ASTRAZENECA

Moderator: Pascal Soriot
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Operator: This is conference # 75191806.

Good afternoon. Welcome, ladies and gentlemen, to AstraZeneca's First Half Year Results Analyst Conference. Before I hand over to AstraZeneca, I'd like to read the Safe Harbor Statement.

The Company intends to utilize the Safe Harbor provisions of the United States Private Securities Litigation Reform Act of 1995. Participants on this call may make forward-looking statements with respect to the operations and financial performance of AstraZeneca. Although we believe our expectations are based on reasonable assumptions by their very nature, forward-looking statements involve risks and uncertainties and maybe influenced by factors that could cause actual results to differ materially from those expressed or implied by the forward-looking statements. Any forward-looking statements made on this call reflect the knowledge and information available at the time of this call. The Company undertakes no obligation to update forward-looking statements.

I will now hand you over to the room, where the conference will begin shortly.

Pascal Soriot: Hello, everyone. This is Pascal Soriot, CEO of AstraZeneca. Welcome to the first half 2015 results conference call for investors and analysts. Slides are posted online for you to follow via telephone or webcast.

I'm joined today by Marc Dunoyer, our CFO; Luke Miels, our Executive Vice President for Global Product and Portfolio Strategy and Corporate Affairs; as well as Mondher Mahjoubi, Head of Oncology in Global Product and Portfolio Strategy. We also have a number of colleagues on the telephone line, in particular Elisabeth Björk, who is our Interim CMO. It's great to have so many of you on the phone and online today, and we look forward to taking you through the results and our achievements so far in 2015.

So please turn to Slide 2. Before we get started, this is the usual Safe Harbor statement.

Moving on to Slide 3. The plan today is for me to provide a short overview, then handover to Luke for an update on our products and growth platforms and then to Marc for the financials and guidance. From there, we'll then take you through exciting news and developments in lung cancer, and then we'll end with concluding remarks before we take your questions. We plan to have about 45 minutes for the presentations and a similar amount of time for the Q&A.

Moving on to Slide 4. Within the half year results today, total revenue was up 1 percent to $12.4 billion. And Q2 marked sixth consecutive quarters of top line growth. We're very pleased with this performance, which looked unlikely only one or two years ago. The main reasons behind this performance are the five growth platforms that grew collectively 11 percent in the first half and now comprise 56 percent of total revenue.

Core EPS was stable in the first half, reflecting the promised reduction in core SG&A relative to total revenue and a sustained increase in core R&Dinvestment.

We delivered strong news flow from the pipeline, including the approval of Iressa in the U.S. and the regulatory submission of AZD9291 in lung cancer.

We also had exciting immuno-oncology combination data at ASCO in June where we showed durvalumab PD-L1. As a reminder, durva was formerly known as a MEDI4736. So the combination of durva and tremelimumab came nicely together as a potential new treatment for lung cancer and other

types of cancer, in particular for PD-L1 negative patients. We'll hear a lot more about lung cancer as we go further into today's presentation.

Finally, we are able to upgrade our top line guidance today. Total revenue for the full year is now expected to decline by low single-digit percent versus the prior guidance of a mid-single-digit decline. Core EPS guidance at CER for the year is unchanged, and core EPS is expected to increase by low single-digit percent, reflecting the continued accelerated investment in R&D.

Moving on to Slide 5. As mentioned, there was continuous pipeline news flow during the second quarter. Full details are listed on the slides, but please let me highlight the increasing presence in lung cancer with the Iressa U.S. approval and AZD9291 regulatory submission in the U.S. and the EU. I want to highlight the fact that in the United States, we were able to start the promotion of Iressa four hours after we received the approval. So really kudos to our U.S. team that did a stellar job. And it's really a demonstration of our commercial strength in the U.S. but around the world as well.

Japan follows this quarter, which is record speed for oncology regulatory resubmission. So as you know, we have big hope for 9291 in Japan because in Asia, of course, EGFR mutated lung cancer is very frequent.

We obtained the U.S. Priority Review for Brilinta to expand the label to include the PEGASUS data in post-myocardial infarction. And we obtained regulatory submission acceptances for CAZ-AVI in serious infections and for cediranib in ovarian cancer both in the EU. CAZ-AVI is off to a strong start in the U.S. market where it's being sold by our partner, (Allergan).

As can be expected in our business, there was one trial that did not meet its primary endpoint, selumetinib in uveal melanoma. It's a small indication and a specific combination. We do not see any impact to the ongoing trials in other tumor types and with other combinations, and we do not see any impact to the overall prospect of selumetinib, which as you know, is really focused on lung cancer. We delivered on Phase III starts for PT010 program in COPD and for anifrolumab in lupus.

Lastly but importantly, we had an exciting ASCO meeting last month where we shared the combination data for durva and tremelimumab. We found the dose for Phase III and announced multiple new Phase III trials in lung cancer as well as key trials in new tumor type like gastric, pancreas and bladder cancer. Outside solid tumors, we are working with our partner, Celgene, to bring durvalumab to patients with haematological malignancies or blood cancers, and we have great hope for this hematology core indications.

Please turn to Slide 6. And here, you will see the key financials and our guidance. Total revenue was up 1 percent in the half year, 2 percent in Q2, partly reflecting the income from the strategic collaboration with Celgene hematology. But I really want to highlight that the growth and the performance is very much driven by our products overall, so it's very much a product sales performance. And our upgraded guidance is on the back of this product sales performance, not on the back of externalization revenue.

So this performance was accompanied by the very strong performance from our growth platforms I mentioned a moment ago, and they're all doing extremely well. They represent 56 percent of our sales now.

Core SG&A cost to total revenue ratio reduced to 35 percent in the second quarter from 44 percent in Q4 '14 and 39 percent in Q1 this year. With the added benefit from externalization, we can continue redeploying resources into the pipeline and follow our strategy, which is to focued on science and innovation.

Core R&D expenses grew by 24 percent in the first half as we accelerated investment in 15 new molecular entities in Phase III or under registration. Important to remember that even though our investment in R&D is growing a lot, our productivity is tremendously increasing when you consider the massive amount of new programs that have moved into late-stage development. We expect core R&D for the full year to remain in growth mode, which is made possible by today's increase in revenue guidance.

Core EPS for the half year was stable and increased 3 percent in the quarter, enhanced by a one-off tax benefit. Total revenue for the full year is now

expected to decline by low single-digit percent versus the prior guidance of a mid-single-digit decline. Core EPS guidance at CER for the year is unchanged, and core EPS is expected to increase by low single-digit percent, reflecting the continued accelerated investment in R&D.

To sum up, given the continued top line performance and early steps we've taken to reduce SG&A costs, I'm encouraged by the progress we made in the first half. And I would like to say that we are very much on track with our plans. I would dare say even that, we are slightly ahead of our plans and we are very confident for our mid- to long-term targets.

And with this, I'll hand over to Luke.

Luke Miels: Thanks, Pascal. Next slide. Thank you. So looking first at the growth platforms. These are a key component, of course, to achieving our medium- and long-term revenue goals. And the solid performance quarter-after-quarter is building our confidence.

I'll cover each of these in more detail later, but broadly, Respiratory maintained share in the developed markets despite competitive headwinds and grew strongly in Emerging Markets. Brilinta continued to grow and outgrow the market. Important regulatory guideline and clinical news flow is expected in the coming quarters for Brilinta. Diabetes was driven by the progression of strong product launches and AstraZeneca's global commercial capability. Emerging Markets showed notable strength, particularly in China, and Japan returned to growth in the second quarter.

Please turn to Slide 9. Turning to our Respiratory franchise. It grew 9 percent in the first half, outpacing market growth of around 7 percent. Performance was driven by the results from our Emerging Markets business and the availability of our new products in key markets.

Symbicort remains stable. And in the first half, U.S. sales were down 1 percent, with volume growth offset by additional access and copay assistance after recent formulary changes. The recovery and subsequent growth of share in the U.S. since the formulary change in January speak to the strength and resilience of the brand and the preference of patients that we've signaled in the

past. In Europe, the business remains impacted by up to three analogues now in the market.

Symbicort and Pulmicort both had notable growth in Emerging Markets, particularly in China, in asthma and COPD, the large patient populations. And the trend from acute to chronic maintenance treatment continued to make China a significant opportunity. For Pulmicort, up 43 percent and remains a leading product in China with a run rate of nearly $0.5 billion a year, while as we look to the future, Symbicort, up 64 percent, is increasing rapidly to approximately a fourth of that.

As to the new products, Tudorza and Eklira, single bronchodilators, nice progress in the U.S. and also Europe. Duaklir dual bronchodilator launch is progressing well and continues to gain share under AstraZeneca's promotion. And it's also approaching 1/5 of the dual market in markets such as Germany and the U.K. In total, around 10 countries have launched so far with around 10 more to come later in the year.

Please turn to Slide 10. So today is a great opportunity to highlight the breadth and depth of our Respiratory franchise strategy. And it's something that's not always understood by everyone.

Starting with our established products like Symbicort. This is a product which will benefit over time from being used earlier and in milder disease. We also have expanded our presence in inhaled medicines and built a comprehensive portfolio with unique device offerings augmented by acquisitions of the Almirall products. From there, combination therapy is increasingly becoming the standard of care, and we look forward to bringing the first pill medicine to patients. The PT003 dual bronchodilator is differentiated by pressurised delivery, which is good for COPD patients. And it's on track for regulatory submission acceptance.

Next, the first patient is now being dosed in the Phase III program for PT010 in COPD, and the benefit of the triple being controlling exacerbations.

Thirdly, we will build our Respiratory capabilities in the biologics with the potential to modify the underlying disease. We have ongoing and fully

recruited Phase III studies for benra, which targets the IL-5 receptor. That's fully recruited in asthma, I must say. And we'll have data as soon as next year. Phase II studies are also underway for tralo, which targets the IL-13 pathway including IPF. These targeted therapies use biomarkers to identify patients who are more likely to benefit from therapy.

Let me continue to commit to finding future innovative respiratory treatments. And we also have an emerging portfolio of potentially disease modifying and inhaled products including the P38 inhaled interferon and other approaches in earlier clinical studies.

Please turn to Slide 11. For Brilinta, the medicine grew at 42 percent in the half, outpacing the underlying market growth, with particular strength in Emerging Markets. In the U.S., we achieved a Priority Review designation for the post-MI indication in Q2. And we expect an updated label this quarter. Treatment guidelines for the U.S. and EU are also expected to be updated in the second half. Until the new label is issued, we do not expect to see any significant commercial uptake as we cannot promote the benefits of PEGASUS yet.

The next data points for thePARTHENON programme are Phase III results for SOCRATES trial in stroke, which we expect in the first half of 2016, and the EUCLID trial, which is in PAD, which we expect in the second half of 2016. Each of the ongoing outcome studies have significant potential to bring additional benefit to patients and are roughly about the same size in terms of commercial potential.

Please turn to slide 12. In the U.S., Brilinta remains the branded oral anti-platelet market leader as measured by new-to-brand prescriptions, and we delivered 10 percent new-to-brand prescription market share during Q2, which is a new milestone for the medicine. As for Europe, Brilinta continued market share growth across countries. And with more new indications expected, as just discussed, there is room to further expand the usage of Brilinta and the proven benefit it brings to patients.

Next slide. Looking at Diabetes. Encouraging growth of 32 percent in the first half was driven by Farxiga and Bydureon Pen. Diabetes sales were also up a full 88 percent in Emerging Markets in the half. Second quarter was the first quarter with an apples-to-apples comparison in Diabetes, reflecting full ownership, and this showed a 21 percent growth versus an estimated 14 percent growth in the market for non-insulin diabetes medicines. And we're also very pleased to grow ahead of the market.

Onglyza, the sales were up 4 percent globally, driven by Europe and Emerging Markets. The U.S., however, was down 16 percent, and the U.S. continued to experience challenges from the competitive market with more than 30 branded medicines and the deliberate deprioritization by our sales force for Onglyza, which focused on Farxiga and Bydureon. Following the AdCom meeting in April, there's an ongoing review of the SAVOR trial, and we await the label update.

Farxiga continued its strong growth across all geographies including Europe and Emerging Markets. U.S., total prescription shift for the Farxiga market family remains at around 27 percent, and this is in a growing market. We're also excited about the continued success of Farxiga as we prepare for saxa/dapa. And Bydureon sales had a growth of 41 percent, ahead of the growing market of GLP-1 medicines, reflecting a successful global Pen launch.

Next slide. Thanks. Farxiga has maintained over 80 percent of the share in the SGLT2 class. And uniquely, Europe now represents more than 25 percent of total product sales. For the Bydureon Pen in the U.S., volumes continue to grow despite an increasing level of competition, and conversion is up to between 55 percent and 60 percent. At the end of Q2, the Pen is launched in the EU5, the Nordics, Japan and among others, with further launches expected in the rest of the EU and the Rest of World markets in the second half.

Next slide. Thanks. This chart provides you a perspective on the paradigm and where our products sit within that. Like Respiratory, we wanted to first emphasize the breadth of our product portfolio this time in this area, but we also wanted to illustrate specifically the potential opportunity for saxa/dapa.

Given its combination of strong glucose control and weight reduction, saxa/dapa has a natural place in the treatment algorithm before the use of injectables. It expands the use and convenience of oral medicines and also simplifies the patient access in many countries, with the potential shift to earlier treatment and the idea of treat-to-goal instead of treat-to-fail. This may further expand the market potential for saxa/dapa to the benefit of many patients. We look forward to the PDUFA date for saxa/dapa in October, and we'll keep everyone updated as we progress with the review.

Turning next to Emerging Markets. There was a continued strong performance in the half. After a very brisk Q1, with 18 percent growth overall and 28 percent in China, Q2 normalized to 9 percent growth, in line with our long-term view. China sales were slower in Q2 with a growth of 10 percent, equating to 19 percent over the year – over the half year.

Growth was spread across all main therapeutic areas. In the first half, Respiratory was up 30 percent in Emerging Markets to $556 million; Brilinta, up 80 percent to $47 million; Diabetes, up 88 percent to $117 million; and finally, Oncology, up 18 percent to $483 million. Going to the second half of 2015, our expectation is to deliver continued double-digit growth in China.

Slide 17. Thank you. For Japan, as we signaled to you in the past quarter, it's returned to growth in Q2 with an increase in sales of 6 percent and 2 percent for the first half overall. Further, Q2 provided an apples-to-apples comparison as we lapped regular price adjustments that occurred last year and affected a number of products. The key growth brands, Crestor, Nexium and Symbicort, together represented 52 percent of the Japanese business and all saw renewed growth in Q2 and either maintained or increased market shares. As we look forward, we plan to submit AZD9291 for regulatory approval in Q3 in Japan, which is only one quarter after the U.S. and EU regulatory submissions. This is in line with our strategy of bringing innovative medicines to patients as soon as possible.

Next slide. For Lynparza, the launch is containing strongly. After just 6 months in a narrow indication, there's a strong uptake in the U.S. We estimate 50 percent penetration in the U.S. patient pool of around 1,400 patients.

There's also very high brand awareness, and more than 1,000 women have started therapy. The Product is now launched in 10 countries and is the first-in-class PARP inhibitor that provides a valuable treatment option to BRCA-mutated ovarian patients. We look forward to coming data on Lynparza in the clinical trials program to potentially further the use of this important medicine.

In addition to Iressa, as Pascal had signaled, it was approved in the U.S., first-line metastatic EGFR mutated lung cancer. And we made the sales very quickly after that. We look forward to bringing more choice to patients in this setting, and Iressa is an important steppingstone for the expected lunch of AZD9291 later this year.

Finally, the Movantik launch is off to an encouraging start in the U.S. We launched at the beginning of April, and Daiichi Sankyo had committed and contributed from the beginning of May. More than 50 percent of the business is from new therapy starts, and we have a significant number of patients who were previously on OTC medicines coming across. And we have a very rapid uptake with over 3,000 users. Movantik has now been available to patients in Nordic countries, and additional launches are planned in the second half of the year in Europe and Canada.

And with this, I'll now hand over to Marc for the financials.

Marc Dunoyer: Thanks, Luke, and hello, everyone. I'm going to spend the next few minutes taking you through the financial headlines for the first half. I will then comment on the improved outlook for the full year.

If you want to turn to next slide. Looking at the first half, we delivered another robust performance. As Pascal said, total revenue was up 1 percent despite the impact of the U.S. Branded Pharmaceutical Fee now treated as a deduction from product sales. Externalization revenue, mostly weighted almost entirely towards the first half of the year, underpinned the top line. Our gross margin on product sales, improved further this time to over 83 percent, as we realised combined benefit from the growth platforms, the mix of product sales and manufacturing efficiencies.

As I said previously, we will deliver lower core SG&A costs this year, both in value and as a percentage of total revenue. This focus, which I will take you through in a moment, led to the intended reduction in the core SG&A cost ratio in the second quarter this time to 35 percent of total revenue.

This combination of top line growth, a strong gross margin and improving outlook for core SG&A enable us to continue the accelerated investment in core R&D, which was up 24 percent in the first half. Mondher will show you in a moment the significant impact this investment is going to have for patients with lung cancer.

Total revenue for the full year is now expected to decline by low single-digit percent versus the prior guidance of a mid-single-digit decline. Core EPS guidance at CER for the year is unchanged. Core EPS is expected to increase by low single-digit percent, reflecting the continued accelerated investment in R&D.

If you can turn to Slide 21. Turning to the P&L in more detail. Total revenue grew by 1 percent in the first half and 2 percent in the second quarter, enhanced by the Celgene collaboration. Encouraging progress in the cost of sales and the gross margin I mentioned a moment ago was accompanied by better core SG&A performance, especially in the second quarter, which allowed the strong levels of core R&D funding to continue. The core tax rate fell to 14 percent in the first half after one-off benefit in quarter two. We anticipate the full year tax rate to be in the lower half of the 16 percent to 20 percent range outlined earlier in the year. Excluding the tax impact, the underlying core EPS performance in the second quarter supports the full year guidance.

Please turn to Slide 22. Core SG&A cost reduction has been a key focus for the business, and we are now beginning to see early progress. I'm pleased that the ratio of core SG&A to total revenue at 35 percent was 3 percentage points lower than a year ago and a full 4 percentage points lower than quarter 1 2015.

We are clear on the five actions that we are taking to reduce core SG&A by dollar value and relative to total revenue this year. We are continuing to

improve our sales, marketing and medical effectiveness, which includes leveraging programs globally rather than on a country-by-country basis. We are centralizing select functions and processes to deliver centralization and economies of scale. Third party spend has been reduced as we fully engaged with our suppliers to ensure we are getting maximum value. As mentioned last quarter, we are going to deliver savings across a number of areas, including our support function in IT. And finally, footprint optimization will continue in both the U.K. and U.S. This is an encouraging start to the program, and I look forward to updating you on further progress later in the year.

Please turn to Slide 23. As I mentioned earlier, our full year guidance, which is at constant exchange rates, reflects an improvement in the total revenue guidance. Total revenue is now expected to decline by low single-digit percent given our performance in the first half. With the accelerated investment in core R&D as more of our products become late stage, we expect core EPS to increase by low single-digit percent this year. This guidance is unchanged.

Although not guidance, we also tried to help you understand the impact of exchange rate movements in the year. Based on current exchange rates, total revenue is expected to decline by high single-digit percent. We continue to expect full year core EPS at current rates to be broadly in line with 2014.

Turn to Slide 24. Finally, I want to turn to the outlook for the rest of the year. Last quarter, we highlighted that on top of our business-as-usual execution, we incorporated core SG&A savings and the acceleration of externalization revenues into our full year guidance. As you can see from the results, we have made early progress, particularly in the second quarter. We expect full year core SG&A cost to be down versus last year where 2015 externalization revenue has largely been realized in the first half.

I look forward to the second half where we expect to continue the progress we are making in particular on core SG&A. Thank you for listening, and I will now hand over to Mondher.

Mondher Mahjoubi: Thank you, Marc. Good afternoon, everyone. A few weeks ago, actually, in Chicago – of last month, we shared with you the progress of our pipeline and gave you the perspective across different tumor types. Today, we chose to focus on the disease area perspective in order to help you really get the breadth of our portfolio, but at the same time, a sense of our strategy. And we chose lung cancer as one of the first indications because of very obvious reasons.

First of all, this is one of the deadliest disease. It's the number one cancer killer for both men and women. It causes more deaths than colorectal cancer, breast cancer and prostate cancer combined. And according to the WHO, 1.8 million new cases are diagnosed every year. And every year, 1.6 million die from lung cancer. So huge unmet medical need.

But at the same time, AstraZeneca has a history in lung cancer. We have been pioneers in delivering novel medicine to treat lung cancer. Iressa was the first EGFR inhibitor developed for lung cancer, targeted to the EGFR mutated non-small cell lung cancer. And up to now, more than 240,000 patients were treated with Iressa, and several hundreds of them are still in remission for more than a decade. And as Pascal said, we are extremely pleased that Iressa is now approved in the U.S., both in first and second line.

We didn't stop there. We continued to do what we are best at, follow the science to address key areas of unmet need, and in particular, try to understand why patients become resistant to first-generation EGFR inhibitors. Actually, we designed and developed AZD9291 to overcome one of the most frequent mechanisms of resistance to first generation of tyrosine kinase inhibitor, which is the T790M mutation frequent in 60 percent of patients. AZD9291 is progressing extremely well, and we are delighted to announce that we completed submission in the U.S. and in Europe early June. I will come back later on, on our strategy and plan for AZD9291.

So we are committed to continue to work and deliver breakthrough innovation that can transform the treatment of lung cancer and improve patient's lives. And we firmly believe that we have the portfolio to achieve this ambition. We have a pipeline – a portfolio of nine products, five of them are in the late

stage and four are in the early stage, covering multiple targets and combining both small molecule and immuno-oncology.

Let's move to Slide 27 just to probably put things into perspective and provide some context on the significant change that we are seeing in the lung cancer landscape. So lung cancer is a very heterogenous disease from a clinical, biological, histological but also from a molecular viewpoint. It is comprised of two histologic subtype – the small-cell lung cancer, very well defined; and another segment less well defined and which is the non-small cell lung cancer.

Actually, over the past decade, several subsets of non-small cell lung cancer were further characterized and defined at the molecular level by the type of mutation that occur in multiple oncogenes. You are familiar probably with the EGFR, with the AKT, with the ALK, with the BRAF, with the KRAS and multiple other mutation that are driving specific segment of this disease. EGFR and ALK are the only two mutation with approved targeted therapy. And with AZD9291, we are well positioned to reshape the EGFR mutated lung cancer scape. So that's it from a small molecule viewpoint.

Now immunotherapy is transforming the lung cancer treatment paradigm. It provides one of the most promising options even though there is still work to be done to better select patients and develop effective and safe combinations. PD-L1 expression is emerging as potential predictive marker for the benefit from anti-PD-1, PD-L1 monotherapy. And yet another way to segment this market is the level of expression of PD-L1.

We know that PD-L1 positive patients derive clear benefit from anti-PD-1 or PD-L1 monotherapy when compared to chemotherapy. But they represent only 25 percent to 30 percent of the patients. The vast majority of the patients have low expression of their PD-L1, or eventually, are considered as PD-L1 negative. And for those patients, the benefit of immunotherapy seems modest, and there is clearly a need there for another strategy, and in particular, a combination strategy. And we firmly believe that AstraZeneca is positioned to lead this lung cancer treatment paradigm change and establish immunotherapy as a treatment backbone while developing the next wave of combination.

Move to Slide 28 to give you more perspective on the EGFR mutant segment, and in particular, AZD9291. AZD9291 is on track to be first and best in class. It represents clearly a breakthrough in the industry. In a little over two years, we went from first in human back in March 2013 to submission in Europe and in the U.S., as I said, in June this year. Regulatory submission is for the second line indication, T790M mutation, and we received Breakthrough Therapy designation in the U.S. and accelerated assessment in Europe. Early access program is in place, while we are working with the health authority to ensure patients have access to the AZD9291 as soon as possible.

But the second line indication is just the first step, and AZD9291 is important selective EGFR inhibitor that is active in second line but works equally well in first line and earlier settings of the disease. We are very encouraged by the data we shared with you at ASCO in first line. And in addition to the first line Phase III trial that we initiated earlier this year, we are starting a new trial in the adjuvant setting to assess the benefit of AZD9291 for early-stage disease.

On Slide 29, you have probably a summary of our strategy in the EGFR mutant segment. Today, with the positioning of Iressa and 9291 sequentially in first and second line, but as I said, we are moving the monotherapy of 9291 in the earlier setting of the disease, both in adjuvant and in the first line. And more importantly, we are working on improving the durability of AZD9291 activity by combining it to immunotherapy and combining this with durvalumab. In addition, we have early Phase Ib data suggesting that the combination of AZD9291 with a MEK inhibitor or with a MET inhibitor can prevent the development of mechanism of resistance. So we are working on also trying to escape the mechanistic resistance to AZD9291 when used in second line. Very bold and ambitious life cycle plan.

Now moving to Slide 30, and again, bringing the immuno-oncology back into the topic of today. I-O is transforming the way we treat cancer and is likely to become the backbone of lung cancer treatment. There is a growing body of evidence that suggests lung cancer patients with PD-L1 positive tumor derived greater benefit from PD-1 or PD-L1 monotherapy and have improved overall survival when compared to patients with PD-L1 negative tumors.

So there is still high unmet medical need for the PD-L1 negative tumors for which the monotherapy is probably not enough. And there are clearly three strategic approach – we can combine PD-1 or PD-L1 with chemotherapy; we can combine with small molecule targeted therapy; and finally, we can combine with other immunotherapy approaches, and in particular, other checkpoint inhibitors. We are extremely encouraged by the promising data we've seen in our Phase Ib trial combining durva and tremelimumab. Not only have we a very strong scientific rationale, but today, we have the clinical evidence that the combination of an anti-CTLA-4 and an anti-PD-L1 can provide a better benefit for patient with PD-L1 negative tumors. And the response rate we observed is extremely encouraging. It's five times what we are usually seeing in monotherapy in this type of patient. Finally, the combination is safe with a very low rate of discontinuation, which prompted us to move it into the Phase III program in lung cancer and also in other tumor types.

And in the next slide, you have a very comprehensive summary of what we are doing with immuno-oncology and with durva and treme, in particular in lung cancer, the nine pivotal trials that are ongoing covering the full spectrum of lung cancer from early to late stage and combining durvalumab with tremelimumab, combining durvalumab with chemotherapy and combining durvalumab with small molecules in the EGFR mutant segment. We are the first company to start trial in the adjuvant setting and in the unresectable Phase III. And we are extremely proud to announce that our MYSTIC trial and the CAURAL trial have already randomized the first patients, which are ready to be dosed. So extremely ambitious program that will recruit more than 5,600 patients.

Slide 32 is a nice summary of our leadership strategy in lung cancer. We start with our foundation, the EGFR mutant disease, developing second line approach but at the second time moving AZD9291 in earlier setting of the disease, expanding to a new segment with the immuno-oncology, and in particular, the combination of durva and tremelimumab in the advanced disease, third line and first line. But we also explore new segments like the KRAS mutant with the combination of selumetinib and chemotherapy as well

as other potential segments in the lung cancer space, and in particular, the small cell lung cancer where we know immunotherapy plays a major role and we are working on developing durva and treme in that setting as well.

Last slide is a brief summary of what's coming next. World Cancer conference is in a couple of weeks, and we are delighted with 100 percent acceptance of twenty five abstracts at the meeting. And we will share data on Iressa, 9291 and ongoing trial with durvalumab. We will have also another update end of September at the European Cancer Congress that will cover lung cancer and other tumor types. But the new tumor types coming from our study 1108 and the update on study 006 combining durva and treme will come probably early 2016.

With that, I hand over back to Pascal for the closing remarks.

Pascal Soriot: Thank you, Mondher. So if you want to turn to Slide 35. I would like to finish by taking you through the usual scorecard that we have shared with you each quarter.

Since the last update, we've taken care of the regulatory submissions for AZD9291, cediranib and CAZ AVI. But we also saw selumetinib not meet its primary endpoint in uveal melanoma, which as I said before, is a small indication. The core of this program is in lung cancer. As for brodalumab, we have conducted an initial evaluation of the data, which confirms that broda demonstrated strong efficacy in psoriasis and indicates that the observations of suicidal ideation and behavior are unlikely to be causally related to brodalumab therapy. Whilst continuing the transfer of the program from Amgen, we're proceeding with a full analysis and evaluating potential partnering options in parallel. We will communicate our definitive decision in due course. As we move forward, we'll keep you updated on the progress we are making.

Turning to Slide 36. Between now and the end of the year, we expect a number of catalysts including regulatory decisions, submissions and major data presentations and readouts. As it relates to regulatory decisions, we expect to hear in December on lesinurad in the U.S., in September for

Brilinta's new label in the U.S. and in October from the FDA on saxa/dapa. The timing of news on AZD9291 is unknown, but we anticipate bringing these medicine to patients as soon as possible. With the recent launch of Iressa in the U.S., we are ready to go. We also expect to make a decision on brodalumab's potential regulatory submission outside Japan as well as receive regulatory submission acceptance for PT003 in COPD. We'll also submit AZD9291 in Japan in record time.

As Mondher mentioned, there is plenty of data being presented on AZD9291 in the autumn. And finally, our MedImmune colleagues are looking forward to presenting anifrolumab data on lupus at ACR in November. We expect data from tremelimumab in mesothelioma and durvalumab, the PD-L1 antibody in third line PD-L1 positive lung cancer.

Moving to Slide 37. Summarizing the first half of 2015. Total revenue grew, and we now have had 6 consecutive quarters of growth. We now have an improved outlook for this year's top line. Core EPS was stable as we reduced core SG&A relative to total revenue and increased core R&D investments in line with our strategy to support our innovative pipeline. We saw very good news flow from the pipeline, and we are on track to deliver on our long-term goals.

I want to finish with a message on Slide 38 and return to some elements we've discussed with you in the past. Our first goal announced early last year was to have 2017 revenue broadly in line with 2013 revenue at constant exchange rates. In order to illustrate the current progress on our journey, we have recalculated 2013 total revenue on the chart at current rate. As you all know, currency changes over time, but this is our current starting point. Nobody knows what the exchange rate in 2017 will be. It could change in the other direction again, but we wanted to make a like-for-like comparison.

Since 2013, we grew our top line in 2014 by 4 percent at constant rate. And we are now guiding total revenue to be down low single-digit in 2015. This means that by the end of 2015, we will already be at the same level as 2013. A couple of years ago, no one would have expected that. The forecast was for AstraZeneca to decline much more than that.

For May next year, as you all know, we would expect – we are expecting to see competition – generic competition to Crestor in the U.S. marketplace. This is a significant and sizable business for us, of course. On the other hand, we also expect a continued strong performance from our growth platforms, including the Emerging Markets. We expect to see incremental sales from new products – Lynparza for sure; Iressa in the U.S.; Movantik in the U.S., which is showing a very nice early start; and 9291 as we get approval and start the launch roll out. Two of these will have a positive full year product sales impact in 2016. Then the potential new product sales from immuno-oncology PT003. New uses of Brilinta, in particular the PEGASUS data, which as you know, we haven't been able to promote because we haven't got them in the label. But by the end of this year and into next year, we'll be able to promote this, and we expect a positive impact on Brilinta from that. We have also saxa/dapa, as Luke just explained.

In short, our job and our challenge is to mitigate the loss of Crestor by launching and growing major new products. An important message here also is that we're going to move from a very concentrated portfolio supported by two or three very large products to a portfolio that is made of a larger number of products that all are growth drivers, and therefore, the risk across our portfolio will be much less. The other key message is we will see more products in specialty care, in particular oncology, and that over time should help us with our profitability, as you know.

With these new revenues in 2016, we are confident about delivering 2017 revenues broadly in line with 2013. And in fact, the consensus, as you see on this graph, is showing some similar numbers. We are already halfway to 2017. We made good progress, and we have an exciting launch program ahead of us. It's this combination that underpins my confidence in our company.

With this, I would like to thank you for your attention, and we'll now begin the Q&A. Please go ahead.

The first caller is actually James Gordon at JPMorgan. James, go ahead.

James Gordon: Hello. Thanks for taking my questions. I had a few oncology questions and one on the base business as well. On the oncology business, one was I saw the biosimilar Avastin program. My question on that was when do you think you could start combination studies with Avastin with your immuno-oncology agents? And also, would you initiate it with Avastin or would you do the initial trials with the biosimilar immediately?

And another question was just clarifying that for PD-L1 plus chemo for the combo studies, when do you think you could start the Phase III program?

And the third oncology question, which is on the NEPTUNE study. So that's a version of MYSTIC but with an overall survival endpoint in first line. Is a crossing over going to be an issue? Or will you stop patients from crossing over to the PD-L1 therapy if they're in the placebo arm?

Then one base business question, which was just contracting for next year. Do you think pricing and mix is going to be any better for Diabetes and Respiratory next year based on discussions you had so far? Or should we assume similar pressures?

Pascal Soriot: Thanks, James. So quite a number of questions. Maybe I could allocate the questions. I think we have Rob on the line, and Rob will cover the NEPTUNE question. The PD-L1 combo, Mondher, do you want to cover that one? And Luke, if you want to address the contracting questions. Will that be okay with you? And maybe, Mondher, you could also comment on the Avastin program.

Just a very quick comment here, James, is just to answer your question that I have read a little bit about, I mean, essentially, our idea with this bevacizumab program is really to look at combination. We're not launching into a biosimilar program. We are doing what we said we would do before, which is to look at combinations and try to develop regimens that we can – that we can offer to payers at a manageable cost. And so we'll consider biosimilars like Avastin in the context of that strategy.

Now maybe, Mondher, you could cover this – say a few more words on that and cover the PD-L1 combo question.

Mondher Mahjoubi: Yes. So you asked a question about whether we are using our own biosimilar or the Avastin product for combination. The answer, for the ongoing trial, we are using Avastin. Of course, the biosimilar has to go through the regulatory process, and we will be starting the combination with our own biosimilar when it's approved by the health authority.

For the PD-L1 chemotherapy, we cannot disclose details about the design, and we will be sharing this when it is posted on the clinicaltrials.gov. But we are working on implementing the Phase III with the same pace as we've done with MYSTIC and NEPTUNE. For NEPTUNE, I will hand over to Rob to give you more details about the design of the trial, and in particular, the crossover question.

Robert Iannone: Yes. So NEPTUNE is a very large global trial, which will initiate very shortly. And we think crossover will be minimized given the current availability of alternative PD-1 therapies across the globe.

Pascal Soriot: Thanks, Rob. Contracting question.

Luke Miels: So James, we expect a number of decisions over the next couple of months in Diabetes and also Respiratory. But I think it's fair to assume that the pressure will remain on those two areas, and that's certainly our planning assumption for 2016.

Pascal Soriot: Yes, absolutely. We'll hear more over the next month or two. The negotiation is ongoing now, but certainly, we don't expect that things will improve dramatically. It's going to be a very competitive marketplace, no doubt.

Andrew Baum at Citigroup has the next question. Andrew, do you want to cover your question? Andrew?

Andrew Baum: Hello. Could you …

Pascal Soriot: Yes. Go ahead.

Andrew Baum: Hello. Can you hear me?

Pascal Soriot: Yes.

Andrew Baum: Hi. Sorry about that. Three questions, please. Firstly, there has been significant discussion about the cost burden for Medicare and alternate payment models. Given we're going into a presidential election year and Astra is becoming increasingly geared towards oncology, any thoughts on both noise and ultimate evolution and time line for changes in Medicare reimbursement will be interesting.

Second, Luke, perhaps if you could comment on the outlook in China in terms of pricing. Several of your competitors have outlined increasing pressure on pricing in that market.

And then finally, given your legacy presence with Crestor and more recently with Epanova, perhaps you can talk about your interest in CETP in addition as an interesting modality to continue to extend your cardiometabolic franchise.

Pascal Soriot: So Luke, do you want to cover the last two? And Mondher, will you cover the first one later or – yes.

Luke Miels: Sure. So on CETP, we wouldn't speculate. If we look at China, I think it's fair to say that there is a structural slowing in the market, which I don't think is a surprise to anyone who's following the overall economy in China.

That being said, where our focus is – I mean, clearly we have a strong position in the large Eastern provinces, but as we go to lower-tier cities in the West, we have a concentrated expansion program there. Also, our mix of products right now, there is a lot of volume reflex. Of course, if you do see pricing pressure with products such as Crestor and Nexium, you do tend to see an offset in terms of volume.

So again, we believe we can grow ahead of the market, but there will be some more pricing pressure. But again, that should be offset by uptake in volume.

If we look into the future, again, if we look at products such as Pearl and also the oncology portfolio, again we're well placed if we look at the 5- to 10-year horizon.

Pascal Soriot: And although this evolution in China is something that we have been expecting a long time, we've said many times there will be, as Luke said, price pressure. And so we are expanding in the West, and we have a very substantial expansion program in China to unlock growth potential in those areas that are economically developing, so we expect to maintain this.

The same for Medicare, we've expected cost prices – cost pressures, sorry, in oncology to grow. Everybody is talking about diabetes and respiratory price pressures, but those cost considerations will expand to the entire marketplace including oncology. So we have been expecting this. And that's essentially why we've embarked on this combination strategy, where we think we have our plans in place to manage the total cost of combinations.

Mondher, if you want to add anything.

Mondher Mahjoubi: Yes. Thank you, Pascal. As you know, Andrew, the combination strategy is something we don't know actually where are we going to go because there are so many potential combination for so many segments. But the name of the game is that the more assets you have in your portfolio, and more flexibly you have in negotiating the prices. So clearly, the ability to have, in our portfolio, 27 different entities, both small molecule and in immuno oncology, help us in this endeavor.

The second element is, clearly, the biosimilar strategy, and whenever it's possible to include, generics in the portfolio that can help manage the pressure on the innovative drug is something we will do.

And last but not least, I think we have clearly, with the duration of therapy, one way to limit the cost and – to make a long story short, we are looking at innovate pricing model where we can look at the disease from – look at treatment from a disease perspective rather than from a product or from a cycle perspective. I cannot provide more detail here, but think of lung cancer as an entire basket of drugs that could be used. And this is probably also something that we will leverage given the multiple assets we have in the portfolio for each indication.

Pascal Soriot: So maybe we can move to Sachin. Sachin, do you – Sachin Jain at Bank of America, do you have a question, Sachin?

Sachin Jain: Hi. Thanks for the questions. A couple of financial and a couple of product. Firstly on SG&A, a couple of slides talking about it declining as a percentage of revenues. That's obviously, influenced by externalization. I think, it's roughly flat year-on-year in percentage of sales and a 1 percent decline in CER. So given that, which doesn't seem a particularly aggressive decline, can you just sort of give some color on what CER declines you're looking at for the rest of this year and then more importantly into '16 as you think about offsetting the Crestor patent expiry and the various one-off incomes that you've had this year that probably won't repeat next year?

Secondly, a question on Slide 38, which you talked about, Pascal, or you listed the various product launches. I think when you first gave the full year '17 guidance the comments were limited regarding pipeline contributions within that. Given the various pipeline launches you're now listing, I wondered whether the pipeline contribution to maintain '17 flat has increased given various pressures you're seeing in the base business.

A couple of product questions on the Onglyza Farxiga fixed-dose combination, just wondering what your perspective on the potential heart failure safety label is as you head into the PDUFA. And if you do have that safety label, how do you think you position relative to Januvia monotherapy, which might not have that or the competitor fixed-dose combination, which also might not have that?

And then a final question just on the I-O lung positioning post-ASCO, and now you've had more opportunity to take feedback from KOLs, I just wonder you could give us an updated perspective of your I-O, I-O in lung relative to chemo combination firstly. And then secondly, relative to Bristol where some feedback remains at Bristol's first mover advantage in second line will give them a substantial halo effect in the first line setting?

Pascal Soriot: Okay. Thanks, Sachin. Mondher, maybe you can cover the last one. I'll ask Elisabeth, who is on telephone line, to cover the safety label for Onglyza. And maybe, Luke, if you have anything you want to add to this.

The pipeline question actually, Sachin, we stand by what we said before. I mean the – I would say the pipeline contribution will not be massive by 2017. As you can expect, we are in launch mode. I would say it's probably going to be a little bit better than what we had expected of course, because we have made more progress with our pipeline than we expected back in 2013 or early 2014 when we made that forecast.

9291 is progressing very nicely, actually faster than we thought. Moventig is now on the market in the U.S. and doing well so far. Lynparza is on the market, even though in a small indication, is doing well, and it will be expanding in other indications. So the greater contribution, but still from a relatively small base.

So I think, broadly speaking, we can say we are more or less on track . Over a longer period of time, I think it would be fair to say that there's probably a bit of downward pressure on our forecast in diabetes, as you all would expect from the price pressure in the marketplace. And there is upward pressure, positive pressure on our oncology portfolio, products are looking pretty good.

So we're still confident that we are on track. Probably, it was slightly different mix of products overall, which actually is a positive because the products that are out are more profitable. And overall – but overall, I would say more or less on track.

As far as SG&A, I'll ask Marc to give you more color. But just to correct maybe comments you made, actually, Sachin, you said marginal decline versus last year, Q2 last year. If you go back to Mark's slide, the SG&A was 38 percent of sales. And Q2 this year is 35 percent. So we have a decline there. And we expect to continue managing these costs. Mark, do you want to comment there?

Marc Dunoyer: Yes, I think the …

Sachin Jain: That's as a percentage of revenues, which includes externalization, I think. But I may be wrong, excluding externalization is flat and 1 percent CER decline.

Pascal Soriot: I see, yes.

Marc Dunoyer: So just to cover this. So I think we need to see this as a time series. If you look at quarter 4 of last year, quarter 1 of this year, where the SG&A, we're still increasing at plus 10 percent. I think you will see that the reduction of the SG&A on the second quarter was quite impressive. And we are no way on the end of our efforts. We need to redouble our efforts to be in line with what we have provided early in the year, which is we will have an SG&A, which is under the level of 2014 and also the ratio will be under the ratio of 2014. So we need to – and we are determined to continue our efforts in that direction.

Pascal Soriot: Elisabeth, do you want to cover this, the Onglyza label question?

Elisabeth Björk: Yes. And I'm very happy to do that. We are still in discussions with the FDA around what the safety label will be for Onglyza. But I can't comment exactly on what that outcome is going to be.

What I can say is for the combination of saxa/dapa, we are ignoring the potential to do more mechanistic work to see really the impact of the two parts there, reminding everybody of the fact that also dapa have a small diuretic effect that very well could counterbalance whatever is seen with saxa. So we have a lot of confidence in the combination in treating patients broadly and across the board.

Luke Miels: Yes. And I would also add. If we – it's potentially you can over read the results with Onglyza because we'd made the decision last year to reduce resources. And then earlier this year, we further reduced resources around Onglyza to concentrate on Farxiga. So I mean what saxa/dapa offers is – I mean, is profound efficacy around A1C, a very strong weight reduction. And again, there's another factor, we have the advantage of being one company promoting a combination of our own two products which, as you can no doubt imagine, gives us a fair amount of flexibility in terms of how we market that and structure that and price that compound. So we remain confident.

Pascal Soriot: Thanks, Luke. And I mean the key message as you can hear it, Sachin, is that Onglyza is a secondary priority for us. In fact, our two priorities are Farxiga and Bydureon as you said. And the key question for us as far as the label is the combination and what label the combination is able to get. And the additional mechanistic work Elisabeth was referring to is very important in that context of the combination of the two agents.

The final question on lung, Mondher.

Mondher Mahjoubi: Yes. Actually, Sachin, you had two questions. One is about the IO-IO combination and feedback from KOLs and investigators. It's consistent with what we had seen at ASCO, very positive, pleased with the safety profile, the very low discontinuation rate and, of course, the high response rate observed in the PD-L1 negative.

I think the fact that we have been able to randomize already the first patient in MYSTIC is clearly a sign of this excitement. We have all the big names and the big sites participate in this trial. And everyone is looking forward to develop the first chemo-free regimen in first-line in non-small cell lung cancer.

With regard to your second question about the availability , I cannot comment. What I can say is that the second line trial was against docetaxel. Docetaxel is approved, but has a very bad safety profile. And the response rate as well as the duration is not as good as what we have in first line. In first line, standard of care has 15, 16-month median survival response rate in the range of 40 percent. So it's really hard to think that the monotherapy can beat such combination of chemotherapy. But again, I think only data can answer this question.

Pascal Soriot: Thanks, Mondher. So we'll take maybe one e-mail question and return to the online questions in a minute. So the e-mail question is for you, Marc, it's from Kristofer Liljeberg at Carnegie, given the low tax rate of 14 percent in the first half, what is the tax rate assumption in '15 for the core EPS guidance?

Marc Dunoyer: In my prepared remark I had commented on this. We anticipate the full year tax rate to be in the lower half of the 16 percent to 20 percent range that we had described earlier in the year. So that's the best indication we can provide.

Pascal Soriot: Thanks, Marc. Returning to the online questions. Jo Walton at Credit Suisse.

Matthew Weston: It's actually Matthew Weston for Jo. A number of questions, please. The first, Pascal, on brodalumab, you have made your position clear. I think in the past you've also suggested it may be a product that needs a partner. Have you had any expressions of interest since you've had the right to return back from Amgen.

Secondly, on Iressa in the U.S. and the launch. Can you tell us how you're trying to position that with managed care? Are you using it to try and make way for a smooth ride for 9291 and thinking of a strategy where you offer both products to first and second line? Or are you treating it as a completely separate launch?

Secondly, – or sorry, thirdly, you made comments around saxa/dapa. How do you expect that to be positioned in the market? It's always surprised us that Glyxambi is already there and seems to be being forced to offer exactly the same discounts and free access as the single agent new molecules despite the fact that it has no direct competition. So do you think you'll be able to position that product with less competitively or do you think it will be more so?

And then finally, a numbers one. Working capital in first half last year, there were inflows of $700 million in first half. This year there seem to be outflows of $760 million. Marc, can you tell us what's happening in working capital?

Pascal Soriot: Okay. So Marc will have this question. The broader – thanks, Matt, many good questions here. The broader question, we've actually had several expression of interest. In fact, we've also – we've already received offers, and we are considering those and engaging in discussions with potential partners. But it was really encouraging to see that we didn't get one, we got several expressions of interest from a variety of partners.

But the key is really, first of all, to go through the data in more details, and that's what we are still doing, and suddenly decide how we progress this together with the partner that we would select.

The Iressa question, let me just give it a try and, Mondher, if you have anything you want to add. For us actually, the – first of all, the – bringing Iressa to patients is really exciting because this product we invented, we brought to patients around the world everywhere, so we wanted to bring it to U.S. patients as well, secondly, it is a nice launch for our oncology sales force, the lung oncology sales force, and they can reestablish contacts with key customers, introduce a product that many oncologists in the U.S. know, of course, from their global experience and historical experience. So it's kind of a nice training ground, if you want, for our sales force.

But I also have to revert back to Mondher's slide, which showed you clearly that in the initial phase, 9291 will be labeled for second line. So there is a need for first line use for Iressa for a period of time over the next few years. As 9291 gets developed and approved for first line use, we'll be able to shift our focus to 9291. But in the meantime, clearly Iressa goes into first line and 9291 in resistant form of EGFR mutated cancer.

And finally, it is also true that from a price – from an access viewpoint, certainly having two products to treat lung cancer helps us a little bit. But it's essentially, really, a portfolio play, if you want, addressing the various needs of lung cancer patients. And the saxa – Mondher, anything you wanted to add now? Okay. So the saxa/dapa question, Luke, do want to cover that one?

Luke Miels: So I mean, I think it's always good to be first to market, but there are some advantages in being second. And I think this is one of the examples where, I mean, we're actively looking at the positioning of this product, the contracting strategy. And again, I think we believe that we have a competitive offering for the reasons I outlined before and also the simplicity of one company. And we have a good understanding of what drives behaviors around combinations.

So that's probably all I'll say today, but we'll certainly communicate more on this as we get closer to the launch.

Pascal Soriot: Mark, do you want to comment?

Marc Dunoyer: Yes. So regarding the movement in the working capital, the largest volumes comes from the unfolding of rebates of Nexium, the rebates that are due to managed care organization. This has been the largest movement. There are two other movements to consider. We have integrated the inventories of Actavis Almirall in the first half of the year. And there was also a third factor, which is the outflow of expenses that we incurred in the latter part of 2014 which, obviously, we're at a relatively high level. So these are the three main factors.

Let me mention, though, that we are still making progress on our receivables. And we have – we are continuing our efforts, in particular, to collect overdues, and we have improved our receivable by a few days. The trade variables, if I include the specific case of Nexium in the United States, have also improved. So we are continuing our efforts on working – towards a working capital.

Pascal Soriot: The next question is from Tim Anderson at Bernstein.

Timothy Anderson: A few questions, please. I guess when we look at spending ratios, it does seem to us more appropriate to look at the percent of product – as a percent of product revenues because externalization, obviously, it's not something that's going to continue in perpetuity. When I look at R&D spending on that basis, it hit 23 percent in the quarter. It's been steadily marching up, of course, you're making pipeline progress. My question is where can we expect that ratio to settle out as you really look beyond 2015, but into 2016 and 2017? Is 23 percent a good run rate or could actually go higher?

Second question is on externalization itself. It's obviously, been a source of controversy for some investors. And my question is whether there's any chance that the company would reconsider the earnings targets that kind of drive that need to do externalization. Is that something the board might reconsider? Or should we expect that's going to continue?

And then last question is on durvalumab. In the past, you've talked about your early filing strategy, how that's partly contingent on what happens with the

competition. We've got Merck's application ending before FDA. We could get a decision fairly soon. And if that gets labeled just in PD-L1 positive patients, that could potentially close your window. And I'm wondering if you – I'm assuming that you have a view on what Merck may get because of that direct impact it would have on your product, and I'm hoping you can share that view.

Pascal Soriot: So thank you very much Tim. So three questions here. Maybe, Robert, who will give you a couple of minutes to answer this. I'll turn to you in a few minutes to cover the durvalumab question.

I mean, just to address the externalization one. I think what I would like to say here, Tim, is that, to be honest, if we didn't have these goals, we would probably – for sure, in fact, surely do the same as we are doing today because what we are doing really is partnering where we don't have the capabilities to develop and market products. I mean, the best partner which really is a great example of this, the partnering of Moventig with Daiichi because we don't have the presence in the patient – the prescribers group, sorry, that we wanted to target in the U.S. This is a good example of partnering, where we don't have the capability, and we will keep doing this especially in areas that are not core areas.

We'd also do it in other areas where we need these capabilities. I mean, the Celgene deal to be honest for me is sort of mind-boggling that people are kind of wondering about it because it's a no-brainer. I mean, we're partnering with the best hematology company in the industry. Nobody has any value for hematology in their spreadsheets for durvalumab. We are potentially going to create enormous value in hematology. Of course, we'll have only 50 percent of that value, but it will be 50 percent of a large value because now we have the ability to be a leader in the field of hematology, whereas before we would have been sort of trailing the pack and building capabilities that we don't have. We have strong capabilities in solid tumors. We also have a few hematologists in our company with no hematology, but we don't have company's capabilities, if you will.

So I would still do that because strategically it makes sense. It also strategically makes sense for us to keep honing our portfolio. We buy assets because we believe we are better owners of those assets than the company that is selling those assets. In the same way, we are selling assets that we don't believe we are the best owner for, and if we can extract immediate value for those assets that would be declining in our hands because we are focused elsewhere, why not do it. And then Entocort is a good example of this. It enables us to really focus our efforts in where we need to be focused.

And finally, what we do through all of this is generating cash flow that enables us to reinvest in our business and delivers our dividend comfortably. So I really don't believe, I would manage the business very differently because, at the end of the day, the company has to be profitable. It's pretty simple. I mean, we have to deliver our cash flow. We have to pay our dividends. And so the goal would not change dramatically what we do quite frankly.

But as far as the board changing it, I would leave you to ask that question to our Chairman at some point. But quite frankly, again, it would not change our approach.

The question about R&D, and maybe, Marc, you want to cover a little bit more. But just briefly I would say, I think where you see us spend in R&D from as a percentage of sales, product service or revenue, look at it the way you want it, you're probably in the sort of right ballpark of where we would be. Certainly, we do not expect R&D to keep growing at the same rate as we see this year, that's very clear.

Marc, can you …

Marc Dunoyer: Yes. I think this is exactly this. We are going to – we continued managing our cost, and we have done some great efforts on SG&A in 2015. And this has enabled us to fuel the investment on the R&D. As we move towards '16, we also have to manage our cost on the R&D line, and the growth will obviously slow down. We are – it's a bit too early to provide any more precise color on this. And we will do it as we come toward the end of the year or

guidance next year. But you can expect a slowdown in the rate of increase of the R&D in the future.

Pascal Soriot: Thanks, Marc. Rob, are you ready for the durvalumab question?

Robert Iannone: Yes, I am. So I would just remind you that only full approvals based on randomized control trials would exclude additional approvals in the same indication for an accelerated approval. But I would also reinforce that, to Mondher's earlier presentation, we have many opportunities to be highly competitive, especially with our combination therapy across indications, especially the very important lung cancer indications.

Pascal Soriot: Thanks, Rob. Mondher, anything you want to add to that? No? Okay, so we'll move to Alexandra Hauber. We will start with the question, Alexandra Hauber, over to you.

Alexandra Hauber: Two questions left, two on 9291, you said you got to submit in Japan this quarter. Unfortunately, don't know the Japanese regulatory situation very well. Is there any way for accelerated approval there? Or when is the earliest time you can actually, not file, but get approval for it?

Also on 9291, you said the filing is for second line in patients with the T79 mutations. Various commentaries from KOL whether we really need that mutation as an – in the indication, do you expect that to be – that, that is actually required or be used in practice? Or is this going to be anyone who progresses from sort of first-generation EGFR inhibitors?

Moving onto Lynparza, obviously, great progress here. But when is the first – the earliest time you can get a label expansion in ovarian cancer? It appears that all the solo studies are still recruiting. So are those readouts being pushed out?

And then final question on, I still call it MEDI treme, the new studies, which were those described in the press release today, but also at ASCO in the new indications, are they going to still stop this year or this quarter or is this coming at some point in the future?

Pascal Soriot: Thanks, Alexandra. A lot of great questions. By the way, the MEDI is called durvalumab and durva like durable, and valuable. So the first question is about Japan. We'll ask our resident Japanese expert Marc to address that question.

Marc Dunoyer
Thank you. So it's not exactly an accelerated approval. The Japanese call it a priority review. But at the end of the day, it's a reduction of the time of the review, and it can come down to about nine months. The Japanese have regularly reduced their review times and, with a priority review, one can estimate that the product would be approved nine months later.

Pascal Soriot: Thanks, Marc. And Mondher, the other three questions, I guess, are for you.

Mondher Mahjoubi: Yes.

Pascal Soriot: Second line Lynparza – second line 9291, then Lynparza expansion.

Mondher Mahjoubi: Yes. So thank you, Alexandra. Let's start with the 9291. First of all, we have today a body of evidence showing that the response rate and the disease control actually in the T790M mutation positive is extremely high. So from, I would say, a clinical viewpoint, if you had a patient who progressed on a first-generation TKI, I think it's extremely important to better understand where we – whether we have this mutation or not because the body of evidence in this so-called T790M negative is still very limited and very controversial to say the least.

We have question about the testing itself, a question about whether the free interval between the end of the first administration of the first-generation TKI and the second treatment could be maybe biased. And again, I think we have an opportunity with the launch of AZD9291 to reshape this market and to establish the mutation of T790M as one of the predictive factor for the use of this extremely powerful selective EGFR inhibitors.

I think when it comes to Lynparza, as you know, Lynparza has a very wide life cycle plan. We have 10 label extension in five different tumor types. Of course, a number of them are in ovarian cancer, both in the platinum sensitive

second line relapse as well as in the platinum – as well as in the first line. The SOLO2 is, as you know, event-driven today, the filing is expected for the first half of 2016. We expect to have the database locked by the end of the quarter this year. But there are a number of other readouts that I expected next year, in particular, in breast cancer and in gastric cancer and in pancreatic cancer. So we will have a number of readouts for the SOLO – for the Lynparza that can help expand the indication.

For the durva trial, I'm not sure I completely understood the question. Were you asking about the other tumor type where we could develop the combination of durva and treme? And …

Alexandra Hauber: Exactly, yes, the combination. And just I think you said database lock on SOLO2 before year end. According to clinical trials that's still recruiting, so I shouldn't worry about that. It's really going to finish – complete this year.

Mondher Mahjoubi: Yes. So we have a very, very concrete example. The head and neck trial, for instance, there were two trials, the HAWK and the CONDOR. One is the PD-L1 positive and the other one is in the PD-L1 negative. The HAWK trial clearly benefit from the fact that now we are opening the CONDOR trial because patient in – at one point in time when they are on the rise in the site they have more than one option, where I think now they didn't have the option but to be PD-L1 positive.

So we are accelerating the activation of the sites in the head and neck trial in order to have – those recruitment finished on time. So there is no change in the timeline when it comes to the accrual for the PD-L1 treme combo in head and neck, but also in the other tumor type that we already announced, which are pancreatic cancer, gastric cancer and bladder cancer, in addition to the lung cancer program.

Pascal Soriot: Thanks, Mondher. So should we move on to Kerry Holford, Kerry at Exane.

Kerry Holford: Thank you. Three questions please. Firstly on respiratory, given the difficulties that are being faced by one of your peers in moving from LAMA monotherapy to LABA/LAMA combination, I'd be interested in your

experience, your own experience with Duaklir and also just your general thoughts on the treatment paradigms in COPD?

Secondly, on 9291. Can you just remind me, how you believe that product is differentiated versus the competitor from Clovis, which I think is running along in a very similar regulatory timeline?

And then thirdly, just to clarify in your guidance, being raised for the year in terms of total revenues. Does that purely reflect the additional externalization revenues? Or is there also an uplift to the underlying base business? Thank you.

Pascal Soriot: Thank you so much, Kerry. So three questions here. One 9291 for Mondher. The revenue guidance Marc, maybe you want to cover this one and LABA/LAMA. In a nutshell really the experience we have was directly on Europe so far because we have only launched it in Europe in some markets, both in the U.K. and Germany, so far is a very good experience. Now it's very clear that it is a market that we need dedication to grow and develop, there's no doubt about it. But so far clear we are very satisfied with the progress we're making.

Luke, anything you want to add there?

Luke Miels: Yes. I think it's a promising start. We have got $24 million in revenue. Around 3.5 percent market share. And if you add in our partner of course, it's around 8 percent. We've had some good results in Germany. Days of treatment, if you look at Ultibro 74 percent; 9 percent and the combined aclidinium molecules is 17 percent.

So I think, it's probably taken longer than people expected. We've discussed this on past calls in terms of LAMA/LABA. But we remain very confident about the combination, and in Europe, we have a very clear strategy. I mean, with the symptomatic patients is really where we're positioning Duaklir and for Symbicort, it's in patients who experience exacerbations and then ultimately in the long term if you look at this cohort with the exacerbations, there is the opportunity for the free combination free triple, free triple with

Eklira, which again can further improve that patient's quality of life, both in terms of symptoms and exacerbation.

So the short answer is, it's an encouraging start, and we're very focused on it. If you go right back to the rationale that we had for the Almirall deal at the time, which is a year ago, for the European component of the transaction, we clearly said that as we have a very effective commercial machine in Europe with respiratory. And what we're looking for is new products that we could drive growth with in Europe. And I think so far the signs are encouraging with those products.

Pascal Soriot: And Mondher, anything to add?

Mondher Mahjoubi: So there have been no studies to compare 9291 to other TKIs so it's therefore inappropriate to speculate on how they but let me say that this is – AZD9291 is a highly selective once daily oral EGFR inhibitors, that it was specifically, designed to inhibit T790M mutation while avoiding the off target toxicity, including those derived from the inhibition of (EGFR 1R) such as hyperglycemia. We're also very excited with the preliminary activity shown by AZD9291 on CNS diseases. And finally, our combination strategy with other small molecule from our pipeline and with the durval, as I said, is another way to differentiate and to position AZD9291 as the best in class.

Pascal Soriot: Thanks, Mondher. With the revenue, I mean, you saw that at the end of June for the first half, essentially, our total revenue is doing well. But our product sales are doing well. So the revenue guidance is, of course, influenced by the fact that the product sales are doing well. I mean, the externalization revenue is more or less in line with what we would have expected. So that's – Marc, I don't know if you want to add anything to that.

Marc Dunoyer: Absolutely the case. I think the – to answer your question, is it due to externalization or sales? It goes to sales performance. And the three main products or franchises that are causing this is Nexium, the generic is doing less impact, it's taking less impact on our sales. The good progression of respiratory, but also the good progression of Farxiga in particular in the

United States, but also in other markets. So they are – it's basically a sales, an organic sales story rather than an externalization story.

Pascal Soriot: So let's move to Jeff Holford of Jefferies.

Jeffrey Holford: I wonder if you could just give us your updated thoughts on business development. Are you still hopeful at all of a bridging deal for AstraZeneca? Or is time marching on the progress in your pipeline or perhaps are you seeing little value out there at current market prices inhibiting any potential of that happening prior to 2017?

And then secondly, to really appreciate, if there's any early color on the Celgene collaboration and when we'll get to hear more updates on the trials coming up for that partnership?

Pascal Soriot: So Mondher, let's get to – comment on the Celgene collaboration. What I'm hearing from our teams and from Celgene themselves is that it's going extremely well. And the teams are working very, very well together. Everybody is enthusiastic, and we're moving very expeditiously. Mondher, maybe in a minute you can comment.

On the deal question, Jeff, we're constantly looking at options of course, as you would imagine, like everybody else is doing. We do realize that certainly acquisitions that would be accretive would help us bridge to 2017 faster. There's no doubt we are well aware of this. But at the end of the day, our core focus is implementing our strategy and delivering our pipeline. And if we were to find a deal, it would have to be a deal at the right price and you highlighted yourself that prices these days are pretty hefty. And you can be accretive with many things. The issue is also do you have an appropriate rate of return on your investment? That's really also what we're looking at.

So we'll continue looking, but I can't say that it is really something that we would be able to do. Certainly, we'll do it, if we find assets that we believe we are better owners of going back to the other question, we have – that has to make strategic sense for us. We have to be better owners of the assets, meaning we have to be able to generate the synergies, and the price has to be right.

Celgene, Mondher, do want to add any color to that collaboration?

Mondher Mahjoubi: Yes. To say we are progressing extremely well with the collaboration. There has been a number of studies that were approved by the current steering committee in non-Hodgkin lymphoma both follicular and in multiple myeloma, front line and relapse and refractory as well as in MDS refractory and relapse as well as in first line. It's difficult to speculate on the time line because many of these studies are combination studies, combining durva with the standard of care, and it will be data driven. If we have significant results from the Phase I/ II we could probably think of an accelerated approval. Otherwise, we will have plans to going into Phase III. So we will be very pleased to share with you the data as soon as they come – become available.

Pascal Soriot: Thanks, Mondher. Nicolas Guyon at Morgan Stanley. Nicolas, go ahead.

Nicolas Guyon-Gellin: I have two actually. The first one is about the PD-L1 CTLA-4 combo. So BMS will start a very similar trial to the MYSTIC one for the CheckMate-227. Design and timing look quite similar. But they seem to have overpowered their trial. So any comment on that? And whether you have the ability to potentially recruit more patients would be great.

And the second question is about the long-term target. You made several optimistic comments about your ability to hit those 2023 targets of $45 billion revenues. Please correct me if I'm wrong, but this seems to contradict your December 2014 interview in The Times, where you said you would be lucky to hit those targets. So has anything changed since December last year? Thank you very much.

Pascal Soriot: Thank you, Nicolas. So you gave me a great chance to correct an inaccuracy. People tend to report all sorts of things and all sorts of rumors by the way, as you probably noticed recently about the rumor about us acquiring two companies that we actually didn't intend to acquire and didn't acquire.

So this statement about the long-term target being difficult to achieve is completely incorrect. I never made such a statement. And quite frankly, I still – our plans, which we update on a regular basis, and once a year in

November, we present this to the board and we'll do that again this year. Our plans are still very much delivering, showing that we can deliver the same.

Now the only comment I would make here is, as you would expect, when you do a plan, you do a risk adjusted plan. You have a variety of projects and products in the plan. And then some will do better and others will do less well. And it's always the way it is, when you do a plan, especially over such a long period of time.

So the only general comment I would make is certainly we see a bit of downward pressure on some aspects of our forecast like in diabetes and upward pressure in oncology. I have to say our oncology pipeline is developing very, very well and we're very pleased with that. And we have great hope with 9291 for instance in first line a year ago, might not have – we might not have been as hopeful as we are today that in first line we could get a pretty big opportunity for 9291 there because, of course, you have generic Iressa and Tarceva to consider over the next few years.

The data – I mean the product is looking and so overall oncology is up and diabetes we can still deliver, but clearly we have to acknowledge there's a bit of pressure there. But overall, we're still on track. The durva treme question and the BMS study being overpowered. Rob, do you want to address that question?

Robert Iannone: I would just say that as we're rolling out MYSTIC and discussing with investigators, it's being met with a great deal of enthusiasm, both because of the data we generated around our combination and the confidence in our dose selection, but also in the overall design. And so we are poised to execute that very swiftly in a global study.

Pascal Soriot: Okay. We'll take the last question from Richard Parkes at Deutsche Bank. Richard, go ahead.

Richard Parkes: Hi, yes, thanks for taking my questions. To focus on diabetes actually. Just on Farxiga, I noticed that the new NRx in the U.S., the growth there has been slowing. And also in the context, if you look at your prescriptions, sales per

prescription and compare it to what J&J reports, it looks like you're already heavily rebating there. I think you're around 2/3 of the level for INVOKANA. So I wondered, if you got any room there to react to that pressure on your NRx?

And secondly, Onglyza is clearly suffering from the lack of promotional support and whether – I'm wondering whether there is any thoughts around adjusting how the two products are marketed together? Whether there is any second thoughts about having the same sales force selling those two products?

And then finally, on Bydureon, the suspension product is obviously key to continuing to drive growth there. I wondered if you could give us any more detail around that device? And what it brings, and whether you have been able to improve the needle gauge?

Pascal Soriot: So thank you very much, Richard, for those questions. Luke, most of those are for you. Maybe quickly on the sales per script, let me just say that the difference is not only a rebate, it's also payers – not payers, patients assistance, sorry. When we pay – when we help with co-pays and we have free coupons for co-pays. And rebates typically, when you give rebates, it's hard to take them back. But certainly, patients assistance coupons to support co-pays you can flex that up or down of course. And that's certainly something that we have the ability to flex a little bit. But we also – we'll consider this in the overall framework of access we get. Do we get back onto Caremark or not? And so it's not a decision we make in isolation from the general environment.

Luke, do you want to cover the other questions?

Luke Miels: Yes, so with Farxiga there was a slight distortion in quarter one because our WAC was below INVOKANA. I think, it's a very fair statement in terms of INVOKANA clearly being first to market has stronger access than us. But that's something we're very focused on. We've been very mindful of our net price, so there's focus there. And hopefully, we'll have some more news on that in the future.

That being said, again it's a very competitive product. If you look at price for the half year, there was no change in price. But we had a 340 percent increase in volume in the U.S. So again it remains competitive.

On your point about Onglyza, it's – I mean, ultimately, unless we're going to build a huge amount of infrastructure in the U.S., we did have to make a choice, and our view was and our view still is that Farxiga is had a lot more differentiation than Onglyza. And so we had to make a choice where we placed our bets. And I think so far that's working out. That's in the U.S.

However, if you pull back from that and look overall globally, I mean, we've got good growth in other markets in Onglyza, in emerging markets, in Europe. In Europe for example, we had 35 percent volume growth, translating to around 23 percent growth. So again that business is building in the U.S. again provides a lot of opportunity for growth. But Europe and emerging markets are still very attractive.

In terms of the auto injector and the formulation there, we continue to focus on that. We think there is a place for that. And we'll have more update on that in the future.

Pascal Soriot: Onglyza in the U.S. is really a product that will be relaunched, if I may say so through the saxa/dapa combination. But it can’t be a priority for us. Maybe one last quick comment on the NRx Farxiga question you asked. We are stable. In fact, there are three weeks we have seen some increase in our market share. And in fact, there are four elements that could help us drive this up over the next few months. First, we have an increased DTC. We are on time competing in share of voice in DTC, so that will have a further impact. Two, we've deployed our sales force, so we are hoping to have a share of voice impact there. Three, hopefully, we get a better access. We're constantly working on access with Farxiga. So there is a number of things we're doing there that give us hope. And also we've changed our marketing campaign. So there's a few things that give us hope to – for this new prescription share, which as I said, over the last three weeks has been going up a little bit.

So with this, I would like to conclude and thank you all for your attention. Just in conclusion, I would like to remind you, our first half year really showed very strong growth. We've experienced now six quarters of top-line growth. We're delivering on our SG&A cost reduction. Q2 was the first step, and we expect to see more reduction over the next few quarters. We've made importantly really strong progress with our pipeline. And we're starting to launch those new products, and those launches are doing well, well with Lynparza, well with Moventig and there is more to come with Iressa and others over the next few months.

We are on track to deliver our goals, our short-term goals, and deliver our guidance with a slight improvement of our guidance on revenue for this year. And we're very much on track to deliver our mid-to long-term revenue growth. With that, thank you so much.

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