CORPORATE PRESENTATION

# Aiming to transform the standard of care for hypertrophic cardiomyopathy and related conditions.

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## BHB-1893

Next-generation oral cardiac myosin inhibitor in Phase 3 development

## Two indications

Obstructive HCM (oHCM) and non-obstructive HCM (nHCM)

## Compelling Phase 2 data across efficacy, safety, and ease of use

September 2026

# Disclaimer: Forward Looking Statements

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Highlights

# Braveheart is developing a differentiated CMI for hypertrophic cardiomyopathy patients

## *BHB-1893 is being developed as a next generation CMI*

### Validated mechanism, differentiated profile

Cardiac myosin inhibition is clinically and commercially validated with 2 approved CMIs

BHB-1893 is engineered for rapid onset, predictable PK, and a shallow LVEF dose-response curve

### Compelling Phase 2 oHCM & nHCM data

oHCM: 86% complete gradient response in Phase 2; corroborated in ongoing OLE (n=42)

nHCM Phase 2 data suggested greater improvements in diastolic function, biomarkers, clinical endpoints at early time point (12 weeks)

### Wide therapeutic index

Low rate of LVEF events, with early data suggesting differentiated efficacy

Consistent PK, with balanced hepatic and renal clearance; no major DDIs identified

### Ease of use

89% of BID patients managed on 40 or 60 mg in Phase 2 oHCM study

Supports potential for a simplified, low-monitoring dose regimen

### Two large, underserved indications

oHCM and nHCM represent ~700K–960K U.S. patients with significant unmet need

No approved therapy exists for nHCM

### Strong financial position

Well-capitalized following IPO to execute global Phase 3 studies in oHCM and nHCM

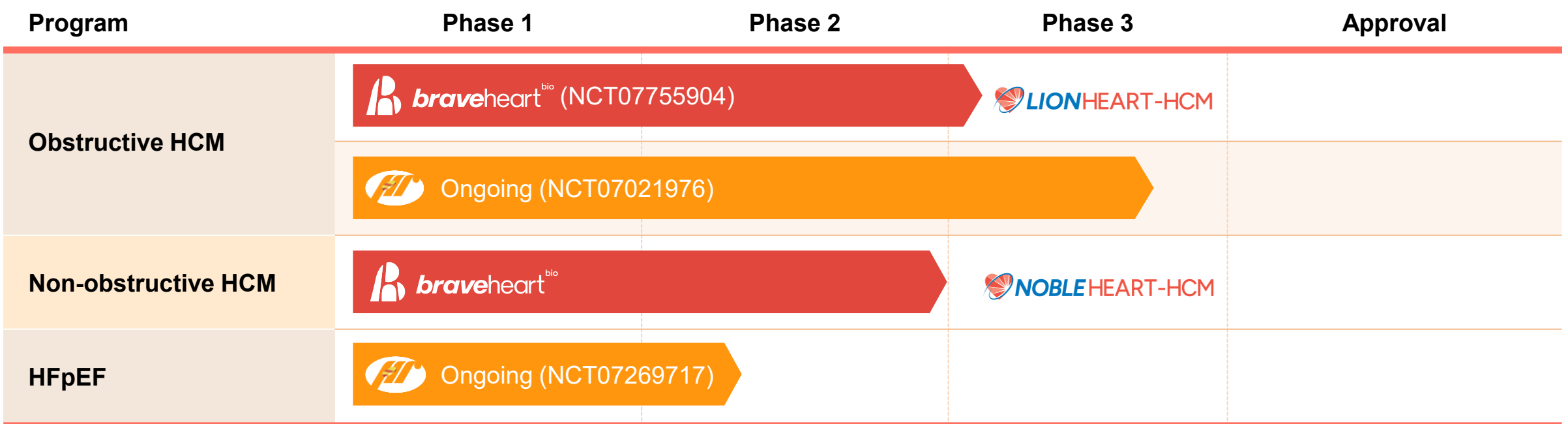
Experienced leadership team with history of public-company entry and strategic exits

*OLE: open-label extension; PK: pharmacokinetic; DDI: drug-drug interaction.*

# Planned global Phase 3 development in both oHCM and nHCM

***oHCM Phase 3 trial initiation underway (open IND); nHCM Phase 3 study startup underway (open IND)***

- *BRVE oHCM Phase 3 trial – planned H2H design against beta-blocker with minimal or no BHB-1893 dose titration*
- *Hengrui ongoing oHCM Phase 3 trial – HRS-1893 on top of SoC in China*




*IND: Investigational New Drug; H2H: Head-to-head; SoC: Standard of care.*

# Over 300 subjects dosed with BHB-1893 to date

| | Population | Status | Description |
|---|---|---|---|
| **Phase 3** | | | |
| NCT07021976 | oHCM | Ongoing | Randomized, double-blind, placebo-controlled |
| **Phase 2** | | | |
| NCT06516068 | oHCM | **Completed** | Randomized, multi-cohort |
| NCT06816251 | nHCM | **Completed** | Randomized, double-blind, placebo-controlled |
| NCT07021963 | HCM | Ongoing | Long-term extension |
| NCT07269717 | HFpEF | Ongoing | Randomized, double-blind, placebo-controlled |
| **Phase 1** | | | |
| NCT07033455 | HVs | **Completed** | Ethnic PK study |
| NCT06775834 | Impaired renal function | **Completed** | Renal impairment safety, PK |
| NCT06354556 | HVs | **Completed** | Verapamil DDI Study |
| NCT05879523 | HVs & oHCM | **Completed** | HVs and oHCM patients |
| NCT07272330 | HVs | Ongoing | Bioavailability and food effect |

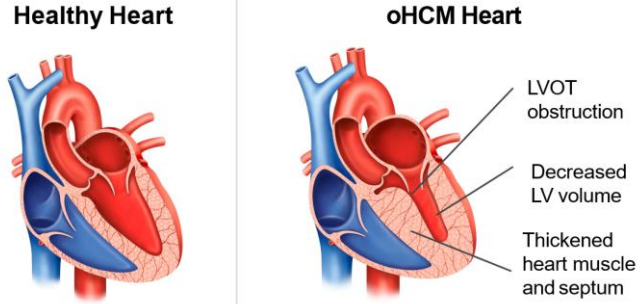
*Source: ClinicalTrials.gov and internal data on file as of June 9, 2026. All listed trials initiated by Hengrui, our partner in Greater China.*

# HCM disease overview

The Problem

# HCM is the most common inherited cardiac disease with significant unmet medical need

*A serious, lifelong condition with limited and burdensome treatment options*




## What is HCM?

Hypertrophic cardiomyopathy (HCM) is a chronic, progressive cardiac disease characterized by abnormal thickening of the heart muscle.

**Two principal forms:**

**Obstructive HCM (oHCM):** blood flow is obstructed at the left ventricular outflow tract

**Non-obstructive HCM (nHCM):** impaired diastolic filling and elevated cardiac biomarkers without obstruction

Symptoms include shortness of breath, chest pain, exertional fatigue, and syncope. HCM is also associated with significant risk of:

**Atrial fibrillation, heart failure, stroke, and sudden cardiac death**

## Patient burden in the U.S.

| | |
|---|---|
| **~700K–960K** | ***U.S. patients estimated to have HCM*** |
| **~1 in 345** | ***Prevalence in the general population*** |
| **~38%** | ***Annual hospitalization rate*** |
| **Lifelong** | ***Chronic disease requiring ongoing therapy*** |

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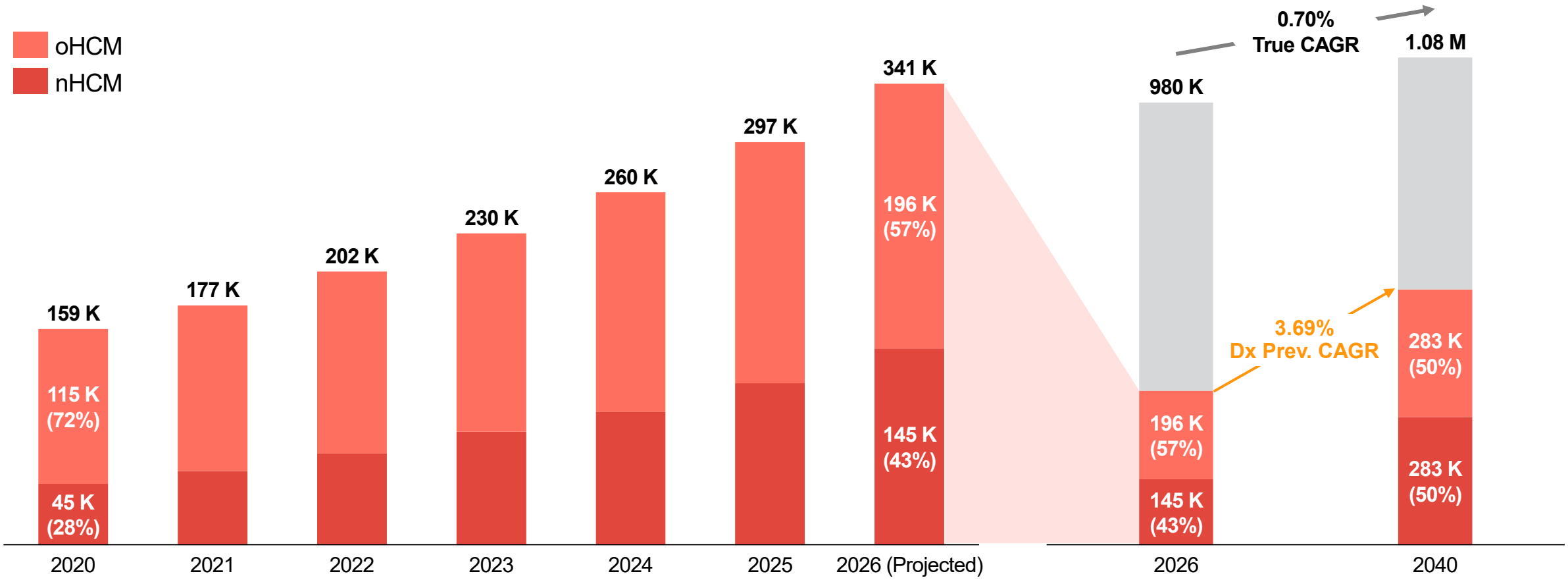
*Source: Jain et al. J Med Economics. 2021; Pelliccia et al. Intl J Cardiol. 2017; UpToDate; ClearView Analysis.*
*LV: left ventricle; LVOT: left ventricular outflow tract.*

# True U.S. HCM prevalence is expected to reach ~1.1 M patients with an approximate 50/50 split of oHCM vs. nHCM

## U.S. HCM Diagnosed Prevalence[1]

## Projected U.S. HCM True Prevalence

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[1] *Using Forian claims data. nHCM: Non-Obstructive Hypertrophic Cardiomyopathy. CAGR: Compound Annual Growth Rate. Source: Maron. AI Am Coll Cardiol. 1999; Forian Claims; ClearView Analysis.*

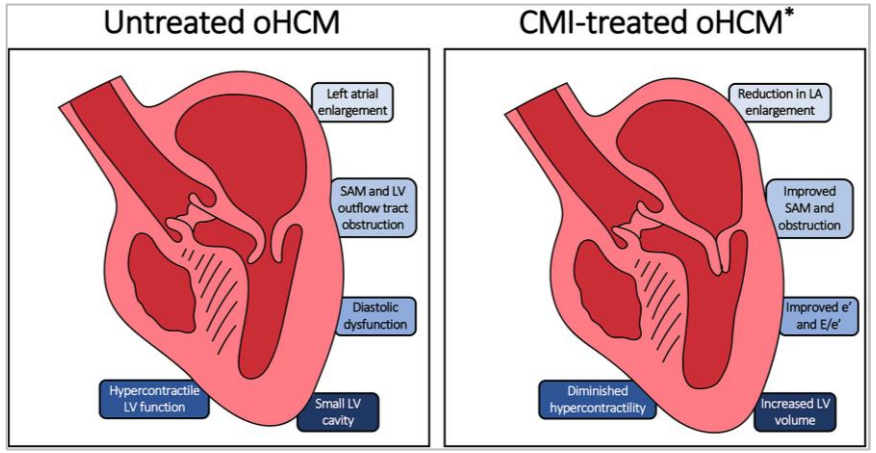
# CMIs transformed oHCM care, but safety, monitoring, and efficacy gaps leave significant unmet medical need

## What CMIs delivered

- First disease-targeted class in HCM, inhibiting cardiac myosin to reduce actin-myosin cross-bridge formation
- Meaningful LVOT-G reduction, with complete gradient response in ~50% to 60% of oHCM patients in Phase 3 trials
- Improved exercise capacity (pVO2) and health status (KCCQ-CSS, NYHA class)
- Validated the mechanism and establishing the oHCM market

## Where limitations remain

- No FDA- or EMA-approved therapy for nHCM
- Systolic dysfunction (LVEF below 50%) is a mechanism-based class effect
- “LVEF cost” caps benefit, leaving many patients short of target gradient
- Long half-life drives slow onset and a multi-week reversibility gap
- REMS-mandated serial echocardiograms and multi-step titration, 4 to 12 weeks to target dose




*Adapted from JACC Heart Failure 2023;11(7):735–748. SAM, systolic anterior motion.*

***These limitations define the opportunity for a next-generation CMI.***

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Source: Company prospectus and cited Phase 3 trials.

Comparison of CMI Echocardiogram Schedules

# Approved CMIs have required complex titration

| Ending dose[1] | SV | D1 | W2 | W4 | W6 | W8 | W12 | W16 | W20 | W24 | # echos[2] / min. weeks |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **CAMZYOS™ (mavacamten) 2.5, 5, 10, 15mg capsules** | | | | | | | | | | | |
| 5 mg (49%)[3] | ▲ | ▲ | | ▲ | | ▲ | ▲ | | | | **5 / 12** |
| 10 mg (33%) | ▲ | ▲ | | ▲ | | ▲ | ▲ | ▲ | | ▲ | **7 / 24** |
| **MYQORZO™ (aficamten) 5·10·15·20mg tablets** | | | | | | | | | | | |
| 15 mg (35–40%)[3] | ▲ | ▲ | ▲ | ▲ | ▲ | | | | | | **5 / 6** |
| 20 mg (36–49%) | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ | | | | | **6 / 8** |

*Note: Estimated titration timing assumes echocardiograms are performed as early as possible and that no down-titration is required. Triangles represent scheduled echocardiograms.*
*SV = screening visit to confirm drug eligibility; D1 = patient enrollment*

[1] *Ending dose (% in Phase 3 trials) – EXPLORER, SEQUOIA, MAPLE.*
[2] *Number includes eligibility echocardiogram and patient enrollment form.*
[3] *Patients are initiated at 5mg.*

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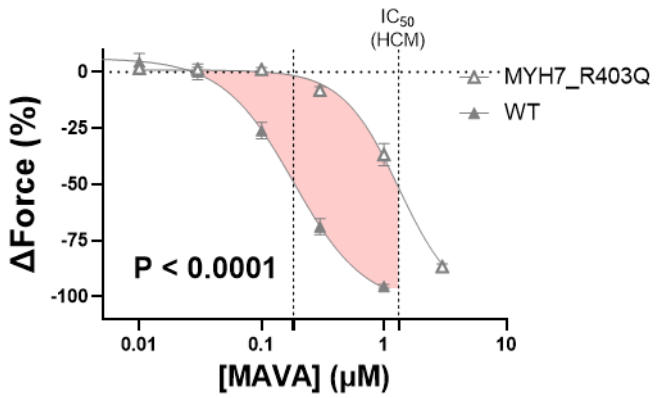
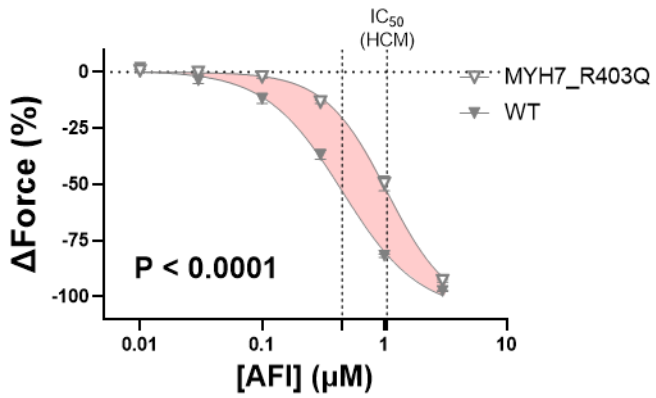
# Preclinical engineered heart tissue experiment suggests potential for mechanistic differentiation compared to other CMIs

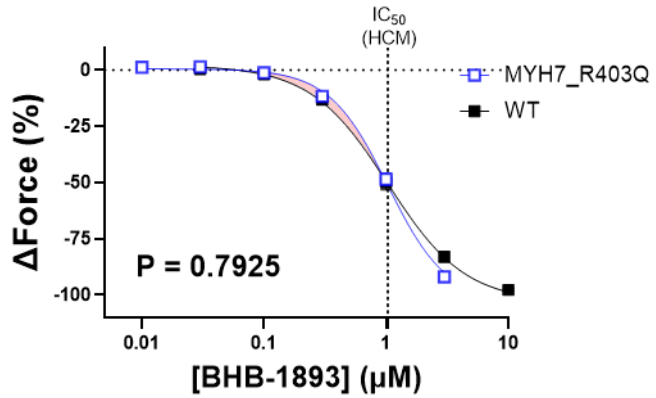
**a) mavacamten**




**b) aficamten**




**c) BHB-1893**




**We believe this finding is consistent with the observed minimal variability in BHB-1893 exposure/LVEF relationship observed in clinical trials and further support BHB-1893's potentially distinct pharmacology from the first-generation CMIs.**

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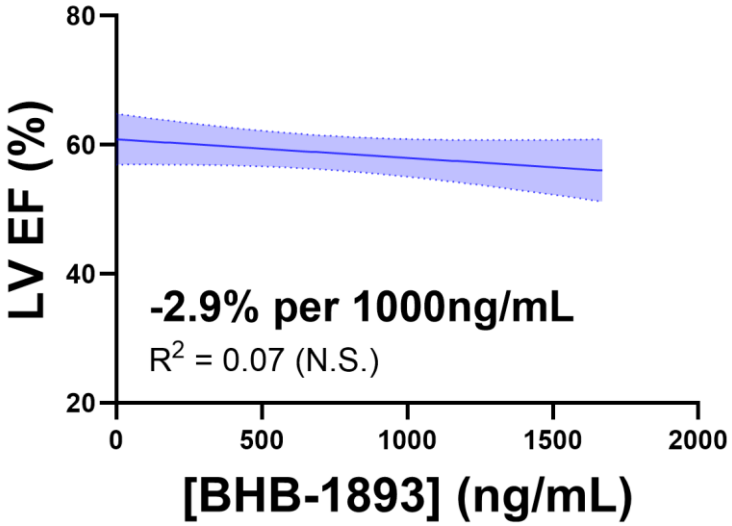
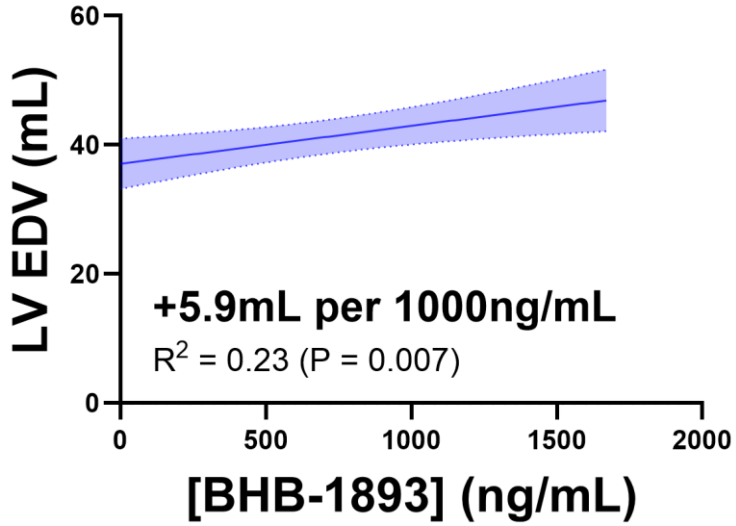
*Note: Data presented as mean ± SEM and non-linear line of best fit. Vertical dotted lines denote 50% inhibitory concentration ("IC50").*
*EHT: engineered heart tissue; WT: wild type EHT; MYH7-R403Q: HCM mutant EHT.*

# BHB-1893 observed to preserve LVEF with increased LV end-diastolic volumes, while slowing early contraction velocity




**Exposure-dependent LVEF change of −2.9% per 1,000 ng/mL**

**For a corresponding +18.1% mean increase in LVEDV**

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*Note: Represents linear regression and 95% confidence interval.*
*LVEF: Left ventricular ejection fraction; LVEDV: Left ventricular end-diastolic volume.*

# BHB-1893: a differentiated profile supported by oHCM and nHCM in Phase 2 trials

## Improved cardiac performance

**Deeper gradient reduction**: more patients achieved normal gradient compared to first gen CMIs in oHCM, with wide therapeutic index[1]

**Improved diastolic relaxation**: demonstrated ability to improve diastolic function across HCM populations

## Favorable safety & DDI profile

**Shallow LVEF/dose-response curve:** observed to enable target efficacy without clinically-meaningful LVEF 'cost'

**Predictable PK across populations**: confirmed multi-pathway metabolism without significant DDIs

## Rapid onset, minimal titration

**Short effective half-life**: demonstrated rapid onset of action and rapid reversibility

**Simplified dosing paradigm**: enabled most patients to be well served on starting dose, minimizing potential titration & echos

**Differentiated emerging clinical profile as Braveheart Bio prepares to advance into global Phase 3 trials**

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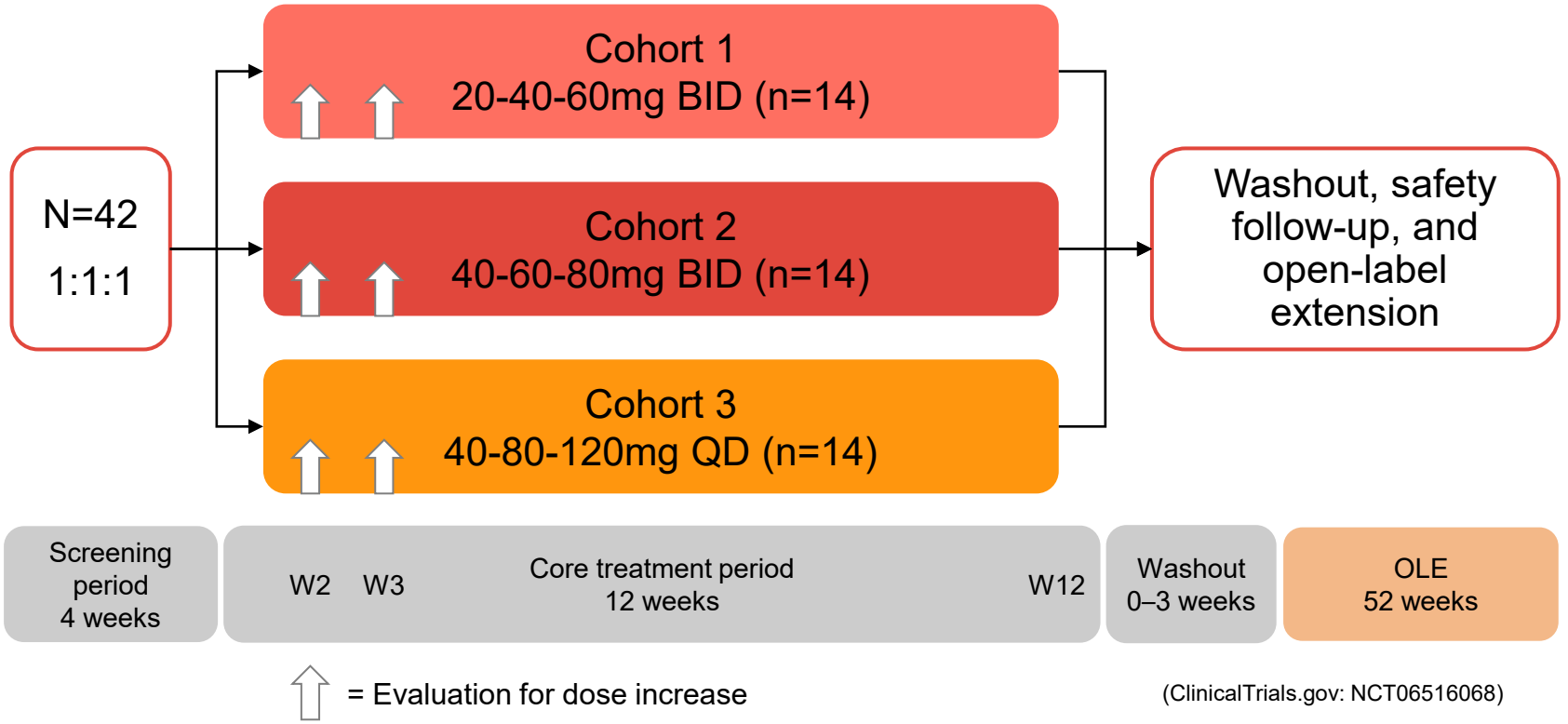
*[1] Note: Certain data in this presentation are based on cross-trial comparison. We have not conducted, and do not intend to conduct any head-to-head clinical trials. Cross-trial comparisons are inherently limited and may suggest misleading similarities or differences in outcome.*

# Obstructive HCM (oHCM)

# Robust dose-ranging across 3 regimens, ongoing OLE using Cohort 2 dosing

Adult patients with symptomatic oHCM who had resting LVOT-G ≥50 mmHg (or resting LVOT-G ≥30 mmHg and Valsalva LVOT-G ≥50 mmHg), LVEF ≥60%, and NYHA Class II-III were enrolled. **Option for dose titration** to occur weekly **if Valsalva LVOT-G > 30 mmHg** and LVEF > 55%

## Design




(ClinicalTrials.gov: NCT06516068)

## Key Endpoints

**Primary Endpoint**

- Change in Valsalva LVOT gradient, baseline to W12

**Key Secondary Endpoints**

Change from baseline in:

- Peak oxygen uptake (pVO2)
- KCCQ-CSS
- Resting LVOT-G
- NT-proBNP

Proportion with NYHA class improvement of ≥1

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*oHCM: obstructive hypertrophic cardiomyopathy; LVOT-G: left ventricular outflow tract gradient; LVEF: left ventricular ejection fraction; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire-Clinical Summary Score; NYHA: New York Heart Association; BID: twice daily; QD: once daily; OLE: open-label extension. Phase 2 study was sponsored by Hengrui in China.*

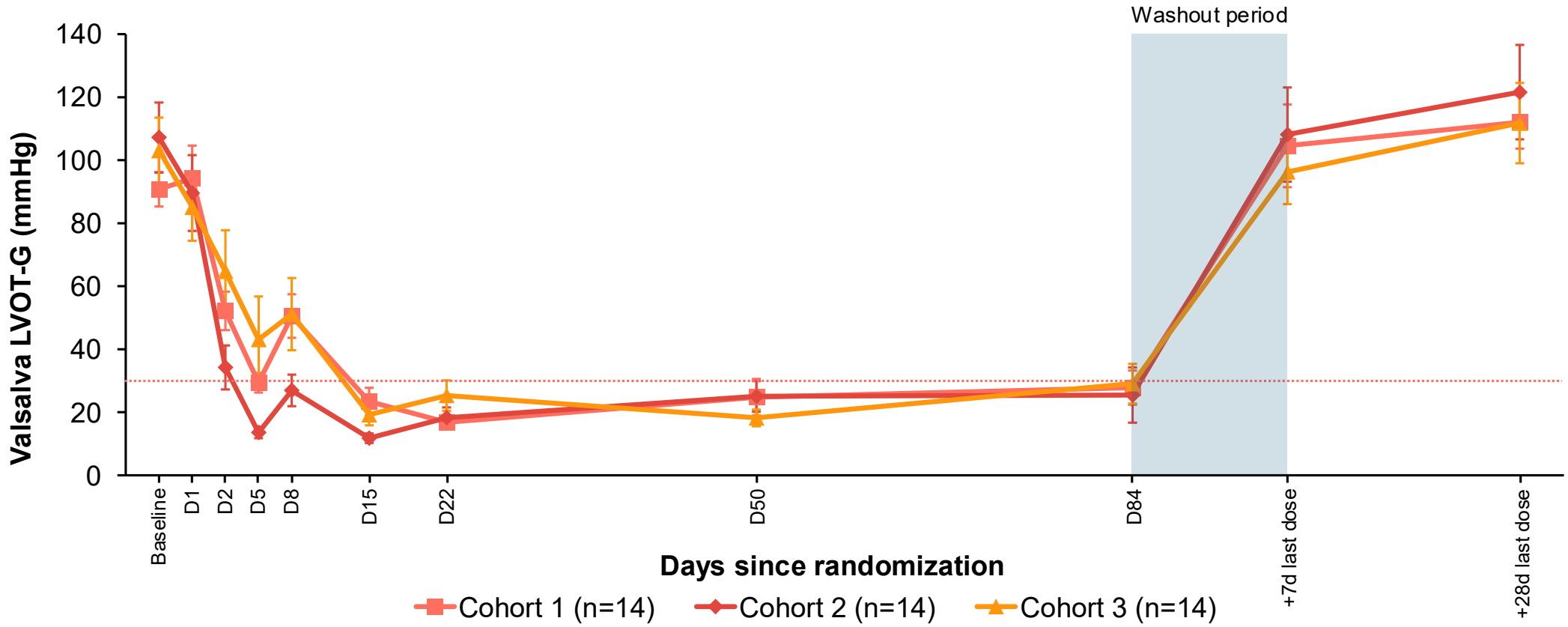
# Baseline characteristics

| | Cohort 1<br>20-40-60 BID<br>(N = 14) | Cohort 2<br>40-60-80 BID<br>(N = 14) | Cohort 3<br>40-80-120 QD<br>(N = 14) |
|---|---|---|---|
| **Age, years** | 48.4 (12.5) | 51.5 (10.4) | 54.8 (11.2) |
| **Male, n (%)** | 10 (71.4) | 9 (64.3) | 7 (50.0) |
| **Background therapy, n (%)** | | | |
| Beta blockers | 13 (92.9) | 12 (85.7) | 12 (85.7) |
| Calcium channel blockers | 0 (0.0) | 1 (7.1) | 1 (7.1) |
| **Valsalva LVOT-G, mmHg** | 90.8 (20.4) | 107.2 (41.7) | 103.1 (39.2) |
| **Resting LVOT-G, mmHg** | 69.2 (15.4) | 80.3 (33.4) | 67.9 (24.5) |
| **LVEF, %** | 71.0 (2.8) | 69.3 (3.5) | 69.2 (3.5) |
| **pVO2, mL/kg/min** | 19.3 (2.9) | 17.5 (3.2) | 18.4 (4.3) |
| **NYHA class, n (%)** | | | |
| Class II | 12 (85.7) | 14 (100.0) | 14 (100.0) |
| Class III | 2 (14.3) | 0 (0.0) | 0 (0.0) |
| **KCCQ-CSS** | 82.6 (13.3) | 86.0 (12.9) | 76.4 (13.2) |

*Data are shown as mean (standard deviation) unless otherwise specified.*
*LVOT-G: left ventricular outflow tract gradient; LVEF: left ventricular ejection fraction; pVO2: peak oxygen uptake; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire-Clinical Summary Score; NYHA: New York Heart Association.*

# Data demonstrated rapid and deep LVOT-G reductions through Week 12 at all doses, with rapid reversal following washout

## Valsalva LVOT-G values over time

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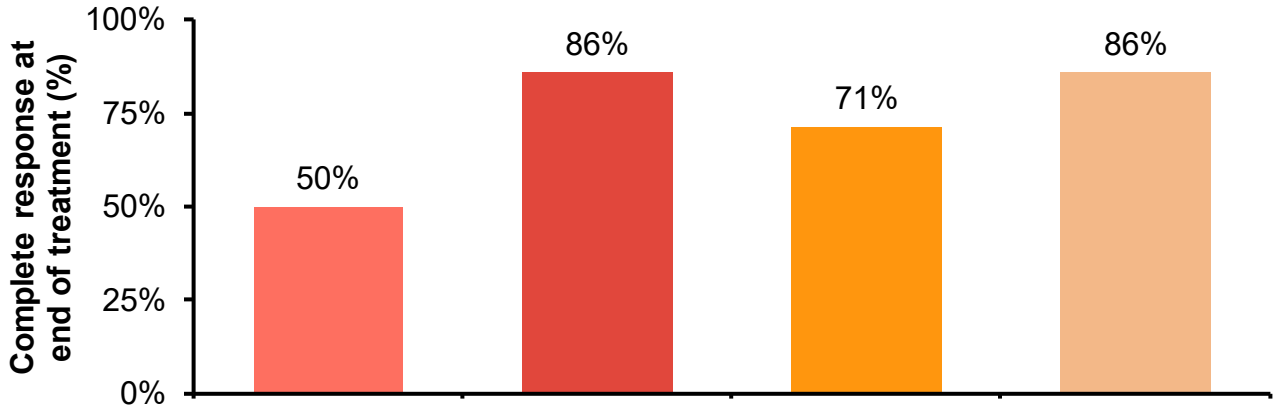
*Source: internal data on file; Data are presented as mean ± standard error. LVOT-G: left ventricular outflow tract gradient. Dotted line indicates significant LVOT obstruction: defined as a peak gradient 30 mmHg (rest or provoked).*

# 86% of patients in Cohort 2 achieved post-Valsalva LVOT-G <30 mmHg response




| | BHB-1893 | | | |
|---|---|---|---|---|
| | Cohort 1 (N=14) | Cohort 2 (N=14) | Cohort 3 (N=14) | OLE (N=42) |
| **Treatment duration (weeks)** | 12 | 12 | 12 | 28 |
| **Baseline Valsalva LVOT-G (mmHg)** | 90.8 (20.4) | 107.2 (41.7) | 103.1 (39.2) | 114.8 |
| **Valsalva LVOT-G <30mmHg** | **50% (7/14)** | **86% (12/14)** | **71% (10/14)** | **86% (36/42)** |

Cohort 1 (n=14) Cohort 2 (n=14) Cohort 3 (n=14) OLE (n=42)

**100% (42 of 42) patients in the 12-week core treatment rolled into the ongoing OLE study. At week 28 of OLE treatment period 86% had Valsalva LVOT-G < 30 mmHg.**

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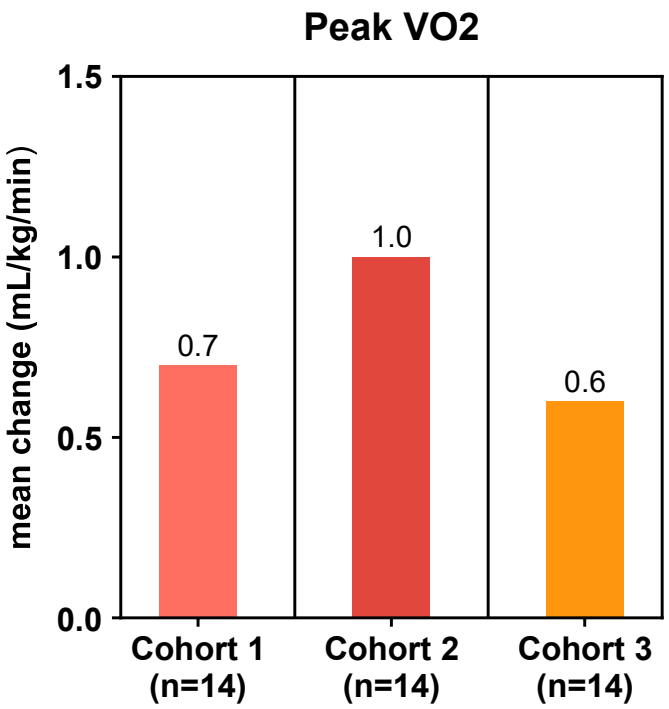
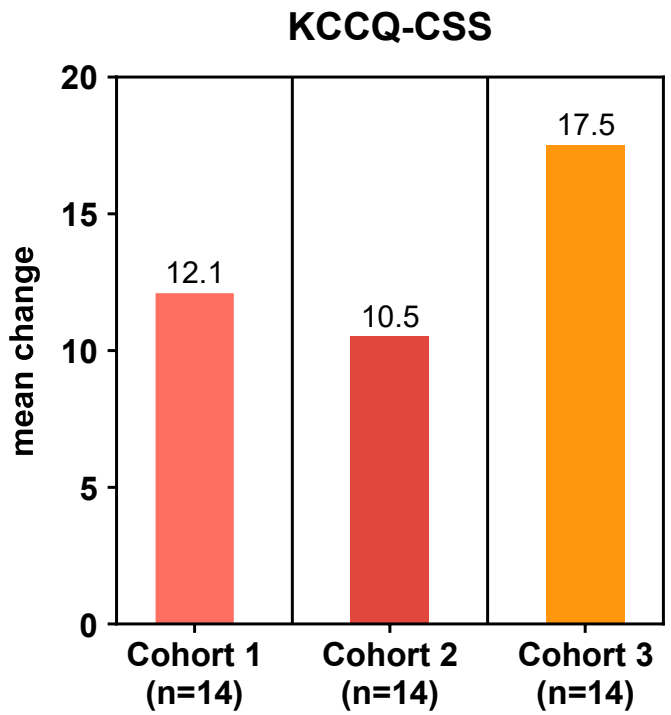
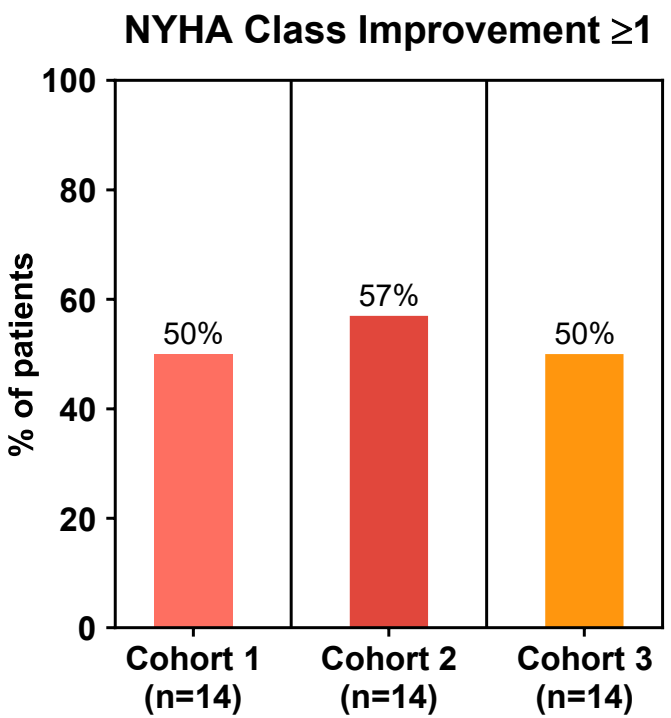
*Source: Internal data on file; ongoing OLE data cutoff as of October 24, 2025. LVOT-G: left ventricular outflow tract gradient.*

# Functional capacity and symptom improvement displayed across clinical endpoints

*12 week core treatment period*



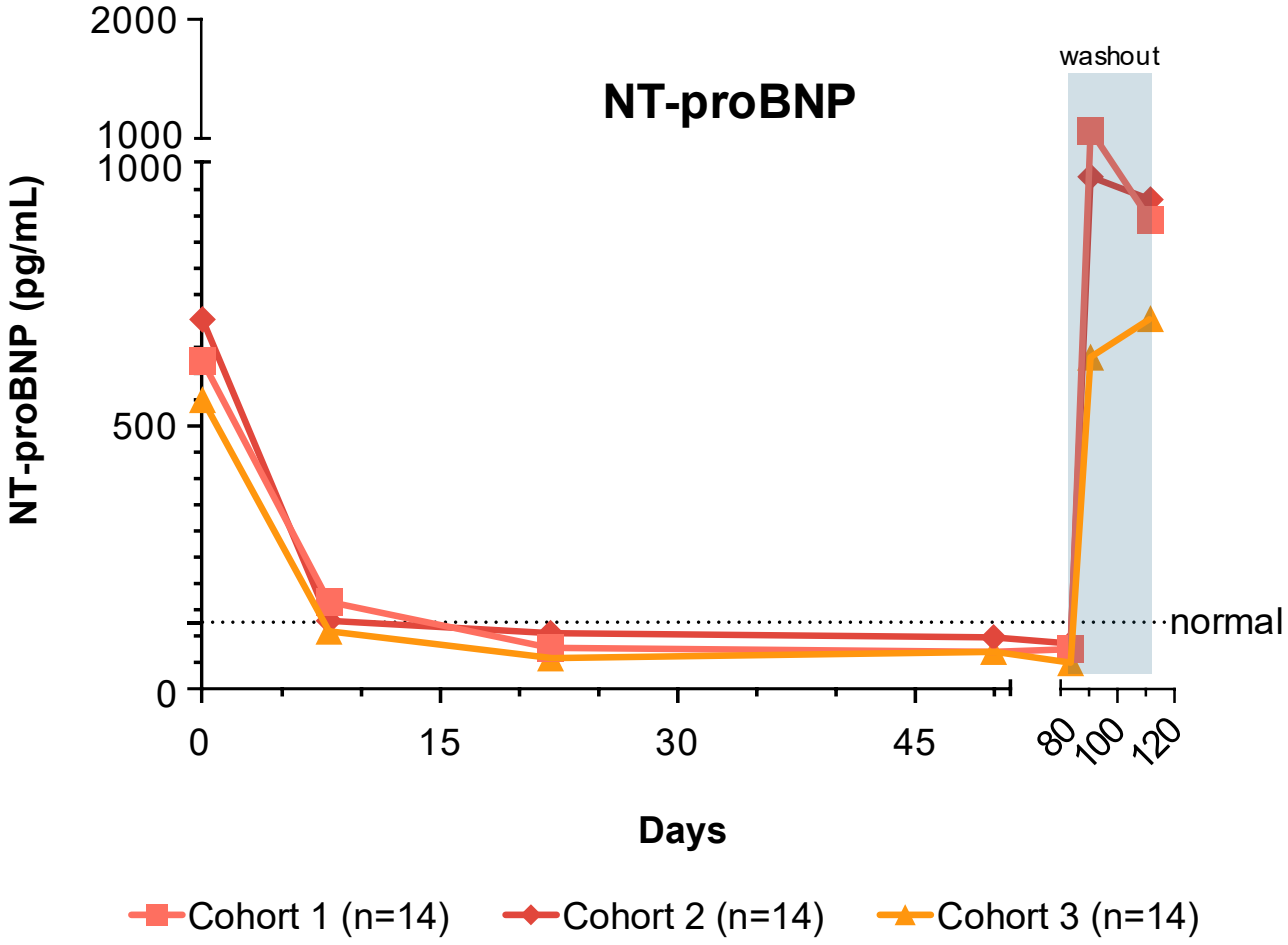




**100% cycle based CPET**

*Peak VO2: peak oxygen uptake; CPET: cardiopulmonary exercise test; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire-Clinical Summary Score; NYHA: New York Heart Association; NT-proBNP: N-terminal pro-B-type natriuretic peptide.*

# NT-proBNP, key biomarker of heart failure, rapidly normalized in >80% of patients




| NT-proBNP (pg/mL) | Cohort 1 | Cohort 2 | Cohort 3 |
|---|---|---|---|
| Baseline (Geometric Mean) | 622.8 | 701.9 | 549.2 |
| Post - Treatment (Geometric Mean) | 73.9 | 84.1 | 48.0 |
| Post - Treatment to Baseline Ratio (Geometric Mean) | 0.12 | 0.12 | 0.09 |

**>80%**

of patients achieved normal NT-proBNP levels

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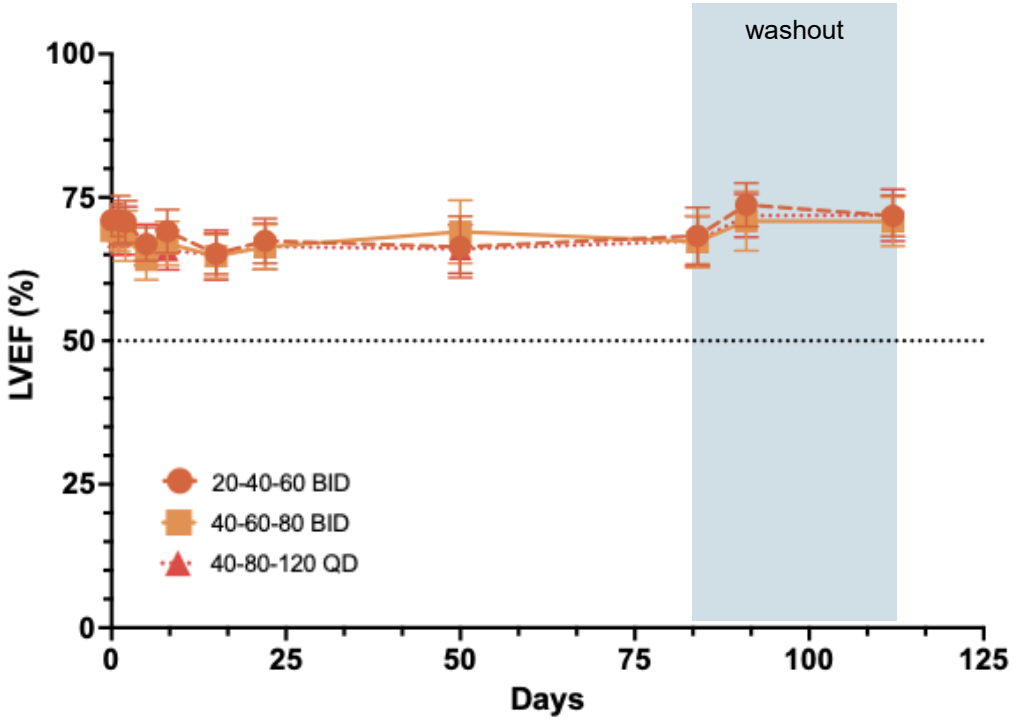
*Data are shown as geometric mean.*
*NT-proBNP: N-terminal pro-B-type natriuretic peptide.*

# BHB-1893 observed to drive deep and rapid reductions in LVOT-G with shallow reduction to LVEF

**0**
Dose reductions

**0**
LVEF events below 55%

| Dose (mg) Schedule | LVEF, change (D84) |
|---|---|
| Cohort 1<br>20-40-60 BID | -2.7% |
| Cohort 2<br>40-60-80 BID | -2.1% |
| Cohort 3<br>40-80-120 QD | -1.8% |




*Note: Data are shown as mean, SD.*
*LVEF: left ventricular ejection fraction.*

# BHB-1893 profile could enable a highly simplified titration regimen

Dose distribution at Week 12 BID Cohorts

| | 20 mg BID | 40 mg BID | 60 mg BID | 80 mg BID |
|---|---|---|---|---|
| **Cohort 1** 20-40-60 mg BID (n=14) | 2 | 8 | 4 | |
| **Cohort 2** 40-60-80 mg BID (n=14) | | 9 | 4 | 1 |

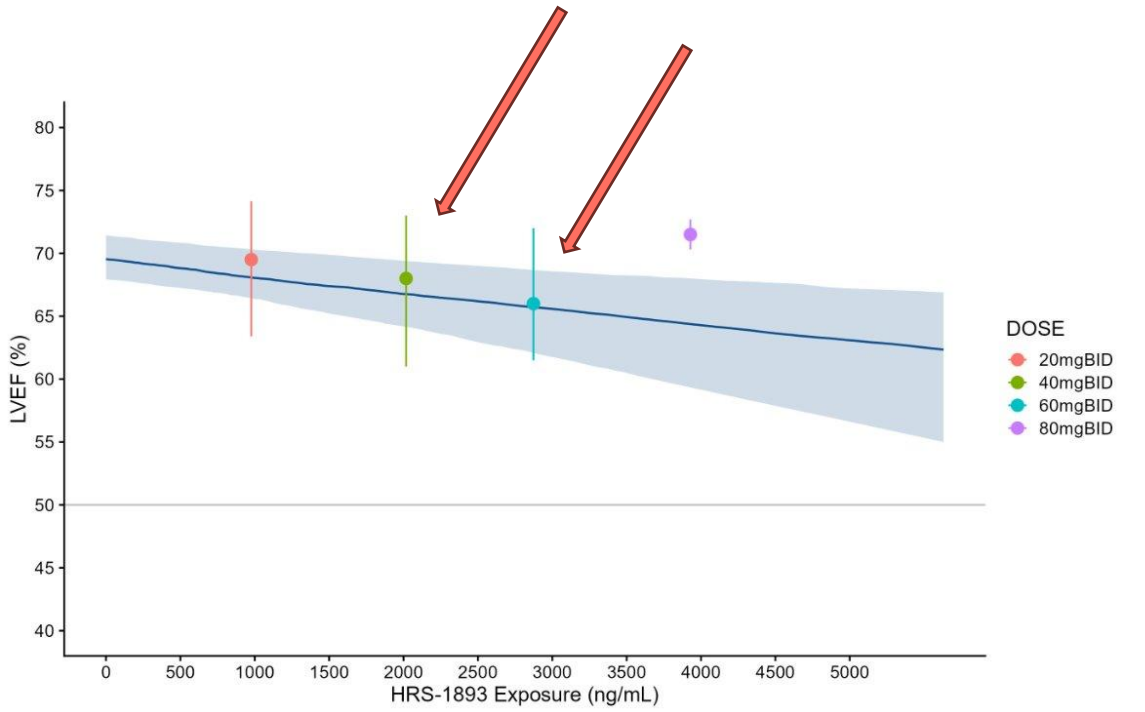
**89%**
of patients received 40 or 60 mg BID at last dose

**100%**
of doses selected by LVOT-G < 30 mmHg

# Shallow LVEF exposure response and deep LVOT-G reduction, suggesting low LVEF cost

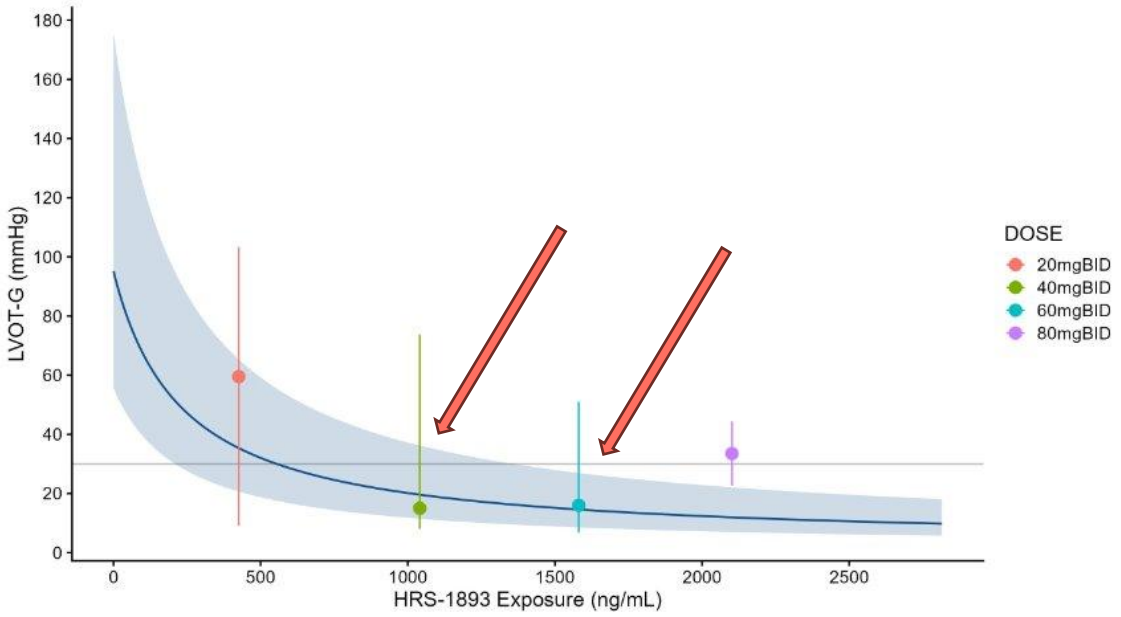
**Reduction in LVEF at Cmax exposures** modeled (Solid Blue Line) and measured average concentrations from Study 201 (Dots)

Arrows highlight 40 and 60 mg doses with predicted reduction of LVEF of 2.7% and 3.4%, absolute LVEF%




**Valsalva gradient relief at trough exposures** modeled (Solid Blue Line) and measured average concentrations from Study 201 (Dots)

Arrows highlight 40 and 60 mg doses with predicted Valsalva LVOTG reduction below 30 mmHg

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*Note: For the 80 mg BID group, there were only two observed values from one subject in Study 201.*

# Overview of adverse events

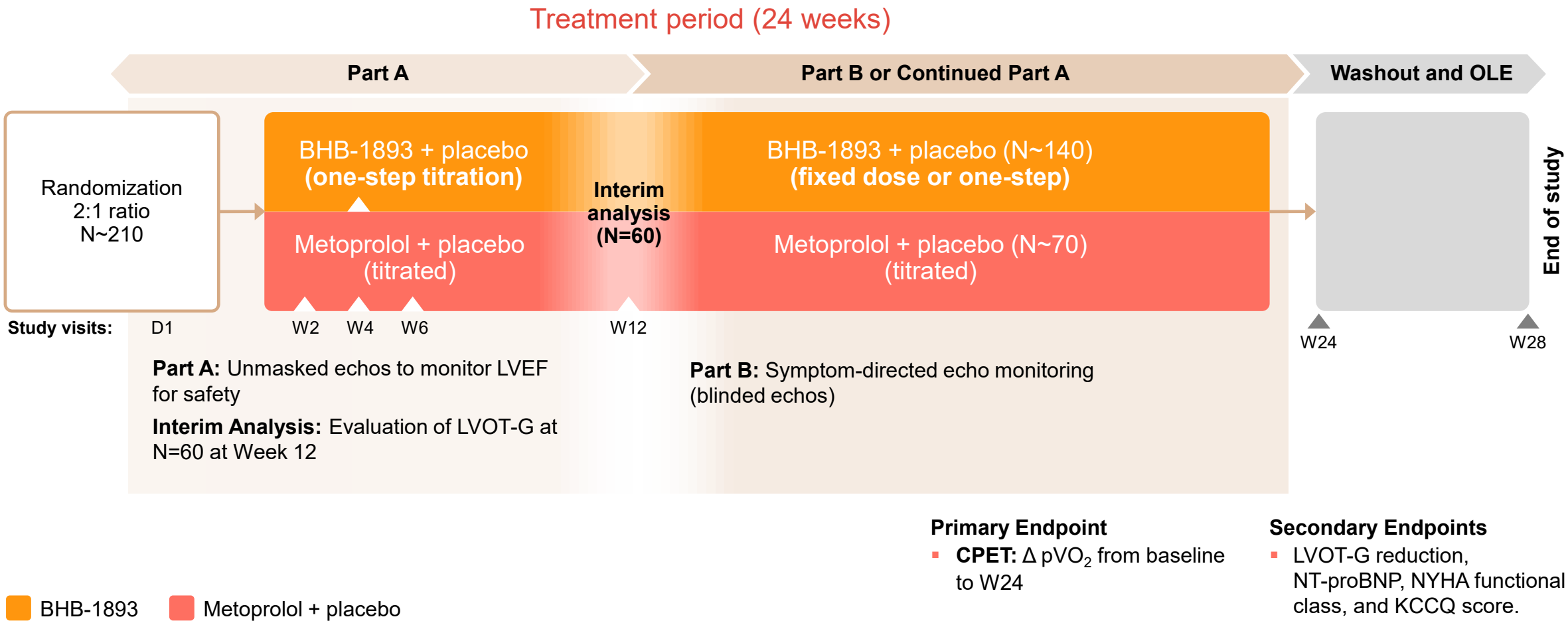
AEs were mild or moderate in severity.

There were no serious AEs or AEs leading to treatment interruption, discontinuation, or death.

| n (%) | Cohort 1 (N = 14) | Cohort 2 (N = 14) | Cohort 3 (N = 14) | Total (N = 42) |
|---|---|---|---|---|
| **Any TEAEs** | **12 (85.7)** | **10 (71.4)** | **14 (100)** | **36 ( 85.7)** |
| Mild | 11 (78.6) | 8 (57.1) | 14 (100) | 33 (78.6) |
| Moderate | 1 (7.1) | 2 (14.3) | 0 | 3 (7.1) |
| Severe | 0 | 0 | 0 | 0 |
| **Any TRAEs** | **3 (21.4)** | **3 (21.4)** | **8 (57.1)** | **14 (33.3)** |
| Mild | 3 (21.4) | 2 (14.3) | 8 (57.1) | 13 (31.0) |
| Moderate | 0 | 1 (7.1) | 0 | 1 (2.4) |
| Severe | 0 | 0 | 0 | 0 |

*AE: adverse event; TEAE: treatment-emergent adverse event; TRAE: treatment-related adverse event.*

# Proposed Phase 3 design aimed at simplifying dose titration complexity




**Primary Endpoint**

- **CPET:** Δ $pVO_2$ from baseline to W24

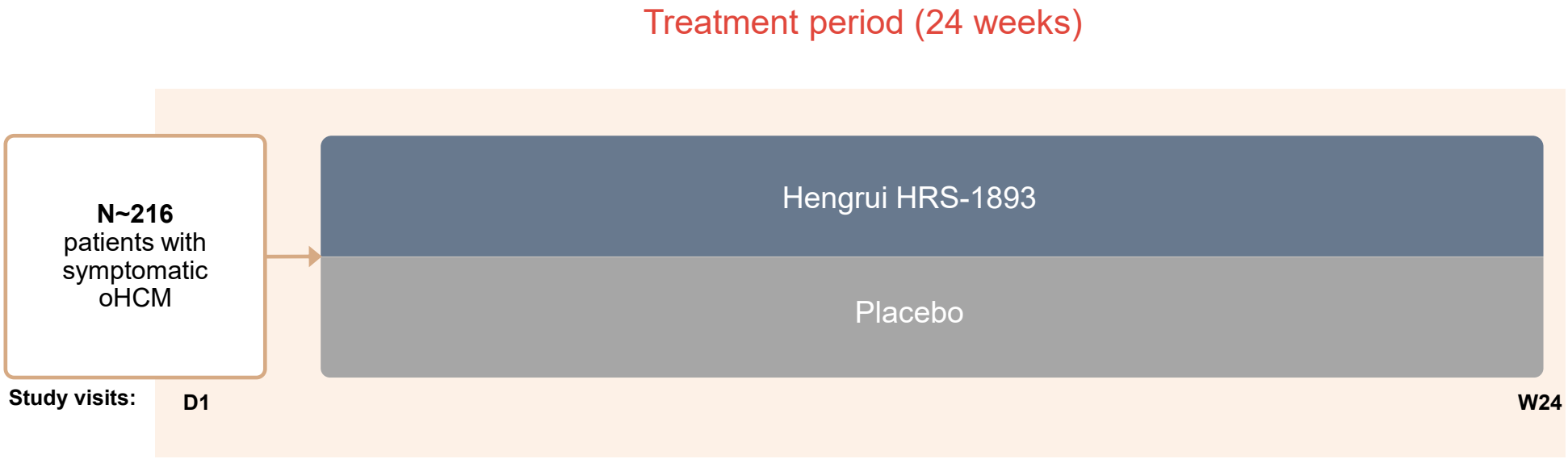
**Secondary Endpoints**

- LVOT-G reduction, NT-proBNP, NYHA functional class, and KCCQ score.

*Evaluation for BHB-1893 dose titration at W4 and for metoprolol dose titration at W2, W4, W6.*
*CPET, Cardiopulmonary exercise test; KCCQ, Kansas City Cardiomyopathy Questionnaire; LVEF, left ventricular ejection fraction; LVOT-G, left ventricular outflow tract gradient; NT-proBNP, N-terminal pro-B-type natriuretic peptide; NYHA, New York Heart Association; oHCM, obstructive hypertrophic cardiomyopathy; OLE, open-label extension; pVO2, peak oxygen uptake; W, week.*

# HRS-1893-301 ongoing Phase 3 multicenter trial in China (on top of SoC)

Enrollment on track to support top line data readout in 1H27




**Primary Endpoint**

- Composite of pVO2 improvement & stabilization or improvement in NYHA class at W24

**Secondary Endpoints**

- LVOT-G reduction, NT-proBNP, NYHA functional class, and KCCQ score.

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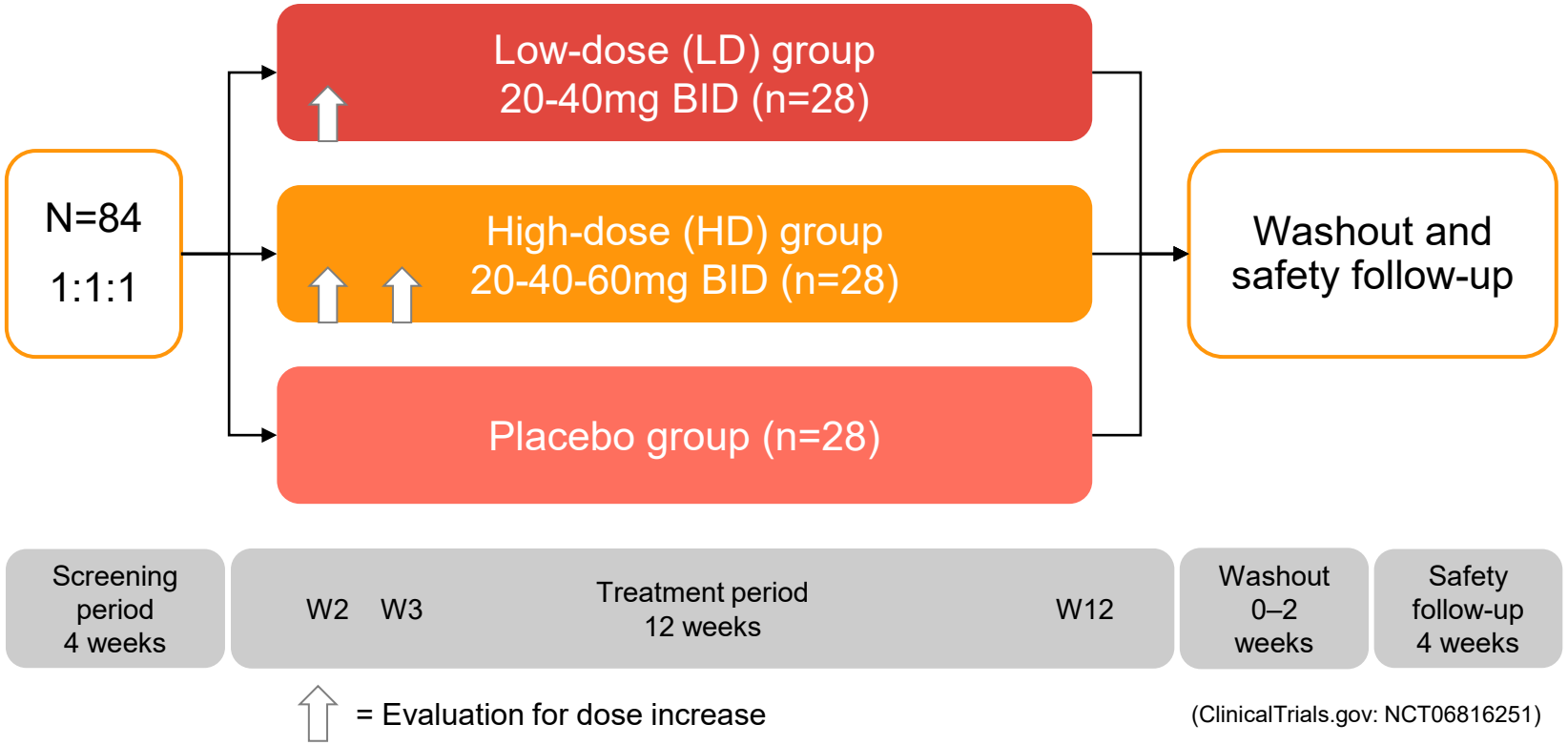
*Source: www.clinicaltrials.gov, www.chinadrugtrials.org.cn.*
*KCCQ, Kansas City Cardiomyopathy Questionnaire; LVEF, left ventricular ejection fraction; LVOT-G, left ventricular outflow tract gradient; NT-proBNP, N-terminal pro-B-type natriuretic peptide; NYHA, New York Heart Association; oHCM, obstructive hypertrophic cardiomyopathy; D, day; W, week; SoC, Standard of Care*

# Non-obstructive HCM (nHCM)

# Phase 2 nHCM Study Design: BHB-1893-202

This study enrolled adult nHCM patients with: LVEF ≥60%, NYHA class II-III, resting and Valsalva LVOT-G <30 mmHg at screening, maximal wall thickness ≥15 mm or ≥13 mm with family history of HCM, and KCCQ-CSS ≥30 to ≤85.

## Design




(ClinicalTrials.gov: NCT06816251)

## Key Endpoints

Primary endpoint: Safety; LVEF < 50%

Biomarkers: NT-proBNP, cardiac troponin I

Feel and function: KCCQ-CSS, pVO2

Echo: Diastolic, structural

## Dose Titration Criteria

| LVEF (%) | Adjustment |
|---|---|
| ≥55% | Increase Dose |
| <55% and ≥50% | Maintain Dose |
| <50% and ≥45% | Decrease Dose |
| <45% | Drug Interrupted |

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*nHCM: non obstructive hypertrophic cardiomyopathy; LVOT-G: left ventricular outflow tract gradient; LVEF: left ventricular ejection fraction; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire-Clinical Summary Score; BID: twice daily; QD: once daily; OLE: Open Label Extension. Phase 2 study was sponsored by Hengrui in China.*

# Baseline characteristics

| | BHB-1893 Low-dose group (N=28) | BHB-1893 High-dose group (N=28) | Placebo (N=28) |
|---|---|---|---|
| **Age (years)** | 44.5 (11.0) | 51.0 (12.0) | 47.3 (14.6) |
| **Sex: Female** | 14 (50.0%) | 8 (28.6%) | 9 (32.1%) |
| **BMI (kg/m2)** | 25.3 (3.87) | 25.0 (3.39) | 24.6 (3.54) |
| **LVEF (%)** | 68.2 (3.97) | 68.2 (4.14) | 68.0 (4.21) |
| **KCCQ-CSS** | 72.5 (8.23) | 68.7 (8.85) | 69.9 (7.96) |
| **NYHA Class II** | 100% | 100% | 100% |
| **pVO2 (mL/min/kg)** | 19.7 (1.81) | 18.3 (3.27) | 18.5 (4.93) |
| **NT-proBNP (pg/mL)** | 1026 (1.8) | 646 (2.0) | 972 (2.0) |
| **hs-cTnI (pg/mL)** | 108 (7.2) | 63.8 (6.4) | 69.2 (4.4) |

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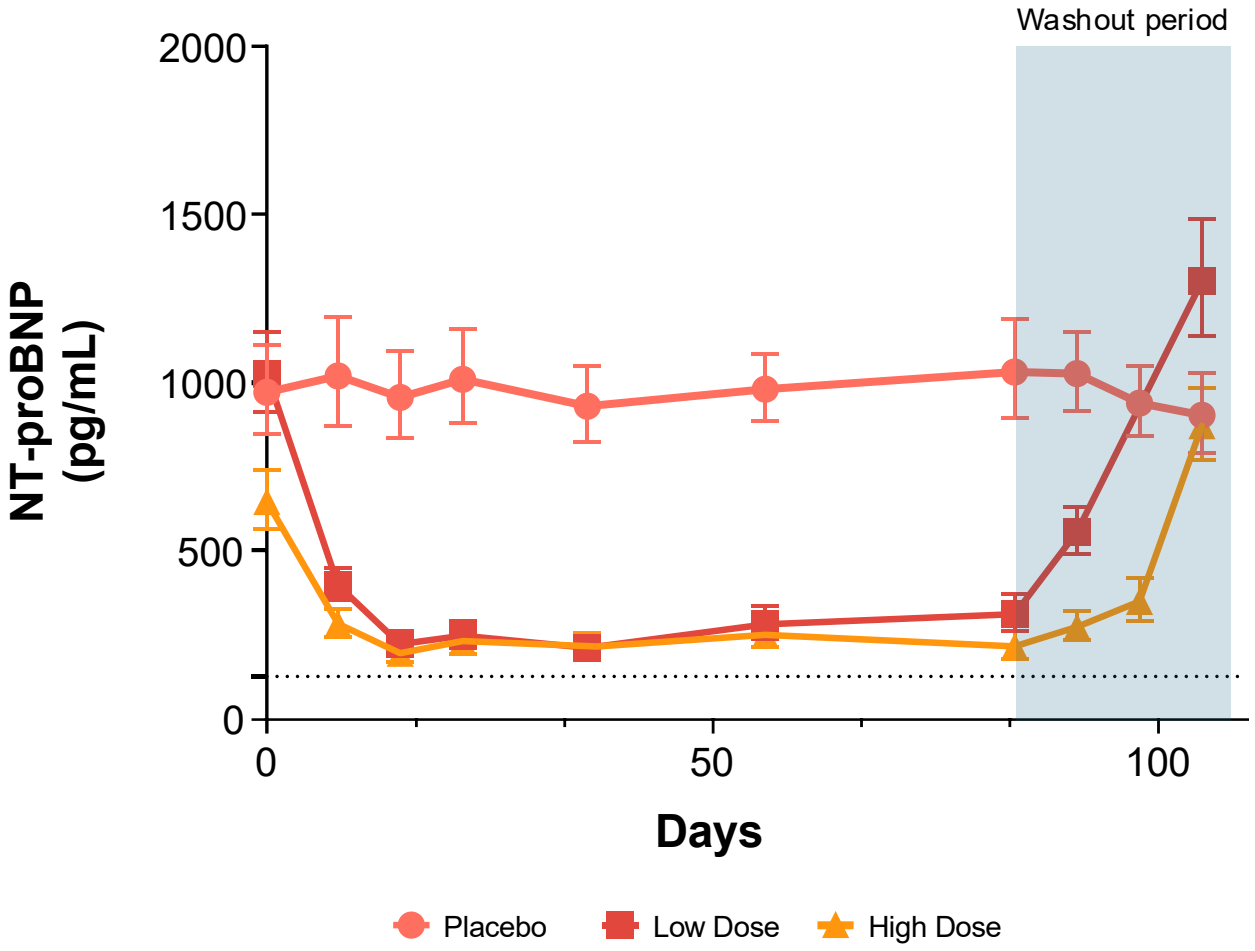
*Data are shown as mean (SD) unless otherwise specified. NT-proBNP and hs-cTnI geometric mean (geo SD). NYHA: New York Heart Association; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire-Clinical Summary Score; pVO2: peak oxygen uptake; LVEF: left ventricular ejection fraction; NT-proBNP: N-terminal pro-B-type natriuretic peptide. pVO2 data presented for the prespecified analysis on adequate CPET*

# Distribution of dose levels indicated most patients titrated to highest dose available

| Last Dose (mg) | BHB-1893 Low-dose (N=28) | BHB-1893 High-dose (N=28) | BHB-1893 Total (N=56) | Placebo (N=28) |
|---|---|---|---|---|
| **20 mg BID** | 1 (3.6%) | 1 (3.6%) | 2 (3.6%) | 0 (0.0%) |
| **40 mg BID** | 27 (96.4%) | 7 (25.0%) | 34 (60.7%) | 15 (53.6%) |
| **60 mg BID** | Not applicable | 20 (71.4%) | 20 (35.7%) | 13 (46.4%) |

# NT-proBNP, a key biomarker of heart failure, fell rapidly, deeply, and durably




**68%**

**Drop from baseline in high dose group**

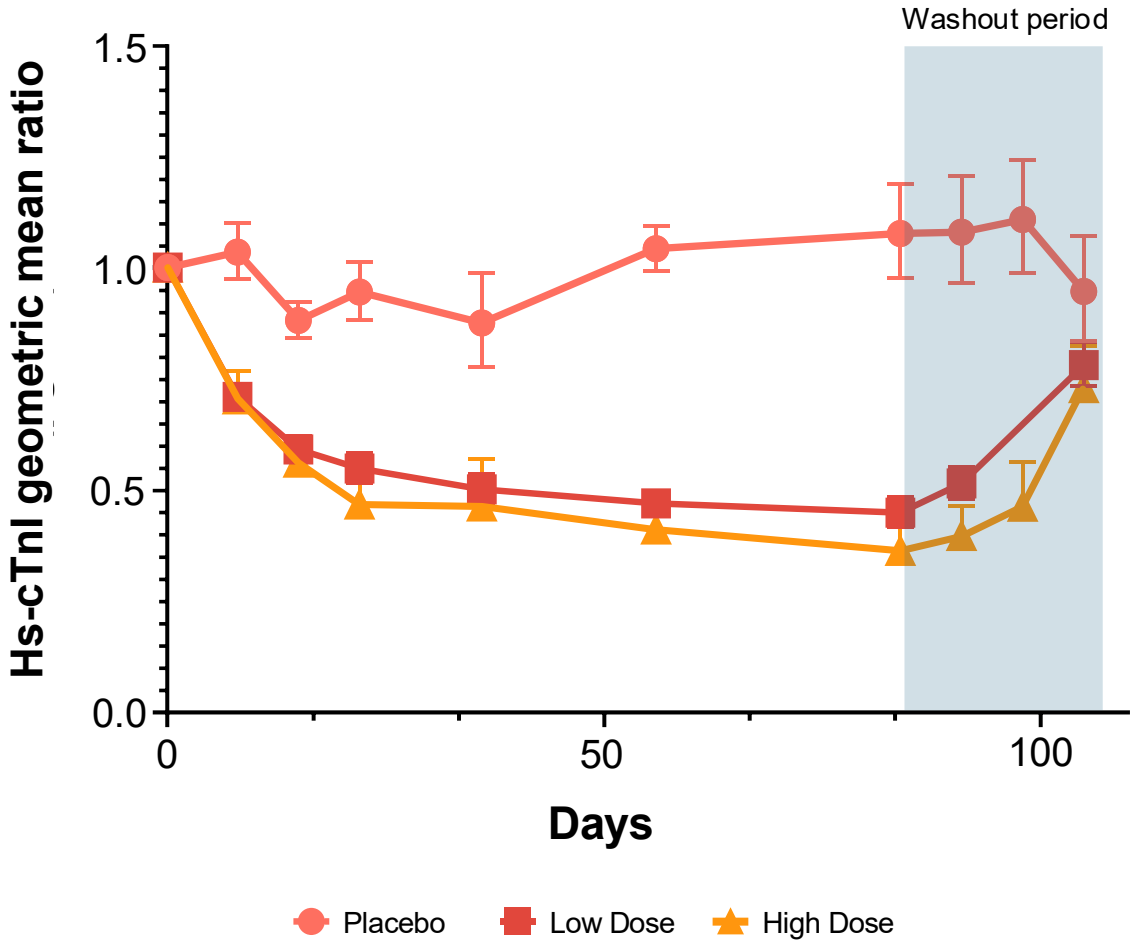
**42%**

**of patients at 60 mg below 125 pg/mL[1]**

*Geometric mean and SE; n≥27 (D0 to D84).*

*[1] 125 pg/mL upper limit of normal for individuals < 75 years old and cutoff for ruling out heart failure: 2022 AHA/ACC/HFSA guidelines.*

# cTnI levels fell rapidly and low levels were sustained, indicating reduction in heart tissue injury



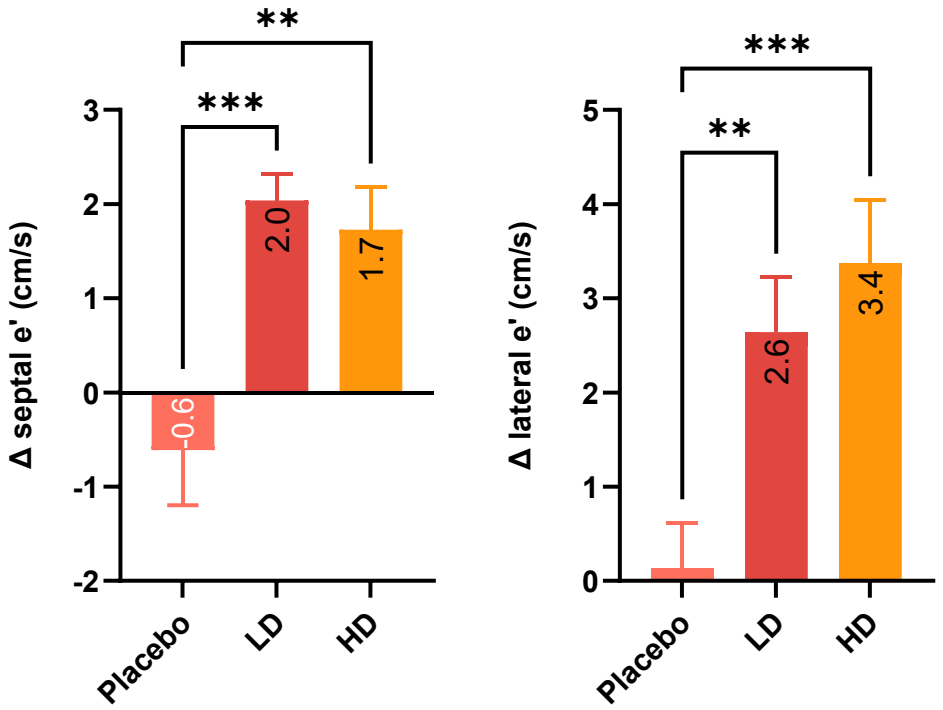

**60%**

**decrease from baseline in HD group**

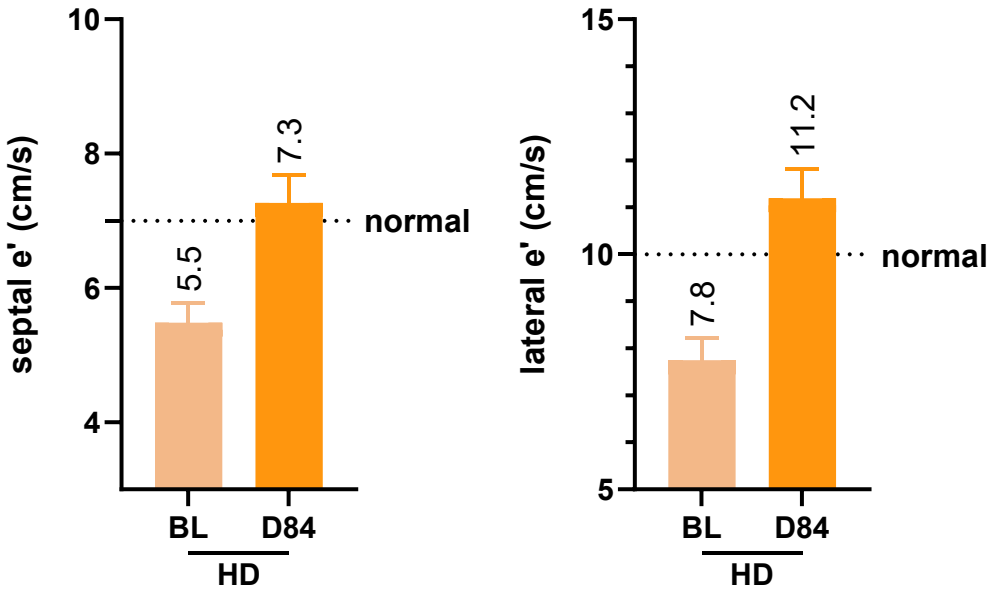
*Geometric mean and SE; n ≥27 (D0 to D84); LD: low dose; HD: high dose.*
*Hs-cTnI: high sensitivity cardiac troponin I, a marker of heart muscle injury, often associated with microvascular ischemia or wall stress*

# Myocardial relaxation improved with BHB-1893

## Early diastolic relaxation improved

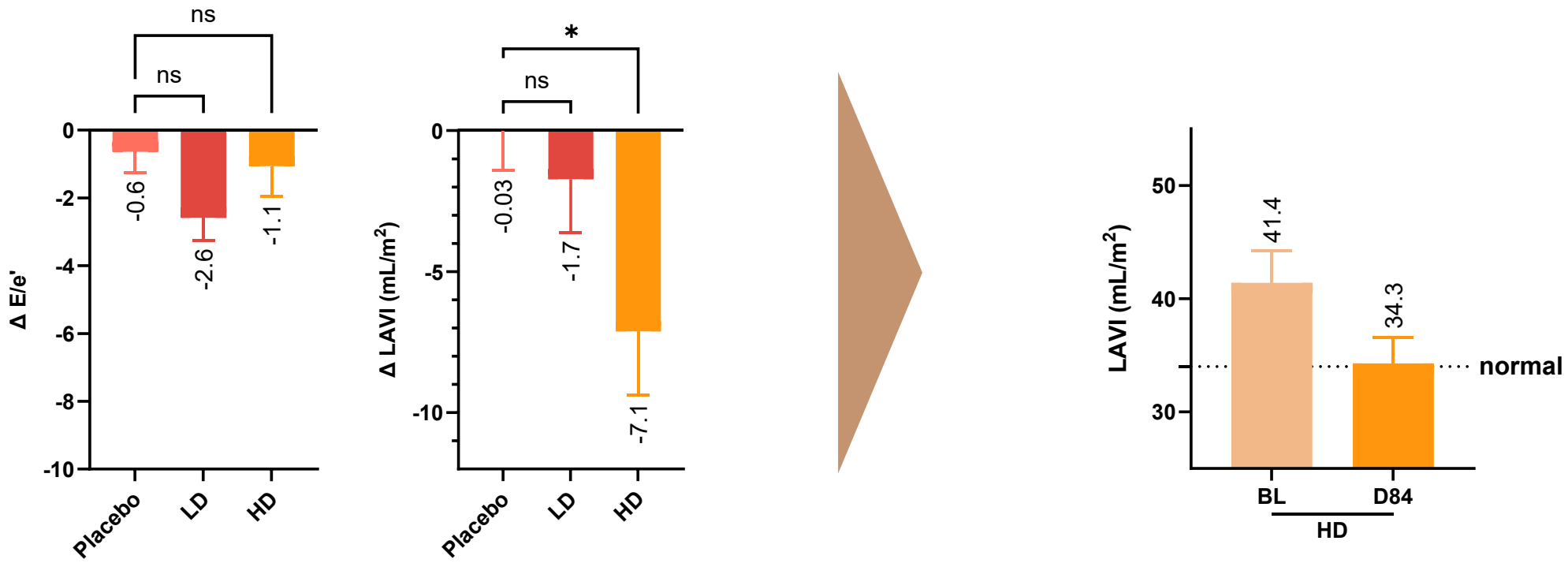



## Velocities moved from abnormal toward normal




*Data presented as mean (SEM); **: p<0.01; ***: p<0.001; BL = baseline.*

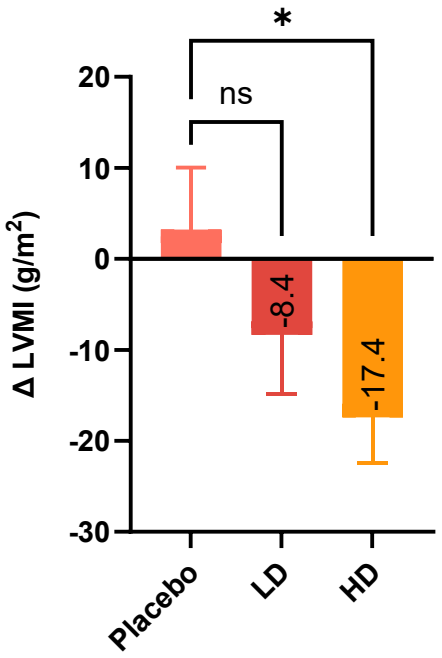
# Hemodynamic benefit observed with BHB-1893, with left atrial volume normalizing

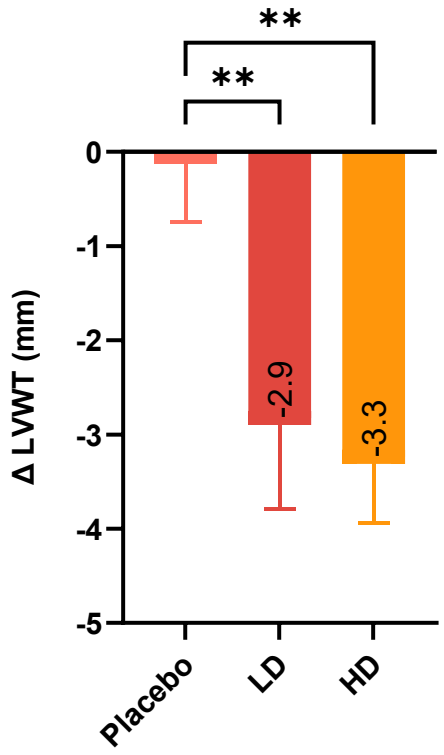



**Observed normalization of left atrial volume index suggests the atrium is no longer pressure-overloaded**

*Data presented as mean (SEM); n.s.: not significant; *: p<0.05;*
*E/e' = Mitral inflow velocity / average (lateral and septal) mitral annular velocity: an estimate of left ventricular filling pressure; LAVI = left atrial volume index; BL = baseline.*

# Left ventricular mass and wall thickness decreased showing structural reverse remodeling in the absence of outflow tract obstruction




**In contrast to oHCM where LVOT-G reductions drive mechanical relief of wall stress, reductions in LVMI and LVWT in nHCM suggest potential disease modification**

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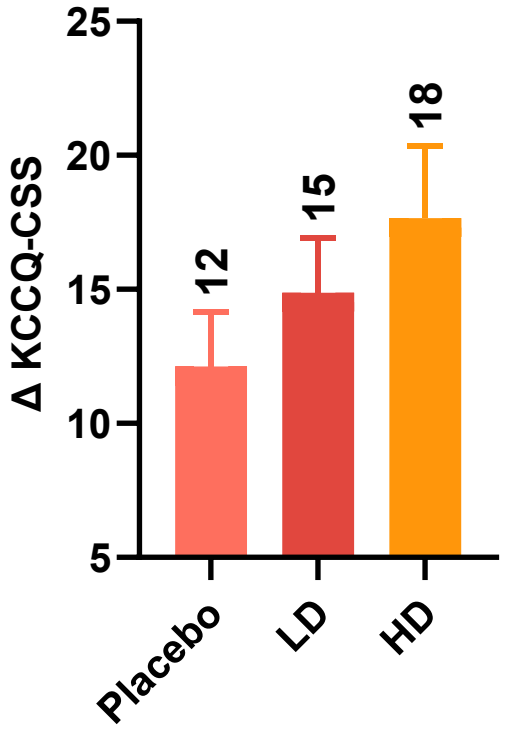
*Data presented as mean (SEM); n.s.: not significant; *: p<0.05; **: p<0.01; LVMI = left ventricular mass index; LVWT = left ventricular wall thickness*

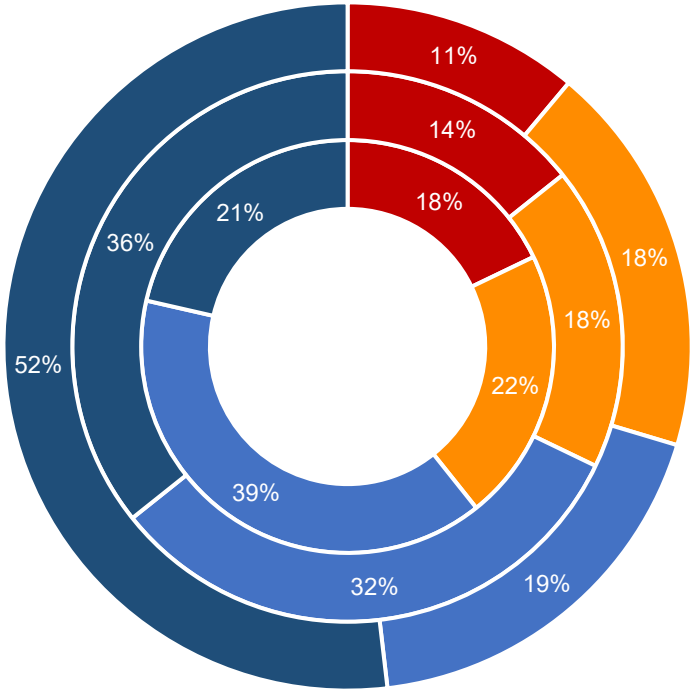
# BHB-1893 demonstrated a dose-dependent, placebo-adjusted, mean improvement in KCCQ-CSS




**Placebo-adjusted increase of +5.5 pts in HD group**

**52% of HD group reported symptom improvement in the ≥ 20 pt category**

## Distribution of KCCQ Change Categories




*Inner: Placebo  Middle: Low Dose  Outer: High Dose*

Change <5  Change >5-10  Change >10-20  Change ≥20

*KCCQ-CSS = Kansas City Clinical Questionnaire clinical summary score. Data is mean (SEM), distribution based on D84 assessment. LD: low dose; HD: high dose.*

# BHB-1893 demonstrated a placebo-adjusted improvement in pVO2 after 12 weeks of treatment

Placebo-adjusted
**+0.5 mL/min/kg**
mean improvement in pVO2 in high dose group,
**+1.7 mL/min/kg**
absolute change

**55%**
of patients in high dose group achieved
**≥1.5 mL/min/kg**
mean increase from baseline pVO2

Placebo-adjusted
**+0.9 mL/min/kg**
mean improvement in patients receiving **60 mg BID,**
**+2.1 mL/min/kg**
absolute change

**100% cycle-based CPET**; prespecified analysis on adequate CPET

# Safety and tolerability were generally consistent with prior studies of BHB-1893

- There were no serious AEs or AEs leading to treatment interruption, discontinuation, or death
- LVEF <50%: LVEF 46% to 49% all returned to normal with dose reduction

| | BHB-1893 Low-Dose (N = 28) | BHB-1893 High-Dose (N = 28) | BHB-1893 Total (N = 56) | Placebo (N = 28) |
|---|---|---|---|---|
| **Any TEAEs** | 23 (82.1) | 24 (85.7) | 47 (83.9) | 19 (67.9) |
| **Mild** | 18 (64.3) | 18 (64.3) | 36 (64.3) | 17 (60.7) |
| **Moderate** | 5 (17.9) | 6 (21.4) | 11 (19.6) | 2 (7.1) |
| **Severe** | 0 | 0 | 0 | 0 |
| **Any TEAE leading to permanent discontinuation** | 0 | 0 | 0 | 0 |
| **Any TEAE leading to study drug interruption** | 0 | 0 | 0 | 1 (3.6) |
| **Any serious TEAE[1]** | 2 (7.1) | 1 (3.6) | 3 (5.4) | 1 (3.6) |
| **LVEF<50%** | 1 (3.6) | 3 (10.7) | 4 (7.1) | 0 |

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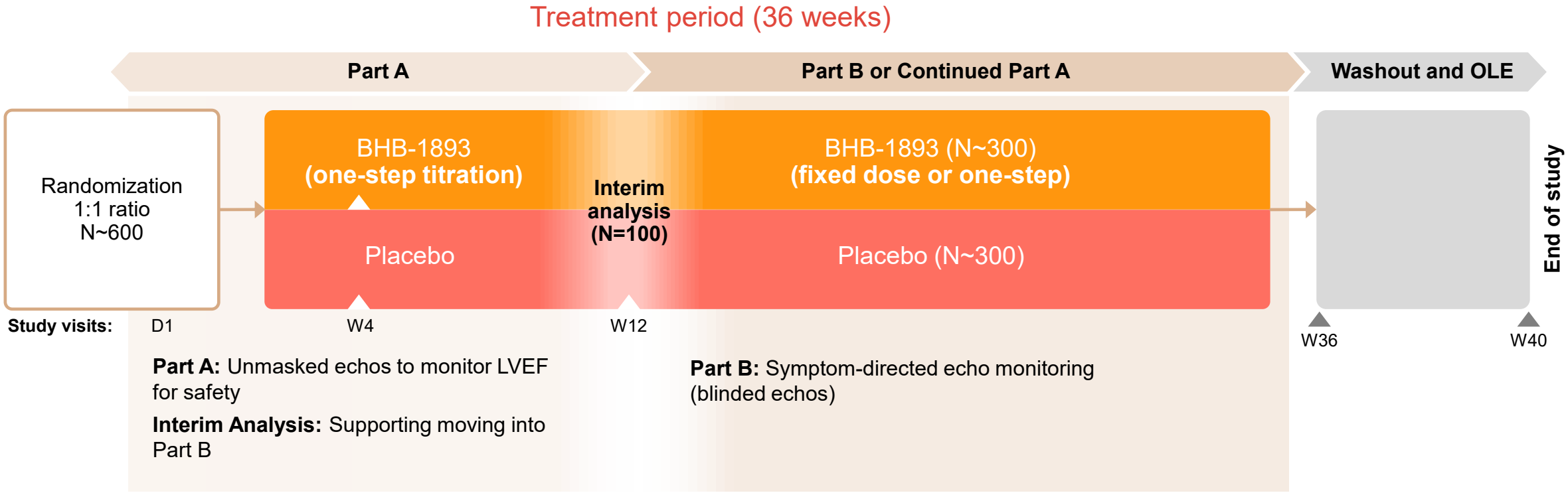
[1] *LD: cellulitis (n=1), otolithiasis (n=1); HD: atrial fibrillation (n=1); placebo: atrial tachycardia (n=1)*

# Proposed Phase 3 design in nHCM




**Primary Endpoints**

- **KCCQ-CSS:** Δ from baseline to W36
- **CPET:** Δ $pVO_2$ from baseline to W36

**Secondary Endpoints**

- NT-proBNP, NYHA functional class, structural measures.

*Evaluation for BHB-1893 dose titration at W4.*
*CPET, Cardiopulmonary exercise test; KCCQ, Kansas City Cardiomyopathy Questionnaire; LVEF, left ventricular ejection fraction; LVOT-G, left ventricular outflow tract gradient; NT-proBNP, N-terminal pro-B-type natriuretic peptide; NYHA, New York Heart Association; oHCM, obstructive hypertrophic cardiomyopathy; OLE, open-label extension; pVO2, peak oxygen uptake; W, week.*

# Thank you