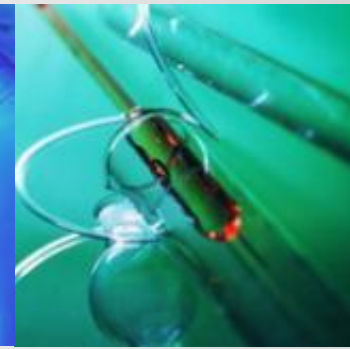




Puma Biotechnology

Corporate Presentation

September 2023



Forward-Looking Safe-Harbor Statement

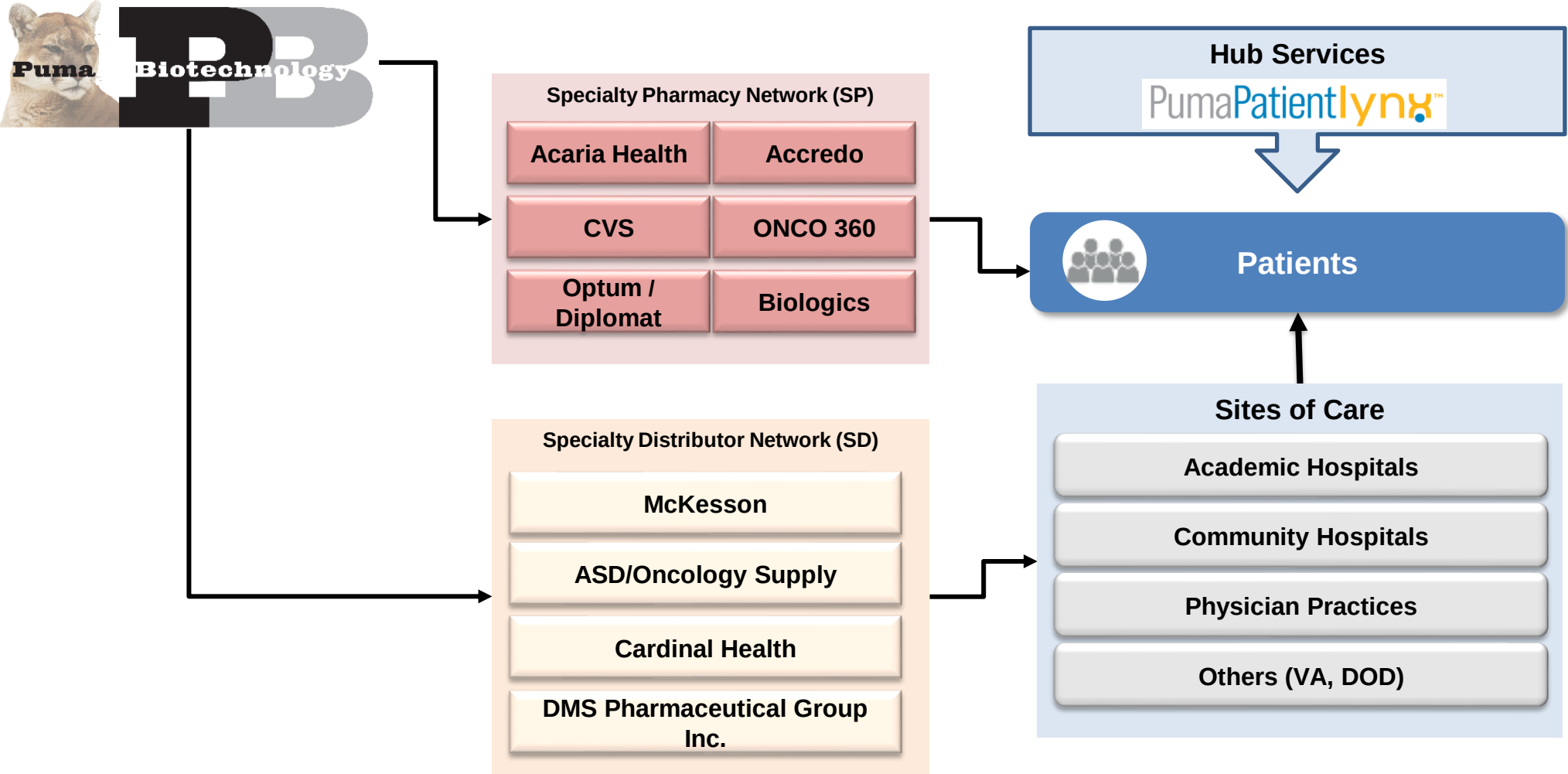
This presentation contains forward-looking statements, including statements regarding commercialization of NERLYNX® and the potential indications and development of our drug candidates. All forward-looking statements involve risks and uncertainties that could cause our actual results to differ materially from the anticipated results and expectations expressed in these forward-looking statements. These statements are based on our current expectations, forecasts and assumptions, and actual outcomes and results could differ materially from these statements due to a number of factors, which include, but are not limited to, any adverse impact on our business or the global economy and financial markets, generally, from the global COVID-19 pandemic, and the risk factors disclosed in our periodic and current reports filed with the Securities and Exchange Commission from time to time, including our Annual Report on Form 10-K for the year ended December 31, 2022, and subsequent filings. Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof. We assume no obligation to update these forward-looking statements except as required by law.



Product Pipeline

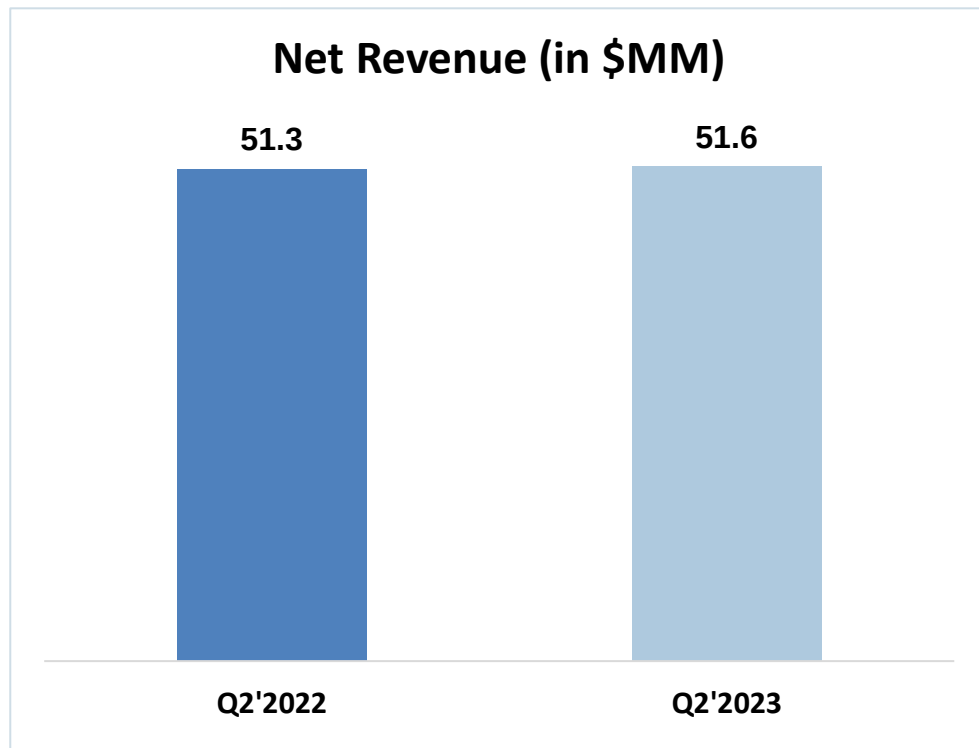
	Phase I	Phase II	Phase III	Registration	Approval
<u>Neratinib: Tyrosine kinase inhibitor</u>					
HER2+ Breast Cancer					
Extended adjuvant <i>Neratinib monotherapy</i>	ExteNET (Phase III HER2+ EBC*)				
Metastatic <i>Monotherapy or combo therapy</i>	NALA (Phase III 3 rd Line HER2+ MBC**)				
Metastatic w/ brain mets <i>Monotherapy or combo therapy</i>	TBCRC-022 (T-DM1 + neratinib)				
<u>Alisertib: Aurora kinase A inhibitor</u>					
HRc+*** HER2-negative MBC	TBCRC-041 (fulvestrant + alisertib)				
	NCT02187991 (paclitaxel + alisertib)				
Triple-negative MBC	NCT02187991 (paclitaxel + alisertib)				
	NCT02038647 (paclitaxel + alisertib)				
Small cell lung cancer	PUMA-ALI-4201 (alisertib)				
	Initiation in Q4'23				

Puma's Pharmacy and Distributor Network



\$51.6 Million net NERLYNX revenue in Q2'23

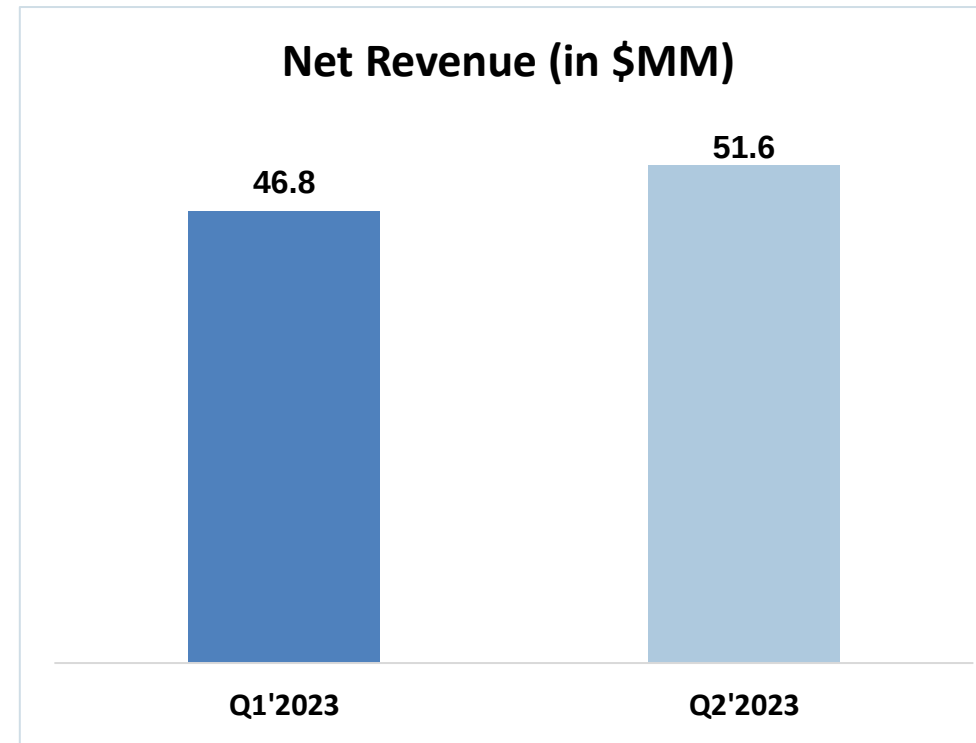
~0.6% growth compared to Q2'22



Inventory Change (\$)

Q2'22	Q2'23
+ \$2.7 mil	- \$1.5 mil

~10% growth compared to Q1'23

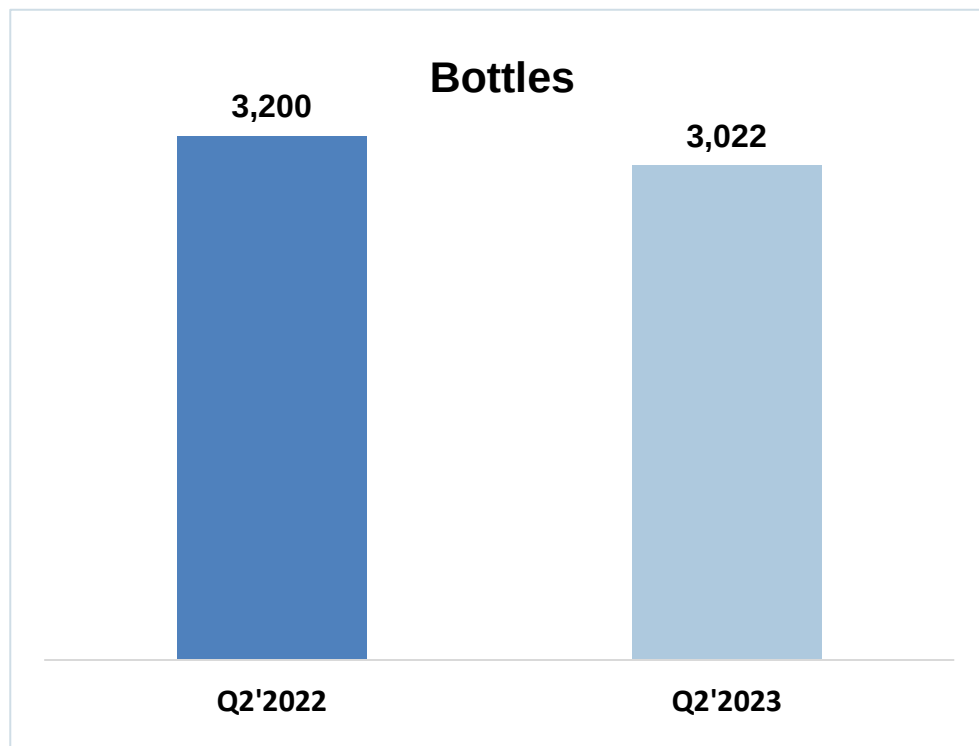


Inventory Change (\$)

Q1'23	Q2'23
- \$3.8 mil	- \$1.5 mil

3,022 Ex-factory bottles were sold in Q2'23

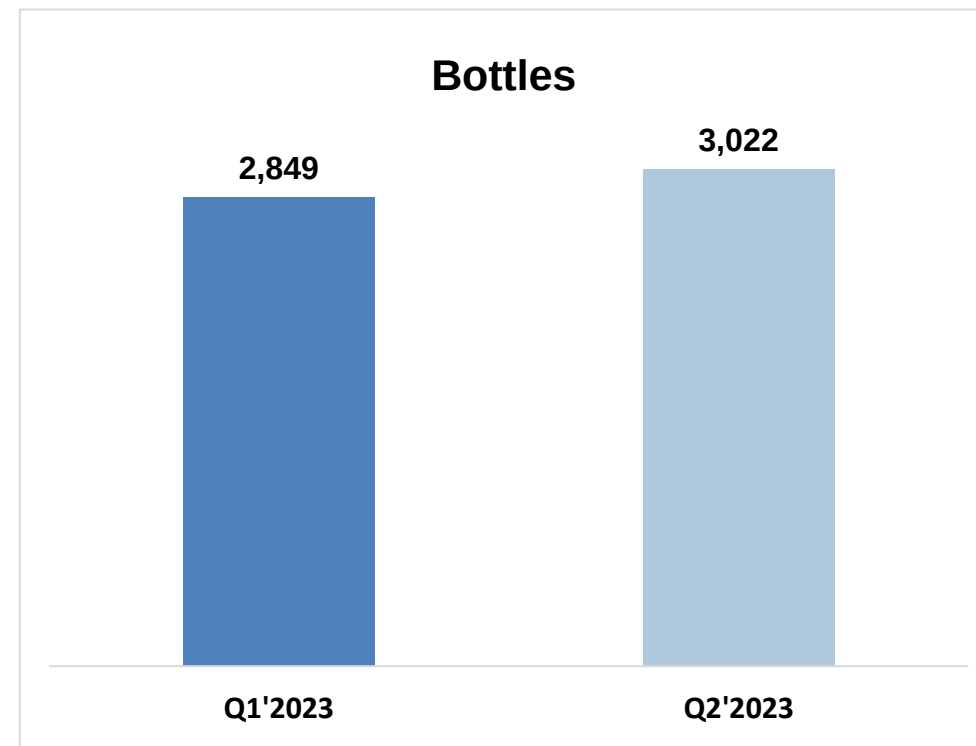
~6% decline compared to Q2'22



Inventory Change Bottles

Q2'22	Q2'23
179	-89

~6% growth compared to Q1'23

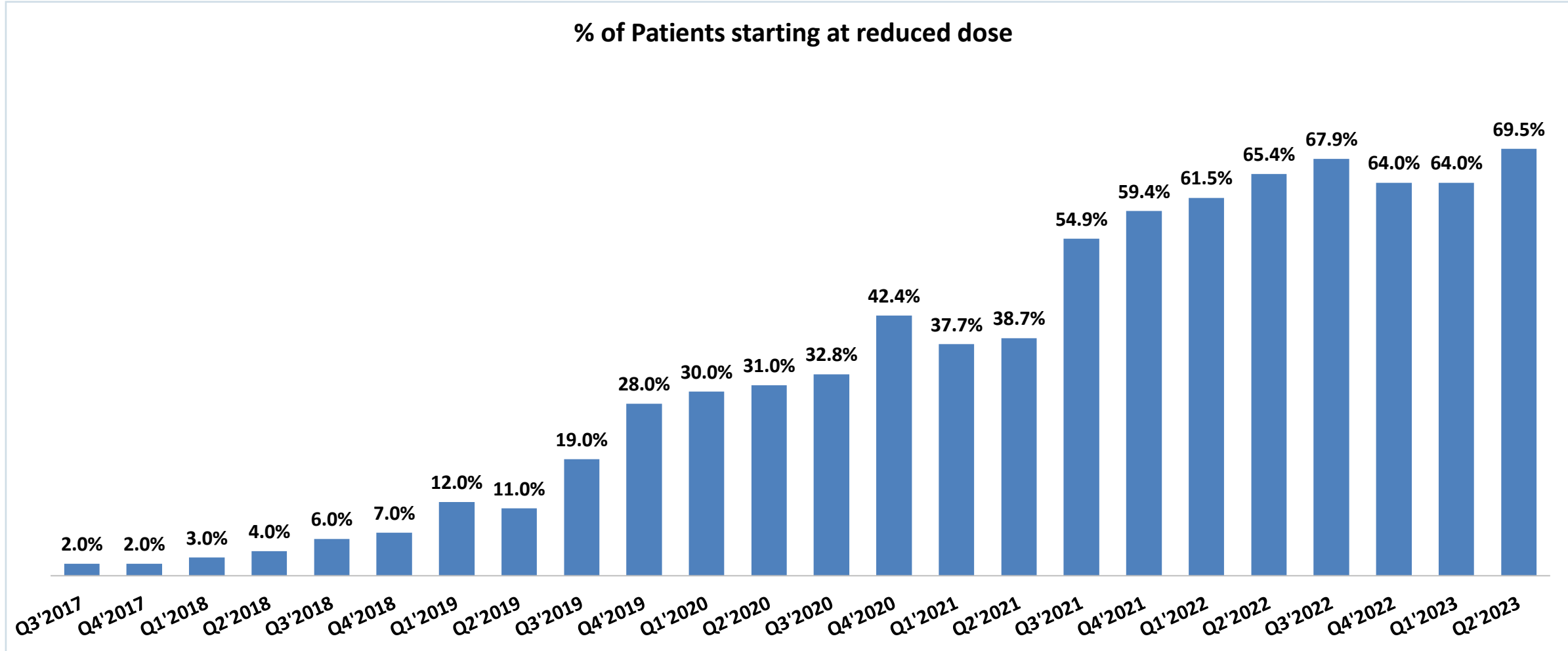


Inventory Change Bottles

Q1'23	Q2'23
-236	-89

Includes commercial SP & SD bottles
Change in inventory declined ~100 bottles in Q2'23 vs Q2'22.

~70% of patients in Q2'23 started at a reduced dose*



*Reduced dose defined as fewer than 6 pills per day

Rest of World Partnerships – Timelines

Region	Partner	Regulatory Approvals	Commercial Launches
Australia / SE Asia		• 2019 – Ext. Adj. in Australia, Singapore • 2020 – Ext. Adj. in Brunei, Malaysia, New Zealand • Q2 2022 – Ext. Adj. in the Philippines • Q3 2022 – mBC in Singapore	• 2020 – Singapore • Q2 2021 – Malaysia • Q3 / Q4 2021 – Brunei, New Zealand
Israel		• 2020 – Approved in Ext. Adj. and mBC	• 2020 – Launched
Canada		• 2019 – Ext. Adj. approved • Q2 2021 – mBC approved	• 2020 – Launched
Latin America		• 2019 – Ext Adj in Argentina • 2020 – Ext. Adj in Chile, Ecuador; mBC in Argentina • 2021 – Ext Adj and mBC in Peru; mBC in Chile; Ext. Adj. in Brazil • Q1 2022 – Ext. Adj. in Mexico • Q3 2022 – mBC in Ecuador • Q1 2023 – mBC in Colombia	• 2020 – Argentina • Q2 2021 – Chile • Q4 2021 – Peru • Q3 2022 – Brazil • Q1 2023 – Mexico
Europe Greater China Middle East North and West Africa South Africa Turkey		• 2019 – EMA approval • 2019 – Ext. Adj. in Hong Kong • 2020 – Ext. Adj. in China, Taiwan • Q4 2021 – mBC in Taiwan • Q1 2023 – Ext Adj. in Morocco, South Africa	• 2019 – Germany, UK, Austria • 2020 – Sweden, Finland, Scotland, Switzerland, Denmark • 2020 – Hong Kong • Q1 2021 – China (added to 2021 NRDL), Taiwan • Q1 2021 – Greece, Czech Republic • Q1 2022 – Ireland • Q3 2022 – Spain • Q2 2023 – Slovakia
South Korea		• Q4 2021 – Ext. Adj. in S. Korea	• Q1 2022 – Launched

NERLYNX[®] Extended Adjuvant HER2+ Breast Cancer Market Size

- Approximately 28,300 patients (US) with early stage HER2+ breast cancer treated with adjuvant treatment¹
- Approximately 6,000 patients (US) with HR positive early stage HER2+ breast cancer and no pathological complete response to neoadjuvant treatment (high risk disease)
- Approximately 37,000 patients (EU) with early stage HER2+ breast cancer treated with adjuvant treatment¹
 - Approximately 65–70% of patients have HR positive disease

¹Roche epidemiology slides 09/18

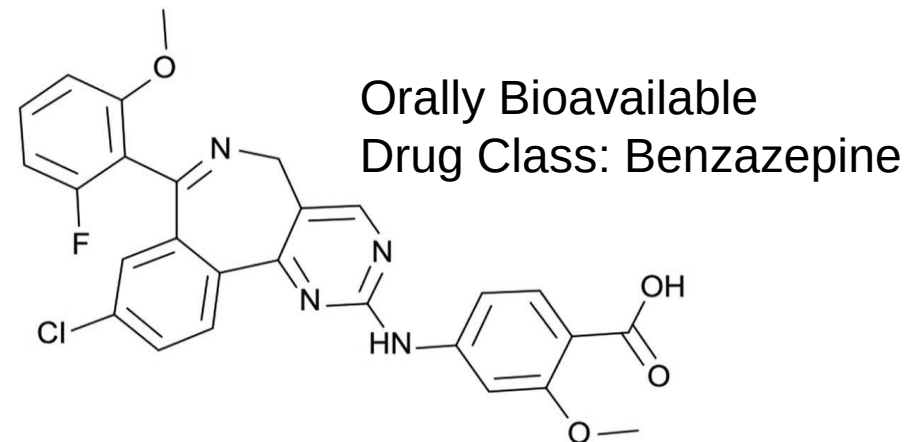
ALISERTIB

Breast Cancer and Small-Cell Lung Cancer



Alisertib (MLN 8237)

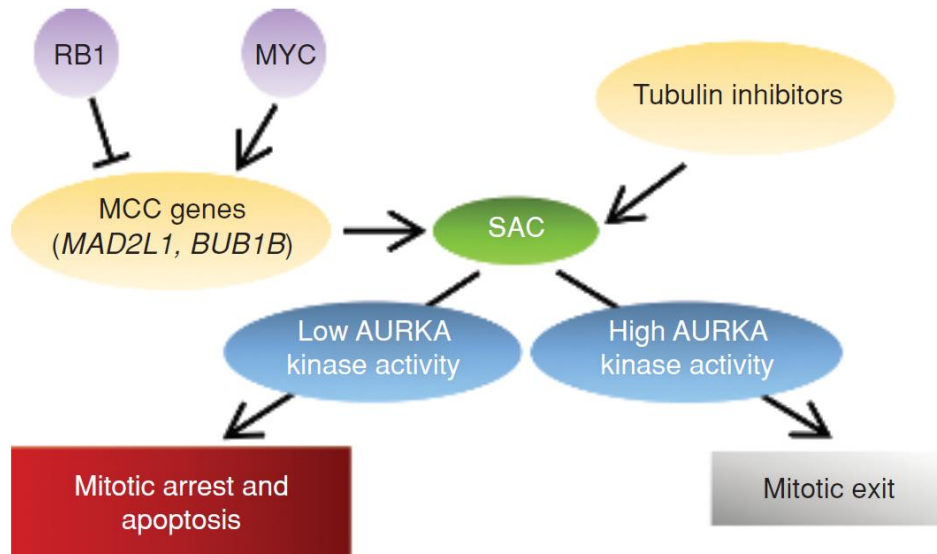
Aurora Kinase A
(AURKA) inhibitor



- Single-agent and combinational clinical activity in solid tumors including hormone receptor-positive breast cancer (HR+ MBC), triple negative breast cancer (TNBC), small cell lung cancer (SCLC), and head and neck cancer
- Single-agent clinical activity in hematologic malignancies including peripheral T-cell lymphoma (PTCL) and aggressive non-Hodgkin's lymphoma (NHL)
- Well-characterized safety profile: ~1,300 patients treated across 22 company-sponsored trials

Synthetic Lethality of AURKA and Rb1

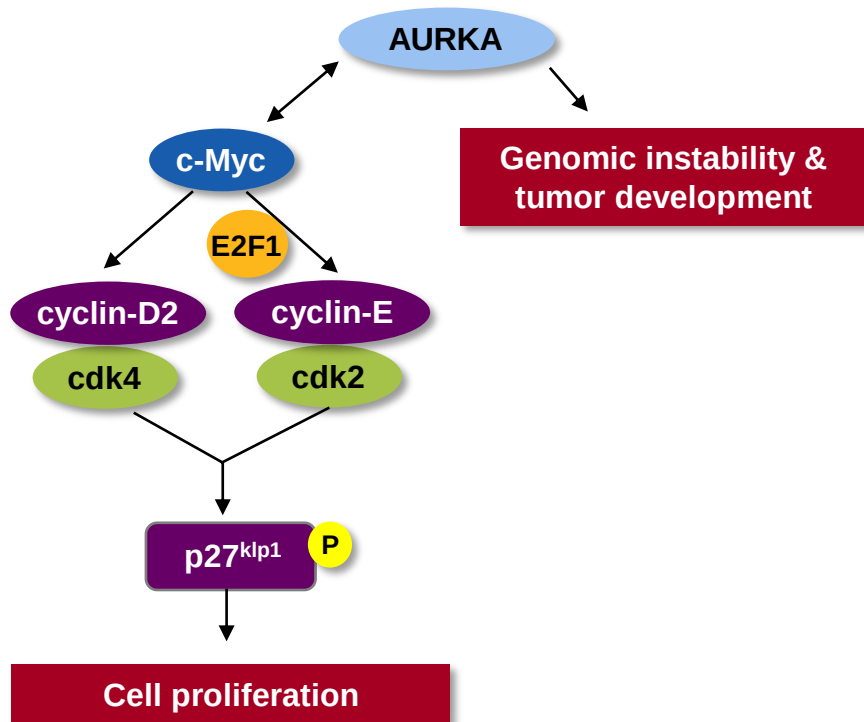
Cancers with a hypersensitive spindle assembly checkpoint (SAC) depend on AURKA for mitotic exit and survival¹



- Loss of function of Rb1 is a common event in cancer and can emerge as a mechanism of resistance to EGFR, CDK4, and ER-targeted therapies in breast and lung cancers
- Rb1 controls entry into S phase of mitosis, and loss of Rb1 function leads to a hyperactivated, primed, SAC
- Cancers with a hyperactivated SAC depend on AURKA in order to overcome SAC priming, which leads to stalled mitosis

AURKA and c-Myc Co-regulate Each Other

Nuclear AURKA exerts kinase-independent functions by acting as a transcription factor



- AURKA and c-Myc transcriptionally upregulate each other, suggesting the existence of a positive feedback loop
- c-Myc upregulates Cyclin D2, CDK4, and cyclin-E, contributing to complex formation and subsequent phosphorylation of p27Kip1, which leads to cell proliferation

Clinical Development in Small-Cell Lung Cancer

Phase 2 Study of Alisertib Monotherapy in Solid Tumors

- SCLC Cohorts

Study design:

- Pts had to have undergone ≤ 2 previous cytotoxic regimens, not including adjuvant or neoadjuvant treatments
- Alisertib administration: orally in 21-day cycles at 50 mg twice daily for 7 days followed by a break of 14 days
- 1° Endpoint: Objective Response Rate (RECIST 1.1)

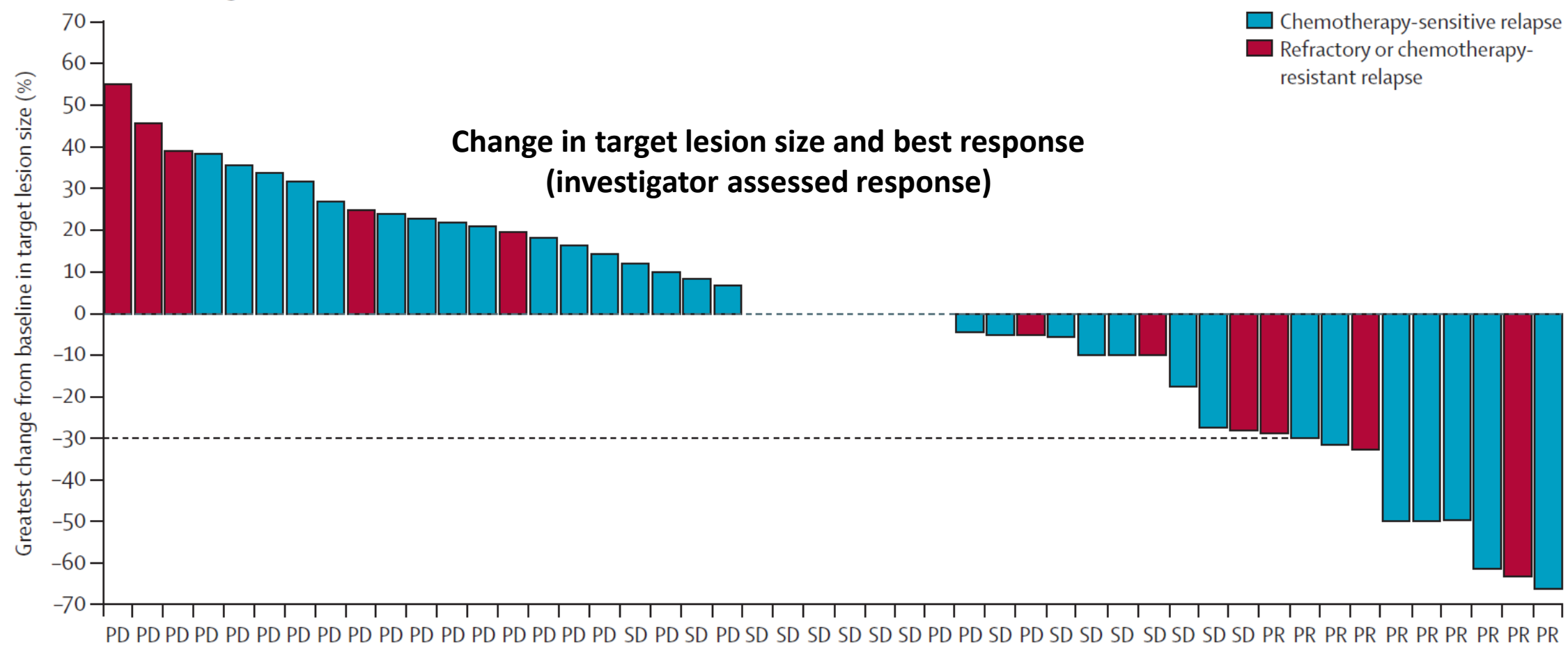
	All (n=48)	Chemotherapy-sensitive relapse (n=36)	Refractory or chemotherapy-resistant relapse (n=12)
Median (range) number of cycles	2.0* (1-17)	3.5 (1-17)	2.0 (2-6)
Best response			
Objective response†	10 (21%) (10-35)	7 (19%)	3 (25%)
Stable disease	16 (33%) (20-48)	13 (36%)	3 (25%)
Stable disease for ≥ 6 months	2 (4%)	2 (6%)	0
Progressive disease	22 (46%) (31-61)	16 (44%)	6 (50%)
Duration of response (months)	4.1 (3.1-NE)	3.1	4.3
Progression-free survival (months)	2.1 (1.4-3.4)	2.6 (1.4-3.7)	1.7 (1.2-3.9)
Time to progression (months)	2.6 (1.4-3.8)	2.8 (1.4-3.9)	1.4 (1.2-4.4)

Table adapted from Melichar B Lancet Oncol 2015. Data are either number of patients (%) (95% CI), or median (95% CI), unless otherwise stated. NE=not estimable. *Safety population. †All were partial responses. All responses were based on investigator tumor assessments (RECIST v1.1).

Phase 2 Study of Alisertib Monotherapy in Solid Tumors

- SCLC Cohorts

10 (21%; 95% CI 10–35) of 48 patients had an objective response; all responders achieved a partial response



PD=progressive disease. SD=stable disease. PR=partial response. Dotted line at -30% represents a partial response, according to RECIST 1.1 (investigator tumor assessments).

Phase 2 Study of Alisertib Monotherapy in Solid Tumors

- SCLC Cohorts

All-cause adverse events in safety evaluable SCLC cohort (n=60)

	Grade 1-2	Grade 3-4
Any adverse event	14 (23%)	43 (72%)
Neutropenia	5 (8%)	22 (37%)
Fatigue	23 (38%)	5 (8%)
Anaemia	9 (15%)	10 (17%)
Alopecia	16 (27%)	NA
Diarrhoea	16 (27%)	2 (3%)
Nausea	18 (30%)	0
Leukopenia	4 (7%)	8 (13%)
Stomatitis	9 (15%)	4 (7%)
Decreased appetite	18 (30%)	0
Vomiting	10 (17%)	1 (2%)
Thrombocytopenia	5 (8%)	6 (10%)
Somnolence	8 (13%)	1 (2%)
Dyspnoea	10 (17%)	0
Constipation	5 (8%)	0
Pyrexia	4 (7%)	0
Peripheral oedema	4 (7%)	0
Headache	8 (13%)	1 (2%)
Insomnia	7 (12%)	0
Cough	5 (8%)	0
Asthenia	6 (10%)	1 (2%)
Dehydration	3 (5%)	3 (5%)

Table adapted from Melichar B Lancet Oncol 2015. Data are number of patients with AE (%) for AEs of any grade in at least 10% of patients overall. NA = not applicable

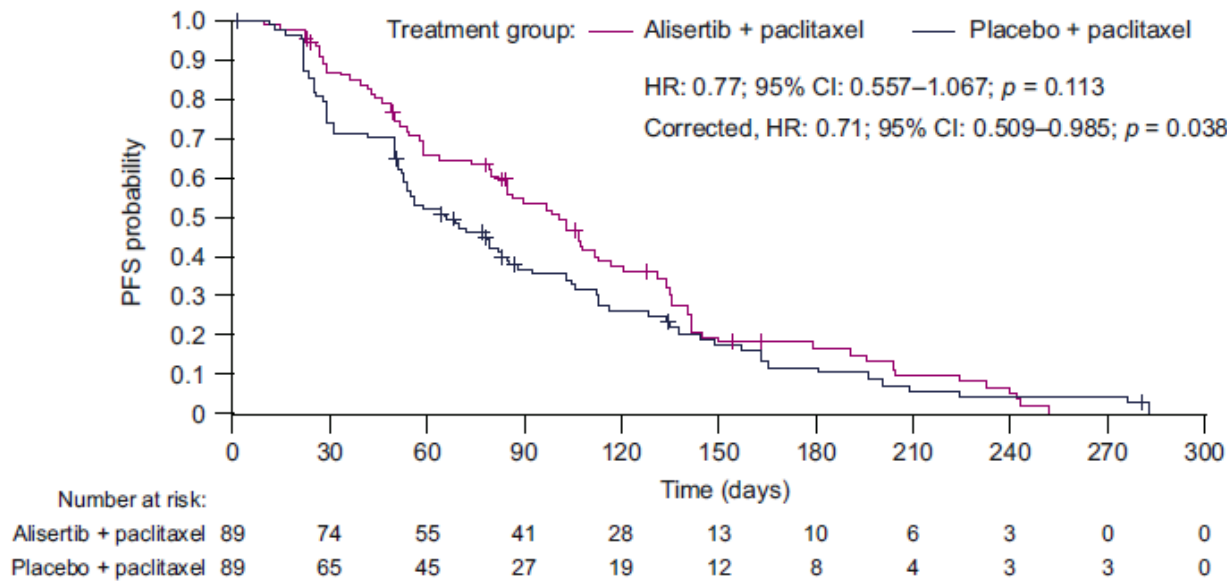
Randomized Phase 2 Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Primary Analysis

Study design:

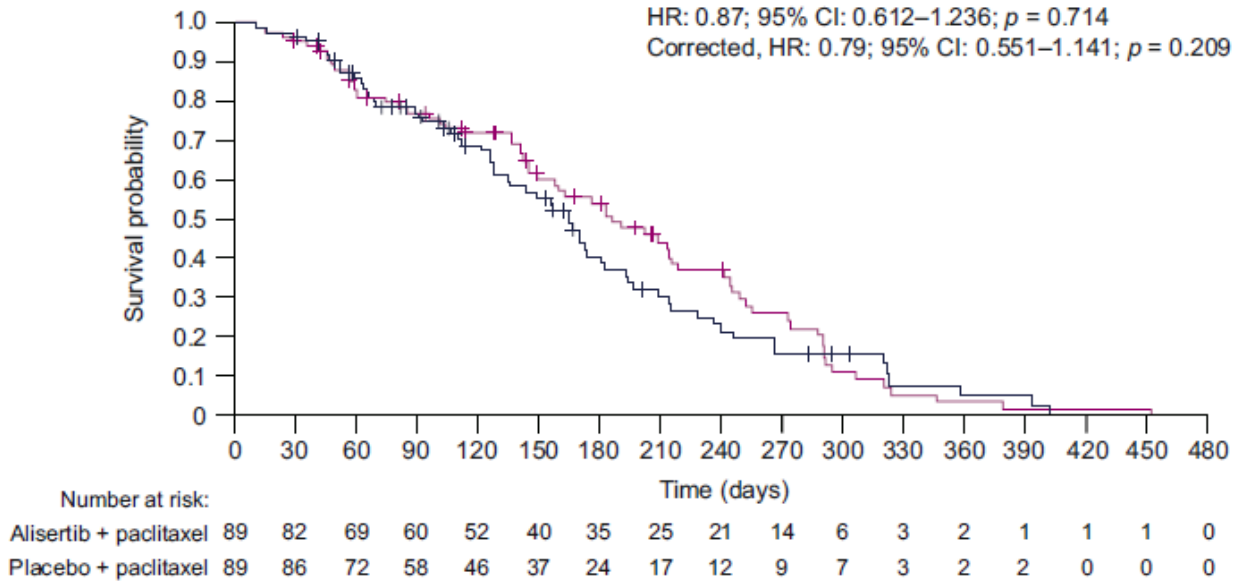
- Patients with relapsed or refractory SCLC stratified by relapse type (sensitive vs resistant or refractory)
- Randomized 1:1 to alisertib + paclitaxel or placebo + paclitaxel in 28-day cycles
- Alisertib (40 mg BID for 3 weeks on days 1–3, 8–10, and 15–17) plus paclitaxel (60 mg/m2 intravenously on days 1, 8, and 15) or placebo plus paclitaxel (80 mg/m2 intravenously on days 1, 8, and 15) in 28-day cycles
- 1° endpoint PFS

Biomarkers: associations between c-Myc expression in tumor tissue (prespecified) and genetic alterations in ctDNA (retrospective) with clinical outcome

PFS in ITT



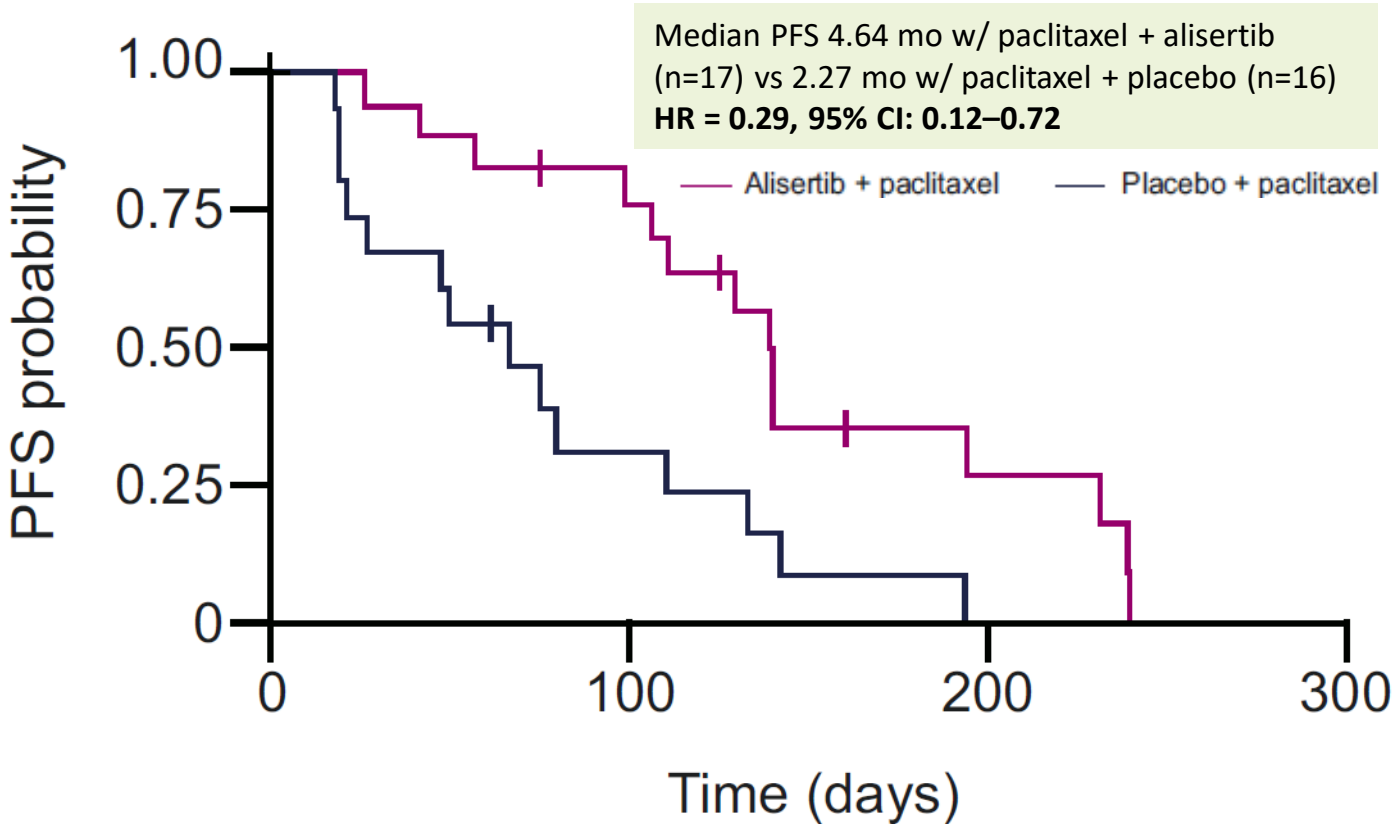
OS in ITT



Randomized Phase 2 Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Correlative Biomarker Analysis

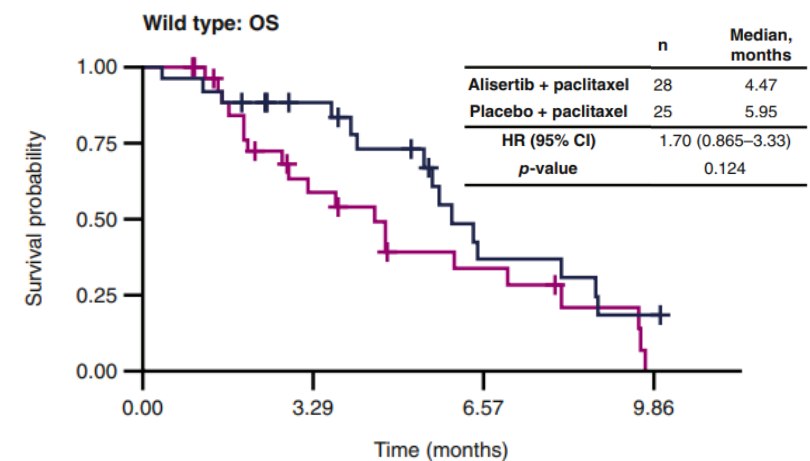
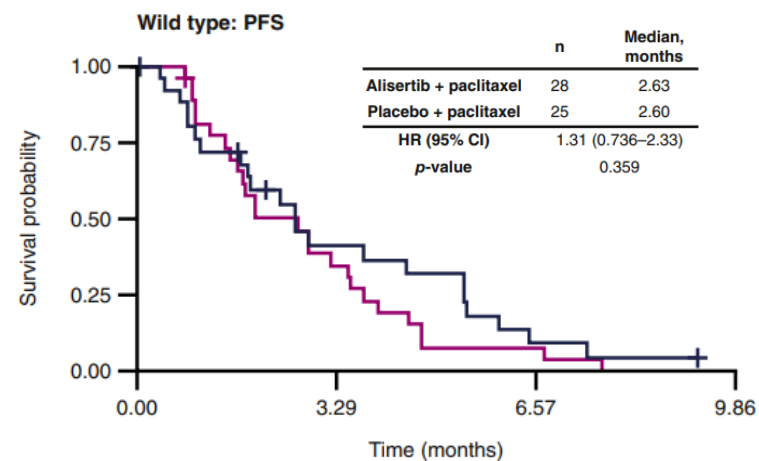
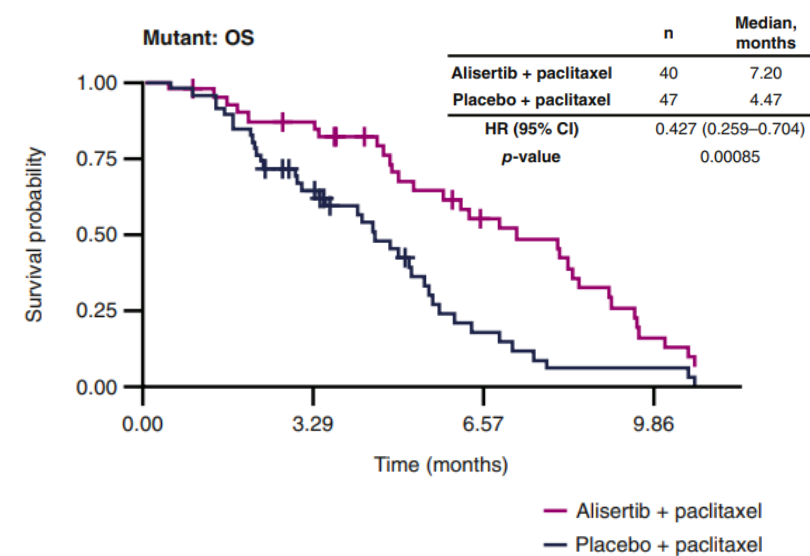
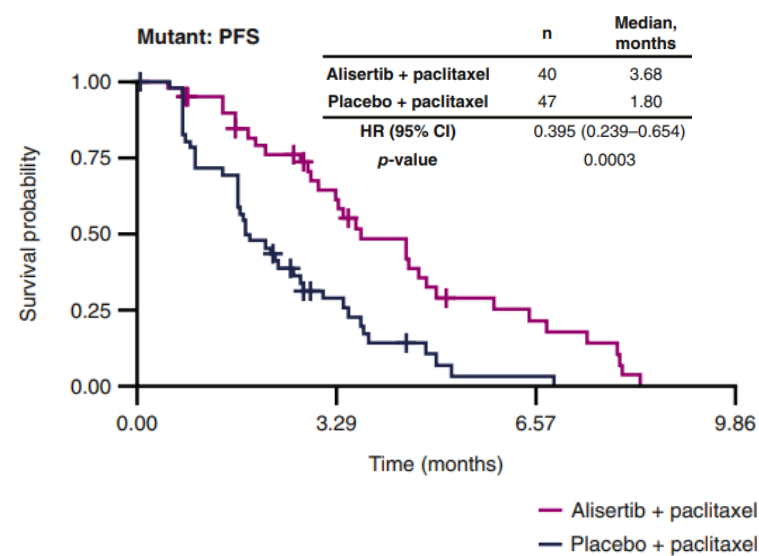
Improved PFS observed among patients positive versus negative for *c-Myc* expression

PFS in patients positive for *c-Myc* expression



Randomized Phase 2 Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Correlative Biomarker Analysis

Improved outcomes among pts with genetic alternations in cell cycle genes *CDK6*, *RBL1*, *RBL2*, and *RB1* (collectively referred to as “mutant”)



Randomized Phase 2 Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Safety

Table 3. Most Frequently Reported All-Cause and Drug-Related Treatment-Emergent AEs, Occurring in at Least 15% (All-Cause) or at Least 10% (Drug-Related) of Patients Overall (Any Grade) in Either Arm, Respectively, with the Corresponding Grade 3 or higher AEs (Safety Population), and All Drug-Related Fatal AEs

AE	Alisertib/Paclitaxel (n = 87)		Placebo/Paclitaxel (n = 89)	
	Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
All-cause AE, n (%)	86 (99)	66 (76)	85 (96)	45 (51)
Diarrhea	51 (59)	14 (16)	18 (20)	1 (1)
Fatigue	38 (44)	9 (10)	29 (33)	5 (6)
Nausea	29 (33)	2 (2)	30 (34)	4 (4)
Anemia	38 (44)	12 (14)	18 (20)	3 (3)
Neutropenia	43 (49)	35 (40)	7 (8)	5 (6)
Vomiting	28 (32)	2 (2)	21 (24)	3 (3)
Decreased appetite	29 (33)	3 (3)	19 (21)	3 (3)
Dyspnea	21 (24)	4 (5)	19 (21)	2 (2)
Stomatitis	29 (33)	12 (14)	6 (7)	2 (2)
Cough	17 (20)	0	17 (19)	0
Constipation	8 (9)	1 (1)	21 (24)	0
Asthenia	14 (16)	3 (3)	11 (12)	0
Dizziness	14 (16)	0	8 (9)	0
Alopecia	14 (16)	0	5 (6)	0
Leukopenia	13 (15)	7 (8)	5 (6)	2 (2)
Decreased neutrophil count	14 (16)	11 (13)	4 (4)	1 (1)
Weight decreased	13 (15)	0	5 (6)	0
Drug-related fatal AE, n (%)				
Neutropenic sepsis	—	1 (1)	—	0
Sepsis	—	1 (1)	—	0
Febrile neutropenia	—	1 (1)	—	0
Septic shock	—	1 (1)	—	0

AE, adverse event

PUMA-ALI-4201 Phase II study design

Key inclusion criteria

- Pathologically confirmed ES-SCLC
- Progression on or after first-line platinum-based chemo; must have prior immunotherapy
- Measurable disease per RECIST v1.1
- Must provide tissue biopsy, archival tissue acceptable; if unavailable, fresh tissue biopsy required
- Treated, stable brain mets allowed
- ECOG PS 0-1

N = up to 60

Alisertib
50 mg po BID on days 1-7 of every 21-day cycle

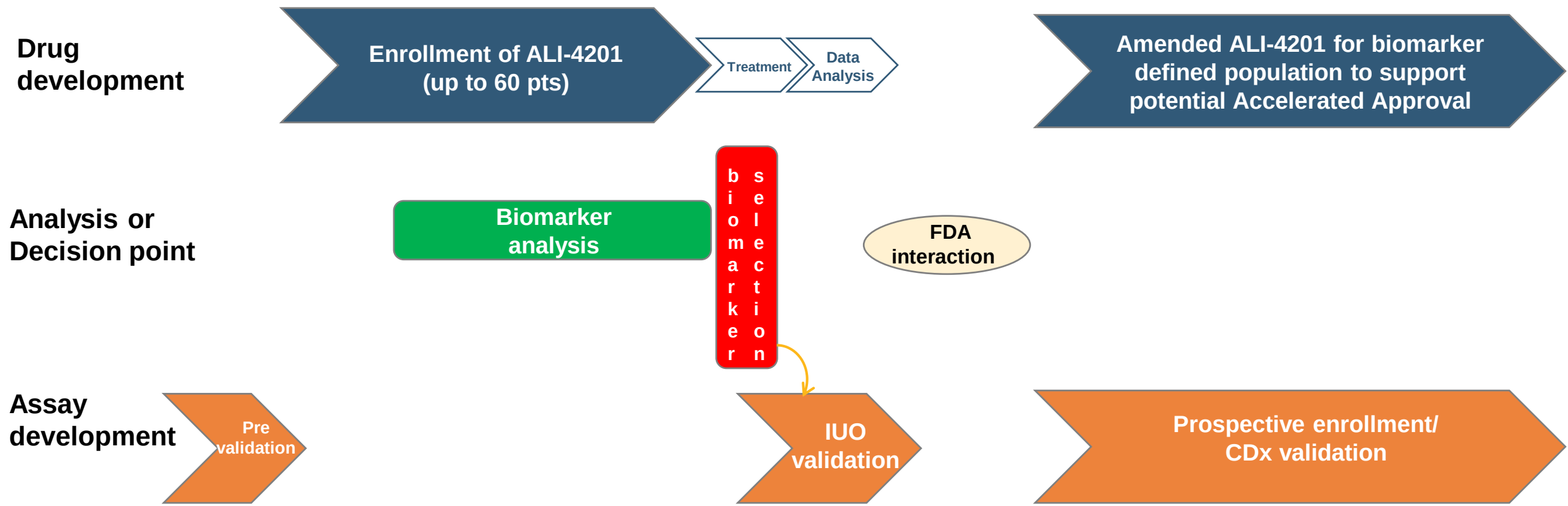
Anticipate initiation of PUMA-ALI-4201 Phase II trial in Q4 2023

Efficacy and safety objectives and endpoints

Objective
Primary Endpoint
Proportion of patients with confirmed complete responses (CR) or partial responses (PR) as defined by Response Evaluation Criteria in Solid Tumors version 1.1 (RECIST v1.1)
Secondary Endpoints
- Duration of response (DOR) - Disease control rate (DCR) - Progression free survival (PFS)
Overall survival (OS)
Adverse events (AEs) and serious adverse events (SAEs) per National Cancer Institute Common Terminology Criteria for Adverse Events Version 5.0 (NCI CTCAE v.5.0)
Plasma alisertib concentrations on Cycle 1 Day 1 and Day 8
Exploratory Endpoints
ORR, DOR, DCR, PFS, and OS within selected biomarker subgroups from formalin-fixed paraffin-embedded (FFPE) tissue and/or from plasma (circulating tumor DNA [ctDNA])

Parallel Clinical and Biomarker Development

- Comprehensive biomarker strategy supports clinical development and commercialization



Clinical Development of Alisertib in Breast Cancer

Phase 2 Study of Alisertib Monotherapy in Solid Tumors

- Breast Cancer Cohorts

Study design:

- Pts had to have undergone ≤ 2 previous cytotoxic regimens, not including adjuvant or neoadjuvant treatments
- Alisertib administered orally in 21-day cycles at 50 mg twice daily for 7 days followed by a break of 14 days
- 1° Endpoint: Objective Response Rate (RECIST 1.1)

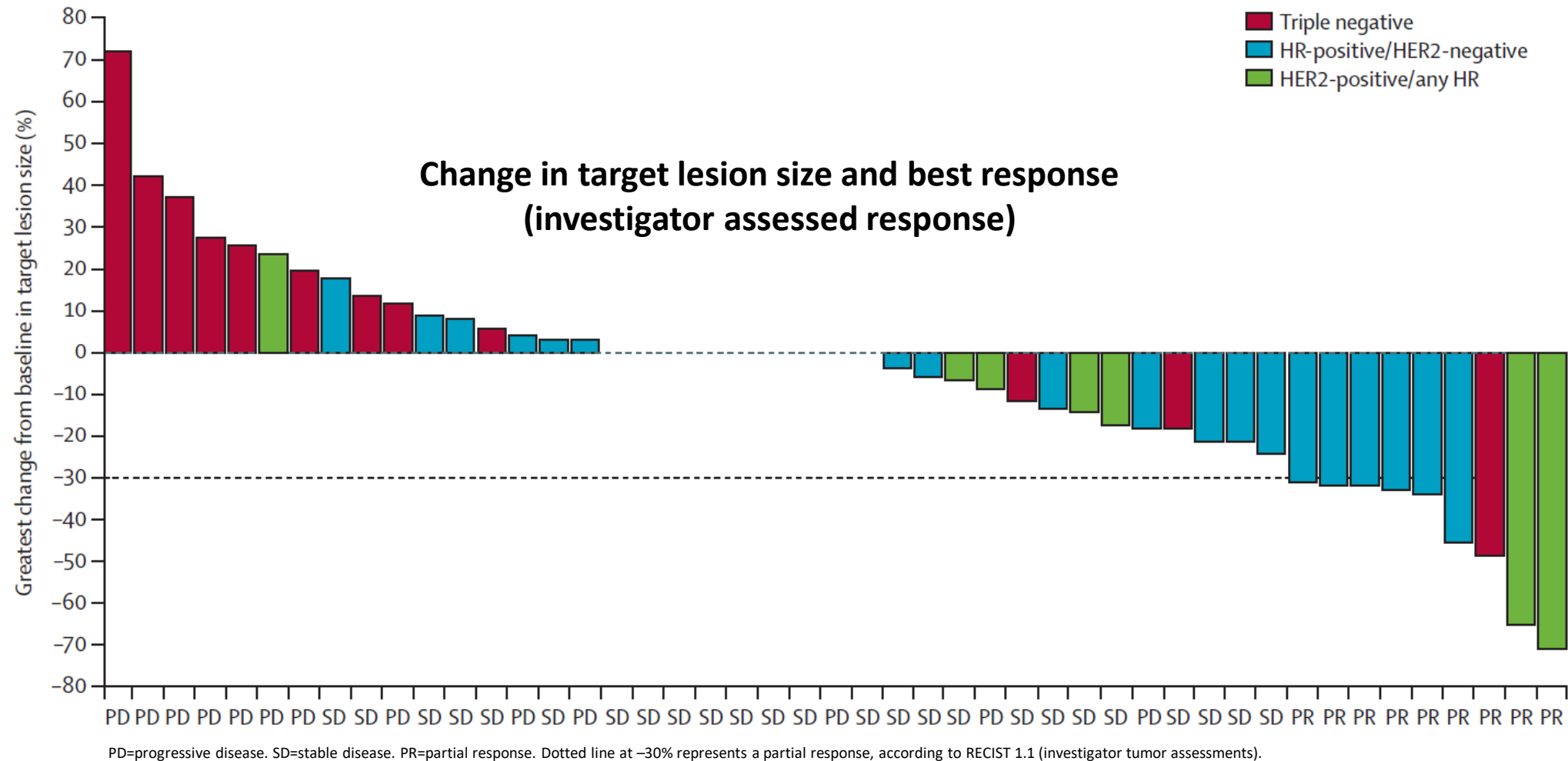
	All (n=49)	Hormone receptor-positive and HER2-negative (n=26)	HER2-positive (n=9)	Triple negative (n=14)
Median (range) number of cycles	4.0* (1-23)	8.0 (1-23)	6.0 (1-19)	2.0 (1-14)
Best response				
Objective response†	9 (18%) (9-32)	6 (23%)	2‡ (22%)	1 (7%)
Stable disease	25 (51%) (36-66)	17 (65%)	3 (33%)	5 (36%)
Stable disease for ≥ 6 months	10 (20%)	8 (31%)	1 (11%)	1 (7%)
Progressive disease	15 (31%) (18-45)	3 (12%)	4 (44%)	8 (57%)
Duration of response (months)	5.6 (2.8-12.0)	4.2	11.2	4.2
Progression-free survival (months)	5.4 (2.6-7.9)	7.9 (4.2-12.2)	4.1 (0.95-15.0)	1.5 (1.2-3.2)
Time to progression (months)	5.4 (2.6-7.9)	7.9 (4.2-12.2)	4.1 (0.95-15.0)	1.5 (1.2-3.2)

Data are either number of patients (%) (95% CI), or median (95% CI), unless otherwise stated. For the breast cancer subgroup, numbers of patients were too small to calculate 95% CIs. *Safety population. †All were partial responses. ‡ These two patients had the only hormone receptor-negative tumors in the cohort. All responses were based on investigator tumor assessments (RECIST v1.1).

Phase 2 Study of Alisertib Monotherapy in Solid Tumors

- Breast Cancer Cohorts

9 / 49 patients (18%; 95% CI 9–32) had an objective response; all responders achieved a partial response



Phase 2 Study of Alisertib Monotherapy in Solid Tumors

- Breast Cancer Cohorts

All-cause adverse events in safety evaluable breast cancer cohort (n=53)

	Grade 1-2	Grade 3-4
Any adverse event	8 (15%)	44 (83%)
Neutropenia	3 (6%)	30 (57%)
Fatigue	23 (43%)	6 (11%)
Anaemia	17 (32%)	4 (8%)
Alopecia	26 (49%)	NA
Diarrhoea	25 (47%)	2 (4%)
Nausea	15 (28%)	2 (4%)
Leukopenia	5 (9%)	19 (36%)
Stomatitis	16 (30%)	8 (15%)
Decreased appetite	13 (25%)	0
Vomiting	11 (21%)	1 (2%)
Thrombocytopenia	8 (15%)	4 (8%)
Somnolence	14 (26%)	1 (2%)
Dyspnoea	9 (17%)	3 (6%)
Constipation	9 (17%)	0
Pyrexia	4 (8%)	1 (2%)
Peripheral oedema	9 (17%)	0
Headache	11 (21%)	0
Insomnia	6 (11%)	0
Cough	8 (15%)	1 (2%)
Asthenia	2 (4%)	3 (6%)
Dehydration	5 (9%)	3 (6%)

Table adapted from Melichar B Lancet Oncol 2015. Data are number of patients with AE (%) for AEs of any grade in at least 10% of patients overall. NA = not applicable

Phase 2 Randomized Trial of Alisertib + Fulvestrant vs Alisertib in Advanced HR+ Breast Cancer

Patients (n=96)

Inclusion Criteria

- Post-menopausal women
- Histologically-proven ER+ (>10% expression) and HER2 negative
- No more than two prior chemotherapy regimens
- Prior treatment with fulvestrant in the metastatic setting required
- Disease that is measurable as defined by the RECIST criteria

Regimen & Schedule

- **Alisertib + Fulvestrant:** Alisertib 50 mg PO BID on days 1-3, 8-10, 15-17 q 28-day cycle with fulvestrant 500 mg IM on days 1 and 15 of cycle 1 then day 1 of all subsequent cycles
- **Alisertib Alone:** Alisertib 50 mg PO BID on days 1-3, 8-10, 15-17 q 28-day cycle

Patient Characteristics

	Alisertib (n=45)	Alisertib + Fulvestrant (n=45)
Prior Chemotherapy		
(Neo)Adjuvant Setting	27 (60.0%)	27 (60.0%)
Metastatic Setting	21 (46.7%)	31 (69.9%)
Prior Adjuvant Endocrine Therapy		
Aromatase Inhibitor	24 (53.3%)	20 (44.4%)
Tamoxifen	14 (31.1%)	22 (48.8%)
Fulvestrant	7 (15.5%)	2 (4.4%)
Prior Endocrine Therapy for MBC		
Anastrozole/Letrozole	26 (57.8%)	35 (77.8%)
Exemestane	15 (33.3%)	26 (57.8%)
Fulvestrant	44 (97.8%)	45 (100.0%)
Prior Targeted Therapy for MBC		
CDK 4/6 inhibitor	45 (100%)	45 (100%)
Everolimus	16 (35.6%)	26 (57.8%)

Clinical Outcomes

	Alisertib (n=45)	Alisertib + Fulvestrant (n=45)
Confirmed Responses	8 PR	1 CR; 8 PR
Objective Response Rate	17.8% (90% CI: 9.2-29.8%)	20.0% (90% CI: 10.9-32.3%)
Clinical Benefit Rate (24-week)	42.2% (90% CI: 29.7-55.6%)	28.9% (90% CI: 18.0-42.0%)
Median PFS (months)	5.6 (95%CI: 3.9 – 9.3)	5.1 (95%CI: 3.8 – 7.6)
Deaths	n=10	n=14
6-month OS rate	90.6% (95% CI: 82.2-99.8%)	75.6% (95% CI: 63.9-90.2%)

Phase 2 Randomized Trial of Alisertib + Fulvestrant vs Alisertib in Advanced HR+ Breast Cancer

Safety				
	Alisertib (n=45)		Alisertib + Fulvestrant (n=45)	
	G3	G4	G3	G4
Hematologic Adverse Events				
Anemia	13%	2%	9%	0%
Lymphocyte Count Decreased	2%	0%	13%	0%
Neutropenia Count Decreased	24%	18%	20%	22%
White Blood Cell Count Decreased	13%	4%	22%	9%
Non-Hematologic Adverse Events				
Fatigue	0%	0%	11%	0%

Reason for Treatment Discontinuation	Alisertib* (n=45)	Alisertib + Fulvestrant (n=45)
Disease progression	28	28
Intolerability	2	6
Patient Refusal	0	4
Physician Decision	1	0
Second Primary	0	1
Death	2	1
*Discontinuation of monotherapy		

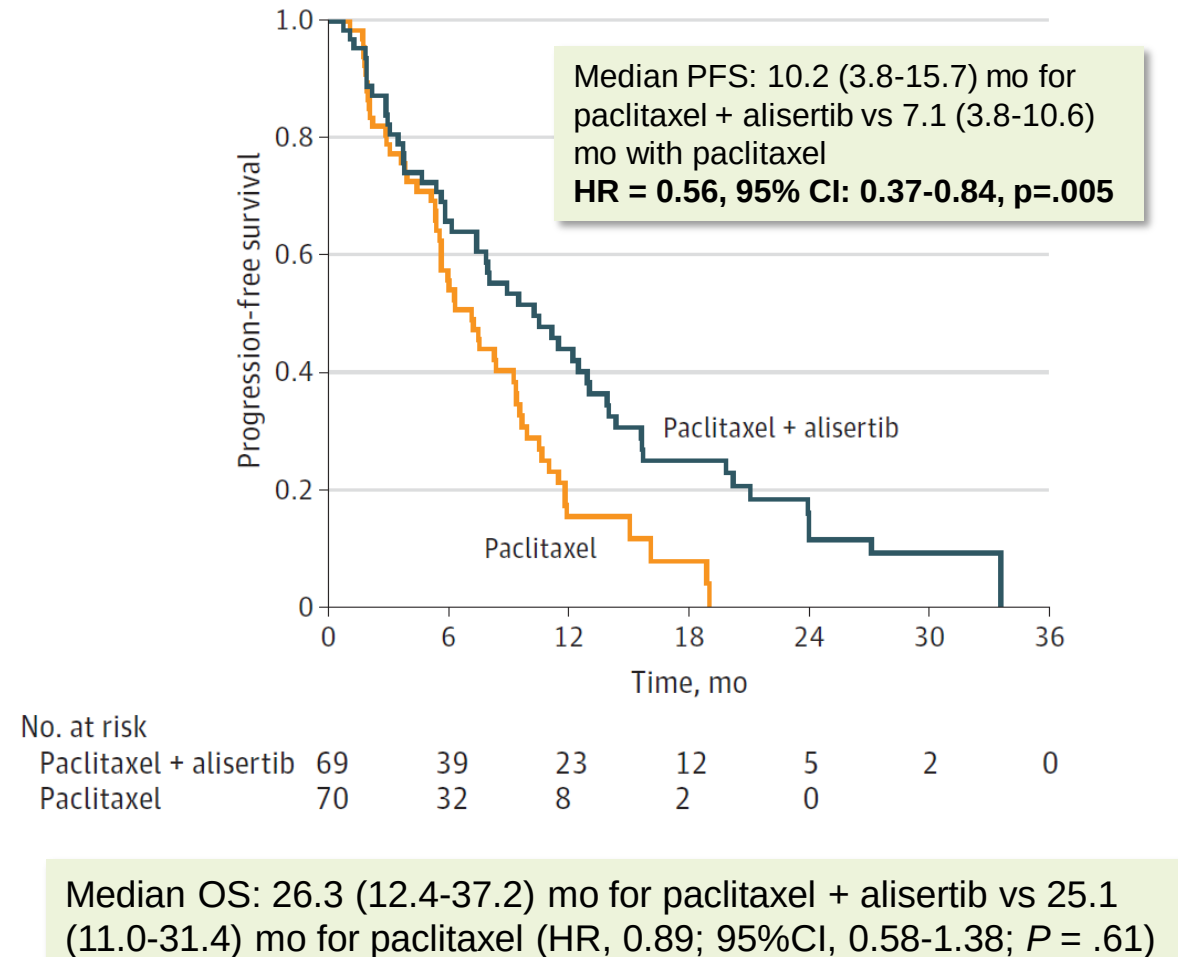
Phase 2 Randomized Study of Paclitaxel + Alisertib vs Paclitaxel Alone

- Efficacy in ER+/HER2- MBC Cohort

Study design:

- Patients with ER+/HER2- or triple negative metastatic breast cancer stratified by prior neo or adjuvant taxane and by line of metastatic therapy
- Randomized 1:1 to paclitaxel + alisertib or paclitaxel alone in 28-day cycles
- Paclitaxel 60mg/m² intravenously (IV) on days 1, 8, and 15 plus alisertib 40 mg twice daily on days 1 to 3, 8 to 10, and 15 to 17 of a 28-day cycle or to single agent paclitaxel 90mg/m² IV on days 1, 8, and 15 of a 28-day cycle
- 1° endpoint PFS

PFS in ER+/HER2- ITT



Phase 2 Randomized Study of Paclitaxel + Alisertib vs Paclitaxel Alone

- Efficacy in ER+/HER2- MBC Cohort Pretreated with Palbociclib

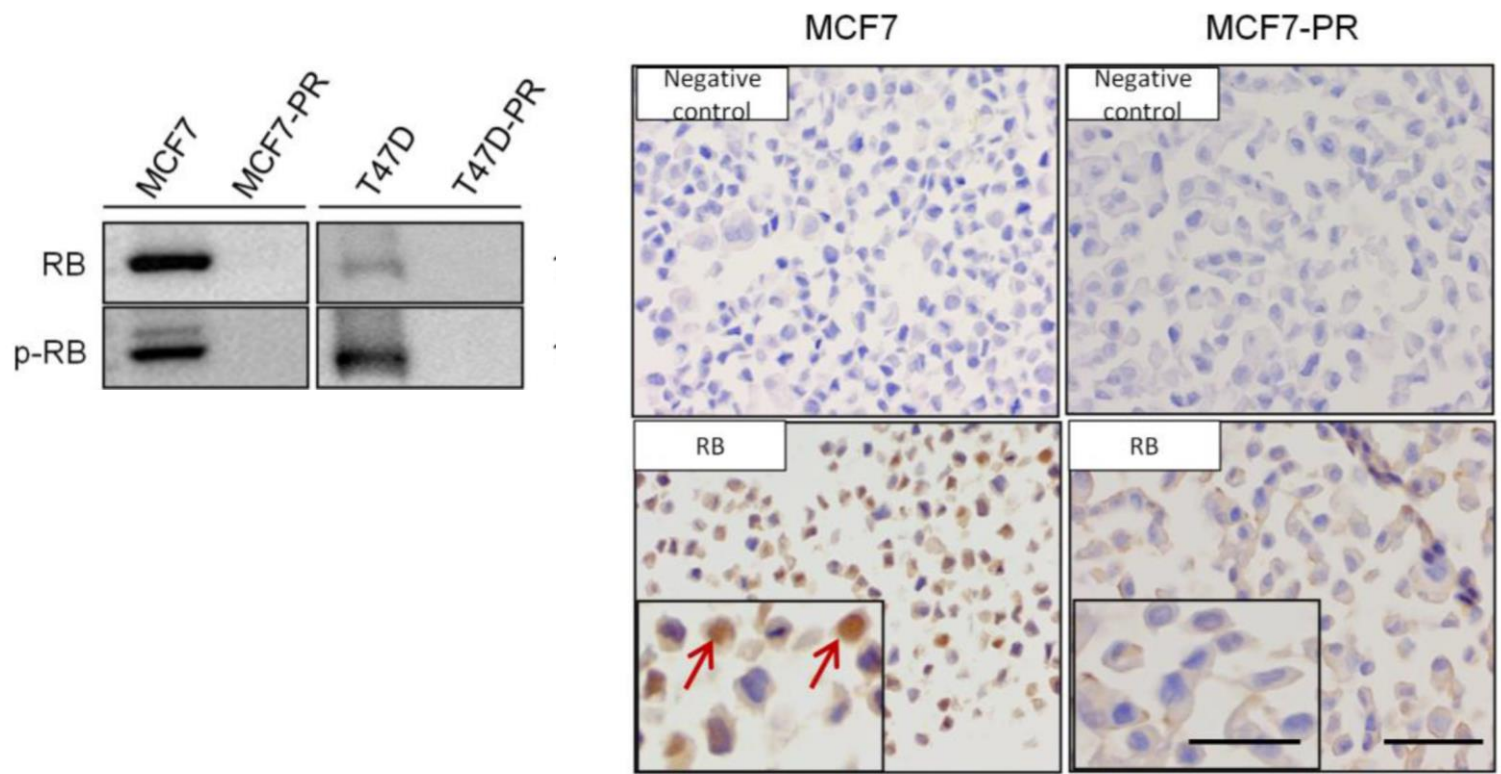
Efficacy in patients pretreated with palbociclib (n=30)

- Median PFS: 13.9 (5.6-15.6) mo (14 pts) w/ paclitaxel + alisertib vs 5.6 (3.0-10.6) mo (16 pts) w/ paclitaxel alone (HR, 0.58; 95%CI, 0.26-1.32; $P = .19$)
- CBR: 61.5% w/ paclitaxel + alisertib (95%CI, 31.6%-86.1%) vs 37.5% (95%CI, 15.2%-64.6%) w/ paclitaxel alone

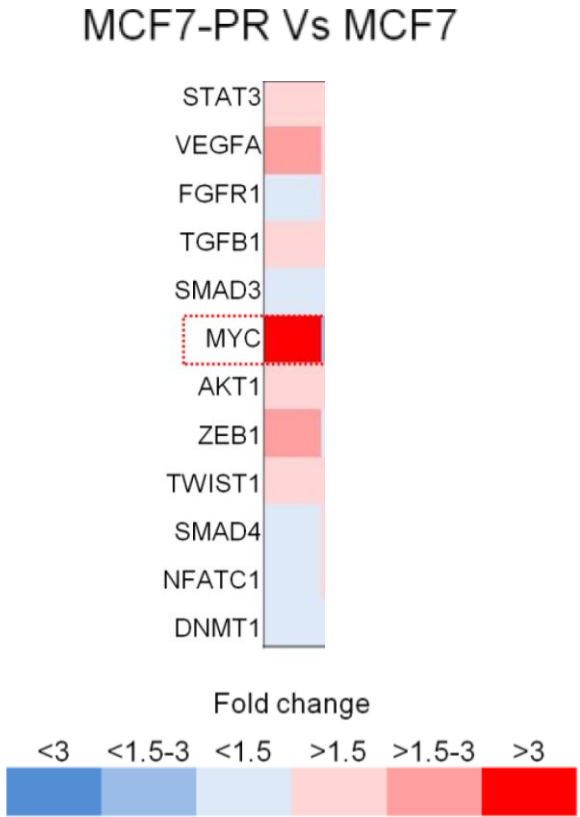
Rb1 Loss and c-Myc Upregulation Correlate with Palbociclib Resistance

Both RB1 loss and MYC upregulation were observed in palbociclib-resistant HR+ breast cancer cell lines, supporting a role for alisertib in this setting

RB1 Loss



C-Myc Upregulation



Study-related Neutropenia in Metastatic Breast Cancer

- Alisertib compared to other agents

Regimen	All-grade Neutropenia (%)	Grade 3/4 Neutropenia (%)	Febrile Neutropenia (%)
Alisertib monotherapy 50 mg BID ¹	63% ¹	57% ¹	4% ¹
Alisertib monotherapy 50 mg BID ²	Not reported ²	42% ²	Not reported ²
Alisertib 50 mg BID + fulvestrant ²	Not reported	42%	Not reported
Alisertib 40 mg BID + paclitaxel ³	67.9%	59.5%	1.2%
Eribulin mesylate (HALAVEN) ⁴	82%	57%	5%
Physician's Choice of Chemotherapy ⁵	51.2%	40.7%	Not reported
Palbociclib (IBRANCE) ⁶ + fulvestrant (PALOMA-3) or letrozole (PALOMA-2)	P+F: 83% P+L: 80%	P+F: 66% P+L: 66%	P+F: 0.9% P+L: 2.5%
Sacituzumab govitecan (TRODELVY) ⁷ for ER+	70%	51% (G ≥3 neutropenia)	5%
Sacituzumab govitecan (TRODELVY) ⁸ for TNBC	64%	52%	6%

1. alisertib: 21-day cycle, 7 days followed by 14-day break, 2. alisertib: 28-day cycle, on days 1-3, 8-10, 15-17, 3. paclitaxel: 28-day cycle on days 1, 8, and 15

Alisertib-associated neutropenia is thought to be cumulative and possibly can be managed/reduced with G-CSFs for prophylaxis of neutropenia per NCCN Guidelines⁹

¹Melichar B Lancet Oncol 2015, ²Haddad SABCS 2020 PD2-05, ³O'Shaughnessy J JAMA Netw Open 2021, ⁴HALAVEN USPI, ⁵Modi S N Engl J Med 2022, ⁶IBRANCE USPI,

⁷Rugo HS ASCO 2022, ⁸TRODELVY USPI, ⁹NCCN Guideline Hematopoietic Growth Factors Version 1.2022

Overview of Alisertib Clinical Development Plan in Breast Cancer

Target Patient Population(s)	Rationale for Selected Indication	Potential Biomarker-defined Subgroups
HR+/HER2- metastatic breast cancer (MBC)	• Prior Clinical Data • Puma experience in breast cancer	• <i>c-Myc</i> amplification • Rb1 deficiency

Puma plans to meet with FDA to discuss alisertib clinical development plan in HR positive breast cancer and Project Optimus in H2 2023

Intellectual Property for Nerlynx (neratinib)

- Composition of matter patent issued (expires 2030)
 - Extended by USPTO in November 2021 per Hatch/Waxman
- Use in the treatment of cancer issued (expires 2025)
- Two polymorph patents issued (both expire 2028)
- Combination with capecitabine (expires 2031)
- Use in extended adjuvant breast cancer (expires 2030)
- Composition of specific salt of neratinib (recently issued)

Intellectual Property for alisertib

- Composition of matter patent issued (expires 2029)
- Use in the treatment of proliferative disorders (expires 2032)
- Use in the treatment of small cell lung cancer (expires 2033)
- Use in the treatment of breast cancer (expires 2034)
- Additional patents being filed and prosecuted

Potential for up to 5 year Hatch/Waxman extension
on expiration date of above listed patents

Intellectual Property on *EGFR* T790M Mutations

- Issued claims in Europe, Asia, Australia (expires 2026)
 - Possibility to extend up to 5 years
- Issued claims in United States (expires 2026)
- Patent claims upheld after European Opposition Hearing (February 2014)
 - Patent claims upheld after Appeal to European Opposition (December 2020)
- Claims for the pharmaceutical composition comprising an irreversible EGFR inhibitor for use in treating cancer having a T790M mutation
- Claims for the pharmaceutical composition for use in the treatment of cancer including lung cancer and non-small cell lung cancer

Puma – Expected Milestones

- Initiate a Phase II clinical trial of alisertib in small cell lung cancer (H2 2023)
- Conduct a meeting with the FDA to discuss the clinical development and registration pathway for alisertib in hormone receptor-positive breast cancer (Q4 2023)
- Report data from an ongoing investigator sponsored Phase I/II trial of alisertib plus pembrolizumab for the treatment of patients with Rb-deficient head and neck squamous cell cancer (H2 2023)

Experienced Management Team

Alan H. Auerbach

Chairman, Chief Executive Officer, President, Founder

– *Chief Executive Officer, President, Founder, Cougar Biotechnology*

Jeff Ludwig

Chief Commercial Officer

– *Eli Lilly, Astellas, Amgen*

Maximo F. Nougues

Chief Financial Officer

– *Getinge AB, Boston Scientific, The Clorox Company*

Alvin Wong, Pharm.D.

Chief Scientific Officer

– *Proteolix, Novacea, Genentech*

Douglas Hunt

Senior Vice President, Regulatory Affairs

– *ArmaGen, Baxter Healthcare, Amgen*

Board of Directors

Alan H. Auerbach

Chairman, Chief Executive Officer, President, Founder, Puma Biotechnology, Inc.

Alessandra Cesano, MD, PhD

Chief Medical Officer, ESSA Pharmaceuticals; NanoString; Cleave Biosciences; Nodality; Amgen; Biogen; SmithKline

Allison Dorval

CFO, Verve Therapeutics; Former CFO Voyager Therapeutics, Inc.; VP and Controller, Juniper Pharmaceuticals, Inc.

Michael Miller

Former EVP U.S. Commercial, Jazz Pharmaceuticals; VP, Sales & Marketing, Genentech

Jay Moyes

CFO, Sera Prognostics, Inc.; Former CFO, Myriad Genetics

Adrian Senderowicz, MD

Senior Advisor and former SVP and Chief Medical Officer, Constellation Pharmaceuticals; Ignyta; Sanofi; AstraZeneca; FDA (Division of Oncology Drug Products)

Brian Stuglich, R.Ph.

CEO, Verastem; Founder, Proventus Health Solutions; Former VP and Chief Marketing Officer, Eli Lilly Oncology

Troy Wilson, PhD, JD

CEO, Kura Oncology; CEO, Wellspring Biosciences; CEO Avidity Nanomedicines; Former CEO, President, Intellikine

Puma Biotechnology – Financial

- Currently trading on NASDAQ: PBYI
- Cash, cash equivalents and marketable securities at June 30, 2023: \$74 million
- Net income in Q2 2023: \$2.1 million
- Cash earned in Q2 2023: \$3.2 million
- Private placements:
 - March 2022: 3,584,228 shares issued to Alan Auerbach and Athyrium Capital Management
 - December 2022: 568,181 shares issued to Alan Auerbach
- Shares issued and outstanding: 47.5 million

Company Highlights

- NERLYNX® – first HER2-directed drug approved by FDA for extended adjuvant treatment of early-stage HER2+ breast cancer in patients who have received prior trastuzumab
- NERLYNX® – first HER2-directed tyrosine kinase inhibitor approved in both early stage and metastatic HER2+ breast cancer
- Retain full U.S. commercial rights to NERLYNX®
- Clinical activity demonstrated for alisertib in Phase 2 clinical trials in HR-positive, HER2-negative breast cancer, Triple Negative Breast Cancer (TNBC), Small Cell Lung Cancer (SCLC)
- Potential for novel biomarker directed commercial opportunities with alisertib compared to other marketed drugs and drugs in development

Puma Biotechnology

Corporate Presentation

September 2023

