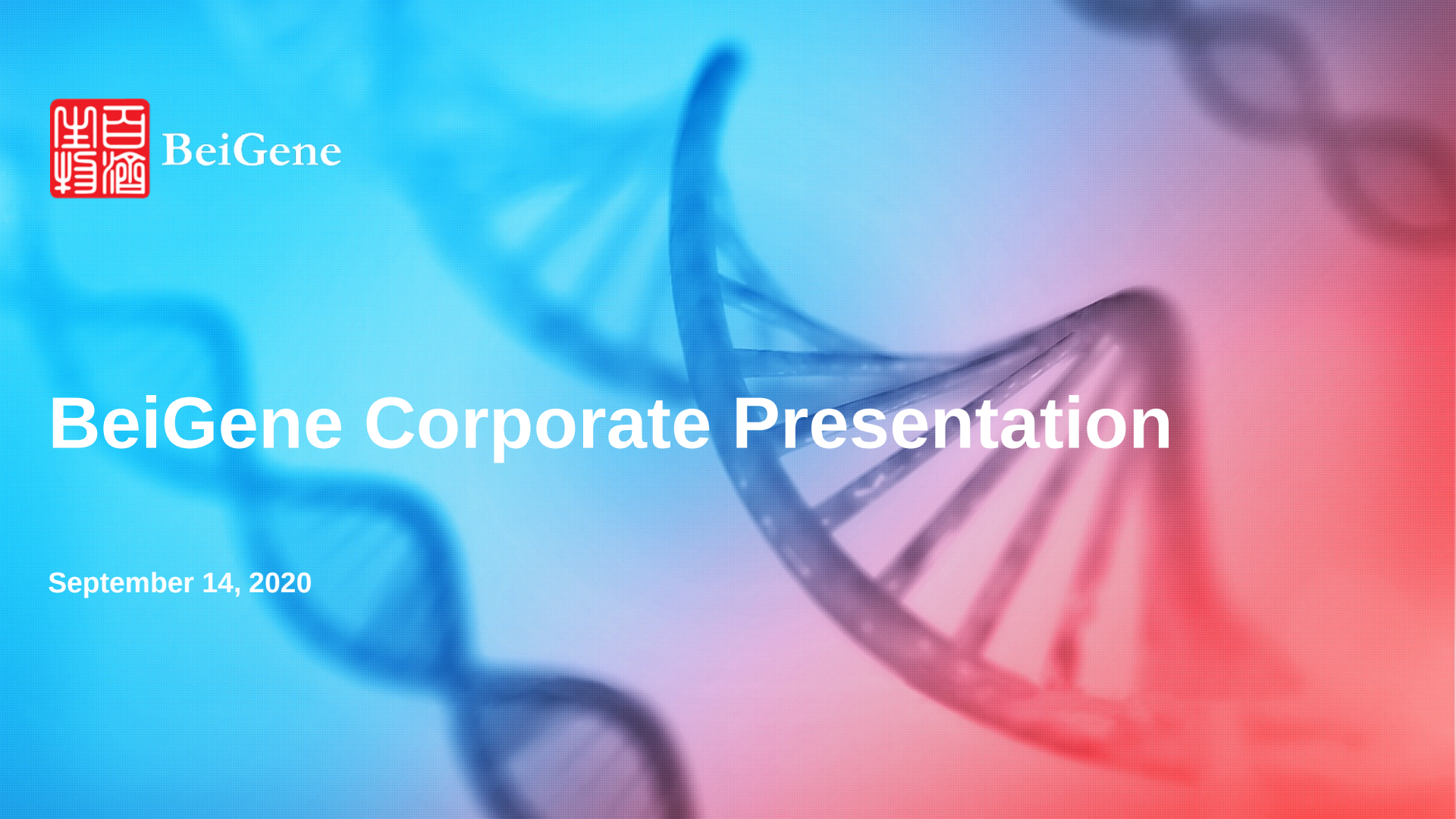


BeiGene Corporate Presentation

September 14, 2020

Disclosures

- Certain statements contained in this presentation and in the accompanying oral presentation, other than statements of fact that are independently verifiable at the date hereof, may constitute forward-looking statements. Examples of such forward-looking statements include statements regarding BeiGene's research, discovery, and pre-clinical and early-stage clinical programs and plans; recent clinical data for BeiGene's product candidates and approvals of its products; the conduct of late-stage clinical trials and expected data readouts; additional planned commercial product launches; the advancement of and anticipated clinical development, regulatory milestones and commercialization of BeiGene's products and drug candidates. Actual results may differ materially from those indicated in the forward-looking statements as a result of various important factors, including BeiGene's ability to demonstrate the efficacy and safety of its drug candidates; the clinical results for its drug candidates, which may not support further development or marketing approval; actions of regulatory agencies, which may affect the initiation, timing and progress of clinical trials and marketing approval; BeiGene's ability to achieve commercial success for its marketed products and drug candidates, if approved; BeiGene's ability to obtain and maintain protection of intellectual property for its technology and drugs; BeiGene's reliance on third parties to conduct drug development, manufacturing and other services; BeiGene's limited operating history and BeiGene's ability to obtain additional funding for operations and to complete the development and commercialization of its drug candidates; the impact of the COVID-19 pandemic on the Company's clinical development, commercial and other operations, as well as those risks more fully discussed in the section entitled "Risk Factors" in BeiGene's most recent quarterly report on Form 10-Q, as well as discussions of potential risks, uncertainties, and other important factors in BeiGene's subsequent filings with the U.S. Securities and Exchange Commission. All information in this presentation is as of the date of this presentation, and BeiGene undertakes no duty to update such information unless required by law.
- Some of the clinical data in this presentation relating to BeiGene's investigational drug candidates is from pre-clinical studies or early phase, single-arm clinical trials. When such data or data from later stage trials are presented in relation to other investigational or marketed drug products, the presentation and discussion are not based on head-to-head trials between BeiGene's investigational drug candidates and other products unless specified in the trial protocol. BeiGene is still conducting pre-clinical studies and clinical trials and, as additional patients are enrolled and evaluated, data on BeiGene's investigational drug candidates may change.
- This presentation and the accompanying oral presentation contain data and information obtained from third-party studies and internal company analysis of such data and information. BeiGene has not independently verified the data and information obtained from these sources. Forward-looking information obtained from these sources is subject to the same qualifications noted above.

BeiGene

Fully-Integrated Global Biotech Company With Unique Strategic Competitive Advantages in Clinical Science and China Commercial

Broad portfolio over 30 assets

- **6** approved drugs
- **8** NDAs in registration in China
- **30+** commercial or clinical stage assets, including 10+ with global rights, 20+ with China/APAC rights
- **27** filed or potentially registration-enabling trials ongoing, 60+ studies in total

Global 4,200+ organization

- 10 offices on 5 continents
- Global clinical development: 1,350+
- Commercial: 1,200+ (China)
  100+ (U.S.)
- Research: 400+
- Internal manufacturing capabilities

Key 2020-21 catalysts

- Up to 11 commercial products
- Potentially several launches of internal and collaborative products
- More than 10 Phase 3 or potentially registration-enabling trial readouts
- $2 billion follow-on further strengthens balance sheet for future growth

Brukinsa™ zanubrutinib 80mg capsules

U.S. launch for R/R MCL[1]; China launch for R/R MCL, R/R CLL/SLL[2]

tislelizumab 百泽安®

R/R cHL & R/R UC launched[3], 1L Sq & non-Sq NSCLC sNDAs accepted, 2L/3L HCC sNDA accepted[4]

BeiGene + AMGEN

Global strategic collaboration
$2.8 billion investment
Commercial and pipeline assets

1. November 14, 2019; this indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial. 2. June 3, 2020 for adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) who have received at least one prior therapy, and for the treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy. 3. December 26, 2019; approved for patients with classical Hodgkin's lymphoma who have received at least two prior therapies. April 10, 2020 for the treatment of patients with previously treated locally advanced or metastatic urothelial carcinoma (bladder cancer). 4. April 20, 2020, June 19, 2020, July 1, 2020, respectively.

Transformational Collaboration with Amgen

Validates BeiGene's China-inclusive global development and commercial capabilities

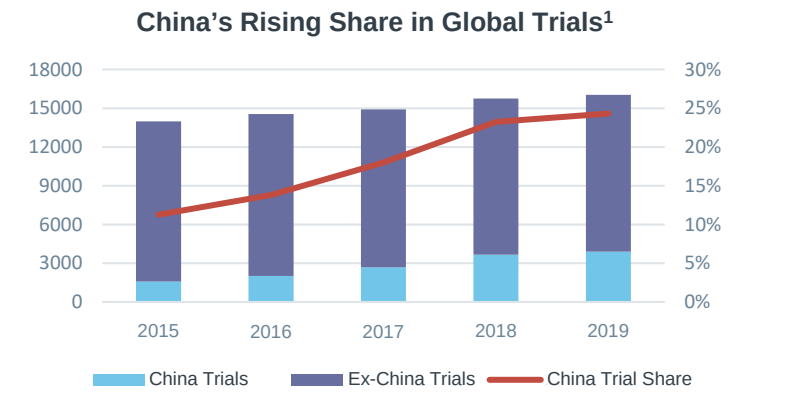
- **Collaboration rationale**
  - Joining forces to fight one common enemy: cancer
  - Expected to accelerate access to important oncology medicines for patients in China and globally
- **BeiGene expects to launch three Amgen oncology medicines in China**

XGEVA® (denosumab) Kyprolis™ (carfilzomib) for injection BLINCYTO® (blinatumomab) for injection 35 mcg single-dose vial

- **Companies to jointly develop Amgen oncology pipeline assets**
  - BeiGene to lead development and commercialization in China as well as contribute to funding global development
  - BeiGene receives royalties on global ex-China sales (excluding AMG 510) and on China sales after commercialization
- **Investment by Amgen of $2.8B for 20.5% stake of BeiGene**
- **Tony Hooper, former Amgen EVP of Global Commercial Operations, joined the BeiGene board**

BeiGene

Regulatory Reforms and Reimbursement Expansion in China Create a Historical Opportunity for the Industry



China is Now An Integral Part of Industry Development

- Increasing share of trials run in China after joining ICH in 2017, bringing China's large patient pool into to global clinical science ecosystem – which has the potential to dramatically accelerate development and reduce costs
- Beginning to meaningfully contribute to paying for innovation
  - MNC oncology product sales in China witnessed a significant uptick as a result of expanded NRDL coverage
  - AZ revenue in H1-2020 was $2.7 billion from China, which was 21% of total global revenue and 61% of emerging markets total revenue

Future Key Success Factors

- Clinical excellence through
  - Global, highly China-inclusive clinical trials
  - Next generation clinical technology approaches
- Creation of science/medicine-based commercial capabilities in China
- Global business model provides broader access and supports pricing that enables the ROW to contribute to covering the cost of innovation

Source: 1. Trialtrove; Industry association; 2. BeiGene analysis

Our Strategies for Building a Leading Global Innovative Biotech Company from China

- **Realize two large internally-developed near-term commercial opportunities**
  - **BRUKINSA (zanubrutinib)** for the global market as a potentially best-in-class BTK inhibitor
  - **Tislelizumab** as a uniquely designed PD-1 antibody for the most common cancers in China and Asia
- **Utilize our key strategic capabilities**
  - Research team 400+, proven track record, 11 molecules discovered in-house, advanced to clinic in 10 years
  - Development team 1,200+ integrated across China/U.S./AU/EU
  - Commercial platforms in China and the U.S., the two largest pharmaceutical markets
- **Expand our portfolio by leveraging our clinical and commercial capabilities**
  - Capture opportunities created by regulatory reforms in China
  - Accelerate global development through China-inclusive global trials
- **Pursue a new global model for long-term growth in the industry**
  - Uniquely positioned due to strong China presence and global development capabilities

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Brukinsa (Zanubrutinib) Overview

Potentially best-in-class BTK inhibitor

ADVANTAGES

- **Second generation, maximize BTK occupancy, minimize off-target binding**
- **Advantageous label in R/R MCL (dose flexibility-QD/BID, 100% BTK occupancy, PPI/H2RA)**
- **Randomized Phase 3 data demonstrated improved safety / tolerability and suggested improved efficacy**
- **Priced more affordably than competitors in U.S. (8.7% v acalabrutinib, 7.4% v ibrutinib)**

KEY TARGET INDICATIONS

Chronic lymphocytic leukemia/small lymphocytic lymphoma, Waldenström's macroglobulinemia, mantle cell lymphoma, follicular lymphoma, marginal zone lymphoma

CLINICAL DATA

86-patient R/R MCL[1]	83-patient R/R WM[2]	101-patient R/R CLL/SLL[3]	109-patient 1L CLL/SLL Del17p[4]
▪ 84% ORR ▪ 59% CR	▪ 94% ORR ▪ 28% VGPR	▪ 95% ORR ▪ 14% CR	▪ 93% ORR ▪ 2% CR

REGULATORY STATUS

- **U.S. FDA accelerated approval in R/R MCL on November 14, 2019**
- **NMPA approval in China for R/R MCL and R/R CLL/SLL on June 3, 2020**
- Fast Track in WM and Breakthrough Therapy in MCL by U.S. FDA

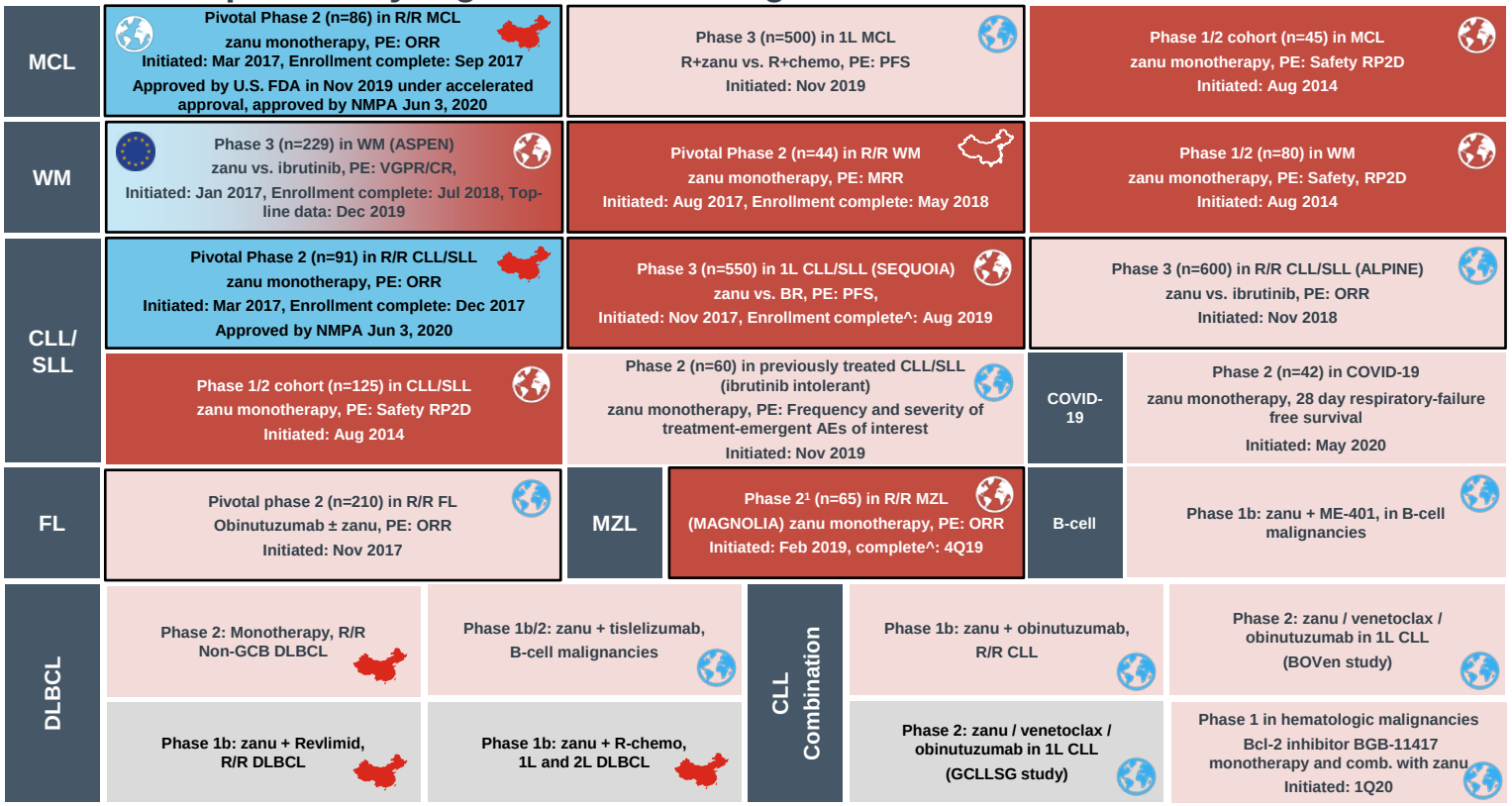
BREADTH OF PROGRAM

- **Over 2,700[5] patients treated with zanubrutinib in clinical trials, safety data on over 600 patients in FDA label**
- Over 25 clinical trials in eight indications
- Over 40 presentations of zanubrutinib clinical data
- Potential internal Bcl-2 inhbitor combination

Sources: 1. ICML 2019 Song et. al.; 2. ASCO 2020 Tam et. al.; 3. Cull et. al. ASH 2019; 4. Tam et. al. ASH 2019; 5. As of June 15, 2020. BTK: Bruton's tyrosine kinase; CLL/SLL: chronic lymphocytic leukemia/small lymphocytic lymphoma; CR: complete response; FL: follicular lymphoma; MCL: mantle cell lymphoma; MZL: marginal zone lymphoma; MRR: major response rate; NDA: new drug application; ORR: overall response rate; R/R: relapsed/refractory; RT: Richter's transformation; VGPR: very good partial response; WM: Waldenström's macroglobulinemia.

Brukinsa Broad Clinical Development Program

Nine filed or potentially registration-enabling studies



^Time of the announcement of the enrollment completion; 1L: First Line; CLL/SLL: Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma; CR: Complete Response; DLBCL: Diffuse Large B-Cell Lymphoma; FL: Follicular Lymphoma; GCB: Germinal Center B-cell-like; MCL: Mantle Cell Lymphoma; MRR: Major Response Rate; MZL: Marginal Zone Lymphoma; NHL: Non-Hodgkin's Lymphoma; ORR: Overall Response Rate; PCNSL: Primary Central Nervous System Lymphoma; PE: Primary endpoint; PFS: Progression-Free Survival; RP2D: Recommended Phase 2 Dose; R/R: Relapsed / Refractory; RT: Richter's Transformation; VGPR: Very Good Partial Response; WM: Waldenström's Macroglobulinemia. 1. global trial and potentially registration-enabling in certain countries.

Tislelizumab Overview

PD-1 inhibitor targeting Asia-prevalent tumors

ADVANTAGES

- **Differentiated mechanism: minimized binding to FcγR**
- **Differentiated Hodgkin's data with high CR rate**
- **To enable broad reimbursement, aggressively pursuing label in most common cancers in Asia**
- **World-class manufacturing partner with BI, 35 years of experience, >35 molecules brought to market**

KEY TARGET INDICATIONS

Breadth wins in China's label-based reimbursement: Lung, liver, gastric, and esophageal cancers, classical Hodgkin's lymphoma, urothelial carcinoma, nasopharyngeal, MSI-High

CLINICAL DATA

360-patient 1L Sq NSCLC[1]

- **Tisle+PC ORR 73%, CR 4%**
- **Tisle+nPC ORR 75%, CR 3%**
- **PC ORR 50%, CR <1%**

65-patient China label data R/R cHL[2]

- **77% ORR**
- **62% CR**

101-patient China label 2L+ PD-L1+ UC[3]

- **25% ORR**
- **10% CR**

REGULATORY STATUS

- **China NMPA approval of tislelizumab in R/R cHL on December 26, 2019**
- **China NMPA approval of tislelizumab in R/R PD-L1+ UC on April 10, 2020**
- NMPA accepts sNDAs for 1L sq-NSCLC, 1L Non-sq-NSCLC, 2L/3L HCC on April 20, June 19 and July 1, 2020

BREADTH OF PROGRAM

- **Over 5,800[4] patients enrolled in tislelizumab studies**
- Over 25 clinical trials in a dozen indications
- Over 30 presentations of tislelizumab clinical data

Sources: 1. Wang et. al., ASCO 2020; 2. Chinese cHL label; 3. Chinese UC label; 4. As of June 14, 2020. cHL: classical Hodgkin's lymphoma; CR: complete response; MSI: microsatellite instability; NDA: new drug application; NMPA: National Medical Products Administration; nPC: *nab*-paclitaxel; NSCLC: non small cell lung cancer; ORR: overall response rate; PC: paclitaxel; PD-L1: programmed death ligand-1; R/R: relapsed/refractory; Sq: squamous; Tisle: tislelizumab; UC: urothelial carcinoma.

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Tislelizumab Broad Late-stage Development Program

Sixteen filed or potentially registration-enabling studies

Lung	Phase 3 (n=320) in 1L Stage IIIB or IV non-squamous NSCLC tislelizumab+ chemo (platinum-pemetrexed) vs. chemo, PE: PFS Initiated: Jul 2018, Enrollment complete^: Aug 2019, sNDA accepted Jun 2020	Phase 3 (n=360) in 1L Stage IIIB or IV squamous NSCLC tislelizumab+ paclitaxel and carboplatin combo or nab-paclitaxel and carboplatin combo vs. paclitaxel and carboplatin combo, PE: PFS Enrollment complete^: Aug 2019, sNDA accepted Apr 2020
	Phase 3 (n=800) in 2L NSCLC tislelizumab vs. docetaxel, PE: OS Initiated: Nov 2017	Phase 3 (n=364) in 1L SCLC Tislelizumab+ chemo (Carboplatin /Cisplatin, Etoposide) vs. placebo + chemo, PE: PFS, OS Initiated: July 2019
	Phase 3 (n=380) Neoadjuvant in Stg II/IIIA NSCLC Tislelizumab+ chemo (Platinum doublet) vs. placebo + chemo, followed by tislelizumab or placebo Initiated: May 2020	**GC** Phase 3 (n=720) in 1L advanced GC tislelizumab or placebo + platinum- and fluoropyrimidine-based chemo, Co-PE: PFS and OS Initiated: Dec 2018
HCC	Phase 3 (n=640) in 1L HCC tislelizumab vs. sorafenib, PE: OS Initiated: Jan 2018, Enrollment complete^: Nov 2019	Phase 2 (n=225) in 2L/3L HCC tislelizumab monotherapy, PE: ORR by IRC Initiated: Apr 2018, Enrollment complete^: Feb 2019, sNDA accepted Jul 2020
ESCC	Phase 3 (n=450) in 2L ESCC tislelizumab vs. single-agent chemo (paclitaxel, docetaxel, or irinotecan), PE: OS Initiated: Jan 2018, Enrollment complete^: 1Q20	Phase 3 (n=480) in 1L advanced ESCC tislelizumab or placebo + platinum- and fluoropyrimidine-based chemo, Co-PE: PFS and OS Initiated: Dec 2018
	Phase 3 (n=316) in localized ESCC tislelizumab + chemoradiotherapy vs chemoradiotherapy, PE: OS Initiated: May 2019	**MSI-H or dMMR solid tumors** Pivotal phase 2 (n=60) in MSI-H or dMMR solid tumors tislelizumab monotherapy, PE: ORR Initiated: Sep 2018
UC	Pivotal phase 2 (n=110) in 2L UC tislelizumab monotherapy, PE: ORR, Initiated: Jul 2017 Enrollment complete: Aug 2018, NDA accepted in May 2019 and approved by NMPA in May 2020	Phase 3 (n=420) in 1L UC tislelizumab + chemo (cisplatin + carboplatin + gemcitabine) vs placebo + chemo PE: OS Initiated: June 2019
cHL	Pivotal phase 2 (n=70) in R/R cHL tislelizumab monotherapy, PE: ORR Initiated: Apr 2017, Enrollment complete: Nov 2017, NDA accepted in Aug 2018 and approved by NMPA Dec. 2019	**NPC** Phase 3 (n=256) in 1L tislelizumab + chemo (gemcitabine plus cisplatin) vs. placebo + chemo PE: PFS Initiated: Apr 2019

Approved
Filed, in NDA review
Enrollment complete
Enrolling
Planned
Filed or potentially registrational

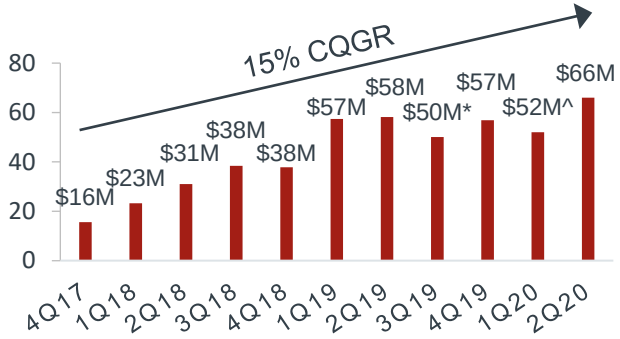
China
Global

^Time of the announcement of the enrollment completion; *Tislelizumab dosage 200mg every three weeks, Q3W. Global Ph2 in R/R/ NK/T-cell lymphoma and Ph2 trial in MSI-H or dMMR solid tumors in China are potentially registrational-enabling trials. 1/2L: First/Second Line; cCRT: concurrent chemoradiotherapy; cHL: Classical Hodgkin's Lymphoma; ESCC: Esophageal Squamous-Cell Carcinoma; GC: Gastric Cancer; HCC: Hepatocellular Carcinoma; IRC: Independent Review Committee; ITT: Intent-to-treat; MSI-H or dMMR: Microsatellite Instability High or Deficient Mismatch Repair; NDA: New Drug Application; NK: Natural Killer; NSCLC: Non-Small Cell Lung Cancer; ORR: Overall response rate; OS: Overall survival; PE: Primary Endpoint; PFS: Progression-free survival; R/R: Relapsed / Refractory; UC: Urothelial Carcinoma;

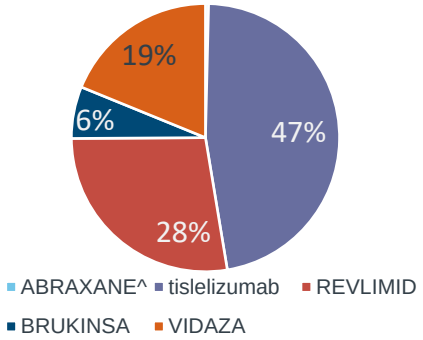
BeiGene

Commercial Footprint in Two Largest Pharmaceutical Markets and Science and Medicine-Based Team in China

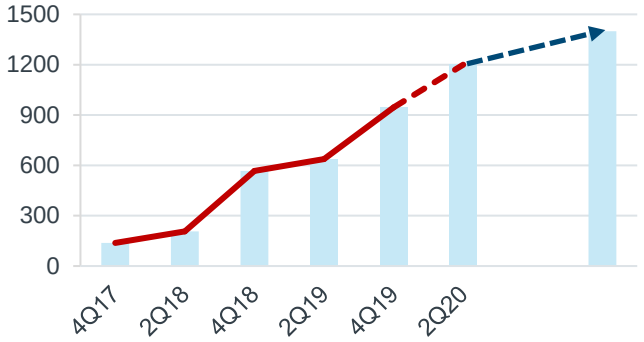
Marketed brand revenue since transition to BeiGene



2Q 2020 China Marketed Products Breakdown



A growing 1,200+[1] top innovative oncology commercial team covering 800 – 1,000 hospitals in China



Xiaobin Wu, Ph.D.
GM of China, President
Pfizer
Wyeth
Bayer

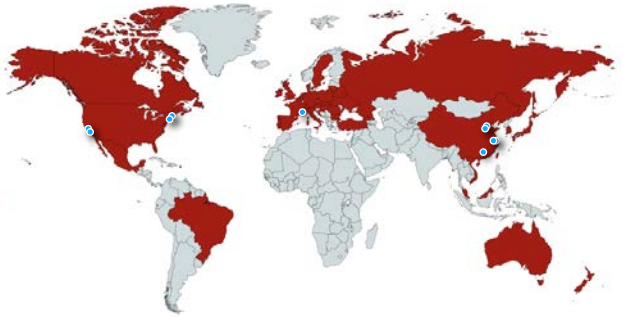
Anita Wu
Chief Commercial Officer, Greater China
Sanofi
AstraZeneca

Lily Liu
VP, Head of Marketing, Greater China
Takeda
Pfizer

Josh Neiman
Head, U.S. Commercial
Flatiron
Onyx Pharmaceuticals
Genentech

1. As of March 31, 2020; * Sales negatively impacted by temporary supply disruptions of ABRAXANE; ^ Revenues in the first quarter were subject to the negative impact of the COVID-19 pandemic, increased generic competition, and the suspension of ABRAXANE sales in China by the NMPA in March 2020.

Running global trials of the highest quality through China



BeiGene trials in over 35 countries & regions

- **Global clinical development organization of over 1,200 people across 10 offices and 5 continents**
- **Over 9,000 patients enrolled by BeiGene**
- **Running 60+ clinical trials in over 35 countries or regions**
  - 27 Phase 3 or potentially registration-enabling studies

Jane Huang, M.D.
Chief Medical Officer, Hematology
Genentech, Acerta

Yong Ben, M.D.
Chief Medical Officer, Immuno-Oncology
BioAtla, AstraZeneca

Lai Wang, Ph.D.
SVP, Head of Global Research, Clinical Operation & Biometrics and APAC Clinical Development
UT Southwestern Medical Center

Melika Davis
VP, Global Head of Clinical Operations
SVP, Global Head of Drug Development Quality at Novartis

John Freeman
SVP, Chief Safety Officer
SVP, Head of Global Drug Safety & Risk Management at Celgene

BeiGene

Research Delivered 11 Molecules to the Clinic in its First 10 Years

2011–2018

Beijing Research Center
(ONLY 1ST AND 2ND FLOOR)

- Team size <200
- **6-8 preclinical programs**

TODAY

Beijing Research Center

- Team size 400+
- **~12 preclinical programs**

NEAR FUTURE

Beijing Research Center
Shanghai Research Center

- Team size 650+
- **Capability for ~24 preclinical programs**

BeiGene

Strong Manufacturing Capabilities

MULTI-FUNCTIONAL MANUFACTURING FACILITY IN SUZHOU

- Aligned with the design criteria of **U.S., EU, and China**
- **Commercial-scale** small molecule drug products facility
- Pilot-scale biologic facility

- Manufacturing collaborations with leading high-quality manufacturers in **biologics** and **small molecules**
- **BI collaboration** established in 2013; cell line and CMC process for tislelizumab developed by BI

EXPERIENCED, HIGH-QUALITY MANUFACTURING PARTNERS

BIOLOGICS MANUFACTURING FACILITY IN GUANGZHOU

- **100,000 square meter** manufacturing site; **50,000-liter** commercial-scale biologics manufacturing facility under construction
- Initial phase and facility validation **completed in September** 2019; received clinical GMP certificate, and in the process of commercial validation
- Second phase construction begun

William Novotny, Advisor, Technical Operations

BMS, *VP and Global Lead in Supply Chain*
Merck, *AVP in Global Supply Chain Management and Product Operations*

Zhengming Du, Ph.D. Head of Chemistry Manufacturing & Control (CMC)

Roche China, *Head of Process and Synthesis, Deputy Head of CMC*

Jonathan Liu, Ph.D. SVP, Bio-Manufacturing

J&J, *Head of China Pharmaceutical Development and Manufacturing Sciences*

Michael Garvey VP, Head of Guangzhou Biologics Manufacturing

Samsung Biologics, *VP of Manufacturing*

Growing Commercial-Stage Portfolio

PRODUCT	LEAD INDICATIONS	MECHANISM OF ACTION	REGULATORY STATUS	COMMERCIAL RIGHTS	2019 GLOBAL SALES	PARTNER
Brukinsa (zanubrutinib)	R/R MCL (U.S.)/ R/R MCL and R/R CLL/SLL (China)	BTK inhibitor	Approved in the U.S./ Approved in China	Global	NA	N/A
tislelizumab 百泽安	R/R classical Hodgkin's lymphoma	Anti-PD-1 antibody	Approved in China	Global	NA	N/A
pamiparib	Ovarian, Breast, Prostate Cancers	PARP Inhibitor	NDA filed in China	Global	NA	N/A
Abraxane (nanoparticle albumin-bound paclitaxel)	Breast cancer	Microtubule inhibitor	Approved in China[1]	Mainland China	$1.3B*	BMS
Revlimid (lenalidomide)	R/R adult multiple myeloma, newly diagnosed multiple myeloma	Direct anti-tumor, anti-angiogenesis, immunomodulation	Approved in China	Mainland China	$10.8B*	BMS
Vidaza azacitidine for injection	Myelodysplastic syndromes, acute myeloid leukemia, chronic myelomonocytic leukemia	DNA hypomethylation, direct cytotoxicity	Approved in China	Mainland China	$605M*	BMS
XGEVA (denosumab)	Giant cell tumor of bone / Skeletal Related Events (SREs)	Anti-RANK ligand antibody	Approved in China / NDA accepted in China	Mainland China	$1.9B^	Amgen
Kyprolis (carfilzomib)	Multiple myeloma	Proteasome inhibitor	NDA filed in China	Mainland China	$1.0B^	Amgen
BLINCYTO (blinatumomab)	Acute lymphocytic leukemia	Anti-CD19 x anti-CD3 bispecific (BiTE) antibody	NDA filed in China	Mainland China	$312M^	Amgen
sylvant (siltuximab)	Idiopathic multicentric Castleman disease	IL-6 antagonist	Fast track listed in China	Greater China		EUSA
QARZIBA (dinutuximab beta)	High-risk neuroblastoma	Anti-GD2 antibody	Fast track listed in China	Mainland China		EUSA

1 As announced previously, the NMPA suspended the importation, sales and use of ABRAXANE® (nanoparticle albumin-bound paclitaxel) in China supplied to BeiGene by Celgene Corporation, a Bristol Myers Squibb (BMS) company. Source: * Celgene, ^ Amgen. MCL = mantle cell lymphoma, CLL/SLL = chronic lymphocytic leukemia/small cell lymphoma.

BeiGene's Internal Pipeline

Three late-stage, and eight early-stage clinical assets

Global
China

ASSETS	PROGRAMS	DOSE ESC.	DOSE EXPANSION		PIVOTAL		FILED	MARKET
		PH1a	PH1b	PH2*	PH2**	PH3		
zanubrutinib *(BTK)*	**monotherapy**	*R/R MCL (Accelerated approval in the U.S. 11.14.19)*						
		WM† (MAA accepted 06.18.20), R/R MCL (NDA in Israel accepted 05.21.20)						
		R/R MCL, R/R CLL/SLL (Approved by NMPA in China 06.03.20)						
		R/R WM						
		1L CLL/SLL, R/R CLL/SLL						
		R/R MZL						
		Previously treated CLL/SLL (ibrutinib intolerant)						
	combination	*+rituximab 1L MCL*						
		+obinutuzumab R/R FL						
tislelizumab *(PD-1)*	**monotherapy**	*R/R cHL (approved 12.26.19), 2L+ UC (approved 04.10.20)*						
		2L/3L HCC						
		2L NSCLC, 1L HCC, 2L ESCC						
		R/R NK/T-cell lymphoma						
	+ chemo	*1L Non-Sq. NSCLC (sNDA accepted 06.19.20), 1L Sq. NSCLC (sNDA accepted 04.04.20)*						
		1L NPC, 1L SCLC, Stage II/IIIA NSCLC, Localized ESCC						
		1L GC, 1L ESCC						
	+ pamiparib *(PARP)* **+ zanubrutinib** *(BTK)*	*Solid tumors*						
		B-cell malignancies						
pamiparib *(PARP)*	**Monotherapy**	*1L platinum-sensitive GC maintenance*						
		2L platinum-sensitive OC maintenance						
		3L gBRCA+ OC						
		HER2- BRCA mutated breast cancer						
		Solid tumors						
	+ TMZ *(chemo)*	*Solid tumors*						
	+ RT/TMZ *(RT/chemo)*	*Glioblastoma*						
lifirafenib *(RAF Dimer)*	**Monotherapy**	*B-Raf- or K-RAS/N-RAS-mutated solid tumors*						
		B-Raf- or K-RAS/N-RAS-mutated solid tumors						
BGB-A333 *(PD-L1)*	**monotherapy & + tislelizumab**	*Solid tumors*						
BGB-A425 *(TIM-3)*	**monotherapy & + tislelizumab**	*Solid tumors*						
BGB-A1217 *(TIGIT)*	**+ tislelizumab**	*Solid tumors*						
BGB-A445 *(OX40)*	**+ tislelizumab**	*Solid tumors*						
BGB-11417 *(Bcl-2)*	**monotherapy & + zanubrutinib**	*B-cell malignancies*						
BGB-10188 *(PI3-Kδ)*	**mono; + tislelizumab; + zanubrutinib**	*B-cell malignancies; Solid tumors*						
BGB-15025 *(HPK1)*	**monotherapy & + tislelizumab**	*IND enabling studies ongoing*						

*Some indications will not require a non-pivotal Ph2 clinical trial prior to beginning pivotal Ph2 or Ph3 clinical trials. **Confirmatory clinical trials post approval are required for accelerated approvals. † R/R or not suitable for chemo-immunotherapy 1. By MapKure, a JV with SpringWorks

BeiGene's Collaborative Pipeline

Over 20 compounds

Global
China

COMPOUND	(TARGET) / PROGRAM	DOSE ESC.	DOSE EXPANSION		PIVOTAL		COMMERCIAL RIGHTS	PARTNER
		PH1a	PH1b	PH2*	PH2**	PH3		
AMG 510	*(KRAS G12C)*	*Solid Tumors, NSCLC, CRC*					*China*	Amgen
AMG 701^^	*(BCMA)*	*MM*						
AMG 176	*(Mcl-1, SM (i.v.))*	*Hematologic malignancies*						
AMG 397	*(Mcl-1, SM (oral))*	*Hematologic malignancies*						
AMG 330^	*(CD33)*	*Myeloid malignancies*						
AMG 673^^	*(CD33)*	*AML*						
AMG 427^^	*(FLT3)*	*AML*						
AMG 562^^	*(CD19)*	*NHL*						
AMG 596^	*(EGFRvIII)*	*Glioblastoma*						
AMG 757^^	*(DLL3)*	*SCLC*						
AMG 160^^	*(PSMA)*	*Prostate cancer*						
AMG 506	*(FAP x 4-1BB, DARPin®)*	*Solid Tumors*						
AMG 199^^	*(MUC17)*	*GC/GEJC*						
Sitravatinib	*(multi-kinase inhibitor) + tislelizumab* *Mono, + tislelizumab*	*NSCLC, RCC, OC, MEL* *HCC, GC/GEJC*					*Asia ex-Japan, AU, NZ*	Mirati
Zanidatamab†	*(HER2, bispecific antibody)*	*Breast cancer, GEA*					*Asia ex-Japan, AU, NZ*	Zymeworks
ZW49	*(HER2, bispecific ADC)*	*Planned (in Ph1 ex-China by Zymeworks)*					*Asia ex-Japan, AU, NZ*	Zymeworks
BGB-3245	*(B-RAF)*	*Solid tumors*					*Asia ex-Japan*	SpringWorks[1]
BA3017	*(CTLA4) Mono, + tislelizumab*	*Phase 1 study startup ongoing*					*Global*	BioAtla
SEA-CD70	*(anti-CD70)*	*Planned (starting Ph.1 ex-Asia by Seattle Genetics)*					*Asia ex-Japan, AU, NZ*	Seattle Genetics
DKN-01	*(DKK1) + tislelizumab ± chemo*	*Trials in GC/GEJ planned*					*Asia ex-Japan, AU,NZ*	Leap Therapeutics
ABI-H0731	*(HBV core inhibitor)*	*Chronic Hepatitis B Virus*					*China*	Assembly Bio
ABI-H2158	*(HBV core inhibitor)*	*Chronic Hepatitis B Virus*						
ABI-H3733	*(HBV core inhibitor)*	*Chronic Hepatitis B Virus*						

Addition compounds from Amgen collaboration not yet disclosed

* Some indications will not require a non-pivotal Ph2 clinical trial prior to beginning pivotal Ph2 or Ph3 clinical trials. **Confirmatory clinical trials post approval are required for accelerated approvals. ^ BiTE, ^^ HLE BiTE, † ZW25, AML: acute myeloid leukemia, HLE BiTE: Half-life extended Bi-specific T-cell engagers, GC/GEJ: gastric cancer/gastroesophageal junction, HCC: hepatocellular carcinoma, IND: Investigational New Drug, MEL: melanoma, MM: multiple myeloma, NHL: non-Hodgkin's lymphoma, N/SCLC: non-/small cell lung cancer, OC: ovarian cancer, RCC: renal cell carcinoma, SM: small molecule; 1. By MapKure, a JV with SpringWorks

Striving to Be the Partner of Choice

Leveraging China for global clinical development

- **Potential to accelerate global trials through heavily China-inclusive clinical development**
  - Hard-to-recreate ability, and scale
  - Leader for innovative science-based commercial sales in China
  - Portfolio of backbone agents with strong synergies for combinations
- **Amgen collaboration validates clinical and commercial platforms and expands our portfolio**
- **Continue to have capacity available for additional collaborations**
  - First-in-class compounds: KRAS inhibitor AMG 510 (Amgen)
  - Differentiated agents: bi-specific HER2 antibody and ADC (Zymeworks)
  - Combination opportunities: multi-kinase inhibitor sitravatinib (Mirati)
  - New market growth: inhibitor for chronic Hepatitis B Infection (Assembly Biosciences)

Bristol-Myers Squibb — Agreement: July 2017

MIRATI THERAPEUTICS — Agreement: January 2018

zymeworks — Agreement: November 2018

Ambrx — Agreement: March 2019

bioatla — Agreement: April 2019

AMGEN — Agreement: October 2019

SeattleGenetics — Agreement: November 2019

leaptherapeutics — Agreement: January 2020

EUSAPharma — Agreement: January 2020

assemblybio — Agreement: July 2020

百奥泰 BIO-THERA — Agreement: August 2020

ADC: antibody-drug conjugate; HER2: human epidermal growth factor receptor 2.

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Financial Summary

Selected Financials Amounts in millions of U.S. dollars	Three Months Ended June 30, 2020 (unaudited)	 June 30, 2019 (unaudited)	Six Months Ended June 30, 2020 (unaudited)	 June 30, 2019 (unaudited)
Total Revenue	$ 66	$ 243	$ 118	$ 321
Product revenue, net	66	58	118	116
Collaboration revenue	--	185	--	206
Total Expenses	(425)	(329)	(850)	(581)
Cost of sales – products	(14)	(18)	(28)	(33)
Research and development	(286)	(229)	(590)	(407)
Selling, general and administrative	(124)	(82)	(231)	(140)
Net loss attributable to BeiGene, Ltd.	$ (335)	$ (86)	$ (699)	$ (253)
Cash, cash equivalents, restricted cash and short-term investments[1]	$ 3,158	$ 1,561	$ 3,158	$ 1,561
Cash used in operations[2]	$ (263)	$ (46)	$ (605)	$ (218)

$2.07 billion cash received during registered direct offering in July 2020

1. Cash, cash equivalents, restricted cash and short-term investments as of June 30, 2020 does not include $2.07 billion of net cash received from the sale of ADSs in a registered direct offering of ordinary shares to existing shareholders received on July 15, 2020. 2. Cash used in operations for the quarters ended June 30, 2020 and June 30, 2019 exclude capital expenditures of $32.61 million and $21.45 million, respectively. Cash used in operations for the quarter ended June 30, 2019 excludes $20.00 million in up-front payments. Cash used in operations for the six-month periods ended June 30, 2020 and June 30, 2019 exclude capital expenditures of $54.14 million and $43.28 million, respectively, and up-front payments of $43.00 million and $ 49.00 million, respectively.

Upcoming Milestones and Catalysts

	Zanubrutinib (BTK Inhibitor)	Timing
Submission	▪ File sNDA for WM in China	▪ 2020
Regulatory	▪ Discuss ASPEN data with US FDA	▪ 2020
Data	▪ Potential top-line result of Phase 3 of zanubrutinib vs. bendamustine rituximab (BR) in 1L CLL, SEQUOIA	▪ as early as 2H20
Enrollment	▪ Complete expanded enrollment in Phase 3 R/R CLL zanubrutinib vs. ibrutinib, ALPINE	▪ 2020
	Tislelizumab (PD-1 Antibody)	
Regulatory	▪ Have discussions with health authorities re global Phase 2 in 2L/3L HCC	▪ 2020
Data	▪ Top-line Phase 3 result from China study in 1L Non-Sq NSCLC	▪ 2020
Data	▪ Top-line data from Phase 3 study in 2L/3L NSCLC and global Phase 3 study in 2L ESCC	▪ 2020 or early 2021
	Pamiparib (PARP inhibitor)	
Data	▪ Present data from Phase 1/2 in BRCA-mutated OC	▪ 2020
Data	▪ Top-line data from China Phase 3 comparing pamiparib vs. placebo as maintenance in platinum-sensitive OC	▪ 2020 or 1H21
Data	▪ Present updated Phase 1 data in combination with tislelizumab in advanced solid tumors	▪ 2020
	Early-Stage and Collaboration Assets	
Data	▪ Present Phase 1 data of BGB-A1217 (TIGIT)	▪ 2020 or early 2021
Data	▪ Present Phase 1 data on sitravatinib + tislelizumab	▪ 2020
Enrollment	▪ Participate in registration-enabling trial of zanidatamab in refractory HER2+ biliary tract cancer	▪ 2020
Enrollment	▪ Participate in registration-enabling trial of zanidatamab in first-line HER2+ gastroesophageal adenocarcinoma	▪ Late 2020 or early 2021

Recent Accomplishments and Upcoming Milestones

China
Global

Past 11 Months (From 4Q19 – YTD)

Preclinical Assets Advanced into Clinic	Trials Enrolled	Phase 3 Data Readouts	NDA Filings	Approvals or Launches	Assets Added Through Collaborations	Organizational Progress
4	5		5	6	25+	
BGB-10188 Pi3k-δi	BRUKINSA MZL	3	Pami 3L gBRCA+ OC	BRUKINSA R/R CLL/SLL	AMGEN	Biologics manufacturing in process validation & expanded
BGB-A445 anti OX40	Tisle 2/3L NSCLC	BRUKINSA HTH in WM	Tisle 2/3L HCC	BRUKINSA R/R MCL	SeattleGenetics	
BGB-3245 B-RAFi	Tisle 2L ESCC	Tisle 1L Sq NSCLC	Tisle 1L Nsq NSCLC	XGEVA GCTB	leaptherapeutics	Amgen transitional activities progressing
BGB-11417 Bcl-2i	Pami Breast cancer	Tisle 1L Nsq NSCLC	Tisle 1L Sq NSCLC	BRUKINSA R/R MCL	EUSAPharma	
	Tisle 1L HCC		BRUKINSA WM (EU)	Tisle cHL	assemblybio	Angus Grant as Chief Business Executive
				Tisle UBC		

Disclosed Milestones Over Next 18 Months

Early Data Readouts	Potential Phase 3* Readouts and Potential Filings	Potential NDA Filings or Regulatory Discussion	Commercial Portfolio
4	9	6	11
OX40 and tisle +OX40	Tisle 1L NPC	Tisle 2/3L HCC	Brukinsa zanubrutinib
Bcl-2i, and BRUKINSA + Bcl-2i	Tisle 1L ESCC	BRUKINSA WM (USA)	tislelizumab
TIGIT, and Tisle + TIGIT	BRUKINSA R/R MZL	BRUKINSA WM	百泽安
Tisle + sitra Data	BRUKINSA HTH CLL/SLL	Pami OC Maintenance	pamiparib
	Tisle 2/3L NSCLC	SYLVANT Castleman	XGEVA (denosumab)
	Tisle 2L ESCC	QARZIBA neuroblastoma	Kyprolis (carfilzomib)
	Tisle dMMR / MSI-H		BLINCYTO (blinatumomab)
	Pami Plt-sensitive OC		Abraxane nanoparticle albumin bound paclitaxel
	BRUKINSA 1L CLL/SLL		Vidaza azacitidine for injection
			Revlimid (lenalidomide)
			QARZIBA (dinutuximab beta)
			sylvant siltuximab

* Phase 3 or registrational enabling trials

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Key Takeaways

- **BeiGene has an established platform to leverage the highly impactful developments in China**
  - Strategic collaboration with Amgen provides validation of our clinical and commercial capabilities
- **A compelling emerging growth story with up to 11 products on market by YE 2021**
  - Robust upcoming news flow from clinical readouts of more than 10 Phase 3 or potentially registration-enabling trials, including indications with large market opportunities (Brukinsa in CLL and tislelizumab in 1L NSCLC in China)
- **Diverse early-stage pipeline of assets drives long-term potential upside, including:**

Sitravatinib (multi-kinase inhibitor)	BGB-A1217 (TIGIT antibody)
Zanidatamab, ZW49 (bispecific HER2 antibody and ADC)	BGB-A445 (non-ligand competing OX40 agonist antibody)
AMG 510 (KRAS G12C inhibitor)	BGB-11417 (Bcl-2 inhibitor)

- **On this journey BeiGene is striving to:**
  - Become an oncology and scientific leader
  - Expand beyond oncology into other areas of need
  - Continue to build sustainable and competitive advantages
  - Become the best global clinical organization – addressing the biggest issue of the industry
  - Transform the industry to bring better medicine to more patients more affordably

Review of Product Candidates

Overview of Zanubrutinib (BGB-3111)

Potentially best-in-class BTK inhibitor

Brukinsa™ 80mg zanubrutinib capsules

OVERVIEW

- **Optimized pharmacologic properties relative to ibrutinib: superior bioavailability and higher selectivity**
- **Development hypothesis: more complete target inhibition, deeper responses, and favorable safety profile**

CLINICAL DATA

- More than 2,700[1] patients enrolled across trials, including combinations
- **Clinical experience to date supports best-in-class hypothesis**
  - ASPEN primary endpoint numerically favorable but not statistically significant
  - ASPEN: Demonstrated clinically meaningful and favorable differences in safety vs. ibrutinib; Early, landmark PFS and OS analyses are directionally consistent with higher VGPR rate observed in zanubrutinib arm
  - Strong suggestion of deeper responses in WM and MCL
  - Favorable response rate, depth, and durability in CLL/SLL
  - High overall and complete response rates in FL with obinutuzumab combination
  - Low rate of toxicity/tolerability-related discontinuation

DEVELOPMENT PLAN

- Fast Track in WM and Breakthrough Therapy in MCL designations
- Global registrational trials: WM (H2H vs. ibrutinib), 1L CLL/SLL (vs. BR), R/R CLL/SLL (vs. ibrutinib), 1L MCL (R+zanu vs. BR), R/R FL (potential for global first-in-class BTK approval in FL); and R/R MZL (global pivotal Ph 2 trial)
- China registration trials for WM (enrollment completed)

MILESTONES AND STATUS

- **U.S. FDA accelerated approval for use in R/R MCL 11.14.19**
- **China NMPA approval for use in R/R MCL and R/R CLL/SLL 06.03.20**
- R/R or not suitable for chemo-immunotherapy WM (MAA accepted 06.18.20)
- R/R MCL (NDA in Israel accepted 05.21.20)

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1 As of June 15, 2020.

Zanubrutinib Clinical Program

Global China

PROGRAM (TARGET)	DOSE ESCALATION	DOSE EXPANSION		PIVOTAL		FILED	MARKET***
	PH1a	PH1b	PH2*	PH2**	PH3		
zanubrutinib *(BGB-3111, BTK)*	*R/R MCL (Accelerated approval by US FDA 11.14.19)*						
	R/R MCL (Approved by NMPA 06.03.20)						
	R/R CLL/SLL (Approved by NMPA 06.03.20)						
	R/R or not suitable for chemo-immunotherapy WM (MAA accepted 06.18.20), R/R MCL (NDA in Israel accepted 05.21.20)						
	TN CLL/SLL: zanubrutinib vs. BR, SEQUOIA						
	R/R CLL/SLL: zanubrutinib vs. ibrutinib, ALPINE						
	TN MCL: zanubrutinib + R vs. BR, MANGROVE						
	R/R MZL[2] MAGNOLIA						
	Previously treated CLL/SLL (ibrutinib intolerant)						
	R/R WM						
	R/R DLBCL						
	B-cell malignancies						
+ GAZYVA® *(CD20)*	*R/R FL[2]: zanubrutinib + GAZYVA® vs. GAZYVA®*						
	B-cell malignancies						
+ GAZYVA® + venetoclax *(CD20 + BCL2)*	*TN CLL/SLL*						
+ tislelizumab *(PD-1)*	*Hematological tumors*						
+ ME-401 *(PI3-Kδ)*	*R/R CLL/SLL or B-cell malignancies*						
+ BGB-11417 (Bcl-2 inhibitor)	*B-cell malignancies*						

More than 2,700 patients[1] treated with zanubrutinib across program, including combination trials.

* Some indications will not require a non-pivotal Ph2 clinical trial prior to beginning pivotal Ph2 or Ph3 clinical trials. ** Confirmatory clinical trials post approval are required for accelerated approvals. 1. as of 06.15.20. 2. global study and potentially registration-enabling in certain countries; DLBCL: Diffuse Large B-cell Lymphoma. *** U.S. only.

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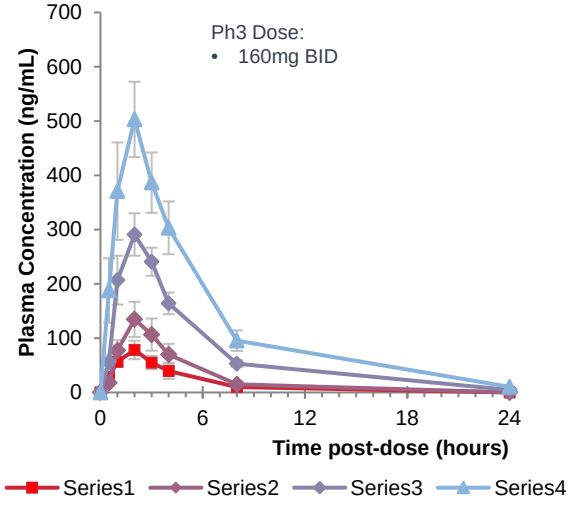
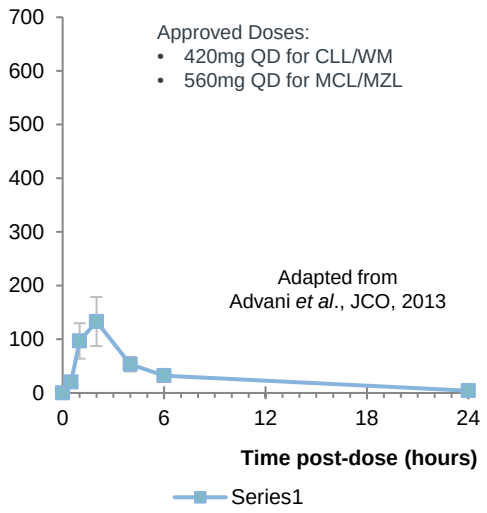
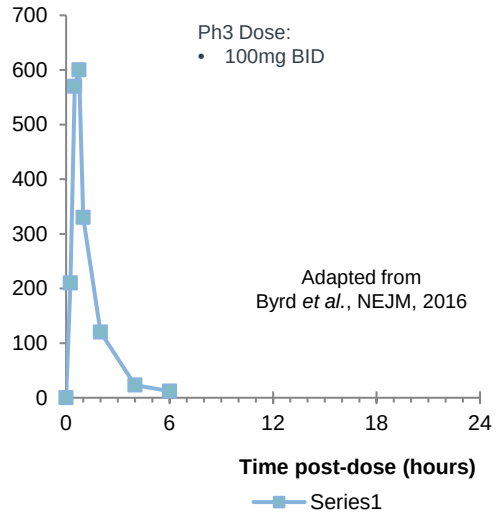
Zanubrutinib – Pharmacokinetics Profile

zanubrutinib	ibrutinib	acalabrutinib

Data from separate Ph1/2 trials^







- Cmax and AUC of zanubrutinib at 80mg QD appear to be similar to those of ibrutinib at 560mg
- Free drug exposure of zanubrutinib at 40mg QD appears to be comparable to that of ibrutinib at 560mg
- Distinct profile compared to acalabrutinib which has a short half-life (1 hour)[2] and lower *in vitro* BTK inhibition IC50[1-4]
- *In vitro* BTK inhibition IC50 relative to ibrutinib: 1.11 (zanubrutinib) and 3.42–7.23 (acalabrutinib)

^Cross-trial comparison

Source: 1. Tam et al., ASH, 2015; 2. Byrd et al., NEJM, 2016; 3. Lannutti et al., AACR, 2015, 4. BeiGene data

ASPEN Topline Efficacy Summary

Primary Endpoint

Response Rate*

	Relapsed or Refractory†		Overall†		Overall August 2019‡		Overall January 2020‡	
	Zanubrutinib (N = 83)	Ibrutinib (N = 81)	Zanubrutinib (N = 102)	Ibrutinib (N = 99)	Zanubrutinib (N = 102)	Ibrutinib (N = 99)	Zanubrutinib (N = 102)	Ibrutinib (N = 99)
CR	0	0	0	0	0	0	0	0
VGPR	28.9	19.8	28.4	19.2	28.4	17.2	30.4	18.2
PR	49.4	60.5	49.0	58.6	48.0	59.6	48.0	59.6
MR	15.7	13.6	16.7	15.2	18.6	17.2	16.7	16.2
No response	4.8	4.9	4.9	5.0	3.9	5.0	1.0	2.0
VGPR+CR rate, %	28.9[1]	19.8[1]	28.4	19.2	28.4	17.2^	30.4	18.2
VGPR+CR rate difference			10.2 *p*-value[2] = 0.0921		12.1 *p*-value[2] = 0.0437		13.2 *p*-value[2] = 0.0302	

* Groups were generally well-balanced for number of prior therapies, IPSS score, baseline IgM, and baseline hematologic parameters. Overall CXCR4 mutation was 10.9%. [1.] 2-sided p=0.1160. [2.] 2-sided descriptive. † Source: IRC Data, data cutoff August 31, 2019. ‡ Source: Tam et. al., ASCO 2020, Investigator-Assessed Data, VGPR+CR rate difference adjusted for stratification and age group. *p*-value for descriptive purpose only. ^Excluded two patients with VGPR by IRC: MR (EMD present) and PR (IgM assessment by local SPEP M-protein).

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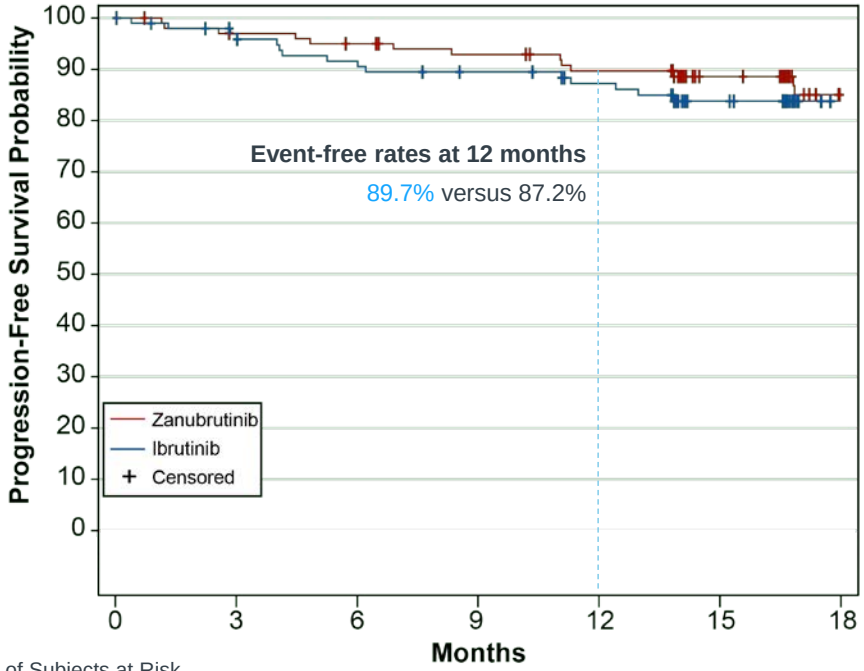
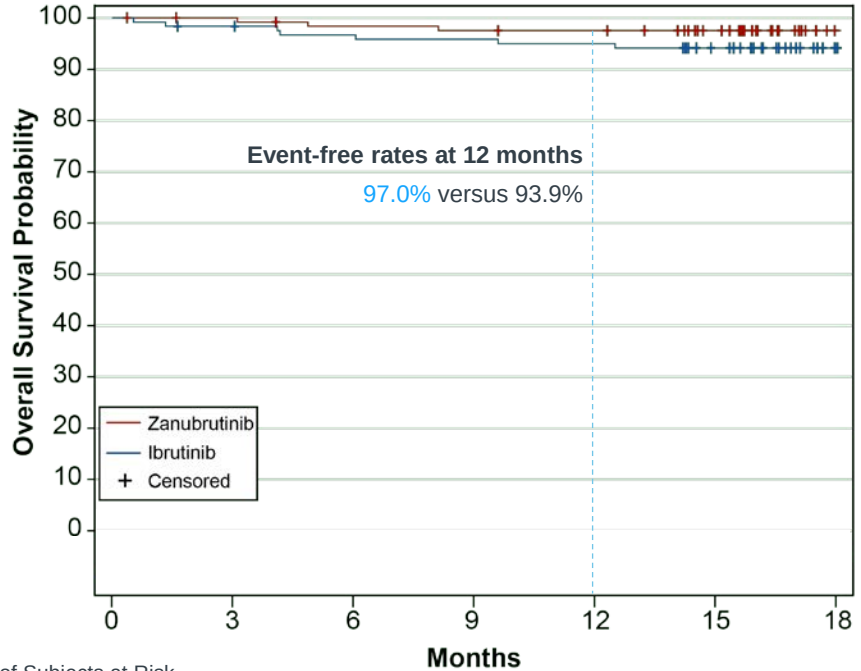
ASPEN: Progression-Free and Overall Survival in ITT population



No. of Subjects at Risk

Zanubrutinib	102	96	93	89	84	63	43
Ibrutinib	99	92	86	82	77	62	42



No. of Subjects at Risk

Zanubrutinib	102	100	97	96	95	86	62
Ibrutinib	99	96	93	92	91	83	61

Source: Tam et. al., ASCO 2020
IRC, independent review committee; VGPR, very good partial response.
Disease progression determined by IRC.

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ASPEN Topline Safety: Overall Summary

Category, n (%)	Overall	
	Ibrutinib (n = 98)	Zanubrutinib (n = 101)
Patients with ≥ 1 AE	97 (99.0)	98 (97.0)
Grade ≥3	62 (63.3)	59 (58.4)
Serious	40 (40.8)	40 (39.6)
AE leading to death	4 (4.1) [a]	1 (1.0) [b]
AE leading to treatment discontinuation	9 (9.2) [c]	4 (4.0) [d]
AE leading to dose reduction	23 (23.5)	14 (13.9)
AE leading to dose held	55 (56.1)	47 (46.5)
Patients with ≥ 1 treatment-related AE	84 (85.7)	80 (79.2)
Patients with ≥ 1 AE of interest	81 (82.7)	86 (85.1)

Source: Tam et. al., ASCO 2020.
AE, adverse event (treatment-emergent); G, grade.
[a] cardiac failure acute; sepsis (n=2); unexplained death.
[b] cardiac arrest after plasmapheresis
[c] G5 sepsis (n=2); G5 unexplained death; G3 acute myocardial infarction; G3 hepatitis ; G3 pneumonia; G2 drug-induced liver injury; G2 pneumonitis; G1 pneumonitis.
[d] G5 cardiac arrest after plasmapheresis; G4 neutropenia; G4 subdural hemorrhage ; G2 plasma cell myeloma.

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ASPEN Adverse Events of Special Interest

AE Categories, n (%) (Pooled Terms)	All Grades		Grade ≥3	
	Ibrutinib (n=98)	Zanubrutinib (n=101)	Ibrutinib (n=98)	Zanubrutinib (n=101)
Atrial fibrillation/flutter†	**15 (15.3)**	2 (2.0)	4 (4.1)	0 (0.0)
Diarrhea (PT)	**31 (31.6)**	21 (20.8)	1 (1.0)	3 (3.0)
Hemorrhage	**58 (59.2)**	49 (48.5)	8 (8.2)	6 (5.9)
Major hemorrhage*	9 (9.2)	6 (5.9)	8 (8.2)	6 (5.9)
Hypertension	17 (17.3)	11 (10.9)	**12 (12.2)**	6 (5.9)
Neutropenia†,‡	13 (13.3)	**30 (29.7)**	8 (8.2)	**20 (19.8)**
Infection	66 (67.3)	67 (66.3)	19 (19.4)	18 (17.8)
Second malignancy	11 (11.2)	12 (11.9)	1 (1.0)	2 (2.0)

Source: Tam et. al., ASCO 2020.
Higher AE rate in bold red with ≥10% difference in any grade or ≥5% difference in grade 3 or above. No tumor lysis syndrome was reported. Opportunistic infection ibrutinib (n=2), zanubrutinib (n=1).
AE, adverse event; BTKi, Bruton tyrosine kinase inhibitor; PT, preferred term.
*Defined as any grade ≥3 hemorrhage or any grade central nervous system hemorrhage.
†Descriptive 2-sided $P<0.05$.
‡Including PT terms of neutropenia, neutrophil count decreased, febrile neutropenia, agranulocytosis, neutropenic infection, and neutropenic sepsis.

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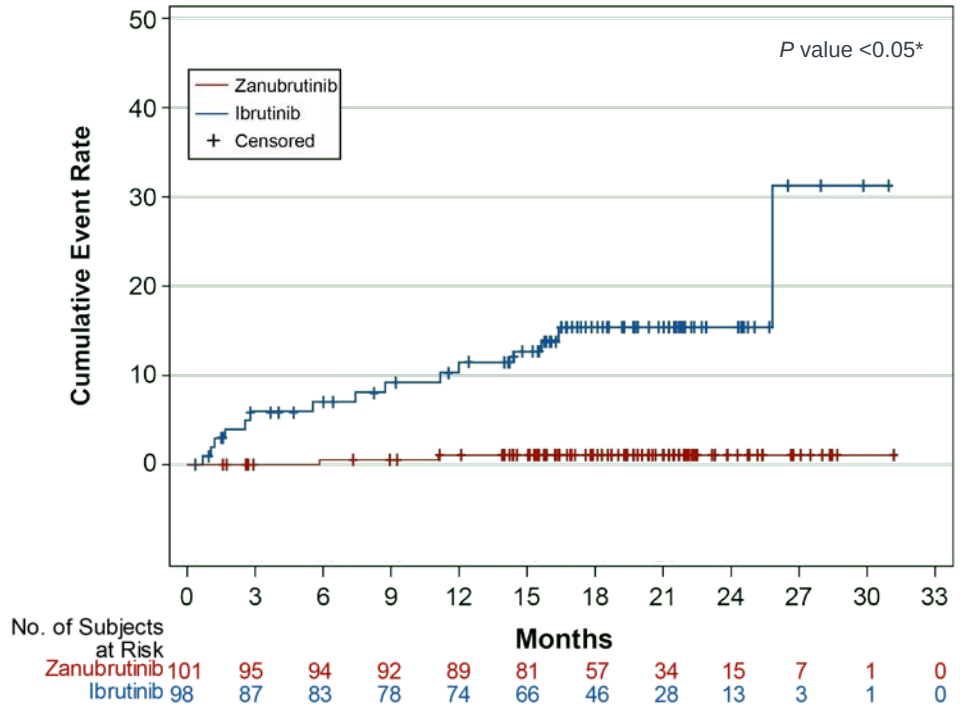
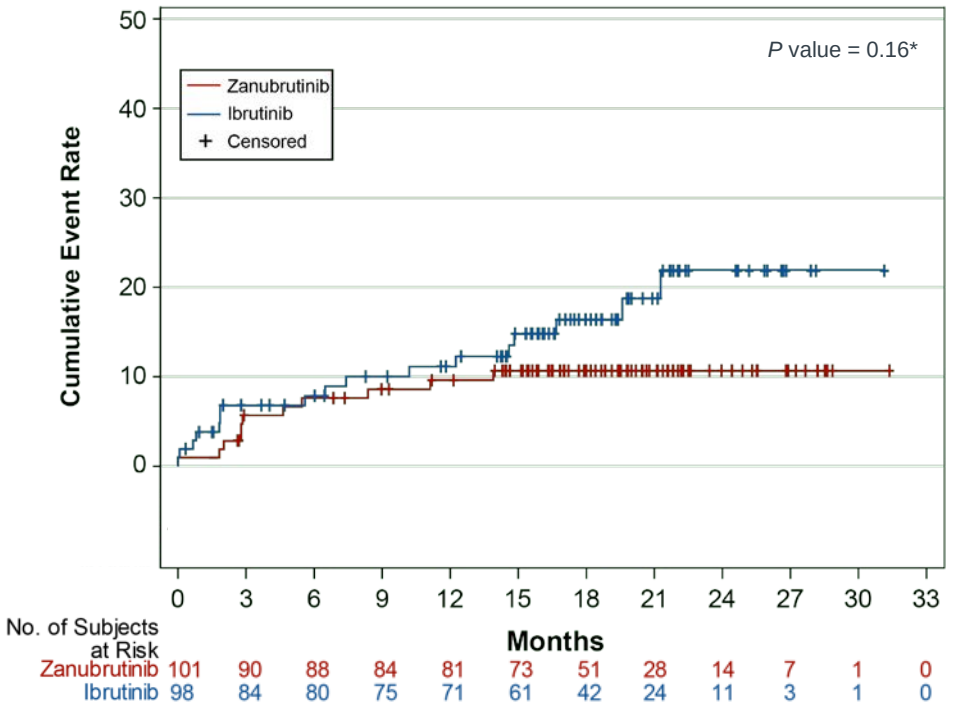
ASPEN: Time to AE – Risk Analysis Over Duration of Treatment

Kaplan-Meier Curve: Time to **Atrial Fibrillation / Flutter**



Kaplan-Meier Curve: Time to **Hypertension**



Source: Tam et. al., ASCO 2020. AE, adverse event. *Descriptive purpose only.

Data Suggest Activity in Difficult to Treat WM MYD88^{WT} Patients

Best response, n (%)	ASPEN cohort 2[1] (n=26)	Phase 1[2] (n=8)
	ASCO 2020	EHA 2019
ORR	**21 (80.8)**	**7(87.5)**
MRR	**14 (53.9)**	**5(62.5)**
CR / VGPR	**7 (26.9)**	**2(25.0)**
PR	6 (23.1)	3(37.5)
MR	8 (30.8)	2(25.0)
SD	4 (15.4)	1(12.5)
PD	1 (3.8)	0
Median Follow-up months (range)	17.9 (2.3 - 21.7)	24.3 (4.1-45.7)*

ASPEN cohort 2 safety summary. The most frequently reported adverse events (AEs) were diarrhea, anemia, contusion, pyrexia, and upper respiratory tract infection. Major hemorrhage was reported in 2 patients, and atrial fibrillation was reported in 1 patient. There were no fatal AEs.
Phase 1 safety summary for full WM n=77 cohort. Patients with an event n (%): Patients with ≥1 AE grade ≥3 40 (51.9); Patients with ≥1 serious AE 36[3] (46.8); AE leading to treatment discontinuation 8[2] (10.4); Fatal AE 5c (6.5). [3]Includes serious AEs possibly related to zanubrutinib (n=6): hemothorax+pleural effusion+anemia (n=1), atrial fibrillation (n=1), colitis (n=1), febrile neutropenia (n=1), pneumonia (n=1), and cellulitis (n=1); septic arthritis relatedness was unknown. [2]Abdominal sepsis (fatal), septic arthritis (fatal), worsening bronchiectasis (fatal), gastric adenocarcinoma (fatal), prostate adenocarcinoma, metastatic neuroendocrine carcinoma, acute myeloid leukemia, and breast cancer (each n=1).

Sources: 1 Tam et. al. ASCO 2020, Data cut: Aug 31, 2019, Safety summary above; 2 Tam et al, EHA 2019. * Follow up for full WM cohort.

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Zanubrutinib Efficacy in R/R MCL

From U.S. approved label

Best Response	Zanubrutinib	
	RR	RR
Source	Study BGB-3111-206 Ph2 study	BGB-3111-AU-003 Ph1/2 study
Evaluable for efficacy, n	86	32
Median DoR in months	19.5 (16.6, NE)	18.5 (12.6, NE)
Response Criteria	Lugano 2014	
Median Prior Lines of Therapy	2 (1-4)	1 (1-4)
ORR	84%	84%
CR	**59%**	**22%***
PR	24%	62%

The most common adverse reactions (> 10%) with BRUKINSA were decreased neutrophil count, decreased platelet count, upper respiratory tract infection, decreased white blood cell count, decreased hemoglobin, rash, bruising, diarrhea, cough, musculoskeletal pain, pneumonia, urinary tract infection, blood in the urine (hematuria), fatigue, constipation, and hemorrhage. The most frequent serious adverse reactions were pneumonia (11%) and hemorrhage (5%).

Of the 118 patients with MCL treated with BRUKINSA, eight (7%) patients discontinued treatment due to adverse reactions in the trials. The most frequent adverse reaction leading to treatment discontinuation was pneumonia (3.4%). One (0.8%) patient experienced an adverse reaction leading to dose reduction (hepatitis B).

Source: Brukinsa™ U.S. label; * FDG-PET scans were not required for response assessment; RR: relapsed refractory; NE: not estimable; DoR: duration of response.

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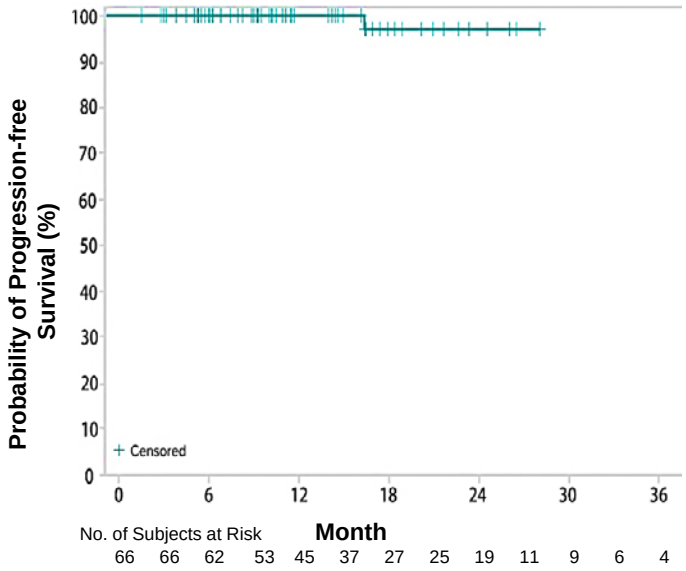
Zanubrutinib Efficacy in CLL/SLL

Frequent and durable responses – Phase 1/2

Overall Response Rate (ORR)

zanubrutinib	TN CLL	R/R CLL	Total CLL
n	16	50	66
Median follow-up (mo)	7.6	14.0	10.5
Best Response			
ORR	**16 (100%)**	**46 (92%)**	**62 (94%)**
CR	1 (6%)	1 (2%)	2 (3%)
PR	13 (81%)	41 (82%)	54 (82%)
PR-L	2 (13%)	4 (8%)	6 (9%)
SD	0	3 (6%)	3 (5%)
Non-evaluable*	0	1 (2%)	1 (2%)

Progression Free Survival (PFS)



Source: Seymour et al. 14-ICML 2017 (abstract 237) poster; *Discontinuation prior to first assessment

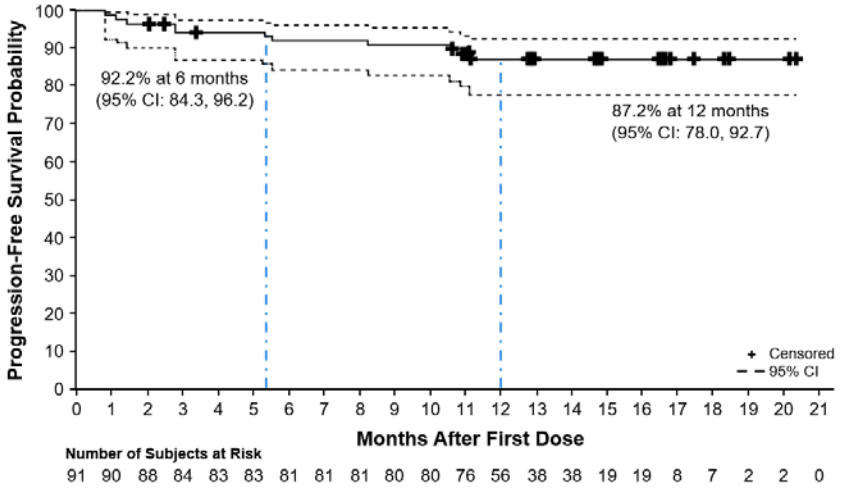
Zanubrutinib Efficacy in CLL/SLL

Frequent and durable responses – Phase 2

Best Overall Response by IRC (ORR)

zanubrutinib	Total CLL
n	91
Median follow-up (mo)	15.1
Best Response	
ORR	**77 (84.6%)**
CR	3 (3.3%)
PR	54 (59.3%)
PR-L	20 (22.0%)
SD	4 (4.4%)
Non-evaluable[a]	3 (3.3%)

Progression Free Survival by IRC (PFS)



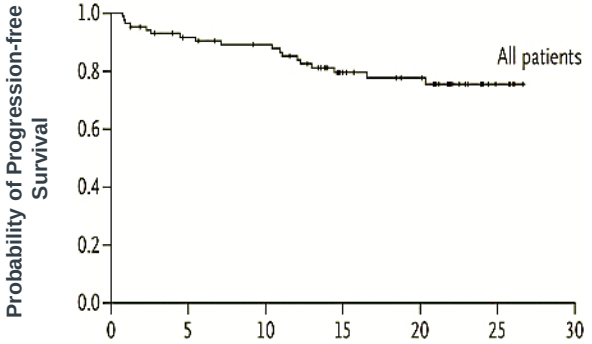
Source: Xu et al. 15-ICML 2019; [a]Missing anatomy imaging for 2 patients, and without evidence of response maintenance for at least 2 months for 1 patient, separately.

Ibrutinib Efficacy in CLL/SLL

Overall Response Rate (Relapsed / Refractory)

	n=85
Median FU (mo)	20.9
Best Response	
ORR	**75 (88%)**
CR	2 (2%)
PR	58 (68%)
PR-L	15 (18%)
SD	NR
PD	NR

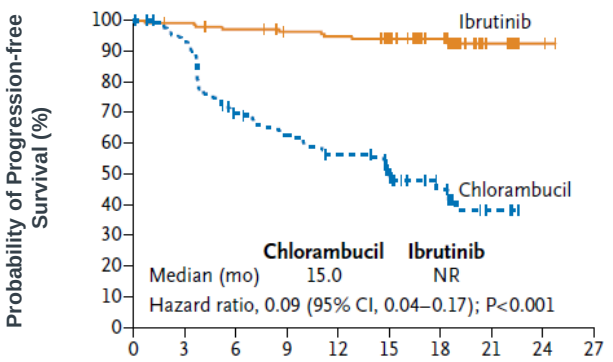
Progression Free Survival (Relapsed / Refractory)



Overall Response Rate (Treatment-Naïve)

	n=136
Median FU (mo)	18.4
Best Response	
ORR	**117 (86%)**
CR	5 (4%)
PR	107 (79%)
PR-L	5 (4%)
SD	NR
PD	NR

Progression Free Survival (Treatment-Naïve)



Source: For TN, Burger, et al New Engl J Med 2015. For R/R, Byrd, et al New Engl J Med 2013

Ibrutinib

Discontinuation for toxicity or progression in CLL/SLL

	Treatment-Naïve (n=80)	Relapsed/Refractory (n=536)	Total (n=616)
Median Follow-Up	14.5 months		
Total Treatment Discontinuation	**19 (24%)**	**231 (43%)**	**250 (41%)**
Toxicity/Tolerability	***12 (15%)***	***117 (22%)***	***129 (21%)***
CLL/SLL Progression	***3 (4%)***	***49 (9%)***	***52 (8%)***
Transformation (RT or HD)	***0 (0%)***	***10 (2%)***	***10 (2%)***
Death Unrelated to Treatment	1 (1%)	28 (5%)	29 (5%)
Physician or Patient Decision	2 (2%)	15 (3%)	17 (3%)
Transplant	0 (0%)	8 (1.5%)	8 (1%)
Financial Concerns	0 (0%)	1 (0.2%)	1 (0.2%)
Secondary Malignancy	1 (1%)	2 (0.5%)	3 (0.5%)

Source: Mato ASH 2016; Note: at med follow-up 24.5 mos, 22% discontinuation rate with acalabrutinib in R/R CLL; 9% AE-related, 8% PD-related. Byrd ASH 2017.

Zanubrutinib

Discontinuation for toxicity or progression in CLL/SLL is uncommon

	Treatment-Naïve (n=18)	Relapsed/Refractory (n=51)	Total (n=69)
Median Follow-Up	10.3 months		
Total Treatment D/C	**0 (0%)**	**2 (4%)**	**2 (3%)**
Toxicity/Tolerability	***0 (0%)***	***1 (2%)***	***1 (1%)***
CLL/SLL Progression	***0 (0%)***	***0 (0%)***	***0 (0%)***
Transformation (RT or HD)	***0 (0%)***	***1 (2%)***	***1 (1%)***

Source: Seymour, ICML 2017

BeiGene

Zanubrutinib

Safety and tolerability summary; over 600-patient experience

Adverse Events of Interest for BTK Inhibitors in Patients Treated with Zanubrutinib

AE of Interest (All Causes)[1]	Zanubrutinib (Including Patients Enrolled in Combo Studies)
Patient Number	N=641
Mean Exposure Time	7.7 mo
Atrial Fibrillation	**1.7%**
Major Hemorrhage	**1.9%**

AE of Interest (All Causes)[2]	Zanubrutinib (Single Agent Only)
Patient Number	N=682
Median Exposure Time	13.4 mo
Atrial Fibrillation (Gr ≥3)	**1.9% (0.6%)**
Major Hemorrhage*	**2.5% (2.1%)**
Diarrhea (Gr ≥3)	**19.4% (0.9%)**

- Very low rates of headache and hypertension (6.7% and 6.3%)
- Concomitant use of anti-coagulants was allowed in these zanubrutinib trials
- Low rate of treatment discontinuation for drug-related adverse events

Major hemorrhage includes serious or grade ≥3 bleeding of any site, or central nervous system bleeding of any grade.

Source: pooled safety analysis of ongoing zanubrutinib clinical trials; 1 Seymour, ICML 2017; 2 Tam et, al., EHA 2019 (Data cut-off dates: BGB-3111-207: Sept 2018; BGB-3111 AU-003, -1002, -205 and 210: Dec 2018; BGB-3111-206: Feb 2019)

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Zanubrutinib Responses Across Additional B-Cell Malignancies

	MZL	MCL	MCL	FL	FL	DLBCL
Source	EHA 2020[5]	ICML 2019[3]	China pivotal data ASH2018[2]	ASH 2017[1]	CSCO 2018[4]	ASH 2017[1]
n	20	48	85	17	26	26
Follow-up (med)	27.1 mo	16.7 mo	35.9 wk	7.8 mo	9.5 mo	4.2 mo
Prior Lines (med)	2 (1-5)	1 (1-4)	2 (1-4)	2 (1-8)	3 (1-9)	2 (1-10)
ORR	**80%**	**85%**	**84%**	**41%**	**42%**	**31%**
CR	**15%**	**29%***	**59%****	**18%**	**8%**	**15%**
VGPR	**--**	**--**	**--**	**--**	**--**	**--**
PR/PR-L	65%	56%	25%	24%	35%	15%
MR	--	--	--	--	--	--

- Despite relatively early follow-up, responses were observed in multiple B-cell malignancies
- Consistency across tumor types suggests that zanubrutinib is a highly active BTK inhibitor

Sources: 1. Tam et. al., ASH 2017; 2. Song et al., ICML 2019; 3. Tam et al., ICML 2019; 4. Song et. al., CSCO 2018; 5. Tedeschi et al, EHA 2020; * CT response assessment; ** PET-CT response assessment.

BeiGene

Zanubrutinib Plus Obinutuzumab Combination in Follicular Lymphoma

Data from separate trials

FL	Zanubrutinib + Obinutuzumab	Zanubrutinib	Ibrutinib	Obinutuzumab	Idelalisib
Source	ICML 2019[1]	ASH 2017[2]	ASH 2016[3]	JCO 2013[4]	NEJM 2014[5]
n	36	17	110	34	72
Population	prior alkylator and CD20, mixed rituximab-sensitive and -refractory	median 2 prior lines of therapy, range 1-8	prior alkylator and CD20, last response <12 months	mixed rituximab-sensitive and -refractory	alkylator and rituximab-refractory relapse
Follow-up (med)	20.1 mo	7.8 mo	27.7 mo	33.7 mo	NR
ORR	**72%**	**41%**	**21%**	**50%**	**54%**
CR	**39%**	**18%**	**11%**	**18%[6]**	**6%**

- Overall response rate and complete responses to date compare favorably to those achieved with respective single-agents and recently approved therapies

Sources: 1. Tam et al., ICML 2019; 2. Tam et al., ASH (abstract 152), 2017; 3. Gopal, et al ASH 2016; 4. Salles, et al J Clin Oncol 2013; 5. Gopal, et al N Engl J Med 2014; 6. 18% represents complete response rate in the 40 indolent lymphoma patient population that include 34 FL patients. Note: data on slide are cross-trial comparison;

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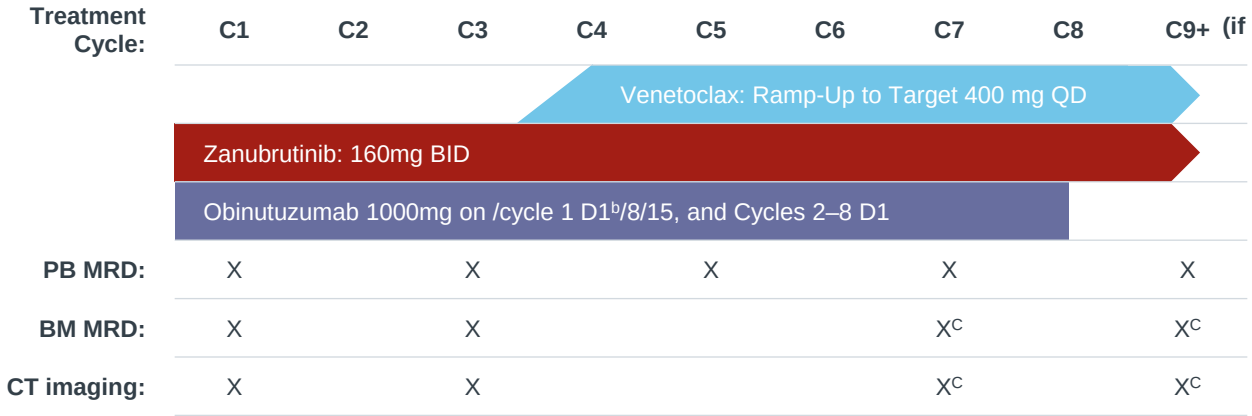
BOVen: Treatment Schema



BOVen discontinued if:

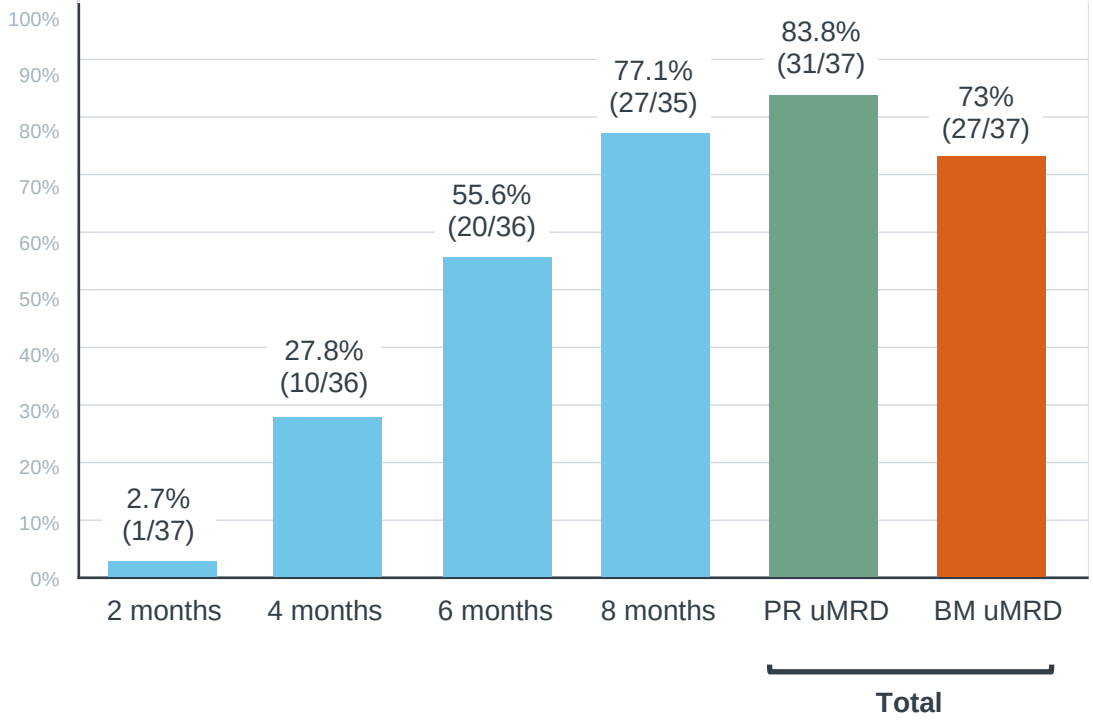
- Prespecified uMRD end point[a]
- Min 8 cycles; Max 24 cycles

a. Once peripheral blood (PB) uMRD is determined and confirmed in bone marrow (BM), patients complete 2 additional cycles followed by confirmatory MRD peripheral blood testing; if PB uMRD x 2 and BM uMRD x 1, therapy is discontinued.

b. Obinutuzumab split over days 1-2 of cycle 1 if ALC >25,000.

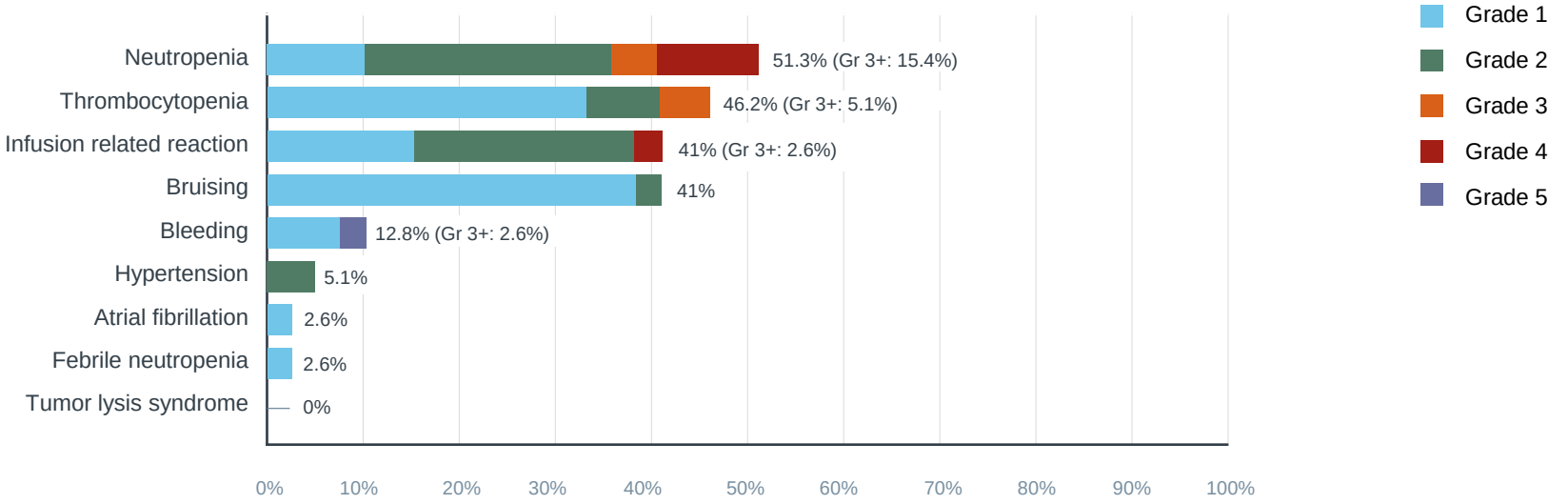
c. BM biopsy obtained at Screening and C3D1; thereafter BM is only obtained if PB-uMRD. CT imaging obtained at Screening, C3D1, C7D1, EOT, then every 6 months during post-treatment surveillance.

BOVen: Achieved Rapid Undetectable MRD



- Follow up: 11 months (2-14+)
- Median time to uMRD in marrow: 6 months (2-14+)
- 62% (23/37) met the uMRD endpoint and have stopped therapy at median 8 months (6 months of triplet)

BOVen: Adverse Events of Special Interest



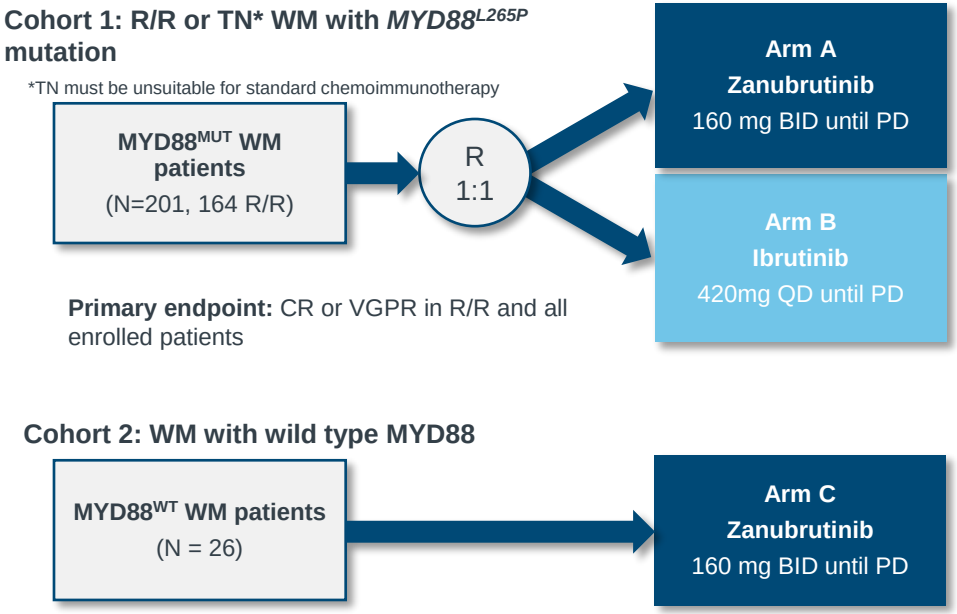
- Bleeding included one grade 5 ICH on cycle 1 day after initiating intravenous heparin for pulmonary emboli, one grade 1 conjunctival hemorrhage, and one grade 1 vaginal bleeding
- Atrial fibrillation occurred in one patient who had a history of prior paroxysmal atrial fibrillation

BOVen Treatment emergent hematologic and non-hematologic adverse events occurring in ≥5% of patients - Heme: Neutropenia 51.3% (Gr 3+: 15.4%), Thrombocytopenia 46.2% (15.4%), Anemia 18%; Non-Heme: Infusion related reaction 41% (2.6%), Bruising 41%, Diarrhea 41%, Nausea 23.1%, Fatigue 20.5%, Myalgia 15.4%, Rash 12.8% (2.6%), Sinusitis 12.8%, GERD 10.3%, Lung infection 7.7% (5.1%), Abdominal pain 7.7%, Arthralgia 7.7%, Constipation 7.7%, Edema limbs 7.7%, Petechiae 7.7%

Ongoing Global Phase 3 Studies

ASPEN topline results announced in December 2019

Zanubrutinib vs. Ibrutinib in WM

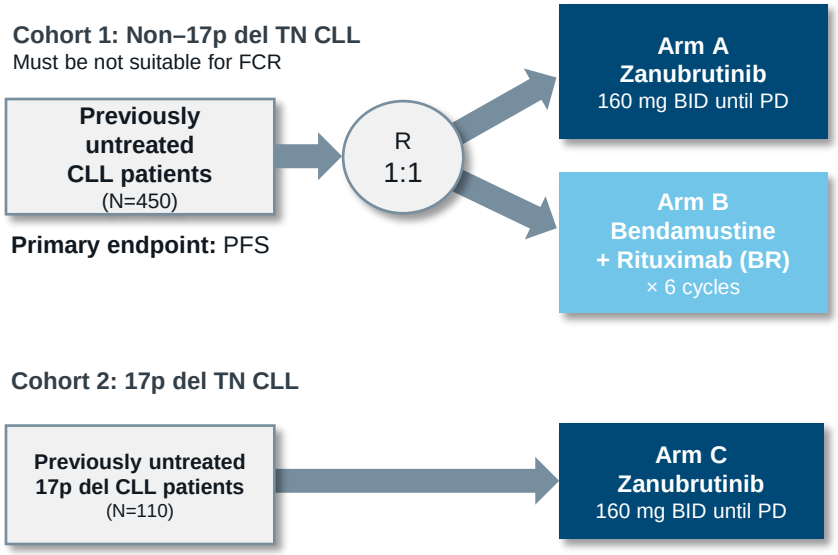


WM=Waldenström's macroglobulinemia, BID=twice daily, CR=complete response, MUT=mutation, PD=progressive disease, QD=once daily, R=randomization, R/R=relapsed/refractory, TN=treatment naïve, VGPR=very good partial response, WT=wild type. This study is registered at ClinicalTrials.gov (NCT03053440)

Ongoing Global Phase 3 Studies in CLL/SLL

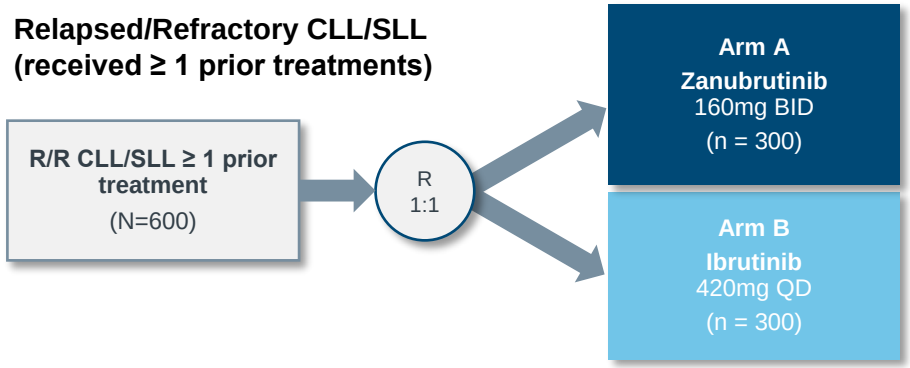
SEQUOIA and ALPINE

Zanubrutinib vs. BR in 1L CLL/SLL



Full trial enrollment completed in June 2019

Zanubrutinib vs. Ibrutinib in R/R CLL/SLL



Primary Endpoint: ORR (non-inferiority and superiority)

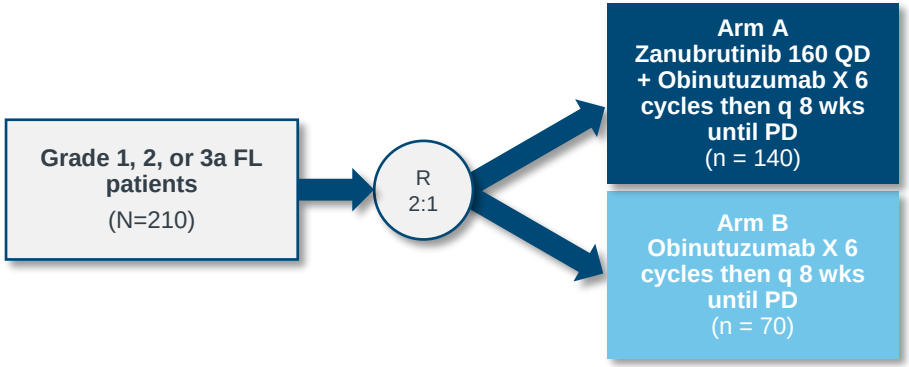
Complete enrollment expected in 2020

1L=first-line treatment, BID=twice daily, CLL=chronic lymphocytic leukemia, del=deleted, FCR=fludarabine, cyclophosphamide, and rituximab, ORR=overall response rate, PD=progressive disease, PFS=progression-free survival, QD=once daily, R=randomized, SLL=small lymphocytic lymphoma, TN=treatment naïve. These studies are registered at ClinicalTrials.gov (NCT03734016) and (NCT03336333).

Ongoing Pivotal Study

Phase 2 Zanubrutinib + Obinutuzumab vs Obinutuzumab in R/R FL

Relapsed/Refractory FL (received ≥2 prior treatments*)



Primary Endpoint: ORR

CLL/SLL=chronic lymphocytic leukemia/small lymphocytic lymphoma, FL=follicular lymphoma, ORR=overall response rate, PD=progressive disease, PFS=progression-free survival, QD=once daily, R=randomization. *Must have received prior treatment with rituximab and an alkylator; relapsed <12 months from end of last treatment OR refractory to last treatment. This study is registered at ClinicalTrials.gov (NCT03332017).

Zanubrutinib Potentially Addresses Areas of Need for Patients Treated with BTK Inhibitors

Efficacy

- Complete and sustained target inhibition may result in better response quality
  - We are testing this hypothesis in Phase 3 head-to-head trials against ibrutinib in WM and CLL

Tolerability

- In “real-world” ibrutinib use in CLL, not only acute/ serious toxicities (atrial fibrillation, serious bleeding), but cumulative tolerability issues (myalgia, arthralgia, hypertension) are frequently treatment-limiting
- Zanubrutinib to date has been associated with low rates of toxicity-related discontinuations and cumulative “off-target” toxicities[1]

Drug-Drug Interactions

- Based on drug interaction studies, co-administration with strong CYP3A inhibitors is permitted
  - Includes important agents in management of leukemia/ lymphoma patients, such as azole anti-fungals
- Co-administration of proton pump inhibitor (PPIs) or other Acid-Reducing Agents (ARA) does not affect zanubrutinib exposure based on PK models
- Patients have been allowed to receive anticoagulants and aspirin on zanubrutinib single arm trials

Source: 1. Tam et. al. EHA 2019

U.S. BRUKINSA Launch Progress

BRUKINSA made commercially available within four days of November 2019 approval

Josh Neiman
Head, U.S. Commercial
Flatiron
Onyx Pharmaceuticals
Genentech

Brukinsa™
zanubrutinib 80mg capsules

- myBeiGene™ PATIENT SUPPORT launched within minutes of approval
- Commercial team in field and focused on driving awareness of BeiGene and BRUKINSA
- Initial feedback from clinicians:
  - Impressed by response rates from 206 and 003 studies
  - Appreciate QD / BID dosing flexibility and ability to combine with PPIs and H2-RAs
  - Encouraged by 100% median BTK occupancy
  - See BRUKINSA as a differentiated BTKi

BRUKINSA™ (zanubrutinib) received accelerated approval in the U.S. for R/R MCL[1]

BRUKINSA is the only FDA-approved BTK inhibitor shown to deliver 100% median occupancy in peripheral blood cells and the only BTK inhibitor with the flexibility to be taken once or twice daily

1. This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial. PPIs = proton pump inhibitors; H2-RAs = H2 receptor antagonists.

BeiGene

Overview of Tislelizumab (BGB-A317)

Broad integrated global and China development program

tislelizumab 百泽安

OVERVIEW

- **Tislelizumab is a PD-1 checkpoint inhibitor designed to minimize binding to FcγR, which is believed to play an essential role in activating phagocytosis in macrophages to minimize its negative impact on T effector cells.[1]**
  - China label data: 77% ORR (62% CR) in R/R cHL
- **Broad development in Asia-prevalent cancers**
  - 15 ongoing or filed Ph. 3 or potentially registration-enabling trials: 5 in lung cancer, 2 in liver cancer, 3 in esophageal cancer, 1 in gastric cancer, 2 in bladder cancer, 1 in MSI-H or dMMR tumors, and 1 in nasopharyngeal cancer
  - Aimed to support broad label and label-based reimbursement
- **Strong manufacturing capabilities with emphasis on quality**
  - Manufacturing process and initial capacity developed by Boehringer Ingelheim
  - BeiGene's state-of-the-art 50,000L facility in Guangzhou in commercial validation phase

CLINICAL DATA

- **Clinical experience in more than 5,800 patients[2] enrolled, has demonstrated encouraging clinical activity and generally well-tolerated safety profile**

DEVELOPMENT PLAN

- **Broad development program designed to capture worldwide commercial opportunities**
  - Two China accelerated approval trials : cHL and urothelial cancer (both approved)
  - Global Ph2 trials in NK/T cell lymphomas and 2L/3L HCC, China pivotal Ph2 in MSI-H or dMMR solid tumors, 6 global Ph3 trials in 1L GC, 1L and 2L ESCC, 1L HCC and 2L NSCLC; 7 Ph3 trials in 1L non-sq and sq NSCLC, 1L SCLC extensive stage, neoadjuvant stage II/IIIA NSCLC, 1L UC, localized ESCC and 1L NPC in China
  - Combinations ongoing with BeiGene's PARP, BTK, PD-L1, TIM3 and TIGIT inhibitors
  - Additional Ph3 trials planned

MILESTONES AND STATUS

- **NDA in China for R/R cHL approved (priority review) by NMPA 12.27.19; sNDA for 2L+ UC approved (priority review) 04.10.20; sNDA for 1L Squamous NSCLC accepted 04.20.20; sNDA for 1L Non-squamous NSCLC accepted 06.19.20**
- Announced Ph 3 in 1L Non-Squamous NSCLC trial met PFS at interim analysis
- Presented first report of Ph 3 data in Squamous NSCLC at ASCO 2020

BeiGene

Sources: 1. Dahan et al., Cancer Cell, 2015; Arlauckas et al., Sci. Transl. Med., 2017; 2. as of 12.06.19

Tislelizumab Clinical Program

Broad development for Asia-prevalent cancers

PROGRAM (TARGET)	TUMOR	DOSE ESCALATION	DOSE EXPANSION		PIVOTAL		FILED	MARKET
		PH1a	PH1b	PH2*	PH2**	PH3		
tislelizumab *(PD-1)*	Heme	*R/R cHL (Approved by NMPA 12.27.19)*						
		R/R NK/T-cell lymphoma						
	Bladder	*2L+ UC (Approved by NMPA 04.10.20)*						
		1L UC						
	Lung	*2L NSCLC*						
		1L non-squamous NSCLC (sNDA accepted by NMPA 06.19.20)						
		1L squamous NSCLC (sNDA accepted by NMPA 04.20.20)						
		1L SCLC						
		Stage II/IIIA SCLC						
	Liver	*1L HCC*						
		2L/3L HCC (sNDA by NMPA accepted 07.01.20)[2]						
	Esophageal	*2L ESCC*						
		1L ESCC						
		Localized ESCC						
	Gastric	*1L GC*						
		1L NPC						
		MSI-H or dMMR solid tumors						
		Solid tumors						
+ pamiparib *(PARP)*		*Solid tumors*						
+ zanubrutinib *(BTK)*		*Hematologic tumors*						
+ sitravatinib *(multi-kinase)*		*NSCLC, RCC, OC, melanoma^*						
+ sitravatinib *(multi-kinase)*		*HCC, GC^*						
+ A333 *(PD-L1)*		*Solid tumors*						
+ A425 *(TIM3)*		*Solid tumors*						
+ A1217 *(TIGIT)*		*Solid tumors*						
+A445 *(OX40)*		*Solid tumors*						

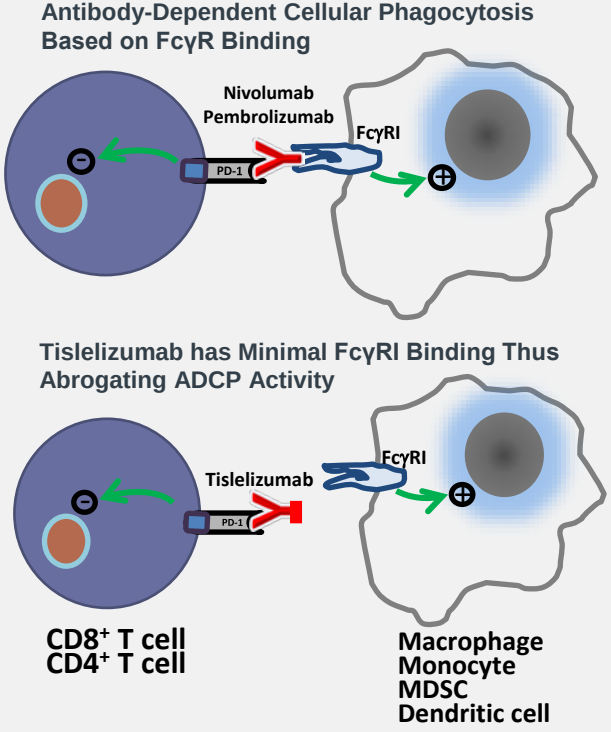
- More than 5,800 patients[1] enrolled over 3 years across tislelizumab program, including combination trials
- Broad development global program with additional Ph3/potential registration-enabling trials planned in lung, gastric, liver, and esophageal cancers

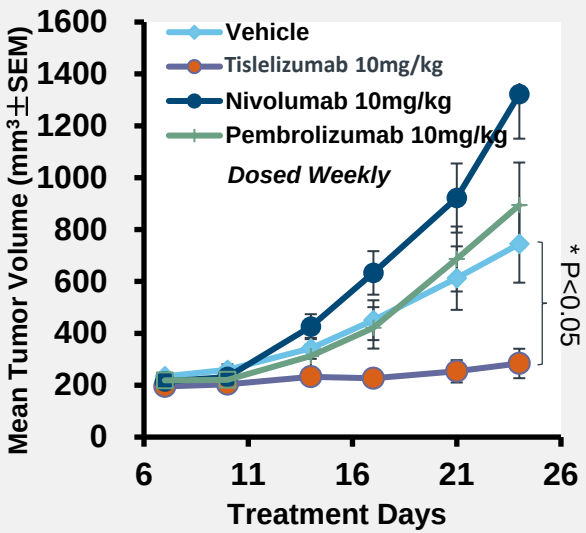
*Some indications will not require a non-pivotal Ph2 clinical trial prior to beginning pivotal Ph2 or 3 clinical trials. **Confirmatory clinical trials post-approval are required for accelerated approvals.
^Trials conducted in the APAC region. 1. as of June 14, 2020. 2. global study and potentially registration-enabling in certain countries

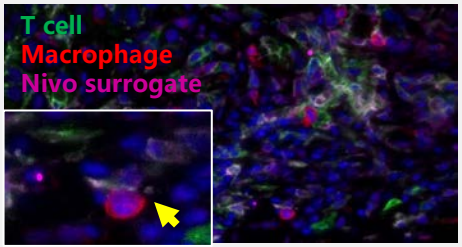
BeiGene

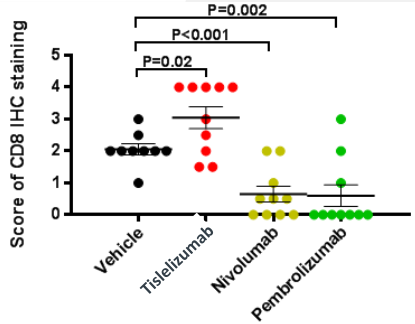
Tislelizumab's Lack of FcγR Binding Was Designed to Prevent Macrophage-Mediated T-Cell Clearance

We believe the different FcγR design may have meaningful differences in the clinic







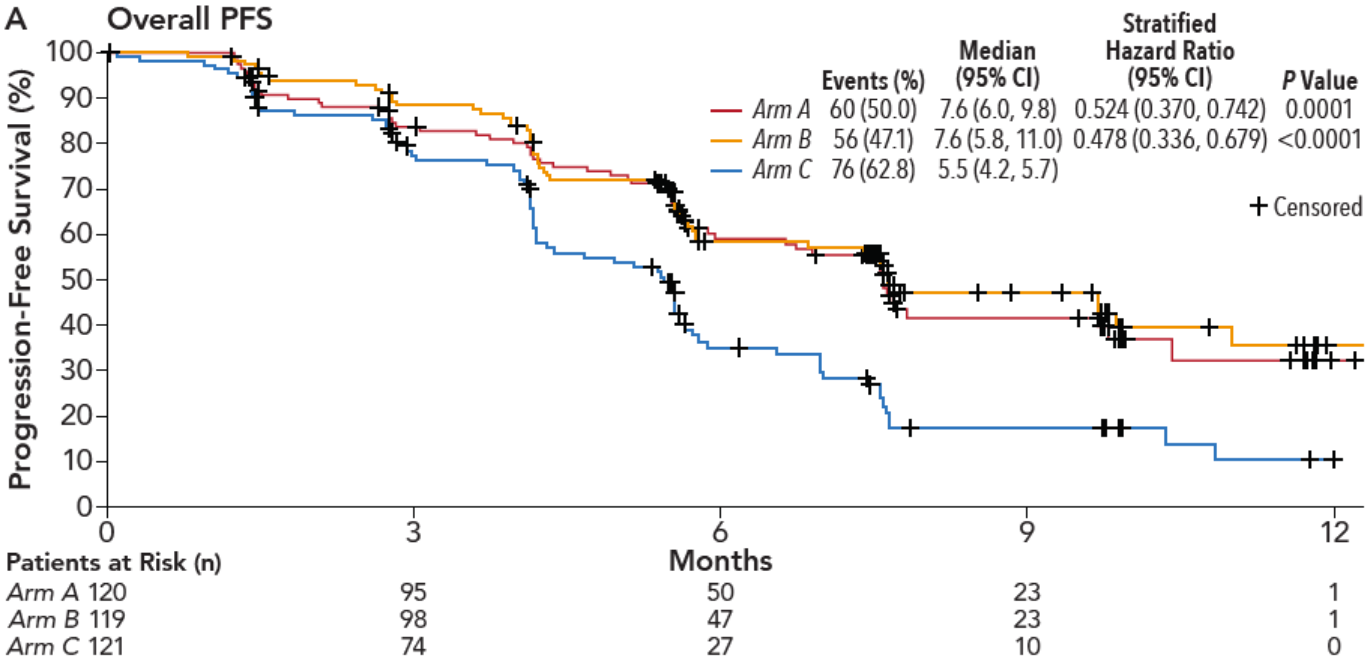


- Tislelizumab was specifically engineered to minimize binding to FcγR on macrophages, thereby abrogating antibody-dependent cellular phagocytosis (ADCP), a potential mechanism of T-cell clearance
- ***Hypothesis supported by literature:*** Dahan et al. reported that FcγR engagement compromises the anti-tumor activity of anti-PD-1 Abs; Arlauckas et al. showed in a mouse model that anti-PD-1 Abs could be transferred from PD-1+ T cells to macrophages in FcγR-dependent manner

Sources: Dahan et al., Cancer Cell, 2015; Arlauckas et al., Sci. Transl. Med., 2017; FcγRI=Fc gamma receptor-1, MDSC=myeloid-derived suppressor cell.

BeiGene

Tislelizumab in 1L Sq NSCLC: PFS by IRC



Source: Wang et. al., ASCO 2020; Abbreviations: CI, confidence interval; PD-L1, programmed death ligand-1; PFS, progression-free survival; TC, tumor cell.

Tislelizumab in 1L Sq NSCLC: Response

		Arm A Tislelizumab + PC (n=120)	**Arm B** Tislelizumab + *nab*-PC (n=119)	**Arm C** PC (n=121)
BOR, n (%)	CR	5(4)	3 (3)	1 (< 1)
	PR	82 (68)	86 (72)	59 (49)
	SD	18 (15)	19 (16)	36 (30)
	Non-CR/non-PD	0	0	1 (< 1)
	PD	12 (10)	5 (4)	11 (9)
	NE/missing	3(3)	6 (5)	13 (11)
ORR, % (95% CI)		73 (63.6, 80.3)	75 (66.0, 82.3)	50 (40.4, 58.8)
DCR, % (95% CI)		88 (80.2, 92.8)	91 (84.1, 95.3)	80 (71.9, 86.9)
CBR, %* (95% CI)		81 (72.6, 87.4)	80 (71.5, 86.6)	56 (46.9, 65.2)
Median DoR, months (95% CI)		8.2 (5.0, NE)	8.6 (6.3, NE)	4.2 (2.8, 4.9)

Source: Wang et. al., ASCO 2020; DCR=CR+PR+SD. *Includes patients with BOR in CR or PR or ≥24 weeks SD.
Abbreviations: BOR, best overall response; CBR, clinical benefit rate; CI, confidence interval; CR, complete response; DCR, disease control rate; IRC, Independent Review Committee; ITT, intent-to-treat; nab, nanoparticle albumin-bound; NE, not evaluable; ORR, objective response rate; PC, paclitaxel and carboplatin; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

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Tislelizumab in 1L Sq NSCLC: Safety

Overall Summary

	Arm A Tislelizumab + PC (n=120)	Arm B Tislelizumab + *nab*-PC (n=119)	Arm C PC (n=121)
Patients with ≥ 1 TEAE	120 (100.0)	117 (99.2)	117 (100.0)
Serious TEAE	44 (36.7)	45 (38.1)	29 (24.8)
TEAE leading to permanent discontinuation of any study treatment component	15 (12.5)	35 (29.7)	18 (15.4)
TEAE leading to death	4 (3.3)	5 (4.2)	5 (4.3)

Data presented as n (%).

- Investigator-assessed TEAEs related to any study treatment were reported in 99.2%, 99.2%, and 100% of patients in Arms A, B, and C, respectively
- The most commonly reported treatment-related AEs (TRAEs) associated with any study component were mainly hematologic in nature

TRAEs Associated With Any Study Component and Occurring in ≥ 20% in Any Arm

Preferred Term, n (%)	Arm A Tislelizumab + PC (n=120)		Arm B Tislelizumab + *nab*-PC (n=119)		Arm C PC (n=121)	
	All Grades	Grades ≥3	All Grades	Grades ≥3	All Grades	Grades ≥3
Anemia	99 (82.5)	6 (5.0)	104 (88.1)	24 (20.3)	87 (74.4)	11 (9.4)
Alopecia	77 (64.2)	0	81 (68.6)	0	72 (61.5)	0
Neutrophil count decreased	75 (62.5)	62 (51.7)	72 (61.0)	54 (45.8)	68 (58.1)	53 (45.3)
White blood cell count decreased	63 (52.5)	26 (21.7)	68 (57.6)	32 (27.1)	62 (53.0)	28 (23.9)
Leukopenia	57 (47.5)	19 (15.8)	66 (55.9)	30 (25.4)	56 (47.9)	21 (17.9)
Neutropenia	51 (42.5)	40 (33.3)	50 (42.4)	32 (27.1)	55 (47.0)	47 (40.2)
Decreased appetite	50 (41.7)	1 (0.8)	49 (41.5)	1 (0.8)	35 (29.9)	1 (0.9)
ALT increased	48 (40.0)	2 (1.7)	40 (33.9)	2 (1.7)	27 (23.1)	0
Platelet count decreased	40 (33.3)	5 (4.2)	52 (44.1)	16 (13.6)	28 (23.9)	2 (1.7)
AST increased	39 (32.5)	0	38 (32.2)	1 (0.8)	13 (11.1)	0
Nausea	34 (28.3)	0	48 (40.7)	0	29 (24.8)	1 (0.9)
Thrombocytopenia	33 (27.5)	7 (5.8)	47 (39.8)	15 (12.7)	32 (27.4)	7 (6.0)
Pain in extremity	33 (27.5)	3 (2.5)	8 (6.8)	0	23 (19.7)	0
Blood bilirubin increased	27 (22.5)	0	14 (11.9)	0	15 (12.8)	0
Asthenia	26 (21.7)	0	19 (16.1)	0	23 (19.7)	1 (0.9)
Hypoesthesia	25 (20.8)	0	11 (9.3)	0	19 (16.2)	0
Vomiting	24 (20.0)	0	22 (18.6)	0	15 (12.8)	2 (1.7)

Source: Wang et. al., ASCO 2020; Abbreviations: ALT, alanine aminotransferase; AST, aspartate aminotransferase; nab, nanoparticle albumin-bound; PC, paclitaxel and carboplatin; TEAE, treatment-emergent adverse event, TRAE, treatment-related adverse event.

Tislelizumab China cHL Pivotal Trial Data

Deep and frequent responses observed in both transplant-ineligible patients and patients who failed transplant

Baseline Characteristics	Total (N=70)
Age (years), median (range)	32.5 (18, 69)
Age group <65 / 65-74 years, n (%)	66 (94.3) / 4 (5.7)
Sex, male / female, n (%)	40 (57.1) / 30 (42.9)
Time since first diagnosis of cHL (months), median (range)	25.33 (4.6, 262.3)
Stage IV at study entry, n (%)	42 (60.0)
Bulky disease*, n (%)	8 (11.4)
Bone marrow involvement, n (%)	22 (31.4)
B-symptom(s), n (%)	26 (37.1)
Ineligible for prior ASCT†, n (%)	
Failure to achieve an objective response to salvage chemotherapy	**53 (75.7)**
Inadequate stem cell collection or unable to collect stem cells	2 (2.9)
Co-morbidities	2 (2.9)
Prior lines of systemic therapy, median (range)	3 (2-11)
Type of prior therapy, n (%)	
Chemotherapy	70 (100.0)
Radiotherapy	21 (30.0)
ASCT	**13 (18.6)**
Immunotherapy‡	15 (21.4)
Brentuximab vedotin	4 (5.7)

IRC Dataset	cHL
Enrolled Patients	N=70
Median Follow-up	13.9 months
Prior Lines, Median (range)	3 (2-11)
ORR	**87.1%**
CR	**62.9%**
PR	24.3%

-- Majority of transplant-ineligible patients had failed to respond to salvage chemotherapy

Source: Song et al., EHA 2019. *Mediastinal mass ratio of 0.33 or size of any single node/nodal mass ≥10 cm in diameter; ‡All received ≥2 prior regimens.

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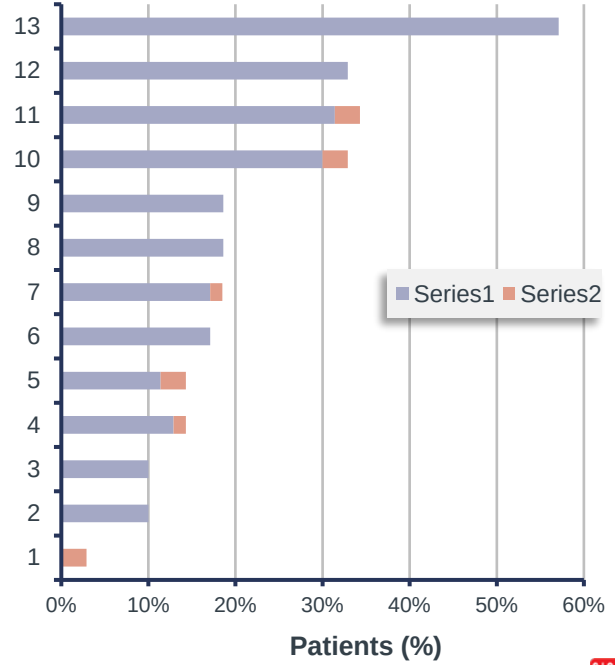
Summary of Tislelizumab Adverse Events

cHL pivotal trial

Summary of Treatment-Emergent Adverse Events

Event, n (%)	N=70
Grade ≥3 TEAE	21 (30)
Serious TEAE	12* (17.1)
TEAE leading to treatment discontinuation	4† (5.7)
TEAE leading to death	0 (0.0)
Immune-related (ir) TEAEs (by aggregate category)	
≥1 irTEAE	27 (36.8)
Thyroid disorder	16 (22.9)
Pneumonitis	5 (7.1)
Skin adverse reactions	6 (8.6)
Myositis/rhabdomyolysis/cardiomyopathy‡	1 (1.4)
Nephritis and renal dysfunction	1 (1.4)
Other immune-related reactions (lipase increased	1 (1.4)

TEAEs in ≥10% of Patients and Grade ≥3 TEAEs in ≥2 Patients Regardless of Causality



Source: Song et al., EHA 2019; Data cut: 11.26.18; TEAE, treatment-emergent adverse events by individual preferred term.
*SAEs in 11 of the 12 patients determined to be possibly related to tislelizumab
†Pneumonitis (n=2), focal segmental glomerulosclerosis (n=1), organizing pneumonia (n=1); ‡Blood creatine phosphokinase increased.

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Tislelizumab China UC Pivotal Trial Data

Activity in previously treated patients

	UC
Enrolled Patients/evaluable	N=113/104
Median Follow-up	8 months
ORR	23.1%
CR	7.7%
PR	15.4%
PFS median (95% CI)	2.1 (2.00, 2.46)
OS median (95% CI)	9.8 months (7.46, 13.50)

- IRC assessed
- Per the investigator, treatment-related AEs (TRAEs) were reported in 93% (n=105/113) of patients with PD-L1+ UC. A total of 12 (11%) patients experienced a TRAE that led to treatment discontinuation. Drug eruption (n=2) was the only TRAE that led to treatment discontinuation in >1 patient.
- Anemia (27%), decreased appetite (19%), and pyrexia (17%) were the only TRAEs occurring in >15% of patients; the majority of reported TRAEs were grade ≤2 in severity. Anemia (7%) was the only grade 3-4 TRAE occurring in ≥5% patients.
- A total of 64% of patients experienced an immune-related TEAE. Common immune-related TEAEs included immune-mediated skin adverse reaction (n=38; 34%), immune-mediated hepatitis (n=27; 24%), thyroid disorders (n=15; 13%), and immune-mediated nephritis and renal dysfunction (n=13; 12%). No immune-related TEAEs ≥ grade 3 occurred in over 5% of patients.
- Four patients experienced a fatal TRAE (hepatic failure, n=2; respiratory arrest, n=1; renal impairment, n=1). The events of hepatic failure and respiratory arrest were reported as possibly related by the investigator; the event of renal impairment was reported as possibly unrelated by the investigator.

Source: Ye et al., ESMO 2019

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Tislelizumab Response Data in Disease-Specific Cohorts

Tumor Type	Gastric Cancer	Esophageal Cancer	Esophageal Cancer	Head & Neck SCC	Ovarian Cancer	HCC	Urothelial Cancer	NSCLC	MSI-H / dMMR	NPC
Source	ESMO-IO 2018[1]	ESMO-IO 2018[1]	CSCO 2019[8]	ESMO 2017[2]	ESMO 2017[3]	ESMO-IO 2018[1]	ESMO 2019[4]	WCLC 2019[7]	CSCO 2018[5]	ASCO 2019[6]
Median Treatment Duration	--	--	--	104 days (30-339)	71 days (29-540)	--	--	--	2.2 mo (0.69-11.1)	7.5 mo (2.1-15.8)
Median Follow-up Time	4.9 mo (0.9-25.4)	5.2 mo (0.2-22.7)	13.0 mo (12.3-14.0)	--	--	10.8 mo (0.7-31.6)	7.6 mo (0.4-17.4)	11.2 mo (0.5-34.5)	4.4 mo (0.1-10.7)	11.7 mo (4.9-15.7)
Median Duration of Response	8.5 mo	NR	12.8 mo	--	--	15.7 mo	18.7 mo (6.2-18.7)	NR	--	8.3 mo
Evaluable Patients	N=54	N=54	N=15	N=17	N=50	N=49	N=104	N=46	N=14	N=21
CR (Confirmed)	--	1	--	--	--	--	8	--	--	--
PR	7	5	7	3	2	6	16	6	4	9
SD	9	14	5	6	20	19	14	23	4	9
Patients Remaining on Treatment*	3	3	4	3	6	5	30	7	9	9

- Objective responses observed with limited follow-up in multiple disease-specific cohorts. NR = Not reached

Sources:1. Ph1A/1B data as of 08.31.18, ESMO Immuno-Oncology 2018 Congress (Sanjeev et al); 2. Ph1 data as of 06.08.17, ESMO 2017 Congress (Horvath et al, Abstract 389P); 3. Ph1 data as of 06.08.17, ESMO 2017 Congress (Meniawy et al, Abstract 388P); 4. Ph2 data as of 02.28.19, ESMO 2019 Congress (Ye et al); 5. Ph1 data as of 05.11.18, CSCO 2018; 6. Ph1/2 as of 12.01.18, ASCO 2019 (Wang et al); 7. Ph1/2 as of 05.20.19, WCLC 2019 (Barlow et al); 8. Ph2 as of 03.31.19, CSCO 2019 (Xu et al); * At time of data cutoff.

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China Label: Summary of Adverse Reactions Occurring in ≥5% of Patients in Phase 2 cHL Study[1]

Tislelizumab	200mg every 3 weeks n=70	
Preferred term†	All grades*, n(%)	≥Grade3**, n(%)
General disorders and administration site conditions		
Pyrexia	38 (54.3)	0 (0.0)
Fatigue[a]	7 (10.0)	0 (0.0)
Chills	4 (5.7)	0 (0.0)
Endocrine disorders		
Hypothyroidism	23 (32.9)	0 (0.0)
Investigations		
Weight increased	19 (27.1)	2 (2.9)
Weight decreased	6 (8.6)	0 (0.0)
Skin and subcutaneous tissue disorders		
Pruritius[b]	12 (17.1)	0 (0.0)
Rash[c]	10 (14.3)	0 (0.0)
Infections and infestations		
Upper respiratory tract infection	12 (17.1)	0 (0.0)

Tislelizumab	200mg every 3 weeks n=70	
Preferred term	All grades*, n(%)	≥Grade3**, n(%)
Respiratory, thoracic and mediastinal disorders		
Cough	8 (11.4)	0 (0.0)
Pneumonitis[d]	4 (5.7)	3 (4.3)
Metabolism and nutritional disorders		
Hyperlipidemia	5 (7.1)	0 (0.0)
Hyperuricemia	4 (5.7)	0 (0.0)
Musculoskeletal and connective tissue disorders		
Musculoskeletal pain[e]	5 (7.1)	1 (1.4)
Pain in extremity	5 (7.1)	0 (0.0)
Gastrointestinal disorders		
Diarrhea	4 (5.7)	0 (0.0)
Blood and lymphatic system disorders		
Anemia	4 (5.7)	0 (0.0)
Nervous System disorders		
Headache	4 (5.7)	0 (0.0)

1. Adverse reactions in this package insert are defined as: adverse events that assessed by investigator as related, definitely related, probably related, possibly related, unlikely related or missing causal relationship. Only adverse events that are assessed by investigator as definitely unrelated are excluded. The cutoff date of the data is 11.26.18. † Preferred term is based on ICH MedDRA Chinese version 20.0. * Severity of adverse reactions per NCI CTCAE v4.03. ** No Grade 5 adverse event was reported in this study.

a. Fatigue is a composite term which includes fatigue, asthenia, and malaise. b. Pruritus is a composite term which includes pruritus and urticaria. c. Rash is a composite term which includes G1-2 rash, dermatitis and eczema. d. Pneumonitis is a composite term which includes pneumonitis, interstitial lung disease and organizing pneumonia. e. Musculoskeletal pain is a composite term which includes back pain, neck pain and musculoskeletal chest pain and spinal pain.

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Tislelizumab Phase 1 Common AEs in ≥ 10% of Patients

System Organ Class Preferred Term	Phase 1a N=116 n (%)	Phase 1b N=335 n (%)	Total N=451 n (%)
Patients with at least one TEAE	114 (25.3)	322 (71.4)	436 (96.7)
Fatigue	47 (10.4)	78 (17.3)	125 (27.7)
Nausea	41 (9.1)	68 (15.1)	109 (24.2)
Decreased appetite	19 (4.2)	71 (15.7)	90 (20.0)
Diarrhea	32 (7.1)	49 (10.9)	81 (18.0)
Constipation	26 (5.8)	50 (11.1)	76 (16.9)
Abdominal pain	26 (5.8)	38 (8.4)	64 (14.2)
Vomiting	20 (4.4)	43 (9.5)	63 (14.0)
Back pain	22 (4.9)	40 (8.9)	62 (13.7)
Cough	15 (3.3)	45 (10.0)	60 (13.3)
Rash	23 (5.1)	37 (8.2)	60 (13.3)
Dyspnea	12 (2.7)	33 (7.3)	45 (10.0)

Source: BGB-A317 IB v6.0; All grades, regardless of causality; Data cut-off 27 April 2018; 6 months after Last Patient Enrolled; Of the 451 total patients in the Safety Population for Study BGB A317_001, 203 (45.0%) experienced at least 1 Grade 3 or higher TEAE. The most commonly occurring Grade 3 or higher TEAEs (≥ 2%; 9 or more patients overall incidence) were pneumonia (22 patients, 4.9%), anemia (18 patients, 3.2%), and hypokalemia (9 patients, 2.0%).

Tislelizumab Chemotherapy Combination Data in Lung Cancers

Responses	Non-Sq Tislelizumab + pemetrexed + platinum (n=16)	Sq Tislelizumab + paclitaxel + platinum (n=15)	Sq Tislelizumab + gemcitabine + platinum (n=6)	SCLC Tislelizumab + etoposide + platinum (n=17)	Total (N=54)
Best Overall Response, n (%)					
CR	0	0	0	0	0
PR	7 (43.8)	12 (80.0)	4 (66.7)	13 (76.5)	36 (66.7)
SD	8 (50.0)	2 (13.3)	1 (16.7)	2 (11.8)	13 (24.0)
PD	1 (6.3)	0	0	1 (5.9)	2 (3.7)
Missing	0	1 (6.7)	1 (16.7)	1 (5.9)	3 (5.6)
ORR confirmed %	43.8	80.0	66.7	76.5	66.7
Median PFS, months*	9.0	7.0	NR	6.9	
OS, months	NR	NR	NR	15.6	

Source: Wang et. al., CSCO 2019; Sq: squamous; SCLC: small cell lung cancer. Median follow-up 15.3 months. * Median PFS data cutoff 06.30.19.

Treatment-emergent adverse events (TEAEs) occurred in all 54 patients; adverse events (AEs) reported as related to tislelizumab occurred in 46 patients (85.2%), and seven patients (13%) discontinued tislelizumab treatment due to AEs; Grade ≥3 TEAEs occurred in 43 patients, with the most common being decreased neutrophil count (48.1%), anemia (18.5%), decreased white blood cell count (13%), decreased platelet count (13%), thrombocytopenia (11.1%), neutropenia (7.4%), and increased alanine aminotransferase (ALT; 5.6%). A total of 14 patients (25.9%) experienced at least one immune-related adverse event (irAE), with the most common being thyroid disorders (16.7%), immune-mediated pneumonitis (7.4%), and immune-mediated hepatitis (3.7%); The most common TEAEs of any grade reported to be related to tislelizumab included asthenia (18.5%); hypothyroidism (13%); decreased appetite (11.1%); increased ALT (11.1%); and increased aspartate aminotransferase (AST; 11.1%); and fourteen patients (25.9%) experienced at least one serious TEAE; one patient with squamous NSCLC (cohort A) had a fatal AE of immune-mediated myositis/rhabdomyolysis/cardiomyopathy after one dose of tislelizumab.

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Overview of Pamiparib (BGB-290)

Selective Inhibitor of PARP1 and PARP2

OVERVIEW

- **Highly selective PARP1 and PARP2 inhibitor with potential brain penetration and strong PARP trapping activity in preclinical studies**

CLINICAL DATA

- More than 1,200[1] patients enrolled across trials, including combinations
- **Ph1/2 data demonstrated pamiparib was generally well-tolerated with promising anti-tumor activity in ovarian cancer**
  - Low incidence of hematological toxicities (e.g. thrombocytopenia), no liver toxicity

DEVELOPMENT PLAN

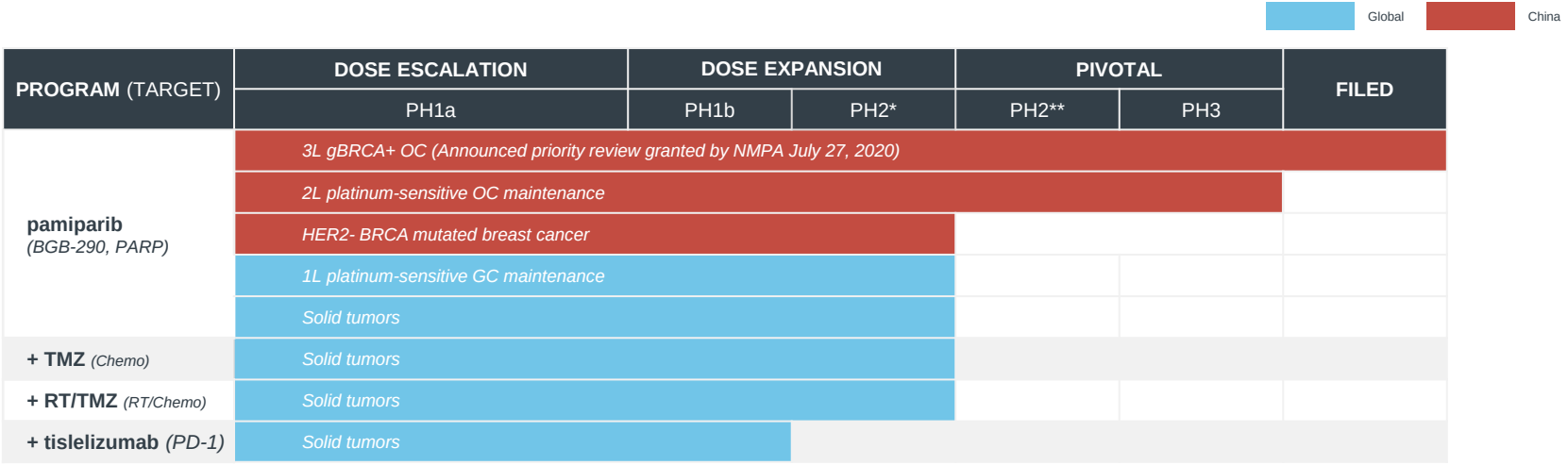
- Priority review granted by NMPA in patients with gBRCA+ ovarian cancer
- Two ongoing global Ph1b/2 trials with chemotherapy: combination with radiation therapy and temozolomide (TMZ) in glioblastoma or combination with TMZ in advanced solid tumors
- Enrollment complete in Ph3 trial in China as maintenance therapy in patients with platinum-sensitive recurrent ovarian cancer
- Enrolling patients for a global Ph2 trial in gastric cancer as maintenance therapy
- Internal combination with tislelizumab: preliminary anti-tumor activity observed in multiple solid tumors

DATA PRESENTATIONS

- Presented updated Ph 1/2 combination data in GBM at SNO 2018
- Presented Ph 1/2 data in high-grade ovarian cancer at CSCO 2019
- Presented Ph 1/2 data in several tumor types at ESMO 2019

1 As of June 15, 2020.

Pamiparib Clinical Program



- Two ongoing global Ph1b/2 trials with chemotherapy: combination with radiation therapy and temozolomide (TMZ) in glioblastoma or combination with TMZ in advanced solid tumors

- Internal combination with tislelizumab: preliminary anti-tumor activity observed in multiple solid tumors

*Some indications will not require a non-pivotal Ph2 clinical trial prior to beginning pivotal Ph2 or 3 clinical trials. **Confirmatory clinical trials post-approval are required for accelerated approvals.

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