BeyondSpring

Leading Expert Webinar on Plinabulin for the Prevention of Severe Chemotherapy-Induced Neutropenia (CIN)

March 2021 | NASDAQ: BYSI

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This presentation and any accompanying oral commentary contain forward-looking statements about BeyondSpring Inc. ("BeyondSpring" or the "Company"). Forward- looking statements are based on our management's beliefs and assumptions and on information currently available to our management, including those described in the forward-looking statements and risk factors sections of the Company's 20-F filed on April 30, 2020 and other filings with the United States Securities and Exchange Commission (SEC).

Such statements are subject to known and unknown risks, uncertainties, and other factors that may cause our or our industry's actual results, levels of activity, performance, or achievements to be materially different from those anticipated by such statements. In some cases, you can identify forward-looking statements by terminology such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "predicts," "potential," "intends," or "continue," or the negative of these terms or other comparable terminology. Forward-looking statements contained in this presentation include, but are not limited to, (i) statements regarding the timing of anticipated clinical trials for our product candidates and our research and development programs; (ii) the timing of receipt of clinical data for our product candidates; (iii) our expectations regarding the potential safety, efficacy, or clinical utility of our product candidates; (iv) the size of patient populations targeted by our product candidates and market adoption of our product candidates by physicians and patients; and (v) the timing or likelihood of regulatory filings and approvals.

Except as required by law, we assume no obligation to update these forward-looking statements publicly, or to update the reasons why actual results could differ materially from those anticipated in the forward-looking statements, even if new information becomes available in the future.

The market data and certain other statistical information used throughout this presentation are based on independent industry publications, governmental publications, reports by market research firms or other independent sources. Some data are also based on our good faith estimates. Although we believe these third-party sources are reliable, we have not independently verified the information attributed to these third-party sources and cannot guarantee its accuracy and completeness. Similarly, our estimates have not been verified by any independent source.

By attending this presentation, you acknowledge that you will be solely responsible for your own assessment of the market and our market position and that you will conduct your own analysis and be solely responsible for forming your own view of the potential future performance of our business.

Agenda

10:00 a.m.	**Introduction** Lan Huang, Ph.D., CEO and co-founder of BeyondSpring Inc.
10:05 a.m.	**Unmet medical need and current treatment landscape in CIN** Jeffrey Vacirca, M.D., F.A.C.P. New York Cancer & Blood Specialists
10:20 a.m.	**Clinical trials, what is the solution?** Douglas Blayney, M.D., Stanford University
10:35 a.m.	**Live Q&A**
11:00 a.m.	**Closing Remarks** Lan Huang, Ph.D., CEO and co-founder of BeyondSpring Inc.

BeyondSpring: Key Highlights

Mission

Committed to raising the standard of care for cancer patients in the largest global markets with first-in-class treatments that improve lives and clinical outcomes for millions of patients in need

2 near-term NDAs Global Market Opportunities

PLINABULIN: Raising SOC in CIN & NSCLC

- ✓ First-in-Class immune agent
- ✓ New Chemical Entity
- ✓ IP through 2036 in 36 jurisdictions

CIN: Combo with G-CSF

- ✓ Positive Ph 3 topline data Nov 2020
- ✓ NDA submission 1Q 2021
- ✓ Market: $4.5B (US)
- ✓ Breakthrough Designation (US, China)

NSCLC: Combo with docetaxel

- ✓ Final Ph 3 topline data 1H2021
- ✓ Early 2022 NDA submission
- ✓ $30B+ global market

Broad Pipeline

PLINABULIN: A pipeline in a drug

- ✓ Triple combo w/IO agents and radiation/chemo
- ✓ Expansion to additional solid tumors

Targeted Protein Degradation Platform

- ✓ Seed Therapeutics (Subsidiary)
- ✓ Collaboration with Eli Lilly

Three Pre-Clinical IO Agents

Global Capabilities Continuous Innovation

Strong clinical development

- ✓ Enrolled 1,000+ patients to final filing stage for CIN and NSCLC
- ✓ Dual U.S. and China development strategy
- ✓ Strong clinical investigator network

Deep Regulatory Expertise

Commercialization Planning Underway

Two Near-term NDAs & Robust Drug Development Pipeline

	Indication / Target	Program	Trial name / collaborator	Preclinical	Phase 1	Phase 2	Phase 3	Commercial rights	Status/Next Milestone
Late stage	**CIN (All cancer, all chemo)**	Plinabulin + pegfilgrastim	PROTECTIVE-1 & PROTECTIVE-2	Phase 3 primary endpoint met in pivotal data announced November 2020				Global[1]	China NDA Submission **Q1 2021** U.S. NDA Submission **Q1 2021**
	NSCLC (2^{nd}/3^{rd} line)	Plinabulin + docetaxel	DUBLIN-3	Phase 3 second interim analysis completed				Global[1]	Global Final topline Ph3 data **H1 2021**
Triple Combo IO (IIT)	SCLC	Plinabulin + nivolumab + ipilimumab	Rutgers University					Global[1]	Ongoing
	Multi-cancer (2^{nd}/3^{rd} line)	Plinabulin + PD-1/PD-L1 + radiation/chemo	MD Anderson					Global[1]	Initiate Phase 1 in 7 cancers **Q1 2021**
Investigator-initiated IO	Oral T cell co-stimulator	BPI-002						Global	
	IKK inhibitor	BPI-003						Global	
	Oral neo-antigen generator	BPI-004						Global	
Subsidiary	KRAS and additional targets	Targeted Protein degradation (TPD, molecular glue)	Seed Therapeutics					Global	Potential additional partnerships
Subsidiary	3x targets		Lilly					Global	$800M collaboration

Note: Global rights to Plinabulin ex-China. 58% ownership of Chinese subsidiary, Dalian Wanchunbulin Pharmaceuticals Ltd., which owns Chinese rights to Plinabulin. Seed Therapeutics is a subsidiary of BeyondSpring Group. BeyondSpring Inc. owns 100% of global rights

Leading Expert Speaker Biographies

Jeffrey Vacirca, M.D., F.A.C.P.

Jeffrey Vacirca, M.D., F.A.C.P. is a board-certified hematologist and oncologist, serving as Chief Executive Officer and Chairman of the board at New York Cancer & Blood Specialists. Dr. Vacirca serves on the executive board of Community Oncology Alliance (COA) and is the medical director for the International Oncology Network (ION), Oncology Network Development at Mt. Sinai Health Network, and for Long Island Aids Care (LIAC). Dr. Vacirca serves on the board of directors of Spectrum Pharmaceuticals, OneOncology, BeyondSpring, and the American Red Cross of Greater New York.

Dr. Vacirca is the founder and chairman of the New York Cancer Foundation, which provides financial assistance to patients undergoing cancer treatment. He is also co-founder and former vice-chairman of Odonate Therapeutics, and director and chair of the Compensation Committee of Spectrum Pharmaceuticals. Dr. Vacirca is the co-founder and president of the National Translational Research group.

Dr. Vacirca has received numerous awards and accolades for his efforts in providing outstanding patient care including Humanitarian of the Year by the American Red Cross, the Theodore Roosevelt Award for outstanding dedication to patient care, and being named in Newsday's Top Doctors. Additionally, he was honored for his role in enabling LIAC staff to bring state of the art HIV testing to New York.

Douglas W. Blayney, M.D.

Douglas W. Blayney, M.D. is a Professor of Medicine (Oncology) at Stanford, former Medical Director of Stanford Cancer Center, and specializes in the treatment of breast cancer. He has a special interest in the quality and value of cancer care. Dr. Blayney is a past president of the American Society of Clinical Oncology (ASCO), a founder of the ASCO Quality Symposium, a co-author of the ASCO value framework descriptions, and instigated the ASCO clinical "big data" effort, which is now CancerLinQ. He received the inaugural Ellen Stovall Award for Leadership in Patient Centered Care from the National Coalition for Cancer Survivorship in 2016. He was previously a Professor of Internal Medicine and Medical Director of the Comprehensive Cancer Center at the University of Michigan, and prior to that practiced and led Wilshire Oncology Medical Group, Inc. a physician owned multidisciplinary oncology practice in southern California. He has expertise on clinical trial development, use of oncology drugs in clinical practice, reimbursement and marketing strategies and information technology use.

Dr. Blayney's research interests include breast cancer, febrile neutropenia mitigation, and the use big data to improve cancer care quality and value. He has over 90 scientific publications. Dr. Blayney has served on the Food and Drug Administration's Oncologic Drugs Advisory Committee and is Founding Editor-in-Chief and Editor-in-Chief Emeritus of ASCO's Journal of Oncology Practice. He has a degree in electrical engineering from Stanford, is a graduate of the University of California, San Diego School of Medicine, and received post graduate training at UCSD and at the National Cancer Institute in Bethesda, Maryland.

Jeffrey Vacirca, M.D., F.A.C.P.

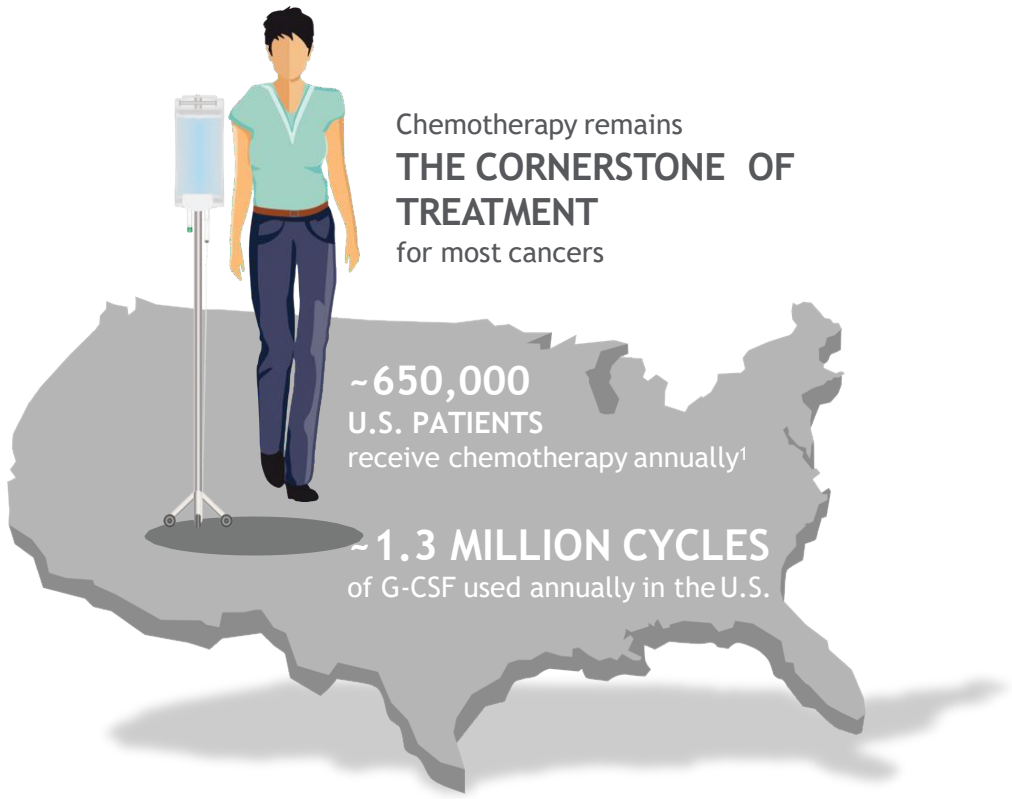
Chemotherapy Induced Neutropenia

CIN Overview

- Chemotherapy-induced-Neutropenia (CIN) is a common side effect of myelosuppressive chemotherapeutic treatment in many cancer patients.
- Chemotherapy kills fast dividing cells, which includes cancer cells, and white blood cells in bone marrow.
- Patients with severe (grade 4) neutropenia have an abnormally low blood neutrophil level (one type of white blood cell) and are more susceptible to severe infection, that often require chemotherapy regimen adjustment, compromising the effectiveness of chemotherapy and eventual survival of the patients (Lalami 2017).
- Moreover, infection resulting from neutropenia manifested as febrile neutropenia (FN) can lead to hospitalization, morbidity, and mortality in as many as 10% of patients (Link 2001; Kuderer 2006; Burris 2010).
- No matter what chemotherapy is used, the ANC (absolute neutrophil count) Nadir occur at day 7-10 after chemotherapy use in cycle 1 (Cheng 2014).
- Therefore, CIN is a problem with bone marrow, not related to specific cancer or chemotherapy (Cheng 2014; Burris 2010), and it is a serious life-threatening condition.

CIN is a Large and Growing Market PD-1 + chemo approved, so chemo will not go away

Plinabulin + G-CSF in each cycle of chemo in non-myeloid cancers prevented or reduced the severity of neutropenia



U.S. Sales -- $4.5 Billion[2]

As a combination therapy Plinabulin's base of business is G-CSF units

G-CSF cycles/year:

- U.S.: 1.3 million[2]
- Global: 4 million[3]

Unit growth (U.S.):[2]

- MAT Aug '19: 6.8%
- MAT Aug '20: 1.1%*

50%+ growth expected in use of first-line chemotherapy by 2040 worldwide[4]

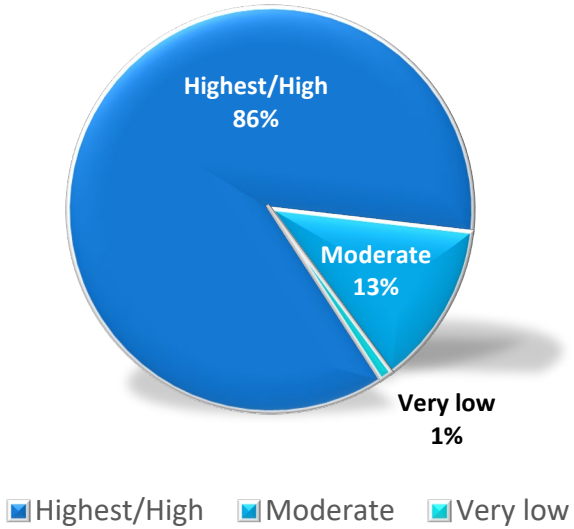
Note: [1] Centers for Disease Control and Prevention. Information for Health Care Providers. Available at: www.cdc.gov/cancer/preventinfections/providers.htm. Accessed February 21, 2020; [2] NSP IQVIA July '20; [3]G-CSF market size based on IQVIA data (MIDAS for ex-U.S. and DDM MD for U.S.; Q3 '16 to Q2 '18. Standardized G-CSF units. 4. Wilson B, Jacob S, Yap ML, et al. Estimates of global chemotherapy demands and corresponding physician workforce requirements for 2018 and 2040: a population-based study. Lancet Oncology 2019; 20(6): 769-780.
* Growth despite a 20% decline in chemotherapy cycles nationwide from March – June '20 due to the pandemic.

CIN: The #1 Reason for Chemotherapy Disruptions

DISRUPTIONS TO CHEMOTHERAPY CAN HAVE DEVASTATING EFFECTS ON OUTCOMES

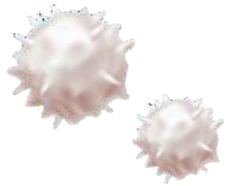
MONOTHERAPY G-CSF CAN'T ADDRESS THE UNMET NEED

ONCOLOGISTS: CIN AS A PRIORITY AMONG CHEMOTHERAPY-RELATED TREATMENT DECISIONS[1]

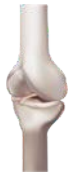


QA08: In a patient's overall treatment plan, how much of a priority is treating CIN relative to other complications of chemotherapy (e.g. liver/renal toxicity, nausea/vomiting, anemia, etc.)?; n=110

MONOTHERAPY GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) DOESN'T ALLOW FOR CHEMOTHERAPY OPTIMIZATION[2,3]



CIN
remains the #1 reason for FN, ER visits, hospitalization, sepsis, mortality and chemotherapy disruption[2]

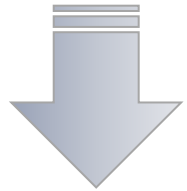


BONE PAIN
remains significant clinical issue[3]

SLIGHT CHANGES IN DOSING OR DELIVERY CAN HAVE A DEVASTATING IMPACT ON SURVIVAL[4]

15%

REDUCTION IN RELATIVE DOSE INTENSITY



50%

REDUCTION IN OVERALL SURVIVAL

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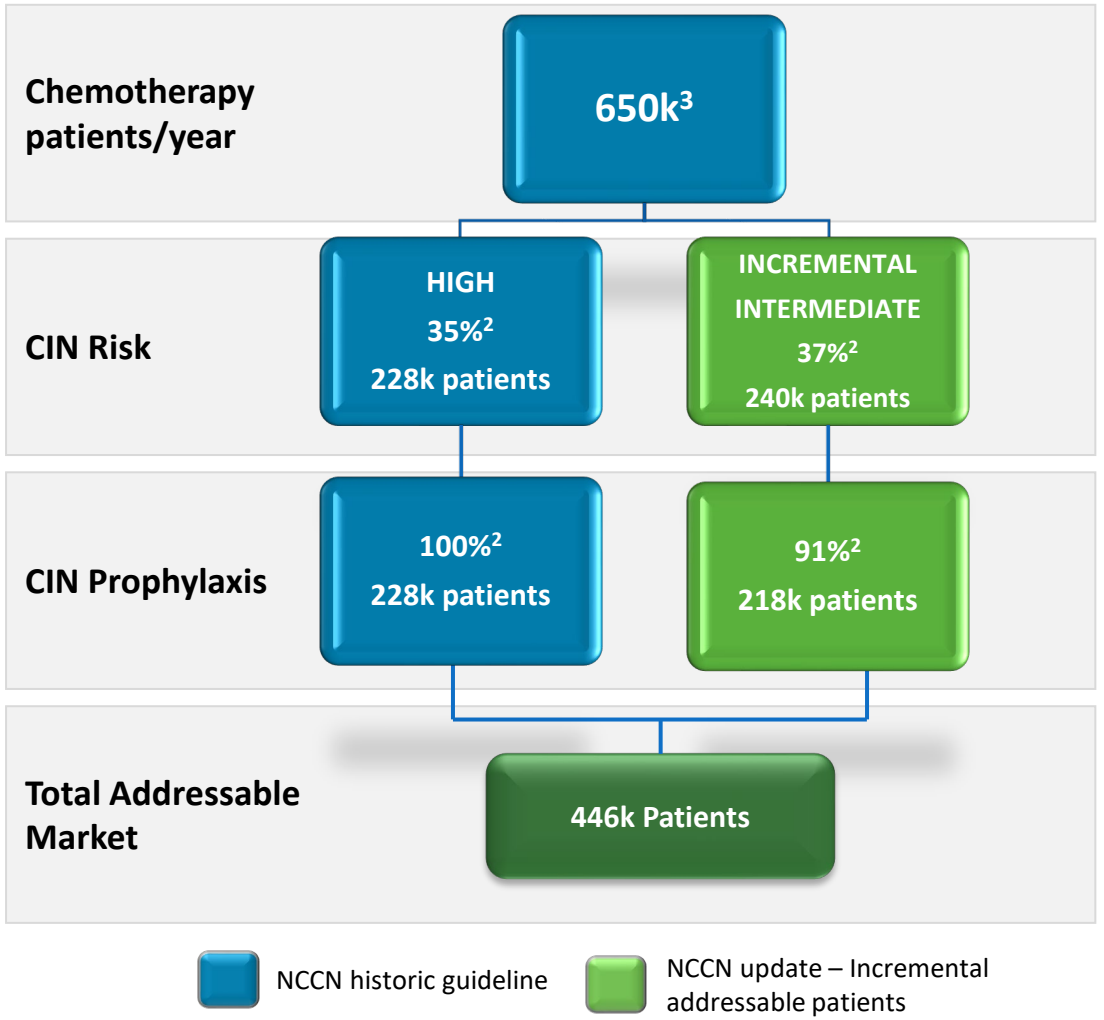
Source: [1] Proprietary market research (Sept 2020), BYSI Summer/Fall 2019. [2] LaLami. [3] Moore. [4] Bonadonna G, Valagussa P, Moliterni A et al. Adjuvant cyclophosphamide, methotrexate, and fluorouracil in node-positive breast cancer. N Engl J Med 1995;332:901-906

New CIN Guidelines Double the Addressable US Market

- **CIN guidelines modified in early 2020:**
  - COVID-19 recognized as a universal risk factor
  - Prophylaxis now recommended for both high and intermediate risk patients

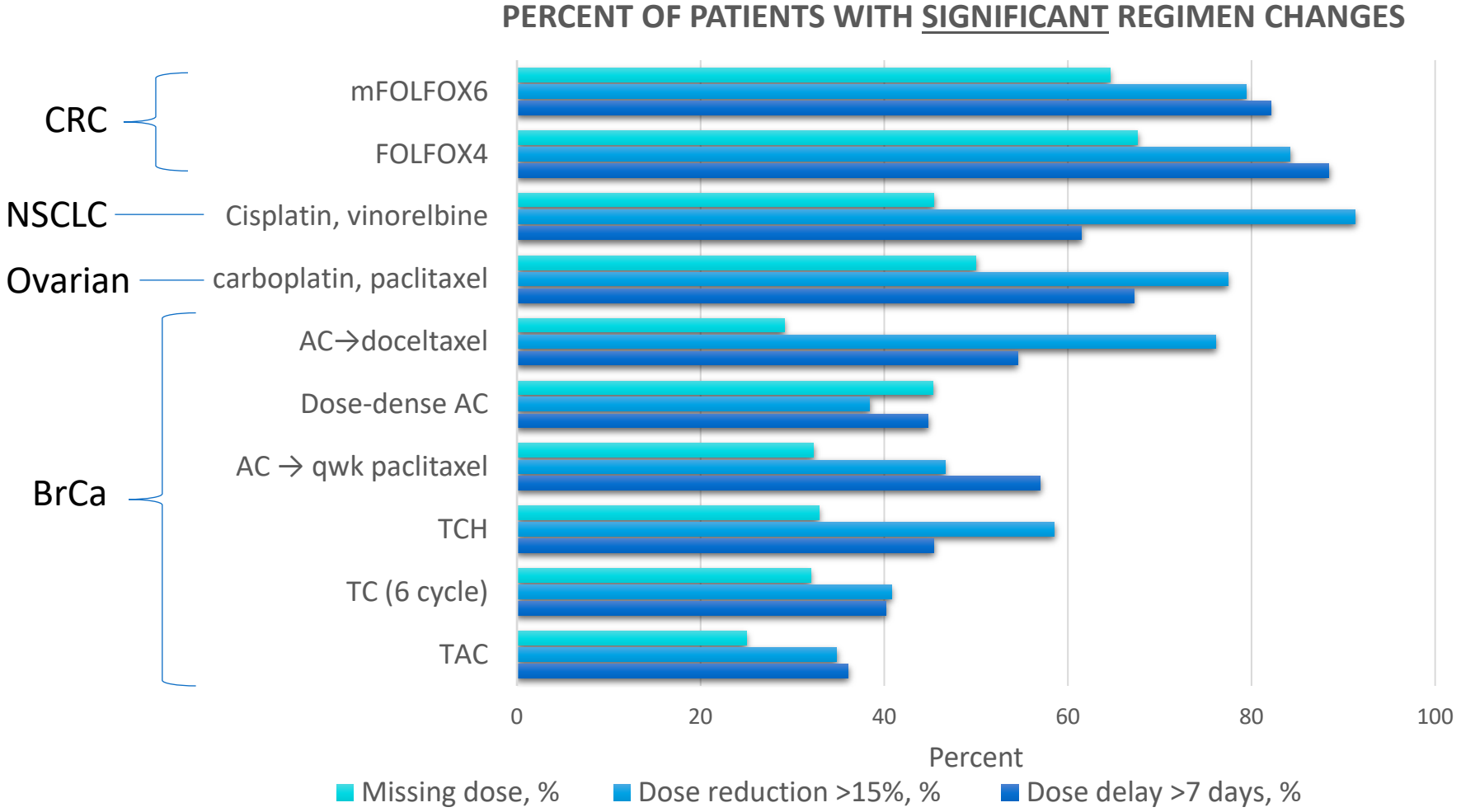
- **The addressable population increased by 100%:**
  - **2019:** 30% of intermediate risk patients received prophylaxis for CIN[1]
  - **2020**: 60% - dramatic jump in approach to preventing CIN[2]

CIN Prophylaxis Market Dynamics Post-Guideline Update



1 BYSI qual market research Sept 2019, 2 BYSI qual Market research Aug 2020, 3 https://www.cdc.gov/cancer/preventinfections/providers.html

Monotherapy G-CSF Fails to Prevent Chemo Regimen Changes



Chemo regimen changes occur in an unacceptably high percentage of patients resulting in:

- Reduction in dose
- Delays in administration
- Overall reduction in RDI

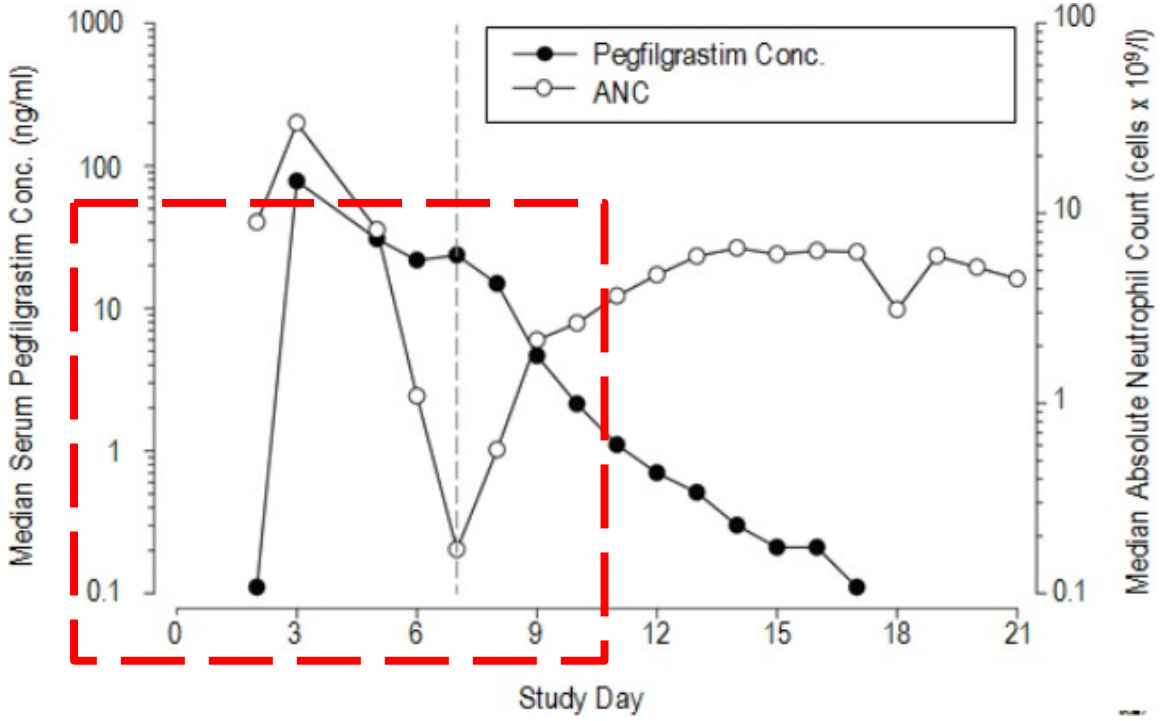
[1]Published, 2015. Per EMR review of 16,233 patients with 6 different tumor types 2007-2011. JNCCN—Journal of the National Comprehensive Cancer Network Volume 13 Number 11 November 2015, [2]Denduluri et al.

Abbreviations: 5-FU, 5-fluorouracil; ABVD, doxorubicin, bleomycin, vinblastine, dacarbazine; AC, doxorubicin, cyclophosphamide; CRC, colorectal cancer; FOLFOX4/mFOLFOX6, folinic acid, 5-fluorouracil, oxaliplatin; NHL, non-Hodgkin lymphoma; NSCLC, non–small cell lung cancer; R-CHOP/CHOP, cyclophosphamide, doxorubicin, vincristine, prednisone ± rituximab; RCVP/CVP, cyclophosphamide, vincristine, prednisone ± rituximab; RDI, relative dose intensity; TAC, docetaxel, doxorubicin, cyclophosphamide; TC, docetaxel, cyclophosphamide; TCH, docetaxel, carboplatin, trastuzumab.

“The Neutropenia Vulnerability Gap” – the First 10 days

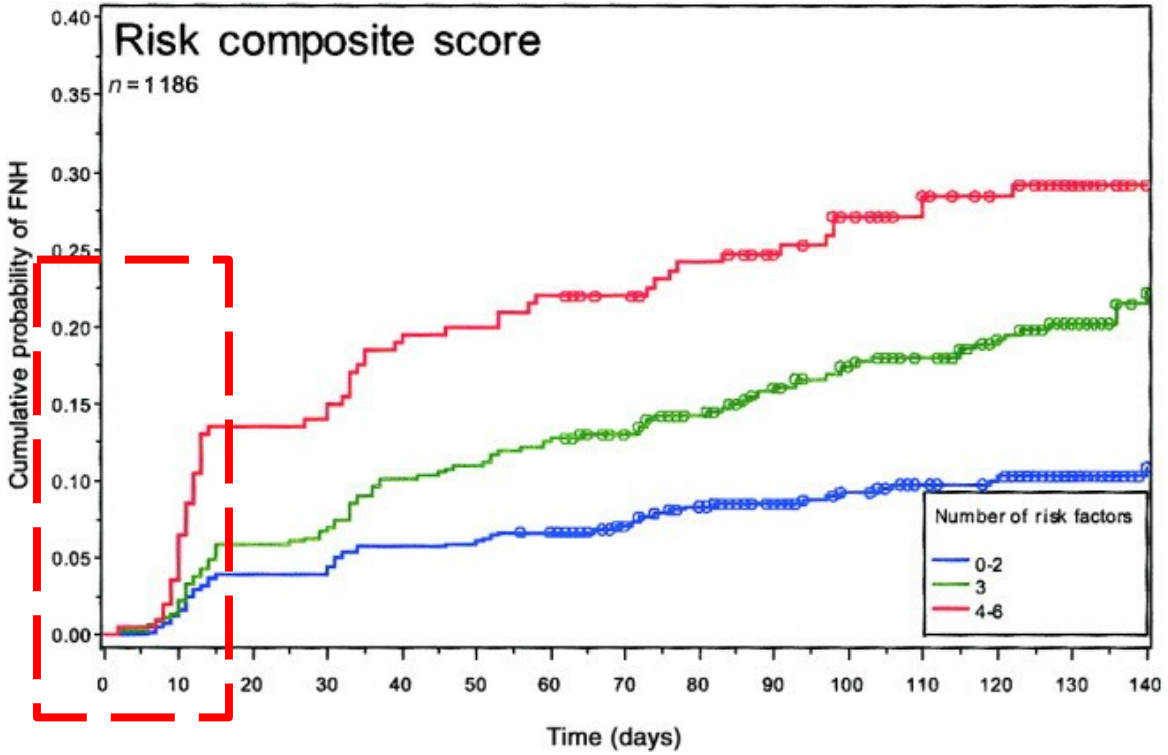
FEBRILE NEUTROPENIA RISK: FIRST 10 DAYS OF CHEMOTHERAPY

MONTHERAPY G-CSF CAN LEAVE PATIENTS UNPROTECTED ATTHE MOST CRUCIAL TIME DURING CHEMOTHERAPY



Neulasta PI, https://www.medicines.org.uk/emc/product/6770/smpc#PHARMACOLOGICAL_PROPS

FIRST 10 DAYS AFTER CHEMOTHERAPY PRESENT THE GREATEST ACCELERATION IN RISK OF HOSPITALIZATION

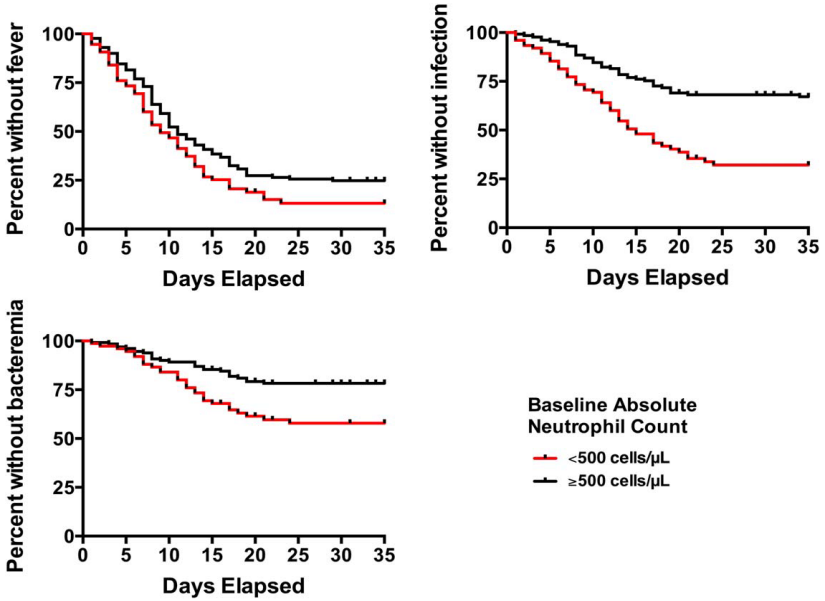


Risk and timing of hospitalization for febrile neutropenia in patients receiving CHOP, CHOP-R, or CNOP chemotherapy. Risk composite: Age >= 65; Albumin level <=3.5 g/dl; ANC < 1.5x10^9 cells/L; planned ARDI >=80%; hepatic comorbidity; no early use of G-CSF

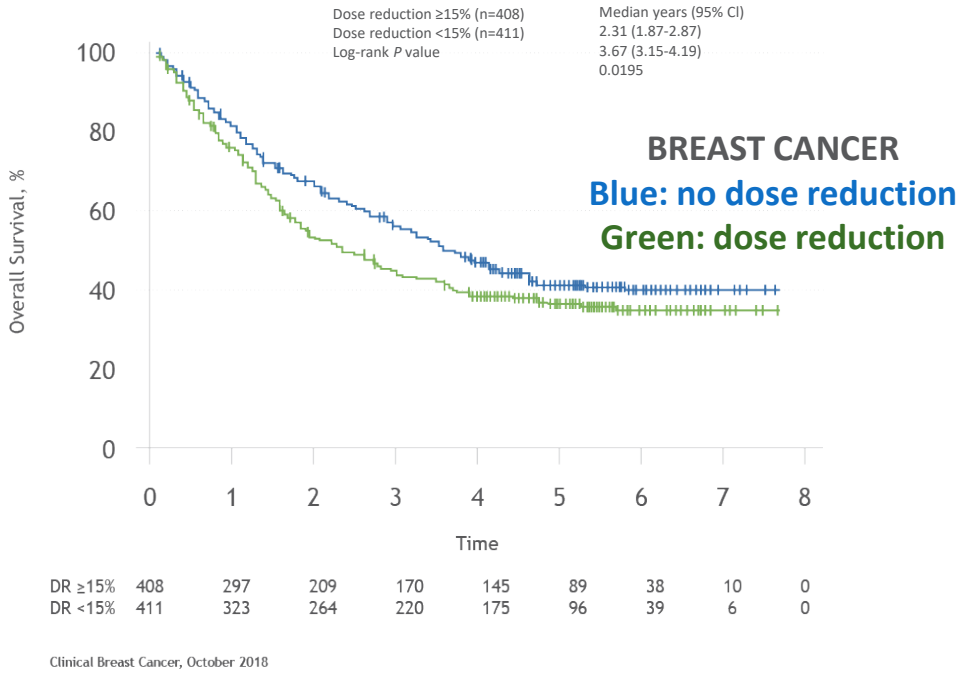
Cancer, Volume: 98, Issue: 11, Pages: 2402-2409, First published: 17 November 2003, DOI: (10.1002/cncr.11827)

Grade 4 neutropenia leads to development of fever and infection; and to chemo dose reduction and less survival

Grade 4 neutropenia was associated with fever (p = 0.04), documented infection (p < 0.0001), and bacteremia (p = 0.002)[1]



Grade 4 neutropenia leads to dose reduction to <85% of optimum dose → lower OS[2]



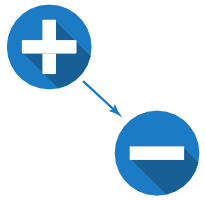
Note: [1]Buckley SA et al., "Prediction of adverse events during intensive induction chemotherapy for acute myeloid leukemia or high-grade myelodysplastic syndromes." American J. Hematology 2014; 89(4): 423-28.
2. Denduluri N et al., Clinical Breast Cancer 18(5): 380-386 (2018); Lalami et al. Critical Reviews in Oncology / Hematology 120: 163-179 (2017).

The Unmet Clinical Need: Monotherapy G-CSF Is Not Enough

DESPITE A BROAD USE OF MONOTHERAPY G-CSFS, THE "4DS" ARE A VEXING CLINICAL CHALLENGE FOR PREVENTING NEUTROPENIA

DECREASED
recommended dose

DELAYED
cycles



DOWNGRADE
chemotherapy regimen

DISCONTINUED
chemotherapy

…CIN and/or febrile neutropenia may have long-term effects with clinical impact on the overall chemotherapy treatment plan, resulting in dose reductions and/or treatment delays, chemotherapy discontinuation, or a switch to less toxic alternatives, and potentially less effective regimens, leading finally to decreased response and survival rates[1].

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Source: 1 Segal et al., 2008; Schwenglenks et al., 2006

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Douglas W. Blayney, M.D.

Plinabulin: New GEF-H1 Activation Small Molecule , Non-G-CSF, with Neutropenia Protection and Anti-Cancer Activity

Under Clinical Development

Plinabulin: "Pipeline in a Drug" for Multiple Cancer Indications

Foundation

CIN

CIN indication (broad label)

- 6 clinical trials confirm benefit
- CIN benefit in multiple chemo

Next Milestone

- U.S. & China NDA submission: Q1 2021 for CIN

NSCLC

NSCLC indication (+ docetaxel)

- 2 clinical trials show anti-cancer activities

Next Milestone

- Global final topline data in NSCLC H1 2021

Translation

+ additional solid tumors

Safety demonstrated in >700 patients

- Plinabulin potentially adds OS and reduces CIN of any chemo
- Expand in additional cancer indications in combo with docetaxel and other chemo

Transformation

triple combo with IO + radiation/chemo

The "attractive" triple combo

- MOA and pre-clinical data support combo approach and benefits from triple therapy
- Plinabulin: induces tumor antigen specific T cells
- PD-1/PD-L1 Ab: release brake for T cells to target and kill cancers

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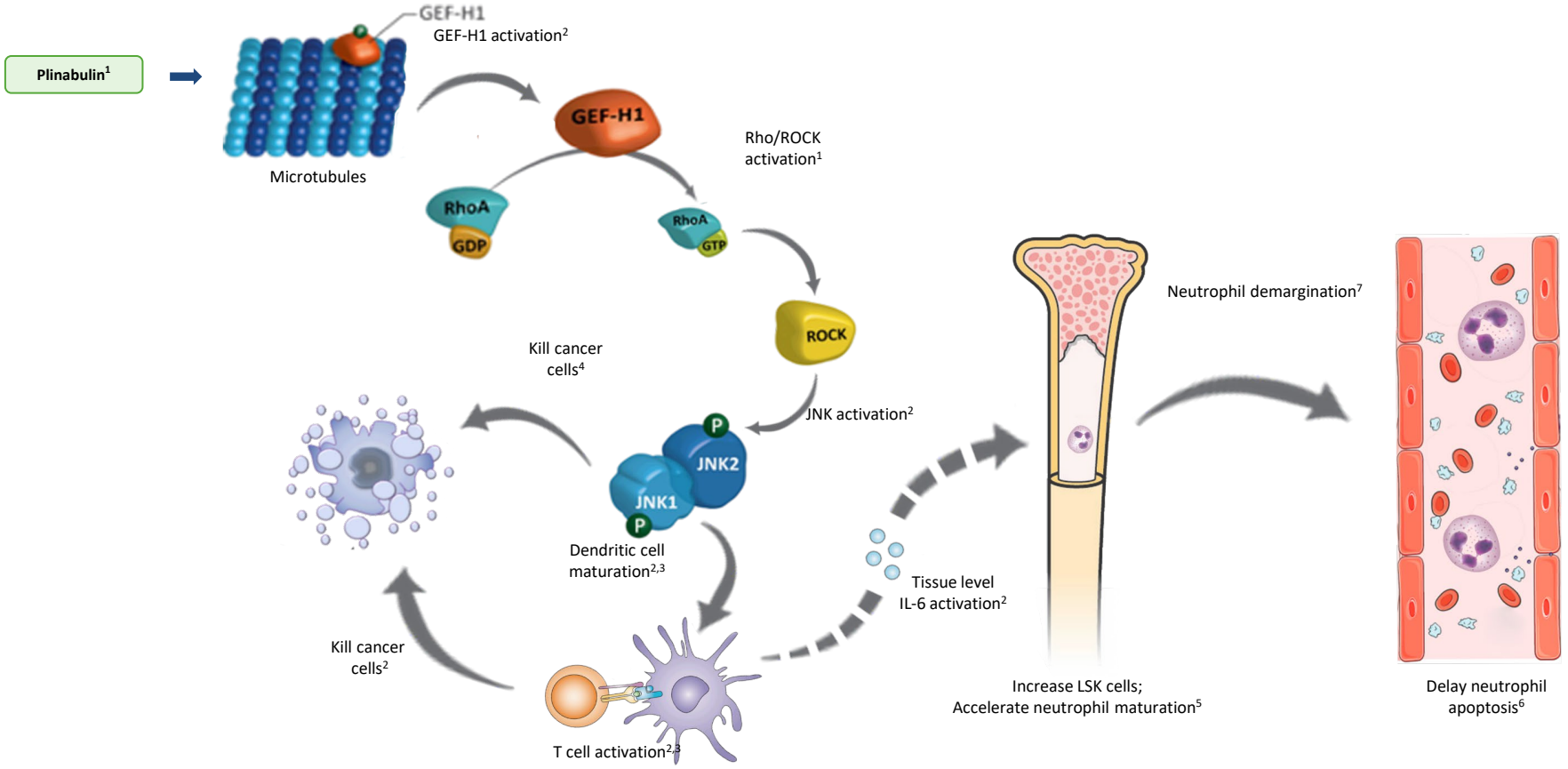
Mechanism of Action

First-in-Class Stem Cell Modulator via GEF-H1 Activation

Plinabulin: First-in-Class Agent, Stimulating Innate and Adaptive Immune System (Proven Target: Immune Defense Protein GEF-H1)



For animated MOA Click Here

Plinabulin's immune mechanism designed to enable its effects in multiple cancer indications:

- **Chemotherapy Induced Neutropenia (CIN):** Designed to protect progenitor cells from chemo assault in bone marrow with week 1 benefit, which compliments G-CSF week 2 benefit for improved benefit potential
- **NSCLC:** Chemo (e.g. docetaxel) introduces real time tumor antigen, Plinabulin is designed to mature DC, leading to T cell activation, and durable anti-cancer benefit
- **Multiple Cancer Indications:** Triple combo combines "tumor antigen generation" from chemo/radiation, plinabulin "adding T cell gas", and PD-1/PD-L1 "release the brake" for potential maximum durable anti-cancer benefit

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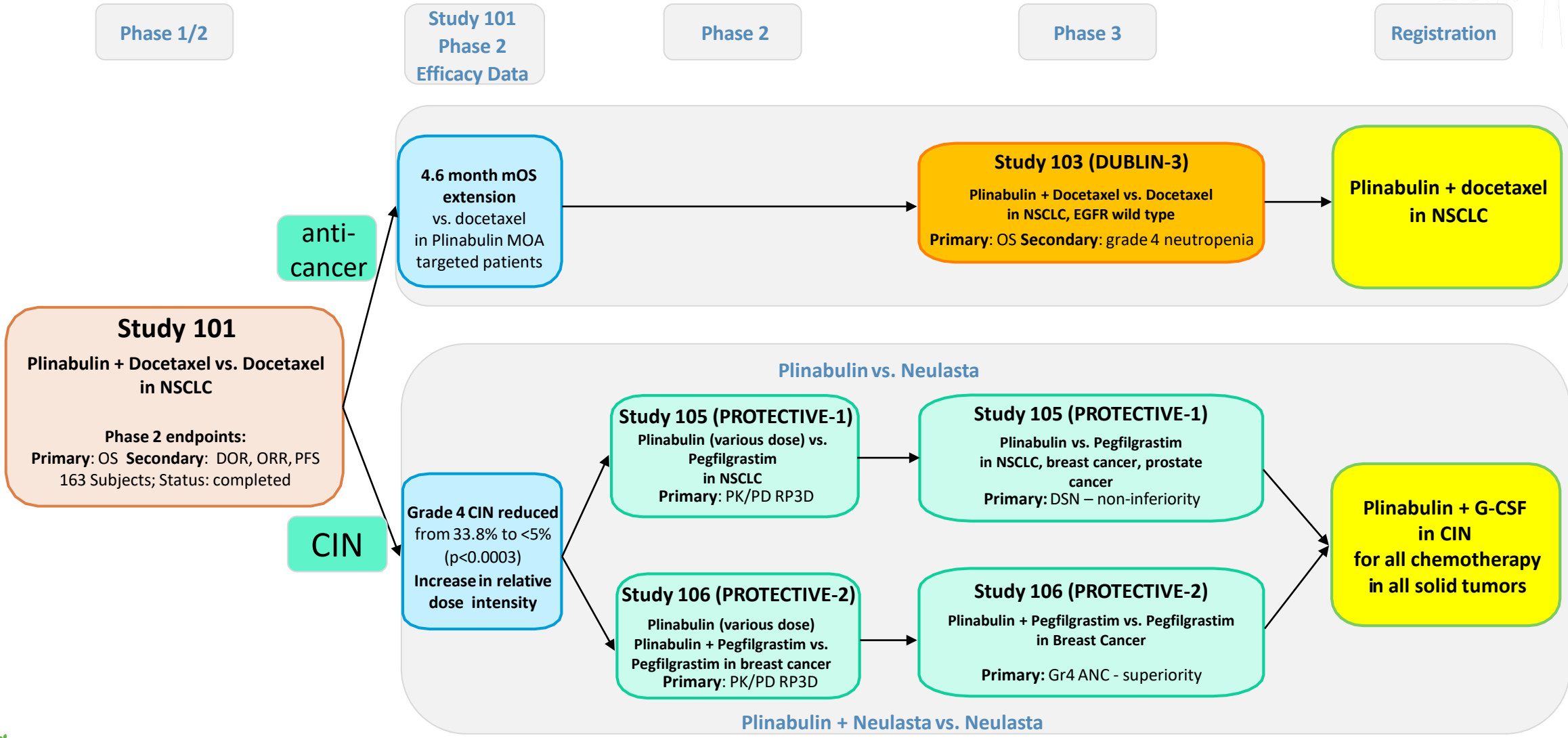
Note: 1 La Sala et al., 2019 Chem. 2 Kashyap et al., 2019 Cell Reports. 3 Zhang et al., 2005 Mol Cell Biol. 4 Singh et al., 2011 Blood. 5 Suwa et al., 2000 Am J Physiol Heart Circ Physiol; Ghosh et al., 2018 ACR Annual Conference; Blayney et al., Society of Leukocyte Biology. 6 Asensi et al., 2004 Infection and Immunity.

Plinabulin Registration Studies



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Breakthrough Therapy Designation (US & China FDA) - NDA submission Q1 2021

Plinabulin + G-CSF in Chemotherapy-Induced Neutropenia (CIN)

New CIN Guidelines Double the Number of Potential Patients

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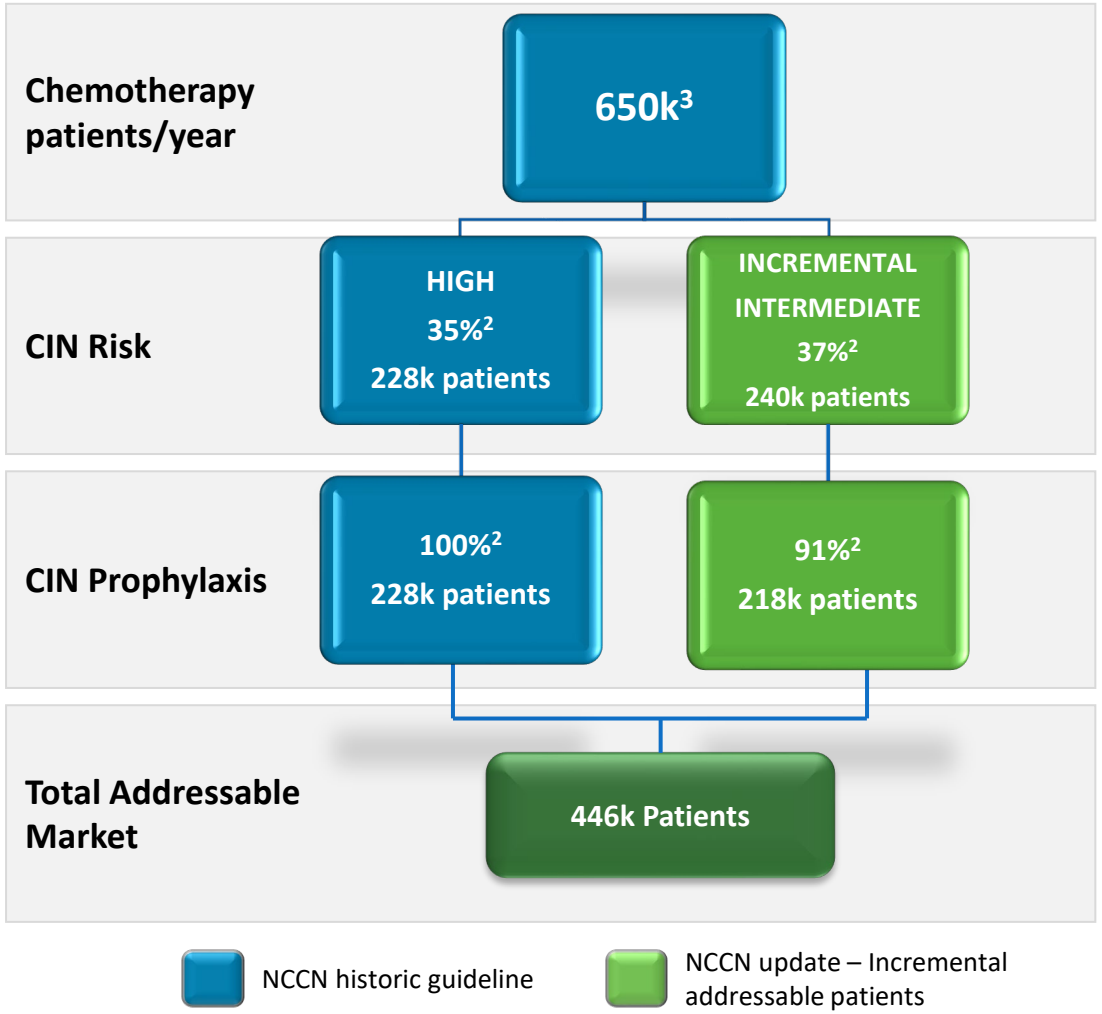
CIN Prophylaxis Market dynamics post-guideline update



1 BYSI qual market research Sept 2019, 2 BYSI qual Market research Aug 2020, 3 https://www.cdc.gov/cancer/preventinfections/providers.html

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CIN: Severe Unmet Medical Need, Despite Use of G-CSF

Current Standard of Care for CIN Still Presents Severe Unmet Medical Need Even with the Use of G-CSF (e.g. TAC, breast cancer)

Efficacy issue

Pegfilgrastim used after TAC for breast cancer

Efficacy	Pegfilgrastim 6 mg[1] n=29	Pegfilgrastim 6 mg[2] n=61
Neutropenia (grade 3/4)	96.6%	100%
Neutropenia (grade 4)	**93.1%**	**83.3%**
DSN	1.4 ± 0.7	1.8 ± 1.2
Mean ANC nadir (10^9/L)	0.255 ± 0.287	0.266

- Guidelines for grade 3/4 neutropenia are to reduce or delay chemotherapy dosing by 5-7 days[5]
- In cancer patients with <85% relative dose intensity (RDI), patient survival is 50% of those with >=85% RDI[5]
- TAC is a very effective chemo treatment with ORR at 83%[6], but because of its high severe neutropenia rate, TAC needs to be changed to less effective TC (with ORR at 42%)[7] and TA (with ORR at 51%)[8]

Safety issue

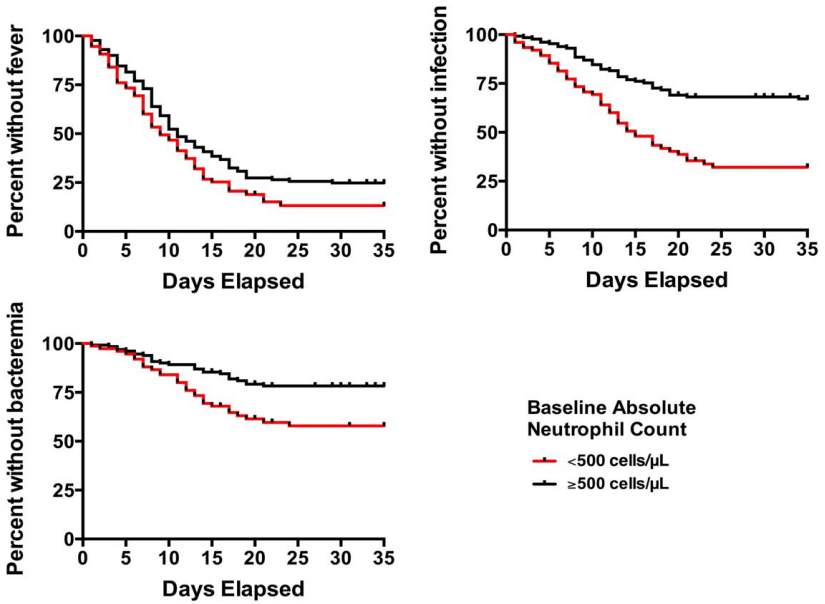
Pegfilgrastim used after chemotherapy

Safety	Pegfilgrastim 6 mg[3] n=100	Pegfilgrastim 6 mg[4]
Bone pain (score of 1-10)	59%	71%
Severe bone pain (score of 6-10)	**24%**	**27%**

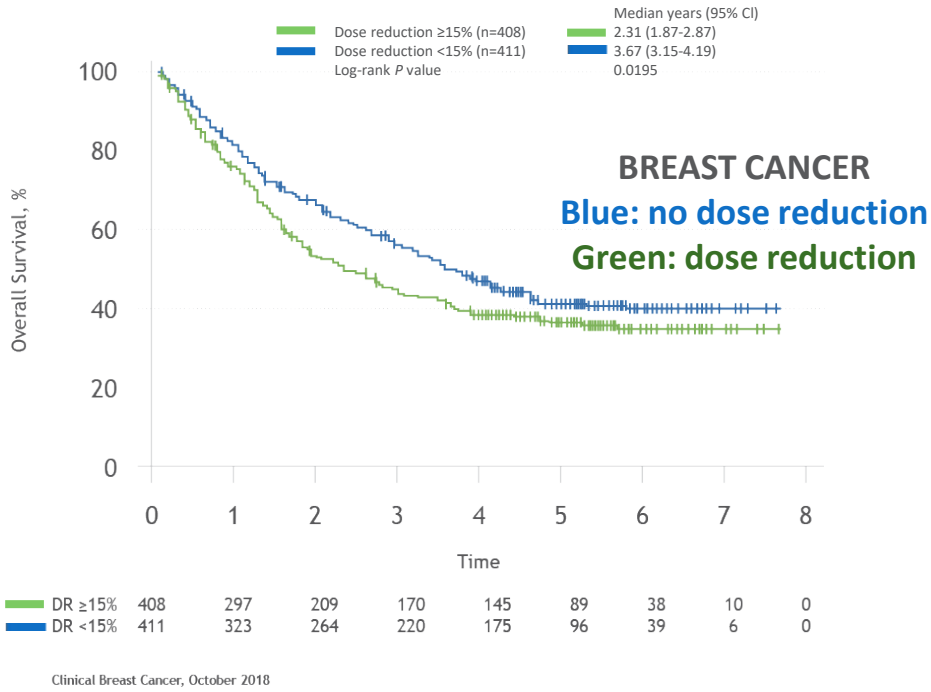
Note: 1 Masuda N et al., Support Care Cancer 23: 2891-2898 (2015). 2 Lee J et al., Annals of Surgical Treatment and Research 94(5): 223-238 (2018). 3 Kirshner et al., Comm Onc 4:455-459 (2007). 4 Xu et al., Support Care Cancer 24:723-730 (2016). 5 Lalami et al., Critical Reviews in Oncology / Hematology 120 163-179 (2017).). 6 O'Regan et al., Clinical Breast Cancer 6(2): 163-168 (2005). 7 Vasey et al., British J Cancer 87: 1072-78 (2002). 8 Alba et al. JCO 22(13): 2587-93 (2002).

Grade 4 Neutropenia Leads to Development of Fever and Infection; and to Chemo Dose Reduction and Less Survival

Grade 4 neutropenia was associated with fever (p = 0.04), documented infection (p < 0.0001), and bacteremia (p = 0.002)[1]



Grade 4 neutropenia leads to dose reduction to <85% of optimum dose → lower OS[2]



Clinical Breast Cancer, October 2018

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Note: 1Buckley SA et al., "Prediction of adverse events during intensive induction chemotherapy for acute myeloid leukemia or high-grade myelodysplastic syndromes." American J. Hematology 2014; 89(4): 423-28.
2. Denduluri N et al., Clinical Breast Cancer 18(5): 380-386 (2018); Lalami et al. Critical Reviews in Oncology / Hematology 120: 163-179 (2017).

Plinabulin CIN Program

Plinabulin's Chemotherapy-Induced Neutropenia Program

1	**Study 101** Phase 2	**NSCLC**	Plinabulin vs Placebo	Plinabulin reduced the incidence of grade 4 neutropenia from 33.8% in the docetaxel arm to less than 5% in the Plinabulin + docetaxel arms ($p < 0.0003$) on Day 8 of the first cycle of chemotherapy
2	**Study 105** Phase 2 Protective 1	**CIN** Advanced or Metastatic NSCLC	Plinabulin vs pegfilgrastim	Both Plinabulin and pegfilgrastim had a 14% incidence of grade 4 neutropenia, but Plinabulin demonstrated a superior safety profile, with less bone pain, thrombocytopenia and immune suppression
3	**Study 105** Phase 3 Protective 1	**CIN** Breast, Prostate, Lung	Plinabulin vs pegfilgrastim	Plinabulin achieved non-inferior duration of severe neutropenia (DSN) and more rapid onset of action compared with pegfilgrastim Data submitted to ASCO May 2021 annual meeting for presentation
4	**Study 106** Phase 2 Protective 2	**CIN** Breast	Plinabulin + pegfilgrastim vs pegfilgrastim and Plinabulin	Plinabulin combined with pegfilgrastim demonstrated chemotherapy induced neutropenia efficacy superiority by increasing the rate of prevention of grade 4 neutropenia by 53% increase, and safety superiority with less bone pain
5	**Study 106** Phase 3 Protective 2	**CIN** Metastatic Breast	Plinabulin + pegfilgrastim vs pegfilgrastim	Recently completed registration trial and has met primary and secondary endpoints Data submitted to ASCO May 2021 annual meeting for presentation

4 chemotherapy induced neutropenia clinical trials (on 400+ patients) already proved Plinabulin's potential to statistically reduce grade 4 neutropenia

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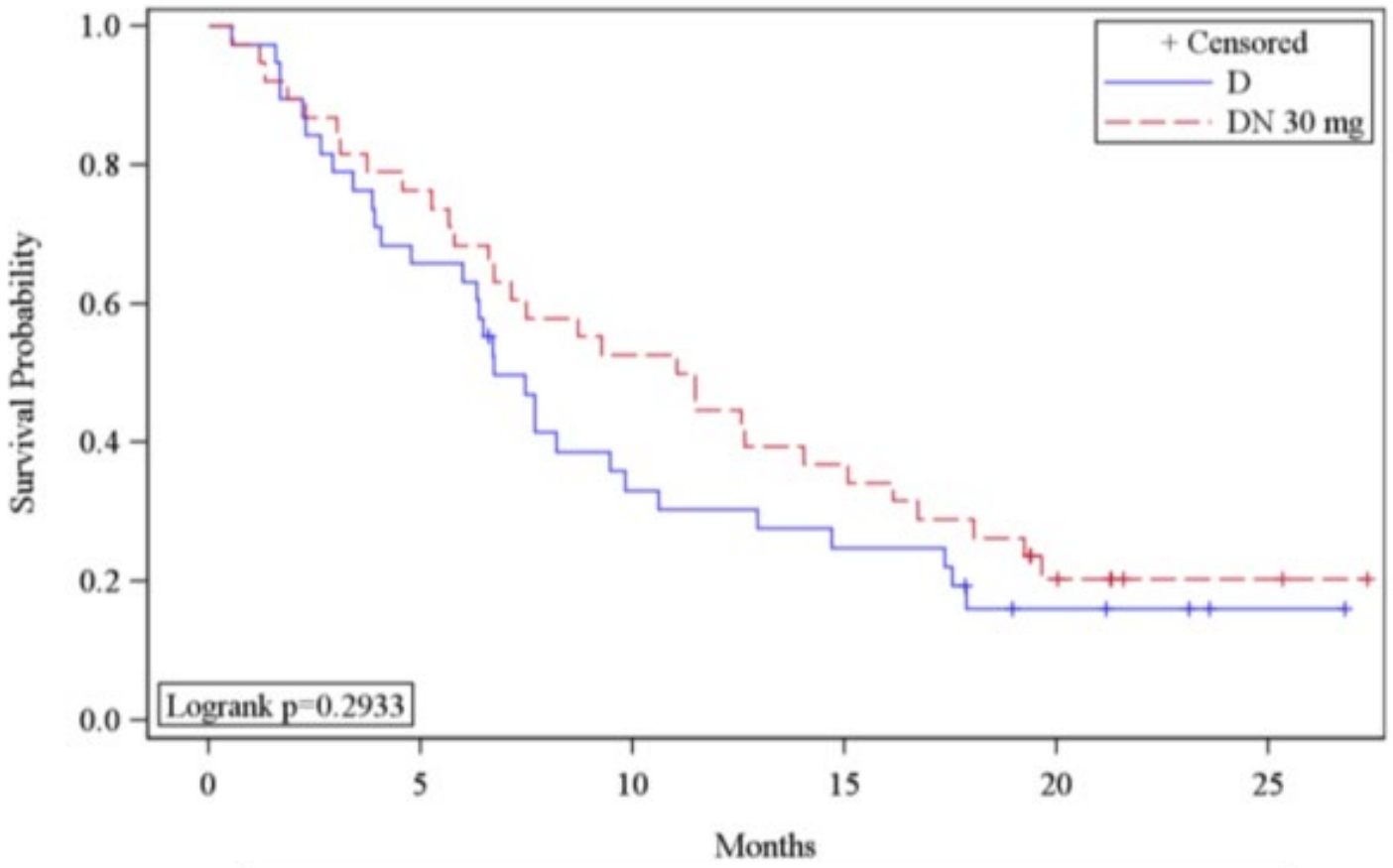
Phase 2: Study 101 NSCLC

Phase 2 Study 101: Plinabulin has Anticancer Activity in NSCLC

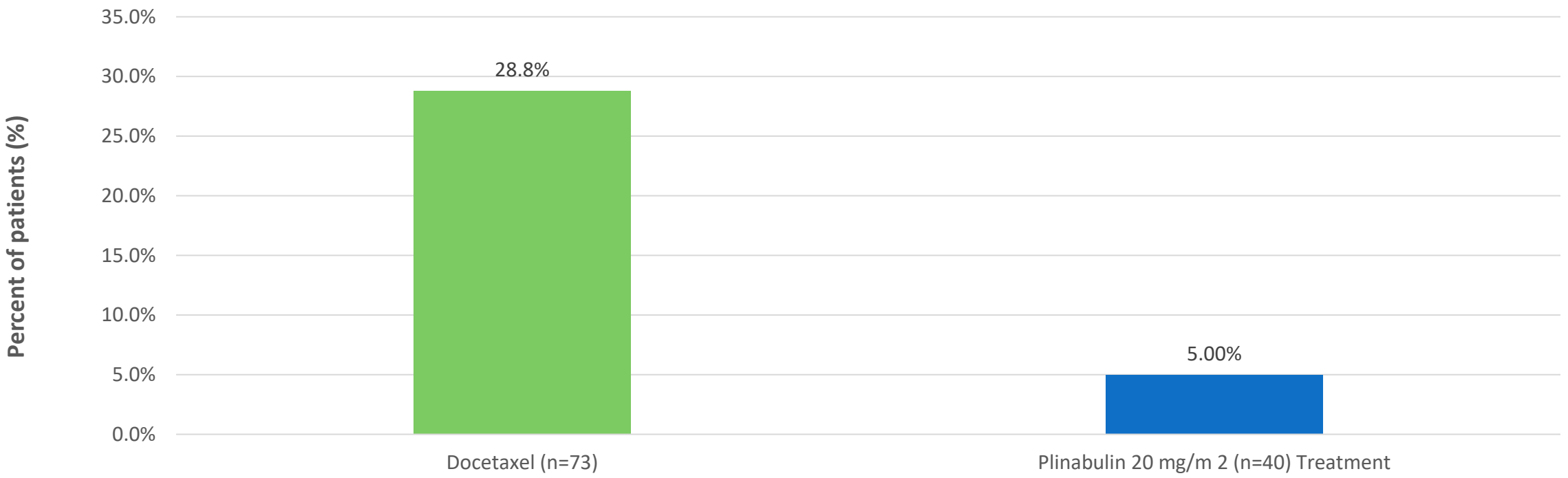


	Subjects	Event	Censored	Median Survival	95% CL
D	38	31(82%)	7(18%)	6.733	(6, 9.833)
DN 30 mg	38	30(79%)	8(21%)	11.25	(6.733, 15.07)

- Plinabulin MoA- targeted patients: Measurable lung lesion with RECIST 1.1 (CT scan > 1 cm in lung), which is around 70% of NSCLC
- Improved QoL and favorable Safety profile

Study 101 Phase 2: Plinabulin has Superior Grade 4 Chemotherapy Induced Neutropenia Prevention vs 'Placebo'

Incidence of neutropenia in patients treated with Docetaxel vs. Docetaxel + Plinabulin-20 mg/m2



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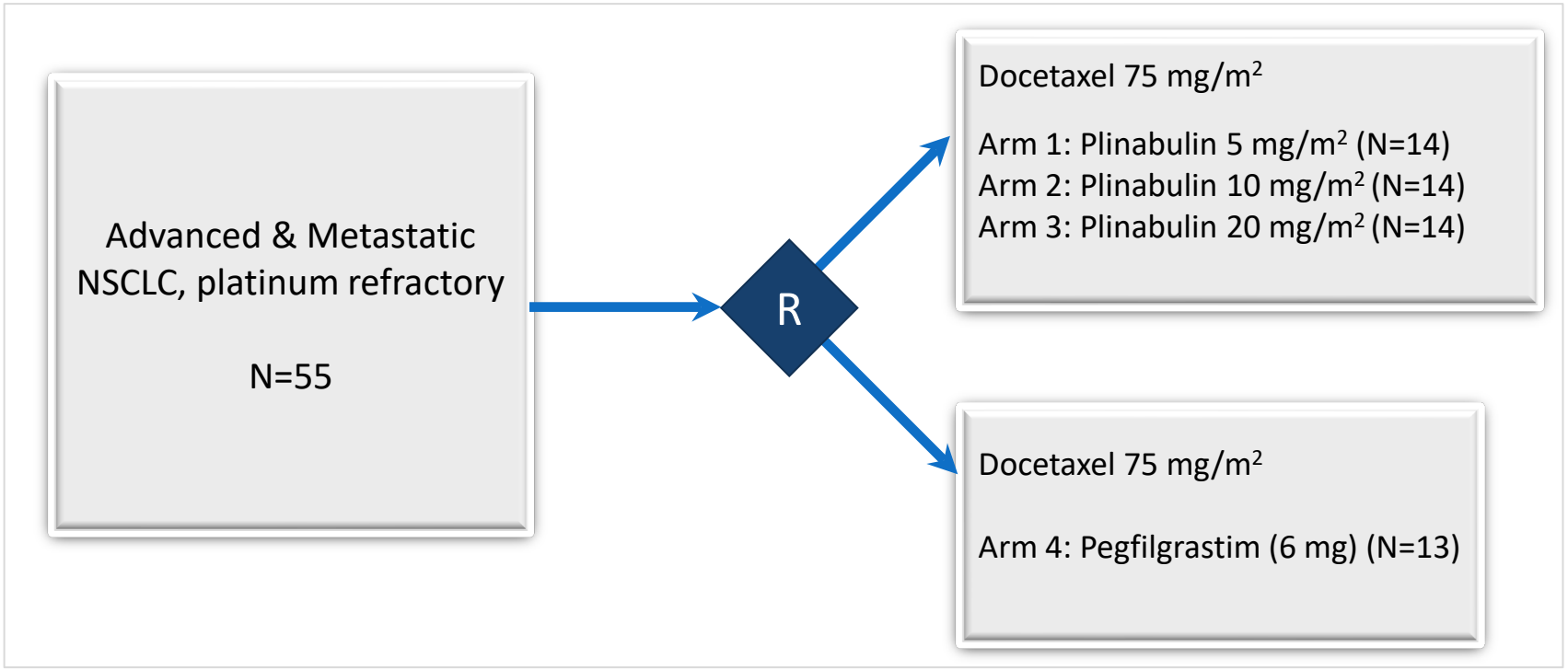
Protective-1 Phase 2 (Study 105)

PROTECTIVE-1 Phase 2 (Study 105): Plinabulin vs. Pegfilgrastim

Protective-1 Phase 2 Design



Key Endpoints:

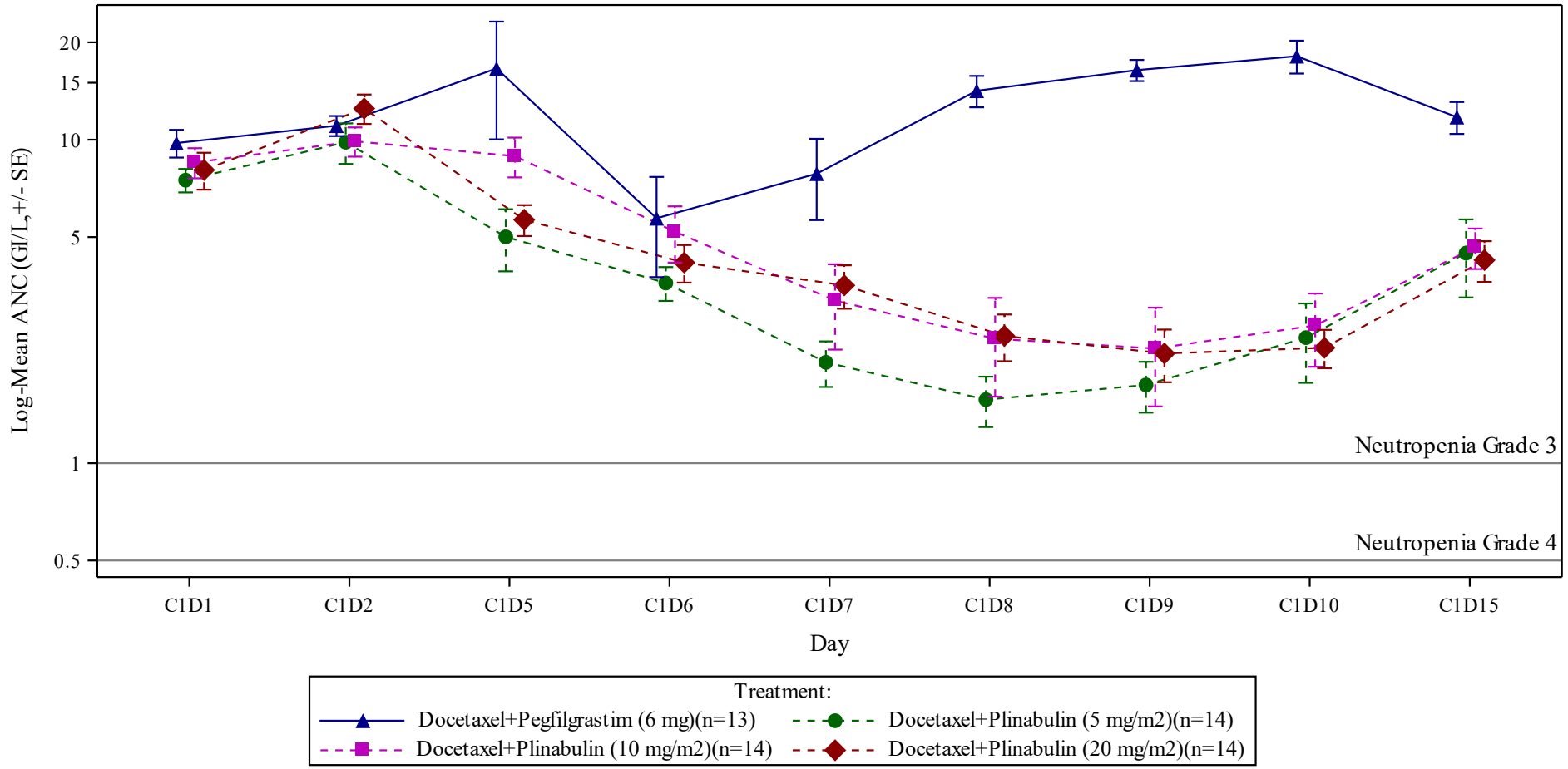
- Establish recommended Phase III dose based on PK/PD analysis
- Assess DSN in treatment cycle 1.
- Assess blood pressure 15 min/intervals
- Docetaxel 75 mg/m^2
- Characterize PK profile: plinabulin & docetaxel
- Exposure-response relationships between measures of plinabulin exposure and the PD endpoint DSN
- Exposure-safety relationships between measures of plinabulin exposure and safety events of interest

Open label, global trial (CRO & central lab: Covance)

JAMA Oncology DOI:10.1001/jamaoncol.2020.4429 Published Online September 24, 2020

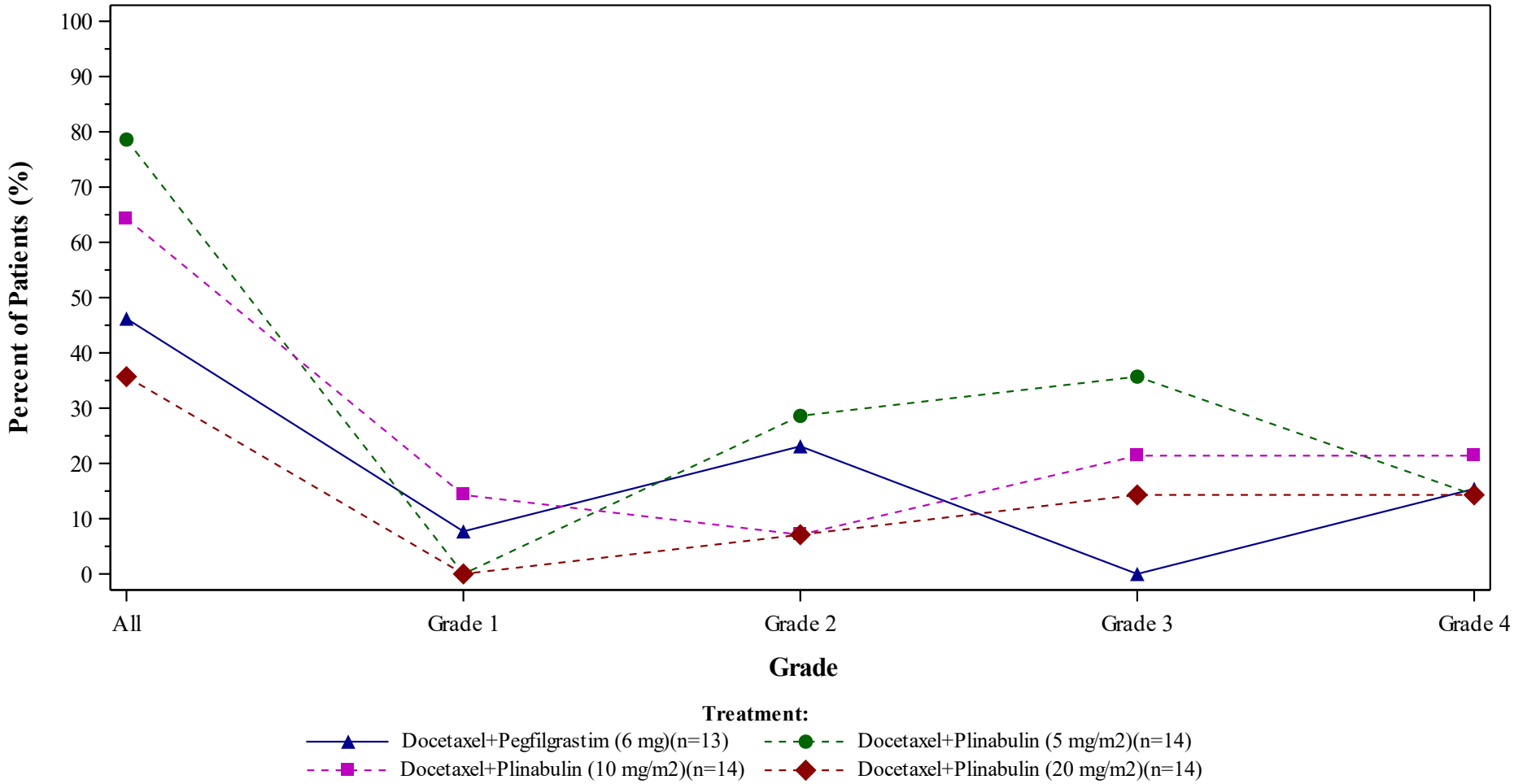
Protective-1 Phase 2 (Study 105) : Single Agent Plinabulin prevents Grade 3/4 Neutropenia

Log Transform Absolute Neutrophil Count Measured During Cycle 1



Protective-1 Phase 2 (Study 105): Plinabulin 20 mg/m² and Pegfilgrastim have Equal Efficacy

The Maximum Neutrophil Toxicity Grade in Cycle 1 for Patients in each Treatment Arm



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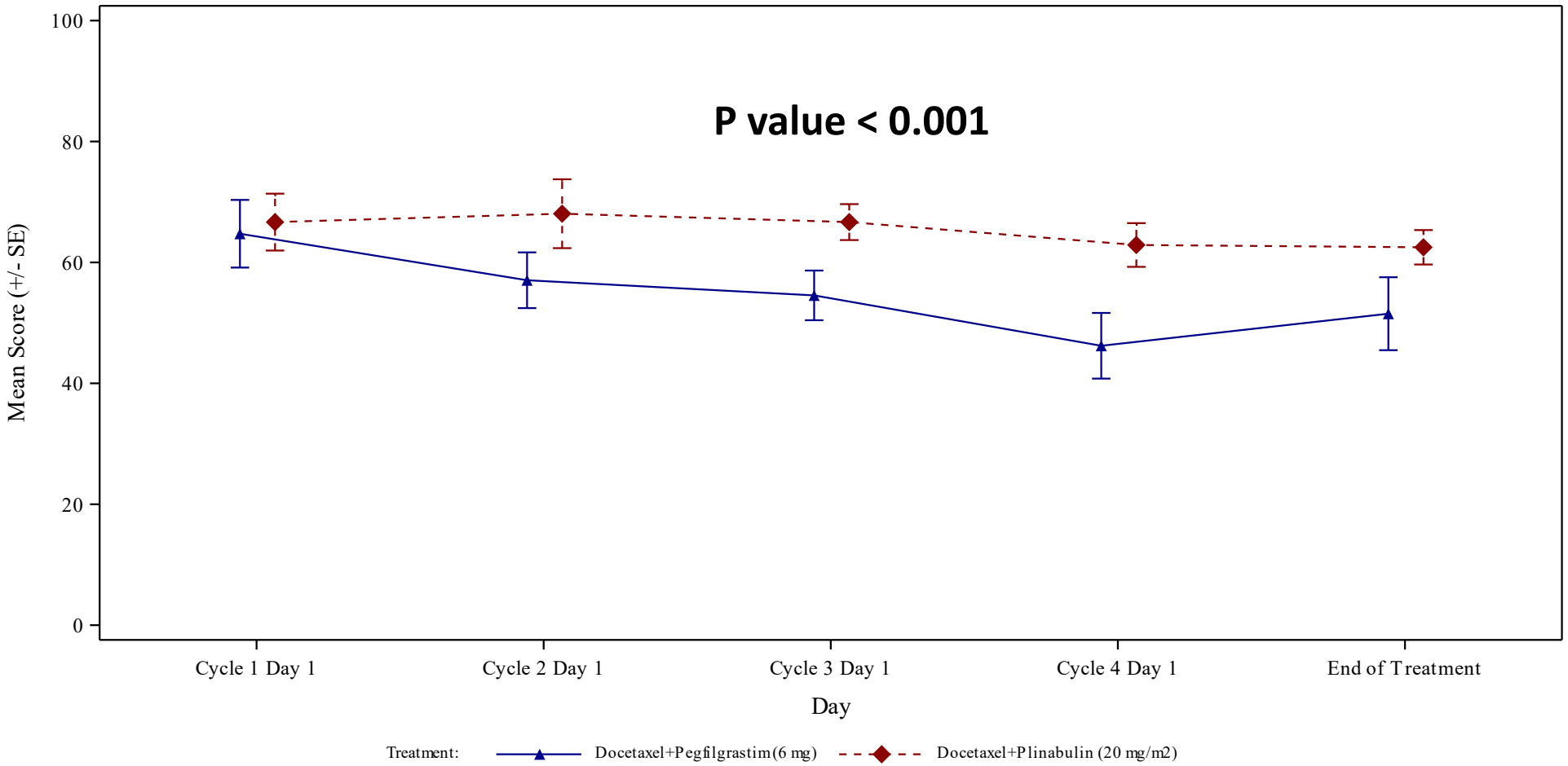
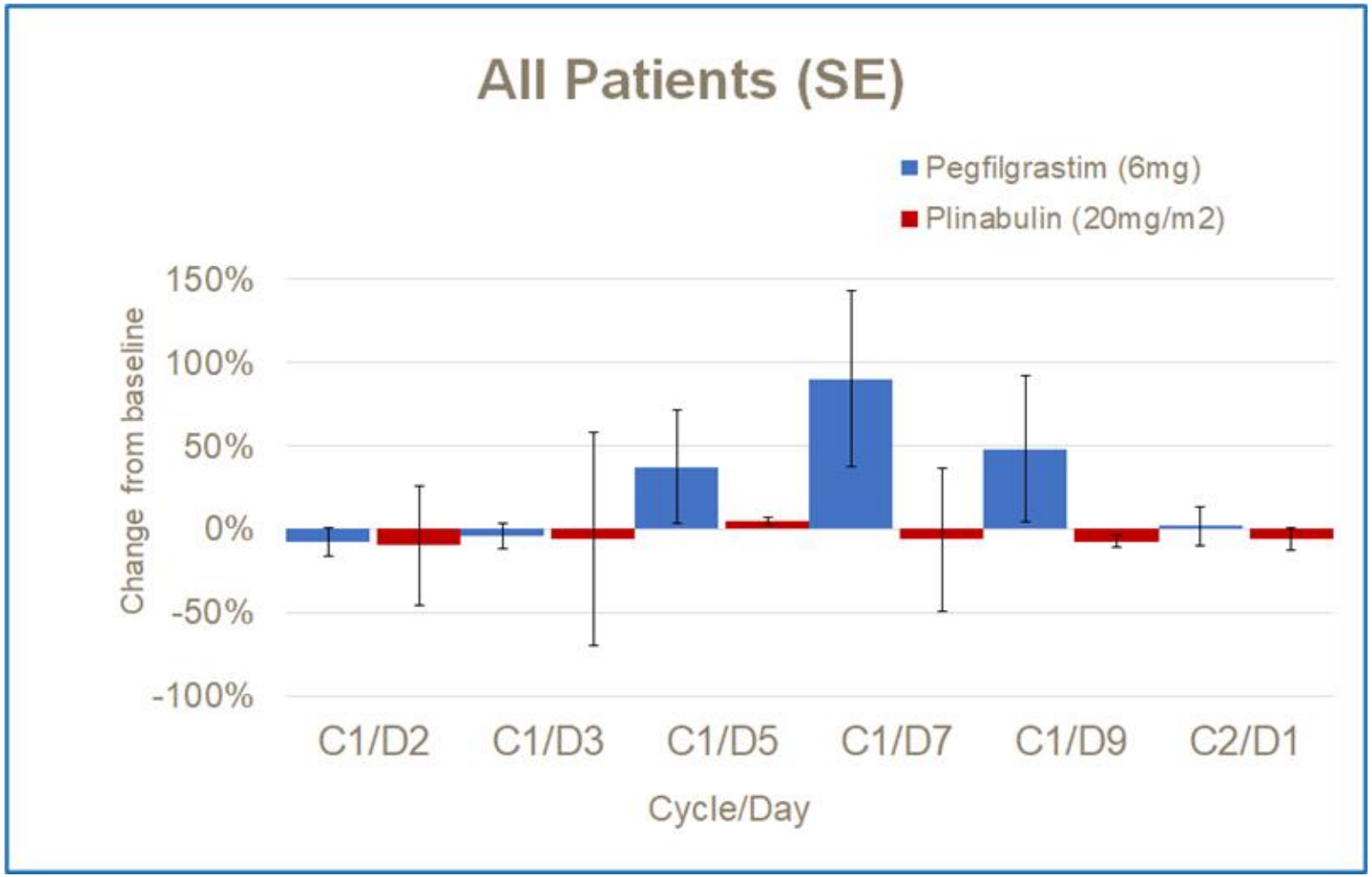
Protective-1 Phase 2 (Study 105): Plinabulin Demonstrated Improved QoL vs Pegfilgrastim

Global Health Status (Quality of Life)



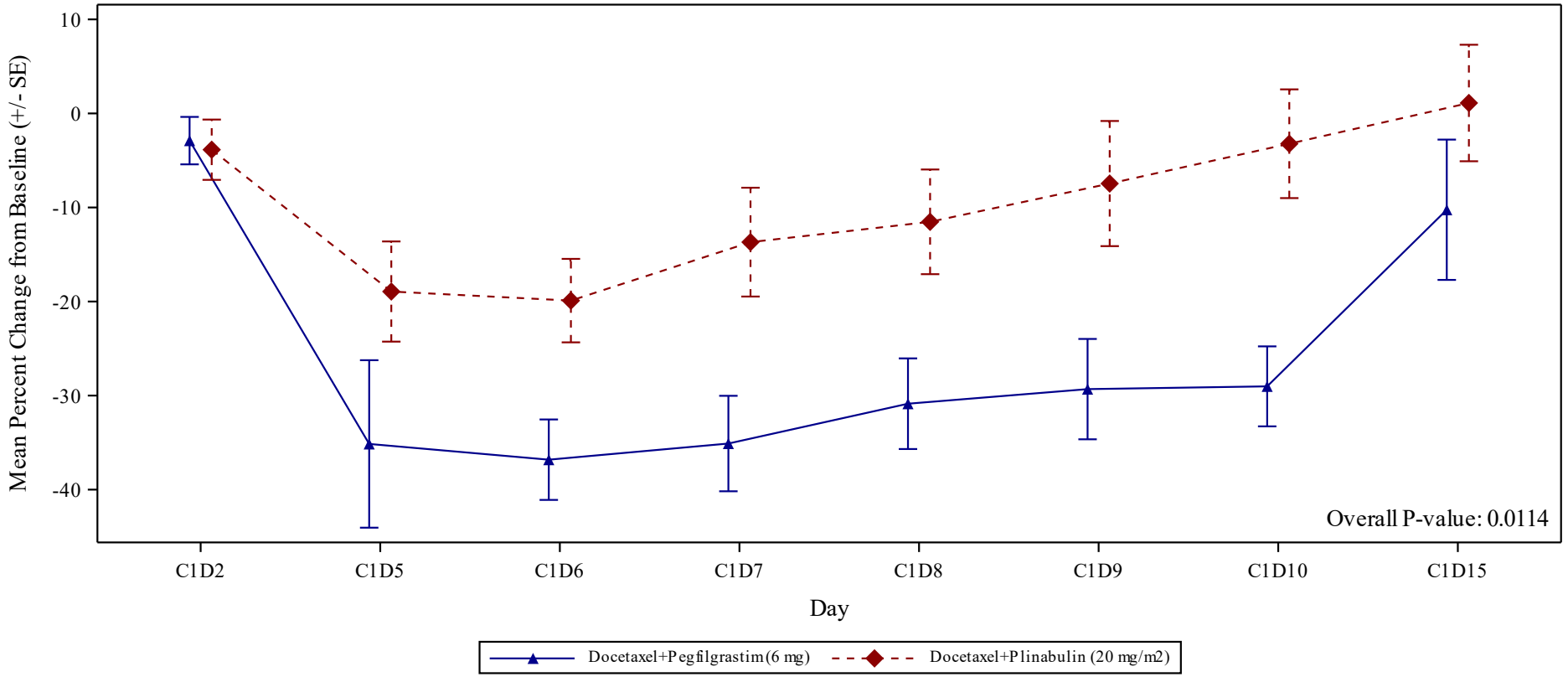
Protective-1 Phase 2 (Study 105): Plinabulin does not cause Bone Pain

Pain at its Worst in the Last 24 Hour



Protective-1 Phase 2 (Study 105): Plinabulin has less Thrombocytopenia vs Pegfilgrastim

Mean Percent Change in Platelets from Baseline in Cycle 1



P-value	0.5455	0.2040	0.0325	0.0061	0.0187	0.0066	0.0011	0.2899

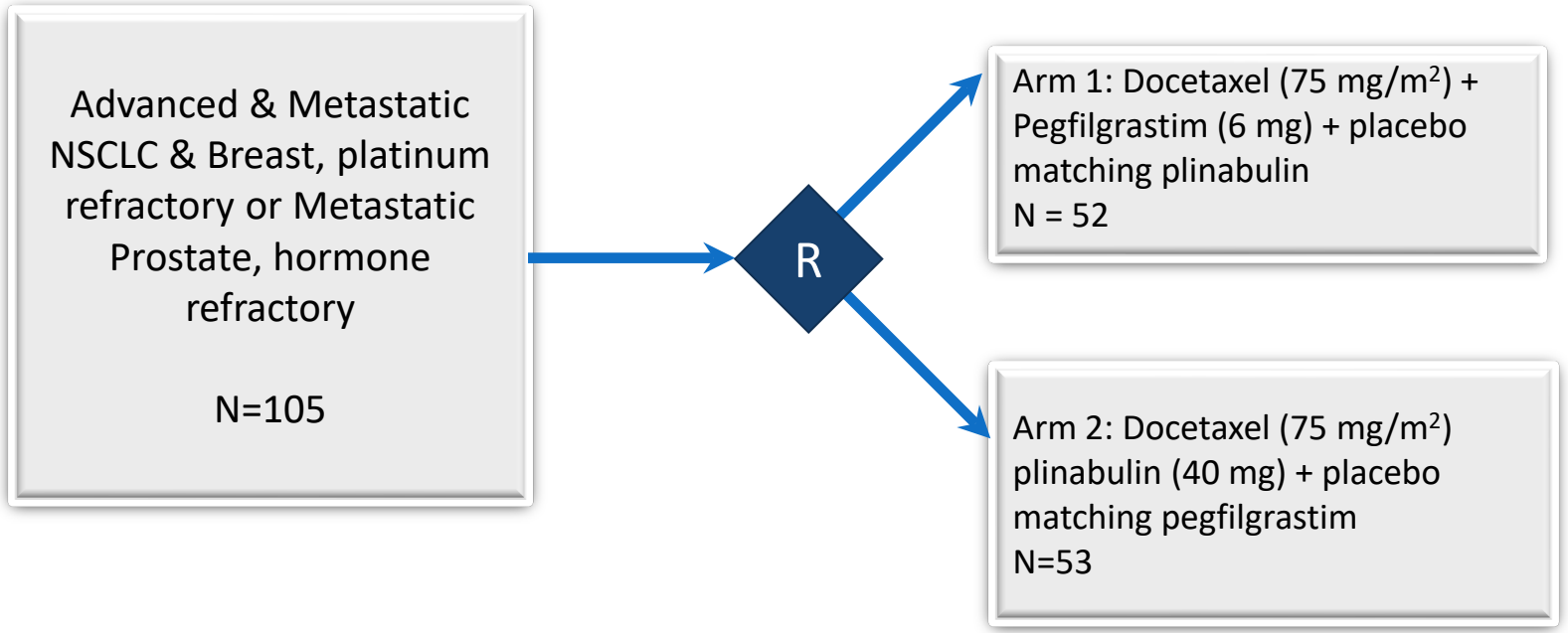
Summary for Plinabulin vs. G-CSF

	Pegfilgrastim	Plinabulin
Dosing	Day 2	Day 1, 30 minutes after chemo
Chemotherapy induced neutropenia benefit	Similar	Non-inferior
% Bone pain	Yes	No from day 3
Thrombocytopenia	Yes	No
Immune suppression	Yes	No
Anti-cancer activity	No	Yes

Protective-1 Phase 3 (Study 105)

PROTECTIVE-1 Phase 3 (Study 105): Plinabulin vs. Pegfilgrastim - Met non-inferiority DSN endpoint at phase 3 interim

Protective-1 Phase 3 Design (4 cycles)



Double blind, global trial (CRO & central lab: Covance)

Key Endpoints:

- Assess DSN in treatment cycle 1 (primary endpoint)
- Assess mean bone pain score from pre-dose Day 1 through Day 8 in Cycle 1
- Proportion of patients with neutrophil-to-lymphocyte ratio (NLR) >5 after Day 7 through Day 15 in Cycle
- Proportion of patients with Bands >0 in Cycles 1 to 4
- Incidence of infections in Cycles 1 to 4
- Proportion of patients with Grade 4 neutropenia in Cycles 1, Day 1 to Day 7

JAMA Oncology DOI:10.1001/jamaoncol.2020.4429 Published Online September 24, 2020

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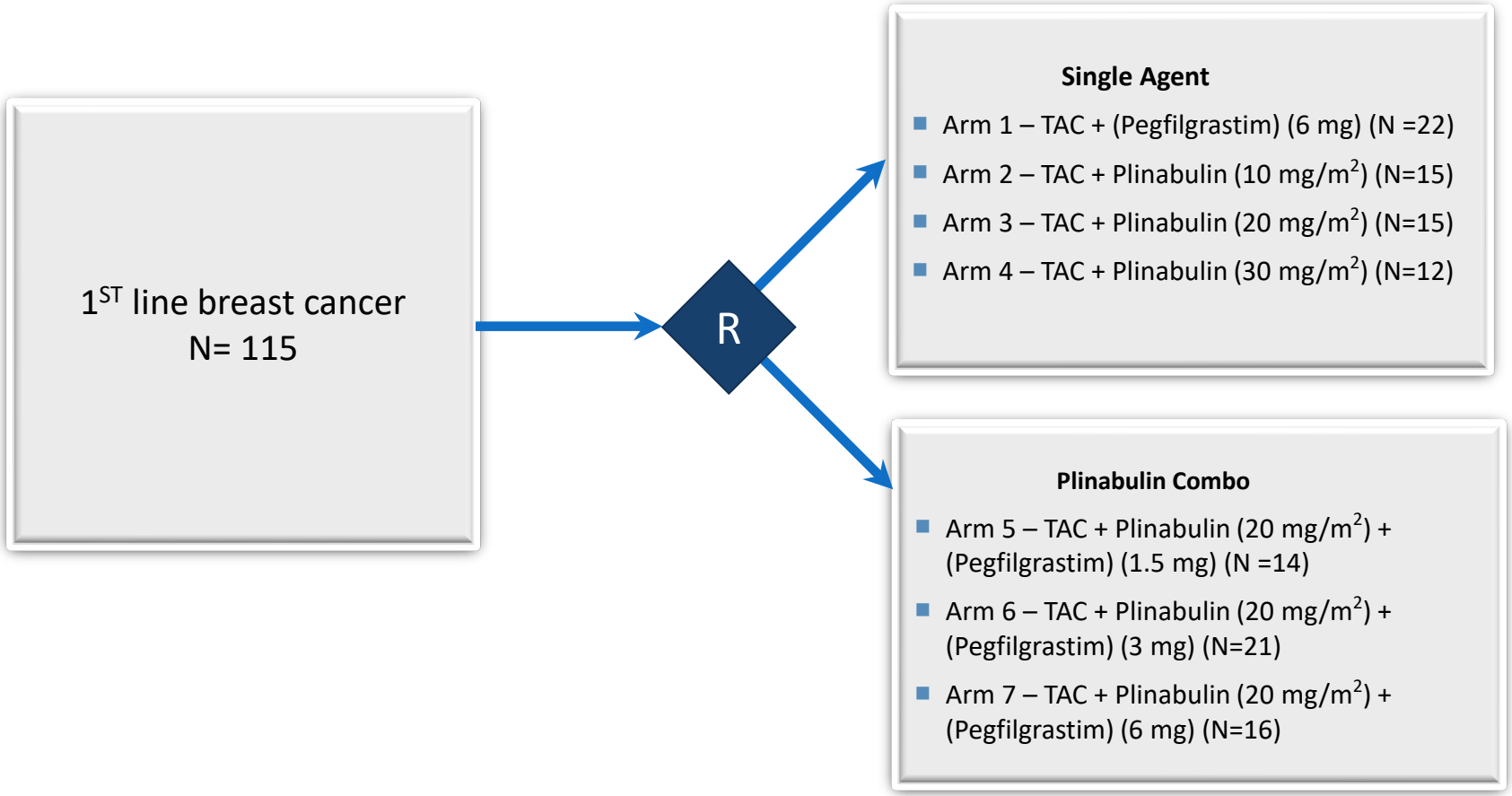
Protective 2: Phase II (Study 106)

PROTECTIVE-2 Phase 2 (Study 106) : Plinabulin vs. Pegfilgrastim

Protective-2 Phase 2 Design



Key Endpoints:

- Establish recommended Phase III dose based on PK/PD analysis
- Assess DSN in treatment cycle 1.
- Assess blood pressure 15 min/intervals
- Frequency of patients with at least 1 day of Grade 4 neutropenia (ANC
- <0.5 x 10^9/L) in the different treatment groups
- Bone pain scale from pre-dose Day 1 to Day 8 in Cycle 1
- Change in bone pain score from pre-dose Day 1 through Day 8 in Cycle1
- To characterize the PK profiles of plinabulin, pegfilgrastim, and TAC

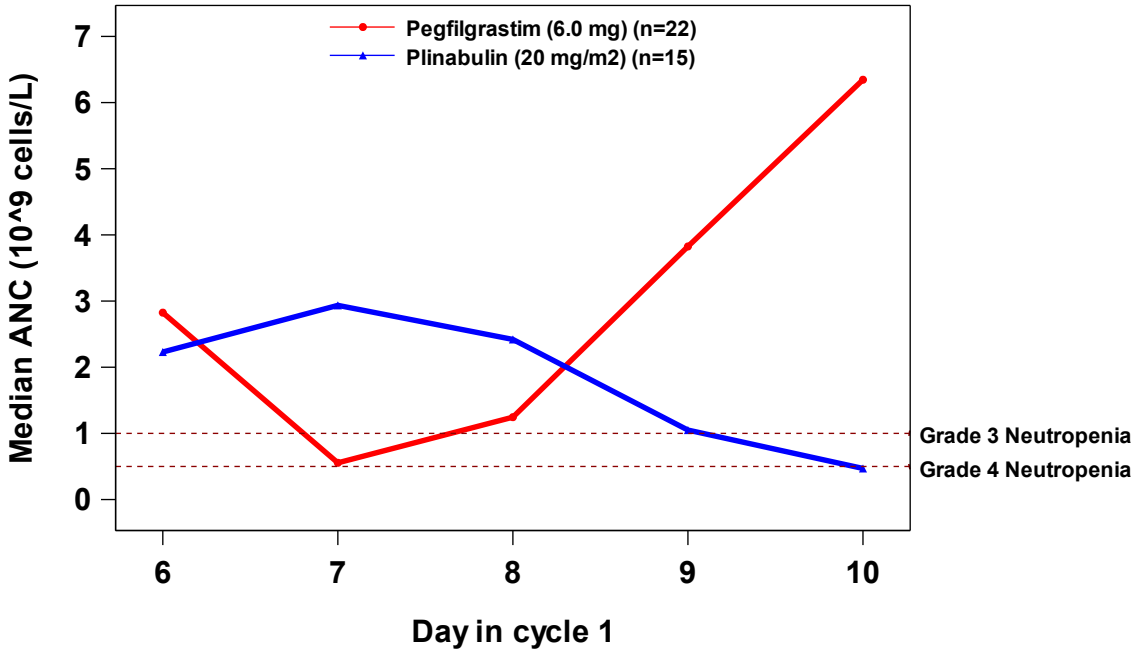
Open label, Randomized, global trial (CRO & central lab: Covance)

Protective 2 Phase 2 (Study 106) : Rationale for combining Plinabulin (week 1 protection) with Pegfilgrastim (week 2 protection)

Median ANC in cycle 1 after TAC for breast cancer

Single Agent

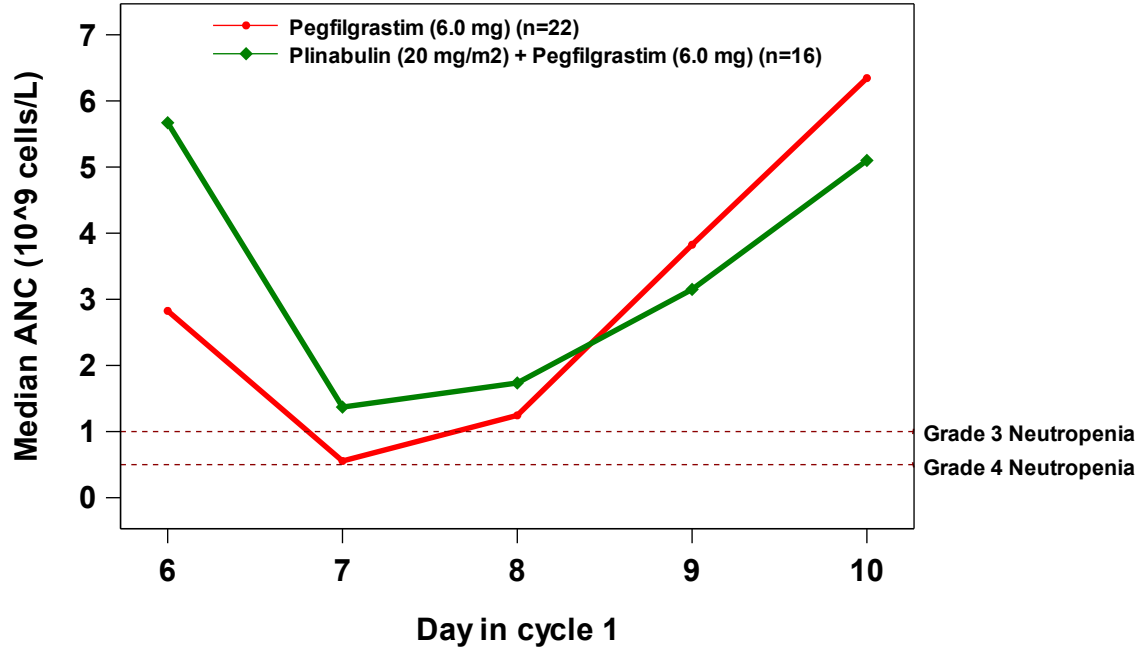
Plinabulin vs Pegfilgrastim



7.0

Combination Therapy

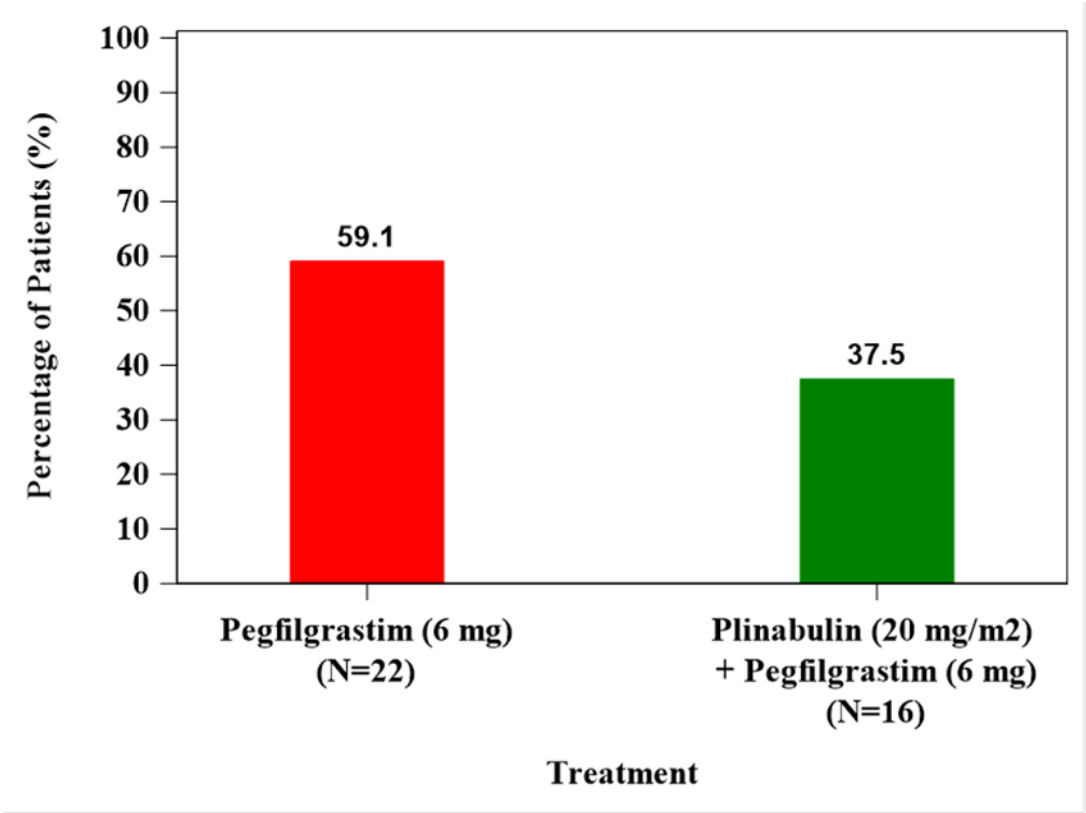
Plinabulin+ Pegfilgrastim vs Pegfilgrastim



Plinabulin chemotherapy induced neutropenia MOA: rapid onset of action in week 1, complimentary to G-CSF

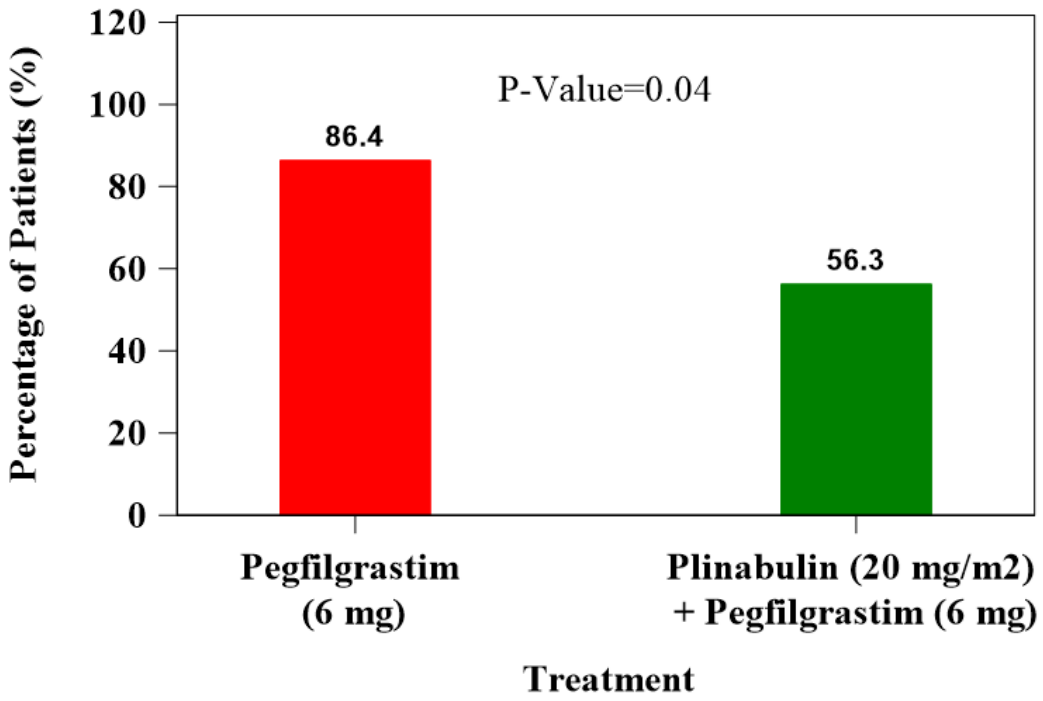
PROTECTIVE 2, Phase2 (Study 106) : Plinabulin + G-CSF Offers Significant Improvements over SOC in CIN

Percentage of Patients with Grade 4 Neutropenia in Cycle 1

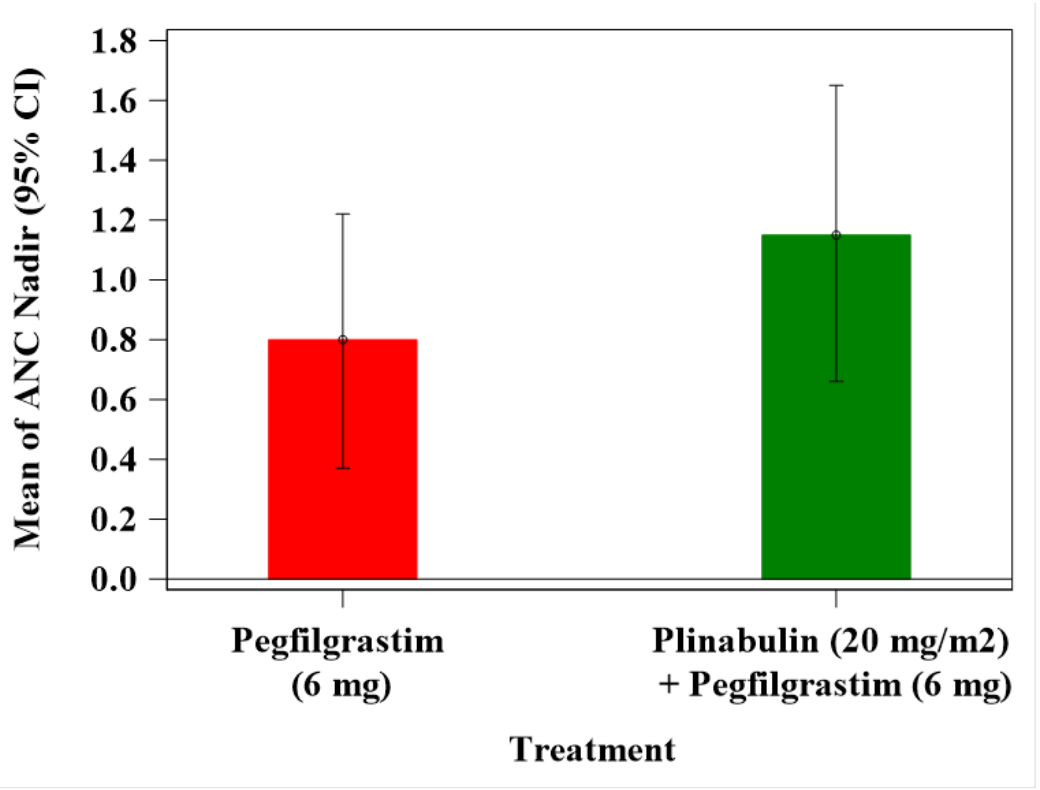


PROTECTIVE 2, Phase2 (Study 106) : Plinabulin + G-CSF Offers Significant Improvements over SOC in CIN

Percentage of Patients with Grade 3 or Grade 4 Neutropenia in Cycle 1



Mean of ANC Nadir during Cycle 1



Protective 2 Phase 2 (Study 106): Plinabulin / Pegfilgrastim Combo Demonstrates a Clear Superiority Profile Against Neulasta, Standard of Care

Plinabulin / Pegfilgrastim Combo demonstrates a clear superiority profile after TAC for breast cancer		
	Pegfilgrastim	**Plinabulin /Pegfilgrastim Combo**
DSN (grade 3/4)	Over 1 day	Less than 1 day
% neutropenia (grade 3/4)	High (> 80%)	Low (50%) p<0.05
Median ANC nadir (10^9 cells/L)	0.47 (> 50% with grade 4 neutropenia)	1.00 (> 50% avoid grade 3/4 neutropenia)
% bone pain	Almost all	Limited
Immune suppression	Yes	Limited
Anti-cancer	No	Yes

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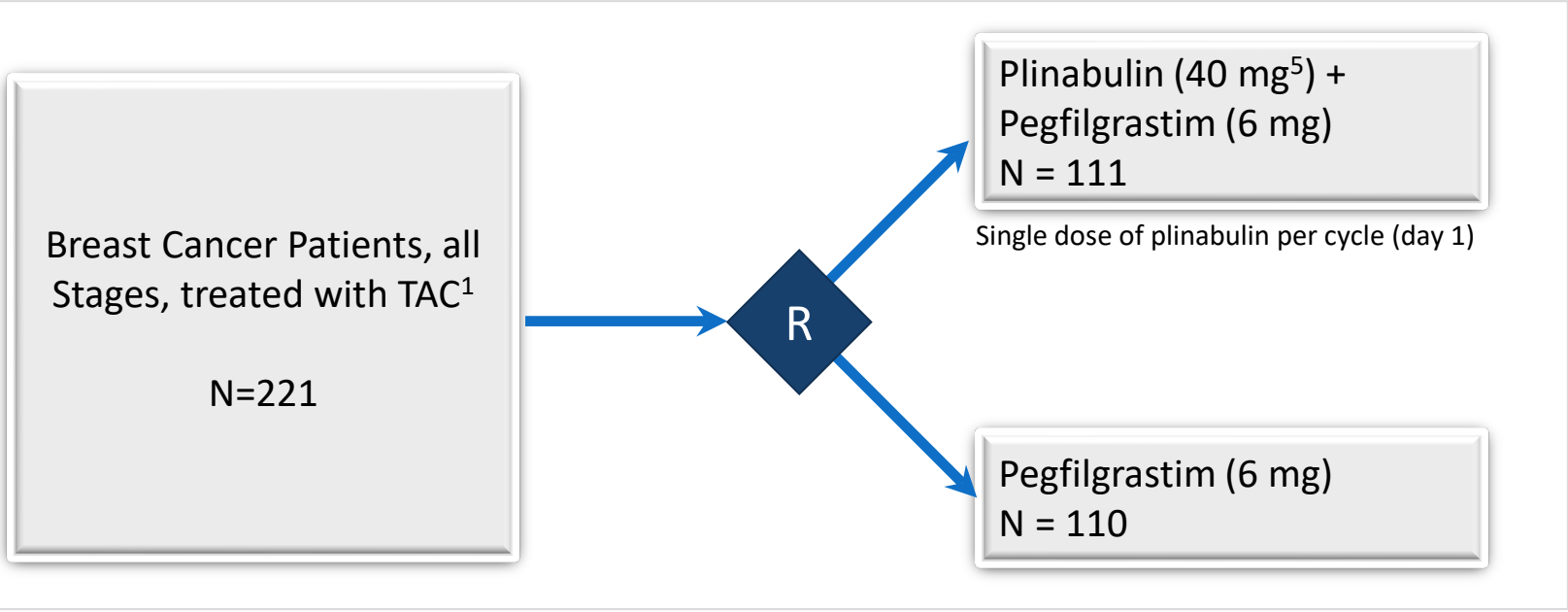
Protective 2: Phase III (Study 106)

Plinabulin Trials Designed to Maximize Broad Potential: Plinabulin + G-CSF for all Chemo in Non-Myeloid Cancers

Protective-2 Phase 3 Design (4 cycles of chemo treatment)



Key Endpoints:

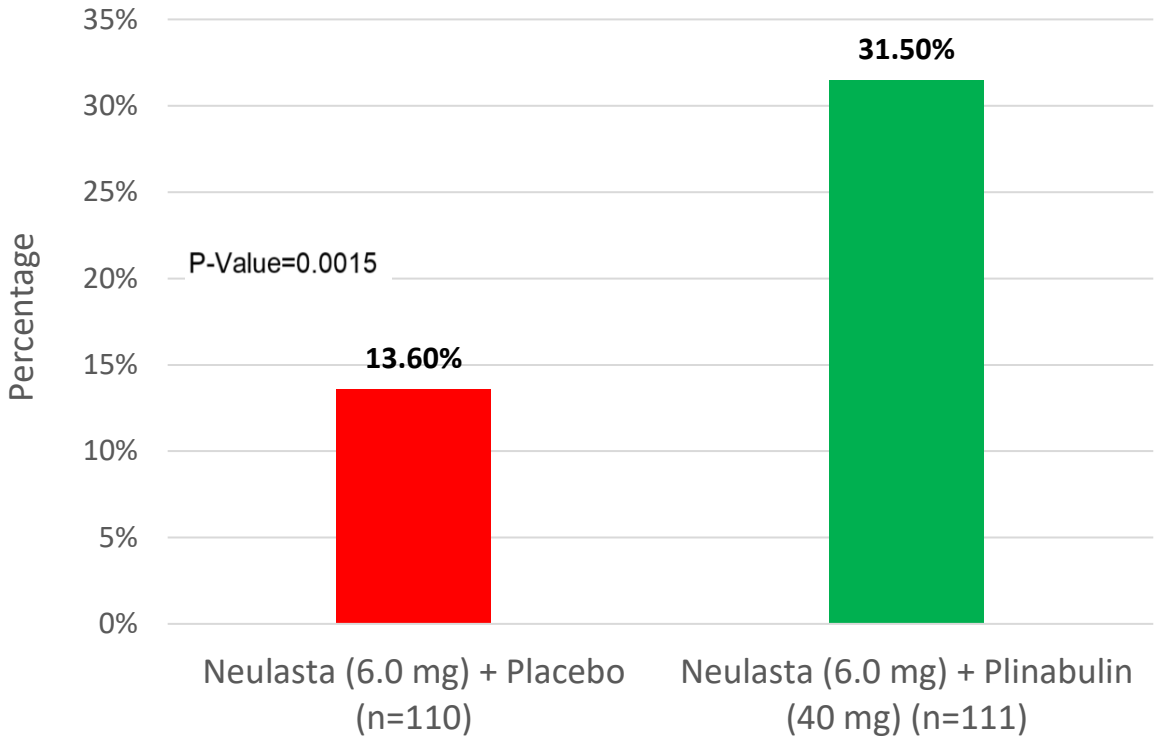
- % prevent Grade 4 neutropenia (Cycle 1)
- Mean DSN[2] (Cycle 1, Day 1-8)
- Mean ANC[3] nadir (Cycle 1)
- % of prevention of grade 3 and 4 neutropenia (Cycle 1)
- DSN (Cycle 1)
- % of bone pain (Cycle 1)
- Composite risk
- % of RDI[4] < 85%

Double blinded, active controlled, global trial (CRO & central lab: Covance)

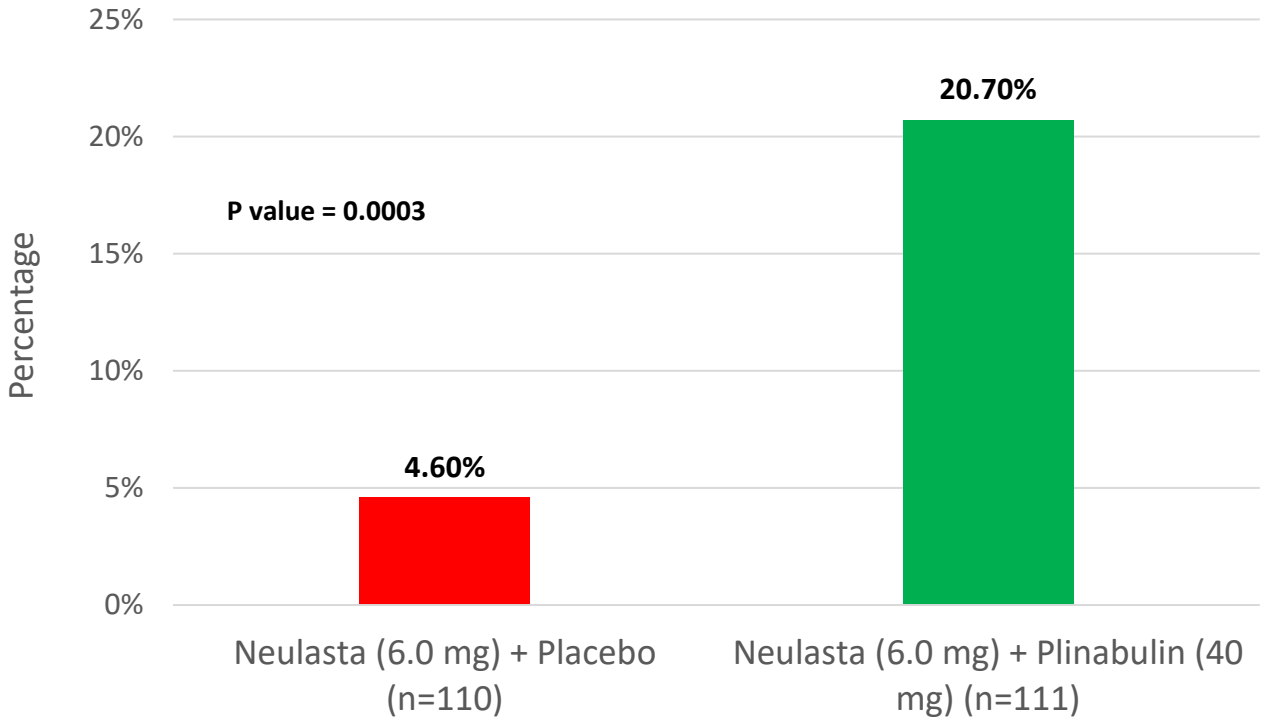
[1]TAC=Docetaxel, doxorubicin and cyclophosphamide.
[2]Duration of Severe (Grade 4) Neutropenia
[3]Absolute Neutrophil Count
[4]Relative Dose Intensity
[5]Fixed dose, equivalent to 20 mg/m²

Superior CIN Prevention G-CSF vs G-CSF + Plinabulin Combo after TAC for Breast Cancer in Cycle 1

Prevention of Grade 4 Neutropenia



Prevention of Grade 3 and 4 Neutropenia



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PROTECTIVE-2 Phase 3 data: positive topline results with statistical significance favoring the combination

Key Efficacy Endpoints	Results (combo n=111, pegfilgrastim n=110)
Primary endpoint:	
Proportion of patients with prevention of grade 4 neutropenia in Cycle 1	• 31.5% vs. 13.6%, p=0.0015 • **>100% better prevention rate** in combination of plinabulin + G-CSF
Key secondary endpoints (based on ANC):	
Mean DSN in Cycle 1, Day 1-8	• p = 0.0065 • Plinabulin's MoA of early onset in Week 1
Mean DSN in Cycle 1 (severe neutropenia: ANC < 0.5 x 10^9 cells/L)	• p = 0.0324 • Combination is better in CIN benefit vs. G-CSF in cycle 1
Mean ANC Nadir (x 10^9 cells/L)	• 0.538 vs. 0.308, p = 0.0002 • The combination helps to lift patients away from grade 4 danger zone
Mean Duration of Profound Neutropenia in cycle 1 (Profound Neutropenia: ANC < 0.1 x 10^9 cells/L)	• p = 0.0004 • Combo better than G-CSF alone in CIN benefit

Better safety profile in the combination vs. SoC

- **>20% less grade 4 AEs** in the combination (**58.6%**), compared to pegfilgrastim alone **(80.0%)**

Profound Neutropenia leads to 80% death in first week of infection[1], 48% FN and 50% Infection[2].

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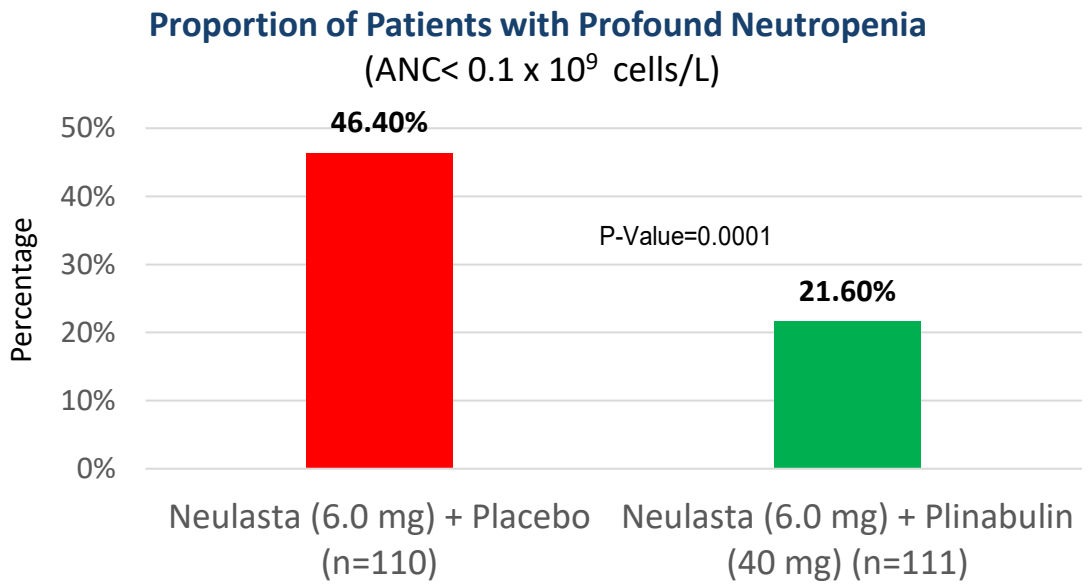
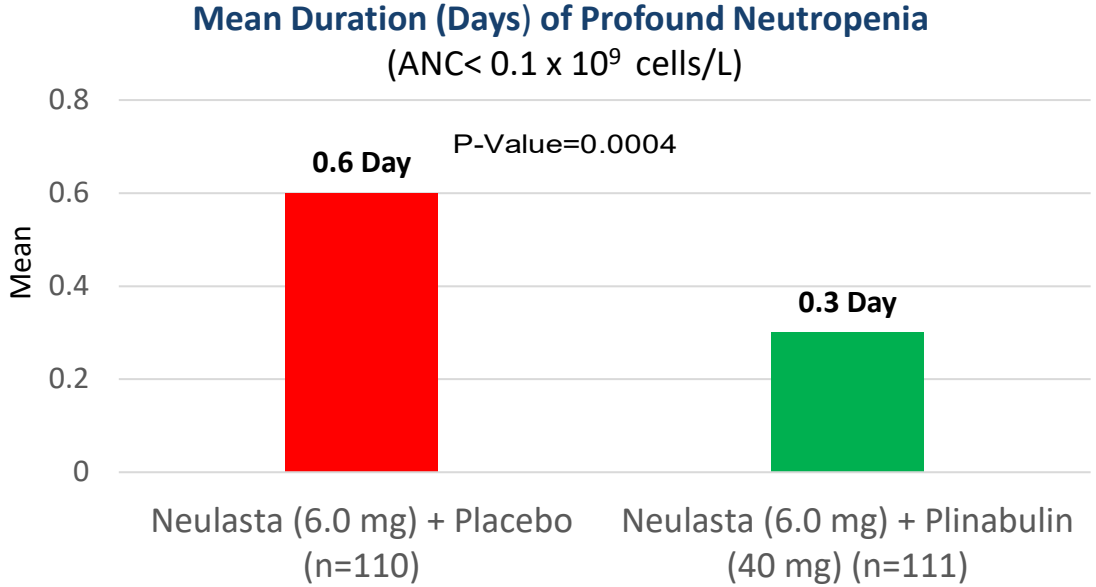
1. Bodey et al. Ann Intern Med 64(2): 328 (1966); 2. Bodey et al. Cancer 41(4): 1610 (1978)

Protective-2 (Phase 3): Superior prevention of Profound Neutropenia with Combination vs G-CSF alone





The combination reduces the incidence of Profound Neutropenia by >50% Compared to G-CSF Alone, which correlates to >40% FN risk reduction in the combo vs. G-CSF.

In Summary

- Plinabulin is a novel, **non-GSF**, small-molecule agent for the **prevention of CIN** through GEF-H1 activation
  - **Plinabulin + G-CSF** is **superior** to G-CSF alone
  - Plinabulin as a **single agent** is **non-inferior** to pegfilgrastim

- The **unmet need** with pegfilgrastim is **in week 1** of the cycle:
  - Plinabulin protects in week 1
  - Pegfilgrastim protects in week 2
  - This is the rational of the combination

- Plinabulin has a proven **anti-cancer effect**

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