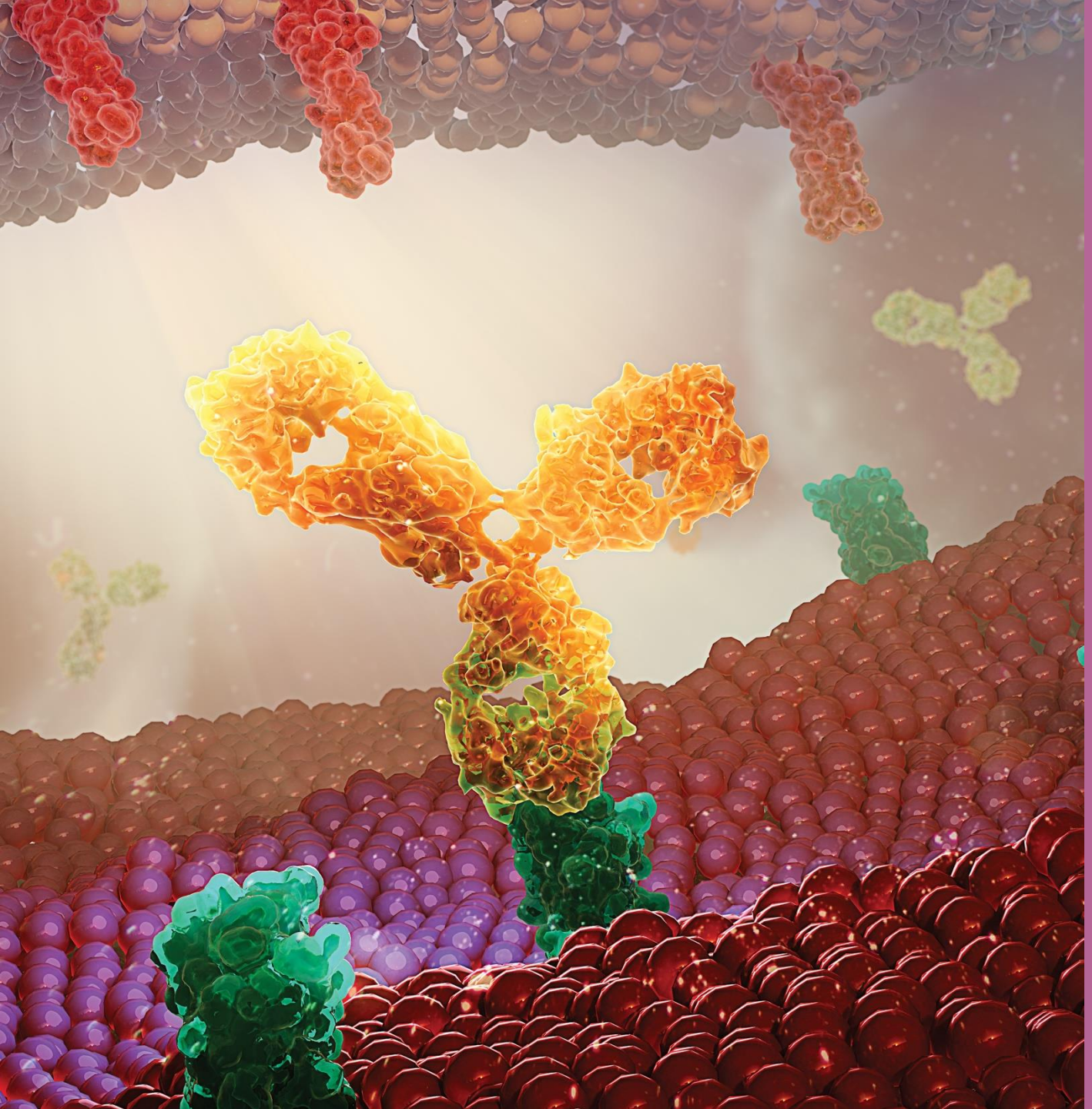


Meet AZN Management: ASCO

Investor Event

1 June 2026

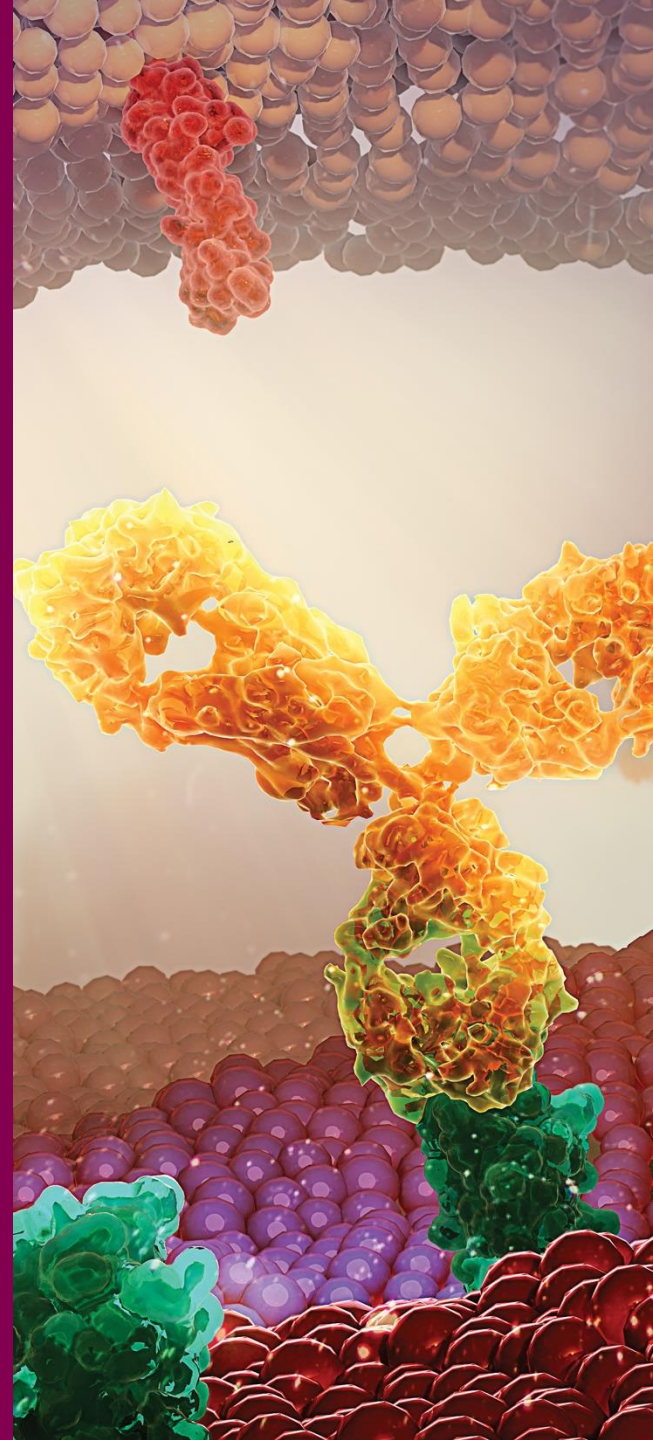
Forward-looking statements

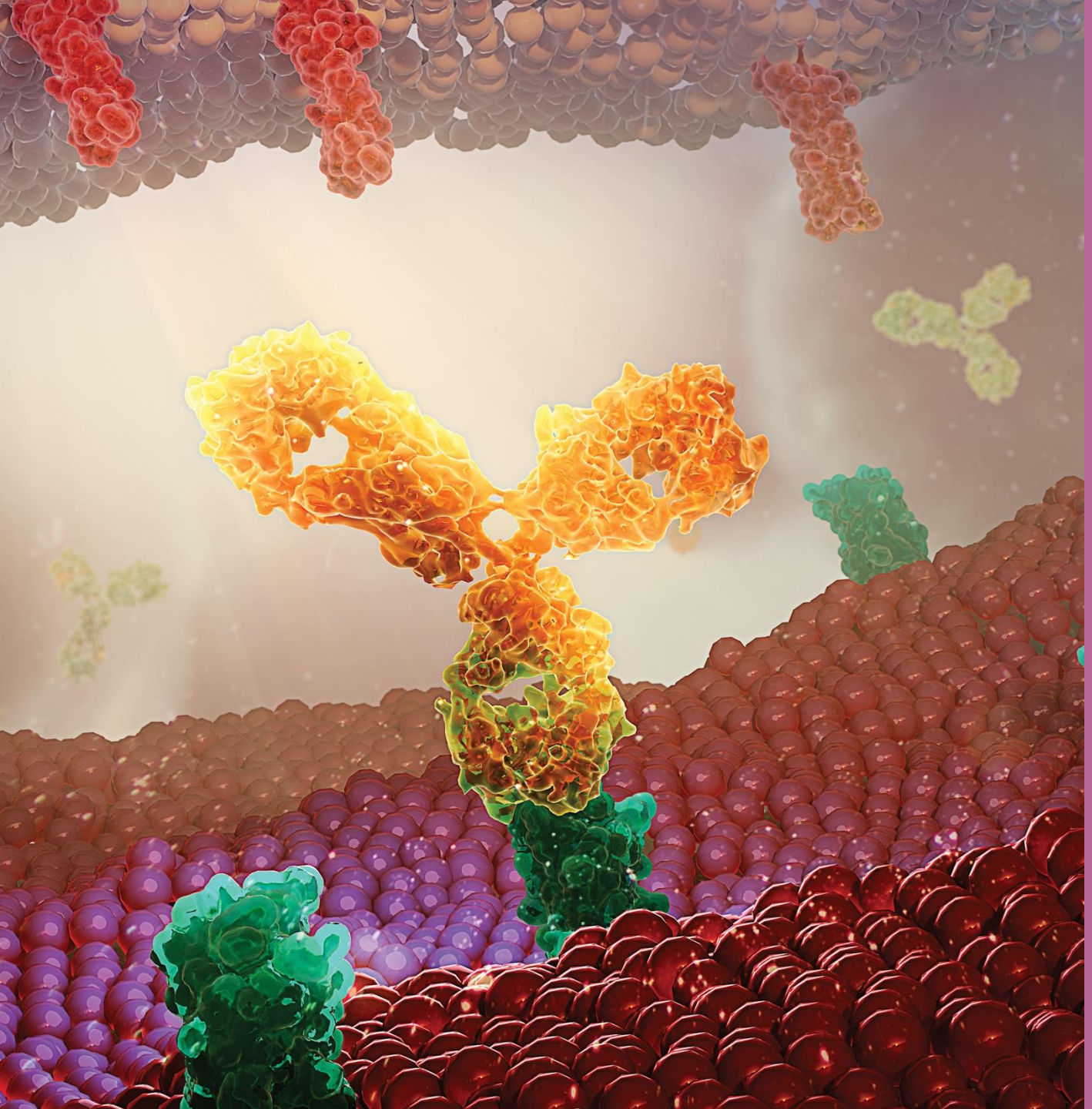
In order, among other things, to utilise the 'safe harbour' provisions of the US Private Securities Litigation Reform Act of 1995, AstraZeneca (hereafter 'the Group') provides the following cautionary statement:

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.

AstraZeneca @ ASCO 2026

Furthering the AstraZeneca ambition	**Pascal Soriot,** Chief Executive Officer
Redefining management of embolisation-eligible liver cancer Including Q&A session	**Ghassan Abou-Alfa,** Attending Physician and Professor at Memorial Sloan Kettering Cancer Center
Realising our ambition in Oncology	**Dave Fredrickson,** EVP, Oncology Haematology Business
Establishing the pipeline for tomorrow	**Susan Galbraith,** EVP, Oncology Haematology R&D
Q&A session	**Dave Fredrickson,** EVP, Oncology Haematology Business





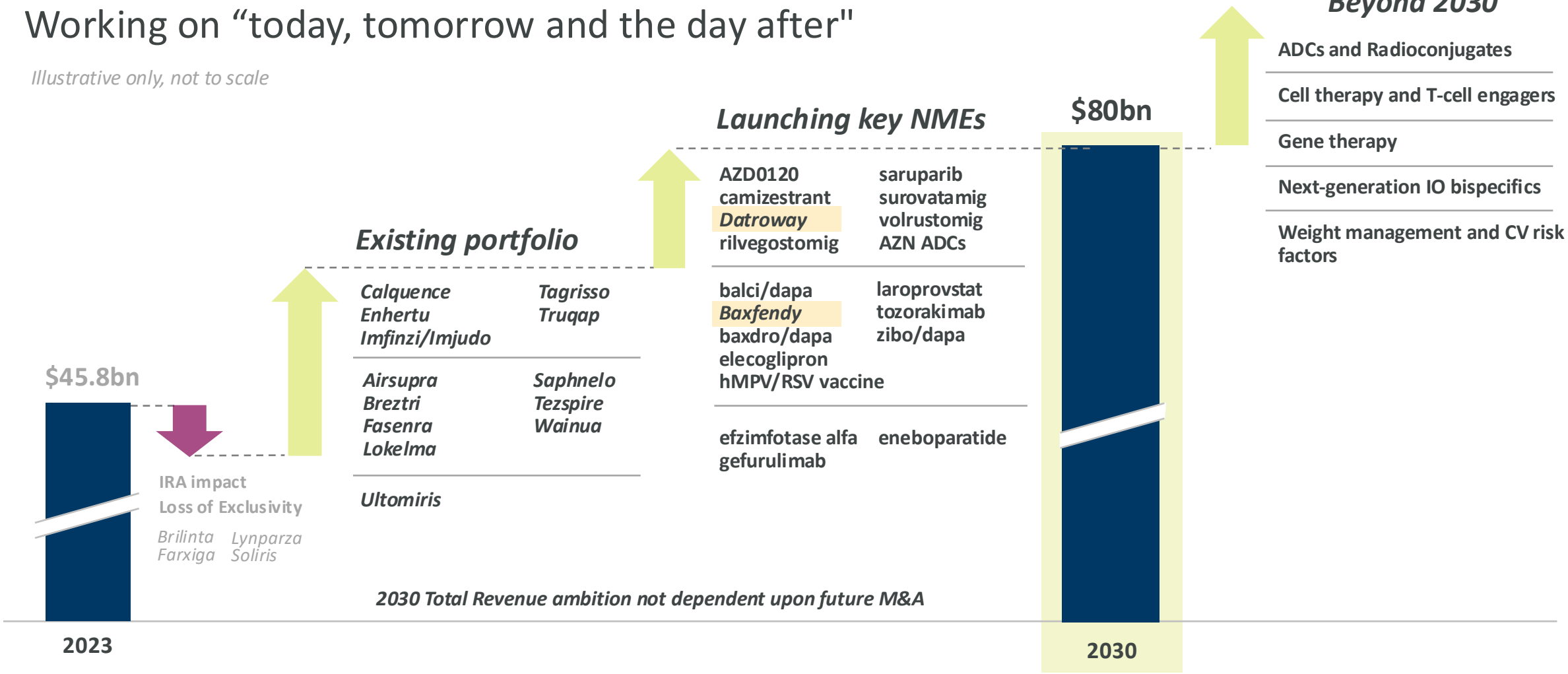
Furthering the AstraZeneca ambition

Pascal Soriot
CHIEF EXECUTIVE OFFICER

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. Iaroprovstat previously AZD0780 and elecoglipron previously AZD5004.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Amgen (*Tezspire*), Ionis (*Wainua*), Merck & Co., Inc. (*Lynparza*). Appendix: Glossary.

Phase III pipeline momentum continues across 2026

H1 2026

EMERALD-3 | *Imfinzi + Imjudo*
embolisation-eligible hepatocellular carcinoma

VOLGA | *Imfinzi ± Imjudo* **NEW[1]**
muscle-invasive bladder cancer

OBERON/TITANIA/MIRANDA |
tozorakimab COPD

I CAN | *Ultomiris*
IgA Nephropathy

TMA-313 | *Ultomiris*
HSCT-TMA (adults)

HICKORY/CHESTNUT/MULBERRY |
efzimfotase alfa Hypophosphatasia

H2 2026

AVANZAR | *Datroway + Imfinzi*
1L non-squamous/non-squamous TROP2+ NSCLC

TROPION-Lung15 | *Datroway ± Tagrisso*
2L *EGFR*m NSCLC

PACIFIC-9 | *Imfinzi +* oleclumab/ monalizumab
unresectable stage III NSCLC

SAFFRON | *Tagrisso + Orpathys*
2L *EGFR*m NSCLC

SERENA-4 | camizestrant
1L HR+ HER2- advanced breast cancer

CLARITY-Gastric01 | sonesitatug vedotin 2L+
CLDN18.2+ gastric cancer

CROSSING | *Tezspire*
eosinophilic esophagitis

CARDIO-TTRansform | *Wainua*
ATTR-CM

TILIA | tozorakimab
lower respiratory tract disease

~~**ARTEMIS** | *Ultomiris*~~
~~CSA-AKI~~

Readouts in 2026 represent additional combined risk-adjusted >$10bn PYR opportunity[2]

Key upcoming pipeline catalysts are defined by a threshold of non-risk adjusted global peak year revenue expectations as of 10 February 2026. 1. Readout announced since AstraZeneca Q1 2026 results. 2. Combined risk-adjusted Peak-Year Revenue of all readouts in 2026, including those depicted on the slide. Individual PYR may occur at different timepoints for different trials. Collaboration partners: Daiichi Sankyo (*Datroway*), Hutchmed (*Orpathys*), Ionis (*Wainua*), Amgen (*Tezspire*), Innate Pharma (monalizumab). Appendix: Glossary.

Oncology | BioPharma | Rare

Strategically investing to deliver growth beyond 2030

	CURRENT PROGRESS	NEXT WAVE OF INNOVATION
Weight management and CV risk factors	– **laroprovstat** PhIII data 2027 – **elecoglipron** PhIII initiating – details at ADA	– Ongoing trials targeting **GLP-1-GCG & amylin** – **Long-acting agents** and **new mechanisms**
ADCs and Radioconjugates	– **8 wholly owned** ADCs in clinic, 3 in Phase III – VECTRA-01 moves **(225Ac) zada-gu** into PhIII	– **Novel linker payload** combinations – **Dual payload** ADCs – *first data at AACR 2026*
Next-gen IO bispecifics	– **14 PhIII trials** across 8 tumour types – 4 Phase III trials in combination with ADCs	– Broad portfolio enabling **novel, unique combinations**
Cell therapy and T-cell engagers	– **AZD0120** first PhIII DURGA-4 started in 2026 – 2 PhIII trials ongoing for **surovatamig**	– **Multiple approaches to CAR-T and TCR-T** – **TCE platforms** with improved therapeutic window
Gene therapy and gene editing	– **First gene therapy** in clinic	– **Additional gene therapy programmes**

Continued strong clinical trial execution means R&D expense anticipated to remain at upper end of low-20%s of Total Revenue

Appendix: Glossary.

AstraZeneca

at ASCO 2026

>80 abstract acceptances

52 poster presentations

25 oral presentations

Transforming care today

- ***Imfinzi/Imjudo*** | **EMERALD-3** (LBA4000), **POTOMAC** (#4624)
- **camizestrant** | **SERENA-6** (LBA1007)
- ***Datroway*** | **TROPION-Breast02** (#1002)
- ***Enhertu*** | **DESTINY-Breast09** (#1021)
- **anselamimab** | **CARES programme** (#7501)

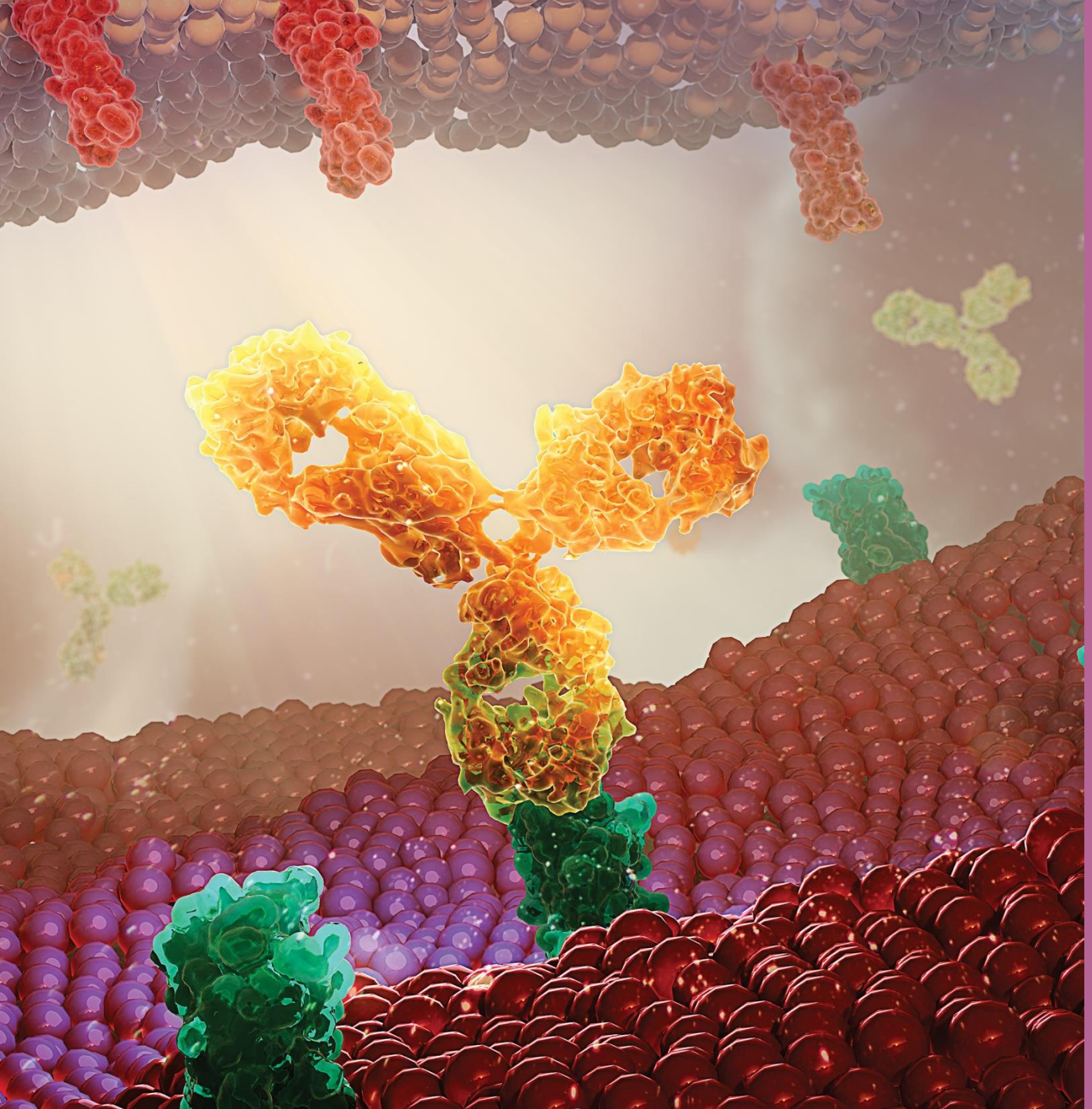
Establishing the pipeline for tomorrow

- **puxi-sam** B7-H4 ADC | **BLUESTAR** (#4106) US BTD
- **sone-ve** Cldn18.2 ADC | **CLARITY-PanTumor01** (#4023)
- **rilvegostomig** PD-1/TIGIT mAb | **GEMINI-HBP** (#4105), **DESTINY-Gastric03** (#4022)
- **volrustomig** PD-1/CTLA-4 mAb | **eVOLVE-02** (#6025)
- **AZD3470** PRMT5i | **PRIMAVERA** (#7003)

Data spans 23 approved and potential medicines across >15 tumour types

Collaboration partners: Daiichi Sankyo (*Datroway*).

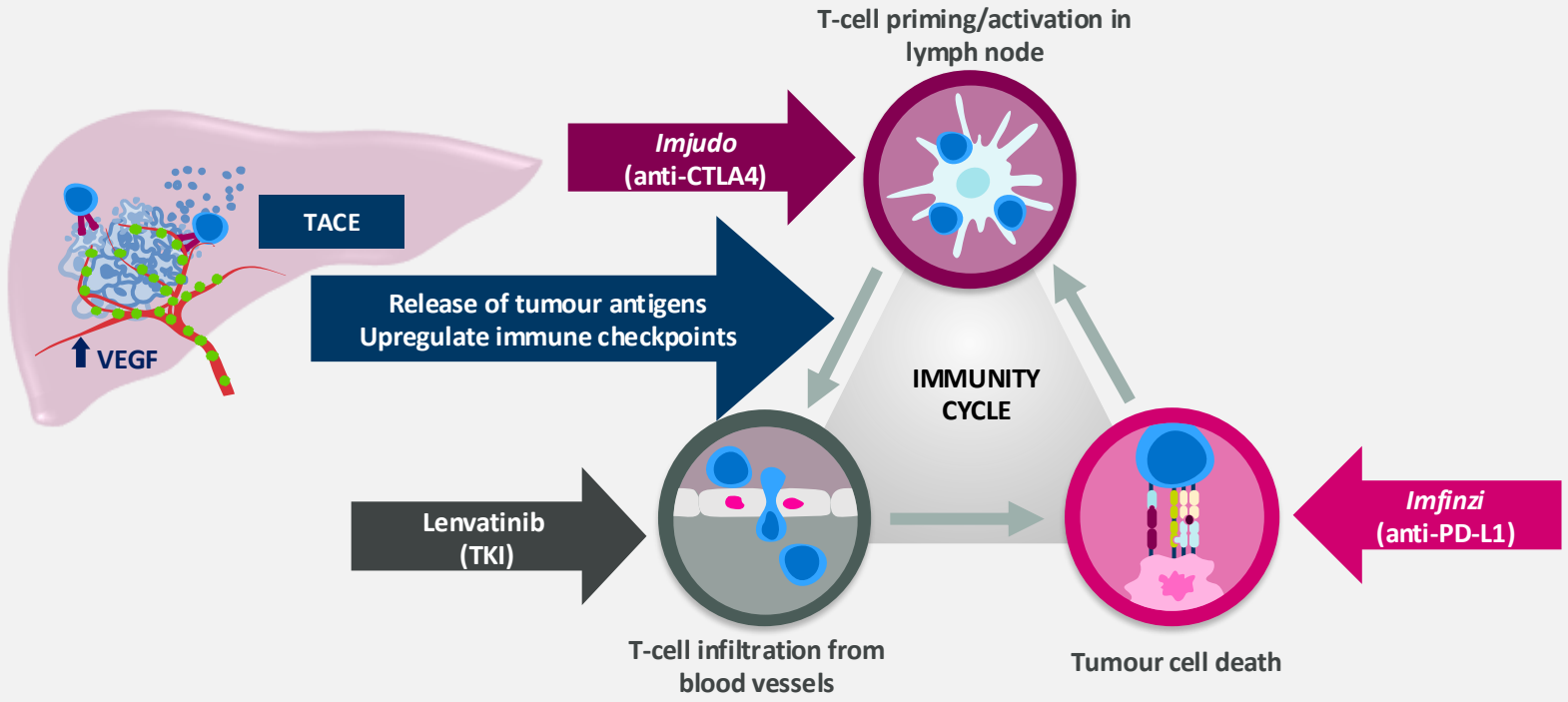
Appendix: Glossary.



EMERALD-3

Dr Ghassan Abou-Alfa
ATTENDING PHYSICIAN, PROFESSOR OF MEDICINE, MEMORIAL SLOAN KETTERING CANCER CENTER

Rationale for STRIDE in embolisation-eligible HCC



EMERALD-3

Role of STRIDE in combination with TACE[1] and anti-angiogenic therapy

Value of STRIDE demonstrated in HIMALAYA in advanced HCC with sustained OS benefit through 6 years of follow-up vs sorafenib[2]

1. Abou-Alfa G et al. Abstract LBA4000 presented at the American Society of Clinical Oncology 2026. 2. Sangro B, et al. Abstract 149P presented at the European Society of Medical Oncology 2025.
Appendix: Glossary.

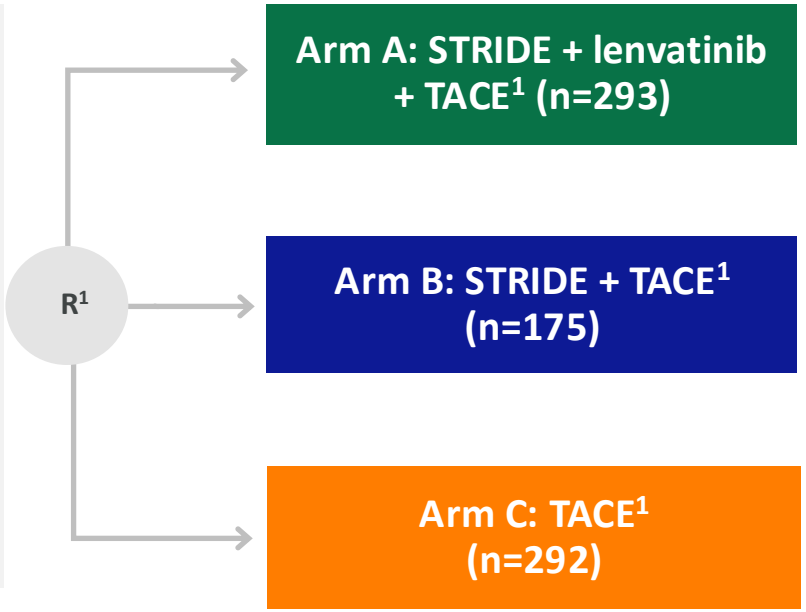
EMERALD-3: Bringing STRIDE to unresectable eeHCC

Study population:

- Pathologically or radiologically confirmed HCC
- Not amenable to curative treatment, but amenable to embolisation
- Child-Pugh A
- ECOG PS 0 or 1
- No extrahepatic disease
- Excludes Vp3 and Vp4
- No prior systemic therapy

Stratification factors:

- Geography (JPN vs Asia ex-JPN vs ROW)
- Prior palliative locoregional therapy (>6 months vs <6 months vs none)
- Baseline tumour burden (>7 vs ≤7)



[1]Participants were randomised 1:1:1 to Arms A, B, C until each arm reached 175 participants; following this, randomisation continued 1:1 to Arms A and C until reaching ~275 participants in these two arms

Primary endpoint:

- PFS (Arm A vs C; BICR RECIST v1.1)

Key secondary endpoints:

- OS (Arm A vs C)
- PFS (Arm B vs C; BICR RECIST v1.1)
- OS (Arm B vs C)

Other secondary endpoints:

- ORR, DCR, DoR, TTP, PFS2
- PROs, safety, QoL

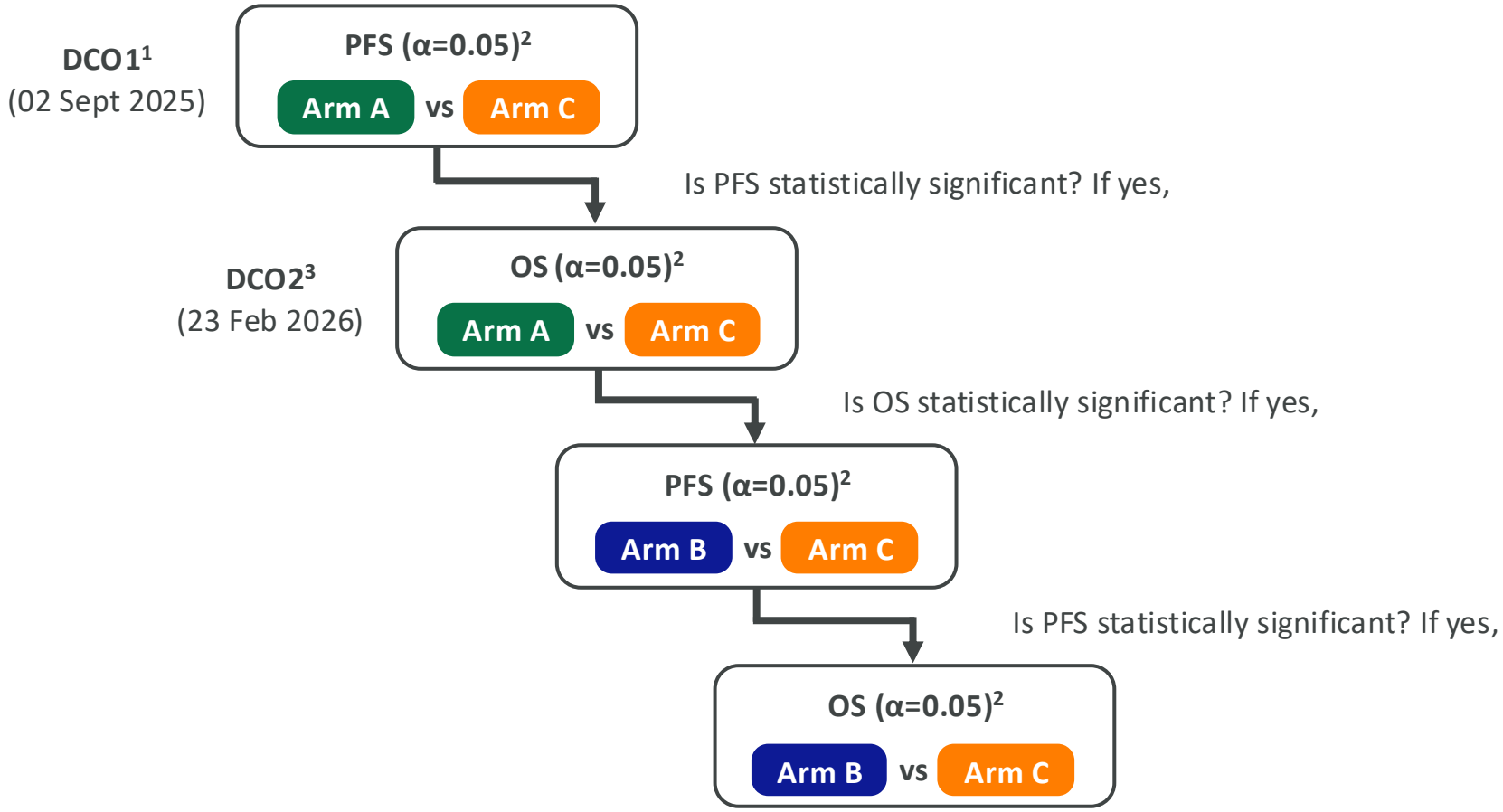
1. DEB-TACE or cTACE. TACE starts at least 7 days after *Imjudo* + *Imfinzi* ± lenvatinib for Arms A and B or within 7 days of randomisation for Arm C, followed by additional procedures at the investigator's discretion.

Abou-Alfa G et al. Abstract LBA4000 presented at the American Society of Clinical Oncology 2026

Appendix: Glossary.

EMERALD-3: Statistical considerations

Multiple testing procedure



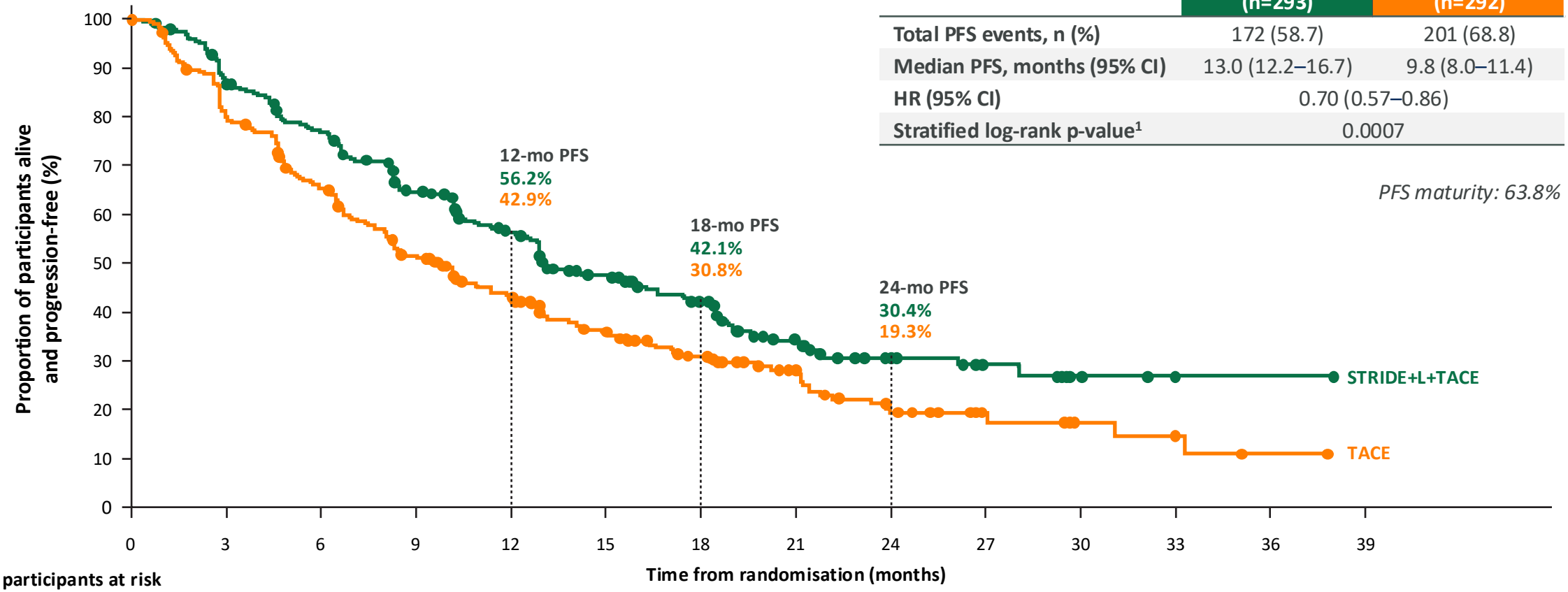
EMERALD-3 continues to follow participants for final OS

1. Interim PFS analysis for Arm A vs Arm C. 2. 2-sided α . 3. Interim OS analysis for Arm A vs Arm C..
Abou-Alfa G et al. Abstract LBA4000 presented at the American Society of Clinical Oncology 2026.
Appendix: Glossary.

EMERALD-3: Statistically significant and clinically meaningful PFS benefit with STRIDE + lenvatinib + TACE

	STRIDE+L+TACE (n=293)	TACE (n=292)
Total PFS events, n (%)	172 (58.7)	201 (68.8)
Median PFS, months (95% CI)	13.0 (12.2–16.7)	9.8 (8.0–11.4)
HR (95% CI)	0.70 (0.57–0.86)	
Stratified log-rank p-value[1]	0.0007	

PFS maturity: 63.8%



Number of participants at risk

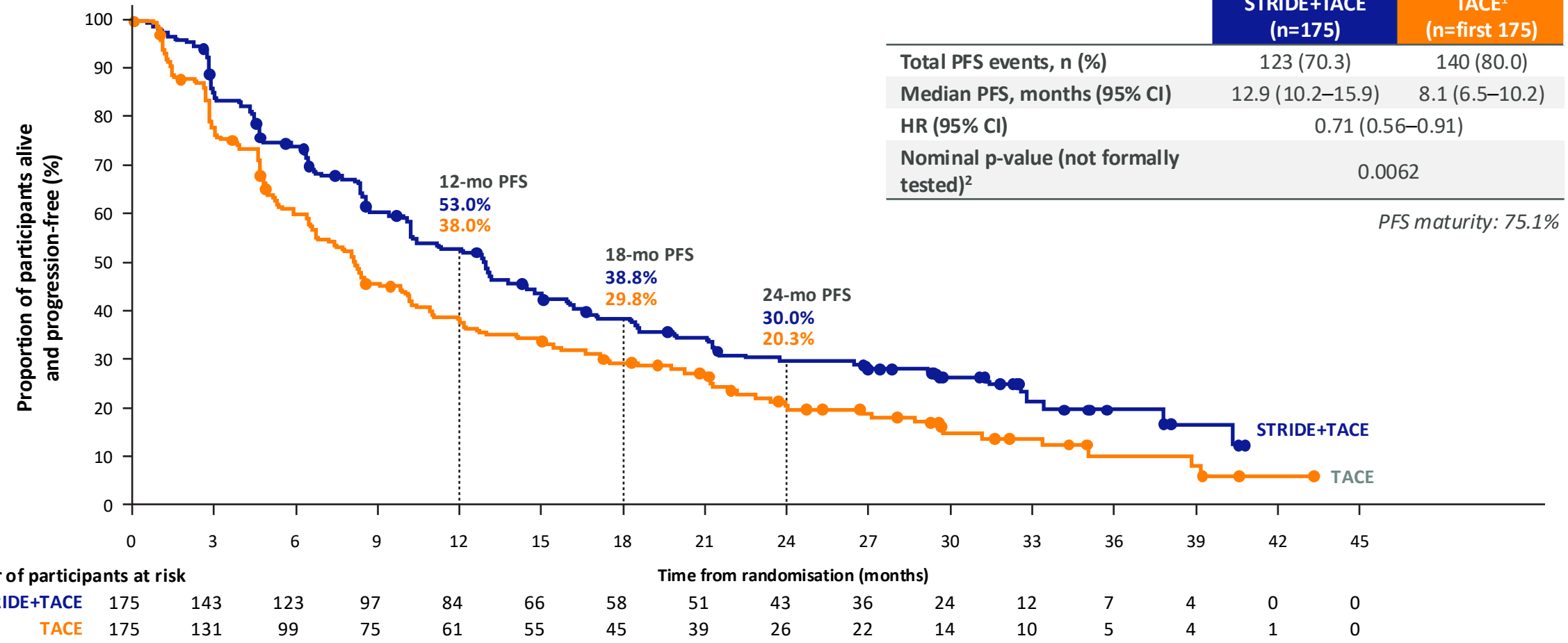
STRIDE+L+TACE	293	245	213	172	140	104	80	49	28	12	3	1	1	0
TACE	292	229	181	138	105	78	57	33	20	10	6	4	1	0

DCO1: Sep 2, 2025. Median (range) duration of follow up was 11.0 (0.03–38.0) months for STRIDE+L+TACE and 8.3 (0.03–37.8) months for TACE. PFS was assessed by BICR per RECIST v1.1. 1. p-value boundary threshold to declare statistical significance was 0.0315.

Abou-Alfa G et al. Abstract LBA4000 presented at the American Society of Clinical Oncology 2026.

Appendix: Glossary.

EMERALD-3: Strong trend to PFS benefit with STRIDE + TACE



	STRIDE+TACE (n=175)	TACE[1] (n=first 175)
Total PFS events, n (%)	123 (70.3)	140 (80.0)
Median PFS, months (95% CI)	12.9 (10.2–15.9)	8.1 (6.5–10.2)
HR (95% CI)	0.71 (0.56–0.91)	
Nominal p-value (not formally tested)[2]	0.0062	

PFS maturity: 75.1%

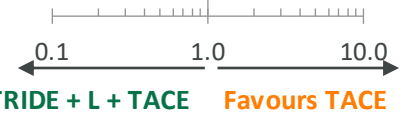
DCO2: Feb 23, 2026. Median (range) duration of follow up was 10.3 (0.03–40.7) months for STRIDE+TACE and 7.7 (0.03–43.3) months for TACE. 1. Includes first 175 participants randomised to this treatment arm. 2. Arm B PFS is descriptive per the pre-specified multiplicity / hierarchy; no formal statistical inference is claimed.

Abou-Alfa G et al. Abstract LBA4000 presented at the American Society of Clinical Oncology 2026.

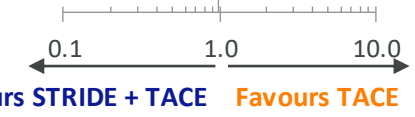
Appendix: Glossary.

EMERALD-3: Broadly consistent benefit for STRIDE regimens observed across key subgroups

Arm A vs Arm C	HR (95% CI)	STRIDE+L +TACE (n/N)	TACE (n/N)
All subjects	0.70 (0.57–0.86)	172/293	201/292
Geographic region			
Japan	0.29 (0.11–0.67)	7/22	19/22
Asia without Japan	0.71 (0.54–0.91)	110/172	124/173
Rest of world	0.88 (0.61–1.27)	55/99	58/97
Baseline tumour burden			
Within Up-to-7 (≤7)	0.71 (0.50–1.01)	57/115	72/115
Beyond Up-to-7 (>7)	0.71 (0.55–0.91)	115/178	129/177
Virology status			
Hepatitis B	0.66 (0.49–0.89)	79/131	99/138
Hepatitis C	0.72 (0.40–1.30)	20/39	25/37
Viral aetiology			
Yes	0.69 (0.53–0.89)	100/173	129/183
No	0.75 (0.54–1.04)	72/120	72/109
ALBI grade			
1	0.67 (0.51–0.87)	104/188	119/183
≥2	0.84 (0.60–1.15)	68/105	82/109



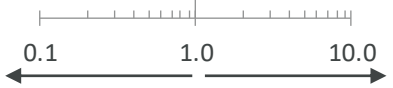
Arm B vs Arm C	HR (95% CI)	STRIDE +TACE (n/N)	TACE (n/N)
All subjects	0.71 (0.56–0.91)	123/175	140/175
Geographic region			
Japan	1.35 (0.54–3.51)	11/11	10/10
Asia without Japan	0.70 (0.53–0.93)	92/137	107/138
Rest of world	0.67 (0.36–1.22)	20/27	23/27
Baseline tumour burden			
Within Up-to-7 (≤7)	0.89 (0.58–1.37)	44/60	41/60
Beyond Up-to-7 (>7)	0.63 (0.47–0.85)	79/115	99/115
Virology status			
Hepatitis B	0.70 (0.51–0.97)	67/99	82/106
Hepatitis C	0.92 (0.42–2.00)	13/19	15/18
Viral aetiology			
Yes	0.75 (0.56–1.00)	81/119	100/129
No	0.61 (0.39–0.95)	42/56	40/46
ALBI grade			
1	0.59 (0.42–0.81)	65/105	85/111
≥2	1.01 (0.69–1.47)	58/70	55/64



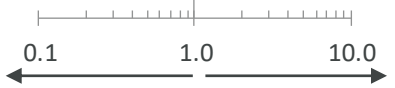
DCO1 for Arm A vs Arm C: Sep 2, 2025. DCO2 for Arm B vs Arm C: Feb 23, 2026. PFS was assessed by BICR per RECIST v1.1.
Abou-Alfa G et al. Abstract #LBA4000 presented at the American Society of Clinical Oncology 2026
Appendix: Glossary.

EMERALD-3: Pre-planned exploratory analysis shows Arm A vs B PFS improvement in patients with non-viral aetiology

Arm A vs Arm B	HR (95% CI)	STRIDE+L+TACE[1] (n/N)	STRIDE+TACE (n/N)
All subjects	0.94 (0.73–1.21)	125/175	123/175
Geographic region			
Japan[2]	NC	5/10	11/11
Asia without Japan	1.00 (0.75–1.33)	98/137	92/137
Rest of world	1.23 (0.67–2.30)	22/28	20/27
Baseline tumour burden			
Within Up-to-7 (≤7)	0.81 (0.52–1.25)	37/60	44/60
Beyond Up-to-7 (>7)	1.03 (0.76–1.40)	88/115	79/115
AFP level			
≤400 ng/mL	1.04 (0.69–1.57)	47/66	45/66
>400 ng/mL	0.79 (0.49–1.26)	33/43	38/46
BCLC stage			
A	0.95 (0.53–1.71)	23/35	23/33
B	0.90 (0.65–1.23)	75/99	82/114
C	1.17 (0.65–2.16)	27/41	18/28
ECOG PS			
0	0.89 (0.67–1.17)	97/139	103/145
1	1.30 (0.73–2.34)	28/36	20/30
Virology status			
Hepatitis B	1.07 (0.76–1.49)	74/106	67/99
Hepatitis C	1.14 (0.52–2.49)	13/18	13/19
Viral aetiology			
Yes	1.06 (0.79–1.44)	88/125	81/119
No	0.70 (0.44–1.09)	37/50	42/56
Child-Pugh score			
Class A – score of 5	0.99 (0.75–1.30)	108/151	98/144
Class A – score of 6	0.85 (0.45–1.59)	16/23	25/31
ALBI grade			
1	1.06 (0.77–1.48)	78/119	65/105
≥2	0.90 (0.61–1.32)	47/56	58/70



Favours STRIDE + L + TACE Favours STRIDE + TACE



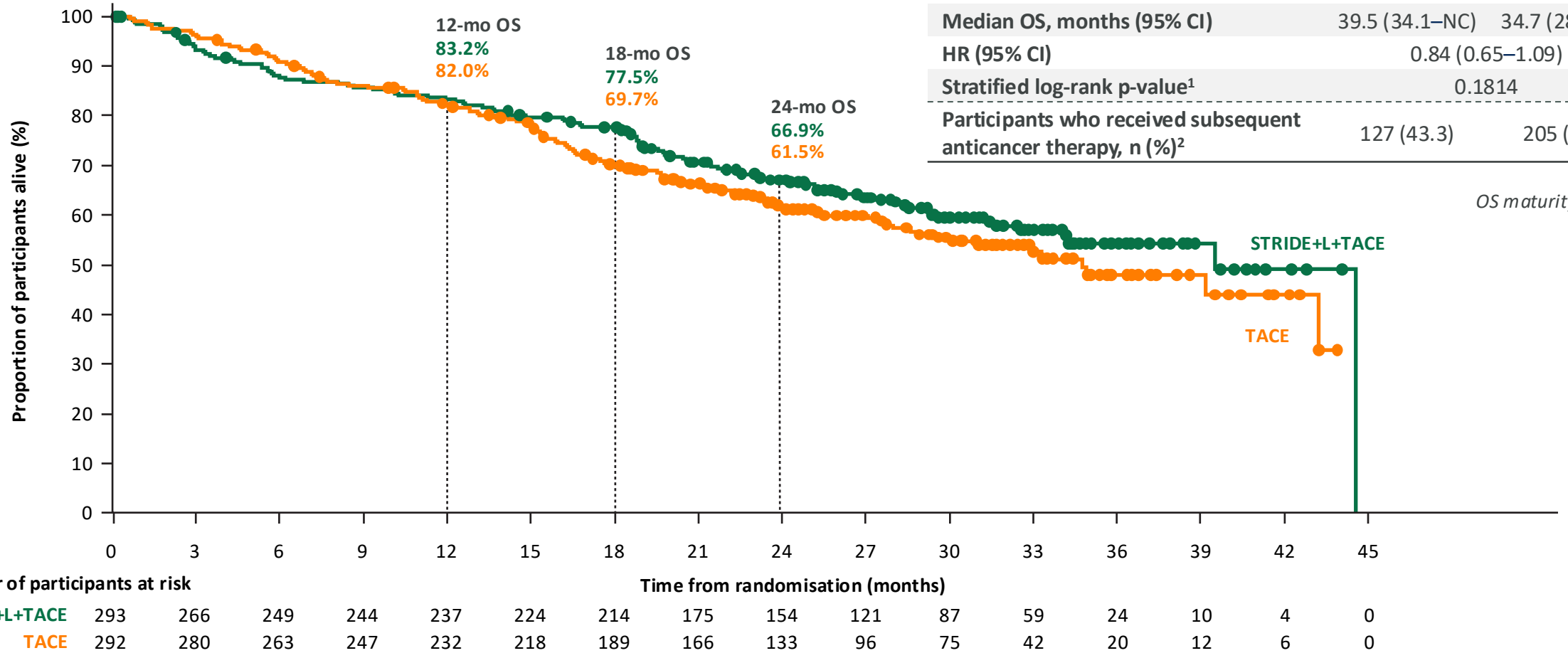
Favours STRIDE + L + TACE Favours STRIDE + TACE

DCO2: Feb 23, 2026. PFS was assessed by BICR per RECIST v1.1. 1. First 175 participants. 2. Per the prespecified analysis if there are fewer than 20 events in a subgroup, the hazard ratio will not be derived.
Abou-Alfa G et al. Abstract #LBA4000 presented at the American Society of Clinical Oncology 2026
Appendix: Glossary.

EMERALD-3: Trend to OS benefit with STRIDE + lenvatinib + TACE

	STRIDE+L+TACE (n=293)	TACE (n=292)
Total number of deaths, n (%)	112 (38.2)	124 (42.5)
Median OS, months (95% CI)	39.5 (34.1–NC)	34.7 (28.8–NC)
HR (95% CI)	0.84 (0.65–1.09)	
Stratified log-rank p-value[1]	0.1814	
Participants who received subsequent anticancer therapy, n (%)[2]	127 (43.3)	205 (70.2)

OS maturity: 40.3%



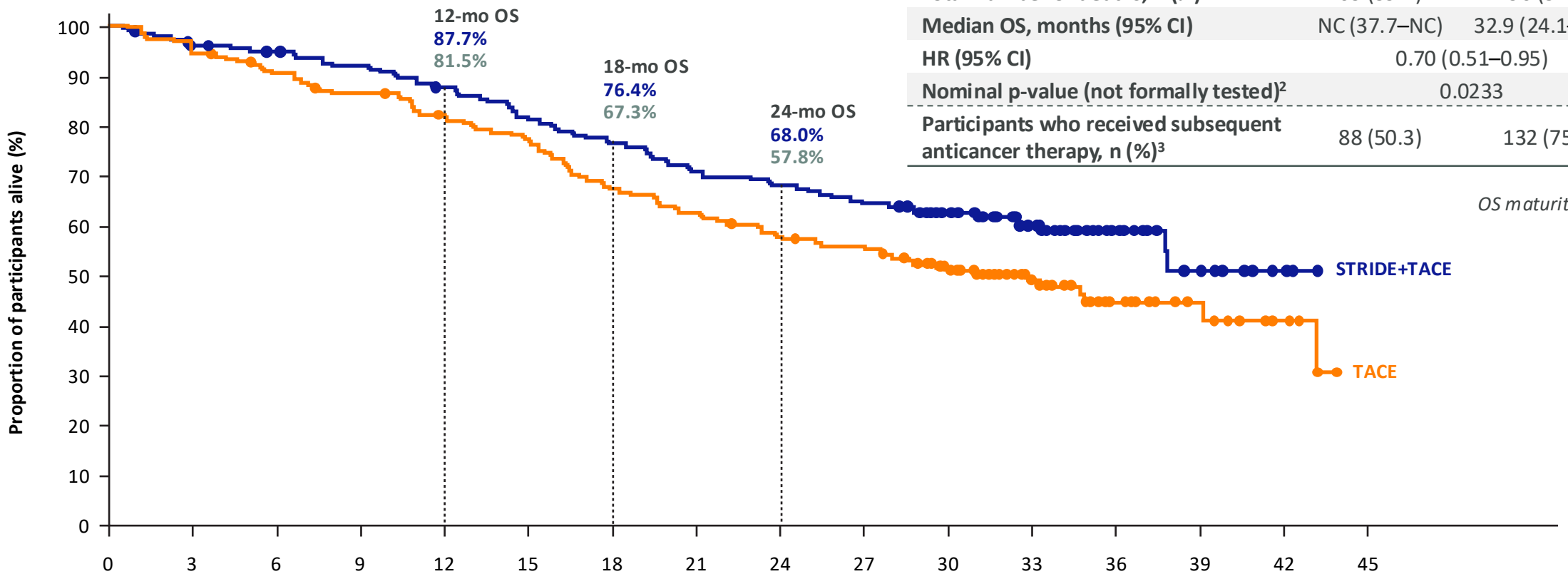
DCO2: Feb 28, 2026. Median (range) duration of follow up was 24.6 (0.07–44.6) months for STRIDE+L+TACE and 22.9 (0.56–44.0) months for TACE. 1. P-value boundary threshold to declare statistical significance was 0.021. 2. Therapies post discontinuation of study treatment. Abou-Alfa G et al. Abstract #LBA4000 presented at the American Society of Clinical Oncology 2026.

Appendix: Glossary.

EMERALD-3: Strong favourable trend to OS benefit with STRIDE + TACE

	STRIDE+TACE (n=175)	TACE[1] (n=first 175)
Total number of deaths, n (%)	69 (39.4)	90 (51.4)
Median OS, months (95% CI)	NC (37.7–NC)	32.9 (24.1–43.2)
HR (95% CI)	0.70 (0.51–0.95)	
Nominal p-value (not formally tested)[2]	0.0233	
Participants who received subsequent anticancer therapy, n (%)[3]	88 (50.3)	132 (75.4)

OS maturity: 45.4%



Number of participants at risk

STRIDE+TACE	175	165	161	155	147	136	128	119	114	108	91	60	24	11	4	0
TACE	175	166	156	148	138	131	114	106	97	92	75	42	20	12	6	0

DCO2: Feb 23, 2026. Median (range) duration of follow up was 30.2 (0.49–43.2) months for STRIDE+TACE and 28.0 (0.69–44.0) months for TACE. Median OS was calculated using the Kaplan-Meier technique. CI for median OS was derived based on Brookmeyer-Crowley method. The HR and its CI were estimated using a stratified Cox proportional hazards model. 1. Includes first 175 paticipants randomised to this treatment arm. 2. Arm B OS is descriptive per the pre-specified multiplicity / hierarchy; no formal statistical inference is claimed. 3. Therapies post discontinuation of study treatment.Abou-Alfa G et al. Abstract #LBA4000 presented at the American Society of Clinical Oncology 2026.
Appendix: Glossary.

EMERALD-3: Manageable AE profile consistent with known safety profiles of STRIDE, lenvatinib and TACE

	STRIDE + L + TACE (n=287)	STRIDE + TACE (n=175)	TACE (n=290)
Any grade AE, n (%)	**286 (99.7)**	**173 (98.9)**	**256 (88.3)**
Possibly related to any study treatment[1]	280 (97.6)	168 (96.0)	215 (74.1)
Provoked by TACE[1]	194 (67.6)	135 (77.1)	215 (74.1)
Any AE of max CTCAE Grade 3 or 4, n (%)	**205 (71.4)**	**112 (64.0)**	**83 (28.6)**
Possibly related to any study treatment[1]	180 (62.7)	85 (48.6)	54 (18.6)
Provoked by TACE[1]	72 (25.1)	39 (22.3)	54 (18.6)
Any SAEs (including events with outcome of death), n (%)	**184 (64.1)**	**89 (50.9)**	**68 (23.4)**
Possibly related to any study treatment[1]	141 (49.1)	63 (36.0)	46 (15.9)
Provoked by TACE[1]	53 (18.5)	24 (13.7)	46 (15.9)
Any AE leading to interruption of any study investigational product, n (%)	**241 (84.0)**	**77 (44.0)**	**N/A**
Leading to interruption of *Imfinzi*	172 (59.9)	77 (44.0)	N/A
Leading to interruption of lenvatinib	226 (78.7)	N/A	N/A
Leading to dose reduction of lenvatinib	142 (49.5)	N/A	N/A
AE leading to discontinuation of any study investigational product, n (%)	**102 (35.5)**	**36 (20.6)**	**N/A**
Leading to discontinuation of *Imfinzi*	68 (23.7)	36 (20.6)	N/A
Leading to discontinuation of lenvatinib	88 (30.7)	N/A	N/A

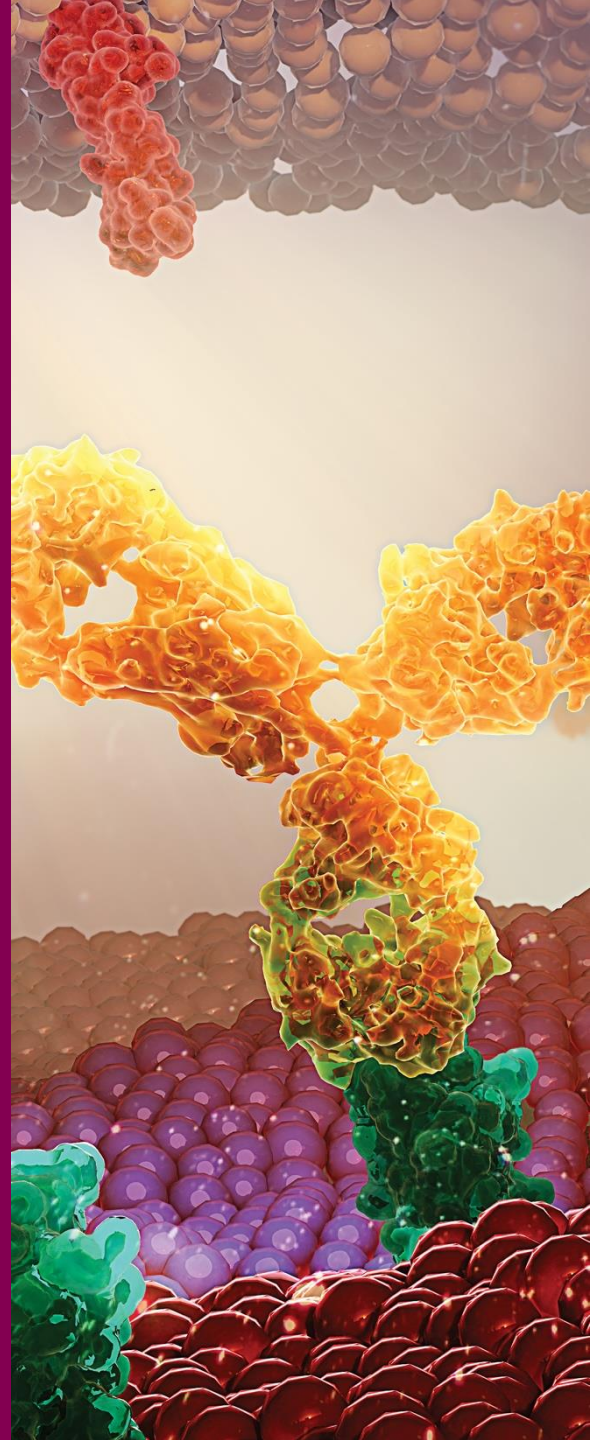
DCO2: Feb 23, 2026. AEs were coded by the Medical Dictionary for Regulatory Activities and graded per National Cancer Institute CTCAE v5. 1. As assessed by investigator.
Abou-Alfa G et al. Abstract #LBA4000 presented at the American Society of Clinical Oncology 2026.
Appendix: Glossary.

EMERALD-3: STRIDE-based regimen delivers benefit over long-standing standard-of-care TACE

- **STRIDE + L + TACE significantly improved PFS** vs TACE alone (HR 0.70 (0.57-0.86); p=0.0007)
- **STRIDE + L + TACE showed favourable OS trend** vs TACE alone (HR 0.84 (0.65-1.09); p=0.1814). OS data maturity 40%, to be re-tested at a future DCO.
- **STRIDE + TACE showed clinically meaningful improvements in PFS and OS** vs TACE alone (not yet formally tested)
- **STRIDE drives efficacy** in EMERALD-3
- **Acceptable safety profile** consistent with known profiles of components

EMERALD-3 supports a STRIDE-based regimen as a potential new treatment option in eeHCC

Abou-Alfa G et al. Abstract #LBA4000 presented at the American Society of Clinical Oncology 2026.
Appendix: Glossary.



Opportunity for Q&A

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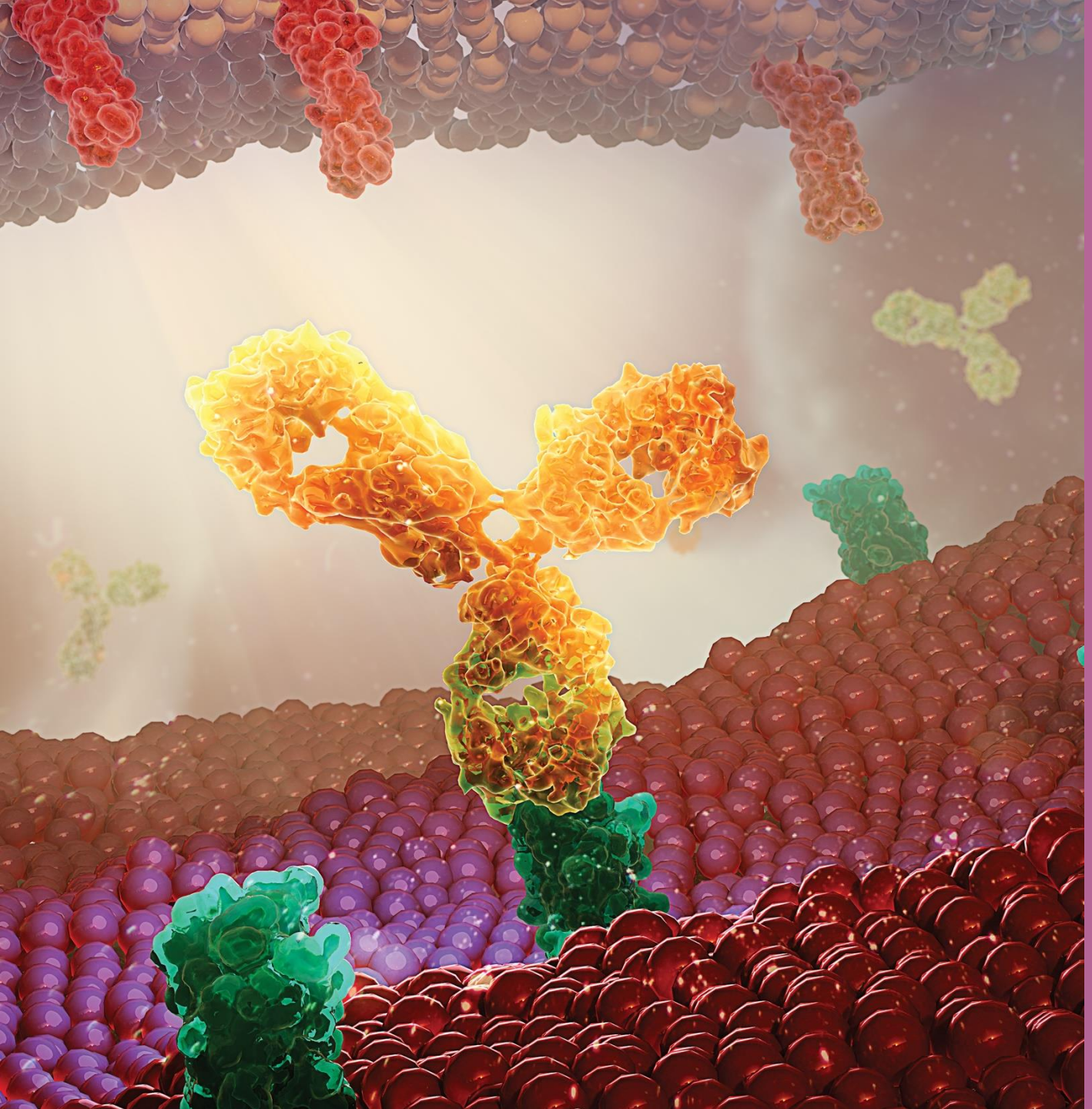
Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS

KEY EXTERNAL EXPERT
Ghassan Abou-Alfa
ATTENDING PHYSICIAN AND
PROFESSOR AT MEMORIAL SLOAN
KETTERING CANCER CENTER



Realising our ambition in Oncology

Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS

EMERALD-3 enhances our growing presence in GI cancers

EMERALD-3 | meaningful advance in embolisation-eligible liver cancer

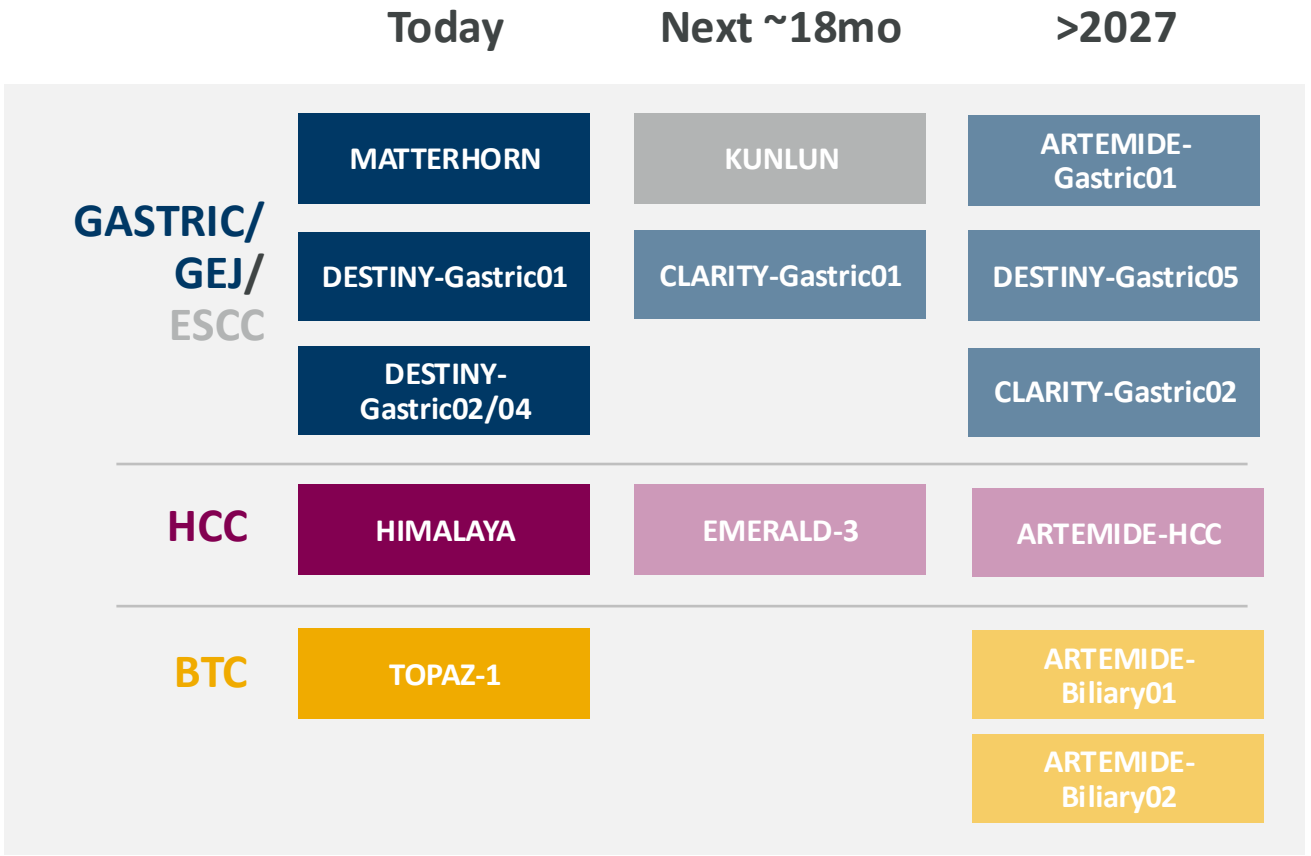
~390k[1] patients | early-stage HCC

~207k[1] patients | embolisation-eligible HCC

EMERALD-3
STRIDE ± lenvatinib + TACE

Final OS analysis in 2027

Maturing pipeline of innovative regimens across range of GI cancers



1. Estimated epidemiology for drug-treated patients in top 8 in 2026.
Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

Continued expansion of *Imfinzi* – the fastest growing PDx

Establish our foundation

- PACIFIC
- CASPIAN
- POSEIDON
- TOPAZ
- HIMALAYA
- DUO-E

Move into earlier stage cancers

- AEGEAN
- ADRIATIC
- PACIFIC-4
- PACIFIC-8
- MATTERHORN
- KUNLUN
- EMERALD-3
- EMERALD-1
- EMERALD-2
- NIAGARA
- VOLGA
- POTOMAC

Deliver *Imfinzi* combinations

PACIFIC-9 + oleclumab/monalizumab

AVANZAR + *Datroway* + CTx

DeLLphi-305[1] + tarlatamab

NILE + CTx +/- *Imjudo*

TROPION Breast03 + *Datroway*

TROPION Breast04 + *Datroway*

TROPION Breast05 + *Datroway*

Four high-value *Imfinzi* readouts in 2026 including positive EMERALD-3 and VOLGA Phase III trials

1. Primary sponsor for DeLLphi-305 is Amgen.
Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

Positive Phase III trial

Extending leadership in breast cancer

SERENA-6 | camizestrant only oral next generation SERD with Phase III data in 1L HR+ aBC

ASCO | PFS2, ctDNA clearance data linked to longer-term efficacy outcomes

85k patients in G7 | 1L HR+ aBC

- **50% | currently receiving AI + CDK4/6i as SoC**
  - **75% | >6 months on CDK4/6i**
    - **30% | detected *ESR1*m prior to progression**

US FDA decision
H2 2026

European decision
H2 2026

Positive CHMP decision

TROPION-Breast02 | *Datroway* first and only therapy to significantly improve overall survival vs CTx in TNBC where IO is not an option

ASCO | secondary efficacy outcomes

17k patients in G7

US FDA approved

European decision | H2 2026

DESTINY-Breast09 | *Enhertu* + pertuzumab opportunity to entrench as 1L SoC for HER2+ mBC

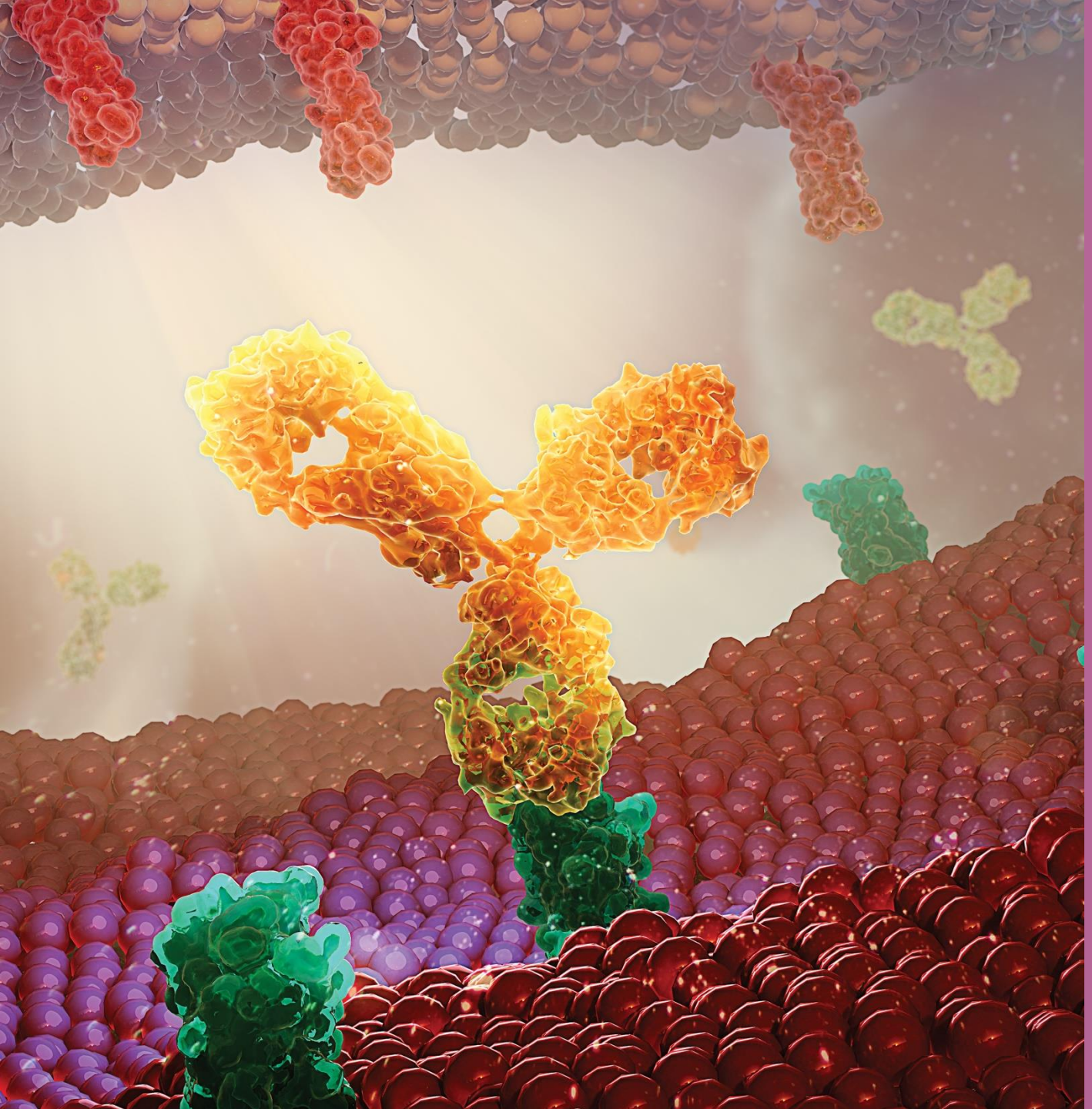
ASCO | outcomes by response to *Enhertu* + pertuzumab

23k patients in G7

US FDA approved

European decision | H2 2026

Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

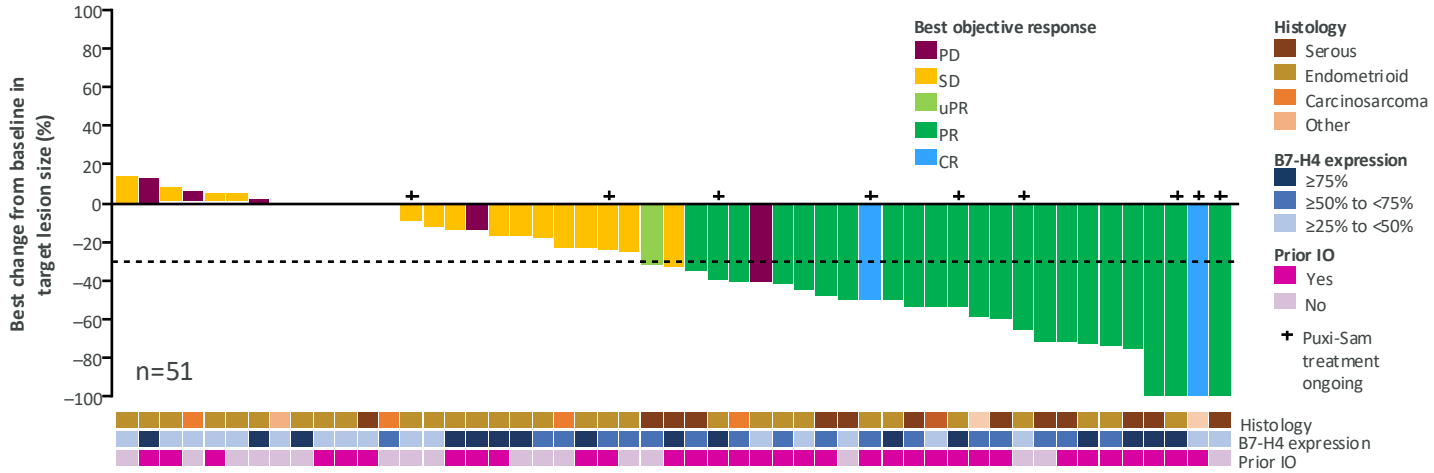


Establishing the pipeline for tomorrow

Susan Galbraith
EVP, ONCOLOGY
HAEMATOLOGY R&D

BLUESTAR data position puxi-sam as potential best-in-class ADC in B7-H4-positive endometrial cancer

BLUESTAR Phase I/IIa | puxi-sam 2.4mg/kg in 2L+ B7-H4+ advanced endometrial cancer



- **All pts:** ORR 47.1%, mPFS 7.2 mo
- **In pts with prior IO:** ORR 60.6%, mPFS 7.1 mo
- Favourable safety profile

Largest dataset and longest follow-up for B7-H4 ADC in endometrial cancer

Leading in Phase III development

2L+ setting | monotherapy

BLUESTAR-Endometrial01

Data 2027

Granted US Breakthrough Designation in May 2026

Mileshkin LR et al. Abstract 5155 presented at the American Society of Clinical Oncology 2026.

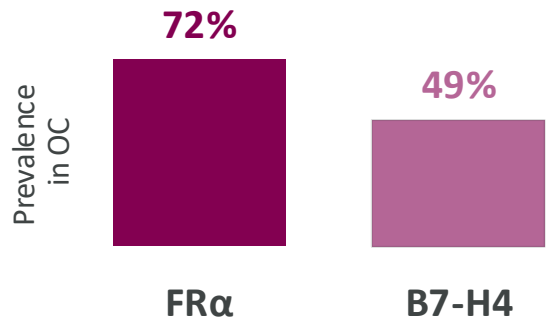
Appendix: Glossary.

Further advancing our ADC programme in gynaecological cancers with torvu-sam in ovarian cancer

torvu-sam| leading programme in ovarian cancer

FRα is a strongly validated target for ADCs in ovarian cancer

- High FRα is a **negative prognostic factor** in ovarian
- **>10x higher FRα** molecules-per-cell vs B7-H4[1]
- **Higher FRα prevalence** vs B7-H4 (≥25% tumour cells)[1]



torvu-sam | differentiated profile

54% ORR across dose levels in heavily pre-treated patients[2]

- Favourable safety

Broadening torvu-sam Phase III programme

2L+ PRR ovarian | monotherapy

TREVI-OC-01 | Data >2027

2 additional Phase III trials

Initiating in 2026

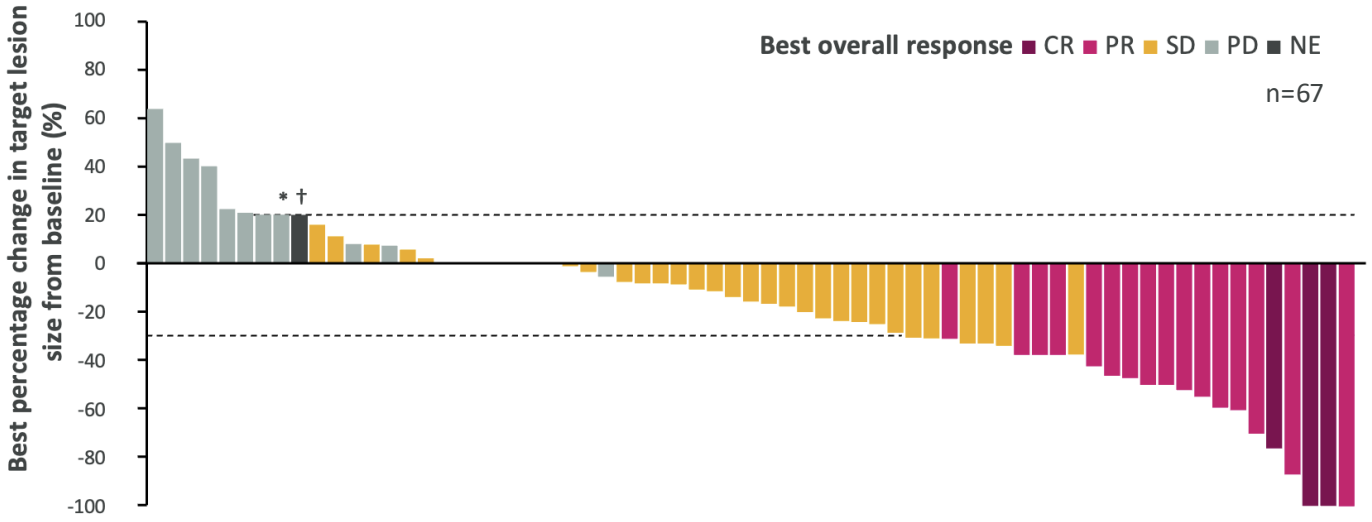
Additional opportunities with combinations and in other FRα-expressing tumours

Best-in-class potential for torvu-sam in ovarian cancer with competitive efficacy and differentiated safety profile

[1]Internal data. [2]Oaknin A et al. Abstract 1065MO presented at the European Society of Medical Oncology 2025. Appendix: Glossary.

Global data support potential of sone-ve in Claudin18.2-positive gastric cancer

CLARITY-PanTumor01 Phase II | global trial of sone-ve of Claudin18.2+ 2L+ gastric/GEJC



- **ORR** 28.4%[1]
- **mPFS** 4.2 months (95% CI: 3.0–7.0)
- Manageable safety profile

Broadening Phase III programme

2L+ setting | monotherapy

CLARITY-Gastric01

Data H2 2026

1L setting | + CTx +/- IO
Includes rilvegostomig

CLARITY-Gastric02

Data >2027

Advancing leadership across GI cancers

Investigator-assessed per RECIST v1.1. [1]Response and progression were defined as –30% and +20% change from baseline, respectively. *Best percentage change from baseline imputed as +20% due to death; †Best percentage change from baseline imputed as +20% due to being NE at the post-baseline measurement. Shitara K et al. Abstract 4023 presented at the American Society of Clinical Oncology 2026.

Appendix: Glossary.

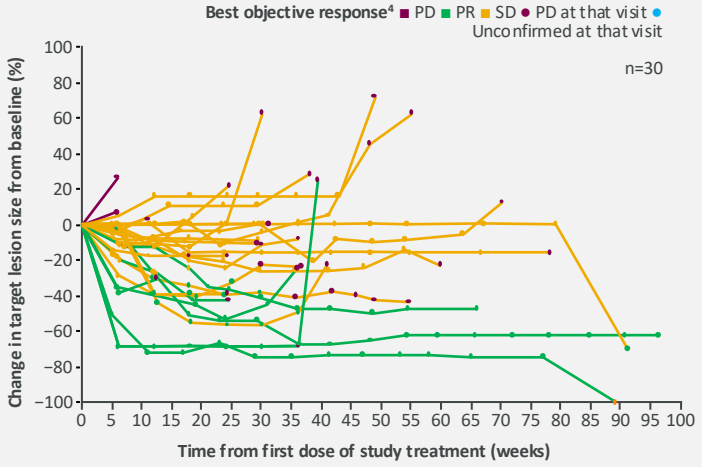
Further data builds confidence in IO bispecific portfolio

rilvegostomig

volrustomig

GEMINI-HPB Phase II[1]

rilvegostomig + CTx in advanced BTC (n=30[5])

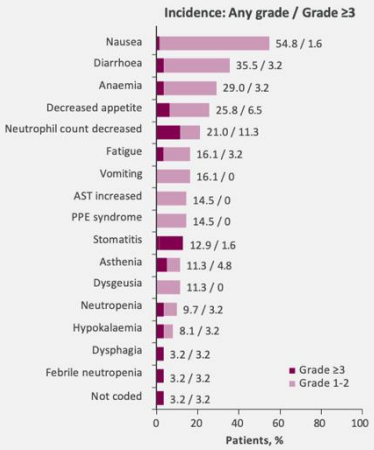


16.9 mo median OS

Further demonstrates durability of responses with rilvegostomig

DESTINY-Gastric03 Phase Ib/II[2,3]

rilvegostomig + *Enhertu* + FP in HER2+ advanced gastric/GEJC (n=62)

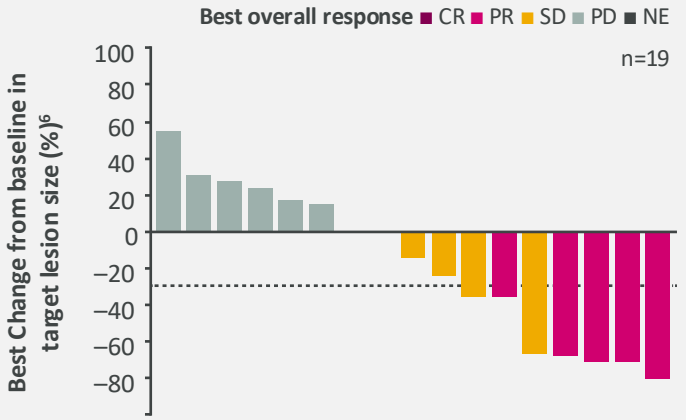


Favourable safety profile

Supports key combinations, including ADCs

eVOLVE-02 Phase II[4]

volrustomig in recurrent/metastatic PD-L1 CPS ≥1 HNSCC(n=19)



26.3% ORR

Informs ongoing Phase III eVOLVE-HNSCC trial

1. Zhou J E et al. Abstract 4105 presented at the American Society of Clinical Oncology 2026. 2. Part 4 of trial. 3.Janjigian Y Y et al. Abstract 4402 presented at the American Society of Clinical Oncology 2026. 4. Guo Y et al. Abstract 6205 presented at the American Society of Clinical Oncology 2026. 5. Response and progression were defined as–30% and +20% change from baseline, respectively. Dots represent study visits. One patient was found to not have a target lesion after baseline and thus was not response-evaluable (N=29). 6. Each bar represents the best percentage change from baseline for a single patient. Collaboration partners: Daiichi Sankyo (*Enhertu*).
Appendix: Glossary.

Expanding haematology pipeline with AZD3470

AZD3470 | MTAP-selective PRMT5 inhibitor

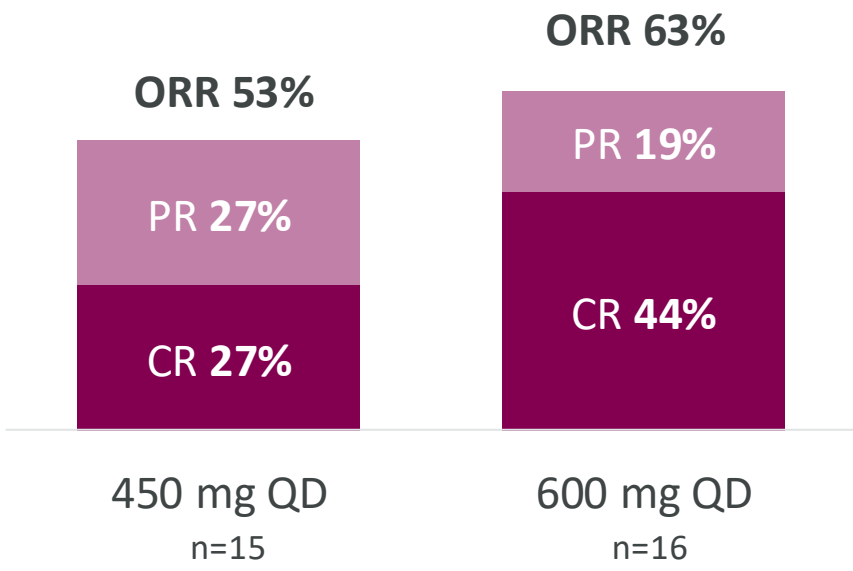
First 2nd generation PRMT5i in haematology

Novel in-house identified MTAP silencing mechanism

MTA-cooperative mechanism enables tumour lethality while sparing normal tissues

Opportunity in both haematological and solid tumours (pancreatic, lung)

PRIMAVERA | AZD3470 in relapsed/ refractory classic Hodgkin lymphoma



AZD3470 potential first-in-class oral PRMT5 inhibitor with a new targeted approach in r/r classic Hodgkin lymphoma

Treatment discontinued for swimmer lanes that do not end with a symbol indicating that treatment is ongoing.
Derenzini E et al. Abstract 7003 presented at the American Society of Clinical Oncology 2026.
Appendix: Glossary.

CARES demonstrates benefit of anselamimab in kappa-isotype AL amyloidosis

anselamimab | chimeric IgG1κ mAb

In AL amyloidosis, amyloid fibrils (kappa and lambda) are deposited in tissues

Accumulation of fibrils in organs drives dysfunction and damage

anselamimab is the first and only anti-fibril Ab to show benefit in kappa light chain patients

CARES | Two Phase III trials of anselamimab in light chain amyloidosis

Highly clinically meaningful improvements in kappa isotype
Trials did not meet primary endpoints

In kappa isotype:

62% reduction in all cause mortality

71% reduction in cardiovascular hospitalisation

- anselamimab was generally well tolerated in the overall population, including the kappa subgroup

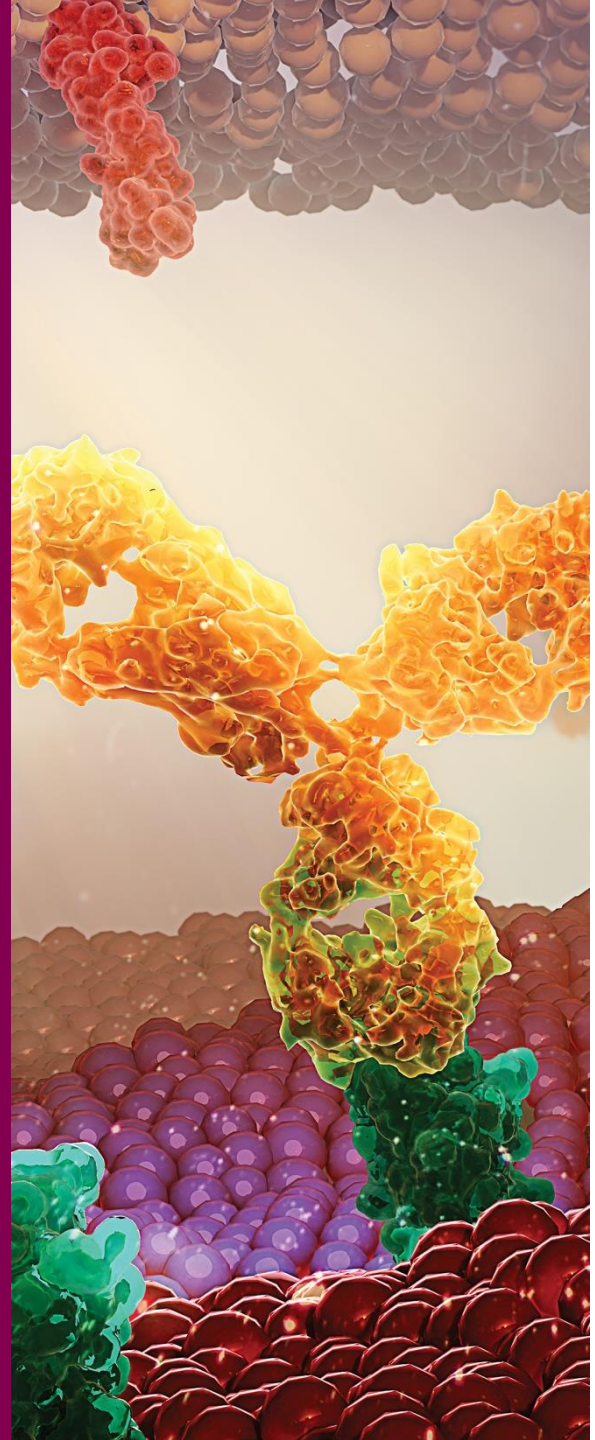
anselamimab potential new treatment option for kappa-isotype AL amyloidosis

n=406 for overall population, including n=72 patients with kappa isotype.
Wechalekar A et al. Abstract #7501 presented at the American Society of Clinical Oncology 2026.
Appendix: Glossary.

Significant progress at ASCO towards Oncology strategy to redefine cancer care

Novel ADCs and Radioconjugates	1	Replace the backbone of chemotherapy and radiotherapy
Novel IO	2	Next wave of IO agents will segment the IO-sensitive space
Cell therapy and T-cell engagers	3	Scalable, accessible therapies in both liquid and solid tumours
Powerful combinations	4	Transform outcomes through new combinations including novel ADC, Radioconjugate and next-generation IO
Early intervention	5	Improve long-term outcomes by acting at the earliest stages of disease

Appendix: Glossary.



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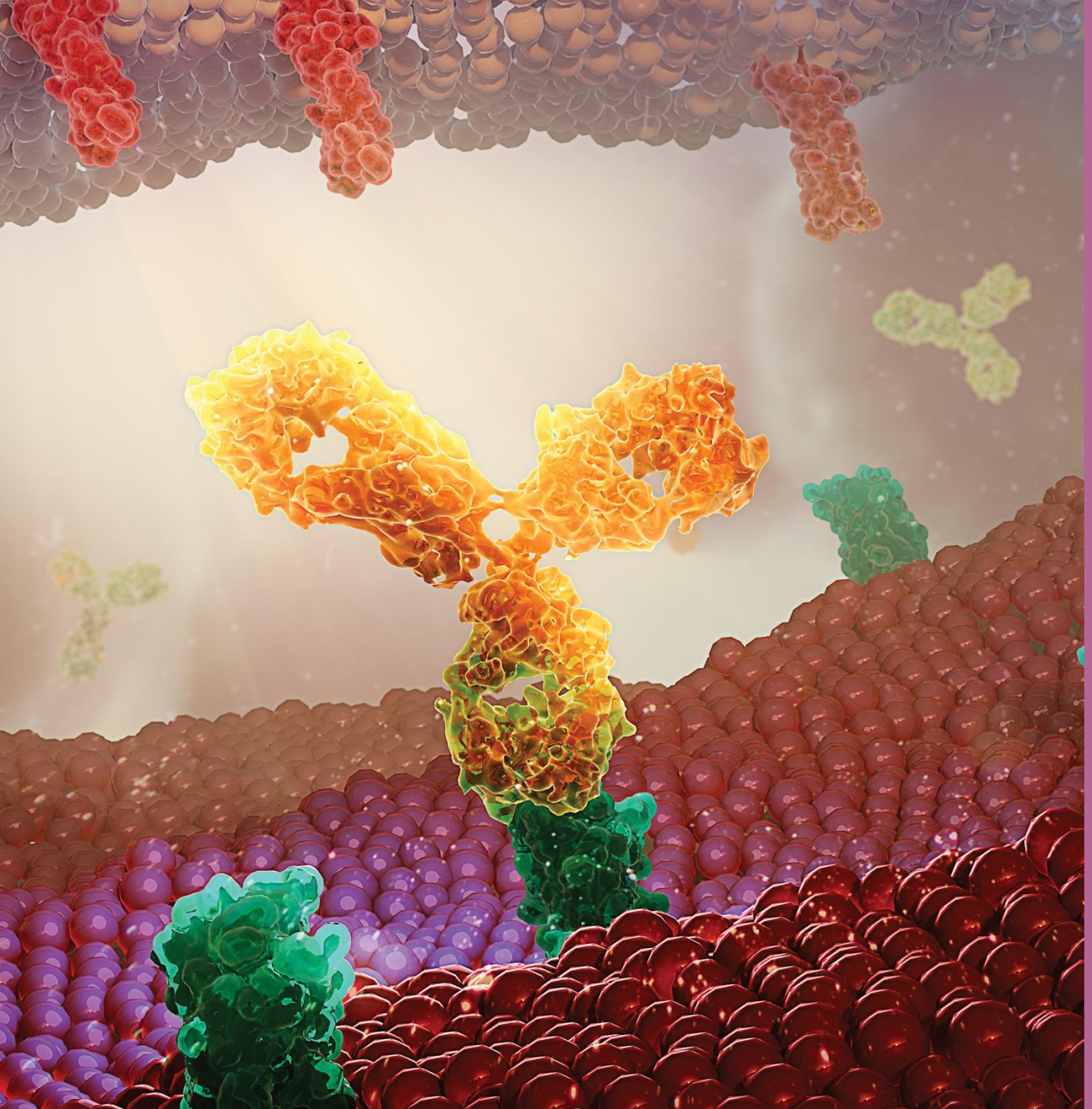
Gianluca Pirozzi
SVP, HEAD OF DEVELOPMENT,
REGULATORY & SAFETY



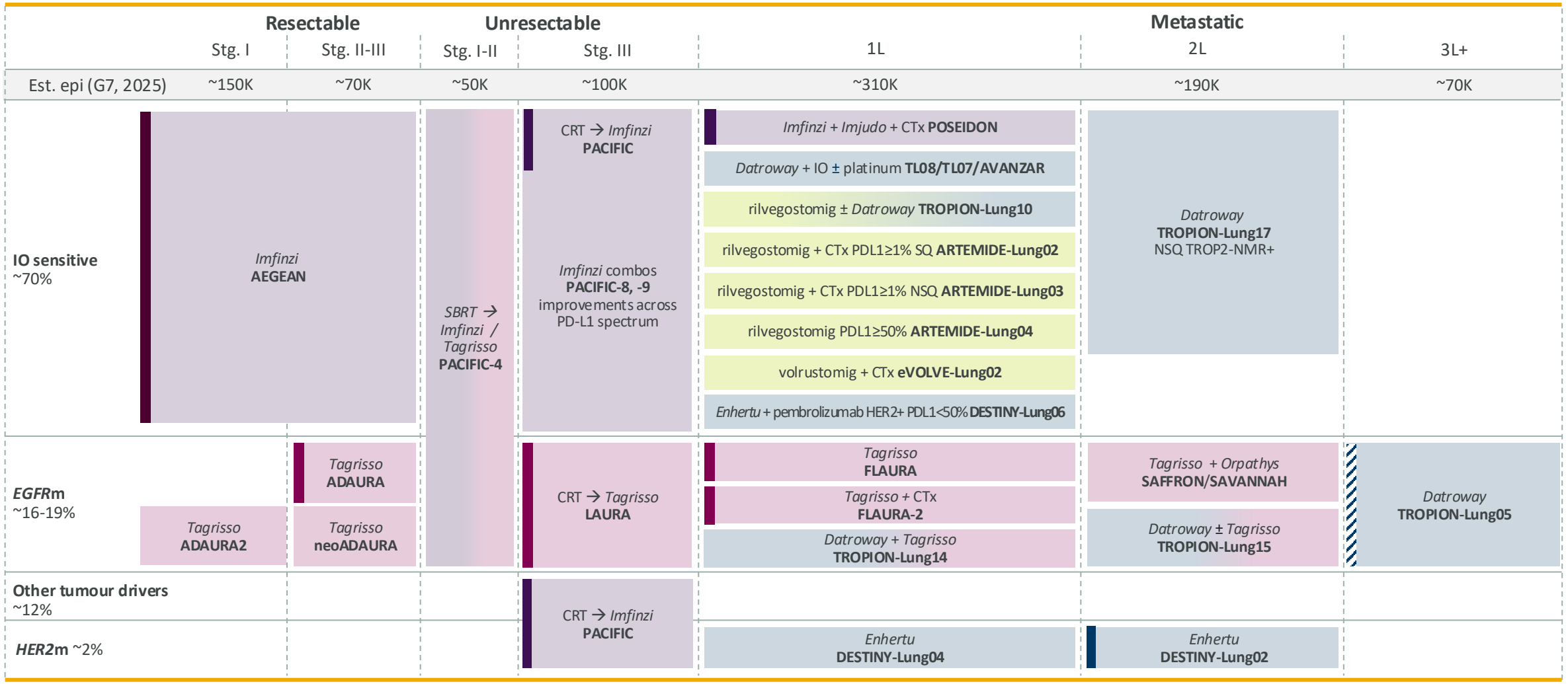
Meet AZN Management: ASCO 2026

APPENDIX

Glossary

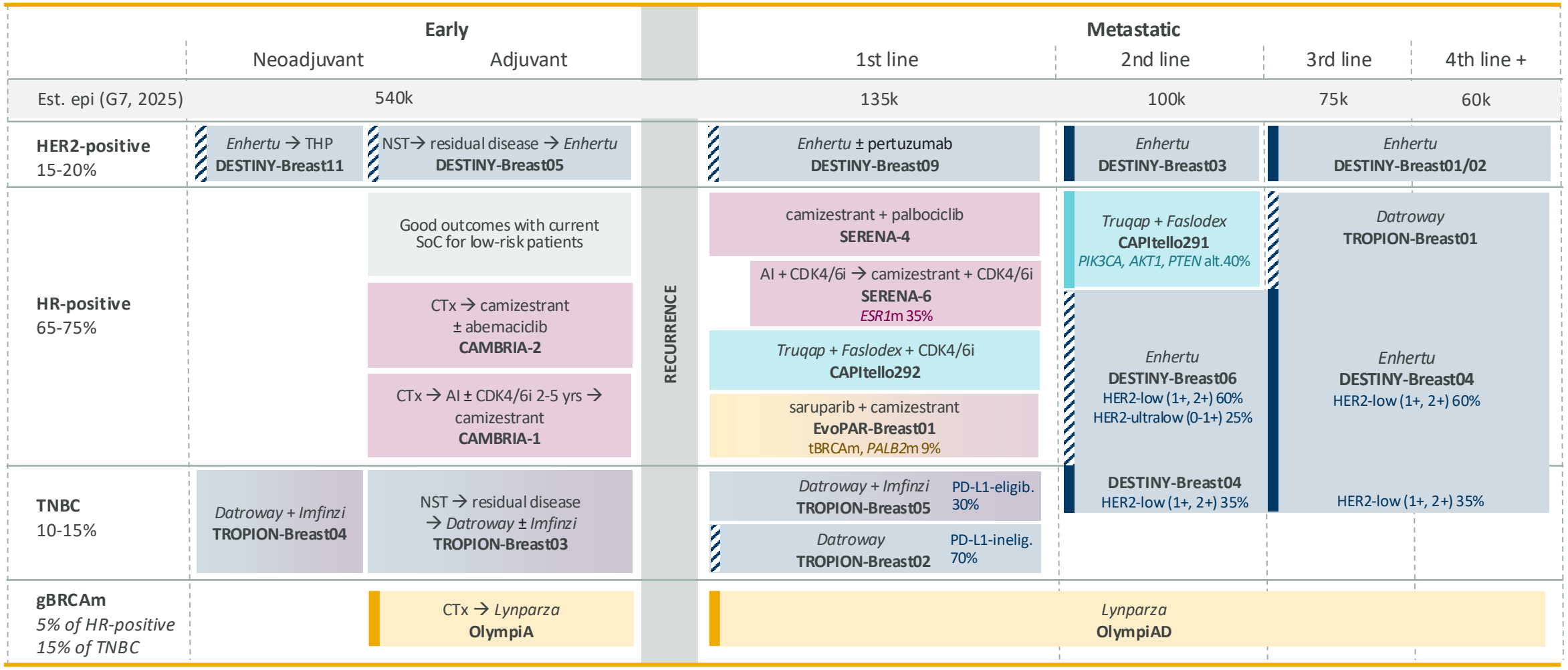
(a)BTC	(advanced) biliary tract cancer
1L, 2L, 3L	first-, second-, third-line
a/mBC	advanced/metastatic breast cancer
ADC	antibody drug conjugate
adj.	adjuvant
AE	adverse event
AI	aromatase inhibitor
AKT1	AKT serine/threonine kinase 1
AKTi	AKT inhibitor
ALBI	Albumin-Bilirubin
AST	aspartate aminotransferase
ATTR-CM	Transthyretin Amyloid Cardiomyopathy
BICR	blinded independent central review
BTD	Breakthrough Designation
CAR-T	chimeric antigen receptor T-cells
CDK4/6i	cyclin-dependent kinase 4/6 inhibitor
CHMP	Committee for Medicinal Products for Human Use
CI	confidence interval
CLDN18.2	Claudin-18.2
COPD	chronic obstructive pulmonary disease
CPS	combined positive score
CR	complete response
CRT	chemoradiotherapy
CSA-AKI	Cardiac Surgery-Associated Acute Kidney Injury
CTCAE	Common Terminology Criteria for Adverse Events version 5
ctDNA	circulating tumour DNA
CTx	chemotherapy
CV	cardiovascular
DCO	data cut-off
DCR	disease control rate
DOR	duration of response
DXd	deruxtecan
ECOG	Eastern Cooperative Oncology Group
ee	embolisation-eligible
EGFRm	epidermal growth factor receptor-mutant
ESR1m	estrogen receptor alpha-mutated
FLOT	fluorouracil, leucovorin, oxaliplatin and docetaxel
FP	fluoropyrimidine
FRα	folate receptor alpha
G7	Group of Seven (major pharmaceutical markets)
gBRCAm	germline BRCA mutation
GC	gastric cancer
GCG	glucagon
GEJ(A) / GEJC	gastroesophageal junction (adenocarcinoma / carcinoma)
GI	gastrointestinal
HCC	hepatocellular carcinoma
HER2	human epidermal growth factor receptor 2
HER2-/negative	human epidermal growth factor receptor 2-negative
HER2-low/ultralow	human epidermal growth factor receptor 2-low/ultralow
HER2+/positive	human epidermal growth factor receptor 2-positive
HER2m	human epidermal growth factor receptor 2-mutant
HNSCC	head and neck squamous cell carcinoma
HR	hazard ratio
HR-/negative	hormone receptor-negative
HR+/positive	hormone receptor-positive
IgA	immunoglobulin A
IO	immuno-oncology
m(PFS/OS)	median (PFS/OS)
M&A	mergers & acquisitions
mAb	monoclonal antibody
mBC	metastatic breast cancer
mDOR	median duration of response
mOS	median overall survival
NC	non-calculable
neoadj.	neoadjuvant
ngSERD	next-generation selective estrogen receptor degrader
NME	new molecular entity
NMR	normalised membrane ratio
NSCLC	non-small cell lung cancer
NSQ	non-squamous
NST	neoadjuvant systemic treatment
ORR	objective response rate
OS	overall survival
PALB2m	partner and localizer of BRCA2
PARPi	PARP inhibitor
PD	progressive disease
PD-(L)1/PD-L1	programmed cell death-(ligand) 1
PDx	PD-1/PD-L1 therapeutics
PFS	progression free survival
PFS2	second progression-free survival
PIK3CA(m)	phosphatidylinositol-4,5-biphosphate 3-kinase catalytic subunit (mutated)
PPE	palmar-plantar erythrodysesthesia syndrome
PR	partial response
PRMT5i	PRMT5 inhibitor
PRO	patient-reported outcome
PRR	platinum-resistant recurrence/relapse
PS	performance status
PTEN	phosphatase and TENsin homolog deleted on chromosome 10
Q2W	every 2 weeks
QoL	quality of life
R	randomised
r/r	relapsed/refractory
RECIST v1.1	Response Evaluation Criteria in Solid Tumors v1.1
SAE	serious adverse event
SBRT	stereotactic brain radiotherapy
SD	stable disease
SERD	selective estrogen receptor degrader
SoC	standard-of-care
SQ	squamous
Stg.	stage
tBRCAm	tumour BRCA mutation
TC	tumour cells
TCE	T-cell engager
THP	docetaxel, trastuzumab and pertuzumab
TIGIT	T-cell immunoreceptor with immunoglobulin and ITIM domains
TKI	tyrosine kinase inhibitor
TNBC	triple negative breast cancer
TROP2	trophoblast cell surface antigen 2
TTP	time to progression
uPR	unconfirmed partial response
Vp3	thrombosis in the right or left portal vein
Vp4	thrombosis in the main trunk of the portal vein

AstraZeneca in non-small cell lung cancer



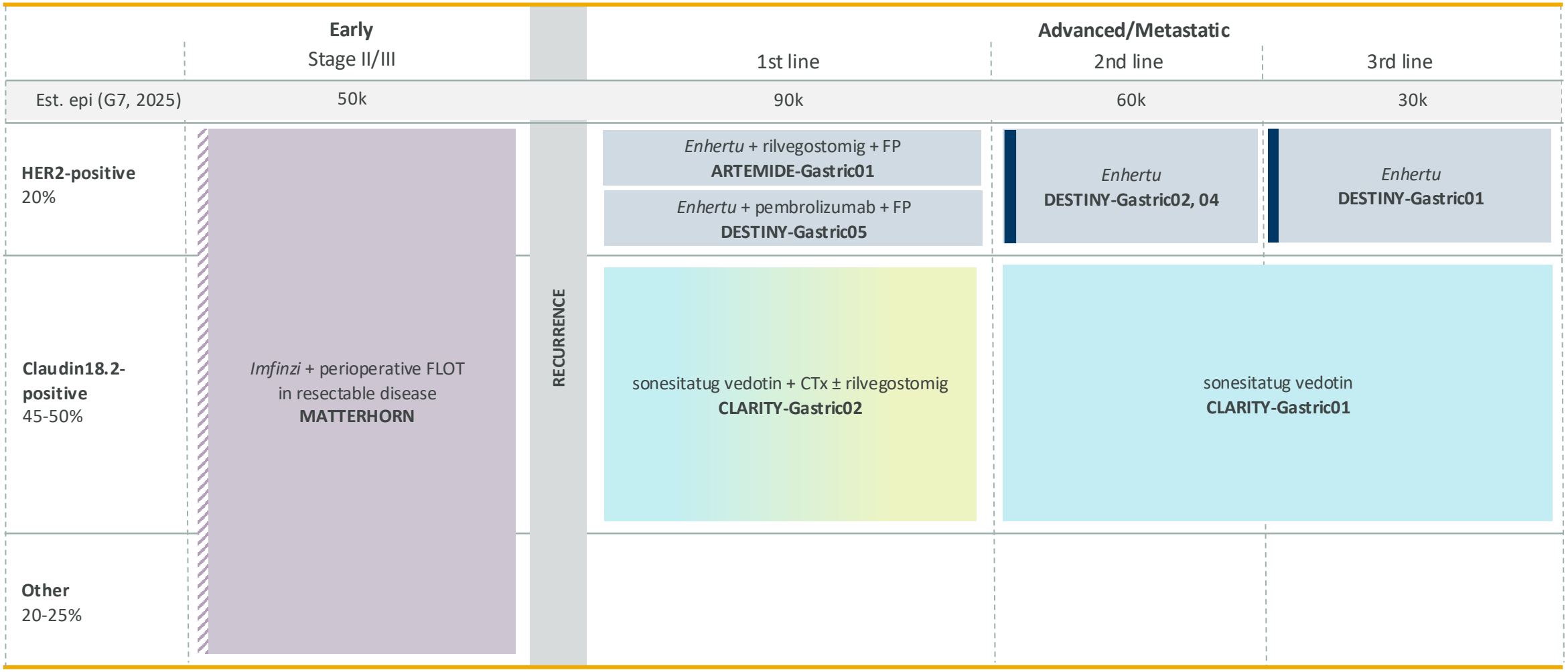
All numbers are approximate. Illustrative settings and populations, not to scale. Lung Cancer map reflects Phase III/pivotal trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Hutchmed (*Orpathys*).
Appendix: Glossary.

AstraZeneca in breast cancer



All numbers are approximate. Illustrative settings and populations, not to scale. Breast Cancer map reflects Phase III/pivotal trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Merck & Co., Inc. (*Lynparza*).
Appendix: Glossary.

AstraZeneca in gastric cancer



All numbers are approximate. Illustrative settings and populations, not to scale. Gastric cancer map reflects ongoing active Phase III/pivotal trials.
Collaboration partner: Daiichi Sankyo (*Enhertu*).
Appendix: Glossary.

AstraZeneca in bladder cancer

High-risk NMIBC	MIBC	1L mUC
96k	68k	46k
Imfinzi + BCG induction and maintenance **POTOMAC**	Neoadjuvant *Imfinzi* + CTx → adjuvant *Imfinzi* **NIAGARA** cis-eligible ~50%	*Imfinzi* + CTx ± *Imjudo* **NILE**
	Neoadjuvant *Imfinzi* + enfortumab vedotin ± *Imjudo* → adjuvant *Imfinzi* ± *Imjudo* **VOLGA** cis-ineligible/ refusal ~50%	

Key: DXd ADC | IO | AZ ADC | IO bispecific | launched and established SoC | launched indication

All numbers are approximate. Illustrative settings and populations, not to scale.
Appendix: Glossary.

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