Puma Biotechnology

H.C. Wainwright 23rd Annual Global Investment Conference

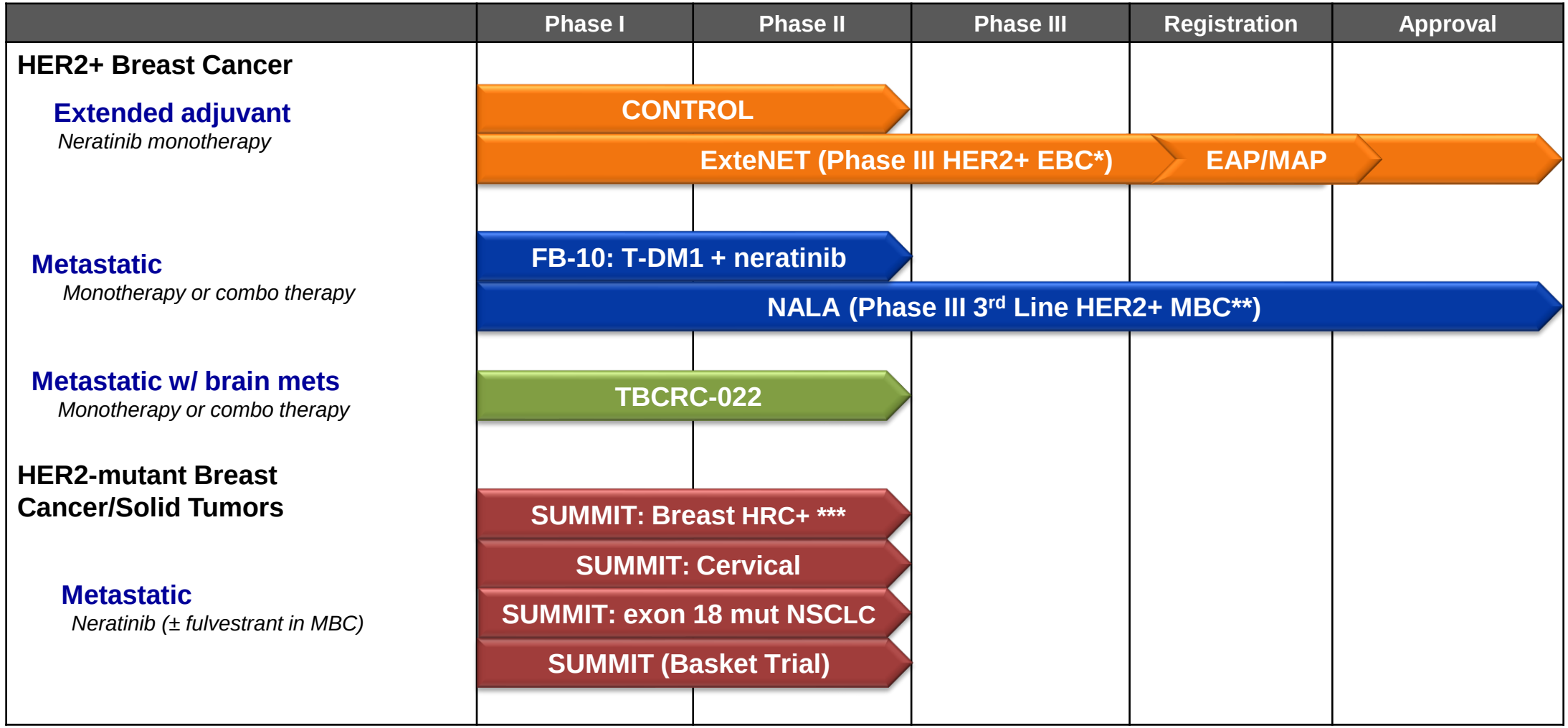
September 2021

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, 2020. 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.

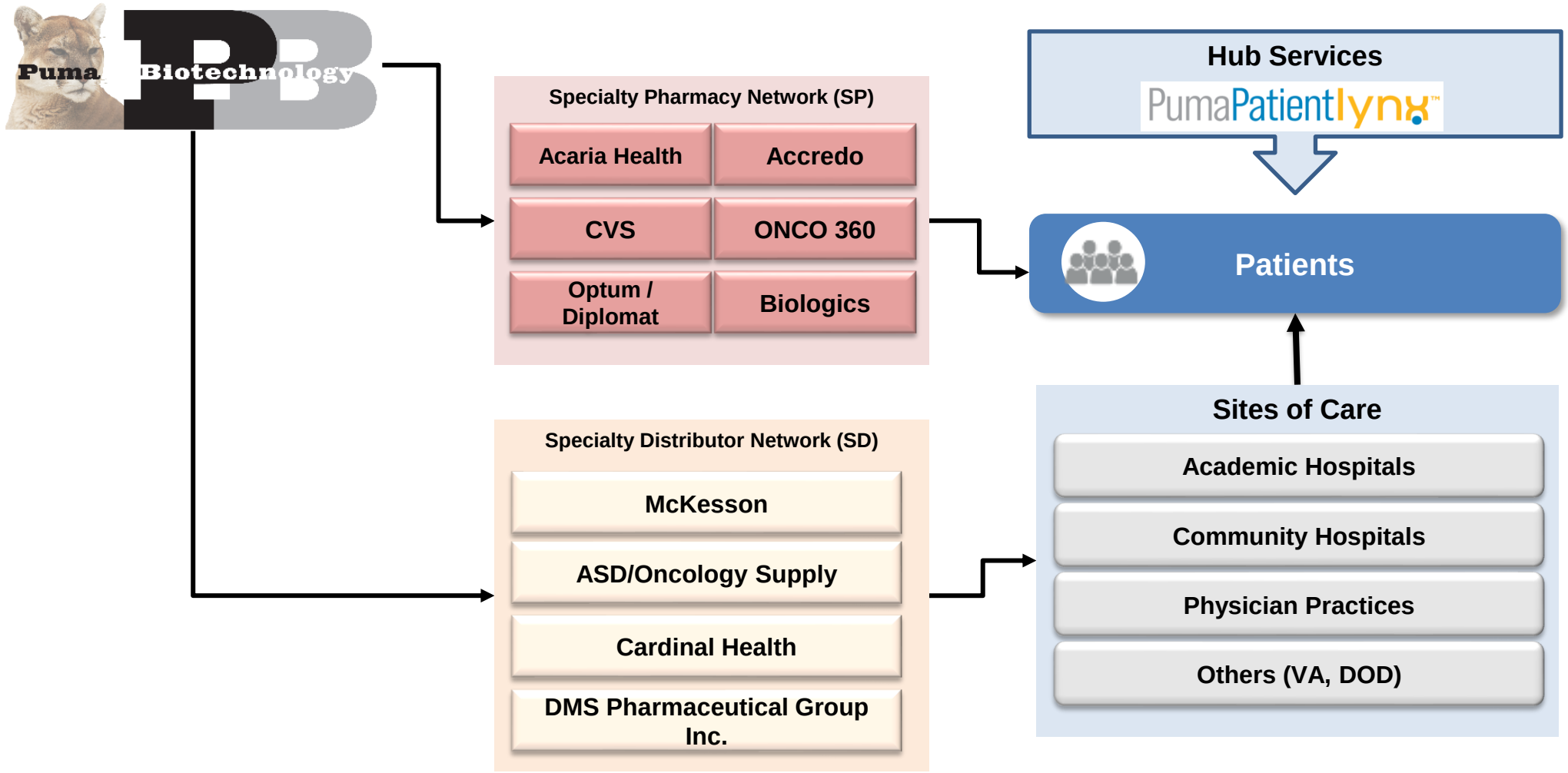
Product Pipeline

Neratinib across the breast cancer therapy spectrum

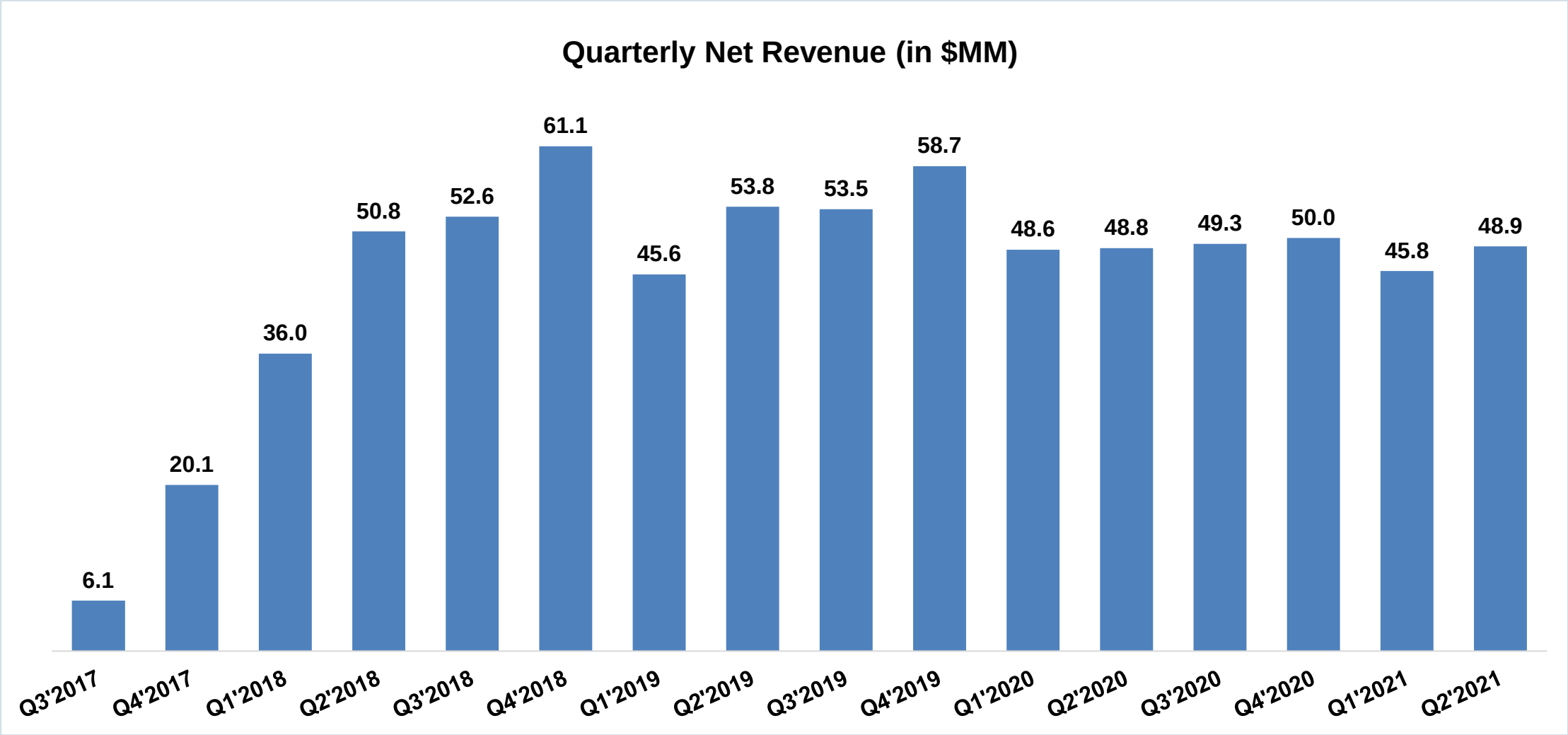


* EBC: Early breast cancer ** MBC: Metastatic breast cancer *** HRC+: Hormone receptor positive

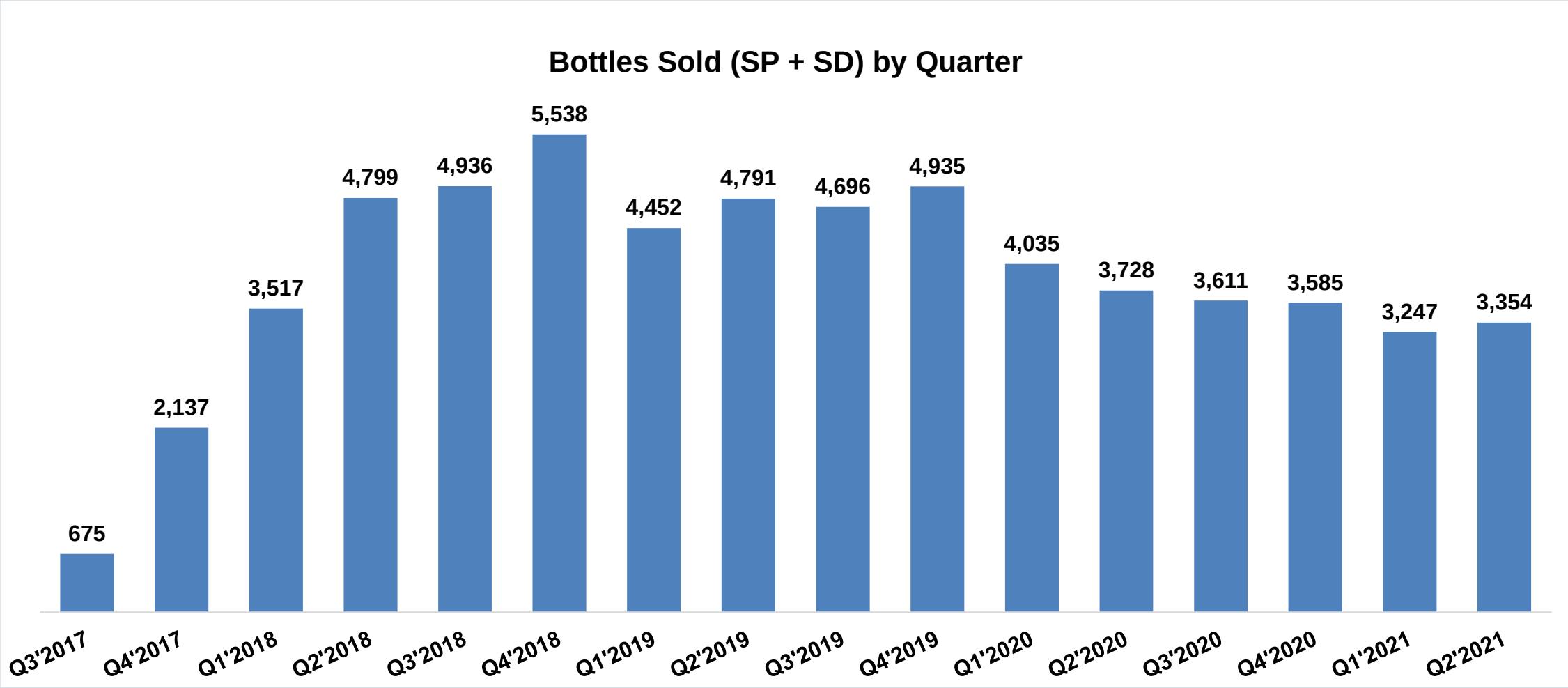
PUMA's Pharmacy and Distributor Network



~$49 Million Net NERLYNX Revenue in Q2’21

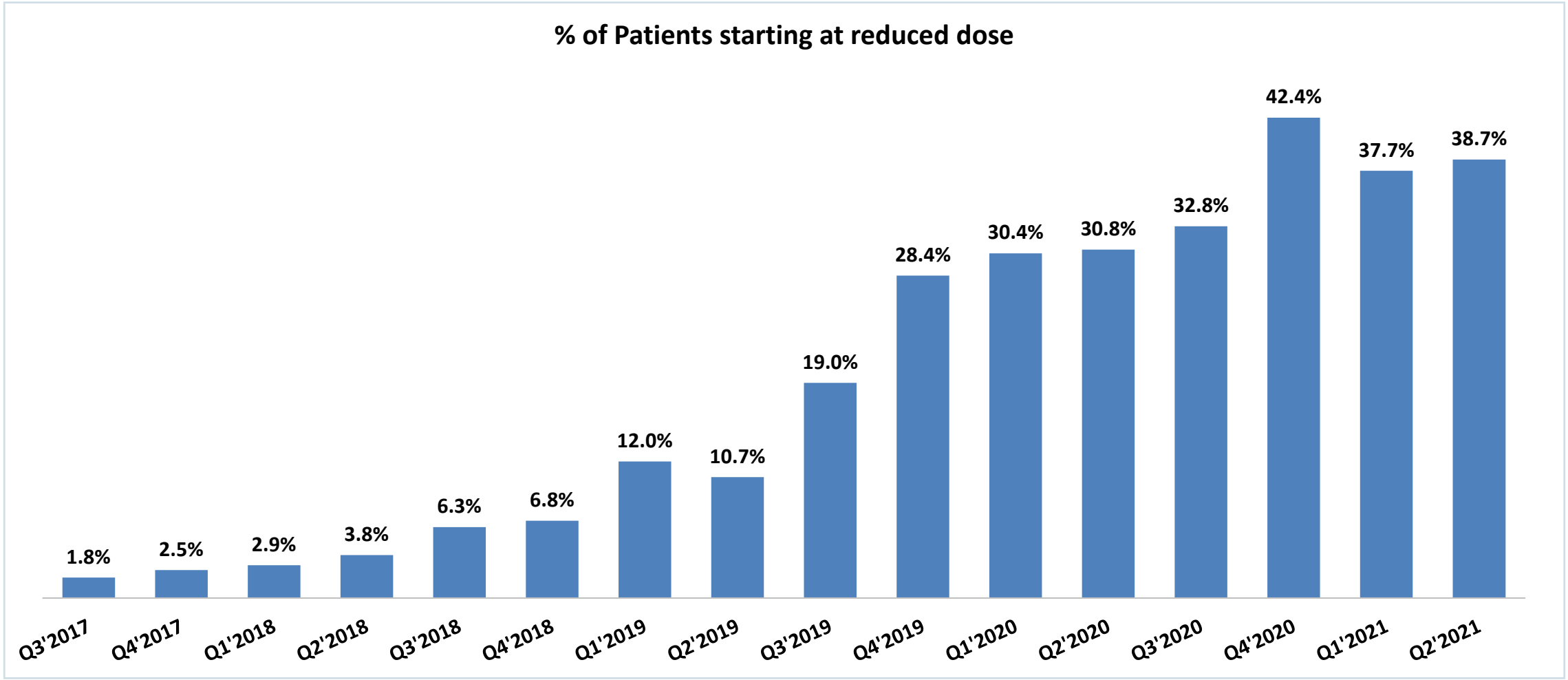


3,354 Ex-factory Bottles were Sold in Q2’21



Includes Commercial SP and SD

~39% of Patients in Q2’21 Started at a Reduced Dose* **



*Reduced dose defined as fewer than 6 pills per day

** FDA approved dose-escalation label supplement in June 2021

Rest of World Partnerships – Timelines

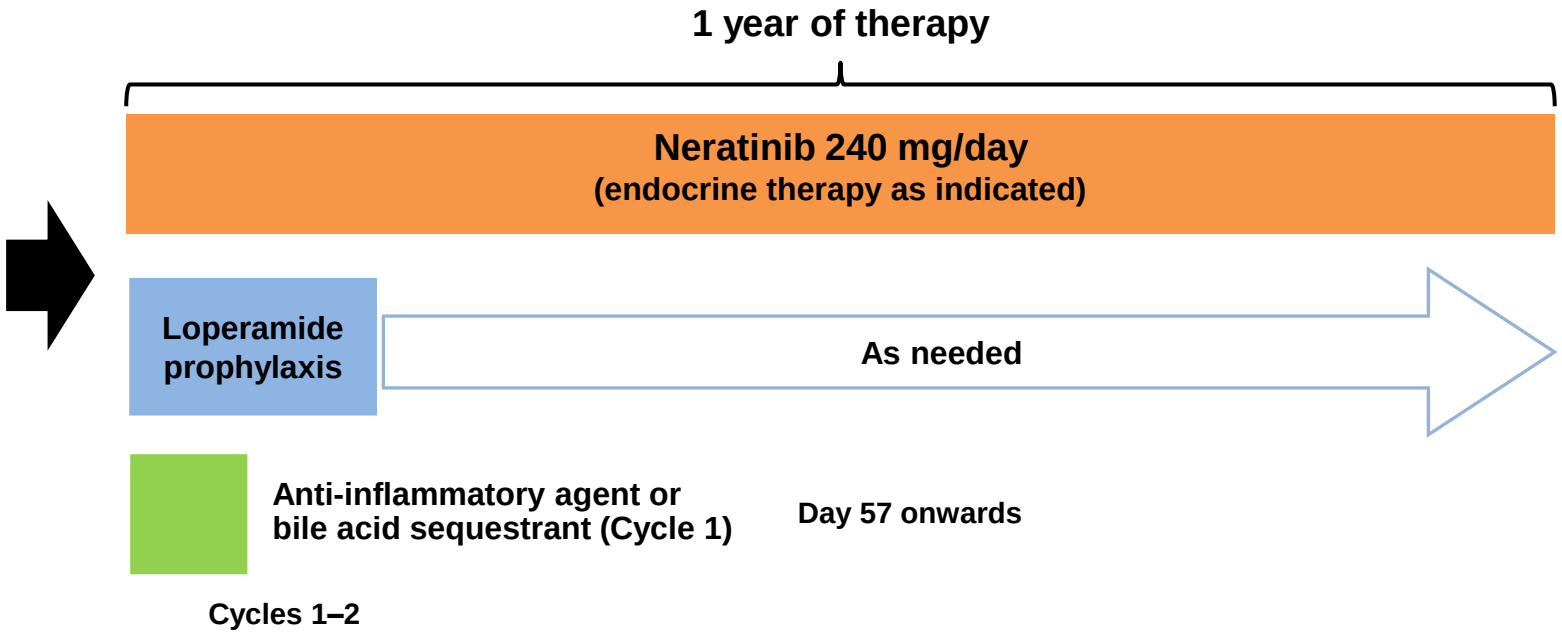
Region	Partner	Regulatory Approvals	Commercial Launches
Australia / SE Asia	Specialised Therapeutics	• 2019 – Ext. Adj. in Australia, Singapore • 2020 – Ext. Adj. in Brunei, Malaysia, New Zealand	• 2020 – Singapore • Q2 2021 – Malaysia • Q3 / Q4 2021 – Brunei, New Zealand
Israel	MEDISON	• 2020 – Approved in Ext. Adj. and mBC	• 2020 – Launched
Canada	Knight	• 2019 – Ext.. Adj. approved • Q2 2021 – mBC approved	• 2020 – Launched
Latin America	PINT PHARMA	• 2019 – Ext Adj in Argentina • 2020 – Ext. Adj in Chile, Ecuador • 2020 – mBC in Argentina • 2021 – Ext Adj and mBC in Peru • 2021 – Expected approvals in Brazil and Mexico	• 2020 – Argentina • Q2 2021 – Chile
Europe Greater China Middle East North and West Africa South Africa Turkey	Pierre Fabre	• 2019 – EMA approval • 2019 – Ext. Adj. in Hong Kong • 2020 – Ext. Adj. in China, Taiwan	• 2019 – Germany, UK, Austria • 2020 – Sweden, Finland, Scotland, Switzerland Denmark • 2020 – Hong Kong • Q1 2021 – China, Taiwan • Q1 2021 – Greece, Czech Republic
South Korea	BIXINK THERAPEUTICS	• 2020 - NDA filed for both Ext. Adj. and mBC	

CONTROL
Study Design

Phase 2 trial to characterize the incidence and severity of diarrhea in patients with HER2+ early breast cancer treated with neratinib and loperamide prophylaxis ± an investigational agent

HER2+ early BC

- Received up to 1 year of adjuvant trastuzumab
- Stage I–3c
- HR (ER/PR) +/–

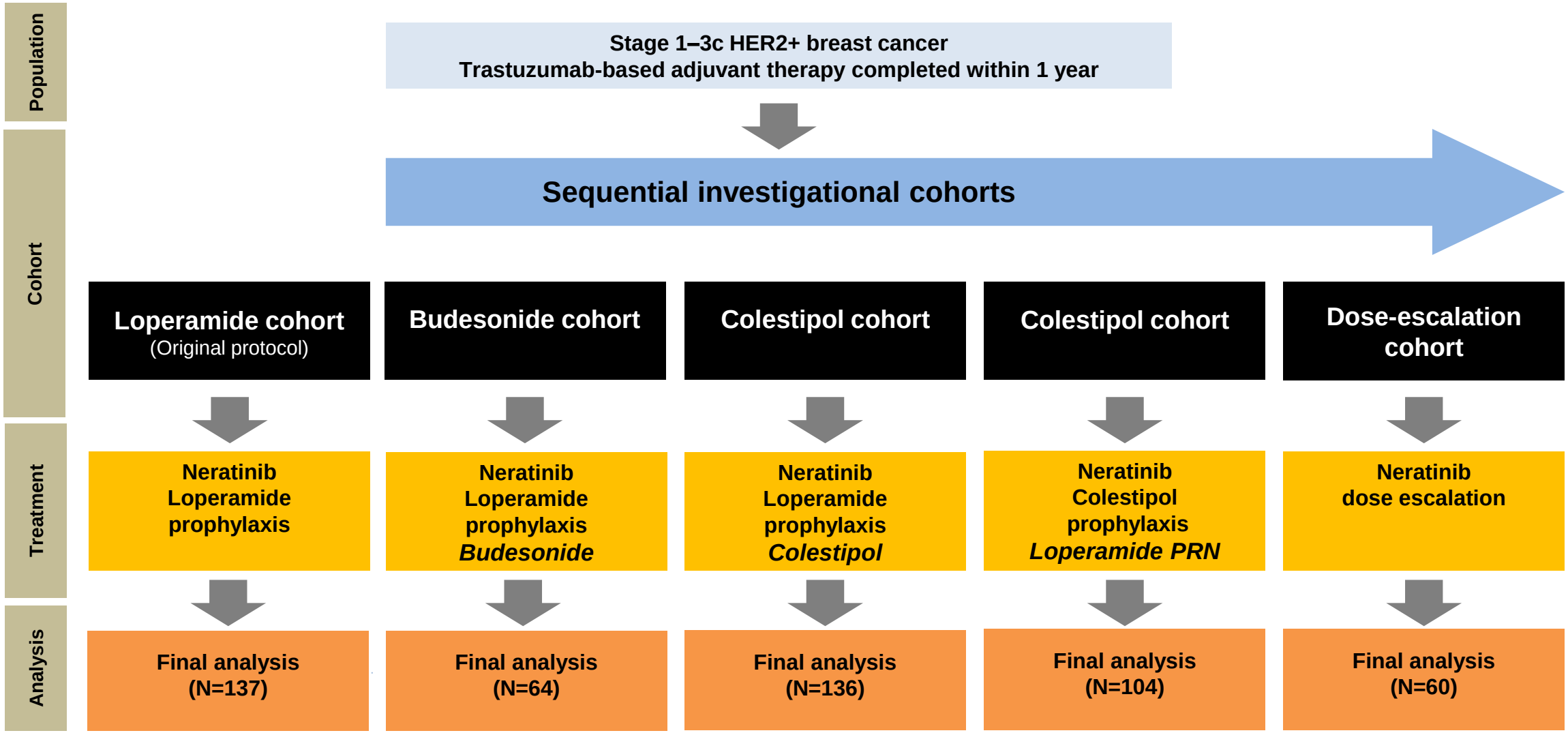


STUDY ENDPOINTS

Primary endpoint: incidence of grade ≥3 diarrhea

Secondary endpoints: frequency distribution of maximum-grade diarrhea; incidence and severity of diarrhea by loperamide exposure

CONTROL
Study Flowchart



CONTROL *vs* ExteNET: Neratinib Treatment-Emergent Diarrhea

Loperamide prophylaxis reduces incidence and severity of diarrhea

	CONTROL[1]					ExteNET[3]
	Loperamide (n=137)	Budesonide + loperamide (n=64)	Colestipol + loperamide (n=136)	Colestipol + loperamide prn (n=104)	Neratinib dose escalation + loperamide prn (n=60)[2]	Loperamide prn (n=1408)
Treatment-emergent diarrhea incidence, n (%)						
No diarrhea	28 (20)	9 (14)	23 (17)	5 (5)	1 (2)	65 (5)
Grade 1	33 (24)	16 (25)	38 (28)	34 (33)	24 (40)	323 (23)
Grade 2	34 (25)	21 (33)	47 (35)	32 (31)	27 (45)	458 (33)
Grade 3	42 (31)	18 (28)	28 (21)	33 (32)	8 (13)	561 (40)
Grade 4	0	0	0	0	0	1 (<1)
Diarrhea leading to discontinuation	28 (20)	5 (8)	5 (4)	8 (8)	2 (3)	237 (17)
Hospitalization (due to diarrhea)	2 (1)	0	0	0	0	20 (1)
Diarrhea leading to dose reduction	10 (7)	3 (5)	10 (7)	12 (12)	2 (3)	372 (26)

1. Barcenas et al. *Annals of Oncology*, 2020
2. Ruiz-Borrego et al. SABCS 2020 3. Chan et al. *Lancet Oncology* 2016

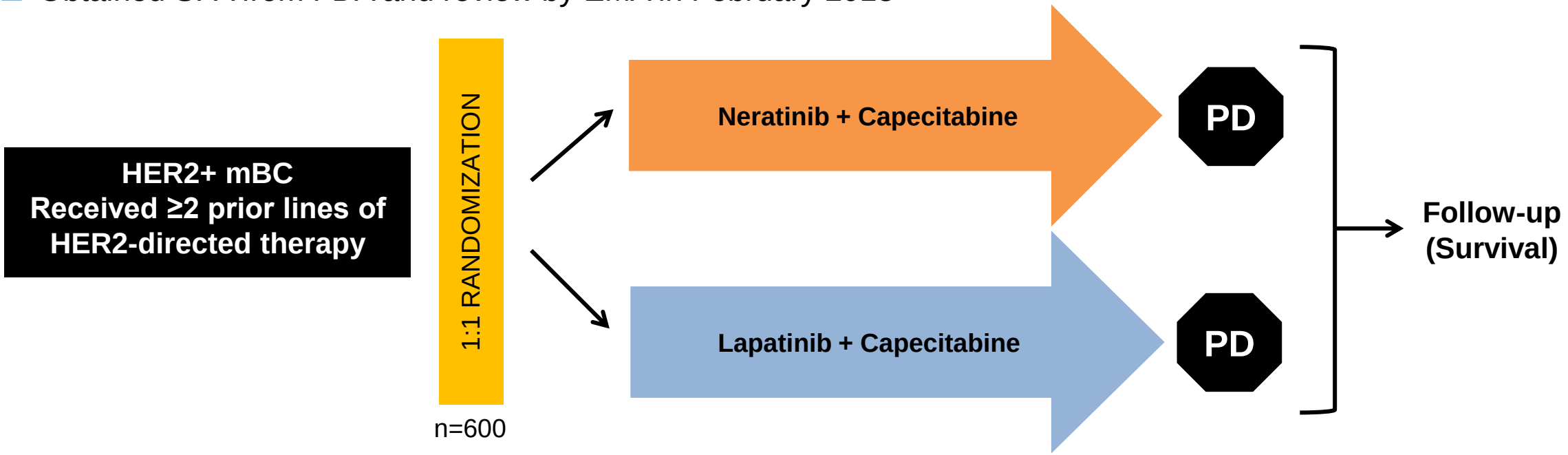
NERLYNX® Extended Adjuvant HER2+ Breast Cancer Market Size

- Approximately 28,300 patients (US) with early stage HER2+ breast cancer treated with adjuvant treatment[1]
  - 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 treatment[1]
  - Approximately 65–70% of patients have HR positive disease

[1]Roche epidemiology slides 09/18

Phase III Trial – Third-Line HER2+ MBC (NALA)
Study Design

- 3rd- or later-line therapy for patients with HER2+ mBC
- Patients with asymptomatic CNS metastatic disease are eligible
- Obtained SPA from FDA and review by EMA in February 2013



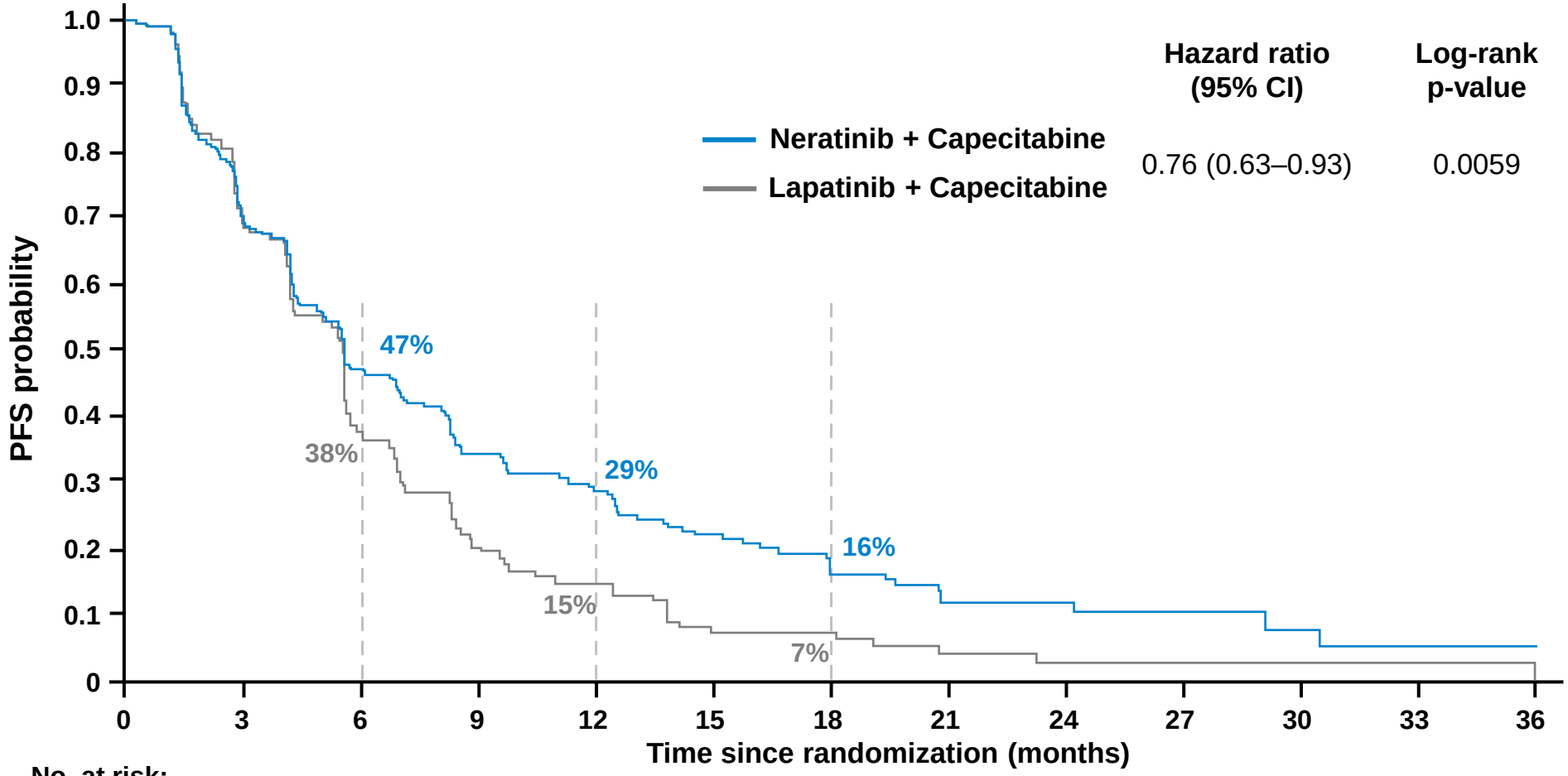
STUDY OBJECTIVES

Co-Primary: PFS (central) and OS

Secondary: PFS (local), ORR, DoR, CBR, time to intervention for CNS metastases, safety, health outcomes

Phase III Trial – Third-Line HER2+ MBC (NALA): Study Results

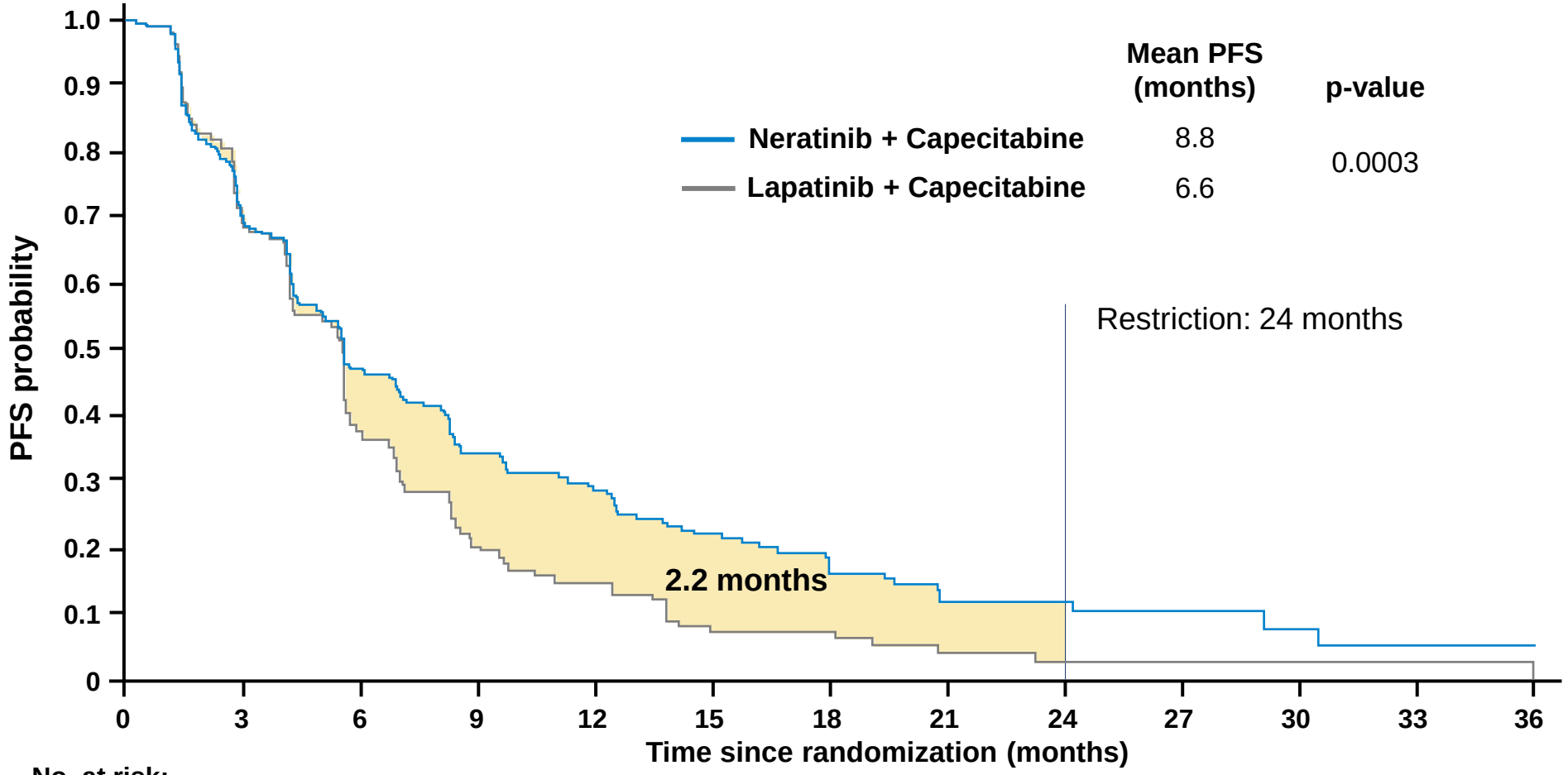
Centrally Confirmed PFS (co-primary endpoint)



Saura et al. ASCO 2019 Oral Session: Breast Cancer – Metastatic. Abstract 10002. Presented Tuesday, June 4, 2019

Phase III Trial – Third-Line HER2+ MBC (NALA): Study Results

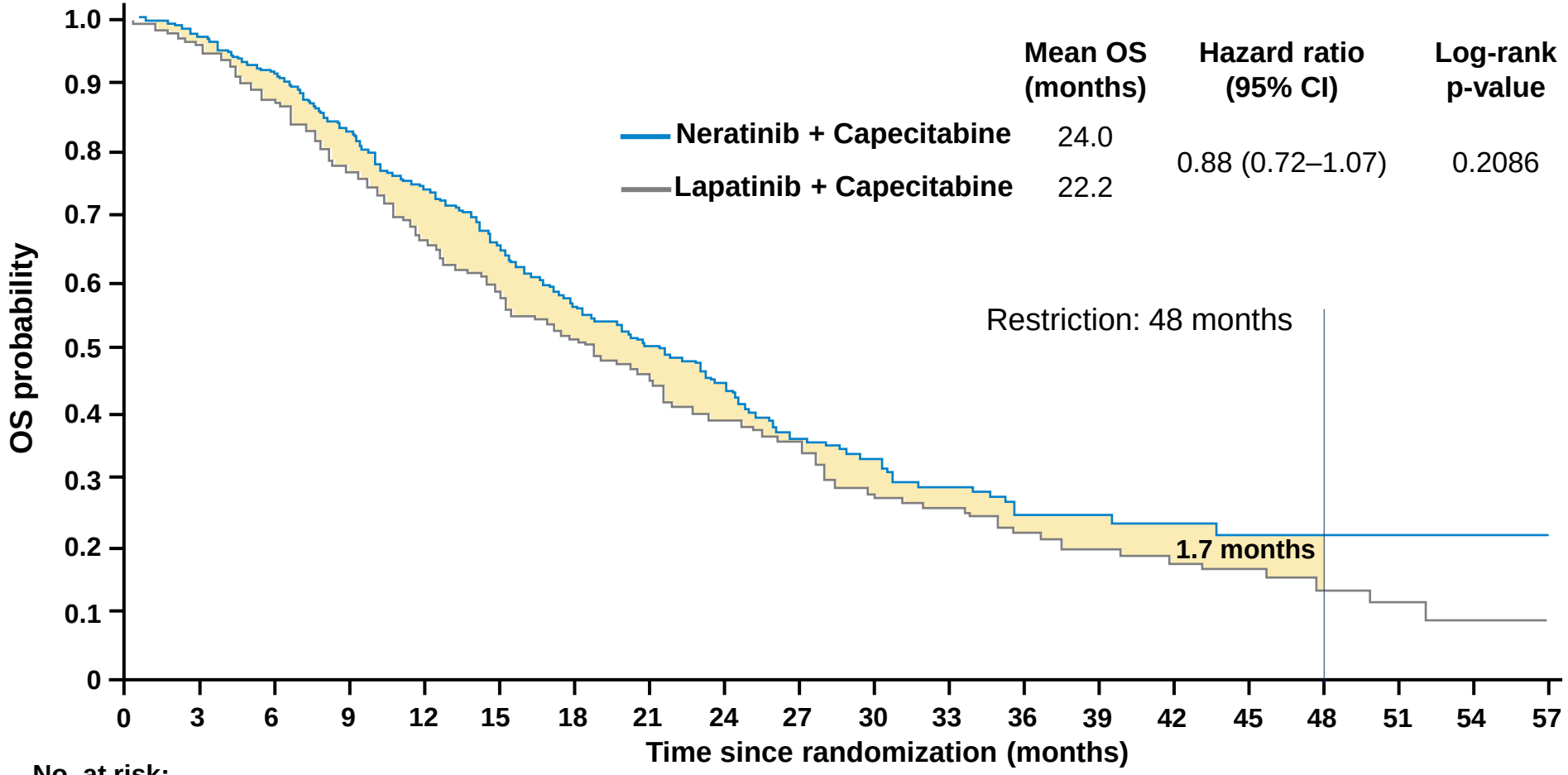
Prespecified restricted means analysis – PFS



Saura et al. ASCO 2019 Oral Session: Breast Cancer – Metastatic. Abstract 10002. Presented Tuesday, June 4, 2019

Phase III Trial – Third-Line HER2+ MBC (NALA): Study Results

OS (co-primary endpoint)



No. at risk:

N+C	307	294	275	244	220	182	142	112	82	64	47	34	28	18	15	13	6	4	2	1
L+C	314	303	273	240	208	170	132	107	84	67	47	36	27	22	17	12	8	4	3	1

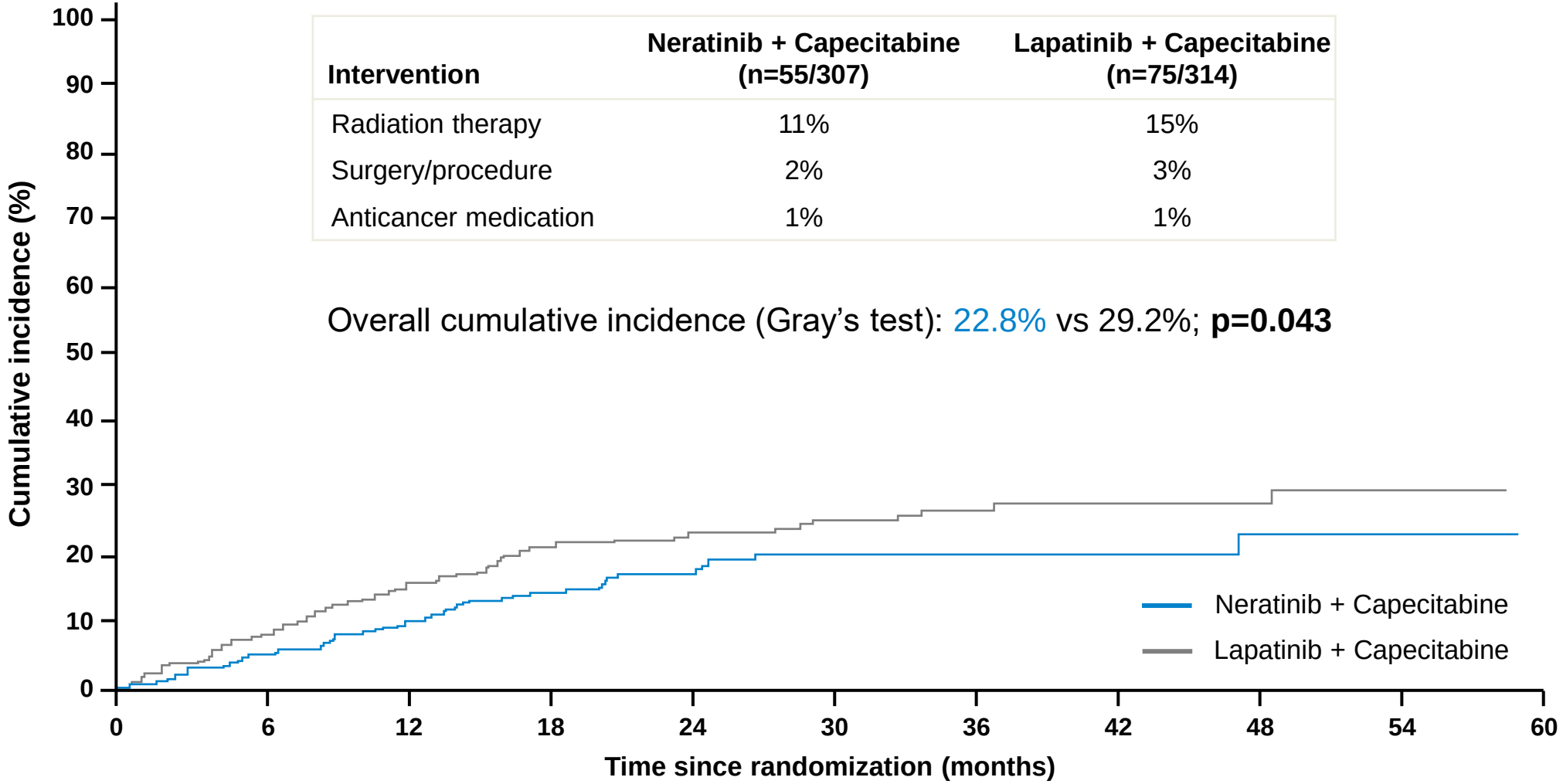
Saura et al. ASCO 2019 Oral Session: Breast Cancer – Metastatic. Abstract 10002. Presented Tuesday, June 4, 2019

Phase III Trial – Third-Line HER2+ MBC (NALA): Study Results

Time to intervention for CNS metastases

Intervention	Neratinib + Capecitabine (n=55/307)	Lapatinib + Capecitabine (n=75/314)
Radiation therapy	11%	15%
Surgery/procedure	2%	3%
Anticancer medication	1%	1%

Overall cumulative incidence (Gray's test): 22.8% vs 29.2%; **p=0.043**



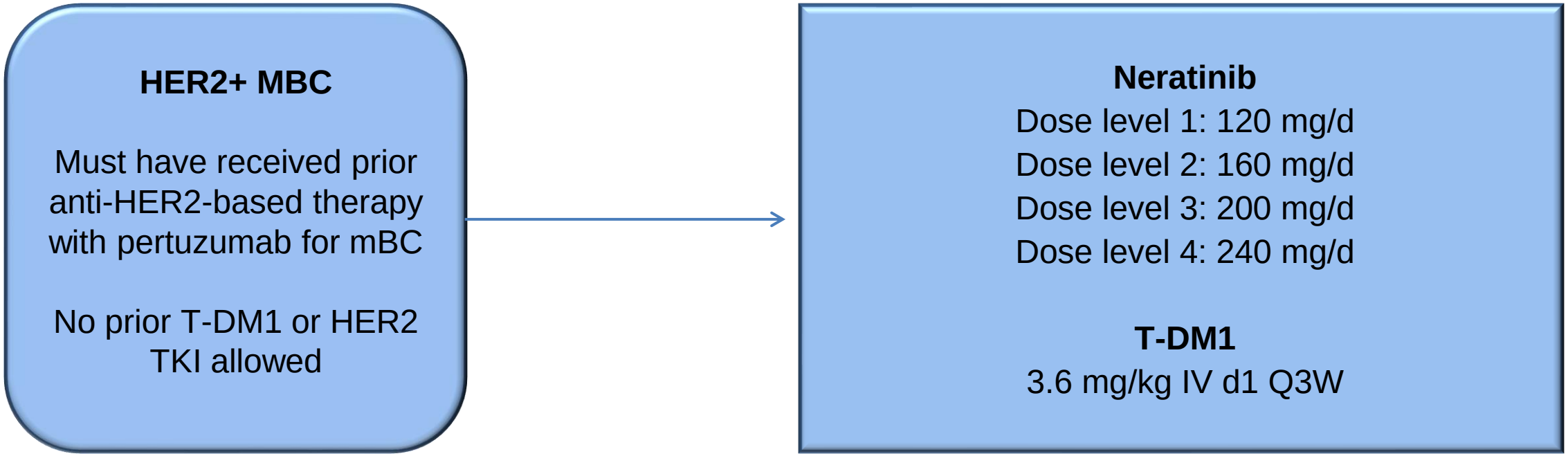
Saura et al. ASCO 2019 Oral Session: Breast Cancer – Metastatic. Abstract 10002. Presented Tuesday, June 4, 2019

Third-Line HER2+ MBC Market Size

- Approximately 6,400 patients (US) with third-line HER2+ metastatic breast cancer and 4,700 patients (US) with fourth-line HER2+ metastatic breast cancer[1]

[1]Roche epidemiology slides 09/18

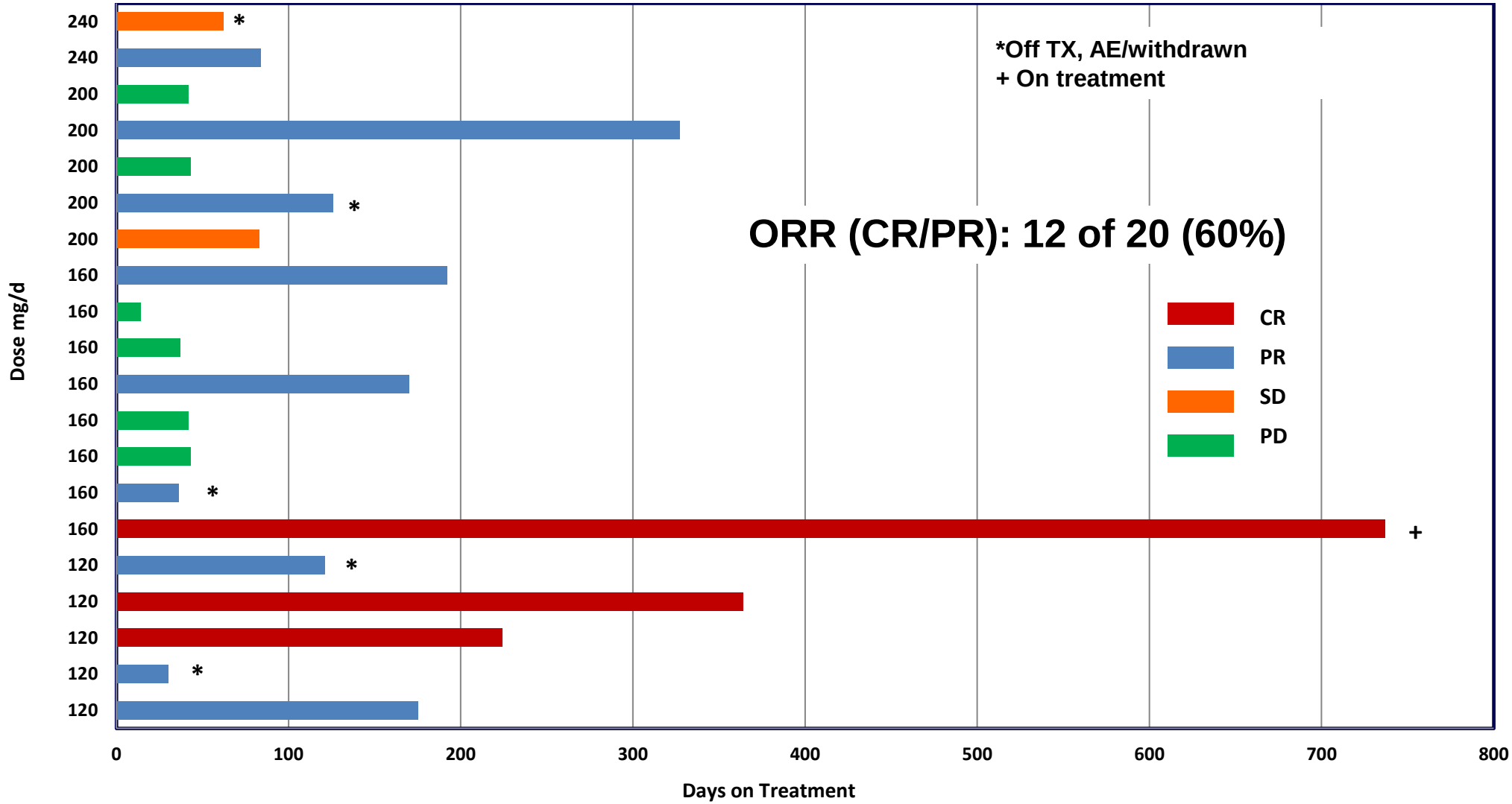
FB-10 – Phase I/II Trial of Kadcyla (T-DM1) + Neratinib



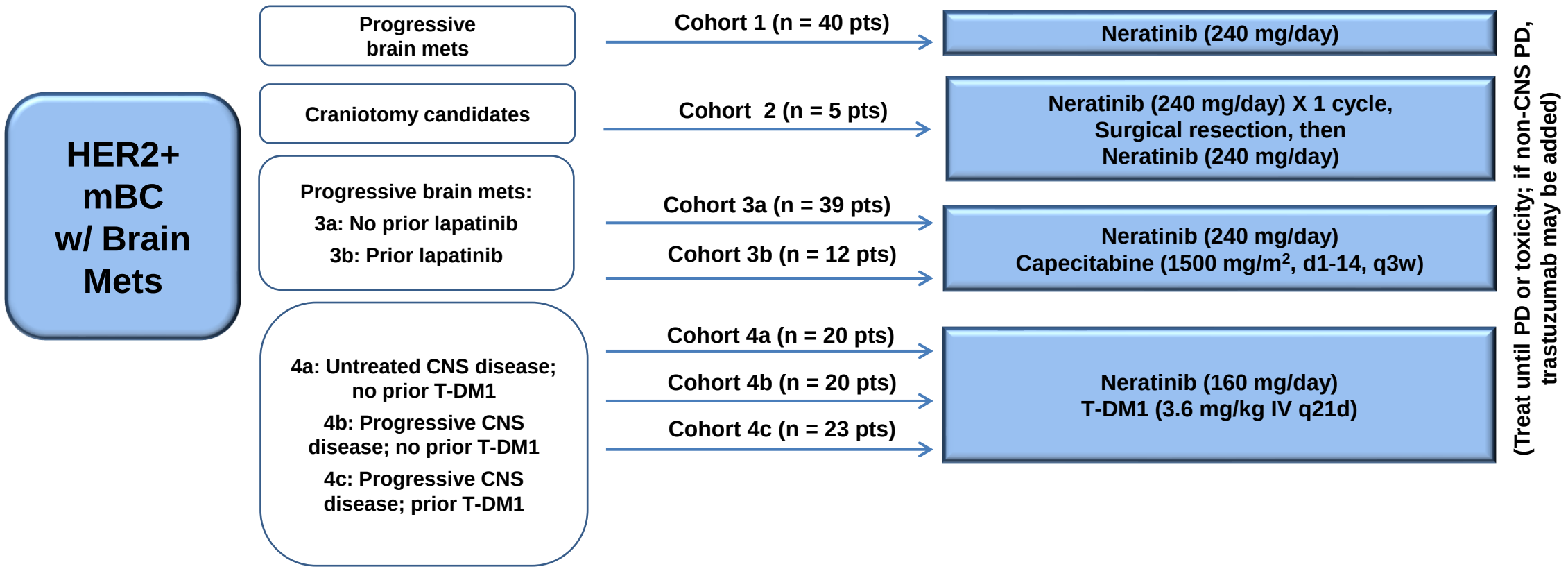
Primary endpoint: Phase I: Recommended dose of neratinib when given with T-DM1; Phase 2: Objective response rate (CR/PR)

Secondary endpoint: Clinical benefit rate (CR/PR/SD), PFS, PK, tumor biopsy for PDX model (optional)

FB-10 – Phase I/II Trial of Kadcyla (T-DM1) + Neratinib



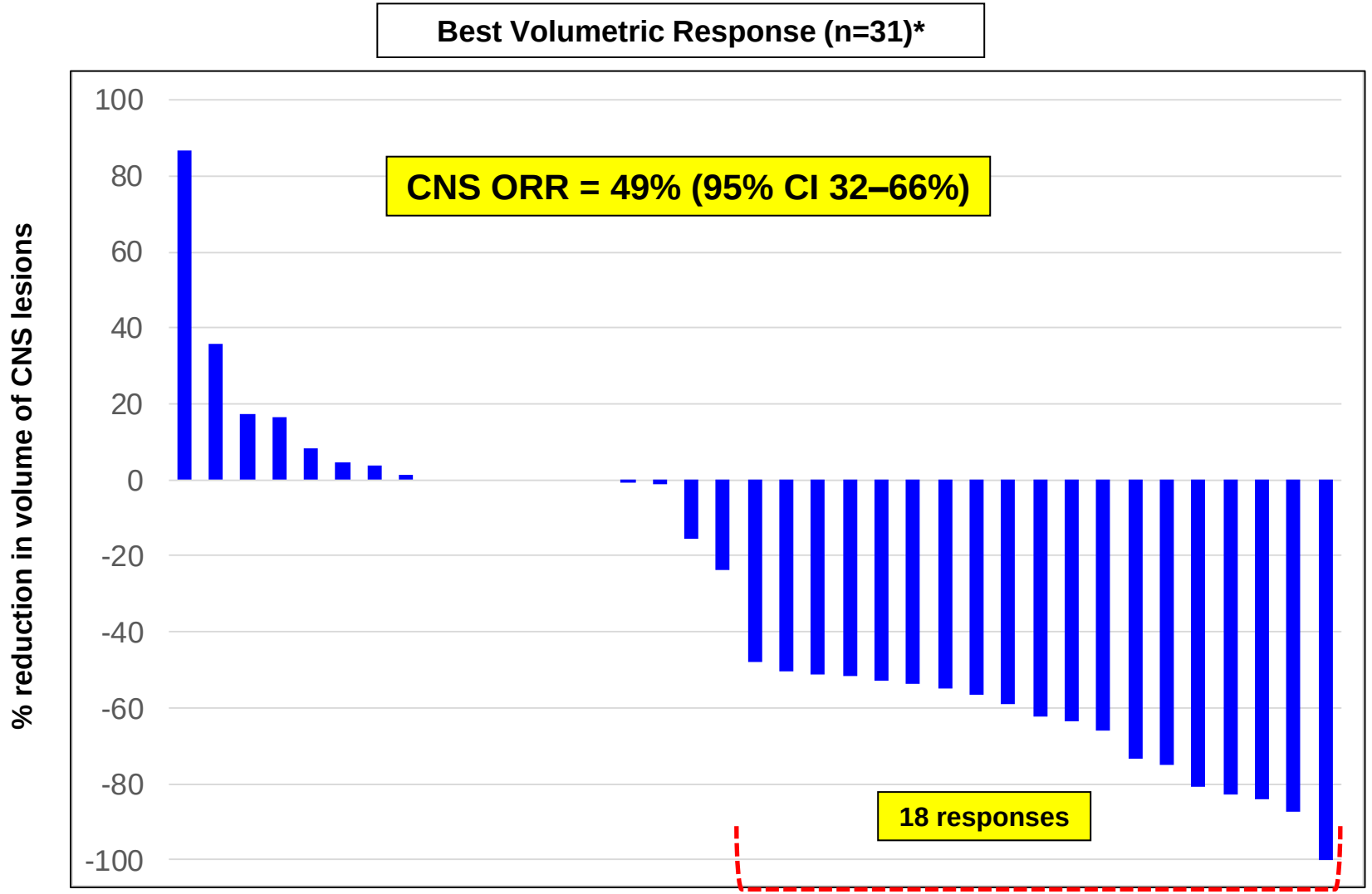
TBCRC 022: Phase II Trial of HKI-272 (Neratinib) + Capecitabine for Patients with HER2+ Breast Cancer and Brain Metastases



Primary endpoint: ORR in CNS: Cohort 1 ≥5 pts (12.5%); Cohort 3a ≥9 pts (25.7%); Cohort 3b ≥2 pts (8%); Cohort 2 PFS

Secondary endpoints: ORR in non-CNS, PFS, OS

TBCRC-022 Cohort 3a
CNS Response



Neratinib Recently Included as a Treatment Option for Recurrent Breast Cancer CNS Metastases By NCCN® Guidelines[1]

Guidelines updated March 2020

Category 2A: Neratinib + Capecitabine

TBCRC 022[2]

A Phase II Trial of Neratinib and Capecitabine for Patients with HER2+ Breast Cancer Brain Metastases (NCT01494662)

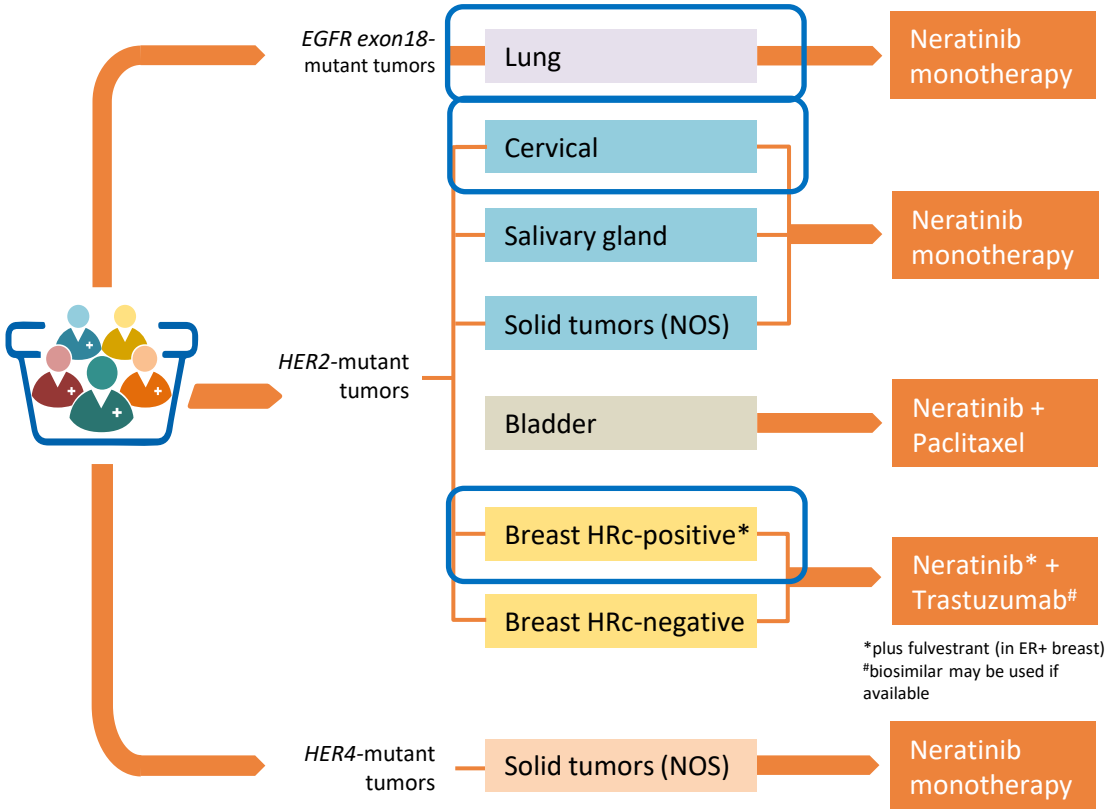
Category 2B: Neratinib + Paclitaxel

NEfERT-T[3,4]

Randomized, Multi-Center, International Study of HER2-Directed Therapy in 1st-line mBC (NCT00915018)

1. NCCN Guidelines v 1.2018. Central Nervous System Cancers.
2. Freedman RA, et al. Presented at ASCO Annual Meeting, 2017. Abstract 1005
3. Awada A, et al. *Poster Presentation at ASCO Annual Meeting, 2015. #610.*
4. Awada A, et al. *JAMA Oncol.* 2016;2:1557-1564.

Current SUMMIT 'Basket' Trial: Study Design



EGFR, HER2 or _HER4_ mutations (documented by local testing)

Primary endpoint
- Objective response rate at first post-baseline tumor assessment (ORR_{first})

Secondary endpoints
- ORR (confirmed)
- Clinical benefit rate (CBR)
- Progression-free survival (PFS)
- Safety
- Biomarkers

Simon 2-stage design
- If ≥1 response in first evaluable 7 patients, expand cohort to Stage 2 (N=18)
- If ≥4 responses in Stage 2, expand or breakout

Tumor assessments
- RECIST v1.1 (primary criteria)
- PET response criteria (RECIST non-evaluable)

Statistical methods
- ORR_{first}, ORR, CBR: associated 95% CI
- Median PFS: Kaplan-Meier estimate with 95% CI

Key Inclusion Criteria
- Histologically confirmed cancers for which no curative therapy exists
- Documented EGFR exon 18, HER2 or HER4 mutation
- ECOG status of 0 to 2
- RECIST 1.1 evaluable disease (measurable or non-measurable disease): if RECIST non-measurable, evaluable by other accepted criteria

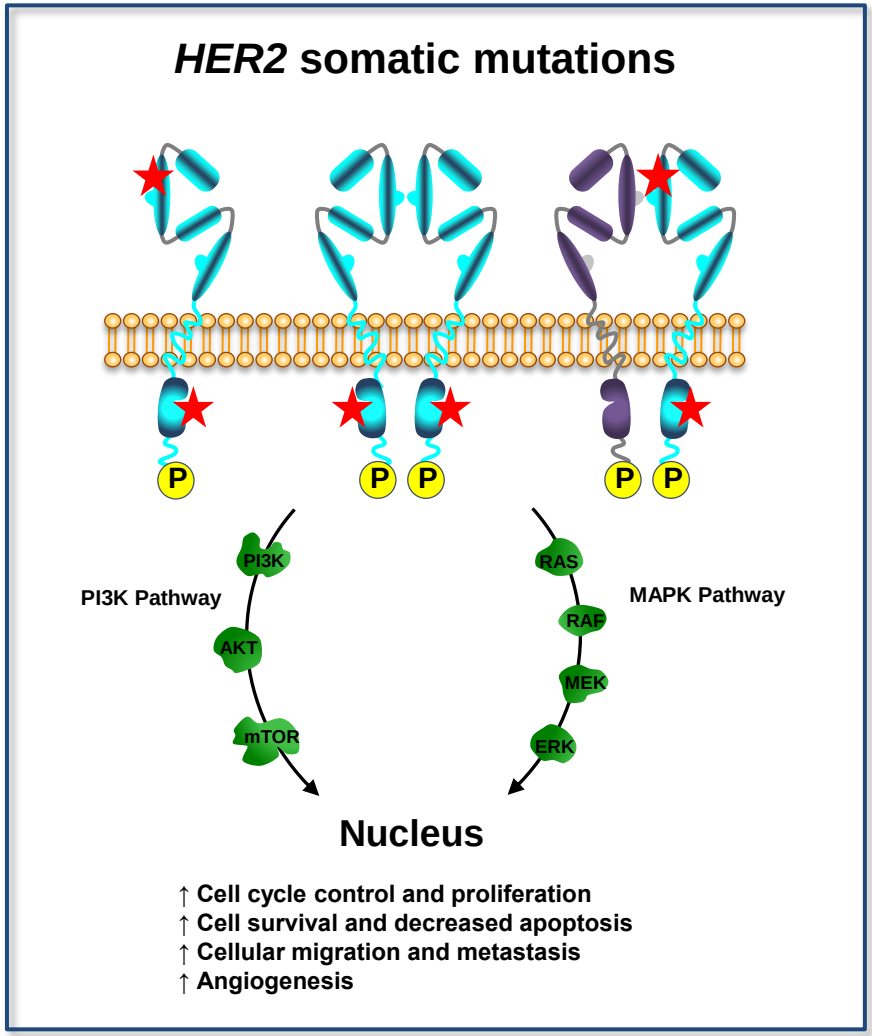
Key Exclusion Criteria
- Prior treatment with any pan-HER TKI (eg, lapatinib, afatinib, dacomitinib, neratinib)
- Patients who are receiving any other anticancer agents
- Symptomatic or unstable brain metastases
- Women who are pregnant or breast-feeding

SUMMIT

Hormone Receptor-Positive Breast Cancer Cohort

Somatic Mutations in *HER2 (ERBB2)* in HR+ Breast Cancer

- **Incidence:**
  - 7–9%, pre-treated ER+ MBC[1]
- **Tumor characteristics:**
  - Usually mutually exclusive to *HER2* amplifications
- **Preclinical evidence of oncogenic activity:**
  - Constitutive activation of intracellular kinase and downstream signaling pathways[2]
  - Increased cell proliferation and tumor growth[2]
  - Cross-talk occurs between ER and *HER2* mutation (modified SUMMIT trial to add fulvestrant to ER-positive patients)
  - *HER2* amplification seen as potential mechanism of resistance to neratinib + fulvestrant (modified SUMMIT trial to add trastuzumab to neratinib + fulvestrant in ER-positive patients)



1. Wagle et al. ASCO 2016; 2. Bose et al. Cancer Discov 2013

HR+ *HER2*-Mutated Breast

Publications from SUMMIT trial *HER2*-mutant breast cohorts

HER2 mutant breast tumors

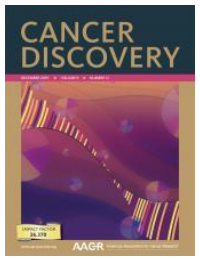
All (HR+/HR-) breast cancer → Neratinib monotherapy

All (HR+/HR-) breast cancer → Neratinib monotherapy

HR-positive breast cancer → Neratinib + fulvestrant

HR-positive breast cancer → Neratinib + trastuzumab fulvestrant

Primary (all monotherapy cohorts) manuscript:
David Hyman *et al*
Nature (2018) **554**:189–194



Breast cohort manuscript:
Lillian Smyth *et al*
Cancer Discovery (2019) in press
(doi: 10.1158/2159-8290.CD-19-0966)

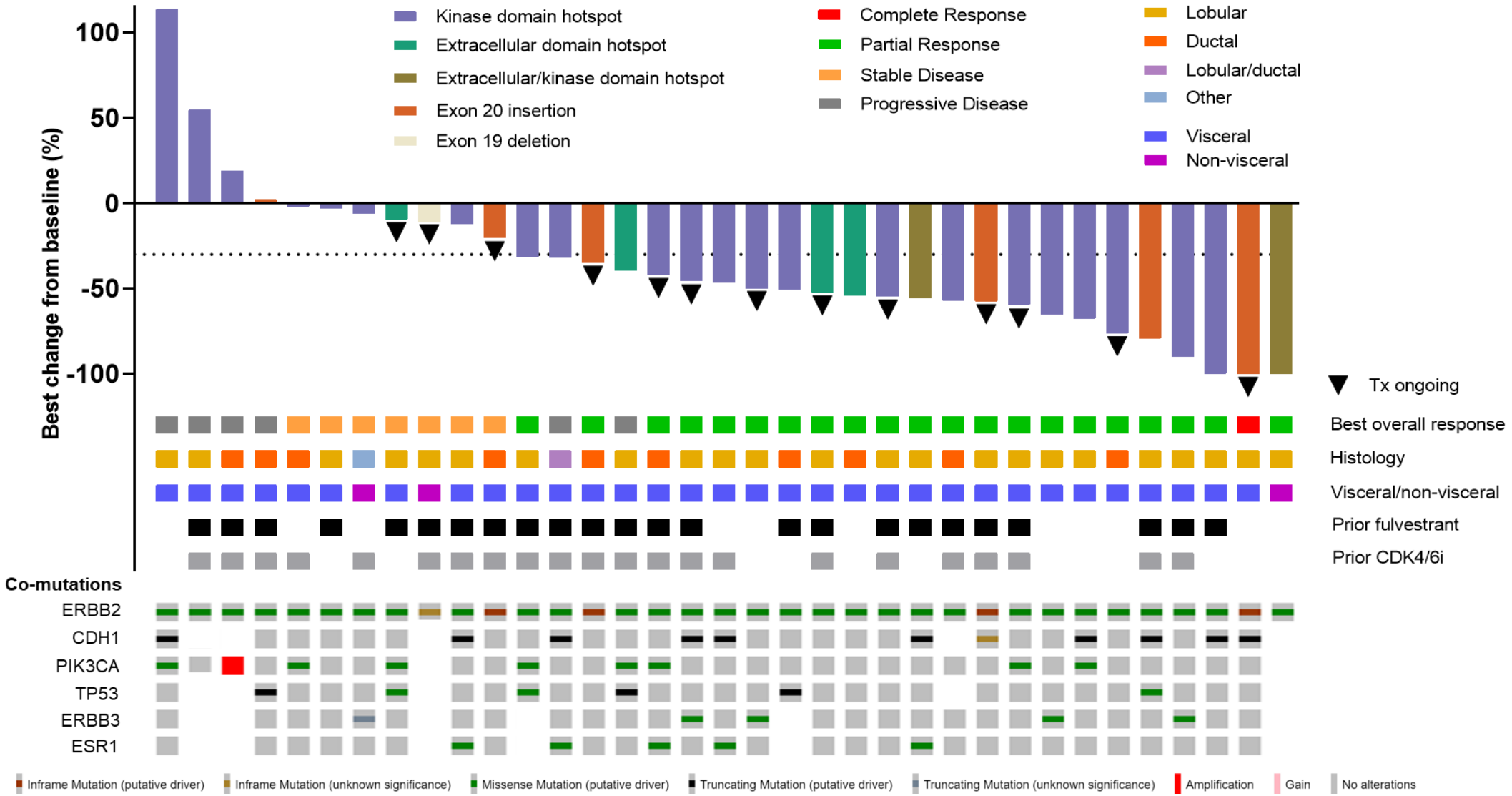
HR+ breast triplet combo cohort:
Komal Jhaveri *et al.*
Spotlight Poster Session, 12/9/20 4:00-5:15 PM
Abstract PD1-05

Other case reports or secondary publications:

1. A. Hanker *et al*. *Cancer Discovery* (2017) 7:575-585 (L869R sensitizing mutation and T798I HER2 gatekeeper mutation – case study)
2. G. Ulaner *et al*. (2019) *Clin Cancer Res*. in press (doi: 10.1158/1078-0432.CCR-19-1658) (Exploring use of FDG-PET imaging for response assessments)
3. A. Medford *et al*. *NPJ Precision Oncology (2019) Jul 16;3:18* (Blood based monitoring identifies actionable HER2 mutations – case study)

HR+ *HER2*-Mutated Breast

Change in tumor size and characteristics with neratinib + trastuzumab + fulvestrant (n=35)[a]

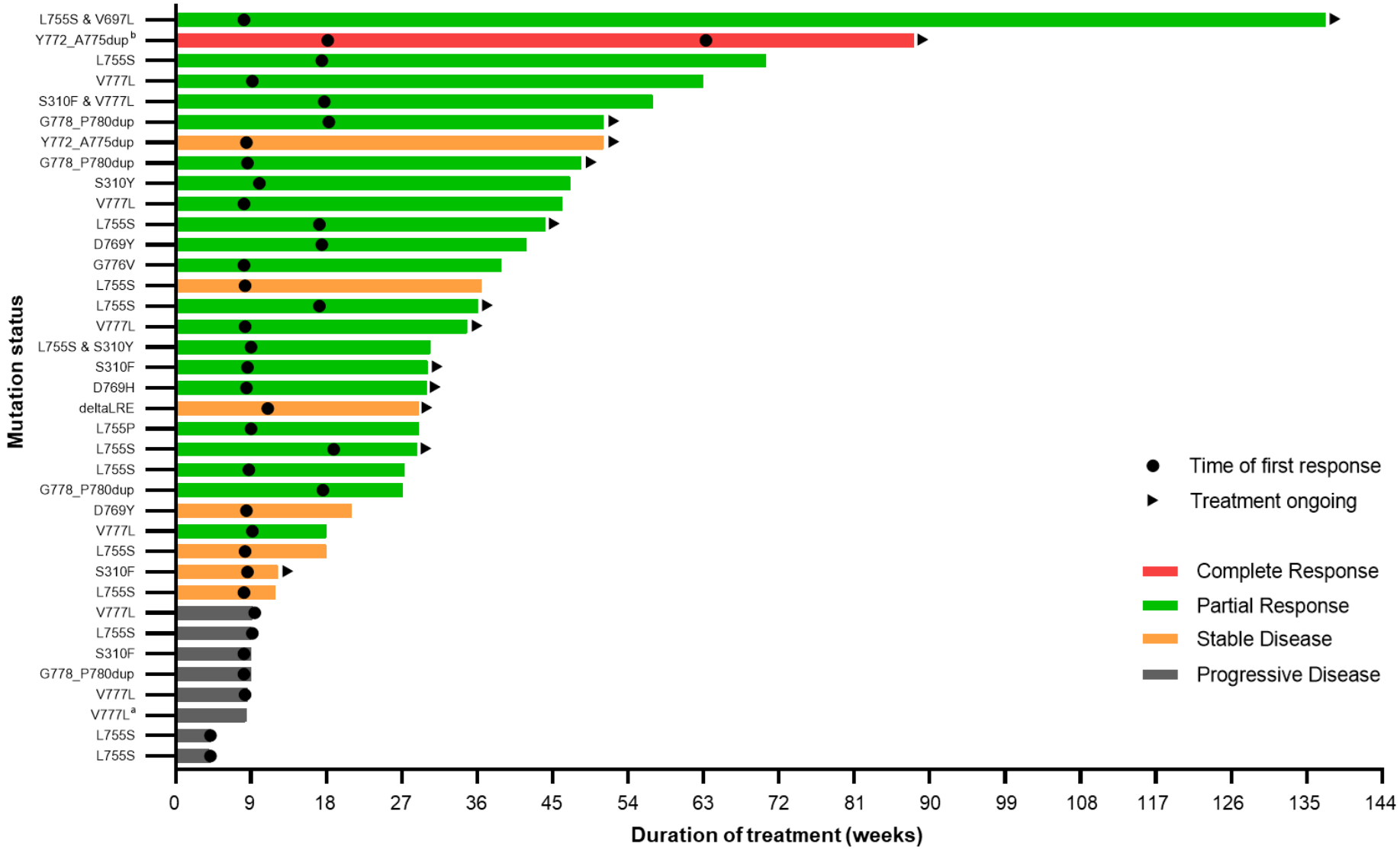


SABCS 2020

[a]Two of the 37 RECIST evaluable patients are not included in this figure because they did not have a tumor assessment before they died

HR+ *HER2*-Mutated Breast

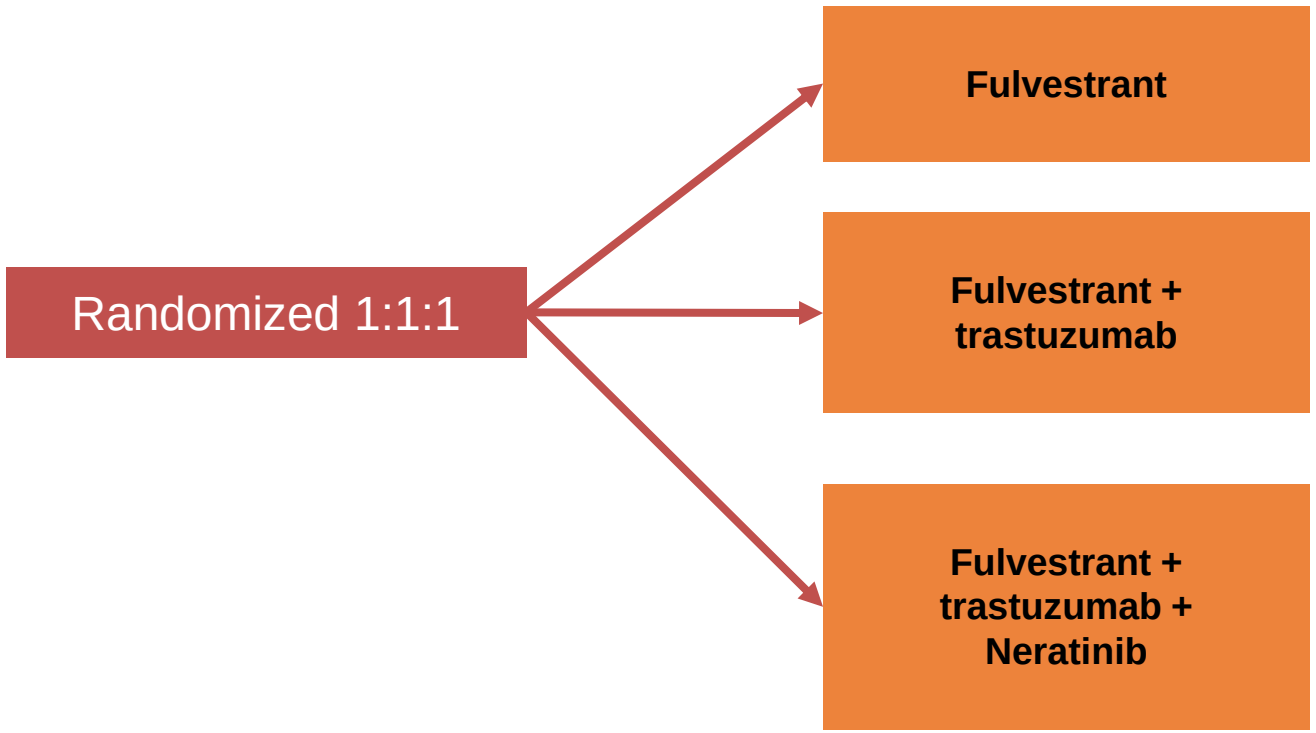
Duration of treatment and best response with neratinib + trastuzumab + fulvestrant (n=37)



SABCS 2020

[a]This patient died in hospice due to clinical progression and did not have a tumor assessment before she died
[b]This patient had a first partial response at week 18 and a first complete response at week 63

Amendment to Breast Cancer Cohort in SUMMIT for HR+/HER2–HER2mut MBC Cohort to Support Accelerated Approval



***HER2* mutations**
(documented by local testing)

Primary endpoint
- Objective response rate

Secondary endpoints
- DOR

Simon 2-stage design

Proposed assessment criteria consistent with original design
- If ≥1 response in first evaluable 7 patients, expand cohort to Stage 2 (N=18)
- If ≥4 responses in Stage 2, expand or breakout

Tumor assessments
- RECIST v1.1 (primary criteria)

Amendment to Breast Cancer Cohort in SUMMIT for HR+/HER2– HER2mut MBC Cohort to Support Accelerated Approval

- **No responses seen in first 7 patients treated in fulvestrant monotherapy cohort**
- **No responses seen in first 7 patients treated in trastuzumab plus fulvestrant cohort**
- **One or more responses seen in first 7 patients treated in neratinib plus trastuzumab plus fulvestrant cohort**
  - Cohort has been expanded to enroll additional patients
- **Puma to schedule pre-NDA meeting with FDA to discuss potential for accelerated approval (anticipated Q4 2021)**

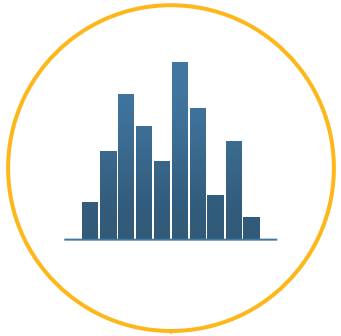
1. Wagle et al. ASCO 2016; 2. Bose et al. Cancer Discov 2013

SUMMIT

Cervical Cancer Cohort

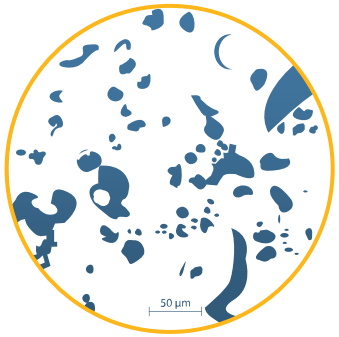
Puma Biotechnology

Characteristics of *HER2*-Mutant Cervical Cancer



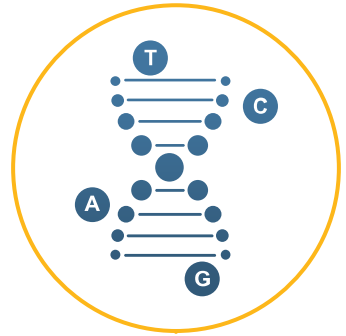
Incidence

- 5% metastatic cervical cancers
- May be negatively prognostic for survival



Histology

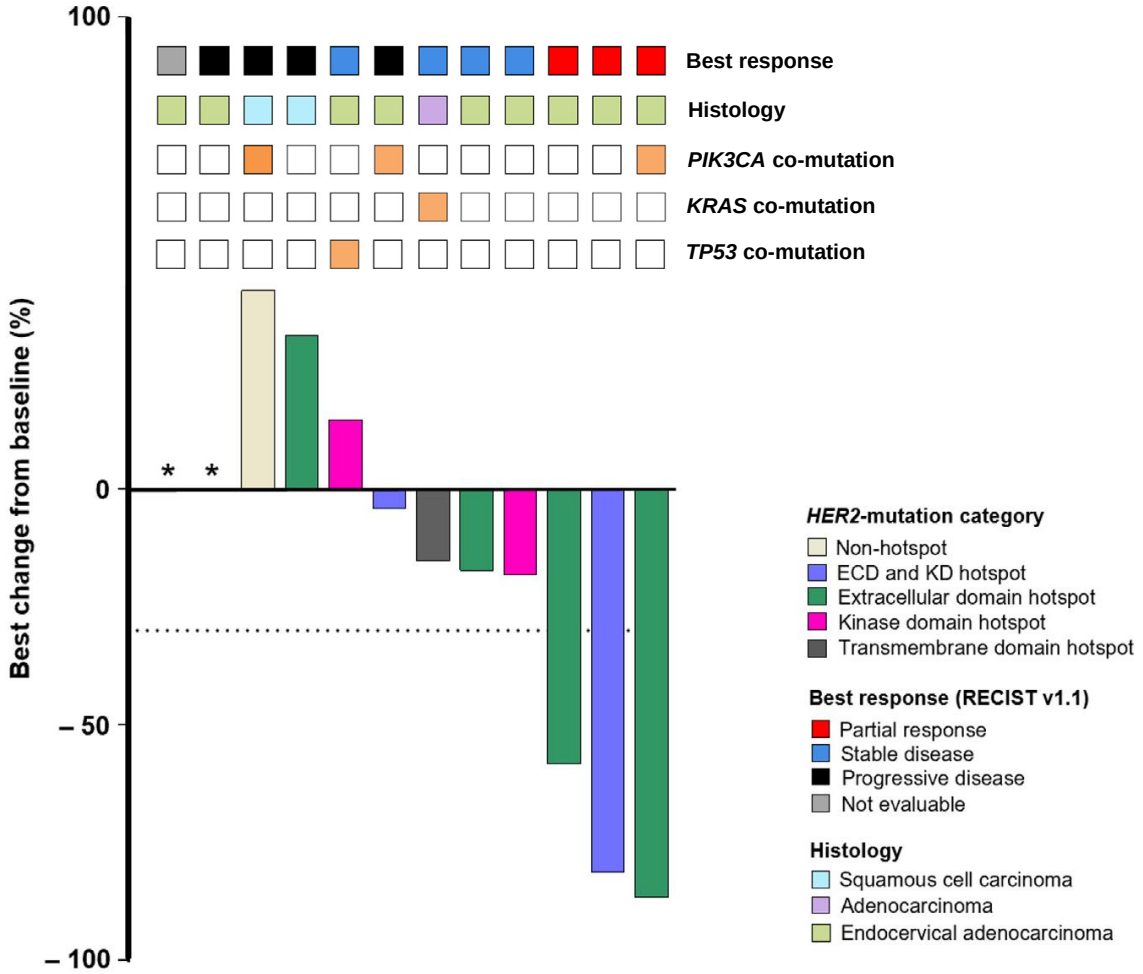
- Enriched in adenocarcinomas
- High occurrence in HPV+ tumors



Genomics

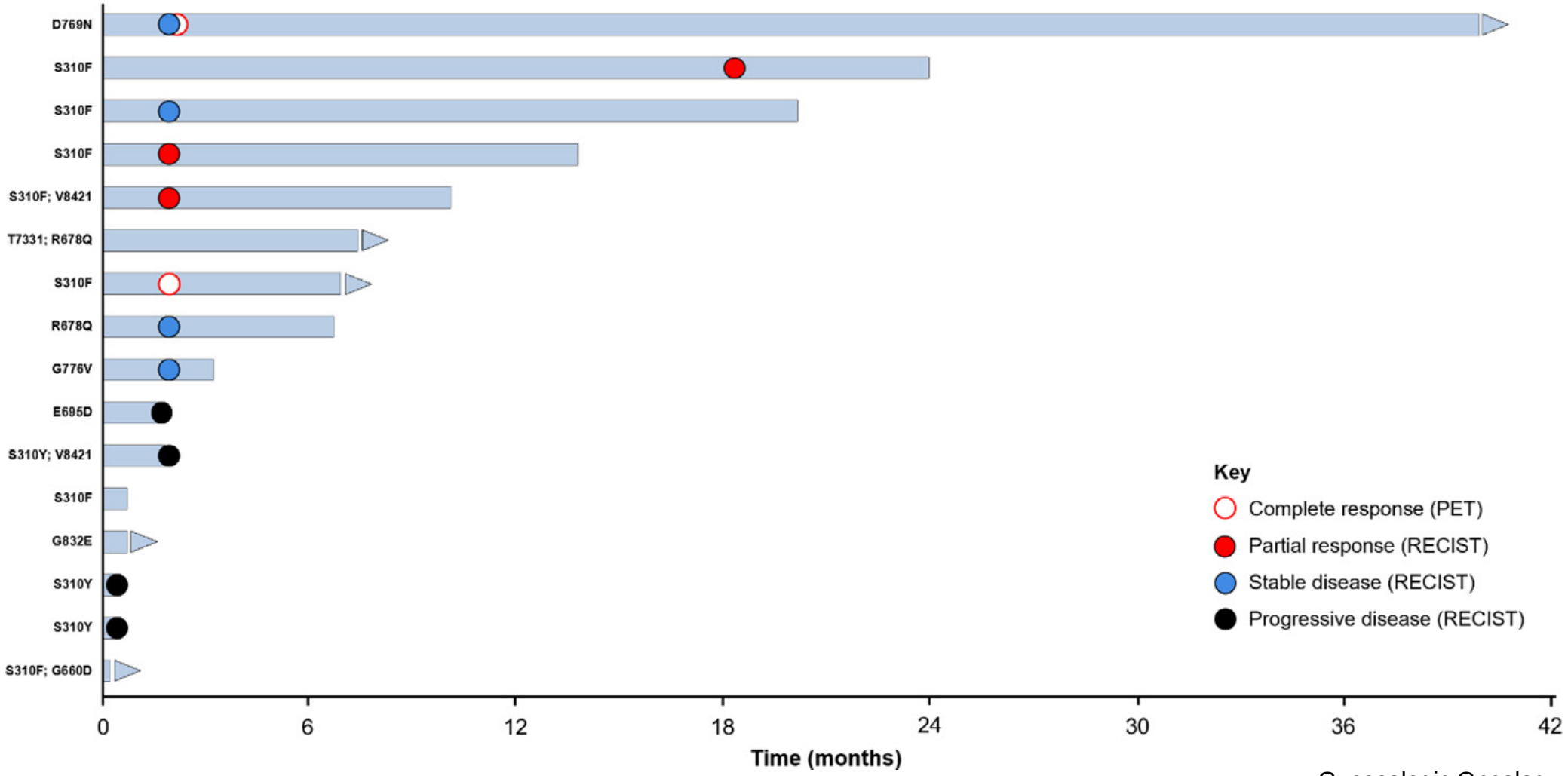
- Most common *HER2*^{mut} is S310 extracellular domain hotspot mutation
- Usually exclusive to *HER2* amplifications
- Most common co-mutations include *TP53*, *PIK3CA*

Neratinib Monotherapy Results Published in Gynecologic Oncology



Gynecologic Oncology, 2020

Neratinib Monotherapy Results Published in Gynecologic Oncology



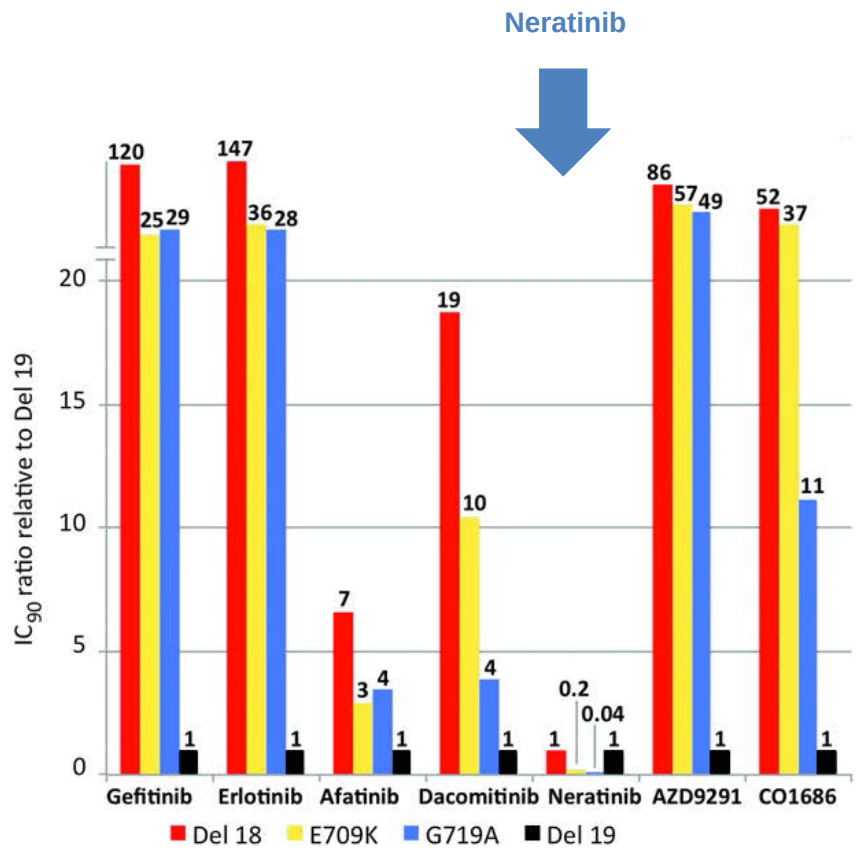
Gynecologic Oncology, 2020

SUMMIT (PUMA-NER-5201) Basket Trial

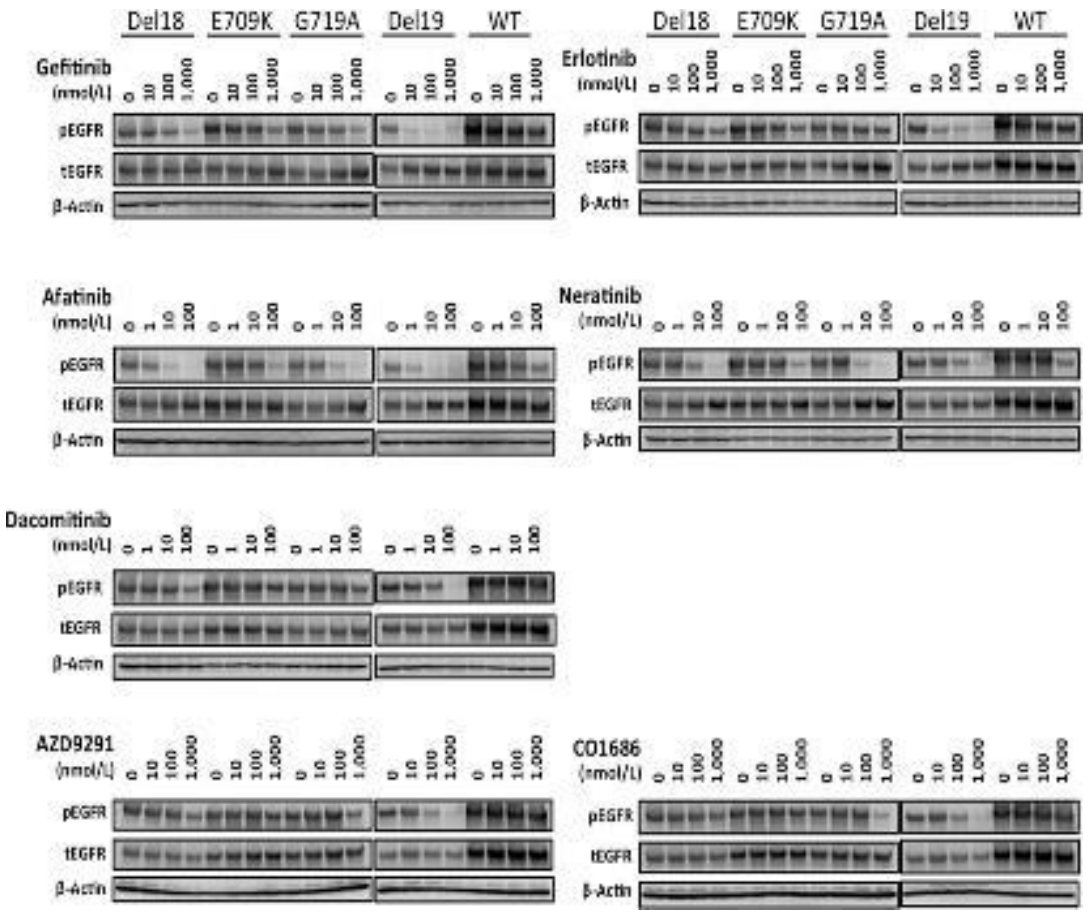
EGFR exon 18 lung cancer cohort update

EGFR Exon 18 Mutations are Highly Sensitive to Neratinib (Irreversible Pan-HER TKIs) *In Vitro* Studies

Comparative TKI affects in *EGFR* exon 18+ cells



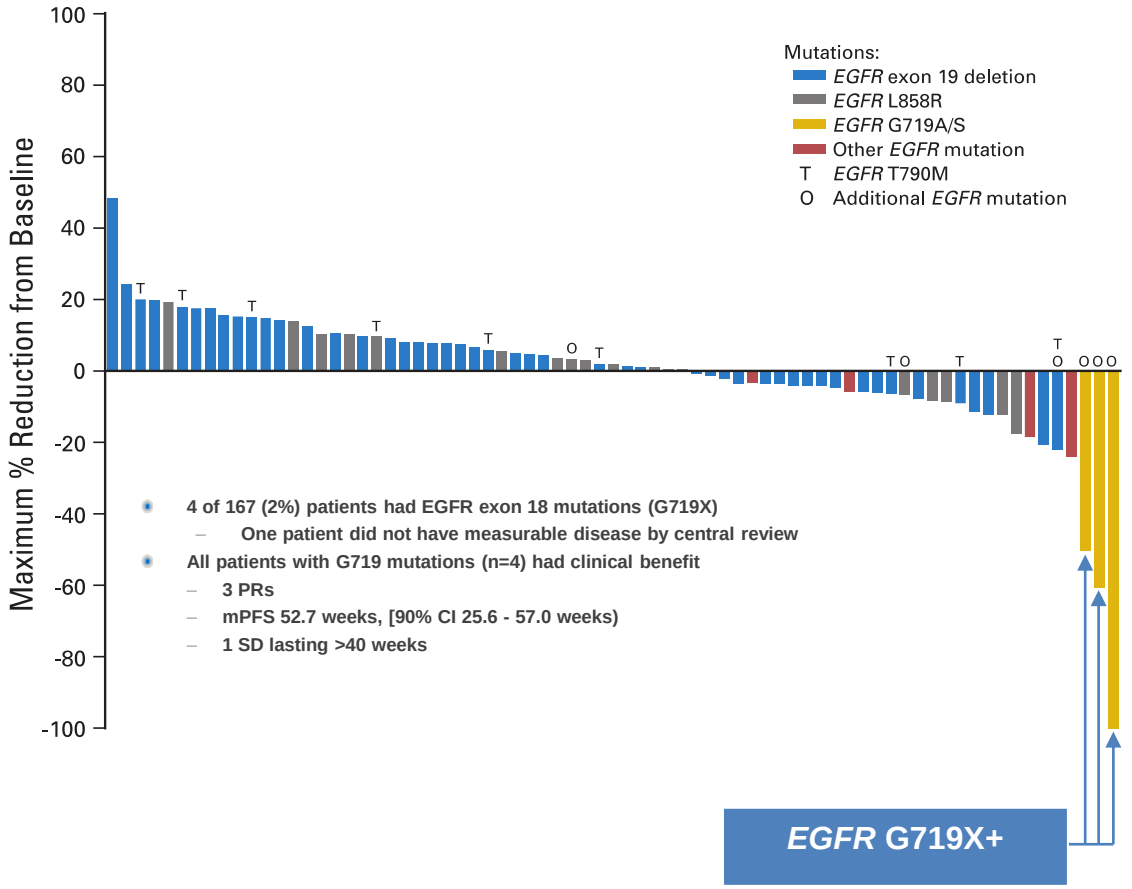
Western blot analyses of transfected HEK293 cells



Source: Kobayashi et al. Clin Cancer Res 2015;21:5305-5313.

EGFR Exon 18 Mutations are Highly Sensitive to Neratinib in NSCLC Patients from POC Trial

Phase 2 trial of neratinib in lung cancer



Source: **L. Sequist et al (2010) *J. Clin. Oncol*. 28:3076-3083..**

EGFR Exon 18-Mutant Lung Cancer Cohort Receiving Neratinib Monotherapy: Baseline Demographics and Patient Characteristics

Patient characteristics	Safety/Efficacy evaluable patients (n=11)
Median (range), years	67 (56-83)
<65 years, n (%)	4 (36)
≥65 years, n (%)	7 (64)
Gender, n (%)	
Female	5 (45)
Male	6 (55)
ECOG performance status, n (%)	
0	5 (45)
1	6 (55)
Race, n (%)	
Black or African American	1 (9)
White	10 (91)
Median number of prior therapies in metastatic/locally advanced setting (range)	2 (1 – 3)
Prior checkpoint inhibitor, n (%)	3 (27)
Prior chemotherapy, n (%)	6 (55)
Prior tyrosine kinase inhibitor, n (%)	**10 (91)**
gefitinib/erlotinib (reversible 1st gen EGFR TKI)	7 (58)
osimertinib (irreversible EGFR T790M TKI)	3 (25)
afatinib (irreversible pan-HER TKI)	2 (17)

Data cut-off: 21-Aug-2020

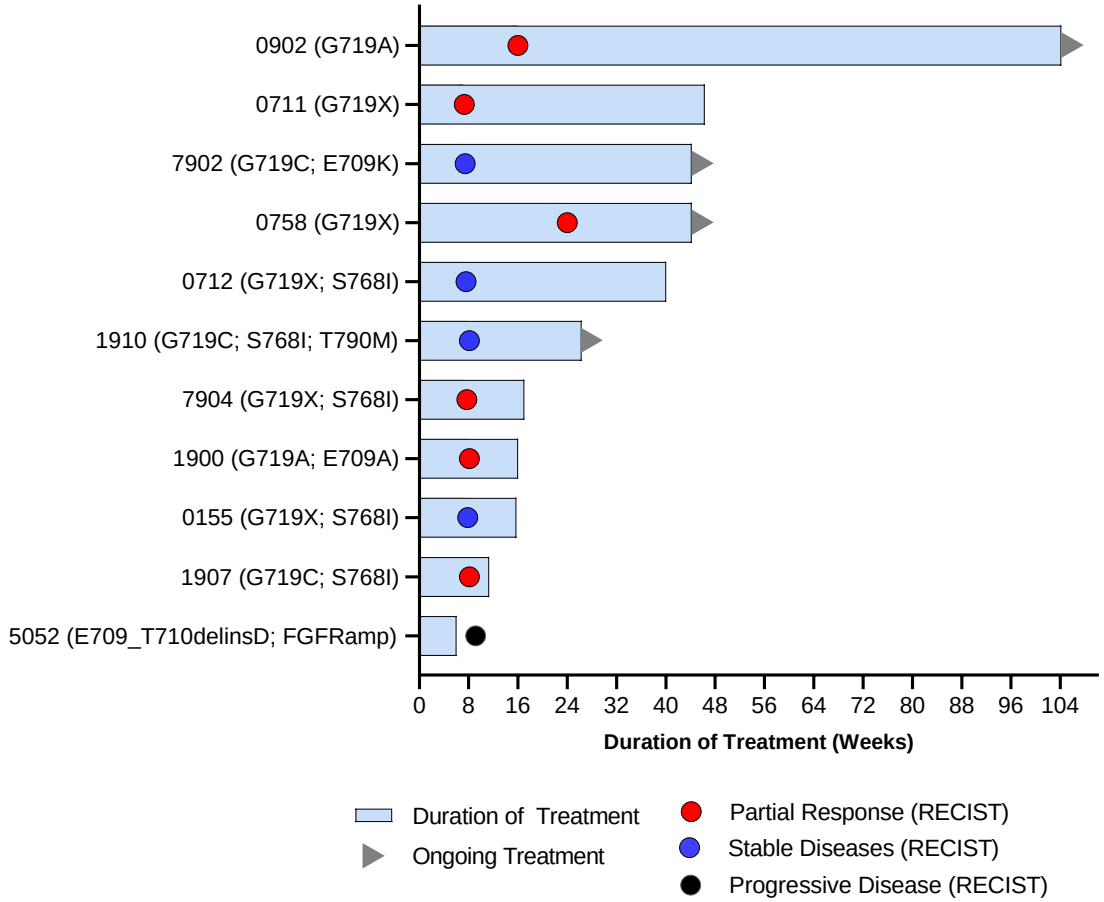
EGFR Exon 18-Mutant Lung Cancer Cohort Receiving Neratinib **Monotherapy:** Efficacy Summary

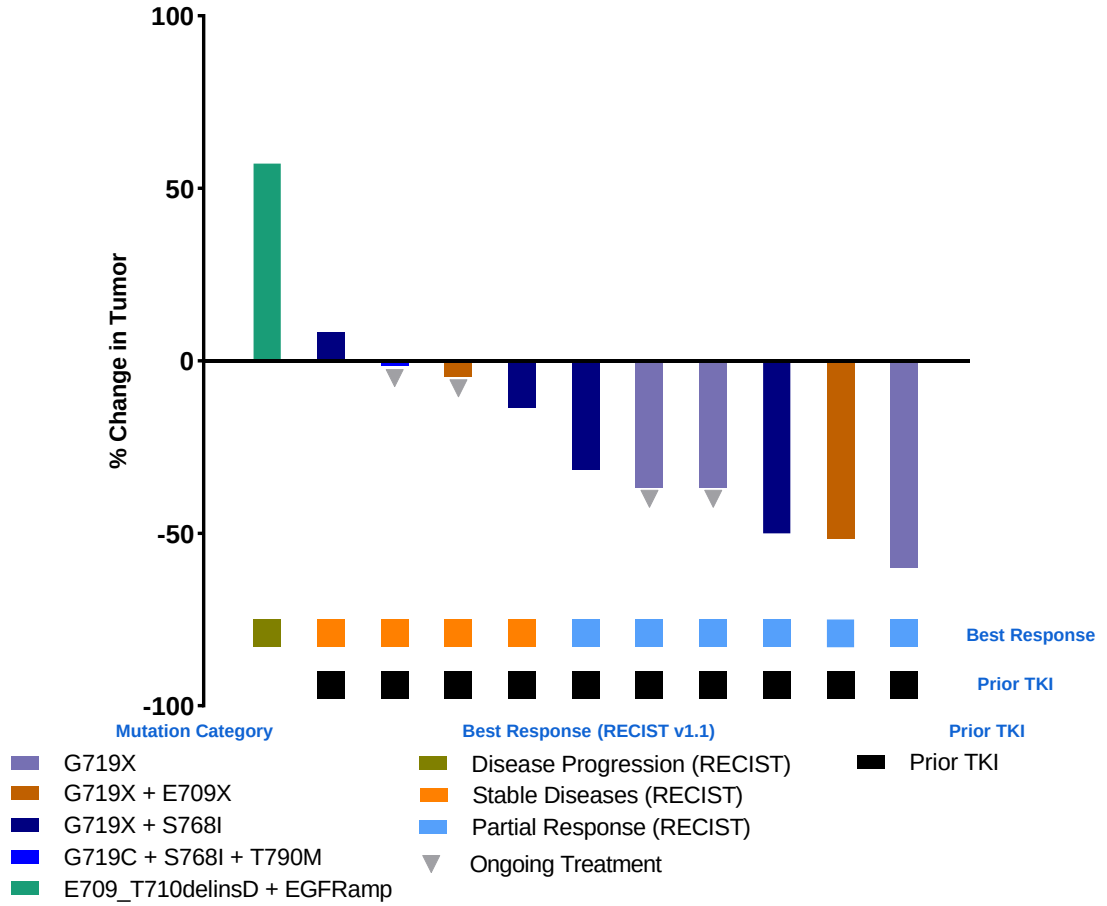
Parameter	Efficacy evaluable patients (n=11)	TKI Pre-Treated (n=10)
Objective response (confirmed),[a] n CR PR Objective response rate, % (95% CI)	**4** 0 4 **36** (11–69)	**4** 0 4 **40** (12–74)
Best overall response, n CR PR Best overall response rate, % (95% CI)	**6** 0 6 **54** (23–83)	**6** 0 6 **60** (26–88)
Median DOR,[b] months (95% CI)	**7.5 (4.0–NE)** **(1.9*, 4.0, 7.5, 9.2*)**	**7.5 (4.0–NE)** **(1.9*, 4.0, 7.5, 9.2*)**
Clinical benefit,[c] n CR or PR SD ≥16 weeks Clinical benefit rate, % (95% CI)	**8** 4 4 **73** (39–94)	**8** 4 4 **80** (44–97)
Median PFS time to event, months (95% CI)	**6.9**[b] (2.1–NA)	**9.1 (3.7–NA)**

[a] Objective response rate (ORR) is defined as either a complete or partial response that is confirmed no less than 4-weeks after the criteria for response are initially met
[b] Kaplan-Meier analysis in safety population. [c] Clinical benefit rate (CBR) is defined as confirmed CR or PR or stable disease (SD) for ≥**16** weeks (within +/– 7-day visit window)
DOR, duration of response; PFS, progression-free survival, * response ongoing

Data cut-off: 21-Aug-2020

EGFR Exon 18-Mutant Lung Cancer Cohort Receiving Neratinib Monotherapy: Treatment Duration, Best Response and Best Change in Tumor





Data cut-off: 21-Aug-2020

EGFR Exon 18-Mutant Lung Cancer Cohort Receiving Neratinib **Monotherapy:** Most Common Treatment-Emergent Adverse Events >10%

TEAE	Safety evaluable patients (n=11)	
	Any grade	Grade ≥ 3
Diarrhea	5 (45.5)	0
Vomiting	4 (36.4)	0
Constipation	3 (27.3)	0
Nausea	3 (27.3)	0
Decreased appetite	3 (27.3)	1 (9.1)
Dizziness	2 (18.2)	0
Hypertension	2 (18.2)	0
Dry mouth	2 (18.2)	0
Fatigue	2 (18.2)	0

Data cut-off: 21-Aug-2020

EGFR Exon 18-Mutant Lung Cancer Cohort Receiving Neratinib Monotherapy: Characteristics of Treatment-Emergent Diarrhea

	Lung EGFR (N=11)
Incidence of diarrhea, n (%)[a]	
Any grade	5 (45.5)
Grade 1	4 (36.4)
Grade 2	1 (9.1)
Grade 3	**0**
Action taken with neratinib, n (%)	
Leading to temporary hold	0
Leading to dose reduction	0
Leading to permanent discontinuation	0
Diarrhea leading to hospitalization, n (%)	0
Time to first diarrhea, median (range) in days	15 (3 – 253)
Time to first grade 2 diarrhea, median (range) in days	8 (8 – 8)
Duration of grade 2 diarrhea per episode, median (range) in days	2 (1 – 2)

Data cut-off: 21-Aug-2020

Historical Response Rates of Afatinib in NSCLC Patients With *EGFR* Exon 18 Mutations (G719X)

TKI-naïve patients

TKI-pre-treated patients

Table 3. Response Rates With Afatinib in Patients With NSCLC Harboring Uncommon Mutations

Mutation Type	CR, n (%)	PR, n (%)	SD, n (%)	PD, n (%)	DCR, n (%)	ORR,n (%)	DoR, Mo (95% CI)
EGFR TKI-naive patients							
Major uncommon mutation (n = 110)	5 (4.5)	61 (55.5)	35 (31.8)	9 (8.2)	101 (91.8)	66 (60.0)	17.1 (11.0-20.8)
G719X (n = 55)	4 (7.3)	31 (56.4)	16 (29.1)	4 (7.3)	51 (92.7)	35 (63.4)	17.1 (10.3-22.0)
L861Q (n = 47)	0 (0.0)	28 (59.6)	14 (29.8)	5 (10.6)	42 (89.4)	28 (59.6)	13.8 (7.4-20.6)
S768I (n = 8)	1 (12.5)	4 (50.0)	3 (37.5)	0 (0.0)	8 (100.0)	5 (62.5)	NR (15.9-NR)
Compound (n = 35)	0 (0.0)	27 (77.1)	5 (14.3)	3 (8.6)	32 (91.4)	27 (77.1)	16.6 (13.8-18.7)
With major uncommon mutation (n = 23)	0 (0.0)	18 (78.3)	4 (17.4)	1 (4.3)	22 (95.7)	18 (78.3)	17.1 (14.7-NR)
Exon 20 insertion (n = 70)	2 (2.9)	15 (21.4)	41 (58.6)	12 (17.1)	58 (82.9)	17 (24.3)	11.9 (5.4-26.7)
T790M (n = 25)	0 (0.0)	6 (24.0)	13 (52.0)	6 (24.0)	19 (76.0)	6 (24.0)	4.7 (3.8-11.0)
Others (n = 23)	0 (0.0)	15 (65.2)	5 (21.7)	3 (13.0)	20 (87.0)	15 (65.2)	9.0 (3.5-11.9)
EGFR TKI-pretreated patients							
Major uncommon mutation (n = 32)	0 (0.0)	8 (25.0)	14 (43.8)	10 (31.3)	22 (68.8)	8 (25.0)	4.9 (2.0-18.0)
G719X (n = 19)	0 (0.0)	2 (10.5)	10 (52.6)	7 (36.8)	12 (63.2)	2 (10.5)	10.0 (2.0-18.0)
L861Q (n = 11)	0 (0.0)	5 (45.5)	3 (27.3)	3 (27.3)	8 (72.7)	5 (45.5)	4.4 (4.3-8.4)
S768I (n = 2)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)	2 (100.0)	1 (50.0)	NR
Compound (n = 21)	0 (0.0)	6 (28.6)	10 (47.6)	5 (23.9)	16 (76.2)	6 (28.6)	16.7 (9.9-21.8)
With major uncommon mutation (n = 8)	0 (0.0)	3 (37.5)	3 (37.5)	2 (25.0)	6 (75.0)	3 (37.5)	16.7 (9.9-16.7)
Exon 20 insertion (n = 21)	0 (0.0)	3 (14.3)	9 (42.9)	9 (42.9)	12 (57.1)	3 (14.3)	3.7 (2.7-10.1)
T790M (n = 64)	0 (0.0)	12 (18.8)	31 (48.4)	21 (32.8)	43 (67.2)	12 (18.8)	6.1 (2.6-7.9)
Others (n = 25)	0 (0.0)	9 (36.0)	8 (32.0)	8 (32.0)	17 (68.0)	9 (36.0)	6.3 (0.8-11.3)

CI, confidence interval; CR, complete response; DCR, disease control rate; DoR, duration of response; PD, progressive disease; ORR, overall response rate; PR, partial response; SD, stable disease; TKI, tyrosine kinase inhibitor; NR, not reported.

Yang *et al*. Journal of Thoracic Oncology (2020) 15(5): 803-815

Milestones for Neratinib in *EGFR* Exon 18-Mutant Lung Cancer Cohort in SUMMIT Study

- The success criteria for the 1st stage and 2nd stage of the Simon's 2-stage design has been met
  - Enrollment in the 2nd stage is continuing up to a total of 30 patients
- Anticipate presentation of additional data from SUMMIT in patients with *EGFR* exon 18-mutant lung cancer in the first half of 2022
- Anticipate scheduling meeting with FDA to discuss potential accelerated approval strategy for patients with *EGFR* exon 18-mutant lung cancer who have been treated with a prior EGFR TKIs in 2022

IST Landscape – Other Cancers

	Colorectal Cancer	Glioblastoma	Breast Cancer	Multiple Tumor Types
ISTs	**FC-7 (NSABP)** Quad Wild-Type mCRC w/ prior cetuximab or panitumumab, dose finding for N + Cetuximab		**NEREA (SOLTI)** HR+/HER2-/HER2-enriched mBC, N + Ex/Ful/Tam	**MCC-17-13821 (VCU)** P1 dose finding N + sodium valproate in advanced solid tumors, expansion in HER2+ BC and K-/N-RAS mutant cancers
	FC-11 (NSABP) Quad Wild-Type mCRC, HER2+ w/ prior EGFR ther or *HER2*-mutated: N+T, HER2+ w/o prior EGFR therapy: N+Cetuximab		**201209135/MutHER (WU)** *HER2*-mutated mBC, ER-: N, ER+: N+Ful	**POE 16-01 (MSKCC)** Pediatric solid tumors and acute leukemias, N dose finding followed by N at RP2D
	ACOMPLI (INSERM) HER2+ or *HER2*-mutated mCRC, N vs. SOC	**INSIGhT (DFCI)** Tumors w/ unmethylated MGMT promoters, w/o IDH1 R132H mutation, SOC (temozolomide) vs. N vs. CC-115 vs. Abemaciclib	**PlasmaMATCH (ICR)** *HER2*-mut mBC, line 2+, ER-: N, ER+: N+Ful	**2016-0430 (MDACC)** Advanced/metastatic cancer with *HER2/3/4* mutation or HER2/3+, N+Everolimus vs. N+Palbo vs. N+Trametinib
			2016-0537 (MDACC) iBC, HER2+: N+Pac+Per+T, HER2-/ER+: N+Pac	
Puma	None	None	SUMMIT (*HER2*-mutated breast cancer)	SUMMIT (*HER2*-mutated tumors)

Puma – Expected Milestones

- Report top line data from cohort of patients in SUMMIT basket trial with HR+ breast cancer with *HER2* mutation (Q4 2021)
- Conduct pre-NDA meeting with the FDA to discuss accelerated approval of neratinib in *HER2*-mutated HR+ breast cancer (Q4 2021)
- Report Phase II TBCRC-022 trial from Cohort 4B and 4C of the combination of Kadcyla + neratinib in patients with HER2+ breast cancer with brain metastases who have previously been treated with Kadcyla (H2 2021/H1 2022)
- Report Phase II data from cohort of patients in SUMMIT basket trial of neratinib in non-small cell lung cancer patients with *EGFR* exon 18 mutations (H1 2022)
- Conduct meeting with the FDA to discuss the potential for an accelerated approval pathway for neratinib in non-small cell lung cancer patients with *EGFR* exon 18 mutations who have been previously treated with an EGFR tyrosine kinase inhibitor (2022)
- Report Phase II data from SUMMIT trial in cervical cancer patients with HER2 mutations (H1 2022)

Intellectual Property

- Composition of matter patent issued (expires 2025)
  - Can be extended w/ 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 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

Experienced Management Team

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

Jeff Ludwig
Chief Commercial Officer
- *Astellas, Amgen*

Maximo F. Nougues
Chief Financial Officer
- *Getinge AB, Boston Scientific, The Clorox Company*

Alvin Wong, Pharma.D.
Chief Scientific Officer
- *Proteolix, Novacea, Genentech*

Douglas Hunt
Senior Vice President, Regulatory Affairs
- *ArmaGen, Baxter Healthcare, Amgen*

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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, 2021: ~$109 million
- Cash burn in Q2 2021: ~$0.1million
- Note purchase agreement (July 2021)
  - Fund managed by Athyrium Capital Management
  - New agreement for $125 million replaces loan of $100 million
  - $100 million drawn down to repay loan from Oxford Finance
  - Provides increased cash flexibility, improved short-term cash flow, ongoing clinical funding
- Shares issued and outstanding: 40.8 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
- Additional potential indications:
  - HER2+ metastatic breast cancer with brain metastases
  - HER2-mutated breast cancer
  - HER2-mutated cervical cancer
  - EGFR exon 18-mutated non-small cell lung cancer
  - HER2-mutated solid tumors
- Retain full U.S. commercial rights to NERLYNX®
- Large initial market opportunity with additional label expansion potential

Puma Biotechnology

H.C. Wainwright 23rd Annual Global Investment Conference

September 2021