SECOND QUARTER 2026 EARNINGS

PREPARED REMARKS

Dan Maller, VP, Head of Investor Relations

Hello and welcome. Thanks for joining us today. I'm Dan Maller, Head of Investor Relations at BeOne Medicines.

Before we begin, please note that you can find additional materials, including a replay of today's webcast and presentation on the Investor Relations section of our website, ir.beonemedicines.com.

[CLICK to SLIDE 2]

I would like to remind all participants that during this call we may make forward-looking statements regarding, among other things, the company's future prospects and business strategy.

Actual results may differ materially from those indicated in the forward-looking statements as a result of various factors, including those risks discussed in our most recent periodic report filed with the SEC. Please also carefully review the forward-looking statements disclaimer in the slide deck that accompanies this presentation.

Reconciliations between GAAP and non-GAAP financial measures discussed on this call are provided in the appendix to our presentation, which is posted to our investor relations website along with our earnings release.

All information in this presentation is as of the date of this presentation, and we undertake no duty to update such information, unless required by law.

[CLICK to SLIDE 3]

Now turning to today's call.

As outlined on slide 3, John Oyler, our Co-Founder, Chairman and CEO will provide a business update; Aaron Rosenberg, our CFO, will provide an update on our second quarter financial results and 2026 financial guidance; and Lai Wang, President and Global Head of R&D, will discuss our R&D and Pipeline Progress.

We will then open the call to questions. Joining the team for the Q&A portion of the call will be Dr. Wu, President and Chief Operating Officer; Matt Shaulis, General Manager of North America; Mark Lanasa, Chief Medical Officer for Solid Tumors; and Amit Agarwal, Chief Medical Officer for Hematology.

I'll now pass the call over to John.

John?

John V. Oyler, Co-Founder, Chairman and CEO

[CLICK to SLIDE 4]

Thank you, Dan, and welcome everyone.

[CLICK to SLIDE 5]

Q2 2026 was a very strong quarter across every dimension of our business.

From a financial perspective, we achieved $1.7 billion in total revenues and 2 dollars and 5 cents in GAAP earnings per ADS. This represents growth of 30% and 144% compared to the prior-year, respectively.

BRUKINSA, our foundational BTK inhibitor, continues to exceed our high expectations in the marketplace. More than six and a half years after its initial launch, BRUKINSA is seeing its highest level of sustained new patient starts, showing favorable early trends in duration of therapy, and it is showing strong growth across all five approved indications.

On the back of these strong results, we are raising our 2026 guidance ranges for revenue and GAAP operating income by $300 million and $250 million, respectively, and Aaron will detail this later.

As impressive as our financial performance was in the quarter, our pipeline progress was equally significant. This is highlighted by the FDA approval of BEQALZI as the first and only BCL2 inhibitor in mantle cell lymphoma; and the success of the Phase 3 MANGROVE study of BRUKINSA, which is so exciting it warrants the entire next slide. We also announced a $300 million dollar expansion of our flagship U.S. manufacturing site in Hopewell, New Jersey.

[CLICK to SLIDE 6]

MANGROVE is yet another example of the growing body of evidence supporting BRUKINSA as the foundational BTK inhibitor.

We are excited about MANGROVE for two key reasons.

The first is because it represents the first chemo-free treatment option for patients with frontline mantle cell.

And secondly, because when you see the data, we believe the efficacy will speak for itself.

We are confident that this BRUKINSA-based chemo-free regimen has the potential to become the future standard of care for the roughly 21,000 new patients diagnosed with MCL each year in the major markets.

Global submissions are planned for the second half of 2026, and we are looking forward to sharing the full data at an upcoming medical meeting.

[CLICK to SLIDE 7]

Let's now turn to BRUKINSA's commercial performance.

In Q2, BRUKINSA global revenues reached over $1.2 billion, representing growth of 31% year over year.

BRUKINSA is the number one BTK inhibitor both in the US and globally, and it has the broadest label of any BTKi, with approvals in five B-cell malignancies. We often talk about BRUKINSA in the context of CLL, and with good reason. But it is important to remember that BRUKINSA is a very important option for patients with other B-cell malignancies, including MCL, Waldenstrom's, Marginal Zone and Follicular Lymphoma.

BRUKINSA has now treated more than 300,000 patients across 80-plus markets.

But market share alone doesn't tell the full story. The reason we're winning is scientific.

[CLICK to SLIDE 8]

And that story has three chapters: differentiated design, differentiated clinical outcomes, differentiated real-world evidence.

At BeOne, we are committed to generating and sharing the evidence needed to fully characterize our medicines for the patients and physicians that we serve.

On the left side of this slide highlights the breadth of Phase 3 data generated for BRUKINSA as a single agent. Here you can see that BRUKINSA has reported the most phase 3 data of any single agent BTK. The right side illustrates the substantial body of data currently being generated in combination, where you can see that BRUKINSA has the most reported and ongoing phase 3 data of any BTKi agent.

This slide demonstrates the scale of BRUKINSA's development plan compared to the more curated efforts of our peers.

In addition to MANGROVE, BRUKINSA has four more potentially market-expanding phase 3 readouts in the next 3 years.

A major wave of data is coming that will extend BRUKINSA's evidence base — and its label — well into the future.

[CLICK to SLIDE 9]

One quick reminder of why BRUKINSA performs the way it does.

From day one, BRUKINSA was designed to deliver complete and sustained BTK inhibition through its potency and its PK profile. Our hypothesis was simple: continuous BTK coverage would translate into a superior therapeutic profile. Over a decade of clinical and real-world evidence has really borne that out — and that's what the next few slides show.

[CLICK to SLIDE 10]

Let me remind you now that BRUKINSA is the only BTK inhibitor that has demonstrated PFS superiority versus ibrutinib in a head-to-head randomized trial.

In ALPINE, BRUKINSA delivered a hazard ratio of 0.69, and that separation has been sustained to a median follow-up of 42.5 months. In ELEVATE-RR, acala showed early separation from ibrutinib, but that separation was not sustained — the curves crossed, and the final hazard ratio was 1.00. And in BRUIN-314, pirto reported a hazard ratio of 0.845. Put simply, there was very little differentiation between the two arms, with 48 PFS events reported for pirto versus 50 for ibrutinib.

And with respect to tolerability, pirto showed numerically more discontinuations due to AEs than ibrutinib, whereas both BRUKINSA and acala each showed markedly fewer discontinuations than ibrutinib in their respective head-to-head trials.

[CLICK to SLIDE 11]

When comparing AFib rates of next-generation BTK inhibitors across studies, it is important to understand protocol differences that may affect patient selection and event reporting.

As you can see on the left, both the BRUKINSA and acala studies in frontline CLL used highly similar eligibility criteria and AFib reporting.

In contrast, the pirto studies utilized more restrictive eligibility criteria that may have resulted in a fitter study population, and they also incorporated sponsor adjudication of AFib events.

As a reminder, AFib events and rates are known to rise substantially with age: in a large study of more than 17,000 adults in US primary care clinics, the absolute prevalence of AFib was nearly 4% higher among those aged 70 to 74

as compared to 65 to 69. So, factoring for this level of age difference in studies really matters.

Despite the differences in inclusion criteria — which may have led to roughly half the percentage of patients above the age of 75 in BRUIN-313, and a 4-year lower median age in the pirto studies, and despite the differences in AFib reporting methods — AFib rates were generally similar in the active treatment arms across studies.

Interestingly, if we apply the more restrictive BRUIN-313 and 314 eligibility criteria to the SEQUOIA population, 15 of the highest-risk patients would have been excluded from the BRUKINSA arm.

And, in fact, those 15 patients had roughly twice the rate of serious grade 3 or higher infections and more than twice the rate of deaths due to AEs compared to the overall study.

This analysis underscores the extent to which differences in protocol inclusion criteria may play a key role in the clinical narrative.

Although some have suggested that pirto may be well suited for use in older patients due to lower AFib risk and improved tolerability, it is the least studied BTK inhibitor in that population. It lacks relevant long-term data with only 28 months of follow up, and the narrative about being more tolerable and having less AFib are not supported by the data.

The totality of evidence continues to support BRUKINSA's best-in-class profile.

[CLICK to SLIDE 12]

One of the key lessons we've recently learned in CLL trials is that long-term follow-up matters. Many regimens can appear highly effective in the first three years, but that is not enough time to understand their true durability.

This slide shows the reported landmark PFS at years 3 through 6 across the respective front-line CLL Phase 3 trials for the front-line treatment regimens.

Recognizing the limitations of cross-trial comparisons, a few items jump out:

One, the landmark PFS rates for BRUKINSA are higher and continue to diverge over time compared to the other two continuous BTKis. In fact, in year 6, the delta between the landmark PFS rates reaches 12%, which is equivalent of 1 in 8 patients not progressing.

Two, there is an even more pronounced delta between BRUKINSA's landmark PFS and that of VO. In year 6, there is a delta of 21% or roughly 1 in 5 patients.

[CLICK to SLIDE 13]

While the all-comer story is compelling, the high-risk story is even more striking. It raises important questions about the use of the current fixed duration regimens in high-risk patients, which I want to point out represent the majority of CLL patients.

This is not a small patient subgroup.

This slide shows how the current fixed duration treatments perform relative to foundational BRUKINSA in unmutated IGHV patients, those with the highest unmet medical need.

BRUKINSA remains durable — 84% landmark PFS at year 3, and 70% at year 6. In contrast, VO drops from 82% at year 3 to just 42% at year 6 — a 40-point collapse.

And AV — Amplify — based on the limited data disclosed to date, shows just 69% at year 3, which of course is lower than VO at a similar timepoint.

There are a few important takeaways from this slide.

First, while we're big believers in the promise of fixed duration, the existing ven-based treatments are not a compelling option for higher-risk patients, where foundational BRUKINSA has generated the best-in-class data.

Second, long-term follow-up is critical in CLL. As you can see on this slide, many regimens look promising at three years, but by six years the outcomes can diverge meaningfully, especially in high-risk patients.

That's why we've consistently prioritized long-term follow-up in our studies and why we believe six-year data provide a more complete picture of treatment durability. It's also why we're concerned when conclusions reached on regimens based on only three years of data, or less, are made. We've been very surprised that some studies have not continued to report longer-term follow up data, because years 3 to 6 are critical to evaluate the true long-term benefit of any CLL therapy.

Patient outcomes are at stake.

[CLICK to SLIDE 14]

The durability advantage we're seeing in the clinical data for foundational BRUKINSA is increasingly being reinforced in the real world — and it's both consistent and it's compelling.

At ASCO 2026, we published an analysis of over 10,500 Medicare fee-for-service patients with previously untreated CLL – this is the largest real-world dataset ever assembled in this setting.

In this patient population, BRUKINSA reported a statistically significant 24% and 36% reduction in the risk of death compared to those treated with acala and ibrutinib, respectively.

24% and 36%.

As you can imagine, this dataset generated significant interest from physicians at ASCO given both its size and the importance of these findings to the real-world U.S. Medicare population. The study has since been published in a peer-reviewed journal.

And importantly, this is now one of several large real-world analyses showing a consistent advantage for BRUKINSA, including a recent study of claims data from 17,000 frontline CLL patients, which also reported improved survival and treatment durability for BRUKINSA versus acala.

[CLICK to SLIDE 15]

Stepping back: BeOne is the only company in the world with foundational medicines across the three mechanisms of action in B-cell malignancies.

BRUKINSA — our foundational BTK inhibitor.

BEQALZI — our recently approved, next-generation, potentially best-in-class BCL2 inhibitor.

And tacabrutideg — our potentially first and best-in-class BTK degrader.

Only BeOne is equipped to provide the best-in-class therapies — as monotherapy or in combination — for every CLL patient and other lymphonas, regardless of their stage of disease, risk status, or treatment preference.

[CLICK to SLIDE 16]

I've spoken about how 2026 is an inflection year for our solid tumor pipeline, and we presented data this quarter that supports our confidence in moving our CDK4 inhibitor, our B7-H4 ADC, and our GPC3x41BB bi-specific antibody into registrational trials. Looking forward to ESMO, we'll be sharing similar proof-of-concept data sets for two more potentially best-in-class medicines, our PRMT5 inhibitor and CEA ADC.

It’s an incredibly exciting time for our company, for our portfolio, and for our pipeline.

With that, I'll hand it over to Aaron for the financial results.

Aaron Rosenberg, Chief Financial Officer

[CLICK to SLIDE 17]

Thanks, John.

Our second quarter financial results reflect strong execution, and a durable and healthy underlying business as we invest with discipline to support growth over the long-term.

[CLICK to SLIDE 18]

Starting with our commercial performance — we delivered another strong quarter across the portfolio, with continued broad-based growth.

Total revenue for the quarter was $1.7 billion, representing 30% growth compared to the prior-year period.

U.S. BRUKINSA sales totaled $893 million, representing growth of 31%, which exceeded expectations due to several underlying factors.

Despite the competitive environment, in Q2, we saw the highest level of sustained new patient starts since BRUKINSA’s launch. Prescribers increasingly selected BRUKINSA for their patients given the totality of evidence for efficacy and durability, supported by the clinical data and their real-world experience.

We also continue to see meaningful growth from indications beyond CLL, which speaks to the breadth of the BRUKINSA label and the diversification of the franchise.

And while duration of therapy remains immature for BRUKINSA, the data suggests favorable duration relative to historical benchmarks. This makes sense given the unprecedented long-term data seen with SEQUOIA, as well as recently published real-world studies that reinforce statistically significant advantages for BRUKINSA in time to discontinuation relative to both acalabrutinib and ibrutinib.

And finally, patient adherence has also improved, potentially linked to the launch of the tablet formulation late last year, which reduced both pill size and burden. High adherence rates are important for patient outcomes, and we are pleased to see this progress.

These factors are not unique to the US, and we expect they will support durable, long-term global demand growth for BRUKINSA.

Beyond BRUKINSA, TEVIMBRA generated $229 million in global sales, representing 18% growth versus the prior-year period. TEVIMBRA maintained its market leadership in China in the face of steep competition. Our global launches are also gaining traction, and this is ahead of the potential catalyst associated with the approval of TEVIMBRA in combination with ZIIHERA and chemotherapy for patients with first-line HER2+ GEA.

Our Amgen in-licensed portfolio also delivered $157 million in revenue, growing 25% year over year.

[CLICK to SLIDE 19]

Next, I'd like to highlight the broad-based nature of our growth across geographies.

The U.S. remained our largest market, contributing approximately $899 million in revenue during the quarter and growing 31% year-over-year.

China contributed approximately $500 million in revenue and grew 17% year-over-year, demonstrating continued strength across our commercial portfolio while maintaining market leadership for both TEVIMBRA and BRUKINSA. Note that foreign exchange contributed 7% of reported growth given year-over-year renminbi strengthening.

Europe continues to be an important growth driver for the company, generating approximately $208 million in revenue and growing 37% year-over-year.

We also continue to see strong momentum across our rest-of-world markets, where revenue more than doubled to approximately $73 million. Key markets such as Japan and Brazil are making contributions that are increasingly meaningful at the enterprise level.

[CLICK to SLIDE 20]

Turning to the GAAP P&L.

Gross profit was $1.5 billion with gross margin of just under 90%, benefiting from mix, as well as productivity improvements for both BRUKINSA and TEVIMBRA.

Operating expenses totaled $1.2 billion, representing 13% growth, reflecting advancement of key clinical programs, and continued investment to support commercial growth.

We continue to demonstrate the scalability of our model in the quarter with income from operations growing to $325 million.

And finally, net income totaled $237 million. This includes the previously disclosed tax audit settlement which had an approximate $60 million impact.

GAAP diluted earnings per ADS were $2.05, compared with $0.84 in the prior-year period.

[CLICK to SLIDE 21]

Now turning to our adjusted results with a full reconciliation provided in the appendix of our results presentation.

Adjusted income from operations increased to $503 million, representing growth of more than 80% year-over-year.

Adjusted net income increased to $444 million, while adjusted diluted earnings per ADS increased to $3.84, compared with $2.25 a year ago.

Cash generation continues to build momentum with free cash flow doubling from the prior-year period to $435 million.

[CLICK to SLIDE 22]

Turning to our updated full-year outlook which reflects the strong first-half performance and confidence in the trajectory of the business.

We are raising our revenue outlook by $300 million to a range of $6.6 to $6.8 billion. This increase reflects the continued strength we are seeing across the portfolio, led by BRUKINSA's performance in the U.S., ongoing global expansion, and continued contributions from the broader commercial portfolio.

We continue to expect gross margin to remain in the high-80% range.

We are investing in both commercial execution and pipeline advancement with a modest increase in operating expenses to an updated range of $4.8 to $5.0 billion.

Including those investments, the strength of the business translates to the bottom line with a guidance raise in 2026 operating income by $250M across the range.

We now expect GAAP operating income of $1.0 billion to $1.1 billion and non-GAAP operating income of $1.7 billion to $1.8 billion.

Other underlying assumptions remain unchanged.

Overall, this updated outlook reflects the strong performance we've delivered year-to-date and our confidence in continued execution for the remainder of the year.

As we have now rounded the first half of the year and while staying away from providing detailed guidance, I would like to provide some perspectives as you update your models and begin thinking beyond this year.

Our 2026 outlook provides confidence in the durability of our commercial business, including the prospects for continued BRUKINSA growth despite the competitive environment.

And, as you see in our implied operating expense guidance for the second half of the year, we are investing to realize the full potential of our pipeline that we believe will drive sustainable, long-term value for shareholders and the potential to address multiple unmet needs for patients.

We remain committed to our dual objectives of growth with measured margin expansion in the near-term.

Operating expenses will continue to be prioritized against our high hurdle rates but can be expected to grow at a year-over-year rate in 2027 similar to what has been seen over the recent two years given the positive progression of key pipeline assets.

We look forward to providing our next financial update in November with Q3 results.

And with that, I'll now pass the presentation over to Lai.

Lai Wang, President, Global Head of R&D

[CLICK to SLIDE 23]

Thank you, Aaron

Hello everyone, thank you for joining us today.

[CLICK to SLIDE 24]

Across our portfolio, we continue to deliver meaningful progress.

Starting with hematology, John already highlighted the positive readout from the MANGROVE study in treatment-naïve mantle cell lymphoma. BRUKINSA plus rituximab has the potential to redefine frontline treatment and become the first chemotherapy-free regimen for these patients.

For BEQALZI, we achieved our first FDA approval in relapsed/refractory mantle cell lymphoma.

Moving onto the CELESTIAL-301 study update, the zanu-sonro regimen did not reach statistical superiority in the uMRD analysis versus the VO regimen. The IDMC recommended the study continue toward its primary regulatory endpoint of progression-free survival. While the uMRD comparison was an interesting scientific question, uMRD superiority represented a very high bar given the historical high uMRD rates associated with VO regimen. Importantly, uMRD rates do not consistently predict PFS outcomes when comparing different MOAs, such as BTK inhibitor vs anti-CD20 antibody. For example, in CLL17, despite 26% lower uMRD rates than VO, the ibrutinib-venetoclax

regimen demonstrated comparable PFS outcomes as VO. As a result, if a BTK inhibitor plus BCL2 inhibitor combination achieves similar uMRD rates as VO, it should translate into better PFS than VO. Given the high uMRD rates and exceptional durability observed with the zanu-sonro regimen in Study 101, we remain highly confident in achieving the PFS endpoint.

Next, our BTK degrader, tacabrutideg, continues to advance through potentially registrational Phase 2 studies, while our Phase 3 CaDAnCe-304 trial against pirto remains on track. Together, these programs support our ambition to lead the next generation of therapy in B-cell malignancies.

In solid tumors, TEVIMBRA reached another important milestone with FDA acceptance and Priority Review of our HER2-positive GEA application. We also made regulatory progress in China, with the CDE accepting submissions for both TEVIMBRA and ZIIHERA.

Beyond TEVIMBRA, we continue to advance a diversified and increasingly innovative pipeline.

Our CDK4 inhibitor has begun Phase 3 development in breast cancer. Our GPC3×4-1BB bispecific recently completed enrollment in a potentially China registration-enabling HCC cohort. We also remain on track to initiate a Phase 3 study in second-line HCC before year-end.

In addition, our PRMT5 inhibitor received FDA Orphan Drug Designation for pancreatic cancer, and we initiated clinical development of our PD-1×VEGF×CTLA-4 trispecific.

[CLICK to SLIDE 25]

The milestones from the last quarter are a reflection of more than strong execution. They demonstrate the power of a focused R&D strategy.

We concentrate our investments in disease areas where we can establish

leadership, building disease franchises rather than standalone products. Supporting that strategy is a growing technology toolkit, from degraders and novel-payload ADCs to cell therapies and T-cell engagers.

Because we are not tied to any single modality, we can pair the right biology with the right therapeutic approach. The result is a pipeline designed not just to be broad, but to be sustainable.

As our innovation engine matures, we are creating depth within each priority disease area, with multiple assets and mechanisms working together. That depth opens the door to proprietary combinations from within our own portfolio, driving differentiation and maximizing the value of our innovation investments.

[CLICK to SLIDE 26]

As we discussed on the previous slide, our innovation engine is generating a growing number of high-quality opportunities across the portfolio.

Historically, our solid tumor pipeline was heavily weighted toward immuno-oncology. The CDK4 inhibitor marked the beginning of a new chapter, one defined by more diversified mechanisms, broader modalities, and a sharper focus on specific tumor types.

Today, that evolution is clearly visible. We now have five solid tumor programs that have achieved clinical proof of concept and are advancing toward pivotal development. Remarkably, each is on track to progress from first-in-human studies to pivotal-stage in approximately two and a half years.

Our CDK4 inhibitor is already enrolling in Phase 3. The B7-H4 ADC is expected to enter a pivotal study in ovarian cancer by year end. For GPC3×4-1BB, we completed enrollment of the China registration-intent expansion cohort with approximately 100 patients in just two and a half months — you heard it right, it's only two and half months — underscoring our ability to execute at an

exceptional speed. Based on this momentum, we also expect to initiate a Phase 3 study in second-line HCC by year end.

In parallel, our CEA ADC and PRMT5 inhibitor have achieved proof of concept and are advancing toward registration-enabling development.

Taken together, these programs demonstrate a repeatable model built on differentiated science, disciplined portfolio strategy, and strong clinical execution. As multiple internally discovered assets advance into late-stage development, we are creating a growing number of value inflection points.

[CLICK to SLIDE 27]

Now let's take a closer look at some of the assets we highlighted at ASCO. Starting with our CDK4 inhibitor, the data continue to be highly encouraging and are consistent with our scientific hypothesis. At ASCO, we reported a potentially best-in-class profile, combining promising efficacy with differentiated hematologic safety.

At the Phase 3 dose, BGB-43395 achieved an objective response rate of around 70% in combination with letrozole in first-line HR-positive, HER2-negative metastatic breast cancer.

Safety remains a key point of differentiation. At 400 mg, the overall neutropenia rate was just 21%, with no Grade 3 or higher events. This compares favorably with both atirmociclib and approved CDK4/6 inhibitors, where severe neutropenia remains a meaningful clinical challenge.

Together, these findings provide strong support for our ongoing Phase 3 program, which is enrolling rapidly. They also create opportunities for novel combinations across our portfolio, including with our CDK2 degrader, BCL2 inhibitor, and KAT6 inhibitor.

[CLICK to SLIDE 28]

Turning to our GPC3 × 4-1BB program, BGB-B2033 continues to demonstrate what could be a breakthrough profile in HCC, combining strong monotherapy activity with a highly favorable safety profile.

At ASCO, we reported an objective response rate of over 30% in second line plus HCC, comparable to current first-line combination regimens and well above what has been reported with available TKIs in the post-IO setting.

Safety remains a key differentiator, enabled by our unique 4-1BB approach. This profile supports development in earlier lines, where approximately 70 patients have already been enrolled in combination with Tevimbra and bevacizumab.

Development momentum also remains strong. We completed enrollment in a potentially China registration-enabling expansion cohort in post-IO, post-TKI HCC. In parallel, we are engaging with global regulatory authorities to explore accelerated approval pathways in second line plus HCC based on the compelling efficacy and the safety profile observed to date.

[CLICK to SLIDE 29]

Turning to our B7-H4 ADC, BG-C9074. At ASCO, we presented data that supports its potential to become a leading program in ovarian cancer.

The key differentiator is safety. At 6 mg/kg, treatment-related Grade 3 or higher adverse events were approximately 26%, less than half the rates reported for other ADCs in development for first-line ovarian cancer without biomarker selection. This profile is particularly attractive in the maintenance setting, where long-term tolerability is critical.

We also reported encouraging efficacy, including activity that appears independent of B7-H4 expression, supporting an all-comers development strategy.

Based on these data, we plan to initiate a Phase 3 study in first-line maintenance ovarian cancer before the end of 2026, while continuing to expand the opportunity to endometrial cancer and TNBC.

Taken together, C9074 combines competitive efficacy with potentially best-in-class tolerability, positioning it as a leading B7-H4 ADC.

[CLICK to SLIDE 30]

We are excited for ESMO, where we have 12 abstracts accepted, including one rapid oral presentation and nine posters.

Highlights include our GPC3 × 4-1BB bispecific phase 1 dose optimization data, the first disclosure of phase 1 proof-of-concept data for our PRMT5 inhibitor with a focus on non-small cell lung cancer and initial evidence of clinically meaningful brain activity, and initial proof-of-concept data for CEA-ADC that underscore its compelling first-in-class potential in non-small cell lung cancer.

Together, these presentations highlight the strength and breadth of our innovation engine.

[CLICK to SLIDE 31]

We've covered most of the milestones already. I'll just call out a few items on this slide.

We remain on track for a potential accelerated approval submission of taca in relapsed/refractory CLL by the end of this year, further expanding our CLL franchise in B-cell malignancies. In addition, we plan to start taca/sonro fix duration combination phase 3 development in relapsed/refractory CLL in 2027.

In solid tumors, we expect to initiate pivotal studies for both our GPC3 × 4-1BB bispecific in second-line plus HCC and our B7-H4 ADC in first-line maintenance ovarian cancer before year-end. Looking further ahead, both our PRMT5 inhibitor and CEA ADC are positioned to enter Phase 3 development in 2027.

I will now turn it back to John.

John V. Oyler, Co-Founder, Chairman and CEO

Thanks so much, Lai.

And we'll now open the call to Q&A.

Q&A

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