and physical exams — through Day 8 in SAD and Day 21 in MAD. Secondary endpoints evaluated pharmacokinetics at both single and multiple doses, including measures of exposure (AUC, Cmax), time course (Tmax, t½), accumulation, and clearance.

Trial Status. We Submitted the clinical trial notification to the TGA and received the acknowledgment from the TGA in June 2021. We initiated the trial in July 2021 and completed the trial in July 2023.

Safety Results. ECC0509 was generally well tolerated.

The most commonly reported TEAEs for participants receiving ECC0509 were general disorder and catheter site conditions (21.2% vs. 25.0% for participants receiving placebo in the MAD phase), nervous system disorders such as headaches and somnolence (21.2% vs. 25.0% for participants receiving placebo in the MAD phase), and infections and infestations (21.2% vs. 12.5% for participants receiving placebo in the MAD phase). The majority of the TEAEs were considered mild in severity. No deaths had been reported with ECC0509. In the MAD phase of the first-in-human trial, 1 participant (60-mg dose level) decided to withdraw from the trial and thereafter experienced 3 severe and serious TEAEs: auditory hallucination, visual hallucination, and suicidal ideation. These SAEs were determined to be unlikely related to the study drug and were considered resolved. The subject had a history of mental health disorders which was not disclosed at screening and were unknown to the clinical research unit at enrolment.

Pharmacokinetics results.

Collectively, the SAD and MAD results establish that ECC0509 demonstrated PK profile compatible with once-daily dosing regimen.

Pharmacodynamic results.

In the SAD portion of the trial, ECC0509 produced rapid, potent, and near-complete inhibition of plasma SSAO activity across all single-dose levels, indicating target engagement after first exposure.

In the MAD portion of the trial, ECC0509 maintained nearly complete inhibition of plasma SSAO activity from Day 2 onward across all daily dose levels from 3 mg to 60 mg and sustained this inhibition throughout the 14-day dosing period and up to the Day 21 follow-up, demonstrating durable target suppression with once-daily administration. Pharmacodynamic substrate responses mirrored the enzymatic readout: plasma methylamine accumulated progressively over the dosing days and reached a steady state by Day 7, with maximal increases observed at once-daily doses of 30 mg and higher. This plateau at $\geq$30 mg indicates that SSAO activity was broadly inhibited in peripheral tissues at these dose levels, providing pharmacologic rationale for dose selection in subsequent Phase II trials.

Conclusion. ECC0509 demonstrated a favorable safety and tolerability profile in the Phase I trial. Pharmacodynamic assessments showed near-complete inhibition of plasma SSAO activity at low doses, while plasma methylamine levels increased in a dose-dependent manner and reached a plateau at 30 mg. Collectively, these findings support the continued development of ECC0509 as a potential once-daily oral therapy for patients with MASH and OA pain.

We also initiated the Phase IIa trial of ECC4703 and ECC0509 as monotherapy and the combination of ECC4703 and ECC0509 for the treatment of MASH in December 2025. For details of the trial, see "ECC4703, our Core Product — Summary of Clinical Trial Results — Planned Phase IIa trial to evaluate the efficacy and safety of ECC4703, ECC0509, and the combination in adults with presumed MASH in the United States" in this section.

*Ongoing Phase IIa trial to evaluate the efficacy and safety of ECC4703, ECC0509, and the combination in adults with presumed MASH in the United States*

This is a U.S.-based, multicenter, randomized, double-blind, placebo-controlled Phase IIa trial that will evaluate the efficacy, safety, PK, and PD of ECC4703, ECC0509 as monotherapy and the combination of ECC4703 and ECC0509 for the treatment of MASH. We designed this parallel-group design to separately characterize the effects of ECC4703 and ECC0509 in the treatment of MASH both as monotherapy and combination therapy. By holding procedures and visit schedules constant and randomizing across arms, the study enables unbiased attribution of any superior pharmacodynamic changes to dual-mechanism engagement and allows a direct comparison of safety profiles between monotherapy and combination of ECC4703 and ECC0509. For details of this trial, please refer to "— ECC4703, our Core Product — Summary of Clinical Trial Results — Ongoing Phase IIa trial to evaluate the efficacy and safety of ECC4703, ECC0509, and the combination in adults with presumed MASH in the United States."

***License, Rights and Obligations***

We are developing ECC0509 in-house and own the global rights to develop and commercialize ECC0509.

***Material Communications with Competent Authorities***

Below is a summary of our material communications with the competent authorities regarding ECC0509 from IND/pre-IND interactions as of the Latest Practicable Date.

*TGA*

On June 15, 2021, we submitted the IND application for the Phase I trial ECC0509 to the TGA, the objective is to evaluate the safety, tolerability, pharmacokinetics and pharmacodynamics of ECC0509. The submission package included the clinical trial protocol and available nonclinical information to support the proposed Phase I trial. The TGA acknowledged the IND application on June 16, 2021, indicating we may proceed with the Phase I trial.

We had strategically chosen to conduct the Phase I trial of ECC0509 in Australia because we have taken into account that (i) Australia is often used for early-phase clinical trials due to a generally faster and more straightforward regulatory start-up than in the United States, while still producing data acceptable to the FDA; (ii) most studies proceed under streamlined TGA pathways, allowing substantially faster trial start-up than in the United States; and (iii) because Australia operates under ICH GCP standards, Phase I data generated there are routinely used to support IND application with the FDA and subsequent development, making Australia a practical and commonly used entry point before transitioning to U.S. Phase II/III programs. We continue to conduct Phase II clinical trials in the United States because we intend to commercialize ECC0509 globally, including in the United States and the Phase II trial evaluates efficacy data in the U.S. population, which allows us to smoothly navigate through FDA regulation.

*FDA*

In April 2025, we submitted a pre-IND meeting request to the FDA in connection with a proposed Phase IIa trial of ECC4703 and ECC0509 for the treatment of MASH as monotherapy and in combination therapy. The FDA reviewed the safety and pharmacokinetic profiles of ECC4703 and ECC0509 from their respective Phase I clinical trials, together with the nonclinical combination toxicology package. The FDA stated that the submitted pharmacokinetic and safety data for each product, together with the nonclinical combination toxicology package, were adequate to support evaluation of the ECC4703 and ECC0509 combination in the proposed clinical trial.

In August 2025, we submitted an IND application to the FDA for the Phase IIa trial of ECC4703 and ECC0509 for the treatment of MASH as monotherapy and in combination therapy under IND 176762. In August 2025, we submitted the IND application for the Phase IIa trial of ECC4703 as monotherapy, ECC0509 as monotherapy and their combination in adults with presumed MASH (IND 176762) to the FDA. On October 2, 2025, the FDA granted the IND approval for IND 176762. For more details, please refer to "— ECC4703, our Core Product — Material Communications with Competent Authorities — FDA" in this section.

The following table sets forth a summary of our material communications with regulatory authorities regarding ECC0509:

| Trial | Milestone/Stage | Timeline |
|---|---|---|
| Phase I first-in-human trial of ECC0509 in healthy volunteers | Submission of clinical trial notification to the TGA | June 2021 |
| | Received acknowledgment from the TGA | June 2021 |
| Phase IIa trial of ECC0509 for the treatment of OA pain | Submission of IND application to the FDA* | February 2025 |
| | IND approval from the FDA | April 2025 |

| Trial | Milestone/Stage | Timeline |
|---|---|---|
| Phase IIa trial . . . . . | Submission of IND application to the FDA* | August 2025 |
| | IND approval from the FDA | October 2025 |

*Note:* * The Phase I clinical trial in Australia was conducted in compliance with ICH-GCP and applicable local regulatory requirements, and that the safety, tolerability, and pharmacokinetic data from this study were submitted to the FDA as part of the IND application to support the Phase IIa study in the United States.

As of the Latest Practicable Date, ECC0509 did not receive any major concerns or objections from the aforementioned regulatory authorities to its clinical development plans.

## WE MAY NOT BE ABLE TO ULTIMATELY DEVELOP AND MARKET ECC0509 SUCCESSFULLY

### Our Preclinical Programs

#### *GIP Receptor Modulator*

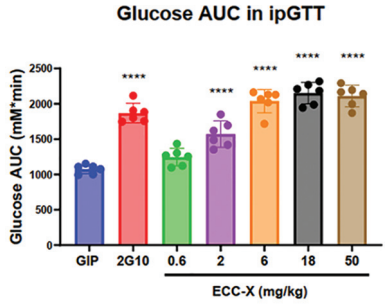
*Overview*

Our GIP receptor modulator program applies the TRANDD workflow system to discover a novel oral small molecule for obesity/overweight, T2D, and related comorbidities. Anchored by human validation of the GIP axis (e.g., Tirzepatide and Maritide), our lead molecule exhibits potent, selective GIPR antagonist activity that complements GLP-1RA. Our GIPR receptor modulator is currently in preclinical stage, and we plan to submit an IND application by 2028.

*Preclinical Data*

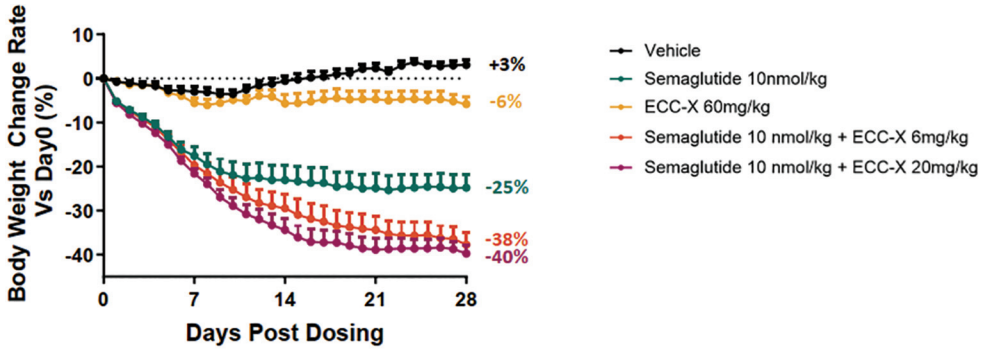
Our GIP receptor modulator blocked GIPR in a dose-dependent way and clearly reversed glucose levels during a glucose tolerance test, suggesting clear target engagement. In a 28-day study in diet-induced obese human-GIPR knock-in mice, our GIP receptor modulator alone modestly lowered body weight and food intake, while combining our GIP receptor modulator (6 or 20 mg/kg) with Semaglutide (10 nmol/kg) produced greater, sustained weight loss with clear reductions in cumulative food intake.

**Dose-dependently Reversed GIP-induced Suppression of Glucose Excursion in Preclinical Models**




*Source: Company Data*

**In Combination with Semaglutide Resulted in Additional Reduction of Body Weight in Preclinical Models**




*Source: Company Data*

***Amylin Receptor Agonist***

*Overview*

Our Amylin receptor agonist program leverages the TRANDD workflow system to create oral small molecule agonists designed for monotherapy and combination with GLP-1RAs. This program is designed to mimic the benefits of natural Amylin signaling while addressing the delivery, tolerability and adherence limitations of injectable peptide drugs. Our Amylin receptor agonist program is currently in preclinical stage, and we plan to submit an IND application by 2028.

*Mechanism, Therapeutic Rationale and Development Plan*

Mechanistically, by activating Amylin receptors, the molecules may help reduce appetite and slow stomach emptying. Based on published research and our TPP, we believe Amylin signaling may complement GLP-1RA on satiety and insulin biology, creating the potential for greater weight loss, better glucose control and more durable metabolic effects when used together. As a small molecule, this drug candidate may enable convenient fixed-dose combinations with GLP-1RA, offering a differentiated option versus injectable Amylin analogs. Our preclinical work includes studies assessing receptor activity, markers related to satiety and gastric motility and effects on weight in standard obesity animal models. Our Amylin receptor is currently in preclinical stage. We plan to continue our IND-enabling studies and submit an IND application by 2028.

***UPA***

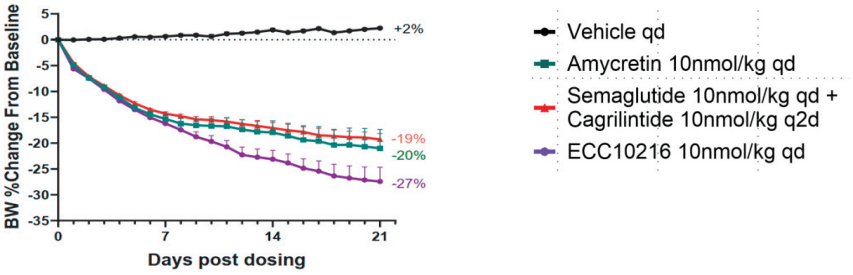
*Overview*

We are developing a UPA program as a single, engineered peptide designed to engage GLP-1R, GIPR, and Amylin receptor simultaneously in a unimolecular poly-agonist format for the treatment of obesity/overweight. This design specifically addresses and mitigates the formulation, manufacturing and pharmacokinetic challenges inherent in trying to combine multiple, separate peptide therapies into a single administered product. Mechanistically, this UPA molecule is designed to deliver coordinated incretin and Amylin receptor activation that produces potent, dose-dependent appetite suppression and delayed gastric emptying, with the potential to reduce body weight. This approach represents a distinct modality that we are pursuing for metabolic treatments and body weight reduction. While we believe oral small molecules offer strong potential for flexible combination therapies, for this specific program, we are leveraging the singular efficacy of a multi-targeted peptide to deliver a single-agent therapy efficiently. The UPA program is current in preclinical development and we plan to submit an IND application by 2028.

*Preclinical Data*

In lean rat studies, a single subcutaneous dose of our UPA produced dose-dependent and sustained reductions in cumulative food intake over 72 hours. In a 21-day study in diet-induced obese rats, once-daily administration of our UPA achieved progressive body weight loss. Together, these preclinical data establish a compelling efficacy profile for our UPA that integrates multi-receptor biology to deliver differentiated weight loss.

**Our UPA Reduces Body Weight in DIO Rats**




*Source: Company Data*

## OUR WORKFLOW SYSTEM

### Translational Research-Aided Drug Discovery and Development Workflow System

Our proprietary TRANDD workflow system is an integrated engine designed to accelerate discovery and improve decision-making in our clinical development process. Leveraging the workflow system, we have been able to advance three distinct drug candidates into clinical development in just four years from the start of the programs, including our Core Product, ECC4703, a liver-targeting THR-β full agonist for the treatment of MASH and obesity/overweight. Our TRANDD workflow system was instrumental at every stage of ECC4703's development, from the initial selection and validation of THR-β as a clinically relevant target, through the rigorous refinement of the target product profile, the disciplined selection of a chemical scaffold with high THR-β selectivity, full receptor agonism, and a liver-preferential distribution profile, the identification of novel indications including the combination of ECC4703 with GLP-1RA for obesity/overweight, and the design of biomarker-enriched early clinical trials that generated promising pharmacological data in human. Drug discovery and development is a complex process with high attrition rates accompanied by substantial and escalating investment along the development journey. Our TRANDD workflow system is designed to greatly enhance the efficiency and lower the attrition rates by integrating the following comprehensive capabilities:

- **Target selection and validation.** The workflow system incorporates systematic procedures for target selection and validation. At the outset of each program, our R&D team identifies and prioritizes biological targets based on scientific rationale, medical need, and the potential for clinical differentiation. This process involves a comprehensive review of available literature, analysis of disease biology, and evaluation of competitive therapies. Once a target is selected, we design and implement customized assays and experimental models to validate the target's relevance to the disease and its potential to deliver meaningful therapeutic benefits. For ECC4703, the workflow system was instrumental in both the selection and validation of the biological target. Specifically, through the process described above, the workflow system helped to emphasize the biological rationale that activation of THR-β in the liver increases fatty acid oxidation and improves lipid metabolism. Through additional research and analysis

of available data, our R&D team was able to confirm that targeting THR-β could address key aspects of the disease pathology. This evidence-based approach supported the decision to advance ECC4703 as a product candidate for our pipeline.

- **Refinement and development of TPP.** We start each program by setting clear goals for what the ideal product candidate should look like through the design of the TPP. For example, when developing treatments for MASH, we identified several key success factors that our product candidate needed to achieve, including but not limited to: high selectivity for THR-β over THR-α, better potential effectiveness than the existing products or product candidates, liver-targeting, and other favorable drug-like properties. Once we set the goals, we design the specific laboratory tests, or assays, to measure whether our product candidate met these criteria. For example, we ran a rat PD assay to see if a product candidate was working in the liver and not caused unwanted effect in the heart. Such tests provided us with more data to decide which compounds to move forward. For instance, in the case of ECC4703, we only advanced the compound after it met all of our TPP criteria in these tests. This careful, step-by-step approach helps us make informed decisions and prioritize the most promising candidates.

- **Analysis and prioritization of chemical scaffold.** After setting the TPP and performing the necessary biological assays, we move to the critical step of analyzing and prioritizing the chemical scaffold, which is the core structure of the molecule that determines its properties and potential as a product candidate. For each program, our R&D team uses the TRANDD workflow system to systematically compare different chemical scaffolds. We look at a range of factors, including but not limited to: how well the scaffold works, its drug-like properties, and the likelihood of causing unwanted side effects. We rely on our own data and insights from publicly available research for the evaluation. For ECC4703, this process was central to identifying a scaffold with full receptor agonism, high selectivity for THR-β over THR-α, a strong liver-preferential distribution profile, and an absence of reactive intermediates, properties that directly underpin ECC4703's differentiated efficacy and safety profile relative to other THR-β candidates. For our small molecule GLP-1RA program, we applied this rigorous approach for scaffold selection. We deliberately chose a scaffold that showed strong in vivo potency and favorable drug-like properties in our early tests. At the same time, we deprioritized another scaffold that, according to Frost & Sullivan, was more prone to off-target liabilities. This disciplined, evidence-based assessment of chemical scaffolds is a key feature of the TRANDD workflow system. By carefully evaluating and prioritizing scaffolds early in the process, we increase the chances of developing products that are both effective and safe, and we avoid investing resources in candidates with a higher risk of failure.

- **Indication selection.** The TRANDD workflow system supported the identification of MASH as a primary indication for ECC4703, grounded in the biological rationale that selective THR-β activation in the liver reduces hepatic lipid accumulation, attenuates inflammation, and may improve fibrosis. In addition, the TRANDD workflow system also guided the hypothesis generation for new indications. We hypothesize how THR-β agonist as an adjunct to GLP-1RA might address these challenges. We identified that a liver-targeting THR-β full agonist could independently activate strong fatty acid oxidation. This means it could help the body burn fat more efficiently, especially when used together with a GLP-1RA.

  We then design and conduct preclinical studies, using obese animal models, to test our hypotheses. In our research, we found that combining our THR-β agonist with a GLP-1RA led to significant additional weight loss, with most of the weight loss coming from fat rather than muscle. These results were observed in our preclinical models and provided strong evidence that this combination could offer meaningful benefits for patients with obesity/overweight. When our preclinical data show promising results, we

assess the potential clinical and strategic value of pursuing this new indication. We consider factors such as the size of the patient population, the severity of the disease, and the competitive landscape. Insights from both human disease biology and our preclinical data are used to design clinical trials that will test our medicines in the new indication. This ensures that our clinical trials are based on solid scientific evidence and are more likely to succeed.

By following this structured process, we are able to identify and prioritize new indications for our product candidates that have clear scientific and clinical value. For example, our work combining a THR-β agonist with a GLP-1RA has generated testable hypotheses and compelling preclinical results, supporting the advancement of this combination into clinical studies for obesity/overweight. This approach is a key part of our broader strategy to expand the potential uses of our product candidates and maximize their impact for patients.

- **Design of early clinical trials.** Once our preclinical research shows that a new product candidate has strong potential, we move to the next step: designing early clinical trials. We design our early clinical trials to be adaptive, meaning we can make adjustments as new data emerges. We also use biomarker-enriched protocols, which means we select and monitor specific biological markers in patients to help us understand how the medicine is working in the body. Our trials are set up to collect detailed data and we work closely with biostatisticians in analyzing the data. We use insights from our preclinical research, including animal studies, to inform the design of our clinical trials. For example, for ECC4703, the duration of the MAD portion of the Phase I trials was 14 days. This study duration was determined by the learning of THR-β's effectiveness within 14 days from our translational evaluation so that a timely assessment of ECC4703's performance in human can be conducted. This helps us make a smooth transition from laboratory research to rapidly gaining translational understanding in humans, while ensuring that our studies are based on solid scientific evidence. Our approach incorporates rapid go/no-go decision points, whereby we systematically review emerging data at predefined intervals throughout the trial. Based on these interim analyses, we make timely, evidence-based decisions to continue, modify, or discontinue a study. This process helps us to allocate resources efficiently and advance only the most promising product candidates.

- **Determination of biomarkers and patient stratification.** For each product candidate, we prospectively identify key translational biomarkers, such as body weight, glucose, and LDL-C, that help confirm whether the product candidate is engaging its intended target and clarify how it works in humans. We select biomarkers based on disease and mechanistic relevance and ability to demonstrate target engagement, monitoring pharmacodynamic changes to inform critical development decisions including dose selection and patient stratification. For example, in the ECC4703 first-in-human trial, we recruited participants with treatment-unnecessary LDL-C under 160 mg/dL in MAD cohorts B2 and B3 to better assess LDL reduction treatment effects, and the placebo-adjusted LDL reduction data provided human evidence of target engagement, informing subsequent trial design. This systematic approach improves study design and advances candidates with higher clinical success potential.

Our TRANDD workflow system was developed internally by our R&D team leveraging our internal expertise, translational insights, and scientific knowledge, supplemented by publicly available research data. The workflow system was designed to support our pipeline, including the discovery and development of our oral small molecule product candidates.

## OUR COLLABORATION AND LICENSING AGREEMENT

During the preclinical research and development of ECC5004, we initiated preliminary discussions with AstraZeneca to explore potential partnership opportunities. As we evaluated the resources and capabilities required to advance ECC5004 into later-stage clinical development and global commercialization, we determined that a collaboration with a global pharmaceutical partner would be appropriate. The discussion with AstraZeneca progressed in 2023 as both parties evaluated strategic alignment and potential for value creation. Through these engagements, we concluded that a partnership with AstraZeneca would best position ECC5004 to realize its full potential while enabling disciplined capital allocation and risk management for our pipeline.

In November 2023, we and AstraZeneca entered into the AstraZeneca Agreement concerning the licensing, development, manufacturing and commercialization of our oral small molecule GLP-1RA compound, ECC5004, and any other small molecule GLP-1RA compound covered by our patent relating to ECC5004 (collectively, the "**Licensed Compounds**") and any pharmaceutical or biologic product that contains a Licensed Compound (the "**Licensed Products**") and related technologies (the "**Licensed Technology**"). For the avoidance of doubt, except for ECC5004, our patent relating to ECC5004 does *not* cover any other product candidates in our pipeline, and the Licensed Compounds and Licensed Products are distinct from our other product candidates. We believe this collaboration enables us to leverage AstraZeneca's global resources, expertise and infrastructure to accelerate the development and commercialization of ECC5004, while effectively managing associated costs and risks.

Pursuant to the AstraZeneca Agreement, we granted AstraZeneca a transferable, sublicensable license to the Licensed Compounds and Licensed Products on a worldwide basis (the "**AstraZeneca Territory**"), except for mainland China, the Special Administrative Region of Hong Kong, the Special Administrative Region of Macau and Taiwan (collectively, the "**Licensor Territory**"). Within the AstraZeneca Territory, AstraZeneca holds exclusive rights to develop and commercialize the Licensed Compounds and Licensed Products. In the Licensor Territory, we and AstraZeneca share co-exclusive rights for the development and commercialization of the Licensed Compounds and Licensed Products.

AstraZeneca also granted us a co-exclusive, royalty-free, sublicensable, and transferable license for certain AstraZeneca's relevant know-how, patents, product-specific technology, and AstraZeneca's interest in jointly developed technology, as well as a grant-back license under AstraZeneca's rights in Licensed Technology. The grant-back license allows us to use any improvements, modifications or developments made by AstraZeneca related to Licensed Technology. We can use these rights solely to carry out our responsibilities and obligations for ECC5004 under the AstraZeneca Agreement. For the avoidance of doubt, the license granted by us to AstraZeneca and the license granted by AstraZeneca to us were solely to enable the other party to perform its respective obligations with respect to ECC5004 under the AstraZeneca Agreement. These licenses or any services rendered by AstraZeneca pursuant to the AstraZeneca Agreement have not contributed to the development of our Core Product, ECC4703, or our ECC0509, in any way. Our patents, know-how, or patent applications covered under the AstraZeneca Agreement, including the Licensed Compounds, Licensed Products and Licensed Technology, do not relate to or compete with the other product candidates in our pipeline. For clarity, GLP-1RAs such as ECC5004 could serve as a backbone therapy for cardiometabolic diseases, while our ECC4703 and ECC0509 product candidates have the potential to synergize with GLP-1RAs. In terms of funding, in addition to the pre-[**REDACTED**] equity financing in the ordinary course of business, other than the equity investment, and the upfront and milestone payments and fees as disclosed under "— Costs and Expenses" below from AstraZeneca and its affiliates, each as disclosed in this document, no third party has provided any funding or made any financial contributions toward the development of ECC5004 or any other product candidates in our pipeline. The license from AstraZeneca to us was solely for the development of ECC5004 pursuant to the AstraZeneca Agreement as discussed above. No third party has contributed, outsourced or acquired R&D or technological contribution to the development of any of our other product candidates.

***Decision-making framework under the AstraZeneca Agreement***

The roles, responsibilities and decision-making powers under the AstraZeneca Agreement are structured to reflect each party's respective territorial rights and operational responsibilities, and are allocated between us and AstraZeneca across the following key areas:

- *Development*: AstraZeneca has the final decision-making power with respect to research and development activities relating to the Licensed Compounds and Licensed Products in the AstraZeneca Territory (i.e., outside Greater China). We have the final decision-making power with respect to research and development activities relating to the Licensed Compounds and Licensed Products in the Licensor Territory (i.e., Greater China), subject to certain limited safeguards as further described under "— JSC" below, which we consider would not materially impair our ability to advance the development of the Licensed Compounds and Licensed Products in the Licensor Territory. See "— Development" below for more details.

  - For ECC5004, we served as the sponsor for the Phase Ib bridging trial in China. For ECC5004's Phase III program, based on the JSC's discussions, the JSC approved a global Phase III MRCT program to be sponsored by AstraZeneca, which will include investigational sites in Greater China for the enrollment of patients within the Licensor Territory. This approach reflects the JSC's determination that a global MRCT program represents the most efficient clinical pathway for Phase III development, enabling patients in Greater China to participate in the global program through investigational sites in the Licensor Territory, rather than through a separate China-specific clinical trial.

- *Regulatory*: AstraZeneca leads the regulatory activities relating to the Licensed Compounds and Licensed Products in the AstraZeneca Territory. We lead the regulatory activities relating to the Licensed Compounds and Licensed Products in the Licensor Territory, except as provided below. See "— Regulatory activities" below for more details.

  - In March 2026, the JSC agreed that, for operational effectiveness and efficiency, AstraZeneca will lead the regulatory activities of the Phase III MRCT program as part of AstraZeneca's global Phase III development for ECC5004, enabling enrollment of patients within Greater China in the global program sponsored and managed operationally by AstraZeneca. We shall exercise our rights and responsibilities for Greater China by appointing a regulatory liaison to work with AstraZeneca on all regulatory activities in Greater China, including reviewing all submissions to, and correspondence and communications with the regulatory authorities in China.

- *Funding and Cost Sharing Arrangement*: AstraZeneca funds all development activities in the AstraZeneca Territory. For development activities conducted jointly in the Licensor Territory (including clinical trials in Greater China that form part of a global clinical trial), we bear 51% and AstraZeneca bears 49% of all shared project expenses. For global development activities conducted outside the Licensor Territory, we bear 4.5% and AstraZeneca bears 95.5% of the relevant costs. The development activities and associated budgets for the Licensor Territory are set out in an Annual Joint Development Plan (as defined below) approved by the JSC on an annual basis. See "— Costs and Expenses" below for more details.

  - On March 20, 2026, we entered into a side letter with AstraZeneca (the "**March 2026 Side Letter**") pursuant to which AstraZeneca agreed to apply a credit of US$75.0 million to offset our share of the shared development expenses attributable to a global Phase III MRCT program to be led by AstraZeneca

discussed above. The credit will be applied in quarterly installments from the third quarter of 2026 through the second quarter of 2029, with any unused portion in a given quarter rolling forward to subsequent quarters until the full credit of US$75.0 million has been utilized.

- *Manufacturing:* AstraZeneca has the sole right to manufacture the Licensed Compounds and Licensed Products for use in both the AstraZeneca Territory and the Licensor Territory. AstraZeneca has final decision-making authority in respect of the manufacturing plan and activities thereunder. See "— Manufacturing" below for more details.

- *Commercialization*: AstraZeneca will lead commercialization in the AstraZeneca Territory upon approval of the Licensed Products. In the Licensor Territory, we and AstraZeneca hold co-exclusive commercialization rights pursuant to a joint commercialization agreement to be negotiated and entered into by the parties in advance of NMPA's approval of the first Licensed Product. Net profits and losses from commercialization in the Licensor Territory will be shared between the parties, with us retaining 51% and AstraZeneca receiving 49%. See "— Commercialization" below for more details.

    - We will be the marketing authorization holder ("**MAH**") for ECC5004 in the Licensor Territory, subject to regulatory requirements. The MAH is the entity that holds the regulatory approval (i.e., the drug registration certificate) issued by the NMPA and is legally responsible for the safety, efficacy and quality of the Licensed Products.

- *Intellectual Property*: Intellectual property rights arising from the collaboration are allocated into three categories: (i) intellectual property made solely by us is owned solely by us; (ii) intellectual property made solely by AstraZeneca, together with any intellectual property specifically related to the Licensed Compound or Licensed Product (including as to composition, formulation, method of use or method of manufacture) whether developed solely by either party or jointly, is owned solely by AstraZeneca, and (iii) any jointly developed intellectual property not belonging under (i) or (ii) above is jointly owned by both parties. See "— Intellectual Property" below for more details.

***JSC***

We and AstraZeneca established a joint steering committee (the "**JSC**") to oversee the collaborative development activities for the Licensed Compounds and Licensed Products in the Licensor Territory. The JSC is currently composed of two representatives from our Company and three representatives from AstraZeneca. The difference in the number of representatives designated by each party reflects the broader scope of AstraZeneca's global development responsibilities across multiple jurisdictions. However, the governance structure of the JSC is designed to ensure parity in decision-making authority between the parties. Pursuant to the AstraZeneca Agreement, each party holds one collective vote on the JSC, irrespective of the number of its designated representatives. Accordingly, neither party is able to unilaterally approve or reject any matter submitted to the JSC by virtue of having a greater number of representatives, and both parties maintain equal voting rights in respect of all matters within the purview of the JSC.

The JSC's primary responsibilities include: (i) overseeing the overall strategic relationship between the parties in respect of the Licensor Territory; (ii) reviewing and approving the Annual Joint Development Plan and associated budgets; (iii) establishing timelines and procedures for public disclosure of clinical data; (iv) overseeing the implementation of manufacturing plans; and (v) providing oversight on quality and compliance matters. The JSC convenes at least three times per year and may establish subcommittees or working teams to address specific areas of responsibility.

The JSC operates on a consensus basis. If a subcommittee or working team cannot reach consensus within 30 days, the matter is referred to the JSC. If the JSC cannot reach consensus within 10 business days, the matter is escalated to the senior officers of both parties, who have an additional 10 business days to resolve it. If senior officers are still unable to reach agreement, the AstraZeneca Agreement allocates final decision-making authority as follows:

- We hold final decision-making authority over research and development activities of the Licensed Compounds and Licensed Products in the Licensor Territory, *subject to the following limitations*: we cannot (i) unilaterally approve the budget for any Annual Joint Development Plan, or authorize any other shared costs or revenues for the Licensor Territory, without AstraZeneca's prior written approval; (ii) act in a manner that AstraZeneca reasonably believes raises serious health or safety concerns; (iii) act in a manner that AstraZeneca reasonably believes would materially and negatively impact the development or commercialization of the Licensed Compounds or Licensed Products in the AstraZeneca Territory, or the manufacture of the Licensed Compounds and Licensed Products in either territory; or (iv) act in a manner that AstraZeneca reasonably believes would violate applicable laws. We are of the view that such limitations would not materially impair our ability to advance the development and commercialization of the Licensed Compounds and Licensed Products in the Licensor Territory in accordance with our strategic objectives.

- AstraZeneca holds final decision-making authority solely with respect to additional development involving combination products that include the Licensed Compounds together with other active agents, provided that, even in exercising that authority, AstraZeneca may not require us to include any other component or active agent owned or controlled by us or our affiliates within the scope of such additional development. To date, the collaboration between AstraZeneca and us has been cooperative. We have not experienced any issues in exercising our decision-making authority, nor any adverse effects on our development activities in the Licensor Territory as a result of the limitations described above.

***Development***

Under the AstraZeneca Agreement, AstraZeneca leads development in the AstraZeneca Territory and has the sole right to undertake any development of the Licensed Compounds and Licensed Products in the AstraZeneca Territory. In addition, AstraZeneca has the sole right to undertake any development of Licensed Compounds and Licensed Products in or for the AstraZeneca Territory that would be useful or necessary to, or the data from which could be used to, support further development of Licensed Compounds and Licensed Products in, or to support or maintain regulatory approval in, one or more countries in the AstraZeneca Territory and the Licensor Territory (collectively, the "**Global Development Activities**"). For the avoidance of doubt, except for any clinical studies or clinical trials in the Licensor Territory that form part of a global clinical study or clinical trial within the Global Development Activities (the "**China-Specific Global Development Activities**"), no Global Development Activities are included in any Annual Joint Development Plan (as defined below).

- In practice, AstraZeneca acts as the operational sponsor for the two completed global Phase IIb trials, VISTA and SOLSTICE, in the AstraZeneca Territory. Our role and responsibilities in relation to these Phase IIb trials were limited to the provision of assistance when expressly requested by AstraZeneca. See "Business — Our Pipeline — ECC5004, Our Key Product — Ongoing Global Phase "IIb Trial of ECC5004 as Monotherapy in Participants with Obesity/Overweight with at Least One Comorbidity (VISTA)" and "Business — Our Pipeline — ECC5004, Our Key Product — Global Phase IIb Trial of ECC5004 as Monotherapy in Patients with T2D (SOLSTICE)" for more details. In addition, AstraZeneca will lead the global Phase III MRCT program of ECC5004, including serving as the sponsor for the trials to be conducted in the Greater China as agreed between the parties pursuant to the March 2026 Side Letter as discussed above.

We have the final decision-making power with respect to research and development activities relating to the Licensed Compounds and Licensed Products in the Licensor Territory (i.e., Greater China), subject to certain limited safeguards as further described under "— JSC" above. The development activities for the Licensor Territory are set out in a binding written annual plan (the "**Annual Joint Development Plan**"). This plan is prepared and approved by the JSC on an annual basis. The Annual Joint Development Plan sets forth, for the applicable year, the overall development strategy, plans and timelines for the development of the Licensed Compounds and/or Licensed Products in the Licensor Territory, and the budget for the same.

- In China, we act as the operational sponsor for the Phase Ib bridging trial, which is conducted under the Annual Joint Development Plan.

- AstraZeneca's role is limited to the provision of assistance if specifically requested by us, but otherwise they have no direct responsibilities with respect to the conduct or execution of the Phase Ib bridging trial in China, for which we retain full responsibility.

- The Phase Ib bridging trial is intended to bridge the global dataset by evaluating key elements of drug profile in the Chinese population, and to potentially support China's participation in a future global program. Data from the Phase Ib bridging trial in China may be reviewed together with the data from the global IIb trials for clinical evaluation and decision-making and future development plans. See "Business – Our Pipeline – ECC5004, Our Key Product – Ongoing Phase Ib Bridging Trial of ECC5004 in Chinese Participants with Obesity or Are Overweight, With or Without T2D in China" for more details.

Under the AstraZeneca Agreement, we agreed not to develop or manufacture the Licensed Compounds and Licensed Products in the Licensor Territory in any new indication or new line of therapy, or as part of any combination product or any therapeutic regimen that includes the administration of one more or more Licensed Compounds or Licensed Products together with other active agents, unless such development is specifically provided in an Annual Joint Development Plan approved by the JSC. Any such additional development activities require the agreement of the parties and inclusion in the Annual Joint Development Plan. This restriction does not apply to, and does not affect the development of, our Core Product, ECC4703. Accordingly, the proposed Phase II trial involving the combination therapy of ECC4703 with GLP-1RA is not subject to or impacted by this restriction under the AstraZeneca Agreement, as our intention for the proof-of-concept clinical trial is to use an already approved and commercialized GLP-1RA and not ECC5004.

***Regulatory activities***

AstraZeneca leads all regulatory activities in the AstraZeneca Territory, including (i) preparing, filing, obtaining and maintaining marketing authorization applications and other regulatory approvals, including IND filings; (ii) managing all correspondence and communications with regulatory authorities; and (iii) reporting all AEs as required by applicable law. We are obligated to provide reasonable support to AstraZeneca as needed for these activities.

We lead all regulatory activities in the Licensor Territory, except for the anticipated global Phase III MRCT program to be led by AstraZeneca as discussed above. With the exception of the global Phase III MRCT program as agreed by the parties, we have the right and responsibility to prepare, obtain and maintain all regulatory approvals and INDs and conduct communications with regulatory authorities in the Licensor Territory. AstraZeneca may choose to attend and participate in regulatory meetings at its own cost, upon our prior written notice to them of any scheduled meeting. In such cases, we are responsible to use commercially reasonable efforts to facilitate AstraZeneca's participation. Such participation rights do not give AstraZeneca decision-making authority or control over regulatory activities in the Licensor Territory. To date, we have not experienced any issues or adverse effects on our regulatory activities in the Licensor Territory as a result of AstraZeneca's exercise of its participation rights.

***Milestones and Payments***

Pursuant to the AstraZeneca Agreement, AstraZeneca paid us a one-time, non-refundable upfront payment of US$185 million in November 2023. In addition, AstraZeneca paid us one-time, non-refundable milestone payments totaling US$60 million for successfully achieving milestones related to the development of ECC5004 including the first patient dosed in the Phase IIb program, which was done by AstraZeneca in connection with the global Phase IIb trials which covers sites in multiple regions. See "Business – Our Pipeline – ECC5004, Our Key Product – Completed Global Phase IIb Trial of ECC5004 as Monotherapy in Participants with Obesity/Overweight with at Least One Comorbidity (VISTA)" for more details. We are also eligible to receive up to US$275.0 million in near-term development and regulatory milestone payments, including (i) US$50.0 million upon the initiation of the first Phase III clinical trial for a Licensed Product by AstraZeneca or any party acting on its behalf (which may include us) in any jurisdiction, (ii) US$150.0 million upon receipt of the first FDA approval by AstraZeneca or any party acting on its behalf for the United States, and (iii) US$75.0 million upon receipt of the first European approval by AstraZeneca or any party acting on its behalf for Europe. Furthermore, we may receive up to an aggregate of US$290.0 million upon the achievement of certain post-approval development and regulatory milestones. Additionally, we are eligible to receive milestone payments totaling up to US$1.2 billion upon the achievement of specified sales milestones, including, but not limited to, reaching certain thresholds in total net sales of all Licensed Products in the AstraZeneca Territory in any calendar year in which such thresholds are met.

AstraZeneca agreed to pay us tiered royalties of high-single to mid-teen percentage of annual net sales of all Licensed Products containing the same active ingredient sold in the AstraZeneca Territory during each calendar year, subject to certain adjustments. AstraZeneca is obligated to pay royalties during the royalty term (the "**Royalty Term**"), which is defined as the period beginning on the date of the first commercial sale of a Licensed Product in a country in the AstraZeneca Territory and ending on the latest to occur of: (i) the expiration of the last-to-expire patent controlled by us or our affiliates (the "**Licensed Patent**") that claims or covers, or shares priority to or with a patent that claims or covers, a Licensed Compound or a Licensed Product, or is necessary or reasonably useful for the exploitation of a Licensed Compound or a Licensed Product, excluding any Joint Agreement Patents (as defined below) in such country, (ii) the expiration of the Regulatory Exclusivity Period (as defined below) in such country and (iii) the 12th anniversary of the first commercial sale of such Licensed Product in such country. For the purpose of the AstraZeneca Agreement, the "**Regulatory Exclusivity Period**" is defined as any period of data, market or other regulatory exclusivity (other than patent exclusivity) granted or afforded by the applicable law or by a regulatory authority in such country that confers exclusive marketing rights with respect to such Licensed Product in such country in the AstraZeneca Territory.

***Costs and Expenses***

Under the AstraZeneca Agreement, the parties have agreed to two separate cost-sharing arrangements depending on the nature of the development activities, as summarized below:

- *Licensor Territory*: we are responsible for 51% and AstraZeneca is responsible for 49% of all shared costs and expenses in respect of (i) China-Specific Global Development Activities (being clinical studies in the Licensor Territory that form part of a global clinical study within the Global Development Activities) and (ii) any other joint development activities conducted solely in or for the Licensor Territory as agreed by the parties (together, the "**Shared Project Expenses**"). Shared Project Expenses for the Licensor Territory include regulatory, clinical and manufacturing expenses (excluding commercial supply manufacturing costs), and any other costs mutually agreed by the parties through the JSC. They exclude general corporate costs, costs attributable to a breach by either party, and commercial and manufacturing activities. All Shared Project Expenses are subject to quarterly reporting, reconciliation and true-up between the parties.

- *AstraZeneca Territory*: we are responsible for 4.5% and AstraZeneca is responsible for 95.5% of all shared development costs and expenses in respect of Global Development Activities in the AstraZeneca Territory (excluding any China-Specific Global Development Activities) and all costs for certain ongoing development activities that we were conducting at the time of the execution of the AstraZeneca Agreement, in each case calculated on a quarterly basis. Such costs and expenses exclude commercialization-related manufacturing costs, general corporate costs and costs arising from any breach under the AstraZeneca Agreement.

As of the Latest Practicable Date, we have received a net total of approximately US$3.1 million from AstraZeneca, reflecting these cost sharing arrangements and the sale of clinical inventory to AstraZeneca as described below. No credits have been received by us under the March 2026 Side Letter as of the Latest Practicable Date. See "— Decision-making framework under the AstraZeneca Agreement" above for more details on the March 2026 Side Letter. Other than this amount, and the upfront and milestone payments discussed above, we have not received any other upfront payment, milestone payments or other fees or pre-payments under the AstraZeneca Agreement as of the Latest Practicable Date.

***Manufacturing***

In accordance with the AstraZeneca Agreement, we provided AstraZeneca with our then-current manufacturing plan for the supply of Licensed Compounds and Licensed Products for Phase I and Phase II clinical trials. In addition, we supplied our clinical inventory to AstraZeneca at a price equal to 105% of our pass-through manufacturing costs, excluding any full-time employee costs.

We have transferred to AstraZeneca our licensed know-how relating to the manufacture of the Licensed Compounds and Licensed Products, including the manufacturing process and any improvements thereto (including but not limited to, all necessary documentation, standard operating procedures, specification and analytical methods, and making available appropriate personnel and our third-party manufacturers.

AstraZeneca has the sole right, at its own expense, to manufacture and supply the Licensed Compounds and Licensed Products for the AstraZeneca Territory and the Licensor Territory. For the Licensor Territory, AstraZeneca is responsible for manufacturing and supplying of the Licensed Compounds and Licensed Products as needed for development and commercialization activities, pursuant to one or more supply agreements to be negotiated and entered into between the parties. The supply price for such compounds and products provided by AstraZeneca to us for use in the Licensor Territory will be determined on a cost-sharing basis, with us bearing 51% and AstraZeneca bearing 49% of the associated manufacturing costs.

We and AstraZeneca established a joint manufacturing committee (the "**Joint Manufacturing Committee**") responsible for reviewing and discuss the status of our current manufacturing plan, developing and approving a comprehensive manufacturing plan, overseeing the ongoing manufacturing activities and recommending updates annually. While the committee operates collaboratively, AstraZeneca retains final decision-making authority over the manufacturing plan and any amendments, except where such decisions would conflict with our contractual rights or obligations under any existing third-party manufacturing agreements.

***Commercialization***

AstraZeneca has the exclusive right to commercialize Licensed Products in the AstraZeneca Territory at its sole cost and expense. AstraZeneca is solely responsible for all activities related to the preparation for sale, offering for sale, and sale of the Licensed Products in the AstraZeneca Territory, including but not limited to invoice and book sales, establish terms of sale, warehouse and distribution. For the avoidance of doubt, AstraZeneca's exclusive commercialization right in the AstraZeneca Territory does not diminish or otherwise affect our commercialization rights in the Licensor Territory.

For the Licensor Territory, we retain co-exclusive commercialization rights with AstraZeneca. We will be responsible for invoicing and booking sales of the Licensed Products in the Licensor Territory. In addition, as discussed above, we will be the MAH for ECC5004 in the Licensor Territory subject to regulatory requirements. Under the agreement, the parties shall begin to negotiate the specific terms and conditions for the co-exclusive commercialization rights in the Licensor Territory no later than 24 months prior to the earliest possible end date of the NMPA drug registration review period for ECC5004, which we expect to be after the [**REDACTED**] based on the current development timelines. The negotiation is expected to take approximately six months or less. The final agreed terms will be memorialized as a separate commercialization agreement or an amendment to the AstraZeneca Agreement (the "**Joint Commercialization Agreement**"). For the avoidance of doubt, the negotiation of the Joint Commercialization Agreement pertains to the operational details of the co-exclusive commercialization arrangement and does not affect or diminish our existing commercialization rights under the AstraZeneca Agreement.

The parties have agreed under the AstraZeneca Agreement that the Joint Commercialization Agreement will include, among others, (i) the sharing and calculation of net profits and losses in the Licensor Territory, with us entitled to 51% and AstraZeneca entitled to 49%, as well as (ii) the detailed provisions relating to governance structure, commercialization budget and plan, marketing initiatives, personnel training and recruitment, and other matters relating to the commercialization of the Licensed Products in the Licensor Territory. For the avoidance of doubt, the specific roles, responsibilities and decision-making authority of the parties and exact terms and conditions regarding these provisions are expected to be established and set out in detail in the Joint Commercialization Agreement. Accordingly, neither party has been designated as the "lead" for commercialization activities in the Licensor Territory under the AstraZeneca Agreement as the parties are expected to share co-exclusive commercialization rights.

***Intellectual Property***

The ownership of any intellectual property, including know-how or inventions, is determined in accordance with the applicable intellectual property laws of the United States, regardless of where such conception, discovery, development or making occurs. Each party has agreed to assign, and cause its affiliates and licensees to assign, to the other party, without additional compensation, all rights, title and interest in and to any know-how or inventions, and any related intellectual property rights, as necessary to fully effect the ownership provisions of the AstraZeneca Agreement.

Each party retains all right, title and interest in and to any know-how or inventions (and any related patents or other intellectual property rights) that are controlled by such party *at or prior* to the effective date of the AstraZeneca Agreement, or that are developed or acquired *independently* (without use of the other party's confidential information) and outside the activities under or in connection with the AstraZeneca Agreement. Under the AstraZeneca Agreement, we continue to retain full ownership over any patent entirely owned by us or patent application solely filed by us.

Under the AstraZeneca Agreement, intellectual property rights arising from the collaboration are divided into three categories based on who develops them and what they relate to.

- First, we solely own any intellectual property rights conceived, discovered, developed or otherwise made solely by us (or our affiliates or sublicensees) under or in connection with the AstraZeneca Agreement, together with any related patents.

- Second, AstraZeneca solely owns: (a) any intellectual property rights conceived, discovered, developed or otherwise made solely by AstraZeneca (or its affiliates or sublicensees) under the AstraZeneca Agreement; and (b) any intellectual property rights, whether developed solely by either party or jointly by both parties , that are specifically related to the Licensed Compound or Licensed Product, including intellectual property rights relating to the composition, formulation, method of use or method of manufacture of or the Licensed Compound and Licensed Product (collectively, the "**AstraZeneca**

**Product-Specific Intellectual Property Rights**"). We are required to assign, and to cause our affiliates and licensees to assign, to AstraZeneca all right, title and interest in and to the AstraZeneca Product-Specific Intellectual Property Rights.

- Third, any intellectual property rights developed jointly by both parties that do not fall within the AstraZeneca Product-Specific Intellectual Property Rights are jointly owned by both parties (the "**Joint Agreement Technology**"). Each party holds an equal, undivided one-half interest in the Joint Agreement Technology and may use and license it without the other party's consent, subject to applicable laws. As of the Latest Practicable Date, no joint patents have been issued based on the collaboration between AstraZeneca and us. To the best of our knowledge, as of the same date, there have been no third parties, including AstraZeneca, which were involved in, or had contributed to, any patents or patent applications solely owned or filed by us, and our ability to exercise those rights are not impacted by third-party contributions.

***Governing Law and Termination Rights***

The AstraZeneca Agreement is governed by the laws of the state of New York, the United States. Either party may provide a termination notice to the other party in the event of a material breach of the AstraZeneca Agreement by the other party. Such termination will become effective 90 days after the delivery of the termination notice (or 60 days in the case of a material breach of a payment obligation) (the "**Notice Period**"), unless (i) the breaching party cures the breach within the Notice Period (or, other than payment obligation, if such default cannot be cured during the Notice Period, if the breaching party commences actions to cure such breach within the Notice Period and thereafter diligently continues such actions); (ii) with respect to any alleged breach by AstraZeneca of its certain diligence obligations, we will deliver a written notice to AstraZeneca and the parties will meet within 30 days of such notice to discuss the alleged breach in good faith, and we will only deliver the termination notice when the discussions have concluded; or (iii) if either party initiates the dispute resolution procedure as permitted under the AstraZeneca Agreement.

AstraZeneca has the right to terminate the AstraZeneca Agreement in its entirety immediately upon written notice to us if, in AstraZeneca's good faith judgment, it is not advisable to continue developing or commercializing the Licensed Products due to safety or efficacy concerns. Additionally, AstraZeneca may terminate the AstraZeneca Agreement in its entirety or on a Licensed Product-by-Licensed Product or country-by-country basis, for any or no reason, upon 90 days' prior written notice to us, or 180 days' prior written notice if such termination occurs after the first commercial sale of any Licensed Product in the AstraZeneca Territory or Licensor Territory. We have the right to terminate the AstraZeneca Agreement on a Licensed Patent-by-Licensed Patent basis by providing 30 days' prior written notice to AstraZeneca if AstraZeneca or its affiliates or sublicensees contests or assists a third party in contesting the scope, validity or enforceability of any Licensed Patent, in any qualified legal proceeding, subject to certain exceptions. In addition, the AstraZeneca Agreement may also be terminated in the event where either party becomes insolvent or files for bankruptcy, in accordance with the terms of the agreement.

Under the AstraZeneca Agreement, in the event where AstraZeneca has the right to terminate the AstraZeneca Agreement for a material breach by us, AstraZeneca may elect to continue the AstraZeneca Agreement as modified by providing written notice to us. In such a case, we will be entitled to substantially reduced development, sales and milestone and royalty payments, as applicable.

***Side Letters***

In November 2023, Eccogene USA and Eccogene Shanghai entered into a side letter with AstraZeneca, pursuant to which Eccogene Shanghai agreed to abide by the terms and obligations set forth in the AstraZeneca Agreement as if it were Eccogene USA, and not to act in any manner

that is inconsistent with the terms and conditions of the AstraZeneca Agreement. In March 2025, Eccogene USA entered into the March 2026 Side Letter in connection with the AstraZeneca Agreement. See "— Decision-making framework under the AstraZeneca Agreement" above for details.

## RESEARCH AND DEVELOPMENT

Research and development supports our ability to foster innovation, advance pipeline assets, and maintain a competitive edge in the global pharmaceutical market. We conduct research and development activities primarily through our in-house scientific and development teams, supplemented by our partners (including but not limited to CDMOs and CROs) engaged from time to time to support preclinical research and clinical trials. For our self-discovered and independently developed Core Product, ECC4703, our dedicated cross-functional team of 16 employees oversees discovery and development, including leadership (CEO, CMO, and CSO), medicinal chemistry, CMC, toxicology, and clinical development. Our research and development team for ECC4703 collectively covers preclinical research, process development and scale-up, non-clinical safety, and global clinical trial design and execution, supported by personnel experienced in ICH and local regulatory standards. In addition, we have established strategic partnerships to accelerate pipeline development across key global markets, enhance our clinical execution capabilities, and facilitate long-term sustainable growth. For more details, see "— Our Collaboration and Licensing Agreement."

### In-house R&D Team

Our in-house R&D team is composed of seasoned industry experts with deep experience across drug discovery and development. As of December 31, 2025, our in-house R&D team consisted of 41 members, including 15 Ph.D. and M.D. holders, mainly in medical science, pharmacology, biology and chemistry. During the Track Record Period and up to the Latest Practicable Date, substantially all key R&D personnel involved in the research and development of our Core Product and Key Products remained employed by us.

Our R&D leadership team is distinguished by deep scientific expertise and a proven track record in drug discovery and development, including:

- **Dr. Jingye Zhou**, our co-founder and CEO, brings decades of experience in small molecule drug discovery and a profound understanding of cardiometabolic diseases. Prior to founding our Company, he served as Head of Chemistry at Lilly China R&D Center, where he led teams to achieve candidate selection milestones for T2D and its complications. Earlier in his career, he was an investigator at GlaxoSmithKline, contributing to drug discovery efforts using disruptive technology, and co-invented Eravacycline, an FDA-approved antibiotic, during his time at Tetraphase Pharmaceuticals. Dr. Zhou holds a Ph.D. in chemistry from Brandeis University and a B.S. in life sciences from Fudan University.

- **Dr. Jianfeng Xu**, our co-founder and CSO, brings over 20 years of R&D experience in metabolic diseases, with deep expertise in the interplay between metabolic and immune systems. Prior to founding our Company, he was a Principal Scientist at Lilly China R&D Center, where he led teams through key milestones from target validation to clinical development. Dr. Xu obtained his bachelor's degree in biochemistry and his Ph.D. in molecular biology and biochemistry from Fudan University, and completed his postdoctoral training at the Salk Institute for Biological Studies and at University of California, San Diego.

- **Dr. Jaikrishna Patel**, our CMO, brings more than 30 years of experience in global clinical drug development across cardiovascular and metabolic diseases. Before joining our Company, Dr. Patel was the Chief Medical Officer at Imbria Pharmaceuticals, a private, clinical-stage biotechnology company developing innovative therapies for the

treatment of cardiometabolic disorders. Previously, he served as Chief Medical Officer at Enterome and NephroGenex. Prior to that, Dr. Patel spent over 20 years at GlaxoSmithKline in positions of increasing responsibility, holding leadership positions across multiple R&D functions including Clinical Development, Medical Affairs, Regulatory Affairs and Project Management. Dr. Patel received a Bachelor of Science in Experimental Pathology from the University of London and completed his medical training at St. Bartholomew's Hospital and Kings College Hospitals, University of London. Dr. Patel is a member of the Royal College of Physicians.

**R&D Process**

Our R&D process is structured across three key stages:

- ***Preclinical Stage.*** The discovery phase lays the scientific foundation for the entire development pipeline. We integrate our TRANDD workflow system throughout the discovery and development process, from target validation and selection through TPP design and R&D workflow optimization, to support differentiation of drug candidates by design. We screen candidate compounds for identity, potency and purity to accelerate early evaluations while thoroughly characterizing compounds to align with our TPP requirements. Throughout this phase, we embrace agile, data driven decision making to enhance execution efficiency and increase the success of translation, enabling the identification of promising therapeutic candidates with optimal pharmacological properties.

- ***Early Clinical Stage.*** Our approach is distinguished by the strengths of our TRANDD workflow system in designing adaptive, biomarker-enriched early clinical trial protocols that generate quality pharmacokinetic and pharmacodynamic data, including critical insights to inform subsequent trial design. This strategy is complemented by the implementation of clear, rapid go/no-go decision points, enabling efficient resource allocation without compromising scientific rigor. For the avoidance of doubt, the development of the TRANDD workflow system was conducted solely by our R&D team, with guidance from our management, without contributions from any third parties, including AstraZeneca, except for the use of publicly available research and data from third parties. Alongside these clinical innovations, we establish robust analytical frameworks and quality controls to underpin initial human trials, continuously improving processes and optimizing methods for efficiency and reliability. Collectively, these efforts ensure that investigational products are positioned to achieve target product profile while prioritizing patient safety throughout early development.

- ***Late Clinical Stage.*** The clinical late stage centers on assessing efficacy and safety in broader, more diverse patient populations to meet global regulatory requirements, while simultaneously finalizing development activities for commercialization.

**Collaboration with CROs**

In addition to our in-house R&D activities, we also collaborate with reputable CROs to support our preclinical research and clinical trials. The services they provide under our oversight include project management, site management, data management, biostatistics, medical monitoring, medical writing, bioanalysis, patient recruitment and pharmacovigilance for our clinical trials, as well as preclinical and clinical laboratory testing and other specialized tasks aligned with our needs.

We select CROs based on their professional qualifications, relevant research experience, service quality, operational efficiency, and industry reputation. We typically enter into a master service agreement with each CRO, under which individual work orders define the scope of work, participant numbers (or sample size), procedures, deliverables, timelines, and payment terms for each preclinical or clinical project. CROs are required to comply with all applicable laws and

regulations and to adhere to our established protocols, ensuring the accuracy and authenticity of clinical trial results. To maintain data integrity and regulatory compliance, we oversee our CRO partners through regular progress meetings and deliverable reviews. Under our master service agreements, we also reserve the contractual right to conduct both scheduled and for-cause audits when necessary. This oversight approach ensures adherence to our protocols and regulatory requirements while enforcing the quality and reliability of data generated from our trials. In turn, this supports the advancement of our pipeline and strengthens our overall clinical development strategy.

Key terms of agreements that we typically enter into with our CROs are set forth below:

- ***Services.*** The CROs shall provide quality services to us, including the implementation and management of a preclinical or clinical research project as specified in the agreement.

- ***Term.*** The CROs are required to perform their services and complete the research project within the prescribed time limit set out in each agreement or work order, usually on a project basis.

- ***Payments.*** We are required to make payments to the CROs in accordance with the payment schedule agreed by the parties.

- ***Intellectual property rights.*** We own all intellectual property rights arising from the clinical research projects conducted by the CROs within the stipulated work scope.

- ***Confidentiality.*** Our CROs are not allowed to disclose confidential information, including but not limited to, any information or data related to research, development, processes and protocols as specified in the agreement, and such obligation generally survives for a specified period.

- ***Risk allocation.*** We are generally responsible for the risks associated with the research project, while the CROs should indemnify us for losses caused by their fault or gross negligence.

## MANUFACTURING

As of the Latest Practicable Date, we did not have any in-house manufacturing facility. To date, all of our manufacturing activities have been conducted through our partners (including but not limited to CDMOs) to support our drug development programs. We currently outsource our manufacturing activities to our partners (including but not limited to several globally recognized CDMOs) with extensive expertise in research, development, and production. We consider a number of factors when selecting a partner for our manufacturing activities, such as their manufacturing capacity and qualifications, relevant expertise, reputation, regulatory track record with applicable regulations and guidelines, geographic proximity, product quality, cost efficiency, as well as alignment with our R&D objectives. We have adopted, and will continue to implement, procedures to ensure that our partners' production qualifications, facilities, and processes comply with the applicable regulatory requirements and our internal guidelines and quality standards. This oversight includes quality audits, qualification reviews, and ongoing monitoring.

We did not experience any material product quality issues in respect of the products manufactured by our partners during the Track Record Period. Under the relevant agreements, they provide manufacturing services based on specified deliverables, location, unit price, volume, and delivery timelines. They are responsible for ensuring product quality in accordance with the agreed standards, cGMP requirements, and applicable regulations, and provide certificates of analysis. Payments are made according to a predefined schedule, typically linked to manufacturing milestones and deliverables. All intellectual property rights related to the products arising from the outsourced manufacturing remain with us. Our partners are also bound by confidentiality obligations, prohibiting the disclosure of technical materials, research data, or other project-related

information, with such obligations generally surviving for a defined period. In cases where a partner fails to deliver products or fulfill key obligations due to their own fault, we reserve the right to terminate the agreement and seek liquidated damages and compensation for resulting losses.

## QUALITY CONTROL

Quality control and assurance are fundamental to our sustained success. Since we do not operate in-house manufacturing facilities, we rely on the comprehensive quality management systems of our partners (including but not limited to CDMOs), which are designed to align with stringent regulatory requirements and recognized industry guidelines.

Our internal team, with extensive industry experience, provides oversight of relevant activities by reviewing and approving key manufacturing documents, providing product specifications and, when necessary, process control instructions, and actively participating in and following up on significant quality events, deviations, and related investigations.

To ensure ongoing compliance and continuous improvement, we conduct audits of our CDMOs. These audits confirm that manufacturing processes remain compliant with cGMP standards, that quality systems are updated in line with evolving global regulations, and that best practices are consistently applied.

By combining rigorous oversight with proactive monitoring of regulatory and scientific developments, we ensure the consistent manufacture of high-quality products to support our development programs and clinical studies. This approach safeguards patient safety, ensures regulatory compliance, and strengthens the reliability of our clinical pipeline.

## COMMERCIALIZATION

As of the Latest Practicable Date, we had not obtained marketing approval for any drug candidates, nor had we generated any revenue from product sales. However, we are strategically developing our commercial planning and portfolio management capabilities. Our strategy dictates a meticulous assessment of various pivotal factors, including the dimensions of the market, the intricacies of clinical needs, the dynamics of the competitive landscape, and the labyrinthine regulatory pathways. This comprehensive evaluation will serve as the bedrock for our determination to either embark upon independent commercialization or to cultivate strategic commercialization partnerships, thereby mitigating inherent risks at the nascent product selection stage while maximizing the market potential.

## INTELLECTUAL PROPERTY

Intellectual property rights are important to the success of our business, and we are committed to the development and protection of our intellectual properties. We rely on a combination of patent and other intellectual property rights, as well as confidentiality procedures, non-disclosure agreements, employee non-disclosure and invention assignment agreements, and other contractual restrictions to establish and protect our commercially important technologies, inventions and know-how related to our business. The inventors named in our patents and patent applications are primarily our employees in R&D function; from time to time, they may also include former employees. As of the dates of the relevant inventions, all inventors were our employees which under agreements that include confidentiality and assignment-of-inventions provisions. Pursuant to these agreements, all rights, title and interest in and to inventions conceived or reduced to practice in the scope of employment are assigned to the Group, and the Group is the sole owner of the resulting intellectual property.

We have a global portfolio of patents to protect our drug candidates and technologies. As of the Latest Practicable Date, we owned (i) five issued patents in China, (ii) six issued patents in the U.S., (iii) 15 issued patents in other jurisdictions, including Japan, South Korea, Australia, Mexico, Saudi Arabia, Macau, South Africa, Israel and the jurisdictions covered by the Eurasian Patent Organization, and (iv) 81 pending patent applications, including nine in China, four in the U.S.,

three under the PCT which have not entered into national phases, 11 under the PCT which may serve as the basis for claiming priority and 54 in other jurisdictions. For more details, see the paragraph headed "Statutory and General Information — B. Further Information about Our Business — 2. Intellectual Property Rights" in Appendix IV to this document.

As of the Latest Practicable Date, with respect to our Core Product, ECC4703, we owned (i) one issued patent in China, (ii) two issued patents in the U.S., (iii) six issued patents in other jurisdictions, along with (iv) 12 patent applications, including one in the U.S., one under the PCT which may enter into national phase, two under the PCT which may serve as the basis for claiming priority, and 8 in other jurisdictions. In addition, we also owned (i) four issued patents in China, (ii) four issued patents in the U.S., and (iii) nine issued patents in other jurisdictions, along with 69 patent applications, including nine in China, three in the U.S., two under the PCT which have not entered into national phases, nine under the PCT which may serve as the basis for claiming priority, and 46 in other jurisdictions. As advised by our intellectual property counsel, our Directors are of the view that our current patent portfolio and pending applications sufficiently cover all material aspects of ECC4703 and its associated technologies. In particular, our portfolio includes claims directed to (1) composition of matter, encompassing both a genus that covers ECC4703 and the specific structure of ECC4703; (2) pharmaceutical compositions comprising such genus and the specific ECC4703 molecule; (3) methods of medical use of such genus and the specific ECC4703 molecule; and (4) combination therapies involving ECC4703 with an approved and commercialized GLP-1RA or with ECC0509. Based on the scope of the granted claims and the pending applications, and taking into account our intellectual property counsel's assessment of claim breadth, layering, and expected patent term, our Directors believe these rights provide comprehensive protection over the core molecule, its formulations, key therapeutic uses, and the relevant combination regimens that are material to ECC4703. The following table sets forth the portfolio of patents and patent applications material to our business operations as of the Latest Practicable Date:

| Drug Candidate | Patent/Patent Application | Scope of the Patent | Patent Holder/Applicant | Jurisdiction | Application Date | Status | Grant Date | Patent Expiration* |
|---|---|---|---|---|---|---|---|---|
| ECC4703 . . | US11780825B2 | Composition of matter | Eccogene USA | U.S. | 2021-01-13 | Granted | 2023-10-10 | 2041-01-13 |
| | US12291518B2 | | Eccogene USA | U.S. | 2021-01-13 | Granted | 2025-05-06 | 2041-01-13 |
| | CN115244037B | | Eccogene USA | China | 2021-01-13 | Granted | 2024-10-25 | 2041-01-13 |
| | US20250320197A1 | | Eccogene USA | U.S. | 2021-01-13 | Pending | / | / |
| ECC5004 . . | US12037339B2** | Composition of matter | Eccogene USA | U.S. | 2021-07-20 | Granted | 2024-07-16 | 2041-07-20 |
| | US11584751B1** | | Eccogene USA | U.S. | 2021-07-20 | Granted | 2023-02-21 | 2041-07-20 |
| | CN116390926A** | | Eccogene USA | China | 2021-07-20 | Pending | / | / |
| | US20250059192A1** | | Eccogene USA | U.S. | 2021-07-20 | Pending | / | / |
| ECC0509 . . | US11472769B2 | Composition of matter | Eccogene USA | U.S. | 2020-10-28 | Granted | 2022-10-18 | 2040-10-28 |
| | US11964942B2 | | Eccogene USA | U.S. | 2020-10-28 | Granted | 2024-04-23 | 2040-10-28 |
| | CN114901649B | | Eccogene USA | China | 2020-10-28 | Granted | 2024-07-23 | 2040-10-28 |
| | US20250326721A1 | | Eccogene USA | U.S. | 2020-10-28 | Pending | / | / |

*Note:* * Patent expiration date does not include any applicable patent term extensions.

** Patents out-licensed to AstraZeneca under the AstraZeneca Agreement.

The actual protection afforded by a patent varies on a claim-by-claim and jurisdiction-by-jurisdiction basis and depends on many factors, including the type of patent, the scope of its coverage, the availability of any patent term extensions or adjustments, the availability of legal remedies in a particular jurisdiction, and the validity and enforceability of the patent. We cannot provide any assurance that patents will be issued with respect to any of our patent applications or any such patent applications that may be filed in the future, nor can we provide any assurance that any of our issued patents or any such patents that may be issued in the future will be commercially useful in protecting our drug candidates and methods of manufacturing the same. See "Risk Factors — Risks Relating to Our Intellectual Property Rights" for a description of risks related to our intellectual property.

As of the Latest Practicable Date, we had four registered trademarks in China, two registered trademarks in other jurisdictions; one trademark application in China, two trademark applications in other jurisdictions. We are also the registered owner of two domain name.

We enter into license and collaboration agreements and other relationships with biopharmaceutical companies and other industry participants, through which we may grant access to our own intellectual property, or gain access to the intellectual property of others. See "— Our Collaboration and Licensing Agreement" for more details.

During the Track Record Period and up to the Latest Practicable Date, (i) we were not involved in any legal, arbitral or administrative proceedings in respect of, and we had not received notice of any material claims of infringement, misappropriation or other violations of third-party intellectual property; and (ii) we were not involved in any proceedings in respect of any intellectual property rights that may be threatened or pending and that may have an influence on the research and development for any of our drug candidates in which we may be a claimant or a respondent.

A freedom-to-operate searches and analyses ("**FTO Analysis**") has been conducted in China and the United States in relation to our Core Product and Key Products, which are the Group's major intended jurisdictions for clinical development and commercialization of our Core Product and Key Products. We determine which jurisdictions are in scope for our FTO by reference to our near- to mid-term clinical and commercialization plans. We do not currently plan to conduct an Australia-specific FTO, as Australia is not within our near- to mid-term clinical or commercialization roadmap for our Core Product or the Key Products. To manage potential IP risks in jurisdictions where a full FTO is not planned, we maintain an interim risk management framework, including (i) global patent family landscape mapping and (ii) continuous patent watch services (covering patent search and analysis, patent status monitoring including renewals, SPC/term extensions and post-grant proceedings etc.) and periodic internal IP committee reviews with external counsel input. Where potential blocking rights are identified, we will consider design-around measures, seek licenses on commercially reasonable terms, pursue oppositions/invalidations as appropriate, and/or adjust the timing, geography or scope of our clinical or commercialization activities to mitigate infringement risk. Based on the FTO Analysis, our Directors are of the view that there are no valid and enforceable patents of any third party in China and the United States covering the chemical structures or indications currently under development of our Core Product and Key Products.

## SUPPLIERS AND PROCUREMENT

During the Track Record Period, our suppliers primarily consisted of CROs, CDMOs, business partner, and suppliers of R&D materials. Our suppliers typically offer us a credit period ranging from 30 days to 60 days during the Track Record Period. Purchases from our five largest suppliers for the years ended December 31, 2024 and 2025 were US$15.2 million and US$20.4 million, respectively, representing 79.6% and 69.2% of our total purchases for the same periods. Purchases from our single largest supplier for the years ended December 31, 2024 and 2025 were US$5.9 million and US$11.0 million, respectively, representing 30.6% and 37.3% of our total purchases for the same periods.

We select our suppliers based on our assessment of their quality, cost-effectiveness, delivery performance, industry reputation, and compliance with relevant regulations and industry standards. We believe that we maintain strong and stable relationships with our major suppliers. During the Track Record Period, we did not experience any material disputes with our suppliers, difficulties in the procurement of raw materials or services, disruptions to our operations due to a shortage of or delay in supply of raw materials or services, or significant fluctuations in raw material and/or service prices.

The following table sets forth details of our five largest suppliers during the Track Record Period:

| Supplier | Supplier background | Products/service purchased | Commencement of business relationship | Credit terms | Purchase amount | % of total purchases |
|---|---|---|---|---|---|---|
| | | | | | *(US$'000)* | |
| ***For the year ended December 31, 2025*** | | | | | | |
| AstraZeneca | A leading global pharmaceutical company, listed on LSE, STO and Nasdaq. | Clinical research Services | 2023 | 60 days | 10,998.6 | 37.3 |
| Supplier C | A CRO service provider headquartered in Dublin, Ireland, founded in 1990. | Clinical Research Services | 2025 | 30 days | 3,779.0 | 12.8 |
| Supplier A | A CRO services provider headquartered in shanghai, established in 2000, and dual listed on SSE and HKSE. | Clinical technology services, including toxicology and pharmacology testing services | 2018 | 30 days | 2,658.6 | 9.0 |
| Supplier B | A global CRO, established in 1996 and headquartered in the U.S., listed on the Nasdaq. | Clinical Research Services | 2024 | 30 days | 1,850.2 | 6.3 |
| Supplier D | A CRO and CDMO services provider headquartered in the U.S., founded in 1996. | Contract development and manufacturing services | 2018 | 60 days | 1,112.4 | 3.8 |
| | | | | | **20,398.8** | **69.2** |

| Supplier | Supplier background | Products/service purchased | Commencement of business relationship | Credit terms | Purchase amount | % of total purchases |
|---|---|---|---|---|---|---|
| | | | | | *(US$'000)* | |
| ***For the year ended December 31, 2024*** | | | | | | |
| Supplier E | A CRO services provider based in U.S., established in 1982 and listed on NYSE. | Clinical research Services | 2022 | 30 days | 5,903.7 | 30.6 |
| AstraZeneca | A global pharmaceutical company, listed on the LSE, STO and Nasdaq. | Clinical research Services | 2023 | 60 days | 4,276.6 | 22.4 |
| Supplier A | A CRO services provider headquartered in shanghai, established in 2000, and dual listed on SHSE and HKSE. | Clinical technology services, including toxicology and pharmacology testing services | 2018 | 30 days | 3,138.6 | 16.5 |

| Supplier | Supplier background | Products/service purchased | Commencement of business relationship | Credit terms | Purchase amount | % of total purchases |
|---|---|---|---|---|---|---|
| | | | | | *(US$'000)* | |
| Supplier F | A pharmaceutical R&D services provider headquartered in Beijing, established in 2004, and dual listed on SZSE and HKSE. | Clinical technology services, including toxicology and pharmacology testing services | 2019 | 30 days | 1,577.6 | 8.3 |
| Supplier G | A CRO and CDMO services provider headquartered in Nanjing, established in 2006 and listed on SZSE. | Contract development and manufacturing services | 2019 | 20 days | 346.4 | 1.8 |
| | | | | | **15,242.9** | **79.6** |

To monitor the quality of supplies, we generally follow a defined procedure for the selection of critical Good Practices ("**GxP**") suppliers. We verify the qualifications and applicable certificates before entering into procurement agreements or equivalent engagements. A list of qualified key GxP suppliers is maintained and is subject to regular review and update.

All of our five largest suppliers during the Track Record Period were Independent Third Parties. None of our Directors or their close associates or, to the knowledge of our Directors, any Shareholder with over 5% of the share capital of our Company (except AstraZeneca), has any interest in any of our five largest suppliers during the Track Record Period.

## CUSTOMER

During the Track Record Period, our revenue was primarily derived from payments we received from AstraZeneca in accordance with the AstraZeneca Agreement. For further details, see "Financial Information — Description of Selected Components of Consolidated Statements of Comprehensive Income — Revenue."

For the years ended December 31, 2024 and 2025, we only had one customer, revenue generated from our customer for each period amounted to US$221.3 million and US$0.6 million, respectively.

| Customer | Customer background | Products/service provided | Commencement of business relationship | Revenue contribution | % of total revenue |
|---|---|---|---|---|---|
| | | | | *(US$'000)* | |
| ***For the year ended December 31, 2025*** | | | | | |
| AstraZeneca | A leading global pharmaceutical company, listed on the LSE, STO and Nasdaq. | License and related services | 2023 | 556.8 | 100.0 |
| | | | | **556.8** | **100.0** |

| Customer | Customer background | Products/service provided | Commencement of business relationship | Revenue contribution | % of total revenue |
|---|---|---|---|---|---|
| | | | | *(US$'000)* | |
| ***For the year ended December 31, 2024*** | | | | | |
| AstraZeneca . . . . | A leading global pharmaceutical company, listed on the LSE, STO and Nasdaq. | License and related services | 2023 | 221,291.2 | 100.0 |
| | | | | **221,291.2** | **100.0** |

To the best of our knowledge, we only had one customer during each period of the Track Record Period which was AstraZeneca, who owned more than 5% of our issued share capital as of the Latest Practicable Date. See "History, Reorganization and Corporate Structure — Pre-[**REDACTED**] Investors — Information of Pre-[**REDACTED**] Investors — AstraZeneca UK Limited" for more details on AstraZeneca's shareholder relationship to us.

## OVERLAPPING OF CUSTOMER AND SUPPLIERS

AstraZeneca, being our only customer during the Track Record Period, was also our supplier in 2024 and 2025. We entered into an exclusive collaboration and licensing with AstraZeneca in November 2023, and we paid AstraZeneca for clinical research services that they undertook in 2024 and 2025 pursuant to the AstraZeneca Agreement. See "— Our Collaboration and Licensing Agreement" and "Financial Information — Description of Selected Components of Consolidated Statements of Comprehensive Income — Revenue" for more details. All of our revenue during the Track Record Period was derived from payments we received from AstraZeneca in accordance with the AstraZeneca Agreement. Our purchases from AstraZeneca as a percentage of our total purchases was 22.4% and 37.3% in 2024 and 2025, respectively. See "Financial Information — Description of Selected Components of Consolidated Statements of Comprehensive Income — Research and Development Expenses" for more details. Our Directors confirm that all of our sales to and purchases from AstraZeneca were conducted in the ordinary course of business under normal commercial terms and on arm's length basis. Our Directors confirm that, saved as disclosed above, none of our major suppliers was our customers, or vice versa, during the Track Record Period.

## COMPETITION

Our industry is highly competitive and subject to rapid and significant change.

We focus on leveraging our industry experience and established R&D capabilities for the in-house discovery and development of differentiated therapeutics primarily for cardiometabolic diseases and inflammatory disorders. The competitive landscape in our core therapeutic area is crowded with approved products and a large number of programs in active clinical development. In addition, we may face increasing competition from lower-cost generic drugs or biosimilars of approved products in the same or adjacent therapeutic areas, particularly as patents or regulatory exclusivities of established therapies expire. The availability of generic drugs or biosimilars may intensify pricing pressure, influence payer coverage and reimbursement decisions, accelerate formulary preference for lower-cost alternatives, and affect physician and patient treatment choices. Such competition could reduce the perceived value of differentiated product candidates, limit our pricing flexibility and market access, slow patient uptake, and adversely affect the market share, commercial potential and profitability of our drug candidates. In particular, in the THR-β field, resmetirom, a THR-β agonist, was approved by the FDA in March 2024 for the treatment of MASH with moderate to advanced liver fibrosis. In addition, Semaglutide injection has also been approved by the FDA for the treatment of adults with MASH with moderate-to-advanced fibrosis under the accelerated approval pathway, further intensifying competition in this indication.

In the obesity/overweight field, competition is also rapidly evolving and already relatively advanced. In April 2026, the FDA approved Foundayo (orforglipron), an oral small-molecule GLP-1RA, for chronic weight management in adults with obesity/overweight with at least one weight-related comorbid condition. In addition, Semaglutide has established a significant market presence across obesity/overweight, cardiovascular risk reduction in certain patients with obesity or overweight, and, more recently, MASH. The broad commercial adoption and strong physician and patient familiarity with GLP-1-based therapies have entrenched the competitive positioning of this class and raised the bar for differentiation across overlapping patient populations. Beyond approved products, a significant number of additional GLP-1RAs and other mechanistically distinct programs are in active clinical development, and we expect further approved competitors to enter the market in the near to medium term.

Moreover, many of our competitors or potential competitors have substantially greater financial resources, larger research and development staffs, more extensive experience in conducting preclinical studies and clinical trials, obtaining regulatory approvals, manufacturing at commercial scale, and commercializing approved products. The number of product candidates in active clinical development targeting cardiometabolic diseases and inflammatory disorders is substantial, and we expect competition to intensify further as additional programs advance through development and reach the market. The increasing presence of approved products may also affect patient recruitment, investigator interest, pricing, reimbursement, market access, and our ability to differentiate our product candidates based on efficacy, safety, tolerability, convenience or other attributes. We face fierce competition from existing products and product candidates under development in the market. We face uncertainties in preclinical and clinical trial development which are subject to a variety of factors, including satisfactory safety and efficacy results from preclinical studies, clinical trials, successful enrollment of patients, and performance of CROs and other parties involved in preclinical and clinical trial development and others. For more information on the competitive landscape of our drug candidates, see "— Our Pipeline" and "Industry Overview."

## EMPLOYEES

As of December 31, 2025, we had a total of 57 full-time employees. The following table sets forth a breakdown of our employees categorized by function as of December 31, 2025:

| Function | Number | Percentage |
|---|---|---|
| Research and development | 41 | 71.9% |
| General and administrative | 16 | 28.1% |
| **Total** | 57 | 100.0% |

We enter into individual employment contracts with our employees that cover key terms such as compensation, bonuses, benefits, workplace safety, confidentiality obligations, intellectual property assignment, and termination conditions. For senior management, key R&D personnel, and other employees with access to sensitive information, we have signed confidentiality and non-competition agreements, or included such clauses within their employment contracts.

To maintain a high level of expertise and operational excellence, we offer ongoing education and training programs — both internal and external — focused on enhancing technical, professional, and managerial skills. We also conduct regular training to ensure employee awareness and compliance with our internal policies and procedures. In addition, we provide competitive compensation packages, including performance-based bonuses and incentive schemes, particularly for key talent.

As of the Latest Practicable Date, we have not established a labor union. We believe that we have maintained good working relationships with our employees. During the Track Record Period and up to the Latest Practicable Date, we did not experience any material labor disputes or strikes that may have a material and adverse effect on our business, financial condition, or results of operations.

## DATA PRIVACY AND PROTECTION

We routinely receive, collect, generate, store, process, transmit and maintain biological and health information records and other personal details of the subjects enrolled in our clinical trials, along with other personal or sensitive information, as well as personal information of researchers, such as their basic personal details. We have established clear data retention periods for all types of data, and will promptly delete or anonymize the data upon expiration of the applicable retention period. As such, we are subject to the relevant local, state, national and international data protection and privacy laws, directives regulations and standards that apply to the collection, use, retention, protection, disclosure, transfer and other processing of personal data in the various jurisdictions in which we operate and conduct our clinical trials, as well as contractual obligations.

We have designed strict data protection policies to ensure that the collection, use, storage, and processing of medical data comply with applicable laws and prevalent industry practices, including our detailed data management plan for each clinical project. We, and our third-party collaborators, collect and process personal data only as permitted by law, and solely to the extent necessary for the conduct of our clinical trials. Personal data of subjects enrolled in our clinical trials, including corresponding clinical data, are collected and processed strictly in accordance with the informed consent provided by the individuals. We obtain explicit consent through signed informed consent forms with each individual, which clearly outline the purposes for collecting and using their personal information. Furthermore, we de-identify all personal data in accordance with relevant laws and regulations. As a result, we have no access to patients' personally identifiable information, such as their names, identity numbers, phone numbers or home addresses.

Furthermore, we require that all internal employees and external parties involved in our clinical trials adhere to strict confidentiality requirements. We generally require CROs to keep all documents, data, records, and information we provide or that they generate during the contract period strictly confidential. CROs also need to ensure their employees, consultants, and other professionals with access to this information are bound by the same confidentiality rules. CROs are usually prohibited from sharing any confidential information with third parties without our prior written consent. Whenever possible, we also require CROs to implement protective measures at least as robust as those they use for their own confidential information to prevent any unauthorized use, disclosure, or leakage of our data.

Any data transfers related to our product development and regulatory communications are conducted in compliance with applicable data protection and privacy laws, including those governing cross-border data transfers. We have established appropriate control measures and governance structures to support secure and compliant data handling. Currently, we transfer personal information of subjects and researchers collected from China to our overseas affiliate for the purposes of new drug clinical development. We have completed the standard contract filing for cross-border transfer of personal information for our current data transfer activities with the Shanghai Office of Cyberspace Administration of China. Despite the evolving nature of data privacy regulations and the potential expansion of our clinical trial activities, we have not encountered any significant issues with data transfers to date. We believe our practices for handling and transferring clinical trial data are consistent with industry standards. As of the Latest Practicable Date, we were in material compliance with all relevant PRC data privacy and protection laws and regulations.

## Internal Control Measures

Given the inherent sensitivity of clinical and related data, we have instituted a comprehensive internal control framework designed to safeguard data privacy and security, prevent data leakage, ensure proper authorization and use of data across our clinical development and business operations, and implement these measures in a manner that supports ongoing legal and regulatory compliance. The following sections summaries the principal elements of this framework.

***Information Security Governance and Risk Management.*** We have adopted a Confidentiality and Business Information Protection Policy that applies to all employees, directors, contractors, and authorised third parties and governs the identification, classification, handling, storage, transmission, and disposal of confidential and proprietary information across our clinical development and business operations. Our information assets are classified into Public, Confidential, and Restricted tiers, with any unclassified information handled by default as Confidential or Restricted, whichever is more protective. Confidential encompasses sensitive business information such as trade secrets, business management information, and employee-related data, while Restricted covers the most sensitive materials, including technical know-how, R&D data, core technologies, and intellectual property. We implement this policy through documented SOPs, role-based access controls, authorised systems requirements, contractual undertakings, and regular training, together providing a governance framework designed to safeguard information throughout its lifecycle.

***Data Privacy, Security, and Leakage Prevention Controls.*** Access to classified or sensitive information is granted strictly on a business necessity and need-to-know basis, aligned with job responsibilities and supported by technical and administrative controls that restrict, monitor, and log access. Classified information must be created, stored, processed, and transmitted only via our authorised systems, with encryption and other safeguards applied as appropriate, and from the moment of creation documents and materials qualifying as our Company secrets are protected through physical measures and logical controls managed by the responsible departments. Personnel with access to important Company secrets execute written confidentiality agreements and, where appropriate, are subject to non-compete obligations; employees are required to avoid unnecessary access or disclosure, to protect technical and trade secrets, to refrain from facilitating unauthorised access, and to report suspected incidents. External agreements that may involve our business secrets contain explicit confidentiality undertakings and remedies for breach, and we maintain monitoring and incident response processes that escalate, investigate, and remediate suspected events, including root-cause analysis, corrective and preventive actions, and regulatory or counterparty notifications as required by law or contract.

***Third-Party Risk Management and Clinical Data Controls.*** For clinical development activities, we appoint qualified CROs and other service providers under written agreements that incorporate data protection, confidentiality, security, and audit provisions, and we implement a study-specific Data Management Plan that defines data collection responsibilities, designated systems and software versions, and backup procedures, and allocates responsibilities among us, CROs, and sites. We engage such providers to support clinical testing services under terms that require compliance with applicable laws and limit the collection and processing of personal data to the minimum necessary to perform the services; where third parties process personal data on our behalf as sponsor, they do so strictly in accordance with our documented instructions and the laws applicable in the territories where services are performed. Our monitors perform source data verification and raise queries within defined timelines, ensure timely data entry, query resolution, electronic Case Report Form ("**eCRF**") completion and electronic signatures at each visit, and oversee adherence to standard operating procedures. Data management activities include ongoing data review conducted in accordance with the applicable standard operating procedures referenced in the study Data Management Plan. Final data outputs and transfers are executed pursuant to the relevant data transfer agreements and applicable standard operating procedures ("**SOPs**"), using defined formats, encryption, transmission protocols, and receipt confirmations to preserve integrity and confidentiality.

***Authorisation, Purpose Limitation, and Compliance Assurance.*** Personal data and proprietary information are collected and processed solely for defined clinical, regulatory, and operational purposes and only to the minimum extent necessary, with any secondary use subject to appropriate approvals, updated notices or consents where required, and consistency with contractual and legal constraints. Role-based authorisation to systems containing personal or Restricted data is periodically reviewed, privileged access is limited and logged, and our personnel receive regular training on the Confidentiality Policy, SOPs, privacy obligations, and incident reporting, with completion tracked. Our controls are designed to support compliance with applicable data protection and clinical frameworks, including Good Clinical Practice and relevant privacy legislation in the jurisdictions of operation, and our vendor contracts require equivalent compliance by service providers and study sites. Implementation is supported by documented processes, system controls, and oversight mechanisms, including periodic internal and vendor reviews and audits, maintenance of records of processing, access permissions, training, data transfers, and incident investigations, and the use of corrective and preventive actions for any identified gaps; based on the design and operation of the measures described above, we believe our internal controls are appropriately designed to protect data privacy and security, prevent data leakage, and ensure proper authorisation and use of data for our clinical development and business operations, and we will continue to assess and enhance these measures in line with evolving regulatory requirements and industry best practices.

## INSURANCE

We maintain insurance policies that we consider to be in line with market practice and adequate for our business to safeguard against risks and unexpected events. Our insurance policies cover clinical trial liability insurance to ensure comprehensive protection against adverse effects as well as director & officer liability insurance. We also maintain social insurance for our employees in accordance with relevant PRC laws and regulations, and we provide supplemental commercial accident and medical insurance for our employees and senior management as well. We believe that our insurance coverage is adequate to cover our programs, facilities, and liabilities. See "Risk Factors — Risks Relating to Our Operations — We have limited insurance coverage, and any claims beyond our insurance coverage may result in our incurring substantial costs and a diversion of resources, which may negatively impact our R&D progress and overall operations."

## SOCIAL, HEALTH, WORK SAFETY AND ENVIRONMENTAL MATTERS

We have deeply integrated Environmental, Social and Governance ("**ESG**") considerations into the core of our business development, establishing them as the foundation for all corporate decision-making and day-to-day operations. We pay attention to the potential impacts of climate-related issues on our business, actively fulfill our environmental and social responsibilities, with the ultimate goal of fully embedding sustainable development principles into our long-term growth strategy.

We adhere to all applicable laws and regulations concerning social responsibility, health, safety, and the environment. Our operations are subject to regular supervision and inspection by relevant local authorities. During the Track Record Period and up to the Latest Practicable Date, we have been in material compliance with all applicable health, occupational safety, and environmental laws and regulations. We have not incurred any material penalties, fines, or claims for violations thereof that could have a material adverse effect on our business, financial condition or results of operations.

### ESG Governance Matters

We place a high priority on ESG governance. The Board of Directors, as the highest decision-making body, bears ultimate responsibility for setting the overall direction, strategy, and objectives for ESG matters, monitoring performance, and overseeing disclosure. We also provide guides and oversees management in the execution of relevant initiatives. Management is

responsible for assisting the Board in coordinating the implementation of ESG initiatives and submitting regular reports to the Board on such matters. At the operational level, we have designated an ESG officer, who is responsible for managing and executing specific ESG tasks. These duties include formulating ESG objectives and strategies, identifying material ESG risks and opportunities, and preparing and publishing ESG reports. This officer reports to management on a quarterly basis to ensure the effective implementation of ESG matters.

We monitor environmental and climate-related risks that may affect our business, strategy and financial performance. To effectively identify, assess and manage ESG risks, we have established standardized management procedures, which are documented in policies covering the entire business process. These include, for example, the *Mechanism for Identification, Assessment and Control of Safety Risks* and the *Safety Accountability System*. In addition, we have formulated various risk contingency plans, such as the *Emergency Response Plan for Hazardous Chemical Incidents* and the *Emergency Response Plan for High-Pressure Sterilization Equipment*, to standardize our approach to ESG risk control. To enhance this framework, we engage qualified independent third-party institutions to identify and assess ESG-related risks, review existing strategies, objectives and internal control systems, and implement necessary improvement measures based on the assessed risk level, with the aim of continuously mitigating risks. In particular, with respect to key areas such as environmental protection, occupational health and workplace safety, we have, with the support of third-party institutions, established management ledgers, conducted regular monitoring, and implemented rectification and supervision measures for identified risks to ensure closed-loop risk management.

We also attach importance to cultivating ESG compliance culture. Through cross-departmental collaboration, we have established communication and training mechanisms to help employees fully understand and strictly comply with relevant ESG laws and requirements. This enables compliance awareness to be embedded into daily business operations and fosters a collaborative ESG management environment across all levels of our Company.

**Environmental Matters**

We fully recognize that sound environmental stewardship is essential to long-term value creation and has incorporated "green operations" into our corporate strategy. We have identified carbon emissions, waste management and resource consumption as priority environmental topics and begun systematically collecting and consolidating the relevant data. In the future, we will establish improvement targets to drive continuous enhancement of our environmental performance.

***Air Emissions, Wastewater and Waste Management***

Our air emissions primarily consist of laboratory exhaust gases. To reduce and control such emissions, we have installed air treatment devices such as activated carbon adsorption systems, with regular replacement of consumables. The treated exhaust gases, which comply with all regulatory standards, are discharged through dedicated exhaust ducts in compliance with relevant requirements.

Our wastewater primarily includes experimental wastewater and domestic sewage. Laboratory wastewater is treated to achieve compliance with applicable standards prior to being discharged into storage tanks, from which it is subsequently released into the industrial park's sewage pipeline network. At our office premises, only domestic sewage is generated, which is discharged into the municipal sewage treatment system in accordance with local requirements.

Our solid waste mainly consists of laboratory solid waste, medical waste and domestic refuse. We have established waste management systems and procedures, including the *Hazardous Waste Management System* and the *Emergency Response Plan for Laboratory Hazardous Waste* and strictly comply with applicable laws and regulations in our operating locations to minimize environmental impact. A complete process has been implemented for classification, labeling,

temporary storage, and disposal through licensed third-party service providers, ensuring that the treatment of all hazardous and non-hazardous waste is in full compliance with national environmental standards. Our disposal methods for major categories of waste are as follows:

| Types of Waste | Compliance Disposal Methods |
|---|---|
| Laboratory Waste | Collected and packaged by category, and subsequently transferred to qualified third-party institutions for disposal. |
| Medical Waste | Sterilized and deactivated through high-temperature and high-pressure autoclaving, and then handed over to qualified third-party institutions for disposal. |
| Domestic Waste | Collected in a classified manner and removed in a centralized manner by the industrial park. |

We have established an internal monitoring program for emissions compliance. Under this program, air emissions, wastewater and noise emissions are tested on a quarterly basis to ensure strict adherence to discharge standards.

***Greenhouse Gas Emissions Management***

We recognize the potential impact of climate change on global public health and the biopharmaceutical industry, and are committed to progressively developing a carbon emissions management mechanism. Presently, we do not have significant Scope 1 greenhouse gas emissions directly generated from energy sources. Our Scope 2 indirect energy emissions primarily include greenhouse gas emissions generated from our use of purchased electricity. In support of the national carbon neutrality target, we actively reduce GHG emissions generated during our operations by enhancing energy efficiency, adopting clean energy sources, and implementing carbon reduction initiatives to minimize the environmental impact of our activities.

We also attach importance to Scope 3 emissions, which include both upstream and downstream emissions such as those generated by suppliers during the production of raw materials and consumables, emissions from product transportation, employee commuting and business travel, as well as emissions resulting from the electricity consumption of municipal wastewater treatment facilities. Although our direct control over Scope 3 emission-generating activities is limited, we remain committed to fostering an environmental culture across our operations and to reducing the carbon footprint of our value chain through the following measures: implementing virtual meetings to replace non-essential business travel; encouraging employees to prioritize the use of public transportation for commuting and business trips to achieve more eco-friendly transportation methods, among others.

***Resource Consumption***

We have embedded the principle of resource conservation into our corporate culture as well as the daily operations of our laboratories and offices. We monitor resource consumption and implement resource-saving measures in laboratories and offices. By formulating standardized operating procedures, providing employee training, and implementing office-specific policies, we cultivate environmental awareness and achieve tangible reductions in resource consumption.

### *Environmental Performance*

We fully recognize the importance of ESG in supporting sustainable development. We track the environmental impact of our operations through relevant metrics, and conduct environmental impact assessments to monitor emission levels, evaluate environmental risks, and consider the establishment of future environmental targets to further mitigate our impact on the environment. The following table sets forth key metrics relating to our energy consumption and waste emissions during the Track Record Period.

| | Year ended December 31, | |
|---|---|---|
| | 2024 | 2025 |
| **Energy consumption** | | |
| Electricity (MWh) | 376.03 | 499.06 |
| Water ($m^3$) | 951.00 | 579 |
| **Waste** | | |
| Hazardous waste (tons) | 7.39 | 11.61 |

*Note:* At our Cambridge premises, utilities such as water and electricity are centrally managed by the property owner, with utility charges included in property management fees. As such, electricity and water consumption at this location cannot be separately measured, and the data presented in the above table only covers operations in Shanghai.

As our business continues to expand and our clinical development and trial activities advance, we expect resource consumption and emissions to increase correspondingly. In anticipation, we remain committed to implementing comprehensive measures to optimize resource utilization efficiency and reduce pollutant emissions. We consistently uphold our commitment to improving environmental performance across the value chain, encompassing key aspects such as optimizing office operations, ensuring supplier compliance, promoting laboratory-based green initiatives, and enhancing waste management practices. On this basis, we also strive to foster a corporate culture guided by environmental protection, while deepening collaboration with business partners to help build a sustainable and environmentally responsible industry ecosystem.

## Social Matters

We ensure a mutually beneficial outcome for employees, partners, and communities through institutionalized employment and labor standards, occupational health and safety systems, talent development pathways, and supplier responsibility management. We also place a high priority on patient data protection, anti-corruption, animal welfare and community investment, thereby ensuring multi-stakeholder value creation and strengthening social trust through transparent governance.

### *Employment and Labor Standards*

We strictly comply with the *Labour Law of the People's Republic of China*, the *Labor Contract Law of the People's Republic of China*, the *Social Insurance Law of the People's Republic of China,* as well as other applicable employment-related laws and regulations in the jurisdictions where we operate, including the United States. We have established an employment management system covering standardized recruitment, compensation policies, career development and promotion pathways, and termination. All of our employees are required to study and sign the Employee Handbook to safeguard their lawful rights and interests.

We are committed to fostering an inclusive, open and equitable workplace. Our recruitment practices strictly follow merit-based selection, ensuring equal opportunities for all employees regardless of gender, age, ethnicity, religion or other social or personal attributes. We expressly

prohibit all forms of discrimination, harassment or forced labor. As of December 31, 2025, women accounted for over 30% of our workforce. We are dedicated to maintaining fair and transparent employment management and to enhancing gender and age diversity within our workforce.

***Occupational Health and Safety***

We attach great importance to occupational health and safety, and are committed to providing employees with a safe and healthy working environment. We strictly comply with applicable local laws, regulations and occupational disease prevention requirements, and have formulated policies such as the *Laboratory Safety Management System* and the *Emergency Response Plan for Fire Incidents*, which cover laboratory operations, equipment usage and emergency response procedures.

Our laboratory facilities are equipped with ventilation systems, biosafety cabinets and first-aid equipment. In addition, employees are provided with personal protective equipment to minimize occupational exposure risks. In addition to providing employees in Shanghai with supplemental commercial insurance that covers outpatient services and medical treatment, we also arrange annual occupational health examinations for laboratory R&D scientists, along with annual health screenings for non-laboratory staff. In addition, we engage third-party institutions to conduct regular professional assessments of workplace safety and employee health, and require the issuance of corresponding reports issued. To reinforce these measures in practice, we enhance employees' safety awareness and emergency response capabilities through activities including annual fire drills and annual hazardous waste leak emergency exercise. These efforts are designed to ensure that the concept of health and safety is deeply embedded in our daily operations.

During the Track Record Period and up to the Latest Practicable Date, no material safety incidents occurred in our operations, nor have we been notified of any material claims relating to occupational health and safety.

***Employee Development and Training***

We regard employees as the cornerstone of our ongoing innovation efforts. We have established a comprehensive training system that includes onboarding, professional skills development, managerial capacity building and compliance education. We encourage employees to participate in industry conferences, academic seminars and external training programs to broaden their professional horizons. We have also established performance evaluation and incentive mechanisms to support career advancement through multiple pathways, including scientific research and management.

***Supply Chain Management***

Our operations are guided by an internal policy framework to ensure adherence to high compliance standards across all supplier partnerships. We implement standardized supplier management procedures to select reputable partners, including CDMOs, CROs and GLP-certified vendors. We conduct due diligence, performance evaluation and compliance oversight for the main suppliers providing raw materials, laboratory services and purchased equipment.

As part of the vendor qualification process, we ask potential suppliers to complete a *Vendor Qualification Questionnaire*, which includes opportunities to provide information on initiatives and ethical considerations, such as environmental protection and business ethics. Suppliers may also share ESG-related certifications or active ESG initiatives, which we take into account during the selection process. Additionally, we clearly define supplier responsibilities for quality, delivery, and compliance in contractual agreements. Currently, all of our CDMOs and our GLP vendor have established ESG programs and published annual ESG reports, and all CROs have made public commitments to ESG principles. Many suppliers have already implemented mature ESG programs with validated targets and regular reporting, while others are developing ESG governance frameworks and disclosure mechanisms to align with industry best practices.

***Product Quality and Safety Management***

Although our business is primarily research-oriented and does not involve large-scale production, we are committed to maintaining product quality and safety. We strictly adhere to GMP requirements and international regulatory standards, and have established a quality management system to support these activities. Our independent Quality Department and CMC Department are responsible for developing standard operating procedures ("**SOPs**"), reviewing batch records, and managing deviations and changes.

We also impose strict regulatory requirements on contract manufacturers to ensure that product and service quality meet contractual and regulatory standards. We sign quality agreements with major CDMOs to confirm and assure compliance with our quality specifications and applicable regulations. These agreements include a responsibility matrix that clearly defines the review responsibilities for critical manufacturing documents. The matrix specifies which documents require review only and which require formal review and approval by us as sponsor. By establishing this structured framework, we promote transparency and accountability across all stages of the manufacturing and quality oversight.

***Patient Data Protection and Prevention of Data Manipulation***

We are committed to protecting Company data as well as the personal information of patients and study participants in accordance with applicable laws, regulations and industry standards. We have established relevant compliance management policies on personal data protection, including *Personal Information Protection Compliance Management Policy* and dedicated "Data Privacy and Confidentiality" sections in our *Quality Manual* and *Vendor Qualification Questionnaire*. We implement full-process controls for data collection, storage, transmission and access, incorporating appropriate permission management and encryption. We strictly prohibit any manipulation or falsification of clinical data, and all data modifications require authorization and maintenance of traceable records.

In addition to our internal safeguards, we rely on the information systems of certain suppliers to support our operations. The security of these systems — including encryption, confidentiality provisions, and access rights management — is managed under each supplier's quality management system, internal policies, and SOPs. We oversee supplier compliance with these controls through our vendor management processes, which include initial qualification, ongoing monitoring, and periodic assessments, supporting the protection of patient data during clinical trial data collection.

***Anti-Corruption***

We uphold integrity and ethical business conduct in our operations, and maintain active integrity-building programs. We explicitly prohibit unethical practices such as bribery, fraud, corruption, extortion and money laundering, having established a whistleblowing mechanism to encourage employees and third parties to anonymously report suspicious activities. Our Employee Handbook sets out clear anti-corruption and anti-bribery requirements. Through the *Vendor Qualification Questionnaire*, we require suppliers and business partners to provide anti-corruption commitments. We provide regular anti-corruption training to employees, and we plan to introduce third-party compliance audits in the future to further strengthen our internal controls.

***Animal Welfare***

We are committed to ensuring that animal testing is only used in drug discovery and early safety assessments when no alternative scientific methods are available, in full compliance with the international "3Rs" principle of Replacement, Reduction and Refinement. We outsource preclinical research to reputable vendors to support our key preclinical projects. For preclinical animal studies, CROs must obtain certification from the Association for Assessment and Accreditation of

Laboratory Animal Care, and research protocols must be reviewed and approved by the Institutional Animal Care and Use Committee. We ensure all studies are conducted in strict compliance with applicable animal care and welfare regulations and guidelines.

***Social Responsibility***

We are committed to improving the quality of life for patients with chronic metabolic diseases worldwide through scientific innovation. We actively participate in public health education, public health outreach and community health promotion programs to enhance public awareness of diseases such as obesity/overweight and diabetes. We encourage employees to participate in volunteer services and charitable projects, which contribute to sustainable development for both us and society.

## PROPERTIES

We currently do not own any land use rights or properties in China and the United States. As of the Latest Practicable Date, we leased one property in the United States for office use, and one property for research and development in Shanghai, each of these two properties has an aggregate gross floor area of approximately 1,400 square meters. We believe that our existing leased premises are adequate for our current business operations and that, should it be needed, suitable additional or alternative space will be available to accommodate our operations.

As of the Latest Practicable Date, the leased property in Shanghai had not been registered and filed with relevant land and real estate management departments in China, and had been mortgaged by the property owners to secure third-party obligations. As of the Latest Practicable Date, we have no plan of relocation with respect to our leased property in China. If we were not able to continue using such property due to the non-registration or because the mortgage is enforced, we believe we are able to identify alternative leasing of other suitable properties in the same locality in a timely manner, and such relocation would not have a material adverse effect on our business, financial condition and results of operations. As of the Latest Practicable Date, we were not aware of any challenges initiated by third parties against our use of these properties.

For risks related to our leased properties, please refer to "Risk Factors — Risks Relating to Our Operations — We are subject to risks associated with leasing space."

## LICENSES, PERMITS AND APPROVALS

As of the Latest Practicable Date, we have obtained all material licenses, permits, approvals and certificates from the relevant government authorities that are material for the business operations of our Group in all applicable jurisdictions.

The following table sets forth the details of our material licenses, permits, approvals, and certificates for our business operations as of the Latest Practicable Date:

| License/Permit/Certificate | Certificate Number | Holder | Issuing Authority | Grant Date |
|---|---|---|---|---|
| Drug Clinical Trial Approval Notice (for ECC4703) . . . . . | 2023LP00104 | Eccogene Shanghai | NMPA | January 13, 2023 |
| Drug Clinical Trial Approval Notice (for ECC4703) . . . . . | 2023LP00105 | Eccogene Shanghai | NMPA | January 13, 2023 |
| Drug Clinical Trial Approval Notice (for ECC4703) . . . . . | 2023LP00106 | Eccogene Shanghai | NMPA | January 13, 2023 |
| Shanghai Pathogenic Microorganism Laboratory Record-filing Certificate . . . | Puzi No. 022019054 | Eccogene Shanghai | Shanghai Pudong New Area Health Commission | August 6, 2019 |

During the Track Record Period and up to the Latest Practicable Date, we had not experienced any material difficulty in renewing the required licenses, permits, approvals, and certificates for our business operations. We currently do not expect there to be any material legal impediment in renewing these licenses, permits, approvals and certificates as they expire in the future, if applicable, as long as we are in compliance with applicable laws, regulations, and rules.

## LEGAL PROCEEDING AND COMPLIANCE

As of the Latest Practicable Date, there was no litigation, arbitration or administrative proceedings pending or threatened against the Company or any of our Directors which could have a material and adverse effect on the research and development of our product candidates, our financial condition or results of operations. Potential future litigation or any other legal or administrative proceeding, regardless of the merit or outcome, is likely to result in substantial costs, diversion of our resources, and have a negative impact on our reputation and brand image, which in turn, would have negative impact on our business, financial condition, and results of operations. For potential impact of legal or administrative proceedings on us, see "Risk Factors — Risks Relating to Our Operations — We may become involved in lawsuits or other legal proceedings, which could adversely affect our business, financial conditions, results of operations and reputation."

During the Track Record Period and up to the Latest Practicable Date, we had complied, in all material respects, with all relevant laws and regulations in all applicable jurisdictions we operate in. We had not been and were not involved in any non-compliance incidents that led to fines, enforcement actions or other penalties that could, individually or in the aggregate, have a material adverse effect on our Group's business operations.

## RISK MANAGEMENT AND INTERNAL CONTROL

We are committed to developing and maintaining risk management and internal control systems comprised of policies and procedures tailored to our business operations. Our dedication lies in the continual enhancement of these systems to ensure their effectiveness.

### Risk Management

We are subject to various risks during our operations. We have established a consolidated risk management system and relevant policies and procedures which we consider suitable for our business operations. Our policies and procedures are aimed at managing and monitoring our business performance.

To monitor the continuous implementation of risk management policies and corporate governance measures after the [**REDACTED**], we have adopted or will continue to adopt, among other things, the following risk management measures:

- establish an audit committee to review and supervise our financial reporting process and internal control system;
- adopt various policies to ensure the compliance with the Listing Rules, including but not limited to policies in respect of risk management, connected transactions and information disclosure;
- provide anti-corruption and anti-bribery compliance training for senior management and employees in order to enhance their knowledge of and compliance of applicable laws and regulations; and
- arrange our Directors and senior management to attend training seminars on Listing Rules requirements and the responsibilities as directors of a Hong Kong-listed company.

We consider that our Directors and members of our senior management possess the necessary knowledge and experience in providing good corporate governance oversight in connection with risk management and internal control.

**Internal Control**

Our Board is responsible for establishing our internal control system and reviewing its effectiveness. We have engaged an internal control consultant to review the effectiveness of our internal control measures related to our major business processes, to identify the deficiencies for improvement, advise on the rectification measures and review the implementation of such measures. During the review process of our internal control consultant, certain internal control matters were identified, and we have adopted corresponding internal control measures to improve on these matters. We have adopted the recommendations made by the internal control consultant and our internal control consultant has completed the follow-up procedures on our internal control system and had no further recommendations.