HUTCHISON CHINA MEDITECH

Company Overview

(AIM/Nasdaq: HCM)

June 2017

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In addition, this presentation contains statistical data and estimates that we obtained from industry publications and reports generated by third-party market research firms, including Frost & Sullivan, an independent market research firm, and publicly available data. All patient population, market size and market share estimates are based on Frost & Sullivan research, unless otherwise noted. Although we believe that the publications, reports and surveys are reliable, we have not independently verified the data. Such data involves risks and uncertainties and are subject to change based on various factors, including those discussed above.

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All references to "Chi-Med" as used throughout this presentation refer to Hutchison China MediTech Limited and its subsidiaries. This presentation should be read in conjunction with Chi-Med's final results for the year ended December 31, 2016, copies of which are available on Chi-Med's website (www.chi-med.com).

A risk-balanced global-focused BioPharma

Innovation Platform

Broad late-stage pipeline

- ✓ 8 oncology drug candidates in 30 studies worldwide.
- ✓ 1st positive Ph.III result – fruquintinib – Launch 2018.
- ✓ 7 further Phase III trials; 3 underway & 4 in-planning.
- ✓ ~330-person Scientific Team.

Commercial Platform

Solid cash flow from operations

- ✓ >3,300-person China Sales Team (~2,200 med. reps).
- ✓ To commercialise Innovation Platform drugs in China.
- ✓ 2016 sales[1] up 21% to $627.4 million.
- ✓ 2016 net income[2] up 180% to $70.3 million.[3]

[1] Aggregate sales of consolidated subsidiaries ($180.9 million) and non-consolidated joint ventures ($446.5 million); [2] Net income attributable to Chi-Med;
[3] Includes the share of gain from land compensation of Shanghai Hutchison Pharmaceuticals Limited in Prescription Drugs Business ($40.4 million).

Innovation Platform

Near term: Driving for first product launches

Mid-longer term: Building the pipeline for future growth

Exceptional scale for pre-approval biotech

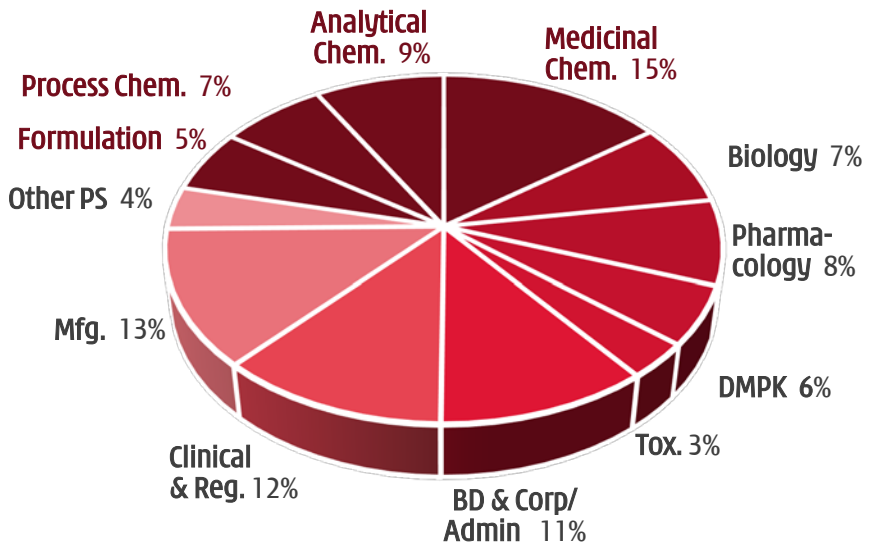
Over 15 years with well over $400 million invested to-date

CHI-MED

One of the leading China-based innovators in oncology & immunology

~330 SCIENTISTS & STAFF[1]

- ✓ 208 with advanced technical degrees
- ✓ 26 M.D.s
- ✓ 54 doctorate degrees



OUR ADVANTAGES

- ✓ **Large-scale fully integrated in house platform**
  chemistry, biology, pharmacology, DMPK, toxicology, CMC, clinical & regulatory, and translational organizations working together seamlessly and continuously.
- ✓ **China clinical speed**
  major unmet medical needs (3.4 million new cancer patients / year[2]), rapid development and regulatory support. Allows for study of multiple indications and proof-of-concept in China.
- ✓ **Competitive costs**
  overall clinical costs, particularly pre-PoC, a fraction of US or Europe.
- ✓ **Constancy of purpose**
  Over 15 years with continuous financial support.

[1] Headcount as of December 31, 2016; Chem. = Chemistry; DMPK = Drug, Metabolism, & Pharmacokinetics; Tox. = Drug Safety Evaluation; PS = Pharmaceutical Science (CMC); Mfg = Manufacturing; Reg. = Regulatory; C&R = Clinical & Regulatory; BD = Business Development; [2] Frost & Sullivan.

Chemistry is our edge

Seriously selective small molecules

CHI-MED

1. Fragment-based design of Novel Chemical Entities.

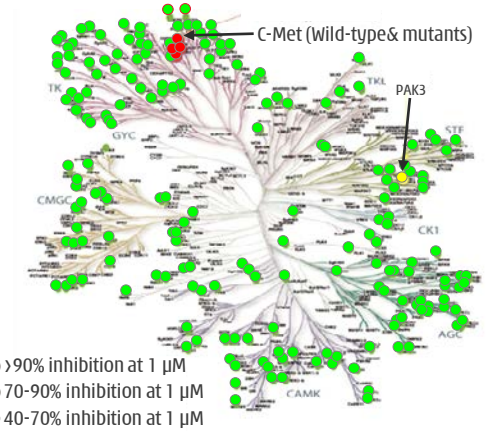
- **Internally designed all 8 clinical drug candidates.**
- Use of co-crystal structures.
- Focus on small molecule interactions with tyrosine kinases - proteins/enzymes involved in cell signaling.

2. Total focus/discipline in designing and progressing drug candidates with superior kinase selectivity.

- **Optimize binding to on target protein**, minimize off-target protein binding.
- No off-target kinase inhibition gives compound the chance to be more potent, attaining **better target coverage** with **less toxicity**.
- Combinability - **clean** compounds **allow for combinations** with other tyrosine kinase inhibitors ("TKIs"), immunotherapy & chemotherapy agents.

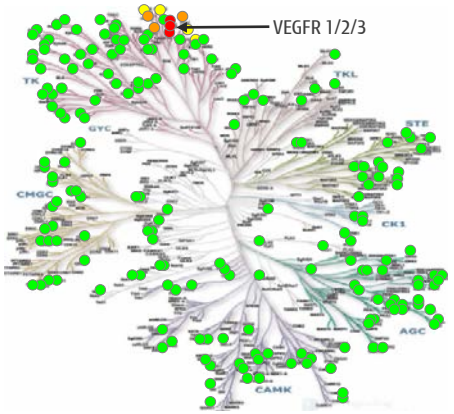
Savolitinib [1]

~1,000-fold more selective to c-Met than next kinase (PAK3)



Fruquintinib [2][3]

~250-fold more selective to VEGFR3 than next kinase (Ret)

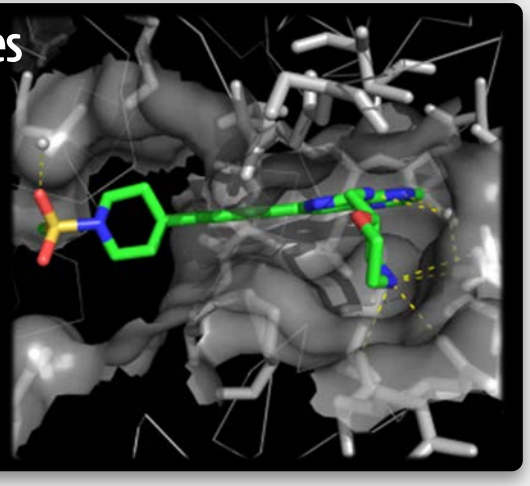


Screening at 1µM against 253 Kinases

Use of co-crystal structures

Focus on small molecule interactions with kinases

- ✓ Optimize binding to on-target protein, for potency.
- ✓ Minimize binding to off-target proteins for selectivity.



[1] W. Su, et al, 2014 American Association of Cancer Research (note legend yellow = ›50%; green = ‹ 50%; [2] Sun et al., Cancer Biology & Therapy 15:12, 1635--1645; December 2014; [3] Ret is the next "Non-VEGFR" kinase.

Superior selectivity = Better tolerability

More patient use = prolonged/total target coverage = better efficacy

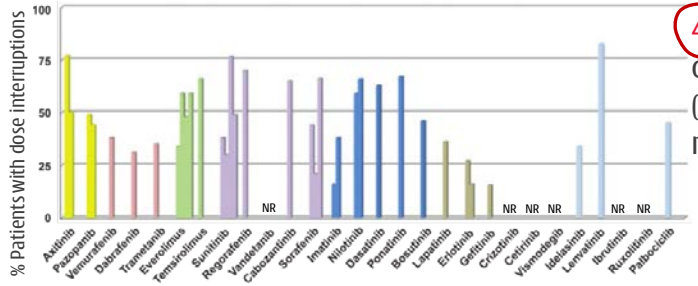
CHI-MED

3. Better tolerability important for sustained usage…

Review of 28 FDA approved small molecule oncology targeted therapies revealed high incidence of toxicity[1]

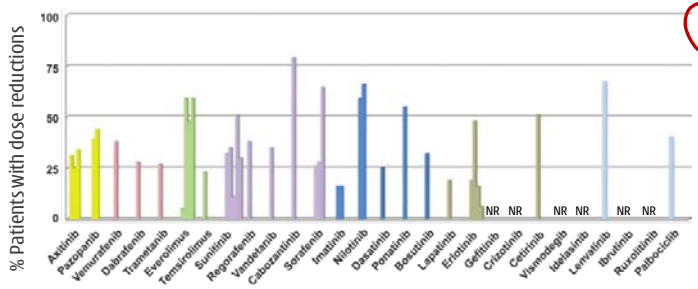
- Pronounced in drugs with narrow therapeutic index (i.e. efficacious dose at or near MTD).
- Combination trials even harder - 64% with grade 3-4 toxicities vs. 37% in monotherapy trials.

Dose interruptions in Phase III studies (where reported)



48% of pts required dose interruptions (only 66% of trials reported)

Dose reductions in Phase III studies (where reported)



41% of pts required dose reductions (only 74% of trials reported)

NR = Not Reported.

4. …whereas 1st gen. multi-kinase inhibitors require substantial dose modifications (interruptions/reductions).

Drug – targets	2016 Sales	Phase III Study	Dose Interruptions	Dose Reductions
Sunitinib (Sutent®) –VEGFR1,2,3, PDGFRβ, FLT3, CSF-1R, c-Kit, Ret	$1.10b	1L RCC – Sunitinib vs. placebo	54% vs 39%	52% vs 27% (Gr 3/4 AE: 77% vs 55%)
Sorafenib (Nexavar®) – RAF, VEGFR2, PDGFRβ, Flt3, c-Kit, FGFR1	$0.87b	1L RCC – Sorafenib Vs. placebo		(Gr 3/4 AE: 38% vs 28%)
Axitinib (Inlyta®) – VEGFR1,2,3, PDGFRα, c-kit	$0.40b	2L RCC – Axitinib Vs. Sorafenib	Dose Mods: 55% vs 62%	34% vs 54%
Pazopanib (Votrient®) - VEGFR1,2,3, c-KIT, ITK, LCK, PDGFRα,β, FGFR1,3, c-Fms	$0.73b	1L/2L RCC – Pazopanib vs. placebo	42%	36%
Regorafenib (Stivarga®) - VEGFR1,2,3, Raf, Ret, PDGFR, c-Kit	$0.31b	2L CRC – Regorafenib vs. placebo	61%	38%
Lenvatinib (Lenvima®) – VEGFR1,2,3, Ret, PDGFR, c-Kit, FGFR1,2,3,4	$0.20b	DTC – Lenvatinib vs. placebo	82% vs 18%	68% vs 5%
Cabozantinib (Cometriq®) – AXL, c-Kit, FLT-3, MET, RET, TIE-2, TrkB, VEGFR1,2,3	$0.14b	2L RCC – Cabozantinib vs. everolimus		62% vs 25%
Savolitinib – c-Met (Ph I/Ib/II)		Several open-label studies	28%	8%
Fruquintinib – VEGFR1,2,3 (Ph II)		≥3L CRC – Fruquintinib vs. placebo	34% vs. 13%	28% vs. 13%
Fruquintinib – VEGFR1,2,3 (Ph II)		3L NSCLC – Fruquintinib vs. placebo	13% vs. 0%	13% vs. 0%
Sulfatinib – VEGFR 1,2,3, FGFR1		Several open-label studies	34%	17%
Epitinib – EGFR (Ph I/II)		NSCLC w/brain mets - Epitinib (Ph I/Ib)	13%	6%

[1] FDA approved btw Jan '02 to Feb '15. Roda D et al. "*Are Doses and Schedules of Small-Molecule Targeted Anticancer Drugs Recommended by Phase I Studies Realistic?*" Clinical Cancer Research 2016 May 1;22(9):2127-32.

[2] Sources: Prescribing information; Chi-Med data.

30 active clinical trials on 8 drug candidates

1st positive pivotal readout – 4 lead candidates all in pivotal Ph.III in 2017

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Program	Target	Partner	Study number/Indication	Latest Status	Line	Target patient	Combo therapy	Site	Preclin.	Ph.I	Proof-of-concept	Pivotal/Ph.III
Savolitinib (AZD6094)	c-Met	AstraZeneca	1. Papillary renal cell carcinoma	Report Ph.II Feb. 2017; **Ph.III start H12017**	1st	c-Met-driven		Global				*
			2. Papillary renal cell carcinoma	NCI Ph.II – savo vs. sunitinib vs. cabozan. vs. crizot.	All	c-Met-driven		US				
			3. Papillary renal cell carcinoma	Ph.Ib enrolling (dose finding)	-	All	**durvalumab** (PD-L1)	UK				*
			4. Clear cell renal cell carcinoma	Start when Study 2/4 begin Ph.Ib expansion stage	2nd	VEGF TKI refractory		UK				*
			5. Clear cell renal cell carcinoma	Ph.Ib enrolling (dose finding)	2nd	VEGF TKI refractory	**durvalumab** (PD-L1)	UK				*
			6. Non-small cell lung cancer	Ph.IIb expans'n enrolling; **Pivotal decision 2017**	2nd	EGFR TKI refractory	**Tagrisso®** (T790M)	Global				*
			7. Non-small cell lung cancer	Ph.II enrolling	3rd	EGFR/T790M TKI	**Tagrisso®** (T790M)	Global				*
			8. Non-small cell lung cancer	Ph.II enrolling	2nd	EGFR TKI refractory	**Iressa®** (EGFR)	China				*
			9. Non-small cell lung cancer	Ph.II enrolling	1st	c-Met+/Ex.14skip		China				*
			10. Pulmonary sarcomatoid ca.	Ph.II enrolling	1st	c-Met+/Ex.14skip		China				*
			11. Gastric cancer	Ph.Ib enrolling	3rd/All	c-Met+		SK/PRC				*
			12. Gastric cancer	Ph.Ib enrolling	2nd	c-Met+	**docetaxel** (chemo)	SK				*
			13. Gastric cancer	Ph.Ib enrolling	2nd	c-Met O/E	**docetaxel** (chemo)	SK				*
Fruquintinib	VEGFR 1/2/3	Lilly (in China only)	14. Colorectal cancer	**Ph.III met all endpoints; NDA mid 2017** ✓	3rd	All		China				
			15. Non-small cell lung cancer	**Ph.III enrolling**	3rd	All		China			n/a	*
			16. Non-small cell lung cancer	Ph.Ib enrolling (dose finding)	1st	All	**Iressa®** (EGFR)	China				*
			17. Caucasian bridging	Ph.I dose escalation start 2017	-	All comers		US				
			18. Gastric cancer	**Ph.III (w/ interim analysis) start 2017**	2nd	All	**paclitaxel** (chemo)	China				*
Sulfatinib	VEGFR/ CSF1R/ FGFR1		19. Pancreatic NET	**Ph.III enrolling**	1st	All		China				*
			20. Non-pancreatic NET	**Ph.III enrolling**	1st	All		China				*
			21. Caucasian bridging	Ph.I dose escalation enrolling	-	All comers		US				
			22. Medullary thyroid ca.	Ph.II enrolling	2nd	Radiotherapy ref.		China				*
			23. Differentiated thyroid ca.	Ph.II enrolling	2nd	Radiotherapy ref.		China				*
			24. Biliary tract cancer	Ph.II enrolling	2nd	Gemcitabine ref.		China				*
Epitinib	EGFRm+		25. Non-small cell lung cancer	**Ph.III start 2017**	1st	EGFRm+ brain mets		China				*
			26. Glioblastoma	Ph.II start 2017	-			China				*

4 pivotal Phase III studies active & 4 more to start in 2017

Oncology | Immunology

Notes: * = when an NDA submission is possible based on the receipt of favorable clinical data; Proof-of-concept = Phase Ib/II study (the dashed lines delineate the start and end of Phase Ib); combo = in combination with; brain mets = brain metastasis; VEGFR = vascular endothelial growth factor receptor; TKI = tyrosine kinase inhibitor; EGFR = epidermal growth factor receptor; NET = neuroendocrine tumors; ref = refractory, which means resistant to prior treatment; T790M= EGFR resistance mutation; EGFRm+ = epidermal growth factor receptor activating mutations; EGFR wild-type = epidermal growth factor receptor wild-type; 5ASA = 5-aminosalicyclic acids; chemo = chemotherapy; c-Met+ = c-Met gene amplification; c-Met O/E = c-Met over-expression; MS = Multiple Sclerosis; RA = Rheumatoid Arthritis; Aus = Australia; SK = South Korea; PRC = People's Republic of China; UK = United Kingdom; US = United States; EU = Europe; Global = >1 country.

Next wave of innovation now in proof-of-concept

4 novel 2nd wave drug candidates in Phase Ib/II studies or about to start

Program	Target	Partner	Study number/Indication	Latest Status	Line	Target patient	Combo therapy	Site	Preclin.	Ph.I	Proof-of-concept	Pivotal/Ph.III
Theliatinib	EGFR WT		27. Solid tumors	Ph.I dose escalation enrolling (continuing)	-	All comers		China				*
			28. Esophageal cancer	Ph.Ib expansion enrolling	1st	EGFR WT		China				*
HMPL-523	Syk		29. Rheumatoid arthritis	Ph. I complete; preparing for Ph.II in 2017	-	Methotrexate ref.		Aus				*
			30. Immunology	Ph.I dose escalation start 2017	-	Healthy volunteers		China				*
			31. Hematological cancers	Ph.I enrolling; target complete Ph.I 2017	2nd/3rd	All comers		Aus			*	
			32. Lymphoma	Ph.I dose escalation enrolling	-	All comers		China			*	
HMPL-689	PI3Kδ		33. Hematological cancers	Ph.I dose escalation (PK analysis)	-	Healthy volunteers		Aus				*
			34. Lymphoma	Ph.I dose escalation start 2017	2nd/3rd	All comers		China				*
HMPL-453	FGFR 1/2/3		35. Solid tumors	Ph.I dose escalation	-	All comers		Aus			*	
			36. Solid tumors	Ph.I dose escalation start 2017	-	All comers		China			*	
HM004-6599	NF-κB (TNF-α)	Nestlé Health Science	Ulcerative colitis (Induction)	HMPL-004 reformulation; Re-submit IND 2017	2nd	5ASA refractory		China				*
			Ulcerative colitis (Maintenance)	Await positive Ph.II in Ulcerative Colitis (Induction)	2nd	5ASA refractory		China				*
NSP DC2	TBD	Nestlé Health Science	Immunology	Preclinical complete end 2017				China				*
Multiple	TBD		Oncology	Four small molecule/antibody programs in preclin.				TBD			*	

Oncology | Immunology

~2,900 patients/subjects treated in studies to date on our drug candidates, with about 711 dosed in 2016 (2015: 705).

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8 shots at pivotal success

First positive pivotal Ph.III readout – fruquintinib in colorectal cancer

CHI-MED

					Breakthrough Therapy ("BTT") potential	Est. Pivotal Read-out (if not BTT)
SAVO	Papillary renal cell carcinoma (c-Met-driven)	Pivotal Phase III	U.S., EU5, Japan	Initiating In H1 2017	Depends on est. c-Met as -ve prognostic 2017	H1 2019
	NSCLC –2L Tagrisso combo (T790M+/- & c-Met+)	Pivotal Phase II/III	U.S., EU5, Japan	Decision based on Ph.IIb data (2017)	Depends on strength of Ph.IIb data set (H1 2017)	H2 2019
FRUQ	3L (or above) Colorectal cancer ("CRC")	Pivotal Phase III	China	Complete Met All Endpoints	✓	March 3rd 2017
	3L Non-small cell lung cancer ("NSCLC")	Pivotal Phase III	China	Enrolling		H1 2018
	2L Gastric cancer combo w/ Taxol	Pivotal Phase III	China	Initiating in 2017		H2 2019
SULF	Pancreatic neuroendocrine tumors	Pivotal Phase III	China	Enrolling		H2 2018
	Non-pancreatic neuroendocrine tumors	Pivotal Phase III	China	Enrolling		H2 2018
EPIT	1L EGFR-mutant NSCLC with brain metastasis	Pivotal Phase III	China	Initiating in 2017		H1 2019

Major market potential

CRC peak net income of ~$20-35m in China is only the start for fruq.

		Pot. launch Year / Territory	Incidence (New pts./yr.)[1]	Approx. WAC [2] of various reference TKIs (US$/month)	Median PFS (months) [3]	Potential Peak (US$) Sales	Potential Peak (US$) Net income
SAVO	Papillary renal cell carcinoma (c-Met-driven)	2020 Global	~25,000	$11,600 (Sutent®) $10,500 (Afinitor®)	6.2 Ph.II (actual)		
	NSCLC -2L Tagrisso combo (T790M+/- & c-Met+)	2019 Global	~35,000 - 40,000	$15,100 (Tagrisso®)	*TBD*		
FRUQ	3L (or above) Colorectal cancer ("CRC")	2018 China	~50,000 - 60,000	$14,000 (Regorafenib - global) $2,900 (Apatinib - China off label)	3.7 Ph.II (actual)	~$110-160m @est. 20-25% penetration[4]	~$20-35m @15-20% tier royalty/other
	3L Non-small cell lung cancer ("NSCLC")	2019 China	~60,000 - 70,000	No approved TKIs $2,900 (Apatinib - China off label)	3.8 Ph.II (actual)		
	2L Gastric cancer combo w/ Taxol	2020 China	~250,000 - 300,000	$2,900 (Apatinib)	3.7 Ph.II (actual)		
SULF	Pancreatic neuroendocrine tumors	2019 China	~5,000 - 6,000	$11,000 (Sutent®/Afinitor® - global) $5,500 (Somatuline® - global)	19.4 Ph.II (actual)		
	Non-pancreatic neuroendocrine tumors	2019 China	~50,000 - 60,000	$11,000 (Sutent®/Afinitor® - global) $5,500 (Somatuline® - global)	13.4 Ph.II (actual)		
EPIT	1L EGFR-mutant NSCLC with brain metastasis	2020 China	~30,000 - 40,000	$15,100 (Tagrisso®) - *Brain pen.* [5] $1,100 (Iressa®) - *min. brain pen.* $850 (Conmana®) - *min. brain pen.*	*TBD*		

[1] Addressable Patient Population = Company estimates considering Frost & Sullivan data, National Central Cancer Registry of China and publicly available epidemiology data; [2] WAC = Wholesaler Acquisition Cost; [3] Last published median Progression Free Survival ("PF S" or time to >20% tumor growth) result for Chi-Med therapy (Chi-Med studies);; [4] Penetration = % of Addressable Patients treated for an average period equivalent to the median PFS; [5] Tagrisso approval in China expected in 2017.

Apatinib/icotinib - Local company TKIs in China [1]

Major un-met medical need in China - fruquintinib's opportunity

CHI-MED

		ATAN® Apatinib	Conmana® Icotinib	Fruquintinib
Company	Manufacturer	**Jiangsu Hengrui Medicine**	**Betta Pharma**	**Chi-Med** [4]
	Listing Location/Ticker	Shanghai: 600276.SS	Shenzhen: 300558.SZ	LSE/Nasdaq: HCM
	Market Capitalisation ($US -- Feb 22, 2017)	$15.9 billion	$3.8 billion	$1.6 billion
	Founded	1970	2003	2000
	2015 Revenue (US$ million / 2013-15 CAGR)	1,479 23%	145 38%	178 na
	2015 R&D Spending (US$ million / % of Revenues)	142 (10% of Rev.)	19 (13% of Rev.)	56 (31% of Rev.)
	2015 Net Profit (US$ million / 2013-15 CAGR)	345 32%	55 39%	8 na
	Commercial Team (# Medical Reps @ end 2015)	5,491	296	~2,200
Therapy	Molecular Target / Innovation source	VEGFR2 (licensed in from U.S. Co.[3])	EGFR (licensed in from U.S.)	VEGFR1/2/3 (in-house HMP China)
	Formulation	Oral tablet	Oral tablet	Oral capsule
	Total Daily Dose (regime)	850mg (425mg -- twice daily)	375mg (125mg -- three times a day)	5mg (5mg -- once daily)
Patient costs	Monthly Cost (28 day cycle) -- at Launch (US$)	~2,900	~1,900	TBD
	Monthly Cost (28 day cycle) -- Current (US$)	~2,900	~850	TBD
	Reimbursement (Note: Likely only for est. 40-50% of people enrolled in Medical Insurance Scheme for Urban Employees)	None	5 Provinces (Zhejiang; Hunan; Guangxi; Gansu; Inner Mongolia); 2 Cities (Qingdao; Shenzhen)	TBD
	Population in mkts. w/ reimbursement (million / % China Pop.)	None 0%	240 17%	TBD
	Patient Assistance Program ("PAP") Partner	PhIRDA [2]	PhIRDA	TBD
	PAP Starting Date	June 2015	July 2011	TBD
	PAP Details	Free drug after 3 paid cycles (i.e. 3 months)	Free drug after 6 paid cycles (i.e. 6 months)	TBD
Market potential	Approved Indication (Appr. Indic.)	Gastric cancer ("GC"), third-line	Non-small cell lung cancer ("NSCLC"), › second-line / first-line EGFRm positive	Colorectal cancer ("CRC"), third-line (TBD)
	Median Progression Free Survival (months / vs. comparator)	2.6 1.8 (pbo)	4.6 / 9.5 3.4 / 9.5 (Iressa®)	3.7 1.0 (pbo)
	Incidence (Overall indication) (Est. New patients/year)	~660,000 (GC)	~625,000 (NSCLC)	~413,000 (CRC)
	Diagnosed (Overall indication) (Est. New patients/year)	~395,000	~600,000 / ~220,000	~377,000
	Addressable Patients (Appr. indication) (Est. New ptnts./year)	~40,000-50,000	~150,000-170,000 / ~220,000	~50,000-60,000
Sales History since launch	China FDA Approval (competitive approvals?)	October 2014 (only appr. 3L GC drug)	June 2011 (multiple appr. EGFR TKIs)	TBD (only appr. 3L CRC drug)
	China NDA Review Time (months)	38	10	TBD
	Launch Date	July 2015	August 2011	2018 (Estimated)
	Year 1 (Revenues US$ million/ Est. Penetration in Appr. Indic.)	2015 40 20%	2011 9 1%	TBD
	Year 2 (Revenues US$ million/ Est. Penetration in Appr. Indic.)	2016 116 30%	2012 48 2%	TBD
	Year 3 (Revenues US$ million/ Est. Penetration in Appr. Indic.)		2013 78 3%	TBD
	Year 4 (Revenues US$ million/ Est. Penetration in Appr. Indic.)		2014 116 5%	TBD
	Year 5 (Revenues US$ million/ Est. Penetration in Appr. Indic.)		2015 145 6%	TBD

Chi-Med investing all resources into R&D

Chi-Med Commercial Platform is important

Fruquintinib highly potent vs. other TKIs

- ✓ 5mg/day vs. 850mg & 375mg
- ✓ Once daily optimal vs. twice/thrice daily

Fruq. robust clinical efficacy vs. other TKIs

China major TKI market potential due to unmet medical need

- ✓ ›$100 million sales in ‹5 years

Apatinib penetration high - off-label use

- ✓ Apatinib used in 3rd line NSCLC, CRC, etc.

Icotinib penetr. low - b/c Iressa®/Tarceva®

[1] China Cancer Registry; Betta Pharma IPO prospectus; China 2010/2015 census; Goldman Sachs; [2] PhIRDA = China Pharmaceutical Innovation & Research Development Association; [3] Advenchen Labs. California; [4] HMP = Hutchison MediPharma

Savolitinib (AZD6094)

Potential first-in-class selective c-Met inhibitor

Savolitinib (AZD6094)

Potential global first-in-class selective c-Met inhibitor

AstraZeneca CHI-MED

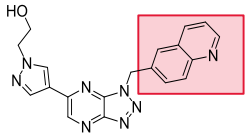
1. In strong position to become first selective c-MET inhibitor approved globally.

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

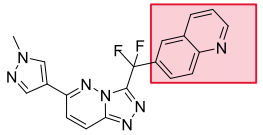
2. c-Met is aberrant in many tumor settings.[3]

	c-MET			New Cases (2015)	
Indication	Amplification	Mutation	Over-Expression	Global	China
Gastric	10%	1%	41%	1,034,000	679,000
Lung (Non-small cell)	8-10%[1]	8%	67%	1,690,000	575,000
Head & Neck		11%	46%	740,000	135,000
Colorectal	10%		65%	1,477,000	376,000
Renal cell Carcinoma (Papillary)	40-70%	100%[2]		50,000	7,000
Renal cell Carcinoma (Clear cell)			79%	270,000	60,000
Esophagus	8%		92%	496,000	251,000

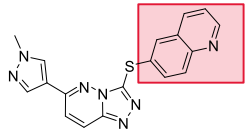
3. Savolitinib design eliminates renal toxicity first generation of selective c-MET inhibitors encountered – **>460 patients treated to-date with no renal toxicity**.



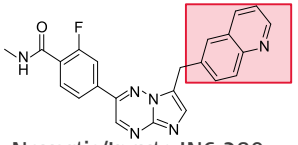
Pfizer PF-04217903



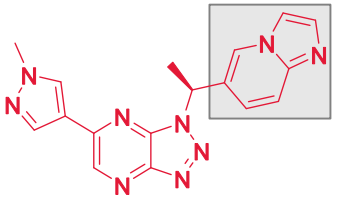
Janssen JNJ-38877605



Lilly SGX-523



Novartis/Incyte INC-280



savolitinib

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

4. AstraZeneca collaboration & 2016 amendment.

- **2011 global licensing agreement:** $20m up front; $120m in development/approvals milestones ($20m paid by Jun'16); significant commercial milestones; **ex-China tiered royalty 9-13%, AZ pay 100% development cost**; China 30% royalty, AZ pay 75% development cost (Chi-Med 25%).
- **2016 amendment:** **Chi-Med pay $50m** towards joint development costs, over 3 years; in return for ex-China **royalty +5% points (to 14% to 18%)**.

[1] Range includes (i) approximately 4% of c-Met+ naïve non-small cell lung cancer patients and (ii) 10 – 30% of EGFRm+ non-small cell lung cancer patients, which 15 to 20% develop EGFRm+ tyrosine kinase inhibitor resistance pathway as c-Met+; [2] Hereditary papillary renal cell carcinoma only; [3] Company estimates considering Frost & Sullivan data, National Central Cancer Registry of China and publicly available epidemiology data.

c-MET +ve PRCC – unmet medical need

1. No treatment choices for non-ccRCC patients.

Approved therapies in RCC [3]

Good efficacy in ccRCC; Multiple treatment options

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

Nothing approved in non-ccRCC

NCCN guideline – "Patients should enter clinical trials"

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

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

Clear-cell RCC
(~$2.7b)
~80% of RCC
~ 270k new patients/yr.[2]

Non-Clear-cell RCC
(~$0.6b)
~20% of RCC
~ 70k new patients/yr.[2]

3. Two crucial questions:

c-MET +ve Papillary RCC
(~$0.2-0.3b)
~7% of RCC
~ 25k new patients/yr.[2]

c-MET -ve Papillary RCC
(~$0.2-0.3b)
~7% of RCC
~ 25k new patients/yr.[2]

Other non-ccRCC
(~$0.1-0.2b)
~5% of RCC
~ 20k new patients/yr.[2]

Question 1: Does savolitinib provide meaningful benefit to patients w/ c-MET +ve PRCC?

Answer: Phase II data (next page)

Question 2: Is c-MET +ve status predictive of worse outcome (PFS/OS) in PRCC patients?

Answer: ›300 pt. PRCC Molecular Epidemiology Study (late 2017 readout).

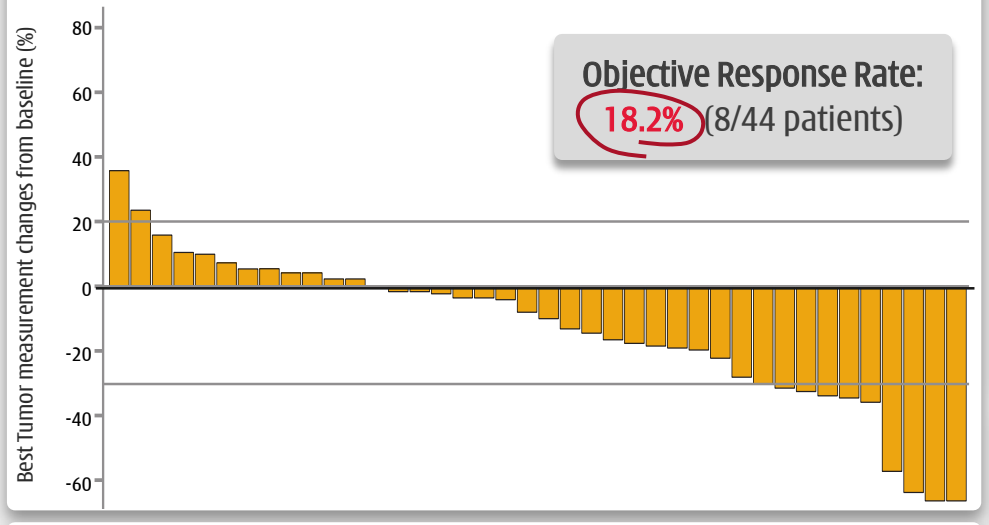
[1] Transparency Market Research, March 2015 – RCC (excl. non-RCC Kidney Cancer). [2] Frost & Sullivan, March 2016. [3] NCCN Guideline for kidney cancer. Version 3.2016, 05/26/16., RCC = renal cell carcinoma ; [4] ORR = Objective Response Rate, mPFS = median Progression Free Survival, mOS = median Overall Survival; [5] ESPN study, Tannir, N. M. et al.

Savolitinib – PRCC Phase II

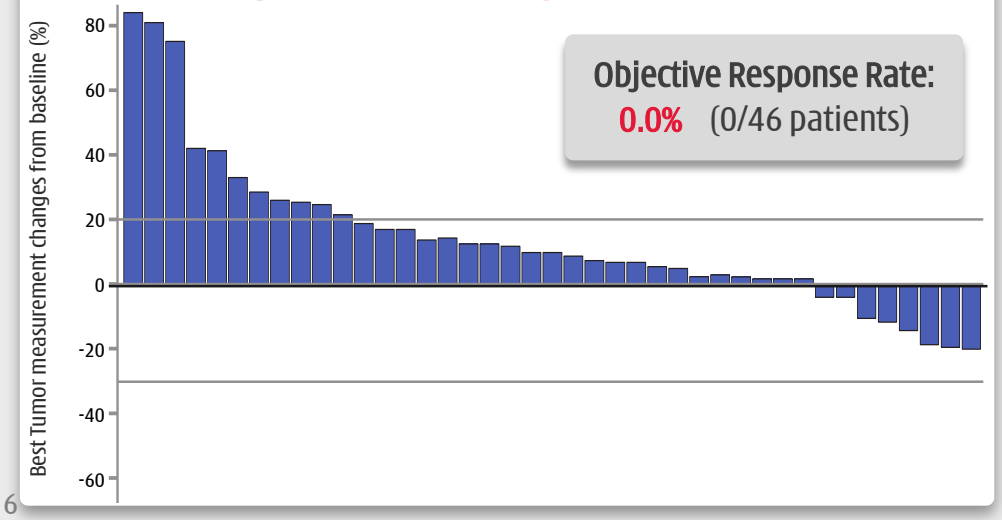
Clear efficacy & durable response in c-MET +ve PRCC patients

CHI-MED

1. Savolitinib clear ORR benefit in c-MET +ve patients.



2. c-MET -ve patients – no response to savo.



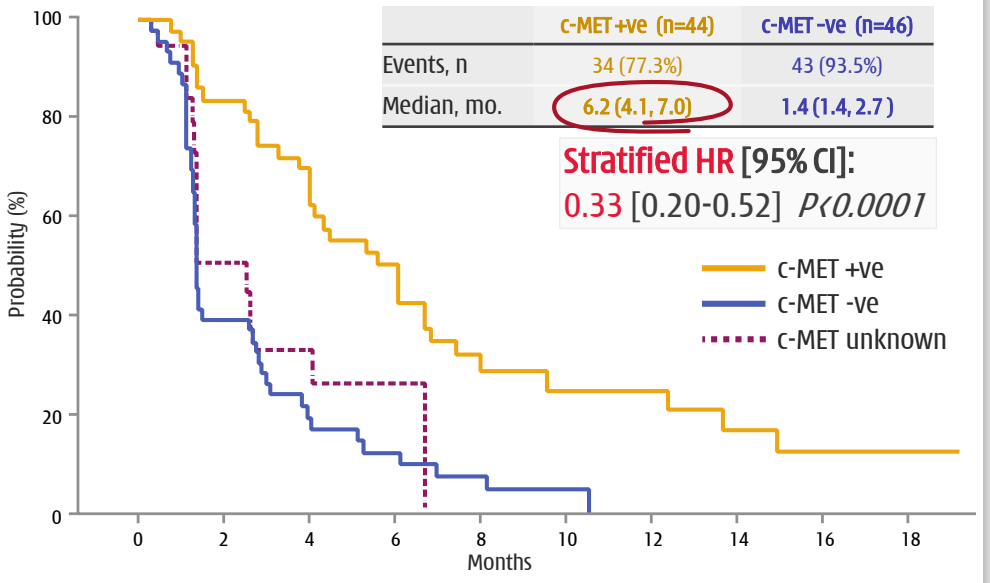
3. Disease Control Rate ("DCR") – big advantage in c-MET +ve with DCR 73.2% vs. c-MET -ve 28.2%.^

Tumor responses in the overall treatment population and by MET status

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

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

4. Median PFS – big advantage in c-MET +ve patients.

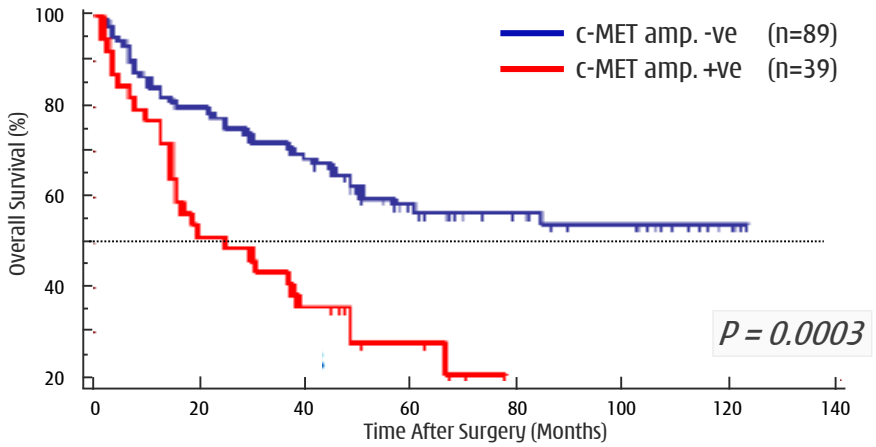


c-MET positive status

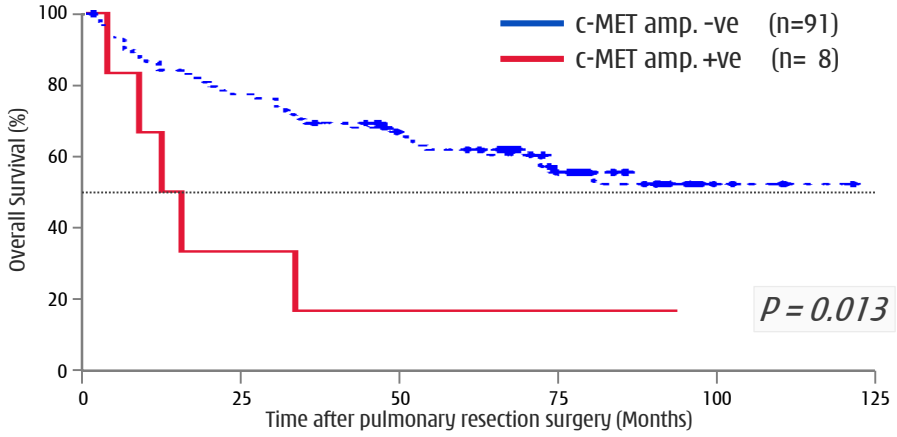
Shown to be a predictor of very poor patient outcome in many cancers

CHI-MED

1. Gastric cancer c-Met +ve .....far worse survival.[1]



2. SCC NSCLC c-MET +ve .....far worse survival.[2]



3. PRCC Molecular Epidemiology Study ("MES") Plan:

- **A pooled analysis of historical data** - Correlation of c-MET-positive PRCC with treatment outcomes.
- **3 collaborations** - GETUG[3] (France); IMDC[4] (N. America, EU, Asia, New Zealand); & Asan GU (Korea). Total ›300 patient data.
- **Timing** - MES to be conducted Q1-Q3 2017- Results end 2017.

UNICANCER Getug | ASAN FOUNDATION 아산재단 ASAN Medical Center | IMDC

PRCC Patient Data (n ›300)

- Tissue samples for c-MET testing
- Medical records - treatment history/outcomes

4. How we will use the MES data set?

- **Possible breakthrough therapy submission** - with clear evidence that c-MET +ve PRCC has far worse treatment outcome/survival than c-MET -ve.
- **Clarity on PFS/OS treatment outcome of c-MET +ve patients** - how do c-MET +ve PRCC patients (vs. c-MET -ve) respond to sunitinib and other approved RCC therapies.

[1] c-MET amplification: gene copy number of ≥4. J Shi et al. Frequent Gene Amplification Predicts Poor Prognosis in Gastric Cancer. *Int. J. Mol. Sci.* 2012, 13, 4714-4726; [2] SCC NSCLC = squamous cell carcinoma non-small cell lung cancer. (~20-30% of NSCLC) -- c-MET gene amplification: ›15 copies in ›10% of tumor cells with 4-10 copies in a gene cluster. H Go et al. High MET Gene Copy Number Leads to Shorter Survival in Patients with Non-Small Cell Lung Cancer. *J. Thorac. Oncol.* 2010, 5, 303-313.; [3] GETUG = Groupe Francais d'Etude des Tumeurs Uro-Genitales; [4] IMDC = International Metastatic Renal Cell Carcinoma Database Consortium.

Savolitinib – PRCC Phase II

Safe & very well tolerated – apparent advantage over other RCC TKIs[7]

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

Better safety data despite higher risk patient population:

- ✓ Only 14% "favorable" vs. 27-58%.

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

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

Highly tolerable vs. other TKIs:

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

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

Savolitinib

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

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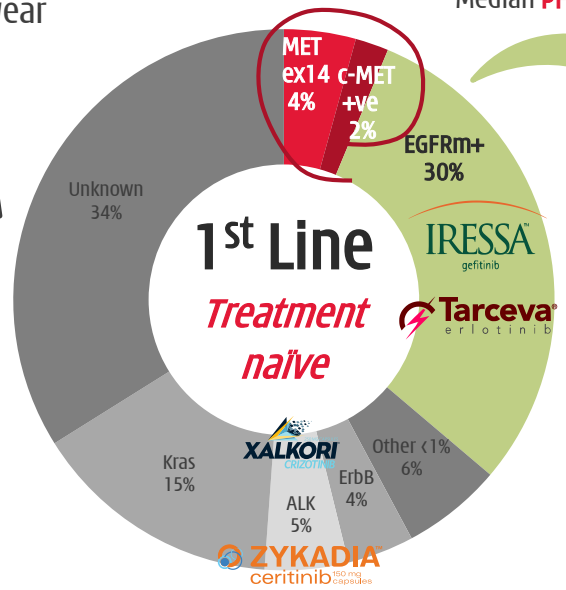
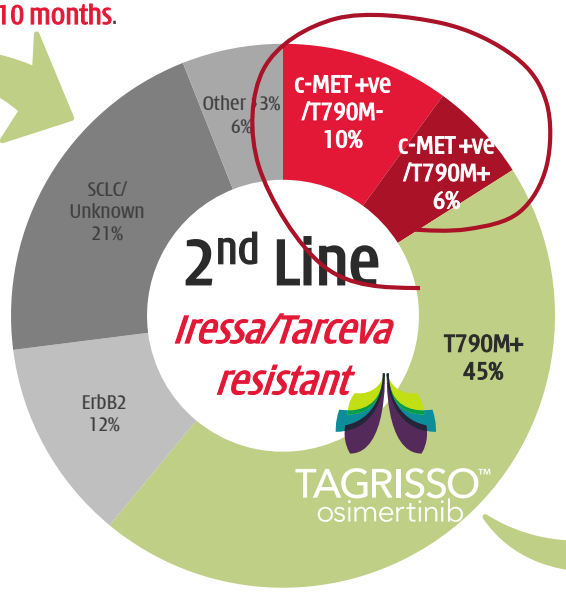
Primary NSCLC

1.7 million NSCLC patients per year

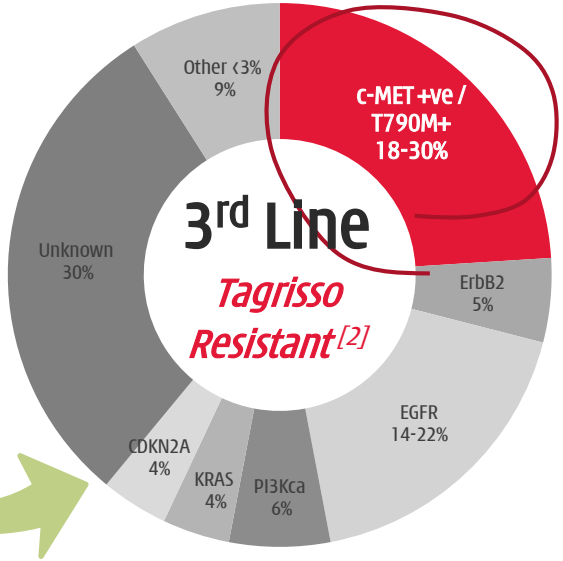


Resistance-driven NSCLC

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



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



	Target	Launch	2016 ($m)	Est.[1] Ptnt. Treat
Iressa	EGFRm+	2003	513	~20,000
Tarceva	EGFRm+	2004	1,137	~50,000
Tagrisso	EGFRm+/T790M	2018/19?		
Xalkori	ALK/ROS1/MET	2011	561	
Zykadia	ALK	2015	91	
Total Sales			2,302	

Est. peak ~$3.0b

Launch	Q4 2015 ($m)[3]	H1 2016 ($m)[3]	H2 2016 ($m)[3]	Est.[3] Ptnt. Treat
Dec-15	~20	143	280	~5,000
	~20	143	280	

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

Savolitinib – 1st Line NSCLC

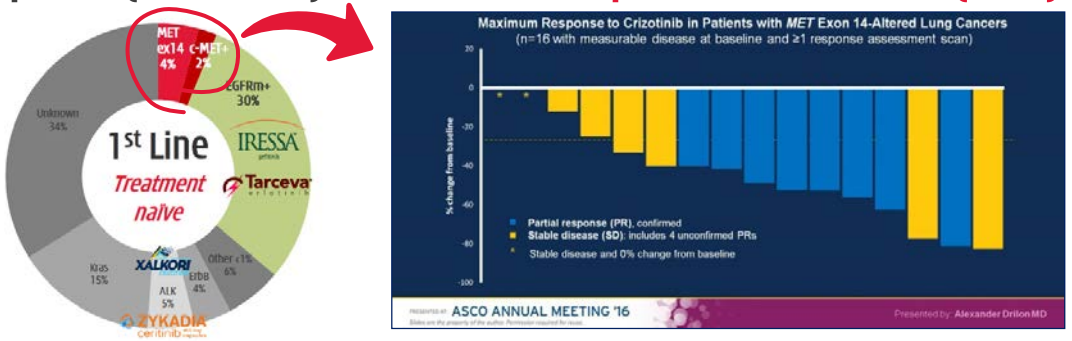
Xalkori® (crizotinib) proof-of-concept in Exon 14 skip 1L NSCLC

CHI-MED

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

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

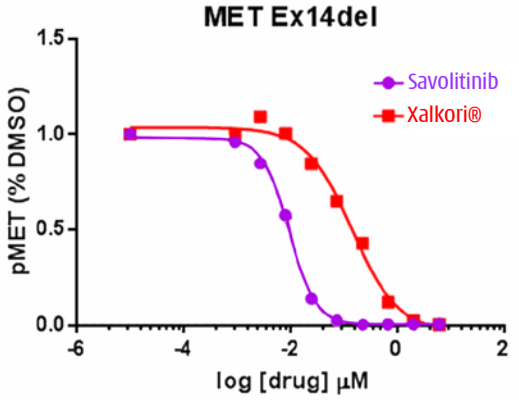
2. 1st line NSCLC – Xalkori® MET Exon14 skipping – 2016 ASCO – strong response (~50% ORR) but >1/3rd of responses not durable (4/12)[1].



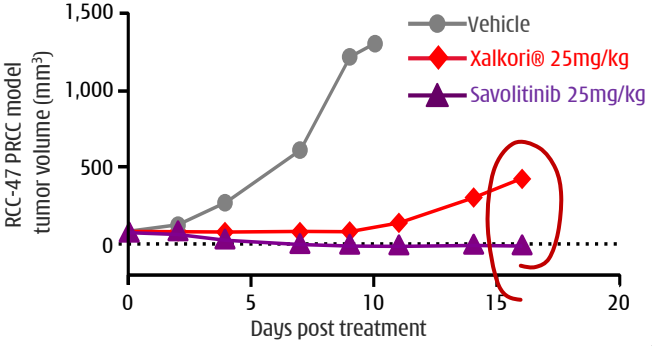
3. Multi-center retrospective analysis of 148 pts. w/ NSCLC MET Exon14 [2]

34 pts. with metastatic NSCLC w/ MET Exon14 skipping:	No exposure to c-MET TKI:	median OS = 8.1 months
	(c-MET+ve pts. mOS = 5.2 mo.; c-MET-ve pts. mOS = 10.5 mo.; p=0.06)	
27 pts. with metastatic NSCLC w/MET Exon14 skipping:	Exposure to c-MET TKI:	median OS = 24.6 months
	(22pts. treated with Xalkori® with median PFS = 7.4 mo.)	

4. Savolitinib versus Xalkori® in MET Ex14del mutant cells[3] – better target coverage.



5. Durable tumour cell suppression for savolitinib but not for Xalkori®[4].



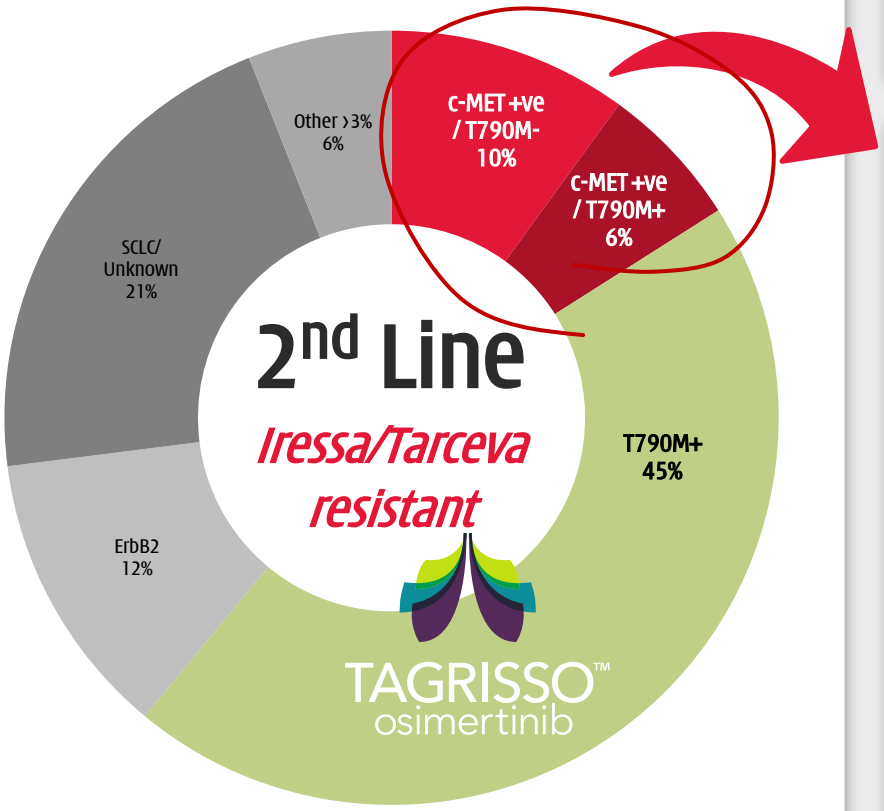
[1] Drilon A, Abstract 108 Efficacy and safety of crizotinib in patients with advanced MET Exon 14-altered non-small cell lung cancer; [2] ASCO 2017, Abstract 8511, Mark M. Awad et al.; [3] Paik, P.K., et al., Response to MET inhibitors in patients with stage IV lung adenocarcinomas harboring MET mutations causing exon 14 skipping. Cancer Discov, 2015. 5(8): p. 842-9.; [4] Schuller AG et al. "Regression in Papillary Renal Cell Carcinoma Patient-Derived Xenograft Models". Clin Cancer Res 2015;21:2811-2819.

Savolitinib – 2nd Line NSCLC Phase Ib/II

Very strong early signal emerging – Clear competitive edge for savolitinib

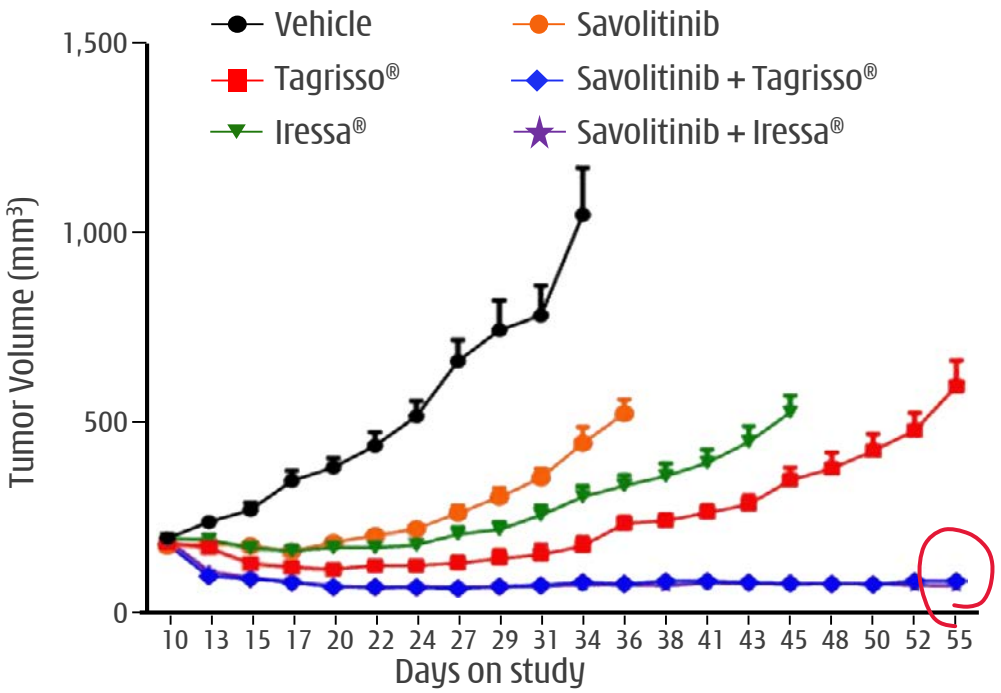
CHI-MED

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



2. Potential in **EGFR TKI resistant NSCLC**:

- ✓ Must **shut down both EGFR & c-Met** signaling pathways;
- ✓ **Prolonged tumor growth suppression** by combining savolitinib with Tagrisso® (osimetinib – EGFR/T790M) or Iressa® (gefitinib/EGFR) **in T790M-, c-MET +ve patients**.



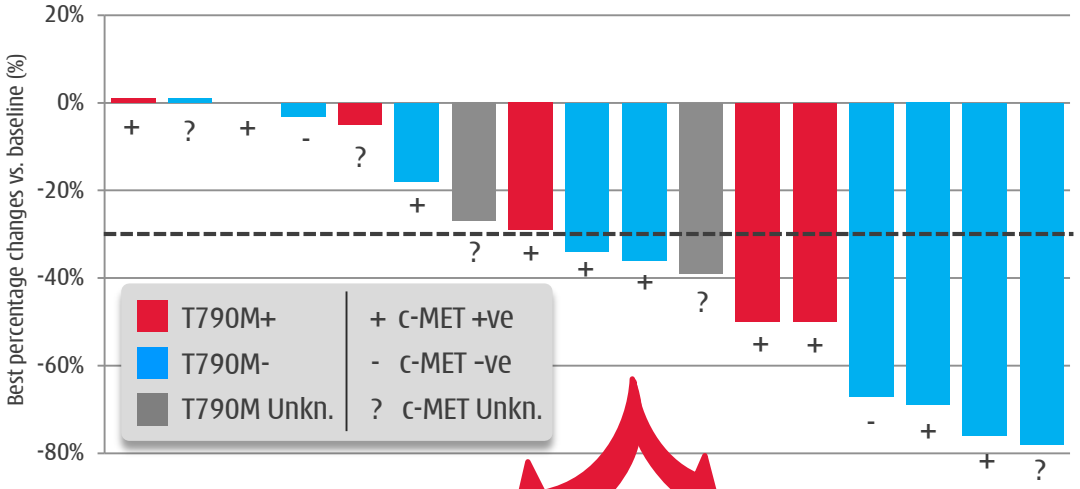
[1] HCC827 NSCLC – EGFRm erlotinib resistant cells (HCC827-ER1) generated *in vitro*. D'Cruz CM et al; #761 Preclinical data for changing the paradigm of treating drug resistance in NSCLC: Novel combinations of AZD6094, a selective MET inhibitor, and AZD9291 an irreversible, selective (EGFRm and T790M) EGFR TKI; American Association of Cancer Research Annual Meeting; April 19, 2015.

Savolitinib – 2nd Line NSCLC

Clear anti-tumor effect in NSCLC patients – Phase IIb to complete 2017

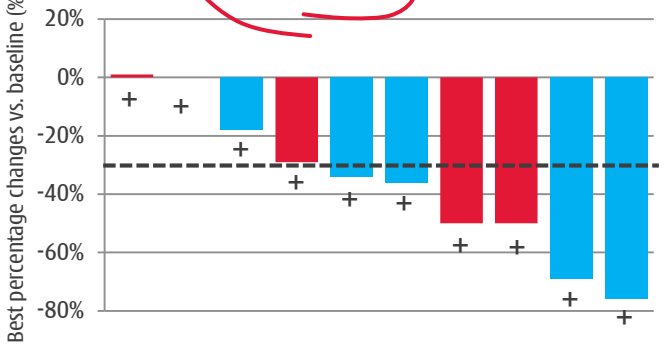
CHI-MED

1. TATTON efficacy…Phase I/IIa exploring combo treatment of 600/800mg savolitinib & 80mg Tagrisso® daily.[1]



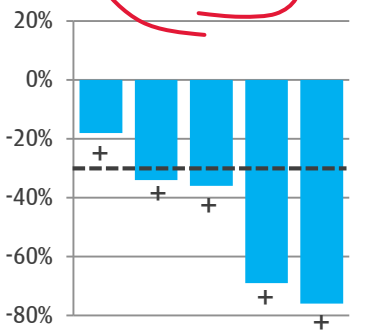
c-MET +ve (T790M + or -)

ORR [2]: 60% (6/10)



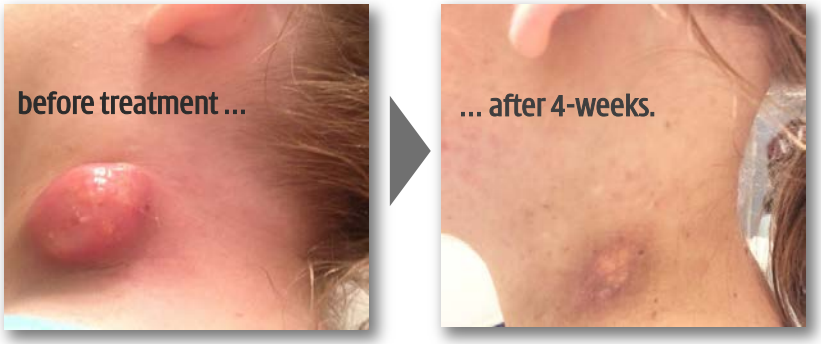
c-MET +ve & T790M-

ORR: 80% (4/5)



2. Particularly encouraging efficacy in 32 yr. old NSCLC patient w/ c-Met +ve & T790M-.

- ✓ Rapidly progressing bone & lung mets. Major solid tumor.
- ✓ Primary progression on prior EGFR TKI (i.e. Tarceva resist.).
- ✓ Brief response to platinum doublet.



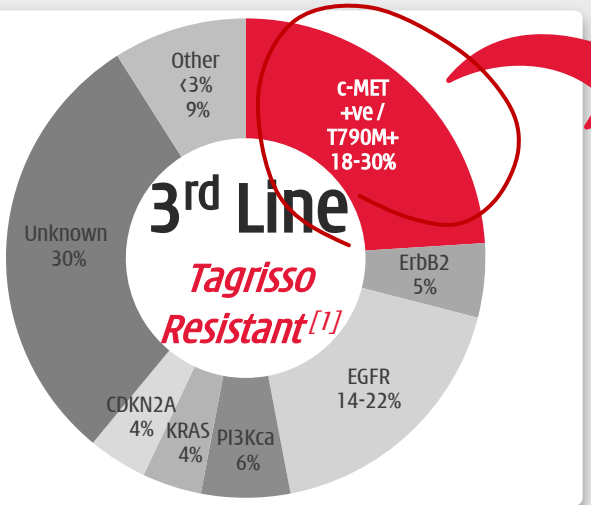
3. TATTON safety – savolitinib & Tagrisso® combo treatment at full doses. No major toxicity.

Number of events, n	600mg (n = 6)		800mg (n = 6)	
Adverse Event occurring in over three instances at any dose	Any Gr.	Gr.≥ 3	Any Gr.	Gr.≥ 3
Vomiting	7	0	3	0
Nausea	3	0	6	1
Rash	4	0	3	0
Pyrexia	3	0	3	0
White blood cell count decrease	4	0	1	1
Decreased appetite	1	0	3	0

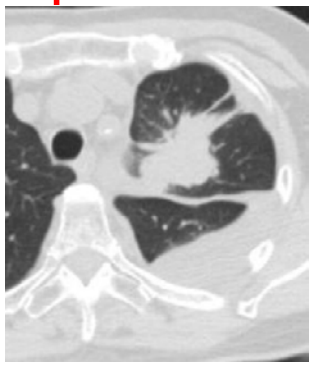
[1] ESMO 2016 Galbraith - Novel Clinical Trials for Precision Medicine; [2] ORR = Objective Response Rate (confirmed Partial Response)

Savolitinib – 3rd Line NSCLC – Tagrisso® resistant

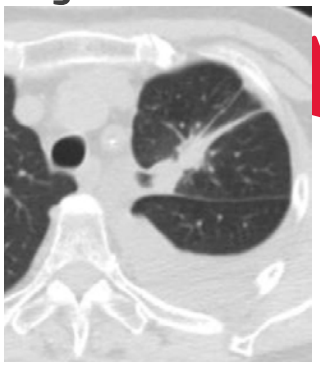
T790M+ & c-Met+ unmet medical need starting to emerge



3/3 patients with T790M+/c-MET+ responded to savo/Tagrisso® combo.



LUL Mass Pre-Treatment



6 wks on savo/Tag. Treatment

Tagrisso® resistant tissue & ctDNA analysis [2]

MASSACHUSETTS GENERAL HOSPITAL CANCER CENTER — HARVARD MEDICAL SCHOOL

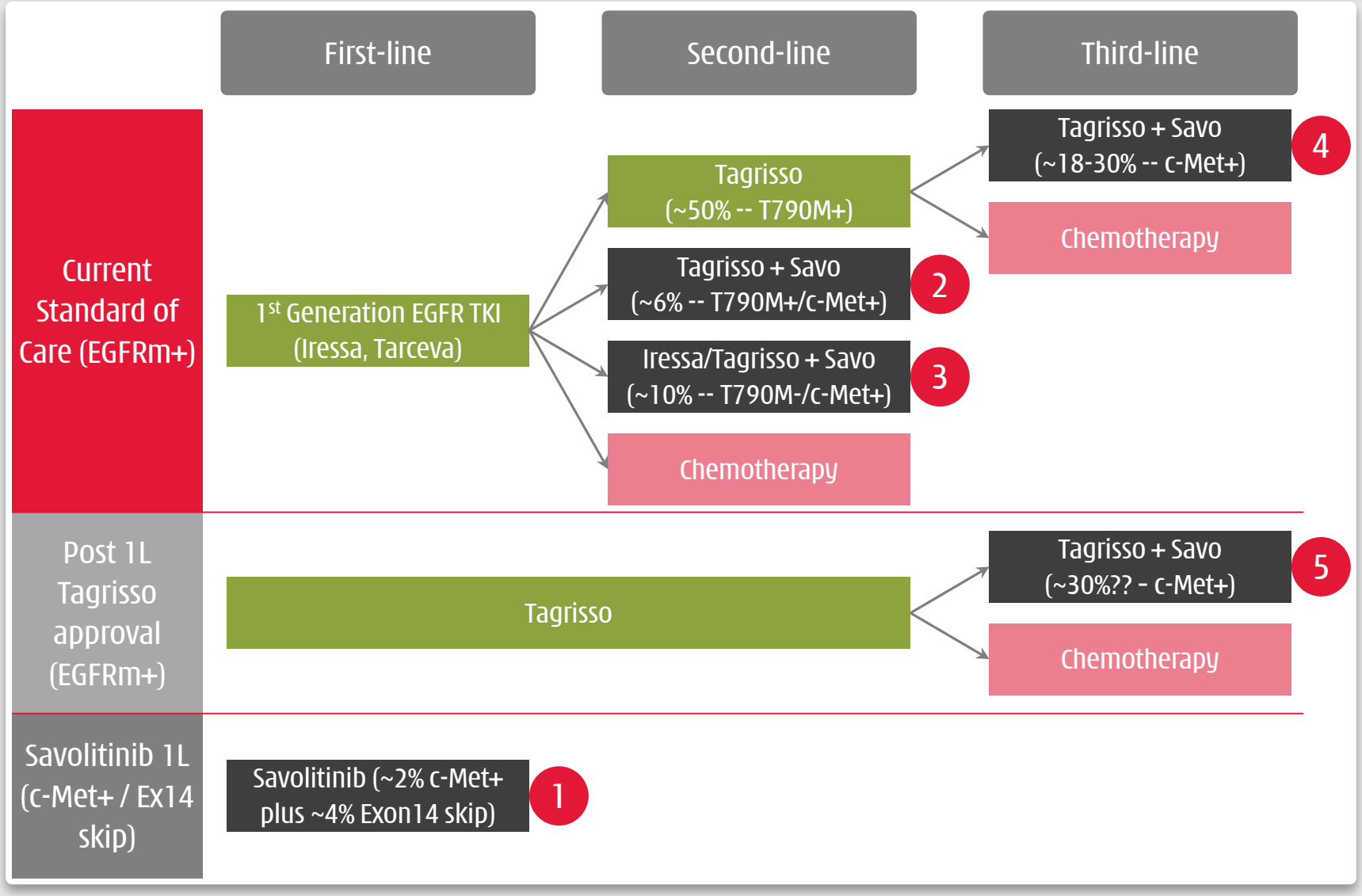
Pt	EGFR mutation	# Prior Therapies	Prior 3rd gen TKI	TISSUE (NGS, FISH)	PLASMA ctDNA (NGS)
1	L858R	1		*MET* amp, T790 WT	*MET* amp, T790M ND
2	Del19	1		-	T790M ND
3	Del19	2	Y	-	T790M ND
4	L858R (de novo T790M)	2	Y	*MET* amp, *EGFR* amp T790M (germline)	-
5	L858R	3	Y	T790wt, *EGFR* amp	T790M ND
6	L858R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

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

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

Savolitinib – NSCLC

Five clear opportunities for savolitinib in the NSCLC treatment algorithm



Savolitinib – Gastric cancer

A major problem in east Asian countries – Japan, South Korea and China

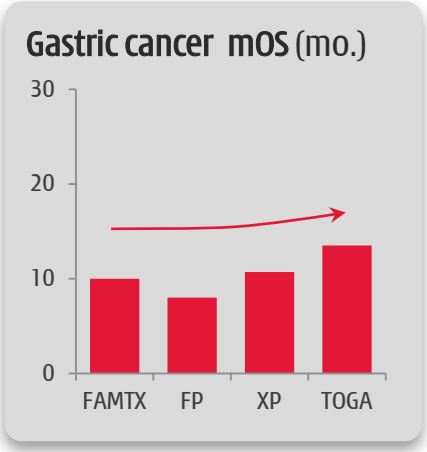
CHI-MED

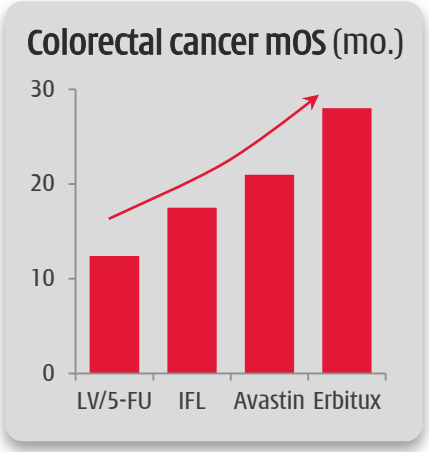
1. Gastric (stomach) cancer is the 5th most common cancer globally – 723,000 deaths/year.

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

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

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





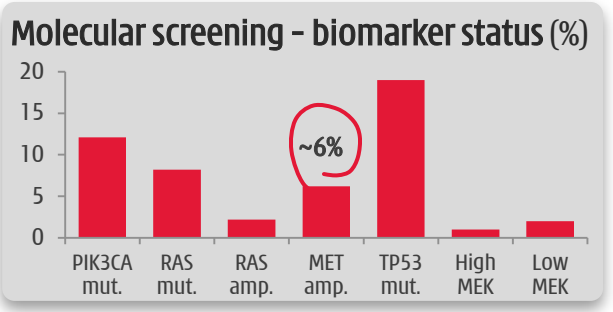
Jeeyun Lee, AACR 2016; Mayer RJ, J Clin Oncol 2015.

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

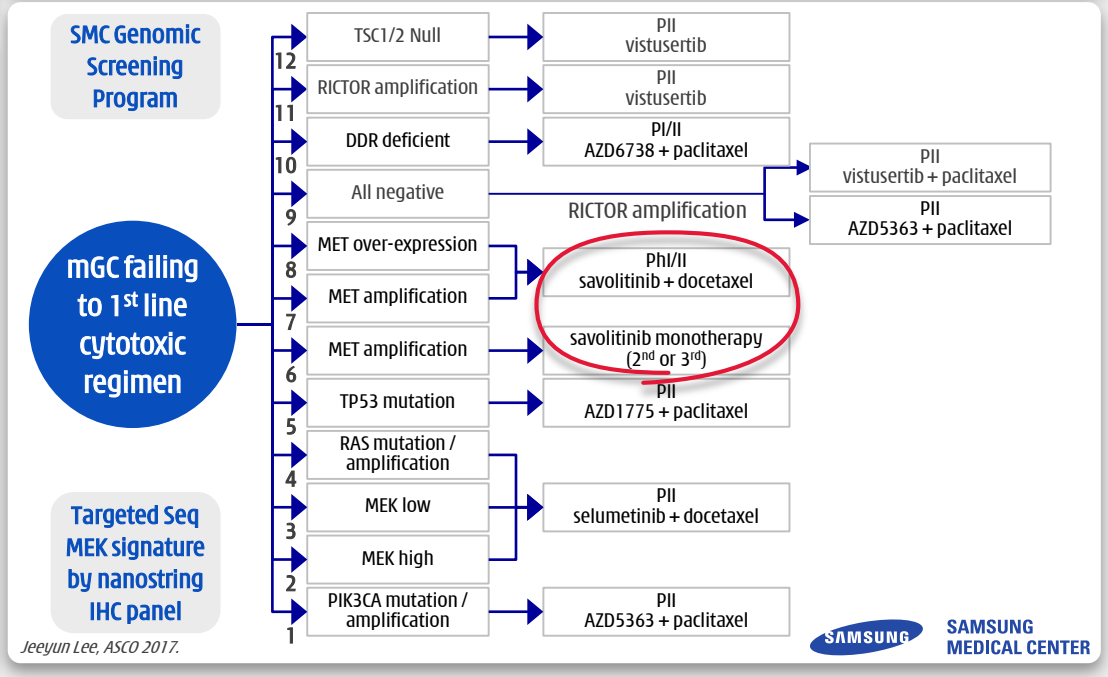
Total of 309 patients enrolled

- Failed due to insufficient tumour volume (n=34)
- Consent withdrawn (n=2)
- Tissue acquisition failure (n=2)
- cfDNA (n=9)

262 patients: targeted sequencing (381 gene)



Jeeyun Lee, AACR 2016.



Jeeyun Lee, ASCO 2017.

SAMSUNG MEDICAL CENTER

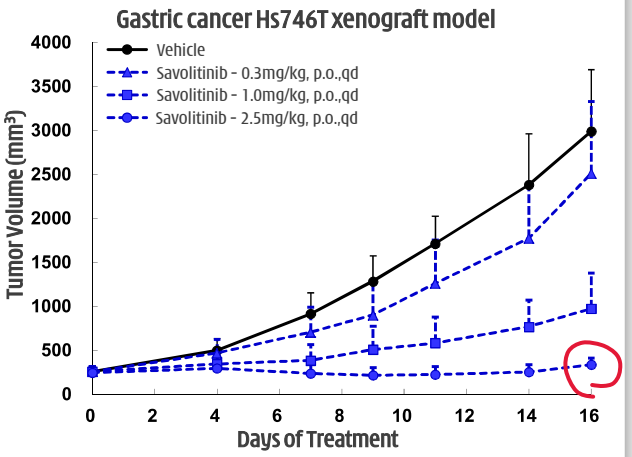
FAMTX = 5-FU + doxorubicin + methotrexate; FP = cisplatin + 5-FU; XP = capecitabine + cisplatin; TOGA = trastuzumab + chemo; LV/5-FU = leucovorin + 5-FU; IFL = irinotecan + 5-FU + leucovorin.

Savolitinib – Gastric cancer

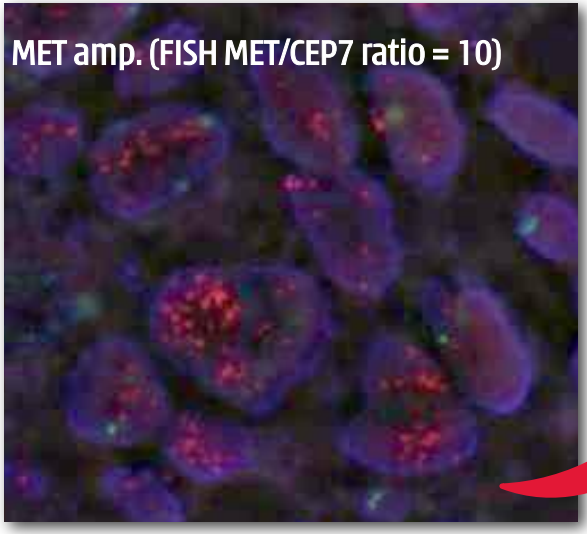
VIKTORY trial – very promising early clinical results in c-MET +ve patients

CHI-MED

1. Strong preclinical efficacy.

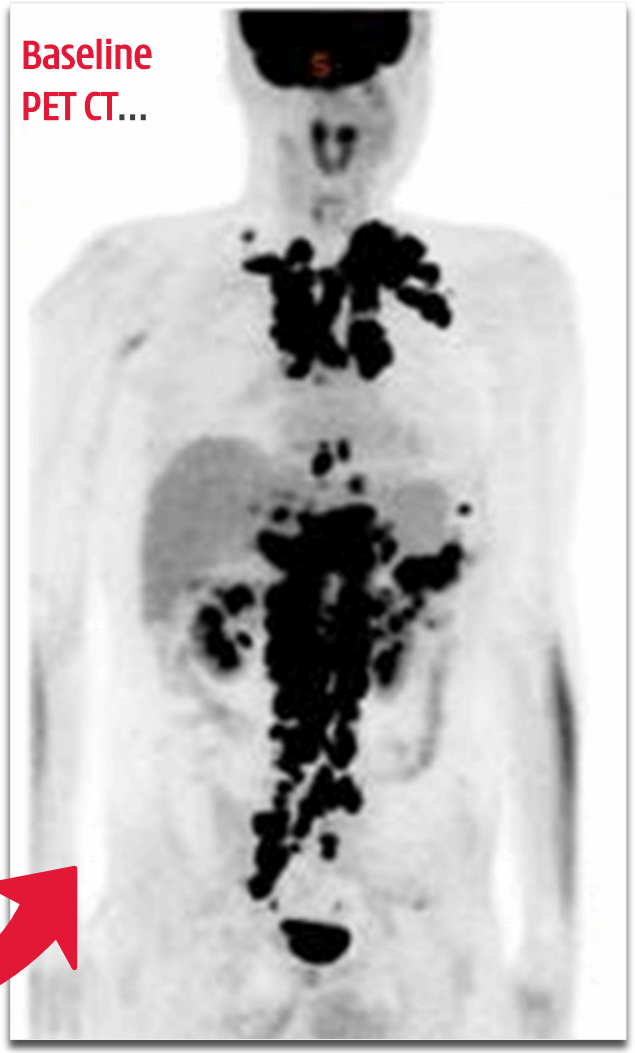


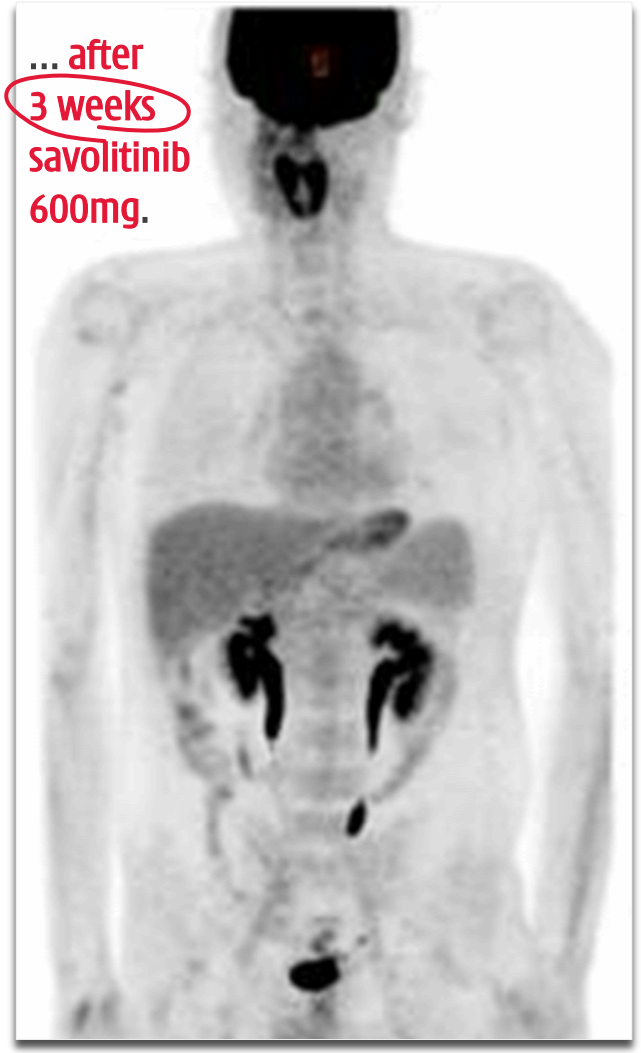
p.o. = by mouth (i.e. orally); qd = one dose per day.



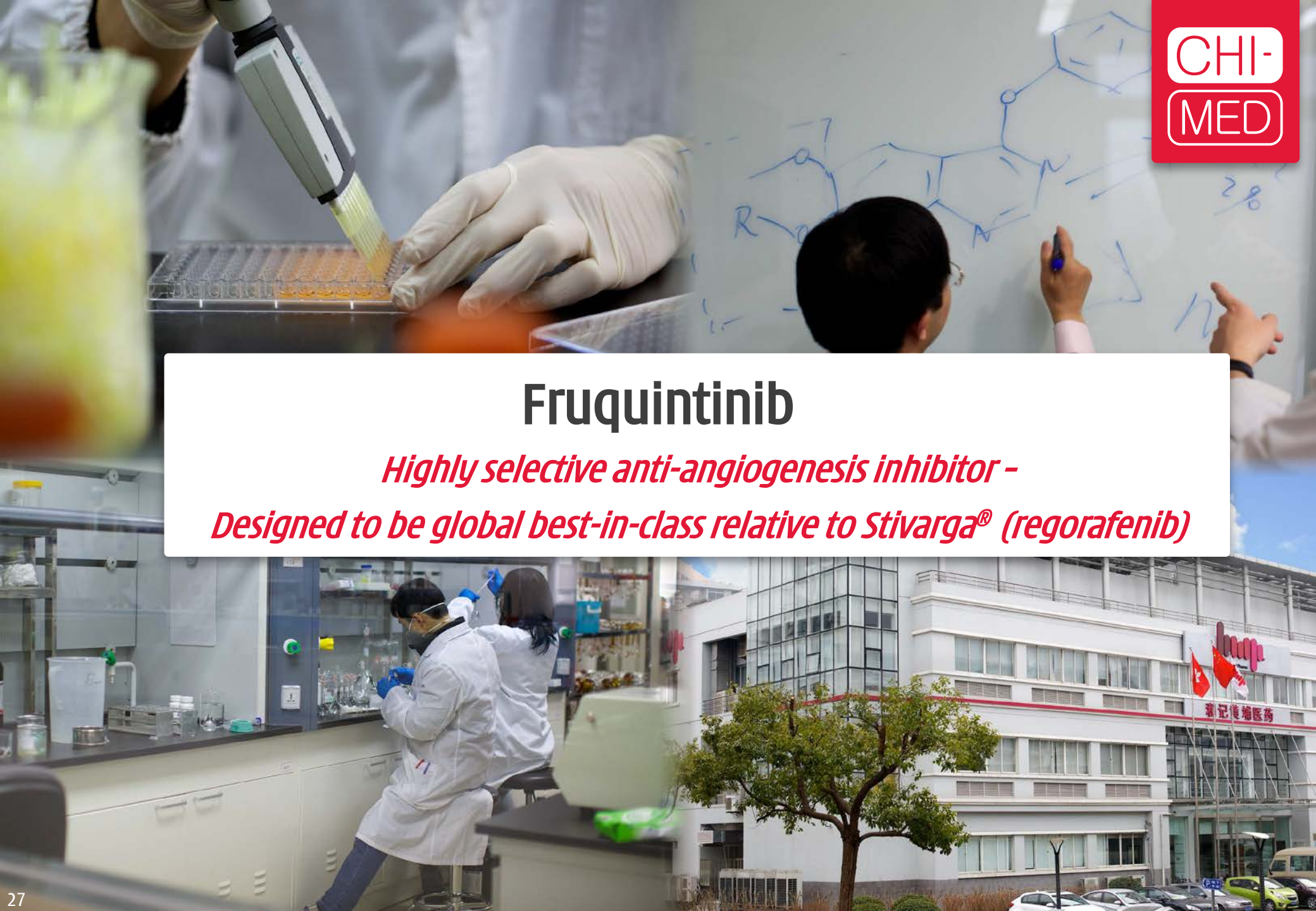
Jeeyun Lee, AACR 2016.

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





Jeeyun Lee, AACR 2016.



Fruquintinib

Highly selective anti-angiogenesis inhibitor –

Designed to be global best-in-class relative to Stivarga® (regorafenib)

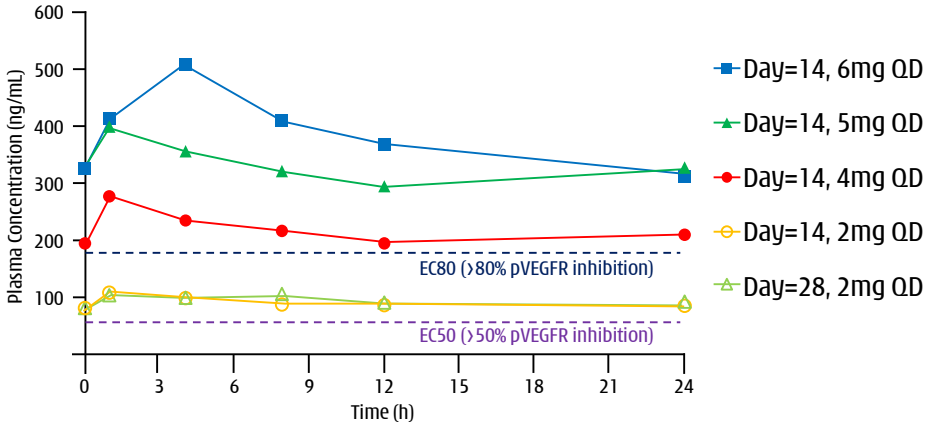
Fruquintinib – 24hr full target coverage

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

1. Substantial progress made in 2016 – fruquintinib China NDA submission mid-2017.

- ✓ Validation of R&D approach – designed to only inhibit VEGFR1,2,3, facilitating **full target coverage & combinations**.
- ✓ **Pivotal Phase III** in **3L CRC met all endpoints – NDA submit mid-2017**.
- ✓ **Pivotal Ph. III** trial in **3L NSCLC well underway** since Q4 2015 initiation.
- ✓ **Ph.Ib Taxol® combo** in **2L gastric cancer** dose finding complete. Phase III pivotal study starting 2017.
- ✓ **Ph.II Iressa® combo** trial in **1L EGFRm+ NSCLC** started early 2017.
- ✓ China GMP **production facility operational** to support launch.

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



3. Selectivity and potency superior to competitor drugs.

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

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

Fruquintinib – Third-line colorectal cancer

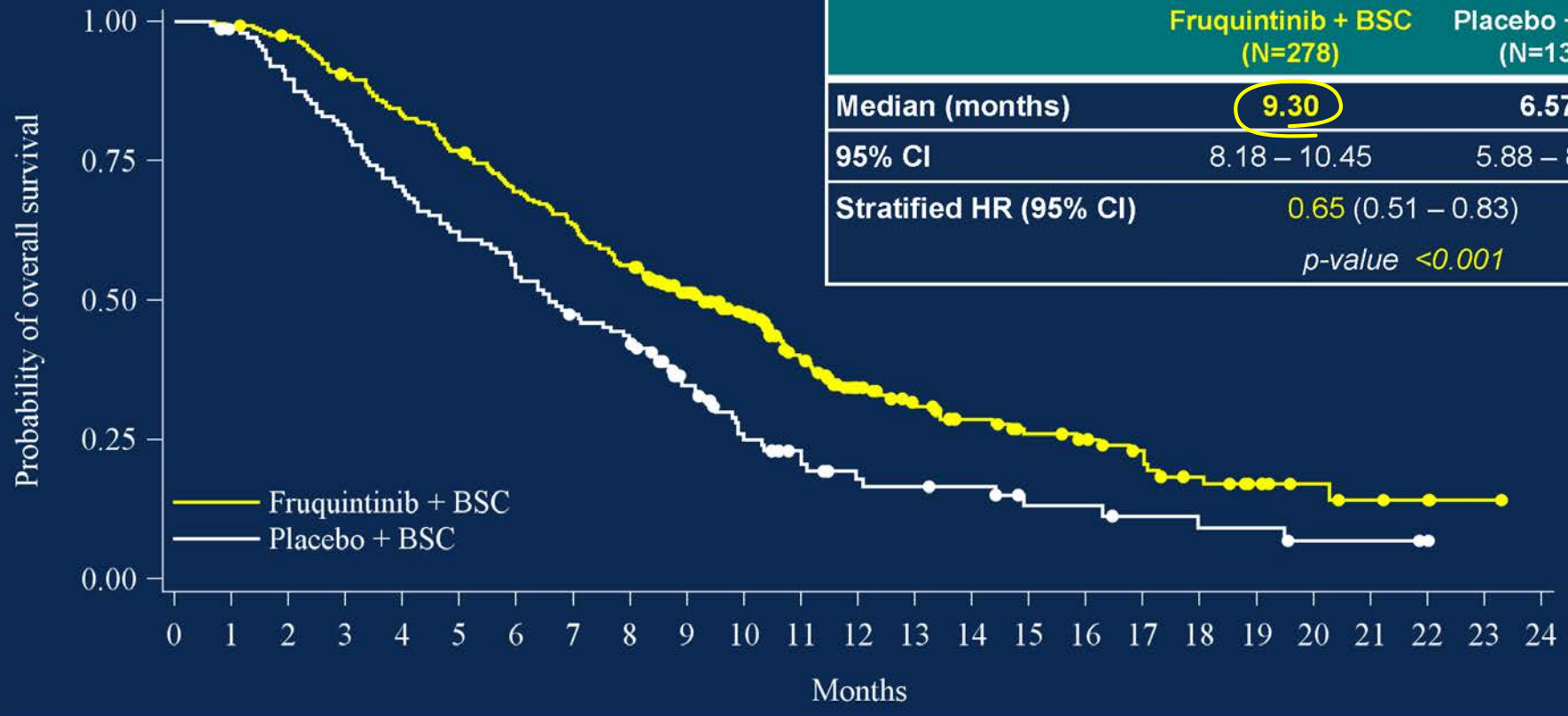
Best-in-class efficacy/safety – Phase III FRESCO data at ASCO 2017[1]

Lilly 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	



PRESENTED AT: ASCO ANNUAL MEETING '17 | #ASCO17

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Presented by: Jin Li, MD PhD

June 5, 2017

10

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

Fruquintinib – FRESCO efficacy in 3L CRC

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

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

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

Fruquintinib – FRESCO safety in 3L CRC

Fruquintinib high VEGFR selectivity – no off-target AEs & more tolerable

Third-Line Metastatic Colorectal cancer ≥G3 AEs in ›4% of Patients	Fruquintinib FRESCO Mainland China		Regorafenib CONCUR Chinese Patients (Mainland China, Hong Kong, Taiwan)[1]	
Treatment arms	**Fruquintinib**	**Placebo**	**Regorafenib**	**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%
NOTE: Baseline Characteristics -- Liver metastasis	66.5%	73.9%	na	na
Tolerability:				
AE Leading to dose interuption	35.3%	10.2%	68.8%	25.0%
AE Leading to dose reduction	47.1%	13.1%	23.2%	0.0%
AE Leading to treatment discontinuation	15.1%	5.8%	14.3%	6.7%

Fruquintinib far more selective than regorafenib

BIOCHEMICAL ACTIVITY	Fruquintinib IC_{50} (nmol/L)	Regorafenib 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

Regorafenib liver toxicity Black-box warning:

- ➔ Increased liver function test monitoring (weekly if elevated) & remedial dose interruption.
- ➔ 3L CRC China – 65-75% liver metastasis – weaker pts.

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

WARNING: HEPATOTOXICITY

See full prescribing information for complete boxed warning.

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

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

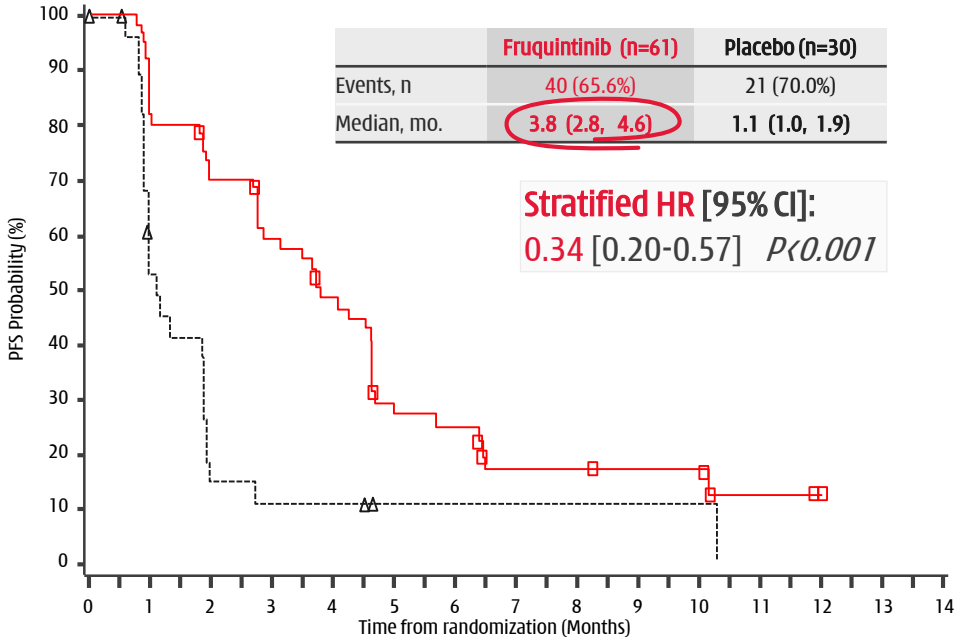
Fruquintinib – Third-line NSCLC

Potential best-in-class efficacy and safety

- **Non-small cell lung cancer ("NSCLC") Phase II PoC.**
  - ✓ 91 3rd line only pts. **enrolled in ~9 months** (Jun'14-Mar '15).
  - ✓ **Clearly met primary endpoint** of reduction in risk of progression. $10 million success milestone from Lilly in Q4 2015.
  - ✓ **AEs consistent** with the known safety profile and generally superior versus 3L colorectal cancer Phase II with lower ›Gr.3 AEs (32.8% vs. 66.0%) and dose reductions (13.1% vs. 27.7%).

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

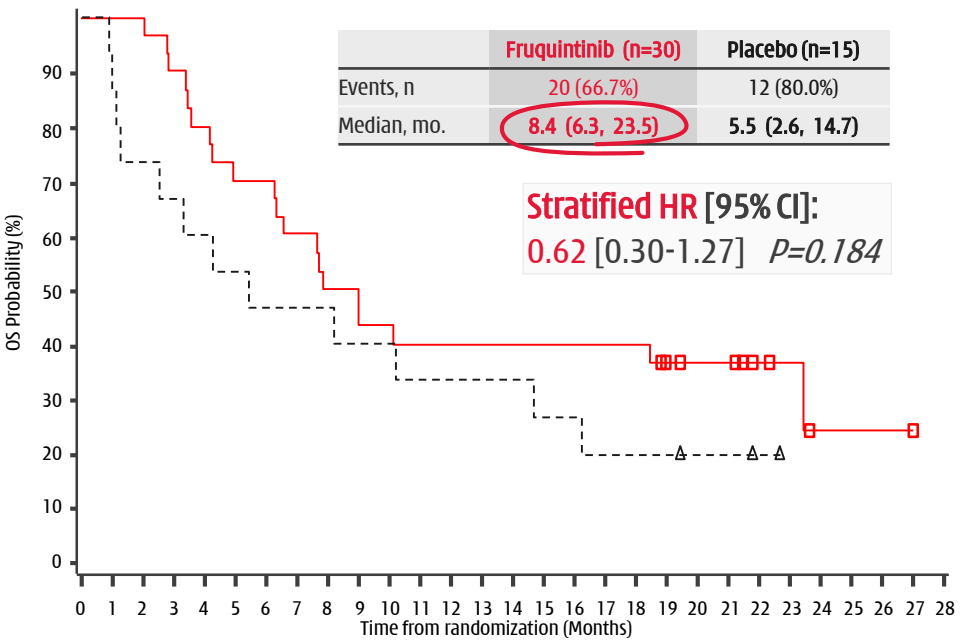
3L NSCLC Phase II: Progression Free Survival



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

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

3L NSCLC Phase II: Overall Survival [1]



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

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

[1] EGFR Mutation positive (n=45)

Fruquintinib – Third-line NSCLC is competitive

…but we believe fruquintinib is well positioned

- **Anlotinib (Sinobiopharm) is about 12-18 months ahead of fruquintinib in 3L NSCLC – their Phase III will reported at ASCO 2017. However, anlotinib Phase II seems to have been in abnormally healthy 3L NSCLC patients (32% placebo DCR[1]; 0% brain mets; & only 20% EGFRm[2]) so close analysis of their Phase III results will be critical.**

Third-line NSCLC		Fruquintinib Phase II *(Blinded Independent Clinical Review)*		Fruquintinib Phase III		Anlotinib Phase II *(Local Physician Review)*		Anlotinib Phase III [SINOBIOPHARM]		Apatinib Phase III *(EGFR mut+ WT)*		Apatinib Phase II (EGFR WT only) [JIANGSU HENGRUI]		Apatinib Phase III (EGFR WT only)		Lenvatinib Phase II [EISAI]	
Timing				FPI Q4-2015				LPI Q2-2016; Topline Q2-2017		Failed on mPFS Primary endpoint				FPI Q1-2015			
		Fruquin.	Placebo	Fruquin.	Placebo	Anlotinib	Placebo	Anlotinib	Placebo	Apatinib	Placebo	Apatinib	Placebo	Apatinib	Placebo	Lenvatinib	Placebo
patients (n)		61	31	520 (enrolling)		60	57	294	143	480		90	45	417 (enrolling)		89	46
Complete Response ("CR")		0 (0%)	0 (0%)			0 (0%)	0 (0%)	0 (0%)	0 (0%)			0 (0%)	0 (0%)			0 (0%)	0 (0%)
Partial Response ("PR")		10 (16%)	0 (0%)			6 (10%)	0 (0%)	27 (9%)	1 (1%)			18 (20%)	1 (2%)			9 (10%)	1 (2%)
Stable Disease ("SD")		33 (54%)	5 (16%)			44 (73%)	18 (32%)	211 (72%)	52 (36%)			44 (49%)	10 (22%)			58 (65%)	12 (26%)
Disease Control Rate ("DCR")		43 (71%)	5 (16%)			50 (83%)	18 (32%)	238 (81%)	53 (37%)			62 (69%)	11 (24%)			67 (65%)	13 (28%)
median Progression Free Survival ("PFS") (m)		3.8	1.2			4.8	1.2	5.4	1.4	Failed mPFS endpoint		4.7	1.9			4.8	1.8
P value		<0.001				<0.001		<0.0001				<0.001				<0.001	
Hazard Ratio ("HR")		0.275				0.320		0.25				0.278				0.400	
median Overall Survival ("OS") (m)		7.7	9.7	mOS Primary endpoint		10.3	6.3	9.6	6.3					mOS Primary endpoint		8.7	5.5
P value		0.264				0.075		0.0018									
HR		0.743				0.656		0.68									
›G3 Adverse Events ("AE")		22 (36%)	8 (27%)			13 (22%)	3 (5%)									61 (69%)	23 (51%)
SAE		6 (10%)	4 (13%)			7 (12%)	8 (14%)									46 (52%)	21 (47%)
HFS ›G3, n (%)		3 (5%)	0 (0%)			2 (3%)											
Fatigue ›G3, n (%)		2 (3%)	0 (0%)														
Hypertension ›G3, n (%)		5 (8%)	1 (3%)			5 (8%)											
Diarrhea ›G3, n (%)		1 (2%)	0 (0%)														
Proteinuria ›G3, n (%)		1 (2%)	0 (0%)														
Triglicerides ›G3, n (%)						3 (5%)											
AE leading to dose interruption		8 (13%)	0 (0%)														
AE leading to dose reduction		8 (13%)	0 (0%)			6 (10%)	0 (0%)										
AE leading to treatment discontinue		4 (7%)	1 (3%)													22 (25%)	8 (18%)
ECOG PS, n (%)	0	4 (7%)	1 (3%)			7 (12%)	3 (5%)					20 (22%)	12 (27%)			17 (19%)	11 (24%)
	1	57 (93%)	29 (97%)			47 (78%)	49 (86%)					70 (78%)	33 (73%)			63 (71%)	29 (63%)
	2					6 (10%)	5 (9%)									8 (9%)	6 (13%)
Stage, n (%)	IIIB					6 (10%)	2 (4%)										
	IV					54 (90%)	55 (96%)										
Brain metastases		11 (12%)				0 (0%)											
EGFR Mutation, n (%)	+ve	30 (49%)	15 (48%)			12 (20%)	9 (15%)										
	-ve (WT)	27 (44%)	13 (42%)			48 (80%)	48 (85%)					90 (100%)	45 (100%)				
	unkn.	4 (7%)	3 (10%)			0 (0%)	0 (0%)										

Phase III Top-line results 2018 ?

Study Ph.III data: (1) Why high placebo DCR? (2) EGFRm ratio? (3) Brain mets? (4) Censoring? (5) AEs? ?

Second try at 3rd line NSCLC – only wild-type EGFR patients (~40-60%) ?

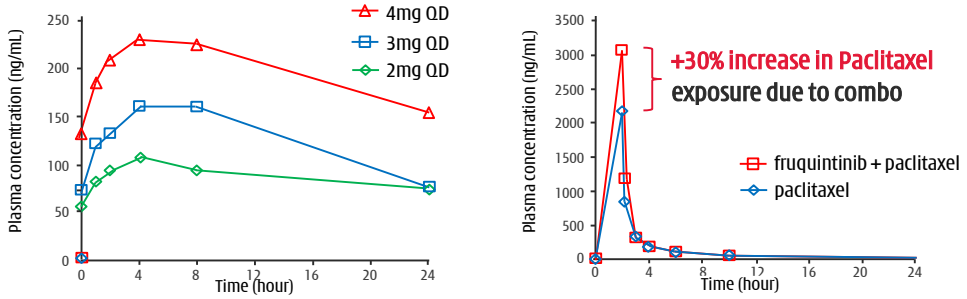
Global price -- ~$13.2k/mo. ✗

[1] DCR = Disease Control Rate; [2] EGFR Mutation positive – In China 40-60% of NSCLC patients harbor EGFR mutation (compared to 10-15% of Caucasian patients in the West).

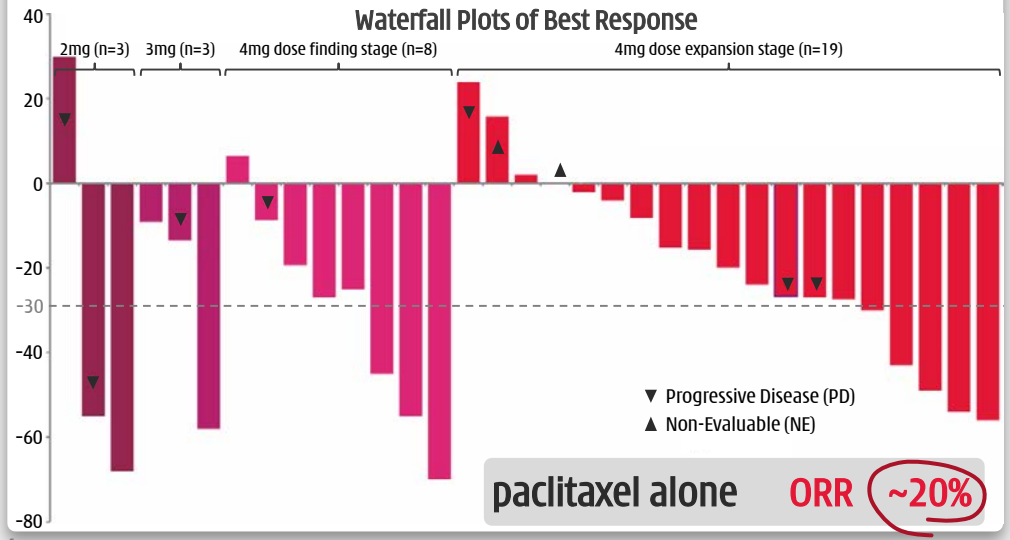
Fruquintinib – Gastric combo with paclitaxel

Clear efficacy, safety as expected & +30% incr. in paclitaxel exposure

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% (10/32) & DCR of 68% in efficacy evaluable pts. Fruquintinib 4mg, ≥16 wk. PFS of 50% & ≥7 mo. OS of 50%.



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

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

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

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

Sulfatinib

A highly active TKI with a unique angio-immuno Mechanism of Action

Neuroendocrine tumors ("NET")

Sulfatinib potential advantages

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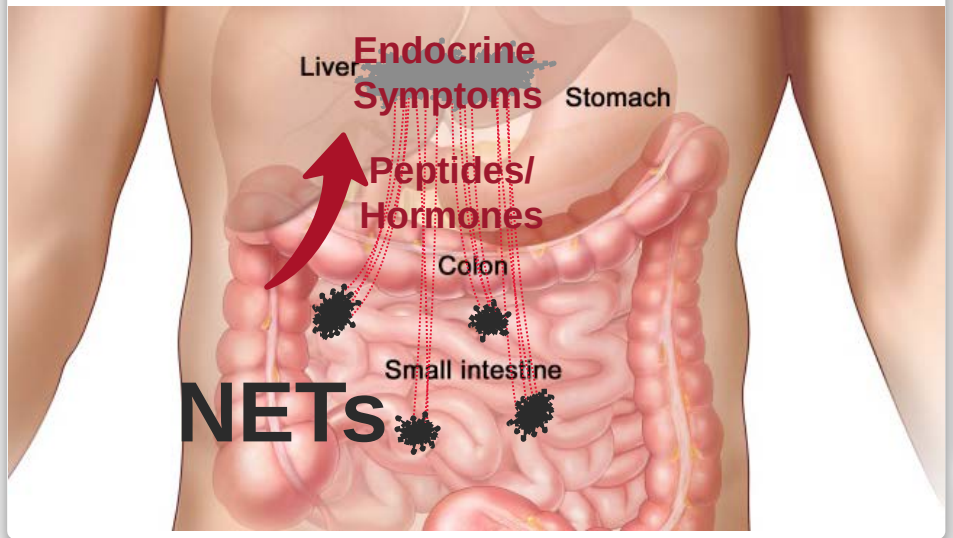
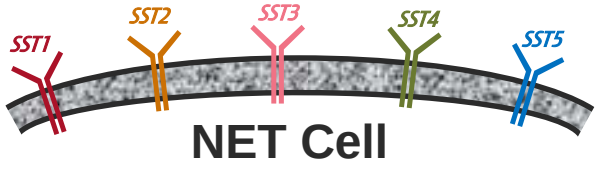
1. NETs release peptides & hormones that cause endocrine symptoms such as hot flushes, diarrhea, nausea, heart palpitations & (abdominal) pain.



2. Somatostatin analogues ("SSTA"): Inhibit peptide/hormone release for symptom control.[3]

Sandostatin® $1.6b 2016 sales (Novartis); Somatuline® $0.6b 2016 sales (Ipsen).



3. Available NET therapies – control symptoms/tumor growth but provide minimal tumour shrinkage:

- Sandostatin® & Somatuline® (SSTAs) are used primarily for symptom control in early stage NET (Ki67 ‹10%) – SSTAs do provide some tumor growth control (DCR/mPFS) but almost no tumor shrinkage (ORR);
- Lutathera® radio nucleotide SSTA – delivers radiation to NET via SST receptors – very effective ~40 mo. mPFS & ~18% ORR in midgut NET (~21% of NETs) with MoA potential in other NETs. Primary issues around logistics – half-life 3 days requiring efficient product supply systems – not very practical for broad scale usage in developing world;
- Sutent® & Afinitor® in pancreatic NET & certain lung/GI NETs – provide tumor growth control (DCR/mPFS) but low tumor shrinkage (‹10% ORR).

4. Emerging advantages of sulfatinib:

- Broad spectrum NET efficacy:
  - (1) Tumor control & shrinkage across all NET sub-types;
  - (2) Unique angio-immuno MoA – 2L usage (post failure on 1L therapy);
  - (3) Efficacy in ~20% of NET patients without overexpressed SST receptors.
- Convenience/cost:
  - (1) Oral formulation vs. very short half-life (3 days) injection (Lutathera®);
  - (2) Cost/pricing – vs. Lutathera® est. ›$200k/yr.; Sutent® $140k/yr.

[1] RP2D = Recommended Phase II dose; [2] BTT = Breakthrough Therapy Designation; [3] MoA = Mechanism of Action.

Sulfatinib's unique angio-immuno kinase profile

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

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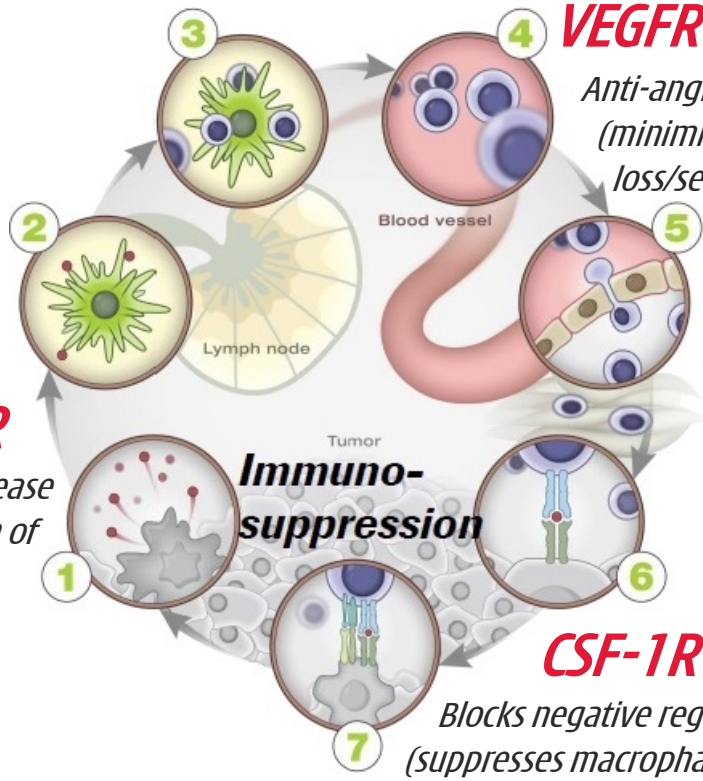
Sulfatinib's unique angio-immuno kinase profile & MoA[2] activates & enhances the body's immune system, namely T-cells, via VEGFR/FGFR while inhibiting the prod- uction of macrophages (CSF-1R) which cloak cancer cells.



VEGFR / FGFR

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

FGFR

Antigen release (activation of T-cells)

CSF-1R

Blocks negative regulators (suppresses macrophage cloak)

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

	Pancreatic NET Phase III	Non-Pancreatic NET Phase III
Primary site	Pancreas	GI, lung, other or unknown
Population	Unresectable or metastatic disease; well differentiated (G1/G2); ≤2 prior systemic drugs.	
# of Sites	20-30 (China)	
# of Patients	~195	~270
Study design	Double-blind. Randomized 2:1 to sulfatinib or placebo, until PD. Predefined interim analysis.	
Dosage	Sulfatinib 300mg QD, 28 days per cycle (vs. placebo)	
Primary Endpoint	Progression-Free Survival (PFS) by BICR evaluation	
Secondary Endpoints	Overall Survival (OS), ORR, safety, etc.	
First Patient In / Readout	March 2016 / 2018	December 2015 / 2018

Activity 2: Global development

- U.S. Phase I bridging in Caucasian patients almost complete - RP2D[3] expected to be same as China - 300mg QD.
- U.S. Phase II in planning, expect to start in 2017 focusing on areas of NET unmet medical need/BTT[4] opportunity.

Activity 3: Exploratory PoC[5] in other indications

- China Ph.II studies underway in: (a) Medullary thyroid cancer; (b) Differentiated thyroid cancer; and (c) Biliary tract cancer.

[1] NET = Neuroendocrine Tumors; [2] MoA = Mechanism of Action; [3] RP2D = Recommended Phase II dose; [4] BTT = Breakthrough Therapy Designation; [5] PoC = Proof-of-concept.

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

Efficacy in pNET & non-pNET; & patients who failed on Sutent®/Afinitor®

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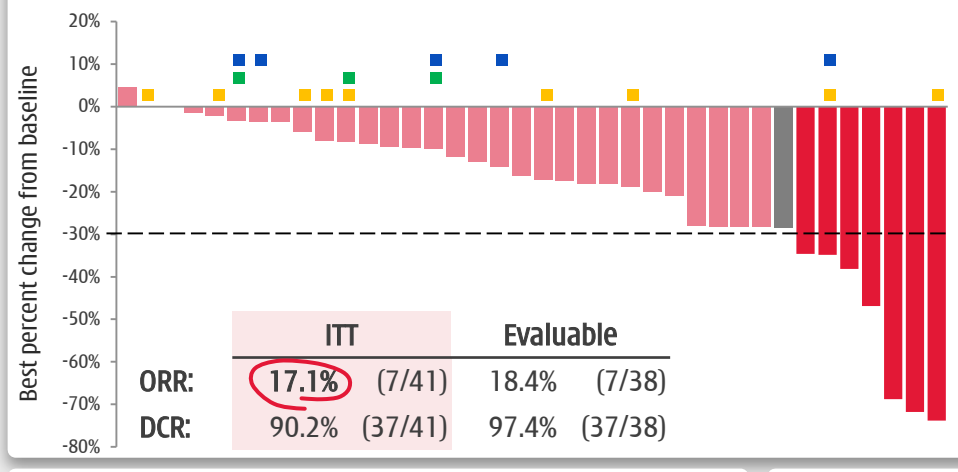
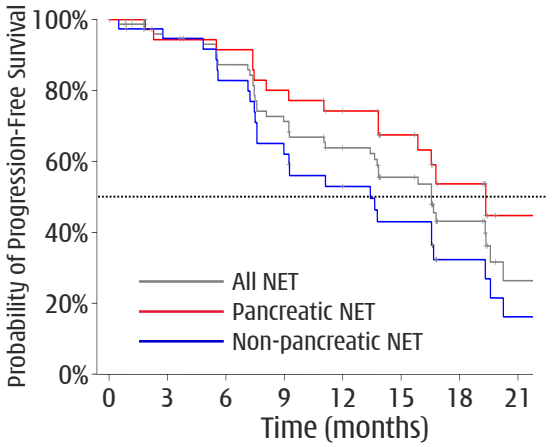
Phase II: Pancreatic NET - Highest ORR seen to date in pNET.



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

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

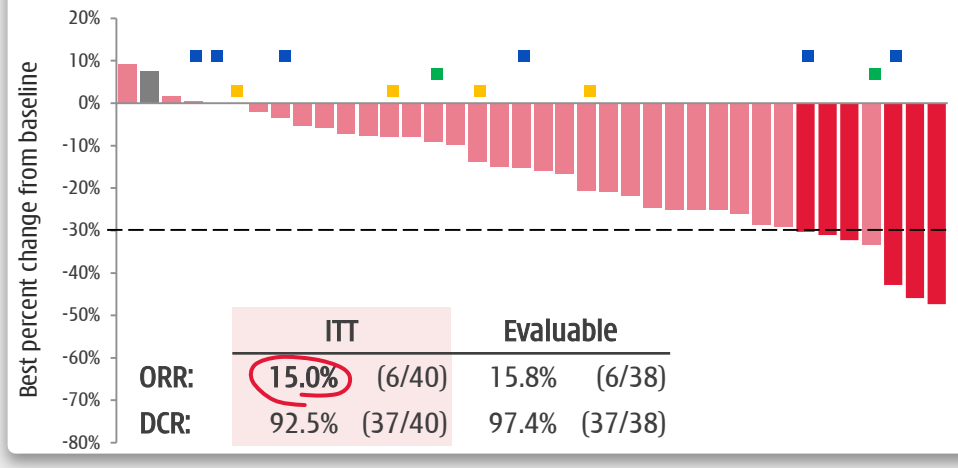
Phase II: Progression-Free Survival (PFS)



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

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

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



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

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

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

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

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

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

Tumor devascularization & central necrosis

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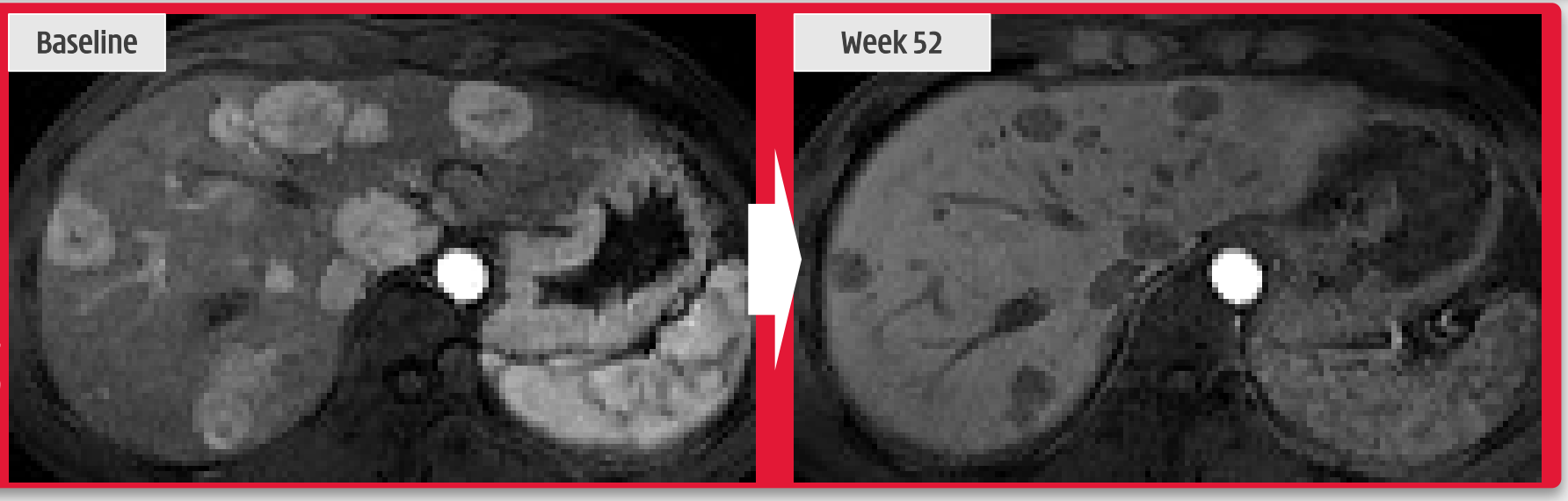
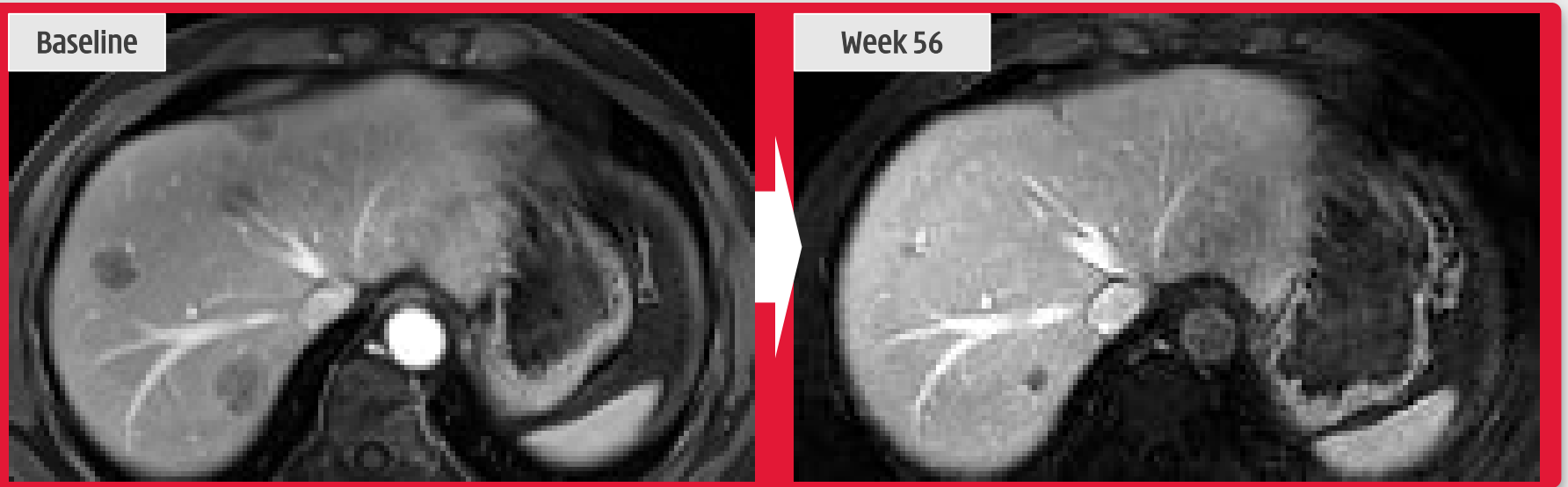
Patient 1
Duodenum NET G2
w/ multiple liver & retroperitoneal lymph node metastases



Patient 2
Rectum NET G2
w/ multiple liver metastases



Epitinib

EGFR mutation kinase inhibitor that penetrates the blood-brain barrier

Entering Phase III trials

Epitinib – Blood-brain-barrier penetrating TKI

Unmet medical need for ~50% NSCLC patients that develop brain mets[1]

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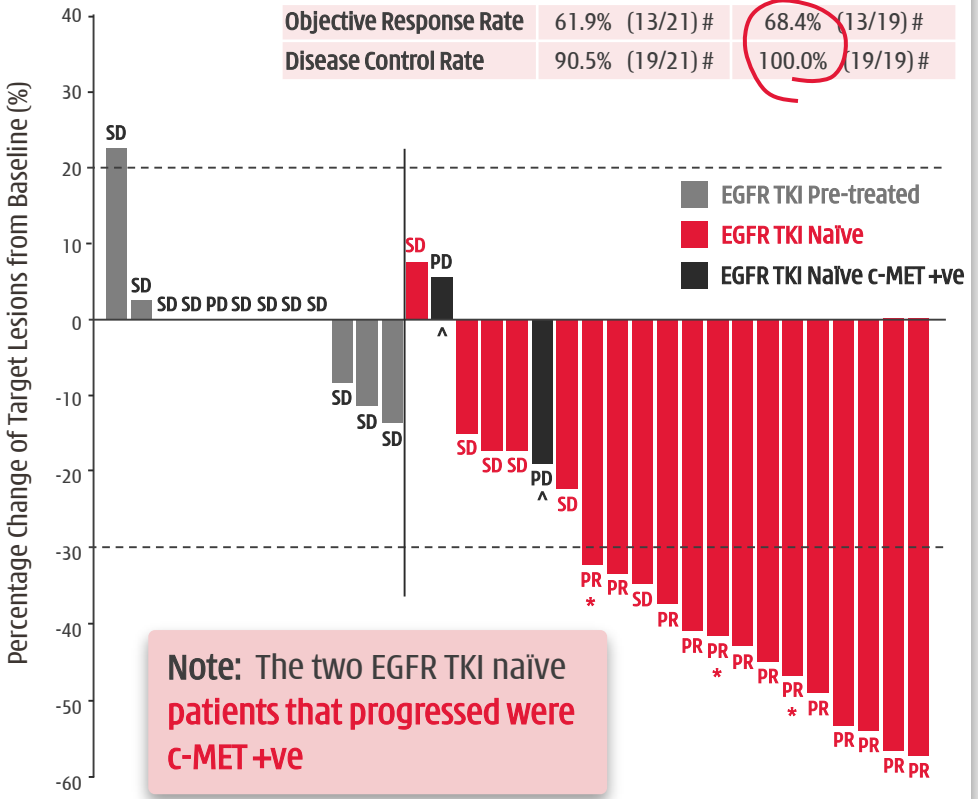
1. Phase Ib [2] – epitinib monotherapy in EGFRm+ NSCLC patients – efficacy in lung in-line with Iressa®/Tarceva®

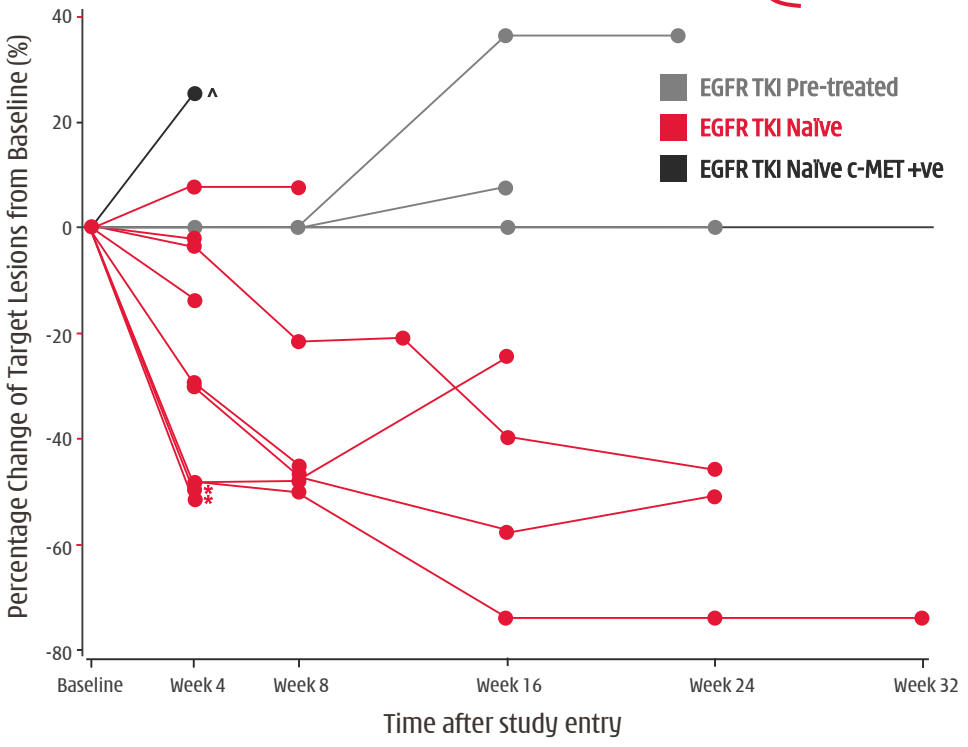
	EGFR TKI naïve (N=21)	EGFR TKI naïve excl. c-MET +ve (N=19)
Objective Response Rate	61.9% (13/21) #	68.4% (13/19) #
Disease Control Rate	90.5% (19/21) #	100.0% (19/19) #



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

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

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



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

Epitinib – Powerful Phase Ib efficacy

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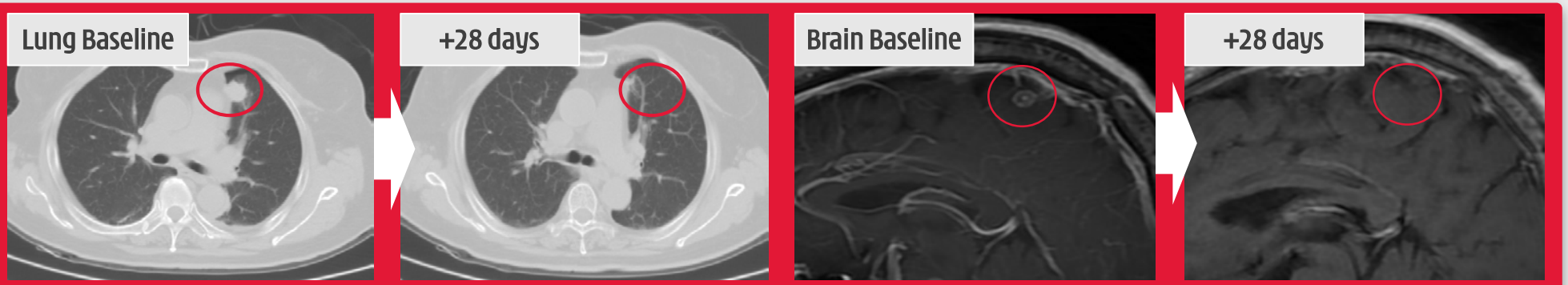
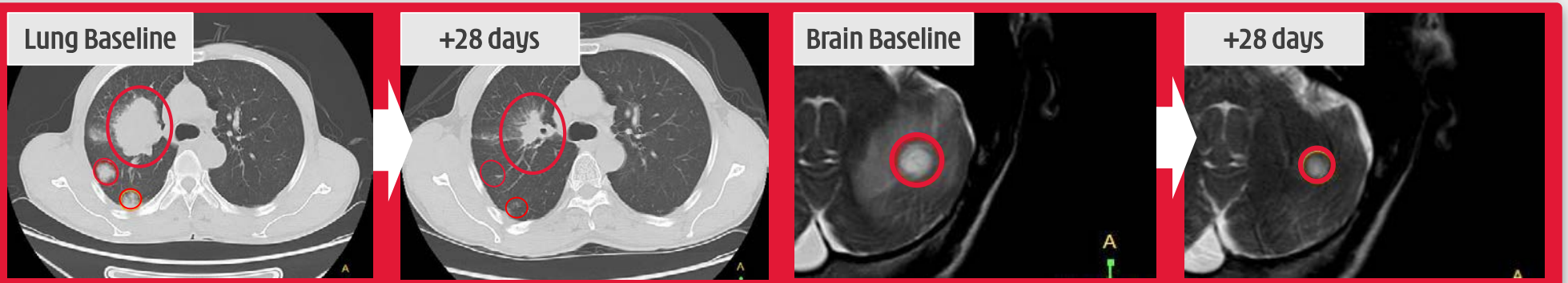
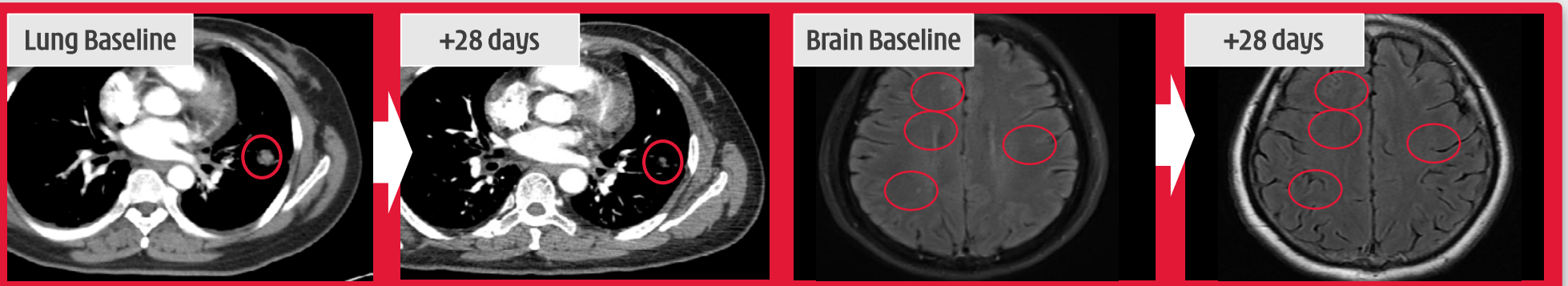
62 year old female



57 year old male



52 year old male



Epitinib – Safe & well tolerated

Pivotal Phase III study to initiate in 2017

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

Dose Escalation Stage (n=35*)
(Drug related AEs reported ›10%)

Adverse Event ("AE")	All Grades n (%)	Grade 3/4 n (%)
Skin rash	21 (60.0%)	1 (2.9%)
Diarrhea	12 (34.3%)	-
AST increase	12 (34.3%)	1 (2.9%)
ALT increase	11 (31.4%)	1 (2.9%)
Total bilirubin increase	10 (28.6%)	2 (5.7%)
Stomatitis	5 (14.3%)	-
Exfoliative dermatitis	5 (14.3%)	-
Pruritus	5 (14.3%)	-
Hyper-pigmentation	4 (11.4%)	-
Gamma-GGT increase	4 (11.4%)	2 (5.7%)
Conjugated bilirubin	4 (11.4%)	1 (2.9%)

Dose Expansion Stage (n=37)
(Drug related AEs reported ›10%)

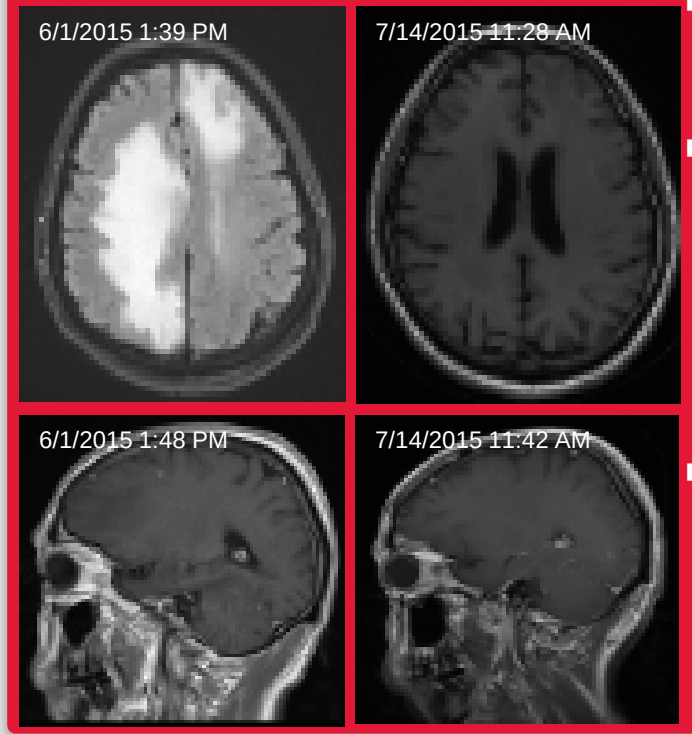
Adverse Event ("AE")	All Grades n (%)	Grade 3/4 n (%)
Skin rash	31 (83.8%)	2 (5.4%)
Hyper-pigmentation	18 (48.6%)	1 (2.7%)
ALT increase	15 (40.5%)	7 (18.9%)
AST increase	15 (40.5%)	4 (10.8%)
ASP increase	11 (29.7%)	1 (2.7%)
Diarrhea	10 (27.0%)	-
Proteinuria	10 (27.0%)	-
Total bilirubin increase	9 (24.3%)	1 (2.7%)
Hyperuricemia	9 (24.3%)	2 (5.4%)
Gamma-GGT increase	7 (18.9%)	4 (10.8%)
Stomatitis	6 (16.2%)	-

4. Now moving into Phase III pivotal study in China.

- Phase III in first-line NSCLC with brain metastasis to start:
  - ↗ Published positive Phase Ib expansion results at World Conference on Lung Cancer Dec 2016, Vienna.
  - ↗ China FDA Phase III clinical trial cleared in July 2016 – initiating Phase III in 2017.
- Glioblastoma (primary brain tumors):
  - ↗ Phase II proof-of-concept planning underway, initiating 2017.

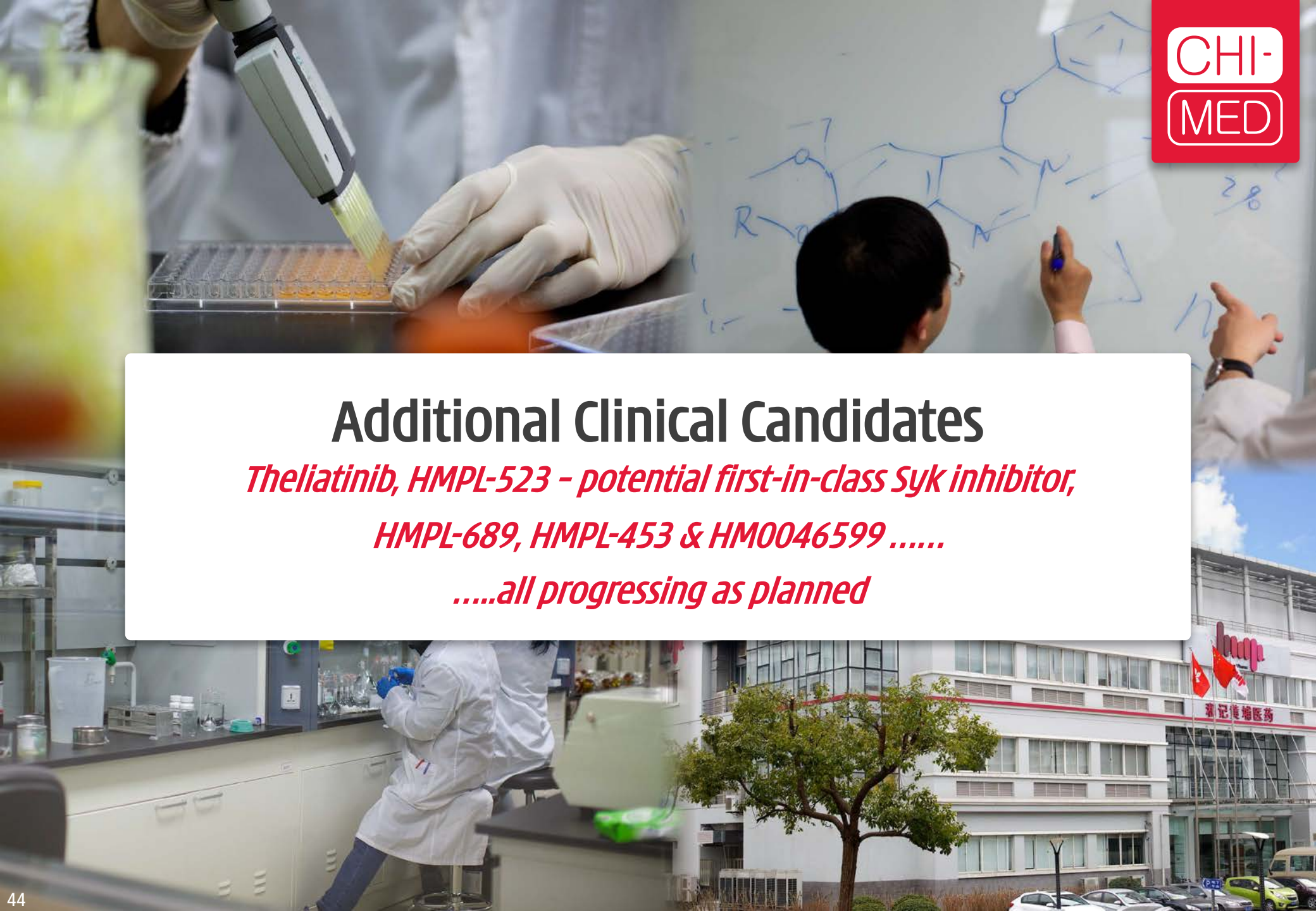
CASE STUDY – EGFR-TKI pretreated patient

- Man, 58 y.o., diagnosed with NSCLC adenocarcinoma (Exon21 L858R) on Dec 12, 2014.
- Tumor lesions located at left lung upper lobe, bone & brain cT1bN3M1.
- 3 days prior brain radiotherapy, followed by Iressa® for 5.5 months with most recent progression in the brain.



- Patient presented walking with crutch assistance.
- Epitinib 160 mg q.d. began on Jun 17, 2015. Achieved stable disease in both intracranial & extracranial lesions from week 8, & could walk without assistance.
- Remained on stable disease for 43 weeks until disease progression (pleural effusion).

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



Additional Clinical Candidates

Theliatinib, HMPL-523 – potential first-in-class Syk inhibitor,

HMPL-689, HMPL-453 & HM0046599 ……

…..all progressing as planned

Theliatinib – encouraging activity observed

Potent & highly selective TKI – strong affinity to wild-type EGFR kinase

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

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

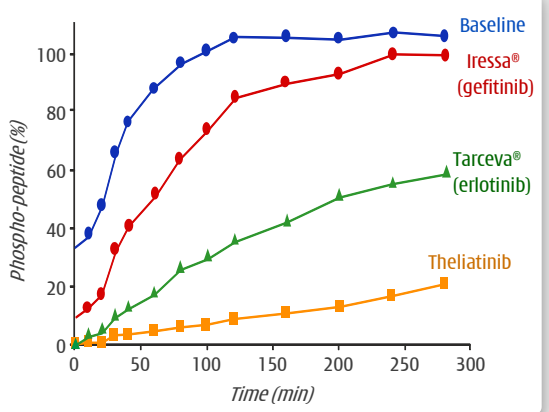
TKIs approved: Iressa®, Tarceva®

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

MAbs approved: Erbitux®, Vectibix®

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

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



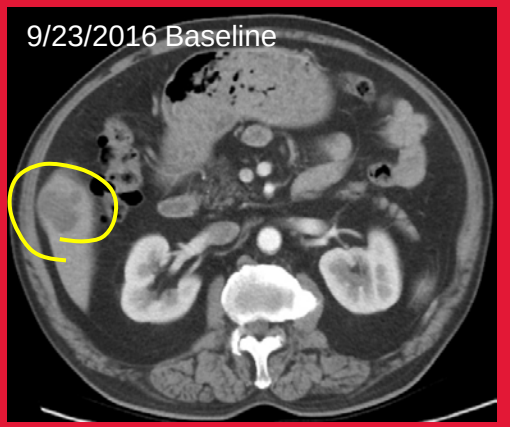
3. Esophageal cancer (EC): No effective treatment options.

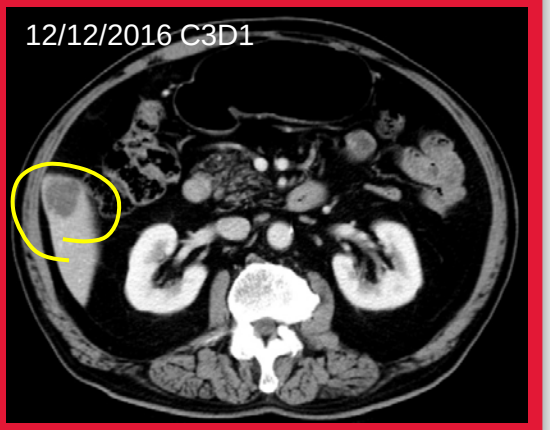
- Major issue in Asia with poor prognosis: 5 year survival 10-20%

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

CASE STUDY – EGFR protein over expression

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



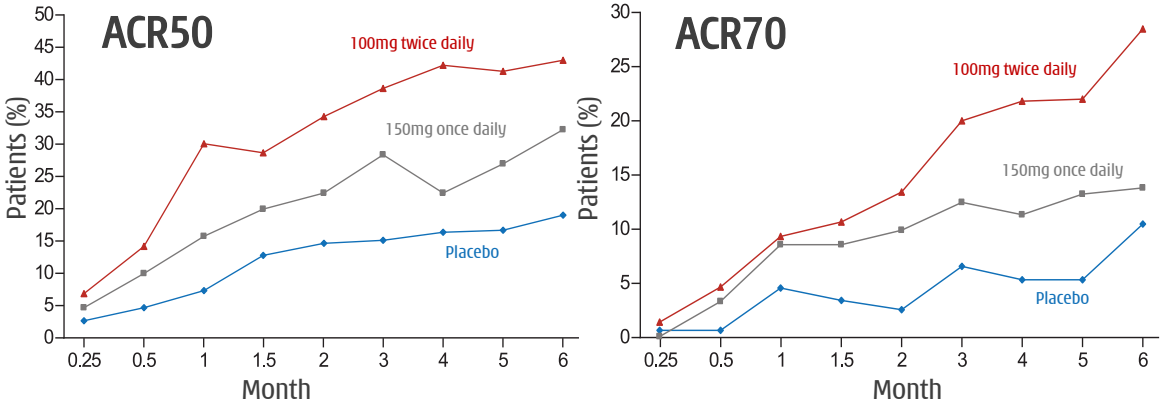


TKIs = tyrosine kinase inhibitors; MAbs = monoclonal antibodies.

HMPL-523 – superiority vs. fostamatinib

Superior selectivity, better target coverage & efficacy

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



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

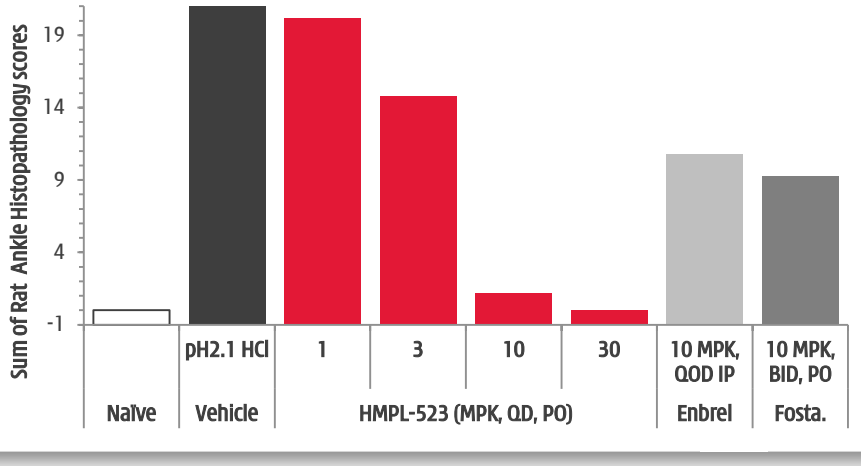
Percent of patients	Placebo (n = 153)	150mg QD (n = 152)	100mg BID (n = 152)
Diarrhea	3.0%	11.8% †	19.1% †
Upper respiratory infection	7.1	7.2	14.5 †
Urinary tract infection	4.6	3.3	5.9
Nausea	4.6	5.9	4.6
Neutropenia	0.7	6.6 †	5.9 †
Headache	5.2	6.6	5.9
Abdominal pain	2.6	6.6 †	5.9 †
ALT ›3x ULN	2.0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

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

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

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

……and very strong efficacy in preclinical RA models.

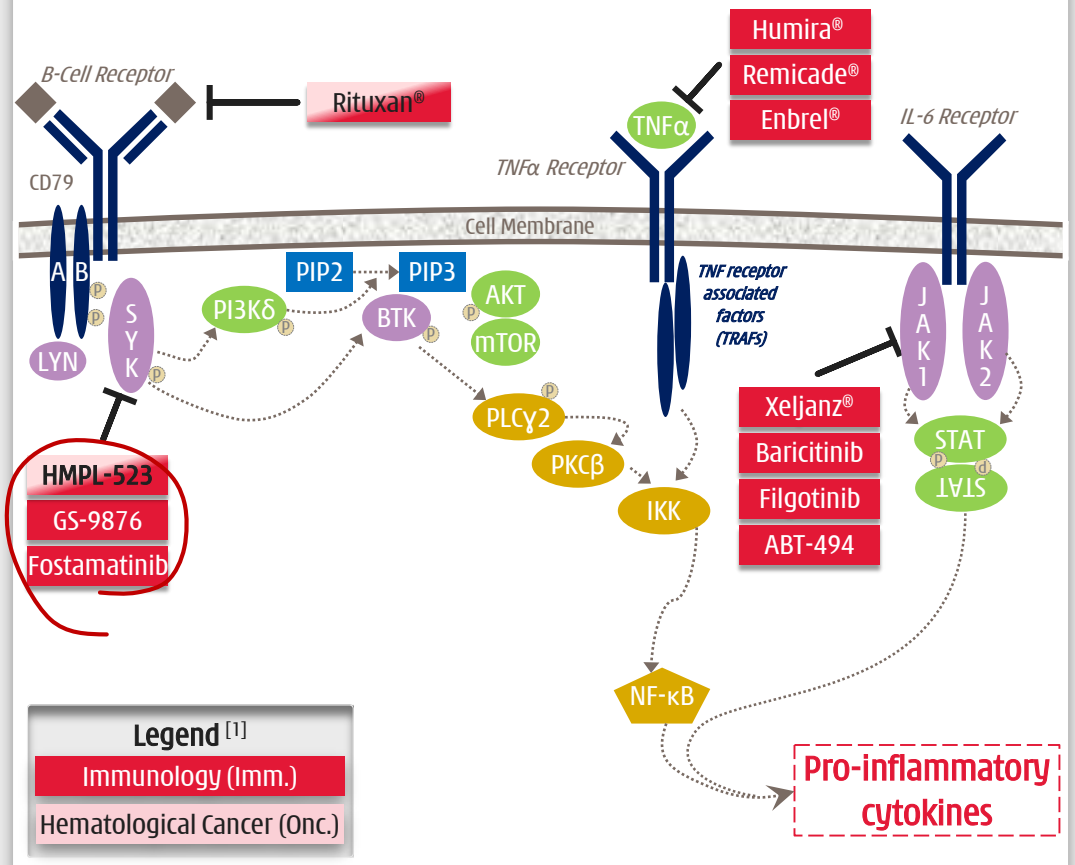


[1] Fostamatinib is a prodrug of the SYK inhibitor R406 - Phase II study data per N ENGL J MED 363;14; *: HMPL data and Eun-ho Lee, 2011; ** Birth Defects Research (Part A) 2009, 85: 130-6; [2] RA = Rheumatoid Arthritis; [3] QD = one dose per day; BID = two doses per day; QOD = one dose every other day; PO = by mouth (i.e. orally); IP = by Intraperitoneal injection; Naïve = model score without induced arthritis.

HMPL-523 – immunology potential

Potential first-in-class Syk inhibitor in immunology – Phase II in planning

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



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

(Methotrexate-IR: placebo adjusted)	ACR20	ACR50	ACR70	2016 Sales ($billion) [2]
B-Cell receptor -- mAbs				
Rituxan® (24-Week)	33%	21%	11%	1.6
Anti-TNFα/NF-κB -- mAbs				
Humira® (24-Week)	33%	29%	18%	16.1
Remicade® (24-Week)	30%	22%	8%	7.0
Enbrel® (24-Week)	44%	36%	15%	8.3
JAK Inhibitors -- Small molecules				
Xeljanz® (24-Week)	25%	23%	13%	0.9
Xeljanz® (12-Week)	28%	21%	8%	
baricitinib 4mg QD (12-Week)	30%	28%	14%	n/a
filgotinib 100mg BID (12-Week)	35%	40%	23%	n/a
ABT-494 24mg QD (12-Week)	32%	24%	18%	n/a
Syk Inhibitor -- Small molecule				
fostamatinib 100mg BID (24-Week)	32%	24%	18%	n/a

3. Substantial market potential remains in RA.

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

[1] Approved drug = ®; All other clinical candidates: mAb = antibody (extracellular); small molecule (intracellular); [2] 2016 sales in immunology only.

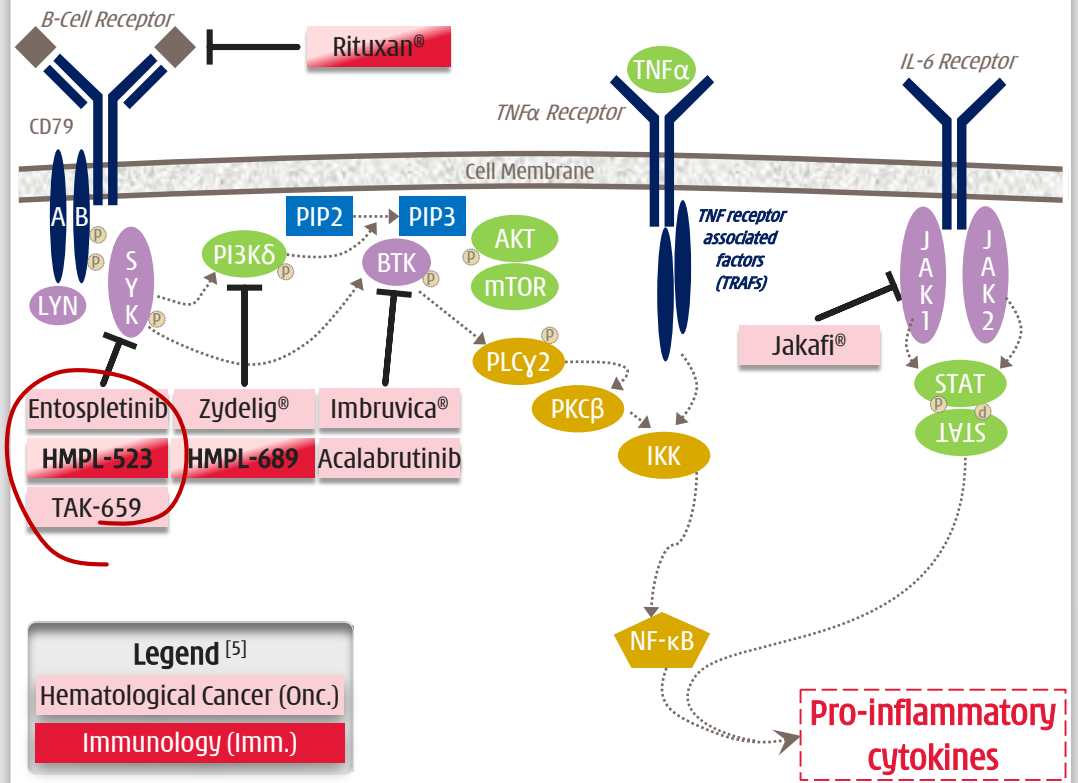
HMPL-523 - hematological malignancies

Syk exciting target emerging in oncology - Lymphoma Phase I ongoing

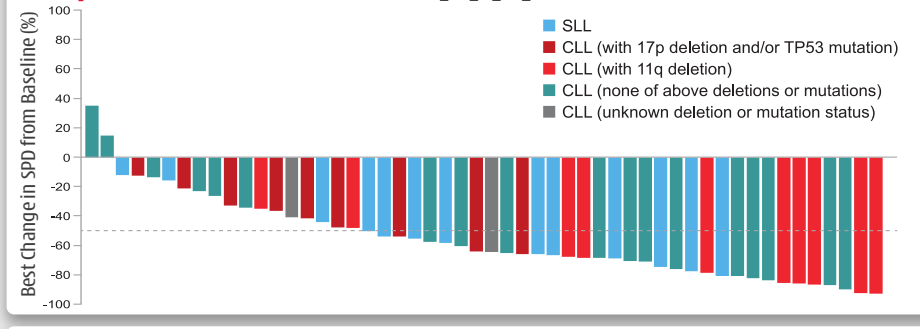
CHI-MED

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

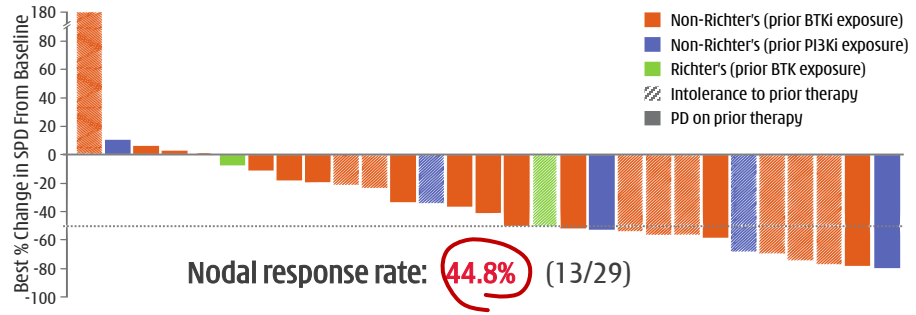
- Sales in 2016 of Imbruvica® were $1.8 billion; Zydelig® $0.2 billion; Jakafi® $0.6 billion; & Rituxan® $6.5 billion[2].



2. Entospletinib ASH[1] Dec 2015 data - 65% Nodal Response Rate in CLL & SLL[3] [6].



3. Entospletinib potential for overcoming resistance/ intolerance to Zydelig® (PI3Kδ) & Imbruvica® (BTK)[6] .



4. Entospletinib not a perfect compound[6].

- Poor solubility/oral absorption & high variation in drug exposure.
- Some CYP[4] inhibition & increased risk of drug-drug interaction.
- 66% Grade ≥3 AEs; 49% SAEs; 46% drug interruption & 20% disco.

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

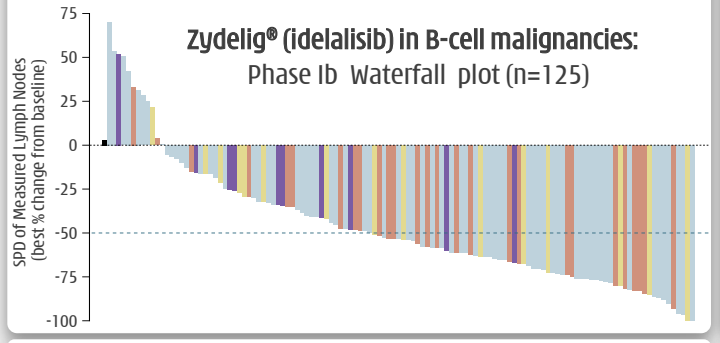
HMPL-689

Designed to be a best-in-class inhibitor of PI3Kδ - Phase I started

CHI-MED

1. PI3Kδ now a proven target.

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



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

Compound		Indication	Status	Issue
Zydelig® (idelalisib) PI3Kδ	Gilead Sciences	Chronic lymphocytic leukaemia, non-Hodgkin's lymphoma	Registered	High incidence of liver toxicity seen with idelalisib (150mg bid)
		Hodgkin's lymphoma	Phase II Trial	
		Waldenstrom's hypergammaglobulinaemia	Preclinical	
AMG-319 PI3Kδ	Amgen	B-cell lymphoma, non-Hodgkin's lymphoma, T-cell lymphoma, chronic lymphocytic leukaemia	Phase I Trial	
duvelisib[1] (IPI-145) PI3Kγ/δ	AbbVie / Infinity	B-cell lymphoma, non-Hodgkin's lymphoma, chronic lymphocytic leukaemia	Phase III Trial	Need to spare PI3Kγ -- serious infection seen with duvelisib due to strong immune suppression
		Asthma, rheumatoid arthritis	Phase II Trial	
		COPD, SLE, psoriasis, MS transplant rejection, allergy, acute lymphocytic leukaemia, T-cell lymphoma	Phase I Trial	

3. HMPL-689 -- Important asset.

Designed to improve on existing PI3Kδ inhibitors:

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

4. HMPL-689 more potent and more selective than idelalisib & duvelisib.

Enzyme IC_{50} (nM)	HMPL-689	Zydelig®	duvelisib
PI3Kδ	0.8 (n = 3)	2	1
PI3Kγ (fold vs. PI3Kδ)	114 (142x)	104 (52x)	2 (2x)
PI3Kα (fold vs. PI3Kδ)	›1,000 (›1,250x)	866 (433x)	143 (143x)
PI3Kδ human whole blood CD63+	3	14	15
PI3Kβ (fold vs. PI3Kδ)	87 (109x)	293 (147x)	8 (8x)

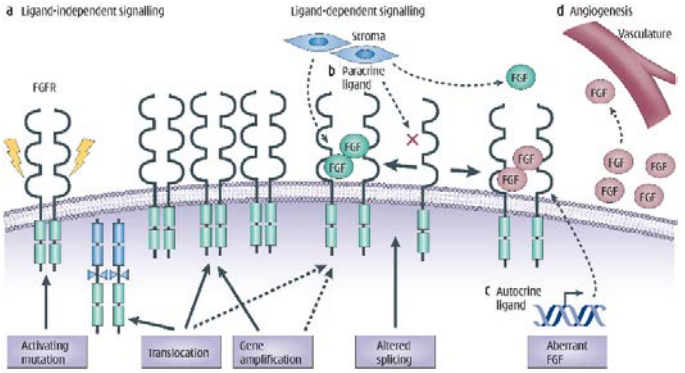
[1] COPD = Chronic obstructive pulmonary disease; SLE = Systemic lupus erythematosus; MS = Multiple Sclerosis.

HMPL-453

Designed to be a first-in-class FGFR1/2/3 inhibitor - Phase I started

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.

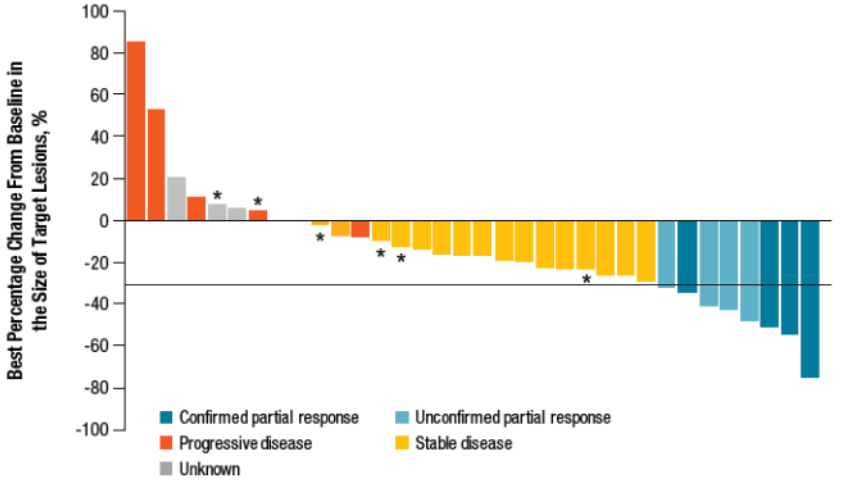


- Diverse and complicated genetic changes and multiple tumor types with low incidence

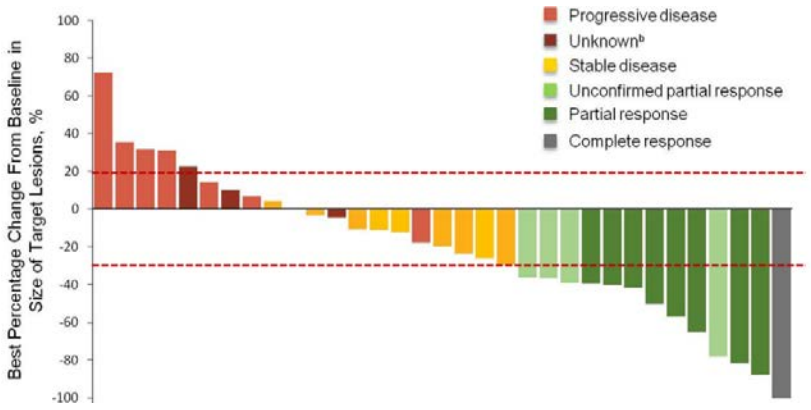
	Gene amplification	Gene translocation	Gene mutation
FGFR1	**Lung squamous** (7~15%) **H&N squamous** (10~17%) **Esophageal squamous** (9%) **Breast** (10~15%)	**Lung squamous** (n/a) **Glioblastoma** (n/a) **Myeloproliferative syndrome** (n/a) **Breast** (n/a)	**Gastric** (4%) **Pilocytic astrocytoma** (5~8%)
FGFR2	**Gastric** (5~10%) **Breast** (4%)	**Intra-hepatic 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%)

Cholangiocarcinoma (CCA) and bladder cancer have made much progress in clinic to date

- BGJ398 Phase II PoC in cholangiocarcinoma (2016 ASCO GI).



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



China Commercial Platform

Providing cash generation to fund R&D in Innovation Platform

Established high-performance pan-China pharma sales organization

Chi-Med's Commercial Platform in China

Long track record of commercial success – important source of cash

2 National house-hold name brands

白云山 上药牌

Focus on largest disease categories

Most common disease diagnosed/treated in rural hospitals[1]:

Cold/Flu:	86%
Cardiovascular:	78%
Diabetes:	46%
GI:	45%

Major commercial & production scale

~2,200 Rx & ~1,200 OTC sales people in about 300[2] cities & towns in China.

Drugs in ~18,700 hospitals detailing ~87,000 doctors.

Sold ~4.5 billion doses of medicine in 2016.

Leadership market shares

Market leader in the sub-categories/markets in which we compete[3]:

SXBX pill:[4][5] Rx Cardiovascular TCM	~12%
Banlangen:[6] OTC Anti-viral /flu TCM	~51%
FFDS tablet:[7] OTC Angina TCM	~32%

JVs with 3 leading China Pharmas

SPH 上海医药 SHANGHAI PHARMA

GPC SINOPHARM

Commercial Platform Performance – 2003-2016[8][9]

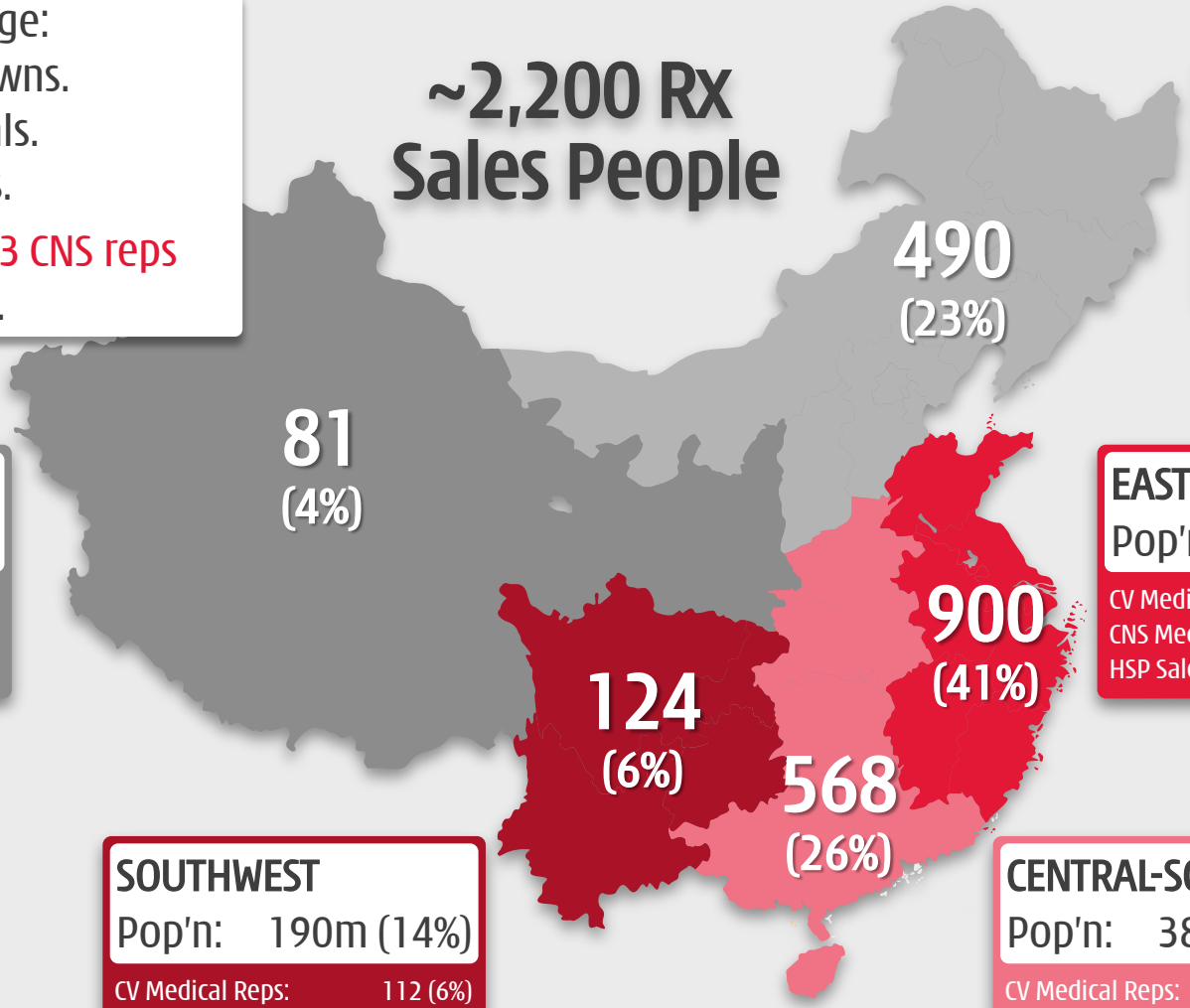
	IFRS										US GAAP				15-16
(US$ millions)	03	04	05	06	07	08	09	10	11	12	13	14	15	16	Growth
Sales	**21.9**	**27.9**	**65.1**	**101.4**	**119.0**	**155.8**	**197.0**	**236.4**	**278.6**	**360.7**	**402.3**	**465.4**	**518.9**	**627.4**	**21%**
Prescription Drugs	*17.2*	*21.8*	*23.3*	*23.2*	*28.1*	*39.5*	*54.4*	*71.2*	*92.4*	*116.5*	*138.2*	*204.9*	*286.6*	*372.3*	*30%*
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*	*10%*
Total Sales Growth	*n/a*	*27%*	*133%*	*56%*	*17%*	*31%*	*26%*	*20%*	*18%*	*29%*	*n/a*	*16%*	*11%*	*21%*	
Net (loss)/income after tax	**(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**	**144.1[11]**	**167%**
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*	*122.2*	*284%*
Consumer Health	*(10.3)*	*(4.9)*	*0.3*	*5.4*	*9.3*	*11.9*	*15.5*	*16.0*	*15.9*	*15.4*	*17.2*	*22.3*	*22.2*	*21.9*	*-1%*
% 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%*	*23.0%*	
Net (loss)/income attrib. to Chi-Med	**(5.7)**	**(3.7)**	**(0.5)**	**1.2**	**4.5[10]**	**5.9[10]**	**9.3[10]**	**12.6[10]**	**13.6[10]**	**14.6[10]**	**18.2[10]**	**22.8[10]**	**25.2[10]**	**70.3[11]**	**180%**
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*	*61.1*	*284%*
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*	*0%*
Net (loss)/income attrib. to Chi-Med growth	*n/a*	*-35%*	*-86%*	*340%*	*275%*	*31%*	*58%*	*35%*	*8%*	*7%*	*n/a*	*26%*	*10%*	*180%*	

[1] Frost & Sullivan; [2] 300 cities & towns covered by Prescription Drug Business and 600 cities & towns including OTC business; [3] Frost & Sullivan 2015 market share data; [4] China coronary heart disease oral Chinese patented drugs market share; [5] She Xiang Bao Xin Pill ("SXBX pill"); [6] Banlangen Granules ("Banlangen") - OTC Antiviral; [7] Fu Fang Dan Shen tablets ("FFDS"); [8] 2003-2006 incl. disco. operation; [9] Prescription Drugs includes SHPL and Hutchison Sinopharm; and Consumer Health includes HBYS, HHO, HHL, and HCPL; [10] Continuing Operations; [11] Included the land compensation from SHPL of US$80.8 million and US$40.4 million at net income after tax and net income attributable to Chi-Med respectively.

A powerful Rx Commercial Platform in China

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

- National Coverage:
  ~300 cities & towns.
  ~18,700 hospitals.
  ~87,000 doctors.
- New team of 143 CNS reps built since 2015.



NORTH
Pop'n: 320m (23%)

CV Medical Reps:	458 (23%)
CNS Medical Reps:	32 (22%)
HSP Sales staff:	0 (0%)

WEST
Pop'n: 100m (7%)

CV Medical Reps:	76 (4%)
CNS Medical Reps:	5 (3%)
HSP Sales staff:	0 (0%)

EAST
Pop'n: 393m (28%)

CV Medical Reps:	808 (40%)
CNS Medical Reps:	61 (43%)
HSP Sales staff:	31 (100%)

SOUTHWEST
Pop'n: 190m (14%)

CV Medical Reps:	112 (6%)
CNS Medical Reps:	12 (9%)
HSP Sales staff:	0 (0%)

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

CV Medical Reps:	535 (27%)
CNS Medical Reps:	33 (23%)
HSP Sales staff:	0 (0%)

Notes: 2010 Population - China State Census;
CV = Cardiovascular; CNS = Central nervous system.
Chi-Med Rx sales team data = 31 December 2016

Deep portfolio of household name drugs

›200 products – Top 7 represent 63% of sales[1] and 92% of gross profit[1]

CHI-MED

Main Products -- SALES[2]	2011	2012	2013	2014	2015	2016
 ***SXBX pill*** Coronary artery disease (Rx) 12% National market share Patent expiry 2029	79,438 *+32%*	102,215 *+29%*	123,587 *+21%*	138,848 *+12%*	159,326 *+15%*	195,371 *+23%*
 ***FFDS tablet*** Angina (OTC) 32% National market share	57,001 *-3%*	60,181 *+6%*	69,996 *+16%*	76,297 *+9%*	60,154 *-21%*	59,906 *0%*
 ***Banlangen granules*** Anti-viral/flu (OTC) 51% National market share	57,278 *+8%*	65,381 *+14%*	72,300 *+11%*	55,573 *-23%*	54,793 *-1%*	56,664 *+3%*
 ***Seroquel tablets*** Bi-polar/Schizophrenia (Rx) 5% National market share	n/a	n/a	n/a	n/a	21,131	34,380 *+63%*
 ***NXQ tablet*** Cerebrovascular disease (Rx) Proprietary formulation	3,741 *+55%*	6,933 *+85%*	10,142 *+46%*	14,681 *+45%*	17,581 *+20%*	21,000 *+19%*
 ***KYQ granules*** Periodontitis (OTC) ›90% National market share	15,412 *+22%*	16,351 *+6%*	16,318 *0%*	18,370 *+13%*	17,051 *-7%*	17,210 *+1%*
 ***Danning tablet*** Gallbladder/stone (Rx) Patent expiry 2027	9,914 *+22%*	11,648 *+17%*	12,364 *+6%*	13,822 *+12%*	13,526 *-2%*	9,041 *-33%*

[1] Based on aggregate sales and gross profit of consolidated subsidiaries and non-consolidated joint ventures; [2] Rx = prescription drug; OTC = over-the-counter drug; SXBX pill = She Xiang Bao Xin pill; FFDS tablet = Fu Fang Dan Shen tablet; NXQ table = Nao Xin Qing tablet; KYQ granules = Kou Yan Qing granules; Market shares according to Frost & Sullivan.

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

Financial Guidance & Upcoming Catalysts

2017 Guidance

Over performance in 2016 – Strong Commercial Platform & property gain

(US$ millions)	2016 Actual	2017 Guidance
Revenues	216.1	225.0 – 240.0
Innovation Platform		
Revenue	35.2	35.0 – 40.0
Innovation platform operating expenses	(76.1)	(85.0) – (90.0)
Commercial Platform		
Sales (consolidated)	180.9	190.0 – 200.0
Sales of non-consolidated joint ventures	446.5	480.0 – 500.0
Net income attributable to Chi-Med – Total	70.3	46.0 – 50.0
- Core business	29.9	32.0 – 34.0
- One-time property compensation gain	40.4 [1]	14.0 – 16.0 [2]
Chi-Med Group Costs		
General & admin. expenses (incl. interest/tax)	(17.9)	(18.0) – (19.0)
Net (Loss)/Income Attributable to Chi-Med	11.7	(13.0) – (28.0)

Balance Sheet

- $173.7m available cash resources (Dec 31, 2016) at Chi-Med Group level.
  - ✓ $103.7m cash & cash equiv. & ST invest.[3]
  - ✓ $70m unutilized banking facilities.
- ~$40m dividend from JV to Group level in mid-2017.
  - ✓ JVs – no bank borrowings.
  - ✓ JV cash $91.0m before dividend payout (Dec. 31, 2016).
- $46.8m bank borrowings as at December 31, 2016.

[1] one-time gain from Shanghai land disposal; [2] one-time gain from Guangzhou land disposal – subject to finalization of Guangzhou urban redevelopment policy; [3] Short-term investments 3-6 month deposits.

Expected 2017 catalysts

Target to publish data on 4 drug candidates in 5 Phase II-III studies:

- ✓ **Savolitinib:**
  1. Phase II **median overall survival data in PRCC** patients;
  2. **Phase IIb data in second-line NSCLC** combinations with Tagrisso® & Iressa®;
  3. Phase II dose finding data in ccRCC combination with durvalumab (PD-L1).
- ✓ **Fruquintinib:**
  4. **Phase III FRESCO study full data set** publication in CRC patients.
- ✓ **Sulfatinib:**
  5. Preliminary Phase II proof-of-concept data in medullary and differentiated thyroid cancer patients.
- ✓ **HMPL-523 (Syk):**
  6. Preliminary Phase Ib proof-of-concept data in hematological cancer patients.

Target to achieve multiple late-stage/global clinical & regulatory milestones by end of 2017:

- ✓ **Savolitinib:**
  1. Initiate **global Phase III study in PRCC** patients;
  2. Initiate **global Phase III study in second-line NSCLC** in combination with Tagrisso®;
- ✓ **Fruquintinib:**
  3. **Submit New Drug Application** ("NDA") in China in third-line CRC;
  4. Initiate **China Phase III study in second-line gastric cancer** patients;
  5. **Complete enrollment of Phase III FALUCA** study in third-line NSCLC;
  6. Initiate **U.S. Phase I bridging study** in Caucasian patients.
- ✓ **Epitinib:**
  7. Initiate **China Phase III study in first-line EGFR-mutant NSCLC** patients with brain metastasis;
  8. Initiate China Phase II study in glioblastoma (primary brain cancer).
- ✓ **Sulfatinib:**
  9. Initiate **U.S. Phase II study in NET** patients.
- ✓ **HMPL-523:**
  10. Initiate **Australian Phase Ib/II expansion study in hematological cancer** patients.
- ✓ **HMPL-689 (PI3Kδ):**
  11. Initiate Phase I studies in China in hematological cancer patients.
- ✓ **HMPL-453 (FGFR-1/2/3):**
  12. Initiate Phase I studies in Australia/China in solid tumor patients.

Appendices

2016 Financial Results

Record net income – despite ~$76 million innovation platform investment

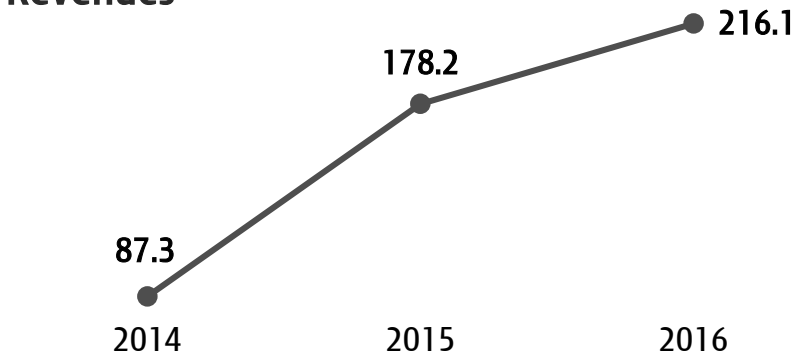
CHI-MED

Financial Summary

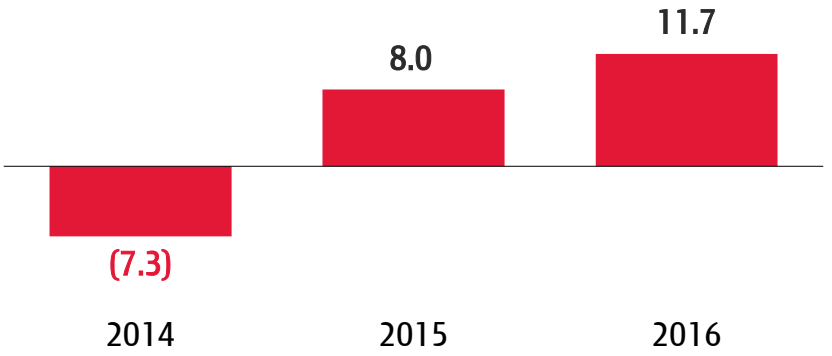
	2014	2015	2016	Change 14-15	Change 15-16
Revenues	**87.3**	**178.2**	**216.1**	**104%**	**21%**
Unconsolidated JV Revenues	*398.4*	*392.7*	*446.5*		
Net (Loss)/Income [1]					
Innovation Platform	**(22.2)**	**(3.8)**	**(40.7)**	**83%**	**~10x**
Base HMP Operations	*(13.8)*	*(0.0)*	*(36.5)*		
50% share of Nestlé JV (NSP) [2]	*(8.4)*	*(3.8)*	*(4.2)*		
Commercial Platform (Con't. Operations)	**22.8**	**25.2**	**70.3**	**10%**	**180%**
Prescription Drugs Business	**13.2**	**15.9**	**61.1**		
- *Base business*	*13.2*	*15.9*	*20.7*	**20%**	**30%**
- *Land compensation (SHPL) [3]*	-	-	*40.4*		
Consumer Health Business	**9.6**	**9.3**	**9.2**	**-4%**	**0%**
Chi-Med Group Costs	**(9.0)**	**(13.4)**	**(17.9)**	**-49%**	**-34%**
General & administrative Expenses	*(6.4)*	*(10.9)*	*(12.6)*		
Interest/Tax	*(2.6)*	*(2.5)*	*(5.3)*		
Discontinued Operations	1.0	-	-	**n/a**	**n/a**
Net (Loss)/Income Attrib. to Chi-Med	**(7.3)**	**8.0**	**11.7**	**n/a**	**46%**
EPS Attrib. to Company (Basic) (US$)	**(0.14)**	**0.15**	**0.20**	**n/a**	**34%**
Accretion per share on redeemable NCI-Non-cash [4]	*(0.48)*	*(0.79)*	-		
EPS Attrib. to Ordinary Shareholders (Basic)[5]	(0.62)	(0.64)	0.20	n/a	n/a

Group Results

Revenues



Net (Loss)/Income [1]



[1] Net (Loss)/Income = Net (Loss)/Income attributable to Chi-Med; [2] NSP = Nutrition Science Partners Limited; [3] SHPL = Shanghai Hutchison Pharmaceuticals Limited; [4] Non-cash accretion relates to Mitsui's share in Innovation Platform, which was exchanged for Chi-Med shares in July 2015; [5] Including adjustment for accretion on redeemable non-controlling interests.

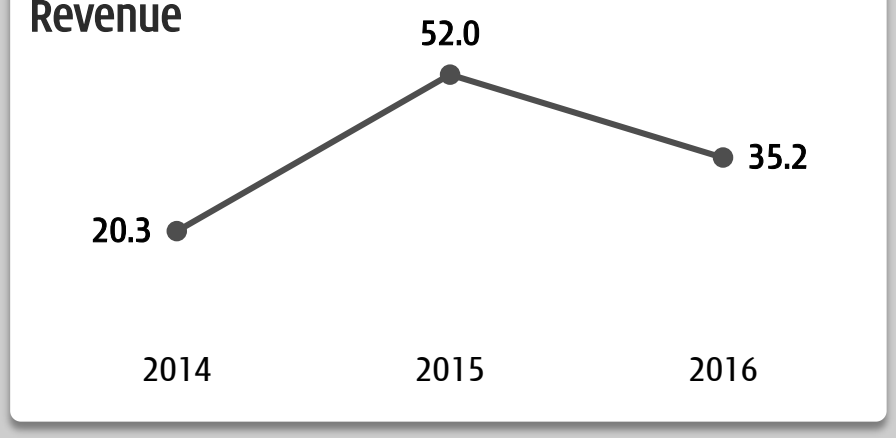
(US$ millions, except per share data)

Financial performance of main platforms

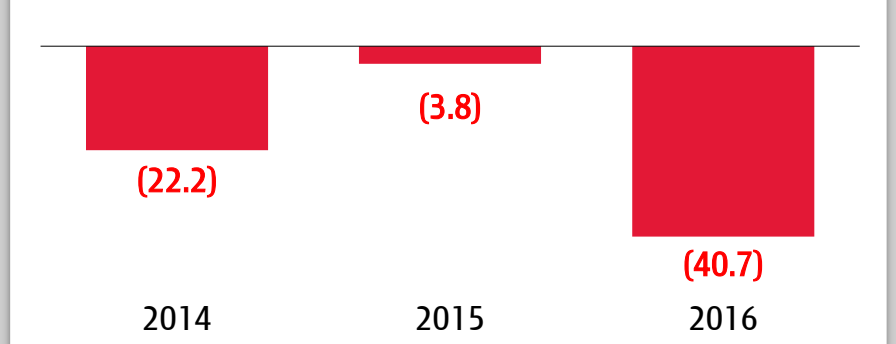
Sustainable biotech business model – ~~$170 million~~ available cash[1]

Innovation Platform

Revenue

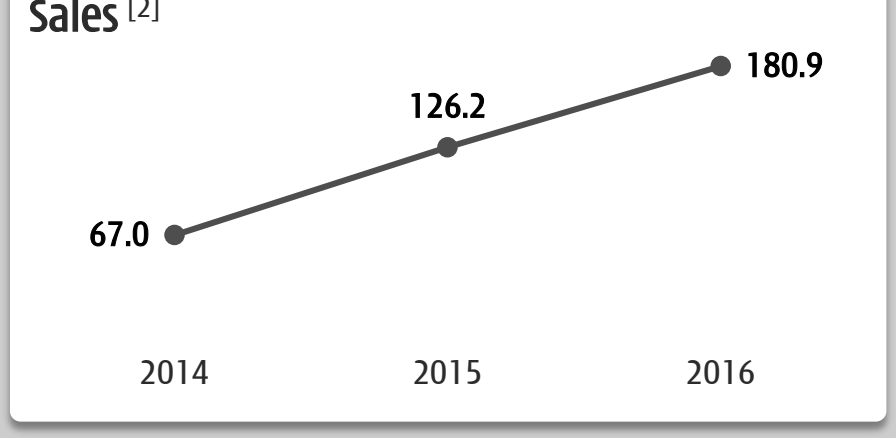


Net Loss [3]

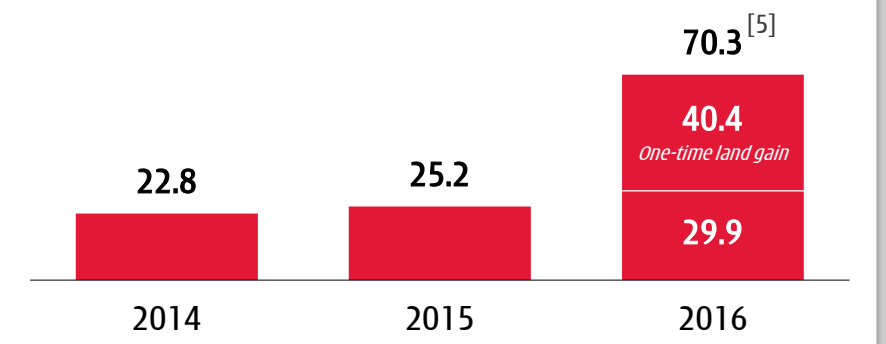


Commercial Platform

Sales [2]



Net Income [3] [4]



(US$ millions)

[1] Cash and cash equivalents, short-term investments and unutilized banking facilities; [2] Only includes sales of subsidiaries for Prescription Drugs and Consumer Health businesses - excludes joint ventures; [3] Net Income/(Loss) = Net Income/(Loss) attributable to Chi-Med; [4] Continuing Operations; [5] Includes share of gain from SHPL's land compensation of US$40.4 million.

Sufficient cash to fund pipeline well into 2019

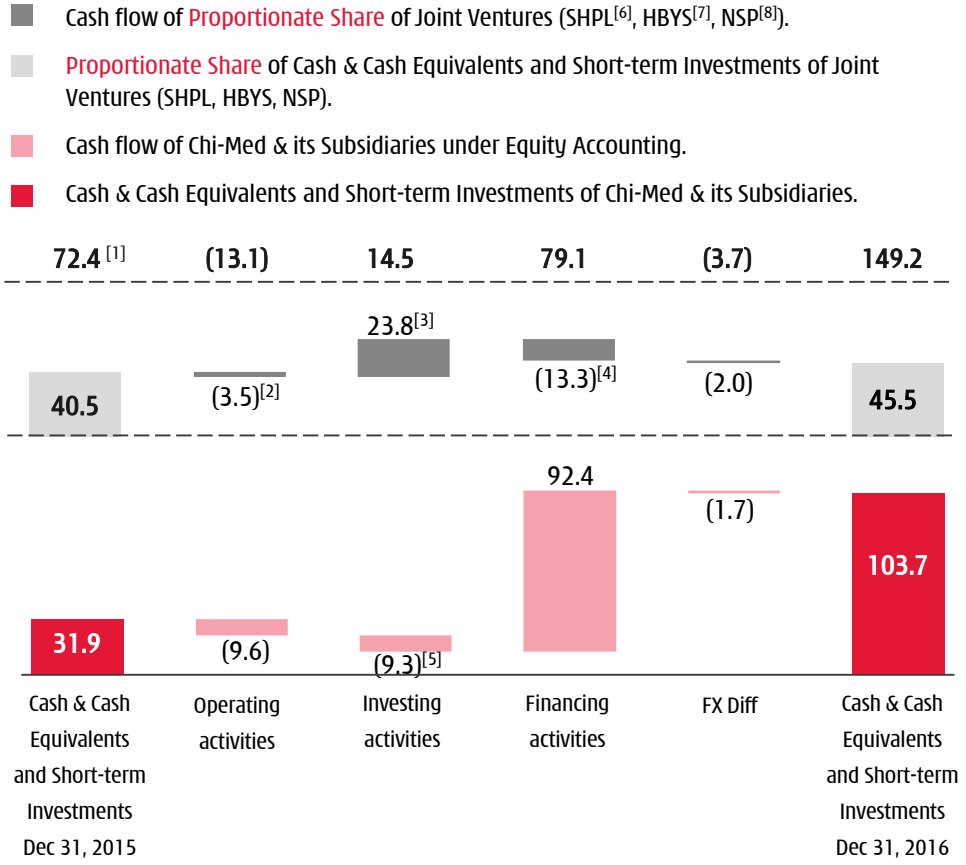
Nasdaq listing, new bank facilities, land compensation & subsidies

Chi-Med Group-level Cash Position:

- **$173.7 million available cash resources as at December 31, 2016** (Dec 31, 2015: $38.8m).
  - ✓ **$103.7m cash & cash equivalents & short-term investments**[9] – raised $95.9m (net of costs) on Nasdaq in Mar 2016.
  - ✓ **$70m in unutilized banking facilities** from BAML, DB & HSBC held as at December 31, 2016 $40m of which expired in Feb 2017[10].
  - ✓ **New $70.0m bank facilities (unutilized)** – Set up new $70.0m unsecured 18 month facilities with BAML/DB in Feb 2017.
- **$46.8 million in bank borrowings as at December 31, 2016** (December 31, 2015: $49.8m).

JV-level Cash Position:

- **$91.0 million available cash as at December 31, 2016** (December 31, 2015: $80.9m).
  - ✓ **JVs have no bank borrowings.**
  - ✓ **~$72m cash from land compensation & subsidies received in 2016**[11] **~$40m dividend to Chi-Med Group level in H1 2017.**



[1] Cash & Cash Equivalents and Short-term Investments of Chi-Med & its Subsidiaries & Proportionate Share of Joint Ventures (SHPL, HBYS, NSP).
[2] $27.0m proportionate share of cash generated from operating activities less $30.5m adjustment of dividend received in consolidation level.
[3] $0.1m proportionate share of cash used in investing activities offset with $5.0m adjustment of capital injection to NSP in consolidation level and $18.9m adjustment of net proceeds from Short-term Investments.
[4] $38.8m proportionate share of cash used in financing activities offset with a net total of $25.5m adjustments of dividend received and NSP capital injection mentioned in items [2] and [3].
[5] $33.6m of cash used in investing activities offset with $24.3m adjustment of net deposit in Short-term Investments.

[6] SHPL = Shanghai Hutchison Pharmaceuticals Limited; [7] HBYS = Hutchison Whampoa Guangzhou Baiyunshan Chinese Medicine Company Limited; [8] NSP = Nutrition Science Partners Limited- JV with Nestlé Health Science S.A.; [9] Short-term investments 3-6 month deposits; [10] BAML = Bank of America Merrill Lynch, DB = Deutsche Bank, HSBC = Hong Kong Shanghai Banking Corporation; [11] In addition to the US$31.1 million (30%) first installment received in December 2015, 60% payment from Shanghai government for surrender of land use rights at old factory and government subsidies was received in 2016.The remaining 10% payment has been received in Feb 2017.

(US$ millions)

Inter-group cash flow

~$103.7m in cash available (end-2016); $70m in undrawn bank facilities

Pharma Partners
AstraZeneca; Janssen; Nestlé; Eli Lilly

Undisclosed

$27.6m

Capital Markets
AIM (~$75m - 19 May'06)
Nasdaq (~$96m - 17 Mar'16)

ESOP & Treasury Shares

Bank loans *(end-2016)*
Drawn down: $46.8m
Unutilised facility: $70.0m

$95.9m[4]

$0.2m

$3.1m

Innovation Platform *(end-2016)*
Cash & Equivalents : $18.1m
(end-2015: $14.9m)

$36.0m

Chi-Med Group Level *(end-2016)*
Cash & Equivalents & S-T investment[5]: $103.7m
(end-2015: $31.9m)

$14.5m

Chi-Med Group
Operating cost: $14.5m

$2.4m[1]

$71.9m[2]

$30.5m

JV Level *(end-2016)*
Cash & Equivalents: $5.4m
(end-2015: $2.6m)

Commercial Platform - SHPL/HBYS *(end-2016)*
Cash Equivalents & S-T investment: $85.6m
(end-2015: $78.3m)

$4.2m[3]

$72.2m

$13.7m

$26.5m

Innovation platform burn:
Spending 2016 : $76.1m
(2015: $55.8m)

Property
SHPL Land compensation[6]

CAPEX
SHPL/HBYS new factory const.

Bank loans *(end-2016)*
Drawn down: $0m
Unutilised facility: Open

[1] $5.0m capital injection to NSP offset by $7.4m service income received from NSP; [2] Including research & development cost and general & admin. expenses; [3] Share of NSP operating loss; [4] Net proceeds: Gross proceeds deducted underwriting discounts and commissions, and other offering expenses; [5] Including $24.3m short-term investment (over 3-month deposit) as at end of 2016; [6] Included cash received for SHPL land compensation and government subsidies in 2016.

(US$ millions)

Risk-balanced pipeline & strategy

CHI-MED

FIRST

be the fastest to solve issues on high potential but difficult targets.

- Fix compound-related issues of failed first movers – c-Met (renal tox.) & Syk (selectivity).
- Difficult novel kinase targets with deep body of evidence – FGFR (patient selection).
- Take fast action while others stuck in debate.

BEST

use world-class chemistry to design differentiated 2nd generation TKIs.

- No target related risk – VEGFR, EGFR & PI3Kδ.
- Create 2nd generation TKIs w/ high selectivity & superior pharmacokinetic properties.
- A lot of room to optimize 1st generation TKIs – tolerability, safety, efficacy.

STRENGTHS

Lower costs, huge team, & low-risk /fast clinical – leveraging China's advantages.

- Large China patient population enables rapid & lower risk development to proof-of-concept.
- Can afford to run ~330-person scientific team to create/manage diversified 8 asset portfolio.
- Practical, minimally dilutive, finance.

- Deep & DIVERSIFIED clinical pipeline.
- MULTIPLE fully funded pivotal studies – Not a binary proposition.
- SOLID CASH flow from Commercial Platform & global partners.

TKI = Tyrosine kinase inhibitors

Three collaborations have major aggregate financial impact

AstraZeneca

Lilly

Nestlé Health Science

~$1.2 billion in Partner payments to HMP/NSP[1]:

- **$118.5 million** in upfront /milestone payments and equity injections as at December 31, 2016.
- **up to $350 million** in further development and approvals milestones
- **up to $145 million** in option payments.
- **up to $560 million** in commercial milestones.
- customary tiered royalties on net sales.

Clinical trial spending[2]:

- clinical costs for partnered drug candidates estimated at several hundred million US dollars.
- **Partners to fund the vast majority of these clinical costs.**

Possible payment events in early 2017:

- **Savolitinib (AZD6094):** Phase III initiation PRCC[3]

[1] Nutrition Science Partners Limited ("NSP") is the 50/50 joint venture between Nestlé Health Science ("Nestlé") and Chi-Med; [2] includes clinical and direct non-clinical costs.
[3] PRCC = papillary renal cell carcinoma.

(US$ millions)

Sulfatinib – global potential

Current approved treatments for NET remain somewhat limited

	Somatostatin Based Therapies			Kinase Inhibitor Therapies		
	Sandostatin® (octreotide)	**Somatuline Depot® (lanreotide)**	**Lutathera® (^{177}Lu-Dotatate) [3]**	**Afinitor® (everolimus)**	**Sutent® (sunitinib)**	**Sulfatinib**
Mechanism of Action	Somatostatin analogue	Somatostatin analogue	Somatostatin receptor targeting radiotherapy	mTOR inhibition	Inhibits multiple receptor tyrosine kinases	VEGFR/FGFR1 & CSF-1R inhibition
Mode of administration	Deep subcutaneous or intravenous injection	Deep subcutaneous injection	Subcutaneous injection or intravenous injection	Oral tablet	Oral capsules	Oral tablet
Shelf-life	3 years	2 years	3 days (½ life)	3 years	3 years	
Primary Tumor Site						
Pancreas (6% NET)	✗	✗	✗	✓	✓	✓
Entire GI tract (67% NET)	✗	✓	✗	✓	✗	✓
with Mid-gut (20% NET)	✓	✓ *(Ki67‹10%)*	✓	✓	✗	✓
Lung & Thymus (27% NET)	✗	✗	✗	✓	✗	✓
Other	✗	✗	✗	✗	✗	✓
	Sandostatin® / Placebo	**Somatuline Depot® / Placebo**	**Lutathera [4] / Sandostatin LAR 30mg**	**Afinitor® / Placebo**	**Sutent® / Placebo**	**Sulfatinib [2] (Ph.II ITT pop. N=81)**
Median PFS (months)	14.3/6.0	NR / 18.0	Est. ~40.0 / 8.4 (mid-gut)	11.0 / 4.6 (pancreatic) 11.0 / 3.9 (lung & GI)	11.4 / 5.5	19.4 (pancreatic) 13.6 (All non-pancreatic)
Hazard Ratio	0.34	0.47	0.21 (mid-gut)	0.35 (pancreatic) 0.48 (lung & GI)	0.42	
(*p-value*)	*0.000072*	*‹0.001*	*‹0.001*	*‹0.001 (pancreatic)* *‹0.001 (lung & GI)*	*‹0.001*	
Objective Response Rate [1]	2% / 2%	NR	18% / 3% (mid-gut)	5% / 2% (pancreatic) 2% / 1% (lung & GI)	9% / 0%	17.1% (pancreatic) 15.0 % (All non-pancreatic)
Disease Control Rate [2]	69% / 40%	NR	95% / 76% (mid-gut)	73% / 51% (pancreatic) 81% / 64% (lung & GI)	72% / 60%	90.2% (pancreatic) 92.5% (All non-pancreatic)

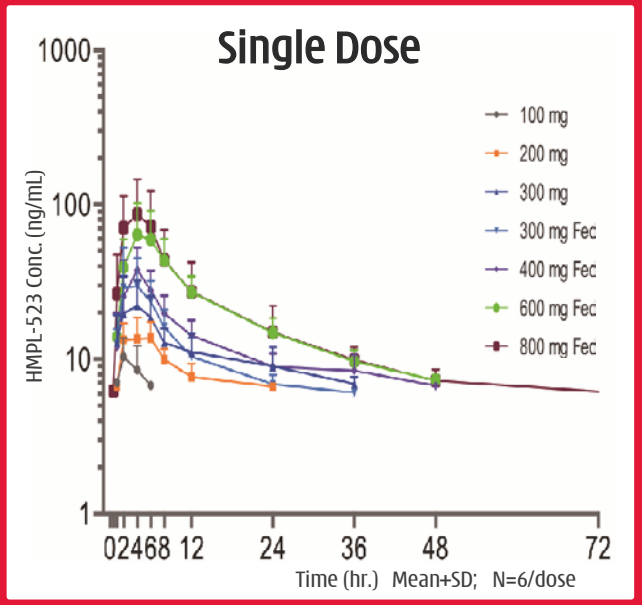
[1] ORR = percent of patients with ›30% tumor diameter shrinkage; [2] Sulfatinib Phase I: Intent to Treat ITT population = 21; patients evaluable for efficacy = 18; 3 patients withdrawn/lost to follow-up/AE); [3] DCR = percent of patients with tumor diameter growth ‹20%; [4] FDA action date December 28, 2016.

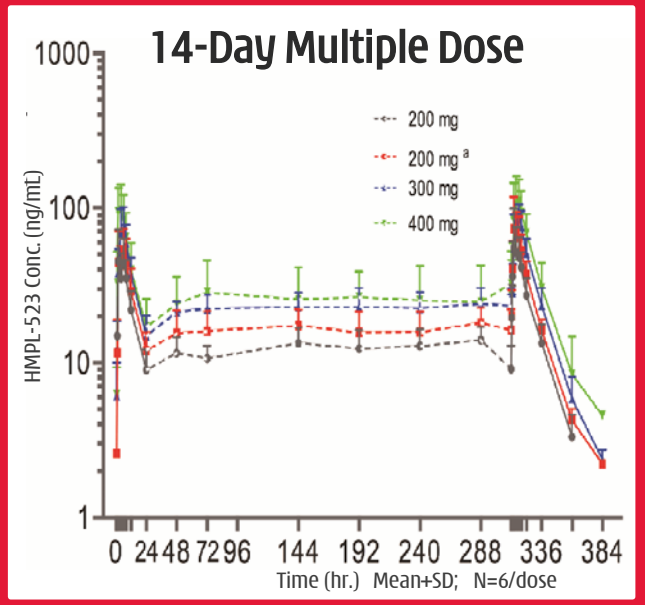
HMPL-523 – Pharmacokinetic profile

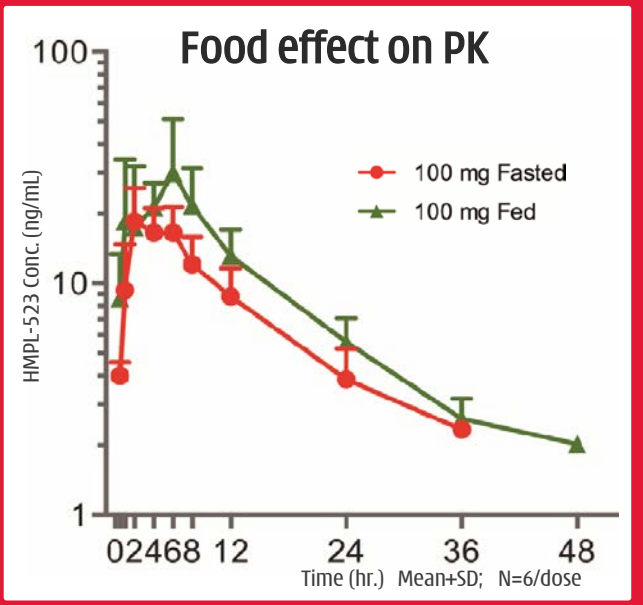
Phase II dose of 300mg or less, once daily, for autoimmune disease

- A dose proportional increase of plasma exposure of HMPL-523 was observed.
- Exposure to HMPL-523 was increased 1.5 times when dosed in a fed condition with high-fat food. The elevated exposure could be a result of an increase in relative bioavailability.
- Preclinical models on HMPL-523 indicated a >10x drug exposure in tissue versus plasma.
- Of the 3 metabolites (M1, M2 and M3), only M1 reached plasma levels that could be characterised. The accumulation of M1 appeared greater over 14-day daily administration of HMPL-523 than that of the parent compound – leading to 3 month toxicology study on the M1 metabolite which is expected to complete in H1 2017.

HMPL-523 CONCENTRATION-TIME PROFILE

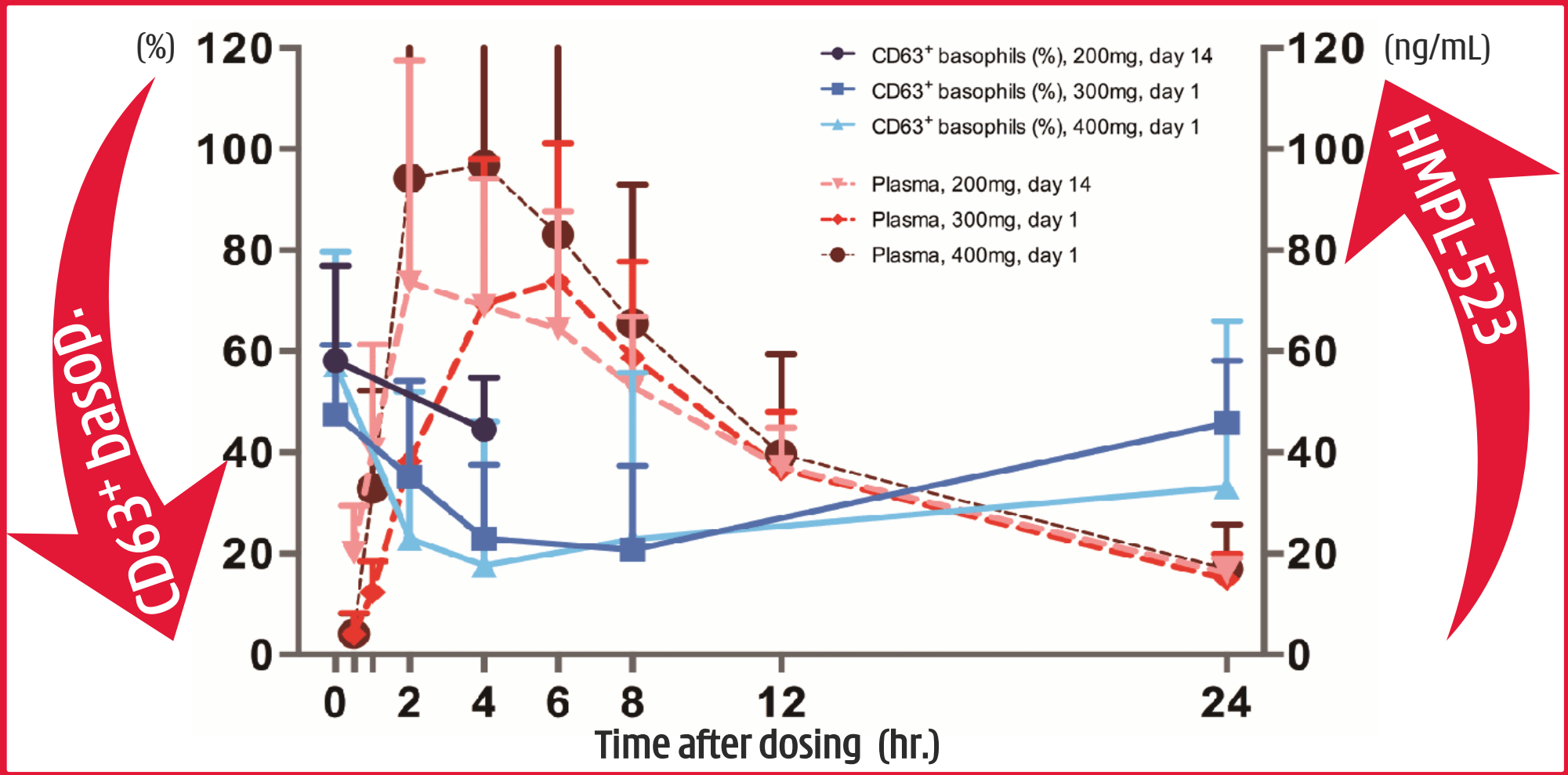






HMPL-523 – Pharmacodynamic profile

Clear dose dependent inhibition of B-cell activation by HMPL-523



- The EC_{50} of HMPL-523 on the inhibition of anti-IgE-induced $CD63^+$ expression in basophil was estimated to be 47.70 ng/mL

HMPL-523 – hematological malignancies

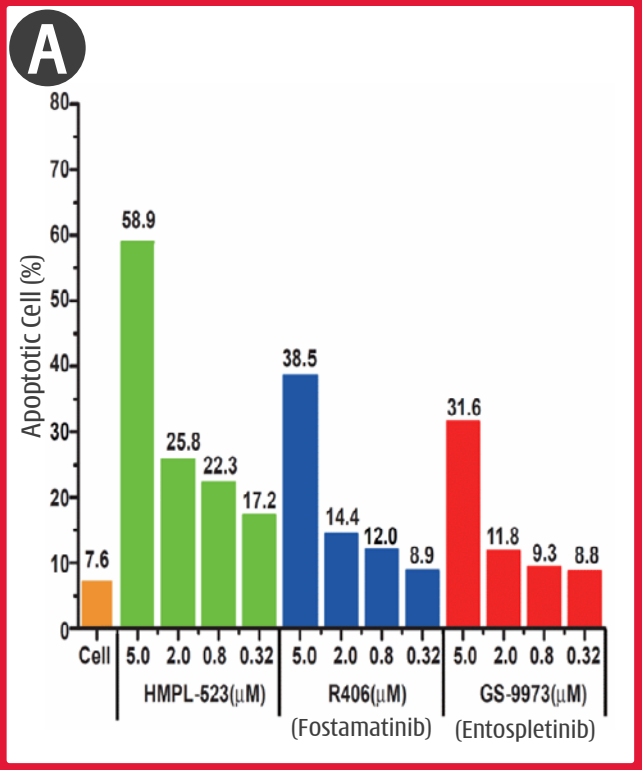
Pre-clinical superiority vs. both BTK/PI3Kδ TKIs as well as GS-9973 [1]

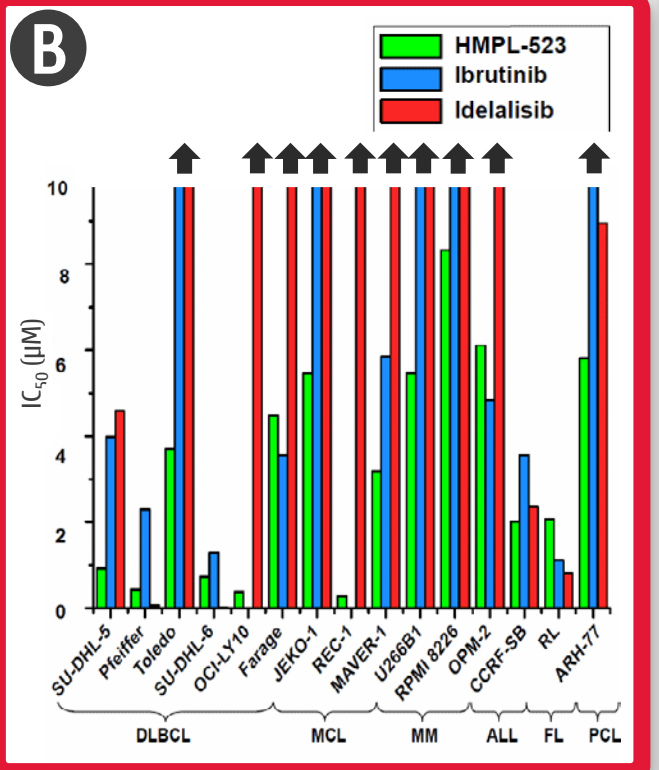
CHI-MED

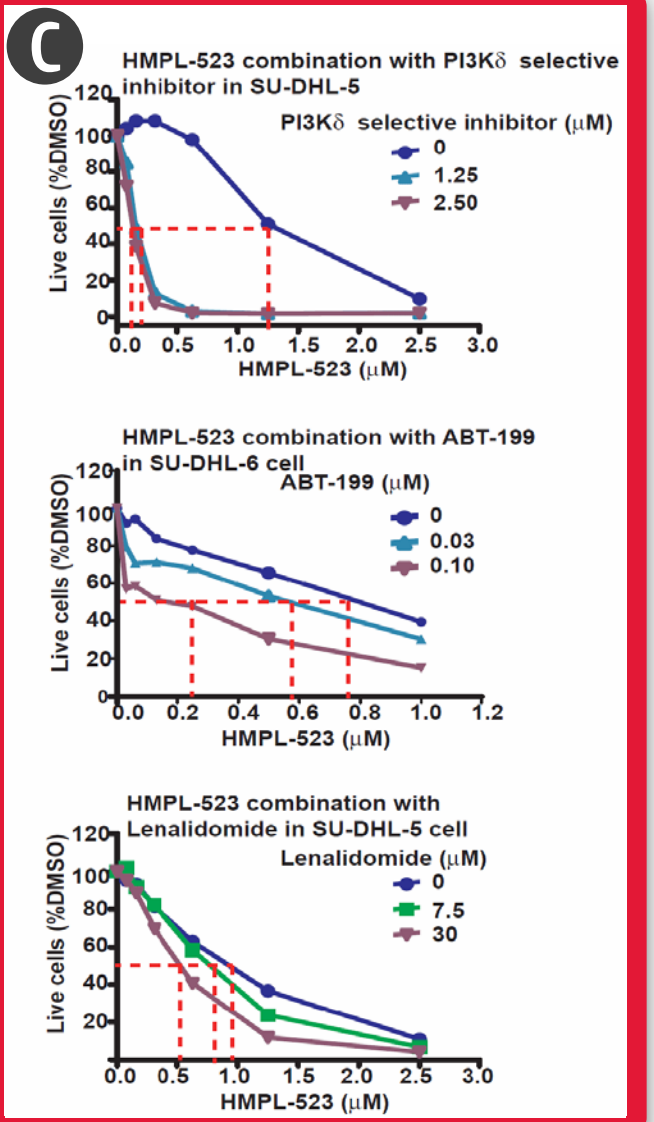
A Syk inhibitors all showed a dose dependent increase in apoptotic rate (cell death) in REC-1 cells with HMPL-523 efficacy stand-out.

B HMPL-523 inhibited cells survival in panel of human lymphoma & leukemia cells – standout efficacy vs. ibrutinib (BTK) & idelalisib (PI3Kδ) inhibitors.

C Combination of HMPL-523 with other drugs (PI3Kδ TKI; ABT-199; Lenalidomide) promote cell killing in DLBCL through inducing apoptosis.





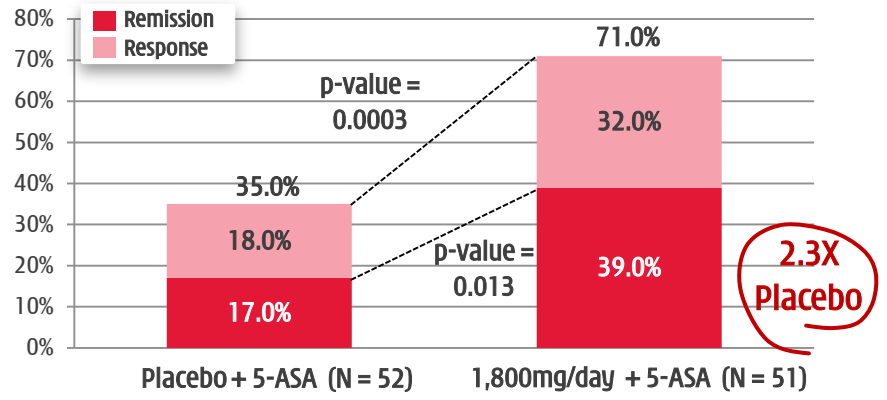


HMPL-004 – Heavy pill burden/compliance issues

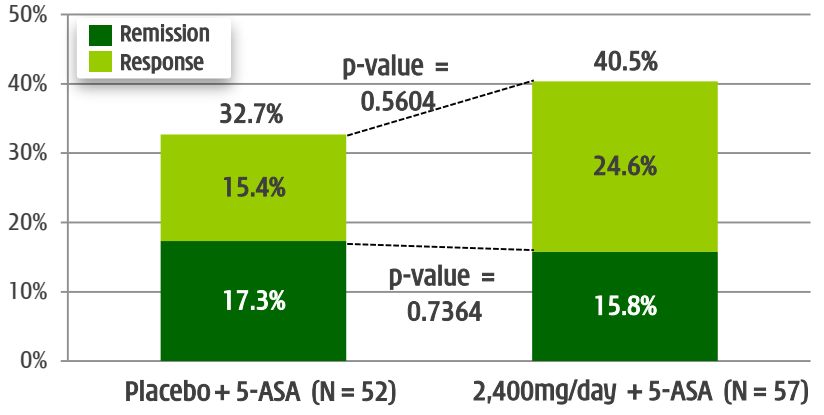
Reformulation – HM0046599 (›70% active) vs. HMPL-004 (~15% active)

CHI-MED

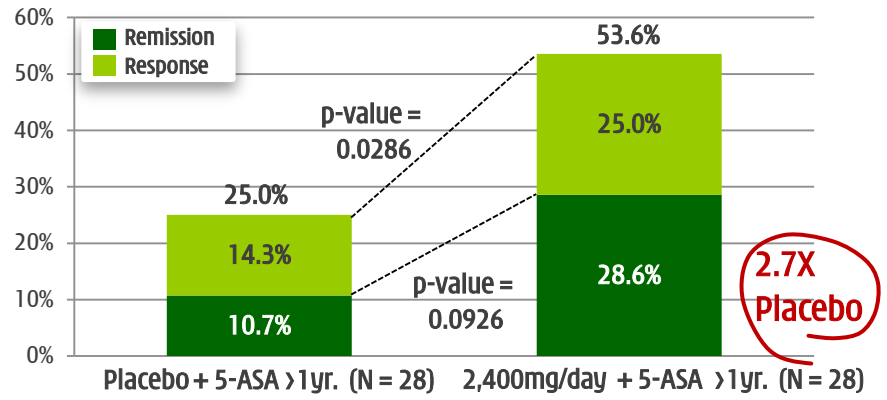
Strong Phase IIb data in UC (co-treat w/ 5-ASA)[2][3]...



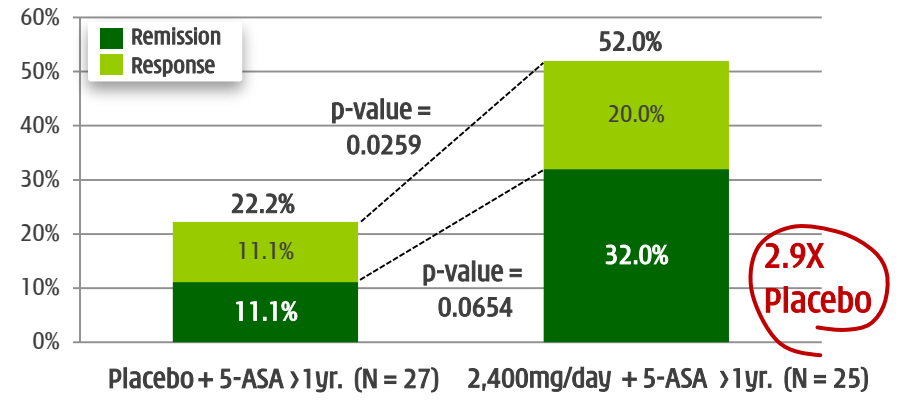
...but surprised by overall NATRUL-3 IA[4] result...



...but HMPL-004 works well in 5-ASA failure patients...



...particularly if difficult to treat patients stratified.



[1] Post-hoc analysis of IA: sub-group base sizes in these analyses are small and should be viewed for general indication purposes only; [2] UC = Ulcerative colitis;
[3] 1,800mg/day HMPL-004 plus Mesalamine (5-ASA) versus Mesalamine (5-ASA) alone (Placebo-arm); [4] IA = Phase III Interim Analysis conducted at ~1/3rd patient enrolment.

Innovation Platform proxy peer group (1/2)

HMP – A very deep pipeline and a very large organization/operation

Name	Mkt Cap 7Mar'17	Mkt Cap 7Mar'16	Mkt Cap 7Mar'15	Ent. Value	Staff	2017 Sales	2017 EBITDA	Drug	Studies	Phase	Partner	# of drugs	# of studies P3	# of studies POC	# of studies P1
Genmab	11,774	7,214	4,522	11,213	205	340	202	Ofatumumab	CLL, follicular lymphoma	Mktd, P3	Novartis	12	3	8	5
								Ofatumumab (subcutaneous)	Relapsing remitting multiple sclerosis	P3	Novartis				
								Daratumumab	Double-refractory MM, relapsed & frontline MM, NHL, natural killer / t-cell lymphoma, solid tumors	Mktd, Reg., P3, 2x P2, P1/2	Janssen				
								Tisotumab vedotin	Solid cancers	P1/2	Seattle Genetics				
								HuMax-AXL-ADC	Solid cancers	P1/2	Seattle Genetics				
								AMG 714	Celiac disease	P2	Amgen				
								Teprotumumab	Graves' orbitopathy, diabetic macular edema	P2, P1	River Vision				
								HuMax-IL8, HuMax-TAC-ADC, JNJ-61186372, -61178104, -63709178	Metastatic solid tumors, lymphoma, acute myeloid leukemia, NSCLC, autoimmune disorder, acute myeloid leukemia	P1b, 4x P1	ADC, Bristol-Myers Squibb, Janssen				
Tesaro	9,499	1,842	2,177	8,845	446	96	(473)	Rolapitant IV (oral: Varubi)	CINV (oral and IV)	Mktd, Reg.	Opko	4	2	3	3
								Niraparib	Ovarian maint., germline BRCAm+ breast, ovarian treat.	Reg., 2x P3, P2	Merck				
								Niraparib + Keytruda	Triple-negative breast cancer or ovarian cancer	P2	Merck				
								Niraparib + bevacizumab	Platinum-sensitive ovarian cancer (AVANOVA study)	P2	ENGOT				
								Niraparib + chemo, TSR-042 (PD-1 mAb), TSR-022 (TIM-3 mAb)	Ewing's sarcoma, various tumor types	3x P1	AnaptysBio, SARC				
Exelixis	6,469	986	596	6,238	115	319	26	Cabometyx / Cometriq (Cabozantinib)	Medullary thyroid cancer, adv. renal CC, adv. hepatocellular carcinoma, NSCLC, genitourinary tumors, & other	Mktd, P3, 8xP2, 2xP1	Ipsen	6	2	19	3
								CS-3150	Hypertension	P3 (Japan)	Daiichi-Sankyo				
								Cobimetinib	CRC, NSCLC, melanoma, TNBC	P2, 3xP1b/2, P1b	Genentech				
								SAR245408	Adv. or recurr. endometrial cancer, ER/PR+ HER2- breast, lym.	P2, P1/2	Sanofi				
								SAR245409	NHL, glioblastoma, lymphoma, leukemia	P2, 3xP1b/2	Sanofi				
								XL888	Solid tumors	P1b, P1	-				
Galapagos	3,376	1,733	664	2,335	510	132	(71)	Filgotinib	RA, Crohn's (CD) , ulcerative colitis, small bowel CD	3xP3, P2	Gilead	7	3	4	3
								GLPG1837	Cystic fibrosis	P2	AbbVie				
								GLPG1690	Idiopathic pulmonary disease	P2	-				
								GLPG2222	Cystic fibrosis	P2	AbbVie				
								GLPG1972, MOR106, GLPG2737	Osteoarthritis, inflammation, cystic fibrosis	3xP1	Servier, Morphosys				
Clovis	2,680	863	2,694	2,695	278	64	(222)	Rucaparib	Cancers: Ovarian treat./maint., prostate, triple negative breast, breast, gastro esophageal, gynecological	Approved, 3xP3, 6x P2, P1		1	3	6	1
Juno	2,205	4,493	4,778	1,473	518	62	(332)	JCAR015	Acute lymphoblastic leukemia, NHL	P2	-	10	0	3	8
								JCAR017	Pediatric acute lymphoblastic leukemia, adult NHL	P1	-				
								JCAR014	Chronic / acute lymphocytic leukemia, NHL	P1	-				
								JTCR016	AML, MDS, CML, NSCLC / mesothelioma	2xP1/2	-				
								JCAR018, BCMA, JCAR023, JCAR020, JCAR024, Lewis Y	Pediatric ALL / NHL, MM, pediatric neuroblastoma, ovarian, NSCLC / breast, lung	6xP1	-				

Source: Company data, FactSet, press.

Key: Lym. = lymphoma; NHL = Non-Hodgkin's Lymphoma; RA = Rheumatoid Arthritis; MM = Multiple Myeloma; CC = Cell Carcinoma; NSCLC = Non-Small Cell Lung Cancer; BC = Breast Cancer; CRC = colorectal cancer; Mktd = Marketed; Reg. = Under Registration.

($ millions unless otherwise stated)

Innovation Platform proxy peer group (2/2)

HMP – A very deep pipeline and a very large organization/operation

Name	Mkt Cap 7Mar'17	Mkt Cap 7Mar'16	Mkt Cap 7Mar'15	Ent. Value	Staff	2017 Sales	2017 EBITDA	Overview of pipeline assets [a] Drug	Studies	Phase	Partner	# of drugs	# of studies P3	# of studies POC	# of studies P1
Agios	2,094	1,806	3,889	1,552	287	44	(299)	Enasidenib (AG-221)	R/R AML, frontline AML	P3, 2xP1/2, P1b	Celgene	4	3	6	3
								Ivosidenib (AG-120)	Frontline AML, R/R AML, solid tumors, cholangiocarcinoma	2xP3, P1/2, P1b, 2xP1	-				
								AG-348	PK deficiency	P2	-				
								AG-881	Solid tumors	P1	Celgene				
Array	1,965	453	1,126	1,879	177	155	(76)	Binimetinib / MEK162	Melanoma, CRC	P3	-	7	2	3	2
								Encorafenib / LGX818	Melanoma, CRC	P3	-				
								Filanesib / ARRY-520	Multiple myeloma	P2	-				
								ARRY-797	Lamin A/C-related dilated cardiomyopathy	P2	-				
								ARRY-502	Asthma	P2	-				
								ARRY-382, ARRY-614	Solid tumors, myelodysplastic syndromes	2xP1	-				
Morphosys	1,856	1,203	2,139	1,699	278	72	(43)	MOR 208	CLL or small lymphocytic lym., diffuse large B-cell lym.	4x P2	-	3	0	5	1
								MOR202	Multiple myeloma	P2	-				
								MOR107	Undisclosed	P1	-				
BeiGene	1,532	939	NA	1,347	318	6	(112)	BGB-3111; BGB-3111 + Ibrutinib	Waldenstrom's macro., relapsed or refractory MCL	P3, P2	-	4	1	7	1
								BGB-A317, -A317 + BGB-290, -A317 + -3111, -290, -3111, BGB-3111 + Obinutuzumab, BGB-283	Advanced cancers, b-cell malignancies, relapsed/refractory b-cell malignancies, b-cell lymphoid malignancies	P1A/1B, 3xP1B, 2xP1A, P1	-				
Puma	1,315	1,729	7,432	1,086	156	24	(307)	Neratinib (PB272)	Adjuvant breast cancer, neoadjuvant BC, metastatic BC, metastatic BC, her2 BC metastatic	NDA,MAA, 2xP3, 8x P2	-	1	2	8	0
Ziopharm	842	1,250	1,535	886	36	7	(62)	Ad-RTS-IL-12 + veledimex	Locally adv. or met. breast can., recurrent or progressive GBM, pediatric brain tumor	P2, P1b/2, P1	Intrexon	2	0	2	2
								CAR / cytokine product	Leukemia/lymphoma, AML	P1	Intrexon, MD Anders.				
Aduro	724	1,071	NA	377	143	31	(106)	CRS-207	Mesothelioma, ovarian cancer, pancreatic cancer	P2, P1b, P1/2	Incyte	4	0	3	3
								ADU-741, ADU-214, ADU-S100	Prostate cancer, lung cancer, multiple tumors	3xP1	Janssen, Novartis				
AVERAGE (13)	3,564	1,968	2,868									5	1	6	2
MEDIAN (13)	2,094	1,250	2,177									4	2	5	2
Chi-Med Innovation Platform, Hutchison MediPharma (HMP)					330	35-40 (45)-(55)		Savolitinib	PRCC, CCRCC, NSCLC, gastric cancer	P3, P2b, 5xP2, 7xP1b	AstraZeneca	8	4	19	7
								Fruquintinib	Colorectal cancer, NSCLC, gastric cancer	2x P3, P1b. P1	Eli Lilly				
								Sulfatinib	NET, US bridging, thyroid cancer, biliary tract cancer	2x P3, 4xP2, P1	-				
								Epitinib	NSCLC, glioblastoma	P3, P2	-				
								Theliatinib	Solid tumors, esophageal cancer	P1b, P1	-				
								HMPL-523	RA, hematological cancers, immunology, lymphoma	4xP1	-				
								HMPL-689	Hematological cancers, lymphoma	2xP1	-				
								HMPL-453	Solid tumors	2xP1	-				

Source: Company data, FactSet, press. (a) Only non-partnered products included for Array and Morphosys.

Key: Lym. = lymphoma; NHL = Non-Hodgkin's Lymphoma; RA = Rheumatoid Arthritis; MM = Multiple Myeloma; CC = Cell Carcinoma; NSCLC = Non-Small Cell Lung Cancer; BC = Breast Cancer; CRC = colorectal cancer; Waldenstrom's macro. = Waldenström's macroglobulinemia aka lymphoplasmacytic lymphoma, a type of NHL; Mktd = Marketed; Reg. = Under Registration.

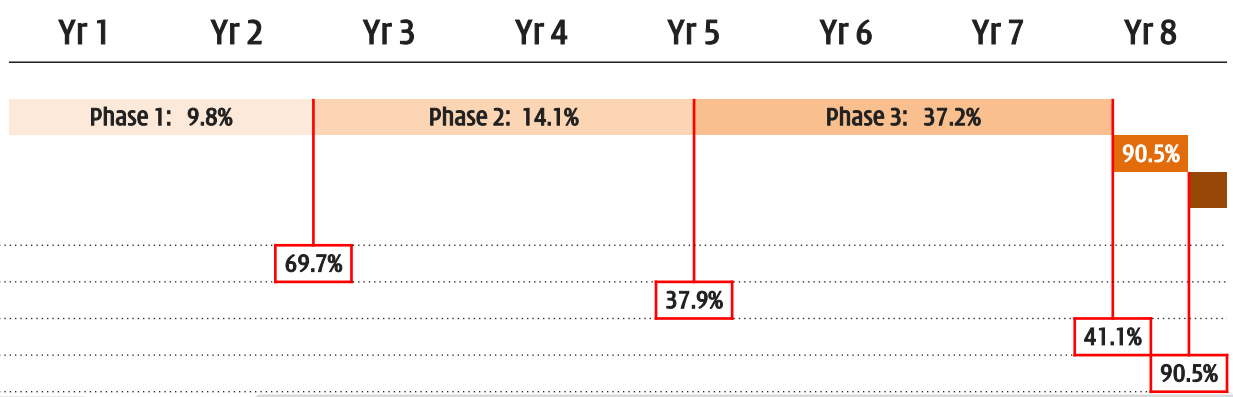
($ millions unless otherwise stated)

Breakthrough Therapy Model

Redefining risk & development speed in oncology

Tufts Conventional Model[1]:

Clinical Development	8.2 yrs
US Approval times	0.6 yrs
Time to Launch	8.8 yrs



Phase 1 to 2 -- transition probability

Phase 2 to 3 -- transition probability

Phase 3 to Submission -- transition probability

Submission to Approval -- probability

General criteria for BT in oncology:

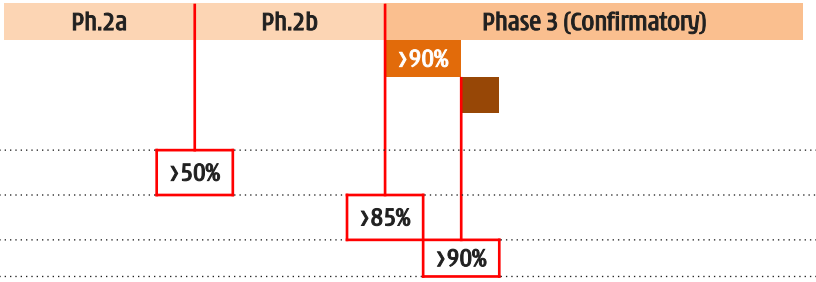
1. **Rare cancer type** - life-threatening, currently untreatable/limited treatments.
2. **Clear understanding of molecular pathways of disease** - patient stratification.
3. **Unprecedented efficacy** - substantial treatment effects in large enough patient pool early in clinical development.

Examples of BTs:

Imbruvica®:	Phase I ORR 82% (9/13) (Ph.II 67%, 50/75) in chronic lymphocytic leukemia; ORR 75% (3/4) (Ph.II 69%, 47/69) in mantle cell lymphoma.
Tagrisso®:	Ph I ORR 64% (57/89) in T790M+ non-small cell lung cancer.
ceritinib:	Ph I ORR 56% (45/80) in ALK+ crizotinib relapsed.
palbociclib:	Ph I ORR 25% (9/36) in HR positive breast cancer. BTT for combo with letrozole in ER+, HER2- post menopausal breast cancer (PFS 26.1mo vs. 7.5mo).
volasertib:	Ph I/II ORR 31% (13/42) in acute myeloid leukemia, ineligible for remission therapies (w/ cytarabine).

Breakthrough Therapy Model ("BT")[2]:

Clinical Development	8.2 yrs
US Approval times	0.6 yrs
Time to Launch	5.5 yrs



Interim Analysis Phase 2 (confirm Phase I data, submit BTT) -- probability

Breakthrough Therapy Designation (based on Interim Analysis data) -- probability

Submission to Approval -- probability

[1] Tufts Center for the Study of Drug Development (Feb 2010) - Transition probabilities for small molecule oncology drugs based on data of the 50 largest pharmaceutical companies 1993 through June 2009; [2] Hypothetical probabilities for BT estimated by Chi-Med - for general reference only, probabilities will vary dramatically based on scale/quality of Phase I data.

AstraZeneca's Tagrisso®

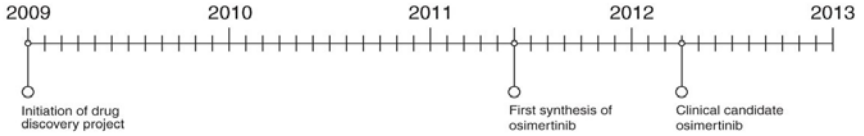
Fastest U.S. FDA drug approval – just 2 yrs. 8 mo.

AstraZeneca

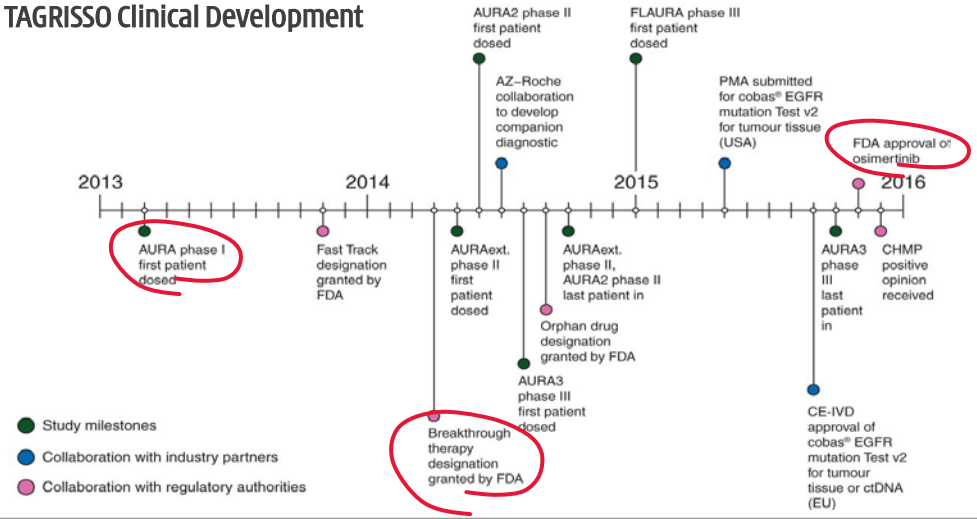
CHI-MED

- Savolitinib has reported **55% Objective Response Rate (6/11 pts.) to-date in second line NSCLC (TATTON)** – if Phase IIb study re-affirms this we could follow the same accelerated approvals path taken by Tagrisso.
- Phase IIb study to complete in 2017 – with **ORR similar to TATTON** we could target:
  - ✓ Potential Breakthrough Therapy designation application in 2017/2018.
  - ✓ Savolitinib submission for approval in 2018 and potential US FDA approval in 2019.

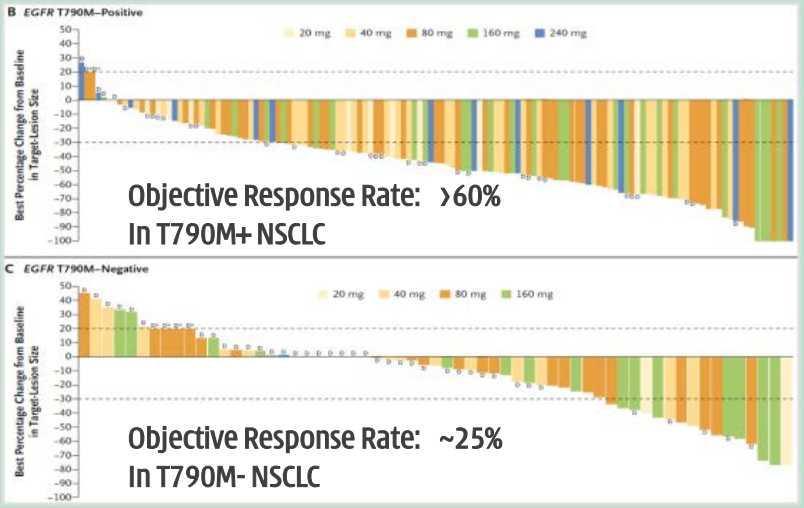
TAGRISSO Discovery



TAGRISSO Clinical Development



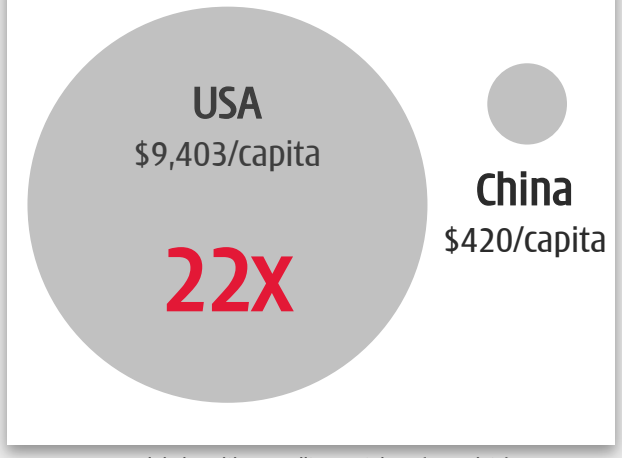
Osimertinib (Tagrisso): EGFR T790M-Positive & -Negative Patients



Jänne, N Engl J Med 2015

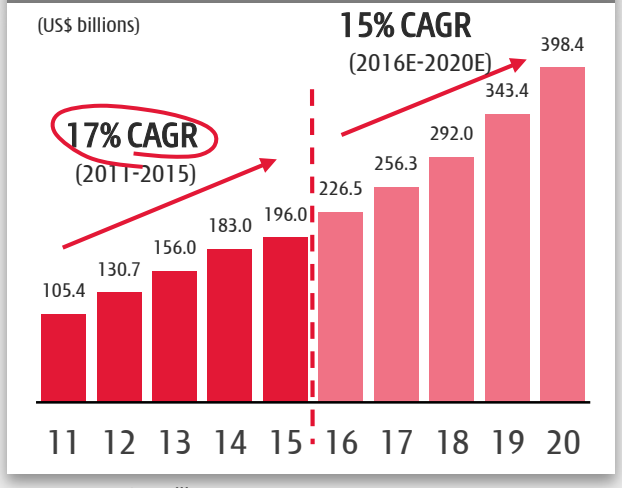
China pharma market set to become the second largest globally in 2016/2017

Per capita Healthcare Spending



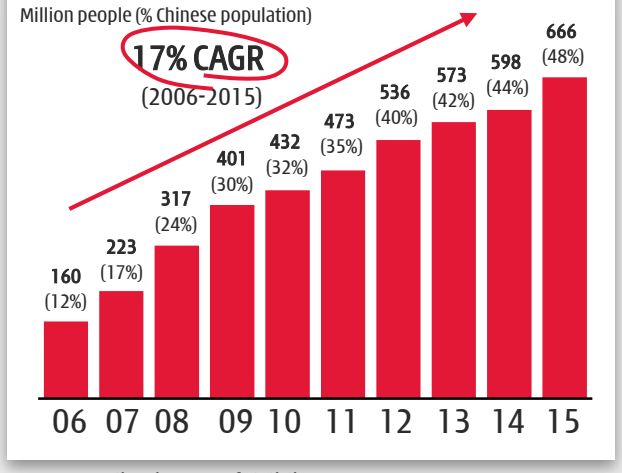
Source: WHO Global Health Expenditure Database (2014 data).

PRC Pharmaceutical Market Size



Source: Frost & Sullivan.

Medical Insurance Enrollment[3]



Source: National Bureau of Statistics.

- China pharmaceutical industry growth 17% CAGR[1] from 2011-2015 - one of the highest rated industries in China with average P/E ratio of 42 for the 61 listed companies (next slide).
- Government healthcare spending grew 14% CAGR[2] from 2011 - 2015 and continues to increase rapidly - Strategic priority.
- Expansion of State Medical Insurance Schemes[3] - Link to increased drug reimbursement & sales.

[1] Compound annual growth rate; [2] National Bureau of Statistics of China; [3] The Basic Medical Insurance Scheme for Urban Employees Residents plus Rural Cooperative Medical Schemes.

Targeted therapies – fastest growth & largest[1]

Pricing beyond reach of the 3.4 million new cancer patients/year in China

CHI-MED

% Oncology Market[4]	Sub-Category	Share of Sub-category[4]	Product	Company	Est. Market Sales ($m)[4]	Approx. patient cost/month ($)[4]	12 mo. treatment (Est. # patients)[4]
20.9%	Targeted Therapies	19.3%	rituximab	Roche	443	16,780	2,200
		15.0%	trastuzumab	Roche	344	5,130	5,592
		14.2%	imatinib	Novartis	326	6,323	4,295
		8.5%	bevacizumab	Roche	195	6,251	2,601
		7.4%	erlotinib	Roche	170	3,108	4,554
		6.8%	gefitinib	AstraZeneca	156	2,730	4,764
		5.3%	cetuximab	BMS/BI	122	14,146	717
		4.6%	sorafenib	Bayer	106	8,329	1,056
		4.0%	bortezomib	Janssen	92	8,133	941
		14.9%	Other		342		
			Total Targeted Therapies		**2,295**		**26,718**
20.4%	Anti-metabolites	29.1%	pemextred	Lilly/Hansoh	652		
		21.5%	capecitabine	Roche	482		
		20.4%	TS-1	Taiho/Qilu	457		
		16.6%	gemcitabine	Lilly/Hansoh	372		
		12.4%	Other		278		
			Total Anti-Metabolites		**2,240**		
19.7%	Plant Alkaloids	49.3%	paclitaxel	BMS/Luye	1066		
		42.4%	docetaxel	Sanofi/Hengrui	916		
		8.4%	Other		181		
			Total Plant Alkaloids		**2,163**		
10.5%	DNA Damaging agents	46.5%	oxaplatin	Sanofi/Hengrui	546		
		21.3%	temzolomide	Merck/Tasly	250		
		13.1%	nedaplatin		154		
		4.3%	carboplatin		51		
		14.8%	Other		174		
			Total DNA Damaging Agents		**1,175**		
6.4%	Hormones	29.8%	letrozole	Novartis/Hengrui	209		
		23.0%	bicalutamide	AstraZeneca	162		
		19.5%	anastrozole	AstraZeneca	137		
		17.1%	exemestane	Pfizer/Qilu	120		
		10.6%	Other		74		
			Total Hormones		**703**		

Source: Frost & Sullivan; [1] 2015 global oncology market at ex-factory price level; [2] 2015 china oncology market at wholesale price level; [3] 2015 China pharmaceutical market at wholesale price level; [4] As of 2014.

China Commercial Platform has substantial value

- Chi-Med's Commercial Platform continues to perform well relative to our peer group.
- The market value, based on China Pharma PE multiples is approximately $2.2-2.7 billion.[3] Given our share in the JVs, Chi-Med's share of this value is approximately $1.0-1.3 billion.

	Code	NET SALES 2014	NET SALES 2015	NET SALES LTM 2016 Jun	NET SALES 14-15 Growth	NET INCOME 2014	NET INCOME 2015	NET INCOME LTM 2016 Jun	NET INCOME 14-15 Growth	NET INCOME LTM Margin	VALUATION Market Cap.	VALUATION P/E[2]
CHI-MED Commercial Platform -- Subsidiaries/JVs[1]		**465.4**	**518.9**	**560.0**	**11%**	**48.8**	**54.1**	**58.5**	**11%**	**10%**	**n/a**	**n/a**
Tianjin Zhong Xin Pharma	600329	1,076.4	1,075.4	1,058.2	0%	57.6	69.5	70.7	21%	7%	1,720	30
Li Zhu Pharma	000513	842.1	1,005.5	1,105.7	19%	84.1	100.2	108.4	19%	10%	3,328	31
Shandong Dong E E Jiao	000423	608.9	827.7	846.7	36%	208.4	248.8	257.6	19%	30%	5,281	21
Zhejiang Kang En Bai Pharma	600572	544.0	805.3	930.8	48%	110.5	76.5	47.1	-31%	5%	2,729	66
Kunming Pharma	600422	625.8	746.6	808.5	19%	46.7	65.5	70.1	40%	9%	1,610	24
Guizhou Yi Bai Pharma	600594	479.5	501.6	522.0	5%	73.1	29.2	46.2	-60%	9%	1,976	42
Jin Ling Pharma	000919	421.0	489.3	525.3	16%	37.2	39.8	37.7	7%	7%	1,044	35
Jiangsu Kang Yuan	600557	389.3	428.4	439.6	10%	49.1	55.5	55.7	13%	13%	1,606	28
Jiang Zhong Pharma	600750	430.5	394.5	327.5	-8%	40.5	55.9	64.2	38%	20%	1,482	25
Zhuzhou Qian Jin Pharma	600479	333.3	371.6	397.2	12%	17.9	13.4	14.6	-25%	4%	801	50
Peer Group -- Weight Avg. (10 Comps. excl. Chi-Med)		**575.1**	**664.6**	**696.2**	**16%**	**72.5**	**75.4**	**77.2**	**4%**	**11%**	**2,158**	**34**
All 61 Listed China Pharma. Companies -- Weight Average		**918.6**	**1008.3**	**1063.3**	**10%**	**68.4**	**80.4**	**89.1**	**18%**	**8%**	**2,784**	**42**

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 2015 Net Sales in the ~$350-1,100 million range.

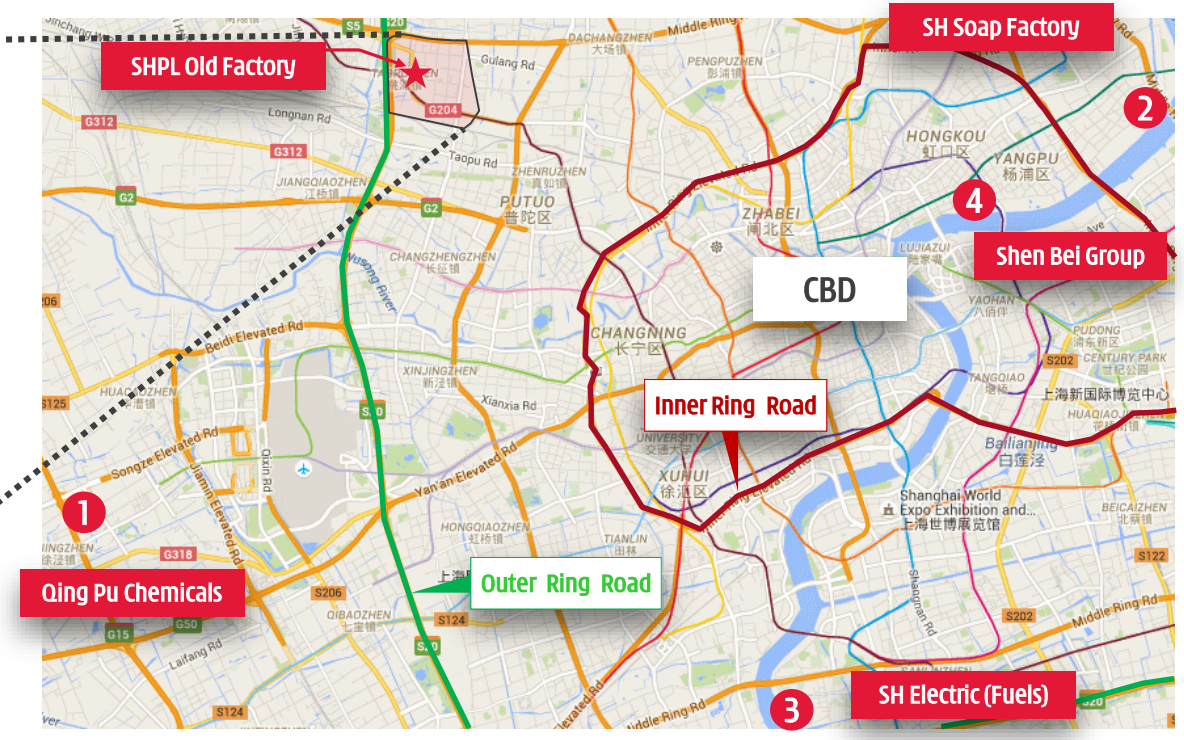
[1] Total aggregate PRC domestic results of Chi-Med's 6 Commercial Platform companies (HBYS, SHPL, Hutchison Sinopharm, HHO, HHL, & HCPL), excluding discontinued operations;
[2] Price Earnings Ratio as at **January 6th, 2017**: Trailing Twelve Month PE weight averaged based on market capitalization;
[3] Peer group/China Pharma multiple of 34-42 x 2016 actual Net income after tax of $63.3million (excluding one-time property gain of $80.8 million).

(US$ millions)

SHPL old factory site surrender of land-use rights

Fully received $113 million in cash compensation & subsidies (Feb 2017)

CHI-MED



4.6 sq.km. new development zone 12km from CBD (re-zoned in 2014).

- "Smart City" new science & tech, commercial and residential area.
- SHPL old factory classified as Cat. 3 residential.

	Land Area (sq.m.)	Other Factors	Approx. Distance to CBD[1] (km)	Approx. Distance to Metro[2] (m)	Actual Compensation (US$ million)	Compensation ($/sq.m.)
★ SHPL Old Factory Plot	57,804	New Dev.	12.4	300	113.1	1,957
1 Qing Pu Chemicals Plot	77,372	Nr. Airport	21.2	2,200	108.4	1,401
2 Shanghai Soap Factory Plot	62,846	Nr. River	8.0	500	122.6	1,951
3 Shanghai Electric (Fuels) Plot	27,091	Nr. River	11.4	2,000	89.1	3,290
4 Shen Bei Group Plot	4,976	Nr. River	3.3	300	34.5	6,928

[1] Approximate distance (direct line) to Central Business District (CBD); [2] Approximate distance (direct line) to nearest Shanghai Metro station.

HBYS Plot 1&2 – 9km from Guangzhou city center

Property compensation expected in the range of ~$120 million[2]

HBYS Plot 2 (26,700 sq.m. plot of land):
2.2 plot ratio, ~58,740 sq.m. of residential floor area.
Estimated Auction Price[1]: $123.4 million ($2,100/sq.m.).

163 Tong Bao Road (131,647 sq.m. plot of land):
Auction Date: November 24th 2014
~3.5 plot ratio, 460,765 sq.m. of residential floor area.
Actual Auction Price: $1,034 million ($2,244/sq.m.).

8-10 Tong Bao Road (65,055 sq.m. plot of land):
Auction Date: May 6th 2013
2.2 plot ratio, 143,121 sq.m. of residential floor area.
Actual Auction Price[1]: $305 million ($2,132/sq.m.).

HBYS Plot 1 (59,400 sq.m. plot of land)

Tong He Metro Station (opened November 2010)

[1] Estimated Auction Price based on Nov 24th 2014 Auction Price of 163 Tong Bao Road Plot; [2] Based on Guangzhou government new urban redevelopment policy combined with precedent land auctions in the vicinity of HBYS Plot 1 and Plot 2, and exchange rate USD/RMB = 6.67.

(US$ millions)

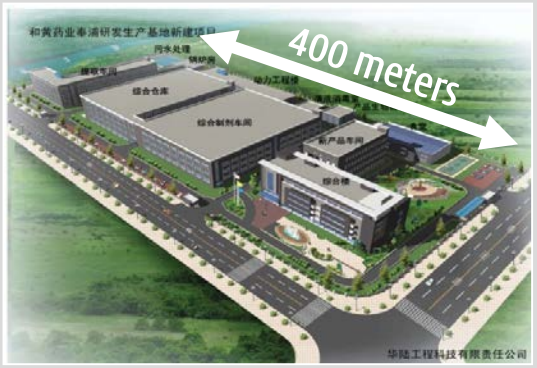
New factories – triple capacity

JVs fund internally – $139m of total $142m (~98%) CAPEX spent

CHI-MED

SHPL New Factory – SOP[1] Sep 2016

Feng Pu District, 78,000 sq.m. plot (~40km south of Shanghai city center).
Approx. 3x designed capacity expansion (extraction & formulation).
Actual total CAPEX: $102m



HBYS New Factory – SOP H1 2017

Bozhou, Anhui province (central China). 230,000 sq.m. plot.
Approx. 3x extraction expansion & new formulation lines.
Estimated total CAPEX: $40 m

[1] SOP = Start of Production post China Good Manufacturing Practice certification.

(US$ millions)

Chi-Med Group structure - major entities

Non-Consolidated Joint Ventures

Chi-Med Subsidiaries

Chi-Med Group Level

Revenues - 2016: $216.1m (2015: $178.2m)
Net Income Attributable to Chi-Med - 2016: $11.7m (2015: $8.0m)

Innovation Platform

Revenue - **2016: $35.2m** (2015: $52.0m)
Net Loss Attributable to Chi-Med - **2016: -$40.7m** (2015: -$3.8m)

99.8%

Hutchison MediPharma ("HMP")

Oncology/Immunology Drug R&D

Revenue:
2016: $35.2m (2015: $52.0m)

50%

Nutrition Science Partners ("NSP")

Botanical Drug /GI Disease R&D

Partner: Nestlé Health Science

Revenue:
2016: nil (2015: nil)

Commercial Platform

Sales of Subs & JVs - **2016: $627.4m** (2015: $518.9m)
Net Income Attributable to Chi-Med - **2016: $70.3m** (2015: $25.2m)

Prescription Drugs

50%

Shanghai Hutchison Pharma ("SHPL")

Prescription Drugs

Partner: Shanghai Pharma Group

Revenue:
2016: $222.4m (2015: $181.1m)

51%

Hutchison Sinopharm ("HSP")[1]

Rx Drug Commercial Co.

Partner: Sinopharm Group

Revenue:
2016: $149.9m (2015: $105.5m)

Consumer Health

50%[2]

Hutchison BYS Chinese Med. ("HBYS")

Over-the-counter Drugs ("OTC")

Partner: Guangzhou Pharma Holdings

Revenue:
2016: $224.1m (2015: $211.6m)

50%

Hutchison Hain Organic ("HHO")

Health Related Consumer Prods.

Partner: Hain Celestial Group

Revenue:
2016: $23.3m (2015: $17.0m)

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

Experienced pharma management team

POSITION	EXPERIENCE (yrs) Industry / Chi-Med	ROLE / BACKGROUND
CHRISTIAN HOGG, BSc, MBA *Chief Executive Officer*	P&G Procter & Gamble — 28 / 17	Led all aspects of the creation, implementation & management of Chi-Med's strategy, business & IPOs since 2000 start - incl. AZ, Lilly, Nestlé deals & est. of pharma business.
WEIGUO SU, PHD *EVP, Chief Scientific Officer*	Pfizer — 27 / 12	Created Chi-Med's R&D strategy, innovation platform & led all pipeline discovery; Director of Med Chem at Pfizer; Harvard Ph.D./post-doc under Nobel Laureate E. J. Corey.
JOHNNY CHENG, BEc, CA *Chief Financial Officer*	Bristol-Myers Squibb, KPMG, Nestlé — 27 / 8	Former VP, Finance at BMS China; 8 years with Nestlé China heading finance & control in multiple businesses; KPMG & PWC in Australia & Beijing.
YE HUA, MD, MPH *SVP, Clinical & Regulatory Affairs*	Novartis, Abbott, Celgene — 18 / 3	Led Revlimid & Pomalyst global development in multiple myeloma; 15 yrs of global registrations incl. Humira, Zometa, Reclast, Femara, Cardioxane, Proleukin.
ZHENPING WU, PHD, MBA *SVP, Pharmaceutical Sciences*	Roche, Pfizer — 23 / 9	Leads all CMC development & manufacturing for Chi-Med's pipeline; Sr Director of PS at Phenomix; Director of Pharma Development at Pfizer San Diego; at Roche in Palo Alto.
MAY WANG, PHD *SVP, Bus. Dev. & Strategic Alliances*	Lilly — 22 / 6	Leads alliance mgmt & BD for Chi-Med; long career in research, primarily biology, strategic alliance management, partnering & business development with Eli Lilly.
MARK LEE, BEng, MBA *SVP, Corp. Finance & Development*	Credit Suisse — 18 / 8	Focuses on strategic management, overall corporate operations & alliance support; Former US/UK banker advising & raising capital for major pharma & biotech.

- **Management team comprised mainly of returnees** averaging ~20 years in multinational pharma & biotech.
- Scientific leadership have **participated in the discovery & development of global blockbusters**.

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