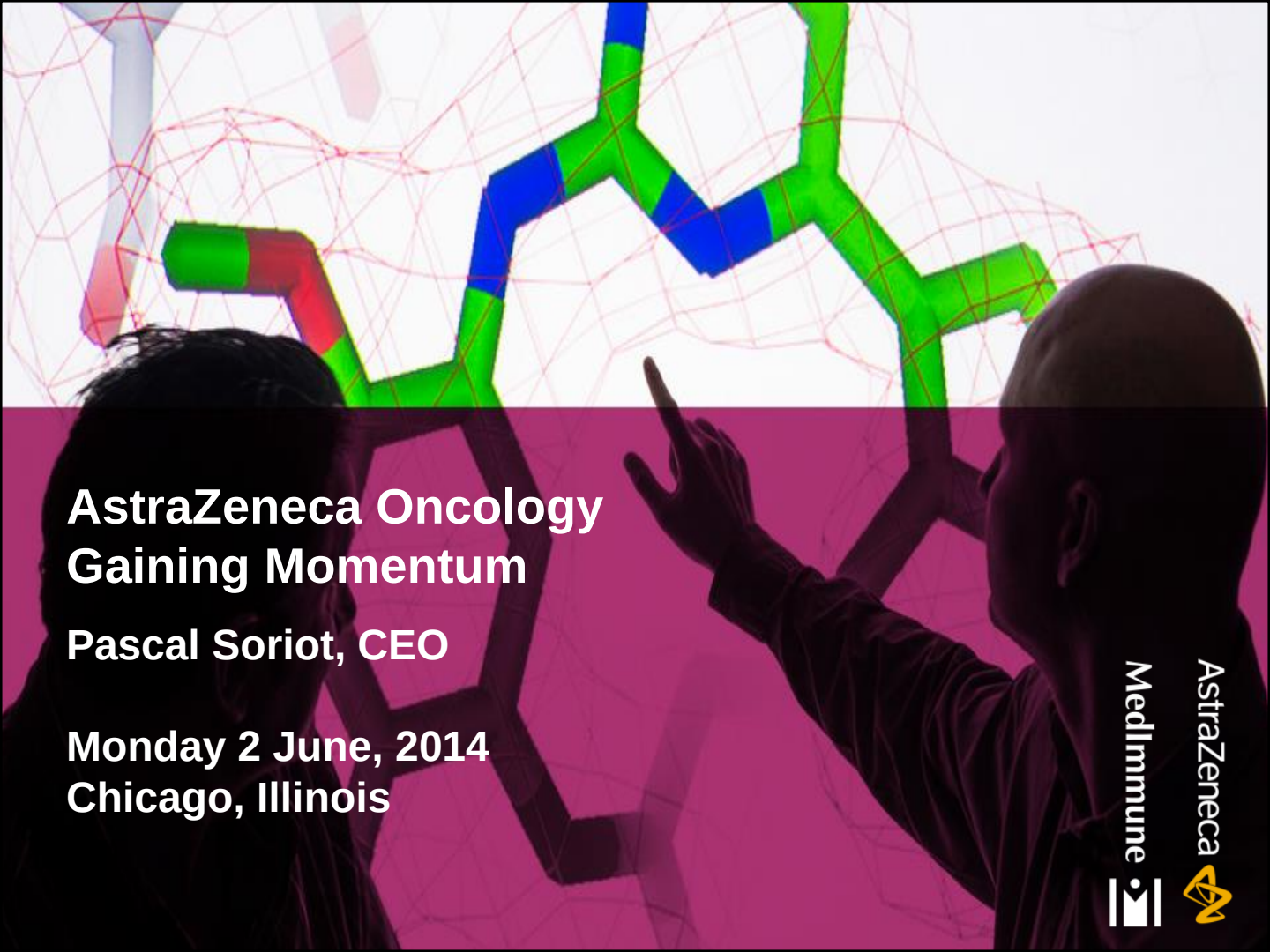


AstraZeneca Oncology Gaining Momentum

Pascal Soriot, CEO

Monday 2 June, 2014
Chicago, Illinois

AstraZeneca
MedImmune

Cautionary statement regarding forward-looking statements

In order, among other things, to utilise the 'safe harbour' provisions of the US Private Securities Litigation Reform Act 1995, we are providing the following cautionary statement: This presentation contains certain forward-looking statements with respect to the operations, performance and financial condition of the Group. Although we believe our 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 presentation and AstraZeneca undertakes no obligation to update these forward-looking statements. We identify 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 our control, include, among other things: the loss or expiration of patents, marketing exclusivity or trade marks, or the risk of failure to obtain patent protection; the risk of substantial adverse litigation/government investigation claims and insufficient insurance coverage; exchange rate fluctuations; the risk that R&D will not yield new products that achieve commercial success; the risk that strategic alliances and acquisitions will be unsuccessful; the impact of competition, price controls and price reductions; taxation risks; the risk of substantial product liability claims; the impact of any failure by third parties to supply materials or services; the risk of failure to manage a crisis; the risk of delay to new product launches; the difficulties of obtaining and maintaining regulatory approvals for products; the risk of failure to observe ongoing regulatory oversight; the risk that new products do not perform as we expect; the risk of environmental liabilities; the risks associated with conducting business in emerging markets; the risk of reputational damage; the risk of product counterfeiting; the risk of failure to successfully implement planned cost reduction measures through productivity initiatives and restructuring programmes; the risk that regulatory approval processes for biosimilars could have an adverse effect on future commercial prospects; and the impact of increasing implementation and enforcement of more stringent anti-bribery and anti-corruption legislation.

Nothing in this presentation should be construed as a profit forecast.

Agenda

- 2014: AstraZeneca Oncology Gaining Momentum
- Immuno-Oncology: Differentiated strategy, leapfrogging competition
- Small molecules: AZD9291, olaparib and cediranib
- Q&A

June 2012: AZ oncology pipeline

Phase I
12 NMEs / 13 projects

Small molecule

- **PIM** haematological
- **JAK 1/2** solid tumours
- **TORC 1/2** solid tumours
- **Androgen receptor** prostate
- **AKT** solid tumours
- **AKT** solid tumours
- **MEK** solid tumours
- **Volitinib** (C-MET) solid tumours
- **Selumetinib + AKT** solid tumours

Large molecule

- **DLL-4** solid tumours
- **Moxetumomab** (CD22) haematological
- **ANG-2** solid tumours
- **CEA BiTE** solid tumours
- **mOX40** solid tumours

Phase II
9 NMEs / 9 projects

Small molecule

- **erbB** Solid tumours
- **Fostamatinib** (SYK) haematological
- **FGFR** solid tumours
- **Olaparib** (PARP) BRCAm ovarian
- **Selumetinib** (MEK) solid tumours

Large molecule

- **PDGFRa** NSCLC/glioblastoma
- **CD19** haematological
- **IGF** solid tumours
- **Tremelimumab** (CTLA-4) solid tumours

Phase III / Registration
2 NMEs / 2 projects

Small molecule

- **Caprelsa** (VEGFR/EGFR/RET) MTC

Large molecule

- **Denosumab** (RANKl) Bone disorders

[1] AstraZeneca development pipeline 30 June 2012

June 2014: AZ oncology pipeline

Phase I
10 NMEs / 22 projects

Small molecule

- **PIM** haematological
- **ATR** CLL, H&N
- **PI3Kβδ** solid tumours
- **STAT3 antisense** haematological
- **Volitinib** (C-MET) solid tumours
- **AR antisense** solid tumours ★
- **Olaparib** (PARP) solid tumours
- **AZD9291 + MEK** EGFRm+ NSCLC ★
- **AZD9291 + C-MET** EGFRm+ NSCLC ★
- **Olaparib + AKT** solid tumours

Large molecule

- **DLL-4** solid tumours
- **Moxetumomab** (CD22) pALL
- **ANG-2** solid tumours
- **CEA BiTE** solid tumours
- **mOX40** solid tumours
- **PD-L1** MDS, solid tumours
- **PD-1** solid tumours
- **PD-L1 + CTLA-4** solid tumours
- **PD-L1 + BRAF + MEK** melanoma
- **PD-L1 + PD-1** malignancies ★
- **PD-L1 + AZD9291** EGFRm+ NSCLC ★
- **PD-L1 + Iressa** EGFRm+ NSCLC ★

Phase II
8 NMEs / 9 projects

Small molecule

- **Wee-1** solid tumours
- **TORC1/2** solid tumours
- **FGFR** solid tumours
- **AKT** breast
- **Selumetinib** (MEK) 2L KRAS- NSCLC ★
- **Volitinib** (C-MET) PRCC
- **Cediranib** (VEGF) ovarian

Large molecule

- **CD19** haematological
- **IGF** metastatic breast

Phase III / Registration*
6 NMEs / 13 projects

Small molecule

- **Olaparib** (PARP) BRCAm PSR ovarian
- **Olaparib** (PARP) BRCAm 1st line ovarian
- **Olaparib** (PARP) BRCAm metastatic breast
- **Olaparib** (PARP) BRCAm adjuvant breast ★
- **Olaparib** (PARP) 2L gastric
- **Selumetinib** (MEK) 2L KRASm+ NSCLC
- **Selumetinib** (MEK) Differentiated thyroid
- **Selumetinib** (MEK) uveal melanoma
- **AZD9291** (EGFRm+) NSCLC* ★

Large molecule

- **Moxetumomab** (CD22) HCL
- **PD-L1** Stage III unres. NSCLC ★
- **PD-L1** 3L NSCLC ★
- **Tremelimumab** (CTLA4) mesothelioma* ★

[1] AstraZeneca development pipeline 2 June 2014; * Pivotal phase II/III ★ Changes since 31 March 2014 – Q1 pipeline update

R&D changes fuelling pipeline transformation

Antoine Yver MD
Head, Oncology, Global Medicines Development
Joined 2009
Experience: Aventis, Schering-Plough and J&J

Rachel Humphrey MD
Head, Immuno-Oncology, Global Medicines Development
Joined 2013
Experience: BMS and Bayer

Mondher Mahjoubi MD
Head, Oncology Global Portfolio & Product Strategy
Joined 2013
Experience: Aventis and Roche/Genentech

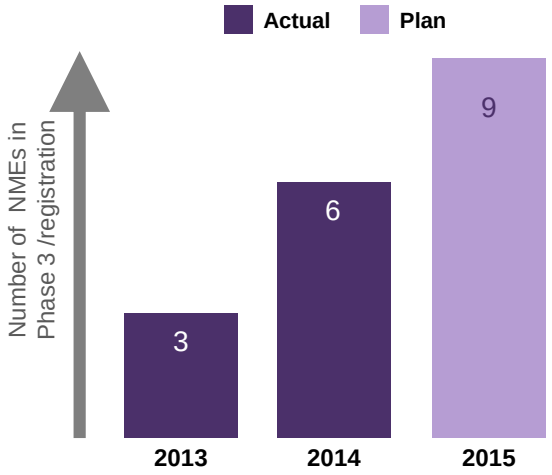
Ed Bradley MD
Head, Innovative Medicines Oncology, MedImmune
Joined 2010
Experience: Incyte, CETUS Sterling-Winthrop

Susan Galbraith MD, PhD
Head, Oncology, Innovative Medicines & Early Development
Joined 2010
Experience: BMS

Oncology: Accelerated late stage pipeline progression

Significant newsflow since ASCO 2013 driving accelerated pipeline progression	
Compound	**Milestone**
PD-L1	Phase III initiated in NSCLC
Tremelimumab	Study amendment to support registration
AZD9291	Breakthrough designation
Olaparib	4 Phase III starts in solid tumours
Olaparib	Priority review in US – PDUFA 3 Oct 2014
Selumetinib	3 Phase III starts in solid tumours
Cediranib	OS benefit in ovarian – ICON6
Iressa	ctDNA EU filing
PD-1	First-in-human start
PD-L1 + PD-1	Phase I start
PD-L1 + CTLA-4	Phase I/II start

9 potential NMEs in Phase III / registration* by 2015



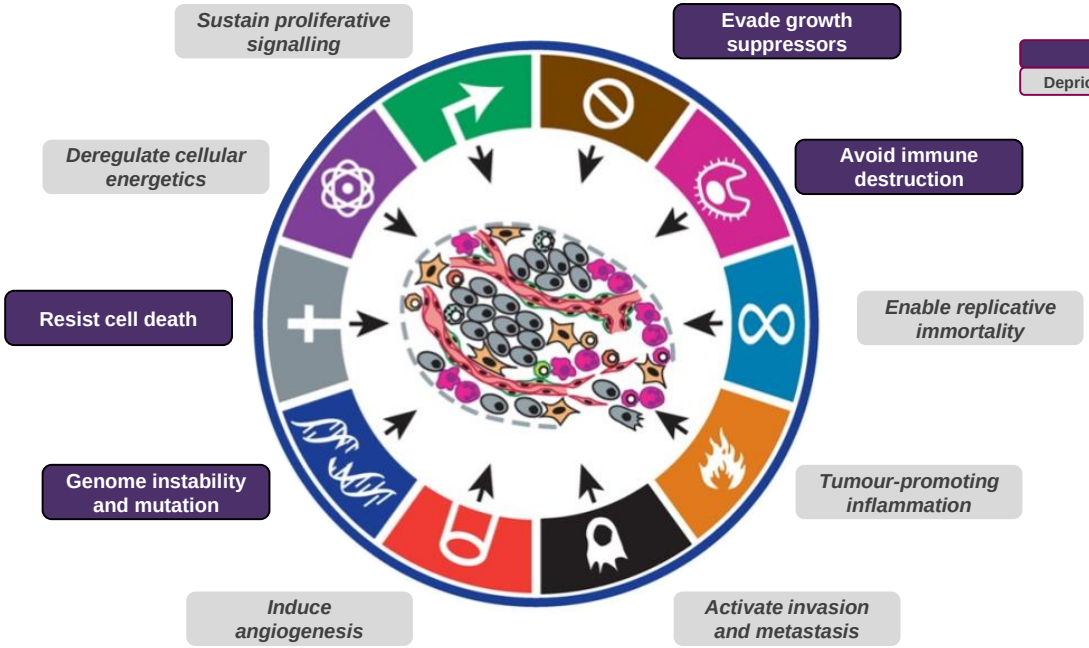
* Pivotal phase II/III

Delivering on the promise of ASCO 2013

Development plans shared at ASCO 2013

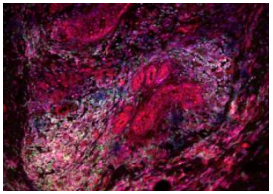
Olaparib – BRCAm ovarian cancer	FSI	Data read-out
Phase III PSR maintenance study	Q3 2013	H2 2015
Phase III 1st line maintenance	Q3 2013	H2 2016
Olaparib – BRCAm breast cancer		
Phase III Metastatic disease	Q1 2014	H1 2016
Phase III Neoadjuvant (combination with paclitaxel)	Q3 2014	H2 2016
Phase III Adjuvant treatment post-chemotherapy	Q2 2014	H1 2020
Olaparib – Gastric cancer		
Phase III 2nd line combination with paclitaxel in Asia	Q3 2013	H2 2016
Olaparib – Prostate cancer		
Phase II combination with abiraterone	Q2 2014	H2 2016
Phase I combination with AKT (AZD5363)	Q2 2014	H2 2015
Selumetinib		
Phase III 2L KRASm+ NSCLC	Q4 2013	H2 2016
Phase IIb Differentiated thyroid cancer	Q3 2013	H2 2016

A clear strategy focused on 4 science platforms



"Hallmarks of cancer" adapted from Weinberg and Hanahan, Cell (2011)

AstraZeneca strongly positioned to combine agents within and between key scientific mechanisms

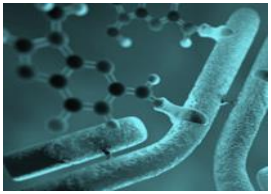


Tumour drivers and resistance

FGFR
selumetinib (MEK)
AZD9291 (EGFR)
AKT
TORC 1/2
Pi3K
IGF 1/2
DLL-4
C-MET

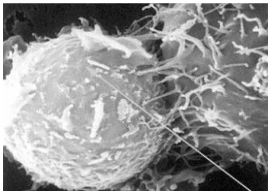
DNA damage response

olaparib (PARP)
Wee-1
ATR
ATM (Pre-clin)



Antibody drug conjugates

Moxetumomab
ADC-Spirogen (Pre-clin)
ADC Bispecific (Pre-clin)



Immunotherapy

PD-L1
Treme (CTLA-4)
OX40
PD-1
CEA-BiTE

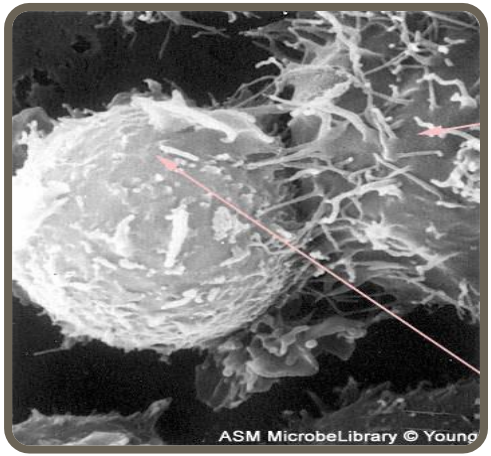
Immuno-Oncology (IO)

Ed Bradley
Head, Innovative Medicines Oncology, MedImmune

Rachel Humphrey
Head, Immuno-Oncology, Global Medicines Development

MedImmune
AstraZeneca

Immune Mediated Therapy: Transforming cancer care



Cancer cell specific

Profoundly potent

Long lasting memory

"If we are ever going to use the word 'cure', the immune system is going to come into play."

Stephen Hodi, M.D., Dana-Farber, WSJ 6/14/11

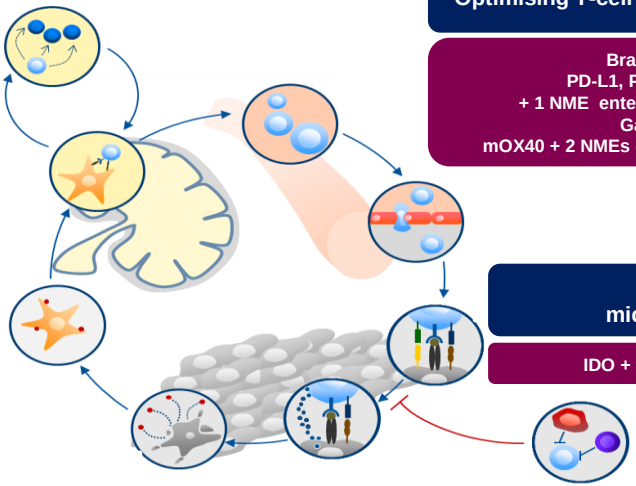
Cancer hijacks every aspect of the normal immune response to escape destruction

Optimising T-cell function and memory

Brakes Off:
PD-L1, PD-1, CTLA-4
+ 1 NME entering clinic 2014/15
Gas On:
mOX40 + 2 NMEs entering clinic 2014/15

Antigen presentation

Radiation, Chemotherapy
Small Molecules, ADCs
+ 4 NMEs entering clinic 2014/15



Inhibition by microenvironment

IDO + 1 NME entering clinic 2014/15

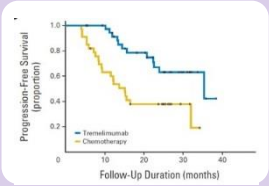
Our growing pipeline will impact the total immune response to cancer

Our comprehensive portfolio allows and supports combinations

Take Brakes Off

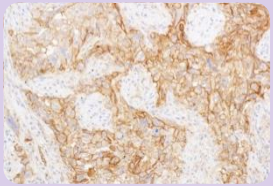
CTLA-4

- Extensive clinical data
- Combinations



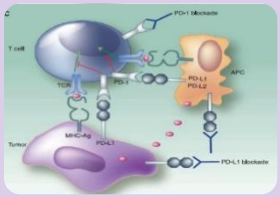
PD-L1

- Active across tumour types
- Combinations
- Anti-drug antibodies rare



PD1

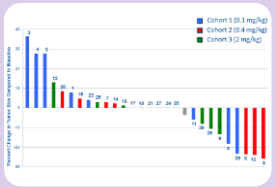
- Blocks PD-L1 and PD-L2
- Combinations



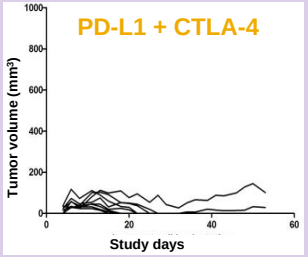
Put Gas On

mOX40

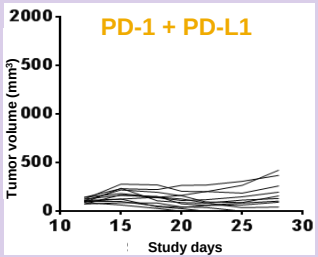
- Enhances tumour killing T cells
- Enhances memory cell generation



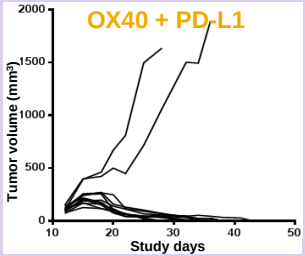
Biology drives unique synergistic combinations



- Ongoing clinical trials in many tumour types
- Positive preliminary data in NSCLC



- Complete blockade of the PD-1 pathway
- Trial enrolling now

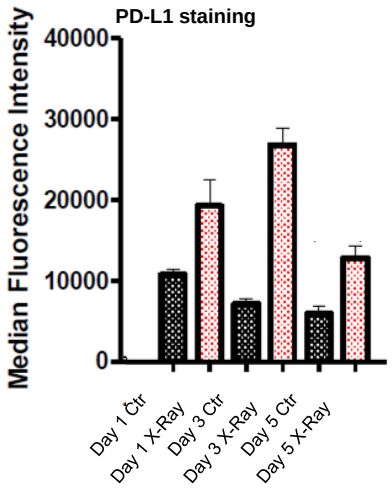


- First in class "Brakes OFF + Gas ON" combination to optimise T cell-mediated tumour killing and memory

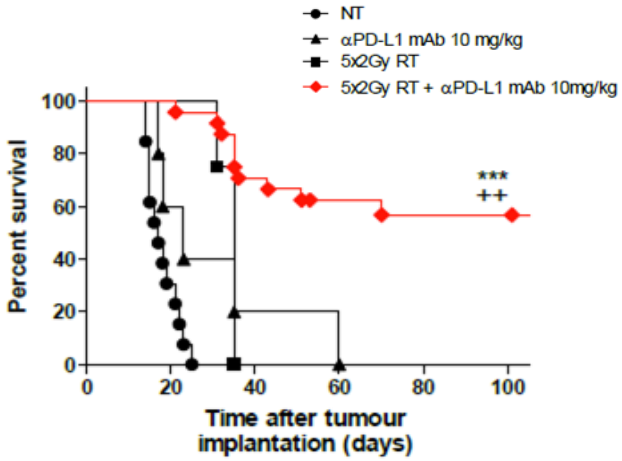
Pre-clinical models; Data on file

Radiation upregulates PD-L1 and is synergistic with anti-PDL1 therapy

Increased PD-L1 expression after radiotherapy (murine model)



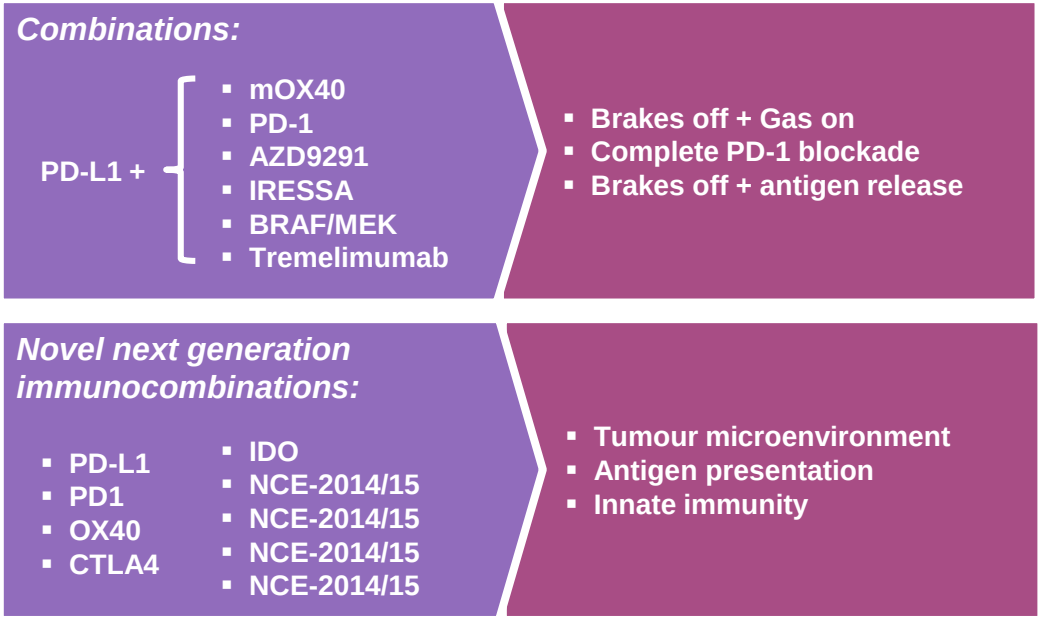
Synergy in a murine model



In collaboration with Tim Illidge and Simon Dovedi

The University of Manchester
Manchester Cancer Research Centre

Multiple synergistic combinations in development, with more to come



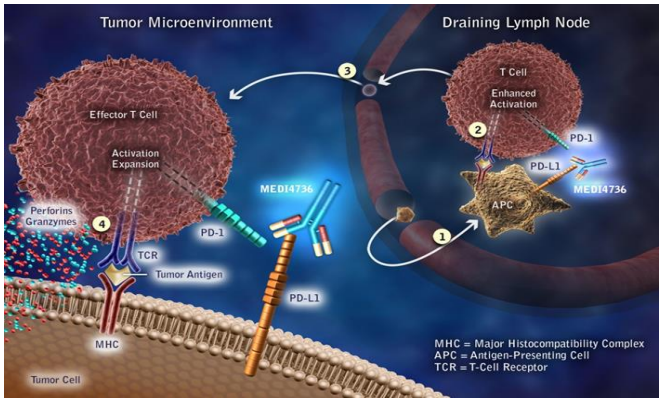
Deep and broad experience in Immuno-Oncology

Wealth of knowledge...	...and extensive leadership experience
▪ 168 years in IO ▪ 276 years in Industry ▪ 32 NME approvals ▪ 627 full-length publications	▪ ipilimumab, nivolumab, tremelimumab, 41BB, CD40 PD-L1, mOX40, PD-1, Lag-3, Kir, IL-21, vaccines, CARs, IL-2, GM-CSF, IFN, Peg-IFN ▪ Multiple combinations and near-term novel pre-clinical immunotherapies

Anti-PDL1 (MEDI4736)

Potent anti-cancer agent with clear potential for differentiation

MEDI4736: An engineered anti-PDL1 antibody



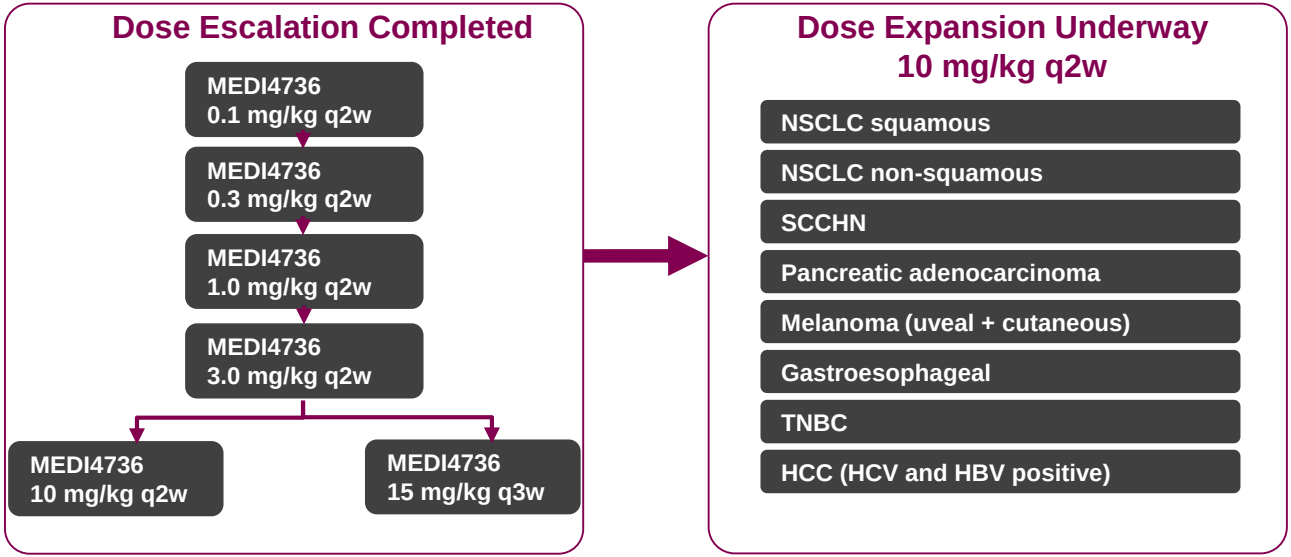
Uniquely engineered human IgG1κ mAb

- Triple mutation in Fc domain removes ADCC activity
- No immunogenicity impacting PK-PD at Phase 3 dose (10mg/kg) to date
- 2/196 patients treated at 10 mg/kg showed anti-drug antibodies (ADA)
- 1/18 patients treated with doses other than 10 mg/kg showed ADA impacting PK-PD

~450 patients treated (monotherapy and in combination)[1]

[1]Data on file, MedImmune/AstraZeneca

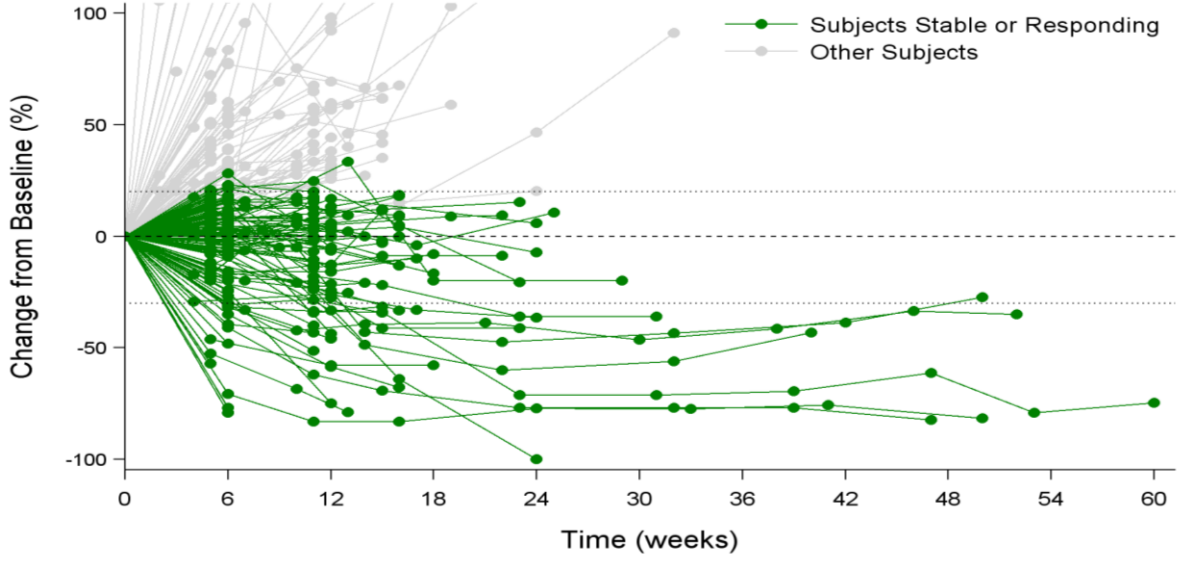
Study 1108: Dose escalation and expansion in multiple tumour types



Anti-PDL1 safety: No colitis, no high grade pneumonitis, no drug-related deaths

Select drug-related AEs of interest*		MEDI4736 10 mg/kg q2w (N= 339)	
System Organ Class	**Event**	**All Grades, n (%)**	**Grade 3/4, n (%)**
Constitutional - General	Fatigue	44 (13)	**2 (1)**
	Pyrexia	9 (3)	**0**
Gastro-Intestinal	Vomiting	16 (5)	**1 (<1)**
	Diarrhea	15 (4)	**0**
	Abdominal Pain	7 (2)	**0**
Endocrine	Hypothyroidism	7 (2)	**1 (<1)**
	Hyperthyroidism	3 (1)	**0**
	Hyperglycemia	1 (<1)	**1 (<1)**
Skin	Rash	16 (5)	**0**
	Pruritus	13 (4)	**1 (<1)**
Respiratory	Dyspnea	14 (4)	**0**
	Pneumonitis	2 (1)	**0**
Hepatic	AST Elevation	7(2)	**2 (1)**
	ALT Elevation	7(2)	**1 (<1)**
Neurotoxicity	Peripheral neuropathy	3 (1)	**0**

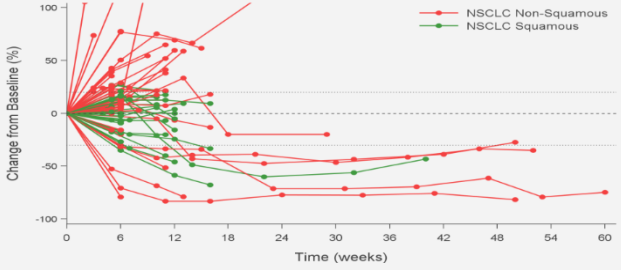
Patients with clinical benefit: Durable activity observed

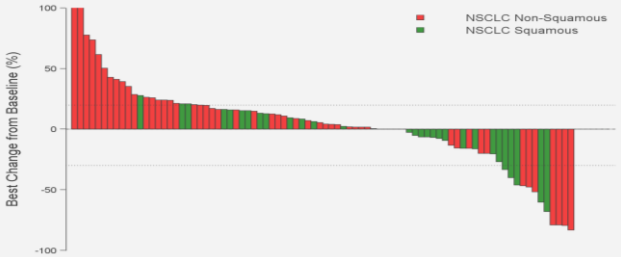


Jose Lutzky, Neil Howard Segal ASCO 2014; *Changes >100% are truncated in plot; Data cut-off: May 12, 2014

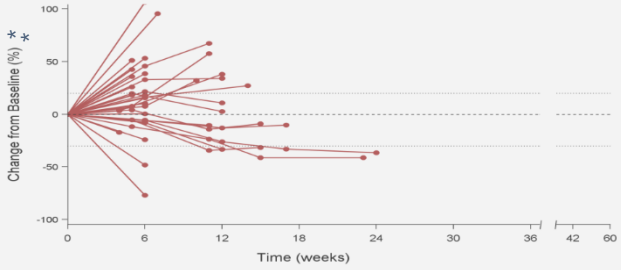
Emerging promising clinical activity in select tumours

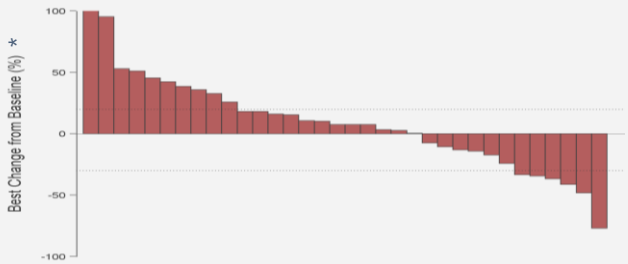
NSCLC (n=84)





H&N (n=34)

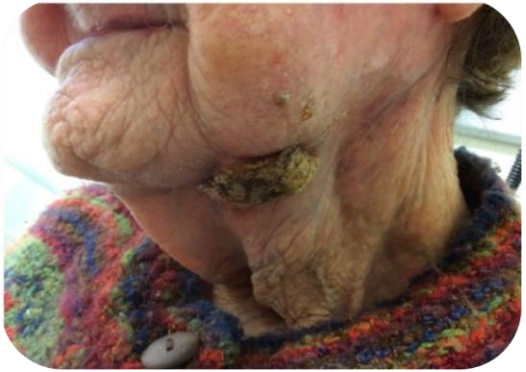




Anti-PDL1: Impressive response in patient with SCCHN

Before anti-PDL1 infusion

After two anti-PDL1 infusions (30 days)



96 year old patient with SCCHN who had progressed on cetuximab and radiation therapy prior to study entry

- HPV negative, PD-L1 positive

SCCHN = Squamous cell carcinoma of head and neck

PD-L1 biomarker: Increased objective response at week 12 in NSCLC and SCCHN at all doses

RECIST Response

	Total study population	NSCLC (All Doses)	NSCLC (10 mg/kg)	SCCHN (10 mg/kg)
PD-L1+	22% (8/37)	25% (5/20)	39% (5/13)	50% (2/4)
PD-L1-	4% (5/113)	3% (1/29)	5% (1/19)	6% (1/16)
Total*	11% (19/179)	16% (9/58)	13% (6/47)	14% (3/22)

Disease Control Rate

	Total study population	NSCLC (All Doses)	NSCLC (10 mg/kg)	SCCHN (10 mg/kg)
PD-L1+	54% (20/37)	45% (9/20)	54% (7/13)	50% (2/4)
PD-L1-	21% (24/113)	24% (7/29)	32% (6/19)	31% (5/16)
Total*	31% (56/179)	35% (20/58)	30% (14/47)	32% (7/22)

Subjects enrolled ≥12 weeks prior to data cut-off date (May 12, 2014)

Median Follow-up is 8 weeks for all subjects in the study

*Not all patients have been analyzed for PDL1 status; Objective Response Rate = confirmed/unconfirmed CR or PR based on conventional RECIST criteria; Disease Control Rate = Objective Response + SD ≥ 12 weeks

Enrichment based on PD-L1 expression in lung cancer: Key driver of response in monotherapy

Agent	ORR PDL1+	ORR PDL1-	% PD-L1 positive at stated cut-off	Source
MK-3475	37% (15/41)	11% (10/88)	25%	2014 AACR
Nivolumab	15% (5/33)	14% (5/35)	49%	2014 ASCO
MPDL3280A	46% (6/13)	15% (6/40)	25%	2013 ESMO
MEDI4736*	**39% (5/13)**	**5% (1/19)**	**40%**	**2014 ASCO**

*Patients treated < 12 wks prior to the data cut were censored

Tremelimumab (anti-CTLA-4)

Phase II/III in mesothelioma

Tremelimumab (anti-CTLA-4): Active anti-cancer agent

- Fully human IgG_2 mAb with no detectable ADCC
- Studied in 23 clinical studies to date with >1500 patients
- Well-established safety profile and risk management algorithms
- Objective responses in multiple cancer types:
- Metastatic Melanoma – 10.7% ORR
- Hepatoma – 18% ORR & 77% DCR
- Mesothelioma – 7% ORR &10.3% irResponse Rate
- Gastroesophageal – 6% ORR
- Colorectal cancer – 2% ORR

	Tremelimumab[1] Monotherapy	Ipilimumab[2] + dacarbazine
Efficacy – 1st line metastatic melanoma		
Median survival	12.6 months	11.2 months
3 year survival	21%	21%
ORR	11%	15%
CR	3%	1%
DoR	35.8 months	19.3 months
Safety (gr 3-4 events) - 1st line metastatic melanoma		
Diarrhea/colitis	18%	4%
Hepatitis	1%	22%
Rash	1%	1%

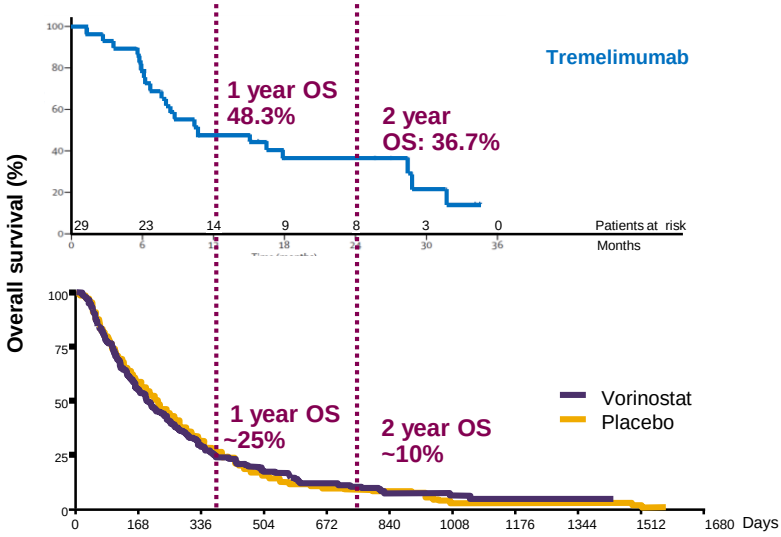
[1] Tremelimumab vs. Chemotherapy (Ribas, 2013) [2] Dacarbazine ± Ipilimumab (Robert, 2011)

Tremelimumab in mesothelioma
37% 2 year survival in ongoing Phase II/III study

Mesothelioma: Unmet medical need

- No current standard (FDA approved) for salvage therapy

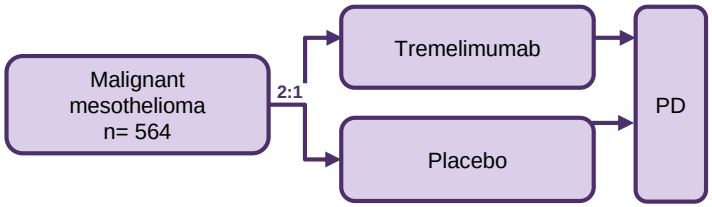
Tremelimumab[1] vs. historical studies[2]



[1]Calabro, Lancet 2013; [2] Kurg LM, et al. ECCO-ESMO 2011. Abstract 3BA

Tremelimumab in mesothelioma: Development plan
Pivotal phase II/III study

Enlarged Phase II/III, 2L



Potentially pivotal phase II/III

Primary end-points: OS
First Subject-in: Q2 2013
Data readout: 2016

Anti-PDL1 + Tremelimumab

Phase I dose escalation in refractory NSCLC

MEDI4736 (anti-PDL1) combines well with tremelimumab

MEDI4736 + tremelimumab: Dose escalation

Cohort	Anti-PDL1 (mg/kg)	Tremelimumab (mg/kg)
1	3	1
2	10	1
3a	15	1
3b	10	3
4	15	3
5	15	10

Current Cohort

Nivolumab + ipilimumab: Dose escalation

Cohort	Nivolumab (mg/kg)	Ipilimumab (mg/kg)
1	0.3	3
2a	1	3
2	3	1
3	3	3
4	10	3
5	10	10

Maximum tolerated dose

Differentiating features		
	MEDI4736 (PD-L1) + tremilimumab	nivolumab (PD-1) + ipilimumab
Scheduling	Q4W for both agents	Q3W for nivolumab 4 x Q3W ipilimumab
Combination dose	PD-L1 dose is higher in all cohorts	CTLA-4 higher at MTD

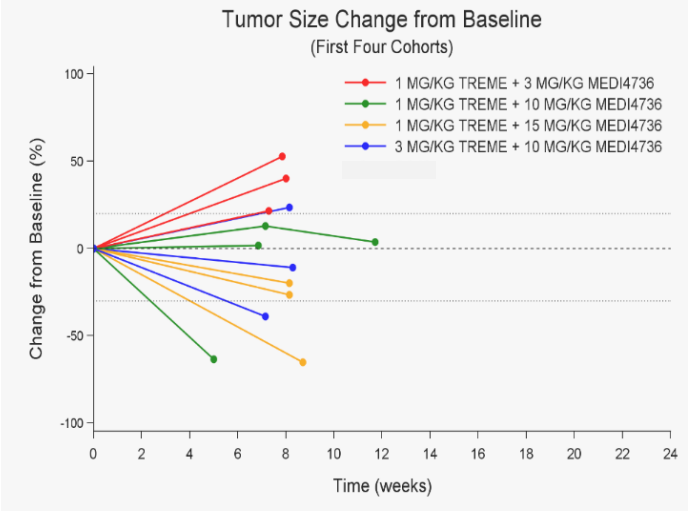
No dose limiting toxicities across 5 dose levels

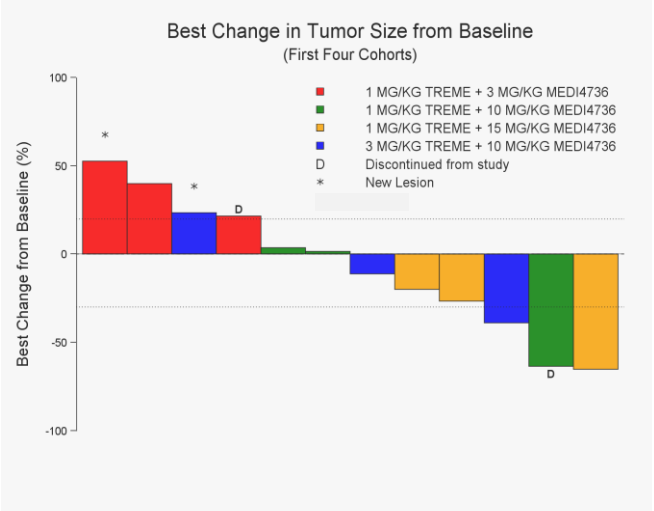
Cohort	n	Anti-PDL1 (mg/kg)	Tremelimumab (mg/kg)	DLT	Related Grade 3-4*	Related Grade 5
1	3	3	1	0	0	0
2	3	10	1	0	0	1 (myasthenia)
3a	3	15	1	0	Colitis,↓Phos (1) ↑ amylase (1)	0
3b	3	10	3	0	Colitis (1)	0
4	3	15	3	0	N/A	0

All Grade 3-4 events were outside the DLT period and rapidly responsive to steroids

Data as of May 31, 2014; DLT= Dose Limiting Toxicity

Encouraging efficacy for PD-L1/CTLA-4 combination in NSCLC





Data as of May 5, 2014; Preliminary unpublished data

Summary: Anti-PDL1 and tremelimumab (CTLA-4)

Anti-PDL1

- Well tolerated
- Active at all doses in multiple tumour types
- No PK-altering ADA at phase 3 dose: predictable pharmacology

Tremelimumab

- On registrational path
- Combines well with PD-L1

Anti-PDL1 + tremelimumab

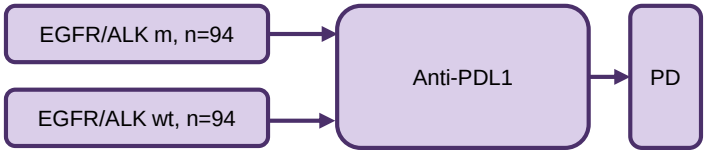
- No dose limiting toxicities to date – dose escalation continues
- Early signs of anti-tumour activity

Clinical Plan

Speed, Differentiation, Leadership

Anti-PDL1 Development in Late Stage NSCLC: Fast to market approach for patients with highest need

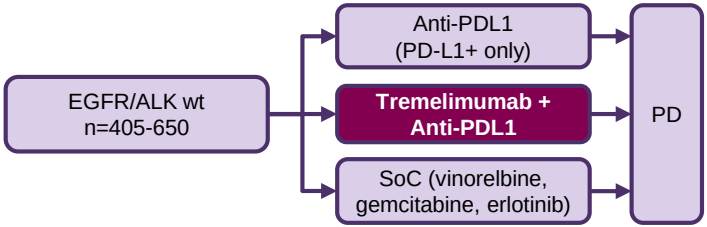
ATLANTIC: 2-cohort, uncontrolled, Ph II 3L NSCLC, PD-L1 positive



Potential registrational study

Primary end-point: ORR
First subject-in: Q1 2014
Primary data readout: 2015
Each arm can be analyzed separately

ARCTIC: Randomised, controlled Ph III 3L NSCLC

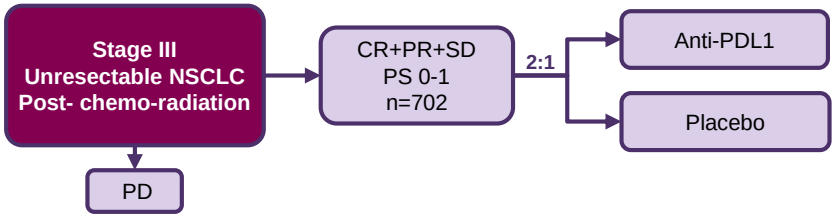


First combo registrational study

Co-Primary end-points: PFS/OS
First subject-in: Q3 2014
Data readout: 2017

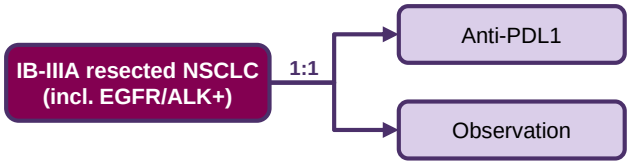
Anti-PDL1 development in early stage NSCLC: First mover advantage

PACIFIC Ph III, Stage 3 unresectable NSCLC



Co-primary end-points: PFS/OS
First Subject-in: Q2 2014
Data readout: 2017

ADJUVANT study*: Randomised, controlled Ph III NSCLC

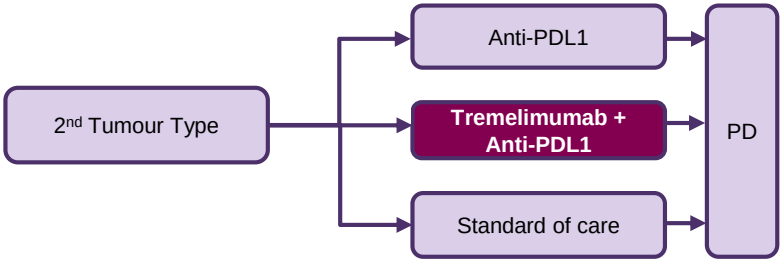


Primary end-point:
Recurrence-Free Survival (RFS)
First subject-in: 2015

*Partnered with a leading cooperative group

Additional cancer types to start phase III in 2014
Potential first mover advantage

At least 1 new cancer type; 3-arms randomised phase III



First Subject-in: H2 2014

Further combination data and plans for new tumour types to be presented at ESMO

Leapfrogging competition with unique indications, novel combinations and speed of execution

1 Speed

Quickest path to approval

Early market entry in IO
- PD-L1 mono stage 3 NSCLC
- PD-L1 mono 3rd line+ NSCLC
- Treme mono Mesothelioma

2 Differentiation

Rapid program expansion
Adaptive decision-making
Patient selection

Novel combinations & New tumour types / indications

- PD-L1 + Treme NSCLC
- PD-L1 + Treme 2nd tumour
- PD-L1 + AZD9291 NSCLC
- PD-L1 + Olaparib OC

3 Leadership

Expand outside T-cell based therapy and explore new technologies

Multiple combinations
- More than 2 agents
- Internal and external assets

High value indications
- Adjuvant & TML (treatment through multiple lines)

Oncology

Susan Galbraith
Head, Oncology, Innovative Medicines & Early Development

Antoine Yver
Head, Oncology, Global Medicines Development

AstraZeneca
MedImmune

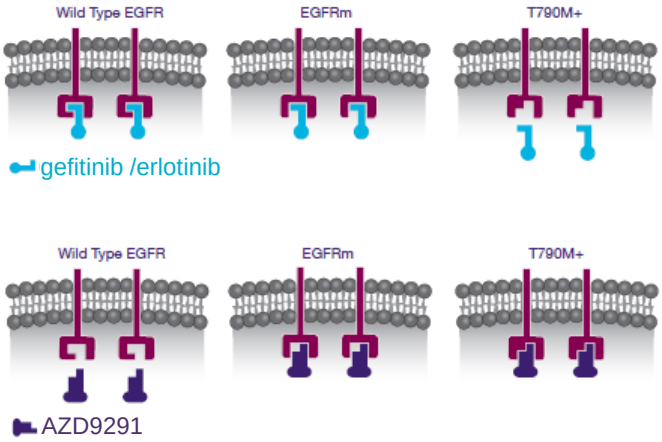
AZD9291

NDA filing 2-2.5 years from first human dosing with breakthrough designation

Differentiated irreversible selective inhibitor of double EGFR mutations

AZD9291: Irreversible selective double mutant inhibitor

Designed to inhibit EGFR Exon19 del, L858R, T790M

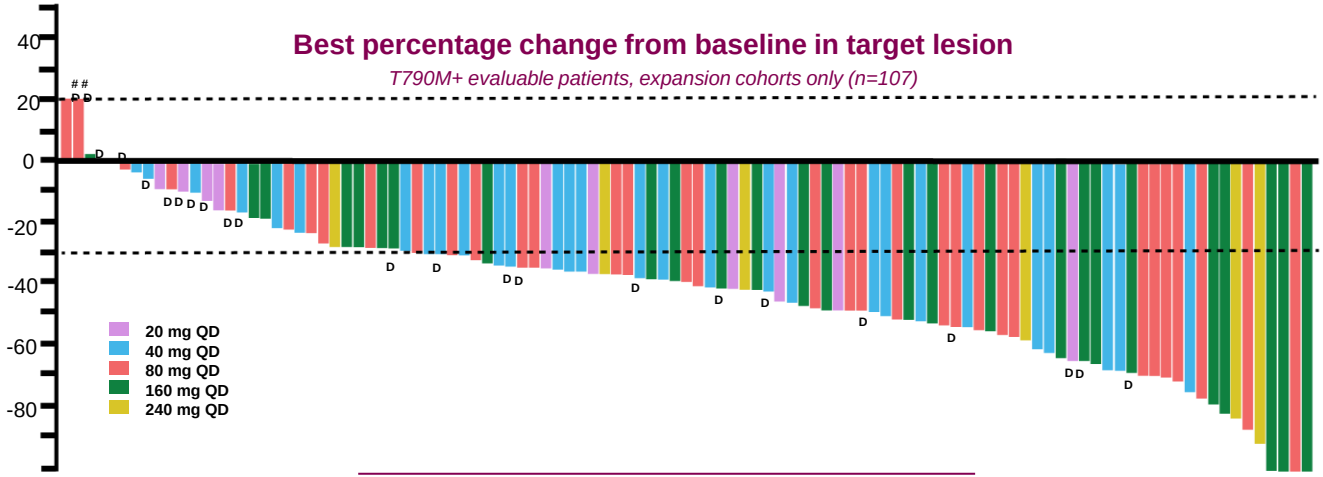


Key differentiation features

- Increased potency towards EGFRm+/T790M
- Large selectivity margin vs. wild-type EGFR / IGFR
- >300 patients enrolled & ~64% Asian population

- ORR 64% in T790M with activity at all doses
- Potential to sustain longer efficacy
- Reduced EGFR wt toxicity, no hyperglycemic effect

AZD9291: Overall response rate* 64% in T790M+; Longest response > 9 months and ongoing

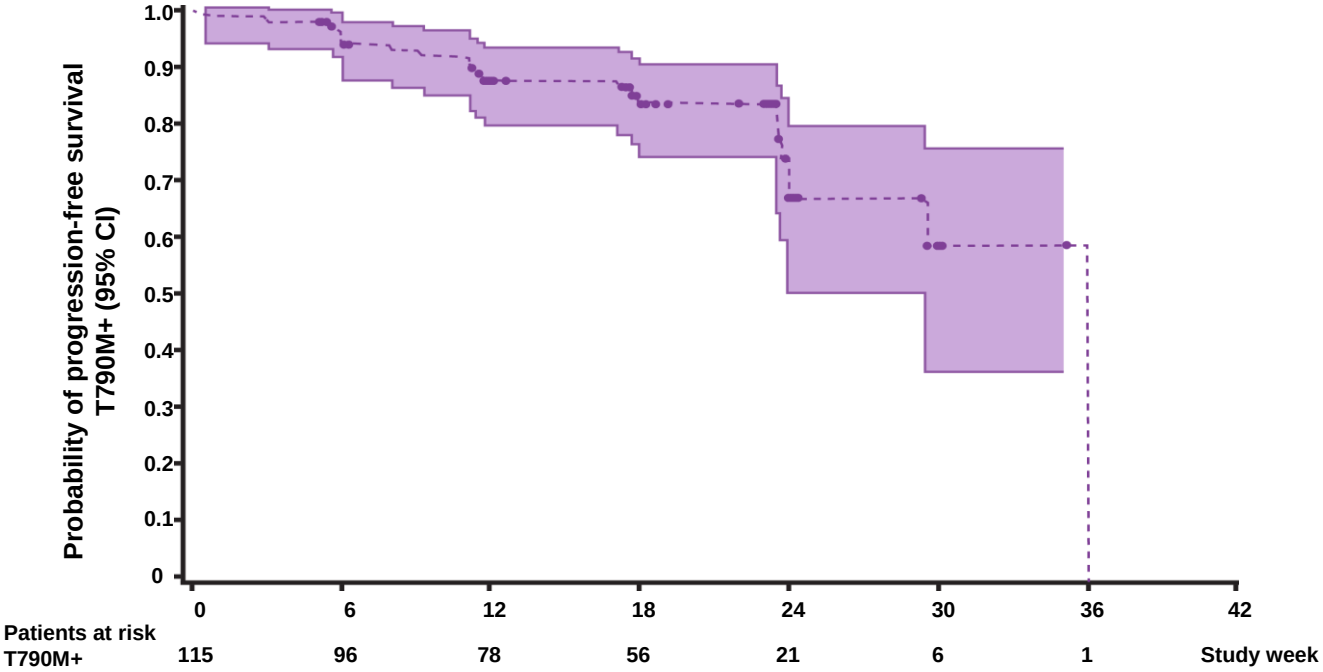


	20 mg	40 mg	80 mg	160 mg	240 mg
ORR% (N)	50% (5/10)	62% (18/29)	68% (23/34)	64% (18/28)	83% (5/6)

Overall disease control rate (CR+PR+SD) = 94%

Janne P et al ASCO 2014 – Abstract 8009. *Includes confirmed responses and responses awaiting confirmation; # represents imputed values. Population: all dosed centrally confirmed T790M+ patients with a baseline RECIST assessment and an evaluable response (CR/PR, SD or PD), N=107 (from 120 T790M+ patients, 13 patients with a current non-evaluable response are not included). QD, once daily; D, Discontinued

AZD9291: Promising PFS for patients with T790M+



Janne P et al ASCO 2014 – Abstract 8009. Dots indicate censored observations, shaded area represents 95% CIs; progression events that do not occur within 14 weeks of the last evaluable assessment (or first dose) are censored. Population: all dosed centrally confirmed T790M+ and T790M- patients, N=170 (115 T790M+, 55 T790M-; six patients for whom start date is not yet known are not included)

AZD9291: Rare grade 3 toxicity in selected dose for phase III

Patients with an AE, %	20 mg (N=21)		40 mg (N=57)		80 mg (N=74)		160 mg (N=60)		240 mg (N=20)	
	Any Gr	Gr ≥3	Any Gr	Gr ≥3	Any Gr	Gr ≥3	Any Gr	Gr ≥3	Any Gr	Gr ≥3
AE by preferred term, occurring in at least 10% of patients overall										
Diarrhoea	14	0	35	0	20	1	63	2	75	5
Rash (grouped terms)	24	0	23	0	27	0	58	2	50	5
Nausea	14	0	18	0	14	0	25	0	20	0
Dry skin	10	0	12	0	11	0	32	0	10	0
Pruritus	10	0	16	0	18	0	17	0	20	0
Decreased appetite	24	0	12	0	11	0	18	0	30	0
Fatigue	19	5	16	0	7	0	13	0	15	5
Constipation	0	0	18	0	12	0	13	0	5	0
Paronychia	10	0	2	0	10	0	22	2	15	0
Cough	10	0	9	0	10	0	17	0	0	0
Select AEs of interest										
Hyperglycemia (n=3)	0	0	0	0	1	0	3	0	0	0
QT prolongation (n=4)	0	0	0	0	1	0	5	0	0	0
ILD-like event* (n=6)	0	0	0	0	3	1	7	3	0	0

Janne P et al ASCO 2014 – Abstract 8009. * ILD=Interstitial Lung Disease , All six patients responded well to treatment with no fatal events. Review of these events is ongoing; Population: all dosed patients, n=232; does not include 1st-line or tablet cohorts

AZD9291: First to market strategy
US filing H2 2015 with potential Q1 2015

Impressive clinical efficacy

- Large Phase I with >300 patients enrolled: 2/3 Asian patients
- Unprecedented response rate 64% & disease control rate 94% in T790M
- Median PFS not reached for patients with T790M
- Once daily dosing

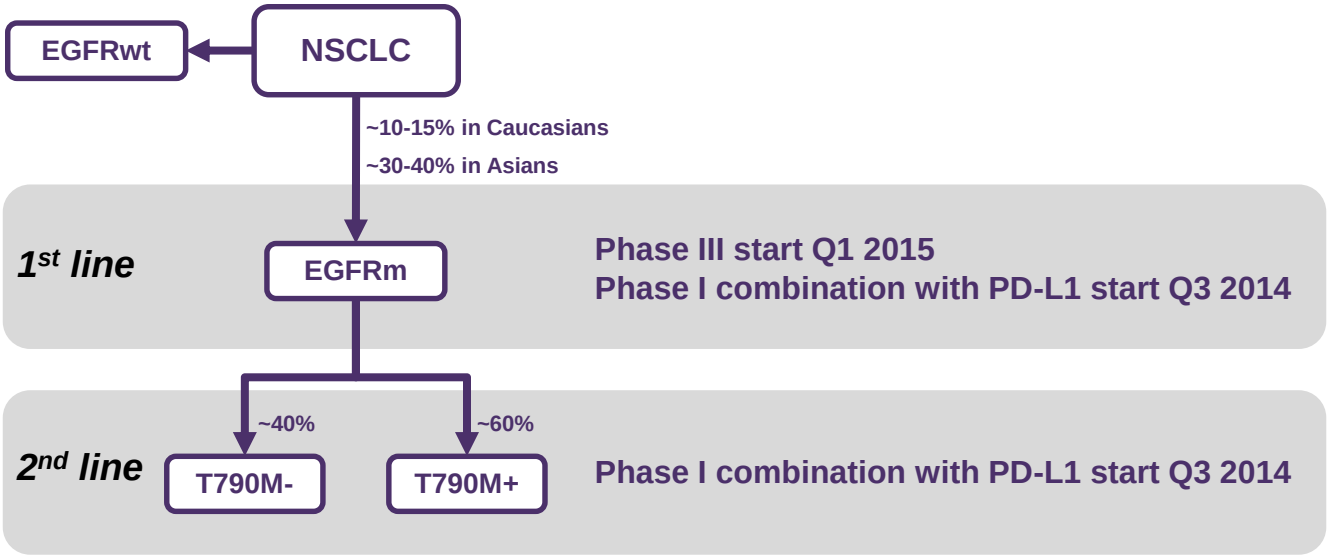
Encouraging tolerability profile

- No IGFR inhibition: no hyperglycemia
- No HERG liability: no QTc concern

Speed of development

- Phase III dose and formulation identified – rapid entry to 1st line
- Breakthrough designation; base case filing H2 2015, potential Q1 2015

AZD9291: Exploring opportunity in 1st line & in combination with PD-L1

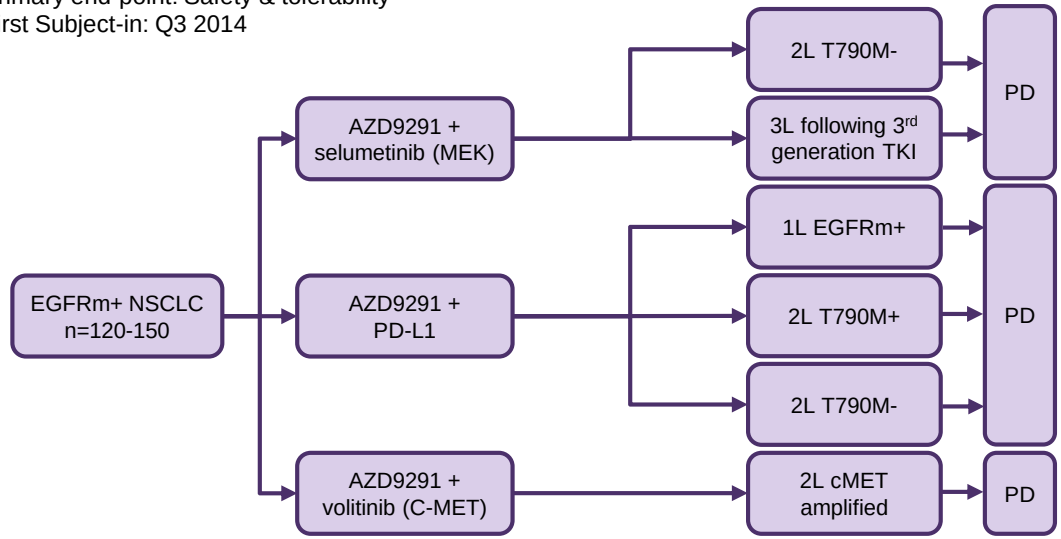


AZD9291: Further combination synergies to explore

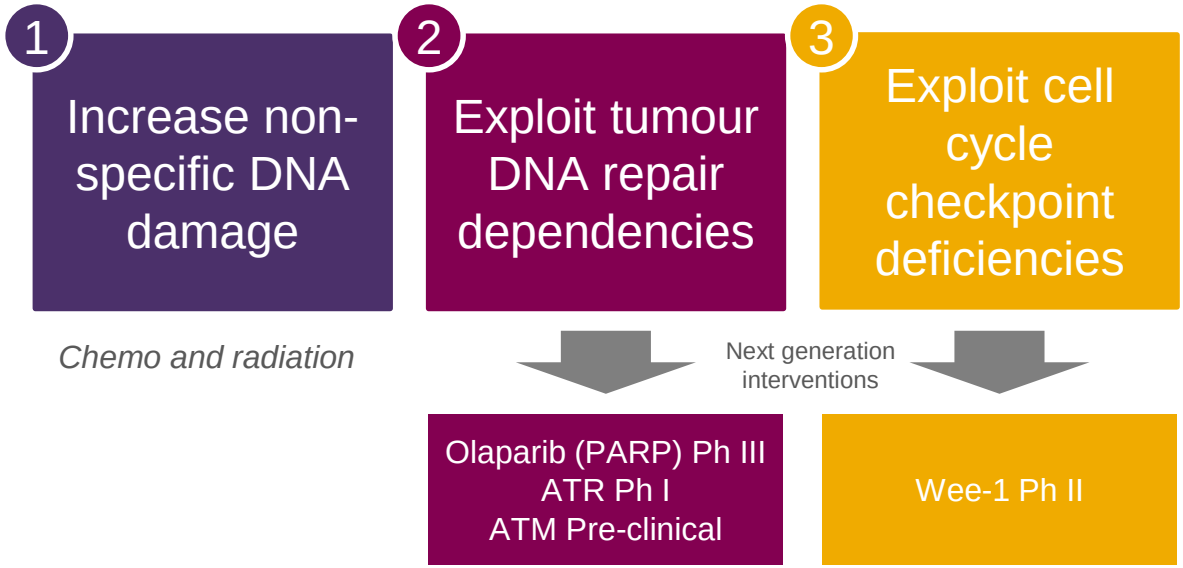
Phase I dose escalation

Potential phase I dose expansion

Primary end-point: Safety & tolerability
First Subject-in: Q3 2014



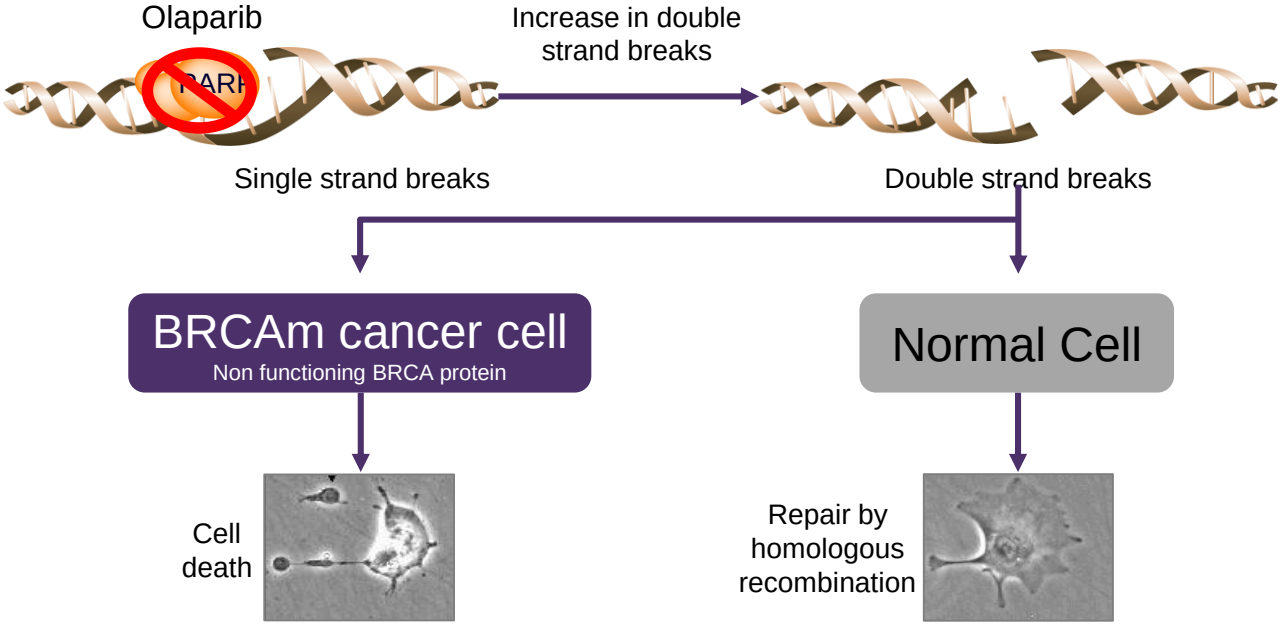
Leading portfolio of DNA Damage Response Inhibitors



Olaparib (PARPi) & cediranib (VEGFi)

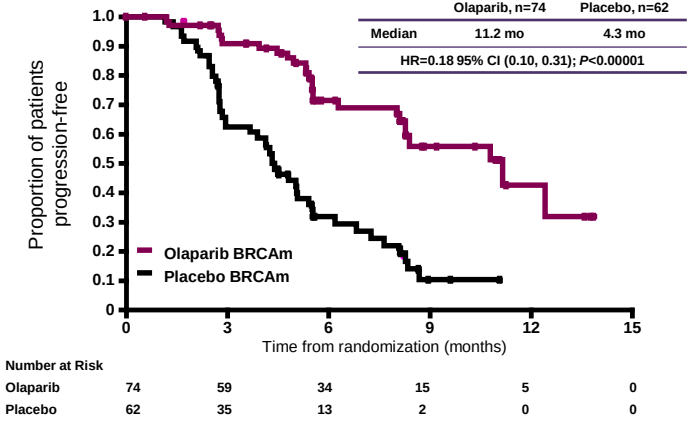
Platinum-sensitive ovarian cancer

Olaparib: Traps PARP on DNA & leads to cancer cell death in BRCAm tumours

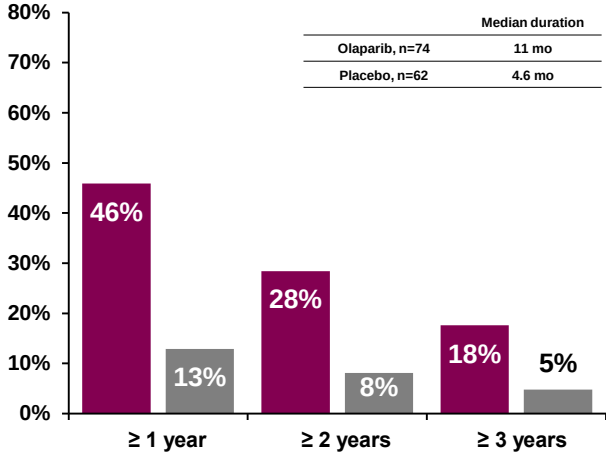


Olaparib: Compelling PFS improvement with long duration on therapy in BRCAm ovarian cancer

6.9 months improvement in median PFS[1]

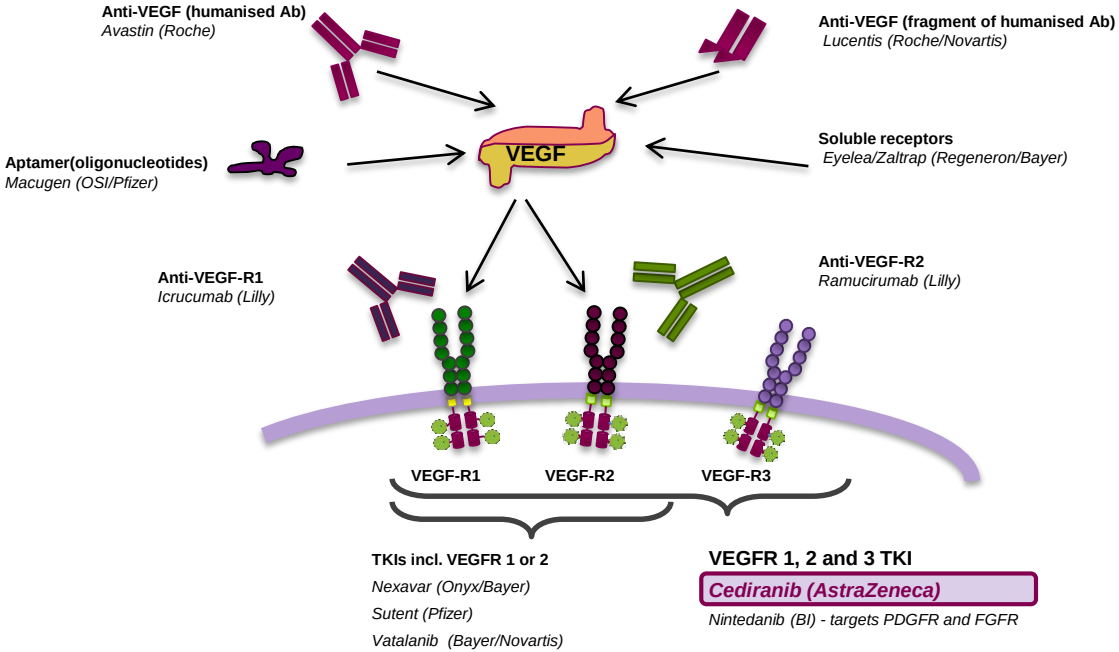


28% BRCAm patients treated for 2 years or more[2]



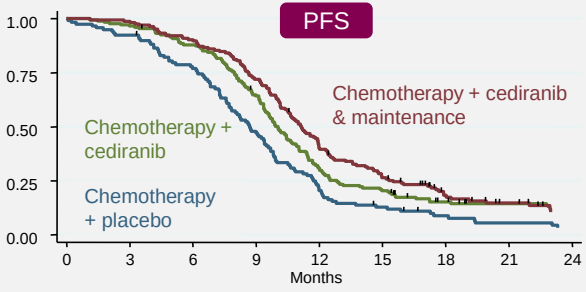
[1] Lederman et al, Lancet Oncology 2014 [2] Data on file

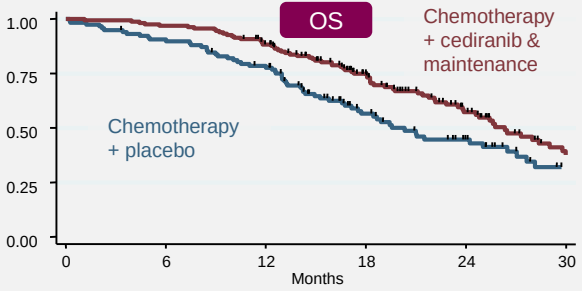
Cediranib: Highly selective VEGFRi targeting VEGFR1,2,3 with OS improvement in ovarian cancer



ICON6: 6 months OS benefit as maintenance treatment in ovarian cancer[1]

Working with MRC and regulatory agencies – decision to file H2 2014





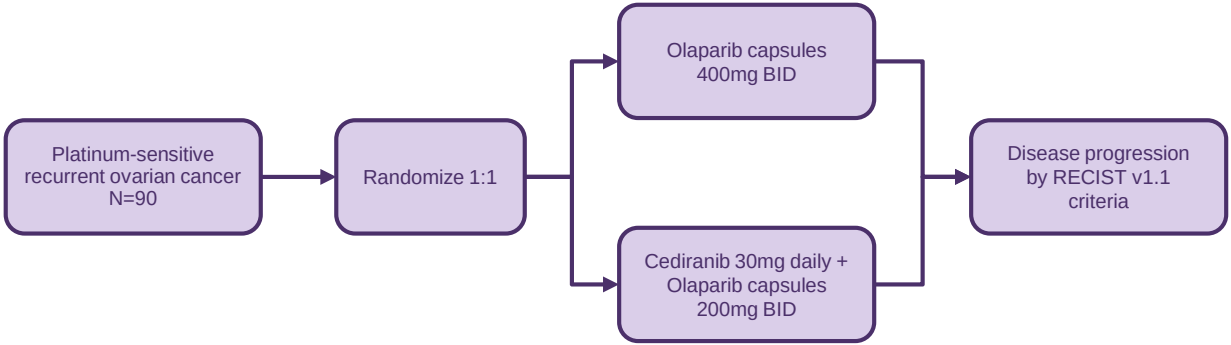
	Chemo	Combinations	Maintenance
PFS events, n (%)	112 (94.9)	152 (87.4)	139 (84.8)
Median, months	8.7	10.1	11.1
Log-rank test (trend)		p=0.0003	
HR vs. Chemo only (95% CI)		0.67 (0.53–0.87)	0.57 (0.44–0.74)

	Chemo	Maintenance
OS events, n (%)	63 (53.3)	75 (45.7)
Median, months	20.3	26.3
Log-rank test (trend)	p=0.042	
HR (95% CI)		0.70 (0.51–0.99)

[1] Lederman et al, ESMO 2013

Olaparib + cediranib in PSR ovarian cancer: Late breaker abstract ASCO 2014

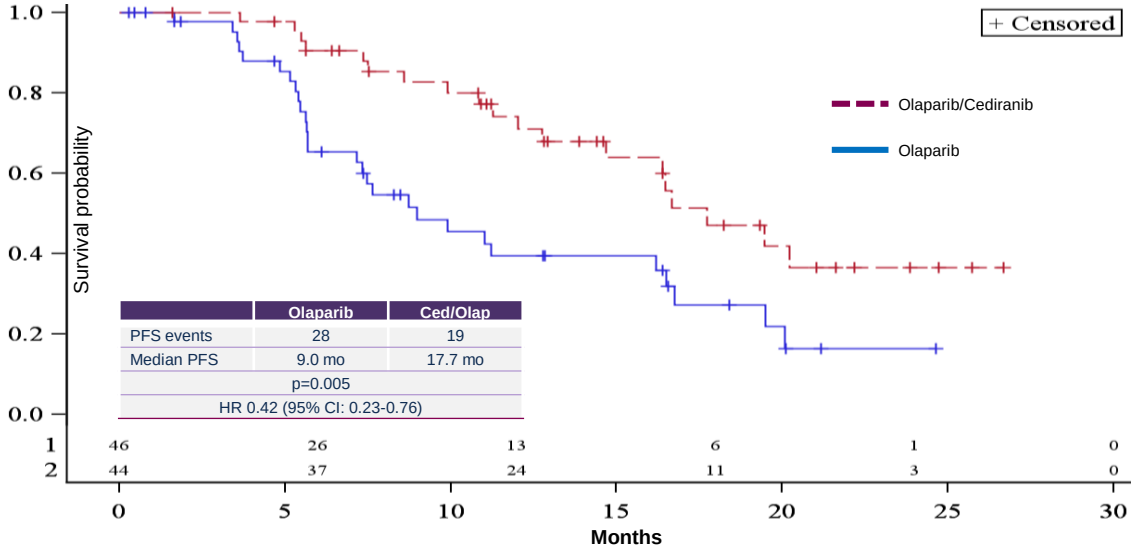
Ph II open-label randomised study, PSR ovarian cancer[1]



[1] Liu et al, ASCO 2014 (NCI)

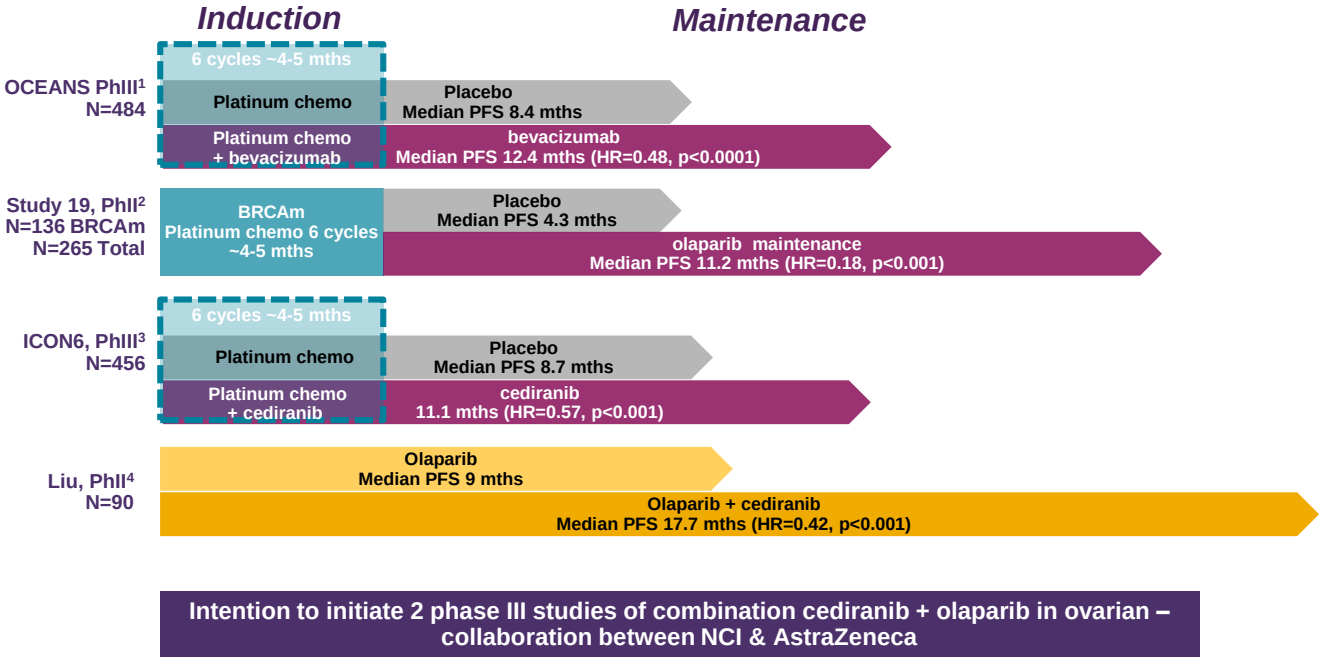
Changing clinical practice: Olaparib + cediranib potentially replacing chemotherapy in PSR ovarian cancer

Near doubling of PFS for combination of olaparib and cediranib vs olaparib alone[1]



[1] Liu et al, ASCO 2014 (NCI)

Olaparib and cediranib in relapsed ovarian cancer: Potential to avoid chemotherapy / IV treatment



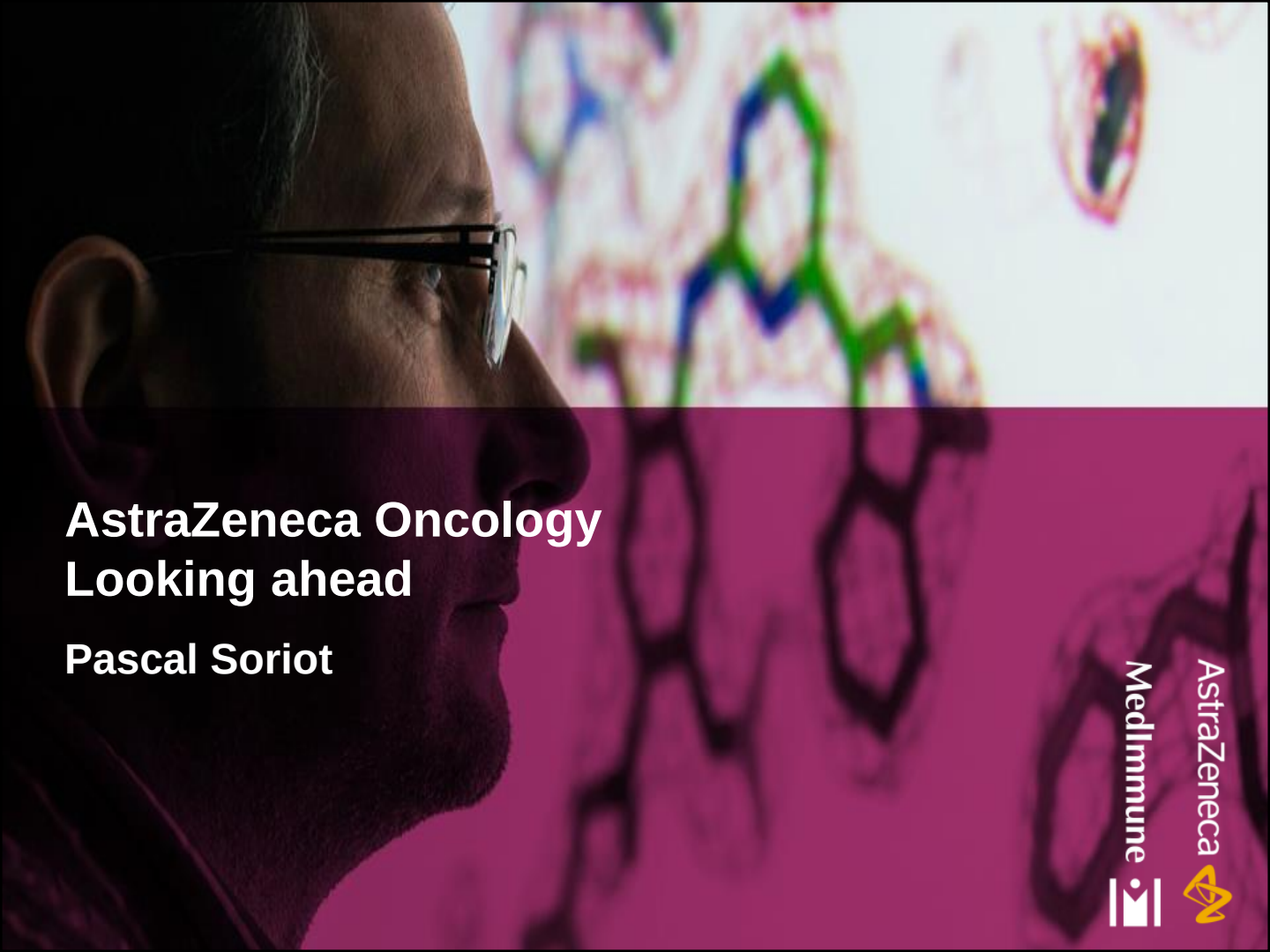
Intention to initiate 2 phase III studies of combination cediranib + olaparib in ovarian – collaboration between NCI & AstraZeneca

[1] C Aghajanian, ASCO 2011; [2] Lederman et al, ASCO 2013; [3] Lederman et al, ESMO 2013; [4] Liu et al, ASCO 2014 (NCI)

Olaparib and cediranib in relapsed ovarian cancer

Unique clinical profile

Safety and convenience	**Oral, non-chemotherapy regimen**
Efficacy	**Impressive clinical activity in ovarian cancer**
Development plan	**Intention to enter phase III in collaboration with NCI**



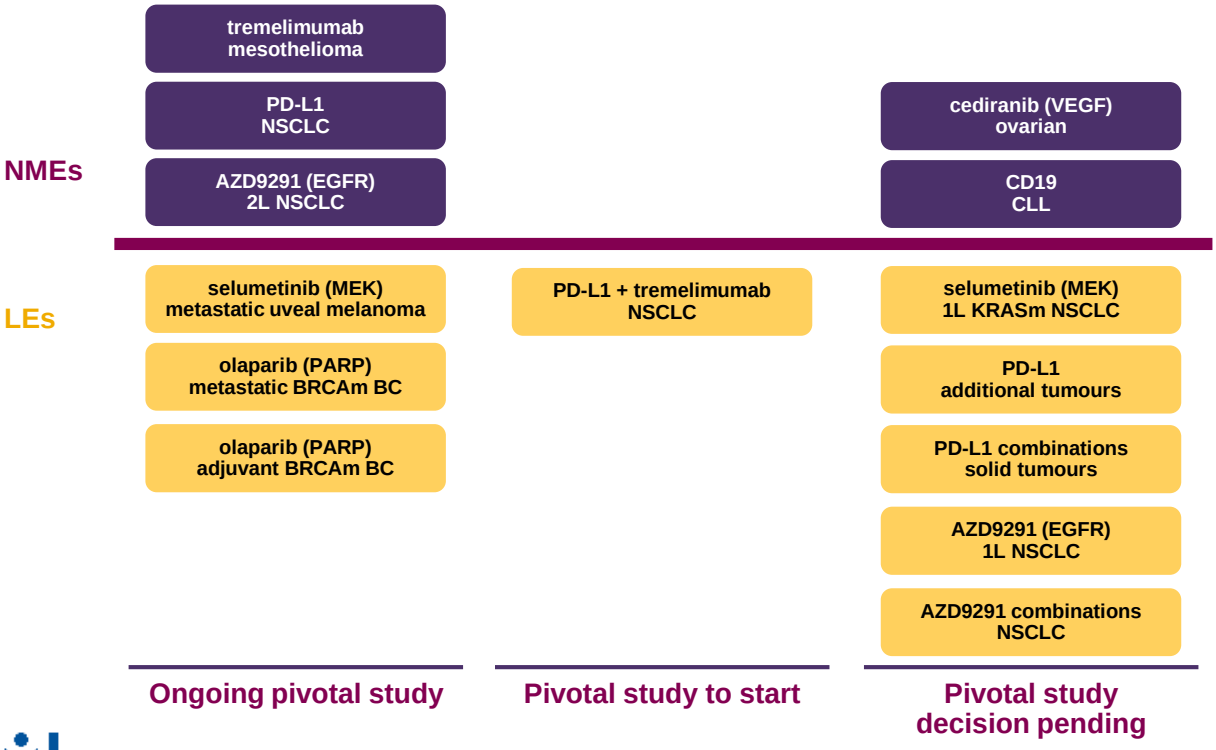
AstraZeneca Oncology
Looking ahead

Pascal Soriot

MedImmune

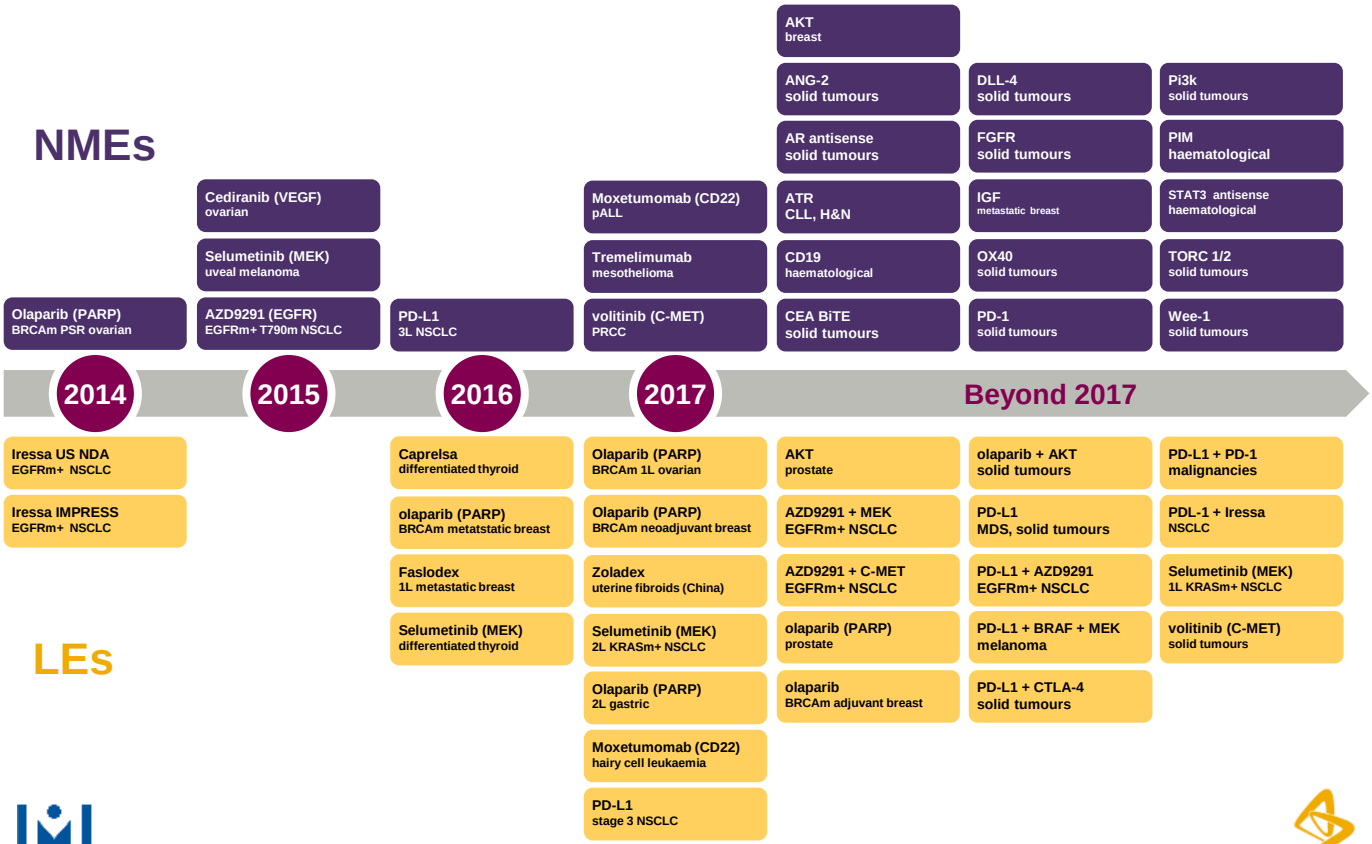
AstraZeneca

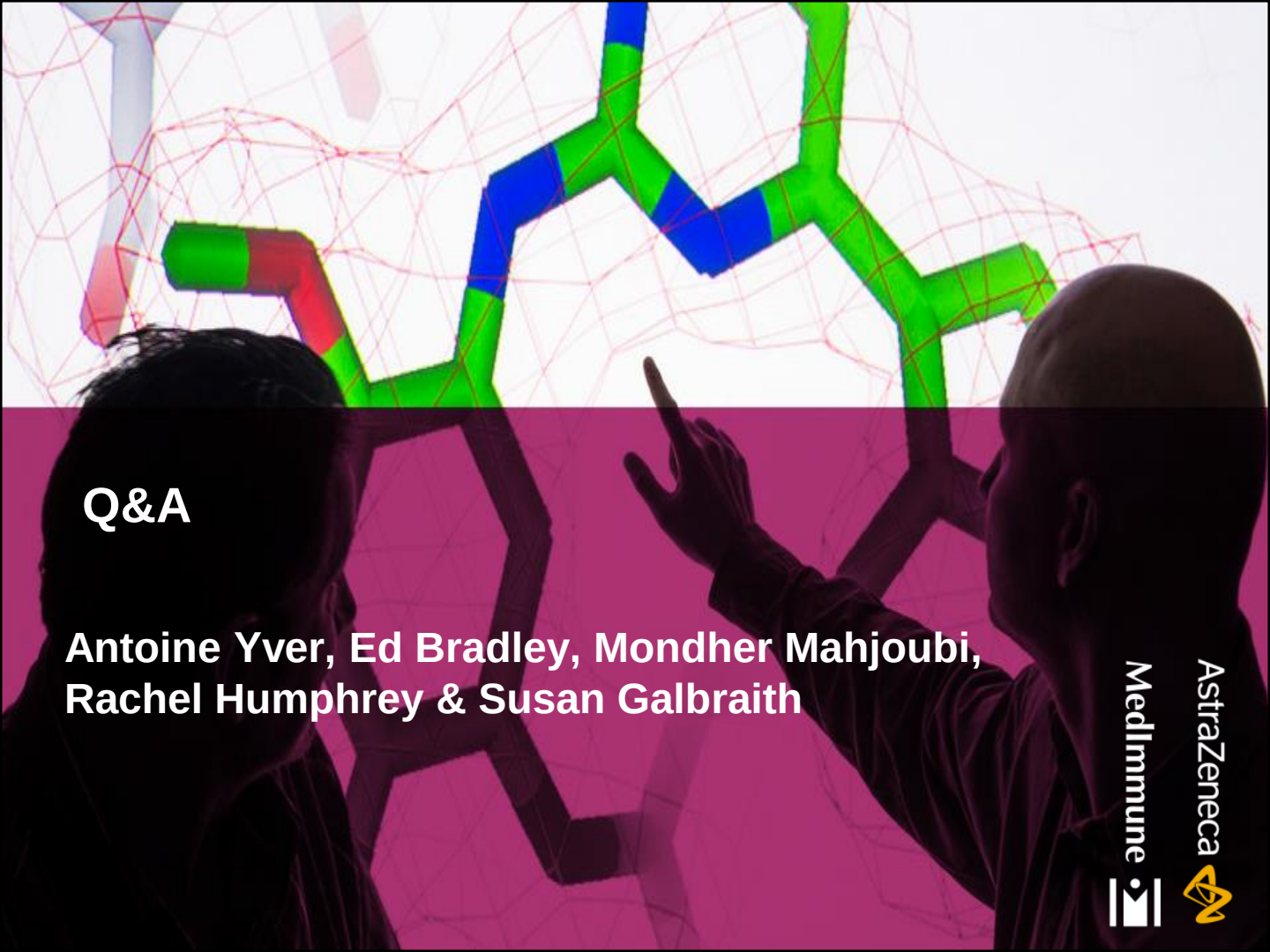
2014: Continued momentum in oncology pipeline



NME=New Molecular Entity, LE=Line extension

Oncology: 24 NME and 27 LE candidates for filing



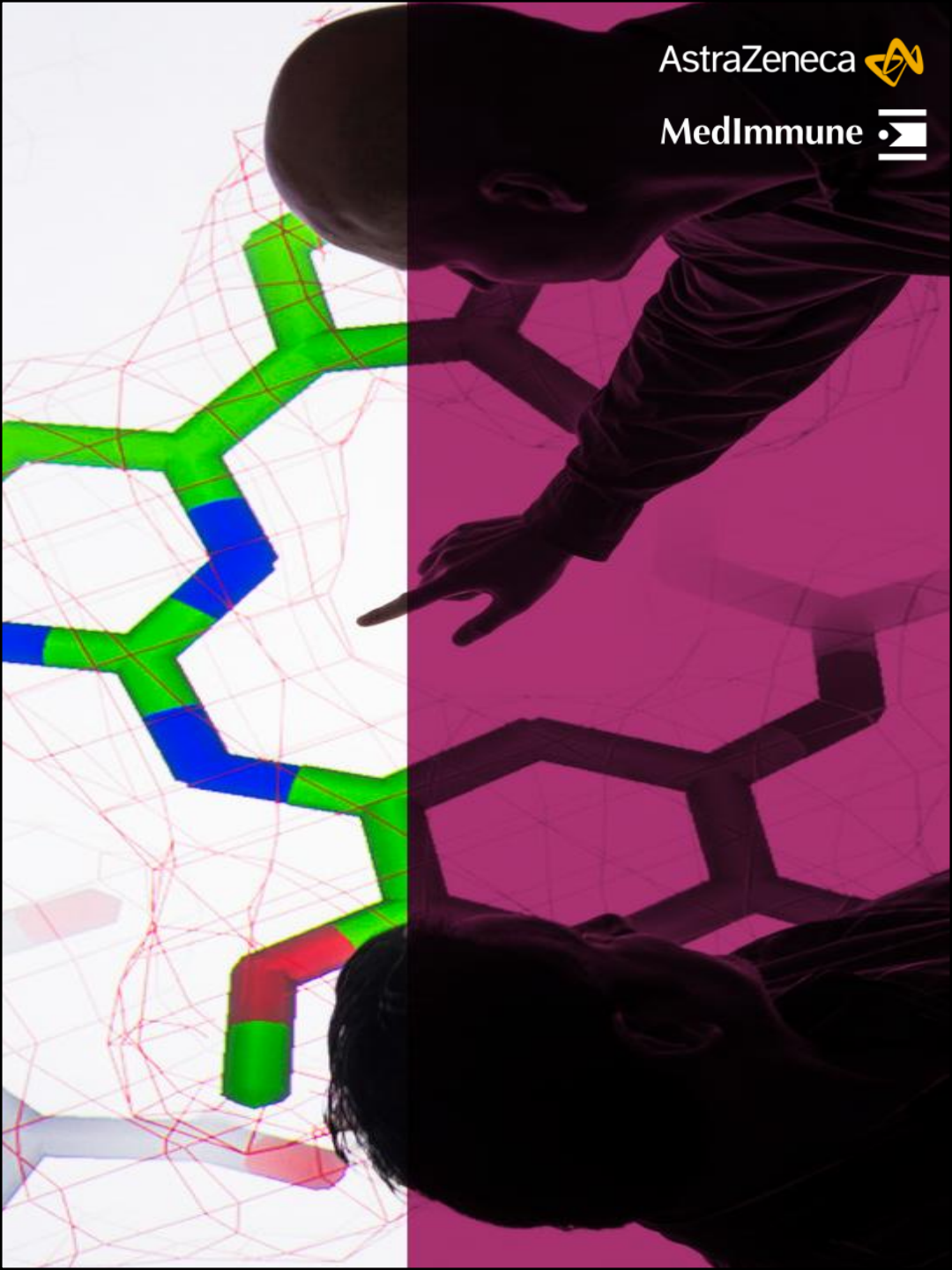


Q&A

Antoine Yver, Ed Bradley, Mondher Mahjoubi, Rachel Humphrey & Susan Galbraith

MedImmune

AstraZeneca


AstraZeneca
MedImmune