CORPORATE PRESENTATION

DECEMBER 2021

Nasdaq/AIM:HCM | HKEX:13

HUTCHMED

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Use of Non-GAAP Financial Measures - This presentation includes certain non-GAAP financial measures. Please see the appendix slides titled "Non-GAAP Financial Measures and Reconciliation" for further information relevant to the interpretation of these financial measures and reconciliations of these financial measures to the most comparable GAAP measures.

A global science-focused biopharma

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

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

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

20+ years novel drug discovery

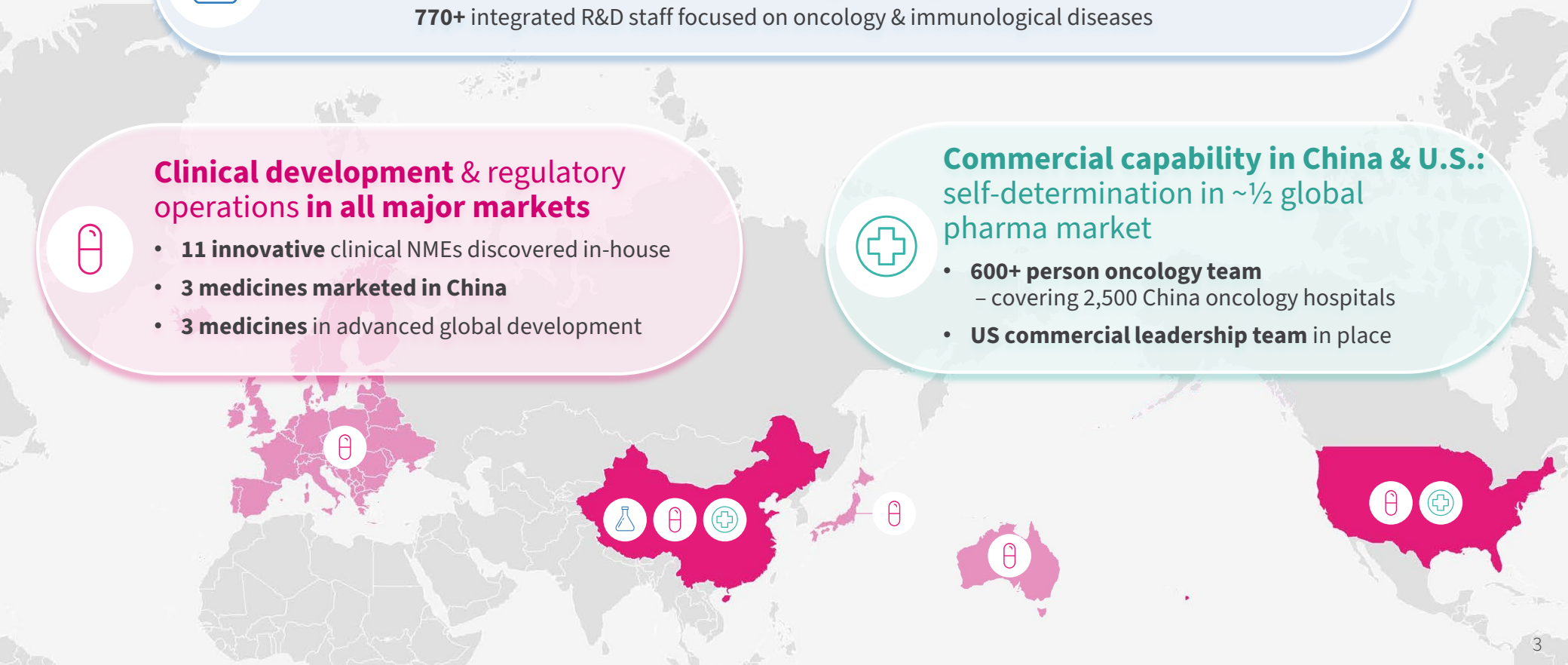
770+ integrated R&D staff focused on oncology & immunological diseases

Clinical development & regulatory operations **in all major markets**

- **11 innovative** clinical NMEs discovered in-house
- **3 medicines marketed in China**
- **3 medicines** in advanced global development

Commercial capability in China & U.S.: self-determination in ~½ global pharma market

- **600+ person oncology team** – covering 2,500 China oncology hospitals
- **US commercial leadership team** in place



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)		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)	PI3Kδ	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** (>200 NHL pts.) **Ph.III** (ITP)	**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 cleared	IND cleared
HMPL-653	CSF-1R	In-house	Solid tumors	None	HCM holds all WW rights	IND cleared	-
HMPL-A83	CD47	In-house	mAb – solid tumors, hematological malignancies	None	HCM holds all WW rights	Target IND ~YE 2021	-

[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.

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

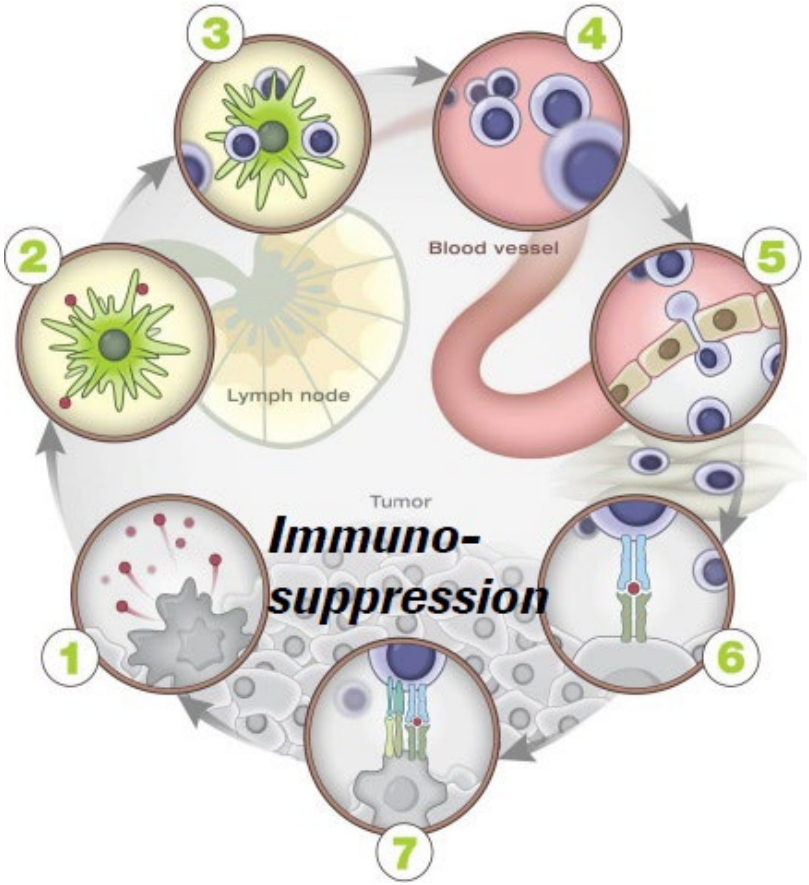
- CD47 (HMPL-A83) — IND submitted
- EZH2 (tazemetostat)* — Approved
- PD-1 collaborations with BeiGene, Innovent, Junshi

Antigen Release

Aberrant genetic drivers

Multiple small molecule programs

- MET (savolitinib) — Approved
- PI3Kδ (amdizalisib) — Ph II Reg-Intent
- Syk (HMPL-523) — Ph III
- FGFR (HMPL-453) — Ph II
- EGFR (epitinib) — Ph II
- IDH 1/2 (HMPL-306) — Ph I
- ERK 1/2 (HMPL-295) — Ph I
- BTK (HMPL-760) — IND cleared
- EZH2 (tazemetostat)* — Approved



Excluded Infiltrate

Inadequate T cell homing

Anti-angiogenesis

- VEGFR (fruquintinib) — Approved
- VEGFR/FGFR (surufatinib) — Approved
- FGFR (HMPL-453) — Ph II
- EZH2 (tazemetostat)* — Approved

Inflamed

Inactivated T cell response

Negative regulators

- Treg (amdizalisib) — Ph II Reg-Intent
- CSF-1R (surufatinib, HMPL-653) — Approved / IND submitted
- EZH2 (tazemetostat)* — Approved

* 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.

2021 highlights

HUTCHMED

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; Q321 in-market sales of $10 million**
- Surufatinib ex-China: U.S. NDA & E.U. MAA accepted, Japan bridging study initiated

Pipeline

- Pipeline Transition in Hematology: Amdizalisib (PI3Kδi) in reg. study, with **Breakthrough Therapy** Designation in China; HMPL-523 (SYKi) reg. study in ITP
- Savolitinib: Started 4 new global & China reg. studies, 1 in planning
- Fruquintinib Monotherapy global registration study enrolled
- Surufatinib & Fruquintinib PD-1 combos: entering reg. studies
- New early-stage Pipeline/Discovery: 5 in-house clinical assets '20-'22 (IDH, 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
- Building New Flagship Manufacturing Facility: Designed for >5X increase small molecule capacity & mAb capability starting 2024
- ~$1.2bn cash & resources

*Represents total sales to third parties as provided by Lilly
.**Represents sales as reported by AstraZeneca

REGULATORY & COMMERCIAL HIGHLIGHTS

3 novel drugs launched

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

Revenues in 2021

Fruquintinib China commercial responsibility assumed Oct 2020

Receiving 70-80% of in-market sales as revenues in China [1]

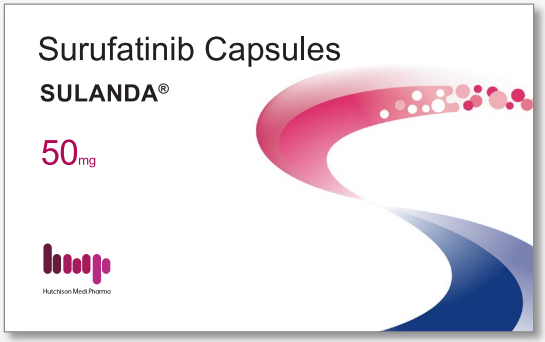
Surufatinib launched in China Jan 2021

HUTCHMED owns all China rights

Savolitinib approved June 2021

First sale milestone in China $25 million

Eligible for 30% royalty on China sales [2]



Revenues 2022 onwards

Global registration study ongoing

Potential NDA & MAA submissions in U.S., E.U. & Japan in 2022/2023

HUTCHMED owns all ex-China rights

U.S. & E.U. filings accepted

Preparing for potential launch in 2022

HUTCHMED owns all ex-China rights

AZ ex-China development

Phase III development in RCC & NSCLC started in H2 2021

Eligible for 9-18% royalty ex-China

[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

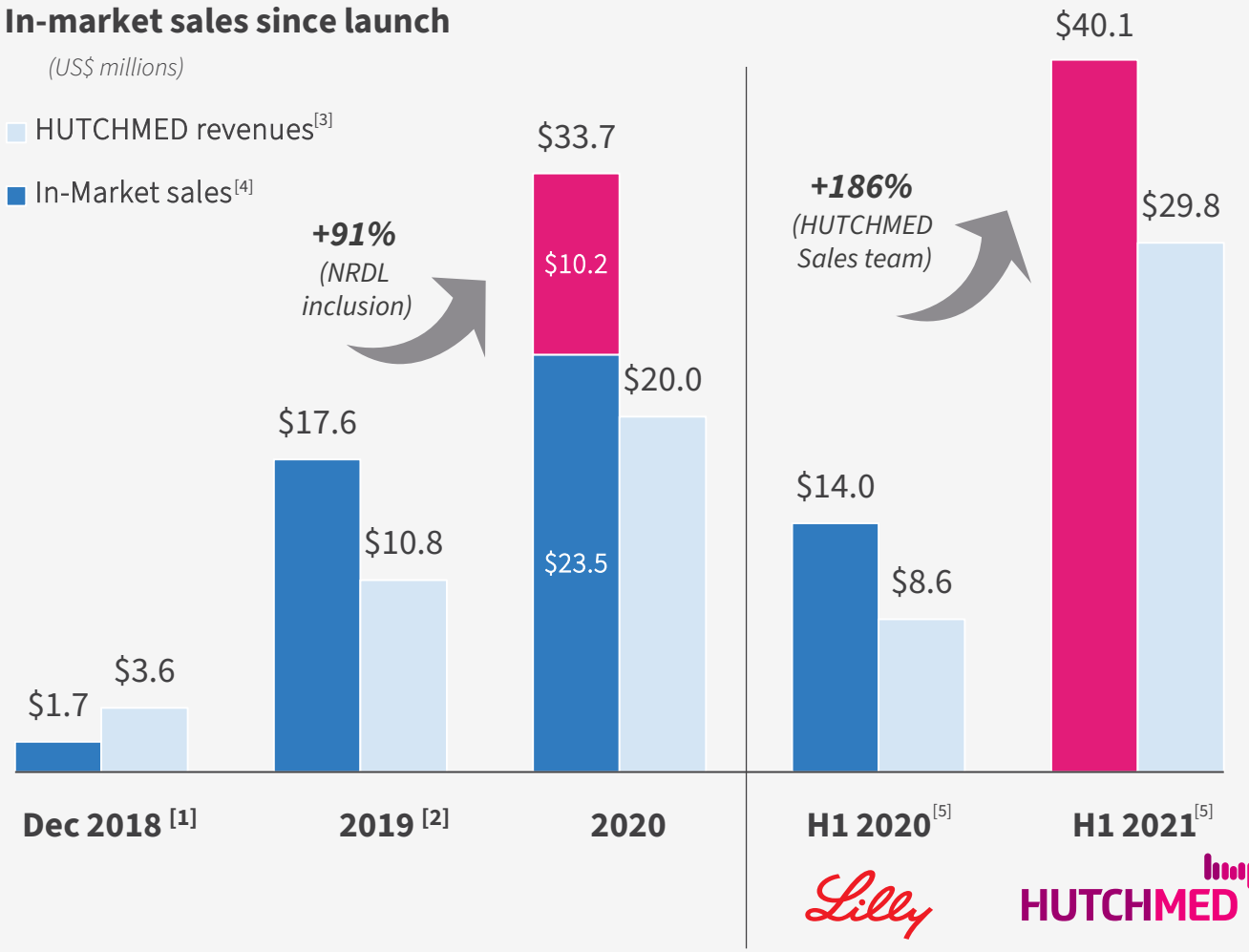
HUTCHMED oncology sales team have made instant impact

HUTCHMED

ELUNATE®
Fruquintinib Capsules

In-market sales since launch

(US$ millions)



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

Dec 30, 2020	Jan 14, 2021	Jan 19, 2021	Jan 29, 2021	Jun 18, 2021
1st NDA Approved	1st order shipped	1st Rx	Prescribed in 30 provinces	2nd NDA Approved

苏泰达® SULANDA®
SURUFATINIB CAPSULES
索凡替尼胶囊

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

First indication approved: MET Exon 14 skipping NSCLC…

Jun 22, 2021 — NDA approved
- *Eligible for 2022 NRDL inclusion (H1 cut-off)*
- *New patent extension policy (for post Jun 1, 2021 approvals.)*

Jun 30 — 1st order shipped *(16 days post approval)*

Jul 8 — >40 prescriptions Day 1
- *Triggering a $25m milestone to HUTCHMED*
- *30% royalty on all sales; &*
- *HUTCHMED manufacturing fees*

MET Exon14 NSCLC – 2-3% of NSCLC (approx. 13,000 pts./year in China); poor prognosis; no prior effective treatments

Marketed by AstraZeneca

#1 MNC in China with 2020 sales of $5.4bn[1]

AZ's China lung cancer franchise

沃瑞沙® Orpathys® 赛沃替尼片 *"Wò Ruì Shā"*

泰瑞沙® TAGRISSO® 甲磺酸奥希替尼片 *"Tài Ruì Shā"*

IRESSA® 易瑞沙® *"Yì Ruì Shā"*

英飞凡™ IMFINZI™ 度伐利尤单抗注射液 durvalumab

[1] AstraZeneca full year 2020 results announcement.

Efficacy in NSCLC, Gastric & PRCC

…and 5 registration studies set to start in H2 2021 / H1 2022

HUTCHMED

沃瑞沙® Orpathys® 赛沃替尼片

SUBSTANTIAL BODY OF PUBLISHED DATA

Study	Journal / Meeting	Primary efficacy
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% CI: 0.21-1.17]
CALYPSO (Savo + IMFINZI®)	2021 ASCO ANNUAL MEETING	**ORR:** 57% in MET-driven **OS:** 27.4mo in MET-driven
TATTON & ORCHARD (Savo + TAGRISSO®)	THE LANCET Oncology; IASLC 2020 World Conference on Lung Cancer Singapore; 2021 ESMO congress	**ORR:** 33-67% **PFS:** 5.5-11.1BD
VIKTORY (Savo mono)	CANCER DISCOVERY	**ORR:** 50% in MET amp
MET ex14 NSCLC	THE LANCET Respiratory Medicine ASCO20 Virtual	**ORR:** 42.9%

SAVOLITINIB REGISTRATION TRIALS STARTING H2

Treatment	Patient focus
Savo + IMFINZI®	**SAMETA:** MET-driven PRCC FPI Oct ’21
Savo + TAGRISSO®	**SAVANNAH 2**: 2L/3L EGFRm+, TAGRISSO® refractory, MET+ NSCLC
Savo + TAGRISSO®	**SACHI:** 2L EGFRm+, EGFR TKI refractory, MET+ NSCLC
Savo + TAGRISSO®	**SANOVO:** Naïve EGFRm+, MET+ NSCLC FPI Sept ’21
Savo mono.	**2L+ MET amplified gastric cancer** *(registration-intent Phase II)* FPI July ’21

HUTCHMED Registration Studies

*10 new registration studies in 2021 started / in planning, based on new data this year…

Drug	Name	Target Disease	Region	Design (N, arms, 1° endpoint)
SAVO	**GASTRIC***	MET amplified GC	China	~75, 1 arm, ORR
	SAMETA*	MET driven PRCC, combo with PD-L1	Global	~200, 3 arms combo vs. monos, PFS
	SANOVO*	1L EGFRm+ NSCLC with MET Over-exp.	China	~320, combo vs. Tagrisso®, PFS
	SACHI*	2L EGFR TKI refractory NSCLC	China	~250, combo vs. chemo, PFS
	SAVANNAH 2*	2L Tagrisso® refractory NSCLC	Global	Not disclosed
SURU	**SURTORI-01***	2L NEC, combo with PD-1	China	~190, combo vs. chemo, OS
FRUQ	**FRESCO-2**	3L+ colorectal cancer	Global	~690, treatment vs. BSC, OS
	FRUTIGA	2L GC, combo with chemo	China	~700, combo vs. chemo, OS
	2L EMC*	2L EMC, combo with PD-1, China	China	Not disclosed
AMDIZ	**3L FL***	3L follicular lymphoma	China	~100, 1 arm, ORR
	2L MZL*	2L marginal zone lymphoma	China	~80, 1 arm, ORR
523	**ESLIM-01***	Immune thrombocytopenia	China	~180, 2 arm (placebo), DRR
TAZ	**SYMPHONY-1***	2L follicular lymphoma, combo with R^2	Global^	~500, combo vs. R^2, PFS
…and 3 new INDs	**HMPL-760**	Third generation BTK inhibitor: U.S., China		
	HMPL-653	CSF-1R inhibitor: China		
	HMPL-A83	CD47 monoclonal antibody: China		

GC = gastric cancer; PRCC = papillary renal cell carcinoma; NSCLC = non-small cell lung cancer; EMC = endometrial cancer. ^ In collaboration with Epizyme. R^2 = rituximab + lenalidomide.

RECENT PIPELINE HIGHLIGHTS

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

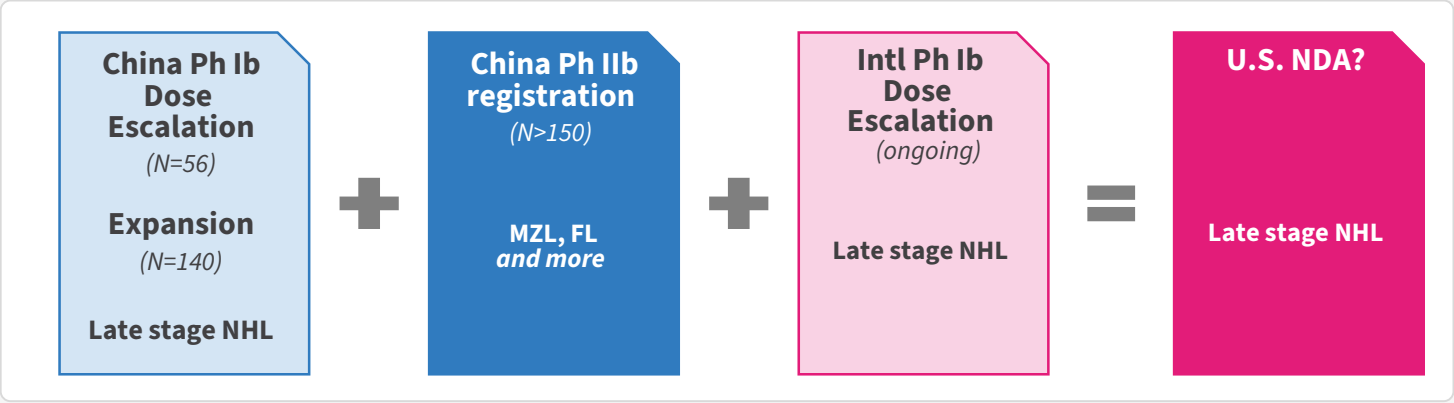
- Additional indications
- Earlier lines
- To start in early 2022

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
- Devise registrational strategy



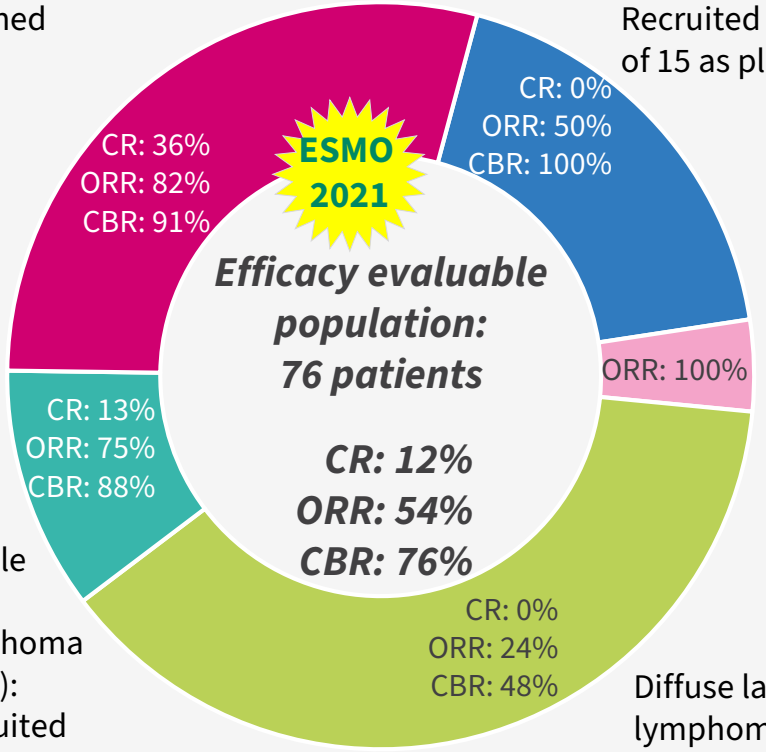
Amdizalisib: Breakthrough Therapy designation

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

Dose Expansion

Follicular lymphoma (FL): Recruited 25 out of 20 as planned

Marginal zone lymphoma (MZL): Recruited 14 out of 15 as planned



CLL/SLL:[1] Recruited 4 out of 20 as planned

Mantle cell lymphoma (MCL): Recruited 10 out of 30 as planned

Diffuse large B-cell lymphoma (DLBCL): Recruited 37 out of 35 as planned

China Registration Intent Study with BT Designation

First patient dosed in April 2021

Additional indications and combinations in planning

Cohort 1: R/R MZL • ≥2L after ≥1L CD20i tx • N~80 • No prior PI3Ki/BTKi	Full enrollment target: H2 2022
Cohort 2: R/R FL • ≥3L after ≥1L CD20i tx • N~100 • No prior PI3Ki/BTKi	Full enrollment target: H1 2022

Tumor evaluations (TE)

- every 8 weeks in the first 24 weeks
- every 12 weeks thereafter

Primary efficacy endpoint

IRC-assessed ORR

Secondary efficacy endpoints

IRC-assessed
CRR, PFS, CBR, TTR & DoR;
Inv-assessed
ORR, CRR, PFS, CBR, TTR, DoR, & OS

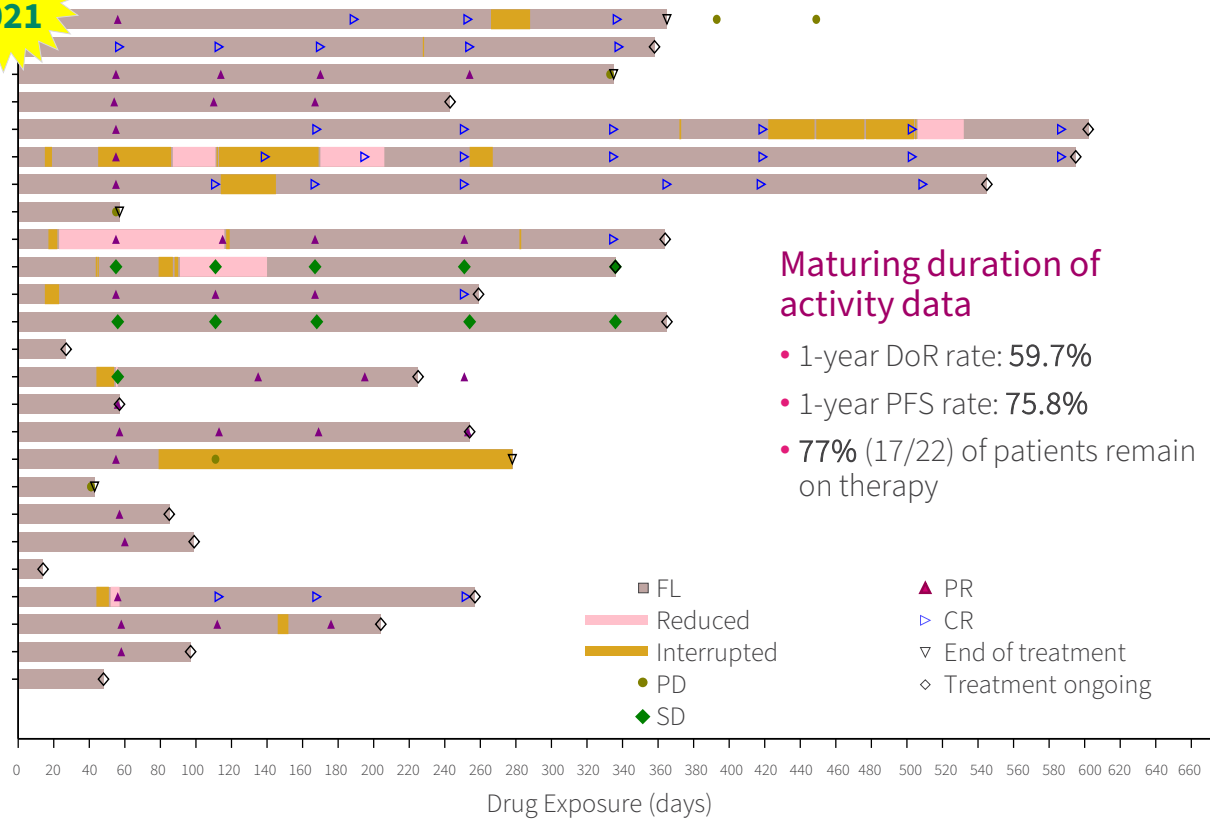
As of June 15, 2021. ESMO 2021: Cao J, et al. #833O - A phase Ib study result of HMPL-689, a PI3Kδ inhibitor, in Chinese patients with relapsed/refractory lymphoma. Annals of Oncology (2021) 32 (suppl_5): S773-S785. doi: 10.1016/annonc/annonc676.
[1] Chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL).

Amdizalisib: follicular lymphoma (FL) highlights

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

8.3 months median follow-up for 22 efficacy evaluable patients

ESMO 2021

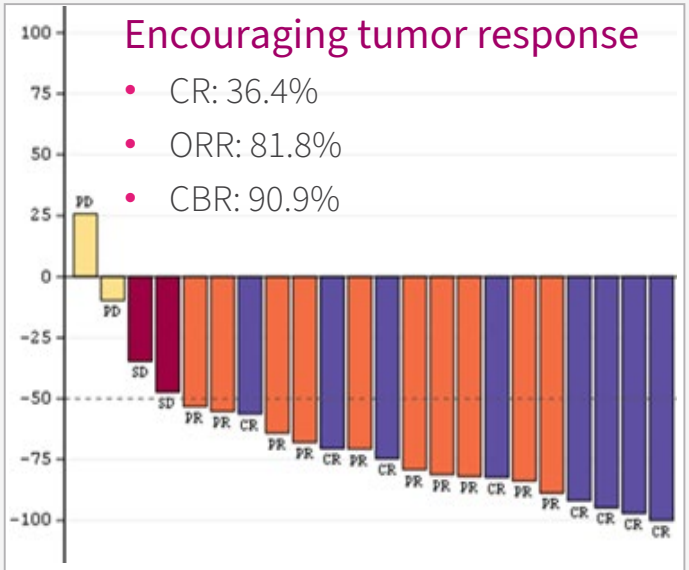


Maturing duration of activity data

- 1-year DoR rate: 59.7%
- 1-year PFS rate: 75.8%
- 77% (17/22) of patients remain on therapy

Encouraging tumor response

- CR: 36.4%
- ORR: 81.8%
- CBR: 90.9%



Dose interruptions & reductions used to manage AEs while on treatment

- 11 of 12 patients reinitiated therapy after incidence of dose reduction/interruption

ESMO 2021: Cao J, et al. #833O - A phase Ib study result of HMPL-689, a PI3Kδ inhibitor, in Chinese patients with relapsed/refractory lymphoma. Annals of Oncology (2021) 32 (suppl_5): S773-S785. 10.1016/annonc/annonc676.

Amdizalisib: FL data vs. other PI3Kδ inhibitors

ORR, CR rate & PFS data is encouraging vs. approved PI3Kδ inhibitors

Treatment option	N	Tx Line	Objective Response Rate (ORR) (95%CI)	Complete Response Rate	Partial Response Rate	Median Progression-Free Survival (mPFS), months (95%CI)
ESMO 2021 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
Umbralisib[5]	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. #833O - A phase Ib study result of HMPL-689, a PI3Kδ 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. TG Therapeutics FDA approval press release. Fowler N, et al. J Clin Oncol. 2021 May 20;39(15):1609-1618. doi: 10.1200/JCO.20.03433. Epub 2021 Mar 8.

Amdizalisib: demonstration of tolerability

30mg QD dose expansion data highly consistent with early data

ESMO 2021

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

	Amdizalisib [1]		Zydelig® (idelalisib) [3]	Aliqopa® (copanlisib) [3]	Copiktra® (duvelisib) [3]	Ukoniq® (umbralisib) [3]	Parsaclisib			Zandelisib	
	Dose escalation [1]	30mg QD [2]					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	103	72	30	121
Neutropenia	43% / 11%	29% / 11%	53% / **25%***	32% / **25%**	34% / **30%**	33% / 16%*	44% / **20%***	16% / 11%	14% / 11%	45% / 13%*	na
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%*	34% / 3%*	17% / 8%	13% / 0%*	na
Thrombocytopenia	11% / 0%	<10% / 2%	26% / 6%*	**22% / 8%**	**17% / 10%**	26 % / 4%*	35% / 10%*	22% / 0%*	19/% / 4%*	22% / 0%*	na
Diarrhea	<5% / 0%	11% / 2%	**47% / 14%**	36% / 5%	**50% / 23%**	**58% / 10%**	**36% / 9%**	**44% / 14%**	**53% / 15%**	**45% / 19%**	na
Rash	11% / 5%	16% / 6%	21% / 3%	15% / 2%	31% / 9%	18% / 3%	31% / 6%	14% / 3%	18% / 3%	42% / 13%	na / 3%
ALT increased	27% / 2%	27% / 0%	50% / **19%**	na	40% / **8%**	33% / **8%**	28% / 1%	30% / 2%	29% / 7%	39% / **6%**	na / **2%**
AST increased	21% / 2%	19% / 0%	41% / **12%**	na	37% / **6%**	32% / **7%**	29% / 1%	29% / 0%	21% / 4%	25% / **6%**	na
Pyrexia	14% / 0%	<10% / 1%	28% / 2%	na	26% / 2%	10% / 0%	18% / 1%	19% / 3%	15% / 1%	<15%	na
Pneumonia	25% / 16%	18% / 13%	25% / 16%	21% / 14%**	21%/15%	**PJP prophylaxis** recommended	na	<10%	**10% with PJP prophylaxis**	<15%	**PJP prophylaxis**
Hypertension	7% / 5%	<10% / 0%	na	**35% / 27%**	na	na	7% / 0%	<10%	<10%	<15%	na
Hyperglycemia	11% / 0%	<10% / 0%	na	**54% / 39%**	na	na	10% / 1%	<10%	<10%	<15%	na
Discontinuation due to AE	na	5.6%	53% (+inter)	16%	29-35%	14%	19%	25%	37.5%	13%	10%

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

[1] ASH 2020 Abstract #1135; [2] ESMO 2021 Abstract #833O; [3] US Prescribing Information; [4] Blood, April 2019 doi: 10.1182/blood-2018-08-867499; [5] ASH 2021 Abstract #338; [6] ASH 2021 Abstract #44; [7] ASCO 2018 Abstract #7519; [8] Company report of TIDAL interim analysis . *Laboratory values; **Lower respiratory tract infections; ***Regardless of causality; PJP = pneumocystis jirovecii pneumonia

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 in November 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
- SAMETA FPI in October 2021

2L TAGRISSO® refractory NSCLC with MET amplification

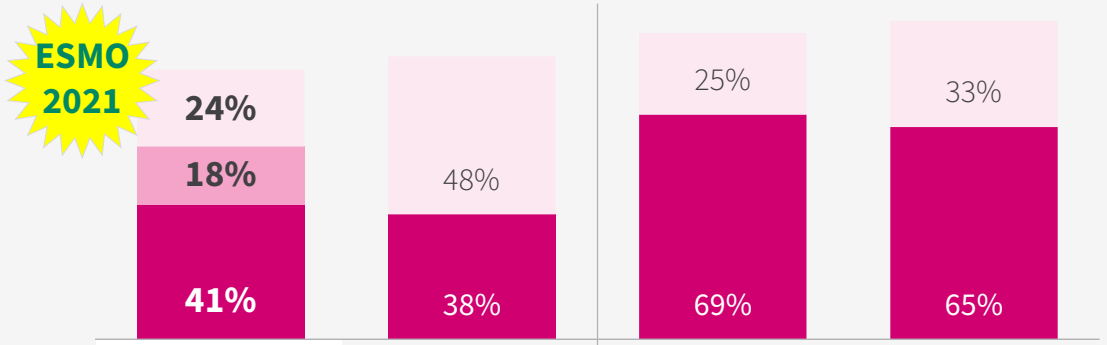
- In planning: Savolitinib + TAGRISSO® Phase III registration study

Savolitinib: EGFRm+ NSCLC w/ MET aberrations

HUTCHMED

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

Consistency of tumor control seen in TATTON & ORCHARD



	ORCHARD	TATTON B1	TATTON B2	TATTON D
	300-600mg QD	*600mg QD*	*600mg QD*	*300mg QD*
	2L, prior 3G EGFR-TKI	**2L+, prior 3G EGFR-TKI**	**2L+, no prior 3G EGFR-TKI**	**2L+, no prior 3G EGFR-TKI**
	n=17	n=60	n=48	n=40
mDoR, mo. [95% CI]	**NR**	**9.5** [4.2–14.7]	**10.7** [6.1–14.8]	**9.7** [4.5–14.3]
mPFS, mo. [95% CI]	**NR**	**5.5** [4.1–7.7]	**9.1** [5.5–12.8]	**9.0** [5.6–12.7]

■ Confirmed response ■ Unconfirmed response ■ Stable disease

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

2L/3L EGFRm+ NSCLC

- After 1L or 2L TAGRISSO®
- MET amp. / over-express.
- No MET inhibitor therapy
- No prior chemo or I-O

Enrolled ✓ → **Savo 300mg QD** *+ TAGRISSO®*

Enrolling → **Savo 300mg BID** *+ TAGRISSO®*

Enrolling → **Savo 600mg QD** *+ TAGRISSO®*

TO FINALIZE FOR GLOBAL PHASE III

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

Data inform Phase III designs

Initiated late 2021 / early 2022

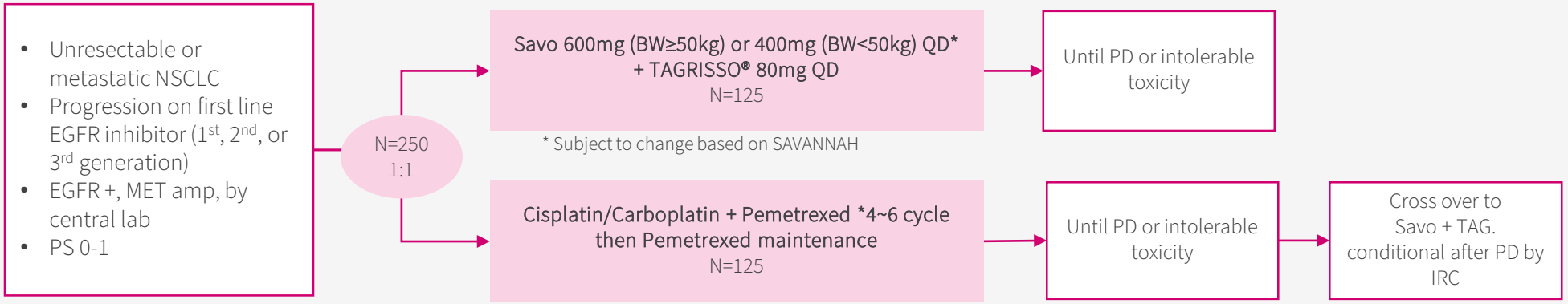
mDoR, median duration of response; mPFS, median progression free survival; CI, confidence interval; NR, not reached; QD, once daily; BID twice daily
an JY, et al. Osimertinib + savolitinib in patients with EGFRm MET-amplified/overexpressed NSCLC: Phase Ib TATTON Parts B and D final analysis. WCLC January 2021 #FP14.03. Data based on ITT set.
ESMO 2021 Abstract # 1239P. Response based on efficacy evaluable set.

SACHI Phase III Study — FPI Nov 2021

Savolitinib plus TAGRISSO® in **2L EGFRm+, EGFR TKI ref., MET+ NSCLC** in China

Population	Patients with locally advanced or metastatic NSCLC with MET amplification after failure of the first-line EGFR inhibitor therapy
Key Objectives	Primary endpoint: PFS assessed by investigators Secondary endpoints: PFS assessed by IRC, OS, ORR, DoR, DCR, TTR and safety

Study Design

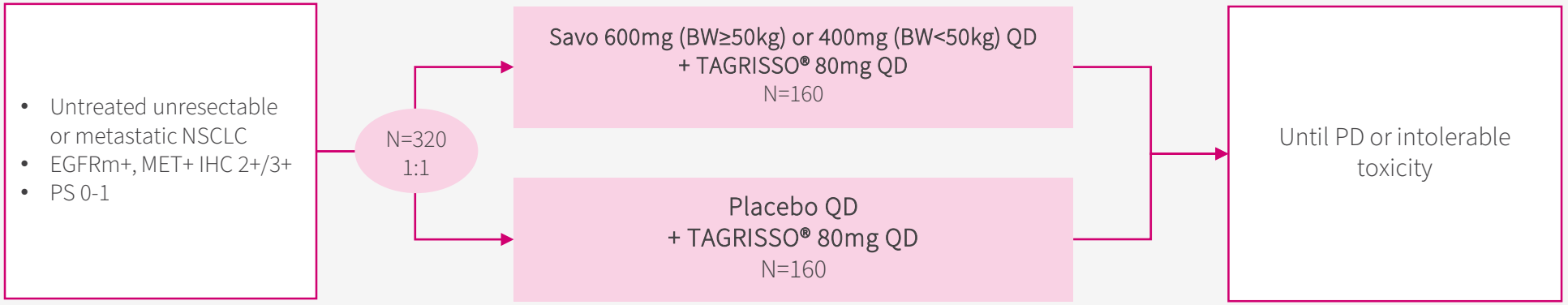


SANOVO Phase III Study — FPI in Sep 2021

Savolitinib plus TAGRISSO® in **1L EGFRm+, MET+ NSCLC** in China

Population	Untreated EGFRm+/MET+ Locally Advanced or Metastatic NSCLC patients
Key Objectives	Primary endpoint: PFS assessed by investigators Secondary endpoints: PFS assessed by IRC, OS, ORR, DoR, DCR, TTR and safety

Study Design



Savolitinib: Promising in MET-driven PRCC

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

HUTCHMED

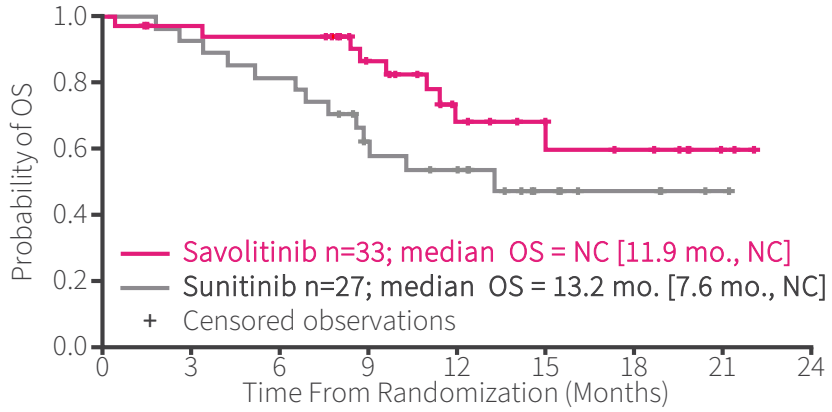
2021 ASCO ANNUAL MEETING

SAVOIR: Single agent anti-tumor activity in MET-driven PRCC

All 9 savo responders remained in response at data cut-off

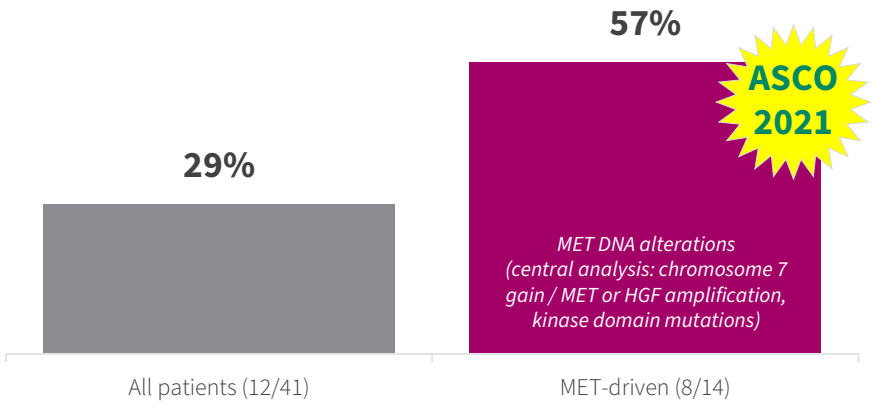
SAVOIR [1]	Savolitinib (N=33)	Sunitinib (N=27)
ORR* [95% CI]	**27% [13.3–45.5]**	**7% [0.9–24.3]**
PFS [95% CI]	7.0 mo. [2.8–NC]	5.6 mo. [4.1–6.9]
	Hazard Ratio: 0.71 [0.37–1.36]	

Strong signal of potential overall survival benefit
Hazard Ratio [95% CI]: **0.51** [0.21-1.17] *P=0.110*



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

Highly correlated to MET-driven alterations / amplif.



	All patients (N=41)	MET-driven (N=14)
ORR	29%	57%
mPFS	4.9 mo. [2.5-10.0]	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]
OS @ 12 mo.	54.3% [37.5-68.4]	64.3% [34.3-83.3]

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

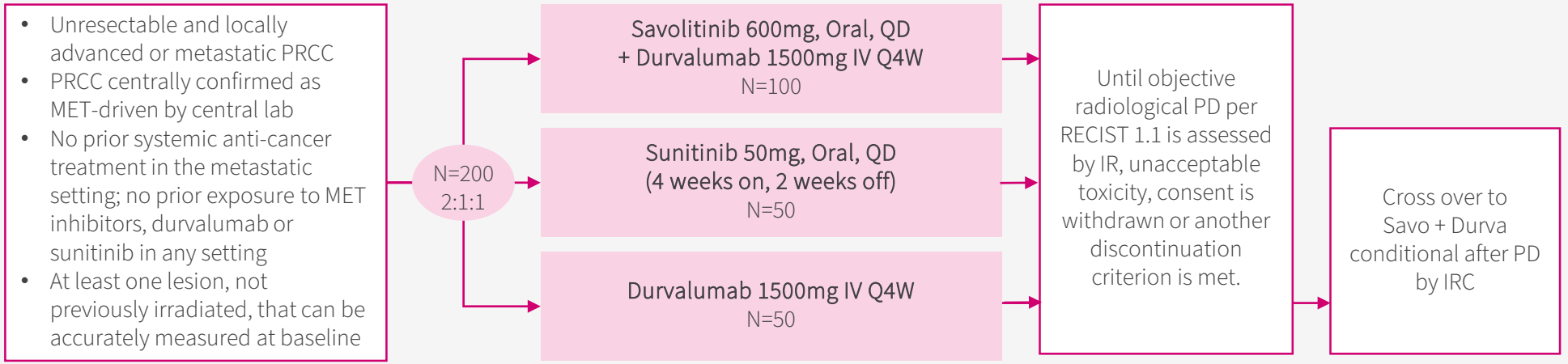
[1] Choueiri TK, et al. Efficacy of Savolitinib vs Sunitinib in Patients With MET-Driven Papillary Renal Cell Carcinoma: The SAVOIR Phase 3 Randomized Clinical Trial. JAMA Oncol. Published online May 29, 2020. doi:10.1001/jamaoncol.2020.2218; [2] ASCO 2021 Suárez C et al. J Clin Oncol 39, 2021 (suppl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

SAMETA Global Phase III — FPI in Oct 2021

Savolitinib plus IMFINZI® in **MET-driven PRCC** vs. sunitinib

Population	Patients with MET-driven advanced PRCC, who have not received any prior systemic anti-cancer therapy in the metastatic setting
Key Objectives	Primary endpoint: PFS Secondary endpoints: OS, ORR, DoR, 6 & 12 mon DCR, PFS2, safety, PK and QoL

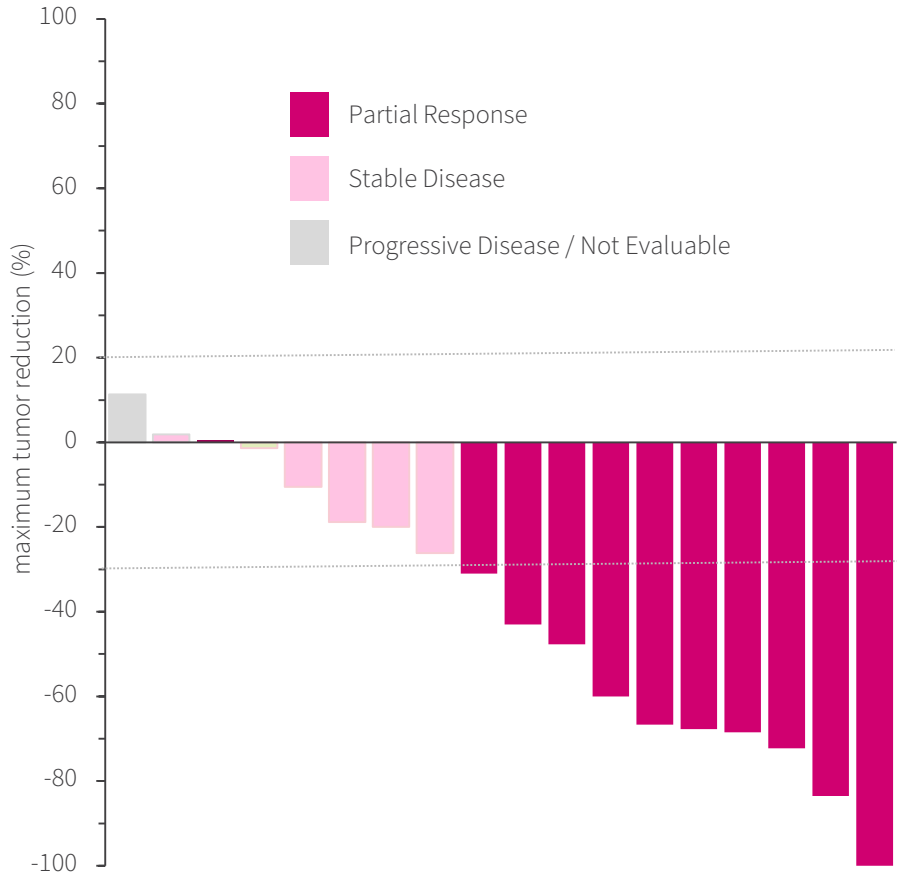
Study Design



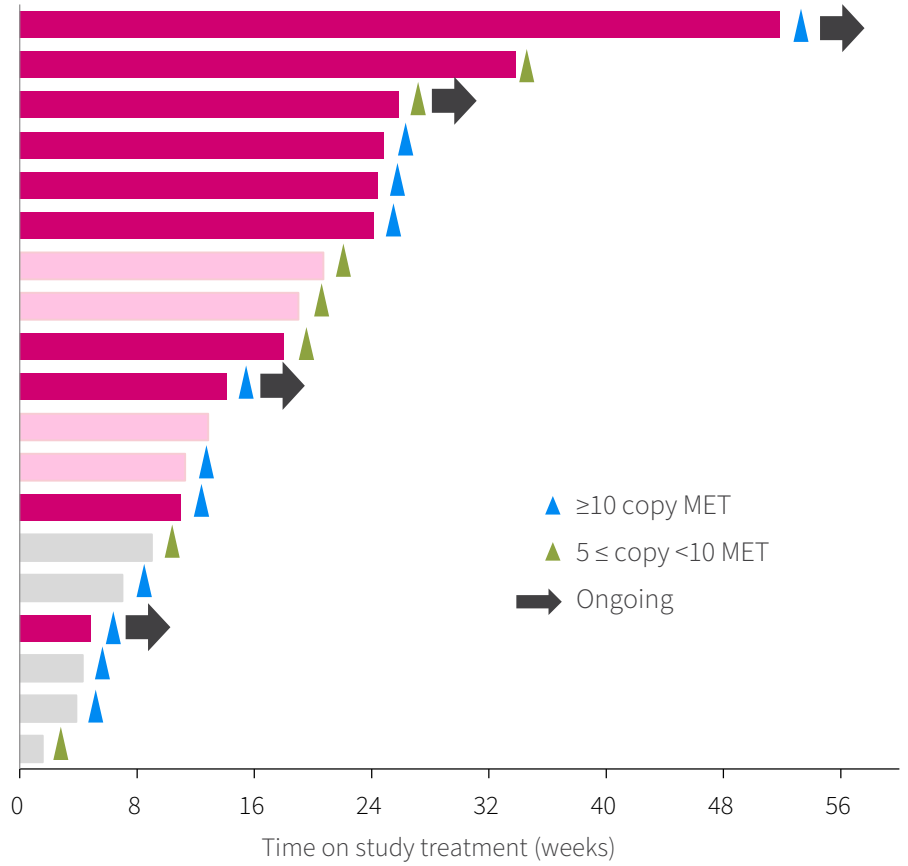
Savolitinib: MET ampl. in gastric cancer

Phase II trial ongoing in China with potential for registration

VIKTORY: Best tumor response (savolitinib arm)



VIKTORY: Duration of response (savolitinib arm)



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.

Savo Phase II Gastric Cancer — FPI in Jul 2021

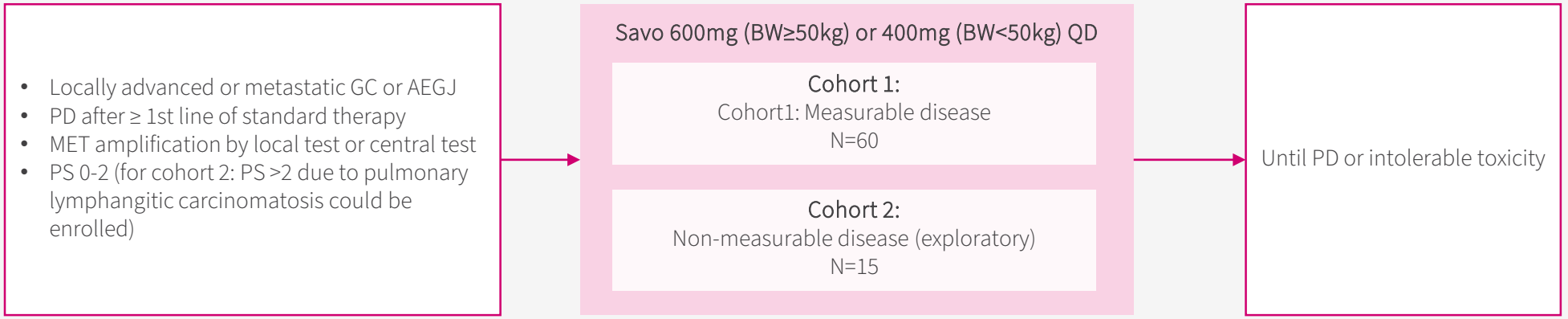
HUTCHMED

Savolitinib in advanced or metastatic **MET amplified GC or adenocarcinoma of the GEJ**

Population	Advanced or metastatic MET amplified gastric cancer (GC)or adenocarcinoma of the gastroesophageal junction (GEJ) patients, whose disease progressed after at least one line of standard therapy.

Key Objectives	Primary endpoint: **Cohort 1:** IRC assessed ORR | **Cohort 2:** IRC assessed 12-wk PFS rate Secondary endpoints: DoR, DCR, PFS, OS, 6-month PFS rate and safety Exploratory endpoints: PK & quality of life (EORTC QLQ C30 & QLQ-STO22)

Study Design



Fruquintinib: Development summary

Current development status and next steps

CHINA

FRUTIGA: Phase III in 2L gastric cancer ongoing

- Expect fully enrolled H1 2022

PD-1

- EMC: converted to registration study H2 2021
- CRC: data promising
- 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 enrolled in U.S., E.U. & Japan at year end 2021
- 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

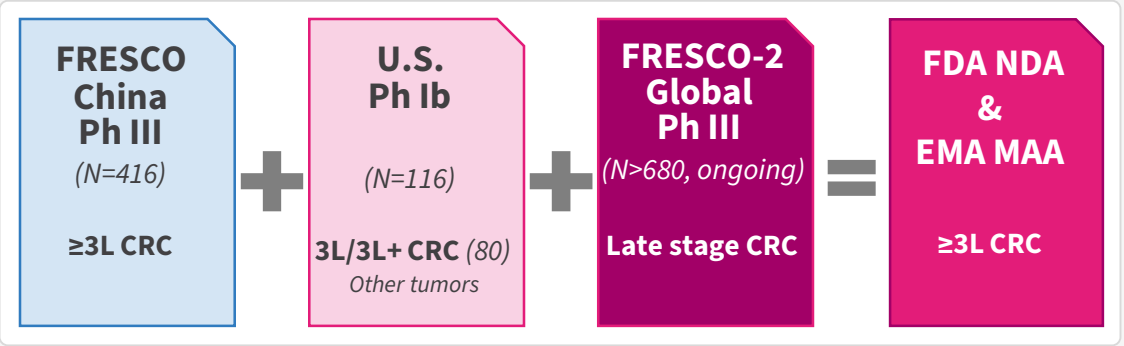
PD-1 combinations

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

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

Regulatory alignment on fruquintinib across all major markets

Basis for U.S., E.U., Japan filings



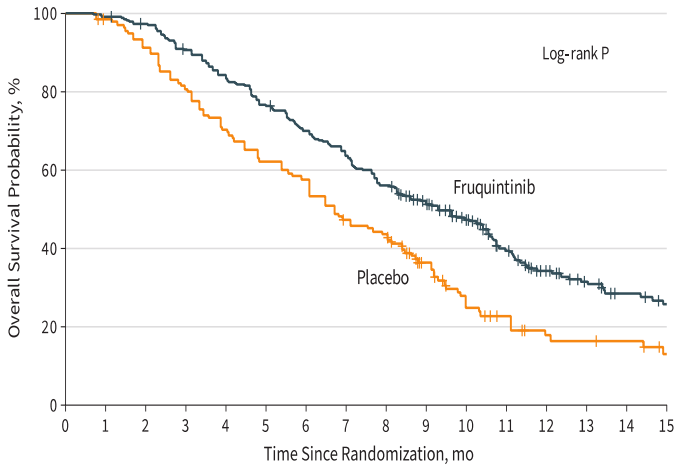
- **Target Patient Population –** We are aiming for aggregate clinical data to support U.S. NDA & E.U. MAA in third-line and above metastatic CRC
- **FRESCO-2 Global Ph.III**
  - Enrolled >150 sites across 14 countries
  - Reached enrollment target end of 2021
- **U.S. Fast Track designation** → potential for rolling submission
- Extensive list of supportive studies

FRESCO China Ph.III (≥3L CRC):

9.30 months vs. 6.57 months

Stratified HR (95% CI): **0.65** (0.51–0.83)

p-value <0.001



Li J, Qin S, Xu RH, 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.

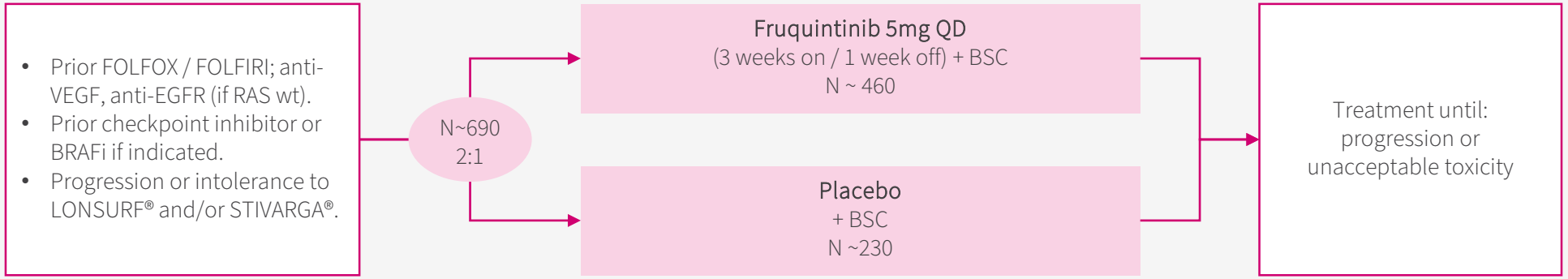
FRESCO-2 Global Phase III — Dec 2021 enrolled

HUTCHMED

Fruquintinib in **3L+ mCRC** patients — **To support U.S./E.U./JP NDA**

Population	Patients with advanced colorectal cancer who have progressed on, or were intolerant to, chemotherapy, biologics, and TAS-102 or regorafenib (N=687)
Key Objectives	Primary endpoint: OS Secondary endpoints: PFS, DCR, ORR, DoR and safety

Study Design



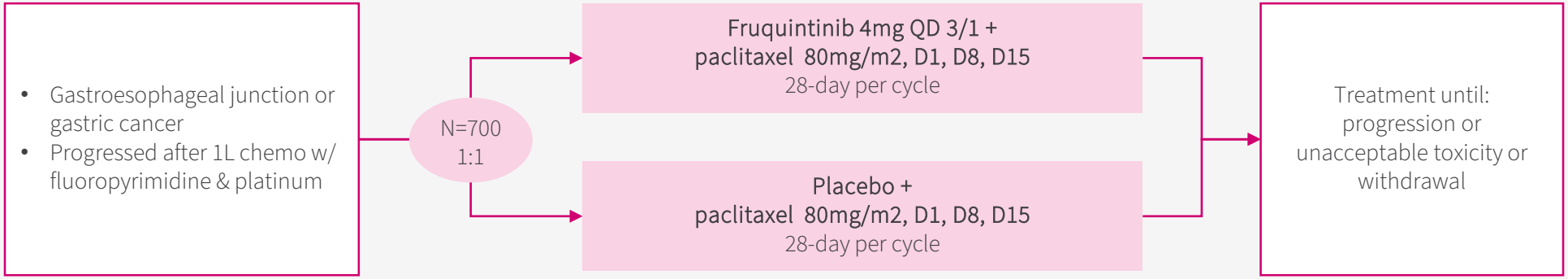
FRUTIGA Phase III Study — ~H1 2022 enrolled

HUTCHMED

Fruquintinib plus paclitaxel in **2L gastric cancer** patients in China

Population	Patients with advanced gastric adenocarcinoma or gastroesophageal junction (GEJ) adenocarcinoma who have progressed after first-line standard chemotherapy.
Key Objectives	Primary endpoint: OS Secondary endpoints: PFS, ORR, DCR, DoR, QoL

Study Design



Fruquintinib: PD-1 inhibitor combinations

HUTCHMED

Durable benefit seen in advanced colorectal cancer

2021 ASCO ANNUAL MEETING

Fruquintinib PD-1 studies Summary

PD-1	Patient focus		Status/ plan
TYVYT®	CRC ASCO 2021	CN	Phase II ongoing Est. N~35
TYVYT® CSCO 2021	Hepatocellular carcinoma	CN	Phase Ib/II ongoing; Total est. N~120 to select 1-2 for registration intent studies
TYVYT® CSCO 2021	Endometrial cancer	CN	
TYVYT® CSCO 2021	RCC	CN	
TYVYT®	Other GI	CN	
Tislelizumab	Triple negative breast cancer, endometrial cancer	US	Phase I/Ib ongoing Est. N~80
Tislelizumab	Solid tumors	TBD	Phase I/Ib In planning Est. N~60+
Geptanolimab	CRC ASCO 2021	CN	Phase Ib ongoing Est. N~15
Geptanolimab	NSCLC	CN	Phase Ib ongoing Est. N~15

	Fruq mono Ph. III (FRESCO)	Fruq + sintilimab[1] (ASCO 2021)	Fruq + geptano-limab[2] (ASCO 2021)	Lenvatinib + pembro-lizumab[3]
Prior lines of tx	≥2	≥2	67% ≥2	94% ≥2
RP2D VEGFRi dose *(n)*	5mg QD 3w/1w *(278)*	5mg QD 2w/1w *(22)*	4mg QD 3w/1w *(15)* [4]	20mg QD *(32)*
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]*
mPFS, months	**3.7 *[3.7–4.6]***	**6.9 *[5.4-8.3]***	**7.3 *[1.9-NR]***	**2.3 *[2.0-5.2]***
OS, months	9.3 *[8.2–10.5]*	11.8 *[8.8-NR]*	*Not mature at DCO*	*7.5 (3.9-NR)*

Note: Illustrative comparison only. No head-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 3564).

Fruquintinib: PD-1 inhibitor combinations

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

Fruquintinib PD-1 studies Summary

PD-1	Patient focus		Status/ plan
TYVYT®	CRC ASCO 2021	CN	Phase II ongoing Est. N~35
TYVYT® CSCO 2021	Hepatocellular carcinoma	CN	Phase Ib/II ongoing; Total est. N~120 to select 1-2 for registration intent studies
TYVYT® CSCO 2021	Endometrial cancer	CN	
TYVYT® CSCO 2021	RCC	CN	
TYVYT®	Other GI	CN	
Tislelizumab	Triple negative breast cancer, endometrial cancer	US	Phase I/Ib ongoing Est. N~80
Tislelizumab	Solid tumors	TBD	Phase I/Ib In planning Est. N~60+
Geptanolimab	CRC ASCO 2021	CN	Phase Ib ongoing Est. N~15
Geptanolimab	NSCLC	CN	Phase Ib ongoing Est. N~15

(Data cut-off: August 31, 2021)

	Advanced Endometrial Cancer[1] CSCO 2021	Advanced Hepatocellular Carcinoma[2] CSCO 2021	Advanced Renal Cell Carcinoma[3] CSCO 2021
Efficacy evaluable pop'n (N)	1L: 4 2L+: 25 2L+ pMMR: 19	19	20
Confirmed ORR*	1L: 100% *[40-100]* 2L: 32% *[15-54]* **2L+ pMMR: 37% *[16-62]***	**31.6%** ***[12.6-56.6]***	**55.0%** ***[31.5-76.9]***
DCR*	1L: 100% *[40-100]* 2L: 92% *[74-99]* 2L+ pMMR: 95% *[74-100]*	89.5% *[66.9-98.7]*	85.0% *[62.1-96.8]*
mPFS, months	1L: NR **2L+: 6.9 *[4.1-NR]***	**6.9** ***[4.1-NR]***	Not reached
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 pretreated patients with advanced hepatocellular carcinoma. [3] Ye D, et al. Fruquintinib plus sintilimab in patients with advanced renal cell carcinoma: results from a phase II clinical trial.

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: initiated Phase III in Sep 2021
- 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

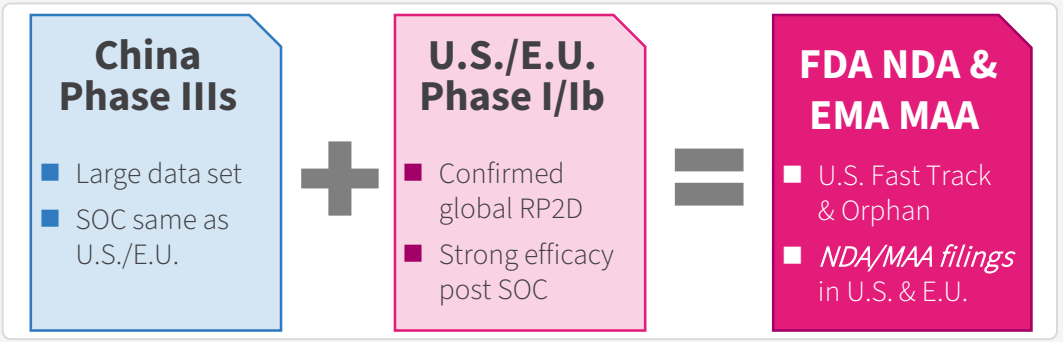
- Fast Track Designations for both pNET & non-pNET
- Orphan Drug designation granted for pNET
- PDUFA date April 30, 2022

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



Surufatinib: Promising PD-1 combos

Initiated SURTORI-01 – first Phase III in China in ≥2L NEC with Junshi; additional registration studies under discussion

Surufatinib PD-1 Studies Summary

PD-1	Patient focus		Status/ plan
TUOYI®	NEC (CSCO 2021)	CN	First Phase III initiated in ≥2L NEC
TUOYI®	Biliary tract	CN	
TUOYI®	Gastric (ASCO 2021)	CN	
TUOYI®	Thyroid	CN	
TUOYI®	Small cell lung	CN	
TUOYI®	Soft tissue sarcoma	CN	Additional reg. studies under discussion
TUOYI®	Endometrial	CN	
TUOYI®	Esophageal	CN	
TUOYI®	NSCLC	CN	
TYVYT®	Solid tumors	CN	Phase I dose escalation completed
Tisle-lizumab	Solid tumors	US EU	Phase I/Ib ongoing Total N~110

ABSTRACT	Surufatinib + toripalimab [1] (CSCO 2021)	Surufatinib + toripalimab [2] (ASCO 2021)	Lenvatinib + pembrolizumab [3]
Indication	Neuroendocrine Carcinoma (2L)	Gastric or GEJ (2L)	Gastric or GEJ (2L)
Efficacy evaluable	21	15	26
Duration of tx, mo. [DCO]	4.9 [Jul 30, 2021]	3 [Dec 31, 2020]	7 [Apr 10, 2020]
ORR	Confirmed: 23.8% [8.2 – 47.2]	Confirmed: 13.3% [1.7 – 40.5]	11.5%
DCR	71% [47.8 – 88.7]	73% [44.9 – 92.2]	58%
mPFS, mo.	4.1 [1.5 – 5.5]	3.7 [1.41 – NR]	2.5 [1.8-4.2]
mOS, mo.	10.3 [9.1 – NR]	Not mature at DCO	5.9 [2.6-8.7]

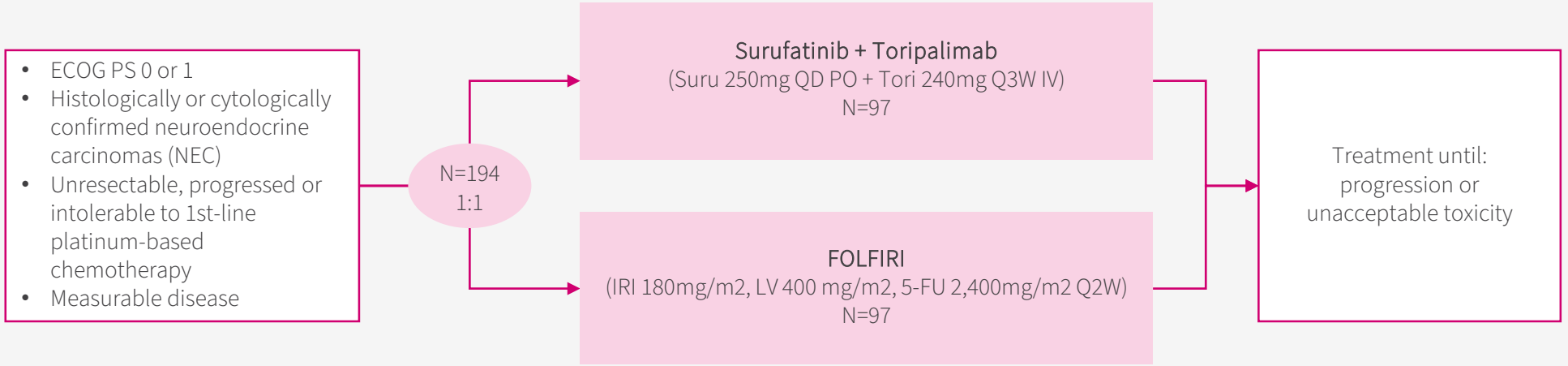
Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.
[1] Shen L, et al. A phase II study of surufatinib in combination with toripalimab in patients with advanced neuroendocrine carcinoma: an updated analysis. 24th Annual Meeting of the Chinese Society 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).

SURTORI-01 Phase III Study — FPI in Sep 2021

Surufatinib plus Toripalimab (PD-1) in **≥ 2L NEC** in China

Population	Patients with advanced neuroendocrine carcinoma (NEC) who have progression of disease or intolerable toxicity after previous 1L chemotherapy
Key Objectives	Primary endpoint: OS Secondary endpoints: PFS, ORR, DoR, DCR, Safety and tolerability, and HRQoL

Study Design



Next wave of innovation

Hematological malignancies assets – internally developed

HMPL-523

- China Ph.Ib dose expansions underway;
- U.S. & E.U. Ph.I dose esc. complete;
- Ph.II/III reg. study in ITP and Ph.II study in AIHA being planned.

HMPL-306

- Addresses mutant IDH switching, from IDH1 to IDH2 or vice versa, a resistance mechanism;
- Dose escalation ongoing.

HMPL-760

- U.S. IND cleared.

HMPL-295

- 10th in-house discovered asset (ERK, MAPK pathway);
- Ph.I started July 2021.

HMPL-453

- Ph.II initiated in IHCC in China;
- Combos study IND filed; initiate study in early 2022.

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

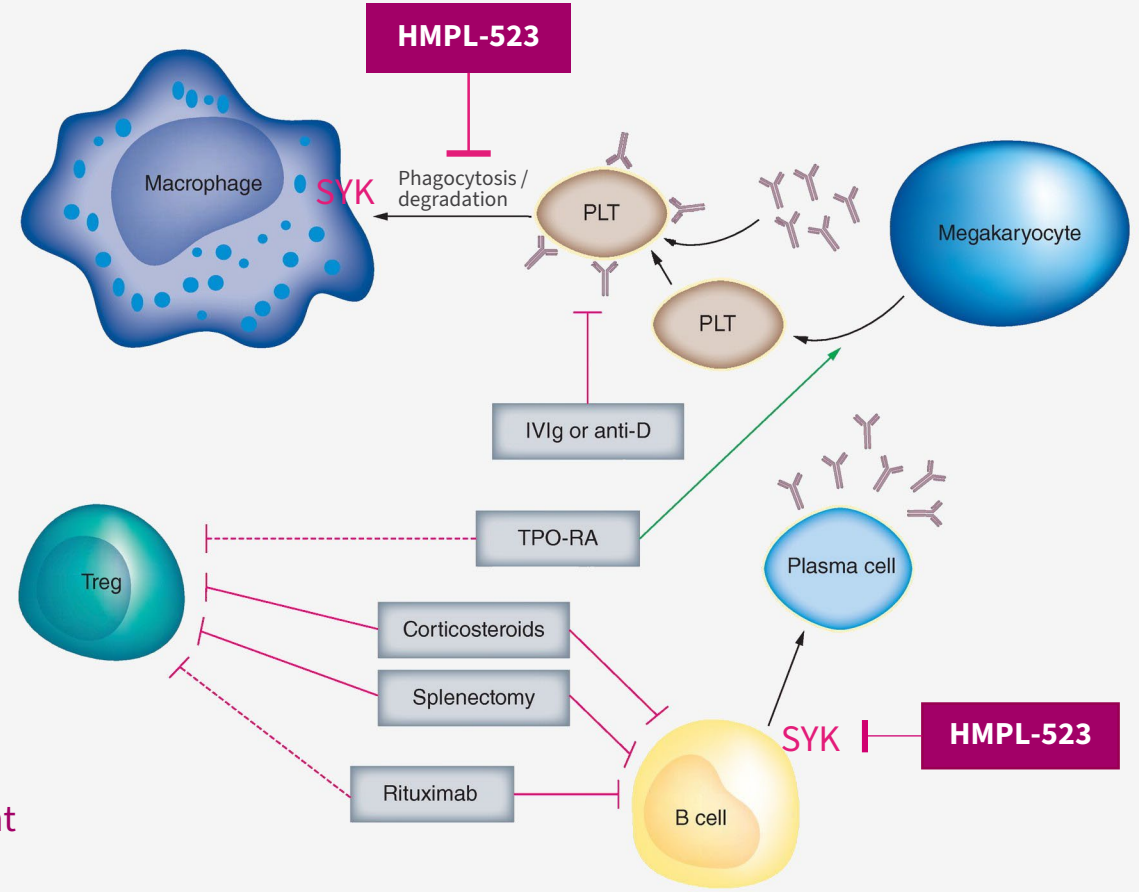
*In planning

Global China

ITP Background[1]

An autoimmune disease where platelets are prematurely destroyed by B or T cells

- Characterized by low platelet count
- Diagnosis via elimination of other causes for low platelet count
- Epidemiology [2]:
  - Incidence of 3.3/100,000 adults per year
  - Prevalence of 9.5 per 100,000 adults
  - Chronic in ~70% of adult ITP patients
- Initial treatments:
  - Short-term glucocorticoids
  - Intravenous immune globulin (IVIG)
  - Anti-Rho(D) immunoglobulin (Anti-D)
- Treatments approaches for chronic management
  - Thrombopoietin-Receptor Agonists (TPO-RA) increases platelet production
  - Immunomodulatory agents to decrease platelet destruction



Adapted from Newland A, et al. Immunotherapy (2018) 10(1), 9–25

[1] Cooper N, Ghanima W. Immune Thrombocytopenia. *N Engl J Med*. 2019;381(10):945-955. doi:10.1056/NEJMcp1810479; [2] Lambert MP, Gernsheimer TB. Clinical updates in adult immune thrombocytopenia. Blood. 2017;129(21):2829-2835. doi:10.1182/blood-2017-03-754119.

Treatment landscape for chronic ITP

SYK inhibitor fostamatinib delivers 44% response and ~25% durable response: requires a better molecule

Treatments for chronic ITP [1]

Agent	Response (1x PLT ≥50×10^9/L)	Durable response	Response after discontin-uation
TPO-RA treatment increases platelet production			
NPLATE® (romiplostim) [2]	79-88% (24 weeks)	38-61% (6/8 visits in weeks 16-24)	14% sustained response ≥ 6 months after discont.
PROMACTA® (eltrombopag)	59-70% (6 weeks) [3]	60% (6/8 visits in weeks 18-26) [4]	~50% of pts maintained response
Treatments to decrease platelet destruction			
RITUXAN® (rituximab)	67% (4 weeks)	Median response duration 27-36 months	
TAVALISSE® (fostamatinib)[5]	**44%** (12 weeks)	**24-26%** (4/6 visits in weeks 14-24)	**n/a**

ASH 2019 guidelines for 2L treatment [6]: shared decision making with patients

Patient preference	Durable response	Avoidance of long-term medication	Avoidance of surgery
TPO-RA	✓		✓
Rituximab		✓	✓
Splenectomy	✓	✓	

SYK is a validated target for ITP

- Syk targets both B cells & macrophages
- Fostamatinib approved in the U.S.
- International consensus report considers evidence for fostamatinib use to be robust [1]
- ASH guideline considers evidence for fostamatinib use in 2L patients insufficient [2]

HMPL-523 Phase III FPI in Oct 2021

- China Phase Ib complete – encouraging efficacy and good safety presented at ASH 2021

[1] Provan D, Arnold DM, Bussel JB, et al. Updated international consensus report on the investigation and management of primary immune thrombocytopenia. *Blood Adv*. 2019;3(22):3780-3817. doi:10.1182/bloodadvances.2019000812; [2] Study 1 & 2 from USPI; [3] Study 773A and B from US PI; [4] RAISE study from US PI; [5] US PI; [6] Neunert C, Terrell DR, Arnold DM, et al. American Society of Hematology 2019 guidelines for immune thrombocytopenia [published correction appears in Blood Adv. 2020 Jan 28;4(2):252]. *Blood Adv*. 2019;3(23):3829-3866. doi:10.1182/bloodadvances.2019000966 .

HMPL-523 in ITP

Phase Ib results – 80% response, 40% durable response – supported initiation of Phase III in China

Compelling Efficacy at RP2D of 300mg QD

ASH 2021

Response	Dose escalation					
	300mg*	Placebo	100mg	200mg	300mg	400mg
Overall response	80% (16/20)	9% (1/11)	50% (3/6)	33% (2/6)	69% (11/16)	33% (2/6)
Durable response	40% (8/20)	9% (1/11)	0	0	31% (5/16)	0

Prior TPO/TPO-RA exposure of responders at 300mg QD

	Overall response	Durable response
TPO/TPO-RA naïve (n=5)	80%	40%
TPO/TPO-RA treated (n=15)	80%	40%
Only TPO (n=3)	100%	67%
Only TPO-RA (n=7)	71%	43%
TPO & TPO-RA (n=5)	80%	20%

Overall response = At least once PLT ≥50×10^9/L over treatment period
Durable response = PLT ≥50×10^9/L in minimal 4 of 6 last scheduled visits
DCO: Sept 30, 2021

Safety profile**: Well-Tolerated at All Dose Levels

No patients discontinued due to treatment related adverse events

300mg median treatment duration 167.5 days (23-170); 142 days (23-170) for all patients

Events ≥ 10% ; N (%)	300mg QD	100-400mg QD
Any TRAE	18 (90%)	30 (73%)
ALT increase	7 (35%)	11 (27%)
AST increase	7 (35%)	11 (27%)
LDH increase	5 (25%)	9 (22%)
Total bile acid increase	5 (25%)	7 (17%)
Amylase increase	3 (15%)	5 (12%)
Neutrophil count decrease	2 (10%)	5 (12%)
WBC count decrease	2 (10%)	5 (12%)***
Bilirubin increase	2 (10%)	3 (7%)
GGT increase	2 (10%)	3 (7%)***
Asthenia	2 (10%)	3 (7%)
Hyperlipidemia	2 (10%)	2 (5%)
Hypertension	2 (10%)***	2 (5%)***

*The 300mg QD cohort includes 4 patients who, after receiving placebo in the first 8 weeks of double blind treatment, received HMPL-523 300mg QD in a 16-week open-label treatment period.
**Includes patients who crossed over from placebo. ***Include 1 case at Grade 3

ASH 2021 #16. Yang H, Zhou Y, Hu JY, et al. Safety, Pharmacokinetics and Preliminary Efficacy of HMPL-523 in Adult Patients with Primary Immune Thrombocytopenia: A Randomized, Double-Blind and Placebo-Controlled Phase 1b Study. *Blood* 2021; 138 (Supplement 1): 16. doi: https://doi.org/10.1182/blood-2021-149895

ESLIM-01 Study for ITP — FPI in Oct 2021

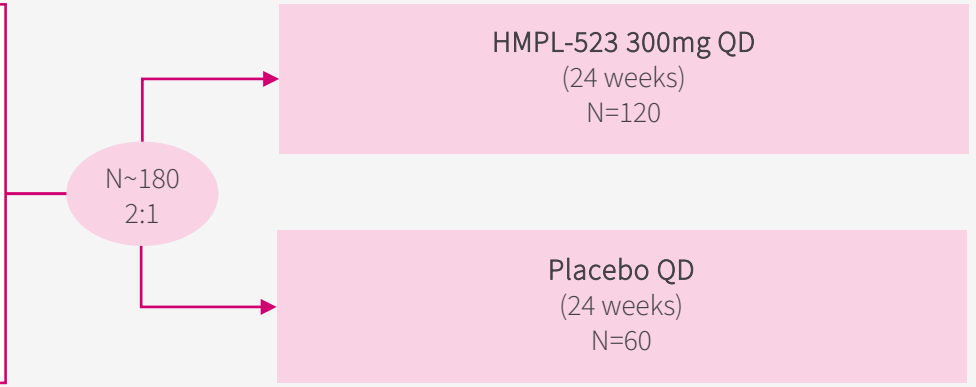
HUTCHMED

HMPL-523 in patients with **Immune Thrombocytopenia (ITP)** in China

Population	Adult patients with immune thrombocytopenia (ITP)
Key Objectives	Primary endpoint: Durable Response Rate Secondary endpoints: Overall response rate, incidence of TEAE , and QoL improvement

Study Design

- ECOG PS score of 0~1;
- Having been diagnosed as ITP prior to randomization, and duration of disease is more than 6 months;
- Intolerance or insufficient response, or recurrence after at least one anti-ITP standard drug therapy;
- A history of response to previous ITP therapy;



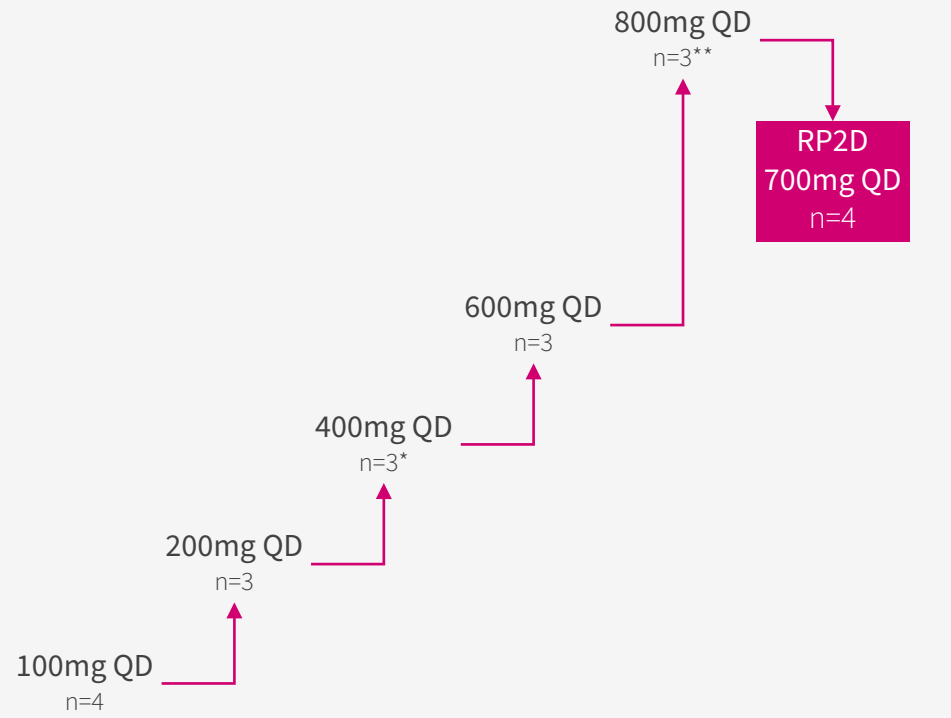
HMPL-523 progressing in r/r lymphoma

International dose expansion ongoing at 700mg QD

Overview of dose escalation study

ASH 2021

Primary endpoint: safety & tolerability
Secondary endpoint: PK profile, efficacy



Target population:
Patients with relapsed/refractory lymphomas

AEs leading to treatment discontinuation occurred in 2 patients (9.5%)

Treatment-Related Adverse Events
Safety evaluable patients: 21

N (%)	All	Grade ≥3
Any	17 (81%)	7 (33%)
Neutropenia	4 (19%)	2 (14%)
Infections	2 (10%)	1 (5%)
ALT increase	4 (19%)	1 (5%)
AST increase	5 (24%)	0
Hyponatremia	2 (10%)	1 (5%)
Anemia	2 (10%)	1 (5%)
Nausea	4 (19%)	0
Thrombocytopenia	1 (5%)	0

Summary of responses (16 efficacy evaluable patients***)

	No. of pts	Indications / Dosage
Complete response	2	FL / 600mg QD HL / 800mg → 600mg QD
Partial response	2	FL / 400mg → 600mg QD MZL / 700mg
Stable disease	4	

DCO: August 25, 2021

*1 up-titrated to 600mg; **2 down-titrated to 600mg; ***received at least 2 cycles of therapy and had at least one follow-up scan.

ASH 2021, poster #2432. Strati P, Chraniuk D, González-Barca E, et al. Preliminary Results from a Phase I Study of HMPL-523, a Selective Oral Syk Inhibitor, in Patients with Relapsed or Refractory Lymphoma. Blood 2021; 138 (Supplement 1): 2432. doi: https://doi.org/10.1182/blood-2021-145641

Strategic Collaboration with Epizyme

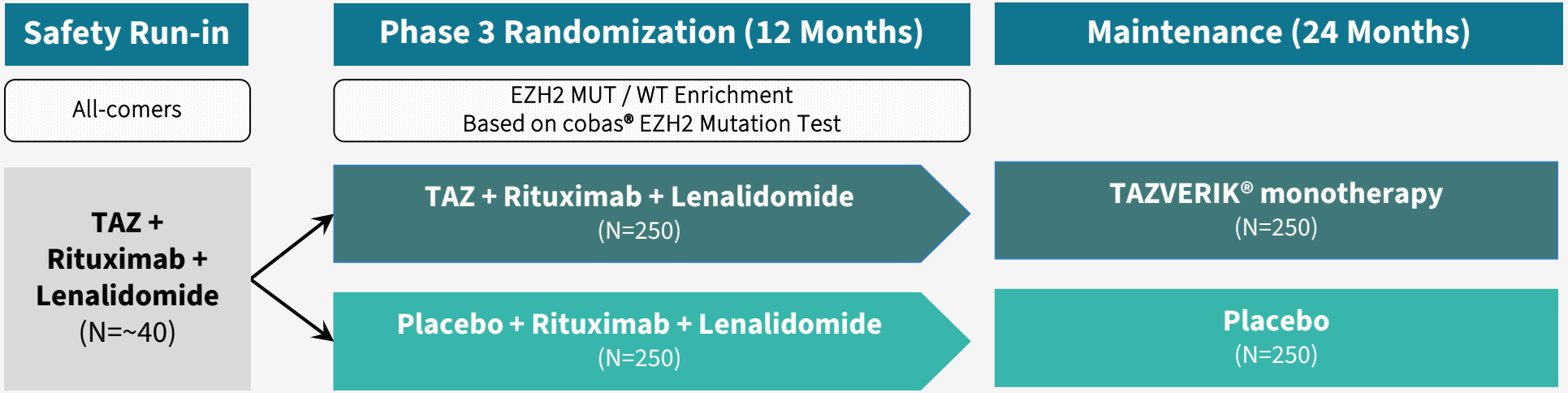
Key financial terms

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 million • Across 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 • *Term:* 4 years • *Amount:* up to US$65m • *Exercise price:* $11.50 per share

SYMPHONY-1 study for 2L+ FL

Induction with rituximab + lenalidomide (R^2) + TAZVERIK®, followed by TAZVERIK® alone

Population	Patients with relapsed / rituximab refractory FL who have been treated with at least one prior systemic therapy
Key Objectives	☑ Phase 1b (safety run-in) Safety, PK, anti-tumor activity Phase 3 (efficacy) Primary: PFS as determined by Investigator; interim analyses for futility Secondary: PFS by IRC, response rate, duration of response, OS, QOL, safety



Stratification for randomized portion by EZH2 mutation status: treatment sensitive vs. refractory to prior rituximab containing regimen, patients treated with 1 prior vs ≥ 2 prior systemic therapies.

RITUXAN® = rituximab; REVLIMID® = lenalidomide; R^2 = RITUXAN® + REVLIMID®.
Source: Epizyme.

SYMPHONY-1: encouraging safety run-in results for TAZVERIK® + R²

HUTCHMED

ASH 2021

Preliminary efficacy [1]

Median duration of tazmetostat treatment was 20 weeks
35/40 were efficacy evaluable*

Best Overall Response[a], n (%)	TAZ + R² (n=35)
Objective response rate	91.4%
Complete response[b]	37.1%
Partial response	54.3%
Stable disease	8.6%
Progressive disease	0

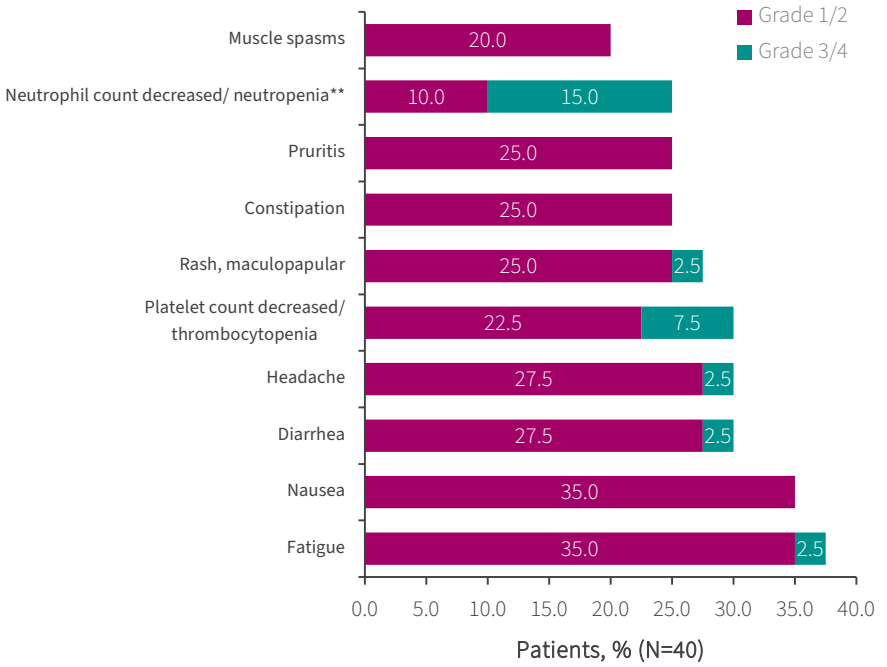
[a] For BOR, there were 27 PET-CT–based responses and 8 CT-based responses.
[b] For CR, 12 were PET-CT–based responses and 1 was a CT-based response.
R², lenalidomide + rituximab; TAZ, tazemetostat.

Tumor response of R² in follicular lymphoma [2]

Study	AUGMENT		MAGNIFY
Treatment	R²	rituximab mono	R²
No. of FL pts	147	148	177
ORR, % [95% CI]	80% [73-86%]	55% [47-64%]	59% [51-66%]

Treatment-Emergent Adverse Events Occurring in ≥20% of Patients in the Safety Population (40 pts) [1]

- No clear dose response for TEAE or dose modifications
- Neutropenia in 22% and 28% of patients in the 600 mg and 800 mg groups, respectively
- Thrombocytopenia in 39% and 22% of patients in the 600 mg and 800 mg groups, respectively

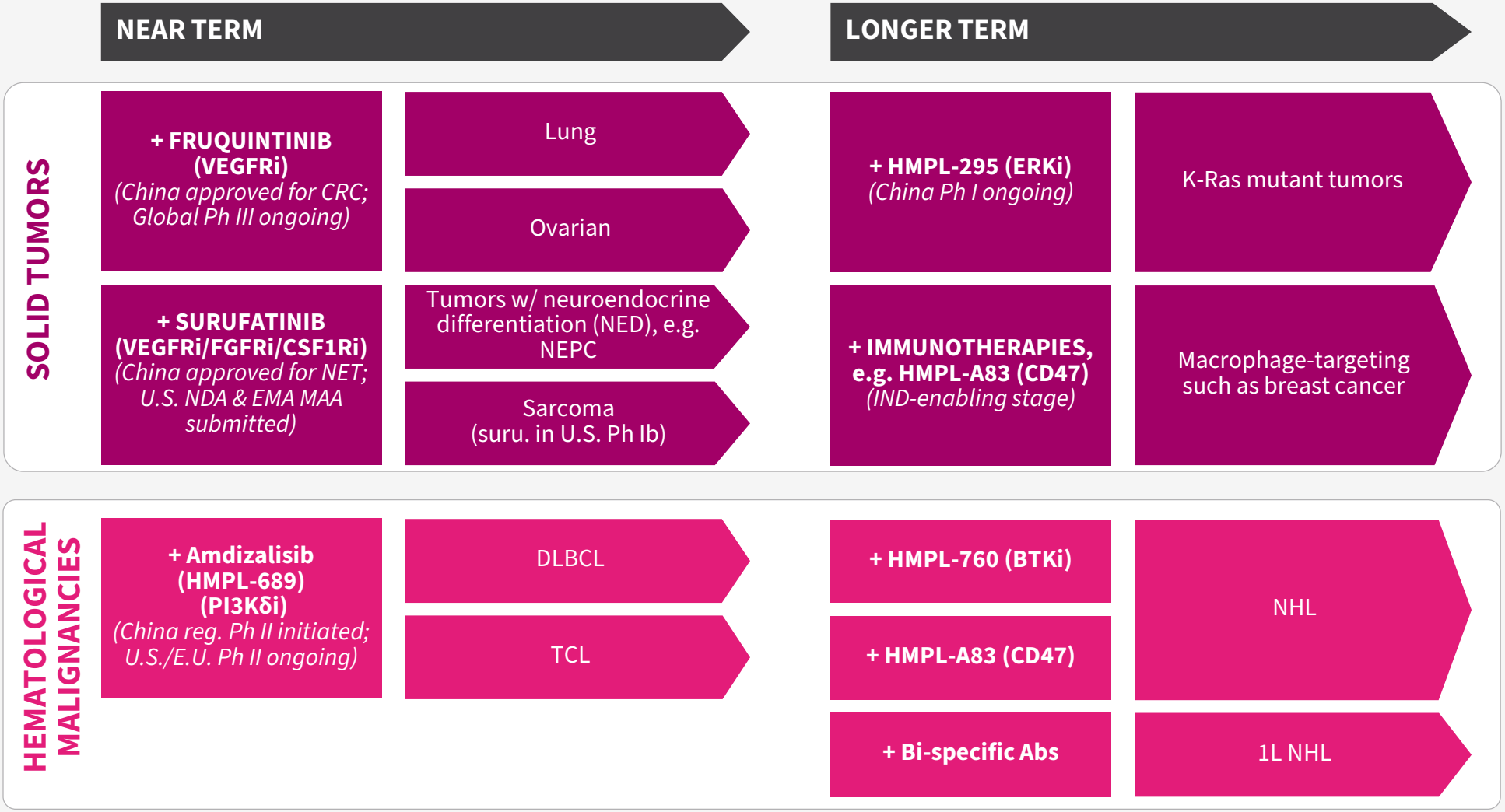


DCO: September 29, 2021
*3/5 non evaluable patients were receiving treatment and had not had first efficacy evaluation.
**Growth factor support was only administered upon incidence of neutropenia and not given until after patients developed neutropenia.
[1] ASH 2021 poster 2207; [2] US PI.

Combination potential of TAZVERIK® with HUTCHMED assets

HUTCHMED

TAZVERIK™ (tazemetostat) tablets



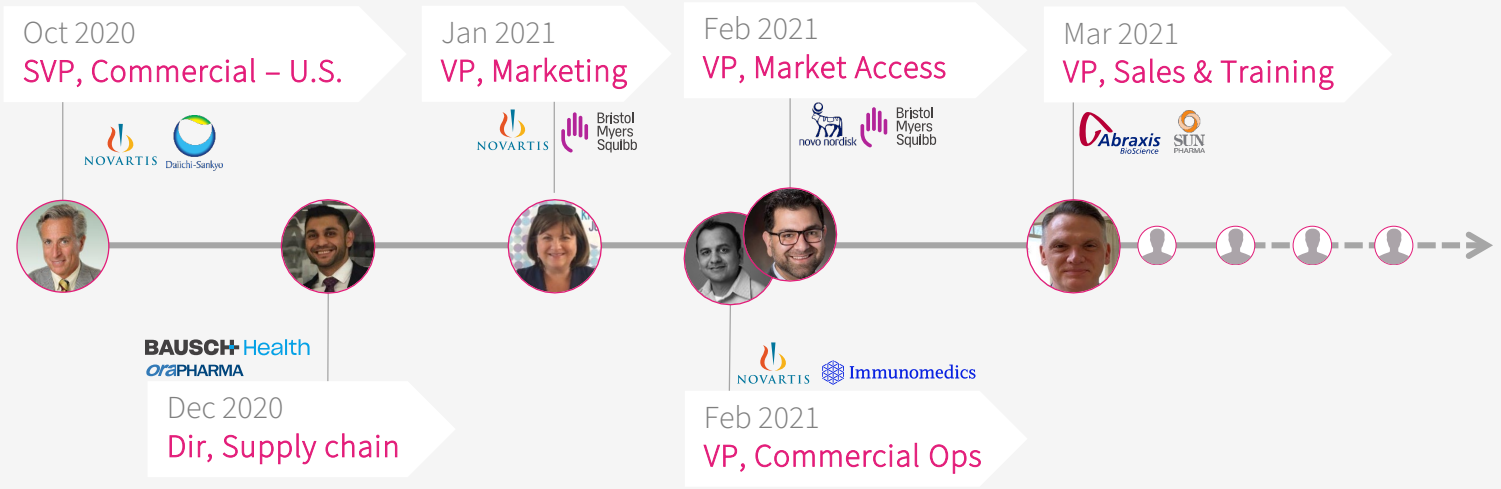
Source: Epizyme.

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

HUTCHMED

Oncology team

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

Shanghai Hutchison Pharmaceuticals

Nationwide distribution & promotion

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

Hutchison Sinopharm Pharmaceuticals

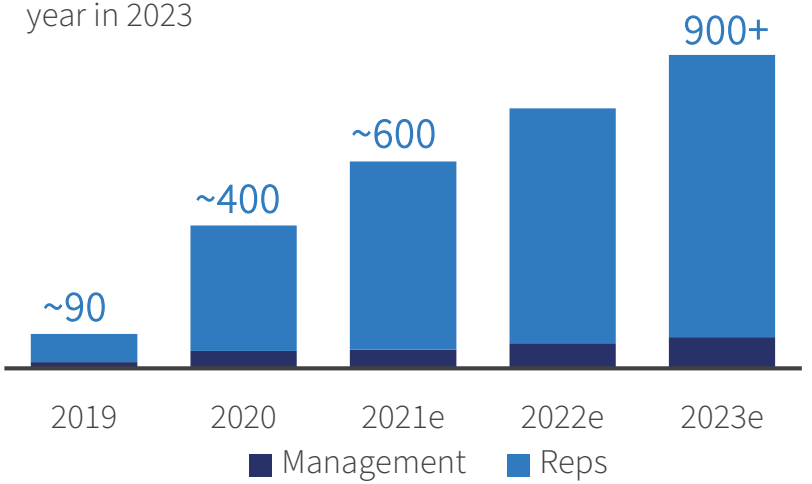
Third-party distribution & logistics

- ✓ Nationwide support from Sinopharm in distribution/logistics
- ✓ Deep Shanghai 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



Oncology commercial team size at year end

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 factory to support production for China and global post 2025

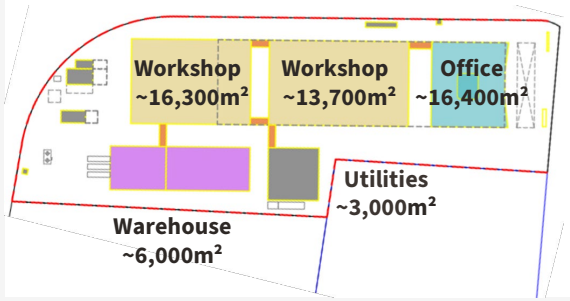
SUZHOU FACTORY

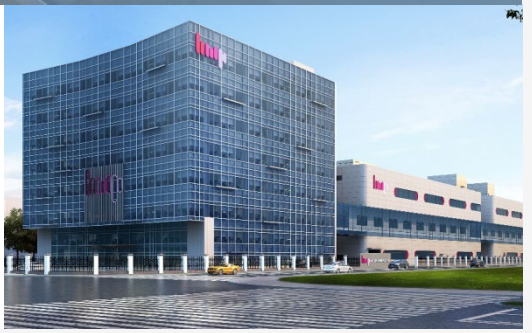
- Built to produce ELUNATE® and SULANDA®
- Manufacturing talent developed
- Suzhou is designed to U.S. GMP standards

SHANGHAI FACTORY

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

Key Aspects	Suzhou Factory	New Shanghai Factory
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	Mid '21	Late '21	2022
Surufatinib *(VEGFR 1/2/3; FGFR1; & CSF-1R inhibitor)*	**NETs mono.**	**NDA**	**U.S. NDA submission**	✓			
	Solid tumors	Ph. Ib/IIs	Tislelizumab PD-1 combo start	✓			
	NETs mono.	MAA	E.U. MAA submission**		✓		
	NETs mono.	**Market**	**U.S. NDA & E.U. MAA approval and launch**				⊛
Fruquintinib *(VEGFR 1/2/3 inhibitor)*	TNBC / EMC PD-1 combo	Ph. Ib/IIs	Tislelizumab PD-1 combo start			✓	
	CRC mono	Ph. III	FRESCO-2: Recruitment completion			✓	
	CRC mono	Ph. Ib	Data at a scientific conference*				○
	CRC mono	**Ph. III**	**FRESCO-2: Readout & NDA subm.*** **				⊛
Savolitinib *(MET inhibitor)*	**PRCC PD-L1 combo**	**Ph. II**	**CALYPSO: IMFINZI® combo data (ASCO)**	✓			
	PRCC PD-L1 combo	**Ph. III**	**SAMETA: IMFINZI® combo start**			✓	
	EGFR-TKI refract., MET+ NSCLC	**Ph. III**	**EGFR combo (TAGRISSO®) start****				⊛
Amdizalisib *(PI3Kδ inhibitor)*	Hematological malignancies	Ph. Ib	Expansion start***			✓	
HMPL-523 *(Syk inhibitor)*	Hematological malignancies	Ph. Ib	Expansion start***				○
		Ph. Ib	Escalation data at scientific conf.			✓	
HMPL-306 *(IDH1/2 inhibitor)*	Hematological malignancies & solid tumors	Ph. I	Start	✓			
		Ph. I	Complete dose escalation and start expansion				○
HMPL-760 *(3G BTK inhibitor)*	Hematological malignancies	Ph. I	Start**				○
New assets	–	–	IND filings***				○

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

* 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, 2020	Jun 30, 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, 2020	6 Mths Ended Jun 30, 2020	2021
Revenues:		*(unaudited)*	
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)

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)

HUTCHMED 2025

Ambitious targets with potential for transformation

	Therapies launched	*Additional therapies in registration studies*
	5 *Suru mono* *Fruq mono* *Savo + TAGRISSO®* *Savo + IMFINZI®* *Amdizalisib (PI3Kδ)*	**+6** *Suru + PD-1 combo* *Fruq + PD-1 combo* *HMPL-523* *Amdizalisib combo* *HMPL-306 (IDH1/2)* *HMPL-760 (3G BTK)*
	9 *Suru mono* ✓ *Suru + PD-1 combo* *Fruq mono* ✓ *Fruq + PD-1 combo* *Savo mono* ✓ *Savo + TAGRISSO®* *Savo + IMFINZI®* *Amdizalisib* *HMPL-523 (Syk)*	**+9** *HMPL-453 (FGFR)* *Amdizalisib multiple combos* *HMPL-306* *HMPL-295 (ERK)* *HMPL-760* *HMPL-653 (CSF-1R)* *HMPL-A83 (CD47)*

Thank you

HUTCHMED

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HUTCHMED

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 DOT [4]
	China	U.S.	EU5	Japan	Total	
Colorectal *MET+ EGFR ref.*	4	3	3	1	11	**TBD**
Esophageal *MET Gene Ampl.*	16	1	1	1	20	**TBD**
Gastric *MET Gene Ampl.*	24	1	3	7	35	**8.0 mo.** *VIKTORY Ph.II*
PRCC *MET positive*	4	4	4	1	14	**7.0 mo.** *SAVOIR Ph.III*
NSCLC *MET+ EGFR TKI refractory (3rd gen.)*	21[5]	7	4	7	40	**5.4 mo.** *TATTON Ph.II*
NSCLC *MET+ EGFR TKI refractory (1st/2nd gen.)*	12	3	2	3	20	**9.0 mo.** *TATTON Ph.II*
NSCLC *MET Gene 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**	

Approved

Registration Studies started / in planning for 2021

Savo FIC & only treatment alternative

[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 DOT [4]
	China	U.S.	EU5	Japan	Total	
EMC,TNBC, RCC, HCC, NSCLC *2nd Line (+ PD-1 mAb)*	TBD	TBD	TBD	TBD	**TBD**	**TBD**
Colorectal *2nd Line (+ PD-1 mAb)*	165	47	72	44	**328**	**TBD**
Gastric *2nd 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

Registration Studies / NDA submissions underway

Proof-of-concept studies underway

[1] Globocan; [2] SEER; [3] Company estimates;
[4] DOT = duration of treatment in latest study

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 DOT [4]
	China	U.S.	EU5	Japan	Total	
Esophageal, Biliary Tract, SCLC, Gastric, Sarcoma, Thyroid, EMC, NSCLC *2nd Line (+ PD-1 mAb)*	TBD	TBD	TBD	TBD	**TBD**	**TBD**
NET / NEC *G3 2nd Line (+ PD-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**	

Approved

Registration Studies / NDA submissions underway

Proof-of-concept studies underway

[1] Globocan; [2] SEER; [3] Company estimates;
[4] DOT = duration of treatment in latest study

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]					Median DOT [4]
	China	U.S.	EU5	Japan	Total	
iNHL: Diffuse Large B-cell Lymphoma *2nd Line*	11	9	8	4	32	**TBD**
iNHL: Mantle Cell Lymphoma *3rd Line*	3	3	3	1	10	**TBD**
iNHL: Marginal Zone Lymphoma *3rd Line*	5	4	4	2	15	**TBD**
iNHL: Follicular Lymphoma *3rd Line*	11	9	9	4	33	**TBD**
	30	**25**	**23**	**11**	**90**	

Registration Studies underway

Registration studies in planning

Proof-of-concept studies underway

[1] Globocan; [2] SEER; [3] Company estimates;
[4] DOT = duration of treatment in latest study

HMPL-523 market potential

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

	Est. Annual Incidence ('000) [1, 2, 3]					Median DOT [4]
	China	U.S.	EU5	Japan	Total	
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**	

Registration studies in planning

Proof-of-concept studies underway

[1] Globocan; [2] SEER; [3] Company estimates;
[4] DOT = duration of treatment in latest study
[5] Immune Thrombocytopenic Purpura (prevalence of immune disorder)

A2

HUTCHMED STRATEGY

World class discovery engine

Most prolific & validated in China biotech

HUTCHMED

1 WORLD-CLASS DISCOVERY & DEVELOPMENT CAPABILITY

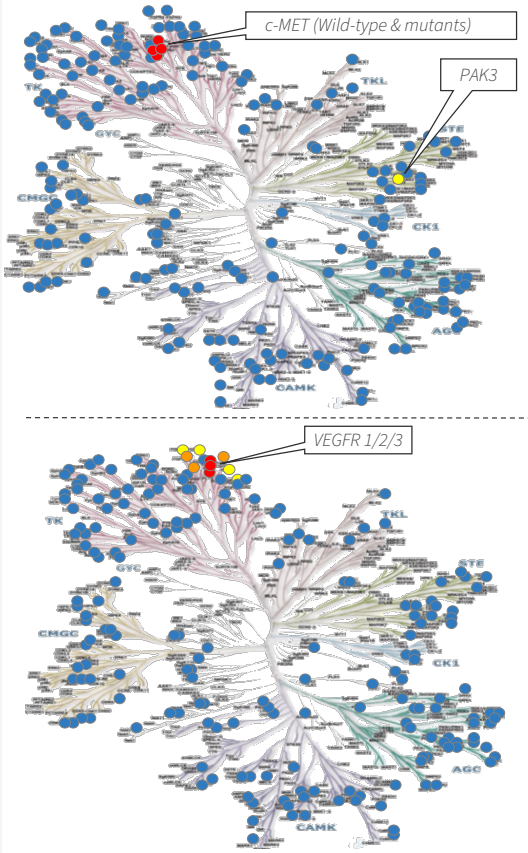
Focus on Global Quality Innovation Proven & Validated at All Levels

- *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
- *2* validating collaborations

AstraZeneca
Savolitinib
2011 Global deal

Lilly
Fruquintinib
2013 China deal

HUTCHMED's Advanced Chemistry Approach Provides Superior Selectivity Profiles



Orpathys®

~1,000 times

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

ELUNATE®
Fruquintinib Capsules

~250 times

more selective to VEGFR3 than next non-VEGFR kinase (Ret) [2]

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

Established global C&R infrastructure

Track record of breakthroughs

HUTCHMED

1 WORLD-CLASS DISCOVERY & DEVELOPMENT CAPABILITY

2 HIGHLY DIFFERENTIATED NME PORTFOLIO AND GLOBAL PIPELINE

- **Integrated development team**
  240+ C&R & 260+ CMC staff located in Shanghai, Suzhou & Florham Park, NJ
- **Broad bandwidth & capacity** of R&D team enables smooth coordination of **trials globally & in China**

- **Important working relationships with China & global regulators** – potentially multiple new global registration studies in 2021

- **4 NDAs approved on 3 lead assets so far**

Fruquintinib (ELUNATE® in China)

ELUNATE® Fruquintinib Capsules

- 1st China-discovered & developed, unconditionally approved cancer therapy
- Global Ph.III started mid-2020, >150 sites in U.S., E.U. & JP
- Ideal combo candidate with limited off-target activity

Savolitinib (ORPATHYS® global brand)

Orpathys®

- China NDA – 1st NDA approved globally & China first-in-class
- Global partnership with AZ – China clinicals by HUTCHMED
- Multiple global indications – potentially 5 reg. studies 2021

Surufatinib (SULANDA® in China)

SULANDA® SURUFATINIB CAPSULE

- 2 China NDAs – unpartnered
- U.S. NDA & E.U. MAA submitted using China Ph.IIIs & U.S. Ph.Ib/II data
- Dual-MoA – anti-angiogenesis and immuno-oncology

6 assets in global development

HUTCHMED

2 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 MET	**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 + IMFINZI® (PD-L1)	Papillary RCC *	All	CALYPSO	UK/Spain	**Powles – Queen Mary's**		
	Savolitinib + IMFINZI® (PD-L1)	Clear cell RCC *	VEGFR TKI refractory	CALYPSO	UK/Spain	**Powles – Queen Mary's**		
	Savolitinib	Gastric cancer *	MET+	VIKTORY	S Korea	**Lee – Samsung Med. Ctr**		
	Savolitinib	Colorectal cancer *	MET+		US	**Strickler – Duke Uni**		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	NET	Refractory		US	**Dasari/Yao – MD Anderson**		
	Surufatinib	NET	Refractory		EU	**Garcia-Carbonero – UCM**		
	Suru. + tislelizumab (PD-1)	Solid tumors			US/EU			
Fruquintinib VEGFR 1/2/3	**Fruquintinib**	Colorectal cancer	Refractory	FRESCO-2	US/EU/JP	**Eng/Desari – MD And.** [1]		
	Fruquintinib	Breast cancer			US	**Tripathy – MD And.**		
	Fruq. + tislelizumab (PD-1)	TNBC & EMC			US			
	Fruq. + tislelizumab (PD-1)	Solid tumors			TBD	In planning - *IND cleared*		
Amdizalisib (HMPL-689) PI3Kδ	**Amdizalisib**	Healthy volunteers			Australia			
	Amdizalisib	Indolent NHL			US/EU	**Zinzani – U of Bologna**		
HMPL-523 Syk	**HMPL-523**	Indolent NHL			Australia			
	HMPL-523	Indolent NHL			US/EU	**Strati/Abrisqueta – MD And. / Vall d'Hebron**		
HMPL-306 IDH 1/2	**HMPL-306**	Solid tumors			US/EU			
	HMPL-306	Hem. malignancies			US/EU			
HMPL-760 BTK, 3G	**HMPL-760**	Hem. malignancies			US/EU	In planning - *IND cleared*		

[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

2 HIGHLY DIFFERENTIATED NME PORTFOLIO AND GLOBAL PIPELINE

…8-10 registration studies planned to start in 2021 (excluding TAZVERIK®)

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.		
Surufatinib VEGFR 1/2/3; FGFR1; CSF-1R	**Surufatinib**	Pancreatic NET	All	SANET-p	China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib	Non-Pancreatic NET	All	SANET-ep	China	Xu Jianming – #5 Med. Ctr.		
	Surufatinib	Biliary tract cancer	2L; chemotherapy refractory		China	Xu Jianming – #5 Med. Ctr.		
	Suru. + TUOYI® (PD-1)	NEN, ESCC, BTC			China	Shen Lin - Beijing Cancer Hosp.		
	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 VEGFR 1/2/3	**Fruquintinib**	Colorectal cancer	≥3L; chemotherapy refractory	FRESCO	China	Li Jin – Fudan Univ.		
	Fruq. + TAXOL®	Gastric cancer	2L	FRUTIGA	China	Xu Ruihua – Sun Yat Sen		
	Fruq. + TYVYT® (PD-1)	CRC, EMC, RCC, HCC			China	Guanghai Dai – PLA Gen. (CRC)		
	Fruq. + 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 (HMPL-689) PI3Kδ	**Amdizalisib**	FL, MZL			China	Cao/Zhou – Fudan/ Tongji		
	Amdizalisib	MCL, DLBCL			China	Cao/Zhou – Fudan/ Tongji		
	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			
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

HUTCHMED

4 SEASONED MGMT TEAM & STRONG GOVERNANCE

Global standards – Reputation & transparency

Christian Hogg
Chief Executive Officer
P&G
32/21

Weiguo Su
Chief Scientific Officer
Pfizer
31/16

Johnny Cheng
Chief Financial Officer
Bristol Myers Squibb
Nestlé
KPMG
32/13

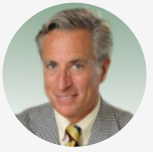
Marek Kania
Managing Director & Chief Medical Officer, International
Lilly
27/3

Karen Atkin
Chief Operating Officer
AstraZeneca
29/1

Junjie Zhou
General Manager, SHPL
SANOFI
30/20

Zhenping Wu
Pharmaceutical Sciences
Roche
Pfizer
27/13

Hong Chen
Chief Commercial Officer, China
Bristol Myers Squibb
NOVARTIS
23/11



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

May Wang
Business Dev. & Strategic Alliances
Lilly
27/11

Mark Lee
Corporate Finance & Development
Credit Suisse
22/12

Charles Nixon
General Counsel
CK HUTCHISON
28/13

Yiling Cui
Government Affairs
SPH
Bristol Myers Squibb
23/2

0 Issues
in governance in
15 years listed on AIM &
5 years on NASDAQ

Nasdaq
HKEX 香港交易所
London Stock Exchange
AIM

Track Record of Successful Partnerships

Across functions verified by our long-term MNC partners

AstraZeneca
Lilly
MERCK

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

HUTCHMED

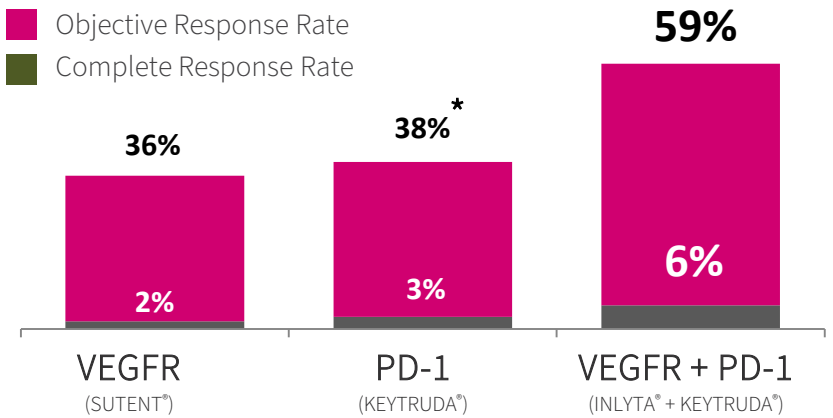
A2a

REALIZING GLOBAL POTENTIAL OF NOVEL ONCOLOGY ASSETS

Immunotherapy combinations

assets potentially ideal TKI combo partners for immunotherapy

1L Clear Cell Renal Cell Carcinoma [1]



Potent two-prong attack – BTD [2]:
Anti-angiogenesis + activated T-cell response

	INLYTA®	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

Multiple global immunotherapy combo deals…

Managed by AstraZeneca

AstraZeneca	
savo + IMFINZI® (PD-L1)	
ccRCC/PRCC/ other solid tumors	

Jointly managed by HUTCHMED & partners

Innovent Biologics	君实生物 JunshiBiosciences	BeiGene
fruquintinib / surufatinib + TYVYT® (PD-1)	surufatinib + TUOYI® (PD-1)	fruquintinib / surufatinib + tislelizumab (PD-1)
Solid tumors	Solid tumors	Solid tumors

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

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

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
Savolitinib c-MET inhibitor		**TAGRISSO ref. MET+ NSCLC** TAGRISSO® combo (TATTON, multi-arm 2L TAGRISSO® or 1st Gen EGFR refractory; & ≥3L TAGRISSO® refractory) **PRCC/ccRCC** [2] IMFINZI® combo (CALYPSO) **MET+ Colorectal cancer** [2]	**TAGRISSO® ref. MET+ NSCLC** TAGRISSO® combo (SAVANNAH) **2L EGFR TKI ref. MET+ NSCLC** TAGRISSO® combo (SACHI) [1] **Naïve MET+ & EGFRm NSCLC** TAGRISSO® combo (SANOVO) **MET+ PRCC** IMFINZI® combo (SAMETA) [1] **MET+ GC** Ph.II Registration-intent	**MET Exon 14 skipping NSCLC** NDA Approved June 2021
Surufatinib **(SULANDA® in China)** VEGFR 1/2/3; FGFR1; & CSF-1R inhibitor	**PD-1 Combo** Tislelizumab – BeiGene **PD-1 Combo** TYVYT® – Innovent Biologics	**TUOYI® PD-1 combo (9 settings)** (NENs, BTC, GC, Thyroid cancer, SCLC, Soft tissue sarcoma, EMC,ESCC & NSCLC) **Soft Tissue Sarcoma & BTC**	**TUOYI® PD-1 combo** SURTORI-01 (NENS) (Additional indications) [1]	**PNET & Non-PNET** U.S. NDA accepted June 2021 E.U. MAA accepted & validated July 2021 **PNET & Non-PNET** China NDA approved Jun 2021 /Dec 2020
Fruquintinib **(ELUNATE® in China)** VEGFR 1/2/3 inhibitor	**PD-1 Combo** Tislelizumab – BeiGene [1]	**TYVYT® PD-1 combo (5 settings)** (CRC, Hepatocellular carcinoma, Endometrial cancer, RCC & GI tumors) **Genor PD-1 combo (2 settings)** (CRC & NSCLC) **TN & HR+/Her2- Breast cancer**	**≥3L Colorectal cancer** (FRESCO-2) **TYVYT® PD-1 combo** (1-2 indications) [1] **2L Gastric cancer** TAXOL® combo (FRUTIGA)	**≥3L Colorectal cancer** NDA Approved Sept 2018
Amdizalisib PI3Kδ 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 initiated trials (IITs).
Note: TKI = Tyrosine kinase inhibitor; NDA = New drug application; NSCLC = Non-small cell lung cancer; GC = Gastric cancer; RCC = Renal cell carcinoma; NET = Neuroendocrine tumor; BTC = Biliary tract cancer; EMC = Endometrial cancer; ESCC = Esophageal squamous cell carcinoma; SCLC = Small cell lung cancer; CRC = Colorectal cancer; GI = Gastrointestinal; TN = Triple negative.

Global | China | IN TRANSITION

Deep NME early pipeline

HUTCHMED

Multiple further waves of innovation progressing

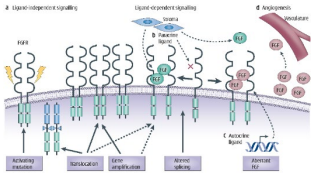
	IND preparation	Dose Finding/ Safety Run-In	Proof-of Concept	Registration Intent
HMPL-523 Syk inhibitor		**iNHL** (CBCL, CLL, FL, MCL, MZL, PTCL, WM/LPL)	**6 iNHL settings** (CLL/SLL, aggressive NHL, MCL, FL, MZL, WM)	
		AIHA (in planning)		**ITP** – Ph.III [1]
HMPL-453 FGFR 1/2/3/ inhibitor	**I/O, chemo combo**		**IHCC**	
HMPL-306 IDH1/2 inhibitor		**2x Hematology & Solid Tumors**		
		AML		
HMPL-295 ERK inhibitor		**Solid tumors**		
HMPL-760 3G BTK inhibitor	**Hematology** (IND filed)	**Hematology** (in planning)		
Oncology discovery	*2 new candidates in IND-enabling toxicology studies,* HMPL-653 (solid tumors) and HMPL-A83 (mAb – solid tumors, hem. malignancies)			
Immunology discovery	*4 new candidates in preclinical – INMAGENE collaboration*			

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

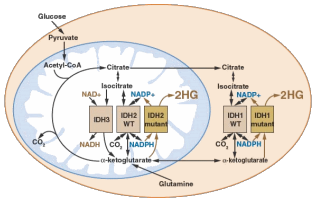
HMPL-453 (FGFR1/2/3)

- 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



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



HMPL-295 (ERK)

- First candidate in MAPK pathway, more to come from HUTCHMED
- Dose escalation enrolling in China

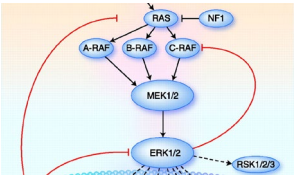


Image sources:
FGFR: Turner N et al. Nat Rev Cancer 2010;10(2):116-129. IDH: Ward PS et al. Cancer Cell 2010; 17: 225-234. ERK: Pratilas C & Solit DB. Clin Cancer Res. 2010; 16: 3329-34.

New candidates' INDs submitted/planned for '21

HUTCHMED

HMPL-760 (3rd gen BTK)	• Reversible, non-covalent, potent against both wild type & **C481S mutant** enzymes • Improved potency in *in vivo* models vs. ibrutinib and ARQ-531 • Potential for combinations with amdizalisib (HMPL-689) (PI3Kδ), HMPL-A83 (CD47) • IND submitted mid-2021 in both China and U.S.; targeting FPI in late 2021 or early 2022
HMPL-653 (CSF-1R)	• Potent and selective CSF-1R inhibitor • Targeting CSF-1R driven tumors (TGCT, Histiocytic, AML) and possibly in adjuvant setting in solid tumors • IND submission Q3 2021 in China
HMPL-A83 (CD47)	• CD47 mAb with unique epitope and high affinity, highly efficacious in animal tumor models • Much reduced effect on RBC • Potential for combinations with amdizalisib (HMPL-689)(PI3Kδ), HMPL-760 (BTK) • IND submission YE 2021 in China and U.S.

Discovery Project Overview

HUTCHMED

01	02	03
Small molecules	**Large molecules**	**New technology**
Six ongoing projects	Multiple mAb and bsAb projects ongoing	Initiating
Apoptosis Cell signaling Epigenetics Protein translation	CD47-based antibody platform	PROTAC Antibody-Drug Conjugate

HUTCHMED

A2b

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]

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

- *Regulatory reforms in China – addressing low SoC* [2]
- *Access to capital*

HUTCHMED innovation

- *Three approved innovative medicines, including ELUNATE® in 3L mCRC; First ever in China* [3]
- *Deep innovation pipeline – 11 NMEs in clinical development*

Major commercial opportunity

- *Original branded medicines expected to grow 10.4% CAGR from 2022-2026, supported by national reimbursement* [4]
- *Tendering for off-patent and generic drugs*

U.S.

~40% of global oncology medicine spending [5] [6]

Innovation is being rewarded

- *Oncology medicine spending projected to exceed $110 billion by 2025, even after considering savings from biosimilar introduction*
- *Regulators continue to utilize programs for expedited development of medicines for serious conditions*

Three potential new medicines in late stage development

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

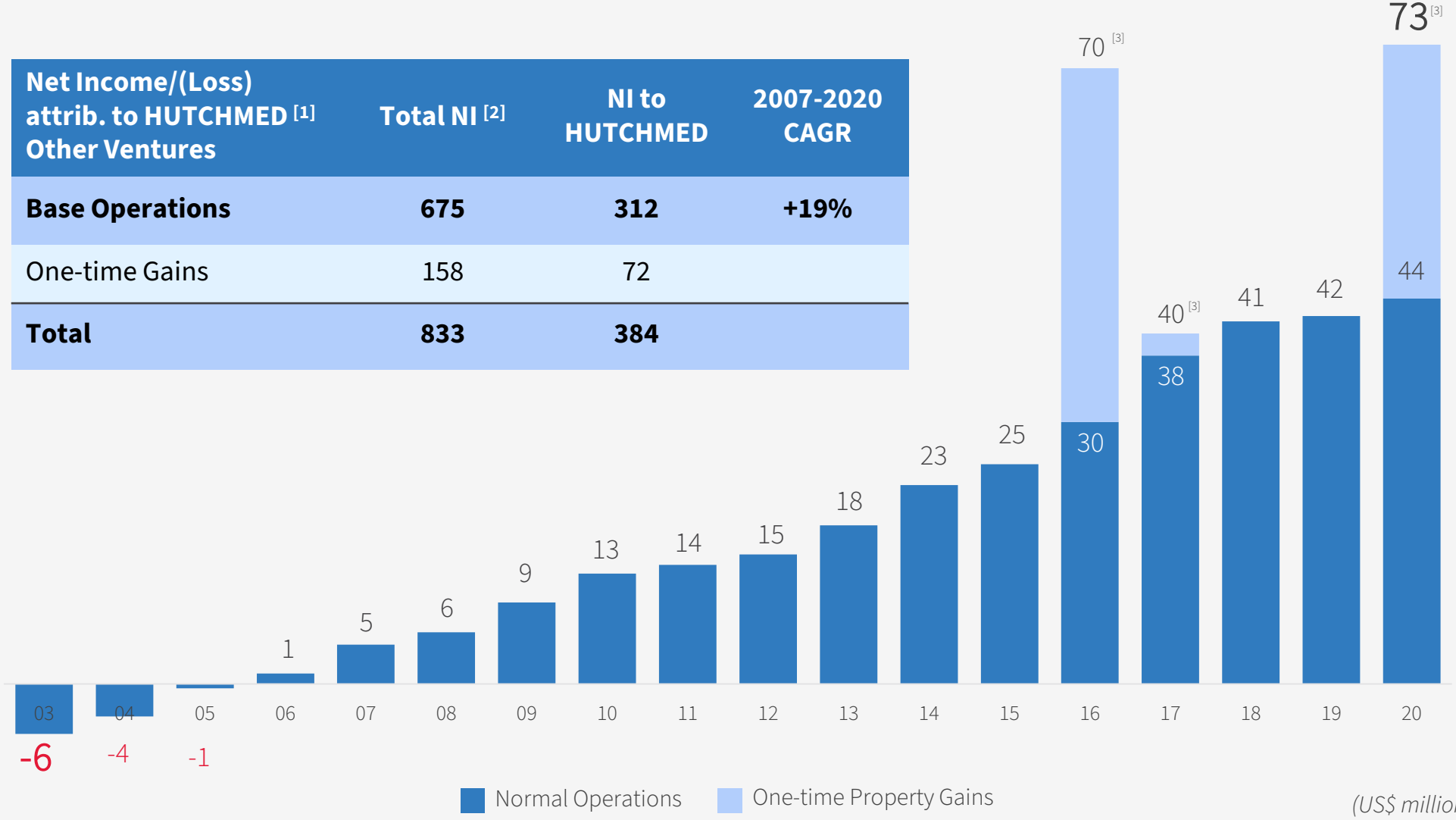
- *HUTCHMED's portfolio of TKIs, designed for clinical differentiation, being studied in combination with PD-1/L1 inhibitors*
- *Global studies initiated for all three late-stage potential new medicines*

[1] Global Cancer Observatory, WHO, ACS, NCCR, Frost & Sullivan analysis; [2] SoC = Standard of Care; [3] Believed to be the first ever China-discovered novel oncology drug to receive full NDA approval in China; [4] IQIVA Institute: The Global Use of Medicines 2022; [5] IQIVA Institute: Global Oncology Trends 2021; [6] IQIVA Institute: The Use of Medicines in the U.S.

HUTCHMED competence in China operations

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

Net Income/(Loss) attrib. to HUTCHMED [1] Other Ventures	Total NI [2]	NI to HUTCHMED	2007-2020 CAGR
Base Operations	**675**	**312**	**+19%**
One-time Gains	158	72	
Total	**833**	**384**	

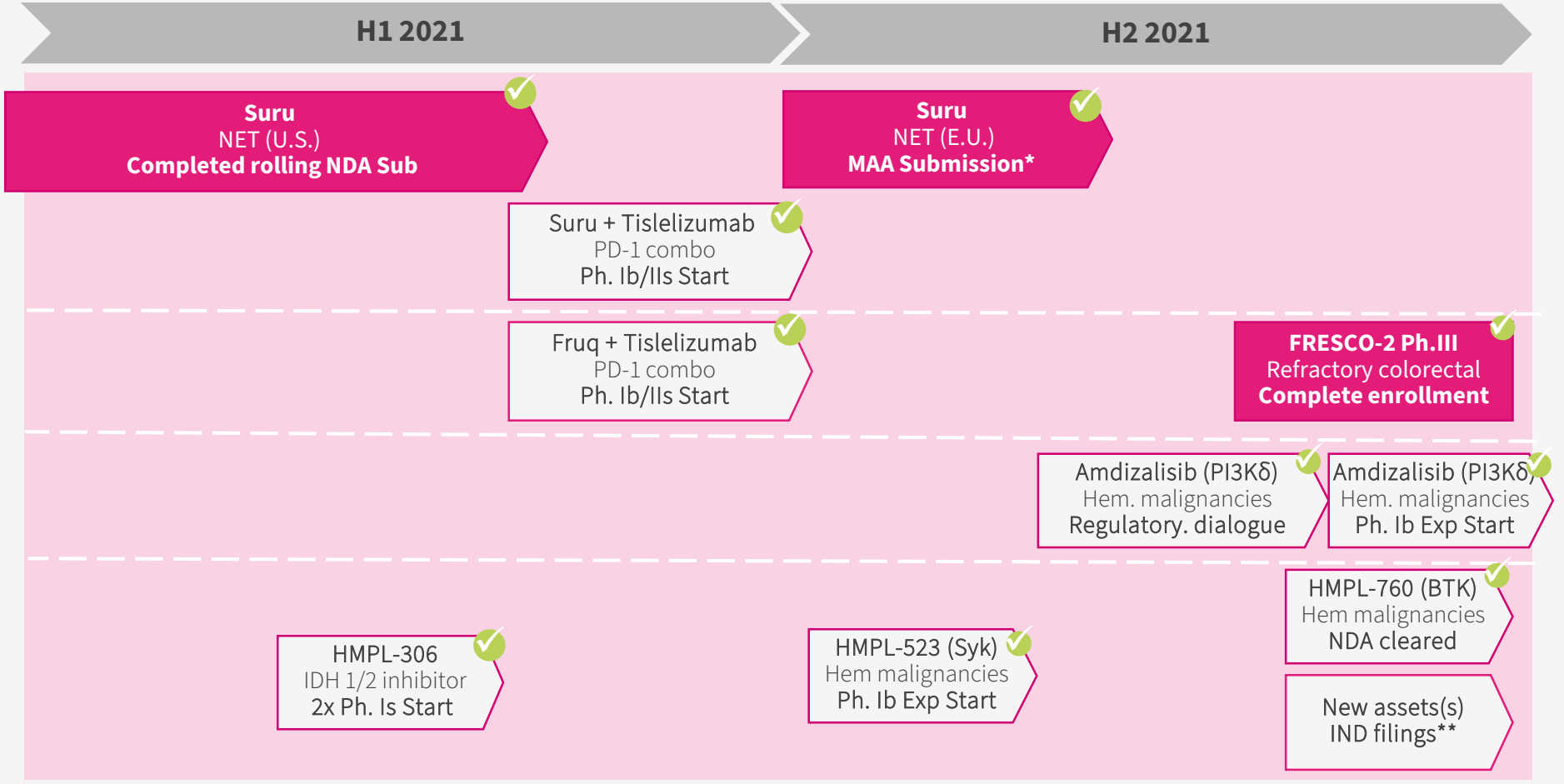


(US$ millions)

[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.

HUTCHMED

A3a

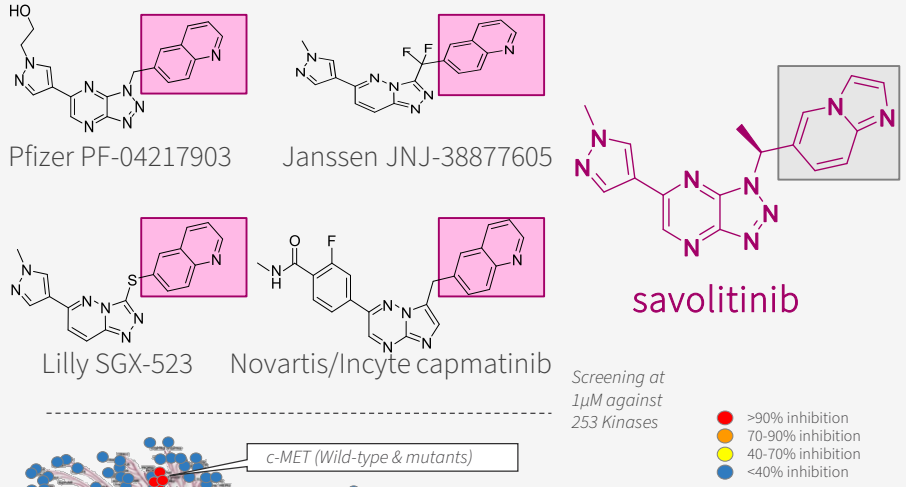
SAVOLITINIB

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.



Savolitinib

~1,000 times

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

Evidence of clinical differentiation

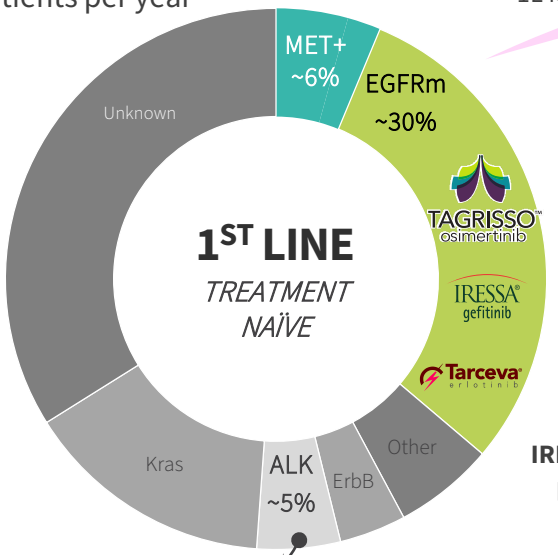
- ~1,200 patients in clinical trials to date
- Competitive anti-tumor effect across multiple MET aberrations in multiple tumor types
- Single agent and combination settings
- First-in-class in China
- Currently testing in multiple tumor types:
  - NSCLC with MET Exon14 skipping
  - EGFRm + NSCLC
  -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

NSCLC by driver aberration

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

Primary NSCLC

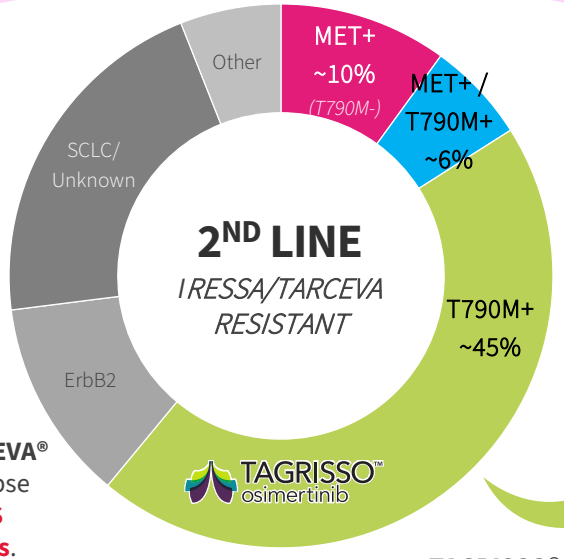
1.8 million NSCLC patients per year



TAGRISSO® patients relapse 1L Median **PFS 19 months**.

IRESSA®/TARCEVA® patients relapse Median **PFS 9-10 months**.

Resistance-driven EGFRm+ NSCLC



TAGRISSO® patients relapse 2L Median **PFS 9-10 months**.

	Target	Launch	2020 ($m) [3]
Iressa	EGFRm	2003	268
Tarceva	EGFRm	2004	170
Tagrisso	EGFRm / T790M	2015	4,328
Xalkori / Lorbrena	ALK / ROS1 / MET	2011/18	748
Alecensa	ALK	2015	1,235
Alunbrig	ALK	2017	80
Total Sales			6,829

Launch	2016	2017	2018	2019	2020
Dec-15	423	955	1,860	3,189	4,328

TAGRISSO™ osimertinib

Est. global sales of ~$8.5 bn by 2025[2].

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

Savolitinib – MET Exon 14 skipping alterations

HUTCHMED

NDA approved June 2021 in China

NSCLC with MET Exon14 skipping alterations

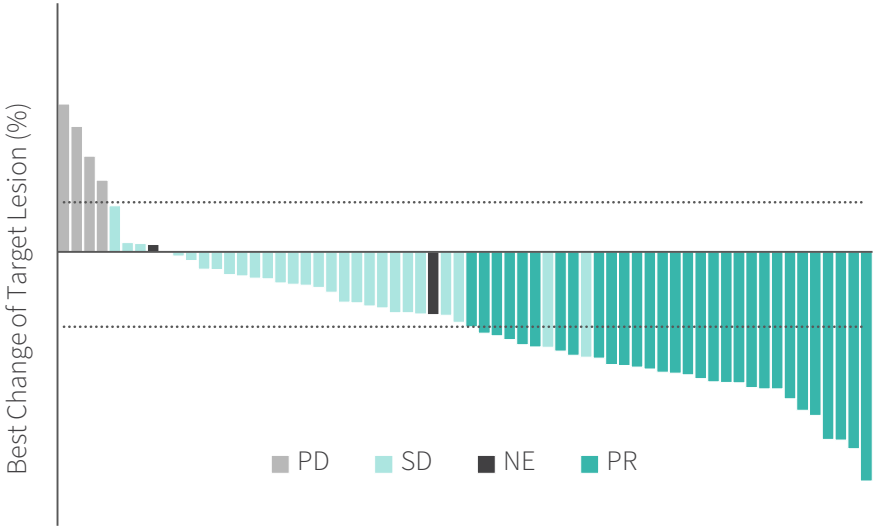
- 2-3% of NSCLC, up to 22% in PSC
- Most common in elderly patients
- No effective treatments with poor prognosis

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)

China Phase II registration [1]	Efficacy Evaluable (N=61)	Full Analysis (N=70)
ORR, % [95% CI]	49.2% [36.1–62.3]	42.9% [31.1–55.3]
DCR, % [95% CI]	93.4% [84.1–98.2]	82.9% [72.0–90.8]
mDoR, mo	8.3 [5.3–16.6]	8.3 [5.3–16.6]



[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

HUTCHMED

China's lead selective MET inhibitor

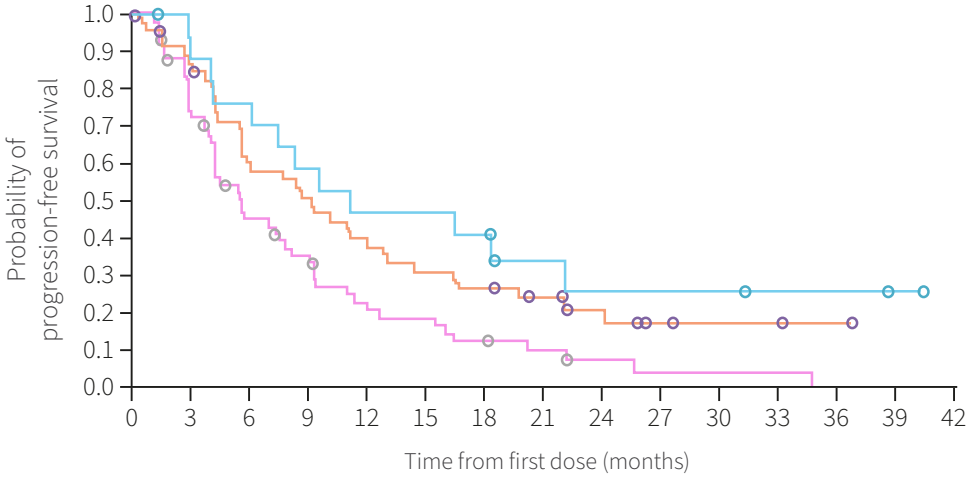
Competitive landscape outside China:

	Treatment Line	MET aberration	N	BICR[1] ORR (%)	DCR (%)	mDoR (months)	mPFS (months)
Capmatinib [2] [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]
Tepotinib							
	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

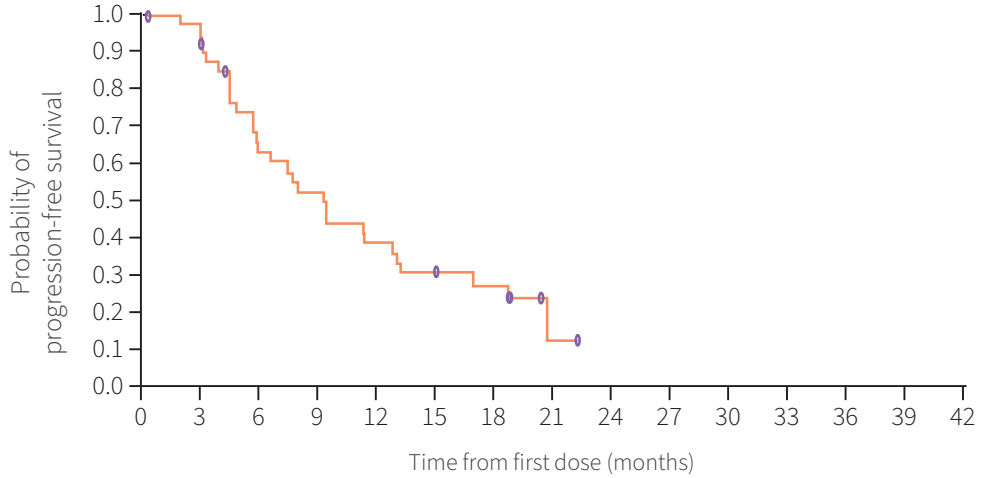
TAGRISSO® + savolitinib in EGFR TKI refractory NSCLC



	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.



	Median PFS, months [95% CI]	Median (range) duration of response, months
Part D No prior third-generation EGFR-TKI, T790M negative; (300 mg; n=42)	9.0 [5.6, 12.7]	9.7 [4.5,14.3]

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 ≤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.

TAGRISSO™ osimertinib + savo in EGFR TKI refractory NSCLC

HUTCHMED

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 final analysis. WCLC January 2021 #FP14.03.

TATTON B & D data – AEs & SAEs

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

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

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

SAE**, n (%)	All Part B (n=138)	Part D (n=42)
Pneumonia	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

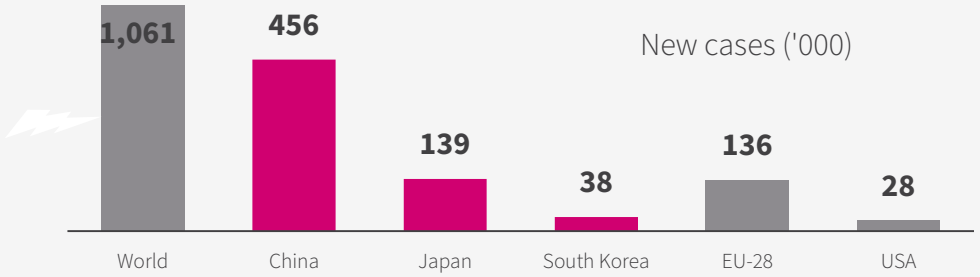
[1] ≥15% in either Part B or Part D for all grades; [2] ≥3% in either Part B or Part D for all grades. #The emergence of drug-related hypersensitivity AEs are characterised by events such as pyrexia; The emergence of hypersensitivity and anaphylaxis events led to a protocol amendment introducing a weight-based 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 JY, Ahn MJ, et al. Osimertinib plus savolitinib in patients with EGFR mutation-positive, MET-amplified, non-small-cell lung cancer after progression on EGFR tyrosine kinase inhibitors: interim results from a multicentre, open-label, phase 1b study. Lancet Oncol. 2020; S1470-2045(19)30785-5. doi:10.1016/S1470-2045(19)30785-5

Savolitinib – MET+ gastric cancer

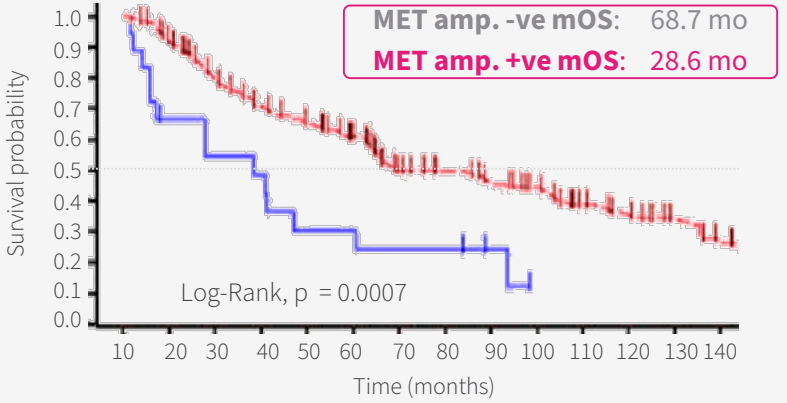
A major problem in east Asia – Japan, Korea & China

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.

2. MET+ disease is more aggressive [1]

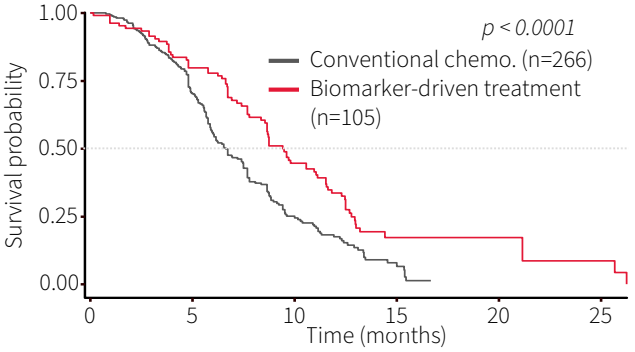


3. VIKTORY: Highest response rate in savolitinib monotherapy arm[2]

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

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

Biomarker guided treatment may prolong overall survival



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

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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

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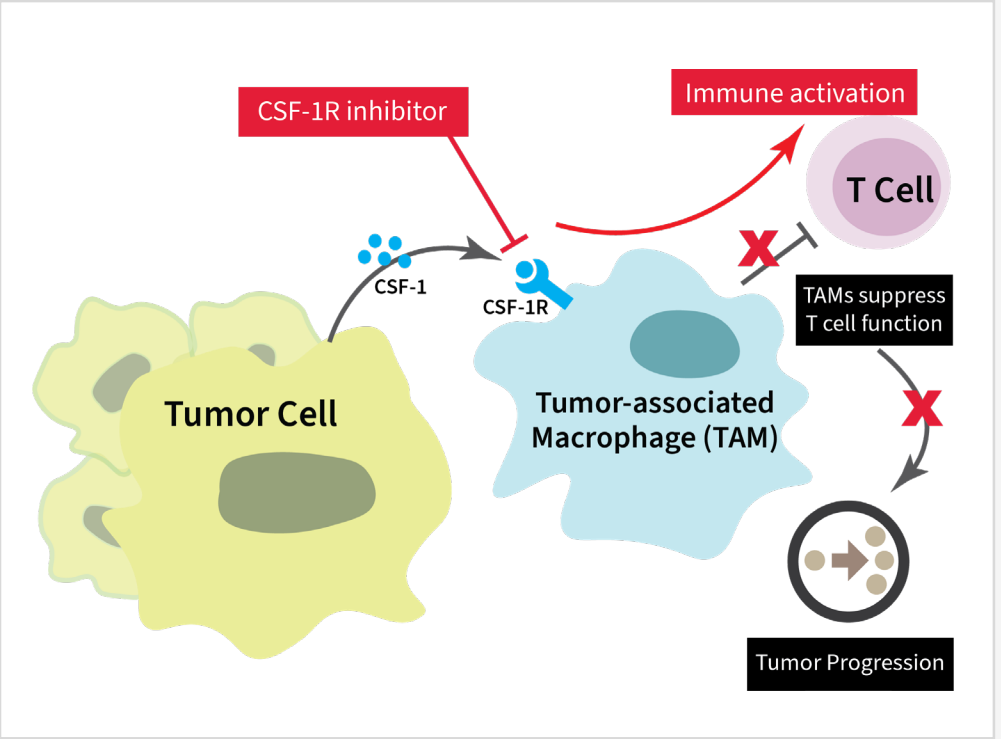
Potentially enhance immune-mediated anti-tumor effect in addition to anti-angiogenesis

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)



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

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

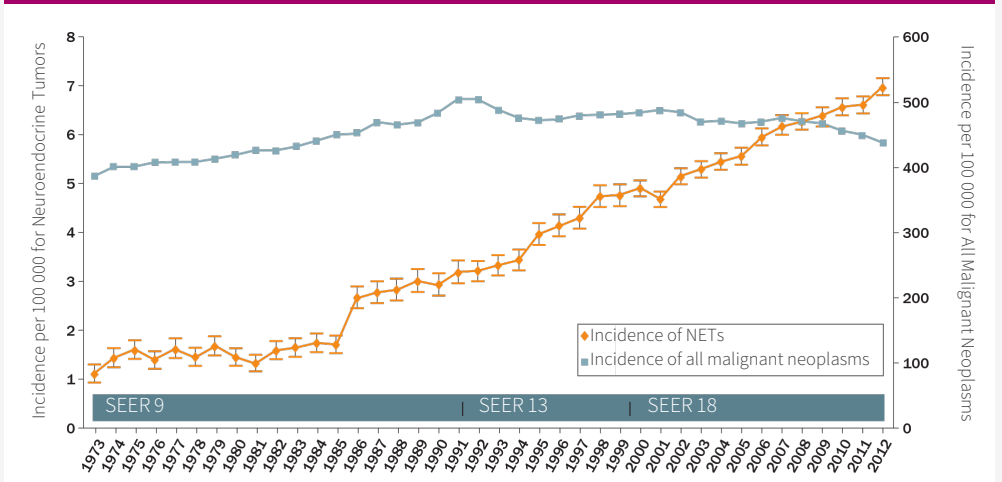
Hormone-related symptoms [1]

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

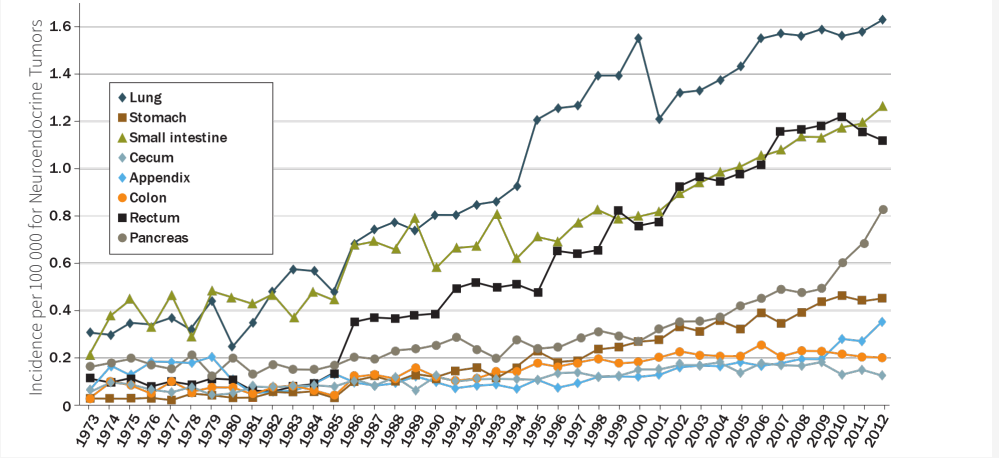
Differentiation & biomarkers for grading:

- 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]

Grade 1 (G1) NET
Localized / Regional

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

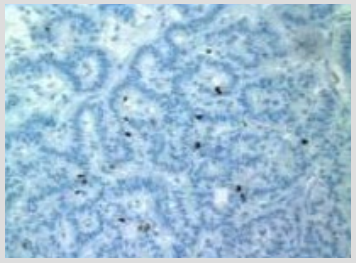
- *94% flushing*
- *78% diarrhea*
- *53% heart plaque*
- *51% cramping*

Symptoms allow early diagnosis

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

- *Octreotide: $1.4b revenue (2020)*
- *Lanreotide: $1.5b revenue (2020)*

mOS: 16.2 yrs.



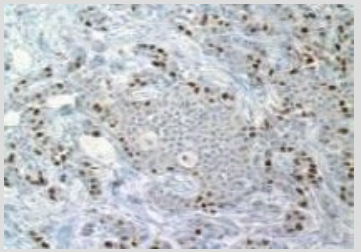
Well Differentiated

Ki-67 Index ≤2; Mitotic Count <2

G1/2 – Advanced NET
Regional / Distant

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

mOS: 8.3 yrs.



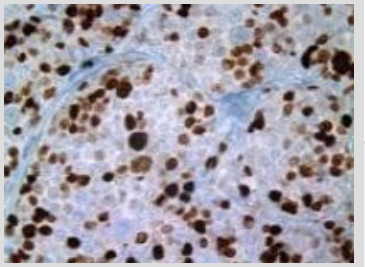
Moderately Differentiated

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

G3 – NET/NEC
Distant

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

mOS: 10 mos.



Poorly Differentiated

Ki-67 Index >20; Mitotic Count >20

[1] Arvind Desari et. al. Trends in the Incidence, Prevalence, and Survival Outcomes in Patients With Neuroendocrine Tumors in the 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

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Global China

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

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

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

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U.S. NET treatment landscape – highly fragmented

	Somatostatin Based Therapies			Kinase Inhibitor Therapies		
	Sandostatin® LAR (octreotide)	**Somatuline Depot® (lanreotide)**	**Lutathera® (¹⁷⁷Lu-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.	• GEP-NETs: unresectable, well or moderately diff., (locally adv. or meta) GEP-NETs to improve PFS. • Carcinoid Syndrome: to reduce frequency of short-acting somatostatin rescue therapy.	• Somatostatin receptor-positive GEP-NETs.	• pNET: progressive pNET (unresectable, locally adv. or meta). • GI-NET or Lung NET: progressive, well-diff., *non-functional* NET (unresectable, locally adv. or meta). Not for *functional* carcinoid tumors.[4]	• pNET: Progressive, well-differentiated pNET (unresectable locally adv. or meta).	• 2 positive RCTs in pNET & epNET 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**	**Afinitor® / Placebo**		**Sutent® / Placebo**	**Surufatinib / Placebo**	
mPFS (mo.)	14.3 / 6.0	NR / 18.0	NR / 8.5	pNET	Lung & GI NET	pNET: 11.4 / 5.5	Ph III pNET	Ph III non-pNET
primary EP				11.0 / 4.6	11.0 / 3.9		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
(*p-value*)	*0.000072*	*<0.001*	*<0.0001*	*<0.001*	*<0.001*	*<0.001*	0.0011	*<0.0001*
ORR	2% / 2%	NR	18% / 3%	5% / 2%	2% / 1%	9% / 0%	19% / 2%	10% / 0%
DCR	69% / 40%	NR	95% / 76%	73% / 51%	81% / 64%	72% / 60%	81% / 66%	87% / 66%
Pivotal	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

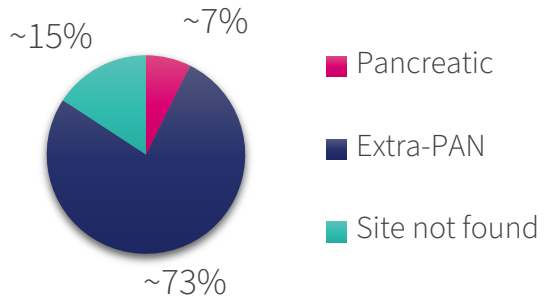
A rare heterogeneous tumor that presents in the metastatic stage in 40-50% of patients

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

PERCENT OF NETS CASES BY LOCATION[1]



TREATMENT LANDSCAPE

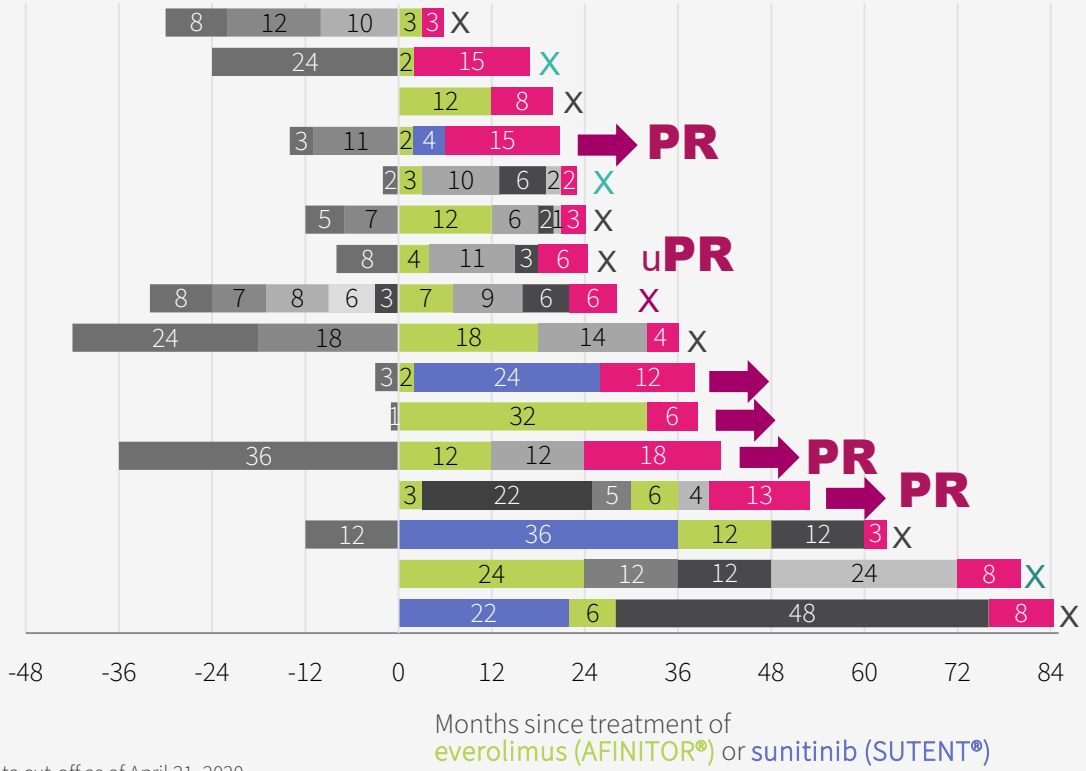
Palliative systemic therapy is mainstay for adv. disease

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

Sources: 1. Neuroendocrine Tumors, cancer.Net; 2.Brayn O. et.al. Neoplasia. 2017 Dec; 19(12): 991–1002; 3. Pancreatic NETs, cancer.Net; 4. Arvind D. et.al. PharmacoEconomics. 2018 Aug; 8(36): 1005–1013; 5. Modlin I.M. et.al. Neuroendocrinology 2014;100:265-277; 6. He CB et.al. Endocr Connect. 2019 Mar 1;8(3):239-251; 7. Da Man et.al. Cancer Manag Res. 2018; 10: 5629–5638

U.S. NET Phase Ib bridging study

Encouraging surufatinib efficacy in everolimus & sunitinib refractory/intolerant patients



Data cut-off as of April 21, 2020.

PR Confirmed PR *(n=3)*

uPR Unconfirmed PR *(n=1)*

⇨ Treatment ongoing *(n=5)*

X Rx stop – AE *(n=1)*

X Rx stop – PD *(n=7)*

X Rx stop – Other *(n=3)*

surufatinib

everolimus

sunitinib

Other Tx

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.

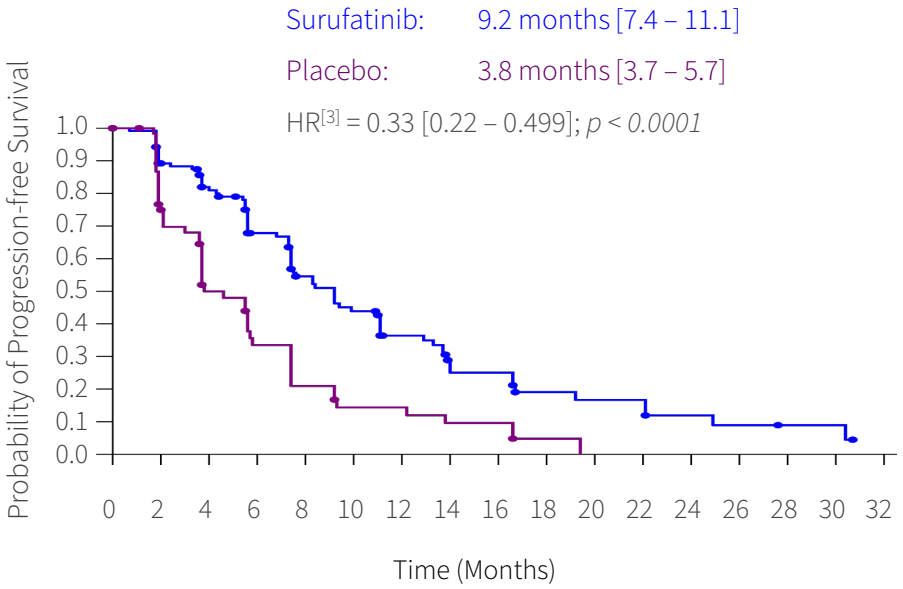
Source: Dasari A, Li D, et al. *Efficacy and safety of surufatinib in United States (U.S.) patients (pts) with neuroendocrine tumors (NETs).* Journal of Clinical Oncology 2020 38:15_suppl, 4610-4610

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

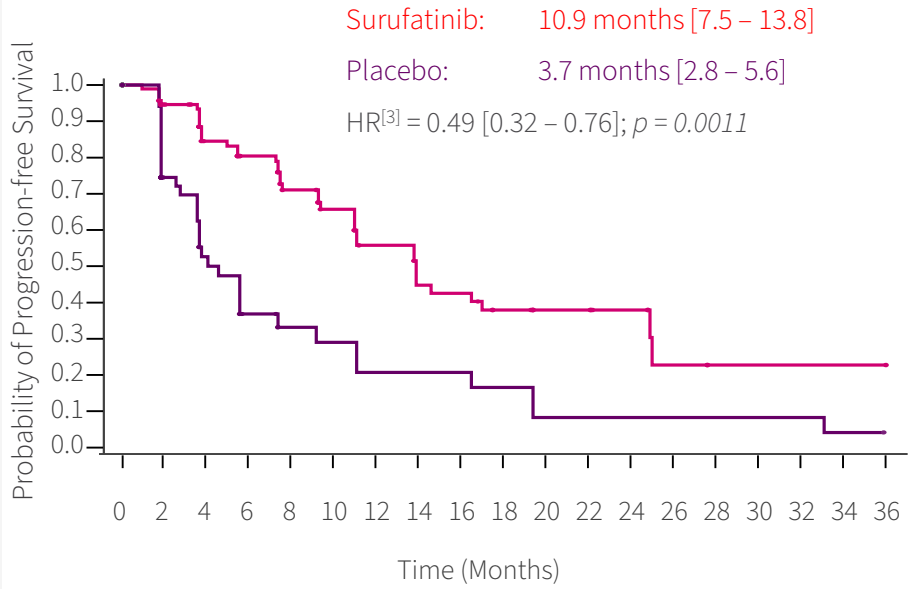
Surufatinib: Monotherapy efficacy across NETs

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

Non-Pancreatic[1] *(SANET-ep, n=198 – ESMO 2019)*



Pancreatic[2] *(SANET-p, n=172 – ESMO 2020)*



[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; CI, confidence interval; HR, hazard ratio.

G1/2 Advanced extra-pancreatic NET

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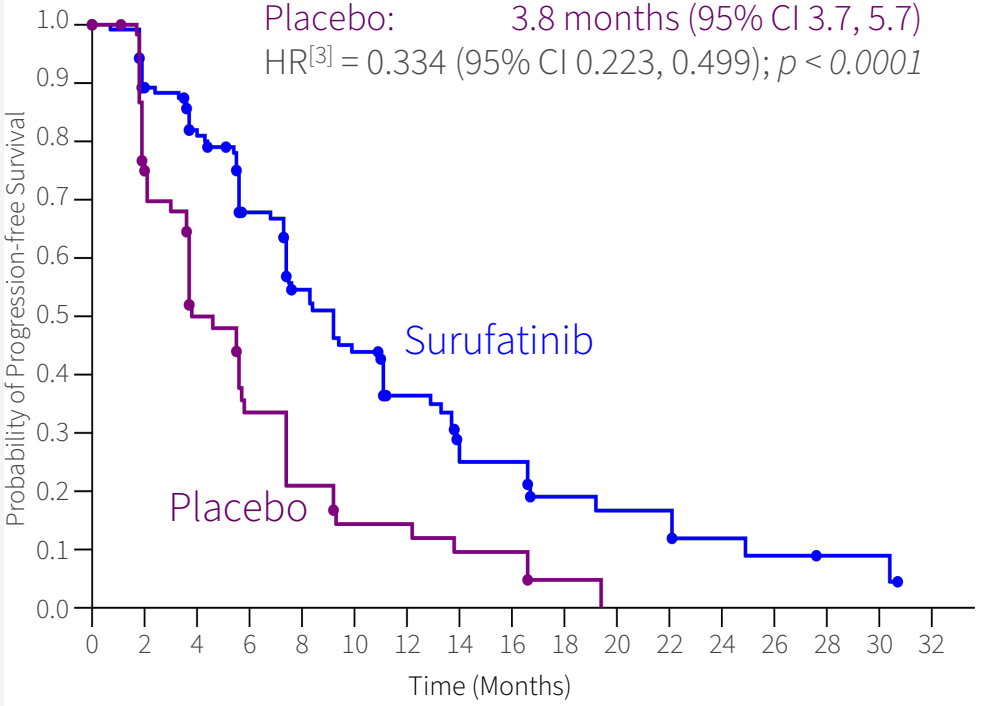
Investigator assessed median PFS

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

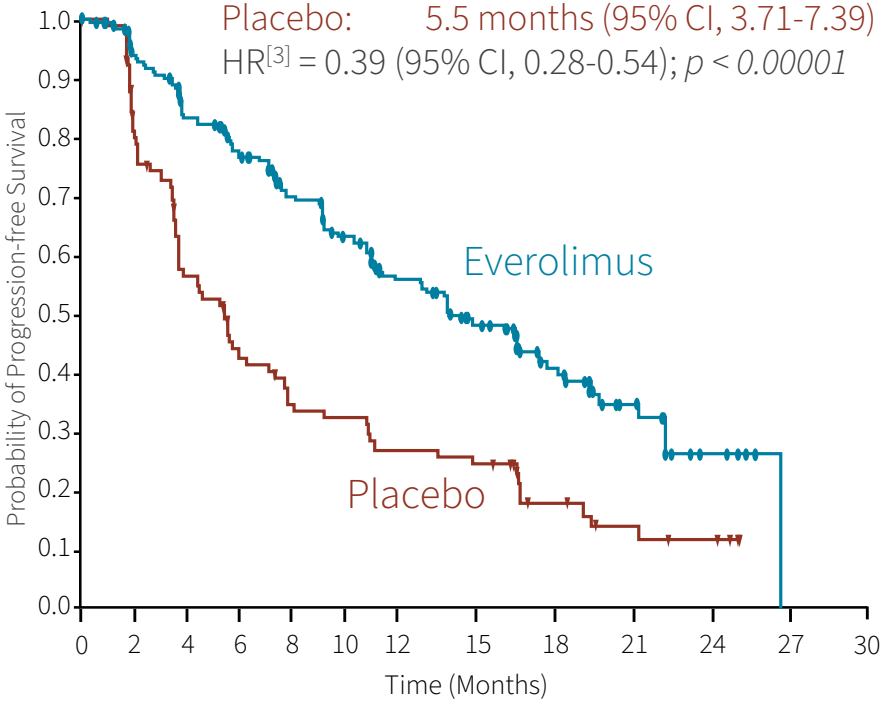
Surufatinib: 9.2 months (95% CI 7.4, 11.1)
Placebo: 3.8 months (95% CI 3.7, 5.7)
HR[3] = 0.334 (95% CI 0.223, 0.499); *p < 0.0001*



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

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

Everolimus: 14.0 months (95% CI, 11.24-17.71)
Placebo: 5.5 months (95% CI, 3.71-7.39)
HR[3] = 0.39 (95% CI, 0.28-0.54); *p < 0.00001*



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

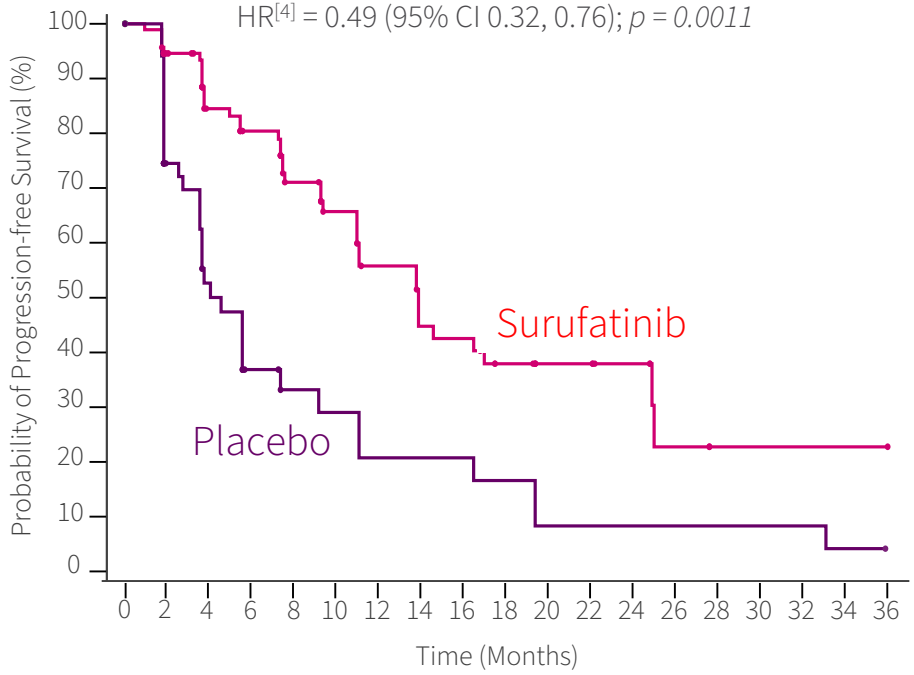
Note: Illustrative comparison only. No head-to-head studies have been conducted. Study parameters differ.
[1] Xu et al. "Surufatinib in advanced extrapancreatic neuroendocrine tumours (SANET-ep): a randomised, double-blind, placebo-controlled, phase 3 study." Lancet Oncol 2020. Published online September 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)

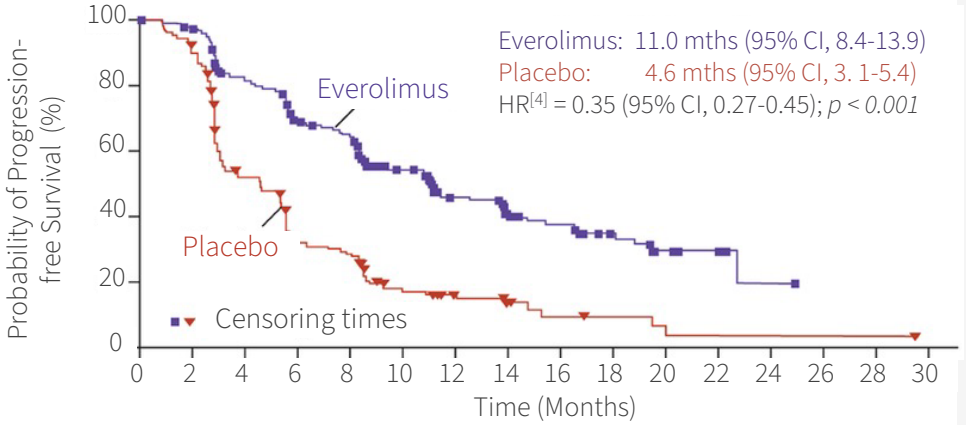
SANET-p[1] *(n=172)*

Surufatinib: 10.9 months (95% CI 7.5, 13.8)
Placebo: 3.7 months (95% CI 2.8, 5.6)
HR[4] = 0.49 (95% CI 0.32, 0.76); *p = 0.0011*



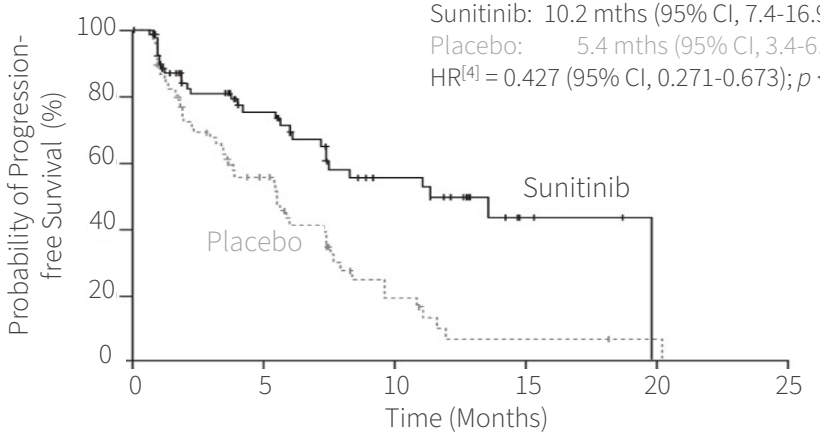
RADIANT-3 (everolimus) [2] *(n=410)*

Everolimus: 11.0 mths (95% CI, 8.4-13.9)
Placebo: 4.6 mths (95% CI, 3. 1-5.4)
HR[4] = 0.35 (95% CI, 0.27-0.45); *p < 0.001*



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

Sunitinib: 10.2 mths (95% CI, 7.4-16.9)
Placebo: 5.4 mths (95% CI, 3.4-6.0)
HR[4] = 0.427 (95% CI, 0.271-0.673); *p < 0.001*



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

Surufatinib vs. everolimus and sunitinib

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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)
	Tsai et al. 2013		Yao et al. 2008	
Non-Pancreatic Tumor Origin				
Gastrointestinal Tract	58%	47%	50%	58%
Rectum	30%	27%	33%	13%
Stomach	7%	10%	8%	4%
Small Intestine	19%	8%	6%	34%
Other GI	3%	3%	4%	7%
Lung	22%	12%	21%	30%
Other Organ Site		28%	Thymus	1%
Thymus		7%		
Liver		6%		
Mediastinum		6%		
Adrenal Gland		2%		
Other		8%		
Unknown Origin		14%	Unknown Origin	12%

SANET-ep

Enrolled more pts with poor prognosis.

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

RADIANT-4

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

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

SANET-ep

Broader pt. coverage.

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

Surufatinib

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

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

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)).

[1] Xu et al. https://doi.org/10.1016/S1470-2045(20)30496-4; [2] Yao et al. doi: 10.1016/S0140-6736(15)00817-X; [3] Xu et al. https://doi.org/10.1016/S1470-2045(20)30493-9; [4] Yao et al. DOI: 10.1056/NEJMoa1009290; [5] Raymond et al. DOI: 10.1056/NEJMoa1003825.

Surufatinib PD-1 combos global aspirations

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

Part 1 – Dose Finding
all-comers

Dose Level 2
SURU 300mg QD
+
TISLE 200mg Q3W

Dose Level 1
SURU 250mg QD
+
TISLE 200mg Q3W

If not tolerable

Dose Level -1
SURU 200mg QD
+
TISLE 200mg Q3W

Part 2 – Expansion Cohorts
indication-specific cohorts

- A: 4L Colorectal Cancer
- B: 2L Neuroendocrine Tumors
  - B1: Thoracic NET
  - B2: GEP NET
- C: 2L SCLC
- D: 3L Gastric Cancer
- E: 2L Soft Tissue Sarcoma
  - E1: Alveolar Soft Part
  - E2: UPS
- F: 3L 1/2L Anaplastic Thyroid

Rationale

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

Status

- Part 1 completed
- Part 2 commenced

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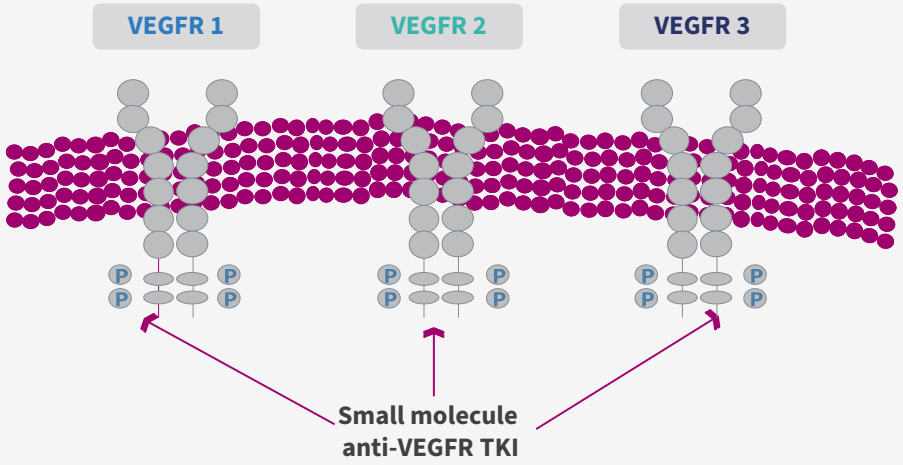
A3c

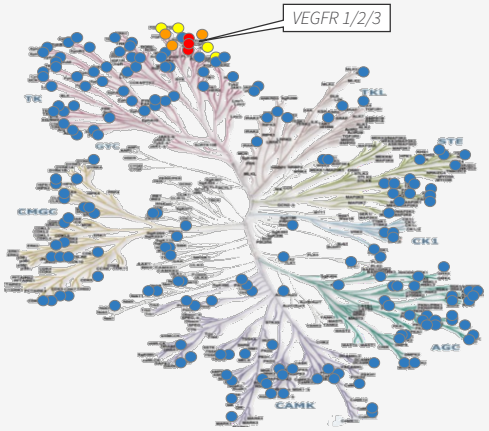
FRUQUINTINIB (ELUNATE® IN CHINA)

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





Screening at 1μM against 253 Kinases

- >90% inhibition
- 70-90% inhibition
- 40-70% inhibition
- <40% inhibition

ELUNATE®
Fruquintinib Capsules

~250 times

more selective to VEGFR3 than next non-VEGFR kinase (Ret) [2]

- **Potent against VEGFR1,2,3**, resulting in consistent clinical benefit for patients who failed bevacizumab
- **Highly selective** vs. other kinases with good safety profile with readily manageable AEs
- **Combinable** with chemo, targeted therapies and IO

3rd-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

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…potentially ideal VEGFR combos for immunotherapy

TKI	1st Generation			2nd Generation			Next Generation	
Selectivity	Multiple targets			Relatively selective			Highly selective	Selective angio-immuno kinase inhibitor
Inhibitors	Sutent®	Nexavar®	Focus V®	Fotivda®	Lenvima®	Inlyta®	Fruquintinib	Surufatinib
Status	Launched	Launched	Launched	Launched	Launched	Launched	Launched	Approved
VEGFR1 (nM)	2	26	27	30	22	3	33	2
VEGFR2 (nM)	9	90	0.2	6.5	4	7	25	24
VEGFR3 (nM)	19	20	0.7	15	5	1	0.5	1
Phos-KDR (nM)	10	30	0.1-1	0.16	0.8	0.2	0.6	2
Other kinases (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

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

Efficacy advantage

ELUNATE® Fruquintinib Capsules

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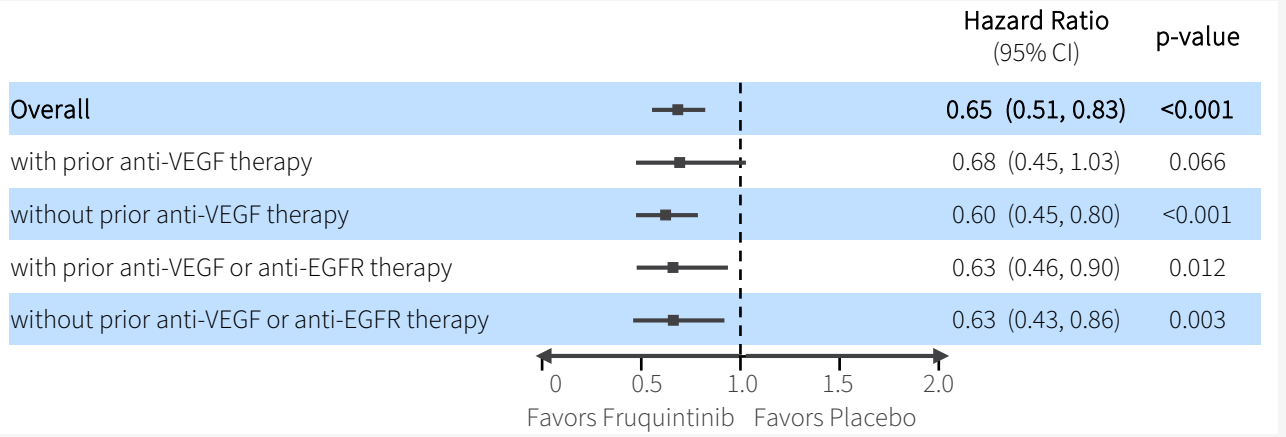
Third-Line Metastatic Colorectal cancer	FRESCO [1] Mainland China		CONCUR Chinese Patients (Mainland China, Hong Kong, Taiwan) [2]		CONCUR Mainland China, Hong Kong, Taiwan, Vietnam, South Korea		CORRECT Global	
Treatment arms	ELUNATE®	Placebo	STIVARGA®	Placebo	STIVARGA®	Placebo	STIVARGA®	Placebo
Patients (n)	278	138	112	60	136	68	505	255
Objective Response Rate, n (%)	4.7%	0.0%	3.6%	0.0%	4.4%	0.0%	1.0%	0.4%
Disease Control Rate, n (%)	62.2% +49.9	12.3%	45.5% +38.8	6.7%	51.5% +44.1	7.4%	41.0% +26.1	14.9%
Median Progression-Free Survival (mPFS) (mo.)	3.7 +1.9	1.8	2.0 +0.3	1.7	3.2 +1.5	1.7	1.9 +0.2	1.7
							100% AVASTIN® prior 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 pts;
- Advantage for ELUNATE® post VEGF/EGFR targeted therapy
  - mOS: 7.69 mo. vs. 5.98 mo. placebo (HR 0.63 & p-value 0.012)
  - mPFS: 3.65 mo. vs. 1.84 mo. placebo (HR 0.24 & p-value <0.001)



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® Fruquintinib Capsules

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BIOCHEMICAL ACTIVITY	ELUNATE® Fruquintinib Capsules IC_{50} (nmol/L)	Stivarga® (regorafenib) tablets IC_{50} (nmol/L)
On-Target Kinases:		
VEGFR1	33	13
VEGFR2	35	4.2
VEGFR3	0.5	46
Off-Target Kinases:		
Ret	128	1.5
FGFR1	181	202
c-kit	458	7
PDGFRβ	>10,000	22
RAF-1	>10,000	2.5
B-RAF	>10,000	28
B-RAF^{V600E}	>10,000	19

Stivarga® liver toxicity black-box warning:

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

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

WARNING: HEPATOTOXICITY

See full prescribing information for complete boxed warning.

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

3rd-Line Metastatic Colorectal cancer	FRESCO Study Mainland China [1]		CONCUR Study (Mainland China, HK, Taiwan) [2]	
Treatment arms	ELUNATE®	Placebo	STIVARGA®	Placebo
Patients (n)	278	138	112	60
≥G3 AE (Safety population)	61.1%	19.7%	69.6%	46.7%
SAE (Safety population)	15.5%	5.8%	31.3%	26.7%
VEGFR on-target related AEs:				
Hypertension ≥G3	21.2%	2.2%	12.5%	8.3%
Hand-Foot Syndrome (Palmar-plantar), ≥G3	10.8%	0.0%	17.0%	0.0%
Off-target (i.e. non-VEGFR) related AEs:				
Hypophosphatemia, ≥G3	0.0%	0.0%	8.0%	0.0%
Hypokalemia, ≥G3	0.7%	0.7%	6.3%	0.0%
Rash/desquamation, ≥G3	0.0%	0.0%	4.4%	0.0%
Lipase increase, ≥G3	0.0%	0.0%	6.3%	1.7%
Hepatic function (Liver function) AEs:				
ALT increased, ≥G3	0.7%	1.5%	7.1%	3.3%
AST increased, ≥G3	0.4%	0.7%	8.9%	0.0%
Blood bilirubin increased, ≥G3	1.4%	1.5%	8.9%	8.3%
Tolerability:				
AE Leading to dose interruption	35.3%	10.2%	68.8%	25.0%
AE Leading to dose reduction	24.1%	4.4%	23.2%	0.0%
AE Leading to treatment discontinuation	15.1%	5.8%	14.3%	6.7%

ELUNATE® superior safety – advantage especially for liver mets patients

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; R Xu.; ≥G3 AEs in >4% of Patients.

NRDL

ELUNATE® Fruquintinib Capsules

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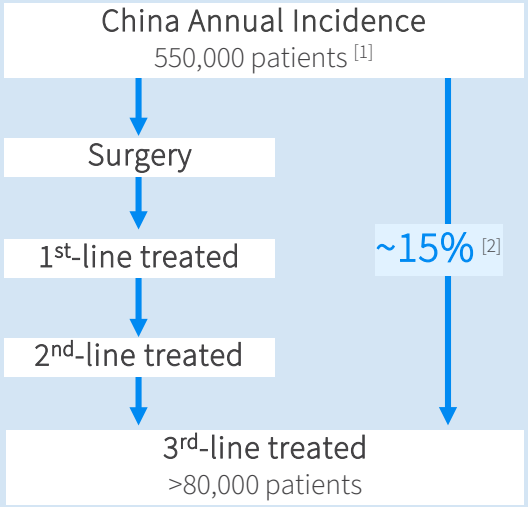
2020 accessible pricing

Epidemiology



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

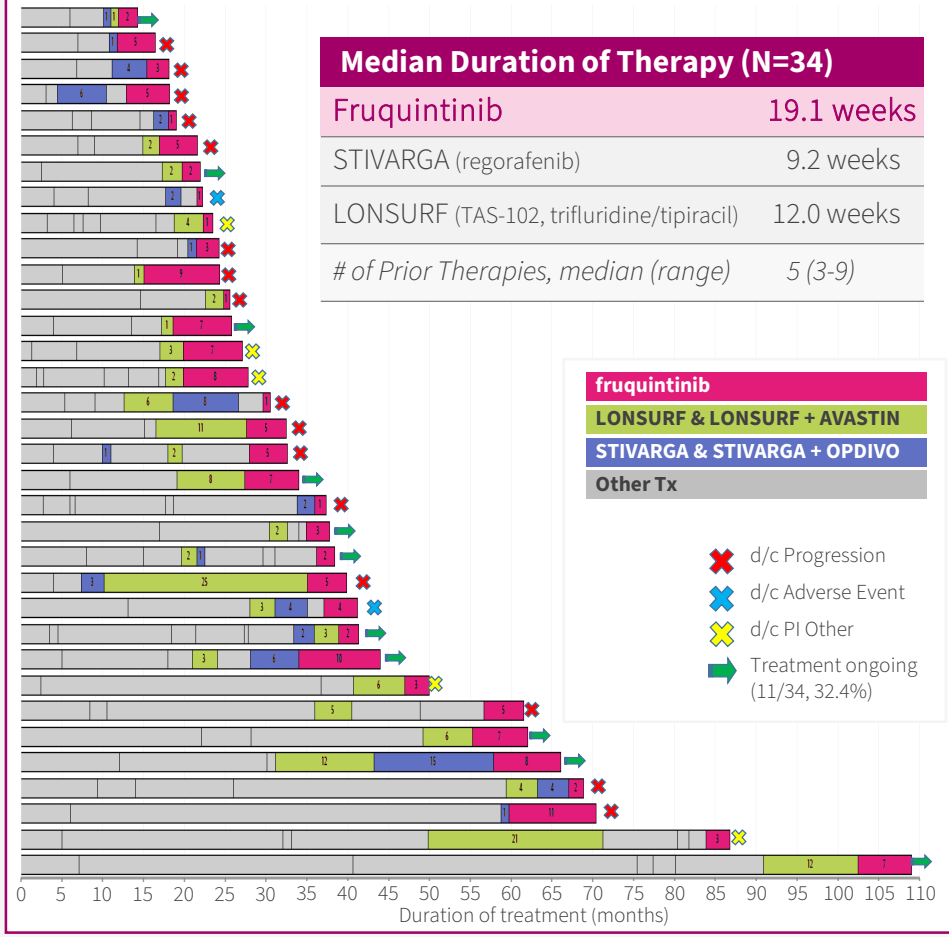
Costs per cycle *(all US$)* [3]		With Medical Insurance	Without Medical Insurance
ELUNATE® (fruquintinib)	Pre-NRDL (without PAP)	3,260	3,260
	Post-NRDL	1,180	1,180
	3L CRC Pts Out-of-Pocket Cost	~350 [5]	~1,180
STIVARGA® (regorafenib)	3L CRC Pts Out-of-Pocket Cost	~670 [5]	~2,220

[1] Globocan; [2] Frost & Sullivan; [3] RMB:USD exchange rate 6.73:1.00; PAP = Patient access program; [4] 2020 In-market sales of ELUNATE®, Lilly invoiced to third parties was $32.7m and HUTCHMED invoiced to third parties was $1.0m; [5] Assumes 70% reimbursement rate.

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)



Median Duration of Therapy (N=34)	
Fruquintinib	19.1 weeks
STIVARGA (regorafenib)	9.2 weeks
LONSURF (TAS-102, trifluridine/tipiracil)	12.0 weeks
# of Prior Therapies, median (range)	*5 (3-9)*

Data cut-off as of Aug 20, 2020.

Global FRESCO-2 fully enrolled Dec 2021

Eligibility

- Prior FOLFOX / FOLFIRI; anti-VEGF, anti-EGFR (if RAS wt).
- Prior checkpoint inhibitor or BRAFi if indicated.
- Progression or intolerance to LONSURF® and/or STIVARGA®.

R

Fruquintinib 5mg QD (3 weeks on / 1 week off) + BSC — N ~460

Placebo + BSC — N ~230

Treatment until: progression or unacceptable toxicity

~150 sites in 14 countries incl. U.S., Europe, Japan & Aus.

~690 pts full enrollment target reached in late 2021

Primary Endpoint: OS in refractory mCRC pts

Secondary Endpoints: PFS, ORR, DCR, DoR, QoL, others

Stratification factors:

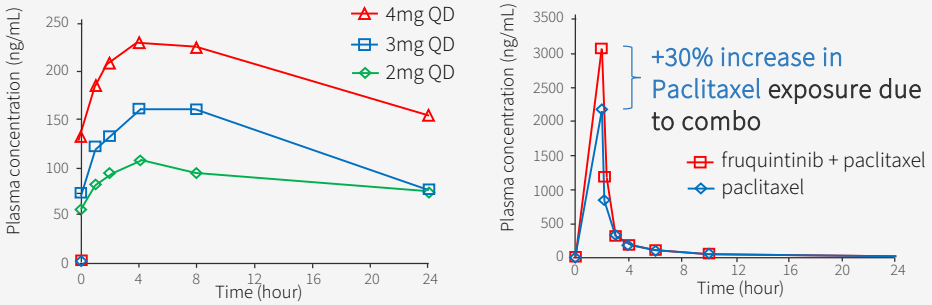
- *Prior TAS-102 vs. prior regorafenib vs. prior TAS-102 & regorafenib.*
- *RAS status (WT vs MT).*
- *Duration of metastatic disease (≤18 mths vs > 18 mths).*

[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.

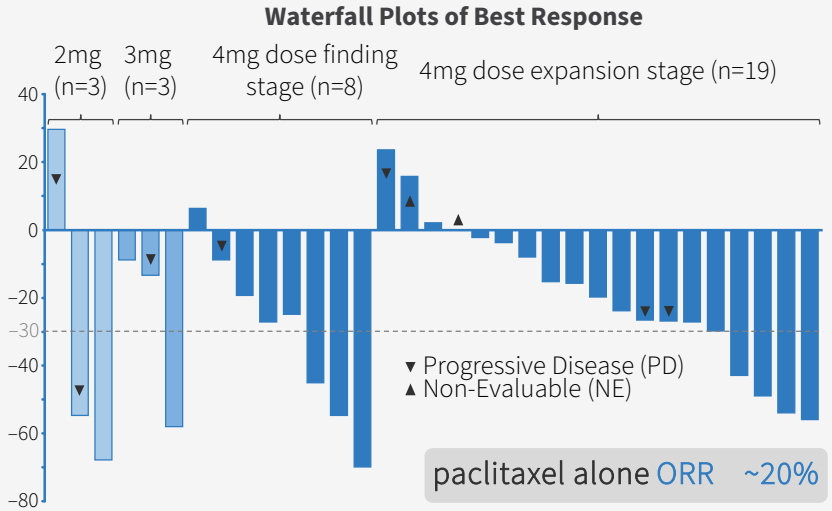
Gastric combo with paclitaxel

Phase 2 results supports ongoing Phase III FRUTIGA

1 Dose proportional increase of fruquintinib AUC at steady state. 30%+ increase in paclitaxel exposure (mean AUC_{0-8}) 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%.



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%)

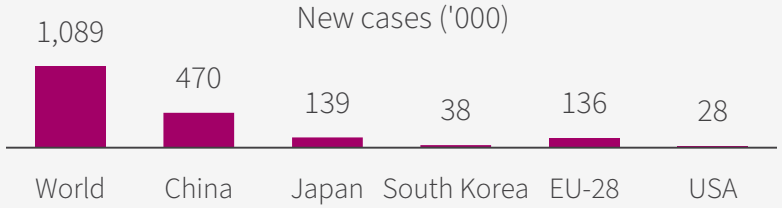
4 AE profile in-line with expectations. Neutropenia – a paclitaxel AE – with 57.9% Grade >3 AEs. Similar to 60% seen ramcirumab (VEGF mAb) RAINBOW study paclitaxel combo in 2L gastric.

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)

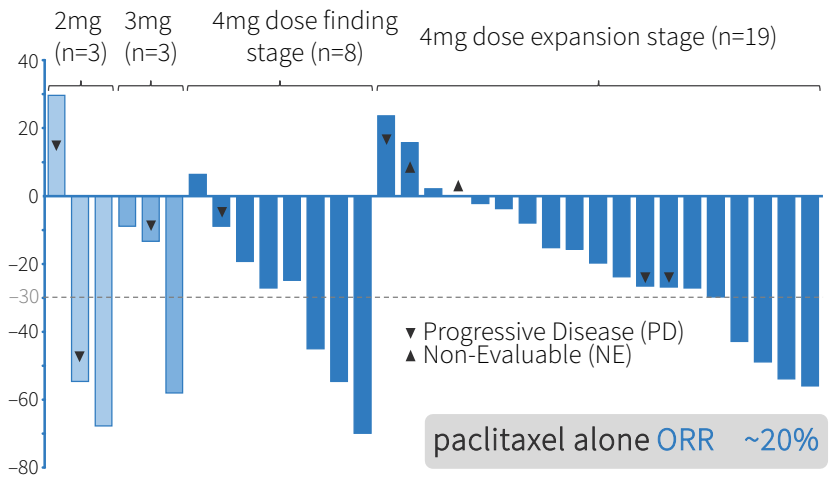
Gastric (stomach) cancer is the 5th most common cancer globally –769,000 deaths/year



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



FRUTIGA study design

Patient eligibility
- Gastroesophageal junction or gastric cancer
- Progressed after 1st line chemo w/ fluoropyrimidine & platinum

N=700

R 1:1

Fruquintinib 4mg QD 3/1 + paclitaxel 80mg/m², D1, D8, D15
28-day per cycle

Placebo + paclitaxel 80mg/m², D1, D8, D15
28-day per cycle

Treatment until: progression or unacceptable toxicity or withdrawal

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)

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

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

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

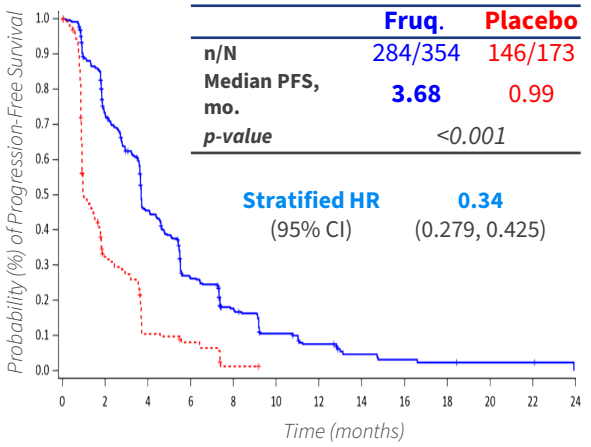
Good safety; most Grade ≥3 TEAEs target-related & clinically manageable.

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

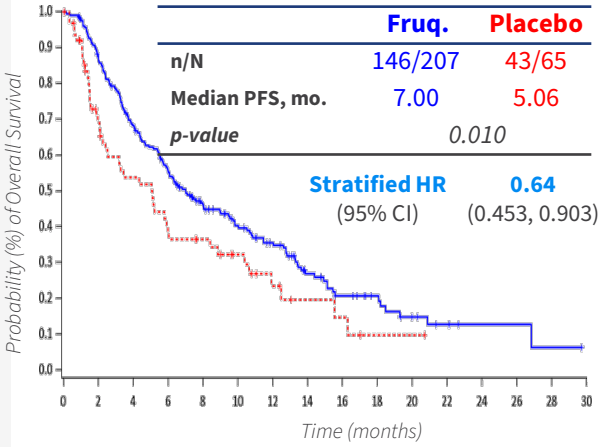
Significant difference in subsequent anti-tumor treatments (ATT)

- 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

PFS in ITT population



OS in pts w/o subsequent ATT



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

HUTCHMED

A4d

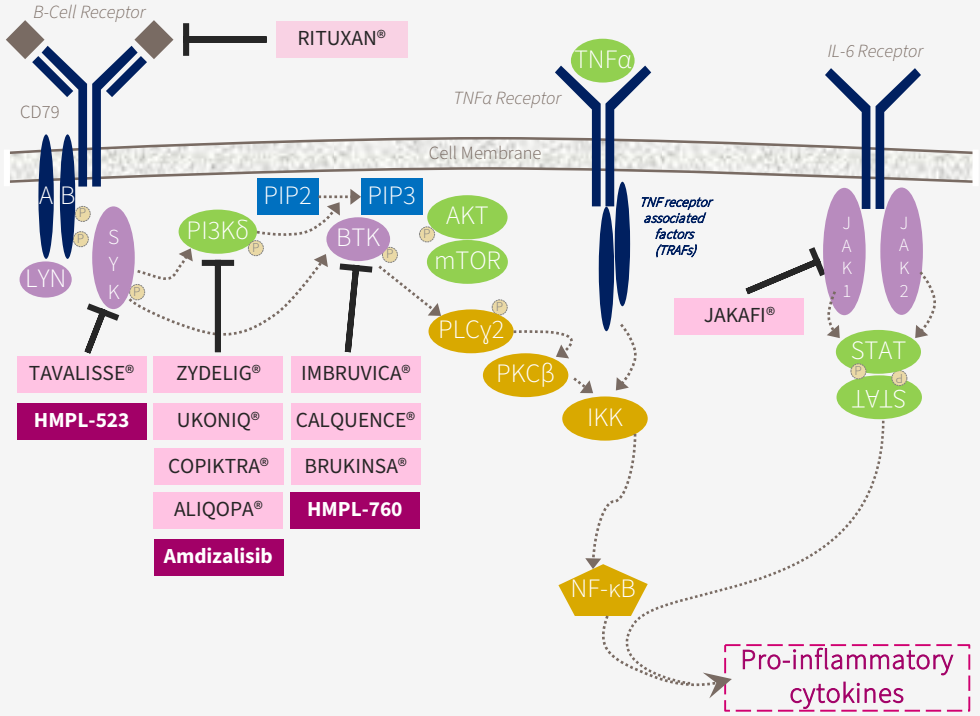
AMDIZALISIB (HMPL-689) & HMPL-523

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 PI3Kδ

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

Enzyme IC_{50} (nM)	Amdizalisib	ZYDELIG®	COPIKTRA®	ALIQOPA®
PI3Kδ	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)**
PI3Kβ (fold vs. PI3Kδ)	87 **(109x)**	293 **(147x)**	8 **(8x)**	3.7 **(5x)**
PI3Kδ human whole blood CD63+	3	14	15	n/a

[1] Approved Drug = ®; [2] Recommended Phase II Dose.

Amdizalisib: finding room for improvement

HUTCHMED

Safety profiles of current PI3Kδ inhibitors are not good

PI3Kδ inhibitors being developed in a broad range of indications.

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

CLL/SLL: chronic lymphocytic leukemia/small lymphocytic lymphoma; FL: follicular lymphoma; MZL: marginal zone lymphoma; MCL: mantle cell lymphoma; DLBCL: diffuse large B cell lymphoma; HL: Hodgkin's lymphoma; NHL: non-Hodgkin's lymphoma.
[1] Accelerated approval was granted based on ORR, continued approval may be contingent upon verification and description of clinical benefit in a confirmatory trials; [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 occurred in ≥ 10% of patients	Dose Esc. (N=56) [1]		Dose Exp. 30mg (N=90) [2]	
	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%

[1] ASH 2020 Abstract #1135; [2] ESMO 2021 Abstract #833O.

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

Dose escalation

Relapsed/refractory lymphomas

- 5mg QD
- 10mg QD
- 15mg QD
- 20mg QD
- 25mg QD (enrolled)
- 30mg QD (RP2D in China)
- Additional doses up to 50mg QD

Primary endpoint: DLT, MTD, RP2D
Secondary endpoints: ORR, PFS, PK, median time of treatment/response

Dose expansion

FL	MZL
CLL/SLL	WM/LPL
MCL	PTCL
CBCL	Additional subgroups

Primary endpoint: safety

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

USA SPAIN POLAND ITALY DENMARK FINLAND FRANCE

HMPL-523 Global NHL Development Overview

International to build on China data, and explore additional subgroups

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

Dose escalation

Relapsed/refractory lymphomas

100mg
200mg
400mg
600mg
RP2D = 700mg
800mg

Primary endpoint: DLT, MTD, RP2D

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

Dose expansion

n = 10 for each cohort, unless otherwise stated

CLL	**CLL (post BTK) (n=20)**
WM/LPL	FL
PTCL	MCL
CBLC	MZL
HL	

Primary endpoint: safety

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

HUTCHMED

A3e

NEXT WAVE OF INNOVATIONS

TAZVERIK® monotherapy efficacy

HUTCHMED

TAZVERIK™ (tazemetostat) tablets

Follicular Lymphoma

	EZH2 Mutant N=42	EZH2 Wild-Type N=53
Overall Response Rate (95% CI)*	69% (53%, 82%)	34% (22%, 48%)
Complete Response	12%	4%
Partial Response	57%	30%
Duration of Response (in months)		
Median (95% CI)	10.9 (7.2, NE)	13.0 (5.6, NE)
Range	0.0+, 22.1+	1, 22.5+

CI = Confidence Interval; NE = Not Estimable.
*Median time to response for patients with EZH2 MT follicular lymphoma was 3.7 months (range 1.6 to 10.9) and for patients with EZH2 WT follicular lymphoma was 3.9 months (range 1.6 to 16.3).

Epithelioid Sarcoma

	N=42
Overall Response Rate (95% CI)*	15% (7%, 26%)
Complete Response	1.6%
Partial Response	13%
Duration of Response	
% with duration ≥ 6 months	67%
Range in months	3.7, 24.5+

CI = Confidence Interval
*Time to response ranged from 1.4 to 18.4 months.

Source: U.S. prescribing information.

Well tolerated safety profile

Minimal overlapping toxicity with other therapies

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TAZVERIK™ (tazemetostat) tablets

Patients with r/r/ Follicular Lymphoma (AEs ≥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 chest pain, 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 pruritic, 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.

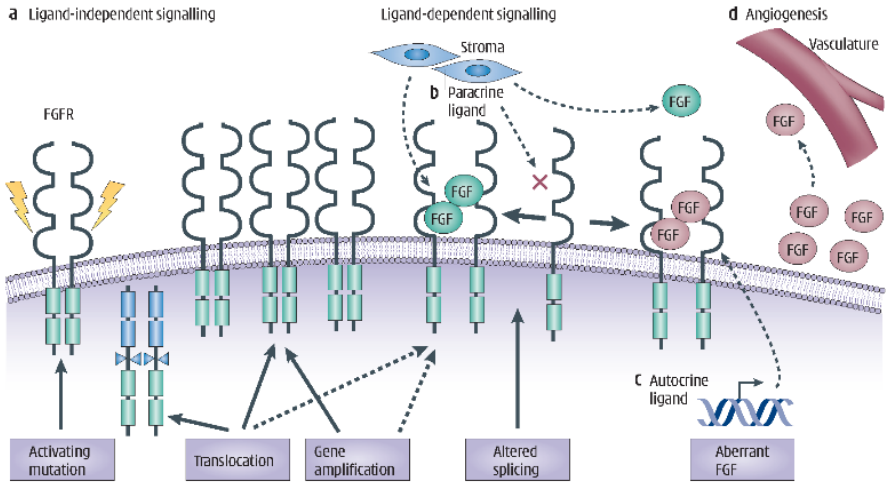
Source: U.S. prescribing information.

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.

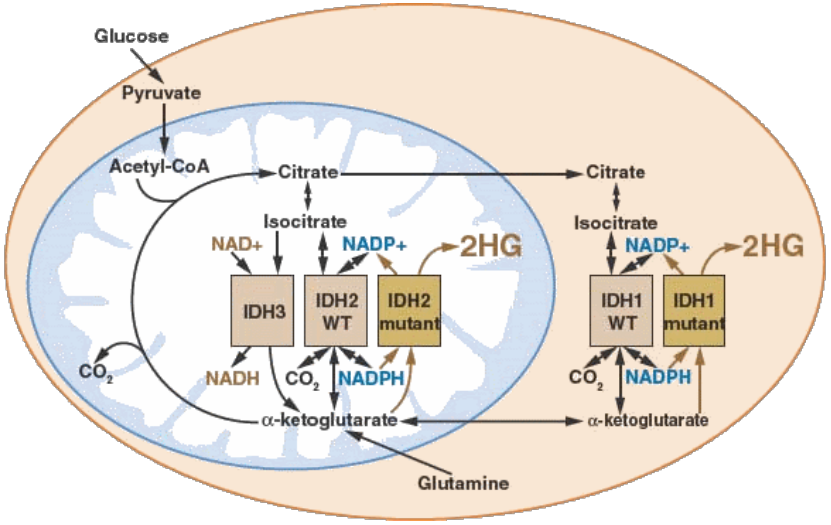
	Gene amplification	Gene translocation	Gene mutation
FGFR1	Lung squamous (7~15%) H&N squamous (10~17%) Esophageal squamous (9%) Breast (10~15%)	Lung squamous (n/a) Glioblastoma (n/a) Myeloproliferative syndrome (n/a) Breast (n/a)	Gastric (4%) Pilocytic astrocytoma (5~8%)
FGFR2	Gastric (5~10%) Breast (4%)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



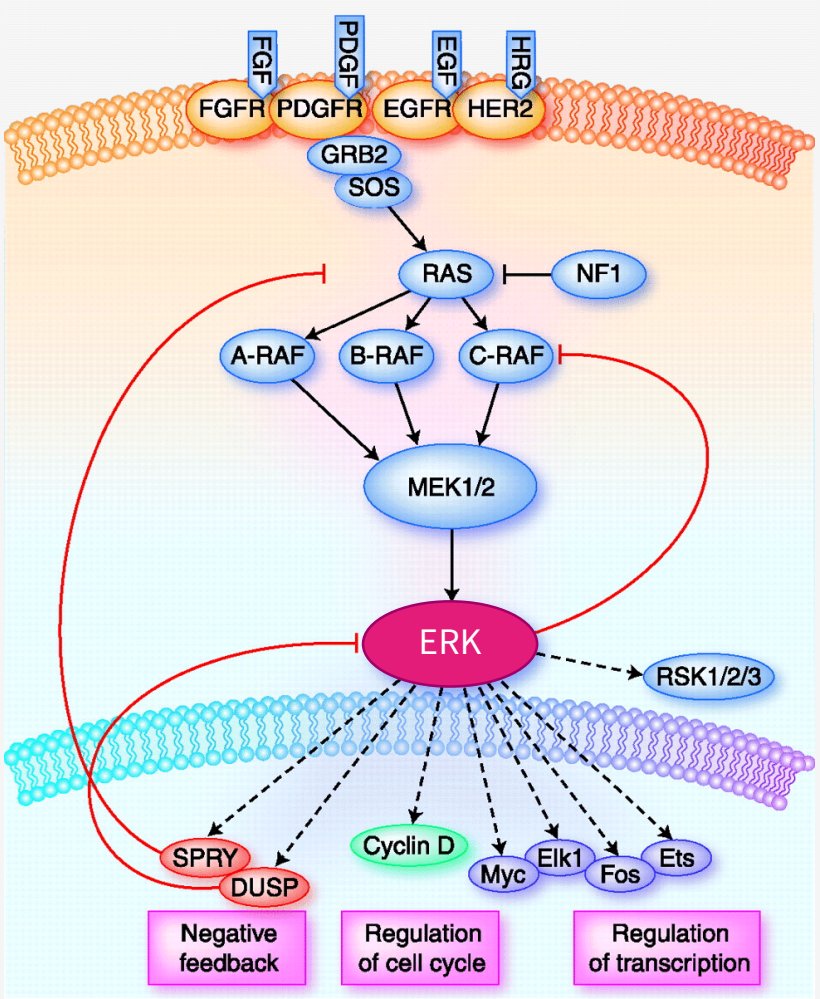
Unmet medical need & potential indications – IDH1/2 mutations are frequent genetic alterations in AML, glioma & solid tumors

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%

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

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

Source: Clin Cancer Res. 2010; 16: 3329-34.

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

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A4

COMMERCIALIZATION

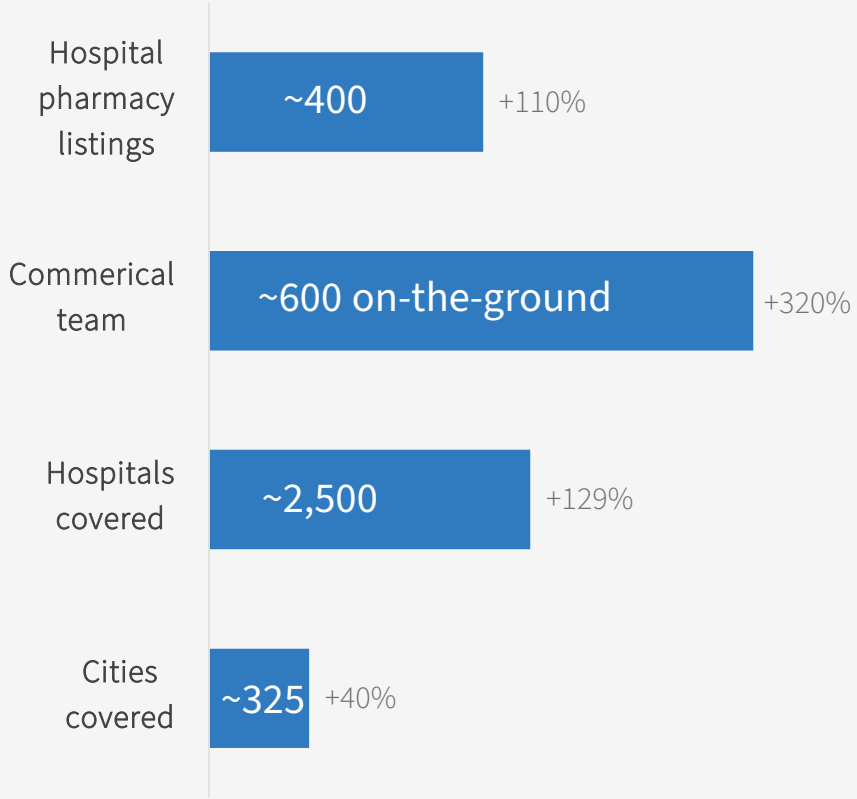
ELUNATE® coverage and key opportunities

HUTCHMED

ELUNATE®
Fruquintinib Capsules

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 2020[1]
- 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

[1]Data source: https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21660

KOL Relationships

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

Academic Platform

Global

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

European ENETS Neuroendocrine Tumor Society

National

CSCO 中国临床肿瘤学会 CHINESE SOCIETY OF CLINICAL ONCOLOGY

中国抗癌协会 CHINA ANTI-CANCER ASSOCIATION

中國初級衛生保健基金會 CHINA PRIMARY HEALTH CARE FOUNDATION

Local

KOL network

National 650 N-KOLs

Provincial 2,600 R-KOLs

16,750+
oncology specialists

Publications

Clear clinical benefits
continuously presented at medical conferences since 2018

Guideline inclusion
Class I recommendation (Level 1A evidence) for the treatment of 3L CRC regardless of RAS and BRAF gene status

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

（三）靶向治疗

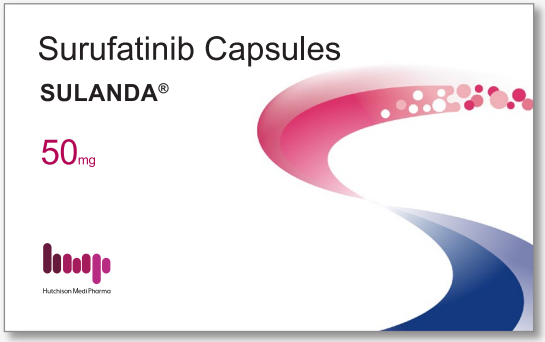
pNET 的靶向治疗主要包括依维莫司（mTOR抑制剂）、舒尼替尼（酪氨酸激酶抑制剂）和索凡替尼（酪氨酸激酶抑制剂）。依维莫司适用于中、低级别的进展期pNET患者，其在抑制肿瘤生长、延长患者中位无进展生存期方面具有明确价值（1A，Ⅰ级推荐）［142］。但依维莫司联合 SSA 可能无法进一步改善患者的远期预后［143］，且其在化疗、PRRT 等失败的患者中可能引起更高的严重不良反应发生率［144］。舒尼替尼通常适用于分化较好的进展期pNET 患者，其能抑制肿瘤生长并延长患者的无进展生存期（1A，Ⅰ级推荐）［145］。但对于亚洲人群，标准剂量（37.5 mg/d）的舒尼替尼常引起较严重的不良反应，而适当降低药物剂量（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**).”

Source: 吴文铭，陈洁，白春梅，等．中国胰腺神经内分泌肿瘤诊疗指南（2020）[J]．中华外科杂志，2021，59（6）：401-421．

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

- ✓ 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

Online symposium

Digital prof. education

Online media center

Lecture tour

Academic promotion

Actively engaging physicians & patients to realize full product value

Medical forum

National brand meetings

Expert consensus group

Medical data sharing

Online platform Offline activities

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A5

MANUFACTURING EXPERTISE

Manufacturing strategy

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Some we control, some we outsource

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

CMC Development & Manufacturing

Leadership

Zhenping Wu, SVP

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

Process Research & Development	Analytical Research & Development	Drug Product Manufacturing & Supply Chain	Biologics CMC
• 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

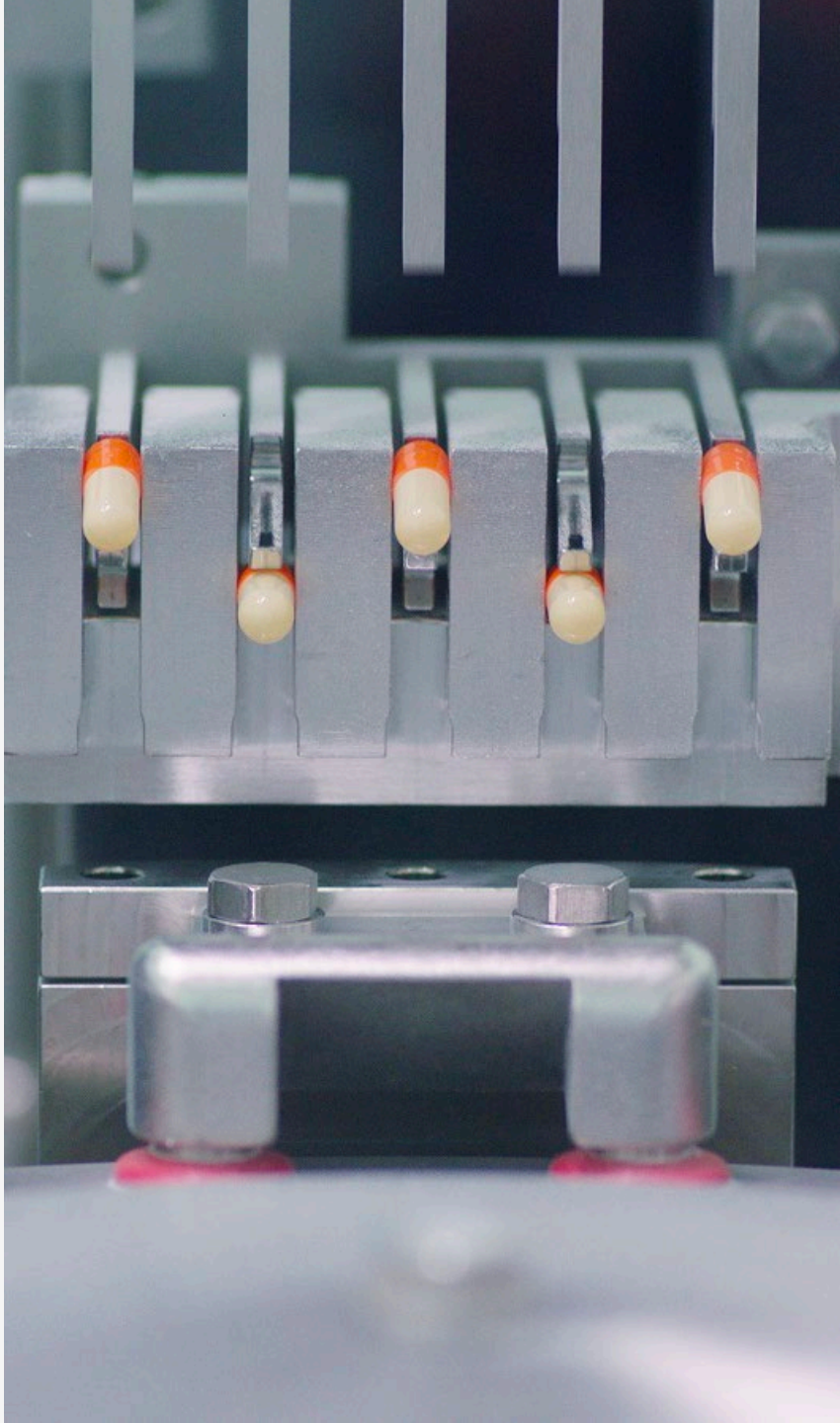
Outsourcing API manufacturing

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



HUTCHMED

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FURTHER CORPORATE INFORMATION

Group Structure

Main Entities / Offices

Consolidated

Non-Consolidated

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

Oncology/Immunology

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

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

Other Ventures[1]

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

Shanghai Hutchison Pharmaceuticals ("SHPL")
(HCM: 50%)
Rx Mfg & Commercialization
Partner: Shanghai Pharma

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

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]

(US$ millions)	Code	NET SALES 2019 Jan-Jun	NET SALES 2020 Jan-Jun	NET SALES 19-20 Growth	NET INCOME 2019 Jan-Jun	NET INCOME 2020 Jan-Jun	NET INCOME 19-20 Growth	NET INCOME 2020 Margin	VALUATION [4] Market Cap.	VALUATION [4] P/E
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

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

	IFRS										US GAAP										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.

National Reimbursement Drug List Pricing

HUTCHMED

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

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

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

National Reimbursement Drug List Pricing

HUTCHMED

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

Brand (generic)	Company	Unit Pricing (US$) [2]				Approximate Monthly Pricing (US$) [2]			Indication coverage
		Dosage	Avg. Tender	Reimbursed	Δ%	Dosage [1]	Avg. Tender	Reimbursed	
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%	1st cycle: 75mg QD for 7 days; 4wk cycle. After 2 cycles increase dose to 100mg, min of 4-6 cycles	$14,022	$5,636	Refractory anemia (RA) or RA with ringed sideroblasts (RARS), RA with excess blasts (RAEB / RAEB-T), and chronic myelomonocytic leukemia (CMMoL)
Inlyta® (axitinib)	Pfizer	5mg	$99	$30	-70%	5mg BID	$5,957	$1,787	2L advanced renal cell carcinoma
Tagrisso® (osimertinib)	AstraZeneca	80mg	$253	$73	-71%	80mg QD	$7,597	$2,201	EGFR TKI refractory T790M+ NSCLC
Ninlaro® (ixazomib)	Takeda	4mg	$3,234	$710	-78%	4mg on Days 1, 8, 15 (28 day cycle)	$12,934	$2,839	2L multiple myeloma
Xalkori® (crizotinib)	Pfizer	250mg	$123	$37	-70%	250mg BID	$7,407	$2,245	Locally adv. or meta. ALK+ or ROS1+ NSCLC
Gilotrif® (afatinib)	Boehringer	40mg	$116	$29	-75%	40mg QD	$3,483	$863	NSCLC with EGFR
Tasigna® (nilotinib)	Novartis	200mg	$39	$14	-65%	400mg BID	$4,645	$1,635	CML
Votrient® (pazopanib)	Novartis	200mg	$66	$23	-65%	800mg QD	$7,891	$2,348	RCC
Sutent® (sunitinib)	Pfizer	12.5mg	$49	$22	-55%	GIST & RCC: 50mg QD pNET: 37.5mg QD	$5,544 $4,455	$2,498 $2,007	RCC, GIST, pNET
Stivarga® (regorafenib)	Bayer	40mg	$52	$28	-46%	160mg QD, 3-wks-on/1-wk-off *	$4,368	$2,352	Meta. CRC, GIST, HCC
Zykadia® (ceritinib)	Novartis	150mg	$108	$28	-74%	450mg QD	$9,699	$2,564	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.

National Reimbursement Drug List Pricing

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

		Unit Pricing (US$) [2]				Approximate Monthly Pricing (US$) [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)	Incyte / 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.

National Reimbursement Drug List Pricing

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

		Unit Pricing (US$) [2]				Approximate Monthly Pricing (US$) [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/m² 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.

National Reimbursement Drug List Pricing

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

Brand (generic)	Company	Unit Pricing (US$) [2]				Approximate Monthly Pricing (US$) [2]			Indication coverage
		Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	
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.

National Reimbursement Drug List Pricing

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

Brand (generic)	Company	Unit Pricing (US$) [2]				Approximate Monthly Pricing (US$) [2]			Indication coverage
		Dosage	Avg. Tender	Reimbursed	Δ%	Dosage	Avg. Tender	Reimbursed	
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)	JNJ	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.