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Company Update

JUNE 5th, 2018

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Forward-Looking Statements

This presentation contains "forward-looking statements" as defined by the Private Securities Litigation Reform Act of 1995. We caution investors that forward-looking statements are based on management's expectations and assumptions as of the date of this presentation, and involve substantial risks and uncertainties that could cause our clinical development programs, future results, performance or achievements to differ significantly from those expressed or implied by the forward-looking statements. These risks and uncertainties include, but are not limited to, those associated with: the potential market opportunity for HTX-011; the timing of the NDA filing for HTX-011; the timing of completion and results of clinical trials for HTX-011; the 2018 net product sales guidance for the CINV franchise; the projected sufficiency of our capital position for future periods; and other risks and uncertainties identified in the Company's filings with the Securities and Exchange Commission. Forward-looking statements reflect our analysis only on their stated date, and we take no obligation to update or revise these statements except as may be required by law.

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Status of Product Portfolio

CINV
Pain

	Preclinical	Clinical	NDA	Approved
SUSTOL® (granisetron) extended-release injection	Approved by U.S. FDA for CINV Prevention			
CINVANTI® (aprepitant) injectable emulsion	Approved by U.S. FDA for CINV Prevention			
HTX-011 bupivacaine + meloxicam ER Local Administration	Postop Pain with Local Administration		• **Fast Track designation granted** • **Positive Phase 3 results**	
HTX-011 bupivacaine + meloxicam ER Nerve Block	Postop Pain with Nerve Block	**Phase 2 data in June**		

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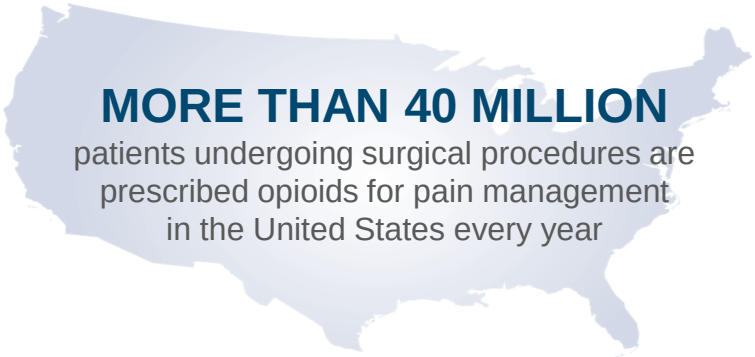
Postoperative Opioids: A Doorway to Addiction



MORE THAN 40 MILLION
patients undergoing surgical procedures are prescribed opioids for pain management in the United States every year

As many as
2.6 MILLION PEOPLE
that take opioids to manage pain after surgery may become persistent opioid users.

Up to 440,000/yr
will become addicted to opioids.

In addition
>BILLION OPIOID PILLS
are taken home from the hospital after surgery

70% of all these opioid pills go unused

90% of these pills remain inside the home in unsecured locations

32% of all opioid addicts report first opioid exposure through leftover pills

>$15 BILLION
of the annual healthcare costs associated with addiction can be attributed to postoperative pain management.

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Large US Market Opportunity

Theoretical and Target Market

~28M Annual US Surgical Procedures Requiring Postoperative Pain Management That Were Considered Potentially Suited For HTX-011

Initial Targets
Higher volume procedures across 4 major specialties
- ~6.5M Orthopedic procedures
- ~4.3M General Surgery procedures
- ~3.3 M OB/GYN procedures
- ~1.1M Plastic Surgery procedures

$4.9B

Secondary Targets
Higher volume procedures in non-core specialties (e.g., ENT, urology, hand, others)

$1.9B

Tertiary Targets
Lower volume procedures and procedures where local anesthetics are not widely used today

$2.3B

Theoretical Market Size*

*Based on the current WAC of Exparel

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9.7 Million Out of the 15 Million Initial Target Procedures (65%) Will Occur in Outpatient Setting

Hospitals account for 76%
[11.4 M procedures]

35% Inpatient
[5.3M procedures]

- **MS-DRG / Bundled Payment**
- **X-Code Opportunity**

41% Hospital Outpatient
[6.1M procedures]

- **C-Code / J-Code**
- **Surgical Supply Package / APCs**

Remaining outpatient facilities account for 24%
[3.6 M procedures]

10% Ambulatory Surgical Centers (ASCs)
[1.5M procedures]

- **C-Code / J-Code**
- **Surgical Supply Package / APCs**

14% Other (Physician Practices)
[2.1M procedures]

- **C-Code / J-Code**
- **Surgical Supply Package / APCs**

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Potential Reimbursement Opportunities with Approval C-Code Overview and Why It Is Important

What is it?

- Specific for procedures that occur in the Outpatient Setting
- Good news: Rolling quarterly application deadlines with 90 days to receive approval
- Once granted, C-Code covers the remainder of 2019 year + 2 additional years to end of 2021. Afterwards, there is an opportunity to convert to a J-Code
- **Medicare reimbursement is ASP + 6%**
- Commercial payers (based on contract with the ASC or HOPD)
  - Can reimburse separately at their discretion OR
  - Raise the cost of bundle procedure payment to account for cost of a drug

Why is it important?

- Medicare largest payer in ASC and HOPD setting since majority of procedures are done in patients ≥65 yo

Potential Reimbursement Opportunities with Approval J-Code Overview and Why It Is Important

What is it?

- CMS code that is assigned and takes into effect once application for J-Code is granted OR the C-Code expires
- Unlike the C-Code, it does not provide for pass-through reimbursement

What is the difference between the Miscellaneous and Permanent J-Code?

- Miscellaneous J-Code creates a more cumbersome claims submission process for commercial payors (Additional information needed to be provided as part of claim to prevent denial)
- Permanent J-Code provides for electronic adjudication of claims

Why is a J-Code important?

- Benefit for Commercial payers since Permanent J-Codes improves utilization tracking, which helps them negotiate an increased bundled rate or a separate negotiated rate for the procedure
- No benefit for Medicare since reimbursement still within surgical supply package rate

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Obtaining a C-Code Will Provide Broad Access for HTX-011 Across 65% of Eligible Procedures

9.7 MILLION OUTPATIENT PROCEDURES (65% of Initial Market)	
Plan for HTX-011	EXPAREL
C-Code providing ASP+6% pass-through	C-Code has expired; now part of CMS Surgical Supply Package without separate pass-through

5.3 MILLION INPATIENT PROCEDURES (35% of Initial Market)	
Plan for HTX-011	EXPAREL
Apply for X-Code	Part of CMS Bundled payment without separate pass-through

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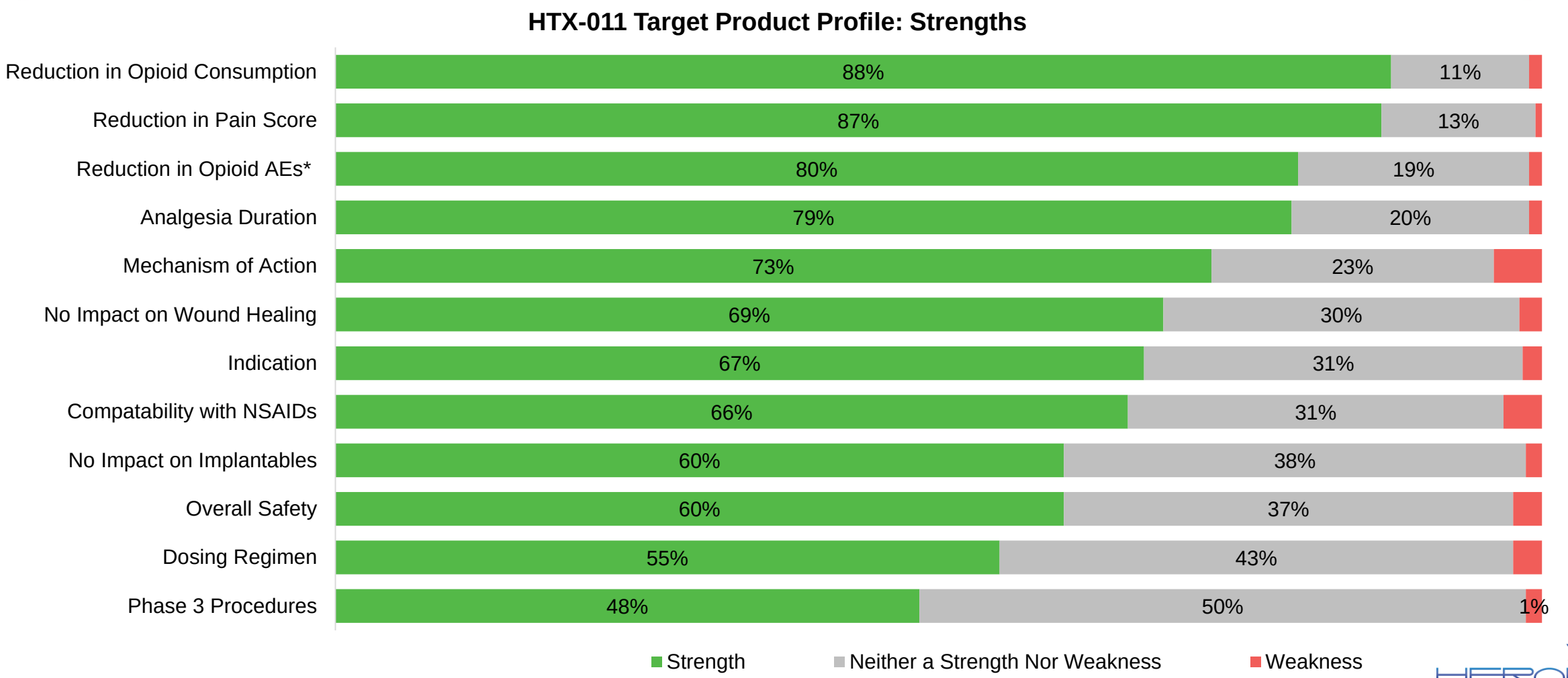
Very Positive Response by Physicians and Pharmacists to HTX-011's Target Product Profile



n = 376 total (101 anesthesiologists, 51 general surgeons, 122 orthopedic surgeons, 50 plastic surgeons, 52 pharmacy directors)
*Opioid AE's are assumed to be reduced with significant reduction in use

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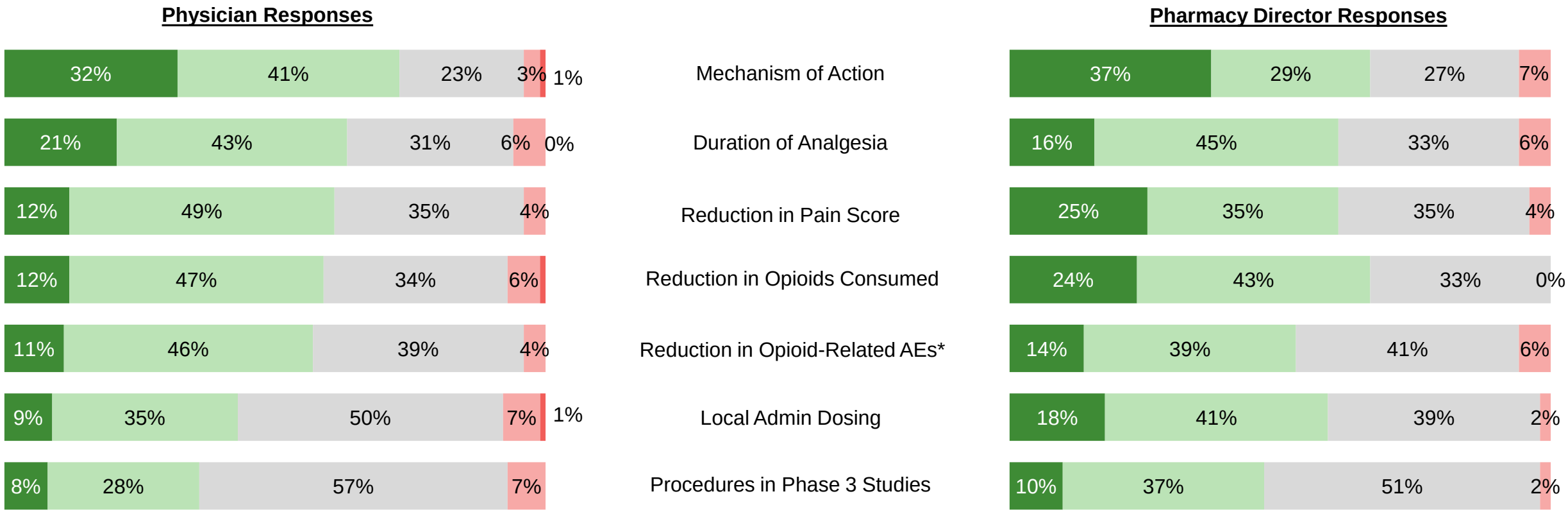
Pharmacy Directors Preferred HTX-011 over Exparel® Based on MOA, Reduction in Pain, and Reduction in Opioids

Preference for HTX-011 vs. Exparel Based on Product Attributes



n = 324 total (101 anesthesiologists, 51 general surgeons, 122 orthopedic surgeons, 50 plastic surgeons)

n = 52 pharmacy directors

Shading Legend:

Strongly favors HTX-011	Somewhat favors HTX-011	Product X and Exparel generally equivalent	Somewhat favors Exparel	Strongly favors Exparel

*Opioid AE's are assumed to be reduced with significant reduction in use

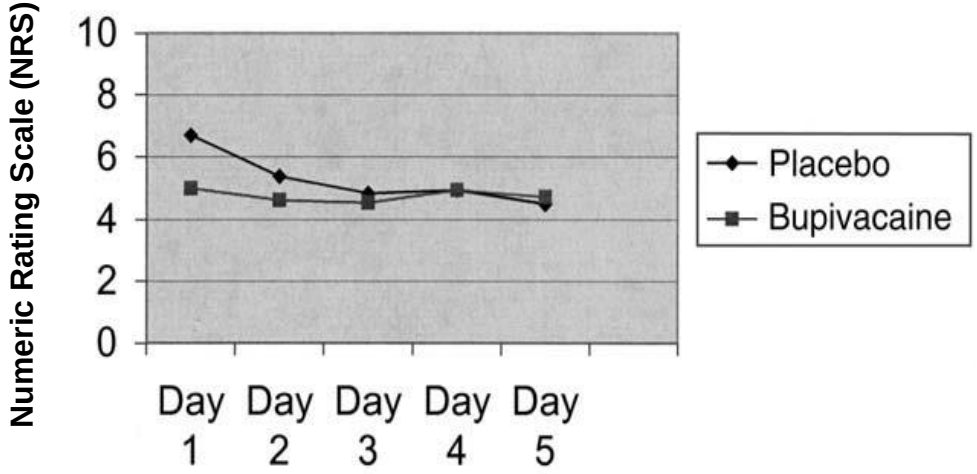
High Procedure Volume in Target Markets Provides a Robust RoW Market Opportunity

Country	Total Surgical Procedures	Total Procedures Requiring Postop Pain Management	Initial Target Procedures	Remaining Secondary, Lower Volume & Procedures Currently Not Using Local Anesthetics
Germany	22,545,000	6,838,000	3,649,000	3,189,000
France	14,545,000	4,357,000	2,292,000	2,065,000
UK	13,882,000	3,835,000	1,790,000	2,045,000
Italy	5,637,000	2,530,000	1,919,000	611,000
Canada	3,416,000	1,638,000	1,282,000	356,000
Japan	25,959,000	6,600,000	2,668,000	3,932,000
Total	**85,984,000**	**25,798,000**	**13,600,000**	**12,198,000**

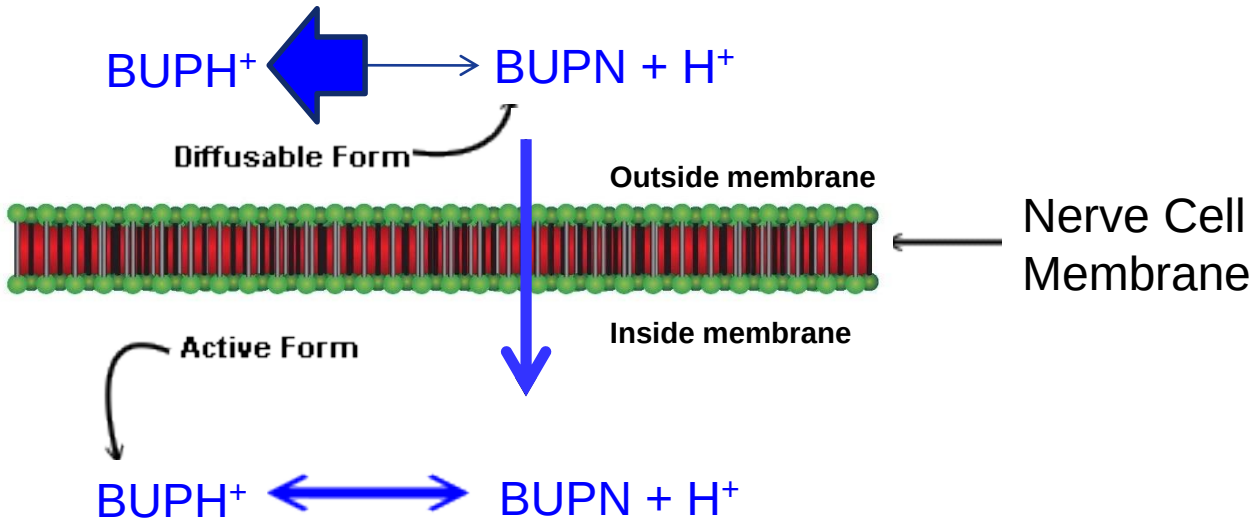
Why Haven't Extended Release Local Anesthetics Penetrated This Large Market

- Regardless of delivery technology, extended release bupivacaine products do not reduce pain sufficiently beyond 24 hours to beat bupivacaine HCl :
  - Exparel® (liposomal ER bupivacaine)
  - Xaracoll™ (bupivacaine collagen matrix)
  - Posimur™ (SABER-bupivacaine)
  - HTX-002 (Biochronomer ER bupivacaine)
  - ON-Q® bupivacaine pump (continuous infusion)

60-Hour Continuous Infusion of Bupivacaine With On-Q Pump in Hernia Repair Was Significantly Different From Placebo for Only 24 hr (Schurr et. al. Surgery 2004;136:761-9)



Inflammation Can Reduce the Activity of Local Anesthetics
HTX-011 is Unique Because It Works to Block Both Pain and Local Inflammation



- Surgical insult produces an immediate drop in pH
- As inflammatory cytokines are released and inflammation sets in, the acidic environment is maintained for many days
- The acidic environment shifts the balance to the ionized form, which is unable to enter the nerve

- Acidic environment associated with inflammation results in far less drug penetrating the nerve membrane and reduced anesthetic effects[1,2]
- Bupivacaine is very sensitive to reduced pH
- Addition of meloxicam is designed to help reduce local inflammation and allow bupivacaine to work better in the first several days after surgery

1. Ueno, et al. J of Inflammation Research 1:41-48 2008.
2. Local anesthetic nerve penetration model adapted from Becker and Reed, Anesth Prog 53:98–109 2006

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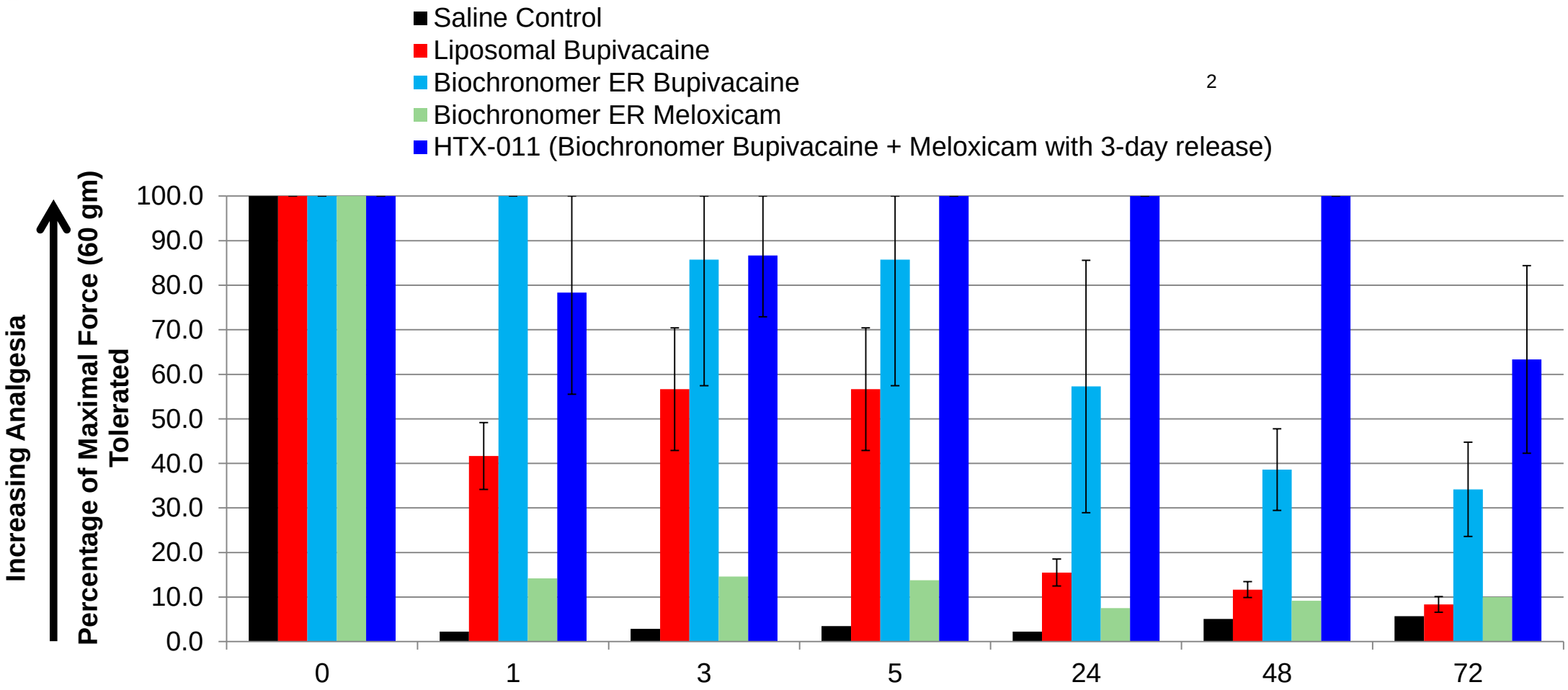
HTX-011 Designed to Produce Marked Analgesia Through the First 72 Hours After Surgery[1]



[1] Postoperative pain model in pigs from Castle et al, 2013 EPJ
[2] Human dose of liposomal bupivacaine with 40% smaller incision
(n=4 pigs in each arm)

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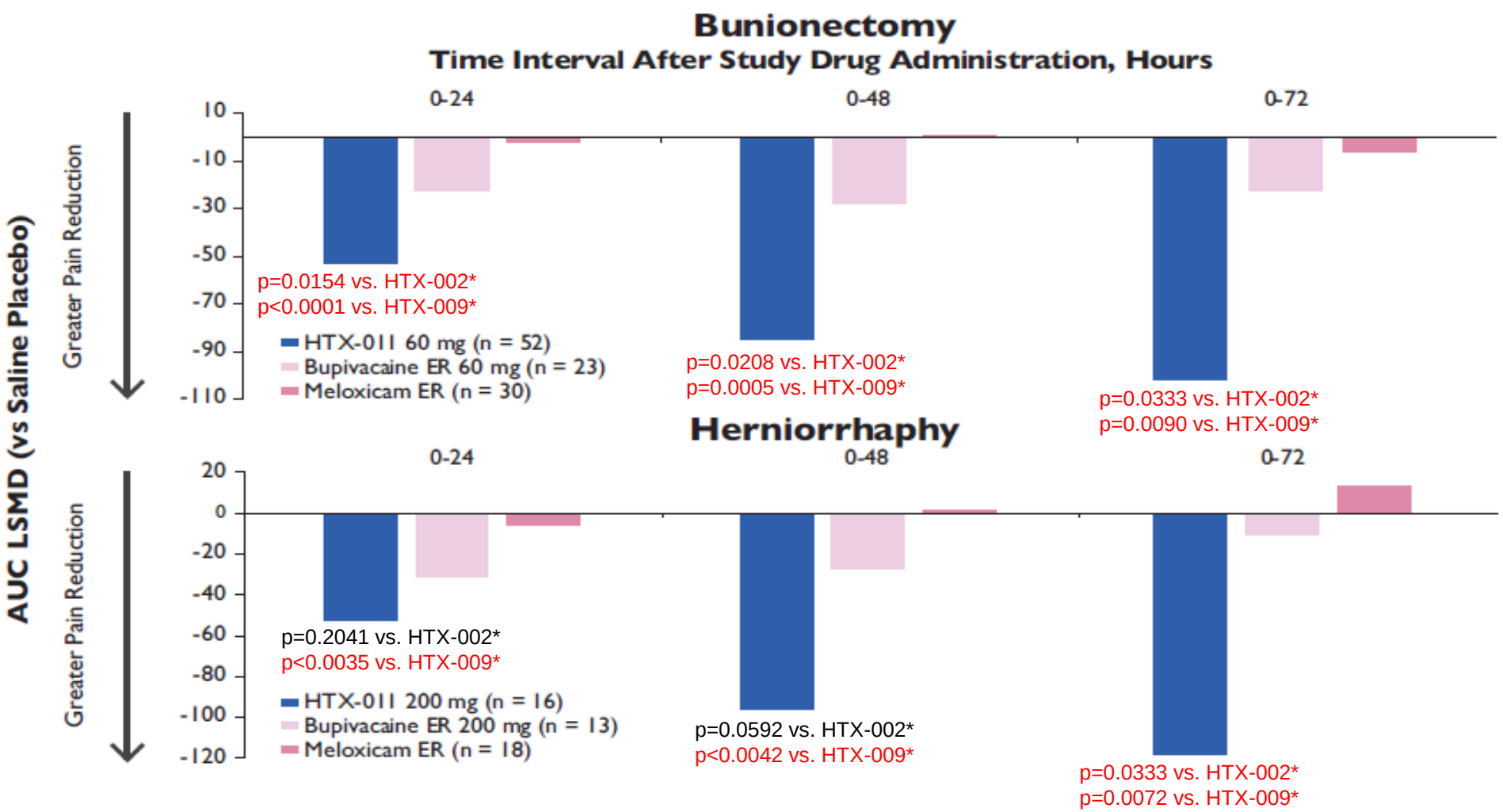
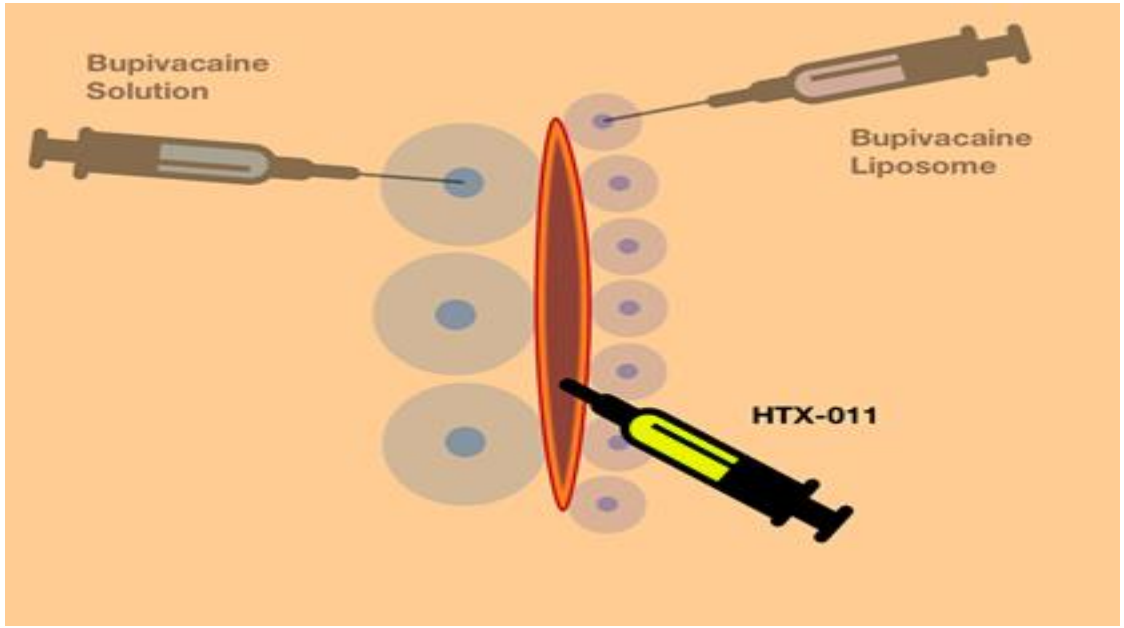
Unique MOA of HTX-011 Produced Significantly Greater Pain Reduction Than ER Versions of Bupivacaine or Meloxicam in Phase 2



*p-value from ANOVA, Least Squares Mean Difference (LSMD) of area under the curve for HTX-011 vs. HTX-002 or HTX-009

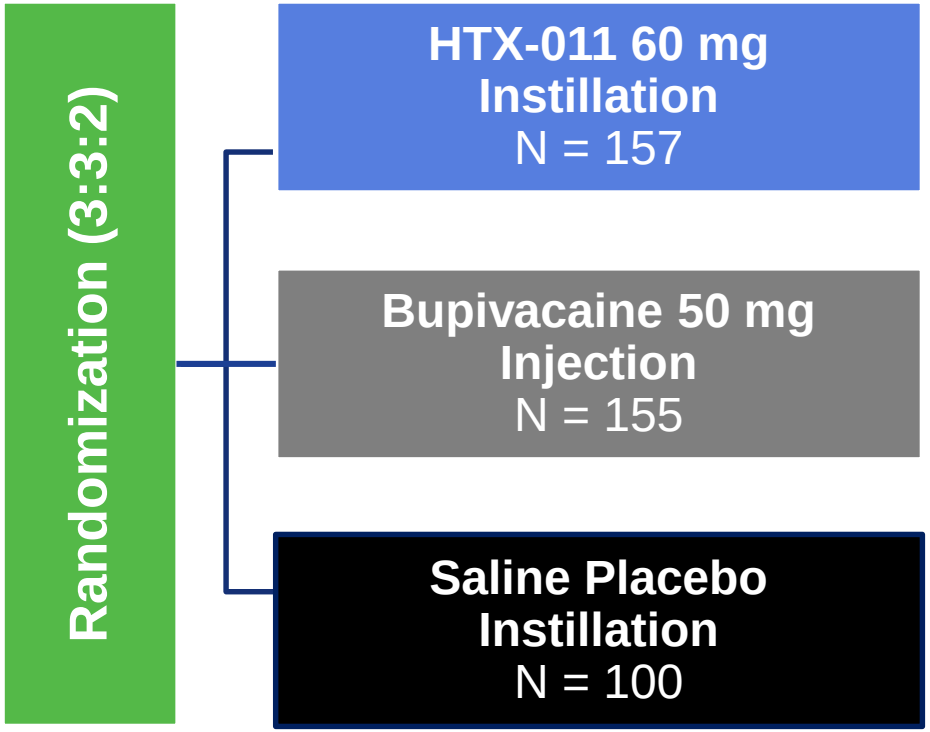
The Properties of HTX-011 Are Ideally Suited for Needle-Free Administration to Coat the Affected Tissue

- HTX-011 is a single dose application of a viscous solution administered directly via needle free syringe to coat the affected tissue within the surgical site prior to suturing
- HTX-011 releases its active ingredients simultaneously over 72 hours
- Release of bupivacaine/meloxicam from polymer is not modulated by where it is administered
- Compared to injection, simply coating the affected tissue is:
  - Easier to administer and less invasive
  - Avoids up to 120 injections
  - Potentially safer, eliminating the risk of venous puncture and accidental needle sticks
  - Since HTX-011 cannot be admixed with bupivacaine solution, there is a low risk of overdose



HTX-011 ACHIEVED ALL PRIMARY AND KEY SECONDARY ENDPOINTS IN BOTH PHASE 3 TRIALS

Study 301/EPOCH1: Phase 3 Bunionectomy
Study Design



Study 301 Endpoints
Primary: Pain Intensity AUC_{0-72} vs. placebo
1st Key Secondary: Pain Intensity AUC_{0-72} vs. bupivacaine
2nd Key Secondary: Opioid use vs. placebo
3rd Key Secondary: Opioid-free vs. bupivacaine
4th Key Secondary: Opioid use vs. bupivacaine

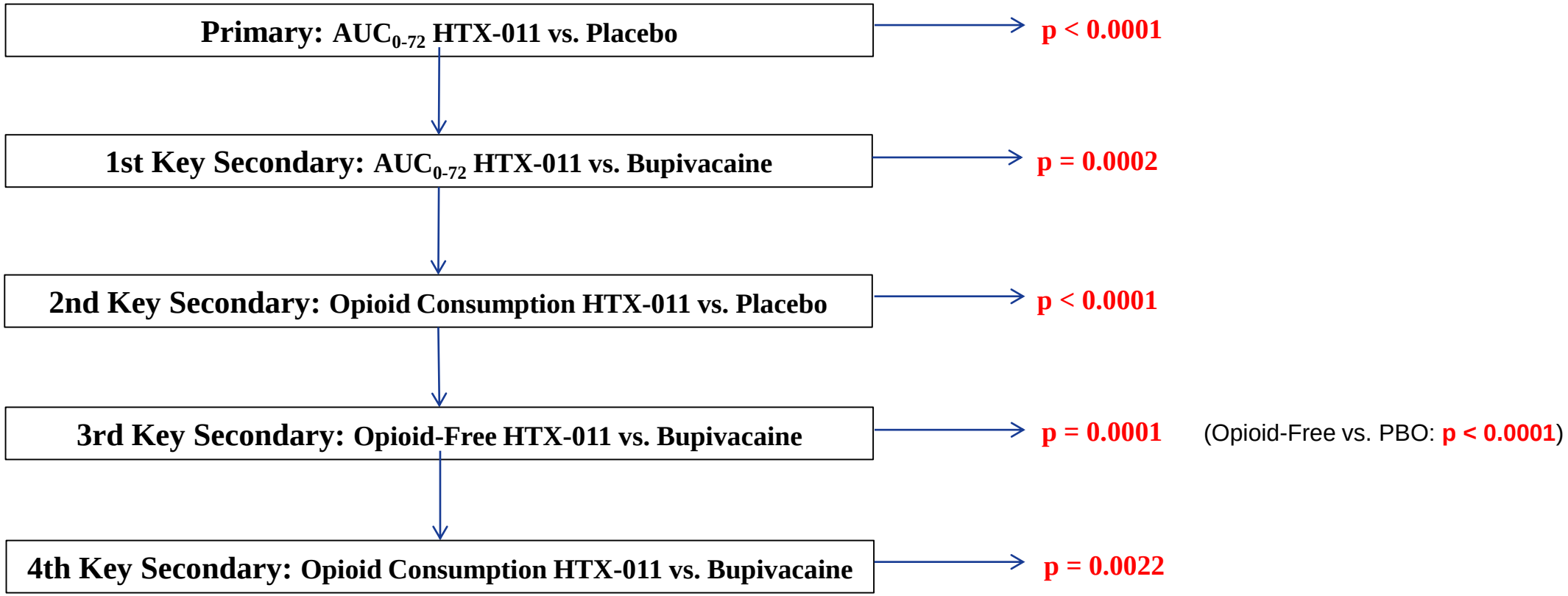
EPOCH
Evaluation of Pain Relief and Opioid Control

Study 301: Subject Demographics

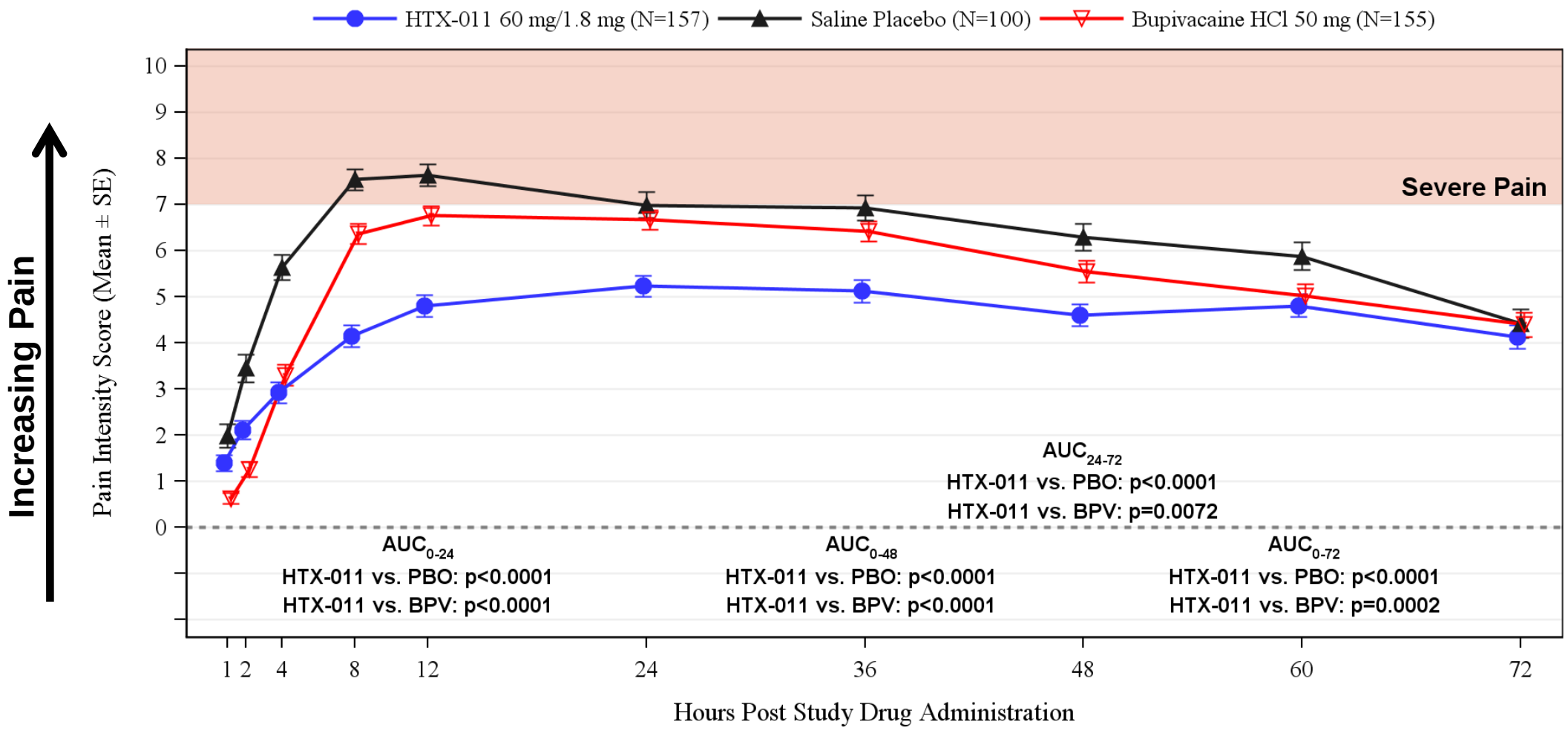
	HTX-011 60 mg (N=157)	Saline Placebo (N=100)	Bupivacaine HCl 50 mg (N=155)	Total (N=412)
Age (years) – mean (SD)	48.0 (14.47)	47.3 (12.83)	45.5 (14.79)	46.9 (14.22)
Sex – %				
Female	87.9%	86.0%	85.2%	86.4%
Male	12.1%	14.0%	14.8%	13.6%
Race – %				
American Indian or Alaskan Native	0.6%	0%	1.3%	0.7%
Asian	5.1%	2.0%	0.6%	2.7%
Black or African Descent	15.3%	12.0%	14.2%	14.1%
Native Hawaiian or Other Pacific Islander	0%	0%	0.6%	0.2%
White	78.3%	86.0%	82.6%	81.8%
Other	0.6%	0%	0.6%	0.5%
Ethnicity – %				
Hispanic or Latino	29.9%	32.0%	31.6%	31.1%
Not Hispanic or Latino	70.1%	68.0%	68.4%	68.9%

Source: Table 14.1.5.1

Study 301: Results Hierarchy
Primary and ALL Key Secondary Endpoints Significant



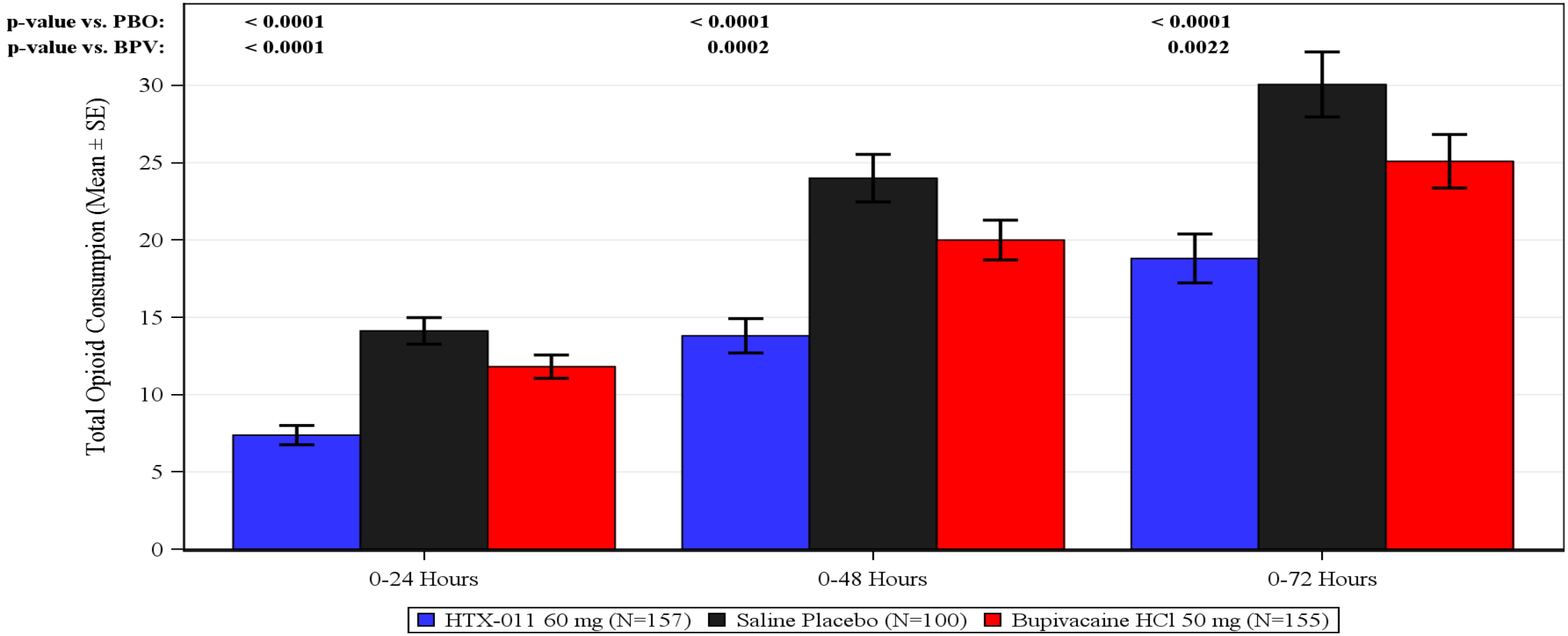
Study 301: HTX-011 Reduces Pain After Bunionectomy Significantly Better Than Placebo or Bupivacaine (Standard-of-Care)



wWOCF, windowed-worst observation carried-forward for use of opioid rescue medication and LOCF for missing data

Source: Figure 14.2.7

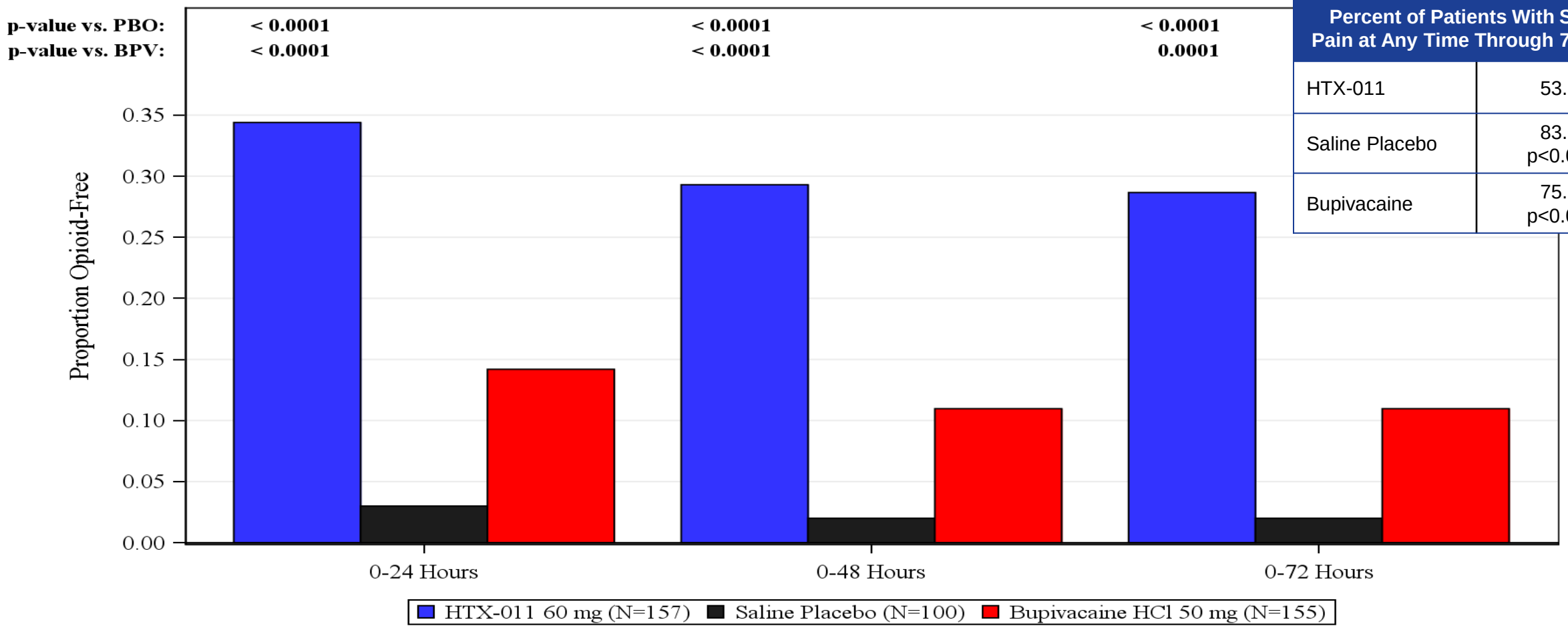
Study 301: HTX-011 Significantly Reduces Total Opioid Use vs Bupivacaine and Placebo



Opioid consumption is presented in mean milligrams of morphine equivalents

Source: Figure 14.2.2

Study 301: HTX-011 Significantly Increases Proportion of Opioid-Free Subjects vs Bupivacaine and Placebo



Percent of Patients With Severe Pain at Any Time Through 72 hours	
HTX-011	53.5%
Saline Placebo	83.0% p<0.0001
Bupivacaine	75.5% p<0.0001

Source: Figure 14.2.3

STUDY 301 SAFETY

Study 301: Incidence of Treatment Emergent Adverse Events Occurring in ≥ 5% in the HTX-011 Group

Preferred Term	HTX-011 60 mg (N=157)	Saline Placebo (N=101)	Bupivacaine HCl 50 mg (N=154)
Any TEAE	83.4%	78.2%	85.1%
Nausea	37.6%	43.6%	45.5%
Dizziness	21.7%	17.8%	23.4%
Incision site oedema	17.2%	12.9%	14.3%
Vomiting	14.6%	18.8%	21.4%
Headache	14.0%	9.9%	13.0%
Incision site erythema	12.7%	7.9%	11.7%
Post procedural contusion	12.1%	12.9%	11.7%
Bradycardia	7.6%	5.9%	7.8%
Impaired healing	6.4%	1.0%	3.9%
Constipation	5.7%	6.9%	11.7%
Muscle twitching	5.7%	5.0%	5.2%
Pruritus	5.1%	5.9%	0.6%

Source: Table14.3.1.3

Study 301: Lower Incidence of Opioid-Related Adverse Events Observed with HTX-011

Preferred Term	HTX-011 60 mg (N=157)	Saline Placebo (N=101)	Bupivacaine HCl 50 mg (N=154)
Any ORAE	43.9%	53.5%	50.6%
Nausea	37.6%	43.6%	45.5%
Vomiting	14.6%	18.8%	21.4%
Pruritus	7.6%	9.9%	5.8%
Constipation	5.7%	6.9%	11.7%
Somnolence	0.6%	0%	0.6%

Source: Table 14.3.1.8.1

HTX-011 Safety in Bunionectomy

HTX-011 was generally well tolerated with:

- No drug-related serious adverse events
- No premature discontinuations due to drug-related adverse events
- No deaths (one death on BPV)
- Fewer opioid-related adverse events
- No evidence of drug-related LAST

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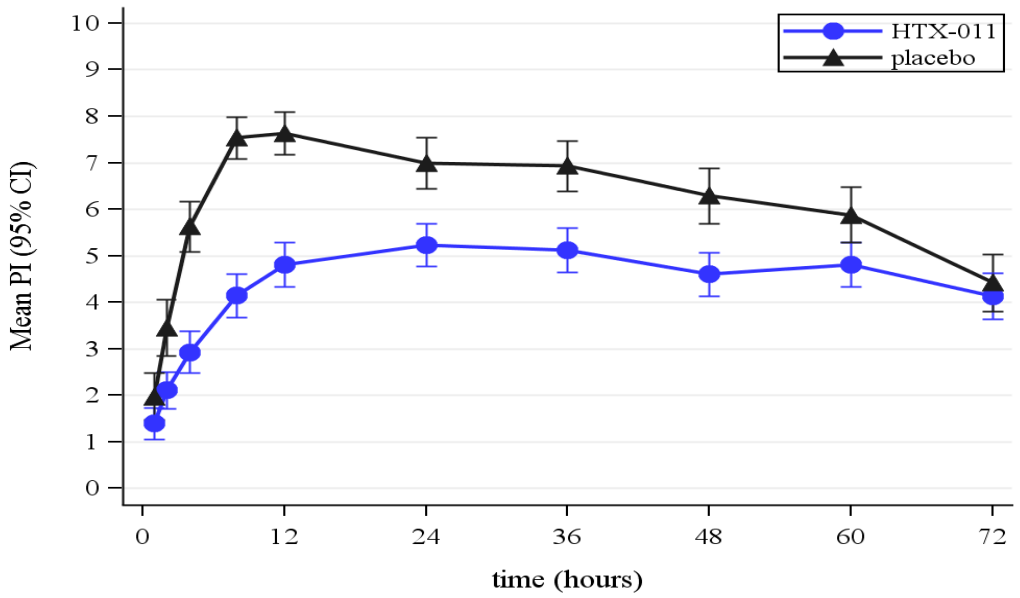
CROSS-STUDY COMPARISON OF HTX-011 VS. EXPAREL IN BUNIONECTOMY

Cross-Study Comparison of Phase 3 Bunionectomy Data
HTX-011 vs EXPAREL

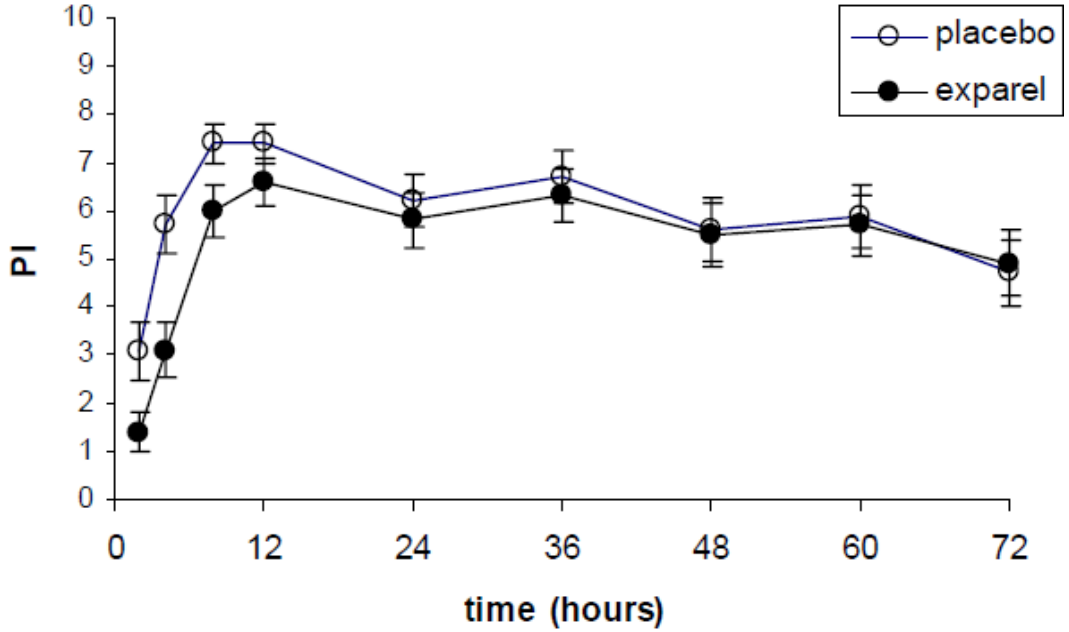
Increasing Mean Pain Intensity

HTX-011 Phase 3



Source: HTX-011 Table 14.2.7.
Primary outcome measure: AUC of NRS pain intensity scores over full 72-hour period.

Exparel Phase 3



Source: Exparel FDA Statistical Review October 2011, Figure 3.
Primary outcome measure: AUC of NRS pain intensity scores over first 24-hour period.

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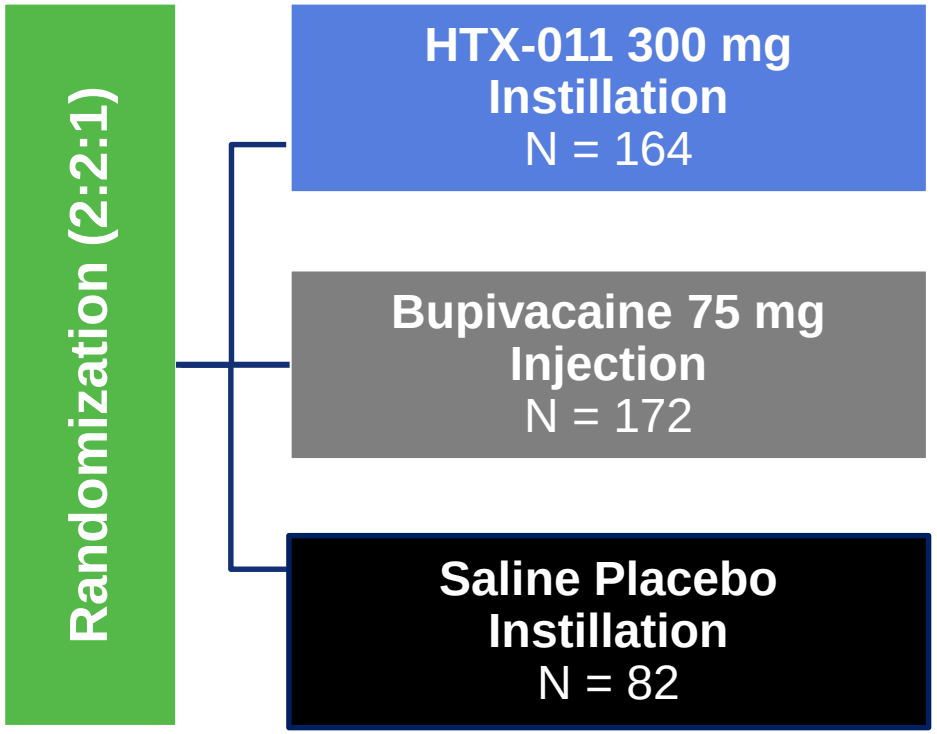
Cross-Study Comparison of Pain Reduction and Proportion of Patients Opioid-Free From Phase 3 Bunionectomy Studies with HTX-011 and EXPAREL

Timepoint	HTX-011 60 mg (N=157)	HTX-011 Placebo (N=100)	Exparel 120 mg (N=97)	Exparel Placebo (N=96)
Pain Intensity AUC_{0-24}				
Mean (SD)	98.7 (59.5)	155.8 (48.5)	123 (49)	141 (41)
Difference	-57.1		-23	
p-value	< 0.0001		0.0002	
% Reduction in Pain vs Placebo	37%		16%	
Pain Intensity AUC_{0-72}				
Mean (SD)	323.3 (182.6)	445.3 (155.8)	398 (171)	429 (153)
Difference	-122.1 (-27%)		-31 (-7%)	
p-value	< 0.0001		0.16	
% Reduction in Pain vs Placebo	**27%**		7%	
Proportion of Patients Opioid-Free Through 72 hrs	**29%**		2%	

Sources: HTX-011 Tables 14.2.5.1 & 14.2.3; Exparel FDA Statistical Review October 2011, Tables 11 & 17.

Study 302/EPOCH2: Phase 3 Herniorrhaphy
Study Design



Study 302 Endpoints
Primary: Pain Intensity $AUC_{0\text{-}72}$ vs. placebo
1st Key Secondary: Pain Intensity $AUC_{0\text{-}72}$ vs. bupivacaine
2nd Key Secondary: Opioid use vs. placebo
3rd Key Secondary: Opioid-free vs. bupivacaine
4th Key Secondary: Opioid use vs. bupivacaine

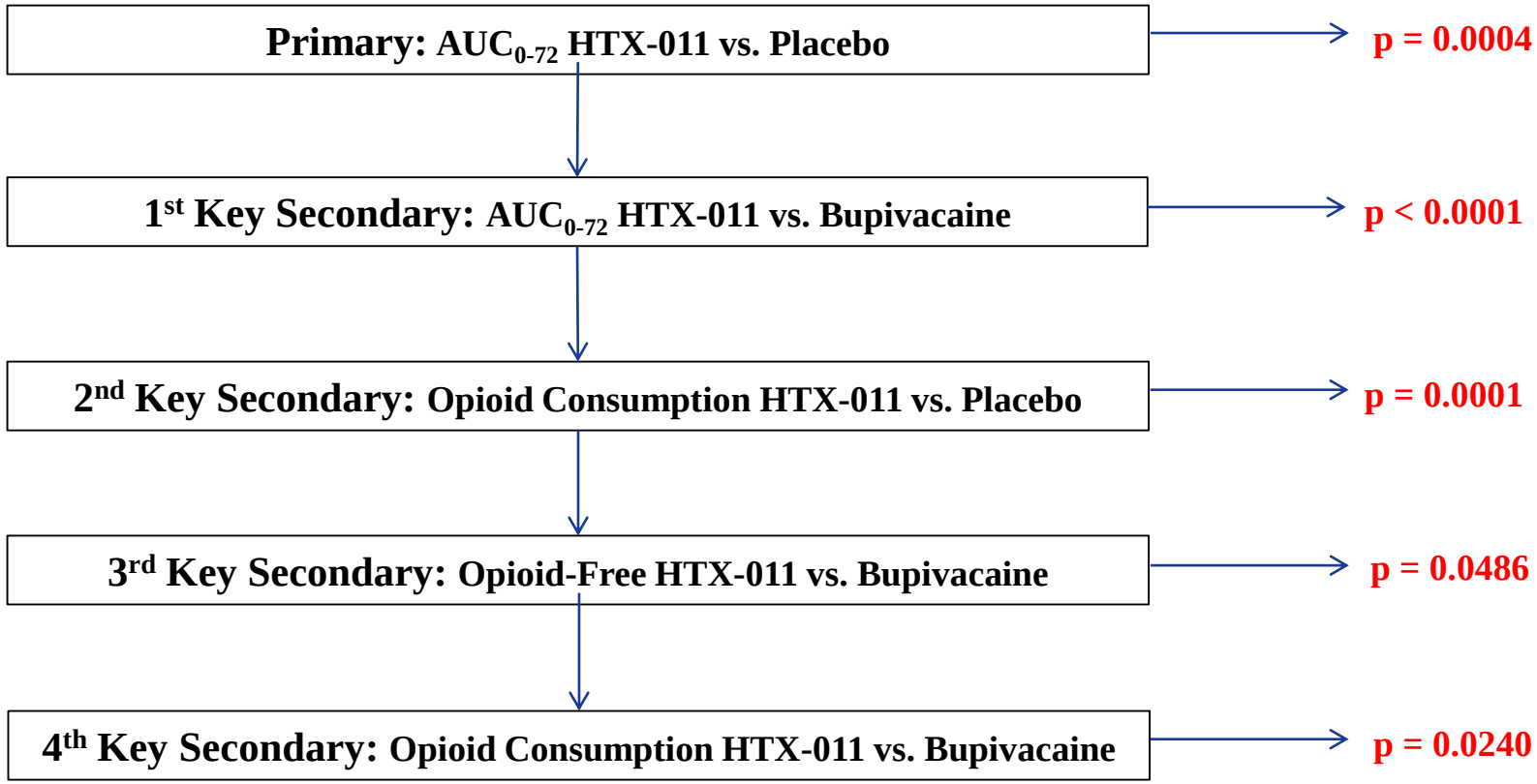
EPOCH
Evaluation of Pain Relief and Opioid Control

Study 302: Subject Demographics

Number of subjects:	HTX-011 300 mg (N=164)	Saline Placebo (N=82)	Bupivacaine HCl 75 mg (N=172)	Total (N=418)
Age (years) – mean (SD)	48.9 (13.29)	48.0 (14.59)	49.4 (11.26)	48.9 (12.75)
Sex – %				
Female	7.3%	3.7%	4.7%	5.5%
Male	92.7%	96.3%	95.3%	94.5%
Race – %				
American Indian or Alaskan Native	1.2%	0%	0%	0.5%
Asian	1.2%	1.2%	1.2%	1.2%
Black or African Descent	10.4%	3.7%	9.3%	8.6%
Native Hawaiian or Other Pacific Islander	2.4%	0%	0.6%	1.2%
White	84.8%	95.1%	89.0%	88.5%
Ethnicity – %				
Hispanic or Latino	26.2%	36.6%	29.7%	29.7%
Not Hispanic or Latino	73.8%	63.4%	70.3%	70.3%

Source: Table 14.1.5.1

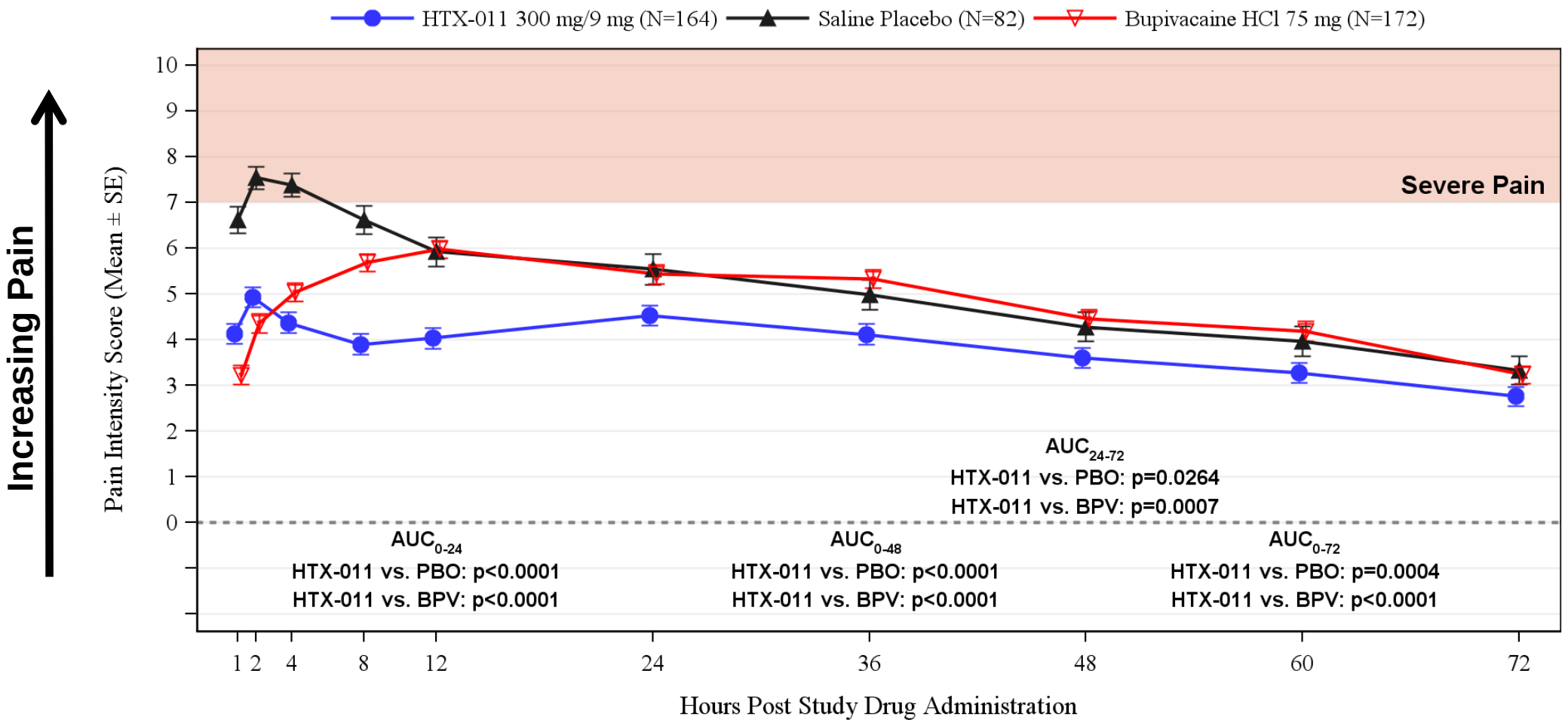
Study 302: Results Hierarchy
Primary and ALL Key Secondary Endpoints Significant



(Opioid-Free vs. PBO: **p < 0.0001**)

PBO: saline placebo; BPV: bupivacaine HCl

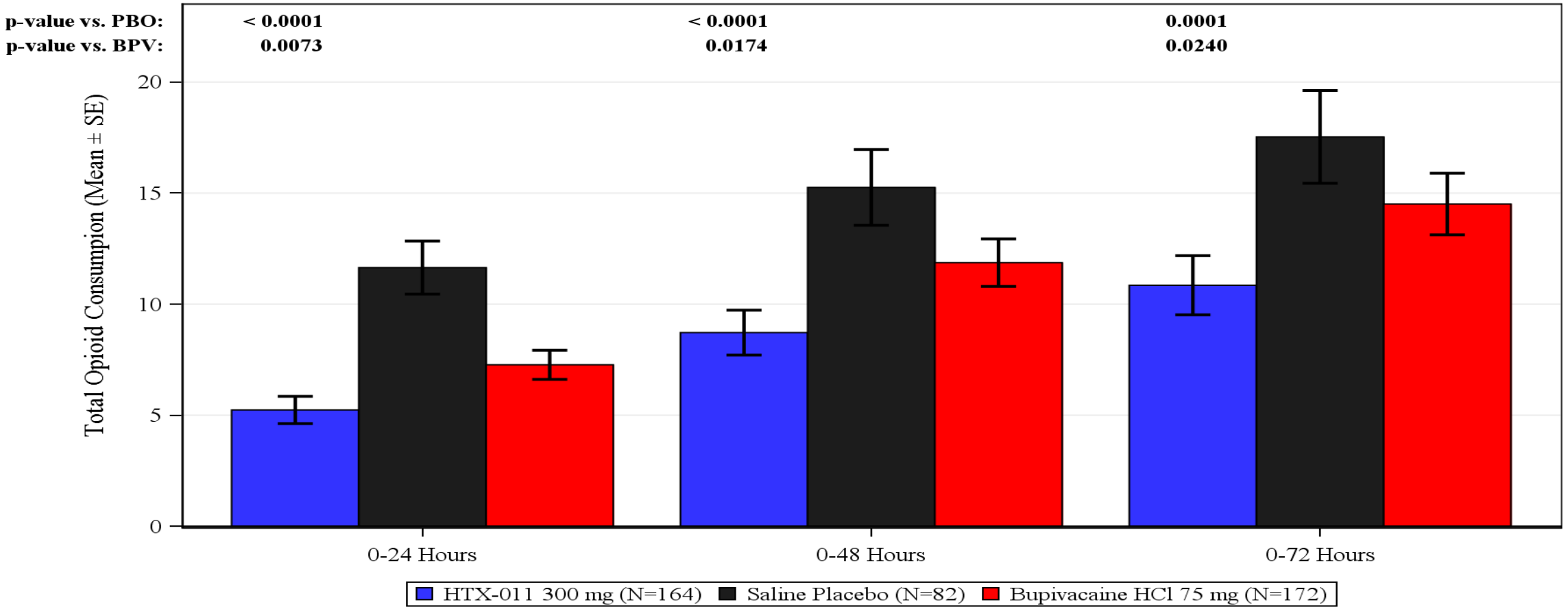
Study 302: HTX-011 Reduces Pain After Herniorrhaphy Significantly Better Than Placebo or Bupivacaine (Standard-of-Care)



wWOCF, windowed-worst observation carried-forward for use of opioid rescue medication and LOCF for missing data

Source: Figure 14.2.7

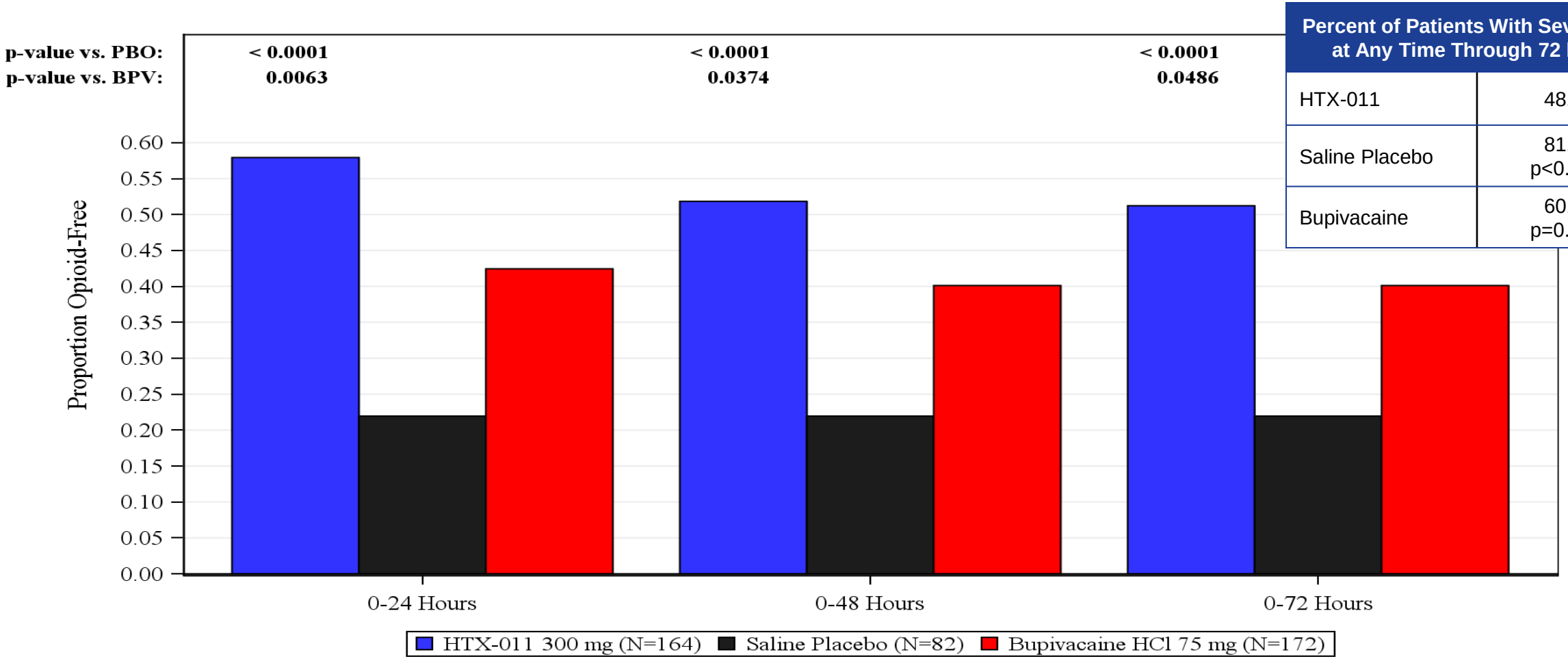
Study 302: HTX-011 Significantly Reduces Total Opioid Use vs Bupivacaine and Placebo



Opioid consumption is presented in mean milligrams of morphine equivalents

Source: Figure 14.2.2

Study 302: HTX-011 Significantly Increases Proportion of Opioid-Free Subjects vs Bupivacaine and Placebo



Percent of Patients With Severe Pain at Any Time Through 72 hours	
HTX-011	48.8%
Saline Placebo	81.7% p<0.0001
Bupivacaine	60.5% p=0.0372

Source: Figure 14.2.3

STUDY 302 SAFETY

Study 302: Incidence of Treatment Emergent Adverse Events Occurring in ≥ 5% in the HTX-011 Group

Preferred Term	HTX-011 300 mg (N=163)	Saline Placebo (N=82)	Bupivacaine HCl 75 mg (N=173)
Any TEAE	73.0%	74.4%	73.4%
Nausea	18.4%	34.1%	21.4%
Constipation	17.2%	18.3%	23.7%
Dizziness	14.7%	15.9%	24.3%
Headache	12.9%	12.2%	13.9%
Bradycardia	9.2%	7.3%	9.2%
Dysgeusia	9.2%	3.7%	12.1%
Skin odor abnormal	8.0%	1.2%	0.6%

Source: Table14.3.1.3

Study 302: Lower Incidence of Opioid-Related Adverse Events Observed with HTX-011

Preferred Term	HTX-011 300 mg (N=163)	Saline Placebo (N=82)	Bupivacaine HCl 75 mg (N=173)
Any ORAE	32.5%	43.9%	42.2%
Nausea	18.4%	34.1%	21.4%
Constipation	17.2%	18.3%	23.7%
Vomiting	4.3%	4.9%	6.9%
Pruritus	1.2%	1.2%	2.3%
Urinary retention	0.6%	1.2%	1.7%

Source: Table 14.3.1.8.1

HTX-011 Safety in Herniorrhaphy

HTX-011 was generally well tolerated with:

- No drug-related serious adverse events
- No premature discontinuations due to adverse events
- No deaths
- Fewer opioid-related adverse events
- No evidence of drug-related LAST

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On-Going Phase 2b Studies

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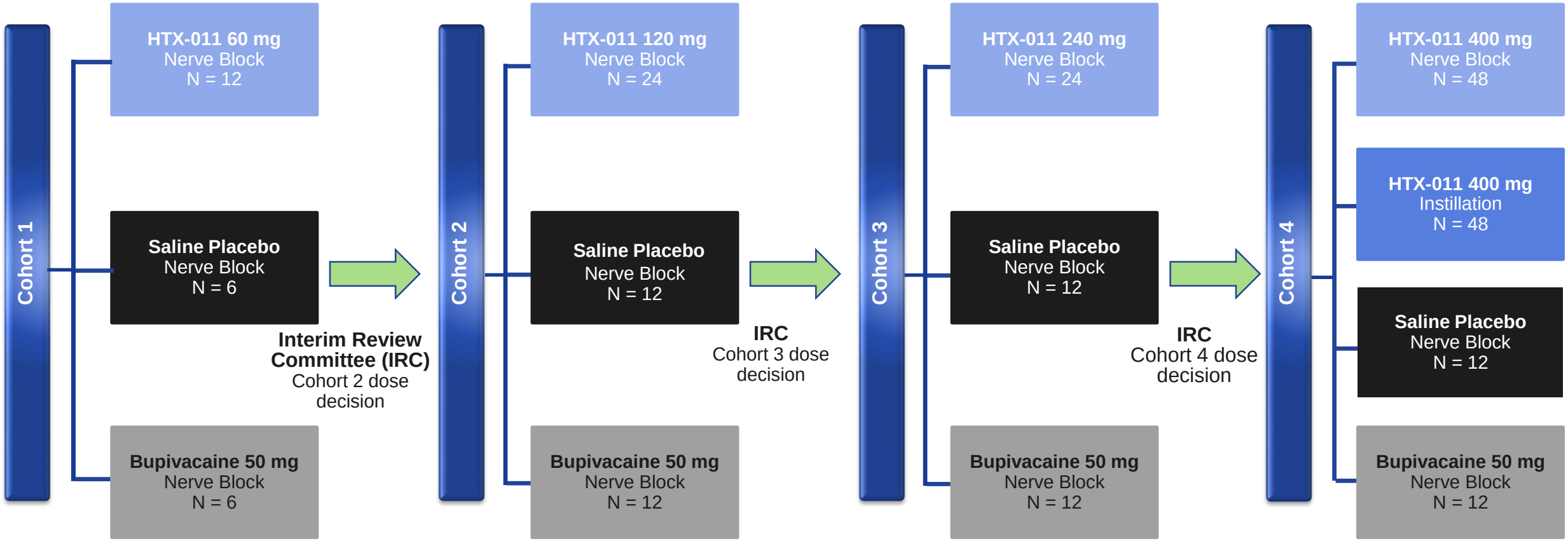
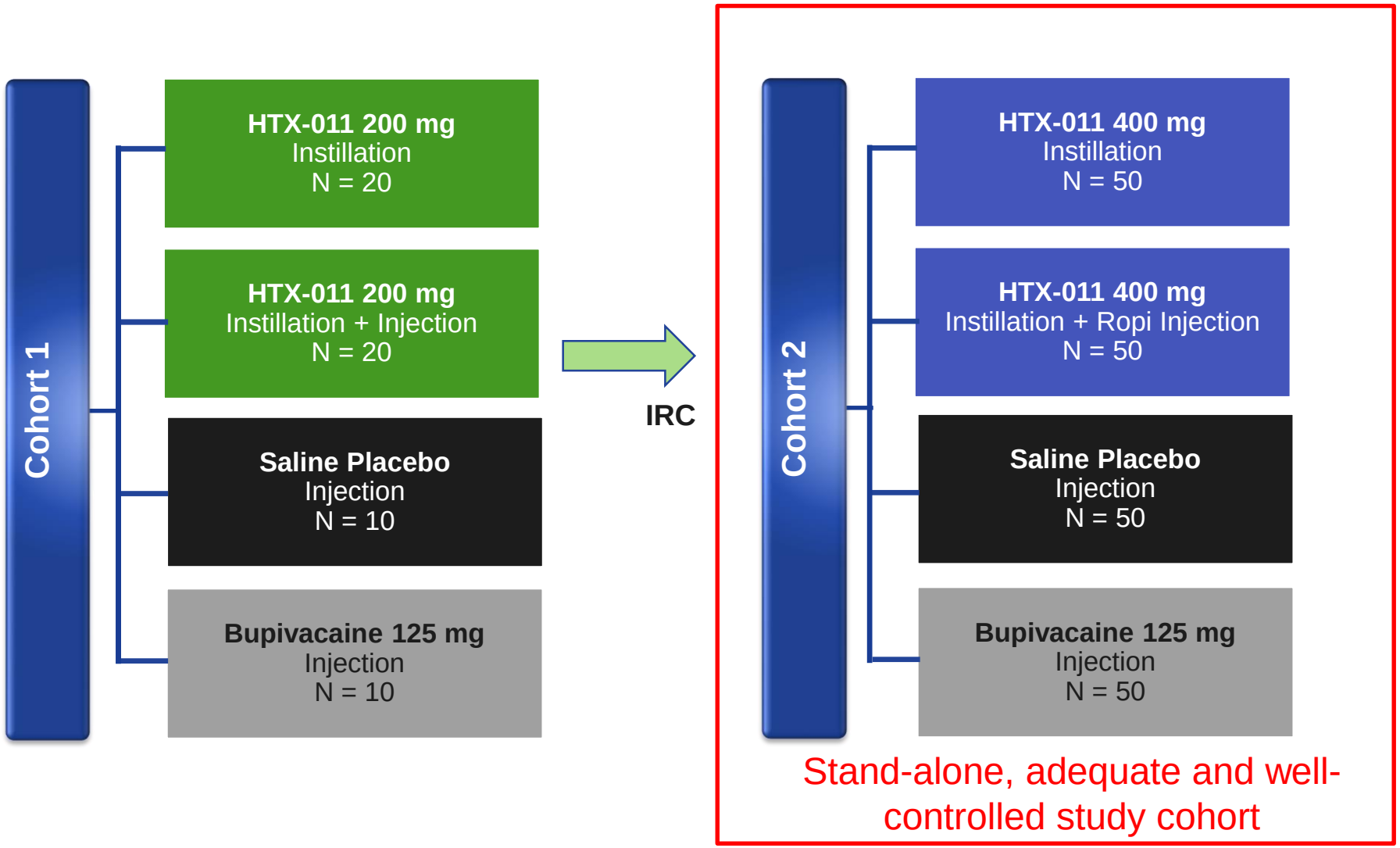
Phase 2b Study 211: Nerve Block in Breast Augmentation Study Design



Protocol includes additional optional cohorts to evaluate other doses and administration techniques.

Phase 2b Total Knee Arthroplasty Study Design



HTX-011 NDA Filing Plans

- Goal is to file an NDA in 2H2018 requesting a broad label for reduction of postoperative pain and opioid analgesics for a full 72 hours after surgery
- NDA will contain data from 5 surgical models to support a broad label:
  - Bunionectomy (positive Phase 2 & 3 data)
  - Herniorrhaphy (positive Phase 2 & 3 data)
  - Abdominoplasty (positive Phase 2 data)
  - TKA (data pending)
  - Breast augmentation (data pending)

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CINV Commercial Update

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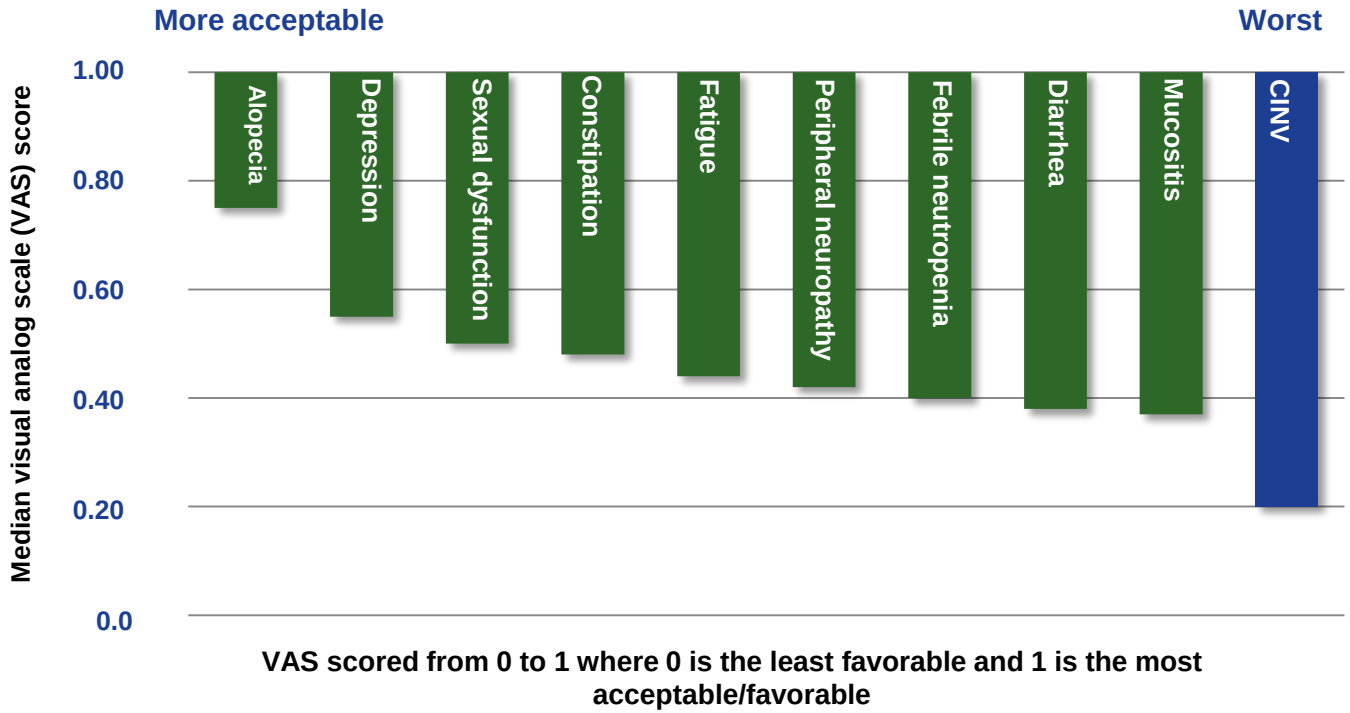
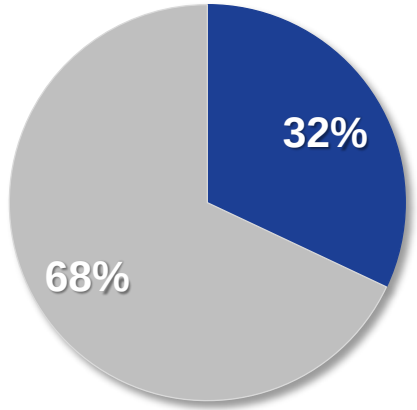
CINV Has a High Clinical Burden – Impacting Patients' QOL and Cancer Treatment

Patients identified CINV as the side effect of chemotherapy they most wanted to avoid



CINV commonly disrupts patients' cancer treatment



32% of oncology HCPs delayed or discontinued chemotherapy due to CINV within the prior year

Sun CC et al. *Support Care Cancer*. 2005;13:219-227.
Van Laar ES et al. *Support Care Cancer*. 2015;23:151-7

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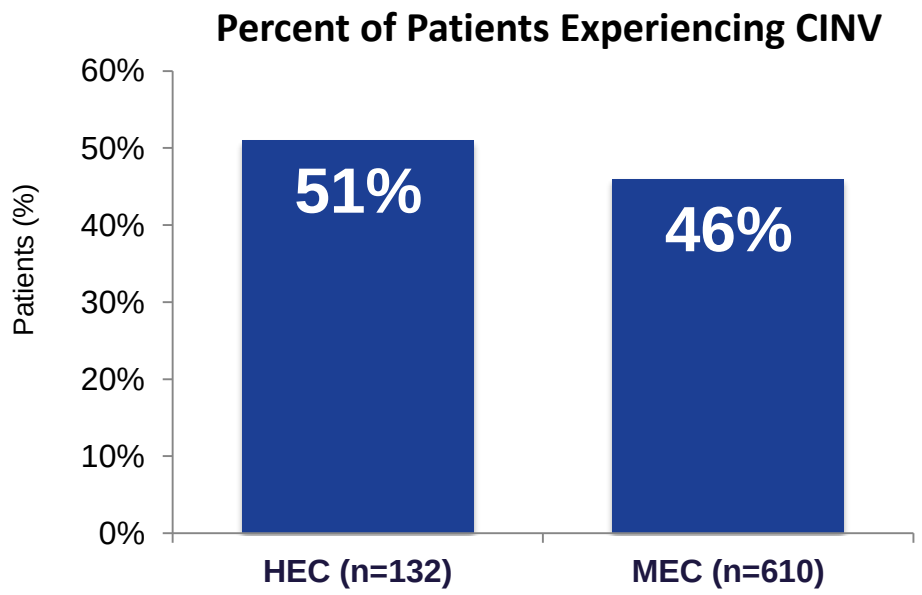
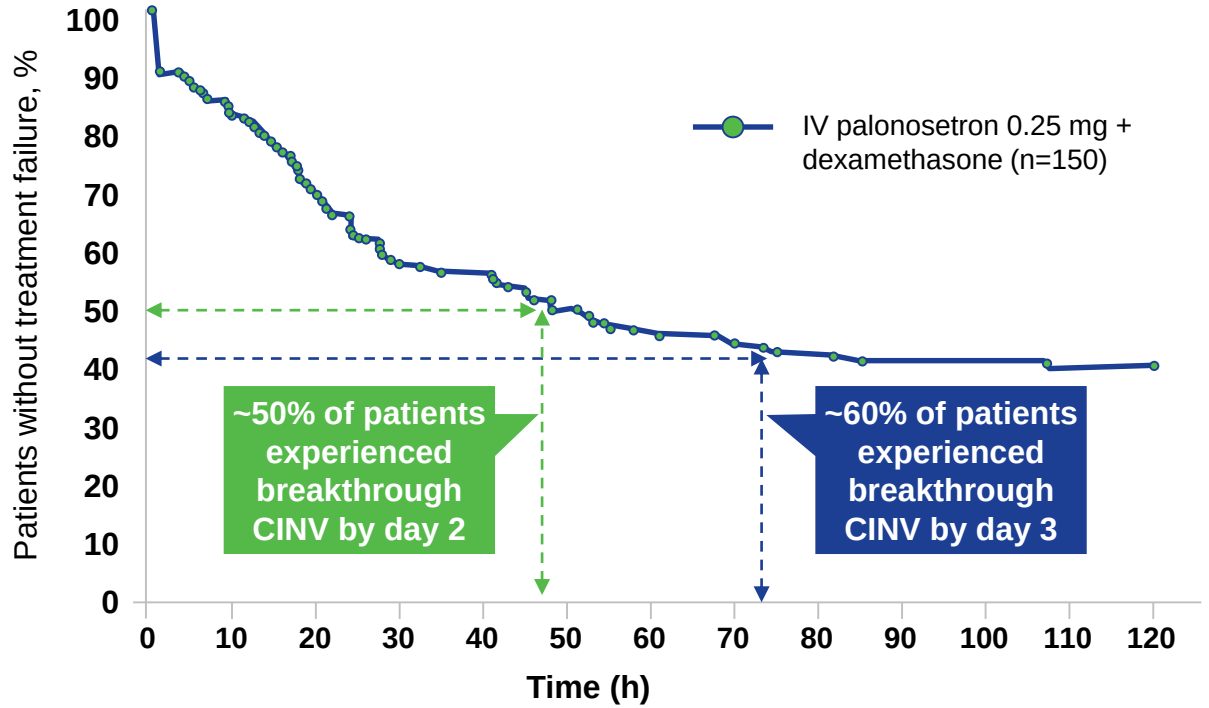
Preventing CINV Remains a Significant Clinical Challenge

- In a prospective observational EMR study of patients receiving single-day MEC or HEC in leading community oncology practices
  - ~50% of patients experienced CINV, despite receiving guideline-consistent prophylaxis (94% of patients received palonosetron as their 5-$HT_{3)}$

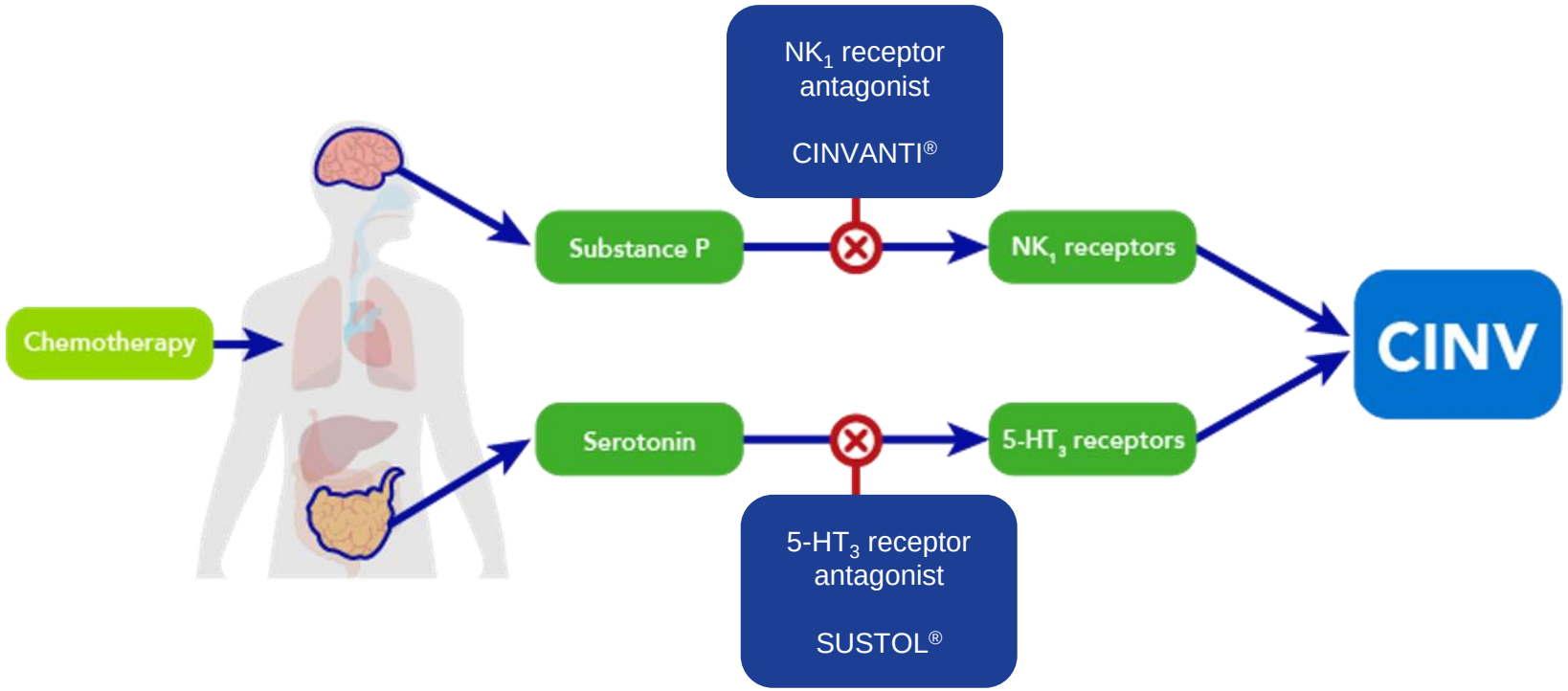


- In palonosetron Phase 3 HEC trial, ~50% of patients experienced breakthrough by day 2 and ~60% by day 3



Gilmore et al. *J Oncol Pract.* 2014
Aapro et al. *Ann Oncol*. 2006

CINV Prophylaxis Typically Requires Two Complimentary Mechanisms of Action



NK_1 receptor antagonists

- Substance P is primary driver of delayed CINV, but related to ~15% of acute failures
- EMEND® IV (fosaprepitant), the US NK_1 market leader, contains the synthetic surfactant polysorbate 80, which has been associated with serious hypersensitivity and infusion site reactions

$5\text{-}HT_3$ receptor antagonists

- Are the backbone of CINV prophylaxis
- Excessive serotonin release is the primary driver for CINV in the acute phase and secondary driver in the delayed phase

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The CINV Market Has Seen Dramatic Changes Creating Long-Term Opportunities for Heron

Market Events	Opportunities
▪ **Q4 2017** Varubi IV launch ▪ **Q1 2018** CINVANTI launch ▪ **Q1 2018** Reports of Varubi IV AEs, label update, suspension of distribution ▪ **Q2 2018** Entry of 7 generic versions of palonosetron initiating the arbitrage ▪ **Q2 2018** Approval of Akynzeo IV with a restricted indication (non-AC HEC)	▪ **SUSTOL** ○ No Aloxi contract ○ More rapid / shorter arbitrage ○ Permanent J code assigned ○ Fewer direct competitors ▪ **CINVANTI** ○ Fewer direct competitors ○ Granted C-code and pass-through status

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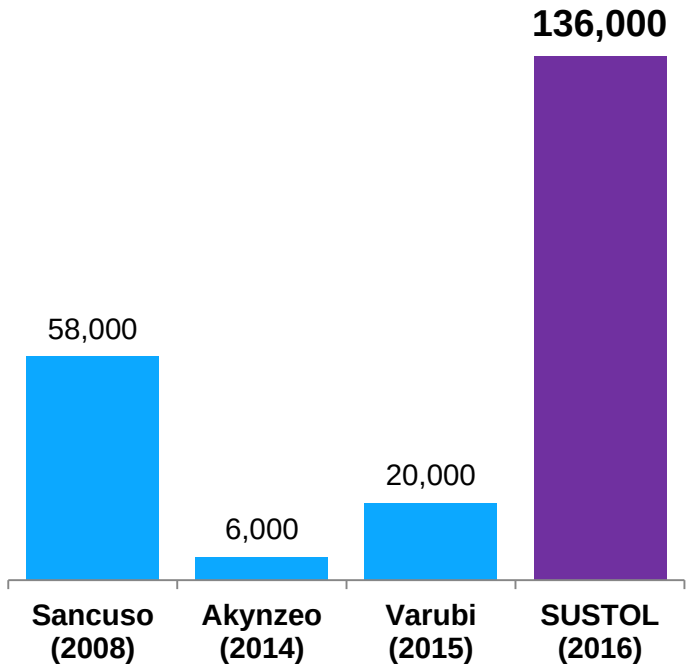
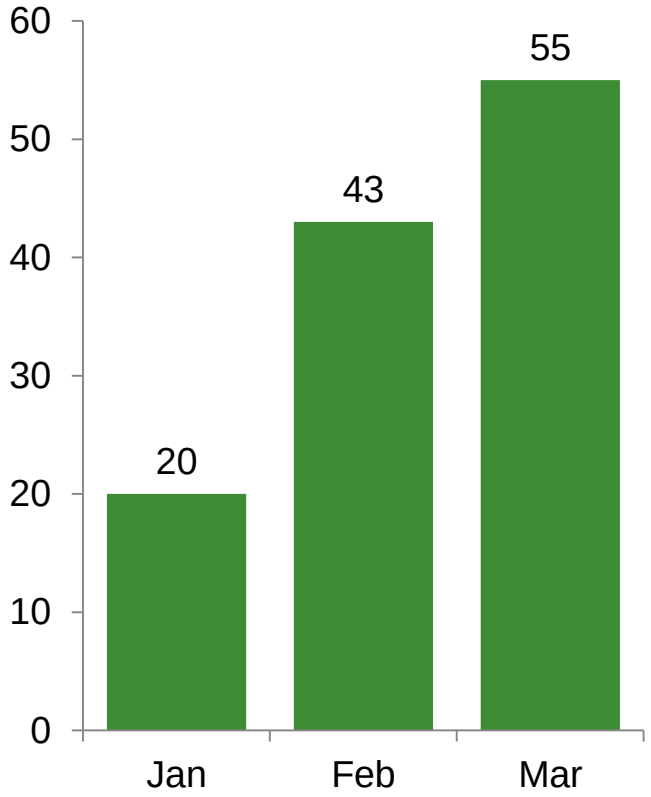
Heron's CINV Portfolio Continues to Outperform All Recent CINV Branded Launches

CINV Brand Launches Since 2008

Approximate administrations in First 18 Months (launch aligned)

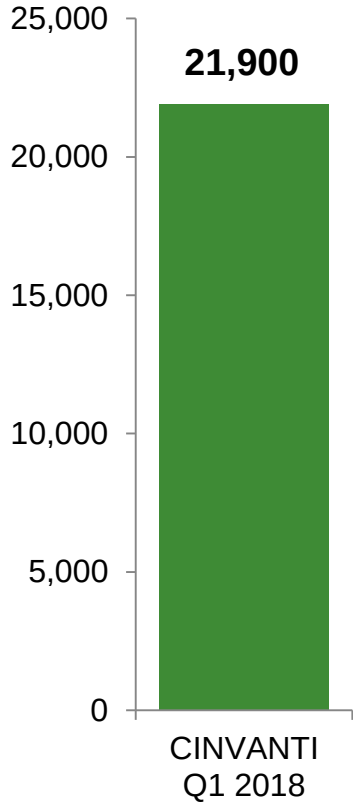


New CINVANTI Accounts By Month



Source: Heron 867 data

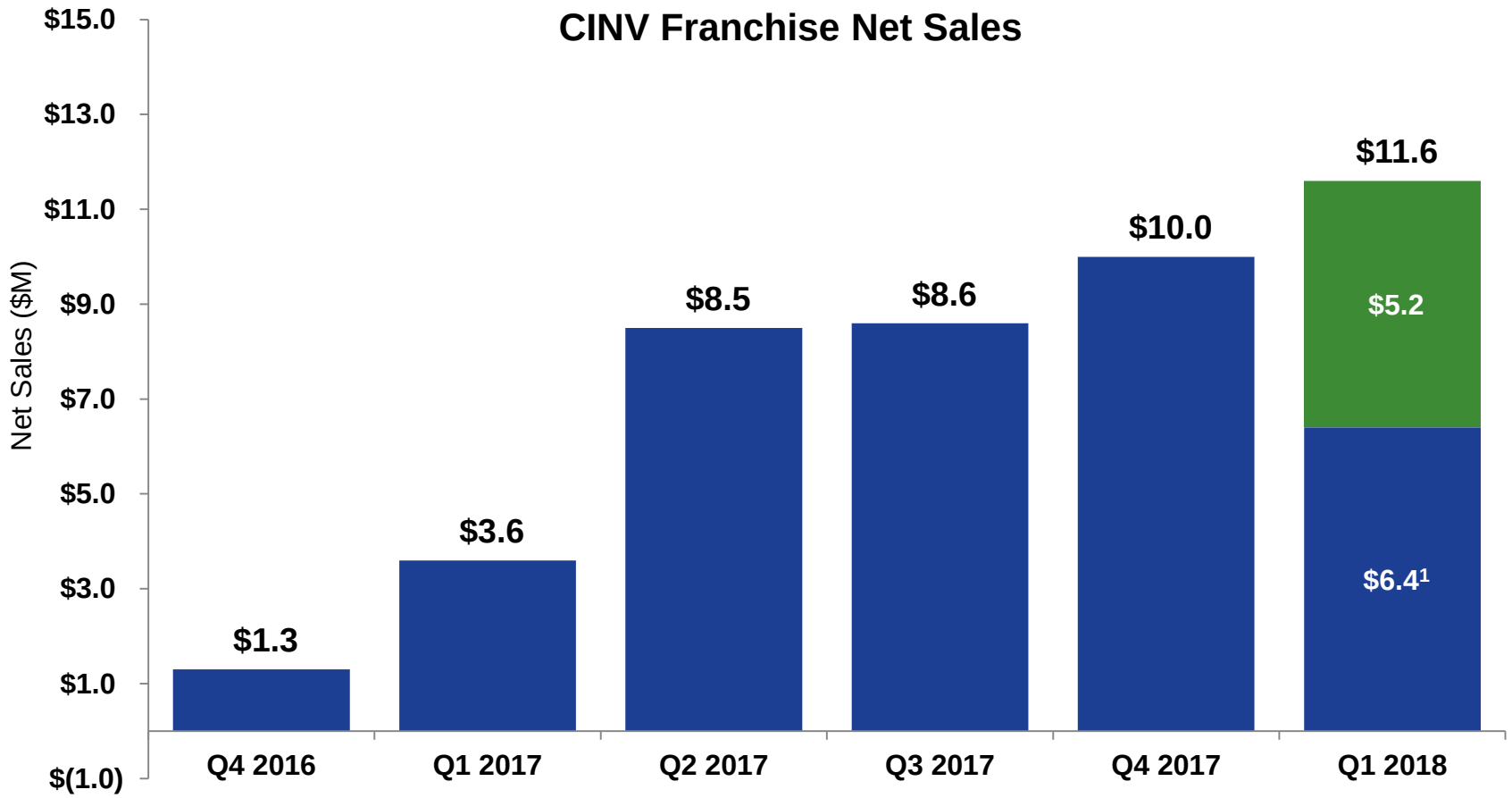
Q1 CINVANTI Provider Demand Units



Source: Heron 867 data

Sources: IMS DDD; Heron actuals (distributor 867 reports); due to data availability, Sancuso data includes actuals for launch months 3-12 and estimates for months 1-2; Varubi includes actuals for launch months 1-15 and estimates for months 16-18

Heron CINV Portfolio achieved $11.6M Q1 2018 Net Sales



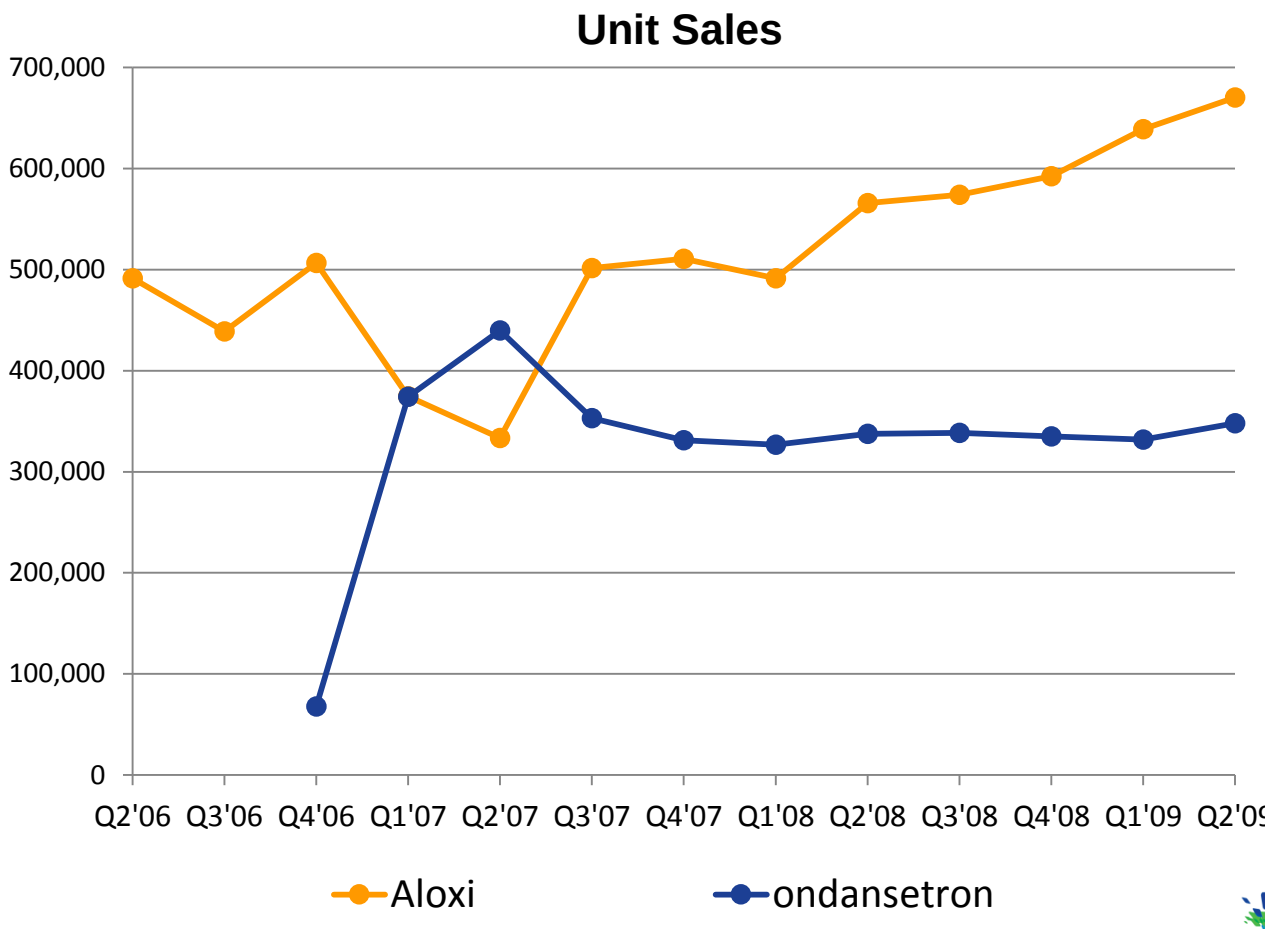
[1]If it were not for the fact that the Company adopted the required revenue recognition rules (Topic 606) on January 1, net sales would have been $7.7M

Source: Heron 867 data

Market Insights Suggest SUSTOL® Will Decline Through the Generic Arbitrage and Grow Thereafter – Consistent with Aloxi® Analogue

Recent Market Insights

- Practices that are converting to SUSTOL are likely to maintain use[1]
- **~67%** of current "dabblers" likely to stop or reduce use of SUSTOL during arbitrage[2]
- **~20%** of SUSTOL non-users would consider initiating SUSTOL during arbitrage[2]
  - *"If generic Aloxi is available, it's going to allow me to start using SUSTOL without having to worry about maintaining my Aloxi contract" – PM*
- **~55% of HCPs said they would be interested in using SUSTOL post-arbitrage (equating to an addressable market of ~650K units)[2]**
  - *"When ASP [erodes], we would switch all patients from generic Aloxi to SUSTOL." – PM*
  - *"SUSTOL usage would increase. There's no reason to keep people on generic Aloxi." – PM*



1 Customer discussions
2 Putnam Associates Qual Research Findings, June 2017

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Heron's CINV Portfolio is Positioned to Lead the CINV Market Well Into the Future

5-HT_3 pathway

	SUSTOL®	Palonosetron
Approved for acute and delayed MEC	**Yes**	Yes
Approved for acute and delayed AC-based HEC	**Yes**	No
Advanced ER polymer technology	**Yes**	No
Branded / contracted agent	**Yes**	No

NK_1 pathway

	CINVANTI®	EMEND® IV
Provides standard of care efficacy with Category 1 NCCN recommendation in HEC and MEC	**Yes**	Yes
Synthetic surfactant-free formulation (ie, no PS80)	**Yes**	No
Emulsion formulation requires no reconstitution	**Yes**	No
Can be stored at room temperature for 60 days	**Yes**	No

	Heron CINV Portfolio SUSTOL® & CINVANTI®		Akynzeo® IV (fosnetupitant + palonosetron)	
	HEC	**MEC**	**HEC**	**MEC**
5-HT_3 pathway	**Yes**[1]	**Yes**	Yes[2]	No
NK_1 pathway	**Yes**	**Yes**	Yes[2]	No
Clinical flexibility of single agents	**Yes**	**Yes**	No	No

[1] AC-based HEC regimens (~2/3 of HEC)

[2] Non AC-based HEC regimens (~1/3 of HEC)

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2018 CINV Franchise Outlook

CINV Franchise

- Reaffirm 2018 guidance of $60M–$70M net sales for the CINV franchise
- Despite the near-term challenge of generic palonosetron, recent market dynamics create long-term opportunities for Heron's CINV franchise
  - Entry of 7 generic versions of palonosetron likely to drive more rapid / shorter arbitrage
  - Suspension of distribution of Varubi IV due to AEs
  - Akynzeo IV approved with restricted indication (non-AC HEC)

SUSTOL®

- Will likely experience temporary decline during arbitrage period – consistent with Aloxi® analogue
- SUSTOL expected to experience growth post-arbitrage when it is likely to be only single-agent, branded / contracted 5-HT_3 on the market

CINVANTI®

- Launch is off to a strong start with Q1 results reflecting solid provider demand
- Heron believes that in oncology supportive care, CINVANTI's synthetic surfactant-free formulation offers the best overall clinical profile of any NK_1

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Financial Summary

As of March 31, 2018, pro-forma cash, cash equivalents and short-term investments, adjusting for the April 2018 public offering, were $282.6 million.

Summary Statement of Operations and Net Cash Used in Operations (In thousands, except per share data)	Three Months Ended March 31, 2018
Net product sales	$ 11,567
Operating expenses[1]	63,557
Other expenses, net	(275)
Net loss[1]	$ (52,265)
Net loss per share[2]	$ (0.81)
Net cash used in operations	$(61,713)

Condensed Balance Sheet Data (In thousands)	March 31, 2018
Cash, cash equivalents and short-term investments	$ 113,938
Accounts receivable, net	$ 37,713
Total assets	$ 183,383
Promissory note payable	$ 25,000
Total stockholders' equity	$ 92,206

Common shares outstanding at March 31, 2018 totaled 65.0 million.

[1] Includes $7.7 million of non-cash, stock-based compensation expense for the three months ended March 31, 2018.
[2] Based on 64.7 million weighted-average common shares outstanding for the three months ended March 31, 2018.

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Key Catalysts in Pain Management & CINV Franchises

HTX-011 for Postoperative Pain	CINVANTI ® and SUSTOL® for CINV
✓ Fast Track designation granted	2018 net sales guidance for CINV franchise: $60M - $70M
✓ Completed enrollment in Phase 3 pivotal trials	
✓ Top-line Pivotal Phase 3 results 1H 2018	
Topline results from breast augmentation and TKA studies late 1H 2018	
NDA filing 2H 2018	

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