Meet AZN Management: ADA 2026

Conference call and webcast for investors and analysts

8 June 2026

Cautionary statements regarding forward-looking statements

In order, among other things, to utilise the 'safe harbour' provisions of the US Private Securities Litigation Reform Act of 1995, AstraZeneca (hereafter 'the Group') provides the following cautionary statement:

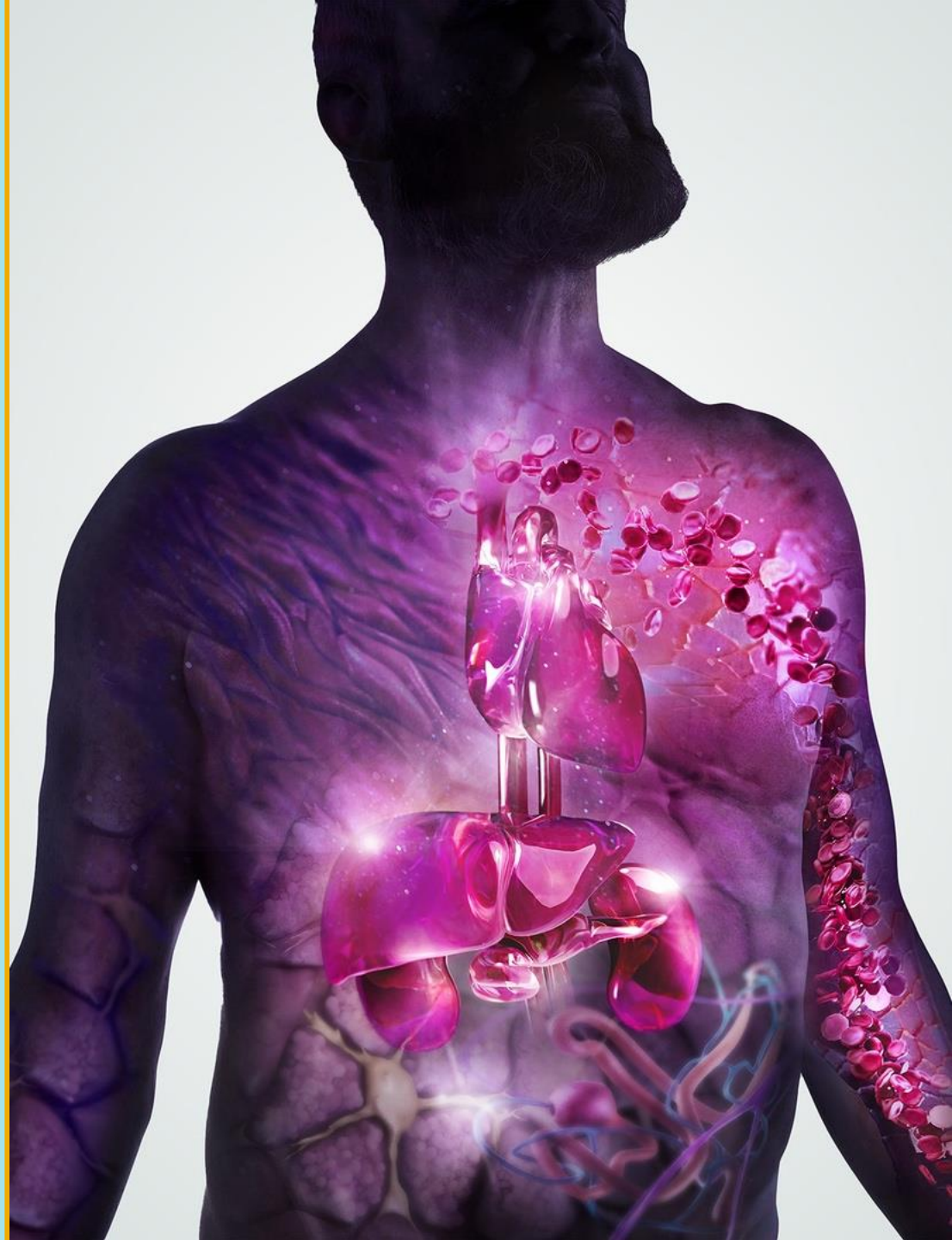
This document contains certain forward-looking statements with respect to the operations, performance and financial condition of the Group, including, among other things, statements about expected revenues, margins, earnings per share or other financial or other measures. Although the Group believes its expectations are based on reasonable assumptions, any forward-looking statements, by their very nature, involve risks and uncertainties and may be influenced by factors that could cause actual outcomes and results to be materially different from those predicted. The forward-looking statements reflect knowledge and information available at the date of preparation of this document and the Group undertakes no obligation to update these forward-looking statements. The Group identifies the forward-looking statements by using the words 'anticipates', 'believes', 'expects', 'intends' and similar expressions in such statements. Important factors that could cause actual results to differ materially from those contained in forward-looking statements, certain of which are beyond the Group's control, include, among other things: the risk of failure or delay in delivery of pipeline or launch of new medicines; the risk of failure to meet regulatory or ethical requirements for medicine development or approval; the risk of failures or delays in the quality or execution of the Group's commercial strategies; the risk of pricing, affordability, access and competitive pressures; the risk of failure to maintain supply of compliant, quality medicines; the risk of illegal trade in the Group's medicines; the risk of reliance on third-party goods and services; the risk of failure in information technology or cybersecurity; the risk of failure of critical processes; the risk of failure to collect and manage data and artificial intelligence in line with legal and regulatory requirements and strategic objectives; the risk of failure to attract, develop, engage and retain a diverse, talented and capable workforce; the risk of failure to meet our sustainability targets, regulatory requirements or stakeholder expectations with respect to the environment; the risk of failure to meet regulatory and ethical expectations on commercial practices, including anti-bribery anti-corruption, anti-fraud and scientific exchanges; the risk of the safety and efficacy of marketed medicines being questioned; the risk of adverse outcome of litigation and/or governmental investigations; intellectual property risks related to the Group's products; the risk of failure to achieve strategic plans or meet targets or expectations; the risk of geopolitical and/or macroeconomic volatility disrupting the operation of our global business; the risk of failure in internal control, financial reporting or the occurrence of fraud; and the risk of unexpected deterioration in the Group's financial position.

Meet AZN Management @ ADA – agenda

Furthering the AstraZeneca ambition with weight management	**Ruud Dobber,** EVP, BioPharmaceuticals Business
Elecoglipron – Phase II VISTA elecoglipron in overweight or obesity	**Vanita R. Aroda, MD** Director, Diabetes Clinical Research, Brigham and Women's Hospital Associate Professor of Medicine, Harvard Medical School
Elecoglipron – Phase II SOLSTICE elecoglipron in Type 2 diabetes	
Elecoglipron as foundation of AZ weight management portfolio	**Mikhail Kosiborod,** SVP, Late CVRM R&D
Delivering CVRM growth into 2030 and beyond	**Sharon Barr,** EVP, BioPharmaceuticals R&D
Closing remarks	**Pascal Soriot,** Chief Executive Officer
Q&A session	

Furthering the AstraZeneca ambition with weight management

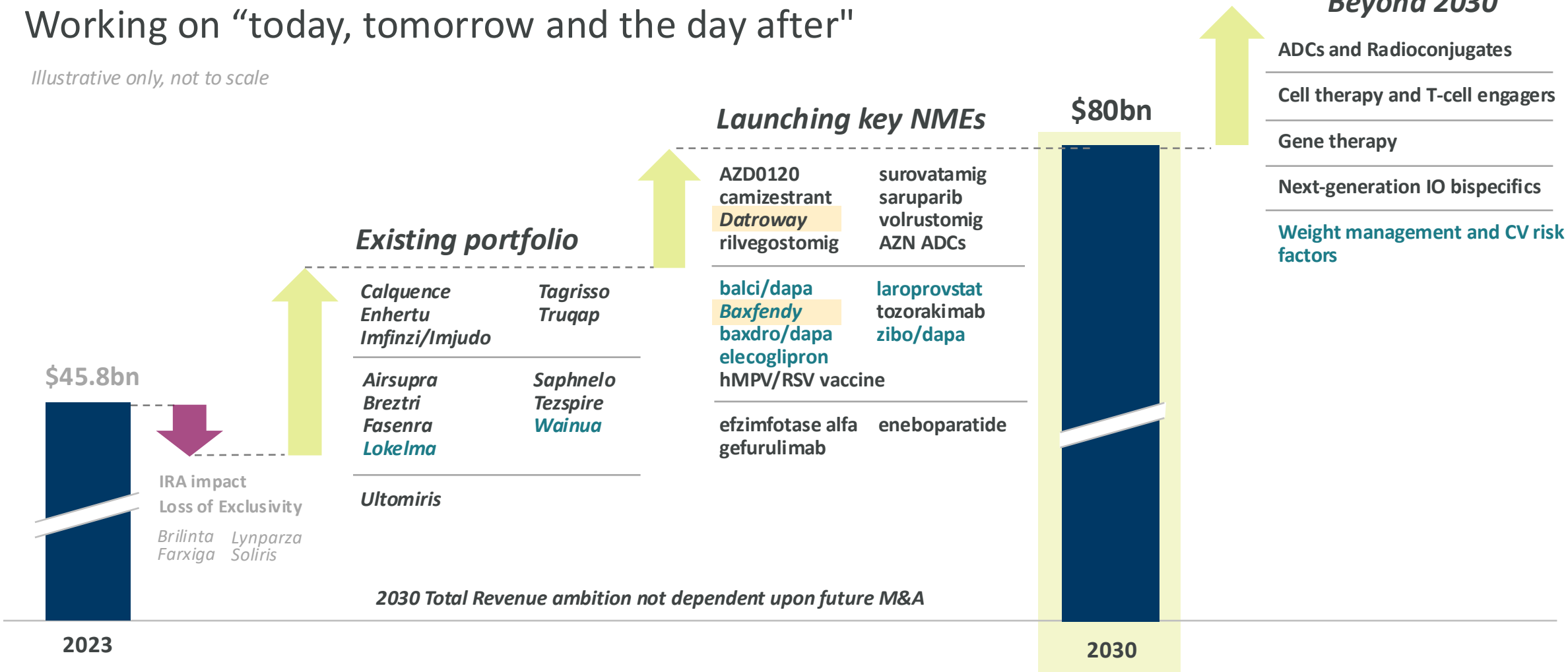
Ruud Dobber
EVP, BIOPHARMACEUTICALS BUSINESS



Ambition – $80bn Total Revenue by 2030 & sustained 2030+ growth

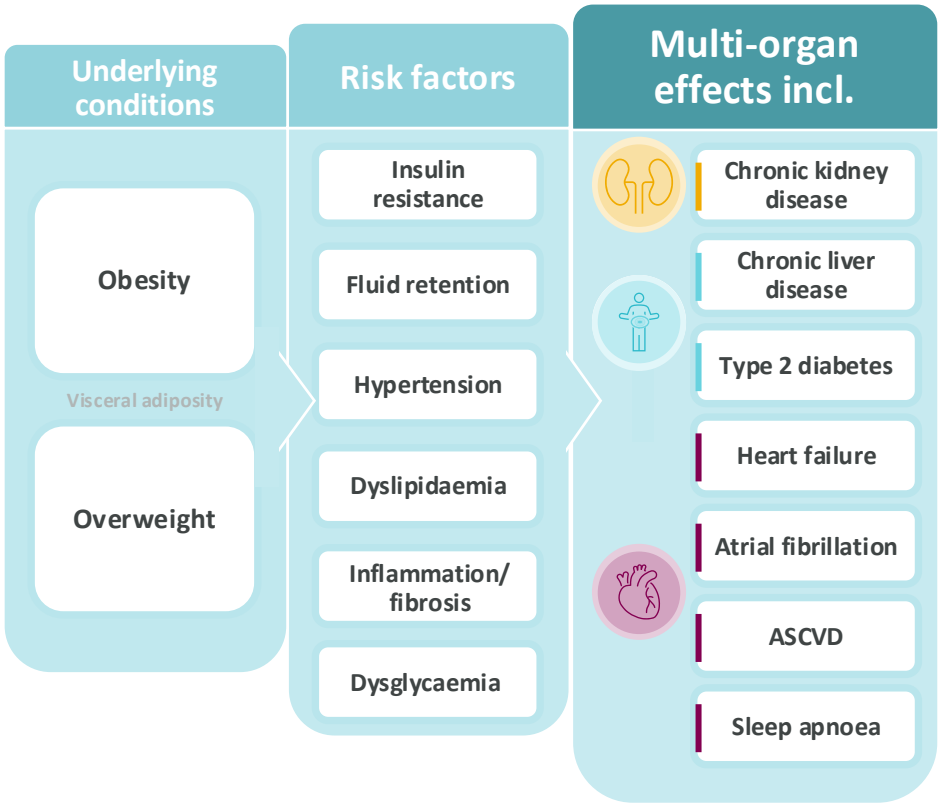
Working on “today, tomorrow and the day after"

Illustrative only, not to scale



Note: Ambition to achieve $80bn in Total Revenue by 2030 is risk-adjusted, based on long-range plan as of AstraZeneca Investor Day May 2024. Medicines and assets listed reflect key contributors to 2030 Total Revenue ambition; however, this list is not exhaustive. Medicines and assets listed in alphabetical order and sorted by therapy area. Laroprovstat previously AZD0780 and elecoglipron previously AZD5004. Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Amgen (*Tezspire*), Ionis (*Wainua*), Merck & Co., Inc. (*Lynparza*). Appendix: Glossary

Sustained weight management is essential for CVRM organ protection



Obesity is a catalyst of interconnected diseases

Obesity and overweight increases CVRM risk

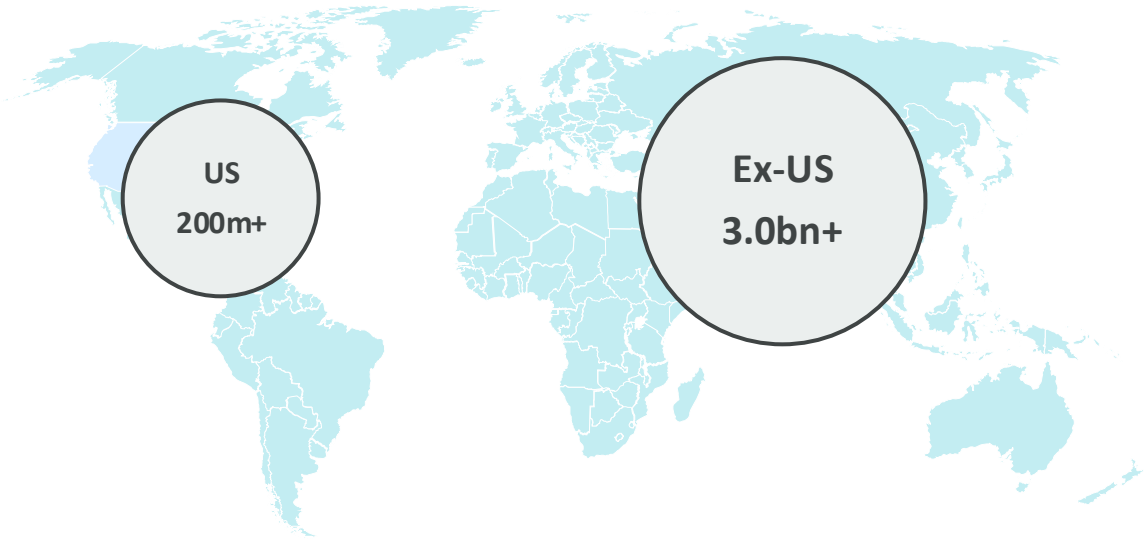
Nearly 9 in 10 patients with obesity or overweight have ≥1 CVRM comorbidity[4]

1. Schnurr TM et al. Diabetologia. 2020 Jul;63(7):1324-1332. 2. Ejerblad E et al. J Am Soc Nephrol. 2006 Jun;17(6):1695-702. 3. Kenchaiah S et al. N Engl J Med. 2002 Aug 1;347(5):305-13. 4. Waki H, et al. Type 2 diabetes associates with higher occurrence of cardiorenal comorbidities in people living with overweight or obesity (the CALOR study). Appendix: Glossary.

AZ commercial expertise to capitalise on significant global unmet need in weight management

Obesity is a growing global epidemic

Expected global population with overweight or obesity by 2035[1]



54%	**of global adult population expected to have obesity / overweight by 2035[1]**
30%	**growth expected in obese / overweight population from 2025 to 2035[1]**

Global CVRM experience and infrastructure to meet global demand

Built **$8.5bn global *Farxiga*** franchise

Established presence in **primary care market**

Industry leading global footprint

AstraZeneca Direct for patients who prefer DTC

1. Figures are approximate and are based on World Obesity Atlas 2024 and 2025. Appendix: Glossary.

Elecoglipron – Phase IIb VISTA

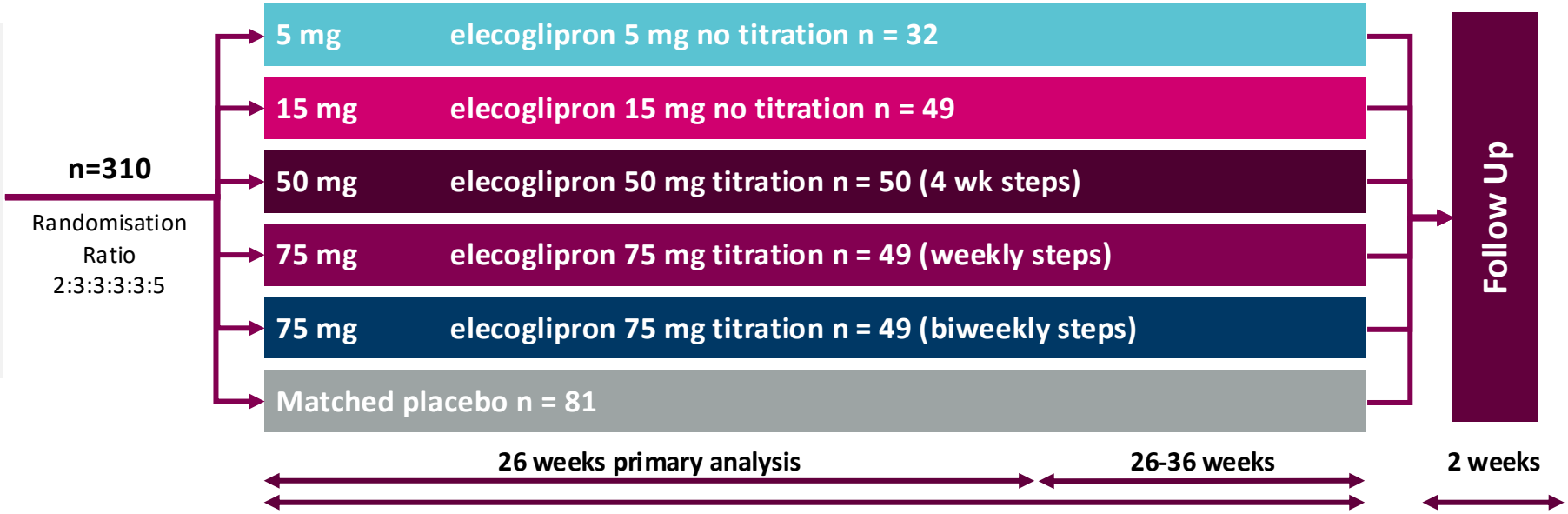
Vanita R. Aroda, MD
Director, Diabetes Clinical Research,
Brigham and Women's Hospital
Associate Professor of Medicine,
Harvard Medical School

Elecoglipron in adults with obesity or overweight

VISTA: Phase IIb Study design

Study population:

- ≥18 years of age
- BMI ≥30 kg/m^2 or BMI ≥27 kg/m^2 + at least one weight related comorbidity



Dual primary endpoints

- Percent change in BW from BL at Week 26
- Achievement of ≥5% weight loss at Week 26

Secondary endpoints

- Percent change in BW from BL at week 36
- Achieved ≥5% weight loss at week 36
- Absolute change in BW from BL at weeks 26 and 36
- Achieved ≥10% and ≥15% weight loss at weeks 26 and 36

Safety and tolerability

- AEs, SAEs, vital signs

Exploratory endpoints

- Changes in cardiometabolic parameters

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VISTA: Baseline characteristics

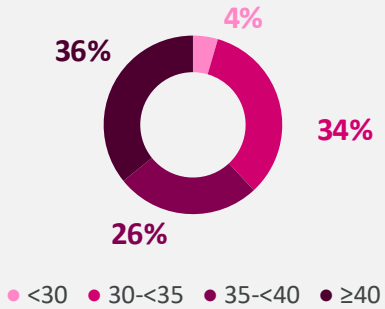
Mean age

48.4 years

Sex

27% 73%

BMI



	elecoglipron					Pooled placebo N = 81	Total N = 310
	5 mg N = 32	15 mg N = 49	50 mg q4wt N = 50	75 mg qwt N = 49	75 mg q2wt N = 49		
Body weight, kg, mean (SD)	107.5 (20.7)	109.7 (21.6)	104.4 (20.8)	106.7 (27.5)	103.5 (28.1)	108.7 (24.2)	106.9 (24.1)
BMI, kg/m^2, mean (SD)	38.7 (5.8)	39.0 (6.8)	37.8 (5.9)	37.4 (8.4)	37.3 (8.3)	38.8 (7.2)	38.2 (7.2)
Obesity-related comorbidities, n (%)							
Hypertension	8 (25.0)	16 (32.7)	17 (34.0)	17 (34.7)	13 (26.5)	27 (33.3)	98 (31.6)
Dyslipidaemia	7 (21.9)	10 (20.4)	7 (14.0)	16 (32.7)	8 (16.3)	14 (17.3)	62 (20.0)
CV disease	1 (3.1)	2 (4.1)	0	1 (2.0)	1 (2.0)	3 (3.7)	8 (2.6)
Obstructive sleep apneoa	6 (18.8)	9 (18.4)	8 (16.0)	6 (12.2)	5 (10.2)	8 (9.9)	42 (13.5)
Waist circumference, cm, mean (SD)							
Males	128.5 (10.9)	123.4 (15.5)	119.4 (15.5)	122.6 (17.6)	129.7 (26.9)	122.9 (17.4)	123.5 (17.3)
Females	109.2 (10.8)	112.6 (17.0)	114.2 (18.7)	106.3 (15.8)	108.7 (12.7)	110.4 (15.1)	110.4 (15.4)
Glycated haemoglobin group, n (%)							
≥5.7%	8 (25.0)	17 (34.7)	15 (30.0)	16 (32.7)	16 (32.7)	35 (43.2)	107 (34.5)

qwt = every week dose escalation. q2wt = every two weeks dose escalation.
Data are reported as mean (SD) unless stated otherwise. Percentages may not total 100 because of rounding.
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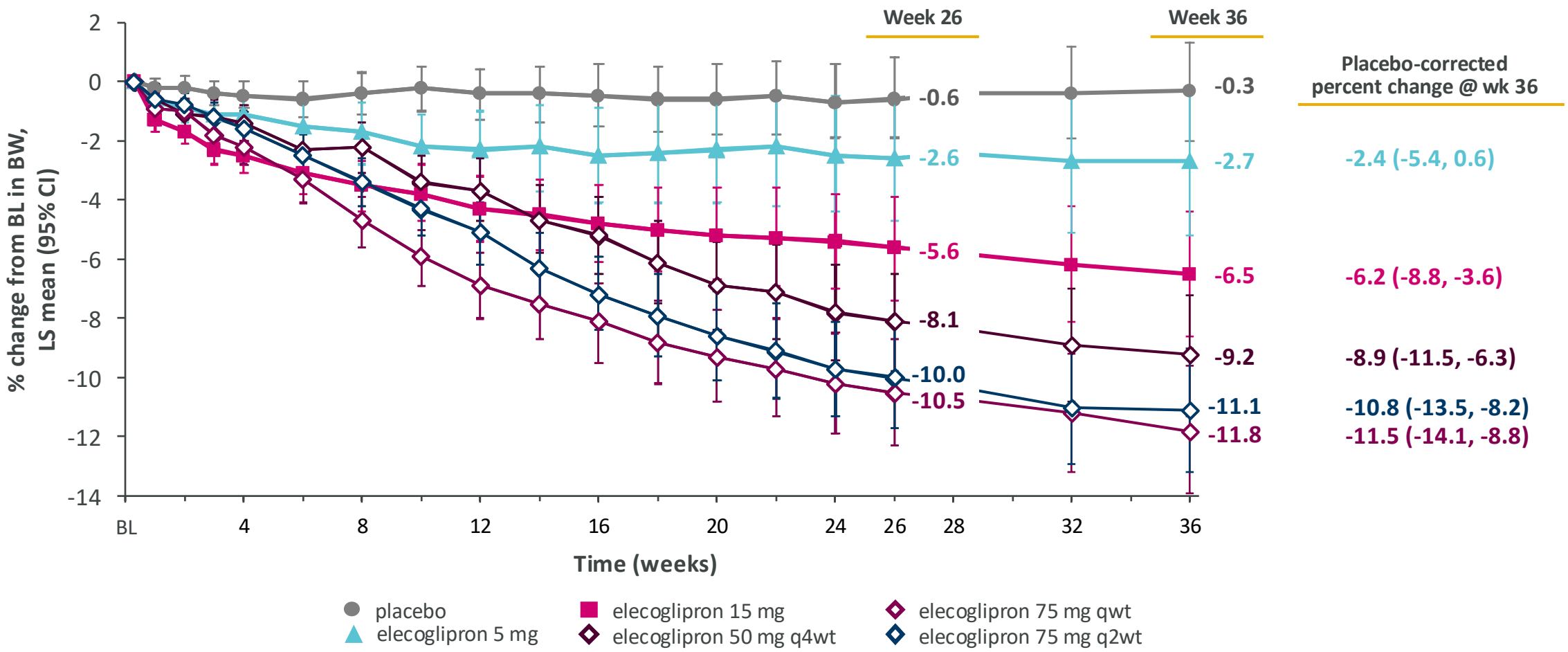
Clinically meaningful and statistically significant weight loss at week 26, further increasing to week 36

Percent change in body weight from BL to Week 26 and 36



Placebo-corrected percent change @ wk 36
-2.4 (-5.4, 0.6)
-6.2 (-8.8, -3.6)
-8.9 (-11.5, -6.3)
-10.8 (-13.5, -8.2)
-11.5 (-14.1, -8.8)

Estimated LS means using MMRM, efficacy estimand.

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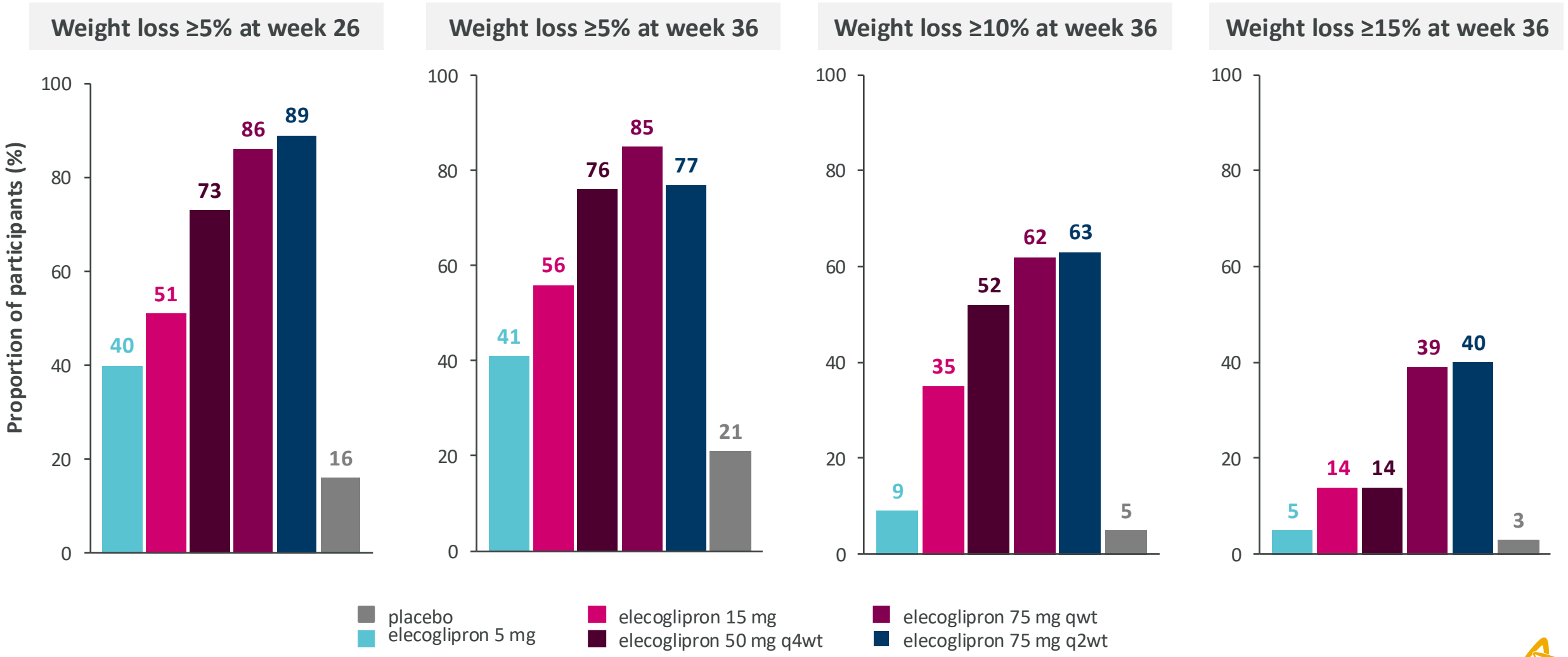
Significant proportion of patients achieved weight loss of at least 5% at weeks 26 and 36



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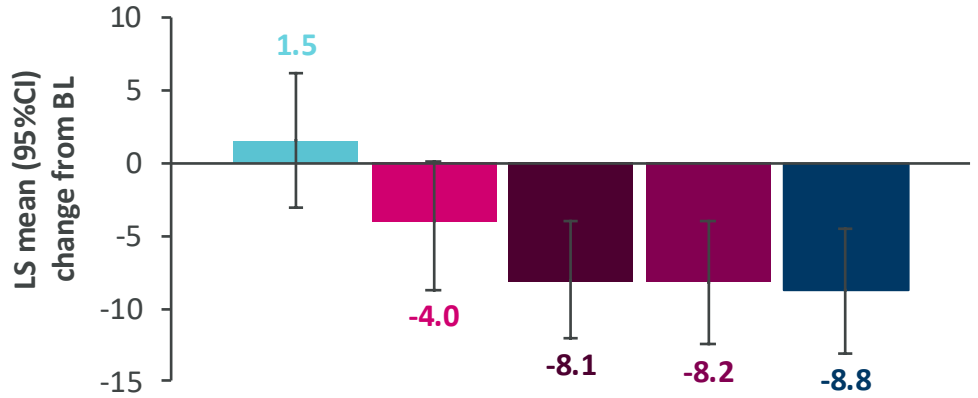
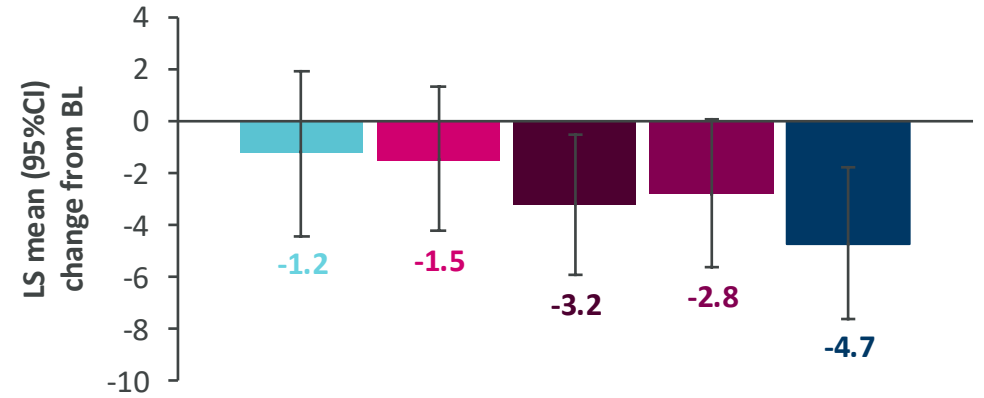
Elecoglipron demonstrated clinically meaningful improvements in cardiometabolic risk factors

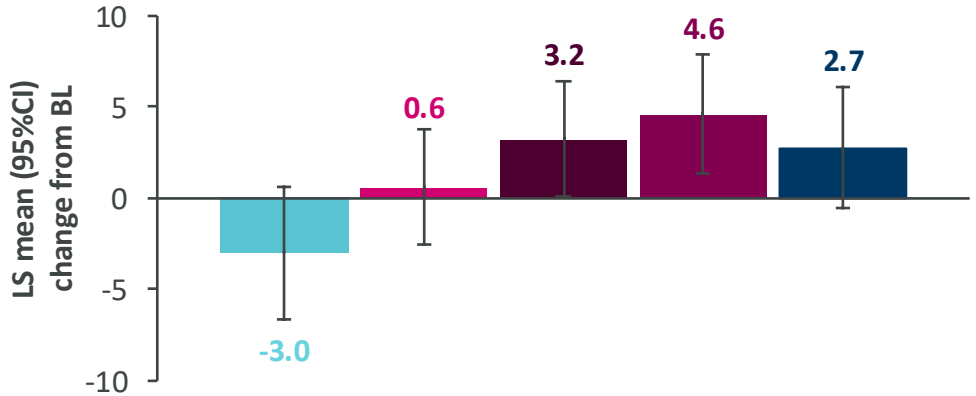
SBP (mmHg) | BL mean 125 mmHg



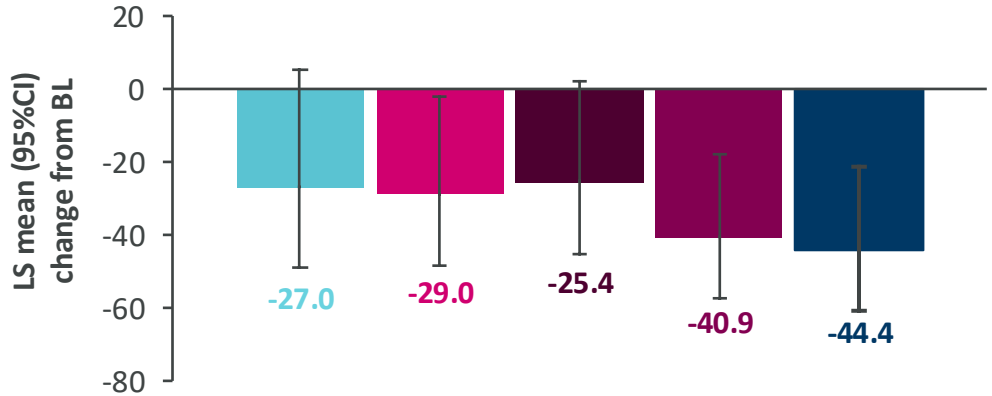
DBP (mmHg) | BL mean 81 mmHg



Heart Rate (bpm) | BL mean 72 bpm



hs-CRP (%) | BL mean 4.9 mg/L



elecoglipron 5 mg
elecoglipron 15 mg
elecoglipron 50 mg q4wt
elecoglipron 75 mg qwt
elecoglipron 75 mg q2wt

Reflects placebo adjusted change from baseline. Estimated LS means using MMRM, efficacy estimand.
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Safety profile of elecoglipron is consistent with the GLP-1 receptor agonist class

Events, n (%)	elecoglipron 5 mg N = 32	elecoglipron 15 mg N = 49	elecoglipron 50 mg q4wt N = 50	elecoglipron 75 mg qwt N = 49	elecoglipron 75 mg q2wt N = 49	Pooled placebo N = 81
Any AEs	27 (84)	43 (87.8)	44 (88.0)	48 (98.0)	45 (91.8)	68 (84.0)
Any SAEs	0	0	0	4 (8.2)	4 (8.2)	2 (2.5)
AEs leading to treatment discontinuation	0	2 (4.1)	3 (6.0)	3 (6.1)	4 (8.2)	3 (3.7)
GI AE leading to treatment discontinuation	0	1 (2.0)	2 (4.0)	1 (2.0)	1 (2.0)	0

- No deaths were reported in the study. SAEs on 75 mg were spread across different organ systems.

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Gastrointestinal effects were most common adverse event and were of mild to moderate severity

Events, n (%)	elecoglipron 5 mg N = 32	elecoglipron 15 mg N = 49	elecoglipron 50 mg q4wt N = 50	elecoglipron 75 mg qwt N = 49	elecoglipron 75 mg q2wt N = 49	Pooled placebo N = 81
Any GI AE	17 (53.1)	38 (77.6)	40 (80.0)	41 (83.7)	38 (77.6)	42 (51.9)
Nausea	3 (9.4)	27 (55.1)	28 (56.0)	27 (55.1)	22 (44.9)	16 (19.8)
Constipation	4 (12.5)	13 (26.5)	21 (42.0)	20 (40.8)	10 (20.4)	5 (6.2)
Diarrhea	4 (12.5)	13 (26.5)	15 (30.0)	17 (34.7)	11 (22.4)	20 (24.7)
Vomiting	2 (6.3)	6 (12.2)	13 (26.0)	13 (26.5)	14 (28.6)	4 (4.9)

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No liver safety signals were observed in VISTA

Participants with ALT, AST or total bilirubin ≥3xULN, emerging post randomisation

n (%)	elecoglipron 5 mg N = 32	elecoglipron 15 mg N = 49	elecoglipron 50 mg q4wt N = 50	elecoglipron 75 mg qwt N = 49	elecoglipron 75 mg q2wt N = 49	Pooled placebo N = 81
ALT	0	0	0	2 (4.1)	0	1 (1.3)
AST	0	0	1 (2.0)	0	0	0
Total bilirubin	0	0	0	0	2 (4.1)	0

All observations were <5xULN. All participants on elecoglipron with ALT/AST/Total bilirubin ≥3xULN continued dosing and the increased values returned to normal.

- Two elecoglipron participants with ALT elevations had titration schedules modified but still reached target dose
- One participant with AST elevation continued dosing on target dose
- Two participants with total bilirubin elevations; one continued on target dose and one down titrated to 50 mg and stayed on that dose until end of trial. Increased total bilirubin values normalised at follow-up

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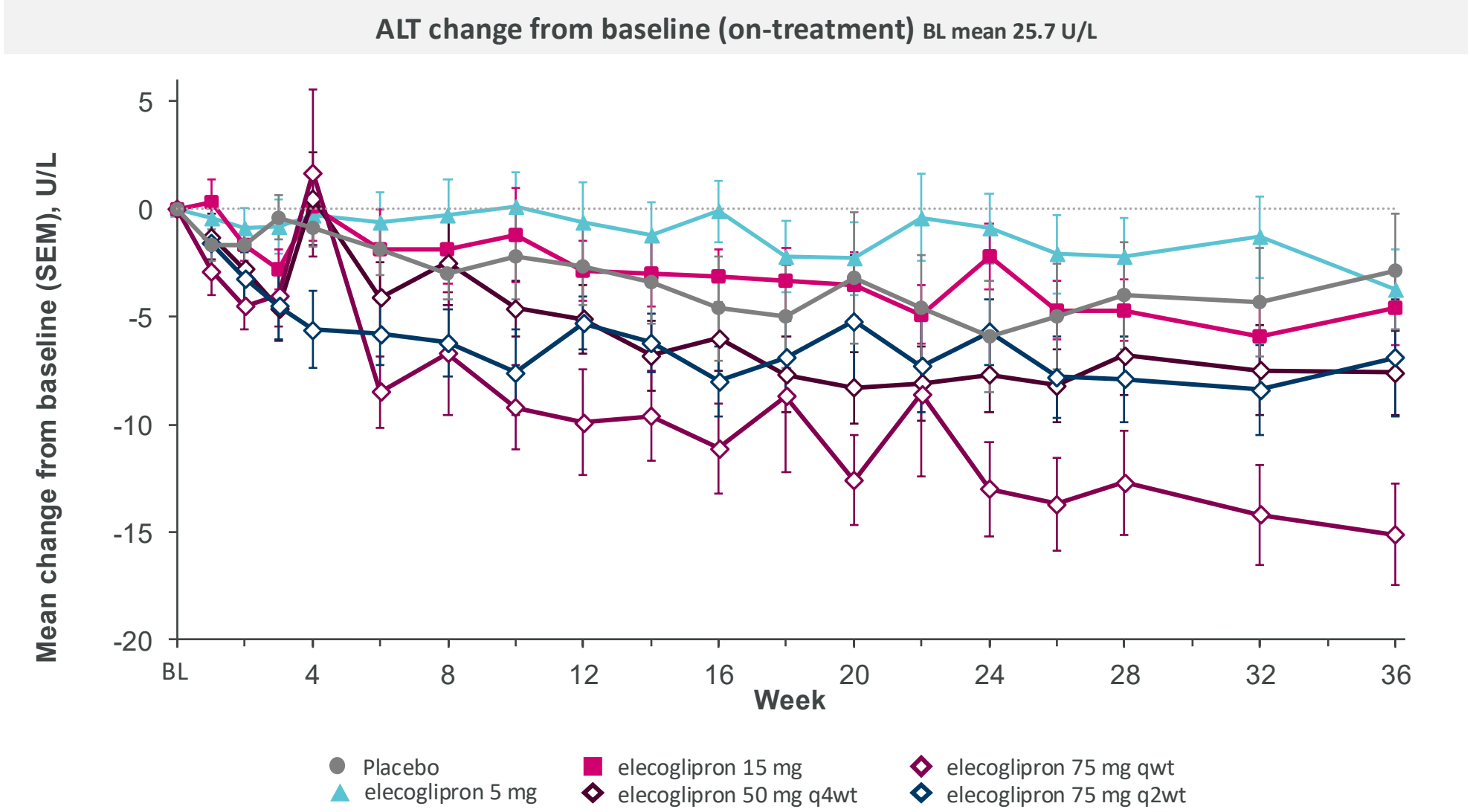
Dose dependent reductions in ALT were observed



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VISTA Phase IIb demonstrates elecoglipron's potential to treat obesity and its related complications

- Daily oral elecoglipron demonstrated clinically meaningful weight reductions in adults living with obesity or overweight without T2D
  - No indication of a plateau in weight loss was observed by 36 weeks
- Safety and tolerability profile was consistent with the GLP-1 RA class with no unexpected safety signals
- Elecoglipron does not have food or fluid dosing restrictions and may offer a convenient, effective, and safe oral therapy for people living with obesity or overweight

VISTA findings support advancement of elecoglipron into Phase III EMBOLD programme

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Elecoglipron – Phase IIb SOLSTICE

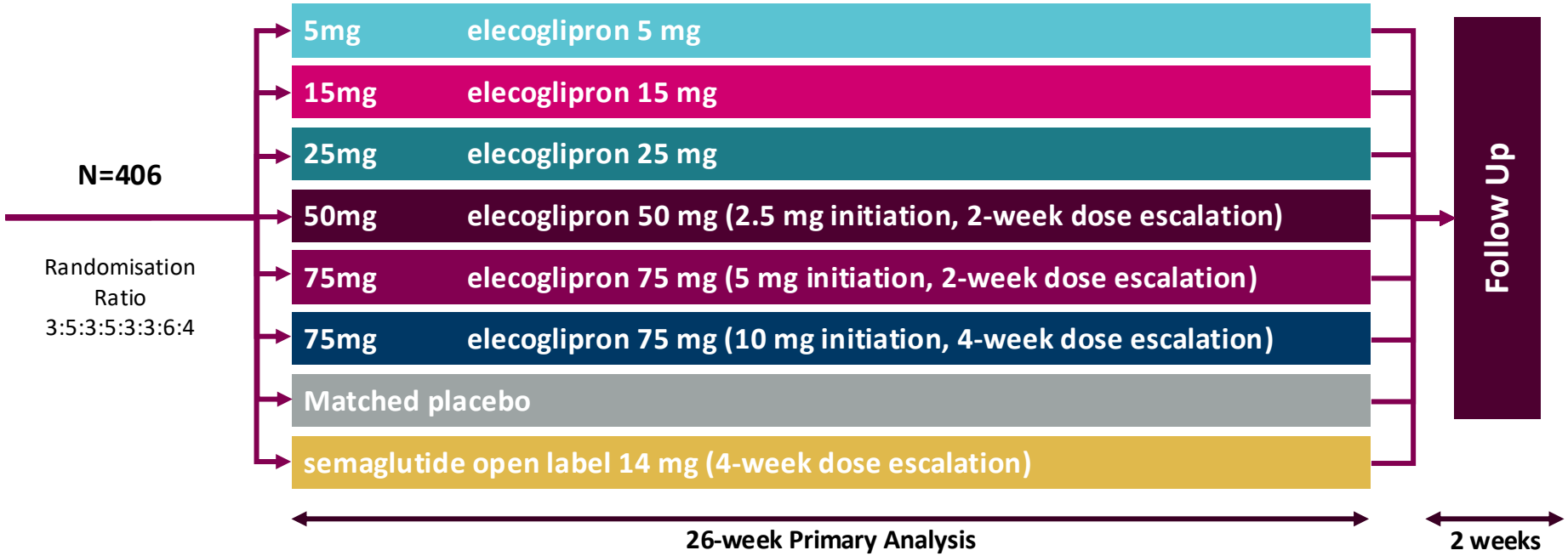
Vanita R. Aroda, MD
Director, Diabetes Clinical Research,
Brigham and Women's Hospital;
Associate Professor of Medicine,
Harvard Medical School

Elecoglipron in adults with type 2 diabetes

SOLSTICE: Phase IIb trial design

Study population:

- ≥18 years of age
- HbA1c 7.0%–10.5%
- T2D managed with diet/exercise alone or stable metformin or SGLT2 inhibitor
- BMI ≥23 kg/m²



Primary endpoint

- Change in HbA1c from baseline to week 26

Secondary glycaemic endpoints

- Change in fasting plasma glucose at weeks 4, 12, 16, and 26
- Achievement of HbA1c ≤6.5% at week 26
- Achievement of HbA1c <7.0% at week 26 in participants with baseline HbA1c ≥7.0%

Other secondary endpoints

- Percent and absolute change in bodyweight from baseline to week 26
- Achievement of weight reduction from baseline of ≥5%, ≥10%, and ≥15% at week 26

Safety and tolerability

Aroda V et al. Symposium CT-SY22-1 presented at the American Diabetes Association 2026 Scientific Sessions. Appendix: Glossary.

SOLSTICE: Baseline characteristics

Solstice

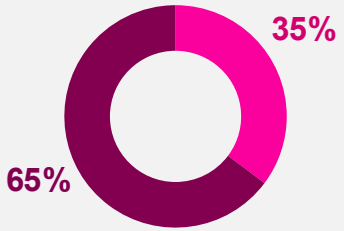
Mean age

58.4 years

Sex

58% 42%

HbA1c



	elecoglipron							
	5 mg (n=38)	15 mg (n=62)	25 mg (n=41)	2.5 mg→ 50 mg q2wt (n=66)	5 mg→ 75 mg q2wt (n=37)	10 mg→ 75 mg q4wt (n=38)	Placebo (n=71)	Semaglutide 3 mg→ 14 mg q4wt (n=51)
HbA1c, %	7.9 (1.0)	7.9 (1.0)	7.9 (1.0)	7.9 (0.9)	8.1 (1.1)	7.8 (1.0)	8.0 (0.8)	7.8 (0.9)
Diabetes duration, years	4.8 (2.7–10.4)	6.6 (2.8–10.4)	6.0 (2.7–10.2)	5.3 (2.3–9.9)	7.3 (3.5–13.0)	6.3 (3.3–10.3)	6.2 (3.2–9.9)	5.9 (1.6–8.3)
Diabetes medication at baseline	27 (71.1)	46 (74.2)	34 (82.9)	50 (75.8)	31 (83.8)	34 (89.5)	52 (73.2)	41 (80.4)
Bodyweight, kg	95.7 (22.7)	101.3 (23.5)	107.1 (20.3)	99.9 (23.9)	98.5 (20.4)	96.4 (20.9)	100.9 (23.2)	97.4 (18.7)
BMI, kg/m^2	33.7 (6.5)	35.8 (8.5)	37.6 (7.5)	35.8 (9.0)	33.0 (6.5)	32.7 (7.0)	34.7 (7.2)	34.4 (5.6)
Macrovascular disease history	1 (2.6)	1 (1.6)	1 (2.4)	2 (3.0)	0	0	2 (2.8)	2 (3.9)
eGFR, mL/min/1.73 m^2	92.3 (19.2)	97.6 (14.8)	95.6 (15.8)	91.3 (16.5)	92.8 (14.0)	95.1 (16.8)	93.7 (15.3)	89.2 (16.4)
Systolic blood pressure, mmHg	129.3 (11.8)	127.5 (13.8)	130.5 (16.4)	130.6 (13.7)	130.7 (12.1)	131.9 (16.6)	127.9 (15.9)	129.8 (10.4)

Elecoglipron and semaglutide arms are described as starting dose → target dose followed by the dose-escalation frequency. All treatment arms reflect once daily oral dosing.
q2wt = every two weeks dose escalation. q4wt = every 4 weeks dose escalation.
Data are mean (standard deviation), n (%), or median (interquartile range).
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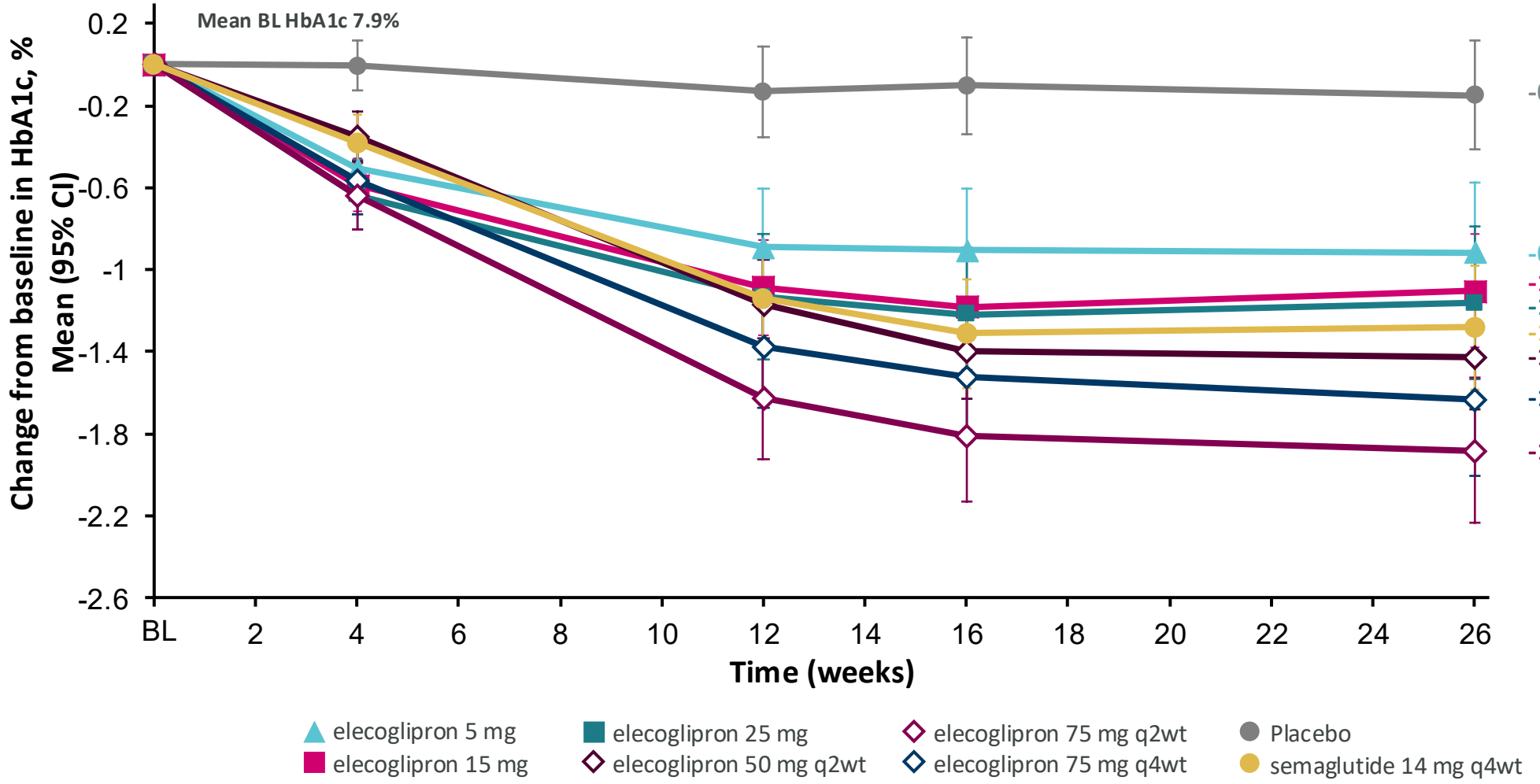
Elecoglipron demonstrated statistically significant and clinically meaningful reductions in HbA1c



Estimated LS means using MMRM, efficacy estimand.

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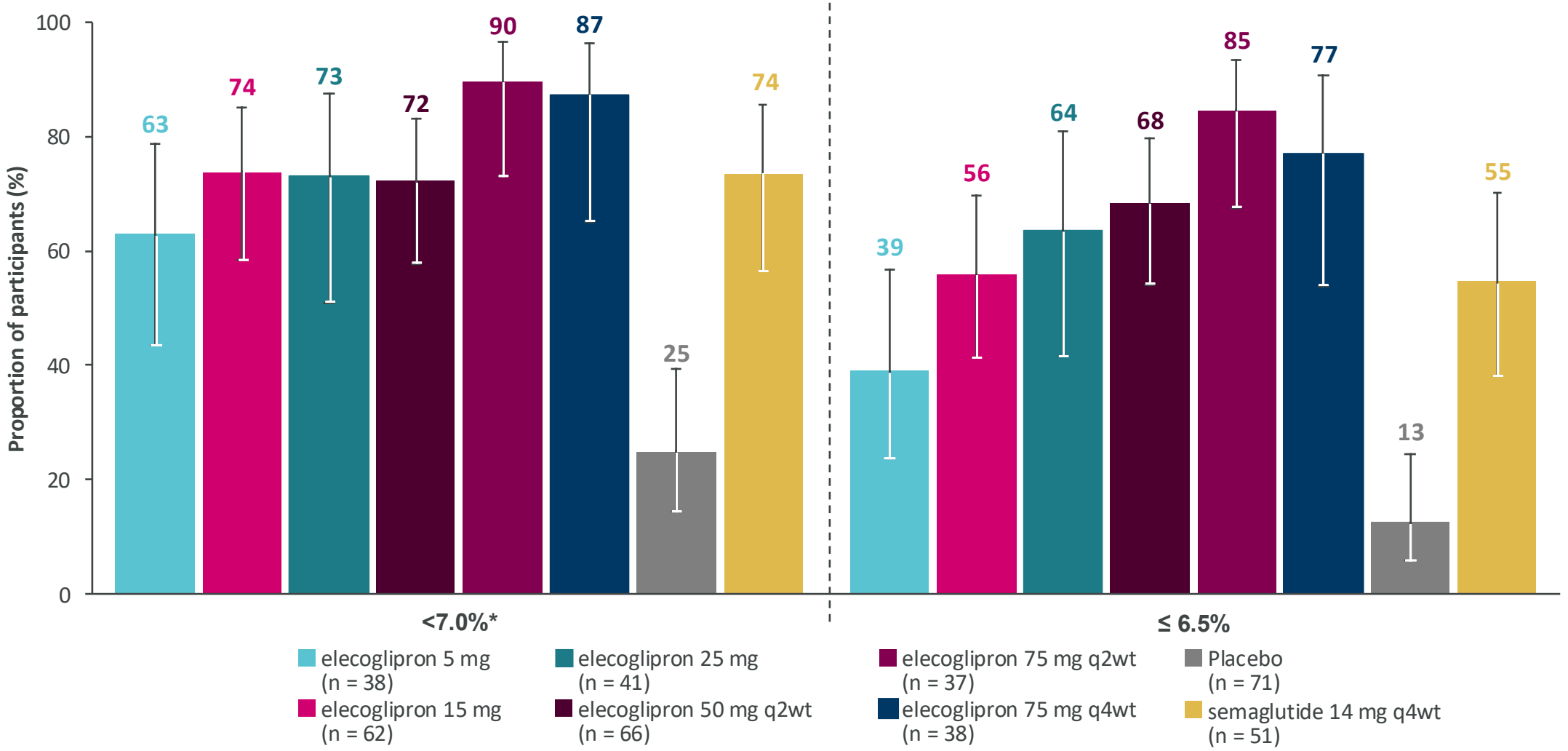
Majority of patients receiving 75mg elecoglipron achieved guideline recommended glycaemic targets



*Proportion of participants who achieved HbA1c < 7.0% who had HbA1c ≥7.0% at baseline.
Estimated proportions and 95% confidence intervals using logic regression, efficacy estimand.
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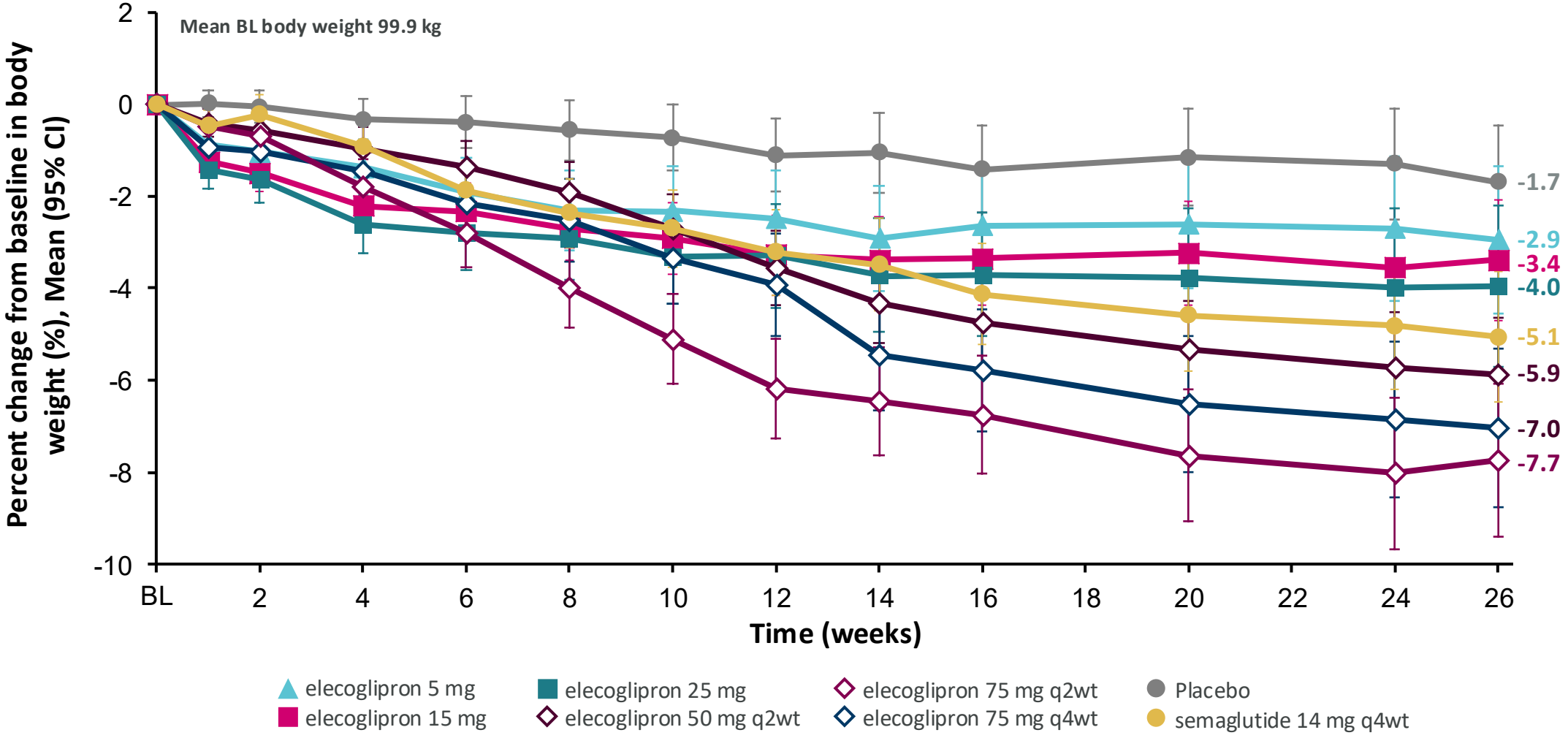
Elecoglipron (doses ≥25 mg) achieved significantly greater reductions in weight compared with placebo

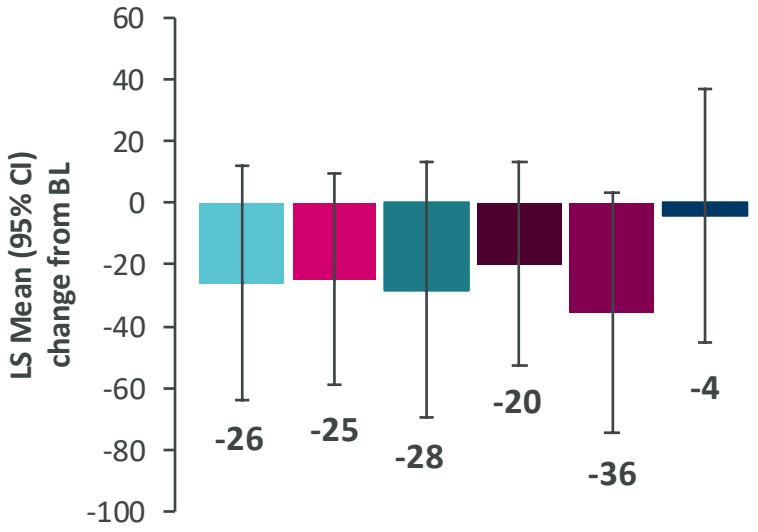


Estimated LS means using MMRM, efficacy estimand.

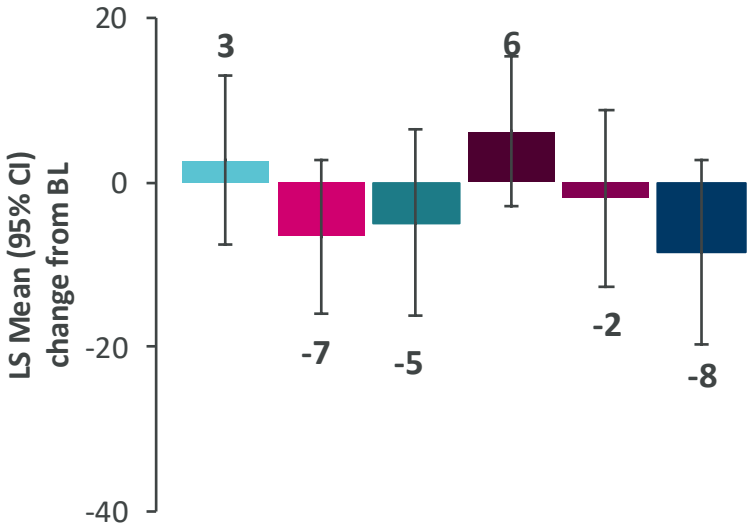
Aroda V et al. Symposium CT-SY22-1 presented at the American Diabetes Association 2026 Scientific Sessions. Appendix: Glossary.

Elecoglipron demonstrated clinically meaningful improvements in cardiometabolic risk factors

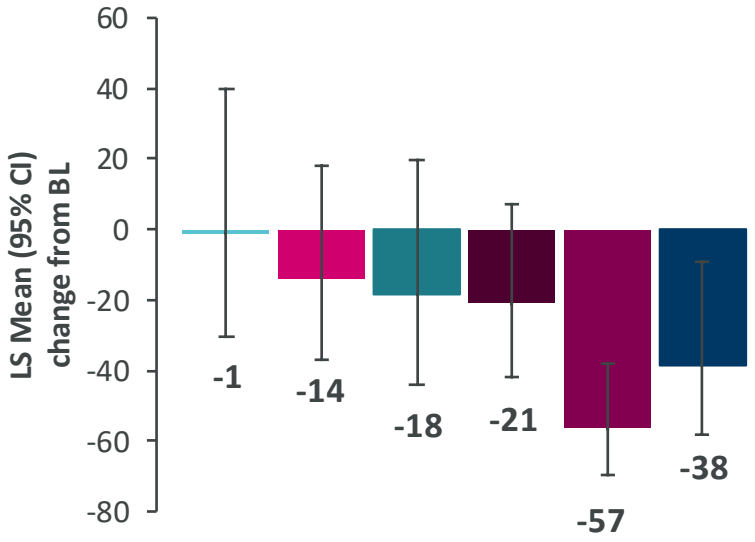
Triglycerides (mg/dL)



LDL-C calculated (mg/dL)



hs-CRP (mg/L)



elecoglipron 5 mg (n = 38)
elecoglipron 15 mg (n = 62)
elecoglipron 25 mg (n = 41)
elecoglipron 50 mg q2wt (n = 66)
elecoglipron 75 mg q2wt (n = 37)
elecoglipron 75 mg q4wt (n = 38)

Reflects placebo adjusted change from baseline. Estimated LS means using MMRM, efficacy estimand.

Aroda V et al. Symposium CT-SY22-1 presented at the American Diabetes Association 2026 Scientific Sessions. Appendix: Glossary.

Safety profile of elecoglipron is consistent with the GLP-1 receptor agonist class

	elecoglipron							
Events, n (%)	5 mg N = 38	15 mg N = 62	25 mg N = 41	2.5 mg→ 50 mg q2wt N = 66	5 mg→ 75 mg q2wt N = 37	10 mg→ 75 mg q4wt N = 38	Placebo N = 71	semaglutide 3 mg→ 14 mg q4wt N = 51
Any AE	24 (63.2)	39 (62.9)	31 (75.6)	47 (71.2)	25 (67.6)	33 (86.8)	45 (63.4)	35 (68.6)
Any SAE	0	5 (8.1)	4 (9.8)	3 (4.5)	2 (5.4)	0	6 (8.5)	1 (2.0)
Deaths	0	0	0	0	0	0	1 (0.01)[1]	0
Any AE leading to dose discontinuation	1 (2.6)	1 (1.6)	7 (17.1)	3 (4.5)	4 (10.8)	6 (15.8)	6 (8.5)	3 (5.9)
Any AE leading to dose interruption	3 (7.9)	5 (8.1)	2 (4.9)	5 (7.6)	3 (8.1)	3 (7.9)	5 (7.0)	4 (7.8)
AEs possibly related to treatment[2]	12 (31.6)	17 (27.4)	26 (63.4)	31 (47.0)	20 (54.1)	24 (63.2)	18 (25.4)	17 (33.3)

1. As assessed by investigator. 2. Haemorrhagic stroke.
Elecoglipron and semaglutide arms described as starting dose → target dose followed by dose-escalation frequency.
Aroda V et al. Symposium CT-SY22-1 presented at the American Diabetes Association 2026 Scientific Sessions. Appendix: Glossary.

Gastrointestinal effects were most common adverse event and were of mild to moderate severity

Events, n (%)	elecoglipron 5 mg N = 38	elecoglipron 15 mg N = 62	elecoglipron 25 mg N = 41	elecoglipron 2.5 mg→ 50 mg q2wt N = 66	elecoglipron 5 mg→ 75 mg q2wt N = 37	elecoglipron 10 mg→ 75 mg q4wt N = 38	Placebo N = 71	semaglutide 3 mg→ 14 mg q4wt N = 51
Nausea	1 (2.6)	10 (16.1)	11 (26.8)	14 (21.2)	9 (24.3)	14 (36.8)	2 (2.8)	9 (17.6)
Constipation	5 (13.2)	6 (9.7)	8 (19.5)	11 (16.7)	3 (8.1)	11 (28.9)	3 (4.2)	3 (5.9)
Diarrhea	3 (7.9)	5 (8.1)	7 (17.1)	9 (13.6)	2 (5.4)	8 (21.1)	11 (15.5)	1 (2.0)
Vomiting	1 (2.6)	6 (9.7)	6 (14.6)	5 (7.6)	4 (10.8)	7 (18.4)	1 (1.4)	2 (3.9)
Dyspepsia	2 (5.3)	1 (1.6)	3 (7.3)	2 (3.0)	6 (16.2)	3 (7.9)	2 (2.8)	1 (2.0)
Decreased appetite	3 (7.9)	1 (1.6)	5 (12.2)	3 (4.5)	2 (5.4)	2 (5.3)	3 (4.2)	1 (2.0)
Headache	1 (2.6)	2 (3.2)	3 (7.3)	4 (6.1)	1 (2.7)	3 (7.9)	4 (5.6)	0
Lipase increased	3 (7.9)	1 (1.6)	0	4 (6.1)	4 (10.8)	2 (5.3)	0	0
Dizziness	3 (7.9)	1 (1.6)	2 (4.9)	2 (3.0)	3 (8.1)	2 (5.3)	8 (11.3)	0
Abdominal pain upper	1 (2.6)	4 (6.5)	1 (2.4)	1 (1.5)	2 (5.4)	3 (7.9)	1 (1.4)	0
Eructation	2 (5.3)	3 (4.8)	2 (4.9)	4 (6.1)	0	1 (2.6)	3 (4.2)	1 (2.0)

Elecoglipron and semaglutide arms described as starting dose → target dose followed by dose-escalation frequency.

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No liver safety signals were observed in SOLSTICE

Participants with ALT, AST or total bilirubin ≥3xULN, emerging post randomisation

	elecoglipron							
n (%)	5 mg N = 38	15 mg N = 62	25 mg N = 41	2.5 mg→ 50 mg q2wt N = 66	5 mg→ 75 mg q2wt N = 37	10 mg→ 75 mg q4wt N = 38	Placebo N = 71	semaglutide 3 mg→ 14 mg q4wt N = 51
ALT	0	1	0	1	1	0	0	1
AST	0	1	0	0	0	0	0	1
Total bilirubin	0	0	0	0	0	0	0	0

*Increases <5x ULN except one SAE of Hepatitis E in 15 mg arm.

Elecoglipron and semaglutide arms are described as starting dose → target dose followed by the dose-escalation frequency.
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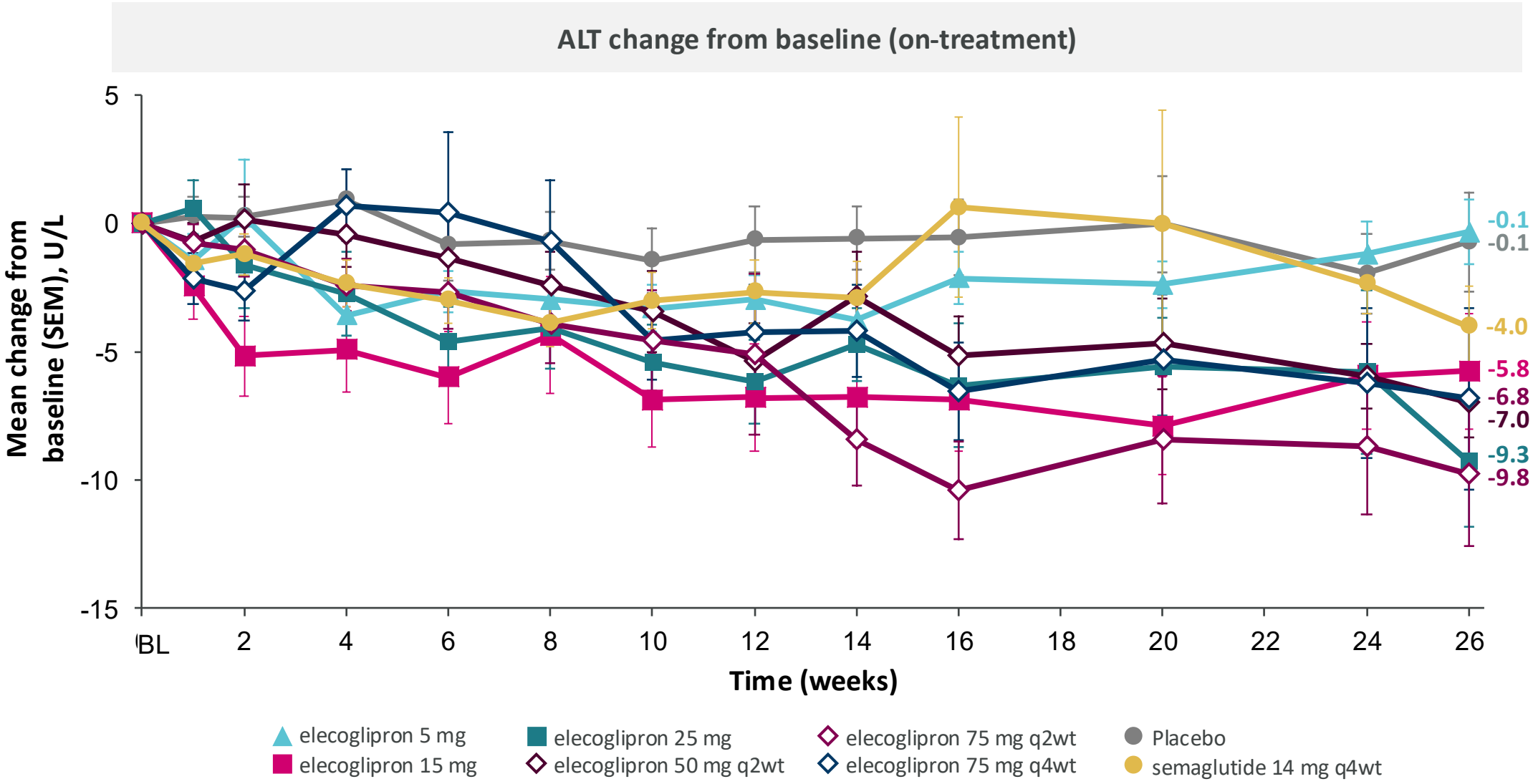
Dose dependent reductions in ALT were observed



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SOLSTICE Phase IIb shows potential for elecoglipron to become important treatment for patients with T2D

- Daily oral elecoglipron achieved clinically meaningful and statistically significant HbA1c and fasting glucose reductions across all doses
- Up to 90% of participants receiving elecoglipron achieved diabetes treatment targets of HbA1c <7% and HbA1c ≤6.5%
- Elecoglipron (doses ≥ 25 mg) achieved significantly greater reductions in weight compared with placebo
- Safety and tolerability profile of elecoglipron was consistent with the GLP-1 RA class

SOLSTICE findings support advancement of elecoglipron into Phase III ELUMINATE programme

Aroda V et al. Symposium CT-SY22-1 presented at the American Diabetes Association 2026 Scientific Sessions. Appendix: Glossary.

Elecoglipron as foundation of AZ weight management portfolio

Mikhail Kosiborod
SVP, LATE CVRM R&D

Phase II VISTA and SOLSTICE trials demonstrate elecoglipron's potential as multi-blockbuster asset

Clinically meaningful weight loss and glycaemic control[1]

- 10.5% weight loss at week 26
- Continuing weight loss at week 36 to 11.8%
- 1.9% HbA1c reduction at week 26

Favourable safety profile

- GI tolerability consistent with GLP-1 RA class
- No unexpected safety signals

Convenient small molecule

- No food or fluid dosing restrictions
- Combinable with other oral small molecules

Positive Phase II data unlocks extensive Phase III programme for elecoglipron

1. Reflects non-placebo adjusted figures. Appendix: Glossary.

Ambitious Phase III programme designed to deliver broad outcome benefits starting H2 2026

Embold

Patients with obesity or overweight

- Elecoglipron monotherapy
- Trials including patients with or without T2D
- Primary endpoint: Change in body weight from baseline (%)

Eluminate

Patients with type 2 diabetes

- Elecoglipron ± dapagliflozin
- Multiple trials across varying patient groups and comparators
- Primary endpoint: Change in HbA1c from baseline (%)

Elevate

Outcomes trials with elecoglipron on background of dapagliflozin + other SoC

HFpEF (Elevate-HF)

- Primary Endpoint: CV death, heart failure hospitalisation, urgent heart failure visit

CKD ± T2D (Elevate-CKD)

- Primary Endpoint: ≥50% sustained decline in eGFR, ESKD, all-cause mortality

Appendix: Glossary.

Weight management portfolio built to address diverse patient needs

Less than 5% of eligible patients with obesity receive treatment today[1]

PATIENT NEED	SOLUTION	ASTRAZENECA ASSET	
Obesity / overweight +/- comorbidities	Oral, no fasting	**elecoglipron** *(oGLP-1 RA)* **eleco combinations**	Ph3[2]
GLP-1 intolerant	Improved GI tolerance	**AZD6234** *(SARA)*	Ph2
Severe obesity with multi-organ complications	Dual/triple combos for max efficacy	**AZD9550** *(GLP-1/GCG RA)* **AZD9550 + AZD6234**	Ph2
Sarcopenia/frailty in older adults	Muscle sparing weight loss	**AZD1043** *(ActRII mAb)*	Ph1
Improved adherence & convenience	Long-acting for infrequent dosing	**SYH2082** *(GLP-1/GIP RA)*	Ph1[2]

Market fragmentation enables a portfolio strategy with multiple paths to leadership

1. IQVIA. Obesity Treatment Rates Increase as GLP-1 Inhibitors Prosper. 2. Trials for these assets are initiating. Appendix: Glossary.

Delivering CVRM growth into 2030 and beyond

Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

Broad-based CVRM pipeline with multiple high-value pipeline assets which address key interrelated diseases

Dyslipidaemia and ASCVD	Hypertension	Heart failure and amyloidosis	Kidney disease	Weight management and diabetes	Liver disease
laroprovstat oPCSK9	**baxdrostat** oASI	**eplontersen** TTR-CM silencer	**balcinrenone/dapa** oMRM/oSGLT2i	**elecoglipron** oGLP-1 RA	**AZD2389** oFAPi
laroprovstat/rosuvastatin oPCSK9/statin	**baxdrostat/dapa** oASI/oSGLT2i	**baxdrostat/dapa** oASI/oSGLT2i	**baxdrostat/dapa** oASI/oSGLT2i	**elecoglipron/dapa** oGLP-1 RA/oSGLT2i	
AZD4954 oLp(a) inhibitor		**balcinrenone/dapa** oMRM/oSGLT2i	**elecoglipron/dapa** oGLP-1 RA/oSGLT2i	**AZD6234** SARA	
Potential combinations		**elecoglipron/dapa** oGLP-1 RA/oSGLT2i	**zibotentan/dapa** oET$_A$ RA/oSGLT2i	**AZD9550** GLP-1/Glucagon RA	
laroprovstat/elecoglipron oGLP-1 RA/oPCSK9		**AZD5462** oral relaxin	**opemalirsen** APOL1	**AZD9550/AZD6234** GLP-1/Glucagon RA/SARA	
laroprovstat/ezetimibe oPCSK9/oNPC1L1i		**cliramitug** TTR fibril depleter	**AZD1613** PAPPA-1mAb	**AZD1043** ActRII mAb	
laroprovstat/AZD4549 oPCSK9/oLp(a)		**eplontersen /cliramitug** TTR silencer/TTR fibril depleter	**AZD4144** oNLRP3	**SYH2082** GLP-1/GIP	

Includes Phase II and Phase III programmes and select Phase I programmes. Appendix: Glossary.

Exciting CVRM portfolio with 5 franchises launching by 2030

BAXFENDY baxdrostat	WAINUA	laroprovstat	balci/dapa, zibo/dapa, baxdro/dapa	elecoglipron, eleco FDCs, AZD6234, AZD9550
UNCONTROLLED AND TREATMENT RESISTANT HYPERTENSION	ATTR-CM	DYSLIPIDAEMIA	CARDIO-RENAL FRANCHISE	WEIGHT MANAGEMENT FRANCHISE
$5bn+[1]	**$5bn+[1]**	**$5bn+[1]**	**$5bn+[1]**	**$5bn+[1]**

1. Peak Year Revenue, non-risk adjusted as per Investor Day (May 2024). Baxfendy PYR estimate includes monotherapy and dapagliflozin combos. Balcinrenone/dapagliflozin and zibotentan/dapagliflozin combinations individually are $3bn-$5bn opportunities. Weight management franchise includes several medicines with multi-blockbuster potential. Appendix: Glossary.

Closing Remarks and Q&A Session

Key External Expert

Vanita R. Aroda, MD
DIRECTOR, DIABETES CLINICAL RESEARCH, BRIGHAM AND WOMEN'S HOSPITAL
ASSOCIATE PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL

AstraZeneca Leadership

Pascal Soriot
CHIEF EXECUTIVE OFFICER

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EVP, BIOPHARMACEUTICALS BUSINESS

Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

Mina Makar
SVP, GLOBAL CVRM BUSINESS

Mikhail Kosiborod
SVP, LATE CVRM R&D

Appendix

Glossary

ADA	American Diabetes Association
ADC	antibody-drug conjugate
AE	adverse event
ALT	alanine aminotransferase
APOL1	apolipoprotein L1
ASCVD	atherosclerotic cardiovascular disease
ASI	aldosterone synthase inhibitor
AST	aspartate aminotransferase
ATTR-CM	transthyretin amyloid cardiomyopathy
AZ	AstraZeneca
BL	baseline
BMI	body mass index
BW	body weight
CKD	chronic kidney disease
CRP	C-reactive protein
CV	cardiovascular
CVRM	cardiovascular, renal and metabolism
DBP	diastolic blood pressure
DTC	direct-to-consumer
eGFR	estimated glomerular filtration rate
ESKD	end-stage kidney disease
ETA	endothelin A
FDC	fixed-dose combination
GCG	glucagon
GI	gastrointestinal
GIP	glucose-dependent insulinotropic polypeptide
GLP-1	glucagon-like peptide-1
HbA1c	glycated haemoglobin
HF	heart failure
HFpEF	heart failure with preserved ejection fraction
hMPV/RSV	human metapneumovirus/respiratory syncytial virus
IO	immuno-oncology
IRA	Inflation Reduction Act
LDL-C	low-density lipoprotein cholesterol
LSM	least-squares mean
M&A	mergers and acquisitions
mAb	monoclonal antibody
MMRM	mixed model for repeated measures
MRM	mineralocorticoid receptor modulator
NME	new molecular entity
NPC1L1i	Niemann-Pick C1-like 1 protein
oGLP-1	oral glucagon-like peptide-1
oLp(a)	oral lipoprotein(a) inhibitor
oPCSK9	oral proprotein convertase subtilisin/kexin type 9
PYR	peak year revenue
qwt	every week titration
q2wt	every two-week titration
q4wt	every four-week titration
R&D	research and development
RA	receptor agonist
SAE	serious adverse event
SARA	selective amylin receptor agonist
SBP	systolic blood pressure
SD	standard deviation
SGLT2i	sodium-glucose cotransporter 2 inhibitor
SoC	standard of care
T2D	type 2 diabetes
TTR	transthyretin
ULN	upper limit of normal
WL	weight loss

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