HUTCHISON CHINA MEDITECH

Corporate Presentation

January 2021

Nasdaq/AIM: 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," "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 impact of the COVID-19 pandemic or other health crises in China or globally; 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, 2020 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.

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

Realizing the **global potential of Chi-Med's novel oncology assets**

Building a **fully integrated oncology business** in **China**

Our strengths

Fully integrated platform built over 20 years

World-Class Discovery & Development Capability

First global-focused novel drug discovery company in China – est. 2002

~600 integrated R&D staff focused on oncology & autoimmune disorders

Highly Differentiated NME Portfolio & Global Pipeline

9 innovative clinical stage NMEs – all discovered in-house by Chi-Med

3 lead assets NDA filed/ approved in China – all in late global development

Seasoned MNC Mgmt. Team – Strong Governance

11 years – median tenure with Chi-Med of 14 person senior mgmt. team

0 governance issues during fourteen years as a listed company

Deep Pan-China Market Access Commercial Platform

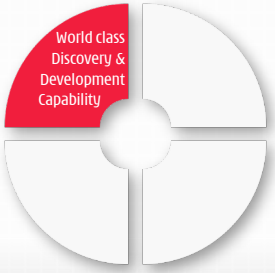
~2,300 person China Rx Sales team – covering about 320 cities

~400 person new oncology commercial team – covering 2,000 hospitals in China

NME = Novel Molecular Entity.

World class discovery engine

Most prolific & validated in China biotech



CHI-MED

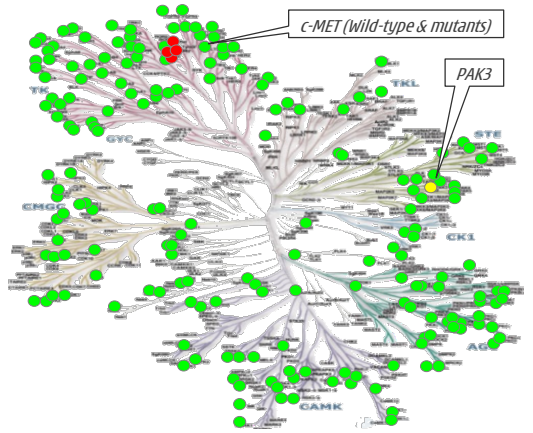
Focus on Global Quality Innovation Proven & Validated at all Levels

- **15+** year track record in oncology, fully integrated ~600 person in-house scientific team
- **40+** oncology indications in development. 9 clinical TKIs incl. VEGFR, c-MET, PI3Kδ, Syk, FGFR & IDH
- **10+** combo therapy trials with chemo, TKI & IO drugs. Our superior selectivity enables combinations
- **4** further in-house late pre-clinical molecules
- **2** validating collaborations

AstraZeneca — *Savolitinib 2011 Global deal*

Lilly — *Fruquintinib 2013 China deal*

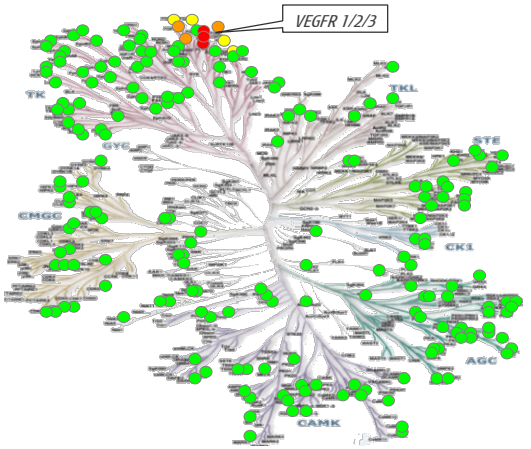
Chi-Med's Advanced Chemistry Approach Provides Superior Selectivity Profiles



Savolitinib

~1,000 times

more selective to c-MET than next kinase (PAK3)[1]



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)[2]

[1] W. Su, et al, 2014 American Association of Cancer Research; [2] Sun et al., Cancer Biology & Therapy 15:12, 1635--1645; December 2014.

Deep global development infrastructure

Track record of breakthroughs

World class Discovery & Development Capability

CHI-MED

- **Integrated development team** of 140+ C&R & ~200 CMC staff located in Shanghai, Suzhou & Florham Park, New Jersey
- **Broad bandwidth & capacity** of R&D team enables smooth coordination of **>25 trials globally & in China**
- **Important working relationships with China & global regulators** - potentially multiple new global registration studies in 2021
- **At launch / filing stage on 3 lead assets** - major regulatory achievements

Elunate® (Fruquintinib)

- **1st China-discovered & developed**, unconditionally approved cancer therapy
- **Global Ph.III started mid-2020** - >100 sites in US, EU & JP
- **Ideal combo candidate** with limited off-target activity; favorable PoC results with chemo & TKIs

Savolitinib

- **China NDA & Priority Review –** first NDA filing globally and first-in-class in China
- **Global partnership with AZ** - China clin. & reg. by Chi-Med
- Multiple global indications - **potentially 3 reg. studies 2021**

Surufatinib

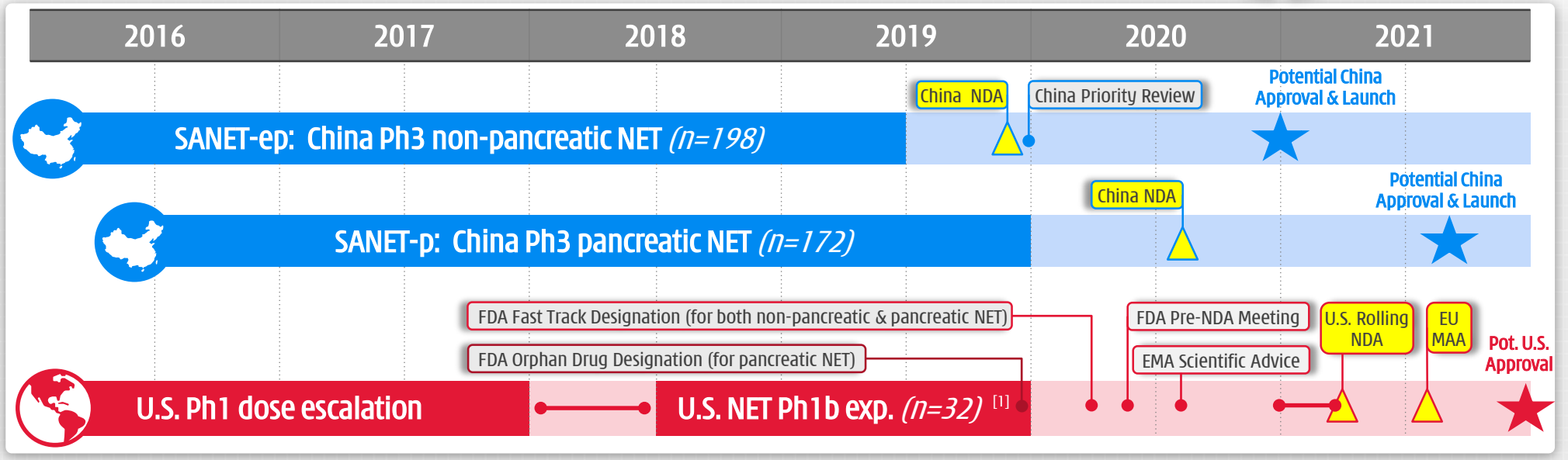
- **2 China NDAs (1 approved & 1 accepted) - unpartnered**
- **US NDA submission using China Ph.IIIs** & US Ph.Ib/II data (late 2020 through early 2021). EU to follow
- **Dual-MoA** - anti-angiogenesis and immuno-oncology

China data support of U.S. NDA & EU MAA

...surufatinib case study in neuroendocrine tumors

World class Discovery & Development Capability

CHI-MED



China Ph IIIs

- Established **profound efficacy** over large base *(n=370)*;
- Robust China **safety data set**;
- Established **equivalence in standard of care in NET** in China & West.

\+

U.S. Ph 1/1b

- Same **RP2D[2] in China & U.S.**;
- **Equivalent pharmacokinetic[3] profile** in Chinese/U.S. patients;
- Meaningful **efficacy post Afinitor® & Sutent®** failure;
- **Supporting safety data** *(n=102)*.

=

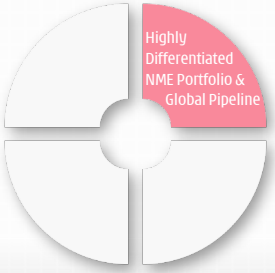
Efficiency

- China Priority Review;
- U.S. Orphan Drug & Fast Track Designations;
- **Aggregate clinical data supporting China NDA; U.S. NDA & EU MAA submissions.**

[1] Safety set n=105; [2] RP2D = recommended phase II dose (300mg QD); [3] A Dasari, S Paulson et al. *Comparison of Pharmacokinetic Profiles and Safety of surufatinib in Patients from China and the United States.* AACR 2020. Abstract CT115.

Maximizing the value of our lead assets

Potential 5 NDAs filings & 8 reg. studies by 2020/2021



CHI-MED

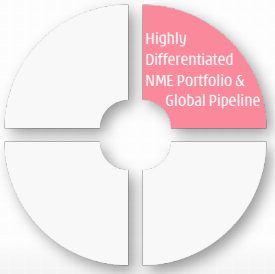
	Dose Finding / Safety Run-In	Proof-of-Concept	Registration Intent	NDA Filed / Marketed
Savolitinib c-MET inhibitor		MET Exon 14 skipping NSCLC		MET Exon 14 skipping NSCLC NDA Accepted May 2020
		PRCC/ccRCC - CALYPSO [2] Imfinzi combo	MET+ PRCC - SAVOIR	
		MET+ Gastric cancer - VIKTORY [2]	MET+ NSCLC - SAVANNAH Tagrisso combo	
		MET+ Colorectal cancer [2]		
Surufatinib VEGFR 1/2/3; FGFR1; & CSF-1R inhibitor		Soft Tissue Sarcoma & BTC		PNET & Non-PNET [3]
	PD-1 Combo Tuoyi - Junshi Bioscience [1]	8 Solid Tumor settings Tuoyi PD-1 combo	2L Biliary Tract cancer	Non-Pancreatic NET NDA Approved Dec 2020
	PD-1 Combo Tiselizumab - BeiGene [1]			Pancreatic NET NDA Accepted Sept 2020
	PD-1 Combo Tyvyt - Innovent Biologics			
Elunate® (Fruquintinib) VEGFR 1/2/3 inhibitor		TN & HR+/Her2- Breast cancer	≥3L Colorectal ca. - FRESCO-2	≥3L Colorectal cancer NDA Approved Sep 2018
		5 Solid Tumor settings Tyvyt PD-1 combo	2L Gastric cancer - FRUTIGA Taxol combo	
	PD-1 Combo Tizelizumab - BeiGene [1]			

Global | China | MAJOR ACTION in PAST 6 mo. | IN TRANSITION

[1] In planning; [2] Investigator initiated trials (IITs); [3] US rolling NDA submission has began Dec 2020.

Deep NME early pipeline

Multiple further waves of innovation progressing



CHI-MED

4 candidates at earlier dev. stages…

	IND preparation	Dose Finding/ Safety Run-In	Proof-of Concept	Registration Intent
HMPL-523 Syk inhibitor		Dose Escalation - Indolent NHL	6 Indolent NHL settings →	
			Immune Thrombocyto. Purpura	
HMPL-689 PI3Kδ inhibitor		Dose Escalation - Indolent NHL		
			8 Indolent NHL settings →	
HMPL-453 FGFR 1/2/3/ inhibitor			Mesothelioma ▲	
			IHCC [1] ▲	
HMPL-306 IDH1/2 inhibitor	IND submission H2 2020			
		Dose Escalation - AML ▲		

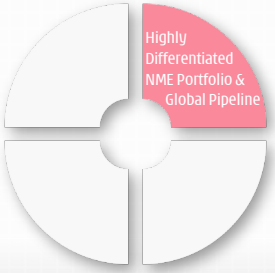
…plus 4 more novel drug candidates in Pre-IND regulatory tox studies - targeting dual U.S. & China IND submissions during 2020-2021

Global | China | MAJOR ACTION In PAST 6 mo. | IN TRANSITION

[1] IHCC= Intrahepatic cholangiocarcinoma

Differentiated portfolio

Designed for global registration – 12 discovered assets



CHI-MED

Product	MOA	Discovery [1]	Indications	Partner	Rights	[2]	[2]
Elunate®	VEGFR 1/2/3	In-house (est. LOE ~2033)	Colorectal, gastric, NSCLC, solid tumors (multiple I/O & TKI combos)	Lilly	HCM has WW rights ex-China; 70%-80% of sales in China [4]	**Marketed** (Colorectal); **Ph.III** (Gastric)	**Ph.III** US, EU, JPN (Colorectal)
Savolitinib	c-MET	In-house (est. LOE ~2035)	NSCLC, kidney, gastric [3], colorectal [3] (multiple I/O & TKI combos)	AZ	AZ has WW rights; China (30% royalty); ex-China (9-18% tiered royalty)	**NDA accepted** (NSCLC)	**Ph.II/III** global (multiple NSCLC) **Ph.III** global (PRCC)
Surufatinib	VEGFR 1/2/3, FGFR1 & CSF-1R	In-house (est. LOE ~2035)	Neuroendocrine tumors (NET), biliary tract, thyroid, solid tumors (multiple I/O combos)	None	HCM holds all WW rights	**Approved** (non-pNET) **NDA accepted** (pNET)	**US NDA filing started YE20 & EU planned in 2021**
HMPL-523	Syk	In-house (est. LOE ~2037)	B-cell malignancies – indolent non-Hodgkin's lymphoma (NHL), ITP	None	HCM holds all WW rights	**Ph.Ib/II** (Treated >200 NHL pts.)	**Ph.I** US, EU, Aus (NHL)
HMPL-689	PI3Kδ	In-house (est. LOE ~2040)	B-cell malignancies – indolent NHL	None	HCM holds all WW rights	**Ph.Ib/II** (Treated >100 NHL pts.)	**Ph.I** US, EU, Aus (NHL)
HMPL-453	FGFR 1/2/3	In-house (est. LOE ~2039)	Malignant mesothelioma, cholangiocarcinoma	None	HCM holds all WW rights	**Ph.II** (Mesothelioma, IHCC)	-
Epitinib	EGFRm+	In-house (est. LOE ~2032)	Glioblastoma	None	HCM holds all WW rights	**Ph.II** (Glioblastoma)	-
HMPL-306	IDH 1/2	In-house (est. LOE ~2043)	Hematological malignancies, solid tumors	None	HCM holds all WW rights	**Ph.I** (Hem. malignancies)	**Ph.I in planning** (start H1 2021)
HMPL-295	Not Disc.	In-house	Solid tumors	None	HCM holds all WW rights	**IND end 2020** (China)	
HMPL-653	Not Disc.	In-house	Solid tumors	None	HCM holds all WW rights	Target **IND 2021** (US/China)	
HMPL-A83	Not Disc.	In-house	mAb – solid tumors, hematological malignancies	None	HCM holds all WW rights	Target **IND 2021** (US/China)	
HMPL-760	Not Disc.	In-house	Hematological malignancies	None	HCM holds all WW rights	Target **IND 2021** (US/China)	

[1] Approximate estimated Loss of Exclusivity (LOE) in key markets considering multiple patent families, extension, and regulatory protection; [2] Represents the most advanced clinical trial stage and indication; [3] Investigator initiated trials (IITs); [4] Subject to meeting pre-agreed sales targets, Lilly will pay Chi-Med an estimated total of 70%-80% of Elunate® sales in the form of royalties, manufacturing costs and service payments.

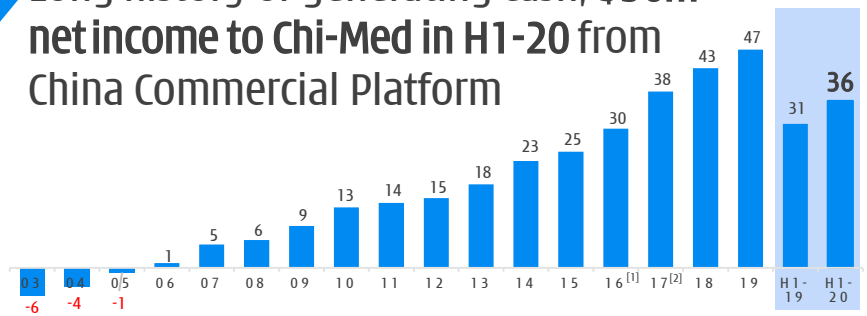
Significant China Commercial Platform

Proven commercial capabilities & deep market access

CHI-MED

Established China Rx Commercial Platform

- ~20 yrs' experience operating in China's complex medical system, Chi-Med mgmt. runs all day-to-day China Rx commercial operations
- ~2,300 Rx sales team – significant national footprint, including about 320 cities & towns; >22,100 hospitals, & >74,000 physicians
- Long history of generating cash; **$36m net income to Chi-Med in H1-20** from China Commercial Platform



Compliant & adaptable across many TAs

- Successfully marketed 3rd party MNC products Concor® (Merck - CV) & Seroquel® (AstraZeneca - CNS)[3]. Global MNC compliance standards

Oncology Commercial Platform & Ambition

- Committed to ongoing significant investment in oncology commercial platform
- First unpartnered oncology drug target late 2020 approval & launch (surufatinib in NET)
- Dedicated oncology team on-track: ~400+ FTEs covering ~2,000 hospitals in 30 provinces / municipalities

High-caliber Team & Rx Commercial Platform

Deep Market Access & Know-how

Compliance, Scale & Profitability in China

Note: excludes land compensation gains and R&D related subsidies in [1] 2016: $40.4m and [2] 2017: $2.5m; [3] Distribution of Seroquel® has been discontinued.

Seasoned executives – MNC veterans

Global standards – Reputation & transparency

CHI-MED

Management Team

Christian Hogg
Chief Executive Officer
P&G
31/**20**

Weiguo Su
Chief Scientific Officer
Pfizer
30/**15**

Johnny Cheng
Chief Financial Officer
Bristol Myers Squibb
KPMG Nestlé
31/**12**

Junjie Zhou
General Manager, SHPL
SANOFI
29/**19**

Marek Kania
Managing Director & Chief Medical Officer, International
Lilly
26/**2**

Zhenping Wu
Pharmaceutical Sciences
Roche
Pfizer
26/**12**

Hong Chen
Chief Commercial Officer, China
Bristol Myers Squibb
NOVARTIS
22/**10**

Tom Held
Head of Commercial, U.S.
Daiichi-Sankyo
NOVARTIS
30/**1**

May Wang
Business Dev. & Strategic Alliances
Lilly
26/**10**

Mark Lee
Corporate Finance & Development
CREDIT SUISSE
21/**11**

Charles Nixon
General Counsel
CK HUTCHISON
28/**13**

Andrew Shih
HR – Organization & Leadership Dev.
MERCK
24/**1**

Yiling Cui
Government Affairs
SPH
Bristol Myers Squibb
22/**1**

Enrico Magnanelli
International Operations
GILEAD
21/**2**

Selected Shareholders

CK HUTCHISON
CAPITAL GROUP
Schroders
Fidelity INTERNATIONAL
M&G
Allianz
GENERAL ATLANTIC
CPP Investments
WELLINGTON MANAGEMENT®
MITSUI&CO.
BB Bellevue
Slater Investments Limited
HUDSON BAY CAPITAL
SANDS CAPITAL
AberdeenStandard Investments
Greenwoods
nikko am Nikko Asset Management
svm

0 Issues

in governance in 14 years listed on AIM & 4 years on NASDAQ

Nasdaq
London Stock Exchange
AIM

Track Record of Successful Partnerships

Across functions verified by our long-term MNC partners

AstraZeneca
Lilly
MERCK

xx/**xx** Years in industry/at Chi-Med; Company logos denote prior experience.

CHI-MED

AstraZeneca

AstraZeneca and Chi-Med

Harnessing the power of Chinese Innovation

1 Savolitinib

Savolitinib – selective MET inhibitor

FAST APPROVAL OF MONOTHERAPY

PAPILLARY RCC
~8% RCC. No biomarker therapies approved.

EXON14 MUTATION NSCLC
NDA under review: Priority Review.
First in China. Global in planning.

COMBINATION OPPORTUNITIES

PD-L1 COMBINATION
Preliminary signal with Imfinzi®.
Exploring further.

POST-EGFR TKI NSCLC
~30% Tagrisso®-resistant pts.
(Tag. 2019 $3.2bn, #1 globally).

› Global collaboration with AstraZeneca

Global
China

Note: Market size and patient population estimates are from Frost & Sullivan.

Savolitinib – MET inhibitor

Current development status

Strong position in NSCLC

- **MET Exon 14m** – NDA accepted in May 2020 & priority review;
- Global Ex.14 study in planning;
- **Savo/Tagrisso®** – Enrollment continues apace.

Renewed RCC strategy

- **Savo monotherapy** – ~60 pt. SAVOIR data; Restart in PRCC;
- **Savo/Imfinzi® combo** – Prelim. durable efficacy & tolerability.

Other exploratory studies

- **Gastric monotherapy** – 50% ORR;
- Exploring colorectal.

Global China

Indication	Treatment	Target Patient	Study Name	Dose Finding / Safety Run-in	Proof-of-concept	Registration
NSCLC	**Savolitinib** + Tagrisso	2L/3L EGFRm; Tagrisso ref.; MET+	SAVANNAH			
	Savolitinib	MET Exon 14 skipping		**		
	Savolitinib	MET Exon 14 skipping				*(NDA accepted)* ★
Kidney	**Savolitinib**	MET+ Papillary RCC	SAVOIR			
	Savolitinib + Imfinzi (PD-L1)	Papillary RCC *	CALYPSO			
	Savolitinib + Imfinzi (PD-L1)	Clear cell RCC *	CALYPSO			
Gastric & Colorectal	**Savolitinib**	MET+ Gastric cancer *	VIKTORY			
	Savolitinib	MET+ Gastric cancer				
	Savolitinib	MET+ Colorectal cancer *				

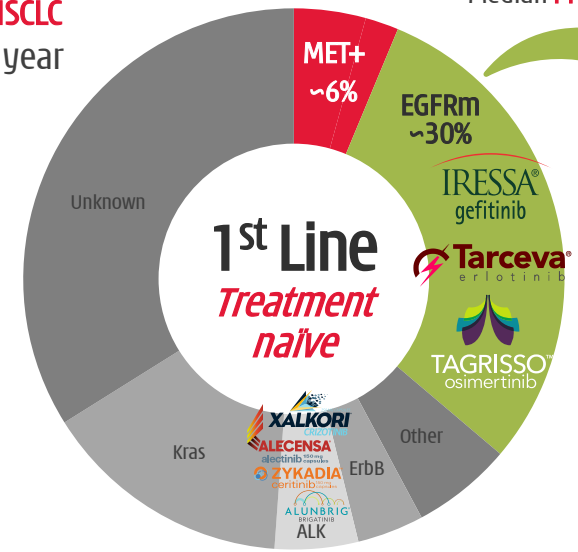
* Investigator initiated trials (IITs); ** In planning

Savolitinib

Biggest opportunity is MET+ NSCLC

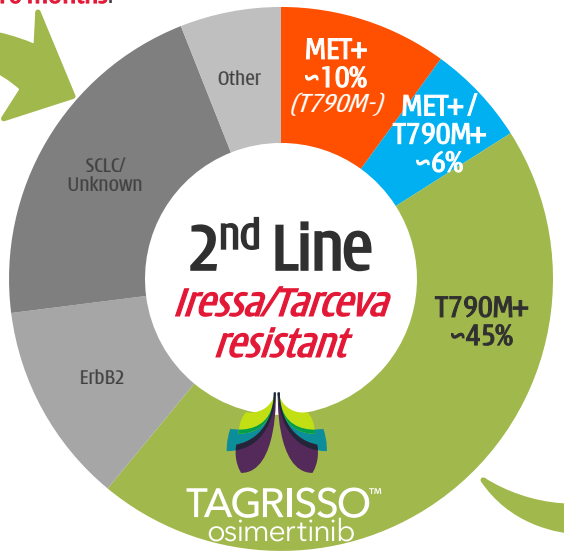
Primary NSCLC

1.8 million NSCLC patients per year

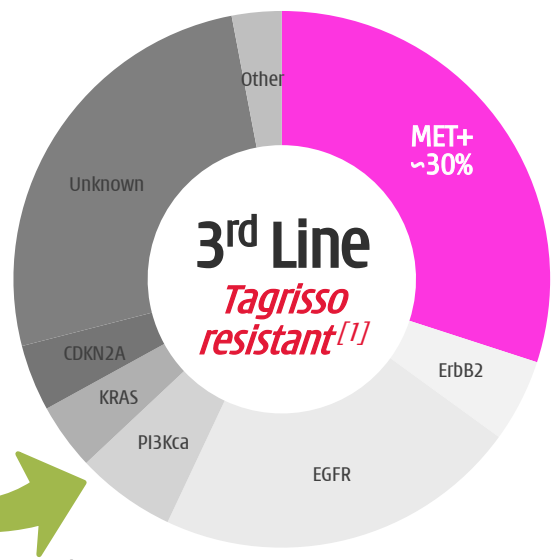


All **Iressa/Tarceva** patients relapse
Median **PFS 9-10 months**.

Resistance-driven EGFRm+ NSCLC



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



	Target	Launch	2019 ($m)[3]
Iressa	EGFRm	2003	423
Tarceva	EGFRm	2004	300
Tagrisso	EGFRm / T790M	2015	3,189
Xalkori	ALK / ROS1 / MET	2011	530
Alecensa	ALK	2015	881
Alunbrig	ALK	2017	60
Total Sales			5,383

Launch	2016	2017	2018	2019
Dec-15	423	955	1,860	3,189 (+74%)

TAGRISSO osimertinib

Est. global sales of ~$6-8 bn by 2023[2].

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

Savolitinib – MET Exon 14 skipping NSCLC

China NDA accepted in May 2020; data at AACR19 & ASCO20

1. MET Exon14 skipping NSCLC NDA filed

2019

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

Jun-Jul '19 -
Study fully enrolled (n~70)

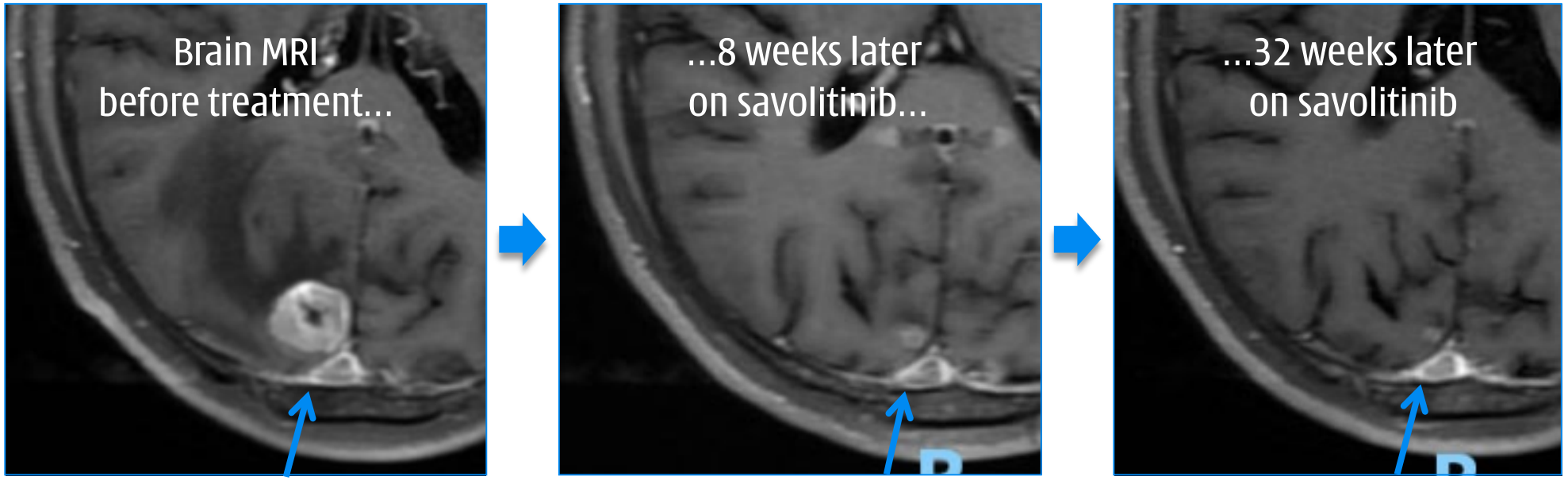
2020

Topline results

May 28, '20 – NDA accepted
- Prior CDE[1] discussion
- Final results
- Incl. global safety data

May 29, '20 -
2020 ASCO Virtual Scientific Program
- 70 patient data

2. Anti-tumor activity observed in brain mets.[2]



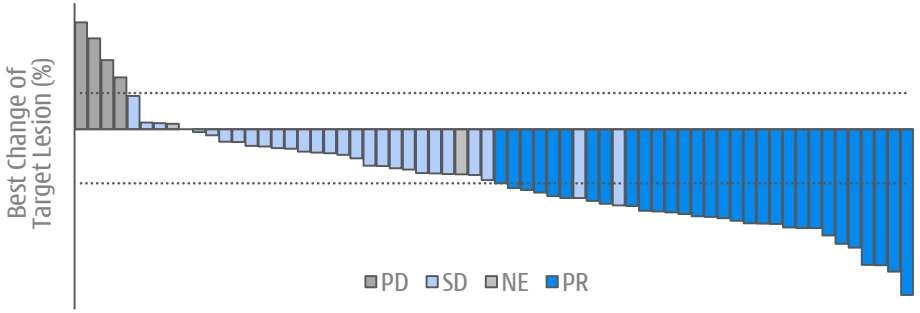
[1] Center for Drug Evaluation of the National Medical Products Administration of China; [2] Lu S et al, Abstract #5707, presented at the 22nd Annual Meeting of the Chinese Society of Clinical Oncology, in Xiamen, China on Sept 20, 2019.

Savolitinib – MET Exon 14 skipping NSCLC [1]

China NDA accepted in May 2020; global dev. in planning

1. Encouraging single agent anti-tumor activity [2]

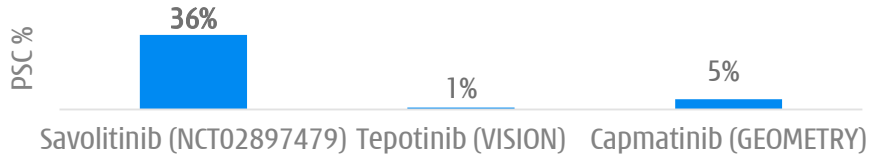
	Efficacy Evaluable (N=61)	Full Analysis (N=70)
ORR, % [95% CI]	49.2 [36.1, 62.3]	42.9 [31.1, 55.3]
DCR, % [95% CI]	93.4 [84.1, 98.2]	82.9 [71.2, 90.8]



2. Generally well-tolerated [2]

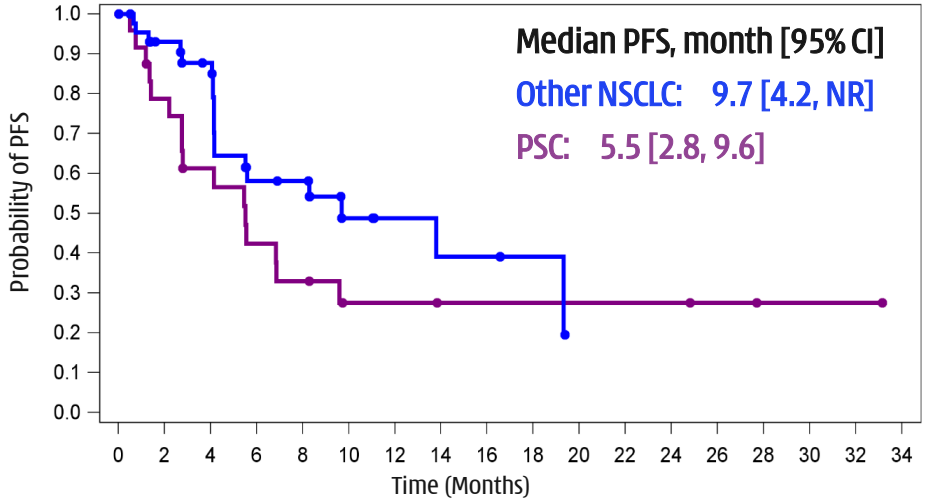
	n (%)
Treatment related serious AE	18 (25.7)
Leading to discontinuation	10 (14.3)
Treatment related AE Grade ≥3	29 (41.4)
Peripheral edema	5 (7.1)
Aspartate aminotransferase increased	9 (12.9)
Alanine aminotransferase increased	7 (10.0)

3. Savo study had 36% pts with PSC, a more aggressive NSCLC sub-type, vs. 1-5% in VISION/GEOMETRY



- PSC standard of care is chemotherapy [3]
  - ↗ ORR: **16.5%**; mPFS: **2 months**; mOS: **6.3 months**

4. DoR, PFS, & OS outcomes are maturing [3]



[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] Data cut-off March 31, 2020. Lu S et al, Abstract # 9519, poster presentation at ASCO20 Virtual Conference May 29-31, 2020; [3] PSC = Pulmonary Sarcomatoid Carcinoma, Vieira, Thibault et al., Journal of Thoracic Oncology, Volume 8, Issue 12, 1574 - 1577.

TAGRISSO™ osimertinib + savo in EGFR TKI refractory NSCLC

TATTON B & D data – efficacy

CHI-MED

	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

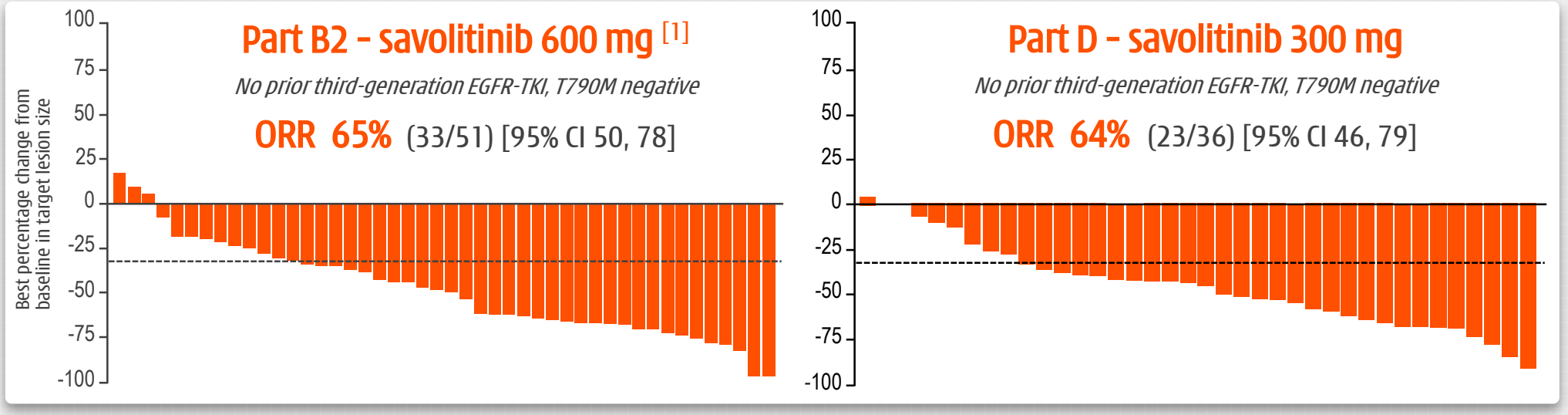
[1] Most patients were enrolled to Part B1, B2, B3 on 600 mg savolitinib, prior to weight-based dosing implementation, but following a protocol amendment in response to a safety signal of hypersensitivity, the final 21 patients enrolled in Part B were dosed with savolitinib by body weight as follows: 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.

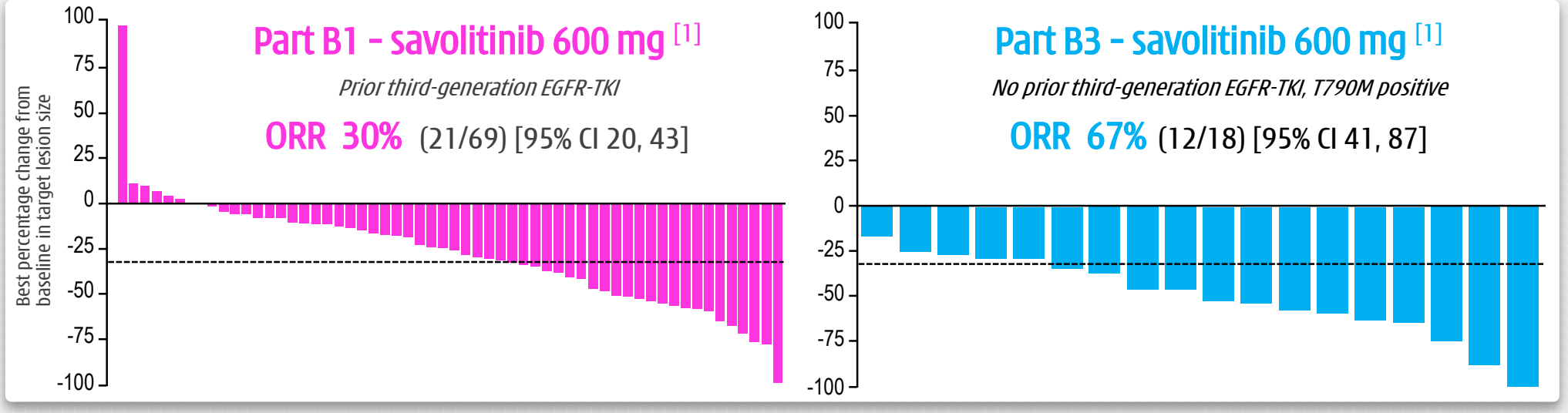
Sequist LV, Han JY, Ahn MJ, et al. Osimertinib plus savolitinib in patients with EGFR mutation-positive, MET-amplified, non-small-cell lung cancer after progression on EGFR tyrosine kinase inhibitors: interim results from a multicentre, open-label, phase 1b study. Lancet Oncol. 2020; S1470-2045(19)30785-5. doi:10.1016/S1470-2045(19)30785-5.

TATTON B & D data - ORR

TAGRISSO™ osimertinib + savolitinib in EGFR TKI refractory NSCLC

CHI-MED





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.

SAVANNAH Study

TAGRISSO™ osimertinib + savolitinib in EGFR TKI refractory NSCLC

CHI-MED

SAVANNAH designed for possible registration of 300mg QD [1]

– in broadest Tagrisso® refractory population – FISH+ and/or IHC+ line agnostic population

2L+ LOCALLY ADV. / METASTATIC EGFRM+ NSCLC PATIENTS

- Progression on 1L or 2L Tagrisso®;
- No prior chemo or immunotherapy;
- MET amplification / over-expression (central FISH/IHC or pre-existing local NGS);
- No prior MET inhibitor therapy;
- Stable/asymptomatic CNS mets. permitted;
- ECOG performance status 0-1.

Enrolled ✓ → Savolitinib **300mg QD** *+ Tagrisso® 80mg QD*

Enrolling → Savolitinib **300mg BID** [2] *+ Tagrisso® 80mg QD*

Enrolling → Savolitinib **600mg QD** *+ Tagrisso® 80mg QD*

PRIMARY ENDPOINT

- **300mg QD** ORR

SECONDARY ENDPOINTS

- **300mg QD**
  - ORR by MET FISH+ / IHC+; PFS; DoR; OS
  - Safety
- **300mg BID & 600mg QD**
  - Efficacy (ORR; PFS; DoR; OS)
  - Safety / tolerability

SAVANNAH will also determine optimal design of planned global Phase III

– optimal biomarkers (FISH/IHC); dose (300mg or 600mg); regimen (QD or BID); & line (post 1L or 2L Tagrisso®)

	% osi. refractory patients	Progression on 1L Osimertinib			Progression on 2L Osimertinib		
		300mg QD	300 mg BID	600mg QD	300mg QD	300 mg BID	600mg QD
FISH+	~30%	*SAVANNAH efficacy & safety data – To be determined*					
FiSH+ &/or IHC+	~50%						

[1] QD = Once daily dose; [2] BID = twice daily dose .

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®/Bavencio® + Inlyta® (PD-X/VEGFR combo)	52-60%	13-15	NR
Opdivo® + Cabometyx® (PD-1/VEGFR multi-kinase combo) [6]	55.7%	16.6	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)	19%	6.7	20.1
Lenvima® + Afinitor® (VEGFR, multi-kinase SM + mTOR)	37%	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

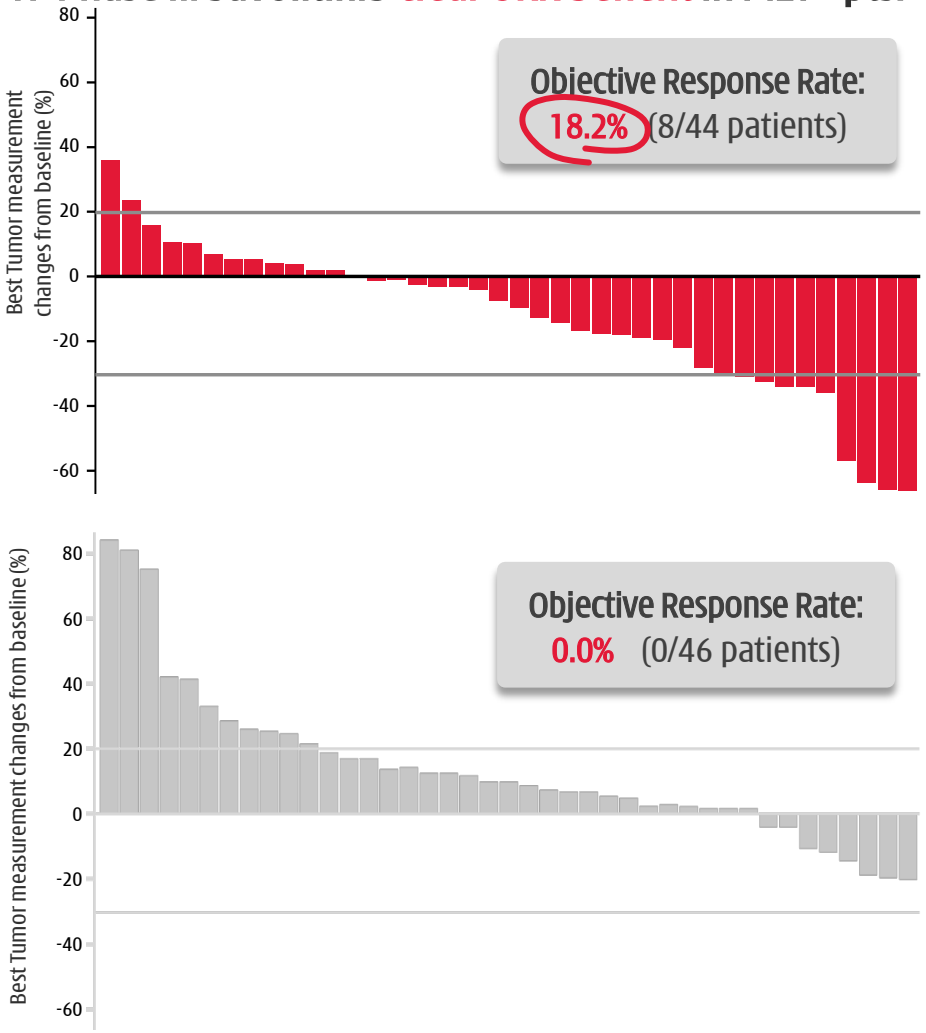
~ 16k new patients/yr.[2]

[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; [6] ESMO 2020.

Savolitinib in PRCC

Phase II study's encouraging efficacy led to SAVOIR Phase III [1]

1. Phase II: Savolitinib clear ORR benefit in MET+ pts.



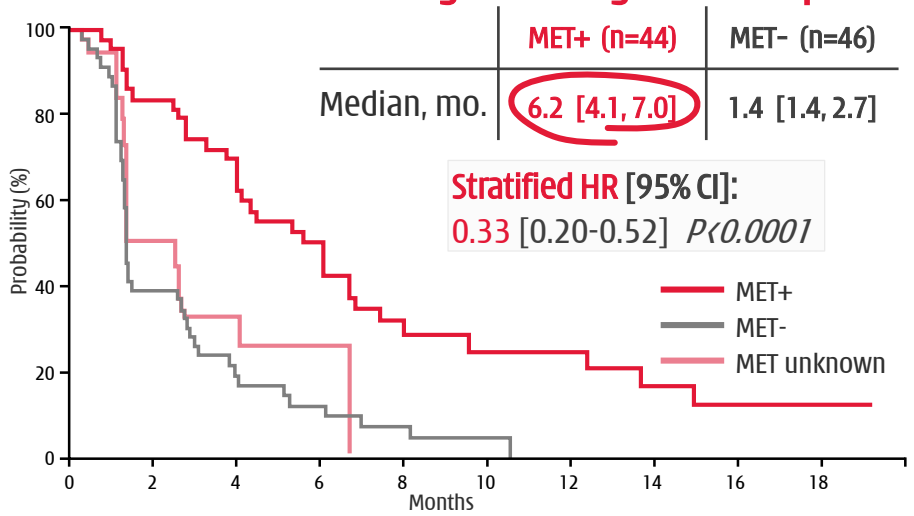
2. Phase II: Disease Control Rate ("DCR") – advantage in MET+ with DCR 73.2% vs. MET- 28.2%.^

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.

3. Phase II: Median PFS – big advantage in MET+ pts.



Source: Choueiri TK, Plimack E, Arkenau HT, et al. Biomarker-Based Phase II Trial of Savolitinib in Patients With Advanced Papillary Renal Cell Cancer. J Clin Oncol. 2017;35(26):2993-3001. doi:10.1200/JCO.2017.72.2967

[1] In late 2018, enrollment was terminated in SAVOIR, a global Phase III registration study of savolitinib monotherapy compared with sunitinib monotherapy in MET-positive PRCC. Data from the approximately 60 patients randomized in SAVOIR prior to termination has matured during 2019 and will be presented at an upcoming scientific conference in mid-2020.

Savolitinib in PRCC

SAVOIR 60 pt. data - actively evaluating progressing clinical work

SAVOIR timeline

2017	2018	2019
Study initiation Planned number of pts = 180 (90 savolitinib / 90 sunitinib)	Enrollment stopped 60 pts enrolled (33 savolitinib / 27 sunitinib)	Data cut-off (DCO) 23 pts remained on therapy (14 savolitinib / 9 sunitinib)

Anti-tumor activity - All 9 savo responders remained in response at DCO

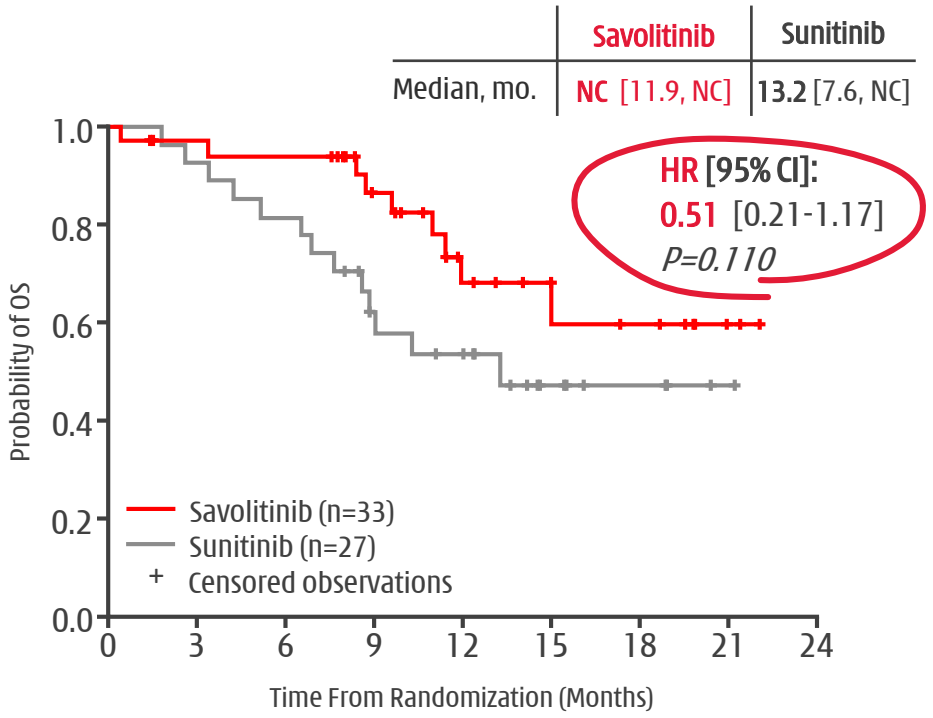
[95% CI]	Savolitinib (N=33)	Sunitinib (N=27)
ORR*	9 (27) [13.3, 45.5]	2 (7) [0.9, 24.3]
PFS	7.0 [2.8, NC]	5.6 [4.1, 6.9]
	Hazard Ratio: 0.71 [0.37, 1.36]	
DCR @ 6 months	16 (48) [30.8, 66.5]	10 (37) [19.4, 57.6]
@ 12 months	10 (30) [15.6, 48.7]	6 (22) [8.6, 42.3]

* One out of two sunitinib responders remained in response at DCO

Better tolerability - 42% savo vs 81% sunitinib AE Gr.≥3

	Savolitinib (N=33)	Sunitinib (N=27)
Treatment related AE Grade ≥3	8 (24)	17 (63)
Any AE Grade ≥3	14 (42)	22 (81)
Anemia	0	4 (15)
Hypertension	0	4 (15)
AST increased	5 (15)	2 (7)
ALT increased	4 (12)	2 (7)

Strong signal of potential overall survival benefit



Choueiri TK, et al. Efficacy of Savolitinib vs Sunitinib in Patients With MET-Driven Papillary Renal Cell Carcinoma: The SAVOIR Phase 3 Randomized Clinical Trial. JAMA Oncol. Published online May 29, 2020. doi:10.1001/jamaoncol.2020.2218

Exploring Savolitinib + PD-L1 inhibitor

CALYPSO Savo/Imfinzi® combo tolerable, w/ durable efficacy

IMFINZI™ durvalumab

CHI-MED

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

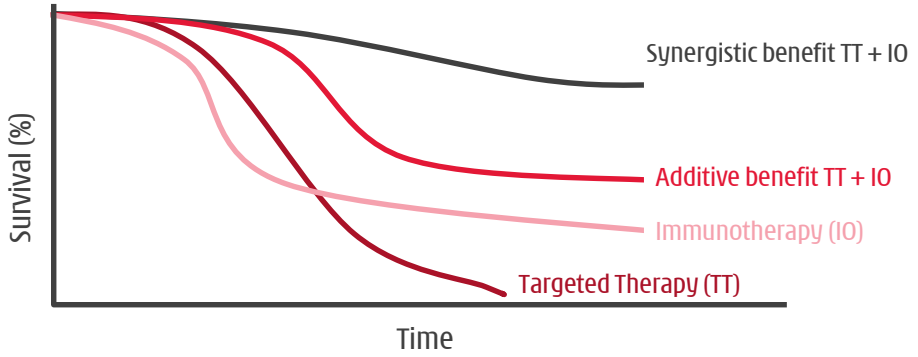
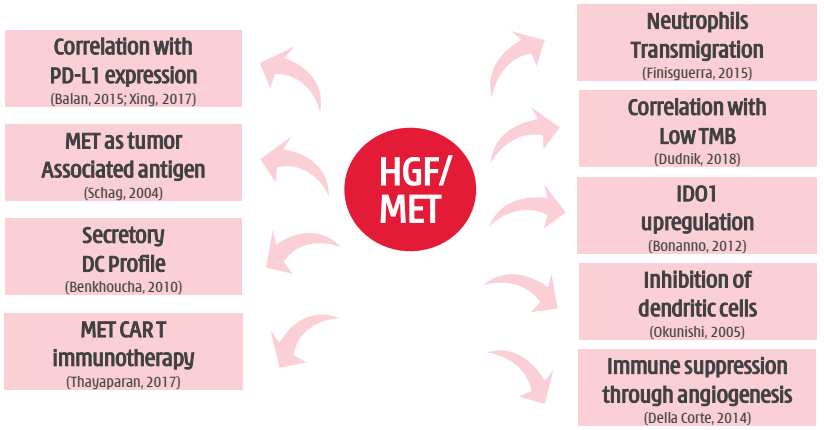


Illustration by Tracy L Rose MD MPH at ASCO GU 2019 presentation, showing what synergistic vs additive benefit could hypothetically look like; not based on clinical data.

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=60)
ORR 27.3%
mPFS 7.0 mo.

Tecentriq®+Cabometyx®
All lines: (n=15)
ORR 40.0%

Keytruda® mono.
First line: (n=118)
ORR 28.8%
DCR 47.5%

Savo + Imfinzi®
All lines: (n=41)
ORR 26.8%
mPFS 4.9 mo.
mOS 12.3 mo.
First line: (n=27)
ORR 33.3%
CALYPSO Interim Data

Tecentriq®+Avastin®
All lines: (n=12)
ORR 25.0%

Tecentriq®+Avastin®
All lines: (n=42)
ORR 26.2%

Keytruda® mono. (all non-ccRCC)
First line: (n=165)
ORR 26.7%
DCR 43.0%
mPFS 4.2 mo.
mOS 28.9 mo.

Tecentriq®+Cabometyx®
All lines: (n=30)
ORR 33.3%
DCR 93.3%

[1] CALYPSO: Suárez C et al. J Clin Oncol 38, 2020 (suppl 6; abstr 619); SAVOIR: ASCO 2020; Keytruda mono - Keynote 427 cohort B ASCO 2020; Tecentriq+Avastin: ASCO 2019; Tecentriq+Cabometyx: ESMO 2020; ORR = Objective Response Rate; DCR = Disease Control Rate; mPFS = median Progression-Free Survival; mOS = median Overall Survival.

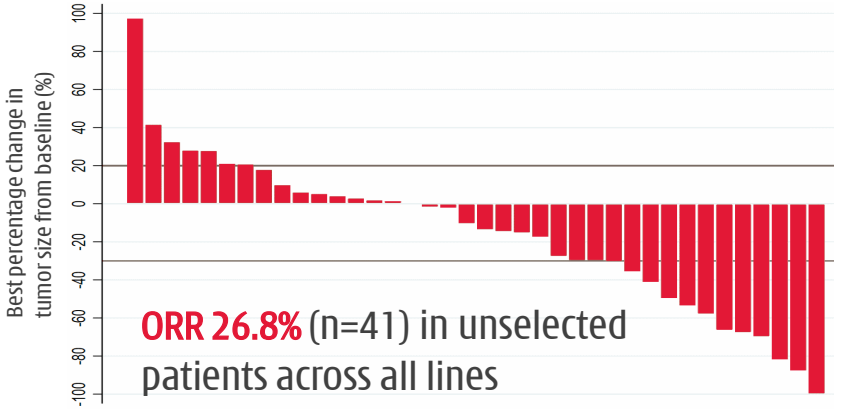
Savo + Imfinzi® in PRCC (CALYPSO)

Continue to accumulate clinical data & explore developments

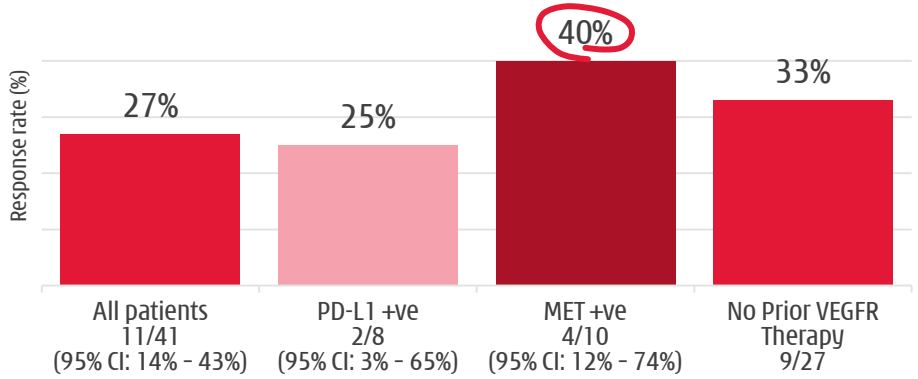
IMFINZI™ durvalumab

CHI-MED

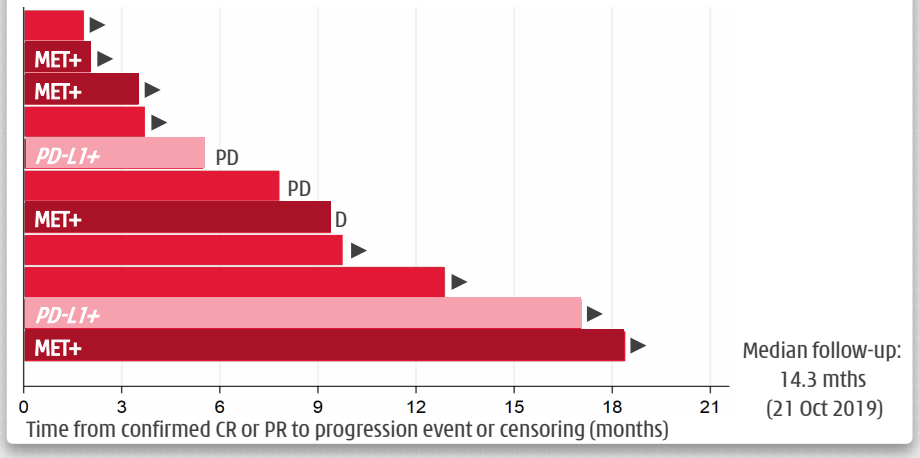
CALYPSO: Encouraging response independent of biomarkers assessed so far



CALYPSO: MET +ve results to be confirmed based on genetic alterations (40% ORR based on IHC ≥3)



CALYPSO: Durable response in a subset of pts



CALYPSO: next steps

- **Further assessment of biomarkers (6 not assessable)**
  - Only MET+ overexpression assessed to date (10/41 positive, 25/41 negative);
  - MET+ gene amplification / other MET aberrations to evaluate.
- **Exploring potential for further expansion of the CALYPSO study**

C. Suarez CALYPSO (PRCC cohort) ASCO GU 2020; Abstract 619. IIT = Investigator Initiated Study; ORR = Objective Response Rate; DCR = Disease Control Rate; mPFS = median Progression-Free Survival; mOS = median Overall Survival; PD = progressive disease; D = discontinued; PD-L1+ defined as: ›25% immune component with SP263 Ab; MET +ve is defined as: ≥ 3+ in ≥ 50% tumor cells with IHC.

CHI-MED

Mechanism of Action

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

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

2 Surufatinib

Surufatinib – VEGFR, CSF-1R & FGFR1 inhibitor

FAST APPROVAL OF MONOTHERAPY

BILIARY TRACT CANCER
Poor prognosis patients.

NET REGISTRATION (GLOBAL)
Fast Track Designation in U.S. & NDA filing started YE2020; EU MAA planned for 2021.

NET LAUNCH (CHINA)
NDA (non-p NET) approved;
Commercial team in place.

COMBINATION OPPORTUNITIES

PD-1 COMBINATIONS
Multiple PD-1s approach;
Potential MOA synergy CSF-1R & PD-1.

PD-1 COMBINATIONS
Multiple PD-1s approach;
Potential MOA synergy CSF-1R & PD-1.

Global
China

Surufatinib - dual VEGFR & CSF-1R inhibitor

Current development status

China NET

- Non-pancreatic NET NDA approved Dec 2020;
- Pancreatic NET - **NDA accepted**.

Global NET

- **U.S. NDA in late 2020** [1];
- **Fast Track Designations** for both pNET & non-pNET;
- **EU MAA planned for 2021**.

Biliary Tract Cancer

- Ph.II/III underway; interim analysis (POC) planned.

PD-1 combos

- Tuoyi® (Junshi) Ph.II (in 8 solid tumor indications);
- Tyvyt® (Innovent);
- Tislelizumab (Beigene).

Indication	Treatment	Target Patient	Study Name	Dose Finding / Safety Run-in	Proof-of-concept	Registration
NET	**Surufatinib**	NET				*(US NDA sub. started)*
	Surufatinib	Pancreatic NET	SANET-p			*(NDA accepted)* ★
	Surufatinib	Non-Pancreatic NET	SANET-ep			*(Approved)* ★
BTC	**Surufatinib**	Biliary tract cancer				
	Surufatinib	2L; chemo ref. biliary tract cancer				
STS	**Surufatinib**	Soft tissue sarcoma				
PD-1 Combo	**Surufatinib** + Tuoyi (PD-1)	Solid tumors		*		
	Surufatinib + Tuoyi (PD-1)	Solid tumors				
	Surufatinib + Tyvyt (PD-1)	Solid tumors				
	Surufatinib + tislelizumab (PD-1)	Solid tumors		*		
	Surufatinib + tislelizumab (PD-1)	Solid tumors		*		

Global

China

* In planning; [1] Chi-Med is now planning a U.S. NDA rolling submission from late 2020 into early 2021.

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:*

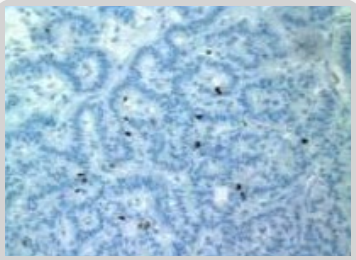
- *94% flushing*
- *78% diarrhea*
- *53% heart plaque*
- *51% cramping*

Symptoms allow early diagnosis

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

- *Octreotide: $1.6b revenue (2019)*
- *Lanreotide: $1.2b revenue (2019)*

mOS: 16.2 yrs.

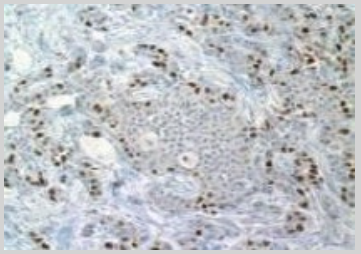


Well Differentiated
Ki-67 Index ≤2; Mitotic Count <2

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.

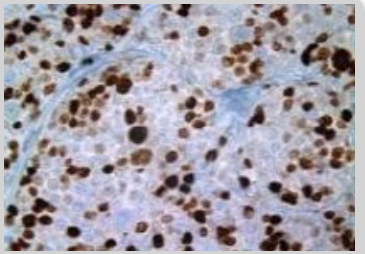


Moderately Differentiated
Ki-67 Index 3-20; Mitotic Count 2-20

G3 – NET/NEC
Distant

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

mOS: 10 mos.



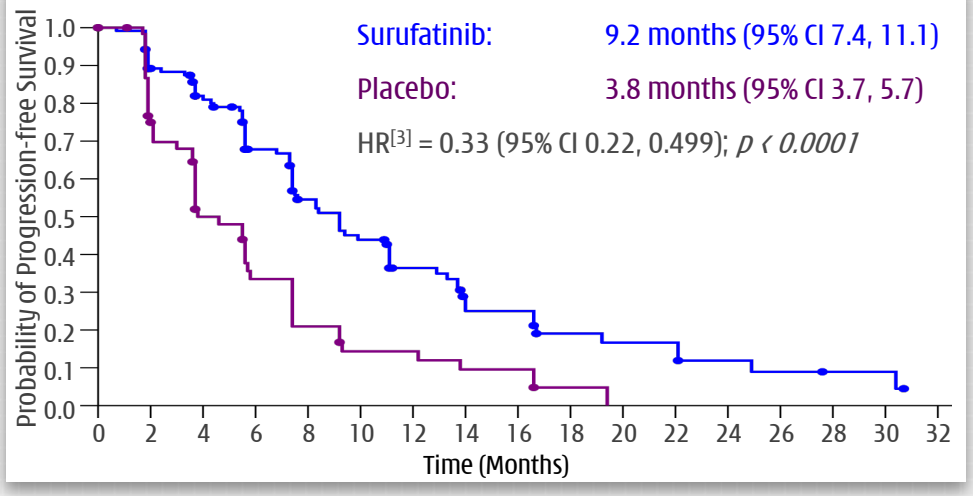
Poorly Differentiated
Ki-67 Index >20; Mitotic Count >20

[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

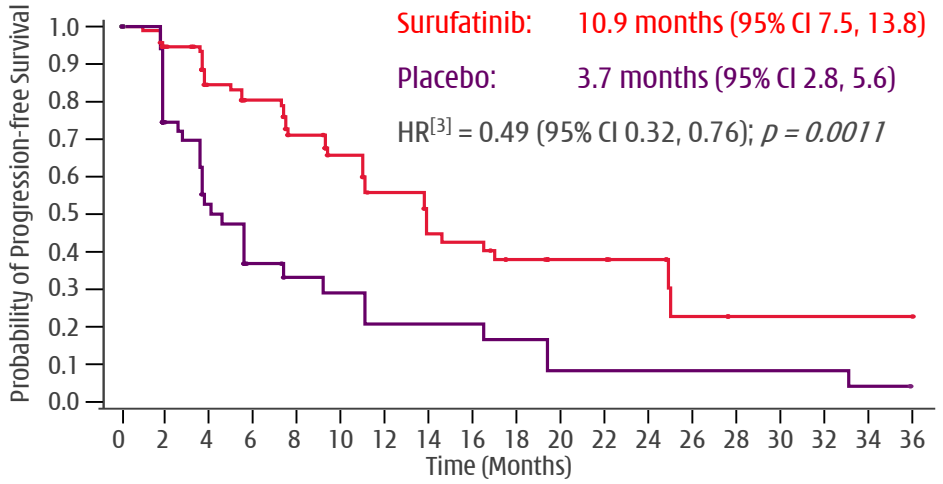
G1/2 Advanced NET

Major unmet need - broad surufatinib efficacy in 2 Phase IIIs

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



Pancreatic[2] *(SANET-p, n=172)*



	China			US		EU5	
	Annual Incidence	Estimated Prevalence	mPFS	Annual Incidence[4]	Estimated Prevalence[4]	Annual Incidence[5]	Estimated Prevalence[5]
Total NET	67,600	~300,000 *(Est. China ratio[4])*		19,000	141,000	18,700	138,800
Non-Pancreatic NET	~54,100	~240,000 *(Est. China ratio[4])*	9.2 mo. *(SANET-ep Ph.III)*	17,000	127,000	16,700	125,000
Pancreatic NET	~13,600	~60,000 *(Est. China ratio[4])*	10.9 mo. *(SANET-p Ph.III)*	2,000	14,000	2,000	13,800

[1] ESMO 2019 LBA#76; [2] ESMO 2020 #1156O; [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] Source: Frost & Sullivan. 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; [5] Estimated based on relative population versus the U.S.

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

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

Site		est. %	Octreotide LAR	Lanreotide autogel	^{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 [3]	SANET-p
Lung		20%						RADIANT-4 [3]	SANET-ep
Other	Other	~17%							SANET-ep
	Unknown Primary	~10%						RADIANT-4 [3]	SANET-ep

Global (ex-China) China

[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).

U.S. NDA rolling submission started YE20

Surufatinib efficacy is highly applicable to U.S. & EU populations

CHI-MED

Basis for NDA & MAA (US FDA / EMA)

SANET-ep (N=198)	SANET-p (N=172)	US Ph 1b (N=105)
Non-pancreatic NET	Pancreatic NET	Non-pan. NET *(16)* Pan. NET *(16)* Other tumors

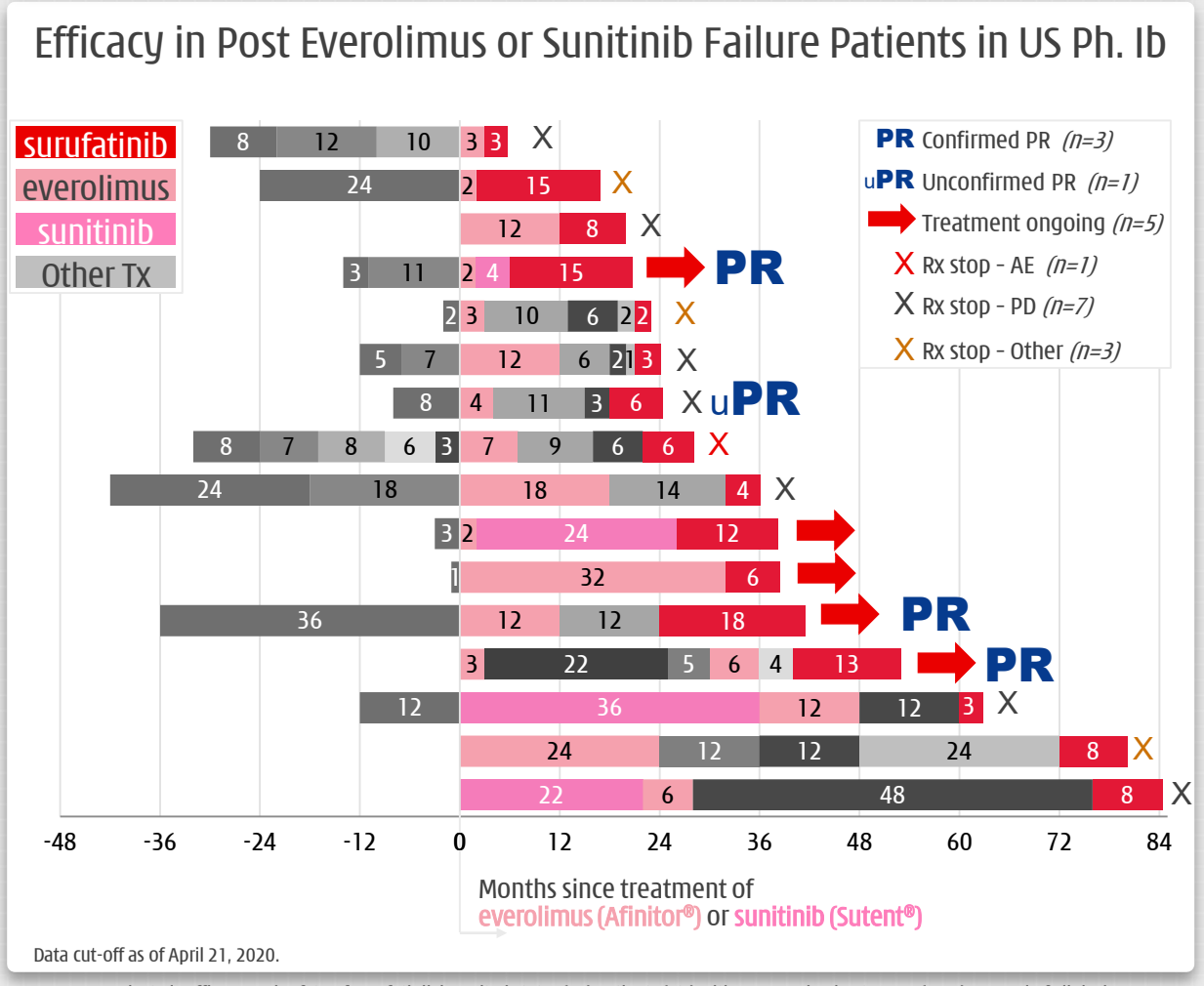
- SANET-ep + SANET-p + existing US NET patients data, could support US NDA & EU MAA sub;
- US Fast Track Designations → rolling sub;
- Extensive list of supportive studies.

Similar PK and Toxicity Profile between China & US patients

- 300mg QD recommended in both populations;
- PK: C_{max} & AUC_{tau} ‹10% difference; no meaningful impact of race on exposure;
- Safety: similar dose intensities; US adverse events at or below China patients.

Source: A Dasari, S Paulson et al. *Comparison of Pharmacokinetic Profiles and Safety of Surufatinib in Patients from China and the United States.* AACR 2020. Abstract CT115.

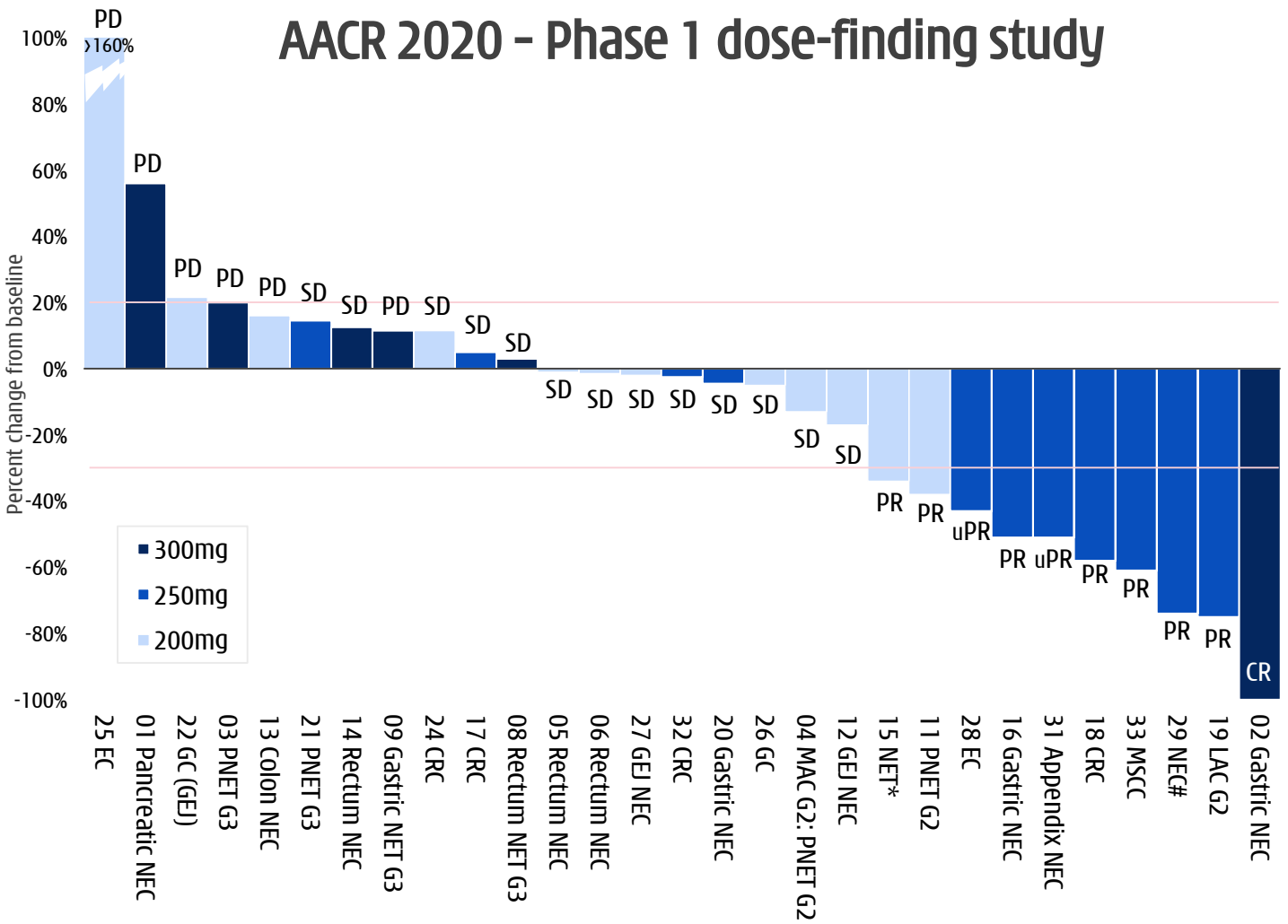
Encouraging prelim. efficacy in heavily pre-treated US NET pts



Source: Dasari, et al. *Efficacy and safety of surufatinib in United States (US) patients (pts) with neuroendocrine tumors (NETs).* Journal of Clinical Oncology 2020 38:15_suppl, 4610-4610

Promising PD-1 combo in difficult G3 NET/NEC pts

Phase II proceeding at 250mg RP2D



- **RP2D 250mg surufatinib** + toripalimab.
  - ↗ (N=11): ORR = 64%, DCR = 100%.
- **Anti-tumor signal,** particularly in NEC & NET.
- **Combination well tolerated**, with no unexpected safety signals.

CR = Complete Response
PR = Partial Response
SD = Stable Disease
PD = Progressive Disease

NET: neuroendocrine tumor; **NEC:** neuroendocrine carcinoma; **CRC:** colorectal carcinoma; **GC:** gastric adenocarcinoma; **EC:** esophageal squamous cell carcinoma; **GEJ:** gastroesophageal junction; **MAC G2:** mediastinal atypical carcinoid; **PNET G2:** Pancreas NET G2; **MSCC:** metastatic squamous cell carcinoma with unknown primary; **LAC:** Lung atypical carcinoid; ***:** Left supraclavicular lymph node neuroendocrine tumor; **#:** Merkel cell carcinoma.

Cao Y, et al. "A phase I trial of surufatinib plus toripalimab in patients with advanced solid tumors." Presented at American Association for Cancer Research (AACR) Virtual Annual Meeting I on April 27, 2020.
RP2D = Recommended Phase 2 Dose.

CHI-MED

3 Elunate® (fruquintinib capsules)

ELUNATE® Fruquintinib Capsules - VEGFR 1/2/3 inhibitor

CHI-MED

FAST APPROVAL OF MONOTHERAPY

CRC REGISTRATION (GLOBAL)
Regulatory interactions complete in U.S./EU & Japan. U.S. FTD. Ph.III start mid-2020

CRC BROADEN ACCESS (CHINA)
NRDL inclusion Jan 2020;
Chi-Med commercializes in China from Q4 '20

COMBINATION OPPORTUNITIES

PD-1 COMBINATIONS
High selectivity enhances tolerability.
Multiple PD-1s approach.

CHEMO COMBINATIONS
FRUTIGA Ph.III in 2L gastric
2x~5x more pts in earlier lines.

- Chi-Med retains all rights ex-China;
- Partnership with Lilly in China

Global (Ex-China) (wholly owned CHI-MED)

China (partnered with Lilly)

ELUNATE® Fruquintinib Capsules - VEGFR1/2/3 inhibitor

Current development status

Elunate® CRC China

- NRDL inclusion from January 1, 2020.

CRC GLOBAL

- U.S. Ph.Ib/II completed;
- **FRESCO-2 Ph.III initiated in U.S., EU & Japan**;
- US FDA **Fast Track Designation**.

FRUTIGA Gastric Ph.III

- 2nd Interim analysis in June 2020 complete;
- Increasing enrollment to 700-pts.

PD-1 combos

- Tyvyt® (Innovent) Ph.II (in 5 solid tumor indications);
- Tislelizumab (BeiGene);
- Geptanolimab (Genor).

Indication	Treatment	Target Patient	Study Name	Dose Finding / Safety Run-in	Proof-of-concept	Registration
CRC	**Fruquintinib**	Colorectal cancer ("CRC")	FRESCO-2			
	Fruquintinib	≥3L; chemotherapy ref. CRC	FRESCO			(Marketed) ★
Gastric	**Fruquintinib** + Taxol	2L gastric cancer	FRUTIGA			
Breast	**Fruquintinib**	Breast cancer				
PD-1 Combos	**Fruquintinib** + Tyvyt (PD-1)	Solid tumors				
	Fruquintinib + geptanolimab (PD-1)	Solid tumors				
	Fruquintinib + tislelizumab (PD-1)	Solid tumors		*		
	Fruquintinib + tislelizumab (PD-1)	Solid tumors		*		

Global

China

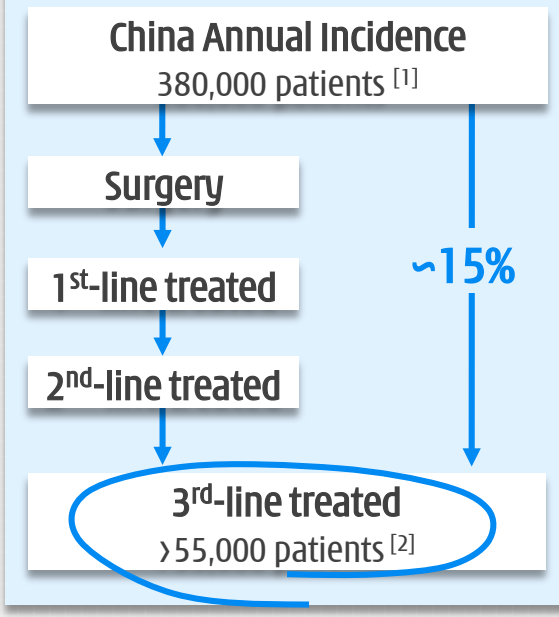
* In planning.

ELUNATE®
Fruquintinib Capsules

NRDL – 2020 accessible pricing

CHI-MED

Epidemiology



H1 2020 estimated penetration:

- ~18,800 cycles used (OOP & PAP);
- Average 5 months per patient;
- ~3,760 patients paid for Elunate;
- Representing ~14% penetration;
- H1 2020 Sales $14.0 million.

National Reimbursement Drug List (NRDL)

Effective Jan 1, 2020:

- 8 newly listed oncology drugs, including Elunate®
- NRDL reimburses 50-70% of patient costs under urban scheme

Costs per cycle *(all US$)* [3]		With Medical Insurance	Without Medical Insurance
Elunate® (fruquintinib)	Pre-NRDL (without PAP)	3,260	3,260
	Post-NRDL	1,180	1,180
	3L CRC Pts Out-of-Pocket Cost	~350 [5]	1,180
Stivarga® (regorafenib)	3L CRC Pts Out-of-Pocket Cost	~750 [5]	2,450

2020 post NRDL: Jan-Jun Sales – $14.0 million[4]

[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] RMB:USD exchange rate 6.73:1.00; PAP = Patient access program; [4] January-June 2020 In-market sales of Elunate®, Lilly invoiced to third parties was $13.7m and Chi-Med invoiced to third parties was $0.3m; [5] Assumes 70% reimbursement rate.

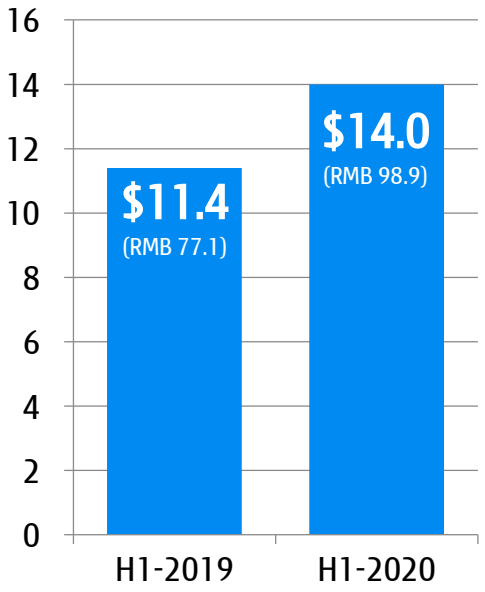
ELUNATE®
Fruquintinib Capsules

H1 2020 performance

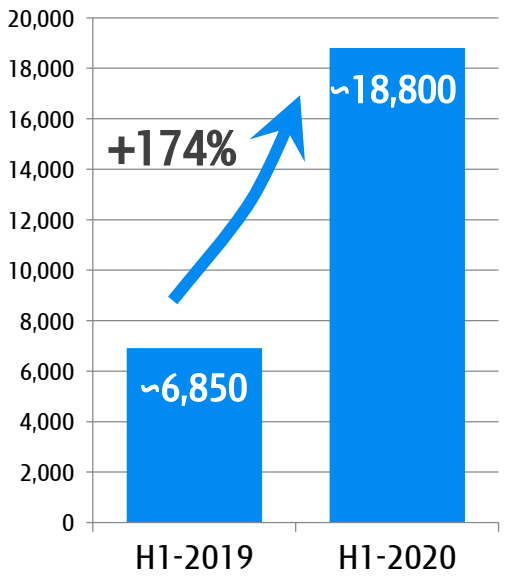
CHI-MED

Elunate® Performance

Sales (millions) [1]



Total Cycles (OOP&PAP) [2]



2020 Lilly Amendment

- Starting October 1, 2020, Chi-Med took on all **medical detailing, promotion** & local/regional **marketing activities across all of China**;
- Lilly will pay Chi-Med **70%-80% of Elunate® sales** in the form of **royalties, mfg. costs & service payments** [3];
- **No upfront payment** by Chi-Med was made to secure these rights.

Elunate® early progress – Chi-Med set to expand rapidly

[1] In-market sales of Elunate®, Lilly invoiced to third parties was $13.7m (H1 2019: $11.4m) and Chi-Med invoiced to third parties was $0.3m (H1 2019: Nil); [2] Treatment cycle = 28 days, 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] Subject to meeting pre-agreed sales targets.

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	2019
STIVARGA® *(regorafenib)* Bayer AG	3L CRC /2L GIST	May 2017	Sales (US$ million) [1]							5	21	81
	2L HCC	Mar 2018	List Price (US$/mo.)							4,368	*NRDL Oct-18*	2,352
NEXAVAR® *(sorafenib)* Bayer AG	Unres. RCC & HCC	2006	Sales (US$ million) [1]	80	96	96	93	91	97	108	130	194
	Diff. Thyroid can.		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	41
			List Price (US$/mo.) [3]							4,455	*NRDL Oct-18*	2,007
INLYTA® *(axitinib)* Pfizer	2L adv. RCC	2015	Sales (US$ million) [1]					3	12	16	13	27
			List Price (US$/mo.)							5,957	*NRDL Oct-18*	1,787
VOTRIENT® *(pazopanib)* Novartis	RCC	2017	Sales (US$ million) [1]							5	12	23
			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	~273
			List Price (US$/mo.)						2,870	*NRDL Jul-17*	1,810	1,810
FOCUSV® *(anlotinib)* Sino Biopharm	3L NSCLC	June 2018	Sales (US$ million) [2]								~190	~400
	Advanced STS	July 2019	List Price (US$/mo.)								*NRDL Oct-18*	981
	3L SCLC	Sept 2019										

VEGFR market is large scale in China – major opportunity for Chi-Med

[1] Frost & Sullivan; [2] Frost & Sullivan and Goldman Sachs Research. Note: Calculations assume at CER, using exchange rate of RMB6.74 per US$1; [3] Sutent® price avg. pre-NRDL $5,544 RCC/GIST, $4,455 pNET; post-NRDL $2,498/$2,007.

ELUNATE®
Fruquintinib Capsules

Efficacy advantage

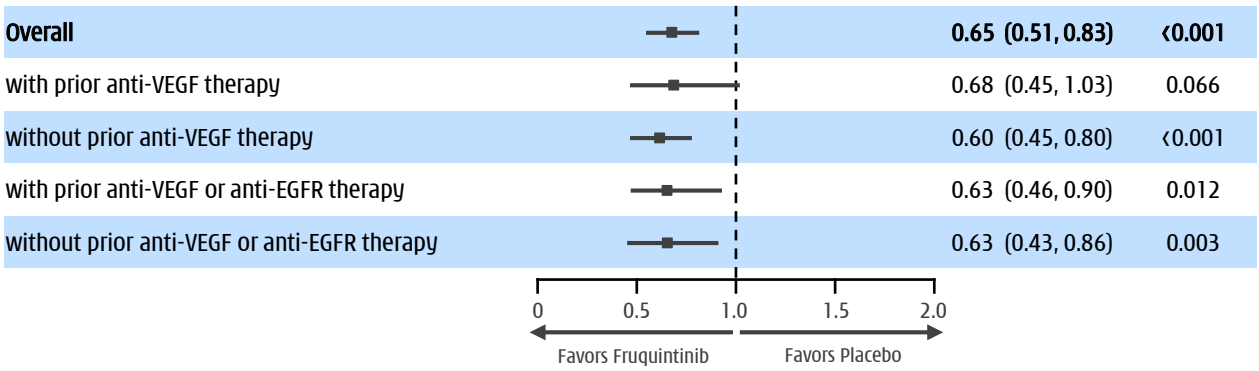
CHI-MED

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®

ELUNATE® Fruquintinib Capsules

CHI-MED

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

FRESCO-2 Ph. III to support ex-China CRC NDA filing

Compelling prelim. US monotherapy efficacy and safety

CHI-MED

Basis for US, EU, Japan filings

FRESCO-2	FRESCO	US Ph Ib
(N›680, ongoing)	*(N=416)*	*(N=116)*
Late stage CRC	3L CRC	3L/3L+ CRC *(80)* Other tumors

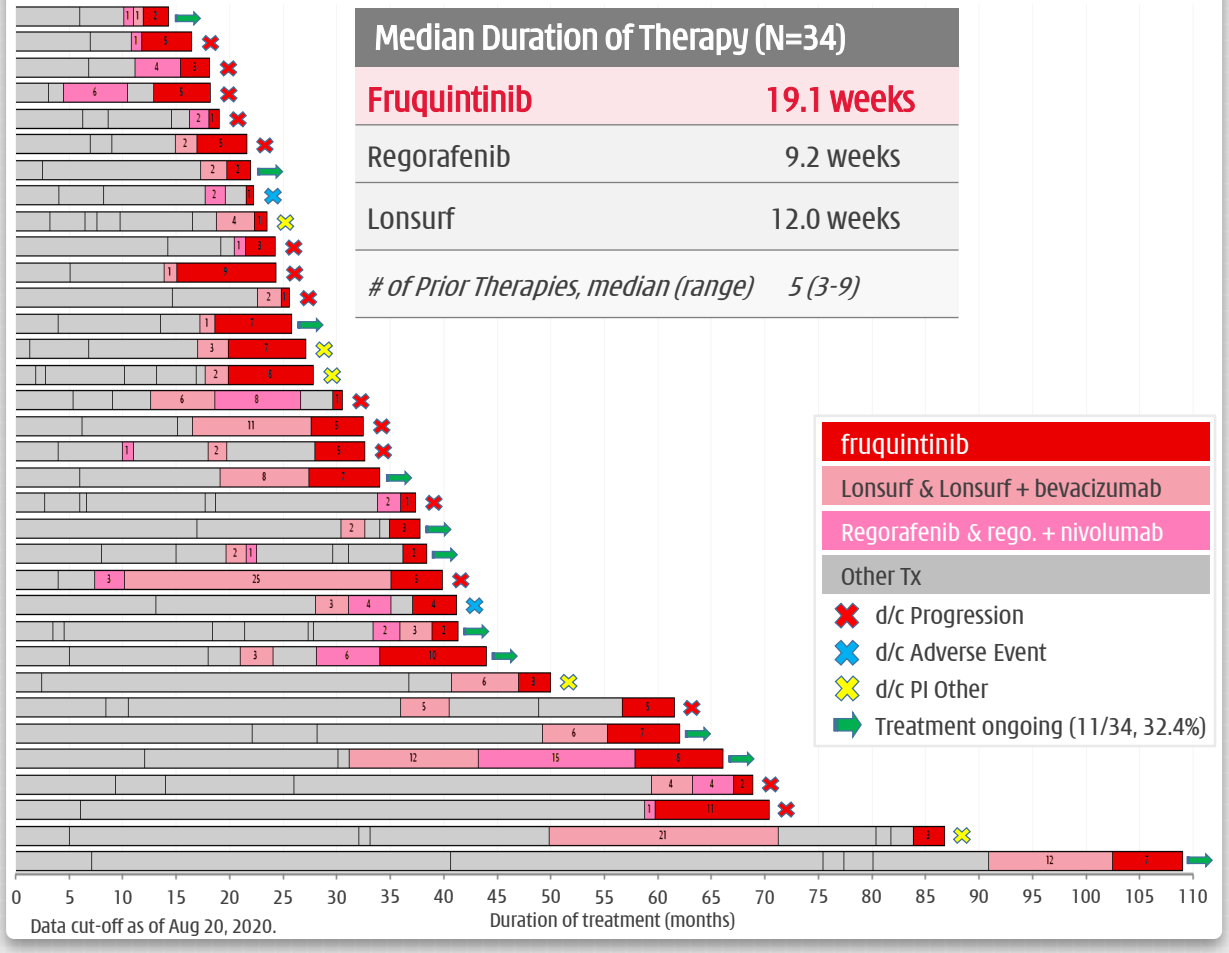
- **FRESCO-2 + FRESCO + US CRC Ph1b** data, could support US NDA & EU MAA subm. in 3L/3L+ CRC;
- US Fast Track Designation → pot. rolling subm.;
- Extensive list of supportive studies.

CONSISTENCY IN SAFETY	Phase Ib [1] United States	FRESCO Phase III Study Mainland China [2]	
Treatment arms	Fruq.	Fruq.	Placebo
Patients (n)	31	278	138
≥G3 AE (Safety population)	79.4%	61.1%	19.7%
VEGFR on-target related AEs ≥ G3:			
Hypertension	23.4%	21.2%	2.2%
Hand-Foot Syndrome (Palmar-plantar)	2.9%	10.8%	0.0%
Hepatic function (Liver function) AEs≥ G3:			
ALT increased, ≥G3	‹5%	0.7%	1.5%
AST increased, ≥G3	0%	0.4%	0.7%
Blood bilirubin increased, ≥G3	‹5%	1.4%	1.5%
Tolerability: AE Leading to			
Dose reduction/interruption	41.2%	47.1%	13.1%
Treatment discontinuation	8.8%	15.1%	5.8%

US PhIb: Encouraging prelim. efficacy in heavily pre-treated CRC pts

Stable disease in 81% of evaluable patients

Median Duration of Therapy (N=34)	
Fruquintinib	**19.1 weeks**
Regorafenib	9.2 weeks
Lonsurf	12.0 weeks
# of Prior Therapies, median (range)	*5 (3-9)*



[1] Dasari, et al. *Phase 1/1b Trial of Fruquintinib in Patients with Advanced Solid Tumors: Preliminary Results of the Dose Expansion Cohort in Refractory mCRC.* ESMO 2020 Abstract #2217; [2] Li J, Qin S, Xu R, 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;319(24):2486-2496. doi:10.1001/jama.2018.7855.

CHI-MED

4 Commercialization & Next Wave of Innovation

400 person dedicated oncology commercial team

Building on >15 yrs Rx commercial knowhow in mainland China

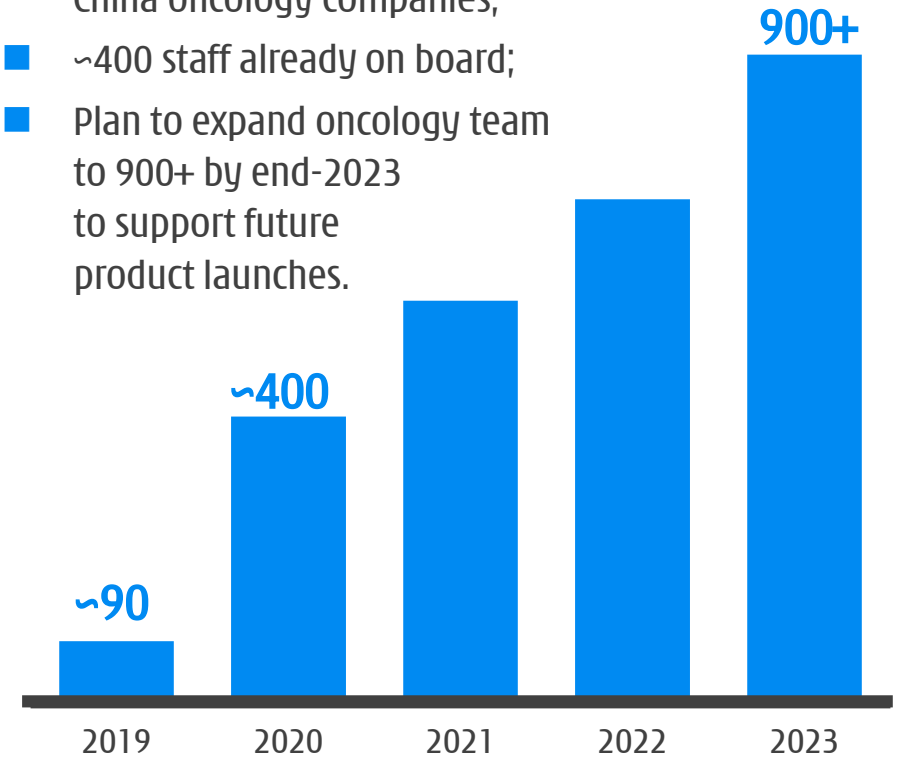
Covering ~2,000 hospitals across China

- Establishing dedicated oncology commercial team to cover ~95% of initial market opportunity;
- Fully in-place & in-training;
- Includes sales reps, sales mgrs., product mktg., medical mktg., distribution, training, mgmt.;

- Covers 30 provinces / municipalities.

Currently detailing fruq; ready for suru launch

- All key senior roles are already in-place;
- Vast majority of new staff from successful China oncology companies;
- ~400 staff already on board;
- Plan to expand oncology team to 900+ by end-2023 to support future product launches.



Oncology commercial team size at year end

Next wave of innovation

Development strategies and current status

HMPL-523 & HMPL-689

- China Ph.Ib dose expansions underway;
- China registration study decisions in 2021.

HMPL-523 & HMPL-689

- Over 20 Ph.I sites in U.S. & Europe enrolling;
- Multiple dose cohorts completed.

HMPL-453

- Ph.IIs initiated in advanced malignant mesothelioma & intrahepatic cholangiocarcinoma in China.

HMPL-306

- 9th in-house discovered asset (IDH1/2) Ph.I;
- Addresses mutant IDH switching, from IDH1 to IDH2 or vice versa, a resistance mechanism.

Program	Treatment	Target Patient	Sites	Dose Finding / Safety Run-in	Proof-of-concept	Registration
HMPL-523 Syk	HMPL-523	Indolent NHL	US/EU/AU			
	HMPL-523	B-cell malignancies	China			
	HMPL-523	ITP	China			
HMPL-689 PI3Kδ	HMPL-689	Healthy volunteers	Australia			
	HMPL-689	Indolent NHL	US/EU			
	HMPL-689	Indolent NHL	China			
HMPL-453 FGFR 1/2/3	HMPL-453	Mesothelioma	China			
	HMPL-453	Intrahepatic cholangiocarcinoma	China			
HMPL-306 IDH 1/2	HMPL-306	Hematological Malignancies	China			

Global

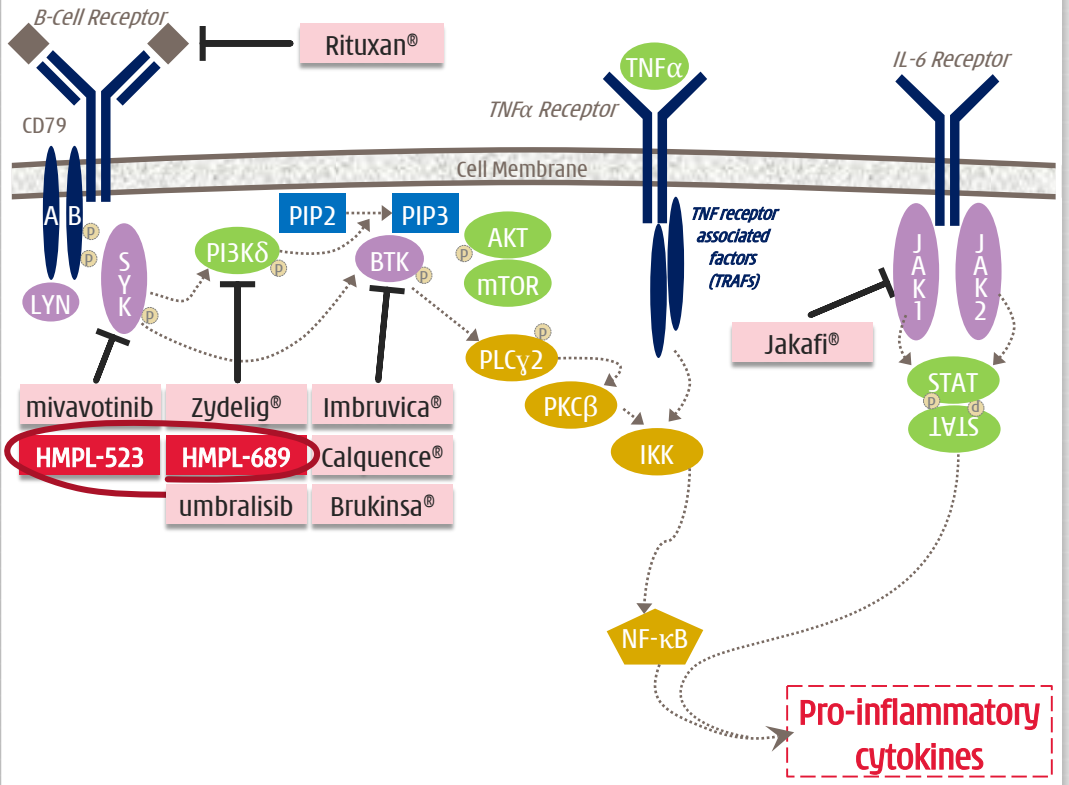
China

HMPL-523 (Syk) & HMPL-689 (PI3Kδ)

Exciting targets emerging - our next wave of innovation

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

- 2019 sales: Imbruvica® $5.7bn; Zydelig® $0.1bn; Jakafi® $2.8bn; & Rituxan® $4.8bn [1][2].



HMPL-523 (Syk inhibitor)

Large Phase Ib expansion in Australia & China

- Ph.I dose escalation complete in Australia & China (n›60) - RP2D [3] determined;
- **Large Ph. Ib dose expansion study (N›200)**, underway in ~30 active sites in Australia & China;
- **US/EU Phase I/Ib enrolling**, with 13 sites.

HMPL-689 (PI3Kδ inhibitor)

Phase I/Ibs in China, US & EU ongoing

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

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

Phase I/Ib data will **inform China registration study decisions on HMPL-523 & -689 in late 2020**.

[1] Rituxan® sales in oncology only; [2] Approved Drug = ®; All others are clinical candidates; [3] Recommended Phase II Dose.

HMPL-689 – finding major room for improvement

Safety profiles of current PI3Kδ inhibitors are not good

PI3Kδ inhibitors being developed in a broad range of indications.

Compound	Company	Indication	Status	Issue
Zydelig® *idelalisib - PI3Kδ*	Gilead	Relapsed CLL/SLL, FL	Approved	**BOXED WARNING: FATAL AND SERIOUS TOXICITIES: HEPATIC, SEVERE DIARRHEA, COLITIS, PNEUMONITIS, INFECTIONS, and INTESTINAL PERFORATION**
Aliqopa® *copanlisib - PI3Kα/δ*	Bayer	Relapsed FL	Approved [1]	**Need to spare PI3Kα** -- high incidence of metabolic & vascular disorders; serious infections.
Copiktra® *duvelisib - PI3Kγ/δ*	Secura Bio/ CSPC [2]	Relapsed or refractory CLL/SLL Relapsed or refractory FL Peripheral T-cell lymphoma	Approved Approved [1] Phase II enrolling	**BOXED WARNING: FATAL AND SERIOUS TOXICITIES: INFECTIONS, DIARRHEA OR COLITIS, CUTANEOUS REACTIONS, and PNEUMONITIS** **Need to spare PI3Kγ**
Umbralisib *PI3Kδ*	TG Therapeutics	Previously treated MZL Previously treated FL Previously treated NHL, CLL	PDUFA Feb 15, 2021 PDUFA Jun 15, 2021 Phase IIb/III	Gastrointestinal & liver AEs
Parsaclisib *PI3Kδ*	Incyte/ Innovent	FL, MZL, MCL Refractory myelofibrosis Autoimmune hemolytic anemia	NDA filing H2-2021 Phase III Phase II	Pending 12 months follow-up data from last responder [3] Phase 2 studies required prophylaxis for pneumocystis jirovecii pneumonia (PJP)
Zandelisib *PI3Kδ*	MEI/Kyowa Hakko Kirin	Relapsed or refractory FL B-Cell Malignancies	Phase II (for pot. AA) Phase I/Ib	Progressing with intermittent dosing to mitigate immune related toxicities; all patients underwent prophylaxis for pneumocystis jirovecii pneumonia (PJP) [4]

CLL/SLL: chronic lymphocytic leukemia/small lymphocytic lymphoma; **FL:** follicular lymphoma; **MZL:** marginal zone lymphoma; **MCL:** mantle cell lymphoma; **DLBCL:** diffuse large B cell lymphoma; **HL:** Hodgkin's lymphoma; **NHL:** non-Hodgkin's lymphoma.

[1] Accelerated approval was granted based on ORR, continued approval may be contingent upon verification and description of clinical benefit in a confirmatory trials;] AbbVie ended collaboration with Infinity in June 2016 following Phase II results in indolent non-Hodgkin's lymphoma. Duvelisib licensed to Verastem in November 2016, who subsequently sold the asset to Secura Bio in September 2020; [3] company announcement Dec 7, 2020; [4] ASCO 2020 Abstract #8016.

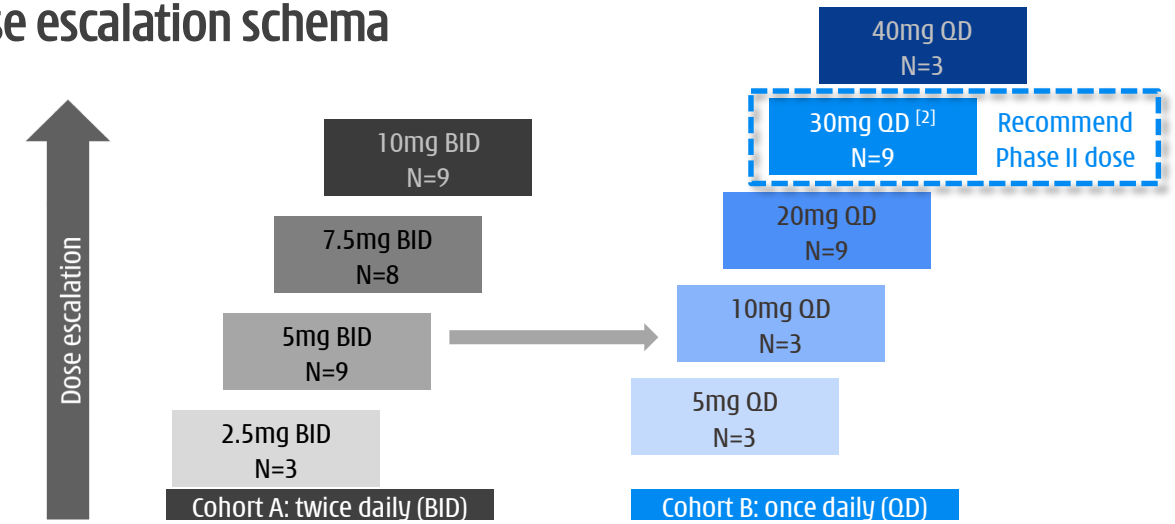
HMPL-689 – designed to be better

Intent to improve safety…

HMPL-689 – Advantages

- **Improved isoform selectivity** – sparing PI3Kγ & PI3Kα.
- **Improved potency at whole blood level** – over five-fold more potent than Zydelig® – to cut compound related toxicity.
- **Improved PK properties** – particularly efflux & drug/drug interaction due to CYP inhibition / induction, critical for combo therapy.

Dose escalation schema



Manageable toxicity profile [1]

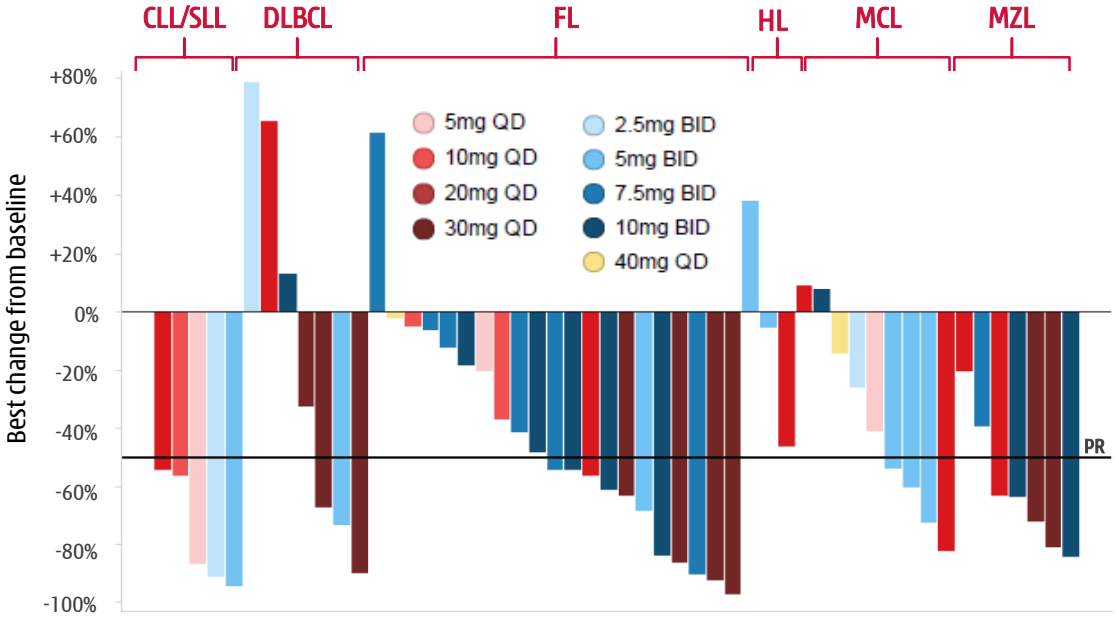
Treatment-emergent AEs occurred in ≥ 5% of patients	All doses (N=56) All grade	Grade ≥3
Neutropenia	43%	11%
Leukopenia	29%	4%
ALT increased	27%	2%
Pneumonia	25%	16%
AST increased	21%	2%
Lipase increased	20%	5%
Cough	18%	-
Anemia	16%	-
Blood bilirubin increased	16%	2%
Mouth ulceration	14%	-
Pyrexia	14%	-
Upper respiratory tract infection	14%	-
Bilirubin unconjugated increased	13%	2%
Asthenia	11%	-
Blood creatinine increased	11%	-
Constipation	11%	-
Hyperglycemia	11%	-

[1] ASH 2020 Abstract #1135.

HMPL-689 – dose escalation

…while maintaining efficacy

Best Response of Target Lesions in Dose Escalation Stage



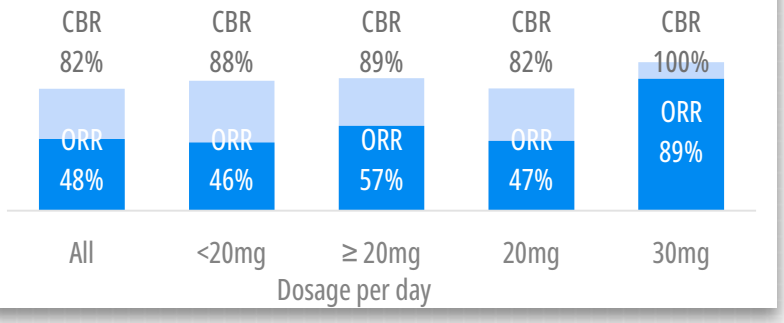
CLL/SLL: chronic lymphocytic leukemia/small lymphocytic lymphoma; **FL:** follicular lymphoma; **MZL:** marginal zone lymphoma; **MCL:** mantle cell lymphoma; **DLBCL:** diffuse large B cell lymphoma; **HL:** Hodgkin's lymphoma; **NHL:** non-Hodgkin's lymphoma.

NE: 2 DLBCL pts EOT due to AE (5mg BID) & voluntary withdraw (7.5 mg BID); 1 FL pt EOT due to AE (20 mg QD) before 1st tumor evaluation.
1 CLL arrive PR based on target lesion, as lymphocyte cell count increased assessed PD at C3D1.

Intent-to-treat (n=56)

Best response	
Complete Response, %	11 (4-22)
Partial Response, %	37
Stable Disease, %	34
Progressive Disease, %	11
Overall Response Rate	**48% (35-62)**
Clinical Benefit Rate	**82% (70-91)**
Time on treatment	5.6 months (0.7-23.2)
Time to response	1.8 months (1.8-1.9)
Duration of response	9.2 months (3.9-NA)
Progression free survival	10.1 months (5.5-15.7)
1yr PFS rate	40.0% (27-57)

Signals of more anti-tumor activity by doses (EE)



[1] ASH 2020 Abstract #1135

HMPL-689 – Phase I dose escalation – All cohorts

Consistent efficacy profile with PI3Kδ inhibitors

1. HMPL-689 – Phase I dose escalation [1]

<20mg / day: n=26
20mg / day: n=18
30mg / day: n=9, RP2D
40mg/day: n=3
Non evaluable: n=4

At Sept 15 cut-off	ITT n=56	Evaluable n=52	CLL/SLL n=5	MZL n=7	FL n=23	MCL n=9	DLBCL n=9	HL n=3
Best response								
Complete Response, %	11	12	40	0	14	0	0	0
Partial Response, %	37	40	40	71	30	44	33	0
Stable Disease, %	34	37	0	29	39	56	11	67
Progressive Disease, %	11	11	20	0	4	0	33	33
Not Evaluable, %	7	na	0	0	9	0	22	0
Overall Response Rate (intent-to-treat)	**48%**		**80%**	**71%**	**48%**	**44%**	**33%**	**0%**
Overall Response Rate (efficacy evaluable)		**52%**	**80%**	**71%**	**52%**	**44%**	**43%**	**0%**
n		*52*	*5*	*7*	*21*	*9*	*7*	*3*

2. Competitive PI3Kδ inhibitors

Overall Response Rate	CLL/SLL	MZL	FL	MCL	DLBCL	HL
Zydelig® *(idelalisib)* [2] [3]	**58%**	**47%**	**54%**	-	**0%**	-
n	*26*	*15*	*72*		*9*	
Aliqopa® *(copanlisib)* [2] [4]	-	**78%**	**59%**	-	-	-
n		*23*	*104*			
Copiktra® *(duvelisib)* [2] [5] [6]	**78%**	**39%**	**42%**	**50%**	-	-
n	*95*	*18*	*83*	*10*		
Umbralisib [7] [8] [9]	**50%**	**49%**	**45%**	**17%**	**57%**	-
n	*22*	*69*	*117*	*6*	*7*	
Parsaclisib [10] [11] [12]	**33%**	**57%**	**70%**	**70%/25%**	**26%**	-
n	*6*	*100*	*108*	*108/53*	*55*	
Zandelisib *(intermittent dosing)* [13]	**100%**	-	**76%**	-	-	-
n	*3*		*17*			

CLL: chronic lymphocytic leukemia/small lymphocytic lymphoma; **FL:** follicular lymphoma; **MZL:** marginal zone lymphoma; **MCL:** mantle cell lymphoma; **DLBCL:** diffuse large B cell lymphoma; **HL:** Hodgkin's lymphoma.

[1] ASH 2020 Abstract #1135; [2] US Prescribing Information; [3] ASH 2015 Abstract # 1543; [4] ICML 2019 Abstract #357; [5] ICML 2019. Abstract 358; [6] Blood. 2018 Feb 22; 131(8): 877-887 doi: 10.1182/blood-2017-05-786566; [7] ASCO 2019 Abstract #7506; [8] Lancet Oncology April 2018 February 20, 2018 DOI:https://doi.org/10.1016/S1470-2045(18)30082-2; [9] ASH 2020 Abstract #2934; [10] Company announcement dated December 7, 2020; [11] Blood, April 2019 doi: 10.1182/blood-2018-08-867499: 10.1182/blood-2018-08-867499; [12] ASH 2020 abstracts #338, #1121, #2044, #2935; [13] ASCO 2020 Abstract #8016.

HMPL-689

Advantages in tolerability versus PI3Kδ inhibitors

Incidence of select treatment emergent adverse events – all AEs / grade ≥3 AEs

	n	Neutropenia	Anemia	Thrombo-cytopenia	Diarrhea or colitis	Rash	ALT increased	AST increased	Pyrexia	Pneumonia	Hyper-tension	Hyper-glycemia
Zydelig® *(idelalisib)* [2]	146	53% / **25%***	28% / 2%*	26% / 6%*	**47% / 14%**	21% / 3%	50% / **19%**	41% / **12%**	28% / 2%	25% / 16%	na	na
Aliqopa® *(copanlisib)* [2]	168	32% / **25%**	na	**22% / 8%**	36% / 5%	15% / 2%	na	na	na	21% / 14%**	**35% / 27%**	**54% / 39%**
Copiktra® *(duvelisib)* [2]	442	34% / **30%**	20% / 11%	**17%/10%**	**50% / 23%**	31% / 9%	40% / **8%**	37% / **6%**	26% / 2%	21%/15%	na	na
Umbralisib* ** *(MZL @ RP2D)* [3]	69	14% / 13%	na	na	**62% / 10%**	18% / 3%	25% / **10%**	29% / **9%**	10% / 0%	na	na	na
Umbralisib* *(UNITY-NHL)* [4]	208	16% /12%	na	na	59% / **10%**	na / 3%	20% / **7%**	19% / **7%**	na	na / 1%	na	na
Parsaclisib *(Dose escalation)* [5]	72	44% / **20%***	31% / 8%*	35% / 10%*	**36% / 9%**	31% / 6%	28% / 1%	29% / 1%	18% / 1%	*na*	7% / 0%	10% / 1%
Parsaclisib *(CITADEL-204/MZL)* [6]	100	13% / 9%	14% / 5%	na	**44% /11%**	17% / 2%	26% / 4%	19% / 2%	13% / 1%	**7% with PJP prophylaxis**	na	na
Zandelisib *(intermittent dosing)* [7]	21	na / 14%	na / 0%	na / 0%	na / 4%	na / 2%	na / 0%	na / 0%	na	**PJP prophylaxis**	na	na
Zandelisib *(Dose escalation)* [8]	30	45% / 13%*	13% / 0%*	22% / 0%*	**45% / 19%**	42% / 13%	39% / **6%**	25% / **6%**	na	na	na	na
HMPL-689 [1]	**56**	43% / 11%	16% / 0%	11% / 0%	‹5% / ‹5%	11% / 5%	27% / 2%	21% / 2%	14% / 0%	25% / 16%	7% / 5%	11% / 2%

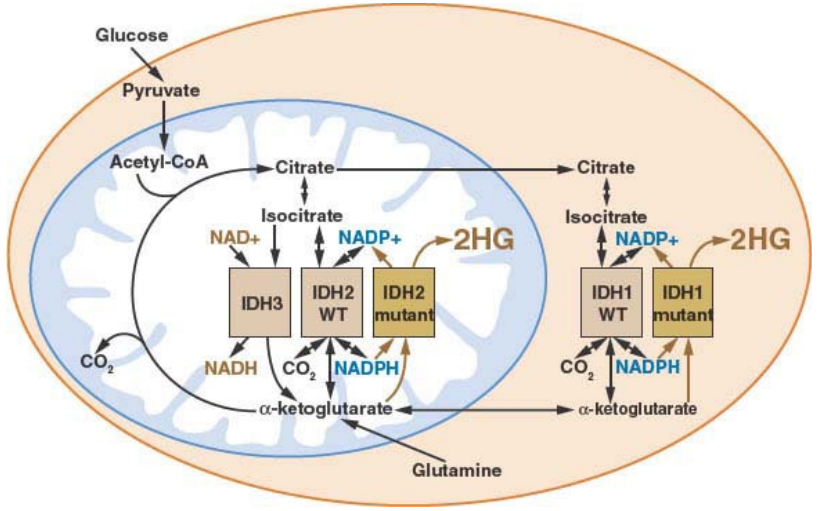
[1] ASH 2020 Abstract #1135; [2] US Prescribing Information; [3] ASCO 2019 Abstract #7506; [4] ASH 2020 Abstract #2934; [5] Blood, April 2019 doi: 10.1182/blood-2018-08-867499; [6]] ASH 2020 Abstract #338; [7] ASCO 2020 Abstract #8016; [8] ASCO 2018 Abstract #7519; *Laboratory values; **Lower respiratory tract infections; ***Regardless of causality; PJP = pneumocystis jirovecii pneumonia

HMPL-306 – Phase I in China underway

Designed as potential best-in-class IDH 1/2 inhibitor

1. The IDH family converts isocitrate to α-KG via oxidative decarboxylation, an important process for normal cellular metabolism.

- Mutant IDH1/2 catalyze the reaction of α-KG to 2-HG, leading to accumulation of 2-HG in tumor cells;
- IDH inhibitors could restore 2-HG levels to normal physiological levels, induce tumor cell differentiation and ultimately stop tumor cell progression;
- **Mutant IDH isoform switching**, either from cytoplasmic mutant IDH1 to mitochondrial mutant IDH2, or vice versa, as a **mechanism of acquired resistance** to IDH inhibition.



2. Unmet medical need and potential indications – IDH1/2 mutations are frequent genetic alterations in AML, glioma and various solid tumors.

Tumor	% IDH Mutation [1]			
	Total	IDH1-R132	IDH2-R140	IDH2-R172
Brain tumor				
Grade 2 and 3 glioma	60-80%	60-80%	0%	1%
Secondary glioblastoma	70%	70%	0%	1%
Hematopoietic tumor				
Acute myelocytic Leukemia (AML)	15-25%	5-10%	5-15%	0-5%
Myelodysplastic syndrome (MDS)	10%	5%	5%	0%
Angioimmunoblastic T-cell lymphoma	26%	0%	1%	25%
Solid tumor				
Chondrosarcoma	55%	40%	0%	15%
Osteosarcoma	25%	0%	0%	25%
Cholangiocarcinoma	22%	20%	0%	2%
Giant cell tumors of bone	80%	0%	0%	80%

3. HMPL-306 is a potent IDH1/2 dual inhibitor.

- IDH1 & 2 mutations are **validated targets** with approval of ivosidenib (IDH1) and enasidenib (IDH2) in R&R AML;
- HMPL-306 provides **comparable efficacy** in preclinical model while **wider safety window**;
- The **higher penetration of blood-brain barrier** with HMPL-306 makes exploring IDHm glioma attractive.

[1] Amary et al., 2011; Paschka et al., 2010; Yan et al., 2009; Fujii T et al., 2016, Abstract 3101, AACR 2016.

What is next from discovery?

Differentiated assets against multiple targets

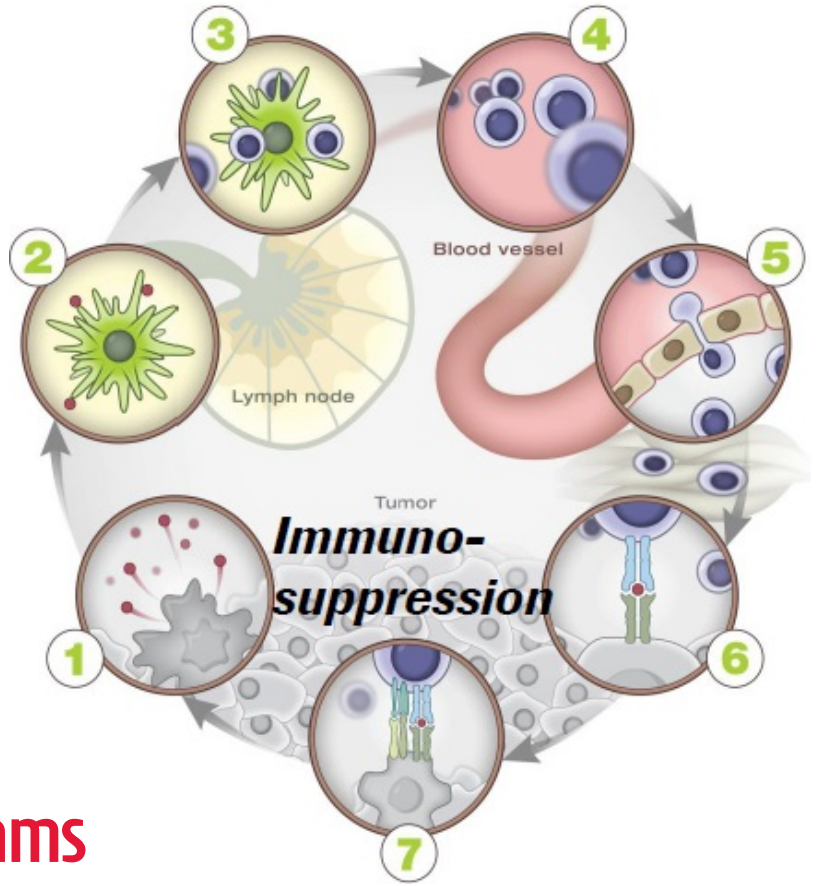
Priming & activations

- **Multiple mAb programs**

Antigen release

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

- **Multiple small molecule programs**



Anti-angiogenesis

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

Negative regulators

- Treg (HMPL-689)
- CSF-1R (surufatinib)

- **Multiple small molecule & mAb programs**

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.

CHI-MED

5 1H 2020 Financial Results, Cash Position & Guidance

H1 2020 Financial Results

Global Innovation

China Commercial

	2019	H1-19	H1-20	Growth	at CER [2] (Non-GAAP)
GROUP REVENUE	**204.9**	**102.2**	**106.8**	**4%**	**9%**
Unconsolidated JV Revenue	*487.5*	*276.9*	*274.8*	*-1%*	*4%*
SEGMENT NET INCOME/(LOSS) [1]					
INNOVATION PLATFORM [3]	**(133.2)**	**(67.1)**	**(73.6)**	**-10%**	**-14%**
COMMERCIAL PLATFORM	**47.4**	**31.0**	**35.5**	**14%**	**19%**
Prescription Drugs Business [3]	*37.5*	*25.1*	*28.9*	*15%*	*20%*
Consumer Health Business	*9.9*	*5.9*	*6.6*	*11%*	*16%*
Chi-Med Group Costs	(20.2)	(9.3)	(11.6)	-24%	-24%
GROUP NET LOSS [1]	**(106.0)**	**(45.4)**	**(49.7)**	**-10%**	**-12%**
EPS Attrib. to Ord. S-H (Basic) (US$)	*(0.16)*	*(0.07)*	*(0.07)*		

(US$ millions, except per share data)

[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; [3] In 2019 annual report, the results of innovative medicines developed by the Innovation Platform have been reallocated from Innovation Platform to Commercial Platform- Prescription Drugs business. H1-19 information has been revised for comparison purpose.

Cash position & 2020 Guidance

$400 million in available cash resources [1]

Cash Position
(at end June 2020)

- **$281m cash** / cash eq. / Short term inv. [2]
- **$119m** additional unutilized banking facilities [3]
- **$103m** additional cash in JVs
- **$100m** PIPE with General Atlantic (Jul 2020)[4]
- **$100m** PIPE with CPPIB (Nov 2020) [5]
- **$27m** in bank borrowings

(US$ millions)	H1 2020 Actual [6]	2020 Current Guidance	Adj. vs. Previous Guidance
Adj. (non-GAAP) Innovation Platform segment operating loss	(81.2)	(180) - (210)	nil
Adj. (non-GAAP) Group net cash flows excl. financing activities	(32.5)	(140) - (160)	nil

- **H1 2020 performance in line with published guidance:**
  - Cash dividends from our JVs; No material impact from COVID-19.
- **Cash investments to rise in H2 2020:**
  - Global C&R activities: FRESCO-2 & U.S. NDA submission (surufatinib);
  - New large-scale oncology manufacturing facility in Shanghai;
  - Expansion of oncology commercial activities (Elunate® & surufatinib).

[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 & HSBC; [4] In early July 2020, we completed a private placement to General Atlantic, raising an additional $100 million in gross proceeds, to further strengthen our cash position; [5] announced on Nov 17, 2020; [6] 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.

CHI-MED

6 Summary

Potential upcoming events

CHI-MED

	Q4 2020	H1 2021	Q3 2021
Global	**Savo** PRCC mono (SAVOIR) PRCC + PD-L1 (CALYPSO) **Data Update**	**Savo + Tagrisso®** NSCLC (SAVANNAH) **Ph. II Data Sweep**	**Savo + Imfinzi®** Papillary RCC (CALYPSO) **Ph. II Data Update***
		Savo PRCC **Ph. III Start**	**Savo + Tagrisso®** NSCLC (SAVANNAH) **Reg. Path clarified**
	Fruq Solid tumors **Ph. Ib Data**	**Suru** NET (US) **Rolling NDA Sub**	**Suru** NET (US) **Complete NDA Sub****
		Fruq Refractory colorectal **Ph. Ib Data***	**Suru** NET (EU) **MAA Submission****
		HMPL-306 IDH 1/2 inhibitor **Ph. I Start**	**HMPL-523 (Syk)** Hem malignancies **Ph. I Exp Start*****
		HMPL-689 (PI3kδ) Hem malignancies **Ph. I Exp Start*****	**Fruq / Suru** PD-1 combos **Ph. I/IIs Start**
			New asset(s) TBD **IND filing*****
China	**Fruq** **China commercial collaboration**	**Suru** Non-pNET (SANET-ep) **Approval & Launch****	**Savo** NSCLC Ex14 mut **App. & Launch by AZ****
			Savo NSCLC & GC Anticipate further Ph. II/III registration studies
	Suru P NET (SANET-p) **Ph. III Data**		**Suru** 2L Biliary tract **Ph. II/III Interim**
			Fruq / Suru + PD-1 Solid tumors **Ph. II Data***
			Suru P NET (SANET-p) **Approval & Launch****
	HMPL-689 (PI3kδ) NHL **Ph. I/Ib Data**		**HMPL-689 (PI3kδ)** Multiple (2x) Indolent NHL **Reg. Study Start*****
			HMPL-523 (Syk) Indolent NHL/ITP **Pot. Reg. Study Start*****
	HMPL-306 IDH 1/2 inhibitor **Ph. I Start**	**HMPL-523** (ITP) **Ph. I dose escalation completion**	**Fruq / Suru** PD-1 combos **Reg. Study Start*****
			New assets(s) TBD **IND filings*****

= Data milestone/readout.

= Development/commercial progress.

* submission to scientific conference; ** subject to regulatory interaction; *** 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; PRCC = Papillary renal cell carcinoma; NSCLC = Non-small cell lung cancer; ITP = Immune thrombocytopenia purpura.

CHI-MED

HUTCHISON CHINA MEDITECH

Thank you

Appendix

CHI-MED

A1a Realizing global potential of novel oncology 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.

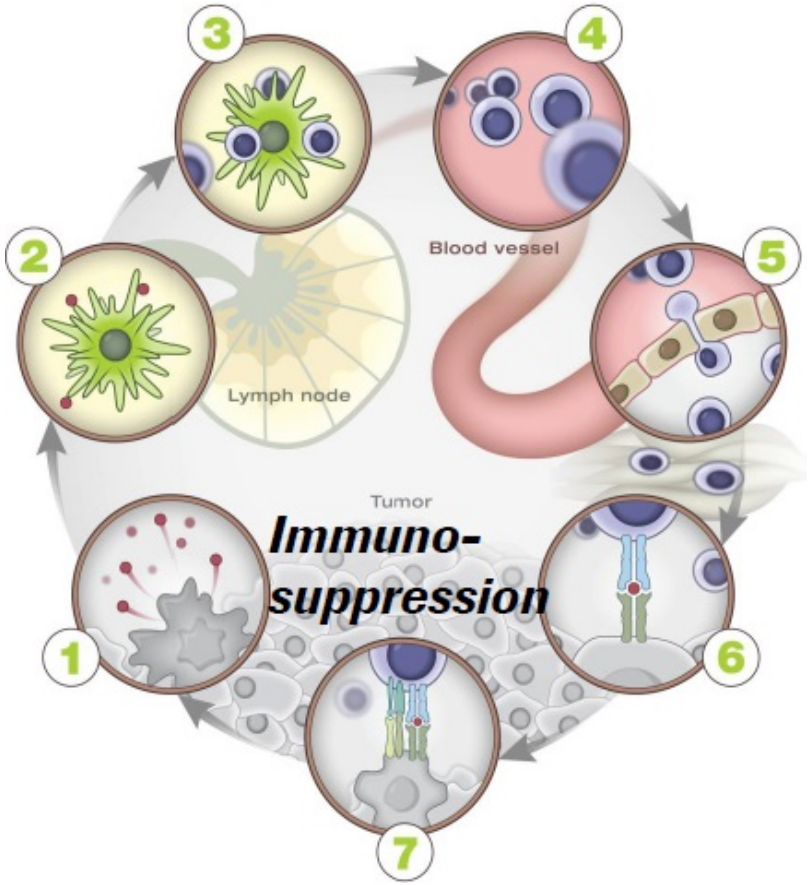
Attack cancer from multiple angles at same time

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.

Superior safety allows for combinations

TKI + TKI combos to address acquired resistance

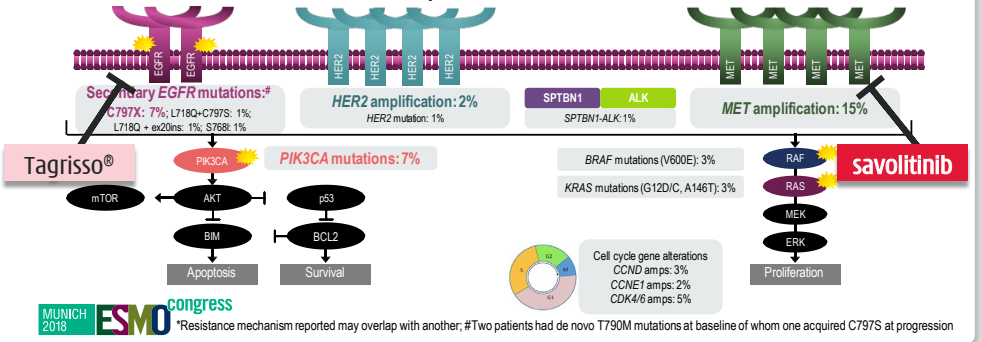
CHI-MED

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

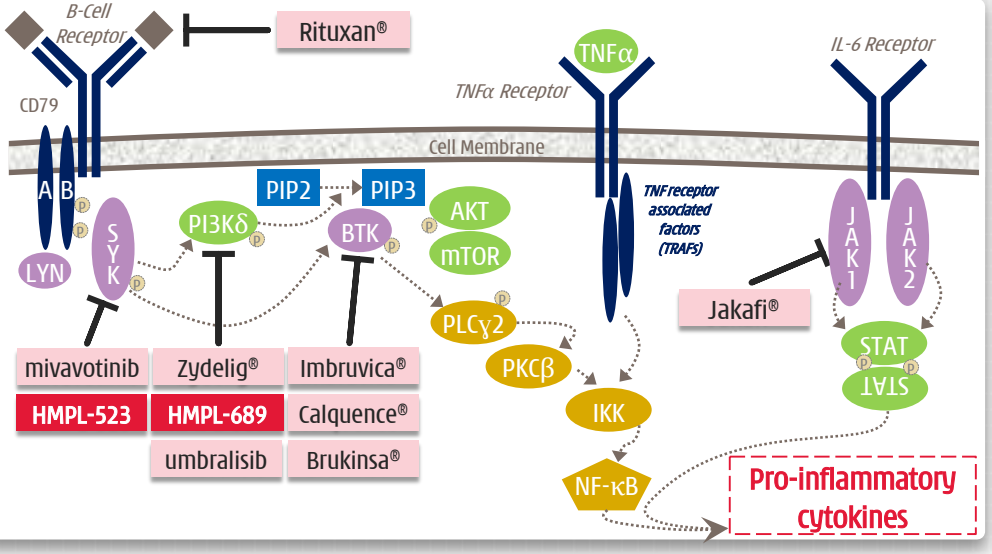


MUNICH 2018 ESMO congress

*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

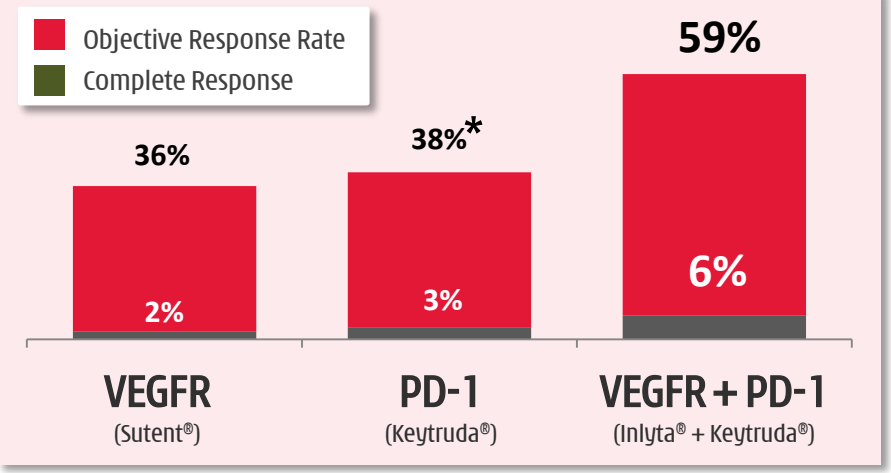
- **C481S / PLCγ2** the most common resistance mechanisms for Imbruvica®.
- Invalidating BTK inhibitor requires a **possible Syk, PI3Kδ &/or BTK TKIs**.



TKI = Tyrosine Kinase Inhibitor

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	Approved
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
First 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
savo + Imfinzi® (PD-L1)
ccRCC/PRCC/other solid tumors

Jointly managed by Chi-Med & partners

Innovent Biologics
fruquintinib / surufatinib + Tyvyt® (PD-1)
Solid tumors

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

BeiGene
fruquintinib / surufatinib + tislelizumab (PD-1)
Solid tumors

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.

Global clinical drug portfolio (1/2)

Savolitinib *(MET)*

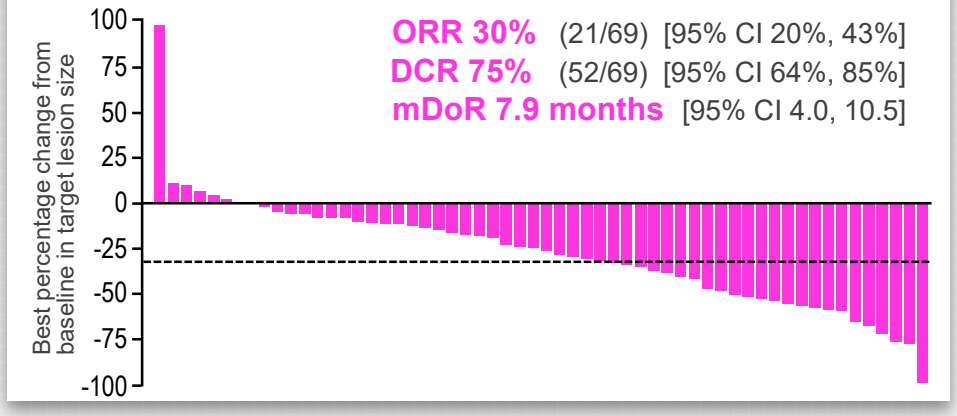
Potential First-in-class small molecule selective MET inhibitor

Indications:	MET-dysregulated NSCLC; RCC; Gastric; Prostate; Colorectal cancer
Dosed to-date: [1]	~1,000 patients
Summary Data:	**NSCLC – Tagrisso® EGFR TKI refractory combinations:** **Post 1st-gen TKI** (n=105): ORR 64-67% **Post 3rd-gen TKI** (n=69): ORR 30% **NSCLC MET ex14** (n=70): ORR 49% **PRCC** (n=60): ORR 27% vs. 7%; OS HR 0.51 (not mature)

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



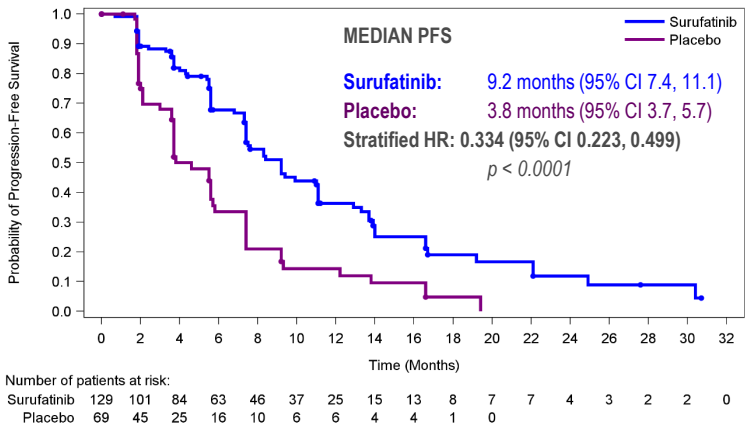
Surufatinib *(VEGFR, FGFR1, CSF-1R)*

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

Indications:	Neuroendocrine tumors (pNET/ep-NET); Biliary Tract
Dosed to-date: [1]	>800 patients
Summary Data:	**ep-NET** (n=198): ORR 10%; mPFS 9.2mo vs 3.8mo (Pbo) **p-NET** (n=172): ORR 19%; mPFS 10.9mo vs 3.7mo (Pbo)

1x China NDA Approved
1x China NDA Accepted
US NDA Filing Started

BARCELONA 2019 ESMO congress — 27 SEPT – 1 OCT 2019



The *MET* gene encodes the receptor tyrosine kinase hepatocyte growth factor, VEGFR = vascular endothelial growth factor receptor, FGFR1 = fibroblast growth factor receptor 1, CSF-1R = colony stimulating factor-1 receptor, NSCLC = non-small cell lung cancer, RCC = renal cell carcinoma, PRCC = papillary RCC, pNET = pancreatic NET, ep-NET = non-pancreatic NET; [1] Patients in all clinical trials (treatment arm); [2] Phase II registration intent study subject to regulatory discussions.

Global clinical drug portfolio (2/2)

Fruquintinib *(VEGFR1/2/3)*

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

Indications:	Colorectal; NSCLC; Gastric cancer
Dosed to-date: [1]	~1,700 patients
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 72% [2] **2L Gastric (Taxol® combo)** (n=28): ORR 36%

Launched in CRC Nov 2018 in China

HMPL-523 *(Syk)*

Potential First-in-class small molecule selective Syk inhibitor

Indications:	Indolent non-Hodgkin's lymphoma; Immunol.
Dosed to-date:	>200 pts. & ~118 healthy vol.
Summary Data:	Dose escalation (5 cohorts) [3] **FL** (n=10): ORR 30% **CLL/SLL** (n=3): ORR 33%

HMPL-689 *(PI3Kδ)*

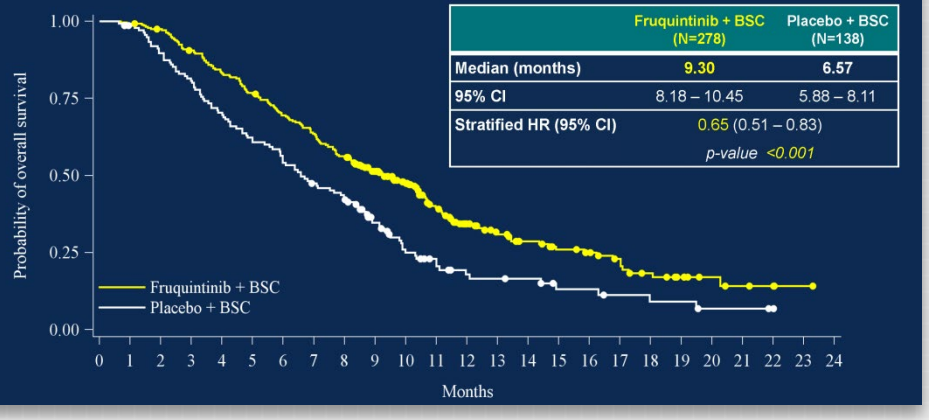
Potential Best-in-class small molecule selective PI3Kδ inhibitor

Indications:	Indolent non-Hodgkin's lymphoma
Dosed to-date:	70 pts. & ~36 healthy vols.
Summary Data:	Dose escalation (9 cohorts) [4] ORR: 52% (all doses; n=52)

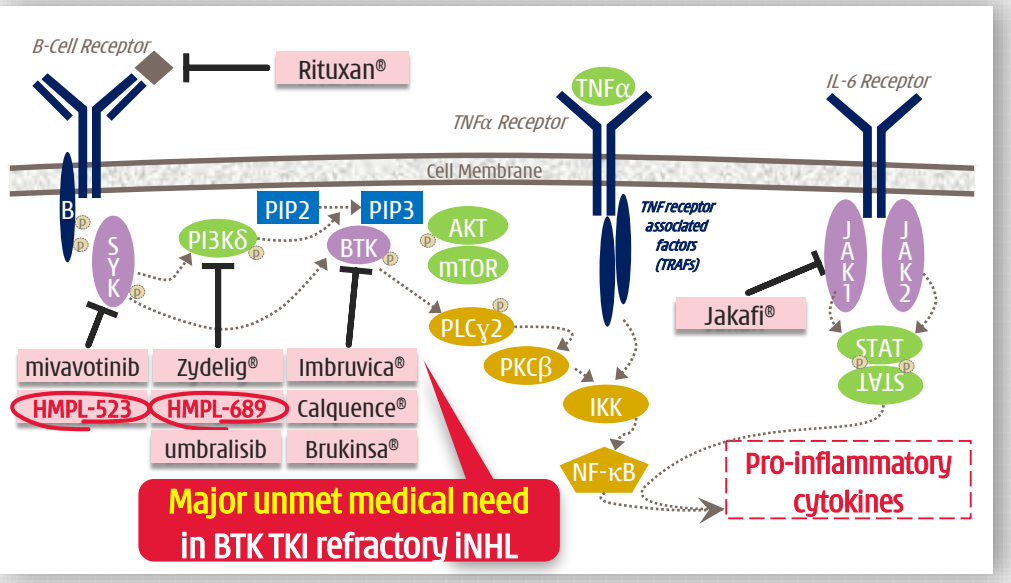
PRESENTED AT: **ASCO ANNUAL MEETING '17**

Overall Survival (Primary Endpoint)

FRESCO clearly succeeded in meeting the primary efficacy endpoint of OS



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



VEGFR = vascular endothelial growth factor receptor, Syk = spleen tyrosine kinase, PI3Kδ = Phosphatidylinositol-3-Kinase delta, CRC = colorectal cancer, NSCLC = non-small cell lung cancer; [1] Dosed to-date = patients in all clinical trials (treatment arm); [2] 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, Nov 23, 2019; [3] Blood, vol. 132 no. Suppl 1 5324 (Nov 2018); [4] ASH 2020 abstract #1135.

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	NSCLC	MET Exon 14 skipping		Global	In planning		
	Savolitinib	Papillary RCC	MET+	SAVOIR	Global	Choueiri – 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	Colorectal cancer *	MET+		US	Strickler – Duke Uni		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	NET	Refractory		US/EU	Dasari/Yao – MD Anderson		
	Surufatinib	Biliary tract cancer			US	Li/City of Hope		
	Surufatinib	Soft tissue sarcoma			US	Patel/Tapp – MD And/ MSKCC		
	Surufatinib + Tuoyi® (PD-1)	Solid tumors				In planning		
	Surufatinib + tislelizumab (PD-1)	Solid tumors				In planning		
Fruquintinib VEGFR 1/2/3	**Fruquintinib**	Colorectal cancer	Refractory	FRESCO-2	US/EU/JP	Eng/Desari – MD And. [1]		
	Fruquintinib	Breast cancer			US	Tripathy – MD And.		
	Fruquintinib + tislelizumab (PD-1)	Solid tumors				In planning		
HMPL-523 Syk	**HMPL-523**	Indolent NHL			Australia			
	HMPL-523	Indolent NHL			US/EU			
HMPL-689 PI3Kδ	**HMPL-689**	Healthy volunteers			Australia			
	HMPL-689	Indolent NHL			US/EU	Ghosh/Cohen – Levine/Emory		
HMPL-306 IDH 1/2	**HMPL-306**	Solid tumors			US/EU	In planning		
	HMPL-306	Hem. malignancies			US/EU	In planning		

Interim PoC at ASCO GU Feb 2020

PoC published in Can. Discovery Oct 2019

US NDA filing started YE20
EU MAA filing 2021

Ph.III (FRESCO-2) start Sept-2020

US/EU Phase I/Ib study enrollment underway

US/EU Phase I/Ib study enrollment underway

[1] in U.S., in E.U. Tabernero – Vall d'Hebron & Sobrero – Genova; * Investigator initiated trials (IITs).

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, NET = neuroendocrine tumors; NHL = Non-Hodgkin's Lymphoma; ASCO GU = American Society of Clinical Oncology Genitourinary Cancer Symposium; PoC = Proof of Concept.

CHI-MED

A1b Building a fully integrated China oncology business

China oncology - ›25% 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 - 9 clinical drug candidates with 3 NDAs submitted in China*

Major commercial opportunity

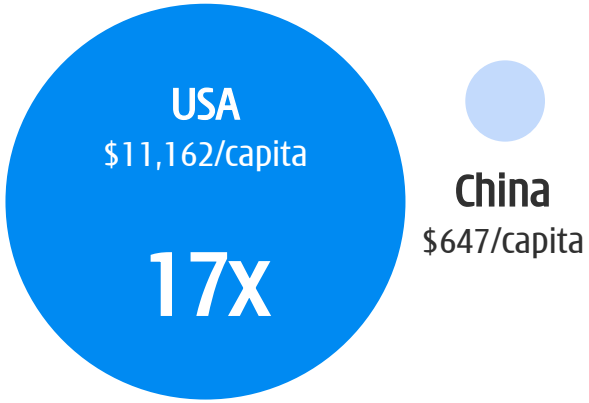
- *National Drug Reimbursement; Medical coverage*

[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

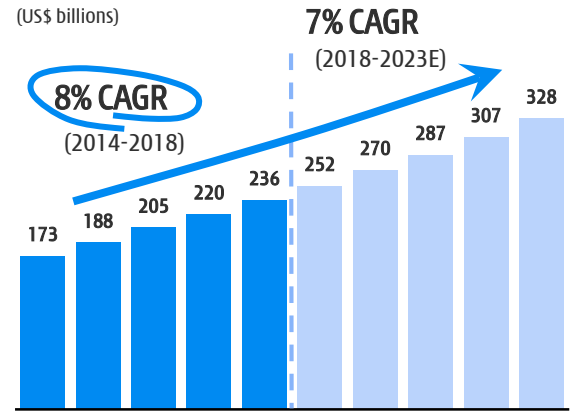
...investment, approvals & access all accelerating rapidly

Per Capita Healthcare Spending



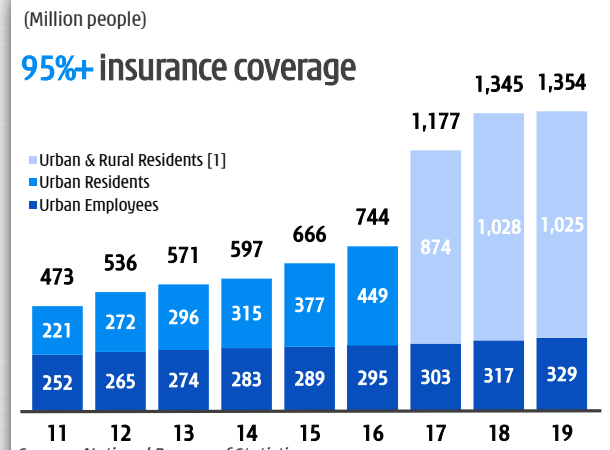
Source: Frost & Sullivan (2018)

PRC Pharmaceutical Market Size



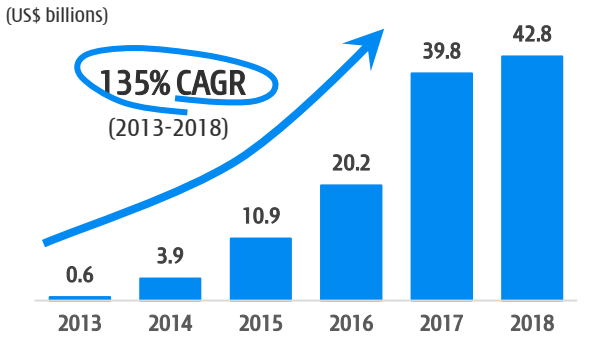
Source: Frost & Sullivan

Medical Insurance Coverage



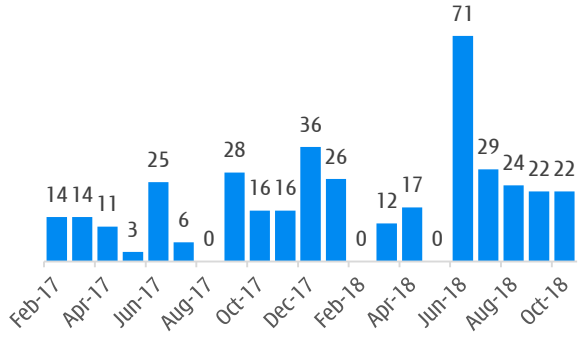
Source: National Bureau of Statistics

PRC Healthcare VC/PE Funds [2]



Source: McKinsey; ChinaBio report

Number of Priority Review NDAs [3]



Source: McKinsey; National Medical Products Administration

Improved Access

- 119 drugs added to NRDL in Dec 2020;
- Further 17 oncology drugs added to NRDL in Dec 2020;
- Essential drug list expanded from 520 to 685 molecules. Including oncology.

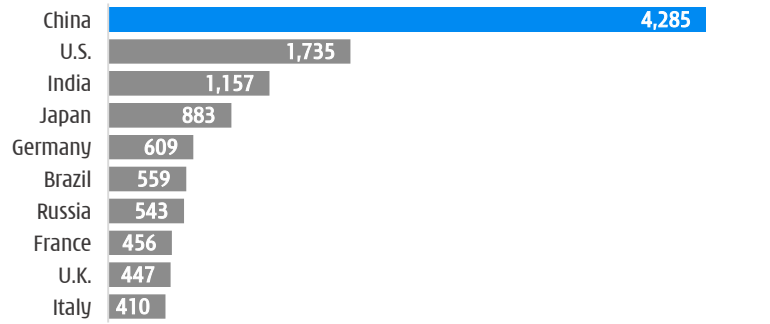
Source: McKinsey

[1] From 2016, China started to consolidate the Urban Resident Medical Insurance Scheme (URBMI) and New Rural Cooperative Medical Insurance Scheme (NRCMI); [2] Funds raised targeting China healthcare; [3] NDA = New Drug Application.
Note: CAGR = Compound annual growth rate.

Cancer is a major unmet need in China

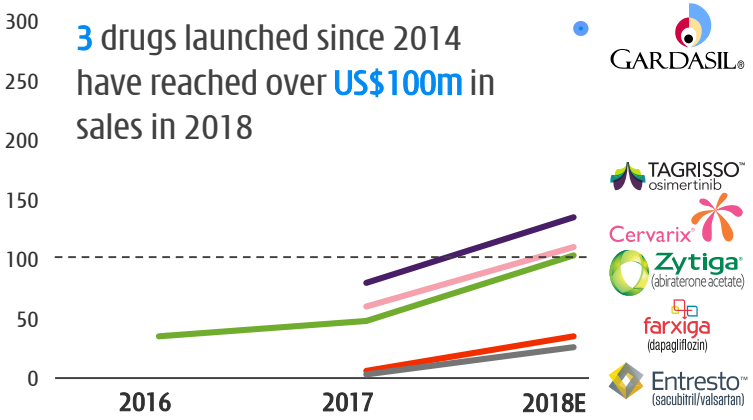
...investments in launches/access starting to have an impact

Cancer Incidence in China (2018)



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

Rapid uptake of new launches in China



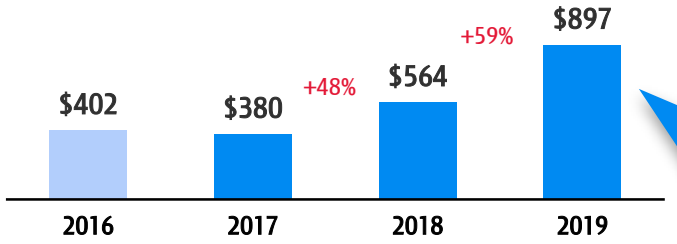
Source: McKinsey; RDPAC 2018 estimated based on Q3 RDPAC data

Novel drugs post NRDL inclusion

Herceptin® trastuzumab

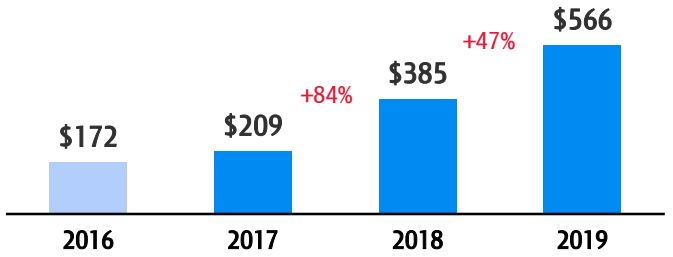
(Bar Chart US$ millions)

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.; Roche 2019 annual report
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 skipping		China	Lu Shun – SH Chest Hosp.		
	Savolitinib	Gastric cancer	MET+		China	Shen Lin – BJ Univ. Tumor		
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 (7 settings)			China	Shen Lin – BJ Univ. Tmr.		
	Surufatinib + Tyvyt® (PD-1)	Solid tumors			China			
	Surufatinib + tislelizumab (PD-1)	Solid tumors			China	In planning		
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 + Tyvyt® (PD-1)	Solid tumors			China	Bai Yuxian – Harbin Med. U.		
	Fruquintinib + geptanolimab (PD-1)	Solid tumors			China	Li Jin – Fudan Univ.		
	Fruquintinib + tislelizumab (PD-1)	Solid tumors			China	In planning		
HMPL-523 Syk	**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		
HMPL-453 FGFR 1/2/3	**HMPL-453**	Mesothelioma			China	Lu Shun – SH Chest Hosp.		
	HMPL-453	IHCC			China	Jianming Xu – BJ PLA 307 Hosp.		
HMPL-306	**HMPL-306** (IDH1/2)	Hem. malignancies			China			
Epitinib	**Epitinib** (EGFR)	Glioblastoma	EGFR gene amplified		China	Ying Mao – SH Huashan		
Theliatinib	**Theliatinib** (EGFR wt)	Esophageal cancer	EGFR over-expression		China			

NDA accepted May 2020

NDA accepted Sept 2020

NDA approved Dec 2020

Launched Nov 2018

2nd Interim June 2020

Phase I/Ib data to **inform registration decisions**

Phase I/Ib data to **inform registration decisions**

Note: ITP = immune thrombocytopenic purpura; IHCC= Intrahepatic cholangiocarcinoma; PoC= proof of concept.

Established Chi-Med Commercial Platform in China

Focus on building out oncology commercial organization

Focus on building out Oncology commercial

Establisheds oncology commercial team of ~400 FTEs by Dec 2020.

Approval of suru in China in late 2020.

Plan to expand to 900+ FTEs[7] by 2023 & take on multiple assets.

Major Commercial & Production Scale

~2,300 RX & ~900 OTC sales people in about 320 [1] cities & towns in China.

Drugs in >22,100 hospitals detailing >74,000 doctors.

Sold ~4.7 billion doses of medicine in 2019.

Leadership Market Shares

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

SXBX pill:[3][4] Rx Cardiovascular TCM	~18%
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

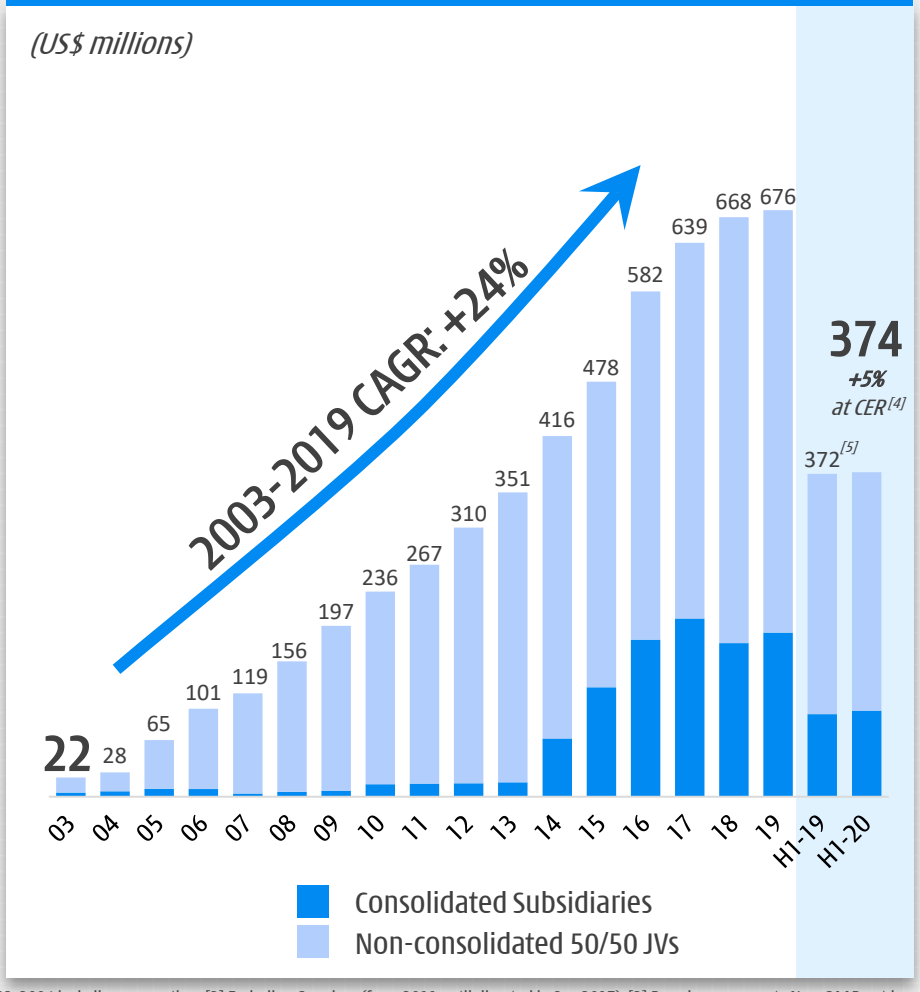
SINOPHARM

[1] 320 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; [7] FTE = full-time employees.

Building a China Specialty Pharma business

Proven track record – major focus on oncology 2020 onwards

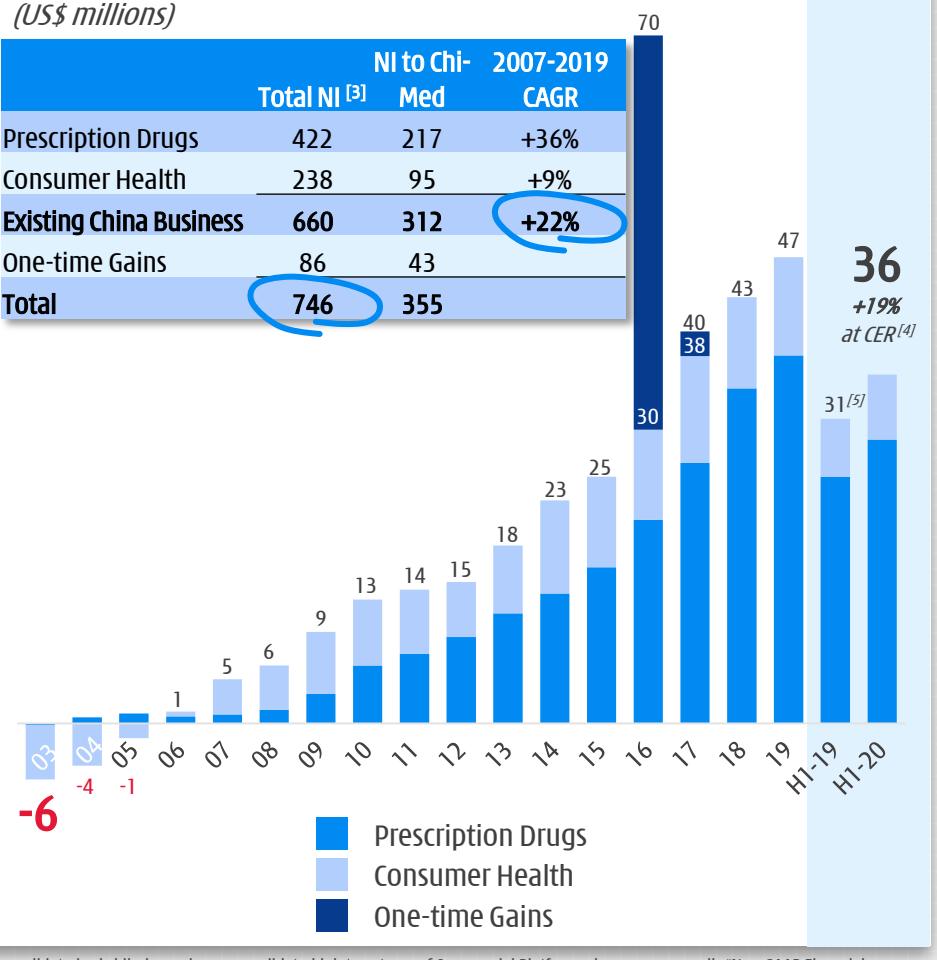
Revenue (Non-GAAP) [1][2]



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

(US$ millions)

	Total NI [3]	NI to Chi-Med	2007-2019 CAGR
Prescription Drugs	422	217	+36%
Consumer Health	238	95	+9%
Existing China Business	**660**	**312**	**+22%**
One-time Gains	86	43	
Total	**746**	**355**	



[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; [5] In 2019 annual report, the results of innovative medicines developed by the Innovation Platform have been reallocated from Innovation Platform to Commercial Platform- Prescription Drugs business. H1-19 information has been revised for comparison purpose.

CHI-MED

A2

Product Candidate Details

Further details on each drug candidate

CHI-MED

A2a

Savolitinib

Potential first-in-class selective MET inhibitor

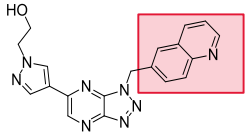
Savolitinib

Potential first-in-class selective MET inhibitor

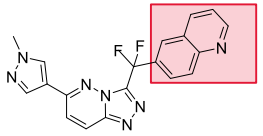
1. Strong potential to become first selective MET inhibitor approved in certain indications.

- ✓ 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**.

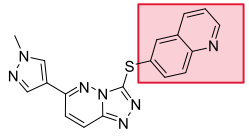
3. Savolitinib design eliminates renal toxicity first generation of selective MET inhibitors encountered – ~1,000 patients involved in clinical studies to date.



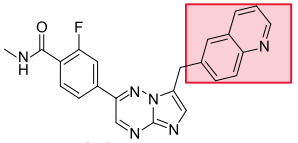
Pfizer PF-04217903



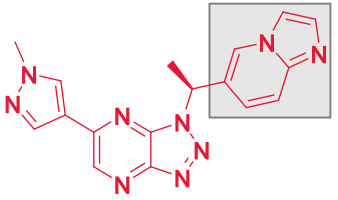
Janssen JNJ-38877605



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 December 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 skipping NSCLC

China's lead selective MET inhibitor

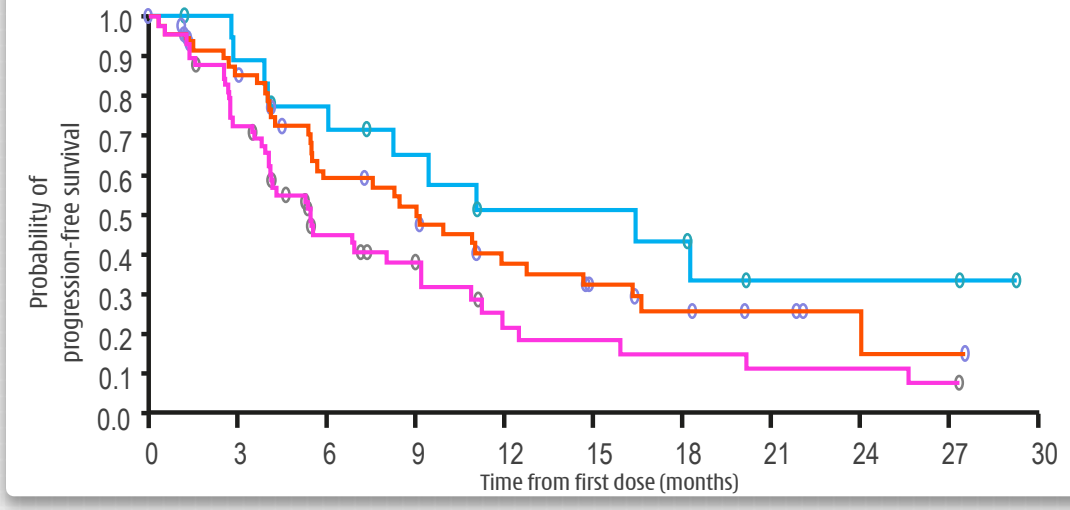
Competitive landscape outside China:

	Treatment Line	MET aberration	N	BICR[1] ORR (%)	DCR (%)	mDoR (months)	mPFS (months)
Capmatinib [2]							
	1L (cohort 5b)	Ex14 skipping	28	**68** [48, 84]	**96** [82,100]	**12.6** [5.6,NE]	**12.4** [8.2,NE]
	2/3L (cohort 4)	Ex14 skipping	69	**41** [29,53]	**78** [67,87]	**9.7** [5.6,13.0]	**5.4** [4.2,7.0]
	2L (cohort 6, group 2)	Ex14 skipping	31	**48.4** [30.2,66.9]	**90.3** [74.2,98.0]	**6.93** [4.17, NE]	**8.11** [4.17, 9.86]
	1L (cohort 5a)	Amp (GCN ≥10)	15 [3]	**40** [16,68]	**67** [38,88]	**7.5** [2.6,14.3]	**4.2** [1.4,6.9]
	2/3L (cohort 1a)	Amp (GCN ≥10)	69	**29** [19,41]	**71** [59,81]	**8.3** [4.2,15.4]	**4.1** [2.9,4.8]
Tepotinib [4]							
	44% 1L, 56% ≥2L	Ex14 skipping	99 [5]	**46 .5** [36.4,56.8]	**65.7** [55.4,74.9]	**11.1** [7.2,NE]	**8.5** [6.7,11.0]

[1] BICR = blinded independent central review; [2] Paik et al. "Tepotinib in Non-Small-Cell Lung Cancer with MET Exon 14 Skipping Mutations." N Engl J Med 2020; 383:931-943 DOI: 10.1056/NEJMoa2004407; [3] closed early due to slow enrollment; [4] Wolf et al. "Capmatinib in MET Exon 14-Mutated or MET-Amplified Non-Small-Cell Lung Cancer." N Engl J Med 2020; 383:944-957 DOI: 10.1056/NEJMoa2002787; [5] patients followed for over 9 months.

TATTON B & D data - PFS

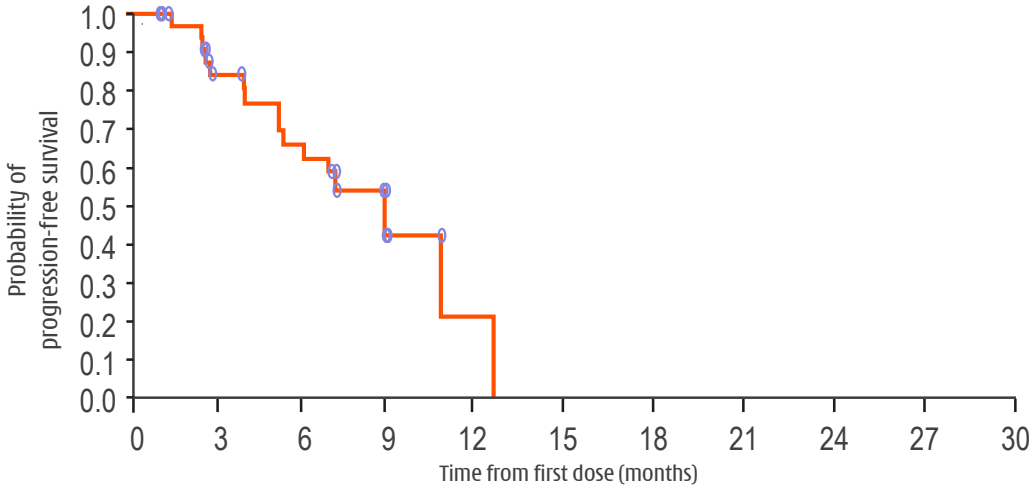
Tagrisso® + savolitinib in EGFR TKI refractory NSCLC



	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.

TAGRISSO™ osimertinib + savo in EGFR TKI refractory NSCLC

TATTON B & D data – AEs & tolerability

Event, n (%)	All Part B (n=138) osimertinib 80 mg + savolitinib 600 mg [1]	Part D (n=42) osimertinib 80 mg + savolitinib 300 mg [1]
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)

[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. 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; Sequist LV, Han JY, Ahn MJ, et al. Osimertinib plus savolitinib in patients with EGFR mutation-positive, MET-amplified, non-small-cell lung cancer after progression on EGFR tyrosine kinase inhibitors: interim results from a multicentre, open-label, phase 1b study. Lancet Oncol. 2020; S1470-2045(19)30785-5. doi:10.1016/S1470-2045(19)30785-5

TATTON B & D data - AEs & SAEs

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

TAGRISSO™ osimertinib

CHI-MED

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)

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%)

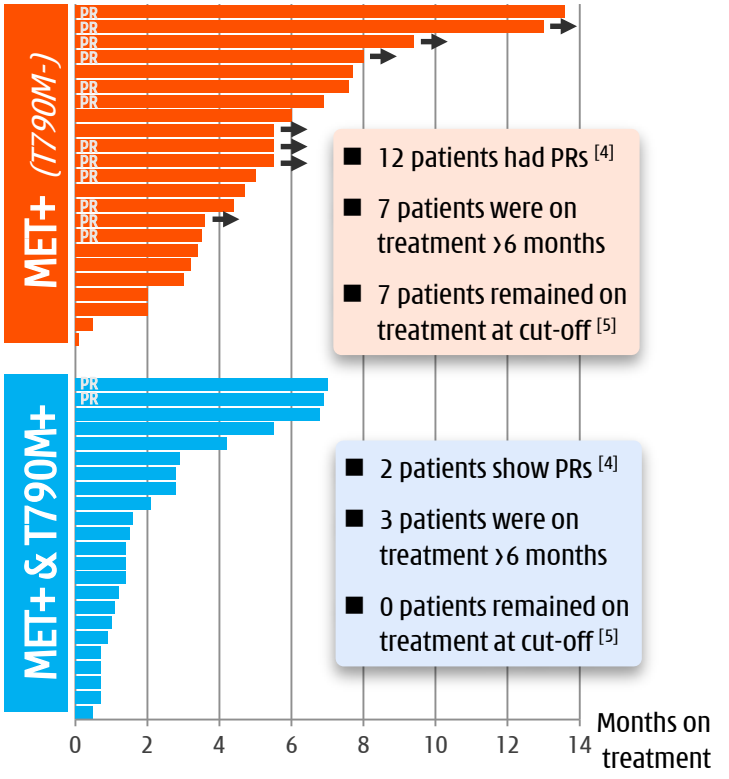
MET status all centrally confirmed.

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

	MET+ / T790M+ (n = 18) Lancet Onc. 2020 [3]	MET+ *(T790M-)* (n = 51) Lancet Onc. 2020 [3]
Confirmed response	12 (67%)	33 (65%)
Stable disease ≥ 6 weeks	6 (33%)	12 (24%)
Progressive disease / death	0 (0%)	3 (6%)
Not Evaluable	0 (0%)	3 (6%)

MET status locally or centrally confirmed.

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

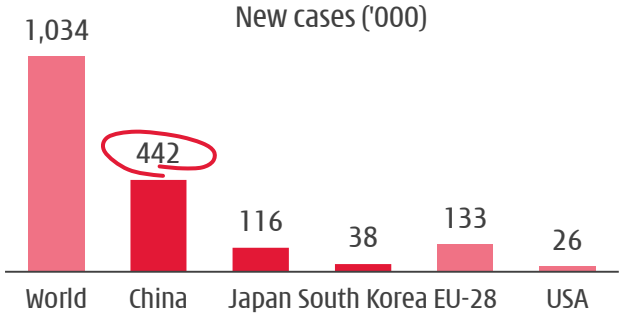


[1] EGFRm NSCLC; [2] WCLC 2017 – Yang J-J, et al. A Ph.Ib Trial of savolitinib plus gefitinib for patients with EGFR-mutant MET-amplified advanced NSCLC; [3] Sequist LV, Han JY, Ahn MJ, et al. Osimertinib plus savolitinib in patients with EGFR mutation-positive, MET-amplified, non-small-cell lung cancer after progression on EGFR tyrosine kinase inhibitors: interim results from a multicentre, open-label, phase 1b study. Lancet Oncol. 2020; S1470-2045(19)30785-5. doi:10.1016/S1470-2045(19)30785-5; [4] PR = Partial Response.

Savolitinib – MET+ gastric cancer

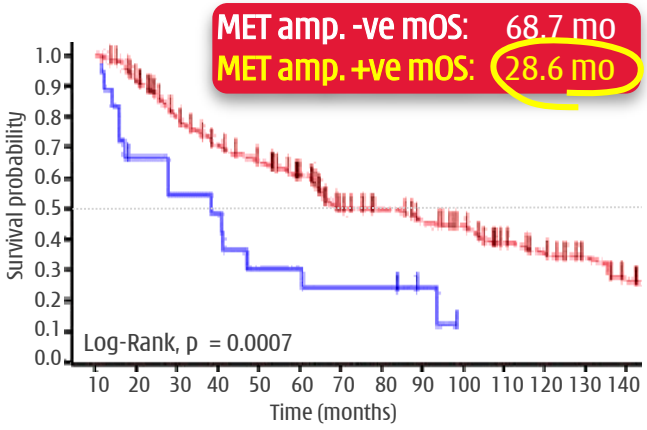
A major problem in east Asia – Japan, South Korea & China

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

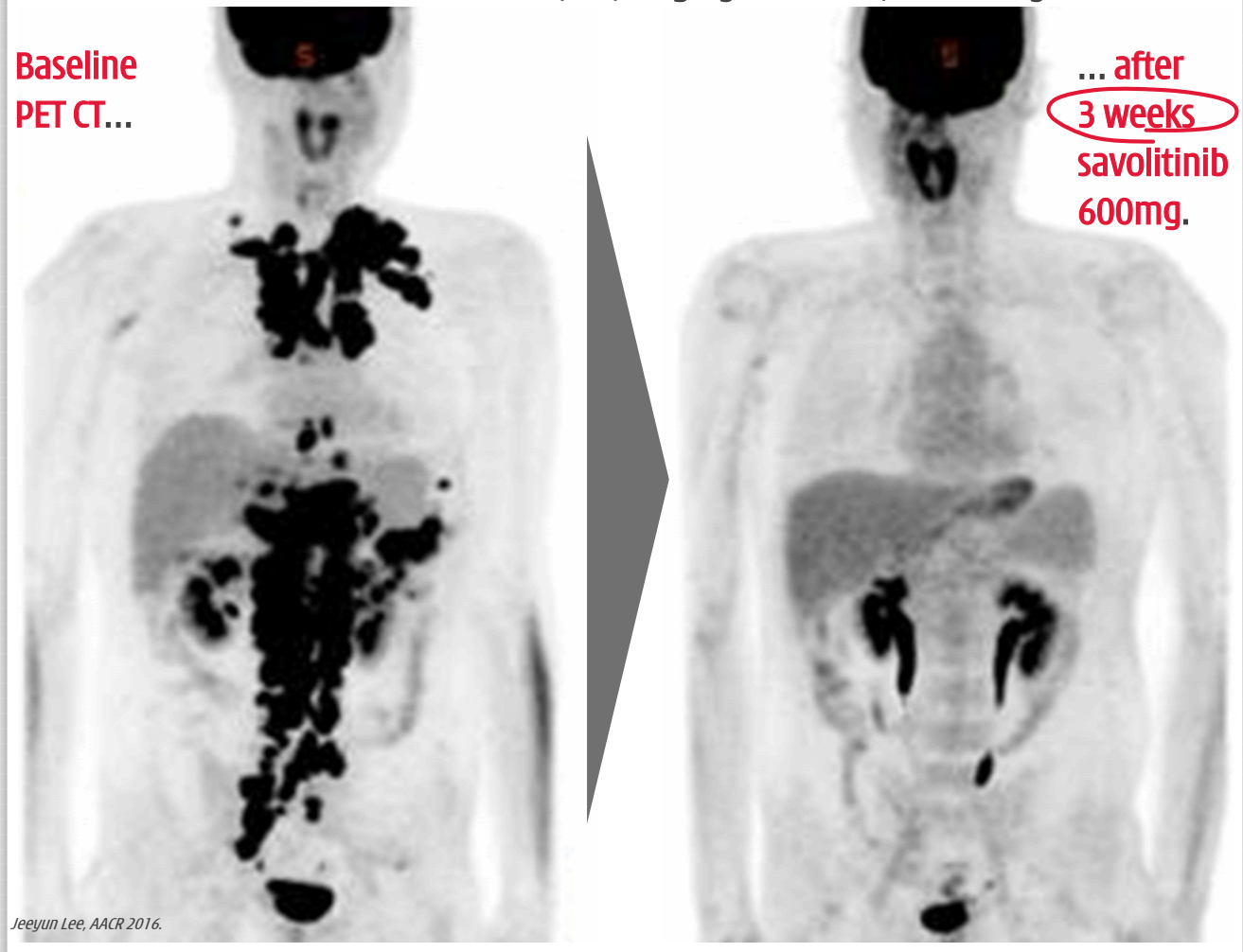


World Cancer Research Fund International, WHO, ACS, NCCR, Lancet, Frost & Sullivan Analysis.

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.

Savolitinib potential in gastric cancer

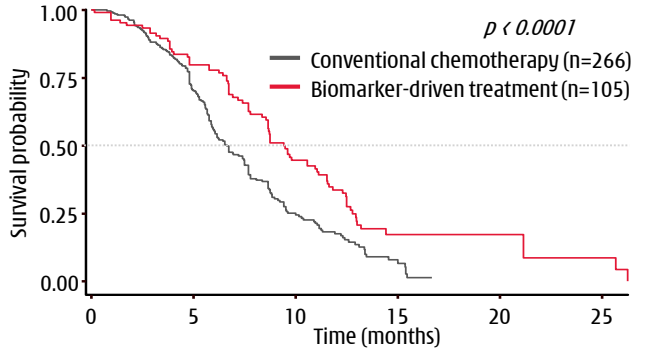
VIKTORY Phase II trial highly promising in MET+ gastric cancer

VIKTORY: Highest response rate in savolitinib monotherapy arm

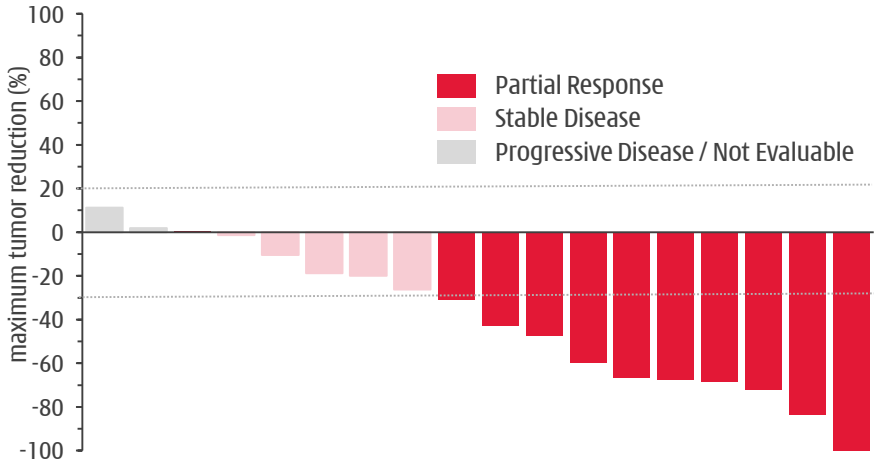
Tumor sequenced (N=715) → Eligible for 2nd line treatment (N=460)
→ Biomarker positive; received targeted treatment (N=105)

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%**	

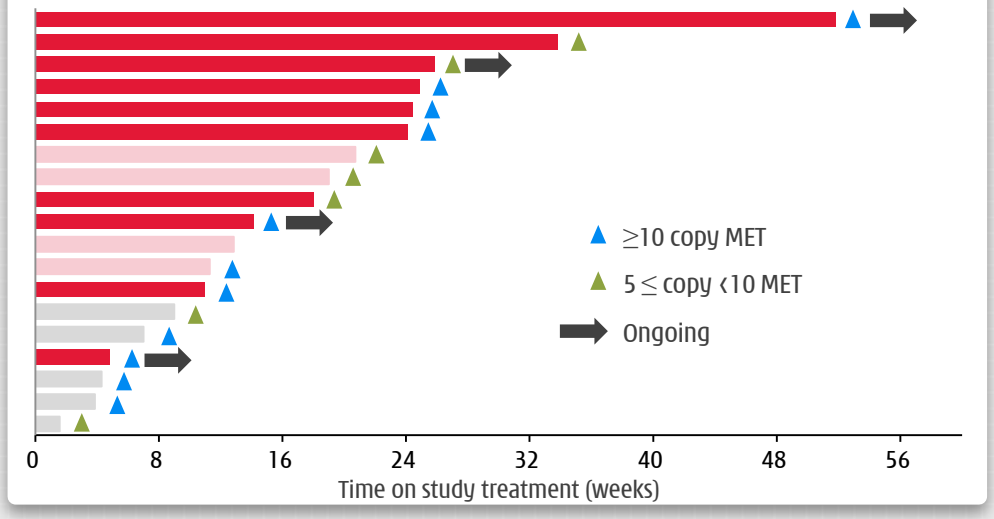
Biomarker guided treatment may prolong overall survival



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

Surufatinib

Highly active TKI with unique angio-immuno activity

Surufatinib

Overview of NET – ~141,000 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.

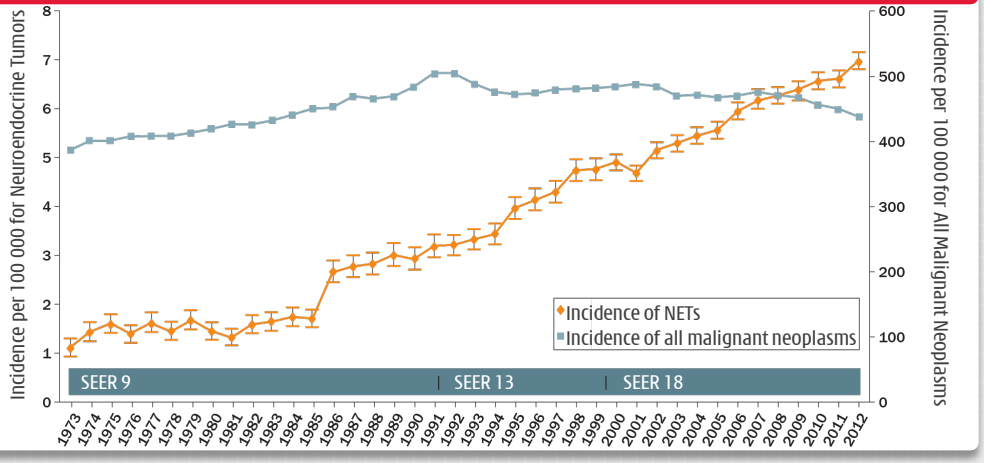
Hormone-related symptoms [1]

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

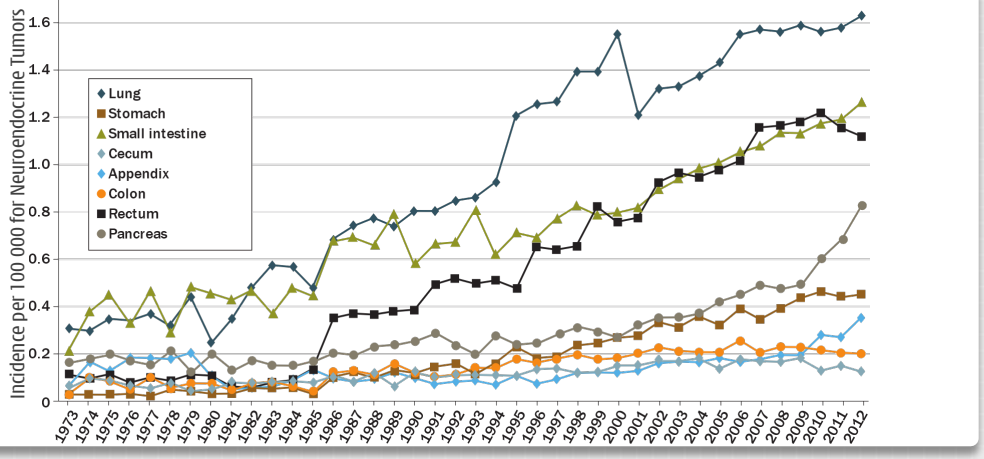
Differentiation & biomarkers for grading:

- 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 [4]



NET epidemiology – highly fragmented [4]



[1] Frost & Sullivan; [2] www.cancer.net (patient information from ASCO) – NET is a subtype of neuroendcrine neoplasms, NENs); [3] IQVIA 2019; [4] 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.

~141,000 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 (Approved in China)
2019 Sales	$1.6bn	$1.2bn	$0.4bn	$1.5bn	$0.9bn	-
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	Intravenous inj. (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 pNET (unresectable locally adv. or meta).	• Two positive RCTs in pNET and epNET conducted in China • NDA for epNET approved in China; NDA for pNET under review • US NDA filing started YE20.
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 III pNET 10.9 / 3.7	Ph III non-pNET 9.2 / 3.8
HR	0.34	0.47	0.21	0.35	0.48	0.42	0.49	0.33
(*p-value*)	*0.000072*	*<0.001*	*<0.0001*	*<0.001*	*<0.001*	*<0.001*	0.0011	*<0.0001*
ORR	2% / 2%	NR	18% / 3%	5% / 2%	2% / 1%	9% / 0%	19% / 2%	10% / 0%
DCR	69% / 40%	NR	95% / 76%	73% / 51%	81% / 64%	72% / 60%	81% / 66%	87% / 66%
Pivotal Trial	PROMID	CLARINET	NETTER-1	RADIANT-3	RADIANT-4	A6181111	SANET-p	SANET-ep

[1] Frost & Sullivan; [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

NET potential ~$100-120m/yr.[1] - under treated/diagnosed

Competitive landscape - *China NET treatments* [1]

Brand	Indication/s	Launched		2017	2018	2019
SUTENT® *(sunitinib - VEGFR)* Pfizer	**Pancr. NET** (& GIST/RCC)	2007	Sales (US$ million)	**27**	**24**	**41**
			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**	**12**
			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**	**23**
			List Price (US$/month)	1,169	*NRDL Oct-18*	835

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

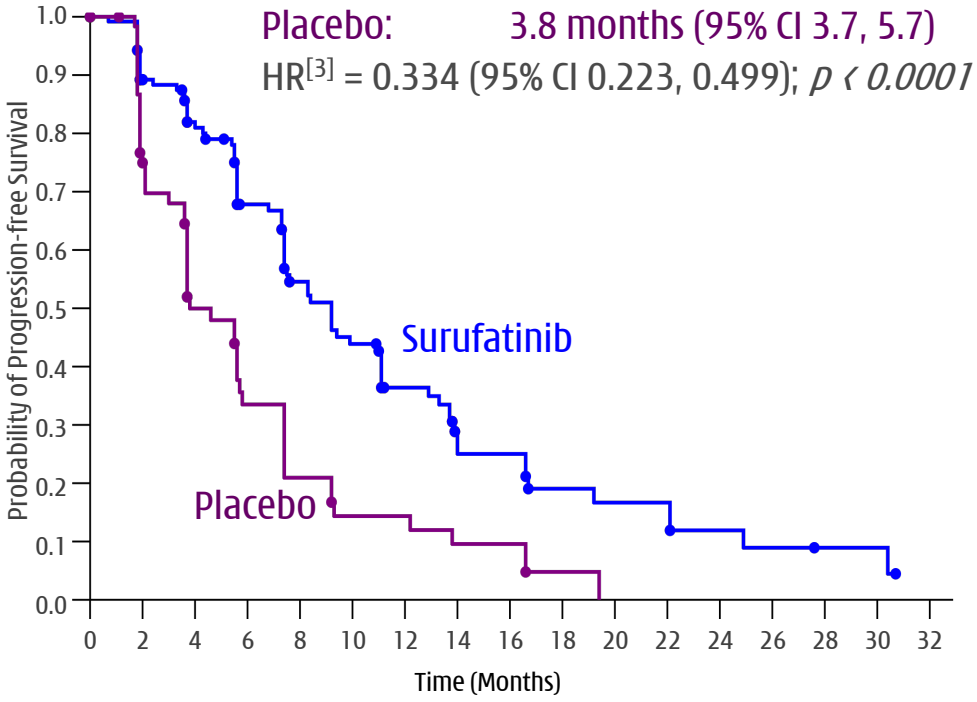
[1] Source: Frost & Sullivan. Note: Calculations assume at CER, using exchange rate of RMB6.74 per US$1; [2] SSA = Somatostatin analogues; [3] GEP-NEN = gastro-entero-pancreatic neuroendocrine neoplasias.

G1/2 Advanced extra-pancreatic NET

Investigator assessed median PFS

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

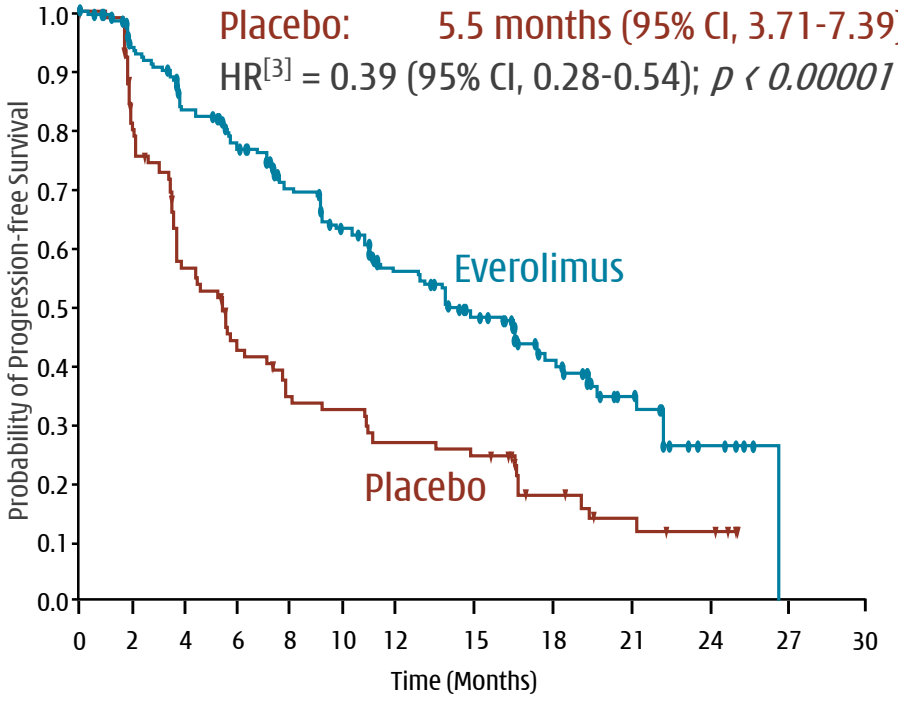
Surufatinib: 9.2 months (95% CI 7.4, 11.1)
Placebo: 3.8 months (95% CI 3.7, 5.7)
HR[3] = 0.334 (95% CI 0.223, 0.499); *p < 0.0001*



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*



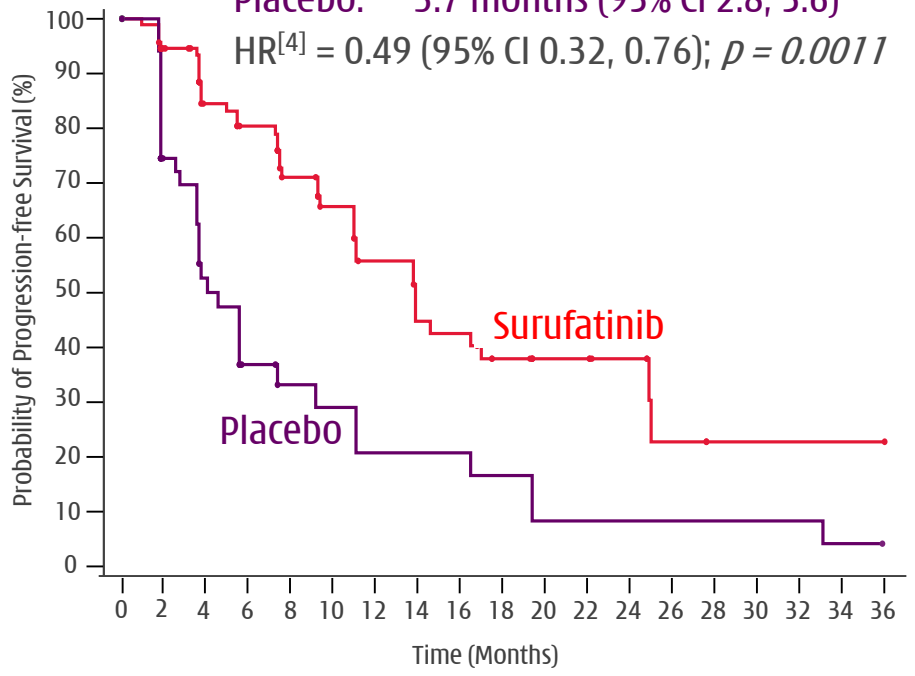
RADIANT-4 Primary (1°) endpoint was BIIRC [4] mPFS
Investigator mPFS not 1° or 2°endpoint

[1] Xu et al. "Surufatinib in advanced extrapancreatic neuroendocrine tumours (SANET-ep): a randomised, double-blind, placebo-controlled, phase 3 study." Lancet Oncol 2020. Published online September 20, 2020. https://doi.org/10.1016/S1470-2045(20)30496-4; [2] Yao et al. "Everolimus for the treatment of advanced, non-functional neuroendocrine tumors 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).

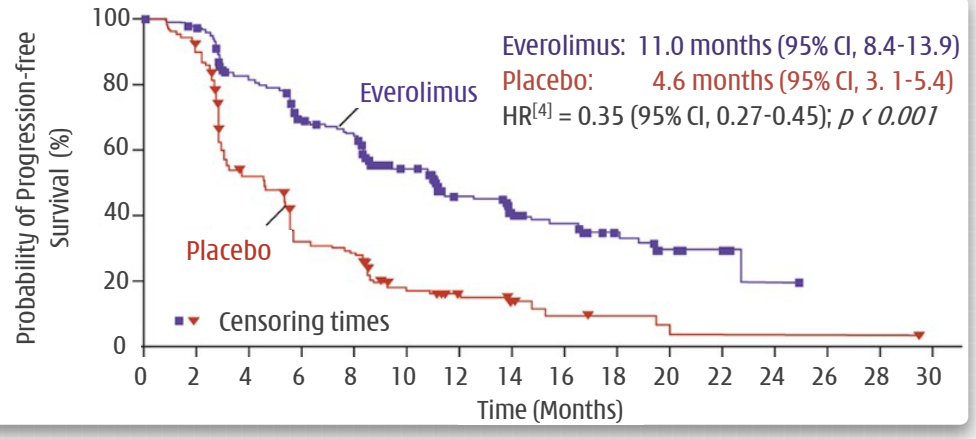
G1/2 Advanced pancreatic NET

Investigator assessed median PFS (primary endpoints)

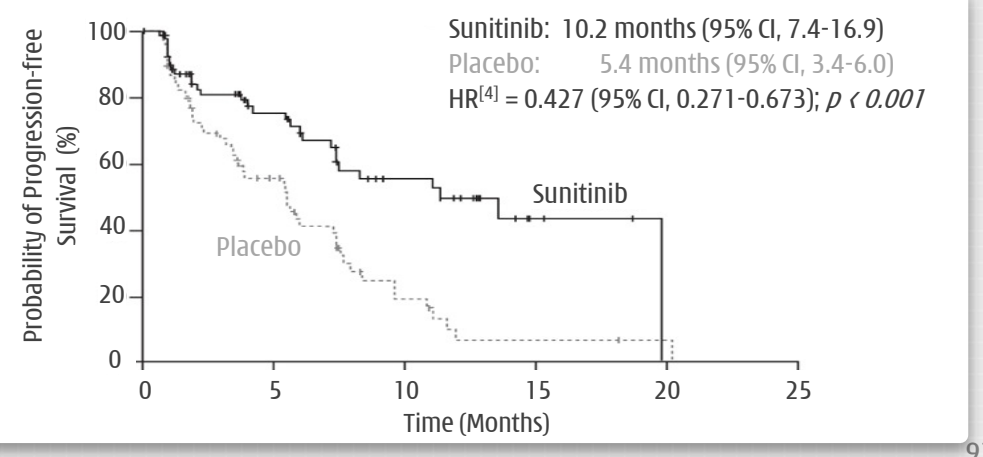
SANET-p[1] *(n=172)*



RADIANT-3 (everolimus)[2] *(n=410)*



A6181111 (sunitinib)[3] *(n=171)*



[1] Xu et al. "Surufatinib in advanced pancreatic neuroendocrine tumours (SANET-p): a randomised, double-blind, placebo-controlled, phase 3 study." Lancet Oncol 2020. Published Online September 20, 2020 https://doi.org/10.1016/S1470-2045(20)30493-9; [2] Yao et al. Everolimus for advanced pancreatic neuroendocrine tumors" N Engl J Med. 2011;364(6):514-23 DOI: 10.1056/NEJMoa1009290; [3] Raymond et al. Sunitinib malate for the treatment of pancreatic neuroendocrine tumors [published correction appears in N Engl J Med. 2011 Mar 17;364(11):1082]. N Engl J Med. 2011;364(6):501-513 DOI: 10.1056/NEJMoa1003825; [4] P-value from SANET-p is obtained from the stratified one-sided log-rank test; Hazard ratio is obtained from stratified Cox model; CI, confidence interval; HR, hazard ratio.

Surufatinib vs. everolimus and sunitinib

Broader range of tumor origins & later-stage patients

Non-Pancreatic Tumor Origin	Asia/China Extra-Pancreatic NET	SANET-ep [1] (n=198) (surufatinib vs placebo)	U.S. Extra-Pancreatic NET	RADIANT-4 [2] (n=302) (everolimus vs placebo)
	Tsai et al. 2013		Yao et al. 2008	
Gastrointestinal Tract	**58%**	**47%**	**50%**	**58%**
Rectum	30%	**27%**	33%	13%
Stomach	7%	**10%**	8%	4%
Small Intestine	19%	8%	6%	**34%**
Other GI	3%	3%	4%	7%
Lung	**22%**	**12%**	**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%**

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 enroll 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.

	NON-PANCREATIC NET		PANCREATIC NET		
	SANET-ep [1] (n=198)	RADIANT-4 [2] (n=302)	SANET-p [3] (n=172)	RADIANT-3 [4] (n=410)	A6181111 [5] (n=171)
Pathology grade					
Grade 1	16%	**65%**	12%	**83%**	n/a
Grade 2	**84%**	35%	**88%**	17%	n/a
ECOG PS 0:1					
PS 0 (treatment : control)	60% (56% : 67%)	74% (73% : 75%)	67% (65% : 73%)	66% (67%: 66%)	55% (62% : 48%)
PS 1 (treatment : control)	40% (44% : 33%)	26% (27% : 26%)	33% (35% : 27%)	31% (30:32%)	44% (38% : 51%)
Prior systemic treatment					
Any Prior Treatment	**67%**	**61%**	**66%**		**69%**
Chemotherapy	40%	25%	26%	50%	66%
Targeted therapy	**10%**	none	9%	none	none
Somatostatin Analogues	32%	55%	44%	50%	36%
Number of organs involved					
≤2	34%	n/a	49%	64%	64%
≥3 or unknown	66%	n/a	51%	36%	36%

Surufatinib

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

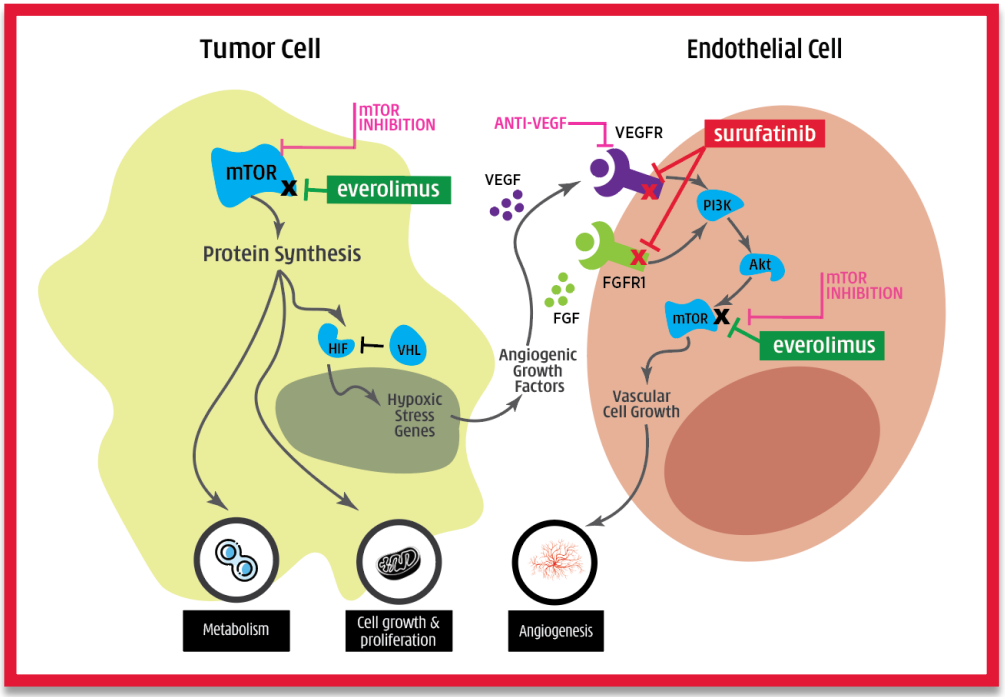
Likely due to later diagnosis in China & availability of everolimus.

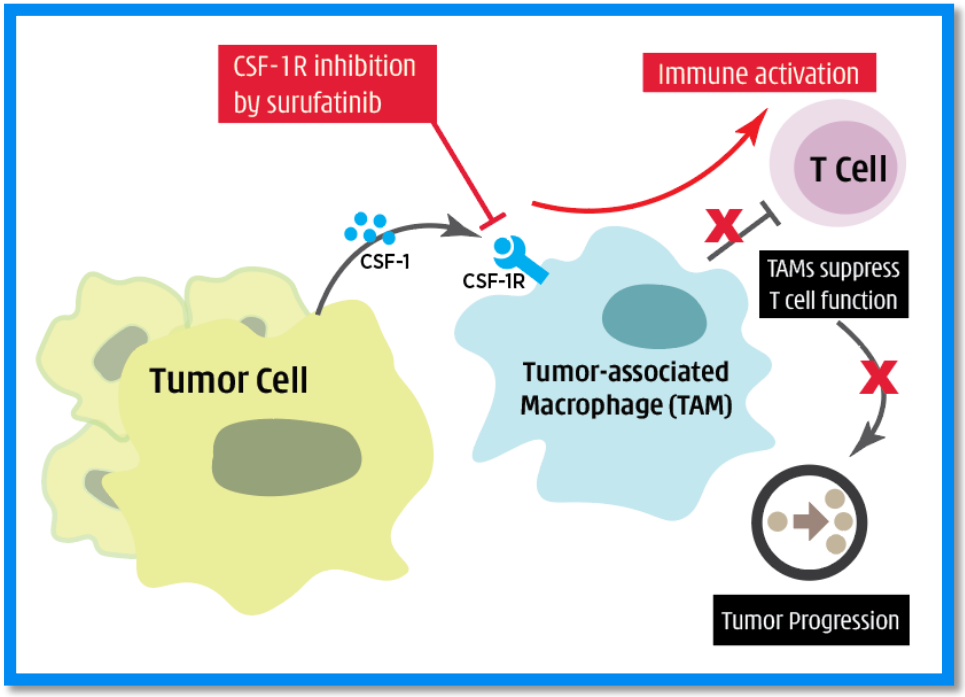
Source: Yao et al, Lancet 2016 387(10022) 968-77; Yao et al, JAMA Oncol 2017 3(10) 1335-42; Excludes 7% pancreatic NET in US series and 6% in Asia series;
Colon-rectum in Tsai et al. (2013) report; Colon approximately 8% in Asian series (Shebani KO et al. (1999)); Colon-rectum in Yao et al. (2008) report; Colon approximately 4-7% in US/EU series (Niederle B et al. (2016)).
[1] Xu et al. https://doi.org/10.1016/S1470-2045(20)30496-4; [2] Yao et al. doi: 10.1016/S0140-6736(15)00817-X; [3] Xu et al. https://doi.org/10.1016/S1470-2045(20)30493-9; [4] Yao et al. DOI: 10.1056/NEJMoa1009290; [5] Raymond et al. DOI: 10.1056/NEJMoa1003825.

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 – China NET

Two positive Ph. III studies unblinded a year ahead of schedule

Epidemiology – *China NET & BTC patient populations*

First targeted therapy ever to address all NET patients, regardless of primary organ site

Registration-intent study in BTC 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	~60,000 (Est. China ratio[1])	10.9 mo. (SANET-p Ph.III)	
Biliary Tract Cancer	100%	64,000		TBD	

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

[1] Source: Frost & Sullivan. 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.

CHI-MED

A2c

Elunate® (fruquintinib capsules)

Highly selective anti-angiogenesis inhibitor

Fruquintinib - 3L+ colorectal cancer

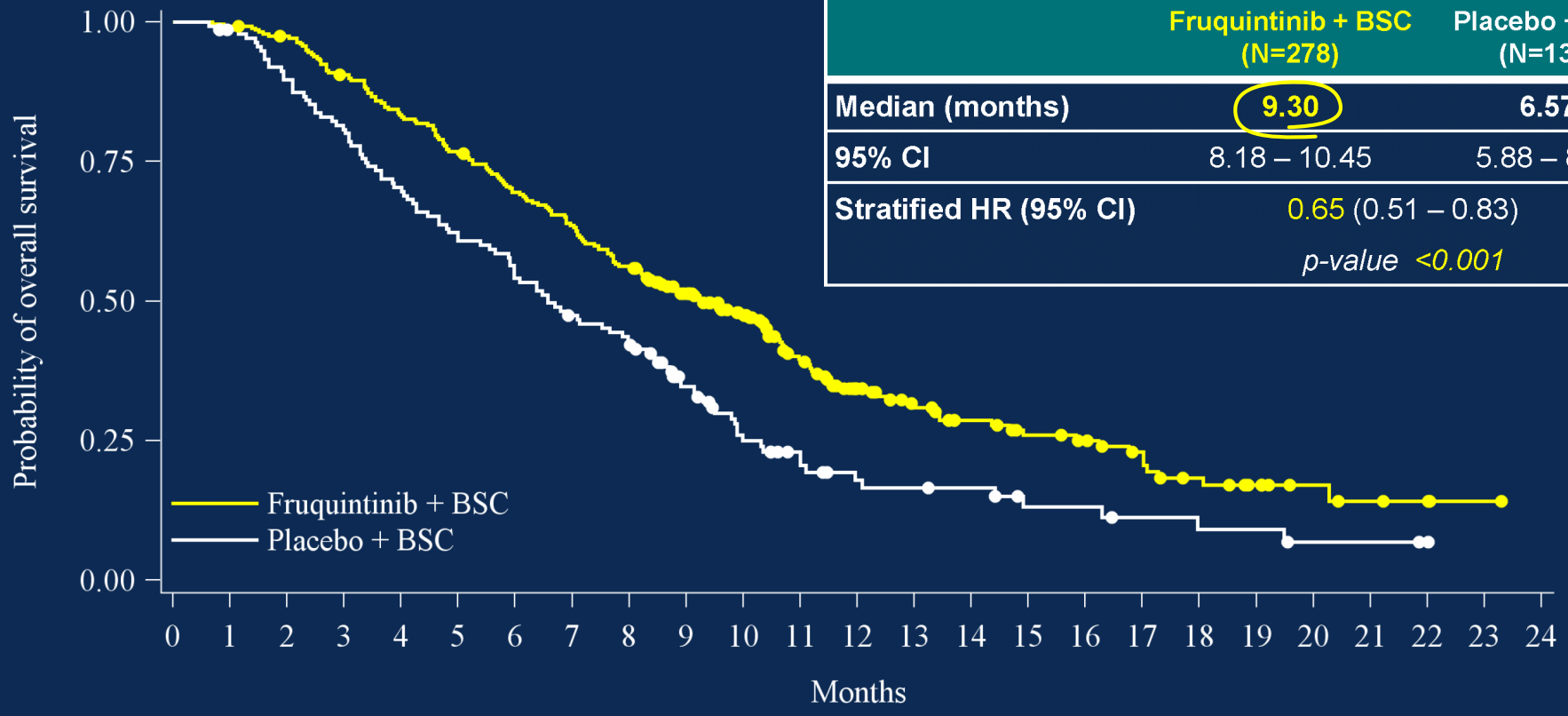
Launched in China, initiated global Ph.III registration study

CHI-MED

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	



ASCO = American Society of Clinical Oncology Annual Meeting.

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
Status	Launched	Launched	Launched	Launched	Launched	Launched	Launched	Approved
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
First Patent Expiration					2021/10/19 (US7253286B2)	2025/04/29 (US6534524B1)	2029 (without extension)	2030 (without extension)

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

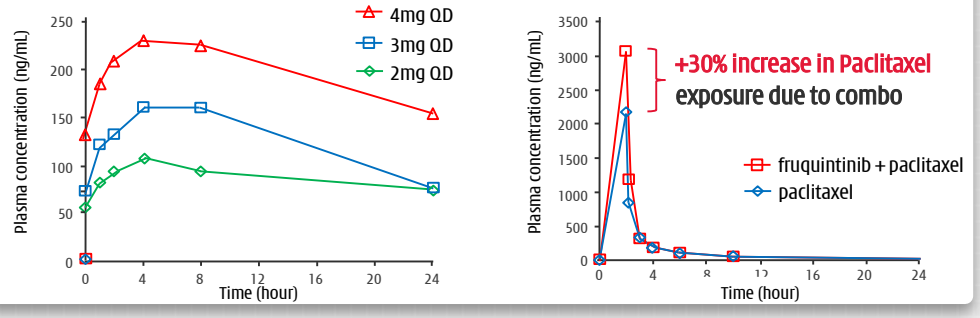
[1] Source: 1. D.D. Hu-Lowe et al, Clin Cancer Res 2008 14(22) 7272-83; 2. Q.L. Sun et al, Cancer Biol Ther 2014 15(12) 1635-45.

FRUTIGA – Gastric combo with paclitaxel

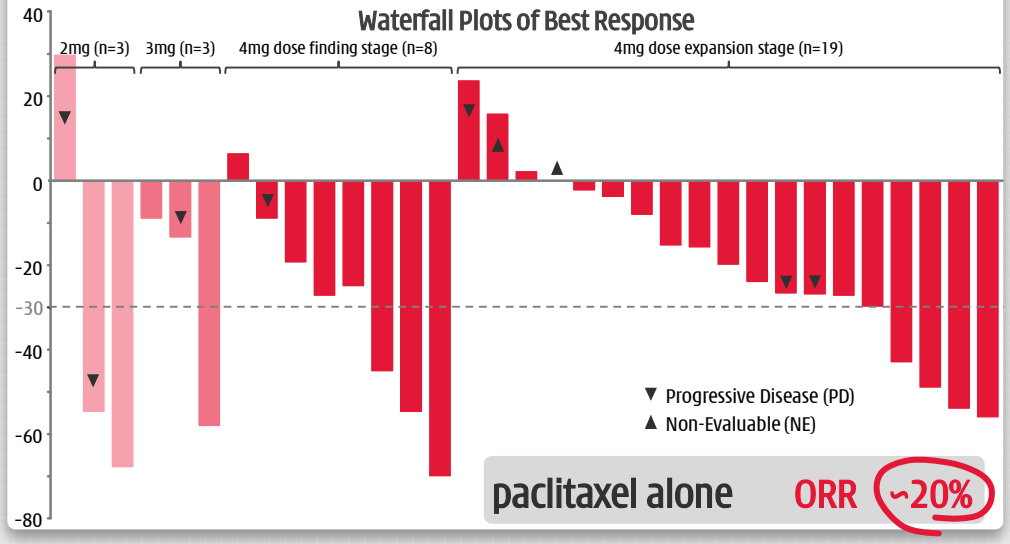
Phase III initiated Oct 2017 – 2nd interim analysis June 2020

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%)

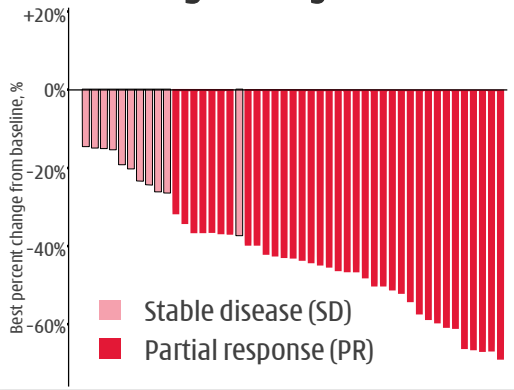
4. **AE profile in-line with expectations**. Neutropenia – a paclitaxel driven AE – with 57.9% Grade ›3 AEs. **Similar to 60% level seen in RAINBOW study of ramcirumab (VEGF mAb)** combo with paclitaxel in 2L gastric cancer.

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

Fruquintinib – 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]



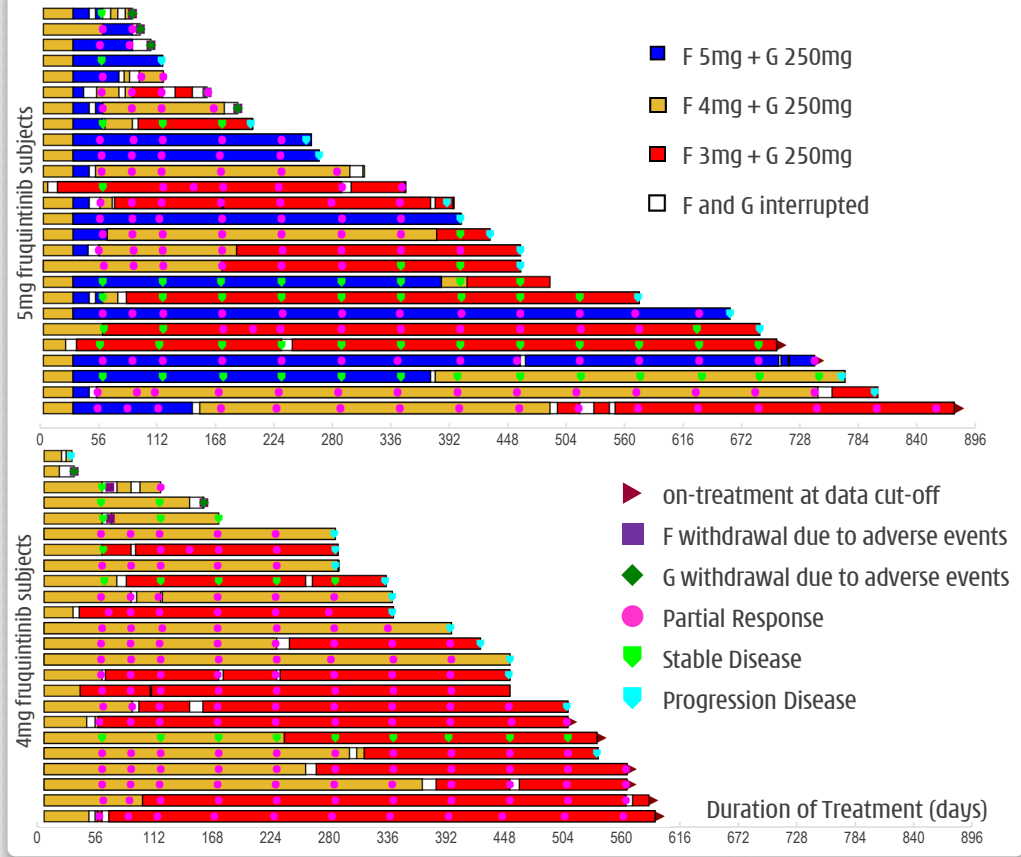
PR, n (%)	36 (72.0%)
SD, n (%)	12 (24.0%)
PD, n (%)	1 (2.0%)
NA, n (%)	1 (2.0%)
DCR, n (%)	48 (96.0%)
mDoR (mths)	12.9 (10.7, 16.6)
mPFS (mths)	14.7 (12.5, 21.2)

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.

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

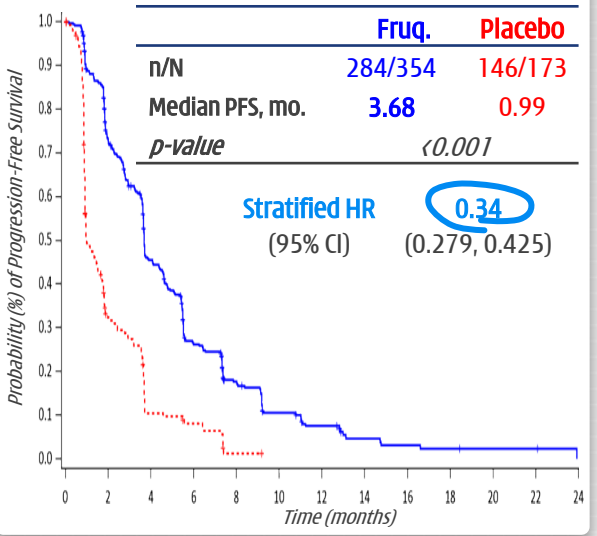
Efficacy Endpoints (Intent-to-Treat) [2]

	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*

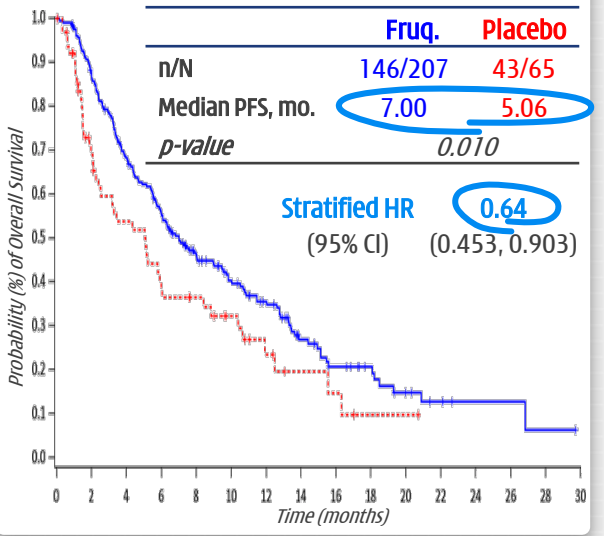
Good safety; most Grade ≥3 TEAEs target-related & clinically manageable.

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.

CHI-MED

A2d

HMPL-523 (Syk)

Potential first-in-class (Syk) asset

HMPL-523 (Syk) in hematological cancer

Phase I/Ib ongoing in Australia, China, US & EU

- 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›200**, underway in ~30 active sites in Australia & China;
- **U.S./E.U. Phase I/Ib enrollment underway**, with 13 sites enrolling;
- These Phase I/Ib data will **inform China registration study decisions**.

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 = 40

N = 27-42

Complete ✓

Studied HMPL-523

100-1,000mg QD & 200-400mg BID

until disease progression, death, intolerable toxicity, etc.

Stage II: dose expansion

…Now enrolling

Relapsed or refractory, measurable disease – multiple arms:

- Chronic lymphocytic leukemia (CLL)
- Small lymphocytic lymphoma (SLL)
- Mantle cell lymphoma (MCL)
- Follicular lymphoma (FL)
- Marginal zone lymphoma (MZL)
- DLBCL (in China) & WM/LPL

Aus N = 25

China N = 190

600mg QD

until disease progression, death, intolerable toxicity, etc.

[1] RP2D = Recommended Phase II doses.

CHI-MED

A2e

HMPL-453 (FGFR)

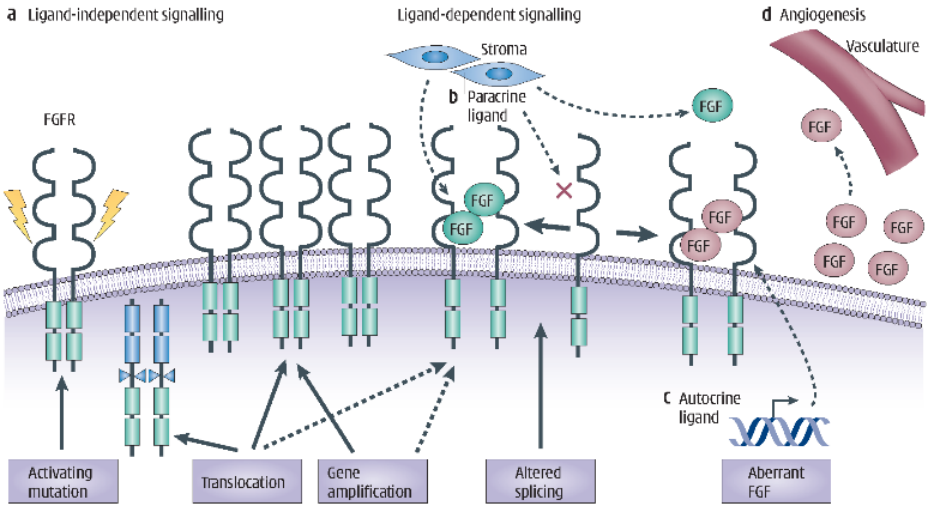
Aim to establish proof-of-concept

HMPL-453 – Phase II in China initiated

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%)

CHI-MED

A3 Further Corporate Information

Chi-Med Group Structure - Main Entities / Offices

Consolidated

Non-Consolidated

Hutchison China MediTech
Group Level (Nasdaq/AIM: HCM)

Hutchison MediPharma

Discovery, development and manufacturing of novel oncology and immunology therapeutics
(Chi-Med ownership: 99.8%)

Shanghai	New Jersey	Suzhou	Beijing
Discovery and development	Clinical development & regulatory affairs	GMP-certified manufacturing	Australia
			E.U.
			Others

Commercial businesses

Prescription Drugs

Hutchison MediPharma
Innovative Medicines Commercialization

Hutchison Sinopharm
Rx Drug Commercialization
Partner: Sinopharm Group *(Chi-Med: 51%)*

Shanghai Hutchison Pharmaceuticals
Rx Drug Manufacturing and Commercialization
Partner: Shanghai Pharma *(Chi-Med: 50%)*

Consumer Health

Hutchison BYS[1]
Over-the-counter drugs
Partner: Guangzhou Pharma *(Chi-Med: 40%)*

Other Consumer Healthcare[2]

[1] Hutchison Whampoa Guangzhou Baiyunshan Chinese Medicine Company Limited (Chi-Med holds 50.0% through its 80.0% owned subsidiary Hutchison BYS (Guangzhou) Holding Limited), a JV with Guangzhou Baiyunshan Pharmaceutical Holdings Co. Limited which holds the other 50.0%.
[2] Mainly Hutchison Hain Organic Holdings Limited, a JV with The Hain Celestial Group, Inc. and Hutchison Healthcare Limited.

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 $1.7 billion.[1]
- Given our share in the JVs, Chi-Med's share of this value is approximately $0.8 billion.

	Code	NET SALES 2018 Jan-Dec	NET SALES 2019 Jan-Dec	NET SALES 18-19 Growth	NET INCOME 2018 Jan-Dec	NET INCOME 2019 Jan-Dec	NET INCOME 18-19 Growth	NET INCOME 2019 Margin	VALUATION [3] Market Cap.	VALUATION [3] P/E
CHI-MED Commercial Platform -- Subsidiaries/JVs[2]		**664.4**	**665.6**	**0%**	**83.6**	**84.9**	**2%**	**13%**	**n/a**	**n/a**
Livzon Pharma	000513	1,265.8	1,340.7	6%	168.8	208.8	24%	16%	5,548	30
CR Double-Crane Pharma	600062	1,175.0	1,340.1	14%	141.4	152.4	8%	11%	1,905	13
Kunming Pharma	600422	1,014.6	1,160.0	14%	48.8	66.8	37%	6%	1,075	17
Zhejiang Pharma	600216	979.8	1,006.3	3%	46.7	41.7	-11%	4%	2,496	49
Tianjin Zhong Xin Pharma	600329	908.4	999.1	10%	81.1	90.8	12%	9%	1,539	18
Zhangzhou Pien Tze Huang	600436	680.9	817.5	20%	161.2	198.1	23%	24%	12,500	61
Shandong Xin Hua Pharma	000756	744.0	800.9	8%	39.2	46.2	18%	6%	933	21
Jiangsu Kang Yuan	600557	546.3	652.3	19%	62.5	73.8	18%	11%	1,165	17
Zhuzhou Qian Jin Pharma	600479	475.5	503.6	6%	43.2	50.3	16%	10%	529	13
Jiu Zhi Tang	000989	446.1	454.8	2%	46.2	26.7	-42%	6%	1,124	37
Peer Group -- Median (10 Comps. excl. Chi-Med)		**826.2**	**908.3**	**9%**	**55.7**	**70.3**	**17%**	**10%**	**1,352**	**20**

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 2019 Net Sales in the ~$450-1,350 million range.

(US$ millions)

Source: Company data, Deutsche Bank, FactSet

[1] Peer group/China Pharma multiple of 20x 2019 actual Net income after tax; [2] Total aggregate PRC domestic results of Chi-Med's 6 Commercial Platform companies (HBYS, SHPL, Hutchison Sinopharm, HHO, HHL & HCPL); [3] Market Capitalization and Price Earnings Ratios as at May 8, 2020: Trailing Twelve Month PE weighted averaged based on market capitalization.

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

Reconciliation of GAAP revenue to Non-GAAP revenue and CER:

$'Millions (except %)	Six Months Ended		Change Amount			Change %		
	June 30, 2019	June 30, 2020	Actual	CER	Exchange effect	Actual	CER	Exchange effect
Consolidated revenue - Group	**102.2**	**106.8**	**4.6**	**8.9**	**(4.3)**	**4%**	**9%**	**-5%**
Consolidated revenue - Commercial Platform	**94.9**	**99.0**	**4.1**	**8.3**	**(4.2)**	**4%**	**9%**	**-5%**
– Prescription Drugs	77.3	83.0	5.7	9.7	(4.0)	7%	13%	-6%
– Consumer Health	17.6	16.0	(1.6)	(1.4)	(0.2)	-9%	-8%	-1%
Non-consolidated joint ventures revenue	**276.9**	**274.8**	**(2.1)**	**10.7**	**(12.8)**	**-1%**	**4%**	**-5%**
– SHPL	158.9	150.7	(8.2)	(1.1)	(7.1)	-5%	-1%	-4%
– HBYS	118.0	124.1	6.1	11.8	(5.7)	5%	10%	-5%
Total Revenue - Commercial Platform (Non-GAAP)	**371.8**	**373.8**	**2.0**	**19.0**	**(17.0)**	**1%**	**5%**	**-4%**

Reconciliation of net (loss)/income attributable to Chi-Med to CER:

$'Millions (except %)	Six Months Ended		Change Amount			Change %		
	June 30, 2019	June 30, 2020	Actual	CER	Exchange effect	Actual	CER	Exchange effect
Consolidated net (loss)/income attributable to Chi-Med:								
Consolidated Group	**(45.4)**	**(49.7)**	**(4.3)**	**(5.5)**	**1.2**	**-10%**	**-12%**	**2%**
Innovation Platform	**(67.1)**	**(73.6)**	**(6.5)**	**(9.3)**	**2.8**	**-10%**	**-14%**	**4%**
Commercial Platform	**31.0**	**35.5**	**4.5**	**6.1**	**(1.6)**	**14%**	**19%**	**-5%**
– Prescription Drugs	25.1	28.9	3.8	5.1	(1.3)	15%	20%	-5%
– Consumer Health	5.9	6.6	0.7	1.0	(0.3)	11%	16%	-5%

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

Reconciliation of Adjusted (non-GAAP) Innovation Platform segment operating loss:	
	H1 2020
Innovation Platform segment operating loss	(73.4)
Less: Segment revenue from external customers – Innovation Platform	(7.8)
Adjusted (non-GAAP) Innovation Platform segment operating loss	**(81.2)**

Reconciliation of Adjusted (non-GAAP) Group net cash flows excluding financing activities:	
	H1 2020
Cash and cash equivalents and short-term investments at end of period	281.0
Exclude: Cash and cash equivalents and short-term investments at beginning of period	(217.2)
Exclude: Net cash generated from financing activities for the period	(96.3)
Adjusted (non-GAAP) Group net cash flows excluding financing activities	**(32.5)**

(US$ millions unless otherwise stated)

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

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

- Prescription Drugs: includes our Consolidated subsidiaries (Hutchison Sinopharm and HMP) 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									H1'19-H1'20
(US$ millions)	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	H1'19	H1'20	Growth
Revenue (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	668.0	676.4[5]	371.8[5]	373.8	1%
Prescription Drugs	***17.2***	***21.8***	***23.3***	***23.2***	***28.1***	***39.5***	***54.4***	***71.2***	***92.4***	***116.5***	***138.2***	***204.9***	***286.6***	***372.3***	***411.0***	***412.1***	***426.6***	***236.2***	***233.7***	***-1%***
- Consolidated subsidiaries	-	-	-	-	-	-	-	-	-	-	-	50.2	105.5	149.9	166.4	136.4	154.5	77.3	83.0	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	272.1	158.9	150.7	-5%
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***	***249.8***	***135.6***	***140.1***	***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	34.4	17.6	16.0	-9%
- 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	215.4	118.0	124.1	5%
Total Revenue Growth	***n/a***	***27%***	***133%***	***56%***	***17%***	***31%***	***26%***	***20%***	***18%***	***29%***	***n/a***	***16%***	***11%***	***21%***	***8%***	***-1%***	***1%***		***1%***	
- GuanBao divested in Sept'2017	-	-	-	-	-	-	-	-	(11.4)	(50.5)	(51.6)	(49.7)	(40.7)	(45.0)	(38.6)	-	-	-	-	*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***	***249.8***	***135.6***	***140.1***	***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	215.4	118.0	124.1	5%
Adjusted Revenue (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***	***668.0***	***676.4***[5]	***371.8***[5]	***373.8***	***1%***
Total Adjusted Revenue Growth	***n/a***	***27%***	***133%***	***56%***	***17%***	***31%***	***26%***	***20%***	***13%***	***16%***	***13%***	***19%***	***15%***	***22%***	***10%***	***5%***	***1%***		***1%***	
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]	85.6	90.8[5]	60.4[5]	67.5	12%
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***	***65.9***	***69.3***	***47.0***	***52.8***	***12%***
- Consolidated subsidiaries	-	-	-	-	-	-	-	-	-	-	-	0.1	0.6	1.6	2.4	6.1	8.0	4.9	4.8	-3%
- 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	61.3	42.1	48.0	14%
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***	***21.5***	***13.4***	***14.7***	***10%***
- 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	1.7	1.2	2.1	82%
- 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	19.8	12.2	12.6	3%
% 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%***	***12.8%***	***13.4%***	***16.2%***	***18.1%***	
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]	43.4	47.4[5]	31.0[5]	35.5	14%
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	34.1	37.5	25.1	28.9	15%
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	9.9	5.9	6.6	11%
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%*	*16%*	*9%*		*14%*	

[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. [5] In 2019 annual report, the results of innovative medicines developed by the Innovation Platform have been reallocated from Innovation Platform to Commercial Platform- Prescription Drugs business. H1'19 information has been revised for comparison purpose.

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).	$2,540	$1,400	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® (ceritinib)	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 & 9 renewed drugs in oncology[1]

		Unit Pricing (US$) [3]				Approximate Monthly Pricing (US$) [3]			
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	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

		Unit Pricing (US$) [3]				Approximate Monthly Pricing (US$) [3]			
Brand (generic)	Company	Dosage	'17 NRDL	'19 NRDL	Δ%	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).
Herceptin® (trastuzumab)	Roche			Undisclosed					Breast: Her2+; Her2+ meta. Her2+ late-stage meta. gastric.
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.
Nexavar® (sorafenib)	Bayer			Undisclosed					RCC or HCC. meta. diff. thyroid after radio-iodine therapy.
Afinitor® (everolimus)	Novartis			Undisclosed					RCC after sunitinib or sorafenib. Pancreatic NETs. TSRA.

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