Investor science conference call: American Society of Clinical Oncology Genitourinary (ASCO GU) Cancers Symposium 2022

Conference call for investors and analysts

23 February 2022

Forward-looking statements

In order, among other things, to utilise the 'safe harbour' provisions of the US Private Securities Litigation Reform Act of 1995, AstraZeneca (hereafter ‘the Group’) provides the following cautionary statement: this document contains certain forward-looking statements with respect to the operations, performance and financial condition of the Group, including, among other things, statements about expected revenues, margins, earnings per share or other financial or other measures. Although the Group believes its expectations are based on reasonable assumptions, any forward-looking statements, by their very nature, involve risks and uncertainties and may be influenced by factors that could cause actual outcomes and results to be materially different from those predicted. The forward-looking statements reflect knowledge and information available at the date of preparation of this document and the Group undertakes no obligation to update these forward-looking statements. The Group identifies the forward-looking statements by using the words 'anticipates', 'believes', 'expects', 'intends' and similar expressions in such statements. Important factors that could cause actual results to differ materially from those contained in forward-looking statements, certain of which are beyond the Group’s control, include, among other things: the risk of failure or delay in delivery of pipeline or launch of new medicines; the risk of failure to meet regulatory or ethical requirements for medicine development or approval; the risk of failure to obtain, defend and enforce effective IP protection and IP challenges by third parties; the impact of competitive pressures including expiry or loss of IP rights, and generic competition; the impact of price controls and reductions; the impact of economic, regulatory and political pressures; the impact of uncertainty and volatility in relation to the UK’s exit from the EU; the risk of failures or delays in the quality or execution of the Group’s commercial strategies; the risk of failure to maintain supply of compliant, quality medicines; the risk of illegal trade in the Group’s medicines; the impact of reliance on third-party goods and services; the risk of failure in information technology, data protection or cybercrime; the risk of failure of critical processes; any expected gains from productivity initiatives are uncertain; the risk of failure to attract, develop, engage and retain a diverse, talented and capable workforce; the risk of failure to adhere to applicable laws, rules and regulations; the risk of the safety and efficacy of marketed medicines being questioned; the risk of adverse outcome of litigation and/or governmental investigations; the risk of failure to adhere to increasingly stringent anti-bribery and anti-corruption legislation; the risk of failure to achieve strategic plans or meet targets or expectations; the risk of failure in financial control or the occurrence of fraud; the risk of unexpected deterioration in the Group’s financial position; and the impact that the COVID-19 global pandemic may have or continue to have on these risks, on the Group’s ability to continue to mitigate these risks, and on the Group’s operations, financial results or financial condition. Nothing in this document, or any related presentation/webcast, should be construed as a profit forecast.

Speakers

Dr Fred Saad

Principal Investigator PROpel, Professor and Chief of Urology, University of Montreal Hospital Centre, Canada

Dave Fredrickson

Executive Vice President, Oncology Business Unit

Andy Barnett

Global Franchise Head, GU and GYN Cancers, DDR and Established Oncology (for Q&A)

Susan Galbraith

Executive Vice President, Oncology R&D

Sunil Verma

Senior Vice President, Global Head of Oncology, Medical (for Q&A)

Agenda

1. Introduction: AstraZeneca @ ASCO GU 2022
2. *Lynparza* Phase III PROpel trial
3. Opportunity and unmet need in mCRPC
4. Other ASCO GU highlights
5. Closing and Q&A

1

Introduction

Susan Galbraith

Executive Vice President,
Oncology R&D

Comprehensive portfolio to combat cancer

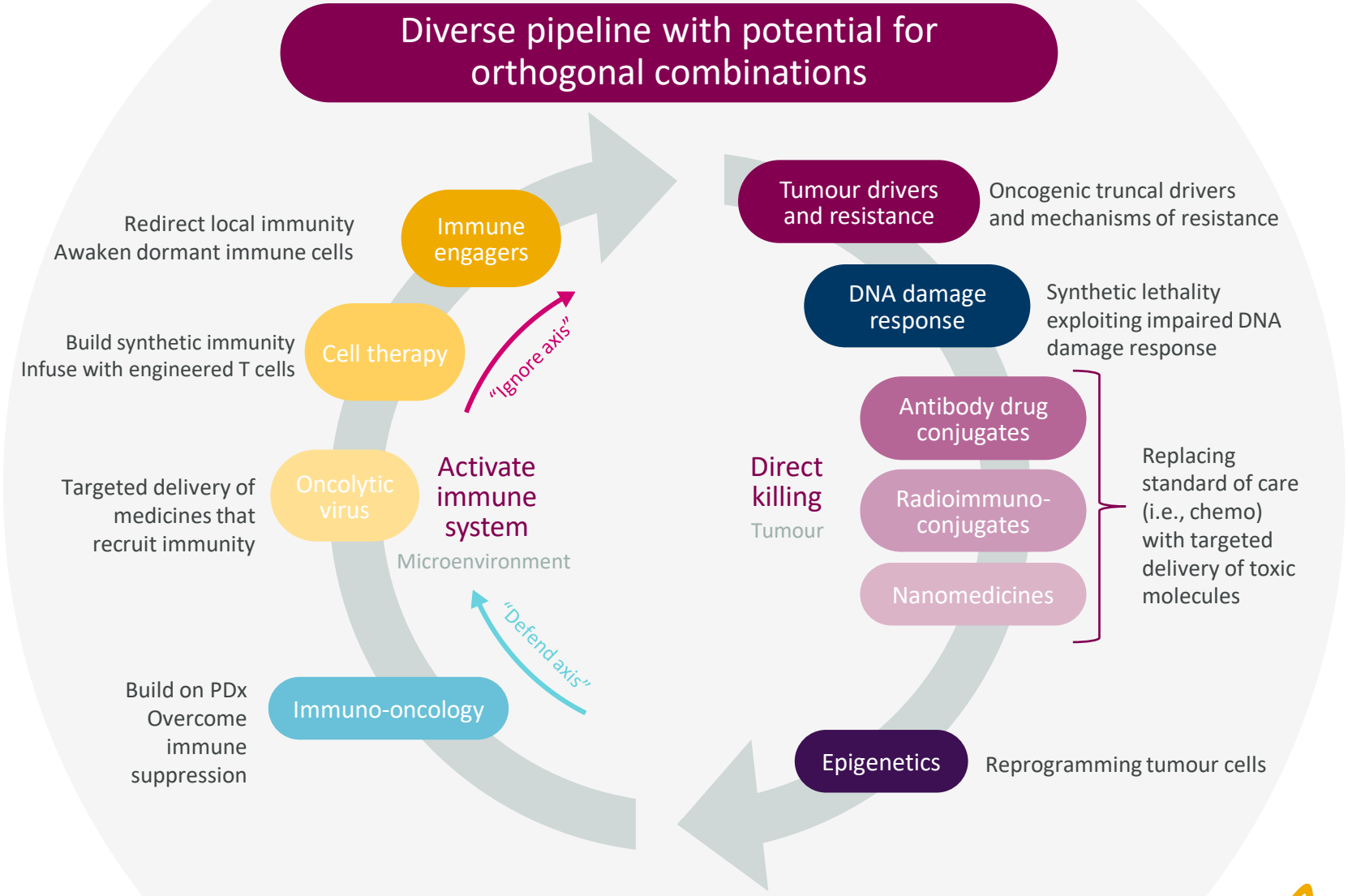
ENHERTU®
fam-trastuzumab deruxtecan-nxki
20 mg/mL INJECTION FOR INTRAVENOUS USE

IMFINZI®
durvalumab
Injection for Intravenous Use 50 mg/mL

Lynparza™
olaparib

TAGRISSO®
osimertinib

CALQUENCE®
(acalabrutinib) 100 mg capsules



Source: AstraZeneca.

ASCO GU 2022

ASCO® Genitourinary Cancers Symposium

19 abstracts with three oral presentations

- **Two** Oral presentations
- **One** Mini-oral presentation
- **16** Posters
- **19** Abstracts accepted

Data highlights

- ***Lynparza* + abiraterone in 1st-line mCRPC**
  PROpel Phase III trial
- ***Lynparza* + *Imfinzi* in 1st-line urothelial carcinoma**
  BAYOU Phase II trial
- ***Enhertu* + nivolumab in HER2+ urothelial carcinoma**
  U105 Phase Ib trial

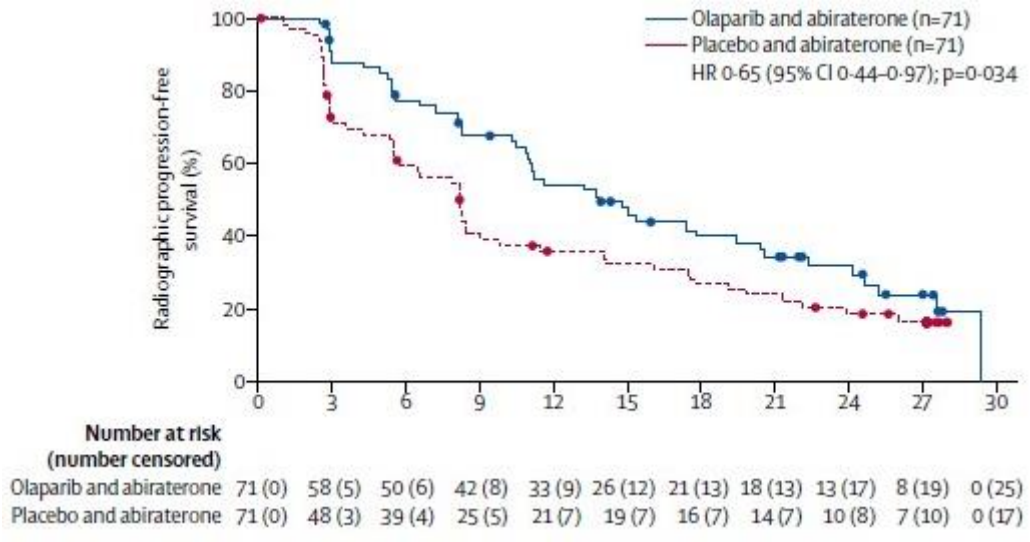
Source: ASCO GU 2022 accepted abstracts. Inclusive of externally sponsored research and partner-led trials. mCRPC = metastatic castration resistant prostate cancer; HER2+ = human epidermal receptor 2 positive.

Lynparza and abiraterone

Success in Study 08 paved the way for PROpel in 1st-line mCRPC

Study 08[1]

Phase II trial



35% risk reduction
Significant rPFS benefit regardless of HRRm status

PARP-signaling and AR-signaling pathway interaction

may explain combined effect

***Lynparza* + abiraterone[2-4]**

PARP involved in androgen-receptor–dependent transcription; **PARP inhibition may increase activity of NHAs[2]**

NHA-induced HRR deficiency **increasing susceptibility to PARP inhibition[3,4]**

Combined effect

Antitumour activity in HRRm and non-HRRm prostate cancer[2-4]

1. Saad et al *Lancet Oncol 2018; 19: 975–86* 2. Schiewer MJ, et al. *Cancer Discov.* 2012;2:1134-1149 3. Polkinghorn WR, et al. *Cancer Discov*. 2013;3:1245-12534. Asim M, et al. *Nat Commun.* 2017;8(1):374.

rPFS = radiographic progression free survival; HRR = homologous recombination repair; HRRm = HRR gene mutation; PARP = poly adenosine diphosphate-ribose polymerase; AR = androgen receptor; NHA = new hormonal agents.

2

Lynparza PROpel

Dr Fred Saad

Principal Investigator,
PROpel Phase III trial

PROpel

A global randomised double-blind Phase III trial

Patient population

- 1L mCRPC
- Docetaxel allowed at mHSPC stage
- No prior abiraterone
- Other NHAs allowed if stopped ≥12 months prior to enrollment
- Ongoing ADT
- ECOG 0–1

Stratification factors

- Site of distant metastases: bone only vs visceral vs other
- Prior taxane at mHSPC: yes vs no

1:1

Olaparib 300 mg bid + abiraterone 1000 mg qd*
n=399

Full dose of olaparib and abiraterone used

Placebo + abiraterone 1000 mg qd*
n=397

Full dose of abiraterone used

Primary endpoint

- Radiographic progression or death (rPFS) by investigator assessment

Key secondary endpoint

- Overall survival (alpha control)

Additional endpoints

- Time to first subsequent therapy or death (TFST)
- Time to second progression or death (PFS2)
- Objective response rate (ORR)
- HRRm† prevalence (retrospective testing)
- Health-related quality of life
- Safety and tolerability

First patient randomized: Nov 2018; Last patient randomized: Mar 2020; DCO1: July 30, 2021, for interim analysis of rPFS and OS.

Multiple testing procedure is used in this study: 1-sided alpha of 0.025 fully allocated to rPFS. If the rPFS result is statistically significant, OS to be tested in a hierarchical fashion with alpha passed on to OS.
†Please access the Supplement at https://bit.ly/3r50msO for more details.

*In combination with prednisone or prednisolone 5 mg bid. †HRRm, homologous recombination repair mutation, including 14 genes panel.
ADT = androgen deprivation therapy; bid = twice daily; ECOG = Eastern Cooperative Oncology Group; mHSPC = metastatic hormone sensitive prostate cancer.

Baseline patient characteristics

Well-balanced between treatment arms

	Olaparib + abiraterone (n=399)	Placebo + abiraterone (n=397)
Median (range) age, years	69.0 (43–91)	70.0 (46–88)
ECOG performance status, n (%)		
0	286 (71.7)	272 (68.5)
1	112 (28.1)	124 (31.2)
Symptomatic,* n (%)	103 (25.8)	80 (20.2)
Site of metastases, n (%)		
Bone	349 (87.5)	339 (85.4)
Distant lymph nodes	133 (33.3)	119 (30.0)
Locoregional lymph nodes	82 (20.6)	89 (22.4)
Lung	40 (10.0)	42 (10.6)
Liver	15 (3.8)	18 (4.5)
Docetaxel treatment at mHSPC stage, n (%)	90 (22.6)	89 (22.4)
Median PSA, ug/L (IQR)	17.90 (6.09–67.00)	16.81 (6.26–53.30)
HRRm status†		
HRRm	111 (27.8)	115 (29.0)
Non-HRRm	279 (69.9)	273 (68.8)
HRRm unknown	9 (2.3)	9 (2.3)

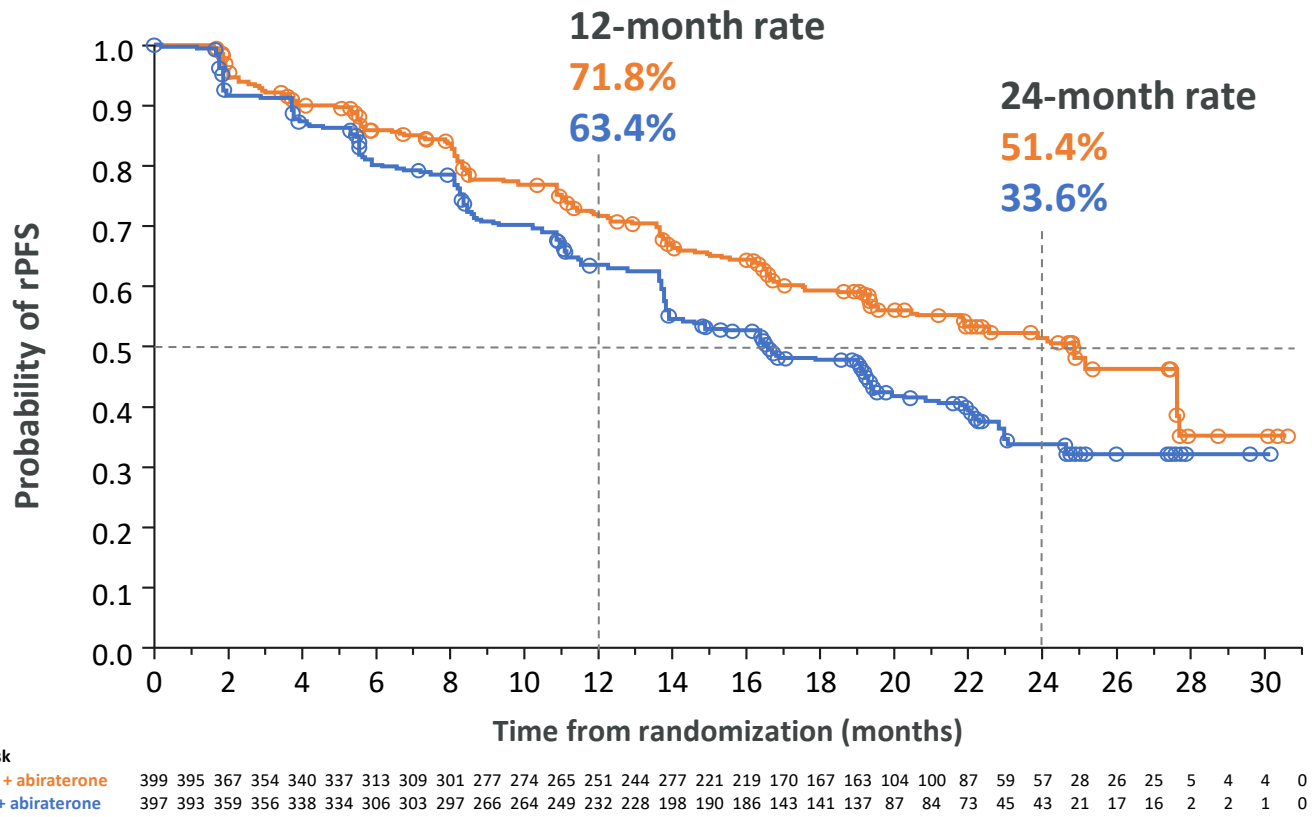
*Patients with symptomatic pain at baseline: BPI-SF item #3 score ≥4 and/or opiate use at baseline.

†The HRRm status of patients in PROpel was determined retrospectively using results from tumor tissue and plasma ctDNA HRRm tests. Patients were classified as HRRm if (one or more) HRR gene mutation was detected by either test; patients were classified as non-HRRm if no HRR gene mutation was detected by either test; patients were classified as unknown HRRm if no valid HRR test result from either test was achieved. Please access the Supplement via the QR code at the end of this presentation for more details.

BPI-SF = Brief Pain Inventory – Short Form; ctDNA = circulating tumor DNA; IQR = interquartile range; PSA = prostate-specific antigen.

Primary endpoint: rPFS by investigator-assessment

34% risk reduction of progression or death with olaparib + abiraterone



	Olaparib + abiraterone (n=399)	Placebo + abiraterone (n=397)
Events, n (%)	168 (42.1)	226 (56.9)
Median rPFS (months)	24.8	16.6
HR (95% CI)	0.66 (0.54–0.81); *P*<0.0001	

Pre-specified 2-sided alpha: 0.0324

Median rPFS improvement of 8.2 months favors olaparib + abiraterone*

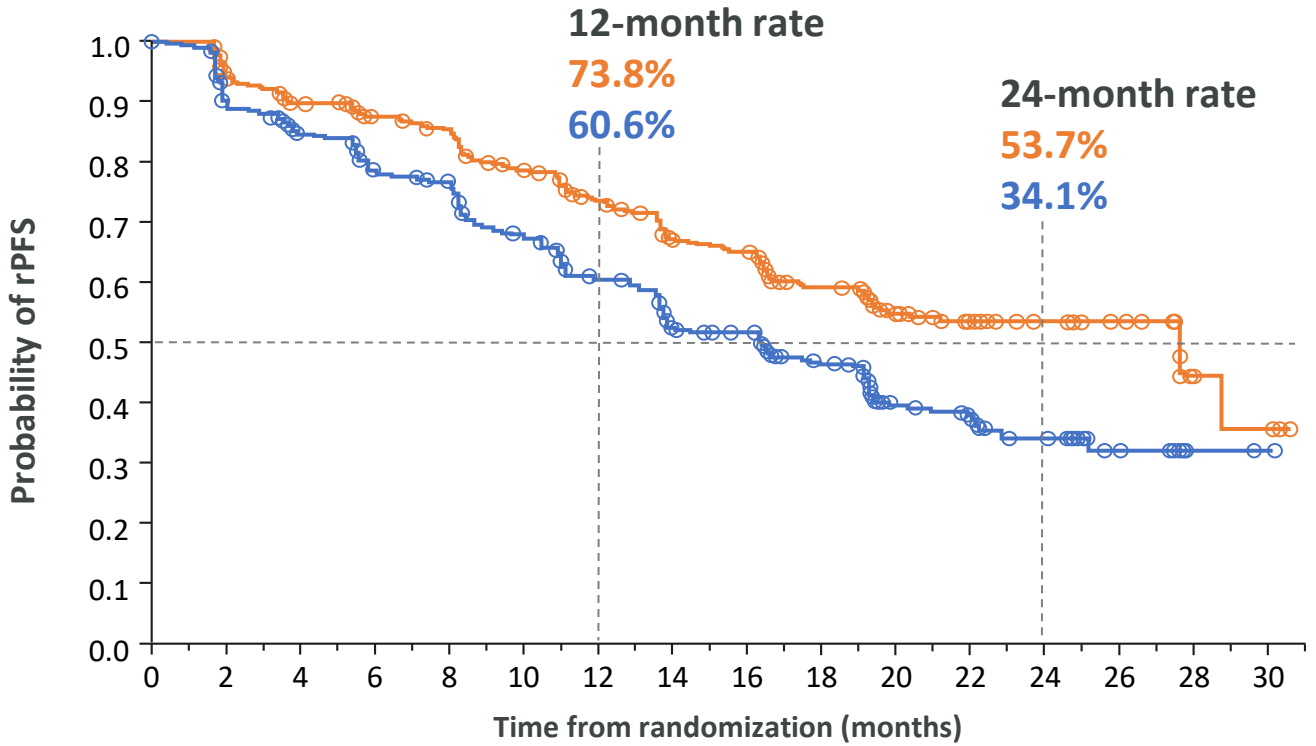
Events: 394; Maturity 49.5%

*In combination with prednisone or prednisolone

CI = confidence interval; HR = hazard ratio.

Secondary endpoint: rPFS by blinded independent central review*

39% risk reduction of progression or death, highly consistent with the primary analysis



	Olaparib + abiraterone (n=399)	Placebo + abiraterone (n=397)
Events, n (%)	157 (39.3)	218 (54.9)
Median rPFS (months)	27.6	16.4
HR (95% CI)	0.61 (0.49–0.74) *P*<0.0001†	

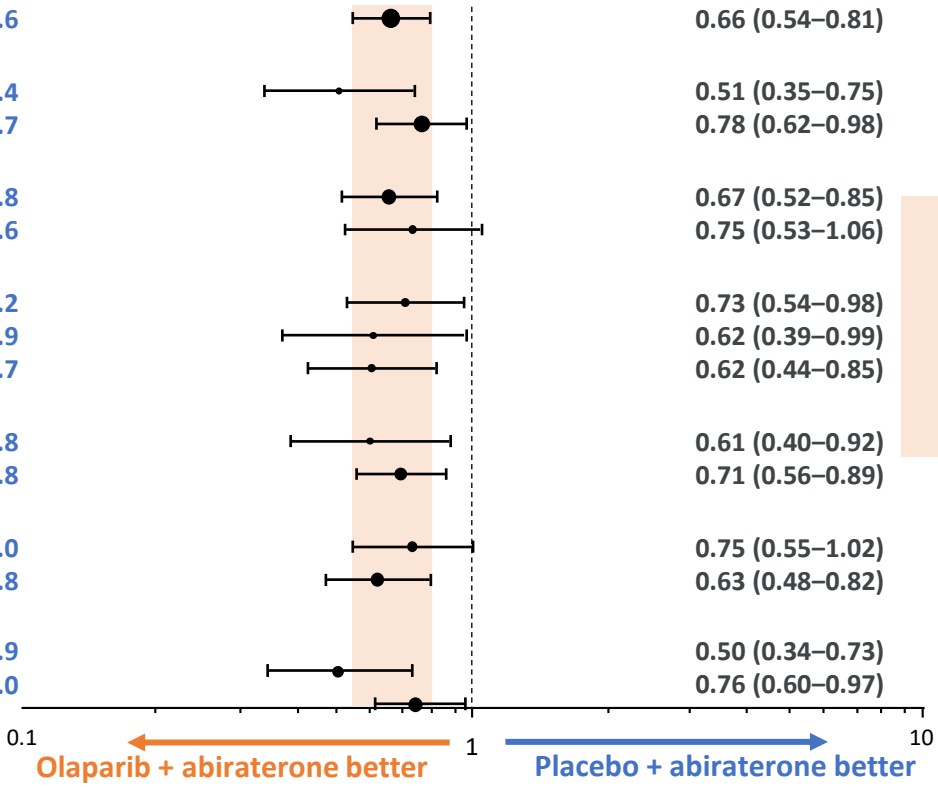
Median rPFS improvement of 11.2 months favors olaparib + abiraterone‡

*Predefined sensitivity analysis. †Nominal. ‡In combination with prednisone or prednisolone.

Subgroup analysis of rPFS

rPFS benefit observed across all pre-specified subgroups

	Number of patients, n	Median rPFS, months		HR (95% CI)
All patients	796	24.8	16.6	0.66 (0.54–0.81)
Age at randomization				
<65	227	NR	16.4	0.51 (0.35–0.75)
≥65	569	22.0	16.7	0.78 (0.62–0.98)
ECOG performance status at baseline				
0	558	24.9	16.8	0.67 (0.52–0.85)
1	236	17.5	14.6	0.75 (0.53–1.06)
Site of distant metastases				
Bone only	434	27.6	22.2	0.73 (0.54–0.98)
Visceral	105	13.7	10.9	0.62 (0.39–0.99)
Other	257	20.5	13.7	0.62 (0.44–0.85)
Docetaxel treatment at mHSPC stage				
Yes	189	27.6	13.8	0.61 (0.40–0.92)
No	607	24.8	16.8	0.71 (0.56–0.89)
Baseline PSA				
Below median baseline PSA	396	25.2	22.0	0.75 (0.55–1.02)
Above or equal to median baseline PSA	397	18.5	13.8	0.63 (0.48–0.82)
HRRm status*				
HRRm	226	NR	13.9	0.50 (0.34–0.73)
Non-HRRm	570	24.1	19.0	0.76 (0.60–0.97)

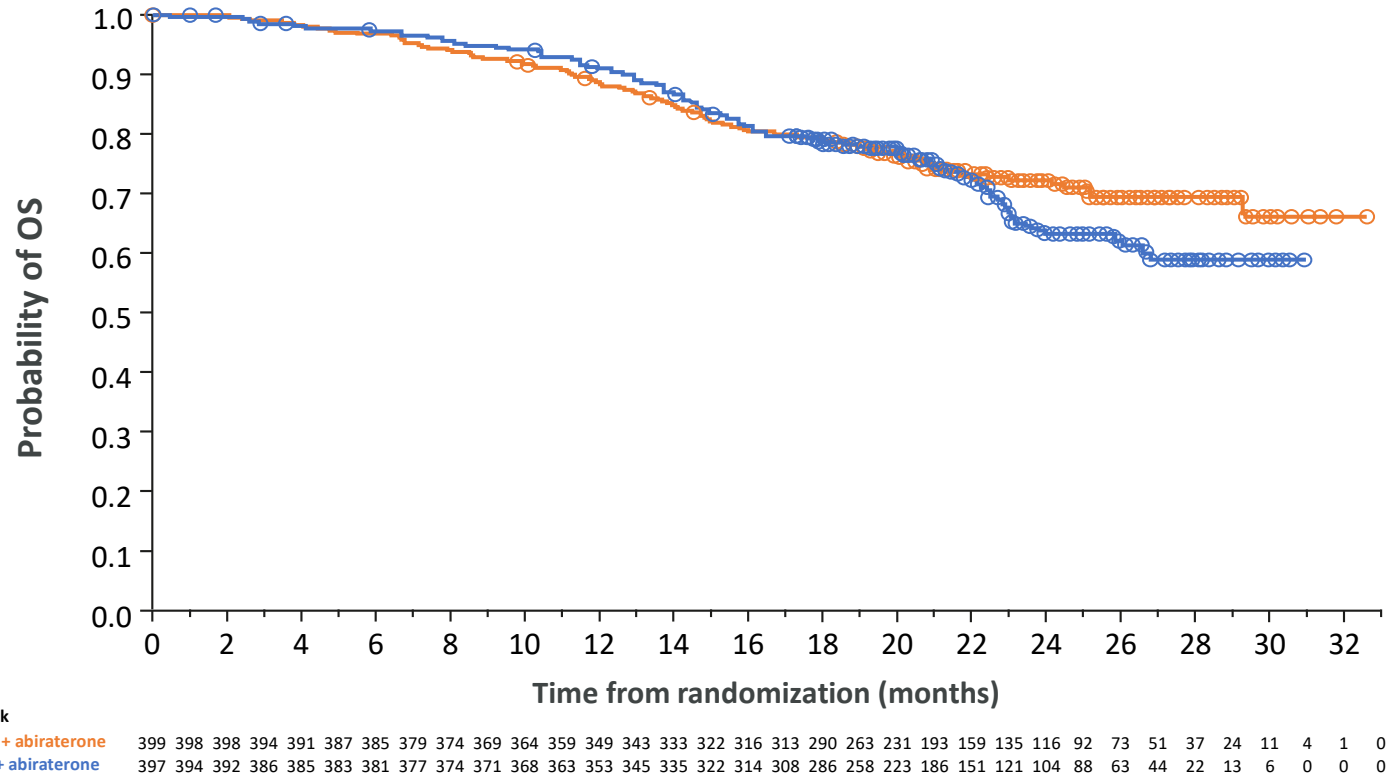


Global interaction test not significant

Global interaction test not significant at 10% level. *The HRRm status of patients in PROpel was determined retrospectively using results from tumor tissue and plasma ctDNA HRRm tests. Patients were classified as HRRm if (one or more) HRR gene mutation was detected by either test; patients were classified as non-HRRm patients if no HRR gene mutation was detected by either test; patients were classified as unknown HRRm if no valid HRR test result from either test was achieved. 18 patients did not have a valid HRR testing result from either a tumor tissue or ctDNA test and were excluded from the subgroup analysis. This subgroup analysis is post hoc exploratory analysis. Please access the Supplement via the QR code at the end of this presentation for more details. NR = not reached.

Secondary endpoint: overall survival

28.6% maturity; trend towards improved OS with olaparib + abiraterone



	Olaparib + abiraterone (n=399)	Placebo + abiraterone (n=397)
Events, n (%)	107 (26.8)	121 (30.5)
Median OS (months)	NR	NR
HR (95% CI)	0.86 (0.66–1.12) *P*=0.29	

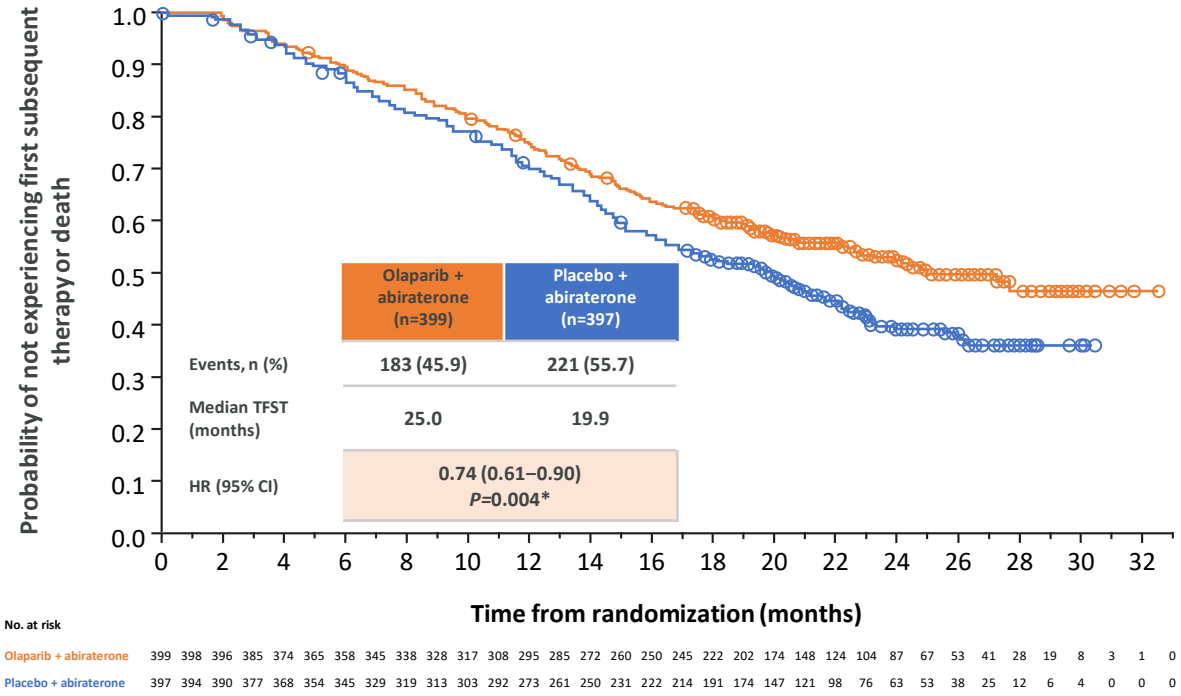
Pre-specified 2-sided alpha: 0.001

Events: 228.

Secondary endpoints: TFST and PFS2

TFST and PFS2 results support longer-term benefit with olaparib + abiraterone

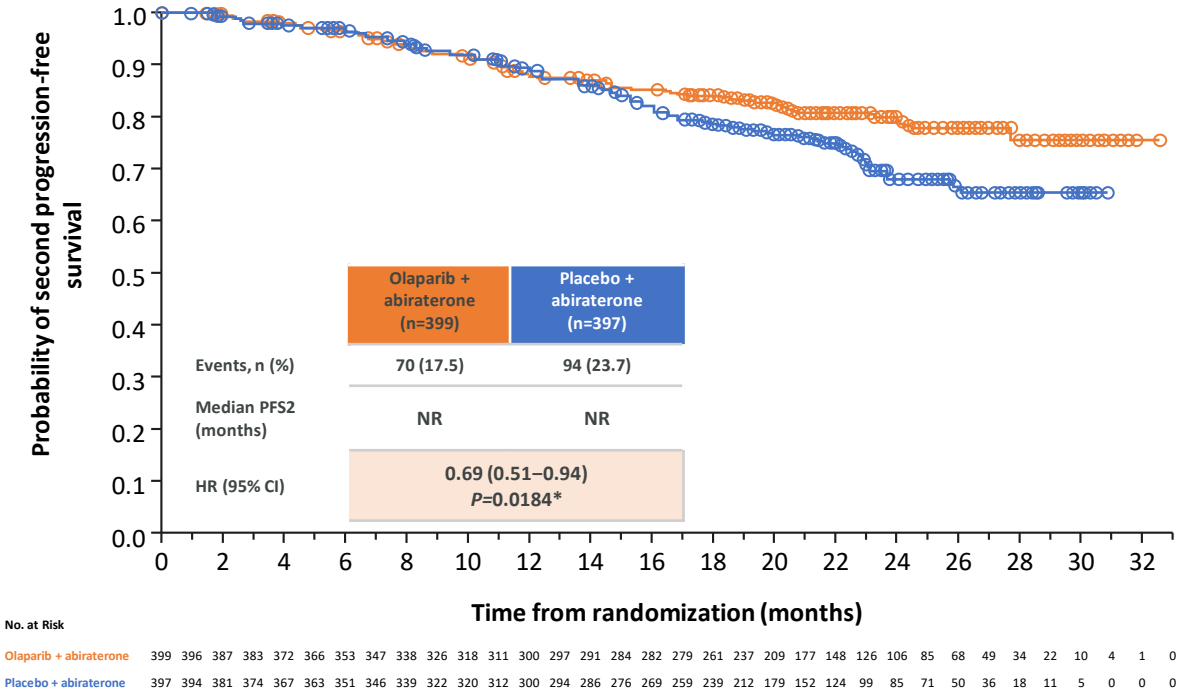
Time to first subsequent therapy or death (TFST)



No. at risk

Olaparib + abiraterone	399	398	396	385	374	365	358	345	338	328	317	308	295	285	272	260	250	245	222	202	174	148	124	104	87	67	53	41	28	19	8	3	1	0
Placebo + abiraterone	397	394	390	377	368	354	345	329	319	313	303	292	273	261	250	231	222	214	191	174	147	121	98	76	63	53	38	25	12	6	4	0	0	0

Time to second progression or death (PFS2)



No. at Risk

Olaparib + abiraterone	399	396	387	383	372	366	353	347	338	326	318	311	300	297	291	284	282	279	261	237	209	177	148	126	106	85	68	49	34	22	10	4	1	0
Placebo + abiraterone	397	394	381	374	367	363	351	346	339	322	320	312	300	294	286	276	269	259	239	212	179	152	124	99	85	71	50	36	18	11	5	0	0	0

*Nominal.

Overall safety profile

A relatively small increase in discontinuations for olaparib vs placebo, discontinuation with abiraterone was similar between treatment arms

n (%)	Olaparib + abiraterone (n=399)	Placebo + abiraterone (n=397)
Any AE	387 (97.2)	376 (94.9)
Any AE CTCAE Grade ≥3	188 (47.2)	152 (38.4)
Death due to an AE	**16 (4.0)**	**17 (4.3)**
Any AE leading to:		
Dose interruption of **olaparib/placebo**	178 (44.7)	100 (25.3)
Dose reduction of **olaparib/placebo**	80 (20.1)	22 (5.6)
Discontinuation of olaparib/placebo	**55 (13.8)**	**31 (7.8)**
Discontinuation of abiraterone	**34 (8.5)**	**35 (8.8)**

AEs of special interest for olaparib

- No MDS/AML reported
- Incidence of new primary malignancies and pneumonitis were balanced between treatment arms

AE = adverse event; AML = acute myeloid leukemia; CTCAE = Common Terminology Criteria for Adverse Events v4.03; MDS = myelodysplastic syndrome.

Cardiac and thromboembolic adverse events

Cardiac failure and arterial thromboembolic events were balanced between the two arms

Numerically higher venous thromboembolic events were reported for olaparib + abiraterone

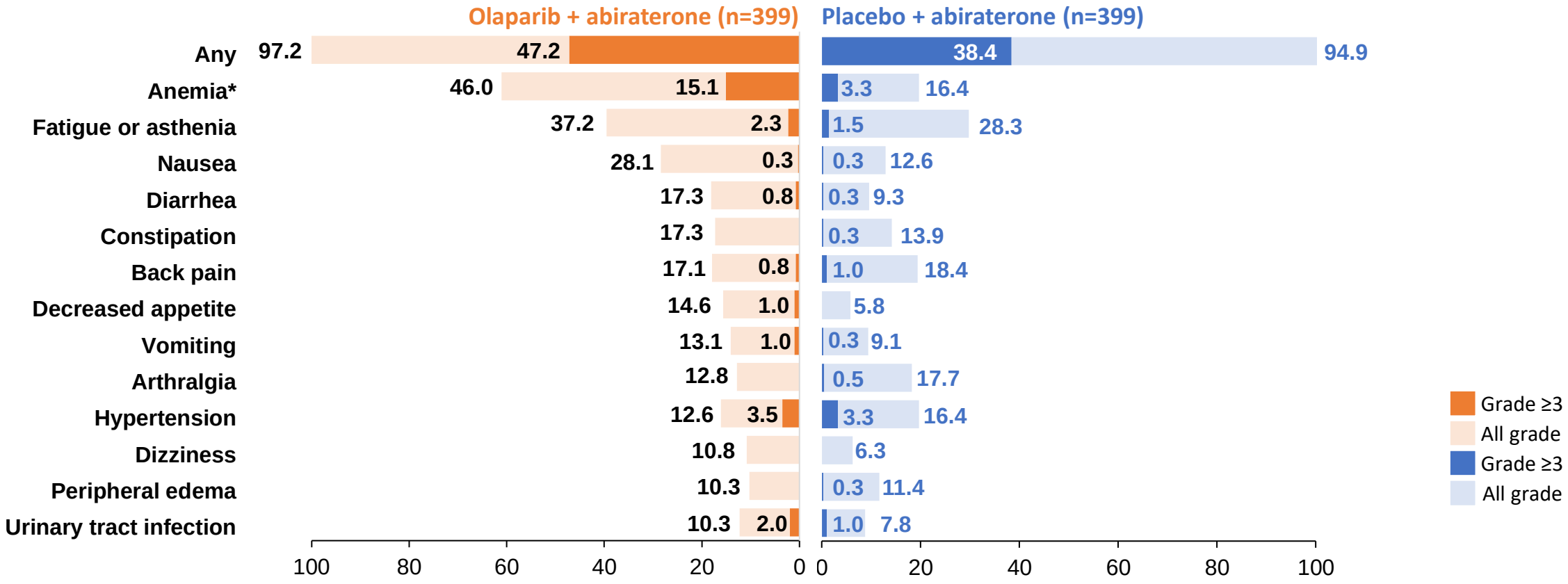
- Pulmonary embolism was the most commonly reported venous thromboembolic event
- Pulmonary embolism events were mostly incidental findings by CT scans and did not lead to discontinuation of olaparib or abiraterone

n (%)	Olaparib + abiraterone (n=399)	Placebo + abiraterone (n=397)
Cardiac failure SMQ	6 (1.5)	5 (1.3)
Embolic and thrombotic events, arterial SMQ	8 (2.0)	10 (2.5)
Embolic and thrombotic events, venous SMQ	29 (7.3)	13 (3.3)
Pulmonary embolism	26 (6.5)	7 (1.8)

CT = computerised tomography; SMQ = Standardised MedDRA Query.

Most common adverse events

AE profile was consistent with the known toxicity profiles for the individual drugs



Safety was assessed through the reporting of AEs according to the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE v4.03) and laboratory assessments.

*Anemia category includes anemia, decreased hemoglobin level, decreased red-cell count, decreased hematocrit level, erythropenia, macrocytic anemia, normochromic anemia, normochromic normocytic anemia, and normocytic anemia.

Conclusions

Olaparib + abiraterone led to a **significant and clinically meaningful improvement in rPFS (HR 0.66 [95% CI 0.54–0.81])** over placebo + abiraterone in 1L mCRPC

- Benefit observed led to a **median rPFS beyond 2 years**
- Benefit was observed **irrespective of HRRm status**

Secondary and exploratory endpoints support the treatment benefit of olaparib + abiraterone over placebo + abiraterone in the overall patient population

The safety profile of olaparib + abiraterone was **consistent with the safety profile for the individual drugs** and there was **no detriment to quality of life** allowing most patients to stay on therapy

The Phase III PROpel study is the first combination approach to deliver consistent **clinical benefits for patients in the 1L mCRPC setting, irrespective of HRRm status**

3

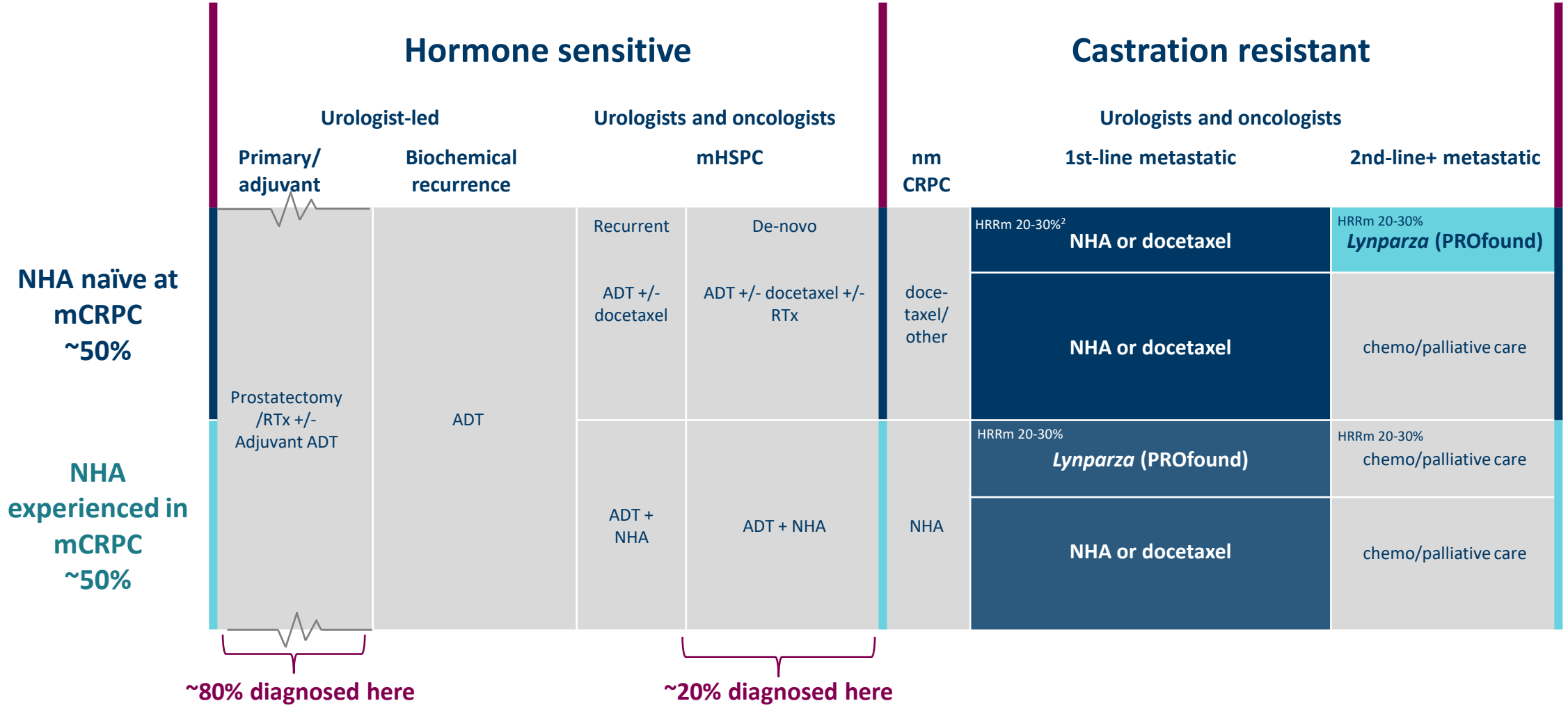
Opportunity and unmet need in mCRPC

Dave Fredrickson

Executive Vice President,
Oncology Business Unit

Prostate is the second most common cancer in male patients

mCRPC therapies are limited; mostly monotherapy, including in first line



Source: AstraZeneca estimates. Indicative populations. Not to scale 1. Rawla P. *World J Oncol*. 2019; 10(2):63-89. 2. Mateo, J, et al. *New England Journal of Medicine*, 2015, 373(18), pp.1697 - 1708.

ADT = androgen deprivation therapy; RTx = radiation therapy; nmCRPC = non-metastatic castration resistant prostate cancer

PROpel - unprecedented clinical benefit without compromising quality of life - a potential new SoC in mCRPC

Outcomes remain poor

in advanced prostate cancer

40%

of patients with prostate cancer will develop metastatic disease[1-3]

30%

the 5-year survival rate for patients with metastatic disease[4]

3 years

median OS for mCRPC patients in the first-line setting[5-9]

50%

of patients receive only one line of active therapy in mCRPC[10]

PROpel

building on the success of PROfound

- Representative **real-world** population - **simple** trial design
- **All-comers** ITT population
- Retrospective **HRR testing** via tissue and ctDNA testing[11]
- Primary endpoint: **radiographic progression free survival**
- Key secondary endpoints: **Overall survival, time to first subsequent therapy, time to second progression or death**

300 mg Lynparza™ olaparib + abiraterone

a potential new standard of care

- **Clinically meaningful and consistent efficacy** across subgroups
- Despite OS immaturity, **strong secondary endpoint results** provide confidence
- **Class-leading tolerability** - full 300mg *Lynparza* dose in combination with abiraterone
- **Quality of life maintained**, allowing adoption of upfront combination therapy

8.2-month median rPFS benefit over abiraterone alone

1. Beltran H, Beer TM, Carducci MA, et al. *Eur Urol*. 2011;60(2):279-290. 2. Sciarra A, Salciccia S. *Eur Urol.* 2014;65(5):905-906. 3. Sartor O, de Bono JS. *N Engl J Med.* 2018;378(7):645-657. 4. Cancer of the Prostate - *Cancer Stat Facts. SEER*. Accessed November 6, 2019. 5. Kelly WK et al. *J Clin Oncol.* 2012;30:1534–40. 6. Quinn DI et al. *Lancet Oncol.* 2013;14:893–900. 7. Araujo JC et al. *Lancet Oncol*. 2013;14:1307–16. 8. Ryan CJ et al. *N Engl J Med.* 2013;368:138–48. 9. Beer TM et al. *N Engl J Med*. 2014;371:424–33. 10. Shore ND et al. *Adv Ther.* 2021;38:4520–40. 11. Tumour tissue and blood samples were collected at baseline for biomarker tests. HRRm status was determined using a tumour tissue test (FoundationOne®CDX) and/or a circulating tumour (ctDNA) based test (FoundationOne®Liquid CDx test).

OS = overall survival; ITT = intent-to-treat.

After almost a decade, the addition of *Lynparza* achieves a similar absolute rPFS improvement compared to the pivotal trial that established abiraterone as first-line SoC

	COU-AA-302[1] (2012)			PROpel (2022)		
	control	abiraterone	Dif.	abi	*Lynparza* + abiraterone	Dif.
Median rPFS	8.2m	16.4m	**8.2m**	16.6m	24.8m	**8.2m**

PROpel median rPFS	abiraterone	*Lynparza* + abiraterone	HR
Investigator assessment	16.6m	24.8m	0.66 (0.54-0.81)
HRRm	13.9m	NR	0.50 (0.34-0.73)
Non-HRRm	19.0m	24.1m	0.76 (0.60-0.97)
BICR	16.4m	27.6m	0.61 (0.49-0.74)

1. Mulders et al. *N Engl J Med* 2013; 368:138-148. Dif. = difference; NR = not reached; HR = hazard ratio.

PROpel: a new treatment approach in 1st-line mCRPC

1st-line metastatic castration-resistant prostate cancer (mCRPC) - US patients

NHA naïve ~50%		Prior NHA use ~50%	
Other (~25%)	Receiving NHA (~75%)	Receiving NHA (~55%)	Other (~45%)
HRRm 20-30%			

Overall, ~65% of 1st-line mCRPC patients receive an NHA today

***Lynparza* + abiraterone (PROpel)[1]**

Lynparza and abiraterone demonstrates a **clear clinical benefit** vs. abiraterone alone in first line patients who are NHA naïve

For NHA experienced patients, *Lynparza* and abiraterone offers **a well tolerated, chemo-free treatment option**

A clear option for NHA-naïve patients regardless of HRRm status

The first combination trial to demonstrate consistent clinical benefit in 1st-line mCRPC

Source: AstraZeneca estimates. 1. Pending health authority authorisation. The PROpel trial data is not currently approved in any jurisdiction.

4

Other ASCO GU highlights

Susan Galbraith

Executive Vice President,
Oncology R&D

New advances in urothelial carcinoma

Phase II data advancing understanding of this aggressive cancer

Imfinzi + *Lynparza*: Phase II BAYOU trial

Platinum-ineligible patients with mUC

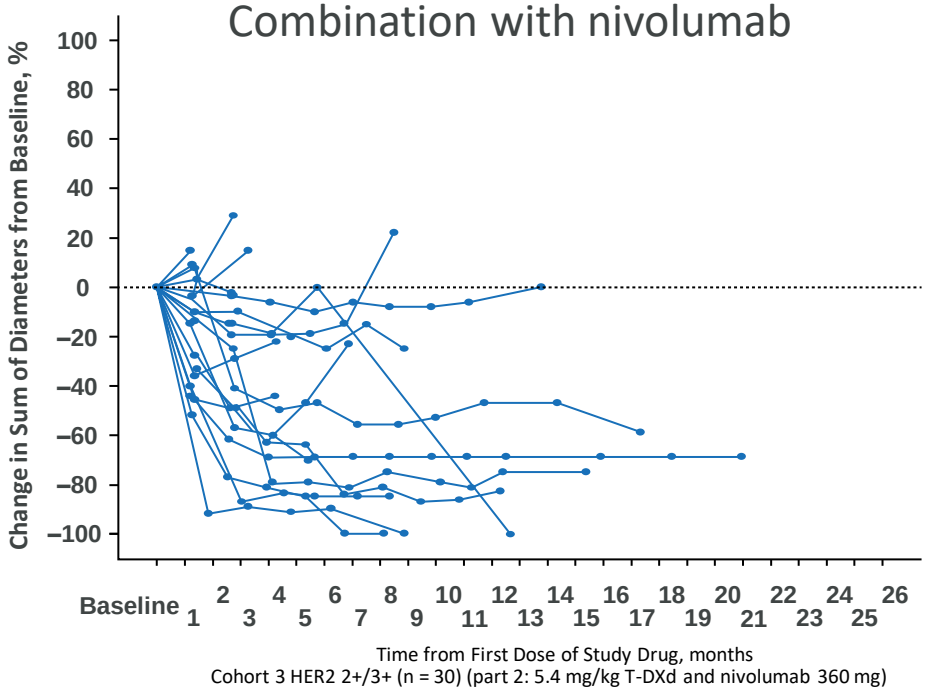
Primary and secondary PFS analyses

	D+O	D+PBO
ITT population	n=78	n=76
Median PFS, mo (95% CI)	4.2 (3.6–5.6)	3.5 (1.9–5.1)
HR (95% CI)	0.94 (0.64–1.39)	
Log-rank p-value	0.789	
HRRm subset*	n=17	n=14
Median PFS, mo (95% CI)	5.6 (1.9–8.1)	1.8 (1.7–2.2)
HR (95% CI)	0.18 (0.06–0.47)	
Log-rank p-value	<0.001	

Data suggests a role for PARP inhibition in HRRm UC

Enhertu: Phase II U105 trial

Combination with nivolumab



HER2+ UC included in DESTINY-PanTumor02

mUC = metastatic urothelial carcinoma; UC = urothelial carcinoma; T-DXd = trastuzumab deruxtecan (*Enhertu*).

5

Closing and Q&A

Investor Relations

Chris Sheldon

chris.sheldon@astrazeneca.com

Josie Afolabi

josie.afolabi@astrazeneca.com

Tom Waldron

tom.waldron@astrazeneca.com

Morgan Sanford

morgan.sanford@astrazeneca.com

Christer Gruvris

christer.gruvris@astrazeneca.com

Philip Sparks

philip.sparks1@astrazeneca.com

Lauren Swales

lauren.swales@astrazeneca.com

Jen Kretzmann

jennifer.kretzmann@astrazeneca.com

A

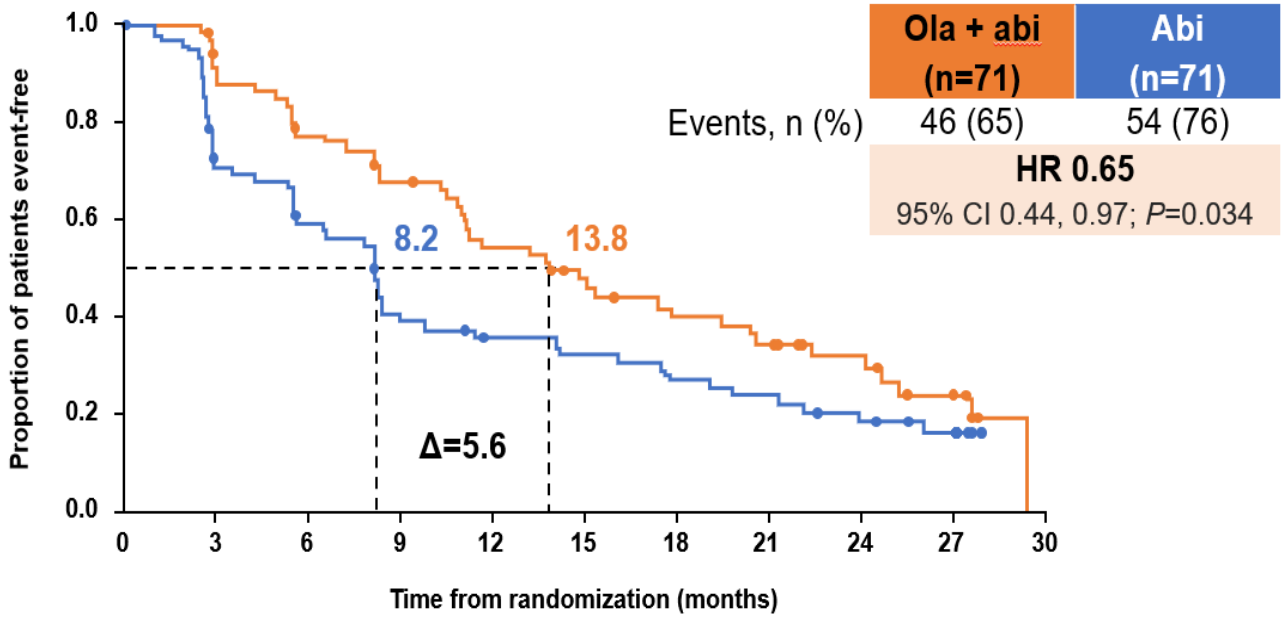
Appendix

PROpel

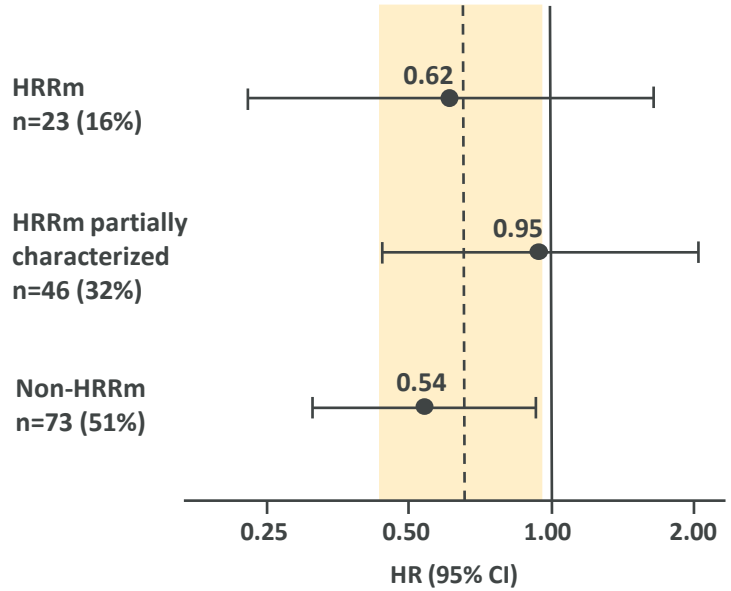
Olaparib and abiraterone: A randomised Phase II trial

- Patients with mCRPC, unselected by HRRm status, with prior docetaxel treatment
- Randomized 1:1 to full dose of olaparib + abiraterone vs placebo + abiraterone
- Statistically significant improvement in rPFS with olaparib + abiraterone, irrespective of HRRm status[1]

Investigator-assessed rPFS[1]



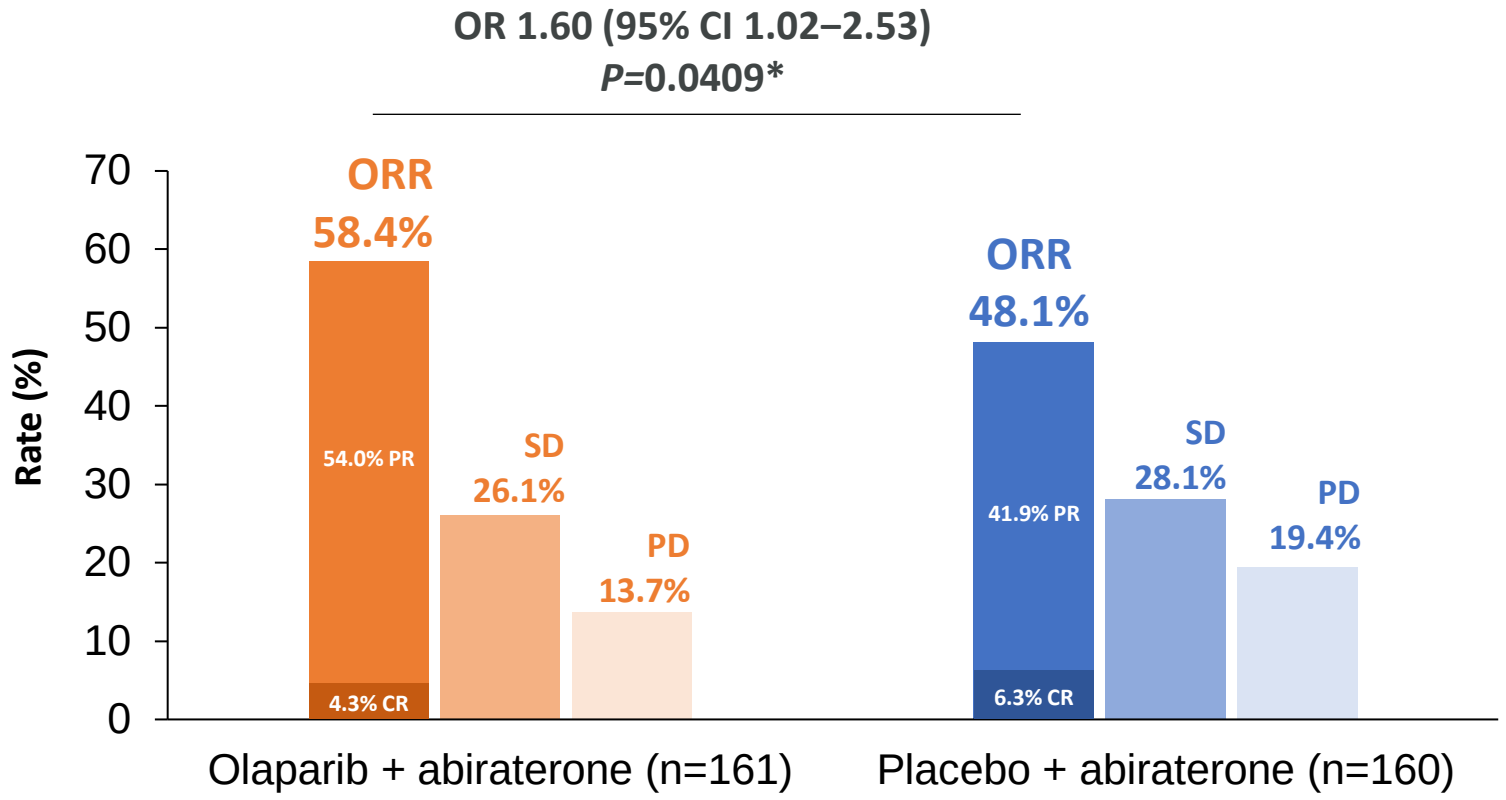
rPFS by HRRm subgroup[2*]



1. Clarke N et al. *Lancet Oncol* 2018;19:975–86. 2. Carr TH et al. *Cancers* 2021;13:5830
*Dashed line and shaded area show HR and 95% CI, respectively, for the intent to treat population.
Please access the Supplement at https://bit.ly/3r50msO for more details including the full citations and further details on the HRRm partially characterised subgroup.

ORR in patients with measurable disease

10% improvement in ORR with olaparib + abiraterone



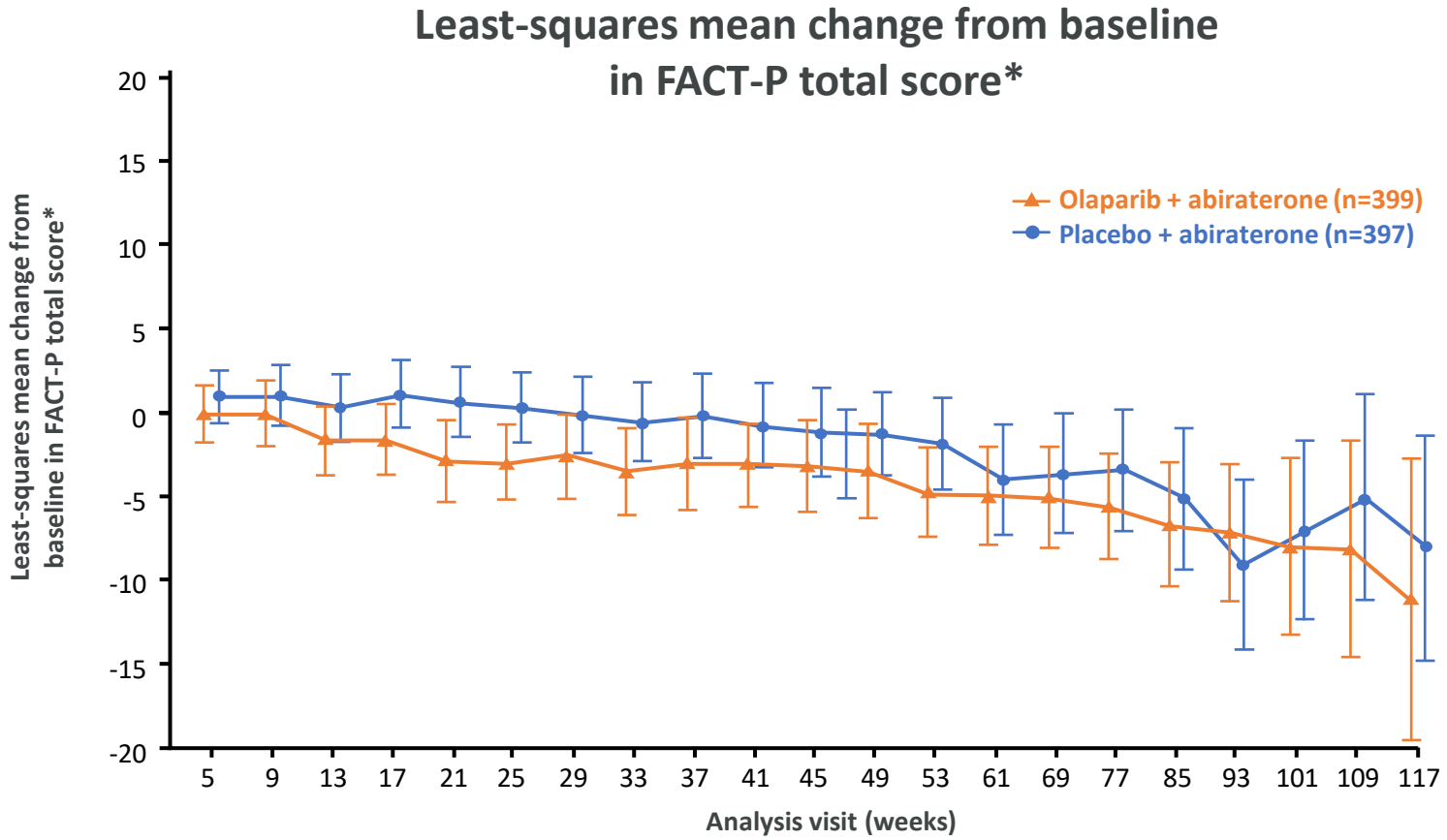
321/796 patients (40.3%) had measurable disease by RECIST v1.1 criteria at baseline

*Nominal.

CR = complete response; OR = odds ratio; ORR = overall response rate; PD = progressive disease; PR = partial response; RECIST = Response Evaluation Criteria in Solid Tumors; SD = stable disease.

FACT-P quality of life over time

Quality of life comparable between treatment arms



*Plot includes 95% confidence limits. FACT-P total score change from baseline values can be a minimum of -156 and a maximum of 156. A clinically meaningful change in FACT-P total score is 1015,16

FACT-P = Functional Assessment of Cancer Therapy-Prostate.

Use of AstraZeneca slides from conference calls and webcasts

The AstraZeneca webcast, conference call and presentation slides (together the 'AstraZeneca materials') are for your personal, non-commercial use only. You may not copy, reproduce, republish, post, broadcast, transmit, make available to the public, sell or otherwise reuse or commercialise the AstraZeneca materials in any way. You may not edit, alter, adapt or add to the AstraZeneca materials in any way, nor combine the AstraZeneca materials with any other material. You may not download or use the AstraZeneca materials for the purpose of promoting, advertising, endorsing or implying any connection between you (or any third party) and us, our agents or employees, or any contributors to the AstraZeneca materials. You may not use the AstraZeneca materials in any way that could bring our name or that of any Affiliate into disrepute or otherwise cause any loss or damage to us or any Affiliate. AstraZeneca PLC, 1 Francis Crick Avenue, Cambridge Biomedical Campus, Cambridge, CB2 0AA. Telephone + 44 20 3749 5000, www.astrazeneca.com