HUTCHISON CHINA MEDITECH

ESMO Investor Update

September 30, 2019

AIM/Nasdaq: HCM

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Use of Non-GAAP Financial Measures - This presentation includes certain 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.

Agenda

1	Introduction	**Christian Hogg** Chief Executive Officer
2	SANET-ep	**Weiguo Su** Chief Scientific Officer
3	Surufatinib international data	**Marek Kania** SVP, Chief Medical Officer, Int'l
4	Discussion	**James Yao** MD Anderson
5	Next Steps and Q&A	**Christian Hogg, All**

1 Introduction - Christian Hogg

Surufatinib

Potentially our first un-partnered oncology drug launch

Two Phase III neuroendocrine tumor ("NET") registration studies...

- 25 China sites.
- 1° endpoint: median PFS.
- 2° endpoints: ORR, DCR, DoR, TTR, OS.

SANET-ep

Non-pancreatic NET *(Actual N=198)*

R (2:1) → Surufatinib / Placebo

Data presentation at ESMO 2019 ✓

- Met all efficacy endpoints
- Well tolerated

SANET-p

Pancreatic NET *(Planned N=195)*

R (2:1) → Surufatinib / Placebo

- SANET-p Interim Analysis in H1 2020.

...preparing for our first China launch...

2019

Jun 14, '19 – SANET-ep Interim Analysis
- Study stopped early, a year ahead of schedule.
- Pre-NDA meeting with CDE.

Sep 29, '19 – SANET-ep Presentation at ESMO
- mPFS primary endpoint
- Tumor control secondary endpoints
- Placebo control

2020

Q4 '19 – Potential NDA submission

Est. Late 2020 China launch

Current ~70 ppl. → Building out Oncology Sales, Mkt., & Med. Aff. Org. → Full China coverage

Surufatinib
Other ongoing trials

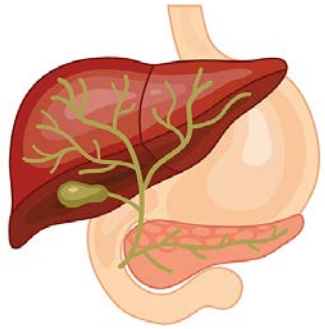
...and global Phase II/III progressing

- U.S. Phase Ib/II in P-NET & BTC initiated July 2018, P-NET & BTC cohort data presentation at ESMO 2019. ✓
- FDA End of Phase II meeting targeted for Q4 2019.
- U.S. & Europe registration study expected to initiate in H1 2020.

FDA

Phase IIb/III study in 2L biliary tract cancer ("BTC") in China

- First patient dosed in March 2019.
- Interim analysis mid-2020, based on first 80 patients.
- Total enrollment ~300 patients.



PD-1 collaborations

- With Junshi (Tuoyi®): dose escalation near completion.
- Dose expansion in multiple tumor types to begin Q4 2019.

君实生物
Junshi Biosciences

CHI-MED

Mechanism of Action

***Anti-angiogenesis**: cut off **blood flow to tumor** (VEGFR/FGFR).*

***Immunotherapy**: inhibit expression of **tumor-associated macrophages** which cloak cancer cells from **T-cell attack** (CSF-1R).*

2 Surufatinib: SANET-ep Data - Weiguo Su

#4979 EFFICACY AND SAFETY OF SURUFATINIB IN PATIENTS WITH WELL-DIFFERENTIATED ADVANCED EXTRAPANCREATIC NEUROENDOCRINE TUMORS (NETS)

Results from the randomized phase III study (SANET-ep) (NCT02588170)

Jianming Xu, Lin Shen, Zhiwei Zhou, Jie Li, Chunmei Bai, Yihebali Chi, Zhiping Li, Nong Xu, Ru Jia, Eenxiao Li, Tianshu Liu, Yuxian Bai, Ying Yuan, Xingya Li, Xiuwen Wang, Jia Chen, Jieer Ying, Xianjun Yu, Shukui Qin, Tao Zhang, Xianglin Yuan, Dianrong Xiu, Yanhong Deng, Ying Cheng, Min Tao, Jing Li, Songhua Fan, Weiguo Su

Study Sponsored by Hutchison MediPharma Ltd.,
a subsidiary of Hutchison China MediTech.

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DISCLOSURE

Weiguo Su, Songhua Fan and Jing Li are employees of Hutchison MediPharma Ltd.

The remaining authors have no conflicts of interest.

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SANET-EP: BACKGROUND

- Treatment options remain limited for patients with extrapancreatic neuroendocrine tumors (NETs).
- Anti-VEGF signalling pathway is a proven strategy for the treatment of pancreatic NETs. However efficacy in extrapancreatic NETs has not yet been proven. [1]
- Surufatinib (HMPL-012, previously named sulfatinib) is a small-molecule kinase inhibitor targeting VEGFRs, FGFR1 and CSF-1R.
- Encouraging efficacy of surufatinib treating patients with advanced NETs regardless of tumor origin was reported (ORR of 19% in pancreatic NETs and 15% in extrapancreatic NET). [2]

1. Raymond E, et al. Sunitinib malate for the treatment of pancreatic neuroendocrine tumors. N Engl J Med 2011;364:501–13.
2. Xu J, et al. Surufatinib in Advanced Well-Differentiated Neuroendocrine Tumors: A Multicenter, Single-Arm, Open-Label, Phase Ib/II Trial. Clin Cancer Res. 2019 Jun 15;25(12):3486-3494. doi: 10.1158/1078-0432.CCR-18-2994. Epub 2019 Mar 4.

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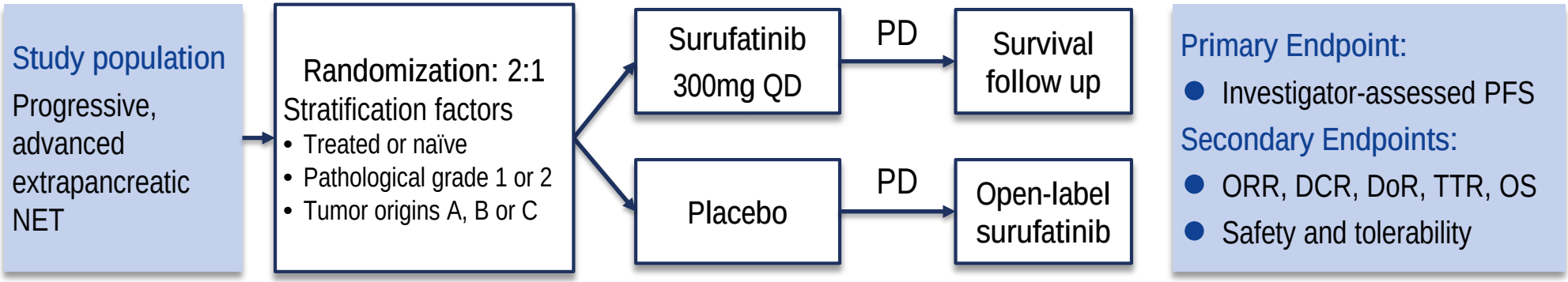
SANET-EP: PHASE III STUDY DESIGN



- Statistical assumption: 273 patients planned based on the assumption of the median PFS of 8 months in placebo arm, HR of surufatinib treatment is 0.6 with a two sided alpha 0.05.
- Interim analysis was planned when 127 PFS events (i.e. 70% of the planned PFS events for final analysis) were observed; study early termination for superiority ($p < 0.015$) was allowed.
- Tumor evaluation was conducted by investigators; a blinded independent image review committee (BIIRC) performed tumor assessment retrospectively in parallel, which was used for sensitivity analysis of PFS.

Tumor origin A: jejunum, ileum, duodenum, thymus, cecum; B: lung, stomach, liver, appendix, colon, rectum; C: others or unknown origin.

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KEY ELIGIBILITY CRITERIA

- Well-differentiated extrapancreatic NETs of pathological grade 1 or 2.
- Locally advanced disease or with distant metastasis.
- Documented radiological disease progression within past one year.
- Progression on two or fewer kinds of prior systemic therapies for advanced disease.
- No progression on prior VEGF/VEGFR inhibitors.
- Functional NETs that required treatment with long-acting SSAs were excluded.

*Prior systemic therapies included somatostatin analogues (SSAs), chemotherapy, interferon, mTOR inhibitor, peptide receptor radionuclide therapies; chemotherapies were considered as one kind of therapy, regardless of the regimens or lines.

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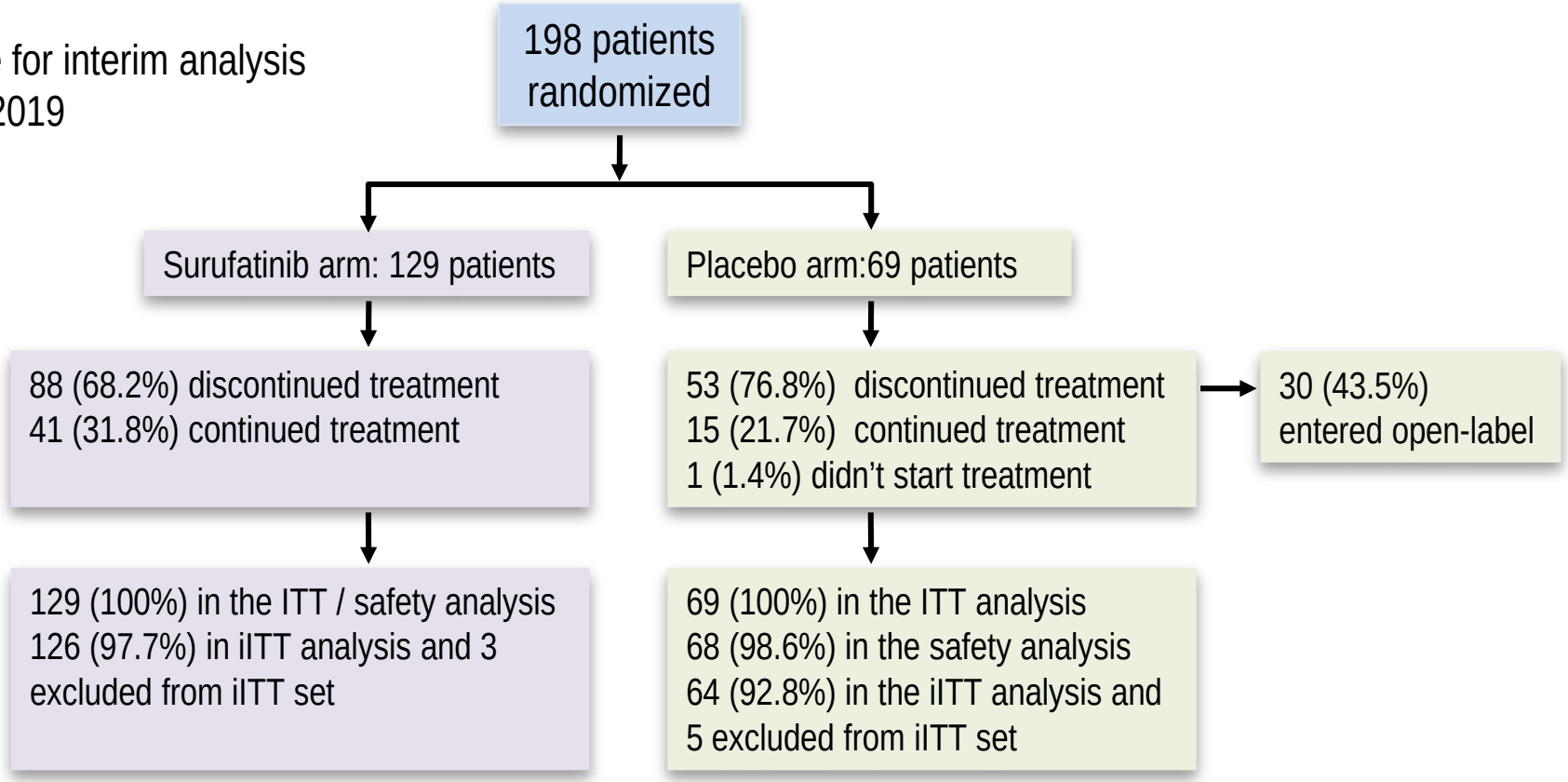
PATIENT DISPOSITION

Cutoff date for interim analysis
31 March 2019



Interim Intent-to-Treat (iITT) Set included patients with at least one post-baseline tumor assessment performed ≥ 6 weeks from first dosing or patients discontinued for any reason. iITT Set was used for the analysis of overall response.

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DEMOGRAPHICS AND BASELINE TUMOR CHARACTERISTICS

	Surufatinib (N=129)	Placebo (N=69)
Age, median (range), years	52.0 (19.0, 72.0)	54.0 (25.0, 79.0)
Male	56.6%	50.7%
ECOG PS 0/1	55.8% / 44.2%	66.7% / 33.3%
Pathological grade 1/2	16.3% / 83.7%	15.9% / 84.1%
Non-functional tumors	94.6%	97.1%
Primary tumor origins		
Gastrointestinal tract (Rectum / stomach / small intestine* / others)	47.3% (29.5% / 7.8% / 7.8% / 2.4%)	46.4% (21.7% / 13.0% / 8.7% / 2.9%)
Lung	9.3%	15.9%
Unknown	14.0%	13.0%
Others	29.4%	24.7%
Liver metastasis	75.2%	76.8%
Previous systemic anti-tumor treatment for advanced disease	69.0%	63.8%
Chemotherapy	40.3%	39.1%
Somatostatin analogue	34.1%	27.5%
Everolimus	7.8%	11.6%
Previous loco-regional therapy	34.1%	23.3%

*Small intestine included the tumor origin reported as jejunum, ileum, duodenum, or small intestine.

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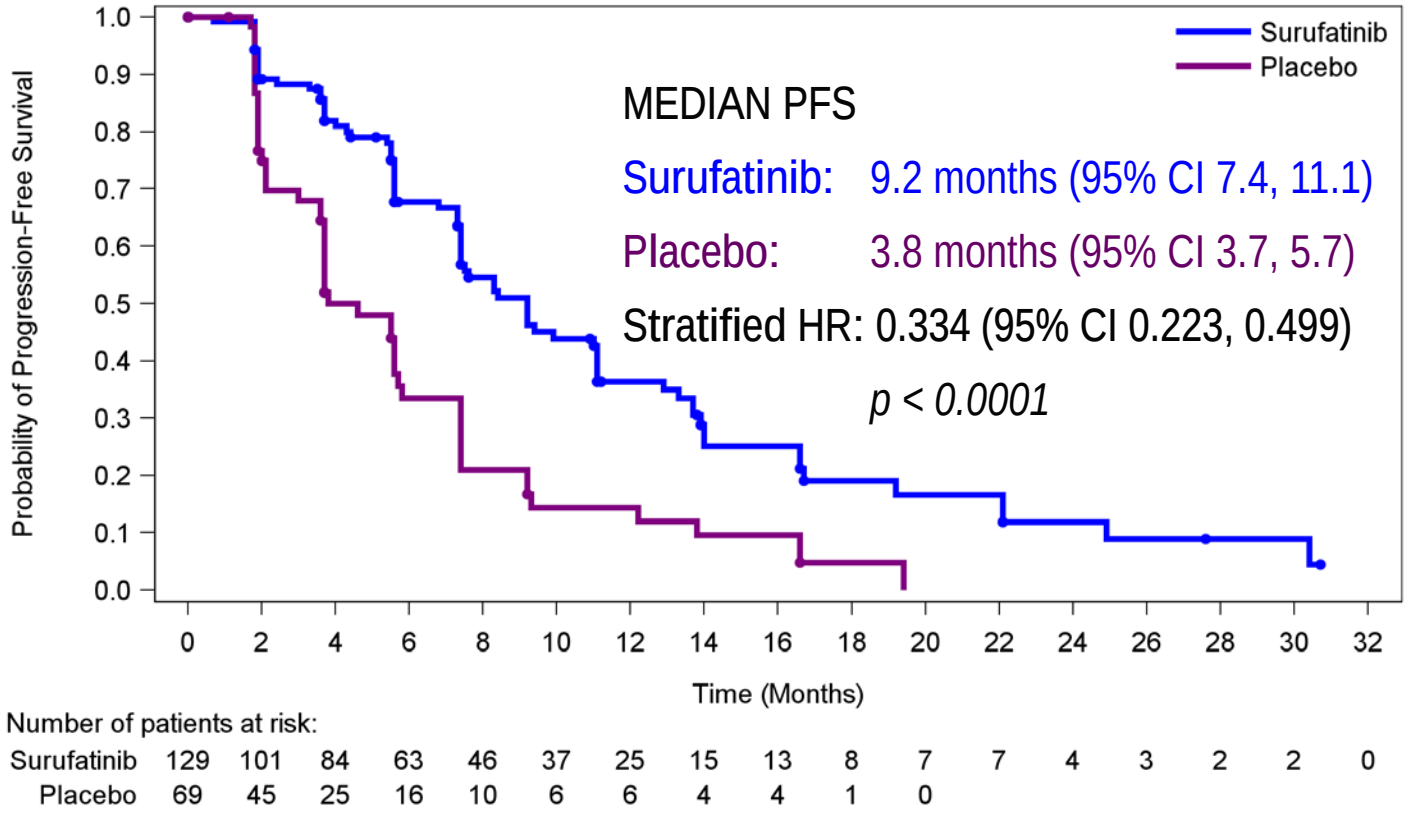
INVESTIGATOR-ASSESSED PFS (PRIMARY)

SANET-ep clearly succeeded in meeting the superiority criteria of PFS



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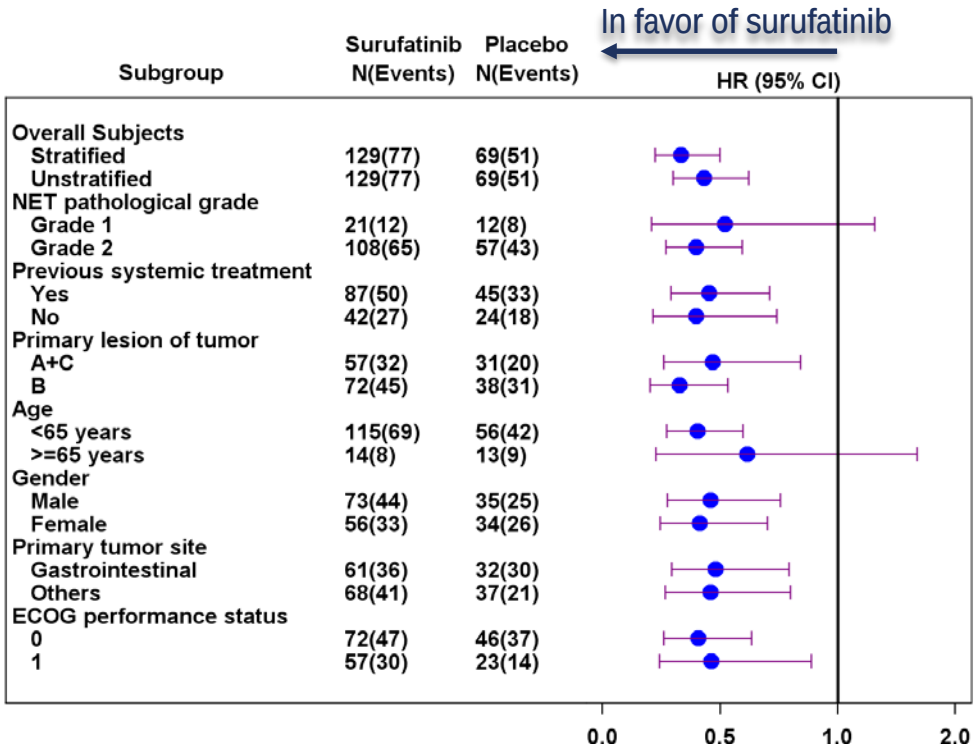
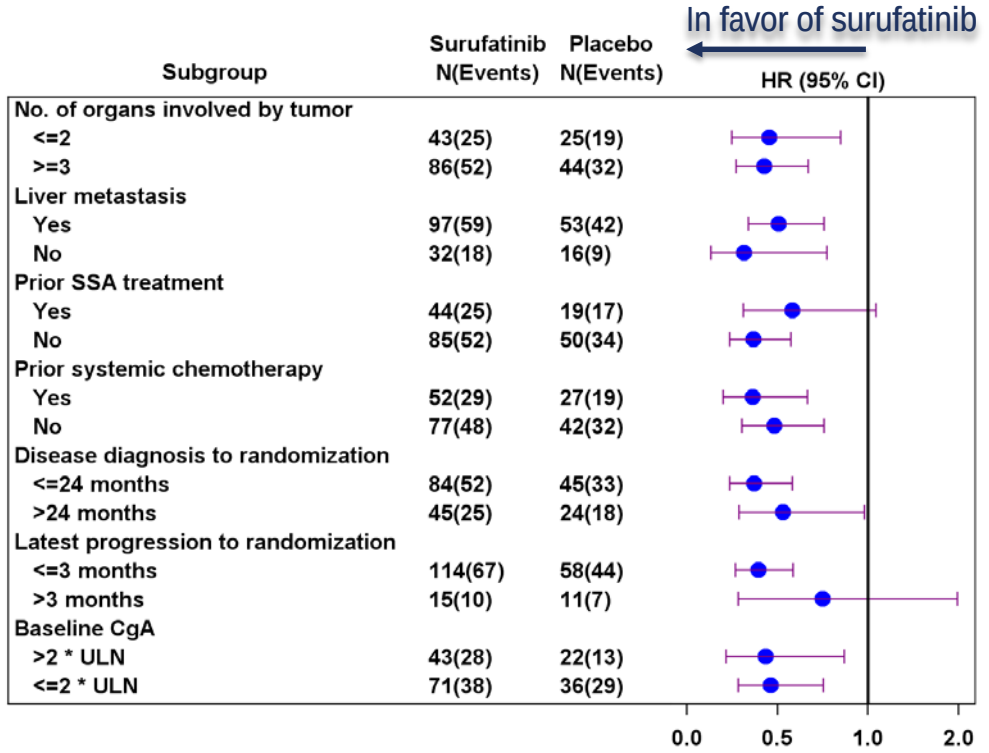
SUBGROUP ANALYSIS OF INVESTIGATOR-ASSESSED PFS





Tumor origin A: jejunum, ileum, duodenum, thymus, cecum; B: lung, stomach, liver, appendix, colon, rectum; C: others or unknown origin.

ULN: upper limit normal; SSA: Somatostatin analogues; CgA: chromogranin A.

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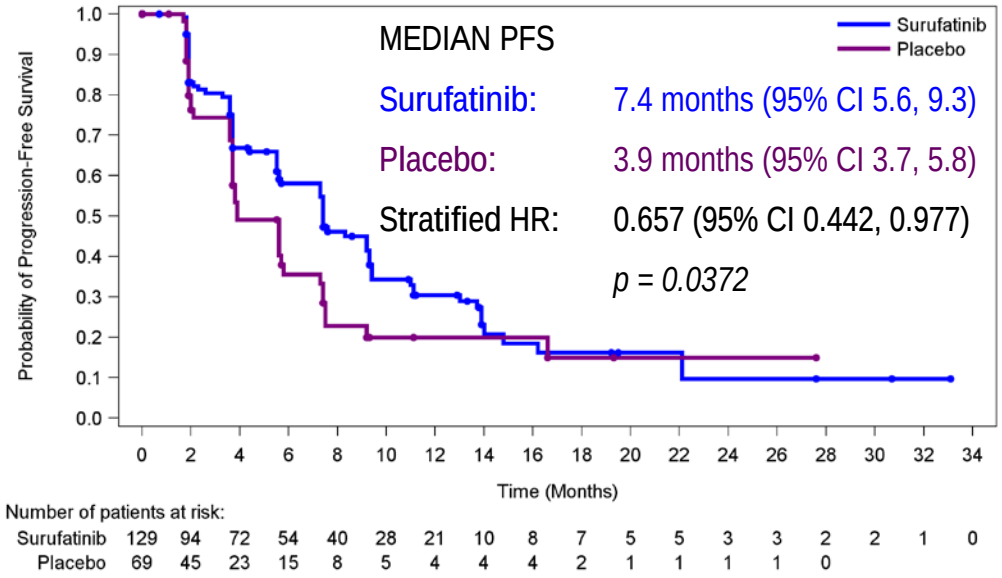
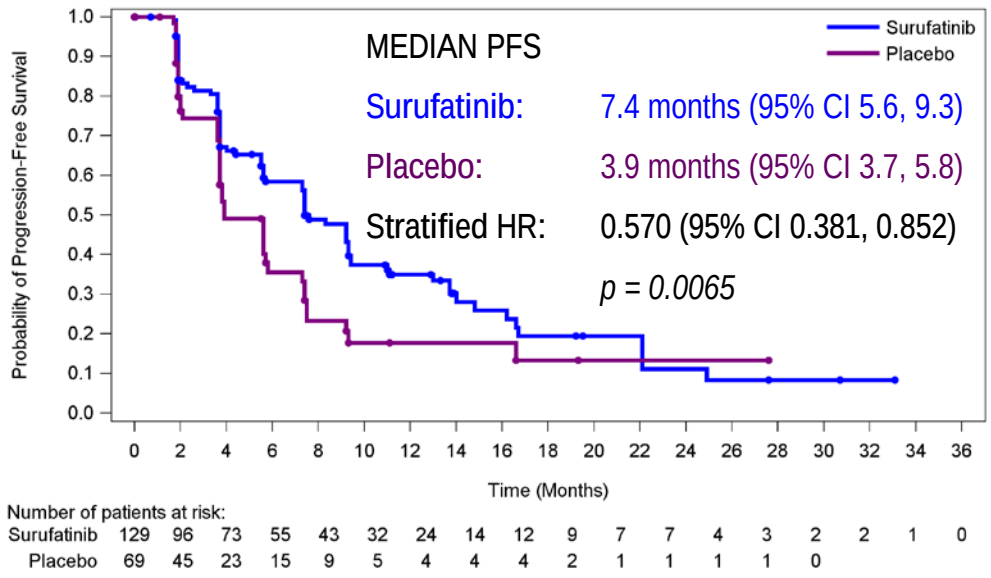
SUPPORTIVE ANALYSIS: BIIRC-ASSESSED PFS



POST-HOC ANALYSIS: ADJUDICATED BIIRC-ASSESSED PFS



Post-hoc blinded image adjudication conducted for 35 patients with PFS discrepancy ≥ 4 cycles (28 days/cycle) between BIIRC and investigators

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POST-HOC SENSITIVITY ANALYSIS OF PFS

Potential reasons for assessment difference between investigators and BIIRC:

- Prior loco-regional therapies (34.1% vs. 23.3%) may have posed challenges to central reviewers.
- The characteristics of liver lesion in CT/MRI likely led to false new lesion / non-target lesion progression (e.g. equidensity at baseline, low-density after treatment).

Excluding 60 patients with prior loco-regional therapy

	Surufatinib (N=85)	Placebo (N=53)	Surufatinib vs. Placebo	
	Median PFS (months)	Median PFS (months)	HR (95% CI)	*P*-value
Investigator	9.9	5.5	0.307 (0.188, 0.502)	<0.0001
BIIRC	9.2	3.9	0.514 (0.319, 0.829)	0.0063

Excluding 17 patients with prior loco-regional therapy and PFS event status discordance

	Surufatinib (N=115)	Placebo (N=66)	Surufatinib vs. Placebo	
	Median PFS (months)	Median PFS (months)	HR (95% CI)	*P*-value
Investigator	9.2	4.6	0.323 (0.212, 0.492)	<0.0001
BIIRC	7.4	3.9	0.546 (0.362, 0.825)	0.0041

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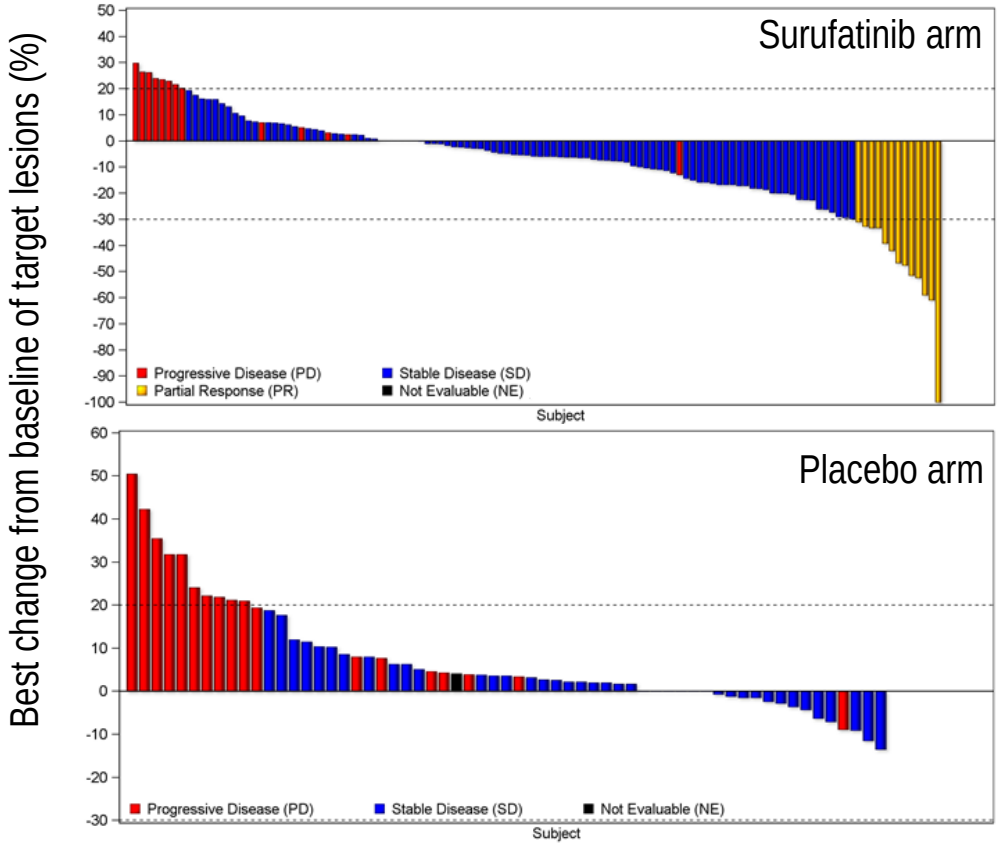
SECONDARY ENDPOINTS: ORR, DCR, TTR, DOR



	Investigator assessment in iITT			
	Surufatinib (N=126)	Placebo (N=64)	Odds Ratio	*P* value
PR-n (%)	13 (10.3)*	0	-	-
SD-n (%)	96 (76.2)	42 (65.6)	-	-
PD-n (%)	13 (10.3)	18 (28.1)	-	-
NE-n (%)	4 (3.2)	4 (6.3)	-	-
ORR- % (95% CI)	10.3 (5.6, 17.0)	0	-	0.0051
DCR- % (95% CI)	86.5 (79.3, 91.9)	65.6 (52.7, 77.1)	3.3 (1.5, 7.3)	0.0022
TTR, months (95% CI)	3.7 (1.8, 5.5)	-	-	-
DOR-months (95% CI)	5.6 (2.0, 17.5)	-	-	-

- OS was immature (18.7% events)

* 11 PR confirmed, 2 PR unconfirmed

Interim Intent-to-Treat (iITT) Set included patients with at least one post-baseline tumor assessment performed ≥ 6 weeks from first dosing or patients discontinued for any reason. iITT Set was used for the analysis of overall response.

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DRUG EXPOSURE-SAFETY ANALYSIS SET

	Surufatinib (N=129)	Placebo (N=68)
Exposure (days) median (range)	217 (4.0, 1032.0)	146 (6.0, 844.0)
Dose intensity (mg/day) mean (std)	259.25 (39.460)	290.34 (26.920)
Relative dose intensity (%) mean (std)	86.42 (13.153)	96.78 (8.973)

SAFETY SUMMARY-SAFETY ANALYSIS SET

	Surufatinib (N=129)	Placebo (N=68)
	n (%)	n (%)
Any treatment emergent adverse events (TEAE)	127 (98.4)	65 (95.6)
CTC AE grade		
Grade 1	7 (5.4)	16 (23.5)
Grade 2	21 (16.3)	26 (38.2)
Grade 3	82 (63.6)	19 (27.9)
Grade 4	14 (10.9)	3 (4.4)
Grade 5	3 (2.3)	1 (1.5)
Any ≥ grade 3 TEAE	99 (76.7)	23 (33.8)
Any serious adverse event (SAE)	34 (26.4)	12 (17.6)
Any TEAE leading to dose interruption	62 (48.1)	15 (22.1)
Any TEAE leading to dose reduction	62 (48.1)	5 (7.4)
Any TEAE leading to dose discontinuation	23 (17.8)	4 (5.9)

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MOST COMMON TEAES WITH FREQUENCY ≥ 20%

(SAFETY Analysis SET)

TEAEs	Surufatinib (N=129) n (%)		Placebo (N=68) n (%)	
	Any grade	≥ grade 3	Any grade	≥ grade 3
Proteinuria	91 (70.5)	25 (19.4)	36 (52.9)	0
Hypertension	83 (64.3)	47 (36.4)	18 (26.5)	9 (13.2)
Diarrhea	60 (46.5)	2 (1.6)	14 (20.6)	0
Blood thyroid stimulating hormone increased	51 (39.5)	0	5 (7.4)	0
Blood bilirubin increased	50 (38.8)	3 (2.3)	12 (17.6)	0
Aspartate aminotransferase increased	47 (36.4)	5 (3.9)	17 (25.0)	2 (2.9)
Fecal occult blood positive	46 (35.7)	0	12 (17.6)	0
Hypertriglyceridemia	41 (31.8)	3 (2.3)	6 (8.8)	0
Hypoalbuminemia	37 (28.7)	0	4 (5.9)	0
Alanine aminotransferase increased	32 (24.8)	4 (3.1)	19 (27.9)	0
Abdominal pain upper	29 (22.5)	1 (0.8)	9 (13.2)	0
Anemia	27 (20.9)	9 (7.0)	11 (16.2)	2 (2.9)

TEAEs: treatment emergent adverse events

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CONCLUSION

- Surufatinib significantly improved PFS for the advanced extrapancreatic NETs patients in this study.
- Surufatinib was generally well tolerated in this study and the safety profile consistent with that previously reported for surufatinib.
- The study was terminated by the recommendation of the Independent Data Monitoring Committee based on the interim analysis.
- Global clinical development of surufatinib in NETs is ongoing, including a phase III trial of surufatinib in pancreatic NETs being conducted in China.

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All study centers participating in this study

- Department of Gastrointestinal Oncology, The Fifth Medical Center, General Hospital of the People's Liberation Army, Beijing, China.
- Department of Gastrointestinal Oncology, Key laboratory of Carcinogenesis and Translational Research (Ministry of Education), Peking University Cancer Hospital & Institute, Beijing, China.
- Department of Gastric Surgery, State Key Laboratory of Oncology in South China, Collaborative Innovation Center for Cancer Medicine, Sun Yat-sen University Cancer Center, Guangzhou, China.
- Department of Oncology, Peking Union Medical College Hospital, Beijing, China.
- Department of Medical Oncology, National Cancer Center/Cancer Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College, Beijing, China.
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- Department of Thoracic Oncology, Jilin Provincial Cancer Hospital, Jilin, China.
- Department of Oncology, The First Affiliated Hospital of Soochow University, Suzhou, China.

3 Surufatinib: International Data - Marek Kania

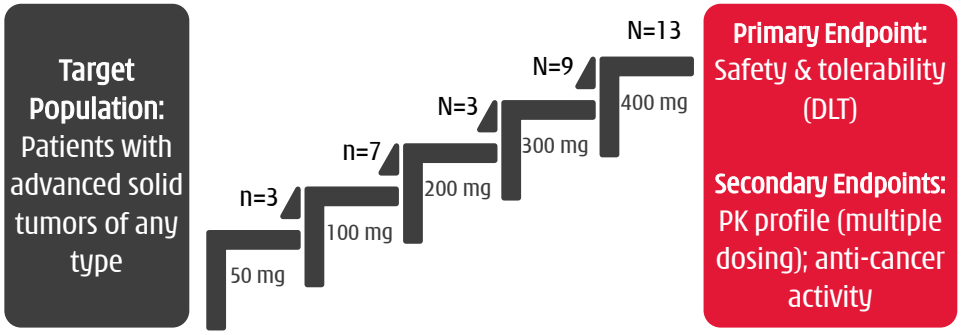
Safety & Tolerability of Surufatinib

U.S. patients with solid tumors

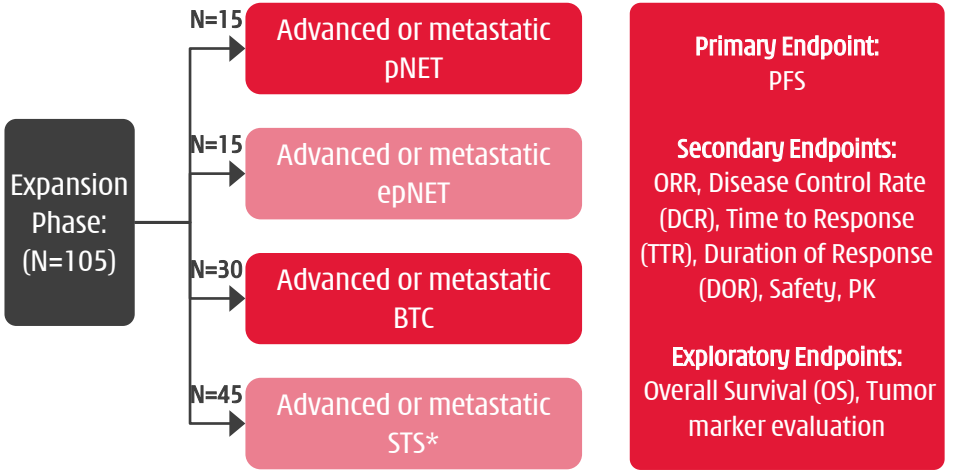
Participating sites and investigators:

Erika Hamilton, M.D.	- Sarah Cannon Research Institute / Tennessee Oncology
Dr. Judy Wang, M.D.	- Florida Cancer Specialists
Arvind Dasari, M.D.	- The University of Texas MD Anderson Cancer Center
James Yao, M.D.	- The University of Texas MD Anderson Cancer Center
Daneng Li, M.D.	- City of Hope Cancer Center
Raymond Wadlow, M.D.	- Virginia Cancer Specialists, PC
Andrew Paulson, M.D.	- Baylor Charles A. Sammons Cancer Center
Allen Cohn, M.D.	- Rocky Mountain Cancer Centers
Max Sung, M.D.	- Icahn School of Medicine at Mount Sinai

Dose Escalation: MTD & RP2D declared as 300 mg QD



Dose Expansion



*Soft Tissue Sarcoma (STS) cohort is planned to open as a future cohort in Q4 2019.

MTD = maximum tolerated dose. RP2D = recommended Phase 2 dose. DLT = dose limiting toxicities. PK = pharmacokinetics. pNET = pancreatic neuroendocrine tumors. BTC = biliary tract cancer. epNET = extra-pancreatic neuroendocrine tumors. STS = soft tissue sarcoma Source: ESMO 2019; abstract #2191

U.S. Phase I/Ib - Overview of results

Data as of Jun 14, 2019

Safety & PK profile of surufatinib at the RP2D is consistent with completed studies performed in Chinese patients

TEAEs	Dose Escalation (N=35) n (%)		Dose Expansion (N=38) n (%)		Total (N=73) n (%)	
	Any Grade	≥ Grade 3	Any Grade	≥ Grade 3	Any Grade	≥ Grade 3
Any TEAEs	35 (100.0)		33 (86.8)		35 (93.2)	
Diarrhea	16 (45.7)		9 (23.7)		25 (34.2)	
Fatigue	14 (40.0)		10 (26.3)		24 (32.9)	
Nausea	16 (45.7)		5 (13.2)		21 (28.8)	
Hypertension	8 (22.9)	4 (11.4)	12 (31.6)	6 (15.8)	20 (27.4)	10 (13.7)
Abdominal pain	8 (22.9)		8 (21.1)		16 (21.9)	
Proteinuria	5 (14.3)	2 (5.7)	8 (21.1)	3 (7.9)	13 (17.8)	5 (6.8)
Vomiting	11 (31.4)				11 (15.1)	
Constipation	5 (14.3)		5 (13.2)		10 (13.7)	
Decreased appetite	5 (14.3)		4 (10.5)		9 (12.3)	
Headache	8 (22.9)				8 (11.0)	
Dehydration	7 (20.0)				7 (9.6)	
Edema peripheral	6 (17.1)				6 (8.2)	
Dizziness	5 (14.3)				5 (6.8)	
Dysphonia	5 (14.3)				5 (6.8)	

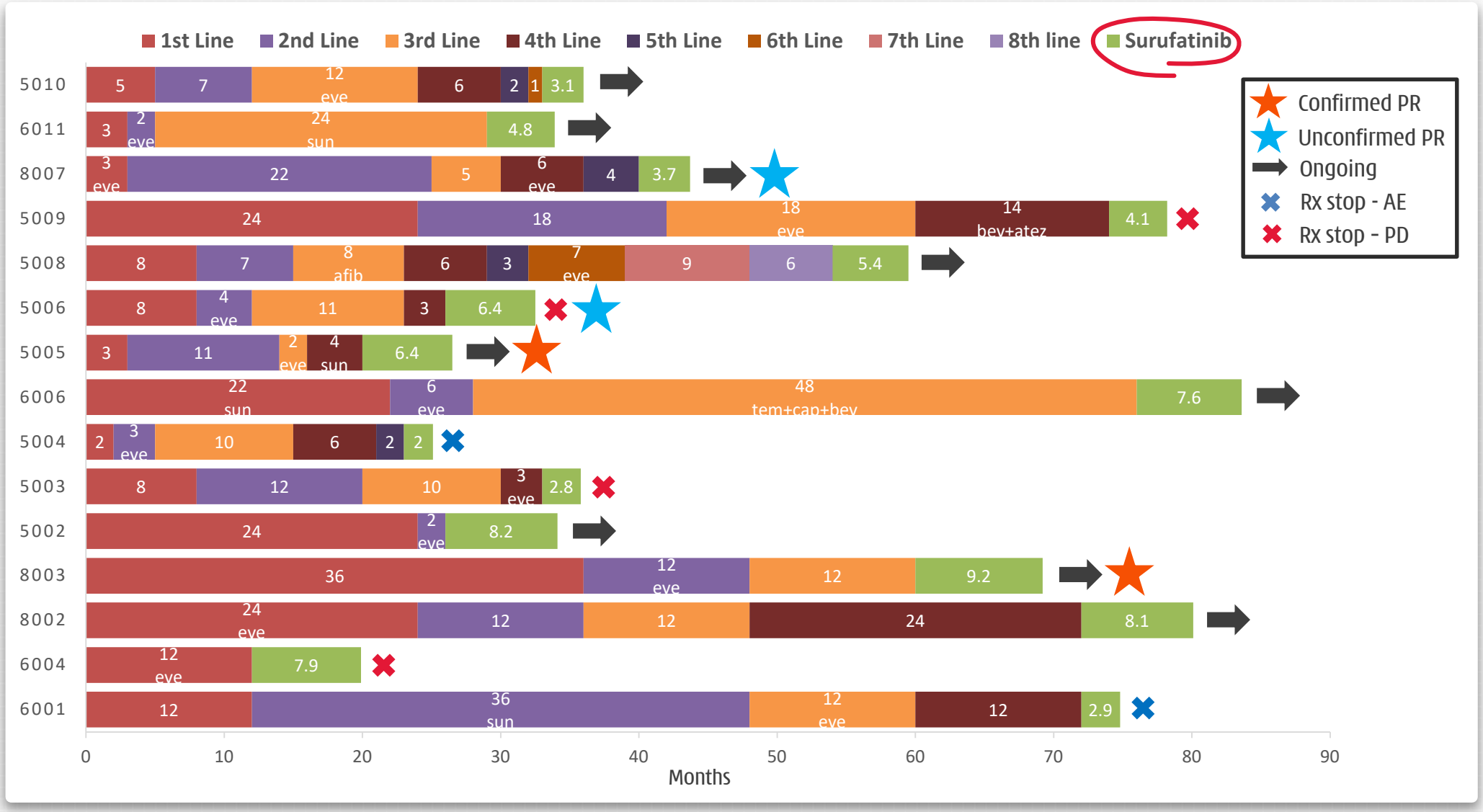
- **25 evaluable patients in dose expansion [1]** with 12 pNET & 13 BTC.
  - **2 pNET patients achieved confirmed PRs**, & 2 additional patients achieved ≥30% tumor reduction on 1 scan.
  - 1 patient in the BTC cohort achieved ≥30% tumor reduction on 1 scan, but no confirmed PR's.
  - 4 (12.9%) patients in dose escalation, & 7 (21.9%) patients in dose expansion were not evaluable.

Tumor Assessment	Dose Escalation N=31 n (%)	Dose Expansion	
		pNET N=15 n (%)	BTC N=17 n (%)
Complete Response (CR)	0	0	0
Partial Response (PR)	0	2 (13.3)	0
Stable Disease (SD)	17 (54.8)	9 (60.0)	5 (29.4)
Progressive Disease (PD)	10 (32.3)	1 (6.7)	8 (47.1)
Objective Response Rate (ORR)	0	2 (13.3)	0
Disease Control Rate (DCR)	17 (54.8)	11 (73.3)	5 (29.4)

[1] at the time of data cut-off

U.S. Phase Ib - pNET Duration of treatment

Data as of Sept 2, 2019



Afib = aflibercept; atez = atezolizumab; bev = bevacizumab; cap = capecitabine; eve = everolimus; sun = sunitinib; tem = temozolomide

U.S. Phase Ib - Conclusions

- **Maximum tolerated dose (MTD) / recommended Phase II dose (RP2D) = 300 mg QD.**
  - Determined by the Safety Monitoring Committee after evaluation of all AEs from 35 patients across 5 dose levels in the dose escalation.
- **RP2D consistent with other studies.**
  - Safety and PK profile of surufatinib at the RP2D is consistent in this patient population when compared to the completed studies performed in Chinese patients.
- **Anti-tumor activity in heavily pre-treated patients.**
  - Patients in the pNET cohort with up to 8 prior lines of therapy still showed anti-tumor activity.
- **Preliminary efficacy across multiple solid tumors.**
  - Data shows promising efficacy across multiple solid tumors, consistent with previously reported trials, including those of SANET-ep Phase III.

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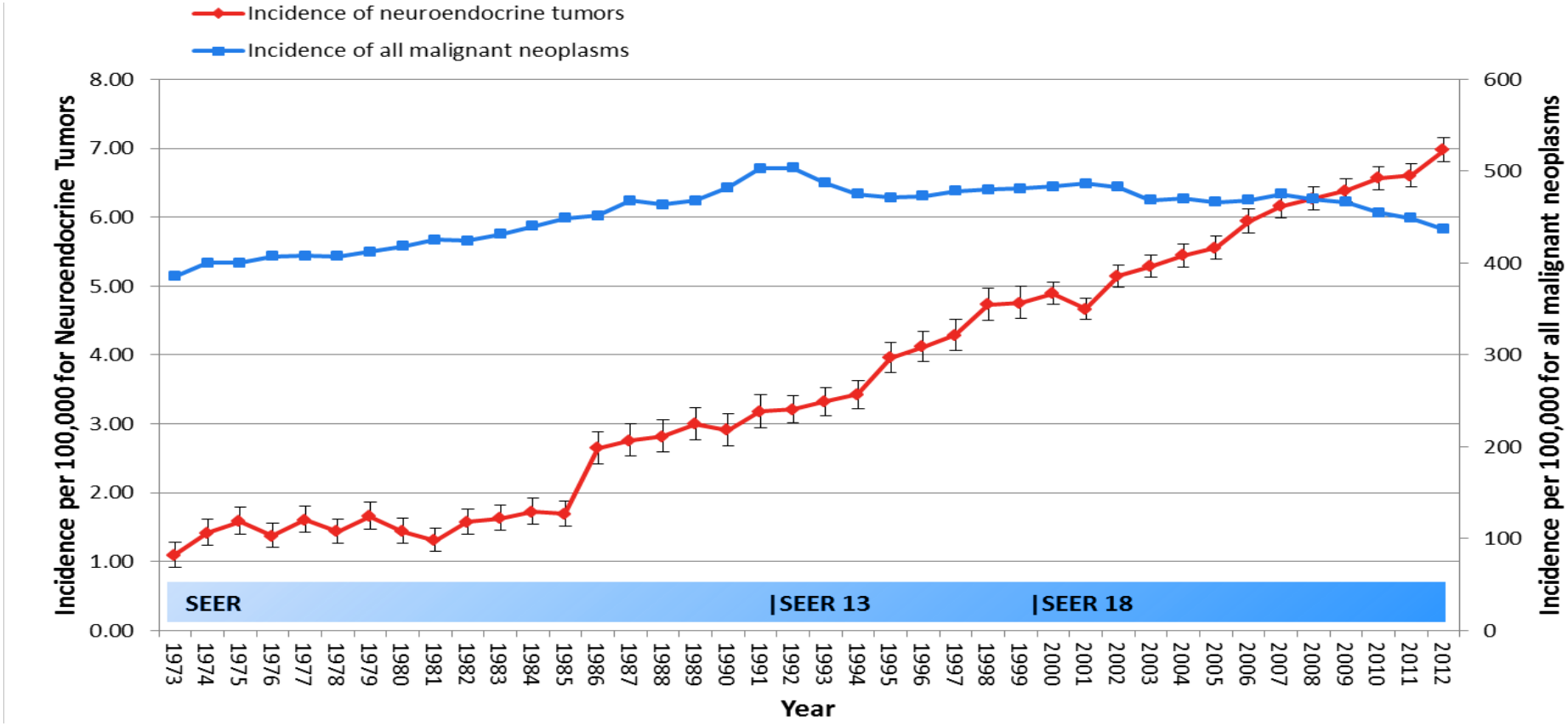
4 Discussion - James Yao

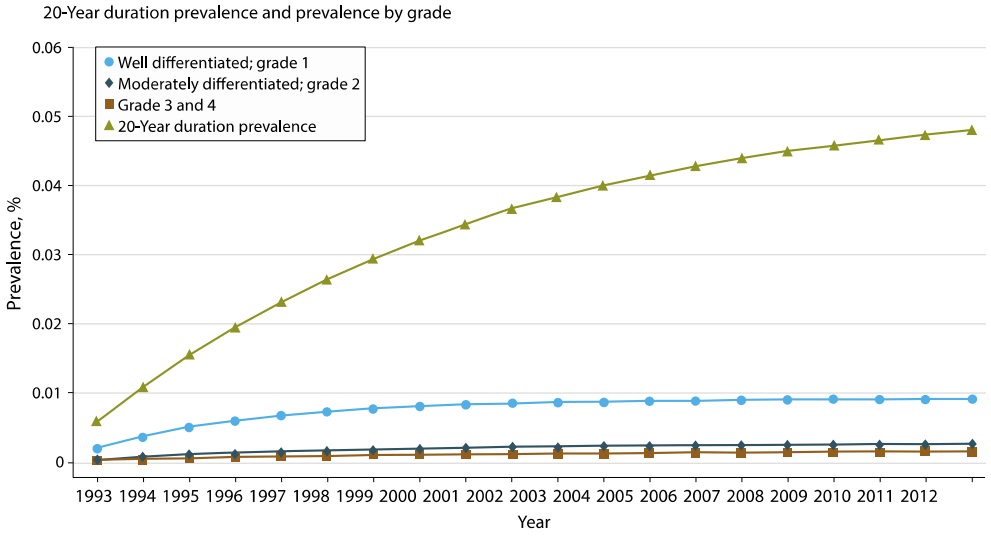
Continued rise in incidence of neuroendocrine tumors

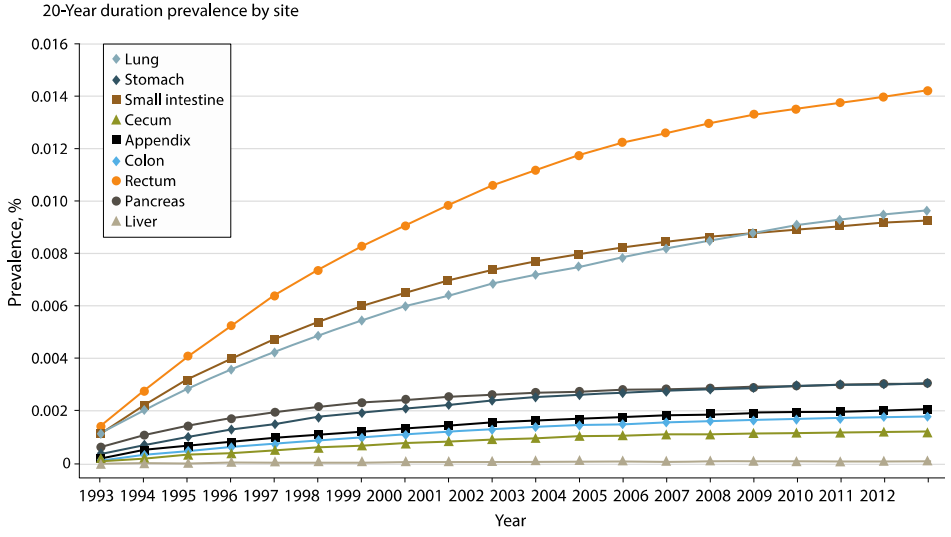


Dasari A *et al*. *JAMA Oncol* 2017;3:1335–1342

Prevalence of Neuroendocrine Tumors

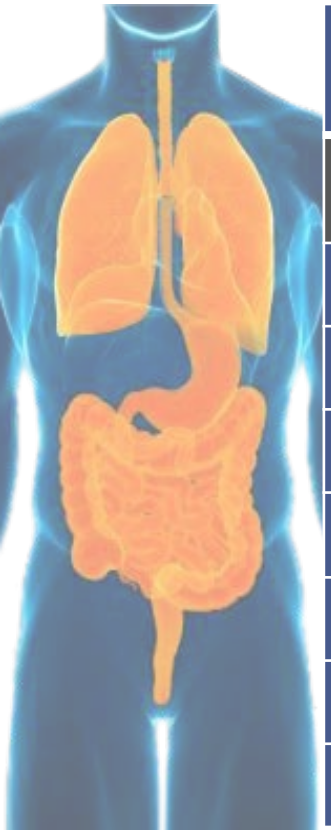
20-Year Limited Duration Prevalence Analyses





Dasari A *et al*. *JAMA Oncol* 2017;3:1335–1342

Evidence Landscape for Advanced NETs by Site



Site	Octreotide	Lanreotide	^{177}Lu-DOTATATE	Streptozocin	Sunitinib	Everolimus	Surufatinib
Disease status	Tx naïve	Stable	Progressive over 3 yrs	Historical	Progressive over 12 mo	Progressive over 6 mo*	Progressive over 12 mo
Lung						RADIANT4	SANET-ep
Stomach		CLARINET	Historical Phase II			RADIANT4	SANET-ep
Pancreas		CLARINET	Historical Phase II	Historical	Phase III	RADIANT3*	
Small bowel Appendix	PROMID	CLARINET	NETTER-1			RADIANT4	SANET-ep
Colon		CLARINET	Historical Phase II			RADIANT4	SANET-ep
Rectum		CLARINET	Historical Phase II			RADIANT4	SANET-ep
Unknown 1°						RADIANT4	SANET-ep

***RADIANT-3 requires documentation of progressive disease (PD) in the prior 12 months. RADIANT-4 requires documentation of PD during prior 6 months.**

Rinke A, et al. *J Clin Oncol.* 2009. Caplin ME, et al. *N Engl J Med.* 2014. Strosberg J, et al. *N Engl J Med.* 2017. Raymond E, et al. *N Engl J Med.* 2011. Yao JC, et al. *J Clin Oncol.* 2008. Yao JC, et al. *N Engl J Med.* 2011. Yao JC, et al. *Lancet*. 2016. Xu J, et al. *ESMO* 2019

Gaps and Limitations for Existing Agents

Agent	Approved Indication	Limitations
Lanreotide	• Gastroenteropancreatic	• Not approved in lung • No data in Ki-67 > 10%
Lu 177 dotatate	• Somatostatin receptor-positive gastroenteropancreatic	• No approved in lung • Only in high somatostatin receptor expressing tumors
Everolimus	• Pancreatic • Non-functional gastrointestinal or lung	• Not indicated for functional extrapanctreatic tumors • No funded in some countries after other targeted agents
Sunitinib	• Pancreatic	• No funded in some countries after other agents

Caplin ME, et al. *N Engl J Med.* 2014. Strosberg J, et al. *N Engl J Med.* 2017. Yao JC, et al. *N Engl J Med.* 2011. Yao JC, et al. *Lancet*. 2016. Raymond E, et al. *N Engl J Med.* 2011.

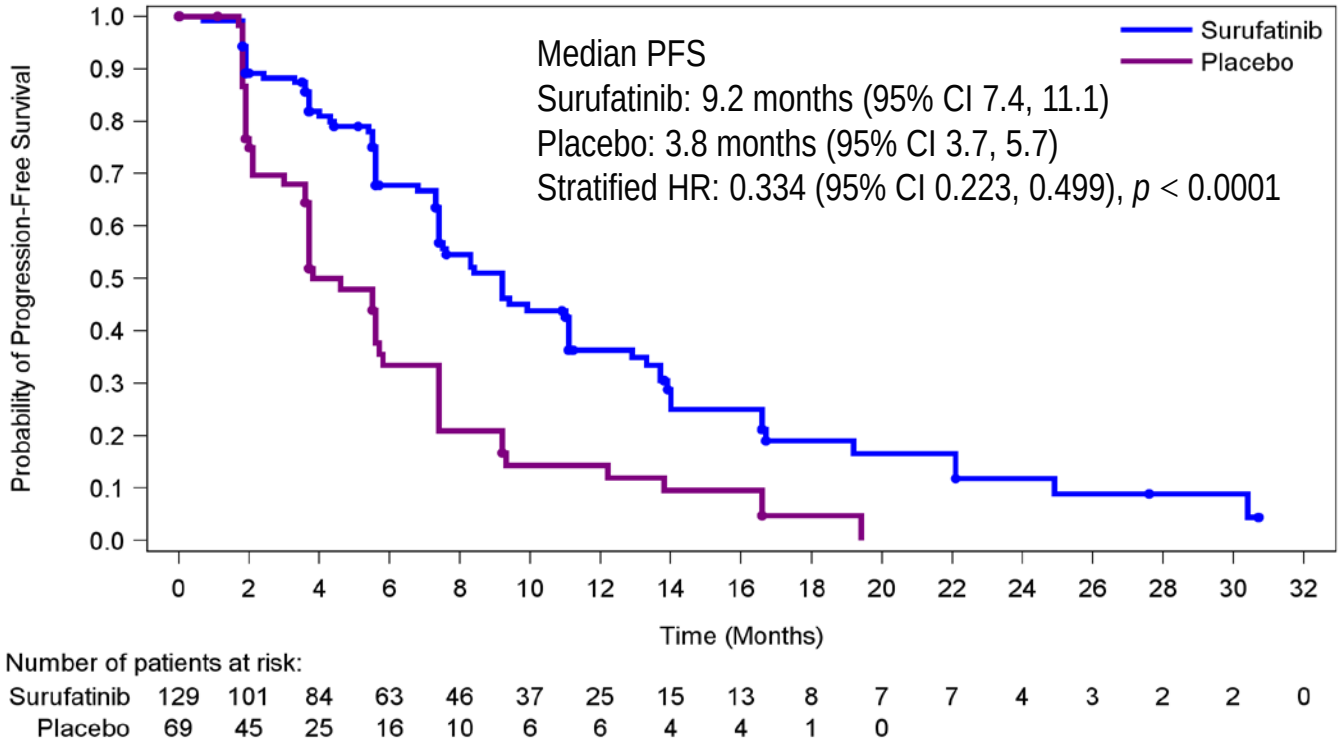
VEGF inhibitors in extra pancreatic NETs

Agent(s)	Control	Study design	Conclusion
Sunitinib	None	Single Arm Phase II	Activity could not be definitively determined
Sorafenib	None	Single Arm Phase II	Modest activity
Cabozantinib	None	Single Arm Phase II	Encouraging PFS
Pazopanib	Placebo	Randomized Phase II	Improves PFS
Bevacizumab + Oct	Interferon + Oct	Randomized Phase III	No difference in PFS compared to interferon
Surufatinib	**Placebo**	**Randomized Phase III**	**Significantly improved PFS**

Kulke MH, et al. J Clin Oncol. 2008. Hobday TJ, et al, ASCO 2007. Chan JA, et al. ASCO 2017. Bergsland EK, et al. ASCO 2019. Yao, JC et al, J Clin Oncol 2016. Xu J et al, ESMO 2019

Surufatinib in Extra-pancreatic NET: SANET-ep

Primary analysis: Investigator-assessed PFS



Xu J, et al. ESMO 2019

Surufatinib in Extra-pancreatic NET: SANET-ep

Supportive Analyses

Analysis	Type	Results	Finding
Primary	**Hypothesis testing**	**HR: 0.334 (95% CI 0.223, 0.499)** **P < 0.0001**	**Significantly improves PFS**
ORR	Secondary endpoint	10.3% vs 0% P = 0.005	Consistent with treatment benefit
DCR	Secondary endpoint	86.5% vs 65.6% P = 0.002	Consistent with treatment benefit
BIIRC	Sensitivity analysis	HR: 0.657 (95% CI 0.442, 0.977) P = 0.0372	Confirms statistical robustness of primary analysis
Adjudicated BIIRC	Sensitivity analysis	HR: 0.570 (95% CI 0.381, 0.852) P = 0.0065	Confirms statistical robustness of primary analysis
Investigator exclude prior loco-regional therapy	Sensitivity analysis	HR: 0.307 (95% CI 0.188, 0.502) P < 0.0001	Confirms statistical robustness of primary analysis
BIIRC exclude prior loco-regional therapy	Sensitivity analysis	HR: 0.514 (95% CI 0.319, 0.829) P = 0.0063	Confirms statistical robustness of primary analysis

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5 Next Steps - Christian Hogg

~140,000 NET patients in U.S. [1][2]

U.S. NET treatment landscape - highly fragmented

	Somatostatin Based Therapies			Kinase Inhibitor Therapies		
	Sandostatin® LAR (octreotide)	Somatuline Depot® (lanreotide)	Lutathera® (^{177}Lu-Dotatate)	Afinitor® (everolimus)	Sutent® (sunitinib)	Surufatinib (preparing China NDA)
2018 Sales	$1.6bn	$1.0bn	$0.17bn	$1.6bn	$1.0bn	-
MOA [3]	Somatostatin analogue	Somatostatin analogue	Somatostatin receptor targeting radiotherapy	mTOR inhibition	Inhibits multiple receptor tyrosine kinases	VEGFR/FGFR1 & CSF-1R inhibition
Admin.	Subcutaneous or intramuscular inj. (LAR)	Subcutaneous injection	Subcutaneous injections (radio-qualified physicians).	Oral tablet	Oral capsules	Oral capsules
Shelf-life	3 years	2 years	72 hours	3 years	3 years	2+ years[5]
Dosage	2 wks: Sando. inj. 0.1-0.6mg per day; then 2 months Sando. LAR 20mg per 4 wks.	120mg inj. every 4 wks.	7.4GBq (one ~25ml vial) inj. every 8 wks - 4 doses total.	10mg orally once daily.	37.5mg taken orally once daily.	300mg orally once daily.
NET indication /s	• LT treatment of severe diarrhea & flushing from meta. carcinoid tumors.	• GEP-NETs: unresectable, well or moderately diff., (locally adv. or meta) GEP-NETs to improve PFS. • Carcinoid Syndrome: to reduce frequency of short-acting somatostatin rescue therapy.	• Somatostatin receptor-positive GEP-NETs.	• pNET: progressive pNET (unresectable, locally adv. or meta). • GI-NET or Lung NET: progressive, well-diff., *non-functional* NET (unresectable, locally adv. or meta). Not for *functional* carcinoid tumors.[4]	• pNET: Progressive, well-differentiated pNETs (unresectable locally adv. or meta).	• Non-pNET: SANET-ep study was in low- or intermediate-grade adv. non-pancreatic NET. • pNET: Phase III ongoing.
Non-NET indication/s	• Acromegaly; watery diarrhea from VIPomas.	• Acromegaly.		• Adv. HR+ HER2-n breast cancer; adv. 2L RCC; renal angiomyolipoma and TSC.	• 2L GIST; adv. RCC; high risk of recurrent RCC.	

	Sandostatin® / Placebo	Somatuline Depot® / Placebo	Lutathera® + Sando. LAR / Sando. LAR	Afinitor® / Placebo		Sutent® / Placebo	Surufatinib / Placebo	
mPFS (mo.)	14.3 / 6.0	NR / 18.0	NR / 8.5	pNET 11.0 / 4.6	Lung & GI NET 11.0 / 3.9	pNET: 11.4 / 5.5	Ph II pNET 19.4	Ph III non-pNET 9.2 / 3.8
HR	0.34	0.47	0.21	0.35	0.48	0.42	Ph III Ongoing	0.33
(*p-value*)	*0.000072*	*<0.001*	*<0.0001*	*<0.001*	*<0.001*	*<0.001*		*<0.0001*
ORR	2% / 2%	NR	18% / 3%	5% / 2%	2% / 1%	9% / 0%	17% (Ph II)	10.3%
DCR	69% / 40%	NR	95% / 76%	73% / 51%	81% / 64%	72% / 60%	90% (Ph II)	87%
Pivotal Trial	PROMID	CLARINET	NETTER-1	RADIANT-3	RADIANT-4	A6181111	SANET-p	SANET-ep

[1] *Dasari A, et al.: Trends in the Incidence, Prevalence, & Survival Outcomes in Patients With Neuroendocrine Tumors in the U.S.*. JAMA Oncol. *2017;3(10):1335-1342;* [2] www.cancer.net (patient information from ASCO) - NET is a subtype of neuroendcrine neoplasms, NENs); [3] MOA = Mechanism of Action; [4] Afinitor is only approved for pancreatic neuroendocrine tumors in China; [5] 2-year stability studies completed so far; mPFS = median progression-free survival; HR = Hazard Ratio; ORR = objective response rate; DCR = Disease control rate.

China NET

Non-Pancreatic NET estimated to represent ~80% of China NET

Epidemiology – *China NET & BTC patient populations*

Potential First suru monotherapy indication Non-pancreatic NET

Two further surufatinib registration-intent studies underway

		Annual Incidence	Estimated Prevalence	mPFS	NRDL Pricing References
China NET	100%	67,600	~300,000 (Est. China ratio[1])		Sutent® (~US$ 2,007/mo.[2]) Afinitor® (~US$ 1,320/mo.[2])
Non-Pancreatic NET	~80%	~54,100	~240,000 (Est. China ratio[1])	9.2 mo. (Ph.III) (SANET-ep)	
Pancreatic NET	~20%	~13,500	~60,000 (Est. China ratio[1])	19.4 mo. (Ph.II) (SANET-p Ph.III -- TBD)	
Biliary Tract Cancer	100%	64,000		TBD	

NET is major unmet medical need in China – with long treatment duration

[1] Current estimated Prevalence to Incidence ratio in China at 4.4, lower than U.S. 7.4 ratio due to lower access to treatment options.
[2] NRDL pricing references calculations assume exchange rate of RMB6.74 per US$1.

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5 Q&A

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Thank you