CHI-MED

HUTCHISON CHINA MEDITECH

Corporate Presentation

December 2019

AIM/Nasdaq: HCM

Safe harbor statement & disclaimer

The performance and results of operations of the Chi-Med Group contained within this presentation are historical in nature, and past performance is no guarantee of future results.

This presentation contains forward-looking statements within the meaning of the "safe harbor" provisions of the U.S. Private Securities Litigation Reform Act of 1995. These forward-looking statements can be identified by words like "will," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "pipeline," "could," "potential," "believe," "first-in-class," "best-in-class," "designed to," "objective," "guidance," "pursue," or similar terms, or by express or implied discussions regarding potential drug candidates, potential indications for drug candidates or by discussions of strategy, plans, expectations or intentions. You should not place undue reliance on these statements. Such forward-looking statements are based on the current beliefs and expectations of management regarding future events, and are subject to significant known and unknown risks and uncertainties. Should one or more of these risks or uncertainties materialize, or should underlying assumptions prove incorrect, actual results may vary materially from those set forth in the forward-looking statements. There can be no guarantee that any of our drug candidates will be approved for sale in any market, or that any approvals which are obtained will be obtained at any particular time, or that any such drug candidates will achieve any particular revenue or net income levels. In particular, management's expectations could be affected by, among other things: unexpected regulatory actions or delays or government regulation generally; the uncertainties inherent in research and development, including the inability to meet our key study assumptions regarding enrollment rates, timing and availability of subjects meeting a study's inclusion and exclusion criteria and funding requirements, changes to clinical protocols, unexpected adverse events or safety, quality or manufacturing issues; the inability of a drug candidate to meet the primary or secondary endpoint of a study; the inability of a drug candidate to obtain regulatory approval in different jurisdictions or gain commercial acceptance after obtaining regulatory approval; global trends toward health care cost containment, including ongoing pricing pressures; uncertainties regarding actual or potential legal proceedings, including, among others, actual or potential product liability litigation, litigation and investigations regarding sales and marketing practices, intellectual property disputes, and government investigations generally; and general economic and industry conditions, including uncertainties regarding the effects of the persistently weak economic and financial environment in many countries and uncertainties regarding future global exchange rates. For further discussion of these and other risks, see Chi-Med's filings with the U.S. Securities and Exchange Commission and on AIM. Chi-Med is providing the information in this presentation as of this date and does not undertake any obligation to update any forward-looking statements as a result of new information, future events or otherwise.

In addition, this presentation contains statistical data, third-party clinical data and estimates that Chi-Med obtained from industry publications and reports generated by third-party market research firms, including Frost & Sullivan, QuintilesIMS/IQVIA, independent market research firms, clinical data of competitors, and other publicly available data. All patient population, market size and market share estimates are based on Frost & Sullivan or QuintilesIMS/IQVIA research, unless otherwise noted. Although Chi-Med believes that the publications, reports, surveys and third-party clinical data are reliable, Chi-Med has not independently verified the data and cannot guarantee the accuracy or completeness of such data. You are cautioned not to give undue weight to this data. Such data involves risks and uncertainties and are subject to change based on various factors, including those discussed above.

Nothing in this presentation or in any accompanying management discussion of this presentation constitutes, nor is it intended to constitute or form any part of: (i) an invitation or inducement to engage in any investment activity, whether in the United States, the United Kingdom or in any other jurisdiction; (ii) any recommendation or advice in respect of any securities of Chi-Med; or (iii) any offer for the sale, purchase or subscription of any securities of Chi-Med.

No representation or warranty, express or implied, is made as to, and no reliance should be placed on, the fairness, accuracy, completeness or correctness of the information, or opinions contained herein. Neither Chi-Med, nor any of Chi-Med's advisors or representatives shall have any responsibility or liability whatsoever (for negligence or otherwise) for any loss howsoever arising from any use of this presentation or its contents or otherwise arising in connection with this presentation. The information set out herein may be subject to updating, completion, revision, verification and amendment and such information may change materially.

All references to "Chi-Med" as used throughout this presentation refer to Hutchison China MediTech Limited and its consolidated subsidiaries and joint ventures unless otherwise stated or indicated by context. This presentation should be read in conjunction with Chi-Med's results for the six months ended June 30, 2019 and Chi-Med's other SEC filings, copies of which are available on Chi-Med's website (www.chi-med.com).

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

CHI-MED

1 Company Overview

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

Global Innovation

- 5 clinical drug candidates in US/EU development
- Building global clinical development footprint
- World-class ~490-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

- Cash generative China Commercial Platform
- Platform for future innovative drug launches

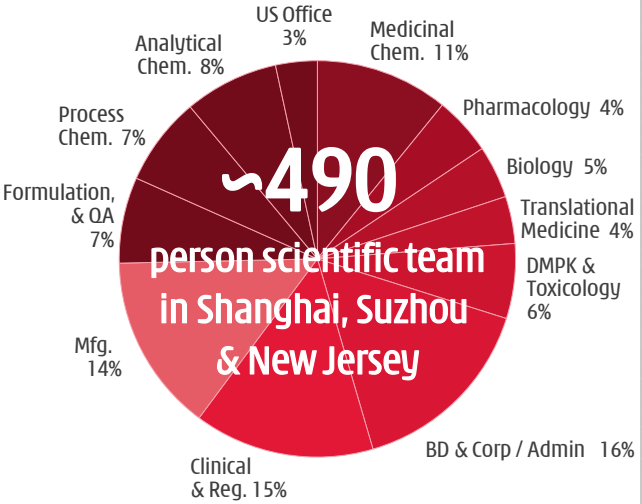
[1] China-discovered novel oncology drug to receive unconditional NDA approval in China.

Proven innovation & commercial operations

Management Team

		Industry / Chi-Med (years)
	**Mr. CHRISTIAN HOGG, BSc, MBA** Chief Executive Officer	P&G Procter & Gamble	30 / 19
	**Dr. WEIGUO SU, PhD** EVP, Chief Scientific Officer	Pfizer	29 / 14
	**Mr. JOHNNY CHENG, BEc, CA** Chief Financial Officer	Bristol-Myers Squibb, Nestlé, KPMG	30 / 11
	**Dr. ZHOU JUN JIE, MD, MBA** General Manager, SHPL	SANOFI	28 / 18
	**Dr. MAREK KANIA, MD, MBA** SVP, Chief Medical Officer, International	Lilly	25 / 1
	**Dr. ZHENPING WU, PhD, MBA** SVP, Pharmaceutical Sciences	Roche, Pfizer	25 / 11
	**Mr. CHEN HONG, BSc, MBA** SVP, Chief Commercial Officer	Bristol-Myers Squibb	21 / 9
	**Dr. MAY WANG, PhD** SVP, Bus. Dev. & Strategic Alliances	Lilly	25 / 9
	**Mr. ANDREW SHIH, DiplIE, MBA** SVP, HR - Org./Leadership Dev.	MERCK	23 / 1
	**Mr. MARK LEE, BEng, MBA** SVP, Corp. Finance & Development	Credit Suisse	20 / 10
	**Mr. ENRICO MAGNANELLI, BA, MBA** Head of International Operations	GILEAD	20 / 1

Integrated Innovation Organization [1]



Commercial Team & Joint Ventures [1]

Commercial Team (subsidiaries):

- **>200** staff covering:
  - Drug distribution & marketing operations; &
  - New Oncology Business Dept.

50/50 Joint Ventures:

- **>2,400** Rx medical sales reps.;
- **~900** person OTC sales team; &
- **>1,500** staff in two major factories

[1] Headcount as of Oct 30, 2019; Chem. = Chemistry; DMPK = Drug, Metabolism, & Pharmacokinetics; Tox. = Drug Safety Evaluation; QA: Quality Assurance; Mfg. = Manufacturing; Reg. = Regulatory; BD = Business Development.

Portfolio summary

Multiple waves of innovation - progressing rapidly

Dose Finding / Safety Run-In	Proof-of-Concept	Registration Intent	Marketed
Fruquintinib + Tyvyt (PD-1) Solid Tumors [1]	**Savolitinib** MET Exon 14 deletion NSCLC	**Savo + Tagrisso (SAVANNAH)** 2L/3L Tagrisso-refractory MET+ NSCLC	**Elunate (Fruquintinib capsules)** ≥3L Colorectal cancer
Surufatinib + Tuoyi (PD-1) Solid Tumors [1]	**Savo / Savo + Imfinzi (CALYPSO)** x2: PRCC & ccRCC	**Savolitinib** MET Exon 14 deletion NSCLC	**SXBX [3] Pills** Coronary artery disease
HMPL-523 (Syk) Indolent NHL [2]	**Savolitinib (VIKTORY)** MET+ Gastric cancer	**Fruquintinib + Taxol (FRUTIGA)** 2L Gastric cancer	**>10 other Rx / OTC drugs**
HMPL-689 (PI3Kδ) Indolent NHL	**Savolitinib (CCGT 1234B)** MET+ Prostate cancer	**Surufatinib (SANET-p)** Pancreatic NET	
Fruquintinib + Tyvyt (PD-1) Solid tumors [1]	**Fruquintinib** 3L/4L Colorectal cancer [1]	**Surufatinib (SANET-ep)** Non-Pancreatic NET	
Fruquintinib + genolimzumab (PD-1) Solid tumors	**Surufatinib** 2L Pancreatic NET	**Surufatinib** 2L Biliary Tract cancer	
Surufatinib + Tuoyi (PD-1) Solid tumors	**Savolitinib + Iressa** 2L 1st Gen EGFR TKI ref. NSCLC		
Surufatinib + Tyvyt (PD-1) Solid tumors	**Fruquintinib + Iressa** 1L EGFRm+ NSCLC		
HMPL-453 (FGFR1/2/3) Solid tumors	**HMPL-523** Indolent NHL		
	HMPL-523 + azacitidine AML		
	HMPL-523 Immune thrombocytopenia purpura		
	HMPL-689 Indolent NHL		
	Epitinib Glioblastoma		

Global Innovation

China Oncology

Existing China Business

IN TRANSITION

[1] In planning / imminent; [2] Proof-of-concept in Australia; [3] SXBX = She Xiang Bao Xin (cardiovascular); [4] Drugs licensed from third parties. Targets: Savolitinib = MET; Fruquintinib = VEGFR1/2/3; Surufatinib = VEGFR1/2/3 / FGFR1 / CSF-1R; HMPL-523 = Syk; HMPL-689 = PI3Kδ; Epitinib = EGFRm in the brain; Theliatinib = EGFR wild-type; HMPL-453 = FGFR1/2/3. Indications: NHL = Non-Hodgkin's Lymphoma; NET = Neuroendocrine tumors; RCC = Renal cell carcinoma; AML = Acute myeloid leukemia; ITP = Immune thrombocytopenia; NSCLC = Non-small cell lung cancer.

Potential upcoming events

CHI-MED

	H1-19	H2-19	H1-20
Global Innovation	**Savo + Imfinzi®** Papillary RCC (CALYPSO) **Ph. II Interim Data** **Savo + Tagrisso®** NSCLC (TATTON) **Ph. Ib Data (AACR)**	**HMPL-523 (Syk)** Indolent NHL **Ph. I Start (US/EU)** **HMPL-689 (PI3Kδ)** Indolent NHL **Ph. I Start (US/EU)** **Savo** 2L gastric (VIKTORY) **Ph. II Data**	**Savo + Imfinzi®** Clear cell RCC (CALYPSO) **Ph. II Interim Data** **Savo Lung Cancer** Anticipate further Ph.II/III studies **Suru** P NET (US/EU) **Ph. II/III Start****	**Savo + Tagrisso®** NSCLC (SAVANNAH) **Ph.II Interim** **Fruq** 3L/4L colorectal (US/EU) **Ph. II/III Start**** **Fruq / Suru + PD-1** Initiation of U.S development
China Oncology	**Savo** NSCLC Exon14del **Ph. II Data (AACR)** **Suru** 2L Biliary tract **Ph.II/III Start** **Fruq / Suru** PD-1 combos **Phase I Start** **Fruq + Taxol®** 2L gastric (FRUTIGA) **1st Ph. III Interim**	**Savo** NSCLC Exon14del **Reg. Study Enrolled** **Suru** Non-P NET (SANET-ep) **Ph.III Interim** **Suru** Non-P NET (SANET-ep) **Ph.III Data (ESMO)** **Suru** Non-P NET (SANET-ep) **NDA Submission** **Fruq** 3L NSCLC (FALUCA) **Ph. III Data (WCLC)** **Reimbursement** Elunate® NRDL inclusion	**Savo** NSCLC Exon14del **NDA Submission**** **Suru** P NET (SANET-p) **Ph.III Interim** **HMPL-306** IDH 1/2 inhibitor **Ph.I Start** **Fruq + Taxol®** 2L gastric (FRUTIGA) **2nd Ph. III Interim**	**Suru** 2L Biliary tract **Ph. Ib/II Data*** **HMPL-523 (Syk)** Indolent NHL **Reg. Study Start****

= Data milestone/readout.

= Development/commercial progress.

* submission to scientific conference; ** subject to supportive data; Targets: Savolitinib = MET; Fruquintinib = VEGFR1/2/3; Surufatinib = VEGFR1/2/3 / FGFR1 / CSF-1R; HMPL-523 = Syk; HMPL-689 = PI3Kδ; Indications: NHL = Non-Hodgkin's Lymphoma; NET = Neuroendocrine tumors; RCC = Renal cell carcinoma; NSCLC = Non-small cell lung cancer.

Global clinical drug portfolio (1/2)

Savolitinib

Potential First-in-class small molecule selective MET inhibitor

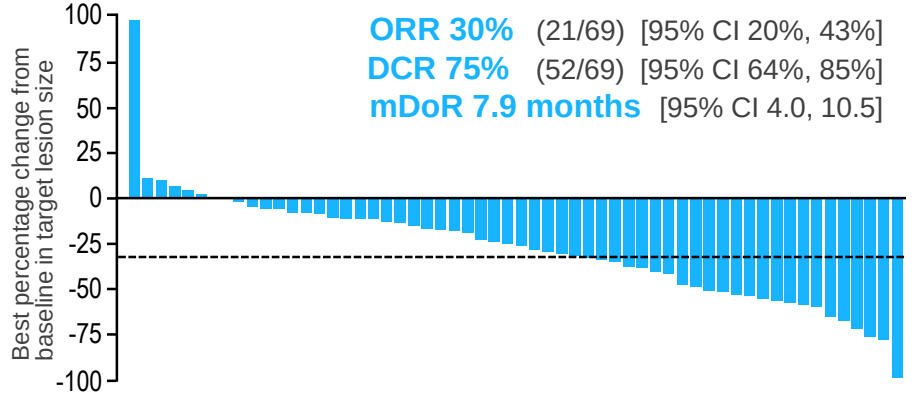
Indications:	MET-driven NSCLC; RCC; Gastric; Prostate cancer
Dosed to-date: [2]	~1,000 patients
Summary Data:	**NSCLC – Tagrisso® EGFR TKI refractory combinations:** **Post 1st-gen TKI** (n=87): ORR 64-69% **Post 3rd-gen TKI** (n=39): ORR 30-36% **PRCC** (n=44): ORR 18%; mPFS 6.2mo.

SAVANNAH global Ph.II/reg. underway[3]
Tagrisso® + savo

SINGAPORE 2019 ESMO ASIA

SINGAPORE
22-24 NOVEMBER 2019

Osimertinib plus savolitinib for patients with disease progression on prior third-generation EGFR-TKI: Preliminary anti-tumor activity



Fruquintinib

Potential Best-in-class small molecule selective VEGFR 1/2/3 inhibitor

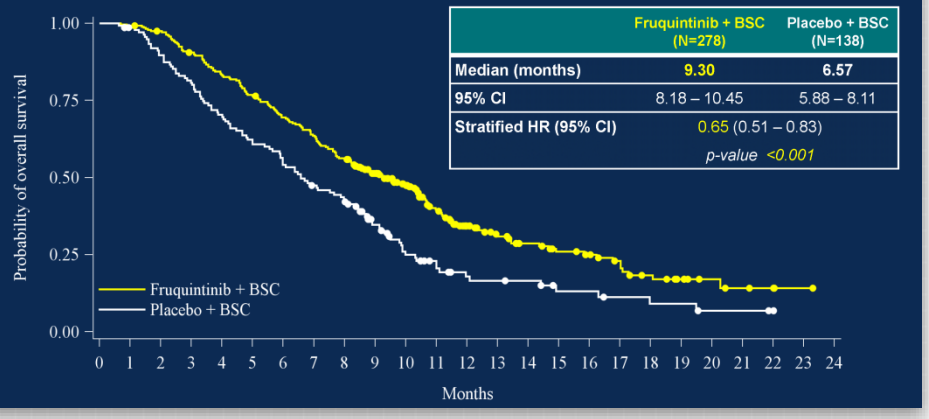
Indications:	Colorectal; NSCLC; Gastric cancer
Dosed to-date:	~1,650 patients in trials
Summary Data:	**3L CRC** (n=416): mOS 9.3mo. vs. 6.6mo. (SoC) **3L NSCLC** (n=91): ORR 13%; mPFS 3.8mo. vs 1.1mo. (SoC) **1L NSCLC (Iressa® combo)** (n=50): ORR 76% [1] **2L Gastric (Taxol® combo)** (n=28): ORR 36%

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



MET = mesenchymal epithelial transition receptor, VEGFR = vascular endothelial growth factor receptor, NSCLC = non-small cell lung cancer, RCC = renal cell carcinoma, PRCC = papillary RCC, CRC = colorectal cancer;
[1] Efficacy Evaluable Patients. Data cut-off: Oct. 10, 2017; [2] Dosed to-date = patients in all clinical trials (treatment & placebo); [3] Phase II registration intent study subject to regulatory discussions.

Global clinical drug portfolio (2/2)

Surufatinib

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

Indications:	Neuroendocrine tumors (pNET/ep-NET); Thyroid; Biliary Tract
Dosed to-date: [1]	~800 patients
Summary Data:	**Ep-NET** (n=198): ORR 10%; mPFS 9.2mo vs 3.8mo (Pbo) **PhII interim pNET** (n=41): ORR 17%; mPFS 19.4mo.

Ep-NET Phase III Met Primary Endpoint

HMPL-523

Potential First-in-class small molecule selective Syk inhibitor

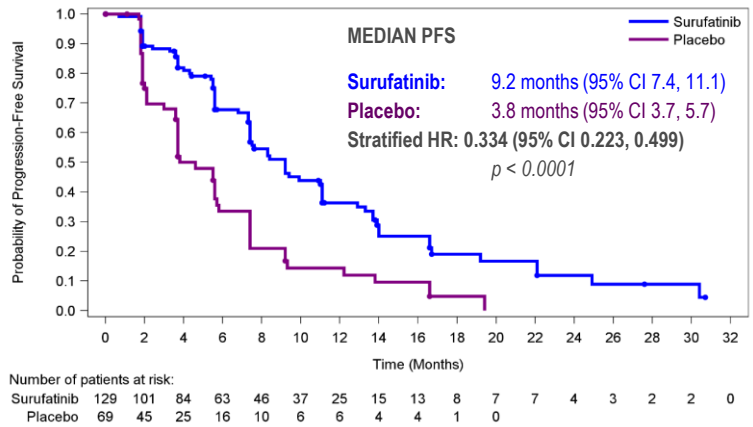
Indications:	Indolent non-Hodgkin's lymphoma; AML; Immunol.
Dosed to-date:	>150 pts. & ~118 healthy vol.
Summary Data:	Dose escalation (5 cohorts) [2] **FL** (n=10): ORR 30% **CLL/SLL** (n=3): ORR 33%

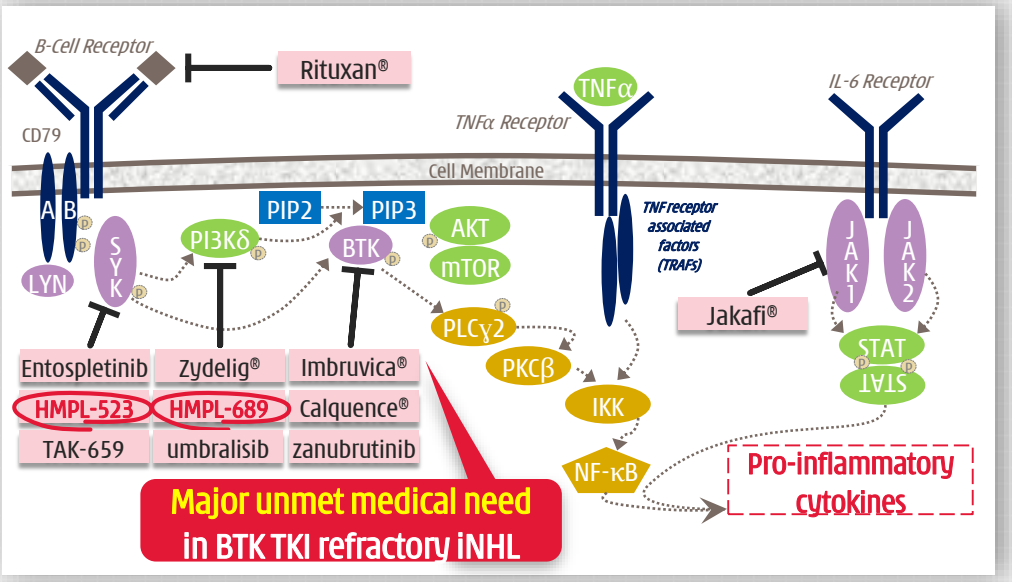
HMPL-689

Potential Best-in-class small molecule selective PI3Kδ inhibitor

Indications:	Indolent non-Hodgkin's lymphoma
Dosed to-date:	~40 pts. & ~48 healthy vols.
Summary Data:	Phase I dose escalation data not yet published

BARCELONA 2019 ESMO congress — 27 SEPT – 1 OCT 2019





[1] Dosed to-date = patients in all clinical trials (treatment & placebo); [2] American Society of Hematology. Blood, vol. 132 no. Suppl 1 5324 (Nov 2018); VEGFR = vascular endothelial growth factor receptor, FGFR1 = fibroblast growth factor receptor 1, CSF-1R = colony stimulating factor-1 receptor, Syk = spleen tyrosine kinase, PI3Kδ = Phosphatidylinositol-3-Kinase delta, pNET = pancreatic neuroendocrine tumors, ep-NET = non-pancreatic neuroendocrine tumors, AML = acute myeloid leukemia, FL = follicular lymphoma, CLL = chronic lymphocytic leukemia, SLL = small lymphocytic leukemia.

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 - 2018	2019
Global Innovation	Established Hutchison MediPharma	Research collaborations	AstraZeneca Global license deal savolitinib (MET) Savo US IND Suru US IND Fruq US IND 523 (Syk) US IND 689 (PI3Kδ) US IND	2017 WCLC savo. + Tagrisso® Ph Ib & II oral presentation Innovent Global PD-1 co-development deals	NSCLC PoC data Savo + Tagrisso® SINGAPORE 2019 ESMO ASIA ASCO GU 2019 CALYPSO data Savo + Imfinzi® (PD-L1) NSCLC reg.-intent Savo + Tagrisso® FPI
China Oncology			Lilly China license deal fruquintinib (VEGFR) 2017 ASCO ANNUAL MEETING Fruquintinib colorectal cancer oral presentation and JAMA publication Suru PRC IND Fruq / Savo PRC IND Epit / Thel PRC INDs 523 (Syk) PRC IND 689 (PI3Kδ) PRC IND 453 (FGFR) PRC IND	ELUNATE Fruquintinib Capsules Approved, mfg GMP certified & launched China PD-1 co-dev. deals	BARCELONA 2019 ESMO congress Suru SANET-ep +ve Ph. III & NDA; pNET orphan AACR Savo Ph.II data MET exon-14del 306 (IDH1/2) 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 HWT 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.			H1-19 Revenue: $367m [1] H1-19 Net Income: $28m [1] >2,400 Med. Sales Reps.

[1] Based on aggregate Non-GAAP revenues and net income / (loss) of consolidated subsidiaries and non-consolidated joint ventures of Commercial Platform.

2 Recent Operating Highlights

Recent Operating Highlights

Surufatinib

- **Positive China Phase III** and **NDA accepted** - non-pancreatic NET - un-blinded a year ahead of schedule;
- Initiated Phase IIb/III - biliary tract cancer; & Phase I for PD-1 combos.

Elunate® (fruquintinib capsules)

- **Early progress on Elunate®** - 3L colorectal cancer in China;
- Cleared Phase III interim analysis - 2L gastric cancer (FRUTIGA);
- Initiated Phase I for PD-1 combos.

Savolitinib

- **Reached enrollment goal on Phase II registration study** - MET Exon 14 deletion NSCLC;
- AstraZeneca collaboration **leading global position in EGFR-TKI resistant NSCLC**;
- **Emerging signal for savolitinib/Imfinzi®** (PD-L1) combo - renal cell carcinoma.

NET = neuroendocrine tumors; combos = concurrent treatment with other cancer therapies; EGFR-TKI = epidermal growth factor receptor mutation tyrosine kinase inhibitor; NSCLC = non-small cell lung cancer.

Other Recent Operating Highlights

B-cell malignancies / non-Hodgkin's lymphoma

- HMPL-523 (Syk) – **›150 patients dosed** in China/Australia Phase I/Ib; to guide registration strategy in late 2019;
- HMPL-689 (PI3Kδ) – **Phase II dose selected** in China & expansion underway;
- **US/EU Phase I 1st patient dosed** for both HMPL-523 & HMPL-689.

Organization

- **Accelerating expansion of New Jersey-based international C&R operations**;
- **Establishing China oncology commercial team** – ~70 commercial staff in place, focused on medical affairs & preparation for potential surufatinib launch.

Discovery

- **IND submission on HMPL-306 –** an isocitrate dehydrogenase (IDH) 1/2 inhibitor.

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).*

2a Surufatinib: angio-immuno kinase inhibitor

Surufatinib

Overview of NET – ~170,000 patients in the U.S. [1][2][3]

What are neuroendocrine tumors ("NET")?

- ~2% of all malignancies.
- Tumor begins in the specialized cells of the body's neuroendocrine system. Cells have traits of both hormone-producing endocrine cells & nerve cells.
- Found throughout the body's organs. Most NETs take years to develop but some can grow fast.

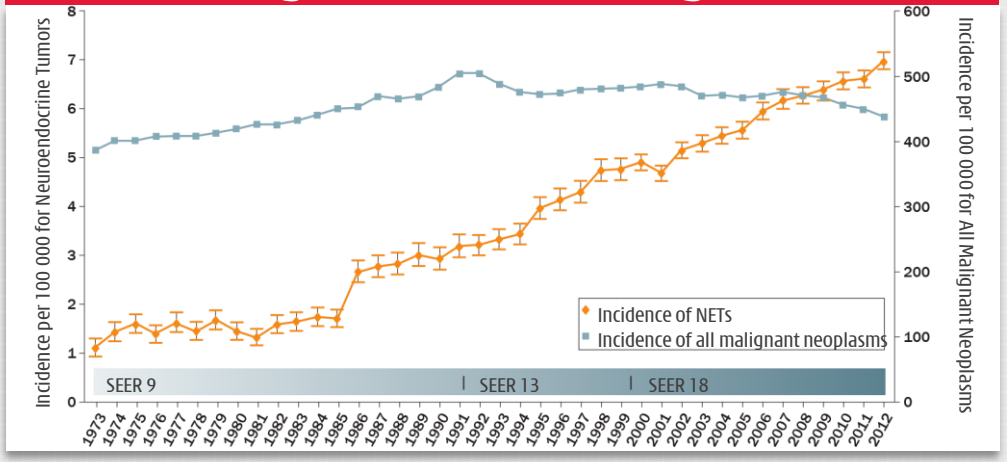
Hormone-related symptoms [1]

- Functional NETs (~8-35% of patients) release hormones / peptides causing symptoms like diarrhea & flushing; Non-functional NETs have no symptoms.

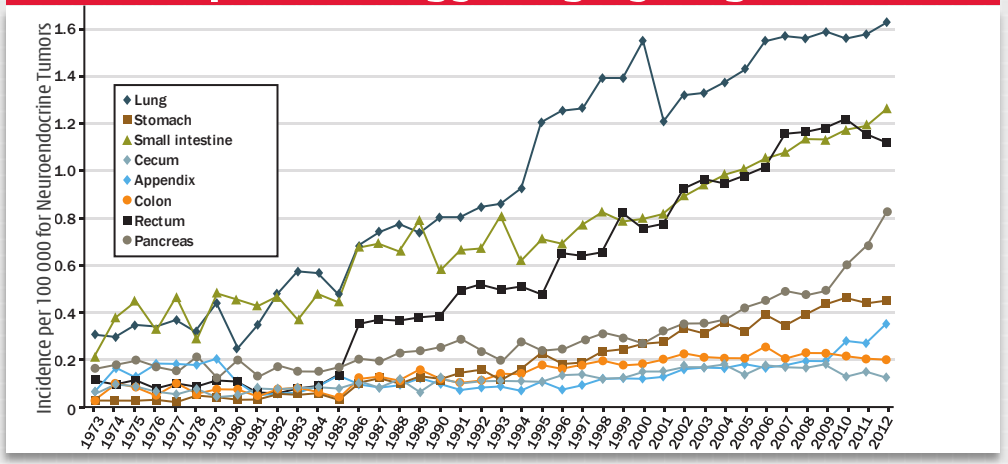
Differentiation & biomarkers for grading:

- Well differentiated: look like healthy cells – grow slowly; Poorly differentiated: look less like healthy cells – grow quickly;
- Mitotic count – Mitosis is process by which tumor cells grow & divide; Ki-67 index – Ki-67 a protein that increases as cells divide.

NET growth – better diagnosis



NET epidemiology – highly fragmented



[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] IQVIA 2019; [4] Gastroentero-pancreatic neuroendocrine tumors = GEP NETs.

High-level NET landscape

Long-term disease – rapid deterioration in later stages [1][2][3]

Grade 1 (G1) NET
Localized / Regional

~8-35% NET patients – Functional NET – *Hormone related symptoms:*

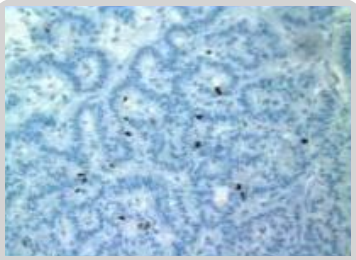
- *94% flushing*
- *78% diarrhea*
- *53% heart plaque*
- *51% cramping*

Symptoms allow early diagnosis

Somatostatin Analogue Treatment – *modulate/ control symptoms related to hormone overproduction & tumor growth:*

- *Octreotide: $1.6b revenue (2018)*
- *Lanreotide: $1.0b revenue (2018)*

mOS: 16.2 yrs.

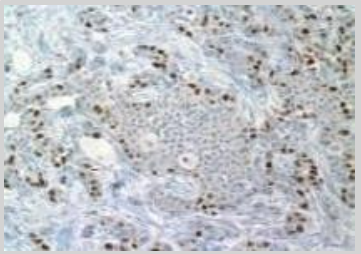


Well Differentiated
Ki-67 Index ≤2; Mitotic Count <2

G1/2 – Advanced NET
Regional / Distant

~60% NET patients – *first diagnosis at advanced disease stage* – **Mostly non-Functional NET** – *TKIs [4]; chemo/ radiotherapy*

mOS: 8.3 yrs.

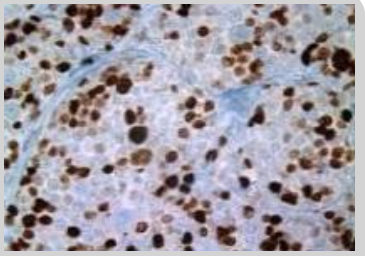


Moderately Differentiated
Ki-67 Index 3-20 ; Mitotic Count 2-20

G3 – NET/NEC
Distant

No approved treatments
– exploring *I/O [5]* *+ TKI combos*

mOS: 10 mos.



Poorly Differentiated
Ki-67 Index >20; Mitotic Count >20

[1] Arvind Desari et. al. Trends in the Incidence, Prevalence, and Survival Outcomes in Patients With Neuroendocrine Tumors in the US, JAMA Oncol. *2017;3(10):1335-1342;* [2] Van Cutsem et al. ESMO – Neuroendocrine Tumors Diagnostic & Therapeutic Challenges; [3] mOS = median overall survival; [4] TKIs = Tyrosine Kinase Inhibitors; [5] I/O = Immuno oncology/immunotherapy

G1/2 Advanced NET [1] *(Ki-67 Index 0-20)*

Global opportunity in lung/other NETs & China wide-open

Site		est. %	Octreotide	Lanreotide	^{177}Lu-Dotatate	Streptozocin	Sunitinib	Everolimus	Surufatinib
Disease status			Treatment naïve	Stable disease	Progressed in past 3 yrs.	Historical	Progressed in past 12 mo.	Progressed in past 6 mo.	Progressed in past 12 mo.
GI Tract	Stomach	7%		CLARINET [2]	Historical Ph.II *SSR over expression*			RADIANT-4 [3]	SANET-ep
	Small bowel/ Appendix	9%	PROMID	CLARINET [2]	NETTER-1			RADIANT-4 [3]	SANET-ep
	Colon & Rectum	31%		CLARINET [2]	Historical Ph.II *SSR over expression*			RADIANT-4 [3]	SANET-ep
	Pancreas	6%		CLARINET [2]	Historical Ph.II *SSR over expression*	Historical	PHASE III	RADIANT-3 [4]	SANET-p *H1 2020 interim*
	Lung	20%						RADIANT-4 [3]	SANET-ep
Other	Other	~17%							SANET-ep
	Unknown 1°	~10%						RADIANT-4 [3]	SANET-ep

[1] Yao ESMO 2019; [2] CLARINET approved only for Ki-67 Index <10 (i.e. est. ~50% of G1/G2); [3] Everolimus approved in non-Functional NET (~60% pNET; 90% Lung NET; majority mid-gut/small bowel NET); [4] RADIANT-3 – Progressed in past 12 months.

Global (ex-China) China

SANET-ep vs. RADIANT-4 - cannot compare

SANET-ep broader range of tumor origins & later-stage patients

	Asia/China Extra-Pancreatic NET	SANET-ep (n=198) (surufatinib vs placebo)		U.S. Extra-Pancreatic NET	RADIANT-4 (n=302) (everolimus vs placebo)
	Tsai et al. 2013			*Yao et al. 2008*	
Tumor Origin					
Gastrointestinal Tract	**58%**	**47%**	**Gastrointestinal Tract**	**50%**	**58%**
Rectum	30%	27%	Rectum	33%	13%
Stomach	7%	10%	Stomach	8%	4%
Small Intestine	19%	8%	Small Intestine	6%	34%
Other GI	3%	3%	Other GI	4%	7%
Lung	**22%**	**12%**	**Lung**	**21%**	**30%**
Other Organ Site		**28%**	**Thymus**		**1%**
Thymus		7%			
Liver		6%			
Mediastinum		6%			
Adrenal Gland		2%			
Other		8%			
Unknown Origin		**14%**	**Unknown Origin**		**12%**
Pathology grade					
Grade 1		16%			**65%**
Grade 2		**84%**			35%
ECOG PS 0:1					
PS 0 (treatment : control)		60% (56% : 67%)			74% (73% : 75%)
PS 1 (treatment : control)		40% (44% : 33%)			26% (27% : 26%)
Prior systemic treatment					
Any Prior Treatment		**67%**			**61%**
Chemotherapy		40%			25%
Targeted therapy		**10%**			none
Somatostatin Analogues		32%			55%
Multiple organ involvement	**66% with multiple organ involvement** 76% had liver metastasis 47% had lymph nodes metastasis 33% had bone metastasis 26% had lung metastasis			79% had liver metastasis 43% had lymph nodes metastasis 19% had bone metastasis 22% had lung metastasis	

SANET-ep

Enrolled more pts with poor prognosis.

Primary Site	mOS	Survival Rate @ 5-yr
Rectum	2.8y	28%
Stomach	2.4y	32%
Small Intestine	8.6y	69%

RADIANT-4

Did not enrol other extra-pancreatic NET organ sites incl. but not limited to

Throat, Kidney, Mediastinum, Retroperitoneal, Parathyroid gland, Liver, Thyroid, Ovary, Adrenal gland, Ampulla vater, Carotid body

→ **SANET-ep** Broader pt. coverage.

SANET-ep

Later-stage patients, more heavily pre-treated (incl. with targeted therapy) & weaker physical status.

Likely due to later diagnosis in China & availability of everolimus.

Source: Xu et al, ESMO 2019 #LBA76; Yao et al, Lancet 2016 387(10022) 968-77; Yao et al, JAMA Oncol 2017 3(10) 1335-42; Excludes 7% pancreatic NET in US series and 6% in Asia series; Colon-rectum in Tsai et al. (2013) report; Colon approximately 8% in Asian series (Shebani KO et al. (1999)); Colon-rectum in Yao et al. (2008) report; Colon approximately 4-7% in US/EU series (Niederle B et al. (2016)).

G1/2 Advanced extra-pancreatic NET

Investigator assessed median PFS

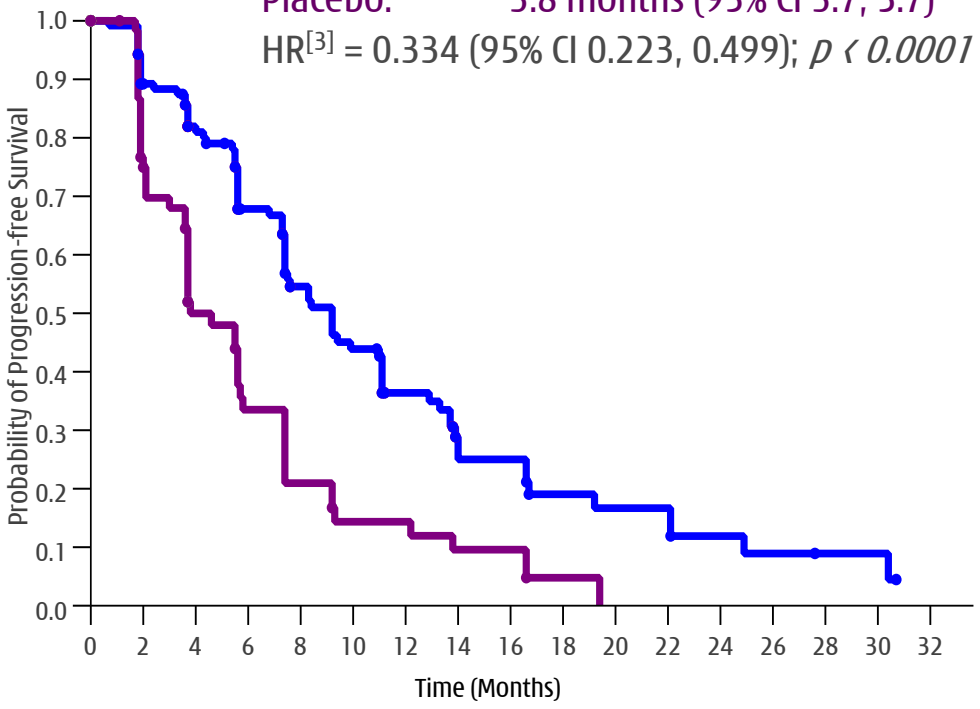
CHI-MED

SANET-ep [1] *(n=198)*

Surufatinib: 9.2 months (95% CI 7.4, 11.1)

Placebo: 3.8 months (95% CI 3.7, 5.7)

HR[3] = 0.334 (95% CI 0.223, 0.499); *p < 0.0001*



SANET-ep Primary (1°) endpoint was Investigator mPFS

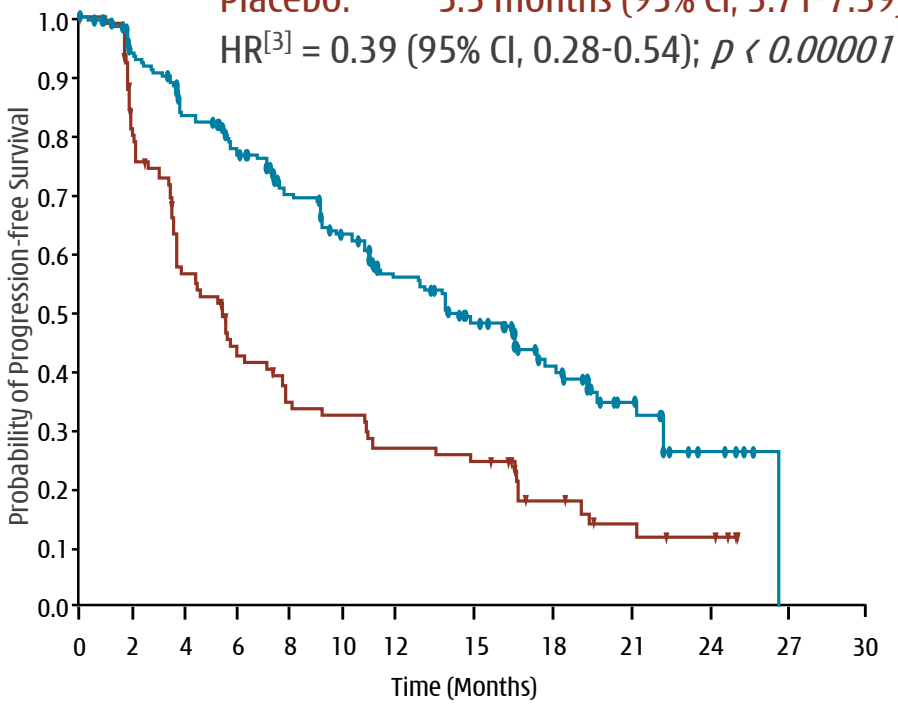
BIIRC [4] mPFS for supportive analysis not 1° or 2°endpoint

RADIANT-4 [2] *(n=302)*

Everolimus: 14.0 months (95% CI, 11.24-17.71)

Placebo: 5.5 months (95% CI, 3.71-7.39)

HR[3] = 0.39 (95% CI, 0.28-0.54); *p < 0.00001*



RADIANT-4 Primary (1°) endpoint was BIIRC [4] mPFS

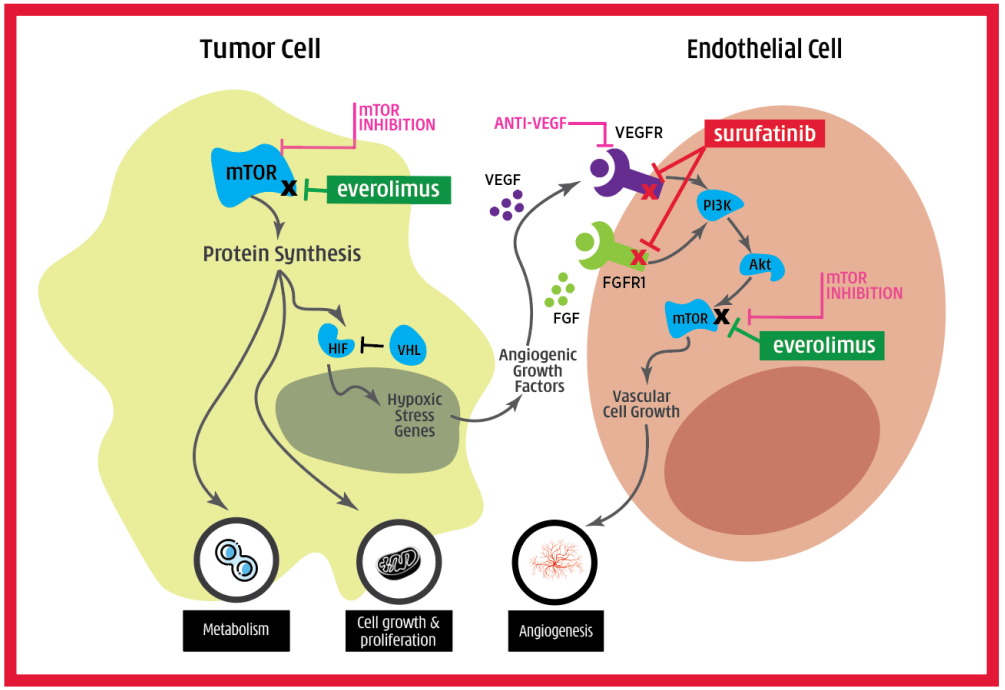
Investigator mPFS not 1° or 2°endpoint

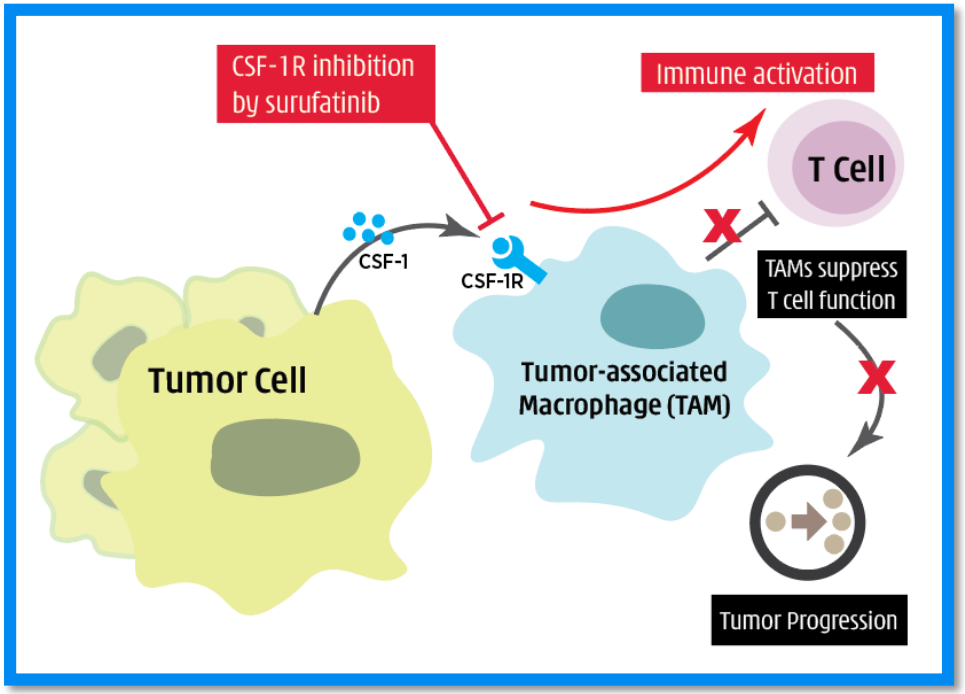
[1] ESMO 2019 LBA#76; [2] Yao et al. "Everolimus for the treatment of advanced, non-functional neuroendocrine tumours of the lung or gastrointestinal tract (RADIANT-4)" Lancet. 2016 Mar 5;387(10022):968-977. doi: 10.1016/S0140-6736(15)00817-X. Epub 2015 Dec 17; [3] P-value is obtained from the stratified one-sided log-rank test; Hazard ratio is obtained from stratified Cox model; CI, confidence interval; HR, hazard ratio; [4] BIIRC = Blinded Independent Image Review Committee (Central).

Very different mechanism of action

Everolimus inhibits **mTOR** and blocks the effects caused by the loss of certain genes thereby reducing cell growth, proliferation, and angiogenesis.

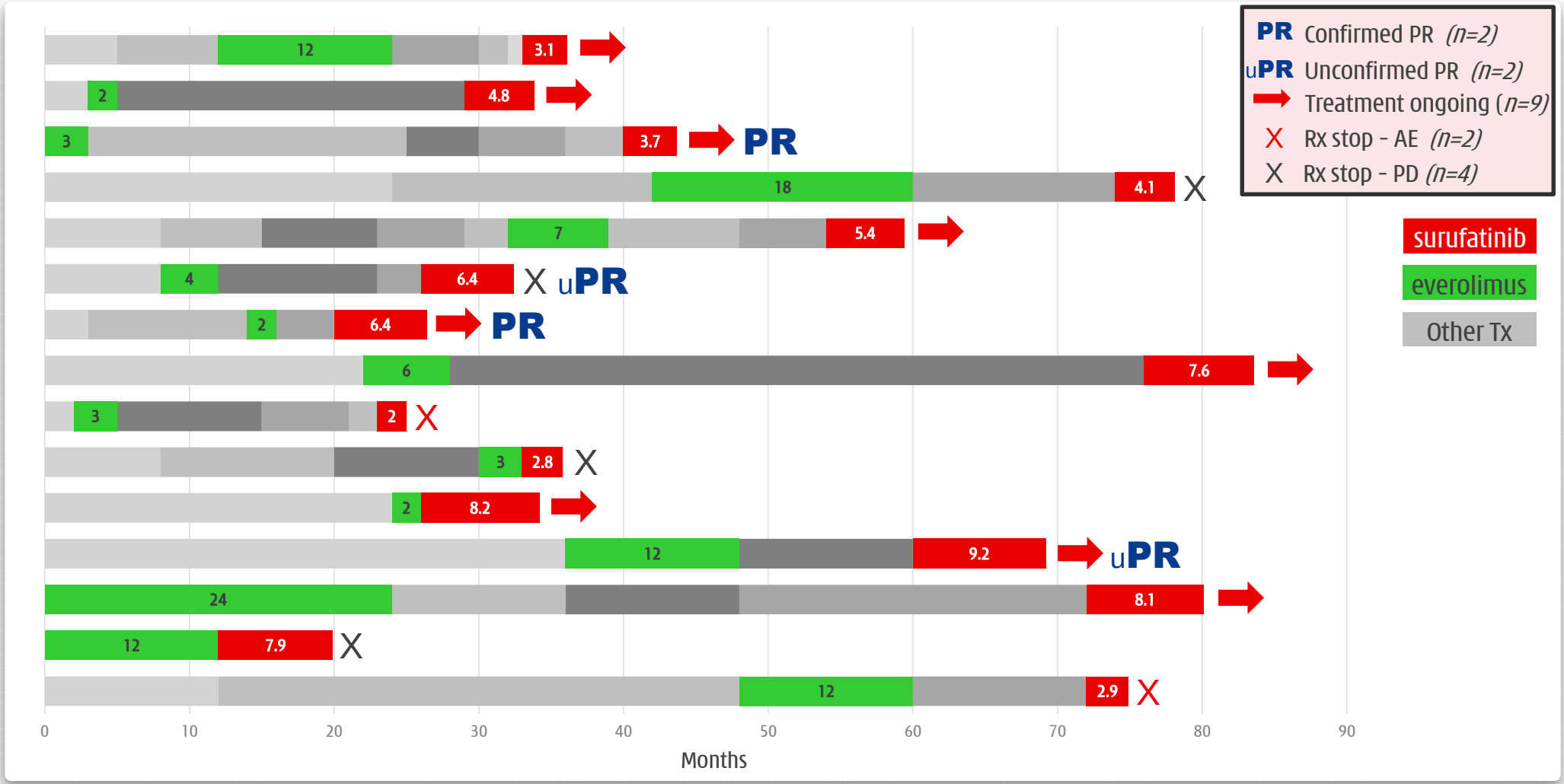
Surufatinib inhibits **VEGFR1/2/3** and **FGFR1** blocking vascular cell growth and angiogenesis; as well as **CSF-1R** which limits the production of TAMs which cloak the cancer cell from T-Cell attack.





Surufatinib efficacy post everolimus failure

U.S. Phase Ib (n=15) - pNET duration of treatment



Encouraging preliminary surufatinib efficacy post everolimus failure - different MOA[1]

Legend: AFIB = aflibercept; ATEZ = atezolizumab; BEV = bevacizumab; CAP = capecitabine; EV = everolimus; SUN = sunitinib; TEM = temozolomide; all at data cut-off as of Sept 2, 2019; [1] MOA = mechanism of action.

Surufatinib - 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. (SANET-ep Ph.III)	
Pancreatic NET	~20%	~13,600	~30,000 (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.

Surufatinib - China NET

NET potential ~$100-120m/yr. - under treated/diagnosed

Competitive landscape - *China NET treatments* [1]

Brand	Indication/s	Launched		2017	2018	Q1-2019
SUTENT® *(sunitinib - VEGFR)* Pfizer	**Pancr. NET** (& GIST/RCC)	2007	Sales (US$ million)	**27**	**24**	**7**
			List Price (US$/month)	4,455	*NRDL Oct-18*	2,007
AFINITOR® *(everolimus - mTOR)* Novartis	**Pancr. NET** (& 2L RCC)	2013	Sales (US$ million)	**9**	**13**	**3**
			List Price (US$/month)	*NRDL Jul-17*	1,320	1,320
SANDOSTATIN LAR® *(octreotide - SSA[2])* Novartis	**GEP-NENs** [3]	2003	Sales (US$ million)	**14**	**15**	**5**
			List Price (US$/month)	1,169	*NRDL Oct-18*	835

Pancreatic-NET market est. ~$10-15m/yr. - Non-Pancreatic NET market ~5-10X

[1] Source: Frost & Sullivan. Note: Calculations assume at CER, using exchange rate of RMB6.74 per US$1; [2] SSA = Somatostatin analogues; [3] GEP-NEN = gastro-entero-pancreatic neuroendocrine neoplasias.

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

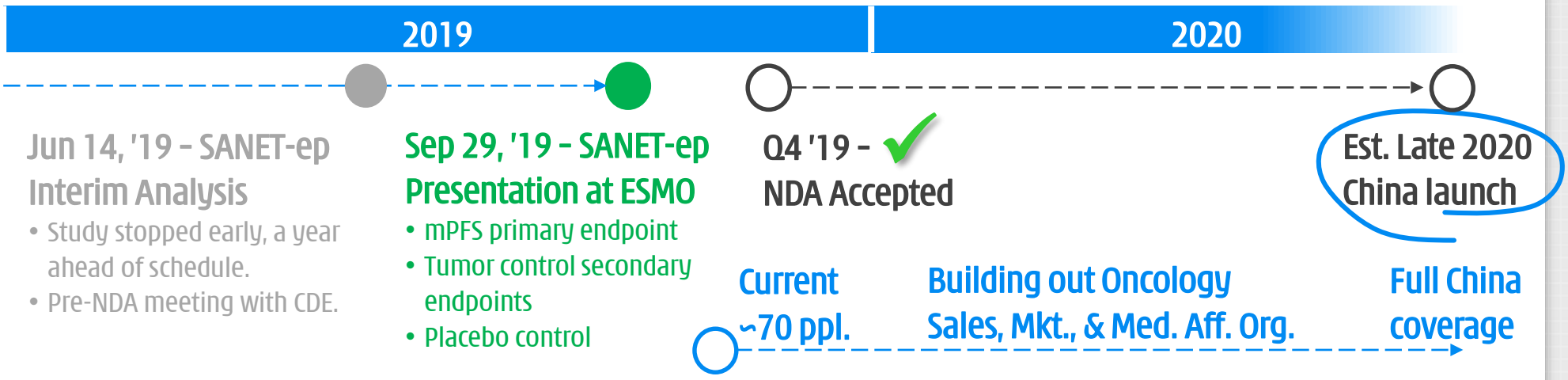
SANET-p

Pancreatic NET *(Planned N=195)*

R (2:1) → Surufatinib / Placebo

- SANET-p Interim Analysis in H1 2020.

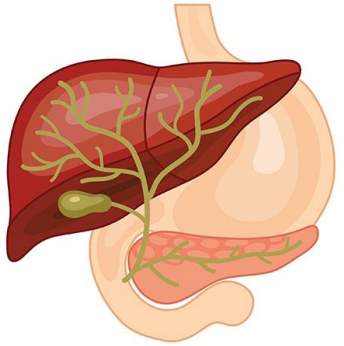
...preparing for our first China launch...



Surufatinib
Other ongoing trials

Phase IIb/III study in 2L BTC

- First patient dosed in March 2019;
- Nearly all planned sites now activated;
- Interim analysis mid-2020, based on first 80 patients;
- Total enrollment ~300 patients.



PD-1 collaborations

- With Junshi (Tuoyi®): Dose expansion in multiple tumor types to begin Q4 2019;
- With Innovent (Tyvyt®): Global studies in planning.

Innovent Biologics

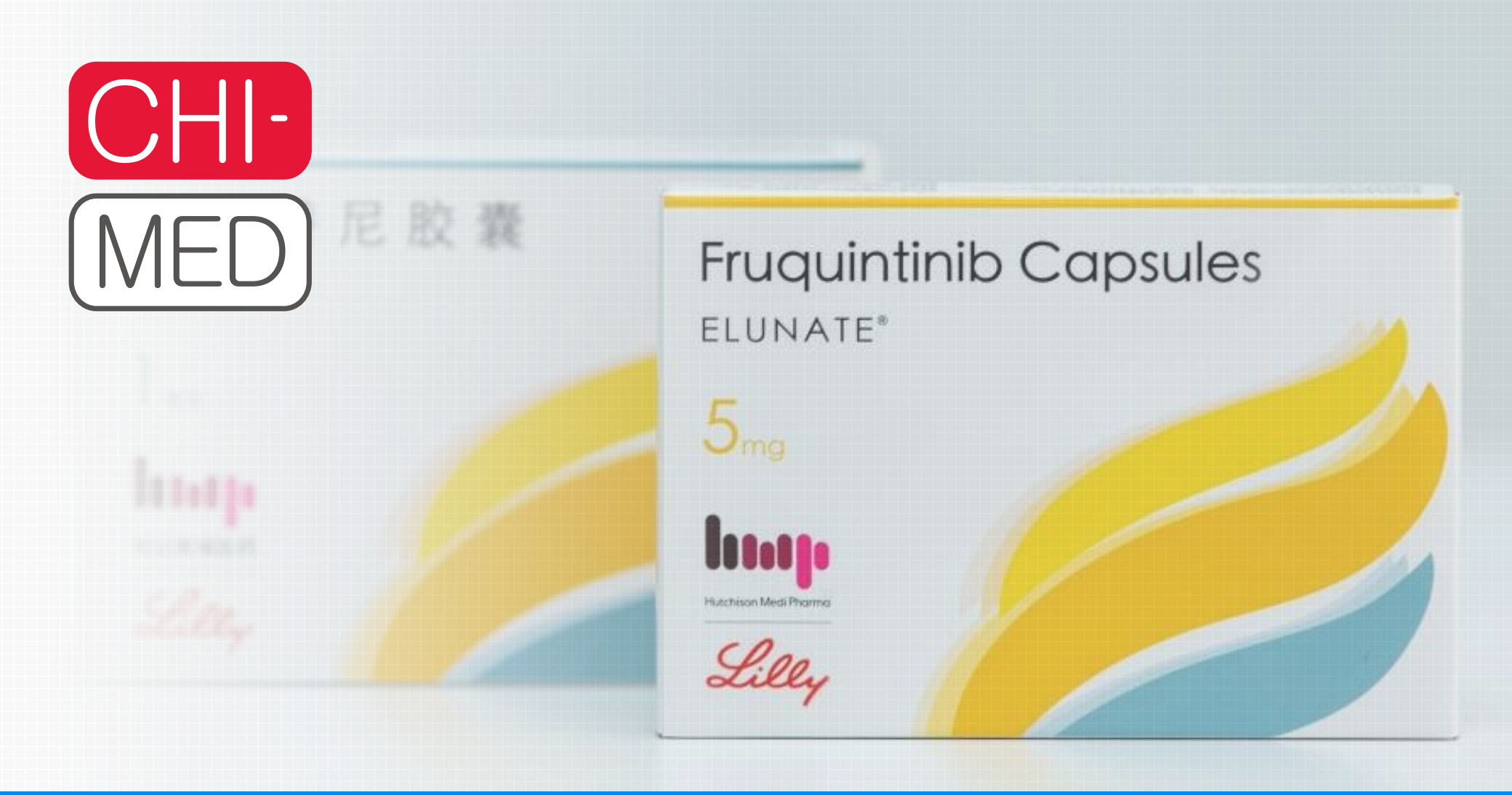
君实生物 Junshi Biosciences

Ex-China development

- U.S. Phase Ib/II in P-NET & BTC initiated July 2018 – NET enrollment complete;
- FDA End of Phase II meeting targeted for Q4 2019;
- U.S. & Europe Phase III registration study expected to initiate in Q1 2020.

FDA

CHI-MED



2b Elunate® (fruquintinib capsules)

ELUNATE®
Fruquintinib Capsules

3rd-line colorectal cancer ("CRC")

CHI-MED

Epidemiology

China Annual Incidence
380,000 patients [1]

↓

Surgery

↓

1st-line treated

↓

2nd-line treated

↓

3rd-line treated
›55,000 patients [2]

~15%

Launch pricing [3]

Launch pricing (OOP [4])
~US$ 3,260 per cycle
(RMB 21,966 per cycle)
(one cycle 4 weeks)

Patient Access Program

- Cycle 1: ~US$ 3,260
- Cycle 2: ~US$ 3,260
- Cycle 3: Free (PAP[5])
- Cycle 4: Free (PAP[5])
- Cycle 5: ~US$ 3,260
- Cycle 6 onwards: Free (PAP[5])

Total OOP cost to patients
~US$ 9,800 (RMB 65,880)

Average Usage
~Avg 5 mths / 5.5 cycles
(to progression; 3.7 mo. mPFS [6])

National Reimbursed Drug List (NRDL)

2019 NRDL released by China's National Healthcare Security Administration ("NHSA")

- Announced Nov. 28, 2019; effective Jan. 1, 2019
- 8 newly listed oncology drugs, including Elunate®
- Reimburse 50-70% of patient costs under urban scheme

OOP costs for 3L CRC Patients per cycle		Urban Med. Insur. Scheme (UMI)	Non-UMI
Population		317m	1,053m
% China		*23%*	*77%*
Elunate® (fruquintinib)	Pre-NRDL	RMB21,966	RMB21,966
	Post-NRDL	7,938	7,938
	3L CRC Pts OOP	**2,381~3,969**	**7,938**
Stivarga® (regorafenib)	Pre-NRDL	RMB30,240	RMB30,240
	Post-NRDL	16,464	16,464
	3L CRC Pts OOP	**4,939~8,232**	**16,464**

[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] Frost & Sullivan; [3] Pricing figures represent retail prices paid per patient to Lilly; [4] OOP = out of pocket; [5] PAP = Patient Access Program, subject to qualification criteria; [6] mPFS = median Progression-Free Survival; [7] PRDL = Provincial Reimbursement Drug List; [8] End-2017, 14,968k people covered by Shanghai PRDL including 10,054k employees and 4,914k retirees; Total SH population 24,183k incl. 14,456k local residents & 9,727k external population; [9] pay for 3 cycles x RMB2,860/box x 3 weeks/box = RMB 25,740 (RMB:US$ exchange rate of 6.74:1).

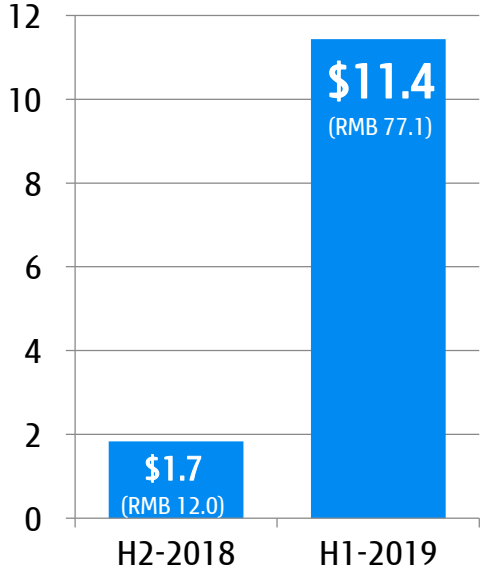
ELUNATE®
Fruquintinib Capsules

H1 2019 performance

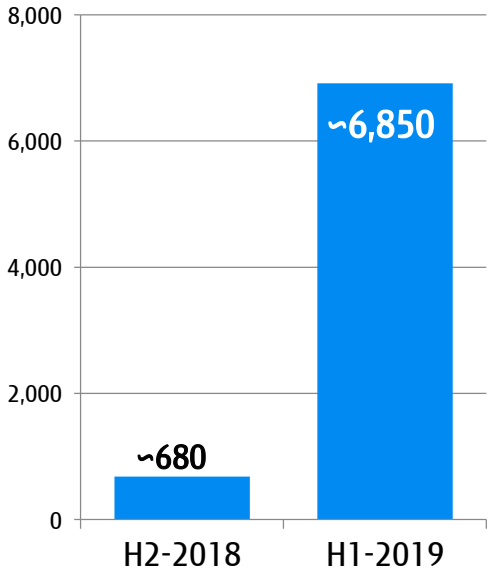
CHI-MED

Elunate® Performance

Sales (millions) [1]



Total Cycles (OOP&PAP) [2]



Chi-Med Revenue (US$ million)

	H2-2018	H1-2019
Manufacturing [3]	$3.3m	$3.0m
Royalty	0.3	1.7
Total HCM Revenue	**3.6**	**4.7**

Elunate® early progress – PAP working but NRDL will provide greater access

[1] Royalties to Chi-Med in H2 2018 and H1 2019 of $0.261m and $1.715m, respectively; at the lowest tier royalty rate of 15%, this implies net sales from third parties to Lilly of $1.7m and $11.4m, respectively; at RMB:US$ exchange rate of 6.87:1 and 6.74:1, respectively, this implies RMB sales of 12m and 77m, respectively; [2] Treatment cycle = 28 day, i.e. assume three x 7 capsule 5mg packs per cycle or five x 21 capsule 1mg packs per cycle; OOP = Out of pocket payment; PAP = Patient access program; [3] Sales of Elunate manufactured by Chi-Med to Eli Lilly.

ELUNATE®
Fruquintinib Capsules

China VEGFR landscape

CHI-MED

Competitive landscape – *small molecule VEGFR TKIs*

Brand	Indication/s	Launch		2011	2012	2013	2014	2015	2016	2017	2018	Q1-2019
STIVARGA® *(regorafenib)* Bayer AG	3L CRC /2L GIST 2L HCC	May 2017 Mar 2018	Sales (US$ million) [1]							5	21	20
			List Price (US$/mo.)							4,368	*NRDL Oct-18*	2,352
NEXAVAR® *(sorafenib)* Bayer AG	Unres. RCC & HCC Diff. Thyroid can.	2006	Sales (US$ million) [1]	80	96	96	93	91	97	108	130	50
			List Price (US$/mo.)						7,250	*NRDL Jul-17*	3,610	3,610
SUTENT® *(sunitinib)* Pfizer	RCC, GIST, pNET	2007	Sales (US$ million) [1]	9	33	41	21	26	29	27	24	7
			List Price (US$/mo.) [4]							5,544	*NRDL Oct-18*	2,498
INLYTA® *(axitinib)* Pfizer	2L adv. RCC	2015	Sales (US$ million) [1]					3	12	16	13	5
			List Price (US$/mo.)							5,957	*NRDL Oct-18*	1,787
VOTRIENT® *(pazopanib)* Novartis	RCC	2017	Sales (US$ million) [1]							5	12	5
			List Price (US$/mo.)							7,891	*NRDL Oct-18*	2,348
AITAN® *(apatinib)* Hengrui	3L Gastric can.	Dec 2014	Sales (US$ million) [2]					~45	~126	219	258	~82
			List Price (US$/mo.)						2,870	*NRDL Jul-17*	1,810	1,810
FOCUSV® *(anlotinib)* Sino Biopharm	3L NSCLC	June 2018	Sales (US$ million) [3]								~190	~83
			List Price (US$/mo.)								*NRDL Oct-18*	981

Elunate® first 6 mo. sales progressing… relative to all MNC VEGFRi China launch sales [5]

[1] Frost & Sullivan; [2] Hengrui 2018 Annual report, dated on Feb 26, 2019; Goldman Sachs Research 2018 & GuoSen Securities research report July 20, 2017; [3] Sinobiopharm 2018 annual report/Citi Research May 2019. Note: Calculations assume at CER, using exchange rate of RMB6.74 per US$1; [4] Sutent® price avg. pre-NRDL $5,544 RCC/GIST, $4,455 pNET; post-NRDL $2,498/$2,007; [5] MNC = multinationals, **Nexavar® Yr.1 sales $18.6m (2007) & Sutent® Yr.1 sales $7.4m (2008).**

ELUNATE®
Fruquintinib Capsules

3rd-line CRC efficacy advantage

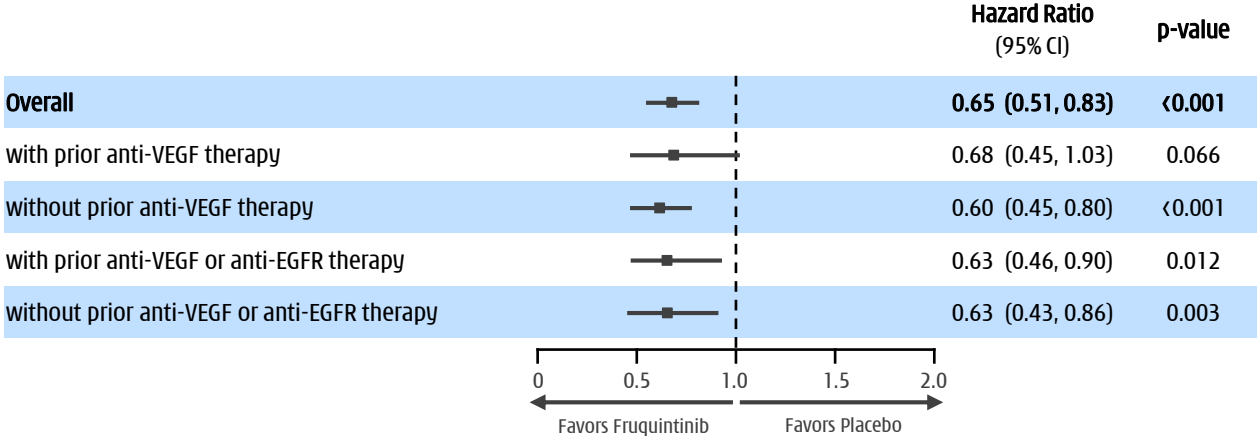
CHI-MED

Third-Line Metastatic Colorectal cancer	FRESCO [1] Mainland China		CONCUR Chinese Patients (Mainland China, Hong Kong, Taiwan) [2]		CONCUR Mainland China, Hong Kong, Taiwan, Vietnam, South Korea		CORRECT Global	
Treatment arms	Elunate®	Placebo	Stivarga®	Placebo	Stivarga®	Placebo	Stivarga®	Placebo
Patients (n)	278	138	112	60	136	68	505	255
Objective Response Rate, n (%)	4.7%	0.0%	3.6%	0.0%	4.4%	0.0%	1.0%	0.4%
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
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

100% Avastin® prior use

- **Advantage for Elunate® efficacy vs. Stivarga® in Chinese metastatic CRC patients;**
- **Advantage for Elunate® post VEGF/EGFR targeted therapy**
  - mOS: 7.69 mo. vs. 5.98 mo. placebo (HR 0.63 & p-value 0.012)
  - mPFS: 3.65 mo. vs. 1.84 mo. placebo (HR 0.24 & p-value <0.001)

Overall Survival subgroup analysis by Prior Treatment [1]



[1] Effect of Fruquintinib vs Placebo on Overall Survival in Patients With Previously Treated Metastatic Colorectal Cancer: The FRESCO Randomized Clinical Trial; [2] Efficacy & safety of regorafenib monotherapy in Chinese patients with previously treated metastatic colorectal cancer: subgroup analysis of the CONCUR trial; R Xu.

Toxicity limitations of Stivarga®

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
$B\text{-}RAF^{V600E}$	›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. (5.1)**
- **Monitor hepatic function prior to and during treatment. (5.1)**
- **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)**

3rd-Line Metastatic Colorectal cancer	FRESCO Study Mainland China [1]		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® superior safety – advantage especially for liver mets patients

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

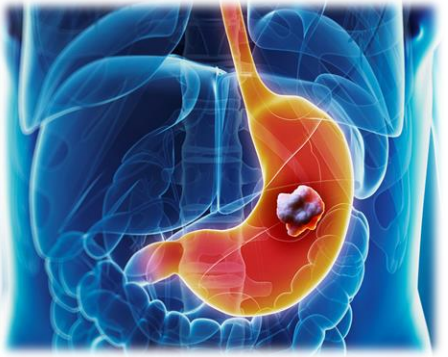
ELUNATE®
Fruquintinib Capsules

CHI-MED

Ongoing trials

Phase III in 2L gastric cancer (FRUTIGA)

- Passed first interim analysis by IDMC, trials continuing per IDMC recommendation;
- On track to complete enrollment Q2 2020.



PD-1 collaborations

- With Innovent (Tyvyt®): dose/regimen finding ongoing;
- With Genor (genolimzumab): dose escalation ongoing;
- Dose expansion expected to kick off starting Q4 2019.

Innovent
Innovent Biologics

嘉和生物药业
Genor Biopharma

Phase II in 1L NSCLC (in combination with Iressa®)

- Study complete and to submit data for presentation at an upcoming scientific conference.

IRESSA®
gefitinib

CHI-MED

AstraZeneca and Chi-Med

Harnessing the power of Chinese Innovation

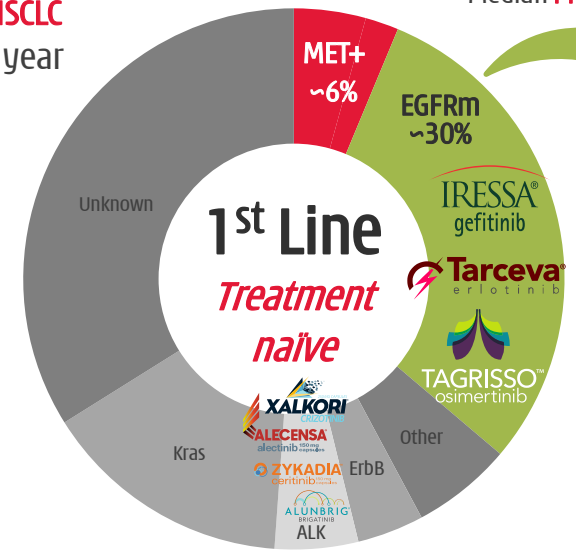
2c **Savolitinib**

Savolitinib

Biggest opportunity is MET+ NSCLC

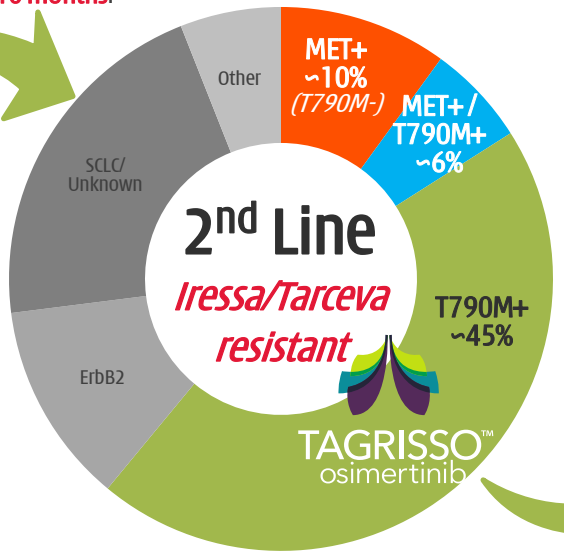
Primary NSCLC

1.8 million NSCLC patients per year



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

Resistance-driven EGFRm+ NSCLC



All **Tagrisso** patients relapse
2L Median **PFS 9-10 months**.

	Target	Launch	2018 ($m)[3]
Iressa	EGFRm	2003	$518m
Tarceva	EGFRm	2004	550
Tagrisso	EGFRm / T790M	2015	1,860
Xalkori	ALK / ROS1 / MET	2011	524
Zykadia	ALK	2015	Not disc.
Alecensa	ALK	2015	650
Total Sales			> 4.1b

Launch	2016	2017	2018	9M 2019
Dec-15	423	955	1,860	2,305 (+82%)

TAGRISSO™ osimertinib

Est. global sales of ~$4-5 bn by 2022[2].

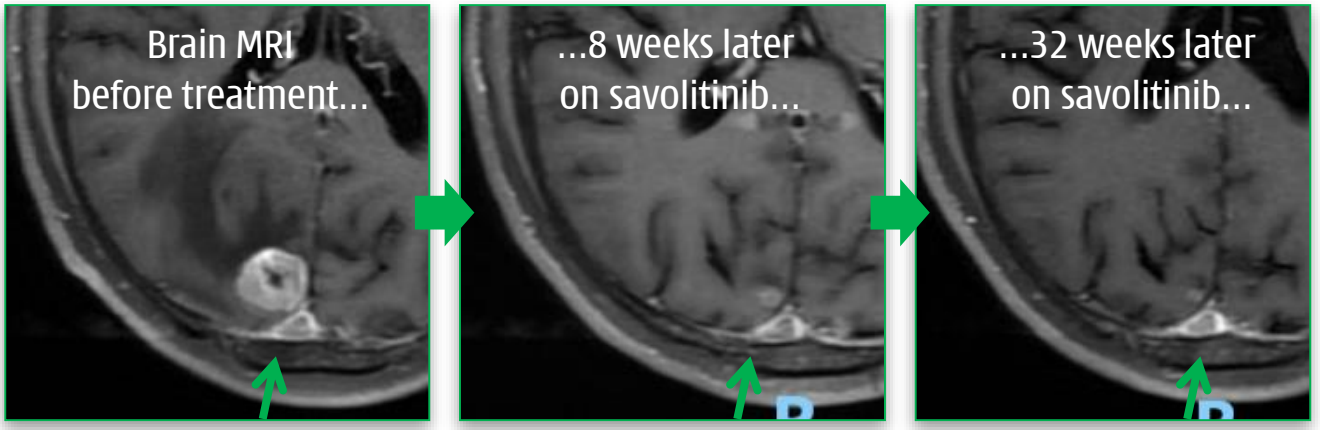
[1] Primary drivers, based on aggregate rocelitinib/Tagrisso data published at 2016/2017 ASCO; [2] Research estimates; [3] company annual reports and Frost & Sullivan.

Savolitinib – MET Exon 14 deletion NSCLC [1]

Potential China NDA submission in 2020 [2]

4. Encouraging MET Exon14d NSCLC study China data at AACR 2019 [3]

- 41 pts; 31 pts efficacy evaluable.
- Promising antitumor activity.
- Rapid, durable tumor response observed.
- Anti-tumor activity observed in brain mets.
- Savolitinib generally well tolerated; most related 1 TEAEs were grade 1 or 2.



5. MET Exon14d NSCLC potential NDA filing 2020 [2]

2019

Mar 31, '19 – Oral AACR Pres.
- 41 patient data

Q4 '19 – Est. topline results available

Jun-Jul '19 – Phase II registration study fully enrolled (n~60)

2020

Potential NDA submission
- CDE[4] discussion
- Final results & potential NDA submission
- Incl. global safety data

6. Savolitinib monotherapy China market opportunity

		Annual Incidence	Estimated mPFS	Pricing Reference
Non-small Cell Lung Cancer [4]	100%	737,400		
MET Exon 14d NSCLC	2%	14,700	TBD	Tagrisso® -- China NRDL
MET gene ampl. NSCLC	2-4%	14,700 - 29,000		
Gastric Cancer	100%	442,300		
MET gene ampl. Gastric Cancer	4-10%	18,000 - 44,000		

Potential first savo monotherapy indication MET Exon14d NSCLC

Two further MET-driven patient populations – savo monotherapy

[1] The trial is focused on patients with MET Exon 14 mutation who have failed prior systemic therapy, or are unable to receive chemotherapy, however the target patient population is intended to be all MET Exon 14 mutation patients; [2] We expect that the Phase II study of savolitinib in MET Exon 14d NSCLC would, if successful, be sufficient to support NDA submission; [3] Data cut-off Feb. 26, 2019. Lu S et al, CT031 - Preliminary efficacy and safety results of savolitinib treating patients with pulmonary sarcomatoid carcinoma (PSC) and other types of non-small cell lung cancer (NSCLC) harboring MET Exon 14 skipping mutations. Presented at American Association of Cancer Research Annual Meeting 2019, Atlanta, GA, Mar. 31, 2019; [4] Center for Drug Evaluation of the National Medicinal Products Administration of China.

TATTON B & D data - efficacy

Tagrisso® + savolitinib in EGFR TKI refractory NSCLC

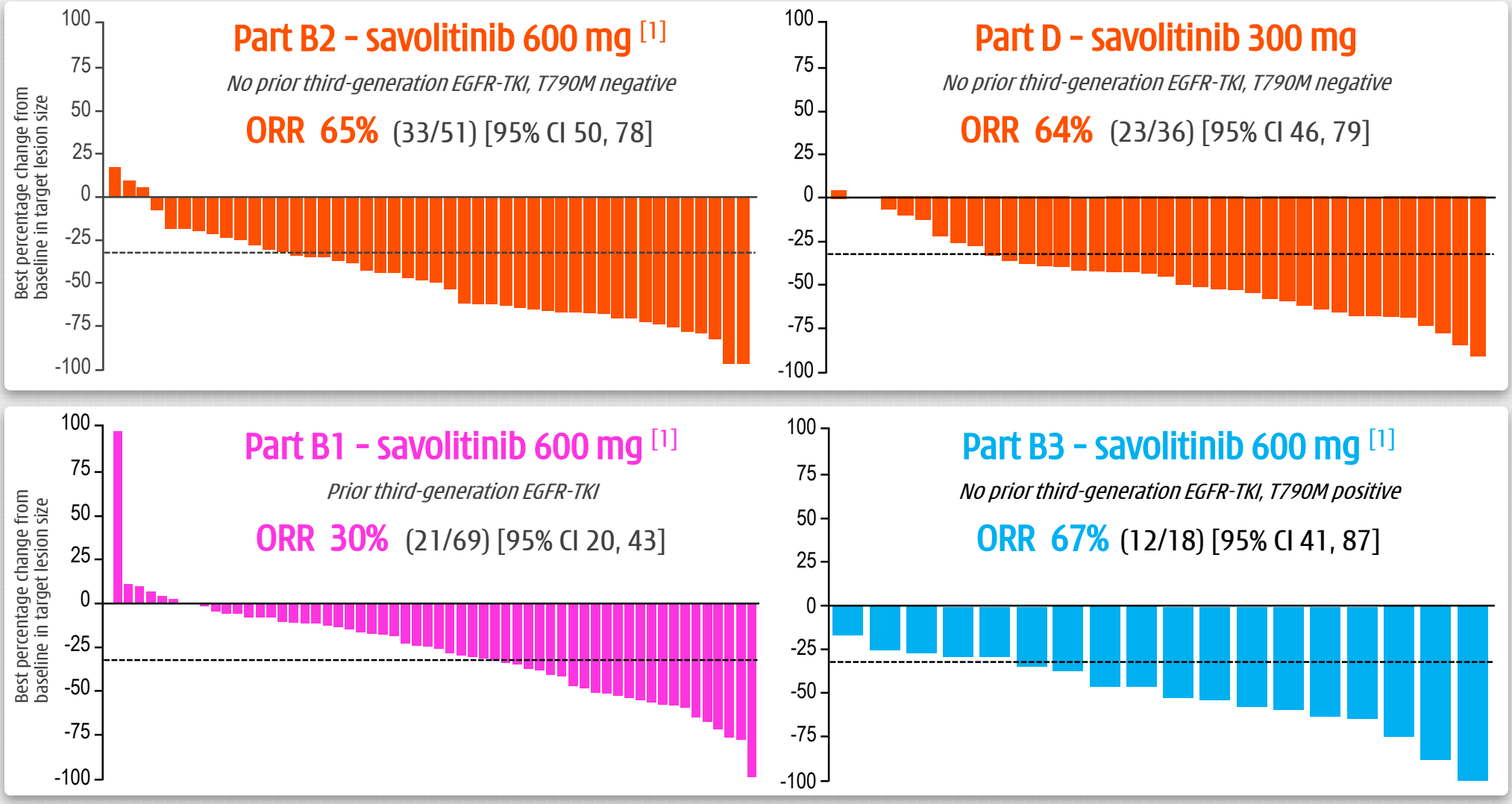
	TATTON Part B osimertinib 80 mg + savolitinib 600 mg [1]			TATTON Part D osimertinib 80 mg + savolitinib 300 mg
	Part B1 (n=69) Prior third-generation EGFR-TKI	**Part B2 (n=51)** No prior third-generation EGFR-TKI (T790M negative)	**Part B3 (n=18)** No prior third-generation EGFR-TKI (T790M positive)	**Part D (n=36)** No prior third-generation EGFR-TKI (T790M negative)
Objective response rate,* % [95% CI]	**30%** [20, 43]	**65%** [50, 78]	**67%** [41, 87]	**64%** [46, 79]
Complete response, %	0	0	0	0
Partial response, %	30%	65%	67%	64%
Non-response, %				
Stable disease (≥ 6 weeks)	45%	24%	33%	28%
Progressive disease	10%	6%	0	3%
Not evaluable	14%	6%	0	6%
Disease control rate,# % [95% CI]	**75%** [64, 85]	**88%** [76, 96]	**100%** [81, 100]	**92%** [78, 98]
Median DoR, months [95% CI]	**7.9** [4.0, 10.5]	**9.0** [6.1, 22.7]	**12.4** [2.8, NR]	**8.0** [4.5, NR]
Median PFS, months [95% CI]	**5.4** [4.1, 8.0]	**9.0** [5.5, 11.9]	**11.0** [4.0, NR]	**9.1** [5.4, 12.9]

No reduction in efficacy with 300mg savo - SAVANNAH converted to 300mg dose

[1] Most patients were enrolled to Part B1, B2, B3 on 600 mg savolitinib, prior to weight-based dosing implementation, but following a protocol amendment in response to a safety signal of hypersensitivity, the final 21 patients enrolled in Part B were dosed with savolitinib by body weight as follows: patients who weighed ≤55 kg (n=8) received 300 mg daily and those weighing >55 kg (n=13) received 600 mg daily; Best response data are for patients who had an opportunity to have two follow-up scans.;
*Complete or partial response confirmed at ≥4 weeks. #Disease control rate = confirmed complete response + confirmed partial response + stable disease at ≥5 weeks.; CI, confidence interval; NR, not reached.

TATTON B & D data - ORR

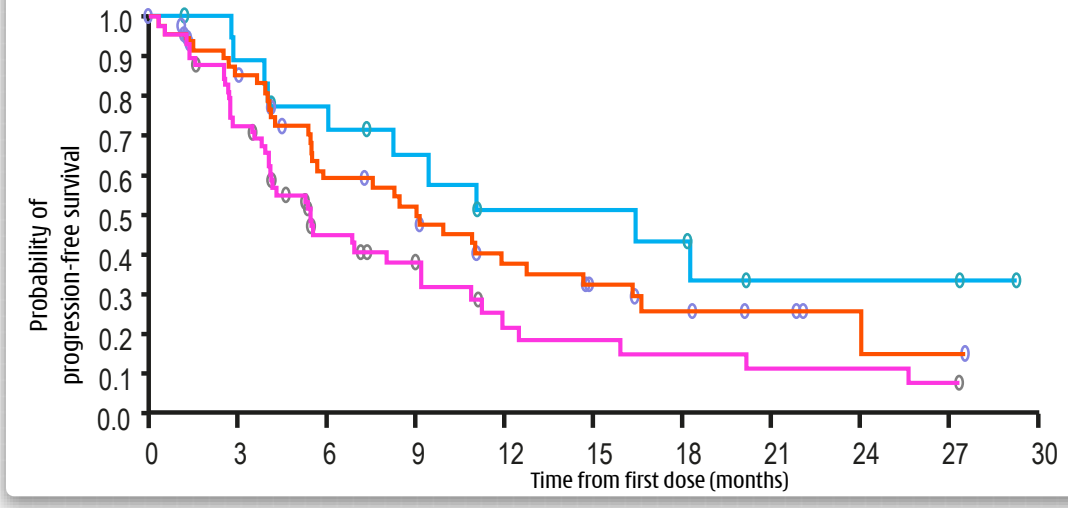
Tagrisso® + savolitinib in EGFR TKI refractory NSCLC



ORR = Objective Response Rate; EGFR = Epidermal Growth Factor Receptor; TKI = Tyrosine Kinase Inhibitor; [1] Most patients were enrolled to Part B1, B2, B3 on 600 mg savolitinib, prior to weight-based dosing implementation, but following a protocol amendment in response to a safety signal of hypersensitivity, the final 21 patients enrolled in Part B were dosed with savolitinib by body weight as follows: patients who weighed ≤55 kg (n=8) received 300 mg daily and those weighing >55 kg (n=13) received 600 mg daily.

TATTON B & D data - PFS

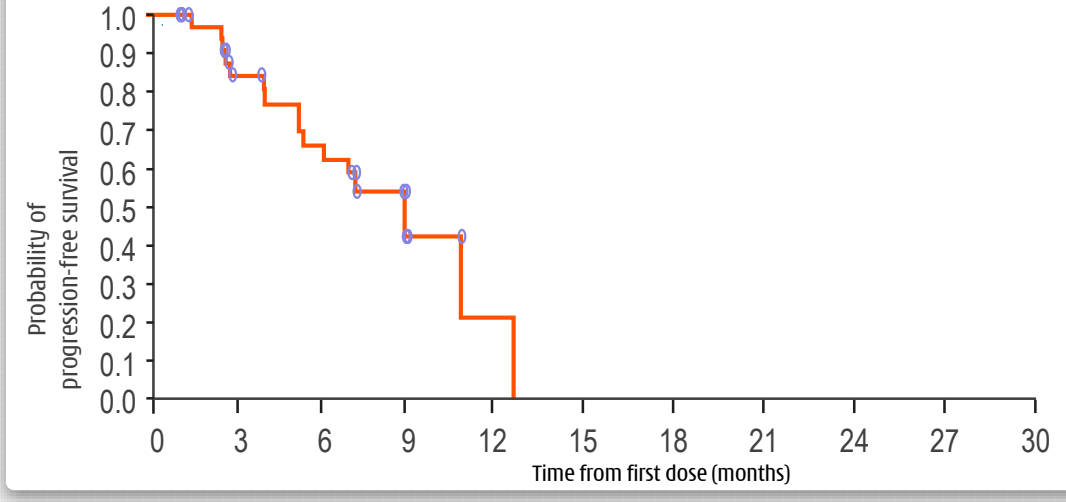
Tagrisso® + savolitinib in EGFR TKI refractory NSCLC



	Median PFS, months [95% CI]	Median (range) duration of follow-up in censored patients, months
Part B1 Prior third-generation EGFR-TKI; (600 mg [1]; n=69)	**5.4** [4.1, 8.0]	**2.6** [0.0-27.3]
Part B2 No prior third-generation EGFR-TKI, T790M negative; (600 mg [1]; n=51)	**9.0** [5.5, 11.9]	**10.1** [0.0-27.5]
Part B3 No prior third-generation EGFR-TKI, T790M positive; (600 mg [1]; n=18)	**11.0** [4.0, NR]	**14.7** [1.2-29.3]

Progression data had a maturity of 62%.

Patients who had not progressed or died at the time of analysis were censored at the time of the latest date of assessment from their last evaluable RECIST assessment. Circles indicate censored observations.



	Median PFS, months [95% CI]	Median (range) duration of follow-up in censored patients, months
Part D No prior third-generation EGFR-TKI, T790M negative; (300 mg; n=42)	**9.1** [5.4, 12.9]	**3.0** [0.0-11.0]

Progression data had a maturity of 40%.

Patients who had not progressed or died at the time of analysis were censored at the time of the latest date of assessment from their last evaluable RECIST assessment. Circles indicate censored observations.

PFS= Progression Free Survival; EGFR = Epidermal Growth Factor Receptor; TKI = Tyrosine Kinase Inhibitor; [1] Most patients were enrolled to Part B1, B2, B3 on 600 mg savolitinib, prior to weight-based dosing implementation, but following a protocol amendment in response to a safety signal of hypersensitivity, the final 21 patients enrolled in Part B were dosed with savolitinib by body weight as follows: patients who weighed ≤55 kg (n=8) received 300 mg daily and those weighing >55 kg (n=13) received 600 mg daily.

TATTON B & D data - AEs & tolerability

Tagrisso® + savolitinib in EGFR TKI refractory NSCLC

Event, n (%)	All Part B (n=138)	Part D (n=42)
Any AE	135 (98)	39 (93)
Any AE possibly related to savolitinib	115 (83)	25 (60)
AE grade ≥3	79 (57)	16 (38)
AE possibly causally related to study treatment leading to discontinuation of:		
Savolitinib	38 (28)	9 (21)
Osimertinib	14 (10)	2 (5)
Any AE leading to death	6 (4)	2 (5)
Any SAE	62 (45)	11 (26)

Part D data are preliminary, therefore, for osimertinib, the mean actual treatment exposure was 8.5 months vs 6.1 months for Parts B and D, respectively, and 7.1 months vs 4.9 months for savolitinib, for Parts B and D, respectively

Han J. et al, "TATTON expansion cohorts: a Phase Ib study of osimertinib plus savolitinib in patients with EGFR-mutant, MET-amplified NSCLC following disease progression on a prior EGFR-TKI", #LBA, ESMO Asia, Singapore, November 23, 2019;

TATTON B & D data - AEs & SAEs

Most common AEs[1] independent of causality & SAEs (≥3%)[2]

AE*, n (%)	All Part B (n=138)		Part D (n=42)	
	All grades	Grade ≥3	All grades	Grade ≥3
Nausea	67 (49%)	4 (3%)	13 (31%)	0
Fatigue	48 (35)	6 (4)	4 (10)	0
Decreased appetite	47 (34)	5 (4)	6 (14)	1 (2)
Vomiting	46 (33)	6 (4)	5 (12)	0
Oedema peripheral	44 (32)	3 (2)	8 (19)	0
Diarrhoea	39 (28)	4 (3)	8 (19)	2 (5)
Paronychia	30 (22)	3 (2)	7 (17)	0
Pyrexia	29 (21)	1 (1)	6 (14)	0

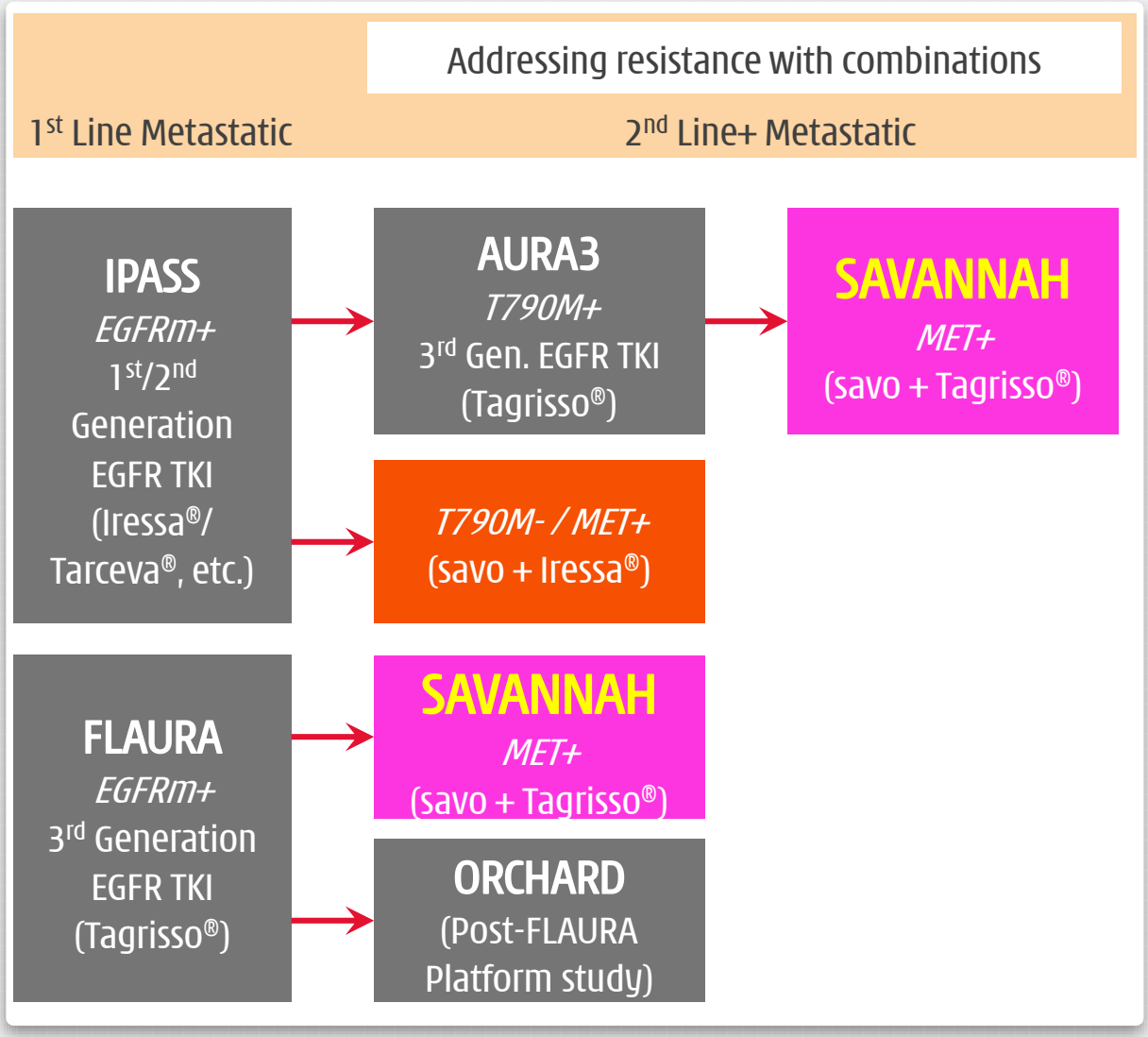
AE*, n (%)	All Part B (n=138)		Part D (n=42)	
	All grades	Grade ≥3	All grades	Grade ≥3
Rash	26 (19%)	3 (2%)	8 (19%)	0
Stomatitis	26 (19)	0	4 (10)	0
Constipation	26 (19)	0	3 (7)	0
Pruritus	24 (17)	1 (1)	5 (12)	0
Headache	23 (17)	0	3 (7)	0
Myalgia	22 (16)	3 (2)	6 (14)	1 (2)
Cough	22 (16)	0	4 (10)	1 (2)
AST increased	21 (15)	9 (7)	2 (5)	0
Pneumonia	15 (11)	7 (5)	7 (17)	5 (12)

SAE**, n (%)	All Part B (n=138)	Part D (n=42)
Pneumonia	5 (4%)	4 (10%)
Anaphylactic reaction	6 (4)	1 (2)
Pneumothorax	6 (4)	1 (2)
Pyrexia#	5 (4)	0
Dyspnoea	5 (4)	0
Drug hypersensitivity	4 (3)	1 (2)
Diarrhoea	4 (3)	1 (2)
Back pain	4 (3)	0
Pulmonary embolism	3 (2)	2 (5)

[1] ≥15% in either Part B or Part D for all grades; [2] ≥3% in either Part B or Part D for all grades. #The emergence of drug-related hypersensitivity AEs are characterised by events such as pyrexia; The emergence of hypersensitivity and anaphylaxis events led to a protocol amendment introducing a weight-based savolitinib dosing regimen (for the last group of patients enrolled in Part B) in parallel to the lower dose of savolitinib (300 mg) being tested (for all patients enrolled in Part D)

SAVANNAH Study

Encouraging TATTON data - led to the initiation of SAVANNAH



SAVANNAH *(NCT03778229)*

Phase II single-arm study:

- Global - N. & S. America, Eur., & Asia.
- Primary endpoint ORR.
- Secondary endpoints: PFS, OS, DoR & percent change in tumor size.
- Primary data completion est. 2021.

Weight-based dosing regimen:

- TATTON D - exploring lower savo dose in order to maximize long-term tolerability for combo.
- TATTON D enrollment complete.

ORCHARD study:

- Post FLAURA Platform study offering targeted treatments for all patients - expect high enrollment.
- MET+ patients prioritize to SAVANNAH.

Savolitinib + Imfinzi® combination

1. Could MET + PD-L1 inhibition be synergistic?

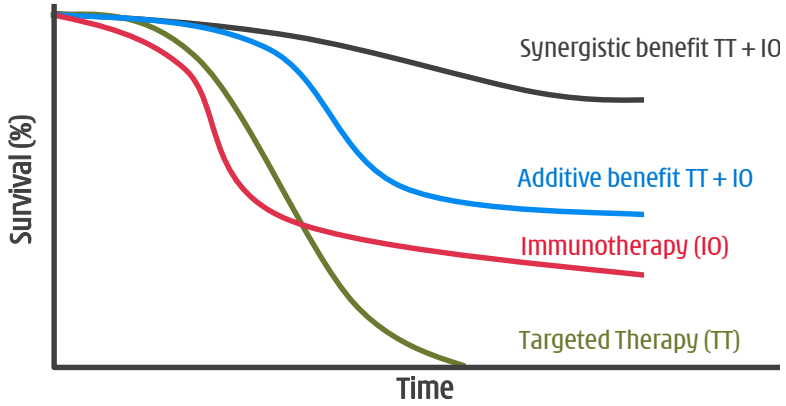
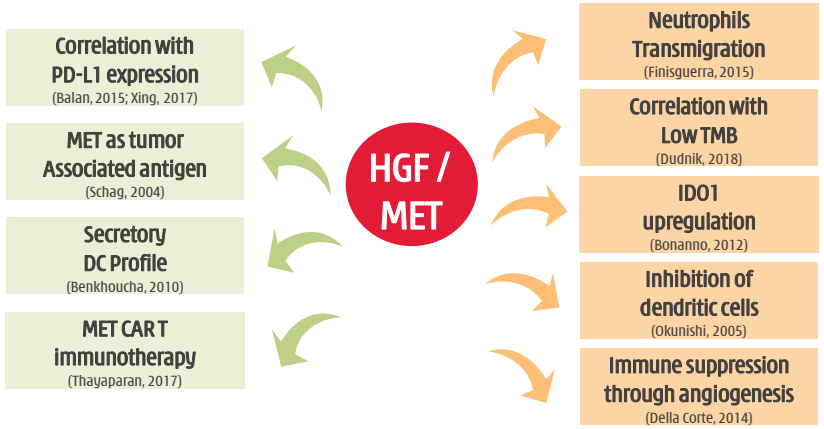


Illustration by Tracy L Rose MD MPH at ASCO GU 2019 presentation, showing what synergistic vs additive benefit could hypothetically look like; not based on clinical data.

2. MET/HGF complex interplay with immune system.



Papaccio et al Int J Molec Sciences, 2018; 19(3595)

3. PD-1/PD-L1s important in non-ccRCC but need to see mature mPFS/mOS & further biomarker analysis [1]

MET+ Papillary RCC (~$1.0b)
~8% of RCC
~ 28k new patients/yr.

MET- Papillary RCC (~$1.0b)
~8% of RCC
~ 28k new patients/yr.

Other non-ccRCC (~$0.6b)
~5% of RCC
~ 16k new patients/yr.

Savo mono.
All lines: (n=44)
ORR 18.2%
DCR 73.2%
mPFS 6.2 mo.

Keytruda® mono.
First line: (n=118)
ORR 25.4%
DCR 43.2%
mPFS na

Savo + Imfinzi®
All lines: (n=41)
ORR 26.8%
DCR na
mPFS 5.3 mo.
First line: (n=28)
ORR 32.1%
DCR na
mPFS na
Interim Data

Tecentriq® + Avastin®
All lines: (n=39)
ORR 25.6%
DCR na
mPFS na
Not confirmed ORR

Keytruda® mono. (all nRCC)
First line: (n=165)
ORR 24.8%
DCR 40.6%
mPFS 4.1 mo.

[1] KEYNOTE 427 (Cohort B) ASCO GU 2019 D. McDermott; CALYPSO (PRCC cohort) ASCO GU 2019 C. Suarez; Abstract 548 (244057) ASCO GU 2019 R.McKay; ORR = Objective Response Rate; DCR Disease Control Rate; mPFS = median Progression-Free Survival.

CHI-MED

3 H1 2019 Financial Results, Cash & Guidance

H1 2019 Financial results

R&D expense accelerated to $74.5m in first 6 months

Global Innovation

China Oncology

Existing China Business

	2018	H1-18	H1-19	Growth	at CER [2] (Non-GAAP)
GROUP REVENUES	**214.1**	**102.2**	**102.2**	**-**	**+5%**
Unconsolidated JV Revenues	*491.5*	*271.7*	*276.9*	*+2%*	*+8%*
SEGMENT NET INCOME/(LOSS) [1]					
INNOVATION PLATFORM	**(102.4)**	**(52.9)**	**(63.8)**	**-21%**	**-29%**
COMMERCIAL PLATFORM	**41.4**	**26.9**	**27.7**	**+3%**	**+9%**
Prescription Drugs Business	*32.1*	*20.8*	*21.8*	*+5%*	*+11%*
Consumer Health Business	*9.3*	*6.1*	*5.9*	*-4%*	*+2%*
Chi-Med Group Costs	(13.8)	(6.7)	(9.3)	-39%	-39%
GROUP NET LOSS [1]	**(74.8)**	**(32.7)**	**(45.4)**	**-39%**	**-48%**
EPS Attrib. to Ord. S-H (Basic) (US$)	*(0.11)*	*(0.05)*	*(0.07)*		

[1] Net Income / (Loss) attributable to Chi-Med; [2] at CER = at Constant Exchange Rate, which is a non-GAAP financial measure used to present period-to-period comparisons without the effects of currency movements by retranslating the current period's performance at the previous period's foreign currency exchange rates. Please refer to the slides titled "Non-GAAP Financial Measures and Reconciliation" for more information and a reconciliation of these measures to the most comparable GAAP measure.

(US$ millions, except per share data)

Cash position & 2019 Guidance

$384 million in available cash resources [1]

Cash Position
(at end June 2019)

- **$237 million cash** / cash equiv. / Short term inv. [2]
- **$147 million** additional unutilized banking facilities [3]
- **$64 million** additional cash in JVs

- **$0 million** in bank borrowings

Global Innovation

China Oncology

(US$ millions)	2019 Guidance
Research & Development Expenses	(130) - (170)
Adj. (non-GAAP) Group Net Cash Flows [4]	(90) - (120)

- **Flexibility on timing of future financing activity**:
  - Sufficient resources to advance pipeline through multiple major value inflection points;
  - Non-dilutive finance from non-core CP divest. [5]

[1] Including cash, cash equivalents, short-term investments & unutilized banking facilities; [2] Short-term investments: deposits over 3 months; [3] From Bank of America Merrill Lynch, Deutsche Bank, Hong Kong Shanghai Banking Corporation; [4] Adjusted (non-GAAP) Group net cash flows excluding financing activities. Please refer to the slides titled "Use of Non-GAAP Measures and Reconciliation" for more information and a reconciliation of these measures to the most comparable GAAP measure; [5] Potential for non-dilutive finance derived from the disposal of certain non-core Commercial Platform assets.

CHI-MED

4 Summary

What is next from discovery?

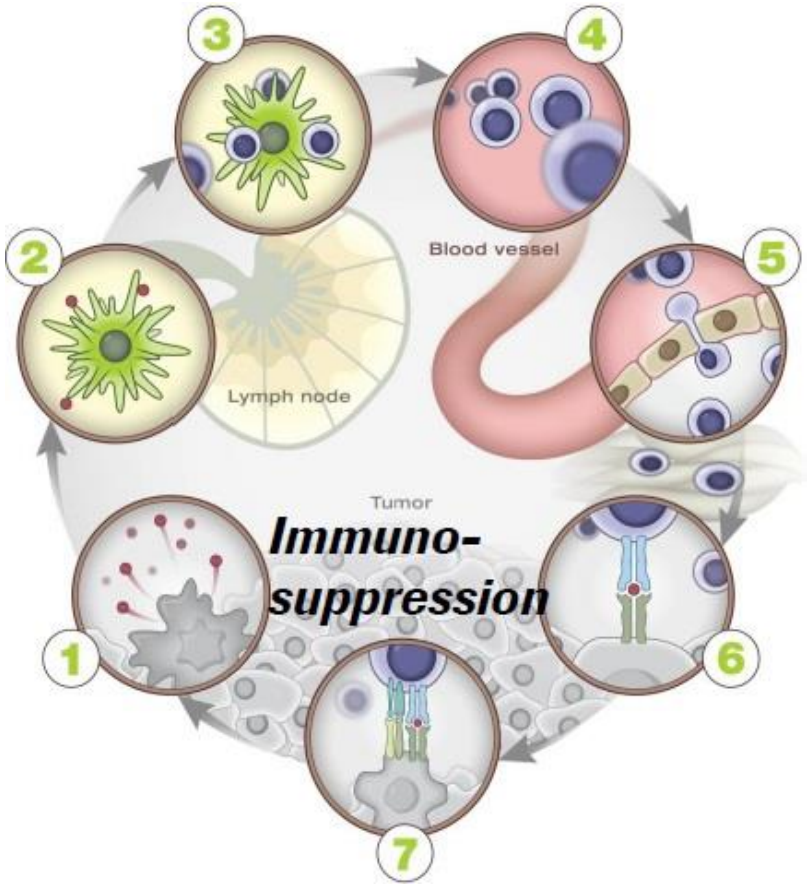
Differentiated assets against multiple targets

Priming & activations

- aOX40
- 4-1BB

Antigen release

- MET (savolitinib)
- EGFR (epitinib/theliatinib)
- Syk (HMPL-523)
- PI3Kδ (HMPL-689)
- FGFR (HMPL-453)
- IDH 1/2 (HMPL-306)
- ERK
- RIP1K



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).

Objectives for existing assets 2019-2021

Global Innovation

- **NDA submission** for savolitinib combo with Tagrisso®
- **Expand savo. Exon14 deletion** development global
- **2 compounds to enter registration studies** in 2020, surufatinib & fruquintinib
- **Proof-of-concept achieved** on both Syk & PI3Kδ compounds

China Oncology

- **Establish Elunate® as best-in-class** VEGFR TKI in >$5bn market by 2026 [1]
- **2 new NDAs in '19/'20**, suru. ep-NET & savo. Exon14d NSCLC
- **2 more compounds into registration trials** in 2020, Syk & PI3Kδ
- **Expanded life cycle development** on all assets, incl. PD-1 combos

Existing China Business

- **Cash generative** China Commercial Platform
- **Platform for future** innovative drug launches

[1] Frost & Sullivan.

Chi-Med in short

19-year track record of achievement & discipline

- **In-house discovery excellence** – world-class scientific talent & strategy – discovery platform that has created all clinical assets internally;
- **Proven development** – the first China company to bring home-grown asset to market[1];
- **Commercial excellence** – deep knowhow & infrastructure in China – profitable.

Risk-balanced – non-binary biotech

- **Multiple shots-on-goal** – 9 novel drug candidates[2] – two proven through pivotal studies[3];
- **World-class partnerships** – AstraZeneca & Eli Lilly – as well as wholly-owned assets.

Ambition

- **Building a global science-focused biopharma company from an established base in China.**

[1] unconditional approval; [2] including HMPL-306 currently under IND review; [3] Fruquintinib in CRC; Surufatinib in non-pancreatic NET.

CHI-MED

HUTCHISON CHINA MEDITECH

Thank you

CHI-MED

Appendix

CHI-MED

A1a

Strategies – Global Innovation

Pushing the envelope on our most valuable assets

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

Global step-change innovation

- *Aiming for multiple potential first-in-class assets*

Kinase selectivity – enable combos

- *Limit off-target toxicity & address TKI resistance*

Discovery of broad range of assets against novel targets

Note: I/O = immuno-oncology; mAb = monoclonal antibody; TKI = tyrosine kinase inhibitor.

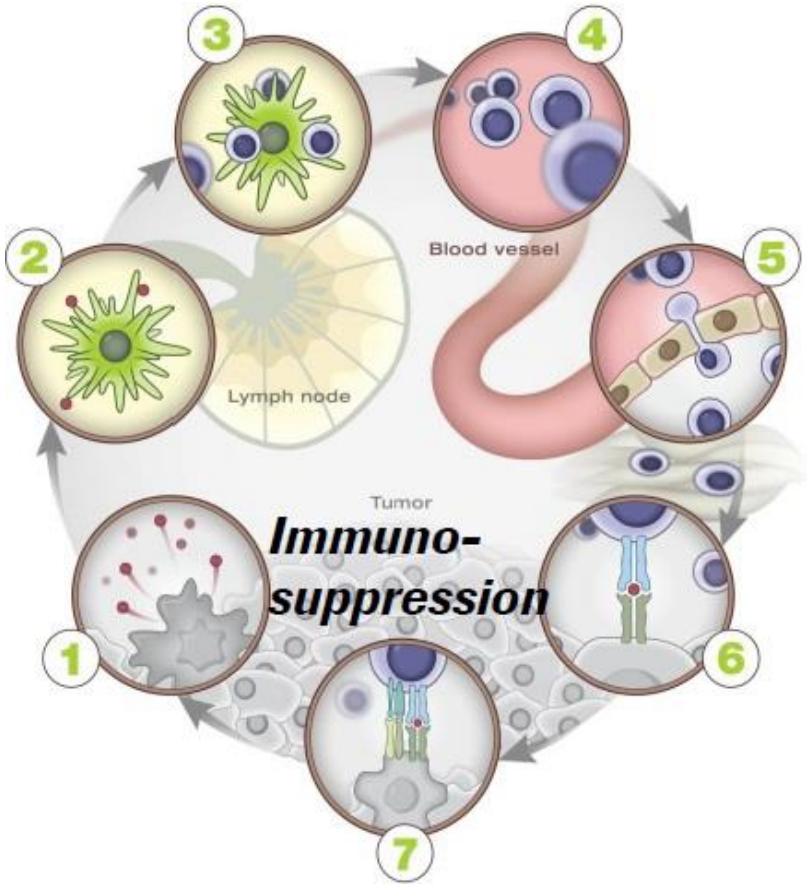
Attack cancer from multiple angles at same time

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

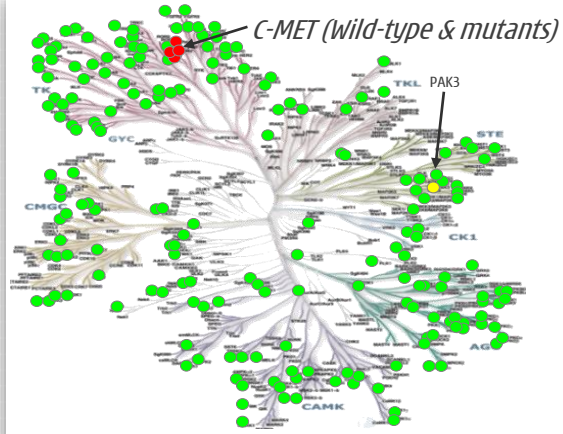
Inflamed
Inactivated T cell response

- Immunotherapies (address negative regulators)
- Vaccines

Need combinations of potent, yet tolerable drugs against specific targets

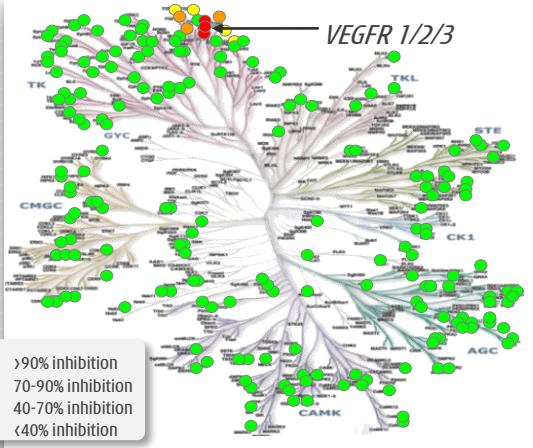
Note: Adapted from Chen DS et al. Oncology Meets Immunology: The Cancer-Immunity Cycle. Immunity, Volume 39, Issue 1, 1 - 10.

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 PRCC (for reference only – not NSCLC) [2]	9%	5%	**14%**
Combination – Tagrisso® + savolitinib			
savolitinib 600mg QD + **Tagrisso®** [3]	29%	6%	**35%**
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] 2019 AACR # CT032, CT033; [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

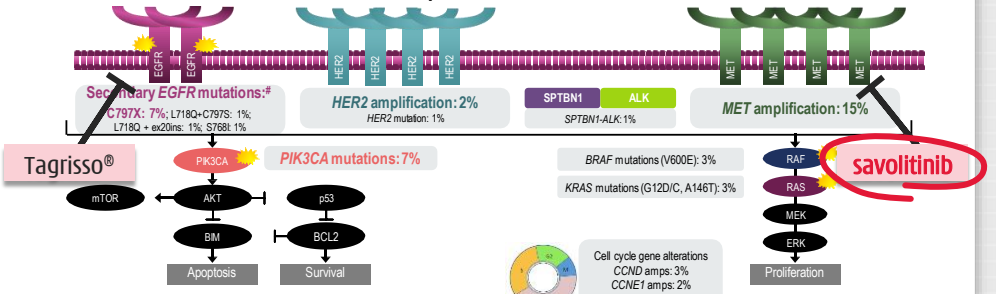
CHI-MED

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

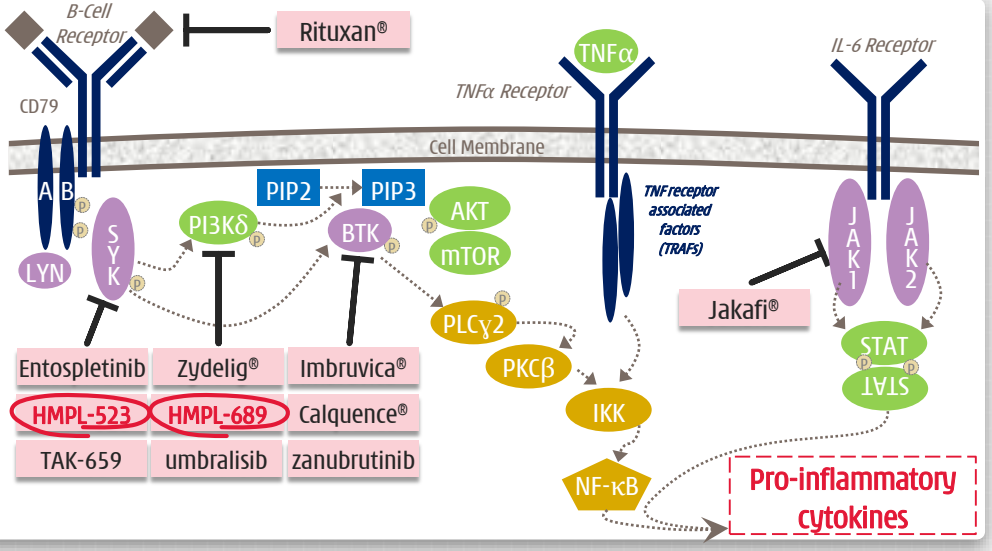


MUNICH 2018 ESMO congress

*Resistance mechanism reported may overlap with another; #Two patients had de novo T790M mutations at baseline of whom one acquired C797S at progression

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

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 MET	**Savolitinib** + Tagrisso®	NSCLC	2L/3L EGFRm; Tagrisso® ref.; MET+	SAVANNAH	Global	Oxnard/Ahn – DF/SMC		
	Savolitinib + Tagrisso®	NSCLC	2L EGFRm; EGFR TKI ref.; MET+	TATTON	Global	Oxnard – Dana Farber		
	Savolitinib + Imfinzi® (PD-L1)	Papillary RCC	All	CALYPSO	UK/Spain	Powles – Queen Mary's		
	Savolitinib + Imfinzi® (PD-L1)	Clear cell RCC	VEGFR TKI refractory	CALYPSO	UK/Spain	Powles – Queen Mary's		
	Savolitinib	Gastric cancer	MET+	VIKTORY	S Korea	Lee – Samsung Med. Ctr		
	Savolitinib + Taxotere®	Gastric cancer	MET+	VIKTORY	S Korea	Lee – Samsung Med. Ctr [1]		
	Savolitinib + Taxotere®	Gastric cancer	MET over-expression	VIKTORY	S Korea	Lee – Samsung Med. Ctr [1]		
	Savolitinib	Prostate cancer	MET+	CCTG I234B	Canada	Kolinsky/Muk'jee/Ong/Chi		
Fruquintinib VEGFR 1/2/3	**Fruquintinib**	Colorectal cancer	3L/4L; Stivarga®/Lonsurf® ref./intol.		US	Eng /Desari – MD And. [2]		
	Fruquintinib + Tyvyt® (PD-1)	Solid tumors			US	In planning		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	Pancreatic NET	2L; Sutent®/Afinitor® refractory		US	Dasari/Yao – MD Anderson		
	Surufatinib + Tuoyi® (PD-1)	Solid tumors				In planning		
HMPL-523 Syk	**HMPL-523**	Indolent NHL			Australia			
	HMPL-523	Indolent NHL			US	Fowler – MD Anderson		
HMPL-689 PI3Kδ	**HMPL-689**	Healthy volunteers			Australia			
	HMPL-689	Indolent NHL			US	Ghosh/Cohen – Levine/Emory		

TATTON B/D Data ESMO Asia Nov 2019

Prelim. PoC at ASCO GU Feb 2019

Prelim. PoC H2 2019

Planning US/EU registr. study based on FRESCO/US Ph.Ib

Planning US/EU registr. study based on China Ph.II/US Ph.Ib

Global Ph.I/PoC data-set now at n ›140

Data-set now emerging in China Ph.I (n ~40)

[1] Further patient enrollment directed to savolitinib monotherapy arm due to the high efficacy observed; [2] in U.S., in E.U. Tabernero – Vall d'Hebron & Sobrero – Genova.

Note: MET = mesenchymal epithelial transition receptor, VEGFR = vascular endothelial growth factor receptor, EGFRm = epidermal growth factor receptor mutation, FGFR1 = fibroblast growth factor receptor 1, CSF-1R = colony stimulating factor-1 receptor, Syk = spleen tyrosine kinase, PI3Kδ = Phosphatidylinositol-3-Kinase delta, NSCLC = non-small cell lung cancer, RCC = renal cell carcinoma, NHL = Non-Hodgkin's Lymphoma, AACR = American Association of Cancer Research annual meeting, ASCO GU = American Society of Clinical Oncology Genitourinary Cancer Symposium , PoC = Proof of Concept.

Global Innovation

Main targets for 2019-2021

- **Aim for Savolitinib / Tagrisso® combo NDA submission**

- **Build out US/EU development operation**
  - *US/EU C&R operation set up in Florham Park, NJ*

- **Accelerate development of 4 un-partnered global assets**
  - *Fruq (ex-China) & suru registration studies & exploration of combos with PD-1s;*
  - *Syk & PI3Kδ registration studies & exploration of combos with other TKIs*

- **Aim to continue to move novel drug candidates into global development each year**

CHI-MED

A1b

Strategies – China Oncology

Next-gen oncology drugs to meet major needs in China

China oncology - ~24% of world's cancer patients[1]

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

- *Regulatory reforms in China - addressing low SoC [2]*
- *Major investment inflow*

Chi-Med is a first mover

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

Major commercial opportunity

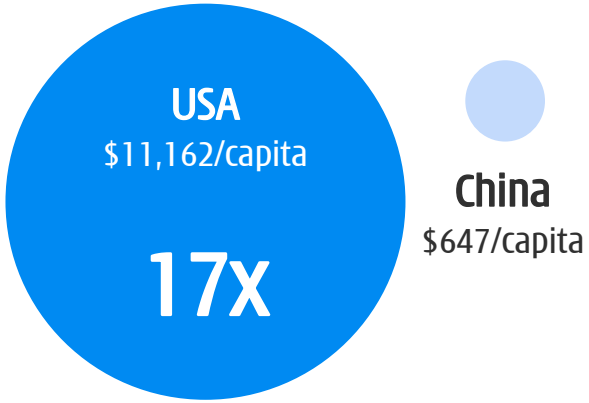
- *National Drug Reimbursement; Medical coverage*

[1] Global Cancer Observatory, WHO, ACS, NCCR, Frost & Sullivan analysis;
[2] SoC = Standard of Care; [3] Believed to be the first ever China-discovered novel oncology drug to receive full NDA approval in China.

China now world's 2nd largest pharma market

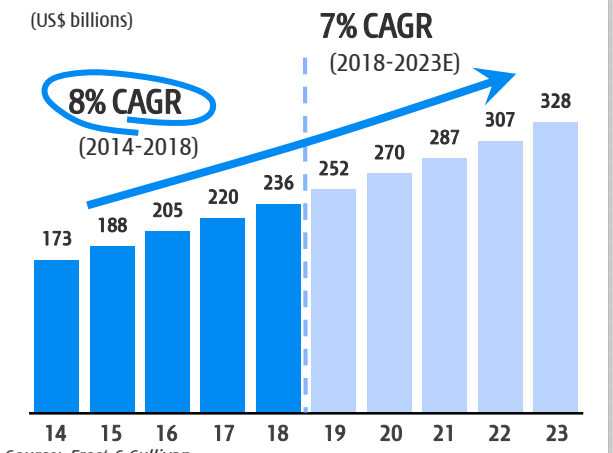
...investment, approvals & access all accelerating rapidly

Per Capita Healthcare Spending



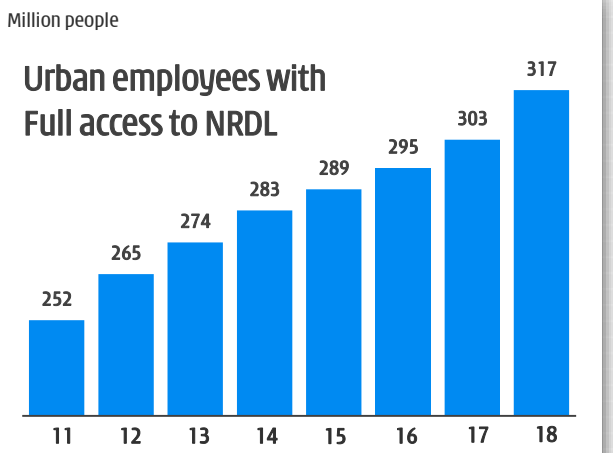
Source: Frost & Sullivan (2018)

PRC Pharmaceutical Market Size

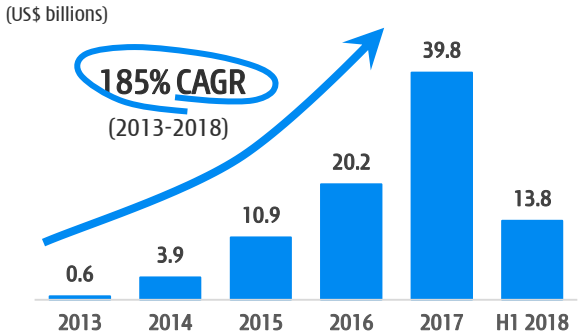


Source: Frost & Sullivan

Medical Insurance Coverage [1]

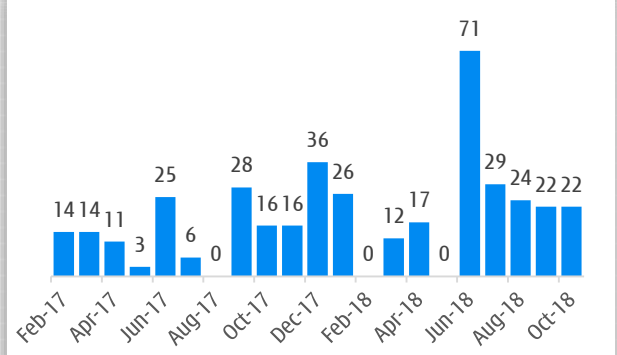


PRC Healthcare VC/PE Funds [2]



Source: McKinsey; ChinaBio 2018 report

Number of Priority Review NDAs [3]



Source: McKinsey; National Medical Products Administration

Improved Access since 2017

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

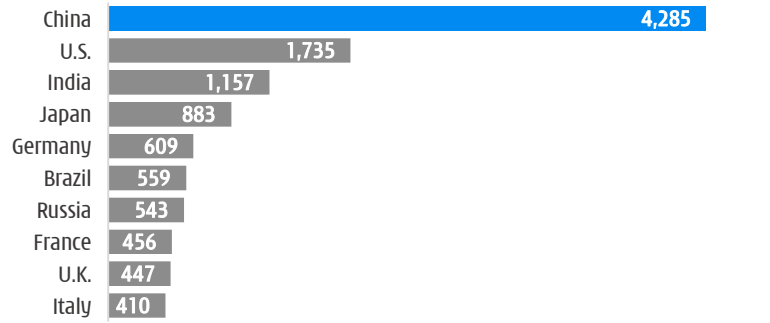
Source: McKinsey

[1] Urban Basic Medical Care Insurance (for both employees & residents) - total persons covered at year-end. National Bureau of Statistics (2017); includes rural residents from 2017 and beyond; [2] Funds raised; [3] NDA = New Drug Application. Note: CAGR = Compound annual growth rate.

Cancer is a major unmet need in China

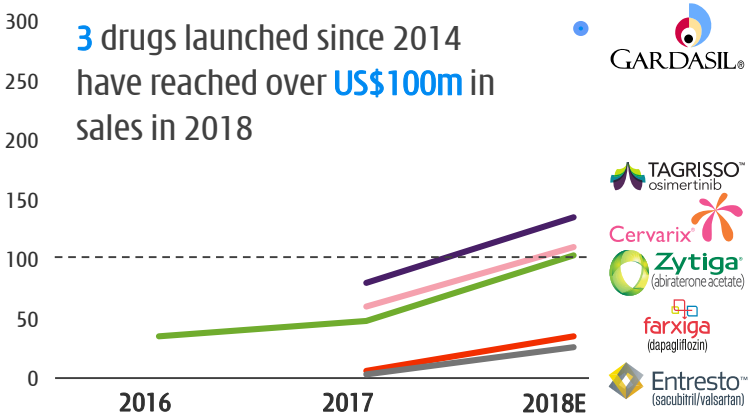
...investments in launches/access starting to have an impact

Cancer Incidence in China (2018)



Source: Global Cancer Observatory, WHO (Incidence '000s)

Rapid uptake of new launches in China



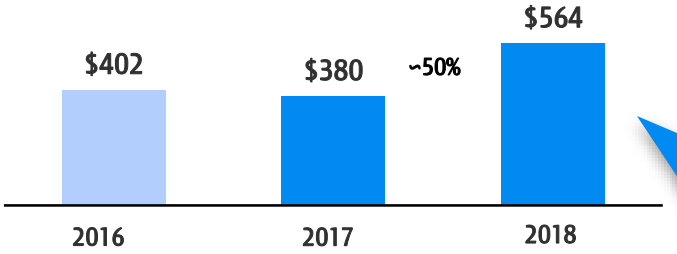
Source: McKinsey; RDPAC 2018 estimated based on Q3 RDPAC data

Novel drugs post NRDL inclusion

Herceptin® trastuzumab

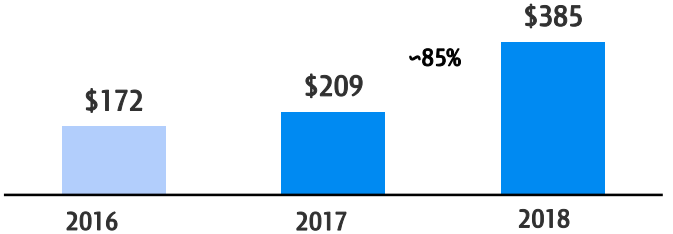
(Bar Chart US$ millions)

Price per cycle: US$4,505 **-66%** US$1,538 (RMB10,364)



AVASTIN® bevacizumab

Price per cycle: US$11,608 **-62%** US$4,447 (RMB29,970)



Major Increases in Access, Volume & Penetration

Source: McKinsey; RDPAC ex-manufacturer sales 2016-2018. Frost & Sullivan. Price per cycle assumptions: Herceptin 440mg 20ml, ~RMB22,267 avg tender price, RMB7,600 NRDL price; Avastin 100mg/4ml, ~RMB5,216 avg tender price, RMB1,998 NRDL price. US$ figures based on calculations assuming a constant exchange rate of US$1 = RMB6.74.

8 assets in China development

...fruq launched – savo/suru NDAs & Syk/PI3Kδ PoC ahead

Program	Treatment	Indication	Target patient	Study name	Sites	Dose find / safety run-in	Proof-of-concept	Registration
Savolitinib 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 + Taxol®	Gastric cancer	2L	FRUTIGA	China	Xu Ruihua – Sun Yat Sen		
	Fruquintinib	NSCLC	3L; chemotherapy refractory	FALUCA	China	Lu Shun – SH Chest Hosp.		
	Fruquintinib + Iressa®	NSCLC	1L EGFRm		China	Lu Shun – SH Chest Hosp.		
	Fruquintinib + Tyvyt® (PD-1)	Solid tumors			China	Bai Yuxian – Harbin Med. U.		
	Fruquintinib + genolimzumab (PD-1)	Solid tumors			China	Li Jin – Fudan Univ.		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	Pancreatic NET	All	SANET-p	China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib	Non-Pancreatic NET	All	SANET-ep	China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib	Biliary Tract cancer	2L; chemotherapy refractory		China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib + Tuoyi® (PD-1)	Solid tumors			China	Shen Lin – BJ Univ. Tmr.		
HMPL-523 Syk	**HMPL-523** + azacitidine	Acute Myeloid Leuke.	1L		China	Wang/Qi – CN Hem. Hosp.		
	HMPL-523	B-cell malignancies	All		China	Multiple leads by sub-types		
	HMPL-523	ITP	All		China	Yang – CN Hem. Hosp.		
HMPL-689 PI3Kδ	**HMPL-689**	Indolent NHL			China	Cao/Zhou – Fudan/ Tongji		
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 [1]		
HMPL-453 FGFR 1/2/3	**HMPL-453**	Solid tumors			China	Xu Ruihua – SYS		

Enrolled n ›70

Launched Nov 2018

Interim OK April 2019

ESMO Asia Nov 2019

Interim H1 2020

NDA accepted Nov 2019

Planning China Ph.II/III in several iNHL types Ph.Ib data now n ›140

Data-set emerging in China Ph.I (n ~40)

[1] Discontinued. ITP = immune thrombocytopenic purpura; PoC= proof of concept.

China Oncology

Main targets 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;*
- *Expand Oncology Commercial Organization in China*

Savolitinib NDA in MET Exon 14 NSCLC

Progress development pipeline

- *Syk & PI3Kδ into registration studies & aim to establish PoC for epitinib, theliatinib & FGFR;*
- *Aim for further novel drug candidates into early development each year*

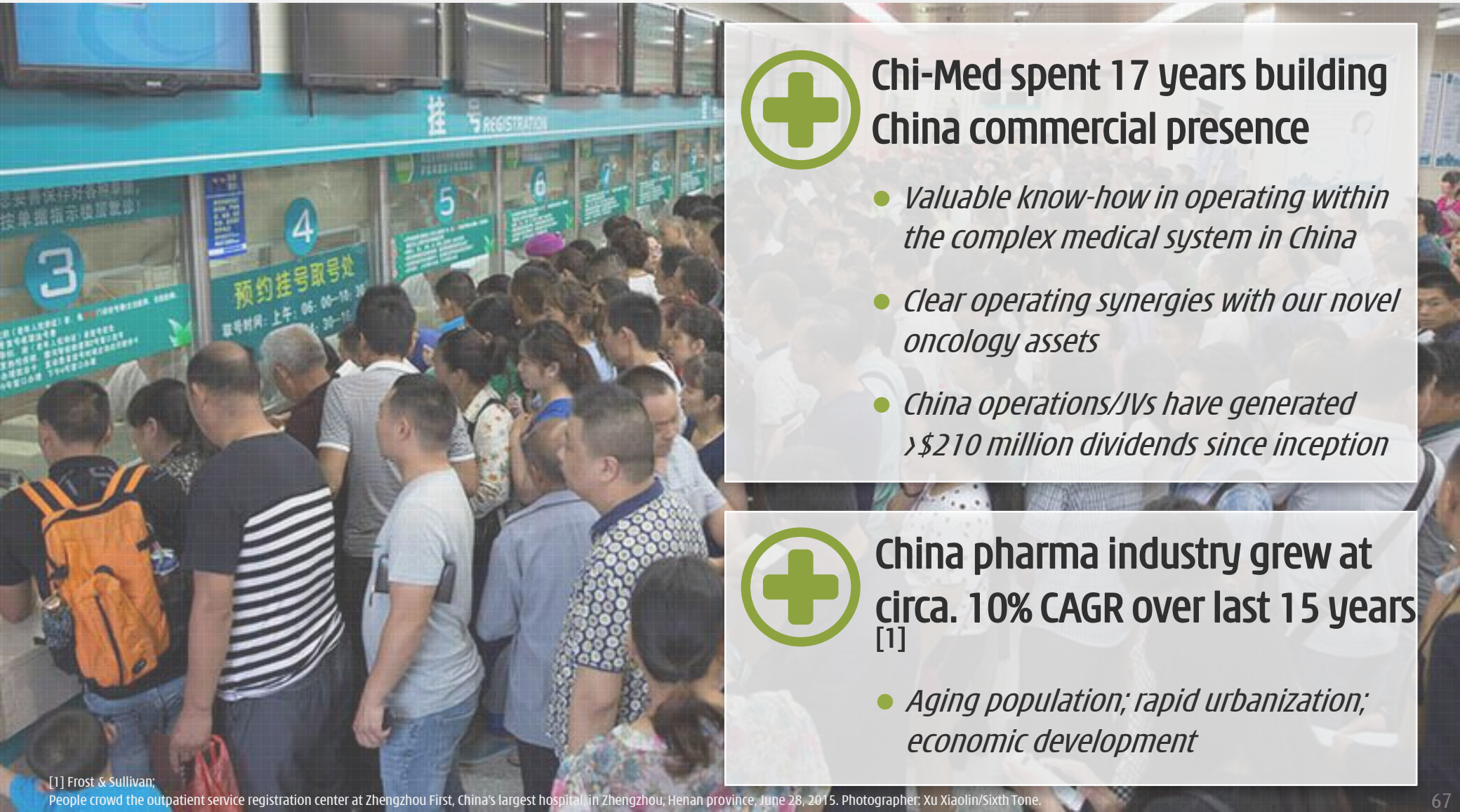
CHI-MED

A1c

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 >$210 million dividends since inception*

China pharma industry grew at circa. 10% CAGR over last 15 years [1]

- *Aging population; rapid urbanization; economic development*

[1] Frost & Sullivan;
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

白云山

上药牌

Major Commercial & Production Scale

›2,400 RX & ~900 OTC sales people in over 330 [1] cities & towns in China.

Drugs in ~24,400 hospitals detailing ~88,400 doctors.

Sold ~4.8 billion doses of medicine in 2018.

Leadership Market Shares

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

SXBX pill:[3][4] Rx Cardiovascular TCM	~17%
Banlangen:[5] OTC Anti-viral /flu TCM	~54%
FFDS tablet:[6] OTC Angina TCM	~38%

JVs with 3 Major China Pharmas

SPH 上海医药 SHANGHAI PHARMA

GPC

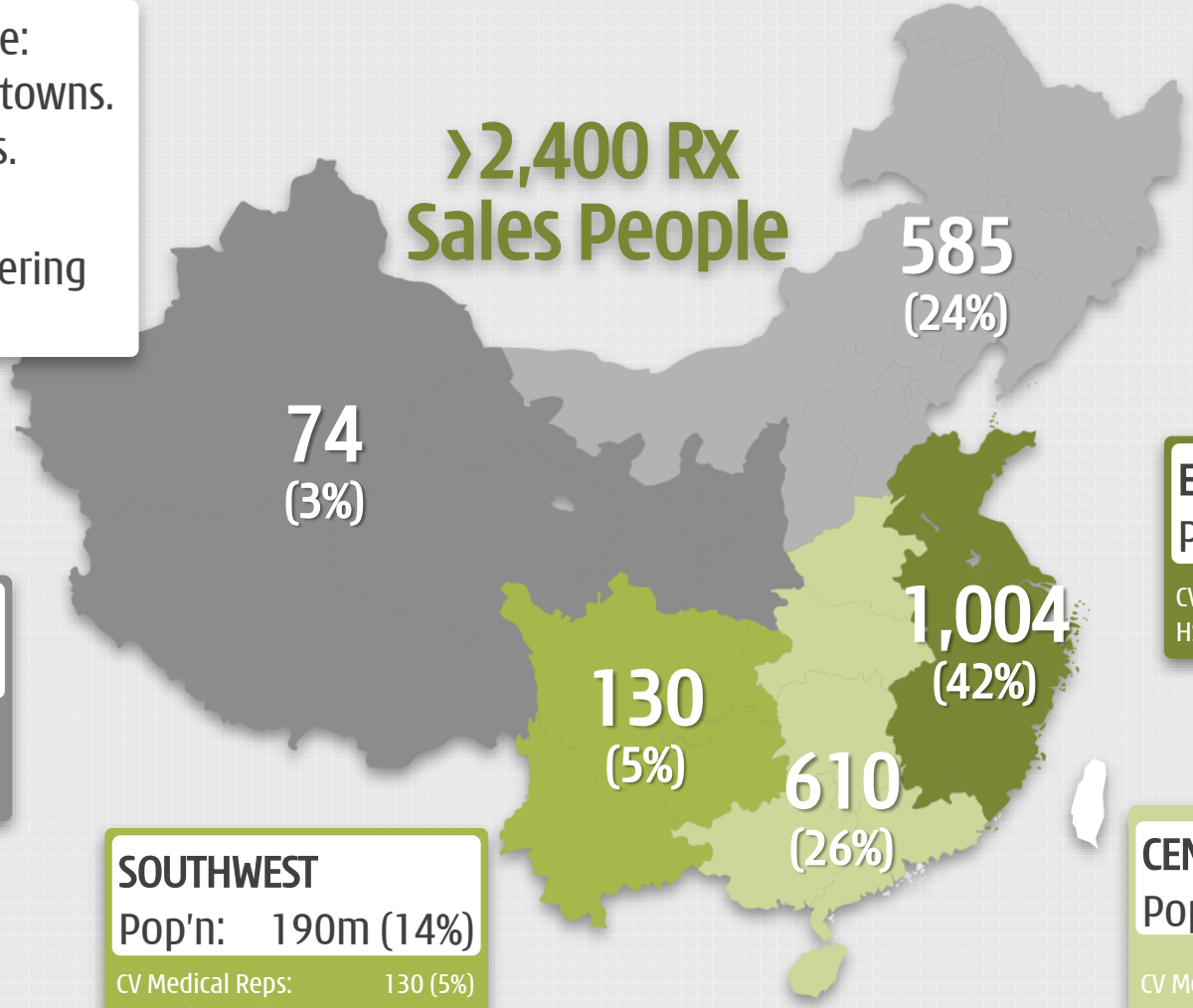
SINOPHARM

[1] 330 cities & towns covered by Prescription Drug Business and 600 cities & towns including OTC business; [2] Frost & Sullivan 2018 market share data; [3] China coronary heart disease oral Chinese patented drugs market share; [4] She Xiang Bao Xin Pill ("SXBX pill") - Rx Coronary artery disease; [5] Banlangen Granules ("Banlangen") - OTC Antiviral; [6] Fu Fang Dan Shen tablets ("FFDS") - OTC Angina.

Established Rx Commercial Platform in Mainland China…

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

- National Coverage:
  Over 330 cities & towns.
  ~24,400 hospitals.
  ~88,400 doctors.
- Medical reps. covering CV nationally.



NORTH
Pop'n: 320m (23%)
CV Medical Reps: 585 (25%)
HSP Sales staff: 0 (0%)

EAST
Pop'n: 393m (28%)
CV Medical Reps: 974 (41%)
HSP Sales staff: 30 (100%)

WEST
Pop'n: 100m (7%)
CV Medical Reps: 74 (3%)
HSP Sales staff: 0 (0%)

SOUTHWEST
Pop'n: 190m (14%)
CV Medical Reps: 130 (5%)
HSP Sales staff: 0 (0%)

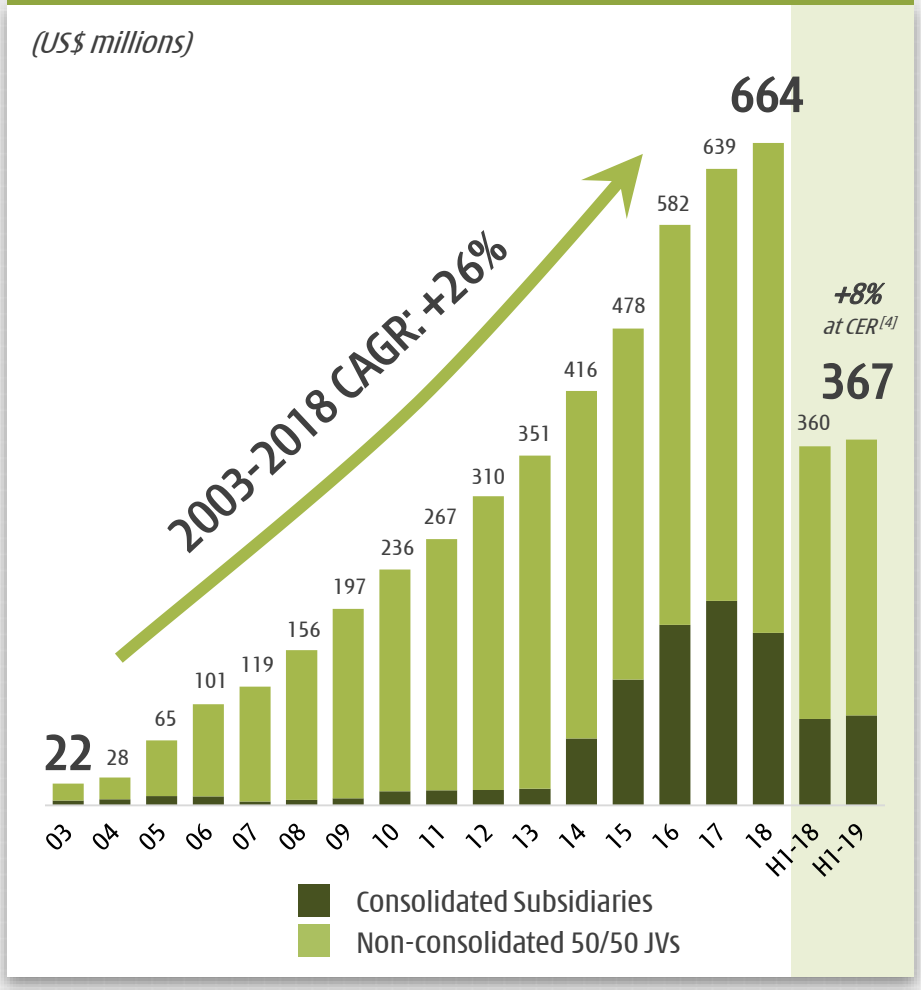
CENTRAL-SOUTH
Pop'n: 383m (28%)
CV Medical Reps: 610 (26%)
HSP Sales staff: 0 (0%)

Notes: 2010 Population - China State Census;
CV = Cardiovascular
Chi-Med Rx sales team data = June 30, 2019

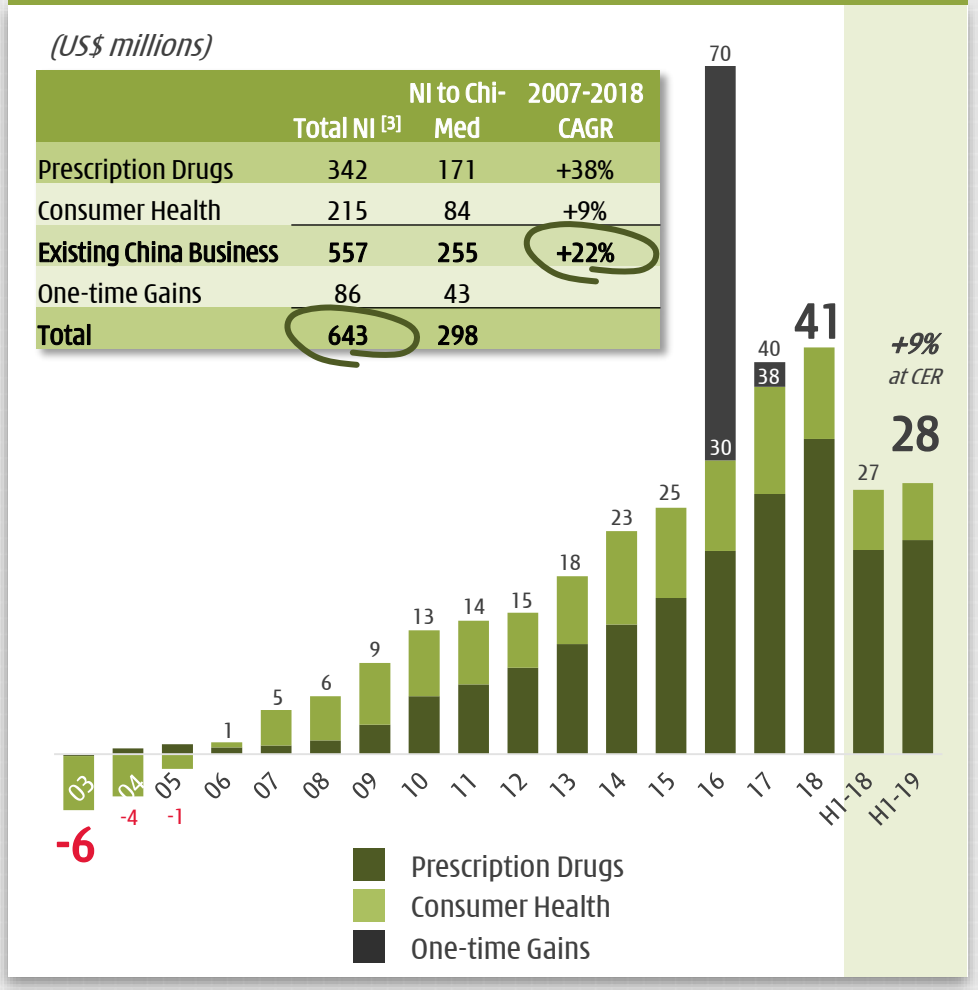
Chi-Med's Commercial Platform in China

Proven track record, ~$300 million in net income since inception

Revenues (Non-GAAP) [1][2]



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



	Total NI [3]	NI to Chi-Med	2007-2018 CAGR
Prescription Drugs	342	171	+38%
Consumer Health	215	84	+9%
Existing China Business	**557**	**255**	**+22%**
One-time Gains	86	43	
Total	**643**	**298**	

[1] 2003–2006 incl. disco. operation; [2] Excluding Guanbao (from 2011 until divested in Sep 2017); [3] Based on aggregate Non-GAAP net income / (loss) of consolidated subsidiaries and non-consolidated joint ventures of Commercial Platform, please see appendix "Non-GAAP Financial Measures and Reconciliation"; [4] at Constant Exchange Rate (at CER), which is a non-GAAP financial measure used to present period-to-period comparisons without the effects of currency movements by retranslating the current period's performance at the previous period's foreign currency exchange rates. Please refer to the slide titled "Non-GAAP Financial Measures and Reconciliation" for more information and a reconciliation of these measures to the most comparable GAAP measure.

Existing China Business

Plans for 2019-2021

Continue organic growth

- *Focus on proprietary prescription drug products*

Build out synergies with China Oncology Organization

Strategically evaluate potential for M&A

Focus on cash generation

CHI-MED

A2

Product Candidate Details

Further details on each drug candidate

CHI-MED

A2a

Savolitinib (AZD6094)

Potential first-in-class selective MET inhibitor

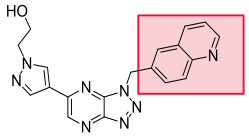
Savolitinib (AZD6094)

Potential first-in-class selective MET inhibitor

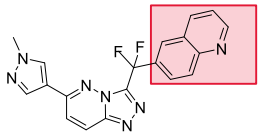
1. Strong potential to become first selective MET inhibitor approved in certain indications.

- ✓ 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) & biomarker testing**.

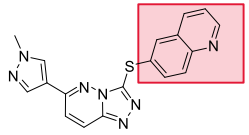
3. Savolitinib design eliminates renal toxicity first generation of selective MET inhibitors encountered – ~900 patients involved in clinical studies to date.



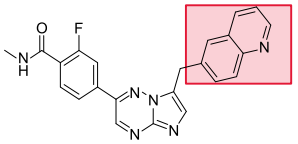
Pfizer PF-04217903



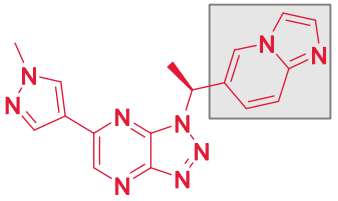
Janssen JNJ-38877605



Lilly SGX-523



Novartis/Incyte INC-280



savolitinib

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

2. MET is aberrant in many tumor settings. [7]

	MET			New Cases (2018)	
Indication	Amplification	Mutation	Over-Expression	Global	China
Gastric	10%	1%	41%	1,033,700	442,300
Non-small Cell Lung Cancer	4%/16%/30% [1]	2% [2]	39%	1,779,800	737,400
Head & Neck	17-39%	11% [3]	46% [4]	887,700	137,000
Colorectal	10%	3%	65%	1,801,000	426,700
Papillary Renal Cell Carcinoma	64%	70-100% [5]	55%	45,400	3,700
Clear Cell Renal Cell Carcinoma	54%	NA	35%	281,300	57,500
Esophagus	8%	NA	92%	572,000	271,600
Prostate	NA	NA	54/83% [6]	1,276,100	99,300

4. AstraZeneca collaboration & 2016 amendment.

- $20m received upfront (Dec 2011);
- $120m in development/approvals milestones ($25m received as of June 2019);
- 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%);
- **From 9% up to 18% tiered royalty ex-China [8]** & 30% flat rate China royalty on all product revenues.

[1] MET amplification in non-small cell lung cancer patients occurs in approximately 4% of patients not previously exposed to systemic therapies and in approximately 16% to 30% of patients with acquired resistance to EGFR inhibitors; [2] MET Exon 14 skipping mutation only; [3] Oropharynx squamous cell cancer only; [4] Head and neck squamous cell cancer only; [5] Type 1 papillary renal cell carcinoma only; [6] MET expression is increased with progression of prostate cancer, which is 54% of lymph node metastases and 83% of bone metastases; [7] Company estimates considering Frost & Sullivan data, National Central Cancer Registry of China and publicly available epidemiology data; [8] Base royalty of 9%-13%. Additional 5% royalty subject to approval in the papillary renal cell carcinoma (PRCC) indication, for a total of 14%-18% tiered royalty. 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 - MET Exon 14 deletion NSCLC

China's lead MET inhibitor

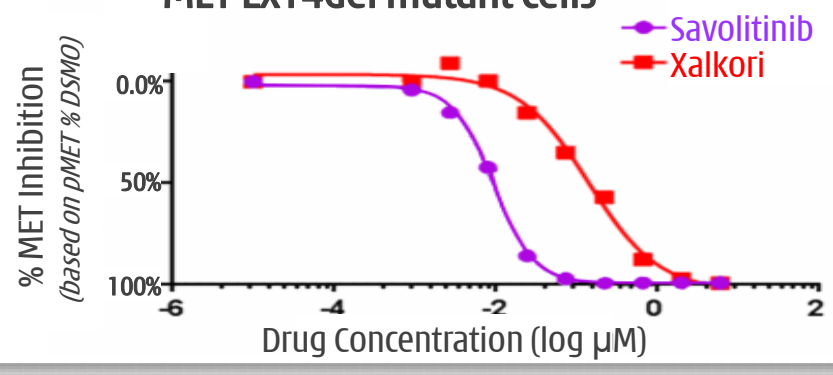
1. Competitive landscape outside China:

			Treatment Line	N	BICR [1] ORR	95% CI
Capmatinib (Novartis/ Incyte)	selective MET	ASCO 2019 #9004	2/3L	69	40.6% (28/69)	28.9%, 53.1%
		ASCO 2019 #9004	1L	28	67.9% (19/28)	47.6%, 84.1%
Tepotinib (Merck Serono)	selective MET	ASCO 2019 #9005	39% 1L, 61% ≥2L	51	45.1% (23/51)	31.1%, 59.7%
Xalkori® (Pfizer)	multi-kinase	WCLC 2018 #13453	38% 1L	65	32.3% (21/65)[2]	21%, 45%[2]
		WCLC 2018 #12937	Median 1L (1L-4L)	25	40.0% (10/25)	21%, 61%

2. Xalkori® a multi-kinase TKI - selective MET inhibitors reporting better response - superior selectivity.

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

3. Savolitinib better target coverage in MET Ex14del mutant cells [3]

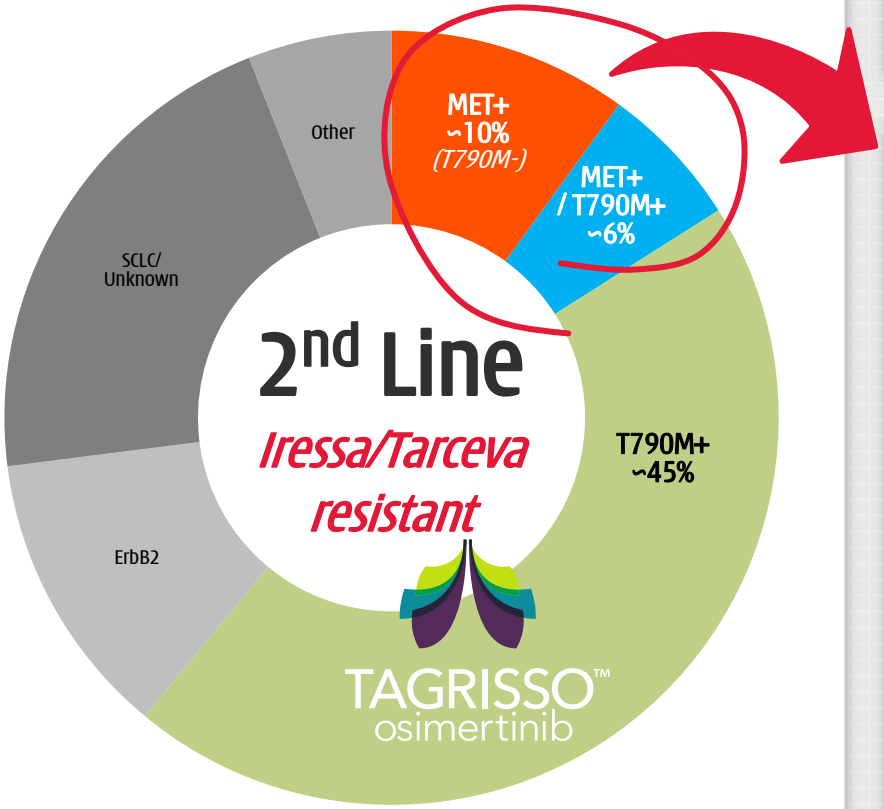


[1] BICR = blinded independent central review; [2] Investigator reviewed data (not BICR); [3] Paik, P.K., et al., Response to MET inhibitors in patients with stage IV lung adenocarcinomas harboring MET mutations causing exon 14 skipping. Cancer Discov, 2015. 5(8): p. 842-9.

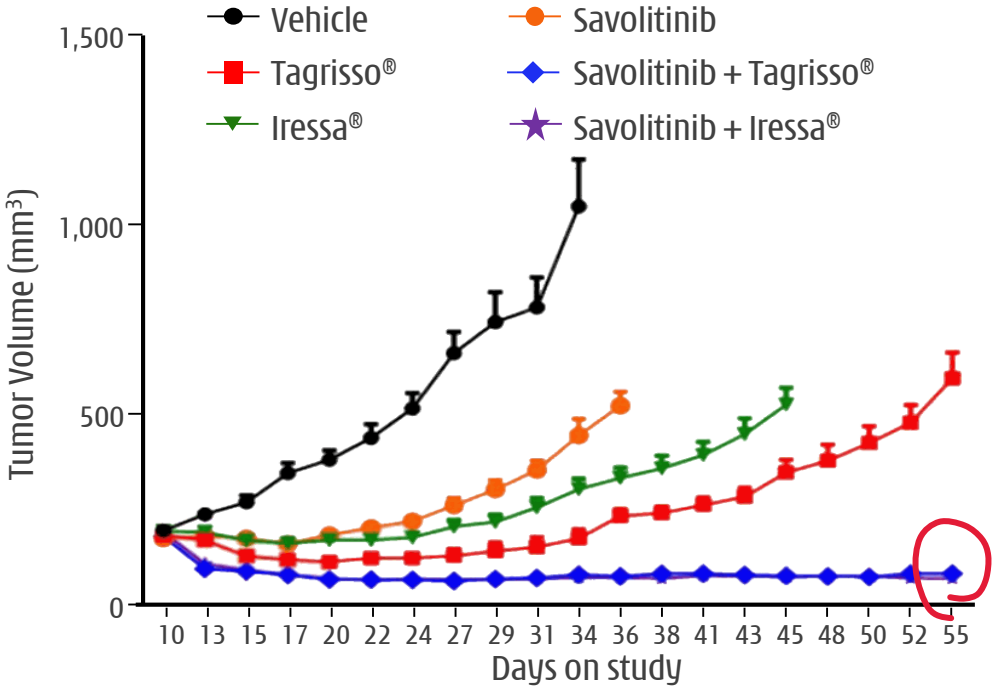
Savolitinib – EGFR-TKI resistant NSCLC

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/ IRESSA® gefitinib

Encouraging in MET+ / T790M-, next step under discussion

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

WCLC 2017	MET+ / T790M+ (n = 23)	MET+ *(T790M-)* (n = 23)	MET+ / T790M unk. (n = 5)
Confirmed response	2 (9%)	12 (52%)	2 (40%)
Stable disease ≥ 6 weeks	9 (39%)	7 (30%)	2 (40%)
Progressive disease / death	7 (30%)	3 (13%)	0
Not Evaluable	5 (22%)	1 (4%)	1 (20%)

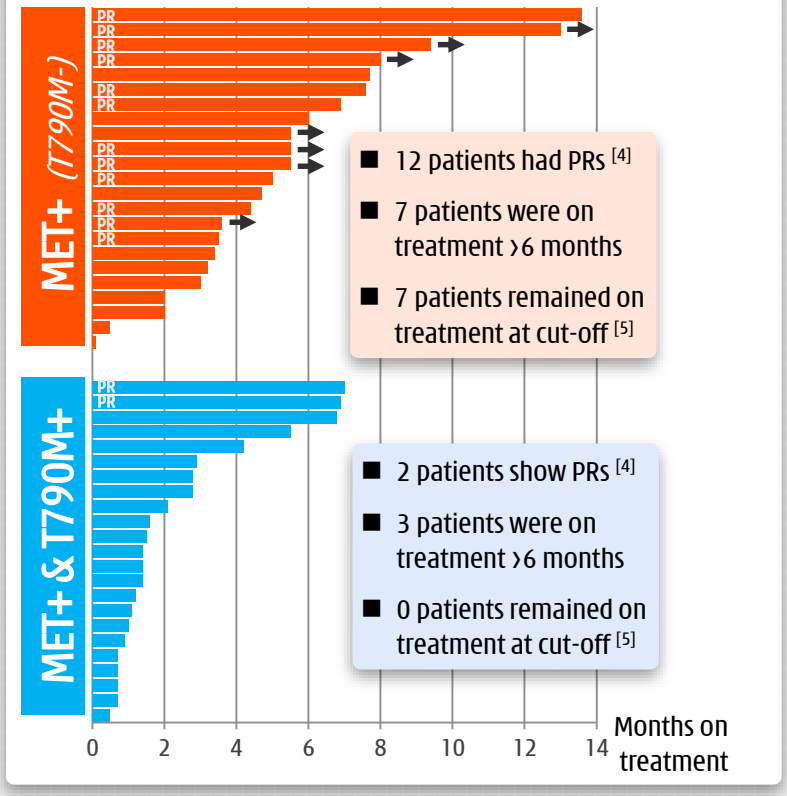
MET status all centrally confirmed.

...vs. TATTON B data (savo / Tagrisso® combo) [3]

	MET+ / T790M+ (n = 11) WCLC 2017 [2]	MET+ *(T790M-)* (n = 46) AACR 2019 [3]
Confirmed response	6 (55%)	24 (52%)
Stable disease ≥ 6 weeks	NA (43% central confirm.)	16 (35%)
Progressive disease / death	NA (0 central confirm.)	3 (7%)
Not Evaluable	NA (0 central confirm.)	3 (7%)

MET status locally or centrally confirmed.

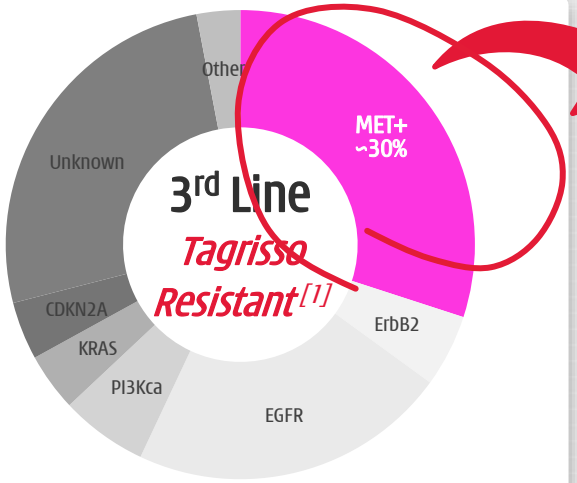
...Iressa® combo – ~6mo. Duration of Response in MET+ / T790M- patients



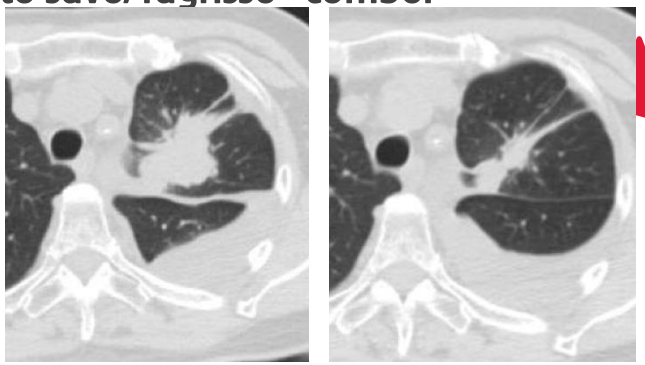
[1] EGFRm NSCLC; [2] WCLC 2017 – Yang J-J, et al. A Ph.Ib Trial of savolitinib plus gefitinib for patients with EGFR-mutant MET-amplified advanced NSCLC; [3] AACR 2019 – Sequist, *et al.* TATTON Phase Ib expansion cohort: Osimertinib plus savolitinib for patients (pts) with EGFR-mutant, MET-amplified NSCLC after progression on prior epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI); [4] PR = Partial Response; [5] Aug 21, 2017.

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	-
14	Del19	2	Y	T790 WT	T790M ND
15	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] Piotrowska, et al. MET amplification (amp) as a resistance mechanism to osimertinib. Journal of Clinical Oncology 2017 35:15_suppl, 9020-9020

Safety & tolerability

Tagrisso® & savo both highly selective/tolerable monotherapies

CHI-MED

US FDA Approval	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) [2]	**≥2L** EGFRm+ MET+ T790M- NSCLC after 1st-gen EGFR TKI (expansion)	51	**52%**	ND	20%	14%	**33%**
	savolitinib 600mg QD + **Tagrisso®** [3]	**≥2L** EGFRm+ MET+ T790M-/+ NSCLC after 1st-gen EGFR TKI **(TATTON B2)**	51	**69%**	9.0	28%	ND	ND
	savolitinib 300mg QD + **Tagrisso®** [3]	**≥2L** EGFRm+ MET+ T790M-/+ NSCLC after 1st-gen EGFR TKI **(TATTON D)**	42	**68%**	9.1	21%	ND	ND
	savolitinib 600mg QD + **Tagrisso®** [4]	**≥3L** EGFRm+ MET+ NSCLC after 3rd-gen EGFR TKI **(TATTON B1)**	69	**36%**	5.4	28%	ND	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 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] WCLC 2017 #8995; [3] ESMO Asia 2019 LBA#2; AE data are pooled for cohort B patients; B2 had 48/51 efficacy evaluable patients; D had 34/36 efficacy evaluable patients; B1 had 59/69 efficacy evaluable patients; [4] Total discontinuations = Discontinuations NOT due to Disease Progression or Death; ND = Not Disclosed.

PRCC – unmet medical need

Lower response rates to treatments

1. Limited treatment options for non-ccRCC

Several approved therapies in ccRCC [3]

Immunotherapy setting new treatment paradigm

FIRST LINE – clear-cell RCC [4]	ORR	mPFS	mOS
Placebo (avg. multiple studies)	~2%	~3.5	~15.0
Torisel® (mTOR)	8.6%	5.5	10.9
VEGFR, multi-kinase small molecule (multiple compounds)	12-31%	6-11	21-28
Opdivo® + Yervoy® (PD-1/CTLA-4 immunotherapy) [5]	42%	~11.6	NR
Keytruda® + Inlyta® (PD-1/VEGFR combo)	59.3%	15.1	NR
Bavencio® + Inlyta® (PD-L1/VEGFR combo)	51.4%	13.8	NR
SECOND LINE – clear-cell RCC			
Placebo (avg. multiple studies)	~0%	~2.0	~14.0
Cabometyx® (VEGFR/MET, multi-kinase SM) *(METEOR)*	17%	7.4	21.4
Inlyta® (VEGFR, multi-kinase SM)	23%	8.3	20.1
Lenvima® + Afinitor® (VEGFR, multi-kinase SM + mTOR)	35%	14.6	25.5
Opdivo® (PD-1 mAb) *(CheckMate025)*	25%	4.6	25.0

non-ccRCC: *NCCN preferred strategy: clinical trials*

No category 1 recommendation

FIRST LINE – non clear-cell RCC [4]	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 [4]			
Sutent® (VEGFR, multi-kinase SM) [4]	10%	1.8	na
Afinitor® (mTOR) [4]	9%	2.8	na

2. RCC est. ~$13.0 bn. market by 2030 [1]

Clear-cell RCC (~$10.4b)

~80% of RCC

~ 290k new patients/yr. [2]

Non-Clear-cell RCC (~$2.6b)

~20% of RCC

~ 73k new patients/yr.[2]

3. Unmet medical need:

MET+ Papillary RCC (~$1.0b)

~8% of RCC

~ 28k new patients/yr.[2]

MET- Papillary RCC (~$1.0b)

~8% of RCC

~ 28k new patients/yr.[2]

Other non-ccRCC (~$0.6b)

~5% of RCC

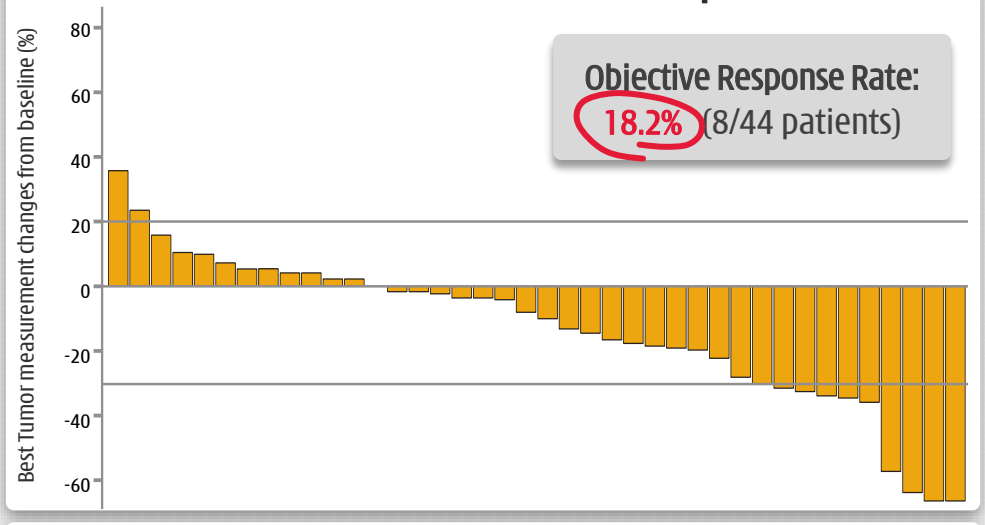
~ 16k new patients/yr.[2]

[1] Frost & Sullivan; [2] Frost & Sullivan, based on US incidence mix and global incidence rate in 2018; [3] NCCN Guideline for kidney cancer (Version 1.2020, June 7, 2019) preferred or category 1 options, RCC = renal cell carcinoma; [4] ORR = Objective Response Rate, mPFS = median Progression-Free Survival, mOS = median Overall Survival, NR = not reached; For approved subgroup of patients; [5] only approved for patients with intermediate or poor risk RCC.

Savolitinib – PRCC Phase II

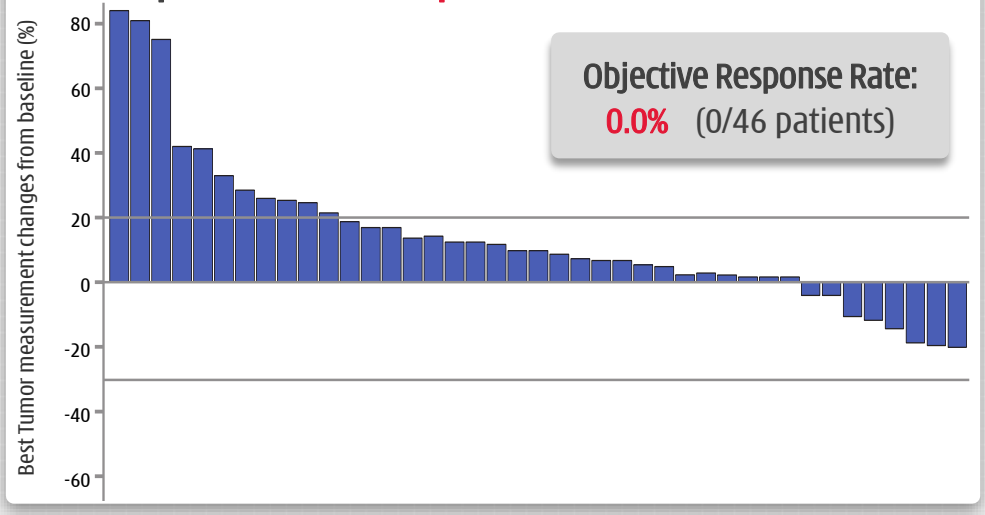
Clear efficacy & durable response in MET+ PRCC patients

1. Savolitinib clear ORR benefit in MET+ patients.



Objective Response Rate:
18.2% (8/44 patients)

2. MET- patients – no response to savo.



Objective Response Rate:
0.0% (0/46 patients)

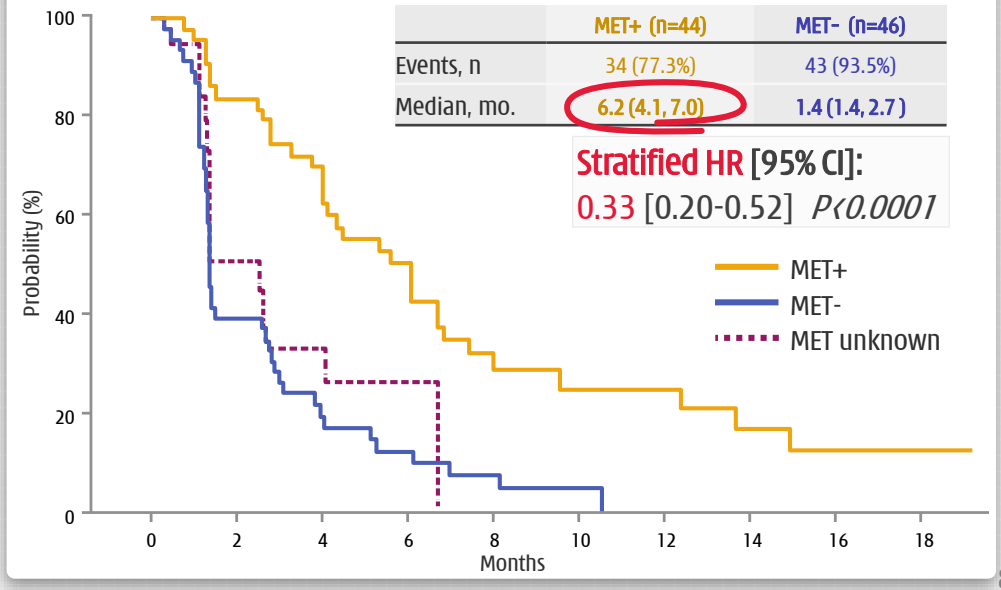
3. Disease Control Rate ("DCR") – big advantage in MET+ with DCR 73.2% vs. MET- 28.2%.^

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.

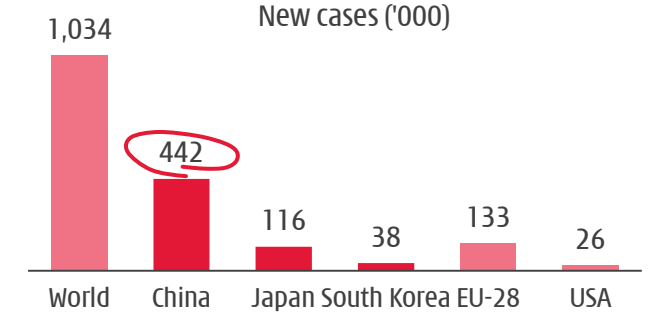
4. Median PFS – big advantage in MET+ patients.



Savolitinib – MET+ gastric cancer

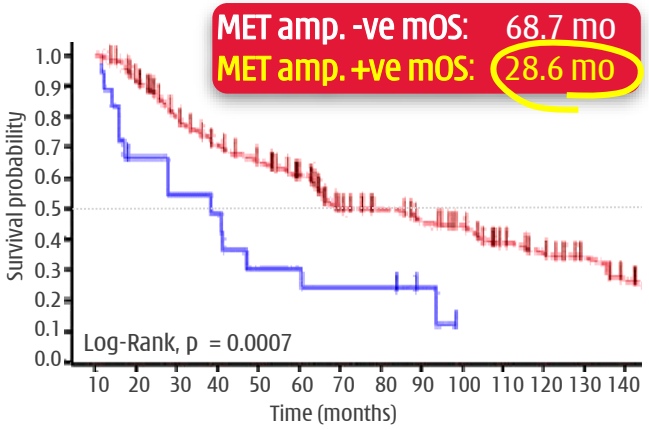
A major problem in east Asia – Japan, South Korea & China

1. Gastric (stomach) cancer is the 5th most common cancer globally – 782,700 deaths/year

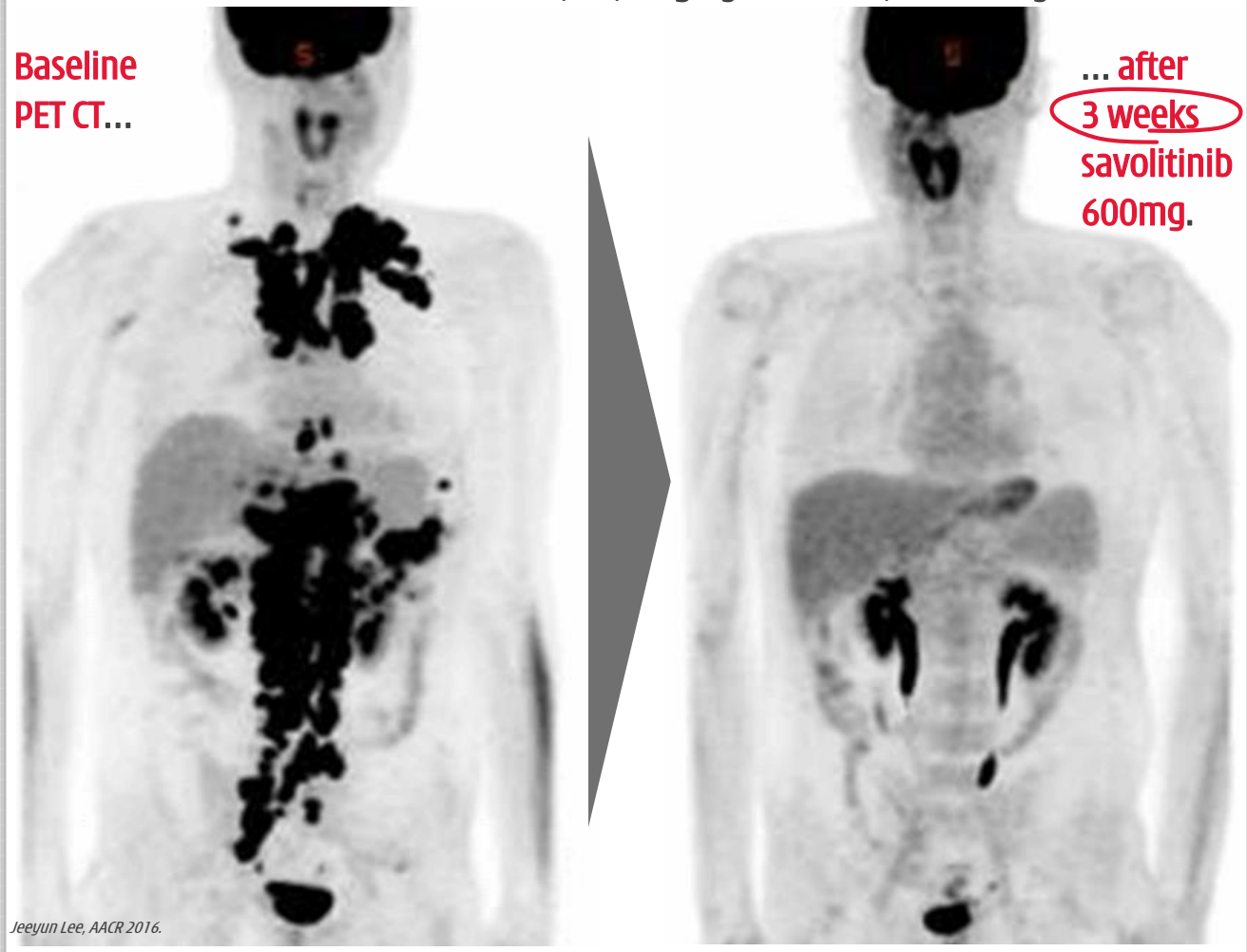


World Cancer Research Fund International, WHO, ACS, NCCR, Lancet, Frost & Sullivan Analysis.

2. MET+ disease is more aggressive [1]



3. VIKTORY trial savolitinib arm – male, 34; surgery ruled-out; failed 4-cycles XELOX.



Jeeyun Lee, AACR 2016.

[1] Catenacci, et al. "MET tyrosine kinase receptor expression and amplification as prognostic biomarkers of survival in gastroesophageal adenocarcinoma." Cancer. 2017 Mar 15; 123(6): 1061-1070. doi: 10.1002/cncr.30437.
[2] Lee, et al. "Tumor genomic profiling guides metastatic gastric cancer patients to targeted treatment: The VIKTORY Umbrella Trial." Cancer Discov. 2019 Jul 17. pii: CD-19-0442. doi: 10.1158/2159-8290.CD-19-0442. ‹5 patients in all other arms.

Savo potential in gastric cancer

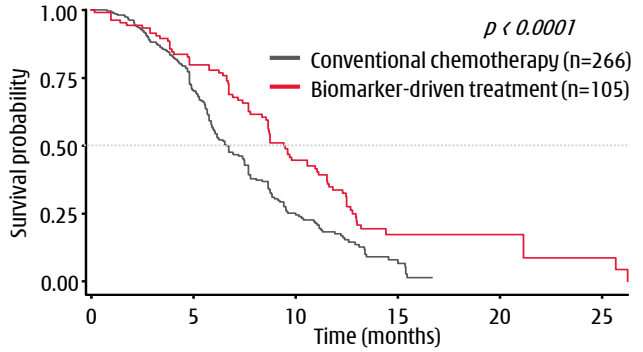
VIKTORY Phase II trial highly promising in MET+ gastric cancer

VIKTORY: Highest response rate in savolitinib monotherapy arm

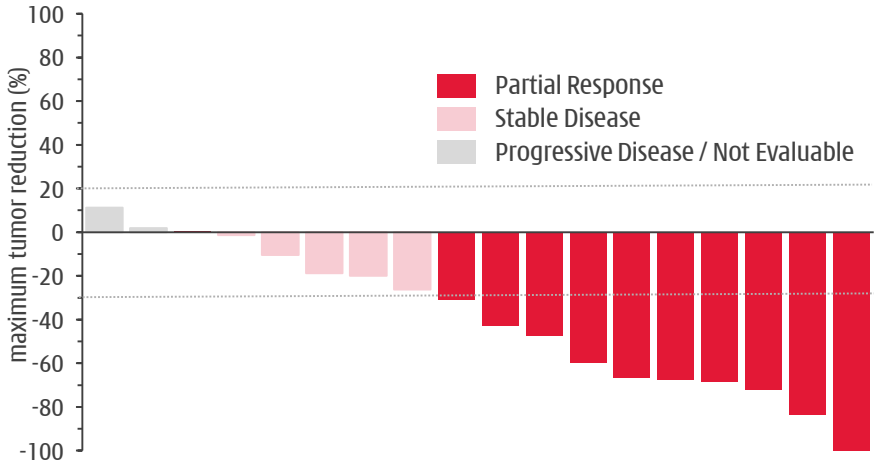
Tumor sequenced (N=715) → Eligible for 2nd line treatment (N=460)
→ Biomarker positive; received targeted treatment (N=105)

RAS/MEK	TP53	PIK3CA	MET amp	Others
(N=25)	(N=25)	(N=24)	(N=20)	
Selumetinib + Docetaxel	Adavosertib + Paclitaxel	Capivasertib + Paclitaxel	Savolitinib monotherapy	Each arm contained <5 patients
ORR = 28%	ORR = 24%	ORR = 33%	ORR = 50%	

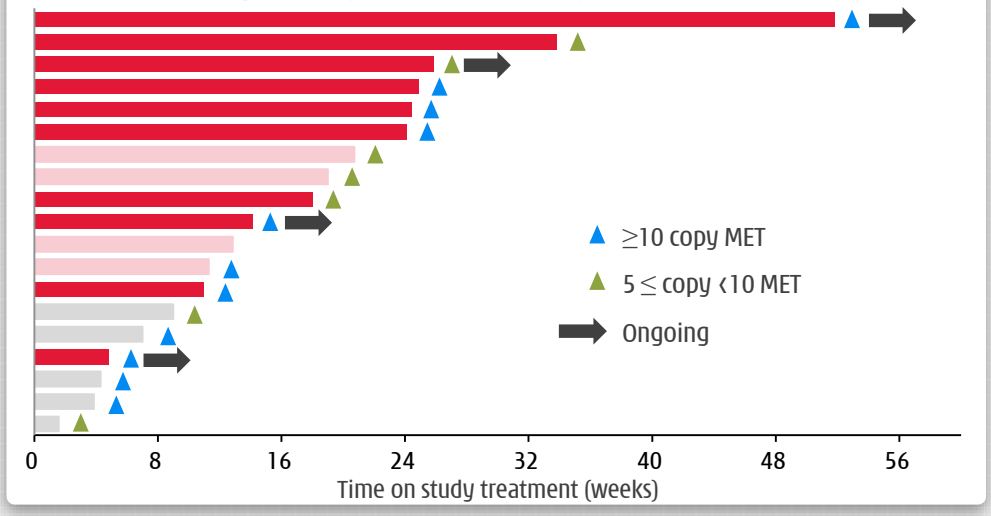
Biomarker guided treatment may prolong overall survival



VIKTORY: Best tumor response (savolitinib arm)



Duration of response (savolitinib arm)



Lee, et al. "Tumor genomic profiling guides metastatic gastric cancer patients to targeted treatment: The VIKTORY Umbrella Trial." Cancer Discov. 2019 Jul 17. pii: CD-19-0442. doi: 10.1158/2159-8290.CD-19-0442. <5 patients in all other arms.

CHI-MED

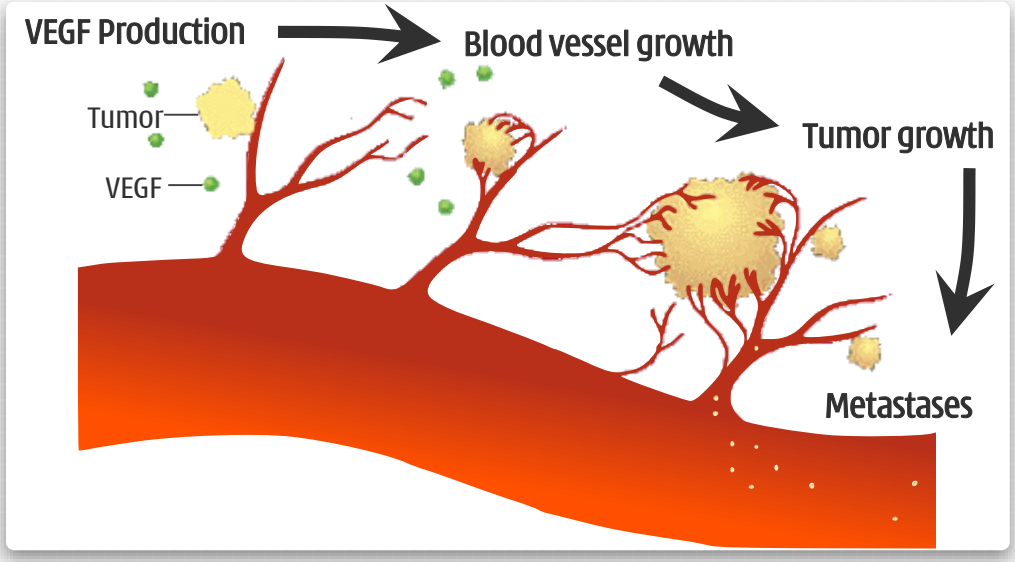
A2b

Elunate® (fruquintinib capsules)

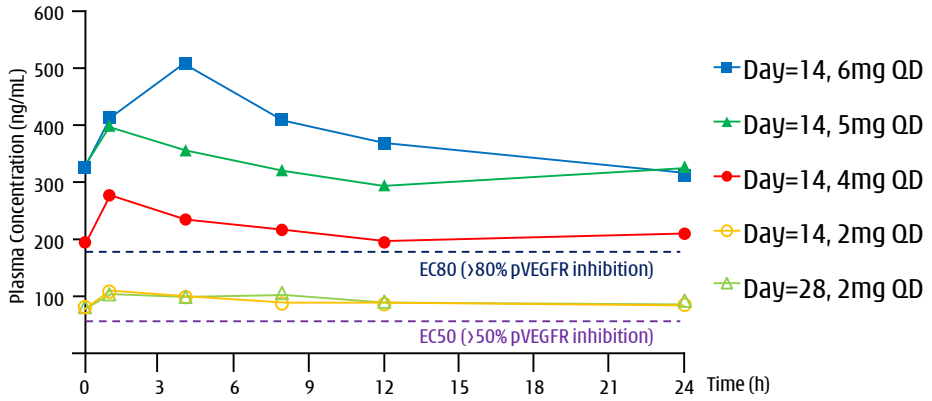
Highly selective anti-angiogenesis inhibitor

Fruquintinib - 24hr full target coverage

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



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



2. 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.

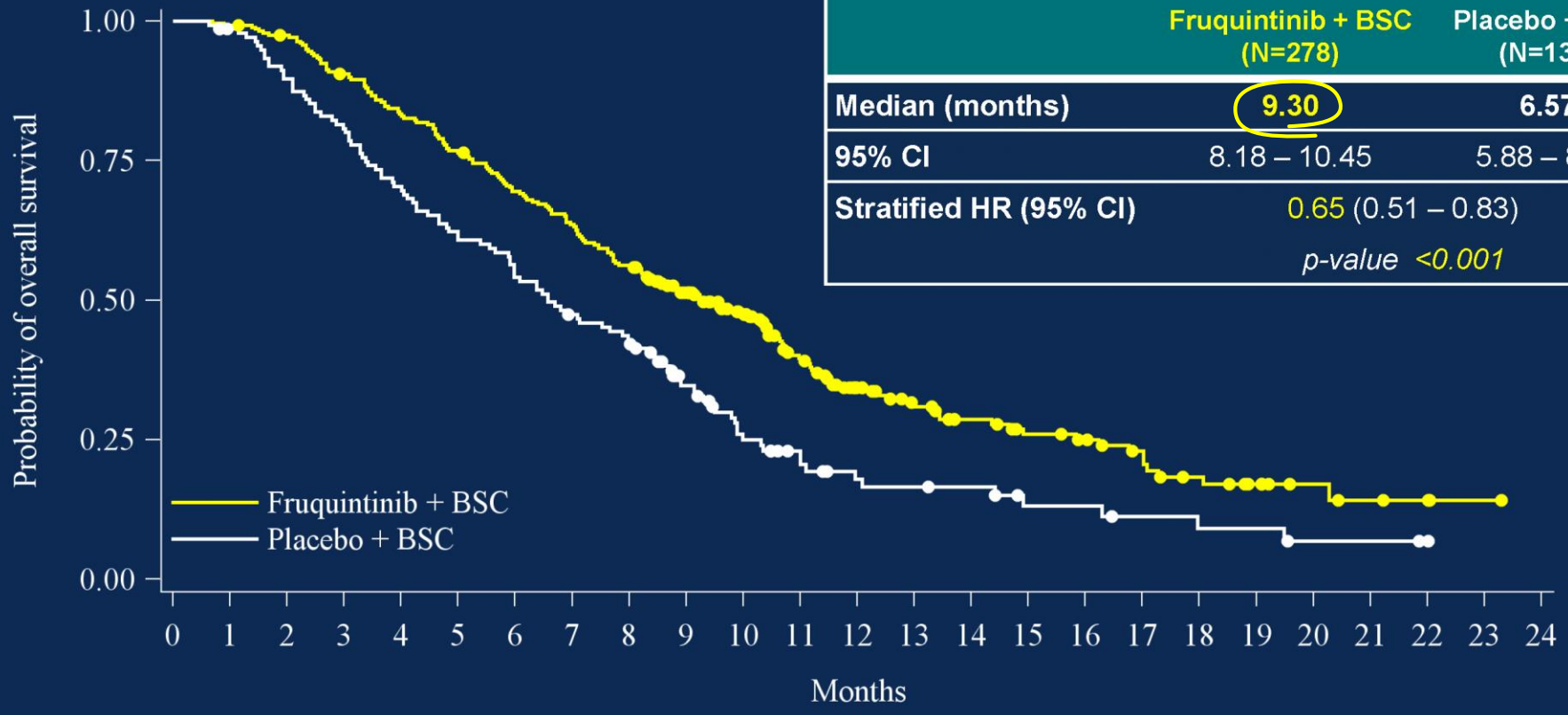
Fruquintinib - 3L/4L colorectal cancer

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	



PRESENTED AT: ASCO ANNUAL MEETING '17 | #ASCO17

Slides are the property of the author. Permission required for reuse.

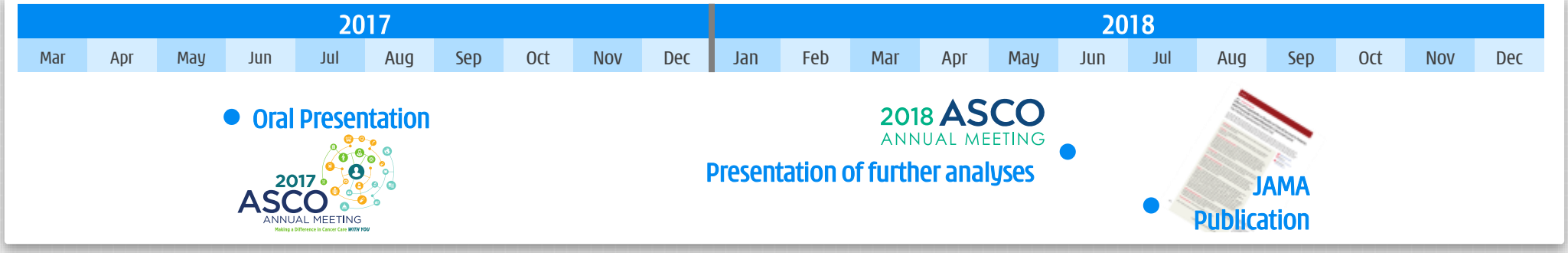
Presented by: Jin Li, MD PhD June 5, 2017 10

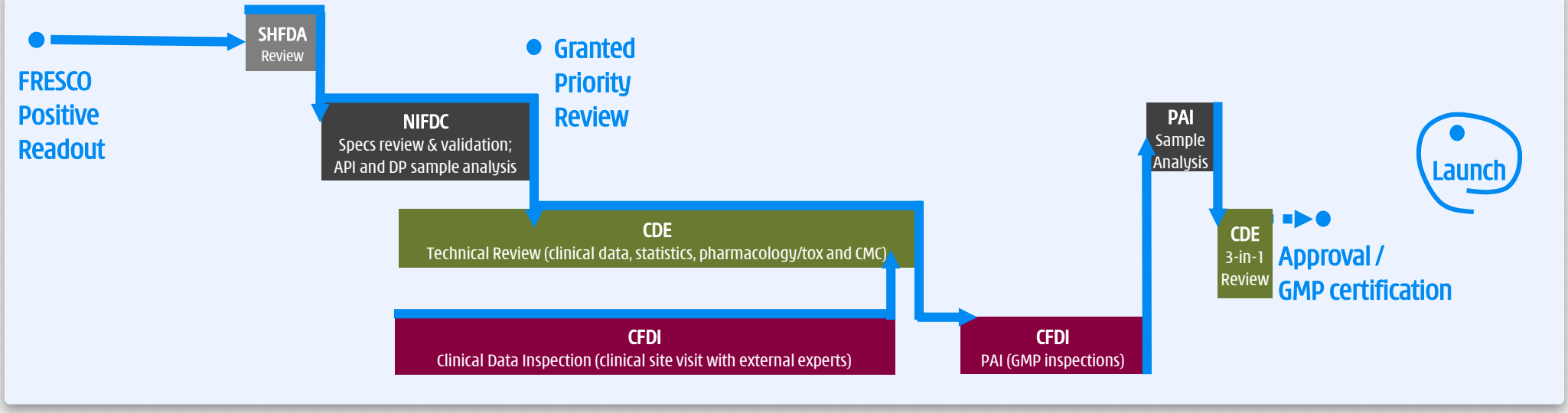
[1] ASCO = American Society of Clinical Oncology Annual Meeting.

ELUNATE®
Fruquintinib Capsules

Many "Firsts" for China biotech

CHI-MED





Shanghai Food and Drug Administration (SHFDA)

National Institutes for Food and Drug Control (NIFDC)

Center for Drug Evaluation (CDE)

Center for Food and Drug Inspection (CFDI)

Critical Path

ELUNATE®
Fruquintinib Capsules

Launched - Nov. 25, 2018

CHI-MED

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

[1] unconditional/Full approval

FALUCA – Third-line NSCLC Monotherapy
Presented at WCLC 2019

CHI-MED

FALUCA Phase III (enrolled Dec. 2015 to Feb. 2018)

- *Met all* secondary endpoints: mPFS; ORR; DCR; & DoR [1];
- Did not achieve primary endpoint of median OS, however:
  - ↗ Anti-tumor therapies after disease progression reduced OS diff.
  - ↗ Higher percentage of placebo pts received subsequent treatments.

Significant difference in subsequent anti-tumor treatments (ATT)

- **Chemotherapy:** Fruq. 29.7% vs. Placebo 53.8%
- **Targeted therapies (VEGFi and/or EGFRi):** Fruq. 20.9% vs. Placebo 31.2%
- **Tagrisso® & anlotinib just approved** in 2017

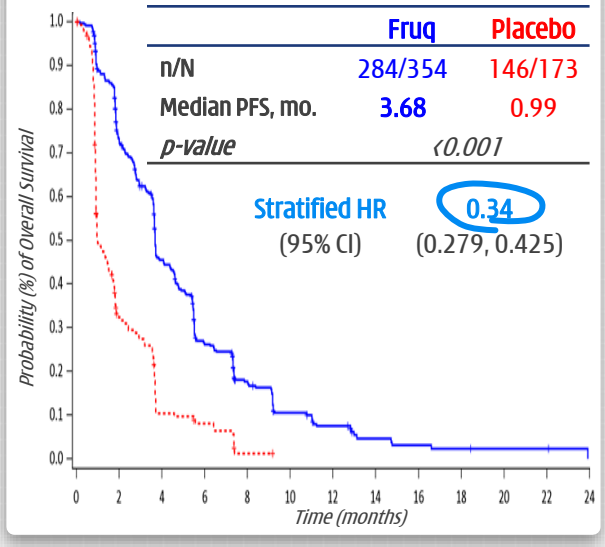
Efficacy Endpoints (Intent-to-Treat) [2]

	Fruq. (N=354)	Placebo (N=173)	*p-value*
mOS (mths)	8.94	10.38	*0.841*
mPFS (mths)	3.68	0.99	*<0.001*
ORR	13.8% (49)	0.6% (1)	*<0.001*
DCR	66.7% (236)	24.9% (43)	*<0.001*

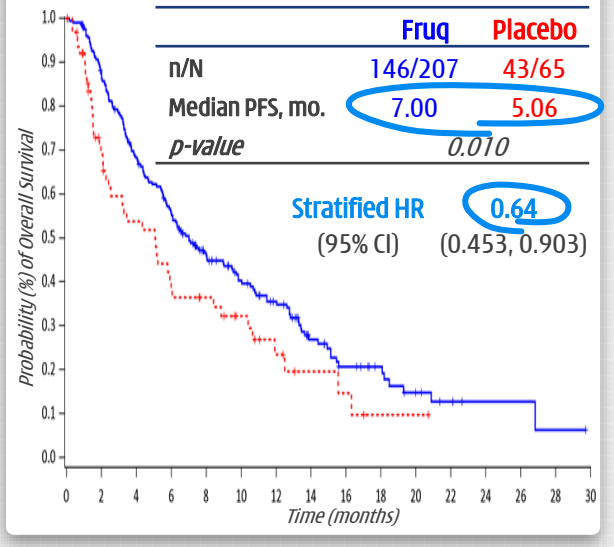
Good safety; most Grade ≥3 TEAEs target-related & clinically manageable.

Patient (%)	Fruq (N=354)	Pbo (N=173)
TEAE ≥ Grade 3	216 (61.2%)	47 (27.6%)
Leading to discontinuation	37 (10.5%)	9 (5.3%)
Leading to interruption	61 (17.3%)	7 (4.1%)
Leading to dose reduction	85 (24.1%)	2 (1.2%)
Hypertension	74 (21.0%)	5 (2.9%)
Hand-foot syndrome	39 (11.0%)	0

PFS in ITT population



OS in pts w/o subsequent ATT

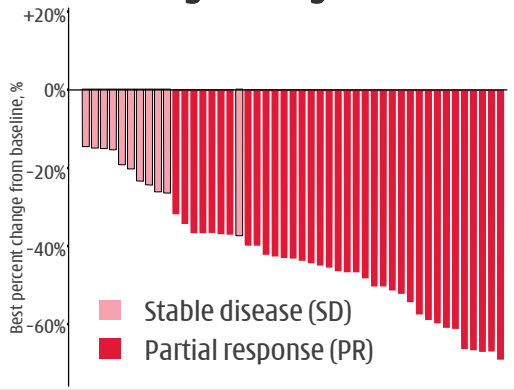


[1] mOS = median Overall Survival; mPFS = median Progression Free Survival; ORR = Objective Response Rate; DCR = Disease Control Rate; DoR = Duration of Response; HR = hazard ratio; 95% CI = 95% Confidence Interval; [2] Lu, et al. "A Randomized Phase III trial of Fruquintinib versus Placebo in Patients with Advanced Non-Small Cell Lung Cancer (FALUCA)." WCLC 2019 Abstract #MA14.05; [3] Lu, et al. Randomized, Double-Blind, Placebo-Controlled, Multicenter Phase II Study of Fruquintinib After Two Prior Chemotherapy Regimens in Chinese Patients With Advanced Non-squamous Non–Small-Cell Lung Cancer. Journal of Clinical Oncology 36, no. 12 (April 20 2018) 1207-1217. DOI: 10.1200/JCO.2017.76.7145; [4] Li, et al. Effect of Fruquintinib vs Placebo on Overall Survival in Patients With Previously Treated Metastatic Colorectal Cancer: The FRESCO Randomized Clinical Trial. JAMA. 2018 Jun 26;319(24):2486-2496. doi: 10.1001/jama.2018.7855. *Post-hoc analysis

Fruquintinib – 1L NSCLC combo w/ IRESSA® gefitinib

Two small molecule TKIs allow for better management of tox.

1. Promising efficacy in first line – 72% ORR (36/50). [1,2,3]



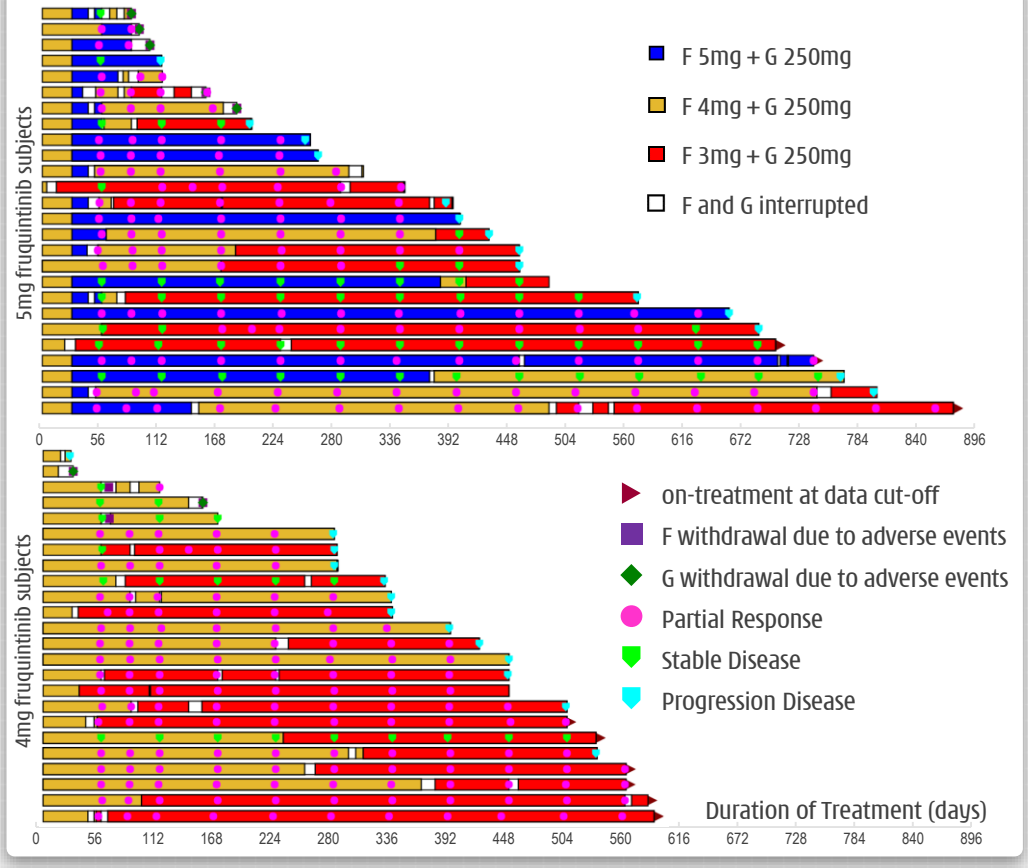
PR, n (%)	36 (72.0%)
SD, n (%)	12 (24.0%)
PD, n (%)	1 (2.0%)
NA, n (%)	1 (2.0%)
DCR, n (%)	48 (96.0%)
mDoR (mths)	12.9 (10.7, 16.6)
mPFS (mths)	14.7 (12.5, 21.2)

Data as of June 28, 2019.

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 (%)	5mg Fruq. + Iressa® N = 26, n (%) [3]	4mg Fruq. + Iressa® N = 24, n (%) [3]
All AEs, any grade	**273 (98%)**	**≥74 (≥99%)**	**26 (100%)**	**24 (100%)**
All AEs, Grade ≥3	**124 (45%)**	**68 (91%)**	**17 (65%)**	**11 (46%)**
AEs leading to death	**6 (2%)**	**0 (0%)**	**3 (12%)**	**0 (0%)**
AEs to VEGFRi disc.	NA	31 (41%)	6 (23%)	4 (16%)
Grade ≥3 AEs:				
Liver function	33 (12%)	6 (8%)	13 (50%)	3 (13%)
Hypertension	NA	45 (60%)	1 (4%)	1 (4%)
Proteinuria	NA	6 (8%)	3 (12%)	1 (4%)
Rash	13 (5%)	19 (25%)	0 (0%)	1 (4%)
Decreased appetite	22 (8%)	1 (1%)	NA	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]



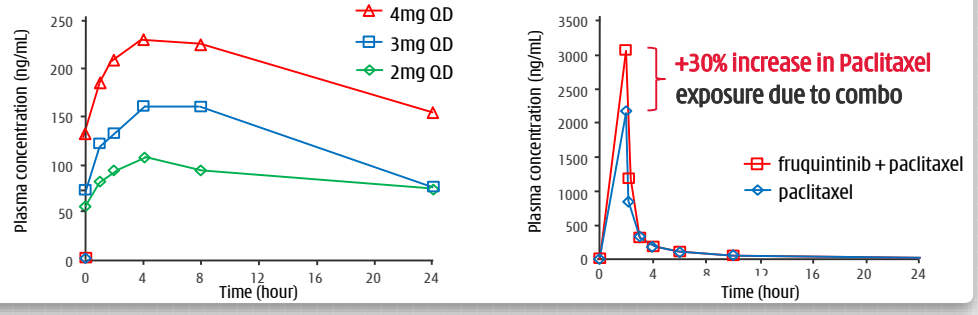
[1] Best tumor response for efficacy evaluable patients (patients who had both baseline and post-baseline tumor assessments); ORR = objective response rate; [2] Four PRs not yet confirmed at the time of data cut-off date; mAb = Monoclonal Antibody;
[3] Lu, S., et al, "Phase II Study of Fruquintinib plus Gefitinib in Stage IIIb/IV NSCLC Patients Harboring EGFR Activating Mutations", #4780 ESMO Asia, Singapore, November 23, 2019;
[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

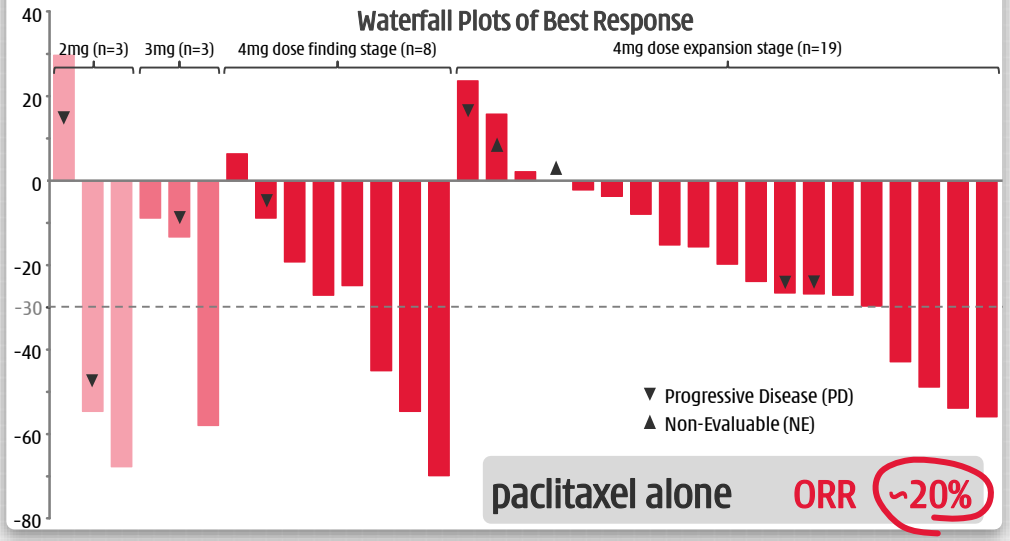
Phase III initiated Oct 2017 – Interim analysis early 2019

CHI-MED

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).

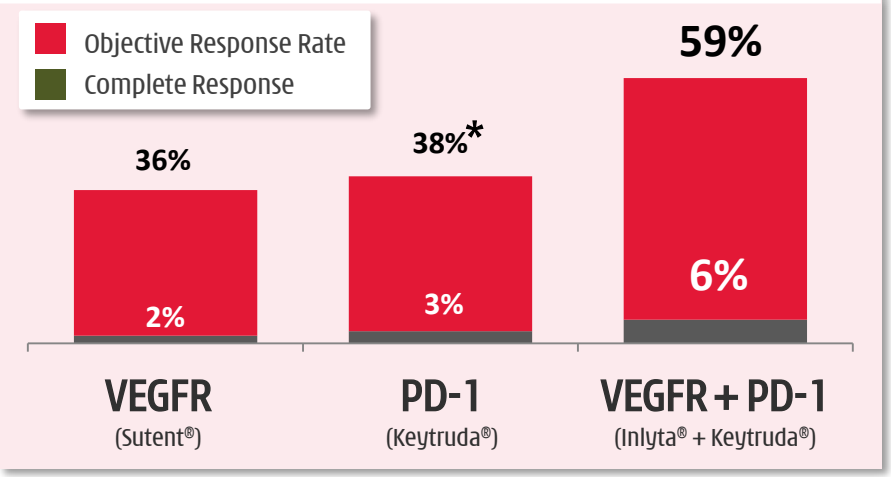
Characteristics (Unit)	Drug Expansion Stage (N=19) Fruquintinib 4 mg + paclitaxel 80 mg/m²	
	Drug interruption	Drug reduction
Dose modification with Fruquintinib N (%)	2 (10.5%)	2 (10.5%)
Dose modification with Paclitaxel N (%)	5 (26.3%)	1 (5.3%)

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%)

Immunotherapy combinations… assets potentially 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

	Inlyta®	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 + Tyvyt® (PD-1)
surufatinib + Tyvyt® (PD-1)
Solid tumors

君实生物 Junshi Biosciences
surufatinib + Tuoyi® (PD-1)
Solid tumors

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

[1] Sources: (i) B. Rini et al, for the for the KEYNOTE-426 Investigators, NEJM 2019 Feb 16. doi: 10.1056/NEJMoa1816714, Pembrolizumab plus Axitinib versus Sunitinib for Advanced Renal-Cell Carcinoma; (ii). 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; * ORR =38.2% for all PD-L1 expression combined positive scores (CPS) - ORR=50.0% for CPS≥1 pts, ORR=26.4% for CPS<1 pts.; [2] BTD = Breakthrough Therapy Designation.

Fruquintinib & surufatinib both unique VEGFR TKIs

...potentially ideal VEGFR combo partners for immunotherapy

TKI	1st Generation			2nd Generation			Next Generation	
Selectivity	Multiple targets			Relatively selective			Highly selective	Selective angio-immuno kinase inhibitor
Inhibitors	Sutent®	Nexavar®	Focus V®	Fotivda®	Lenvima®	Inlyta®	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[2] production** – amplifying PD-1 induced immune response

[1] Surufatinib = HMPL-012, formerly known as sulfatinib; [2] 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.

ELUNATE®
Fruquintinib Capsules

Lilly amendment – Dec 2018
Secures long-term commercial potential

CHI-MED

- **Chi-Med will pay full cost of any future development in China**. In return, Chi-Med gains:
- **Freedom to operate in selecting & pursuing any future indications** in China;
- **Materially higher milestones & royalties** upon launch in new LCI[1];
- **Freedom to collaborate with any third-party** in clinical development; and
- **Possible promotion rights in 30-40% of China for Elunate®**.[2] Not expected before 2021, until then, Lilly responsible for all launch & commercialization costs in China. If we assume promotion rights, we will receive service fees, which we expect to be net income accretive.

	Original 2013 Agreement		Amendment (Dec 2018)
LCI [1] 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 & higher long-term economics on best-in-class asset

[1] LCI = Life Cycle Indication; [2] upon achievement of a non-fruquintinib related Eli Lilly commercial action; [3] Lifecycle Indication – China – per LCI, up to 3 LCIs; [4] On Total Molecule Sales in China triggered upon launch of 1st LCI.

CHI-MED

A2c

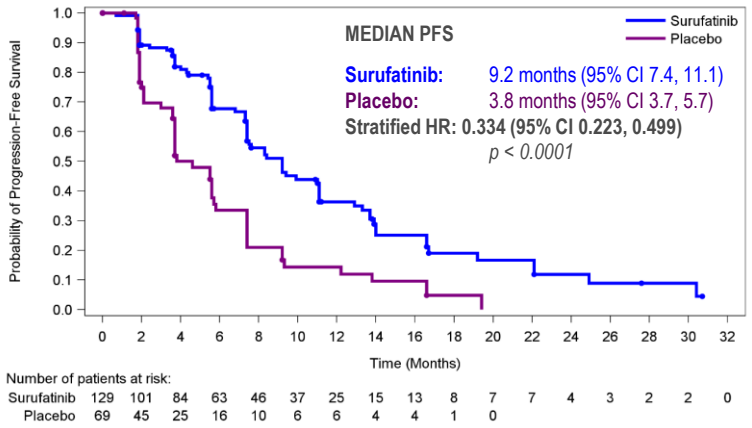
Surufatinib

Highly active TKI with unique angio-immuno activity

Surufatinib - China data [1] [2]

Broad spectrum NET efficacy **incl. Sutent®/Afinitor® failure ptnts.**

Phase III: Non-Pancreatic NET

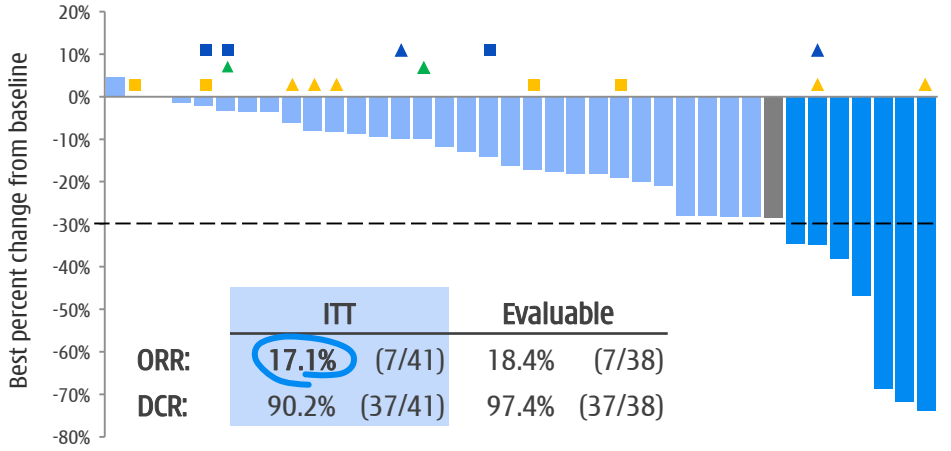


Phase III: Safety - Well tolerated - Adverse Events manageable.

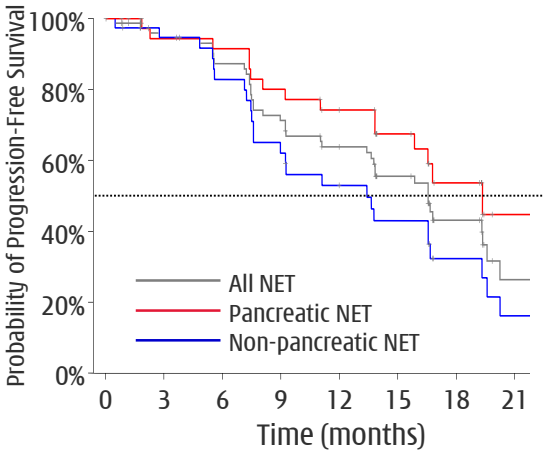
Adverse Events ("AEs")	Suru N=129 n (%)	Pbo N=68 n (%)
Any TEAE	127 (98.4)	65 (95.6)
Any Grade ≥3 AE	99 (76.7)	23 (33.8)
Any SAE	34 (26.4)	12 (17.6)
Drug related AE leading to:		
dose interruption	62 (48.1)	15 (22.1)
dose reduction	62 (48.1)	5 (7.4)
drug withdrawal	23 (17.8)	4 (5.9)

Grade ≥3	Suru N=129 n (%)	Pbo N=68 n (%)
Hypertension	47 (36.4)	9 (13.2)
Proteinuria	25 (19.4)	0
Diarrhea	2 (1.6)	0
Bilirubin increased	3 (2.3)	0
AST increased	5 (3.9)	2 (2.9)
Hypertriglyceridemia	3 (2.3)	0
ALT increased	4 (3.1)	0
Abdominal pain	1 (0.8)	0
Anemia	9 (7.0)	2 (2.9)

Phase II: Pancreatic NET



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.

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

[1] ESMO 2019 LBA76; [2] ENETS = European Neuroendocrine Tumour Society oral presentation of SANET-1. Data cut-off as of Jan 20, 2017; NET = neuroendocrine tumors.

~170,000 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 (China NDA accepted)
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.) *primary EP*	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

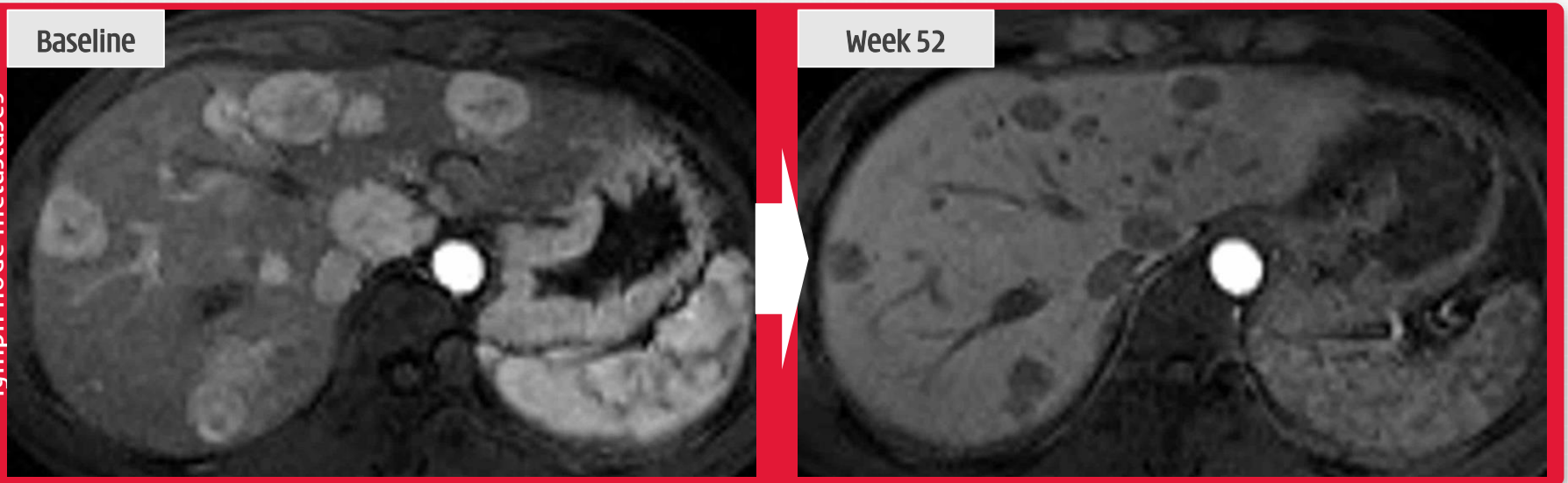
[1] *Dasari A, et al.: Trends in the Incidence, Prevalence, & Survival Outcomes in Patients With Neuroendocrine Tumors in the U.S.*. JAMA Oncol. *2017;3(10):1335-1342;* [2] www.cancer.net (patient information from ASCO) - NET is a subtype of neuroendcrine neoplasms, NENs); [3] MOA = Mechanism of Action; [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.

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

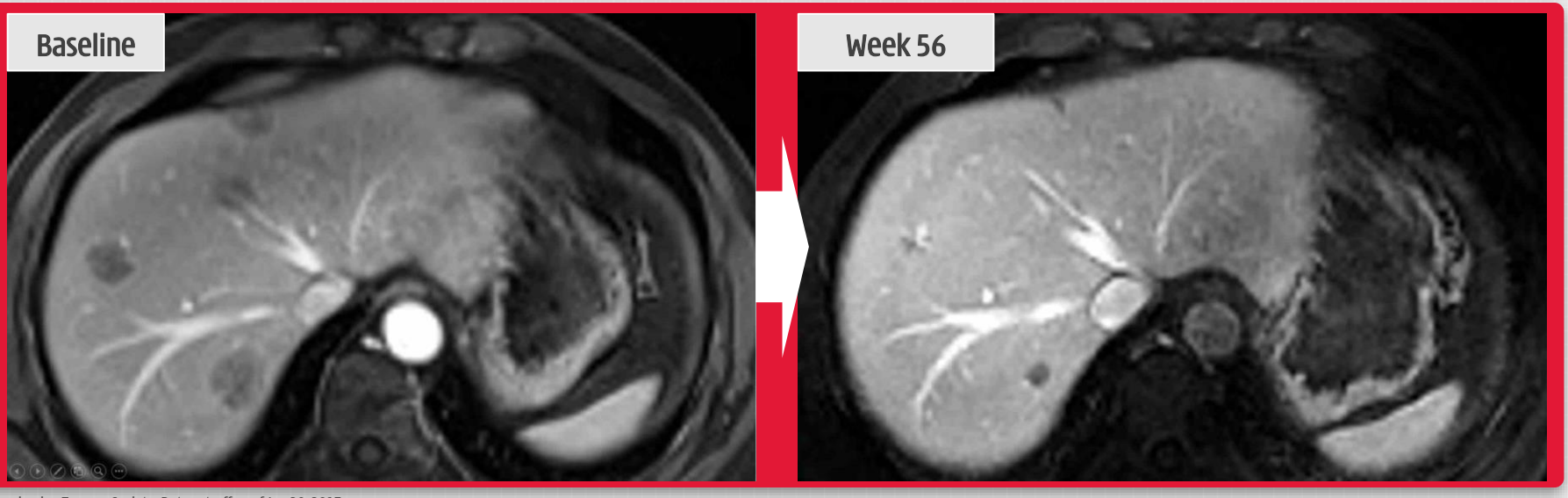
Tumor devascularization & central necrosis

CHI-MED

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

A2d

HMPL-523 (Syk) & HMPL-689 (PI3Kδ)

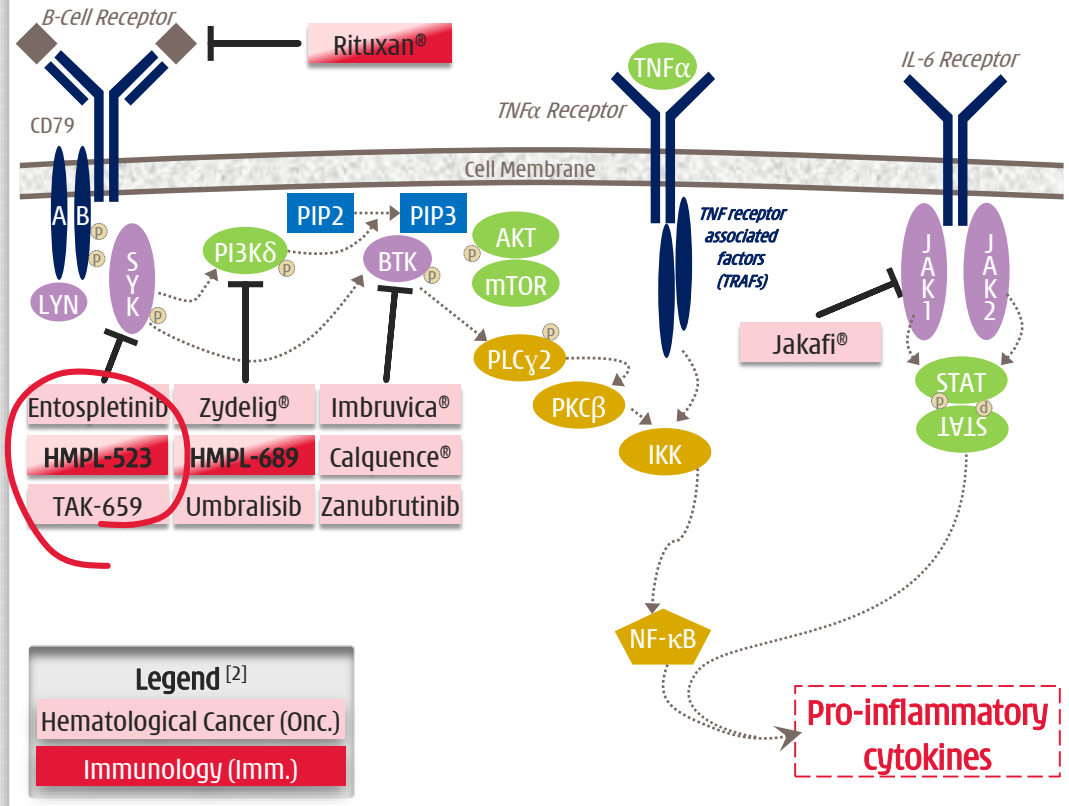
Potential first-in-class (Syk) & best-in-class (PI3Kδ) assets

HMPL-523 – hematological malignancies

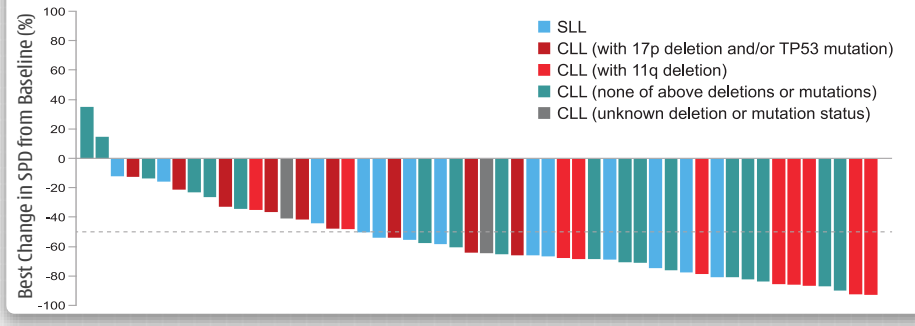
Syk exciting target emerging – Lymphoma PoC ongoing

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

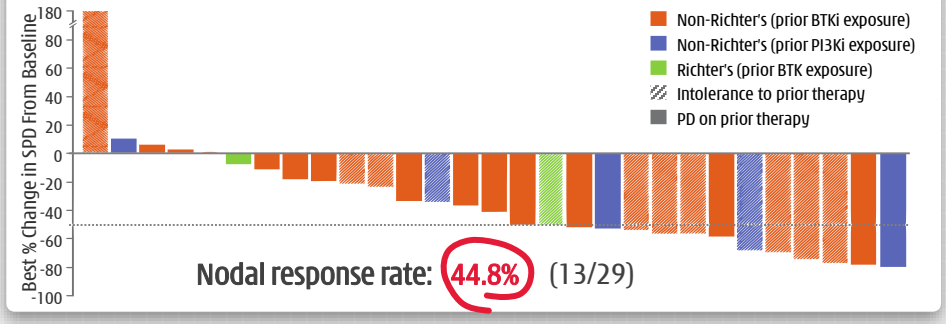
- 2018 sales: Imbruvica® $6.2bn; Zydelig® $0.1bn; Jakafi® $2.4bn; & Rituxan® $5.3bn [1].



2. Entospletinib – 65% Nodal Response Rate 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] Sources: AbbVie, Gilead Sciences, Pfizer and Roche 2018 annual reports; Rituxan® 2018 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 Ph.Ib expansion. US/EU Ph.I imminent

- Extensive **Ph.I dose escalation study now complete** in Australia & China (total n=60);
- RP2D [1] determined & **large Ph. Ib dose expansion study, total n=192**, underway in 13 active sites in Australia & China;
- Phase I/Ib **data set currently >150 patients**;
- **US IND application cleared by FDA** & U.S./E.U. Phase I imminent;
- **Plan to initiate China registration studies in 2019**.

Australia & China Phase I/Ib studies

Stage I: dose escalation

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

"3 + 3" each dose cohort

N = 33

N = 27

Complete ✓

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 (PRC)

Aus N = 40

China N = 152

600mg QD

until disease progression, death, intolerable toxicity, etc.

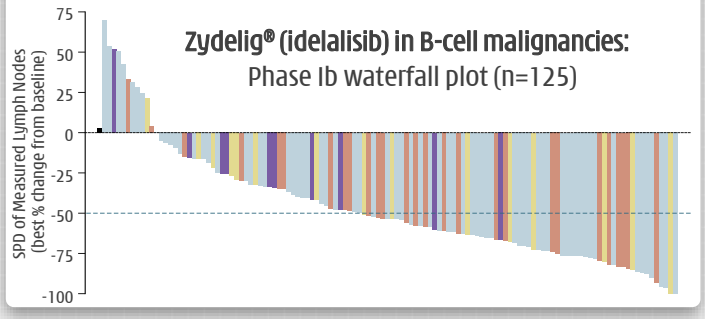
[1] RP2D = Recommended Phase II doses.

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

A2e

Epitinib (EGFR), Theliatinib (EGFRwt) & HMPL-453 (FGFR)

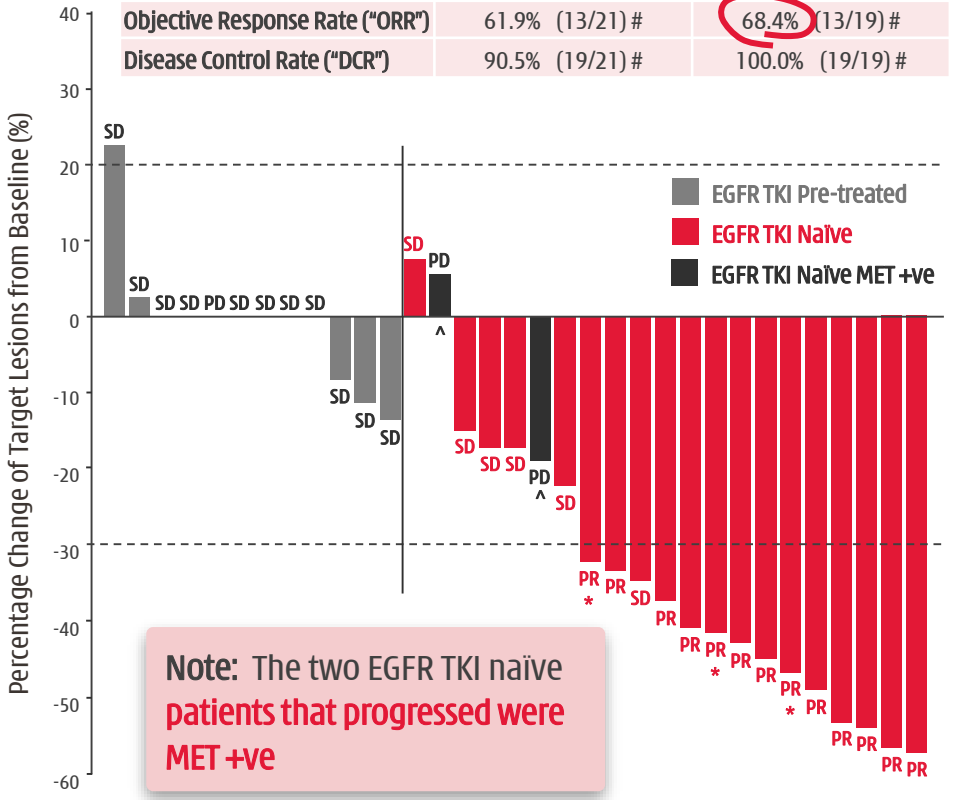
Aim to establish proof-of-concept

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

Unmet medical need. Investment case under review.

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

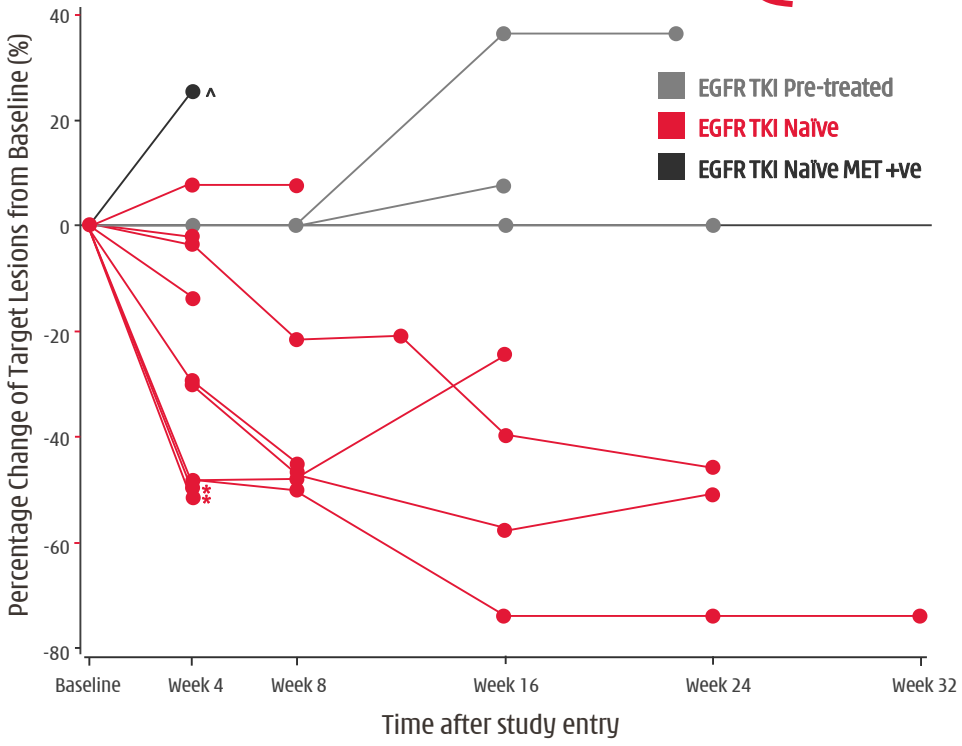
160mg once daily dose ("QD")	EGFR TKI naïve (N=21)	EGFR TKI naïve excl. MET +ve (N=19)
Objective Response Rate ("ORR")	61.9% (13/21) #	68.4% (13/19) #
Disease Control Rate ("DCR")	90.5% (19/21) #	100.0% (19/19) #



Note: The two EGFR TKI naïve patients that progressed were 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. 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] EGFR tyrosine kinase inhibitor treatment naïve patients, 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; ^ MET amplification/high expression identified.

Epitinib – Safe & well tolerated

CHI-MED

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%)

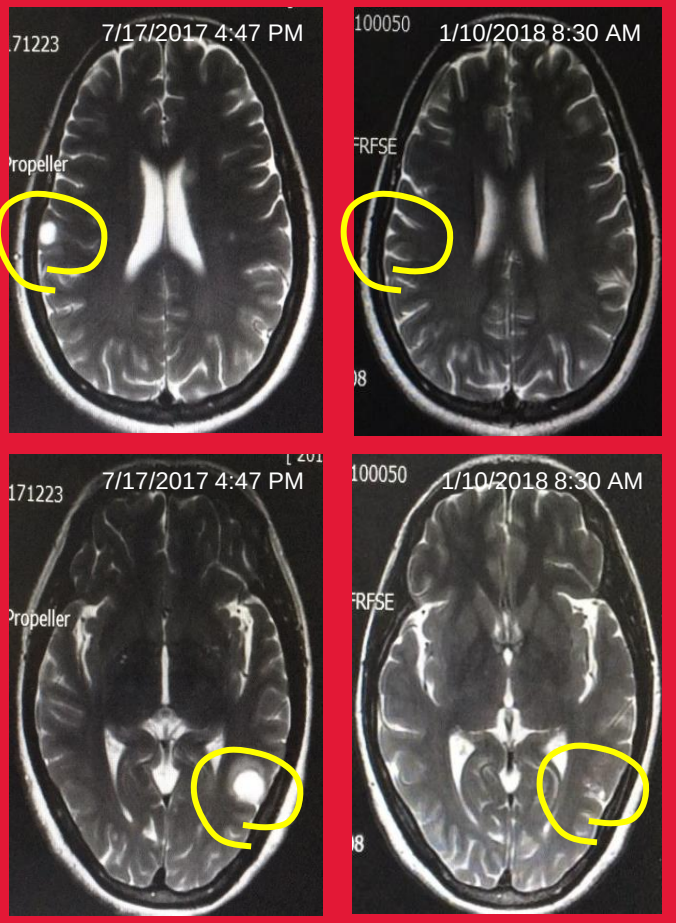
Dose Expansion Stage (n=37) (Drug related AEs reported ›10%)		
160mg QD dose	All Grades n (%)	Grade 3/4 n (%)
Skin rash	31 (83.8%)	2 (5.4%)
Hyper-pigmentation	18 (48.6%)	1 (2.7%)
ALT increase	15 (40.5%)	7 (18.9%)
AST increase	15 (40.5%)	4 (10.8%)
ASP increase	11 (29.7%)	1 (2.7%)
Diarrhea	10 (27.0%)	-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

Theliatinib

Potent & highly selective TKI - strong affinity to EGFRwt kinase

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

- EGFR TKIs are less effective in solid tumors with wild-type EGFR activation (gene amplification & protein over expression).
- Ph.Ib study in esophageal cancer - short-term response & stable disease observed. Does not warrant continued development as monotherapy. Consider potential immunotherapy combo.

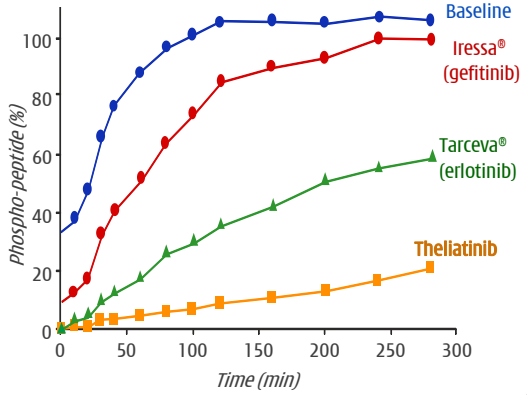
Tumor Types	Wild-type: Gene Amplification	Wild-type: Over Expression	Mutations
NSCLC	29%	62%	10-30%
Esophagus	8-30%	30-90%	12% (esophageal adenocarcinoma)
Stomach	29%	44-52%	‹5%
Glioblastoma	36-51%	54-66%	27-54% (EGFR variant III)
Colorectal	4.5%	*53%*	8%
Head and neck	10-30%	*66-84%*	42% (EGFR variant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

TKIs approved: Iressa®, Tarceva®

MAbs approved: Erbitux®, Vectibix®

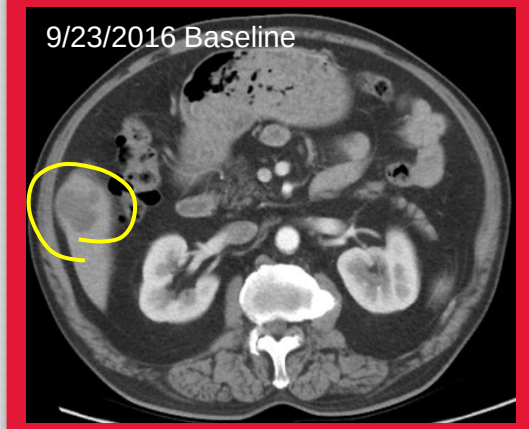
2. Superior anti-tumor activity of theliatinib in pre-clinical studies with wild-type EGFR.

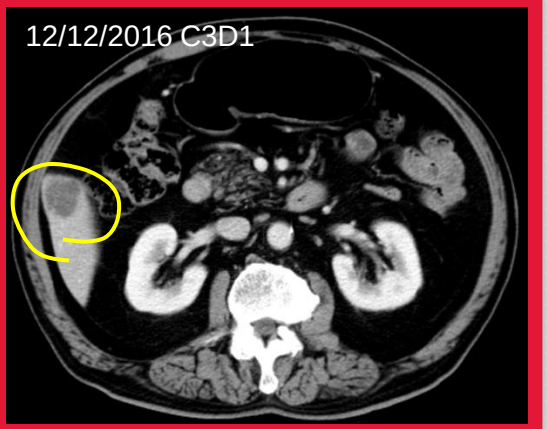
- 5-10-fold more potent than Tarceva®.
- Sustained target occupancy.



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).





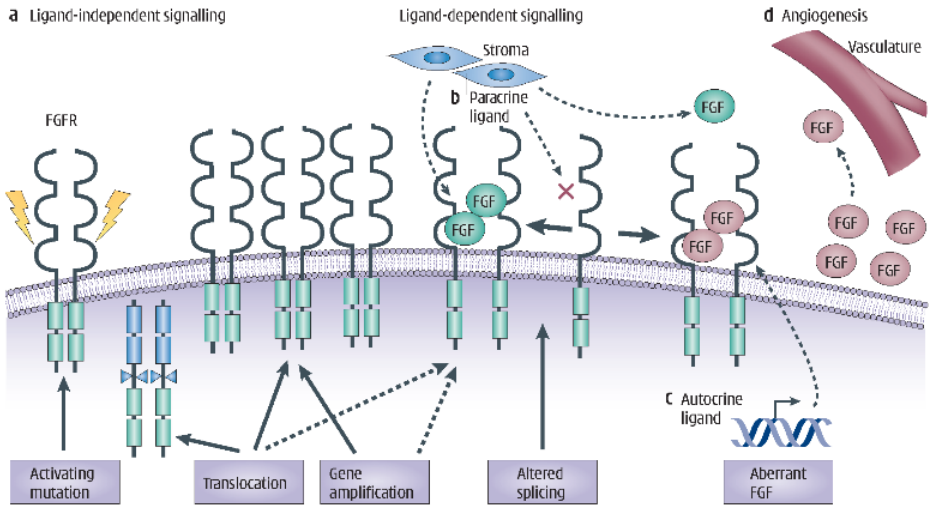
TKIs = tyrosine kinase inhibitors; MAbs = monoclonal antibodies. [1] GLOBOCAN 2012 (http://globocan.iarc.fr/) and Chen W et al. Cancer statistics in China, 2015. CA Cancer J Clin. 2016; 66:115-132

HMPL-453 – Phase I in China ongoing

Designed as best-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%)

A3 Further Corporate Information

Chi-Med Group Structure - Major Entities

Non-Consolidated Joint Ventures

Chi-Med Subsidiaries

Chi-Med Group Level

Revenues - H1 2019: $102.2m (H1 2018: $102.2m)
Net Loss Attributable to Chi-Med - H1 2019: -$45.4m (H1 2018: -$32.7m)

Innovation Platform

Revenue - **H1 2019: $12.0m** (H1 2018: $13.6m)
Net Loss Attributable to Chi-Med - **H1 2019: -$63.8m** (H1 2018: -$52.9m)

99.8%

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

Revenue:
H1 2019: $12.0m (H1 2018: $13.6m)

Hutchison Medi Pharma

Commercial Platform

Sales of Subs & JVs - **H1 2019: $367.1m** (H1 2018: $360.3m)
Net Income Attributable to Chi-Med - **H1 2019: $27.7m** (H1 2018: $26.9m)

Prescription Drugs

50%

Shanghai Hutchison Pharma ("SHPL")
Prescription Drugs
Partner: Shanghai Pharma Group
Revenue:
H1 2019: $158.9m (H1 2018: $152.7m)

51%

Hutchison Sinopharm ("HSP") [1]
Rx Drug Commercial Co.
Partner: Sinopharm Group
Revenue:
H1 2019: $72.6m (H1 2018: $68.0m)

Consumer Health

50% [2]

Hutchison BYS Chinese Med. ("HBYS")
Over-the-counter Drugs ("OTC")
Partner: Guangzhou Pharma Holdings
Revenue:
H1 2019: $118.0m (H1 2018: $119.0m)

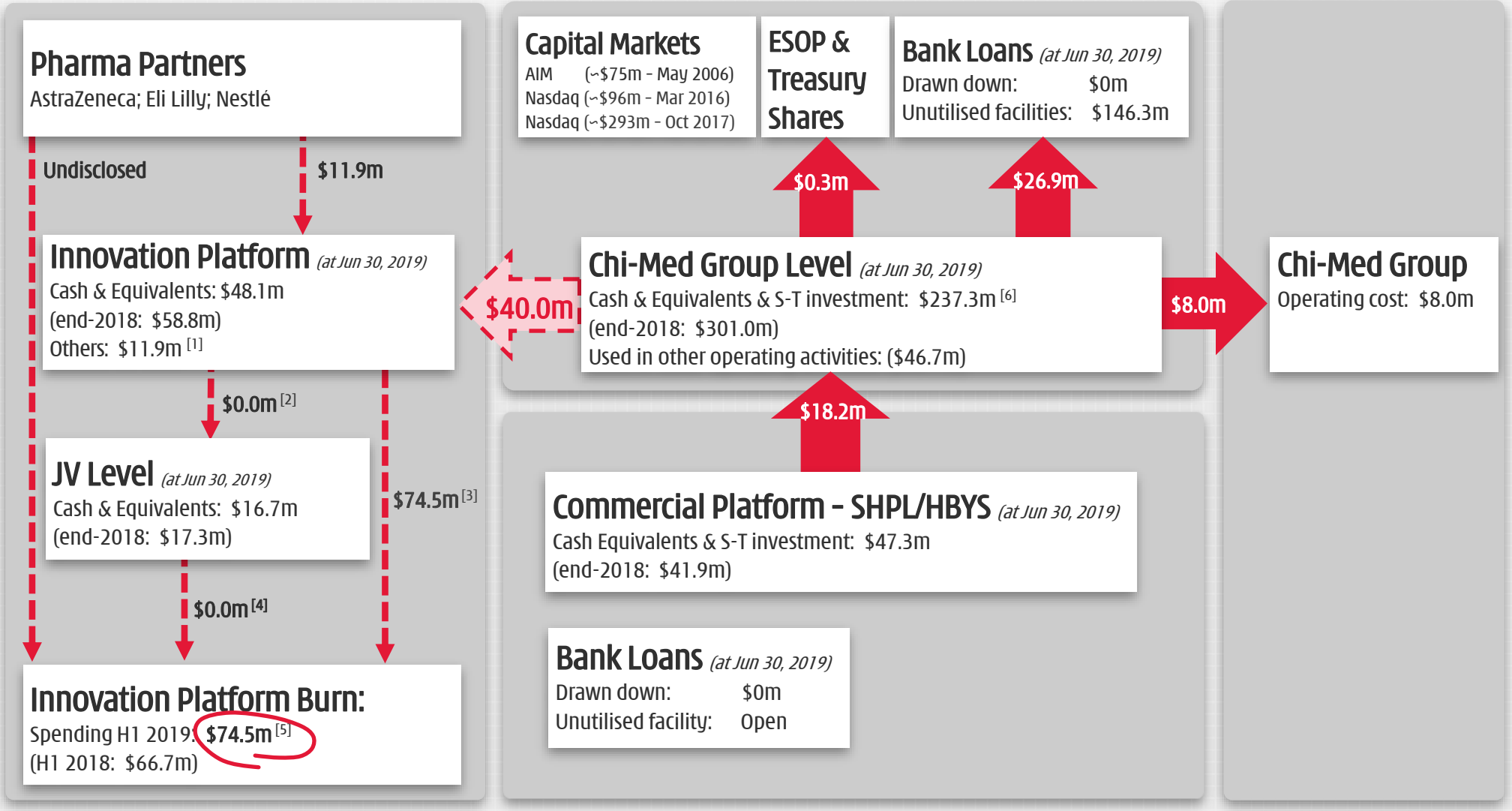
50%

Hutchison Hain Organic ("HHO")
Health Related Consumer Prods.
Partner: Hain Celestial Group
Revenue:
H1 2019: $10.3m (H1 2018: $14.2m)

[1] Excluded HSP's Zhi Ling Tong & Topfer infant nutrition business; [2] Held through an 80% owned subsidiary.

FY2019 H1 Inter-group cash flow

$237.3m cash (Jun 30, 2019); $146.3m in undrawn bank facilities



[1] Others represent changes in working capital, capital expenditure spending and other non-cash items; [2] No capital injection to NSP and no service income received from NSP; [3] Including research & development cost and general & admin. expenses; [4] Share of NSP operating loss; [5] Please see appendix "Non-GAAP Financial Measures and Reconciliation" for a Reconciliation of GAAP to adjusted research and development expenses; [6] Including $153.9m short-term investment (deposits over 3 months) as at June 30, 2019.

(US$ millions)

Non-GAAP Financial Measures and Reconciliation (1/3)

Reconciliation of Adjusted Group net cash flows and Adjusted Group net cash flows excluding financing activities:

	Jun 30, 2019	2019 Current Guidance	2019 Previous Guidance
Cash and cash equivalents and short-term investments at end period	237.3	180-210 [1]	150-180 [1]
Less: cash and cash equivalents and short-term investments at beginning of year	(301.0)	(300)	(300)
Adjusted Group net cash flows	**(63.7)**	**(90) - (120)**	**(120) - (150)**
Add: Net cash used in financing activities for the period	29.5	— [1]	— [1]
Adjusted Group net cash flows excluding financing activities	**(34.2)**	**(90) - (120)**	**(120) - (150)**

Reconciliation of Adjusted Research and Development Expenses:

	H1 2018	H1 2019
Segment operating loss - Innovation Platform	(53.1)	(63.9)
Less: Segment revenue from external customers - Innovation Platform	(13.6)	(12.0)
Add: Costs of goods & service - third parties	—	1.4
Adjusted R&D expenses	**(66.7)**	**(74.5)**

[1] For the purposes of this reconciliation, 2019 guidance for net cash used in or generated from financing activities for the year is not provided and as such, cash and cash equivalents and short-term investments at the end of year excludes the effect of any net cash used in or generated from financing activities for the year.

(US$ millions unless otherwise stated)

Non-GAAP Financial Measures and Reconciliation (2/3)

Reconciliation of GAAP growth to CER growth

$'Million (except %)	Six Months Ended		Growth Amount			Growth %		
	June 30, 2019	June 30, 2018	Actual	at CER	Exchange effects	Actual growth %	CER growth %	Exchange effect %
Consolidated sales	**102.2**	**102.2**	**-**	**5.1**	**(5.1)**	**0%**	**5%**	**-5%**
Commercial Platform	**90.2**	**88.6**	**1.6**	**6.4**	**(4.8)**	**2%**	**7%**	**-5%**
– Prescription Drugs subsidiary	72.6	68.0	4.6	9.1	(4.5)	7%	13%	-6%
– Consumer Health subsidiaries	17.6	20.6	(3.0)	(2.7)	(0.3)	-15%	-13%	-2%
Non-consolidated joint venture sales	**276.9**	**271.7**	**5.2**	**22.3**	**(17.1)**	**2%**	**8%**	**-6%**
– SHPL	158.9	152.7	6.2	15.8	(9.6)	4%	10%	-6%
– HBYS	118.0	119.0	(1.0)	6.5	(7.5)	-1%	5%	-6%
Total Commercial Platform (Non-GAAP)	**367.1**	**360.3**	**6.8**	**28.7**	**(21.9)**	**2%**	**8%**	**6%**
Consolidated net income attributable to Chi-Med	**(45.4)**	**(32.7)**	**(12.7)**	**(15.6)**	**2.9**	**-39%**	**-48%**	**9%**
Innovation Platform	**(63.8)**	**(52.9)**	**(10.9)**	**(15.4)**	**4.5**	**-21%**	**-29%**	**8%**
Commercial Platform	**27.7**	**26.9**	**0.8**	**2.4**	**(1.6)**	**3%**	**9%**	**-6%**
– Prescription Drugs	21.8	20.8	1.0	2.3	(1.3)	5%	11%	-6%
– Consumer Health	5.9	6.1	(0.2)	0.1	(0.3)	-4%	2%	-6%
Sales of SXBX pill	141.0	129.8	11.2	19.7	(8.5)	9%	15%	-6%

Non-GAAP Financial Measures and Reconciliation (3/3)

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								H1'18-H1'19
(US$ millions)	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	H1'18	H1'19	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**	**664.4**	**360.3**	**367.1**	**2%**
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***	***408.5***	***220.7***	***231.5***	***5%***
- Consolidated subsidiary	-	-	-	-	-	-	-	-	-	-	-	50.2	105.5	149.9	166.4	132.8	68.0	72.6	7%
- 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	275.7	152.7	158.9	4%
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***	***255.9***	***139.6***	***135.6***	***-3%***
- 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	40.1	20.6	17.6	-15%
- 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	215.8	119.0	118.0	-1%
Total Sales Growth	***n/a***	***27%***	***133%***	***56%***	***17%***	***31%***	***26%***	***20%***	***18%***	***29%***	***n/a***	***16%***	***11%***	***21%***	***8%***	***-2%***		***2%***	
- GuanBao divested in Sept'2017	-	-	-	-	-	-	-	-	(11.4)	(50.5)	(51.6)	(49.7)	(40.7)	(45.0)	(38.6)	0.0	0.0	0.0	n/a
Adjusted Consumer Health	***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***	***255.9***	***139.6***	***135.6***	***-3%***
- Adjusted Non-consolidated joint venture	0.0	-	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	215.8	119.0	118.0	-1%
Adjusted Sales (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***	***664.4***	***360.3***	***367.1***	***2%***
Total Adjusted Sales Growth	***n/a***	***27%***	***133%***	***56%***	***17%***	***31%***	***26%***	***20%***	***13%***	***16%***	***13%***	***19%***	***15%***	***22%***	***10%***	***4%***		***2%***	
Net (loss)/income after tax (Non-GAAP)	**(10.7)**	**(3.6)**	**2.2**	**6.7**	**11.2**	**14.7**	**21.5**	**27.9**	**30.1**	**33.1**	**39.7**	**48.8**	**54.1**	**63.3** [3]	**77.3** [4]	**83.6**	**55.1**	**57.0**	**3%**
Prescription Drugs	***(0.4)***	***1.3***	***1.9***	***1.3***	***1.9***	***2.8***	***6.0***	***11.9***	***14.2***	***17.7***	***22.4***	***26.5***	***31.9***	***41.4***	***53.0***	***63.9***	***41.5***	***43.7***	***5%***
- Consolidated subsidiary	-	-	-	-	-	-	-	-	-	-	-	0.1	0.6	1.6	2.4	4.1	2.7	1.6	-41%
- Non-consolidated joint venture	(0.4)	1.3	1.9	1.3	1.9	2.8	6.0	11.9	14.2	17.7	22.4	26.4	31.3	39.8	50.6	59.8	38.8	42.1	9%
Consumer Health	***(10.3)***	***(4.9)***	***0.3***	***5.4***	***9.3***	***11.9***	***15.5***	***16.0***	***15.9***	***15.4***	***17.3***	***22.3***	***22.2***	***21.9***	***24.3***	***19.7***	***13.6***	***13.3***	***-2%***
- Consolidated subsidiaries	(10.3)	(4.9)	(2.9)	(2.4)	0.2	-	0.8	1.0	(0.4)	(1.1)	0.1	1.5	0.8	1.5	3.5	2.8	1.6	1.1	-29%
- Non-consolidated joint venture	-	-	3.2	7.8	9.1	11.9	14.7	15.0	16.3	16.5	17.2	20.8	21.4	20.4	20.8	16.9	12.0	12.2	2%
% Margin	***-48.9%***	***-12.9%***	***3.4%***	***6.6%***	***9.4%***	***9.4%***	***10.9%***	***11.8%***	***10.8%***	***9.2%***	***9.9%***	***10.5%***	***10.4%***	***10.1%***	***11.4%***	***12.6%***	***15.3%***	***15.5%***	
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]	**41.4**	**26.9**	**27.7**	**3%**
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*	*32.1*	*20.8*	*21.8*	*5%*
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*	*9.3*	*6.1*	*5.9*	*-4%*
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%*	*10%*		*3%*	

[1] 2003-2006 incl. disco. operation; [2] Continuing Operations; [3] Excludes the land compensation in SHPL of $80.8 million from net income after tax and $40.4 million from net income attributable to Chi-Med for 2016;
[4] Excludes SHPL's R&D related subsidies of $5.0 million from net income after tax and $2.5 million from net income attributable to Chi-Med for 2017.

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 median PE multiples is approximately $1.8 billion.[1] Given our share in the JVs, Chi-Med's share of this value is approximately $0.9 billion.

	Code	NET SALES 2017 Jan-Dec	NET SALES 2018 Jan-Dec	NET SALES FY17-18 Growth	NET INCOME 2017 Jan-Dec	NET INCOME 2018 Jan-Dec	NET INCOME FY17-18 Growth	NET INCOME FY2018 Margin	VALUATION [4] Market Cap.	VALUATION [4] P/E
CHI-MED Commercial Platform -- Subsidiaries/JVs[2]		**638.6** [3]	**664.4**	**4%**	**77.3**	**83.6**	**8%**	**13%**	**n/a**	**n/a**
Li Zhu Pharma	000513	1,292.6	1,342.5	4%	124.2	179.0	44%	13%	3,590	16
Shandong Dong E E Jiao	000423	1,117.0	1,111.9	0%	309.7	316.2	2%	28%	3,384	12
Kunming Pharma	600422	886.7	1,076.1	21%	50.8	51.8	2%	5%	1,247	23
Zhejiang Kang En Bai Pharma	600572	802.1	1,028.3	28%	110.6	122.5	11%	12%	2,655	24
Tianjin Zhong Xin Pharma	600329	862.0	963.4	12%	71.7	86.0	20%	9%	1,560	18
Zhangzhou Pien Tze Huang	600436	562.7	722.1	28%	118.2	171.0	45%	24%	9,654	52
Jiangsu Kang Yuan	600557	496.2	579.4	17%	57.3	66.3	16%	11%	1,333	20
Zhuzhou Qian Jin Pharma	600479	482.2	504.3	5%	37.4	45.8	23%	9%	618	15
Jiu Zhi Tang	000989	581.3	473.1	-19%	109.3	49.0	-55%	10%	1,113	27
Wuhan Jian Min Pharma	600976	410.8	327.5	-20%	13.9	12.3	-11%	4%	356	29
Peer Group -- Median (10 Comps. excl. Chi-Med)		**691.7**	**842.8**	**22%**	**90.5**	**76.2**	**-16%**	**9%**	**1,446**	**21**
All 61 Listed China Pharma. Companies -- Median		**515.1**	**579.4**	**12%**	**50.8**	**49.6**	**-2%**	**9%**	**1,247**	**21**

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 2018 Net Sales in the ~$300-1,400 million range.

(US$ millions)

Source: Company data, Deutsche Bank, FactSet

[1] Peer group/China Pharma multiple of 21x 2018 actual Net income after tax of $83.6 million; [2] Total aggregate PRC domestic results of Chi-Med's 6 Commercial Platform companies (HBYS, SHPL, Hutchison Sinopharm, HHO, HHL & HCPL); [3] Excluding Guanbao (divested); [4] Market Capitalization and Price Earnings Ratios as at **July 26, 2019**: Trailing Twelve Month PE weighted averaged based on market capitalization.

National Reimbursement Drug List Pricing ("NRDL")

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

		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 Reimbursement Drug List Pricing ("NRDL")

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

		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, 3-wks-on/1-wk-off *	$4,368	$2,352	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	$2,369	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.
* Price amended to account for 3-weeks on, 1 week off regimen.

National Reimbursement Drug List Pricing ("NRDL")

Nov'19 update – 8 new and 9 renewed drugs in oncology[1]

Brand (generic)	Company	Unit Pricing (US$) [3] Dosage	Avg. Tender	Reimbursed	Δ%	Approximate Monthly Pricing (US$) [3] Dosage	Avg. Tender	Reimbursed	Indication coverage
Elunate® (fruquintinib)	Chi-Med	5mg	$149	$53.77	-64%	5mg QD 3wks/1wk-off.	$3,350	$1,210	Metastatic colorectal cancer, 3L
Tyvyt® (sintilimab)	Innovent	10ml	$1,114	$404.41	-64%				Classical Hodgkin's lymphoma, 3L
Saiweijian® (raltitrexed)	Sino Biopharm	2mg	$234	$95.16	-59%				colorectal cancer, 5-FU intolerable
Alecensa® (alectinib)	Roche			Undisclosed					NSCLC, ALK+
Lynparza® (olaparib)	AstraZeneca			Undisclosed					Epithelial ovarian, fallopian tube, or peritoneal cancer
Airuini® (pyrotinib)	Hengrui			Undisclosed					Breast cancer, HER2+, 2L
Perjeta® (pertuzumab)	Roche			Undisclosed					Breast cancer, HER2+, neoadjuvant
Jakafi® (ruxolitinib)	Incyte / Novartis			Undisclosed					PMF, PPV-MF, PET-MF

Brand (generic)	Company	Unit Pricing (US$) [3] Dosage	'17 NRDL	'19 NRDL	Δ%	Approximate Monthly Pricing (US$) [3] Dosage	'17 NRDL	'19 NRDL	Indication coverage
AiTan® (apatinib)	Hengrui	425mg [2]	$29.03	$24.56	-15%	850mg QD.	$1,740	$1,470	3L gastric adenocarcinoma or GEJ with adenocarcinoma.
EnDu® (rh-endostatin)	Simcere	15mg	$89.62	$69.70	-22%	7.5mg/m² iv QD 2wks/1wk-off.	$1,430	$1,120	Late-stage NSCLC.
Epidaza® (chidamide)	Chipscreen	5mg	$54.77	$48.79	-11%	30mg QD, 2x per wk.	$2,820	$2,510	2L+ Recurring or refractory peripheral T-cell lymph. (PTCL).
Avastin® (bevacizumab)	Roche			Undisclosed					Late-stage meta. CRC or advanced non-squamous NSCLC.
TheraCIM®[4] (nimotuzumab)	Biotech			Undisclosed					Combo with RT for EGFR+ III/IV nasopharyngeal carcinoma.
Tarceva® (erlotinib)	Roche			Undisclosed					Advanced NSCLC with limited EGFR gene mutation.
Herceptin® (trastuzumab)	Roche			Undisclosed					Breast: Her2+; Her2+ meta. Her2+ late-stage meta. gastric.
Afinitor® (everolimus)	Novartis			Undisclosed					RCC after sunitinib or sorafenib. Pancreatic NETs. TSRA.
Nexavar® (sorafenib)	Bayer			Undisclosed					RCC or HCC. meta. diff. thyroid after radio-iodine therapy.

Source: National Healthcare Security Administration (NHSA); Goldman Sachs equity research.
[1] Excluding botanical oncology drugs; [2] Reference SKU or reference recommended dosage for monthly pricing calculation; [3] Calculation assumes an exchange rate of CN¥7.03 per US$1; [4] Marketed as Tai Xin Sheng® in China.

CHI-MED

HUTCHISON CHINA MEDITECH

Thank you