CORPORATE PRESENTATION

OCTOBER 2021

Nasdaq/AIM:HCM | HKEX:13

HUTCHMED



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Building a global science-focused biopharma



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Global novel oncology **drug discovery & manufacturing** operations based **in China**

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Clinical development and regulatory operations in all major markets

In-house **commercial in China & U.S.** – self-determination in about half of global pharma market



Commercial partnerships in rest of the world markets

Our Strengths



Fully integrated R&D and commercialization platform **built over 20 years**

- >4,500 personnel across HUTCHMED group
- **~1,400** person team in Oncology/Immunology

1	2	3	4
WORLD CLASS DISCOVERY & DEVELOPMENT CAPABILITY	HIGHLY DIFFERENTIATED NME PORTFOLIO & GLOBAL PIPELINE	DEEP PAN-CHINA MARKET ACCESS CAPABILITY	SEASONED MNC MGMT. TEAM – STRONG GOVERNANCE
First global-focused novel drug discovery company in China – established in the early 2000s	11 innovative clinical NMEs – all discovered in-house by HUTCHMED	600+ person oncology team – covering 2,500 China oncology hospitals	11 years – median tenure of 14 person senior mgmt. team
770+ integrated R&D staff focused on oncology & immunological diseases	3 medicines marketed in China – all in advanced global development	Highly profitable Other Ventures with 20-year commercial track record in China	0 governance issues during 14 years as a listed company

HUTCHMED's long-standing R&D strategy



Attack cancer from multiple angles at the same time

Immune Desert

Insufficient T cell response

Multiple mAb Programs

- CD47 (HMPL-A83)
- EZH2 (tazemetostat)*
- TBD

Antigen Release

Aberrant genetic drivers

Multiple small molecule programs

- ✓ MET (savolitinib)
- PI3Kδ (amdizalisib)
- Syk (HMPL-523)
- FGFR (HMPL-453)
- EGFR (epitinib)
- IDH 1/2 (HMPL-306)
- ERK 1/2 (HMPL-295)
- BTK (HMPL-760)
- EZH2 (tazemetostat)*



Excluded Infiltrate

Inadequate T cell homing

Anti-angiogenesis

- ✓ VEGFR (fruquintinib)
- VEGFR/FGFR (surufatinib)
- FGFR (HMPL-453)
- EZH2 (tazemetostat)*

Inflamed Inactivated T cell response

Negative regulators

- Treg (amdizalisib)
- CSF-1R (surufatinib, HMPL-653)
- EZH2 (tazemetostat)*

* TAZVERIK® (tazemetostat) EZH2 inhibitor in collaboration with Epizyme. Note: Adapted from Chen DS et al. Oncology Meets Immunology: The Cancer-Immunity Cycle. Immunity, Volume 39, Issue 1, 1 – 10.

HUTCHMED

Differentiated portfolio

Most discovered in-house, & designed for global differentiation

PRODUCT	MOA	DISCOVERY ^[1]	INDICATIONS	PARTNER	RIGHTS	CHINA ^[2]	GLOBAL ^[2]
Surufatinib (SULANDA®)	VEGFR 1/2/3, FGFR1 & CSF-1R	In-house (est. LOE ~2035)	Neuroendocrine tumors (NET), biliary tract, thyroid, solid tumors (multiple I/O combos)	None	HCM holds all WW rights	Marketed (non-pNET) Marketed (pNET)	U.S. NDA accepted E.U. MAA accepted
Fruquintinib (ELUNATE®)	VEGFR 1/2/3	In-house (est. LOE ~2033)	Colorectal, gastric, NSCLC, solid tumors (multiple I/O & TKI combos)	Lilly	HCM has WW rights ex-China; 70%-80% of sales in China ^[4]	Marketed (Colorectal); Ph.III (Gastric)	Ph.III U.S., E.U., Japan (Colorectal)
Savolitinib (ORPATHYS®)	MET	In-house (est. LOE ~2035)	NSCLC, kidney, gastric ^[3] , colorectal ^[3] (multiple I/O & TKI combos)	S	AZ has WW rights; China (30% royalty); ex-China (9-18% tiered royalty)	Marketed (NSCLC mono) Ph.III (NSCLC combo) Ph.II reg-intent (GC)	Ph.II/III global (multiple NSCLC) Ph.III global (PRCC*)
Amdizalisib (HMPL-689)	ΡΙ3Κδ	In-house (est. LOE ~2040)	B-cell malignancies – indolent NHL	None	HCM holds all WW rights	Ph.II reg-intent (FL & MZL)	Ph.I U.S., E.U., Aus (NHL)
HMPL-523	Syk	In-house (est. LOE ~2037)	ITP, B-cell malignancies – indolent non-Hodgkin's lymphoma (NHL)	None	HCM holds all WW rights	Ph.Ib/II (Treated >200 NHL pts.)	Ph.I U.S., E.U., Aus (NHL)
TAZVERIK®	EZH2	Epizyme	Solid tumors, hematological malignancies	(Epizyme ⁻	HCM has commercial rights in Greater China	IND Cleared (China)	Marketed by Epizyme
HMPL-453	FGFR 1/2/3	In-house (est. LOE ~2039)	Cholangiocarcinoma	None	HCM holds all WW rights	Ph.II (IHCC)	-
Epitinib	EGFRm+	In-house (est. LOE ~2032)	Glioblastoma	None	HCM holds all WW rights	Ph.II (Glioblastoma)	-
HMPL-306	IDH 1/2	In-house (est. LOE ~2043)	Hematological malignancies, solid tumors	None	HCM holds all WW rights	Ph.I (Hem. malignancies)	Ph.I (solid tumor & hem. malignances)
HMPL-295	ERK (MAPK pathway)	In-house	Solid tumors	None	HCM holds all WW rights	Ph.I (Solid tumors)	-
HMPL-760	3G BTK	In-house	Hematological malignancies	None	HCM holds all WW rights	IND submitted June 2021	IND submitted June 2021
HMPL-653	CSF-1R	In-house	Solid tumors	None	HCM holds all WW rights	Target IND 202	L (U.S./China)
HMPL-A83	CD47	In-house	mAb – solid tumors, hematological malignancies	None	HCM holds all WW rights	Target IND 202	L (U.S./China)

*In planning

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

2021 highlights



Regulatory & Commercial

- H1 2021 revenues: Oncology/Immunology up 161% to \$42.9m
- ELUNATE[®] (fruquintinib): In-market sales up +186%*
- SULANDA® (surufatinib): Launches now for NETs of any primary tumor origins
- ORPATHYS[®] (savolitinib): 1st approval & launch in July
- Surufatinib ex-China: U.S. NDA & E.U. MAA accepted, Japan bridging study initiated

Pipeline

- Transitioning Pipeline in Hematology: Amdizalisib (HMPL-689, PI3Kδi) in late stage, with Breakthrough Therapy Designation in China
- Savolitinib: Starting 5 new global & China registration studies in 2021
- Fruquintinib Monotherapy global registration study recruiting
- Surufatinib & Fruquintinib PD-1 combos: entering registration studies
- Early-stage Pipeline & Discovery: 5 new in-house clinical assets 2020-21 (IDH1/2, ERK, CD47, 3G BTK, & CSF-1R)
- Strategic Collaboration with Epizyme: Develop and commercialize TAZVERIK[®] (tazemetostat) in Greater China

Organizational Progress

• International R&D Organization and U.S. Commercial:

Continuing to build for potential surufatinib launch H1 2022 and growing pipeline

- China Commercial: Scaling rapidly to ~600 staff by YE
- Building New Flagship Manufacturing Facility: Designed for >5X increase small molecule capacity & mAb capability starting 2024
- ~\$1.2bn cash & resources



REGULATORY & COMMERCIAL HIGHLIGHTS

3 novel drugs launched



2021 Oncology consolidated revenues guidance **\$110-\$130 million** (vs. 2020 \$30.2m actual)



[1] In a China collaboration with Eli Lilly, HUTCHMED owns all rights outside of China; [2] To be commercialized by AstraZeneca globally.

ELUNATE® commercial update

HUTCHMED oncology sales team have made instant impact





HUTCHMED Sales team assumed all on-the-ground execution responsibilities in Q4 2020

~5,000 educational / scientific events in H1 2021

~83,000 new patients/yr. estimated China incidence of 3L CRC

Est. ~9,000 patients treated in H1 2021

[1] ELUNATE® was launched in late November 2018. HUTCHMED revenues in 2018 primarily relate to manufacturing fees and royalties paid by Lilly.

[2] During Q4 2019, ELUNATE® in-market sales were affected by rebates and downward price adjustments required in the distribution channel in the lead up to NRDL inclusion effective Jan 1, 2020;

[3]Represents manufacturing fees, commercial service fees and royalties paid by Lilly to HUTCHMED and sales to other third parties invoiced by HUTCHMED; [4] Represents total sales to third parties as provided by Lilly; [5] Unaudited.

SULANDA® initial progress encouraging



2 NDAs approved in 6 months, leading to \$8.0m^[1] in 1st half-year on market





H1 2021 commercial activities

- ~34,000 new China pts/yr. with advanced NET
- Launch campaign of local, regional & national events involving ~12,000 HCPs
- Early Access & Patient Access Programs led to use by over 2,000 patients
- Evaluating long term pricing strategy: 2022 NRDL vs. current pricing & access programs
- 30+ exploratory studies including IITs in a broad range of indications – expanding awareness of SULANDA[®] in China

[1] unaudited sales.

ORPATHYS[®] China's first selective MET inhibitor HUTCHMED

First indication approved: MET Exon 14 skipping NSCLC...



China); poor prognosis; no prior effective treatments

Efficacy in NSCLC, Gastric & PRCC

...and 5 registration studies set to start in H2 2021



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SUBSTAI	NTIAL BODY OF PU	IBLISHED DATA	SAVOLITINI	B REGISTRATION TRIALS STARTING H2
Study	Journal / Meeting	Primary efficacy	Treatment	Patient focus
SAVOIR (Savo mono)	JAMA Oncology ASCO20 Virtual	ORR: 27% vs. 7% (Sutent) PFS: 7.0mo vs 5.6mo (Sutent) OS: NC vs. 13.2mo (Sutent) [HR=0.51, 95% Cl: 0.21-1.17]	Savo + IMFINZI®	SAMETA: MET-driven PRCC
CALYPSO (Savo + IMFINZI [®])	2021 ASCO ANNUAL MEETING	ORR: 57% in MET-driven OS: 27.4mo in MET-driven	Savo + TAGRISSO [®]	SAVANNAH 2 : 2L/3L EGFRm+, TAGRISSO [®] refractory, MET+ NSCLC
TATTON & ORCHARD (Savo +	THE LANCET Oncology IASLC 2020 World Conference on Lung Cancer Singapore	ORR: 33-67% PFS: 5.5-11.1BD	Savo + TAGRISSO®	SACHI: 2L EGFRm+, EGFR TKI refractory, MET+ NSCLC
TAGRISSO [®])	2021 ESNO ^{Congress}		Savo +	SANOVO: Naïve EGFRm+, MET+ NSCLC
VIKTORY (Savo mono)	CANCER DISCOVERY	ORR: 50% in MET amp	TAGRISSO®	FPI Sept '21
MET ex14 NSCLC	THE LANCET Respiratory Medicine ASCO 20 Virtual	ORR: 42.9%	Savo mono.	2L+ MET amplified gastric cancer (<i>registration-intent Phase II</i>) FPI July '21



RECENT PIPELINE HIGHLIGHTS

Amdizalisib: Breakthrough Therapy designation HUTCHMED

Registration-intent trial initiated, supported by preliminary dose expansion results



Amdizalisib: follicular lymphoma (FL) highlights HUTCHMED

Encouraging preliminary tumor response in FL – majority of patients still on treatment



Amdizalisib: FL data vs. other PI3Kδ inhibitors

ORR, CR rate & PFS data is encouraging vs. approved PI3K δ inhibitors

Treatment option	Ν	Tx Line	Objective Response Rate (ORR) (95%CI)	Complete Response Rate	Partial Response Rate	Median Progression-Free Survival (mPFS), months (95%CI)
Amdizalisib ¹	22	>1L	82%	36%	46%	NA (NA – NA)
Idelalisib ²	72	>2L	57% (46 – 67)	6%	51%	11.0 (8.0 - 14.0)
Copanlisib ³	104	>2L	59% (49 – 68)	12%	47%	12.5 (0.03 – 44.2)
Duvelisib ⁴	83	>1L	42% (31 – 54)	1%	41%	8.3
Umbralisib⁵	117	>2L	43% (34 – 52)	3%	39%	10.6 (7.2 – 13.7)

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

1. As of June 15, 2021: ESMO 2021: Cao J, et al. #8330 - A phase Ib study result of HMPL-689, a PI3Kô inhibitor, in Chinese patients with relapsed/refractory lymphoma. Annals of Oncology (2021) 32 (suppl_5): S773-S785. doi: 10.1016/annonc/annonc676.

- 2. Witzig TE, et al. J Clin Oncol. 2009 Nov 10;27(32):5404-5409.
- 3. Dreyling M, et al. Am J Hematol. 2020 Apr;95(4):362-371.
- 4. Gopal et al. J Clin Oncol. 2018 Aug 10;36(23):2405-2412.

5. <u>TG Therapeutics FDA approval press release</u>. Fowler N, et al. J Clin Oncol. 2021 May 20;39(15):1609-1618. doi: 10.1200/JCO.20.03433. Epub 2021 Mar 8.

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Amdizalisib: demonstration of tolerability



30mg QD dose expansion data highly consistent with early data

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

2021	Amdizalisib ^[1]		Zvdelig®	Aligona®	Copiktra®	Ukonia®	Ukonig [®] Parsaclisib			Zandelisib		
	Dose escalation ^[1]	30mg QD [2]	(idelalisib) ^[3]	(copanlisib) ^[3]	Aliqopa [®] Copiktra [®] (copanlisib) ^[3] (duvelisib) ^[3] (i		Dose escalation ^[4]	CITADEL-203 / FL ^[5]	CITADEL-204 / MZL ^[6]	Dose e escalation ^[7]	intermittent dosing ^[8]	
n	56	90	146	168	442	221	72	102	72	30	37	
Neutropenia	43% / 11%	29% / 11%	53% / 25% *	32% / 25%	34% / 30%	33% / 16%*	44% / 20% *	14% / 10%	14% / 11%	45% / 13%*	na / 16%	
Leukopenia	29% / 4%	21% / 4%	na	36% / 27%	29% / 8%*	na	50% / 8%	na	na	na	na	
Anemia	16% / 0%	12% / 4%	28% / 2%*	na	20% / 11%	27% / 3%*	31% / 8%*	29% / 2%*	15% / 5%	13% / 0%*	na / <5%	
Thrombocytopenia	11% / 0%	<10% / 2%	26% / 6%*	22% / 8%	17% / 10%	26 % / 4%*	35% / 10%*	20% / 0%*	1/% / 3%*	22% / 0%*	na / <5%	
Diarrhea	<5% / 0%	11% / 2%	47% / 14%	36% / 5%	50% / 23%	58% / 10%	36% / 9%	37% / 11%	49% / 14%	45% / 19%	na / 5%	
Rash	11% / 5%	16% / 6%	21% / 3%	15% / 2%	31% / 9%	18% / 3%	31% / 6%	11% / 2%	17% / 3%	42% / 13%	na / 8%	
ALT increased	27% / 2%	27% / 0%	50% / 19%	na	40% / 8%	33% / 8%	28% / 1%	25% / 2%	29% / 6%	39% / 6%	na / 8%	
AST increased	21% / 2%	19% / 0%	41% / 12%	na	37% / 6%	32% / 7%	29% / 1%	25% / 0%	19% / 2%	25% / 6%	na	
Pyrexia	14% / 0%	<10% / 1%	28% / 2%	na	26% / 2%	10% / 0%	18% / 1%	17% / 3%	13% / 1%	<15%	na / <5%	
Pneumonia	25% / 16%	18% / 13%	25% / 16%	21% / 14%**	21%/15%	PJP prophylaxis recommended	na	<10%	8% with PJP prophylaxis	<15%	PJP prophylaxis	
Hypertension	7% / 5%	<10% / 0%	na	35% / 27%	na	na	7% / 0%	<10%	<10%	<15%	na / <5%	
Hyperglycemia	11% / 0%	<10% / 0%	na	54% / 39%	na	na	10% / 1%	<10%	<10%	<15%	na / <5%	
Discontinuation due to AE	na	5.6%	53% (+inter)	16%	29-35%	14%	19%	22%	35%	13%	8%	

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

[1] ASH 2020 Abstract #1135; [2] ESMÓ 2021 Abstract #8330; [3] US Prescribing Information; [4] Blood, April 2019 doi: 10.1182/blood-2018-08-867499; [5] ASH 2020 Abstract #2935; [6] ASH 2020 Abstract #338; [7] ASCO 2018 Abstract #7519;

[8] ASCO 2021 Abstract #7550 (includes rituximab combo). *Laboratory values; **Lower respiratory tract infections; ***Regardless of causality; PJP = pneumocystis jirovecii pneumonia

Amdizalisib (HMPL-689): Development summary and registration pathway



CHINA

Monotherapy

- Breakthrough Therapy Designation Sep 2021
- FL / MZL registration study started April 2021
 - NDA submission potentially late 2022 / early 2023
- Additional indications will be planned

Combinations

- Additional indications
- Earlier lines
- To start in early 2022

GLOBAL

U.S. & E.U. Ph.I multiple dose cohorts complete

Next steps

- Evaluate efficacy signals using cumulative amdizalisib data from both International and China studies, and RP2D selection
- Engage FDA in late 2021 through End of Phase 1 meeting to confirm registrational path



Savolitinib: EGFRm+ NSCLC w/ MET aberrations HUTCHMED

Phase III registration studies being planned combined with TAGRISSO® (osimertinib, 80mg QD)



SAVANNAH: Broadest TAGRISSO® refractory population – FISH+ and/or IHC+ line agnostic



TO FINALIZE FOR GLOBAL PHASE III

- Dose regimen
- Target patient population
- Diagnostics tools
 - FISH / IHC

Data will inform Phase III designs

Intention to initiate late 2021

an JY, et al. Osimertinib + savolitinib in patients with EGFRm MET-amplified/overexpressed NSCLC: Phase Ib TATTON Parts B and D final analysis. WCLC January 2021 #FP14.03. Data based on ITT set. ESMO 2021 Abstract # <u>1239P</u>, Response based on efficacy evaluable set.

mDoR, median duration of response; mPFS, median progression free survival; CI, confidence interval; NR, not reached; QD, once daily; BID twice daily

Savolitinib: Promising in MET-driven PRCC

Global Phase III trial in planning in combination with IMFINZI[®] (durvalumab)



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SAVOIR: Single agent anti-tumor activity in MET-driven PRCCAll 9 savo responders remained in response at data cut-offSAVOIR [1]Savolitinib (N=33)Sunitinib (N=27)ORR* [95% CI]27% [13.3-45.5]7% [0.9-24.3]PFS [95% CI]7.0 mo. [2.8-NC]5.6 mo. [4.1-6.9]Hazard Ratio: 0.71 [0.37-1.36]



Highly correlated to MET-driven alterations / amplif. 57% ASC 202 29% MET DNA alterations (central analysis: chromosome 7 gain / MET or HGF amplification, kinase domain mutations) All patients (12/41) MET-driven (8/14) All patients (N=41) MET-driven (N=14) ORR 29% 57% 4.9 mo. [2.5-10.0] mPFS 10.5 mo. [2.9-15.7] mOS 14.1 mo. [7.3-30.7] 27.4 mo. [7.3-NR] PFS @ 12 mo. 29.6% [16.1-44.3] 46.2% [19.2-69.6] 64.3% [34.3-83.3] OS @ 12 mo. 54.3% [37.5-68.4]

CALYPSO: IMFINZI[®] (PD-L1i) combination activity^[2]

*1 of 2 sunitinib responders remained in response at data cut-off. NC = not calculated.

[1] Choueiri TK, et al. Efficacy of Savolitinib vs Sunitinib in Patients With MET-Driven Papillary Renal Cell Carcinoma: The SAVOIR Phase 3 Randomized Clinical Trial. JAMA Oncol. Published online May 29, 2020. doi:10.1001/jamaoncol.2020.2218; [2] ASCO 2021 Suárez C et al. J Clin Oncol 39, 2021 (suppl 15; abstr 4511).

Savolitinib: MET ampl. in gastric cancer



Phase II trial ongoing in China with potential for registration



VIKTORY: Best tumor response (savolitinib arm) VIKTORY: Duration of response (savolitinib arm)



Savolitinib development summary



CHINA

MET Exon14 skipping NSCLC

- NDA approved in June 2021
- Commercialized by AstraZeneca
- Present in other tumor types: Secondary GBM, GI tumors, Histiocytic sarcoma

2L EGFR TKI refractory NSCLC with MET amplification

- Savolitinib + TAGRISSO[®] Phase III registration study
- FPI expected late H2 2021 **SACHI Study**

1L EGFRm+ NSCLC with MET overexpression

- Savolitinib + TAGRISSO[®] Phase III registration study
- FPI in September 2021 **SANOVO Study**

Gastric cancer with MET amplification

- Single arm study with potential for registration
- FPI in July 2021

GLOBAL

MET-driven PRCC

- Phase III registration study
- Savolitinib + IMFINZI® vs. sunitinib in MET-driven PRCC
- Expected study initiation H2 2021
 SAMETA Study

2L TAGRISSO[®] refractory NSCLC with MET amplification

- Savolitinib + TAGRISSO[®] Phase III registration study
- FPI expected late YE 2021

FRESCO-2 to support 3L+ mCRC U.S./E.U./JP NDA-UTCHMED

Regulatory alignment on fruquintinib across all major markets



• **Target Patient Population** – We are aiming for aggregate clinical data to support U.S. NDA & E.U. MAA in third-line and above metastatic CRC

• FRESCO-2 Global Ph.III

- Enrolling >150 sites across 14 countries
- Target fully enrolled end of 2021
- U.S. Fast Track designation → potential for rolling submission
- Extensive list of supportive studies

FRESCO China Ph.III (≥3L CRC):



Fruquintinib: PD-1 inhibitor combinations

Durable benefit seen in advanced colorectal cancer

Status/ plan

Est. N~35

Phase II ongoing

Phase Ib/II

to select 1-2 for

Phase I/Ib ongoing

registration intent

ongoing; Total est. N~120

studies

Est. N~80

Fruguintinib PD-1 studies Summary

ASCO

2021

Hepatocellular CN

Triple negative US

breast cancer,

carcinoma

Endometrial

cancer

Other GI

CN

CN

CN

CN

Patient focus

CRC

csco₂

2021

csco

2021

CSCO

2021 RCC

PD-1

TYVYT®

TYVYT®

TYVYT[®]

TYVYT®

Tislelizumab

		ASCO	ASCO	ANNUAL MEETING
	Fruq mono Ph. III (FRESCO)	Fruq + sintilimab ^[1]	Fruq + geptano- limab ^[2]	Lenvatinib + pembro- lizumab ^[3]
Prior lines of tx	≥2	≥2	67%≥2	94% ≥2
RP2D VEGFRi dose (n)	5mg QD 3w/1w <i>(278)</i>	5mg QD 2w/1w <i>(22)</i>	4mg QD 3w/1w (15) ^[4]	20mg QD <i>(32)</i>
Data cut-off	Jan 17, 2017	Apr 7, 2021	Dec 15, 2020	Apr 10, 2020
ORR	4.7% [2.1-7.2]	27.3% [10.7-50.2]	26.7%	21.9% [9.3-40.0]
DCR	62.2% [56.3-68.0]	95.5% [77.2-99.9]	80%	46.9% [29.1-65.3]

	cancer			ORR	[2.1-7.2]	[10.7-50.2]	26.7%
Tislelizumab	Solid tumors	TBD	Phase I/Ib In planning Est. N~60+	DCR	62.2% [56.3-68.0]	95.5% [77.2-99.9]	80%
Geptanolimab	CRC	CN	Phase Ib ongoing Est. N~15	mPFS, months	3.7 [3.7–4.6]	6.9 [5.4-8.3]	7.3 [1.9-NR]
Geptanolimab	NSCLC	CN	Phase Ib ongoing Est. N~15	OS, months	9.3 [8.2–10.5]	11.8 [8.8-NR]	Not mature at DCO
Note: Illustrative	comparison only. No head	d-to-head	studies have been conducted. Study	parameters differ.			

[1] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr 2514) data in patients dosed with RP2D; [2] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e15551) data in 15 ITT patients, of which 6 were dosed with RP2D; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; ab

HUTCHM

2021 ASCO

2.3 *[2.0-5.2]*

7.5 (3.9-NR)

Fruquintinib: PD-1 inhibitor combinations

Encouraging fruq. + sintilimab data presented for EC, HCC and RCC at CSCO

				(Data cut-off: August 31	2021) CSCO	- CSC	0 ⁻ CSCO
Fruquintinib PD-1 studies Summary		(Data cat on. nagast si	2021	202	21 2021		
PD-1	Patient focus		Status/ plan		Advanced	Advanced	Advanced Renal
TYVYT®	CRC	CN	Phase II ongoing Est. N~35		Endometrial Cancer ^[1]		Cell Carcinoma ^[3]
TYVYT® CSCO 2021	Hepatocellular carcinoma	CN	Phase Ib/II ongoing;	Efficacy	1L: 4	10	20
TYVYT® CSCO 2021	Endometrial cancer	CN	Total est. N~120	pop'n (N)	2L+ pMMR: 19	15	20
TYVYT® 2021	RCC	CN	registration intent		1L: 100% [40-100]		
TYVYT®	Other GI	CN	studies	Confirmed	2L: 32% [15-54]	31.6%	55.0%
Tislelizumab	Triple negative breast cancer,	US	Phase I/Ib ongoing Est. N~80	UKK	2L+ pMMR: 37% [16-62]	[12.0-30.0]	[31.3-70.9]
	endometrial cancer				1L: 100% [40-100]	89.5%	85.0%
Tislelizumab	Solid tumors	TBD	Phase I/Ib In planning Est_N~60+	DCK	2L+ pMMR: 95% [74-100]	[66.9-98.7]	[62.1-96.8]
Geptanolimab	CRC	CN	Phase Ib ongoing	mPFS, months	1L: NR 2I +: 6.9 <i>[4, 1-NR]</i>	6.9 [4.1-NR]	Not reached
	2021			months			
Geptanolimab	NSCLC	CN	Phase Ib ongoing Est. N~15	Median duration of tx	1L: 22.1 weeks 2L+: 16.9 weeks	30.1 weeks	38.6 weeks

* Best response rate for efficacy evaluable set (patients who have had at least one tumor evaluation while on treatment); pMMR = proficient mismatch repair.

24th Annual Meeting of the Chinese Society of Clinical Oncology; 2021 Sep 27-29: [1] Wu X, et al. Fruquintinib plus sintilimab in patients with advanced endometrial cancer: a multicentre, open-label, single-arm, phase II clinical trial. [2] Qin S, et al. A phase II study of fruquintinib plus sintilimab in patients with advanced renal cell carcinoma: results from a phase II clinical trial.

NAA .

Fruquintinib: Development summary



Current development status and next steps

CHINA

FRUTIGA: Phase III in 2L gastric cancer ongoing

- Expect fully enrolled around YE 2021
- Top-line data expected H2 2022

PD-1

- CRC: data promising, registration strategy being formulated
- EMC: registration study under discussion with CDE, expect to initiate H2 2021
- HCC and RCC: registration plans currently under discussion with PIs
- 3 new cohorts added and are enrolling
- 20+ exploratory studies ongoing, including IITs

GLOBAL

Colorectal cancer

- FRESCO-2 Phase III initiated in U.S., E.U. & Japan
- U.S. Phase Ib/II completed
- Basis for U.S., E.U. Japan NDA clear
 - Support for U.S. NDA in third-line and above mCRC

PD-1 combinations

• Ongoing proof-of-concept studies across multiple cohorts, led by both HUTCHMED and BeiGene

Surufatinib: Promising PD-1 combos



Initiat addit	2021 ASCO						
Surufatinib PD-1 Studies Summary PD-1 Patient focus Status/ plan				ABSTRACT	2021 Surufatinib + toripalimab ^[1]	2021 Surufatinib + toripalimab ^[2]	Lenvatinib + pembrolizumab ^[3]
TUOYI® TUOYI® TUOYI®	NEC CSCO 2021 Biliary tract Gastric ASCO 2021	CN CN CN		Indication	Neuroendocrine Carcinoma (2L)	Gastric or GEJ (2L)	Gastric or GEJ (2L)
TUOYI® TUOYI®	Thyroid Small cell lung	CN CN	First Phase III initiated in ≥2L NEC	Efficacy evaluable	21	15	26
TUOYI® TUOYI®	Soft tissue sarcoma Endometrial	CN CN	Additional reg. studies under	Duration of tx, mo. [DCO]	4.9 [Jul 30, 2021]	3 [Dec 31, 2020]	7 [Apr 10, 2020]
TUOYI® TUOYI® TYVYT®	Esophageal NSCLC Solid tumors	CN CN	Phase I dose	ORR	Confirmed: 23.8% [8.2 – 47.2]	Confirmed: 13.3% [1.7 – 40.5]	11.5%
			escalation completed	DCR	71% [47.8 - 88.7]	73% [44.9 – 92.2]	58%
Tisle- lizumab	Solid tumors	US EU	Phase I/Ib ongoing	mPFS, mo.	4.1 [1.5 - 5.5]	3.7 [1.41 – NR]	2.5 [1.8-4.2]
			Total N~110	mOS, mo.	10.3 [9.1 – NR]	Not mature at DCO	5.9 [2.6-8.7]

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

[1] Shen L, et al. A phase II study of surufatinib in combination with toripalimab in patients with advanced neuroendocrine carcinoma: an updated analysis. 24th Annual Meeting of the Chinese Society of Clinical Oncology; 2021 Sep 27-29. [2] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr e16040); [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr 4030).

Surufatinib: Development summary



Current development status and next steps

CHINA

Extra-pancreatic (non-pancreatic) NET

- NDA approved Dec 2020
- Launched Jan 2021
- Evaluating long term pricing strategy

Pancreatic NET

- Recommended in China Medical Association guidelines in May 2021
- NDA approved June 2021

PD-1

- NEC: preparing to initiate Phase III
- Gastric / GEJ: registration design under discussion
- BTC & 6 other cohorts: data continuing to mature
- 30+ exploratory studies ongoing, including IITs

GLOBAL

U.S. FDA NDA accepted June 2021

- Fast Track Designations for both pNET & non-pNET
- Orphan Drug designation granted for pNET
- PDUFA date April 30, 2022

EMA MAA submitted and accepted July 2021 Japan registration path agreed with PMDA

PD-1 combinations with tislelizumab in U.S. & E.U.

• CRC, NET, SCLC, gastric, STS cohorts planned: FPI March 2021



Next wave of innovation



Hematological malignancies assets - internally developed



Program	Treatment	Target Patient	Sites	Dose Finding / Safety Run-in	Proof-of-concept	Registration
	HMPL-523	Indolent NHL	US/EU/AU			
HMPL-523	HMPL-523	B-cell malignancies	China			
Syk	HMPL-523	ITP	China			
	HMPL-523	AIHA	China		*	
HMPL-453 FGFR 1/2/3	HMPL-453	IHCC	China			
HMPL-306	HMPL-306	Hematological malignancies	China			
IDH 1/2	HMPL-306	Hematological malignancies & solid tumors	US/EU			
HMPL-295	HMPL-295	Solid tumors	China			
(ERK, MAPK pathway						
HMPL-760	HMPL-760	Hematological malignancies	US/EU	*		
(BTK, 3G)	HMPL-760	Hematological malignancies	China	*		



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Strategic Collaboration with Epizyme

Key financial terms



Asset & Rights	 TAZVERIK[®] is a methyltransferase inhibitor of EZH2, developed by Epizyme U.S. FDA approved for epithelioid sarcoma (ES) and follicular lymphoma (FL) Development and commercial rights to TAZVERIK[®] (tazemetostat) in Greater China
Upfront	US\$25 million
Development & Regulatory Milestones	Up to \$110 millionAcross up to 8 potential indications
Sales Milestones	• Up to US\$175 million
Royalties	 Based on annual sales in Greater China Tiered royalties: mid-teen to low-twenties percent
Warrant Rights	 HUTCHMED has option to acquire Epizyme shares <i>Term:</i> 4 years <i>Amount:</i> up to US\$65m <i>Exercise price:</i> \$11.50 per share

Phase 1b

Population

TAZ + Rituximab + Lenalidomide (N=~40)

> sensitive vs. refractory to prior rituximab containing regimen, patients treated with 1 prior vs \geq 2 prior systemic therapies.

EZH-302 study for 2L+ FL

Induction with rituximab + lenalidomide (R²) + TAZVERIK[®], followed by TAZVERIK[®] alone

prior systemic therapy



Patients with relapsed / rituximab refractory FL who have been treated with at least one





Combination potential of TAZVERIK[®] with HUTCHMED assets





	NEAR TERM		LONGER TERM		
SOLID TUMORS	+ FRUQUINTINIB (VEGFRi)	Lung	+ HMPL-295 (ERKi)	K-Ras mutant tumors	
	(China approved for CRC; Global Ph III ongoing)	Ovarian	(China Ph I ongoing)		
	+ SURUFATINIB (VEGFRi/FGFRi/CSF1Ri)	Tumors w/ neuroendocrine differentiation (NED), e.g. NEPC	+ IMMUNOTHERAPIES,	Macrophage-targeting	
	U.S. NDA & EMA MAA submitted)	Sarcoma (suru. in U.S. Ph Ib)	(IND-enabling stage)	such as breast cancer	
HEMATOLOGICA MALIGNANCIES	+ Amdizalisib (HMPL-689) (PI3Kδi) (China reg. Ph II initiated; U.S./E.U. Ph II ongoing)	DLBCL	+ HMPL-760 (BTKi)	NHL	
		TCL	+ HMPL-A83 (CD47)		
			+ Bi-specific Abs	1L NHL	



OPERATIONAL HIGHLIGHTS

U.S. Commercial Organization



Building on a strong clinical & regulatory team

Experienced functional leads in place for commercialization – fully engaged on all aspects of launch readiness



Full commercial team in place by early 2022

to support potential launches of surufatinib in 2022 & fruquintinib in 2023

In collaboration with established international clinical & regulatory functions

Regulatory Affairs				Medical Affairs					
Clinical Development & Operations					Quality & Safety				
Surufatinib	Fruquintinib	Europe	Early Stage Assets		Clinical Pharmacology	Product Safety & Pharmaco- vigilance	Quality Assurance & Compliance	Non-Clinical Safety & Toxicology	

China Commercial operations infrastructure



Long history of Rx commercialization, through JVs controlled and operated by HUTCHMED

Leverages scale and capabilities from multiple affiliates

litette HUTCHMED

Oncology team

- 600+ (and growing) sales reps
- 2,500+ oncology hosp./clinics \checkmark
- 29,000+ oncology physicians \checkmark

Shanghai Hutchison Pharmaceuticals

Nationwide distribution & promotion

- 2,200+ sales reps \checkmark
- 23,000+ hospitals
- 83,000+ physicians

Hutchison **Sinopharm Pharmaceuticals**

- Third-party distribution & logistics
- Nationwide support \checkmark from Sinopharm in distribution/logistics
- Deep Shanghai \checkmark coverage

Expanding rapidly to support ELUNATE[®] & SULANDA[®] launches

2,500+ oncology hospitals and 29,000+ oncology physicians covered

- Fully in-place since mid-2020; •
- Vast majority of new staff from successful China oncology companies (MNC & locals)
- Expansion planned for future product launches •
- SF productivity targeted to reach to US\$400k per Rep. per year in 2023 900+



Shanghai Hutchison Pharmaceuticals:

Established in April 2001; 50% owned by HUTCHMED, 50% by Shanghai Pharma. Hutchison Sinopharm Pharmaceuticals: Established in April 2014; 51% owned by HUTCHMED, 49% by Sinopharm.
Drug Product and Biological Facilities

New Shanghai Fa



New Shanghai factory to support production for China and global post 2025

SUZHOU FACTORY

- Built to produce ELUNATE[®] and SULANDA[®]
- Manufacturing talent developed
- Suzhou is designed to U.S. GMP standards

SHANGHAI FACTORY

- Capex of \$130 million over 5 years
- Will fulfil additional global production requirements
- Additional capacity for expansion in large molecule production



Ney Aspeets	Suzhoù Fuetory	New Shangharractory	
Property Type	Leased	Owned	
Land Size (sq.m.)	~1,800	~28,700 (16x)	
Building Size (sq.m.)	~4,500 (Office: ~1,000)	~55,000 (12x) (Office: ~16,400)	
Capacity (Cap & Tabs)	50 million	250 million (5x, Phase 1)	
Growth Potential	No capacity for growth	Phase 2 for biologics	







POTENTIAL UPCOMING CLINICAL & REGULATORY EVENTS

Potential upcoming events



Clinical & regulatory milestones in U.S., E.U. & Japan

				Early 21	MIG 21	Late 21	2022
	NETs mono.	NDA	U.S. NDA submission	\checkmark			
Surufatinib (VEGFR 1/2/3:	Solid tumors	Ph. lb/lls	Tislelizumab PD-1 combo start	\checkmark			
FGFR1; & CSF-1R inhibitor)	NETs mono.	MAA	E.U. MAA submission**		\checkmark		
,	NETs mono.	Market	U.S. NDA & E.U. MAA approval and launch				۲
	TNBC / EMC PD-1 combo	Ph. lb/lls	Tislelizumab PD-1 combo start		•	/	
Fruguintinib	CRC mono	Ph.III	FRESCO-2: Recruitment completion			0	
(VEGFR 1/2/3 inhibitor)	CRC mono	Ph.lb	Data at a scientific conference*				0
	CRC mono	Ph. III	FRESCO-2: Readout & NDA subm.***				۲
Savolitinib (MET inhibitor)	PRCC PD-L1 combo	Ph. II	CALYPSO: IMFINZI® combo data (ASCO)	\checkmark			
	PRCC PD-L1 combo	Ph. III	SAMETA: IMFINZI® combo start**		6	•	
1	EGFR-TKI refract., MET+ NSCLC	Ph. III	EGFR combo (TAGRISSO®) start**			۲	
Amdizalisib	Homotological malignancies	Ph.lb	Expansion start***		0		
(HMPL-689) (PI3Kδ inhibitor)	Hematological malignancies		Regulatory dialogue**			0	
HMPL-523	Llematological malignancies	Ph. Ib	Expansion start***		(C	
(Syk inhibitor)	nematological malignancies	Ph.lb	Escalation data at scientific conf.*			0	
HMPL-306	Hematological malignancies &	Ph.I	Start	✓			
(IDH1/2 inhibitor)	solid tumors	Ph.I	Complete dose escalation and start expansion			C)
HMPL-760 (3G BTK inhibitor)	Hematological malignancies	Ph.I	Start**			C)
New assets	_	-	IND filings***			C)

* Subject to acceptance by scientific conference; ** subject to regulatory interaction; *** subject to supportive data. Bold = regulatory progress or new clinical data.

Potential upcoming events



Clinical & regulatory milestones in China

				Early 21	MIA 21	Late 21	2022
	non-pNET & pNET	Market	Approval & launch	\checkmark	\checkmark		
Surufatinib (VEGER 1/2/3:	NEC & GC PD-1 combo	Ph. lb/ll	TUOYI [®] PD-1 combo data (ASCO)	\checkmark			
FGFR1; &	Further PD-1 combo	Ph. Ib/II	Data at CSCO			\checkmark	
CSF-IR IIIIIDILOI)	PD-1 combo	Ph. II	Registration intent study start			\checkmark	
	CRC PD-1 combos	Ph. lb/ll	TYVYT [®] & geptano. combos data (ASCO)	\checkmark			
	Further PD-1 combo	Ph. Ib/II	Data at CSCO			\checkmark	
Fruquintinib (VEGER 1/2/3 inhibitor)	PD-1 combo	Ph. II	Registration intent study start**			0	
(VEGI (1)2)3 minoron	GC paclitaxel combo	Ph. III	FRUTIGA: recruitment completion			0	
	GC paclitaxel combo	Ph. III	FRUTIGA: readout & NDA submission***				\bigotimes
	MET Ex14 skipping NSCLC	Market	Approval & launch by AZ		\checkmark		
Savolitinib	MET+GC	Ph. II	Registration potential study start		\checkmark		
Savolitinib (MET inhibitor)	EGFR-TKI refract., MET+ NSCLC	Ph. III	SACHI: TAGRISSO [®] combo start**			\bigotimes	
	EGFRm+, MET+ NSCLC	Ph. III	SANOVO: TAGRISSO [®] combo start			\checkmark	
Amdizalisib	NHL multiple subtypes	Ph. II	Registration intent studies start	\checkmark			
(HMPL-689)	NHL multiple subtypes	Ph. lb	Expansion data at ESMO			\checkmark	
(PI3Kδ inhibitor)	NHL multiple subtypes	Ph. Ib	Initiate combo studies**				0
	AIHA	Ph. II	Start**			0	
HMPL-523 (Syk inhibitor)	ITP	Ph. Ib	Data at a scientific conf.*			0	
	ITP	Ph. III	Start**			0	
HMPL-453 (FGFR 1/2/3i)	Solid tumors	Ph. Ib	Initiate combo studies**			C)
HMPL-306 (IDH 1/2i)	Hematological malignancies	Ph.I	Complete dose escalation and start expansion			C)
HMPL-295 (ERKi)	Solid tumors	Ph.I	Start		\checkmark		
HMPL-760 (3G BTKi)	Hematological malignancies	Ph.I	Start**			C)
New assets	_	-	IND filings***			C)

* Subject to acceptance by scientific conference; ** subject to regulatory interaction; *** subject to supportive data. Bold = regulatory progress or new clinical data.



FINANCIALS & SUMMARY

Condensed Consol. Balance Sheet



(in US\$'000)

	Dec 31,	Jun 30,
	2020	2021
Assets		(Unaudited)
Cash, cash equivalents & short-term investments	435,176	950,448
Accounts receivable	47,870	58,878
Other current assets	47,694	81,848
Property, plant and equipment	24,170	29,168
Investments in equity investees	139,505	118,316
Other non-current assets	29,703	34,231
Total assets	724,118	1,272,889
Liabilities and shareholders' equity		
Accounts payable	31,612	28,513
Other payables, accruals and advance receipts	120,882	181,610
Bank borrowings	26,861	26,883
Other liabilities	25,814	22,188
Total liabilities	205,169	259,194
Total Company's shareholders' equity	484,116	984,795
Non-controlling interests	34,833	28,900
Total liabilities and shareholders' equity	724,118	1,272,889

As of Jun 30, 2021 Cash Resources: • \$950m cash / cash eq. / ST inv. ^[1]

- Not including **additional ~\$250m** in H2 resulting from:
 - \$77m HK IPO over-allotment, net
 - \$25m ORPATHYS® 1st sale milestone
 - ~\$150m non-core OTC divestment

H1 2021 Equity Financings:

- \$100m PIPE BPEA (Apr 2021)^[2]
- \$508m HK IPO (Jun 2021 net pre-O/A)

Other:

- \$69m unutilized banking facilities [3]
- \$27m in bank borrowings
- \$55m additional cash at SHPL JV

[1] Short-term investments: deposits over 3 months; [2] Private placement to Baring Private Equity Asia. [3] From HSBC & Deutsche Bank.

Condensed Consol. Statement of Operations

(in US\$'000, except share and per share data)

	YE Dec 31,	6 Mths End	led Jun 30,
	2020	2020	2021
Revenues:		(unau	dited)
Oncology/Immunology – Mktd Products	19,953	8,645	37,795
Oncology/Immunology – R&D	10,262	7,747	5,056
Oncology/Immunology total revenue	30,215	16,392	42,851
Other Ventures	197,761	90,373	114,511
Total revenues	227,976	106,765	157,362
Expenses:			
Costs of revenues	(188,519)	(83,572)	(123,249)
R&D expenses	(174,776)	(73,974)	(123,050)
Selling & general admin. Expenses	(61,349)	(27,384)	(54,797)
Total expenses	(424,644)	(184,930)	(301,096)
Loss from Operations	(196,668)	(78,165)	(143,734)
Other income	6,934	1,585	3,287
Loss before income taxes & equity in earnings of equity investees	(189,734)	(76,580)	(140,447)
Income tax expense	(4,829)	(2,032)	(1,859)
Equity in earnings of equity investees, net of tax	79,046	30,366	42,966
Net loss	(115,517)	(48,246)	(99,340)
Less: Net income attrib. to non-controlling interests	(10,213)	(1,448)	(3,057)
Net loss attrib. to HUTCHMED	(125,730)	(49,694)	(102,397)
Losses/share attrib. to HUTCHMED – basic & diluted	(0.18)	(0.07)	(0.14)
Losses/ADS attrib. to HUTCHMED – basic & diluted	(0.90)	(0.35)	(0.70)

HUTCHMED

2021 Guidance

\$110-130m in consolidated Oncology/Immunology revenue

- Accelerating growth on ELUNATE®
- Full year sales on SULANDA®
- ORPATHYS[®] 30% royalties, mfg sales & 1st sale milestone

Rapid expansion of organization & development on 11 novel oncology candidates – 6 in global development

- U.S. & Europe R&D expense grew to \$59.3m in H1 2021 (H1-20: \$19.9m)
- China R&D expense grew to \$63.8m in H1 2021 (H1-20: \$54.1m)

2021: Another busy year for HUTCHMED



	Savolitinib: 5	 2L EGFR TKI refractory NSCLC, China; 2L EGFR TKI refractory NSCLC, global; 1L EGFRm+ with MET overexpression, China; MET driven PRCC, global; MET amplified GC
10 new	Surufatinib: 1	• 2L NEC, in combination with TUOYI®
registration studies	Fruquintinib: 1	• 2L EMC, in combination with TYVYT®
	Amdizalisib (HMPL-689) : 2	• 2L MZL; 3L FL
	HMPL-523: 1	• ITP
	HMPL-760	• Third generation BTK inhibitor: U.S., China
3 new INDs	HMPL-653	CSF-1R inhibitor: China
	HMPL-A83	• CD47 monoclonal antibody: U.S., China

HUTCHMED 2025





Additional therapies in registration studies

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litette

HUTCHMED

Thank you



www.hutch-med.com



Estimated Incidence in Main Target Indications



Strategies

- Realizing global potential of novel oncology assets
- Building a fully integrated China oncology business



Product Candidate Details



Commercial Expertise



Manufacturing Expertise



Further Corporate Information

APPENDIX



A1

ESTIMATED INCIDENCE IN MAIN TARGET INDICATIONS

Savolitinib market potential



First-in-class selective METi in China – global studies planned in NSCLC & PRCC

							Est. Annual Incidence ('000) [1, 2, 3]					Median
							China	U.S.	EU5	Japan	Total	DOT ^[4]
				I	Colorectal	l f.	4	3	3	1	11	TBD
				Esophag MET Gene A	geal Ampl.		16	1	1	1	20	TBD
			G a MET G	o stric ene Ampl.			24	1	3	7	35	8.0 mo. VIKTORY Ph.II
			PRCC <i>MET positive</i>				4	4	4	1	14	7.0 mo. SAVOIR Ph.III
		NSCL MET+ EGF refractory (3	.C R TKI ^{grd} gen.)				21 ^[5]	7	4	7	40	5.4 mo. TATTON Ph.II
	N MET+ refractory	SCLC · EGFR TKI y (1 st /2 nd gen.)					12	3	2	3	20	9.0 mo. TATTON Ph.II
NSC MET Ger	CLC ne Ampl.						26	7	7	4	44	TBD
NSCLC MET Exon14d							13	5	5	3	26	8.3 mo. Registr. Ph.II
							120	32	30	28	210	
			Approve	d	sta	Regist arted / in	ration Stu planning	dies for 2021		Savo FIC	C & only tr alternative	eatment e

[1] Globocan; [2] SEER; [3] Company estimates;

[4] DOT = duration of treatment in latest study; [5] In 2020, Tagrisso treated approximately 20k patients. With NRDL inclusion and 64% price reduction, we estimate Tagrisso is likely to treat approximately 60k patients.

Fruquintinib market potential



Best-in-class selective VEGFRi – global monotherapy in 3rd line CRC; expand through chemo/PD-1 combinations in earlier line settings

						Est. Annual Incidence ('000) ^[1, 2, 3]					Median
						China	U.S.	EU5	Japan	Total	DOT ^[4]
		EMC,TNBC, 2nd Lin	RCC, HCC, NS e (+ PD-1 mAb)	CLC		TBD	TBD	TBD	TBD	TBD	TBD
	Colorec 2nd Line (+ PD	tal -1 mAb)				165	47	72	44	328	TBD
2nc	Gastric d Line (+ Taxol)					234	14	25	68	341	4.0 mo. Ph.Ib study
Colorectal 3rd Line						83	23	36	22	164	4.0 mo. FRESCO Ph.III
						482	84	132	134	832	
		Approved	b		Registrat submis	ion Studie sions und	es / NDA erway		Proof-of- u	concept nderway	studies

Surufatinib market potential



Best-in-class VEGFRi with synergistic activity – global monotherapy in Advanced Grade 1/2 NET; expand through PD-1 combinations in earlier line settings

				Est. Annual Incidence ('000) ^[1, 2, 3]					Median
				China	U.S.	EU5	Japan	Total	DOT ^[4]
		Esophageal, Biliary Tract SCLC, Gastric, Sarcoma, Thyroid, EMC, NSCLC 2nd Line (+ PD-1 mAb)	,	TBD	TBD	TBD	TBD	TBD	TBD
	NET / NE G3 2nd Line (+ PL	C D-1 mAb)		11	8	7	3	29	TBD
	Biliary Tract 2nd Line			39	3	3	1	45	TBD
NET Advan. G1/2				34	16	15	6	71	10.0 mo. SANET Ph.IIIS
				84	26	25	10	145	
[1] Globocan: [2] SEER: [3] Compan	v estimates:	Approved	Registra submi	tion Studie ssions und	es / NDA erway		Proof-of- u	concept : nderway	studies

Amdizalisib (HMPL-689) market potential



Emerging hematological malignancies asset – global and China development moving now in parallel in multiple indolent NHL indications

					Est. Annual Incidence ('000) ^[1, 2, 3] Me					
					China	U.S.	EU5	Japan	Total	DOT ^[4]
		iNHL: Diffuse La Lymphon 2nd Line	rge B-cell na		11	9	8	4	32	TBD
	iNHL: M	antle Cell Lymphoma 3rd Line			3	3	3	1	10	TBD
iNHL: Margina Lymphon 3rd Line	al Zone na				5	4	4	2	15	TBD
iNHL: Follicular Lymphoma 3rd Line					11	9	9	4	33	TBD
					30	25	23	11	90	
[1] Globocan: [2] SFER: [3] Company estimates:		Registratior under	n Studies way	Reg	sistration s	studies in ng		Proof-of- u	concept s nderway	studies
[4] DOT = duration of treatment in latest study										

HMPL-523 market potential

[5] Immune Thrombocytopenic Purpura (prevalence of immune disorder)



Emerging immunology and hematological malignancies asset – first approval opportunity in ITP – global opportunity in BTKi refractory indolent NHL

				E	st. Annual	Incidence	e ('000) ^{[1, 2, 3}	3]	Median
				China	U.S.	EU5	Japan	Total	DOT ^[4]
	Indolent NHL	(MCL, MZL, CLL/SLL, WM) BTKi Refractory		1	13	10	5	30	TBD
ITP ^[5] Post steroids				91	22	21	8	142	TBD
				92	35	31	13	171	
 Globocan; [2] SEER; [3] Company esti DOT = duration of treatment in latest 	nates;		Re	egistration plann	studies in ing		Proof-c	of-concept underway	studies /

53



A2

HUTCHMED STRATEGY

World class discovery engine

Most prolific & validated in China biotech

Focus on Global Quality Innovation Proven & Validated at All Levels

> 15+ year track record in oncology, fully integrated 700+ person in-house scientific team

40+ oncology indications in development. 11 TKIs incl. VEGFR, c-MET, PI3Kδ, Syk, FGFR, IDH, ERK and 3G BTK

> 10+ combo therapy trials with chemo, TKI & IO drugs. Superior selectivity enables combos

2 further in-house late pre-clinical molecules





Fruquintinib 2013 China deal

HUTCHMED's Advanced Chemistry Approach Provides Superior Selectivity Profiles

WORLD-CLASS DISCOVERY & DEVELOPMENT CAPABILITY



Established global C&R infrastructure

Track record of breakthroughs





6 assets in global development



HIGHLY DIFFERENTIATED NME PORTFOLIO AND GLOBAL PIPELINE

Rapid expansion of our U.S./E.U. clinical & regulatory team

Program	Treatment	Tumor type	Setting	Study name	Sites	Dose finding / safety run-in	Proof-of-concept	Registration
	Savolitinib + TAGRISSO®	NSCLC	2L/3L EGFRm; Tagrisso® ref.; MET+	SAVANNAH	Global	Oxnard/Ahn – DF/SMC		
	Savolitinib + IMFINZI® (PD-L1)	Papillary RCC	MET+	SAMETA	Global	In planning		
Savolitinib	Savolitinib + IMFINZI® (PD-L1)	Papillary RCC *	All	CALYPSO	UK/Spain	Powles - Queen Mary's		
MET	Savolitinib + IMFINZI® (PD-L1)	Clear cell RCC *	VEGFR TKI refractory	CALYPSO	UK/Spain	Powles - Queen Mary's		
	Savolitinib	Gastric cancer *	MET+	VIKTORY	S Korea	Lee – Samsung Med. Ctr		
	Savolitinib	Colorectal cancer *	MET+		US	Strickler – Duke Uni		
	Council attach	NET	Deferente en		LIC.			
	Surutatinip	NET	Refractory		05	Dasari/Yao - MD Anderson		
Surufatinib	Surutatinip		Refractory		EU	Garcia-Carbonero – UCM		
VEGFR 1/2/3; FGFR1; CSF-1R	Surufatinib	Billary tract cancer			05			
		Soft tissue sarcoma			05	Patel/Tapp – MD And/ MSKCC		
	Suru. + tislelizumab (PD-1)	Solid tumors			US/EU			
	Fruquintinib	Colorectal cancer	Refractory	FRESCO-2	US/EU/JP	Eng/Desari - MD And. [1]		
Fruguintinib	Fruquintinib	Breast cancer			US	Tripathy – MD And.		
VEGFR 1/2/3	Fruq. + tislelizumab (PD-1)	TNBC & EMC			US			
	Fruq. + tislelizumab (PD-1)	Solid tumors			TBD	In planning - IND cleared		
Amdizalisih	Amdizalisih	Healthywaluptoors			Australia			
(HMPL-689)		Healthy volunteers			Australia			
ΡΙ3Κδ	Amdizalisib	Indolent NHL			US/EU	Zinzani – U of Bologna		
HMPL-523	HMPL-523	Indolent NHL			Australia			
Syk	HMPL-523	Indolent NHL			US/EU	Strati/Abrisqueta – MD And. / Vallo	l'Hebron	
HMPL-306	HMPL-306	Solid tumors			US/EU			
IDH 1/2	HMPL-306	Hem. malignancies			US/EU			
HMPL-760	HMPL-760	Hem. malignancies			US/EU	In planning - IND cleared		
BTK, 3G								

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

Note: MET = mesenchymal epithelial transition receptor; VEGFR = vascular endothelial growth factor receptor; EGFRm = epidermal growth factor receptor mutation; FGFR1 = fibroblast growth factor receptor 1; CSF-1R = colony stimulating factor-1 receptor; Syk = spleen tyrosine kinase; PI3Kδ = Phosphatidylinositol-3-Kinase delta; IDH = isocitrate dehydrogenase; EMC = endometrial cancer; NSCLC = non-small cell lung cancer; RCC = renal cell carcinoma; NET = neuroendocrine tumors; NHL = Non-Hodgkin's Lymphoma; TNBC = triple negative breast cancer.

9 assets in China development



HUTCHMED

HIGHLY DIFFERENTIATED NME PORTFOLIO AND GLOBAL PIPELINE

....8-10 registration studies planned to start in 2021 (excluding TAZVERIK[®])^L

Program	Treatment	Tumor type	Setting	Study name	Sites	Dose find / safety run-in	Proof-of-concept	Registration
Savolitinib MET	Savolitinib	NSCLC	MET Exon 14 skipping		China	Lu Shun – SH Chest Hosp.		
	Savolitinib + TAGRISSO®	NSCLC	2L EGFR TKI ref. NSCLC; MET+	SACHI	China	In planning		
	Savolitinib + TAGRISSO®	NSCLC	Naïve MET+ & EGFRm NSCLC	SANOVO	China	Yilong Wu – GD Pro. Ppl's Hosp.		
	Savolitinib	Gastric cancer	2L; MET+		China	Shen Lin - Beijing Cancer Hosp.		
Surufatinih	Surufatinib	Pancreatic NET	All	SANET-p	China	Xu Jianming - #5 Med. Ctr.		
	Surufatinib	Non-Pancreatic NET	All	SANET-ep	China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib	Biliary tract cancer	2L; chemotherapy refractory		China	Xu Jianming – #5 Med. Ctr.		
VEGFR 1/2/3;	Suru. + TUOYI® (PD-1)	NEN, ESCC, BTC			China	Shen Lin - Beijing Cancer Hosp.		
FGFR1; CSF-1R	Suru. + TUOYI® (PD-1)	SCLC, GC, Sarcoma			China	Shen Lin - Beijing Cancer Hosp.		
	Suru. + TUOYI® (PD-1)	TC, EMC, NSCLC			China	Shen Lin - Beijing Cancer Hosp.		
	Suru. + TYVYT® (PD-1)	Solid tumors			China			
	Fruquintinib	Colorectal cancer	≥3L; chemotherapy refractory	FRESCO	China	Li Jin – Fudan Univ.		
	Frug. + TAXOL®	Gastric cancer	2L	FRUTIGA	China	Xu Ruihua – Sun Yat Sen		
Fruguintinib	Frug. + TYVYT [®] (PD-1)	CRC, EMC, RCC, HCC			China	Guanghai Dai - PLA Gen. (CRC)		
VEGFR 1/2/3	Frug. + TYVYT [®] (PD-1)	GI tumors			China	Jin Li – SH East Hosp. (Others)		
	Fruq. + geptanolimab (PD-1)	CRC			China	Yuxian Bai - Harbin Med. Uni.		
	Fruq. + geptanolimab (PD-1)	NSCLC			China	Shun Lu – SH Chest Hosp.		
Amdizalisib	Amdizalisib	FL, MZL			China	Cao/Zhou – Fudan/ Tongji		
(HMPL-689)	Amdizalisib	MCL, DLBCL			China	Cao/Zhou – Fudan/ Tongji		
PISKO	Amdizalisib	CLL/SLL, HL			China	Cao/Zhou – Fudan/ Tongji		
HMPL-523 _{Syk}	HMPL-523	B-cell malignancies	All		China	Multiple leads by sub-types		
	HMPL-523	ITP	All		China	Yang - CN Hem. Hosp.		
HMPL-453 FGFR 1/2/3	HMPL-453	IHCC			China	Jianming Xu - BJ 307 Hosp.		
HMPL-306	HMPL-306 (IDH1/2)	Hem. malignancies			China			
		Calid turns are			China			
HMPL-295	HMPL-295 (ERK, MAPK pathway)	Solid tumors			China			
Epitinib	Epitinib (EGFR)	Glioblastoma	EGFR gene amplified		China	Ying Mao - SH Huashan		

Note: NSCLC = Non small cell lung cancer; NENs = Neuroendocrine neoplasms; ESCC = Esophageal squamous-cell carcinomas; BTC = Biliary tract cancer; SCLC = Small cell lung cancer; GC = Gastric cancer; TC = Thyroid cancer; EMC = Endometrial cancer; CRC = Colorectal cancer; RCC = Renal cell cancer; HCC = Hepatocellular carcinoma; GI = Gastrointestinal; FL = Follicular lymphoma; MZL = Marginal zone lymphoma; MCL = Mantle cell lymphoma; DLBCL = Diffuse large B cell lymphoma; CLL/SLL = Chronic lymphocytic leukemia/Small lymphocytic lymphoma; HL = Hodgkin's lymphoma; ITP = immune thrombocytopenic purpura; IHCC = Intrahepatic cholangiocarcinoma.

Seasoned executives – MNC veterans

London

Stock Exchange

Global standards – Reputation & transparency



AstraZeneca

xx/xx Years in industry/at HUTCHMED; Company logos denote prior experience.

15 years listed on AIM &

5 years on NASDAQ

32/21

27/3

May Wang

Business Dev. &

Lille

27/11

AGRCK

SEASONED MGMT TEAM & STRONG

GOVERNANCE





REALIZING GLOBAL POTENTIAL OF NOVEL ONCOLOGY ASSETS

Immunotherapy combinations



assets potentially ideal TKI combo partners for immunotherapy



	INLYTA®	LENVIMA®	Fruquintinib	Surufatinib
Selectivity	Relatively selective	Relatively selective	Highly selective	Selective angio- immuno kinase inhibitor
Status	Launched	Launched	Launched	Launched
VEGFR1 (nM)	3	22	33	2
VEGFR2 (nM)	7	4	25	24
VEGFR3 (nM)	1	5	0.5	1
Phos-KDR (nM)	0.2	0.8	0.6	2
Other kinases (IC50 < 100nM)	PDGFRα PDGFRβ c-Kit	PDGFRα PDGFRβ FGFR1-4 Ret c-Kit	none	CSF-1R FGFR1 FLT3 TrkB
First Patent Expiration	2025/04/29 (US6534524B1)	2021/10/19 (US7253286B2)	2029 (without extension)	2030 (without extension)

Fruq. uniquely selective – unlike other TKIs with off-target toxicity **Suru. inhibits TAM production** – amplifying PD-1 induced immune response

Jointly managed by HUTCHMED & partners



[1] Sources: (i) B. Rini et al for the for the KEYNOTE-426 Investigators, NEJM 2019 Feb 16. doi: 10.1056/NEJMoa1816714, Pembrolizumab plus Axitinib versus Sunitinib for Advanced Renal-Cell Carcinoma; (ii) D.F. McDermott et al, ASCO 2018 #4500, Pembrolizumab monotherapy as first-line therapy in advanced clear cell renal cell carcinoma (accRCC): Results from cohort A of KEYNOTE-427; * ORR =38.2% for all PD-L1 expression combined positive scores (CPS) – ORR=50.0% for CPS>1 pts, ORR=26.4% for CPS<1 pts.; [2] BTD = Breakthrough Therapy Designation.

Maximizing the value of our lead assets



3 marketed products, 1 NDA under review & 8-10 reg. studies in 2021

	Dose Finding / Safety Run-In	Proof-of-Concept	Registration Intent	NDA Filed / Marketed
		TAGRISSO ref. MET+ NSCLC TAGRISSO® combo (TATTON, multi-arm 2L TAGRISSO® or 1 st Gen EGFR refractory; & ≥3L TAGRISSO® refractory)	TAGRISSO [®] ref. MET+ NSCLC TAGRISSO [®] combo (SAVANNAH) 2L EGFR TKI ref. MET+ NSCLC	MET Exon 14 skipping NSCLC NDA Approved June 2021
Savolitinib			TAGRISSO [®] combo (SACHI) [1] Naïve MET+ & EGFRm NSCLC TAGRISSO [®] combo (SANOVO)	
C-MET INNIDITOR		PRCC/ccRCC ^[2] IMFINZI [®] combo (CALYPSO)	MET+ PRCC IMFINZI® combo (SAMETA) [1]	
		MET+ Colorectal cancer ^[2]	MET+ GC Ph.II Registration-intent	
Surufatinib	PD-1 Combo Tislelizumab – BeiGene	TUOYI[®] PD-1 combo (9 settings) (NENs, BTC, GC, Thyroid cancer,	TUOYI® PD-1 combo SURTORI-01 (NENS) (Additional indications) ^[1]	PNET & Non-PNET U.S. NDA accepted June 2021 F.U. MAA accepted & validated July 2021
(SULANDA® in China) VEGFR 1/2/3; FGFR1; &	PD-1 Combo TYVYT [•] – Innovent Biologics	EMC,ESCC & NSCLC)		PNFT & Non-PNFT
CSF-1R inhibitor		Soft Tissue Sarcoma & BTC		China NDA approved Jun 2021 /Dec 2020
	PD-1 Combo Tislelizumab – BeiGene ^[1]	TYVYT® PD-1 combo (5 settings) (CRC, Hepatocellular carcinoma, Endometrial cancer, RCC & GI tumors)	≥3L Colorectal cancer (FRESCO-2)	≥3L Colorectal cancer NDA Approved Sept 2018
Fruquintinib			(1-2 indications) ^[1]	
VEGFR 1/2/3 inhibitor		Genor PD-1 combo (2 settings) (CRC & NSCLC)	2L Gastric cancer TAXOL® combo (FRUTIGA)	
		TN & HR+/Her2- Breast cancer		
Amdizalisib PI3Kõ inhibitor		inhl (CBCL, CLL, FL, MCL, MZL, PTCL, WM/LPL)	6 iNHL settings (FL, MZL, MCL, DLBCL, CLL/SLL, HL)	iNHL – Ph.II Registration-intent (FL, MZL; other iNHL planned)
[1] In planning; [2] Investigator init Note: TKI = Tyrosine kinase inhibit carcinoma; NET = Neuroendocrine	iated trials (IITs). or, NDA = New drug application; NSCLC = Non-small cell e tumor; BTC = Biliary tract cancer; EMC = Endometrial ca	lung cancer; GC = Gastric cancer; RCC = Renal cell Incer; ESCC = Esophageal squamous cell carcinoma; SCLC	Global 😋 Chi	na IN TRANSITION

= Small cell lung cancer; CRC = Colorectal cancer; GI = Gastrointestinal; TN = Triple negative.

Deep NME early pipeline



Multiple further waves of innovation progressing



Note: iNHL = Indolent non-Hodgkin's lymphoma; CBCL = Cutaneous B-cell lymphoma; CLL/SLL = Chronic lymphocytic leukemia / Small lymphocytic lymphoma; FL = Follicular lymphoma; MCL = Mantle cell lymphoma; MZL = Marginal zone lymphoma; PTCL = Peripheral T-cell lymphoma; WM = Waldenström's macroglobulinemia; LPL = Lymphoplasmacytic lymphoma; DLBCL = Diffuse large B-cell lymphoma; ITP = Immune Thrombocytopenic Purpura; IHCC= Intrahepatic Cholangiocarcinoma; AML = Acute Myeloid Leukemia.



Early programs summary



HMPL-453 (FGFR1/2/3)	 Phase II in iHCC with FGFR2 fusion enrolling Early signs of clinical activity Combinations study IND filed mid-2021: 1L chemo & IO combos FPI in late 2021 or early 2022 	t filter onderse state of the s
HMPL-306 (IDH1/2)	 Potent IDH1/2 inhibitor with brain penetration Designed to overcome resistance due to isoform conversion in MDS/AML, and explore GBM Dose escalation in China and the U.S. ongoing, targeting completion in late 2021 or early 2022 	Classes Pyruns terrificat t
HMPL-295 (ERK)	 First candidate in MAPK pathway, more to come from HUTCHMED Dose escalation enrolling in China 	RAS NFT ARAF (BRAF) CRAF MEK12 ERK12 RSK123

New candidates' INDs submitted/planned for '21



HUTCHM

Discovery Project Overview









BUILDING A FULLY INTEGRATED ONCOLOGY BUSINESS IN CHINA & U.S.

China and U.S. are key oncology markets



CHINA

~25% of world cancer patients ^[1]

U.S.

~40% of global oncology medicine spending ^{[4] [5]}

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

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

HUTCHMED is a first mover

- ELUNATE® launch in 3L mCRC; First ever in China [3]
- Deep pipeline 11 clinical drug candidates with 3 NDAs submitted in China

Major commercial opportunity

• National Drug Reimbursement; Medical coverage

Innovation is being rewarded

- Oncology medicine spending grew to \$72 bn in 2020 from \$45 bn in 2016, driven primarily by proprietary brands
- Oncology medicine spending is expected to exceed \$110 bn by 2025, even after considering savings from biosimilar introduction
- Regulators continue to utilize programs for expedited development of medicines for serious conditions

Positioned to complement high usage of PD-1/L1 inhibitors

- HUTCHMED's portfolio of TKIs, designed for clinical differentiation, being studied in combination with PD-1/L1 inhibitors
- Global studies initiated or in planning for all 3 late-stage assets

HUTCHMED competence in China operations

HUTCHMED

A 17-year track record of 19% CAGR net income growth in our Other Ventures businesses



[1] 2003–2006 incl. disco. operation; [2] Based on aggregate Non-GAAP net income / (loss) of consolidated subsidiaries and non-consolidated joint ventures of Other Ventures, please see appendix "Non-GAAP Financial Measures and Reconciliation"; [3] Includes the land compensation in SHPL of \$40.4 million from net income attributable to HUTCHMED in 2016, SHPL's R&D related subsidies of \$2.5 million from net income attributable to HUTCHMED in 2017 and the land compensation in HBYS of \$28.8 million from net income attributable to HUTCHMED in 2020.

International development



Rapid expansion of our U.S./E.U. clinical & regulatory team, progressing a broad clinical portfolio of trials and regulatory engagements



Note: excludes savolitinib which is being developed globally by AstraZeneca

* subject to regulatory interaction; ** subject to supportive data.



A3a

SAVOLITINIB

A highly selective small molecule inhibitor of MET being developed broadly across MET-driven patient populations in lung cancer, gastric cancer and renal cell carcinoma

Savolitinib recap: MoA and data summary



Designed to avoid known renal toxicity while retaining potency

Quinolinone metabolite in 1st-gen MET compounds has low solubility in humans and when metabolized by the kidneys, appeared to crystallize, resulting in obstructive toxicity.



Evidence of clinical differentiation

- ~1,200 patients in clinical trials to date
- Competitive anti-tumor effect across multiple MET aberrations in multiple tumor types
- Single agent and combination settings
- First-in-class in China
- Currently testing in multiple tumor types:
 - NSCLC with MET Exon14 skipping
 - EGFRm + NSCLC
 - MET-driven PRCC
 - MET amplified GC
NSCLC by driver aberration



Biggest opportunity is MET+ (mutant / gene amplified) NSCLC



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

Savolitinib – MET Exon14 skipping alterations

NDA approved June 2021 in China

NSCLC with MET Exon14 skipping alterations

- 2-3% of NSCLC, up to 22% in PSC
- Most common in elderly patients
- No effective treatments with poor prognosis

MET Exon14 skipping alterations in other tumor types

- Secondary GBM
- GI tumors
- Histiocytic sarcoma

Phase II in NSCLC harboring MET Exon 14 skipping alterations (data by IRC)

HUTCHM



[1] Independent Review Committee assessed analysis. Investigator-assessed evaluable ORR=53.2%, DCR=91.9%.

Lu S, Fang J, Li X, et al. Once-daily savolitinib in Chinese patients with pulmonary sarcomatoid carcinomas and other non-small-cell lung cancers harbouring MET exon 14 skipping alterations: a multicentre, single-arm, open-label, phase 2 study. Lancet Respir Med. Published online June 21, 2021. https://doi.org/10.1016/S2213-2600(21)00084-9

Savolitinib – MET Exon 14 skipping NSCLC



China's lead selective MET inhibitor

Competitive landscape outside China:

	Treatment Line	MET aberration	N	BICR ^[1] ORR (%)	DCR (%)	mDoR (months)	mPFS (months)
Ca	pmatinib ^{[2][3]}						
	1L (cohort 5b)	Ex14 skipping	28	68 [48, 84]	96 [82, 100]	12.6 [5.6, NE]	12.4 [8.2, 23.4]
	2/3L (cohort 4)	Ex14 skipping	69	41 [29, 53]	78 [67, 87]	9.7 [5.6, 13.0]	5.4 [4.2, 7.0]
	2L (cohort 6, group 2)	Ex14 skipping	31	52 [33, 70]	90 [74, 98]	8.4 [4.2, NE]	6.9 [4.2, 13.3]
	1L (cohort 7)	Ex14 skipping	32	66 [47, 81]	100 [89, 100]	NE	10.8 [6.9, NE]
	1L (cohort 5a)	Amp (GCN≥10)	15 [4]	40 [16, 68]	67 [38, 88]	7.5 [2.6, 14.3]	4.2 [1.4, 6.9]
	2/3L (cohort 1a)	Amp (GCN ≥10)	69	29 [19, 41]	71 [59, 81]	8.3 [4.2, 15.4]	4.1 [2.9, 4.8]
Τe	potinib						
	44% 1L/ 56% ≥2L ^[5]	Ex14 skipping	99 [6]	46.5 [36.4,56.8]	65.7 [55.4, 74.9]	11.1 [7.2, NE]	8.5 [6.7, 11.0]
	1-3L ^[7]	Amp	24	41.7 [22.1-63.4]	45.9	NE [2.8, NE]	4.2 [1.4, NE]

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

[1] BICR = blinded independent central review; [2] Wolf et al. "Capmatinib in MET Exon 14-Mutated or MET-Amplified Non–Small-Cell Lung Cancer." N Engl J Med 2020; 383:944-957 DOI: 10.1056/NEJMoa2002787; [3] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr 9020); [4] closed early due to slow enrollment; [5] Paik et al. "Tepotinib in Non–Small-Cell Lung Cancer with MET Exon 14 Skipping Mutations." N Engl J Med 2020; 383:931-943 DOI: 10.1056/NEJMoa2004407; [6] patients followed for over 9 months; [7] ASCO 2021 J Clin Oncol 39, 2021 (suppl 15; abstr 9021).

TATTON B & D data – PFS



HUTCHMED

TAGRISSO[®] + savolitinib in EGFR TKI refractory NSCLC



	Median PFS, months [95% CI]	Median (range) duration of response, months
Part B1 Prior third-generation EGFR-TKI; (600 mg ^[1] ; n=69)	5.5 [4.1, 7.7]	9.5 [4.2, 14.7]
Part B2 No prior third-generation EGFR-TKI, T790M negative; (600 mg ^[1] ; n=51)	9.1 [5.5, 12.8]	10.7 [6.1, 14.8]
Part B3 No prior third-generation EGFR-TKI, T790M positive; (600 mg ^[1] ; n=18)	11.1 [4.1, 22.1]	11.0 [2.8, NR]

Data-cut off date: March 4, 2020

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





Data-cut off date: March 4, 2020

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

PFS= Progression Free Survival; EGFR = Epidermal Growth Factor Receptor; TKI = Tyrosine Kinase Inhibitor; [1] Most patients were enrolled to Part B1, B2, B3 on 600 mg savolitinib, prior to weight-based dosing implementation, but following a protocol amendment in response to a safety signal of hypersensitivity, the final 21 patients enrolled in Part B were dosed with savolitinib by body weight as follows: patients who weighed \leq 55 kg (n=8) received 300 mg daily and those weighing >55 kg (n=13) received 600 mg daily. Han JY, et al. Osimertinib + savolitinib in patients with EGFRm MET-amplified/overexpressed NSCLC: Phase Ib TATTON Parts B and D final analysis. WCLC January 2021 #FP14.03.





TATTON B & D data – AEs & tolerability

Event, n (%)	All Part B (n=138) osimertinib 80 mg + savolitinib 600 mg ^[1]	Part D (n=42) osimertinib 80 mg + savolitinib 300 mg ^[1]
Any AE	138 (100)	41 (98)
Any AE possibly related to savolitinib	124 (90)	32 (76)
AE grade ≥3	86 (62)	21 (50)
AE possibly causally related to study treatment leading to discontinuation of:		
Savolitinib	49 (36)	15 (36)
Osimertinib	24 (17)	8 (19)
Any AE leading to death	7 (5)	2 (5)
Any SAE	67 (49)	16 (38)

[1] Most patients were enrolled to Part B1, B2, B3 on 600 mg savolitinib, prior to weight-based dosing implementation, but following a protocol amendment in response to a safety signal of hypersensitivity, the final 21 patients enrolled in Part B were dosed with savolitinib by body weight as follows: patients who weighed <55 kg (n=8) received 300 mg daily and those weighing +55 kg (n=13) received 600 mg daily. Part D data are preliminary, therefore, for osimertinib, the mean actual treatment exposure was 8.5 months vs 6.1 months for Parts B and D, respectively, and 7.1 months vs 4.9 months for savolitinib, for Parts B and D, respectively; Han JY, et al. Osimertinib + savolitinib in patients with EGFRm MET-amplified/overexpressed NSCLC: Phase Ib TATTON Parts B and D, respectively.

TATTON B & D data – AEs & SAEs



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

	All Part B	(n=138)	Part D	(n=42)	$AE^{*} p(06)$	All Part B	s (n=138)	Part D	(n=42)
AE*, n (%)	All	Grade	All	Grade	AL , II (90)	All grades	Grade≥3	All grades	Grade≥3
	grades	≥3	grades	≥3	Rash	26 (19%)	3 (2%)	8 (19%)	0
Nausea	67 (49%)	4 (3%)	13 (31%)	0	Stomatitis	26 (19)	0	4 (10)	0
Fatigue	48 (35)	6 (4)	4 (10)	0	Constipation	26 (19)	0	3 (7)	0
Decreased appetite	47 (34)	5 (4)	6 (14)	1 (2)	Pruritus	24 (17)	1(1)	5 (12)	0
Vomiting	46 (33)	6 (4)	5 (12)	0	Headache	23 (17)	0	3 (7)	0
Oedema peripheral	44 (32)	3 (2)	8 (19)	0	Myalgia	22 (16)	3 (2)	6 (14)	1 (2)
Diarrhoea	39 (28)	4 (3)	8 (19)	2 (5)	Cough	22 (16)	0	4 (10)	1 (2)
Paronychia	30 (22)	3 (2)	7 (17)	0	AST increased	21 (15)	9 (7)	2 (5)	0
Pyrexia	29 (21)	1 (1)	6 (14)	0	Pneumonia	15 (11)	7 (5)	7 (17)	5 (12)

SAE**, n (%)	All Part B (n=138)	Part D (n=42)
Pneumonia	7 (5%)	4 (10%)
Anaphylactic reaction	6 (4)	1 (2)
Pneumothorax	6 (4)	1 (2)
Pyrexia [#]	5 (4)	0
Dyspnoea	5 (4)	0
Drug hypersensitivity	4 (3)	1 (2)
Diarrhoea	4 (3)	1 (2)
Back pain	4 (3)	0

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

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

Savolitinib – MET+ gastric cancer



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

1. Gastric (stomach) cancer is the 4th most common cancer globally – 768,000 deaths/year



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

3. VIKTORY: Highest response rate in savolitinib monotherapy arm^[2]



2. MET+ disease is more aggressive ^[1]







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



A3b

SURUFATINIB (SULANDA[®] IN CHINA)

A small molecule inhibitor of VEGFR, FGFR & CSF-1R designed to inhibit tumor angiogenesis and promote the body's immune response against tumor cells via tumor associated macrophage regulation

Surufatinib recap: Unique MOA differentiation HUTCHMED

Potentially enhance immune-mediated anti-tumor effect in addition to anti-angiogenesis

Inhibits VEGFR1/2/3 & FGFR1 – blocking vascular cell growth & angiogenesis

Inhibits CSF-1R – limits production of TAMs which cloak the cancer cell from T-cell attack

Synergistic effect with PD-1 inhibitors (AACR 2020, ASCO 2021)



81



Surufatinib

Overview of NET – 140,000~170,000 patients in the U.S. [1][2][3]

What are neuroendocrine tumors ("NET")?

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

Hormone-related symptoms ^[1]

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

Differentiation & biomarkers for grading:

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

NET growth – better diagnosis^[4]



NET epidemiology – highly fragmented^[4]



[1] Frost & Sullivan; [2] www.cancer.net (patient information from ASCO) – NET is a subtype of neuroendcrine neoplasms, NENs); [3] IQVIA 2019; [4] Dasari A, et al.: Trends in the Incidence, Prevalence, & Survival Outcomes in Patients With Neuroendocrine Tumors in the U.S.. JAMA Oncol. 2017;3(10):1335–1342.

High-level NET landscape



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



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

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

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

Octreotide Lanreotide ¹⁷⁷Lu-Dotatate Site est. % Streptozocin Sunitinib **Everolimus** Surufatinib LAR autogel Progressed in past Progressed in past Progressed in past **Disease status** Treatment naïve Stable disease Progressed in past 3 yrs. Historical 12 mo. 6 mo. 12 mo. CLARINET^[2] RADIANT-4^[3] Historical Ph. II Stomach 6% SANET-ep SSR over expression CLARINET^[2] RADIANT-4^[3] Small bowel / PROMID NETTER-1 SANET-ep 20% appendix **GI Tract** CLARINET^[2] RADIANT-4^[3] Historical Ph. II **Colon & Rectum** SANET-ep 20% SSR over expression CLARINET^[2] Historical Ph. II RADIANT-3^[3] PHASE III 6% SANET-p **Pancreas** Historical SSR over expression RADIANT-4^[3] SANET-ep 27% Lung SANET-ep Other ~10% Other RADIANT-4^[3] Unknown SANET-ep ~10% Primary

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



Global 😋 China

140,000~170,000 NET patients in U.S. [1][2]



U.S. NET treatment landscape – highly fragmented

		Somatostatin Based Therapi	es	Kinase Inhibitor Therapies				
	Sandostatin [®] LAR (octreotide)	Somatuline Depot [®] (lanreotide)	Lutathera [®] (¹⁷⁷ Lu-Dotatate)	Afinitor [®] (everolimus)	Sutent [®] (sunitinib)	Surufatinib (Approved in China)		
2020 Sales	\$1.4bn	\$1.5bn	\$0.4bn	\$1.1bn	\$0.8bn	-		
MOA ^[3]	Somatostatin analogue	Somatostatin analogue	Somatostatin receptor targeting radiotherapy	mTOR inhibition	Inhibits multiple receptor tyrosine kinases	VEGFR/FGFR1 & CSF-1R inhibition		
Admin.	Subcutaneous or intramuscular inj. (LAR)	Subcutaneous injection	Intravenous inj. (radio-qualified physicians).	Oral tablet	Oral capsules	Oral capsules		
Shelf-life	3 years	2 years	72 hours	3 years	3 years	2+ years ^[5]		
Dosage	2 wks: Sando. inj. 0.1-0.6mg per day; then 2 months Sando. LAR 20mg per 4 wks.	120mg inj. every 4 wks.	7.4GBq (one ~25ml vial) inj. every 8 wks – 4 doses total.	10mg orally once daily.	37.5mg taken orally once daily.	300mg orally once daily.		
NET indication /s	 LT treatment of severe diarrhea & flushing from meta. carcinoid tumors. 	 <u>GEP-NETs</u>: unresectable, well or moderately diff., (locally adv. or meta) GEP-NETs to improve PFS. <u>Carcinoid Syndrome</u>: to reduce frequency of short-acting somatostatin rescue therapy. 	Somatostatin receptor- positive GEP-NETs.	 <u>pNET</u>: progressive pNET (unresectable, locally adv. or meta). <u>GI-NET or Lung NET</u>: progressive, well-diff., <i>non-functional</i> NET (unresectable, locally adv. or meta). Not for <i>functional</i> carcinoid tumors.^[4] 	 <u>pNET</u>: Progressive, well- differentiated pNET (unresectable locally adv. or meta). 	 2 positive RCTs in <u>pNET</u> & <u>epNET</u> in China epNET NDA approved in China; pNET under review U.S. NDA filing started YE20. 		
Non-NET indication/s	Acromegaly; watery diarrhea from VIPomas.	Acromegaly.		 Adv. HR+ HER2-n breast cancer; adv. 2L RCC; renal angiomyolipoma and TSC. 	• 2L GIST; adv. RCC; high risk of recurrent RCC.			

	Sandostatin [®] / Placebo	Somatuline Depot [®] / Placebo	Lutathera® + Sando. LAR / Sando. LAR	Afini Plac	Afinitor°/ Sutent°/ Placebo Placebo		Surufatinib / Placebo	
mPFS (mo.)	143/60	NR / 18 0	NR / 8 5	pNET	Lung & GI NET	nNFT: 114/55	Ph III pNET	Ph III non-pNET
primary EP	14.37 0.0	1117/ 10.0	1417 0.5	11.0/4.6	11.0/3.9	phen: 11.47 3.5	10.9 / 3.7	9.2 / 3.8
HR	0.34	0.47	0.21	0.35	0.48	0.42	0.49	0.33
(<i>p-value</i>)	0.000072	<0.001	<0.0001	<0.001	<0.001	<0.001	0.0011	<0.0001
ORR	2%/2%	NR	18% / 3%	5%/2%	2%/1%	9% / 0%	19%/2%	10%/0%
DCR	69% / 40%	NR	95% / 76%	73%/51%	81%/64%	72% / 60%	81%/66%	87% / 66%
Pivotal	PROMID	CLARINET	NETTER-1	RADIANT-3	RADIANT-4	A6181111	SANET-p	SANET-ep

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

[1] Frost & Sullivan; [2] www.cancer.net (patient information from ASCO) – NET is a subtype of neuroendcrine neoplasms, NENs); [3] IQVIA 2019; [4] Dasari A, et al.: Trends in the Incidence, Prevalence, & Survival Outcomes in Patients With Neuroendocrine Tumors in the U.S.. JAMA Oncol. 2017;3(10):1335–1342.

Surufatinib: U.S. NET Market Landscape



A rare heterogeneous tumor that presents in the metastatic stage in 40-50% of patients

NETs are relatively rare and heterogeneous tumor type, comprising ~2% of all malignancies^{1,2}

U.S. 2021 estimates: ^{1,3}

- 140,000~170,000 living with NET
 - 17,000~20,000 diagnosed with Extra-pancreatic NET
 - 1,200~3,900 diagnosed with pancreatic NET
- ~30,000 patients under active treatment in the metastatic setting
- 40%–50% of overall NET patients present with distant metastases at initial diagnosis^{6,7}
 - Metastatic disease generally incurable and current treatments offer palliation only
- 5-year survival is 50~60% in Pancreatic NETs, 60~90% in GI-NETs and 60~90% in Lung NETs



TREATMENT LANDSCAPE

Palliative systemic therapy is mainstay for adv. disease

- Somatostatin analogs
- Targeted Agents
 - Sunitinib
 - Everolimus
- Cytotoxics:
- Peptide receptor radionuclide therapy

U.S. NET Phase Ib bridging study



Encouraging surufatinib efficacy in everolimus & sunitinib refractory/intolerant patients





Similar PK and Toxicity Profile between China & U.S. patients

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

Data cut-off as of April 21, 2020.

Surufatinib: Monotherapy efficacy across NETs HUTCHMED

- >950 patients in clinical trials to date
- Proven single-agent efficacy: SANET-ep & SANET-p Phase IIIs met endpoints at interim



[1] Xu J, Shen L, Zhou Z, et al. Surufatinib in advanced extrapancreatic neuroendocrine tumours (SANET-ep): a randomised, double-blind, placebo-controlled, phase 3 study. Lancet Oncol. 2020;21(11):1500-1512. doi:10.1016/S1470-2045(20)30496-4; [2] Xu J, Shen L, Bai C, et al. Surufatinib in advanced pancreatic neuroendocrine tumours (SANET-p): a randomised, double-blind, placebo-controlled, phase 3 study. Lancet Oncol. 2020;21(11):1489-1499. doi:10.1016/S1470-2045(20)30493-9; [3] P-value is obtained from the stratified one-sided log-rank test; Hazard ratio is obtained from stratified Cox model; Cl, confidence interval; HR, hazard ratio.

G1/2 Advanced extra-pancreatic NET



Investigator assessed median PFS



SANET-ep Primary (1°) endpoint was Investigator mPFS BIIRC ^[4] mPFS for supportive analysis not 1° or 2° endpoint

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

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

[1] Xu et al. "Surufatinib in advanced extrapancreatic neuroendocrine tumours (SANET-ep): a randomised, double-blind, placebo-controlled, phase 3 study." Lancet Oncol 2020. Published online September 20, 2020. https://doi.org/10.1016/S1470-2045(20)30496-4; [2] Yao et al. "Everolimus for the treatment of advanced, non-functional neuroendocrine tumors of the lung or gastrointestinal tract (RADIANT-4)" Lancet. 2016 Mar 5;387(10022):968-977. doi: 10.1016/S0140-6736(15)00817-X. Epub 2015 Dec 17; [3] P-value is obtained from the stratified one-sided log-rank test; Hazard ratio is obtained from stratified Cox model; CI, confidence interval; HR, hazard ratio; [4] BIIRC = Blinded Independent Image Review Committee (Central).

G1/2 Advanced pancreatic NET



Investigator assessed median PFS (primary endpoints)

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



Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ. [1] Xu et al. "Surufatinib in advanced pancreatic neuroendocrine tumours (SANET-p): a randomised, double-blind, placebocontrolled, phase 3 study." Lancet Oncol 2020. Published Online September 20, 2020 https://doi.org/10.1016/S1470-2045(20)30493-9; [2] Yao et al. Everolimus for advanced pancreatic neuroendocrine tumors" N Engl J Med. 2011;364(6):514–23 DOI: 10.1056/NEJMoa1009290; [3] Raymond et al. Sunitinib malate for the treatment of pancreatic neuroendocrine tumors [published correction appears in N Engl J Med. 2011 Mar 17;364(11):1082]. N Engl J Med. 2011;364(6):501-513 DOI: 10.1056/NEJMoa1003825; [4] P-value from SANET-p is obtained from the stratified one-sided log-rank test; Hazard ratio is obtained from stratified Cox model; CI, confidence interval; HR, hazard ratio.

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



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



Surufatinib vs. everolimus and sunitinib



Broader range of tumor origins & later-stage patients

		Asia/China Extra- Pancreatic NET	SANET-ep ^[1] (n=198) (surufatinib vs placebo)		U.S. Extra- Pancreatic NET	RADIANT-4 ^[2] (n=302) (everolimus vs placebo)	SANET-ep Enrolled more pts with poor prognosis.
		Tsai et al. 2013			Yao et al. 2008		Primary Site mOS Rate @ 5-yr
	Gastrointestinal Tract	58%	47%	Gastrointestinal Tract	50%	58%	Rectum 2.8y 28% Stomach 2.4y 2206
Non-Pancreatic	Rectum Stomach Small Intestine	30% 7% 19% 3%	27% 10% 8%	Rectum Stomach Small Intestine	33% 8% 6%	13% 4% 34% 7%	Small Intestine 8.6y 69%
	Lung	22%	12%	Lung	21%	30%	RADIANT-4
	Other Organ Site		28%	Thymus		1%	Did not enroll other extra-pancreatic
	Thymus Liver Mediastinum Adrenal Gland Other		7% 6% 6% 2% 8%				NET organ sites incl. but not limited to Throat Thyroid Kidney Ovary Mediastinum Adrenal gland
	Unknown Origin		14%	Unknown Origin		12%	Retroperitoneal Ampulla vater Broader pt.
	NON-PA	NCREAT	IC NET	PAN	CREATIC	NET	Parathyroid Carotid body coverage. gland Liver
		SANET-ep ^[1] (<i>n</i> =198)	RADIANT-4 ^[2] (<i>n=302</i>)	SANET-p ^[3] (<i>n</i> =172)	RADIANT-3 ^[4] (<i>n</i> =410)	A6181111 ^[5] (n=171)	
Pathology grade	Grade 1 Grade 2	16% 84%	65% 35%	12% 88%	83% 17%	n/a n/a	
ECOG PS 0:1	PS 0 (treatment : control) PS 1 (treatment :	60% (56% : 67%)	74% (73% : 75%)	67% (65% : 73%)	66% (67%: 66%)	55% (62% : 48%)	Surufatinib Later-stage patients, more heavily
	control)	40% (44% : 33%)	26% (27% : 26%)	33% (35% : 27%)	31% (30%:32%)	44% (38% : 51%)	pre-treated (incl. with targeted
	Any Prior Treatment	67%	61%	66%		69%	therapy) & weaker physical status.
Prior systemic	Chemotherapy Targeted therapy	40%	25%	26%	50%	66%	Likely due to later diagnosis in China &
treatment	Somatostatin Analogues	32%	55%	44%	50%	36%	availability of everolimus.
Number of	≤2	34%	n/a	49%	64%	64%	
organs involved	≥3 or unknown	66%	n/a	51%	36%	36%	

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

Source: Yao et al, Lancet 2016 387(10022) 968-77; Yao et al, JAMA Oncol 2017 3(10) 1335-42; Excludes 7% pancreatic NET in U.S. series and 6% in Asia series;

Colon-rectum in Tsai et al. (2013) report; Colon approximately 8% in Asian series (Shebani KO et al. (1999)); Colon-rectum in Yao et al. (2008) report; Colon approximately 4-7% in U.S./E.U. series (Niederle B et al. (2016)).

Surufatinib PD-1 combos global aspirations

Surufatinib + Tislelizumab (PD-1 mAb) first patient enrolled in March 2021



Rationale

HUTCHM

- Global aspirations
- Global PD-1 partner
- May lead to accelerated opp given high unmet need

Status

- Part 1 enrolling rapidly
- Multiple U.S. sites active
- E.U. site pending activation in Part 2



A3c

FRUQUINTINIB (ELUNATE[®] IN CHINA)

A highly selective small molecule inhibitor of VEGFR 1/2/3 designed to improve kinase selectivity to minimize off-target toxicity and thereby improve tolerability

Fruquintinib recap: Highly selective to VEGFR

Efficacy with limited off-target toxicity



• **Potent against VEGFR1,2,3**, resulting in consistent clinical benefit for patients who failed bevacizumab

HUTCHM

- **Highly selective** vs. other kinases with good safety profile with readily manageable AEs
- Combinable with chemo, targeted therapies and IO

3 rd -Line Metastatic Colorectal Cancer	FRESCO	Phase III
Treatment arms	ELUNATE ®	Placebo
≥G3 AE (Safety population)	61.1%	19.7%
VEGFR on-target related AEs ≥ G3:		
Hypertension	21.2%	2.2%
Hand-Foot Syndrome	10.8%	0.0%
Off-target (i.e. non-VEGFR) related AEs	≥ G3:	
Hypophosphatemia	0.0%	1.5%
Hypokalemia	0.7%	0.7%
Rash/desquamation	0.0%	0.0%
Lipase increase	0.0%	0.0%
Hepatic function (Liver function) AEs ≥	G3:	
ALT increased	0.7%	1.5%
AST increased	0.4%	0.7%
Blood bilirubin increased	1.4%	1.5%

Fruquintinib & surufatinib both unique VEGFR TKIs



...potentially ideal VEGFR combos for immunotherapy

TKI 1st Generation				2nc	l Generat	ion	Next Generation		
Selectivity		Multiple targets		Relatively selective			Highly selective	Selective angio-immuno kinase inhibitor	
Inhibitors	Sutent®	Nexavar®	Focus V®	Fotivda®	Lenvima®	Inlyta®	Fruquintinib	Surufatinib	
Status	Launched	Launched	Launched	Launched	Launched	Launched	Launched	Approved	
VEGFR1 (nM)	2	26	27	30	22	3	33	2	
VEGFR2 (nM)	9	90	0.2	6.5	4	7	25	24	
VEGFR3 (nM)	19	20	0.7	15	5	1	0.5	1	
Phos-KDR (nM)	10	30	0.1-1	0.16	0.8	0.2	0.6	2	
Other kinases (IC50 < 100nM)	PDGFRα PDGFRβ c-Kit Flt3 Ret CSF-1R	Raf-1 b-raf Flt3 P38 c-Kit Ret	PDGFRα PDGFRβ FGFR1-4 c-Kit	PDGFRα PDGFRβ EphB2 c-Kit Tie2	PDGFRα PDGFRβ FGFR1-4 Ret c-Kit	PDGFRα PDGFRβ c-Kit	none	CSF-1R FGFR1 FLT3 TrkB	
First Patent Expiration			Apr 2027 / Nov 2028 (with PTE)	2021/10/19 (US7253286B2)	2025/04/29 (US6534524B1)	2029 (without extension)	2030 (without extension)		

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

Efficacy advantage



Thind Line	FRESC	O ^[1]	CON	CUR	CON	CUR	cc	ORRECT	
Metastatic Colorectal cancer	Mainland China		Chinese Patients (Mainland China, Hong Kong, Taiwan) ^[2]		Mainland China, Hong Kong, Taiwan, Vietnam, South Korea			Global	
Treatment arms	ELUNATE ®	Placebo	STIVARGA®	Placebo	STIVARGA®	Placebo	STIVARO	GA® Placebo	
Patients (n)	278	138	112	60	136	68	505	255	
Objective Response Rate, n (%)	4.7%	0.0%	3.6%	0.0%	4.4%	0.0%	1.0%	0.4%	
Disease Control Rate, n (%)	62.2% +49	.9 12.3%	45.5% +38	8 6.7%	51.5% +4	4.1 7.4%	41.0%	+26.1 14.9%	
Median Progression-Free Survival (mPFS) (mo.)	3.7 +1.	<mark>9</mark> 1.8	2.0 +0.	3 1.7	3.2 +	1.5 1.7	1.9	+0.2 1.7	
						100	0% AVASTIN® priol	r use	
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	
Advantage for ELUNATE [®] efficacy vs. Stivarga [®] in Chinese metastatic CRC p	ots;						Hazard F (95% (Ratio p-value	
Advantage for FLUNATE® post	Overall						0.65 (0.51	, 0.83) <0.001	
VEGF/EGFR targeted therapy	with pri	or anti-VEGF	therapy			n 1	0.68 (0.45	, 1.03) 0.066	
• mOS: 7.69 mo. vs. 5.98 mo. placebo	without	t prior anti-V	EGF therapy				0.60 (0.45	,0.80) <0.001	
(HR 0.63 & p-value 0.012)	with pri	or anti-VEGF	or anti-EGFR th	erapy			0.63 (0.46	, 0.90) 0.012	
(HR 0.24 & p-value < 0.001)	without	t prior anti-V	EGF or anti-EGFF	R therapy			0.63 (0.43	, 0.86) 0.003	

Favors Fruquintinib Favors Placebo

1.0

1.5

2.0

0.5

F

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

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

Stivarga[®] tox limitations



	ELUNATE®	Stivarga® (regorafenib) tablets
BIOCHEMICAL ACTIVITY	IC ₅₀ (nmol/L)	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-RAF ^{V600E}	>10,000	19

Stivarga[®] liver toxicity black-box warning:

→ Increased liver function test monitoring (weekly if elevated) & remedial dose interruption.

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

WARNING: HEPATOTOXICITY

See full prescribing information for complete boxed warning.

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

	ELUNATE®		Stivarga [®] (regorafenib) tablets	
3 rd -Line Metastatic Colorectal cancer	FRESCO Study Mainland China ^[1]		CONCUR Study (Mainland China, HK, Taiwan) ^[2]	
Freatment arms	ELUNATE ®	Placebo	STIVARGA®	Placebo
Patients (n)	278	138	112	60
G3 AE (Safety population)	61.1%	19.7%	69.6%	46.7%
GAE (Safety population)	15.5%	5.8%	31.3%	26.7%
/EGFR 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%
ipase increase, ≥G3	0.0%	0.0%	6.3%	1.7%
Hepatic function (Liver function) AEs:				
ALT increased, ≥G3	0.7%	1.5%	7.1%	3.3%
AST increased, ≥G3	0.4%	0.7%	8.9%	0.0%
Blood bilirubin increased, ≥G3	1.4%	1.5%	8.9%	8.3%
Tolerability:				
AE Leading to dose interruption	35.3%	10.2%	68.8%	25.0%
AE Leading to dose reduction	24.1%	4.4%	23.2%	0.0%
AE Leading to treatment discontinuation	15.1%	5.8%	14.3%	6.7%

ELUNATE® superior safety – advantage especially for liver mets patients

Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.

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

NRDL

2020 accessible pricing



2020 estimated penetration:

- ~39,500 cycles used (OOP & PAP);
- Average 4.7 months per patient;
- ~8,400 patients paid for ELUNATE[®];
- Representing ~10% penetration.



National Reimbursement Drug List (NRDL)

Effective Jan 1, 2020: 8 newly listed oncology drugs, including ELUNATE[®] NRDL reimburses 50-70% of patient costs under urban scheme Without Medical With Medical Costs per cycle (all US\$)^[3] Insurance Insurance **ELUNATE**[®] Pre-NRDL (without PAP) 3,260 3,260 (fruquintinib) Post-NRDL 1,180 1,180 3L CRC Pts Out-of-~350 [5] ~1,180 Pocket Cost **STIVARGA®** 3L CRC Pts Out-of-~670 [5] ~2,220 (regorafenib) Pocket Cost

US data Supporting FRESCO-2 Initiation



AACR, ASCO & ESMO presentations demonstrate compelling preliminary monotherapy efficacy and safety in heavily pre-treated U.S. CRC patients

U.S. Ph. Ib: 81% stable disease in evaluable pts (ESMO'20)





~150 sites in 14 countries incl. U.S., Europe, Japan & Aus. ~690 pts full enrollment targeted to complete late 2021

• Interim futility analysis at 1/3 (160) OS events.

Primary Endpoint: OS in refractory mCRC pts Secondary Endpoints: PFS, ORR, DCR, DoR, QoL, others

Stratification factors:

- Prior TAS-102 vs. prior regorafenib vs. prior TAS-102 & regorafenib.
- RAS status (WT vs MT).
- Duration of metastatic disease (≤18 mths vs > 18 mths).

Data cut-off as of Aug 20, 2020.

[1] Dasari, et al. Phase 1/1b Trial of Fruquintinib in Patients with Advanced Solid Tumors: Preliminary Results of the Dose Expansion Cohort in Refractory mCRC. ESMO 2020 Abstract #2217; [2] Li J, Qin S, Xu R, et al. Effect of Fruquintinib vs Placebo on Overall Survival in Patients With Previously Treated Metastatic Colorectal Cancer: The FRESCO Randomized Clinical Trial. JAMA. 2018;319(24):2486–2496. doi:10.1001/jama.2018.7855.

Gastric combo with paclitaxel



Phase 2 results supports ongoing Phase III FRUTIGA

Dose proportional increase of fruquintinib AUC at steady state. 30%+ increase in paclitaxel exposure (mean AUC₀₋₈) after 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%.



Waterfall Plots of Best Response

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) Fruq. 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%)		

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

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%)

FRUTIGA – 2L gastric combo with paclitaxel



Ongoing - interim futility analysis Jun 2020 (~200 OS events)

Gastric (stomach) cancer is the 5th most common cancer globally –769,000 deaths/year



WHO, ACS, NCCR, Lancet, Frost & Sullivan Analysis.

Ph Ib ORR of 36% & DCR of 68% in evaluable pts. 4mg: ≥ 16 week PFS of 50% & ≥ 7 mo. OS of 50%.

Waterfall Plots of Best Response





Tumor response assessment every 4 weeks during first 3 cycles, every 8 weeks thereafter per RECIST v1.1

Primary endpoint: OS Secondary endpoints: PFS, ORR, DCR, DoR, QoL Enrollment targeted to complete around YE 2021

- *Stratified factors:
- GEJ vs GC;
- Peritoneal metastasis Y or N;
- ECOG PS 0 vs 1

FALUCA – Third-line NSCLC Monotherapy

HUTCHMED

Presented at WCLC 2019

FALUCA Phase III (enrolled Dec 2015 to Feb 2018)

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

Significant difference in subsequent anti-tumor treatments (ATT)

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

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

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

Good safety; most Grade ≥3 TEAEs targetrelated & clinically manageable.

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

PFS in ITT population



OS in pts w/o subsequent ATT



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





AMDIZALISIB (HMPL-689) & HMPL-523

Targeting B-cell signaling for hematological cancers and immunology



Amdizalisib (HMPL-689) recap: Highly selective PI3Kδ inhibitor

First in our next wave of innovation targeting B-cell signaling pathway



B-cell signaling is critical in hematological cancer

Designed to be a global best-in-class inhibitor of $\text{PI3K}\delta$

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

Enzyme IC₅₀ (nM)	Amdizalisib	ZYDELIG®	COPIKTRA®	ALIQOPA®
ΡΙ3Κδ	0.8	2	1	0.7
PI3Kγ (fold vs. PI3Kδ)	114 (142x)	104 (52x)	2 (2x)	6.4 (9x)
PI3Kα (fold vs. PI3Kδ)	>1,000 (>1,250x)	866 (433x)	143 (143x)	0.5 (1x)
ΡΙ3Κβ (fold vs. ΡΙ3Κδ)	87 (109x)	293 (147x)	8 (8x)	3.7 (5x)
PI3Kδ human <u>whole</u> <u>blood</u> CD63+	3	14	15	n/a

Amdizalisib: finding room for improvement



Safety profiles of current PI3K δ inhibitors are not good

PI3K δ inhibitors being developed in a broad range of indications.

Compound	Company	Indication	Status	Issue	
Zydelig [®] idelalisib – ΡΙ3Κδ	Gilead	Relapsed CLL/SLL, FL	Approved	BOXED WARNING : FATAL AND SERIOUS TOXICITIES: HEPATIC, SEVERE DIARRHEA, COLITIS, PNEUMONITIS, INFECTIONS, and INTESTINAL PERFORATION	
		Relapsed or refractory CLL/SLL	Approved	BOXED WARNING: FATAL AND SERIOUS TOXICITIES:	
Copiktra	Secura Bio/ CSPC	Relapsed or refractory FL	Approved ^[1]	INFECTIONS, DIARRHEA OR COLITIS, CUTANEOUS REACTION: and PNEUMONITIS	
duvelisib – PI3Ky/o		Peripheral T-cell lymphoma	Phase II enrolling	Need to spare PI3Ky	
Aliqopa [®] copanlisib – ΡΙ3Κα/δ	Bayer	Relapsed FL	Approved ^[1]	Gastrointestinal and liver AEs including hyperglycemia, diarrhea, hypertension, leukopenia, neutropenia, nausea and thrombocytopenia	
Ukoniq® TG Therapeutics Umbralisib - ΡΙ3Κδ		Previously treated MZL	Approved ^[1]		
	TG Therapeutics	Previously treated FL	Approved ^[1]	Gastrointestinal & liver AEs	
		Previously treated NHL, CLL	Phase IIb/III		
		FL, MZL, MCL	NDA filing H2-2021	Pending 12 months follow-up data from last responder [3]	
Parsaclisib Ρι3κδ	Incyte/ Innovent	Refractory myelofibrosis	Phase III	Phase 2 studies required prophylaxis for pneumocystis jirovecii	
		Autoimmune hemolytic anemia	Phase II	– prieumonia (PJP)	
Zandelisib	MEI/Kyowa	Relapsed or refractory FL	Phase II (for pot. AA)	Progressing with intermittent dosing to mitigate immune related	
ΡΙ3Κδ	Hakko Kirin	B-Cell Malignancies	Phase I/Ib	jirovecii pneumonia (PJP) [4]	

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

(1) Accelerated approval was granted based on ORR, continued approval may be contingent upon verification and description of clinical benefit in a confirmatory trials; [2] AbbVie ended collaboration with Infinity in June 2016 following Phase II results in indolent non-Hodgkin's lymphoma. Duvelisib licensed to Verastem in November 2016, who subsequently sold the asset to Secura Bio in September 2020; [3] company announcement Dec 7, 2020; [4] ASCO 2020 Abstract #8016.

Amdizalisib: Designed to be Differentiated

Intent to improve safety and tolerability

HMPL-689 – Advantages

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

Treatment-emergent AEs	Dose Esc. (N=56) [1]		Dose Exp. 30mg (N=90) [2]	
occurred in \ge 10% of patients	All grade	Grade ≥3	All grade	Grade ≥3
Neutropenia	43%	11%	29%	11%
ALT increased	27%	2%	27%	-
Leukopenia	29%	4%	21%	4%
AST increased	21%	2%	19%	-
Pneumonia	25%	16%	18%	13%
Rash	11%	5%	16%	6%
Hypertriglyceridemia	11%	2%	16%	1%
Blood lactate dehydrogenase increased	<5%	-	14%	-
Upper respiratory tract infection	14%	-	13%	-
Anemia	16%	-	12%	4%
Diarrhea	<5%	-	11%	2%
Lipase increased	20%	5%	10%	4%
Amylase increased	<10%	4%	10%	1%
Cough	18%	-	<10%	-
Blood bilirubin increased	16%	2%	<10%	-
Mouth ulceration	14%	-	<10%	-
Pyrexia	14%	-	<10%	1%
Bilirubin unconjugated increased	13%	2%	<10%	-
Asthenia	11%	-	<10%	-
Blood creatinine increased	11%	-	<10%	-
Constipation	11%	-	<10%	-
Hyperglycemia	11%	-	<10%	-
Thrombocytopenia	11%	-	<10%	2%
Hypertension	<10%	5%	<10%	-
Electrocardiogram QT prolonged	<10%	4%	<10%	1%
Hypokalemia	<10%	-	<10%	3%

HUTCH

Amdizalisib: U.S./E.U. Lymphoma Phase Ib

Intl to build on China data, and engage FDA in H2 2021

Next step: Complete dose escalation in Q3 2021

- Amdizalisib (HMPL-689) dose expansion to focus on FL and MZL
- End of Phase I meeting with U.S. FDA H2 2021 to confirm registration path





HUTCHM

HMPL-523: Immune thrombocytopenia (ITP)



- Moderate efficacy
- All patients become refractory

SYK is a validated target for ITP

- Fostamatinib approved in the U.S.
- Moderate efficacy, dose limited by tox
- Syk targets both B cells & macrophages

HMPL-523

- China Phase II complete –encouraging efficacy and good safety
- Phase III planned to initiate late 2021



HUTCH

Adapted from Newland A, et al. Immunotherapy (2018) 10(1), 9-25
HMPL-523 Global NHL Development Overview



International to build on China data, and explore additional subgroups

Next step: Complete dose escalation in Q3 2021

Lymphoma study:

- Establish RP2D for international development
- International expansion cohorts to start
- Explore options to **enrich for post-BTKi** patients in the expansion phase





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Secondary endpoints: ORR, PFS, PK, median time of treatment/response





NEXT WAVE OF INNOVATIONS

TAZVERIK® monotherapy efficacy





Follicular Lymphoma			Epithelioid Sarcoma	
	EZH2 Mutant N=42	EZH2 Wild-Type N=53		N=42
Overall Response Rate (95% CI)*	69% (53%, 82%)	34% (22%, 48%)	Overall Response Rate (95% CI)*	15% (7%, 26%)
Complete Response	12%	4%	Complete Response	1.6%
Partial Response	57%	30%	Partial Response	13%
Duration of Response (in	months)		Duration of Response	
Median (95% CI)	10.9 (7.2, NE)	13.0 (5.6, NE)	% with duration ≥ 6 months	67%
Range	0.0+, 22.1+	1, 22.5+	Range in months	3.7, 24.5+

Source: U.S. prescribing information.

CI = Confidence Interval; NE = Not Estimable.

lymphoma was 3.9 months (range 1.6 to 16.3).

was 3.7 months (range 1.6 to 10.9) and for patients with EZH2 WT follicular

*Median time to response for patients with EZH2 MT follicular lymphoma

CI = Confidence Interval

*Time to response ranged from 1.4 to 18.4 months.

Well tolerated safety profile

Minimal overlapping toxicity with other therapies





Patients with r/r/ Follicular Lymphoma (AEs \geq 10%)

N=99	All Grades	Grade 3 or 4		
General				
Fatigue ^a	36%	5%		
Pyrexia	10%	0%		
Infections				
Upper respiratory tract infection ^b	30%	0%		
Lower respiratory tract infection ^c	17%	0%		
Urinary tract infection ^d	11%	2%		
Gastrointestinal				
Nausea	24%	1%		
Abdominal pain ^e	20%	3%		
Diarrhea	18%	0%		
Vomiting	12%	1%		
Musculoskeletal and connective tissue				
Musculoskeletal pain ^f	22%	1%		
Skin and subcutaneous tissue				
Alopecia	17%	0%		
Rash ^g	15%	0%		
Respiratory and mediastinal system				
Cough ^h	17%	0%		
Nervous system				
Headache ⁱ	13%	0%		

a Incl. fatigue & asthenia. b Incl. laryngitis, nasopharyngitis, pharyngitis, rhinitis, sinusitis, upper respiratory tract infection, viral upper respiratory tract infection. c Incl. bronchitis, lower respiratory tract infection, tracheobronchitis. d Incl. cystitis, urinary tract infection, urinary tract infection staphylococcal . e Incl. abdominal discomfort, abdominal pain, abdominal pain lower, abdominal pain upper . f Incl. back pain, limb discomfort, musculoskeletal discomfort, musculoskeletal pain, myalgia, neck pain, non-cardiac chest pain, pain in extremity, pain in jaw, spinal pain. g Incl. erythema, rash, rash erythematous, rash generalized, rash maculo-papular, rash purutite, rash pustular, skin exfoliation. h Incl. cough and productive cough. i Incl. headache, migraine, sinus headache.

Patients with Epithelioid Sarcoma (AEs ≥10%)

N=62	All Grades	Grade 3 or 4		
General				
Pain ^a	52%	7%		
Fatigue ^b	47%	2%		
Gastrointestinal				
Nausea	36%	0%		
Vomiting	24%	0%		
Constipation	21%	0%		
Diarrhea	16%	0%		
Abdominal pain ^c	13%	2%		
Metabolism and nutrition				
Decreased appetite	26%	5%		
Respiratory, thoracic & mediastinal				
Cough	18%	0%		
Dyspnea ^d	16%	5%		
Vascular				
Hemorrhage ^e	18%	5%		
Nervous system				
Headache	18%	0%		
Investigations				
Weight decreased	16%	7%		

a Incl. tumor pain, pain in extremity, non-cardiac chest pain, flank pain, back pain, arthralgia, bone pain, cancer pain, musculoskeletal pain, myalgia, neck pain. b Incl. fatigue and asthenia. c Incl. abdominal pain, gastrointestinal pain, abdominal pain lower. d Incl. dyspnea and dyspnea exertional. e Incl. wound hemorrhage, rectal hemorrhage, pulmonary hemorrhage, hemorrhage intracranial, cerebral hemorrhage, hemoptysis. *Source: U.S. prescribing information.*

HMPL-453 – Phase II in China initiated



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

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



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

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

Potential best-in-class IDH1/2 inhibitor



Potent IDH1/2 inhibitor with brain penetration

HMPL-306 is a potent IDH1/2 dual inhibitor

- IDH1 & 2 mutations are **validated targets** in R&R AML (IDH1i ivosidenib and IDH2i enasidenib)
- HMPL-306 provides **comparable efficacy** in preclinical model with **wider safety window**
- The higher penetration of blood-brain barrier with HMPL-306 makes exploring IDHm glioma attractive.



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

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

MAPK pathway represents major unmet need



HMPL-295 – the first of several HUTCHMED assets targeting MAPK pathway



The MAPK (RAS-RAF-MEK-ERK) signaling cascade

- ERK (extracellular signal-regulated kinases) a key component
- *Pathway normal activation:* ligand-dependent & tightly regulated by NF-1 and negative feedback
- *In tumors:* activating mutations in RAS, RAF and loss of the tumor suppressor NF1 leads to uncontrolled cell proliferation

~50% of cancers associated with dysregulation in this pathway

- Increased mortality / poor OS
- Decreased the response to existing therapies including immunotherapy
- RAS: KRAS inhibitors in clinical trials
- BRAF/MEK: therapies approved induce initial rapid tumor regression, but acquire resistance developed due to MAPK pathway re-activation



HUTCHMED

INMAGENE Immunology partnership

Accelerating four HUTCHMED drug candidates

Overview

- 4 novel preclinical drug candidates discovered by HUTCHMED for the potential treatment of multiple immunological diseases
- Funded by Inmagene
- Companies working together to move candidates to IND
- Inmagene will pursue global clinical development

Terms

- HUTCHMED granted Inmagene four exclusive options (one per candidate) solely for the treatment of immunological diseases
- Option gives right to further develop, manufacture and commercialize that specific candidate worldwide
- HUTCHMED retains first right to co-commercialization in China
- Development milestones of up to US\$95 million
- Commercial milestones of up to US\$135 million
- Up to double-digit royalties





COMMERCIALIZATION

ELUNATE® coverage and key opportunities

Sales benefitting from deeper coverage...

Increased on-the-ground activities June 30, 2021 vs. Sept 30, 2020



... of approved indications

• CRC: 2nd highest cancer incidence in China, with up to 550,000 new patients in 2020¹

HUTCH

Fruquintinib Capsules

• 3L CRC patients increasing quickly

Clinical development programs in multiple new indications

- **Promising ELUNATE® PD-1 combo data** presented at ASCO 2021, may lead to initiation of additional registration studies
- ~20 investigator-initiated trials (IITs) ongoing exploring treatment of 2L CRC patients intolerant to chemotherapy
- Phase III in 2L gastric cancer (GC) ongoing

KOL Relationships



Good relationships with KOLs in major academic associations, covering solid & hematological cancers



Guidelines for the Diagnosis and Treatment of HUTCHMED Pancreatic Neuroendocrine Tumors in China (2020)



(三) 靶向治疗

pNET 的靶向治疗主要包括依维莫司(mTOR抑制剂)、舒尼替尼(酪氨酸激酶抑制剂)和 索凡替尼(酪氨酸激酶抑制剂)。依维莫司适用于中、低级别的进展期pNET患者,其在抑 制肿瘤生长、延长患者中位无进展生存期方面具有明确价值(1A, I级推荐)[142]。 但依维莫司联合 SSA 可能无法进一步改善患者的远期预后[143],且其在化疗、PRRT 等失败的患者中可能引起更高的严重不良反应发生率[144]。舒尼替尼通常适用于分化较 好的进展期pNET 患者,其能抑制肿瘤生长并延长患者的无进展生存期(1A, I级推荐) [145]。但对于亚洲人群,标准剂量(37.5 mg/d)的舒尼替尼常引起较严重的不良反 应,而适当降低药物剂量(25 mg/d)并不影响舒尼替尼的临床有效性[146]。索凡替 尼同样适用于分化较好的进展期 pNET,其能延长患者的无病生存期,有望成为进展期 pNET 患者新的治疗选择(1A, I级推荐)[147]。 **"Surufatinib** is also suitable for well-differentiated advanced pNET, which can prolong disease-free survival in patients with advanced pNET and is expected to be a new treatment option for patients with advanced pNET (**1A, grade I recommendation**)."

Relationships with Patient Advocacy Groups

>2,000 mCRC pts benefited from fruquintinib PAP program; surufatinib program recently initiated



Fruquintinib PAP program

✓ A successful program:

more than 2,000 mCRC patients benefited

- ✓ Close collaboration: with China Primary Health Care Foundation (Jan. 2019 - Aug. 2020)
- ✓ Donation management: incl. label, tax, free goods management, etc.

Surufatinib PAP program

HUTCH

- ✓ Recently initiated with commercial launch
- ✓ Significant benefit for China NET patients expected given long survival period

Academic Promotion



Diversified Academic Promotion platforms to deliver product value to stakeholders







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MANUFACTURING EXPERTISE

Manufacturing strategy



Some we control, some we outsource

	Small Molecule Manufacturing	Large Molecule Manufacturing		
	Global Manufacturing/ formulation (Suzhou / Shanghai)	Collaborate with CDMOs		
	 Formulation supported by HUTCHMED Suzhou (≤\$500m revenue) 	 2020-22: outsource mAb manufacturing to CDMOs. 		
Formulation	 Long-term formulation (\$0.5-\$2.5bn revenue) incl. China & global product supply → HUTCHMED Shanghai new factory Established <\$0.5bn capacity Suzhou 2018, now at steady 	 In parallel, establish own small scale lab mftg facilities to support discovery. 		
	state; ~\$2.0bn capacity new Shanghai factory by 2024	 Build scale-up mAb mftg facilities in Shanghai new factory as 		
	Global API Manufacturing	necessary.		
	• Continue to outsource API unless we determine IP risk.	Establish CDMO collaboration		
ΑΡΙ	Established Multiple 3 rd -party China-based API manufacturers have been established in past 10 years.	we will establish in-house mAb production.		

CMC Development & Manufacturing



Leadership



Zhenping Wu, SVP

- 13 years with HUTCHMED
- 30 years in pharma manufacturing including Roche and Pfizer



Process Research & Development

- 9 years with HUTCHMED
- 18 years in pharma manufacturing including Apotex and ChemPartner



Analytical Research & Development

- 8 years with HUTCHMED
- 25 years in pharma manufacturing including Merck and Sundia



- Drug Product Manufacturing & Supply Chain
- 11 years with HUTCHMED
- 20 years in pharma manufacturing including Bright Future and Frontage



- **Biologics CMC**
- 1 year with HUTCHMED
- 9 years in pharma manufacturing including Pfizer

- API process development
- Solid form selection
- Clinical material manufacturing
- Commercial API supplies

- Analytical method development
- API & drug product stability
- Commercial specification
- Regulatory CMC

- Formulation development
- Clinical supplies
- Commercial supplies
- Supply chain management

- Biological process development
- Biological formulation
- Biological method development
- Clinical supplies

Outsourcing API manufacturing

Advancing clinical pipeline and produce commercial supplies

• Work with leading CMOs in China for API manufacturing



- Established strong relationships with CMOs from clinical manufacturing through commercialization
- Plan to have two sites qualified for each product for commercial manufacturing to mitigate supply risks





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FURTHER CORPORATE INFORMATION

Group Structure

Main Entities / Offices

HUTCHMED

HUTCHMED Group Level (Nasdaq/AIM: HCM; HKEX:13)

Oncology/Immunology

Discovery, development, manufacturing & commercialization of novel oncology & immunology therapeutics

Shanghai Discovery	New Jersey	Suzhou	Beijing Regulatory	Hong Kong Commercial, Admin	
Development,	Regulatory Affairs,	Manufacturing	Guangzhou	Australia	
Manufacturing	Commercial		E.U. & U.K.	Others	

Other Ventures^[1]

Hutchison Sinopharm ("HSP") (HCM 51%) Rx Commercialization Partner: Sinopharm Group

Shanghai Hutchison Pharmaceuticals ("SHPL")

Rx Mfg & Commercialization Partner: Shanghai Pharma

(HCM: 50%)

 Not shown: Consumer Healthcare businesses, mainly (i) Hutchison Hain Organic JV, and (ii) Hutchison Baiyunshan OTC JV (divestment completed in September 2021).



Consolidated

Non-Consolidated

Our Other Ventures have substantial value



- HUTCHMED's Other Ventures continue to perform well relative to our peer group.
- Market value of our share of these JVs, based on China Pharma median PE multiples, approximately \$0.9 billion.^[1]
- Sep 2021: completed sale of smaller JV (OTC) for ~\$169m cash (~22x 2020 adjusted earnings to HUTCHMED of \$7.7m).^[2]

			NET SALES			NET IN		VALUATION ^[4]		
(US\$ millions)		2019	2020	19-20	2019	2020	19-20	2020	Market Can	D/F
	Code	Jan-Jun	Jan-Jun	Growth	Jan-Jun	Jan-Jun	Growth	Margin	Market cup.	• / -
HUTCHMED Other Ventures Subsidiaries/JVs ^[3]		367.1	365.2	-1%	57.0	62.4	9%	17%	n/a	n/a
Livzon Pharma	000513	705.6	727.9	3%	119.2	190.1	59%	26%	4,545	23
CR Double-Crane Pharma	600062	695.1	592.4	-15%	92.3	80.1	-13%	14%	1,726	12
Kunming Pharma	600422	536.6	489.2	-9%	34.4	32.4	-6%	7%	914	15
Zhejiang Pharma	600216	512.2	504.1	-2%	38.6	58.3	51%	12%	2,103	28
Tianjin Zhong Xin Pharma	600329	504.8	470.1	-7%	50.6	47.7	-6%	10%	1,624	21
Zhejiang Hua Hai Pharma	600521	379.0	472.2	25%	50.2	86.7	73%	18%	5,590	40
Shandong Xin Hua Pharma	000756	446.1	469.4	5%	23.4	26.9	15%	6%	666	17
Jiangsu Kang Yuan	600557	323.2	221.0	-32%	35.1	21.3	-39%	10%	855	19
Zhuzhou Qian Jin Pharma	600479	241.7	240.5	0%	14.8	13.6	-8%	6%	523	19
Jiu Zhi Tang	000989	241.2	261.9	9%	25.0	27.9	12%	11%	1,017	29
Peer Group Median (10 Comps. excl. HUTCHMED)		475.5	471.1	-1%	36.8	40.1	9%	9%	1,321	20

Peer Group: 10 companies (excl. HUTCHMED) selected are ALL listed and profitable mainland Chinese OTC/Rx pharma manufacturing companies, with a focus on similar product types, and 2020 Jan-Jun Net Sales in the ~\$200-750 million range.

Source: Company data, CICC.

[1] Peer group/China Pharma multiple of 20x 2020 actual Net income after tax of \$90.2m, excluding one-time land compensation; [2] HBYS' adjusted net profit attributable to HUTCHMED equity holders (after 20% non-controlling interest) in 2020 of \$7.7 million is a non-GAAP measure which is 40% of HBYS' 2020 net profit of \$91.3 million less \$72.0 million gain on land compensation, net of tax; [3] Total aggregate PRC domestic results of HUTCHMED's 6 Other Ventures companies (HBYS, SHPL, Hutchison Sinopharm, HHO, HHL & HCPL); [4] Market Capitalization and Price Earnings Ratios as at February 19, 2021: Trailing Twelve Month PE weighted averaged based on market capitalization.

Non-GAAP Financial Measures & Reconciliation HUTCHMED

Other Ventures - Reconciliation of Non-GAAP Sales and Non-GAAP Net (Loss)/Income After Tax^[1]

- Consolidated Subsidiaries: includes Hutchison Sinopharm and others
- Non-consolidated joint venture: includes SHPL and HBYS

					IFF	RS									US G	AAP					H1'20- H1'21
(US\$ millions)	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	H1'20	H1'21	Growth
Revenues (Non-GAAP)	21.9	27.9	65.1	101.4	119.0	155.8	197.0	236.4	278.6	360.7	402.3	465.4	518.9	627.4	677.2	664.4	665.6	706.6	365.2	448.6	23%
Consolidated subsidiaries	4.7	6.1	9.3	8.9	3.7	5.5	7.0	14.1	14.9	15.5	16.5	67.0	126.2	180.9	205.2	172.9	178.1	197.8	90.4	114.5	27%
Non-consolidated joint venture	17.2	21.8	55.8	92.5	115.3	150.3	190.0	222.3	263.7	345.2	385.8	398.4	392.7	446.5	472.0	491.5	487.5	508.8	274.8	334.1	22%
Total Revenues Growth	n/a	27%	133%	56 %	17%	31 %	26 %	20 %	18 %	29 %	n/a	16 %	11%	21%	8 %	-2%	0 %	6 %		23%	
- GuanBao divested in Sept'2017	-	-	-	-	-	-	-	-	(11.4)	(50.5)	(51.6)	(49.7)	(40.7)	(45.0)	(38.6)	-	-	-	-	-	n/a
Adjusted Non-consolidated joint venture	17.2	21.8	55.8	92.5	115.3	150.3	190.0	222.3	252.3	294.7	334.2	348.7	352.0	401.5	433.4	491.5	487.5	508.8	274.8	334.1	22%
Adjusted Revenues (Non-GAAP)	21.9	27.9	65.1	101.4	119.0	155.8	197.0	236.4	267.2	310.2	350.7	415.7	478.2	582.4	638.6	664.4	665.6	706.6	365.2	448.6	23 %
Total Adjusted Revenues Growth	n/a	27%	133%	56 %	17%	31 %	26 %	20 %	13%	16 %	13%	19 %	15%	22%	10 %	4%	0 %	6 %		23%	
Net (loss)/Income after tax (Non-GAAP)	(10.7)	(3.6)	2.2	6.7	11.2	14.7	21.5	27.9	30.1	33.1	39.7	48.8	54.1	63.3 [[]	^{3]} 77.3 [[]	^{4]} 83.6	84.9	90.2 [[]	^{5]} 62.4	73.3	^[6] 17%
Consolidated subsidiaries	(10.3)	(4.9)	(2.9)	(2.4)	0.2	-	0.8	1.0	(0.4)	(1.1)	0.1	1.6	1.4	3.1	5.9	6.9	3.8	3.9	1.8	1.5	-20%
Non-consolidated joint venture	(0.4)	1.3	5.1	9.1	11.0	14.7	20.7	26.9	30.5	34.2	39.6	47.2	52.7	60.2	71.4	76.7	81.1	86.3	60.6	71.8	18%
Net (loss)/income attrib. to HUTCHMED	(5.7)	(3.7)	(0.5)	1.2	4.5 [[]	^[2] 5.9 [[]	^{2]} 9.3 [[]	^{2]} 12.6	^[2] 13.6	^[2] 14.6	^[2] 18.2 [[]	^{2]} 22.8 [[]	^{2]} 25.2 [[]	^{2]} 29.9 [[]	^{3]} 37.5 [[]	^[4] 41.4	41.5	44.0	^[5] 30.4	35.7	^[6] 17%
Consolidated subsidiaries	(5.5)	(4.3)	(2.7)	(2.4)	0.2	0.0	0.8	1.0	0.0	(0.7)	0.2	1.3	1.0	1.8	3.9	4.8	2.9	2.8	1.4	1.2	-15%
Non-consolidated joint venture	(0.2)	0.6	2.2	3.6	4.3	5.9	8.5	11.6	13.6	15.3	18.0	21.5	24.2	28.1	33.6	36.6	38.6	41.2	29.0	34.5	19%
Net (loss)/income attrib. to HUTCHMED growth	n/a	-35%	-86%	340%	275%	31%	58%	35%	8%	7%	n/a	26%	10%	19%	25%	10%	0%	6%		17%	

[1] 2003–2006 incl. disco. operation; [2] Continuing Operations; [3] Excludes the land compensation in SHPL of \$80.8 million from net income after tax and \$40.4 million from net income attributable to HUTCHMED for 2016;

[4] Excludes SHPL's R&D related subsidies of \$5.0 million from net income after tax and \$2.5 million from net income attributable to HUTCHMED for 2017;

[5] Excluded the land compensation in HBYS of \$72.0 million from net income after tax and \$28.8 million from net income attributable to HUTCHMED for 2020.

[6] Excluded the land compensation in HBYS of \$14.1 million from net income after tax and \$5.6 million from net income attributable to HUTCHMED for H1 2021.



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

		U	nit Pricing (L	JS\$) ^[3]		Approximate Mon	thly Pricing	g (US\$) ^[3]	
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	Indication coverage
Herceptin® (trastuzumab)	Roche	440mg:20ml	\$3,298.81	\$1,125.93	-66%	Breast: 4mg/kg wk 1, 2mg/kg weekly	\$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)	1&1	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/m ² 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)	1&1	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.



Oct'18 – 17 new drugs in oncology added to NRDL

			Unit Prici	ng (US\$) ^[2]		Approximate Monthly P			
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage ^[1]	Avg. Tender	Reimbursed	Indication coverage
Focus V [®] (anlotinib)	Sino Biopharm	12mg	\$127	\$70	-45%	12mg QD (2 wks-on/1-wk-off)	\$2,500	\$1,417	3L NSCLC
Oncaspar [®] (pegaspargase)	Hengrui	5ml: 3750 IU	\$560	\$429	-23%	≤2ml every 14 days	\$1,231	\$943	1L ALL
Vidaza® (azacitidine)	Celgene	100mg	\$378	\$152	-60%	1 st cycle: 75mg QD for 7 days; 4wk cycle. After 2 cycles increase dose to 100mg, min of 4-6 cycles	\$14,022	\$5,636	Refractory anemia (RA) or RA with ringed sideroblasts (RARS), RA with excess blasts (RAEB / RAEB-T), and chronic myelomonocytic leukemia (CMMoL)
Inlyta® (axitinib)	Pfizer	5mg	\$99	\$30	-70%	5mg BID	\$5,957	\$1,787	2L advanced renal cell carcinoma
Tagrisso [®] (osimertinib)	AstraZeneca	80mg	\$253	\$73	-71%	80mg QD	\$7,597	\$2,201	EGFR TKI refractory T790M+ NSCLC
Ninlaro® (ixazomib)	Takeda	4mg	\$3,234	\$710	-78%	4mg on Days 1, 8, 15 (28 day cycle)	\$12,934	\$2,839	2L multiple myeloma
Xalkori® (crizotinib)	Pfizer	250mg	\$123	\$37	-70%	250mg BID	\$7,407	\$2,245	Locally adv. or meta. ALK+ or ROS1+ NSCLC
Gilotrif® (afatinib)	Boehringer	40mg	\$116	\$29	-75%	40mg QD	\$3,483	\$863	NSCLC with EGFR
Tasigna® (nilotinib)	Novartis	200mg	\$39	\$14	-65%	400mg BID	\$4,645	\$1,635	CML
Votrient [®] (pazopanib)	Novartis	200mg	\$66	\$23	-65%	800mg QD	\$7,891	\$2,348	RCC
Sutent® (sunitinib)	Pfizer	12.5mg	\$49	\$22	-55%	GIST & RCC: 50mg QD pNET: 37.5mg QD	\$5,544 \$4,455	\$2,498 \$2,007	RCC, GIST, pNET
Stivarga® (regorafenib)	Bayer	40mg	\$52	\$28	-46%	160mg QD, 3-wks-on/1-wk-off *	\$4,368	\$2,352	Meta. CRC, GIST, HCC
Zykadia® (ceritinib)	Novartis	150mg	\$108	\$28	-74%	450mg QD	\$9,699	\$2,564	ALK+ adv. or meta. NSCLC
Zelboraf® (vemurafenib)	Roche	240mg	\$30	\$16	-47%	960mg BID	\$7,252	\$2,369	Melanoma
Erbitux [®] (cetuximab)	Merck	100mg	\$571	\$186	-67%	400mg/m2 initial dose, 250mg weekly	\$10,446	\$3,074	Colorectal cancer, head and neck cancer
Sandostatin LAR® (octreotide)	Novartis	20mg	\$1,169	\$835	-29%	20mg Q4W	\$1,169	\$835	GEP-NENs
Imbruvica® (ibrutinib)	JNJ	140mg	\$78	\$27	-65%	MCL: 560mg QD CLL & WM: 420mg QD	\$9,324 \$6,993	\$3,263 \$2,447	MCL, CLL/SLL

Source: Ministry of Human Resources and Social Security (MOHRSS); Yaozhi; China Merchants Securities Research; Citi Global Research; Frost & Sullivan. [1] Reference SKU or reference recommended dosage for monthly pricing calculation; [2] Calculation assumes an exchange rate of CN¥6.95 per US\$1. * Price amended to account for 3-weeks on, 1 week off regimen.



Nov'19 update – 8 new drugs in oncology^[1]

			Unit Pricir	ng (US\$) ^[2]		Approximate Monthl	y Pricing (U	S\$) ^[2]	
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	Indication coverage
Elunate® (fruquintinib)	HUTCHMED	5mg	\$161	\$58	-64%	5mg QD 3wks/1wk-off.	\$3,378	\$1,221	Metastatic colorectal cancer, 3L
Tyvyt® (sintilimab)	Innovent	10ml (100mg)	\$1,206	\$437	-64%	200mg Q3W	\$3,216	\$1,166	Classical Hodgkin's lymphoma, 3L
Saiweijian® (raltitrexed)	Sino Biopharm	2mg	\$232	\$103	-56%	3mg/m ² Q3W	\$765	\$340	Colorectal cancer, 5-FU intolerable
Alecensa® (alectinib)	Roche	150mg	\$32	\$10	-70%	600mg, BID	\$7,689	\$2,343	NSCLC, ALK+
Lynparza® (olaparib)	AstraZeneca	150mg	\$68	\$26	-62%	300mg, BID	\$8,173	\$3,120	Epithelial ovarian, fallopian tube, or peritoneal cancer
Airuini® (pyrotinib)	Hengrui	80mg	\$39	\$13	-66%	400mg QD, 21 days	\$4,118	\$1,389	Breast cancer, HER2+, 2L
Perjeta® (pertuzumab)	Roche	420mg	\$2,892	\$762	-74%	840mg wk1, 420mg Q3W	\$8,676	\$2,286	Breast cancer, HER2+, neoadjuvant
Jakafi® (ruxolitinib)	lncyte / Novartis	5mg	\$20	\$9	-56%	Dose is based on patient's baseline platelet count: • (a) >200 X 10^9 /L: 20 mg BID • (b) 100 X 10^9 /L: 200 X 10^9 /L: 15 mg BID • (c) 50 X 10^9 /L to 100 X 10^9 /L: 5 mg given BID	(a) \$4,800 (b) \$3,600 (c) \$1,200	(a) \$2,160 (b) \$1,620 (c) \$540	PMF, PPV-MF, PET-MF

Source: National Healthcare Security Administration (NHSA); Frost & Sullivan.

[1] Excluding botanical oncology drugs; [2] Calculation assumes an exchange rate of CN¥6.5 per US\$1.



Nov'19 update – 9 renewed drugs in oncology^[1]

		Unit Pricing (US\$) ^[2]				Approximate Monthly	y Pricing (US	\$) [2]	_
Brand (generic)	Company	Dosage	'17 NRDL	'19 NRDL	Δ%	Dosage	'17 NRDL	'19 NRDL	Indication coverage
AiTan® (apatinib)	Hengrui	425mg ^[3]	\$30	\$27	-13%	850mg QD	\$1,823	\$1,594	3L gastric adenocarcinoma or GEJ with adenocarcinoma.
EnDu® (rh-endostatin)	Simcere	15mg	\$97	\$75	-22%	7.5mg/m ² iv QD, 2wks/1wk-off	\$1,681	\$1,308	Late-stage NSCLC.
Epidaza® (chidamide)	Chipscreen	5mg	\$53	\$59	-11%	30mg QD, 2x per wk	\$2,843	\$2,533	2L+ Recurring or refractory peripheral T-cell lymph. (PTCL).
Herceptin® (trastuzumab)	Roche	440mg	\$1,169	\$846	-28%	3wks regimen: 8mg/kg wk1, 6mg/kg Q3W	\$1,276	\$923	Breast: Her2+; Her2+ meta. Her2+ late-stage meta. gastric.
Avastin® (bevacizumab)	Roche	100mg	\$307	\$231	-25%	3wks regimen: CRC: 7.5mg/kg Q3W NSCLC: 15mg/kg Q3W	CRC: \$1,844 NSCLC: \$3,689	CRC: \$1,385 NSCLC: \$2,769	Late-stage meta. CRC or advanced non-squamous NSCLC.
TheraCIM ^{® [4]} (nimotuzumab)	Biotech	50mg	\$262	\$221	-16%	100mg, QW	\$2,092	\$1,766	Combo with RT for EGFR+ III/IV nasopharyngeal carcinoma.
Tarceva® (erlotinib)	Roche	150mg	\$28	\$12	-56%	150mg, QD	\$841	\$374	Advanced NSCLC with limited EGFR gene mutation.
Nexavar® (sorafenib)	Bayer	200g	\$29	\$14	-53%	400g BID	\$3,519	\$1,662	RCC or HCC. meta. diff. thyroid after radio-iodine therapy.
Afinitor® (everolimus)	Novartis	5mg	\$23	\$20	-12%	RCC: 10mg, QD Pan-NETs: 10mg, QD	\$1,366	\$1,200	RCC after sunitinib or sorafenib. Pancreatic NETs. TSRA.

Source: National Healthcare Security Administration (NHSA); Frost & Sullivan.

[1] Excluding botanical oncology drugs; [2] Calculation assumes an exchange rate of CN¥6.5 per US\$1; [3] Reference SKU or reference recommended dosage for monthly pricing calculation; [4] Marketed as Tai Xin Sheng® in China.



Dec'20 update – 13 new oncology drugs through negotiation^[1]

			Unit Pricin	ng (US\$) ^[2]		Approximate Monthly Pricing (US\$) ^[2]			
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	Indication coverage
Lipusu® (paclitaxel liposome)	Luye Pharma	30mg	\$129	\$35	-73%	155mg/m ² Q3W	\$1,470	\$399	1L+ metastatic ovarian cancer, breast cancer, 1L NSCLC
Ciptertin® (inetetamab)	3SBio	50mg	\$235	\$91	-61%	initial 4mg/kg, maintenance 2mg/kg	\$2,260	\$871	HER2+ metastatic breast cancer
Baizean® (tislelizumab)	BeiGene	100mg	\$1,644	\$335	-80%	200mg Q3W	\$4,385	\$894	3L relapsed or refractory classical Hodgkin's lymphoma, locally adv. or meta. urothelial cancer
Tuoyi® (toripalimab)	Junshi Biosciences	240mg	\$1,108	\$323	-71%	3mg/kg Q2W	\$1,662	\$485	Non-excisional or metastatic melanoma
AiRuiKa® (camrelizumab)	Hengrui	200mg	\$3,046	\$450	-85%	cHL&EC: 200mg Q2W NSCLC: 200mg Q3W HCC: 33mg/kg Q3W	\$6,092 \$4,062 \$40,209	\$901 \$601 \$5,946	3L relapsed or refractory classical Hodgkin's lymphoma, advanced HCC, 1L locally adv. or meta. non-squamous NSCLC, esophageal cancer
Xinfu® (flumatinib)	Hansoh Pharma	200g	\$27	\$10	-63%	600mg QD	\$2,430	\$900	Ph+ chronic myelogenous leukemia
Ameile® (almonertinib)	Hansoh Pharma	55mg	\$75	\$27	-64%	110mg QD	\$4,523	\$1,625	EGFR TKI refractory T790M+ locally advanced or metastatic NSCLC
Brukinsa® (zanubrutinib)	BeiGene	80mg	\$27	\$15	-44%	320mg QD	\$3,260	\$1,828	2L MCL, 2L CLL / SLL
Mekinist® (trametinib)	Novartis	2mg	\$142	\$57	-60%	2mg QD	\$4,254	\$1,705	BRAF V600M+ non-excisional or metastatic melanoma
Tafinlar® (dabrafenib)	Novartis	75mg	\$53	\$14	-74%	150mg BID	\$6,380	\$1,705	BRAF V600M+ non-excisional or metastatic melanoma
Lenvima® (lenvatinib)	Eisai	4mg	\$86	\$17	-81%	12mg QD	\$7,754	\$1,495	HCC
Xtandi® (enzalutamide)	Astellas Pharma	40mg	\$49	\$11	-78%	160mg QD	\$5,880	\$1,285	Castration-resistant prostate cancer (CRPC)
Zejula® (niraparib)	Zai Lab	100mg	\$128	\$31	-76%	300mg QD	\$11,534	\$2,769	Relapsed epithelial ovarian, fallopian tube or primary peritoneal carcinoma

Source: National Healthcare Security Administration (NHSA); Frost & Sullivan.

[1] Excluding traditional Chinese medicines; [2] Calculation assumes an exchange rate of CN¥6.5 per US\$1.



Dec'20 update – 15 renewed drugs in oncology^[1]

		Unit Pricing (US\$) [2]				Approximate Monthly	Pricing (US		
Brand (generic)	Company	Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	Indication coverage
Focus V [®] (anlotinib)	Sino Biopharm	12mg	\$75	\$47	-37%	12mg QD (2 wks-on/1-wk-off)	\$1,515	\$952	3L NSCLC, 3L SCLC, STS
Oncaspar [®] (pegaspargase)	Hengrui	5ml: 3750 IU	\$584	\$458	-21%	≤2ml every 14 days	\$1,283	\$1,006	1L ALL
Inlyta® (axitinib)	Pfizer	5mg	\$32	Undisclosed	-	5mg BID	\$1,920	-	2L advanced renal cell carcinoma
Tagrisso® (osimertinib)	AstraZeneca	80mg	\$78	\$28	-64%	80mg QD	\$2,350	\$860	1L NSCLC harboring EGFR exon 19 deletions or exon 21 L858R mutations; EGFR TKI refractory T790M+ NSCLC
Ninlaro® (ixazomib)	Takeda	4mg	\$759	Undisclosed	-	4mg on Days 1, 8, 15 (28 day cycle)	\$2,277	-	2L multiple myeloma
Xalkori® (crizotinib)	Pfizer	250mg	\$40	\$35	-12%	250mg BID	\$2,400	\$2,112	Locally adv. or meta. ALK+ or ROS1+ NSCLC
Tasigna® (nilotinib)	Novartis	200mg	\$15	Undisclosed	-	400mg BID	\$1,800	-	CML
Votrient® (pazopanib)	Novartis	200mg	\$25	Undisclosed	-	800mg QD	\$2,510	-	RCC
Stivarga® (regorafenib)	Bayer	40mg	\$30	\$26	-12%	160mg QD, 3-wks-on/1-wk-off	\$2,520	\$2,217	Meta. CRC, GIST, HCC
Zykadia® (certinib)	Novartis	150mg	\$30	Undisclosed	-	450mg QD	\$2,700	-	ALK+ adv. or meta. NSCLC
Zelboraf® (vemurafenib)	Roche	240mg	\$17	Undisclosed	-	960mg BID	\$4,080	-	BRAF V600 Melanoma
Erbitux® (cetuximab)	Merck	100mg	\$199	Undisclosed	-	400mg/m ^² initial dose, 250mg QW	\$1,990	-	Colorectal cancer, head and neck cancer
Sandostatin LAR® (octreotide)	Novartis	20mg	\$892	Undisclosed	-	20mg Q4W	\$892	-	GEP-NENs
Imbruvica® (ibrutinib)	LNJ	140mg	\$29	Undisclosed	-	MCL: 560mg QD CLL & WM: 420mg QD	MCL: \$3,489 CLL&SLL: \$2,617	-	MCL, CLL/SLL, WM
Lynparza® (olaparib)	AstraZeneca	150mg	\$26	Undisclosed	-	300mg, BID	\$1,560	-	BRCAm epithelial ovarian, fallopian tube, or peritoneal cancer

Source: National Healthcare Security Administration (NHSA); Frost & Sullivan.

[1] Excluding traditional Chinese medicines; [2] Calculation assumes an exchange rate of CN¥6.5 per US\$1.