基石药业
CSTONE
PHARMACEUTICALS

CS2009 First-in-Human ESMO 2025 Data Review

—Novel PD-1/VEGF/CTLA-4 Trispecific Antibody

October 2025

Stock Code: 2616. HK

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To drive business growth by maximizing commercial value of products in the market and advancing innovative Pipeline 2.0

Commercial-stage Programs

Sugemalimab
(PD-L1)

Pralsetinib
(RET)

Avapritinib
(KIT/PDGFRA)

Recurring revenue to fuel pipeline advancement

Key Clinical Programs in Pipeline 2.0

CS5001
(ROR1 ADC)
Top 2 ROR1-ADC globally with best-in-class potential

CS2009
(PD-1/VEGF/CTLA-4 trispecific antibody)
Global first-in-class / best-in-class potential

Strong growth momentum in near term

Innovative Early Programs in Pipeline 2.0

CS5007
(EGFR/HER3 bispecific ADC)

CS2011
(EGFR/HER3 bispecific mAb)

CS5008
(SSTR2/DLL3 bispecific ADC)

CS5005
(SSTR2 ADC)

CS5005-R
(SSTR2 RDC)

CS5006
(ITGB4 ADC)

CS5009
(B7H3/PD-L1 bispecific ADC)

CS2013
(BAFF/APRIL bispecific antibody)

CS2015
(OX40L/TSLP bispecific antibody)

& other exploratory programs

Robust growth engine for the long run

Pipeline 2.0: an innovative portfolio with global rights

CS2009: leading position globally to target PD-1, VEGFA and CTLA-4

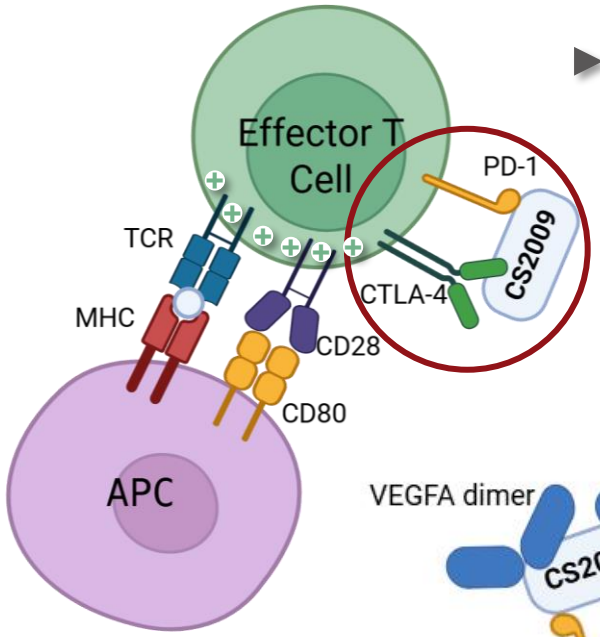
Drug candidate	Right	Indication	Discovery	Preclinical Development	IND-Enabling	FIH	POC
CS5001[1] (ROR1 ADC)		Solid tumors hematologic malignancies					
CS2009 (PD-1/VEGF/CTLA-4 trispecific antibody)		Solid tumors					
CS5007 (EGFR/HER3 bispecific ADC)		Solid tumors					
CS2011 (EGFR/HER3 bispecific antibody)		Solid tumors					
CS5008 (SSTR2/DLL3 bispecific ADC)		Solid tumors					
CS5005 (SSTR2 ADC)		Solid tumors					
CS5005-R (SSTR2 RDC)		Solid tumors					
CS5006 (ITGB4 ADC)		Solid tumors					
CS5009 (B7H3/PD-L1 bispecific ADC)		Solid tumors					
CS2013 (BAFF/APRIL bispecific antibody)		Autoimmune Diseases					
CS2015 (OX40L/TSLP bispecific antibody)		Inflammatory Diseases					

Antibody ADC RDC Global Rights

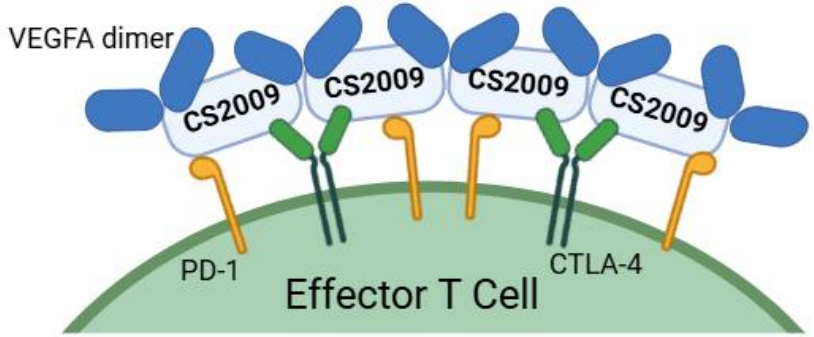
Note: Assets status denotes progress in the region(s) noted in the column titled "Rights"; FIH = First in Human, POC = Proof of Concept,
1. CStone obtains the exclusive global right from LigaChem Biosciences, Inc. (LCB) to lead development and commercialization of LCB71/CS5001 outside the Republic of Korea

Multi-target engagement and synergistic interactions among anti-PD-1, CTLA-4 and VEGFA arms enhance CS2009's activities in TME, while sparing peripheral CTLA4-single-positive T cells, potentially leading to significant improvement of its therapeutic window

Tumor Microenvironment (TME)



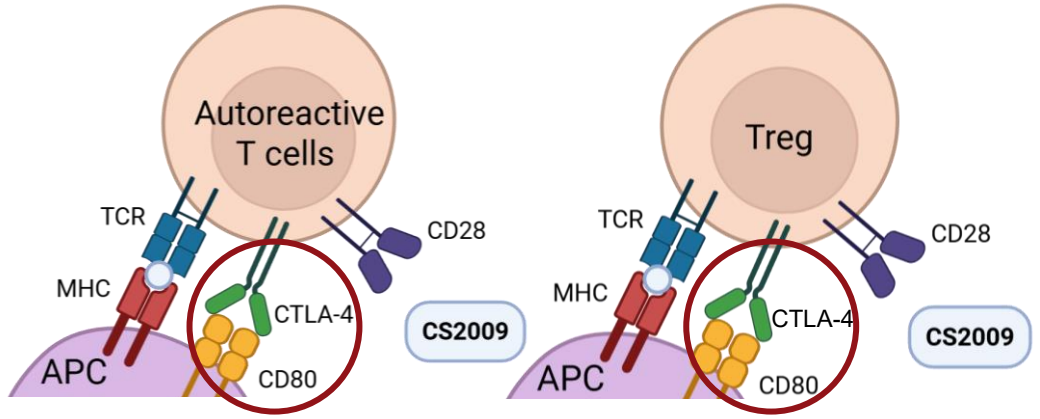
Within the TME, CS2009 **preferentially binds PD-1 and CTLA-4 on double-positive tumor-infiltrating lymphocytes (TILs)** via avidity-driven concurrent engagement of both checkpoints, enhancing its binding affinity and checkpoint inhibitory (CPI) activity to reinvigorate TILs

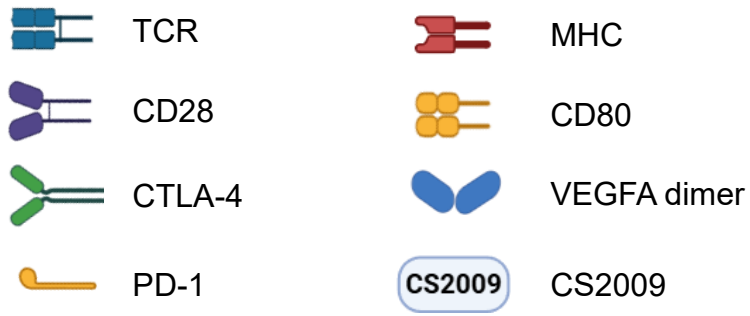


Within the TME, CS2009 forms clusters after crosslinking with VEGFA dimers, which **strengthens its binding affinity to PD-1/CTLA-4-expressing T cells** and further amplifies its CPI activity

Peripheral

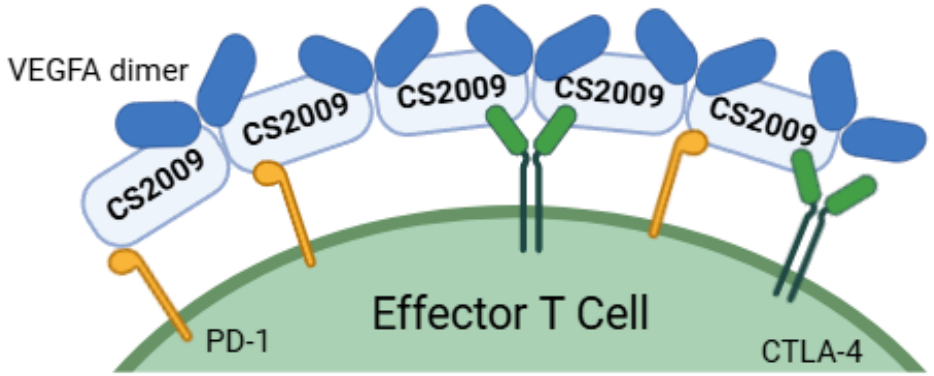
In the peripheral, CS2009's CTLA-4 arm is **unable to block CTLA-4/CD80 interactions** due to low affinity, thereby sparing CTLA-4 single-positive T cells from over-activation, thus reducing systemic autoimmune toxicity



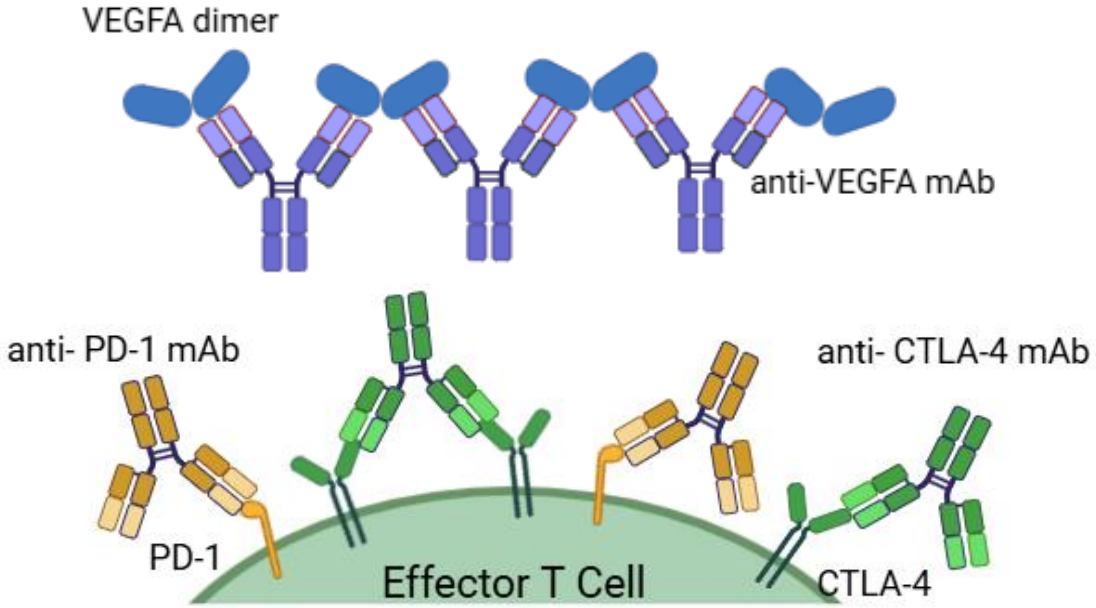


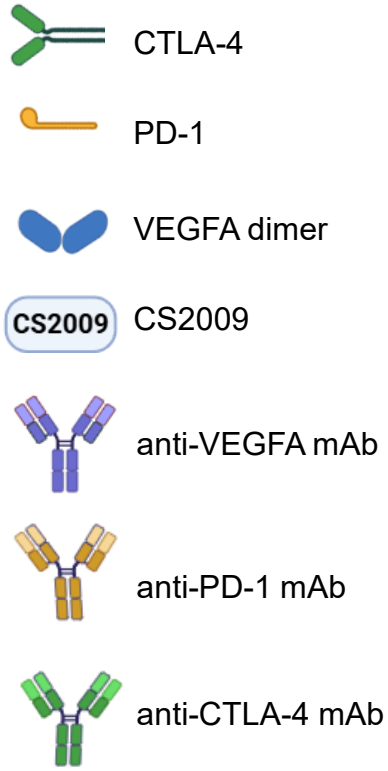
CS2009 clustering with VEGFA dimers leads to significant increase of its binding affinities to PD-1 and CTLA-4 on T cells in the TME

The crosslinking between VEGFA dimers and CS2009 leads to over 20-fold increase of the blocking activities against PD-1 and PD-1/CTLA4 in cell-based assay, due to synergistic binding



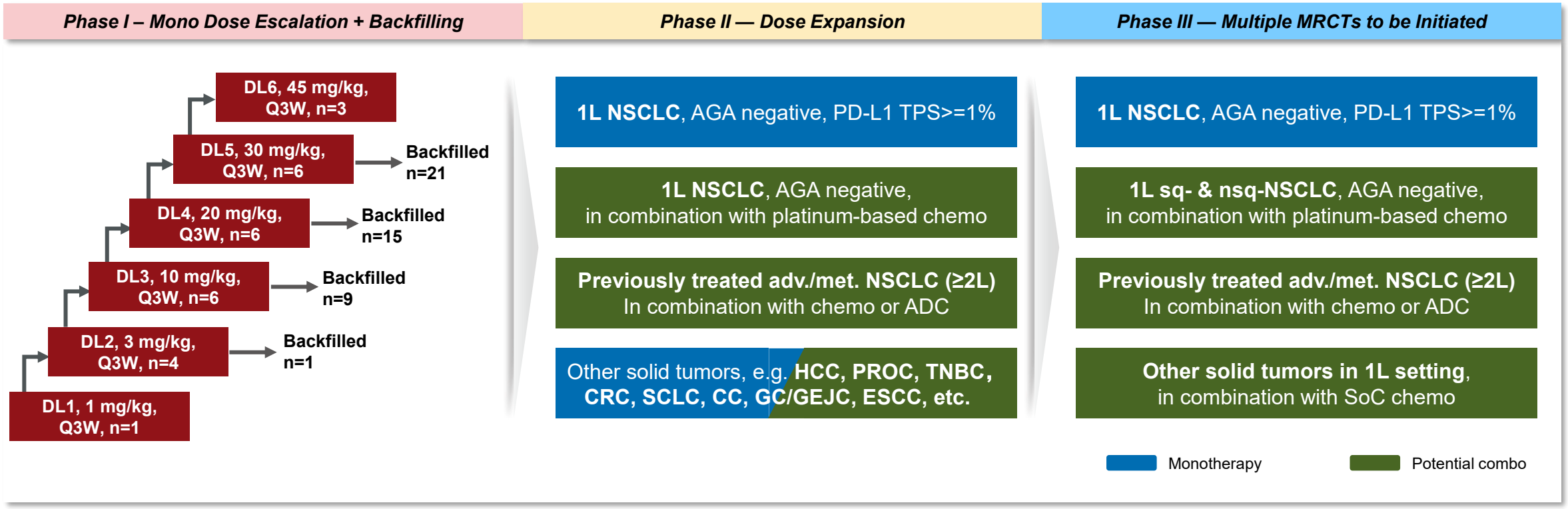
In contrast, combination treatment using three independent monoclonal antibodies unlikely to have synergistic enhancement of neutralizing/ blocking activities within the TME





CS2009 global phase I/II trial ongoing in Australia and China; US IND in preparation

Phase II first-patient-enrollment initiated in Australia



R&D Milestones & Upcoming Catalysts

- **2025-3** — First patient dosed in global phase I trial
- **2025 Q2** — Periodic safety, PK, antitumor activity evaluations
- **2025 Q4** — Phase I data debut at ESMO
- **2026 Q2** — Data presentation at ASCO
- **2026** — **Initiating Phase III registrational trial**

AGA: actionable oncogenic alterations; TPS: tumor proportion score; IO: immuno-oncology therapy; NSCLC: non-small cell lung cancer; HCC: hepatocellular carcinoma; PROC: platinum-resistant ovarian cancer; TNBC: triple-negative breast cancer; CRC: colorectal cancer; SCLC: small cell lung cancer; CC: cervical cancer; GC/GEJC: gastric/gastroesophageal junction cancer; ESCC: esophageal squamous cell carcinoma; sq: squamous; nsq: non-squamous; SoC: standard of care

72 heavily pretreated patients with advanced solid tumors; >50% IO-treated; median follow-up of 1.9 months only

Characteristics	Total (N=72)
Age, years	
Median (range)	60.5 (19-80)
Sex, n (%)	
Female	36 (50.0)
Male	36 (50.0)
Race, n (%)	
Black or African American	1 (1.4)
Asian	31 (43.1)
White	39 (54.2)
Other	1 (1.4)
ECOG PS, n (%)	
0	32 (44.4)
1	40 (55.6)
Prior therapy, n (%)	
1	24 (33.3)
2	17 (23.6)
≥3	27 (37.5)

Characteristics	Total (N=72)
Prior IO therapy, n (%)	37 (51.4)
Prior anti-angiogenic therapy, n (%)	30 (41.7)
Tumor type, n (%)	
Non-small cell lung cancer (NSCLC)	33 (45.8)
Ovarian carcinoma (OC)	10 (13.9)
Soft tissue sarcoma (STS)	9 (12.5)
Renal cell carcinoma (RCC)	4 (5.6)
Triple negative breast carcinoma (TNBC)	4 (5.6)
Adrenocortical carcinoma (AC)	2 (2.8)
Cervical carcinoma (CC)	2 (2.8)
Gastric carcinoma (GC)	2 (2.8)
Prostate carcinoma (PC)	2 (2.8)
Biliary tract carcinoma (BTC)	1 (1.4)
Bladder mucinous adenocarcinoma	1 (1.4)
Hepatocellular carcinoma (HCC)	1 (1.4)
Head and neck squamous cell carcinoma (HNSCC)	1 (1.4)

Median follow-up: 1.9 (0.1-6.7) months

Median treatment duration: 1.4 (0.1-6.7) months

Median treatment cycle: 2.0 (1-10) cycles

Source: ESMO 2025 poster

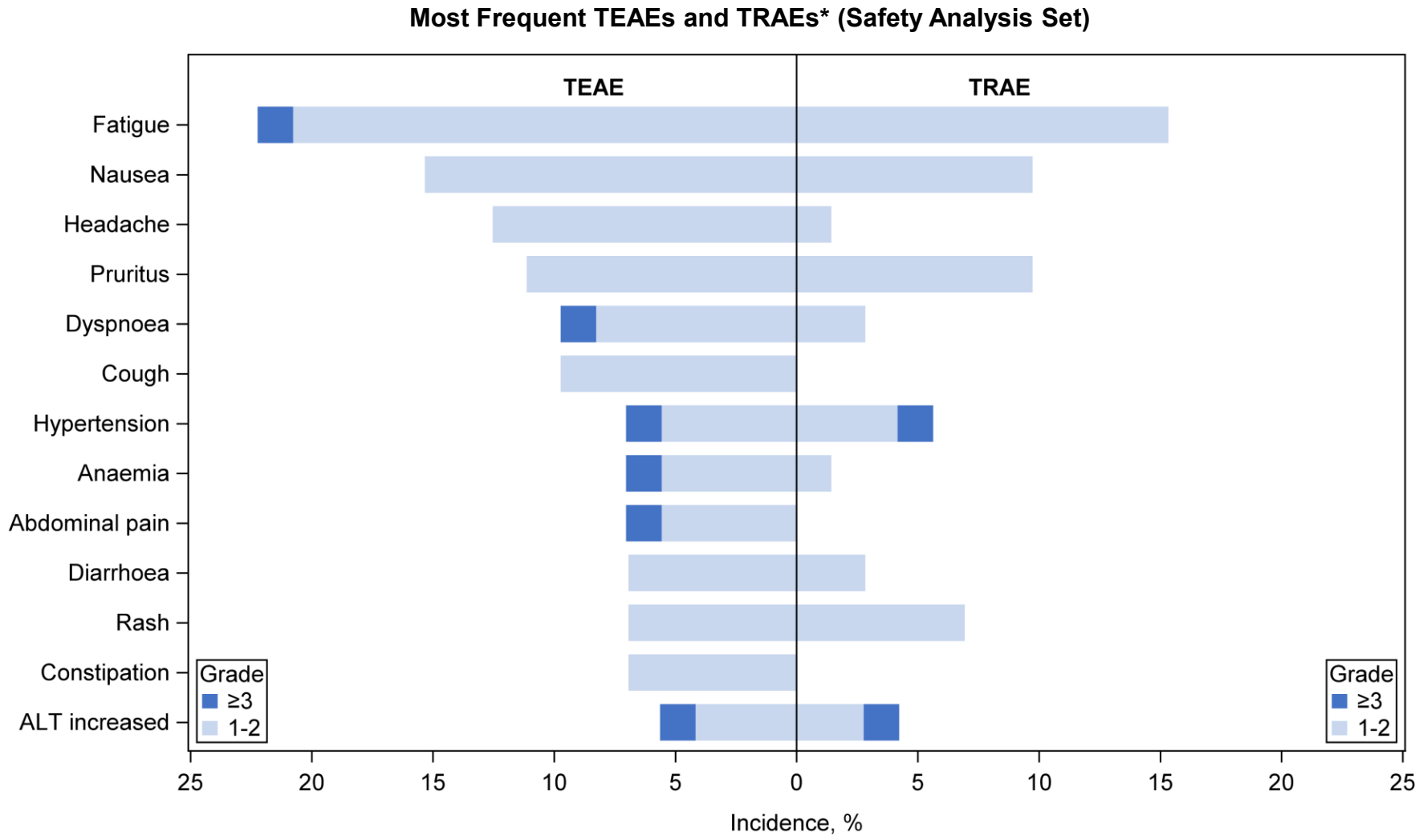
Favorable Safety Profile: Grade ≥3 TRAEs: 13.9%; Grade ≥3 irAEs: 4.2%; No Grade 4/5 TRAEs

CS2009 Safety Overview

n (%)	DL1-3 1-10 mg/kg, Q3W* (N=21)	DL4 20 mg/kg, Q3W (N=21)	DL5 30 mg/kg, Q3W (N=27)	DL6 45 mg/kg, Q3W (N=3)	All DLs (N=72)
No. of patients with ≥1 following event					
Treatment-emergent adverse event (TEAE)	21 (100.0)	19 (90.5)	13 (48.1)	3 (100.0)	56 (77.8)
Grade ≥3 TEAE	8 (38.1)	6 (28.6)	6 (22.2)	1 (33.3)	21 (29.2)
Treatment-related TEAE (TRAE)	18 (85.7)	16 (76.2)	8 (29.6)	3 (100.0)	45 (62.5)
Grade ≥3 TRAE	**5 (23.8)**	**2 (9.5)**	**2 (7.4)**	**1 (33.3)**	**10 (13.9)**
Serious TEAE	7 (33.3)	6 (28.6)	4 (14.8)	0	17 (23.6)
Treatment-related serious TEAE	2 (9.5)	4 (19.0)	0	0	6 (8.3)
Immune-related TEAE	8 (38.1)	2 (9.5)	2 (7.4)	0	12 (16.7)
Grade ≥3 immune-related TEAE	**2 (9.5)**	**1 (4.8)**	**0**	**0**	**3 (4.2)**
Infusion-related reaction	0	1 (4.8)	0	1 (33.3)	2 (2.8)
TEAE leading to drug permanent discontinuation	0	1 (4.8)	0	0	1 (1.4)

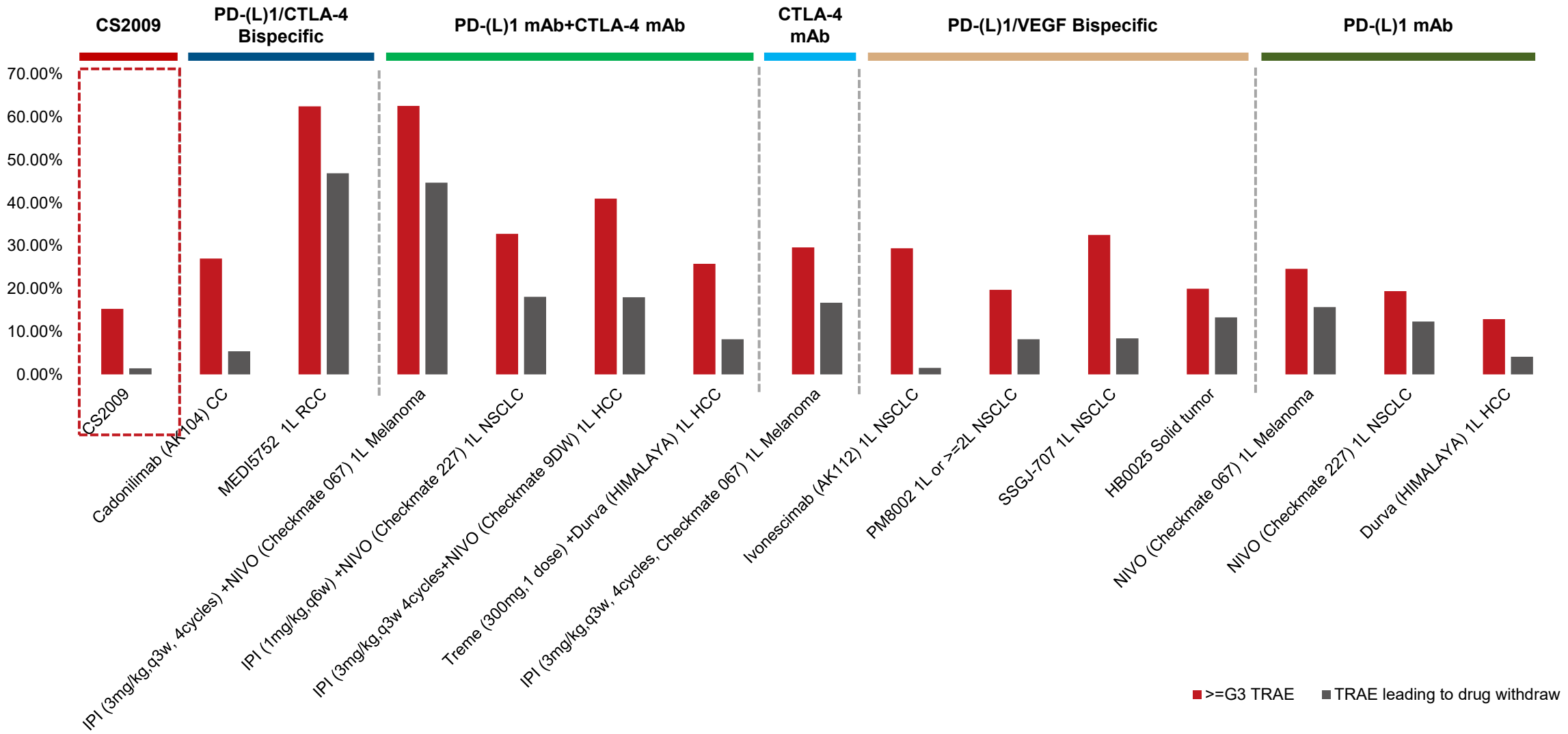
** Patients at DL1-3 (1-10 mg/kg) were permitted for intra-escalation to DL4, 20mg/kg based on investigator assessment of tolerability and potential benefit.*
Abbr: DL, dose level
Source: ESMO 2025 poster

CS2009 was well tolerated; most frequent TRAEs were manageable



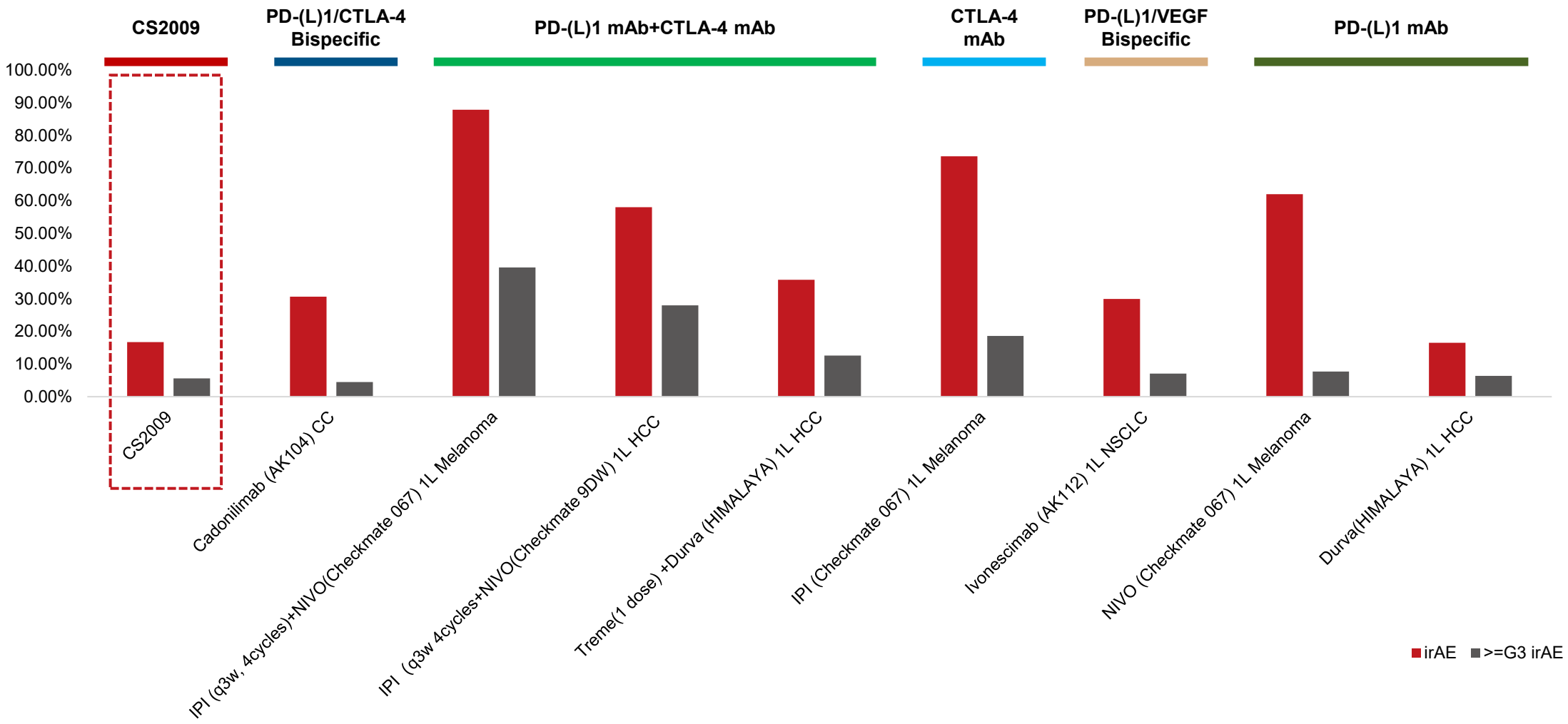
*TEAEs with incidence rate ≥5% and the corresponding TRAEs. AEs were graded according to National Cancer Institute Common Terminology Criteria for AE (NCI-CTCAE) v5.0.
ALT=alanine aminotransferase; TEAE=treatment-emergent adverse event; TRAE=treatment-related adverse event.
Source: ESMO 2025 poster

Safety Comparison (1/4): Much lower incidence of grade ≥3 TRAE and TRAE leading to treatment discontinuation vs. IO bispecific or combination regimens, with the caveat of shorter follow-up



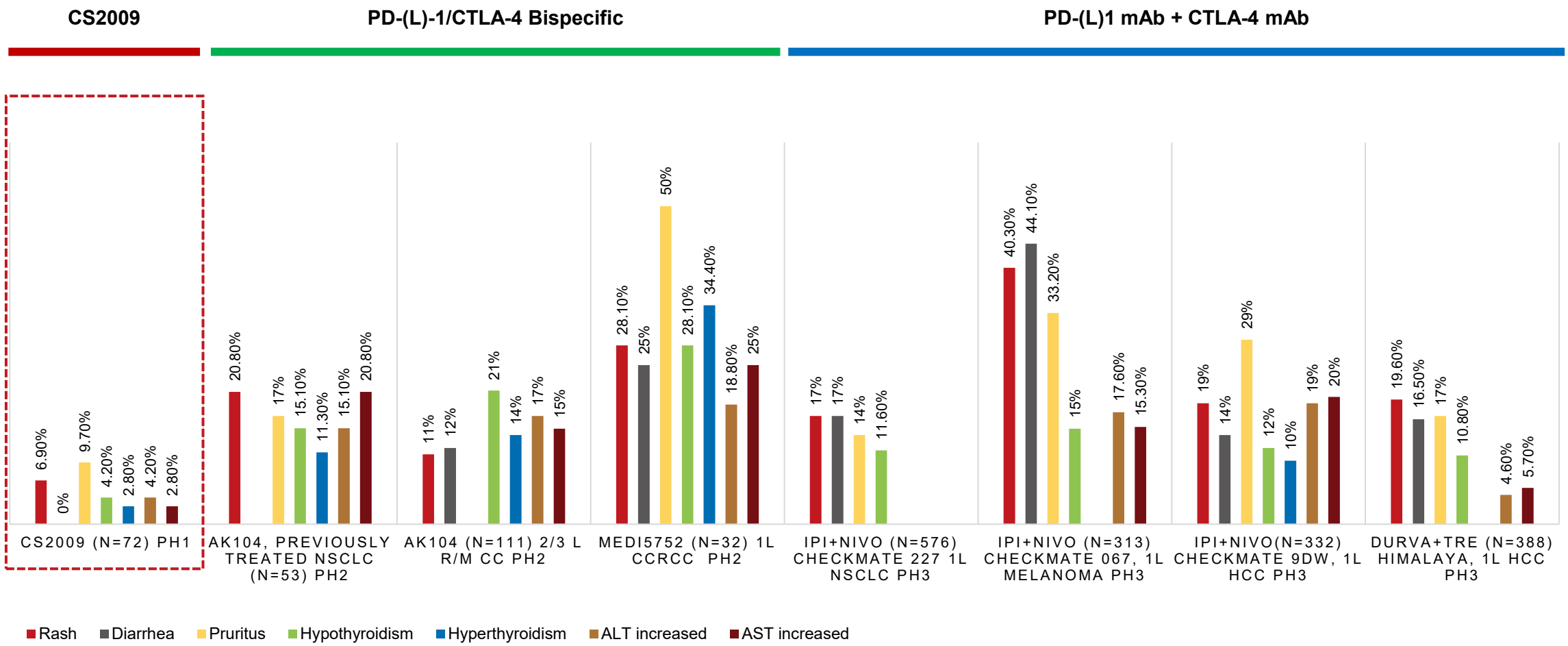
Source: Lancet Oncol 2023; 24: 1134–46; 2023 ESMO; April 16, 2018, at NEJM.org; N Engl J Med. 2025 January 02; 392(1): 11–22; June 6, 2022 NEJM Evid 2022; 1 (8); Lancet 2025; 405: 1851–64; Lancet 2025; 405: 839–49; 2024 ASCO, #8533; 2025 CSCO; 2025 ASCO abstract 8543;

Safety Comparison (2/4): Much lower incidence of any-grade and grade ≥3 irAE vs. IO bispecific or combination regimens, with the caveat of shorter follow-up



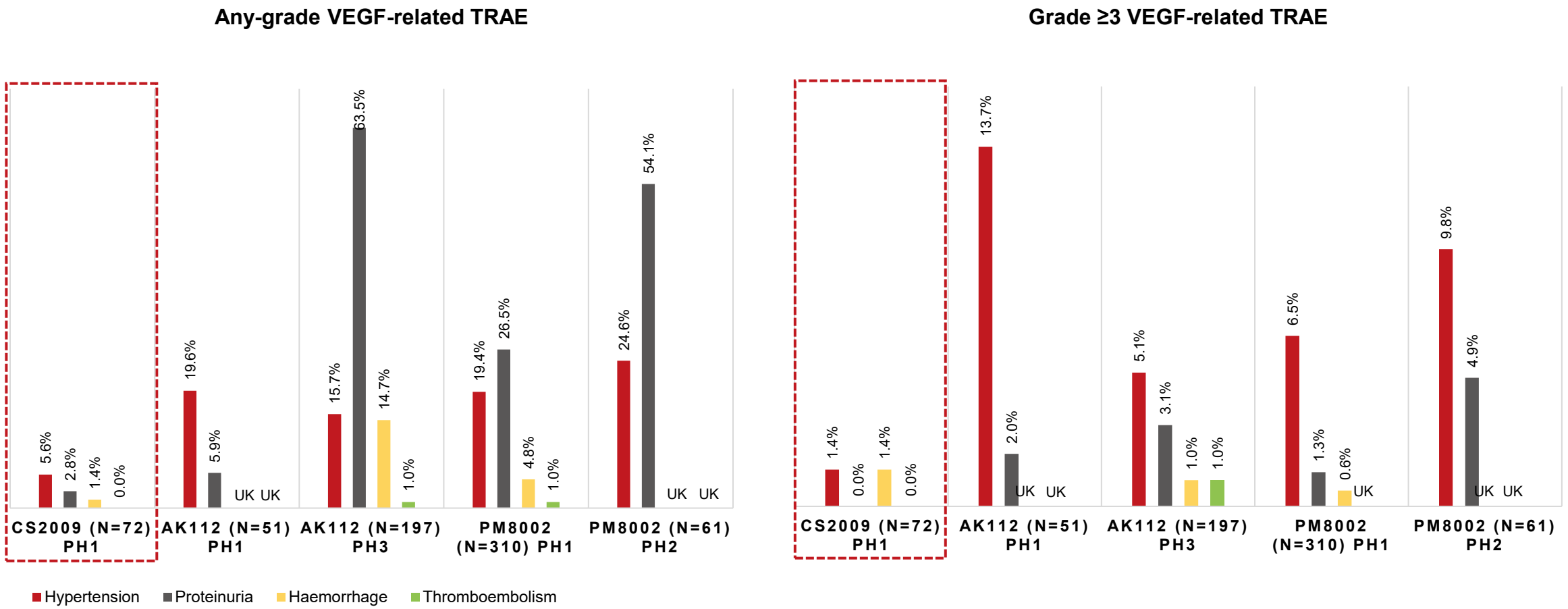
Source: Lancet Oncol 2023; 24: 1134–46; N Engl J Med. 2025 January 02; 392(1): 11–22; June 6, 2022 NEJM Evid 2022; 1 (8); Lancet 2025; 405: 1851–64; Lancet 2025; 405: 839–49

Safety Comparison (3/4): Much lower incidence of frequent any-grade irAE vs. PD-(L)1/ CTLA-4 bispecific or combination regimens, with the caveat of shorter follow-up



Source: Lung Cancer 184 (2023) 107355; Lancet Oncol 2023; 24: 1134–46; 2023 ESMO; April 16, 2018, at NEJM.org; N Engl J Med. 2025 January 02; 392(1): 11–22; Lancet 2025; 405: 1851–64; June 6, 2022 NEJM Evid 2022; 1 (8)

Safety Comparison (4/4): Much lower incidence of any-grade and grade ≥3 VEGF-related TRAE vs. PD-(L)1/VEGF bispecific, with the caveat of shorter follow-up

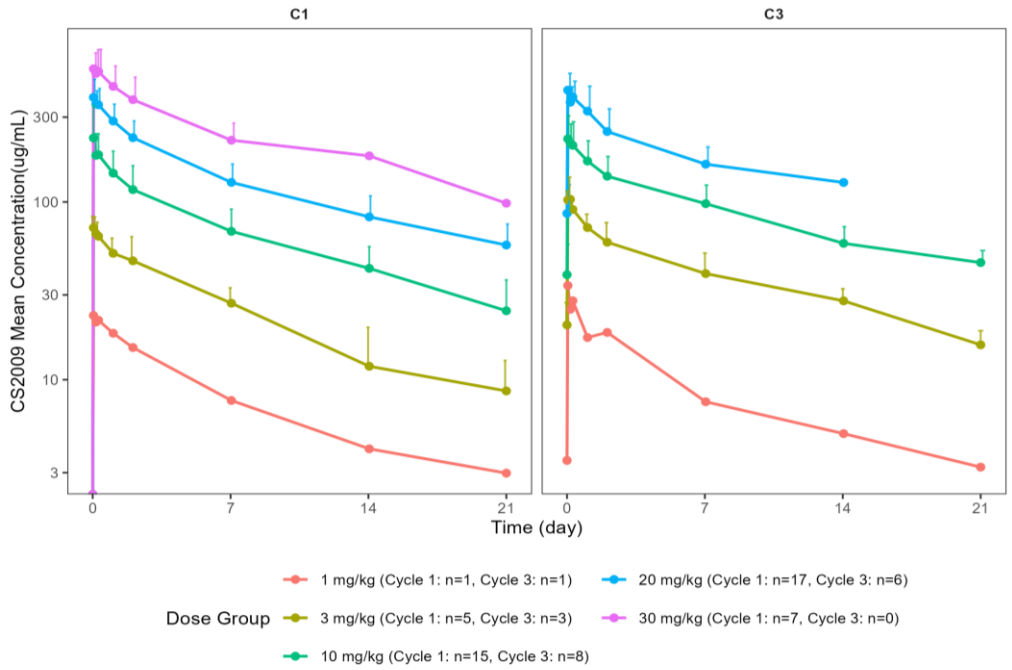


Abbr: UK, unknown

Source: J Immunother Cancer. 2024 Apr 19;12(4):e008037； Lancet 2025; 405: 839–49； 2023 ASCO，#414802；2024 ASCO, #8533

CS2009 PK Profile: Dose-proportional exposure; terminal half-life of ~6-8 days; no significant accumulation after repeated doses; very low ADA-positivity incidence

Mean (+SD) Concentration-Time Profile



CS2009 PK Parameters after First Dose

Parameter	1 mg/kg	3 mg/kg	10 mg/kg	20 mg/kg	30 mg/kg
	n=1	n=5	n=15	n=17	n=7
C_{max} (ug/mL)	23 (-)	71 (16.1)	215 (41.5)	386 (24.3)	580 (23.5)
half-life (h)	175 (-)	151 (68.4)	189 (33.3)	191 (24.5)	- (-)
AUC_{0-504} (ug/mL*h)	3720 (-)	10900 (37.5)	31630 (34.8)	61450 (27.3)	(-)
AUC_{0-inf} (ug/mL*h)	3790 (-)	12670 (48.9)	37590 (44.8)	76630 (37.3)	- (-)

CS2009 PK Parameters after Third Dose

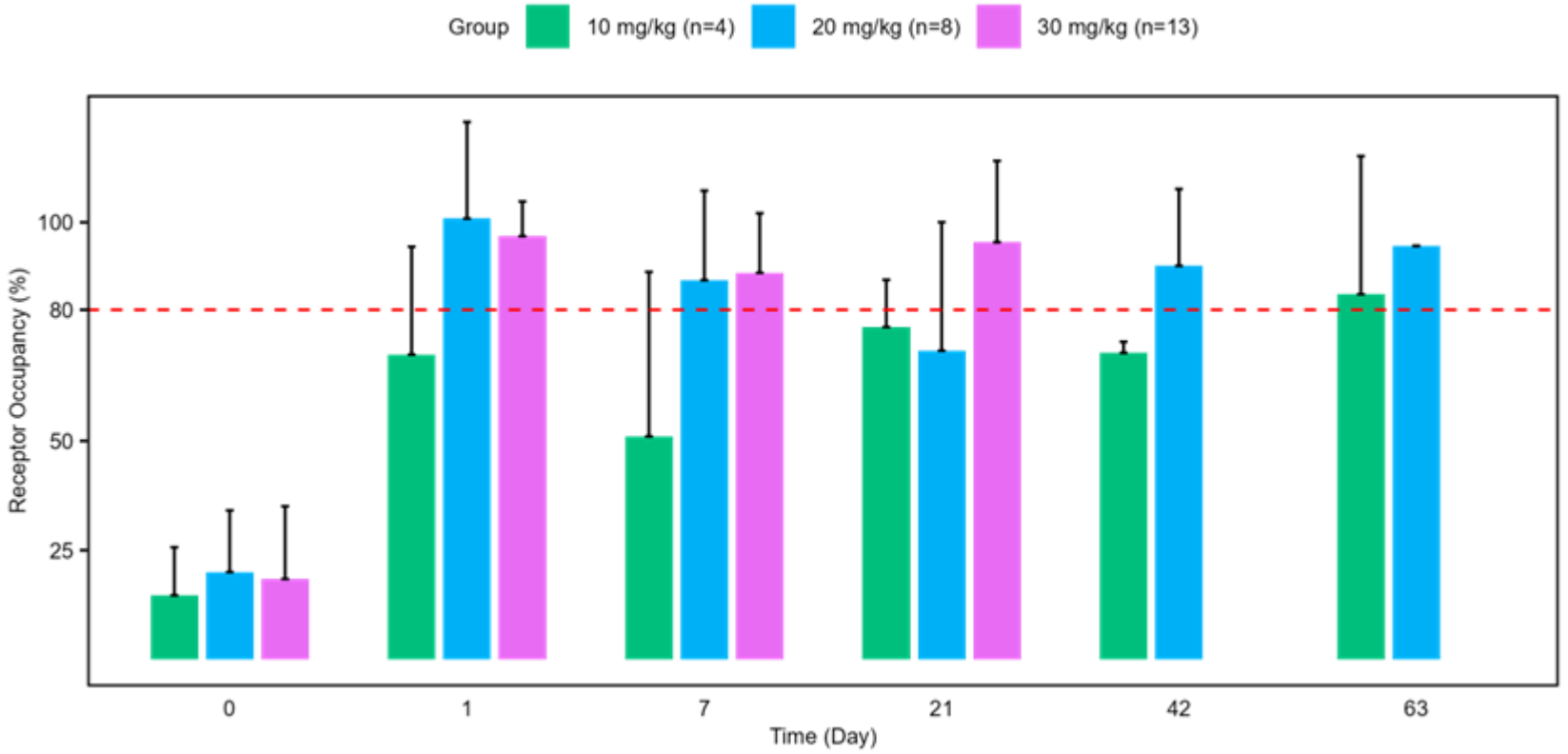
	n=1	n=3	n=8	n=6	
C_{max} (ug/mL)	33.9 (-)	111 (23.5)	232 (32.1)	417 (26.3)	
AUC_{0-504} (ug/mL*h)	4350 (-)	18290 (17.3)	45450 (21.8)	96200 (-)	
Rac, C_{max}	1.47 (-)	1.5 (8.0)	0.92 (68.4)	1.15 (10.4)	
Rac, AUC	1.17 (-)	1.31 (6.6)	1.18 (7.5)	1.5 (-)	

PK Summary

- C_{max} and AUC increased approximately proportionally with dose across the five cohorts evaluated so far.
- The terminal half-life is approximately **6~8 days.**
- No significant accumulation observed at Cycle 3 (accumulation index: 0.9–1.5).

Source: ESMO 2025 poster and in-house data

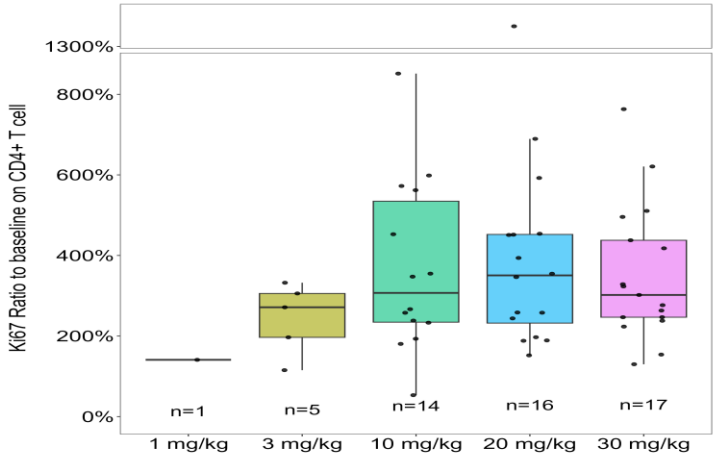
Receptor Occupancy (RO): PD-1/CTLA-4 receptor occupancy on peripheral T cells reached saturation throughout dosing interval at ≥20 mg/kg



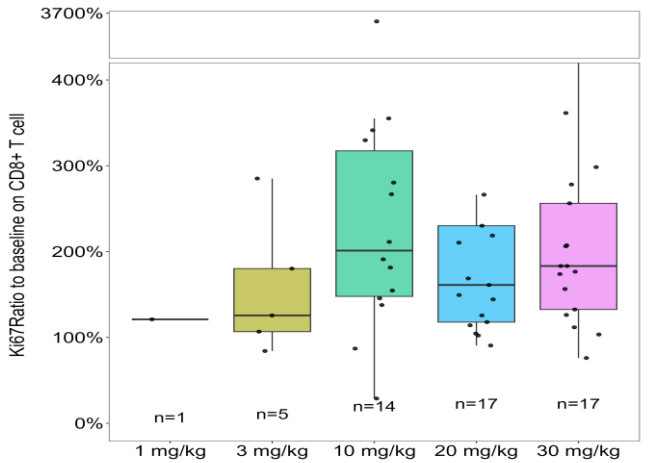
Source: ESMO 2025 poster

T-cell Proliferation & Activation: CS2009 induced notable, dose-dependent upregulation of Ki67 (proliferation due to PD-1 and CTLA-4 blockade) and ICOS (activation due to CTLA-4 blockade) on both CD4+ and CD8+ T cells

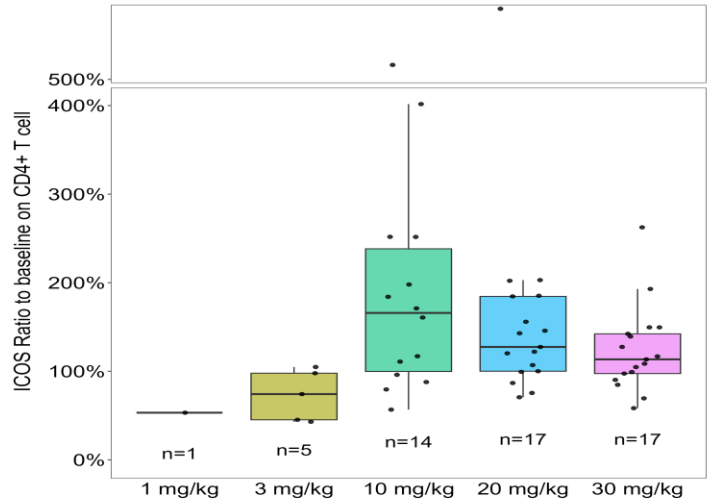
Ki67 expression on CD4+ T cells



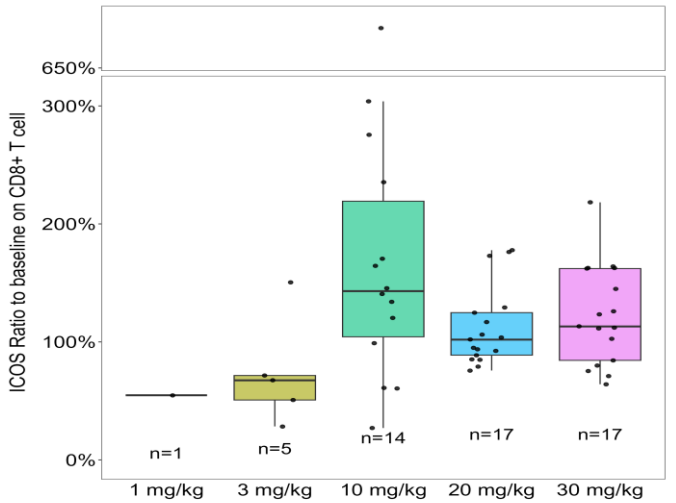
Ki67 expression on CD8+ T cells



ICOS expression on CD4+ T cells

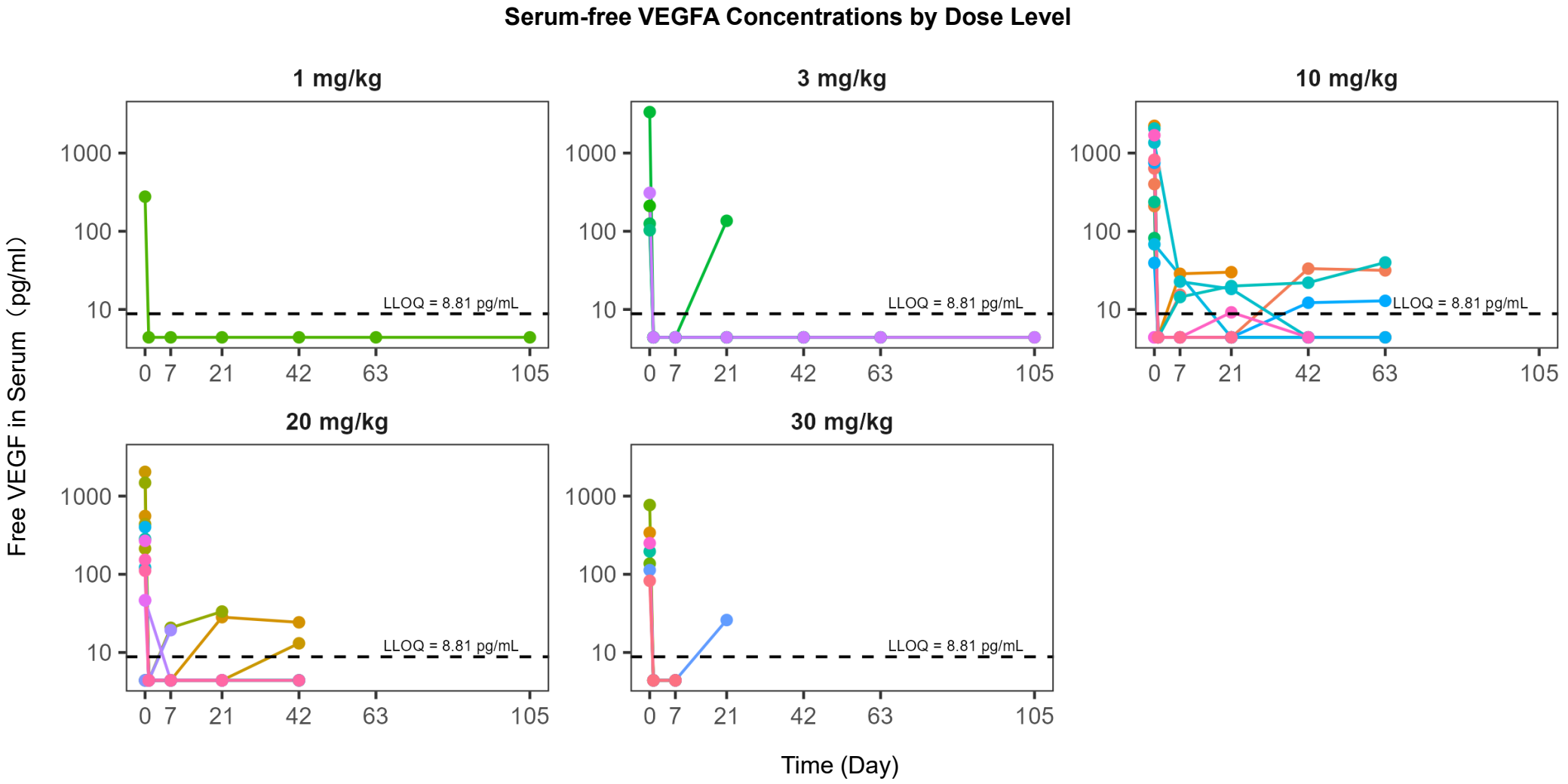


ICOS expression on CD8+ T cells



Source: ESMO 2025 poster

VEGF Neutralization: Serum-free VEGFA reduced deeply and rapidly across all doses, and the effect sustained throughout dose intervals



Note: Concentrations below the lower limit of quantification (LLOQ, 8.81 pg/mL) were imputed as one-half of the LLOQ.
Source: ESMO 2025 poster

Promising Antitumor Activity: Response observed across all dose levels, with dose-dependent uptrend, including 70+% DCR overall and 25% ORR at ≥30 mg/kg (median follow-up ~2 months only)

Best Overall Response in All Evaluable Patients (Efficacy Analysis Set)
(Patients who had at least one post-baseline tumor-assessment)

All Evaluable Patients, n (%)	DL1-3 1-10 mg/kg, Q3W (N=20)	DL4 20 mg/kg, Q3W (N=17)	DL5 30 mg/kg, Q3W (N=9)	DL6 45 mg/kg, Q3W (N=3)	All DLs (N=49)
Overall Response Rate (ORR)	**2 (10.0)**	**1 (5.9)**	**2 (22.2)**	**1 (33.3)**	**6 (12.2)**
Partial Response (PR)	2 (10.0)	1 (5.9)	2 (22.2)	1 (33.3)	6 (12.2)
Stable Disease (SD)	11 (55.0)	12 (70.6)	4 (44.4)	2 (66.7)	29 (59.2)
Progressive Disease (PD)	7 (35.0)	4 (23.5)	3 (33.3)	0	14 (28.6)
Disease Control Rate (DCR)	**13 (65.0)**	**13 (76.5)**	**6 (66.7)**	**3 (100.0)**	**35 (71.4)**

Median follow-up: 1.9 months

Abbr: DL, dose level
Source: ESMO 2025 poster

Post-ESMO Update: One NSCLC patient with stable disease converted to partial response

Best Overall Response in All Evaluable Patients (Efficacy Analysis Set)
(Patients who had at least one post-baseline tumor-assessment)

All Evaluable Patients, n (%)	DL1-3 1-10 mg/kg, Q3W (N=20)	DL4 20 mg/kg, Q3W (N=17)	DL5 30 mg/kg, Q3W (N=9)	DL6 45 mg/kg, Q3W (N=3)	All DLs (N=49)
Overall Response Rate (ORR)	**2 (10.0)**	**2 (11.8)**	**2 (22.2)**	**1 (33.3)**	**7 (14.3)**
Partial Response (PR)	2 (10.0)	2 (11.8)	2 (22.2)	1 (33.3)	7 (14.3)
Stable Disease (SD)	11 (55.0)	11 (64.7)	4 (44.4)	2 (66.7)	28 (57.1)
Progressive Disease (PD)	7 (35.0)	4 (23.5)	3 (33.3)	0	14 (28.6)
Disease Control Rate (DCR)	**13 (65.0)**	**13 (76.5)**	**6 (66.7)**	**3 (100.0)**	**35 (71.4)**

Median follow-up: ~ 2 months

Abbr: DL, dose level
Source: ESMO 2025 poster and post-ESMO data update

Efficacy observed across tumor types despite limited follow-up

Best Overall Response in Specific Tumor Types (Efficacy Analysis Set)
(Patients who had at least one post-baseline tumor-assessment)

Tumor Type, n (%)	NSCLC* (N=17)	Ovarian Cancer (N=6)	TNBC (N=4)	nccRCC (N=3)	STS (N=9)
Prior IO Therapy	17 (100.0)	1 (16.7)	2 (50.0)	2 (66.7)	2 (22.2)
Prior Anti-VEGF Therapy	7 (41.2)	4 (66.7)	1 (25.0)	3 (100.0)	4 (44.4)
Overall Response Rate (ORR)	**3 (17.6*)**	**1 (16.7)**	**1 (25.0)**	**1 (33.3)**	**1 (11.1)**
Partial Response (PR)	3 (17.6)	1 (16.7)	1 (25.0)	1 (33.3)	1 (11.1)
Stable Disease (SD)	11 (64.7)	3 (50.0)	2 (50.0)	2 (66.7)	5 (55.6)
Progressive Disease (PD)	3 (17.6)	2 (33.3)	1 (25.0)	0	3 (33.3)
Disease Control Rate (DCR)	**14 (82.4*)**	**4 (66.7)**	**3 (75.0)**	**3 (100.0)**	**6 (66.7)**

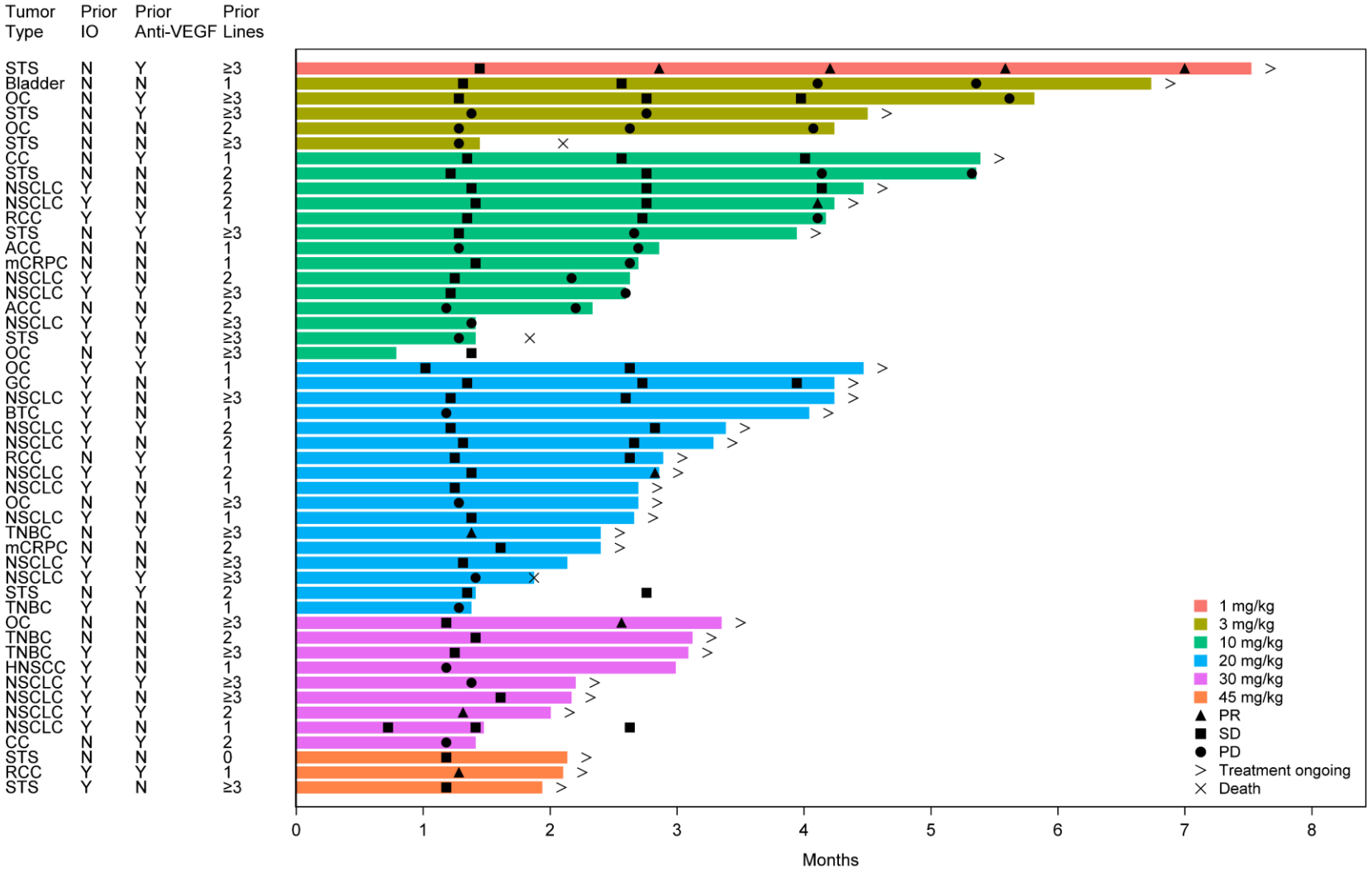
 # For NSCLC, 10 mg/kg (n=5), 20 mg/kg (n=8), 30 mg/kg (n=4), one responder was observed in each cohort

*** In AGA-negative post-IO NSCLC subgroup , ORR reached 25% (3/12), DCR reached 83.3% (10/12)**

Median follow-up: ~ 2 months

Abbr.: NSCLC, non-small-cell lung cancer; TNBC, triple-negative breast cancer; nccRCC, non-clear cell renal cell carcinoma; STS, soft tissue sarcoma
Source: ESMO 2025 poster and post-ESMO data update

Persistent disease control with majority of patients remaining on treatment despite limited follow-up (especially high-dose cohorts)



Durable disease control observed with longer-followed patients in lower dose cohorts

Shorter follow-up for high-dose cohorts with most patients pending post-baseline tumor assessments

Abbr: STS, soft tissue sarcoma; OC, ovarian cancer; CC, cervical cancer; NSCLC, non-small cell lung cancer; RCC, renal cell carcinoma; ACC, adrenocortical carcinoma; mCRPC, metastatic castration-resistant prostate cancer; GC, gastric cancer; BTC, biliary tract cancer; TNBC, triple negative breast cancer; HNSCC, head and neck squamous cell cancer

Source: ESMO 2025 poster and post-ESMO data update

Antitumor Activity in Phase I Trials: CS2009 demonstrated promising ORR and strong DCR (71%) vs. bispecific antibodies, even with much shorter follow-up (median ~2 months) and higher prior-IO exposure (>50%)

Comparative Analysis: CS2009 vs. Lead Bispecific Antibodies in Phase I Trials of Advanced Solid Tumor

	CS2009[1] *PD-1/VEGF/CTLA-4*	AK112[2] *PD-1/VEGF*	AK104[3] *PD-1/CTLA-4*	SSGJ-707[4] *PD-1/VEGF*	KN046[5] *PD-L1/CTLA-4*	IMM2510[6] *PD-L1/VEGF*	SI-B003[7] *PD-1/CTLA-4*
Evaluable patients, n	49	47	119	85	88	19	56
Age Median (range)	60.5 (19-80)	63 (30, 76)	61 (20, 85)	NA	51.5 (21, 73)	55.5 (36, 68)	55.5
Prior IO therapy	**51.4%**	29.4%	16.8%	NA	35.0%	NA	NA
Follow-up Duration, median, mo	**~ 2.0**	12.8	NA	NA	23.2	NA	NA
ORR	14.3%	25.5%	13.4%	14.0%	12.5%	12.0%	16.1%
DCR	**71.4%**	63.8%	NA	59.6%	35.2%	40.0%	50.0%

Note: PM8002 (PD-L1/VEGF, BioNTech), MEDI5752 (PD-1/CTLA-4, AstraZeneca), and HB0025 (PD-L1/VEGF, Huabo Biopharma) excluded from comparative analysis - Phase Ia multi-tumor efficacy data either unpublished or limited to single tumor types per public disclosures

Source:1. ESMO 2025+post-ESMO analysis；2. JITC 2024；3. Cell Reports Medicine 2023；4. JPM 2025；5. JITC 2023；6. ASCO 2024；7. ASCO 2023

Antitumor Activity in NSCLC in Early-phase Trials: Promising ORR and DCR observed for CS2009 in comparison with lead bispecific antibodies in post-IO NSCLC

	CS2009[1] (PD-1/VEGF/CTLA-4)	AK104+AK109[2] (PD-1/CTLA-4+VEGF)	AK104+anlotinib[3] (PD-1/CTLA-4+TKI)	AK104[4] (PD-1/CTLA-4)	AK104[5] (PD-1/CTLA-4)	AK112[6] (PD-1/VEGF)	PM8002[7] (PD-L1/VEGF)
Stage of data cited	Phase 1 dose escalation	Phase 1b/2	Phase 1b/2	Phase 1 dose escalation	Phase 1b/2	Phase 1 dose escalation	Phase 1b/2a
Evaluable patients, n	17*	47^	6	6	23†	2	8^
Follow-up Duration, median, mo	**~ 2.0**	16.7	NA	25	NA	12.8	5.8
ORR	**3/17 (17.6%)**	**6/47(12.8%)**	**1/6 (16.7%)**	**0/6 (0%)**	**0/23 (0%)**	**0/2 (0%)**	**1/8 (12.5%)**
DCR	**14/17 (82.4%)**	**45/47(95.7%)**	**6/6 (100%)**	**2/6 (33.3%)**	**7/23 (30.4%)**	**1/2 (50%)**	**5/8 (62.5%)**

*** In AGA-negative, ≥2L post-IO NSCLC subgroup, ORR reached 25% (3/12) and DCR reached 83.3% (10/12)**
^ All patients are AGA-negative and 2L post-IO NSCLC
† All patients are AGA-negative/unknown and ≥2L post-IO NSCLC

Note: 1. ESMO 2025+post-ESMO analysis；2. 2025 WCLC；3. 2021 ESMO；4. Cell Reports Medicine 2023；5. Lung Cancer 2023；6. JITC 2024；7. 2024 ASCO；

Lead bispecific antibodies generated impressive efficacy in 1L NSCLC despite low ORR observed in post-IO NSCLC in early-phase trials —CS2009 phase II trial in 1L NSCLC started, with global pivotal trials in preparation

Monotherapy	AK112[1] (PD-1/VEGF)	SSGJ-707[2] (PD-1/VEGF)
Stage of data cited	Phase 3 *(vs. pembrolizumab monotherapy)*	Phase 2
ORR	ITT: **50.0%** vs 38.5%	ITT: **67.6%** PD-L1 ≥50%: 77% PD-L1 1-49%: 62%
DCR	ITT: 89.9% vs 70.5%	ITT: 97% PD-L1 ≥50%: 100% PD-L1 1-49%: 95%

Combination therapy (+PT-CT)	AK112[3] (PD-1/VEGF)	MEDI5752[4] (PD-1/CTLA-4)	SSGJ-707[5] (PD-1/VEGF)	HB0025[6] (PD-1/VEGF)	IMM2510[7] (PD-1/VEGF)
Stage of data cited	Phase 2	Phase 1b	Phase 2	Phase 2	Phase 2
ORR	Nsq 52.0% Sq 77.8%	Nsq 43.7% Sq 65.0%	Nsq 58.3% Sq 81.3%	Nsq 62.3% Sq 82.8%	Nsq 46% Sq 80%

*Note: 1. 2024&2025 WCLC，HARMONi-2, ph3；2. 2025 ASCO，ph2；3. 2023 ASCO，ph2；4. 2024 WCLC，*ARTEMIDE-01, ph1b*；5. 2025 JPM，ph2；6. 2025 CSCO，ph2；7. Jul 2025 PR，ph2；*

Key Takeaways

1 Safety & Tolerability

- **CS2009 is well tolerated** in heavily pretreated patients with advanced solid tumor across dose levels of 1 to 45mg/kg, Q3W
- **No Grade 4 or 5** TRAE observed
- **No DLTs** observed, **MTD not reached**
- Low incidence of infusion-related reactions

2 Pharmacokinetics (PK)/Pharmacodynamics Profile

- Linear PK with **half life of 6-8 days**, low incidence of ADA positivity
- **Sustained PD-1/CTLA-4 receptor occupancy** at doses ≥20 mg/kg
- Robust, dose-dependent increase of pharmacodynamic biomarkers (Ki67 and ICOS) confirming **effective PD-1 and CTLA4 blockade**
- **Serum-free VEGFA reduced deeply and rapidly** across all doses, and the effect **sustained** throughout dose intervals

3 Anti-tumor Activity

- CS2009 demonstrates **promising anti-tumor activities** across tumor types; data remains immature due to **limited follow-up time** as of the cutoff date
- **Promising phase I ORR: 14.3%** (7/49); strong **DCR**: **71.4%** (35/49); **higher ORR** at tentative RP2D (30 mg/kg) and above: **25.0%** (3/12)
- **Post-IO NSCLC**: Promising **ORR** of **17.6%** (3/17) and strong **DCR** of **82.4%** (14/17); **higher ORR** of **25%** (3/12) and **DCR** of **83.3%** (10/12) in AGA-negative subgroup

4 Future Development Plan

- Phase 2 dose expansion in **1L patients** started in selected tumor types for dose optimization and to generate data supporting **registration trials in 1L NSCLC and other tumors** as monotherapy or in combinations

Thanks for Listening!