BeyondSpring

Corporate Presentation

November 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.

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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.

BeyondSpring Investment Highlights (Nasdaq: BYSI)

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

Headquarters	New York, NY
Lead Asset	Plinabulin for CIN, US NDA PDUFA November 30, 2021 Plinabulin for NSCLC, est. NDA filing 1H 2022
Partnerships	Plinabulin in Greater China – Co-development & Commercial Partnership with Hengrui Subsidiary SEED Therapeutics (proprietary TPD Platform) $800M partnership with Eli Lilly
Cash position	$76.3M as of June 30, 2021 + $45M from Hengrui upfront and investment commitment

Lead Asset Plinabulin: "A Pipeline in a Drug"

NSCLC

- DUBLN-3: Plinabulin + Docetaxel for 2nd/3rd line NSCLC, EGFR wild type
- Positive Topline Final phase 3 OS data reported in August 2021
- Late-breaking oral presentation of DUBLIN-3 data at ESMO on 9/20/2021

CIN

- Plinabulin + G-CSF for CIN Prevention Indication
- Breakthrough Designation (BTD) and NDA accepted with Priority Review from US and China FDA

IO

- Triple I/O combo in multiple cancer indications in early development, including 7 cancers at MD Anderson
- Efficacy data for phase 1 SCLC at ASCO 2021

Robust Plinabulin Pipeline: 2 Near-term NDAs & I/O Clinical Trials

	Indication / Target	Program	Trial Name / Collaborator	Preclinical	Phase 1	Phase 2	Phase 3	Commercial Rights[1]	Status/Next Milestone
Late stage	NSCLC (2nd/3rd line)	Plinabulin + docetaxel	DUBLIN-3	Phase 3 primary and secondary endpoints met in pivotal data announced August 2021				Global	• Positive topline Phase 3 data August 2021 • Late-breaking presentation at ESMO Sept 20, 2021 • Hengrui partnership in Greater China
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. and China NDA accepted with Priority Review; US PDUFA Nov. 30, 2021 • Hengrui partnership in Greater China
Triple Combo IO (IIT)	SCLC	Plinabulin + nivolumab + ipilimumab	US sites, including Rutgers University as lead site					Global	Phase 2
Triple Combo IO (IIT)	7 cancers (PD-1/PD-L1 failed)	Plinabulin + PD-1/PD-L1 + radiation/chemo	THE UNIVERSITY OF TEXAS MD Anderson Cancer Center					Global	Phase 1 in 7 cancers in June 2021
Investigator-initiated IO	Oral T cell co-stimulator	BPI-002						Global	
Investigator-initiated IO	IKK inhibitor	BPI-003						Global	
Investigator-initiated IO	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
SEED Therapeutics	Multiple		Lilly					Global	$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.

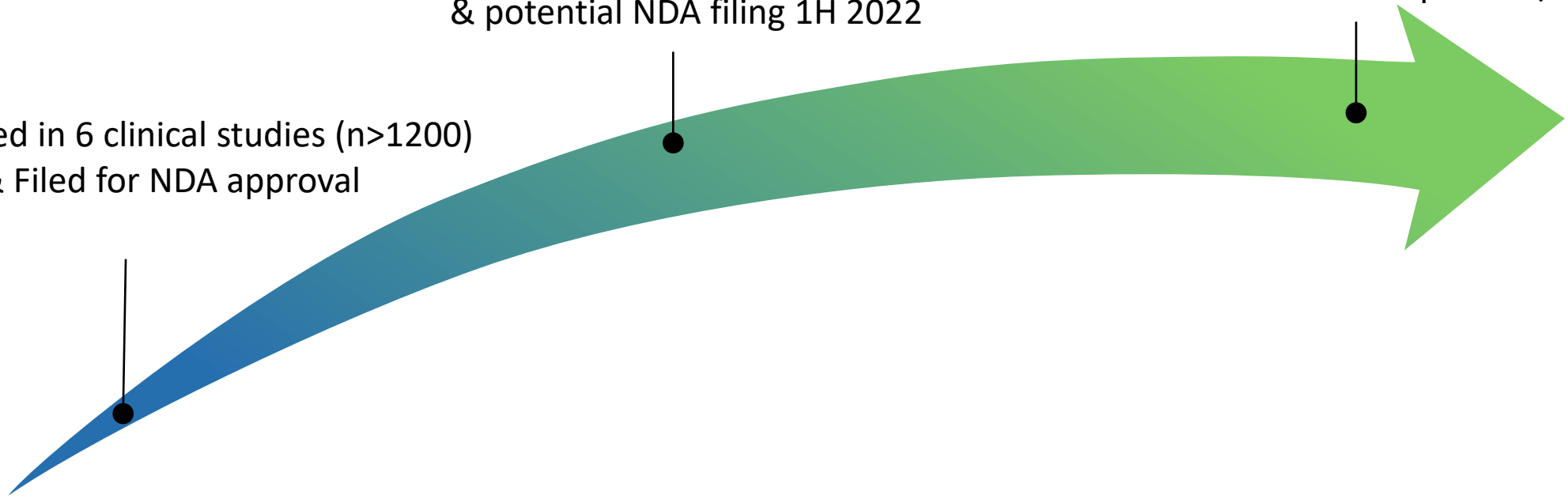
Plinabulin Franchise: “Pipeline in a Drug”

Clinical Confirmation → **Expand** → **Transform**

Confirmed in 6 clinical studies (n>1200)
& Filed for NDA approval

Positive Phase 3 OS data (n=559)
& potential NDA filing 1H 2022

Promising early clinical efficacy data
– 7 different cancers in phase 1/2 study



CIN (BTD & Priority Review)
- **Superior Regimen vs. SOC**
- **PDUFA 11/30/2021**

NSCLC
- **Strong MOA Rationale**
- **Successful DUBLIN-3 phase 3 Study**

Multiple Cancers (I/O Combo)
- Synergistic MOA with Checkpoint Inhibitors
- Promising Preclinical & Early Clinical Efficacy Data

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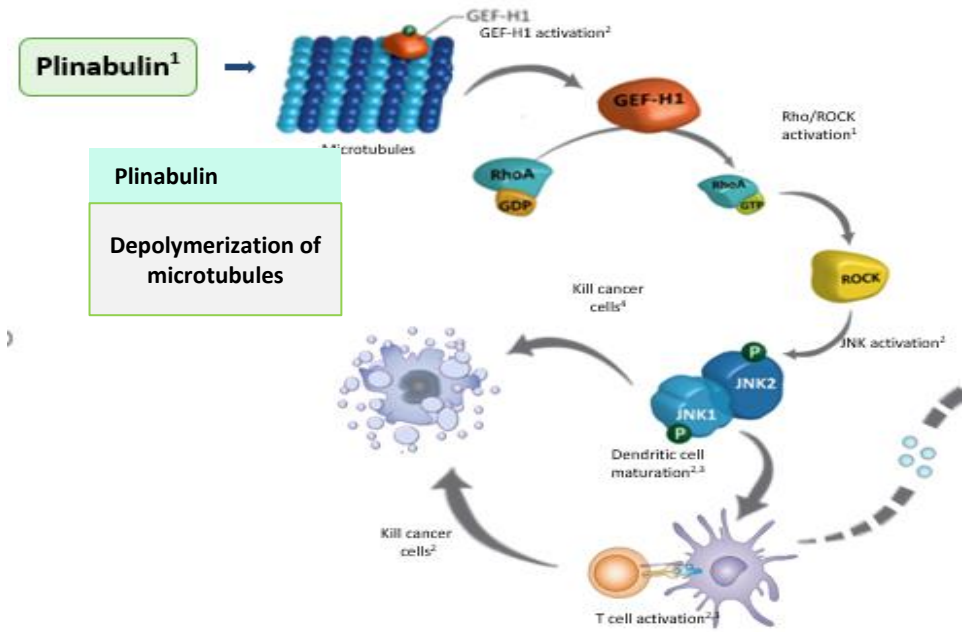
Plinabulin: “Pipeline in a Drug”

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

Novel Mechanism of Action

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

- Plinabulin Induces Dendritic Cell Maturation (the most potent APC), a Key Step in Initiating Anti-Cancer Durable Response

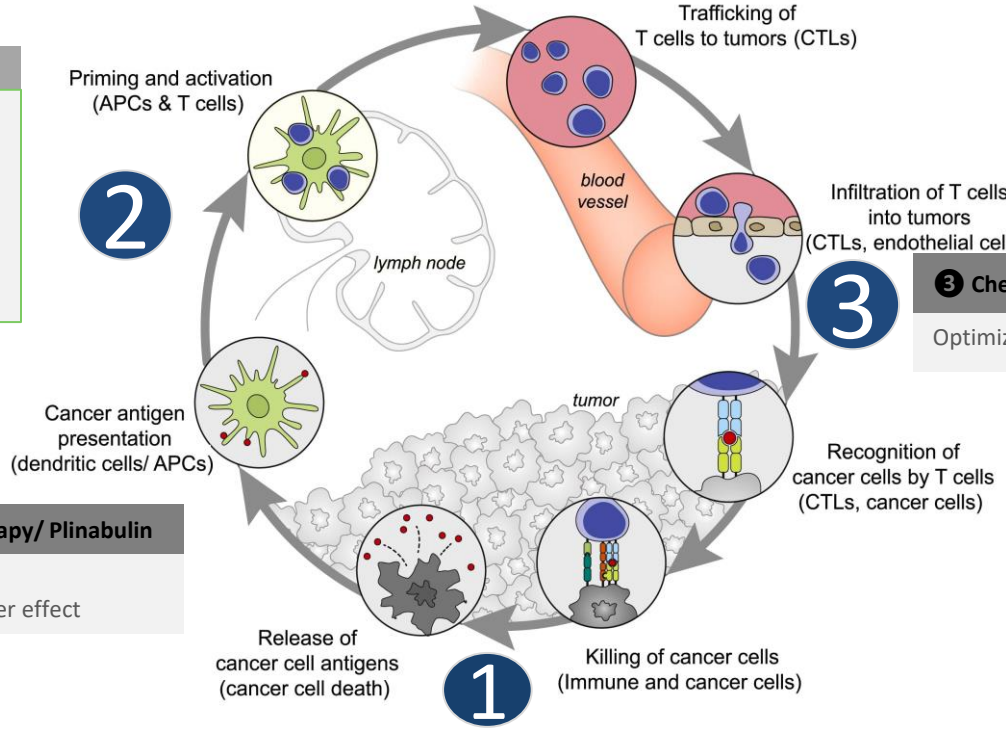


Plinabulin

Depolymerization of microtubules

❷ Plinabulin

Stimulate maturation of dendritic cells to increase antigen presentation.
Dendritic cells are the most important antigen-presenting cells



❸ Checkpoint Inhibitors

Optimize T cell response

❶ Radiation/Chemotherapy/ Plinabulin

Release Tumor Antigens
For more potent anti-cancer effect

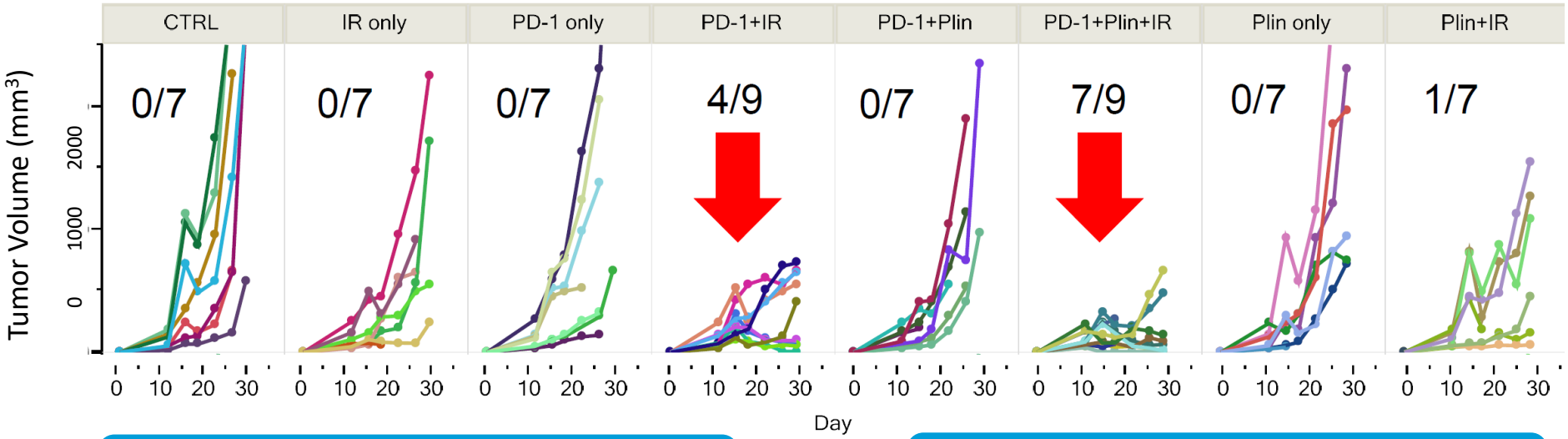
Plinabulin Novel Target: Immune Defense Protein GEF-H1

❶ + ❷ + ❸ → Optimal Immuno-Oncology Response

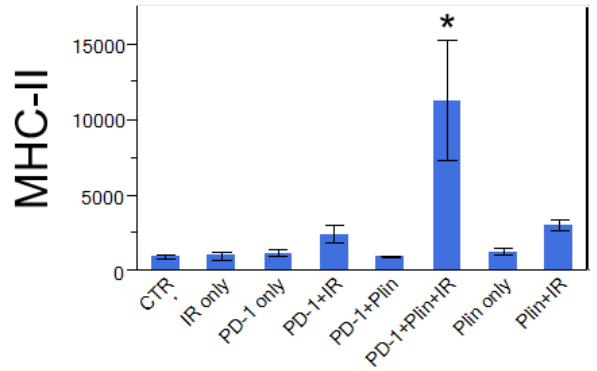
Note: [1] La Sala et al., 2019 Chem. [2] Kashyap et al., 2019 Cell Reports. [3] Zhang et al., 2005 Mol Cell Biol. [4] Singh et al., 2011 Blood. [5] Suwa et al., 2000 Am J Physiol Heart Circ Physiol; Ghosh et al., 2018 ACR Annual Conference; Blayney et al., Society of Leukocyte Biology. [6] Asensi et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

Triple I/O Combo: Plinabulin + PD-1 + Radiation (IR)

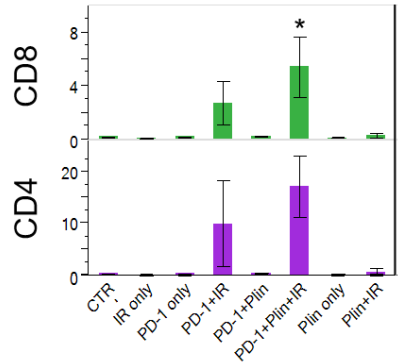
Best Tumor Response in PD-1 Non-Responsive Tumor Model (MD Anderson)



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

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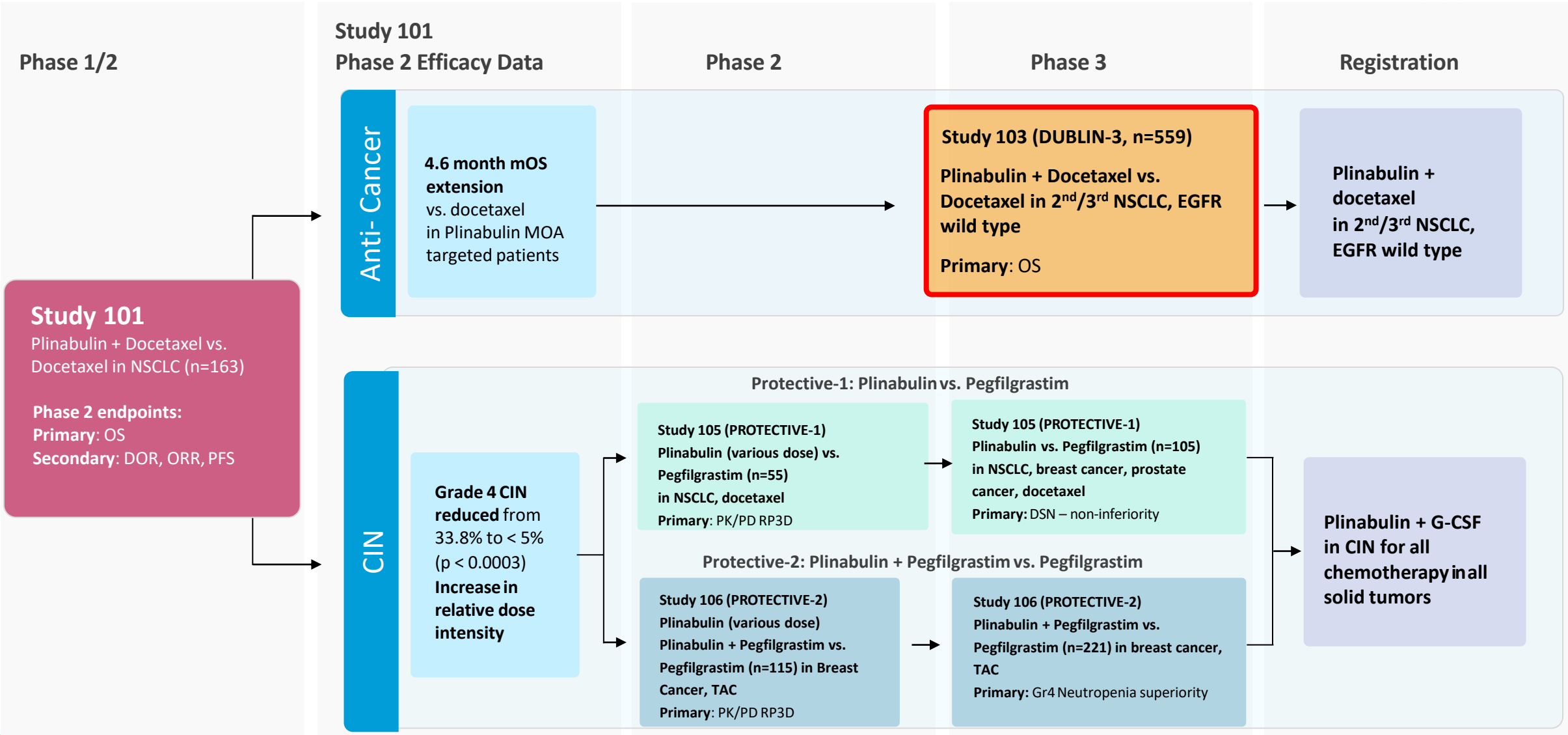
*Neri S. et al. Plinabulin, a microtubule destabilizing agent, improves tumor control by enhancing dendritic cell maturation and CD8 T cell infiltration in combination with immunoradiotherapy, AACR June 2020

Plinabulin Clinical Development Program



Plinabulin Opportunity

1. **Plinabulin is a novel mechanism, first-in-class immunomodulating microtubule-binding agent, complementary to existing standard of care**
2. **DUBLIN-3 provides compelling clinical data in 2L/3L NSCLC; potential to move into earlier lines of therapy and into broad range of tumor types**
3. **Near-term revenue opportunity in Chemotherapy Induced Neutropenia (CIN)**
4. **Transformative potential as a cornerstone in immuno-oncology combinations**

Delivering the Plinabulin Value Proposition

Near Term Opportunity

Longer-Term Potential

ANTI-CANCER w/ Chemotherapy

Improve Survival and Quality of Life

CIN

Raise the Standard of Care

ANTI-CANCER w/ Immuno-Oncology

Potential APC Cornerstone of emerging regimens

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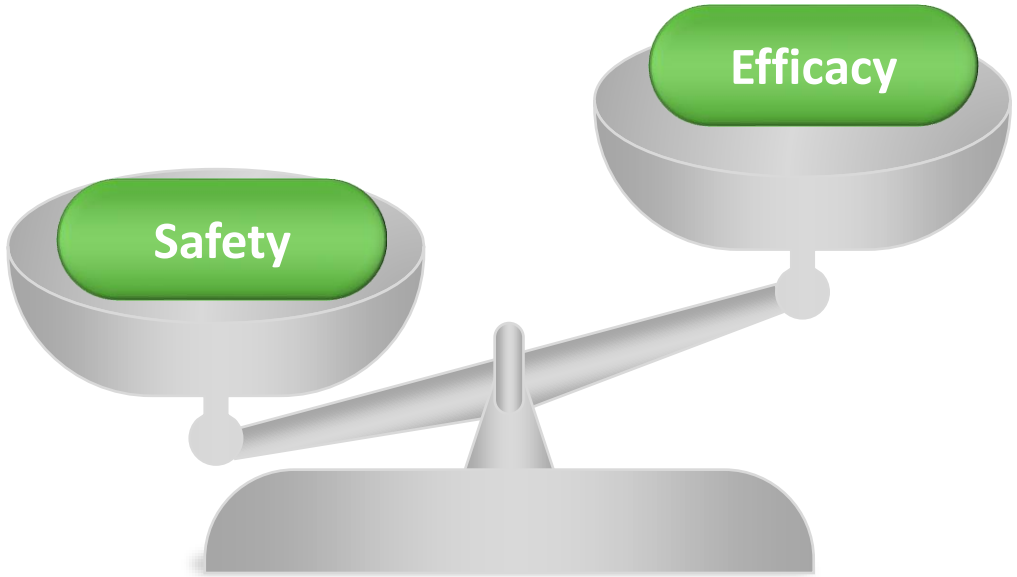
Anti-Cancer with Chemotherapy

NSCLC: Severe Unmet Medical Needs – 2nd/3rd Line, EGFR Wild Type



- Large patient population with limited treatment options
  - EGFR wild type: ~85% western NSCLC and ~70% of Asian NSCLC patients
  - With immunotherapies moved to first line, Docetaxel-based therapies are the mainstay therapy
  - TKIs are worse than docetaxel[1]
- Docetaxel-based Therapies (SOC)
  - Limited efficacy
  - >40% severe neutropenia

Since nivolumab was approved 6 years ago, no new agent with novel mechanism has been approved in this indication.

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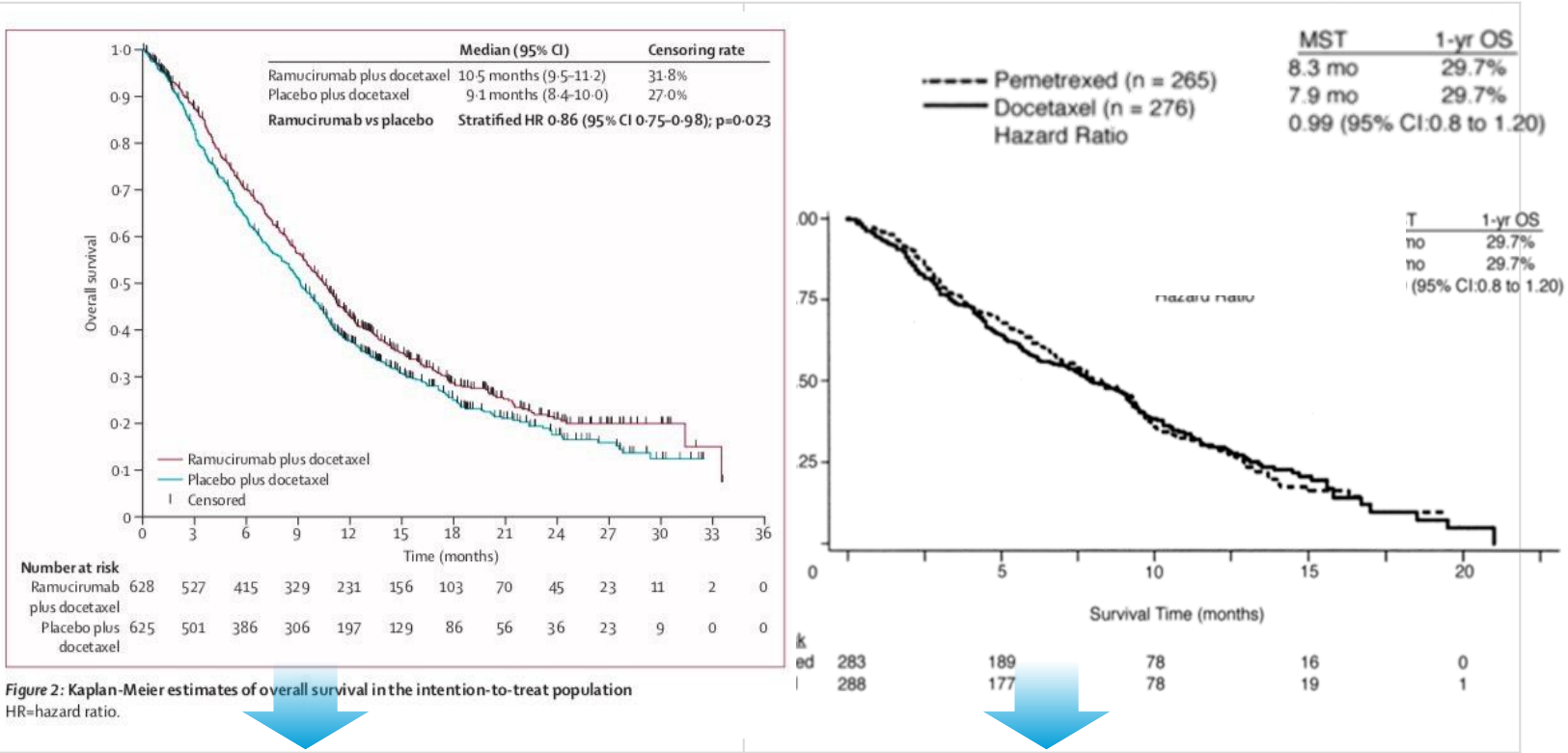
[1] Lancet Oncol. 2013 Sep;14(10):981-8.

Underserved Market: 2nd/3rd Line NSCLC Treatment

With PD-1/PD-L1 Moved To First Line, Patients are Left with Efficacy and Safety Tradeoffs and Suboptimal Regimens



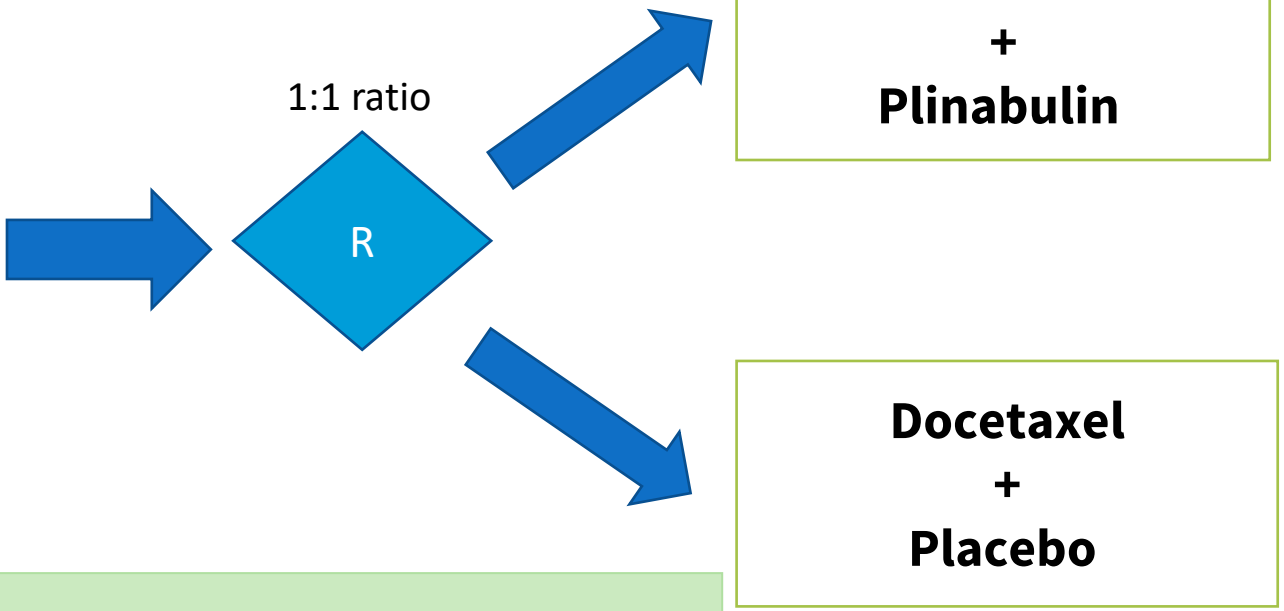
Treatment	Ramuciramab + Docetaxel vs. Docetaxel[1]	Pemetrexed vs Docetaxel[2]
Pros	Limited efficacy; OS HR: 0.86	Low CIN risk (severe neutropenia: 5.3% pemetrexed vs. 40.2% docetaxel)
Cons	High CIN risk (severe neutropenia: 49% combo vs. 39% docetaxel) Bleeding or hemorrhage: 29% combo vs. 15% in docetaxel	Low Efficacy, OS HR: 0.99 (no survival benefit vs. docetaxel)

[1] Lancet 384 (9944): 665-673 (2014). [2] JCO 22(9): 1589-1597 (2004)。

DUBLIN-3: Docetaxel + Plinabulin (DP) vs. Docetaxel + Placebo (D) in Patients With 2nd/3rd line NSCLC, EGFR wild type

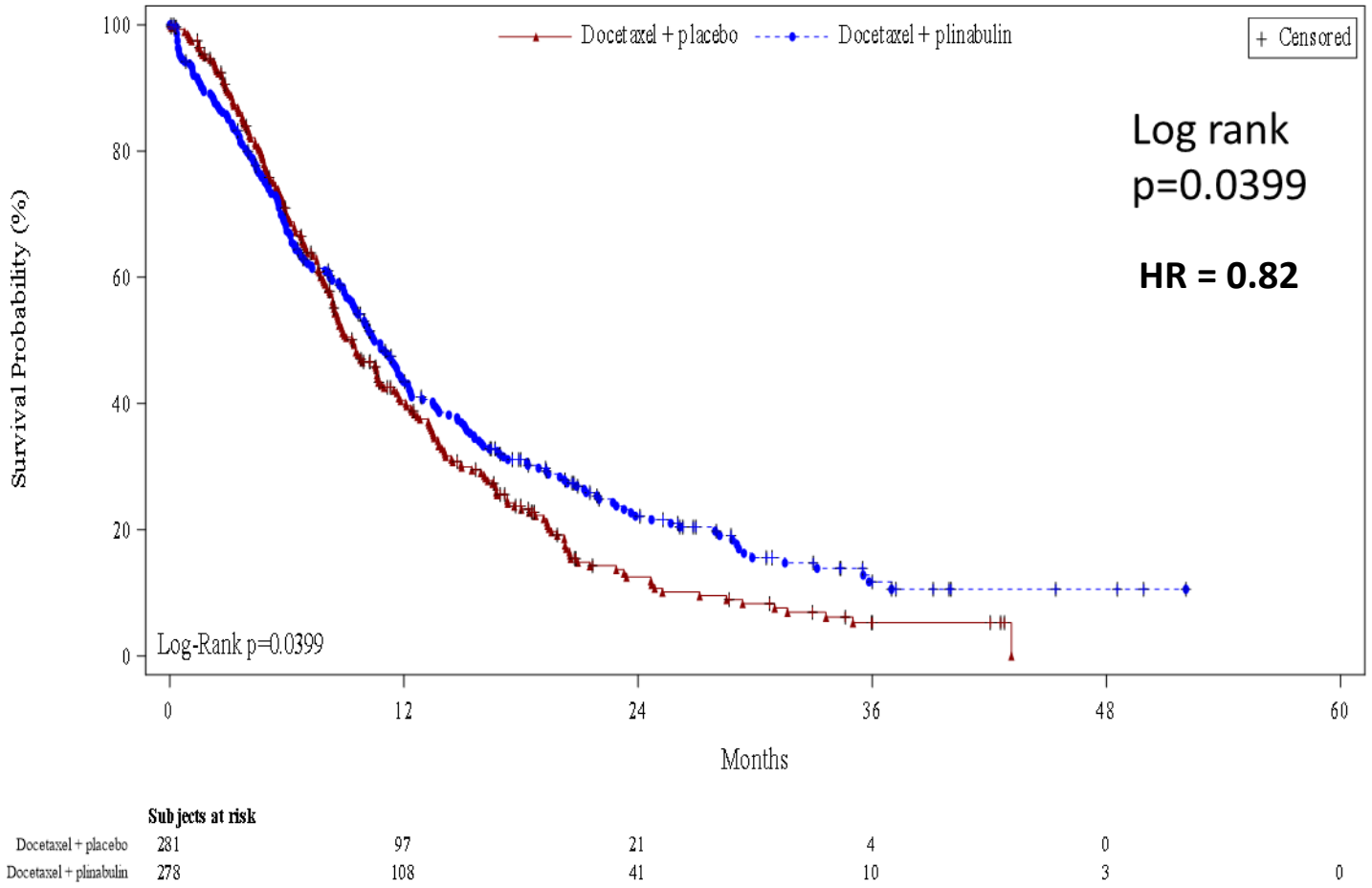
Global, Randomized, Single-Blinded (blinding for patients only)
Stratified for: Region (Asia/non-Asia), Prior Line, ECOG score
Around 60 sites: U.S., China, and Australia
CRO: ICON; Central Lab for PK and ANC: Covance.

- Non-squamous or squamous **NSCLC**
- Stage IIIb/IV
- ECOG performance status ≤ 2
- Progression during or after treatment with one or two treatment regimen containing platinum
- Must have at least one measurable lung lesion
- Prior checkpoint inhibitor therapy allowed



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

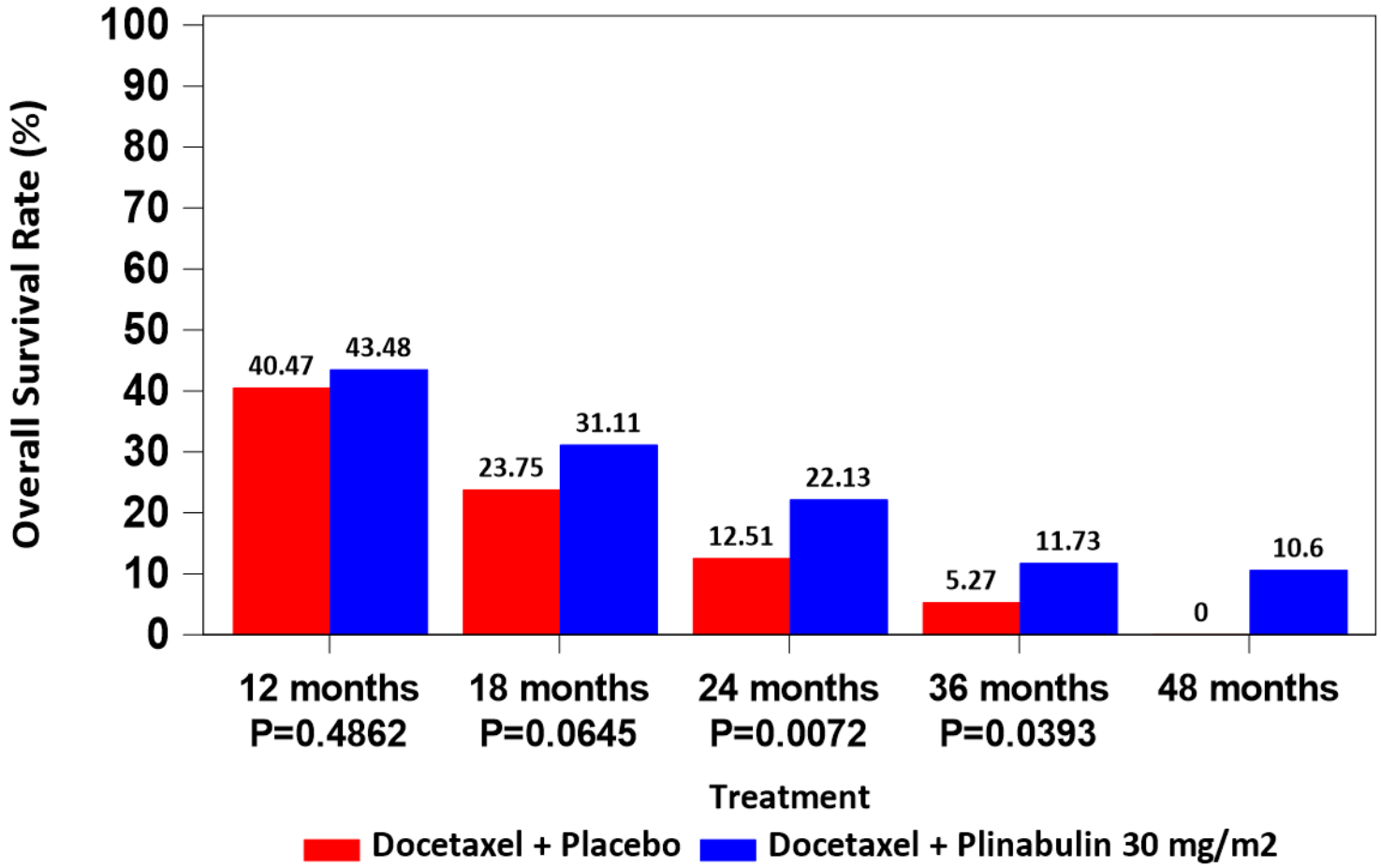
Met Primary Objective in Overall Survival (OS)



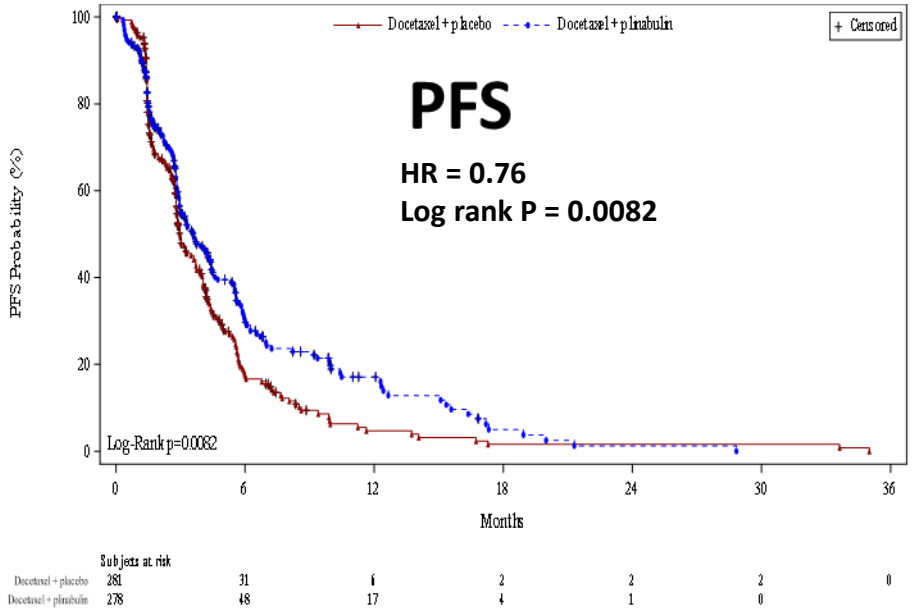
ITT population	Docetaxel (75 mg/m2) N=281	Plinabulin (30 mg/m2) + Docetaxel (75 mg/m2) N=278
OS (Months)	Mean OS (SE): 12.77 (0.676) Median OS (95% CI): 9.4 (8.4, 10.7)	Mean OS (SE): 15.08 (0.848), p=0.0332 Median OS (95% CI): 10.5 (9.3, 11.9) Log-rank p=0.0399; HR = 0.82 (0.68,0.99)

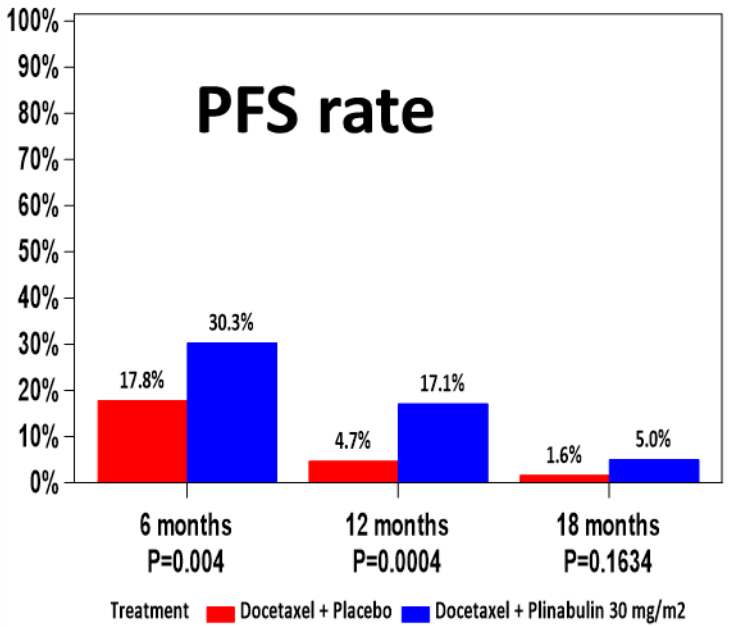
Significantly Increase Long-term OS Rate at 24 M and 36 M

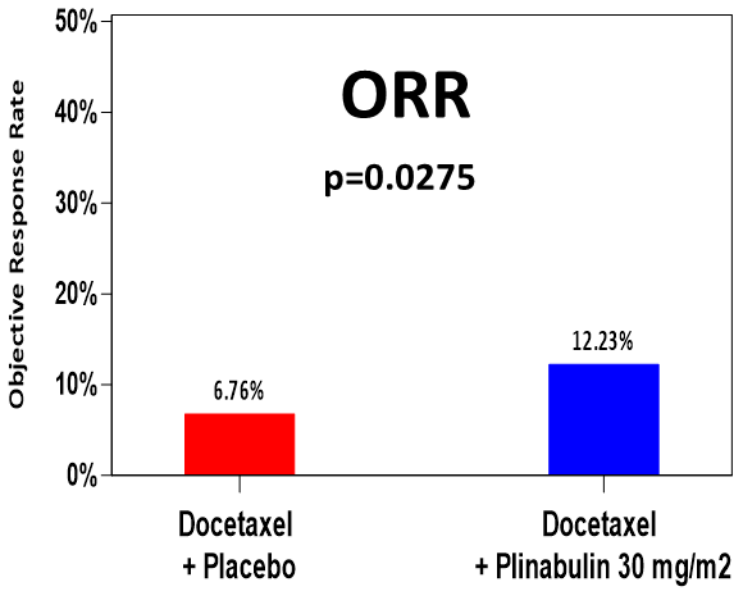
Doubling of OS rate in 24 M, 36 M, and 48 M OS rate in DP (10.6%) vs. D (0%)



Significant Improvement in PFS, Double ORR





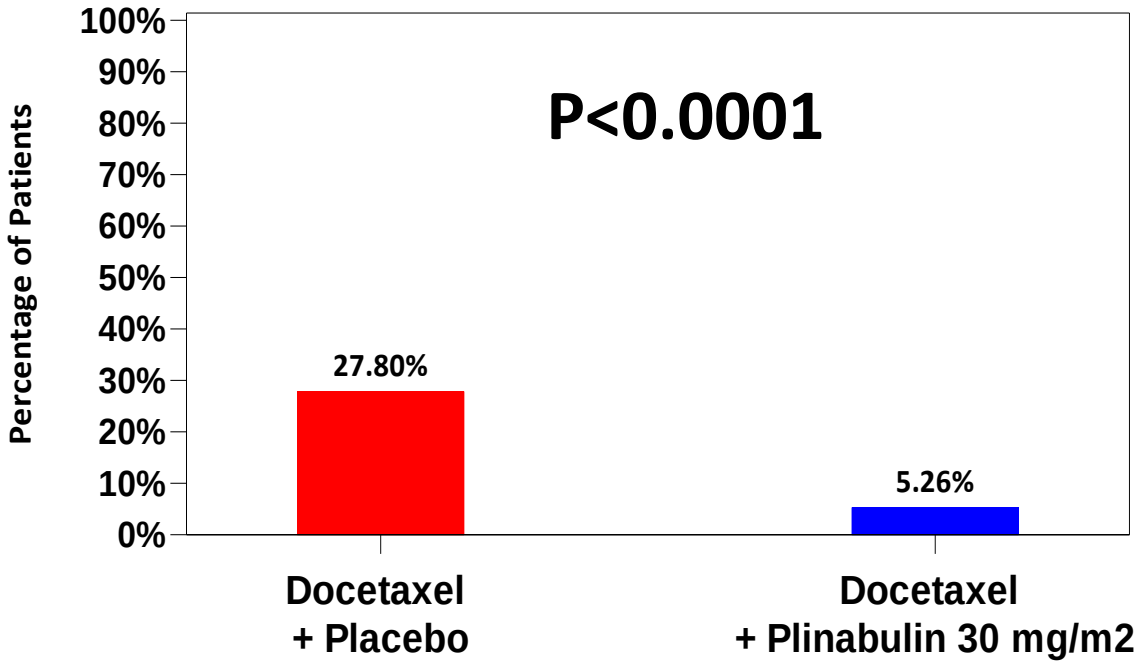


Secondary Endpoint (ITT population)	Docetaxel(75 mg/m2) N=281	Plinabulin (30 mg/m2) + Docetaxel (75 mg/m2) N=278
PFS* (months or M)	Mean PFS (SE): 4.4 (0.3)	Mean PFS (SE): 6.0 (0.4); p=0.0062
	Median PFS (95% CI): 3.0 (2.8, 3.7)	Median PFS (95% CI): 3.6 (3.0, 4.4), Log-rank p=0.0082; HR=0.76 (0.63, 0.93)

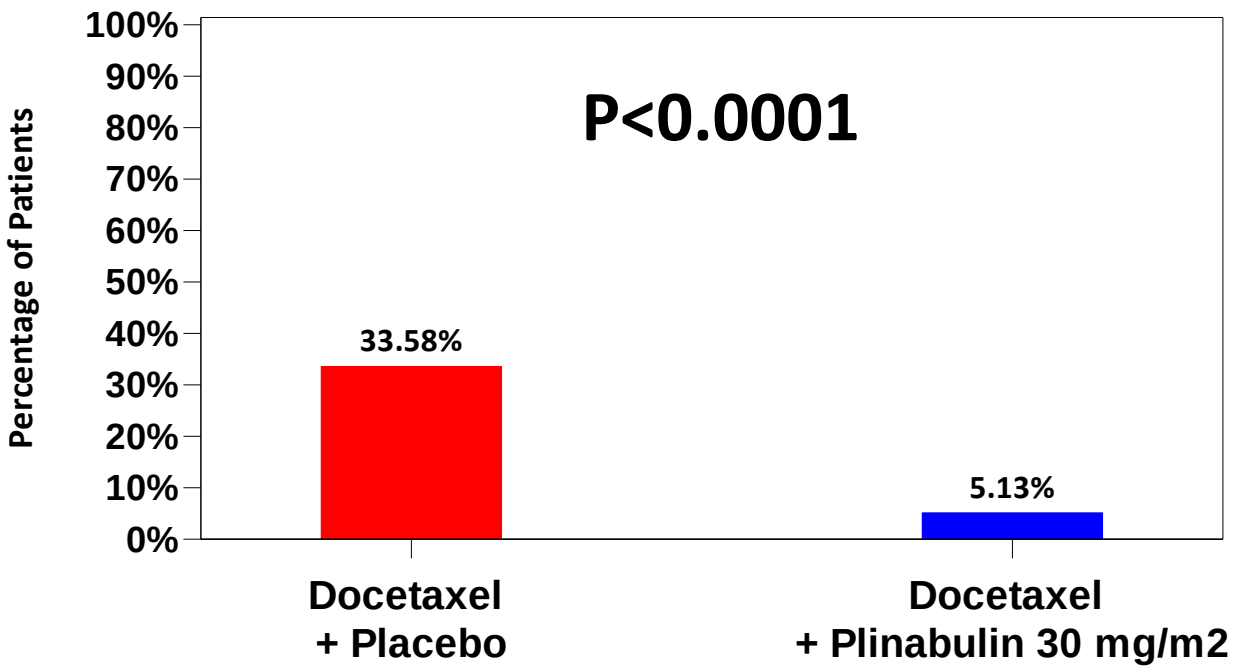
*Investigator-Assessed

Significant Reduction in Grade 4 Neutropenia Cycle 1 Day 8 and All Cycles Day 8

Grade 4 neutropenia, Cycle 1 Day 8

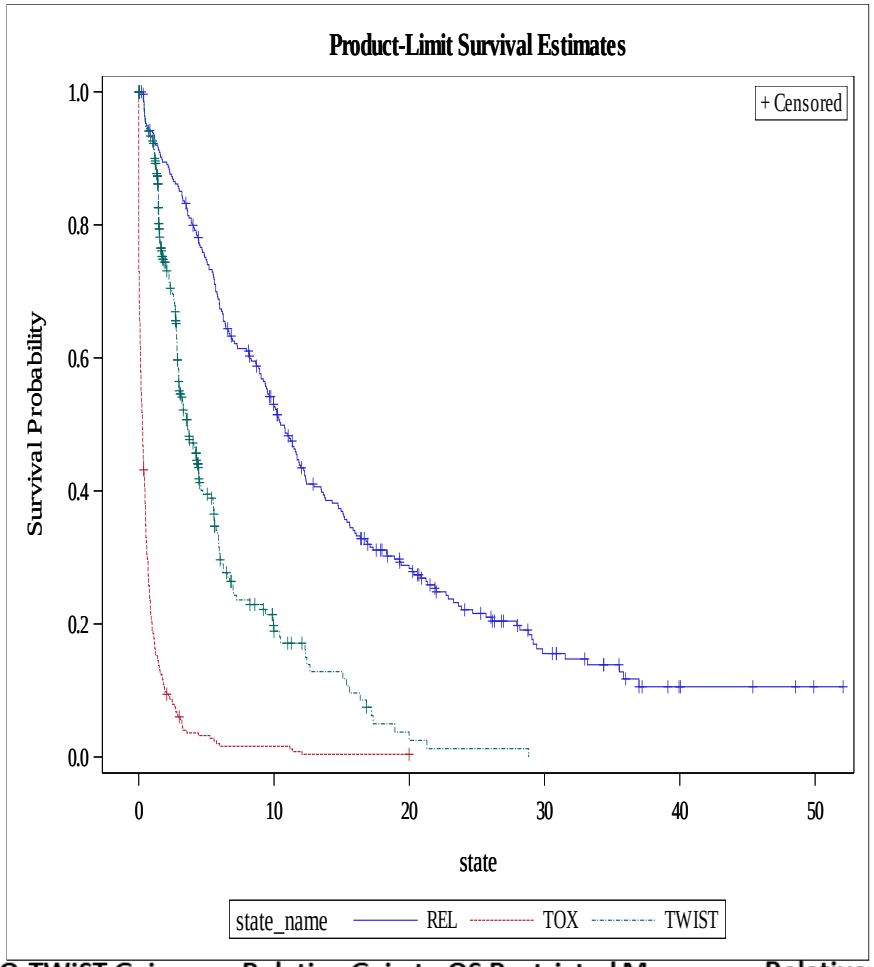


Grade 4 neutropenia, All Cycles Day 8

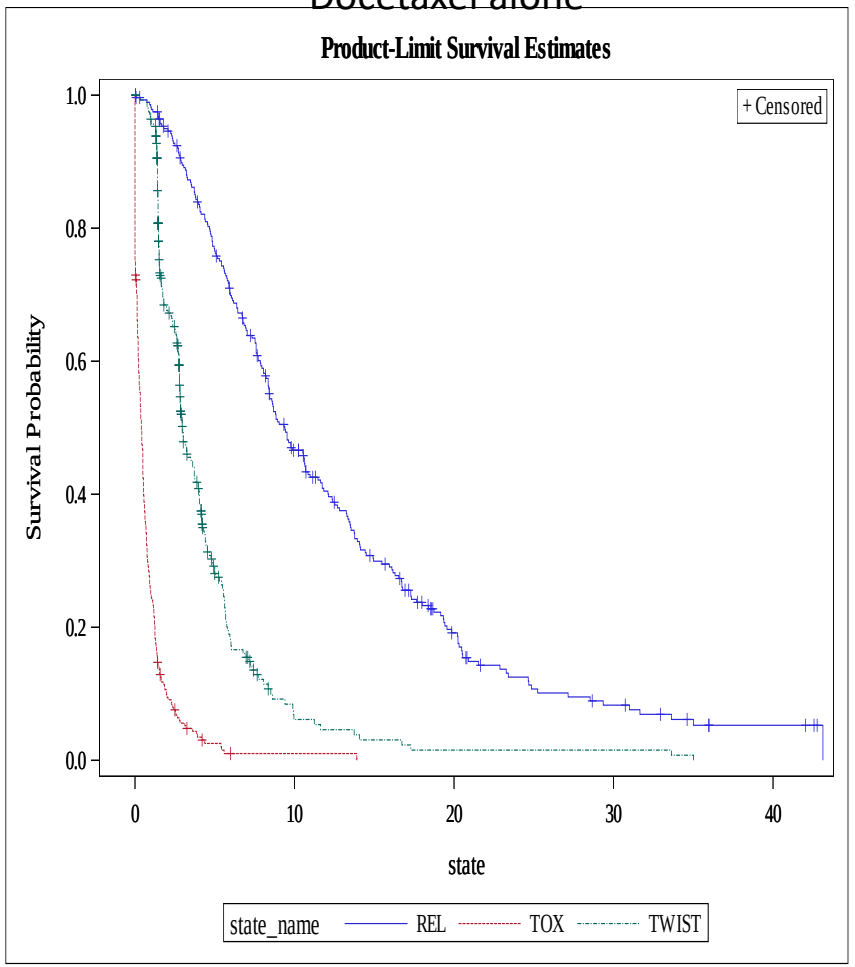


Significant Improve Quality of Life Benefit
- Q-TWiST (Quality-Adjusted Time Without Symptoms of Disease and Toxicity)

Plinabulin + Docetaxel



Docetaxel alone



Q-TWiST Gain	Relative Gain to OS Restricted Mean	Relative Gain to Q-TWiST
1.93	15.11%	18.43%
	(1.72% to 30.63%)	(2.07% to 37.20%)
	p-value=0.0396	p-value=0.0393

Improvement >18% in Q-TWiST, which is clinically meaningful.

Dublin-3: Superior Efficacy (OS, PFS, ORR) and Significant Reduction in Grade 4 CIN (DP vs. D)

Primary Endpoint	Docetaxel (75 mg/m2) N=281	Plinabulin (30 mg/m2) + Docetaxel (75 mg/m2) N=278
OS (months or M)	Mean 12.77 M (0.676) Median 9.4 M (8.4, 10.7)	Mean 15.08 M (0.848); p=0.03 Median 10.5 M (9.3, 11.9), Log-rank p=0.0399 HR = 0.82 (0.68 – 0.99)

Doubling OS rate in 24 M, 36 M, and 10.6% >48 M OS rate – Plinabulin Immune Durable Anti-cancer Benefit

Secondary Endpoint - Hierarchy Order		
ORR (%)	6.76%	12.23%; p=0.0275
PFS (months or M)	Mean 4.4 M (0.3) Median 3.0 M (2.8, 3.7)	6.0 M (0.4); p=0.006 3.6 M (3.0, 4.4), Log-rank p=0.008 HR = 0.76 (0.63, 0.93)
Grade 4 neutropenia, cycle 1 Day 8 (%)	27.8%	5.3%; p<0.0001
24 Month OS Rate (%)	12.5%	22.1%; p = 0.0072
36 Month OS Rate (%)	5.3%	11.7%; p = 0.0393
48 Month OS Rate (%) - exploratory	0%	10.6%; p value cannot be calculated
Q-TWiST • Relative Gain to Q-TWiST	10.47 M (9.34, 11.63)	12.40 M (10.99, 13.83) 18.43% (2.07%, 37.20%); p=0.0393

NSCLC: Favorable Benefit/Risk Profile vs. Standard of Care (SOC)
(Plinabulin + Docetaxel for 2nd/3rd line NSCLC, EGFR wild type)

Next steps: Discuss filing plan with FDA & NMPA in 2021 with potential filing 1H 2022

- Consistent Long survival trend in PD-1/PD-L1 exposed patients and in western patients

Docetaxel (Current SOC)	Plinabulin - Docetaxel Combination
• Modest survival benefit	• **Survival benefit**, doubling 2-year & 3-year OS rate; 4-year OS rate 10.6%
• Severe safety concerns, e.g., CIN	• **Favorable safety profile**, including significant CIN reduction
• Poor Quality of Life	• **Improved quality of life** (Clinically meaningful Q-TWiST benefit)

- **Lower Grade 4 AE frequency and a shift to lower grade AE**
- **No unexpected AE concerns were identified**

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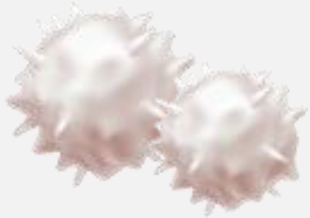
Chemotherapy Induced Neutropenia (CIN)

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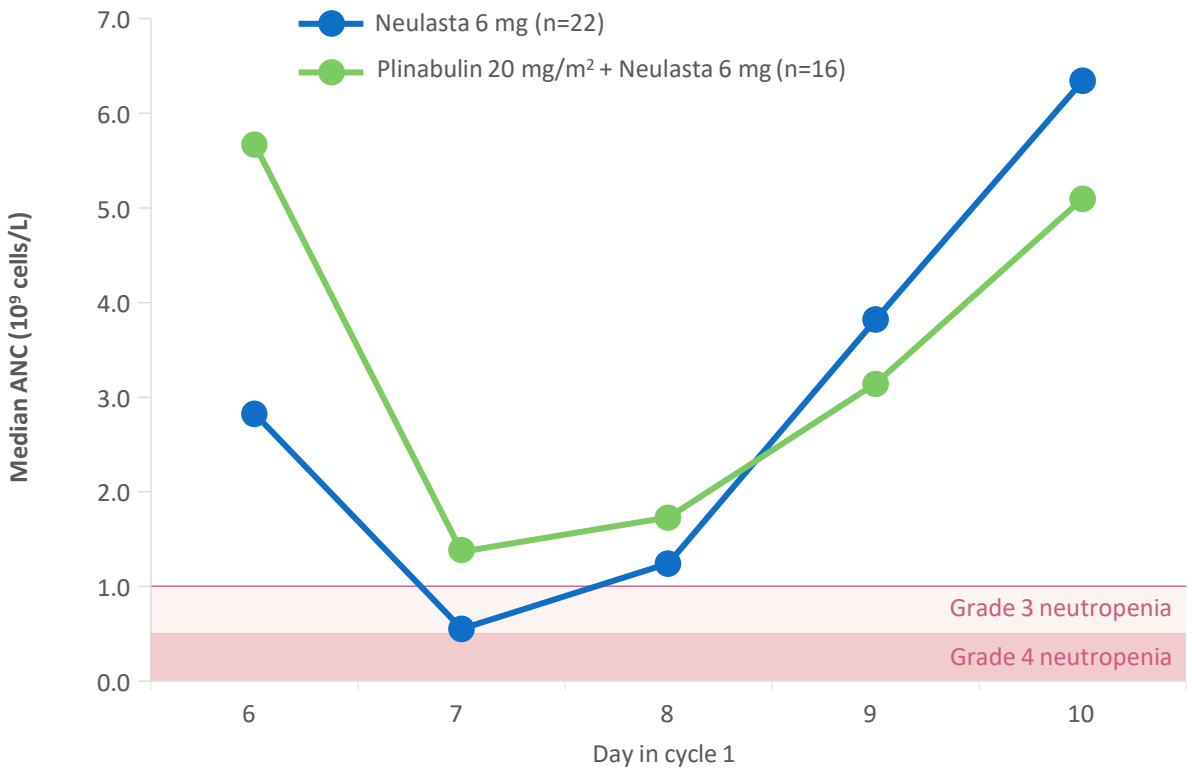
Source: 1 Lalami Y, Klastersky J.. Crit. Rev Oncol Hematol. 2017; 120:163-179. 2 Bonadonna G, Valagussa P, Moliterni A et al. Adjuvant cyclophosphamide, methotrexate, and fluorouracil in node-positive breast cancer. N Engl J Med 1995;332:901-906.

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

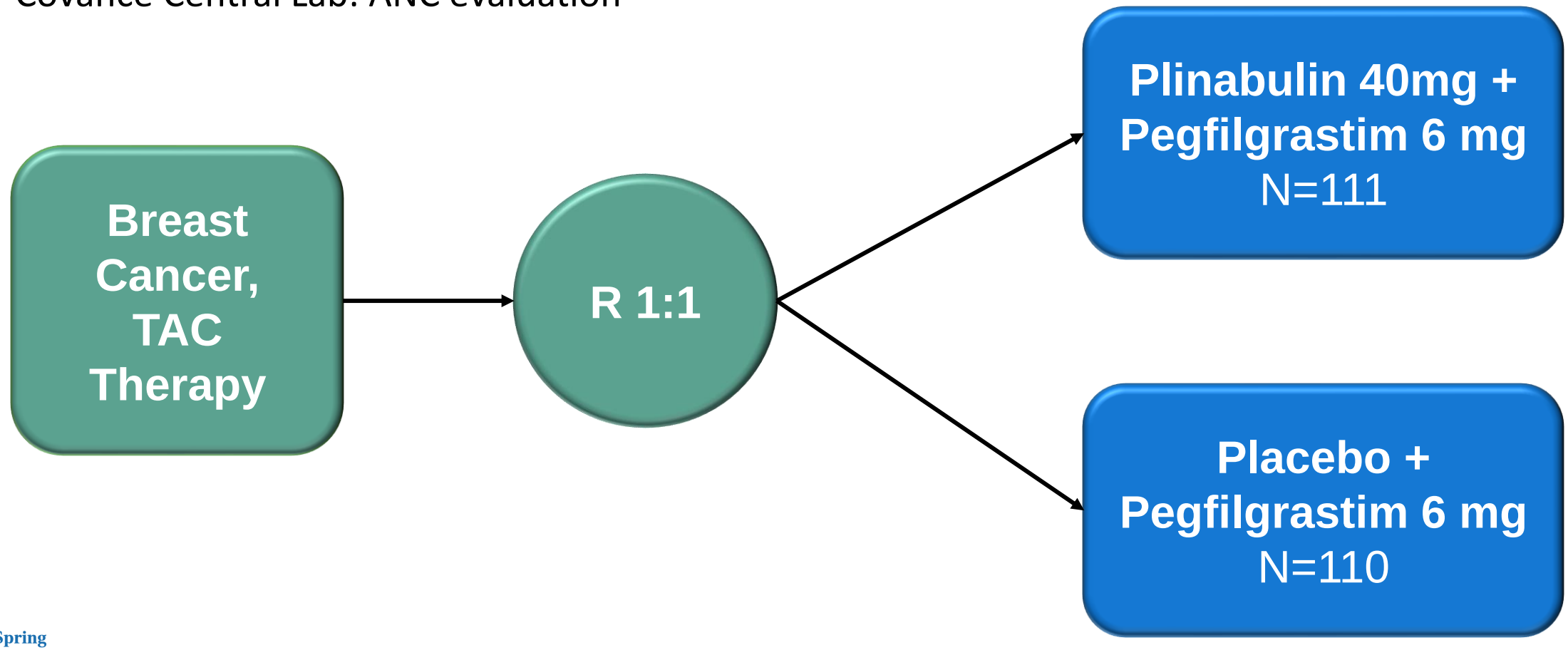


Median ANC in cycle 1 after TAC for breast cancer

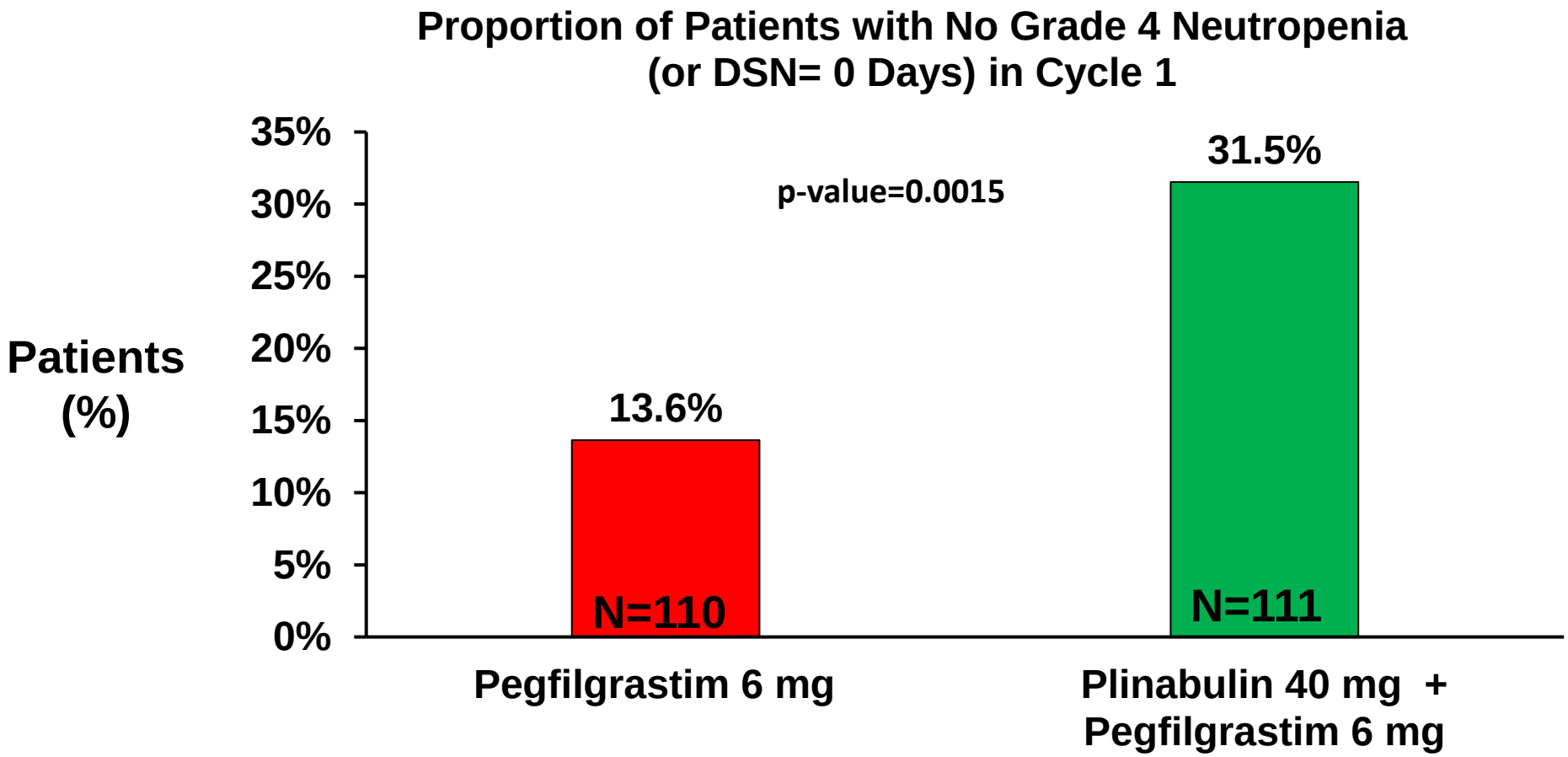
PROTECTIVE-2 (Phase 2) study: Plinabulin + Neulasta vs Neulasta monotherapy.

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 Phase 3: 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

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 (primary endpoint) • 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**

NDA accepted with Priority review by U.S. and China FDA
U.S. PDUFA 11/30/2021

Seeking NDA Approval for "Plinabulin + G-CSF Combination" in a broad CIN Prevention label: all solid tumors, all chemotherapy

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 → combination provides maximum CIN prevention

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]

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

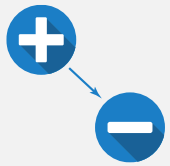
STABLE DOSE
maintaining ≥85%

DELAYED
cycles

SUSTAINED CYCLES
cycles on time

DISCONTINUED
chemotherapy

STAY THE COURSE
complete all cycles



DOWNGRADE
chemotherapy regimen

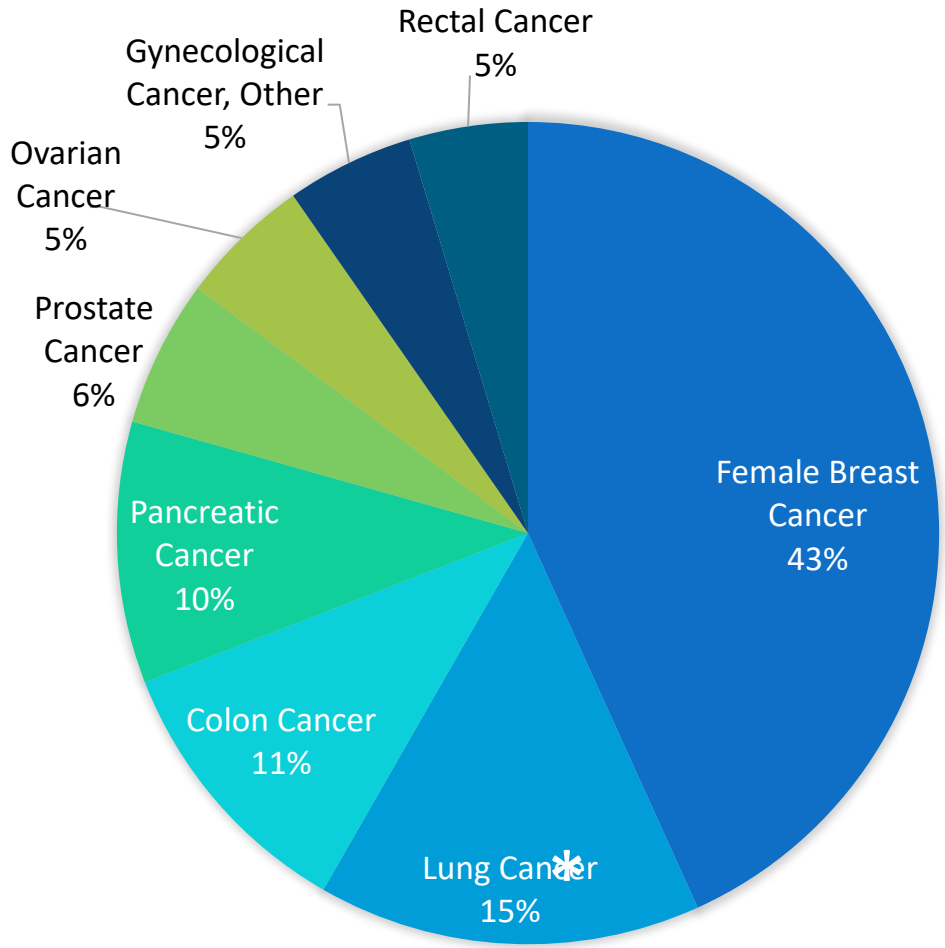
STRONGEST REGIMEN
of chemotherapy

Plinabulin + G-CSF

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

Plinabulin Has Potential 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

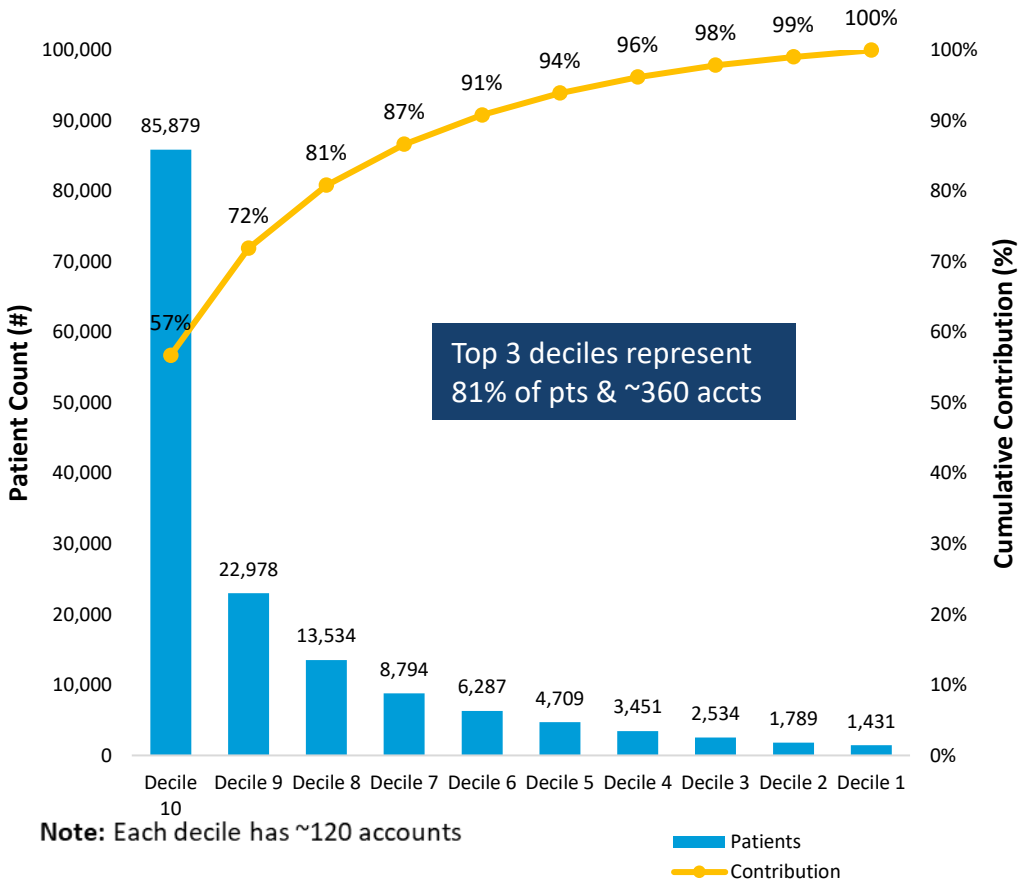
* SCLC ~15% of all lung cancer diagnoses

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

Efficient Commercialization Plan – Concentrated Accounts, Small Salesforce

CIN

Pegfilgrastim Patient Distribution[1] – Top 1200 Centers



Note: Each decile has ~120 accounts

FOCUS: Elevating the SOC in Chemotherapy

Field Staff of approx. 83, including 60 sales reps

DRIVE AWARENESS Neutropenia Vulnerability Gap

POSITION Plinabulin with Key Decision Makers

ACTIVATE Key Accounts for Broad Access & Availability

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.

Breakthrough Therapy Designation with Priority Review: Potential to Elevate Standard of Care 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

Delivering the Plinabulin Value Proposition

Near Term Opportunity

Longer-Term Potential

ANTI-CANCER w/ Chemotherapy

Improve Survival and Quality of Life

CIN Near-Term Market Opportunity

Raise the Standard of Care

ANTI-CANCER w/ Immuno-Oncology

Potential APC Cornerstone of emerging regimens

Plinabulin as Potential "Cornerstone Add-on Therapy" to Current I/O Regimens to Address Severe Unmet Medical Needs

I/O

PD-1/PD-L1 Inhibitors
- $30B global annual sales

Potential to greatly expand the addressable market

Current Severe Unmet Medical Needs

- PD-1/PD-L1 resistant patients need later line therapies
- PD-1 + chemo double efficacy of PD-1, but with CIN risk
- PD-1 or PD-1+CTLA-4 with high ir-SAE
- PD-1/PD-L1 non-responsive tumor;
- Patients who cannot use PD-1/PD-L1

+"Easy-to-use" APC Inducer

Plinabulin Clinical Development

- Plinabulin + I/O + chemo/radiation
- Plinabulin is developed as a CIN prevention agent (pan cancer, pan chemo)
- Plinabulin+PD-1+CTLA-4 in SCLC
- Plinabulin+ I/O + chemo/radiation
- Plinabulin + chemo

Plinabulin in Triple Combo Development for Multiple Cancer Indications in PD-1/PD-L1 Failed Patients

I/O

	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, Presented at ASCO June 2021
	SCLC Checkpoint refractory patients	Plinabulin + Nivolumab (PD-1) + Ipilimumab (CTLA-4)	Big Ten Study	Global	Phase 2
	7 Cancers* PD-1/PDL1 failed pts	Plinabulin + PD-1/PD-L1 + radiation/chemo	MD Anderson	Global	Initiated Phase 1 in 7 cancers in June 2021

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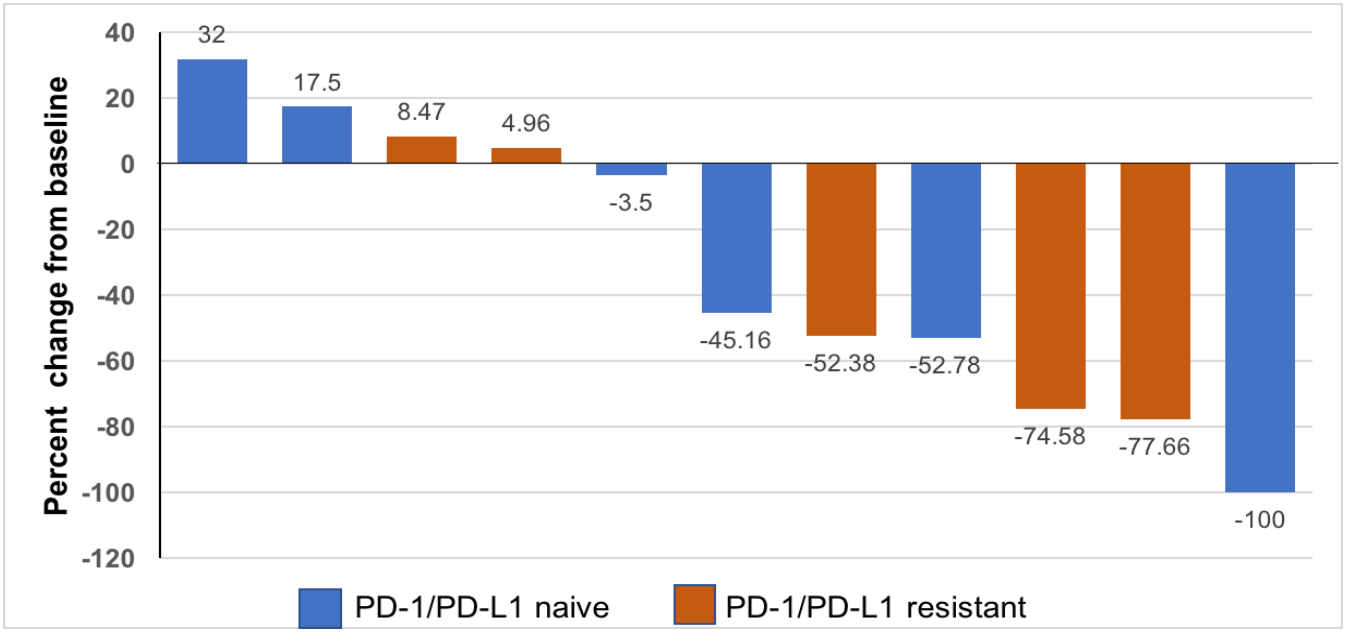
*NSCLC, SCLC, Renal Cell, Bladder, Merkel Cell, Melanoma, Cancers with high levels of microsatellite instability

Efficacy Analysis (Phase I) Plinabulin + Nivolumab + Ipilimumab in SCLC

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 as a Potential Synergistic “Cornerstone” Agent in I/O 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.

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Corporate Highlights

Plinabulin: Hengrui and Wanchunbulin Partnership in Greater China

(BeyondSpring Inc. owns 58% of Wanchunbulin)

Hengrui is the oncology leader in China, with great synergies with Plinabulin
- Manages commercialization risk and optimizes return on plinabulin franchise

Hengrui: Plinabulin Rights in Greater China

- Exclusive commercialization of all indications
- Receives fixed % of net sales
- Co-develops additional indications; Wanchunbulin leads clinical protocol design and development

Terms (est. USD*)

- Wanchunbulin receives $30M upfront + up to $170M in milestones
- Wanchunbulin books sales proceeds, retains significant fixed % of net sales
- Hengrui pays 100% commercial and 50% development costs for new indications
- Wanchunbulin retains manufacturing control & pays for 100% COGS
- Hengrui invests $15M equity in Wanchunbulin at $560M valuation

* $1 USD = 6.47 RMB

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 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 NSCLC & CIN

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

NSCLC: Combo with docetaxel – Global Market $30+ B

- ✓ Positive Final Topline Ph 3 OS data 08/2021, ESMO late breaking oral presentation 09/2021
- ✓ Potential NDA submission in 1H 2022

CIN: Combo with G-CSF (superior efficacy vs. SOC) – Global Market: $7B

- ✓ NDA accepted w/ Priority Review (US, China)
- ✓ Breakthrough Designation (US, China)

Broad Pipeline

Plinabulin: "A pipeline in a drug"

- ✓ Triple combo w/IO agents and radiation/chemo in 7 cancers
  - 2 Phase 1/2 trials underway
- ✓ Expansion to additional solid tumors and first line cancers

Three Pre-Clinical I/O Agents

Targeted Protein Degradation Platform

- ✓ SEED Therapeutics (Subsidiary)
- ✓ $800 M 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, Hengrui partnership in Greater China

Cash position at $76.3M at 6/30/2021 + Hengrui $30M upfront + $15M equity commitment

www.beyondspringpharma.com