ASH Investor Event

December 10, 2023

Forward-Looking Statements

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, constitute forward-looking statements. Examples of such forward-looking statements include statements regarding the impact of BeiGene's medicines and drug candidates on the world; BeiGene's ability to transform the industry with more affordable medicines, improved quality and lowered costs; future internal manufacturing capabilities of BeiGene; BeiGene's pipeline programs and related plans as well as recent clinical data and the conduct of clinical trials; expansion of BeiGene medicines into new indications and combinations; and the overall advancement of and anticipated clinical development, regulatory milestones and commercialization of BeiGene's medicines 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 medicines and drug candidates, if approved; BeiGene's ability to obtain and maintain protection of intellectual property for its medicines and technology; BeiGene's reliance on third parties to conduct drug development, manufacturing, commercialization and other services; BeiGene's limited experience in obtaining regulatory approvals and commercializing pharmaceutical products and its ability to obtain additional funding for operations and to complete the development and commercialization of its drug candidates and achieve and maintain profitability, as well as those risks more fully discussed in the section entitled "Risk Factors" in BeiGene's most recent periodic report filed with the U.S. Securities and Exchange Commission ("SEC"), as well as discussions of potential risks, uncertainties, and other important factors in BeiGene's subsequent filings with the SEC. Except where otherwise noted, 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 obtained from these sources is subject to the same qualifications noted above.

Today’s Agenda

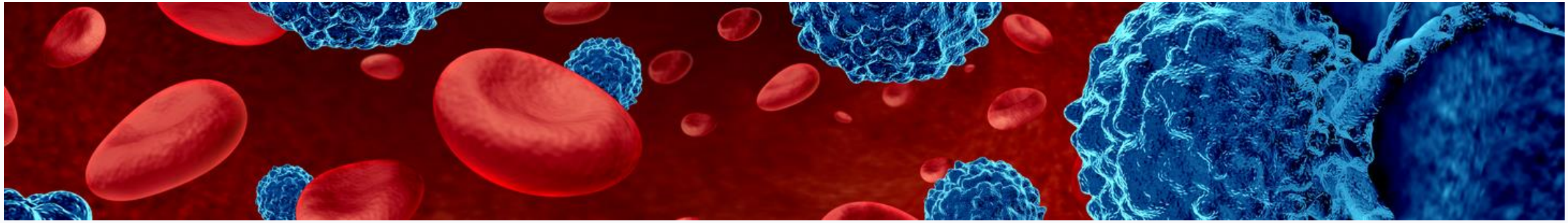
Introduction	**John V. Oyler**	Co-Founder, Chairman and CEO	BeiGene
Our R&D Innovation	**Dr. Lai Wang**	Global Head of R&D	BeiGene
Hematology Franchise Overview	**Dr. Mehrdad Mobasher**	CMO, Hematology	BeiGene
ASH Data - BRUKINSA	**Dr. Mazyar Shadman**	Associate Professor	Fred Hutchinson Cancer Center / University of Washington School of Medicine
ASH Data - Sonrotoclax	**Dr. Constantine Tam**	Head of Lymphoma Service / Professor of Haematology	Alfred Health / Monash University
	Dr. Hang Quach	Professor of Haematology / Director of Clinical Haematology and Clinical Haematology Research	University of Melbourne / St. Vincent's Hospital Melbourne
ASH Data - BGB-16673 (BTK CDAC)	**Dr. John Seymour**	Director of the Department of Haematology	Peter MacCallum Cancer Center / The Royal Melbourne Hospital
Hematology Closing	**Dr. Mehrdad Mobasher**	CMO, Hematology	BeiGene
Q&A Session	**Invited speakers and management team**		
Closing Remarks	**John V. Oyler**		BeiGene

Introduction

John V. Oyler

Co-Founder, Chairman and CEO

Our Goals and Mission as an Oncology Innovator



1 Impact

Become most impactful oncology company to patients everywhere in the world

2 Transform

Transform industry to enable more affordable medicines, to dramatically lower costs, and to speed new medicines to patients

3 Innovate

Innovative, agile and productive leadership in oncology research

Unique Strategic Capabilities

Cost & Time Advantaged Clinical Development

- Advantaged in many rapid recruiting, lower cost countries (e.g., Australia, Poland, Italy, China, Brazil)
- 3000+ strong, CRO-free team*
- Self-developed technology advancements

Commercial Distribution

- Commercial distribution advantages
- Built #1 team in second largest market (and most important for volume)
- Becoming leader in Heme in US, EU, JP
- Active in ROW

Innovation at Scale

- One of largest (1,100+) oncology research teams
- Meaningful speed and cost advantages
- Track record of success

Capacity to Manufacture

- Substantial internal manufacturing capabilities to lower cost and enable speed

* Include FSPs – Functional Service Providers

Our R&D Innovation

Dr. Lai Wang

Global Head of R&D

Delivering Impactful Innovation

Driven by scientific strength, efficient execution and robust decision-making

Pioneering Research	Diverse Modalities	Clinical Development Leadership	Deep Portfolio in Focused Tumor Types	'Fast to PoC'
1,100+ entrepreneurial research team advancing science with urgency and agility	Expertise across diverse platforms allows us to follow the science with optimal modality	CRO-free global development capability, leveraging lower cost and regulatory-friendly markets for fast patient recruitment	Science-based target selection with different modalities in priority tumor types for increased success and combination potential	Delivering clinical PoC faster with high quality and at lower cost. Major prioritization at PoC, the key value inflection point.

Broad research in priority tumor types, cutting edge platforms and technology

PoC = Proof of Concept

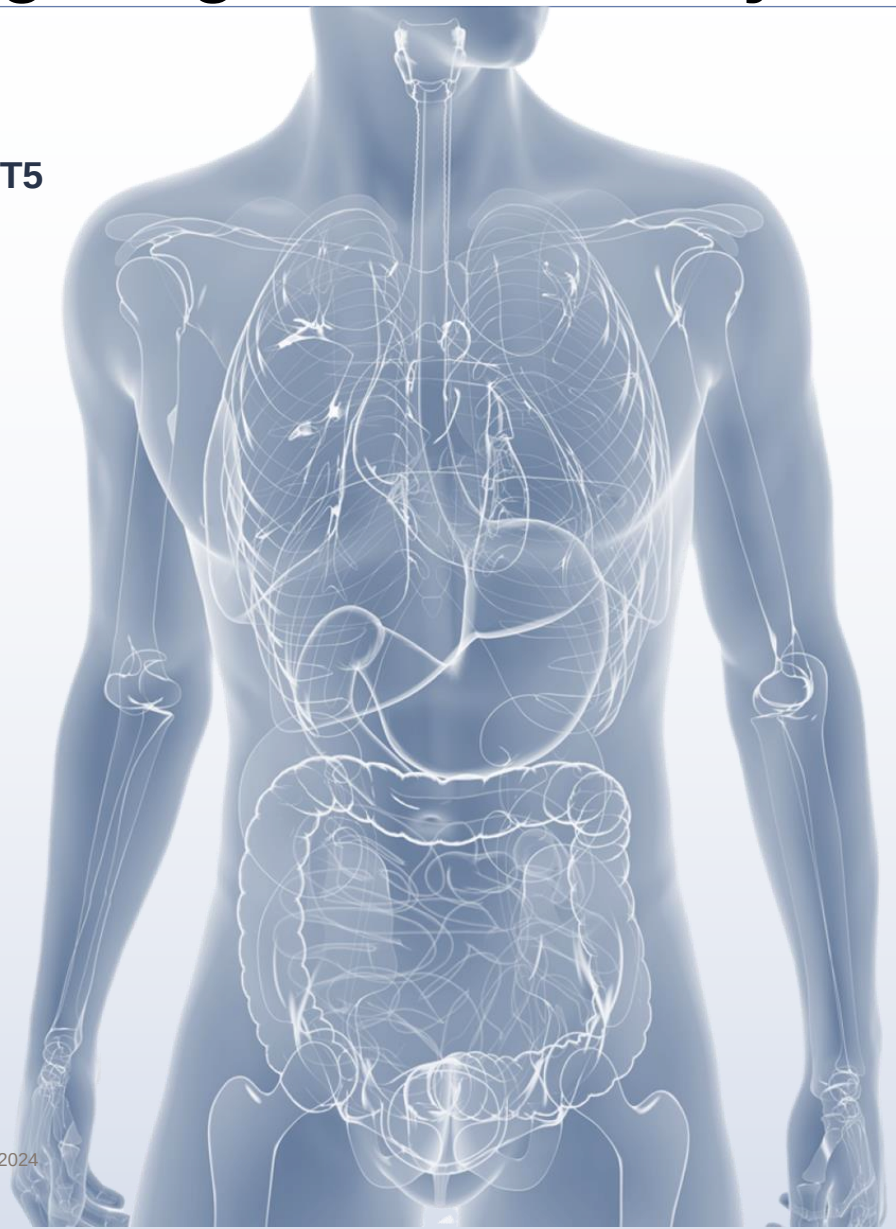
Innovative Solid Tumor Portfolio: Accelerating Programs in Priority Tumor Types

NSCLC
panKRAS
MTA-Cooperative PRMT5
CDK4i
EGFR-CDAC
B7H3-ADC
CEA-ADC
MUC1xCD16
Claudin6xCD3

GI
B7H3-ADC
CEA-ADC
FGFR2b-ADC
panKRAS

Breast
CDK4i*
B7H4-ADC[1]
BCL2i*
CDK2i[2]

Head and Neck
SMAC Mimetic*
B7H3-ADC



*In the clinic
All other molecules planned to enter the clinic in 2024
[1]Exclusive global option from Duality
[2]From Ensem

panKRAS
Addressing broad range of KRAS mutations while sparing NRAS/HRAS in multiple tumor types

MTA-cooperative PRMT5
2nd generation, MTA-cooperative PRMT5 inhibitor selectively kills MTAP-deleted tumor cells avoiding normal hematological cells, with great brain penetration

CDK4i
Highly potent and selective, with robust efficacy and improved tolerability due to low CDK6 affinity

EGFR-CDAC
Differentiated MOA (degrader) to completely abolish EGFR signaling by targeting broad range of EGFR mutations while sparing WT, as well as eliminating scaffold function

Hematology Franchise Overview

Mehrdad Mobasher, M.D., M.P.H.

Chief Medical Officer, Hematology

BeiGene Has a Diverse Hematology Portfolio
24 Abstracts at ASH 2023 from Next Generation Differentiated Assets

BTK inhibitor

BRUKINSA

Superior, deep and durable efficacy and safety across indications, including H2H vs ibrutinib

Highest CR among all BTKi

Broadest label

CLL/SLL, WM, MCL, MZL, FL

Extending lifecycle with novel combination strategies

$15B BTKi class projected in 2028*

Brukinsa® zanubrutinib

*Source: Evaluate Pharma

BCL2 inhibitor

Sonrotoclax

Differentiated efficacy and **safety in 600+ patients** across indications

Broad clinical development plan with BIC potential and **ability to use by all physicians**

Initiated Phase 3 in **TN CLL**

Compelling efficacy and safety in **AML/ MDS** and **Multiple Myeloma**

$4B BCL2i market projected in 2028*

CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
WM - Waldenström's Macroglobulinemia
MCL - Mantle Cell Lymphoma
MZL - Marginal Zone Lymphoma
FL - Follicular Lymphoma

BTK CDAC

BGB-16673

Clinically meaningful data with **128 patients** enrolled

Robust development plans; fast to market opportunity, combinations and phase 3s starting in 2024

Potency and distinct MOA provides opportunities in **Richter's** and **LBCL**

Most advanced BTK degrader to complement and grow franchise including in BTKi resistant patients agnostic of mutations

AML - Acute Myeloid Leukemia
MDS - Myelodysplastic syndromes
MM - Multiple Myeloma
LBCL - Large B-cell Lymphoma
RT - Richter's Transformation

PD-1 inhibitor

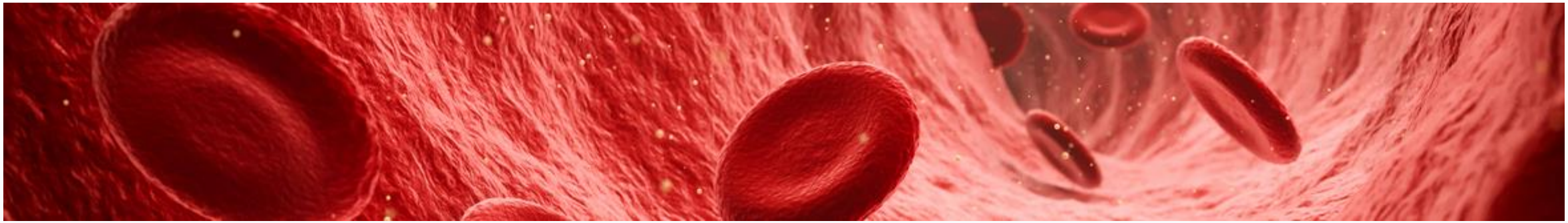
TEVIMBRA

Compelling data in **Richter's transformation** with TEVIMBRA + BRUKINSA

RT- **High unmet medical** need with no SOC

Opportunity in Hodgkin's disease

BeiGene: Accelerating Development of Differentiated Assets as a Leader in Hematology



1 Cement BRUKINSA

Cement BRUKINSA as best-in-class BTKi and only BTKi demonstrating **H2H superiority**

Continue to take market share with broadest label globally and exciting lifecycle strategies

2 Solidify leadership in hematology

Solidify leadership in B-cell malignancies with advancement of novel products: **Sonrotoclax, BTK-CDAC and TEVIMBRA**

- best-in-disease combinations
- strategic treatment sequencing
- fixed duration therapy

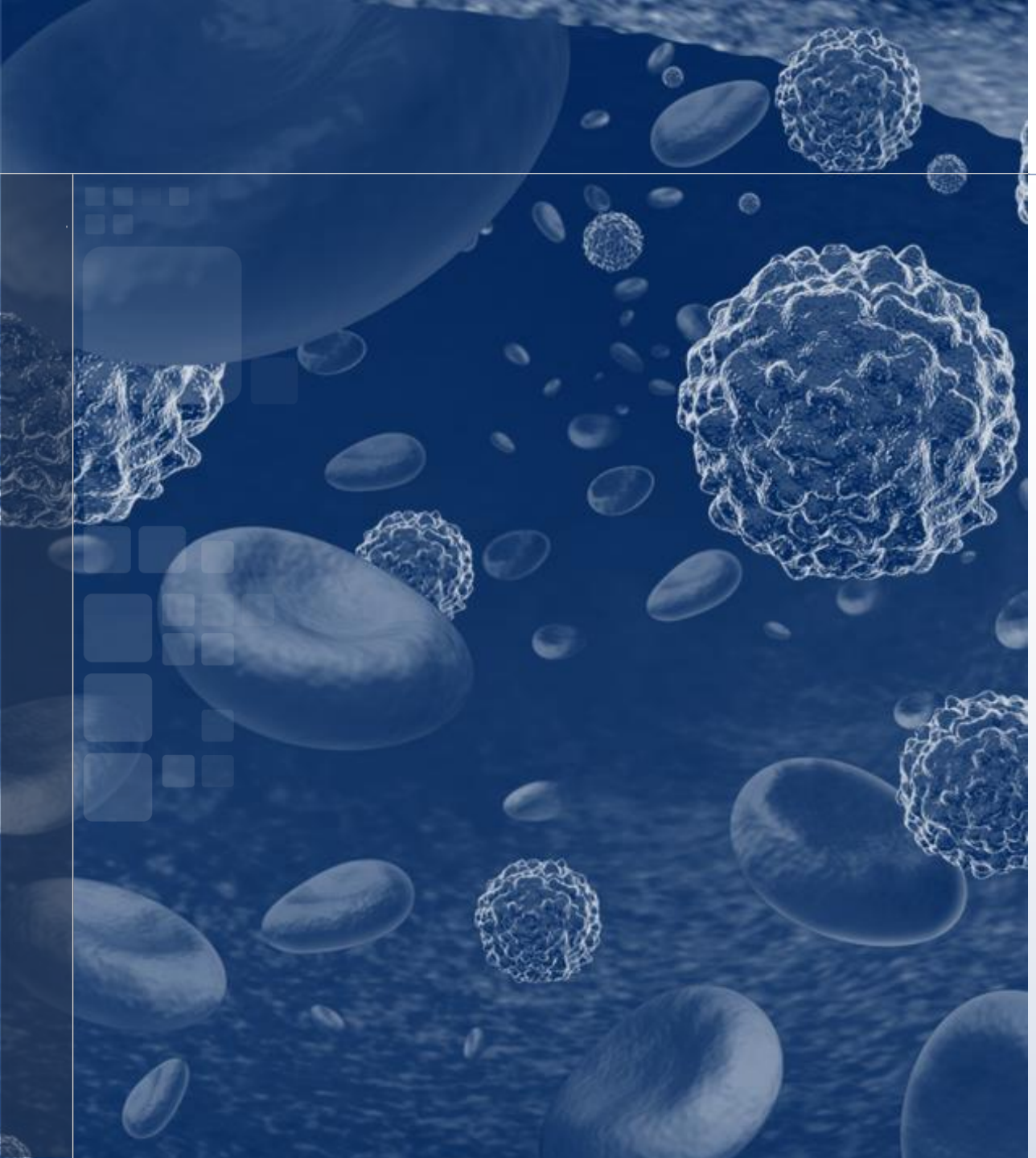
Extend into new indications of high unmet need

3 Expand our footprint and access to medicines

Greater **impact on patient outcomes** with best in disease treatments

BRUKINSA is currently approved in over **65 countries and rapidly growing**

Clinical trials active across 5 continents in **~50 countries**



BRUKINSA

Sonrotoclax

BGB-16673
(BTK CDAC)

TEVIMBRA

Best-in-Class BTKi with Broadest Label Globally

Specific, potent and sustained BTK inhibition

Engineered to exhibit **high potency**, **bioavailability**, and **kinase selectivity** that led to best in disease improved efficacy and safety in indications

~5,000 patients enrolled globally

Efficacy and safety of **BRUKINSA** confirmed in numerous indications **across the globe, in 35+ trials**

Two major Phase 3 head-to-head trials against ibrutinib

Only BTKi to demonstrate PFS and ORR superiority to ibrutinib in **CLL/SLL**

Deeper and **more durable responses in WM** patients than ibrutinib

BTKi with the broadest label

Broadest label:

- **CLL/SLL**
- **WM**
- **MCL**
- **MZL**, and now
- **FL**

Expanding development program

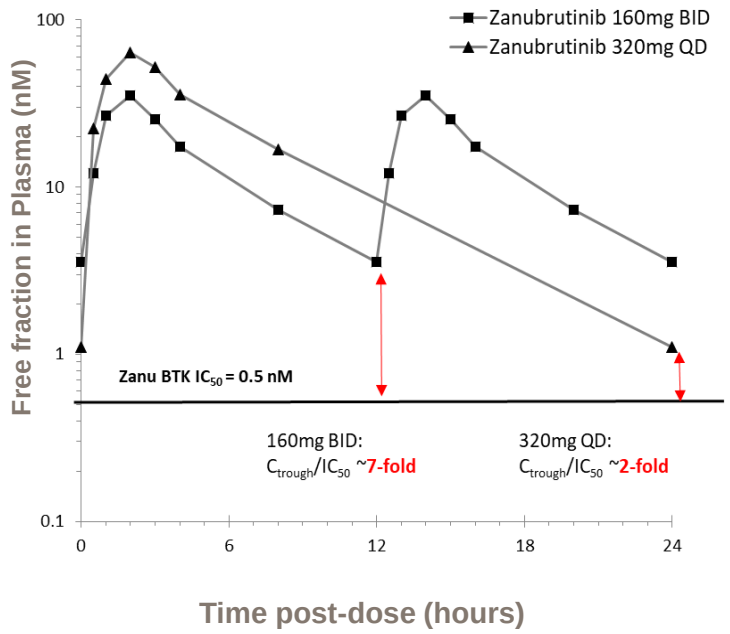
Novel combinations with both external and internal assets (sonrotoclax and TEVIMBRA)

PFS – Progression Free Survival
ORR – Overall Response Rate
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
WM - Waldenström's Macroglobulinemia
MCL - Mantle Cell Lymphoma
MZL - Marginal Zone Lymphoma
FL - Follicular Lymphoma

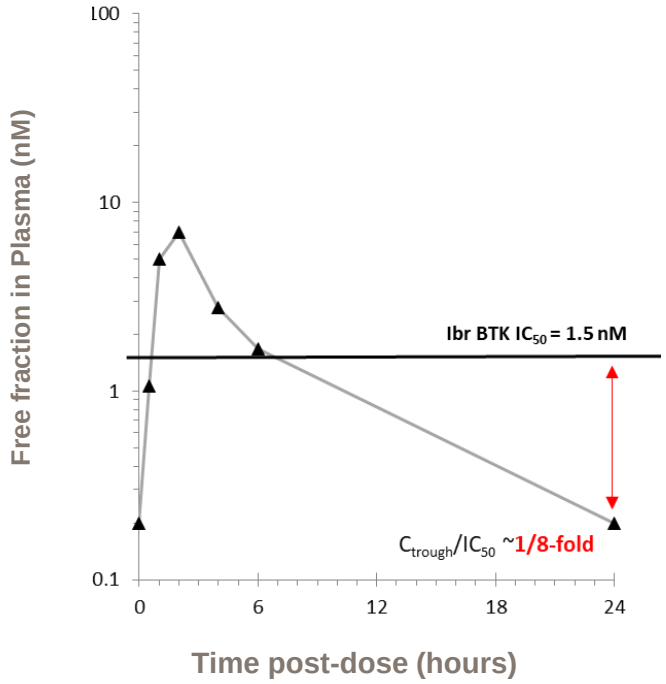
Brukinsa® zanubrutinib

BRUKINSA: Full BTKi IC50 Coverage Over 24 Hours Versus Limited Coverage by Ibrutinib and Acalabrutinib

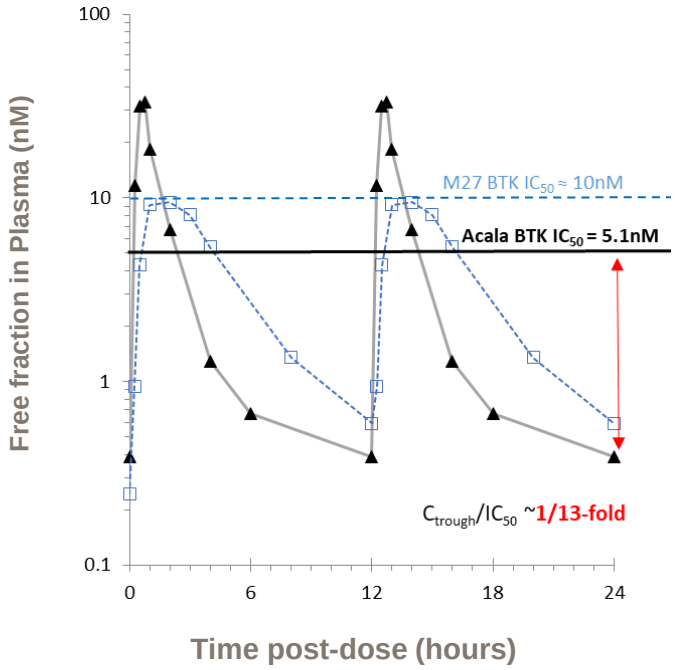
Zanubrutinib



Ibrutinib 560 mg QD



Acalabrutinib 100 mg BID



Free drug concentration time profiles relative to IC50

Source: 1. Kaptein, et al. Blood. 2018;132:1871. 2. Ou, et al. Leuk Lymphoma. In press. 3. Marostica, et al. Cancer Chemother Pharmacol. 2015;75:111-121.0 QD, Quaque Die; BID, Bis in die

ASH 2023 Clinical Presentations

Study	Title	First author/significance	Date / time
BGB-3111-305 (ALPINE) RR CLL	Extended Follow-up of ALPINE Randomized Phase 3 Study Confirms Sustained Superior Progression-Free Survival of Zanubrutinib Vs. Ibrutinib for Treatment of R/R CLL/SLL	**Jennifer R. Brown, MD, PhD** Sustained PFS superiority data of BRUKINSA over ibrutinib at median follow up of 39 months ELEVATE-RR study of acalabrutinib showed only non-inferiority at similar time point	Oral 12/09/2023 2:45 pm
BGB-3111-215	Zanubrutinib in Acalabrutinib-Intolerant Patients with B-Cell Malignancies	**Mazyar Shadman, MD, MPH** Data indicating the advantage for patients who are intolerant to acalabrutinib to switch to BRUKINSA	Poster 3279 12/10/2023 6:00 pm
Long Term Extension (LTE-1) Study WM	Clinical Outcomes in Patients with Waldenström Macroglobulinemia Receiving Ibrutinib on the Phase 3 ASPEN Study ≥1 Year After Transitioning to Zanubrutinib	**Ramon Garcia-Sanz, MD** Data demonstrating advantages for WM patients who switch to BRUKINSA from ibrutinib in the ASPEN study	Poster 3043 12/10/2023 6:00 pm

Dr. Mazyar Shadman

- **Dr. Shadman** focuses on lymphoid malignancies with a clinical research goal to identify the best treatment sequence or combination for patients with high-risk lymphoma and CLL
- Innovators Network Endowed Chair
- Associate Professor, Lymphoid Malignancies and Immunotherapy Fred Hutchinson Cancer Center
- Associate Professor, Hematology and Medical Oncology Division University of Washington School of Medicine
- He received his M.P.H in, Cancer Epidemiology from the University of Washington, and his M.D. from Tehran University of Medical Sciences
- Dr. Shadman held a Hematology and Medical Oncology fellowship from the University of Washington/Fred Hutchinson Cancer Research Center (2011-2014, and did his Internal Medicine Residency at Cleveland Clinic (2008-2011)

BIOGRAPHY

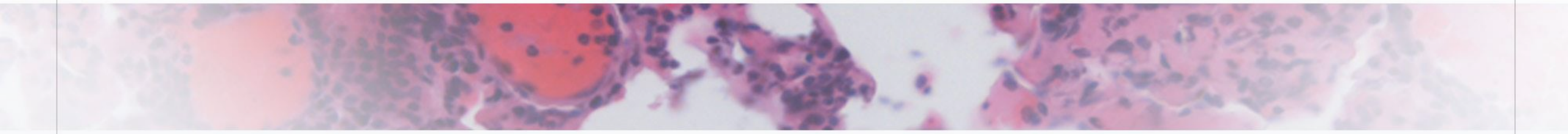
Fred Hutch Cancer Center

UW Medicine

Mazyar Shadman, M.D., M.P.H

Associate Professor,
Fred Hutch Cancer Center and
University of Washington

American Society of Hematology
Helping hematologists conquer blood diseases worldwide



Extended Follow-up of ALPINE Randomized Phase 3 Study Confirms Sustained Superior Progression-Free Survival of Zanubrutinib Versus Ibrutinib for Treatment of Relapsed/Refractory Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma (R/R CLL/SLL)

Jennifer R. Brown, MD, PhD[1]; Barbara Eichhorst, MD[2]; Nicole Lamanna, MD[3]; Susan M. O'Brien, MD[4]; Constantine S. Tam, MBBS, MD[5,6]; Lugui Qiu, MD[7]; Maciej Kaźmierczak, MD, PhD[8]; Wojciech Jurczak, MD, PhD[9]; Keshu Zhou, MD, PhD[10]; Martin Simkovic, MD, PhD[11,12]; Jiri Mayer, MD[13]; Amanda Gillespie-Twardy, MD[14]; Alessandra Ferrajoli, MD[15]; Peter S. Ganly, BMBCh, MD[16]; Robert Weinkove, MBBS, PhD[17,18]; Sebastian Grosicki, MD, PhD[19]; Andrzej Mital, MD, PhD[20]; Tadeusz Robak, MD, PhD[21]; Anders Osterborg, MD, PhD[22,23]; Habte A. Yimer, MD[24]; Megan (Der Yu) Wang, PharmD[25]; Tommi Salmi, MD[26]; Jessica Li, MS[27]; Kenneth Wu, PhD[25]; Aileen Cohen, MD, PhD[25]; **Mazyar Shadman, MD, MPH[28,29]**

[1]Department of Medical Oncology, Dana-Farber Cancer Institute, Boston, MA, USA; [2]Department of Internal Medicine, University of Cologne, Center for Integrated Oncology Aachen, Bonn, Cologne, Duesseldorf, Cologne, Germany; [3]Herbert Irving Comprehensive Cancer Center, Columbia University, New York, NY, USA; [4]Chao Family Comprehensive Cancer Center, University of California, Irvine, CA, USA; [5]The Alfred Hospital, Melbourne, Victoria, Australia; [6]University of Melbourne, Melbourne, Victoria, Australia; [7]State Key Laboratory of Experimental Hematology, National Clinical Research Center for Hematological Disorders, Institute of Hematology and Blood Diseases Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College, Tianjin, China; [8]Department of Hematology and Bone Marrow Transplantation, Poznan University of Medical Sciences, Poznan, Poland; [9]MSC National Research Institute of Oncology, Krakow, Poland; [10]Affiliated Cancer Hospital of Zhengzhou University, Henan Cancer Hospital, Zhengzhou, China; [11]4th Department of Internal Medicine – Haematology, Faculty of Medicine in Hradec Králové, University Hospital and Charles University in Prague, Hradec Kralove, Czech Republic; [12]Faculty of Medicine, Charles University, Prague, Czech Republic; [13]Department of Internal Medicine-Hematology and Oncology, Masaryk University and University Hospital, Brno, Czech Republic; [14]Blue Ridge Cancer Care, Roanoke, VA, USA; [15]Department of Leukemia, The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [16]Department of Haematology, Christchurch Hospital, Christchurch, New Zealand; [17]Te Rerenga Ora Blood and Cancer Centre, Te Whatu Ora Health New Zealand Capital Coast & Hutt Valley, Wellington, New Zealand; [18]Cancer Immunotherapy Programme, Malaghan Institute of Medical Research, Wellington, New Zealand; [19]Medical University of Silesia, Katowice, Poland; [20]Department of Hematology and Transplantology, Medical University of Gdańsk, Gdańsk, Poland; [21]Medical University of Lodz, Lodz, Poland; [22]Department of Oncology-Pathology, Karolinska Institutet, Stockholm, Sweden; [23]Department of Hematology, Karolinska University Hospital, Stockholm, Sweden; [24]Texas Oncology-Tyler/US Oncology Research, Tyler, TX, USA; [25]BeiGene USA, Inc., San Mateo, CA, USA; [26]BeiGene International GmbH, Basel, Switzerland; [27]BeiGene (Beijing) Co., Ltd., Beijing, China; [28]Fred Hutchinson Cancer Center, Seattle, WA, USA; [29]Department of Medicine, University of Washington, Seattle, WA, USA

ALPINE Study Design (NCT03734016) in R/R CLL/SLL

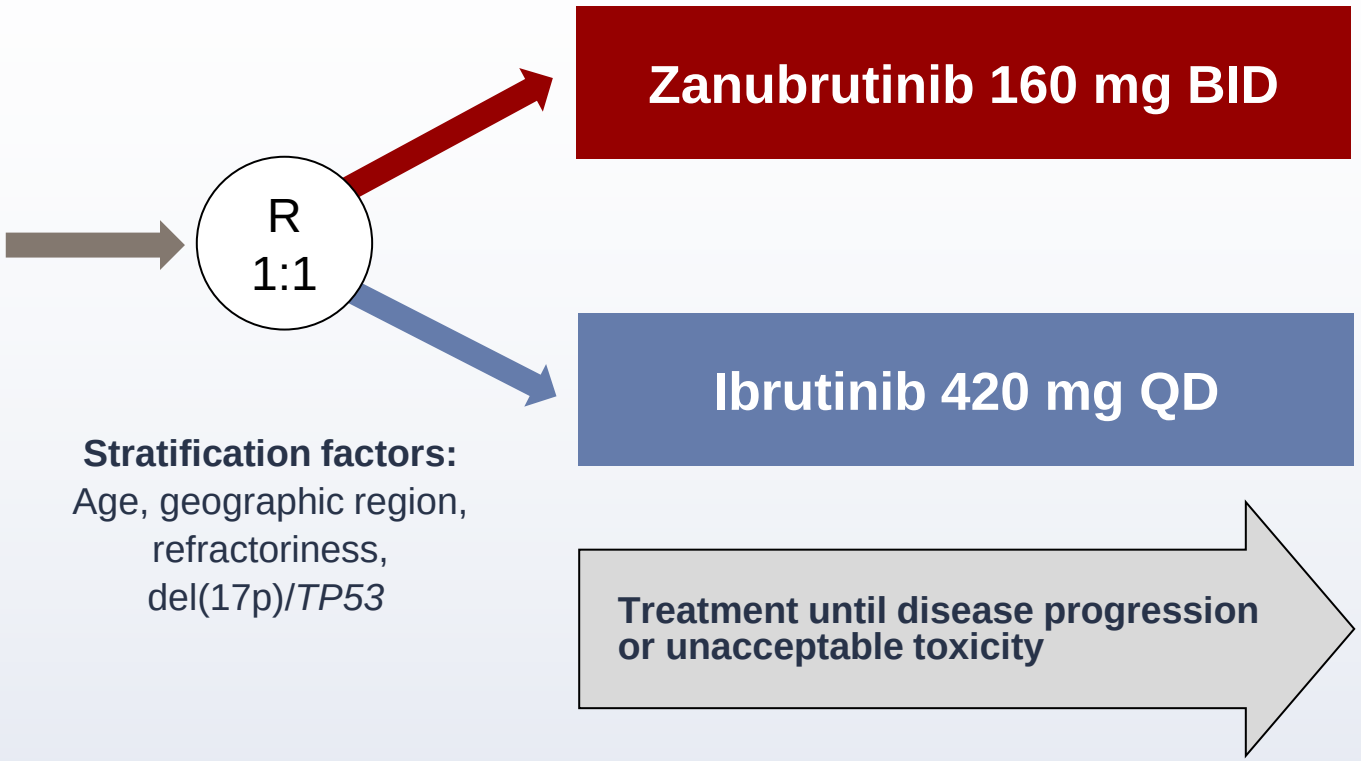
R/R CLL/SLL with ≥1 prior treatment
(N=652)

Key inclusion criteria

- R/R to ≥1 prior systemic therapy for CLL/SLL
- Measurable lymphadenopathy by CT or MRI

Key exclusion criteria

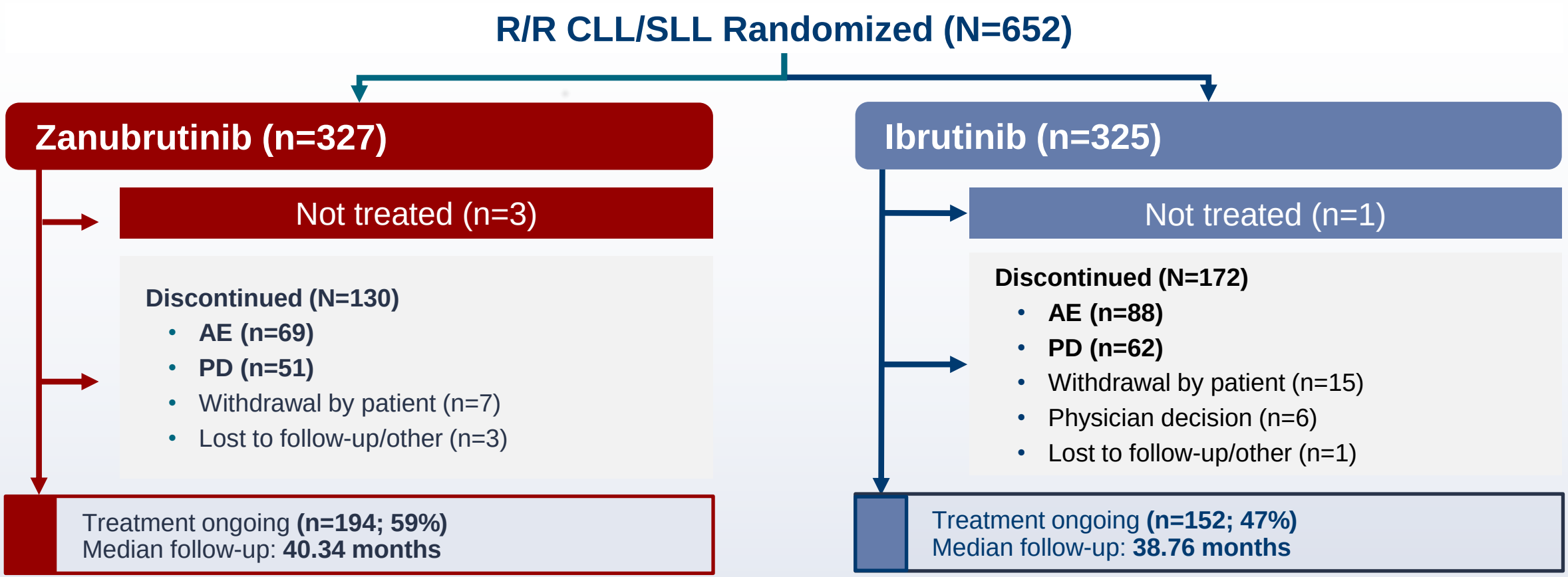
- Prior BTK inhibitor therapy
- Treatment with warfarin or other vitamin K antagonists



Brown JR, Eichhorst B, Hillmen P, et al. N Engl J Med. 2023;388:319-332.

Abbreviations: BID, twice daily; CT, computed tomography; MRI, magnetic resonance imaging; QD, once daily; R, randomized.

ALPINE Patient Disposition at Extended Follow-up Across Arms, Median Study Follow-up Was 39 Months

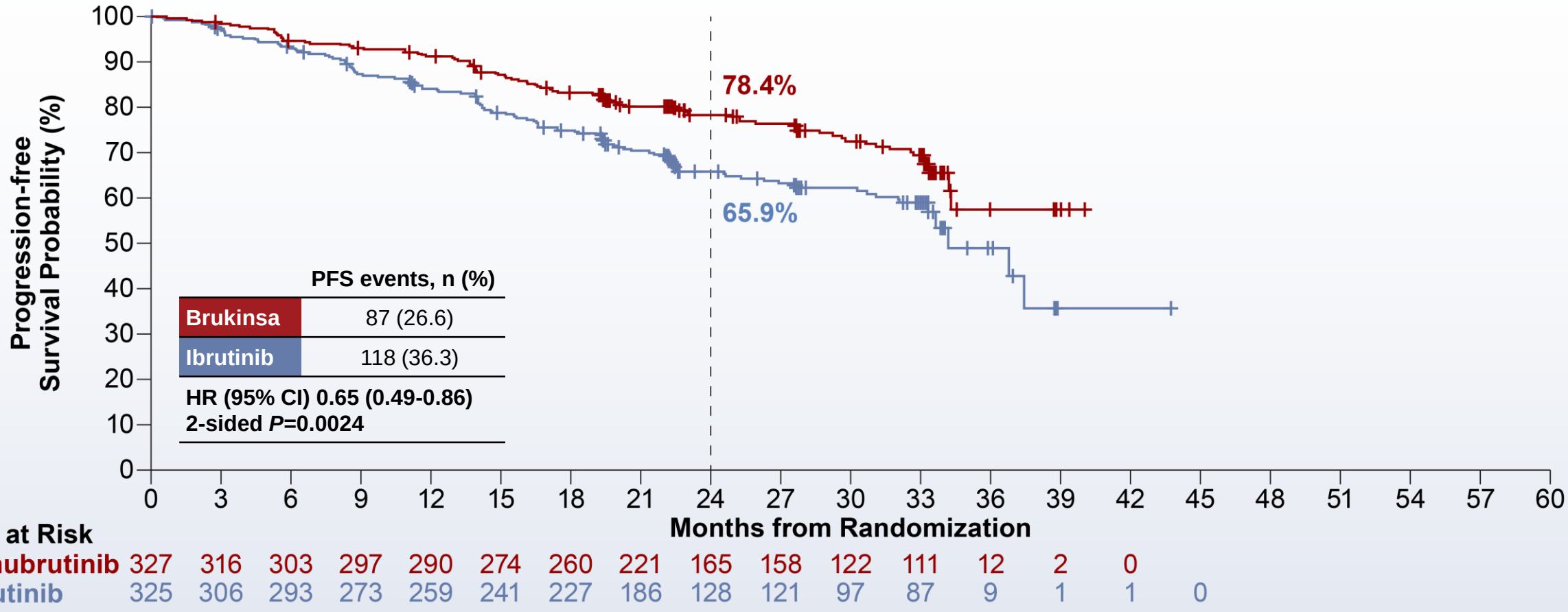


R/R – Relapsed Refractory
AE – Adverse Event
PD – Progressive Disease
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma

Data cutoff: September, 2023

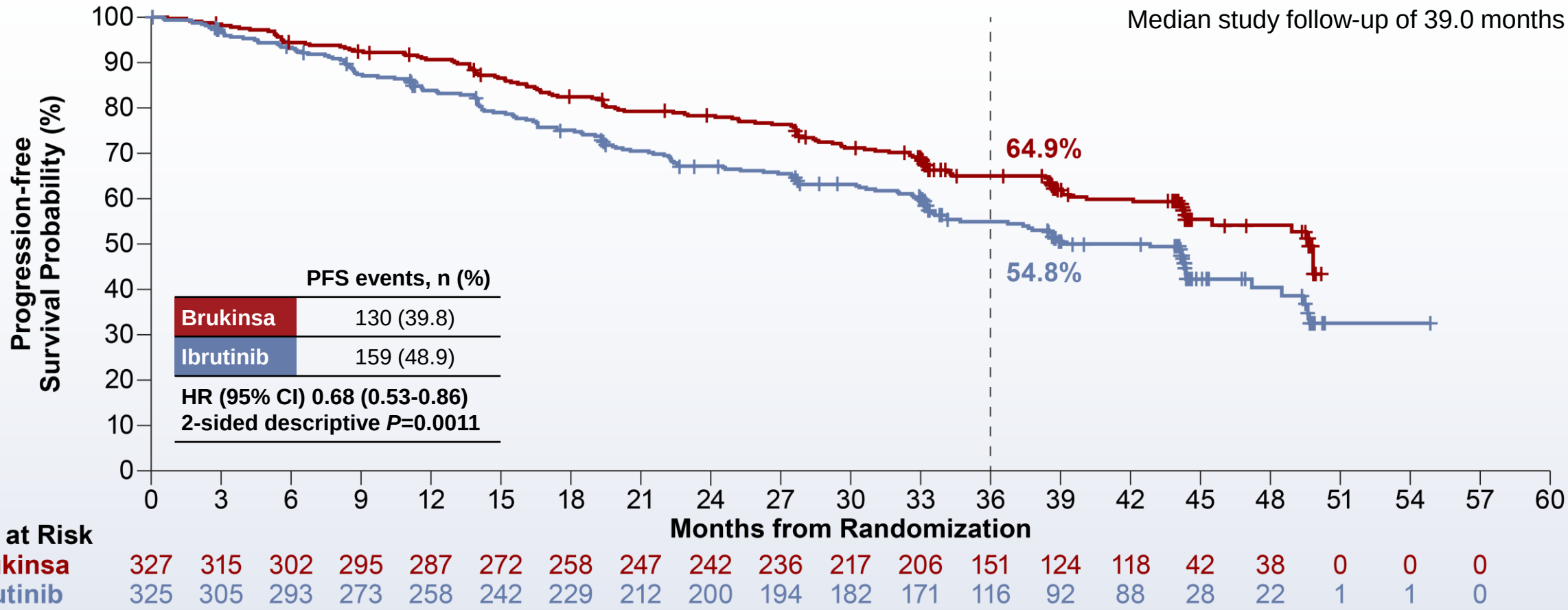
Previous Report Demonstrated Clinical and Statistical Superiority to Ibrutinib

Median study follow-up of 29.6 months



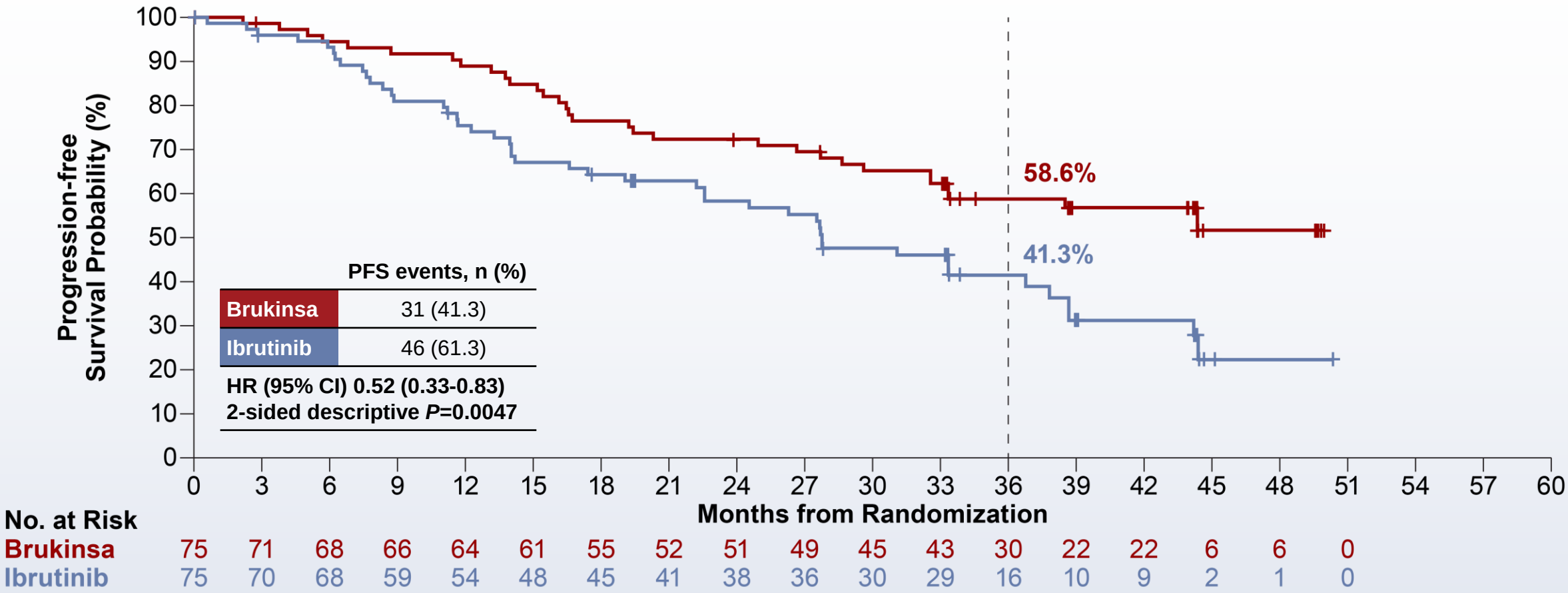
Brown JR, Eichhorst B, Hillmen P, et al. N Engl J Med. 2023;388:319-332.
Data cutoff: August 8, 2022

With Longer Follow-up, ALPINE Demonstrated Sustained PFS Benefit Over Ibrutinib



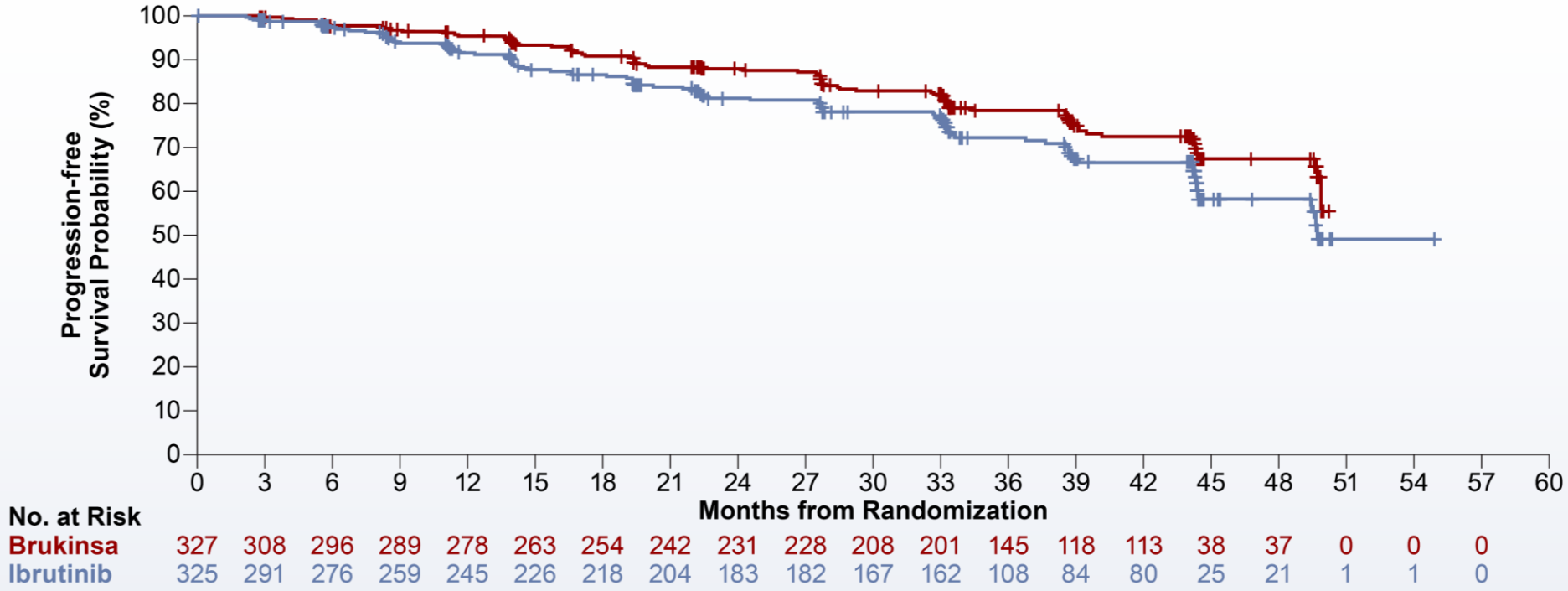
Data cutoff: September, 2023

PFS Benefit Over Ibrutinib Demonstrated in Patients with del(17p)/TP53mut



Data cutoff: September 2023

PFS Benefit Is Consistent Across Multiple Sensitivity Analyses

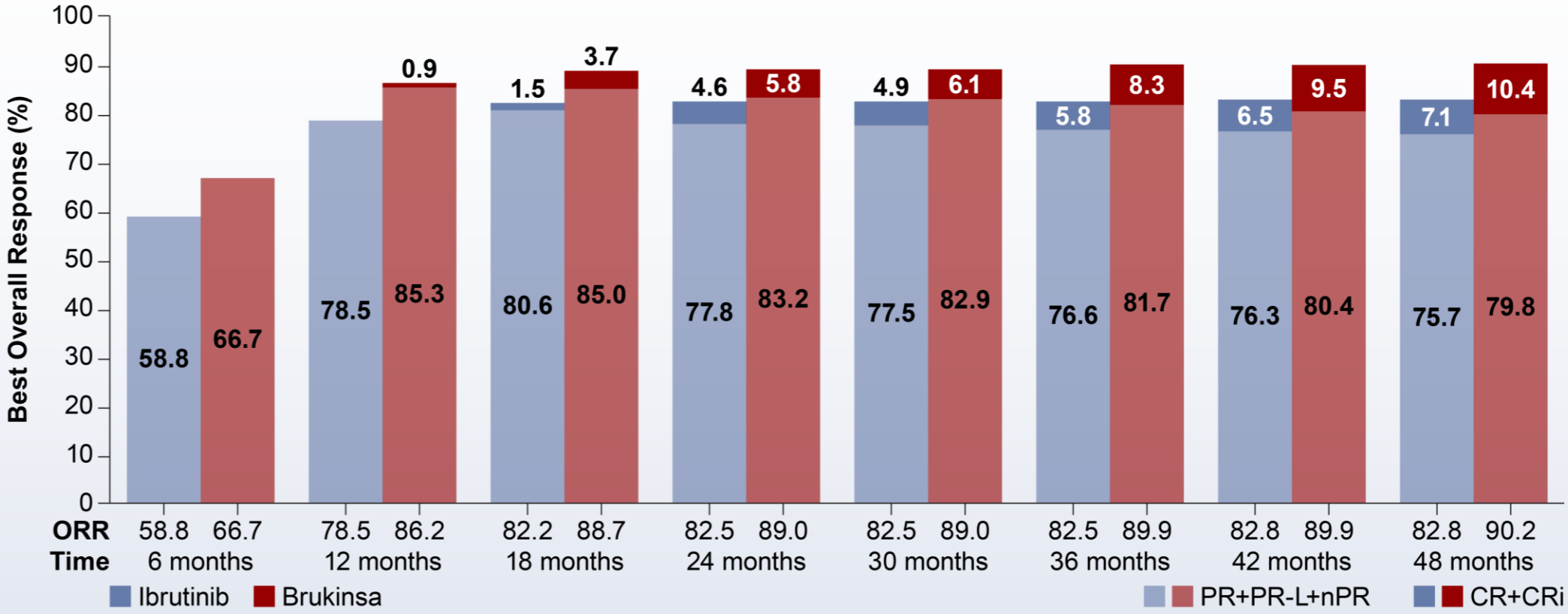


Analysis Type	Zanubrutinib - n (%)	Ibrutinib - n (%)	HR (95% CI)	2-sided *P*-value
On active treatment	76 (23.2)	85 (26.2)	0.69 (0.50, 0.95)	0.0206
Prior to new therapies	129 (39.4)	157 (48.3)	0.68 (0.54, 0.86)	0.0014
Without COVID-19 deaths	115 (35.2)	142 (43.7)	0.66 (0.52, 0.85)	0.0013

Data cutoff: September, 2023

Responses Deepen Over Time with Zanubrutinib

More patients achieved CR with zanubrutinib with longer follow-up with CR/CRi rates of 5.8% and 10.4% at 24 and 48 months

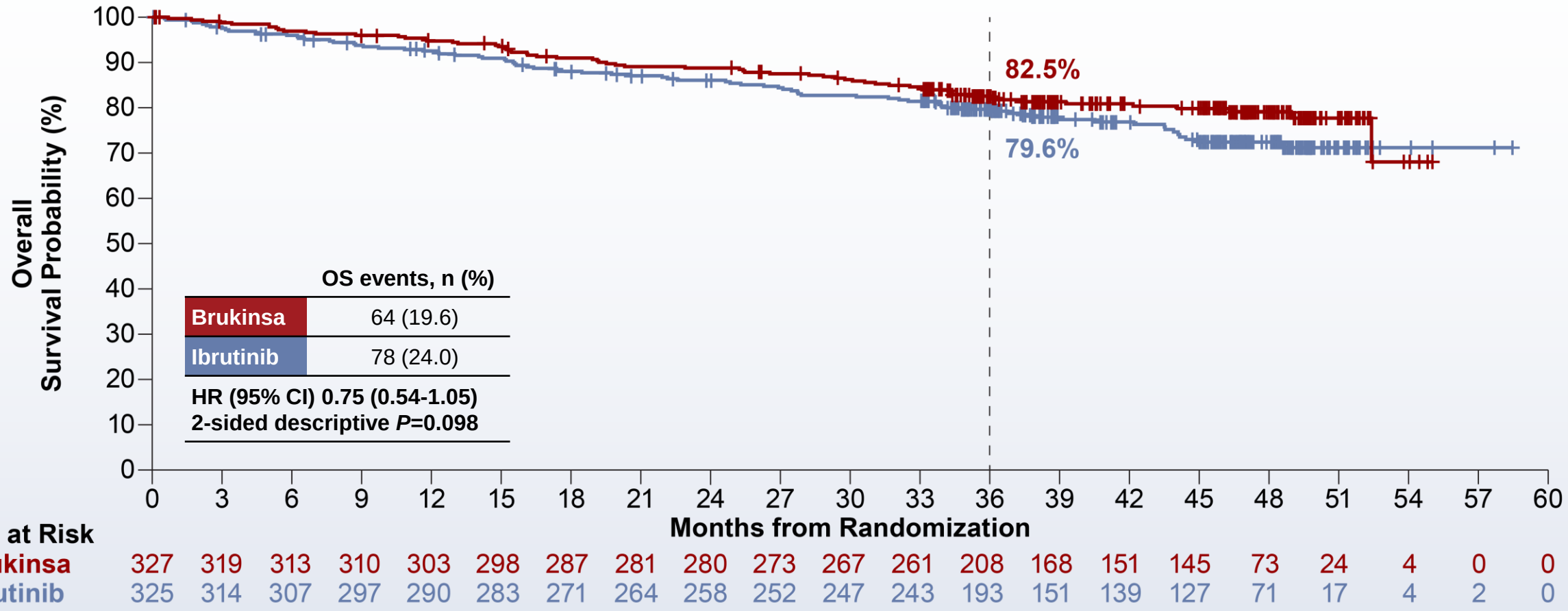


In the ASCEND study, CR rate for acalabrutinib was 5% with 46.5 months follow-up

CR – Complete Remission
CRi – Complete Remission with incomplete count recovery

Data cutoff: September 2023

Overall Survival at Longer Follow-up Demonstrates Fewer Deaths with Zanubrutinib Compared with Ibrutinib



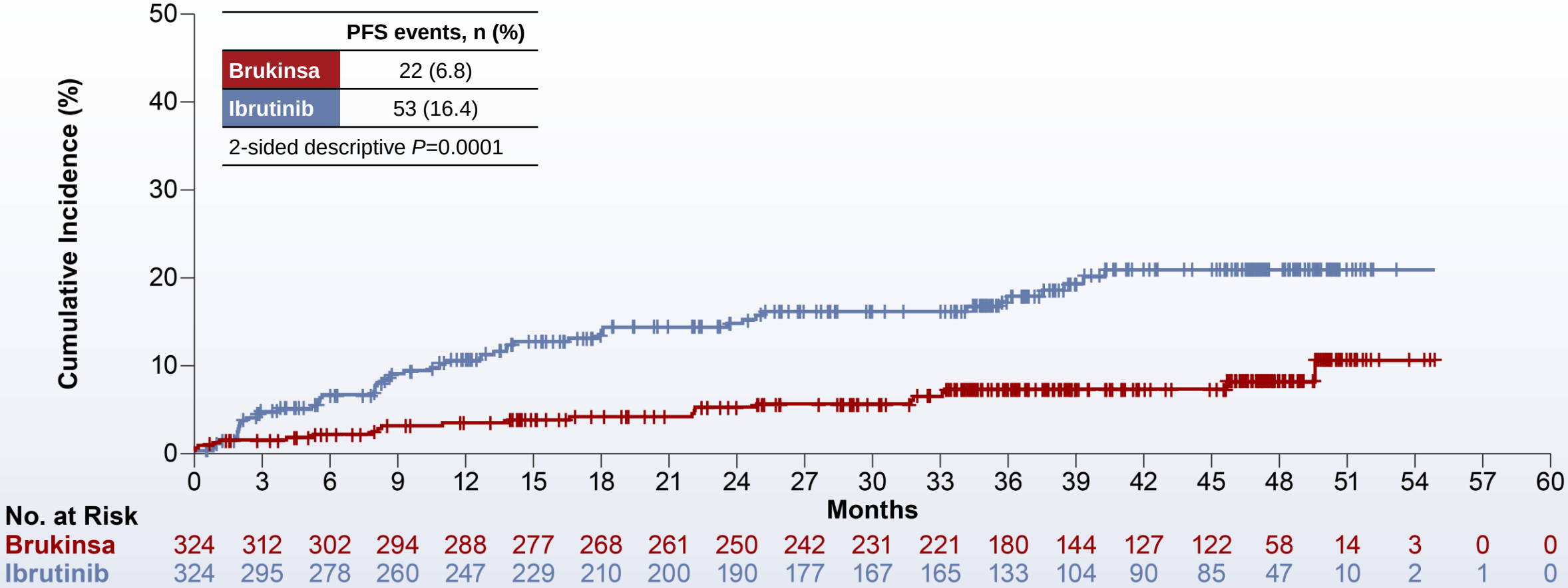
Data cutoff: September 2023

Overall Safety/Tolerability Profile Remained Favorable Versus Ibrutinib

	Zanubrutinib (n=324)	Ibrutinib (n=324)
Median treatment duration, months	**38.3 (0.4, 54.9)**	**35.0 (0.1, 58.4)**
Any grade adverse event	**320 (98.8)**	**323 (99.7)**
Grade 3 to 5	235 (72.5)	251 (77.5)
Grade 5	41 (12.7)	40 (12.3)
Serious adverse event	**165 (50.9)**	**191 (59.0)**
Adverse events leading to		
Dose reduction	**47 (14.5)**	**59 (18.2)**
Dose interruption	**196 (60.5)**	**201 (62.0)**
Treatment discontinuation	**64 (19.8)**	**85 (26.2)**

Data cutoff: September,2023

Significantly Fewer Atrial Fibrillation/Flutter Events than with Ibrutinib



Median study follow-up 39.0 months
Data cutoff: September 2023

Continues to Demonstrate a More Favorable Cardiac Safety Profile

- Serious cardiac adverse events were lower with zanubrutinib vs. ibrutinib
  - Atrial fibrillation/flutter (3 vs. 13)
  - Ventricular fibrillation (0 vs. 2)
  - MI[a]/Acute coronary syndrome (3 vs. 3)
- **Fatal cardiac events[b]:**
  - **Zanubrutinib, n=0 (0%)**
  - **Ibrutinib, n=6 (1.9%)**

	Zanubrutinib (n=324)	Ibrutinib (n=324)
Cardiac adverse events	**80 (24.7)**	**112 (34.6)**
Serious cardiac adverse events	**11 (3.4)**	**31 (9.6)**
Cardiac adverse events leading to treatment discontinuation	**3 (0.9)**	**15 (4.6)**
Ventricular extrasystoles	1 (0.3)	0
Atrial fibrillation/flutter	1 (0.3)	6 (1.9)
Cardiac failure	1 (0.3)	2 (0.6)
Cardiac arrest	0	2 (0.6)[b]
Cardiac failure acute	0	1 (0.3)[b]
Congestive cardiomyopathy	0	1 (0.3)[b]
Myocardial infarction	0	1 (0.3)[b]
Palpitations	0	1 (0.3)
Ventricular fibrillation	0	1 (0.3)

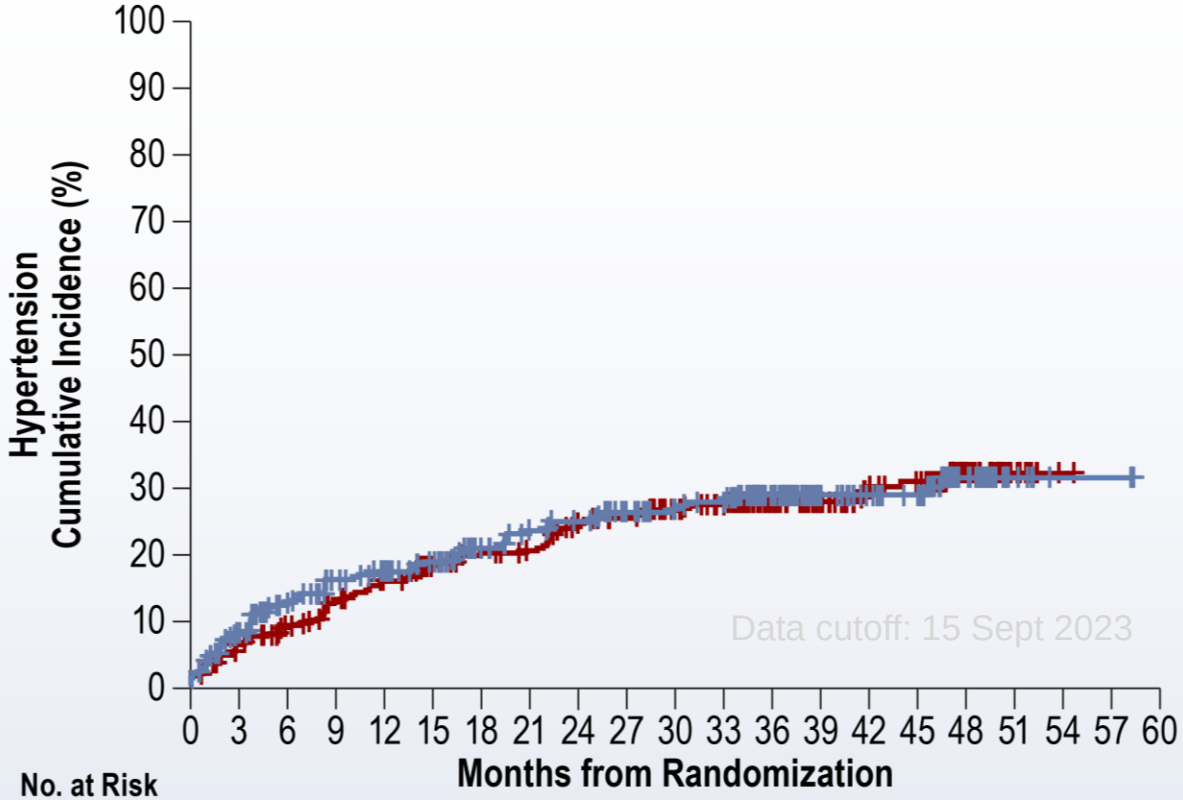
Abbreviations: A fib, atrial fibrillation; ACS, acute coronary syndrome; CHF, congestive heart failure; MI, myocardial infarction.

[a]Including acute MI.

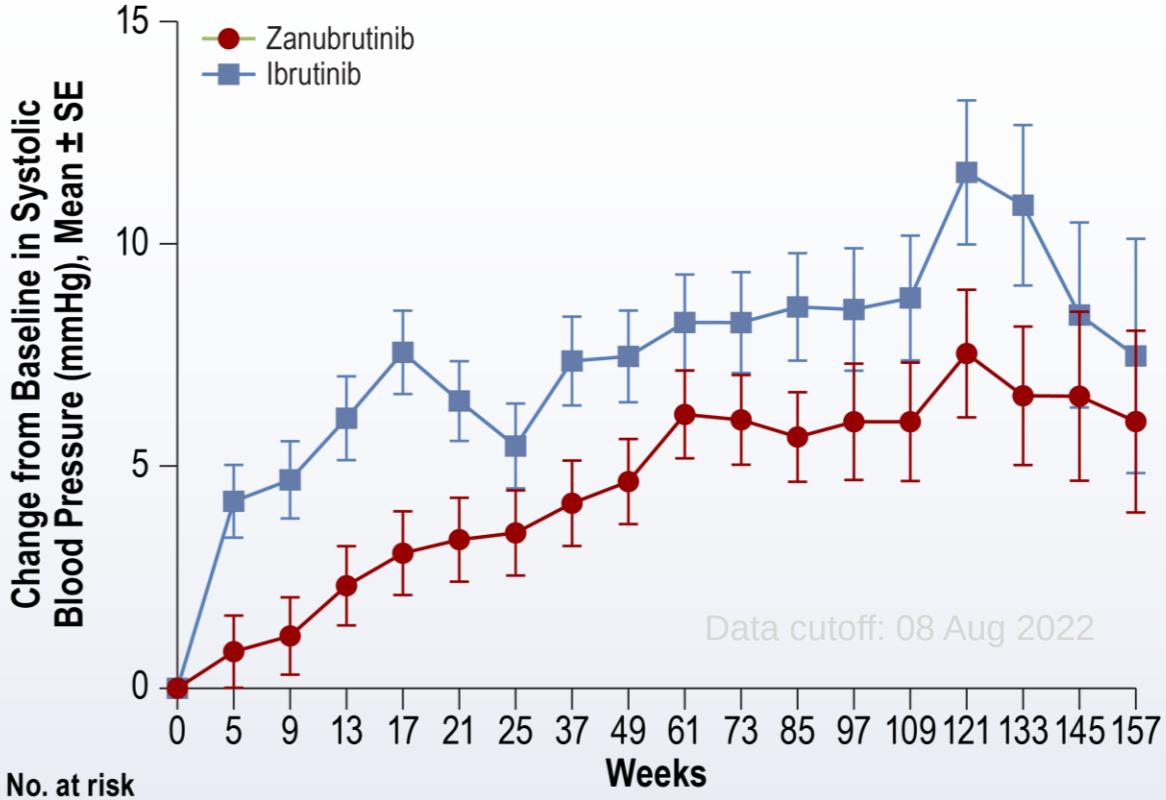
[b]Fatal cardiac event (n=6); 1 death (myocardial infarction with ibrutinib) was not listed due to discontinuation due to diarrhea 14 days prior to the fatal event.

Data cutoff: September 2023

Despite Similar Hypertension Rates Change in Systolic Blood Pressure Was Lower with Zanubrutinib



No. at Risk																				
Brukinsa	324	296	279	262	247	232	220	215	196	188	175	165	133	108	91	86	37	10	1	0	0
Ibrutinib	324	280	253	231	221	207	185	172	164	150	140	136	108	79	69	64	32	7	2	2	0

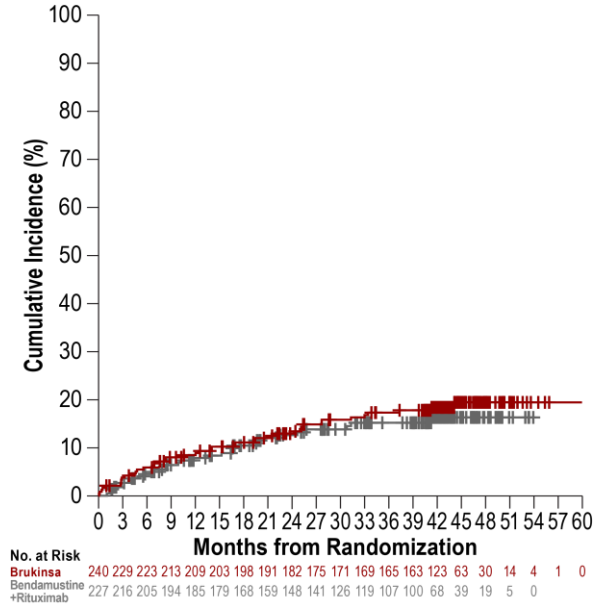


No. at risk																				
Brukinsa	327	316	317	314	308	298	295	298	288	281	267	268	231	191	164	150	114	51		
Ibrutinib	325	317	311	301	293	279	278	268	255	248	230	223	190	145	124	112	93	42		

ALPINE Hypertension Rates Are an Outlier From Other Phase 3 Zanubrutinib Studies

BRUKINSA
BTK inhibitor

SEQUOIA (TN CLL)

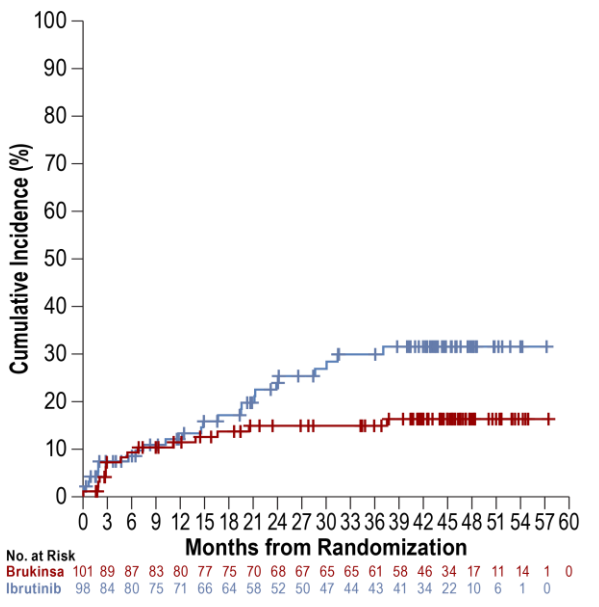


Median follow-up: **43 months**

Data cutoff: October, 2022

- Zanubrutinib vs fixed duration (n=6 months) BR have similar rates of hypertension
- These data suggest that the hypertension rate for zanubrutinib is similar to background as the curves overlap

ASPEN (WM)

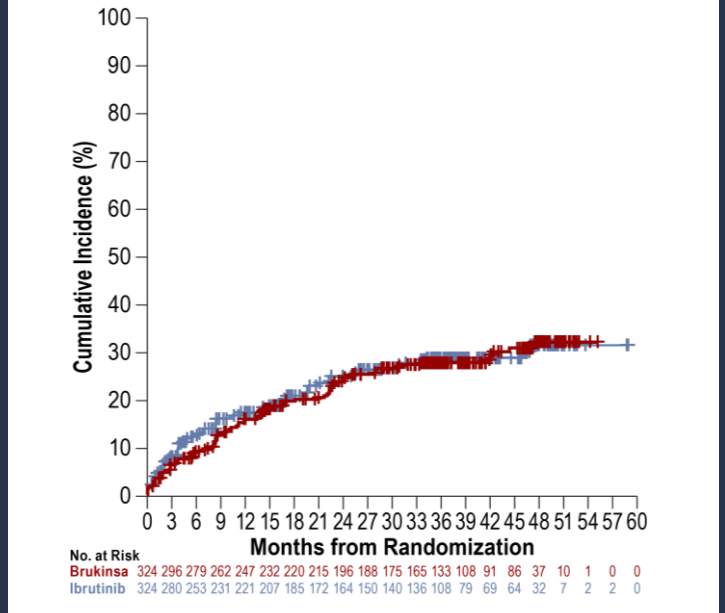


Median follow-up: **44 months**

Data cutoff: October, 2021

- Rate of hypertension for zanubrutinib in ASPEN is similar to SEQUOIA and represents the background rate
- Ibrutinib has close to double the rate of hypertension over time compared to zanubrutinib

ALPINE (R/R CLL)



Median follow-up: **39 months**

Data cutoff: September, 2023

- ALPINE is an outlier compared with other zanubrutinib studies for hypertension
- There are fewer new drug starts for hypertension with zanubrutinib vs ibrutinib, and lower rise in SBP over time, suggesting a qualitatively different adverse event than ibrutinib

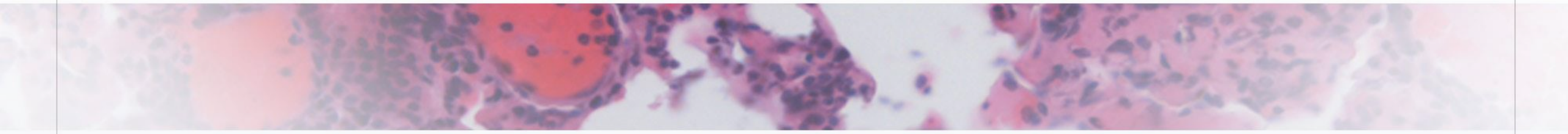
Author Conclusions

- ALPINE is the only study to demonstrate PFS superiority in a head-to-head comparison of BTK inhibitors
- Zanubrutinib demonstrated sustained PFS benefit over ibrutinib in patients with R/R CLL/SLL with a median follow-up of 39 months
  - Durable PFS benefits seen across major subgroups, including the del(17p)/*TP53*^{mut} population
  - PFS benefit is consistent across multiple sensitivity analyses demonstrating that PFS advantage with zanubrutinib was primarily driven by efficacy and not tolerability
- While responses deepened over time in both arms, ORR was higher with zanubrutinib with increased rates of CR/CRi compared with ibrutinib
- Zanubrutinib continues to demonstrate a more favorable safety/tolerability profile compared with ibrutinib
  - Lower rate of grade ≥3 and serious AEs, fewer AEs leading to treatment discontinuation, and dose reduction
  - Safer cardiac profile than ibrutinib with significantly lower rates of atrial fibrillation, serious cardiac events, cardiac events leading to treatment discontinuation, and no fatal cardiac event
- With over 3 years of follow-up, these data reconfirm zanubrutinib improved efficacy over ibrutinib and a more favorable safety profile in patients with R/R CLL/SLL

Brukinsa continues to demonstrate superiorty over Ibrutinib in PFS and a more favorable safety profile in patients with R/R CLL with 3 years of follow-up

PFS – Progression Free Survival
R/R – Relapsed Refractory
CLL - Chronic Lymphocytic Leukemia
ORR- Overall Response Rate
CR – Complete Remission
CRi – Complete Remission with incomplete count recovery
AE – Adverse Event
CLL//SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

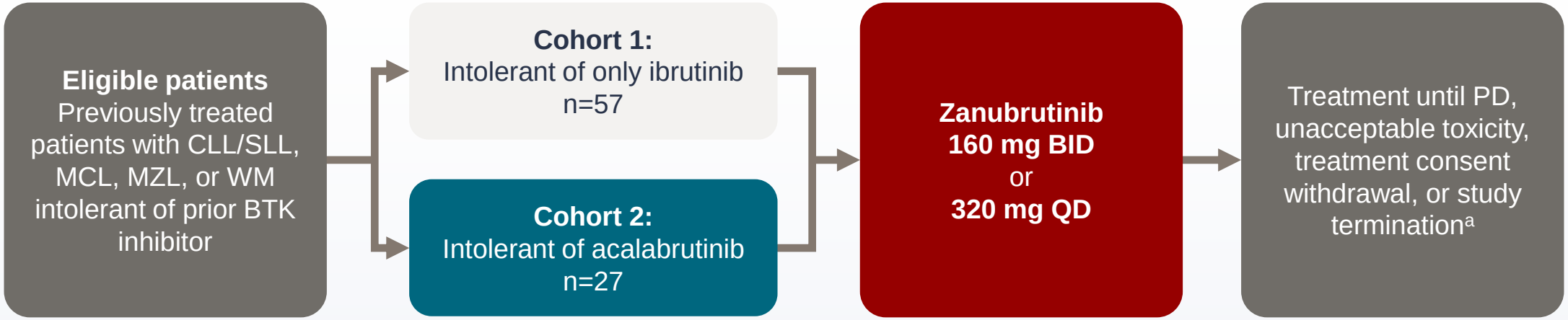


Zanubrutinib in Acalabrutinib-Intolerant Patients With B-Cell Malignancies

Mazyar Shadman,[1] Ian W. Flinn,[2] Edwin C. Kingsley,[3] Benjamin B. Freeman,[4] Moshe Y. Levy,[5] Charles M. Farber,[6] James D'Olimpio,[7] Jennifer L. Cultrera,[8] Ben Zhang,[9] Rocco J. Crescenzo,[10] Adam Idoine,[10] Xiaoping Zhang,[10] Kunthel By,[10] Jeff P. Sharman[11]

[1]Fred Hutchinson Cancer Research Center, University of Washington, Seattle, WA, USA; [2]Sarah Cannon Research Institute/Tennessee Oncology, Nashville, TN, USA; [3]Comprehensive Cancer Centers of Nevada, Las Vegas, NV, USA; [4]Summit Medical Group, Florham Park, NJ, USA; [5]Texas Oncology-Baylor Charles A. Sammons Cancer Center, Dallas, TX, USA; [6]Atlantic Hematology Oncology, Morristown Medical Center, Morristown, NJ, USA; [7]Clinical Research Alliance, Westbury, NY, USA; [8]Florida Cancer Specialists & Research Institute, Leesburg, FL, USA; [9]Minnesota Oncology Clinic, Burnsville, MN, USA; [10]BeiGene (Beijing) Co, Ltd, Beijing, China, and BeiGene USA, Inc, San Mateo, CA, USA; [11]Willamette Valley Cancer Institute and Research Center, Eugene, OR, USA

Study Design: Zanubrutinib in Acalabrutinib-Intolerant Patients with B-Cell Malignancies



- **Primary objective:** evaluate safety of zanubrutinib in acalabrutinib-intolerant patients, as assessed by recurrence and change in severity of acalabrutinib-intolerance AEs
- **Secondary objective:** evaluate efficacy of zanubrutinib by investigator-assessed ORR, DCR, PFS, and patient-reported outcomes
- **Acalabrutinib intolerance** generally defined as:
  - Persistent Grade ≥1 non-hematologic toxicity of any duration with ≥ 3 recurrent episodes; or Grade ≥1 non-hematologic toxicity for >7 days or Grade ≥3 non-hematologic toxicity for any duration, Grade 3 neutropenia with infection or fever; Grade 4 hematologic toxicity leading to treatment discontinuation

[a]Study is ongoing. ClinicalTrials.gov: NCT04116437, Data cutoff: May 15, 2023
CLL, chronic lymphocytic leukemia
DCR, disease control rate
MCL, mantle cell lymphoma
MZL, marginal zone lymphoma
SLL, small lymphocytic lymphoma
WM, Waldenström macroglobulinemia

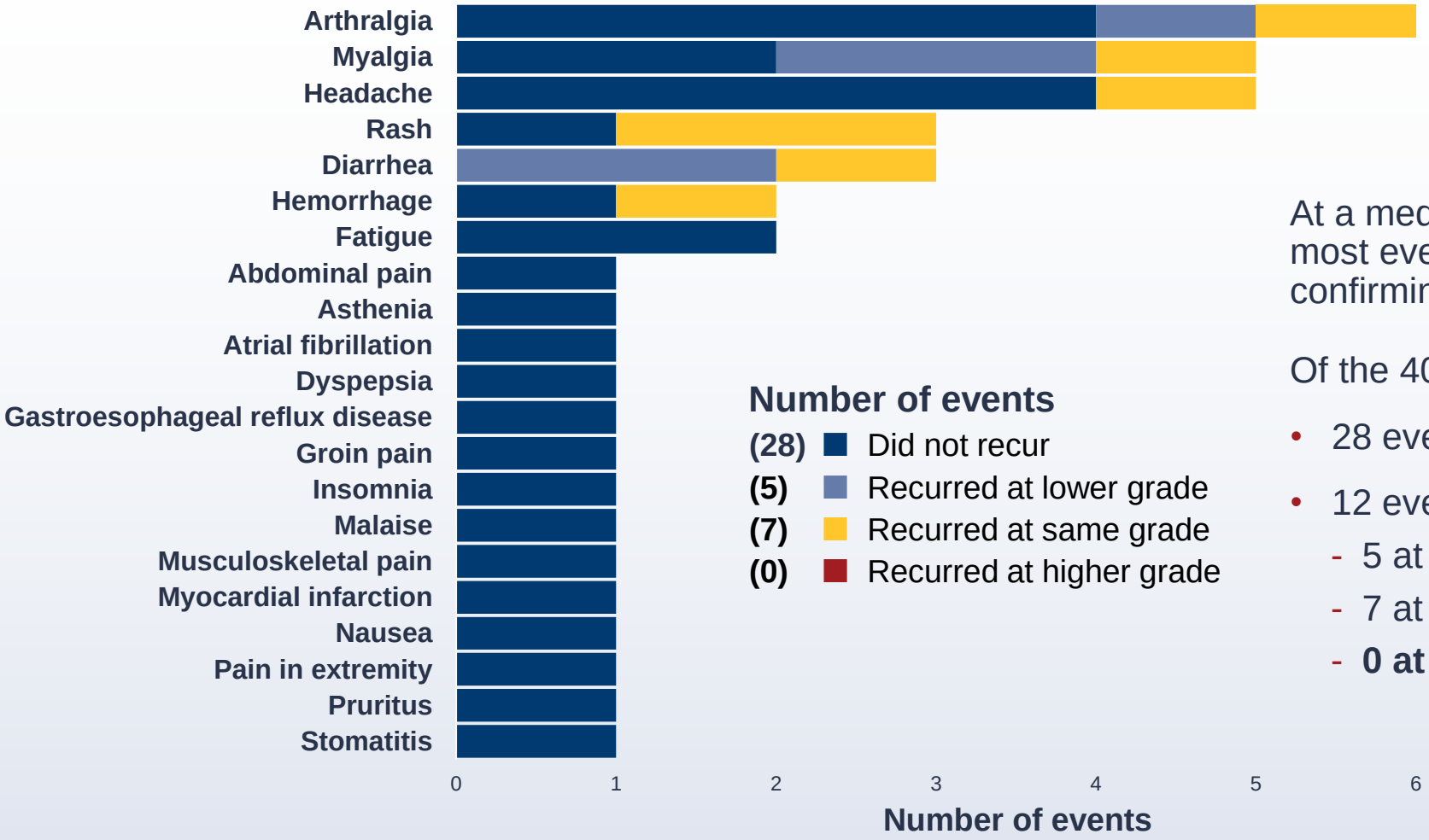
Demographics of Acalabrutinib-Intolerant Patients

Characteristic	Acalabrutinib intolerant (N=27)
Indication, n (%)	
CLL	17 (63)
SLL	2 (7)
MCL	2 (7)
MZL	2 (7)
WM	4 (15)
Age, median (range), years	73 (51-87)
Sex, n (%)	
Male	17 (63)
Female	10 (37)
ECOG PS, n (%)	
0	18 (67)
1	7 (26)
2	2 (7)
No. of prior anticancer therapy regimens, median (range)	2 (1-6)
Prior BTKi, n (%)	
Ibrutinib monotherapy	12 (44)
Ibrutinib combination therapy	1 (4)
Acalabrutinib monotherapy	26 (96)
Acalabrutinib combination therapy	1 (4)
Cumulative acalabrutinib exposure, median (range), months	5.4 (0.5-33.7)
On-study zanubrutinib dosing regimen, n (%)	
160 mg BID	19 (70)
320 mg QD	8 (30)

CLL - Chronic Lymphocytic Leukemia
SLL - Small Lymphocytic Lymphoma
MCL - Mantle Cell Lymphoma
MZL - Marginal Zone Lymphoma
WM - Waldenström's Macroglobulinemia
BID – twice daily dosing
QD – once daily dosing

- **27** acalabrutinib intolerant patients, most had CLL/SLL or WM
- 13 (48%) acalabrutinib-intolerant patients were also intolerant to ibrutinib
- Median exposure to acalabrutinib was 5.4 months before patients discontinued acalabrutinib due to intolerance

Most Acalabrutinib Intolerances Did Not Recur on Zanubrutinib



At a median follow up of **11.4 months**, most events did not recur on zanubrutinib confirming safety of zanubrutinib

Of the 40 acalabrutinib-intolerance events:

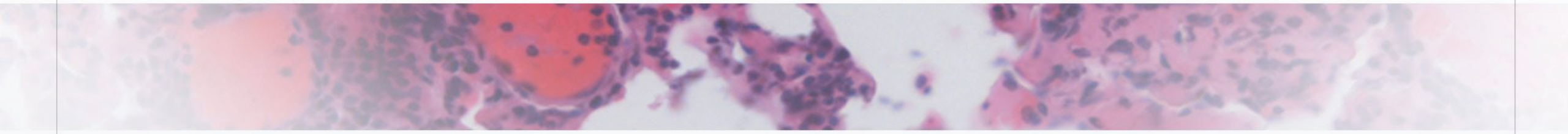
- 28 events (70%) did not recur
- 12 events did recur
  - 5 at a lower grade
  - 7 at same grade
  - **0 at a higher grade**

Author Conclusions

- With a median zanubrutinib exposure of 11.4 months (>2X reported cumulative acalabrutinib exposure before discontinuation)
  - **63% of patients did not experience any recurrence of their prior acalabrutinib-intolerance events**
- Zanubrutinib provided clinically meaningful benefit as measured by **a disease control rate of 96%** in efficacy-evaluable patients who were previously intolerant of acalabrutinib

The results from this study demonstrate that zanubrutinib may be a viable treatment option for patients who are intolerant to acalabrutinib

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

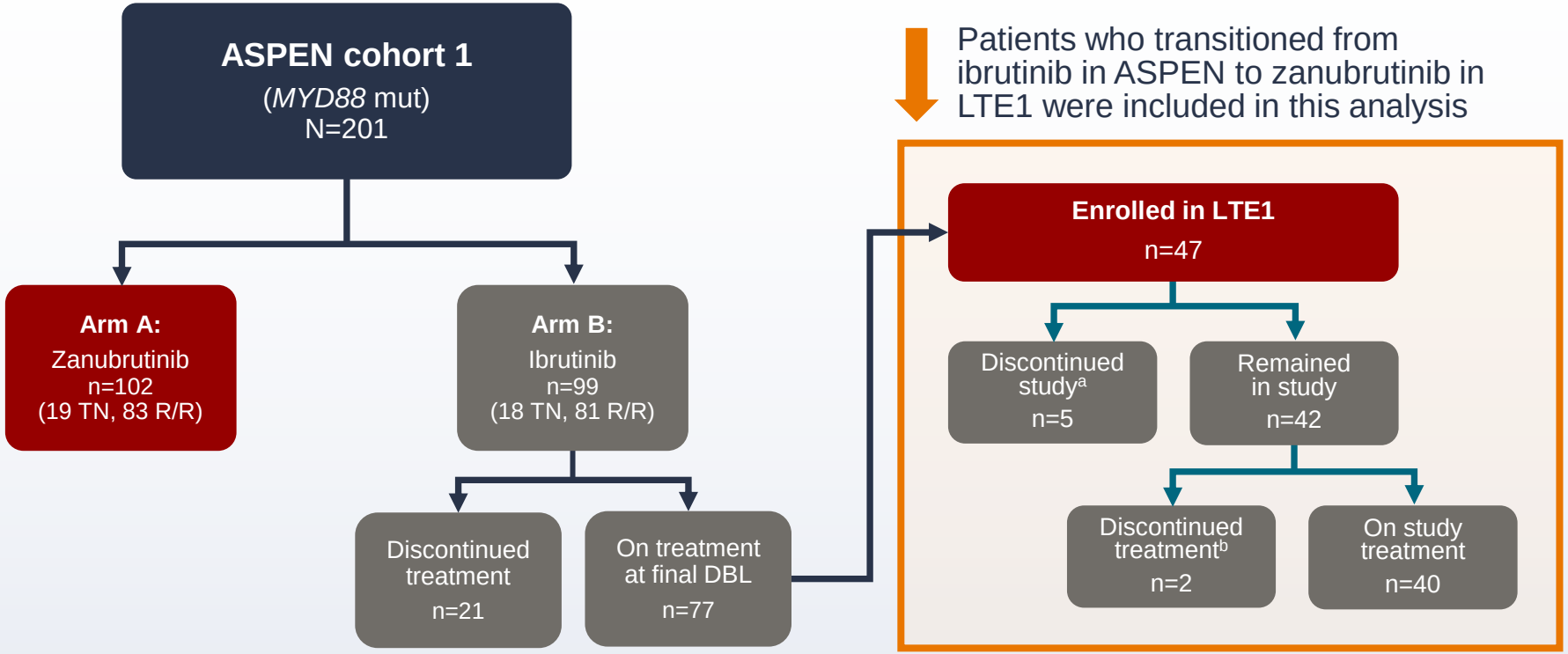


Clinical Outcomes in Patients With Waldenström Macroglobulinemia (WM) Receiving Ibrutinib on the Phase 3 ASPEN Study ≥1 Year After Transitioning to Zanubrutinib

Ramon Garcia-Sanz[1], Roger Owen[2], Wojciech Jurczak[3], Meletios Dimopoulos[4], Helen McCarthy[5], Gavin Cull[6], Stephen Opat[7], Jorge J. Castillo[8], Marie José Kersten[9], Bjorn Wahlin[10], Sebastian Grosicki[11], Radha Prathikanti[12], Tian Tian[12], Heather Allewelt[12], Aileen Cohen[12], Constantine Tam[13]

[1]Hospital Universitario de Salamanca, Salamanca, Spain; [2]St. James's University Hospital, Leeds, England; [3]MSC National Research Institute of Oncology, Krakow, Poland; [4]General Hospital of Athens-Alexandra, Llisia, Greece; [5]Royal Bournemouth Hospital, Bournemouth, England; [6]Sir Charles Gairdner Hospital, Nedlands, Australia; [7]Monash Health, Victoria, Australia; [8]Dana-Farber Cancer Institute, Boston, United States; [9]Amsterdam University Medical Centers, Location University of Amsterdam, Amsterdam, Netherlands; [10]Karolinska Universitetssjukhuset Solna, Solna, Sweden; [11]Medical University of Silesia, Katowice, Poland; [12]BeiGene USA, Inc, San Mateo, CA, USA; [13]The Alfred, Melbourne, Australia

Patients with WM Receiving Ibrutinib at End of ASPEN Were Eligible to Receive Zanubrutinib in Long Term Extension (LTE1)



Median time on ibrutinib 50.4 months (range 26-59.3 months)

- **47 patients** from ibrutinib arm of ASPEN enrolled into LTE1 received zanubrutinib
- At the data cut 40 patients are ongoing on therapy
- **Median zanubrutinib treatment duration was 15.3 months** (range: 5.1–22.1)

[a] Reasons for study discontinuation (5 patients): death (n=3); lost to follow-up (n=1); and withdrawal (n=1).

[b] Reasons for treatment discontinuation (5 patients who left the study plus 2 who remained in the study): ''other'' reasons (n=3); AEs (n=2); PD (n=1); and withdrawal (n=1)

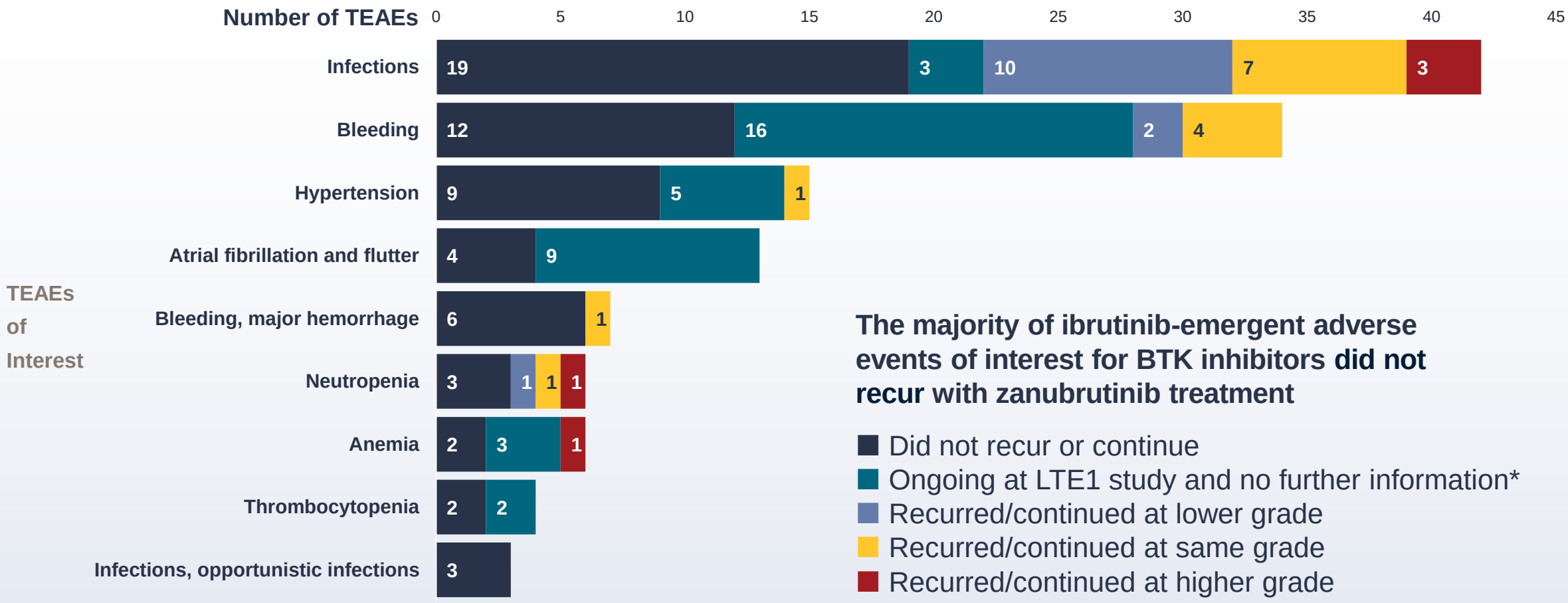
AE - Adverse Events
DBL - Database Lock
MYD88 - Myeloid differentiation primary response 88
PD - Progressive Disease
R/R - Relapsed/Refractory

Waldenström Macroglobulinemia Population on LTE-1 Demographics

Patient/Disease Characteristics	WM n=47
Age at LTE1 enrollment, median (range), years	73 (44-89)
Age group at LTE1 enrollment, n (%)	
< 65 years	8 (17)
≥ 65 and < 75 years	21 (44.7)
≥ 75 years	18 (38.3)
Sex, n (%)	
Male	34 (72.3)
Female	13 (27.7)
ECOG performance status at LTE1 enrollment, n (%)	
0	27 (57.4)
1	17 (36.2)
2	1 (2.1)
Missing	2 (4.3)
Disease status at ASPEN enrollment, n (%)	
Treatment naïve	10 (21.3)
Relapsed/refractory	37 (78.7)
Number of lines of therapy prior to ibrutinib, median (range)	1 (1-6)
Time from ibrutinib treatment initiation to LTE1 C1D1, median (range), months	**50.4 (26-59.3)**

ECOG, Eastern Cooperative Oncology Group
R/R, relapsed/refractory
TN, treatment naïve
C1D1: Cycle 1, Day 1

Safety Profile Generally Improved on Zanubrutinib



The majority of ibrutinib-emergent adverse events of interest for BTK inhibitors did not recur with zanubrutinib treatment

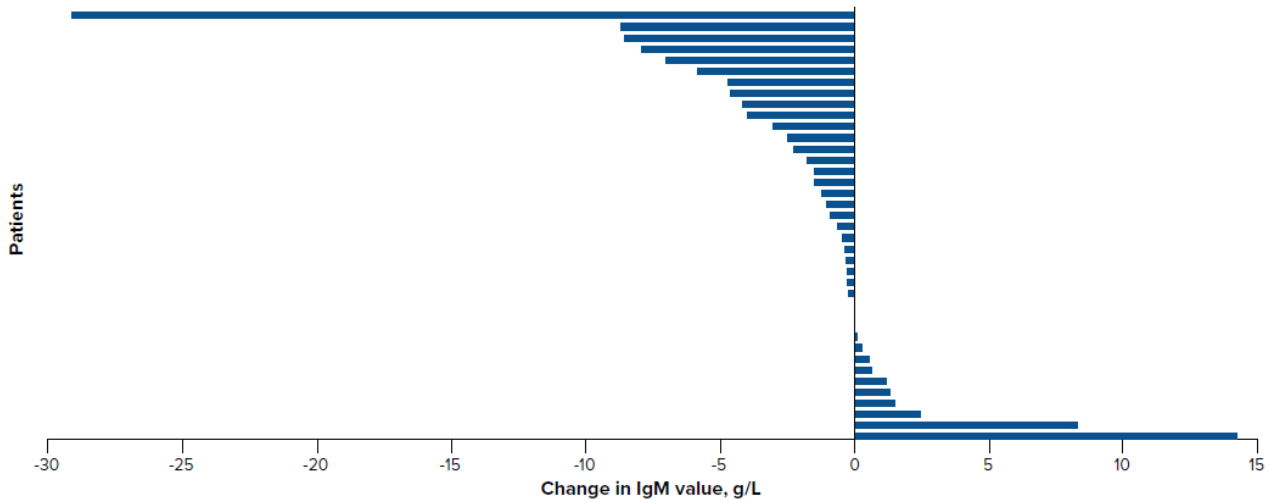
- Did not recur or continue
- Ongoing at LTE1 study and no further information*
- Recurred/continued at lower grade
- Recurred/continued at same grade
- Recurred/continued at higher grade

*No further information available regarding severity or resolution of ibrutinib-emergent adverse events
TEAE, Treatment-Emergent Adverse Event

WM Disease Response Was Maintained or Improved in the Majority of Evaluable Patients Following Transition to Zanubrutinib

Overall response assessment by PI	ASPEN Best Response	ASPEN Last Response	LTE1 Best Response
		ibrutinib	zanubrutinib
		n, % (N=47)	
CR	0	0	**2 (4.3)**
VGPR	15 (31.9)	**13 (27.7)**	**17 (36.2)**
PR	31 (66)	**27 (57.4)**	**23 (48.9)**
MR	1 (2.1)	3 (6.4)	3 (6.4)
IgM flare	N/A	1 (2.1)	N/A
PD	N/A	2 (4.3)	N/A
Not evaluable	N/A	1 (2.1)	N/A
No evidence of PD	N/A	N/A	1 (2.1)
Discontinued prior to assessment	N/A	N/A	1 (2.1)

Change in [IgM] from last response assessment in ASPEN study to best overall response in LTE1 study



2 patients achieved CR after switching to zanubrutinib*

[a]Grouped terms

BOR - Best Overall Response
CR - Complete Response (*negative immunofixation, not confirmed by bone marrow biopsy)
IgM - immunoglobulin M
MR - Minor Response
N/A, not applicable
PD - Progressive Disease
PI - Principal Investigator
PR - Partial Response
RA - Response Assessment
VGPR - Very Good Partial Response

Author Conclusions

- While limited by sample size and non-randomized/ad hoc analysis, data suggest that patients who are tolerating ibrutinib may switch to zanubrutinib without compromising, and may improve upon, safety or efficacy; long term follow-up is ongoing
- Waldenström Macroglobulinemia disease response was maintained or improved in 44/46 of efficacy-evaluable patients

The majority of ibrutinib-emergent adverse events did not recur nor worsen with zanubrutinib treatment, despite advanced and increasing age

Cornerstone Asset in Hematology Portfolio Only BTKi to Demonstrate Superiority

Best-in-Class BTKi

- Plasma exposure **fully covering BTK IC50 over 24-hour time period** while **both acalabrutinib and ibrutinib only cover ~6 hours**
- **The only BTKi with H2H superiority** of **PFS** in CLL vs ibrutinib while acalabrutinib showed only non-inferiority (HR=1.00)
- **Favorable ORR/CR/PFS** across indications among BTKis

Favorable Safety

- Superior **overall safety** including **cardiac profile** vs ibrutinib in 2 H2H studies
- Well- tolerated in acalabrutinib **intolerant** patients
- **Minimal treatment related headache**

Broadest Label with Superior Data

- **TN CLL, R/R CLL, MCL, WM, MZL**

and

- **Only BTKi approved in FL**
- Ongoing phase 3 studies in **MAHOGANY** (RR FL and RR MZL) and **MANGROVE** (TN MCL) to **confirm and expand labels**

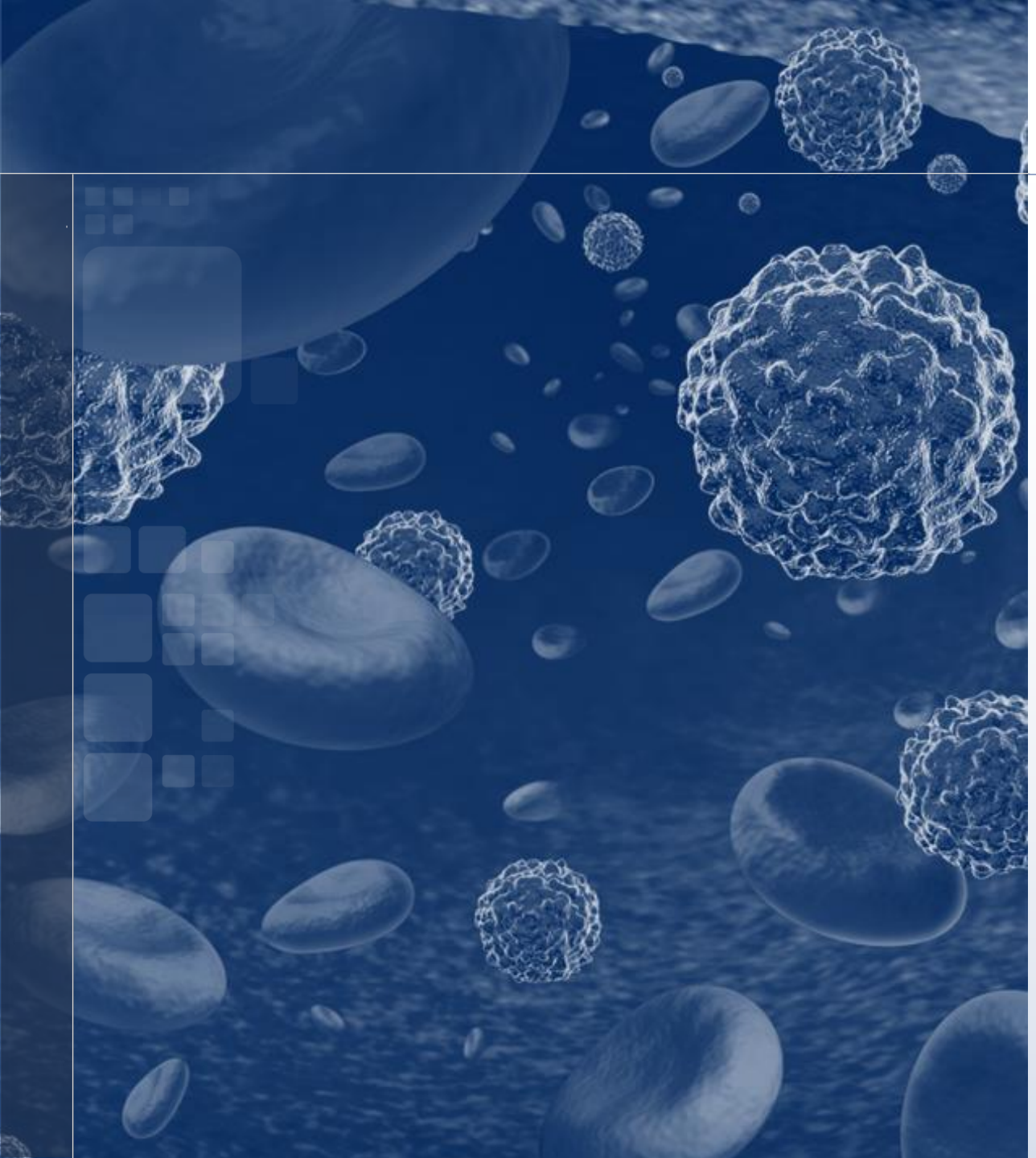
Cornerstone Asset

Combination partner with sonrotoclax, TEVIMBRA, and external assets to **maximize value of lifecycle**

IC50 – Half-maximal inhibitory concentration
H2H – Head to Head
PFS – Progression Free Survival
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
ORR – Overall Response Rate
CR – Complete Response

TN – Treatment Naïve
R/R – Relapsed Refractory
MCL - Mantle Cell Lymphoma
WM - Waldenström's Macroglobulinemia
MZL - Marginal Zone Lymphoma
FL - Follicular Lymphoma

Brukinsa® zanubrutinib



BRUKINSA

Sonrotoclax

BGB-16673
(BTK CDAC)

TEVIMBRA

Potential Best-in-Class BCL2 Inhibitor with Differentiated Profile

More potent and specific BCL2i

- **Greater potency** vs. venetoclax in preclinical models
- **Active against mutated G101V BCL2** (known resistance mechanism to venetoclax)
- **Higher selectivity** towards BCL2 believed to translate to **improved tolerability**

Enables broader clinical use

- Shorter **half-life** vs. venetoclax and **no drug accumulation** leading to a **better safety profile**
- **Easier ramp-up and eliminating monitoring** unlocks use **by all physicians**

Improved clinical profile

- **With 600+ patients treated,** clinical experience **reinforces pre-clinical data** and supports the potential to be **best in class**
- Safe and tolerable in combination with BRUKINSA; **deep and durable responses in TN CLL** are **better than reported venetoclax combos** V+O and V+I at same timepoints

Broad development plan

- **Initiated Phase 3 registrational study in TN CLL** with potential to be best in disease **fixed duration combination and SOC** globally
- **Monotherapy** potential in post-BTKi setting with **early registration options** in CLL, WM and MCL in key countries

Extends our footprint in other heme malignancies

- Compelling efficacy and safety data in **AML/MDS** in combination with Aza
- Encouraging data with potential to be first BCL2i approved in **MM with t(11,14)**

TN – Treatment Naïve
CLL - Chronic Lymphocytic Leukemia
WM - Waldenström's Macroglobulinemia
MCL - Mantle Cell Lymphoma
AML - Acute Myeloid Leukemia
MDS - Myelodysplastic syndromes
MM - Multiple Myeloma

ASH 2023 Clinical Presentations

Study	Title	First author/significance	Date / time
BGB-11417-101 TN CLL cohort	Combination Treatment with Second-Generation BCL2i/Bruton Tyrosine Kinase Inhibitors Sonrotoclax (BGB-11417) and Zanubrutinib is Well Tolerated and Achieves Deep Responses in Patients With Treatment-Naive Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma: Preliminary Data From Ongoing Phase 1/2 Study	**Constantine S. Tam, MD** First report of a large data set (>100 pt) showing the safety and efficacy of BRUKINSA + sonrotoclax combination in TN CLL Improved safety profile and deep responses compare favorably to venetoclax based combos at similar timepoints in TN CLL patients, reinforcing potential to become global SOC	**Oral** **12/9/2023** **4:00 pm**
BGB-11417-101 R/R MZL	Monotherapy With Second-Generation BCL2 Inhibitor Sonrotoclax (BGB-11417) Is Well Tolerated with High Response Rates in Patients with Relapsed/Refractory Marginal Zone Lymphoma: Data from an Ongoing Phase 1 Study	**Alessandra Tedeschi, MD** Sonrotoclax data in MZL shows promising safety and efficacy with 40% CR rates (no CR reported with Ven) confirming potency promise	**Poster 3043** **12/10/2023** **6:00 pm**
BGB- 11417-105 R/R MM t(11;14)	Sonrotoclax (BGB-11417) in Combination With Dexamethasone for the Treatment of Relapsed/Refractory Multiple Myeloma With t(11;14): Safety, Efficacy, and Determination of Recommended Phase 2 Dose	**Hang Quach, MD** Data demonstrating deep responses and favorable safety for sonrotoclax + dexamethasone cohort at RP2D Given recent failure of venetoclax in MM (CANOVA study), this data positions sonrotoclax as the potential first and only safe and effective BCL2 inhibitor in t(11;14) MM patients	**Oral** **12/11/2023** **4:30 pm**

Professor Constantine Tam

- **Dr. Tam** is passionate about developing new treatments for blood cancers. He is the global lead for zanubrutinib and oversaw its development from the first human dosed (in Melbourne) to successful international licensing studies worldwide
- Dr. Tam designed and performed the first global study to combine ibrutinib and venetoclax, publishing the results in *The New England Journal of Medicine* 5 years after inception
- He has 280 peer-reviewed papers in *New England Journal of Medicine, Lancet, Journal of Clinical Oncology, Blood* and other top-tier journals. His work has been cited >20,000 times in the literature
- Dr. Tam is Associate Editor for *Blood Advances*
- He received his M.B.B.S.(Hons) and M.D. degrees from the University of Melbourne. After dual training in Haematology and Haematopathology, he completed his Leukemia Fellowship at MD Anderson Cancer Center. Prior to moving to the Alfred, Dr. Tam served as Disease Group Lead for Low Grade Lymphoma and CLL at Peter MacCallum Cancer Centre and Royal Melbourne Hospital for over 10 years

BIOGRAPHY

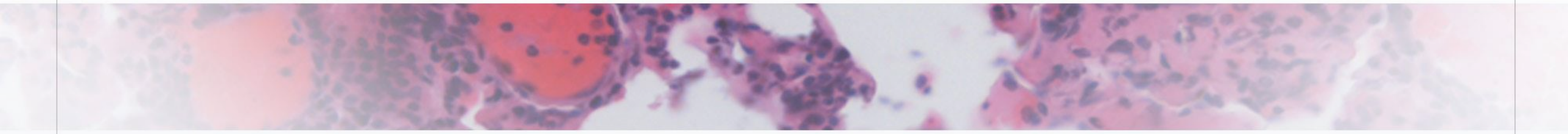
AlfredHealth

MONASH University

Constantine (Con) Tam, M.D., M.B.B.S

Head of Lymphoma Service at Alfred Health and Professor of Haematology at Monash University

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

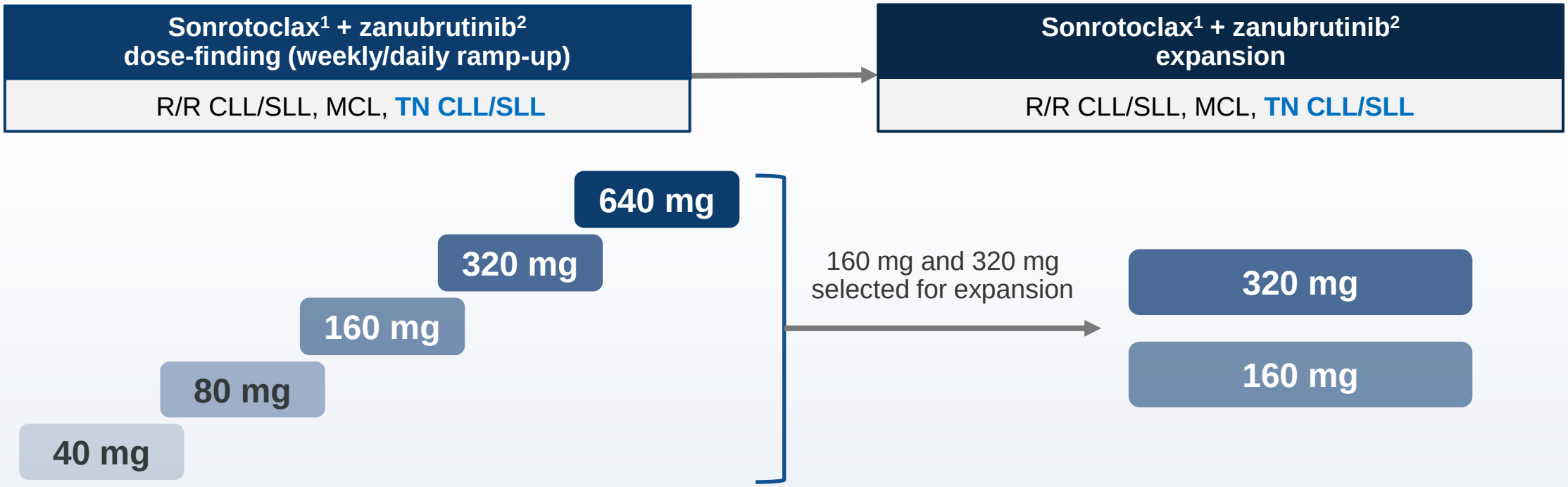


Combination Treatment with Second-Generation BCL2/Bruton Tyrosine Kinase Inhibitors Sonrotoclax (BGB-11417) and Zanubrutinib is Well Tolerated and Achieves Deep Responses in Patients With Treatment-Naive Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma: Preliminary Data From Ongoing Phase 1/2 Study

Constantine S. Tam[1,2]; Mary Ann Anderson[3,4]; Masa Lasica[5]; Emma Verner[6,7]; Stephen Opat[2,8]; Shuo Ma[9]; Robert Weinkove[10,11]; Raul Cordoba[12]; Jacob Soumerai[13]; Paolo Ghia[14]; Sophie Leitch[15]; James Hilger[16]; Yiqian Fang[16]; David Simpson[16]; Haiyi Guo[16]; Chan Y. Cheah[17-19]

[1]Alfred Hospital, Melbourne, VIC, Australia; [2]Monash University, Clayton, VIC, Australia; [3]Peter MacCallum Cancer Centre, Melbourne, VIC, Australia; [4]Division of Blood Cells and Blood Cancer, The Walter and Eliza Hall Institute, Parkville, VIC, Australia; [5]St Vincent's Hospital Melbourne, Fitzroy, VIC, Australia; [6]Concord Repatriation General Hospital, Concord, NSW, Australia; [7]University of Sydney, Sydney, NSW, Australia; [8]Monash Health, Clayton, VIC, Australia; [9]Northwestern University Feinberg School of Medicine, Robert H. Lurie Comprehensive Cancer Center, Chicago, IL, USA; [10]Te Rerenga Ora Wellington Blood & Cancer Centre, Te Whatu Ora Health New Zealand Capital, Coast & Hutt Valley, Wellington, New Zealand; [11]Cancer Immunotherapy Programme, Malaghan Institute of Medical Research, Wellington, New Zealand; [12]Hospital Universitario Fundación Jiménez Díaz, Madrid, Spain; [13]Massachusetts General Hospital Cancer Center and Harvard Medical School, Boston, MA, USA; [14]Università Vita-Salute San Raffaele and IRCCS Ospedale San Raffaele, Milan, Italy; [15]Waitematā District Health Board, Auckland, New Zealand; [16]BeiGene (Shanghai) Co., Ltd., Shanghai, China and BeiGene USA, Inc., San Mateo, CA, USA; [17]Department of Haematology, Sir Charles Gairdner Hospital and PathWest Laboratory Medicine, Nedlands, WA, Australia; [18]Medical School, University of Western Australia, Crawley, WA, Australia; [19]Linear Clinical Research, Nedlands, WA, Australia

BGB-11417-101 Study Design and Methods



- The BGB-11417-101 is a phase 1/2 study evaluating sonrotoclax as monotherapy, in combination with zanubrutinib, and in combination with obinutuzumab ± zanubrutinib in patients with B-cell malignancies
- Main study objectives in TN CLL cohorts: determine safety and tolerability and define the RP2D of sonrotoclax when given in combination with zanubrutinib (160 mg BID or 320 mg QD)

1. Sonrotoclax was dosed orally, once daily, 30 minutes after a low-fat meal utilizing a weekly or daily ramp-up schedule to reach the target dose
2. 8-12 weeks of Zanubrutinib mono was given prior to sonrotoclax dosing (12 weeks if high tumor burden)

R/R – Relapsed Refractroy
TN – Treatment Naïve
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
MCL - Mantle Cell Lymphoma

Baseline Characteristics in Phase BGB-11417-101 Study

Characteristics	Sonrotoclax 160 mg (n=51)	Sonrotoclax 320 mg (n=56)	All patients (N=107)
Study follow up time (range), Mons	7.2 (0.3-21.1)	9.8 (0.5-17.4)	9.7 (0.3-21.1)
Age, median (range), years	63 (38-82)	61 (34-84)	62 (34-84)
≥65 years, n (%)	20 (39)	19 (34)	39 (36)
≥75 years, n (%)	4 (8)	7 (13)	11 (10)
Sex, n (%)			
Male	37 (73)	44 (79)	81 (76)
Disease type, n (%)			
CLL	49 (96)	52 (93)	101 (94)
SLL	2 (4)	4 (7)	6 (6)
Risk status, n/tested (%)[a]			
del(17p)	6/49 (12)	6/54 (11)	12/103 (12)
del(17p) and/or *TP53*^{mut}	12/50 (24)	15/55 (27)	27/105 (26)
IGHV status, n/tested (%)			
Unmutated	33/47 (70)	28/51 (55)	61/98 (62)
Tumor bulk at baseline, n (%)			
High[b]	20 (39)	14 (25)	34 (32)
Low[c]	31 (61)	42 (75)	73 (68)

CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma

[a] TP53 mutations defined as >10% VAF.
[b] Nodes ≥10 cm or nodes >5 cm and ALC >25x109/L.
[c] Nodes <5 cm or nodes ≥5 and <10 cm and ALC <25x109/L.

Data cutoff: August 15, 2023

Dose Modification and Summary of Adverse Events

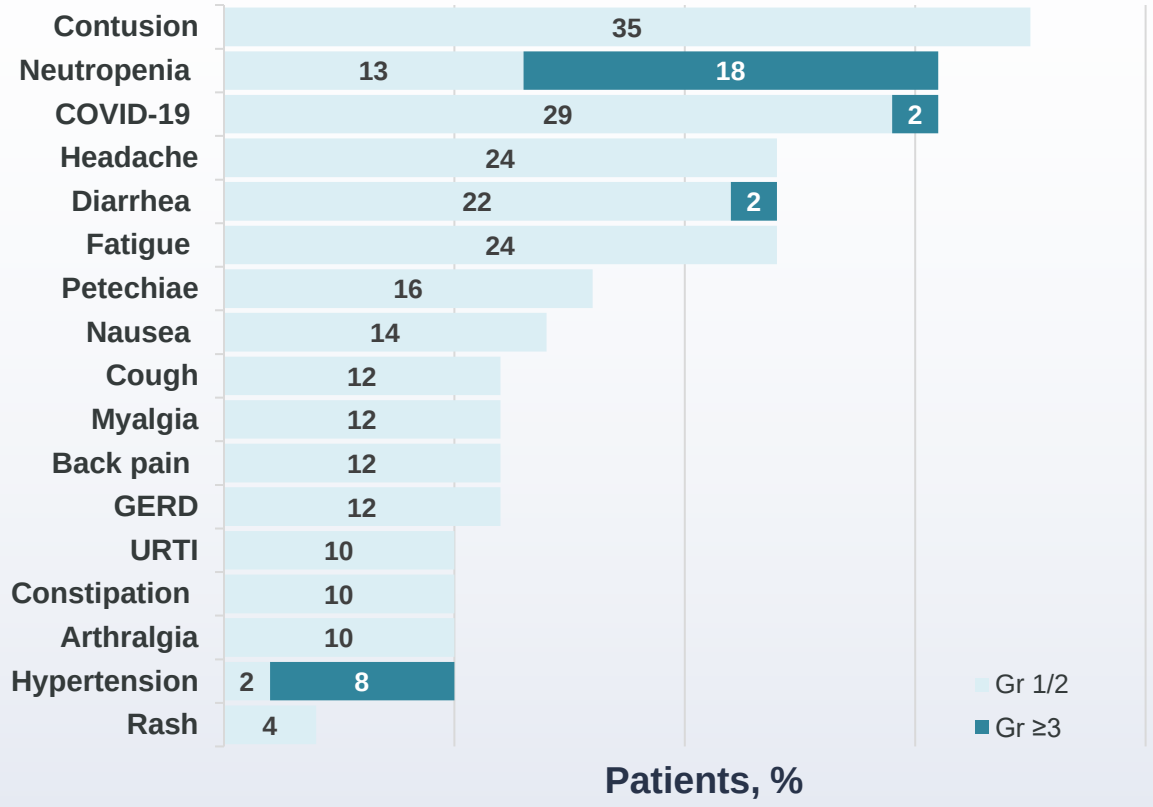
Patients[a], n (%)	Sonrotoclax 160 mg (n=51)	Sonrotoclax 320 mg (n=56)	All Patients (N=107)
Any AEs	47 (92.2)	49 (87.5)	96 (89.7)
Grade ≥3	22 (43.1)	21(37.5)	43 (40.2)
Serious AEs	7 (13.7)	8 (14.3)	15 (14.0)
Leading to death	0	0	0
Leading to dose reduction of zanubrutinib	1 (2.0)	2(3.6)	3(2.8)
Leading to discontinuation of zanubrutinib[b]	1 (2.0)	0	**1 (0.9)**
Treated with sonrotoclax	41 (80.4)	53 (94.6)	94 (87.9)
Leading to hold of sonrotoclax	11 (26.8)	10 (18.9)	21 (22.3)
Leading to dose reduction of sonrotoclax	2 (4.9)	3 (5.7)	5 (5.3)
Leading to discontinuation of sonrotoclax[b]	1 (2.4)	0	**1 (1.1)**

Sonrotoclax in combination with zanubrutinib is well tolerated and has a generally favorable safety profile, with very low rates of treatment discontinuation, dose reductions, and no deaths observed

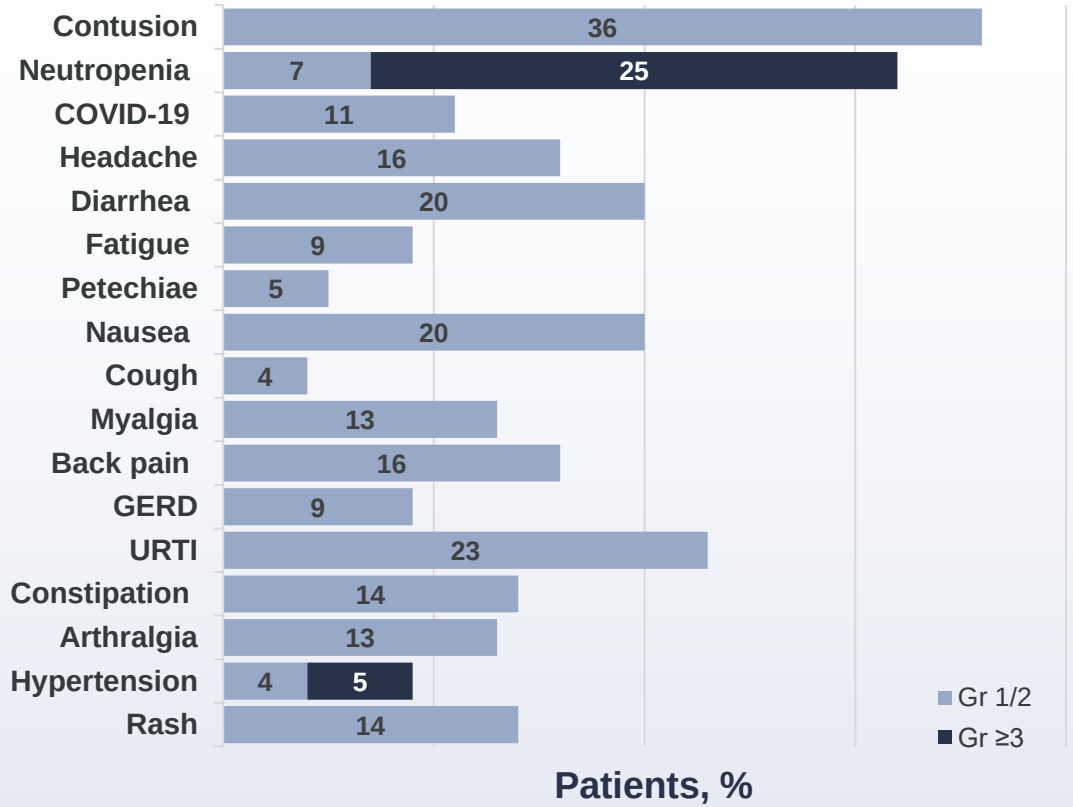
a Includes 13 patients who are still in zanubrutinib pretreatment phase and have not yet received sonrotoclax.
b One patient stopped both sonrotoclax and zanubrutinib due to fungal infection.

Most Frequent Adverse Events (AEs) Are Grade 1/2 for Both Dose Levels (Incidence ≥5 Patients)

Sonrotoclax 160 mg + zanu (n=51)

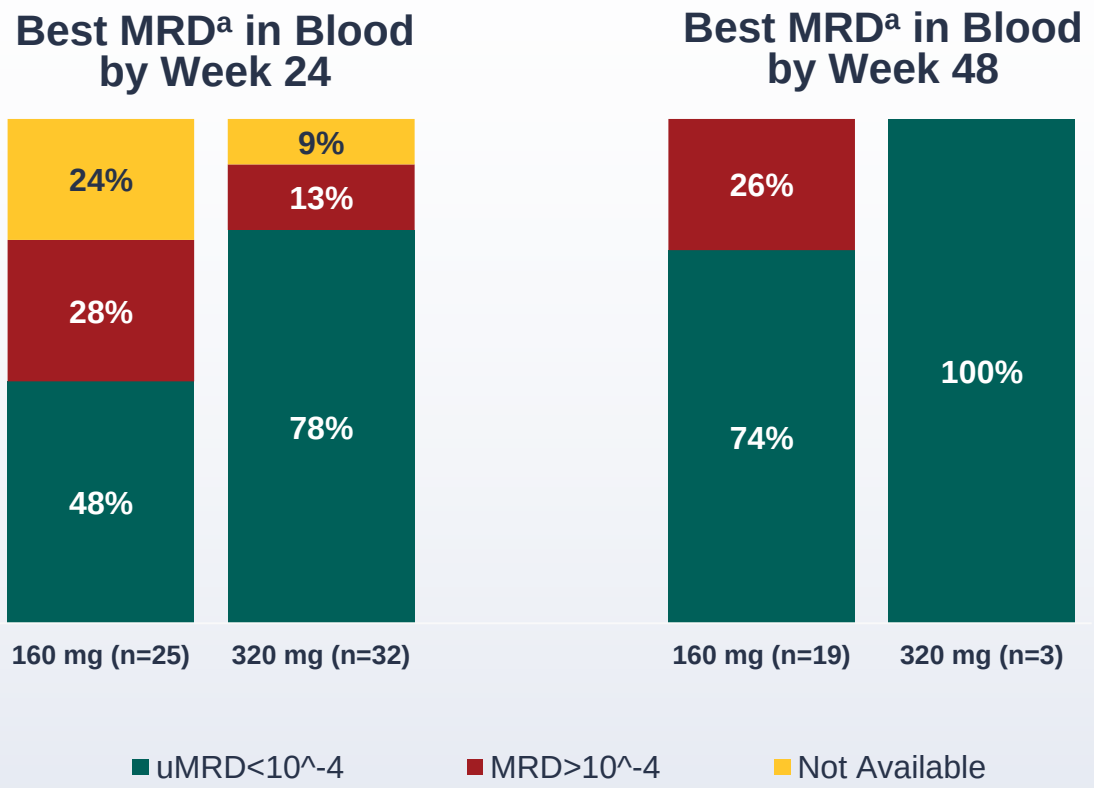


Sonrotoclax 320 mg + zanu (n=56)



- Early AEs predominantly neutropenia, and GI events attenuate after week 12
- No new signal emerges with longer treatment duration
- No TLS, no cardiac toxicity, low rates of GI AEs and infections

High Minimal Residual Disease Achieved in Peripheral Blood

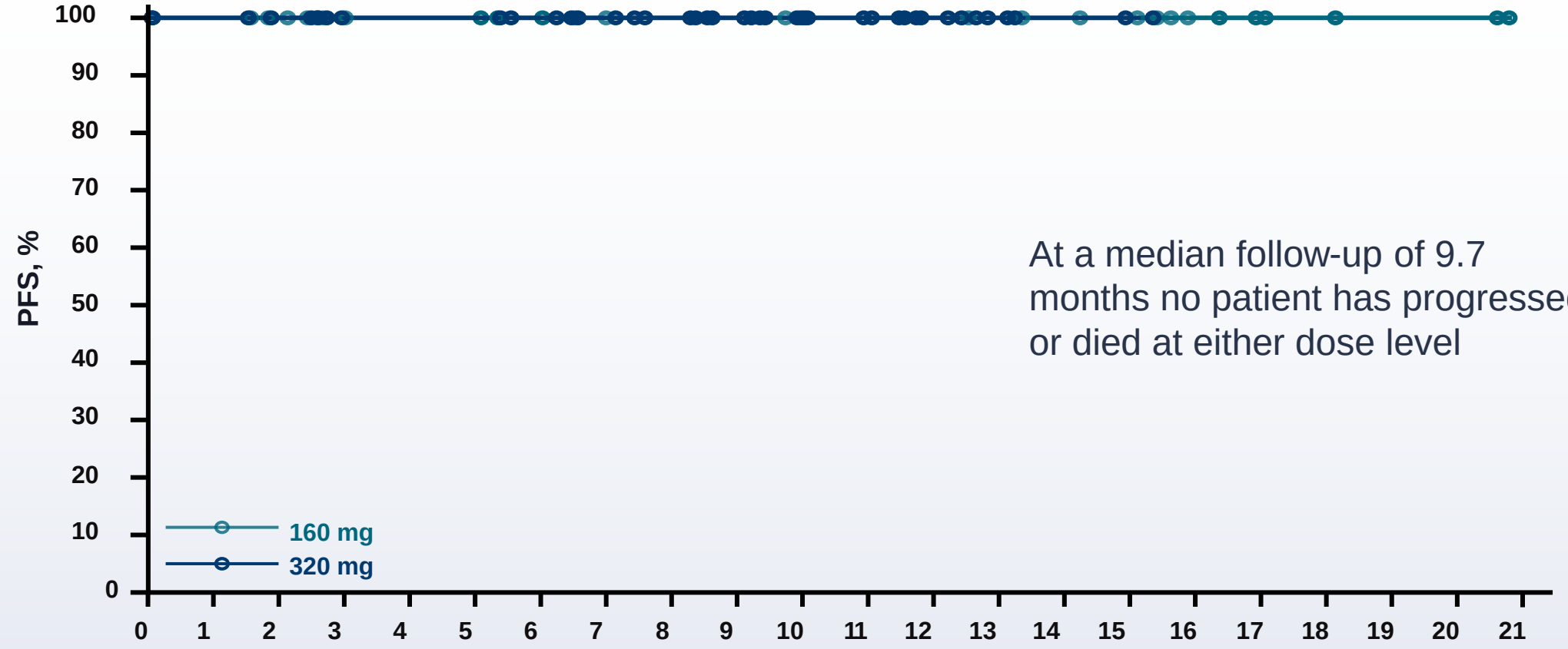


- **High uMRD achieved in TN CLL at both dose levels**
- **Trend for higher uMRD rates with 320 mg**
- **Evidence of deepening response over time**
- uMRD4 in blood after ~6 cycles of V+I combination was 52%
- uMRD4 in blood after ~12 cycles of V+I
  - V+I CAPTIVATE (fit) – 70%
  - V+I GLOW (unfit) – 55%

uMRD – Undetectable Minimal Residual Disease
TN CLL – Treatment Naïve Chronic Lymphocytic Leukemia
V+I – Venetoclax + Ibrutinib
MRD was measured by ERIC flow cytometry with 10^-4 sensitivity. uMRD4 is defined as CLL cells out of total nucleated cells <10^-4.

[a] MRD is best reported within a two-weeks window following the W24D1 and W48D1 MRD assessment timepoints, respectively
Week 24 or 48 represents 24 or 48 weeks at target dose, following zanubrutinib monotherapy and sonrotoclax ramp-up to target dose.

All 107 TN CLL Patients Remain on Study and Remain PFS- Free



At a median follow-up of 9.7 months no patient has progressed or died at either dose level

No. at risk

160 mg	51	42	40	32	31	31	27	24	24	24	22	22	22	19	17	16	7	5	4	3	3	0
320 mg	56	53	51	44	44	44	42	36	31	27	20	17	8	4	2	1	0	0	0	0	0	0

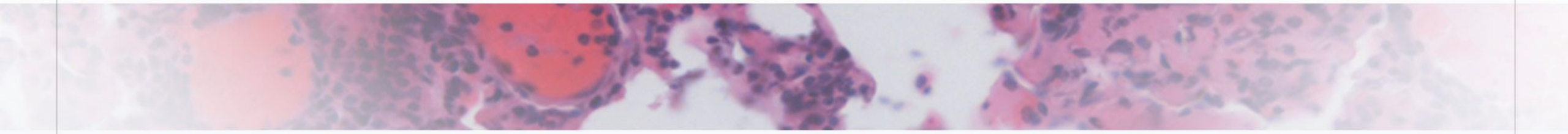
Author Conclusions

- Sonrotoclax 160 or 320 mg in combination with zanubrutinib 160mg BID or 320 mg QD was safe and well tolerated
  - A total of 106/107 patients remain on both drugs
  - No TLS and no cardiac toxicity were observed; low rates of GI AEs (predominantly Grade 1)
  - Most commonly reported grade ≥3 AE was neutropenia, mostly transitory, and not requiring dose modifications or interruptions
- Efficacy was promising in this all-comer TN CLL/SLL population
  - ORR was 100%
  - High blood MRD negativity by Week 24, with deepening response by week 48 of combination therapy
  - No PFS events were observed as of the data cut off

Sonrotoclax in combination with zanubrutinib is well tolerated with promising efficacy in TN CLL/SLL

BID – twice daily dosing
QD – once daily dosing
TLS – Tumor Lysis Syndrome
TN – Treatment Naïve
CLL - Chronic Lymphocytic Leukemia
SLL - Small Lymphocytic Lymphoma
ORR – Overall Response Rate
MRD – Minimal Residual Disease
PFS – Progression Free Survival

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

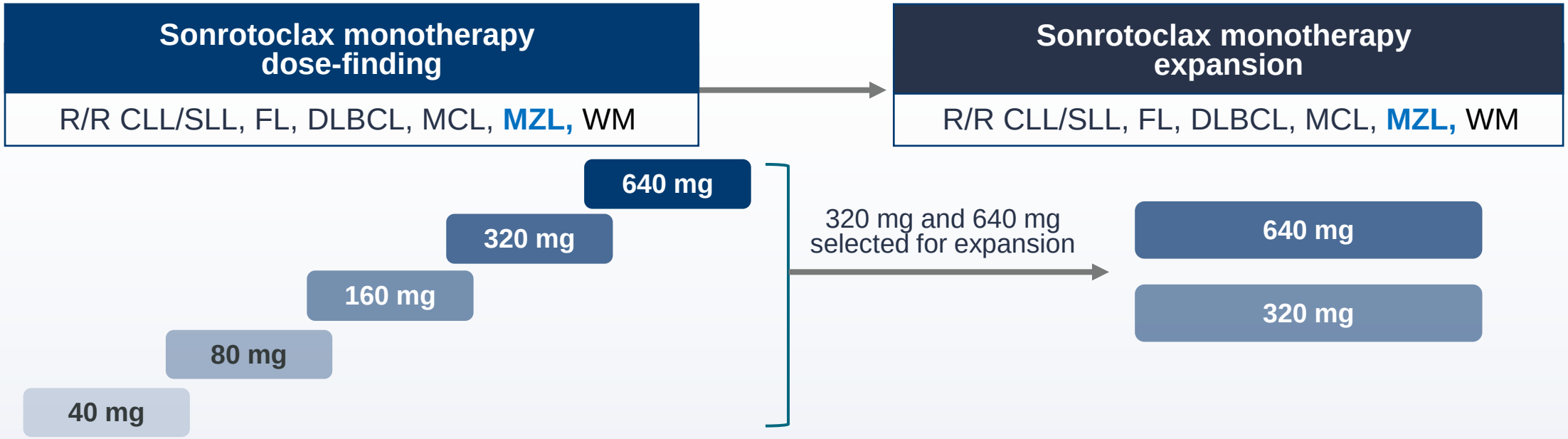


Monotherapy with Second-Generation BCL2 Inhibitor Sonrotoclax (BGB-11417) Is Well Tolerated With High Response Rates in Patients with Relapsed/Refractory Marginal Zone Lymphoma: Data from an Ongoing Phase 1 Study

Alessandra Tedeschi[1]; Chan Yoon Cheah[2,3]; Stephen S. Opat[4,5]; Emma Verner[6,7]; Laura Magnano[8]; Narendranath Epperla[9]; James Hilger[10]; Yiqian Fang[11]; David Simpson[10]; Haiyi [11]; and Mary Ann Anderson[12]

[1]ASST Grande Ospedale Metropolitano Niguarda, Milan, Italy; [2]Medical School, University of Western Australia, Crawley, Western Australia, Australia; [3]Sir Charles Gairdner Hospital and Pathwest Laboratory Medicine, Nedlands, Western Australia, Australia; [4]Monash University, Melbourne, VIC, Australia; [5]Department of Clinical Haematology, Monash Health, Melbourne, VIC, Australia; [6]Concord Repatriation General Hospital, Concord, NSW, Australia; [7]University of Sydney, Sydney, NSW, Australia; [8]Department of Hematology, Hospital ClÃnic, Barcelona, Barcelona, Spain; [9]The James Cancer Center, The Ohio State University Wexner Medical Center, Columbus, OH; [10]BeiGene USA, Inc., San Mateo; [11]BeiGene (Shanghai) Co., Ltd., Shanghai, China; [12]Peter Mac Callum Cancer Centre, Melbourne, VIC, Australia

BGB-11417-101 Study Design – R/R MZL Cohorts



- First-in-human study evaluating the safety, tolerability, pharmacokinetics, and preliminary antitumor activity of sonrotoclax monotherapy or in combo with zanubrutinib and/or obinutuzumab in B-cell malignancies, including RR MZL
- Dose expansion started with 640 mg; the 320 mg dose was later expanded based on efficacy signal seen in MZL
- Patients received 3-day ramp-up (6-day ramp up was implemented in patients with circulating cells)

R/R – Relapsed Refractory
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
FL - Follicular Lymphoma
DLBCL – Diffuse Large B-Cell Lymphoma
MCL - Mantle Cell Lymphoma
MZL - Marginal Zone Lymphoma
WM - Waldenström's Macroglobulinemia

Data cutoff: August 15, 2023

Promising Preliminary Efficacy Observed with Monotherapy

Best response, n (%)	40mg (n=1)	160 mg (n=2)	320mg (n=7)	640mg (n=12)	All (n=22)
Median follow-up, months (range)	38.9	27.7 (27.4-28.1)	1 (0-3.4)	7.2 (2.1-15.4)	6.5 (0-38.9)
Efficacy evaluable	**1**	**2**	**0**	**10**	**13**
ORR, n (%)	0	1 (50)	-	7 (70)	8 (62)
CR	0	0	-	4 (40)	4 (31)
PR	0	1 (50)	-	3 (30)	4 (31)
SD	1 (100)	0	-	2 (20)	3 (23)
PD	0	1 (50)	-	1 (10)	2 (15)

- Overall response rates of 70% were observed including 40% CR
- Responses were seen in all 4 BTKi refractory patients (CR, 3; PR, 1)

ORR – Overall Response Rate
CR – Complete Response
PR – Partial Response
SD – Stable Disease
PD – Progressive Disease
R/R – Relapsed Refractory

Author Conclusions

- Sonrotoclax doses as high as 640 mg QD were well tolerated, and the MTD was not reached and 640 mg was the maximum assessed dose
- Sonrotoclax demonstrated promising single-agent activity in patients with R/R MZL
  - An ORR of 70% (including a CR rate of 40%) was observed at the dose of 640 mg; efficacy data from the 320 mg expansion dose level is forthcoming
  - Responses at 640 mg were durable with 6 of 10 patients continuing on treatment at a median follow-up of 8.7 month
- No clinical TLS was observed. Only 2 transitory laboratory TLS that resolved quickly without need for dose modification were seen in patients with high baseline levels of circulating cells

Sonrotoclax has demonstrated promising single agent activity in R/R MZL

QD – Single daily dose
MTD - Maximum Tolerated Dose
CR – Complete Response
TLS – Tumor Lysis Syndrome
R/R – Relapsed Refractory
MZL - Marginal Zone Lymphoma

Professor Hang Quach

- **Professor Hang Quach** is a professor of haematology of the University of Melbourne and is the director of Clinical Haematology and Clinical Haematology Research at St. Vincent's Hospital Melbourne
- She currently serves as the chair of the Australasian Leukemia Lymphoma Group's Myeloma Working Group and deputy chair of the Myeloma Scientific Advisory Group for Myeloma Australia, where she leads the development and biennial update of the Australian National Treatment Guideline for Multiple Myeloma
- Prof. Quach is a member of the International Myeloma Working Group. Her clinical and research activity focuses on novel therapeutics and their impact on the immunology and the microenvironment in multiple myeloma
- Through competitive grants, industry collaborations, and philanthropy, she has secured research funding of more than 16 million AUD (12.262 million AUD as chief investigator), and is highly published in the field of multiple myeloma

BIOGRAPHY

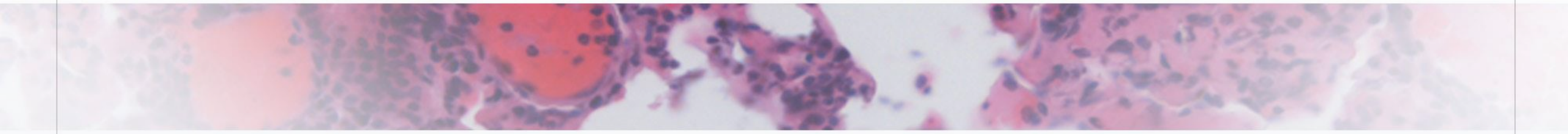
THE UNIVERSITY OF MELBOURNE

ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Hang Quach,
MBBS (Hons),
SpecCertOC
FRACP FRCPA MD

University of Melbourne

American Society of Hematology
Helping hematologists conquer blood diseases worldwide



Sonrotoclax (BGB-11417) in Combination With Dexamethasone for the Treatment of Relapsed/Refractory Multiple Myeloma With t(11;14): Safety, Efficacy, and Determination of Recommended Phase 2 Dose

Hang Quach[1]; Doug Sborov[2]; Dickran Kazandijan[3]; Andrew Spencer[4]; Michael Low,[5]; Susan Bal[6]; Natalie Callander[7]; Huan Cheng[8]; Sheel Patel[8]; Rocco Crescenzo[8]; Amit Agarwal[8]; Binod Dhakal[9]

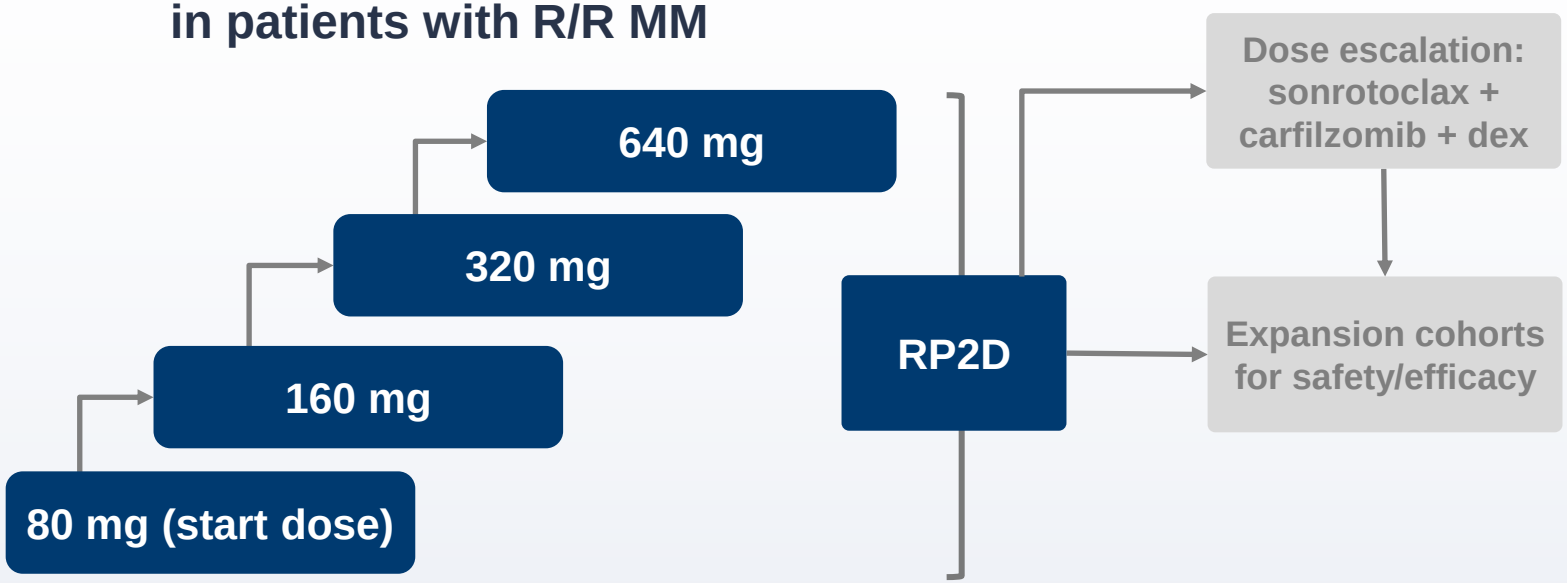
[1]St. Vincent's Hospital Melbourne, University of Melbourne, Melbourne, VIC, Australia; [2]University of Utah School of Medicine, Salt Lake City, UT, USA; [3]University of Miami, Coral Gables, FL, USA; [4]Alfred Health - Monash University, Melbourne, VIC, Australia; [5]Monash Health, Melbourne, VIC, Australia; [6]University of Alabama at Birmingham Medicine, Birmingham, AL, USA; [7]UW Health University Hospital, Madison, WI, USA; [8]BeiGene USA, Inc, San Mateo, CA, USA; [9]Medical College of Wisconsin, Milwaukee, WI, USA

BGB-11417-105 (NCT04973605) Multiple Myeloma t(11;14) Study Design: In Combination with Dexamethasone

Eligible patients

- Relapsed or refractory to most recent therapy line
- t(11;14) positive by FISH
- Failed ≥3 prior lines of therapy including a proteasome inhibitor, IMiD, and an anti-CD38 monoclonal antibody

Dose escalation for sonrotoclax + dex in patients with R/R MM



Primary endpoints: Safety and tolerability, MTD/MAD, RP2D

Key secondary/exploratory endpoints: PK, biomarkers, disease response per IMWG 2016 criteria

R/R – Relapsed Refractory
MM – Multiple Myeloma
IMiD – Immunomodulatory Agents
MTD – Maximum Tolerated Dose
RP2D – Recommended phase 2 dose
PK – Pharmacokinetics
IMWG – International Myeloma Working Group

Safety for BGB11417-105 Multiple Myeloma t(11;14) Study

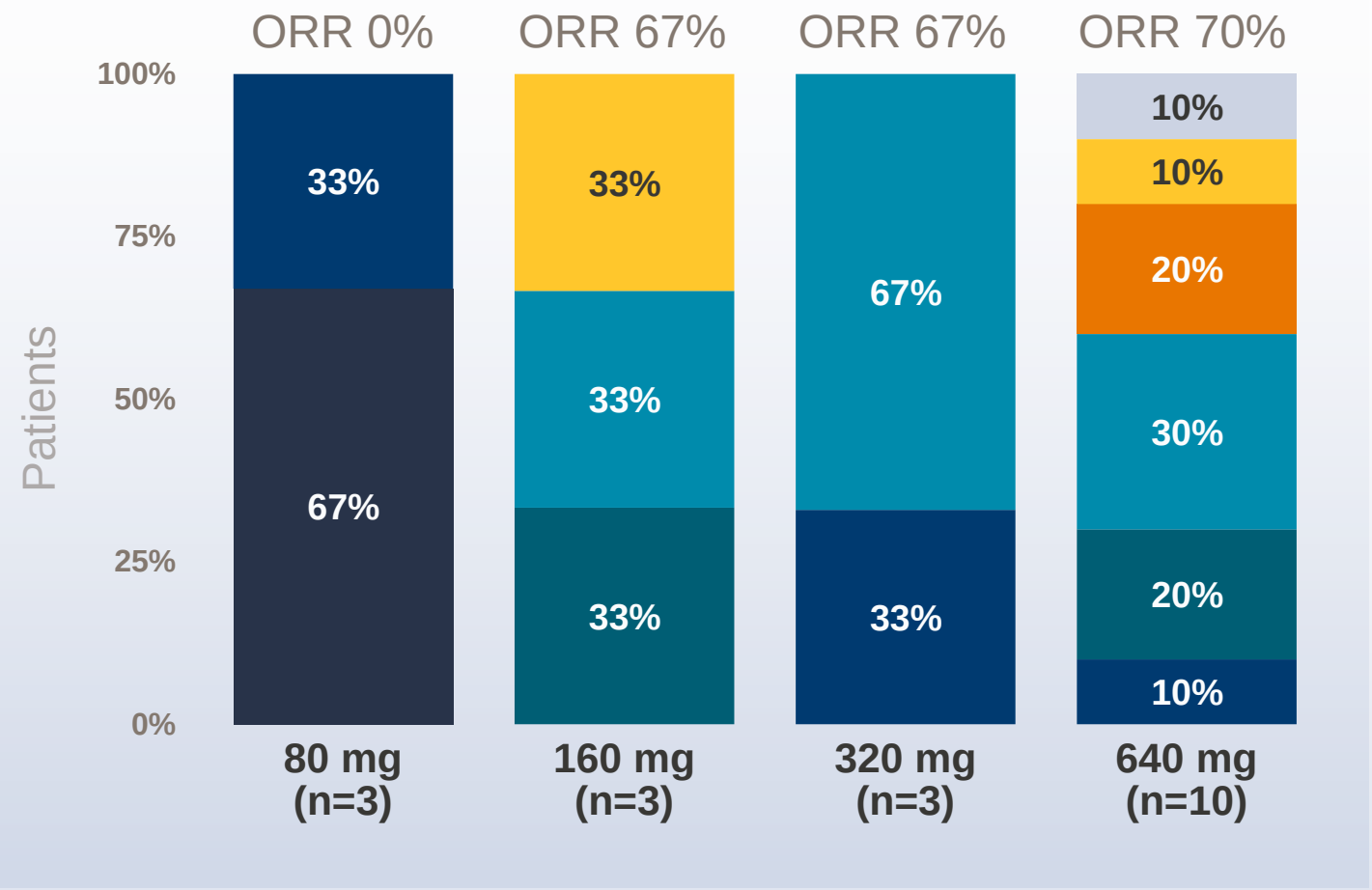
- Sonrotoclax + dexamethasone is well tolerated at all tested doses
- Early AEs predominantly insomnia, nausea and arthralgia
- No DLTs or related deaths

Patients, n (%)	All (N=19)
Most common TEAEs (≥ 20%)	
Insomnia	9 (47)
Fatigue	6 (32)
Nausea	5 (26)
Arthralgia	4 (21)
≥ Grade 3 TEAE	3 (16)
COVID-19	3 (16)
TEAEs leading to treatment discontinuation	3 (16)
DLTs	0
Deaths	4 (21)
Related to study treatment	0

TEAE - Treatment-Emergent Adverse Event
DLT - Dose-Limiting Toxicities.
AE – Adverse Event
TAES leading to treatment discontinuation include: COVID-19, Hematuria, Cancer pain (originally reported as a TEAE but was subsequently found to have PD)

Data cutoff: May 28, 2023

Promising Efficacy Observed Starting with Lower Dose Levels



- **The VGPR or better rate of 40% observed in a heavily pre-treated patient population (median of 4 prior lines of therapy)**
- **The longest DoR was 18.9 months which was still ongoing at data cutoff**
- Venetoclax monotherapy in a similar population showed an ORR of 40%
- CANOVA study showed an ORR of 62% in 2L+

sCR – Stringent complete response
CR – Complete response
VGPR – Very good partial response
PR – Partial response
MR – Minor response
SD – Stable disease
PD – Progressive Disease

Author Conclusions

- Sonrotoclax + dexamethasone combination treatment was well tolerated, with no DLTs observed at any tested dose level and the majority of patients only experienced grade 1 or 2 AEs
- Only 1 infection was grade ≥3 (COVID-19)
- Sonrotoclax + dexamethasone of 640 mg has been recommended for expansion cohort by the safety monitoring committee
- Recruitment is ongoing for the sonrotoclax + dexamethasone + carfilzomib dose-finding arms and the sonrotoclax + dexamethasone expansion cohort

Sonrotoclax + dexamethasone is generally well tolerated with promising efficacy in R/R multiple myeloma with t(11;14)

DLT - Dose-Limiting Toxicities.
AE – Adverse Event
R/R – Relapsed Refractory

Data cutoff: May 28, 2023

Pivoting to Registration

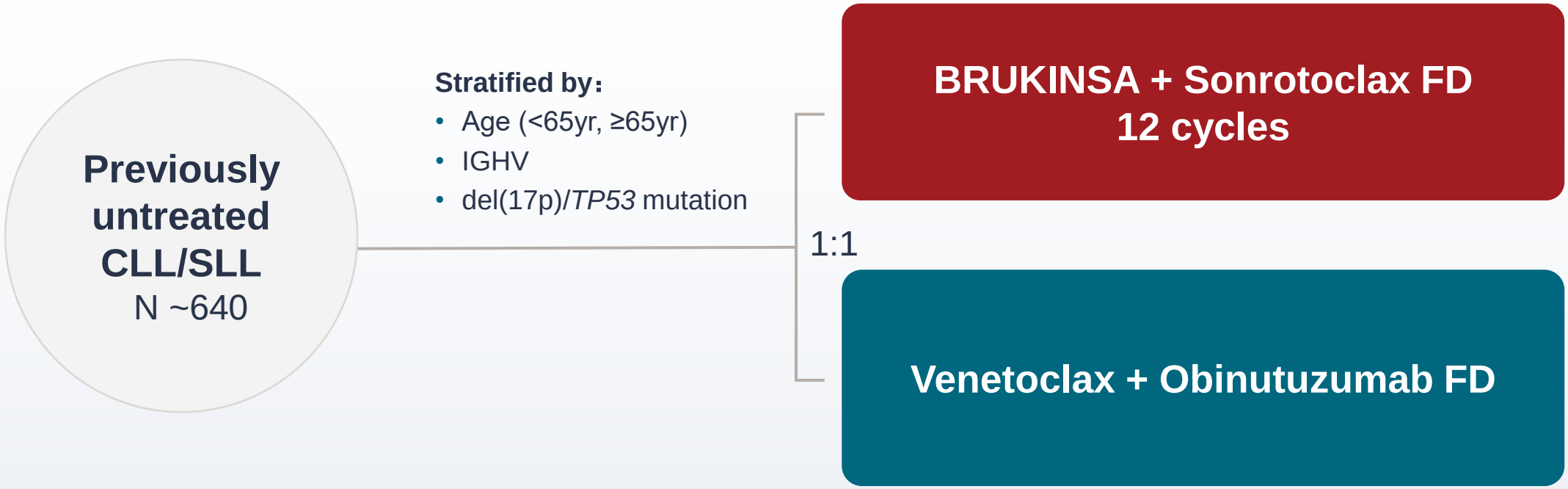
Expansion to earlier lines of B-cell malignancies, myeloid malignancies and multiple myeloma

Sonrotoclax
BGB-11417 (BCL2 inhibitor)

R/R MCL	Phase 2	**Potentially pivotal.** Monotherapy in patients with **R/R MCL post-BTKi** in the BGB-11417-201 trial
R/R CLL/SLL	Phase 2	**Potentially pivotal.** Monotherapy in patients with **R/R CLL/SLL post- BTKi** in the BGB-11417-202 trial in China
R/R WM	Phase 2	**Potentially pivotal.** Monotherapy in patients with **R/R WM post-BTKi** and post-chemoimmunotherapy in the BGB-11417-203 global trial
TN CLL/SLL	Phase 3	**Pivotal.** Fixed duration combination with BRUKINSA in **TN CLL/SLL** patients in the BGB-11417-301 global pivotal trial
		Under consideration
R/R CLL/SLL	Phase 3	***Pivotal Option starting in 2024.*** Combination with CD20 in **R/R CLL/SLL** patients
TN MCL	Phase 3	***Confirmatory Option.*** Combination with BRUKINSA in **TN MCL** patients
TN WM	Phase 3	***Confirmatory Option.*** Combination with BRUKINSA in **TN WM** patients
1L AML / MDS	Phase 3	***Pivotal Option.*** Combination with HMA in **1L Unfit AML and/or HR-MDS** patients
R/R MM	Phase 3	***Pivotal Option.*** Combination with SOC agents in **R/R MM** patients

R/R – Relapsed Refractory
MCL - Mantle Cell Lymphoma
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
WM - Waldenström's Macroglobulinemia
TN – Treatment Naive
AML - Acute Myeloid Leukemia
HR-MDS – High Risk Myelodysplastic syndromes
MM - Multiple Myeloma

Initiated Phase 3 Study in 1L CLL/SLL To Develop Best in Disease Fixed Duration Regimen



- **Primary endpoint**: PFS superiority by IRC
- **Secondary endpoints**: **uMRD at end of treatment, CR/CRi, OS,**ORR, DOR, PFS by INV, PRO, safety

CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
PFS – Progression Free Survival
IRC – Independent Review Committee
uMRD – undetectable Minimal Residual Disease
CR – Complete Response
CRi – Complete Remission with incomplete count recovery
DOR – Duration of Response
PRO – Patient Reported Outcome

Best-in-Class Potential To Expand and Grow Hematology Franchise

Best-in-Class Potential in Efficacy

- **More potent** BCL2i compared to venetoclax
- **Best combination data of a BCL2i** and BTKi in **TN CLL**
- **Encouraging efficacy** in other indications compared to venetoclax
  - Deep and durable responses in MZL, MM
  - Deep response in AML

Best-in-Class Potential in Safety and Convenience

- **More selective with favorable safety profile** vs venetoclax and **improved combinability** across indications
- **Shorter half-life** and **no accumulation**
  - No clinical TLS observed
  - Can lead to less monitoring and better utilization in all practices

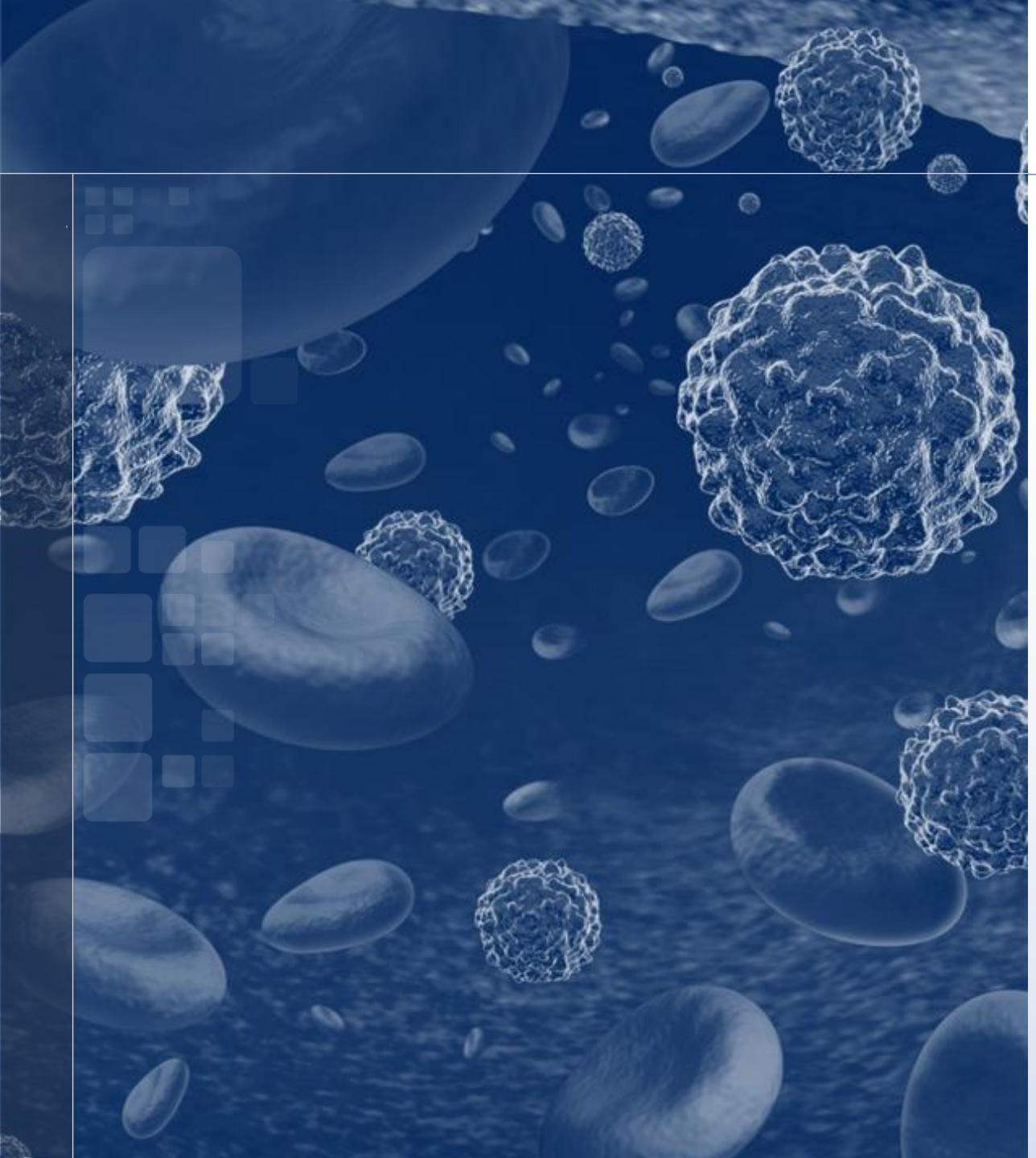
Multiple Registrational Opportunities

- **Initiated P3 in combination with BRUKINSA** in TN CLL based on strong efficacy
- **Multiple fast to market trials ongoing**
- **Planned registration enabling trials in** earlier line settings and AML
- Major opportunity **in Multiple Myeloma** after recent failure of venetoclax in MM (CANOVA)

Hematology Leadership

- **Best**-in-Disease **combinations**
- **Fixed duration treatment**
- Opportunity to expand franchise into **new indications**

TN – Treatment Naïve
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
WM - Waldenström's Macroglobulinemia
MCL - Mantle Cell Lymphoma
MZL - Marginal Zone Lymphoma
MM – Multiple Myeloma
TLS – Tumor Lysis Syndrome
AML - Acute Myeloid Leukemia



BRUKINSA

Sonrotoclax

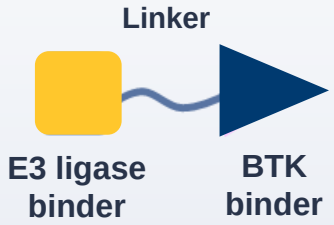
BGB-16673
(BTK CDAC)

TEVIMBRA

Chimeric Degradation Activation Compound
A Novel and Differentiated Approach to BTK Pathway

CDAC platform developed by BeiGene

- **Bivalent molecule** that co-opts a process leading to degradation of target protein



Differentiated BTK degrader

- **MOA agnostic of any BTK mutations,** including C481, T474*, and L528W*
- **Potency** benefits given **complete protein degradation** vs inhibition
- Lack of IMiD activity (vs competitors) allows for **improved safety compared to other degraders**

Robust clinical plans

- **Two Phase 1 studies** currently enrolling (**128** patients to date) with compelling emerging data
- Expansion cohort in **RR MCL** imminent with **fast to market potential**
- Combination studies & initiation of confirmatory trial in 2024

Expanding in more heme malignancies

- **Become backbone** therapy for patients progressing after BTKi and then earlier lines of therapy
- Degradation may **expand in additional disease areas** (LBCL, Richter's, Follicular)

MoA – Mechanism of Action
IMiD – Immunomodulatory Agent
LBCL – Large B-Cell Lymphoma

**pirto resistance mutations

2023 ASH Poster

Study	Title	Author	Date / time
16673-101 Dose finding	**First Results from a Phase 1, First-in-Human Study of the Bruton's Tyrosine Kinase (BTK) Degrader BGB-16673 in Patients (Pts) with Relapsed or Refractory (R/R) B-Cell Malignancies**	**John Seymour, MD** First scientific presentation of BGB-16673 demonstrating compelling safety and efficacy in dose escalation cohorts of patients including those with prior BTKi and BCL2i treatment	**Poster 4401** **12/11/2023** **6:00 pm**

Professor John Seymour

- **Professor John Seymour AM** is a clinical haematologist and Director of the Department of Haematology of the Peter MacCallum Cancer Centre and the Royal Melbourne Hospital in Melbourne, Australia
- He received his MB, BS degrees from the University of Melbourne in 1987, completed a translational research fellowship at the MD Anderson Cancer Center in Houston, and subsequently received their Distinguished Alumnus award in 2011. He also completed PhD studies in the pathobiology of haematopoietic growth factors at the Ludwig Institute for Cancer Research
- He served for more than a decade as Executive member and Chairman of the major national clinical trials co-operative group in haematologic malignancies, the Australasian Leukaemia and Lymphoma Group, and 6 years as Associate Director of Research (Clinical) for Peter Mac
- Professor Seymour has authored 20 book chapters, more than 600 peer reviewed publications (with more than 50,000 literature citations and h-index of 97), and over 900 conference abstracts. Actively involved in a broad range of collaborative research, Professor Seymour has been the principal investigator on more than 90 clinical trials predominantly in the domains of early drug development and the indolent lymphoproliferative disorders, especially CLL and follicular lymphoma

BIOGRAPHY

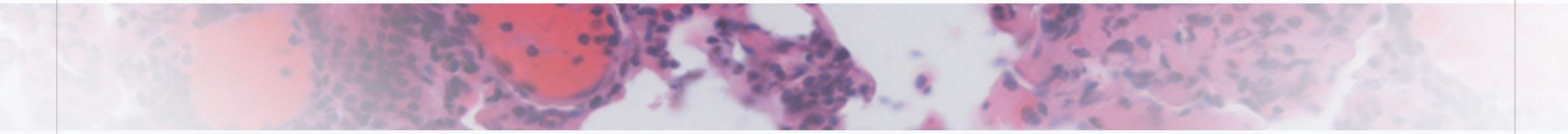
Peter Mac
Peter MacCallum Cancer Centre
Victoria Australia

The Royal Melbourne Hospital

John Seymour

Director of the Department of Haematology of the Peter MacCallum Cancer Centre and the Royal Melbourne Hospital

American Society of Hematology
Helping hematologists conquer blood diseases worldwide

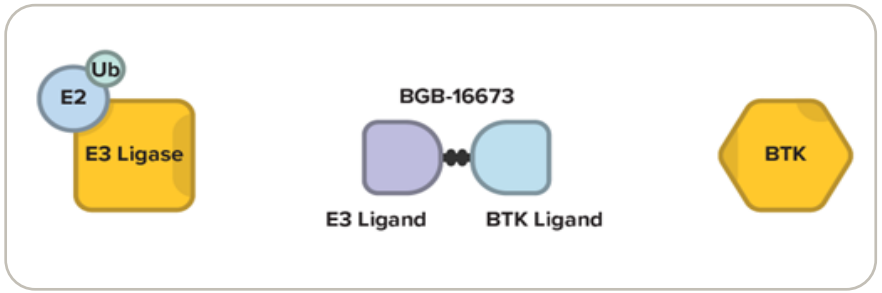


First Results From a Phase 1, First-in-Human Study of the Bruton Tyrosine Kinase Degrader BGB-16673 in Patients With Relapsed or Refractory B-Cell Malignancies (BGB-16673-101)

John F. Seymour[1];Chan Y. Cheah[2-4]; Ricardo Parrondo[5]; Meghan C. Thompson[6]; Don Stevens[7]; Masa Lasica[8]; Michael Wang[9]; Abhijeet Kumar[10]; Judith Trotman[11]; Maan Alwan[12]; Wei Ding[13]; Kunthel By[14]; Bilal Tariq[14]; Xiangmei Chen[14]; Shannon Fabre[14]; Jason Paik[14]; Amit Agarwal[14]; Constantine S. Tam[15,16]

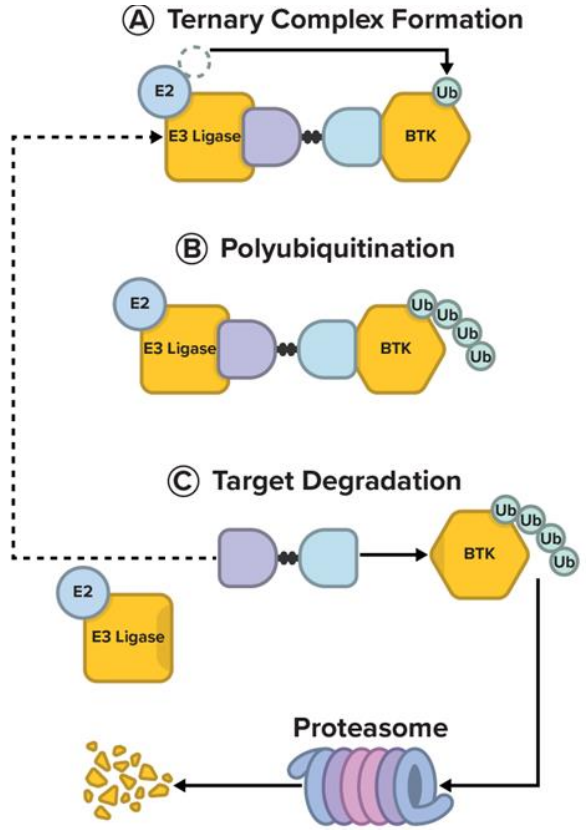
[1]Peter MacCallum Cancer Centre, Royal Melbourne Hospital, and University of Melbourne, Melbourne, VIC, Australia; [2]Department of Haematology, Sir Charles Gairdner Hospital and Pathwest Laboratory Medicine, Nedlands, WA, Australia; [3]Medical School, University of Western Australia, Crawley, WA, Australia; [4]Linear Clinical Research, Nedlands, WA, Australia; [5]Mayo Clinic-Jacksonville, Jacksonville, FL, USA; [6]Memorial Sloan Kettering Cancer Center, New York, NY, USA; [7]Norton Healthcare, Louisville, KY, USA; [8]St Vincent's Hospital Melbourne, Fitzroy, VIC, Australia; [9]MD Anderson Cancer Center, Houston, TX, USA; [10]University of Arizona College of Medicine – Tucson, Tucson, AZ, USA; [11]Concord Repatriation General Hospital, University of Sydney, Concord, NSW, Australia; [12]Perth Blood Institute, West Perth, WA, Australia; [13]Mayo Clinic-Rochester, Rochester, MN, USA; [14]BeiGene (Shanghai) Co, Ltd, Shanghai, China, and BeiGene USA, Inc, San Mateo, CA, USA; [15]Alfred Hospital, Melbourne, VIC, Australia; [16]Monash University, Clayton, VIC, Australia

Our BTK Degrader Has a Differentiated Mechanism of Action



Molecule attributes and potential advantages of BGB-16673

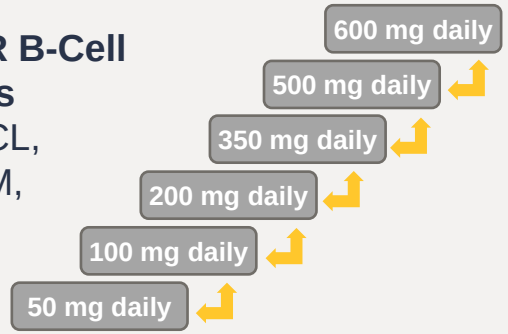
- Catalytic pharmacology that does not require sustained target binding
- Can interrupt formation of oncogenic protein complexes (“scaffolding”)
- Potential to overcome resistance mutations such as BTK C481, T474, and L528W
- Has substantially reduced immunomodulatory drug activity;
  Aiolos and Ikaros are not significantly degraded



BGB-16673-101 Phase 1a/b Study in B-Cell Malignancies

Dose escalation

Selected R/R B-Cell Malignancies
(MZL, FL, MCL, CLL/SLL, WM, DLBCL, RT)



Safety expansion

Up to 20 patients enrolled at each dose level

RP2D

Dose expansion

Cohort 1:
Post BTKi R/R CLL/SLL

Cohort 2:
Post BTKi R/R MCL

Objectives

- Characterizing safety / PK / biomarker properties, MTD, and RP2D in escalation and safety expansion
- Safety/efficacy at the RP2D in dose expansion

MZL - Marginal Zone Lymphoma
FL - Follicular Lymphoma
MCL - Mantle Cell Lymphoma
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
WM - Waldenström's Macroglobulinemia
DLBCL – Diffuse Large B-Cell Lymphoma
RT - Richter's Transformation
PK – Pharmacokinetics
MTD – Maximum Tolerated Dose
RP2D – Recommended phase 2 dose

A Potent BTK Degrader for the Treatment of B-Cell Malignancies Safety

Safety profile is favorable in heavily pre-treated patient population, MTD not reached
No atrial fibrillation, hypertension seen

Safety overview	N=26
Any TEAE	23 (88.5%)
Grade 3 or higher	12 (46.2%)
Serious	10 (38.5%)
Leading to treatment discontinuation	0
Leading to dose reduction[a]	2 (7.7%)
DLT[b]	1 (3.8%)

[a] Hematuria (50 mg) in the context of subsequently identified recurrent urothelial carcinoma; arthralgia (100 mg) in the context of a previous history of BTK inhibitor–associated arthralgia;

[b] DLT occurred at 200 mg. DLT was a grade 3 maculopapular rash on Day 27. After 5-day dose hold, assigned dose was recommenced with persistent grade1 rash

MTD – Maximum Tolerated Dose
TEAE – Treatment Emergent Adverse Events
DLT - Dose Limiting Toxicity.

A Potent BTK Degrader for the Treatment of B-Cell Malignancies-AESI

Adverse events of interest (pooled, %)	N=26	
	Any grade	Grade ≥3
Contusion[a]	8 (30.8%)	0
Neutropenia	6 (23.1%)	4 (15.4%)
Lipase increase[b]	6 (23.1%)	1 (3.8%)
Pyrexia	6 (23.1%)	0
Hypertension	0	0
Atrial fibrillation	0	0

[a] Hematuria (50 mg) in the context of subsequently identified recurrent urothelial carcinoma; arthralgia (100 mg) in the context of a previous history of BTK inhibitor–associated arthralgia;

[b] All transient and asymptomatic.

AESI – Adverse Events of Special Interest

Promising Efficacy Observed Starting at Lower Dose Levels Including in Patients with BTK Mutations

Responses by dose in evaluable patients

	50 mg (n=4)	100 mg (n=7)	200 mg (n=7)	All doses (N=18)
CR	1 (25.0)	0	0	1
PR	1 (25.0)	2 (28.6)	5 (71.4)	8
PR-L	0	1 (14.3)	1 (14.3)	2
MR	0	1 (14.3)	0	1
SD	0	2 (28.6)	1 (14.3)	3
PD	2 (50.0)	1 (14.3)	0	3
ORR, n (%)[a]	2 (50.0)	4 (57.1)	6 (85.7)	

CR – Complete Response
PR – Partial Response
PR-L – Partial Response with Lymphocytosis
SD – Stable Disease
PD – Progressive Disease
ORR – Overall Response Rate

[a] Proportion of patients who achieved a BOR better than SD
[b] Time to first qualifying response in patients with a BOR better than SD

BGB-16673-101:
Efficacy by Patient with Promising Durability Data

X, patient discontinued study. DCO 15JU
BGB-16673-101 Efficacy By Patient N2023
Median number of prior treatments = 4
cBTKi - covalent BTKi ncBTKi - non-covalent BTKi

Author Conclusions

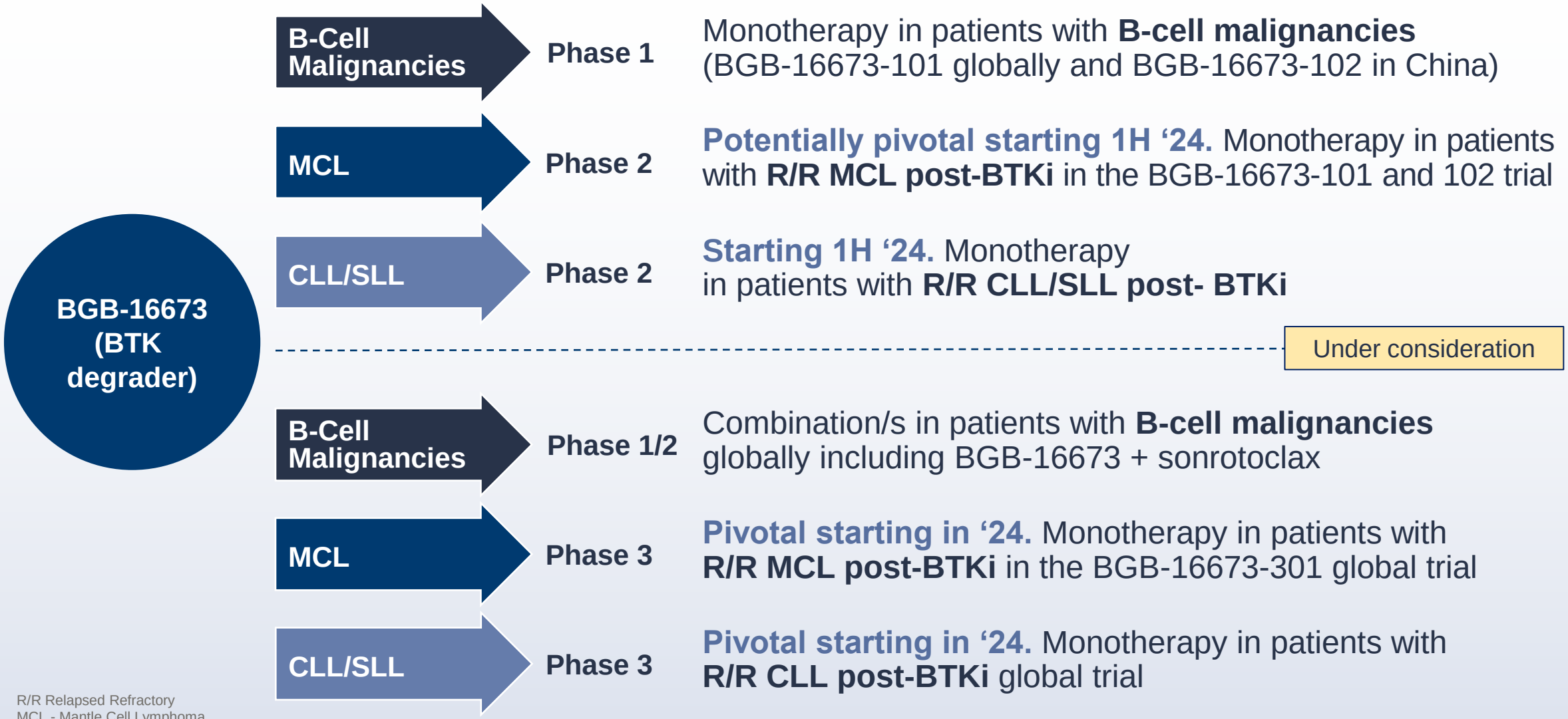
- Preliminary results from this ongoing, first-in-human study of the novel BTK degrader BGB-16673 demonstrate meaningful clinical responses with a short time to response in heavily pretreated patients with B-cell malignancies
- The safety profile of BGB-16673 appears tolerable to date with a single DLT (rash) reported and the study continues
  - No atrial fibrillation or hypertension has been reported
- Taken together, these data support further examination of the clinical activity of BGB-16673 across several B-cell malignancies; phase 2 dose expansions are planned within this study for patients with CLL/SLL and MCL

BTK CDAC has meaningful clinical responses with a short time to response and good tolerability in Phase 1 study

DLT – Dose Limiting Toxicity
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
MCL - Mantle Cell Lymphoma

[a] Proportion of patients who achieved a BOR better than SD.
[b] Time to first qualifying response in patients with a BOR better than SD.
BOR, best overall response; ORR, overall response rate.

BGB-16673 BTK CDAC Broadening Development Program



R/R Relapsed Refractory
MCL - Mantle Cell Lymphoma
CLL/SLL - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma

Most Advanced BTK Degrader in the Clinic

Clinically Meaningful Efficacy Data

- BTK degradation and efficacy seen **starting at lowest dose including patients with BTK mutations**
- Clinical responses observed in **prior cBTKi and ncBTKi (e.g. pirtobrutinib)** treated patients
- **Short time to response**

Favorable Safety Profile

- **Lack of IMiD activity**
- **Safe and tolerable in 128 patient treated**
- **No atrial fibrillation and hypertension**; low Gr3/4 neutropenia in heavily pre-treated patients

Robust Registration Plan

- Expansion cohort in **RR MCL** imminent with **fast to market potential**
- Phase 3 studies in **MCL and CLL in 2024**

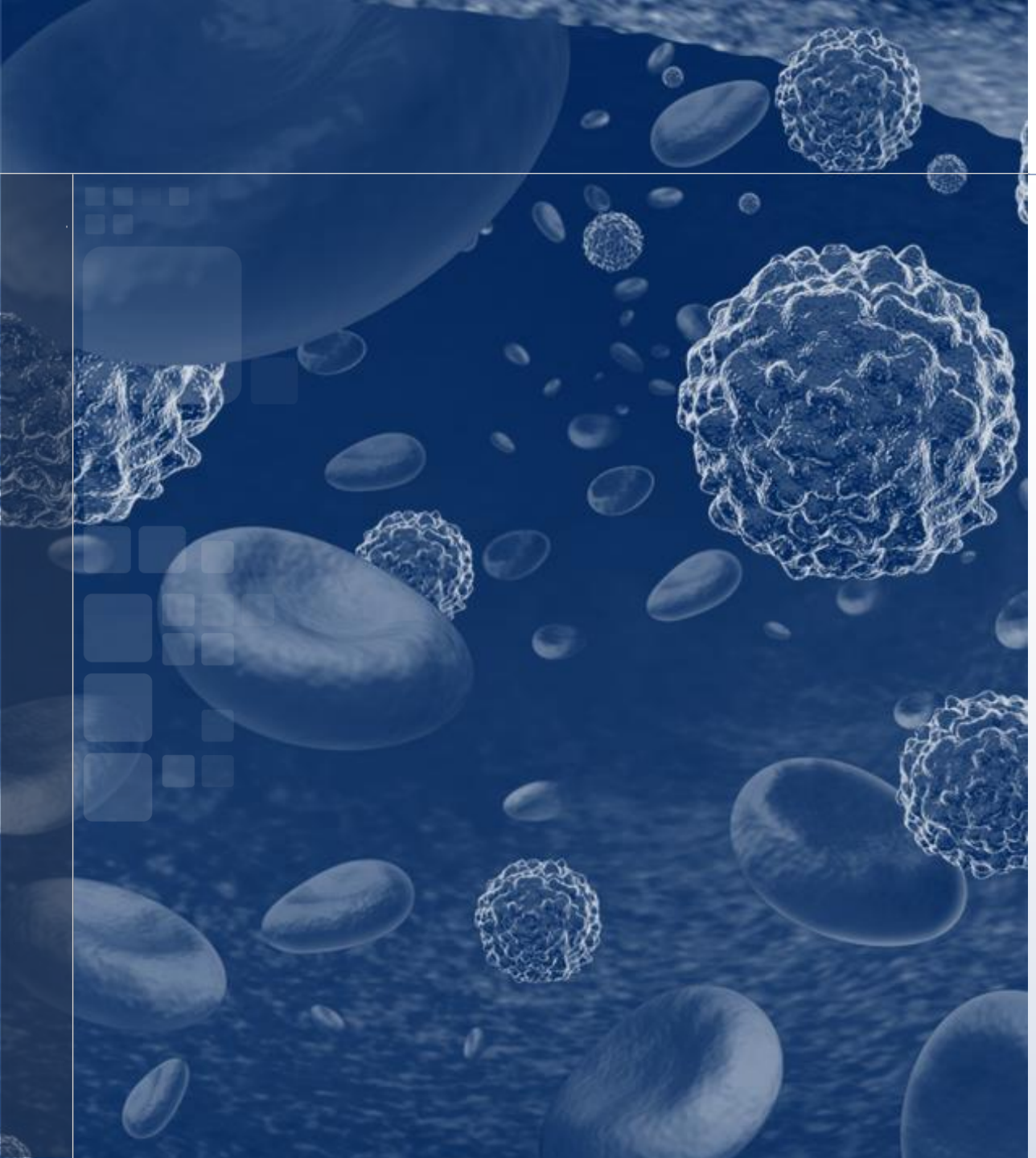
Growing our Hematology Franchise

- Potential to be used in several B-cell malignancies as **monotherapy and in combination**
- **Platform study** to explore novel combinations

cBTKi –covalent BTKi
ncBTKi – non-covalent BTKi
IMiD – Immunomodulatory Agents
R/R - Relapsed Refractory
MCL - Mantle Cell Lymphoma
CLL- Chronic Lymphocytic Leukemia

2023 ASH Poster

Study	Title	Authors	Date / time
16673-101 **Dose finding**	**First Results from a Phase 1, First-in-Human Study of the Bruton's Tyrosine Kinase (BTK) Degrader BGB-16673 in Patients (Pts) with Relapsed or Refractory (R/R) B-Cell Malignancies**	**John Seymour**, Chan Y. Cheah, Ricardo Parrondo, Meghan C. Thompson, Don Stevens, Masa Lasica, Michael Wang, Abhijeet Kumar, Judith Trotman, Maan Alwan, Wei Ding, Kunthel By, Bilal Tariq, Xiangmei Chen, Shannon Fabre, Jason Paik, Amit Agarwal, and Constantine S. Tam	**Poster 4401** **12/11/23** **6:00-8:00 pm** **Session: 623**



BRUKINSA

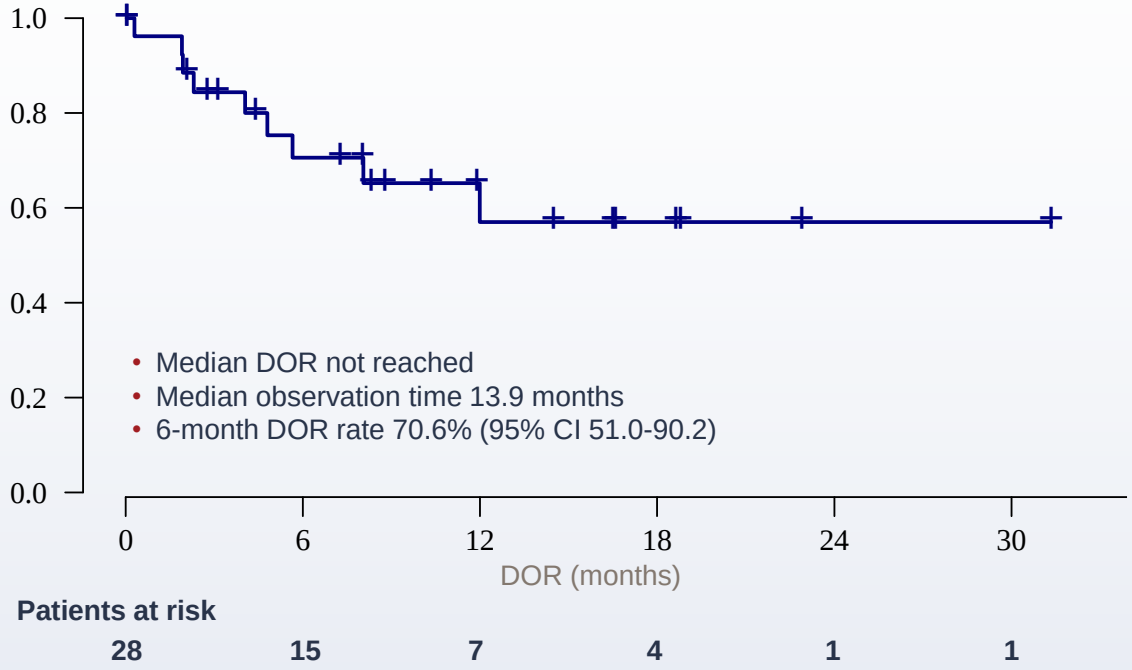
Sonrotoclax

BGB-16673
(BTK CDAC)

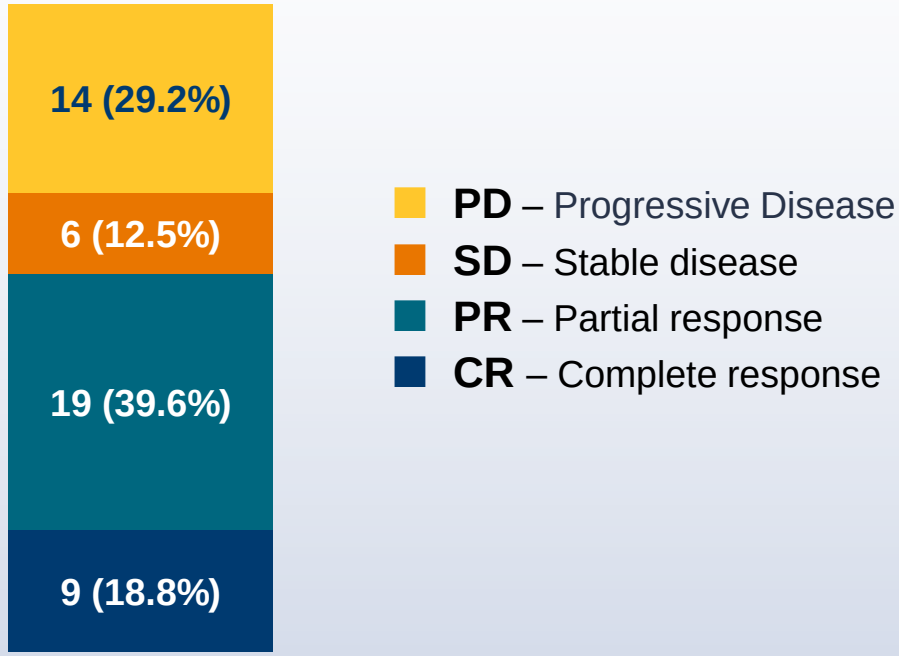
TEVIMBRA

Combined TEVIMBRA and BRUKINSA Delivers Good Response in Patients with Richter's Transformation

Duration of Response is 70.6% at 6 months



Primary Endpoint Met With ORR of 58.3%



ORR of 58%, 1-year PFS 47% and 1-year OS 75%
Limited cardiotoxicity and **immune-related adverse events**

UNIKLINIK KÖLN | Department I of Internal Medicine University Hospital of Cologne

DEUTSCHE STUDIENGRUPPE

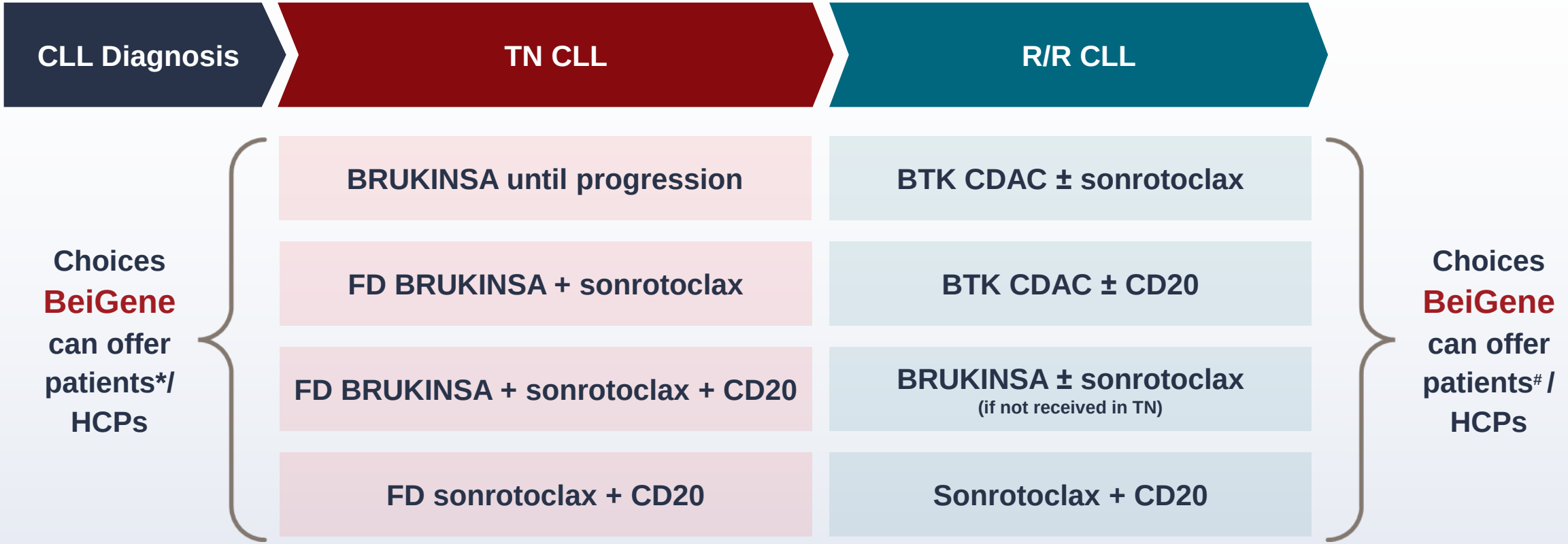
nature medicine

Hematology Closing

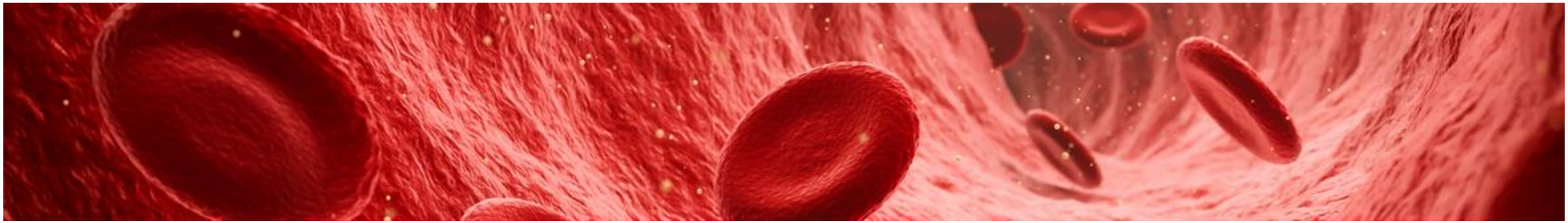
Mehrdad Mobasher, M.D., M.P.H.

Chief Medical Officer, Hematology

Covering the Entire CLL Patient Journey: Confirming Our Leadership in the Treatment of the CLL Disease Setting



Accelerating Development of Differentiated Assets as a Leader in Broad Range of Hematologic Malignancies



1 Cement Leadership

BRUKINSA as the **best-in-class** and **only BTKi for CLL with superior data**

ALPINE ePFS **reconfirms sustained, superior efficacy** and **safety** vs. ibrutinib

Broadest label globally and exciting lifecycle strategies

2 Grow Leadership

Advancing sonrotoclax as **differentiated BCL2i with best-in-class potential** to registration

BTK CDAC has a novel and **mutation agnostic** MOA and clinically **meaningful efficacy and safety** with a defined path to registration

3 Expand

Best-in-disease combinations with 3 differentiated molecules

Ability to **address all lines of therapy** with our own heme portfolio

Expanding into new indications with high unmet medical needs: **AML/MDS, MM, Richter's and LBCL**

4 Impact

Greater **impact on patient outcomes**

Significant market share in hematologic diseases

CLL - Chronic Lymphocytic Leukemia
AML - Acute Myeloid Leukemia
MDS - Myelodysplastic syndromes
MM - Multiple Myeloma
RT - Richter's Transformation
LBCL - Large B-cell Lymphoma

Q&A Session

John V. Oyler
Co-Founder,
Chairman and CEO
BeiGene

Dr. Lai Wang
Global Head
of R&D
BeiGene

Dr. Mehrdad Mobasher
CMO,
Hematology
BeiGene

Julia Wang
Chief Financial Officer
BeiGene

Josh Neiman
Chief Commercial Officer,
North America and Europe
BeiGene

Dr. Mazyar Shadman
Associate Professor
Fred Hutchinson Cancer Center /
University of Washington School of Medicine

Dr. Constantine Tam
Head of Lymphoma Service /
Professor of Haematology
Alfred Health /
Monash University

Dr. Hang Quach
Professor of Haematology /
Director of Clinical Haematology and
Clinical Haematology Research
University of Melbourne /
St. Vincent's Hospital Melbourne

Dr. John Seymour
Director of the Department
of Haematology
Peter MacCallum Cancer Center /
The Royal Melbourne Hospital

Closing Remarks

John V. Oyler

Co-Founder, Chairman and CEO

Thank You!

BeiGene