ASCO 2018 investor event: a leading, diversified oncology business
Forward-looking statements

In order, among other things, to utilise the ‘safe harbour’ provisions of the US Private Securities Litigation Reform Act 1995, we are providing the following cautionary statement: This 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 we believe our expectations are based on reasonable assumptions, any forward-looking statements, by their very nature, involve risks and uncertainties and may be influenced by factors that could cause actual outcomes and results to be materially different from those predicted. The forward-looking statements reflect knowledge and information available at the date of preparation of this document and AstraZeneca undertakes no obligation to update these forward-looking statements. We identify the forward-looking statements by using the words ‘anticipates’, ‘believes’, ‘expects’, ‘intends’ and similar expressions in such statements. Important factors that could cause actual results to differ materially from those contained in forward-looking statements, certain of which are beyond our control, include, among other things: the loss or expiration of, or limitations to, patents, marketing exclusivity or trademarks, or the risk of failure to obtain and enforce patent protection; effects of patent litigation in respect of IP rights; the impact of any delays in the manufacturing, distribution and sale of any of our products; the impact of any failure by third parties to supply materials or services; the risk of failure of outsourcing; the risks associated with manufacturing biologics; the risk that R&D will not yield new products that achieve commercial success; the risk of delay to new product launches; the risk that new products do not perform as we expect; the risk that strategic alliances and acquisitions, including licensing and collaborations, will be unsuccessful; the risks from pressures resulting from generic competition; the impact of competition, price controls and price reductions; the risks associated with developing our business in emerging markets; the risk of illegal trade in our products; the difficulties of obtaining and maintaining regulatory approvals for products; the risk that regulatory approval processes for biosimilars could have an adverse effect on future commercial prospects; the risk of failure to successfully implement planned cost reduction measures through productivity initiatives and restructuring programmes; the risk of failure of critical processes affecting business continuity; economic, regulatory and political pressures to limit or reduce the cost of our products; failure to achieve strategic priorities or to meet targets or expectations; the risk of substantial adverse litigation/government investigation claims and insufficient insurance coverage; the risk of substantial product liability claims; the risk of failure to adhere to applicable laws, rules and regulations; the risk of failure to adhere to applicable laws, rules and regulations relating to anti-competitive behaviour; the impact of increasing implementation and enforcement of more stringent anti-bribery and anti-corruption legislation; taxation risks; exchange rate fluctuations; the risk of an adverse impact of a sustained economic downturn; political and socio-economic conditions; the risk of environmental liabilities; the risk of occupational health and safety liabilities; the risk associated with pensions liabilities; the impact of failing to attract and retain key personnel and to successfully engage with our employees; the risk of misuse of social medial platforms and new technology; and the risk of failure of information technology and cybercrime. Nothing in this presentation / webcast should be construed as a profit forecast.
Presenters

Pascal Soriot
Executive Director and Chief Executive Officer

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Executive Vice President, Oncology Business Unit

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Senior Vice President, Head of Oncology, IMED Biotech Unit

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Senior Vice President, Head of IO Franchise

Jean-Charles Soria
Senior Vice President, Head of Oncology, MedImmune

Break-out sessions
Agenda

AstraZeneca Oncology

Key data at ASCO 2018 Annual Meeting

Break-out sessions

~19:45 - 1st set of four concurrent breakout sessions + Q&A (30 minutes)

10 minutes break to allow for room changes

~20:25 - 2nd set of four concurrent breakout sessions + Q&A (30 minutes)

~21:00 - End

Break-out sessions are recorded and will be made available at astrazeneca.com
### AstraZeneca: a leading, diversified oncology business

New medicines grew 122% in Q1 2018; a solid lifecycle to follow

<table>
<thead>
<tr>
<th>Multiple cancers</th>
<th>Lung cancers</th>
<th>Blood cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lynparza™</strong> olaparib</td>
<td><strong>TAGRISSO®</strong> osimertinib</td>
<td><strong>IMFINZI™</strong> durvalumab</td>
</tr>
<tr>
<td><strong>CALQUENCE™</strong> (acalabrutinib) 100 mg capsules</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Ovarian and breast cancers
- Lifecycle programme (2018+)
- MRK collaboration
- Stage IV 2nd line T790M\(^1\) moving to Stage IV 1st line EGFRm\(^2\)
- Adjuvant and Stage III EGFRm (2020+)
- Unresectable Stage III NSCLC\(^3\)
- Lifecycle programme in early and advanced stages and combinations (2018+)
- First AstraZeneca medicine in blood cancer
- MCL\(^4\) launched
- CLL\(^5\) and other lifecycle (2019+)

### Rich and early pipeline, including combinations

1. Substitution of threonine (T) with methionine (M) at position 790 of exon 20 mutation.
2. Epidermal growth factor receptor mutation.
5. Chronic lymphocytic leukaemia.

() First / next data anticipated.
**Lynparza**
The leading PARP inhibitor across multiple tumour types

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**Product Sales**
**Q1 2018: 100% growth**

**Lifecycle opportunities have significant growth potential**

- **Potential launches**
  1. Potential number of launches in the US, EU, Japan and China from ongoing Phase III trials.
  2. Vascular endothelial growth factor (receptor).

**Source:** Q1 2018 Results announcement.

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**Chart legend:** US Europe Emerging Markets Established Rest of World. Absolute values at actual exchange rates; change at CER.
Lung cancers: *Tagrisso*
Expanding patient benefits into earlier lines of treatment

**Product Sales**
Q1 2018: 89% growth

**Now expanding into the Stage IV 1st-line setting**

- **Wild type**
- **ALKm**
- **EGFRm**

$\text{~370k}$
Total patients

$\text{70k}$
1st-line EGFRm patients

**Approved US, Brazil**
**Regulatory decision EU Q2, JP H2‘18**

**With Stage I-III (adjuvant) as a future opportunity**

**ADAURA Phase III trial**
Up to 3 years
Treatment duration

Stage IB-IIIA EGFR-mutation positive NSCLC $n=700$

- **R**
  - Tagrisso $n=350$
  - Placebo $n=350$

Primary endpoint: disease-free survival

Source: AstraZeneca data on file.

1. Anaplastic lymphoma kinase translocation mutation.
Epidemiology: internal estimates based on external market research, top-eight countries; China generally includes a market-access adjustment.
Lung cancers: *Imfinzi*

First and only in early lung cancer; now with proven survival

The strong US uptake reflects patient benefit

Significant unmet need in unresectable, Stage III

*Imfinzi* in early lung cancer

- PACIFIC OS announced 25 April
- PACIFIC-2 concurrent trial starting
- ADJUVANT BR.31 trial data 2020

*Imfinzi* outside early lung cancer

1. Be first and lead in early-stage PDx-sensitive tumours
2. Establish *Imfinzi* as backbone in advanced PDx-sensitive tumours
3. Unlock insensitive tumours via novel combinations

Epidemiology: internal estimates based on external market research, top-seven countries.

Source: external market research.
**Lung cancers: Imfinzi**

Stage III: last chance for treatment with curative intent

### Lung cancer patients at diagnosis (%)

<table>
<thead>
<tr>
<th>Stage</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>27%</td>
</tr>
<tr>
<td>Stage II</td>
<td>11%</td>
</tr>
<tr>
<td>Stage III</td>
<td>25%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Five-year survival rates by stage**

- **Stage I**: 79%
- **Stage II**: 66%
- **Stage III**: 15%
- **Stage IV**: 6%

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*Imfinzi* is not approved for use in Stage I, Stage II, Stage IV NSCLC. Epidemiology: internal estimates based on external market research.

Sources: Maione 2010/p251/Col1¶1; Auperin 2010/p2184/col1¶3; col2¶1; p2186/Fig2A; Epicast 2016/p46/Table15 [Calc: Stage I=16.68+10.09=-27; Stage II=3.22+7.77=-11; Stage III=12.31+12.81=-25]; and Goldstraw 2016/p46/Figure 2A.
Haematology: *Calquence* and moxetumomab
Emerging franchise; initially in smaller indications

**Calquence**
Best-in-class BTK inhibitor in MCL

- Launched in the US in R/R\(^1\) MCL
- Median duration of response (DoR) was not reached; the 12-month DoR rate was 72% (95% CI: 62%, 80%)

**Development plans**

<table>
<thead>
<tr>
<th>Phase</th>
<th>WM(^2)</th>
<th>MCL</th>
<th>CLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB/II</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 20 clinical trials in haematology
- >3,200 patients in clinical trials in haematology

**Moxetumomab pasudotox**

- First AstraZeneca/MedImmune immunotoxin
- Under US priority regulatory review with a Q3 2018 PDUFA/action date
- Intended indication is 3rd-line+ hairy cell leukaemia
- Small indication with ~1,000 new US patients per year

**Anticipated fifth new Oncology medicine**

1. Relapsed/refractory.

2. Waldenström macroglobulinemia; a type of non-Hodgkin lymphoma.

Epidemiology: internal estimates based on external market research.
# Oncology: industry-leading pipeline

## Rich and deep pipeline across Phase I-III

### Phase I

**31 New Molecular Entities**

<table>
<thead>
<tr>
<th>Small molecule</th>
<th>Large molecule</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZD5312</td>
<td>VCT-ATIR nanomolar inhibitors</td>
</tr>
<tr>
<td>AZD6005</td>
<td>VCT-ATIR, VEGF</td>
</tr>
<tr>
<td>AZD2171</td>
<td>YK143, VEGF</td>
</tr>
<tr>
<td>AZD8863</td>
<td>VCT-ATIR, VEGF</td>
</tr>
<tr>
<td>AZD9051</td>
<td>VCT-ATIR</td>
</tr>
<tr>
<td>AZD9049</td>
<td>VCT-ATIR, VEGF</td>
</tr>
<tr>
<td>AZD9046</td>
<td>VCT-ATIR, VEGF</td>
</tr>
</tbody>
</table>

### Phase II

**21 New Molecular Entities**

<table>
<thead>
<tr>
<th>Small molecule</th>
<th>Large molecule</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZD6169</td>
<td>E7A3771 inhibitory antibody, PARP inhibitor, DNA damage response, NAD+ depletion</td>
</tr>
<tr>
<td>AZD1776</td>
<td>HHR2 solid tumors</td>
</tr>
<tr>
<td>AZD1775</td>
<td>E7A3771 inhibitory antibody, PARP inhibitor, DNA damage response, NAD+ depletion</td>
</tr>
<tr>
<td>AZD0137</td>
<td>E7A3771 inhibitory antibody, PARP inhibitor, DNA damage response, NAD+ depletion</td>
</tr>
</tbody>
</table>

### Phase III

**8 New Molecular Entities**

<table>
<thead>
<tr>
<th>Small molecule</th>
<th>Large molecule</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZD1940</td>
<td>PARP inhibitor, DNA damage response, NAD+ depletion</td>
</tr>
<tr>
<td>AZD1293</td>
<td>PARP inhibitor, DNA damage response, NAD+ depletion</td>
</tr>
<tr>
<td>AZD9079</td>
<td>PARP inhibitor, DNA damage response, NAD+ depletion</td>
</tr>
<tr>
<td>AZD9051</td>
<td>VCT-ATIR</td>
</tr>
<tr>
<td>AZD9049</td>
<td>VCT-ATIR, VEGF</td>
</tr>
<tr>
<td>AZD9046</td>
<td>VCT-ATIR, VEGF</td>
</tr>
<tr>
<td>AZD9045</td>
<td>VCT-ATIR</td>
</tr>
<tr>
<td>AZD9044</td>
<td>VCT-ATIR</td>
</tr>
</tbody>
</table>

### Oncology Combinations

- **Induction:**
  - AZD5312 + PO4
  - AZD5312 + PO3
  - AZD5312 + PO2
  - AZD5312 + PO1

- **Maintenance:**
  - AZD5312 + PO4
  - AZD5312 + PO3
  - AZD5312 + PO2
  - AZD5312 + PO1

- **Combination:**
  - AZD5312 + PO4
  - AZD5312 + PO3
  - AZD5312 + PO2
  - AZD5312 + PO1

Includes significant lifecycle management projects and parallel indications for projects in Phase III or beyond. Excludes lifecycle management projects already launched in a major market. # Partnered and/or in collaboration; ¶ Registrational Phase III study.
Agenda

AstraZeneca Oncology

Key data at ASCO 2018 Annual Meeting

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AstraZeneca at ASCO 2018 Annual Meeting
Increasing quality; more oral presentations and poster discussions

**Abstract scorecard**

- **2018**: 91 presentations
  - 74% Oral presentations
  - 16% Poster discussions
  - 10% Posters

- **2017**: 100 presentations
  - 81% Oral presentations
  - 11% Poster discussions
  - 8% Posters

- **2016**: 58 presentations
  - 74% Oral presentations
  - 14% Poster discussions
  - 12% Posters

**Highlights**

- **Lynparza**
  - Study 08 randomised Phase II trial in prostate cancer

- **moxetumomab pasudotox**
  - Study ’1053’ Phase III trial in hairy cell leukaemia

- **selumetinib**
  - SPRINT Phase II trial in paediatric neurofibromatosis type 1 (NF-1)

- **capivasertib (AZD5363, AKT inhibitor)**
  - PAKT Phase II trial in triple-negative breast cancer

- **Lynparza + vistusertib (AZD2014, mTORC1/2 inh.)**
  - Trial in ovarian cancer and triple-negative breast cancer

*Source: AstraZeneca analysis based on submitted and accepted ASCO 2018 Annual Meeting abstracts.*
Lynparza
Prostate cancer - Study 08 - trial design

**Trial design**

- mCRPC
- Prior treatment with docetaxel for mCRPC
- ≤2 prior lines of chemotherapy
- No prior 2nd-generation antihormonal agents
- Candidate for abiraterone treatment

**Randomized 1:1 Double-blind**

- Olaparib tablets 300 mg bid + abiraterone* 1000 mg od
- Placebo + abiraterone* 1000 mg od

**Treatment until disease progression**

**Primary endpoint:**
- Radiologic progression-free survival (RECIST 1.1; PCWG2)

**Secondary endpoints:**
- rPFS by HRRm status
- Time to second progression (PFS2)
- Overall survival (OS)
- Objective response rate (ORR)
- Times to first and second subsequent therapies (TFST/TSST)
- CTC-conversion rate
- Health-related quality of life (HRQoL)
- Safety and tolerability

*Prednisone/prednisolone (5 mg) was administered alongside abiraterone as indicated. bid, twice daily; CTC, circulating tumor cell; HRRm, homologous recombination repair gene mutation; mCRPC, metastatic castration-resistant prostate cancer; od, once daily; PCWG, Prostate Cancer Working Group; RECIST, Response Evaluation Criteria in Solid Tumors; rPFS, radiologic progression-free survival.
Lynparza
Prostate cancer - Study 08 - primary endpoint (rPFS)

Primary endpoint: investigator-assessed rPFS

<table>
<thead>
<tr>
<th>Time from randomization (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olap +abi (n=71)</td>
</tr>
<tr>
<td>Abi (n=71)</td>
</tr>
<tr>
<td>Events, n (%)</td>
</tr>
<tr>
<td>KM median, months</td>
</tr>
<tr>
<td>46 (65)</td>
</tr>
<tr>
<td>13.8</td>
</tr>
<tr>
<td>HR 0.65</td>
</tr>
<tr>
<td>95% CI 0.44, 0.97; P=0.034</td>
</tr>
</tbody>
</table>

Abi, abiraterone; CI, confidence interval; HR, hazard ratio; KM, Kaplan-Meier; olap, olaparib
# Safety Summary

<table>
<thead>
<tr>
<th></th>
<th>Olaparib + abiraterone (n=71)</th>
<th>Abiraterone (n=71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median duration of olaparib/placebo, days</td>
<td>309</td>
<td>253</td>
</tr>
<tr>
<td>Median duration of abiraterone, days</td>
<td>338</td>
<td>253</td>
</tr>
<tr>
<td>Any adverse event, n (%)</td>
<td>66 (93)</td>
<td>57 (80)</td>
</tr>
<tr>
<td>Grade ≥3 adverse event, n (%)</td>
<td>38 (54)</td>
<td>20 (28)</td>
</tr>
<tr>
<td>Serious adverse event, n (%)</td>
<td>24 (34)</td>
<td>13 (18)</td>
</tr>
<tr>
<td>Fatal adverse event, n (%)</td>
<td>4 (6)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Adverse event leading to dose interruption, n (%)</td>
<td>24 (34)</td>
<td>9 (13)</td>
</tr>
<tr>
<td>Adverse event leading to dose reduction, n (%)</td>
<td>13 (18)</td>
<td>0</td>
</tr>
<tr>
<td>Adverse event leading to treatment discontinuation, n (%)</td>
<td>21 (30)</td>
<td>7 (10)</td>
</tr>
</tbody>
</table>
Lynparza
Prostate cancer - Study 08 - conclusions

Conclusions

• Olaparib plus abiraterone provided a significant rPFS benefit to mCRPC patients, who had previously received docetaxel, compared with abiraterone alone
  • Benefit seen in a population unselected by HRR mutation status
• Less favorable tolerability profile offset by improved efficacy
• First trial to show a significant efficacy benefit with a PARP inhibitor-androgen synthesis inhibitor combination
• Phase III study based on the results of this trial is planned
Moxetumomab pasudotox
Hairy cell leukaemia 3rd line+ - Study ‘1053’ - introduction

Introduction

• HCL is a rare B-cell malignancy characterized by high CD22 expression

• Relapsed/refractory HCL remains incurable, and there is an unmet need for new treatment

• Moxetumomab pasudotox (formerly CAT-8015 or HA22) is a first-in-class recombinant immunotoxin targeting CD22

HCL, hairy cell leukemia.
Moxetumomab pasudotox
Hairy cell leukaemia 3rd line+ - Study ‘1053’ - trial design

Study Design and Treatment Regimen

- Pivotal, multicenter, single-arm, open-label study (NCT01829711) conducted at 34 centers in 14 countries
- Moxetumomab pasudotox treatment
  - 40 µg/kg IV on days 1, 3, and 5 of 28-day treatment cycles
  - Up to 6 treatment cycles
  - Discontinued if disease progression, start of alternate therapy, or unacceptable toxicity
  - Option to discontinue with <6 cycles if patient achieved MRD-negative CR (investigator assessed, by flow cytometry)
- Disease response and IHC MRD assessed by blinded independent review

CR, complete response; IHC, immunohistochemistry; IV, intravenously; MRD, minimal residual disease.
Moxetumomab pasudotox
Hairy cell leukaemia 3rd line+ - Study ‘1053’ - patient disposition

Patient Disposition

TREATMENT (N=80)
- Completed 6 cycles (n=50, 62.5%)
- Discontinued, MRD− CR in <6 cycles (n=12, 15%)
- Discontinued treatment due to:
  • Adverse event (n=12, 15%)
    • Treatment-related AE (n=8, 10%)
  • Death (n=1, 1.3%)
  • Disease progression (n=2, 2.5%)
  • Lack of benefit (n=3, 3.8%)

FOLLOW-UP (N=80)
- Ongoing in follow-up (n=50, 62.5%)
- Discontinued study due to:
  • Disease progression/new HCL treatment (n=24, 30%)
  • Death (n=3, 3.8%)
  • Withdrawal of consent (n=2, 2.5%)
  • Lost to follow-up (n=1, 1.3%)

Median duration of follow-up was 16.7 months as of data cutoff of May 24, 2017

AE, adverse event; CR, complete response; HCL, hairy cell leukemia; MRD, minimal residual disease.
**Moxetumomab pasudotox**
Hairy cell leukaemia 3rd line+ - Study ‘1053’ - primary endpoint (CR)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>BICR</th>
<th>Investigator-assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%) [95% CI]</td>
<td>n (%) [95% CI]</td>
</tr>
<tr>
<td>Durable CR</td>
<td>24 (30%) [20, 41]</td>
<td>38 (48%) [36, 59]</td>
</tr>
<tr>
<td>Best overall response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR</td>
<td>33 (41%) [30, 53]</td>
<td>41 (51%) [40, 63]</td>
</tr>
<tr>
<td>CR, MRD-negative</td>
<td>27 (34%) [24, 45]</td>
<td>26 (33%) [22, 44]</td>
</tr>
<tr>
<td>PR</td>
<td>27 (34%)</td>
<td>22 (28%)</td>
</tr>
<tr>
<td>SD</td>
<td>12 (15%)</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>PD</td>
<td>2 (3%)</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>NE</td>
<td>6 (8%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>ORR (CR or PR)</td>
<td>60 (75%) [64, 84]</td>
<td>63 (79%) [68, 87]</td>
</tr>
</tbody>
</table>

*By IHC; †Two-sided confidence interval was calculated using the exact probability method based on the binomial distribution.

BICR, blinded independent central review; CI, confidence interval; CR, complete response; MRD, minimal residual disease; NE, not evaluable; ORR, overall response; PD, progressive disease; PR, partial response; SD, stable disease.
Moxetumomab pasudotox
Hairy cell leukaemia 3rd line+ - Study ‘1053’ - duration of response

- Median duration of CR, hematologic remission from CR, and PFS not reached
- In phase 1 study, IHC MRD status was associated with longer duration of response (82.7 vs 54.7 mos)

CI, confidence interval; CR, complete response; IHC, immunohistochemistry; MRD, minimal residual disease; NA, not available; NE, not evaluable; NR, not reached; PFS, progression-free survival; PR, partial response; SD, stable disease.
## Treatment-Related Grade 3/4 Adverse Events

<table>
<thead>
<tr>
<th>AE (Observed in ≥2% of Patients)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any treatment-related grade 3/4 AE</td>
<td>24 (30.0%)</td>
</tr>
<tr>
<td>Lymphocyte count decreased</td>
<td>6 (7.5%)</td>
</tr>
<tr>
<td>Hemolytic uremic syndrome</td>
<td>4 (5.0%)</td>
</tr>
<tr>
<td>Capillary leak syndrome</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>Nausea</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>Anemia</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>White blood cell count decreased</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>Platelet count decreased</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>2 (2.5%)</td>
</tr>
<tr>
<td>Acute kidney injury</td>
<td>2 (2.5%)</td>
</tr>
</tbody>
</table>

AE, adverse event.
Moxetumomab pasudotox
Hairy cell leukaemia 3rd line+ - Study ‘1053’ - safety summary

CLS and HUS events

• Characteristics
  • 10 patients developed CLS and/or HUS (3 CLS, 3 HUS, 4 CLS and HUS)
  • Occurred in any treatment cycle
  • All events resolved with supportive care and/or treatment discontinuation (n=6)

• Management
  • Prophylactic oral hydration during the first week of each cycle and proper intravenous fluid supplementation on the day of infusion
  • Close monitoring of blood pressure, body weight, and blood creatinine
  • Monitoring of schistocytes in peripheral blood smear if HUS suspected
  • Supportive medical care
  • For severe cases, intensive care (without plasma exchange) and treatment discontinuation

CLS, capillary leak syndrome; HUS, hemolytic uremic syndrome.
Conclusions

• Moxetumomab pasudotox resulted in a deep and durable response and eradicated MRD in a substantial proportion of pretreated patients with relapsed/refractory HCL

• Moxetumomab pasudotox had an acceptable tolerability profile
  • Low rates of treatment-related AEs leading to discontinuation
  • CLS and HUS were manageable and reversible with close monitoring and best supportive care

• Moxetumomab pasudotox is a non-chemotherapeutic agent that has the potential to become a standard of care for patients with relapsed/refractory HCL

CLS, capillary leak syndrome; HCL, hairy cell leukemia; HUS, hemolytic uremic syndrome; MRD, minimal residual disease.
Neurofibromatosis type 1 (NF-1) is an incurable genetic condition that can cause tumours to form in the nervous system, including the brain, spinal cord and nerves.

- In many cases, careful monitoring and treatment can help people with NF-1 live a full life. However in some people, the risk of some complications can reduce life expectancy by up to 15 years.
- Symptoms are often evident at birth or shortly afterwards, and almost always by age 10.
- NF-1 affects approximately one in 3,000 births. There is no variation in prevalence regardless of race or gender.

**Family history**
In around 50% of all cases, the mutated gene is passed from parent to child.

**Spontaneous mutation**
In 50% of NF-1 cases, the mutation happens spontaneously just before conception.

Source: AstraZeneca data on file; NF-1 backgrounder.
Selumetinib
NF-1 - SPRINT trial - trial overview

Phase 2 Selumetinib in NF1 PN
Multi-Institutional CTEP Sponsored Study

Study Objectives:
• Primary: Complete and partial response (PR) rate as measured by volumetric MRI
• Secondary:
  • Effect on pain, quality of life, disfigurement and physical functioning
  • Long term safety and tolerability
  • Pharmacodynamics (endothelial progenitors, cytokines)

Eligibility:
• Children 2-18 years old with NF1 and inoperable PN causing morbidity

Selumetinib Administration:
• 25 mg/m²/dose BID continuous dosing (1 cycle = 28 days)

Response Evaluations:
• Volumetric MRI every 4 cycles for 2 years (then every 6 cycles)
Selumetinib
NF-1 - SPRINT trial - primary endpoint (PR)

Best Response Through November 2017

32/36 PR were confirmed on consecutive restaging scans (4 months apart)
Selumetinib
NF-1 - SPRINT trial - safety summary

Safety and Tolerability

- Median cycles on study: 19.5 (range 0 - 29)
- Most common: GI, CPK increase, rash, paronychia
- 12 patients with dose reductions:
  - 4 patients removed from treatment for adverse event at least possibly related to study drug

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Cycle Off Treatment</th>
<th>Adverse Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>4019001</td>
<td>3</td>
<td>Diarrhea (Grade 3)</td>
</tr>
<tr>
<td>3019003</td>
<td>8</td>
<td>Elevated creatinine (Grade 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anemia (Grade 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypocalcemia (Grade 3)</td>
</tr>
<tr>
<td>1019028</td>
<td>9</td>
<td>Weight gain (Grade 3)</td>
</tr>
<tr>
<td>2019007</td>
<td>15</td>
<td>Paronychia (Grade 3)</td>
</tr>
</tbody>
</table>
Selumetinib
NF-1 - SPRINT trial - conclusions

Phase 2 Selumetinib Trial Conclusions:

• Confirmation of phase I study observed PR rate (71% / 72%)
• Responses are durable
• Selumetinib is well tolerated with reversible AE’s
• Functional & PRO evaluations are feasible
• Improvement in functional and PRO endpoints
• Database validation and additional analyses ongoing
Other highlights
Additional key data; details available in break-out sessions

### DNA damage response
- **Lynparza + vistusertib**
  (AZD2014, mTORC1/2 inhibitor)
  ovarian cancer and TNBC

### Immuno-Oncology
- **Imfinzi**
  - unresectable Stage III NSCLC - Phase III PACIFIC trial (safety)
- **Imfinzi + treme**
  - GI cancers - Phase I Study 1108/021 trials
- **Imfinzi + CTx**
  - mesothelioma - Phase II DREAM trial

### Tumour drivers
- **Imfinzi**
  - NSCLC Stage IV 3rd line - Phase II ATLANTIC trial (updated results)
- **capivasertib**
  (AZD5363, AKT inhibitor)
  TNBC - Phase II

### Haematology
- **Calquence**
  Waldenström Macroglobulinemia (WM) - Phase I/II

1. Triple-negative breast cancer.
2. Small cell lung cancer.
Agenda

AstraZeneca Oncology

Key data at ASCO 2018 Annual Meeting

Break-out sessions

~19:45 - 1st set of four concurrent breakout sessions + Q&A (30 minutes)

10 minutes break to allow for room changes

~20:25 - 2nd set of four concurrent breakout sessions + Q&A (30 minutes)

~21:00 - End

Break-out sessions are recorded and will be made available at astrazeneca.com
Break-out sessions
Each session will run twice; **19:45** and **20:25**

<table>
<thead>
<tr>
<th>Session 1 in Columbus G</th>
<th>Session 2 in Columbus H</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sales &amp; Marketing execution</strong></td>
<td><strong>Lynparza lifecycle; MRK collaboration</strong></td>
</tr>
<tr>
<td>Host: Dave Fredrickson</td>
<td>Host: Klaus Edvardsen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 3 in Columbus I/J</th>
<th>Session 4 in Columbus K/L</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Next-gen DNA damage response and tumour drivers</strong></td>
<td><strong>Next-gen Immuno-Oncology</strong></td>
</tr>
<tr>
<td>Host: Susan Galbraith</td>
<td>Hosts: David Berman &amp; Jean-Charles Soria</td>
</tr>
</tbody>
</table>
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