HUTCHISON CHINA MEDITECH

Company Overview

AIM/Nasdaq: HCM

November 2017

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All references to "Chi-Med" as used throughout this presentation refer to Hutchison China MediTech Limited and its consolidated subsidiaries and joint ventures unless otherwise stated or indicated by context. This presentation should be read in conjunction with Chi-Med's interim results for the period ended June 30, 2017, copies of which are available on Chi-Med's website (www.chi-med.com).

Chi-Med Highlights

Transforming into a fully integrated pharma

Deep pipeline approaching approvals

First NDA
June 2017

Break-through
PoC NSCLC data

6 Phase III trials
underway/completing

18 Phase Ib/II PoCs
on 8 candidates

Prolific Discovery Engine

Chemistry Focused
~350 scientific team

8 Clinical Candidates
discovered in-house

2nd-gen IO INDs
every 1~2 years

Established Commercial Organization

Pan-China Sales & Marketing
~2,200 medical reps

Product Launch Ready
proven success in new indications

IO = immuno-oncology; PoC = Phase Ib/II proof of concept study.

Potential milestones for late 2017 & early 2018

Data presentations/clinical achievements on multiple candidates

Savolitinib	1. AZ decision on **strategy for Phase III registration & potential Breakthrough Therapy in NSCLC in combination with Tagrisso®/Iressa®**; ★ 2. Molecular epidemiology study (n›300) in PRCC.
Fruquintinib	3. **Potential NDA approval & launch in China in third-line CRC**; ★ 4. **Complete enrollment of Phase III FALUCA study in third-line NSCLC**; 5. Initiate U.S. Phase I bridging study in Caucasian patients.
Epitinib	6. **Initiate China Phase III study in first-line EGFRm NSCLC patients w/ brain mets**; 7. Initiate China Phase II study in glioblastoma (primary brain cancer).
Sulfatinib	8. Initiate Phase II expansion study in NET patients in the U.S.
HMPL-523 *(Syk)*	9. Initiate dose expansion proof-of-concept studies in hematological cancer in both Australia & China. 10. Potential presentation of prelim. **efficacy data from Phase I/Ib dose escalation / expansion studies in hematological cancer**. ★
HMPL-689 *(PI3Kδ)*	11. Initiate Phase Ib expansion studies in China in hematological cancer patients; 12. Present Phase I dose escalation data in Australian healthy volunteers.

Summary Balance Sheet and P&L

Over $400m available cash after October equity offering

1. Chi-Med Group-level Cash Position

- **$192.5 million available cash as at Jun 30, 2017** (Dec 31, 2016: $173.7m).
  - ✓ **$112.5m cash & cash equivalents.**
  - ✓ **$80.0m unutilized banking facilities** from BAML, DB & HSBC[1] held as at Jun 30, 2017.
- **$46.9 million in bank borrowings as at Jun 30, 2017** (Dec 31, 2016: $46.8m). Weighted avg. total cost of borrowing on outstanding loan 2.8% (H1 2016: 2.4%).
- **~$292.0 million from follow-on offering on Oct 30, 2017**

2. JV-level Cash Position

- **$88.8 million available cash as at Jun 30, 2017** (Dec 31, 2016: $91.0m).
  - ✓ **$42.6m dividend to Chi-Med Group level in H1 2017.**

3. Income Statement

	2016 Actual	2017 Guidance (7/31)
Revenues	216.1	225 - 240
Innovation Platform		
Revenue	35.2	35 - 40
Adjusted R&D expenses (non-GAAP)[2]	(76.1)	(85) - (90)
Commercial Platform		
Sales (consolidated)	180.9	190 - 200
Sales of non-consolidated joint ventures	446.5	480 - 500
Net Income		
One-time property comp. / R&D gain	*40.4*[3]	*3 - 16*[4]
Net income attrib. to Chi-Med *(incl. one-time gains)*	70.3	35 - 50
Chi-Med Group Costs		
General & admin. expenses (incl. int./tax)	(17.9)	(18) - (19)
Net Income/(Loss) Attributable to Chi-Med	11.7	(13) - (28)

(US$ millions)

[1] BAML = Bank of America Merrill Lynch, DB = Deutsche Bank, HSBC = Hong Kong Shanghai Banking Corporation; [2] R&D expenses, as adjusted (non-GAAP) excludes the actual or estimated impact of the revenue received from external customers of our Innovation Platform, which is reinvested into our clinical trials; [3] One-time gain from Shanghai land; [4] One-time gain from Guangzhou land - timing subject to Guangzhou government policy, and R&D related subsidies to SHPL ($2.5m net income attributable to Chi-Med).

Innovation Platform

Near term: Driving for first product launches

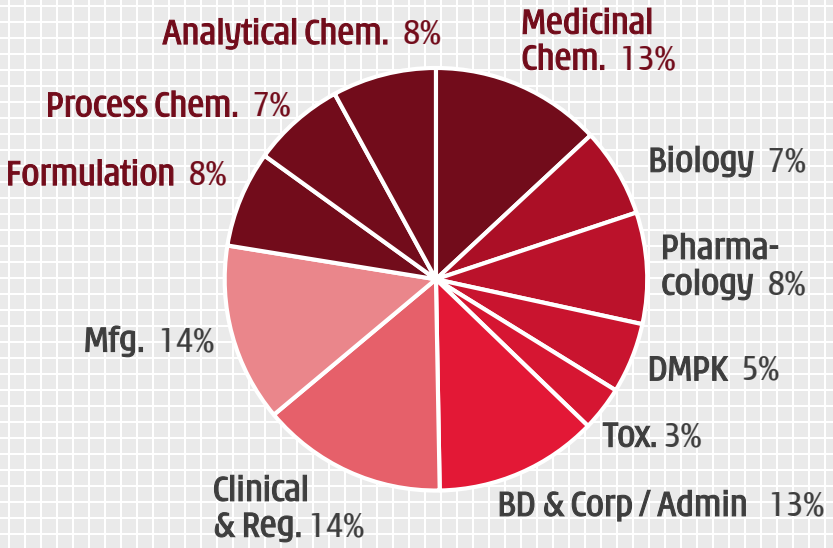
Mid-longer term: Building the pipeline for future growth

Exceptional scale for pre-approval biotech

Over 16 years with about $500 million invested to-date

~350 SCIENTISTS & STAFF[1]

- ✓ 202 with advanced technical degrees
- ✓ 21 M.D.s
- ✓ 51 doctorate degrees



✓ **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 16 years with stable financial support.

[1] Headcount as of Sept 30, 2017; Chem. = Chemistry; DMPK = Drug, Metabolism, & Pharmacokinetics; Tox. = Drug Safety Evaluation; PS = Pharmaceutical Science (CMC); Mfg = Manufacturing; Reg. = Regulatory; BD = Business Development;
[2] Frost & Sullivan.

Chemistry is our edge

Seriously selective small molecules

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.

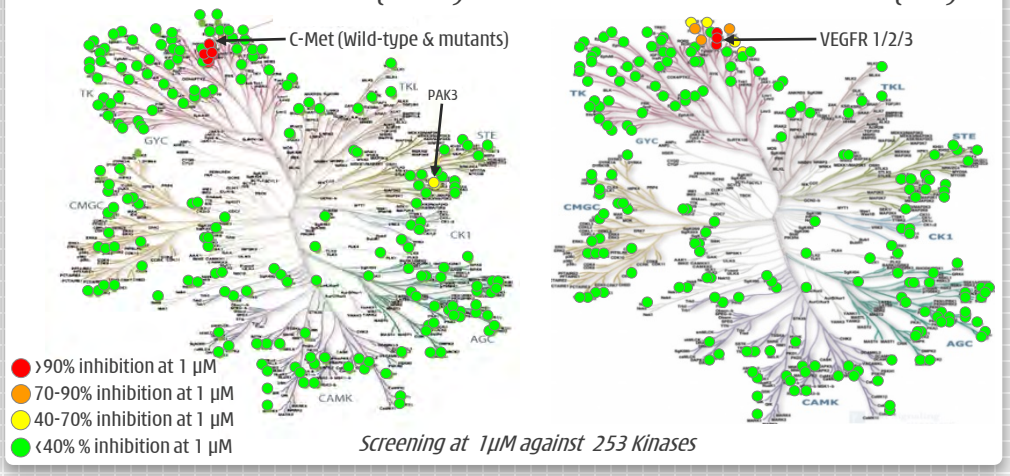
- **Optimize binding to on-target protein**, minimize off-target protein binding.
- No off-target kinase inhibition gives compound the chance to be more potent, attaining **better target coverage** with **less toxicity**.
- Combinability – **clean** compounds **allow for combinations** with other tyrosine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

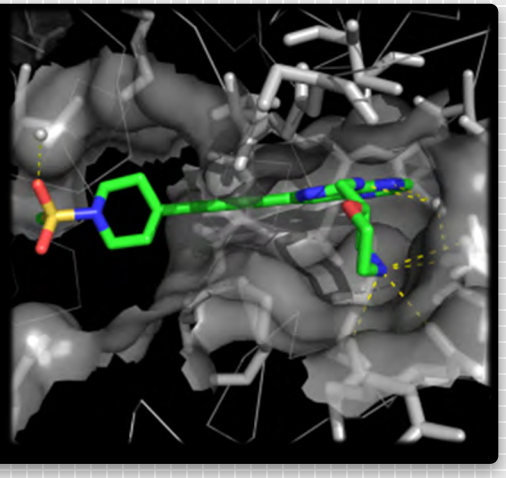


Screening at 1µM against 253 Kinases

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

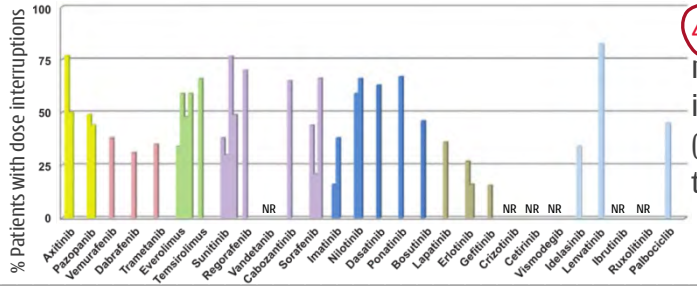
More use = prolonged/total target coverage = better efficacy

3. Better tolerability important for sustained usage…

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

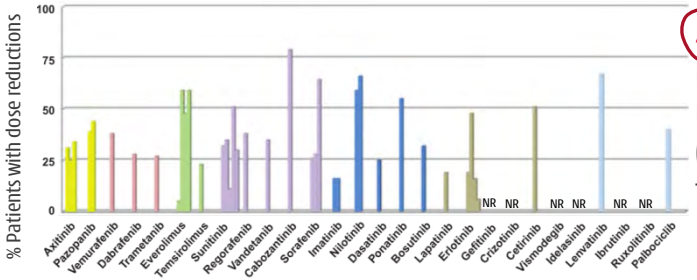
- Pronounced in drugs with narrow therapeutic index (i.e. efficacious dose at or near MTD).
- Combination trials even harder - 64% with grade 3-4 toxicities vs. 37% in monotherapy trials.

Dose interruptions in Phase III studies (where reported)



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

Dose reductions in Phase III studies (where reported)



41% of patients 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	3L CRC – Regorafenib vs. placebo (CONCUR)	63%	40%
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 (Cabometyx®) – 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 (FRESCO)		≥3L CRC – Fruquintinib vs. placebo	35% vs. 10%	24% vs. 4%
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.
Sources: Prescribing information; Chi-Med data.

31 active or completing trials on 8 drug candidates

Four drug candidates in Ph.III, or about to start

CHI-MED

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	Ph.III enrolling	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	-	All	**durvalumab** (PD-L1)	UK			*	
			4. Clear cell renal cell carcinoma	Start when Study 3/5 begin Ph.Ib expansion stage	2nd	VEGF TKI refractory		UK			*	
			5. Clear cell renal cell carcinoma	Ph.Ib enrolling	2nd	VEGF TKI refractory	**durvalumab** (PD-L1)	UK			*	
			6. Non-small cell lung cancer	Ph.II expansion enrolling; Pivotal decision 2017	2nd	EGFR TKI refractory	**Tagrisso®** (T790M)	Global				
			7. Non-small cell lung cancer	Ph.II enrolling; Pivotal decision 2017	3rd	EGFR/T790M TKI	**Tagrisso®** (T790M)	Global				
			8. Non-small cell lung cancer	Ph.II complete; Pivotal decision 2017	2nd	EGFR TKI refractory	**Iressa®** (EGFR)	China				
			9. Non-small cell lung cancer	Ph.II enrolling	1st	c-Met-driven		China			*	
			10. Lung cancer	Ph.II enrolling	1st	c-Met-driven		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 submitted Jun 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.II enrolling	1st	All	**Iressa®** (EGFR)	China				*
			17. Caucasian bridging	Ph.I dose escalation start 2017	-	All comers		US				
			18. Gastric cancer	Ph.III enrolling	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	Chemo ref.		China				*
Epitinib	EGFRm+		25. Non-small cell lung cancer	Ph.III start early 2018	1st	EGFRm+ brain mets		China				*
			26. Glioblastoma	Ph.II start 2017	-			China				*

6 pivotal Phase IIIs active or completing, & 4 more planning underway

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-aminosalicylic acids; chemo = chemotherapy; c-Met+ = c-Met gene amplification; c-Met O/E = c-Met over-expression; FGFR = Fibroblast Growth Factor Receptor; CSF1R = Colony Stimulating Factor-Receptor 1; NCI = U.S. National Cancer Institute; Aus = Australia; SK = South Korea; PRC = People's Republic of China; UK = United Kingdom; US = United States; Global = >1 country.

Next wave of innovation now in proof-of-concept

Four novel drug candidates in Phase I/II

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

~3,100 patients/subjects treated in studies to date on our drug candidates, with over 300 dosed in H1 2017.

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; PK analysis = Pharmacokinetic analysis; FGFR = Fibroblast Growth Factor Receptor; CSF1R = Colony Stimulating Factor-Receptor 1; NCI = U.S. National Cancer Institute; Aus = Australia; SK = South Korea; PRC = People's Republic of China; UK = United Kingdom; US = United States; Global = >1 country.

10 shots at pivotal success

First positive Ph.III outcome – fruquintinib in colorectal cancer

					Breakthrough Therapy ("BTT") potential	Est. Pivotal Read-out (if not BTT)
SAVO	Papillary renal cell carcinoma (MET-driven)	Pivotal Phase III	U.S., EU5	Enrolling	Molecular epidemiology study MET as -ve prognostic H1-2018	2020
	NSCLC –2L 1st Gen EGFR TKI refract, Tagrisso combo (MET+, T790M+/-)	Pivotal Phase III	U.S., EU5, Asia	AZ Decision based on Ph.Ib/II data (Nov 2017)	ORR MET+ / T790M+ 55% ORR MET+ / T790M- 61%	2020
	NSCLC –3L 3rd Gen EGFR TKI refract. Tagrisso combo (MET+)	Pivotal Phase III	U.S., EU5, Asia	AZ Decision based on Ph.Ib/II data (Nov 2017)	ORR MET+ 33%	2020
	NSCLC –2L 1st Gen EGFR TKI refract, Iressa combo (MET+, T790M-)	Pivotal Phase III	China	AZ Decision based on Ph.Ib/II data (Nov 2017)	ORR MET+ / T790M- 52%	2020
FRUQ	3L (or above) Colorectal cancer ("CRC")	Pivotal Phase III	China	Complete, **Met All Endpoints, NDA submitted**	✓	March 3, 2017
	3L Non-small cell lung cancer ("NSCLC")	Pivotal Phase III	China	Enrolling		H2 2018
	2L Gastric cancer combo with Taxol	Pivotal Phase III	China	Enrolling		2020
SULF	Pancreatic neuroendocrine tumors	Pivotal Phase III	China	Enrolling		H1 2019
	Non-pancreatic neuroendocrine tumors	Pivotal Phase III	China	Enrolling		H1 2019
EPIT	1L EGFR-mutant NSCLC with brain metastasis	Pivotal Phase III	China	Initiating early 2018		H2 2019

Savolitinib (AZD6094)

Potential first-in-class selective c-Met inhibitor

Savolitinib (AZD6094)

Potential first-in-class selective c-Met inhibitor

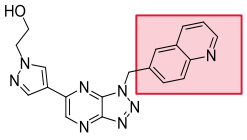
1. In strong position to become first selective c-MET inhibitor approved.

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

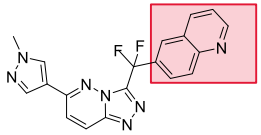
2. c-Met is aberrant in many tumor settings.[3]

	c-MET			New Cases (2015)	
Indication	Amplification	Mutation	Over-Expression	Global	China
Gastric	10%	1%	41%	1,034,000	679,000
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

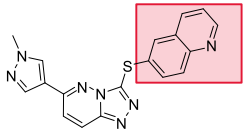
3. Savolitinib design eliminates renal toxicity first generation of selective c-MET inhibitors encountered - >460 patients treated to-date with no renal toxicity.



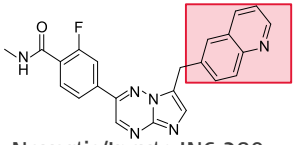
Pfizer PF-04217903



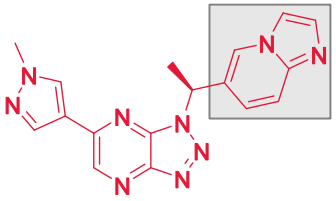
Janssen JNJ-38877605



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.

- $20m paid upfront (Dec 2011);
- $120m in development/approvals milestones ($25m paid as of Jun 2017);
- Several hundred million in commercial milestones;
- Development costs: AZ pay 100% ex-China (excl. $50m by Chi-Med) & 75% development cost in China (Chi-Med 25%).
- **14-18% tiered royalty ex-China**; & 30% flat rate China royalty on all product revenues.

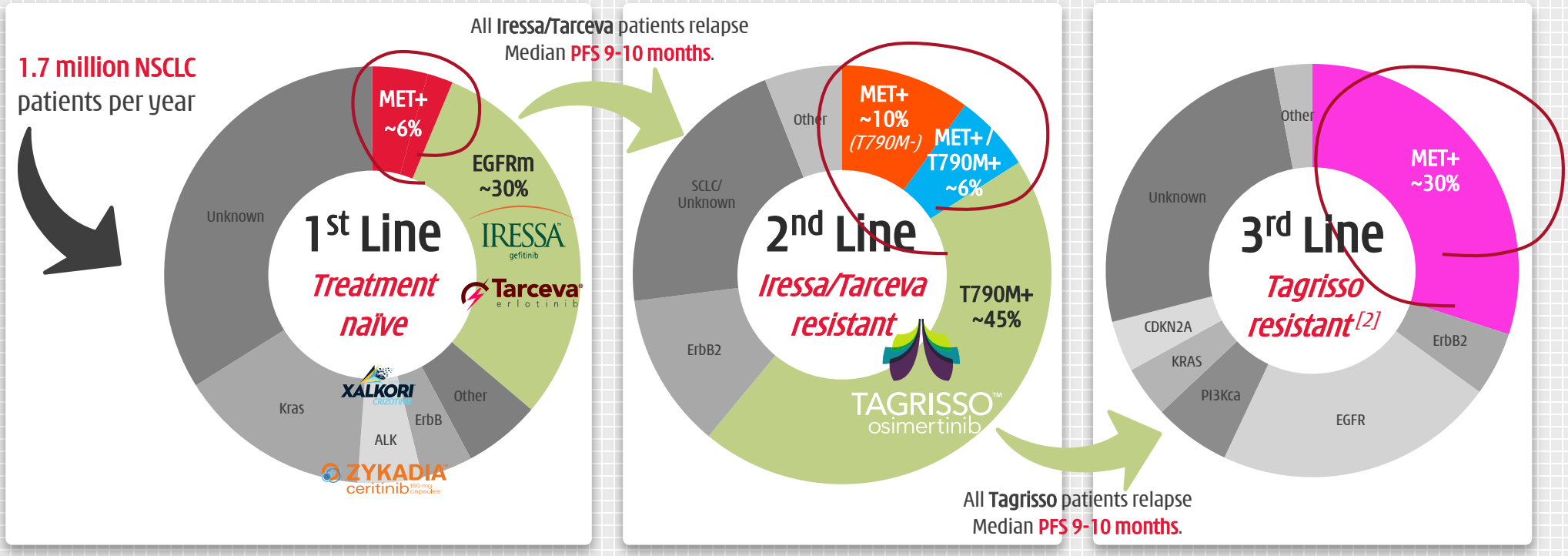
[1] Range includes (i) approximately 4% of c-Met+ naïve non-small cell lung cancer patients and (ii) 10 - 30% of EGFRm+ non-small cell lung cancer patients, which 15 to 20% develop EGFRm+ tyrosine kinase inhibitor resistance pathway as c-Met+; [2] Hereditary papillary renal cell carcinoma only; [3] Company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

Savolitinib

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

Primary NSCLC

Resistance-driven EGFRm+ NSCLC



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

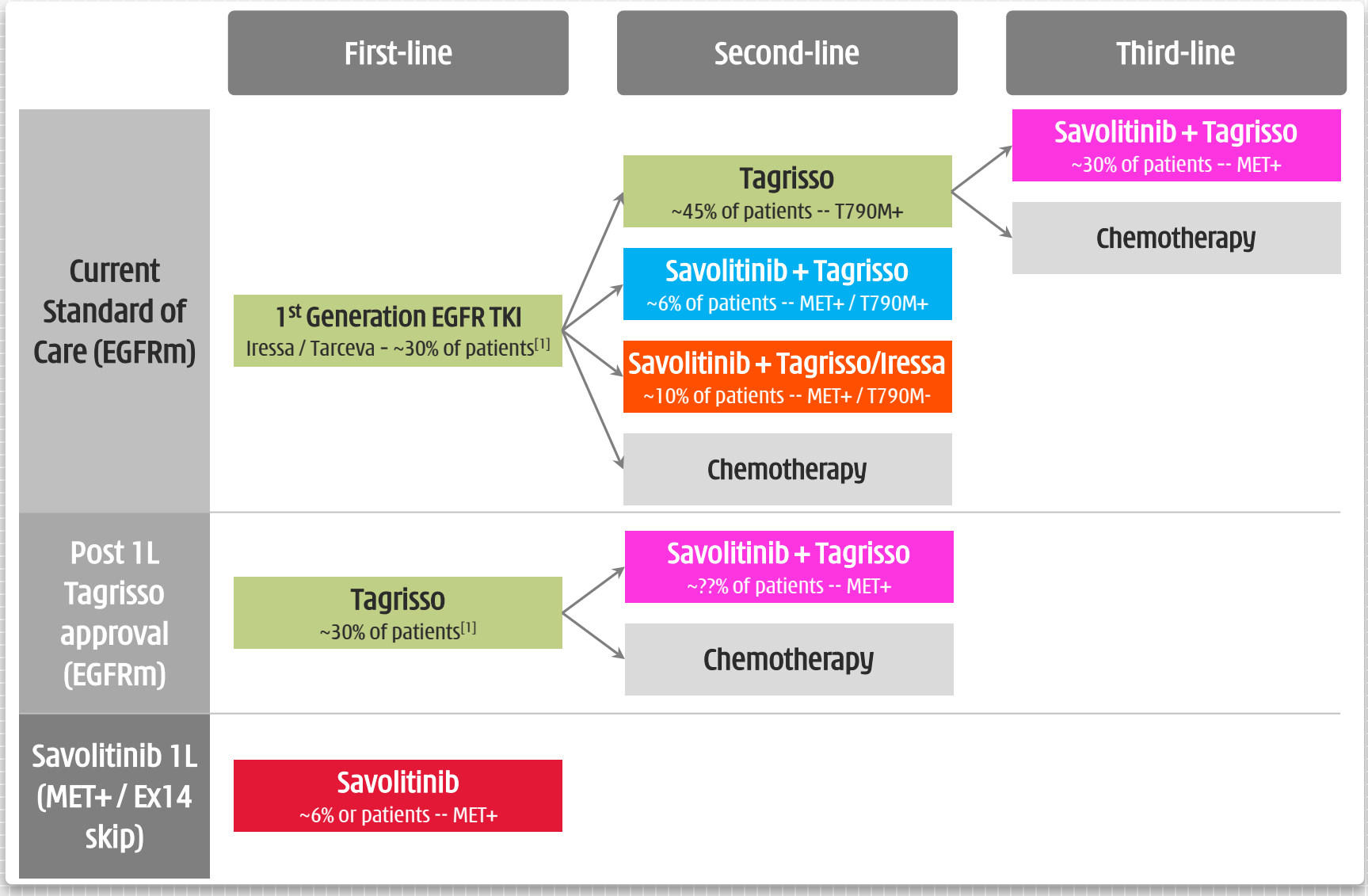
Est. peak ~$3-4b

Launch	2016 ($m)[3]	H1 2017 ($m)[3]	Q2 2017 ($m)[3]	Est.[3] Pts Treated/yr.
Dec-15	423	403	232	~5-10,000
	423	403	232	

[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 /17 results.

Savolitinib - NSCLC

Five opportunities for savo in NSCLC - Ph.III decisions end 2017

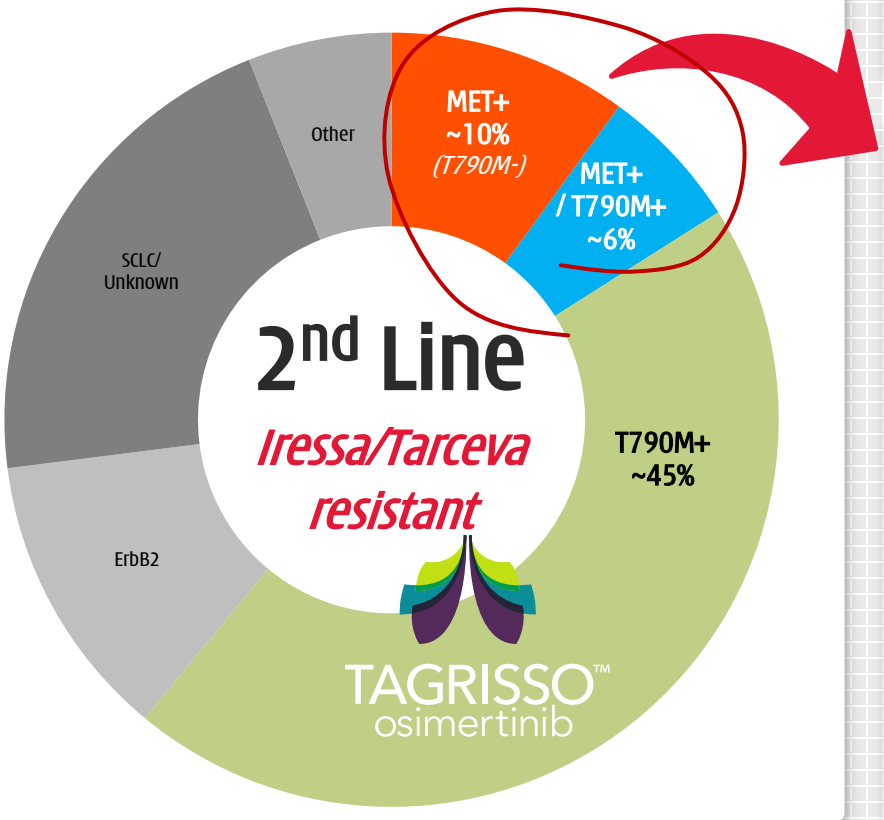


[1] General estimate based on EGFRm prevalence in approx. 10-15% of Caucasian NSCLC patients & 50-60% of Asian NSCLC patients.

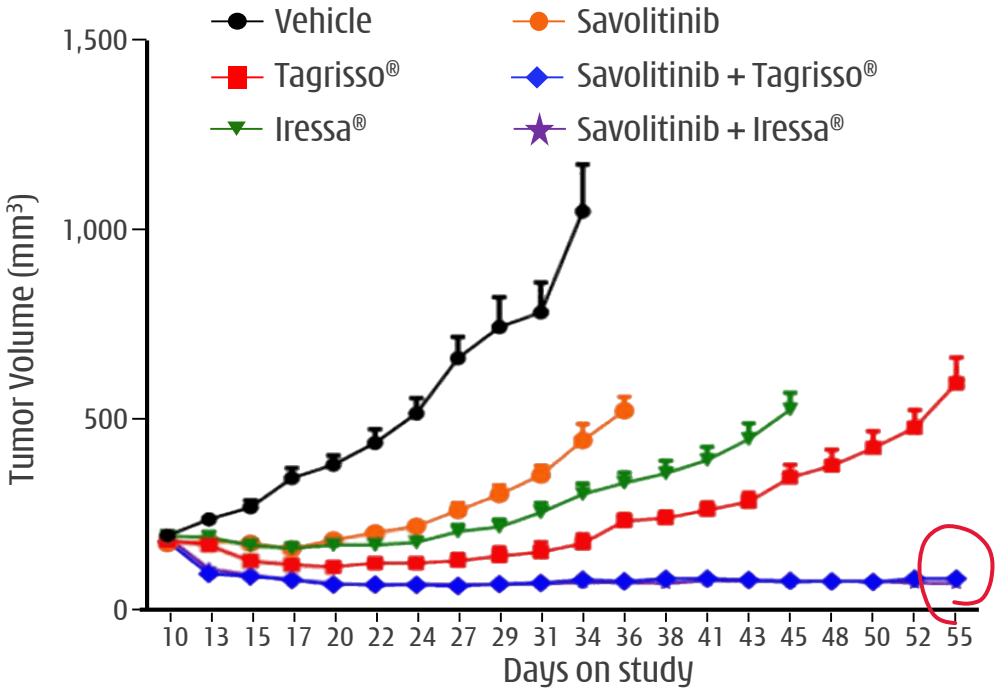
Savolitinib – 2nd Line EGFRm NSCLC

Very strong preclinical rationale for combination w/ EGFR-TKIs

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 EGFRm & MET** signaling pathways;
   - ✓ **Prolonged tumor growth suppression** by combining savolitinib with Tagrisso® (osimetinib – EGFR/T790M) or Iressa® (gefitinib/EGFR) **in MET+ / T790M- patients**.



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

TATTON A/B consistent & compelling data set – Ph.III ready / BTD [2]

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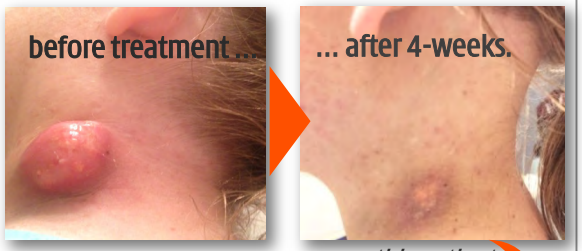
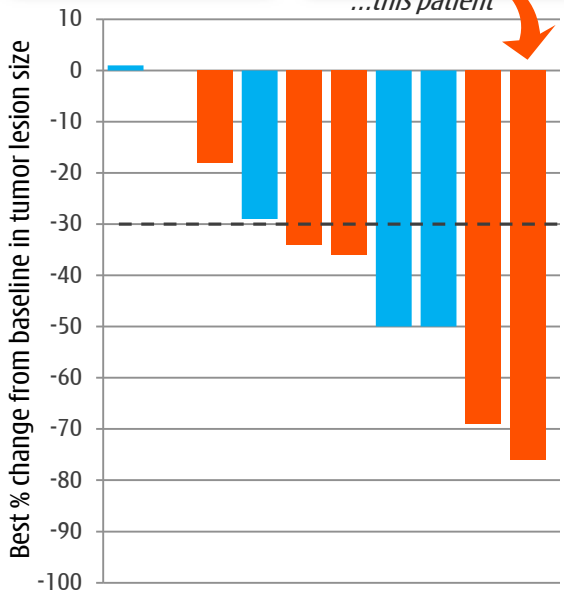
TATTON A [3] – signal…

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



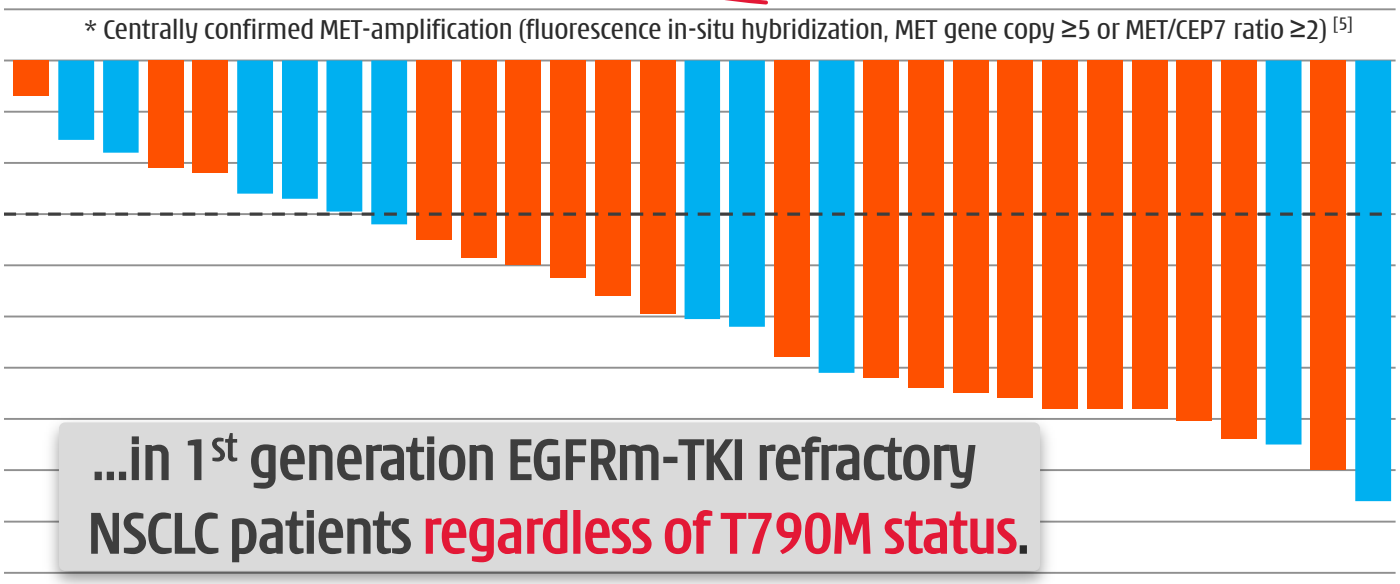
…this patient



…TATTON B [4] – …confirmation…

MET testing confirmation	Objective response rate, n (%)	MET+ / T790M+ (n = 11)	MET+ *(T790M-)* (n = 23)	Total (n = 34)
Local or Central	Confirmed PR	6 (55%)	14 (61%)	20 (59%)
		(n = 7)	(n = 15)	(n = 22)
Central *	Confirmed PR	4 (57%)	8 (53%)	12 (55%)
	Stable Disease ≥6 weeks	3 (43%)	6 (40%)	9 (41%)
	Progressive Disease/death	0	1 (7%)	1 (5%)
	Not Evaluable	0	0	0 (0)
	DoR, months (range)	9.7 (2.8*-9.7)	NR (1.6*-5.9*)	NR (1.6*-9.7)

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



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

[1] EGFRm NSCLC; [2] U.S. FDA Breakthrough Therapy designation potential; [3] ESMO 2016 Galbraith - Novel Clinical Trials for Prec. Med.; [4] WCLC 2017 – Ahn M-J, *et al.* TATTON Phase Ib expansion cohort – No prior 3rd generation EGFR-TKI exposure; [5] Some local MET-status determined via IHC+3 in ≥ 50% of tumor cells).; [6] PR = Partial Response;

Savolitinib – 2nd Line NSCLC[1] combo w/ IRESSA gefitinib

Strong & durable response in MET+ / T790M- patients

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

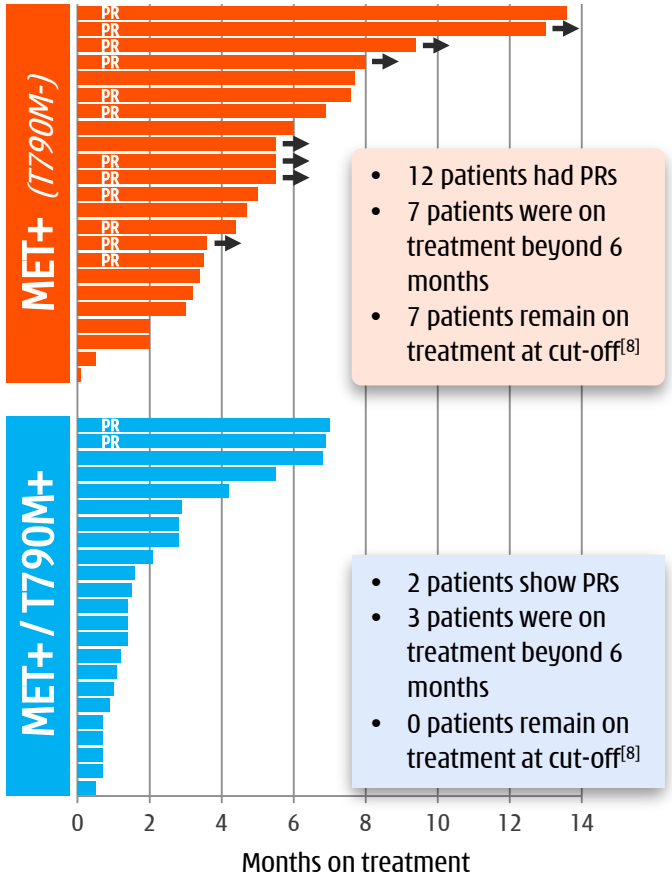
MET testing confirmation	Objective response rate, n (%)	MET+ / T790M+ (n = 23)	MET+ *(T790M-)* (n = 23)	MET+ / T790M unk. (n = 5)	Total (n = 51)
Central *	Confirmed PR [3]	2 (9%)	12 (52%)	2 (40%)	16 (31%)
	SD [4] ≥6 weeks	9 (39%)	7 (30%)	2 (40%)	18 (35%)
	PD [5] /death	7 (30%)	3 (13%)	0	10 (20%)
	NE	5 (22%)	1 (4%)	1 (20%)	7 (14%)

…vs. TATTON B data (savo / tagrisso combo) [6]

MET testing confirmation	Objective response rate, n (%)	MET+ / T790M+ (n = 11)	MET+ *(T790M-)* (n = 23)	MET+ / T790M unk. (n = 0)	Total (n = 34)
Local or Central	Confirmed PR	6 (55%)	14 (61%)	0	**20 (59%)**
		(n = 7)	(n = 15)	(n = 0)	(n = 22)
Central *	Confirmed PR	4 (57%)	8 (53%)	0	12 (55%)
	SD ≥6 weeks	3 (43%)	6 (40%)	0	9 (41%)
	PD/death	0	1 (7%)	0	1 (5%)
	NE	0	0	0	0 (0)

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

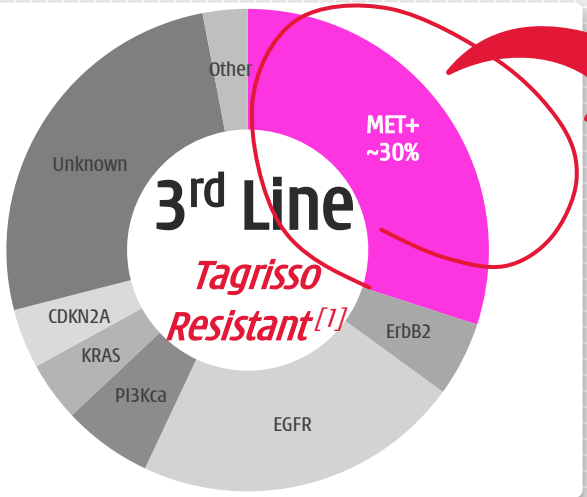
…Iressa® combo – ~6mo. DoR [7] in MET+ / T790M- patients



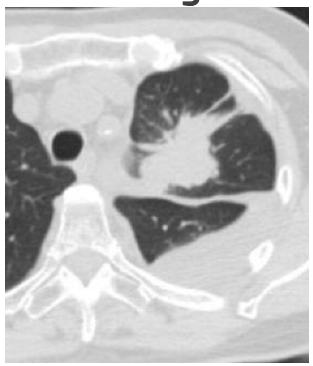
[1] EGFRm NSCLC; [2] WCLC 2017Yang J-J, et al. A Ph.Ib Trial of savolitinib plus gefitinib for patients with EGFR-mutant MET-amplified advanced NSCLC; [3] PR = Partial Response; [4] SD = Stable Disease; [5] PD = Progressive Disease; [6] WCLC 2017 – Ahn M-J, *et al.* TATTON Phase Ib exp. cohort; [7] DoR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

Savolitinib – 3rd Line NSCLC[1] – TAGRISSO™ osimertinib resistant

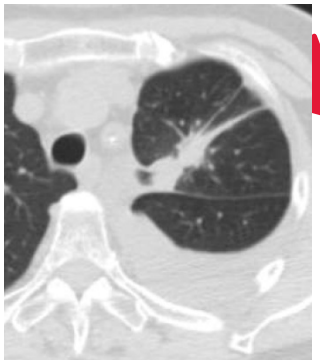
MET+ driven resistance in ~30% of patients



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



LUL Mass Pre-Treatment



6 wks. on savo/Tag. Treatment

Tagrisso® resistant tissue & ctDNA analysis [2]

Massachusetts General Hospital Cancer Center | Harvard Medical School

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

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

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

Savolitinib – 3rd Line NSCLC[1] combo w/ TAGRISSO™ osimertinib

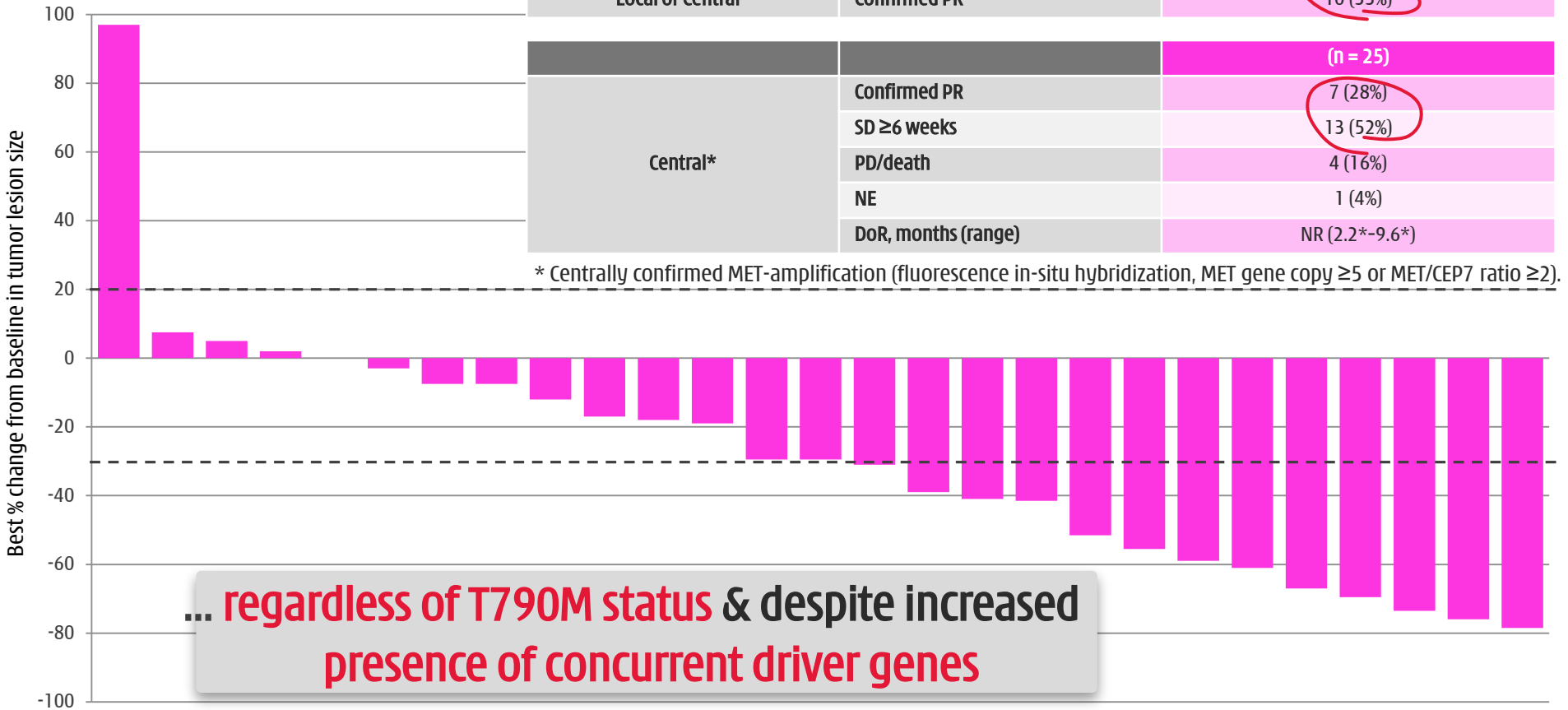
Currently no effective treatment options post Tagrisso® failure

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

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

		(n = 25)
Central*	Confirmed PR	7 (28%)
	SD ≥6 weeks	13 (52%)
	PD/death	4 (16%)
	NE	1 (4%)
	DoR, months (range)	NR (2.2*-9.6*)

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



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

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

Safety - savolitinib plus IRESSA™ gefitinib or TAGRISSO™ osimertinib

Adverse event profiles of combinations - manageable & tolerable

CHI-MED

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

Sources: [1] Figures where any grade AE ≥10% patients. Ahn M-J, et al. Abstract #8985. Presented at the World Lung Cancer Congress (WCLC) 2017, Japan, October 2017. [2] Figures where any grade AE ≥10% patients. Yang J-J, et al. Abstract #8995. Presented at WCLC 2017, Japan, October 2017.

WBC = white blood cell. ALP = alkaline phosphatase.

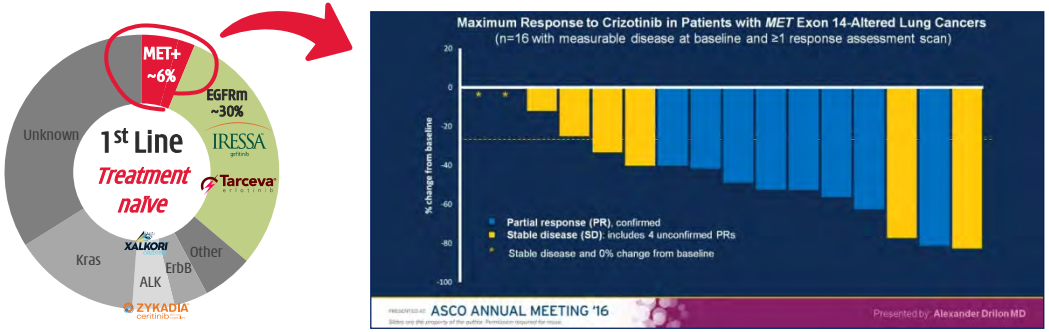
Savolitinib – 1st Line NSCLC

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

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].

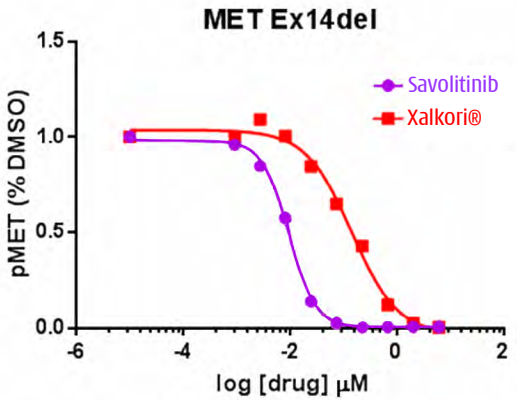


3. Multi-center retrospective analysis of 148 pts. w/ NSCLC MET Exon14 [2]

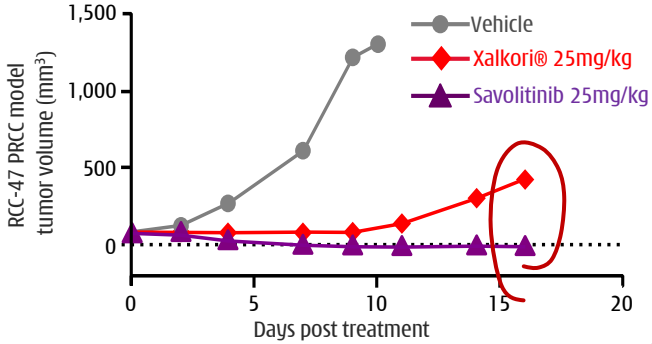
	MET Exon14 skipping: Exposed to c-MET TKI	MET Exon14 skipping: Never exposed to c-MET TKI
No. of pts	27	34
Median OS	24.6 months	8.1 months

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

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



5. Durable tumor 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.

MET+ PRCC – unmet medical need

1. No treatment choices for non-ccRCC patients.

Approved therapies in RCC [3]

Good efficacy in ccRCC; Multiple treatment options

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

Nothing approved in non-ccRCC

NCCN guideline – "Patients should enter clinical trials"

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

2. RCC est. ~$3.3 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:

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

MET- 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/ MET+ PRCC?

Answer: Phase II data (next page)

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

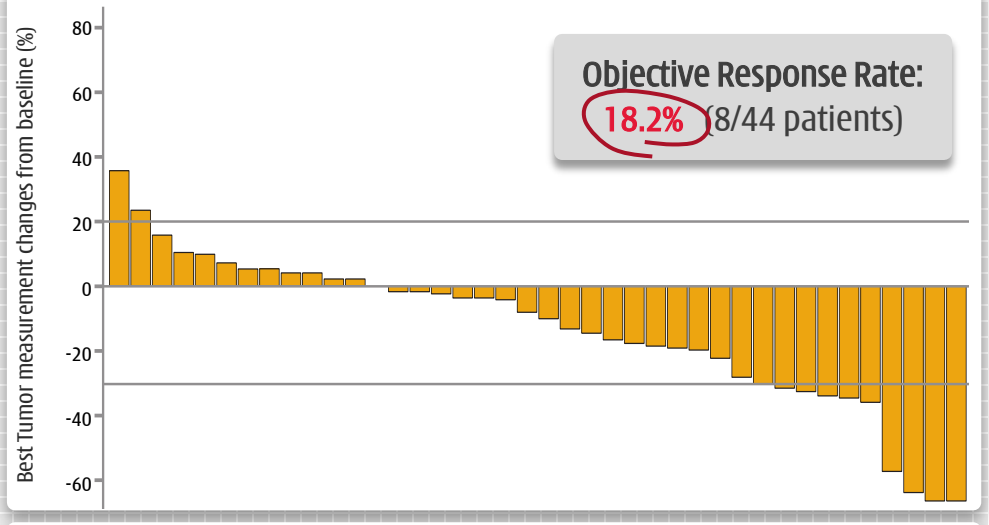
Answer: ›300 pt. PRCC Molecular Epidemiology Study (late 2017 readout).

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

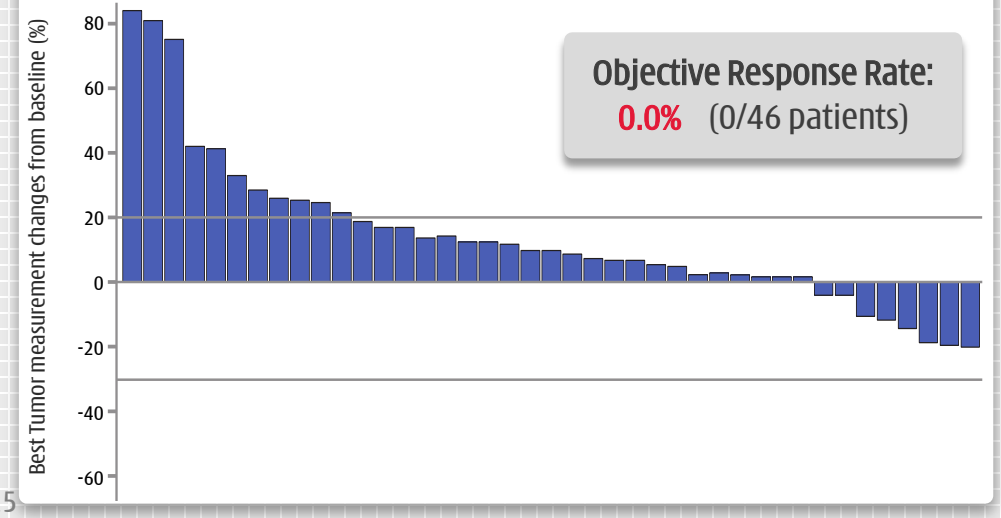
Savolitinib – PRCC Phase II

Clear efficacy & durable response in MET+ PRCC patients

1. Savolitinib clear ORR benefit in MET+ patients.



2. MET- patients – no response to savo.



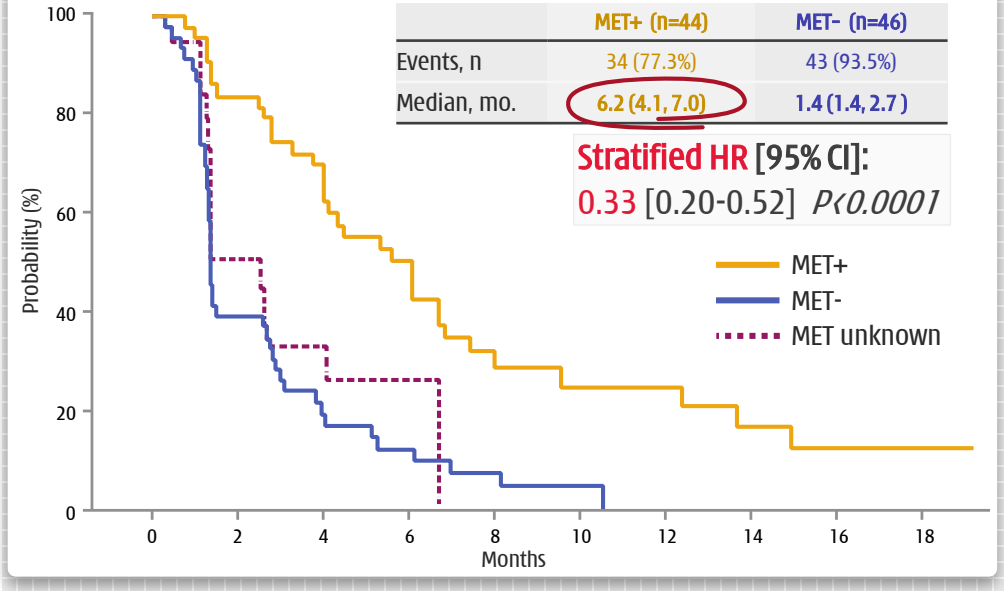
3. Disease Control Rate ("DCR") – big advantage in MET+ with DCR 73.2% vs. MET- 28.2%.^

Tumor responses in the overall treatment population and by MET status

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

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

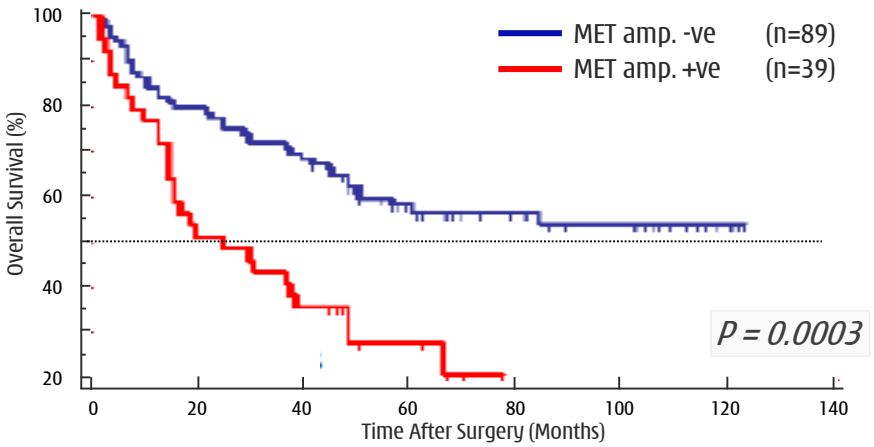
4. Median PFS – big advantage in MET+ patients.



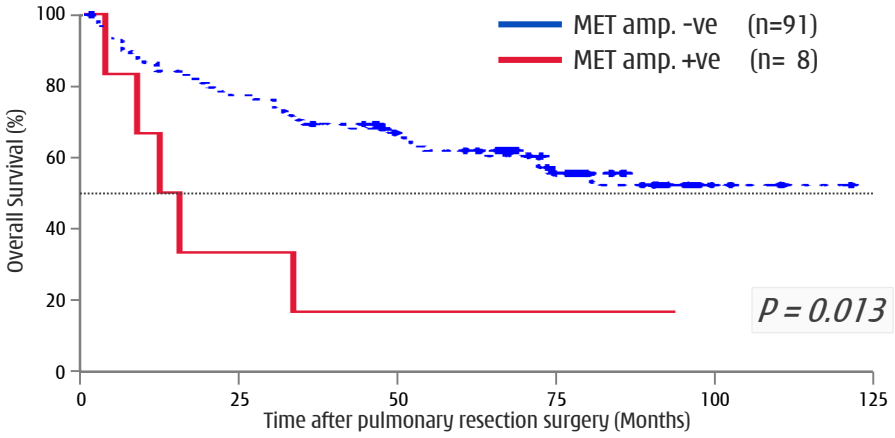
MET-driven disease

A predictor of very poor patient outcome in many cancers

1. Gastric cancer MET-driven …far worse survival.[1]



2. SCC NSCLC MET -driven …far worse survival.[2]



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

- **A pooled analysis of historical data** - to correlate MET-driven PRCC status with documented historical 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 - Results H1 2018.

UNICANCER Getug | ASAN FOUNDATION 아산재단 ASAN Medical Center | IMDC

PRCC Patient Data (n ›300)

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

4. How we will use the MES data set?

- **Possible Breakthrough Therapy discussion** - with clear evidence that c-MET-driven PRCC has far worse treatment outcome/survival than MET-independent.
- **Clarity on PFS/OS treatment outcome of MET-driven patients** - how do MET-driven PRCC patients (vs. MET-independent) 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 d'Étude des Tumeurs Urogénitales; [4] IMDC = International Metastatic Renal Cell Carcinoma Database Consortium.

Savolitinib – PRCC Phase II

Safe & very well tolerated -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 - Gastric cancer

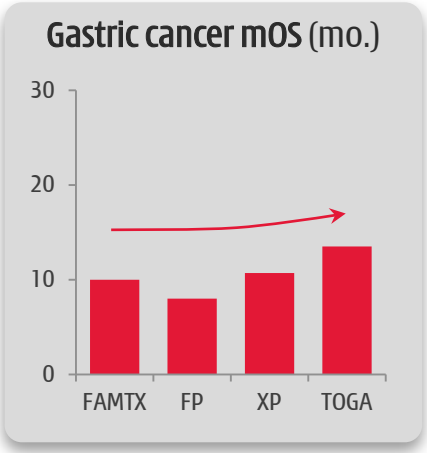
A major problem in east Asia - Japan, South Korea & China

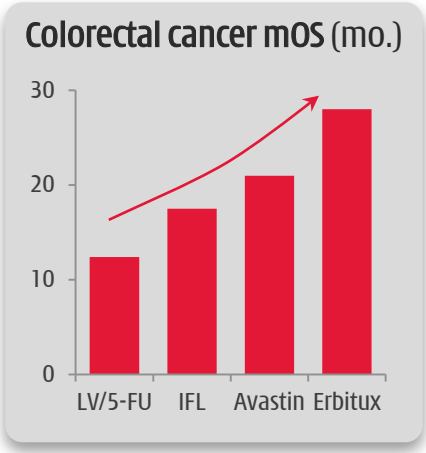
1. Gastric (stomach) cancer is the 5th most common cancer globally - 723,000 deaths/year.

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

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

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





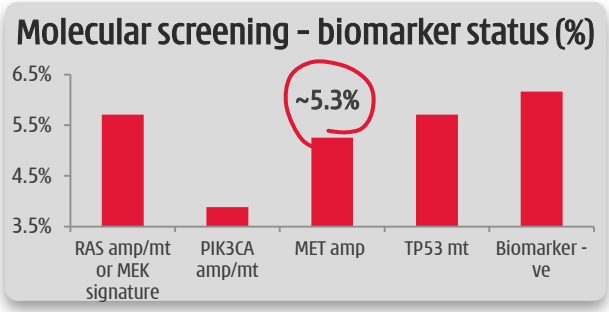
Jeeyun Lee, AACR 2016; Mayer RJ, J Clin Oncol 2015.

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

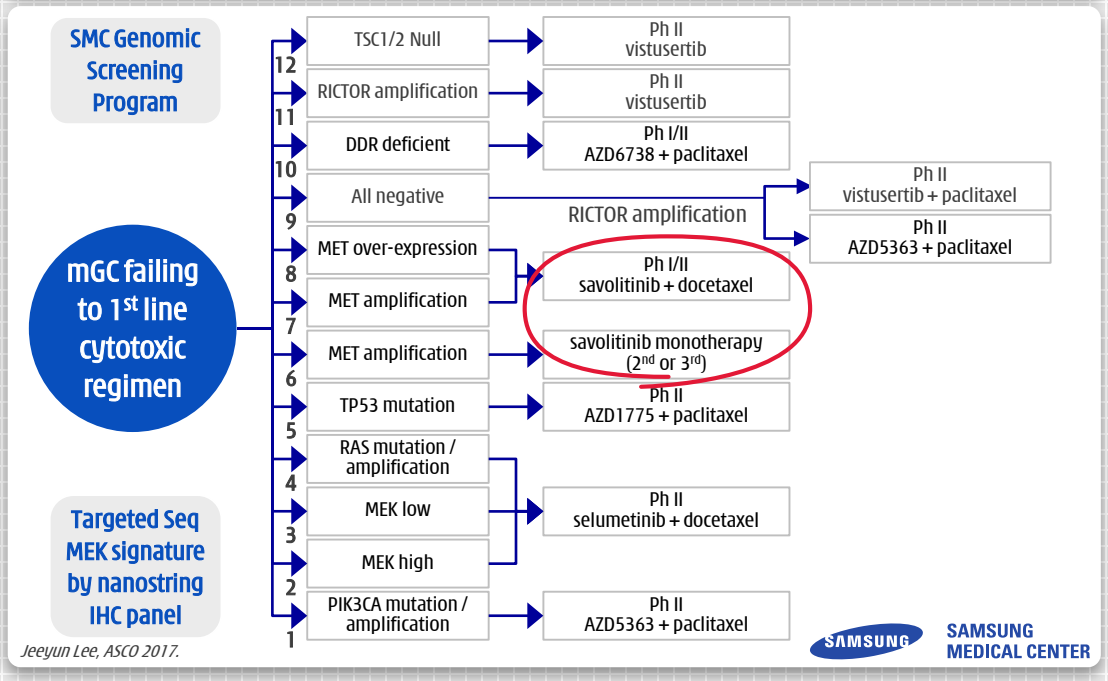
Total of 438 patients screened for genomic profiling [1]

↓

102 (23.3%) patients enrolled



Jeeyun Lee, ASCO 2017



Jeeyun Lee, ASCO 2017.

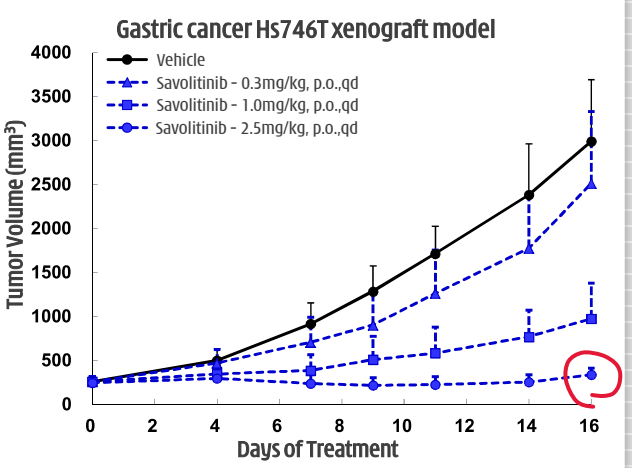
SAMSUNG MEDICAL CENTER

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

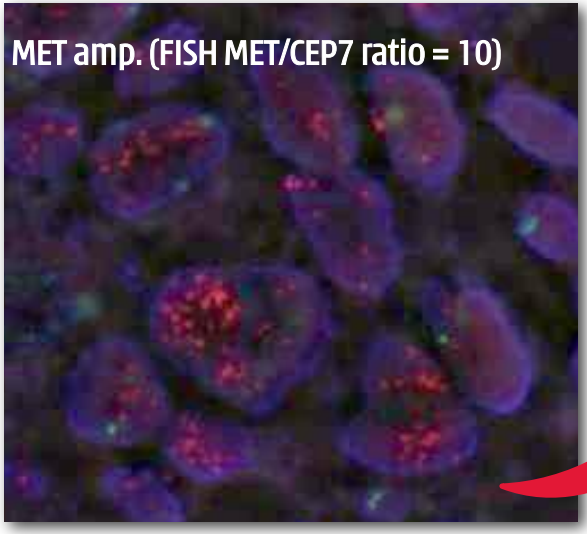
Savolitinib - Gastric cancer

VIKTORY trial - very promising early clinical results in MET+ ptnts.

1. Strong preclinical efficacy.

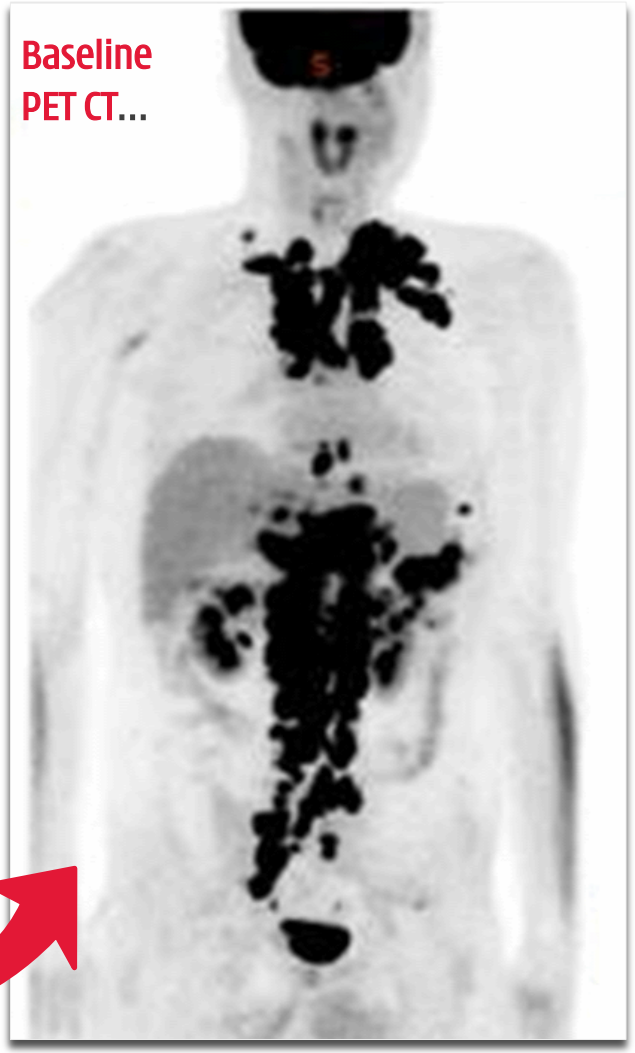


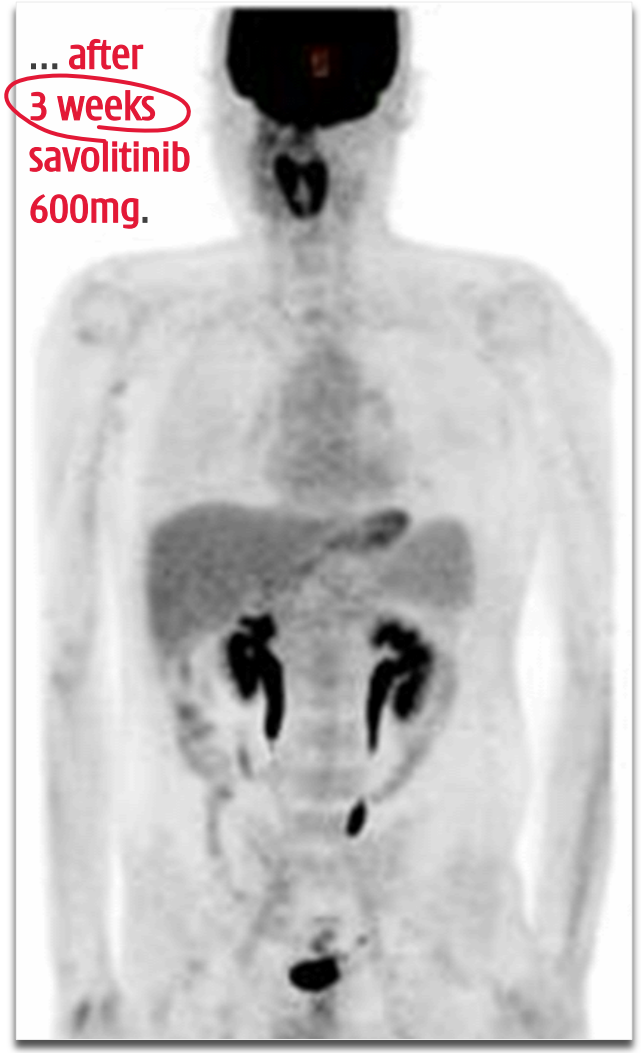
p.o. = by mouth (i.e. orally); qd = one dose per day.



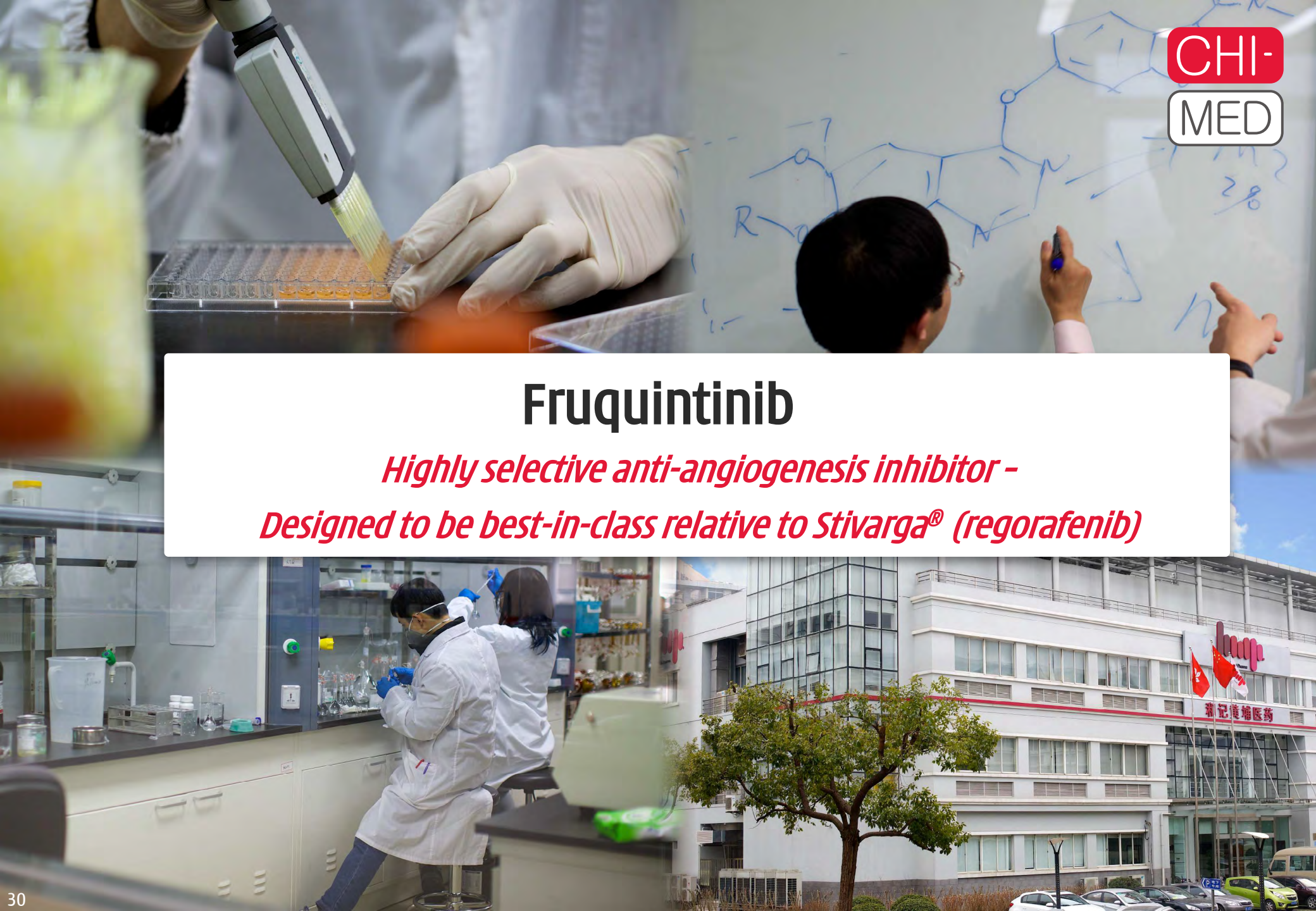
Jeeyun Lee, AACR 2016.

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 best-in-class relative to Stivarga® (regorafenib)

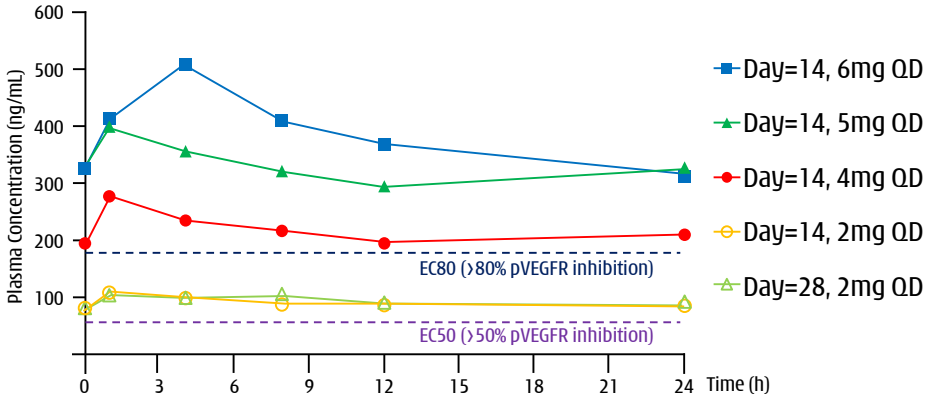
Fruquintinib – 24hr full target coverage

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

1. Substantial progress made in 2016 – fruquintinib China NDA submission June 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 submitted**.
- ✓ **Pivotal Phase III** in **3L NSCLC well underway** since Q4 '15 initiation.
- ✓ **Pivotal Phase III Taxol® combo** in **2L gastric cancer initiated** Oct 2017.
- ✓ **Phase II Iressa® combo** in **1L EGFRm+ NSCLC** ongoing / early data at WCLC 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.

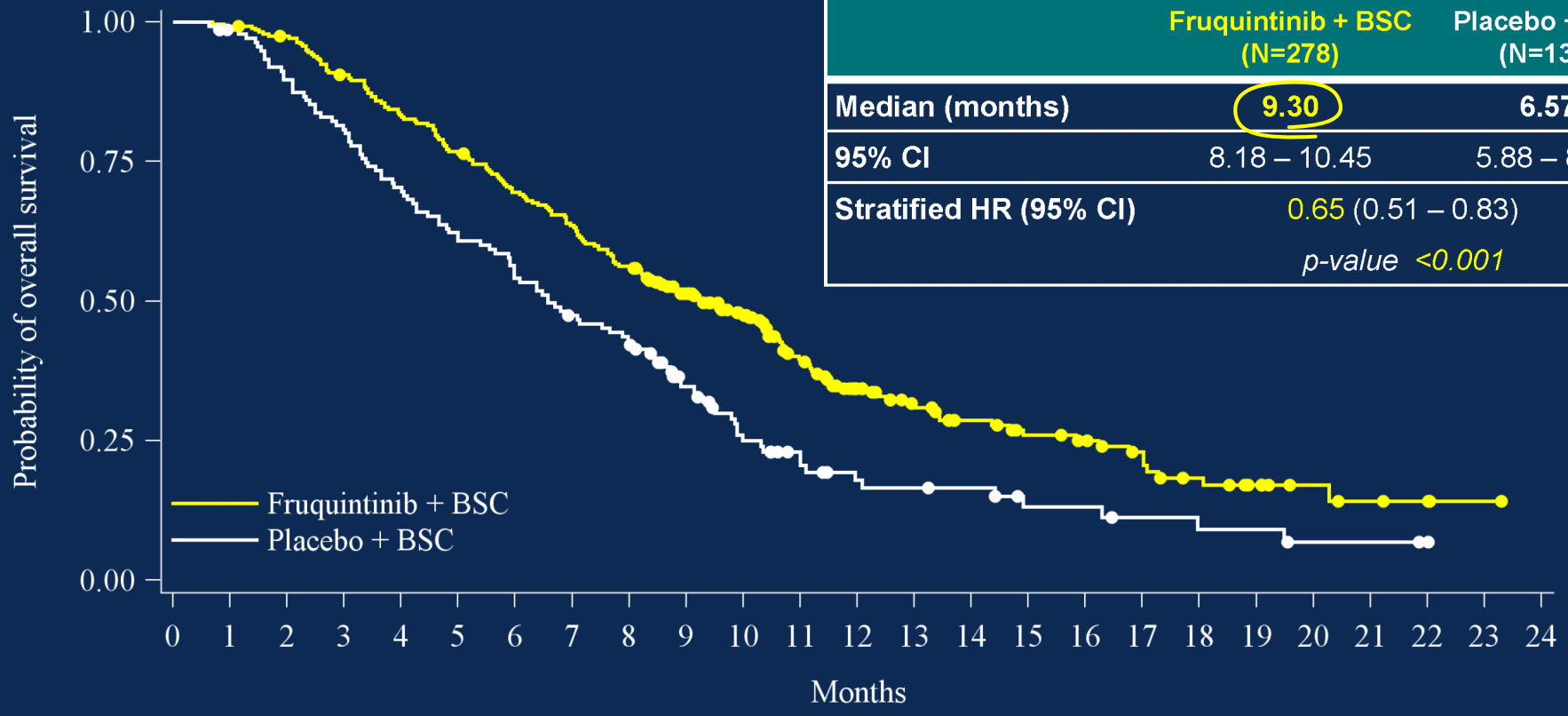
Fruquintinib - Third-line colorectal cancer

Best-in-class efficacy/safety - Ph.III FRESCO data ASCO 2017 [1]

Overall Survival (Primary Endpoint)

FRESCO clearly succeeded in meeting the primary efficacy endpoint of OS

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



PRESENTED AT: ASCO ANNUAL MEETING '17 | #ASCO17

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Presented by: Jin Li, MD PhD

June 5, 2017

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[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

High VEGFR selectivity - lower 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 interruption	35.3%	10.2%	68.8%	25.0%
AE Leading to dose reduction	24.1%	4.4%	23.2%	0.0%
AE Leading to treatment discontinuation	15.1%	5.8%	14.3%	6.7%

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 – FALUCA Phase III in 3L NSCLC

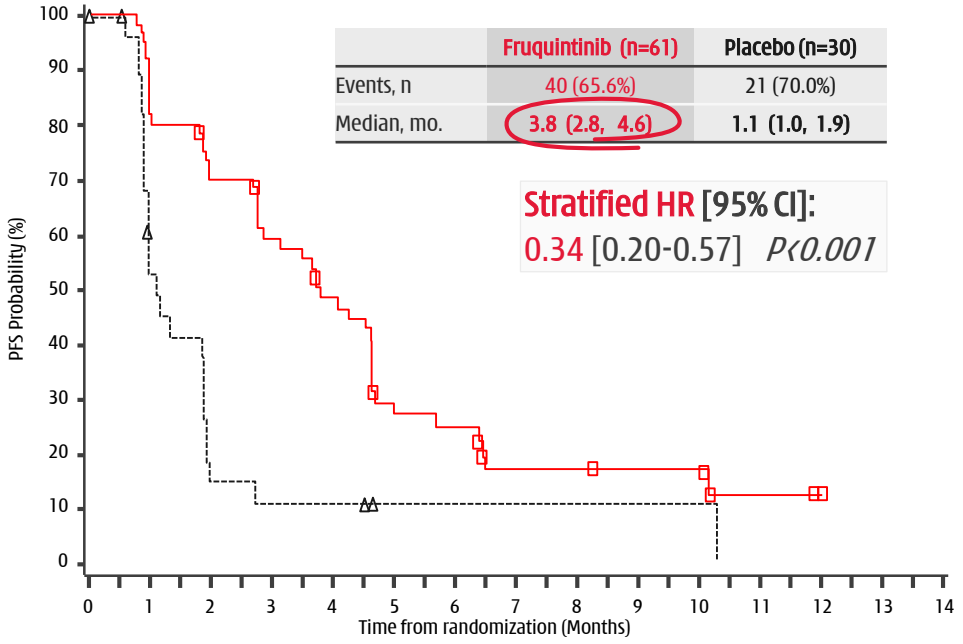
Phase III last patient will enroll early 2018

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

- ✓ 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%)

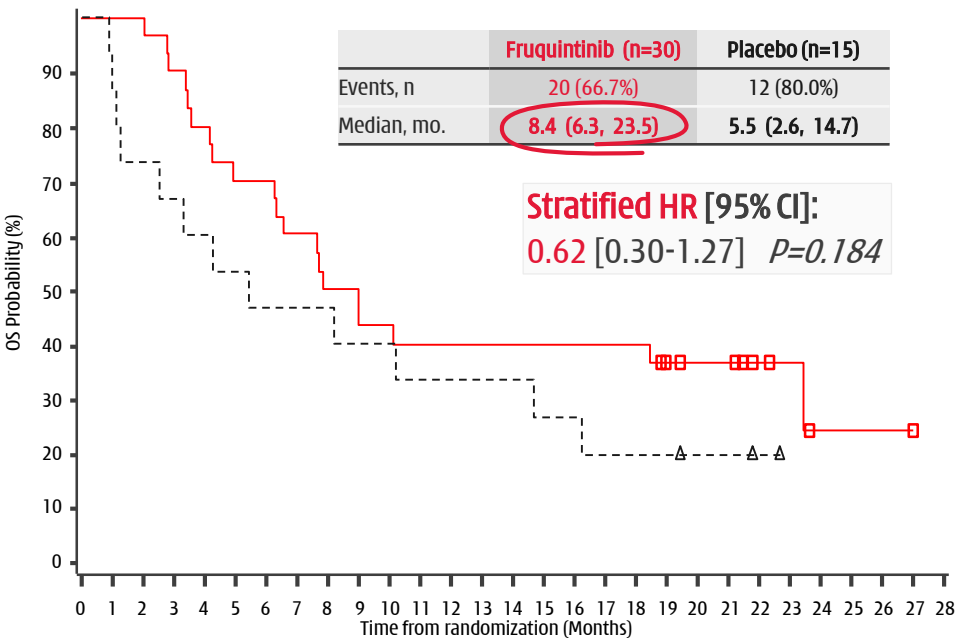
3L NSCLC Phase II: Progression Free Survival



	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)

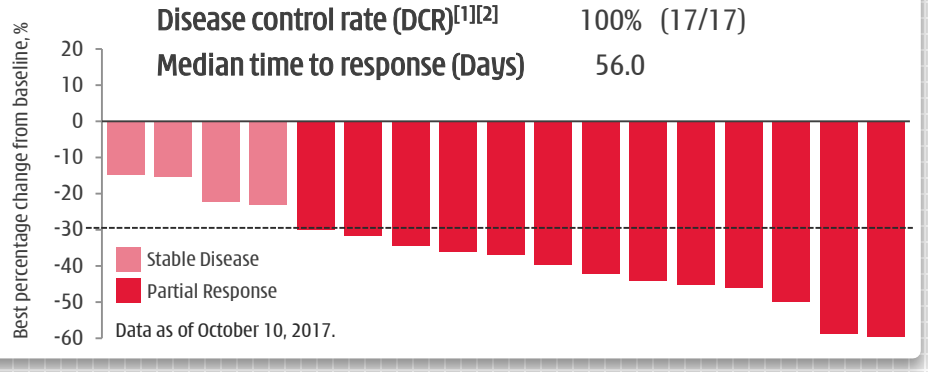
Stratified HR [95% CI]:
0.62 [0.30-1.27] *P=0.184*

[1] EGFR Mutation positive (n=45)

Fruquintinib – 1L NSCLC combo w/ IRESSA gefitinib

Two small molecule TKIs allow for better management of tox.

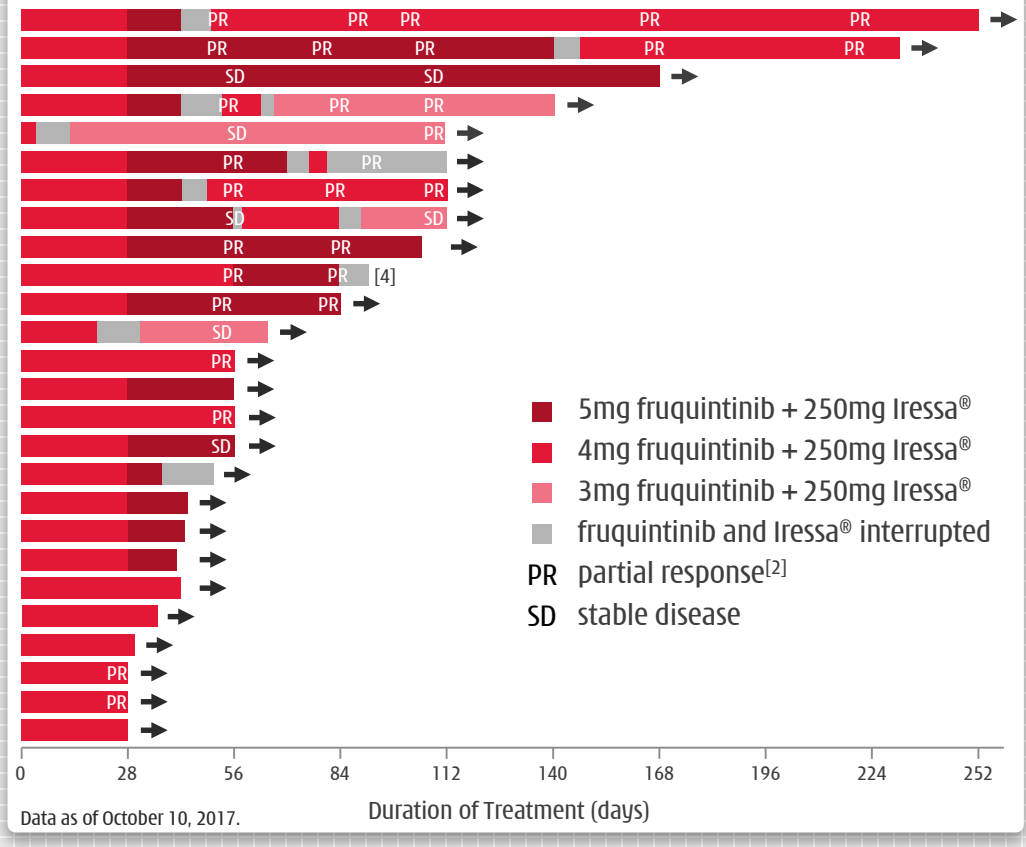
1. Promising efficacy in first-line – 77% ORR (13/17).[1,2,3]



2. Safety data: fruq. better for combos vs. other VEGFRis.

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

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

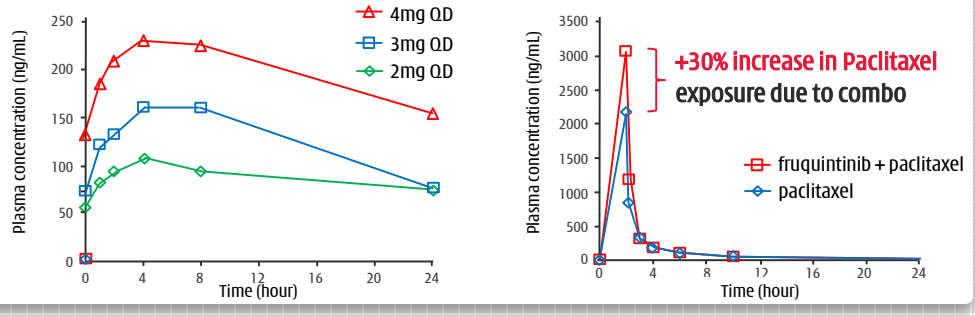


[1] Best tumor response for efficacy evaluable patients (patients who had both baseline and post-baseline tumor assessments); ORR = objective response rate; [2] Four PRs not yet confirmed at the time of data cut-off date; [3] Lu, S., et al, "A Phase II study of fruquintinib in combination with gefitinib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

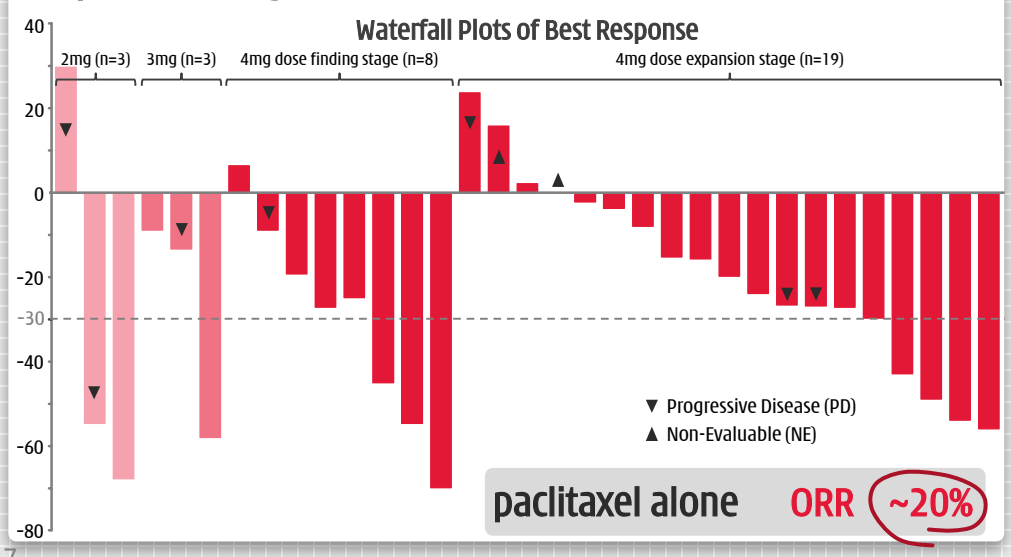
Fruquintinib - Gastric combo with paclitaxel

Phase III initiated October 2017

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



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



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

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

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

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

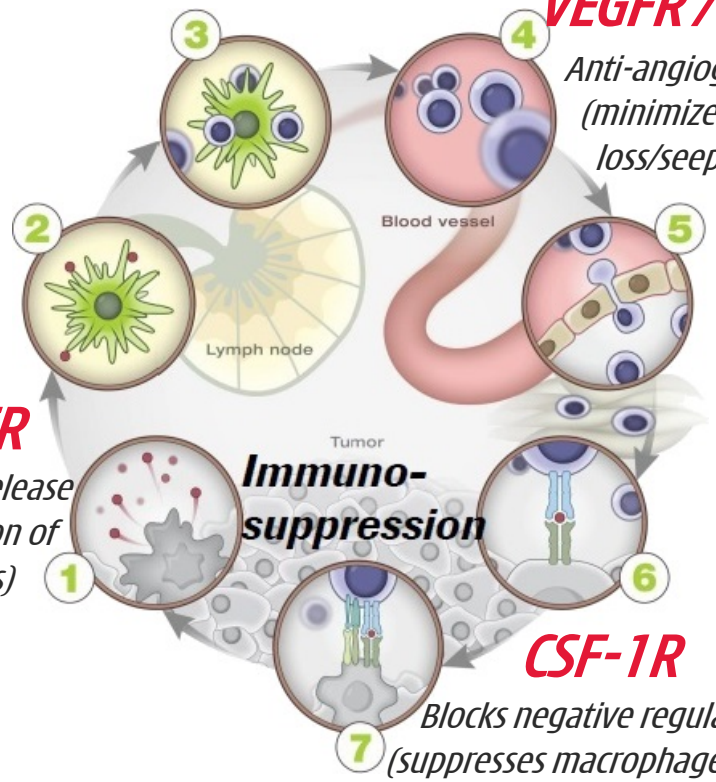
Sulfatinib

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

Sulfatinib's unique angio-immuno kinase profile

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

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 production of macrophages (CSF-1R) which cloak cancer cells.



VEGFR / FGFR

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

FGFR

Antigen release (activation of T-cells)

CSF-1R

Blocks negative regulators (suppresses macrophage cloak)

Activity 1: 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

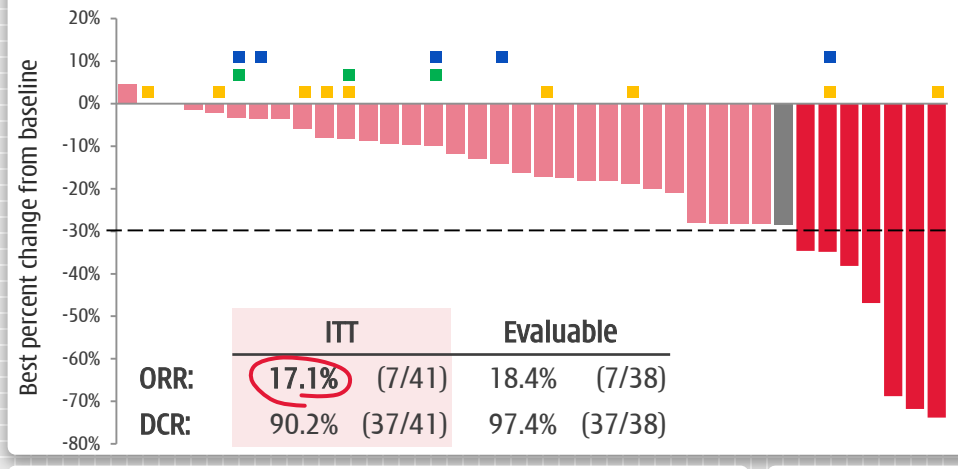
- China Ph.II studies underway in: (a) Medullary thyroid cancer; (b) Differentiated thyroid cancer; and (c) Biliary tract cancer.

[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 all NET; & patients who failed on Sutent®/Afinitor®

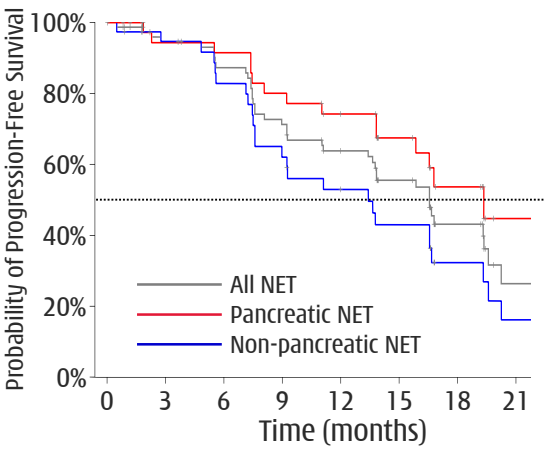
Phase II: Pancreatic NET - Highest ORR seen to date in pNET.



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

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

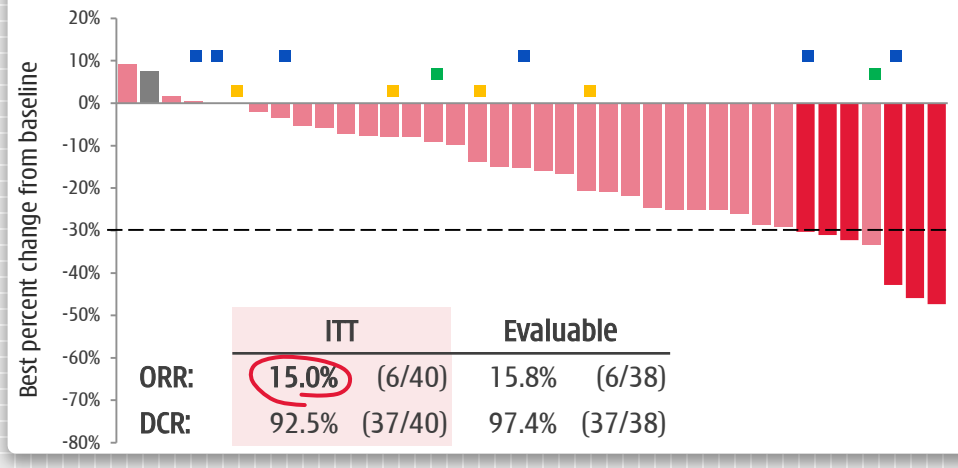
Phase II: Progression-Free Survival (PFS)



	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)**

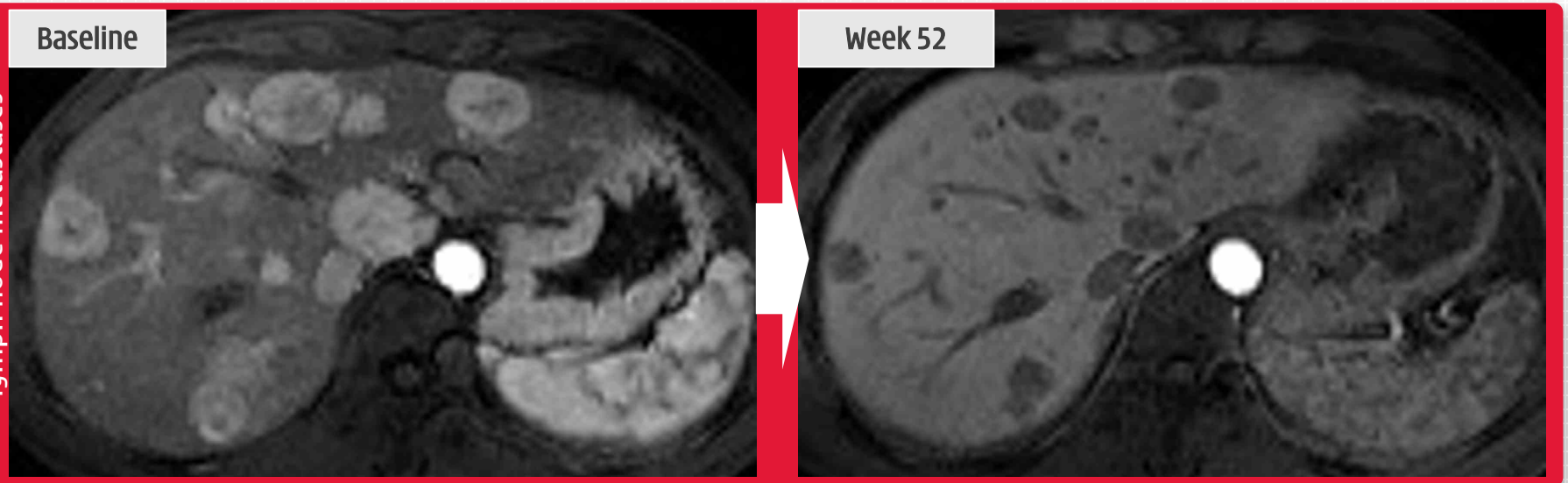
[1] ENETS = European Neuroendocrine Tumour Society. Data cut-off as of Jan 20, 2017.

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

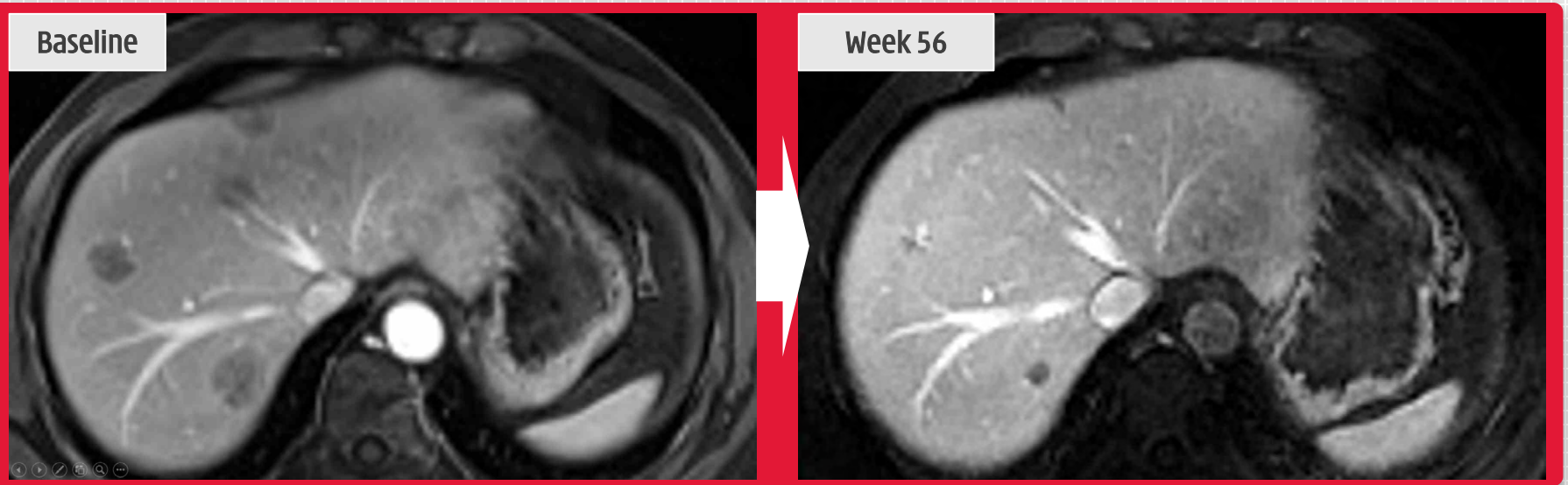
Tumor devascularization & central necrosis

CHI-MED

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



Patient 2
Rectum NET G2
w/ multiple liver metastases



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

Epitinib

EGFR mutation kinase inhibitor that penetrates the blood-brain barrier

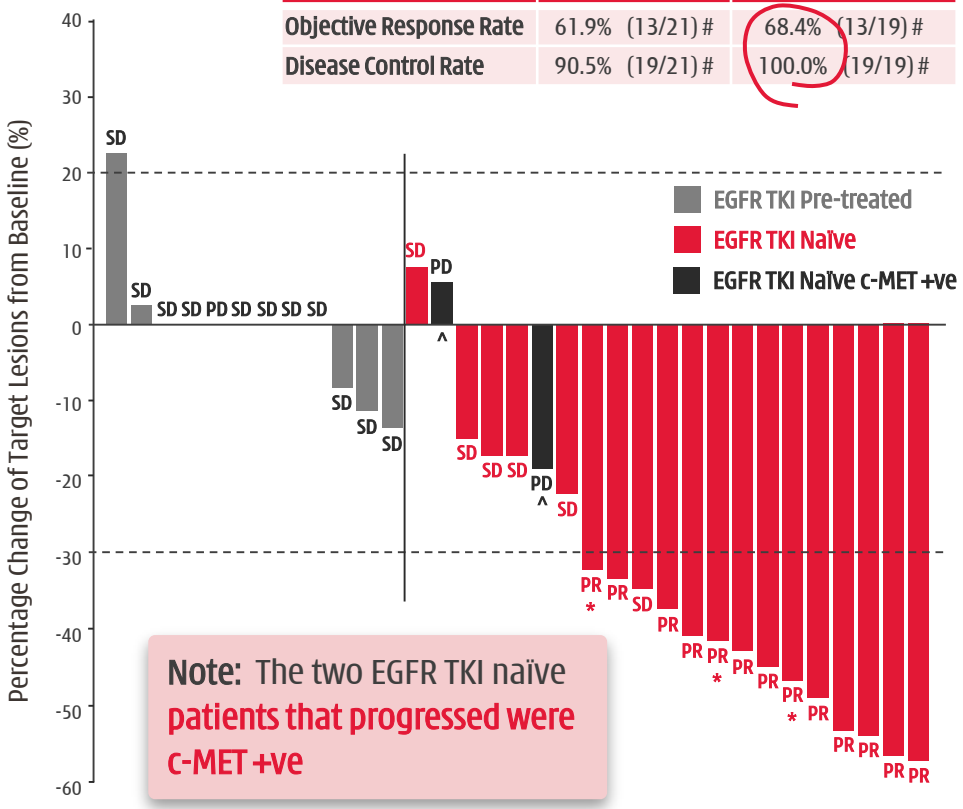
Entering Phase III trials

Epitinib – 70% response in NSCLC w/ brain mets[2]

Unmet medical need for ~50% of NSCLC patients w/ brain mets[1]

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

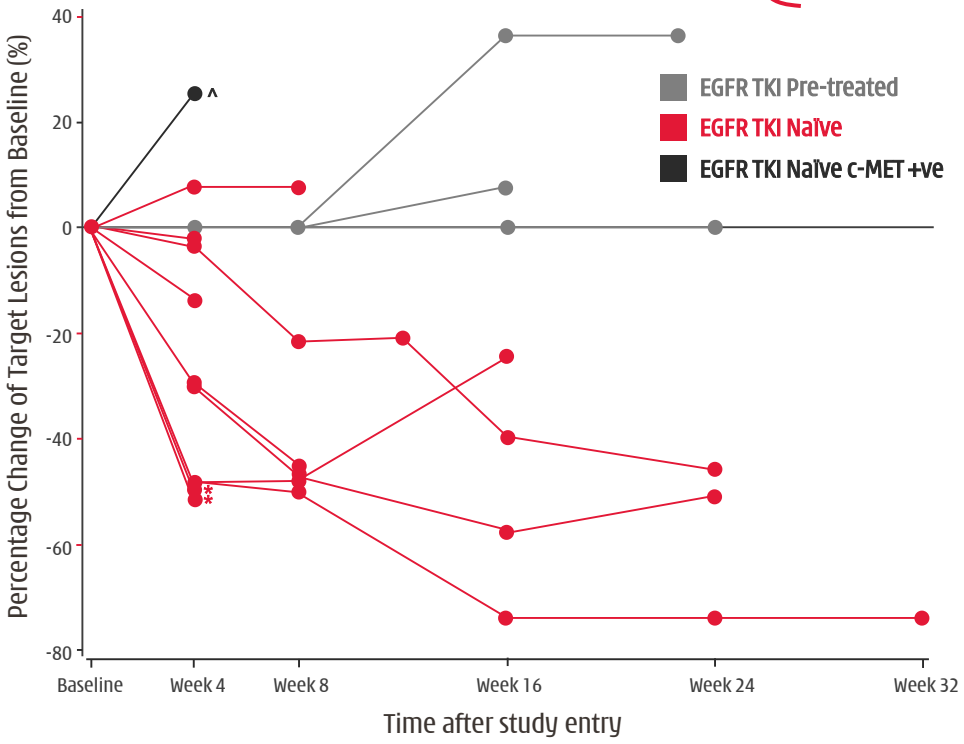
	EGFR TKI naïve (N=21)	EGFR TKI naïve excl. c-MET +ve (N=19)
Objective Response Rate	61.9% (13/21) #	68.4% (13/19) #
Disease Control Rate	90.5% (19/21) #	100.0% (19/19) #



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

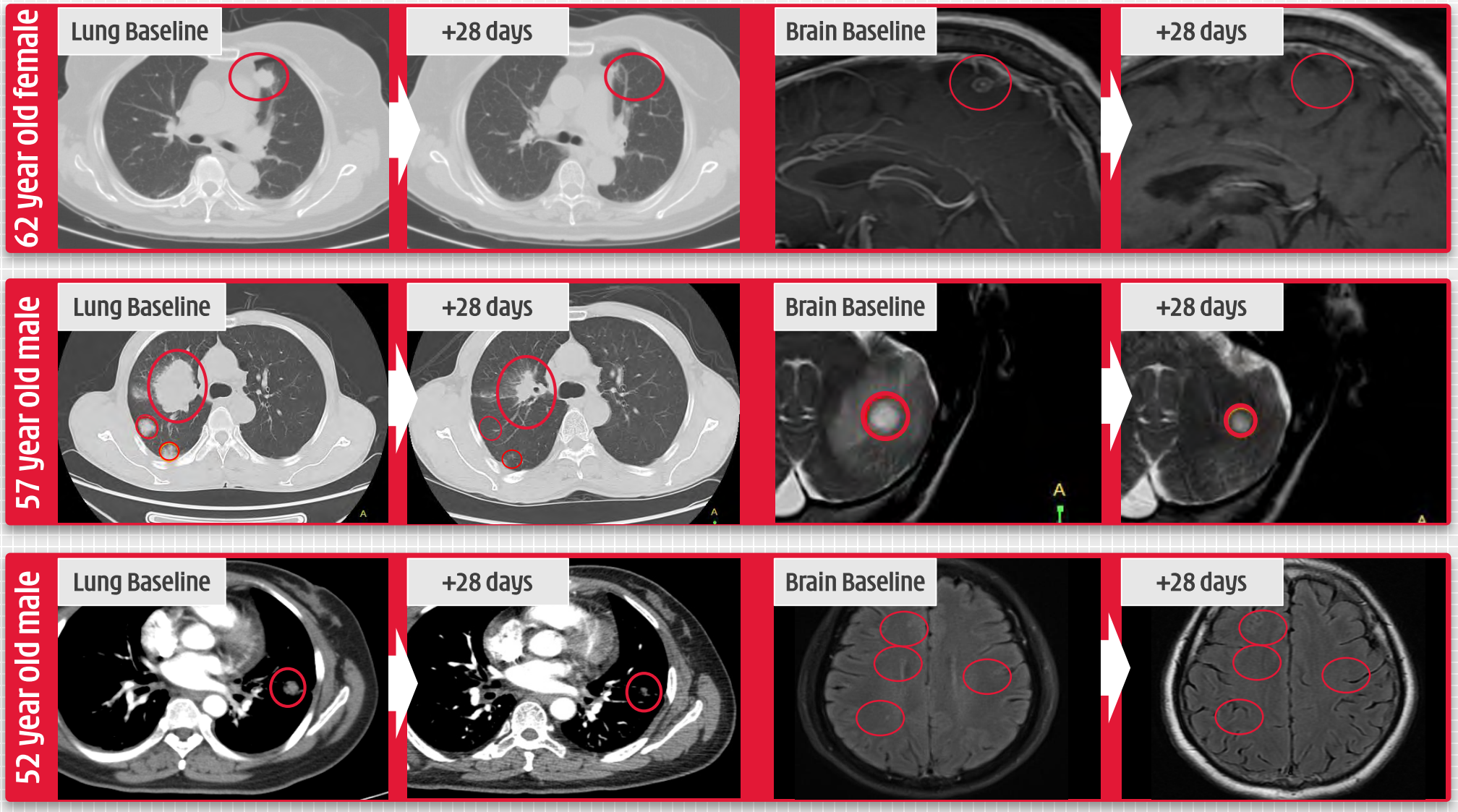
2. Phase Ib [2] – solid/durable efficacy in brain in EGFRm+ NSCLC patients with measurable brain mets (>10mm).

	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 – Strong PoC efficacy



Epitinib – Safe & well tolerated

Pivotal Phase III study to initiate in early 2018

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

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

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%)	-

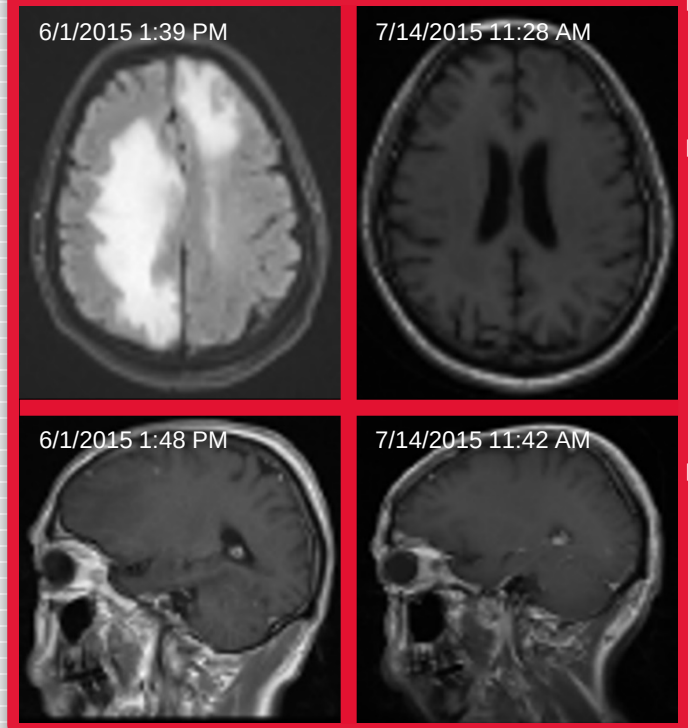
4. Now moving into Phase III pivotal study in China.

- 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.

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

CASE STUDY – EGFR-TKI pretreated patient

- Man, 58, 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).

Additional Clinical Candidates

HMPL-523 – potential first-in-class Syk inhibitor, Theliatinib, HMPL-689, HMPL-453 & HM0046599…

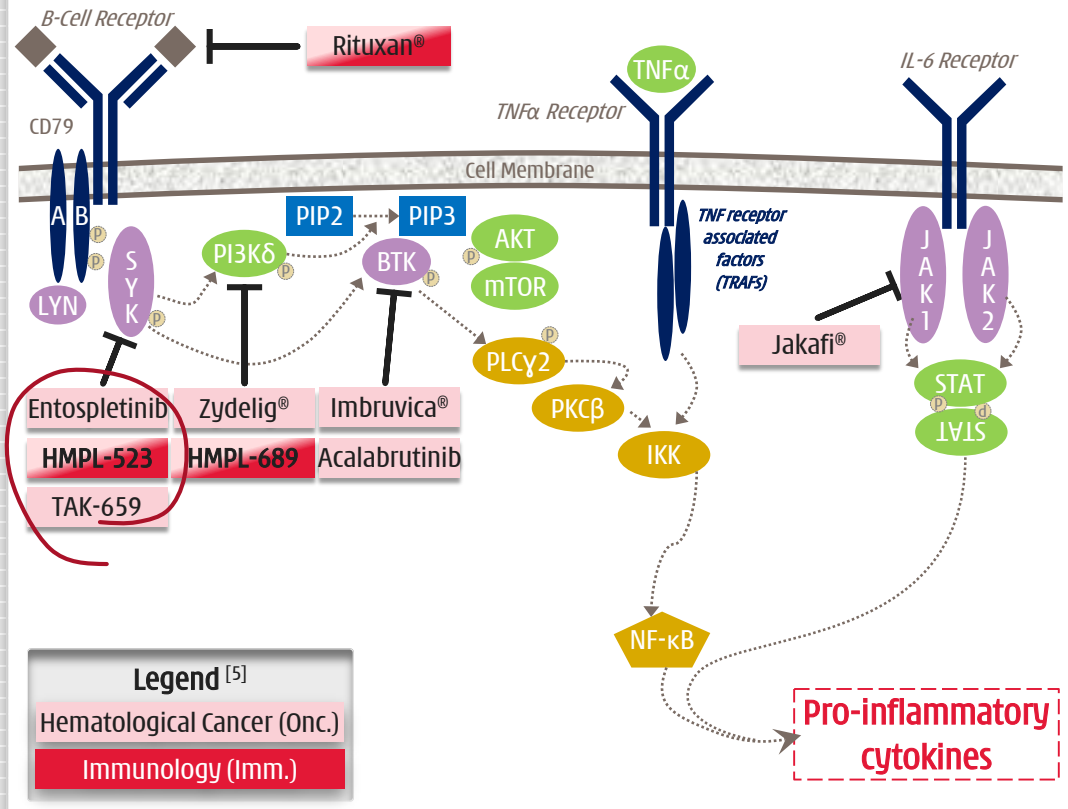
…all progressing as planned

HMPL-523 – hematological malignancies

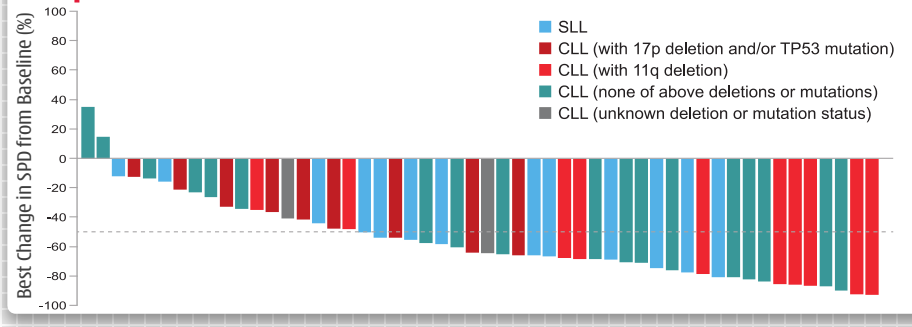
Syk exciting target emerging – Lymphoma PoC ongoing

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

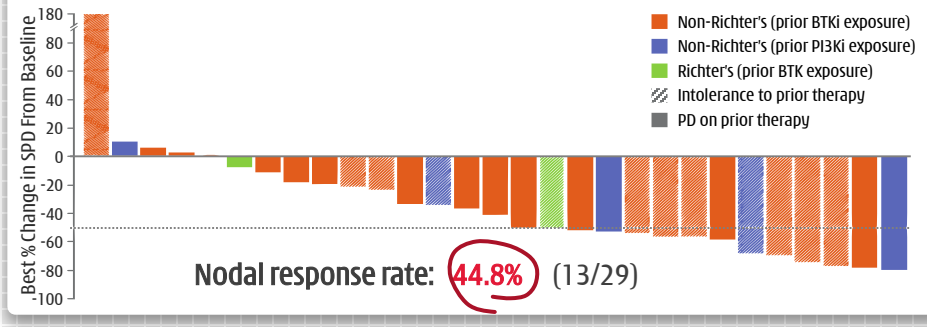
- Sales in 2016 of Imbruvica® were $1.8 billion; Zydelig® $0.2 billion; Jakafi® $0.6 billion; & Rituxan® $6.5 billion[2].



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].

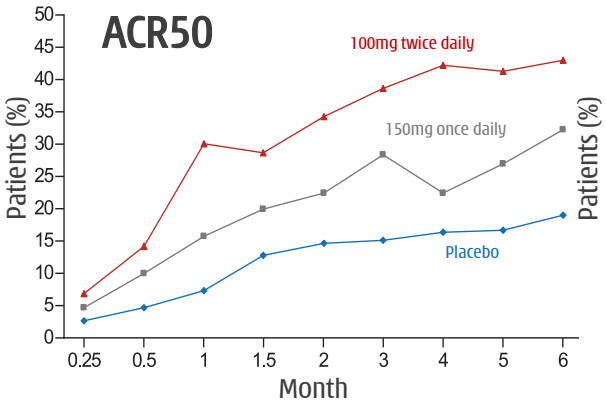
- Poor solubility/oral absorption & high variation in drug exposure.
- Some CYP[4] inhibition & increased risk of drug-drug interaction.
- 66% Grade ≥3 AEs; 49% SAEs; 46% drug interruption & 20% disco.

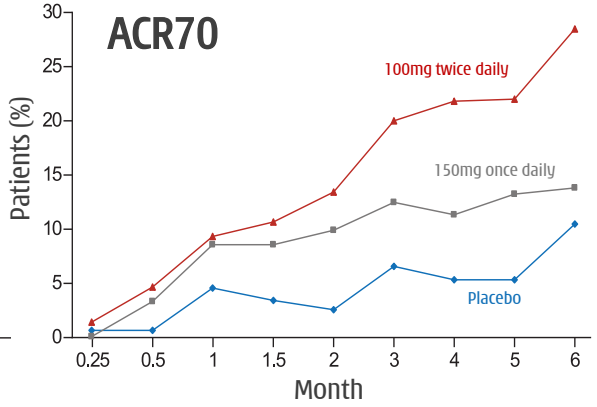
[1] ASH = American Society of Hematology; [2] Rituxan® 2016 sales in oncology only; [3] Chronic lymphocytic leukemia ("CLL") & small lymphocytic lymphoma ("SLL"); [4] CYP3A4, CYP2D6 and CYP 1A2; [5] Approved Drug = ®; All others are clinical candidates; [6] Sharman et al, ASH Meetings 2015 & 2016.

HMPL-523 – immunology potential

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

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





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

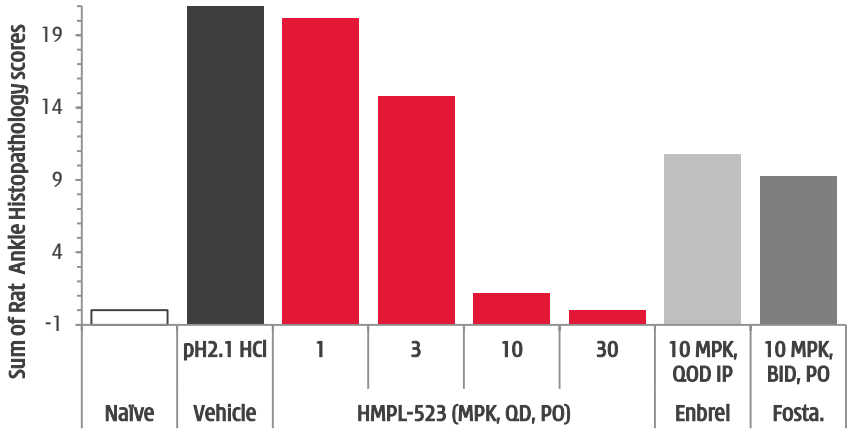
Percent of patients	Placebo (n = 153)	150mg QD (n = 152)	100mg BID (n = 152)
Diarrhea	3.0%	11.8% †	19.1% †
Upper respiratory infection	7.1	7.2	14.5 †
Urinary tract infection	4.6	3.3	5.9
Nausea	4.6	5.9	4.6
Neutropenia	0.7	6.6 †	5.9 †
Headache	5.2	6.6	5.9
Abdominal pain	2.6	6.6 †	5.9 †
ALT ›3x ULN	2.0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

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

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

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

…and very strong efficacy in preclinical RA models.

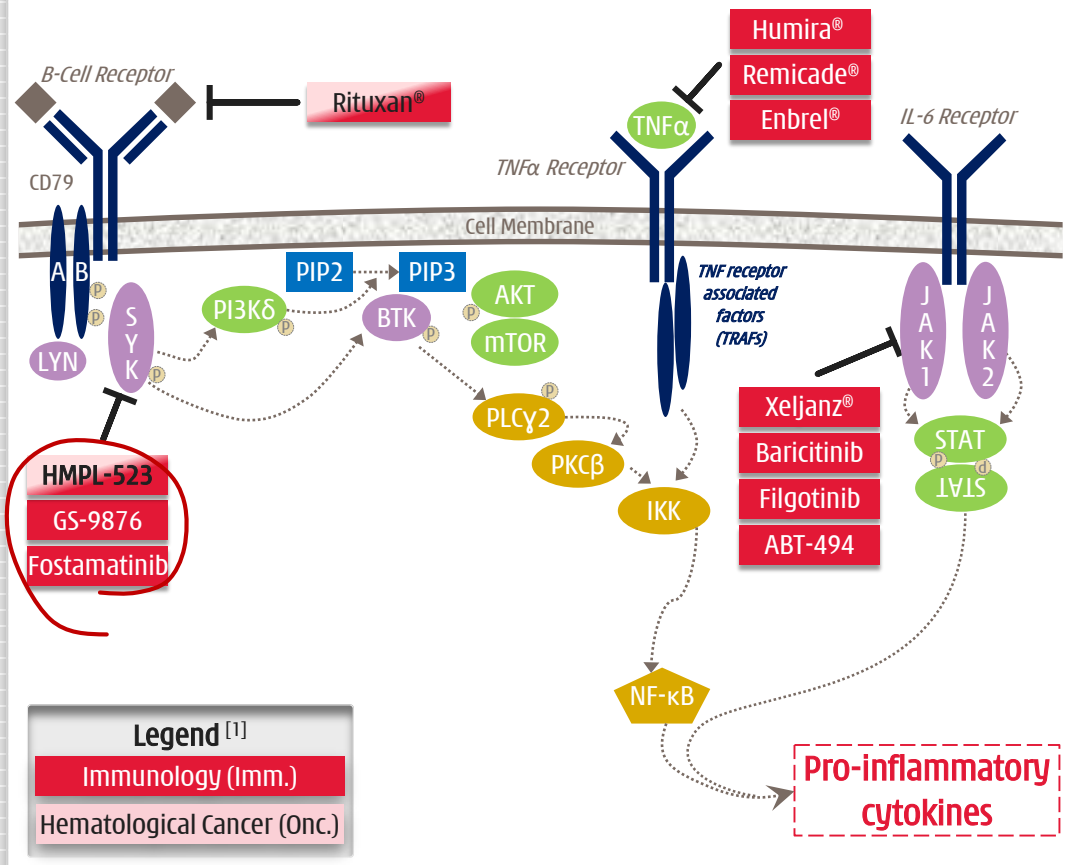


[1] Fostamatinib is a prodrug of the SYK inhibitor R406 - Phase II study data per N ENGL J MED 363;14; *: HMPL data and Eun-ho Lee, 2011; ** Birth Defects Research (Part A) 2009, 85: 130-6; [2] RA = Rheumatoid Arthritis; [3] QD = one dose per day; BID = two doses per day; QOD = one dose every other day; 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 TKI in immunology – Ph.II in planning

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



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

(Methotrexate-IR: placebo adjusted)	ACR20	ACR50	ACR70	2016 Sales ($billion) [3]
B-Cell receptor -- mAbs				
Rituxan® (24-Week)	33%	21%	11%	1.6
Anti-TNFα/NF-κB -- mAbs				
Humira® (24-Week)	33%	29%	18%	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] Frost & Sullivan; [3] 2016 sales in immunology only.

Theliatinib – encouraging activity observed

Potent & highly selective TKI – strong affinity to EGFRwt kinase

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

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

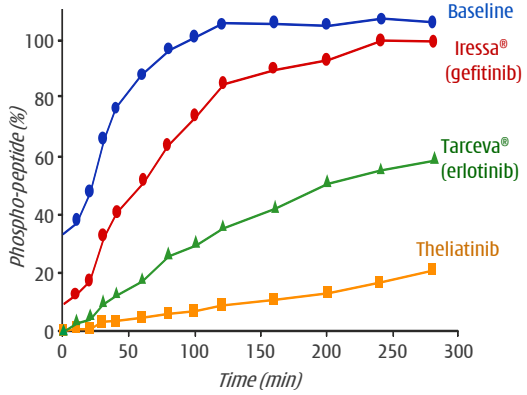
TKIs approved: Iressa®, Tarceva®

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

MAbs approved: Erbitux®, Vectibix®

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

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



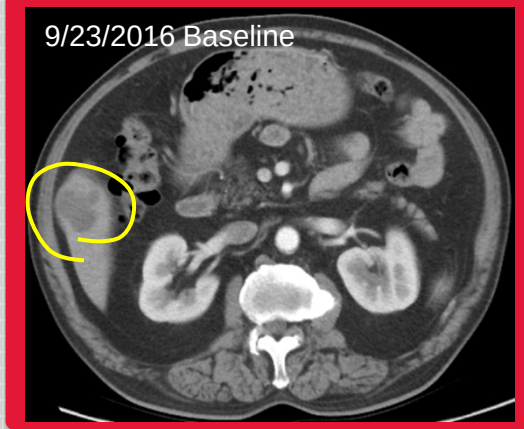
3. Esophageal cancer (EC): No effective treatment options.

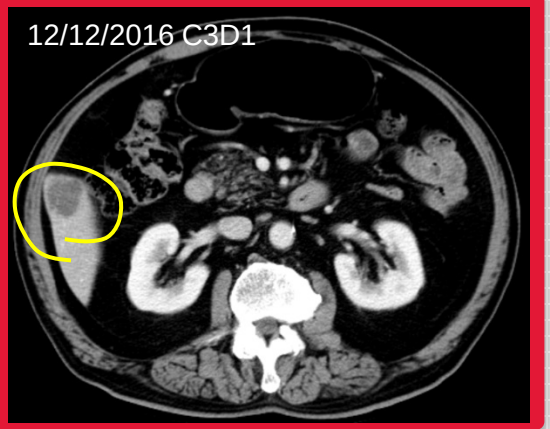
- Major issue in Asia with poor prognosis: 5 year survival 10-20%

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

CASE STUDY – EGFR protein over expression

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





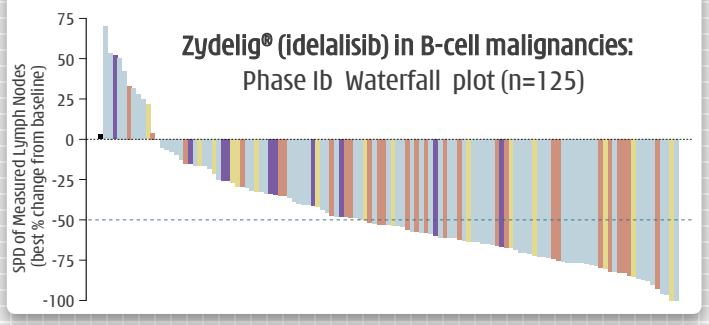
TKIs = tyrosine kinase inhibitors; MAbs = monoclonal antibodies. [1] GLOBOCAN 2012 (http://globocan.iarc.fr/) and Chen W et al. Cancer statistics in China, 2015. CA Cancer J Clin. 2016; 66:115-132

HMPL-689 – Phase I Aus. started & China to start

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

1. PI3Kδ now a proven target.

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



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

Compound		Indication	Status	Issue
Zydelig® (idelalisib) PI3Kδ	Gilead	Chronic lymphocytic leukaemia, non-Hodgkin's lymphoma	Marketed	High incidence of liver toxicity seen with idelalisib (150mg bid)
		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[2]	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[2]	
	Verastem/ Infinity[2]	COPD, SLE, psoriasis, MS transplant rejection, allergy, acute lymphocytic leukaemia, T-cell lymphoma	Phase I Trial[2]	

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)

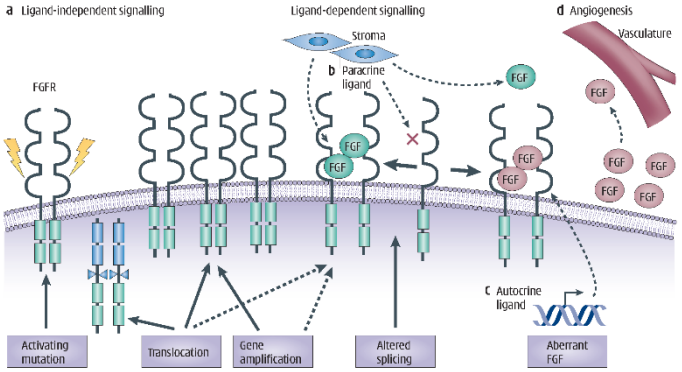
[1] COPD = Chronic obstructive pulmonary disease; SLE = Systemic lupus erythematosus; MS = Multiple Sclerosis. [2] AbbVie ended collaboration in June 2016 following Phase II results in indolent non-Hodgkin's lymphoma. Trials summary relates to status just prior to the Phase II results. Duvelisib now licensed to Verastem.

HMPL-453 – Phase I Aus. & China underway

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

1. FGFR genetic alterations are oncogenic drivers

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

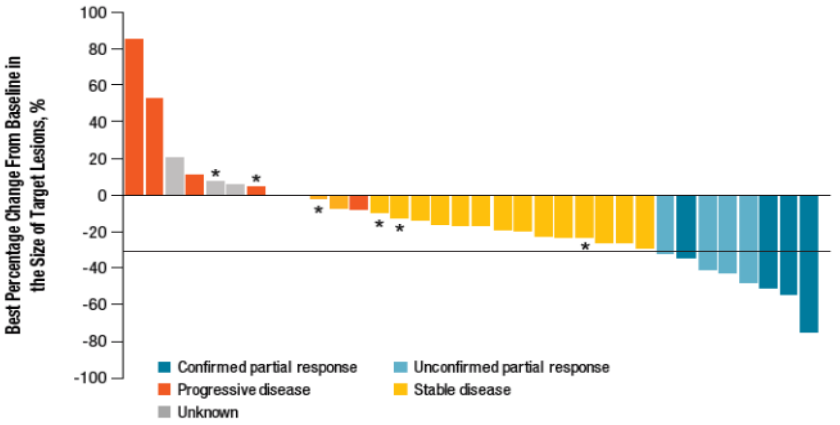


2. FGFR – diverse & complicated genetic changes with multiple tumor types harboring low incidence

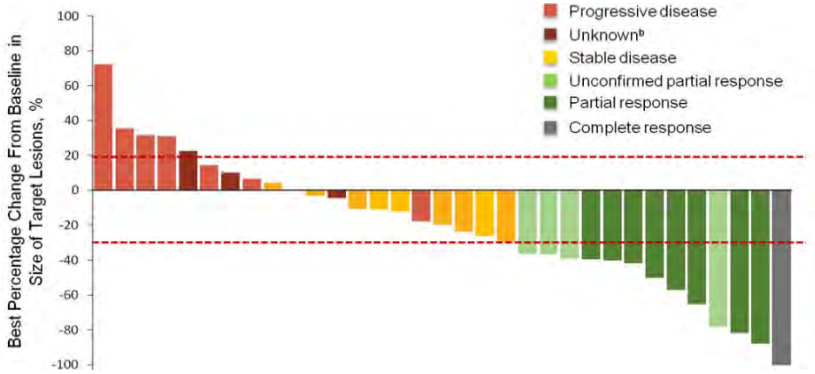
	Gene amplification	Gene translocation	Gene mutation
FGFR1	**Lung squamous** (7~15%) **H&N squamous** (10~17%) **Esophageal squamous** (9%) **Breast** (10~15%)	**Lung squamous** (n/a) **Glioblastoma** (n/a) **Myeloproliferative syndrome** (n/a) **Breast** (n/a)	**Gastric** (4%) **Pilocytic astrocytoma**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

3. Cholangiocarcinoma 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 - good source of cash

2 National house-hold name brands

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

Commercial Platform Performance - 2003-H1 2017[8][9]

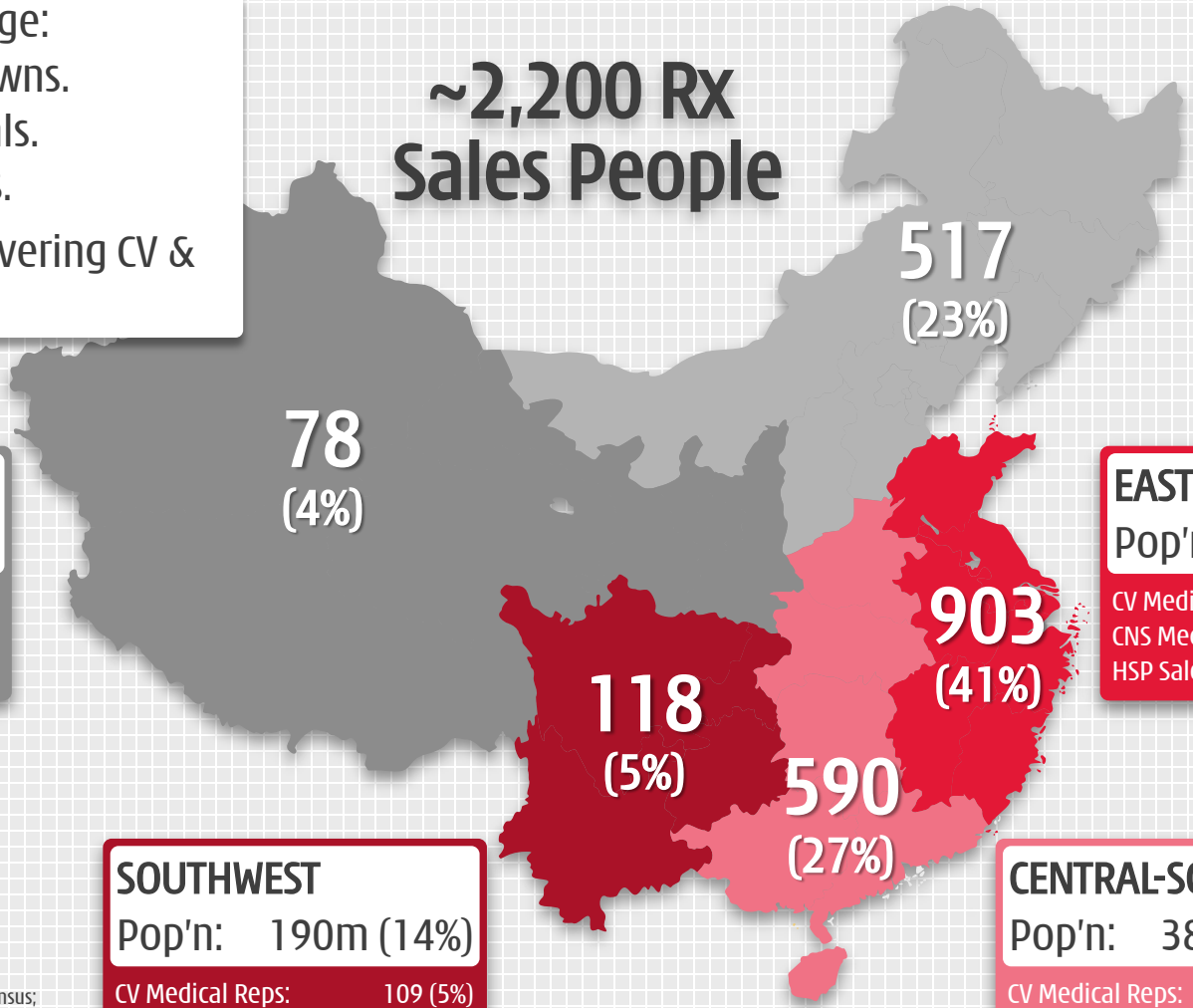
	IFRS										US GAAP						H1 16-H1 17
(US$ millions)	03	04	05	06	07	08	09	10	11	12	13	14	15	16	H1 16	H1 17	Growth
Sales (Non-GAAP)	**21.9**	**27.9**	**65.1**	**101.4**	**119.0**	**155.8**	**197.0**	**236.4**	**278.6**	**360.7**	**402.3**	**465.4**	**518.9**	**627.4**	**331.9**	**357.0**	**8%**
Prescription 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*	*194.5*	*215.5*	*11%*
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*	*137.4*	*141.5*	*3%*
Total % Growth	*n/a*	*27%*	*133%*	*56%*	*17%*	*31%*	*26%*	*20%*	*18%*	*29%*	*n/a*	*16%*	*11%*	*21%*	*16%*	*8%*	
Net (loss)/Income after tax (Non-GAAP)	**(10.7)**	**(3.6)**	**2.2**	**6.7**	**11.2**	**14.7**	**21.5**	**27.9**	**30.1**	**33.1**	**39.7**	**48.8**	**54.1**	**144.1**[11]	**47.9**	**51.9**[12]	**8%**
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*	*30.6*	*38.8*	*27%*
Consumer Health	*(10.3)*	*(4.9)*	*0.3*	*5.4*	*9.3*	*11.9*	*15.5*	*16.0*	*15.9*	*15.4*	*17.3*	*22.3*	*22.2*	*21.9*	*17.3*	*13.1*	*-24%*
% 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%*	*14.4%*	*14.5%*	
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]	**22.1**	**25.2**[12]	**14%**
Prescription Drugs	*(0.2)*	*0.6*	*1.0*	*0.7*	*0.9*	*1.4*	*3.0*	*5.9*	*7.1*	*8.8*	*11.2*	*13.2*	*15.9*	*61.1*	*15.3*	*19.4*	*27%*
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*	*6.8*	*5.8*	*-16%*
Total % growth	*n/a*	*-35%*	*-86%*	*340%*	*275%*	*31%*	*58%*	*35%*	*8%*	*7%*	*n/a*	*26%*	*10%*	*180%*	*12%*	*14%*	

[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 - please see appendix "Non-GAAP Financial Measures and Reconciliation"; [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; [12] Included SHPL's R&D related subsidies of US$5.9 million and $2.5 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.
- Medical reps. covering CV & CNS nationally.



NORTH
Pop'n: 320m (23%)

CV Medical Reps:	493 (24%)
CNS Medical Reps:	24 (21%)
HSP Sales staff:	0 (0%)

WEST
Pop'n: 100m (7%)

CV Medical Reps:	73 (4%)
CNS Medical Reps:	5 (4%)
HSP Sales staff:	0 (0%)

EAST
Pop'n: 393m (28%)

CV Medical Reps:	819 (40%)
CNS Medical Reps:	53 (45%)
HSP Sales staff:	31 (100%)

SOUTHWEST
Pop'n: 190m (14%)

CV Medical Reps:	109 (5%)
CNS Medical Reps:	9 (8%)
HSP Sales staff:	0 (0%)

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

CV Medical Reps:	564 (27%)
CNS Medical Reps:	26 (22%)
HSP Sales staff:	0 (0%)

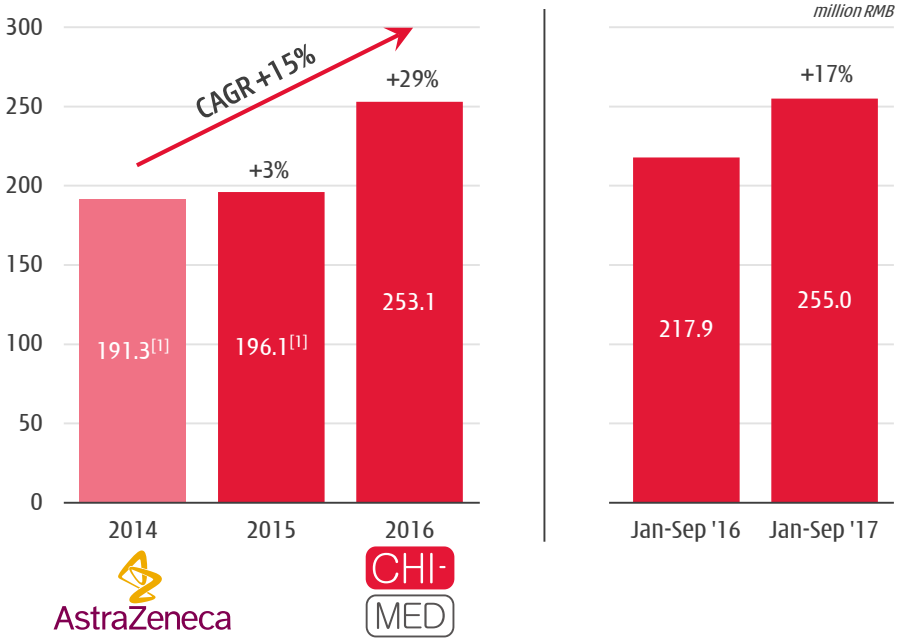
Notes: 2010 Population - China State Census; CV = Cardiovascular; CNS = Central nervous system.
Chi-Med Rx sales team data = 31 December 2016

....and highly adaptable

Sales of Seroquel® & Concor® up significantly since we took over

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

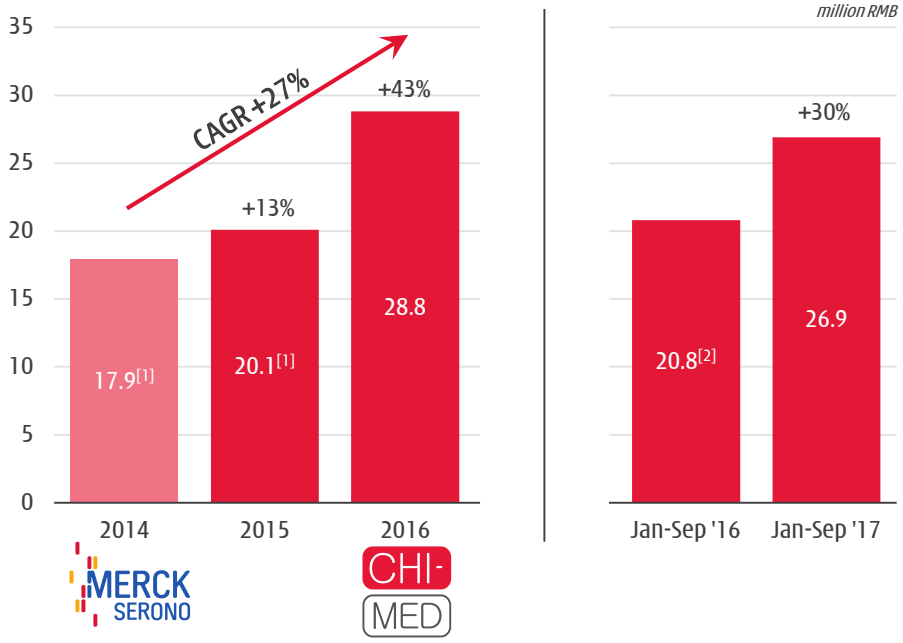
- Chi-Med holds exclusive all China commercial rights - full service commercial role.
- Took over from AZ Apr-2015.
- New team of ~120 CNS reps built from scratch.



[1] 2014 full year and Q1 2015 were managed by AstraZeneca. Chi-Med took over commercial function for Seroquel across all-China in Apr 2015.

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

- Chi-Med runs six core territories w/ 360 mn. people - full service commercial role (fee for service).
- Took over from MS Jan-2015 [2].
- Leverages SHPL's existing >1,800 CV medical reps.



[1] 2014 full year was managed by Merck Serono. Chi-Med took over commercial function for Concor in 3 original territories on fee-for-service basis in Jan 2015; [2] Excludes sales into 3 new territories which were added from Q3 2017: RMB 14.1 million.

Deep portfolio of household name drugs

Top 7 products represent 61% of sales[1] and 89% of gross profit[1]

Main Products [2] – SALES (Non-GAAP)	2011	2012	2013	2014	2015	2016	H1 2016	H1 2017
 ***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%*	110,063 *+16%*	110,384 *+0%*
 ***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%*	37,668 *-6%*	36,059 *-4%*
 ***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%*	32,263 *-3%*	28,253 *-12%*
 ***Seroquel tablets*** Bi-polar/Schizophrenia (Rx) 5% National market share	n/a	n/a	n/a	n/a	21,131	34,380 *+63%*	17,184 *+282%*	18,900 *+10%*
 ***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%*	9,315 *+18%*	8,744 *-6%*
 ***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%*	9,972 *-13%*	7,707 *-23%*
 ***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%*	5,414 *-3%*	8,762 *+62%*

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

[1] Based on aggregate Non-GAAP sales (refer to page 54) and gross profit of consolidated subsidiaries and non-consolidated joint ventures of Commercial Platform, please see appendix "Non-GAAP Financial Measures and Reconciliation"; [2] Rx = prescription drug; OTC = over-the-counter drug; SXBX pill = She Xiang Bao Xin pill; FFDS tablet = Fu Fang Dan Shen tablet; NXQ tablet = Nao Xin Qing tablet; KYQ granules = Kou Yan Qing granules; Market shares according to Frost & Sullivan or QuintilesIMS.

Appendices

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 — 28 / 9	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, Celgene, Abbott — 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 — 23 / 7	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**.

HUMIRA® adalimumab · INCIVEK® (telaprevir) 375 mg Tablets · Revlimid® (lenalidomide) capsules · SUTENT® capsules sunitinib malate · ZITHROMAX® AZITHROMYCIN · ZOMETA® (zoledronic acid) 4 mg/5 mL Injection

A risk-balanced global-focused BioPharma

Innovation Platform

Deep late-stage pipeline

- ✓ 8 oncology drug candidates in 31 studies worldwide.
- ✓ 1st positive Ph.III result - fruquintinib - Launch 2018.[1]
- ✓ 9 further Phase III trials; 5 enrolling & 4 in-planning.
- ✓ ~350-person Scientific Team.

Commercial Platform

Solid cash flow from operations

- ✓ >3,300-person China Sales Team (~2,200 med. reps).
- ✓ To commercialize Innovation Platform drugs in China.[1]
- ✓ H1 2017 sales (non-GAAP)[2] up 8% to $357.0 million.
- ✓ H1 2017 net income[3] up 14% to $25.2 million.[4]

[1] If approved; [2] H1 2017 sales (non-GAAP) represents the sum of (1) the H1 2017 GAAP revenue from external customers of our Commercial Platform ($103.9 million), (2) the H1 2017 revenue of our non-consolidated joint venture Shanghai Hutchison Pharmaceuticals Limited ("SHPL") ($129.7 million) and (3) the H1 2017 revenue of our non-consolidated joint venture Hutchison Whampoa Guangzhou Baiyunshan Chinese Medicine Company Limited ("HBYS") ($123.4 million). SHPL and HBYS revenues are as reported in the unaudited consolidated financial statements of each of these companies which are prepared in accordance with IFRS; [3] Net income attributable to Chi-Med; [4] Includes the share of a one-time gain from SHPL's R&D related subsidies ($2.5 million).

Chi-Med Group structure - major entities

Non-Consolidated Joint Ventures

Chi-Med Subsidiaries

Chi-Med Group Level

Revenues - H1 2017 $126.6m (H1 2016: $104.5m)
Net Income Attributable to Chi-Med - H1 2017: $1.7m (H1 2016: $0.5m)

Innovation Platform

Revenue - **H1 2017: $22.7m** (H1 2016: $22.3m)
Net Loss Attributable to Chi-Med - **H1 2017: -$14.8m** (H1 2016: -$13.7m)

99.8%

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

Revenue:
H1 2017: $22.7m (H1 2016: $22.3m)

50%

Nutrition Science Partners ("NSP")
Botanical Drug /GI Disease R&D
Partner: Nestlé Health Science
Revenue:
H1 2017: nil (H1 2016: nil)

Commercial Platform

Sales of Subs & JVs - **H1 2017: $357.0m** (H1 2016: $331.9m)
Net Income Attributable to Chi-Med - **H1 2017: $25.2m** (H1 2016: $22.1m)

Prescription Drugs

50%

Shanghai Hutchison Pharma ("SHPL")
Prescription Drugs
Partner: Shanghai Pharma Group
Revenue:
H1 2017: $129.7m (H1 2016: $126.8m)

51%

Hutchison Sinopharm ("HSP") [1]
Rx Drug Commercial Co.
Partner: Sinopharm Group
Revenue:
H1 2017: $85.8m (H1 2016: $67.6m)

Consumer Health

50% [2]

Hutchison BYS Chinese Med. ("HBYS")
Over-the-counter Drugs ("OTC")
Partner: Guangzhou Pharma Holdings
Revenue:
H1 2017: $123.4m (H1 2016: $122.7m)

50%

Hutchison Hain Organic ("HHO")
Health Related Consumer Prods.
Partner: Hain Celestial Group
Revenue:
H1 2017: $13.7m (H1 2016: $11.5m)

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

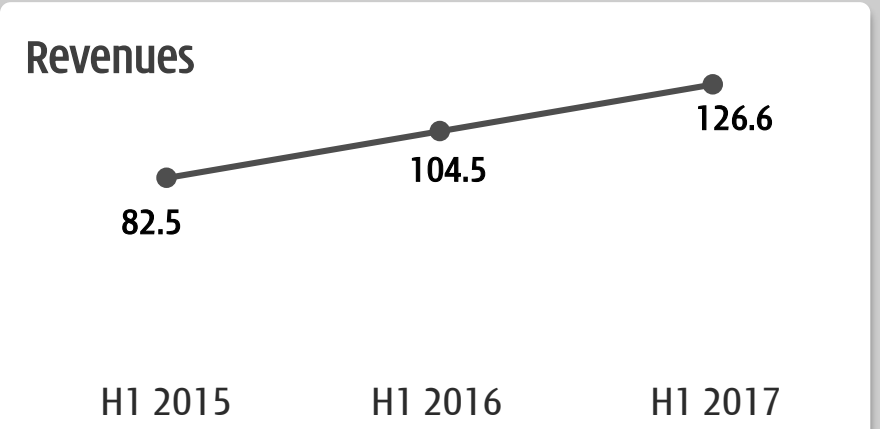
H1 2017 Financial Results

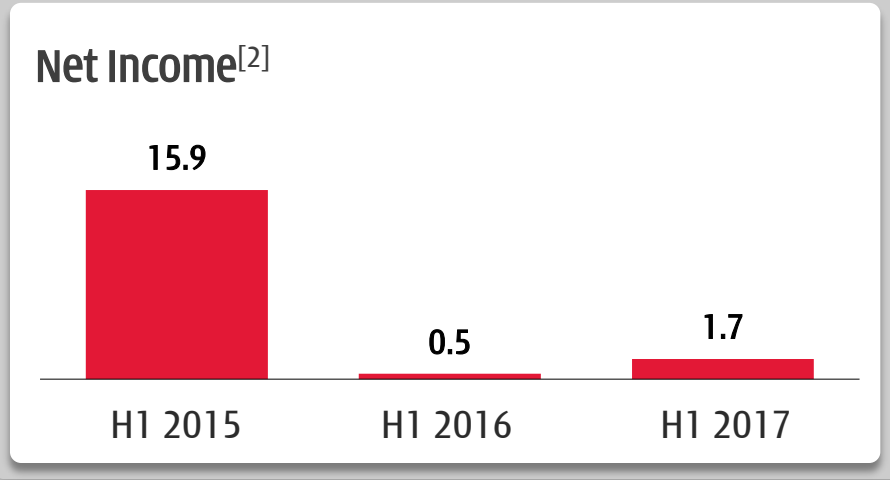
Profitable – including $37.5 million in innovation investment[1]

Financial Summary

	H1-2015	H1-2016	H1-2017	Change 15-16	Change 16-17
REVENUES	**82.5**	**104.5**	**126.6**	**27%**	**21%**
Unconsolidated JV Revenues	*229.8*	*249.6*	*253.1*		
NET INCOME/(LOSS) [2]					
INNOVATION PLATFORM	**2.0**	**(13.7)**	**(14.8)**	**n/a**	**-8%**
Base HMP Operations	*4.0*	*(11.6)*	*(12.4)*		
50% share of Nestle JV (NSP) [3]	*(2.0)*	*(2.1)*	*(2.4)*		
COMMERCIAL PLATFORM	**19.8**	**22.1**	**25.2**	**12%**	**14%**
Prescription Drugs Business	*11.9*	*15.3*	*19.4*		
Consumer Health Business	*7.9*	*6.8*	*5.8*		
Chi-Med Group Costs	**(5.9)**	**(7.9)**	**(8.7)**	**-33%**	**-10%**
General & Administrative Expenses	*(4.2)*	*(5.8)*	*(6.6)*		
Interest/Tax	*(1.7)*	*(2.1)*	*(2.1)*		
Net Income Attrib. to Chi-Med	**15.9**	**0.5**	**1.7**	**-97%**	**+213%**
Accretion on redeemable NCI [4]	*(42.0)*	-	-		
Net (Loss)/Income Attrib. to Ord. S-H	**(26.1)**	**0.5**	**1.7**		
EPS Attrib. to Ord. S-H (Basic) (US$) [5]	*(0.49)*	*0.01*	*0.03*		

Group Results





[1] GAAP R&D expenses were $31.6m in H1 2017 (H1 2016: $31.2m) – please see appendix "Non-GAAP Financial Measures and Reconciliation"; [2] Net Income/(Loss) = Net Income/(Loss) attributable to Chi-Med; [3] NSP = Nutrition Science Partners Limited; [4] Non-cash accretion relates to Mitsui's share in Innovation Platform, which was exchanged for Chi-Med shares in July 2015; [5] Includes adjustment for accretion on redeemable non-controlling interests.

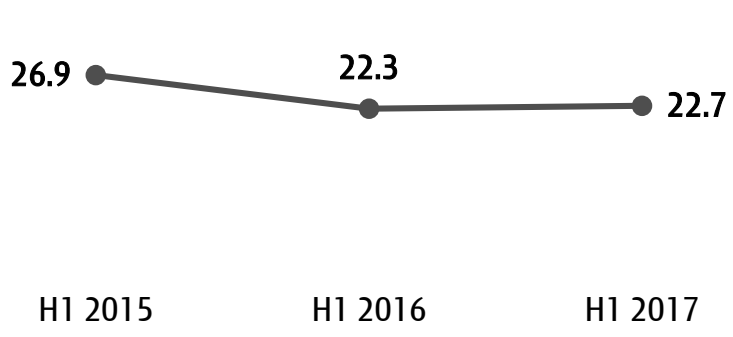
(US$ millions, Except per share data)

Financial performance of main platforms

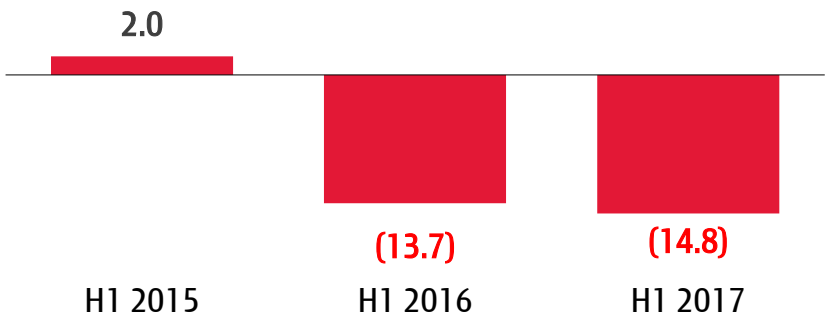
Sustainable business model - >$190 million available cash[1]

Innovation Platform

Revenue

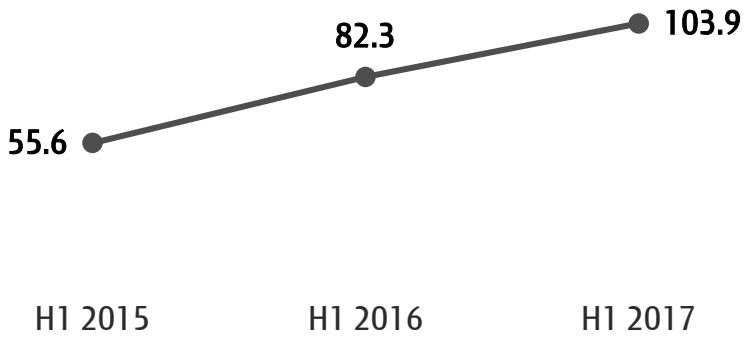


Net Income/(Loss) [3]

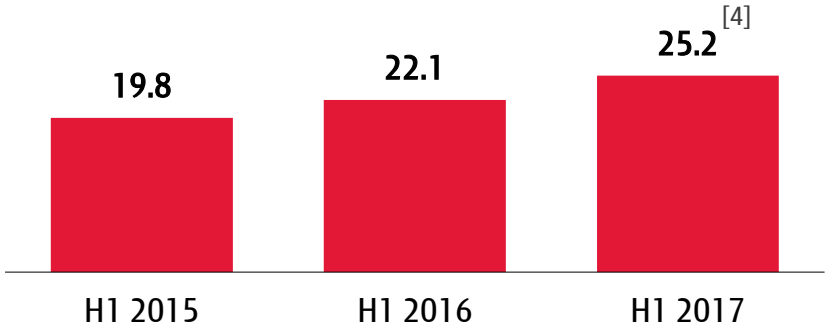


Commercial Platform

Sales [2]



Net Income [3]

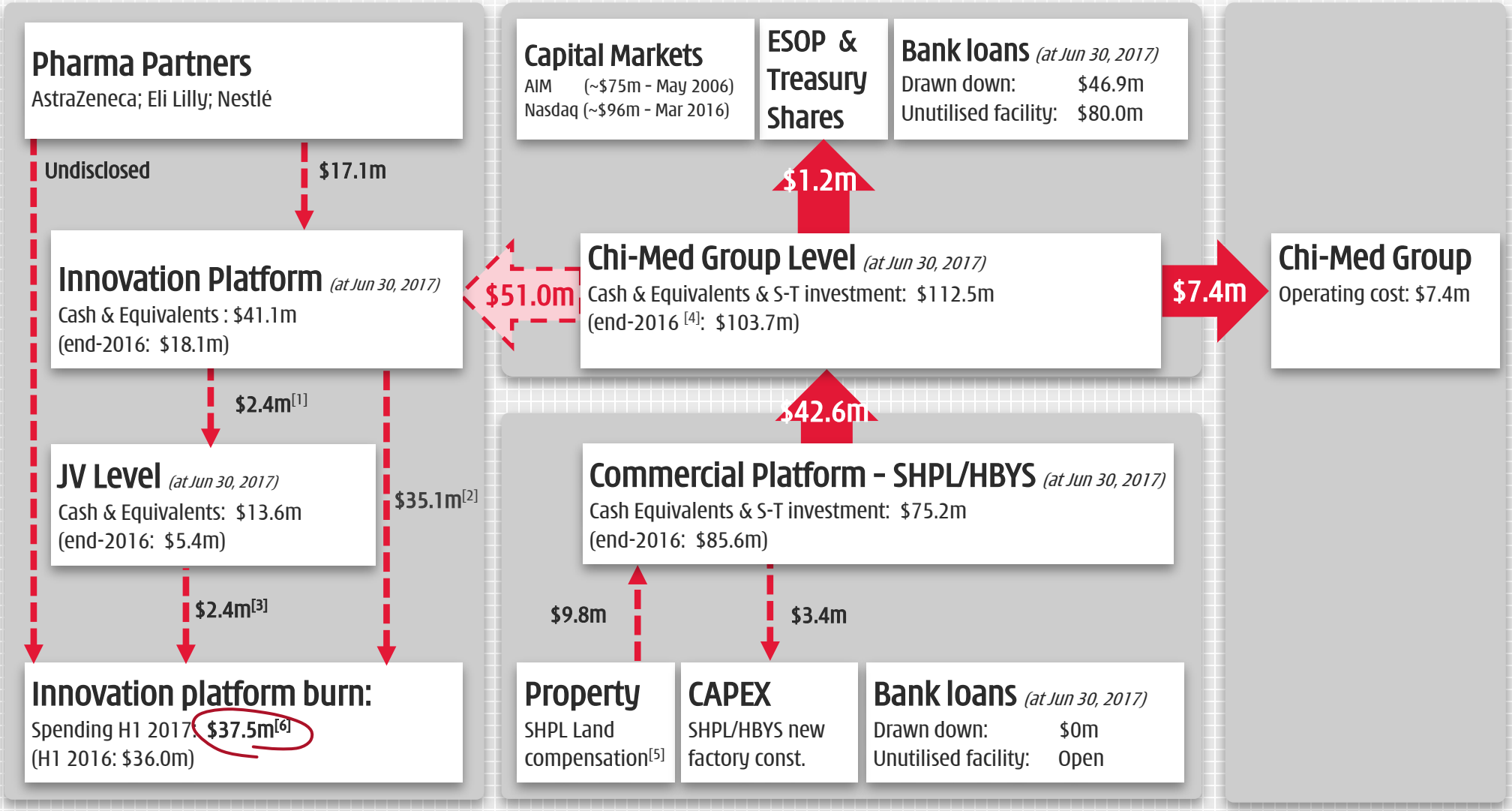


[1] Cash & cash equivalents and unutilized banking facilities; [2] Only includes sales of subsidiaries for Prescription Drugs and Consumer Health businesses - excludes joint ventures; [3] Net Income/(Loss) = Net Income/(Loss) attributable to Chi-Med; [4] Includes the share of a one-time gain from SHPL's R&D related subsidies of US$2.5 million.

(US$ millions)

Inter-group cash flow

$112.5m cash available (Jun 30, 2017); $80m in undrawn facilities



[1] $7.0m capital injection to NSP offset by $4.6m service income received from NSP; [2] Including research & development cost and general & admin. expenses; [3] Share of NSP operating loss;
[4] Including $24.3m short-term investment (over 3-month deposit) as at end of 2016; [5] Cash received for SHPL land compensation (10% of total compensation) in Feb'17;
[6] Please see appendix "Non-GAAP Financial Measures and Reconciliation" for a Reconciliation of GAAP to adjusted research and development expenses.

(US$ millions)

Three collaborations have major aggregate financial impact

AstraZeneca

Lilly

Nestlē Health Science

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

- **$135.5 million** in upfront /milestone payments and equity injections as at June 30, 2017.
- **up to $340 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 majority of these clinical costs.**

Possible payment events in H2 2017:

- **Fruquintinib (HMPL-013):** NDA approval for third line CRC[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] CRC = Colorectal Cancer.

(US$ millions)

Risk-balanced pipeline & strategy

FIRST-IN-CLASS
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-IN-CLASS
use 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, & lower-risk / faster clinical – leveraging China's advantages.

- Large China patient population enables rapid & lower risk development to proof-of-concept.
- Can afford to run ~350-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

Major market potential

		Pot. launch Year / Territory	Incidence (New pts./yr.)[1]	Approx. WAC [2] of various reference TKIs (US$/month)	Median PFS (months)[3]	Potential Peak (US$)[4] Sales	Potential Peak (US$)[4] Net Income
SAVO	Papillary renal cell carcinoma (c-Met-driven)	2021 Global	~25,000	$11,600 (Sutent®) $10,500 (Afinitor®)	6.2 Ph.II (actual)		
	NSCLC -2L 1st Gen EGFR TKI refract, Tagrisso combo (MET+ , T790M+/-)	2021 Global	~35,000 - 40,000	$15,100 (Tagrisso®)	*TBD*		
	NSCLC -3L 3rd Gen EGFR TKI refract. Tagrisso combo (MET+)	2021 Global	*TBD*	$15,100 (Tagrisso®)	*TBD*		
	NSCLC -2L 1st Gen EGFR TKI refract, Iressa combo (MET+, T790M-)	2021 China	*TBD*	$1,100 (Iressa®)	*TBD*		
FRUQ	3L (or above) Colorectal cancer ("CRC")	2018 China	~50,000 - 60,000	$14,000 (Regorafenib - global) $2,870 (Apatinib - China off label)	3.7 Ph.II (actual)	~$110-160m @est. 20-25% penetration[5]	~$20-35m @15-20% tier royalty/other
	3L Non-small cell lung cancer ("NSCLC")	2019 China	~60,000 - 70,000	No approved TKIs $2,870 (Apatinib - China off label)	3.8 Ph.II (actual)		
	2L Gastric cancer combo with Taxol	2020 China	~250,000 - 300,000	$2,870 (Apatinib appr. 3L Gastric) $1,810 (Apatinib NDRL[7] reimbursed)	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) $2,190 (Afinitor® China NDRL) $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.*[6] $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 ("PFS" or time to >20% tumor growth) result for Chi-Med therapy (Chi-Med studies); [4] represents present company estimates; [5] Penetration = % of Addressable Patients treated for an average period equivalent to the median PFS; [6] Tagrisso approval in China expected in 2017; [7] NDRL = National Drug Reimbursement List.

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

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

		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$)	~2,870	~1,900	TBD
	Monthly Cost (28 day cycle) -- Current (US$)	~2,870	~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 1.8 (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

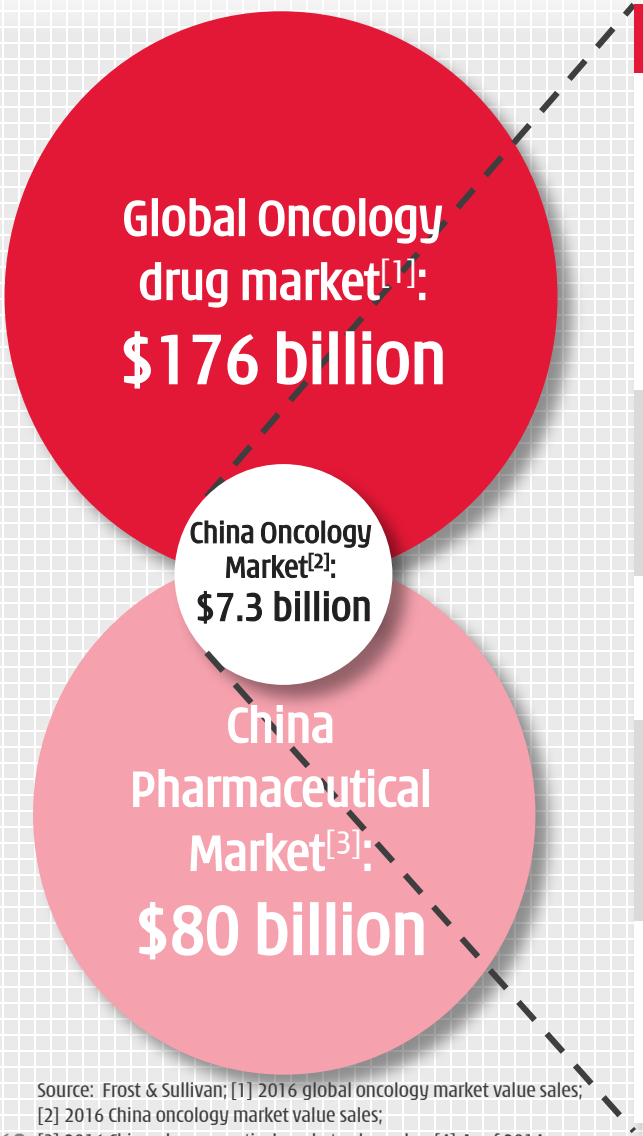
- ✓ Apatinib used in 3rd line NSCLC, CRC, etc.

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

Targeted therapies – fastest growth & largest[1]

Pricing beyond reach of the 8.1 million cancer patients in China



% of Oncology Market [4]	Sub-Category	Share of Sub-category	Product	Company	Value Sales ($m)	Approx. Monthly Pricing ($)	12 mo. treatment (Est. # patients)
23.0%	Targeted Therapies	19.5%	rituximab	Roche	327	13,090	2,090
		14.9%	trastuzumab	Roche	250	4,500	4,640
		14.2%	imatinib	Novartis	238	6,320	3,140
		9.5%	gefitinib	AstraZeneca	160	2,730	4,870
		8.2%	bevacizumab	Roche	138	11,590	990
		7.4%	erlotinib	Roche	124	2,040	5,070
		5.3%	cetuximab	BMS/BI	89	14,150	520
		4.6%	sorafenib	Bayer	77	7,250	890
		4.0%	bortezomib	Janssen	67	6,360	880
		12.4%	Other		208		
			Total Targeted Therapies		**1,679**		**23,080**
20.4%	Anti-metabolites	29.1%	pemetrexed	Lilly/Hansoh	433		
		21.5%	capecitabine	Roche	320		
		20.4%	TS-1	Taiho/Qilu	304		
		16.6%	gemcitabine	Lilly/Hansoh	247		
		12.4%	Other		185		
			Total Anti-Metabolites		**1,489**		
19.7%	Plant Alkaloids	49.3%	paclitaxel	BMS/Luye	709		
		42.4%	docetaxel	Sanofi/Hengrui	609		
		8.4%	Other		120		
			Total Plant Alkaloids		**1,438**		
10.5%	DNA Damaging agents	46.5%	oxaplatin	Sanofi/Hengrui	356		
		21.3%	temzolomide	Merck/Tasly	163		
		13.1%	nedaplatin		100		
		4.3%	carboplatin		33		
		14.8%	Other		113		
			Total DNA Damaging Agents		**767**		
6.1%	Hormones	29.8%	letrozole	Novartis/Hengrui	133		
		23.0%	bicalutamide	AstraZeneca	102		
		19.5%	anastrozole	AstraZeneca	87		
		17.1%	exemestane	Pfizer/Qilu	76		
		10.6%	Other		47		
			Total Hormones		**445**		

High-level analysis for general reference only

Source: Frost & Sullivan; [1] 2016 global oncology market value sales; [2] 2016 China oncology market value sales; [3] 2016 China pharmaceutical market value sales; [4] As of 2014.

National Drug Reimbursement List Pricing ("NDRL")

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

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

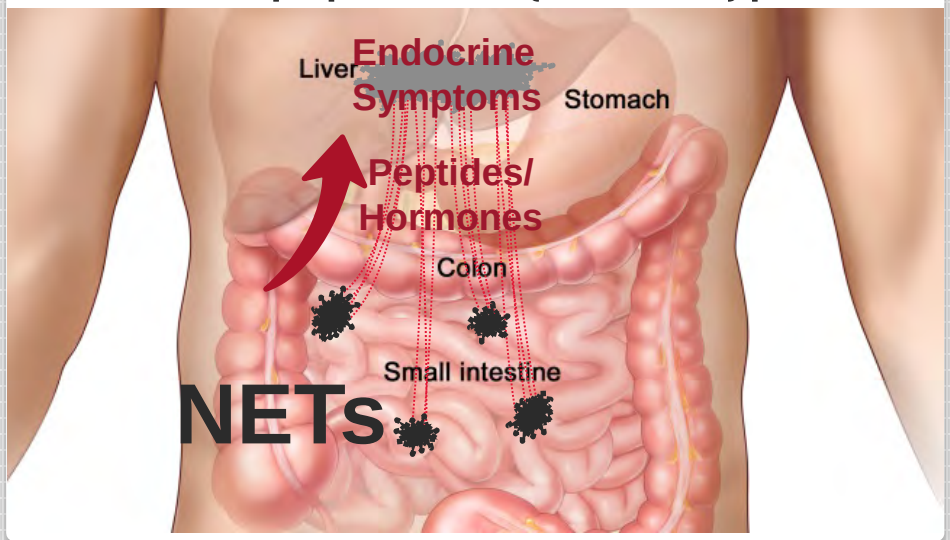
Source: Ministry of Human Resources and Social Security (MOHRSS); Yaozhi; BofA Merrill Lynch Global Research.
[1] Excluding 3 botanical oncology drugs; [2] Reference SKU or reference recommended dosage for monthly pricing calculation; [3] Calculation assumes an exchange rate of CN¥6.75 per US$1; [4]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

Neuroendocrine tumors ("NET")

Sulfatinib potential advantages

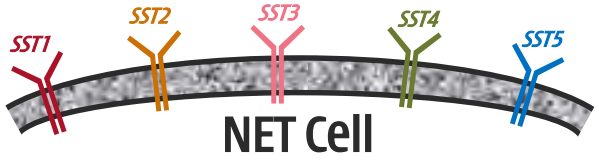
CHI-MED

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.

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



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

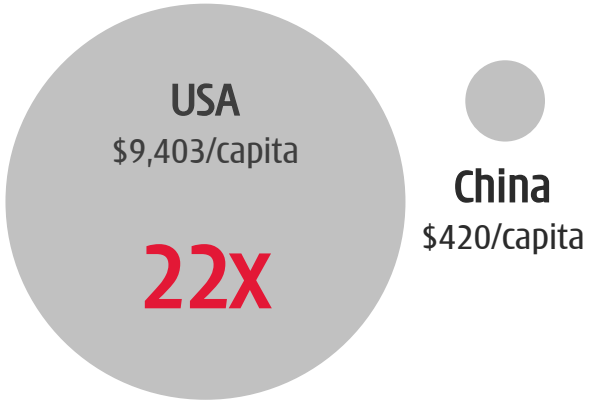
- Sandostatin® & Somatuline® (SSTAs) are used primarily for symptom control in early stage NET (Ki67 ‹10%) – SSTAs do provide some tumor growth control (DCR/mPFS) but almost no tumor shrinkage (ORR);
- Lutathera® radio nucleotide SSTA – delivers radiation to NET via SST receptors – very effective ~40 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.

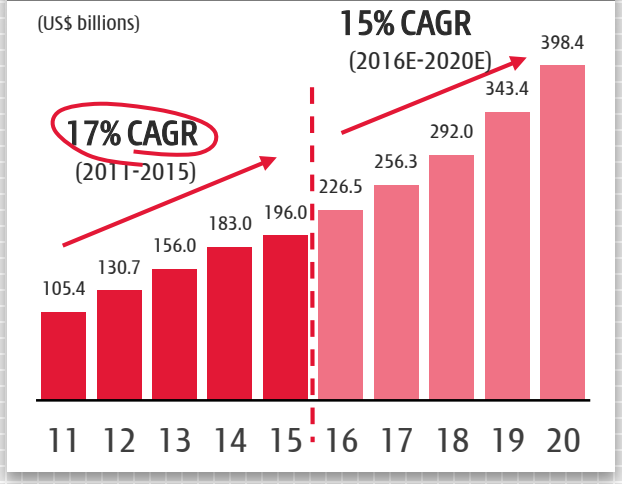
China pharma market set to become the second largest globally in 2016/2017

Per capita Healthcare Spending



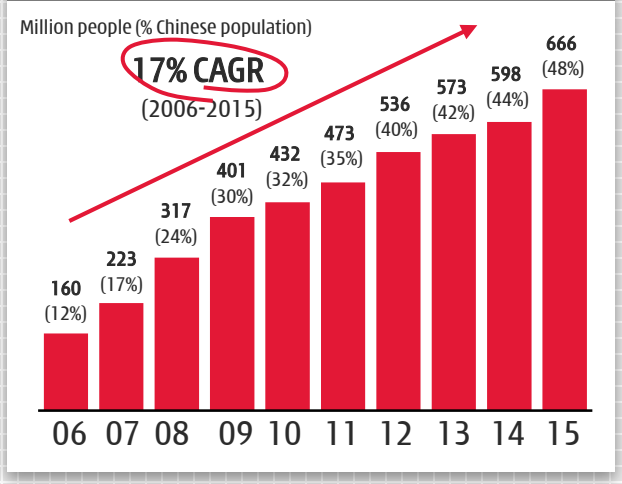
Source: WHO Global Health Expenditure Database (2014 data).

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 36 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.

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 $2.0 – 2.3 billion.[3] Given our share in the JVs, Chi-Med's share of this value is approximately $1.0 – 1.1 billion.

		NET SALES			NET INCOME				VALUATION	
	Code	2015	2016	15-16 Growth	2015	2016	15-16 Growth	2016 Margin	Market Cap.	P/E[2]
CHI-MED Commercial Platform -- Subsidiaries/JVs[1]		**518.9**	**627.4**	**21%**	**54.1**	**63.3**	**17%**	**10%**	**n/a**	**n/a**
Tianjin Zhong Xin Pharma	600329	1,075.4	925.0	-14%	69.5	61.0	-12%	7%	2.062	29
Li Zhu Pharma	000513	1,005.5	1,145.5	14%	100.2	124.2	24%	11%	4,868	33
Shandong Dong E E Jiao	000423	827.7	945.7	14%	248.8	277.7	12%	29%	6,557	21
Zhejiang Kang En Bai Pharma	600572	805.3	901.3	12%	76.5	60.5	-21%	7%	2,865	35
Kunming Pharma	600422	746.6	763.6	2%	65.5	61.3	-6%	8%	1,389	25
Guizhou Yi Bai Pharma	600594	501.6	551.9	10%	29.2	58.9	102%	11%	1,642	24
Jin Ling Pharma	000919	489.3	535.7	9%	39.8	33.3	-16%	6%	822	32
Jiangsu Kang Yuan	600557	428.4	449.1	5%	55.5	56.3	2%	13%	1,452	23
Zhuzhou Qian Jin Pharma	600479	371.6	428.9	15%	13.4	26.0	93%	6%	726	27
ZhangZhou Pian Zai Huang	600436	282.3	345.7	21%	13.4	75.9	8%	22%	5,425	52
Peer Group -- Weighted Avg. (10 Comps. excl. Chi-Med)		**653.8**	**699.2**	**7%**	**75.4**	**83.5**	**9%**	**12%**	**2,781**	**32**
All 61 Listed China Pharma. Companies -- Weighted Average		**1,008.3**	**1,155.0**	**15%**	**80.4**	**96.1**	**19%**	**8%**	**3,238**	**36**

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 2016 Net Sales in the ~$350-1,200 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 and land compensation from SHPL; [2] Price Earnings Ratio as at **September 13th, 2017**: Trailing Twelve Month PE weight averaged based on market capitalization; [3] Peer group/China Pharma multiple of 32-36x 2016 actual Net income after tax of $63.3 million (excluding one-time property gain of $80.8 million).

(US$ millions)

Innovation Platform proxy peer group (1/2)

A very deep pipeline and a very large organization/operation

Name	Mkt Cap (Oct 16) 2017	2016	2015	Ent. Value[1]	Staff	Overview of pipeline assets: Drug	Studies	Phase	Partner	# of drugs	# of studies P3	P2	P1
Genmab	13,909	10,006	5,682	13,16	205	Arzerra (ofatumumab)	CLL, follicular lymph.	Mktd, P3	Novartis	**11**	**3**	**7**	**5**
						Ofatumumab (subcutaneous)	Relapsing multiple sclerosis	P3	Novartis				
						Darzalex (daratumumab)	Double-refractory MM, Amyloidosis, NHL, natural killer / t-cell lym., myelodysplastic syndromes, solid tumors	Mktd, Reg., P3, 3x P2,	Janssen				
						Tisotumab vedotin	Solid cancers	P2	Seattle Gen.				
						HuMax-AXL-ADC	Solid cancers	P2	Seattle Gen.				
						AMG 714	Celiac disease	P2	Amgen				
						Teprotumumab	Graves' orbitopathy	P2	Horizon				
						HuMax-TAC-ADC (ADCT-301), JNJ-61186372, -64007957, -63709178	Lymphoma, AML, NSCLC, relapsed or refractory MM, AML	5xP1	ADC, JNJ				
Exelixis	8,529	2,607	1,307	8,682	287	Cabometyx / Cometriq (Cabozantinib)	Medullary thyroid cancer, adv. renal CC, adv. hepatocellular carcinoma, NSCLC, genitourinary tumors & other indications	2xMktd, Reg., 3xP3, 14xP2	Ipsen, Takeda	**6**	**6**	**22**	**4**
						CS-3150 (esaxerenone)	Hypertension, diabetic nephropathy	2xP2	Daiichi-S.				
						Cotellic (cobimetinib)	Metastatic or unresectable locally advanced melanoma, CRC, BC	Mktd, 3xP3, P2, P1	Genentech				
						SAR245408 (XL147)	Variety of cancer indications	P2	Sanofi				
						SAR245409 (XL765)	NHL, glioblastoma, lym., BC, leukemia, combos w/ Treanda, Rituxan	4xP2, P1	Sanofi				
						XL888	BRAF V600 Mutation-Pos advanced melanoma, Malignant melanoma	2xP1					
Tesaro	6,519	5,910	1,808	6,124	446	Rolapitant IV (oral: Varubi)	CINV (oral and IV)	Mktd, Reg.	Opko	**4**	**1**	**3**	**3**
						Zejula (niraparib)	Ovarian cancer maintenance, ovarian cancer treatment	Mktd, Reg., P3, P2	Merck				
						Niraparib + Keytruda (pembro.)	Triple-negative BC or ovarian cancer (TOPACIO study)	P2	Merck				
						Niraparib + Avastin (bevaciz.)	Ovarian cancer (AVANOVA study)	P2	Roche				
						Niraparib + chemotherapy; TSR-042; TSR-022	Ewing's sarcoma, various tumor types	3x P1	AnaptysBio, SARC				
Galapagos	5,209	3,002	1,897	3,490	530	Filgotinib	RA, CD, ulcerative colitis, small bowel CD, Fistulizing CD, Sjogren's syndrome, ankylosing spondylitis, psoriatic arthritis, cutaneous lupus erythematosus, uveitis	3xP3, 8xP2	Gilead	**8**	**3**	**12**	**3**
						GLPG1837	Cystic fibrosis	P2	AbbVie				
						GLPG1690	Idiopathic pulmonary disease	P2	-				
						GLPG2222	Cystic fibrosis	P2	AbbVie				
						GLPG1972, MOR106, GLPG2737	Osteoarthritis, Atopic dermatitis, cystic fibrosis	3xP1	Servier, Morphosys				
						GLPG1205	Undisclosed - targets GPR 84	P2	-				
Juno	4,788	2,961	5,049	3,794	548	JCAR018	Acute lymphoblastic leukemia, NHL	2xP1	Celgene	**9**	**0**	**2**	**10**
						JCAR017	NHL	P1	Celgene				
						JCAR014	NHL, CLL	2xP1	-				
						JTCR016	AML, NSCLC / mesothelioma	2xP2	-				
						BCMA, JCAR023, JCAR020, JCAR024, Lewis Y	MM, pediatric neuroblastoma, ovarian, NSCLC / BC, lung	5xP1	-				

Source: Company data, FactSet, Press

[1] As of October 16, 2017

Key: Lym. = lymphoma; NHL = Non-Hodgkin's Lymphoma; AML = acute myeloid leukemia; 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, CD = Crohn's disease

($ millions unless otherwise stated)

Innovation Platform proxy peer group (2/2)

A very deep pipeline and a very large organization/operation

Name	Mkt Cap (Oct 16) 2017	2016	2015	Ent. Value[1]	Staff	Overview of pipeline assets: Drug	Studies	Phase	Partner	# of drugs	# of studies: P3	P2	P1
Puma	4,619	1,766	2,679	4,441	174	Neratinib (PB272)	Adjuvant BC, neoadjuvant BC, metastatic BC, metastatic BC, met. her2 BC	Mktd., P3, 8xP2	-	1	1	8	0
Clovis	4,118	1,225	3,707	3,431	278	Rubraca (rucaparib)	Advanced ovarian cancer, ovarian cancer treat./maint., prostate, triple negative BC, BC, gastro esophageal, gynecological	Mktd, 3xP3, 6xP2, P1	-	1	3	6	1
BeiGene[a]	3,750	1,038	NA	3,492	397	BGB-3111; BGB-3111 + Gazyva	Waldenstrom's macro., relapsed or refractory MCL	P3, P2, P1b	-	4	1	6	4
						BGB-A317	Advanced cancers, b-cell malignancies	P2, P1b	Celgene				
						BGB-290	Solid tumors, glioblastoma	P1b, P1					
						BGB-283	Solid tumors	P1b, P1					
						BGB-A317 + BGB-290; BGB-A317 + BGB-3111	Solid tumors	2xP1					
Agios	3,428	1,978	2,656	2,739	287	Idhifa (enasidenib / AG-221)	R/R AML, frontline AML	Mktd., P3, 2xP2	Celgene	4	3	5	3
						Ivosidenib (AG-120)	Frontline AML, R/R AML, solid tumors, cholangiocarcinoma	2xP3, 2xP2, 2xP1	-				
						AG-348	PK deficiency	P2	-				
						AG-881	Solid tumors	P1	Celgene				
Morphosys[b]	2,592	1,207	1,717	2,401	351	MOR 208	CLL, SLL, DLBCL	P3, 3xP2	-	3	3	4	1
						MOR202	Multiple myeloma	P2	-				
						MOR107	Undisclosed	P1					
Array[b]	2,358	1,068	761	1,869	177	ARRY-797	LMNA-related DCM	P2	-	2	0	2	0
						ARRY-382	Solid tumors	P2	-				
Ziopharm	800	665	1,450	877	36	Ad-RTS-IL-12	Locally adv. or met. BC, recurrent or progressive glioblastoma, pediatric brain tumor	P3, 3xP1	Intrexon	4	1	0	10
						CAR / cytokine product, NK Cells program, TCR program	Leukemia / lym., AML, undisclosed	7xP1	Intrexon, MD Anders., Merck				
AVERAGE	**5,052**	**2,786**	**2,610**	**4,548**	**299**					5	2	6	4
MEDIAN	**4,369**	**1,872**	**1,897**	**3,491**	**287**					4	2	6	3
Innovation Platform					~350	Savolitinib (AZD6094)	PRCC, CCRCC, NSCLC, gastric cancer, pulmonary sarcomatoid carcinoma	P3, 6xP2, 6xP1b	AstraZeneca	8	6	18	11
						Fruquintinib	CRC, NSCLC, caucasian bridging, gastric cancer	Reg., 2xP3, P2, P1	Eli Lilly				
						Sulfatinib	Pancreatic and non-pancreatic NETs, Caucasian bridging, medullary thyroid cancer, differentiated thyroid cancer, biliary tract	2xP3, 3xP2, P1	-				
						Epitinib	NSCLC, glioblastoma	P3, P2	-				
						Theliatinib	Solid tumors, esophageal cancer	P1b, P1	-				
						HMPL-523	RA, hematological cancers, immunology, lym.	4xP1	-				
						HMPL-689	Hematological cancers, lym.	2xP1	-				
						HMPL-453	Solid tumors	2xP1	-				

a) Collaboration with Celgene announced 07/05/17 in which BeiGene acquired Celgene's commercial operations in China including rights in China to the commercial drugs Abraxane, Revlimid and Vidaza as well as pipeline agent CC-122. Celgene paid $413mm upfront and up to $980mm in future milestone payments to BeiGene for ex-Asia (excluding Japan) rights to BGB-A317

b) Only non-partnered products included for Morphosys and Array

Source: Company data, FactSet, Press

[1] As of October 16, 2017

Key: Lym. = lymphoma; NHL = Non-Hodgkin's Lymphoma; AML = acute myeloid leukemia; 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, CD = Crohn's disease

($ millions unless otherwise stated)

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

Reconciliation of Adjusted Research and Development Expenses: (Page 62 and Page 64)

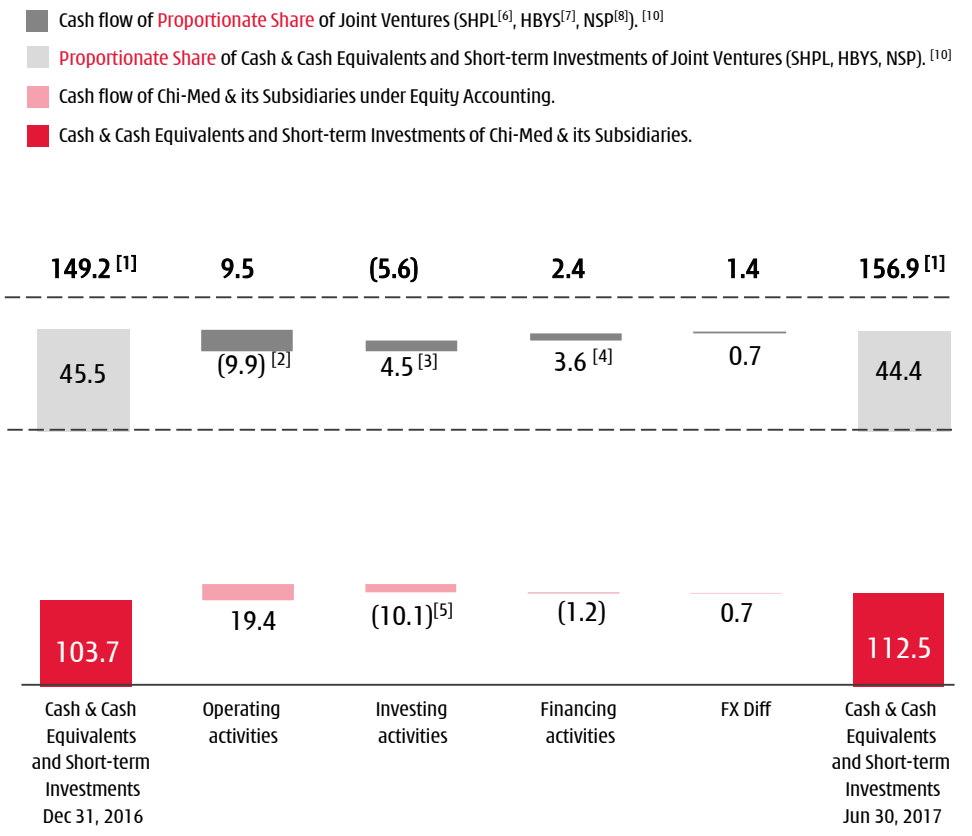
	H1 2017	H1 2016
Research and development expenses	(31.6)	(31.2)
Plus: Innovation Platform - administrative and other expenses	(3.6)	(2.8)
Plus: Equity in earnings of equity investees - NSP and other	(2.4)	(2.1)
Plus: Innovation Platform - interest income	0.1	0.1
Adjusted research and development expenses	**(37.5)**	**(36.0)**

Reconciliation of Top 7 products' Gross Profit as Percentage of Aggregated Gross Profit for Commercial Platform: (Page 57)

	H1 2017
Sales of goods—third parties and related parties	103.9
Less: Costs of sales of goods—third parties and related parties	(89.4)
Consolidated gross profit	**14.5**
Plus: Gross profit—HBYS and SHPL	140.9
Adjusted gross profit	**155.4**
Top 7 products gross profit	**137.7**
% of Top 7 products to adjusted gross profit	89%

(US$ millions unless otherwise stated)

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



[1] Cash & Cash Equivalents and Short-term Investments of Chi-Med & its Subsidiaries & Proportionate Share of Joint Ventures (SHPL, HBYS, NSP).
[2] $32.7m proportionate share of cash generated from operating activities less $42.6m adjustment of dividend received in consolidation level.
[3] $15.1m proportionate share of cash generated in investing activities and $7.0m adjustment of capital injection to NSP in consolidation level offset by $17.6m adjustment of net proceeds from short-term investments.
[4] $32.0m proportionate share of cash used in financing activities offset by $35.6m adjustment mentioned in item [2] and [3].
[5] $14.2m of cash from investing activities offset with $24.3m adjustment of net deposit in short-term investments.

Reconciliation of Cash Flow of Proportionate Share of Joint Ventures (SHPL, HBYS, NSP)

	As at Dec 31, 2016	Operating Activities	Investing Activities	Financing Activities	Effect of FX	As at Jun 30, 2017
Summary for SHPL, HBYS and NSP (100%)	**91.0**	**65.4**	**(5.0)**	**(63.9)**	**1.3**	**88.8**
Chi-Med share (50%)	45.5	32.7	(2.5)	(32.0)	0.7	44.4
Adjust dividend paid by HBYS and SHPL from financing activities to operating activities	-	(42.6)	-	42.6	-	-
Adjust NSP Capital injection from financing activities to investing activities	-	-	7.0	(7.0)	-	-
Total after adjustments	**45.5**	**(9.9)**	**4.5**	**3.6**	**0.7**	**44.4**

(US$ millions unless otherwise stated)

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

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

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

	IFRS										US GAAP						H1'16-H1'17
(US$ millions)	03	04	05	06	07	08	09	10	11	12	13	14	15	16	H1'16	H1'17	Growth
Sales (Non-GAAP)	21.9	27.9	65.1	101.4	119.0	155.8	197.0	236.4	278.6	360.7	402.3	465.4	518.9	627.4	331.9	357.0	8%
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*	*194.5*	*215.5*	*11%*
- Consolidated subsidiary	-	-	-	-	-	-	-	-	-	-	-	*50.2*	*105.5*	*149.9*	*67.6*	*85.8*	*27%*
- Non-consolidated joint venture	*17.2*	*21.8*	*23.3*	*23.2*	*28.1*	*39.5*	*54.4*	*71.2*	*92.4*	*116.5*	*138.2*	*154.7*	*181.1*	*222.4*	*126.8*	*129.7*	*2%*
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*	*137.4*	*141.5*	*3%*
- Consolidated subsidiaries	*4.7*	*6.1*	*9.3*	*8.9*	*3.7*	*5.5*	*7.0*	*14.1*	*14.9*	*15.5*	*16.5*	*16.8*	*20.7*	*31.0*	*14.6*	*18.1*	*24%*
- Non-consolidated joint venture	-	-	*32.5*	*69.3*	*87.2*	*110.8*	*135.6*	*151.1*	*171.3*	*228.7*	*247.6*	*243.7*	*211.6*	*224.1*	*122.7*	*123.4*	*1%*
Total Sales Growth	*n/a*	*27%*	*133%*	*56%*	*17%*	*31%*	*26%*	*20%*	*18%*	*29%*	*n/a*	*16%*	*11%*	*21%*	*16%*	*8%*	
Net (loss)/Income after tax (Non-GAAP)	(10.7)	(3.6)	2.2	6.7	11.2	14.7	21.5	27.9	30.1	33.1	39.7	48.8	54.1	144.1 [3]	47.9	51.9 [4]	8%
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*	*30.6*	*38.8*	*27%*
- Consolidated subsidiary	-	-	-	-	-	-	-	-	-	-	-	*0.1*	*0.6*	*1.6*	*1.0*	*1.1*	*5%*
- Non-consolidated joint venture	*(0.4)*	*1.3*	*1.9*	*1.3*	*1.9*	*2.8*	*6.0*	*11.9*	*14.2*	*17.7*	*22.4*	*26.4*	*31.3*	*120.6*	*29.6*	*37.7*	*28%*
Consumer Health	*(10.3)*	*(4.9)*	*0.3*	*5.4*	*9.3*	*11.9*	*15.5*	*16.0*	*15.9*	*15.4*	*17.3*	*22.3*	*22.2*	*21.9*	*17.3*	*13.1*	*-24%*
- Consolidated subsidiaries	*(10.3)*	*(4.9)*	*(2.9)*	*(2.4)*	*0.2*	-	*0.8*	*1.0*	*(0.4)*	*(1.1)*	*0.1*	*1.5*	*0.8*	*1.5*	*0.2*	*1.6*	*>100%*
- Non-consolidated joint venture	-	-	*3.2*	*7.8*	*9.1*	*11.9*	*14.7*	*15.0*	*16.3*	*16.5*	*17.2*	*20.8*	*21.4*	*20.4*	*17.1*	*11.5*	*-33%*
% 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%*	*14.4%*	*14.5%*	
Net (loss)/income attrib. to Chi-Med	(5.7)	(3.7)	(0.5)	1.2	4.5 [2]	5.9 [2]	9.3 [2]	12.6 [2]	13.6 [2]	14.6 [2]	18.2 [2]	22.8 [2]	25.2 [2]	70.3 [3]	22.1	25.2 [4]	14%
Prescription Drugs	*(0.2)*	*0.6*	*1.0*	*0.7*	*0.9*	*1.4*	*3.0*	*5.9*	*7.1*	*8.8*	*11.2*	*13.2*	*15.9*	*61.1*	*15.3*	*19.4*	*27%*
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*	*6.8*	*5.8*	*-16%*
Net (loss)/income attrib. to Chi-Med growth	*n/a*	*-35%*	*-86%*	*340%*	*275%*	*31%*	*58%*	*35%*	*8%*	*7%*	*n/a*	*26%*	*10%*	*180%*	*12%*	*14%*	

[1] 2003-2006 incl. disco. operation; [2] Continuing Operations; [3] 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; [4]Included SHPL's R&D related subsidies of US$5.9 million and $2.5 million at net income after tax and net income attributable to Chi-Med respectively.


CHI-
MED
HUTCHISON CHINA MEDITECH
Thank you