The information and statistics set out in this section and other sections of this document were extracted from a report prepared by Frost & Sullivan, which was commissioned by us, and from various official government publications and other publicly available publications. We engaged Frost & Sullivan (Beijing) Inc., Shanghai Branch Co. to prepare the Frost & Sullivan Report, an independent industry report, in connection with the [**REDACTED**]. *The information from official government sources has not been independently verified by us, the Joint Sponsors,* [**REDACTED**]*, any of their respective directors, employees, agents or advisors, or any other persons or parties involved in the* [**REDACTED**]*, and no representation is given as to its accuracy, fairness and completeness. For a discussion of the risks relating to our industry, see "Risk Factors." Our Directors and the Joint Sponsors have exercised reasonable care in selecting and identifying the named information sources, compiling, extracting and reproducing the information, and ensuring that no material information has been omitted. Our Directors confirm that, after making reasonable enquiries, there is no adverse change in the market information since the date of the Frost & Sullivan Report that would qualify, contradict or have a material impact on the information in this section.*

CKM SYNDROME AND MANAGEMENT FRAMEWORK

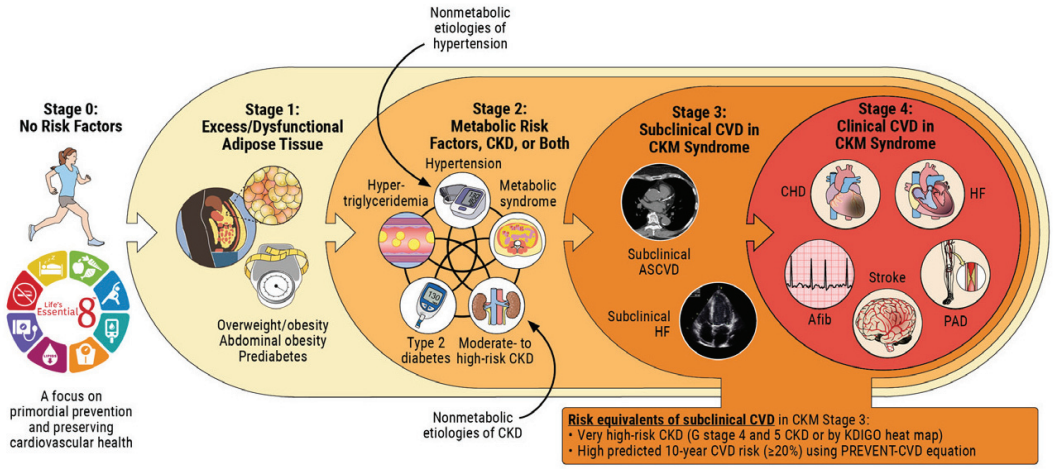
CKM Syndrome

Cardiovascular disease ("**CVD**"), chronic kidney disease ("**CKD**"), and metabolic disorders collectively represent a substantial burden on the global public health system. Given the chronic and progressive nature of these diseases, patients frequently experience comorbidities rather than isolated single-organ disorders. Recognizing such clinical complexity, the industry is undergoing a strategic shift from symptomatic intervention to disease-modifying therapies aimed at improving control rates for chronic diseases and enhancing long-term patient survival and quality of life. In this context, integrated management of cardiovascular-kidney-metabolic ("**CKM**") diseases has emerged as a systemic clinical paradigm.

In 2023, the American Heart Association ("**AHA**") formally defined CKM syndrome as a systemic disorder characterized by pathophysiological interactions among metabolic risk factors, CKD, and the cardiovascular system, leading to multiorgan dysfunction and a high rate of adverse cardiovascular outcomes. These conditions demonstrate a high degree of epidemiological correlation and comorbidity, with the prevalence of the underlying patient population having nearly doubled over the past two decades. In 2025, the global prevalence of CKM syndrome reached 88.9% among adults. Low control rates of CKM conditions are strongly linked to increased mortality. CKM syndrome is a leading cause of mortality worldwide, with an at-risk population of over 1 billion each year.

Integrated CKM Management

The AHA classifies CKM syndrome into stages 0 through 4, as illustrated in the diagram below. The CKM staging construct emphasizes stratified, precision management: progressing from lifestyle interventions and metabolic risk control in the early stages (Stages 0-1) to the synergistic management of multiple risk factors in the intermediate stage (Stage 2), and finally to multidisciplinary collaboration and combined pharmacological and device interventions in advanced stages (Stages 3-4). Globally, in 2025, patients at Stage 2 of the CKM syndrome accounted for 47.4% of all adults.



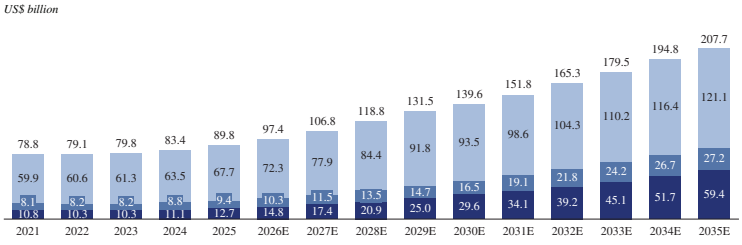
Source: AHA

The staging of CKM syndrome provides a scientific framework for arresting disease progression during the reversible phases and mitigating the risk of end-stage organ damage. Novel mechanisms of action, new technologies, as well as long-acting and/or oral formulations designed to improve patient adherence have emerged as a critical focus in this field. Alongside clinical progress, a focused approach to the CKM syndrome facilitates efficient indication expansion, improves R&D efficiency, and secures access to high-value market segments. This, in turn, enables companies to address broader patient populations, integrate R&D resources, and apply cross-disciplinary insights to maximize asset value.

CKM Drug Market

The markets for CVD drugs, CKD drugs, and metabolic disease drugs are subsets of the CKM drug market. Globally, the market size of CKM drugs increased at a CAGR of 8.7% from US$363.9 billion in 2021 to US$507.8 billion in 2025, and is projected to increase at a CAGR of 8.2% from 2025 to US$751.7 billion in 2030. In China, the market size of CKM drugs increased at a CAGR of 3.3% from US$78.8 billion in 2021 to US$89.8 billion in 2025, and is projected to increase at a CAGR of 9.2% from 2025 to US$139.6 billion in 2030, outpacing the forecasted growth rate of the global market over the same period. The following chart sets forth the market size of CKM drugs in China for the periods indicated:

China's CKM Drug Market, 2021-2035E



Type	CAGR		
	2021-2025	2025-2030E	2031E-2035E
CVD	3.1%	6.7%	5.3%
CKD	3.8%	11.8%	10.6%
Metabolic Diseases	4.1%	18.4%	15.0%
Total	3.3%	9.2%	8.3%

Source: Publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

Key Growth Drivers

The growth in China's CKM drug market has been primarily driven by the escalating disease burden, supportive policies on innovative drugs, and the accelerated commercialization of domestically-developed CKM therapies. Innovation-driven companies like us are also expected to benefit from the long-tail effect in the sales of well-established originator drugs.

Supportive Policies on Innovative Drugs

On June 30, 2025, the NHSA and the NHC jointly announced several measures to support the high-quality development of innovative drugs. The notice lists 16 action items, with priorities given to (i) innovative drug research and development, (ii) the inclusion of innovative drugs in insurance catalogues, (iii) clinical application of innovative drugs, (iv) diversifying payment channels for innovative drugs.

- ***Accelerated R&D.*** The government will harness data analytics in the healthcare sector to more effectively inform national research priorities, targeting areas such as uncommon, pediatric, chronic, and infectious diseases. With our focus firmly on CKM syndrome—a chronic condition squarely within this priority framework—we expect to leverage the supportive policy to refine our clinical trial strategies, and accelerate the development of innovative therapies in addressing China's growing chronic disease burden.

- ***Medical Insurance Inclusion.*** The notice encourages medical insurance authority to optimize the dynamic adjustment to BMI catalog. The relevant authority should take into full consideration the affordability of the medical insurance fund, clinical needs, patient benefits, market competition, and R&D investment of innovative therapies. We proactively pursue the inclusion of our innovative therapies in the NRDL, and expect to benefit from the optimized NRDL inclusion and renewal rules. For details, see "Regulatory Overview—PRC Laws and Regulations—Laws and Regulations in Relation to the Pharmaceutical Industry—China's National Medical Insurance System."

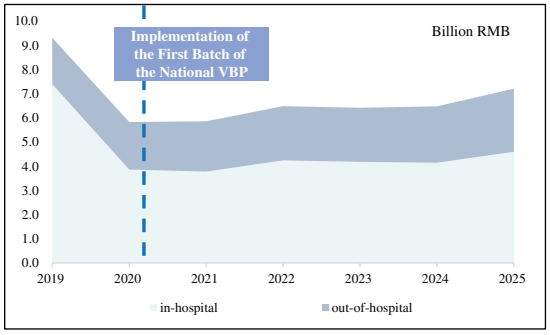
- ***Clinical Application.*** The notice requires an expedited access of innovative drugs to designated healthcare institutions, and promotes the "dual-channel" mechanism for patients to access innovative therapies at designated retail pharmacies. This supportive policy is expected to expand the market opportunities of our innovative drugs in both in-hospital and out-of-hospital channels.

- ***Diversifying Payment Channels.*** The notice encourages the inclusion of innovative drugs in commercial health insurance and medical mutual aid programs. The first-ever Commercial Health Insurance Innovation Drug List (the "**CHIIDL**") was released in December 2025. For details, see "Regulatory Overview—PRC Laws and Regulations—Laws and Regulations in Relation to the Pharmaceutical Industry—China's National Medical Insurance System." We will closely monitor the regulatory development of the CHIIDL, and explore feasible approaches to expanding the commercial insurance coverage of our innovative therapies.

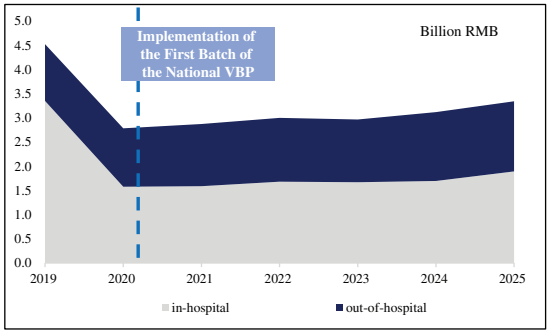
Long-Tail Effect

Because CKM conditions are chronic in nature, patients require long-term—often lifelong—treatment and therefore place strong emphasis on drug quality and brand reputation. In addition, CKM therapies are generally more affordable than treatments for severe diseases. These factors lead to more stable and resilient demand for high-quality originator products even after their loss of exclusivity. Lipitor and Norvasc, for example, are two well-established originator chronic disease medicines. As illustrated in the diagrams below, despite the inclusion of their generics in the national VBP, these two originator drugs have successfully maintained approximately 70% of their sales revenue in China. In addition, the growth of the out-of-hospital market and rising awareness of chronic disease management are expected to further drive sales growth for well-established originator drugs.

Sales Revenue of Lipitor



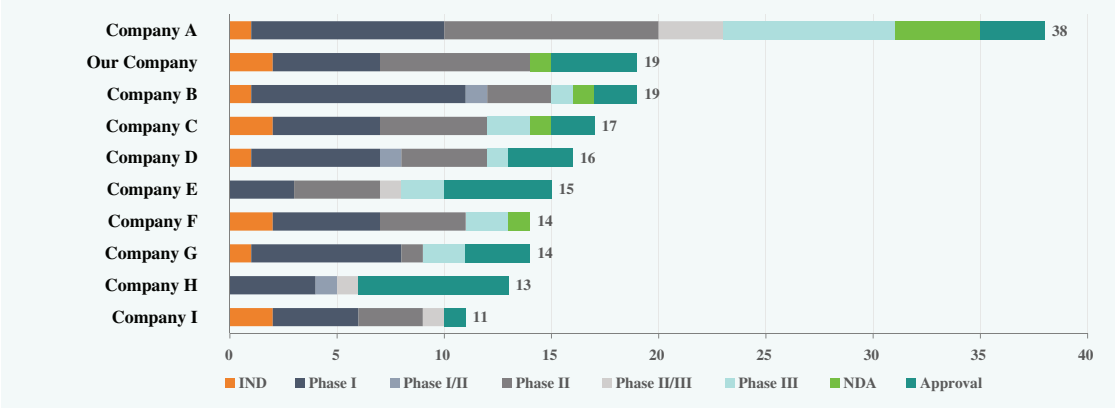
Sales Revenue of Norvasc



Source: Menet, publicly available annual reports, literature review, expert reviews, and Frost & Sullivan analysis

Major Players in CKM Drug Market

As of the Latest Practicable Date, we ranked second among domestic companies by the number of marketed NMEs and pipeline candidates in or beyond the IND stage for CKM syndrome. The following chart sets forth the top 10 Chinese pharmaceutical companies ranked by this measure:



Note: Company A, founded in 1970 and headquartered in Lianyungang, Jiangsu Province, is a publicly listed company engaged in the R&D, production, and sales of prescription drugs, with core therapeutic areas covering oncology, cardiovascular diseases, and metabolic disorders; Company B, founded in 1997 and headquartered in Shijiazhuang, Hebei Province, is a publicly listed company engaged in the R&D, production, and sales of innovative drugs, generics, biopharmaceuticals, and APIs, with core therapeutic areas covering oncology, cardiovascular diseases, and infectious diseases; Company C, founded in 1995 and headquartered in Lianyungang, Jiangsu Province, is a publicly listed company developing innovative drugs and high-end generics for oncology, central nervous system disorders and anti-infective treatments; Company D, founded in 2021 and dual-headquartered in California, United States and Shanghai, is a private clinical-stage biotech company developing siRNA therapeutics for coagulation disorders, cardiometabolic diseases and obesity; Company E, founded in 1987 and headquartered in Beijing, is a centrally administered state-owned enterprise operating a full-industry chain in healthcare, integrating R&D, manufacturing, logistics distribution, retail pharmacy chains, medical services, and international operations across the entire healthcare ecosystem; Company F, founded in 2000 and headquartered in Beijing, is a publicly listed pharmaceutical company focused on the R&D, production and sales of innovative drugs, generics and biosimilars, with core therapeutic areas covering liver diseases, oncology and respiratory diseases; Company G, founded in 1993 and headquartered in Hangzhou, Zhejiang Province, is a publicly listed company operating in pharmaceutical manufacturing, distribution, medical aesthetics and industrial microbiology, focusing on nephrology, immunology, and oncology; Company H, founded in 1995 and headquartered in Shenzhen, Guangdong Province, is a pharmaceutical service company specializing in the marketing, promotion, and sales of prescription drugs, with a primary focus on cardiology and cerebrovascular, gastroenterology, ophthalmology, dermatology, and aesthetic medicine; and Company I, founded in 2003 and headquartered in Dongguan, Guangdong Province, is a publicly listed company that develops and manufactures pharmaceuticals for infection, oncology and metabolic diseases.

Source: PharmCube, publicly available annual reports, literature review, expert reviews, and Frost & Sullivan analysis

CVD DRUG MARKET

Under the CKM management framework, CVD refers to cardiac and vascular disorders arising from metabolic abnormalities. Globally, the market size of CVD drugs increased from US$232.0 billion in 2021 to US$308.0 billion in 2025 at a CAGR of 7.3%, and is projected to increase at a CAGR of 6.1% from 2025 to US$413.8 billion in 2030. In China, the market size of CVD drugs increased at a CAGR of 3.1% from US$59.9 billion in 2021 to US$67.7 billion in 2025, and is projected to increase at a CAGR of 6.7% from 2025 to US$93.5 billion in 2030, outpacing the forecasted growth rate of the global market over the same period.

The growth in China's CVD drug market has been primarily driven by the rising prevalence of CVD in China. In China, the population with CVD increased from 443.1 million in 2021 to 479.9 million in 2025, and is projected to increase to 520.1 million in 2030 and 558.8 million in 2035. Favorable national policies for innovative drugs and the expanding inclusion of CVD drugs in medical insurance programs have also fueled growth in China's CVD drug market.

In the context of CKM syndrome, hypertension, dyslipidemia, thrombosis, and chronic heart failure are no longer viewed as isolated pathologies but rather as conditions exhibiting high comorbidity and mutual convertibility. Long-term hypertension and hyperlipidemia damage the vascular endothelium and promote atherosclerosis. Plaque rupture or erosion can cause acute thrombotic events, which may lead to myocardial infarction and ischemic stroke. Chronic blood pressure overload due to hypertension can further lead to heart failure with preserved ejection fraction ("**HFpEF**"), characterized by ventricular hypertrophy and stiffness. This may ultimately progress to heart failure with reduced ejection fraction ("**HFrEF**"), often due to ischemic injury following myocardial infarction. The hypertension drug market, the dyslipidemia drug market, and the heart failure drug market are major subsets of the CVD drug market, details of which are described in the following sections.

HYPERTENSION DRUG MARKET

Hypertension and Treatment Paradigm

Hypertension is considered a main driver of CKM syndrome, interacting with cardiac dysfunction, metabolic disorders, and renal decline. In terms of physiopathology, elevated blood pressure can cause structural and functional changes in the arterial vascular system and perfused tissues, resulting in target organ damage and increasing the risk of cardiovascular and cerebrovascular events, which may ultimately lead to the functional failure of vital organs, particularly the heart and kidneys.

Globally, the population with hypertension increased from 1,553.0 million in 2021 to 1,606.6 million in 2025, and is projected to increase to 1,674.6 million by 2030. In China, the population with hypertension increased from 332.3 million in 2021 to 359.9 million in 2025, and is projected to increase to 390.1 million by 2030.

The treatment paradigm of hypertension typically includes (i) hypertension therapy to lower elevated blood pressure, (ii) integrated management of comorbid risk factors and hypertension-related organ damage or clinical complications, and (iii) evaluation for and, where appropriate, treatment of identifiable secondary causes. The overarching objectives are to achieve effective blood pressure reduction, slow disease progression, and prevent or delay major adverse outcomes such as stroke, myocardial infarction, heart failure, and renal impairment.

Upon diagnosis, physicians are required to measure patients' blood pressure (i.e., office blood pressure). The following table sets forth the classification of hypertension by office blood pressure level:

	Description (Office Blood Pressure)
Elevated Blood Pressure	systolic 120-139 mmHg/diastolic 80-89 mmHg
Grade 1 (mild) Hypertension	systolic 140-159 mmHg/diastolic 90-99 mmHg
Grade 2 (moderate) Hypertension	systolic 160-179 mmHg/diastolic 100-109 mmHg
Grade 3 (severe) Hypertension	systolic ≥180 mmHg/diastolic ≥110 mmHg

*Source: Chinese Guidelines for the Prevention and Treatment of Hypertension (2024 Revision) (《中國高血壓防治指南(2024年修訂版)》) (the "**Guideline**"); Frost & Sullivan analysis*

Physicians concurrently evaluate patients' overall cardiovascular risk profile by identifying other cardiovascular and cerebrovascular risk factors, assessing target-organ damage, and determining the presence of relevant clinical complications and comorbidities (such as CVD, cerebrovascular disease, or kidney disease). Based on these comprehensive assessments, patients are further stratified into low-, moderate-, high-, and very high-risk categories to guide the disease treatment. In addition to lifestyle intervention, the current standard of care for hypertension is set forth in the table below:

Classification	Standard of Care
Elevated blood pressure with high- to very high-risk	**Single agent:** (i) renin-angiotensin-aldosterone system ("**RAAS**") inhibitors, (ii) beta-blockers, (iii) CCBs, or (iv) diuretics. RAAS inhibitors (also known as "**A**" regimen) include angiotensin-converting enzyme inhibitors ("**ACEi**"), angiotensin II receptor blockers ("**ARB**"), and angiotensin receptor-neprilysin inhibitors ("**ARNi**"). Patients who fail to achieve target blood pressure after receiving monotherapy may be escalated to combination regimens.
Grade 1 or 2 hypertension with low- to moderate-risk	
Grade 1 or 2 hypertension with high- to very high-risk	**Dual-agent combination regimens:** RAAS inhibitors in combination with CCBs or diuretics (also known as "**A+C**" or "**A+D**" regimen), or CCBs in combination with diuretics or beta-blockers (also known as "**C+D**" or "**C+B**" regimen). To improve patients' adherence, single-pill combinations are recommended by treatment guidelines.
Grade 3 hypertension	

Source: the Guideline; Frost & Sullivan analysis

In addition, patients with clinical complications and comorbidities require individualized management. For example, for patients with heart failure and CKD accompanied by proteinuria, the blood pressure target should be below 130/80 mmHg. ACEi, ARB and ARNi are preferred therapies. Furthermore, patients experiencing special phenotypes of hypertension such as nocturnal and masked hypertension are required to implement ambulatory and home blood-pressure monitoring to ensure 24-hour blood pressure control, minimize blood pressure volatility, and extend time-in-target-range, thereby reducing cardiovascular events.

Under the Guideline, patients will be classified into a clinical state of "resistant hypertension," if (i) their blood pressure remains above the target value (such as office blood pressure >140/90 mmHg) despite enhanced lifestyle intervention and the concurrent use of maximally tolerated doses of at least three hypertension drugs of different classes (including one thiazide diuretic) for at least four weeks with confirmed adherence, or (ii) their blood pressure control requires the use of four or more hypertension drugs. For resistant hypertension, the current standard of care is based on a triple-agent regimen combining RAAS inhibitors, CCBs, and thiazide diuretics, which may be supplemented with a fourth hypertension drug. The Guideline recommends mineralocorticoid receptor antagonists ("**MRA**") as the fourth hypertension drug for the treatment of resistant hypertension.

Unmet Medical Needs

Globally, despite cost-effective and clinically proven hypertension drugs, only 25% of patients achieve targeted blood pressure levels, and 30% to 40% of patients demonstrate poor medication adherence. In China, hypertension treatment and control rates remained low at 46% and 17%, compared to 73% and 49% in the United States. Notably, resistant hypertension remains a clinical challenge in China, which affects approximately 34.8% of the hypertension population, representing a heavy disease burden.

Comparison of Hypertension Drugs

Traditional Agents for Hypertension

The following drugs are considered as traditional agents for the treatment of hypertension. These segments are primarily dominated by generic drugs:

- ***Diuretics*** (also known as "**D**" regimen)—first modern therapy for hypertension and cornerstone of combination regimens. By increasing renal sodium excretion, diuretics promote water excretion and thus reduce circulating blood volume. Major side effects such as electrolyte disturbances and metabolic effects (glucose, lipids, uric acid) make it unsuitable for patients with high uric acid, severe renal dysfunction, or hypokalemia.

- ***Sympathetic Modulators*** (β-blockers, α-blockers, central agents) (also known as "**B**" regimen)—less-used legacy therapies with niche use in specific patient populations. Sympathetic modulators reduce heart rate and contractility through various mechanisms, which leads to lower cardiac output that would help treat hypertension. This, however, also gives rise to fatigue and bradycardia (i.e., with a too-slow heart rate), resulting in worse long-term tolerability and patient compliance. As such, sympathetic modulators are less used today.

- ***Calcium Channel Blockers ("CCBs")*** (also known as "**C**" regimen)—widely-used first-line therapy and a core component of fixed-dose combinations. CCBs block Ca^{2+} influx into vascular smooth muscle, leading to reduced peripheral resistance. Major side effects such as edema, headache, and palpitations make it unsuitable for patients with severe heart failure and CKD.

RAAS Inhibitors: Backbone Disease-modifying Approach

RAAS is a crucial mediator of cardiac, vascular, and renal physiology, which acts through regulating vascular tone and salt/water homeostasis. Hypertension is found to be a neurohormonal disease primarily driven by RAAS overactivation. The discovery of RAAS, or the renin-angiotensin-aldosterone system, has transformed the treatment of hypertension from merely lowering blood pressure to modifying the underlying disease biology and protecting organs.

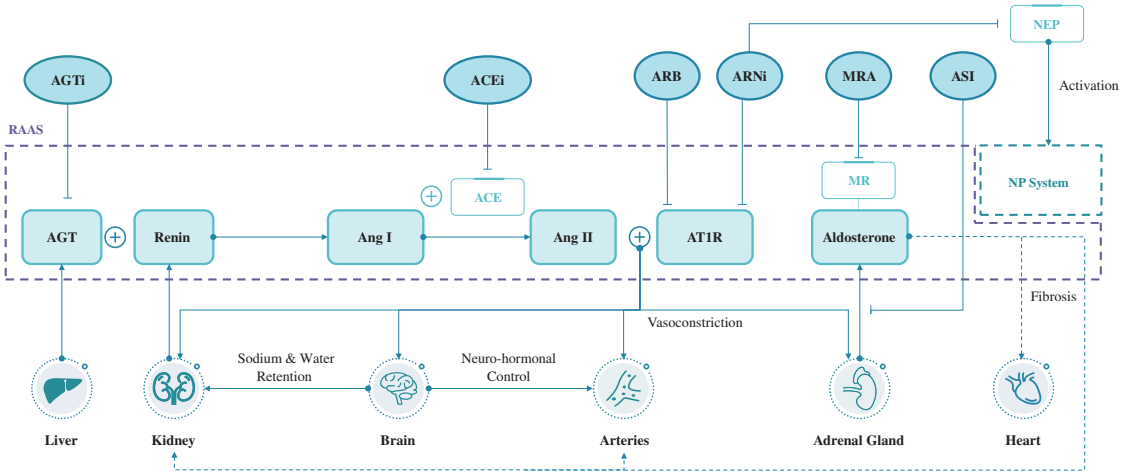
- ***Traditional RAAS inhibitors.*** RAAS inhibitors block the RAAS activation cascade by interfering with different reaction steps. **ACEi** (first approved in the 1980s) and **ARB** (first approved in the 1990s) are two foundational types of RAAS inhibitors. They are widely used as the standard of care and serve as the backbone of combination therapies. ARBs, due to better tolerability, are often preferred in clinical practice. Although traditional RAAS agents are cornerstone therapies for cardiorenal diseases, their clinical application is limited by adverse reactions such as hyperkalemia and worsening renal function. The phenomenon of "aldosterone escape" also undermines their long-term protective effects.

- ***New RAAS inhibitors.*** Research and development in the field are focused on precision treatment, enhanced patients' adherence, and multi-organ protection. **ARNi** (first approved in 2021 for the treatment of hypertension in China) represents a next-generation cardio-renal therapy. **ARNi** can simultaneously block the RAAS axis and amplify the protective natriuretic peptide ("**NP**") system, which is considered the body's natural "brake" for overactivation of RAAS and sympathetic systems. As such, ARNi achieves both upstream suppression and downstream counterbalance, transforming treatment from purely suppressing harmful pathways into actively restoring physiological balance and meaningful cardio-renal protection beyond blood pressure reduction. **AGT siRNA** under clinical development is a potential next frontier in long-acting hypertension therapy. Angiotensinogen ("**AGT**"), generated by the liver, sits at the top of the RAAS cascade. It historically has been difficult to target because broad upstream suppression lacked precision and AGT is produced at high quantities and circulating levels, making traditional pharmacologic inhibition impractical. However, liver-targeted siRNA therapies now enable slow, scalable, and controlled AGT reduction at liver site, with more stable RAAS suppression and reduced adherence issues.

Therapies for Resistant Hypertension

Despite treatments with RAAS inhibitors described above, aldosterone rebound may lead to resistant hypertension. **Mineralocorticoid receptor antagonists** ("**MRAs**") can directly bind to the aldosterone receptor, the final stage of the effector arm of RAAS. As of the Latest Practicable Date, spironolactone was the only MRA recommended under the Guideline. However, due to the off-target blockade of multiple receptors, it is often associated with prevalent dose-limiting adverse effects, such as gynecomastia in men and menstrual irregularities and postmenopausal bleeding in women, which significantly restrict its real-world application. Unlike MRAs which block the aldosterone receptor, **aldosterone synthase inhibitors** ("**ASIs**") block aldosterone synthesis at the source. They are an emerging drug class under development to address the "aldosterone escape" phenomenon. With more precise blockage and fewer side effects, ASIs hold potential clinical benefits to constructively address the persistent damage to target organs including the heart, kidneys, and blood vessels. They are considered a novel, highly effective and safe therapeutic option for patients with resistant hypertension, chronic heart failure with high aldosterone level, and CKD with persistent proteinuria.

The following diagram illustrates the major mechanisms of action of the RAAS inhibitors and other emerging classes of hypertension drugs described above:



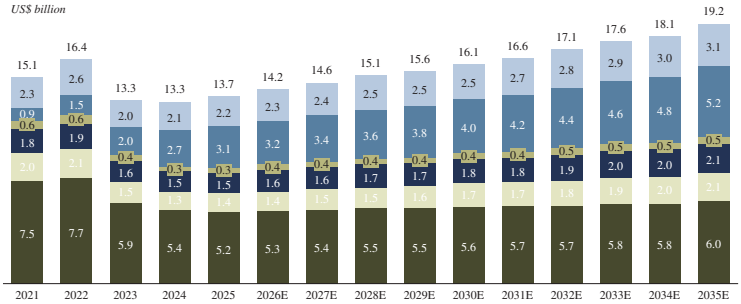
Source: Literature review, Frost & Sullivan analysis

While the RAAS is widely regarded as the most important system for regulating blood pressure, compensatory "escape" mechanisms are often triggered when this pathway is blocked. This makes the endothelin ("**ET**") system a critical target for hypertension treatment. Historically, **endothelin receptor Type A ("ETAR") antagonists** were primarily used for pulmonary arterial hypertension; however, the landscape has shifted with a recent U.S. FDA approval. In March 2024, aprocitentan (by Idorsia) was approved by the U.S. FDA for the treatment of uncontrolled hypertension. As of the Latest Practicable Date, aprocitentan was the only marketed ETAR antagonist worldwide. Globally, **dual-antagonists of AT1R/ETAR**, acting through both the RAAS and the ET system, are also under research and development, which are expected to deliver stronger blood pressure reduction and organ protection effects.

Market Size of Hypertension Drugs

Globally, the market size of hypertension drugs reached US$37.8 billion in 2025, and is projected to increase to US$50.7 billion in 2030 at a CAGR of 6.0%, and further to US$68.5 billion at a CAGR of 6.2% from 2030 to 2035. In China, the market size of hypertension drugs reached US$13.7 billion in 2025, and is projected to increase to US$16.1 billion in 2030 at a CAGR of 3.5%, and further to US$19.2 billion at a CAGR of 3.7% from 2030 to 2035. The following chart sets forth a breakdown of China's hypertension drug market by drug class for the periods indicated:

China's Hypertension Drug Market, 2021-2035E



Drug Class	CAGR		
	2021-2025	2025-2030E	2030E-2035E
ARB	-1.0%	3.5%	3.7%
ARNI	34.3%	5.3%	5.7%
ACEI	-11.9%	4.3%	4.6%
A+C	-3.6%	3.3%	5.7%
A+D	-8.7%	4.3%	4.6%
Others	-8.8%	1.5%	1.5%
Total	-2.3%	3.3%	3.6%

Source: Publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

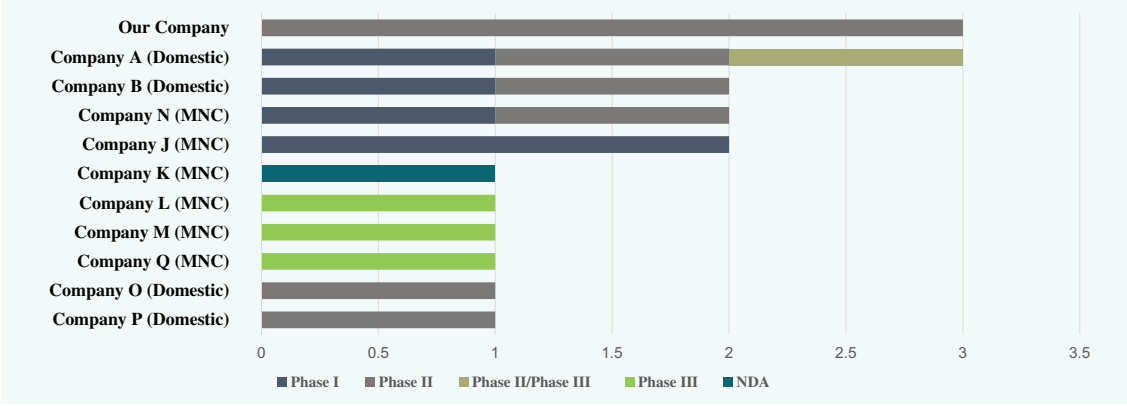
Key Growth Drivers

The key growth drivers for the hypertension drug market primarily include the upgrade of traditional agents and emerging precision therapies. The upgrade of traditional agents—through formulation innovations (e.g., ARNi and AGT siRNA) and the replacement of free combination therapy with single-pill combinations—will drive market growth due to enhanced antihypertensive efficacy, organ protection, and long-acting potential. Meanwhile, emerging precision therapies with novel mechanisms of action, such as ASIs and ETAR antagonists, are expected to offer new treatment pathways for patients with uncontrolled or resistant hypertension. Globally, the market size of ETAR antagonists for the treatment of hypertension is estimated to reach US$2,217.6 million by 2030, representing a CAGR of 156.4% from 2025 to 2030, and further increase to US$7,382.3 million in 2035, representing a CAGR of 27.2% from 2030 to 2035. Globally, the market size of ASIs for the treatment of hypertension is projected to reach US$1,080.0 million in 2030, representing a CAGR of 178.5% from 2027 to 2030, and further increase to US$5,620.7 million in 2035, representing a CAGR of 39.1% from 2030 to 2035. We are well-positioned to capitalize on these market opportunities by developing a hypertension drug portfolio that encompasses all of these treatment options.

Key Factors Affecting Competition in the Hypertension Drug Market

Because hypertension patients differ in blood pressure levels, disease progression, as well as clinical complications and comorbidities, competition in the hypertension drug market focuses on offering effective and safe therapies, while delivering comprehensive and personalized treatment coverage. For example, patients not meeting blood pressure targets with monotherapy may be advanced to combination regimens. Resistant hypertension also requires more innovative therapeutics with novel mechanisms of action.

Our Directors and Frost & Sullivan are of the view that our broad portfolio of marketed and pipeline hypertension drugs enhances our competitive advantages over other competitors targeting the same indication, and mitigates the risk of any single product or any single drug class being replaced by newer therapies indicated for the treatment of hypertension. Globally, we ranked first in terms of the number of NME hypertension drug candidates in IND or later stages of development as of the Latest Practicable Date, as illustrated in the diagram below:



Note: *Company J, founded in 2002 and headquartered in Incheon, South Korea, is a biopharmaceutical company specializing in the research, development, and production of biosimilars and innovative monoclonal antibody drugs; Company K, founded in 1885 and headquartered in Osaka, Japan, is a subsidiary of Mitsubishi Tanabe Pharma Corporation that researches, develops and markets pharmaceuticals focusing on neurology, nephrology and rare diseases; Company L, founded in 1896 and headquartered in Basel, Switzerland, is a publicly listed global healthcare company specializing in pharmaceuticals and diagnostics, focused on cancer, autoimmune disorders, and infectious diseases; Company M, founded in 1885 and headquartered in Ingelheim, Germany, is a global research-driven biopharmaceutical company operating across human pharmaceuticals and animal health, with a strong focus on breakthrough therapies in cardiovascular and metabolic diseases, respiratory diseases, oncology, immunology, and central nervous system disorders; Company N, founded in 1996 and headquartered in Basel, Switzerland, is a publicly listed global healthcare company that researches, develops, manufactures and markets innovative pharmaceuticals, generics, biosimilars and eye care products; Company O, founded in 2011 and headquartered in Jiangsu Province, is a HKEX-listed biotech company dedicated to the R&D and commercialization of innovative antibody drugs for oncology, metabolism, autoimmune diseases and other areas; Company P, founded in 2022 and headquartered in Sichuan Province, is a biotech company focusing on the R&D and technological development of nucleic acid-based therapeutics; and Company Q, founded in 1945 and headquartered in Gwacheon, South Korea, is a publicly listed biopharmaceutical company specializing in the development and manufacturing of innovative new drugs across multiple therapeutic areas, including gout, rare neurodevelopmental disorders, and metabolic diseases.*

Source: PharmCube, publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

Competitive Landscape of ARBs for Treatment of Hypertension

Marketed Drugs

We currently market two NME hypertension drugs, namely XinLiTan and XinChaoTuo, and two other innovative hypertension drugs, namely FuLiTan and FuLiAn, in China. In terms of sales revenue, XinLiTan and FuLiTan are our major marketed drugs. XinChaoTuo and FuLiAn also demonstrated strong sales growth during the Track Record Period.

XinLiTan

In October 2013, XinLiTan was approved by the NMPA for the treatment of mild-to-moderate essential hypertension. In China, the population with mild-to-moderate essential hypertension increased from 209.0 million in 2021 to 235.6 million in 2025.

XinLiTan is the first domestically-developed ARB in China. As of the Latest Practicable Date, there were 185 ARBs, comprising nine innovative drugs and 176 generic drugs, marketed in China for the treatment of hypertension. The following table provides an overview of top five players in the ARB drug market, ranked by market share:

Rank	Brand Name	Generic Name	Type	Manufacturer	Retail Price	NRDL Inclusion
1	**XinLiTan (信立坦)**	**allisartan isoproxil**	**Innovative Drug**	**our Company**	**RMB24**	**Yes**
2	LanSha (兰沙)	olmesartan medoxomil	Generic Drug	Foyou Pharma	RMB13-27	Yes
3	BeiYi (倍怡)	losartan potassium	Generic Drug	Huahai Pharma	RMB13-15	Yes
4	Diovan	valsartan	Innovative Drug	Novartis	RMB20-27	Yes
5	Approvel	irbesartan	Innovative Drug	Sanofi	RMB24-28	Yes

Source: NMPA, Frost & Sullivan analysis

In 2025, these top five players together held a total market share of 54% in terms of in-hospital sales revenue of ARBs in China. XinLiTan, with a 29.1% market share, ranked first among all ARBs and third among all hypertension drugs marketed in China. XinLiTan outperforms competing products, due to its potent nocturnal blood pressure control and uric acid lowering effects. For details, see "Business—Our Drugs and Drug Candidates—Hypertension—XinLiTan (Allisartan Isoproxil Tablets) (信立坦(阿利沙坦酯片))."

FuLiTan

In May 2024, FuLiTan was approved by the NMPA for the treatment of essential hypertension. Specifically, this fixed-dose combination is indicated in adult patients whose blood pressure is not adequately controlled on monotherapy with either allisartan isoproxil or amlodipine. In China, the population with hypertension receiving a fixed-dose combination therapy of ARB/ACEi and CCB increased from 39.2 million in 2021 to 40.3 million in 2025.

FuLiTan is the first domestically-developed fixed-dose combination of ARB (allisartan) and CCB (amlodipine) in China. As of the Latest Practicable Date, there were 30 fixed-dose combinations of ARB/ACEi and CCB marketed in China for the treatment of hypertension, comprising nine innovative drugs and 21 generic drugs. The following table provides an overview of top five players in the market of fixed-dose combinations of ARB/ACEi and CCB, ranked by market share:

Rank	Brand Name	Generic Name	Type	Manufacturer	Retail Price	NRDL Inclusion
1	Coveram (开素达)	perindopril and amlodipine	Innovative Drug	Servier	RMB44-51	Yes
2	Exforge (倍博特)	amlodipine and valsartan	Innovative Drug	Novartis	RMB44-56	Yes
3	BaiAnXin (百安新)	amlodipine and benazepril	Generic Drug	Yangzijiang Pharma	RMB36-49	Yes
4	RuiXinAn (瑞心安)	valsartan and amlodipine	Generic Drug	Hengrui Pharma	RMB11-30	Yes
5	**FuLiTan (复立坦)**	**allisartan isoproxil and amlodipine**	**Innovative Drug**	**our Company**	**RMB28**	**Yes**

In 2025, these top five players together held a total market share of 85.9% in terms of in-hospital sales revenue of fixed-dose combinations of ARB/ACEi and CCB in China. FuLiTan, with a 3.8% market share, ranked fifth among the same class of drugs marketed in China. FuLiTan outperforms competing products, due to its potent 24-hour blood pressure management. For details, see "Business—Our Drugs and Drug Candidates—Hypertension—FuLiTan (Allisartan Isoproxil and Amlodipine Tablets) (复立坦(阿利沙坦酯氨氯地平片))."

Competitive Landscape of ETAR Antagonists and ASIs for Treatment of Hypertension

ETAR Antagonists

Globally, aprocitentan (by Idorsia) was the only marketed ETAR antagonist as of the Latest Practicable Date. In March 2024, aprocitentan was approved by the U.S. FDA for the treatment of uncontrolled hypertension. SAL0120, our ETAR antagonist, was undergoing a Phase II clinical trial for the treatment of uncontrolled or resistant hypertension as of the Latest Practicable Date, and it was the only ETAR antagonist under clinical development in China.

ASIs

Globally, baxdrostat (by AstraZeneca) was the only marketed ASI for the treatment of hypertension as of the Latest Practicable Date. In May 2026, baxdrostat was approved by the U.S. FDA for the treatment of uncontrolled or resistant hypertension. SAL0140, our ASI, was undergoing a Phase II clinical trial for the treatment of uncontrolled or resistant hypertension as of the Latest Practicable Date. The following table provides an overview of ASIs under clinical development in China for the treatment of resistant hypertension as of the Latest Practicable Date:

Drug Name/Code	Company	Stage	First Posted Date
Baxdrostat	AstraZeneca	NDA	Feb 13, 2026
SAL0140	**our Company**	**Phase II**	**Nov 25, 2025**
QLS1410	QILU	Phase II	Mar 16, 2026
VB19055	Vybio	Phase I	Sep 4, 2025

Source: CDE, Frost & Sullivan analysis

DYSLIPIDEMIA DRUG MARKET

Dyslipidemia and Treatment Paradigm

Dyslipidemia is defined as a pathological state where serum lipid parameters exceed normal reference ranges. The routine clinical tests for blood lipids typically include total cholesterol ("**TC**"), triglycerides ("**TG**"), low-density lipoprotein cholesterol ("**LDL-C**"), and high-density lipoprotein cholesterol ("**HDL-C**"). Clinically, major types of dyslipidemia include hypercholesterolemia, hypertriglyceridemia, mixed hyperlipidemia, and low HDL-cholesterolemia. The following chart illustrates the abnormal changes in relevant lipid parameters for each major type of dyslipidemia:

Phenotype	TC	TG	HDL-C
Hypercholesterolemia	↑	–	–
Hypertriglyceridemia	–	↑	–
Mixed hyperlipidemia	↑	↑	–
Low HDL-cholesterolemia	–	–	↓

Source: Chinese Guidelines for Lipid Management (2023) (《中國血脂管理指南(2023年)》)

Globally, the population with dyslipidemia increased from 3,188.1 million in 2021 to 3,325.7 million in 2025, and is projected to further increase to 3,496.8 million in 2030 and 3,665.9 million in 2035. In China, the population with dyslipidemia increased from 505.4 million in 2021 to 513.4 million in 2025, and is projected to increase to 522.5 million in 2030 and 535.2 million in 2035.

Imbalance in lipid metabolism and transport systems constitutes a core independent risk factor for atherosclerotic cardiovascular disease ("**ASCVD**"). Increasing awareness, treatment, and control rates of dyslipidemia is a core strategy for the prevention of ASCVD. Among the commonly used lipid indicators, LDL-C is the lipid parameter that demonstrates a causal relationship with ASCVD risk and often serves as the primary clinical treatment target. Currently, statins are the first-line treatment for lowering LDL-C in most clinical settings. However, a significant proportion of patients do not achieve acceptable LDL-C levels using statins alone. Statin intolerance (e.g., myalgia) and suboptimal patient adherence to long-term daily drug administration also complicate lipid management.

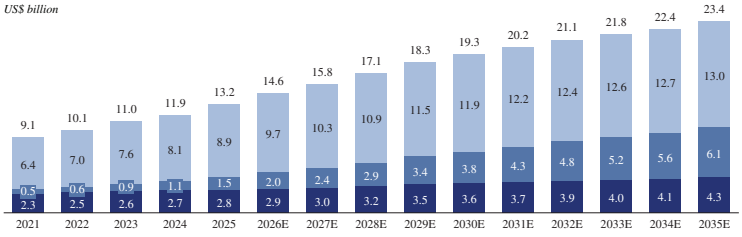
Unmet Medical Needs

The treatment and control rates for dyslipidemia remain suboptimal globally (46.7% and 23.4%, respectively) and are markedly lower in China (10.1% and 4.8%, respectively). Consequently, the development of innovative therapeutics with superior potency, improved safety profiles, and extended dosing intervals (e.g., long-acting injectables or oral formulations)—particularly those targeting novel pathways such as PCSK9 and Lp(a)—has become a strategic priority in the industry.

Market Size of Dyslipidemia Drugs

The market of dyslipidemia drugs is a subset of the CKM drug market. Globally, the market size of dyslipidemia drugs increased at a CAGR of 9.8% from US$27.3 billion in 2021 to US$39.8 billion in 2025, and is projected to increase at a CAGR of 7.6% from 2025 to US$57.4 billion in 2030. In China, the market size of dyslipidemia drugs increased at a CAGR of 9.7% from US$9.1 billion in 2021 to US$13.2 billion in 2025, and is projected to increase at a CAGR of 7.9% from 2025 to US$19.3 billion in 2030, outpacing the forecasted growth rate of the global market over the same period. The following chart sets forth a breakdown of China's dyslipidemia drug market by major drug class for the periods indicated:

China's Dyslipidemia Drug Market, 2021-2035E



Drug Class	CAGR		
	2021-2025	2025-2030E	2031E-2035E
Statins	8.6%	4.7%	0.8%
PCSK9	90.1%	35.9%	19.4%
Others	9.0%	8.6%	0.6%
Total	9.7%	7.9%	3.9%

Source: Publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

Key Growth Drivers

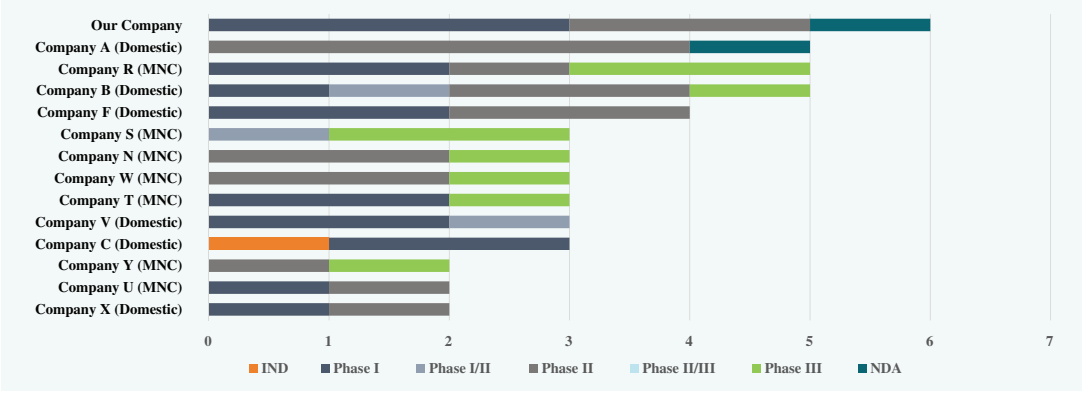
Traditional statin-based therapies face challenges of intolerance and low target achievement rates. The growth of China's dyslipidemia drug market is expected to be primarily driven by the rapid penetration of novel lipid-lowering therapies:

- **PCSK9-targeting therapies**. PCSK9 is a meaningful target for lowering LDL-C while reducing ASCVD risk. PCSK9-targeting therapies can achieve potent lipid-lowering effect by increasing LDL receptors, precisely serving high-risk patients with inadequate response to statins. Those with extended dosing intervals or orally formulated therapies can further improve patient adherence. In China, the market size for PCSK9-targeting therapies increased from US$40.1 million in 2021 to US$522.4 million in 2025 at a CAGR of 90.0%, and is projected to increase to US$2,501.2 million in 2030 and US$6,373.0 million in 2035, representing a CAGR of 36.8% from 2025 to 2030 and 20.6% from 2030 to 2035.

- **Other novel therapies**. Recent studies also suggest that other apolipoprotein B-containing lipoproteins, including triglyceride-rich lipoproteins and their remnants, as well as lipoprotein(a) ("**Lp(a)**") are involved in the pathophysiological processes of ASCVD. Novel therapies focused on these meaningful targets are expected to further drive the market growth.

Major Players in Dyslipidemia Drug Market

The following table sets forth major players in the development of dyslipidemia drugs, ranked by the total number of NME dyslipidemia drug candidates in IND or later stages of development, as of the Latest Practicable Date. We ranked first globally, with a total of six such NME drug candidates:

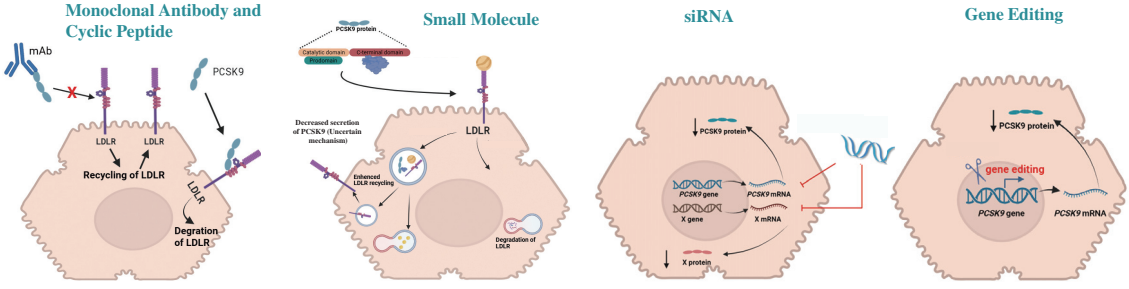


Note: Company R, founded in 1876 and headquartered in Indiana, United States, is a publicly listed global pharmaceutical company engaged in the research, development, and commercialization of innovative medicines for diabetes, oncology, immunology, and neurodegenerative diseases; Company S, founded in 1989 and headquartered in California, United States, is a publicly listed biotech company engaged in the development of RNA interference therapeutics for the treatment of liver diseases, cardiovascular diseases, and rare genetic disorders; Company T, founded in 1999 and headquartered in Cambridge, United Kingdom, is a publicly listed global biopharmaceutical company focused on the research, development, and commercialization of medicines for oncology, cardiovascular, renal, metabolic, respiratory, and immunology diseases; Company U, founded in 1891 and headquartered in New Jersey, United States, is a global biopharmaceutical company focused on the discovery and development of innovative medicines, vaccines, biologic therapies, and animal health products; Company V, founded in 2021 and headquartered in Shanghai, is a private biotech company focused on innovative RNA-based medicines for the treatment of metabolic diseases, cardiovascular diseases, and other serious conditions; Company W, founded in 1923 and headquartered in Bagsværd, Denmark, is a publicly listed global healthcare company with expertise in diabetes care, obesity, and rare blood disorders; Company X, founded in 1990 and headquartered in Zhejiang Province, is a publicly listed pharmaceutical company focused on the research, development, and commercialization of neurological and cardiovascular drugs; and Company Y, founded in 1989 and headquartered in California, United States, is a pharmaceutical company focused on RNA-targeted medicines for the treatment of neurological and cardiometabolic disorders.

Source: PharmCube, publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

Competitive Landscape of PCSK9-Targeting Therapies

Our PCSK9-targeting drug candidates encompass mAb, small-molecule inhibitor, gene-editing therapy, cyclic peptide, and dual-target siRNA. The following diagram illustrates their differing mechanisms of action:



Source: Literature review, Frost & Sullivan analysis

As of the Latest Practicable Date, there were seven PCSK9 drugs marketed in China for the treatment of dyslipidemia, and there were nine PCSK9 drug candidates in IND or later stages of development. The following table provides an overview of the PCSK9 drug candidates in IND or later stages of development for the treatment of dyslipidemia in China:

Drug Code	Company	Modality	Stage	First Posted Date
SAL003	**our Company**	**mAb**	**NDA**	**Sep 19, 2025**
SYH2053	CSPC	siRNA	Phase III	Feb 19, 2026
QLC7401	Qilu Pharmaceutical	siRNA	Phase III	June 3, 2026
HRS-1301	Hengrui Pharma	Small-molecule inhibitor	Phase II	Oct 11, 2025
DNV001	Dingxin Gene Technology	siRNA	Phase II	Dec 16, 2025
SAL0139	**our Company**	**Small-molecule inhibitor**	**Phase II**	**Aug 7, 2026**
RN0191	Darui	siRNA	Phase I	Nov 15, 2023
SAL061	**our Company**	**Gene-editing therapy**	**Phase I**	**Oct 28, 2025**
SAL0167	**our Company**	**Cyclic peptide**	**Phase I**	**Jul 2, 2026**

Source: CDE, Frost & Sullivan analysis

HEART FAILURE DRUG MARKET

Heart Failure and Treatment Paradigms

Heart failure is a complex clinical syndrome defined by structural or functional cardiac abnormalities that impair the ability of the ventricle to fill with or eject blood, resulting in reduced cardiac output or elevated intracardiac pressures at rest or during exertion. Under the CKM management framework, heart failure is recognized as the core clinical manifestation in Stage 4 of CKM syndrome. Heart failure presents a critical clinical challenge characterized by extremely high rates of hospitalization and mortality.

Globally, the population with chronic heart failure increased from 58.9 million in 2021 to 64.2 million in 2025, and is projected to further increase to 69.3 million in 2030 and 73.0 million by 2035. In China, the population with chronic heart failure expanded from 14.5 million in 2021 to 15.4 million in 2025, and is projected to increase to 16.8 million in 2030 and 18.2 million in 2035.

The current treatment of chronic heart failure emphasizes ejection fraction-based stratification. Based on left ventricular ejection fraction ("**LVEF**"), heart failure is categorized into heart failure with reduced ejection fraction ("**HFrEF**") and heart failure with preserved ejection fraction ("**HFpEF**"). Globally, HFrEF and HFpEF constituted the predominant patient groups, accounting for approximately 35-40% and 38-47% of total heart failure cases in 2024, respectively. The following table sets forth the key symptoms and implications of HFrEF and HFpEF:

	Key Symptom	Implication
HFrEF	Weakened left ventricle unable to adequately contract	Heart expels less oxygen-rich blood into the body
HFpEF	Heart contracts normally, but exhibits abnormal cardiac relaxation, stiffness, or filling	Inadequate cardiac output despite normal ventricle activity

Source: Literature review, Frost & Sullivan analysis

- For patients with HFrEF, the clinical objective is to initiate the "quadruple therapy" and titrate to the maximum tolerated dose. "Quadruple therapy" refers to a four-drug combination of (i) ARNi, ACEi or ARBs, (ii) beta-blockers, (iii) MRAs, and (iv) sodium-glucose cotransporter-2 ("**SGLT2**") inhibitors. In practice, however, patients frequently fail to achieve target dosages of the "quadruple therapy" due to factors such as hypotension (or low blood pressure) and renal dysfunction.

- For patients with HFpEF, only two approved treatment options are currently available. Treatment prioritizes the use of SGLT2 inhibitors combined with diuretics to alleviate congestion and symptoms.

Unmet Medical Needs

Generally, existing treatment paradigms for heart failure are focused more on alleviating symptoms and reducing re-hospitalization rates. In addition, due to the causal interplay between cardiac and renal function, the use of many heart failure drugs is often restricted in patients with CKD and requires precise dosage adjustments. Furthermore, approximately 50% of chronic heart failure patients are affected by combined pre- and post-capillary pulmonary hypertension ("**cpcPH**"). The five-year mortality rate for patients with chronic heart failure worldwide and patients with HFpEF in China continues to exceed 50%, a rate surpassing that of many malignancies. Importantly, in contrast to HFrEF, few therapies have historically been shown to significantly reduce the mortality of HFpEF. These indicate a significant unmet medical need for therapeutics that are capable of reversing ventricular remodeling and reducing cardiovascular mortality. Future advancements also require precision medicine approaches based on genomics, metabolomics, and distinct heart failure phenotypes (e.g., mechanical versus inflammatory) to optimize therapeutic efficacy.

Market Size of Heart Failure Drugs

The market of heart failure drugs is a subset of the CKM drug market. Globally, the market size of heart failure drugs increased at a CAGR of 25.6% from US$11.9 billion in 2021 to US$29.7 billion in 2025, and is projected to increase at a CAGR of 13.5% from 2025 to US$55.9 billion in 2030. In China, the market size of heart failure drugs increased at a CAGR of 28.0% from US$1.5 billion in 2021 to US$3.9 billion in 2025, and is projected to increase at a CAGR of 14.5% from 2025 to US$7.8 billion in 2030, outpacing the respective growth rates of the global market over the same periods.

Key Growth Drivers

The growth of the heart failure drug market is driven by the introduction of more therapeutic options, particularly novel therapies with differing mechanisms of action:

- **ARNi**. ARNi has been widely regarded as the cornerstone of the "quadruple therapy" for heart failure. In July 2017, Entresto (by Novartis) was approved by the NMPA for the treatment of heart failure. As of the Latest Practicable Date, Entresto was the only marketed ARNi co-crystal in China for the treatment of heart failure. XinChaoTuo, our innovative drug approved for the treatment of hypertension, is undergoing a Phase III clinical trial in China for the treatment of heart failure. We consider it a pipeline innovative drug with significant market potential. If approved, XinChaoTuo, as the only domestically-developed ARNi, is expected to fuel the growth of China's heart failure drug market.

- **NRG-1-targeting therapy**. NRG-1 is a clinically validated growth factor with demonstrated activity in heart failure. NRG-1 regenerative therapies aim to achieve myocardial repair, targeting patients with refractory HFrEF and HFpEF, opening a new frontier in disease modification. NRG-1 acts through two different pathways—ErbB2/ErbB4 and ErbB2/ErbB3. Globally, there was no approved NRG1-ErbB3-targeting therapy as of the Latest Practicable Date. JK07 (SAL007) is currently undergoing a global multi-regional Phase II clinical trial in patients with HFrEF and HFpEF, and it was the only NRG1-ErbB3 antibody fusion protein under clinical development.

DRUG ELUTING MEDICAL DEVICE MARKET

Combining drugs and medical devices has been found to optimize clinical pathways and improve patient engagement. Drug eluting medical devices, for example, through a combination of physical and pharmacological solutions, offer more targeted diagnostic and therapeutic solutions for the treatment of CKM syndrome, to prevent the onset of severe complications and recurrence of symptoms.

Vertebral artery stenosis ("**VAS**"), as a typical manifestation of CKM-associated atherosclerosis in the posterior circulation, is closely correlated with ischemic cerebrovascular events. It has been a clinical challenge in the field of neurointervention. Clinical data indicate that there are over 3 million new cases

of ischemic stroke in China annually, with approximately 25% to 40% occurring in the posterior circulation; among these posterior circulation stroke patients, approximately 20% present with concurrent VAS. In China, the population with ischemic stroke caused by stenosis of the intracranial arteries or the extracranial segment of the vertebral artery increased from 1.2 million in 2021 to 1.4 million in 2025. In the absence of timely intervention, the cumulative risk of recurrent posterior circulation ischemic stroke over five years can reach as high as 30%. Despite this substantial clinical burden, the penetration rate of interventional therapy for extracranial VAS in China remains low, at approximately 1.3% among the eligible patient population, primarily due to the lack of approved, dedicated stent products.

Drug eluting stents ("**DES**") have been developed to address the clinical challenge of high restenosis rates in extracranial VAS, which represents a very recent innovation in this field. DES typically utilize advanced coating technologies (such as fluoride coatings) to ensure superior biocompatibility while achieving high drug loading and sustained release of anti-proliferative agents. This mechanism is designed to effectively reduce the incidence of post-procedural restenosis and adverse events, providing a safer and more effective therapeutic option for patients suffering from ischemic stroke and transient ischemic attacks.

Maurora Sirolimus Eluting Vertebral Artery Stent System ("**Maurora**"), our Class III medical device, was approved by the NMPA in July 2020 for the treatment of extracranial VAS. Maurora is also the world's first approved DES. As of the Latest Practicable Date, there was only one other approved DES for vertebral artery stenosis in China. In 2025, Maurora dominated the market with a market share of 69.9% in terms of sales revenue. Based on the foregoing, Maurora outperforms competing products targeting the same indications in China.

CKD DRUG MARKET

CKD and Treatment Paradigms

CKD is defined as abnormalities of kidney structure or function, present for a minimum of three months, with health implications. Within the CKM management framework, CKD management is shifting from episodic, siloed care to a holistic, coordinated decision-making model. The core objective of this approach is to delay the deterioration of renal function while simultaneously mitigating the risk of cardiovascular complications.

Clinically, CKD is characterized by a decline in estimated glomerular filtration rate ("**eGFR**"), pathological proteinuria, and hematuria. The primary etiologies include diabetic nephropathy, hypertensive nephropathy, primary glomerulonephritis (such as IgA nephropathy), and chronic interstitial nephritis. As the disease progresses, approximately 10% of patients eventually develop end-stage renal disease ("**ESRD**"), necessitating dialysis or transplantation. CKD is typically classified based on cause, GFR category (G1-G5), and albuminuria category (A1-A3), also known as the CGA staging system. The following table sets forth the prognosis of CKD by GFR and albuminuria categories:

Prognosis of CKD by GFR and albuminuria categories: KDIGO 2012				**Persistent albuminuria categories Description and range**		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol
GFR categories (ml/min/1.73m²) Description and range	G1	Normal or high	≥90			
	G2	Mildly decreased	60-89			
	G3a	Mildly to moderately decreased	45-59			
	G3b	Moderately to severely decreased	30-44			
	G4	Severely decreased	15-29			
	G5	Kidney failure	<15			

Notes:

1. Green: low risk (denotes no CKD if no other markers of kidney disease); Yellow: moderately increased risk; Orange: high risk; Red: very high risk.
2. GFR=glomerular filtration rate

Source: KDIGO 2023 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease; Frost & Sullivan analysis

Globally, the population with CKD increased from 779.0 million in 2021 to 895.0 million in 2025, and is projected to further increase to 1,029.0 million in 2030 and 1,147.6 million by 2035. In China, the population with CKD increased from 144.9 million in 2021 to 172.7 million in 2025, and is projected to increase to 207.9 million in 2030 and 241.0 million in 2035. In China, the primary causes of CKD are diabetes and hypertension, which together account for 48.6% of the total CKD patient population.

Current CKD treatment guidelines emphasize individualized pharmacotherapy based on disease staging, comorbidities, and risk stratification, with the objectives of delaying the decline in renal function and reducing cardiovascular events. The pillars of the current standard of care include RAAS inhibitors, SGLT2 inhibitors, glucagon-like peptide-1 receptor agonists ("**GLP-1RAs**"), and MRAs.

Unmet Medical Needs

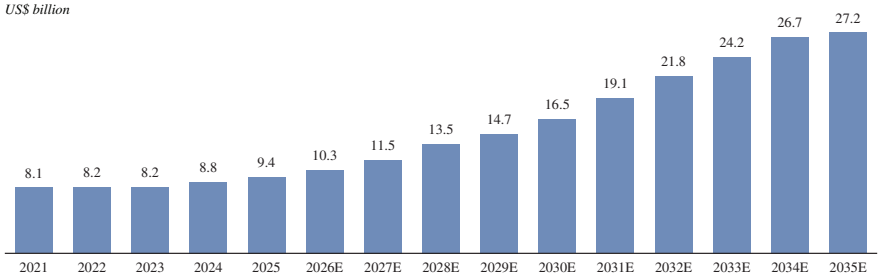
Existing CKD therapies face significant limitations in clinical practice. In patients with moderate-to-severe CKD, the use of RAAS inhibitors is prone to inducing hyperkalemia; SGLT2 inhibitors are contraindicated in patients with an eGFR below 30 mL/min/1.73 m^2, and their diuretic effects in elderly patients pose risks of hypotension and ketoacidosis. GLP-1RAs are characterized by high costs, supply shortages, and gastrointestinal adverse reactions. These may lead to poor patient compliance and necessitate dose reduction or discontinuation when eGFR falls below 30 mL/min/1.73 m^2. Similarly, the administration of MRAs in patients with moderate-to-severe CKD is associated with a significantly elevated risk of hyperkalemia. Consequently, there remains a lack of novel therapeutic options for patients with late-stage CKM syndrome that are renal-safe and offer comprehensive benefits.

Market Size of CKD Drugs

The market of CKD drugs is a subset of the CKM drug market. Globally, the market size of CKD drugs increased at a CAGR of 5.0% from US$51.2 billion in 2021 to US$62.2 billion in 2025, and is projected to increase at a CAGR of 7.3% from 2025 to US$88.4 billion in 2030. In China, the market size of CKD drugs increased at a CAGR of 3.8% from US$8.1 billion in 2021 to US$9.4 billion in 2025, and is projected to increase at a CAGR of 11.8% from 2025 to US$16.5 billion in 2030, outpacing the forecasted growth rate of the global market over the same period. The following chart sets forth the market size of China's CKD drug market for the periods indicated:

China's CKD Drug Market, 2021-2035E

Period	CAGR	
	China	Global
2021-2025	3.8%	5.0%
2025-2030E	11.8%	7.3%
2030E-2035E	10.6%	7.2%



Source: Publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

Key Growth Drivers

The key driver for the growth in China's CKD drug market is the development and commercialization of innovative CKD therapies. The CKD treatment is evolving from universal RAAS blockade toward a new era focused on renal safety, anti-fibrosis, and multi-target synergy in patients with moderate-to-severe renal impairment. ETAR antagonists and ASIs are found to hold potential for addressing the limitations of the current standard of care:

- ETAR antagonists improve renal blood flow, reduce intraglomerular pressure, and directly target fibrosis, precisely addressing progressive kidney injury driven by ET-1 overexpression in both diabetic and non-diabetic nephropathy. The market size of ETAR antagonists for the treatment of CKD is projected to reach US$54 million in 2028 and US$21,451.3 million in 2035 at a CAGR of 135.1% from 2028 to 2035.

- ASIs block aldosterone escape at the source, avoid off-target side effects of MRAs, and provide stronger anti-fibrotic and organ-protective effects, targeting high-risk patients who continue to experience persistent proteinuria or progressive renal decline despite RAAS inhibitor and SGLT2 inhibitor therapy. The market size of ASIs for the treatment of CKD is projected to reach US$51 million in 2028 and US$15,648.0 million in 2035 at a CAGR of 126.6% from 2028 to 2035.

Competitive Landscape of ETAR Antagonists and ASIs for Treatment of CKD

ETAR Antagonists

Globally, there were no ETAR antagonists approved for the treatment of CKD as of the Latest Practicable Date. SAL0120, our ETAR antagonist, was undergoing a Phase II clinical trial in China for the treatment of CKD as of the Latest Practicable Date. The following table provides an overview of ETAR antagonists in Phase II clinical trial or beyond in China for the treatment of CKD as of the Latest Practicable Date:

Drug Name/Code	Company	Stage	First Posted Date
Zibotentan	AstraZeneca	Phase III	May 27, 2024
SC0062	BioCity Biopharma	Phase II	Mar 9, 2023
SAL0120	**our Company**	**Phase II**	**Oct 21, 2024**

Source: CDE, Frost & Sullivan analysis

ASIs

Globally, there were no ASIs approved for the treatment of CKD as of the Latest Practicable Date. SAL0140, our ASI, was undergoing a Phase II clinical trial in China for the treatment of CKD as of the Latest Practicable Date. The following table provides an overview of ASIs under clinical development in China for the treatment of CKD as of the Latest Practicable Date:

Drug Name/Code	Company	Stage	First Posted Date
Baxdrostat	AstraZeneca	Phase III	May 6, 2024
BI 690517	Boehringer Ingelheim	Phase III	Mar 13, 2025
SAL0140	**our Company**	**Phase II**	**May 28, 2026**

Source: CDE, Frost & Sullivan analysis

Renal Anemia and Treatment Paradigms

Renal anemia represents an inextricable complication of CKD, with a prevalence that increases precipitously alongside the decline in renal function. Clinically, renal anemia is defined as a pathological state where hemoglobin ("**Hb**") levels fall below 130 g/L for men and 120 g/L for non-pregnant women, due to a confluence of factors stemming from chronic renal failure, including an absolute or relative deficiency of erythropoietin ("**EPO**"), accumulation of uremic toxins, systemic inflammation, and dysregulated iron metabolism.

Globally, the population with renal anemia increased from 26.8 million in 2021 to 31.7 million in 2025, and is expected to further increase to 38.5 million in 2030 and 43.9 million in 2035. In China, the population with renal anemia increased from 5.3 million in 2021 to 6.2 million in 2025, and is expected to increase to 7.5 million in 2030 and 9.3 million in 2035. Non-dialysis cases accounted for 80% of the total patients with renal anemia in China. Without effective management, severe renal anemia not only significantly diminishes patient quality of life but also exacerbates cardiovascular risks and mortality.

The therapeutic objective in managing renal anemia is to correct Hb levels, alleviate symptoms, and minimize the risk of cardiovascular events and mortality. The current clinical treatment paradigm is tailored based on the patient's Hb levels, iron status, and CKD staging. Core interventions include iron supplementation, erythropoiesis-stimulating agents ("**ESAs**"), and hypoxia-inducible factor prolyl hydroxylase inhibitors ("**HIF-PHIs**"). As of the Latest Practicable Date, there were ten innovative drugs and 33 generic drugs approved for the treatment of renal anemia in China. These therapies aim to supplement exogenous EPO to stimulate bone marrow hematopoiesis.

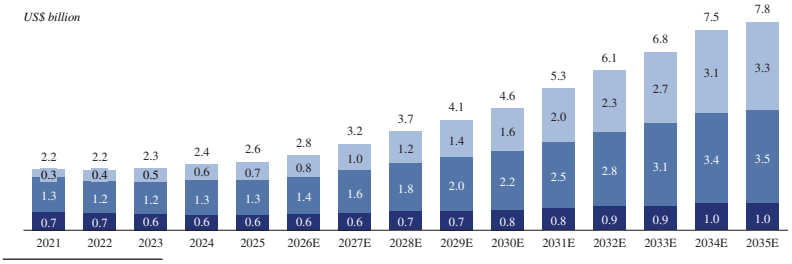
Unmet Medical Needs

Traditional ESA therapies require frequent injections and are prone to hyporesponsiveness or efficacy failure in patients with inflammatory states. Moreover, the administration of high-dose ESAs and intravenous iron has been associated with increased risks of hypertension, thromboembolism, and adverse cardiovascular events. This indicates medical needs for therapies overcoming EPO resistance in inflammatory states, as well as oral innovative therapies with superior cardiovascular safety profiles that enhance patient adherence.

Market Size of Renal Anemia Drugs

The market of renal anemia drugs is a subset of the CKM drug market. Globally, the market size of renal anemia drugs increased at a CAGR of 5.1% from US$14.1 billion in 2021 to US$17.2 billion in 2025, and is projected to increase at a CAGR of 7.5% from 2025 to US$24.6 billion in 2030. In China, the market size of renal anemia drugs increased at a CAGR of 4.0% from US$2.2 billion in 2021 to US$2.6 billion in 2025, and is projected to increase at a CAGR of 12.0% from 2025 to US$4.6 billion in 2030, outpacing the forecasted growth rate of the global market over the same period.

China's Renal Anemia Drug Market, 2021-2035E



Drug Class	CAGR		
	2021-2025	2025-2030E	2030E-2035E
HIF-PHI	26.2%	17.6%	15.1%
ESAs	1.0%	10.8%	10.2%
Others	-4.4%	6.0%	5.1%
Total	4.0%	12.0%	11.3%

Source: Publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

Key Growth Drivers

The key growth drivers of China's renal anemia drug market primarily include the rising population of CKD patients, including those necessitating dialysis, and the expanding inclusion of renal anemia drugs in medical insurance programs. In China, the population with CKD increased from 144.9 million in 2021 to 172.7 million in 2025, and is projected to increase to 207.9 million in 2030 and 241.0 million in 2035. The market is expected to be further fueled by improvements in diagnosis and treatment rates of renal anemia.

Competitive Landscape of HIF-PHIs for Renal Anemia Treatment

Marketed

As of the Latest Practicable Date, there were three HIF-PHIs marketed in China. EnNaLuo has been approved by the NMPA for the treatment of renal anemia in adult patients, both on dialysis and not on dialysis. In 2025, EnNaLuo held an 8.4% market share in terms of in-hospital sales revenue in China. The following table provides an overview of these drugs:

Brand Name	Generic Name	Manufacturer	First NMPA Approval	Retail Price	NRDL Inclusion
Airuizhuo (爱瑞卓)	Roxadustat	AstraZeneca	Dec 17, 2018	RMB60-69	Yes
EnNaLuo (恩那罗)	**Enarodustat**	**our Company**	**Jun 7, 2023**	**RMB182**	**Yes**
Yifuxin (亿福欣)	Desidustat	CMS	Mar 10, 2026	N.A.	No

Source: NMPA, Frost & Sullivan analysis

EnNaLuo outperforms competing products due to its favorable safety profile compared to first-generation HIF-PHIs and potent hepcidin lowering effects. For details, see "Business—Our Drugs and Drug Candidates—CKD and Renal Anemia—EnNaLuo (Enarodustat Tablets) (恩那罗(恩那度司他片))."

Pipeline

As of the Latest Practicable Date, there were four HIF-PHI drug candidates under clinical development for the treatment of renal anemia in China. The following table provides an overview of these drug candidates:

Drug Code	Company	Stage	First Posted Date
AND017	Andao	Phase III	Sep 15, 2025
HIF-117	3SBio	Phase II	Oct 14, 2022
HEC53856	HEC Pharma	Phase I	May 15, 2019
ISM4808	Insilico Medicine	Phase I	Feb 2, 2026

Source: CDE, Frost & Sullivan analysis

METABOLIC DISEASES DRUG MARKET

Metabolic Diseases and Treatment Paradigms

Metabolism refers to the entire chain of chemical reactions occurring within living organisms, including energy conversion and the synthesis and breakdown of various substances. In China, the population with metabolic disease increased from 296.2 million in 2021 to 306.6 million in 2025, and is projected to increase to 314.6 million in 2030 and 322.8 million in 2035. Obesity, type 2 diabetes, and metabolic dysfunction-associated steatohepatitis ("**MASH**") are central metabolic disorders within the CKM management framework.

Overweight and obesity. Current first-line treatments focus on diet and exercise control, but these have a long-term success rate below 30% due to reliance on sustained discipline. Pharmacotherapy has therefore become a necessary option to address the gap. However, dominant injection-based treatments can lead to suboptimal adherence and are often associated with side effects such as gastrointestinal disturbances. These limitations hinder safe, effective, and sustainable long-term weight management for many patients.

Type 2 diabetes. Type 2 diabetes accounts for approximately 90% of global diabetes cases and over 95% of Chinese diabetes cases. Treatment of diabetes requires an integrated approach that combines lifestyle modifications, pharmacological interventions, and complication management. Metformin is a

first-line oral medication, and traditional therapies also include DPP-4 inhibitors such as our fotagliptin. However, traditional treatments can cause hypoglycemia, weight gain, and complex pill regimens, harming adherence and offering inconsistent organ protection. Novel options such as GLP-1RAs are gaining more popularity due to their benefits in glycemic control and weight management, as well as reduced risk of complications.

MASH. MASH is a progressive, advanced form of hepatic steatosis, accompanied by hepatocyte injury and lobular inflammation, which collectively promote the progression of liver fibrosis. MASH is the primary cause of chronic liver disease worldwide, and has become the most prevalent chronic liver disease in China. In addition, studies indicate that 20% to 30% of patients with MASH ultimately die from cirrhosis or liver cancer, posing an urgent public health threat. Current treatment of MASH is multidisciplinary and centers on lifestyle interventions, such as dietary restructuring and regular exercise, with a target weight loss of at least 10% to improve steatosis and inflammation. Pharmacotherapy is recommended for patients with comorbid type 2 diabetes or significant fibrosis.

Unmet Medical Needs

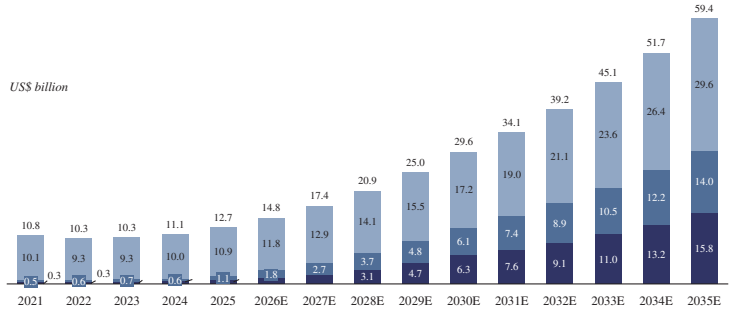
Today, metabolic care is shifting toward more precise, integrated, and patient-centric treatment models. Against this backdrop, there remain medical needs for safer, long-acting therapies with more convenient drug administration.

In the field of GLP-1RA therapies, as of the Latest Practicable Date, semaglutide (oral) and orforglipron were the only two marketed oral GLP-1RA therapies worldwide. As of the Latest Practicable Date, our SAL0150 was undergoing a Phase I clinical trial, and there were only two other oral GLP-1RA drug candidates under clinical development globally for the treatment of obesity with a weekly dosing regimen. In the field of MASH therapies, it was not until 2024 that the U.S. FDA approved the first dedicated MASH therapy. As of the Latest Practicable Date, there were only two innovative drugs approved for the treatment of MASH worldwide, and neither was yet approved in China. We are developing SAL0145, an HSD17B13-targeting siRNA therapy, for the treatment of MASH.

Market Size of Metabolic Disease Drugs

The market of metabolic disease drugs is a subset of the CKM drug market. Globally, the market size of metabolic disease drugs increased at a CAGR of 14.3% from US$80.7 billion in 2021 to US$137.7 billion in 2025, and is projected to increase at a CAGR of 12.6% from 2025 to US$249.5 billion in 2030. In China, the market size of metabolic disease drugs increased at a CAGR of 4.1% from US$10.8 billion in 2021 to US$12.7 billion in 2025, and is projected to increase at a CAGR of 18.4% from 2025 to US$29.6 billion in 2030, outpacing the forecasted growth rate of the global market over the same period.

China's Metabolic Disease Drug Market, 2021-2035E



Disease	CAGR		
	2021-2025	2025-2030E	2030E-2035E
T2D	1.9%	9.6%	11.5%
Obesity	23.9%	40.6%	18.2%
MASH	30.7%	53.8%	20.0%
Total	4.1%	18.4%	15.0%

Source: Publicly available annual reports, literature review, expert interviews, and Frost & Sullivan analysis

The growth in China's metabolic disease drug market has been primarily driven by (i) the rising prevalence of metabolic diseases resulting from aging and lifestyle changes, (ii) the continued emergence of novel therapies, and is expected to be further fueled by the anticipated growth of novel therapies.

POSTMENOPAUSAL OSTEOPOROSIS

Overview of Postmenopausal Osteoporosis

Due to differences in hormone secretion, the treatment of postmenopausal osteoporosis differs from that of other forms of osteoporosis. In postmenopausal women, the rapid decline in estrogen levels accelerates bone loss and impairs bone microstructure, increasing bone fragility and reducing bone strength. This significantly elevates the risk of osteoporosis and fractures. Consequently, early diagnosis and proactive intervention are critical in the management of osteoporosis in this population.

The global population with postmenopausal osteoporosis increased from 238.3 million in 2021 to 282.1 million in 2025, and is projected to reach 311.7 million by 2030 and 337.7 million by 2035. In China, the population with postmenopausal osteoporosis expanded from 52.6 million in 2021 to 62.1 million in 2025, and is projected to reach 69.1 million by 2030 and 75.4 million by 2035.

Market Size and Growth

Globally, the market size of drugs for postmenopausal osteoporosis increased from US$2.2 billion in 2021 to US$2.9 billion in 2025 at a CAGR of 6.5%, and is projected to increase to US$4.1 billion in 2030 and US$5.8 billion in 2035, representing a CAGR of 7.8% from 2025 to 2030 and 6.8% from 2030 to 2035.

In China, the market size of drugs for postmenopausal osteoporosis increased from US$0.8 billion in 2021 to US$0.8 billion in 2025 at a CAGR of 0.8%, and is projected to increase to US$1.3 billion in 2030 and US$2.0 billion in 2035, representing a CAGR of 9.2% from 2025 to 2030 and 8.4% from 2030 to 2035.

Competitive Landscape of Teriparatide

Teriparatide significantly reduces the risk of vertebral (spinal) fractures and promotes bone formation, demonstrating a superior efficacy compared to other osteoporosis treatments. It is also the preferred choice for patients at extremely high fracture risks. In 2024, the market size for teriparatide in China reached US$206.7 million, which is expected to experience continued growth in the future. The following table sets forth marketed teriparatide injections in China as of the Latest Practicable Date:

Brand Name	Company	Dosage Form	First NMPA Approval
Forsteo	Eli Lilly	Liquid	Mar 4, 2011
ZhenGu	United Cell Biotech	Powder	Mar 22, 2017
XinFuTai	**our Company**	**Powder**	**Sep 29, 2019**
XinFuTai Pro	**our Company**	**Liquid**	**Apr 19, 2022**
BoGuTai	Uni-Bioscience	Liquid	Jan 16, 2024
ZhenGu	United Cell Biotech	Liquid	Feb 6, 2024
XinFuTai Plus	**our Company**	**Powder**	**May 12, 2026**

Source: NMPA, Frost & Sullivan analysis

ANALYSIS OF OUR MAJOR GENERIC DRUG

Market Overview of Generic Drugs

China's pharmaceutical market has witnessed a shift from dominance by imported originator drugs to accelerated substitution by domestic generics. A key driver of this transition is the Generic Drug Quality and Efficacy Consistency Evaluation administered by the NMPA, which serves as a mandatory market-entry requirement for domestic generic drugs. Only after passing this evaluation can a manufacturer obtain a drug registration certificate and participate in the centralized procurement process.

Originator drugs with established brand names may maintain their market share through long-term clinical data validation and physician trust. Competition in the market of generics, in contrast, is focused more on factors such as the inclusion in centralized procurements, prescribing inertia, differences in dosage forms, as well as the manufacturer's reputation, brand recognition, and supply chain stability.

China's implementation of VBP has further enhanced the pricing adjustment and competition. The market has witnessed downward pricing pressure since the launch of the national pilot "4+7" VBP scheme. From 2018 to 2023, the average price decline of generic drugs in China ranged from 48% to 59%. Looking ahead, while policy normalization is expected to continue, the pricing mechanism is expected to shift from a "lowest bid wins" approach to a "volume-price balance" that values price stabilization and quality improvement.

Clopidogrel Generics

Treatment of Clopidogrel

In terms of sales revenue, TaiJia (clopidogrel bisulfate tablets) is our major marketed generic drug. It is the first-to-market generic of clopidogrel in China.

Clopidogrel is a first-line antiplatelet agent for the management of acute coronary syndrome. It is a platelet aggregation inhibitor that acts by irreversibly binding to the platelet ADP receptor, selectively blocking the interaction between ADP and its receptor, and inhibiting the activation of the downstream GPIIb/IIIa complex, thereby suppressing platelet aggregation. In addition, it inhibits non-ADP-induced aggregation but does not affect phosphodiesterase activity. The most common adverse reaction to clopidogrel is bleeding, which typically occurs within the first month of treatment. Other adverse reactions include thrombocytopenia, headache, dizziness, diarrhea, abdominal pain, and rash. In severe cases, thrombotic thrombocytopenic purpura and aplastic anemia may occur, although such events are rare.

TaiJia was approved for the prevention of atherothrombotic events. In China, the population with atherosclerotic thrombosis increased from 13.2 million in 2021 to 13.8 million in 2025, and is projected to increase to 15.0 million in 2030 and 15.4 million in 2035.

Competitive Landscape

As of the Latest Practicable Date, there were 28 clopidogrel generics marketed in China for the prevention of atherothrombotic events. In 2025, TaiJia, with a market share of 12% in terms of sales revenue, ranked second in the clopidogrel market in China. Plavix, the originator drug, captured the largest market share of 57%. The following table provides an overview of the top five players in the clopidogrel drug market:

Rank	Brand Name	Manufacturer	NMPA Approval	NRDL Inclusion	VBP Participation as of LPD
1	Plavix	Sanofi	Jan 22, 2001	Yes	No
2	**TaiJia**	**our Company**	**Feb 26, 2002**	**Yes**	**Yes**
3	Encun	CSPC Ouyi Pharmaceutical	Mar 18, 2011	Yes	Yes
4	Boyiwei/Delun	Gaozhi Pharma	Dec 18, 2019	Yes	No
5	Shuaitai	Lepu Pharmaceuticals	Nov 26, 2008	Yes	Yes

Source: NMPA, NHSA, and Frost & Sullivan analysis

Originator drugs with established brand names may maintain their market share through long-term clinical data validation and physician trust. Competition in the market of generics, in contrast, is focused more on factors such as the inclusion in centralized procurements, prescribing inertia, differences in dosage forms, as well as the manufacturer's reputation, brand recognition and supply chain stability.

Key Growth Drivers

The growth drivers for TaiJia have shifted from broad market expansion to structural growth. We create cost advantages through integrated API-to-formulation capabilities. This allows us to enjoy greater pricing flexibility of TaiJia in the VBP re-bidding processes, and therefore a favorable market position in price-sensitive markets such as primary care and retail channels. Furthermore, over 20 years of clinical application have established strong prescribing inertia and brand trust. This enables us to effectively secure our market share, while withstanding competition from subsequent generics.

Key Entry Barriers

The following are the main entry barriers of China's clopidogrel drug market:

- ***Policy Compliance and Technical Threshold.*** Originator drugs and first-to-market generics can establish a time-based moat. The NMPA requires that generics pass consistency evaluation before participating in VBP, compelling companies to invest substantial capital in bioequivalence studies and regulatory review. In addition, stability of API supply and cost control capabilities demand vertical integration of the industrial chain, making it difficult for new entrants to replicate the API-to-formulation integration advantage in the short term.

- ***Market Channel and Clinical Inertia.*** Late-to-market generics typically face challenges in accessing core hospital channels, as originator drugs and early-to-market generics have gained market advantage through long-term clinical data accumulation, physician usage experience, and prescribing habits. New entrants need to invest heavily in market education to shift clinical prescribing preferences.

Pricing Trend

Following the national pilot "4+7" VBP scheme in 2019, the prices for the 75mg dosage of clopidogrel declined from a range of RMB2.87 to RMB13.55 per tablet in 2019 to RMB2.50 to RMB4.28 per tablet in 2020, representing a reduction of approximately 70% in the upper end of the price range. In 2025, the prices for the 75mg dosage of clopidogrel range from RMB1.13 to RMB1.83 per tablet. Looking ahead, the prices of clopidogrel drugs are expected to remain relatively stable.

SOURCE OF INFORMATION

In connection with the [**REDACTED**], we engaged Frost & Sullivan, an independent market research consultant, to conduct an analysis of, and to prepare a report on, the major markets for which our existing and in-development products are positioned. Frost & Sullivan is an independent global consulting firm that was founded in 1961 in New York. The information from Frost & Sullivan disclosed in this document has been extracted from the Frost & Sullivan Report, a report commissioned by us for a fee of RMB680,000, and is disclosed with the consent of Frost & Sullivan. Except for the Frost & Sullivan Report, we did not commission any other industry report in connection with the [**REDACTED**].

In compiling and preparing the Frost & Sullivan Report, Frost & Sullivan has adopted the following assumptions: (i) the global economy is likely to maintain steady growth in the next decade; (ii) the global social, economic, and political environment is likely to remain stable in the forecast period; (iii) no opposing government measures are introduced and an increasing level of acceptance of Company's products is maintained; and (iv) there is no war or large-scale disaster during the forecast period. Frost & Sullivan has conducted detailed primary research, which involved discussing the status of the industry with leading industry participants and industry experts. Frost & Sullivan has also conducted secondary research, which involved reviewing annual financial reports of listed companies, independent research reports, and data from its own research database.