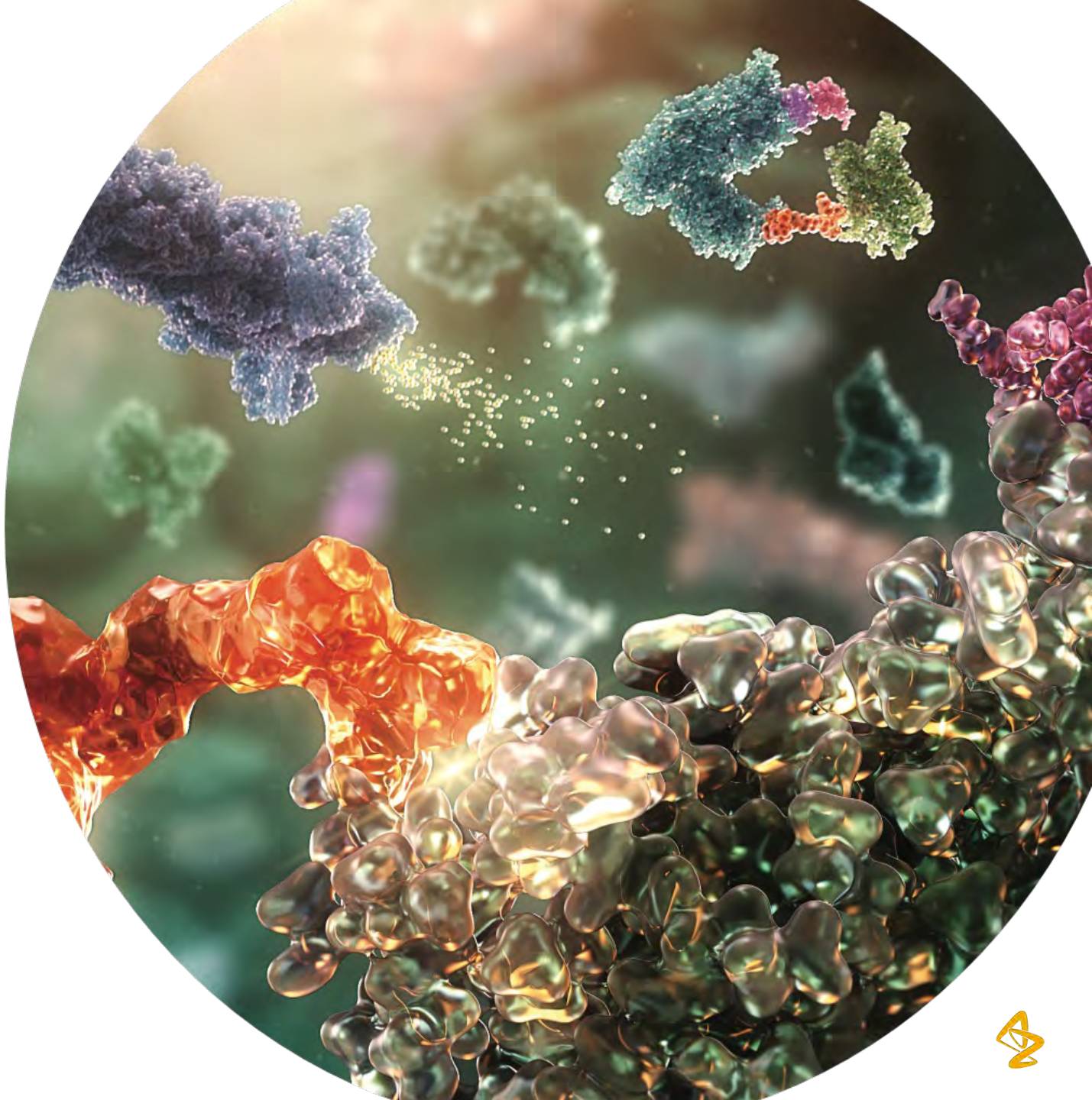
AstraZeneca

ASCO 2023

Meet AZN Management

For investors and analysts

05 June 2023



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AstraZeneca @ ASCO 2023

AGENDA |

Furthering our oncology ambition @ ASCO 2023	–	***Pascal Soriot**, CEO*
Strengthening our presence in lung cancer & advancing emerging portfolio	–	***Susan Galbraith**, EVP, Oncology R&D* ***Dave Fredrickson**, EVP, Oncology Business* ***Dr Roy Herbst**, Deputy Director, Yale Cancer Center*
Q&A session I – Focus on lung cancer		
Investigating novel combinations in ovarian cancer	–	***Susan Galbraith**, EVP, Oncology R&D* ***Dave Fredrickson**, EVP, Oncology Business*
Expanding *Enhertu* beyond breast, lung and gastric	–	***Susan Galbraith**, EVP, Oncology R&D* ***Dave Fredrickson**, EVP, Oncology Business*
Reinforcing *Calquence* positioning in BTKi class	–	***Anas Younes**, SVP, Haematology*
Q&A session II – AZN management		

AstraZeneca @ ASCO 2023

Speakers and panelists

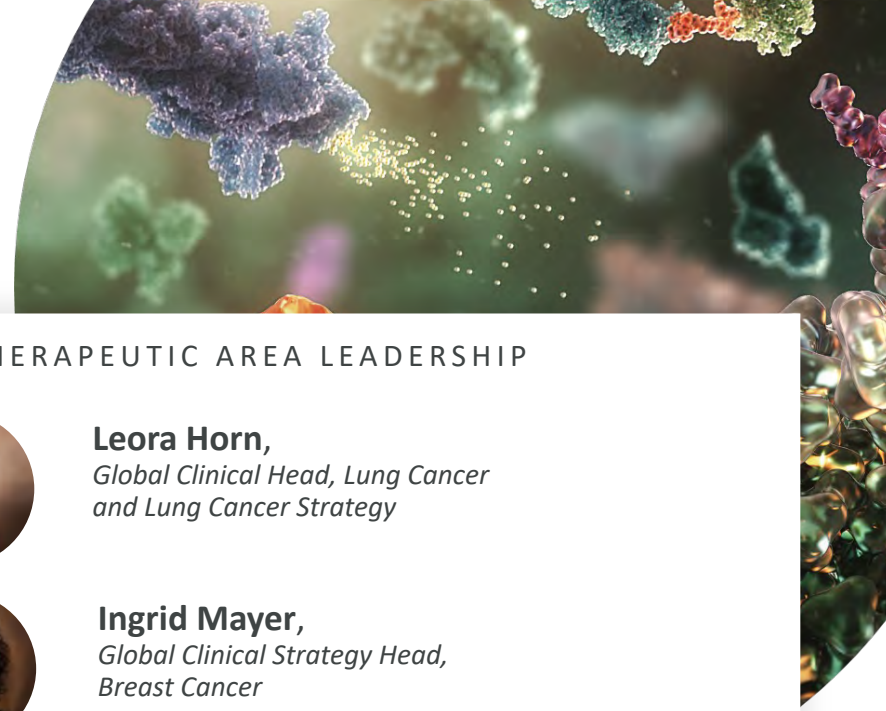
KEY EXTERNAL EXPERT
Dr Roy Herbst,
Deputy Director, Yale Cancer Center

Pascal Soriot,
Chief Executive Officer

Susan Galbraith,
Executive Vice President
Oncology R&D

Dave Fredrickson,
Executive Vice President
Oncology Business

Sunil Verma,
Global Head of Oncology,
Medical



THERAPEUTIC AREA LEADERSHIP

Leora Horn,
Global Clinical Head, Lung Cancer
and Lung Cancer Strategy

Ingrid Mayer,
Global Clinical Strategy Head,
Breast Cancer

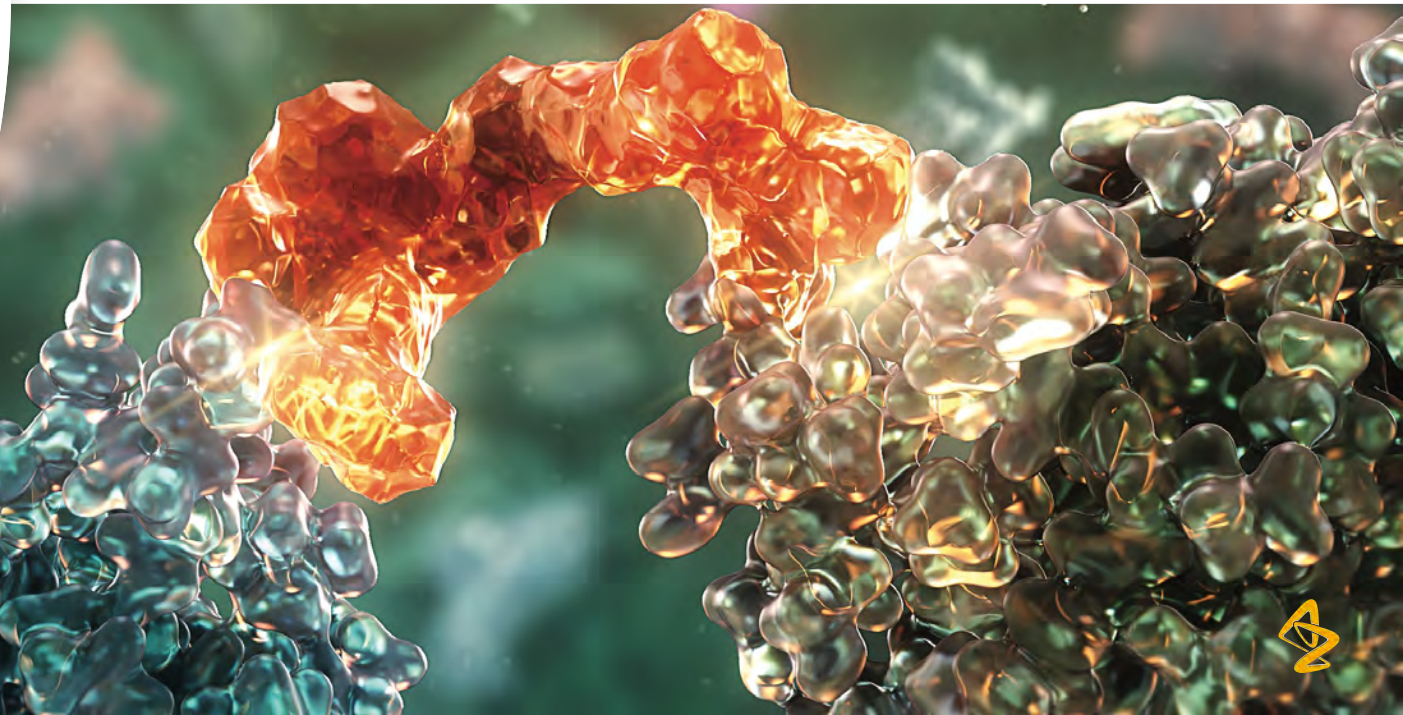
Osama Rahma,
Global Clinical Strategy Head,
GI Cancer

Ashok Gupta,
Global Clinical Strategy Head,
GU/GYN Cancer

Anas Younes,
Senior Vice President, Hematology

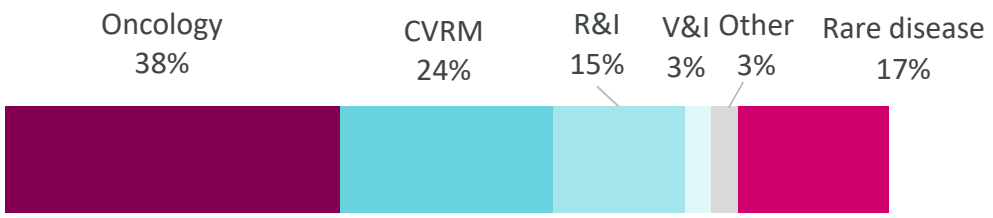
Furthering our oncology ambition @ ASCO 2023

Pascal Soriot
CHIEF EXECUTIVE OFFICER

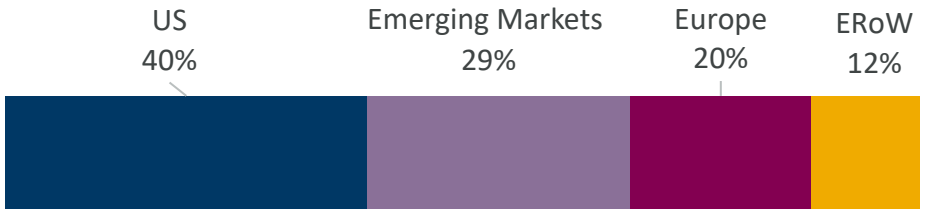


Broad-based, diverse source of revenue

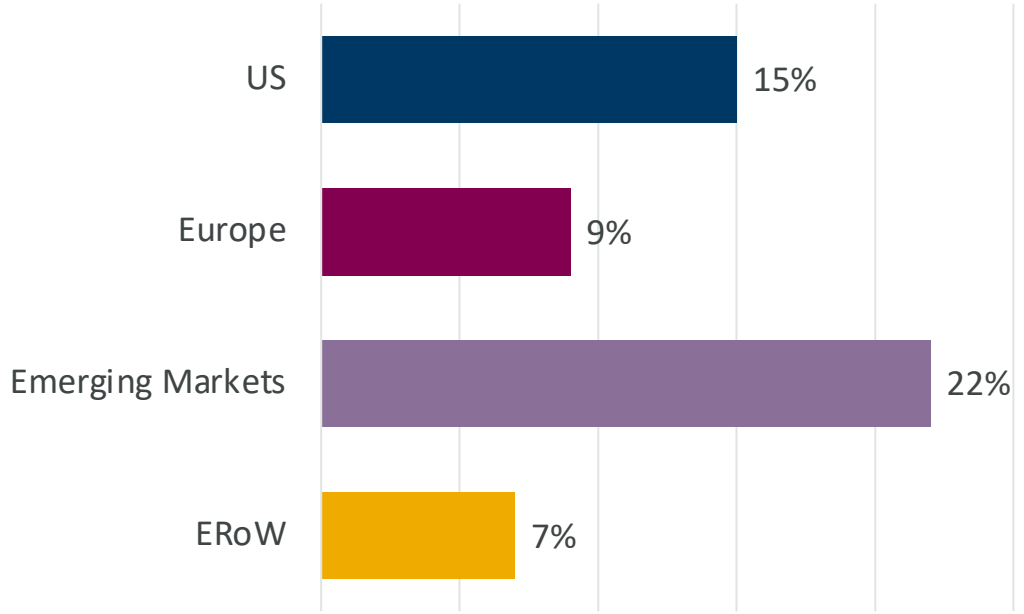
Q1 2023 | % Total Revenue by therapy area



Q1 2023 | % Total Revenue by geography



Q1 2023 | % YoY growth by region, ex. COVID



Industry-leading outlook underpinned by broad portfolio and geographic footprint

All growth rates in CER.

CVRM = Cardiovascular, Renal & Metabolism; R&I = Respiratory & Immunology; V&I = Vaccines & Immune Therapies; ERoW = Established Rest of World; YoY = year-on-year; ex. = excluding.

AstraZeneca

2023 ASCO ANNUAL MEETING

134 abstracts with 12 oral presentations

1	plenary presentation
11	oral presentations
6	poster discussions
87	posters
29	online publications

>40% more abstracts vs ASCO 2019

Key data highlights

ADAURA OS (LBA3)

DUO-O (LBA5506)

DESTINY-PanTumor02 (LBA3000)

TROPION-Lung02 (9004)

***Calquence* r/r MAIC** (7540)

ARTEMIDE-01 (9050)

5 years of Plenary Presentations

2019 POLO

2020 ADAURA

2021 OlympiA

2022 DB04

2023 ADAURA OS

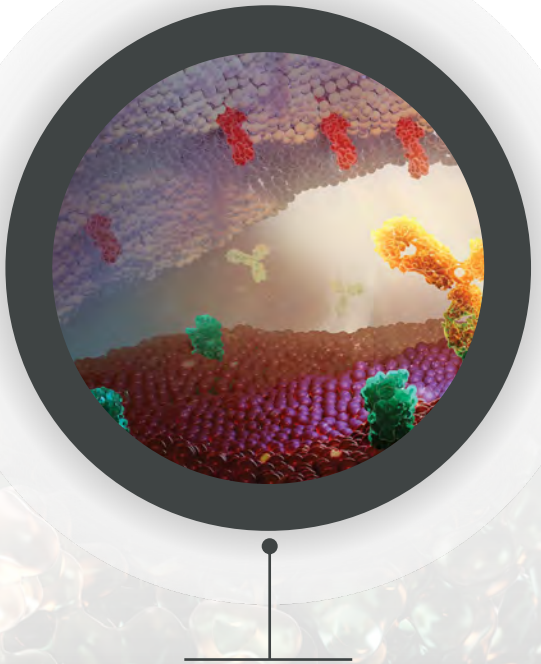
OS = overall survival; DB04 = DESTINYBreast-04; r/r = relapsed/refractory; MAIC = matched adjusted indirect comparison.
Collaboration partners: Daiichi Sankyo (Enhertu, Dato-DXd).

AstraZeneca 2023 – oncology outlook

Strengthening existing leadership positions and expanding innovative pipeline

Reinforce tumour area leadership

Advance novel modalities



Pursue innovative combinations

AstraZeneca in oncology

Diverse portfolio of novel modalities and medicines, supporting potential combinations

Cell therapy

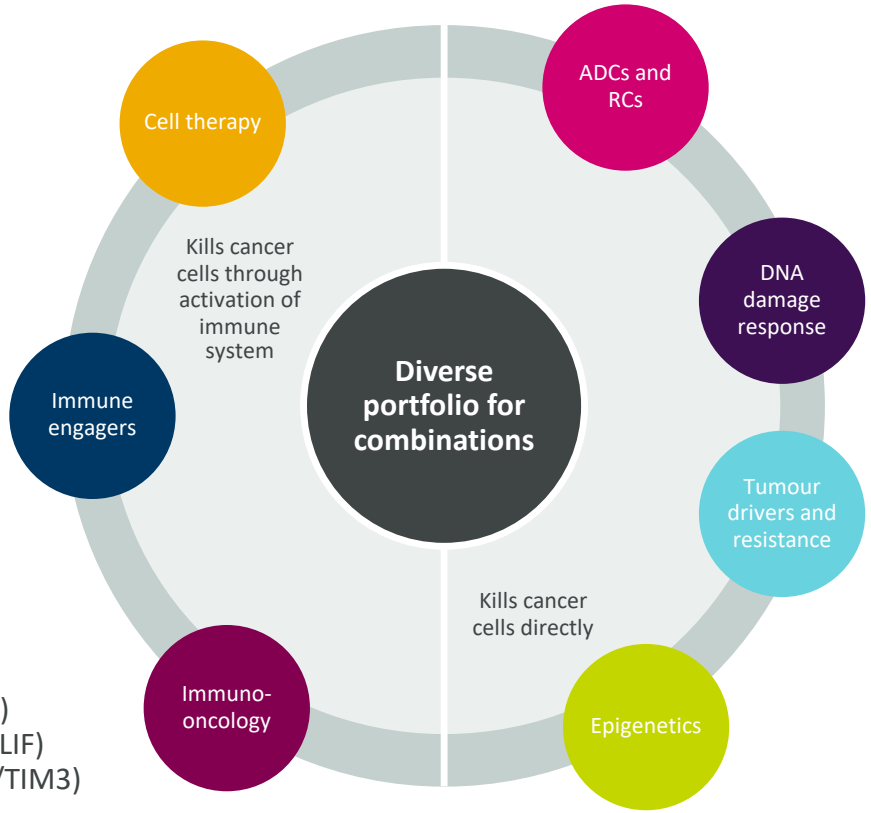
- armoured GPC3 CAR-T
- NT-125 (TCR-T)

Immune engagers

- AZD0486 (CD19xCD3)

Immuno-oncology

- oleclumab
- monalizumab
- volrustomig (PD1/CTLA4)
- rilvegostomig (PD1/TIGIT)
- IPH5201 (CD39)
- AZD0171 (anti-LIF)
- AZD7789 (PD1/TIM3)



ADCs + RCs

- Dato-DXd
- AZD8205 (B7-H4)
- AZD9592 (EGFR/cMET)
- AZD0901 (CLDN18.2)

DNA Damage Response

- ceralasertib (ATR)
- AZD9574 (PARP1BBB)
- saruparib (PARP1sel)
- AZD1390 (ATM)

Tumour Drivers and Resistance

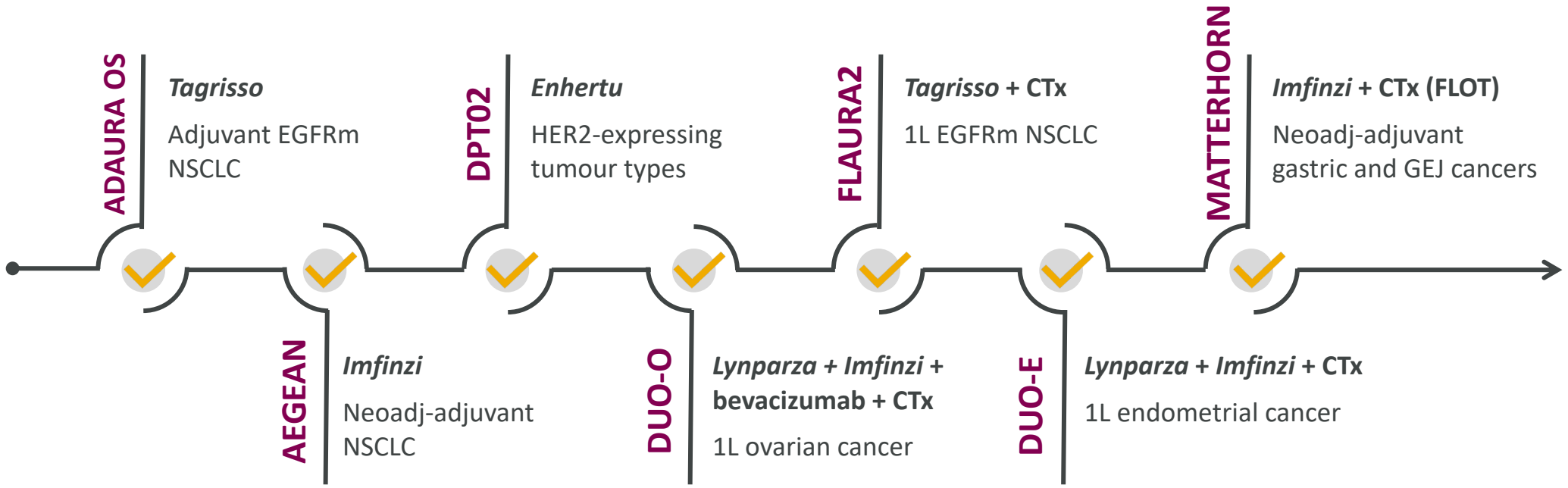
- capivasertib (AKT)
- camizestrant (SERD)
- AZD4573 (CDK9)
- AZD0466 (BCL2-xL)

Epigenetics

GPC3 CAR-T = glypican 3 protein, chimeric antigen receptor t-cell; TCR-T = T-cell receptor-based therapy; CD19xCD3 = cluster of differentiation 19 x cluster of differentiation 3; PD1/CTLA4 = programmed cell death protein 1/cytotoxic t-lymphocyte-associated antigen 4; PD1/TIGIT = programmed cell death protein 1/T cell immunoreceptor with Ig and ITIM domains; CD39 = cluster of differentiation 39; anti-LIF = anti-leukemia inhibitory factor; PD1/TIM3 = programmed cell death protein 1/T cell immunoglobulin mucin-3; ADC = antibody drug conjugate; RC = radioconjugate; B7-H4 = B7 family homolog 4; EGFR/cMET = epidermal growth factor receptor mutant/mesenchymal-epithelial transition factor; CLDN18.2 = Claudin-18.2; ATR = ataxia telangiectasia and Rad3-related protein; PARP1sel = Poly (ADP-ribose) polymerase 1 selective; PARP1BBB = PARP1 blood brain barrier penetrant; ATM = ataxia telangiectasia mutated; AKT = protein kinase B; SERD = selective estrogen receptor degrader/down regulator; CDK9 = cyclin-dependent kinase 9; BCL2-xL = B-cell lymphoma-extra large. Collaboration partners: Daiichi Sankyo (Dato-DXd); Compugen (rilvegostomig).

AstraZeneca oncology momentum in 2023

Pipeline news flow continues with early efficacy signal in Phase III MATTERHORN trial



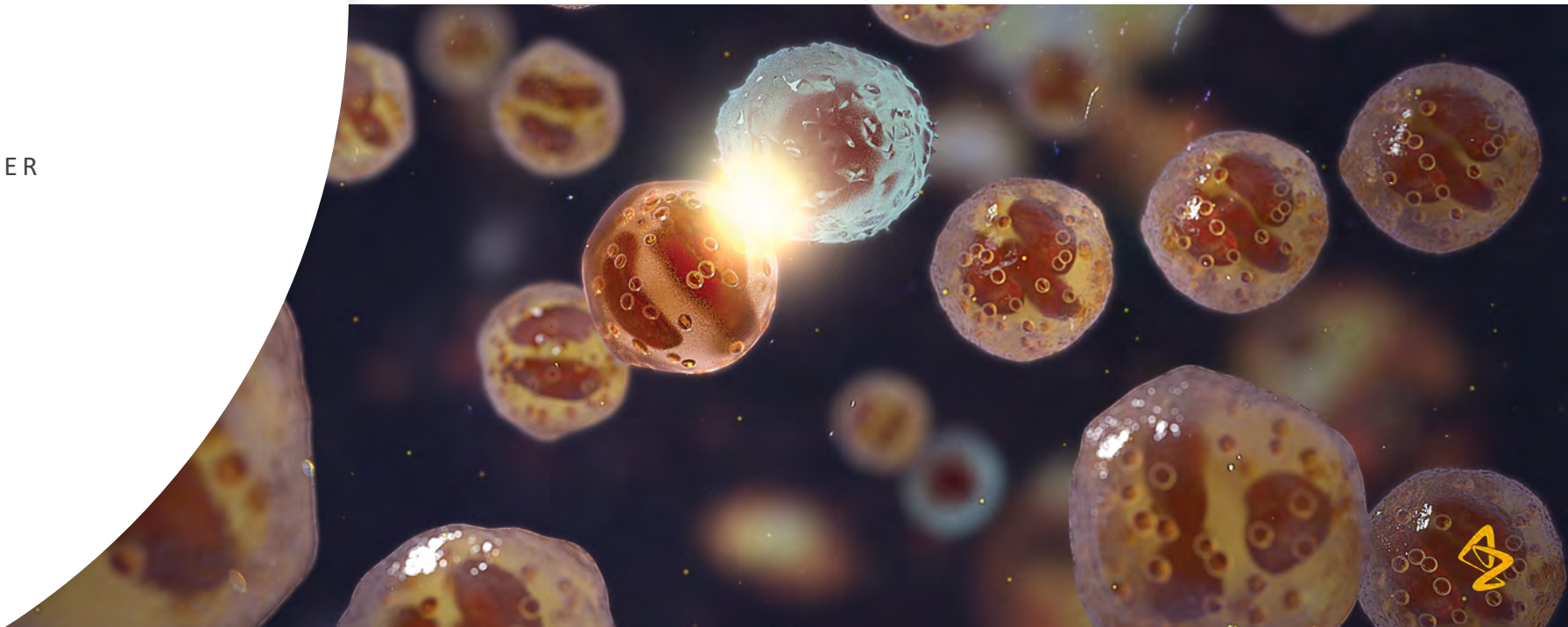
7 positive key oncology data read-outs to date in 2023

OC = ovarian cancer; NSCLC = non-small cell lung cancer; CTx = chemotherapy; EGFRm = epidermal growth factor receptor-mutant; EC = endometrial cancer; FLOT = fluorouracil, leucovorin, oxaliplatin and docetaxel; GEJ = gastroesophageal junction cancer; ECOG PS = Eastern Cooperative Oncology Group performance status; PD-L1 = programmed cell death ligand 1; TAP = tumour area positivity; Q4W = every four weeks; EFS = event-free survival; ITT = intent-to-treat; pCR = pathologic complete response.

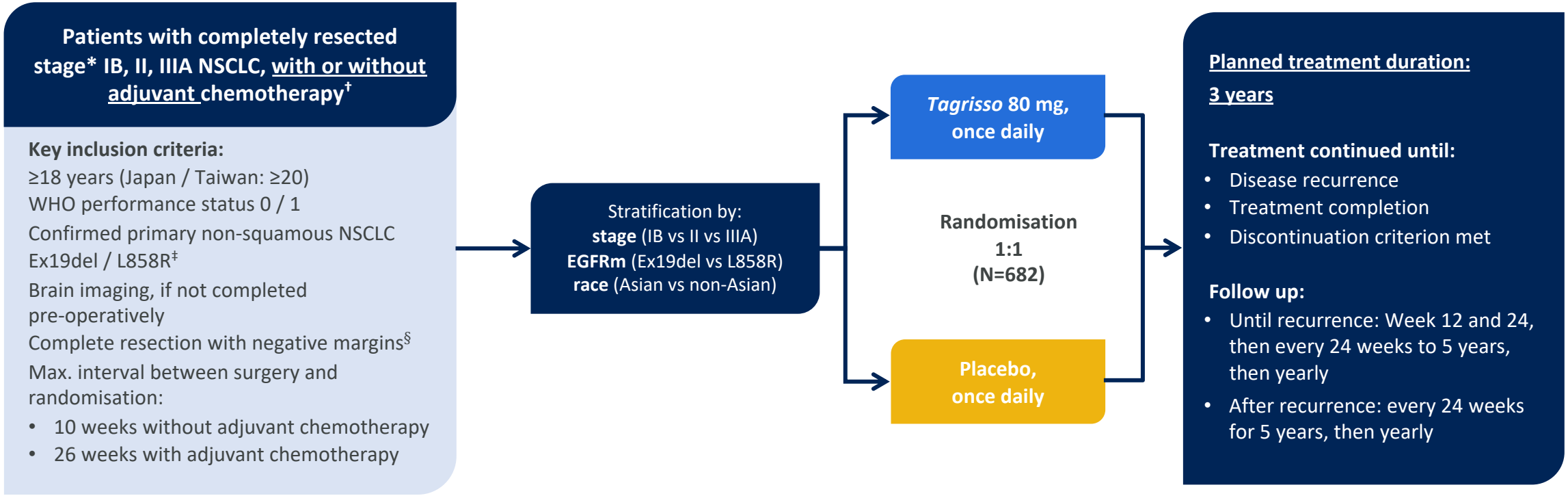
Setting a new milestone in EGFRm NSCLC

ADAURA OS

Roy Herbst
DEPUTY DIRECTOR, YALE CANCER CENTER
AND SMILOW CANCER HOSPITAL



ADAURA Phase III trial design



Endpoints

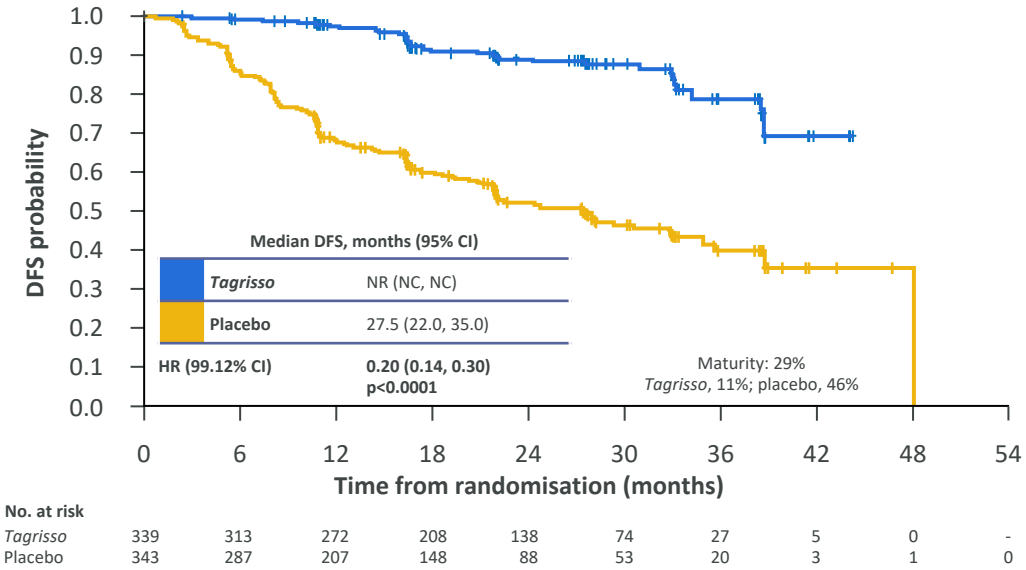
- **Primary endpoint:** DFS by investigator assessment in stage II / IIIA patients
- **Key secondary endpoints:** DFS in the overall population (stage IB–IIIA), landmark DFS rates, OS, safety, health-related quality of life

*At the time of recruitment, staging was determined by the AJCC / UICC Staging Manual 7th edition. Patients with stage IB disease were not eligible in Japan. †Pre-operative, post-operative, or planned radiotherapy was not allowed.
‡Centrally confirmed in tissue. §Patients received a CT scan after resection and within 28 days prior to treatment.
NSCLC = non-small cell lung cancer, EGFRm = epidermal growth factor receptor mutant; DFS = disease-free survival; OS = overall survival.

Adjuvant *Tagrisso* has significantly improved DFS

ADAURA primary DFS analysis[1,2] (stage IB–IIIA)*

Published in NEJM October 2020

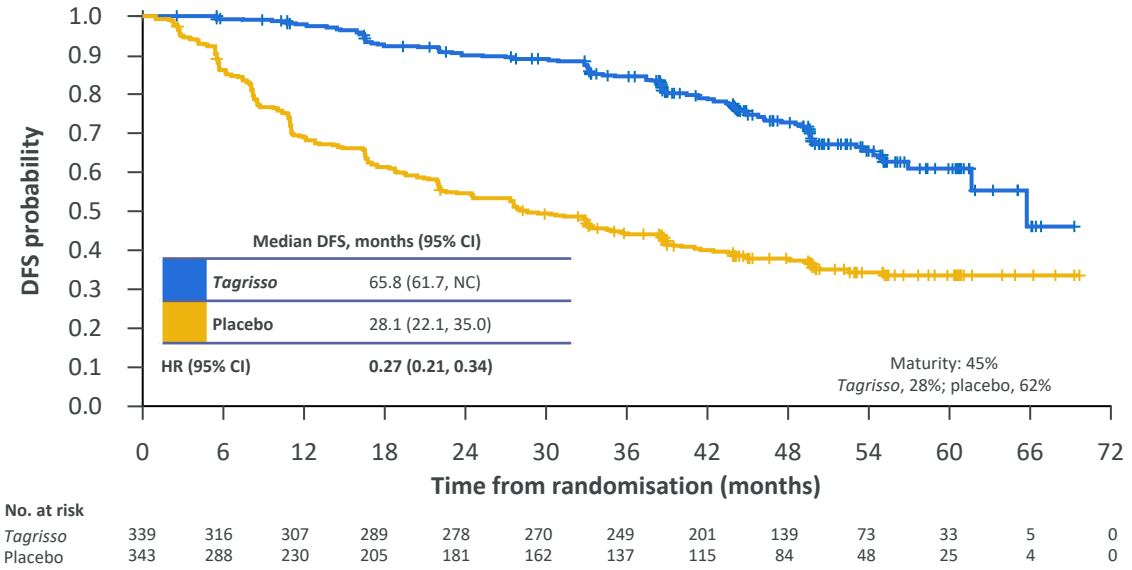


No. at risk

Tagrisso	339	313	272	208	138	74	27	5	0	-
Placebo	343	287	207	148	88	53	20	3	1	0

ADAURA updated DFS analysis[3,4] (stage IB–IIIA)†

Published in JCO January 2023



No. at risk

Tagrisso	339	316	307	289	278	270	249	201	139	73	33	5	0
Placebo	343	288	230	205	181	162	137	115	84	48	25	4	0

- Adjuvant *Tagrisso* has demonstrated a highly statistically significant[1,2] and clinically meaningful improvement in DFS in completely resected, EGFRm NSCLC vs placebo in both the primary (stage II–IIIA) and overall (IB–IIIA) populations, along with a tolerable safety profile[1–4]

*Data cut-off: January 17, 2020. † Data cut-off: April 11, 2022.

1. Wu et al. N Engl J Med 2020;383:1711–1723; 2. Herbst et al. J Clin Oncol 2020;38(Suppl 18): abstract / oral LBA5; 3. Herbst et al. J Clin Oncol 2023;41:1830–1840; 4. Tsuboi et al. Ann Oncol 2022;33(Suppl 7): abstract / oral LBA47.

DFS = disease free survival; NEJM = New England Journal of Medicine; JCO = Journal of Clinical Oncology; HR = hazard ratio;; CI = confidence interval; NC = not calculable; NR = not reached; no. = number; EGFRm = epidermal growth factor receptor-mutated; NSCLC = non-small cell lung cancer.

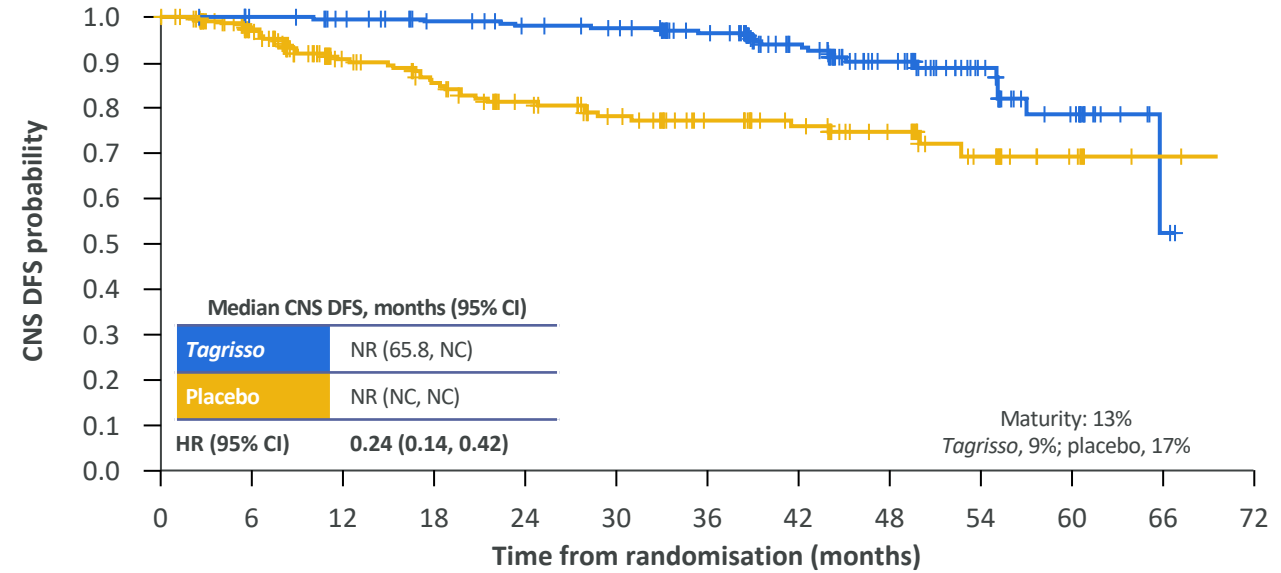
Adjuvant *Tagrisso* has significantly improved CNS DFS

Improved CNS efficacy with *Tagrisso* treatment

- *Tagrisso* has been shown to achieve clinically significant exposure in the brain compared with other EGFR-TKIs, and has shown greater penetration of the blood-brain barrier[1-3]
- Adjuvant *Tagrisso* demonstrated CNS DFS benefit vs placebo in both the Stage II–IIIA and IB–IIIA populations; in the updated CNS DFS analysis, 63 patients (*Tagrisso* n=22, placebo n=41) had CNS DFS events[4,5]*

ADAURA updated CNS DFS analysis[4,5] (stage II–IIIA)

Published in JCO January 2023



No. at risk													
Tagrisso	233	222	216	202	196	192	175	138	90	45	20	2	0
Placebo	237	192	142	126	107	91	74	61	41	23	11	1	0

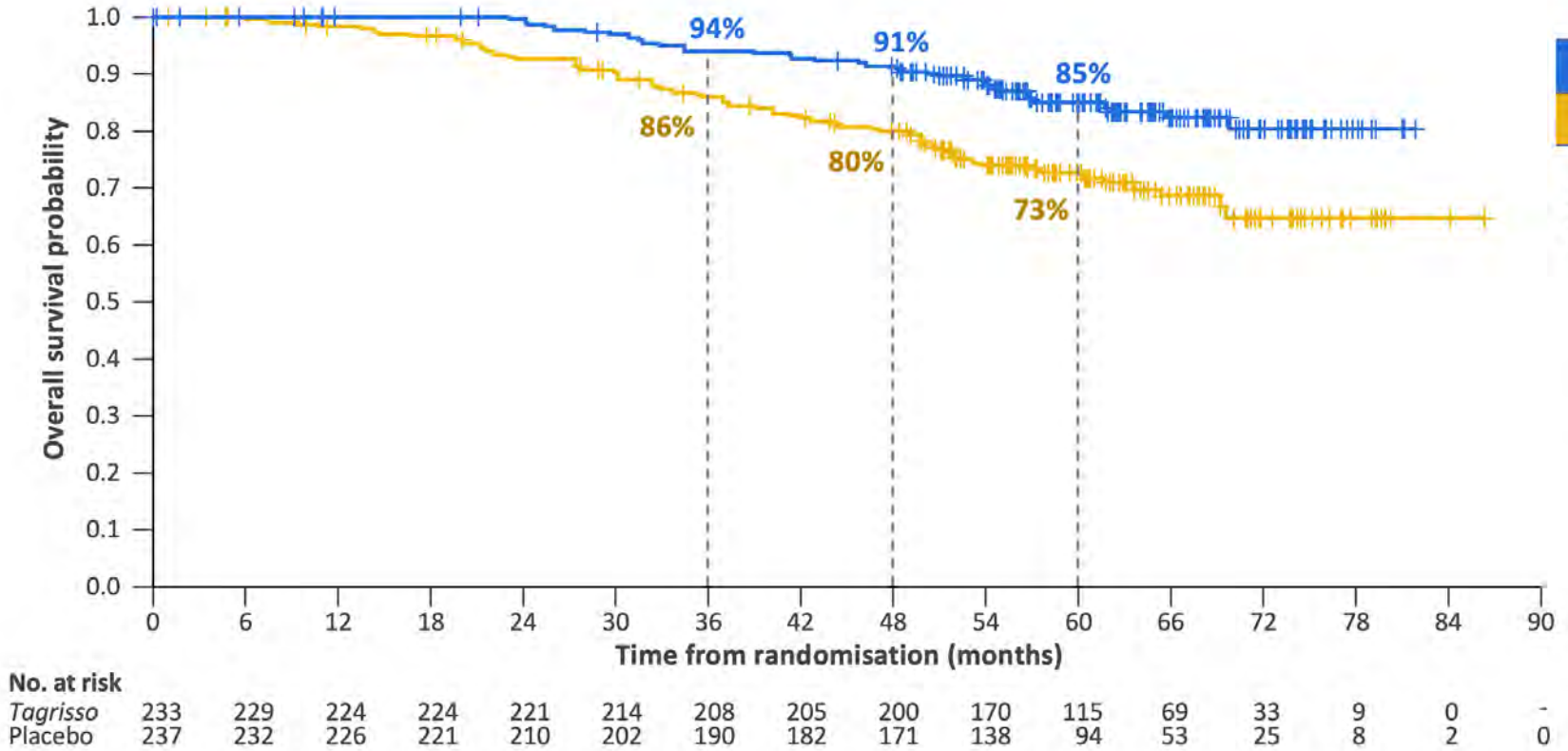
CNS metastases are a poor prognostic factor among patients with NSCLC, associated with deterioration in quality of life[6]

Data cut-off: April 11, 2022. *Defined as CNS as the first site of disease recurrence, or death without any disease recurrence.

Colclough et al. Eur J Cancer 2016;69:S28; 2. Ballard et al. Clin Cancer Res 2016;22:5130–5140; 3. Vishwanathan et al. Cancer Res 2018; 78:CT013; 4. Herbst et al. J Clin Oncol 2023;41:1830–1840; 5. Tsuboi et al. Ann Oncol 2022;33(Suppl 7): abstract / oral LBA47; 6. Peters et al. Cancer Treat Rev 2016;45:139–162.

CNS = central nervous system; DFS = disease-free survival; EGFR-TKI = EGFR = epidermal growth factor receptor tyrosine kinase inhibitor; HR = hazard ratio; CI = confidence interval; no. = number; NC = not calculable; NR = not reached; NSCLC = non-small cell lung cancer; JCO = Journal of Clinical Oncology

Overall survival: patients with stage II/IIIA disease



5-year OS rate, % (95% CI)	
***Tagrisso* (n=233)**	85 (79, 89)
Placebo (n=237)	73 (66, 78)

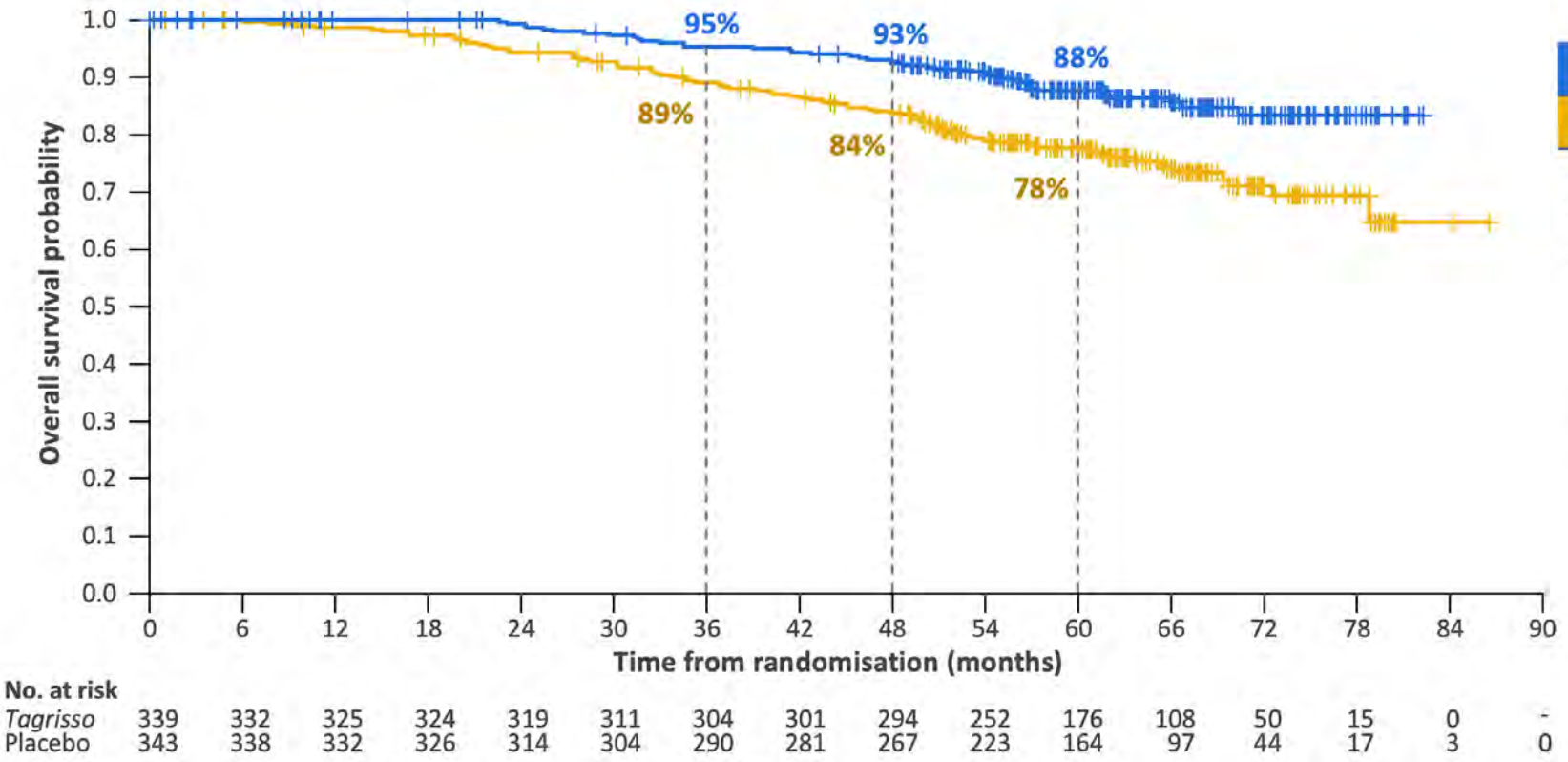
Overall OS HR (95.03% CI) **0.49 (0.33, 0.73); p=0.0004**

Maturity: 21%
Tagrisso 15%, placebo 27%

Median follow-up for OS* (censored patients):
***Tagrisso* 61.7 months, placebo 60.4 months**

Data cut-off: January 27, 2023.
Tick marks indicate censored data. Alpha allocation of 0.0497. *Median follow-up for OS (all patients): *Tagrisso* 59.9 months, placebo 56.2 months.
OS = overall survival; HR = hazard ratio; CI = confidence interval; no. = number.

Overall survival: overall population (stage IB/II/IIIA disease)



5-year OS rate, % (95% CI)	
Tagrisso (n=339)	88 (83, 91)
Placebo (n=343)	78 (73, 82)

Overall OS HR (95.03% CI) **0.49 (0.34, 0.70); p<0.0001**

Maturity: 18%
Tagrisso 12%, placebo 24%

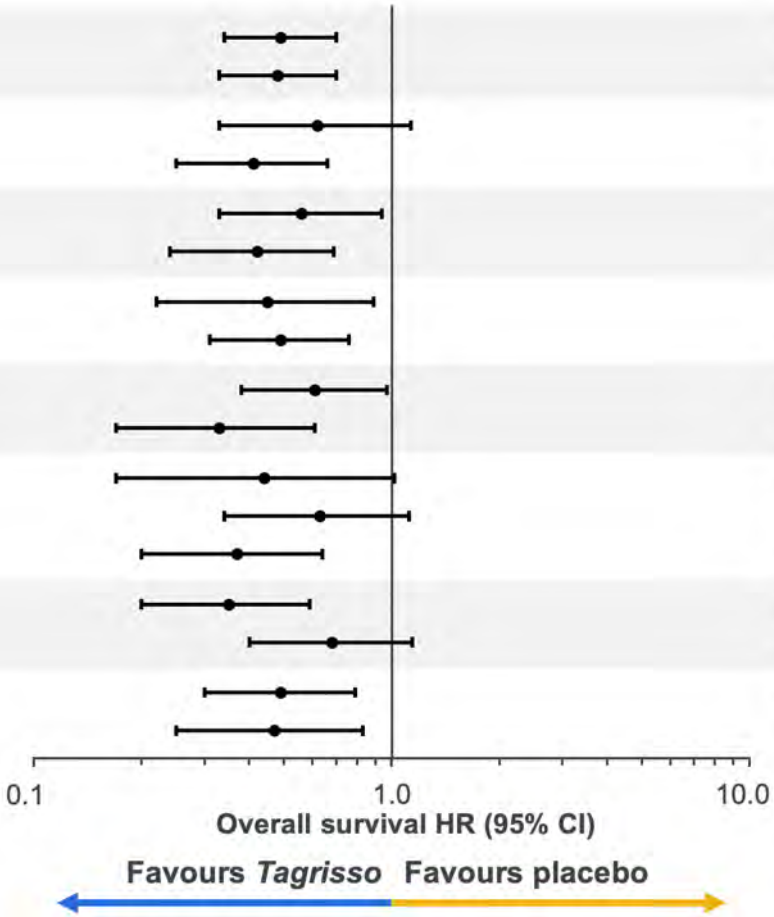
Median follow-up for OS* (censored patients):
***Tagrisso* 61.5 months, placebo 61.5 months**

- Adjuvant *Tagrisso* demonstrated a statistically and clinically significant improvement in OS vs placebo in the overall population of stage IB-IIIA disease

Data cut-off: January 27, 2023.
Tick marks indicate censored data. Alpha allocation of 0.0497. *Median follow-up for OS (all patients): *Tagrisso* 60.4 months, placebo 59.4 months.
OS = overall survival; HR = hazard ratio; CI = confidence interval; no. = number.

OS across subgroups: overall population (stage IB/II/IIIA)

Subgroup		No. of events / patients	HR	95% CI
Overall (N=682)	Stratified log-rank	124 / 682	0.49	0.34, 0.70
	Unadjusted Cox PH	124 / 682	0.48	0.33, 0.70
Sex	Male	42 / 204	0.62	0.33, 1.13
	Female	82 / 478	0.41	0.25, 0.66
Age	<65 years	60 / 380	0.56	0.33, 0.94
	≥65 years	64 / 302	0.42	0.24, 0.69
Smoking history	Yes	34 / 194	0.45	0.22, 0.89
	No	90 / 488	0.49	0.31, 0.76
Race	Asian	73 / 434	0.61	0.38, 0.97
	Non-Asian	51 / 248	0.33	0.17, 0.61
Stage*	IB	24 / 212	0.44	0.17, 1.02
	II	46 / 236	0.63	0.34, 1.12
	IIIA	54 / 234	0.37	0.20, 0.64
EGFR mutation	Ex19del	65 / 378	0.35	0.20, 0.59
	L858R	59 / 304	0.68	0.40, 1.14
Adjuvant chemotherapy	Yes	74 / 410	0.49	0.30, 0.79
	No	50 / 272	0.47	0.25, 0.83



Data cut-off: January 27, 2023.
*AJCC / UICC 7th edition.
OS = overall survival; HR = hazard ratio; CI = confidence interval; PH = proportional-hazards model; EGFR = epidermal growth factor receptor; AJCC = American Joint Committee on Cancer; UICC = Union for International Cancer Control.

Safety summary

- At the final DFS analysis (data cut-off: 11 April 2022), all patients had completed or discontinued study treatment; the safety profile of adjuvant *Tagrisso* with extended follow-up[1,2] was consistent with the ADAURA primary analysis[3]

AE, any cause*, n (%)	***Tagrisso* (n=337)**	**Placebo (n=343)**
Any AE	330 (98)	309 (90)
Any AE Grade ≥3	79 (23)	48 (14)
Any AE leading to death	1 (<1)	2 (1)
Any serious AE	68 (20)	47 (14)
Any AE leading to discontinuation	43 (13)	9 (3)
Any AE leading to dose reduction	42 (12)	3 (1)
Any AE leading to dose interruption	91 (27)	43 (13)
AE, possibly causally related*†, n (%)		
Any AE	308 (91)	199 (58)
Any AE Grade ≥3	36 (11)	7 (2)
Any AE leading to death	0	0
Any serious AE	10 (3)	2 (1)

- At the time of the current data cut-off (27 January 2023), one additional serious AE (COVID-19 pneumonia) had been reported, which occurred >28 days after treatment discontinuation; the investigator determined that this was not treatment-related and the patient made a full recovery

*Data cut-off: April 11, 2022. Patients with multiple events in the same category counted only once in that category. Patients with events in more than one category counted once in each of those categories. Includes AEs with an onset date on or after the date of first dose and up to and including 28 days following the discontinuation of study treatment and before starting subsequent cancer therapy. †As assessed by the investigator.

1. Herbst et al. J Clin Oncol 2023;41:1830–1840; 2. John et al. J Thorac Oncol 2023; accepted and under revision; 3. Wu et al. N Engl J Med 2020;383:1711–1723.

DFS = disease-free survival; AE = adverse event; COVID-19 = coronavirus disease 2019.

Conclusions

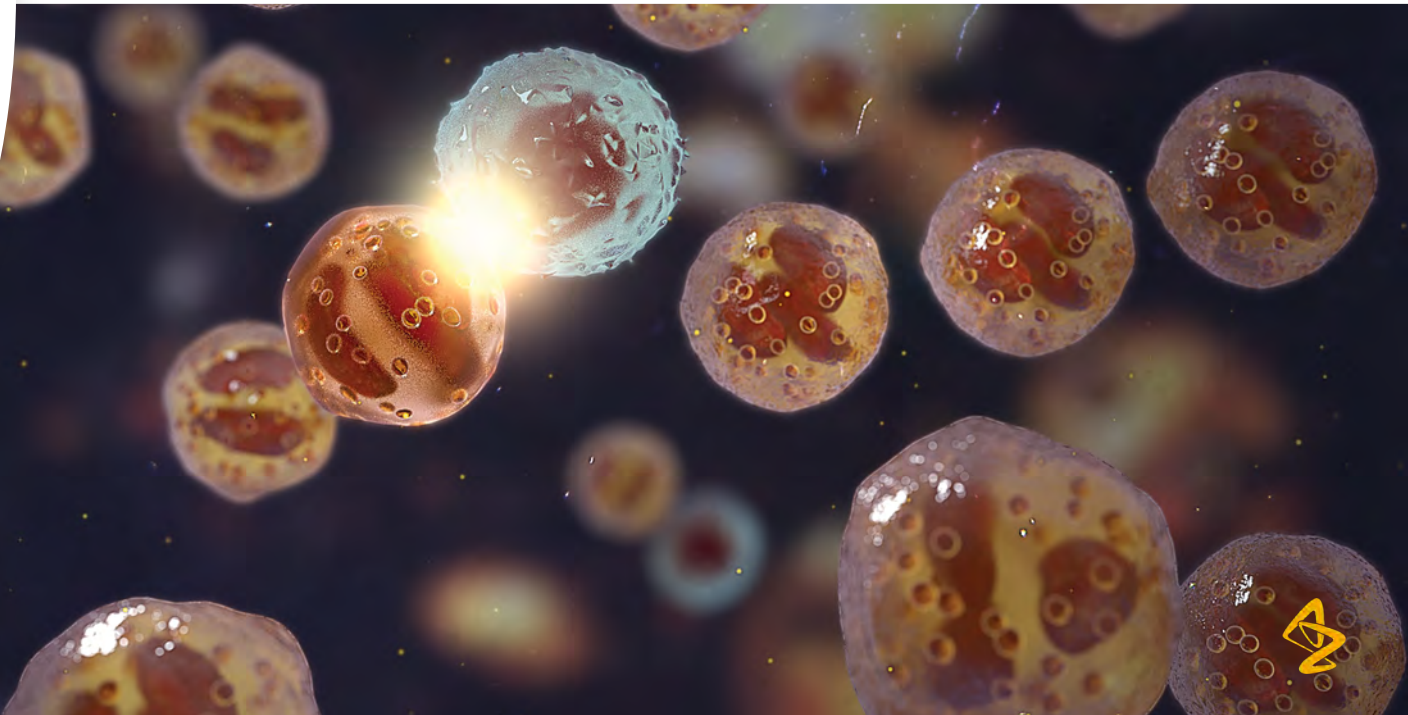
- In the ADAURA primary analysis, adjuvant *Tagrisso* demonstrated a statistically significant[1] and clinically meaningful DFS benefit vs placebo in resected EGFRm stage IB–IIIA NSCLC, along with improved CNS DFS and a tolerable safety profile[1,2]
- **DFS benefit in ADAURA has translated into a statistically significant OS benefit with adjuvant *Tagrisso* vs placebo**
  - **Primary (stage II–IIIA) population, OS HR 0.49; 95.03% CI 0.33, 0.73; p=0.0004**
  - **Overall (stage IB–IIIA) population, OS HR 0.49; 95.03% CI 0.34, 0.70; p<0.0001**
- OS benefit with adjuvant *Tagrisso* vs placebo was generally consistent across subgroups, including by disease stage (IB / II / IIIA) and prior adjuvant chemotherapy use (yes / no)
- **ADAURA is the first global Phase III study to demonstrate statistically significant and clinically meaningful OS benefit with targeted treatment in this patient population, reinforcing adjuvant *Tagrisso* as the standard of care for patients with resected EGFRm stage IB–IIIA NSCLC**

Data cut-off: January 27, 2023.

1. Wu et al. N Engl J Med 2020;383:1711-1723; 2. Herbst et al. J Clin Oncol 2023; 41: 1830-1840.

DFS = disease-free survival; EGFRm = epidermal growth factor receptor-mutated; NSCLC = non-small cell lung cancer; CNS = central nervous system; OS = overall survival; HR = hazard ratio.

Strengthening presence in lung cancer & advancing emerging portfolio



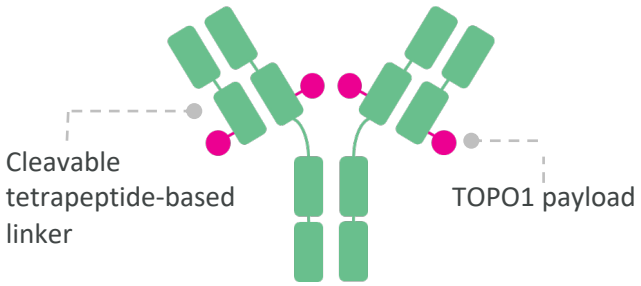
Susan Galbraith
ONCOLOGY R&D

Dave Fredrickson
ONCOLOGY BUSINESS

Dato-DXd

Best-in-class TROP2 ADC investigated in monotherapy and novel combinations

Dato-DXd



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

Clinical development programme supports Dato-DXd strategy

Potential to replace CTx as monotherapy and as backbone

- First Phase III trials in lung and breast HLR anticipated 2023
- Ongoing signal generation in multiple tumour types beyond lung and breast

Further outcomes with novel combination regimens

- Emerging IO combination efficacy with studies in 1L metastatic and earlier-line setting
- Signal-finding with other assets ongoing (e.g., *Tagrisso*)

Assess predictive value of TROP2 biomarker

7 ongoing Phase III trials across NSCLC and breast cancer

Lung

- TROPION-Lung01 (HLR H1 2023)
- TROPION-Lung07 (HLR >2024)
- TROPION-Lung08 (HLR >2024)
- AVANZAR (HLR >2024)

Breast

- TROPION-Breast01 (HLR H2 2023)
- TROPION-Breast02 (HLR 2024)
- TROPION-Breast03 (HLR >2024)

Data-driven Phase III opportunities across multiple tumour areas

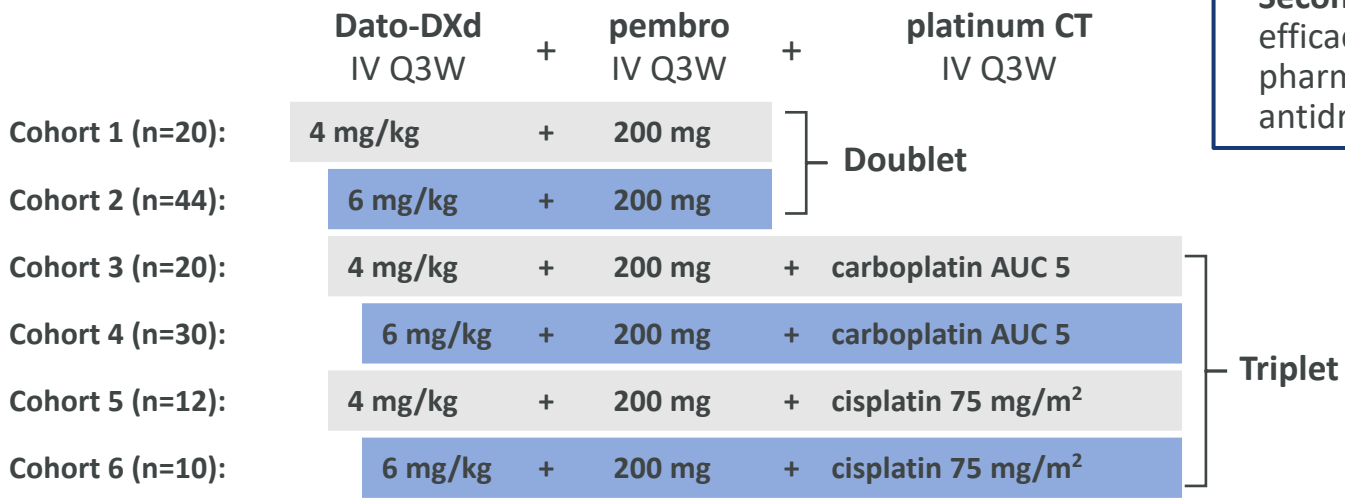
Dato-DXd = datopotamab deruxtecan; TROP2 = trophoblast cell-surface antigen 2; ADC = antibody drug conjugate; TOPO1 = topoisomerase 1; DAR = drug to antibody ratio; CTx = chemotherapy; IO = immuno-oncology; 1L = 1st-line; NSCLC = non-small cell lung cancer; HLR = high-level results.
Collaboration partners: Daiichi Sankyo (Dato-DXd).

TROPION-Lung02

Phase Ib investigating Dato-DXd + pembrolizumab ± PDx in 1L/2L+ mNSCLC

Key eligibility criteria

- Advanced/metastatic NSCLC
- **Dose escalation**[a]: ≤2 lines of prior therapy[b]
- **Dose expansion**
  - ≤1 line of platinum-based CTx (cohorts 1 and 2)[b]
  - Treatment naive (cohort 2; enrollment after Jun 30, 2022)[b]
  - Treatment naive (cohorts 3-6)[b]

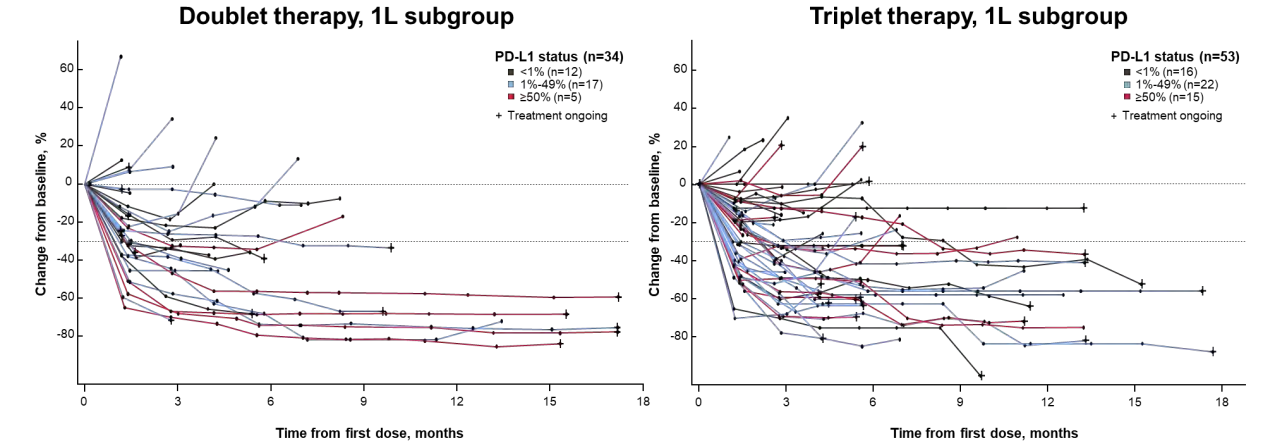


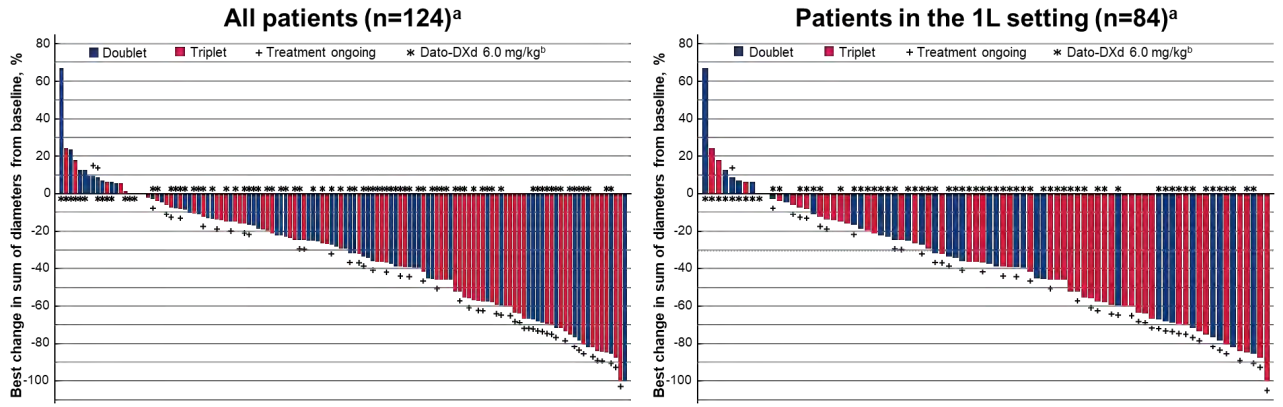
- **Primary objectives:** safety and tolerability
- **Secondary objectives:** efficacy, pharmacokinetics, and antidrug antibodies

[a]The first 3 to 6 patients in each cohort were enrolled to confirm acceptable safety/DLT rate; the remaining patients are considered part of dose expansion (for which enrollment was ongoing at the time of data cutoff). [b]Prior therapy requirements are for treatment in the advanced/metastatic setting.
Dato-DXd = datopotamab deruxtecan; pembro = pembrolizumab; PDx = platinum chemotherapy ; 1L = 1st-line; 2L = 2nd-line; mNSCLC = metastatic non-small cell lung cancer; CTx = chemotherapy; IV = intravenous; Q3W = every three weeks; AUC = area under the free carboplatin plasma concentration versus time curve.
Collaboration partners: Daiichi Sankyo (Dato-DXd).

TROPION-Lung02

Further follow-up reinforces encouraging efficacy with doublet and triplet regimens





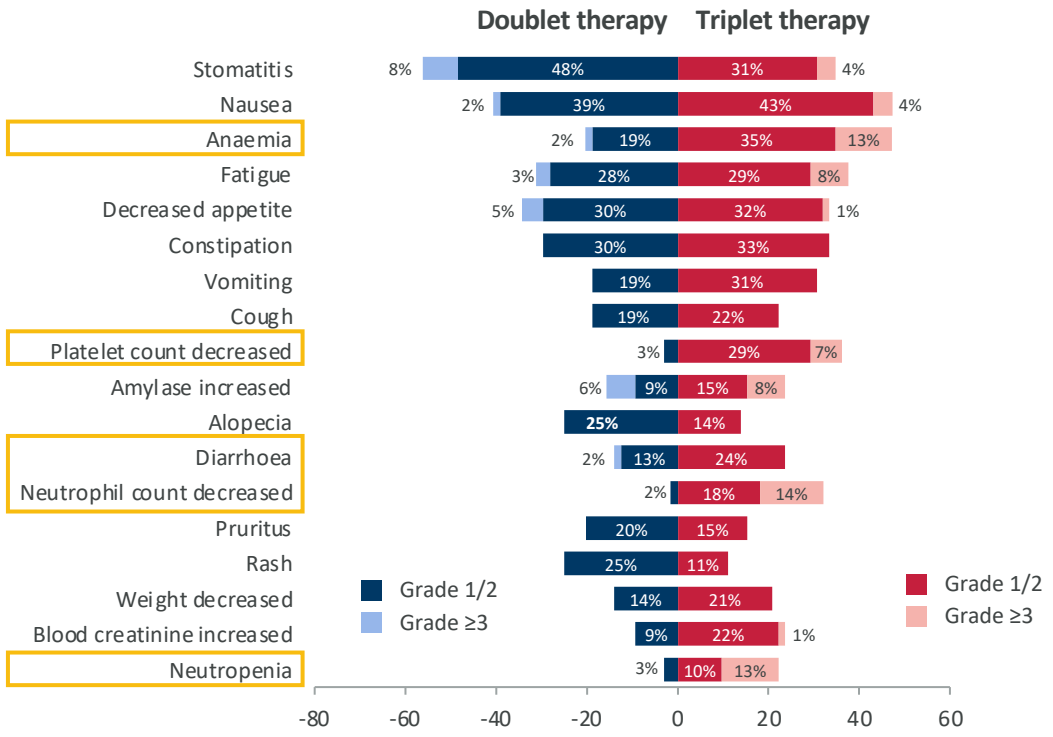
- Overall DCR 84% (doublet), 87% (triplet)
  - In 1L setting DCR 91% (doublet and triplet
- In 1L, ORR 50% (doublet) and 57% (triplet)
- mPFS 8.3 months (doublet), 7.8 months (triplet)[c]
- TROPION-Lung02 findings supportive of ongoing pivotal Phase III 1L trials:
  - TROPION-Lung07 (non-squamous w/o AGA, PD-L1 <50%)
  - TROPION-Lung08 (w/o AGA, PD-L1 ≥ 50%)
  - AVANZAR (w/o AGA)

[a]Patients with no baseline target lesions or no postbaseline tumor assessments were excluded from the waterfall plots. [b]Planned dose level; [c]Preliminary PFS is limited by immature duration of follow-up.
Dato-DXd = datopotamab deruxtecan; pembro = pembrolizumab; PDx = platinum chemotherapy ; 1L = 1st-line; 2L = 2nd-line; mNSCLC = metastatic non-small cell lung cancer; PD-L1 = programmed cell death ligand 1; DCR = disease control rate; ORR = objective response rate; mPFS = median progression-free survival; AGA = actionable genomic alterations.
Collaboration partners: Daiichi Sankyo (Dato-DXd).

TROPION-Lung02

Safety and tolerability profile supports dose for ongoing Phase III 1L trials

TEAEs occurred in ≥20% of patients



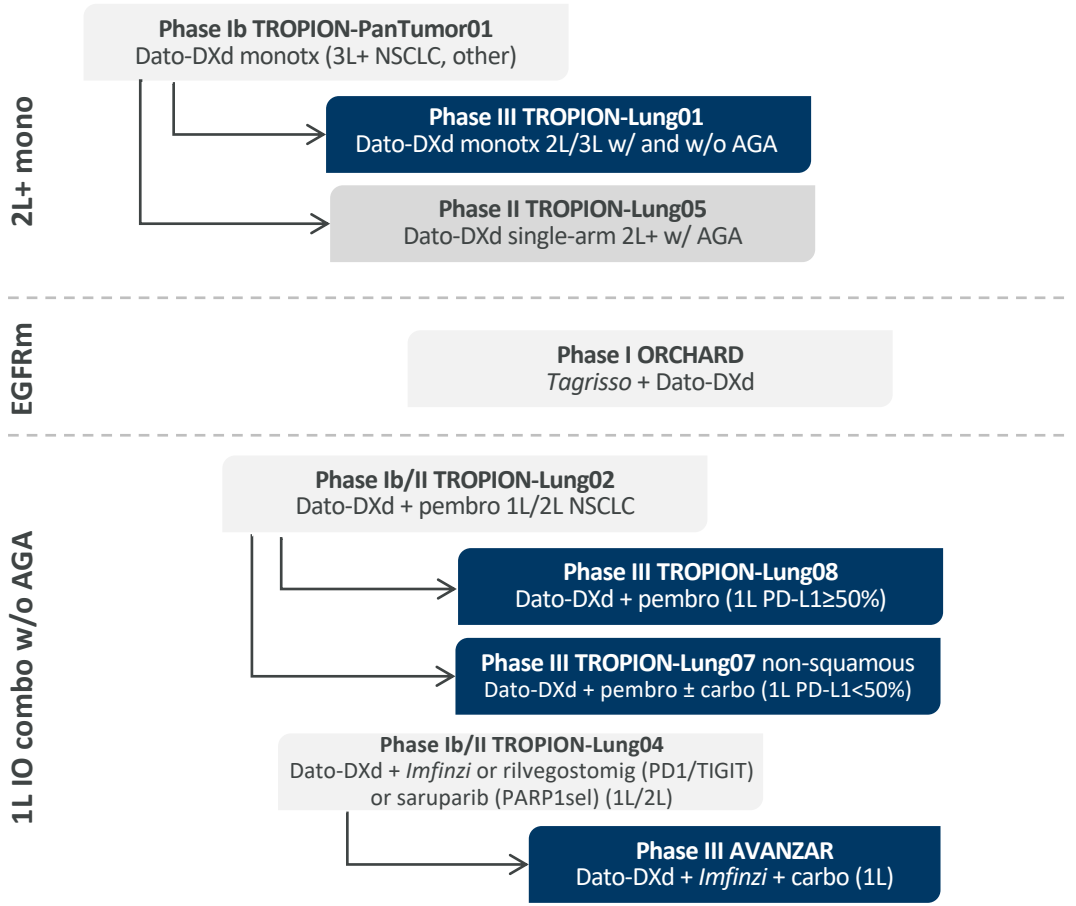
Safety summary

- No new safety signals were observed
- No adjudicated Grade 4 or 5 ILDs attributable to Dato-DXd
- Grade ≥3 ILD 3% for both doublet and triplet; similar rates to existing SoC
- Haematological toxicity was manageable with lower rates observed in doublet arm
- Safety data supports use of 6mg/kg dose in 1L NSCLC pivotal Phase III trials (TROPION-Lung07 and TROPION-Lung08)

1L = 1st-line; TEAE = treatment-emergent adverse event; ILD = interstitial lung disease; SoC = standard of care; NSCLC = non-small cell lung cancer.
Collaboration partners: Daiichi Sankyo (Dato-DXd).

Dato-DXd in NSCLC

Potential to replace current SoC CTx in 2L+ and establish Dato-DXd as backbone in 1L



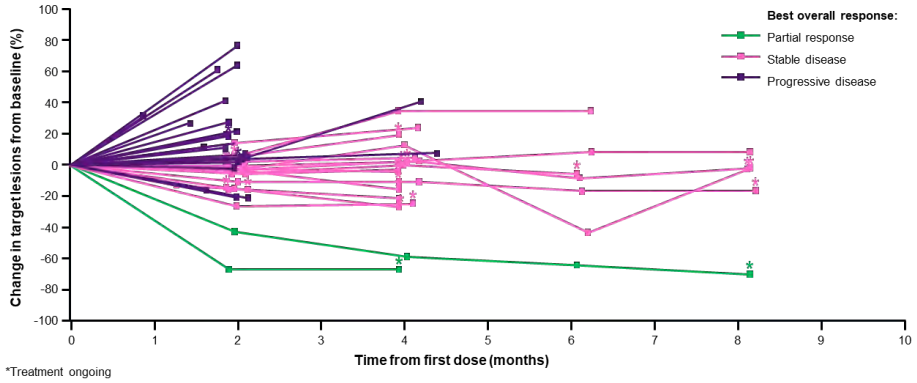
- **Replace current chemotherapy as monotherapy**
- **Pursue novel combinations based on supportive evidence (TROPION-PanTumor01)**
- **Move Dato-DXd earlier in treatment paradigm in combinations to improve outcomes**
- **Provide evidence across spectrum of PD-L1 levels**
- **Assess predictive value of TROP2 biomarker**

Dato-DXd = datopotamab deruxtecan; NSCLC = non-small cell lung cancer; SoC = standard of care; CTx = chemotherapy; 2L = 2nd-line; 1L = 1st-line; monotx = monotherapy; 3L = 3rd-line; AGA = actionable genomic alterations; pembro = pembrolizumab; PD-L1 = programmed cell death ligand 1; carbo = carboplatin; PARP1sel = PARP1 selective; TROP2 = trophoblast cell-surface antigen 2.
Collaboration partners: Daiichi Sankyo (Dato-DXd).

ARTEMIDE-01

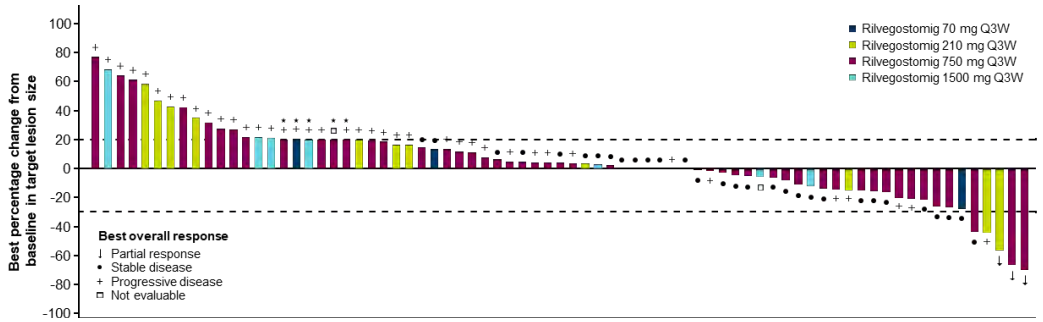
Rilvegostomig showed encouraging preliminary anti-tumour activity in CPI-experienced NSCLC

Percentage change from baseline in target lesion size over time at RP2D (750mg IV Q3W)



*Treatment ongoing

Best percentage change from baseline in target lesion size, all doses[1]



RECIST version 1.1.

Summary and key conclusions

- Demonstrated encouraging preliminary anti-tumour activity as 2L+ in pre-treated mNSCLC
- Rationale to further test rilvegostomig in CPI-naïve mNSCLC patients (expansion Part C and D)
- Safety established at all doses in patients previously treated with CPI and PDx
- No DLTs observed during dose escalation

Planning to initiate Phase III trial in 2023

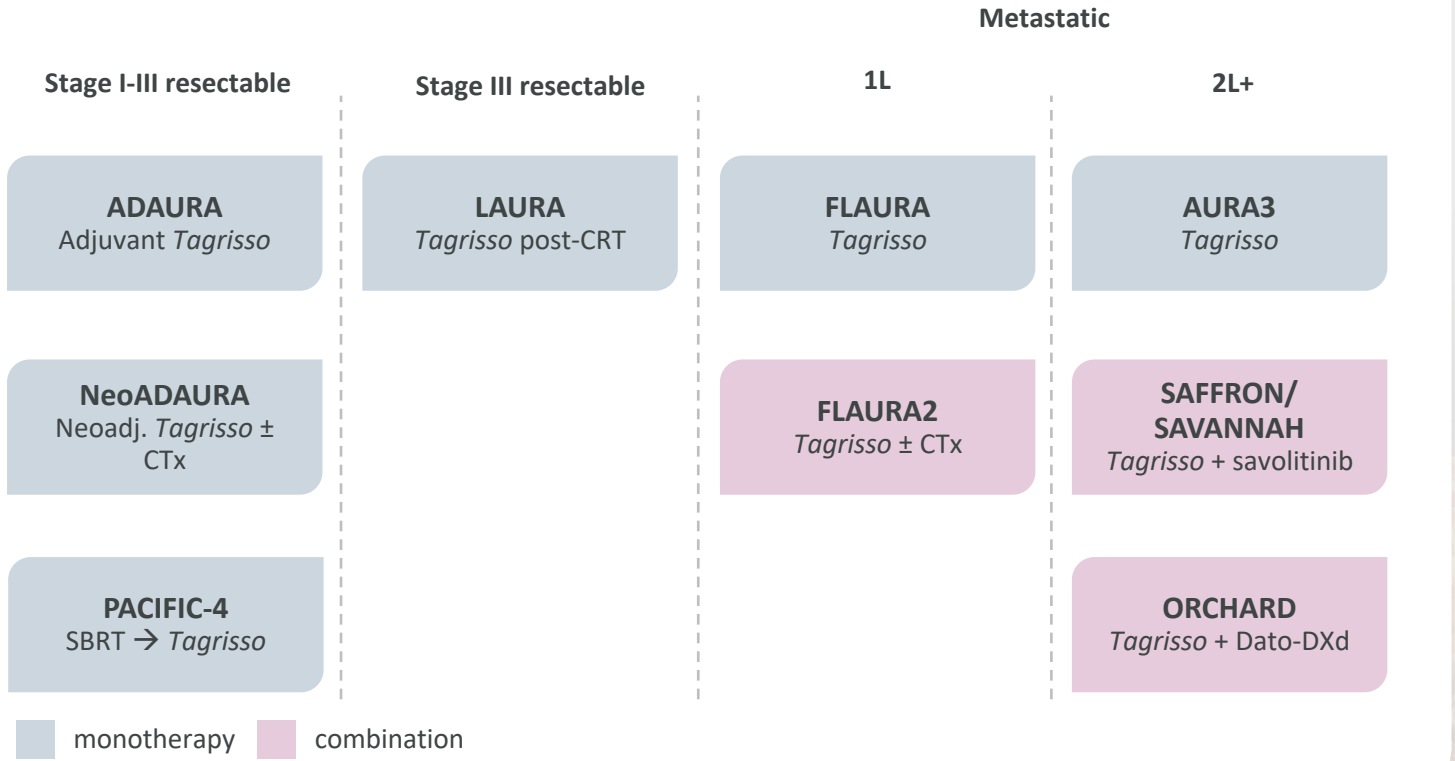
1. Imputed data: If best percentage change cannot be calculated due to missing data (including if the patient has no TLs at baseline), a value of +20% is imputed in the following situations: if a patient has no post baseline assessment and has died, if a patient has new lesions or progression of NTLs or TLs, or if a patient has withdrawn due to progressive disease and has no evaluable TL data before or at progression

PD1 = programmed cell death protein 1; TIGIT = T cell immunoreceptor with Ig and ITIM domains; (m)NSCLC = (metastatic) non-small cell lung cancer; RP2D = recommended Phase II dose; IV = intravenous; Q3W = every 3 weeks; RECIST = response evaluation criteria in solid tumours; NTL = non-target lesion; TL = target lesion; CPI = checkpoint inhibitor; PDx = platinum chemotherapy; DLTs = dose limiting toxicities.

Collaboration partners: Compugen (rilvegostomig).

Tagrisso

On track to establish *Tagrisso* as backbone TKI for the treatment of EGFRm NSCLC



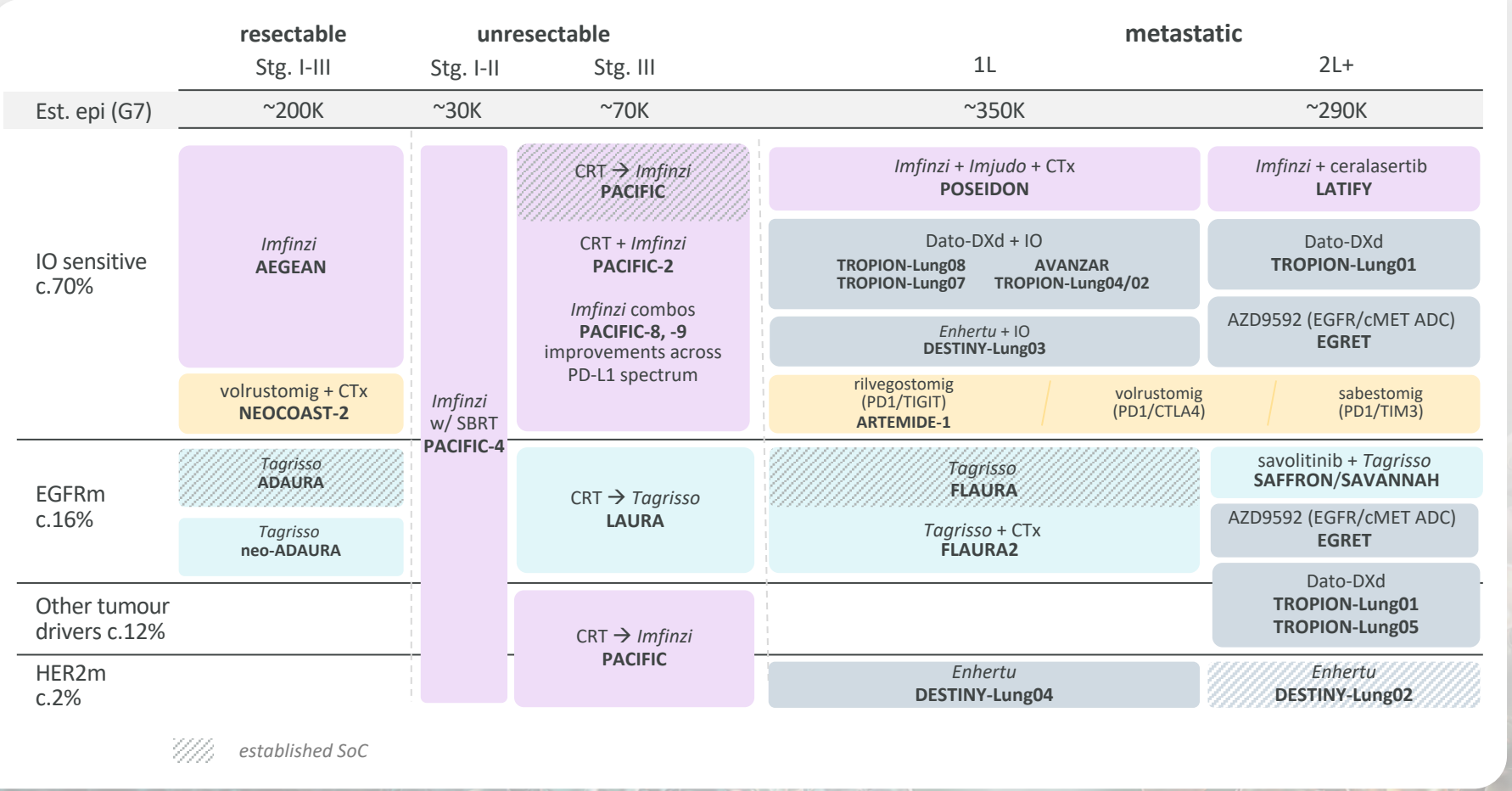
- ADAURA OS expands potential geographic reach in adjuvant
  - Closing care caps
  - Reimbursement
- Anticipate FLAURA remains SoC in 1L EGFRm NSCLC; FLAURA2 offers CTx combination approach
- Address biomarker-driven resistance and advance novel combinations

ADAURA OS data, FLAURA2 Phase III HLR expands patient reach

TKI = tyrosine kinase inhibitors; EGFRm = epidermal growth factor receptor mutant; NSCLC = non-small cell lung cancer; neoadj. = neoadjuvant; CTx = chemotherapy; CRT = chemoradiation therapy; 1L = 1st-line; 2L = 2nd-line; OS = overall survival; Dato-DXd = datopotamab deruxtecan; SoC = standard of care; HLR = high-level results; SBRT = stereotactic body radiotherapy.
Collaboration partners: Daiichi Sankyo (Dato-DXd).

AstraZeneca in Lung Cancer

Ambition for >50% of lung cancer patients to be eligible for AZN medicine by 2030



Leading the future of lung cancer treatment

- *Tagrisso* established TKI backbone in EGFRm
- *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 + ADC
- Investing behind new technologies and platforms, including cell therapy, testing/screening

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).

AstraZeneca @ ASCO 2023

Q&A Session I: Focus on Lung Cancer

KEY EXTERNAL EXPERT

Roy Herbst
DEPUTY DIRECTOR,
YALE CANCER CENTER AND
SMILOW CANCER HOSPITAL

ABBREVIATED BIOGRAPHY

Dr Herbst is nationally recognised for his leadership and expertise in lung cancer treatment and research. He is best known for his work in developmental therapeutics and the personalised therapy of non-small cell lung cancer, in particular the process of linking genetic abnormalities of cancer cells to novel therapies.

Prior to his appointment at Yale, Dr Herbst was the Barnhart Distinguished Professor and Chief of the Section of Thoracic Medical Oncology in the Department of Thoracic/Head and Neck Medical Oncology, at The University of Texas M.D. Anderson Cancer Center (UT-MDACC) in Houston, Texas. He also served as Professor in the Department of Cancer Biology and Co-Director of the Phase I Clinical Trials Program.

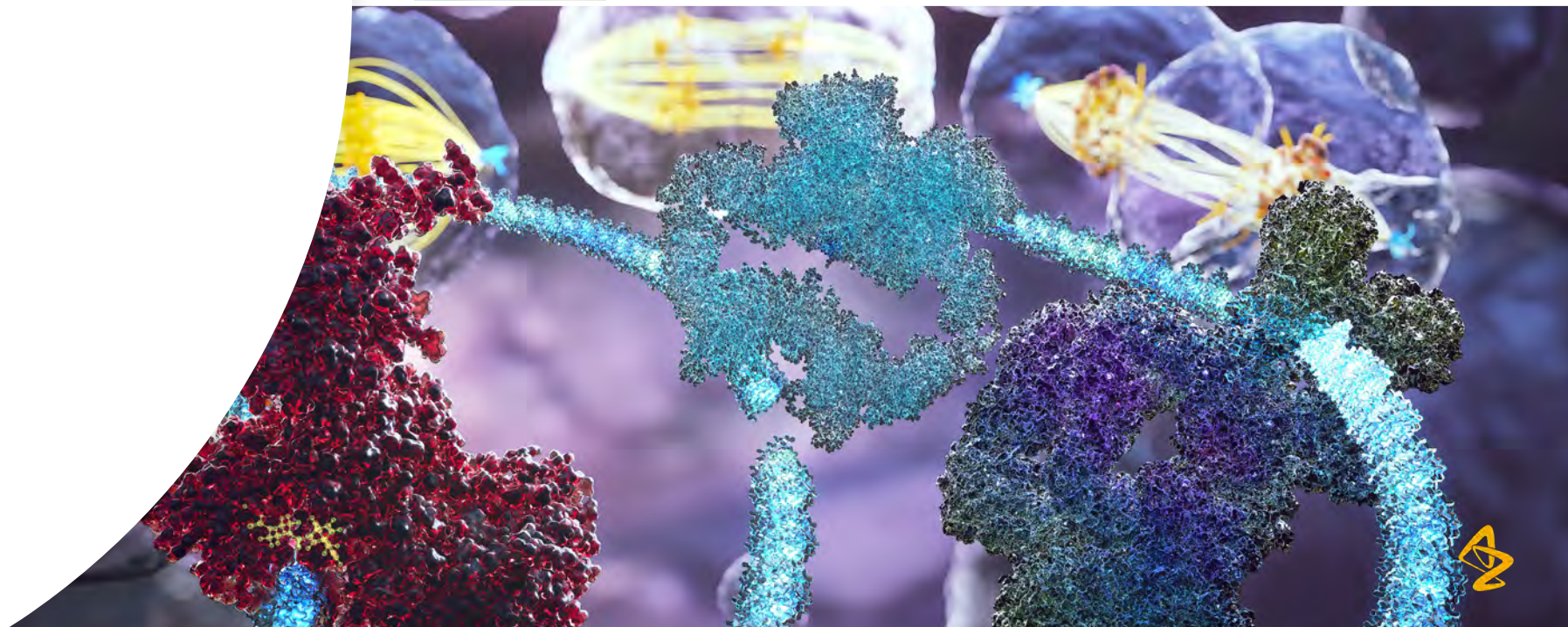
MODERATORS

Susan Galbraith,
Executive Vice President, Oncology R&D

Dave Fredrickson,
Executive Vice President, Oncology Business

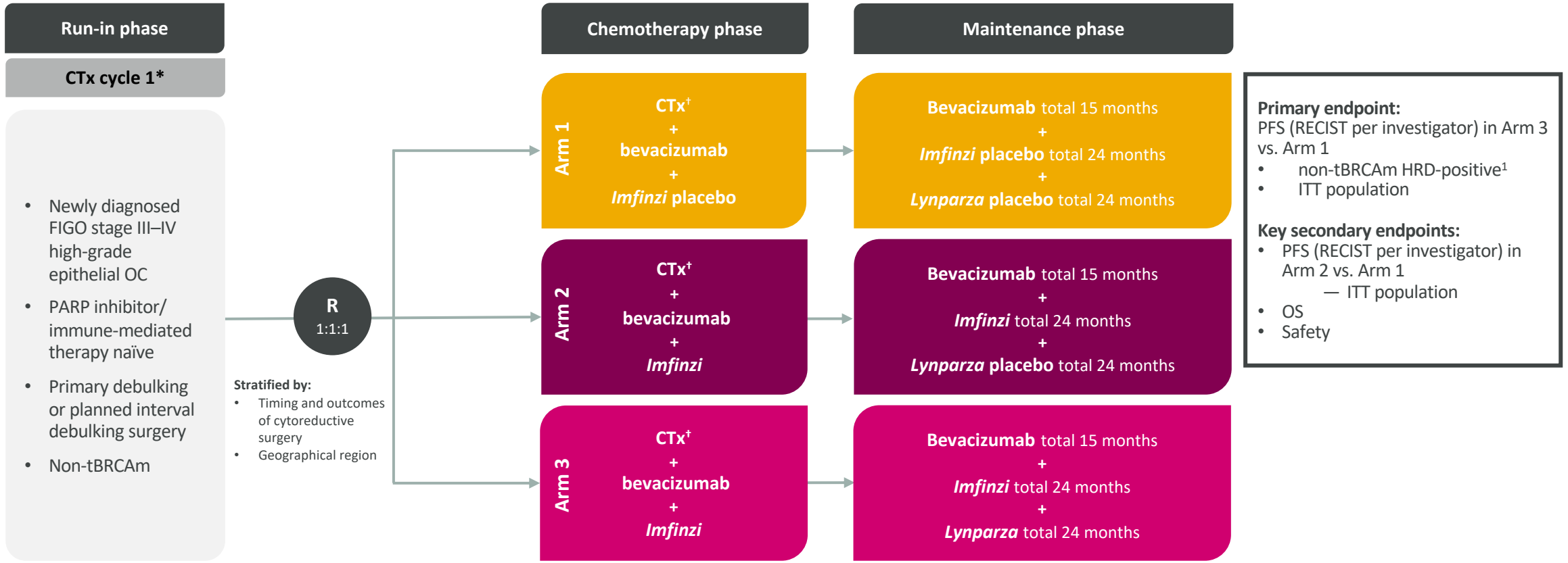
Investigating novel combinations in ovarian cancer

Susan Galbraith
ONCOLOGY R&D



DUO-O Phase III

Investigating combination of *Lynparza*, *Imfinzi*, chemotherapy and bevacizumab



DCO: December 5, 2022. DUO-O also included an independent single arm open label tBRCAm cohort – results are not presented.

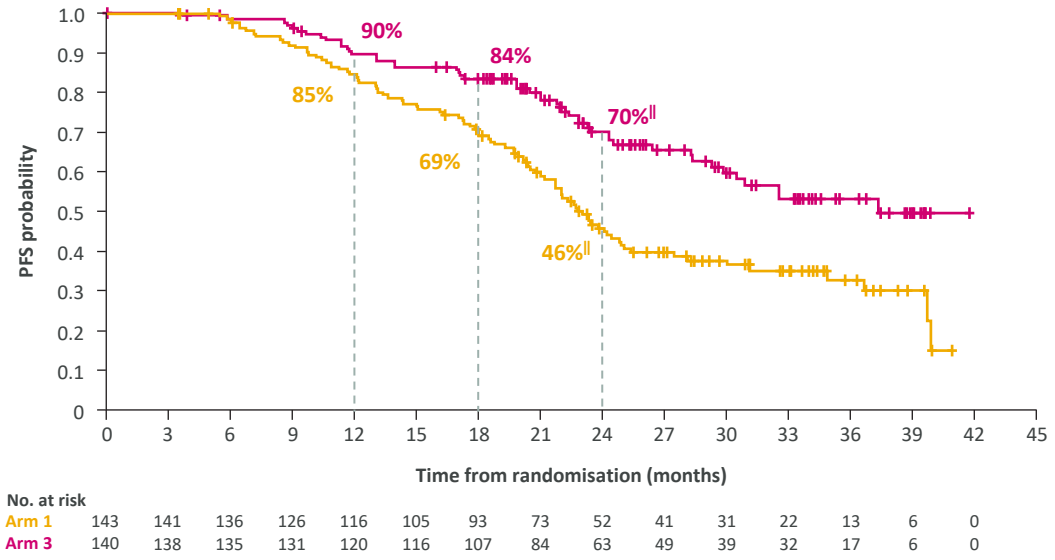
*With or without bevacizumab according to local practice; †Cycles 2–6; ‡Genomic instability score ≥42 assessed by Myriad MyChoice CDx assay.

CTx, chemotherapy; FIGO, International Federation of Gynecology and Obstetrics; OC = ovarian cancer; tBRCAm = tumour BRCA-mutated; R = randomisation; PC = paclitaxel/carboplatin; bev = bevacizumab; PFS = progression-free survival; RECIST = Response Evaluation Criteria for Solid Tumours; HRD = homologous recombination deficiency; ITT = intent-to-treat; OS = overall survival.

DUO-O Phase III

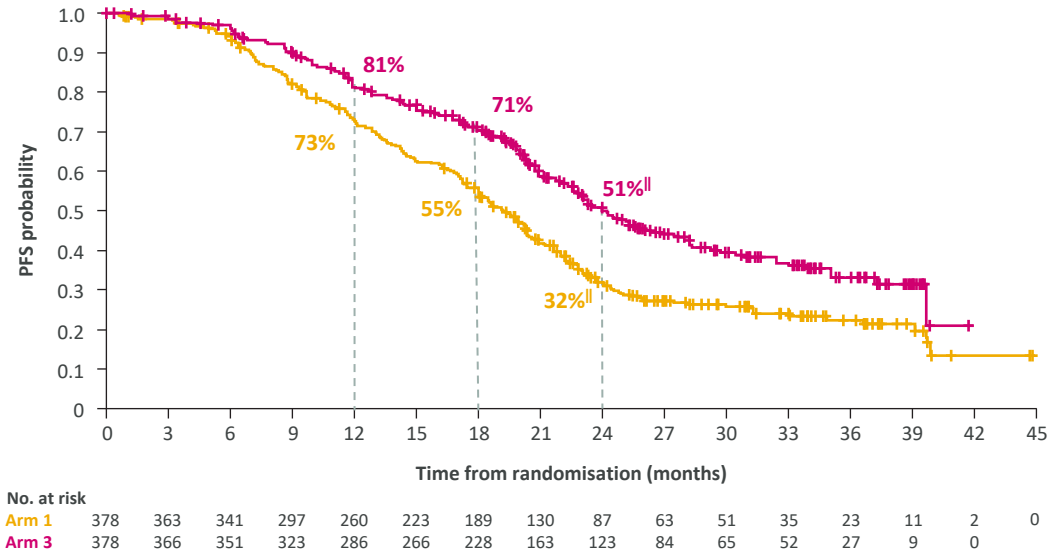
Significant improvement in HRD-positive and overall population vs chemotherapy + bevacizumab

PFS: HRD-positive subgroup (n=431, 38% population*)



	Arm 1 PC + bev N=143	Arm 3 PC + bev + *Imfinzi* + *Lyn* N=140
Events, n (%)	86 (60)	49 (35)
Median PFS,† m	23.0	37.3‡
HR (95% CI) vs Arm 1	**0.49** (0.34–0.69)§ *P*<0.0001	

PFS: ITT (n=1130)



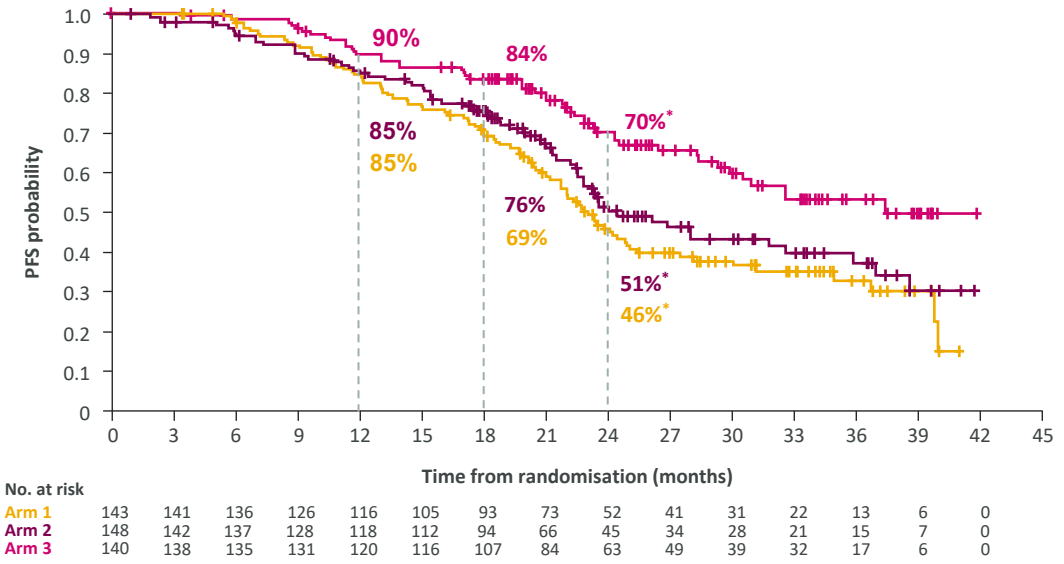
	Arm 1 PC + bev N=378	Arm 3 PC + bev + *Imfinzi* + *Lyn* N=378
Events, n (%)	259 (69)	193 (51)
Median PFS,† m	19.3	24.2
HR (95% CI) vs Arm 1	**0.63** (0.52–0.76)§ *P*<0.0001	

Median follow-up in HRD-positive subgroup: Arm 1 28.8 months, Arm 3 25.6 months; ITT: Arm 1 25.5 months, Arm 3 23.3 months (median follow up in censored patients).
*n=434 includes patients in all arms, Arm 1 n=144, Arm 2 n=150, Arm 3 n=140; †Medians and rates were estimated by KM method; ‡24-month PFS rates unstable. Median PFS in Arm 3 unstable. §HR and CI were estimated from a stratified Cox proportional hazards model. *P* value from a stratified log rank text. Model stratified by timing and outcome of cytoreductive surgery.
PFS = progression-free survival; HRD = homologous recombination deficient; ITT = intent-to-treat; no. = number; PC = paclitaxel/carboplatin; bev = bevacizumab; *Lyn* = *Lynparza*; m = months; HR = hazard ratio; CI = confidence interval; KM = Kaplan–Meier.

DUO-O Phase III

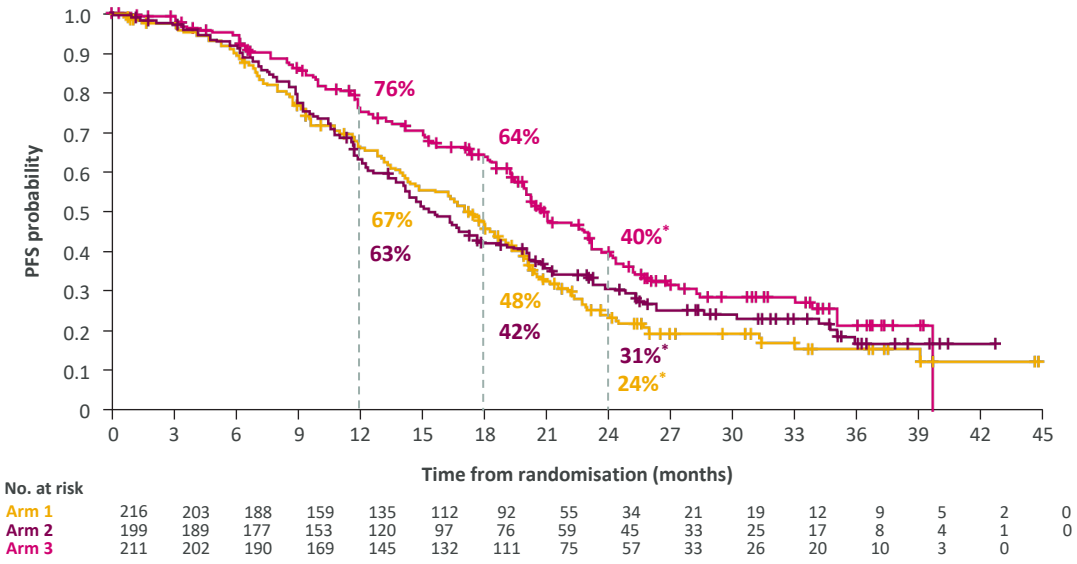
PFS benefit observed across HRD subgroups

PFS: HRD-positive subgroup (n=431, 38% population)



	Arm 1 PC + bev N=143	Arm 2 PC + bev + *Imfinzi* N=148	Arm 3 PC + bev + *Imfinzi* + *Lyn* N=140
Events, n (%)	86 (60)	69 (47)	49 (35)
Median PFS,† m	23.0	24.4‡	37.3‡
HR (95% CI) vs Arm 1		**0.82** (0.60–1.12)§	**0.51** (0.36–0.72)§

PFS: HRD-negative subgroup (n=626, 55% population)



	Arm 1 PC + bev N=216	Arm 2 PC + bev + *Imfinzi* N=199	Arm 3 PC + bev + *Imfinzi* + *Lyn* N=211
Events, n (%)	157 (73)	142 (71)	127 (60)
Median PFS,† m	17.4	15.4	20.9
HR (95% CI) vs Arm 1		**0.94** (0.75–1.18)§	**0.68** (0.54–0.86)§

*Medians and rates were estimated by KM method. †24-month PFS rates unstable. Median PFS in HRD-positive subgroup Arm 3 and Arm 2 unstable. ‡HR and CI were estimated from an unstratified Cox proportional hazards model

PFS = progression-free survival; HRD = homologous recombination deficient; no. = number; PC = paclitaxel/carboplatin; bev = bevacizumab; *Lyn = Lynparza*; m = months; HR = hazard ratio; CI = confidence interval; KM = Kaplan–Meier.

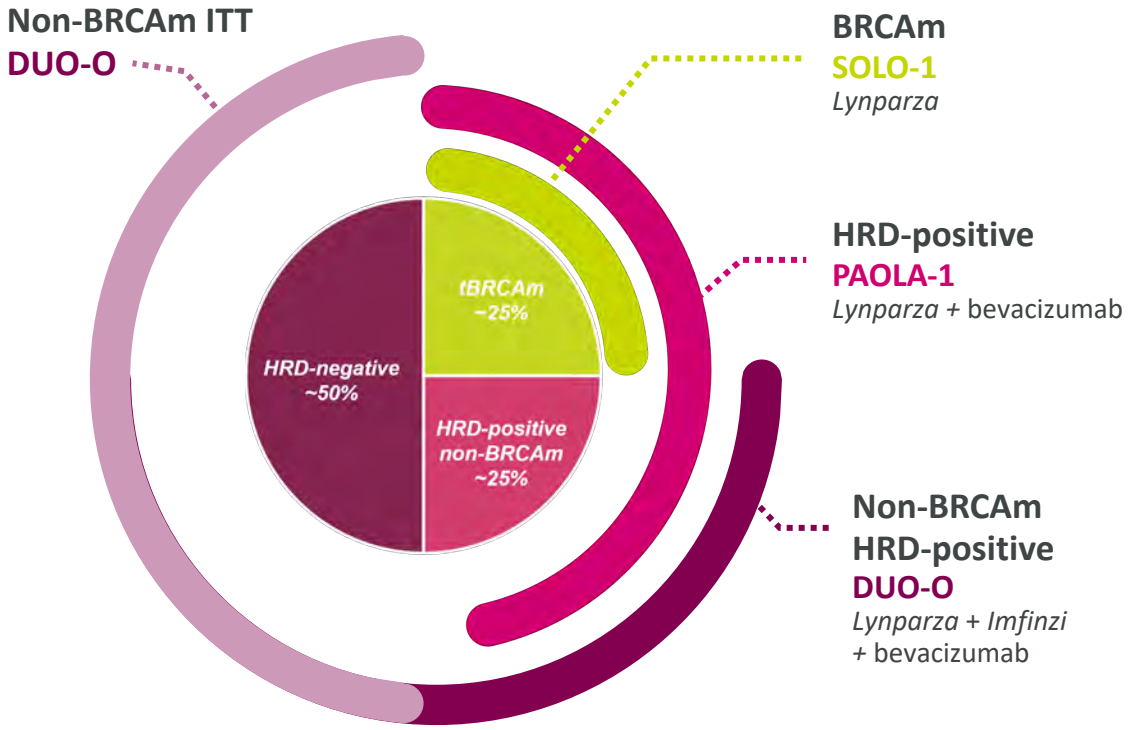
DUO-O Phase III

Imfinzi + *Lynparza* added to CTx + bevacizumab potential new option for patients

Conclusions

- Statistically significant and clinically meaningful improvement in PFS with addition of *Imfinzi* + *Lynparza* to CTx + bevacizumab vs CTx + bevacizumab in advanced OC patients
- PFS benefit observed across subgroups, including those patients with HRD-negative disease
- Numerical, but not statistical improvement in PFS for addition of *Imfinzi* to chemotherapy + bevacizumab in ITT
- Safety generally consistent with the known profiles of each individual agent
- DUO-O Phase III trial follow-up continues

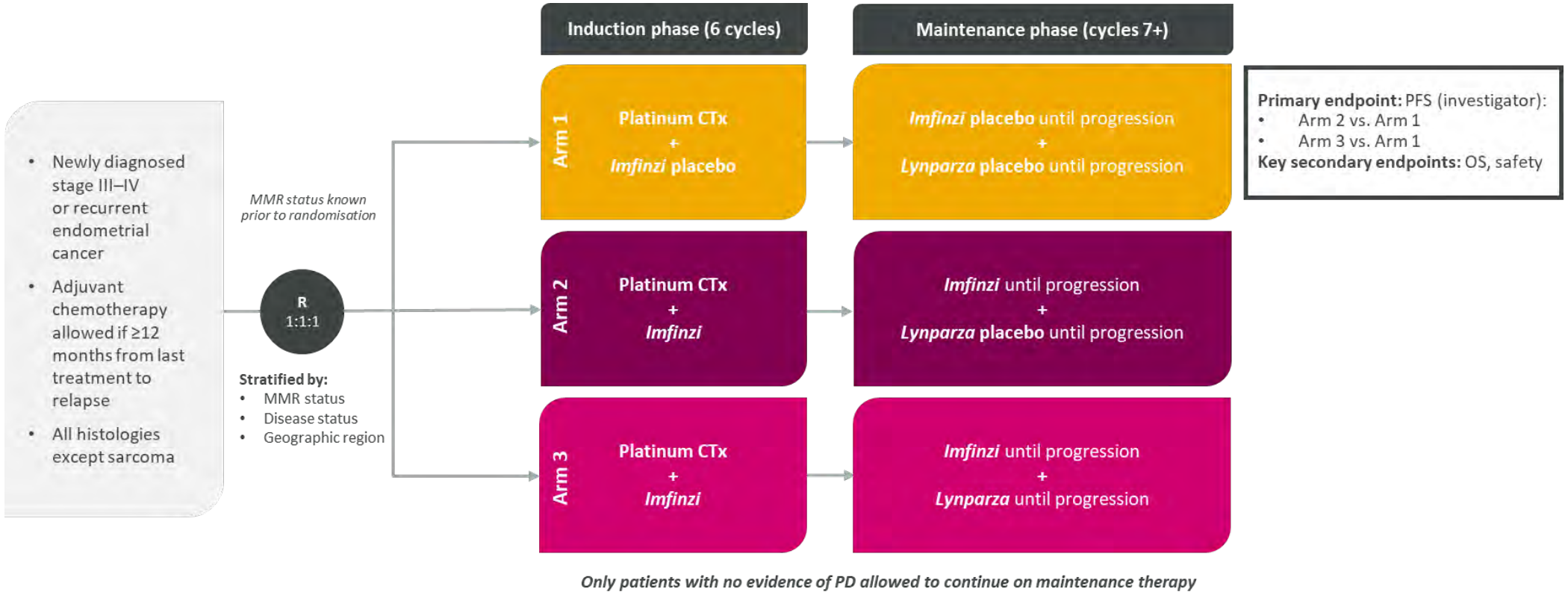
Lynparza data across the entire newly diagnosed ovarian cancer space



CTx = chemotherapy; PFS = progression-free survival; OC = ovarian cancer; HRD = homologous recombination deficient; ITT = intent-to-treat; BRCAm = BRCA-mutated.
Collaboration partners: Merck & Co., Inc. (*Lynparza*).

DUO-E Phase III in advanced endometrial cancer

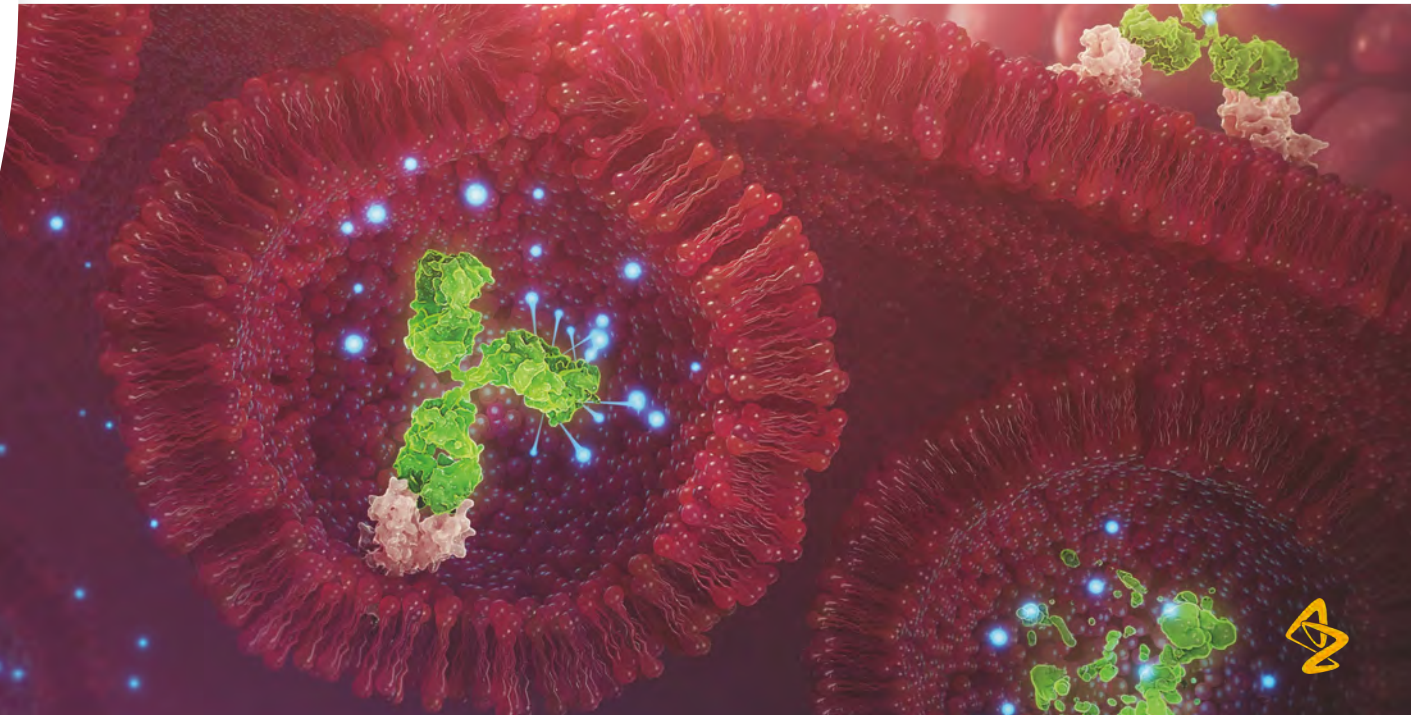
Imfinzi plus *Lynparza* and *Imfinzi* alone significantly improved PFS when added to chemotherapy



DUO-E Phase III results to be presented at upcoming medical congress

PFS = progression-free survival; MMR = mismatch repair; R = randomisation; PC = paclitaxel/carboplatin; CTx = chemotherapy; PD = progressive disease; OS = overall survival.

Expanding *Enhertu* beyond breast, lung and gastric

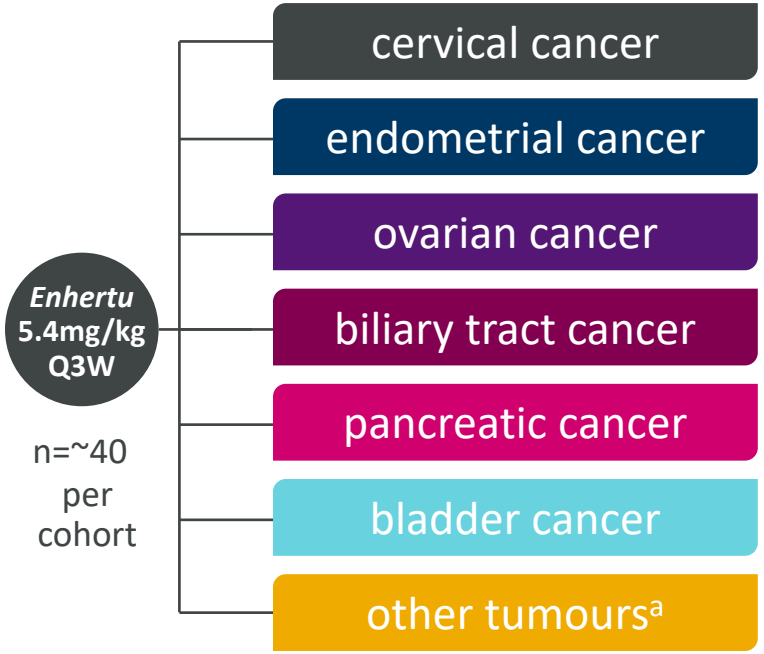


Susan Galbraith
ONCOLOGY R&D

Dave Fredrickson
ONCOLOGY BUSINESS

DESTINY-Pantumor02 Phase II

Enhertu for HER2-expressing solid tumors



Primary endpoint

- Confirmed ORR (investigator)[b]

Secondary endpoints

- DoR[b]
- DCR[b]
- PFS[b]
- OS
- Safety/ tolerability

Data cut-off for analysis:

- 16 November 2022

Key trial criteria

- Advanced solid tumours not eligible for curative therapy
- 2L+ patient population
- HER2 expression (IHC 3+ or IHC 2+)
  - Local testing or central testing by Herceptest if local testing not feasible (ASCO/CAP gastric cancer guidelines[1])[c]
- Prior HER2-targeting therapy allowed
- ECOG/WHO PS 0-1

1. Hofmann M, et al. Histopathology 2008;52:797-805.

[a]Patients that express HER2, excluding the tumors in the tumor-specific cohorts, and breast cancer, non-small cell lung cancer, gastric cancer, and colorectal cancer; [b]Investigator-assessed per Response Evaluation Criteria In Solid Tumors version 1.1; [c]Patients were eligible by either test. All patients were centrally confirmed.

HER2 = human epidermal growth factor receptor 2; Q3W = every three weeks; ORR = objective response rate; DoR = duration of response; DCR = disease control rate; PFS = progression-free survival; OS = overall survival; 2L = 2nd-line; IHC = immunohistochemistry; ASCO = American Society of Clinical Oncology; CAP = College of American Pathologists;; ECOG/WHO PS = Eastern Cooperative Oncology Group / World Health Organisation performance status.

Collaboration partners: Daiichi Sankyo *(Enhertu)*.

DESTINY-Pantumor02 Phase II

Clinically meaningful activity observed across broad range of HER2-expressing solid tumours

	Cervical (n=40)	Endometrial (n=40)	Ovarian (n=40)	BTC (n=41)	Pancreatic (n=25)	Bladder (n=41)	Other (n=40)	All patients (n=267)
ORR, n (%)	20 (50.0)	23 (57.5)	18 (45.0)	9 (22.0)	1 (4.0)	16 (39.0)	12 (30.0)	99 (37.1)
Best overall response, n (%)								
Complete response	2 (5.0)	7 (17.5)	4 (10.0)	1 (2.4)	0	1 (2.4)	0	15 (5.6)
Partial response	18 (45.0)	16 (40.0)	14 (35.0)	8 (19.5)	1 (4.0)	15 (36.6)	12 (30.0)	84 (31.5)
Stable disease	11 (27.5)	12 (30.0)	13 (32.5)	23 (56.1)	16 (64.0)	16 (39.0)	20 (50.0)	111 (41.6)
Progressive disease	7 (17.5)	4 (10.0)	7 (17.5)	7 (17.1)	7 (28.0)	7 (17.1)	3 (7.5)	42 (15.7)
Not evaluable	1 (2.5)	0	1 (2.5)	0	0	0	1 (2.5)	3 (1.1)
DCR[a], n (%)	27 (67.5)	32 (80.0)	28 (70.0)	27 (65.9)	9 (36.0)	29 (70.7)	30 (75.0)	182 (68.2)
Median DoR, months (95% CI)	9.8 (4.2–NE)	NR (9.9–NE)	11.3 (4.1–NE)	8.6 (2.1–NE)	NR	8.7 (4.3–11.8)	NR (4.1-NE)	11.8 (9.8–NE)

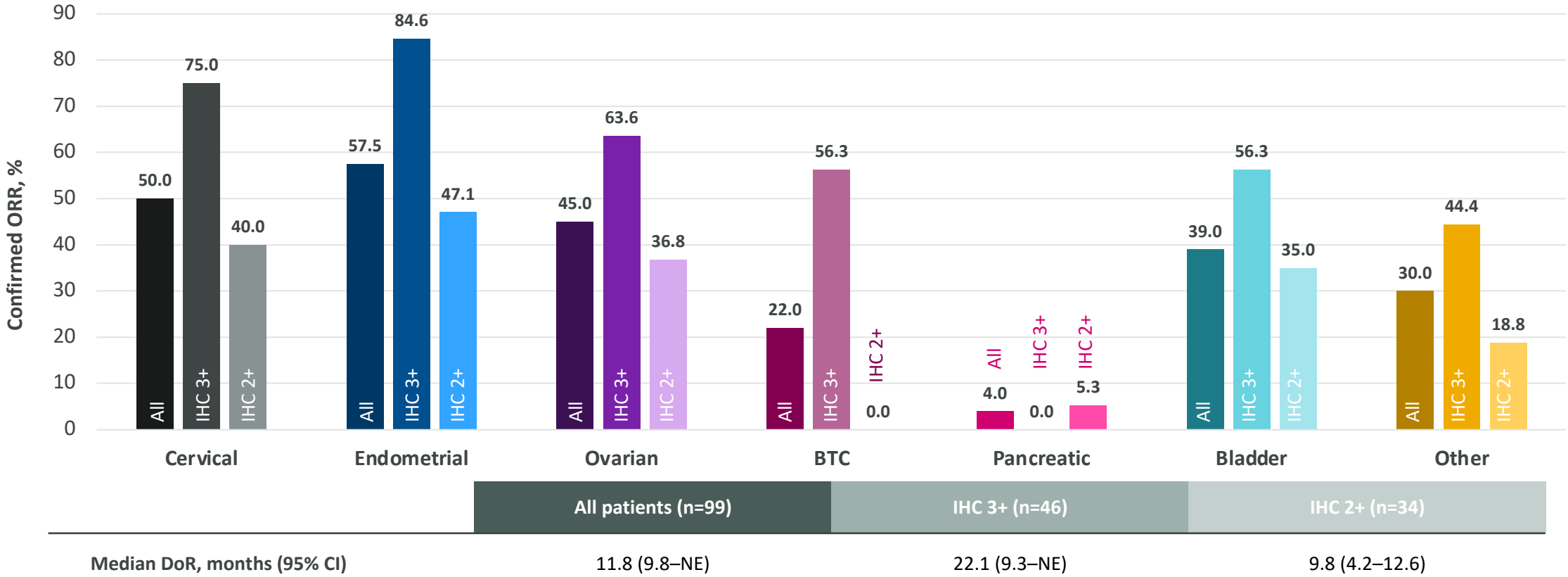
[a]Confirmed complete response, confirmed partial response or stable disease at or after 11 weeks.

HER2 = human epidermal growth factor receptor 2; BTC = biliary tract cancer; ORR = objective response rate; DCR = disease control rate; DoR = duration of response; CI = confidence interval; NE = not estimable; NR = not reached.

Collaboration partners: Daiichi Sankyo *(Enhertu)*.

DESTINY-Pantumor02 Phase II

Responses observed in both IHC 3+ and IHC 2+ populations



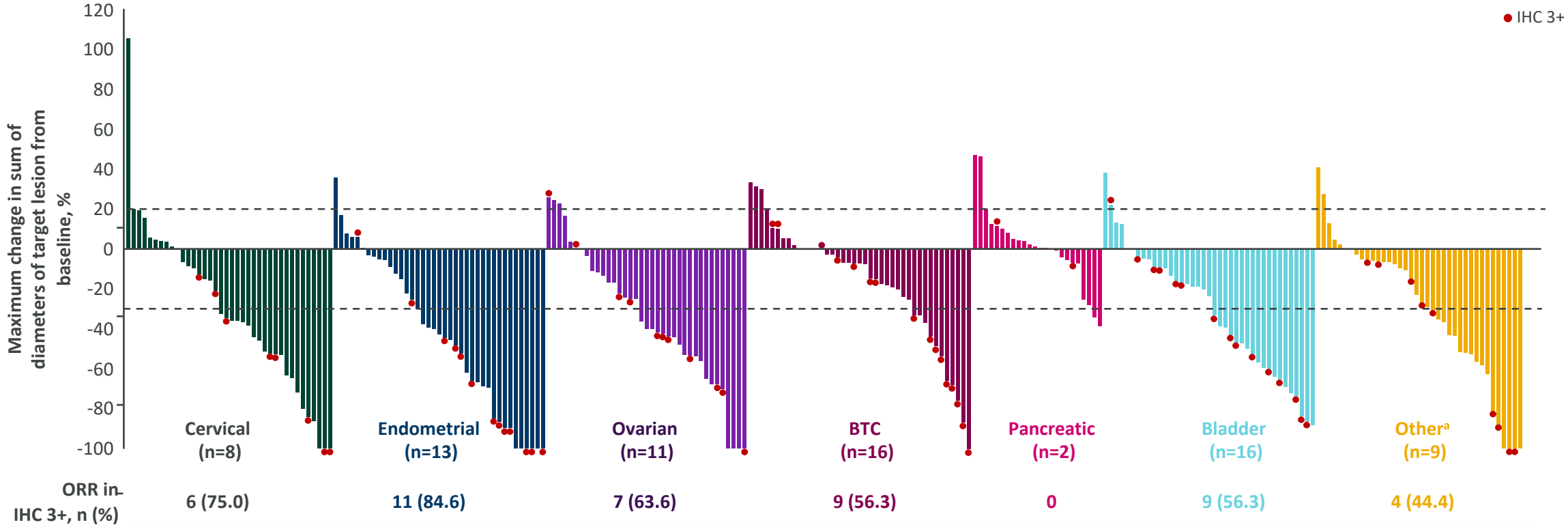
IHC based on central HER2 testing; 67 patients had IHC 1+ (n=25), IHC 0 (n=30) or unknown IHC status (n=12) by central testing. Other includes responses in extramammary Paget disease, head and neck cancer, oropharyngeal neoplasm, and salivary gland cancer.

IHC = immunohistochemistry; ORR = objective response rate; BTC = biliary tract cancer; DoR = duration of response; CI = confidence interval;; NE = non estimable.

Collaboration partners: Daiichi Sankyo *(Enhertu)*.

DESTINY-Pantumor02 Phase II

Best percentage change in target lesion from baseline demonstrates depth of response

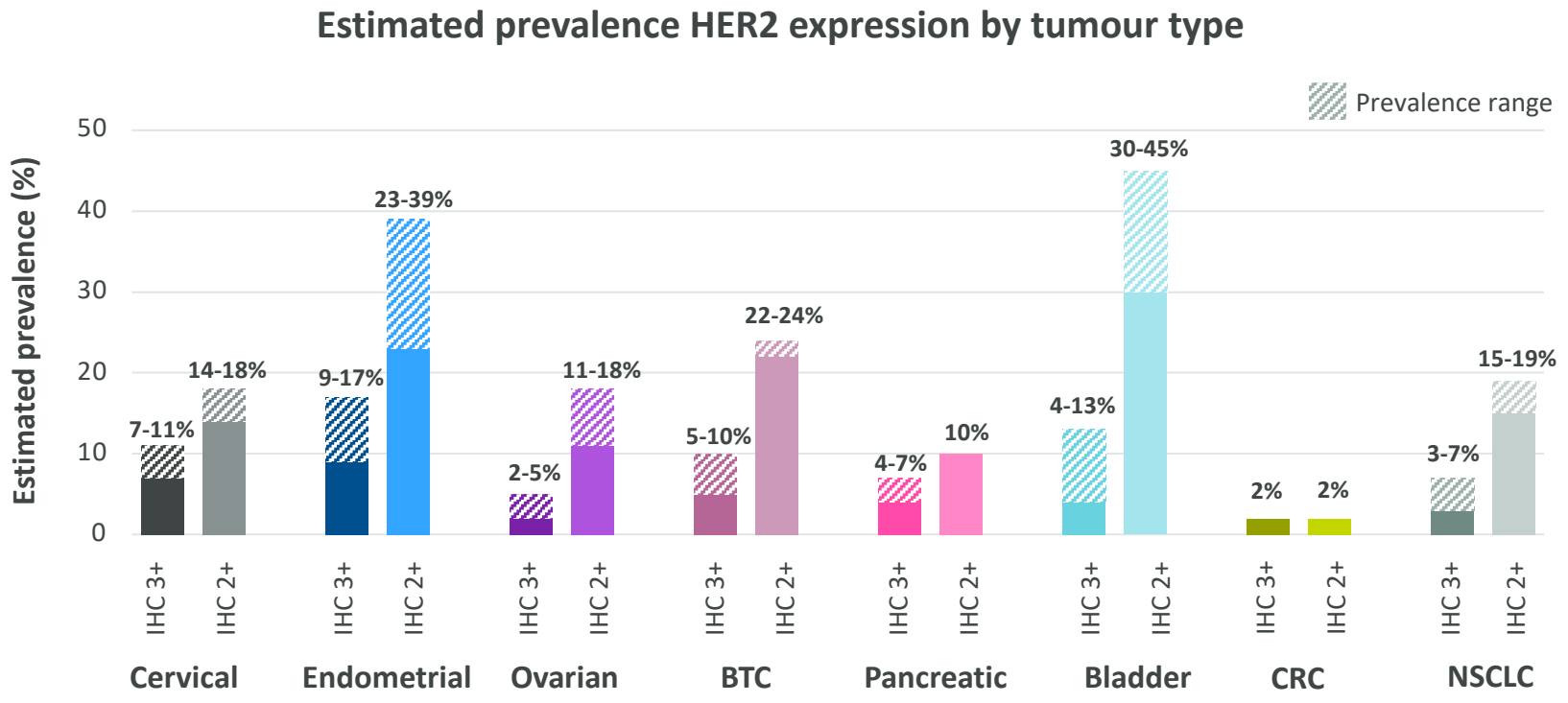


DPT02 trial follow-up continues (PFS and OS)

Analyses were performed in patients who received ≥1 dose of *Enhertu* (n=267). Analysis of ORR in IHC 3+ was performed in patients with centrally confirmed HER2 status (n=75).
[a]Responses in extramammary Paget's disease, head and neck cancer, oropharyngeal neoplasm, and salivary gland cancer.
ORR = objective response rate; BTC = biliary tract cancer; IHC = immunohistochemistry; PFS = progression-free survival; OS = overall survival.
Collaboration partners: Daiichi Sankyo *(Enhertu)*.

DESTINY-Pantumor02 in HER2-expressing cancers

Targeting tumours with HER2-expression beyond breast and gastric



c.8,000-12,000 3L+ patients with HER2-expressing tumours in the US*

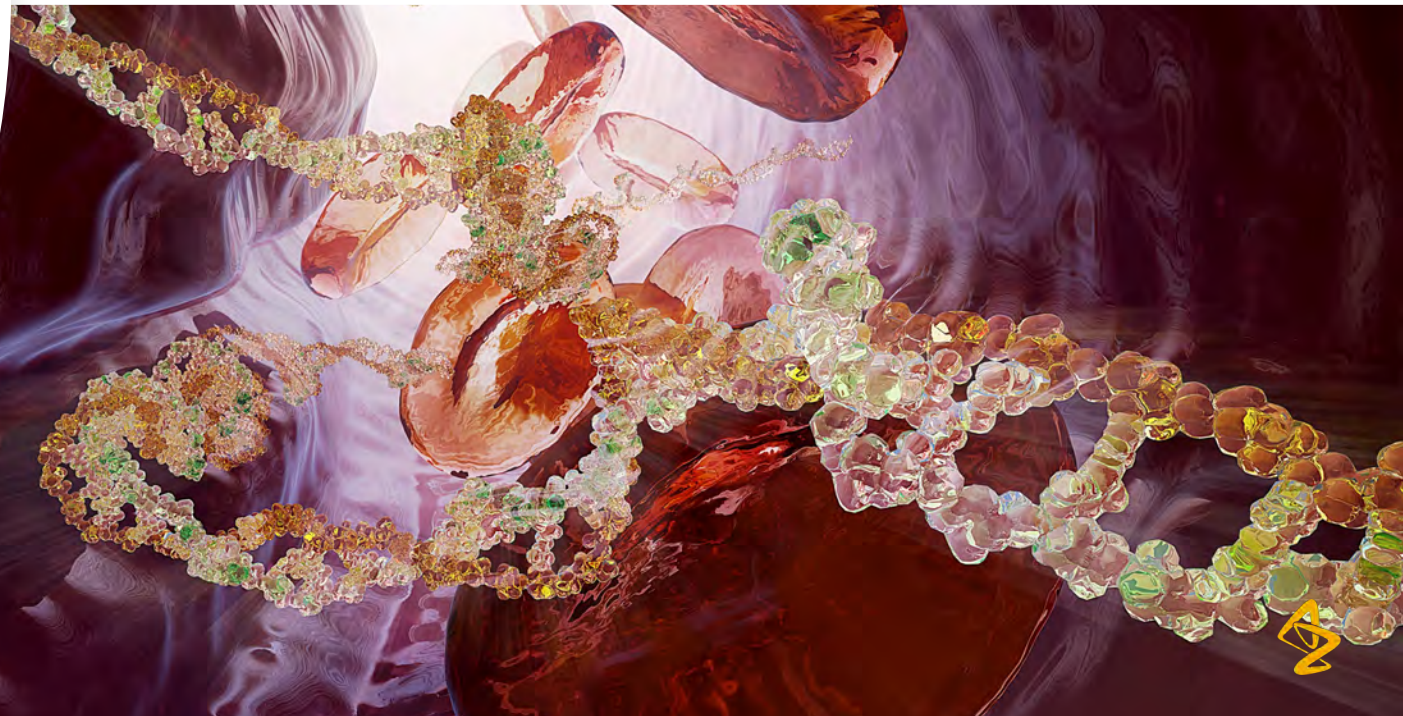
- Levels of HER2 expression differ by tumour type
- Variability in prevalence influenced by timing of biopsy (primary vs metastatic)
- IHC 3+ shows greatest magnitude and consistency of benefit

Planned discussions with regulatory agencies

*Includes solid tumours beyond those in DESTINY-Pantumor02
Estimates uncertain based on literature and AstraZeneca in-house data. No HER2 IHC assay has been approved or tested for these indications, (caveat with antibody-related possible artifacts used for scoring, especially for the assessment of HER2 2+; different algorithms can provide different results) and data / references used for estimates were not specifically designed to evaluate HER2 prevalence.
HER2 = human epidermal growth factor receptor 2 = IHC, immunohistochemistry; BTC = biliary tract cancer.

Reinforcing *Calquence* positioning in BTKi class

Anas Younes
SVP, Haematology



Calquence MAIC

Methodology uses weighting equation to exactly match baseline characteristics

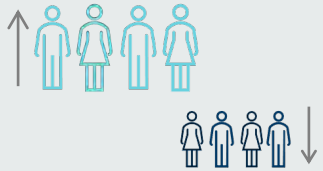
ASCEND vs ALPINE compared through unanchored MAIC

ASCEND trial population

Calquence

*Weighting equation matches baseline characteristics**

ASCEND reweighted



Calquence

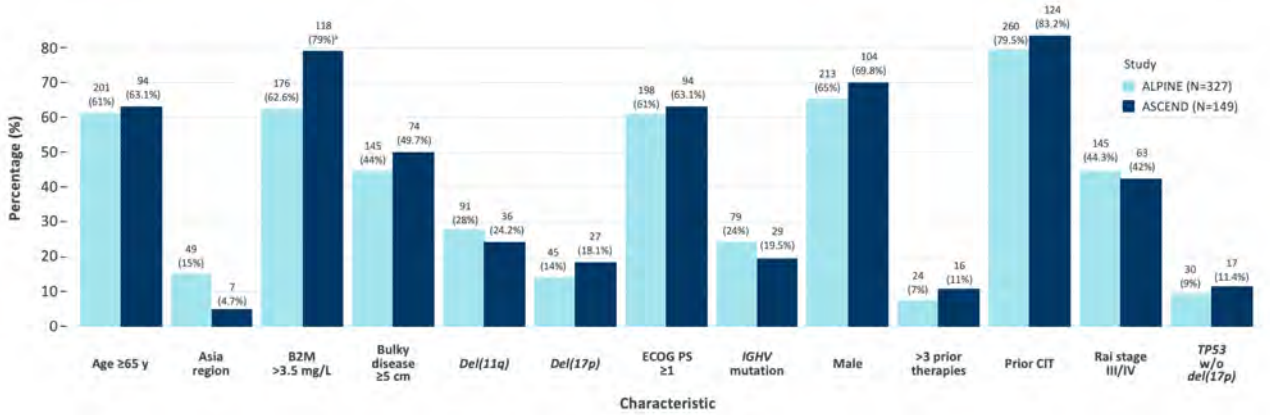
vs

ALPINE (recovered)

zanubrutinib

Non-ALPINE-like patients ALPINE-like patients

Similar baseline characteristics of ASCEND and ALPINE



Inclusion, baseline characteristics enable comparison and reduce selection bias risk

- Unselected for mutation status
- Median one prior line of treatment
- Consistent endpoint definitions

[a]Percentages for B2M were calculated based on those with complete information only (14% of patients had missing data).
*Variables included in matching analysis: gender, bulky disease, prior chemoimmunotherapy, Del(11q), TP53 without del(17p), Del(17p), region, age, ECOG, prior lines of therapy, IGHV, RAI stage.

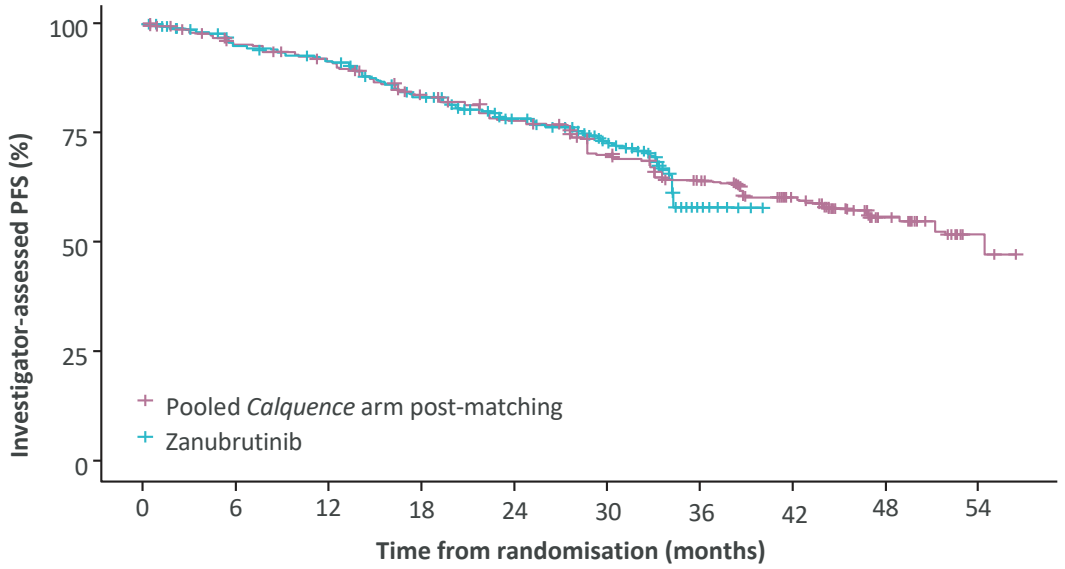
1. Ghia P, et al. *J Clin Oncol.* 2020; 38: 2849–2861. 2. Brown JR, et al. *New Engl J Med.* 2023; 388: 319–332.

MAIC = matched-adjusted indirect comparison; ECOG = Eastern Cooperative Oncology Group; IGHV = immunoglobulin heavy variable.

Calquence MAIC

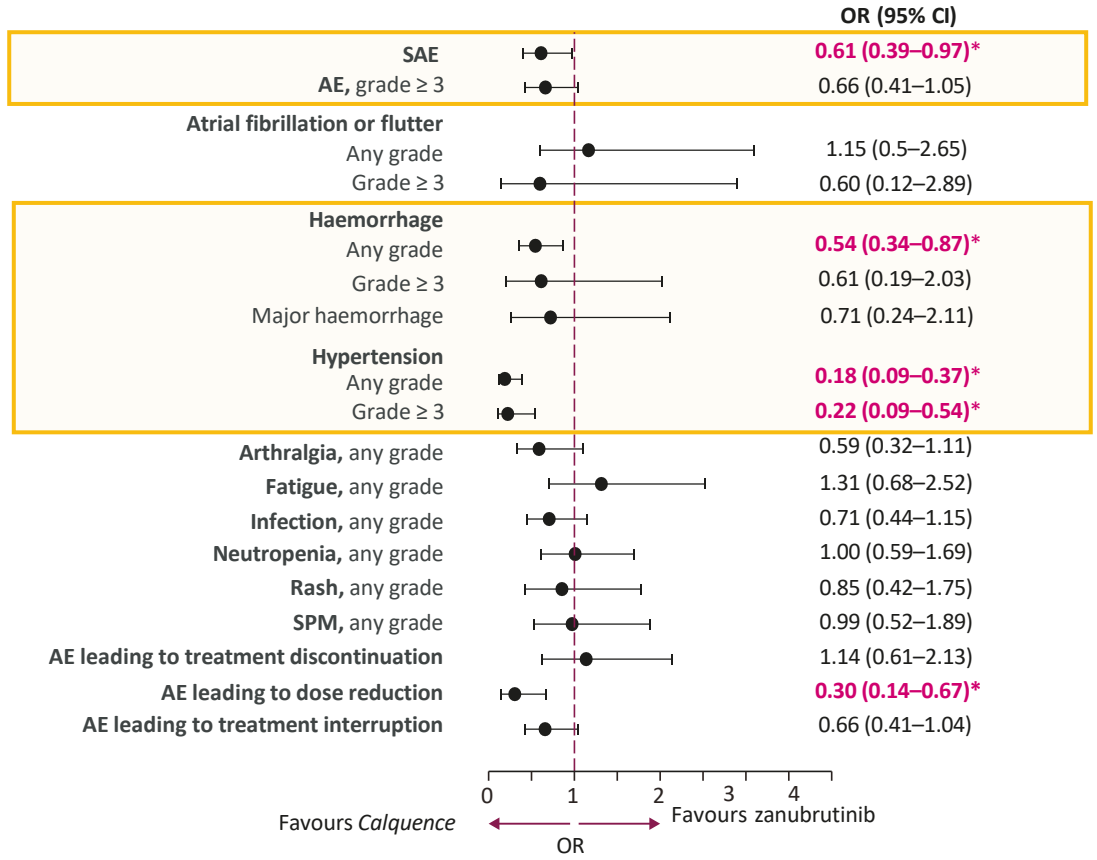
MAIC demonstrates equivalent PFS in r/r CLL but *Calquence* more favourable safety

Calquence vs zanubrutinib PFS



Analysis set	HR for *Calquence* vs. zanubrutinib (CI)	HR for *Calquence* vs. ibrutinib (CI)
Weighted (matched to ALPINE)	0.90 (0.60–1.36)	0.60 (0.40–0.90)

Calquence vs zanubrutinib safety



*Significant odds ratio

MAIC = matched-adjusted indirect comparison; PFS = progression-free survival; r/r = relapsed refractory; CLL = chronic lymphocytic leukemia; HR = hazard ratio; CI = confidence interval; AF = atrial fibrillation; AE = adverse event.

AstraZeneca @ ASCO 2023

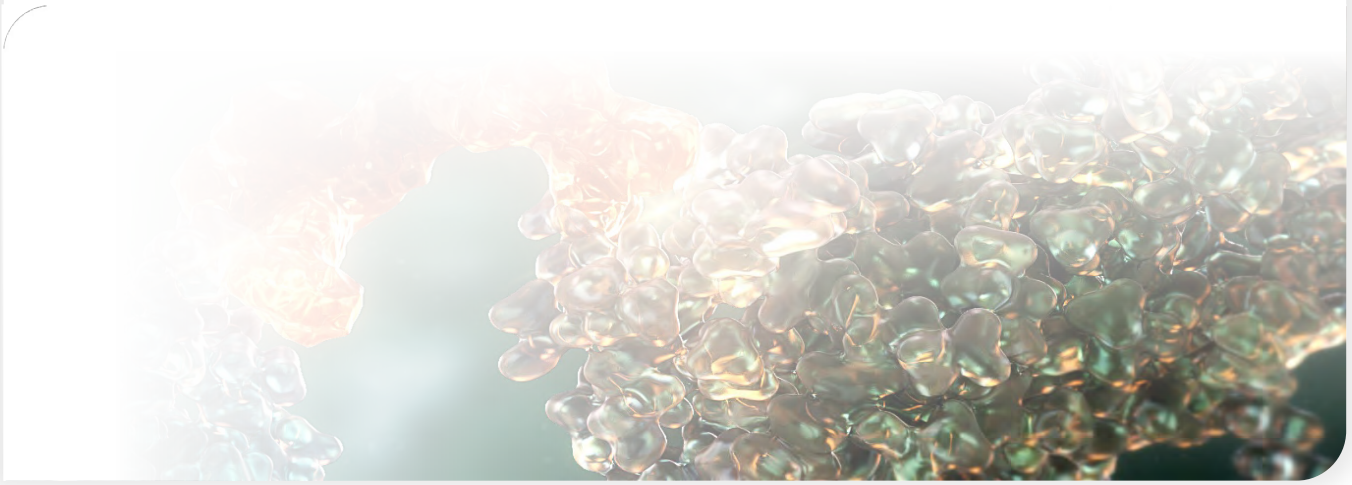
Q&A session

Pascal Soriot,
Chief Executive Officer

Susan Galbraith,
Executive Vice President
Oncology R&D

Dave Fredrickson,
Executive Vice President
Oncology Business

Sunil Verma,
Global Head of Oncology,
Medical



THERAPEUTIC AREA LEADERSHIP

Leora Horn,
Global Clinical Head,
Lung Cancer and Lung Cancer Strategy

Ingrid Mayer,
Global Clinical Strategy Head,
Breast Cancer

Osama Rahma,
Global Clinical Strategy Head,
GI Cancer

Ashok Gupta,
Global Clinical Strategy Head,
GU/GYN Cancer

Anas Younes,
Senior Vice President,
Haematology

Strengthening oncology leadership

ASCO 2023 data reinforces potential to transform patient outcomes in key tumour areas

Lung

- TAGRISSO osimertinib
- IMFINZI durvalumab + IMJUDO tremelimumab-actl
- ENHERTU fam-trastuzumab deruxtecan-nxki
- Orpathys®
- Dato-DXd
- volrustomig
- rilvegostomig
- ceralasertib
- AZD9592 (EGFR-cMET ADC)

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Breast

- ENHERTU fam-trastuzumab deruxtecan-nxki
- Lynparza olaparib
- IMFINZI durvalumab
- Dato-DXd
- capivasertib
- camizestrant

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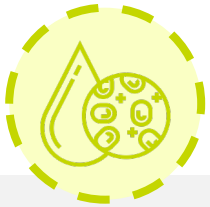
Haematology



- CALQUENCE (acalabrutinib)
- AZD0486 (CD3xCD19 TCE)
- AZD4573 (CDK9)
- capivasertib (AKTi)
- AZD0466 (BCL2-xL)
- sabestomig (PD1/TIM3)

6

GI

- IMFINZI durvalumab
- IMFINZI durvalumab + IMJUDO tremelimumab-actl
- Lynparza olaparib
- ENHERTU fam-trastuzumab deruxtecan-nxki
- IMFINZI durvalumab + Orpathys®
- Orpathys®
- AZD5851 (GPC3 CAR-T)

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GYN/GU

- Lynparza olaparib
- IMFINZI durvalumab
- IMFINZI durvalumab + IMJUDO tremelimumab-actl
- ENHERTU fam-trastuzumab deruxtecan-nxki
- capivasertib (AKTi)

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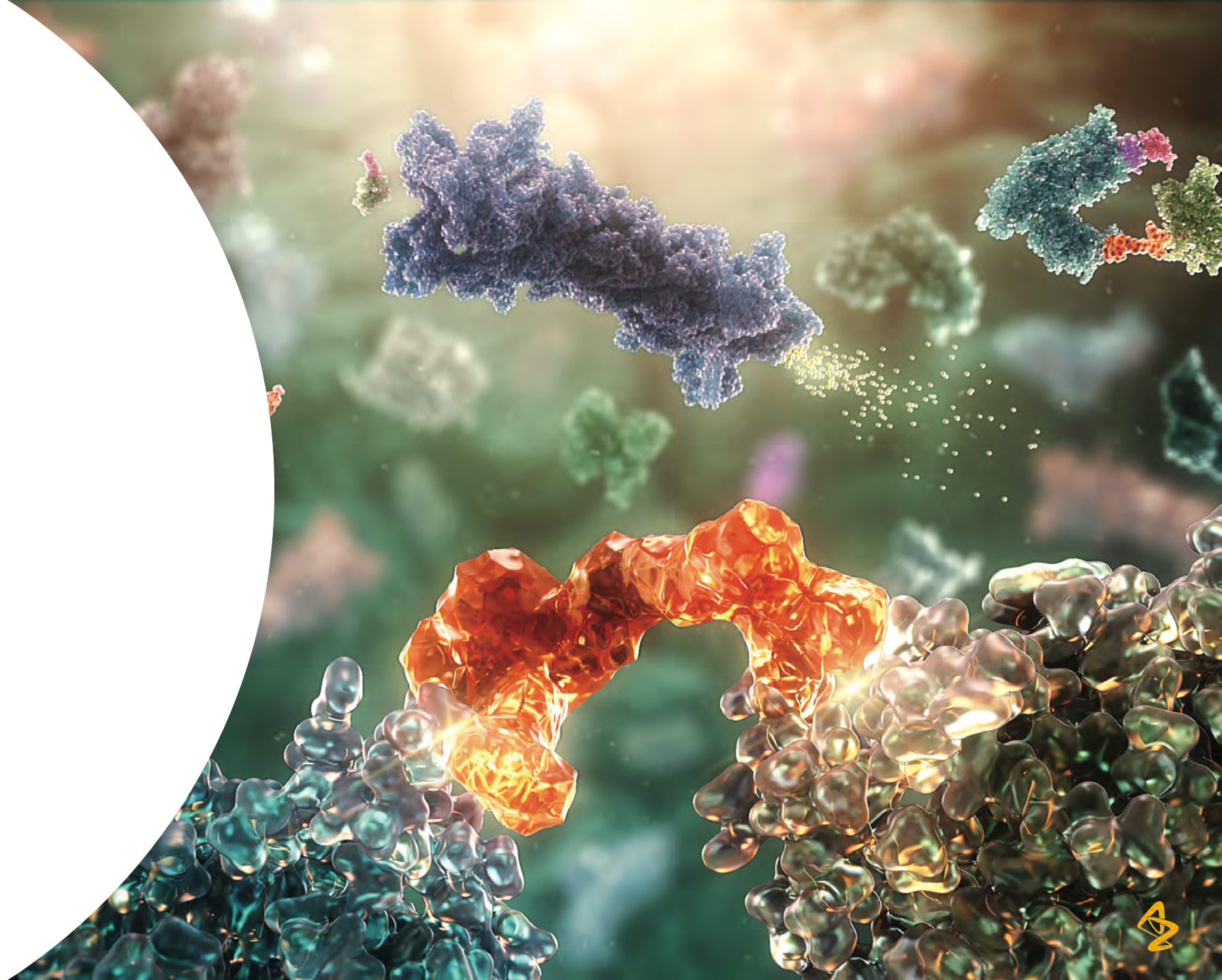
2023 ASCO ANNUAL MEETING

DATA PRESENTATIONS BY TUMOUR AREA

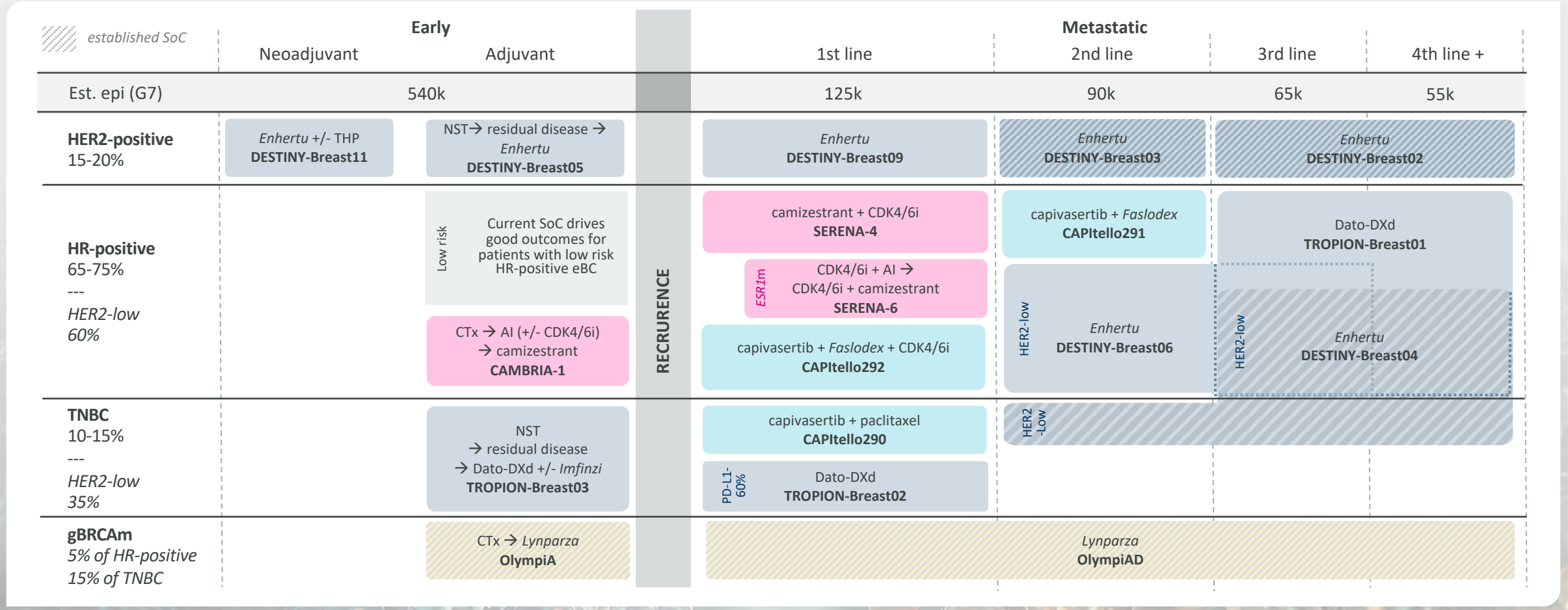
Dato-DXd = datopotamab deruxtecan; EGFR = epidermal growth factor receptor; c-MET = mesenchymal-epithelial transition factor; ADC = antibody-drug conjugate; PARP1sel = poly ADP ribose polymerase-1 selective; CD3xCD19 = cluster of differentiation 3 and cluster of differentiation 19 bispecific; TCE = T cell engager; CDK9 = cyclin-dependent kinase 9; AKTi = protein kinase B inhibitor; BCL2-xL = B-cell lymphoma-extra large; PD1 = programmed cell death protein 1; TIM3 = T-cell immunoglobulin and mucin domain-containing protein 3; GPC3 = glypican 3 protein; CAR-T = chimeric antigen receptor t-cell; CLDN18.2 = Claudin-18.2.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Merck & Co., Inc. (*Lynparza*); Compugen (rilvegostomig).

Appendix



AstraZeneca in Breast Cancer

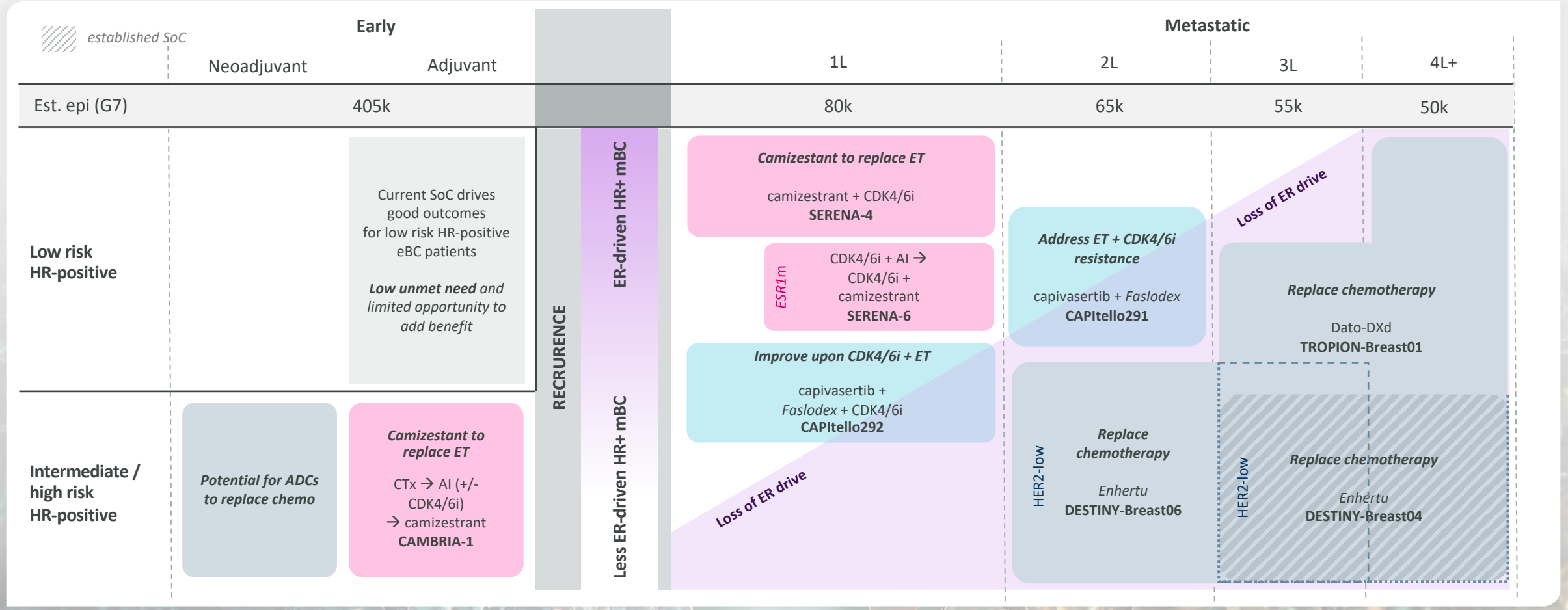
Ambition to eliminate breast cancer as a cause of death



All numbers are approximate. Illustrative settings and populations, not to scale.
1/2/3/4L = 1st/2nd/3rd/ 4th-line; est epi (G7) = estimated epidemiology across G7 (US, EU5, JP for **drug treated patients. HER2 =** human epidermal growth factor receptor 2; THP = docetaxel, trastuzumab, and pertuzumab;NST = neoadjuvant systemic treatment; HR = hormone receptor; SoC = standard of care; CTx = chemotherapy; AI = aromatase inhibitor; CDK4/6i = cyclin-dependent kinase 4 and 6 inhibitor; ESR1m = oestrogen receptor 1 gene mutation; Dato-DXd = datopotamab deruxtecan; TNBC = triple negative breast cancer; PD-L1 = programmed cell death ligand 1; gBRCAm = germline BRCA-mutated.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Merck & Co., Inc. (*Lynparza*).

AstraZeneca in HR-positive Breast Cancer

Ambition to eliminate breast cancer as a cause of death

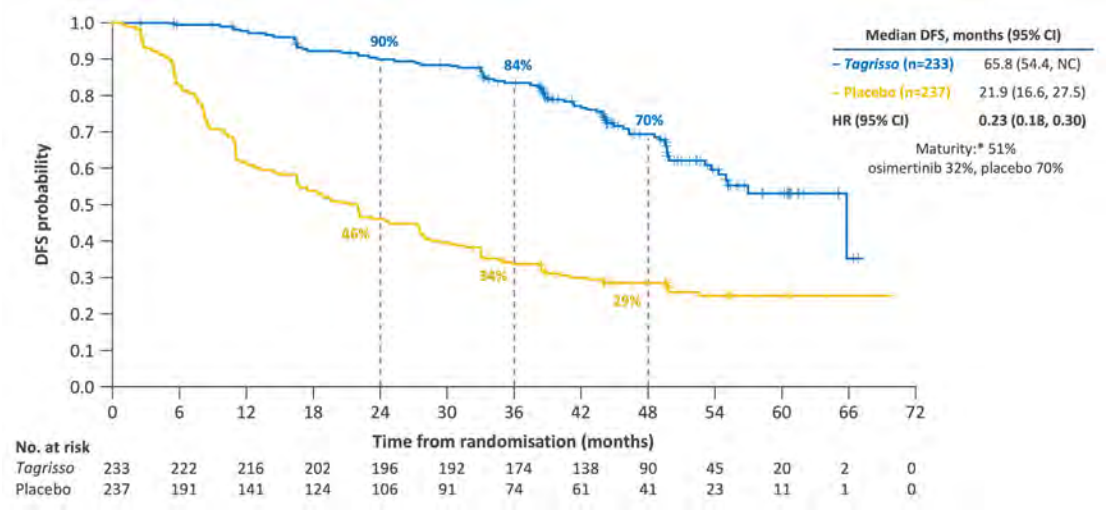


All numbers are approximate. Illustrative settings and populations, not to scale.
HR = hormone receptor; 1/2/3/4L = 1st/2nd/3rd/ 4th-line; est epi (G7) = estimated epidemiology across G7 (US, EU5, JP for drug treated patients; SoC = standard of care; ADC = antibody drug conjugate; ET = endocrine therapy; CTx = chemotherapy; AI = aromatase inhibitor; CDK4/6i = cyclin-dependent kinase 4 and 6 inhibitor; ESR1m = oestrogen receptor 1 gene mutation; ER = oestrogen receptor; Dato-DXd = datopotamab deruxtecan.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd).

ADAURA DFS

Updated disease-free survival data presented at ESMO 2022

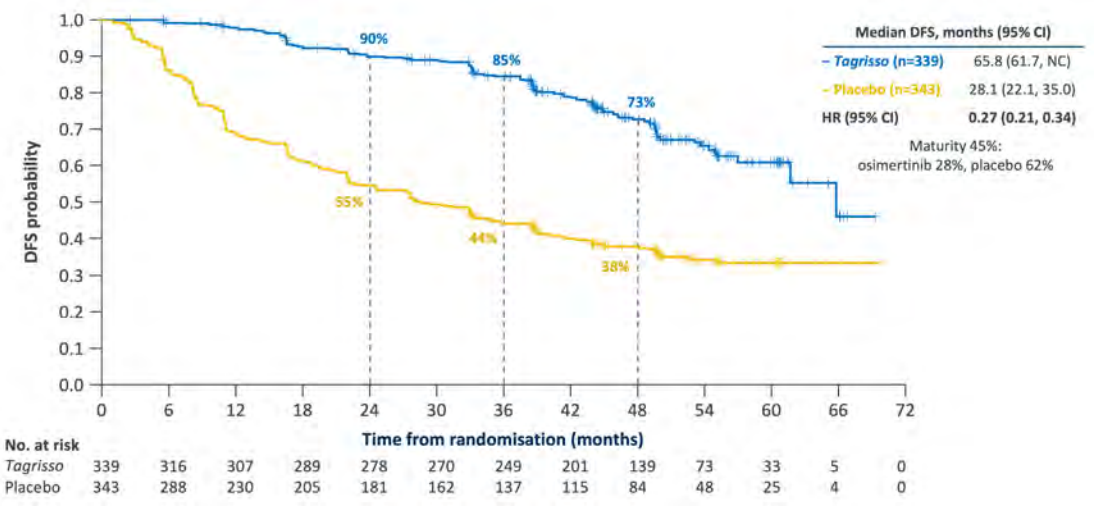
Primary endpoint: updated DFS in Stage II/IIIA



Median follow-up *Tagrisso* 44.2 months (range 0 to 67), placebo 19.6 months (range 0 to 70); DFS by investigator assessment; Tick marks indicate censored data. *Planned maturity for DFS analysis: 50%.

Data cut-off: April 11, 2022.

Updated DFS in the overall population (Stage IB/II/IIIA disease)



Median follow-up *Tagrisso* 44.2 months (range 0 to 69), placebo 27.7 months (range 0 to 70); DFS by investigator assessment; Tick marks indicate censored data.

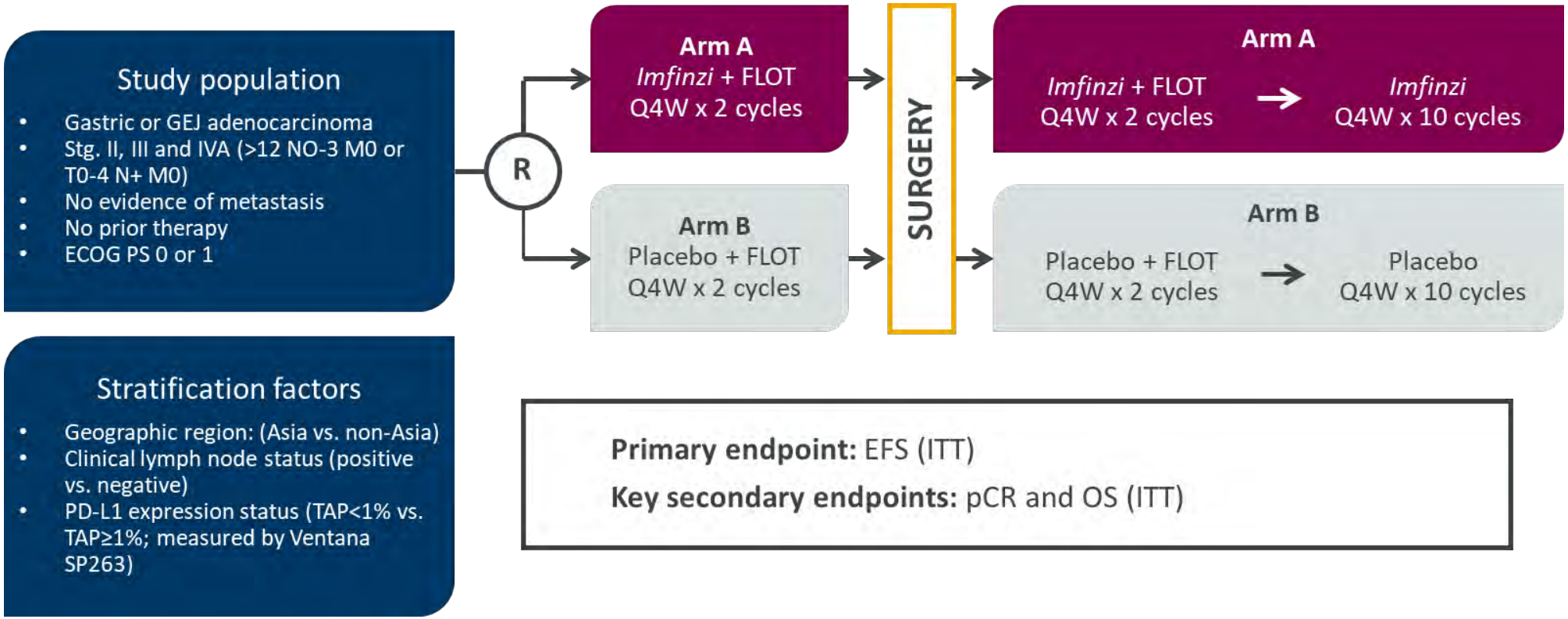
Data cut-off: April 11, 2022.

DFS = disease free survival; CI = confidence interval; HR = hazard ratio; NC = not calculable; no. = number.

MATTERHORN

Imfinzi + FLOT showed statistically significant and clinically meaningful pCR improvement

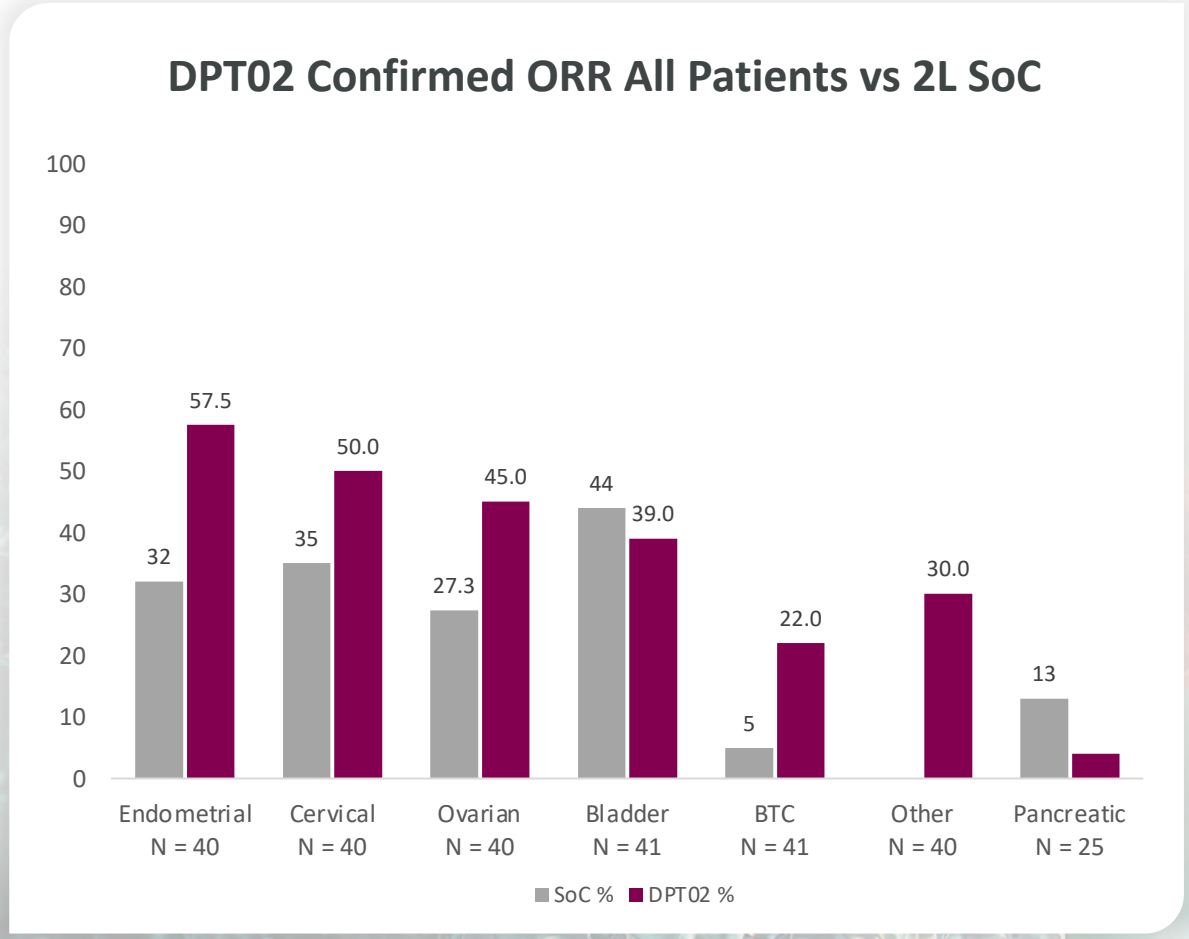
MATTERHORN Phase III trial design

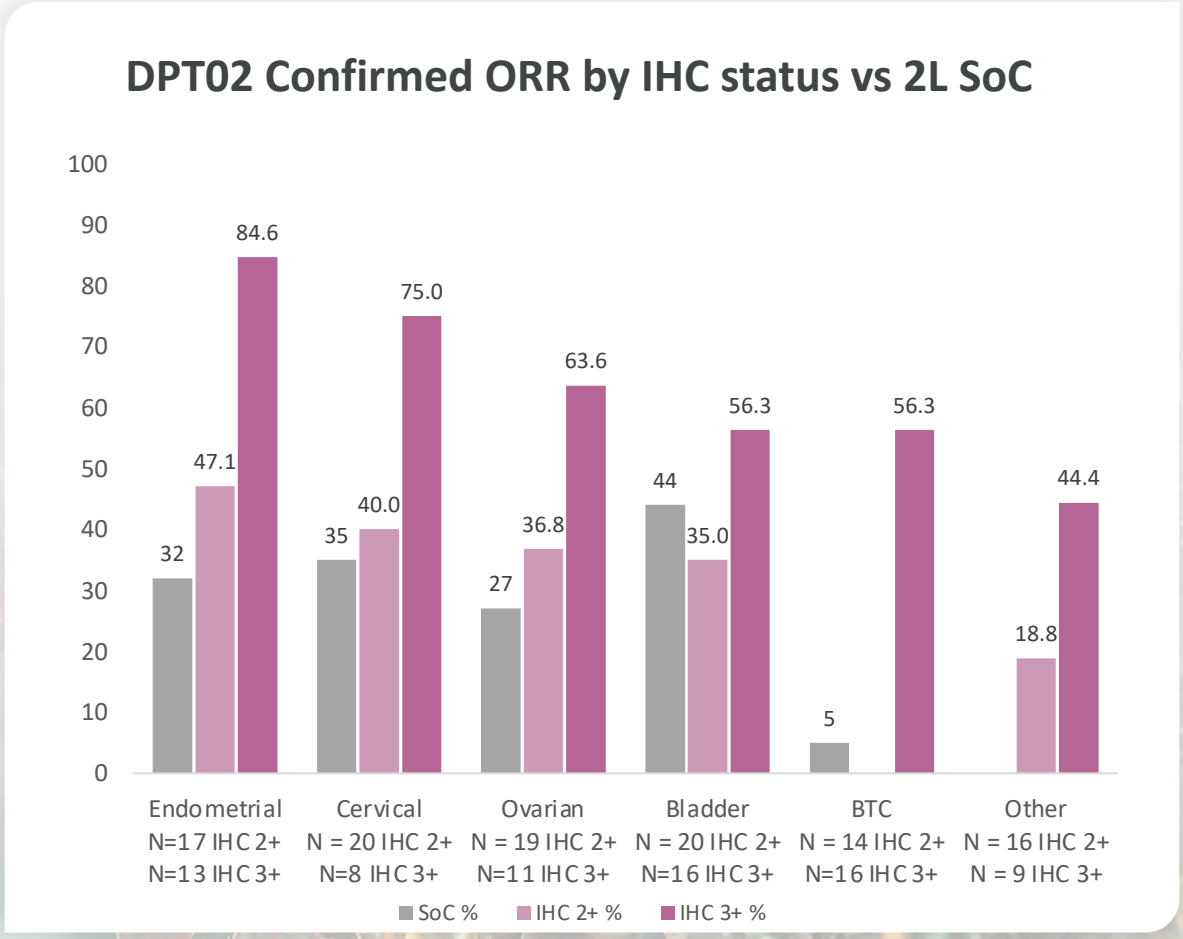


FLOT = fluorouracil, leucovorin, oxaliplatin and docetaxel; GEJ = gastroesophageal junction cancer; Stg. = Stage; ECOG PS = Eastern Cooperative Oncology Group performance status; PD-L1 = programmed cell death ligand 1; TAP = tumour area positivity; Q4W = every four weeks; EFS = event-free survival; ITT = intent-to-treat; pCR = pathologic complete response.

Confirmed ORR in efficacy subset: SoC comparison

Clinically meaningful responses in DESTINY-Pantumor02 vs 2L SoC[1-6] in nearly all cohorts





Note: right graph does not show pancreatic cohort data due to small n (1 patient in IHC 2+ subgroup with response)
Illustrative data only – cross trial comparisons should always be interpreted with caution

1. Makker V et al. *N Engl J Med*. 2022;386(5):437-448; 2. Oaknin A et al. *J Immunother Cancer*. 2022;10(1):e003777; 3. Pujade-Lauraine E et al. *J Clin Oncol*. 2014;32(13):1302-1308; 4. Rosenberg JE et al. *J Clin Oncol*. 2019;37(29):2592-2600; 5. Lamarca A et al. *Lancet Oncol*. 2021;22(5):690-701; 6. Mita N et al. *J Clin Med*. 2019;8(6):761. Published 2019 May 29.

ORR = objective response rate; SoC = standard of care; 2L = 2nd-line; DPT02 = DestinyPantumor02; IHC = immunohistochemistry