HUTCHISON CHINA MEDITECH

JP Morgan Presentation 2019

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AIM/Nasdaq: HCM

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Use of Non-GAAP Financial Measures - Certain financial measures used in this presentation are based on non-GAAP financial measures. Please see the appendix slides titled "Non-GAAP Financial Measures and Reconciliation" for further information relevant to the interpretation of these financial measures and reconciliations of these financial measures to the most comparable GAAP measures.

CHI-MED

1 Company Overview

Building a global science-focused biopharma company from a powerful base in China...

Global Innovation

- 5 clinical drug candidates in US/EU development
- Building global clinical development footprint
- World-class >400 person scientific team

China Oncology

- Major market potential driven by regulatory reforms & high unmet medical need in oncology
- Elunate® (Fruquintinib capsules) first ever home-grown cancer drug launched in China[1]
- 8 oncology assets in China development

Existing China Business

- Foundation of commercial expertise & capability
- Cash generative China pharma business

[1] Believed to be the first China-discovered, unconditionally approved and launched cancer drug.

Important milestones in Chi-Med's evolution

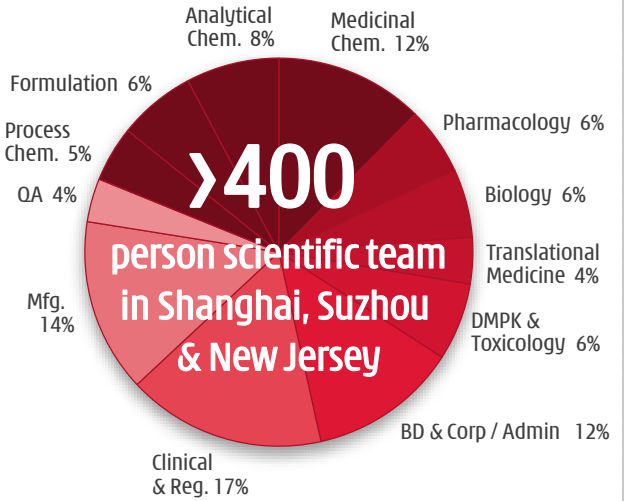
	Innovation Start-up & M&A	Discovery Platform	China Registr. & Global Early Dev.	China Launches & Expanding Global Registration	
	2000 -2005	2006 -2010	2011 -2016	2017	Today
Global Innovation	Established Hutchison MediPharma	Research collaborations	Global license deal savolitinib (c-MET)	2017 WCLC savo. + Tagrisso® Ph Ib & II oral presentation	Global PD-1 co-development deals
			Savo US IND	Suru US IND; Fruq US IND; 523 (Syk) US IND	689 (PI3Kδ) US IND
China Oncology			China license deal fruquintinib (VEGFR)	2017 ASCO ANNUAL MEETING Fruquintinib FRESCO oral presentation; Fruquintinib FRESCO JAMA publication	GMP Certified; ELUNATE® Fruquintinib Capsules Approval & Launch; China PD-1 co-dev. deals
			Suru PRC IND; Fruq/ savo PRC IND; Epit/ Thel PRC INDs	523 (Syk) PRC IND; 689 (PI3Kδ) PRC IND	453 (FGFR) PRC IND
Existing China Business	Shanghai Hutchison Pharmaceuticals 上海和黄药业 Shanghai Pharma Joint Venture (Rx); 白云山和黄中药 HWL Guangzhou Pharma Joint Venture (OTC)	<100 Med. Sales Reps.	Hutchison Sinopharm Pharmaceuticals 国药和黄医药 Sinopharm Joint Venture (Rx)	AstraZeneca MERCK SERONO Seroquel® & Concor® China promotion deals	~1,300 Med. Sales Reps.; ~2,400 Med. Sales Reps.

Broad innovation & commercial operations

Management Team

		Industry / Chi-Med (years)
	**Mr. CHRISTIAN HOGG, BSc, MBA** Chief Executive Officer	P&G Procter & Gamble	29 / 18
	**Dr. WEIGUO SU, PHD** EVP, Chief Scientific Officer	Pfizer	28 / 13
	**Mr. JOHNNY CHENG, BEc, CA** Chief Financial Officer	Bristol-Myers Squibb, Nestlé, KPMG	29 / 10
	**Dr. ZHOU JUN JIE, MD, MBA** General Manager, SHPL	SANOFI	27 / 17
	**Dr. MAREK KANIA, MD, MBA** SVP, Chief Medical Officer, US	Lilly	25 / 1
	**Dr. ZHENPING WU, PHD, MBA** SVP, Pharmaceutical Sciences	Roche, Pfizer	24 / 10
	**Mr. CHEN HONG, BSc, MBA** SVP, Chief Commercial Officer	Bristol-Myers Squibb	20 / 8
	**Dr. MAY WANG, PHD** SVP, Bus. Dev. & Strategic Alliances	Lilly	24 / 8
	**Mr. MARK LEE, BEng, MBA** SVP, Corp. Finance & Development	Credit Suisse	19 / 9
	**Mr. ENRICO MAGNANELLI, BA, MBA** Head of International Operations	GILEAD	20 / 1

Integrated Innovation Organization [1]



Commercial Team & Joint Ventures

Commercial Team (subsidiaries):

›200 staff covering:

- Drug distribution operations; &
- New Oncology Business Dept.

50/50 Joint Ventures:

›2,400 Rx medical sales reps.;

›1,000 person OTC sales team; &

›1,200 staff in two major factories

[1] Headcount as of June 30, 2018; Chem. = Chemistry; DMPK = Drug, Metabolism, & Pharmacokinetics; Tox. = Drug Safety Evaluation; QA: Quality Assurance; Mfg. = Manufacturing; Reg. = Regulatory; BD = Business Development.

Portfolio of step-change global assets; near-term targeted China NDA submissions & marketed drugs

CHI-MED

Dose Finding / Safety	Dose Expansion / Proof-of-Concept	Registration	Marketed
Fruquintinib + sintilimab (PD-1) 1L Hepatocellular carcinoma (HCC) [1]	**Savo / Savo + Imfinzi® (CALYPSO)** x3: 2L clear cell RCC; PRCC	**Savo + Tagrisso® (SAVANNAH)** 2L/3L Tagrisso-refractory NSCLC	**Elunate® (Fruquintinib capsules)** ≥3L colorectal cancer
Surufatinib + toripalimab (PD-1) 2L pancreatic NET [1]	**Savolitinib (NCI PAPMET)** 1L/2L MET+ Papillary RCC	**Savolitinib** 1L Exon 14 NSCLC	**SXBX Pill** Coronary artery disease (FY'17: $209m)
HMPL-523 (Syk) Indolent non-Hodgkin's Lymph. (NHL) [1]	**Savo / Savo + Taxotere® (VIKTORY)** x3: 2L gastric cancer	**Fruquintinib + Taxol® (FRUTIGA)** 2L gastric cancer	**Seroquel® & Seroquel® XR** Schizophrenia/biopolar (FY'17: $35m)
HMPL-689 (PI3Kδ) Indolent NHL [1]	**Savolitinib (CCTG 1234B)** 1L/2L MET+ prostate cancer	**Surufatinib (SANET-p)** Pancreatic NET	**Concor®** Hypertension (FY'17: $2m)
Fruquintinib + sintilimab (PD-1) 1L HCC [1]	**Fruquintinib** 3L/4L colorectal cancer	**Surufatinib (SANET-ep)** Non-pancreatic NET	**›10 other Rx/OTC drugs** (FY'17: ›$230m)
Fruquintinib + GB226 (PD-1) x2: 2L CRC; 2L NSCLC [1]	**Surufatinib** 2L pancreatic NET		
Surufatinib + toripalimab (PD-1) Pancreatic NET [1]	**Fruquintinib + Iressa®** 1L EGFRm+ NSCLC		
Surufatinib + HX008 (PD-1) TBD [1]	**Surufatinib** 2L Biliary tract cancer		
HMPL-453 (FGFR1/2/3) Solid tumors	**Theliatinib** EGFR wild-type esophageal cancer		
Epitinib Glioblastoma	**HMPL-523** x6: Indolent NHL; AML; ITP		
	HMPL-689 Indolent NHL		

Global Innovation

China Oncology

Existing China Business

[1] In planning/imminent; Targets: savolitinib = c-MET; fruquintinib = VEGFR1/2/3; surufatinib = VEGFR/FGFR1/CSF-1R; HMPL-523 = Syk; HMPL-689 = PI3Kδ; epitinib (HMPL-813) = EGFR with brain metastases; Theliatinib (HMPL-309) = EGFR wild-type; HMPL-453 = FGFR1/2/3.

Global clinical drug portfolio (1/2)

Savolitinib

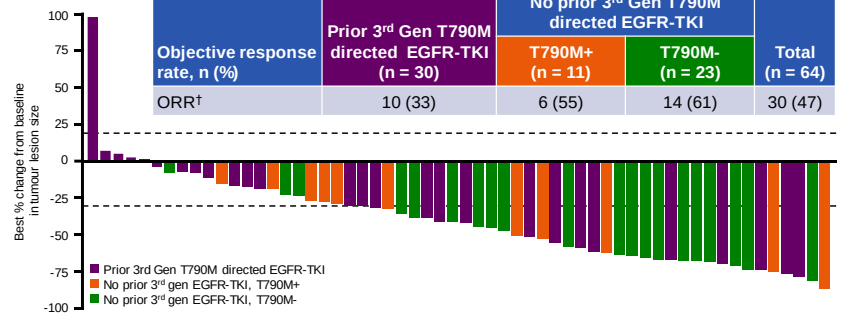
Potential First-in-class small molecule selective c-MET inhibitor	
Point of Differentiation:	No kidney toxicity (no 2-quinolinone metabolite)
Indications:	MET-driven NSCLC; RCC; Gastric; Colorectal; Prostate cancer
Dosed to-date:	~700 patients
Summary Data:	**NSCLC – Tagrisso® EGFR TKI refractory combinations:** **Post 1st-gen TKI** (n=34): ORR 55-61% **Post 3rd-gen TKI** (n=30): ORR 33% **PRCC** (n=44): ORR 18%; mPFS 6.2mo.

SAVANNAH global Ph.II/reg. underway Tagrisso® + savo

IASLC 18TH WORLD CONFERENCE ON LUNG CANCER
October 15–18, 2017 | Yokohama, Japan

Preliminary anti-tumour activity in all MET-positive patients*, n = 64

Objective response rate, n (%)	Prior 3rd Gen T790M directed EGFR-TKI (n = 30)	No prior 3rd Gen T790M directed EGFR-TKI		Total (n = 64)
		T790M+ (n = 11)	T790M- (n = 23)	
ORR†	10 (33)	6 (55)	14 (61)	30 (47)



Waterfall plot based on evaluable patients (n = 64): all patients dosed and with on-treatment assessment or discontinuation prior to first tumour assessment
Data cut-off 31 Aug 2017
*17 patients did not have central FISH confirmation of MET-positive status (n = 6 MET-negative; n = 11 unknown by central lab); †Confirmed by a later scan performed at least 4 weeks after initial response observed

TATTON Part B
NCT02143466

Fruquintinib

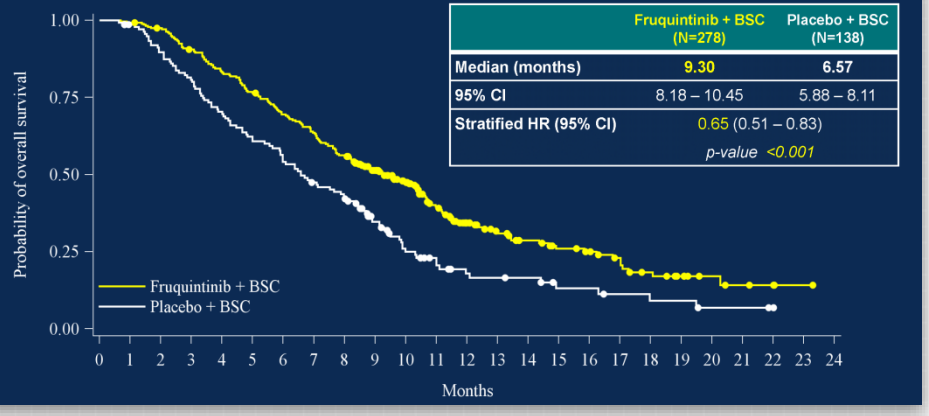
Potential Best-in-class small molecule selective VEGFR 1/2/3 inhibitor	
Point of Differentiation:	No off-target toxicity; full & sustained target coverage
Indications:	Colorectal; NSCLC; Gastric cancer
Dosed to-date:	~1,550 patients in trials
Summary Data:	**3L CRC** (n=416): mOS 9.3mo. vs. 6.6mo. (SoC); **3L NSCLC** (n=91): ORR 16%; mPFS 3.8mo. vs 1.1mo. (SoC) **1L NSCLC (Iressa® combo)** (n=50): ORR 77% [1] **2L Gastric (Taxol® combo)** (n=28): ORR 36%

Launched in CRC Nov 2018 in China

PRESENTED AT: **ASCO ANNUAL MEETING '17**

Overall Survival (Primary Endpoint)
FRESCO clearly succeeded in meeting the primary efficacy endpoint of OS

	Fruquintinib + BSC (N=278)	Placebo + BSC (N=138)
Median (months)	9.30	6.57
95% CI	8.18 – 10.45	5.88 – 8.11
Stratified HR (95% CI)	0.65 (0.51 – 0.83)	
	p-value <0.001	



[1] Efficacy Evaluable Patients. Data cut-off: Oct. 10, 2017.

Global clinical drug portfolio (2/2)

Surufatinib

Unique small molecule VEGFR 1/2/3, FGFR1 & CSF-1R inhibitor

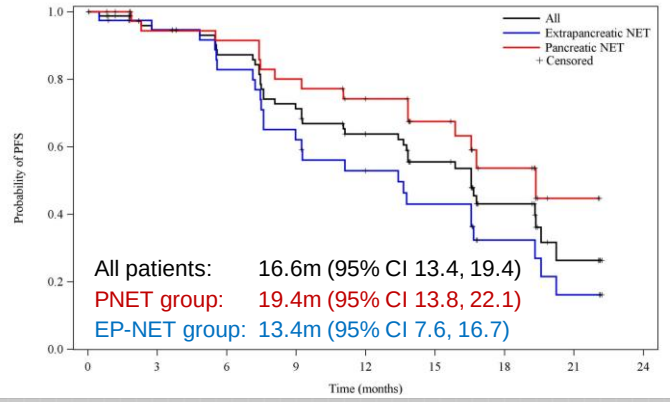
Point of Differentiation:	Angio-immuno kinase profile; angiogenesis & TAM [1] inhibition
Indications:	Neuroendocrine tumors (pNET/ep-NET); Thyroid; Biliary Tract
Dosed to-date:	~600 patients
Summary Data:	**pNET** (n=41): ORR 17%; mPFS 19.4mo. **Ep-NET** (n=40): ORR 15%; mPFS 13.4mo.

Step-change efficacy in pNET

European ENETS Neuroendocrine Tumor Society — **14th Annual ENETS Conference** | 8-10 March 2017

Progression free survival in ITT patients

as of 20 Jan2017



HMPL-523

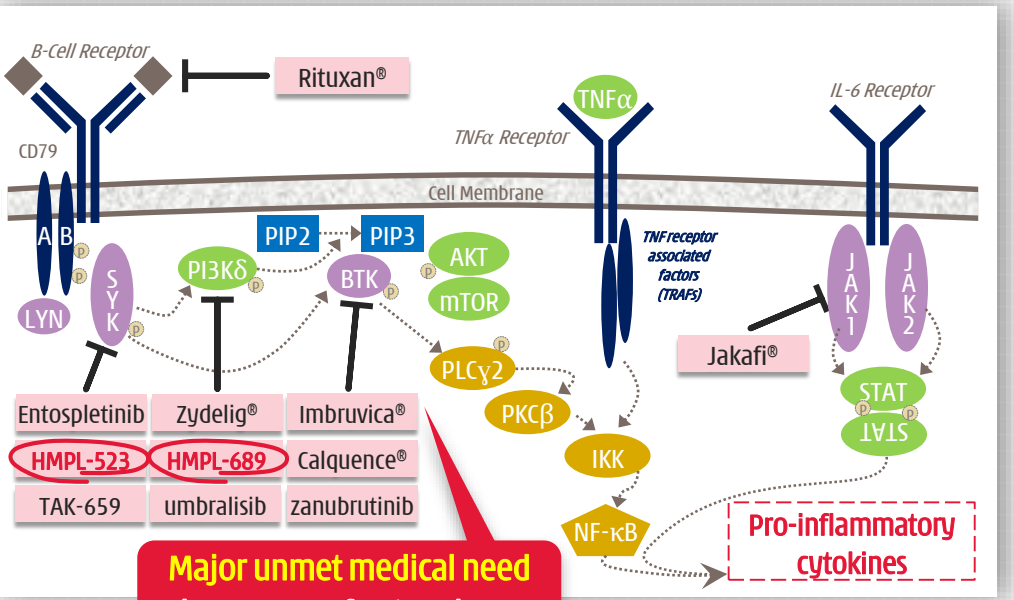
Potential First-in-class small molecule selective Syk inhibitor

POD:	No off-target toxicity; full & sustained target coverage
Indications:	Indolent non-Hodgkin's lymphoma; AML; Immunol.
Dosed to-date:	~106 pts. & ~118 healthy vol. Dose escalation (5 cohorts) [2]
Summary Data:	**FL** (n=10): ORR 30% **CLL/SLL** (n=3): ORR 33%

HMPL-689

Potential Best-in-class small molecule selective PI3Kδ inhibitor

POD:	No off-target toxicity; full & sustained target coverage
Indications:	Indolent non-Hodgkin's lymphoma; AML; Immunol.
Dosed to-date:	~31 pts. & ~48 healthy vols.
Summary Data:	Phase I dose escalation data not yet published



Major unmet medical need in BTK TKI refractory iNHL

[1] TAM = Tumor Associated Macrophages; [2] American Society of Hematology. Blood, vol. 132 no. Suppl 1 5324 (Nov 2018).

CHI-MED

2a

Highlights & Strategies – Global Innovation

Pushing the envelope on our most valuable assets

One of China's largest & most prolific discovery platforms in oncology

Global step-change innovation

- *Multiple potential first-in-class assets*

Kinase selectivity – enable combos

- *Dial out off-target toxicity & address TKI resistance*

Building broad range of assets against novel targets

- *2nd generation I/O & expanding to mAbs*

Note: I/O = immuno-oncology; mAb = monoclonal antibody.

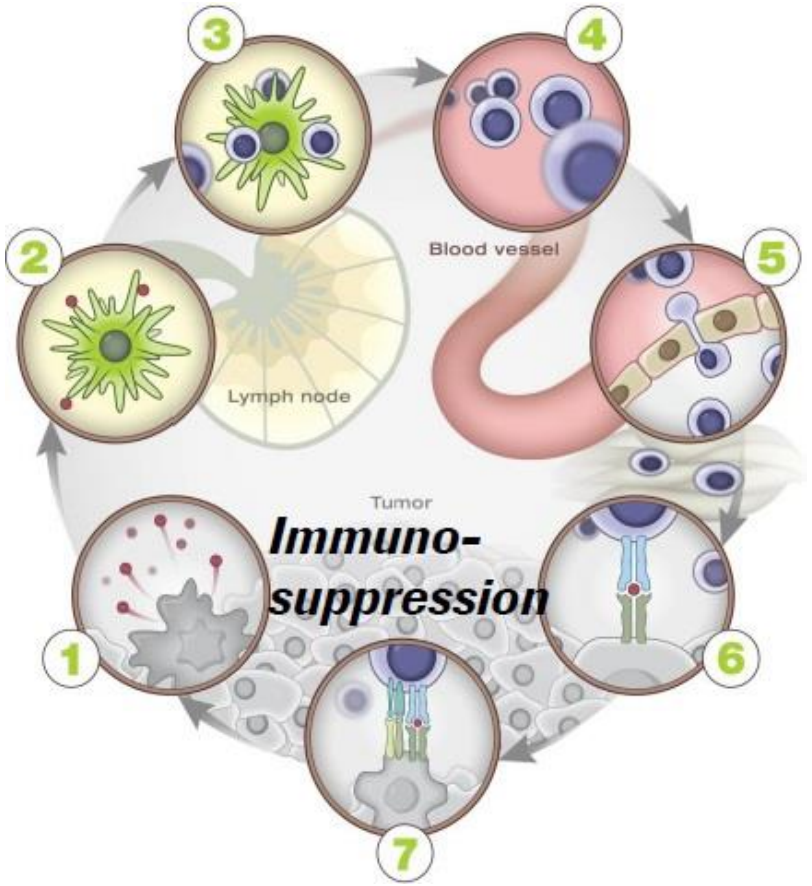
Attack cancer from multiple angles at same time

Immune Desert
Insufficient T cell response

- Chemotherapies
- Vaccines
- CAR-T (pro-inflammatory strategies)
- TCB's

Antigen Release
Aberrant genetic drivers

- Targeted therapies (small molecule & antibody)



Excluded Infiltrate
Inadequate T cell homing

- Anti-angiogenics
- Stromal targets
- Chemokines
- Vaccines

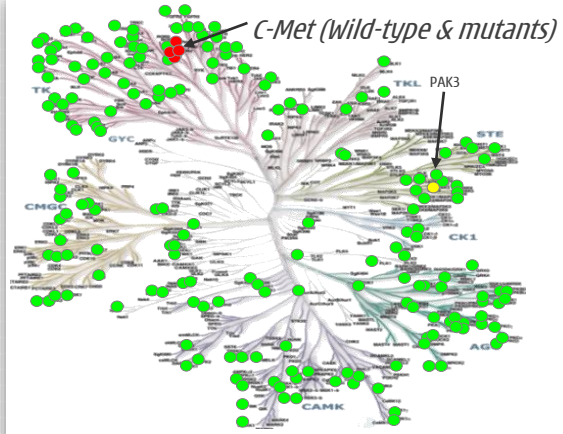
Inflamed
Inactivated T cell response

- Immunotherapies (address negative regulators)
- Vaccines

Need combinations of potent, yet tolerable drugs against specific targets

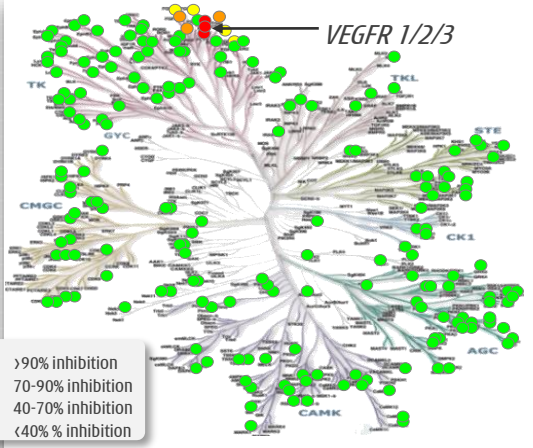
Note: Adapted from Chen DS et al. Oncology Meets Immunology: The Cancer-Immunity Cycle. Immunity, Volume 39, Issue 1, 1 - 10.

Our advanced medicinal chemistry provides superior selectivity & safety profiles…



Savolitinib

~1,000 times
more selective to c-Met than next kinase (PAK3) [5]



Screening at 1μM against 253 Kinases
- ›90% inhibition
- 70-90% inhibition
- 40-70% inhibition
- ‹40% % inhibition

ELUNATE®
Fruquintinib Capsules

~250 times
more selective to VEGFR3 than next non-VEGFR kinase (Ret) [6]

Non-small cell lung cancer (NSCLC)	Discontinuations as % Enrolled		
	Due to AE	Withdrawn / Other	Total [1]
Monotherapy – Tagrisso® / savolitinib			
Tagrisso® (osimertinib)	6%	6%	**13%**
savolitinib 600mg QD monotherapy [2]	9%	5%	**14%**
Combination – Tagrisso® + savolitinib			
savolitinib 600mg QD + **Tagrisso®** [3]	30%	3%	**33%**
savolitinib 600mg QD + **Tagrisso®** [3]			
Approved treatments in NSCLC			
Zykadia® (ceritinib)	10%	10%	**20%**
Cyramza® (ramucirumab) + **Taxotere®**	15%	21%	**37%**
Keytruda® (pembrolizumab) 2mg/kg	10%	26%	**37%**
Opdivo® (nivolumab)	15%	4%	**20%**
Chemo doublet (platinum + pemetrexed)	11%	17%	**27%**
Taxotere® (docetaxel)	13%	22%	**36%**

3rd-Line Metastatic CRC	FRESCO Study Mainland China		CONCUR Study (China, HK, Taiwan) [4]	
Treatment arms	Elunate®	Placebo	Stivarga®	Placebo
VEGFR on-target related AEs:				
Hypertension ≥G3	21.2%	2.2%	12.5%	8.3%
Hand-Foot Syndrome (Palmar-plantar), ≥G3	10.8%	0.0%	17.0%	0.0%
Off-target (i.e. non-VEGFR) related AEs:				
Hypophosphatemia, ≥G3	0.0%	0.0%	8.0%	0.0%
Hypokalemia, ≥G3	0.7%	0.7%	6.3%	0.0%
Rash/desquamation, ≥G3	0.0%	0.0%	4.4%	0.0%
Lipase increase, ≥G3	0.0%	0.0%	6.3%	1.7%
Hepatic function (Liver function) AEs:				
ALT increased, ≥G3	0.7%	1.5%	7.1%	3.3%
AST increased, ≥G3	0.4%	0.7%	8.9%	0.0%
Blood bilirubin increased, ≥G3	1.4%	1.5%	8.9%	8.3%
Tolerability:				
AE Leading to dose interruption	35.3%	10.2%	68.8%	25.0%

[1] Total discontinuations = Discontinuations NOT due to Disease Progression or Death; [2] September 2017 Journal of Clinical Oncology; [3] 2017 World Conference on Lung Cancer; [4] Efficacy & safety of regorafenib monotherapy in Chinese patients with previously treated metastatic colorectal cancer: subgroup analysis of the CONCUR trial; R Xu; [5] W. Su, et al, 2014 American Association of Cancer Research; [6] Sun et al., Cancer Biology & Therapy 15:12, 1635--1645; December 2014.

...superior safety allows for combinations

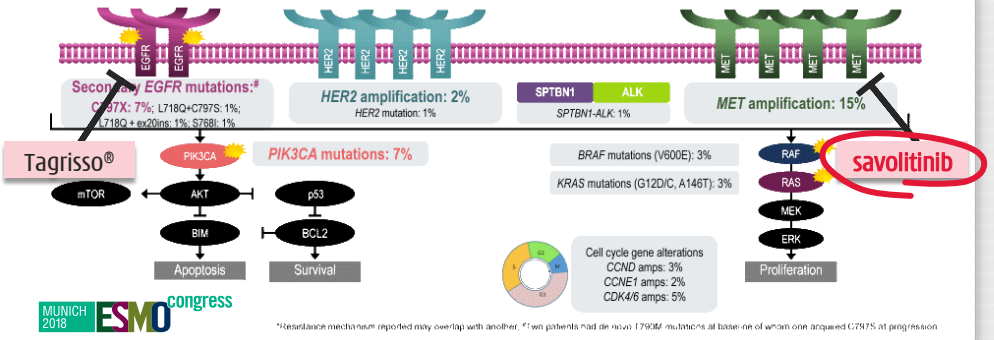
TKI + TKI combos to address acquired resistance

TAGRISSO™ osimertinib

- **MET amplification** is the most common resistance mechanism for Tagrisso®;
- Requires addition of **MET inhibitor – savolitinib – in combo** with Tagrisso®

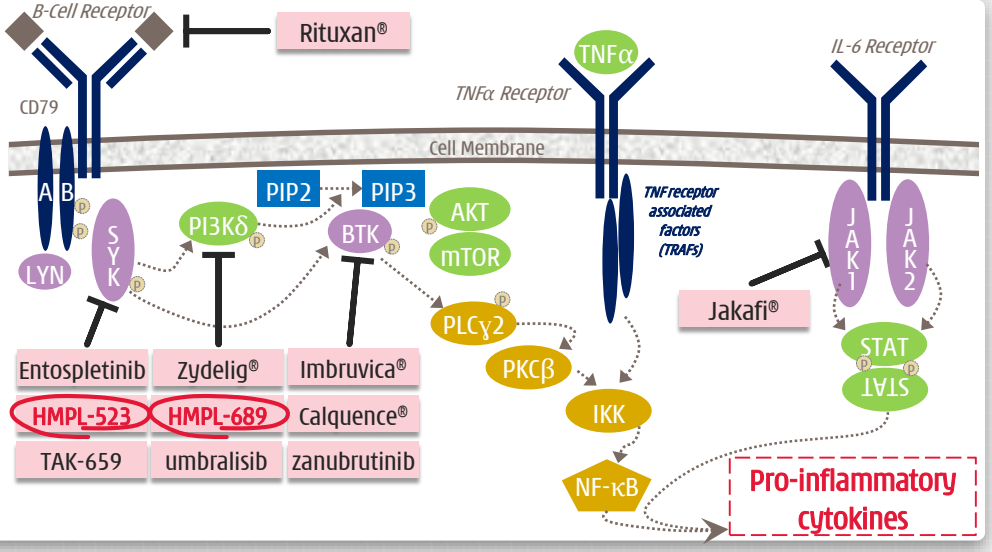
RESULTS: CANDIDATE ACQUIRED RESISTANCE MECHANISMS WITH OSIMERTINIB (n=91)*

- No evidence of acquired EGFR T790M
- The most common resistance mechanisms were *MET* amplification and EGFR C797S mutation
  - Other mechanisms included *HER2* amplification, *PIK3CA* and *RAS* mutations



imbruvica® (ibrutinib) 140mg capsules

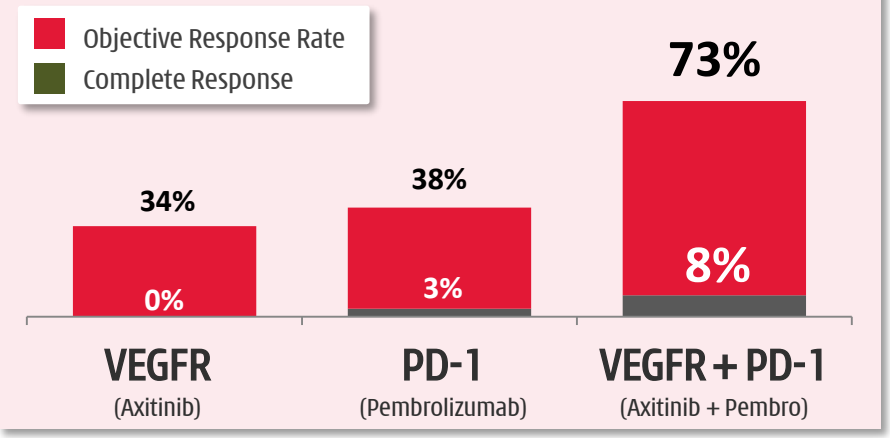
- **C481S or PLCγ** are the most common resistance mechanisms for Imbruvica®;
- Invalidating BTK inhibitor requires a **possible Syk, PI3Kδ &/or BTK TKIs**



TKI = Tyrosine Kinase Inhibitor

...our assets are ideal TKI combo partners for immunotherapy

1L Clear Cell Renal Cell Carcinoma [1]



Potent two-prong attack – BTD [2]:
Anti-angiogenesis + activated T-cell response

	Axitinib	Fruquintinib	Surufatinib
Selectivity	Relatively selective	Highly selective	Selective angio-immuno kinase inhibitor
Status	Launched	Launched	Ph. IIIs ongoing
VEGFR1 (nM)	3	33	2
VEGFR2 (nM)	7	25	24
VEGFR3 (nM)	1	0.5	1
Phos-KDR (nM)	0.2	0.6	2
Other kinases (IC_{50} < 100nM)	PDGFRα PDGFRβ c-Kit	none	CSF-1R FGFR1 FLT3 TrkB
Patent Expiration	2025/04/29 (US6534524B1)	2029 (without extension)	2030 (without extension)

Fruq. uniquely selective – unlike other TKIs with off-target toxicity
Suru. inhibits TAM production – amplifying PD-1 induced immune response

Multiple global immunotherapy combo deals...

Managed by AstraZeneca

AstraZeneca
savolitinib + Imfinzi® (PD-L1)
ccRCC/PRCC

Jointly managed by Chi-Med & partners

Innovent Biologics
fruquintinib + sintilimab (PD-1)
1L HCC;
Niche indications (TBC)

君实生物 Junshi Biosciences
surufatinib + toripalimab (PD-1)
pNET (TBC);
Niche indications (TBC)

3 PD-1 / PD-L1 combos – Development now underway / starting on savo, fruq & suru

[1] Source: 1. B. Rini et al, Lancet Oncol 2013 14(12) 1233-42, Axitinib with or without dose titration for first-line metastatic renal-cell carcinoma: a randomised double-blind phase 2 trial; 2. D.F. McDermott et al, ASCO 2018 #4500, Pembrolizumab monotherapy as first-line therapy in advanced clear cell renal cell carcinoma (accRCC): Results from cohort A of KEYNOTE-427; 3, M.B. Atkins et al, Lancet Oncol 2018 19(3) 405-15, Axitinib in combination with pembrolizumab in patients with advanced renal cell cancer: a non-randomised, open-label, dose-finding, and dose-expansion phase 1b trial. Corporate press release; [2] BTD = Breakthrough Therapy Designation.

5 assets in global development

...US/EU clinical & regulatory team fully operational

Program	Treatment	Indication	Target patient	Study name	Sites	Dose finding / safety run-in	Proof-of-concept	Registration
Savolitinib c-MET	**Savolitinib** + Tagrisso®	NSCLC	2L/3L EGFRm; Tagrisso® ref.; MET+	SAVANNAH	Global	Oxnard/Ahn - DF/SMC		n=172
	Savolitinib	NSCLC	MET Exon 14 deletion	TBD	TBD	TBD		
	Savolitinib + Imfinzi® (PD-L1)	Papillary RCC	All	CALYPSO	UK/Spain	Powles - Queen Mary's		
	Savolitinib	Clear cell RCC	VEGFR TKI refractory	CALYPSO	UK/Spain	Powles - Queen Mary's		Prelim. PoC at conf. early 2019
	Savolitinib + Imfinzi® (PD-L1)	Clear cell RCC	VEGFR TKI refractory	CALYPSO	UK/Spain	Powles - Queen Mary's		
	Savolitinib	Papillary RCC	All	PAPMET	US	Pal - City of Hope		
	Savolitinib	Gastric cancer	MET+	VIKTORY	South Korea	Lee - Samsung Med. Ctr		
	Savolitinib + docetaxel	Gastric cancer	MET+	VIKTORY	South Korea	Lee - Samsung Med. Ctr		Prelim. PoC at conf. mid 2019
	Savolitinib + docetaxel	Gastric cancer	MET over expression	VIKTORY	South Korea	Lee - Samsung Med. Ctr		
	Savolitinib	Prostate cancer	MET+	CCGT 1234B	Canada	Kolinsky/Mukjee/Ong/Chi		
Fruquintinib VEGFR 1/2/3	**Fruquintinib**	Colorectal cancer	3L/4L; Stivarga® ref./intolerant		US	Eng - MD Anderson		Planning US registr. study based on FRESCO/US Ph.Ib
	Fruquintinib + sintilimab (PD-1)	Hepatocellular ca.	1L		US	TBD		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	Pancreatic NET	2L; Sutent®/Afinitor® refractory		US	Dasari/Yao - MD Anderson		Planning US registr. study based on China Ph.II/US Ph.Ib
	Surufatinib + toripalimab (PD-1)	Pancreatic NET				TBD		
HMPL-523 Syk	**HMPL-523**	Indolent NHL			Australia	N/A		Global Ph.I/PoC data-set now at n >100
	HMPL-523	Indolent NHL			US	Fowler - MD Anderson		
HMPL-689 PI3Kδ	**HMPL-689**	Healthy volunteers			Australia			Data-set now emerging in China Ph.I (n ~30)
	HMPL-689	Indolent NHL			US	Ghosh/Cohen - Levine/Emory		

2019-2021 Objectives: (1) Savo/Tagrisso approved & savo monotherapy registration study underway;
(2) Fruq; suru; HMPL-523 & HMPL-689 registration studies underway/enrolling

What is next from discovery?

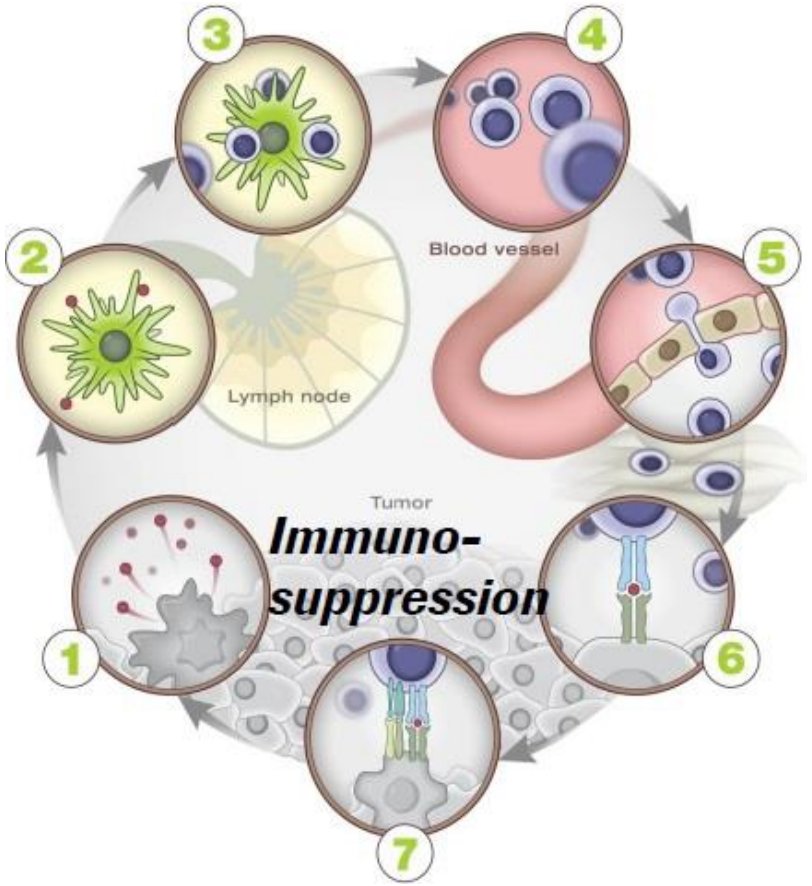
Differentiated assets against multiple targets to emerge 2019-22

Priming & activations

- aOX40
- 4-1BB

Antigen release

- c-MET (savolitinib)
- EGFR (epitinib/theliatinib)
- Syk (HMPL-523)
- PI3Kδ (HMPL-689)
- FGFR (HMPL-453)
- ERK
- RIP1K
- IDH



Anti-angiogenesis

- VEGFR (fruquintinib)
- VEGFR/FGFR (surufatinib)
- FGFR (HMPL-453)

Negative regulators

- Treg (HMPL-689)
- CSF-1R (surufatinib)
- IDOi
- AhRi
- TIM3
- TCBs

Pre-clinical - small molecule
Pre-clinical - antibody

Creating highest-quality range of assets against novel targets for use in combos

Note: Adapted from Chen DS et al. Oncology Meets Immunology: The Cancer-Immunity Cycle. Immunity, Volume 39, Issue 1, 1 - 10.; CAN = Candidate Nomination (clear for regulatory tox).

Global Innovation

Plans for 2019-2021

Aim for Savolitinib / Tagrisso® combo approval & launch

Build out US/EU development operation

- US/EU C&R operation set up in Morris County, NJ in 2018; expected to reach ~30 staff by end 2019

Accelerate development of 4 un-partnered global assets

- Fruq & suru registration studies & exploration of combos with PD-1s;
- Syk & PI3Kδ registration studies & exploration of combos with BTK TKIs

Aim to move ~1 novel drug candidate into global development per year

CHI-MED

2b

Highlights & Strategies – China Oncology

Next-gen oncology drugs to meet major needs in China

China oncology – ~30% of world's cancer patients

World's attention turning to unmet medical need in China oncology

- *Regulatory reforms in China – addressing low SoC [1]*
- *Major investment inflow*

Chi-Med is a first mover

- *Elunate® launch in 3L mCRC; First ever in China [2]*
- *Deep pipeline – 8 clinical drug candidates with 5 registration studies underway/set to start in China*

Major commercial opportunity

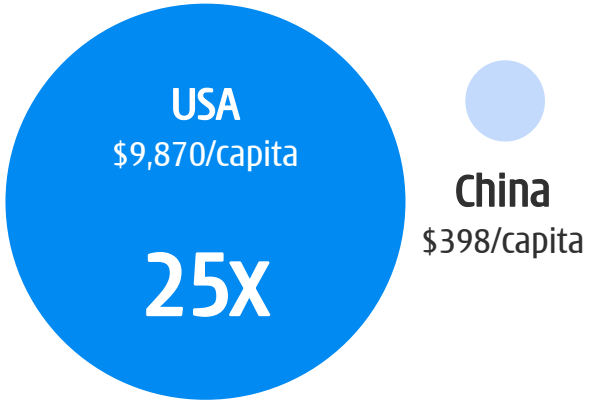
- *National Drug Reimbursement; Medical coverage*

[1] SoC = Standard of Care; [2] Believed to be the first China-discovered, unconditionally approved and launched cancer drug.

China now world's 2nd largest pharma market

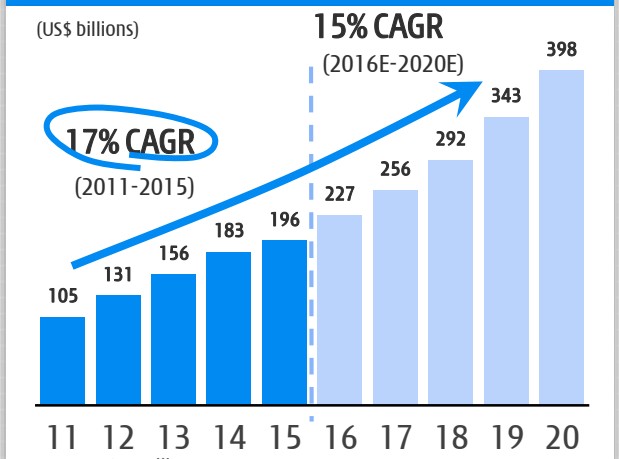
...investment, approvals & access all accelerating rapidly

Per Capita Healthcare Spending [1]



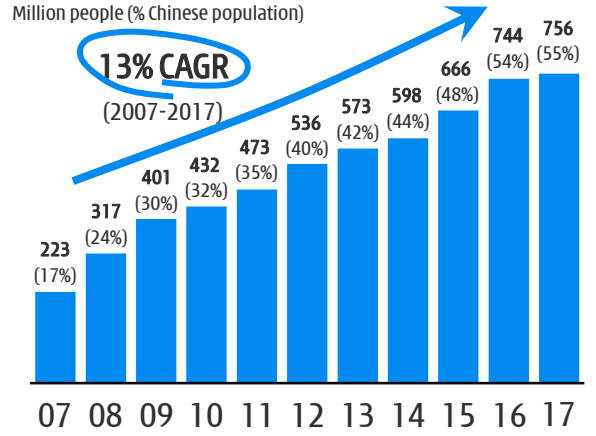
Source: WHO Global Health Expenditure Database (2016 data)

PRC Pharmaceutical Market Size



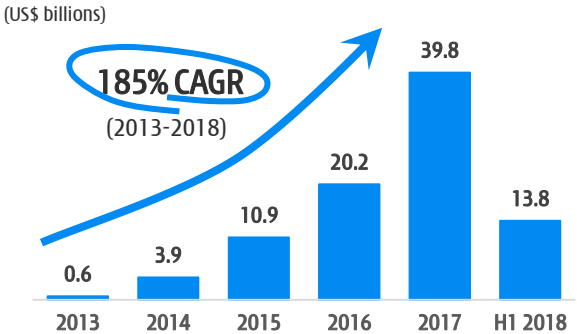
Source: Frost & Sullivan

Medical Insurance Coverage [2]



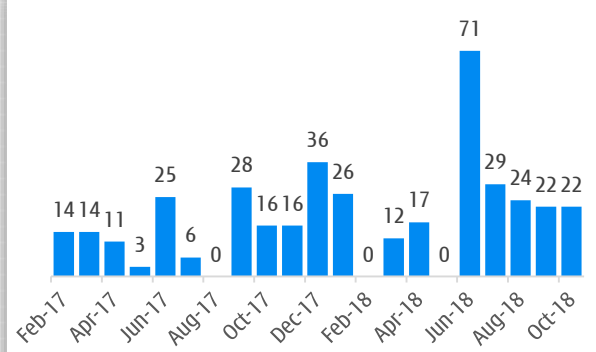
Source: National Bureau of Statistics (2017)

PRC Healthcare VC/PE Funds [3]



Source: McKinsey; ChinaBio 2018 report

Number of Priority Review NDAs [4]



Source: McKinsey; National Medical Products Administration

Improved Access since 2017

- 128 western drugs added to NDRL;
- Further 17 oncology drugs added to NDRL in Oct 2018 (15 in Jul 2017);
- Essential drug list expanded from 520 to 685 molecules. Including oncology.

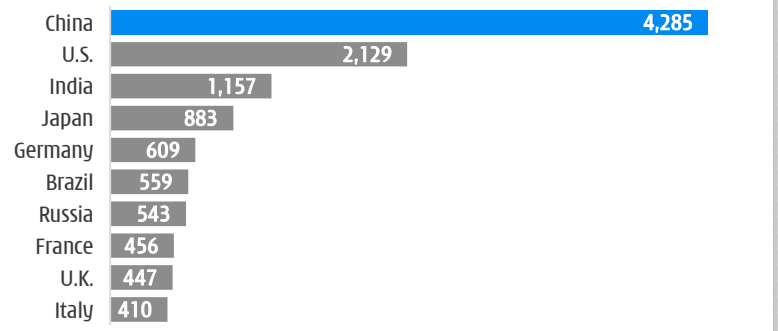
Source: McKinsey

[1] Current health expenditure by revenues of health care financing schemes (in current US$ per capita); [2] Urban Basic Medical Care Insurance (for both employees & residents) - total persons covered at year-end;
[3] Funds raised; [4] NDA = New Drug Application. Note: CAGR = Compound annual growth rate

Cancer is a major unmet need in China

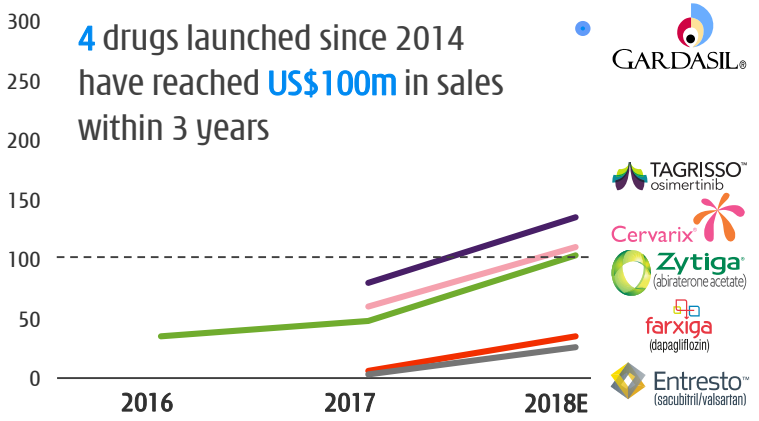
...investments in launches/access starting to have an impact

Cancer Incidence in China



Source: WHO (Incidence '000s)

Rapid uptake of new launches in China

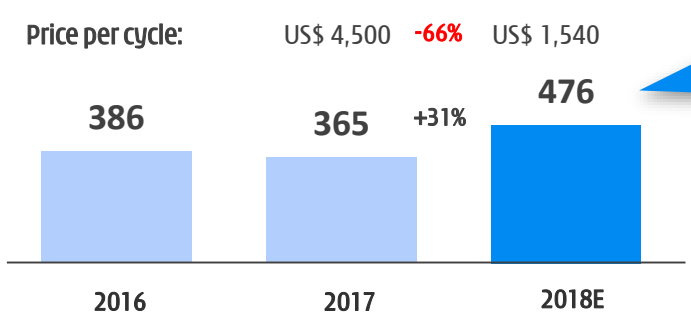


Source: McKinsey; RDPAC 2018 estimated based on Q3 RDPAC data

Novel drugs post NDRL inclusion – approx. 4x penetration[1]

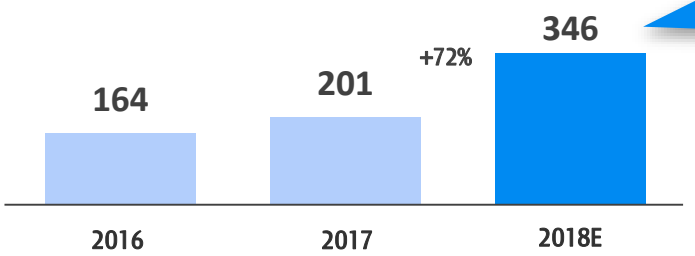
(Bar Chart US$ millions; Price per Cycle US$)

Herceptin® trastuzumab



Est. **3.9x** Volume/ penetration

AVASTIN® bevacizumab



Est. **4.5x** Volume/ penetration

Source: McKinsey; RDPAC 2018 estimated based on Q3 RDPAC data; NDRL.
[1] Estimated volume/penetration increase assumes change in headline prices per cycle approximate change in average sales prices before and after NDRL inclusion, i.e. minimal in discounting and/or patient access programs.

ELUNATE®
Fruquintinib Capsules

Launched - Nov. 25, 2018

CHI-MED

First ever oncology drug discovered & launched in China [1]

[1] unconditional approval

ELUNATE®
Fruquintinib Capsules

3rd-line colorectal cancer ("CRC")

CHI-MED

1. Epidemiology

China Annual Incidence
380,000 patients [1]

↓

Surgery

↓

1st-line treated

↓

2nd-line treated

↓

3rd-line treated
57,000 patients

~15%

2. Price / Usage

Pricing
RMB 21,960 per cycle
(~US$ 3,300 per cycle)
(one cycle 4 weeks)

Patient Access Program [2]

- Cycle 1: RMB 21,960
- Cycle 2: RMB 21,960
- Cycle 3: Free (PAP)
- Cycle 4: Free (PAP)
- Cycle 5: RMB 21,960
- Cycle 6 onwards: Free (PAP)

↓

Progressive Disease

Usage
~Avg 5.0 mths / 5.5 cycles
(to progression; 3.7 mo. mPFS [3])

[1] W. Chen, R. Zheng et al, CA Cancer J Clin. 2016 Mar-Apr;66(2):115-32. Cancer Statistics in China, 2015. doi:10.3322/caac.21338. Epub 2016 Jan 25; [2] PAP = Patient Access Program, subject to qualification criteria; [3] mPFS = median Progression-Free Survival.

ELUNATE®
Fruquintinib Capsules

Lilly amendment – Dec 2018
Important deal on an outstanding asset

CHI-MED

- We believe **Elunate® is a global best-in-class VEGFR TKI**;
- Unique selectivity – **potential in multiple new life cycle indications** ("LCIs");
- We have been driving for over a year **to gain freedom to operate on LCIs on our most valuable asset in China**;
- **Chi-Med & Lilly benefit from 2018 amendment – CRE** [1]

Chi-Med takes over all LCI decision making	Original 2013 Agreement	Amendment (Dec 2018)
LCI Development Costs – Paid by Lilly	70%	0%
LCI Development Costs – Paid by Chi-Med	30%	100%
LCI Regulatory Approval Milestones – Paid to Chi-Med [3]	12.5	20.0
Royalty Payments – Paid to Chi-Med [4]	15 - 20%	15 – 29%
Co-Promotion Rights in China (% of provinces)	0%	30 – 40%
Co-Promotion Service Fees – paid to Chi-Med (% Net Sales)	0%	Not disclosed

More control & better economics on best-in-class asset

Drug (INN Name)	FDA Approved Indications – Indication	Year	2017 Sales
Avastin® (Bevacizumab)	2L bevacizumab-pret. mCRC	2013	$6,796m
	1/2L mCRC	2004	
	1L non-sq NSCLC	2006	
	2L GBM	2009	
	1L ccRCC	2009	
	1L Cervical Ca.	2014	
	1L Ovarian Ca.	2018	
	1/2L platinum-sens. Ovarian Ca.	2016	
	2/3L platinum-res. Ovarian Ca.	2014	
Sutent® (Sunitinib)	2L GIST	2006	$1,081m
	≥1L pNET	2011	
	adjuvant RCC	2017	
	1L RCC	2007	
	≥2L cytokine-ref. ccRCC	2006	
Vargatef® Ofev® (Nintedanib)	2L adeno-NSCLC (by EMA)	2014	$1,076m [2]
Nexavar® (Sorafenib)	≥1L RCC	2005	$923m
	1L HCC	2007	
	Iodine-ref. DTC	2013	
Votrient® (Pazopanib)	1/2L RCC	2009	$808m
	2L STS	2012	
Cyramza® (Ramucirumab)	2L GC	2014	$758m
	2L NSCLC	2014	
	2L mCRC	2015	
Cometriq® Cabometyx® (Cabozantinib)	≥1L MTC	2012	$406m
	1L ccRCC	2017	
	≥2L ccRCC	2016	
Stivarga® (Regorafenib)	3L mCRC	2012	$349m
	2L GIST	2013	
	2L HCC	2017	
Inlyta® (Axitinib)	2L ccRCC	2012	$339m
Lenvima® (Lenvatinib)	Iodine-ref. DTC	2015	$296m
	2L ccRCC	2016	

[1] CRE = Commercially Reasonable Effort – Lilly obligation to maximize sales & profit of Elunate; [2] Includes sales for idiopathic pulmonary fibrosis; [3] Lifecycle Indication – China – per LCI, up to 3 LCIs; [4] on Total Molecule Sales in China triggered upon launch of 1st LCI.

8 assets in China development (1/2)

...where we are today & where we target to be in 3 years

Program	Treatment	Indication	Target patient	Study name	Sites	Dose finding / safety run-in	Proof-of-concept	Registration
Savolitinib c-MET	**Savolitinib**	NSCLC	MET Exon 14 deletion		China	Lu Shun – SH Chest Hosp.		
	Savolitinib + Iressa®	NSCLC	2L EGFRm; Iressa® ref.; MET+		China	Wu Yilong – GD General		
	Savolitinib	Gastric cancer	MET+		China	Shen Lin – BJ Univ. Tumor		
Fruquintinib VEGFR 1/2/3	**Fruquintinib**	Colorectal cancer	≥3L; chemotherapy refractory	FRESCO	China	Li Jin – Fudan Univ.		
	Fruquintinib + genolimzumab (PD-1)	Colorectal cancer	2L		China	Bai Yuxian – HRB Tumor		
	Fruquintinib	NSCLC	3L; chemotherapy refractory	FALUCA	China	Lu Shun – SH Chest Hosp.		
	Fruquintinib + Iressa®	NSCLC	1L EGFRm		China	Lu Shun – SH Chest Hosp.		
	Fruquintinib + genolimzumab (PD-1)	NSCLC	2L		China	Lu Shun – SH Chest Hosp.		
	Fruquintinib + Taxol®	Gastric cancer	2L	FRUTIGA	China	Xu Ruihua – Sun Yat Sen		
	Fruquintinib + sintilimab (PD-1)	Hepatocellular ca.	1L		China	Li Jin -- SH East Hosp.		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	Pancreatic NET	All		China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib + toripalimab (PD-1)	Pancreatic NET	All		China	Shen Lin – BJ Univ. Tumor		
	Surufatinib	Non-Pancreatic NET	All		China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib	Biliary Tract cancer	2L		China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib + HX008 (PD-1)	TBD	All		China	TBD		

n ~60

Launched Nov 2018

Publish 2019

Interim Early 2019

Interim Late 2019

Interim Early 2019

Planning China Ph.II/III
Based on Ph.Ib data

2019-2021 Objectives: (1) Savo mono (Exon 14) launched; Savo / Tagrisso® or Iressa® combo launched;
(2) Fruq with multiple life cycle indications ("LCIs") in registration;
(3) Suru launched in neuroendocrine tumors & multiple LCIs.

8 assets in China development (2/2)

...where we are today & where we target to be in 3 years

Program	Treatment	Indication	Target patient	Study name	Sites	Dose finding / safety run-in	Proof-of-concept	Registration
Epitinib EGFR	**Epitinib**	NSCLC	EGFRm with brain metastasis		China	Wu Yilong - GD General		
	Epitinib	Glioblastoma	EGFR gene amplified		China	Ying Mao - SH Huashan		
Theliatinib EGFR wt	**Theliatinib**	Esophageal cancer	EGFR over expression		China	Shen Lin - BJ Univ. Tumor		
HMPL-523 Syk	**HMPL-523** + azacitidine	Acute Myeloid Lymph.	1L		China	Wang/Qi - CN Hem. Hosp.		
	HMPL-523	CLL / SLL	All		China	Xu Wei - JS People's Hosp.		
	HMPL-523	Indol. NHL: FL; MZL; WM	All		China	Zhu Jun - BJ Cancer Hosp.		
	HMPL-523	Aggressive NHL: DLBCL	All		China	TBD		
	HMPL-523	MCL	All		China	Cao - Fudan Univ. Tumor		
	HMPL-523	ITP	All		China	Yang - CN Hem. Hosp.		
HMPL-689 PI3Kδ	**HMPL-689**	Indolent NHL			China	Cao/Zhou - Fudan/Tongji		
HMPL-453 FGFR 1/2/3	**HMPL-453**	All comers			China	Xu Ruihua - SYS		

Planning China Ph.II/III in several iNHL indications based on Ph.Ib data now at n ›100

Data-set emerging in China Ph.I (n ~30)

2019-2021 Objectives: (1) HMPL-523/HMPL-689 – multiple non-Hodgkin's Lymph. registration studies; (2) Epitinib/Theliatinib/HMPL-453 established proof-of-concept

Note: Chronic lymphocytic leukemia (CLL), small lymphocytic lymphoma (SLL), mantle cell lymphoma (MCL), follicular lymphoma (FL), marginal zone lymphoma (MZL), diffuse large B-cell lymphoma (DLBCL) & Waldenstrom's macroglobulinemia (WG); immune thrombocytopenic purpura (ITP)

China Oncology

Plans for 2019-2021

Establish Elunate® as the best-in-class VEGFR TKI in China market

- Work with Lilly to maximize penetration & sales performance;
- Aggressively expand PD-1 combination collaborations & broader LCI program

Launch our un-partnered oncology drugs

- Target surufatinib NDA in neuroendocrine tumors potentially in late 2019;
- Expand Oncology Commercial Org. from current ~30 people to ~200 by end 2020

Savolitinib NDA in MET Exon 14 NSCLC potentially in early 2020

Progress development pipeline

- Syk & PI3Kδ into registration studies & establish PoC for epitinib, theliatinib & FGFR;
- Aim for 2-3 further novel drug candidates into early development by 2021

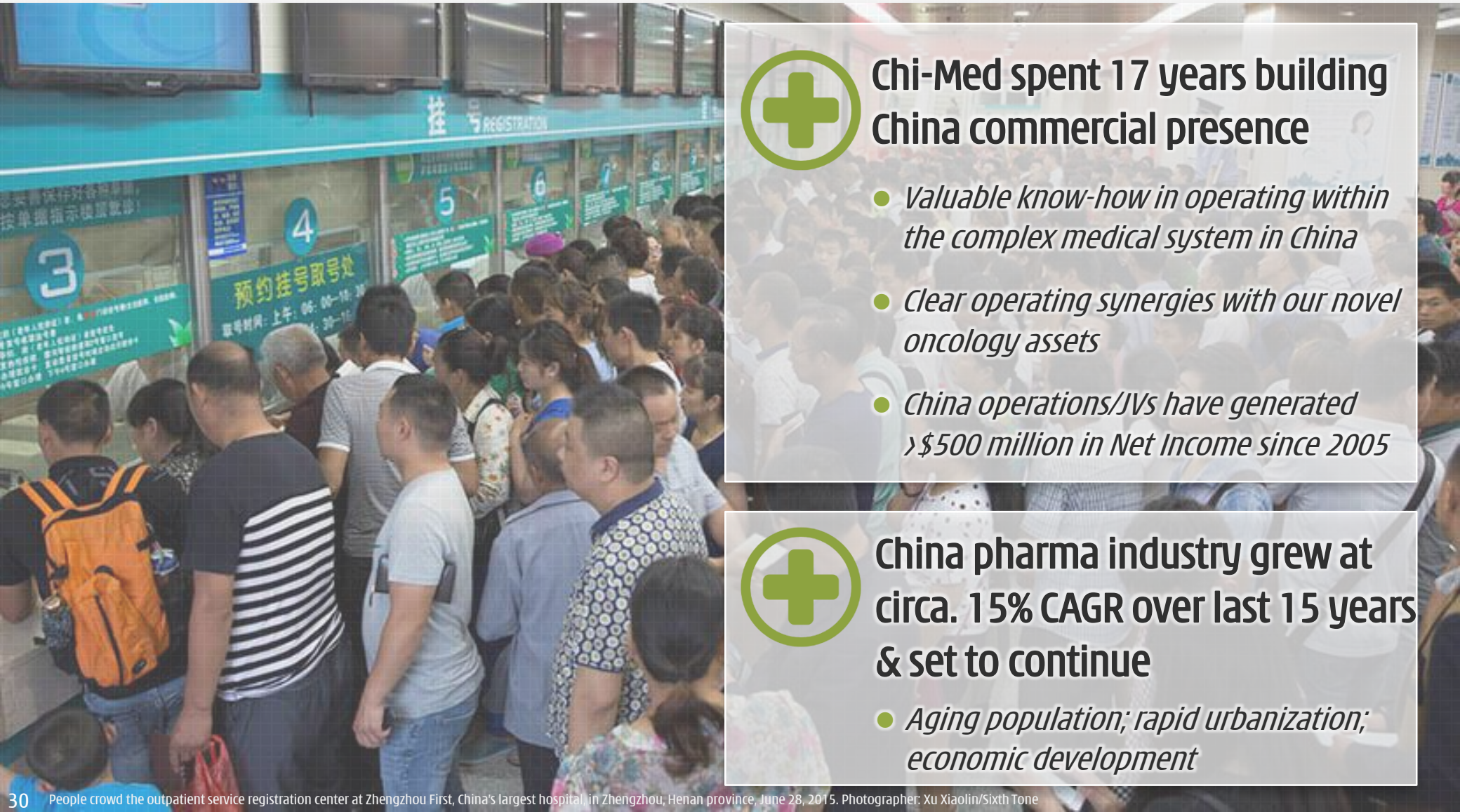
CHI-MED

2c

Highlights & Strategies – Existing China Business

Cash generation & China commercial know-how / infrastructure

Existing China Business



Chi-Med spent 17 years building China commercial presence

- *Valuable know-how in operating within the complex medical system in China*
- *Clear operating synergies with our novel oncology assets*
- *China operations/JVs have generated >$500 million in Net Income since 2005*

China pharma industry grew at circa. 15% CAGR over last 15 years & set to continue

- *Aging population; rapid urbanization; economic development*

People crowd the outpatient service registration center at Zhengzhou First, China's largest hospital, in Zhengzhou, Henan province, June 28, 2015. Photographer: Xu Xiaolin/Sixth Tone

Chi-Med's Commercial Platform in China

Integrated platform built from ground up

2 National House-Hold Name Brands

Major Commercial & Production Scale

~2,400 RX & ~1,000 OTC sales people in about 300 [1] cities & towns in China.

Drugs in ~22,900 hospitals detailing ~106,000 doctors.

Sold ~4.6 billion doses of medicine in 2017.

Leadership Market Shares

Market leader in the sub-categories/markets in which we compete [2]:

SXBX pill:[3][4] Rx Cardiovascular TCM	~15%
Banlangen:[5] OTC Anti-viral /flu TCM	~53%
FFDS tablet:[6] OTC Angina TCM	~38%

JVs with 3 Major China Pharmas

SPH 上海医药 SHANGHAI PHARMA

GPC

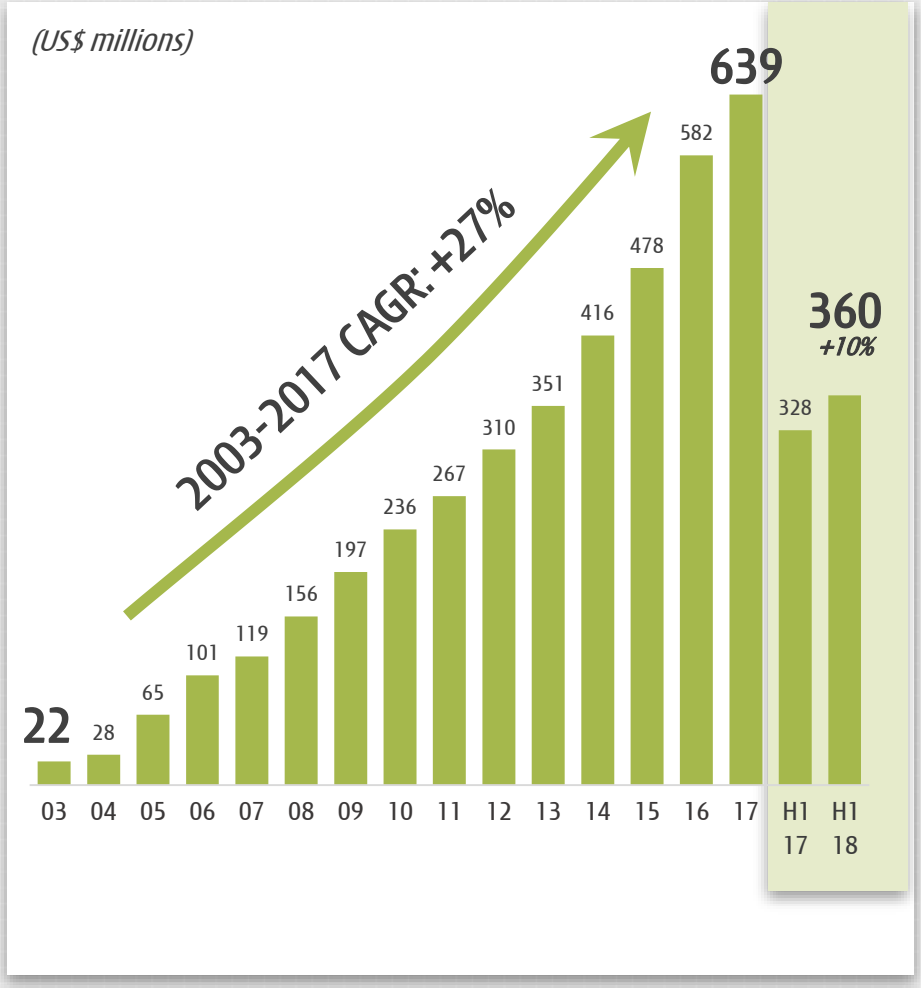
SINOPHARM

[1] 300 cities & towns covered by Prescription Drug Business and 600 cities & towns including OTC business; [2] Frost & Sullivan 2017 market share data; [3] China coronary heart disease oral Chinese patented drugs market share; [4] She Xiang Bao Xin Pill ("SXBX pill"); [5] Banlangen Granules ("Banlangen") - OTC Antiviral; [6] Fu Fang Dan Shen tablets ("FFDS").

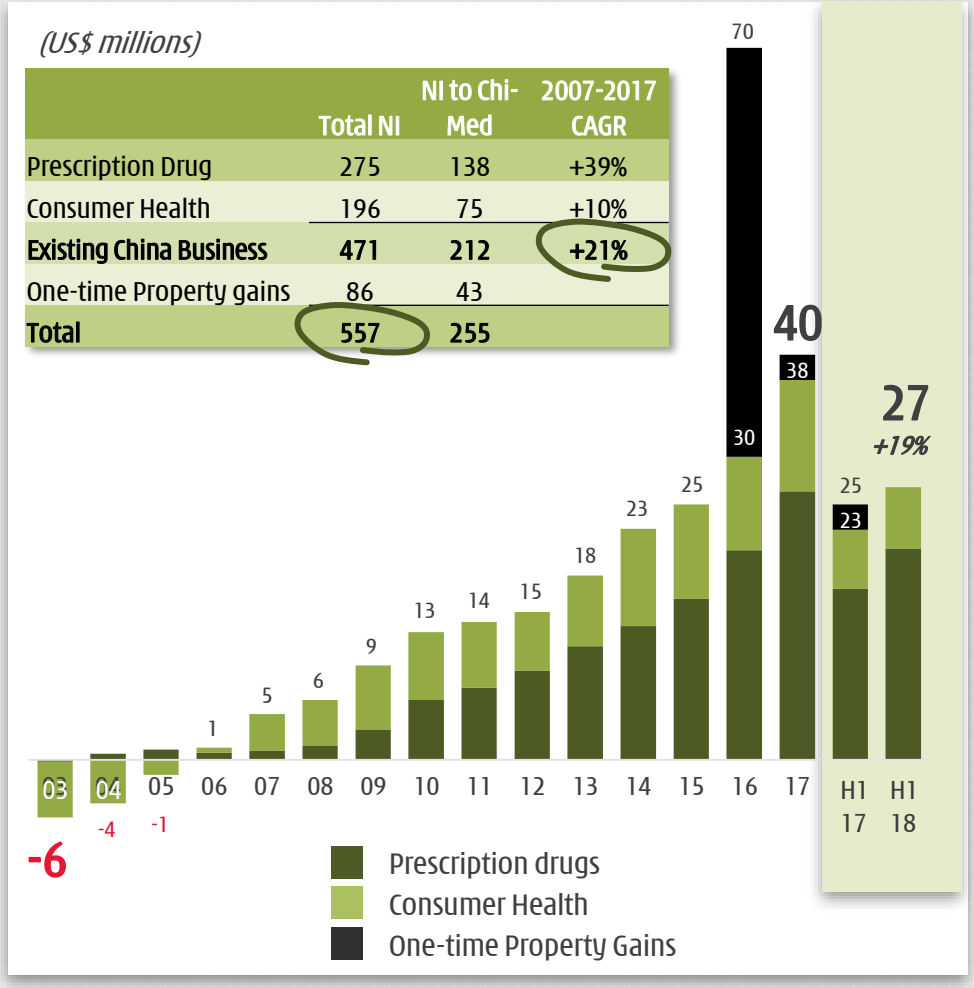
Chi-Med's Commercial Platform in China

Proven track record of success - important source of cash

Sales (Non-GAAP) [1]



Net Income/(Loss) attrib. to Chi-Med

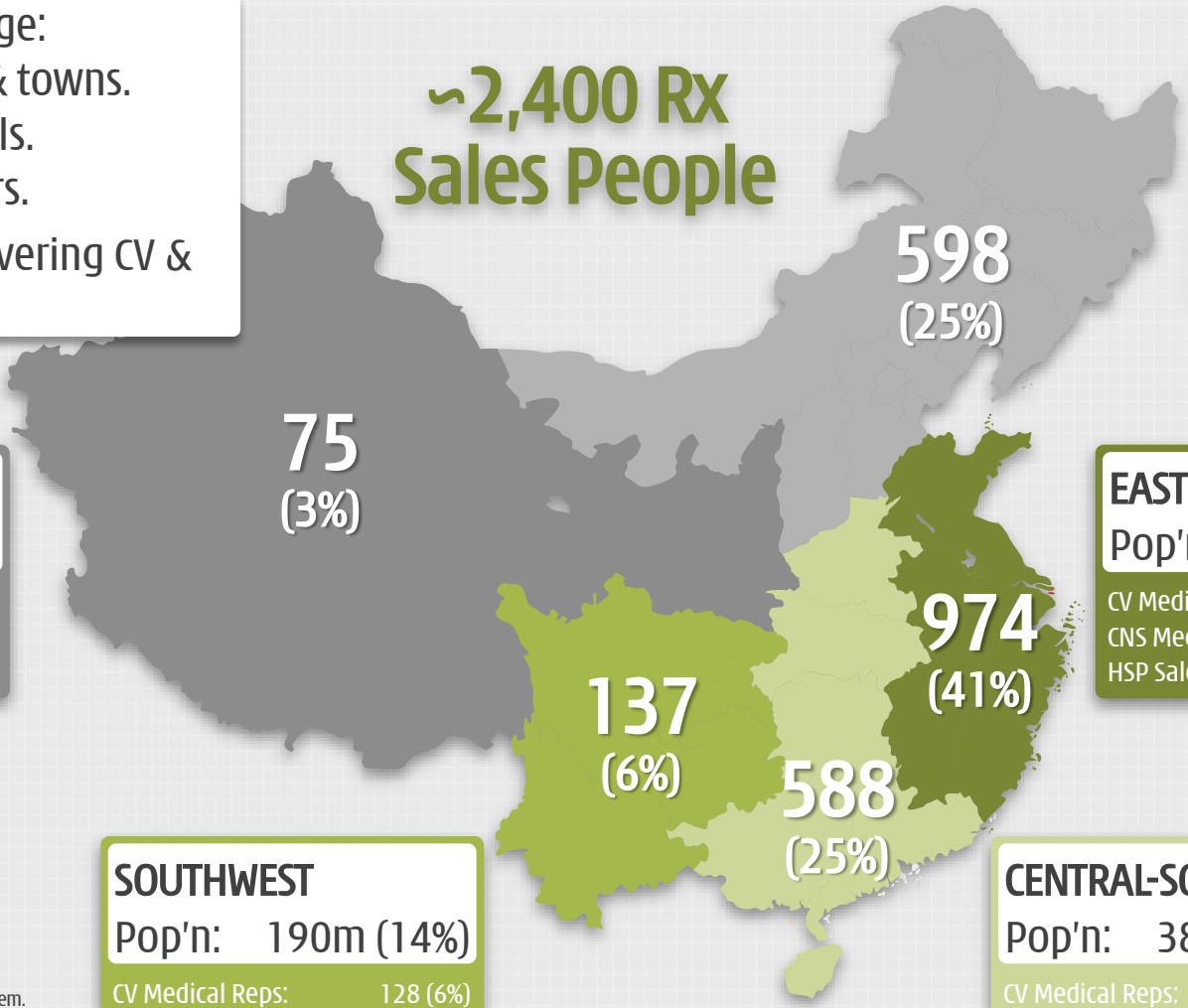


[1] 2003-2006 incl. disco. operation.

A powerful Rx Commercial Platform in China....

Chi-Med management run all day-to-day operations

- National Coverage:
  Over 300 cities & towns.
  ~22,900 hospitals.
  ~106,000 doctors.
- Medical reps. covering CV & CNS nationally.



NORTH
Pop'n: 320m (23%)

CV Medical Reps:	578 (26%)
CNS Medical Reps:	20 (19%)
HSP Sales staff:	0 (0%)

WEST
Pop'n: 100m (7%)

CV Medical Reps:	70 (3%)
CNS Medical Reps:	5 (5%)
HSP Sales staff:	0 (0%)

EAST
Pop'n: 393m (28%)

CV Medical Reps:	896 (40%)
CNS Medical Reps:	47 (44%)
HSP Sales staff:	31 (100%)

SOUTHWEST
Pop'n: 190m (14%)

CV Medical Reps:	128 (6%)
CNS Medical Reps:	9 (8%)
HSP Sales staff:	0 (0%)

CENTRAL-SOUTH
Pop'n: 383m (28%)

CV Medical Reps:	562 (25%)
CNS Medical Reps:	26 (24%)
HSP Sales staff:	0 (0%)

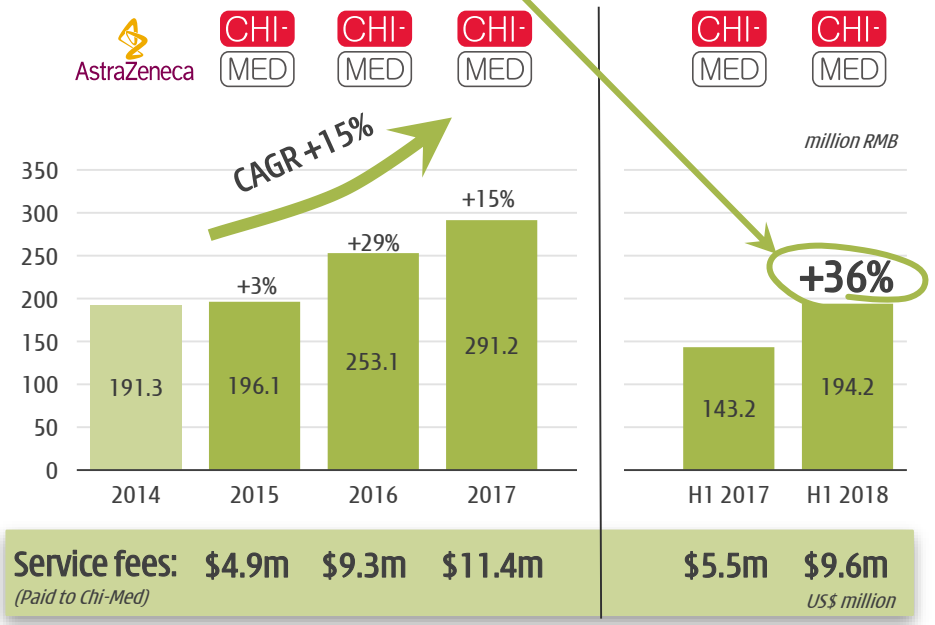
Notes: 2010 Population - China State Census;
CV = Cardiovascular; CNS = Central nervous system.
Chi-Med Rx sales team data = 30 June 2018

...highly adaptable commercial platform

3rd party products - sales of Seroquel® & Concor® up significantly

Seroquel®, or quetiapine, is a second generation antipsychotic approved for the treatment of schizophrenia, bipolar disorder and as adjunct treatment of major depressive disorder.

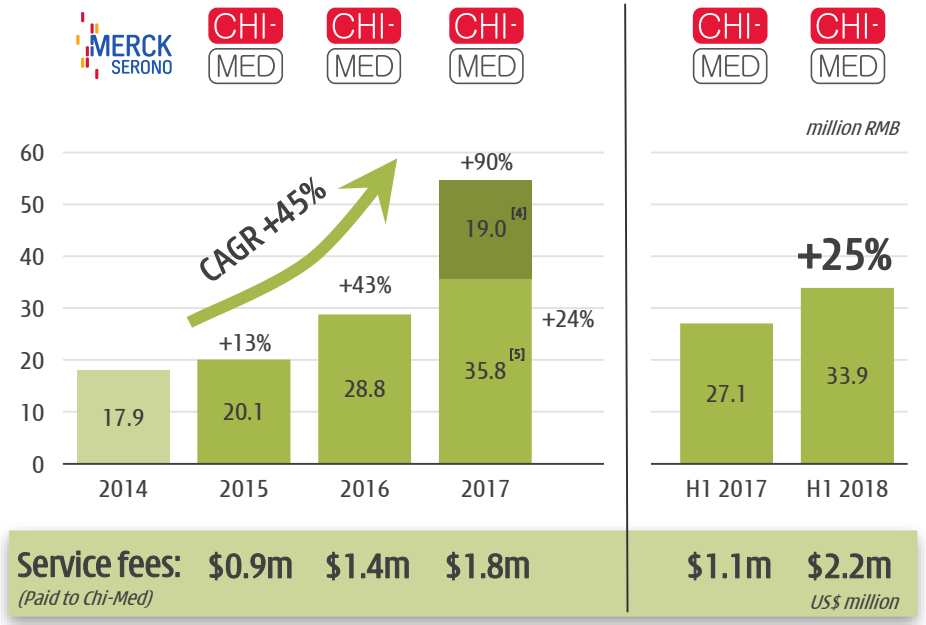
- Chi-Med holds **exclusive all China commercial rights** - full service commercial role (fee-for-service[1][2]).
- Luye acquisition no effect. **Chi-Med retains rights through 2025 if we hit sales targets**. 2018 target RMB354m or +22% & +15% p.a. thereafter.



[1] In Oct 2017, as a result of the new NMPA Two-Invoice System policy, the Seroquel® operating model changed to a "fee-for-service" model vs. the prior model in which Chi-Med consolidated the sales of Seroquel® -- the change has no material impact on net income earned;
[2] 2014 full year and Q1 2015 were managed by AstraZeneca. Chi-Med took over commercial function for Seroquel® across all-China in April 2015.

Concor®, or bisoprolol hemifumarate, is a beta-blocker approved for the treatment of hypertension.

- Chi-Med runs **six core territories covering 360m people** - full service commercial role (fee-for-service).
- Took over from MS Jan-2015 [3].
- Leverages SHPL's existing **›2,200 cardiovascular medical reps**.



[3] 2014 full year was managed by Merck Serono. Chi-Med took over commercial function for Concor® in 3 original territories on fee-for-service basis in Jan 2015; [4] Sales into 3 new territories (Tianjin, Anhui and Jiangsu) were added from 2017: RMB19.0 million; [5] 3 original territories (Shandong, Henan and Shanghai) contributed RMB35.8 million in 2017 (+24.3%).

Existing China Business

Plans for 2019-2021

Continue organic growth

- Target high single-digit percentage growth in product sales;
- Focus on proprietary prescription drug products

Build out synergies with China Oncology Organization

Strategically evaluate potential for M&A

- Expand the scope & scale of our joint ventures
- Continue to evaluate potential for divestment of certain non-strategic assets

Focus on cash generation

3 Cash & News Flow

Latest updates

FY 2018 Guidance & June 30 Balance Sheet

	2017 Actual	2018 Guidance [5]
Revenues	$241.2	$155 - $175
Innovation Platform		
Revenue	36.0	40 - 50
Adj. R&D exp. (non-GAAP) [3]	(88.0)	(142) - (152)
Net Loss	(52.0)	(92) - (112)
Commercial Platform		
Sales (consolidated)	205.2	115 - 125
Sales of non-consolidated JVs	*472.0*	*460 - 480*
Net Income		
Adj. (non-GAAP) excl. one-time gains	*37.5*	*41 - 43*
One-time gains [4]	*2.5*	*0*
Net Income	40.0	41 - 43
Chi-Med Group Costs		
Admin., interest, tax	(14.8)	(16) - (18)
Net Loss Attributable to Chi-Med	(26.7)	(71) - (84)

Chi-Med Net Cash

- $322.5m cash / cash equiv. / ST inv. [1]
- $94.4m additional unutilized banking facilities [2]
- $26.7m in bank borrowings
  - ✓ Avg. cost 2.3%
- $62.5m additional cash in JVs

[1] Short-term investments: 91-183 days deposits; [2] From Scotiabank, Bank of America Merrill Lynch, Deutsche Bank, Hong Kong Shanghai Banking Corporation; [3] R&D expenses, as adjusted (non-GAAP) excludes the actual or estimated impact of the revenue received from external customers of our Innovation Platform, which is reinvested into our clinical trials; [4] SHPL's R&D related subsidies of US$2.5 million at net income attributable to Chi-Med for 2017; [5] Updated as of December 20, 2018.

(US$ millions)

Major targets/news flow in 2019

	H1	H2
Global Innovation	**Savo / Savo + Imfinzi® (CALYPSO)** x3: 2L clear cell RCC; PRCC **Phase II Data**	**Fruquintinib** 3L/4L colorectal cancer **Phase II/III Start (US)**
	HMPL-523 (Syk) Indolent non-Hodgkin's Lymph. (NHL) **Phase I/Ib Start (US/EU)**	**Savo / Savo + Taxotere® (VIKTORY)** x3: 2L gastric cancer **Phase II Data**
	HMPL-689 (PI3Kδ) Indolent NHL **Phase I/Ib Start (US/EU)**	**Savolitinib Lung Cancer** Anticipate announcing plans for further Ph.II/III studies in 2019
		Fruquintinib / Surufatinib PD-1 combos Anticipate initiating US development
China Oncology	**Surufatinib** 2L Biliary tract cancer **Ph.II/III Start**	**Surufatinib (SANET-ep)** Non-Pancreatic NET **Ph.III Interim Data**
	Fruquintinib + Taxol® (FRUTIGA) 2L gastric cancer **Ph.III Interim Data**	**HMPL-523 / HMPL-689** Indolent NHL **Ph.I/Ib PoC Data**
		Savolitinib 1L Exon 14 NSCLC **Registration Study Enrolled**
		Surufatinib (SANET-p) Pancreatic NET **Ph.III Interim Data**
	Fruquintinib 3L Colorectal Cancer Anticipate release of prescription & sales performance data during 2019	

Targets: Savolitinib = c-MET; fruquintinib = VEGFR1/2/3; surufatinib = VEGFR/FGFR1/CSF-1R; HMPL-523 = Syk; HMPL-689 = PI3Kδ.

CHI-MED

4

Deep Dive on Clinical Drug Candidates

Update on all key assets

CHI-MED

4a

Savolitinib (AZD6094)

Potential first-in-class selective c-Met inhibitor

Savolitinib (AZD6094)

Potential first-in-class selective c-Met inhibitor

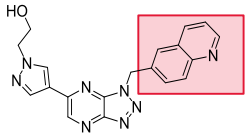
1. Strong potential to become first selective c-Met inhibitor approved.

- ✓ Clear clinical efficacy observed in **non-small cell lung ("NSCLC"), kidney, gastric and colorectal** cancers.
- ✓ Partnered with AstraZeneca – **key comp. advantages in NSCLC (Tagrisso® combo) & molecular selection**.

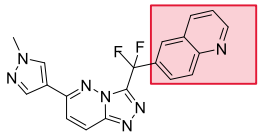
2. c-Met is aberrant in many tumor settings. [3]

	c-MET			New Cases (2015)	
Indication	Amplification	Mutation	Over-Expression	Global	China
Gastric	10%	1%	41%	1,034,000	679,100
Lung	8-10% [1]	8%	67%	1,690,000	733,300
Head & Neck		11%	46%	740,000	135,000
Colorectal	10%		65%	1,477,000	376,300
Renal cell Carcinoma (Papillary)	40-70%	100% [2]		50,000	7,000
Renal cell Carcinoma (Clear cell)			79%	270,000	60,000
Esophagus	8%		92%	496,000	477,900
Prostate [4]			54-83%	1,100,000	60,300

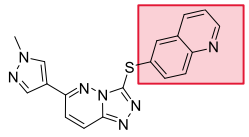
3. Savolitinib design eliminates renal toxicity first generation of selective c-Met inhibitors encountered – >700 patients involved in clinical studies to date.



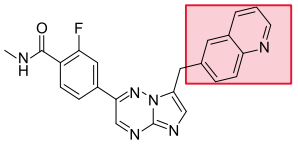
Pfizer PF-04217903



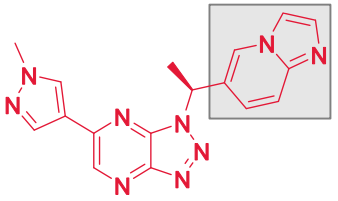
Janssen JNJ-38877605



Lilly SGX-523



Novartis/Incyte INC-280



savolitinib

2-quinolinone metabolite in humans in 1st-gen c-Met compounds has dramatically reduced solubility and appeared to crystallize in the kidney resulting in obstructive toxicity.

4. AstraZeneca collaboration & 2016 amendment.

- $20m received upfront (Dec 2011);
- $120m in development/approvals milestones ($25m received as of Jun 2018);
- Several hundred million in commercial milestones;
- Development costs: AZ pay 100% ex-China (excl. $50m by Chi-Med) & 75% development cost in China (Chi-Med 25%);
- **14-18% tiered royalty ex-China [5]** & 30% flat rate China royalty on all product revenues.

[1] Range includes (i) approximately 4% of c-Met+ naïve non-small cell lung cancer patients and (ii) 10 – 30% of EGFRm+ non-small cell lung cancer patients, which 15 to 20% develop EGFRm+ tyrosine kinase inhibitor resistance pathway as c-Met+; [2] Hereditary papillary renal cell carcinoma only; [3] Company estimates considering Frost & Sullivan data, National Central Cancer Registry of China and publicly available epidemiology data; [4] By IHC, c-Met overexpression in 54% of lymph node disease and 83% of bone metastases. Varkaris et al, Expert Opin Investig Drugs. 2011 Dec; 20(12): 1677-1684; [5] Subject to approval in the papillary renal cell carcinoma (PRCC) indication and after total aggregate sales of savolitinib have reached $5bn, the royalty will step down over a two-year period, to an ongoing royalty rate of 10.5% to 14.5%.

Savolitinib

Biggest opportunity is MET+ non-small cell lung cancer ("NSCLC")

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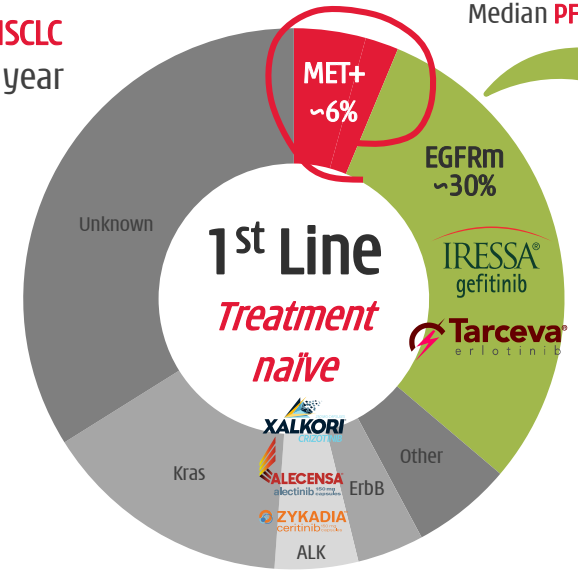
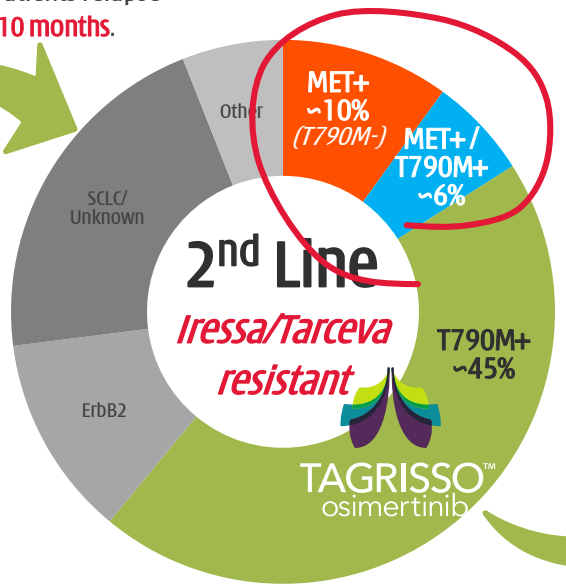
Primary NSCLC

1.7 million NSCLC patients per year

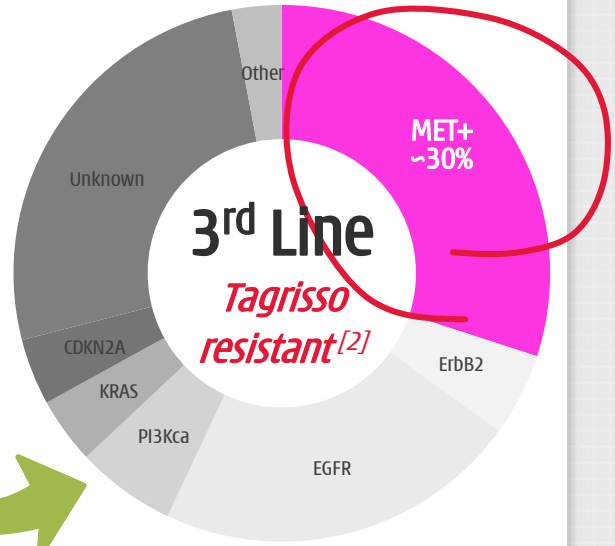


All **Iressa/Tarceva** patients relapse
Median **PFS 9-10 months**.

Resistance-driven EGFRm+ NSCLC



All **Tagrisso** patients relapse
Median **PFS 9-10 months**.



	Target	Launch	2017 ($m)	Est.[1] Pts Treated/yr.
Iressa	EGFRm	2003	528	~20,000
Tarceva	EGFRm	2004	860	~50,000
Tagrisso	EGFRm / T790M	2018		
Xalkori	ALK / ROS1 / MET	2011	594	
Zykadia	ALK	2015	Not disc.	
Alecensa	ALK	2015	369	
Total Sales			› 2.3b	

Launch	2016 ($m)	2017 ($m)	H1 2018 ($m)	Est.[3] Pts Treated/yr.
Dec-15	423	955	760	~5-10,000
	423	955	760	

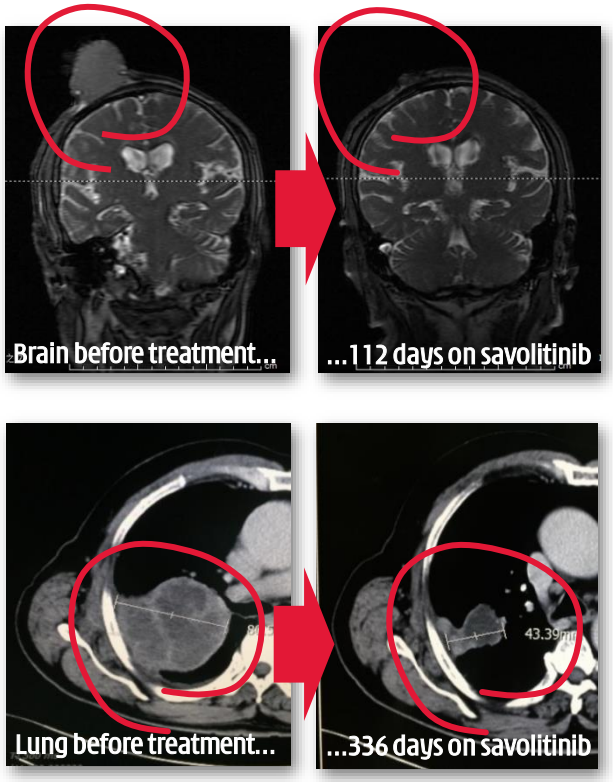
TAGRISSO™ osimertinib

Est. global peak sales ~$3-4 bn[4].

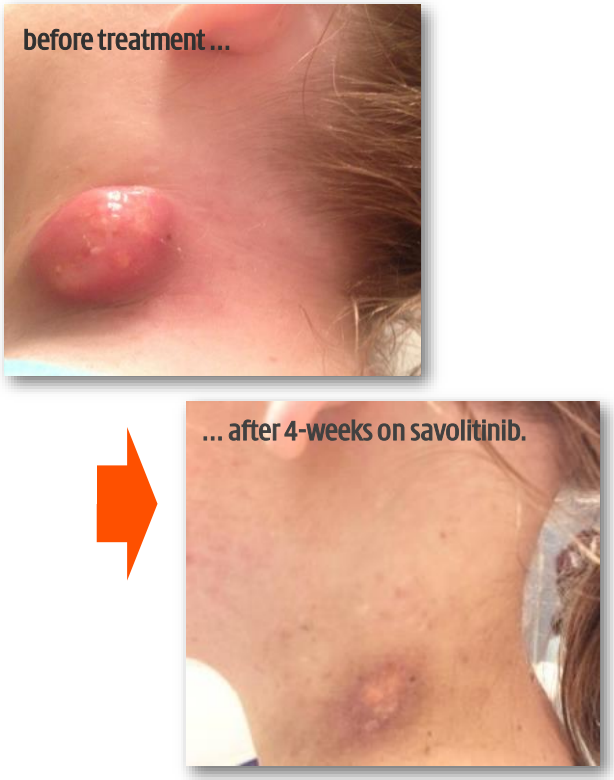
[1] General estimate based on mPFS ~9 mo. average cost/cycle ~$2,500-3,000; [2] Primary drivers, based on aggregate rocelitinib/Tagrisso data published at 2016/2017 ASCO; [3] AstraZeneca 2016 /17 results; [4] Company estimates.

Savo standout efficacy in all MET+ NSCLC subsets…

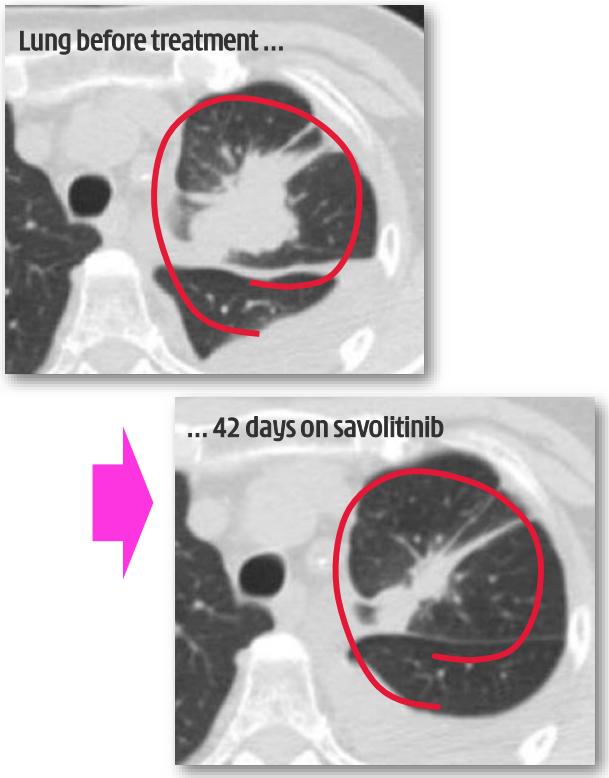
1L NSCLC [1]



2L post Iressa®/ Tarceva®



2L/3L post Tagrisso®



[1] The trial is focused on patients with MET Exon 14 mutation who have failed prior systemic therapy, or are unwilling or unable to receive chemotherapy, however the target patient population is intended to be all MET Exon 14 mutation patients.

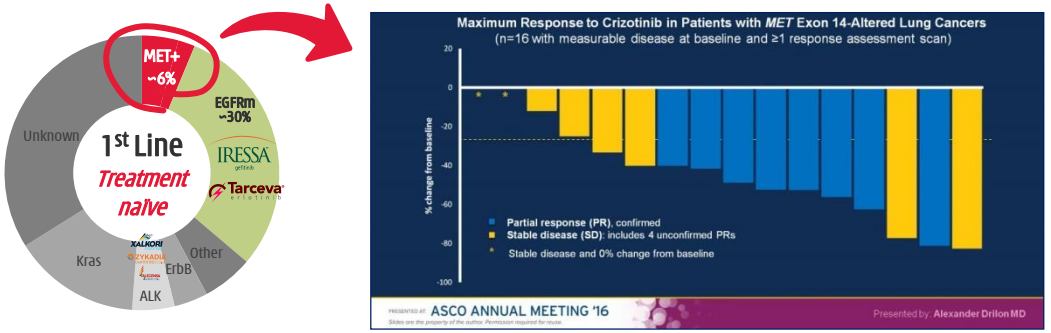
1L MET Exon 14 deletion NSCLC [1]

Savolitinib superior target coverage vs. Xalkori®

1. Xalkori® is a multi-kinase inhibitor with ALK, ROS1, & MET inhibition – savolitinib is uniquely selective and >10X more potent against c-Met.

IC_{50} (nM)	Savolitinib	Xalkori® (crizotinib)	Savolitinib vs. Xalkori®
EBC1 Viability	2	19	10x
EBC1 pMET	1	39	40x
293T MET (wild type)	7	79	11x
293T MET (Ex14del)	9	140	16x

2. 1st line NSCLC – Xalkori® MET Exon14 del – 2016 ASCO – strong response (~50% ORR) but >1/3 of responses not durable (4/12) [2].

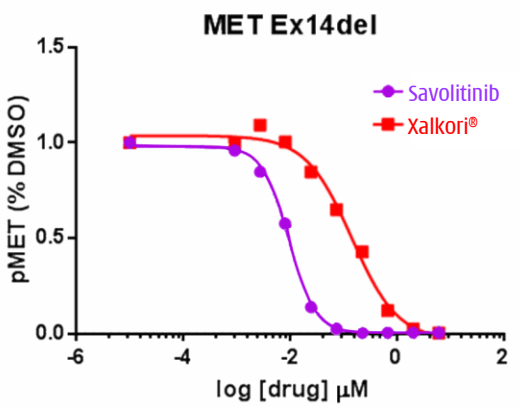


3. Multi-center retrospective analysis of 148 pts. w/ NSCLC MET Exon14 [3]

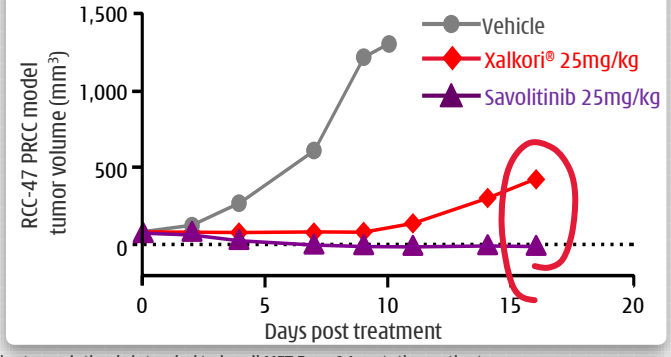
	MET Exon14 skipping: Exposed to c-MET TKI	MET Exon14 skipping: Never exposed to c-MET TKI
No. of pts	27	34
Median OS	24.6 months	8.1 months

Epidemiology of never-exposed to c-MET TKI		
	With concurrent c-MET amplification	Without concurrent c-MET amplification
Median OS	5.2 months	10.5 months
	P=0.06	

4. Savolitinib versus Xalkori® in MET Ex14del mutant cells [4] – better target coverage.



5. Durable tumor cell suppression for savolitinib but not for Xalkori® [5].

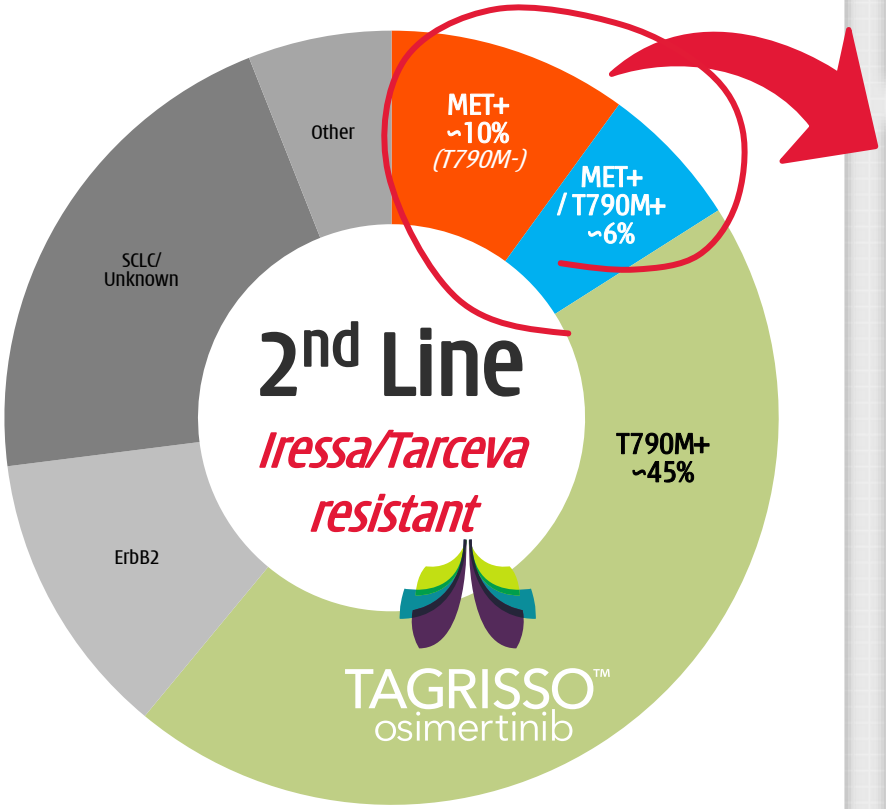


[1] The trial is focused on patients with MET Exon 14 mutation who have failed prior systemic therapy, or are unwilling or unable to receive chemotherapy, however the target patient population is intended to be all MET Exon 14 mutation patients;
[2] Drilon A, Abstract 108 Efficacy and safety of crizotinib in patients with advanced MET Exon 14-altered non-small cell lung cancer; [3] ASCO 2017, Abstract 8511, Mark M. Awad et al.; [4] Paik, P.K., et al., Response to MET inhibitors in patients with stage IV lung adenocarcinomas harboring MET mutations causing exon 14 skipping. Cancer Discov, 2015. 5(8): p. 842-9.; [5] Schuller AG et al. "Regression in Papillary Renal Cell Carcinoma Patient-Derived Xenograft Models". Clin Cancer Res 2015;21:2811-2819.

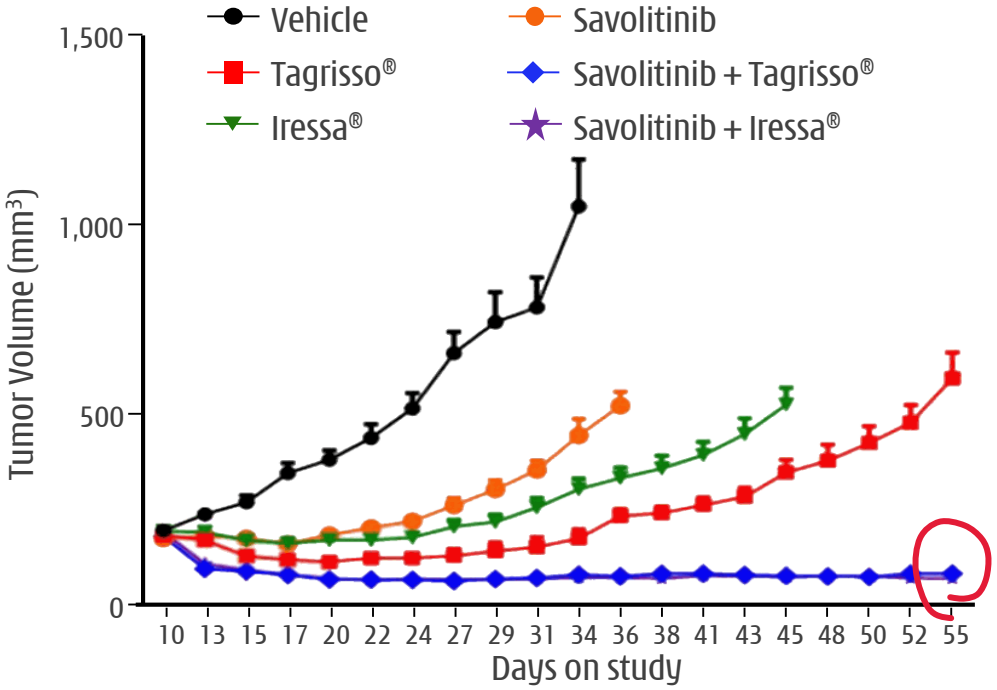
Savolitinib - 2L EGFRm NSCLC

Very strong preclinical rationale for combination w/ EGFR-TKIs

1. 2nd Line NSCLC is a **fast and attractive indication for savolitinib** to go after. Also important unmet medical need and potential **Breakthrough Therapy** area.



2. Potential in **EGFR-TKI resistant NSCLC**:
   - ✓ Must **shut down both EGFRm & MET** signaling pathways;
   - ✓ **Prolonged tumor growth suppression** by combining savolitinib with Tagrisso® (osimertinib - EGFR/T790M) or Iressa® (gefitinib/EGFR) **in MET+ / T790M- patients**.



Savolitinib – 2L NSCLC[1] combo w/ TAGRISSO™ osimertinib

To announce plans for further studies during 2019

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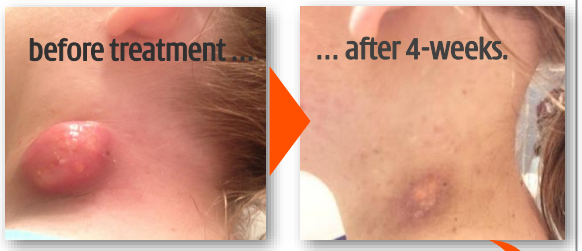
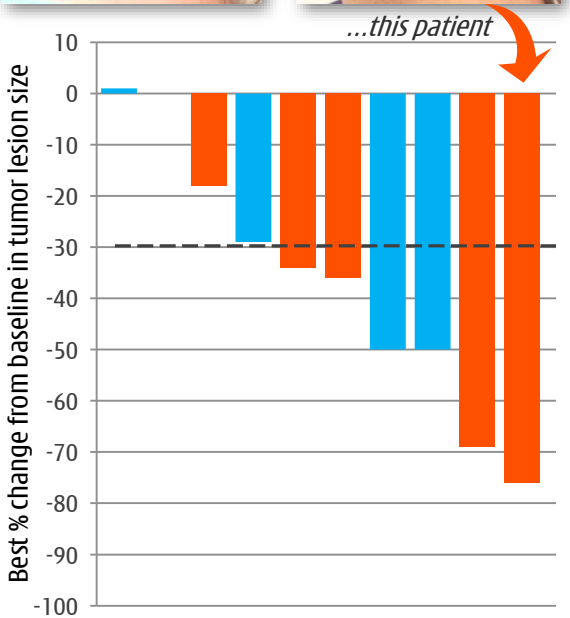
TATTON A [2] – signal…

MET testing confirmation	Objective response rate, n (%)	Total (n = 10)
Local or Central	Confirmed PR [6]	6 (60%)



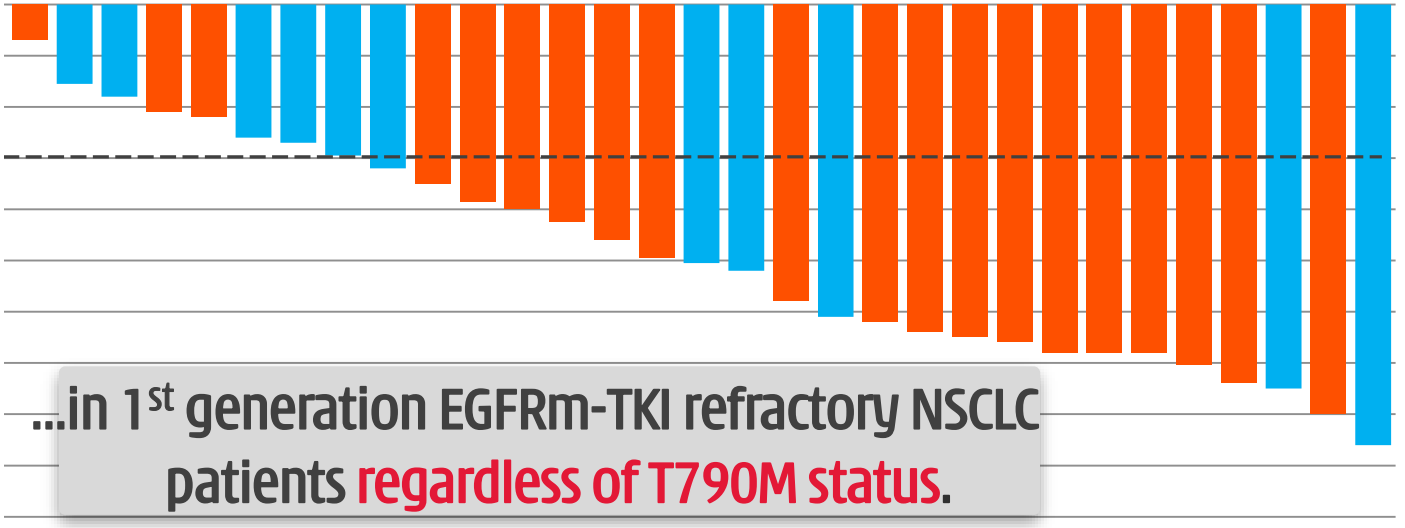


…TATTON B [3] – …confirmation… and BTD [4] potential?

MET testing confirmation	Objective response rate, n (%)	MET+ / T790M+ (n = 11)	MET+ *(T790M-)* (n = 23)	Total (n = 34)
Local or Central	Confirmed PR [6]	6 (55%)	14 (61%)	20 (59%)

		(n = 7)	(n = 15)	(n = 22)
Central *	Confirmed PR [6]	4 (57%)	8 (53%)	12 (55%)
	Stable Disease ≥6 weeks	3 (43%)	6 (40%)	9 (41%)
	Progressive Disease/death	0	1 (7%)	1 (5%)
	Not Evaluable	0	0	0 (0)
	DoR, months (range)	9.7 (2.8*-9.7)	NR (1.6*-5.9*)	NR (1.6*-9.7)

* Centrally confirmed MET-amplification (fluorescence in-situ hybridization, MET gene copy ≥5 or MET/CEP7 ratio ≥2) [5]



…in 1st generation EGFRm-TKI refractory NSCLC patients regardless of T790M status.

[1] EGFRm NSCLC; [2] ESMO 2016 Galbraith - Novel Clinical Trials for Prec. Med.; [3] WCLC 2017 – Ahn M-J, *et al.* TATTON Phase Ib expansion cohort; [4] U.S. FDA Breakthrough Therapy designation potential; [5] Some local MET-status determined via IHC+3 in ≥ 50% of tumor cells); [6] PR = Partial Response.

Savolitinib – 2L NSCLC[1] combo w/ IRESSA® gefitinib

Compelling in MET+ / T790M-, pivotal decision under discussion

CHI-MED

Savo / Iressa® combo in 1st gen. EGFRm-TKI refractory patients [2]...outstanding response in MET+ / T790M-

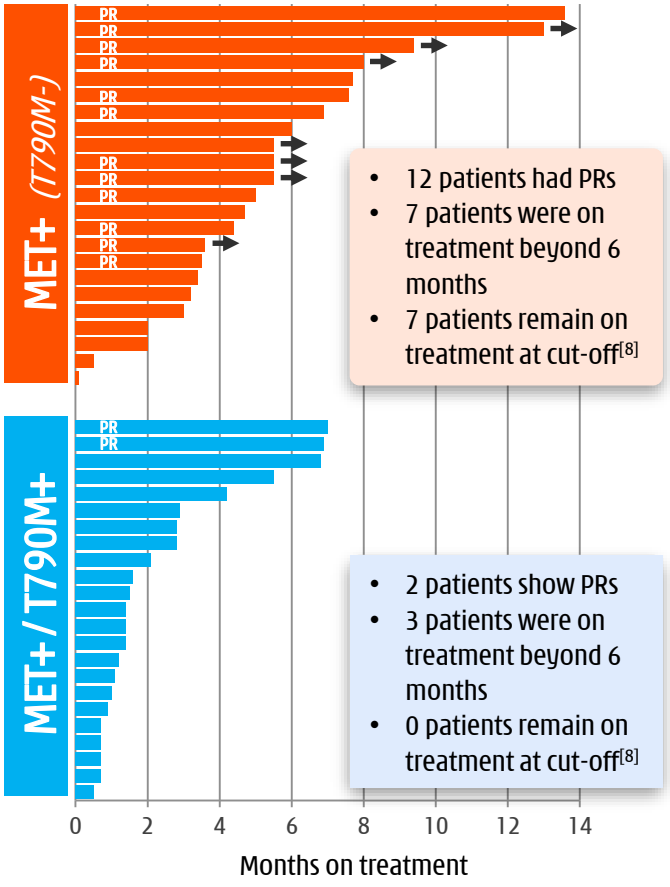
MET testing confirmation	Objective response rate, n (%)	MET+ / T790M+ (n = 23)	MET+ *(T790M-)* (n = 23)	MET+ / T790M unk. (n = 5)	Total (n = 51)
Central *	Confirmed PR [3]	2 (9%)	12 (52%)	2 (40%)	16 (31%)
	SD [4] ≥ 6 weeks	9 (39%)	7 (30%)	2 (40%)	18 (35%)
	PD [5] / death	7 (30%)	3 (13%)	0	10 (20%)
	Not Evaluable	5 (22%)	1 (4%)	1 (20%)	7 (14%)

...vs. TATTON B data (savo / Tagrisso® combo) [6]

MET testing confirmation	Objective response rate, n (%)	MET+ / T790M+ (n = 11)	MET+ *(T790M-)* (n = 23)	MET+ / T790M unk. (n = 0)	Total (n = 34)
Local or Central	Confirmed PR [3]	6 (55%)	14 (61%)	0	**20 (59%)**
		(n = 7)	(n = 15)	(n = 0)	(n = 22)
Central *	Confirmed PR [3]	4 (57%)	8 (53%)	0	12 (55%)
	SD [4] ≥ 6 weeks	3 (43%)	6 (40%)	0	9 (41%)
	PD [5] / death	0	1 (7%)	0	1 (5%)
	Not Evaluable	0	0	0	0 (0)

* Centrally confirmed MET-amplification (fluorescence in-situ hybridization, MET gene copy ≥5 or MET/CEP7 ratio ≥2) [9].

...Iressa® combo – ~6mo. DoR [7] in MET+ / T790M- patients



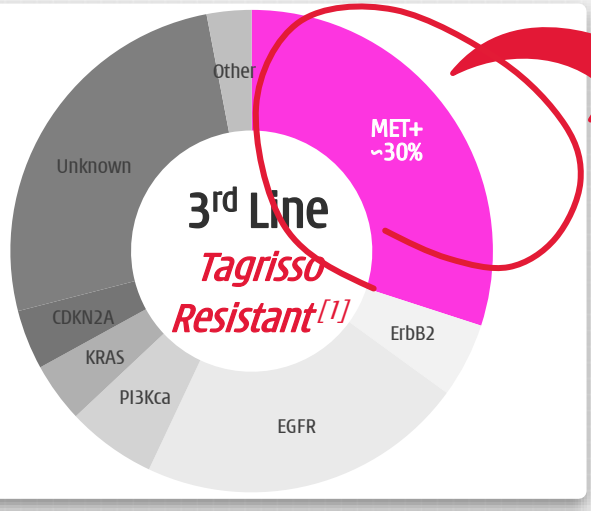
- 12 patients had PRs
- 7 patients were on treatment beyond 6 months
- 7 patients remain on treatment at cut-off[8]

- 2 patients show PRs
- 3 patients were on treatment beyond 6 months
- 0 patients remain on treatment at cut-off[8]

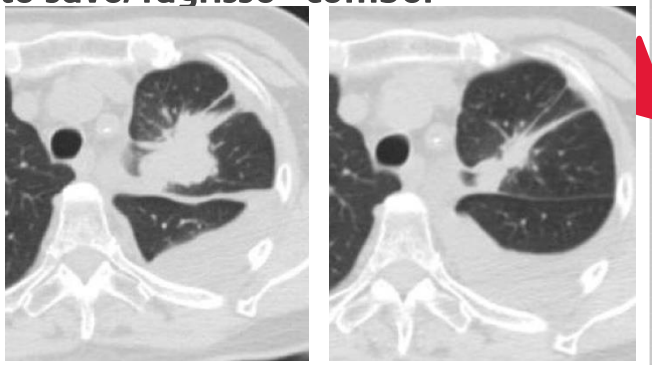
[1] EGFRm NSCLC; [2] WCLC 2017Yang J-J, et al. A Ph.Ib Trial of savolitinib plus gefitinib for patients with EGFR-mutant MET-amplified advanced NSCLC; [3] PR = Partial Response; [4] SD = Stable Disease; [5] PD = Progressive Disease; [6] WCLC 2017 - Ahn M-J, *et al.* TATTON Phase Ib exp. cohort; [7] DoR = Duration of Response; [8] Aug 21, 2017; [9] On TATTON B, some local MET-status determined via IHC+3 in ≥ 50% of tumor cells.

Savolitinib - 2L/3L NSCLC[1] - TAGRISSO™ osimertinib resistant

MET+ driven resistance in ~30% of patients



3 out of 3 MET+ patients responded to savo/Tagrisso® combo.



LUL Mass Pre-Treatment | 6 wks. on savo/Tag. Treatment

Tagrisso® resistant tissue & ctDNA analysis [2]

MASSACHUSETTS GENERAL HOSPITAL CANCER CENTER | HARVARD MEDICAL SCHOOL

Pt	EGFR mutation	# Prior Therapies	Prior 3rd gen TKI	TISSUE (NGS, FISH)	PLASMA ctDNA (NGS)
1	L858R	1		*MET* amp, T790 WT	*MET* amp, T790M ND
2	Del19	1		-	T790M ND
3	Del19	2	Y	-	T790M ND
4	L858R (de novo T790M)	2	Y	*MET* amp, *EGFR* amp T790M (germline)	-
5	L858R	3	Y	T790wt, *EGFR* amp	T790M ND
6	L858R	4	Y	T790 WT	T790M ND
7	Del19	3	Y	-	T790M ND
8*	Del19	3		T790M/C797S	T790M/C797S
9	L858R	4	Y	T790 WT	-
10	Del19	3	Y	-	*PIK3CA* E545K, *PIK3CA* amp, T790M ND
11	Del19	2	Y	*MET* amp, *EGFR* amp, T790 WT	T790M ND
12	Del19	2	Y	-	T790M/C797S
13	Del19	9		T790 WT	-
[illegible]	Del19	2	Y	T790 WT	T790M ND
[illegible]	Del19	1		T790 WT	*FGFR1* D60N, *FGFR1* amp, T790M ND
16	L858R	2		*MET* amp, T790 WT	*MET, EGFR* amp, T790M ND
17	L858R	3	Y	T790 WT	T790M ND
18	Del19 (de novo T790M)	3		SCLC, T790 WT	T790M ND, *EGFR* amp
19	Del19	3	Y	T790 WT	T790M/C797S, *MET* amp, *EGFR* amp
20	L858R	2		*MET* amp, *EGFR* amp, T790 WT	-
21	L858R	3		-	T790M/C797S, *EGFR* amp
22*	L858R	1		MET amp, T790 WT	-
23	Del19	4	Y	-	T790M/C797S

(-) Testing not performed; EGFR - Epidermal Growth Factor Receptor; TKI- Tyrosine Kinase Inhibitor; amp - amplification; WT - wild type; ND - not detected

[1] Based on rocelitinib/Tagrisso data published at 2016/2017 ASCO; [2] In xenograft model H820, with EGFRm, T790M+ and MET CN gain. D'Cruz CM et al; #761 Preclinical data for changing the paradigm of treating drug resistance in NSCLC: Novel combinations of AZD6094, a selective MET inhibitor, and AZD9291 an irreversible, selective (EGFRm and T790M) EGFR TKI; American Association of Cancer Research Annual Meeting; April 19, 2015.

Savolitinib – 2L/3L NSCLC[1] combo w/ TAGRISSO™ osimertinib

Initiated SAVANNAH global registration study

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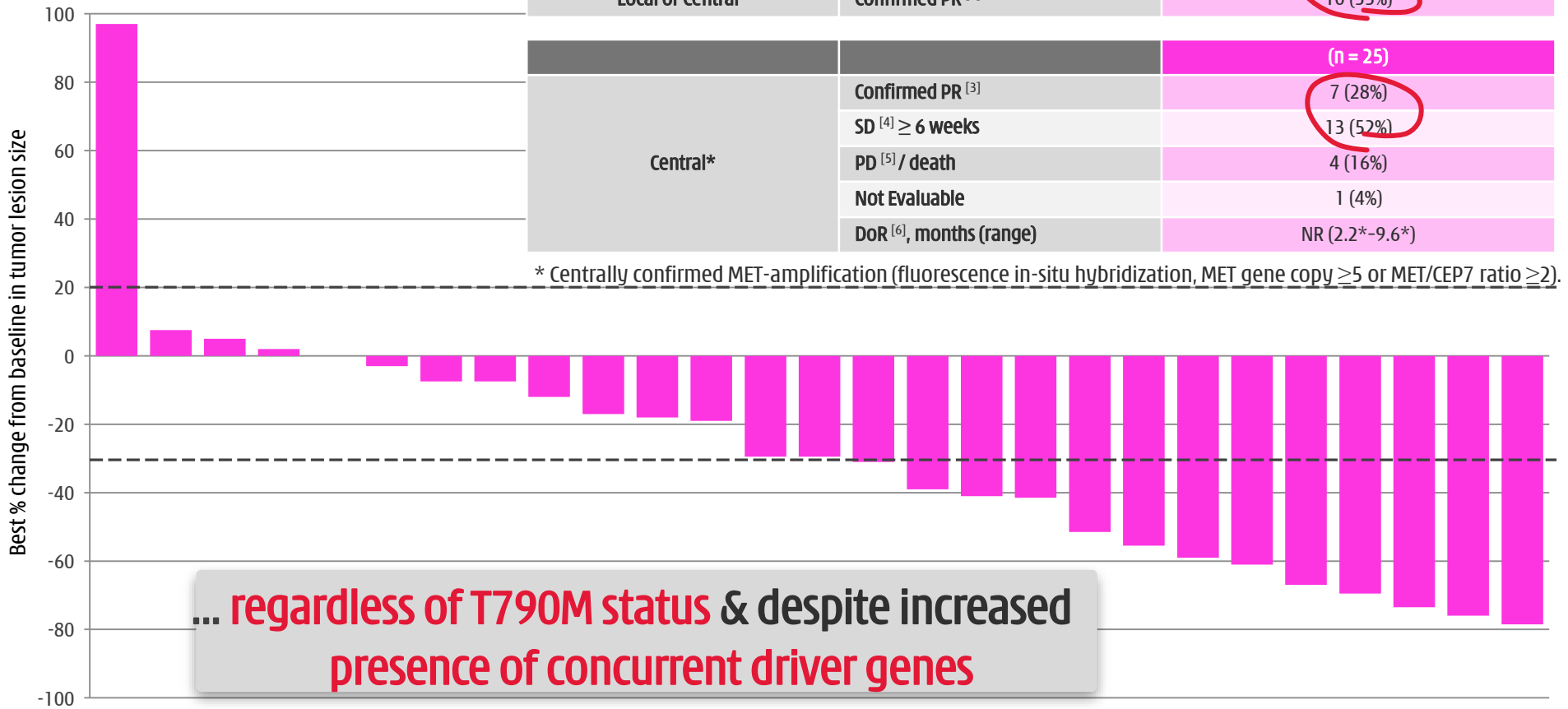
…TATTON B [2] – …promising efficacy in MET+ Tagrisso failure patients…

MET testing confirmation	Objective response rate, n (%)	Prior 3rd Gen. T790M directed EGFR-TKI MET+ (n = 30)
Local or Central*	Confirmed PR [3]	10 (33%)

		(n = 25)
Central*	Confirmed PR [3]	7 (28%)
	SD [4] ≥ 6 weeks	13 (52%)
	PD [5] / death	4 (16%)
	Not Evaluable	1 (4%)
	DoR [6], months (range)	NR (2.2*-9.6*)

* Centrally confirmed MET-amplification (fluorescence in-situ hybridization, MET gene copy ≥5 or MET/CEP7 ratio ≥2).



… regardless of T790M status & despite increased presence of concurrent driver genes

[1] EGFRm NSCLC; [2] WCLC 2017 – Ahn M-J, *et al.* TATTON Phase Ib expansion cohort; Waterfall plot based on evaluable patients (n=30): all patients dosed and with on-treatment assessment or discontinuation prior to first tumour assessment; Data cut-off 31 Aug 2017; [3] PR = Partial Response; [4] SD = Stable Disease; [5] PD = Progressive Disease; [6] DoR = Duration of Response.

Combinations

Tagrisso® & savo both highly selective/tolerable monotherapies

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US FDA Approval Date	Treatment	Disease setting	n	Efficacy		Discontinuations as % Enrolled		
				ORR	Median PFS (mo.)	Due to AE	Withdrawn / Other	Total [5]
Monotherapy – Tagrisso® / savolitinib								
30-Mar-17	**Tagrisso®** (osimertinib)	**2L** EGFRi-refractory T790M+ NSCLC (AURA3)	279	**71%**	10.1	6%	6%	**13%**
	savolitinib 600mg QD monotherapy [3]	**All-lines** Papillary RCC -- *FOR REFERENCE ONLY NOT NSCLC*	109 [1]	**18%**	6.2	9%	5%	**14%**
Combination – Tagrisso® + savolitinib								
	savolitinib 600mg QD + **Iressa®** (gefitinib) [4]	**≥2L** EGFRm+ c-MET+ T790M- NSCLC after 1st-gen EGFR TKI (expansion)	51 [2]	**52%**	ND	20%	14%	**33%**
	savolitinib 600mg QD + **Tagrisso®** [4]	**≥2L** EGFRm+ c-MET+ T790M-/+ NSCLC after 1st-gen EGFR TKI (TATTON B)	34	**59%**	ND	30%	3%	**33%**
	savolitinib 600mg QD + **Tagrisso®** [4]	**≥3L** EGFRm+ c-MET+ NSCLC after 3rd-gen EGFR TKI (TATTON B)	30	**33%**	ND			
Approved treatments in NSCLC								
29-Apr-14	**Zykadia®** (ceritinib)	**2L** ALK+ NSCLC after Xalkori (single arm)	163	**56%**	6.9	10%	10%	**20%**
12-Dec-14	**Cyramza®** (ramucirumab) + **Taxotere®**	**2L** NSCLC after plat-chemo	624	**23%**	4.5	15%	21%	**37%**
24-Oct-16	**Keytruda®** (pembrolizumab) 2mg/kg	**2L** PD-L1+ (TPS≥1%) NSCLC after plat-chemo (KEYNOTE-010)	345	**18%**	3.9	10%	26%	**37%**
2-Oct-15	**Keytruda®** (pembrolizumab) 10mg/kg	**2L** PD-L1+ (TPS≥1%) NSCLC after plat-chemo (KEYNOTE-010)	346	**18%**	4.0	9%	27%	**36%**
9-Oct-15	**Opdivo®** (nivolumab)	**2L** NSCLC after plat-chemo	292	**19%**	2.3	15%	4%	**20%**
4-Mar-15	**Opdivo®** (nivolumab)	**2L** squ. NSCLC after plat-chemo	135	**20%**	3.5	12%	8%	**20%**
2008	**Chemo doublet** (platinum + pemetrexed)	**2L** NSCLC *(AURA3)*	136	**31%**	4.4	11%	17%	**27%**
1999	**Taxotere®** (docetaxel)	**2L** NSCLC *(REVEL; KEYNOTE-010; Opdivo x2 aggregate total)*	1,391	**12%**	3.5	13%	22%	**36%**

Tagrisso® + savo combo tolerable even in very sick late-stage ≥3L patients

[1] PRCC Phase II - Efficacy data from MET+ patients (n=44), discontinuation data from late 2017 data cut-off; Tolerability data from all patients (n=109); [2] TATTON Study - Efficacy data for noted molecular subsets; Tolerability data from all patients (n=64);
[3] September 2017 Journal of Clinical Oncology; [4] 2017 World Conference on Lung Cancer; [5] Total discontinuations = Discontinuations NOT due to Disease Progression or Death; ND = Not Disclosed.

Safety - savolitinib plus IRESSA® gefitinib or TAGRISSO™ osimertinib

Adverse event profiles of combinations - manageable & tolerable

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	IPASS Phase III 1st-Line EGFRm NSCLC			FLAURA Phase III 1st-Line EGFRm NSCLC		AURA3 Phase III 2nd-Line EGFRm NSCLC		
Grade ≥3 AEs, Preferred term, n (%)*	IPASS Iressa® (N=607)	IPASS carbo. + Taxol® (N=589)	≥ 2nd-Line [2] Savo + Iressa® (N=51)	Tagrisso® (N=279)	Iressa® or Tarceva® (N=277)	Tagrisso® (N=279)	Chemo-doublet (plat. + pemetrex.) (N=136)	≥ 2nd-Line [1] Savo + Tagrisso® (N=66)
Any Grade ≥3 AE	**29% (Gr. 3-4)**	**61% (Gr. 3-4)**	**17 (33%)**	**94 (34%)**	**124 (45%)**	**63 (23%)**	**64 (47%)**	**33 (50%)**
Vomiting	1 (<1%)	16 (3%)		0	4 (1%)	1 (<1%)	3 (2%)	5 (8%)
Rash or acne	19 (3%)	5 (1%)		3 (1%)	19 (7%)	2 (1%)		4 (6%)
AST/ALT increase			8 (16%)	3 (1%)	37 (13%)	6 (2%)	2 (2%)	4 (6%)
Nausea	2 (<1%)	9 (1%)	1 (2%)	0	0	2 (1%)	5 (4%)	3 (5%)
Decreased appetite				7 (3%)	5 (2%)	3 (1%)	4 (3%)	3 (5%)
Fatigue				2 (1%)	2 (1%)	3 (1%)	1 (1%)	3 (5%)
Neutropenia	22 (4%)	387 (67%)				4 (1%)	16 (12%)	3 (5%)
ALP increased			11 (22%)					
Neurotoxic effects	2 (<1%)	29 (5%)						
Anemia	13 (2%)	61 (11%)		3 (1%)	3 (1%)	2 (1%)	16 (12%)	
Leukopenia	9 (1%)	202 (35%)					5 (4%)	
Thrombocytopenia						1 (<1%)	10 (7%)	

Sources: [1] TATTON B - Figures where any grade AE ≥10% patients. Ahn M-J, et al. Abstract #8985. Presented at the World Lung Cancer Congress (WCLC) 2017, Japan, October 2017;
[2] Phase Ib/II study - Figures where any grade AE ≥10% patients. Yang J-J, et al. Abstract #8995. Presented at WCLC 2017, Japan, October 2017.
AST = aspartate aminotransferase; ALT = alanine aminotransferase; ALP = alkaline phosphatase.

MET+ PRCC – unmet medical need

1. No treatment choices for non-ccRCC patients.

Approved therapies in RCC [3]

Good efficacy in ccRCC; Multiple treatment options

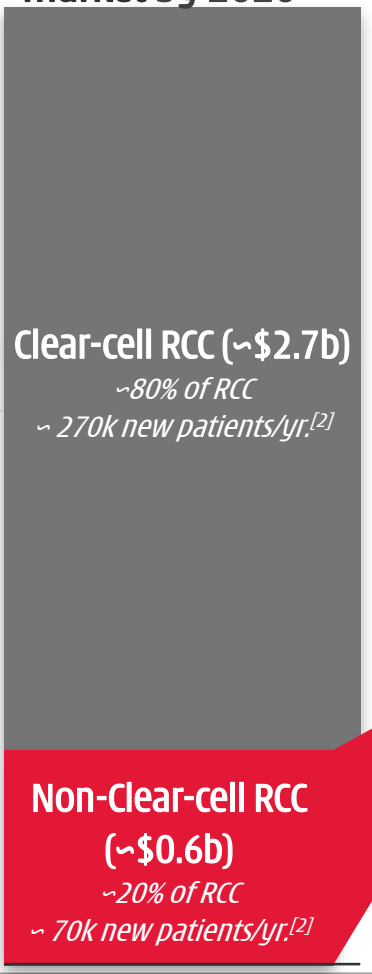
FIRST LINE – clear-cell RCC [4]	ORR	mPFS	mOS
Placebo (avg. multiple studies)	~2%	~3.5	~15.0
Interferon-α	6%	5.0	21.8
Nexavar® (VEGFR, multi-kinase SM) (avg. multiple studies)	~12%	~6.0	~21.0
Sutent® (VEGFR, multi-kinase SM) (avg. multiple studies)	~28%	~10.5	~27.0
Votrient® (VEGFR, multi-kinase SM)	31%	10.5	28.4
SECOND LINE – clear-cell RCC			
Placebo (avg. multiple studies)	~0%	~2.0	~14.0
Afinitor® (mTOR) *(METEOR)*	3%	3.9	16.5
Afinitor® (mTOR) *(CheckMate025)*	5%	4.4	19.6
Inlyta® (VEGFR, multi-kinase SM)	23%	8.3	20.1
Opdivo® (PD-1 mAb) *(CheckMate025)*	25%	4.6	25.0
Cabometyx® (VEGFR/MET, multi-kinase SM) *(METEOR)*	17%	7.4	21.4

Nothing approved in non-ccRCC

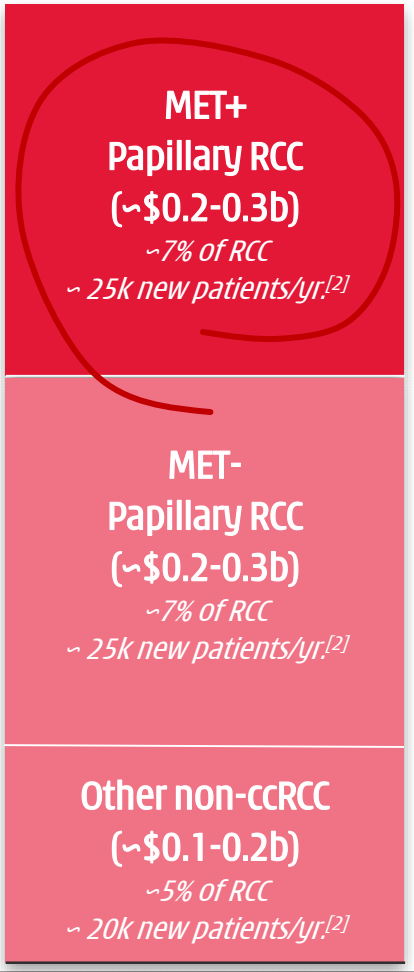
NCCN guideline – "Patients should enter clinical trials"

FIRST LINE – non clear-cell RCC	ORR	mPFS	mOS
Sutent® (VEGFR, multi-kinase SM) [4]	9%	6.1	16.2
Afinitor® (mTOR) [4]	3%	4.1	14.9
SECOND LINE – non-clear-cell RCC			
Sutent® (VEGFR, multi-kinase SM) [4]	10%	1.8	na
Afinitor® (mTOR) [4]	9%	2.8	na

2. RCC est. ~$3.3 bn. market by 2020 [1]



3. Unmet medical need:

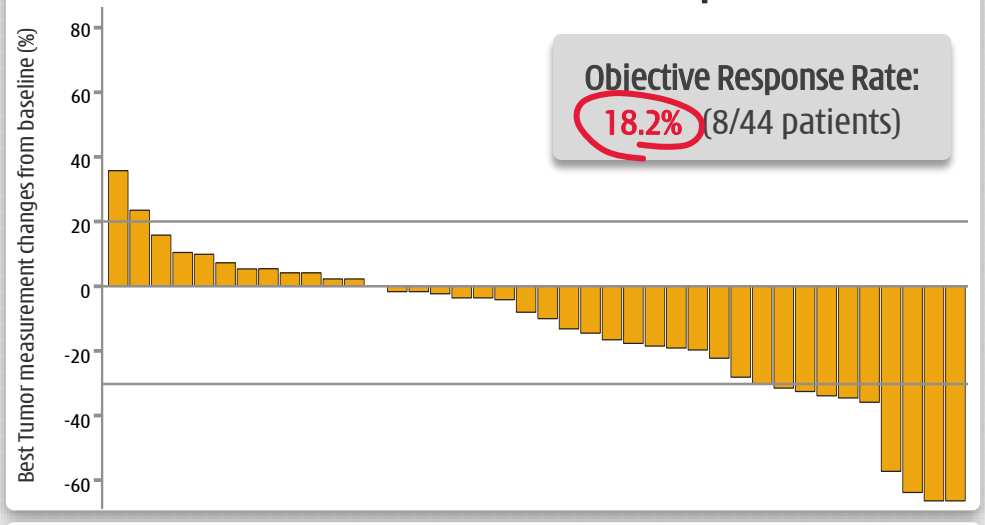


[1] Transparency Market Research, March 2015 – RCC (excl. non-RCC Kidney Cancer) global market size; [2] Frost & Sullivan, March 2016; [3] NCCN Guideline for kidney cancer. Version 3.2016, 05/26/16, RCC = renal cell carcinoma;
[4] ORR = Objective Response Rate, mPFS = median Progression Free Survival, mOS = median Overall Survival

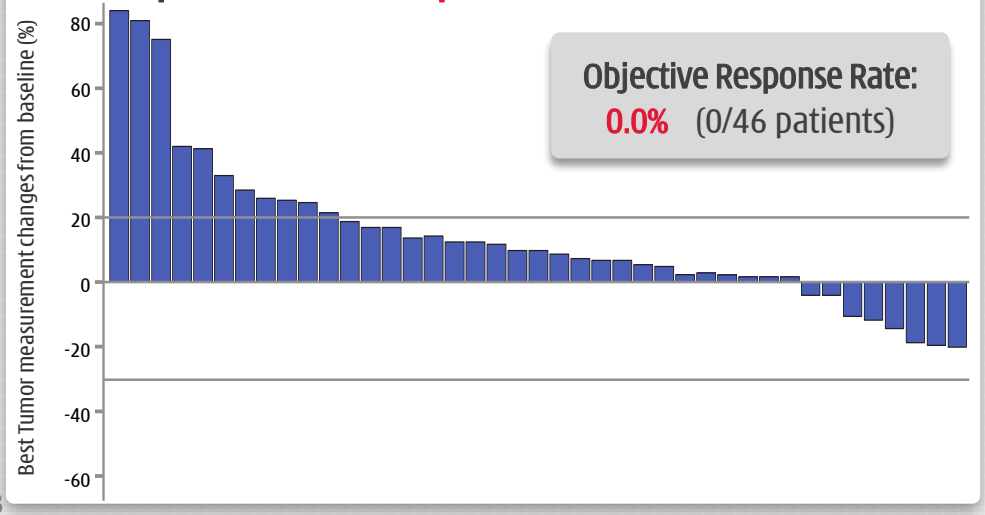
Savolitinib – PRCC Phase II

Clear efficacy & durable response in MET+ PRCC patients

1. Savolitinib clear ORR benefit in MET+ patients.



2. MET- patients – no response to savo.



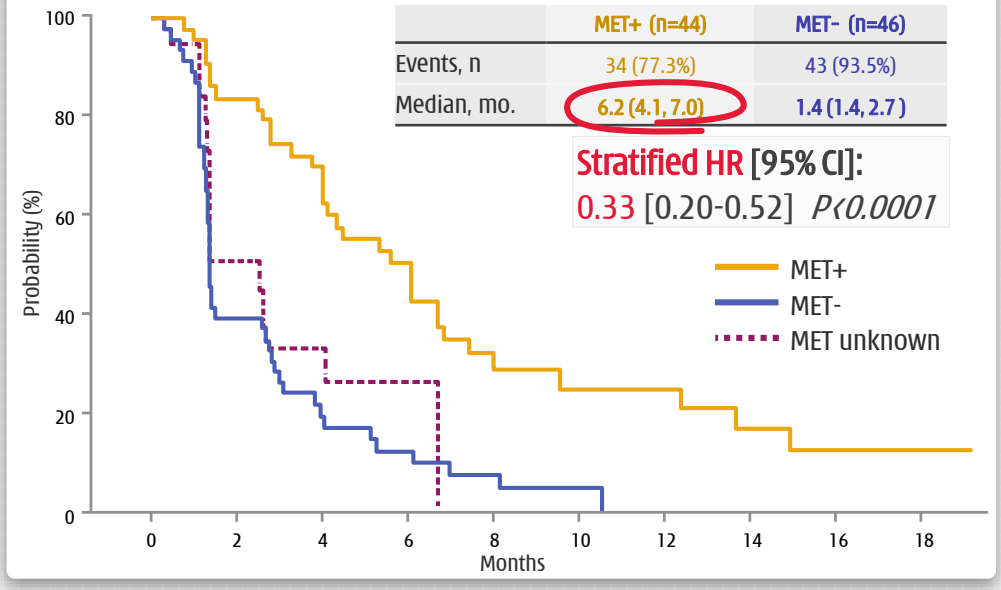
3. Disease Control Rate ("DCR") – big advantage in MET+ with DCR 73.2% vs. MET- 28.2%.^

Tumor responses in the overall treatment population and by MET status

RECIST response, n (%)	MET+ (n=44)	MET- (n=46)	MET unknown (n=19)	Total (n=109)
Partial Response†	8 (18.2%)*	0 (0.0%)	0 (0.0%)	8 (7.3%)
Stable Disease	22 (50.0%)	11 (23.9%)	5 (26.3%)	38 (34.9%)
Progressive Disease	11 (25.0%)	28 (60.9%)	9 (47.3%)	48 (44.0%)
Not Evaluable	3 (6.8%)	7 (15.2%)	5 (26.3%)	15 (13.8%)

* P=0.002 versus MET-independent subgroup (Fisher exact test). Responses assessed according to RECIST version 1.1. † Unconfirmed responses excluded. ^ Evaluable patients.

4. Median PFS – big advantage in MET+ patients.



Highest selectivity delivers better tolerability

		PRCC PHASE II	COMPARZ PHASE III [1]		METEOR PHASE III [2]		SINGLE-ARM PHASE III [3]
		Savolitinib 1L/2L (n=109)	Sunitinib 1L (n=548)	Pazopanib 1L (n=554)	Cabozantinib 2L (n=331)	Everolimus 2L (n=322)	Sunitinib 2L (n=106)
MSKCC Risk Group	Favorable	14%	27%	27%	45%	46%	58%
	Intermediate	45%	59%	58%	42%	41%	42%[6]
	Poor	9%	9%	12%	12%	13%	
	Missing	32%	4%	3%	0%	0%	0%
Number of prior systemic therapies	0	55%	100%	100%	0%	0%	0%
	1	23%	0%	0%	71%	70%	100%
	≥2	22%	0%	0%	29%	30%	0%
Grade ≥3 AEs:	Any AE	47%			68%	58%	
	Any treatment-related AE [4]	19%	77%[5]	76%[5]			
		TRAEs	TRAEs	TRAEs	All AEs	All AEs	
All Grade≥3 AEs with ≥5% incidence (AND selected savolitinib AEs for comparison)	Hypertension	0%	15%	15%	15%	3%	6%
	Fatigue	2%	17%	11%	9%	7%	11%
	Hand-foot-syndrome	0%	12%	6%	8%	<1%	7%
	Diarrhea	0%	8%	9%	11%	2%	
Hematologic Abnormalities Grade≥3 AEs with ≥5% incidence:	Neutropenia	0%	20%	5%	0%	0%	16%
	Thrombocytopenia	0%	24%	4%	0%	0%	6%
	Lymphocytopenia	0%	14%	5%	0%	0%	
	Leukopenia	0%	6%	1%	0%	0%	
	Anemia	<1%	7%	2%	5%	16%	6%
Lab Abnormalities Grade≥3 AEs with ≥5% incidence:	Increased ALT	5%	4%	17%	2%	<1%	
	Increased AST	3%	3%	12%	2%	<1%	
	Hypophosphatemia	0%	9%	4%	4%	2%	
	Hyponatremia	3%	7%	7%	0%	0%	
	Hypokalemia	0%	1%	3%	5%	2%	
	Hyperglycemia	0%	4%	5%	<1%	5%	
Tolerability	Treatment discontinuation due to any AE [7]:	8%	20%	24%	12%	11%	11%
	Dose reduction due to AE:	13%	51%	44%	62%	25%	

Better safety data despite higher risk patient population:

- ✓ Only 14% "favorable" vs. 27-58%.

Superior safety profile vs. other TKIs – Most ≥3 G3 AEs ≈ 0-2%:

- ✓ Hypertension: 0% vs. 6~17%.
- ✓ Fatigue: 2% vs. 6~12%.
- ✓ Diarrhea: 0% vs. ~10%.
- ✓ Anemia: <1% vs. 7~16%.
- ≈ ALT/AST Increase: 3-5% vs. 0~17%.
- ✓ Other Lab Abnorm: 0% vs. ≤9%.

Highly tolerable vs. other TKIs:

- ✓ Discontinued: 8% vs. 10~24%.
- ✓ Dose reduction: 13% vs. 44-62%.

[1] RJ Motzer et al, *Pazopanib versus Sunitinib in Metastatic Renal-Cell Carcinoma*, N Engl J Med 369;8, Aug 22, 2013; [2] TK Choueiri et al, *Cabozantinib versus everolimus in advanced renal cell carcinoma (METEOR)*, Lancet Oncol.17;7, Jun 5, 2016; [3] RJ Motzer et al, *Sunitinib in Patients with Metastatic Renal Cell Carcinoma*, JAMA 295;21 Jun 7, 2006; [4] As assessed by investigator; [5] Includes Grade 5AEs; [6] Includes Intermediate & Poor. TRAEs = Treatment-Related Adverse Events; [7] Early 2017 ASCO Genitourinary Cancers Symposium data cut-off.

Savolitinib – Gastric cancer

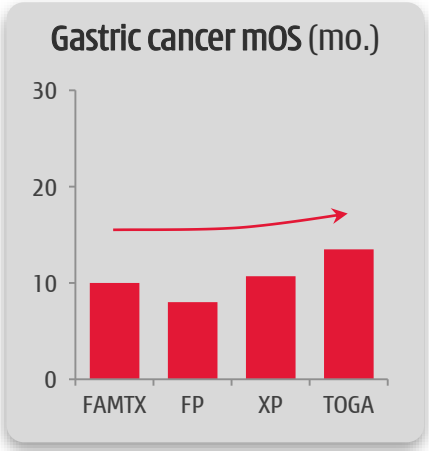
A major problem in east Asia – Japan, South Korea & China

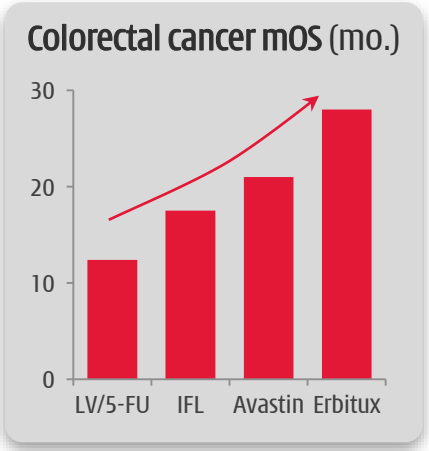
1. Gastric (stomach) cancer is the 5th most common cancer globally – 723,000 deaths/year.

	Est. Age Standardised Rates (cases/100,000)	New cases ('000)	Deaths ('000)	5-year Prevalence ('000)
World	17.0	952	723	1,538
South Korea	41.8	22	17	32
Japan	29.9	38	29	56
China	22.7	405	325	594
EU-28	9.0	82	58	119
USA	6.8	21	12	32

Jeeyun Lee, AACCR 2016; IARC, WHO 2012; Jung KW, Cancer Research Treatment 2013; World Cancer Research Fund International.

2. Little progress in gastric cancer[2] in improving overall survival ("OS") in first-line palliative setting.



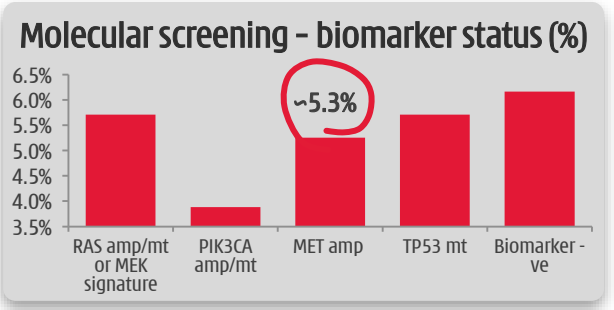


Jeeyun Lee, AACR 2016; Mayer RJ, J Clin Oncol 2015.

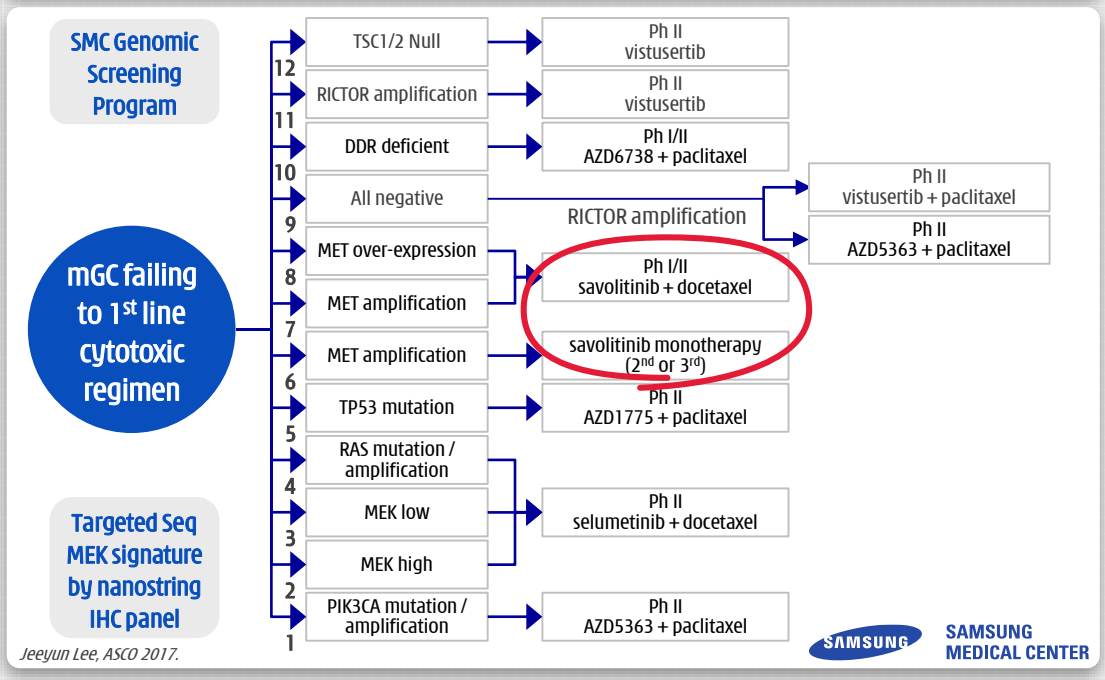
3. VIKTORY – umbrella trial in gastric cancer *(South Korea).*

Total of 438 patients screened for genomic profiling [1]

102 (23.3%) patients enrolled



Jeeyun Lee, ASCO 2017



Jeeyun Lee, ASCO 2017.

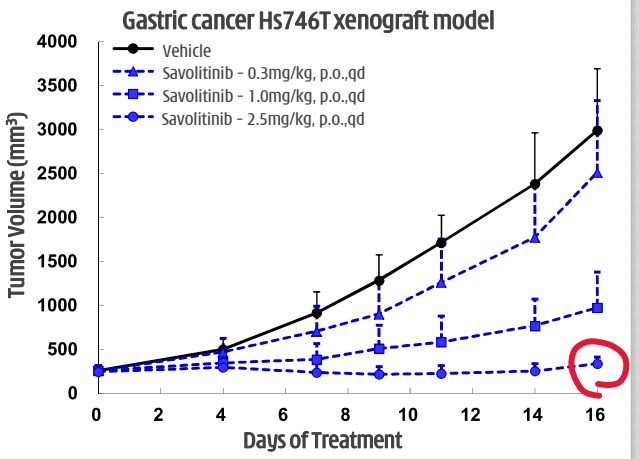
SAMSUNG MEDICAL CENTER

[1] Since June 2014; [2] FAMTX = 5-FU + doxorubicin + methotrexate; FP = cisplatin + 5-FU; XP = capecitabine + cisplatin; TOGA = trastuzumab + chemo; LV/5-FU = leucovorin + 5-FU; IFL = irinotecan + 5-FU + leucovorin.

Savo potential not only in NSCLC…

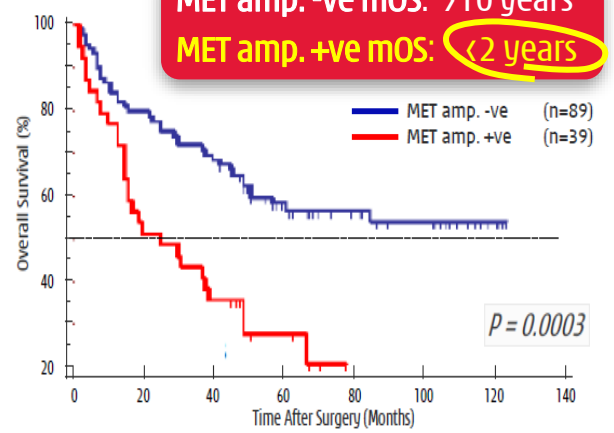
…highly promising efficacy in MET+ gastric cancer (…& kidney)

Strong preclinical efficacy.

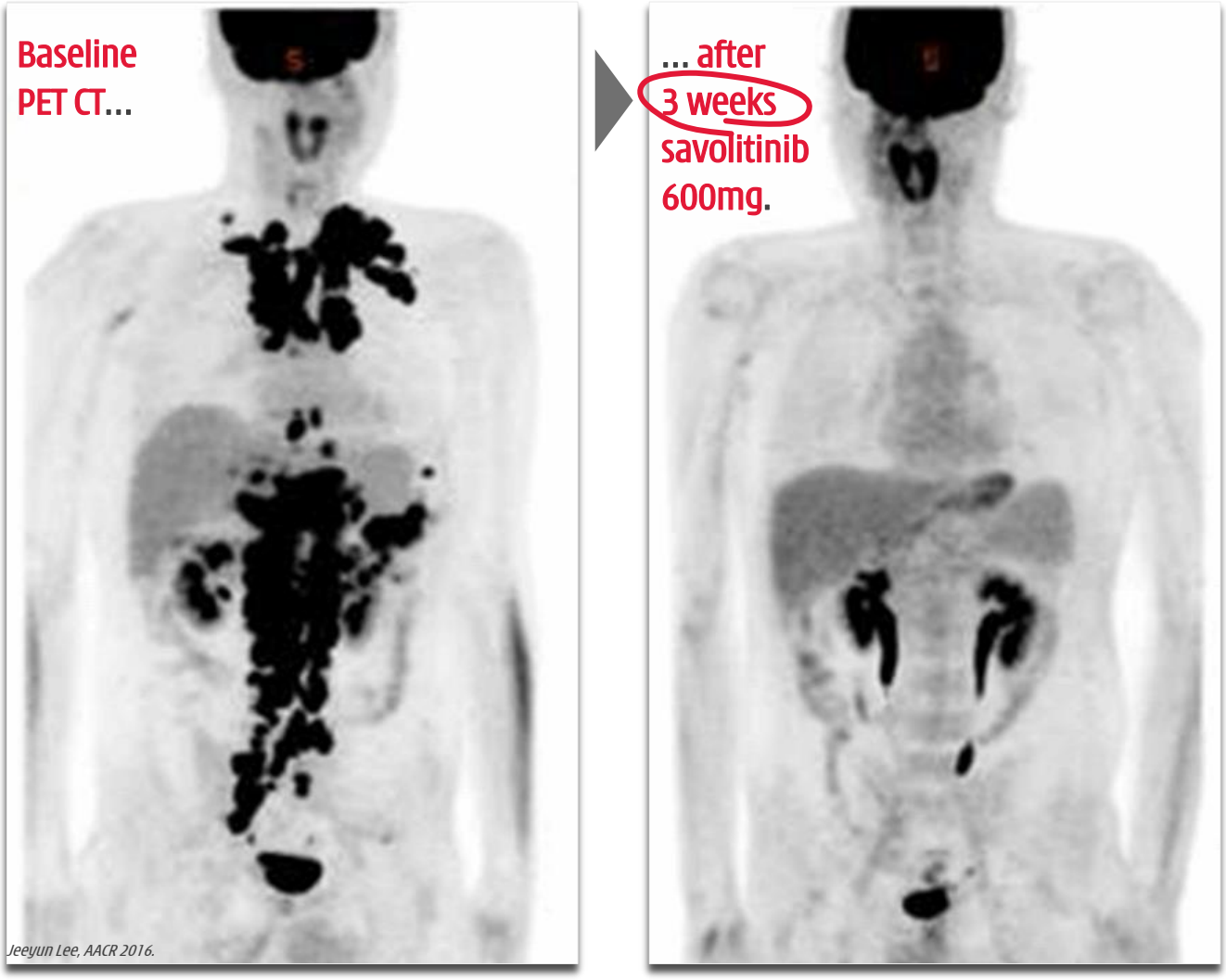


p.o. = by mouth (i.e. orally); qd = one dose per day.

MET+ gastric – very poor survival.[1]



3. VIKTORY trial – 34-year old male; surgery ruled-out; failed 4-cycles XELOX.



[1] mOS = median overall survival post surgery.

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4b

Elunate® (fruquintinib capsules)

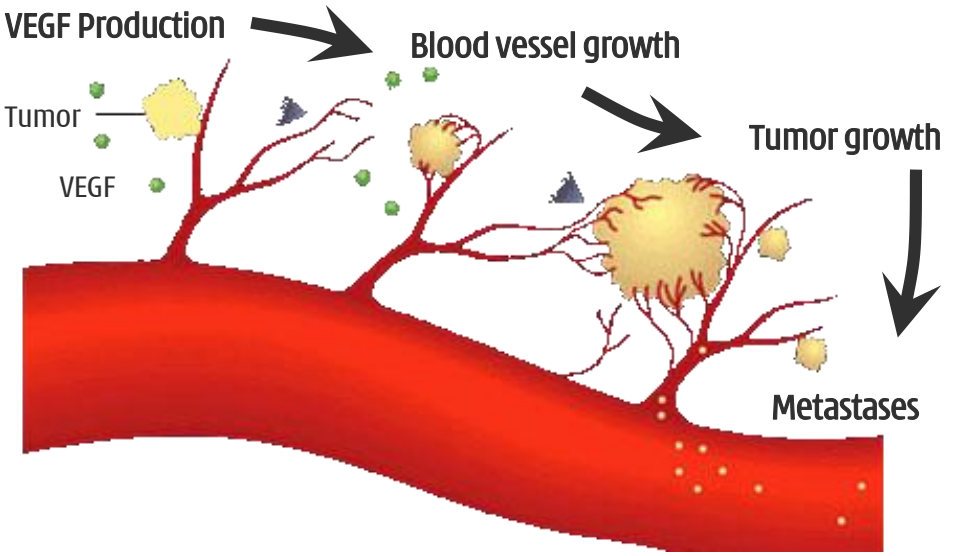
Highly selective anti-angiogenesis inhibitor

Fruquintinib best-in-class VEGFR TKI

Cutting off blood flow a ~$18 bn market in ~30 tumor settings

Company	Drug (INN Name)	FDA Approved Indications		2017 Sales
		Indication	Year	
Roche	Avastin® (Bevacizumab)	2L bevacizumab-pretreated mCRC	2013	$6,796.0m
		1/2L mCRC	2004	
		1L non-sq NSCLC	2006	
		2L GBM	2009	
		1L ccRCC	2009	
		1L Cervical Ca.	2014	
		1L Ovarian Ca.	2018	
		1/2L platinum-sensitive Ovarian Ca.	2016	
		2/3L platinum-resistant Ovarian Ca.	2014	
Pfizer	Sutent® (Sunitinib)	2L GIST	2006	$1,081.0m
		≥1L pNET	2011	
		adjuvant RCC	2017	
		1L RCC	2007	
		≥2L cytokine-ref. ccRCC	2006	
Boehringer Ingelheim	Vargatef® Ofev® (Nintedanib)	2L adeno-NSCLC (by EMA)	2014	$1,076.0m [1]
Bayer	Nexavar® (Sorafenib)	≥1L RCC	2005	$923.2m
		1L HCC	2007	
		Iodine-ref. DTC	2013	
Novartis	Votrient® (Pazopanib)	1/2L RCC	2009	$808.0m
		2L STS	2012	
Lilly	Cyramza® (Ramucirumab)	2L GC	2014	$758.3m
		2L NSCLC	2014	
		2L mCRC	2015	
Exelixis/ Ipsen	Cometriq® Cabometyx® (Cabozantinib)	≥1L MTC	2012	$406.2m
		1L ccRCC	2017	
		≥2L ccRCC	2016	
Bayer	Stivarga® (Regorafenib)	3L mCRC	2012	$348.7m
		2L GIST	2013	
		2L HCC	2017	
Pfizer	Inlyta® (Axitinib)	2L ccRCC	2012	$339.0m
Merck/ Eisai	Lenvima® (Lenvatinib)	Iodine-ref. DTC	2015	$295.9m
		2L ccRCC	2016	

Company	Drug (INN Name)	FDA Approved Indications		2017 Sales
		Indication	Year	
Takeda	Iclusig® (Ponatinib)	CML	2012	$237.9m
		Ph+ ALL	2012	
Hengrui	AiTan® (Apatinib)	3L GC (by CFDA)	2015	$230.0m
Sanofi	Zaltrap® (Ziv-Aflibercept)	2L mCRC	2012	$83.0m
Simcere	Endu® (rh-Endostatin)	≥1L NSCLC (by CFDA)	2005	$58.1m
Sanofi	Caprelsa® (Vandetanib)	≥1L MTC	2011	NA
Aveo	Fotivda® (Tivozanib)	1/2L ccRCC (by EMA)	2017	NA
Sino Biopharm	FocusV® (Anlotinib)	3L NSCLC (by CFDA)	2018	NA



Note: * Active indications in US as of July 3, 2018. Some indications have been approved for frontline therapy. Sources: FDA approved label; Medtrack; Corporate annual reports; D. Ribatti, Oncotarget 2017 8(24) 38080-1, Sales for anti-angiogenic drugs.

[1] Includes sales for idiopathic pulmonary fibrosis

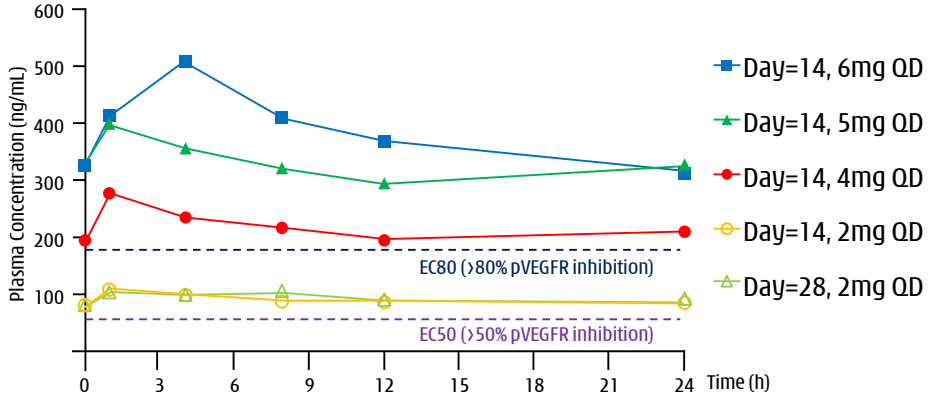
Fruquintinib – 24hr full target coverage

The most selective VEGFR inhibitor in clinical trials globally [1]

1. Fruquintinib Approved by NMPA Sept 2018.

- ✓ Validation of R&D approach – designed to only inhibit VEGFR1,2,3, facilitating **full target coverage & combinations**.
- ✓ **Approval** and **launch** for **3L CRC**.
- ✓ **Pivotal Phase III Taxol® combo** in **2L gastric cancer** – **initiated** Oct 2017.
- ✓ **Phase II Iressa® combo** in **1L EGFRm+ NSCLC** – early data at WCLC 2017.
- ✓ **Phase I in solid tumors in US** – initiated Q4 2017.
- ✓ China GMP **facility built and certified** to support launch.
- ✓ **PD-1 combination collaborations**.

2. Only inhibits VEGFR – limits off-target toxicity & allows for full & sustained target inhibition.



3. Selectivity and potency superior to competitors' drugs.

	Sutent® (sunitinib)	Nexavar® (sorafenib)	Stivarga® (regorafenib)	Tivozanib	Fruquintinib
Kinase profile	VEGFR1,2,3, PDGFRβ, FLT3, CSF-1R, c-Kit, Ret	RAF, VEGFR2, PDGFRβ, Flt3, c-Kit, FGFR1	VEGFR1,2,3, Raf, Ret, PDGFR, c-Kit	VEGFR1,2,3, BRK, PDGFRα, PDGFRβ, c-Kit, Tie2, EphB2	VEGFR1,2,3
AUC at ED50/ED60 in mouse (ng/mL*hr)	2,058	25,473	na	1,640	898
MTD in human (mg/day)	50, qd	400, bid	160, qd	1.5, qd	4, qd; 6, 3wk/1wk
AUC, 0~24h at Steady state MTD (ng/mL*hr)	592	47,780 x2 (D28)	58,270 (D21)	1,180 (D28)	5,000~6,000 (D28)
Efficacy in Phase I	22 patients PR: 4 (18%), DCR: 27%	45 patients [2] PR: 1 (2%), DCR: 58%	53 patients PR: 3 (6%), DCR: 66%	37 evaluable patients PR: 1 (3%), DCR: 51%	34 evaluable patients PR: 13 (38%), DCR: 82%

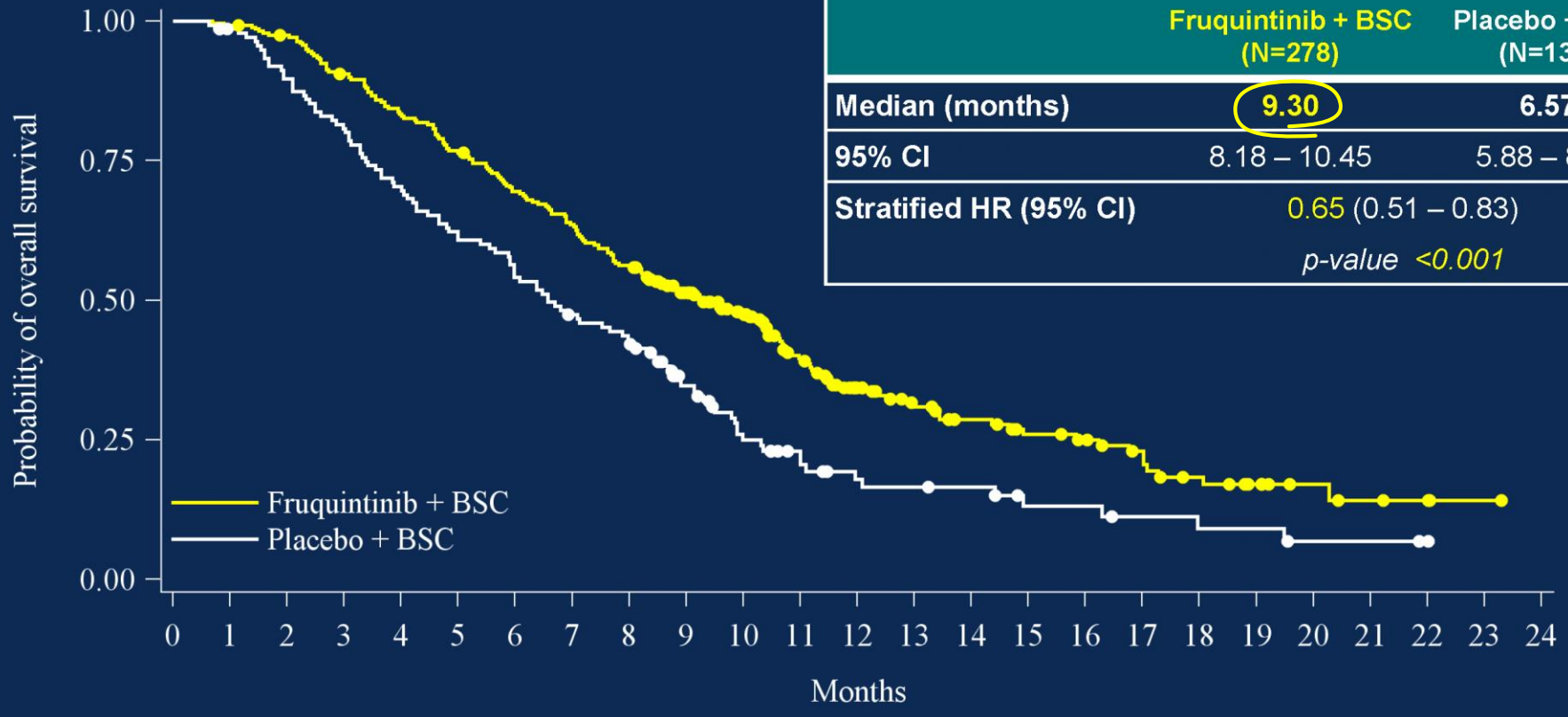
[1] Among small molecule tyrosine kinase inhibitors and to the best of Chi-Med's knowledge; [2] (≥100 mg bid); PR = Partial Response; DCR = Disease Control Rate.

Fruquintinib - 3L/4L colorectal cancer

Develop in US/EU for rego/TAS-102 ref./intol. patients[1]

Overall Survival (Primary Endpoint)

FRESCO clearly succeeded in meeting the primary efficacy endpoint of OS



	Fruquintinib + BSC (N=278)	Placebo + BSC (N=138)
Median (months)	9.30	6.57
95% CI	8.18 – 10.45	5.88 – 8.11
Stratified HR (95% CI)	0.65 (0.51 – 0.83)	
	p-value <0.001	

[1] ASCO = American Society of Clinical Oncology Annual Meeting.

Better tolerability = Better efficacy

Third-Line Metastatic Colorectal cancer	Fruquintinib		Regorafenib		Regorafenib		Regorafenib	
	FRESCO		CONCUR		CONCUR		CORRECT	
	Mainland China		Chinese Patients (Mainland China, Hong Kong, Taiwan) [1]		Mainland China, Hong Kong, Taiwan, Vietnam, South Korea		Global	
Treatment arms	**Fruquintinib**	**Placebo**	**Regorafenib**	**Placebo**	**Regorafenib**	**Placebo**	**Regorafenib**	**Placebo**
Patients (n)	278	138	112	60	136	68	505	255
Complete Response, n (%)	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Partial Response, n (%)	4.3%	0.0%	3.6%	0.0%	4.4%	0.0%	1.0%	0.4%
Stable Disease, n (%)	57.6%	12.3%	40.2%	6.7%	45.6%	7.4%	42.8%	14.5%
Disease Control Rate, n (%)	**62.2%**	**+49.9** **12.3%**	**45.5%**	**+38.8** **6.7%**	**51.5%**	**+44.1** **7.4%**	**41.0%**	**+26.1** **14.9%**
Median Progression-Free Survival (mPFS) (mo.)	**3.7**	**+1.9** **1.8**	**2.0**	**+0.3** **1.7**	**3.2**	**+1.5** **1.7**	**1.9**	**+0.2** **1.7**
mPFS p-value	‹0.001		not published		‹0.0001		‹0.000001	
mPFS Hazard Ratio	0.26		0.32		0.31		0.49	
Median Overall Survival (mOS) (mo.)	**9.3**	**+2.7** **6.6**	**8.4**	**+2.2** **6.2**	**8.8**	**+2.5** **6.3**	**6.4**	**+1.4** **5.0**
mOS p-value	‹0.001		not published		0.0002		0.0052	
mOS Hazard Ratio	0.65		0.56		0.55		0.77	

- **Good fruquintinib efficacy over regorafenib in Chinese patients** – specifically in terms of Disease Control Rate; median Progression-Free Survival and median Overall Survival.
- **FRESCO is a fully-powered Phase III registration study** (n=416) whereas **CONCUR was an under-powered Asia region study** (n=204, including only 129 mainland Chinese patients [2]).
- CONCUR results should be regarded as directional only – **China approval resulted from CORRECT** study (n=760).

[1] Efficacy & safety of regorafenib monotherapy in Chinese patients with previously treated metastatic colorectal cancer: subgroup analysis of the CONCUR trial; R Xu; [2] China FDA website.

ELUNATE®
Fruquintinib Capsules

CHI-MED

BIOCHEMICAL ACTIVITY	ELUNATE® Fruquintinib Capsules IC_{50} (nmol/L)	Stivarga® (regorafenib) tablets IC_{50} (nmol/L)
On-Target Kinases:		
VEGFR1	33	13
VEGFR2	35	4.2
VEGFR3	0.5	46
Off-Target Kinases:		
Ret	128	1.5
FGFR1	181	202
c-kit	458	7
PDGFRβ	›10,000	22
RAF-1	›10,000	2.5
B-RAF	›10,000	28
B-RAF^{V600E}	›10,000	19

Stivarga® liver toxicity black-box warning:

➔ Increased liver function test monitoring (weekly if elevated) & remedial dose interruption.

STIVARGA (regorafenib) tablets, oral
Initial U.S. Approval: 2012

WARNING: HEPATOTOXICITY

See full prescribing information for complete boxed warning.

Severe and sometimes fatal hepatotoxicity has been observed in clinical trials. Monitor hepatic function prior to and during treatment. Interrupt and then reduce or discontinue Stivarga for hepatotoxicity as manifested by elevated liver function tests or hepatocellular necrosis, depending upon severity and persistence. (2.2, 5.1)

3rd-Line Metastatic Colorectal cancer	ELUNATE® Fruquintinib Capsules FRESCO Study Mainland China [1]		Stivarga® (regorafenib) tablets CONCUR Study (Mainland China, HK, Taiwan) [2]	
Treatment arms	Elunate®	Placebo	Stivarga®	Placebo
Patients (n)	278	138	112	60
≥G3 AE (Safety population)	61.1%	19.7%	69.6%	46.7%
SAE (Safety population)	15.5%	5.8%	31.3%	26.7%
VEGFR on-target related AEs:				
Hypertension ≥G3	21.2%	2.2%	12.5%	8.3%
Hand-Foot Syndrome (Palmar-plantar), ≥G3	10.8%	0.0%	17.0%	0.0%
Off-target (i.e. non-VEGFR) related AEs:				
Hypophosphatemia, ≥G3	0.0%	0.0%	8.0%	0.0%
Hypokalemia, ≥G3	0.7%	0.7%	6.3%	0.0%
Rash/desquamation, ≥G3	0.0%	0.0%	4.4%	0.0%
Lipase increase, ≥G3	0.0%	0.0%	6.3%	1.7%
Hepatic function (Liver function) AEs:				
ALT increased, ≥G3	0.7%	1.5%	7.1%	3.3%
AST increased, ≥G3	0.4%	0.7%	8.9%	0.0%
Blood bilirubin increased, ≥G3	1.4%	1.5%	8.9%	8.3%
Tolerability:				
AE Leading to dose interruption	35.3%	10.2%	68.8%	25.0%
AE Leading to dose reduction	24.1%	4.4%	23.2%	0.0%
AE Leading to treatment discontinuation	15.1%	5.8%	14.3%	6.7%

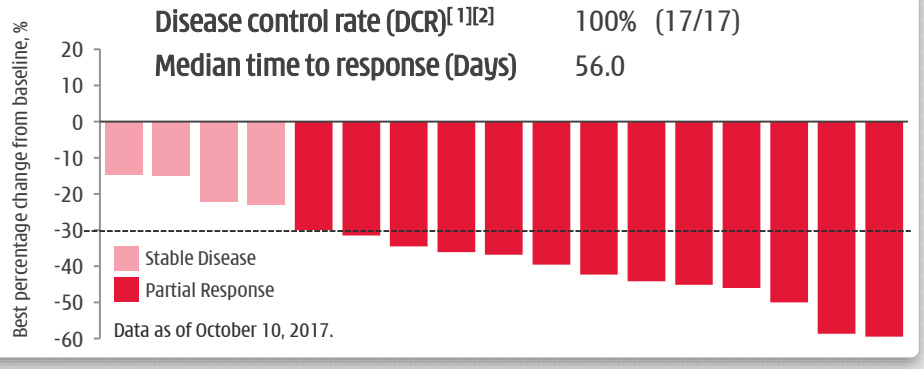
Elunate® higher selectivity; lower off-target toxicity; superior tolerability

[1] Treatment Related AEs (FRESCO study); [2] All AEs -- Efficacy & safety of regorafenib monotherapy in Chinese patients with previously treated metastatic colorectal cancer: subgroup analysis of the CONCUR trial; R Xu.; ≥G3 AEs in ›4% of Patients.

Fruquintinib – 1L NSCLC combo w/ IRESSA® gefitinib

Two small molecule TKIs allow for better management of tox.

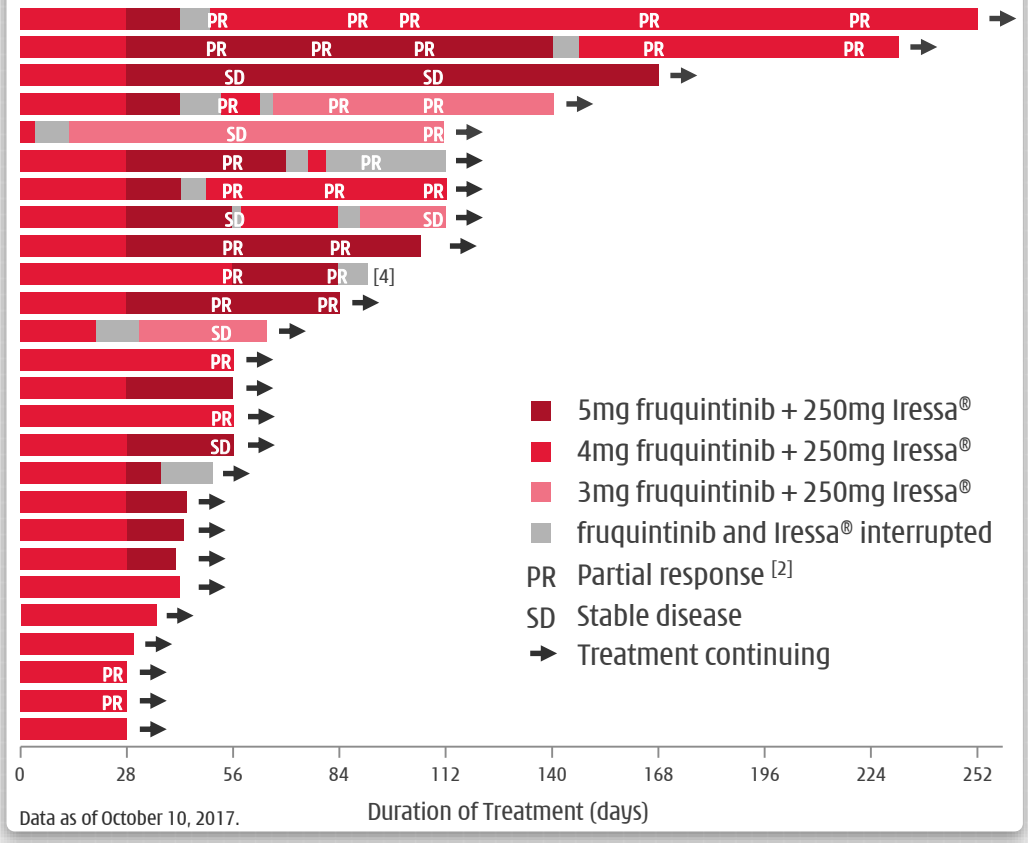
1. Promising efficacy in first line – 76% ORR (13/17). [1,2,3]



2. Prelim. safety data: fruquintinib vs. other VEGFRis.

Adverse Events ("AEs")	Iressa® or Tarceva® FLAURA [5] N = 277, n (%)	Avastin® + Tarceva® [6] N = 75, n (%)	Fruquintinib + Iressa® N = 26, n (%) [3]
All AEs, any grade	273 (98%)	≥74 (≥99%)	23 (89%)
All AEs, Grade ≥3	124 (45%)	68 (91%)	8 (31%)
AEs leading to death	6 (2%)	0 (0%)	0 (0%)
AEs leading to VEGFRi discontin.	NA	31 (41%)	1 (4%)
Grade ≥3 AEs:			
Liver function (e.g. ALT, AST incr.)	33 (12%)	6 (8%)	6 (23%)
Hypertension	NA	45 (60%)	1 (4%)
Proteinuria	NA	6 (8%)	1 (4%)
Rash	13 (5%)	19 (25%)	0 (0%)
Decreased appetite	22 (8%)	1 (1%)	NA

3. Combination of highly selective TKIs vs. mAbs: daily dose flexibility improves tolerability. This enables maintained drug exposure, leading to more durable response. [2,3]



[1] Best tumor response for efficacy evaluable patients (patients who had both baseline and post-baseline tumor assessments); ORR = objective response rate; [2] Four PRs not yet confirmed at the time of data cut-off date; mAb = Monoclonal Antibody; [3] Lu, S., et al, "A Phase II study of fruquintinib in combination with gefitinib in stage IIIb/IV NSCLC patients harboring EGFR activating mutations", ID 10907 IASLC 18th World Conference on Lung Cancer, Yokohama, Japan, October 15-18, 2017; [4] Drug discontinuation due to Grade 3 proteinuria and Grade 3 QTc prolonged; [5] Ramalingam S. et al, "LBA2_PR Osimertinib vs standard of care (SoC) EGFR-TKI as first-line therapy in patients (pts) with EGFRm advanced NSCLC: FLAURA", ESMO 2017 Congress, Madrid, Spain, September 9, 2017; [6] Seto, T., et al, "erlotinib alone or with bevacizumab as first-line therapy in patients with advanced non-squamous non-small-cell lung cancer harbouring EGFR mutations (JO25567); an open-label, randomised, multicenter, phase 2 study", The Lancet 2014, 15 (11) 1236-1244.

Fruquintinib – Gastric combo with paclitaxel

Phase III initiated Oct 2017 – Interim analysis planned early 2019

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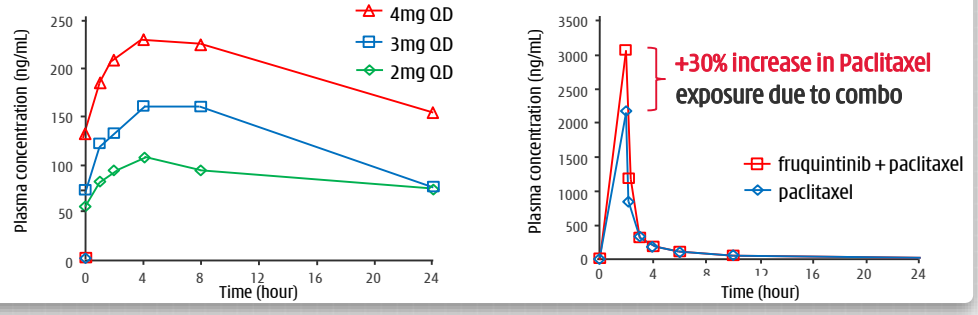
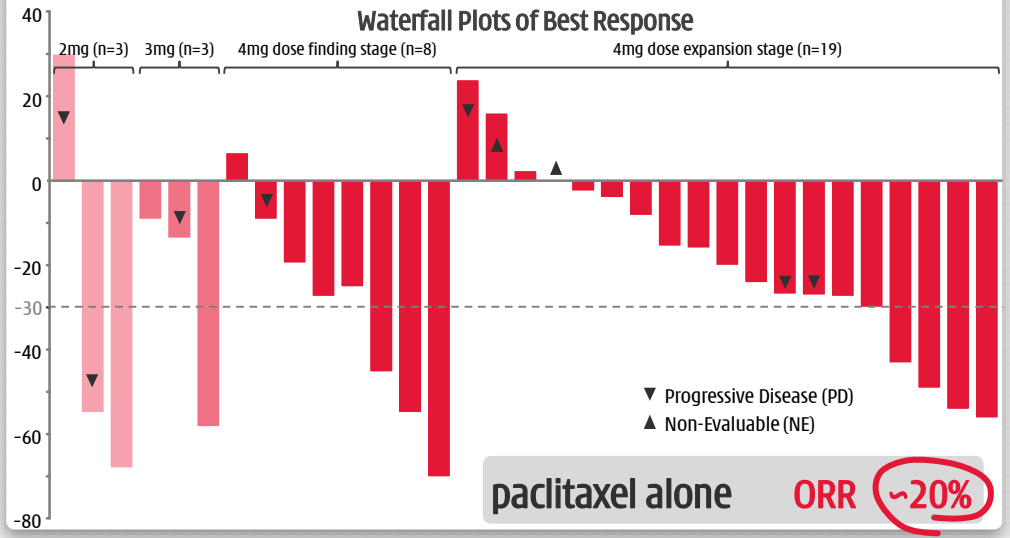
1. **Dose proportional increase of fruquintinib** AUC at steady state. Over **30% increase in paclitaxel drug exposure** (mean AUC_{0-8}) following multiple dose fruquintinib.



2. **ORR of 36%** (10/28) & **DCR of 68%** in efficacy evaluable pts. Fruquintinib 4mg, **≥16 wk. PFS of 50%** & ≥7 mo. OS of 50%.



3. Encouragingly low level of dose reduction/interruption. Actual mean administered dose in the first cycle was **3.32mg/day for fruquintinib** (83.0% planned dose) & **78.6 mg/m2/week for paclitaxel** (98.3% planned dose).

Characteristics (Unit)	Drug Expansion Stage (N=19) Fruquintinib 4 mg + paclitaxel 80 mg/m²	
	Drug interruption	Drug reduction
Dose modification with Fruquintinib N (%)	2 (10.5%)	2 (10.5%)
Dose modification with Paclitaxel N (%)	5 (26.3%)	1 (5.3%)

4. **AE profile in-line with expectations**. Neutropenia – a paclitaxel driven AE – with 57.9% Grade ›3 AEs. **Similar to 60% level seen in RAINBOW study of ramcirumab (VEGF mAb)** combo with paclitaxel in second-line gastric cancer.

Drug related grade 3 or 4 AEs (NCI-CTCAE v 4.0) term	Dose Expansion Stage (N=19) Fruquintinib 4 mg + paclitaxel 80 mg/m²
Neutropenia	11 (57.9%)
Leukopenia	4 (21.0%)
Hypertension	2 (10.6%)
PLT decreased	1 (5.3%)
Anemia	1 (5.3%)
HFSR	1 (5.3%)
Mucositis oral	1 (5.3%)
Hepatic disorder	1 (5.3%)
Upper gastrointestinal hemorrhage	1 (5.3%)

Fruquintinib – FALUCA Phase III in 3L NSCLC

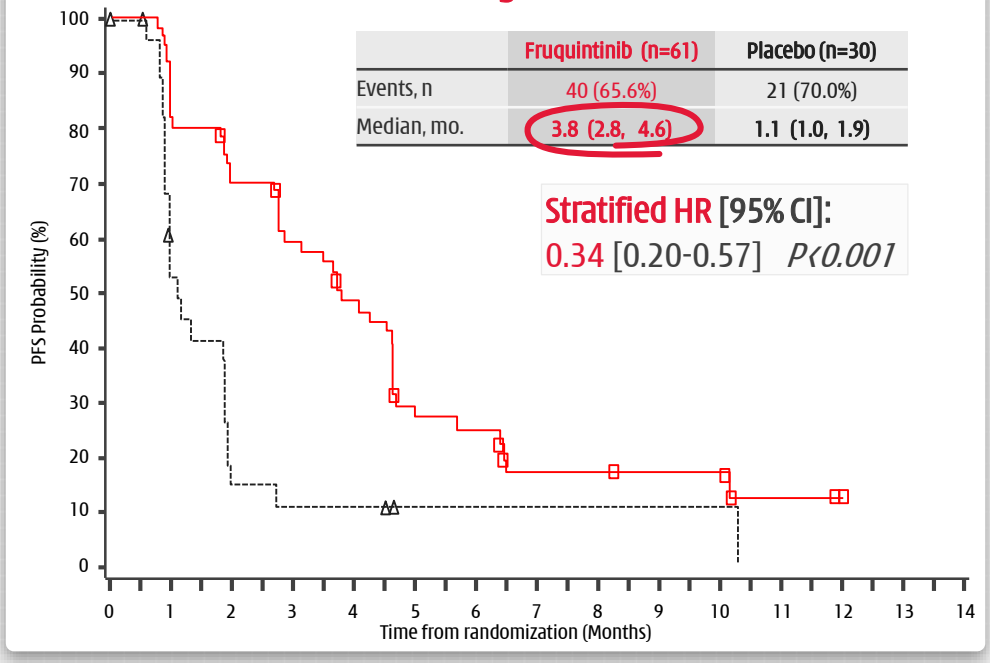
Phase III enrolment complete (n=527); top-line results Q4 2018

Non-small cell lung cancer ("NSCLC") Phase II PoC Results

- ✓ 91 3L only patients **enrolled in ~9 months** (Jun'14-Mar'15).
- ✓ **Clearly met primary PoC endpoint** of reduction in risk of progression.
- ✓ **AEs consistent** with the known safety profile and generally superior versus ≥3L colorectal cancer Phase III with lower >Gr.3 AEs (32.8% vs. 61.1%) and dose reductions (13.1% vs. 24.1%).

Patients, %	Fruquintinib (n=61)	Placebo (n=30)
All AEs, any grade	61 (100%)	27 (90.0%)
All AEs, grade ≥3	20 (32.8%)	6 (20.0%)
Hypertension, grade ≥3	5 (8.2%)	1 (3.3%)
Hand-foot syndrome ("HFS"), grade ≥3	3 (4.9%)	0
All other AEs, grade ≥3 (each)	≤2 (≤3.3%)	0
Leading to dose interruption	9 (14.8%)	0
Leading to dose reduction	8 (13.1%)	0
Leading to treatment discontinuation	6 (9.8%)	1 (3.3%)

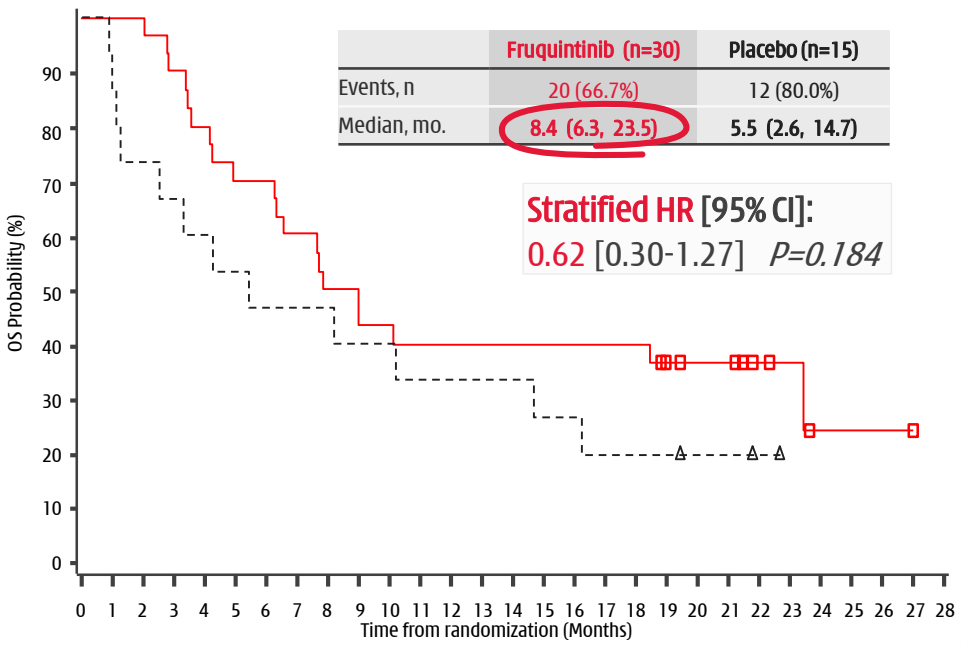
3L NSCLC Phase II: Progression-Free Survival



	Fruquintinib (n=61)	Placebo (n=30)
Events, n	40 (65.6%)	21 (70.0%)
Median, mo.	3.8 (2.8, 4.6)	1.1 (1.0, 1.9)

Stratified HR [95% CI]:
0.34 [0.20-0.57] *P<0.001*

3L NSCLC Phase II: Overall Survival [1]



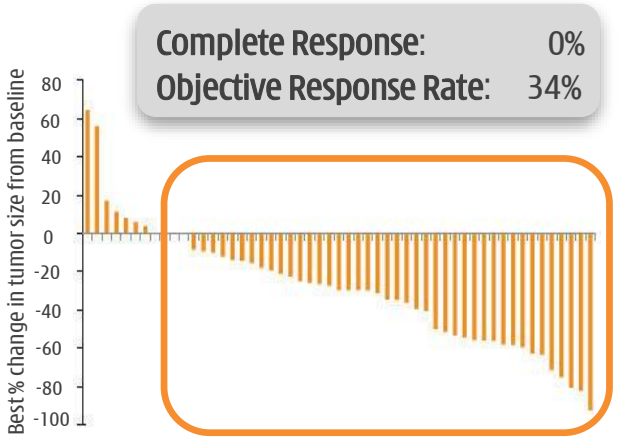
	Fruquintinib (n=30)	Placebo (n=15)
Events, n	20 (66.7%)	12 (80.0%)
Median, mo.	8.4 (6.3, 23.5)	5.5 (2.6, 14.7)

Stratified HR [95% CI]:
0.62 [0.30-1.27] *P=0.184*

[1] EGFR Mutation positive (n=45)

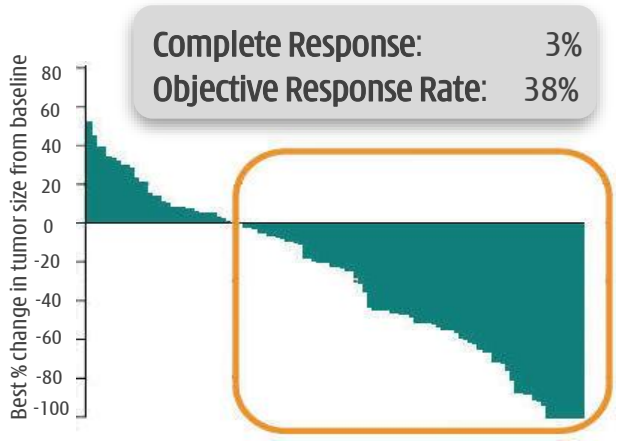
VEGFR / immunotherapy (PD-1s) combinations

Axitinib (VEGFR) monotherapy in 1L ccRCC



75% patients (n=56) experienced a reduction in tumor burden

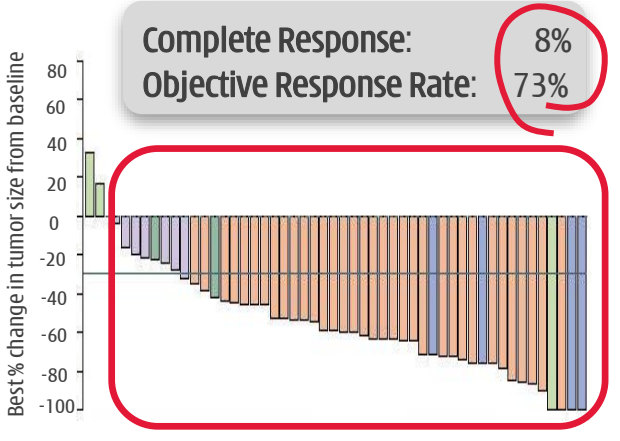
Pembrolizumab (PD-1) monotherapy in 1L ccRCC



67% patients (n=110) experienced a reduction in tumor burden

- Both axitinib & pembro provide **strong single-agent efficacy** to clear cell renal cell carcinoma ("ccRCC").

Axitinib + Pembrolizumab combination in 1L ccRCC



96% patients (n=52) experienced a reduction in tumor burden

- **Combination breakthrough efficacy.** U.S. FDA BTD [1] granted Jul 2017.

Potent two prong attack – Anti-angiogenesis + activated T-cell response

[1] BTD = Breakthrough Therapy Designation; Source: 1. B. Rini et al, Lancet Oncol 2013 14(12) 1233-42, Axitinib with or without dose titration for first-line metastatic renal-cell carcinoma: a randomised double-blind phase 2 trial; 2. D.F. McDermott et al, ASCO 2018 #4500, Pembrolizumab monotherapy as first-line therapy in advanced clear cell renal cell carcinoma (accRCC): Results from cohort A of KEYNOTE-427; 3, M.B. Atkins et al, Lancet Oncol 2018 19(3) 405-15, Axitinib in combination with pembrolizumab in patients with advanced renal cell cancer: a non-randomised, open-label, dose-finding, and dose-expansion phase 1b trial. Corporate press release.

Fruquintinib & surufatinib both unique VEGFR TKIs

...ideal VEGFR combination partners for immunotherapy

TKI	1st Generation			2nd Generation			Next Generation	
Selectivity	Multiple targets			Relatively selective			Highly selective	Selective angio-immuno kinase inhibitor
Inhibitors	Sunitinib	Sorafenib	Anlotinib	Tivozanib	Lenvatinib	Axitinib	Fruquintinib	Surufatinib [1]
Status	Launched	Launched	Launched	Launched	Launched	Launched	Launched	Ph. IIIs ongoing
VEGFR1 (nM)	2	26	27	30	22	3	33	2
VEGFR2 (nM)	9	90	0.2	6.5	4	7	25	24
VEGFR3 (nM)	19	20	0.7	15	5	1	0.5	1
Phos-KDR (nM)	10	30	0.1-1	0.16	0.8	0.2	0.6	2
Other kinases (IC_{50} < 100nM)	PDGFRα PDGFRβ c-Kit Flt3 Ret CSF-1R	Raf-1 b-raf Flt3 P38 c-Kit Ret	PDGFRα PDGFRβ FGFR1-4 c-Kit	PDGFRα PDGFRβ EphB2 c-Kit Tie2	PDGFRα PDGFRβ FGFR1-4 Ret c-Kit	PDGFRα PDGFRβ c-Kit	none	CSF-1R FGFR1 FLT3 TrkB
Patent Expiration					2021/10/19 (US7253286B2)	2025/04/29 (US6534524B1)	2029 (without extension)	2030 (without extension)

- **Fruquintinib is uniquely selective** – unlike other TKIs with off-target toxicity
- **Surufatinib inhibits TAM[1] production** – amplifying PD-1 induced immune response

[1] Surufatinib = HMPL-012, formerly known as sulfatinib; Source: 1. D.D. Hu-Lowe et al, Clin Cancer Res 2008 14(22) 7272-83; 2. Q.L. Sun et al, Cancer Biol Ther 2014 15(12) 1635-45.

Chi-Med immunotherapy collaborations

Global Development

Managed by AstraZeneca

AstraZeneca

savolitinib + Imfinzi® (PD-L1)

ccRCC/PRCC

Jointly managed by Chi-Med & partners

Innovent Biologics

fruquintinib + sintilimab (PD-1)

1L HCC;
Niche indications (TBC)

君实生物 Junshi Biosciences

surufatinib + toripalimab (PD-1)

1L pNET (TBC);
Niche indications (TBC)

China only

Managed by partners

嘉和生物药业 Genor Biopharma

fruquintinib + GB226 (PD-1)

2L mCRC;
2L NSCLC (TBC)

Taizhou Hanzhong 泰州翰中生物医药

surufatinib + HX008 (PD-1)

1L BTC (TBC);
Niche indications (TBC)

5 PD-1/PD-L1 combos underway/starting on savolitinib, fruquintinib & surufatinib

CHI-MED

4C

Surufatinib

Highly active TKI with unique angio-immuno activity

Surufatinib's unique angio-immuno kinase profile

Multi-indication global development program, initially for NETs[1]

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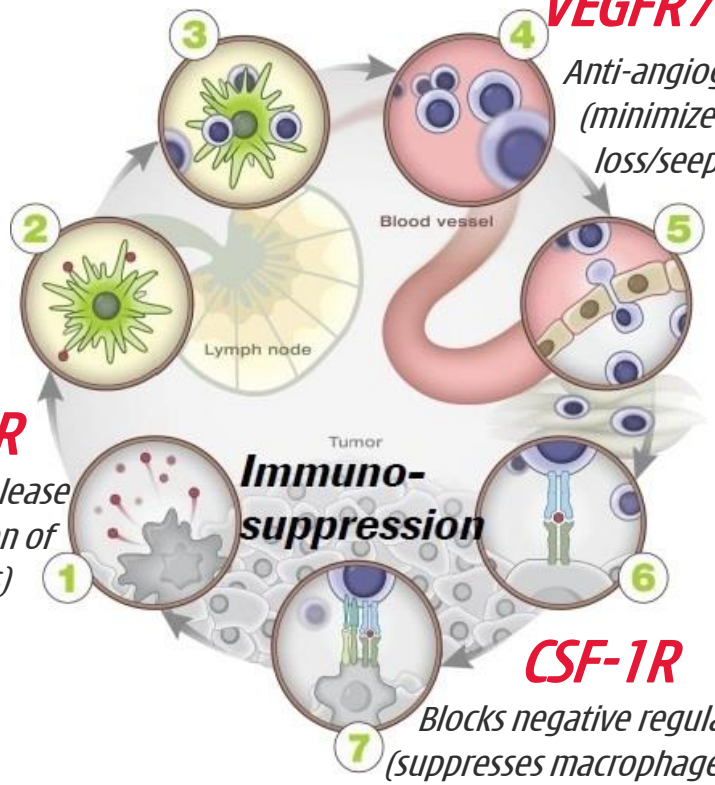
Surufatinib's unique **angio-immuno kinase profile & MoA[1]** activates & enhances the body's immune system, namely T-cells, via VEGFR/FGFR while inhibiting the production of macrophages (CSF-1R) which cloak cancer cells.



VEGFR / FGFR

Anti-angiogenesis (minimize T-cell loss/seepage)

FGFR

Antigen release (activation of T-cells)

CSF-1R

Blocks negative regulators (suppresses macrophage cloak)

Activity 1: Aiming for fast/first approval in China for all NET [2] patients – 2x pivotal Phase III trials in progress

	Pancreatic NET Phase III	Non-Pancreatic NET Phase III
Primary site	Pancreas	GI, lung, other or unknown
Population	Unresectable or metastatic disease; well differentiated (G1/G2); ≤2 prior systemic drugs.	
# of Sites	20-30 (China)	
# of Patients	~195	~270
Study design	Double-blind. Randomized 2:1 to surufatinib or placebo, until PD. Predefined interim analysis.	
Dosage	Surufatinib 300mg QD, 28 days per cycle (vs. placebo)	
Primary Endpoint	Progression-Free Survival (PFS) by BICR evaluation	
Secondary Endpoints	Overall Survival (OS), ORR, safety, etc.	
First Patient In / Readout	March 2016 / 2019	December 2015 / 2019

Activity 2: Global development

- U.S. Phase I (dose escalation) in solid tumors completed
- U.S. Phase Ib/II initiated in July 2018, focusing on pancreatic NET and biliary tract cancer
- PD-1 combination collaborations

Activity 3: Exploratory PoC [3] in other indications

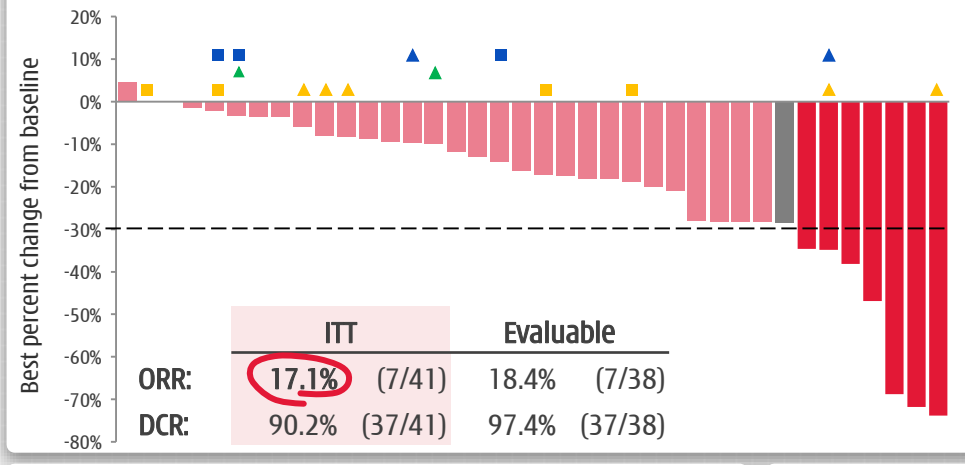
- China Ph.II studies underway in: (a) medullary thyroid cancer; (b) differentiated thyroid cancer; and (c) biliary tract cancer.

[1] MoA = Mechanism of Action; [2] NET = Neuroendocrine Tumors; [3] PoC = Proof-of-concept.

Surufatinib - China NET - Phase II *(ENETS 2017[1])*

Efficacy in all NET & patients who failed on Sutent®/Afinitor®

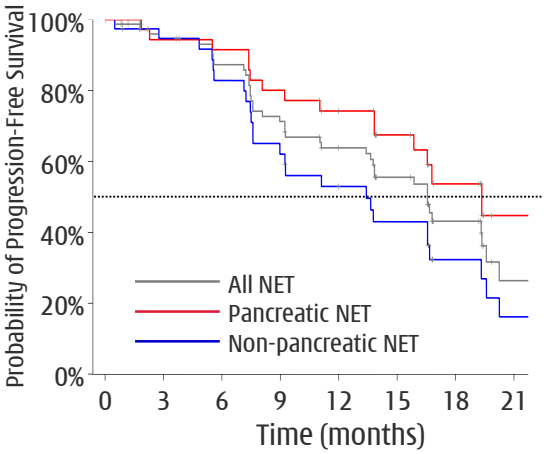
Phase II: Pancreatic NET - Highest ORR seen to date in pNET.



	ITT		Evaluable	
ORR:	17.1%	(7/41)	18.4%	(7/38)
DCR:	90.2%	(37/41)	97.4%	(37/38)

Partial Response | Stable Disease | Progressive disease | Prior Sutent® | Prior Famitinib (VEGFR) | Prior Afinitor® | Progressive Disease on Prior TKI

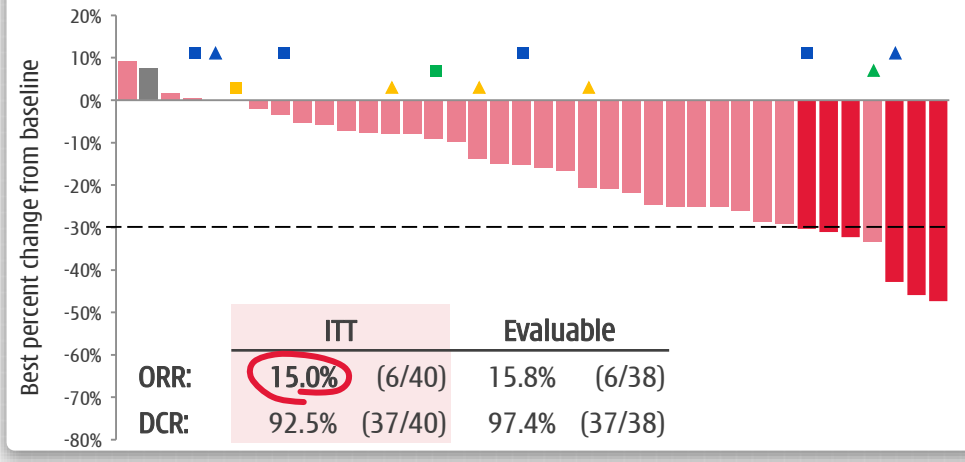
Phase II: Progression-Free Survival (PFS)



	Median PFS (months)	PDs or Deaths (% pts)
All NET (n=81)	16.6m (13.4, 19.4)	51.9% (42/81)
P-NET (n=41)	19.4m (13.8, 22.1)	39.0% (16/41)
Non-P NET (n=40)	13.4m (7.6, 16.7)	65.0% (26/40)

Data has yet to reach maturity - data cut-off as of Jan 20, 2017.

Phase II: Non-Pancreatic NET - High ORR in non-pNET also.



	ITT		Evaluable	
ORR:	15.0%	(6/40)	15.8%	(6/38)
DCR:	92.5%	(37/40)	97.4%	(37/38)

Phase II: Safety - Well tolerated - Adverse Events manageable.

	Grade ≥3 (≥4pts) n (%)
Hypertension	25 (30.9)
Proteinuria	11 (13.6)
Hyperuricemia	8 (9.9)
Hypertriglyceridemia	7 (8.6)
Diarrhea	6 (7.4)
ALT increased	5 (6.2)
Anemia	4 (4.9)
Hypokalemia	4 (4.9)
Hepatic function abnormal	4 (4.9)

Adverse Events ("AEs") - Regardless of causality	N=81 n (%)
Any AE	81 (100.0)
Grade ≥3 AE	63 (77.8)
Any SAE	21 (25.9)
Any drug-related AE	81 (100)
Any drug-related grade ≥3 AE	58 (71.6)
Any drug related SAE	10 (12.3)
Drug related AE leading to:	
dose interruption	**40 (49.4)**
dose reduction	**20 (24.7)**
drug withdrawal	**7 (8.6)**

[1] ENETS = European Neuroendocrine Tumour Society. Data cut-off as of Jan 20, 2017.

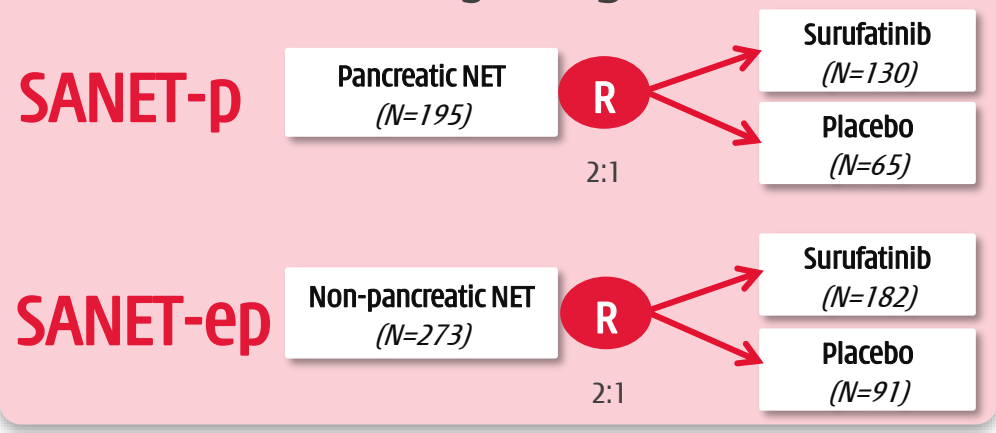
Surufatinib - global development

First un-partnered asset through China PoC & started US study

Pancreatic NET ("P-NET") & Non-Pancreatic NET ("EP-NET")

- SANET-p & SANET-ep active in 25 China sites;
- Primary endpoint - median PFS;
- Target to conduct Interim Analysis in 2019 - on SANET-ep in H1 2019 & SANET-p in H2 2019;
- Enrolment expected for both Phase III studies to complete late 2019 / early 2020;
- Potential launch in China in late 2020 / 2021 - first un-partnered oncology asset for Chi-Med.

China Phase III study design:



Biliary Tract Cancer ("BTC")

- Clear unmet medical need - a few agents being tested in 2L BTC but standard of care not yet established;
- Phase II PoC initiated in early 2017;
- Planning for Phase II/III pivotal study in BTC in China is underway aiming to initiate H1 2019.

U.S. Development Expanding

- Phase I dose escalation study in the U.S. completed (N=29), 5 dose cohorts (50-400mg QD), established 300mg. QD as RP2D (same as China);
- U.S. Phase Ib/II study in P-NET & BTC initiated July 2018;
- Chi-Med C&R Team now in place in U.S. to manage.

Surufatinib - China NET - Phase II *(ENETS 2017 [1])*

Tumor devascularization & central necrosis

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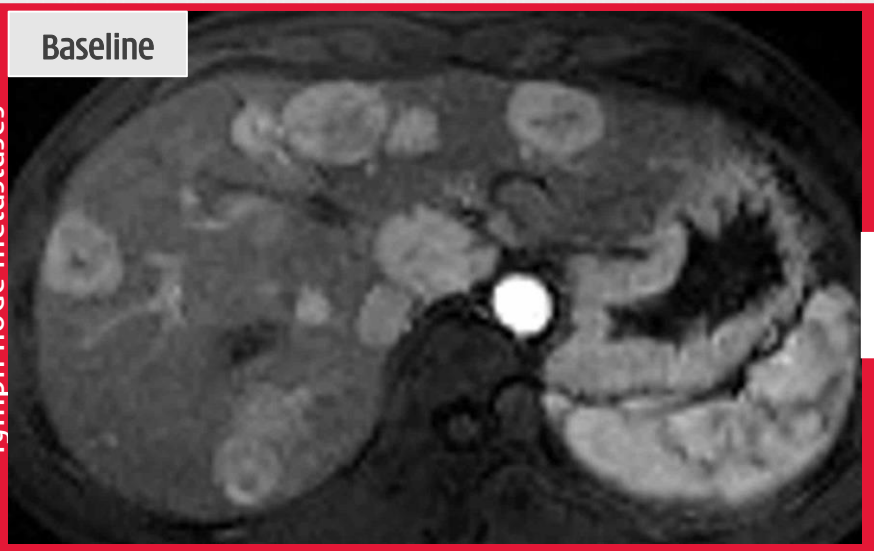
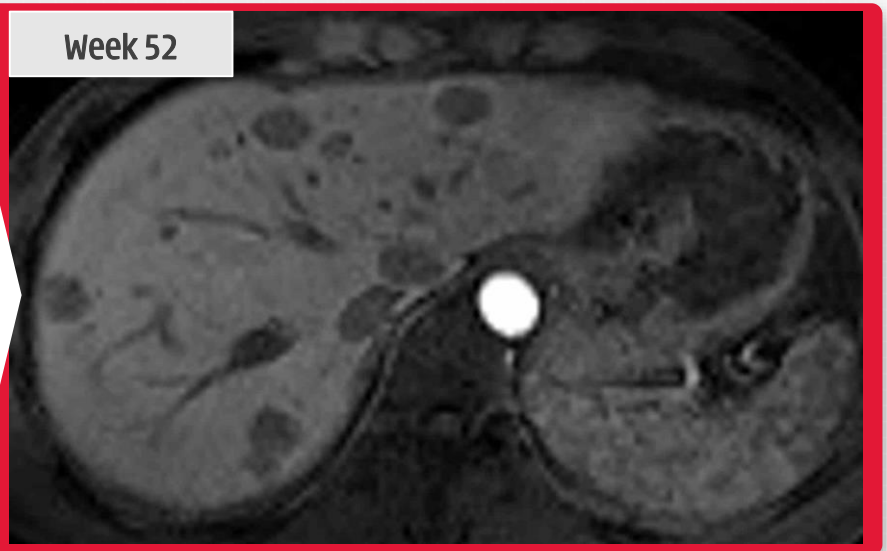
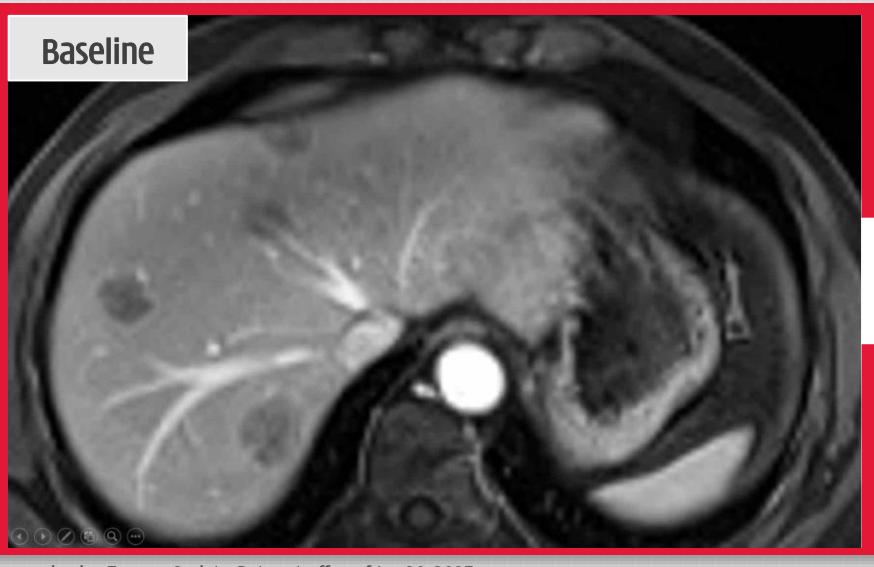
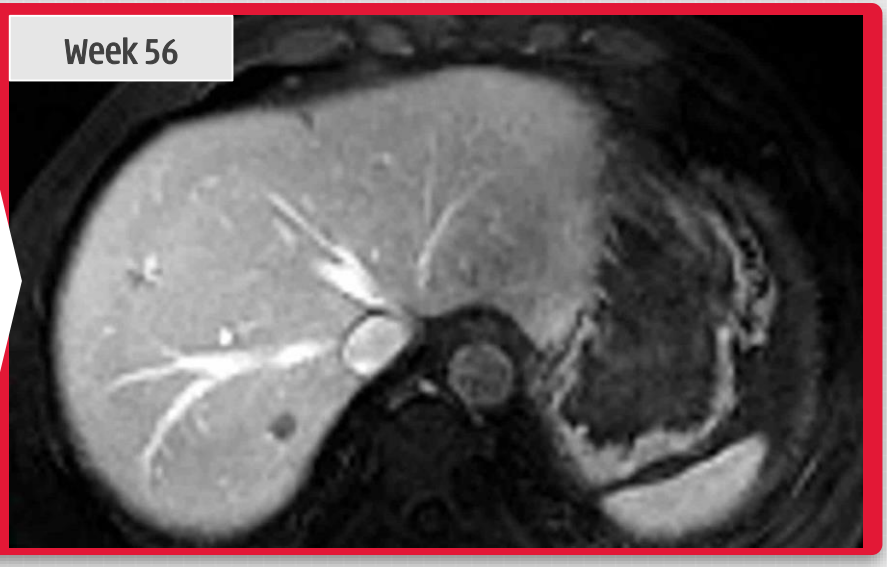
Patient 1
Duodenum NET G2
w/ multiple liver & retroperitoneal lymph node metastases





Patient 2
Rectum NET G2
w/ multiple liver metastases





[1] ENETS = European Neuroendocrine Tumour Society. Data cut-off as of Jan 20, 2017.

CHI-MED

4d

HMPL-523 (Syk) & HMPL-689 (PI3Kδ)

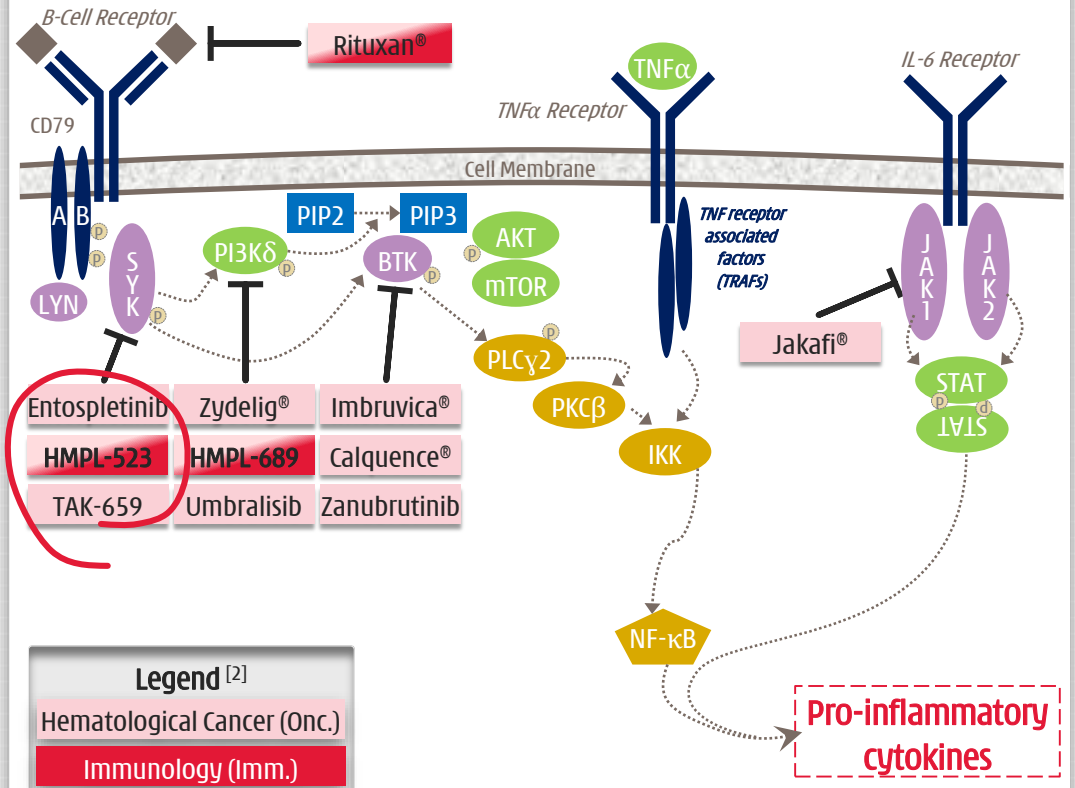
Potential first-in-class (Syk) & best-in-class (PI3Kδ) assets

HMPL-523 – hematological malignancies

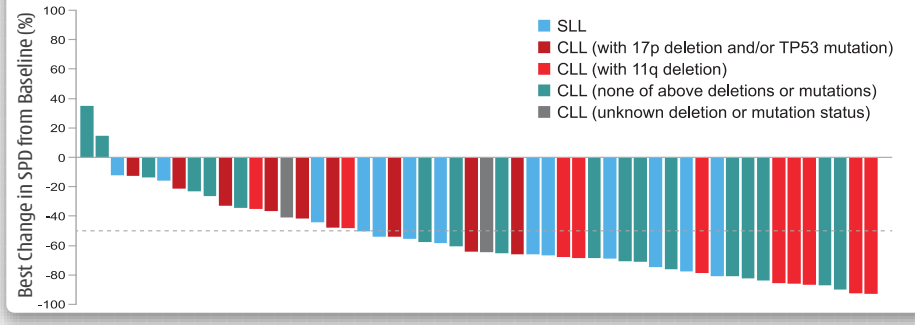
Syk exciting target emerging – Lymphoma PoC ongoing

1. The B-cell signaling is critical in hematological cancer with three breakthrough therapies recently approved.

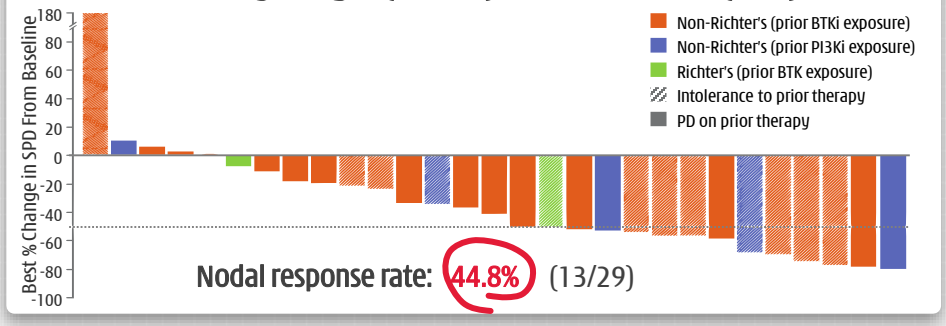
- 2017 sales: Imbruvica® $1.9bn; Zydelig® $0.5bn; Jakafi® $1.1bn; & Rituxan® $6.0bn [1].



2. Entospletinib ASH [3] Dec 2015 data – 65% Nodal Response Rate in CLL & SLL [4] [5].



3. Entospletinib potential for overcoming resistance/ intolerance to Zydelig® (PI3Kδ) & Imbruvica® (BTK) [5].



4. Entospletinib not a perfect compound [6].

- Poor solubility/oral absorption & high variation in drug exposure.
- Some CYP [6] inhibition & increased risk of drug-drug interaction.
- 66% Grade ≥3 AEs; 49% SAEs; 46% drug interruption & 20% disco.

[1] Rituxan® 2017 sales in oncology only; [2] Approved Drug = ®; All others are clinical candidates; [3] ASH = American Society of Hematology; [4] Chronic lymphocytic leukemia ("CLL") & small lymphocytic lymphoma ("SLL"); [5] Sharman et al, ASH Meetings 2015 & 2016; [6] CYP3A4, CYP2D6 and CYP 1A2.

HMPL-523 (Syk) in hematological cancer

Australia & China – large Phase Ib expansion now moving faster

- Extensive Ph.I dose escalation study now complete in Australia & China (total n=60);
- Published China Ph.I dose escalation data 2018 ASH [1] conference;
- RP2D [2] determined & large Ph. Ib dose expansion study, total n=192, underway in 13 active sites in Australia & China;
- US IND application cleared by FDA & planning underway for a Phase II PoC [3] study

Australia & China Phase I/Ib studies

Stage I: dose escalation

"3 + 3" each dose cohort

Complete ✓

- **Australia:** Relapsed/refractory hematologic malignancy
- **China:** Relapsed/refractory mature B lymphoma

N = 33

N = 27

Studied HMPL-523

100-1,000mg QD & 200-400mg BID in 13 dose cohorts

until disease progression, death, intolerable toxicity, etc.

Stage II: dose expansion

…Now enrolling

Relapsed or refractory, measurable disease – multiple arms:

- Chronic lymphocytic leukemia
- Small lymphocytic lymphoma
- Mantle cell lymphoma
- Follicular lymphoma
- Diffuse large B-cell lymphoma

Aus N = 40

China N = 152

600mg QD

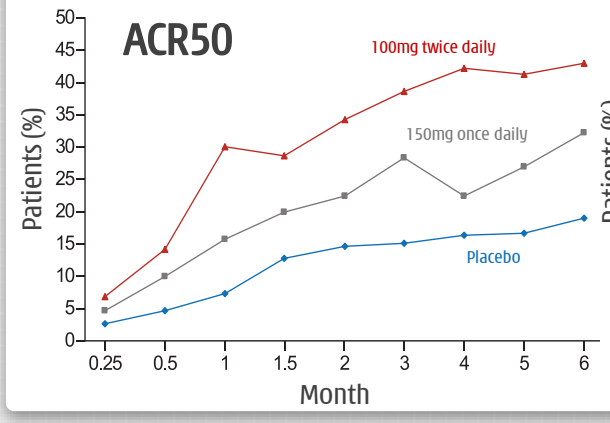
until disease progression, death, intolerable toxicity, etc.

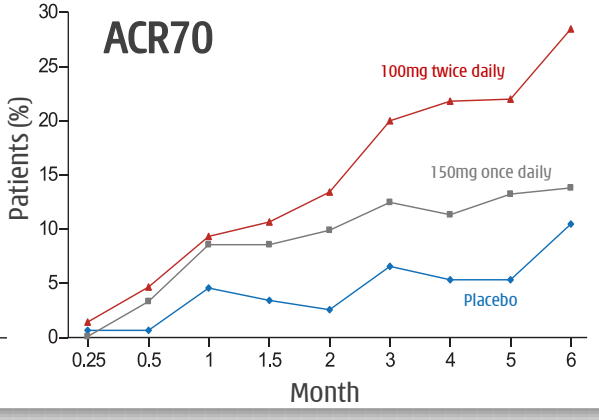
[1] ASH = American Society of Hematology; [2] RP2D = Recommended Phase II doses; [3] PoC = Proof-of-concept.

HMPL-523 - immunology potential

Superior selectivity, better target coverage & efficacy vs. fosta.

1. Fostamatinib good Phase II[1] RA[2] dose response...





...but GI toxicity, infection & 23% put on antihypertensives.

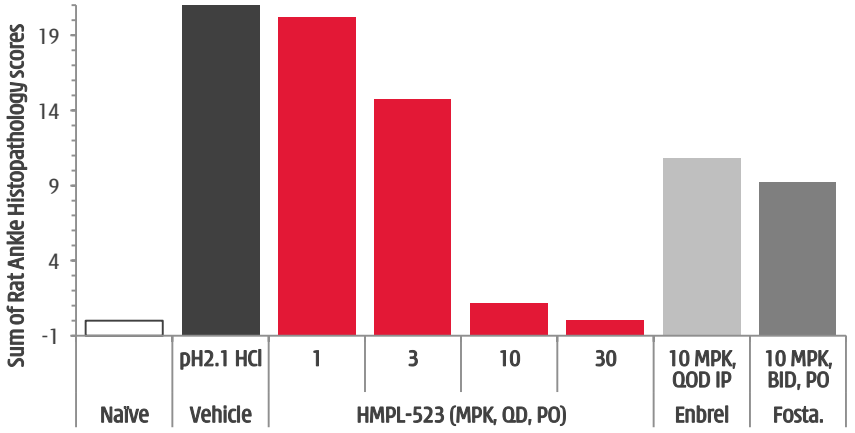
Percent of patients	Placebo (n = 153)	150mg QD (n = 152)	100mg BID (n = 152)
Diarrhea	3.0%	11.8% †	19.1% †
Upper respiratory infection	7.1	7.2	14.5 †
Urinary tract infection	4.6	3.3	5.9
Nausea	4.6	5.9	4.6
Neutropenia	0.7	6.6 †	5.9 †
Headache	5.2	6.6	5.9
Abdominal pain	2.6	6.6 †	5.9 †
ALT ›3x ULN	2.0	3.9	3.9
Dizziness	2.0	2.6	4.6
Hypothyroidism	2.6	2.6	3.3
Cough	2.6	2.0	3.3

† P ‹ 0.05 for comparison with placebo group; ALT = alanine aminotransferase.

2. HMPL-523 - far superior selectivity to fostamatinib...

Selectivity	HMPL-523 IC_{50} (nM)	fostamatinib IC_{50} (nM)
Syk enzyme	25 ± 5 (n=10)*	54 ± 16 (n=10)*
JAK 1,2,3 enzyme	›300, ›300, ›300*	120, 30, 480*
FGFR 1,2,3	›3,000, ›3,000, ›3,000	89, 22, 32*
FLT3 enzyme	63*	9*
LYN enzyme	921*	160*
Ret enzyme	›3,000*	5**
KDR enzyme	390 ± 38 (n=3)*	61 ± 2 (n=3)*
KDR cell	5,501 ± 1,607 (n=3)*	422 ± 126 (n=3)*

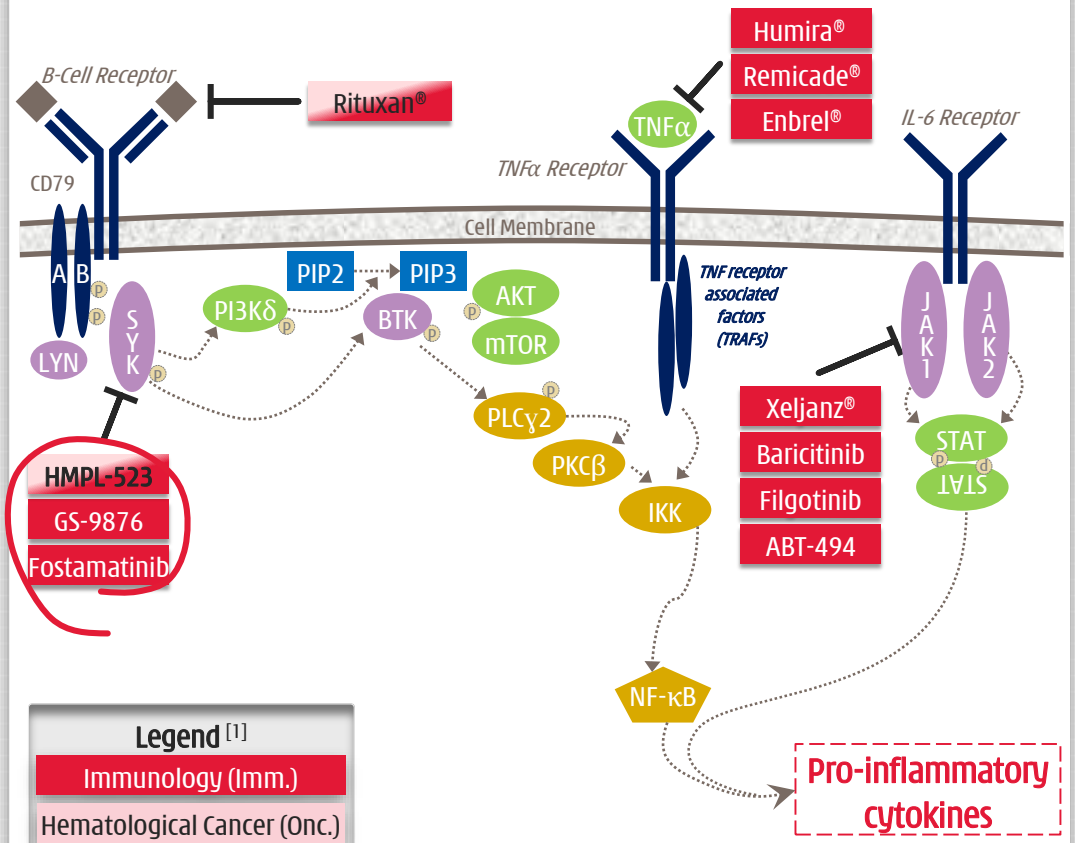
...and very strong efficacy in preclinical RA models.



[1] Fostamatinib is a prodrug of the SYK inhibitor R406 - Phase II study data per N ENGL J MED 363;14; *: HMPL data and Eun-ho Lee, 2011; ** Birth Defects Research (Part A) 2009, 85: 130-6; [2] RA = Rheumatoid Arthritis; GI = Gastrointestinal; QD = one dose per day; BID = two doses per day; QOD = one dose every other day; PO = by mouth (i.e. orally); IP = by Intraperitoneal injection; Naïve = model score without induced arthritis.

HMPL-523 – immunology potential

1. Syk, the most upstream B-cell pathway kinase target is clinically validated in rheumatoid arthritis ("RA"), but we believe currently Chi-Med & Gilead are the only companies pursuing.



2. RA expected to be a $45 billion[2] market in 2020 with B-cell pathway; anti-TNF; & JAK the main focus.

(Methotrexate-IR: placebo adjusted)	ACR20	ACR50	ACR70	2017 Sales ($ billion) [3]
B-Cell receptor -- mAbs				
Rituxan® (24-Week)	33%	21%	11%	1.6
Anti-TNFα/NF-κB -- mAbs				
Humira® (24-Week)	33%	29%	18%	18.4
Remicade® (24-Week)	30%	22%	8%	6.3
Enbrel® (24-Week)	44%	36%	15%	7.9
JAK Inhibitors -- Small molecules				
Xeljanz® (24-Week)	25%	23%	13%	1.3
Xeljanz® (12-Week)	28%	21%	8%	
baricitinib 4mg QD (12-Week)	30%	28%	14%	n/a
filgotinib 100mg BID (12-Week)	35%	40%	23%	n/a
ABT-494 24mg QD (12-Week)	32%	24%	18%	n/a
Syk Inhibitor -- Small molecule				
fostamatinib 100mg BID (24-Week)	32%	24%	18%	n/a

3. Substantial market potential remains in RA.

- mAbs intravenous administration and shut down immune system for 4-6 weeks – high infection / lymphoma risks.
- First-in-class JAKs in RA limited by compound-related tox.
- Syk inhibition shown to benefit patients – but fostamatinib failed due to major off-target toxicity.

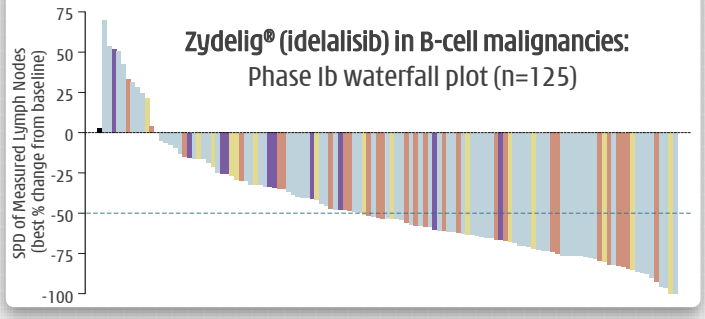
[1] Approved drug = ®; All other clinical candidates: mAb = antibody (extracellular); small molecule (intracellular); [2] Frost & Sullivan; [3] 2017 sales in immunology only.

HMPL-689 – Phase I Australia & China ongoing

Designed to be a best-in-class inhibitor of PI3Kδ

1. PI3Kδ now a proven target.

- PI3Kδ activation associated with allergy, inflammation & oncology.
- Evidence that PI3Kδ inhibitors effective in ibrutinib-resistant mutant population.



2. PI3Kδ inhibitors being developed in a very broad range of indications.

Compound		Indication	Status	Issue
Zydelig® (idelalisib) PI3Kδ	Gilead	Chronic lymphocytic leukaemia, non-Hodgkin's lymphoma	Marketed	High incidence of liver toxicity seen with idelalisib (150mg bid)
AMG-319 PI3Kδ	Amgen	B-cell lymphoma, non-Hodgkin's lymphoma, T-cell lymphoma, chronic lymphocytic leukaemia	Phase I Trial	
Copiktra® (duvelisib) PI3Kγ/δ	Verastem/ Infinity [1]	Relapsed or refractory chronic lymphocytic leukaemia / small lymphocytic lymphoma	Approved	Need to spare PI3Kγ -- serious infection seen & associated with a boxed warning for 4 fatal and/or serious toxicities
		Relapsed or refractory follicular lymphoma	Approved [2]	
		Peripheral T-cell lymphoma	Phase II enrolling	
Aliqopa® (copanlisib) PI3Kα/δ	Bayer	Relapsed follicular B-cell non-Hodgkin lymphoma	Approved [2]	Serious and fatal infections and AEs

3. HMPL-689 -- Important asset.

Designed to improve on existing PI3Kδ inhibitors:

- **Improved isoform selectivity** (sparing PI3Kγ).
- **Improved potency at whole blood level** (›5x more potent than idelalisib) to cut compound related toxicity.
- **Improved PK properties** particularly efflux and drug/drug interaction due to CYP inhibition / induction, critical for combo therapy.

4. More potent / more selective than Zydelig®, Copiktra® & Aliqopa®.

Enzyme IC_{50} (nM)	HMPL-689	Zydelig®	Copiktra®	Aliqopa®
PI3Kδ	0.8 (n = 3)	2	1	0.7
PI3Kγ (fold vs. PI3Kδ)	114 (142X)	104 (52X)	2 (2X)	6.4 (9X)
PI3Kα (fold vs. PI3Kδ)	›1,000 (›1,250X)	866 (433X)	143 (143X)	0.5 (1X)
PI3Kδ human whole blood CD63+	3	14	15	n/a
PI3Kβ (fold vs. PI3Kδ)	87 (109X)	293 (147X)	8 (8X)	3.7 (5X)

[1] AbbVie ended collaboration with Infinity in June 2016 following Phase II results in indolent non-Hodgkin's lymphoma. Duvelisib now licensed to Verastem; [2] Accelerated approval was granted based on ORR, and continued approval may be contingent upon verification and description of clinical benefit in a confirmatory trials.

CHI-MED

4e

Epitinib

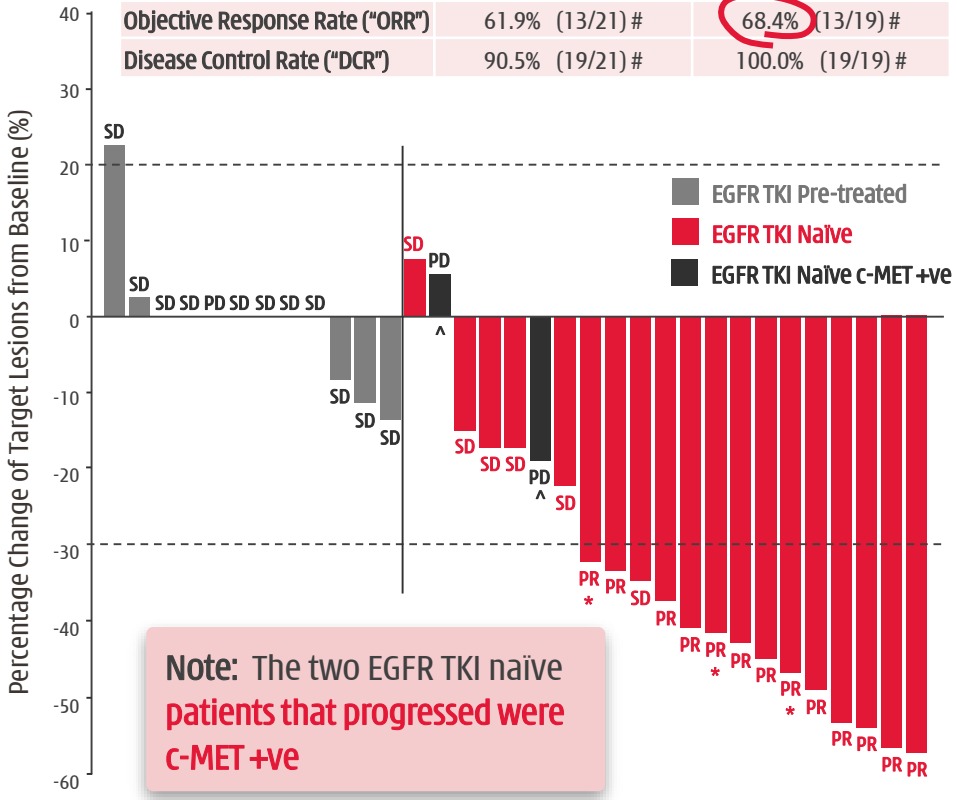
EGFR inhibitor with blood-brain-barrier penetration

Epitinib – 70% response in NSCLC w/ brain mets[1]

Unmet medical need for ~50% of NSCLC patients w/ brain mets[2]

1. Phase Ib [1] – epitinib monotherapy in EGFRm+ NSCLC patients – efficacy in lung in-line with Iressa®/Tarceva®.

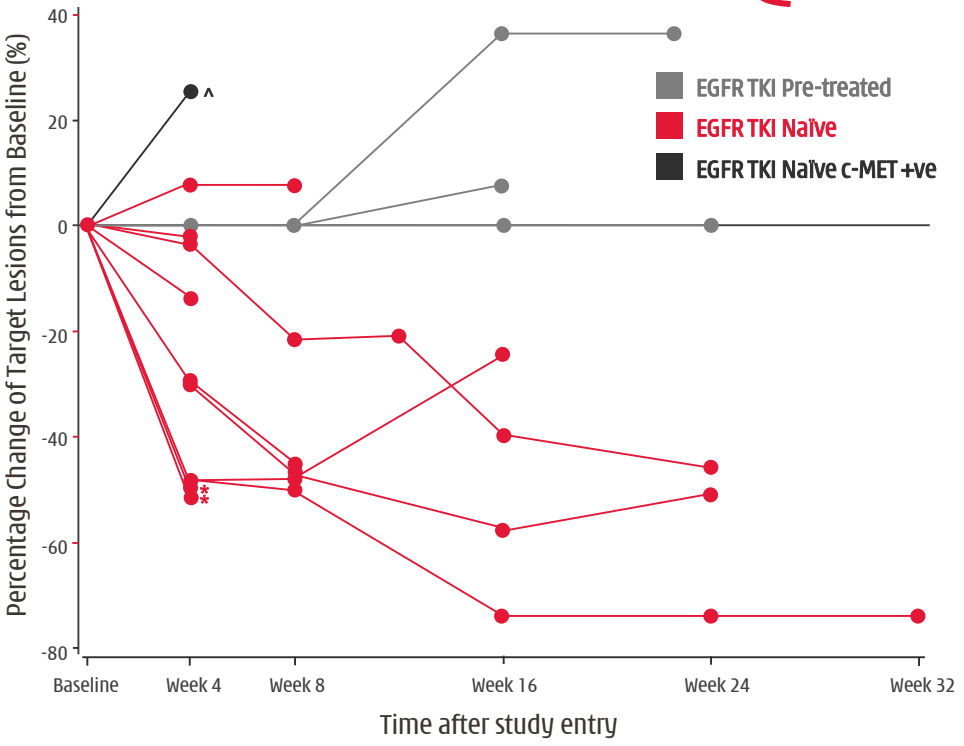
160mg once daily dose ("QD")	EGFR TKI naïve (N=21)	EGFR TKI naïve excl. c-MET +ve (N=19)
Objective Response Rate ("ORR")	61.9% (13/21) #	68.4% (13/19) #
Disease Control Rate ("DCR")	90.5% (19/21) #	100.0% (19/19) #



Note: The two EGFR TKI naïve patients that progressed were c-MET +ve

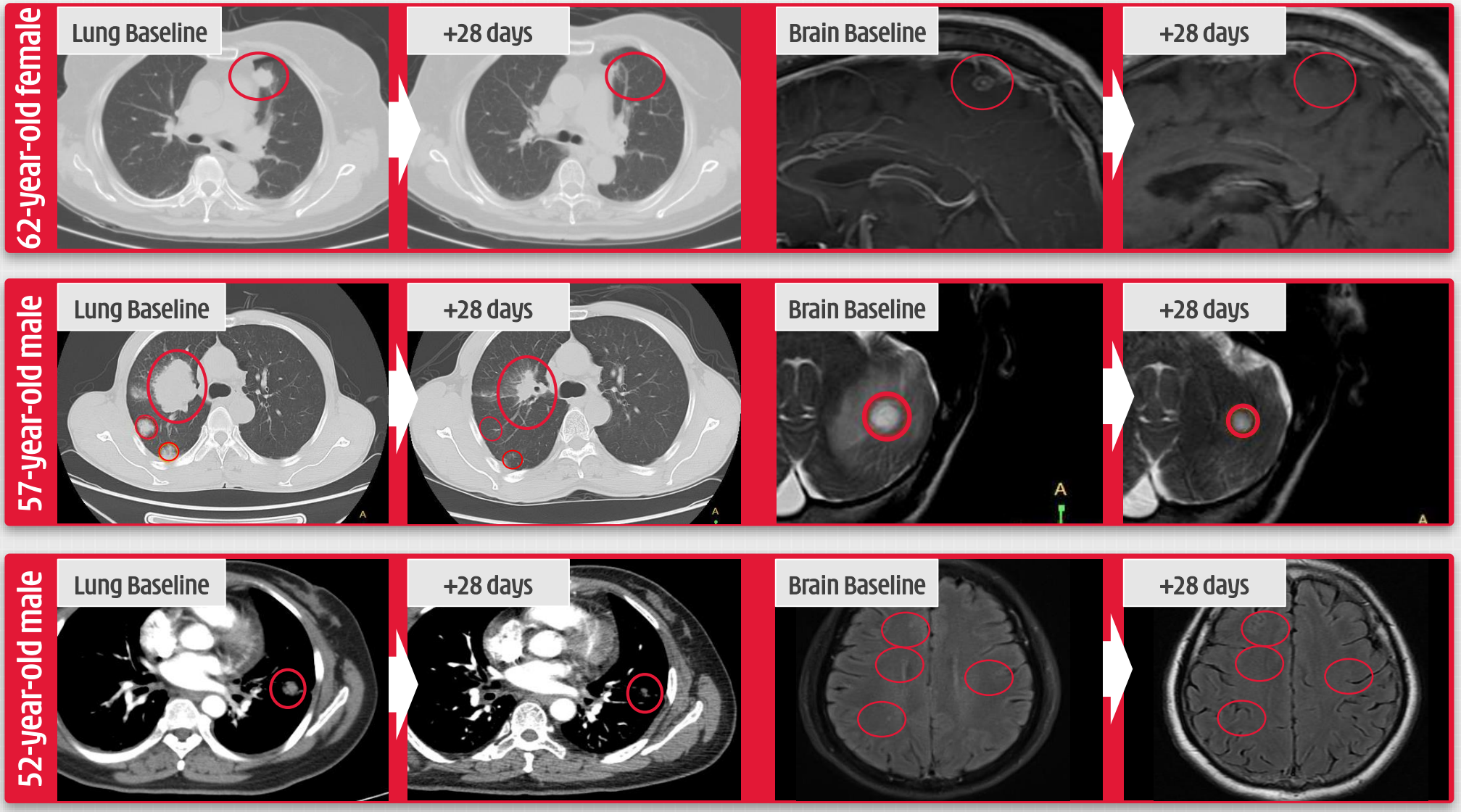
2. Phase Ib [1] – solid/durable efficacy in brain in EGFRm+ NSCLC patients with measurable brain mets (>10mm).

160mg QD dose	EGFR TKI naïve (N=11)	EGFR TKI naïve excl. c-MET +ve (N=10)
Intracranial ORR	63.6% (7/11) #	70.0% (7/10) #
Intracranial DCR	90.9% (10/11) #	100.0% (10/10) #



[1] Dose expansion stage – data cut-off September 20, 2016; [2] Li B, Bao YC, Chen B, *et al.* Therapy for non-small cell lung cancer patients with brain metastasis. Chinese-German J Clin Oncol, 2014, 13: 483-488;
***** Unconfirmed PR, due to no further assessment at cut-off date; **#** Includes both confirmed and unconfirmed PRs; **^** c-MET amplification/high expression identified.

Epitinib - Strong PoC efficacy - 160mg QD dose



Epitinib – Safe & well tolerated

3. Epitinib well tolerated by patients[1] w/advanced solid tumors. Safety profile is consistent with that of approved EGFR-TKIs (e.g. Iressa®/ Tarceva®).

Dose Escalation Stage (n=35*) (Drug related AEs reported ›10%)		
160mg QD dose	All Grades n (%)	Grade 3/4 n (%)
Skin rash	21 (60.0%)	1 (2.9%)
Diarrhea	12 (34.3%)	-
AST increase	12 (34.3%)	1 (2.9%)
ALT increase	11 (31.4%)	1 (2.9%)
Total bilirubin increase	10 (28.6%)	2 (5.7%)
Stomatitis	5 (14.3%)	-
Exfoliative dermatitis	5 (14.3%)	-
Pruritus	5 (14.3%)	-
Hyper-pigmentation	4 (11.4%)	-
Gamma-GGT increase	4 (11.4%)	2 (5.7%)
Conjugated bilirubin	4 (11.4%)	1 (2.9%)

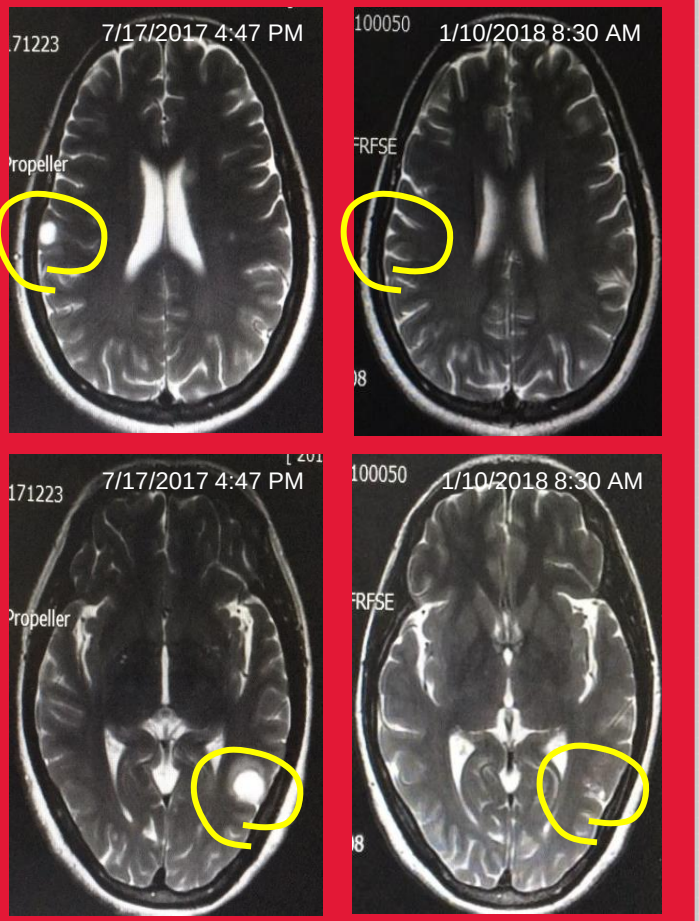
Dose Expansion Stage (n=37) (Drug related AEs reported ›10%)		
160mg QD dose	All Grades n (%)	Grade 3/4 n (%)
Skin rash	31 (83.8%)	2 (5.4%)
Hyper-pigmentation	18 (48.6%)	1 (2.7%)
ALT increase	15 (40.5%)	7 (18.9%)
AST increase	15 (40.5%)	4 (10.8%)
ASP increase	11 (29.7%)	1 (2.7%)
Diarrhea	10 (27.0%)	-
Proteinuria	10 (27.0%)	-
Total bilirubin increase	9 (24.3%)	1 (2.7%)
Hyperuricemia	9 (24.3%)	2 (5.4%)
Gamma-GGT increase	7 (18.9%)	4 (10.8%)
Stomatitis	6 (16.2%)	-

4. EGFR gene amplified Glioblastoma (primary brain tumors):

- Phase Ib/II proof-of-concept underway.

CASE STUDY – EGFR-TKI naïve patient

- Male, 46, diagnosed with Stage IV NSCLC adenocarcinoma (Exon21)
- Metastases in the brain, meninges, & bone
- 1st-line chemo naïve
- 120mg QD dosage
- 25 weeks (177 days) on treatment with clear response in multiple measurable (›10mm diameter) brain lesions



[1] No Dose Limiting Toxicity ("DLT") was observed in any cohort; * One patient did not join multiple dosing.

CHI-MED

4f

Theliatinib (EGFRwt) & HMPL-453 (FGFR)

Potential best-in-class (EGFRwt) & first-in-class (FGFR1/2/3) assets

Theliatinib

Potent & highly selective TKI - strong affinity to EGFRwt kinase

1. Major unmet medical need for wild-type EGFR activation tumors.

- EGFR activation affects multiple tumor types. Current EGFR TKIs are less effective in treating solid tumors with wild-type EGFR activation (gene amplification & protein over expression).
- Phase Ib expansion study on theliatinib in esophageal cancer is currently underway in China.

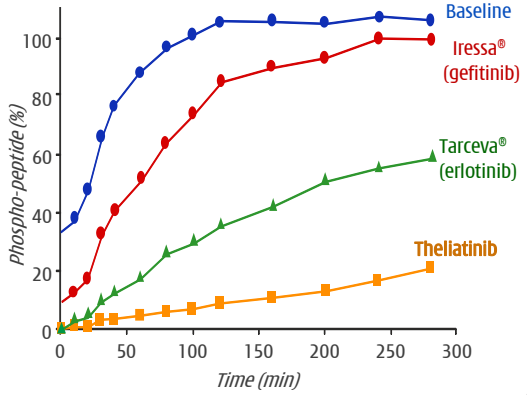
TKIs approved: Iressa®, Tarceva®

Tumor Types	Wild-type: Gene Amplification	Wild-type: Over Expression	Mutations
NSCLC	29%	62%	10-30%
Esophagus	8-30%	30-90%	12% (esophageal adenocarcinoma)
Stomach	29%	44-52%	‹5%
Glioblastoma	36-51%	54-66%	27-54% (EGFR variant III)
Colorectal	4.5%	*53%*	8%
Head and neck	10-30%	*66-84%*	42% (EGFR variant III)

MAbs approved: Erbitux®, Vectibix®

2. Superior anti-tumor activity of theliatinib in pre-clinical studies with wild-type EGFR.

- 5-10-fold more potent than Tarceva®.
- Sustained target occupancy.



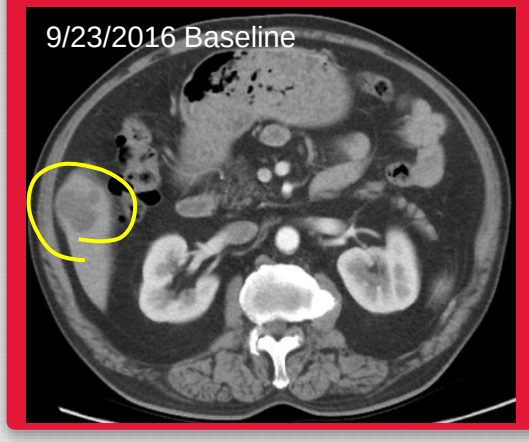
3. Esophageal cancer (EC): No effective treatment options.

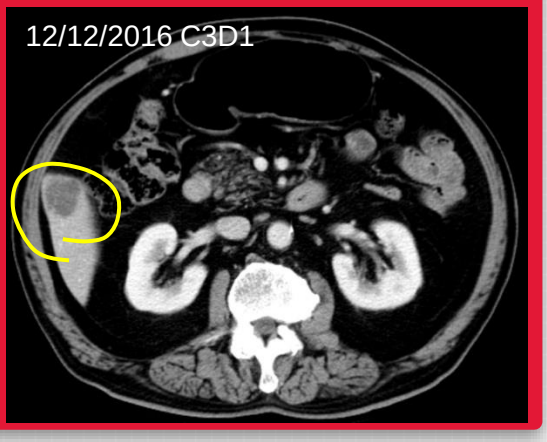
- Major issue in Asia with poor prognosis: 5-year survival 10-20%

	new cases/year	deaths/year
U.S.	16,940[1]	15,690[1]
China	477,900[1]	375,000[1]

CASE STUDY - EGFR protein over expression

- May 4, 2016: Man, 62, stage IV **esophageal squamous cell cancer** cT3N0M1with **liver metastasis**. **High protein overexpression** - EGFR IHC local test: ›75% of tumor cells 3+.
- May 4 to Sep 23, 2016: nimotuzumab/placebo + paclitaxel + cisplatin - **6 cycles with best tumor response: PD**.
- Oct 11, 2016: began theliatinib 400mg daily.
- Dec 12, 2016: Cycle 3 Day 1 (C3D1) tumor assessment: **Target lesion (liver metastasis) shrank -33%** (36mm to 23mm diameter) - unconfirmed PR.
- Jan 23, 2017: Withdrew from study due to AEs - Gr 1 (diarrhea/pruritus/dental ulcer), Gr 2 (epifolliculitis/dermatitis).





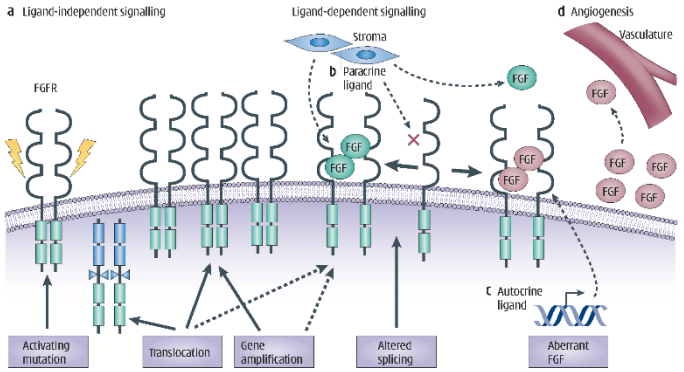
TKIs = tyrosine kinase inhibitors; MAbs = monoclonal antibodies. [1] GLOBOCAN 2012 (http://globocan.iarc.fr/) and Chen W et al. Cancer statistics in China, 2015. CA Cancer J Clin. 2016; 66:115-132

HMPL-453 – Phase I in China ongoing

Designed as first-in-class FGFR1/2/3 inhibitor

1. FGFR genetic alterations are oncogenic drivers.

- FGF/FGFR signaling normally involved in embryonic development, tissue repair, angiogenesis, neuroendocrine and metabolism homeostasis.
- Multiple oncogenic driver genetic alterations in FGFR pathway: gene amplification, mutation, translocation, fusion, splicing, etc.

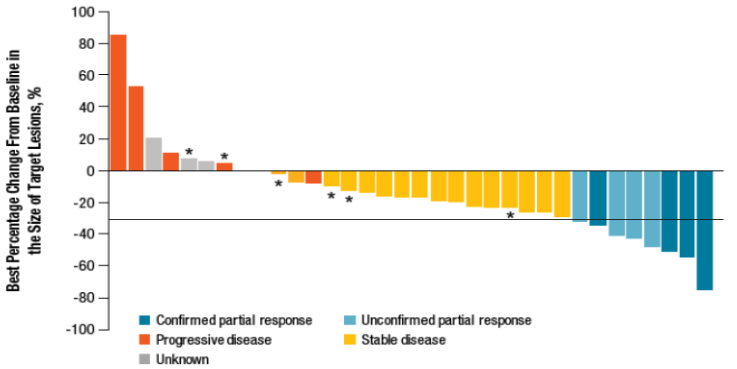


2. FGFR – diverse & complicated genetic changes with multiple tumor types harboring low incidence.

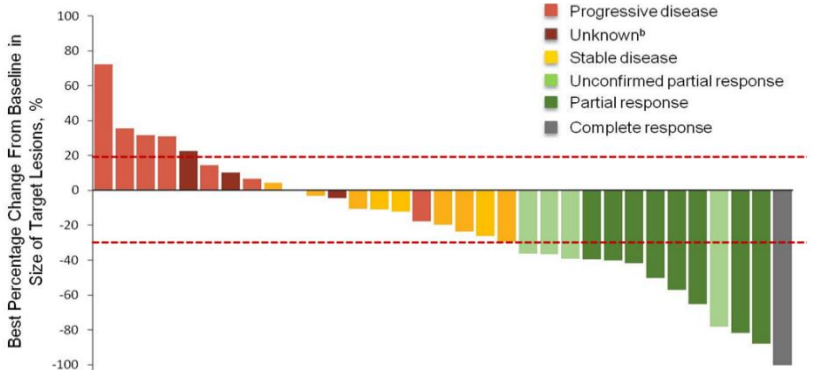
	Gene amplification	Gene translocation	Gene mutation
FGFR1	**Lung squamous** (7~15%) **H&N squamous** (10~17%) **Esophageal squamous** (9%) **Breast** (10~15%)	**Lung squamous** (n/a) **Glioblastoma** (n/a) **Myeloproliferative syndrome** (n/a) **Breast** (n/a)	**Gastric** (4%) **Pilocytic astrocytoma** (5~8%)
FGFR2	**Gastric** (5~10%) **Breast** (4%)	**Intra-hepatic biliary tract cancer (cholangiocarcinoma)** (14%) **Breast** (n/a)	**Endometrial** (12~14%) **Lung squamous** (5%)
FGFR3	**Bladder** (n/a) **Salivary adenoid cystic** (n/a)	**Bladder** (3~6%); **Lung squamous** (3%); **Glioblastoma** (3%) **Myeloma** (15~20%)	**Bladder** (60~80% NMIBC; 15~20 MIBC) **Cervical** (5%)

3. Biliary Tract Cancer (cholangiocarcinoma) and bladder cancer have made much progress in clinic to date.

- BGJ398 Phase II PoC in biliary tract cancer (2016 ASCO GI).



- BGJ398 Phase II PoC in bladder cancer (2016 ASCO).



CHI-MED

5 Appendices

H1 2018 Financial Results

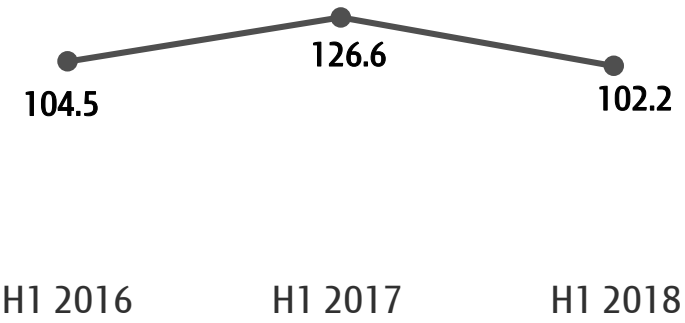
Including $66.7 million in innovation investment [1][2]

Financial Summary

	H1-2016	H1-2017	H1-2018	Change 16-17	Change 17-18
REVENUES	104.5	126.6	102.2	21%	-19%
Unconsolidated JV Revenues [3]	*227.5*	*224.2*	*271.7*	*-1%*	*21%*
NET INCOME/(LOSS) [2]					
INNOVATION PLATFORM	(13.7)	(14.8)	(52.9)	-8%	-258%
Base HMP Operations	*(11.6)*	*(12.4)*	*(50.5)*		
50% share of Nestle JV (NSP) [4]	*(2.1)*	*(2.4)*	*(2.4)*		
COMMERCIAL PLATFORM	22.1	22.7	26.9	2%	19%
Prescription Drugs Business	*15.3*	*16.9*	*20.8*		
Consumer Health Business	*6.8*	*5.8*	*6.1*		
Chi-Med Group Costs	(7.9)	(8.7)	(6.7)	-10%	23%
General & Administrative Expenses	*(5.8)*	*(6.6)*	*(4.9)*		
Interest/Tax	*(2.1)*	*(2.1)*	*(1.8)*		
R&D Related Subsidies	-	2.5	-	100%	n/a
Net Income/(Loss) Attrib. to Chi-Med	0.5	1.7	(32.7)	213%	n/a
EPS Attrib. to Ord. S-H (Basic) (US$)	*0.01*	*0.03*	*(0.49)*		

Group Results

Revenues



Net Income/(Loss) [5]

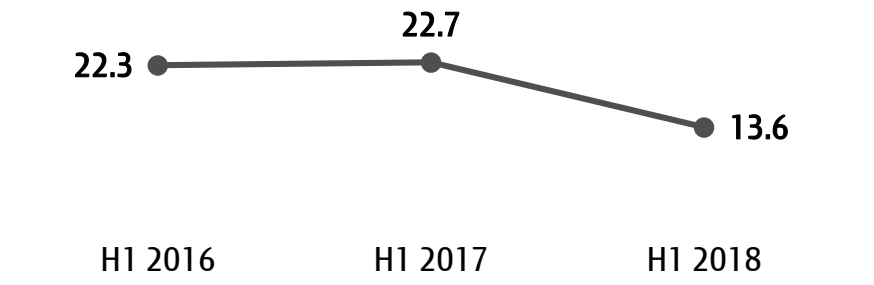
[1] R&D expenses (Non-GAAP); H1 2017: $37.5m; [2] GAAP R&D expenses were $60.1m in H1 2018 (H1 2017: $31.6m) - please see appendix "Non-GAAP Financial Measures and Reconciliation";
[3] Excluding Guanbao (divested); [4] NSP = Nutrition Science Partners Limited; [5] Net Income/(Loss) = Net Income/(Loss) Attributable to Chi-Med.

(US$ millions, Except per share data)

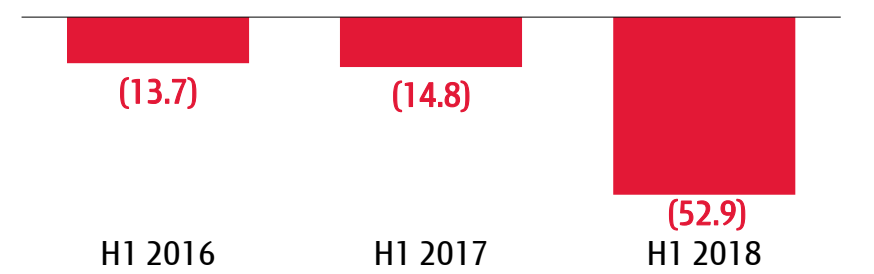
Financial Performance of Main Platforms

Innovation Platform

Revenues



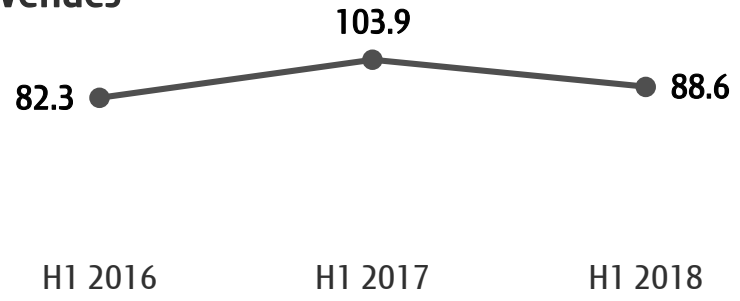
Net Loss [3]



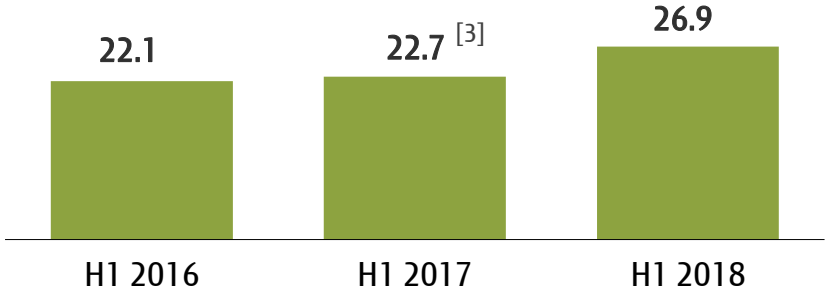
- No milestones in H1 2018, expected H2 2018;
- Increased R&D expense: Acceleration in growth in operations & clinical trial activities.

Commercial Platform

Revenues [1]



Net Income [2]



- China Two-Invoice System (TIS) implemented: Move to fee-for-service model from revenue consolidation on some 3rd party drugs. No effect on net income.

(US$ millions)

[1] Only includes revenues of subsidiaries for Prescription Drugs and Consumer Health businesses - excludes joint ventures; [2] Adjusted Net Income/(Loss) = Adjusted Net Income/(Loss) attributable to Chi-Med (non-GAAP);
[3] Excludes the share of a one-time gain from SHPL's R&D related subsidies of US$2.5 million.

Chi-Med Group Structure - Major Entities

Non-Consolidated Joint Ventures

Chi-Med Subsidiaries

Chi-Med Group Level

Revenues - H1 2018 $102.2m (H1 2017: $126.6m)
Net (Loss)/Income Attributable to Chi-Med - H1 2018: -$32.7m (H1 2017: $1.7m)

Innovation Platform

Revenue - **H1 2018: $13.6m** (H1 2017: $22.7m)
Net Loss Attributable to Chi-Med - **H1 2018: -$52.9m** (H1 2017: -$14.8m)

99.8%

Hutchison MediPharma ("HMP")
Oncology/Immunology Drug R&D

Revenue:
H1 2018: $13.6m (H1 2017: $22.7m)

50%

Nutrition Science Partners ("NSP")
Botanical Drug /GI Disease R&D
Partner: Nestlé Health Science
Revenue:
H1 2018: nil (H1 2017: nil)

Commercial Platform

Sales of Subs & JVs - **H1 2018: $360.3m** (H1 2017: $357.0m)
Net Income Attributable to Chi-Med - **H1 2018: $26.9m** (H1 2017: $25.2m)

Prescription Drugs

50%

Shanghai Hutchison Pharma ("SHPL")
Prescription Drugs
Partner: Shanghai Pharma Group
Revenue:
H1 2018: $152.7m (H1 2017: $129.7m)

51%

Hutchison Sinopharm ("HSP") [1]
Rx Drug Commercial Co.
Partner: Sinopharm Group
Revenue:
H1 2018: $68.0m (H1 2017: $85.8m)

Consumer Health

50% [2]

Hutchison BYS Chinese Med. ("HBYS")
Over-the-counter Drugs ("OTC")
Partner: Guangzhou Pharma Holdings
Revenue:
H1 2018: $119.0m (H1 2017: $123.4m)

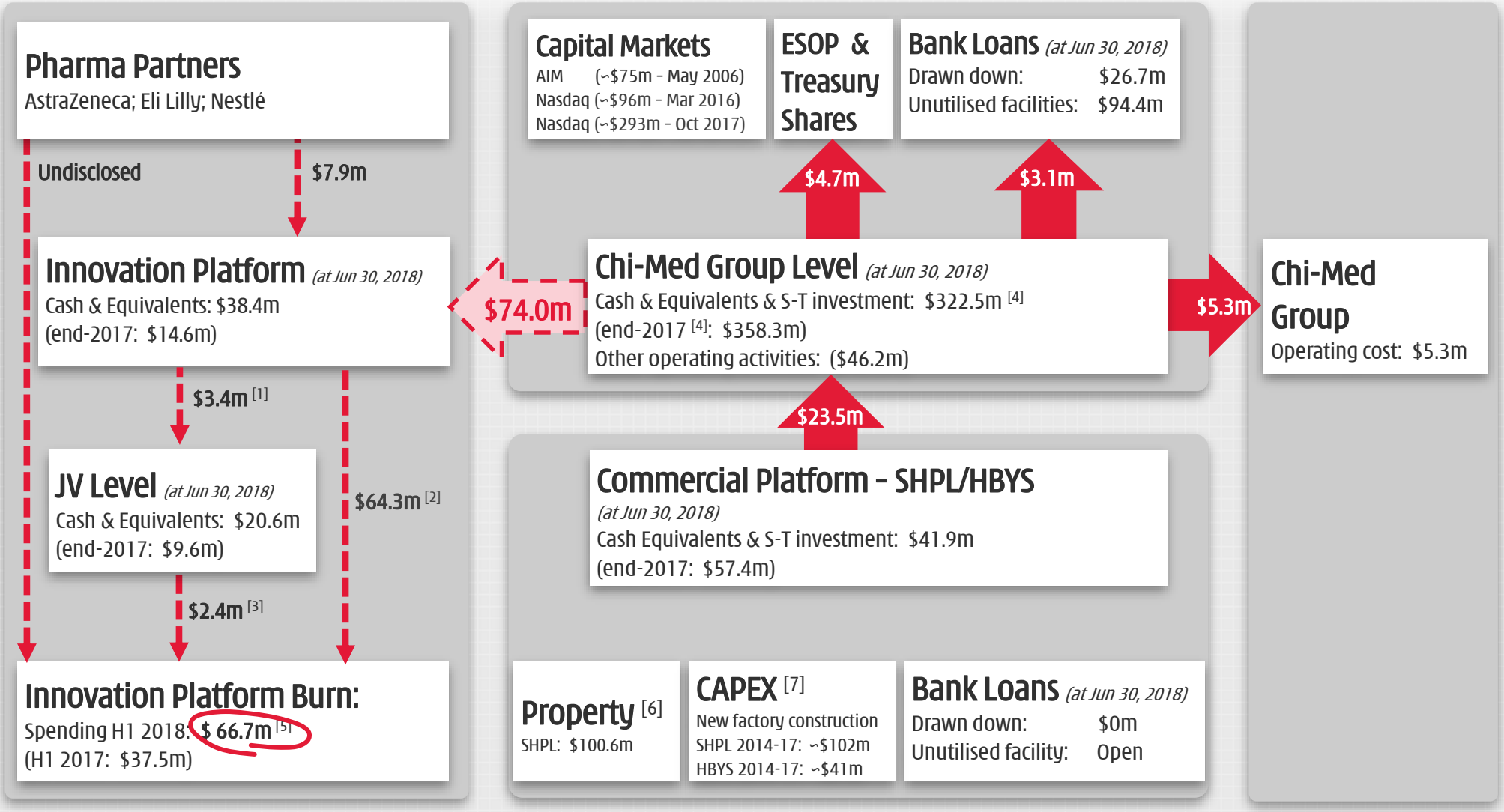
50%

Hutchison Hain Organic ("HHO")
Health Related Consumer Prods.
Partner: Hain Celestial Group
Revenue:
H1 2018: $14.2m (H1 2017: $13.7m)

[1] Excluded HSP's ZLT business; [2] Held through an 80% owned subsidiary.

Inter-group cash flow

$322.5m cash (Jun 30, 2018); $94.4m in undrawn bank facilities



[1] $8.0m capital injection to NSP offset by $4.6m service income received from NSP; [2] Including research & development cost and general & admin. expenses; [3] Share of NSP operating loss; [4] Including $247.2m short-term investment (91-183 day deposit) as at end of June 2018; [5] Please see appendix "Non-GAAP Financial Measures and Reconciliation" for a Reconciliation of GAAP to adjusted research and development expenses; [6] Cash received for SHPL land compensation; [7] CAPEX required to build new Shanghai (SHPL) and Bozhou (HBYS) factories.

(US$ millions)

China Commercial Platform has substantial value

- Chi-Med's Commercial Platform continues to perform well relative to our peer group.
- The market value, based on China Pharma PE multiples is approximately $2.9 – 3.1 billion.[1] Given our share in the JVs, Chi-Med's share of this value is approximately $1.4 – 1.5 billion.

	Code	NET SALES 2016 Jan-Dec	NET SALES 2017 Jan-Dec	NET SALES FY16-17 Growth	NET INCOME 2016 Jan-Dec	NET INCOME 2017 Jan-Dec	NET INCOME FY16-17 Growth	NET INCOME FY2017 Margin	VALUATION[3] Market Cap.	VALUATION[3] P/E
CHI-MED Commercial Platform -- Subsidiaries/JVs[2]		**627.4**	**677.2**	**8%**	**63.3**	**77.3**	**22%**	**11%**	**n/a**	**n/a**
Tianjin Zhong Xin Pharma	600329	925.0	851.7	-8%	61.0	70.8	16%	8%	2,039	22
Li Zhu Pharma	000513	1,145.5	1,277.1	11%	102.0	122.8	20%	9.6%	4,727	38
Shandong Dong E E Jiao	000423	945.7	1,103.6	17%	277.7	306.0	10%	28%	5,242	20
Zhejiang Kang En Bai Pharma	600572	901.3	792.5	-12%	60.5	109.3	81%	14%	3,046	23
Kunming Pharma	600422	763.6	876.1	15%	61.3	50.2	-18%	6%	972	25
Guizhou Yi Bai Pharma	600594	551.9	570.0	3%	58.9	61.0	4%	11%	1,069	23
Jin Ling Pharma	000919	535.7	477.8	-11%	33.3	25.9	-22%	5%	573	30
Jiangsu Kang Yuan	600557	449.1	490.2	9%	56.3	56.6	1%	12%	1,136	22
Zhuzhou Qian Jin Pharma	600479	428.9	476.5	11%	26.0	36.9	42%	8%	651	26
ZhangZhou Pian Zai Huang	600436	345.7	556.0	61%	75.9	116.8	54%	21%	11,196	55
Peer Group -- Weighted Avg. (10 Comps. excl. Chi-Med)		**699.2**	**747.2**	**7%**	**81.3**	**95.6**	**18%**	**13%**	**3,065**	**37**
All 61 Listed China Pharma. Companies -- Weighted Average		**1,155.1**	**1,270.1**	**10%**	**96.0**	**123.5**	**29%**	**10%**	**3,533**	**40**

Peer Group: 10 companies (excl. Chi-Med) selected as ALL listed and profitable mainland Chinese OTC/RX pharma manufacturing companies, with a focus on similar product types, and FY2017 Net Sales in the ~$400-1,300 million range.

Source: Company data, Deutsche Bank, FactSet

[1] Peer group/China Pharma multiple of 37x-40x 2017 actual Net income after tax of $77.3 million (excluding SHPL's R&D related subsidies of US$5.0 million at net income after tax);

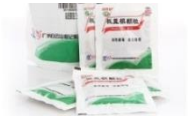
[2] Total aggregate PRC domestic results of Chi-Med's 6 Commercial Platform companies (HBYS, SHPL, Hutchison Sinopharm, HHO, HHL & HCPL), excluding discontinued operations and land compensation from SHPL;

[3] Market Capitalization and Price Earnings Ratios as at **July 19, 2018**: Trailing Twelve Month PE weighted averaged based on market capitalization.

(US$ millions)

Deep portfolio of household name drugs

Top 7 products represent 71% of sales[1] and 90% of gross profit[1]

Main Products [2] – SALES (Non-GAAP)	2012	2013	2014	2015	2016	2017	H1 2017	H1 2018
 ***SXBX pill*** Coronary artery disease (Rx) 15.4% National market share Patent expiry 2029	102,215 *+29%*	123,587 *+21%*	138,848 *+12%*	159,326 *+15%*	195,371 *+23%*	209,246 *+7%*	110,384 *+0%*	129,806 *+18%*
 ***Banlangen granules*** Anti-viral/flu (OTC) 53% National market share	65,381 *+14%*	72,300 *+11%*	55,573 *-23%*	54,793 *-1%*	56,664 *+3%*	59,898 *+6%*	28,253 *-12%*	37,899 *+34%*
 ***FFDS tablet*** Angina (OTC) 38% National market share	60,181 *+6%*	69,996 *+16%*	76,297 *+9%*	60,154 *-21%*	59,906 *0%*	58,936 *-2%*	36,059 *-4%*	32,767 *-9%*
 ***Seroquel tablets*** Bi-polar/Schizophrenia (Rx) 6% National market share	n/a	n/a	n/a	21,131	34,380 *+63%*	35,359 *+3%*	18,900 *+10%*	16,993[3] *-10%*
 ***NXQ tablet*** Cerebrovascular disease (OTC) Proprietary formulation	6,933 *+85%*	10,142 *+46%*	14,681 *+45%*	17,581 *+20%*	21,000 *+19%*	20,408 *-3%*	8,744 *-6%*	17,026 *+95%*
 ***KYQ granules*** Periodontitis (OTC) ›90% National market share	16,351 *+6%*	16,318 *0%*	18,370 *+13%*	17,051 *-7%*	17,210 *+1%*	17,620 *+2%*	7,707 *-23%*	10,820 *+40%*
 ***Danning tablet*** Gallbladder/stone (Rx) Patent expiry 2027	11,648 *+17%*	12,364 *+6%*	13,822 *+12%*	13,526 *-2%*	9,041 *-33%*	16,089 *+78%*	8,762 *+62%*	9,510 *+9%*

(US$'000)
(Growth % vs. Year Ago)

[1] Based on aggregate Non-GAAP sales and gross profit of consolidated subsidiaries and non-consolidated joint ventures of Commercial Platform, please see appendix "Non-GAAP Financial Measures and Reconciliation"; [2] Rx = prescription drug; OTC = over-the-counter drug; SXBX pill = She Xiang Bao Xin pill; FFDS tablet = Fu Fang Dan Shen tablet; NXQ tablet = Nao Xin Qing tablet; KYQ granules = Kou Yan Qing granules; Market shares according to Frost & Sullivan or QuintilesIMS; [3] From October 2017, the majority of sales changed to a fee-for-service model due to the CNDA Two-invoice policy. Net service fee increased by 75% from H1 2017: $5.5m to H1 2018: $9.6m.

Non-GAAP Financial Measures and Reconciliation (1/2)

Reconciliation of Adjusted Research and Development Expenses:

	H1 2018	H1 2017
Research and development expenses	(60.1)	(31.6)
Plus: Innovation Platform – administrative and other expenses	(4.3)	(3.6)
Plus: Equity in earnings of equity investees – NSP and other	(2.3)	(2.4)
Plus: Innovation Platform – interest income	0.0	0.1
Adjusted research and development expenses	**(66.7)**	**(37.5)**

Reconciliation of Top 7 products' Gross Profit as Percentage of Aggregated Gross Profit for Commercial Platform:

	H1 2018
Sales of goods – third parties and related parties	88.6
Less: Costs of sales of goods – third parties and related parties	(71.9)
Consolidated gross profit	**16.7**
Plus: Gross profit – HBYS and SHPL	168.0
Adjusted gross profit	**184.7**
Top 7 products gross profit	**166.0**
% of Top 7 products to adjusted gross profit	90%

(US$ millions unless otherwise stated)

Non-GAAP Financial Measures and Reconciliation (2/2)

Reconciliation of Non-GAAP Sales and Non-GAAP Net (loss)/income after tax [1]

- Prescription Drugs: includes our Consolidated subsidiary (Hutchison Sinopharm) and Non-consolidated joint venture (SHPL);
- Consumer Health: includes our Consolidated subsidiaries (HHO, HHL and HCP) and Non-consolidated joint venture (HBYS).

	IFRS										US GAAP							H1'17-H1'18
(US$ millions)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	H1'17	H1'18	Growth
Sales (Non-GAAP)	**21.9**	**27.9**	**65.1**	**101.4**	**119.0**	**155.8**	**197.0**	**236.4**	**278.6**	**360.7**	**402.3**	**465.4**	**518.9**	**627.4**	**677.2**	**357.0**	**360.3**	**1%**
Prescription Drugs	***17.2***	***21.8***	***23.3***	***23.2***	***28.1***	***39.5***	***54.4***	***71.2***	***92.4***	***116.5***	***138.2***	***204.9***	***286.6***	***372.3***	***411.0***	***215.5***	***220.7***	***2%***
- Consolidated subsidiary	-	-	-	-	-	-	-	-	-	-	-	*50.2*	*105.5*	*149.9*	*166.4*	*85.8*	*68.0*	*-21%*
- Non-consolidated joint venture	*17.2*	*21.8*	*23.3*	*23.2*	*28.1*	*39.5*	*54.4*	*71.2*	*92.4*	*116.5*	*138.2*	*154.7*	*181.1*	*222.4*	*244.6*	*129.7*	*152.7*	*18%*
Consumer Health	***4.7***	***6.1***	***41.8***	***78.2***	***90.9***	***116.3***	***142.6***	***165.2***	***186.2***	***244.2***	***264.1***	***260.5***	***232.3***	***255.1***	***266.2***	***141.5***	***139.6***	***-1%***
- Consolidated subsidiaries	*4.7*	*6.1*	*9.3*	*8.9*	*3.7*	*5.5*	*7.0*	*14.1*	*14.9*	*15.5*	*16.5*	*16.8*	*20.7*	*31.0*	*38.8*	*18.1*	*20.6*	*14%*
- Non-consolidated joint venture	-	-	*32.5*	*69.3*	*87.2*	*110.8*	*135.6*	*151.1*	*171.3*	*228.7*	*247.6*	*243.7*	*211.6*	*224.1*	*227.4*	*123.4*	*119.0*	*-4%*
Total Sales Growth	***n/a***	***27%***	***133%***	***56%***	***17%***	***31%***	***26%***	***20%***	***18%***	***29%***	***n/a***	***16%***	***11%***	***21%***	***8%***		***1%***	
- GuanBao divested in Sept 2017	-	-	-	-	-	-	-	-	*(11.4)*	*(50.5)*	*(51.6)*	*(49.7)*	*(40.7)*	*(45.0)*	*(38.6)*	*(29.0)*	-	*n/a*
Adjusted Consumer Health excl. GuanBao	***4.7***	***6.1***	***41.8***	***78.2***	***90.9***	***116.3***	***142.6***	***165.2***	***174.8***	***193.7***	***212.5***	***210.8***	***191.6***	***210.1***	***227.6***	***112.5***	***139.6***	***24%***
- Adjusted Non-consolidated joint venture	-	-	*32.5*	*69.3*	*87.2*	*110.8*	*135.6*	*151.1*	*159.9*	*178.2*	*196.0*	*194.0*	*170.9*	*179.1*	*188.8*	*94.4*	*119.0*	*26%*
Adjusted Sales excl. GuanBao (Non-GAAP)	***21.9***	***27.9***	***65.1***	***101.4***	***119.0***	***155.8***	***197.0***	***236.4***	***267.2***	***310.2***	***350.7***	***415.7***	***478.2***	***582.4***	***638.6***	***328.0***	***360.3***	***10%***
Total Adjusted Sales Growth	***n/a***	***27%***	***133%***	***56%***	***17%***	***31%***	***26%***	***20%***	***13%***	***16%***	***13%***	***19%***	***15%***	***22%***	***10%***		***10%***	
Net (loss)/income attrib. to Chi-Med	**(5.7)**	**(3.7)**	**(0.5)**	**1.2**	**4.5** [2]	**5.9** [2]	**9.3** [2]	**12.6** [2]	**13.6** [2]	**14.6** [2]	**18.2** [2]	**22.8** [2]	**25.2** [2]	**29.9** [3]	**37.5** [4]	**22.7** [4]	**26.9**	**19%**
Prescription Drugs	*(0.2)*	*0.6*	*1.0*	*0.7*	*0.9*	*1.4*	*3.0*	*5.9*	*7.1*	*8.8*	*11.2*	*13.2*	*15.9*	*20.7*	*26.5*	*16.9*	*20.8*	*23%*
Consumer Health	*(5.5)*	*(4.3)*	*(1.5)*	*0.5*	*3.6*	*4.5*	*6.3*	*6.7*	*6.5*	*5.8*	*7.0*	*9.6*	*9.3*	*9.2*	*11.0*	*5.8*	*6.1*	*7%*
Net (loss)/income attrib. to Chi-Med growth	*n/a*	*-35%*	*-86%*	*340%*	*275%*	*31%*	*58%*	*35%*	*8%*	*7%*	*n/a*	*26%*	*10%*	*19%*	*25%*		*19%*	

[1] 2003–2006 incl. disco. operation; [2] Continuing Operations; [3] Excludes the land compensation from SHPL of US$40.4 million at net income attributable to Chi-Med; [4] Excludes SHPL's R&D related subsidies of US$2.5 million at net income attributable to Chi-Med for 2017 and H1 2017.

National Drug Reimbursement List Pricing ("NDRL")

July'17 update – 15 new drugs in oncology[1] added to NDRL

		Unit Pricing (US$) [3]				Approximate Monthly Pricing (US$) [3]			
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	Indication coverage
Herceptin® (trastuzumab)	Roche	440mg:20ml	$3,298.81	$1,125.93	-66%	Breast: 4mg/kg wk 1, 2mg/kg weekly. [2]	$4,500	$1,540	Breast: Her2+; Her2+ meta. Her2+ late-stage meta. gastric.
Avastin® (bevacizumab)	Roche	100mg:4ml	$772.74	$296.00	-62%	10mg/kg Q2W.	$11,590	$4,440	Late-stage meta. CRC or advanced non-squamous NSCLC.
TheraCIM®[4] (nimotuzumab)	Biotech Pharma	50mg:10ml	$435.26	$251.85	-42%	100mg weekly.	$3,730	$2,160	Combo with radiotherapy for EGFR+ Stage III/IV nasopharyngeal carcinoma.
Rituxan® (rituximab)	Roche	500mg:50ml [2]	$2,544.74	$1,228.15	-52%	375 mg/m² weekly.	$13,090	$6,320	Restorative or resistant follicular central type lym.; CD20+ stage III-IV follicular NHL, CD20+ DLBCL.
Tarceva® (erlotinib)	Roche	150mg [2]	$68.15	$28.89	-58%	150mg QD.	$2,040	$870	Advanced NSCLC with limited EGFR gene mutation.
Nexavar® (sorafenib)	Bayer	0.2g	$60.44	$30.07	-50%	400mg BID.	$7,250	$3,610	Unresectable RCC. Unresectable HCC. meta. Diff. thyroid after radio-iodine therapy.
Tykerb® (lapatinib)	GSK	250mg	$17.63	$10.37	-41%	1,500mg QD.	$3,170	$1,870	Adv./meta. breast cancer with Her2 O/E, after anthracycline, paclitaxel, trastuzumab.
AiTan® (apatinib)	Hengrui	425mg [2]	$47.85	$30.22	-37%	850mg QD.	$2,870	$1,810	3L gastric adenocarcinoma or esophageal junction with adenocarcinoma.
Velcade® (bortezomib)	J&J	3.5mg [2]	$1,873.78	$906.07	-52%	1.3mg/m² quartic every 3 wks.	$6,360	$3,080	Myeloma; recurring or refractory mantle cell lymphoma.
EnDu® (rh-endostatin)	Simcere	15mg	$132.15	$93.33	-29%	7.5mg/m² iv QD 2-wks-on / 1-week-off.	$2,110	$1,490	Late-stage NSCLC.
Epidaza® (chidamide)	Chipscreen	5mg	$81.48	$57.04	-30%	30mg QD, 2x per wk.	$4,190	$2,930	2L+ Recurring or refractory peripheral T-cell lymphoma (PTCL).
Zytiga® (abiraterone)	J&J	250mg	$45.63	$21.48	-53%	1,000mg QD.	$5,480	$2,580	Metastatic or ovariectomized prostate cancer.
Faslodex® (fulvestrant)	AstraZeneca	250mg:5ml	$806.81	$355.56	-56%	500mg per month.	$1,610	$710	Advanced ER/PR+ breast can., failing aromatase inhibitor.
Afinitor® (everolimus)	Novartis	5mg [2]	$36.44	$21.93	-40%	10mg QD.	$2,190	$1,320	Adv. RCC after sunitinib or sorafenib. Adv./meta. pancreatic NETs. Tuberous sclerosis with renal angiomyolipoma.
Revlimid (lenalidomide)	Celgene	25mg [2]	$413.93	$163.26	-61%	25mg QD 3-wks-on / 1-wk-off.	$9,310	$3,670	2L+ Recurring myeloma.

Source: Ministry of Human Resources and Social Security (MOHRSS); Yaozhi; BofA Merrill Lynch Global Research.
[1] Excluding 3 botanical oncology drugs; [2] Reference SKU or reference recommended dosage for monthly pricing calculation; [3] Calculation assumes an exchange rate of CN¥6.75 per US$1; [4] Marketed as Tai Xin Sheng® in China.

National Drug Reimbursement List Pricing ("NDRL")

Oct'18 update - 17 new drugs in oncology added to NDRL

		Unit Pricing (US$) [2]				Approximate Monthly Pricing (US$) [2]			
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage [1]	Avg. Tender	Reimbursed	Indication coverage
Focus V® (anlotinib)	Sino Biopharm	12mg	$127	$70	-45%	12mg QD (2 wks-on/1-wk-off)	$1,783	$981	3L NSCLC
Oncaspar® (pegaspargase)	Hengrui	5ml:3750 IU	$560	$429	-23%	≤2ml every 14 days	$1,231	$943	1L ALL
Vidaza® (azacitidine)	Celgene	100mg	$378	$152	-60%	1st cycle: 75mg QD for 7 days; 4wk cycle. After 2 cycles increase dose to 100mg, min of 4-6 cycles	$14,022	$5,636	Refractory anemia (RA) or RA with ringed sideroblasts (RARS), RA with excess blasts (RAEB / RAEB-T), and chronic myelomonocytic leukemia (CMMoL)
Inlyta® (axitinib)	Pfizer	5mg	$99	$30	-70%	5mg BID	$5,957	$1,787	2L Advanced renal cell carcinoma
Tagrisso® (osimertinib)	AstraZeneca	80mg	$253	$73	-71%	80mg QD	$7,597	$2,201	EGFR TKI refractory T790M+ NSCLC
Ninlaro® (ixazomib)	Takeda	4mg	$3,234	$710	-78%	4mg on Days 1, 8, 15 (28 day cycle)	$12,934	$2,839	2L Multiple myeloma
Xalkori® (crizotinib)	Pfizer	250mg	$123	$37	-70%	250mg BID	$7,407	$2,245	Locally adv. or meta. ALK+ or ROS1+ NSCLC
Gilotrif® (afatinib)	Boehringer	40mg	$116	$29	-75%	40mg QD	$3,483	$863	NSCLC with EGFR
Tasigna® (nilotinib)	Novartis	200mg	$39	$14	-65%	400mg BID	$4,645	$1,635	CML
Votrient® (pazopanib)	Novartis	200mg	$66	$23	-65%	800mg QD	$7,891	$2,348	RCC
Sutent® (sunitinib)	Pfizer	12.5mg	$49	$22	-55%	GIST & RCC: 50mg QD pNET: 37.5mg QD	$5,544 $4,455	$2,498 $2,007	RCC, GIST, pNET
Stivarga® (regorafenib)	Bayer	40mg	$52	$28	-46%	160mg QD	$6,216	$3,384	Meta. CRC, GIST, HCC
Zykadia® (certinib)	Novartis	150mg	$108	$28	-74%	450mg QD	$9,699	$2,564	NSCLC
Zelboraf® (vemurafenib)	Roche	240mg	$30	$16	-47%	960mg BID	$7,252	$3,868	Melanoma
Erbitux® (cetuximab)	Merck	100mg	$571	$186	-67%	400mg/m2 initial dose, 250mg weekly	$10,446	$3,074	Colorectal cancer, head and neck cancer
Sandostatin LAR® (octreotide)	Novartis	20mg	$1,169	$835	-29%	20mg Q4W	$1,169	$835	GEP-NENs
Imbruvica® (ibrutinib)	JNJ	140mg	$78	$27	-65%	MCL: 560mg QD CLL & WM: 420mg QD	$9,324 $6,993	$3,263 $2,447	MCL, CLL/SLL

Source: Ministry of Human Resources and Social Security (MOHRSS); Yaozhi; China Merchants Securities Research; Citi Global Research.
[1] Reference SKU or reference recommended dosage for monthly pricing calculation; [2] Calculation assumes an exchange rate of CN¥6.95 per US$1.

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Thank you