BeyondSpring

Corporate Presentation

June 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, 2021 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.

Investment Highlights

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

Partnerships	Research subsidiary, SEED Therapeutics, with $800 million partnership with Eli Lilly (Proprietary TPD Platform)
Cash position	$90.6 million as of March 31, 2021
Headquarters	New York
Nasdaq Ticker Symbol	BYSI

Lead Asset Plinabulin: a Pipeline in a drug upcoming milestones

CIN

- Breakthrough Designation (BTD)
- US CIN NDA accepted with Priority Review
- China NDA submitted
- Preparing for commercialization

NSCLC

- Fully enrolled Phase 3 DUBLIN-3
- Topline OS data expected in mid-2021

IO

- Triple I/O combo in multiple cancer indications in early development, including 7 cancers at MD Anderson
- Efficacy data for SCLC at ASCO 2021

Two Near-Term NDAs & Robust Drug Development Pipeline

	Indication / Target	Program	Trial Name / Collaborator	Preclinical	Phase 1	Phase 2	Phase 3	Commercial Rights[1]	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	• U.S. NDA accepted with Priority Review • China NDA submitted March 2021
	NSCLC (2^{nd}/3^{rd} line)	Plinabulin + docetaxel	DUBLIN-3	Phase 3 second interim analysis completed				Global	Global Final topline Phase 3 data Mid 2021
Triple Combo IO (IIT)	SCLC	Plinabulin + nivolumab + ipilimumab	10 US sites, including Rutgers University as lead site					Global	Phase 1 completed
	Multi-cancer (2^{nd}/3^{rd} line)	Plinabulin + PD-1/PD-L1 + radiation/chemo	THE UNIVERSITY OF TEXAS MD Anderson Cancer Center					Global	Initiate Phase 1 in 7 cancers Q2 2021
Investigator-initiated IO	Oral T cell co-stimulator	BPI-002						Global	
	IKK inhibitor	BPI-003						Global	
	Oral neo-antigen generator	BPI-004						Global	
SEED Therapeutics	KRAS and additional targets	Targeted Protein degradation (TPD, molecule glue platform)	SEED THERAPEUTICS					Global	Potential additional partnerships
	Multiple		Lilly						$800M collaboration

[1]Global rights to Plinabulin ex-China. 58% ownership of Chinese subsidiary, Dalian Wanchunbulin Pharmaceuticals Ltd., which owns Chinese rights to Plinabulin. BeyondSpring owns 100% of global rights to Plinabulin. SEED Therapeutics is a ~60%-owned BeyondSpring subsidiary.

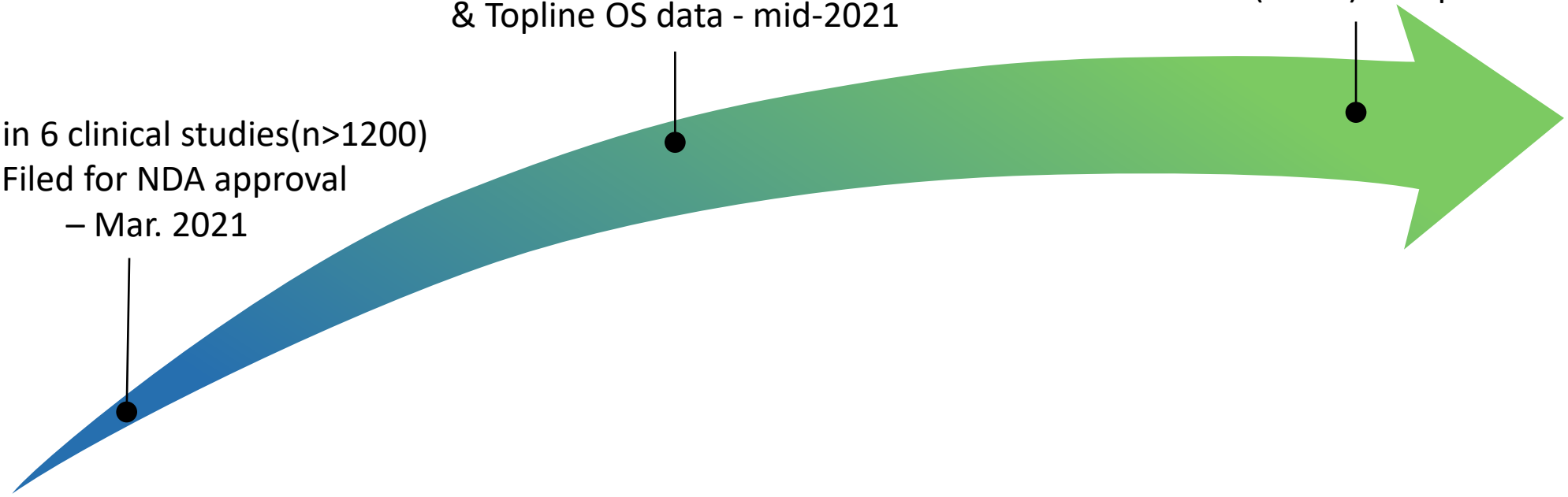
Plinabulin Value Generation Roadmap

Proven → **Expand** → **Transform**

Proven in 6 clinical studies(n>1200) & Filed for NDA approval – Mar. 2021

Phase 3 study fully enrolled (n=559) & Topline OS data - mid-2021

Promising early clinical efficacy data – June 2021 (ASCO) & Expected in 2022



CIN (BTD)

- Superior Regimen vs. SOC
- US NDA Accepted with Priority Review
- NDA Filed in China

NSCLC

- Strong MOA Rationale &
- Promising Preliminary Clinical Data

Multiple Cancers (I/O Combo)

- Synergistic MOA with Checkpoint Inhibitors & Promising Preclinical &
- Early Clinical Efficacy Data

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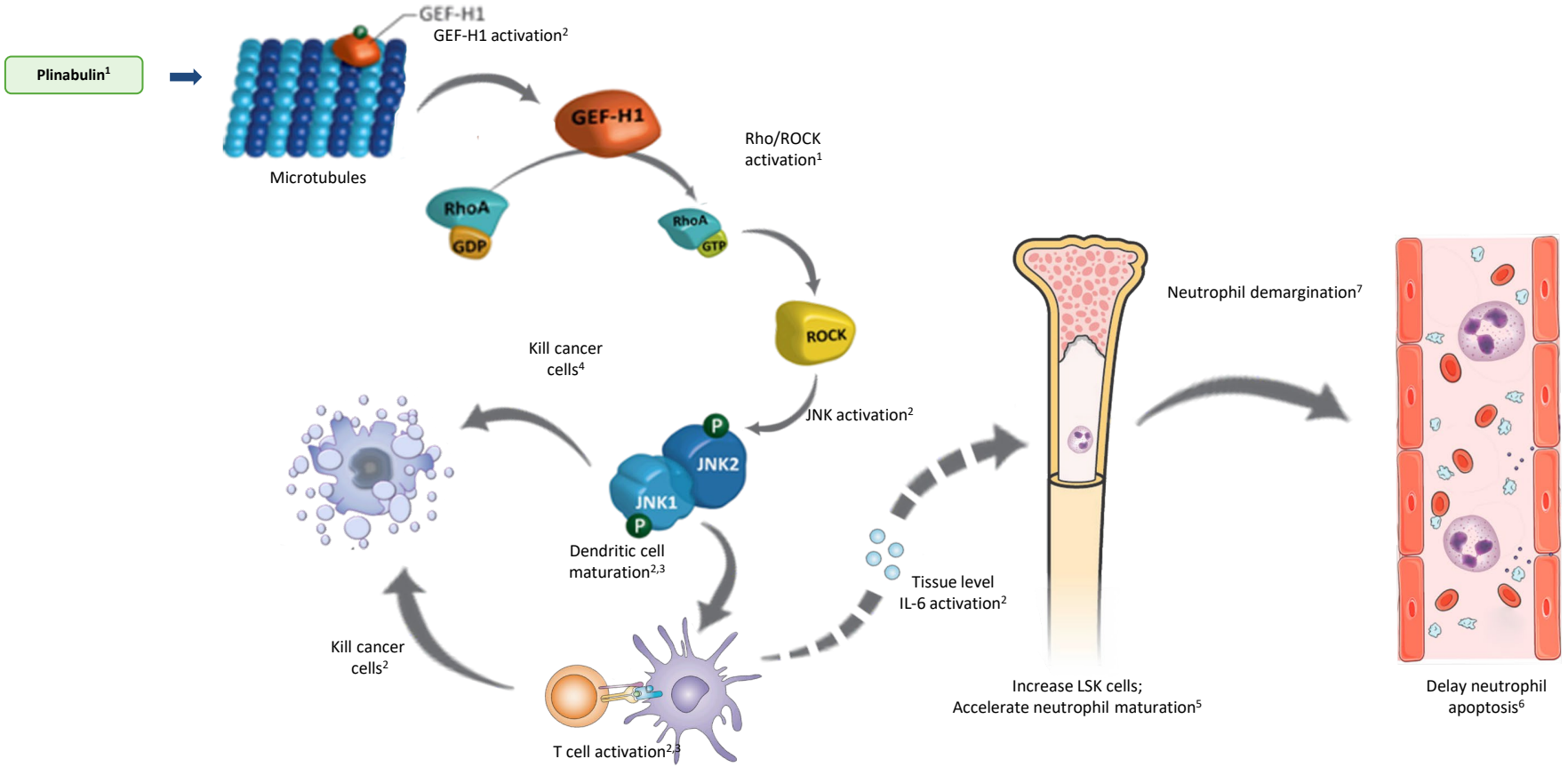
Plinabulin: “Pipeline in a Drug”

- First-in-Class, Selective Immunomodulating Microtubule Binding Agent (SIMBA)

Plinabulin: A SIMBA with Potential for Multiple Cancer Indications



First-in-class Agent 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

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.

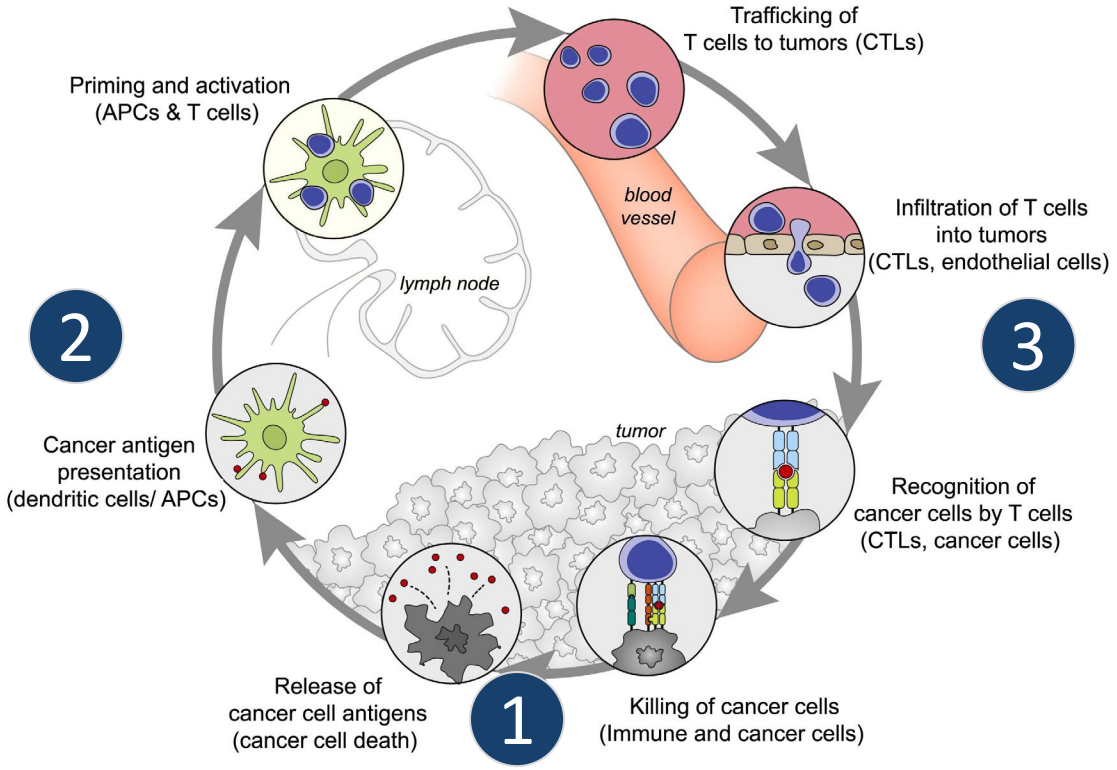
Plinabulin Induces Dendritic Cell Maturation, a Key Step in Initiating Anti-cancer Durable Response in IO Combo

2 Plinabulin

Hit the Gas

Stimulate maturation of dendritic cells to increase antigen presentation

Dendritic cells are the most important antigen-presenting cells



3 Checkpoint Inhibitors

Release the Brakes

Optimize T cell response

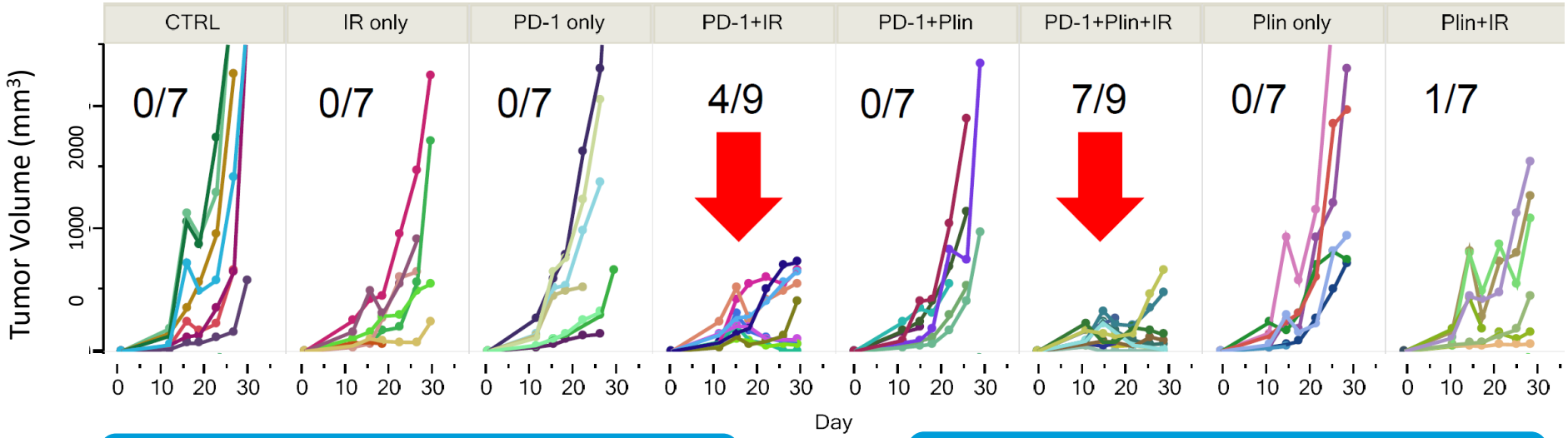
1 Radiation/Chemotherapy

Release Tumor Antigens

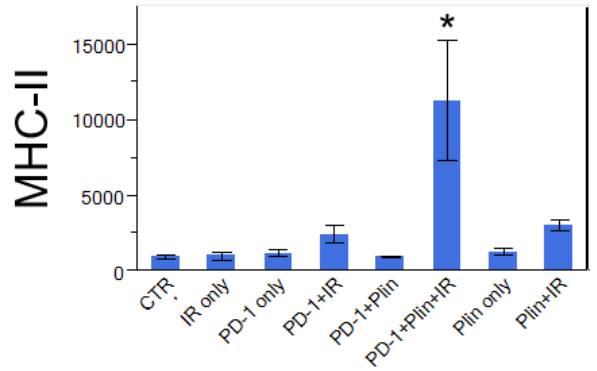
For more potent anti-cancer effect

1 + 2 + 3 → Optimal Immuno-Oncology Response

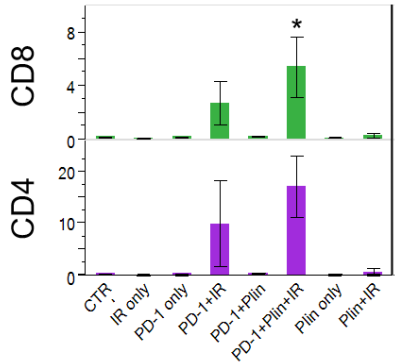
Triple I/O Combo: Plinabulin + PD-1 + Radiation (IR), Best Tumor Response in PD-1 Non-Responsive Tumor Model (MD Anderson)



DC activation is most dramatic in triple I/O combination



T cell doubles in triple I/O Combination vs. PD1 + IR

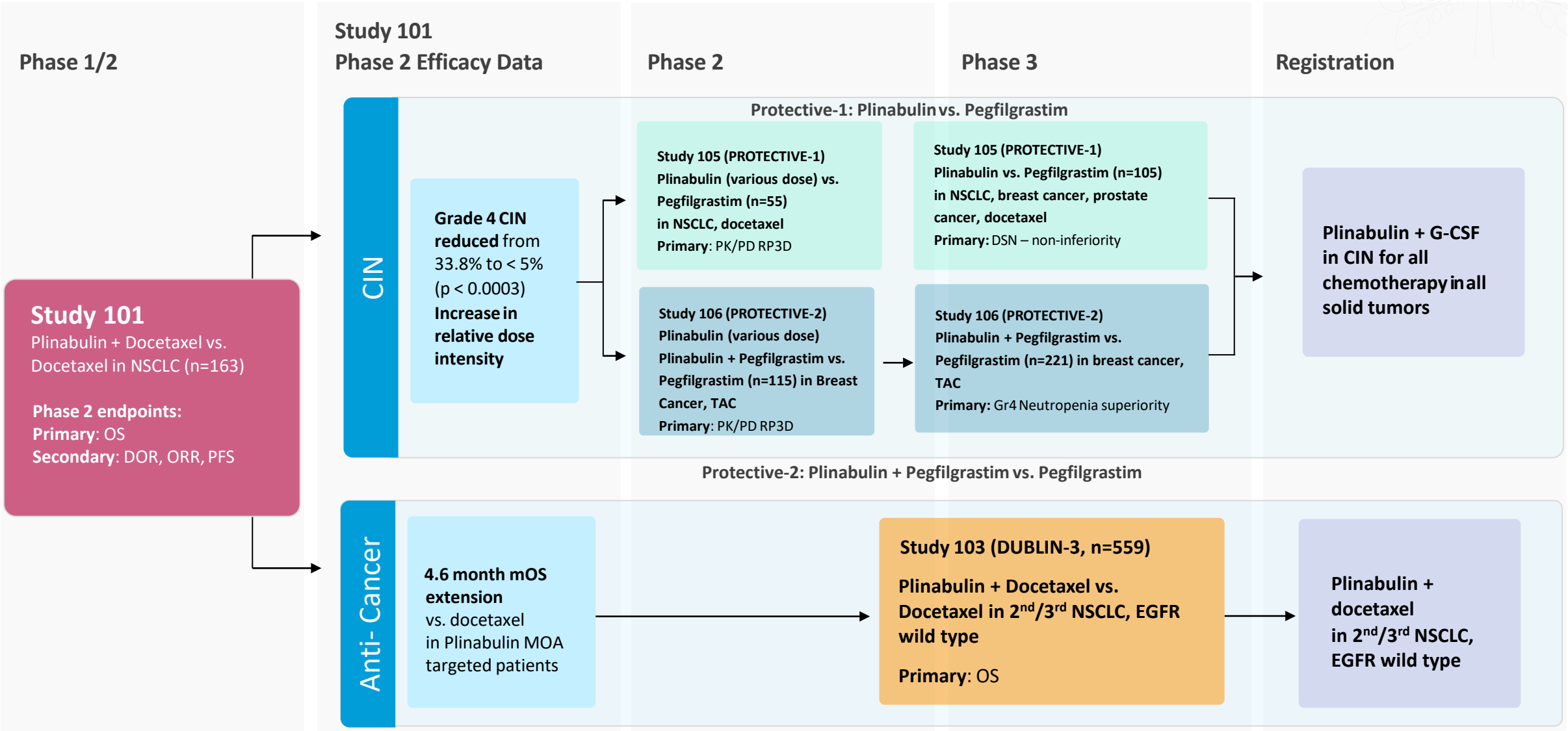


Biomarker data in tumor 30 days after drug intake

Doubled the Anti-cancer Benefit in Tumor Reduction in Triple I/O Combo vs. PD-1+IR

*Neri S. et al. Plinabulin, a microtubule destabilizing agent, improves tumor control by enhancing dendritic cell maturation and CD8 T cell infiltration in combination with immunoradiotherapy, AACR June 2020

Plinabulin Clinical Development Program



Building the Plinabulin Franchise

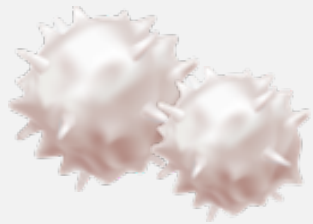
CIN	Anti-Cancer with Chemotherapy	Anti-Cancer with Immuno-Oncology
Raise the Standard of Care	Improve survival and quality of life	Potential APC cornerstone of emerging regimens

Severe Unmet Medical Need is Basis for Breakthrough Designation and Priority Review for Plinabulin + G-CSF Regimen in CIN Prevention

Despite widespread G-CSF use, CIN #1 reason for FN, ER visits, hospitalization, sepsis, mortality, and chemotherapy disruption[1]

Short-term Outcome Benefit

G-CSF monotherapy is suboptimal and leaves a significant clinical gap



Long-term Outcome Benefit

Chemotherapy's anti-cancer effectiveness is linear to its dose

15% Reduction in Relative Dose Intensity = 50% Reduction in Overall Survival[2]

The Unmet Medical Need: Week 1 "Neutropenia Vulnerability Gap (NVP)"

- >75% clinical complications occur in week 1 after chemo, which G-CSF cannot protect

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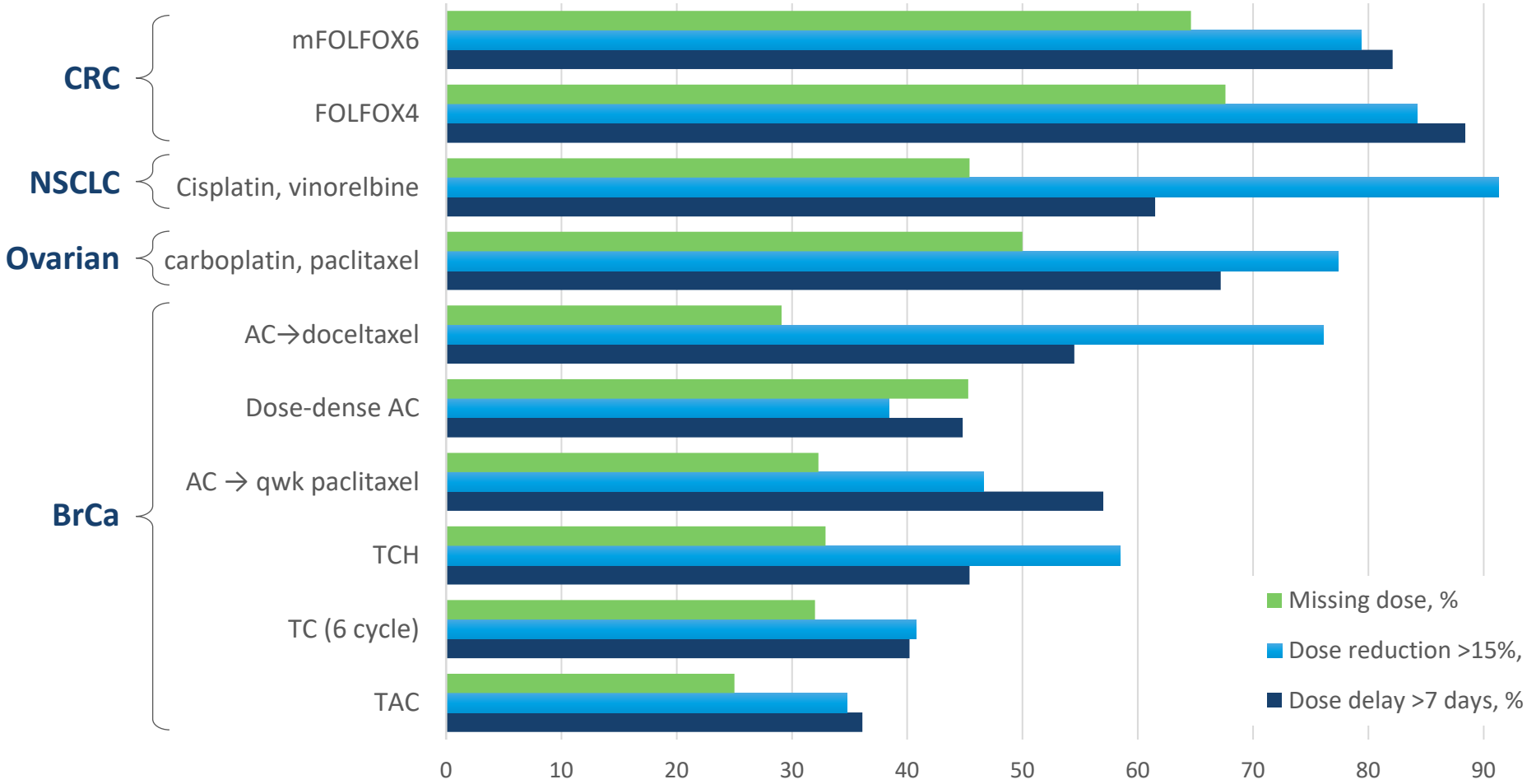
Source: 1 Lalami Y, Klastersky J.. Crit. Rev Oncol Hematol. 2017; 120:163-179. 2 Bonadonna G, Valagussa P, Moliterni A et al. Adjuvant cyclophosphamide, methotrexate, and fluorouracil in node-positive breast cancer. N Engl J Med 1995;332:901-906.

Monotherapy G-CSF Fails to Prevent Chemo Regimen Changes

Percent of patients with **significant** regimen changes



Chemo regimen changes are unacceptably high

Patients' experience:

- Dose reduction
- Dose delays
- Overall reduction in RDI

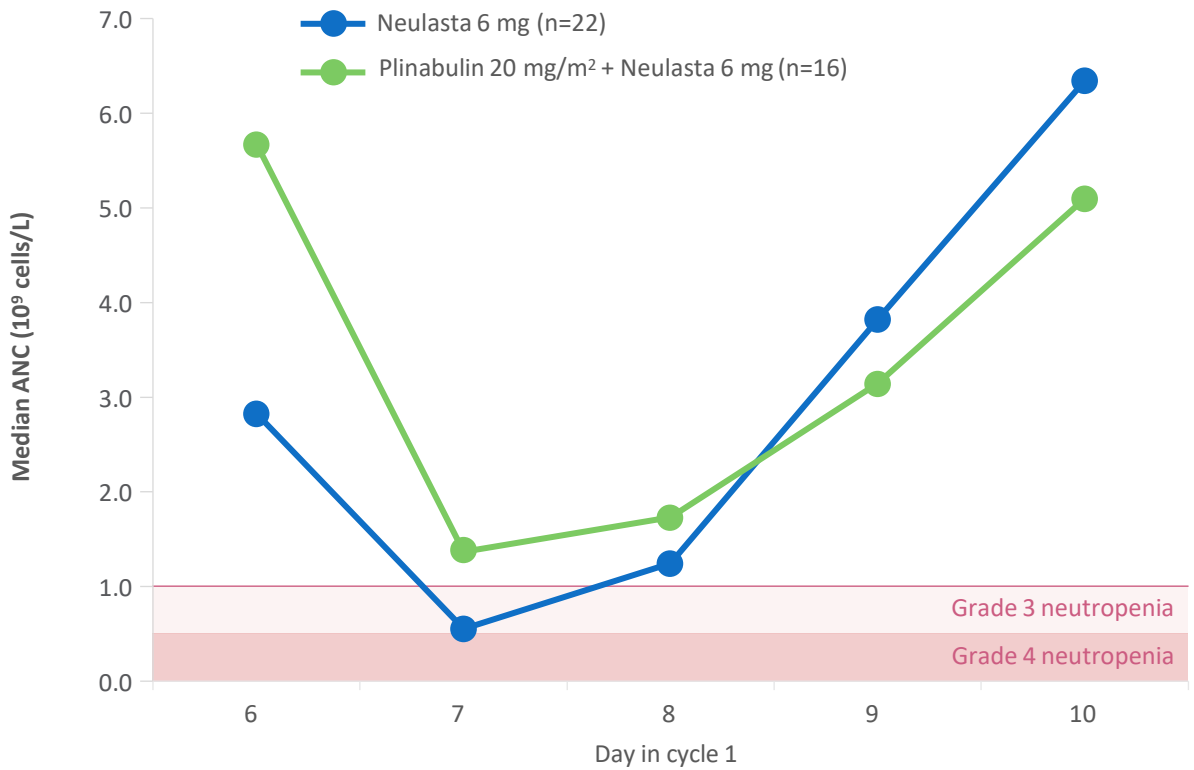
[1]Published, 2015. Per EMR review of 16,233 patients with 6 different tumor types 2007-2011. JNCCN—Journal of the National Comprehensive Cancer Network Volume 13 Number 11 November 2015, [2]Denduluri et al.

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.

Plinabulin + G-CSF Combination Addresses Unmet Medical Need

Plinabulin is the only product – in development –
that has demonstrated the potential to elevate the standard of care (SOC) to prevent CIN

- Breakthrough Therapy Designation: Unmet need, and potential superior regimen vs. SOC recognized by FDA and NMPA
- Plinabulin prevents CIN in week 1; and G-CSF prevents CIN in week 2
- Combination maximizes the prevention of CIN for the full cycle



Median ANC in cycle 1 after TAC for breast cancer

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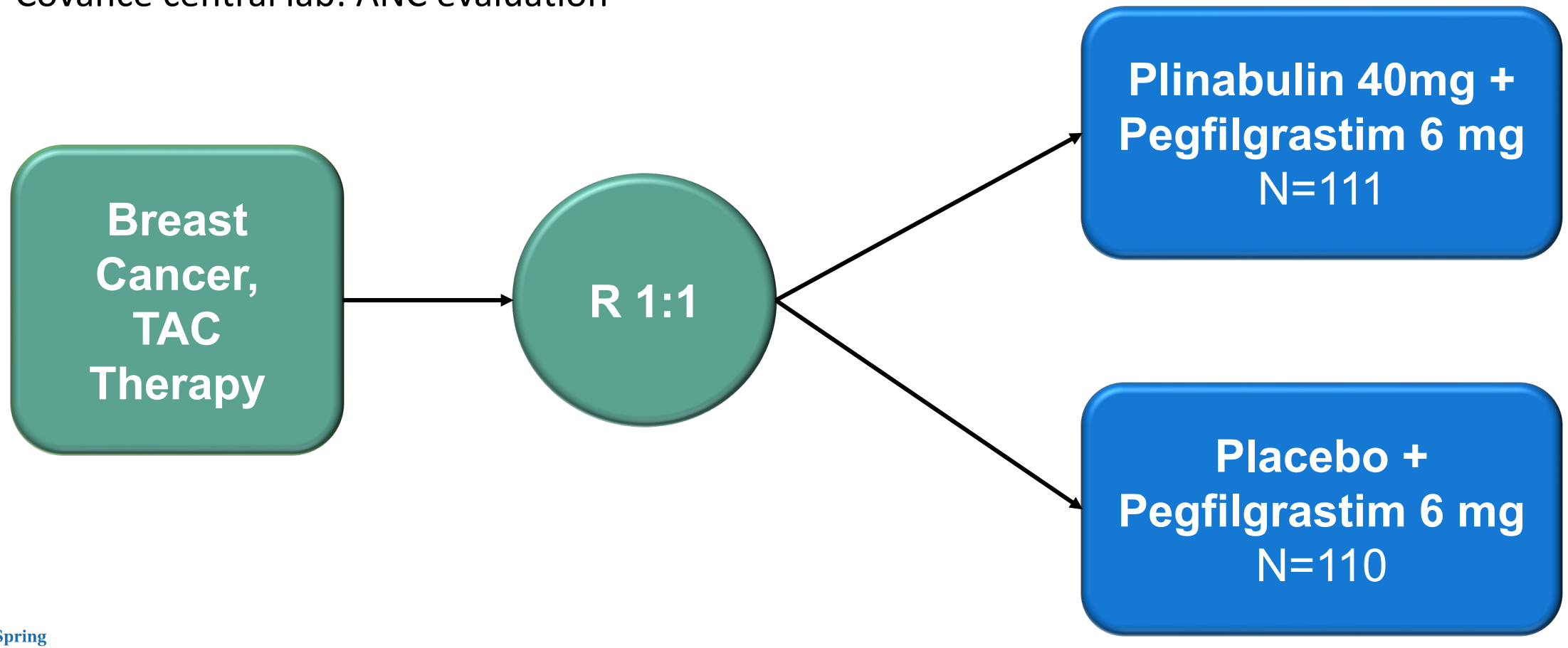
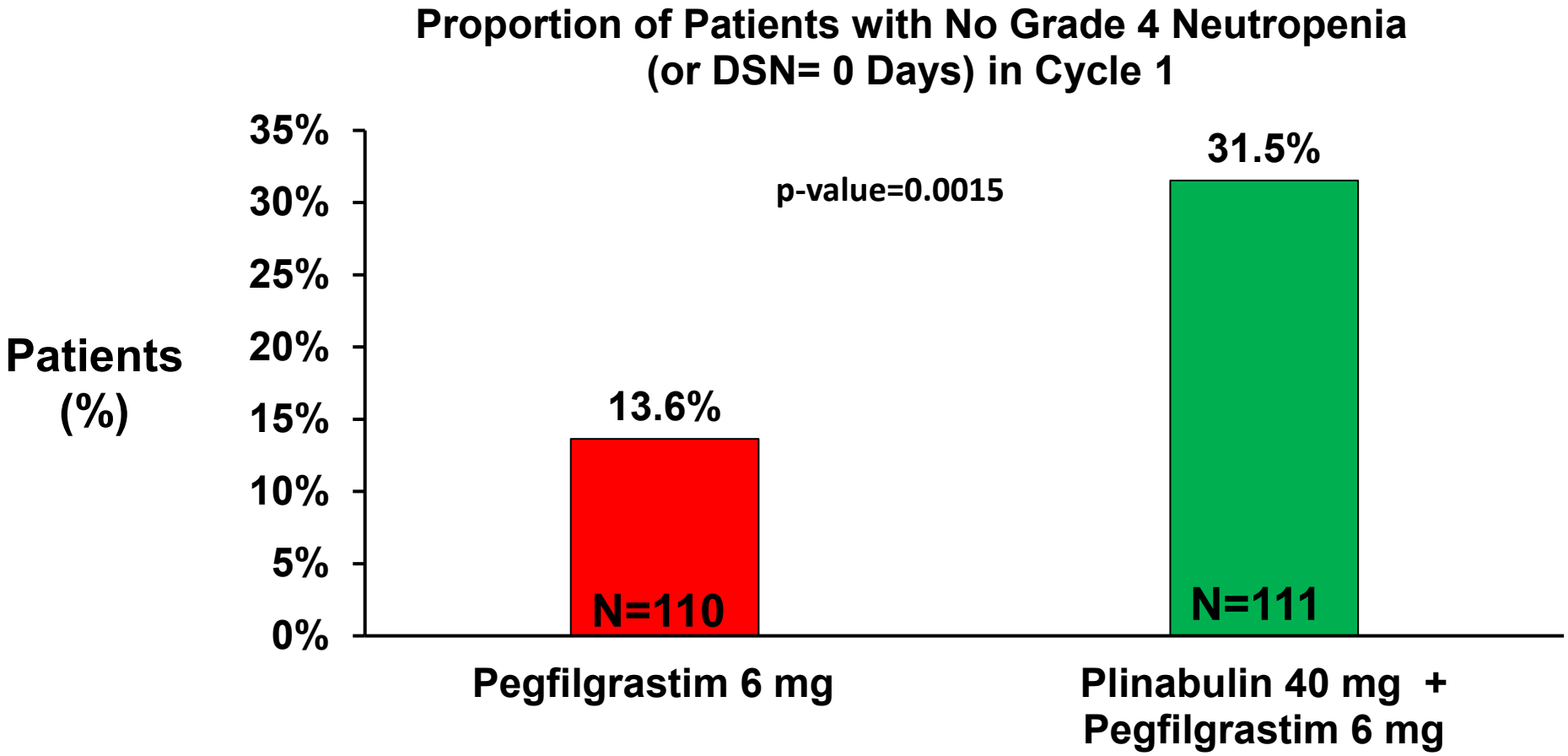
PROTECTIVE-2 (Phase 2) study: Plinabulin + Neulasta vs Neulasta monotherapy.

Protective-2 (Study 106) Ph 3: Registration Study Design

- Double blind, global study (19 centers); 4 cycles
- Covance: CRO
- Covance central lab: ANC evaluation



PROTECTIVE-2 Ph3: Primary Endpoint Met



- Grade 4 neutropenia (ANC < 0.5 x 10^9 cells/L) during Cycle 1 was prevented (DSN=0) for more than twice as many subjects in the plinabulin/pegfilgrastim arm than subjects in the pegfilgrastim arm

PROTECTIVE-2 Ph 3: Clinical Consequences of CIN also Reduced by Combination

ANC Nadir	Pegfilgrastim 6 mg N=110	Plinabulin 40 mg + Pegfilgrastim 6 mg N=111
Mean nadir for FN patients ($x10^9$ cells/L)	0.06	0.13
Mean nadir for all patients ($x10^9$ cells/L)	0.31	0.54

ANC benefit of the combination improves clinical benefit (~50% better)

	Pegfilgrastim 6 mg N=110	Plinabulin 40 mg + Pegfilgrastim 6 mg N=111
Incidence of FN by grade, (n) %	Total: 6.3% (n=7) Grade 3: 2.7% (n=3) Grade 4: 3.6% (n=4)	Total: 3.6% (n=4) Grade 3: 2.7% (n=3) Grade 4: 0.9% (n=1)
Duration of FN (days)	2.28 days	1.25 days
Hospitalization, %	6.3%	2.7%
Duration of hospitalization (days)	7.14 days	3.75 days
Change of chemotherapy dose and/or regimen in later cycles, %	6.3%	2.7%

Adverse Reactions Occurring in ≥ 5% of Patients in the Plinabulin + Pegfilgrastim vs. Pegfilgrastim

Body System/Preferred Term	Pegfilgrastim 6 mg N=132		Plinabulin 40 mg** + Pegfilgrastim 6 mg N=127	
	All Grade	Grade 3/4	All Grade	Grade 3/4
Gastrointestinal disorders	22 (16.7%)	1 (0.8%)	49 (38.6%)	9 (7.1%)
Diarrhea	6 (4.5%)	1 (0.8%)	33 (26.0%)	4 (3.1%)*
Nausea	11 (8.3%)	0	14 (11.0%)	1 (0.8%)*
Constipation	2 (1.5%)	0	10 (7.9%)	1 (0.8%)*
Vomiting	2 (1.5%)	0	10 (7.9%)	1 (0.8%)*
Abdominal pain	1 (0.8%)	0	9 (7.1%)	2 (1.6%)
Abdominal distension	1 (0.8%)	0	10 (7.9%)	2 (1.6%)
General disorders and administration site conditions	17 (12.9%)	0	24 (18.9%)	1 (0.8%)
Fatigue	2 (1.5%)	0	10 (7.9%)	0
Malaise	10 (7.6%)	0	11 (8.7%)	1 (0.8%)
Musculoskeletal and connective tissue disorders	48 (36.4%)	0	20 (15.7%)	0
Bone pain	37 (28.0%)	0	8 (6.3%)	0
Pain in extremity	7 (5.3%)	0	8 (6.3%)	0
Back pain	5 (3.8%)	0	4 (3.1%)	0
Nervous system disorders	4 (3.0%)	0	12 (9.4%)	0
Headache	1 (0.8%)	0	8 (6.3%)	0
Vascular disorders	2 (1.5%)	0	10 (7.9%)	7 (5.5%)
Hypertension	1 (0.8%)	0	8 (6.3%)	7 (5.5%)*

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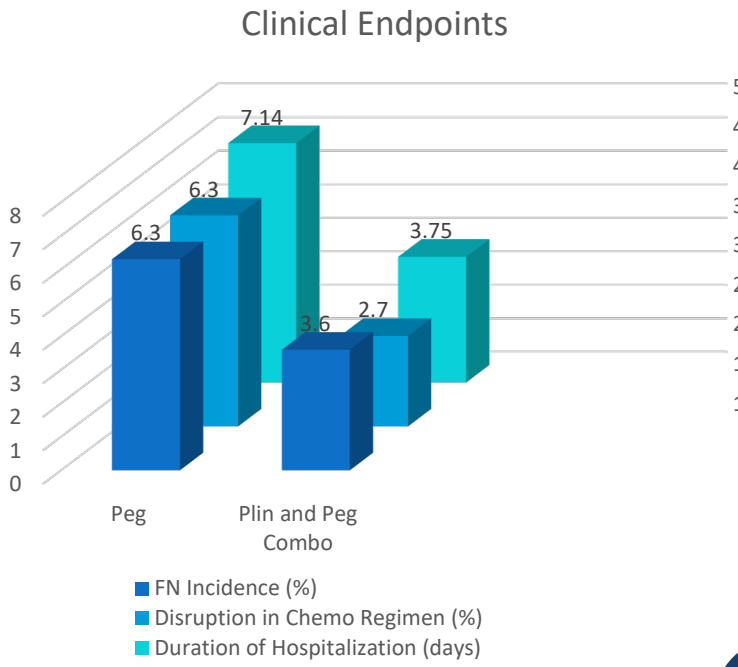
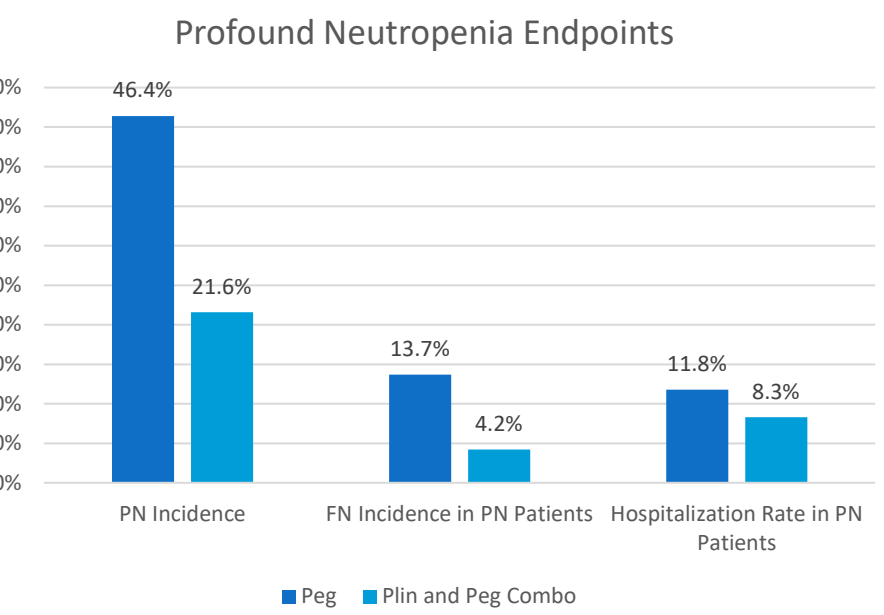
The combination with Superior Improvement in Clinically Meaningful Endpoints compared to Pegfilgrastim alone

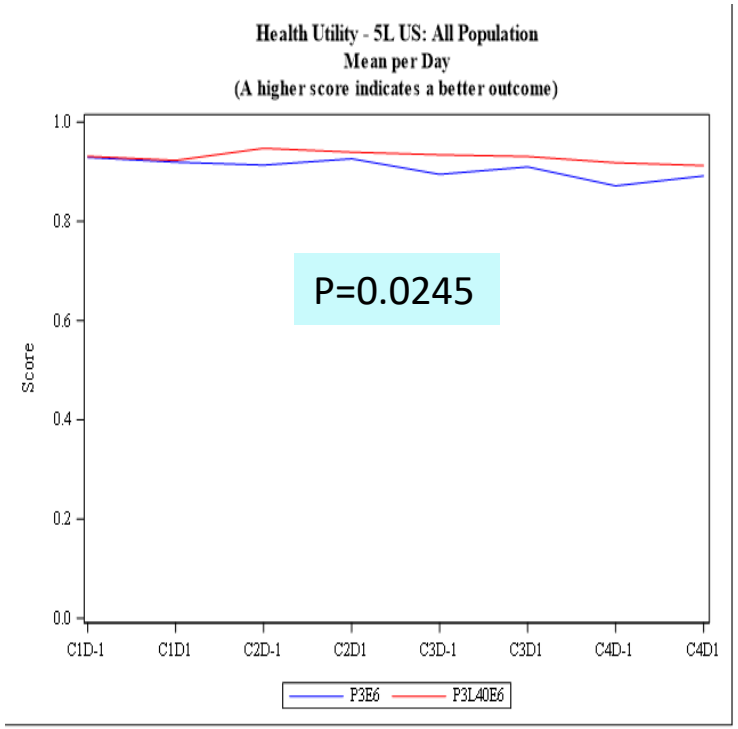
Reduction of Incidence and Severity of FN and Hospitalization



Reduction of Profound Neutropenia (PN) Related Benefits



Improvement of Quality of Life



June 2021 ASCO Presentations

Favorable Benefit/Risk Ratio (Plinabulin + G-CSF vs. G-CSF alone)

Improved Efficacy (ANC based in Cycle 1) – 106 Phase 3	Improved Efficacy (FN) – 106 Phase 3	Favorable Safety – 106 Phase 2+3
No Grade 4 Neutropenia • 31.5% vs. 13.6% (incidence), p=0.0015 **No Grade 3/4 Neutropenia** • 4.55% vs. 20.72% (incidence), p=0.0003 **Mean ANC Nadir** • 0.54 vs. 0.31 (x 10^9 cells/L), p=0.0002 **DSN Cycle 1 day 1-8** • 1.1 day vs. 1.4 day, p=0.0065 **DSN Cycle 1** • 1.2 day vs. 1.5 day, p=0.0324 **Profound Neutropenia** • 21.6% vs. 46.4% (incidence), p=0.0001 • 0.3 day vs. 0.6 day (duration), p=0.0004	**FN** • 3.6% vs. 6.3% (incidence) • 0.9% vs. 3.6% (grade 4 incidence) • 1.25 day vs. 2.28 day (duration) **Hospitalization for FN patients** • 2.7% vs. 6.3% • 3.75 day vs. 7.14 day (duration) **Change of Chemo dose/regimen in later cycles** • 2.7% vs 6.3%	**Grade 4 TEAE** • 20% less Grade 4 TEAEs in the combination (55.9%) compared to pegfilgrastim alone (75.8%) **SAEs** • Higher SAE frequency, however, less Grade 4 and more Grade 3 events **AEs leading to discontinuation** • Similar frequency, mostly single events **Bone pain (AE)** • 6.3% bone pain in the combination vs. 28.0% in pegfilgrastim **Low grade GI track side effects and transient hypertension**

Plinabulin's Regulatory strategy for CIN, FDA NDA Acceptance with Priority Review: Superior Profile in a Broad Label

Plinabulin shown to statistically reduce Grade 4 neutropenia in 6 clinical trials (1,200+ patients)

Supporting Studies

Plinabulin vs. placebo (Dublin-3, phase 3)

- Grade 4 reduction highly statistically significant (Study 101 and DUBLIN-3, $p<0.0003$ and $p<0.0001$ respectively)

Registration Study

Plinabulin + G-CSF combo vs. G-CSF mono (Protective-2, phase 3)

- Superior CIN prevention in primary and key secondary endpoints

MOA support from 5 additional studies:

Plinabulin early onset in Week 1, G-CSF effect in Week 2

Supporting Studies

Plinabulin vs. G-CSF (Protective-1, phase 2 & 3)

- Non-inferior CIN activity
- Superior adverse event profile: limited bone pain, limited platelet reduction, and limited immune suppression[1]

700+ cancer patients treated with Plinabulin (various doses)

1. Blayney et al. JAMA Oncology 6(11): e204429 (2020)

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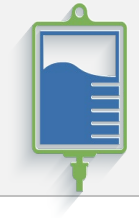
Plinabulin + G-CSF Combination

- Commercial Plan in CIN Prevention

Chemotherapy Without Compromise: Turning the **4 Ds** into the **4 Ss**

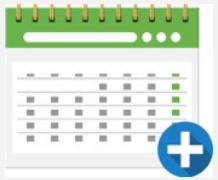


DECREASED
recommended dose

STABLE DOSE
maintaining ≥85%

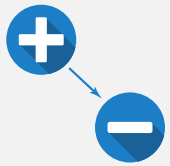
DELAYED
cycles

SUSTAINED CYCLES
cycles on time



DISCONTINUED
chemotherapy

STAY THE COURSE
complete all cycles



DOWNGRADE
chemotherapy regimen

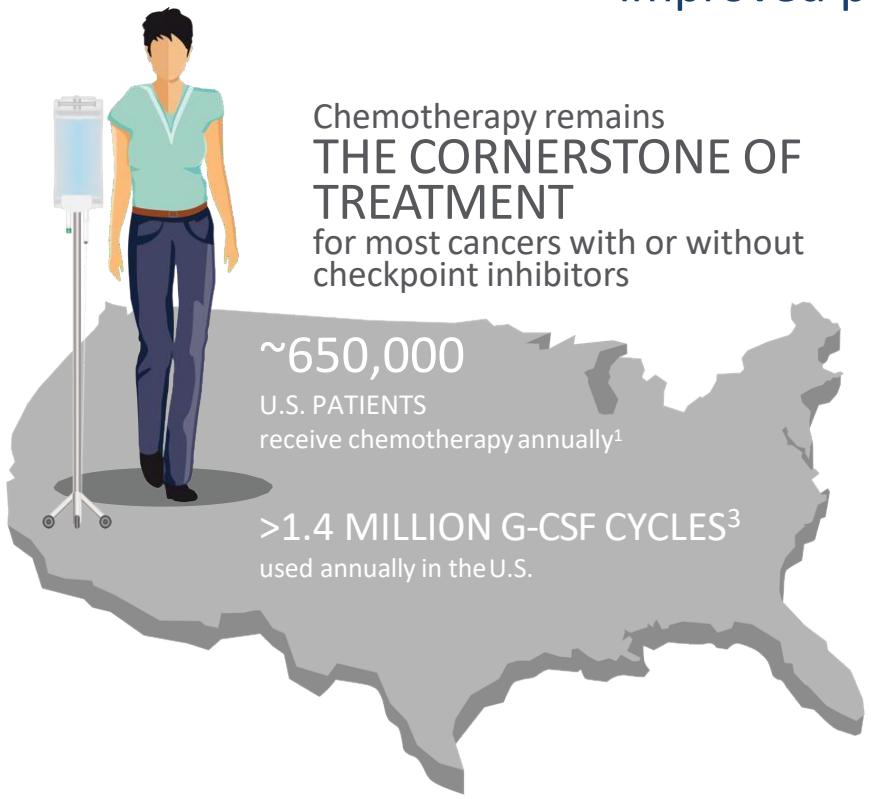
STRONGEST REGIMEN
of chemotherapy

Plinabulin + G-CSF

- Differentiated clinical profile, potential to improve SOC
- Greater clinical control
- Improved outcomes

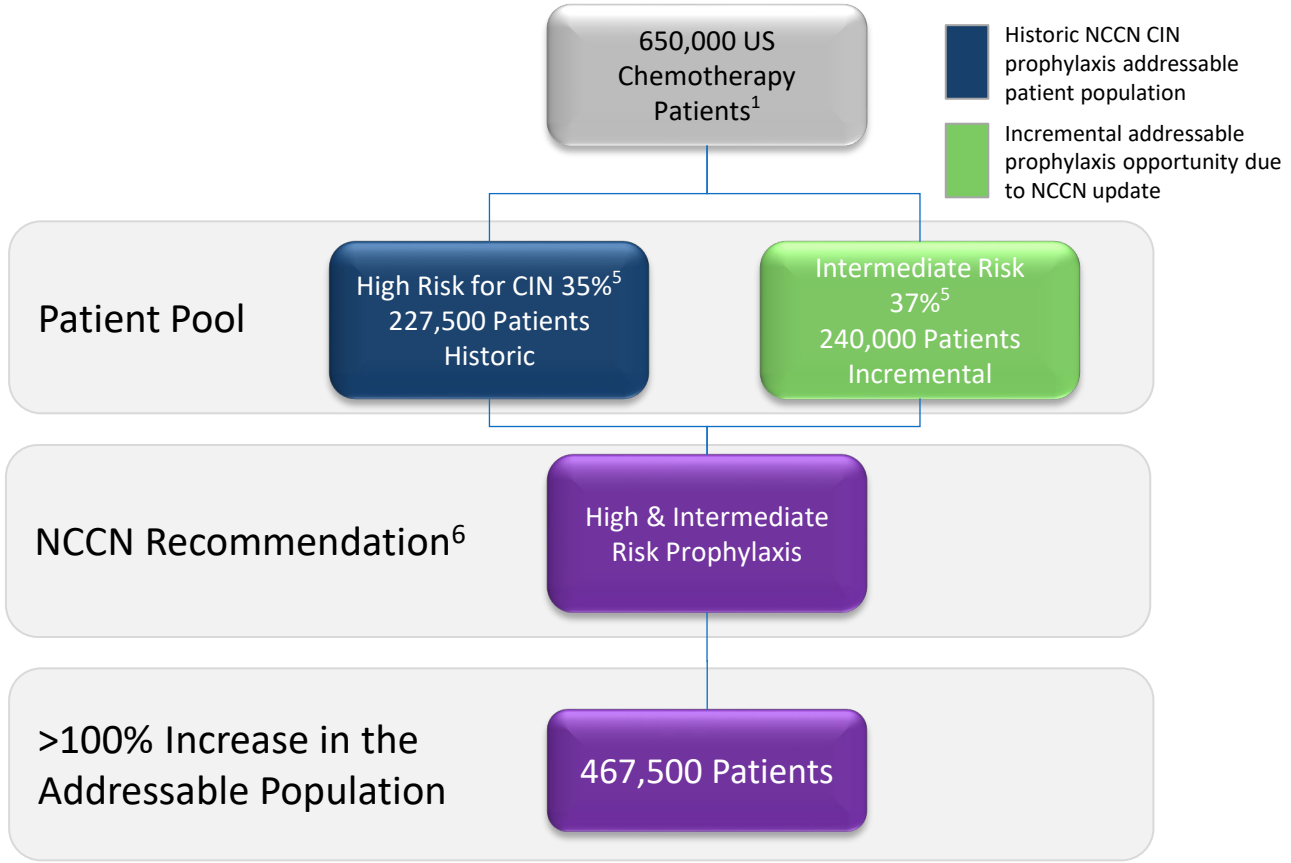
CIN: Large and Expanding Market Potential

Plinabulin can be used with each cycle of G-CSF in non-myeloid cancers to provide improved protection from neutropenia



Global:[3,4]
- 4 million cycles of G-CSF per year
- $7 billion in sales

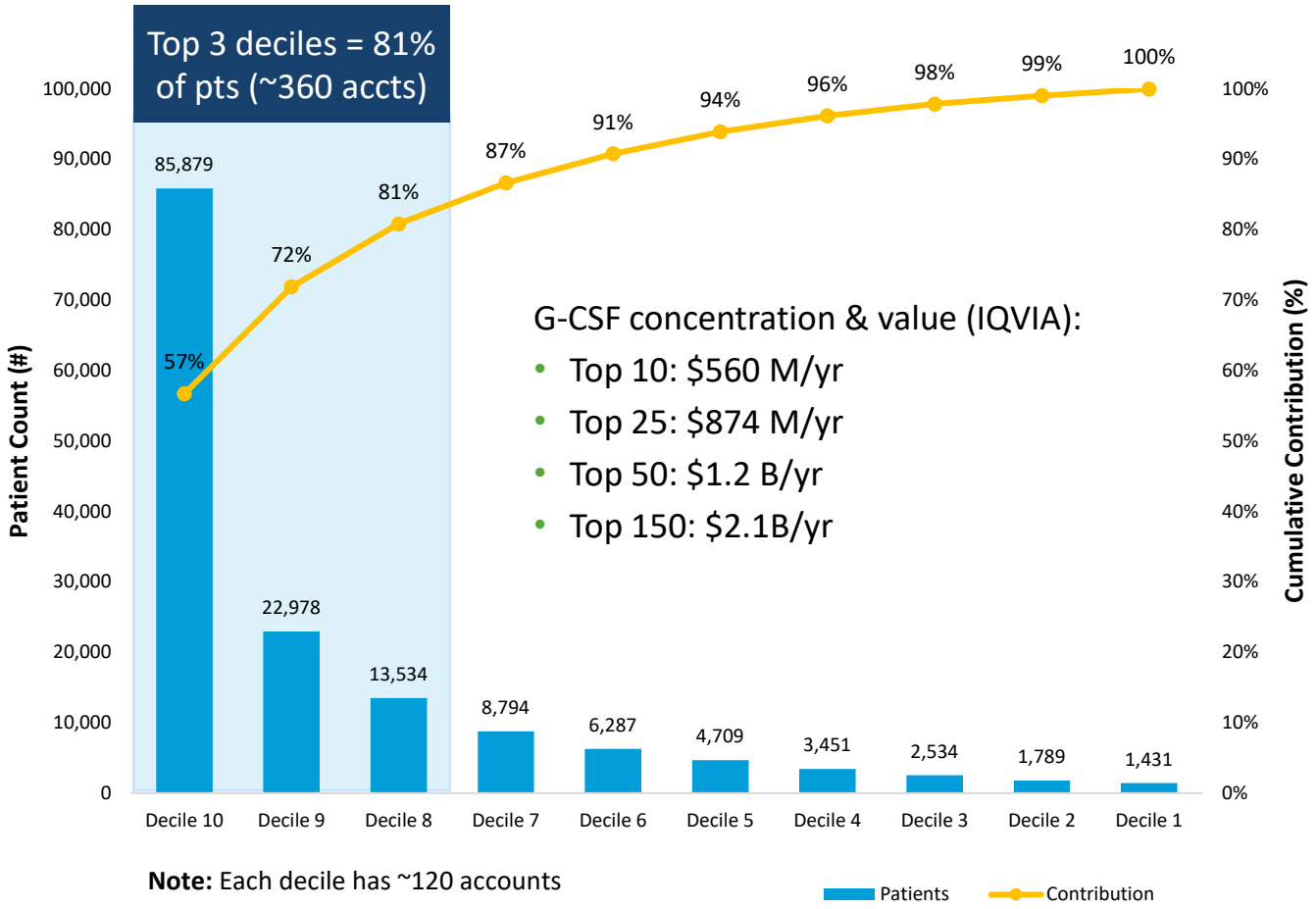
NCCN Guidelines Doubled the US Market for CIN



Note 1 Centers for Disease Control and Prevention: www.cdc.gov/cancer/preventinfections/providers.htm. accessed April 3, 2021; [2] NSP IQVIA Dec '20; [3]G-CSF market size based on IQVIA data; 4 MIDAS for ex-U.S. and DDM MD for U.S.; Q3 '16 to Q2 '18. Standardized G-CSF units; 5 BYSI market research, Aug – Oct '20; 6 NCCN.org

Prioritize on Large and Rapid Adopters at Launch

Pegfilgrastim Patient Distribution[1] – Top 1200 Centers

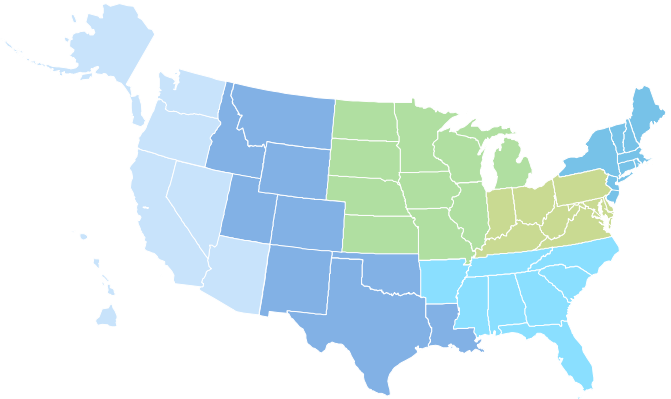


G-CSF concentration & value (IQVIA):

- Top 10: $560 M/yr
- Top 25: $874 M/yr
- Top 50: $1.2 B/yr
- Top 150: $2.1B/yr

Note: Each decile has ~120 accounts

US Regional Coverage



Top 360 multi-location oncology accounts identified and prioritized

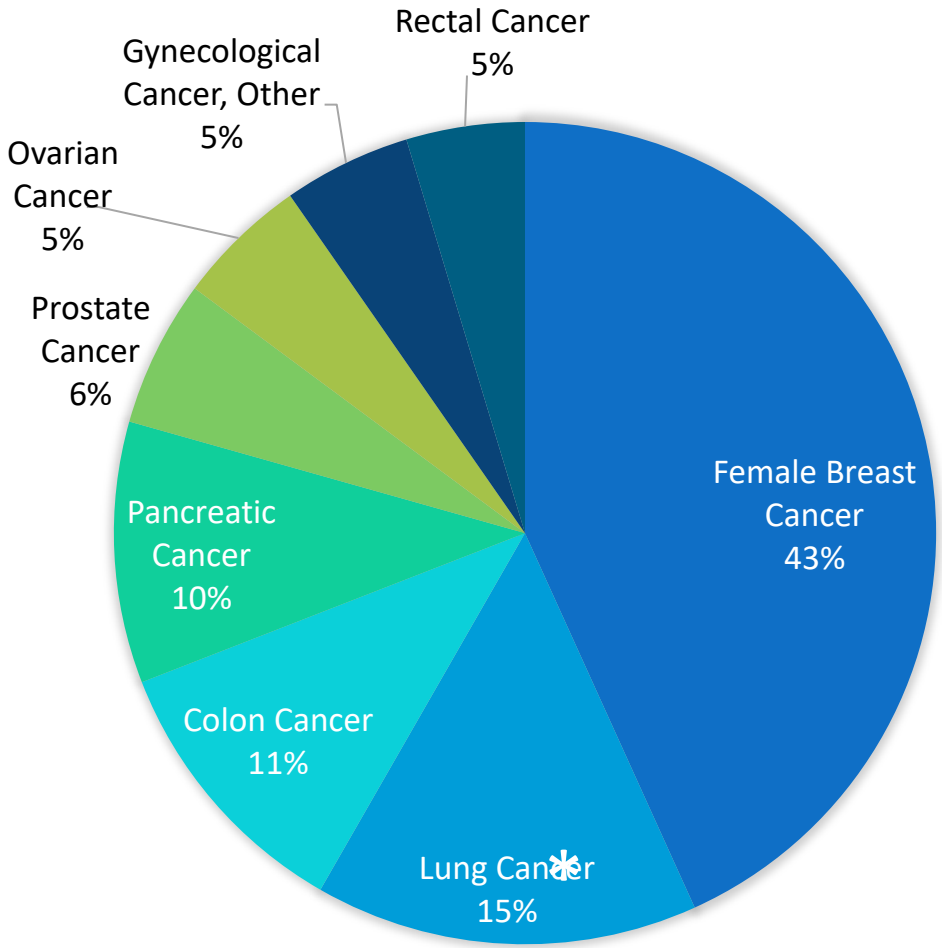
Field Team of 83, covering 6 regions:

- 6 Medical Science Liaisons
- 6 Regional Business Directors
- 60 Oncology Account Specialists
- 4 National/Regional Account Directors
- 1 Group Purchasing Director
- 6 Regional Reimbursement Specialists

1 Komodo Health, Inc. Komodo Health, Inc. makes no representation or warranty as to the accuracy or completeness of the data ("Komodo Materials") set forth herein and shall have, and accept, no liability of any kind, whether in contract, tort (including negligence) or otherwise, to any third party arising from or related to use of the Komodo Materials by BeyondSpring Inc. Any use which BeyondSpring Inc.or a third party makes of the Komodo Materials, or any reliance on it, or decisions to be made based on it, are the sole responsibilities of BeyondSpring Inc. and such third party. In no way shall any data appearing in the Komodo Materials amount to any form of prediction of future events or circumstances and no such reliance may be inferred or implied.

Plinabulin: Potential for Use Across the Spectrum of Solid Tumors

G-CSF Administrations: Solid Tumor



G-CSF use by cancer type:

- Improved control of CIN with Plinabulin can prove important in cancers with more aggressive therapeutic approaches
- Plinabulin's broad label has potential applicability in a broad array of cancer types and with a wide variety of chemotherapies

* SCLC ~15% of all lung cancer diagnoses

Source: IQVIA G-CSF Tumor Analysis; 7/19 – 6/20

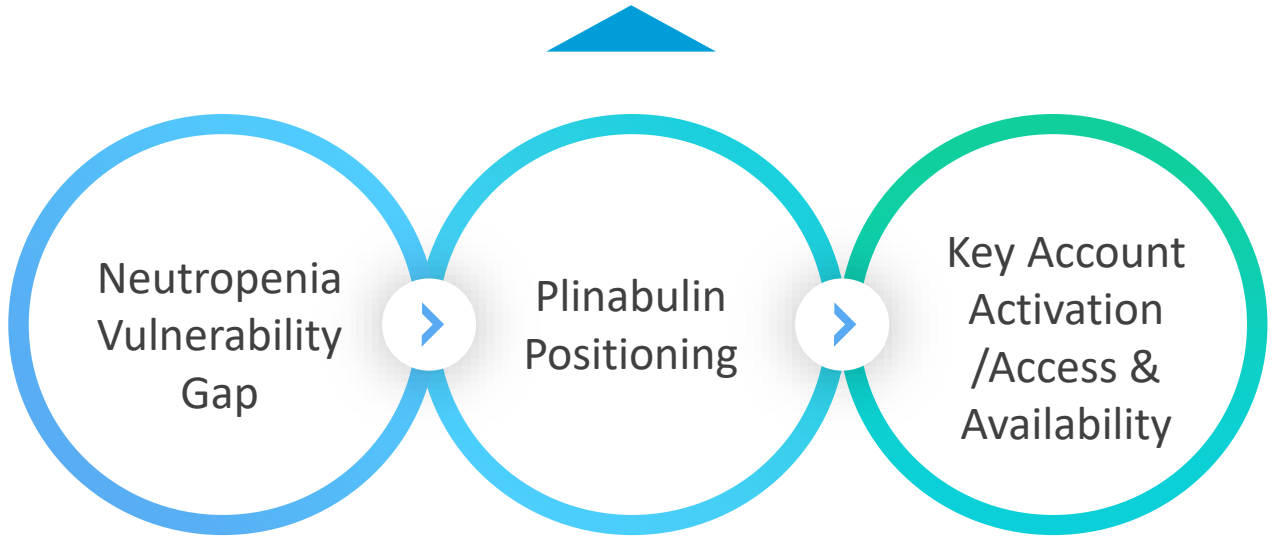
Targeted Commercialization Plan

01 Drive awareness of the "Neutropenia Vulnerability Gap" and unmet need

02 Position Plinabulin with key decision makers

03 Activate key accounts and ensure broad access and availability

FOCUS: Elevating the SOC in chemotherapy



Detailed Commercialization Plan

1

Neutropenia Vulnerability Gap and Unmet Need Awareness

KOLs:

- Major health care congresses:
  - ASCO, SABCC. Chemo Foundation
  - Publications/abstracts, booth
  - KOLs to lead all education efforts
  - MSL outreach

Market Dynamics:

- Disease awareness:
  - CME sponsorship
  - CINRisk.com: >1M hits to date
- Advisory boards with HCPs, payers, practice managers
- > 700 market research interactions with U.S. oncologists, RNs and practice managers
- Payer interactions:
  - >40 with National, regional payers
  - Representing >130M unique lives
- Targeting the top 360 accounts (80%+ of the market) at launch

2

Positioning Plinabulin with Key Decision Makers

- Advocacy and Expert network partnerships:
  - Guidelines:
    - Targeting NCCN, ASCO, Key IDNs
    - Apply immediately upon approval
  - Clinical Pathway adoption for broad use across large accounts
  - Targeted contracting with GPOs and high control payers to drive share

Provider and Payer Focus:

- Dedicated field teams
  - National/Regional Account Managers
  - Group Purchasing/Government
  - MSL team clinical support
- J Code to secure reimbursement

Education Programs:

- CME programs
- Top 400 oncology KOLs and key community-based HCPs
- Peer-to-peer; virtual/in-person

3

Activating Key accounts and Ensuring Broad Patient Access

State of the Art Promotion Programs:

- Dedicated team of Oncology Account Specialists
- Virtual Teach-ins and sales calls
- In person sales calls and programs
- Commercial focus:
  - High-volume/rapid adopting G-CSF oncologists
  - Top clinics/hospitals

Plinabulin Plus – Patient Assistance:

- Dedicated Field Reimbursement Specialists
- Benefits investigation and adjudication
- Prior authorization support
- Co-pay assistance & Patient assistance programs*
- Educational support for patients

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*Medicare, Medicaid and Federal/state program patients will not be eligible for the commercial co-pay program. The Patient Assistance Program will not cover the costs related to Plinabulin infusion.

Breakthrough Therapy with FDA NDA Priority Review: Potential to Elevate SOC for CIN Prevention

Opportunity

- ✓ Market size
- ✓ Market growth
- ✓ NCCN guideline change
- ✓ Managed care coverage

Unmet need

- ✓ Grade 4 neutropenia complications
- ✓ CIN: #1 reason for therapy change (4Ds)
- ✓ G-CSF – excellent drug; can't cover early cycle challenges
- ✓ 4Ds result in reduced OS

Product differentiation

Plinabulin + G-CSF addresses 3 oncologist needs:

- ✓ Keeps ANC out of the danger zone and thus ***less*** severe CIN, FN, ER visits and hospitalization
- ✓ Significantly reduces bone pain
- ✓ Maintains chemo regimen

Plinabulin+ G-CSF has the potential to:

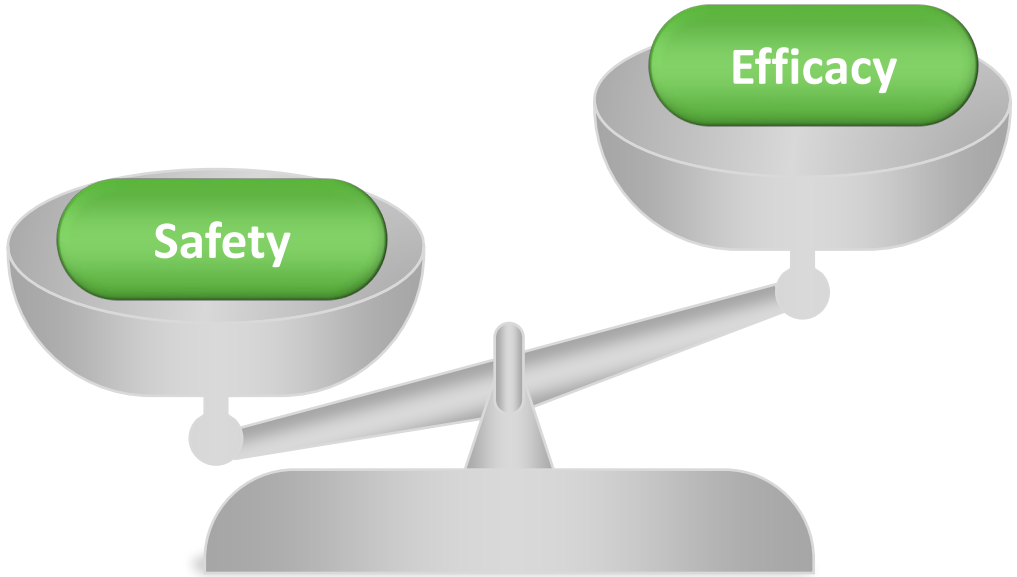
- Address the oncologist's desire for increased control
- Reduce patient anxiety and fears associated with interrupted therapy and adverse events
- Deliver improved chemotherapy care with the potential for improved long-term outcomes
- Clear differentiation from G-CSF provides rationale for superior pricing vs G-CSF in CIN

Anti-cancer potential – Opportunity for premium pricing and deeper market penetration

Building the Plinabulin Franchise

CIN	Anti-Cancer with Chemotherapy	Anti-Cancer with Immuno-Oncology
Raise the Standard of Care	Improve survival and quality of life	Potential APC cornerstone of emerging regimens

Unmet Medical Need – 2nd/3rd Line NSCLC, EGFR Wild Type



- Large patient population with limited treatment options
  - EGFR wild type: ~85% western NSCLC and ~70% of Asian NSCLC patients
  - only four therapies approved
  - TKI is worse than docetaxel[1]
- Limited efficacy
- Severe side effects, including severe neutropenia

Factors such as the Efficacy and Safety tradeoff cause significant % of patients to forego their next round of chemotherapy for NSCLC

[1] Lancet Oncol. 2013 Sep;14(10):981-8.

Limited Options

- Four therapies approved in NSCLC (2nd/3rd line, EGFR wild type)
- SOC Docetaxel: Limited overall survival with CIN severe neutropenia ~40%

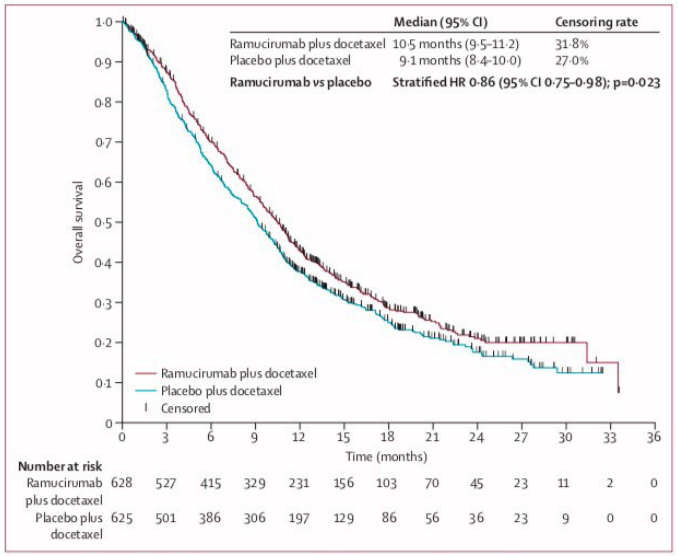
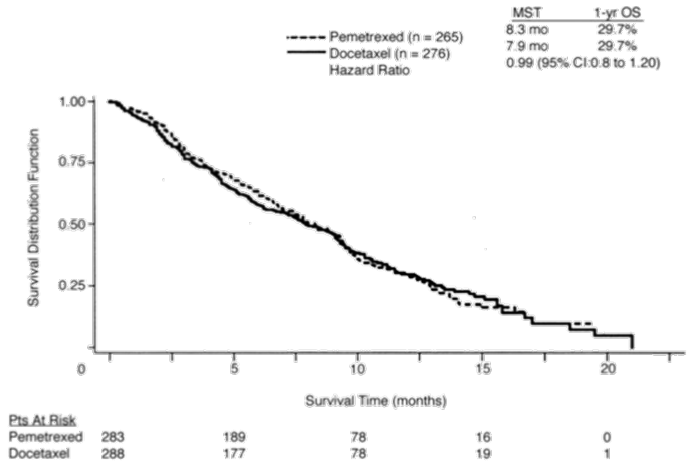
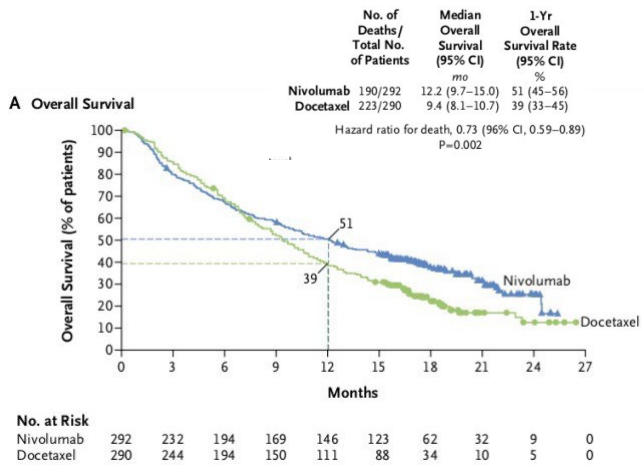


Figure 2: Kaplan-Meier estimates of overall survival in the intention-to-treat population
HR=hazard ratio.

Pemetrexed and PD-1/PD-L1 Moved To First Line





Treatment	Ramuciramab + Docetaxel vs. Docetaxel[1]	Pemetrexed vs Docetaxel[2]	Nivolumab (PD-1 Ab) vs. Docetaxel[3]
Pros	Limited efficacy; HR for mOS: 0.86 (1.4 M mOS benefit vs. Docetaxel)	Low CIN risk	Improved efficacy; HR for OS: 0.73 (2.8 M mOS benefit vs. Docetaxel)
Cons	High CIN risk (49% severe neutropenia)	Low Efficacy, HR for mOS: 0.99 (no survival benefit vs. Docetaxel)	potential cytokine storm, Moved to 1st line, thus PD-1 failed 1st line pts cannot use this in 2nd line.

Ideal regimen would improve efficacy (survival) without compromising on CIN

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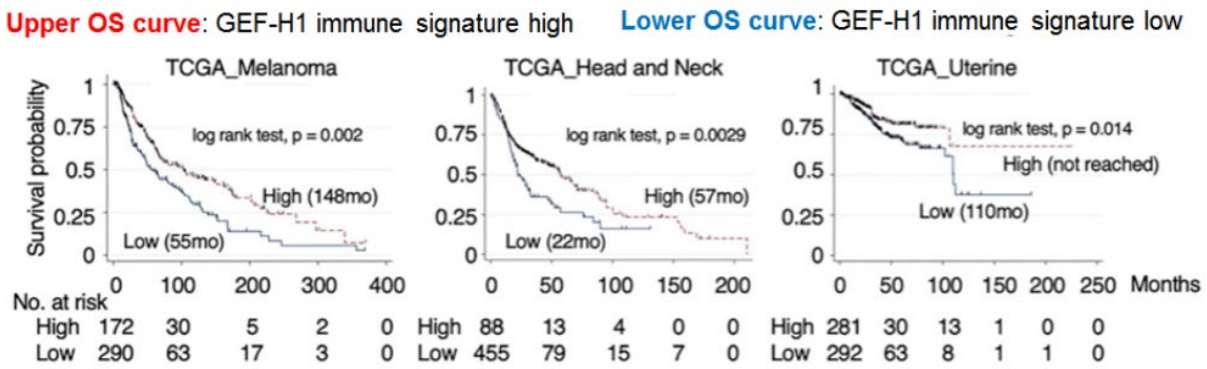
[1] Lancet 384 (9944): 665-673 (2014). [2] JCO 22(9): 1589-1597 (2004)。 [3] NEJM 373: 1627-1639 (2015)。

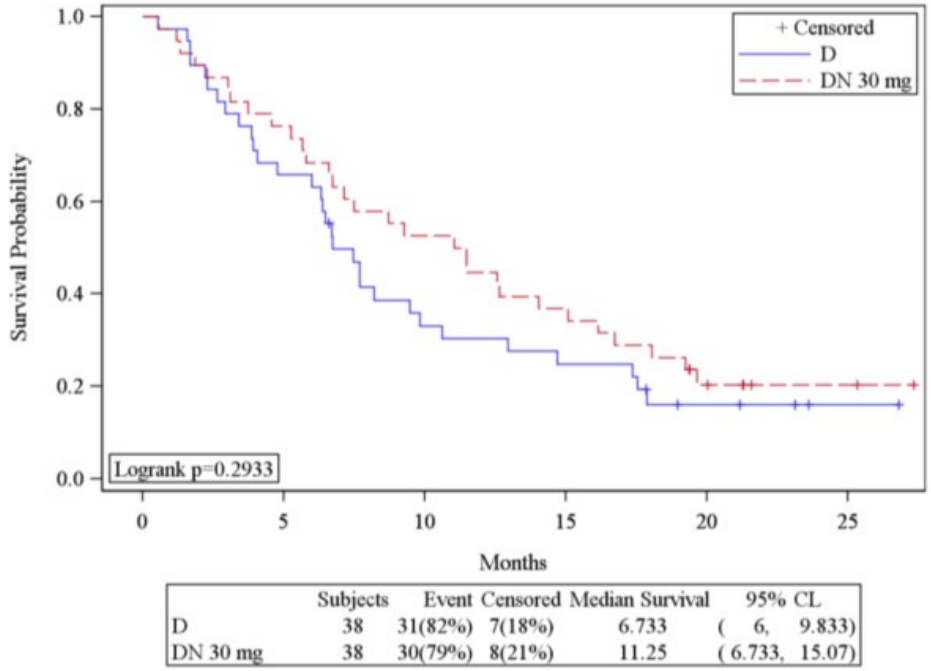
Rationale for Advancing Plinabulin in NSCLC Study

Mode of Action Rationale

Higher GEF-H1 immune signatures associated with longer OS in cancer [1]



Preliminary Clinical Evidence (Phase 2)



	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)

- Post-Hoc Ph2 data from Plinabulin in NSCLC in mechanism targeted patients (measurable lung lesion) shows overall survival benefit[2]
- **Represents Ph3 patient selection and study design**

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[1] Kashyap et al., Cell Reports 28(13): 3367-80 (2019 [2] ASCO-SITC 2017 meeting oral presentation.

DUBLIN-3 (Study 103): Phase 3 in 2nd/3rd NSCLC, EGFR Wild Type

Design

EGFR wild-type NSCLC (Pre-specified MOA target patients: Measurable lung lesion)

- Plinabulin + docetaxel vs docetaxel, 1:1 randomization, n=559 (fully enrolled)
- Approval possible with a single, qualified study
- Final analysis: at least 439 patient death events; study succeeds if $p < 0.046$ for Overall Survival, Expected Mid-Year 2021

Endpoints

Primary Endpoint: Overall Survival

Secondary Endpoints:

- ORR, PFS
- Percent of patients without severe neutropenia on Day 8 of Cycle 1
- Month 24 OS rate, Month 36 OS rate
- DoR
- Q-TWiST
- QoL
- Proportion of patients who received docetaxel >8 cycles, >10 cycles, and >12 cycles

- Secondary Endpoints go beyond OS
- Provide opportunity to demonstrate important benefits and address a range of unmet medical needs

Preliminary Data

- 2 successful interim analyses: DSMB recommended trial to continue without modification

Target Product Profile

Current Standard of Care

- Modest survival benefit
- Severe safety concerns, e.g. CIN
- Poor Quality of Life

Plinabulin - Docetaxel Combination

- Potential survival benefit, with more long survivals due to GEF-H1 IO MOA
- Potential superior safety profile, including CIN reduction
- Potential superior quality of life

Building the Plinabulin Franchise

CIN	Anti-Cancer with Chemotherapy	Anti-Cancer with Immuno-Oncology
Raise the Standard of Care	Improve survival and quality of life	Potential APC cornerstone of emerging regimens

Triple I/O Combo Development for Multiple Cancer Indications in PD-1/PD-L1 Failed Patients – Severe Unmet Medical Needs

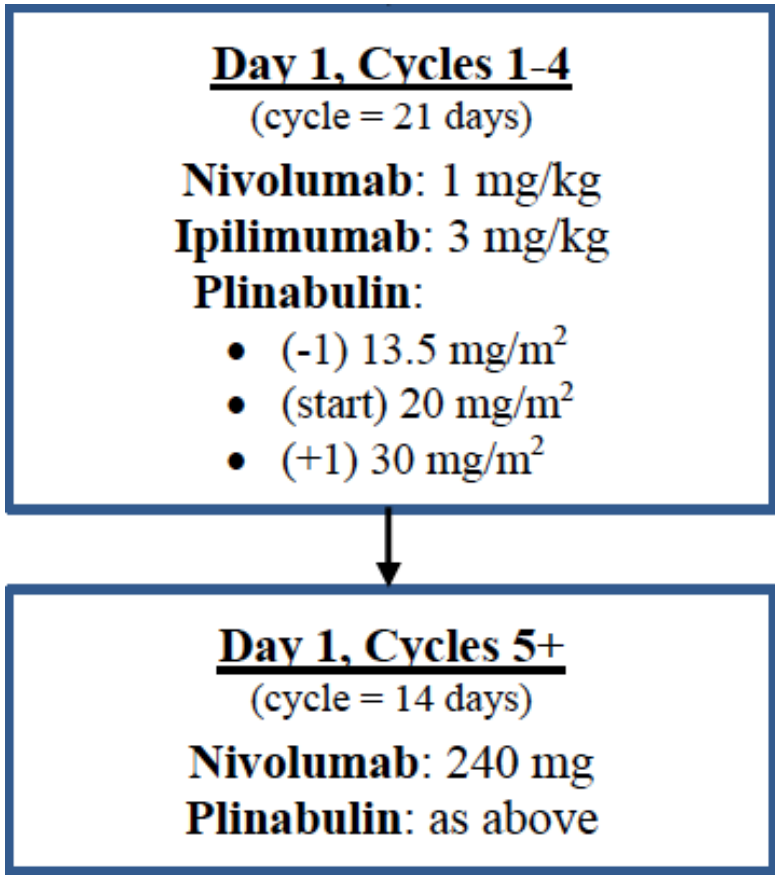
	Indication / Target	Program	Trial Name / Collaborator	Commercial Rights	Status
Triple Combo IO (IIT)	SCLC Checkpoint naïve and checkpoint refractory patients	Plinabulin + Nivolumab (PD-1) + Ipilimumab (CTLA-4)	7 US sites, including Rutgers University as lead center (Big Ten)	Global	Phase 1 completed, Presenting at ASCO June 2021
	SCLC Checkpoint refractory patients	Plinabulin + Nivolumab (PD-1) + Ipilimumab (CTLA-4)	Big Ten Study	Global	Initiating Phase 2
	7 Cancers* PD-1/PDL1 failed pts	Plinabulin + PD-1/PD-L1 + radiation/chemo	MD Anderson	Global	Initiating Phase 1 in 7 cancers in Q2 2021

*NSCLC, SCLC, Renal Cell, Bladder, Merkel Cell, Melanoma, Cancers with high levels of microsatellite instability

Plinabulin+ Nivolumab +Ipilimumab in SCLC: Study Design

Dose-escalation phase I study 3+3 Design

- In patients with extensive-stage SCLC who had progressed on or after prior platinum-based chemotherapy (±PD-1/PD-L1)



Primary objective

- To determine dose-limiting toxicities (DLT's) and recommended Phase 2 dose (RP2D).
  - Patients received treatment until progression or intolerable toxicity.
  - Patients were evaluable for DLT if they received at least 2 cycles of therapy
  - DLT period was defined as the first 6 weeks from C1D1.

Secondary endpoints:

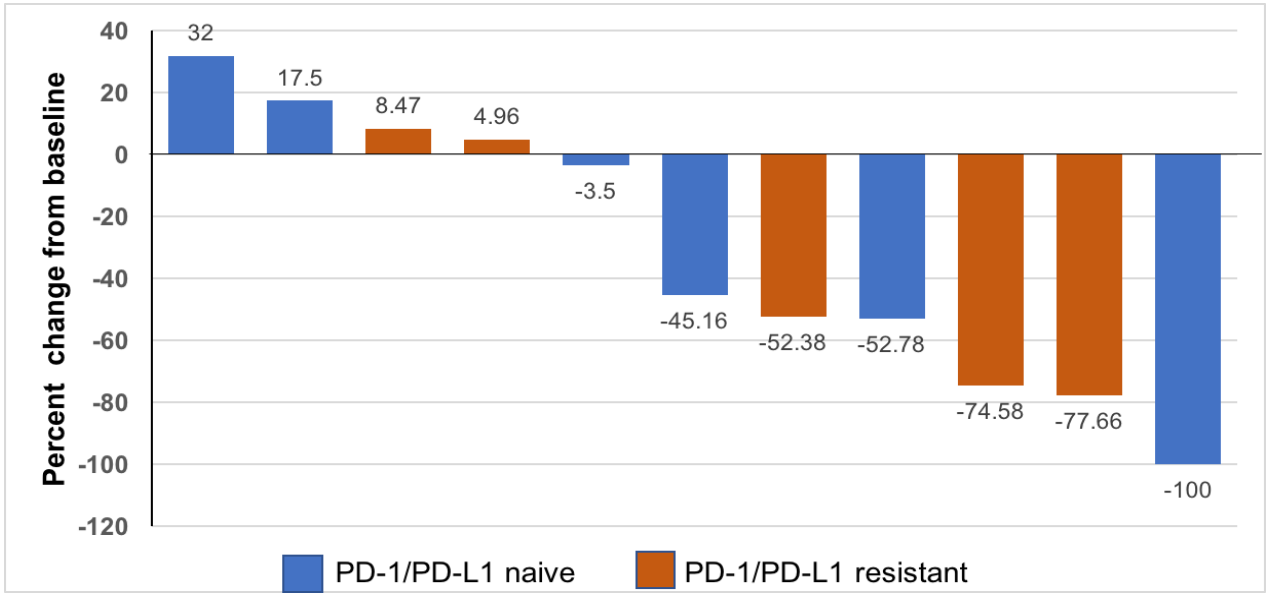
- ORR, PFS
- Frequency of Ir-AEs.

Efficacy Analysis

Data cutoff –December 30,2020

Efficacy Analysis	PD-1/PD-L1 therapy naïve (n= 6)	PD-1/PD-L1 resistant (n=7)
Number of patients with PR	3 (50%)	3 (43%)

*PR –Partial Response - RESIST 1.1 : At least a 30% decrease in the sum of diameters of target lesions, taking as reference the baseline sum diameters.

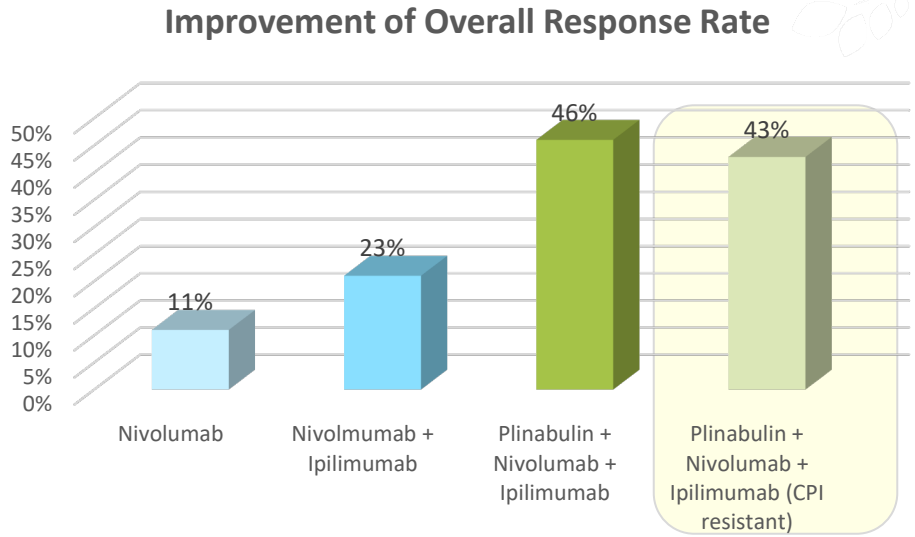


Waterfall plot of best overall response in target lesions compared to baseline

- **13 patients were evaluable for efficacy**
  - 1 withdrew consent,
  - 1 death from unrelated cause,
  - 1 replaced for DLT
- **6 patients had PR (ORR 46%).**
  - There were 3 PRs in PD-1/PD-L1 therapy naïve patients (3/6; 50%).
  - There were 3 PRs in PD-1/PD-L1 resistant patients (3/7; 43%).
  - These 3 patients continued treatment for 3 months, 5 months (still on treatment) and 18 months

Plinabulin+ Nivolumab +Ipilimumab in SCLC: Big Ten ITT Phase 1 Study

Efficacy Summary



Immune-Related AE Summary

Reduction of Grade 3/4 Immune-Related AEs

- Plinabulin + Nivolumab + Ipilimumab: **12.5%**
- Nivolumab +Ipilimumab (historical): **37%**

1.Iams, W.T., Porter, J., Horn, L. Immunotherapeutic approaches for small cell lung cancer, Nat Rev Clin Oncol, 2020 May;17(5):300-312.

Plinabulin as a Potential Synergistic “Cornerstone” Agent in IO Therapy

Data

- High response rate to previous CPI failures (43%)
- Improved Anti-cancer Response (46% ORR vs. 12-23% CPI)
- Durable response (1 pt on combo for 18 M vs. PFS 1.4-2.6 M for CPI)

Conclusion

- Immune system re-sensitized
- Increased antigen presentation simulates T cell activation
- Immune response contributes to long treatment duration

Plinabulin reduces Immune related AE of Checkpoint inhibitors.

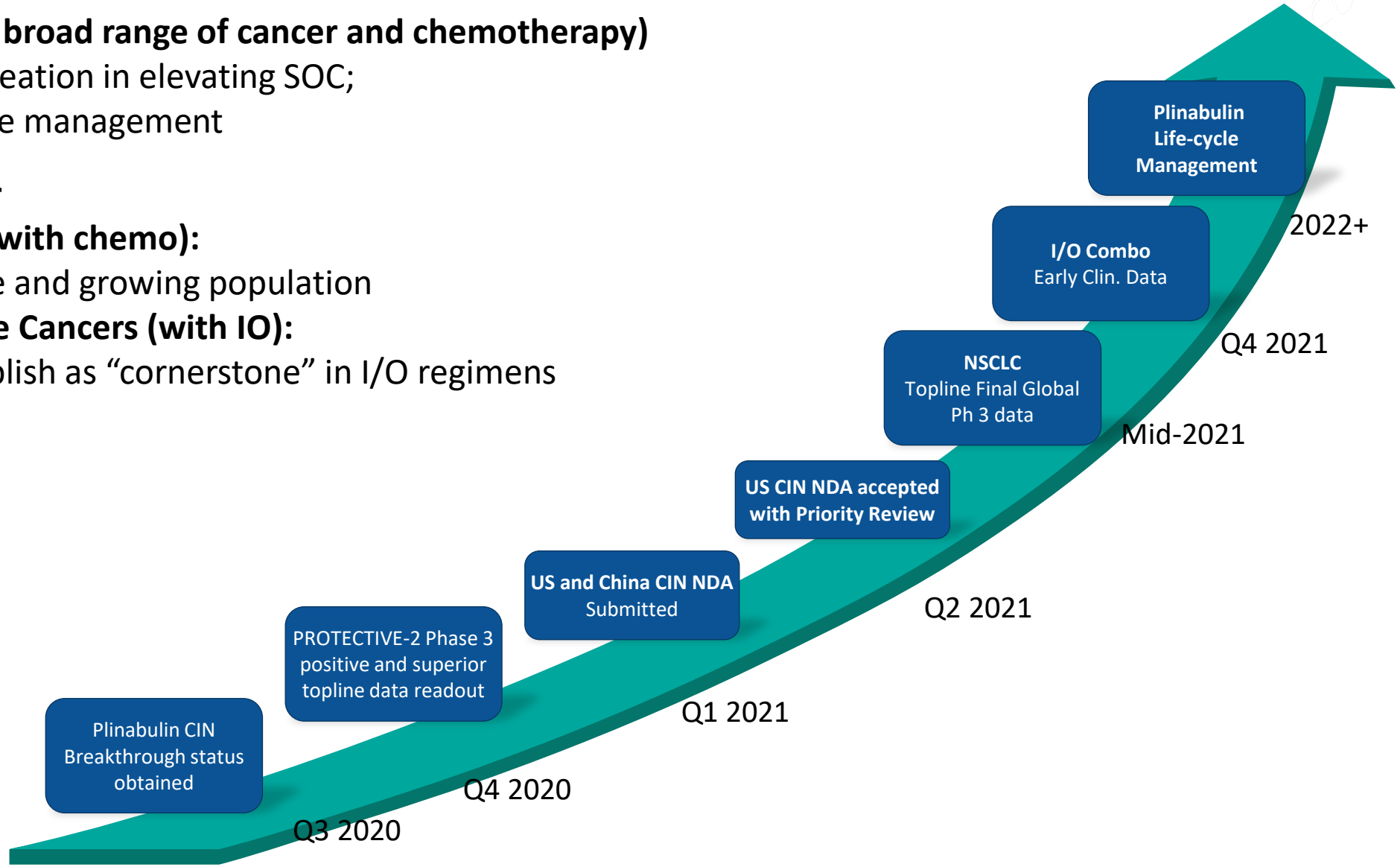
Recent Goals Achieved, Near Term Milestones for Value Creation

CIN (Target broad range of cancer and chemotherapy)

- ✓ Value creation in elevating SOC;
- ✓ Life cycle management

Anti-cancer

- ✓ **NSCLC (with chemo):**
  - Large and growing population
- ✓ **Multiple Cancers (with IO):**
  - Establish as “cornerstone” in I/O regimens



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Corporate Highlights

SEED Therapeutics Subsidiary – Pipeline Potential

SEED: subsidiary pursuing "Molecular Glue" targeted protein degradation to degrade disease-causing proteins previously believed to be undruggable

- $800M collaboration with Eli Lilly on three targets
- Own targets (e.g., KRAS)
- Structure conducive to having additional collaborations

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

Near-term Global Market Opportunities

Plinabulin: Raising SOC in CIN & NSCLC

- ✓ First-in-Class Selective Immunomodulating Microtubule-Binding Agent (SIMBA)
- ✓ IP through 2036 in 36 jurisdictions

CIN: Combo with G-CSF (superior efficacy vs. SOC)

- ✓ US NDA accepted with Priority Review
- ✓ China NDA submitted March 2021
- ✓ Breakthrough Designation (US, China)
- ✓ Global Market: $7B

NSCLC: Combo with docetaxel

- ✓ Final Topline Ph 3 data mid-year 2021
- ✓ Potential NDA submission in 2022
- ✓ $30B+ global market

Broad Pipeline

Plinabulin: A pipeline in a drug

- ✓ Triple combo w/IO agents and radiation/chemo
  - 2 Phase 1/2 trials underway
- ✓ Expansion to additional solid tumors

Three Pre-Clinical I/O Agents

Targeted Protein Degradation Platform

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

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

Attractive COGS - Simple manufacturing process, work with leading global CMOs

Commercialization Planning Underway

Cash position at $90.6M at 3/31/2021 to enable execution on our vision

thank you!

www.beyondspringpharma.com