AstraZeneca at #WCLC23

Highlights from key programmes presented at the World Conference on Lung Cancer (WCLC) Annual Meeting 2023

09-12 September 2023

Oncology at AstraZeneca

We have the vision to **redefine cancer care** and, one day, eliminate cancer as a cause of death. It is through **persistent innovation that we have built an industry-leading pipeline** across multiple scientific platforms, with the aim of transforming outcomes and **increasing the potential for cures.**

AstraZeneca attendance at the World Conference on Lung Cancer (WCLC) Annual Meeting

1
presidential plenary presentation

9
oral presentations

40+
abstracts

"Our data at WCLC support our ambition to have the right AstraZeneca medicine for more than half of all patients treated for lung cancer by 2030 and underscore the need to increase screening and early diagnosis to improve patient outcomes. The strong results from FLAURA2 will further establish Tagrisso as the backbone therapy in EGFR-mutated non-small cell lung cancer, and the recent Breakthrough Therapy Designation in the US is a significant validation of the potential we see for this regimen."

Dave Fredrickson
Executive Vice President, Oncology

For any questions or requests for follow-up information, please contact us at

IRDirectors@astrazeneca.com

AstraZeneca's ambition in Oncology

Our Oncology strategy is built with one goal in mind – to push the boundaries of science to change the practice of medicine and transform the lives of patients living with cancer. Our broad pipeline of next-generation medicines, together with our focus on excellence in execution, is aimed at expanding treatment options and improving outcomes for patients with solid tumours and haematological cancers.

We focus on four strategic priorities:

1. Pioneering research across multiple scientific platforms and modalities.
2. Advancing innovative clinical strategies to treat patients with early stages of disease and relapsed or refractory patients.
3. Building expertise and leadership in the most prevalent and highest mortality rate tumour types.
4. Delivering across our global footprint.

Latest advances being showcased at the World Conference on Lung Cancer 2023

Optimising outcomes across early and late-stage *EGFR*m NSCLC

- FLAURA2 (*Tagrisso* + CTx)
- AEGEAN (*Imfinzi*)
- PACIFIC-R (*Imfinzi*)

Realising the potential of ADCs in advanced NSCLC

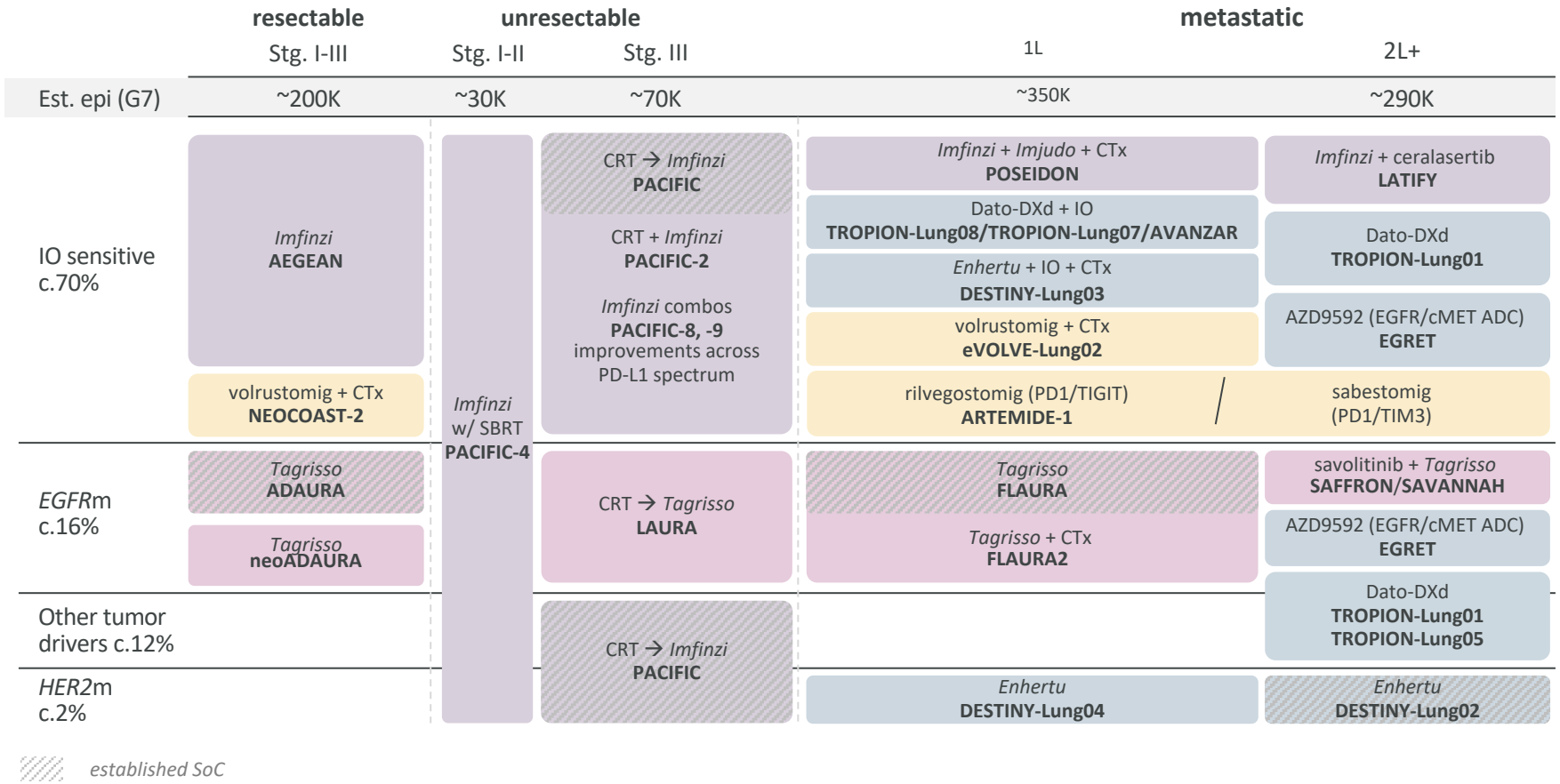
- TROPION-Lung04 (Dato-DXd + *Imfinzi* ± CTx)
- DESTINY-Lung02 (*Enhertu*)

Expanding novel IO and combinations across lung cancer settings

- AEGEAN (*Imfinzi*)
- POSEIDON (*Imfinzi* ± *Imjudo* + CTx)

CTx = chemotherapy; ADC = antibody drug conjugate; IO = immunotherapy.
Collaboration partner: Daiichi Sankyo (*Enhertu*, Dato-DXd).

AstraZeneca in NSCLC

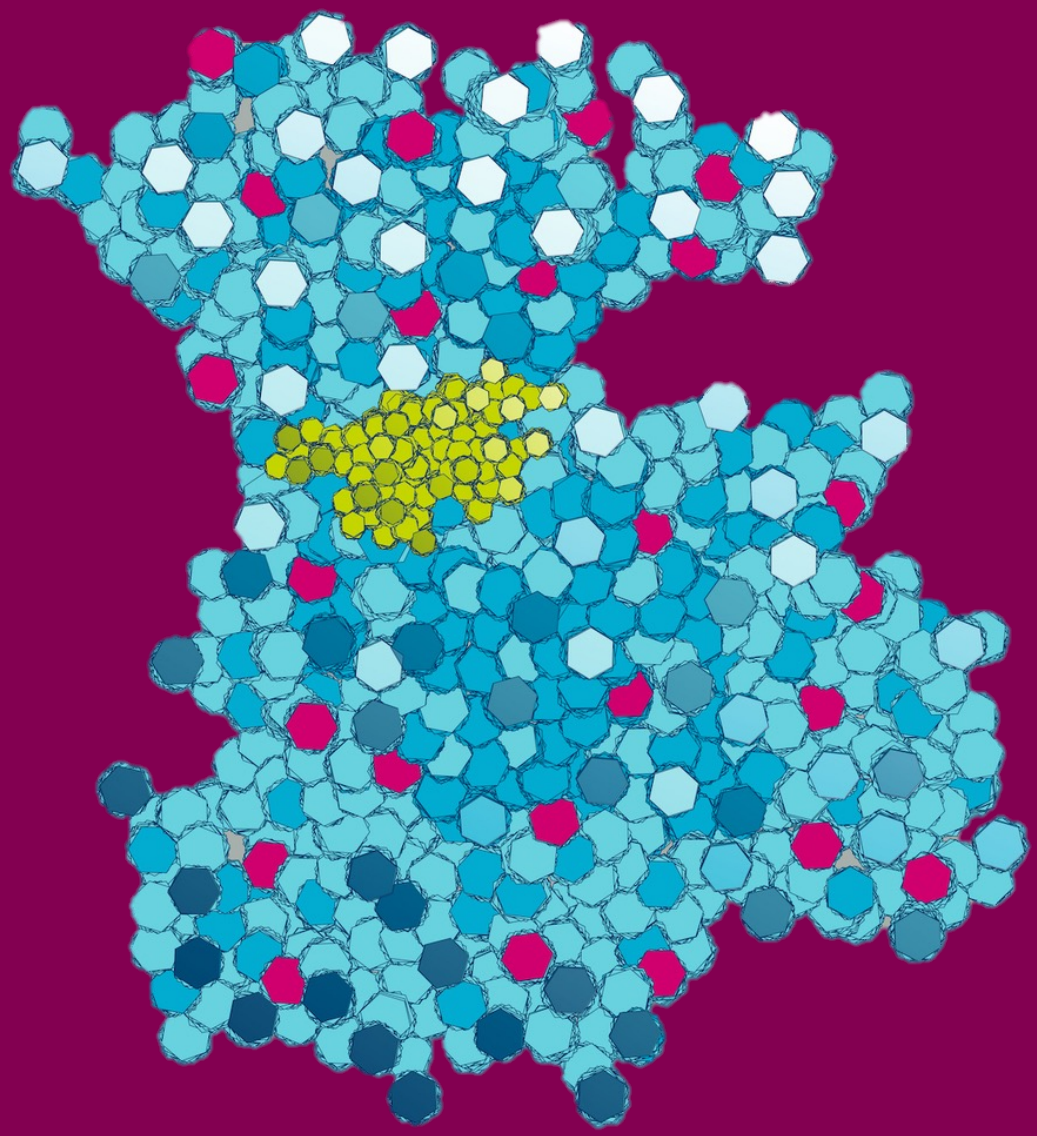


- Establishing *Tagrisso* as backbone TKI in *EGFR*m
- *Imfinzi* leading IO in unresectable
- Advancing best-in-class ADCs to replace systemic chemotherapy
- Delivering next-wave bispecifics to improve on PD1/PD-L1
- Developing novel combinations, including IO + ADCs
- Investing behind new technologies and platforms, including cell therapy and testing/screening

Ambition for >50% of all treated lung cancer patients to be eligible for an AstraZeneca medicine by the year 2030

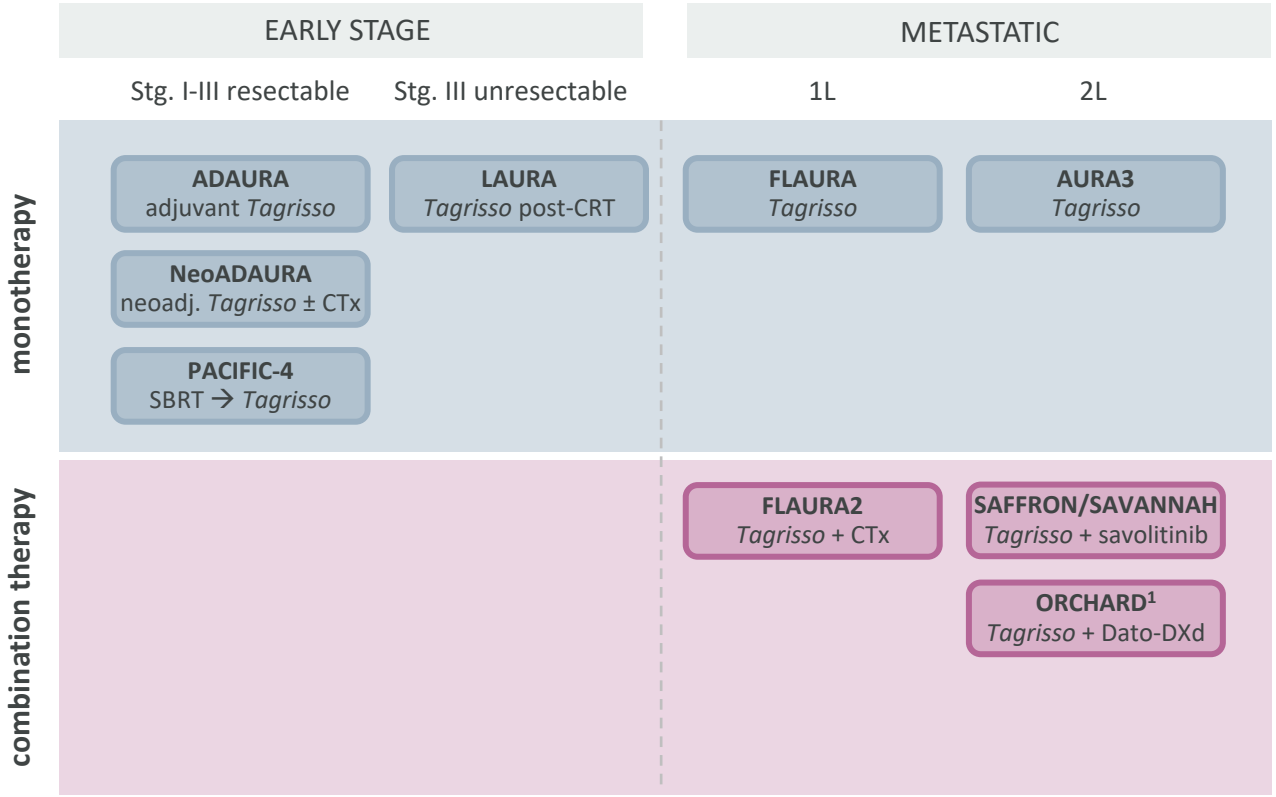
Est epi (G7) = estimated epidemiology across G7 (US, EU5, JP); Stg. = stage; CTx = chemotherapy; SBRT = stereotactic body radiation therapy; CRT = chemoradiotherapy; pembro = pembrolizumab; IO = immunotherapy; ADC = antibody-drug conjugate; PD1 = programmed cell death protein 1; EGFR = epidermal growth factor receptor; c-MET = mesenchymal-epithelial transition factor; TIGIT = T-cell immunoreceptor with immunoglobulin and ITIM domains; CTLA4 = cytotoxic T-lymphocyte associated protein 4; TIM3 = T-cell immunoglobulin and mucin domain-containing protein 3; SoC = standard of care; TKI = tyrosine kinase inhibitor.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Compugen (rilvegostomig).

Optimising outcomes across early and late-stage *EGFR*m NSCLC



Advancing the treatment of *EGFR*m NSCLC

Establishing *Tagrisso* as backbone TKI for *EGFR*m NSCLC



What's new at #WCLC23

- Phase III **FLAURA2** *Tagrisso* + CTx demonstrates statistically significant, clinically meaningful improvement in PFS vs *Tagrisso* monotherapy
- Additional subgroup analyses from **AEGEAN** and **PACIFIC-R** reinforce the importance of precision medicine in the treatment of NSCLC

H1 2024	**LAURA** Phase III **SAVANNAH** Phase II
H2 2024	**NeoADAURA** Phase III
>2024	**PACIFIC-4** Phase III **SAFFRON** Phase III **ORCHARD** Phase II

1. ORCHARD is Phase II platform trial investigating novel combinations in advanced EGFRm NSCLC patients who have progressed on first-line *Tagrisso*

*EGFR*m = epidermal growth factor receptor mutated; NSCLC = non-small cell lung cancer; TKI = tyrosine kinase inhibitor; Stg. = stage; 1L = 1st-line; 2L = 2nd-line; CTx = chemotherapy; SBRT = stereotactic body radiotherapy; CRT = chemoradiotherapy; PFS = progression-free survival.

Collaboration partner: Daiichi Sankyo (Dato-DXd).

New at #WCLC23: FLAURA2 (*Tagrisso* + CTx) demonstrates statistically significant, clinically meaningful improvement

FLAURA2 offers unsurpassed efficacy with a novel regimen that builds on clinician experience with *Tagrisso* and chemotherapy.

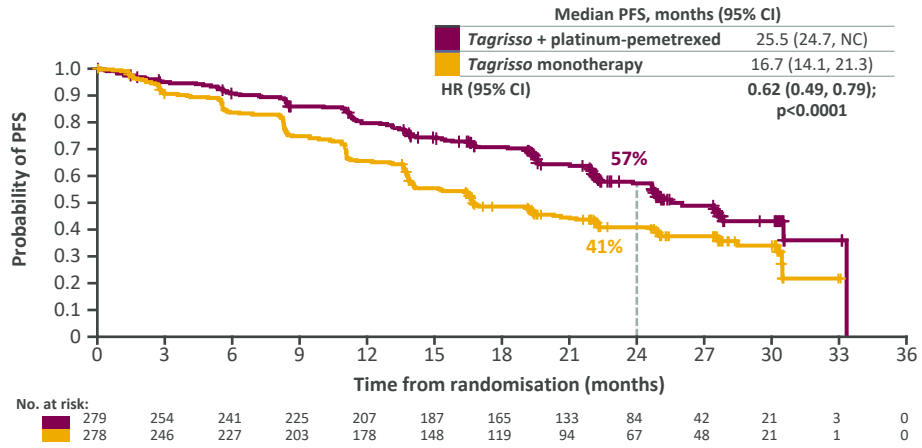
Tagrisso monotherapy is standard of care for 1L *EGFR*m NSCLC. However, despite the observed benefits, most patients will progress following treatment leaving an opportunity for additional 1L treatments.

Data from FLAURA2 demonstrated that *Tagrisso* combined with platinum-pemetrexed resulted in a statistically significant and clinically meaningful improvement in PFS over *Tagrisso* monotherapy in patients with 1L *EGFR*m advanced NSCLC.

In addition, the safety profiles were as expected for each treatment and were manageable with standard medical practice, with only 11% discontinuing *Tagrisso* in the combination arm.

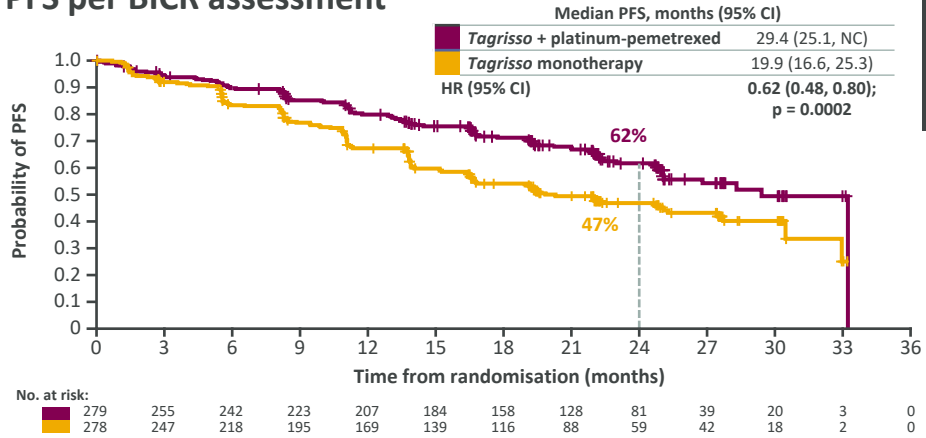
Follow-up continues for PFS2 and OS.

PFS per investigator assessment



mPFS improvement of **8.8 months** per investigator assessment with **HR 0.62**

PFS per BICR assessment



mPFS improvement of **9.5 months** per BICR assessment with **HR 0.62**

Data cut-off: 03 April 2023.

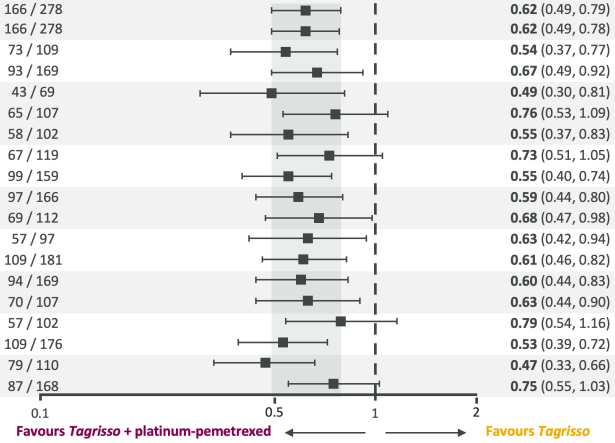
*EGFR*m = epidermal growth factor receptor mutated; NSCLC = non-small cell lung cancer; 1L = 1st-line; PFS = progression-free survival; PFS2 = progression-free survival 2; OS = overall survival; CI = confidence interval; NC = not calculable; HR = hazard ratio; no. = number.

New at #WCLC23: FLAURA2 (*Tagrisso* + CTx) demonstrates statistically significant, clinically meaningful improvement

PFS benefits were consistent across all pre-defined patient subgroups, including in the **~40% of patients with CNS metastases** at baseline as assessed by MRI

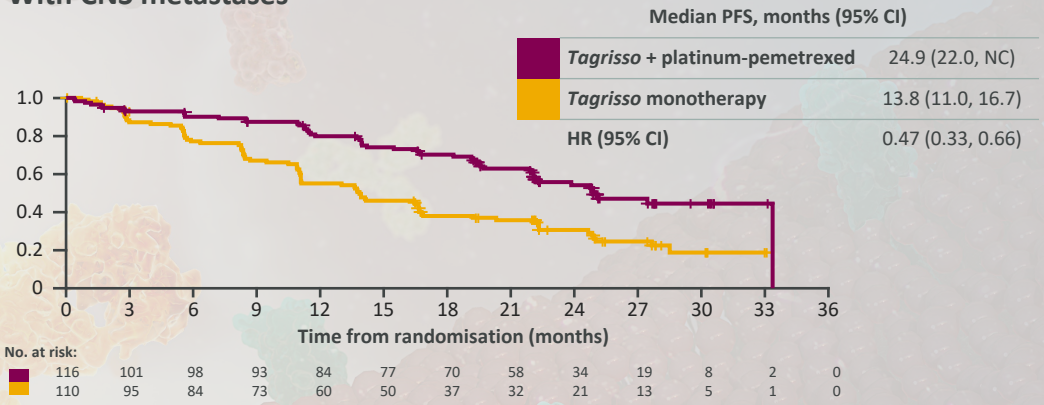
PFS across pre-defined subgroups

Subgroup		*Tagrisso* + platinum-pemetrexed (Events / patients)	*Tagrisso* monotherapy (Events / patients)	HR (95% CI)
All patients	Stratified log-rank	120 / 279	166 / 278	**0.62** (0.49, 0.79)
	Unadjusted Cox PH	120 / 279	166 / 278	**0.62** (0.49, 0.78)
Sex	Male	51 / 106	73 / 109	**0.54** (0.37, 0.77)
	Female	69 / 173	93 / 169	**0.67** (0.49, 0.92)
Race	Chinese Asian	26 / 71	43 / 69	**0.49** (0.30, 0.81)
	Non-Chinese Asian	54 / 107	65 / 107	**0.76** (0.53, 1.09)
	Non-Asian	40 / 101	58 / 102	**0.55** (0.37, 0.83)
EGFR mutation test method	Central	52 / 121	67 / 119	**0.73** (0.51, 1.05)
	Local	68 / 158	99 / 159	**0.55** (0.40, 0.74)
Age at screening	<65 years	73 / 174	97 / 166	**0.59** (0.44, 0.80)
	≥65 years	47 / 105	69 / 112	**0.68** (0.47, 0.98)
Smoking history	Yes	43 / 91	57 / 97	**0.63** (0.42, 0.94)
	No	77 / 188	109 / 181	**0.61** (0.46, 0.82)
EGFR mutation type[1]	Ex19del	65 / 172	94 / 169	**0.60** (0.44, 0.83)
	L858R	55 / 106	70 / 107	**0.63** (0.44, 0.90)
WHO PS	0	48 / 101	57 / 102	**0.79** (0.54, 1.16)
	1	72 / 178	109 / 176	**0.53** (0.39, 0.72)
CNS status at baseline	Yes	52 / 116	79 / 110	**0.47** (0.33, 0.66)
	No	68 / 163	87 / 168	**0.75** (0.55, 1.03)

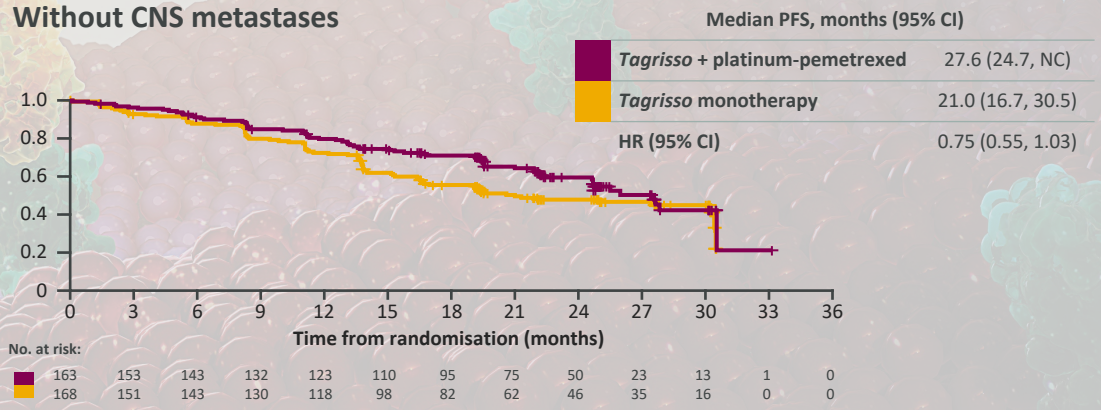


Investigator-assessed PFS with / without CNS metastases at baseline

With CNS metastases



Without CNS metastases

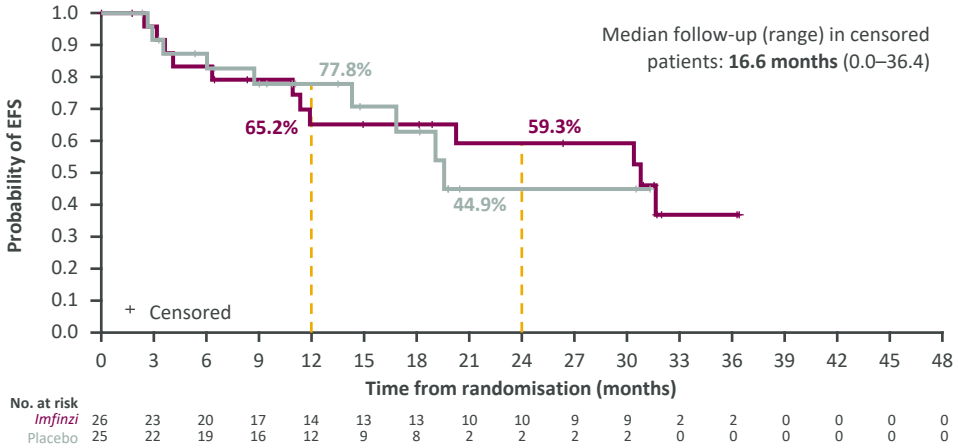


Data cut-off: 03 April 2023. 1.For *EGFR* mutation type, patients with both Ex19del and L858R were included in Ex19del group.
CTx = chemotherapy; PFS = progression-free survival; CNS = central nervous system; MRI = magnetic resonance imaging; WHO PS = World Health Organisation performance score; *EGFR*m = epidermal growth factor receptor mutated; NC = not calculable; HR = hazard ratio; CI = confidence interval; no. = number.

New at #WCLC23: AEGEAN *EGFR*m subgroup analysis reinforces the need for precision medicine approaches in NSCLC

EFS[1] assessed by BICR

*EGFR*m subgroup	*Imfinzi* arm	Placebo arm
No. events / no. patients (%)	12/26 (46.2)	9/25 (36.0)
mEFS, months (95% CI)	30.8 (11.4, NR)	19.6 (14.3, NR)
Unstratified HR[†] (95% CI)	**0.86 (0.35, 2.19)**	

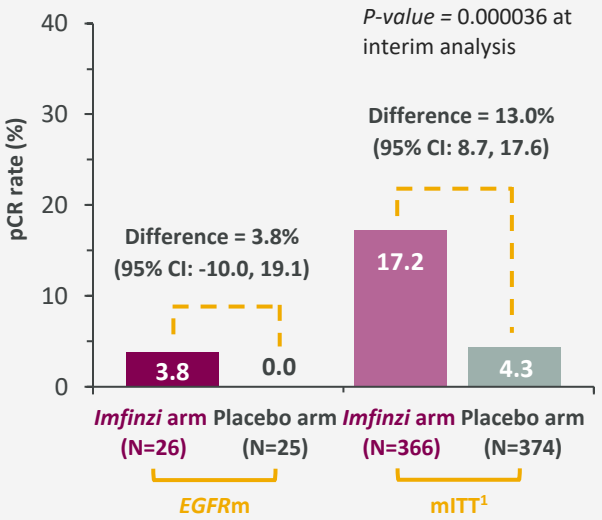


14% reduction in risk of disease recurrence, progression events or death

Reinforces need for EGFRm testing prior to neoadjuvant therapy

Pathological response rates[2] (central lab)

3.8% difference in pCR rates *Imfinzi* vs placebo in EGFRm patient subgroup



Exploratory subgroup analysis from AEGEAN reinforces the importance of early *EGFR*m testing in the resectable setting to inform future treatment decisions.

The Phase III AEGEAN trial demonstrated that perioperative *Imfinzi* + neoadjuvant CTx significantly improved EFS and pCR vs neoadjuvant CTx alone with a manageable safety profile[3].

Whilst initially designed to allow patients with *EGFR/ALK* mutations, after external data presented in 2021 suggested patients with these mutations exhibit limited response to immunotherapy[4-6], AEGEAN was amended to exclude these patients. Prior to this amendment, the trial had already enrolled 51 patients with *EGFR*m (of a total 802 patients).

Exploratory subgroup analysis from AEGEAN assessing outcomes specifically in patients with *EGFR*m NSCLC demonstrated no clear evidence of clinical benefit in this group, with an EFS HR of 0.86 after a median follow-up of 16.6 months and difference in pCR rate of 3.8%.

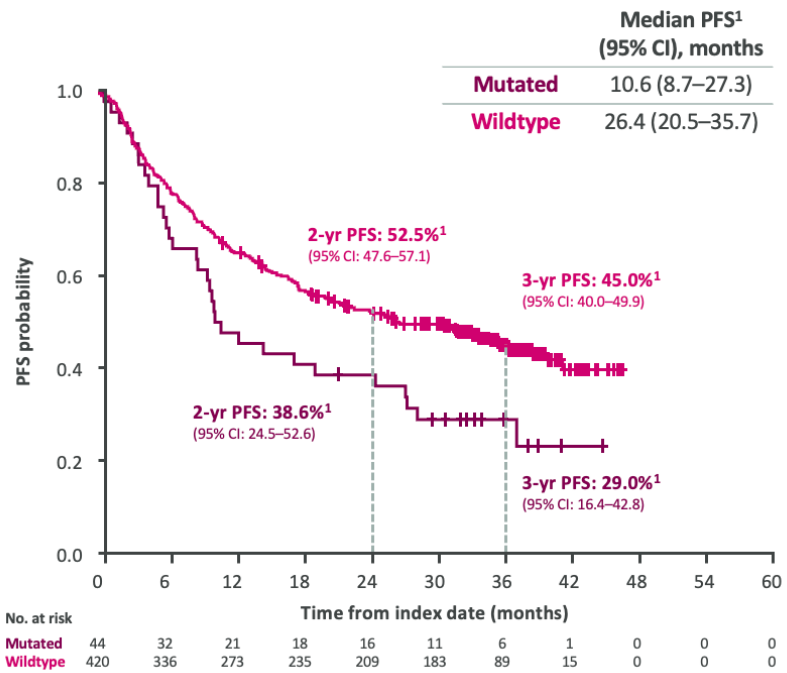
These data support the importance of precision medicine approaches for the treatment of NSCLC.

No clear evidence of clinical benefit with perioperative *Imfinzi* + neoadjuvant CTx in patients with EGFRm resectable NSCLC

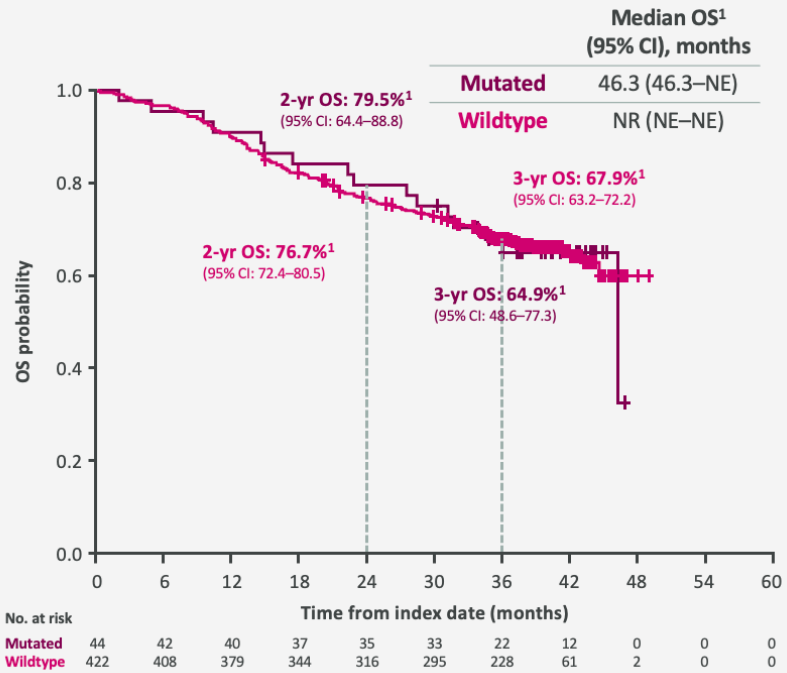
Data cut-off: 10 Nov 2022. 1. Assessed per RECIST v1.1; 2. Assessed per IASLC 2020 methodology; 3. 1Heymach JV, et al. Cancer Res 2023;83 (8_Supplement):CT005; 4. Mazieres J, et al. Ann Oncol 2019;30:1321-28; 5. Huang Q, et al. Oncoimmunology 2018; 7:e1396403; 6. Lee CK, et al. JAMA Oncol 2018;4:210-6. *EGFR*m = epidermal growth factor receptor mutated; NSCLC = non-small cell lung cancer; (m)EFS = (median) event-free survival; BICR = blinded independent central review; no. = number; CI = confidence interval; HR = hazard ratio; NR = not reached; pCR = pathologic complete response; mITT = modified intent-to-treat; CTx = chemotherapy; ALK = anaplastic lymphoma receptor tyrosine kinase; EFS = event free survival.

New at #WCLC23: PACIFIC-R *EGFR*m subgroup analysis reinforces the need for precision medicine approaches in NSCLC

Real-world PFS by *EGFR* status



OS by *EGFR* status



Real-world PFS was lower among patients with *EGFR*m NSCLC vs patients with *EGFR*wt NSCLC, while OS rates were similar across *EGFR*m and *EGFR*wt subgroups

Subgroup analysis from PACIFIC-R reinforces the need for targeted therapy and the potential for the Phase III LAURA trial of maintenance *Tagrisso* in patients with Stage III unresectable *EGFR*m NSCLC.

PACIFIC-R is an ongoing real-world trial that has demonstrated further evidence for consolidation *Imfinzi* post-CRT in a diverse patient population, consistent with findings from the pivotal, Phase III PACIFIC trial[2-5].

Within the trial, 40.4% (466 of 1154) had a known *EGFR* status and 4% (44 of 1154) were identified as *EGFR*m.

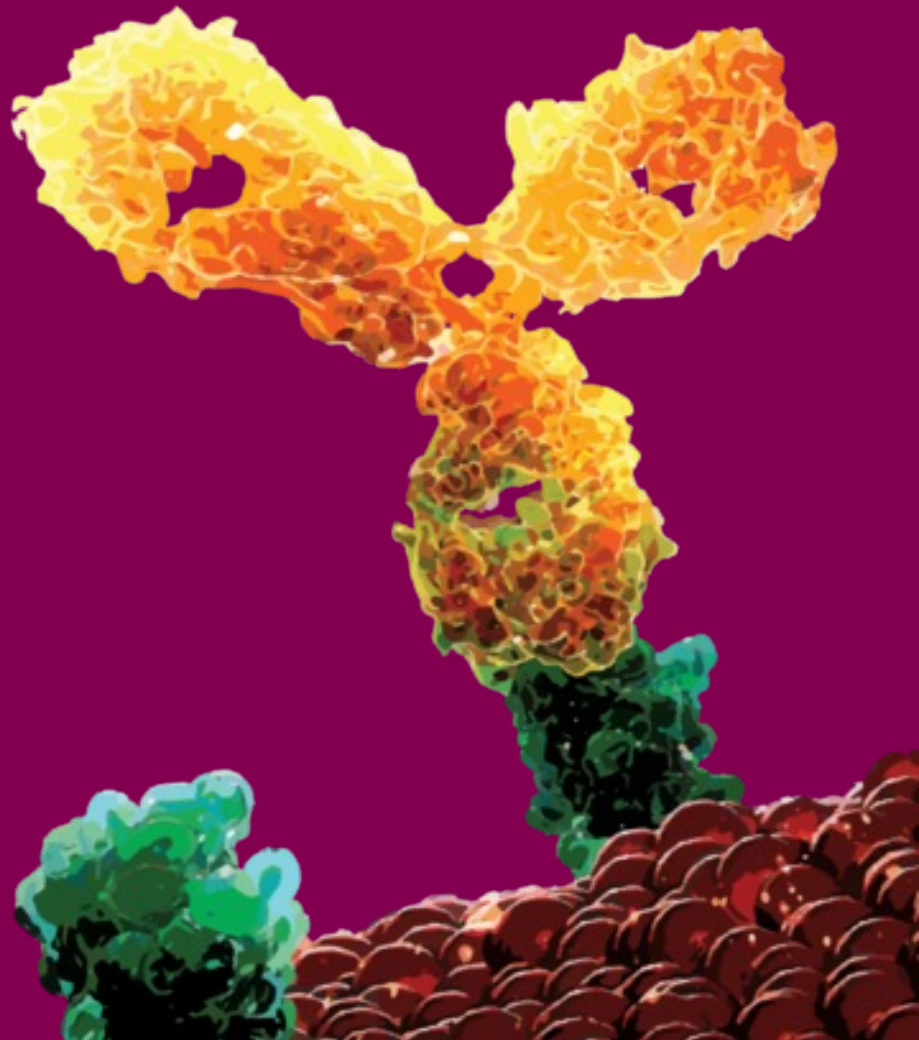
Real-world PFS was lower among patients with *EGFR*m NSCLC compared to those with *EGFR*wt NSCLC (mPFS 10.6 vs 26.4 months), while OS was similar (46.3 months vs NR) in PACIFIC-R; these findings were consistent with PFS and OS findings for this sub-population in the PACIFIC trial.

Similar to the AEGEAN subgroup analysis, these data support the importance of precision medicine approaches for the treatment of NSCLC.

Data cut-off: 30 Nov 2021. 1. Calculated using the Kaplan-Meier method. 2. Girard N et al., Oral Presentation 580. Presented at ESMO IO 2022; 3. Antonia SJ et al., N Engl J Med 2018;379:2342–50; 4. Antonia SJ et al., N Engl J Med 2017;377:1919–29; 5. Spigel DR et al., J Clin Oncol 2022;40:1301–11.

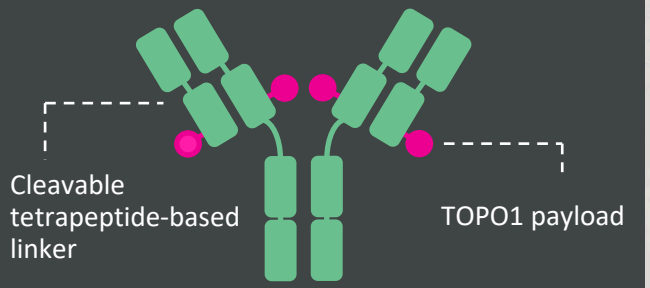
EGFR(m/wt) = epidermal growth factor receptor (mutated/wildtype); NSCLC = non-small cell lung cancer; PFS = progression-free survival; OS = overall survival; CI = confidence interval; yr = year; no. = number; CRT = chemoradiotherapy.

Realising the potential of ADCs in advanced NSCLC



Dato-DXd in NSCLC

Dato-DXd: novel TROP2 ADC



- High-potency TOPO1 payload
- Payload with short systemic half-life
- Optimised DAR ~4
- Tumour-selective cleavable linker
- Bystander anti-tumour effect

1 Potential to replace systemic chemotherapy as monotherapy and as backbone

- First Phase III trial HLR for 2-3L NSCLC in July, with mBC due H2 2023
- Ongoing signal generation in other tumour types

2 Further outcomes with novel combination regimens

- Emerging IO combination efficacy with trials in 1L advanced NSCLC
- Signal-finding in earlier stage and with other assets ongoing (e.g., *Tagrisso*)

3 Assess predictive value of TROP2 biomarker

- Phase III AVANZAR trial ongoing in 1L NSCLC

Ongoing Dato-DXd trials in NSCLC

2L+ mono

- **Phase I TROPION-PanTumor01** — Dato-DXd monotx (3L+ NSCLC, other)
  - **Phase III TROPION-Lung01** — Dato-DXd monotx 2L/3L w/ and w/o AGA
  - **Phase II TROPION-Lung05** — Dato-DXd single-arm 2L+ w/ AGA

EGFRm

- **Phase II ORCHARD** — *Tagrisso* + Dato-DXd

1L IO combo w/o AGA

- **Phase Ib TROPION-Lung02** — Dato-DXd + pembro 1L/2L NSCLC
  - **Phase III TROPION-Lung08** — Dato-DXd + pembro (1L PD-L1≥50%)
  - **Phase III TROPION-Lung07** non-squamous — Dato-DXd + pembro ± CTx (1L PD-L1<50%)
- **Phase Ib TROPION-Lung04** — Dato-DXd + *Imfinzi* or rilvegostomig (PD1/TIGIT) or volrustomig (PD1/CTLA4) (1L/2L)
  - **Phase III AVANZAR** — Dato-DXd + *Imfinzi* + CTx (1L)

Dato-DXd = datopotomab deruxtecan; NSCLC = non-small cell lung cancer; mBC = metastatic breast cancer; ADC = antibody drug conjugate; TOPO1 = topoisomerase type 1; DAR = drug to antibody ratio; IO = immunotherapy; 1L = 1st-line; 3L = 3rd-line; 2L = 2nd-line; HLR = high level results; monotx = monotherapy; AGA = actionable genomic alteration; pembro = pembrolizumab; PD-L1 = programmed death-ligand 1; CTx = chemotherapy; PD1 = programmed death 1; TIGIT = T cell immunoreceptor with Ig and ITIM domains; CTLA4 = cytotoxic T-lymphocyte–associated antigen 4.
Collaboration partners: Daiichi Sankyo (Dato-DXd), Compugen (rilvegostomig).

New at #WCLC23: TROPION-Lung04 shows promising response rates for both doublet and triplet regimens

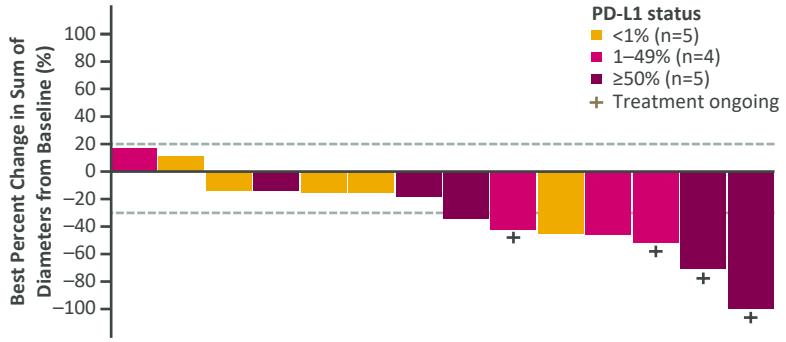
Interim data from TROPION-Lung04 provide encouraging efficacy and safety signals for both doublet and triplet regimens and set the stage for Phase III trials TROPION-Lung07, TROPION-Lung08 and AVANZAR.

TROPION-Lung04 is the second early phase trial to provide evidence for the combination of Dato-DXd + immunotherapy ± chemotherapy in NSCLC, following data presented for TROPION-Lung02 at ASCO 2023. TROPION-Lung04 Cohort 2 focuses on the combinability of Dato-DXd with *Imfinzi* (doublet) and Cohort 4 adds platinum chemotherapy (triplet). The majority of patients received the regimens in the 1L setting (Cohort 2, 74%; Cohort 4, 93%).

Interim efficacy analyses demonstrated promising ORRs with the doublet and triplet combinations, both in the 1L setting and the overall population. Responses were numerically higher with the triplet vs doublet combination, and were observed across all PD-L1 expression levels.

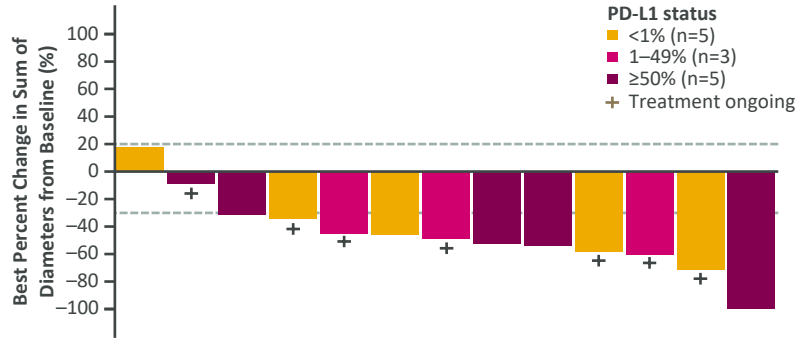
Cohort 2 (doublet), 1L setting (N=14)[1]

ORR: 50.0%; DCR: 92.9%

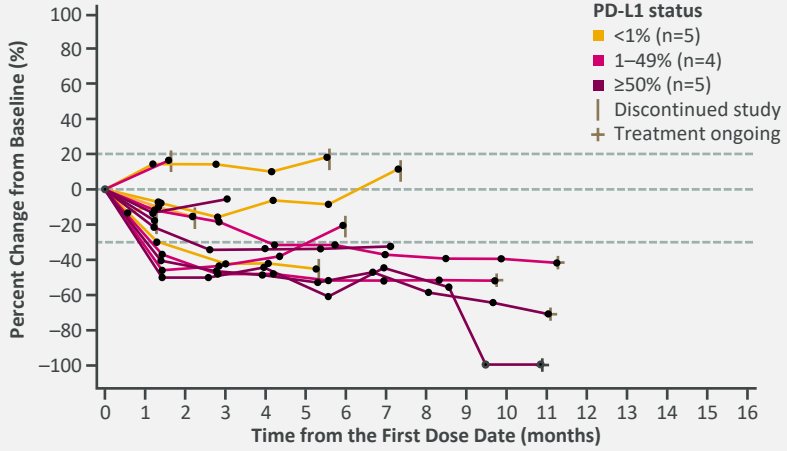


Cohort 4 (triplet), 1L setting (N=13)[1]

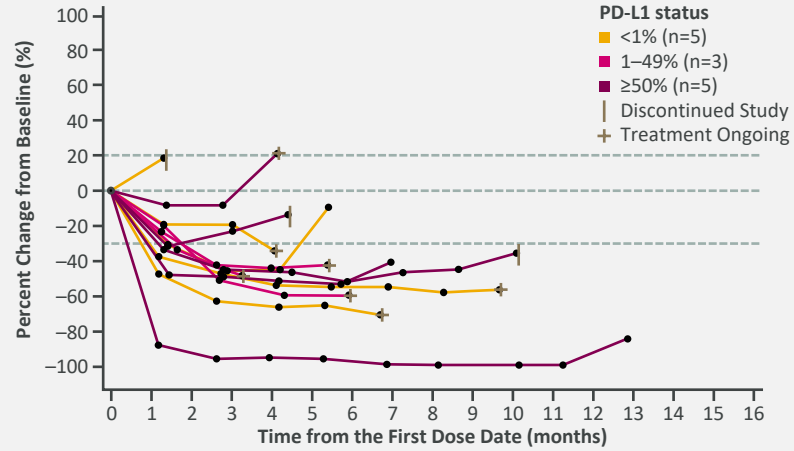
ORR: 76.9%;[2] DCR: 92.3%



Cohort 2 (doublet), 1L setting (N=14)[1]



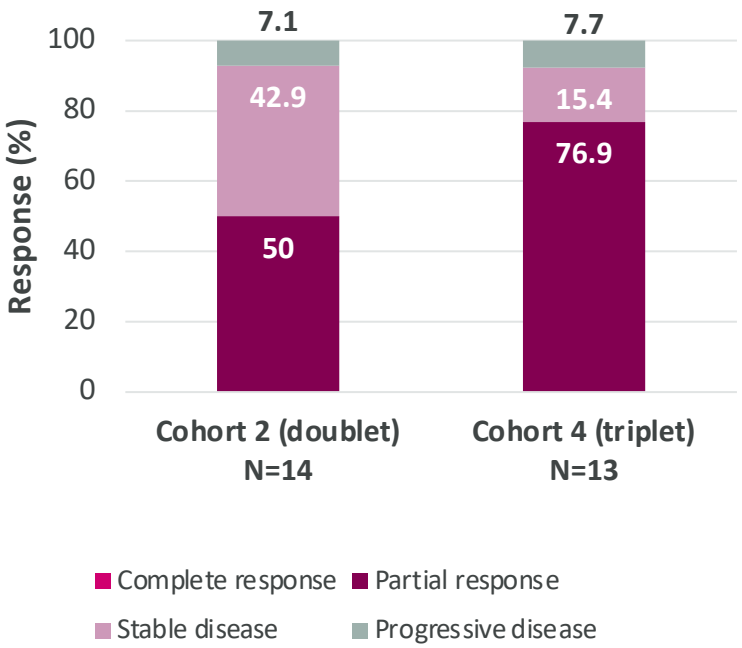
Cohort 4 (triplet), 1L setting (N=13)[1]



Data cut-off: 6 March 2023.
1. As assessed by investigator per RECIST v1.1. 2. One of the 10 partial responses in Cohort 4 was confirmed after data cut-off.
NSCLC = non-small cell lung cancer; Dato-DXd = datopotomab deruxtecan; ASCO = Amercian Society of Clinical Oncology; 1L = 1st-line; PD-L1 = programmed death-ligand 1; ORR = objective response rate; DCR = disease control rate.
Collaboration partner: Daiichi Sankyo (Dato-DXd).

New at #WCLC23: TROPION-Lung04 showed promising response rates for both doublet and triplet regimens

Response in patients in the 1L setting[1]



Responses numerically higher with triplet vs doublet, **76.9% vs 50% ORR**

No new safety signals observed in Cohorts 2 and 4 throughout dose escalation and expansion. **Grade ≥3 TEAEs were more frequently observed with triplet** vs doublet regimen, driven by haematological events.

Three cases of adjudicated ILD, two of which were Grade 1 or 2. No cases of Grade 5 ILD.

Events, n (%)		Cohort 2 (doublet) N=19	Cohort 4 (triplet) N=14
TEAEs		**19 (100)**	**14 (100)**
Study treatment-related[2]		19 (100)	14 (100)
Grade ≥3 TEAEs		**8 (42.1)**	**10 (71.4)**
Study treatment-related[2]		6 (31.6)	8 (57.1)
SAEs		**7 (36.8)**	**5 (35.7)**
Study treatment-related[2]		6 (31.6)	5 (35.7)
TEAEs associated with	Death	0	0
	Discontinuation of any drug	4 (21.1)	3 (21.4)
	Discontinuation of Dato-DXd	4 (21.1)	2 (14.3)
ILD adjudicated as drug-related		3 (15.8)	1 (7.1)
Grade 1		1 (5.3)	
Grade 2		1 (5.3)	1 (7.1)
Grade ≥3		1 (5.3)[3]	

Data cut-off: 6 March 2023. 1. As assessed by investigator per RECIST v1.1; 2. Treatment-related TEAEs are related to Dato-DXd, durvalumab or carboplatin. 3. There was one Grade 4 ILD adjudicated as drug-related in a patient who received sotorasib after PD.

1L = 1st-line; ORR = objective response; TEAE = treatment-emergent adverse event; Dato-DXd = datopotomab deruxtecan; ILD = interstitial lung disease.

Collaboration partner: Daiichi Sankyo (Dato-DXd).

New at #WCLC23: DESTINY-Lung02 demonstrated deep and durable responses with *Enhertu* 5.4mg/kg and 6.4 mg/kg

Primary results of DESTINY-Lung02 reinforce *Enhertu* as the standard of care in previously treated *HER2*m NSCLC.

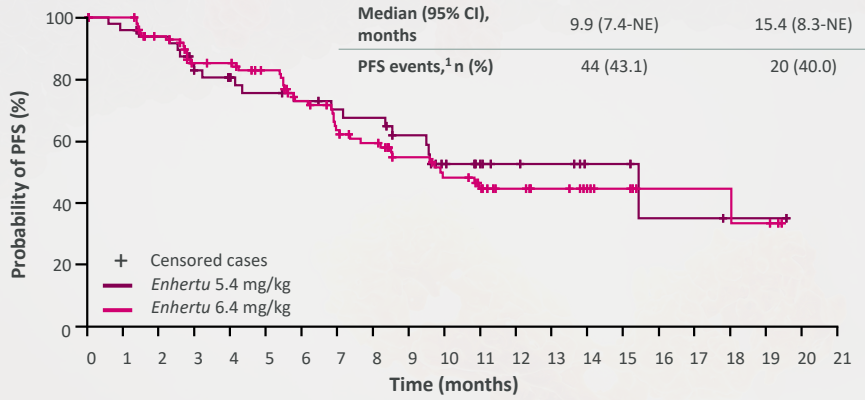
Interim results, presented in 2022, from the Phase III DESTINY-Lung02 trial demonstrated deep and durable responses with a manageable safety profile, leading to the approval of *Enhertu* 5.4mg/kg in *HER2*m mNSCLC.

Primary results of DESTINY-Lung02 reinforced response rates observed at 5.4mg/kg and 6.4mg/kg dose. Responses were consistent regardless of *HER2* mutation type, *HER2* amplification status and prior systemic anticancer therapy.

The observed safety profile was consistent with previous trials, no new safety signals were observed and safety favoured the 5.4mg/kg dose.

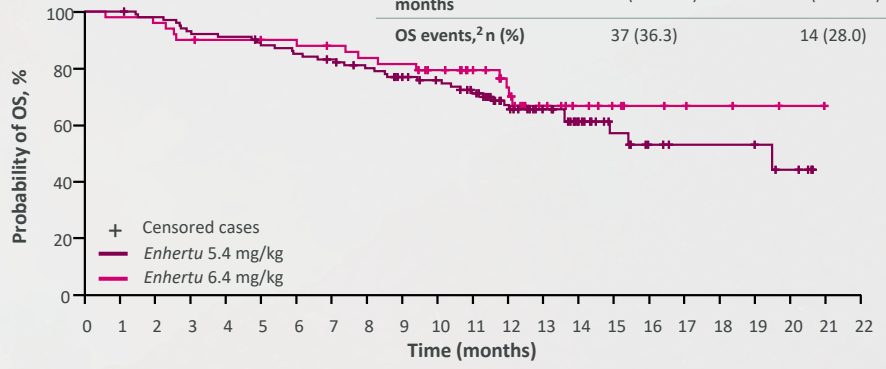
PFS

	Enhertu 5.4 mg/kg N = 102	*Enhertu* 6.4 mg/kg N = 50
Median (95% CI), months	9.9 (7.4-NE)	15.4 (8.3-NE)
PFS events,[1] n (%)	44 (43.1)	20 (40.0)

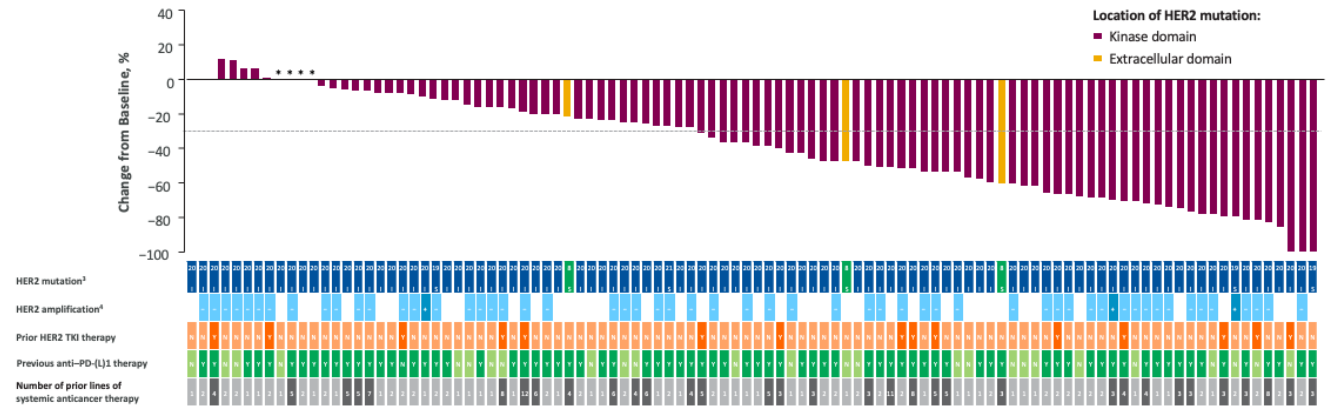


OS

	Enhertu 5.4 mg/kg N = 102	*Enhertu* 6.4 mg/kg N = 50
Median (95% CI), months	19.5 (13.6-NE)	NE (12.1-NE)
OS events,[2] n (%)	37 (36.3)	14 (28.0)



Best percentage change in tumour size by BICR

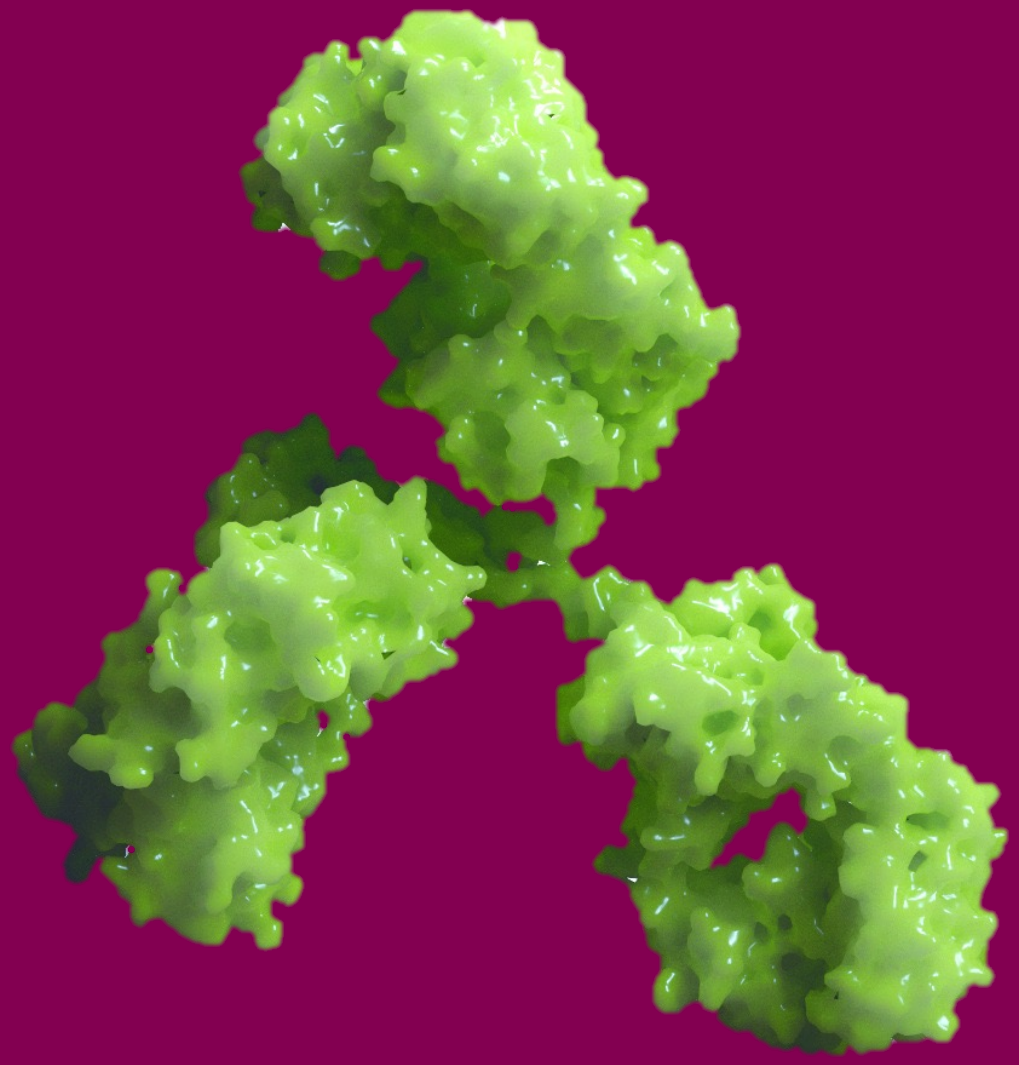


Responses observed regardless of *HER2* mutation type, amplification status and number or type of prior therapies

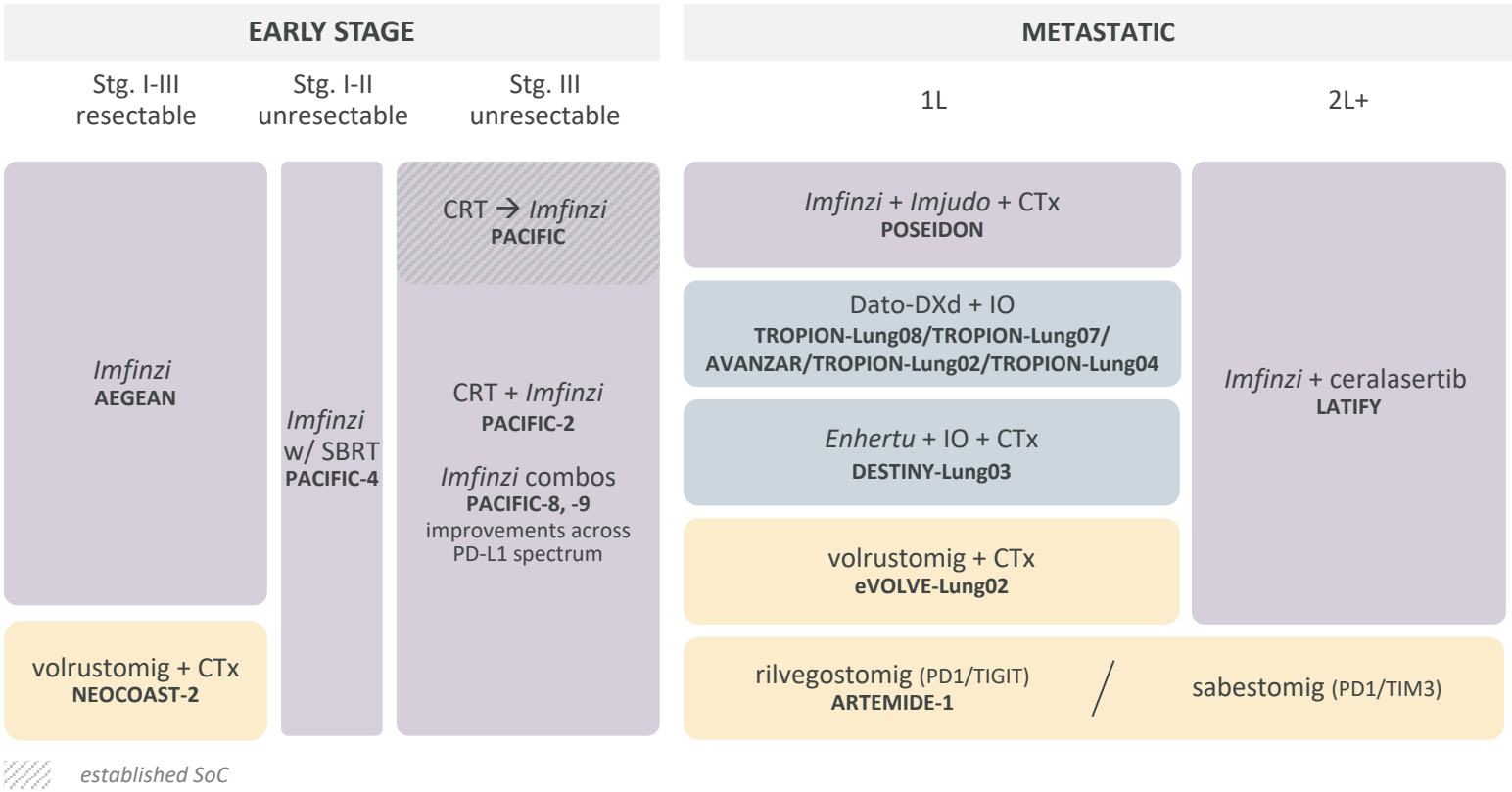
Data cut-off: 23 Dec 2022. 1. 56.9% and 60.0% of patients in the 5.4 mg/kg and 6.4 mg/kg arms were censored; 2. 63.7% and 72.0% of patients in the 5.4 mg/kg and 6.4 mg/kg arms were censored; 3. Activating HER2 mutation documented from an archival or fresh tumor tissue sample by certified local laboratory assessment; 4. HER2 amplification status was evaluated using an exploratory Oncomine DX Target test copy number algorithm on NSCLC formalin-fixed paraffin-embedded tissue samples.

HER2 = human epidermal growth factor receptor 2; (m)NSCLC = (metastatic) non-small cell lung cancer; PFS = progression-free survival; OS = overall survival; CI = confidence interval; BICR = blinded independent centralised review; TKI = tyrosine kinase inhibitor; PD-L1 = programmed death-ligand 1. Collaboration partner: Daiichi Sankyo (*Enhertu*).

Expanding novel IO and combinations across lung cancer



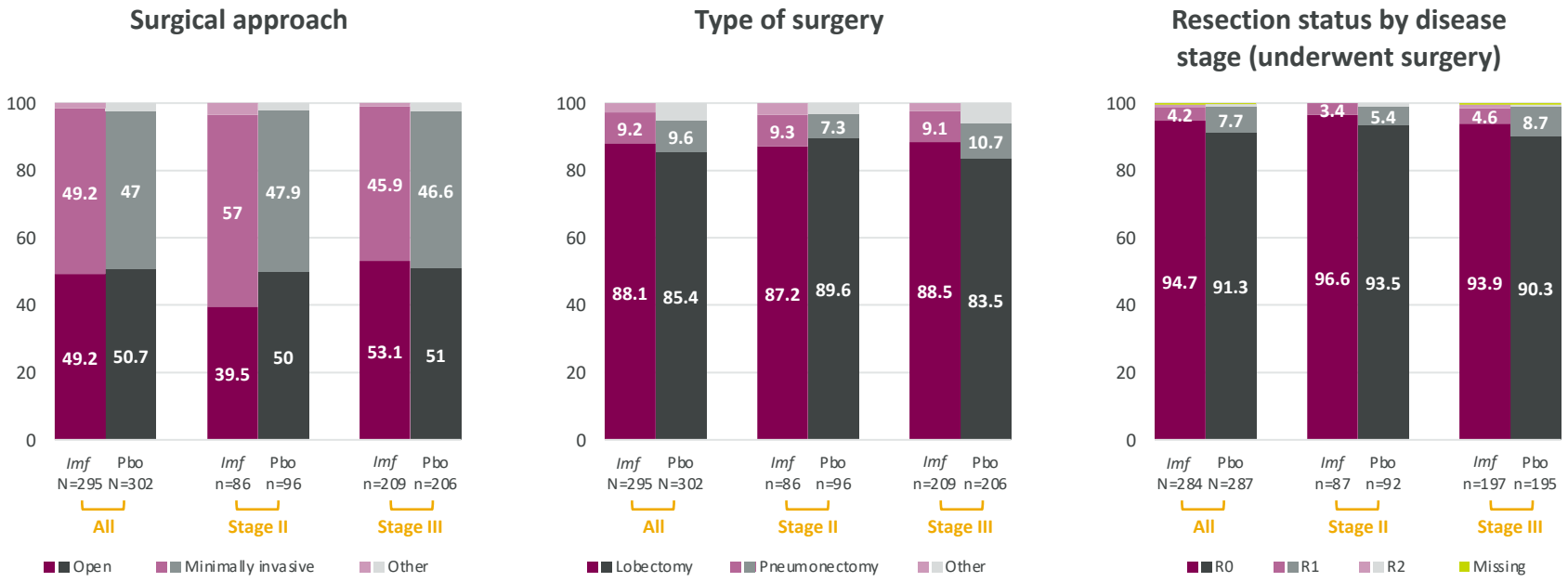
Building blocks for IO expansion in NSCLC



- **PACIFIC** regimen to remain standard of care in Stage III unresectable NSCLC
  - **PACIFIC-4** offers opportunity for entry into Stage I-II unresectable NSCLC
  - **PACIFIC-2, -8**, **-9** explore *Imfinzi* combinations
- **POSEIDON** establishes foundation; opportunity for continued expansion in 1L and 2L+ with novel combinations:
  - **AVANZAR** (*Imfinzi* + Dato-DXd)
  - **LATIFY** (*Imfinzi* + ceralasertib)
- **AEGEAN** moves earlier with perioperative *Imfinzi* in Stage II-III resectable NSCLC
- Novel bispecifics portfolio (rilvegostomig, volrustomig, sabestomig) provide opportunity for next generation IO

IO = immunotherapy; NSCLC = non-small cell lung cancer; stg. = stage; 1L = 1st-line; 2L = 2nd-line; CTx = chenotherapy; SBRT = stereotactic body radiotherapy; CRT = chemoradiotherapy; PD-L1 = programmed death-ligand 1; Dato-DXd = datopotomab deruxtecan; EGFR = epidermal growth factor receptor; cMET = c-mesenchymal-epithelial transition factor; PD-1 = programmed death 1; TIGIT = T-cell immunoreceptor with immunoglobulin and ITIM domains; TIM3 = T-cell immunoglobulin and mucin domain-containing protein 3; SCLC = small-cell lung cancer.
Collaboration partners: Daiichi Sankyo (Dato-DXd), Compugen (rilvegostomig).

New at #WCLC23: AEGEAN surgical outcomes data support utility of perioperative regimen in resectable NSCLC



Addition of perioperative *Imfinzi* to neoadjuvant CTx did not impact the feasibility, type, approach or timing of surgery in patients with resectable NSCLC and resulted in numerically higher R0 resection rates

With clinically meaningful efficacy, no adverse impact on surgical outcomes, and a manageable safety profile, the AEGEAN regimen is a potential new treatment option for patients with resectable NSCLC.

In early-stage NSCLC, surgery remains the primary curative-intent treatment; therefore, ensuring that perioperative therapy does not impact patients' ability to get the required surgery is critical.

Surgical outcomes analyses of AEGEAN showed the addition of perioperative *Imfinzi* to neoadjuvant chemotherapy did not confer any impact on surgery or surgical outcomes and that the perioperative regimen had a manageable surgical safety profile, similar to neoadjuvant chemotherapy alone.

Data cut-off = 10 Nov 2022.
NSCLC = non-small cell lung cancer; *Imf* = *Imfinzi*; pbo = placebo; CTx = chemotherapy.

New at #WCLC23: Patients treated with POSEIDON regimen more likely to receive long-term clinical benefit

Long-term responders analysis reinforces the role of *Imfinzi* + *Imjudo* added to chemotherapy in the management of metastatic NSCLC.

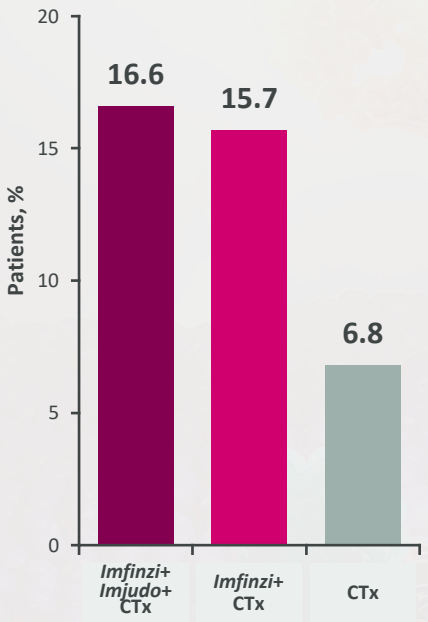
Subgroup analysis of the POSEIDON Phase III trial demonstrated that >2x patients derived long-term clinical benefit when treated with *Imfinzi* + *Imjudo* + chemotherapy vs chemotherapy alone (16.6% vs 6.8%).

Although there were higher percentages of patients with some unfavourable prognostic factors at baseline in the PFS <12 months subgroup across treatment arms, baseline demographics and disease characteristics did not impact which patients derived a long-term benefit with *Imfinzi* + *Imjudo* + chemotherapy vs chemotherapy alone.

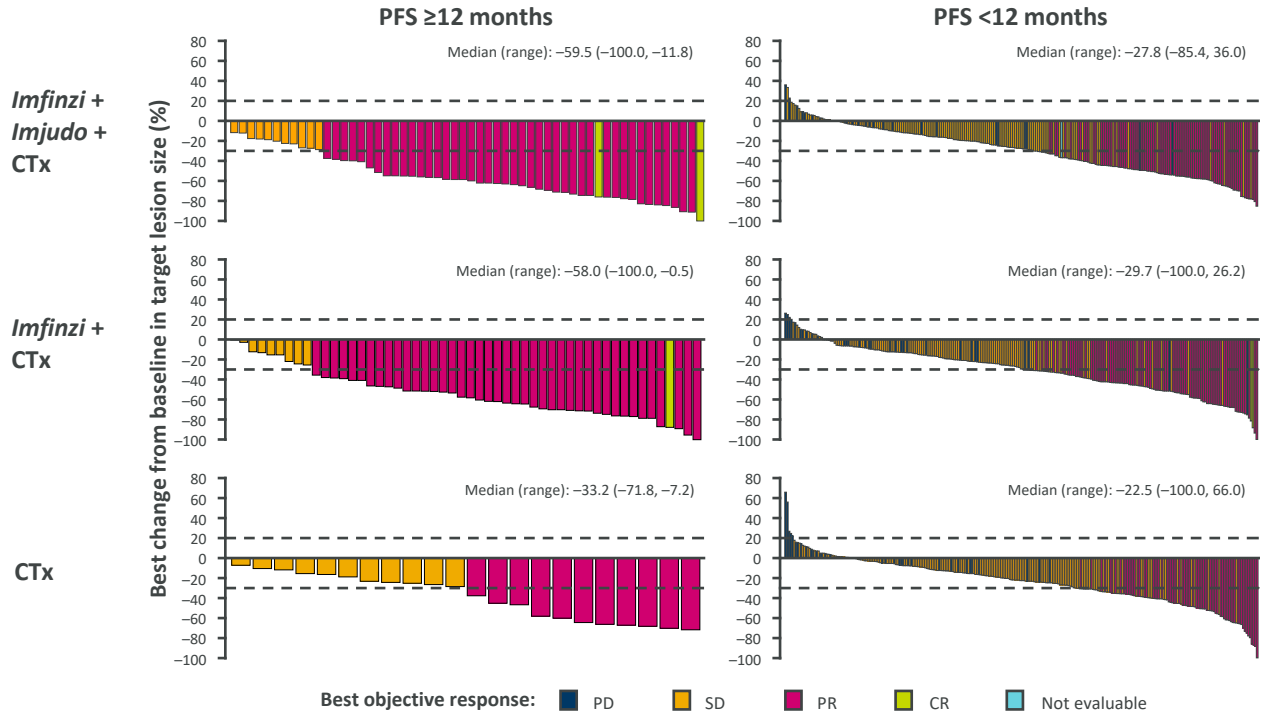
Patients with PFS ≥12 months demonstrated improved ORR, DoR, and OS compared with the PFS <12 months subgroup, with 2-year OS rates ≥87% across the three arms.

>2x patients derived long-term clinical benefit when treated with POSEIDON regimen versus chemotherapy alone

Patients with PFS ≥12 months



Depth of response[1] in the PFS ≥12 months and PFS <12 months subgroups



Data cut-off: 24 Jul 2019.

1. Confirmed objective response by BICR (RECIST v1.1) assessed in patients with measurable disease at baseline. Dashed reference lines at −30% and 20% indicate thresholds for PR and PD.

NSCLC = non-small cell lung cancer; PFS = progression-free survival; ORR = objective response rate; DoR = duration of response; OS = overall survival; CTx = chemotherapy; PD = progressive disease; SD = stable disease; PR = partial response; CR = complete response.

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