Capital markets event
Meet AZN management: ASCO 2020

Pascal Soriot, Dave Fredrickson, José Baselga
IR moderator: Thomas Kudsk Larsen

1 June 2020
Webinar is being recorded
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Agenda

Introduction and overview

Oncology strategy and growth

ASCO 2020 highlights

- Tagrisso adjuvant lung cancer (ADAURA trial)
- Imfinzi small cell lung cancer (CASPIAN trial)
- Enhertu gastric, lung and colorectal cancers (DESTINY trials)

Virtual breakout sessions
Meet AZN management: ASCO 2020
Four Q&A-focused, virtual breakout sessions

Opening session
16:00-16:25 BST
Pascal Soriot, Dave Fredrickson, José Baselga

https://astrazeneca.zoom.us/webinar/register/WN_hEt-K5tqRGOxefPvFbTdg
Webinar ID: 957 3417 3925 | IR moderator: thomas.larsen@astrazeneca.com

Tagrisso and immuno-oncology
Session 1: 16:35 BST
Session 2: 17:15 BST
Dave Fredrickson, Cristian Massacesi

https://astrazeneca.zoom.us/webinar/register/WN_-ScpPma9TRST-SNET3fElg
Webinar ID: 936 3943 3037
IR moderator: craig.marks@astrazeneca.com

Enhertu and breast cancer
Session 1: 16:35 BST
Session 2: 17:15 BST
José Baselga, Mika Sovak, Jon Wildin

https://astrazeneca.zoom.us/webinar/register/WN_Mux3EqBhTmeTmtJ-UuhVYA
Webinar ID: 995 5382 4818
IR moderator: tom.waldron@astrazeneca.com

Lynparza
Session 1: 16:35 BST
Session 2: 17:15 BST
Susan Galbraith, Greg Rossi

https://astrazeneca.zoom.us/webinar/register/WN_gvp6EHQ6TW29LlkUbnx3Q
Webinar ID: 989 7940 1118
IR moderator: nick.stone@astrazeneca.com

Calquence and haematology
Session 1: 16:35 BST
Session 2: 17:15 BST
Michelle Werner, Andrew Mortlock

https://astrazeneca.zoom.us/webinar/register/WN_Tx4eYAfSxi4nQ2x8iMkNA
Webinar ID: 933 8283 0734
IR moderator: henry.wheeler@astrazeneca.com

If you cannot connect using Zoom Webinar on a computer or device, please use the following phone details:
+441314601196 | +46844682488 | +16699006833, including the appropriate Webinar ID

Event closes c. 17:45 BST
ASCO 2020

Increasing presence

103 presented abstracts
26% increase over 2019

Data highlights

- **Tagrisso**
  Phase III ADAURA - adjuvant lung cancer (plenary, late-breaking abstract)

- **Imfinzi**
  Phase III CASPIAN - extensive-stage small cell lung cancer

- **Enhertu**
  Phase II trials in gastric, lung and colorectal cancers and update in breast cancer

Source: ASCO 2020 accepted abstracts. A total of 132 abstracts were accepted of which 29 abstracts were selected for publication only.
**ASCO 2020: data from across the portfolio**

‘What’s next’ pipeline featured in many abstracts

### What’s next

**Phase I/II new medicines, selected**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Data at ASCO</th>
<th>Dose Form</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>adavosertib</td>
<td>Data at ASCO</td>
<td>(WEE1&lt;sup&gt;1&lt;/sup&gt; inhibitor)</td>
<td>solid tumours</td>
</tr>
<tr>
<td>monalizumab</td>
<td>Data at ASCO</td>
<td>(NKG2α&lt;sup&gt;1&lt;/sup&gt; mAb&lt;sup&gt;7&lt;/sup&gt;)</td>
<td>head &amp; neck, colorectal cancers</td>
</tr>
<tr>
<td>ceralasertib</td>
<td>Data at ASCO</td>
<td>(ATR&lt;sup&gt;2&lt;/sup&gt; inhibitor)</td>
<td>solid tumours, blood cancers</td>
</tr>
<tr>
<td>oleclumab</td>
<td>Data at ASCO</td>
<td>(CD73&lt;sup&gt;9&lt;/sup&gt; mAb)</td>
<td>lung, pancreatic cancers</td>
</tr>
<tr>
<td>AZD9833</td>
<td>Data at ASCO</td>
<td>(SERD&lt;sup&gt;3&lt;/sup&gt;, oral)</td>
<td>breast cancer</td>
</tr>
<tr>
<td>AZD4635</td>
<td>Data at ASCO</td>
<td>(A2AR&lt;sup&gt;9&lt;/sup&gt; inhibitor)</td>
<td>solid tumours</td>
</tr>
<tr>
<td>AZD5991</td>
<td>Data at ASCO</td>
<td>(MCL1&lt;sup&gt;4&lt;/sup&gt; inhibitor)</td>
<td>blood cancers</td>
</tr>
<tr>
<td>MEDI5752</td>
<td>Data at ASCO</td>
<td>(PD-1&lt;sup&gt;10&lt;/sup&gt; / CTLA-4&lt;sup&gt;11&lt;/sup&gt;)</td>
<td>solid tumours</td>
</tr>
<tr>
<td>AZD2811</td>
<td>Data at ASCO</td>
<td>(Aurora B inhibitor)</td>
<td>solid tumours, blood cancers</td>
</tr>
<tr>
<td>AZD0466</td>
<td>Data at ASCO</td>
<td>(Bcl-2&lt;sup&gt;5&lt;/sup&gt;/xL)</td>
<td>blood cancers</td>
</tr>
<tr>
<td>MEDI2228</td>
<td>Data at ASCO</td>
<td>(BCMA&lt;sup&gt;13&lt;/sup&gt; ADC&lt;sup&gt;14&lt;/sup&gt;)</td>
<td>blood cancers</td>
</tr>
</tbody>
</table>

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Virtual breakout sessions
Oncology: a leading, diversified portfolio

### Lung cancer
- Stage IV NSCLC\(^1\)
  - EGFRm\(^2\) (1L\(^3\))
  - T790M\(^4\) (2L\(^5\))
- Adjuvant use positive

Next
- Stage III, unresectable NSCLC; combinations

### Ovarian
- Ovarian, breast, pancreatic, prostate cancers\(^7\)
- Merck collaboration

Next
- Adjuvant breast, earlier use in prostate cancer, combinations

### Breast
- Breast cancer (3L\(^8\), HER2+\(^9\))
- Daiichi Sankyo collaboration

Next
- Earlier use, other cancers (gastric, lung, colorectal), HER2 low

### Blood cancer
- Chronic lymphocytic leukaemia
- Mantle cell lymphoma

Next
- Combinations, other blood cancers

### Other cancers
- Extensive-stage SCLC\(^6\)
- Stage III, unresectable NSCLC

Next
- Early / advanced stages of several cancers, combinations

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What’s next:
rich, early to mid-stage pipeline, including combinations and a number of new Phase III medicines

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Oncology: strong growth across medicines and geographies

- **Lung cancer**
  - US launch Q1 2020 in 3L, HER2+ mBC
  - ~30% share of patients in 3L setting

- **Ovarian**
  - Lynparza

- **Breast**
  - US launch Q1 2020
  - ~30% share of patients in 3L setting
  - JP launch Q2 2020; preparing for regulatory submission elsewhere

- **Blood cancer**
  - Calquence (acalabrutinib)

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1. Metastatic breast cancer.

*Legend:

- US
- Europe
- Established Rest of World (RoW)
- Emerging markets

Absolute product sales at actual exchange rates.
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**ADAURA Phase III double-blind study design**

*Patients with completely resected stage*¹ IB, II, IIIA NSCLC, with or without adjuvant chemotherapy

- Key inclusion criteria:
  - ≥18 years (Japan / Taiwan: ≥20)
  - WHO performance status 0 / 1
  - Confirmed primary non-squamous NSCLC
  - Ex19del / L858R²
  - Brain imaging, if not completed pre-operatively
  - Complete resection with negative margins⁵
  - Max. interval between surgery and randomization:
    - 10 weeks without adjuvant chemotherapy
    - 26 weeks with adjuvant chemotherapy

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**Stratification by:**

- stage (IB vs II vs IIIA)
- EGFRm (Ex19del vs L858R)³
- race (Asian vs non-Asian)

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**Randomization**

- 1:1
- (N=682)

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**Planned treatment duration: 3 years**

- Treatment continues until:
  - Disease recurrence
  - Treatment completed
  - Discontinuation criterion met

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**Follow up:**

- Until recurrence: Week 12 and 24, then every 24 weeks to 5 years, then yearly
- After recurrence: every 24 weeks for 5 years, then yearly

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**Endpoints**

- **Primary:** DFS, by investigator assessment, in stage II/III A patients; designed for superiority under the assumed DFS HR of 0.70
- **Secondary:** DFS in the overall population⁶, DFS at 2, 3, 4, and 5 years, OS, safety, health-related quality of life

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- Following IDMC recommendation, the study was unblinded early due to efficacy; here we report an unplanned interim analysis
- At the time of unblinding the study had completed enrollment and all patients were followed up for at least 1 year
Tagrisso ADAURA - 2

All causality adverse events (≥10% of patients)

Median duration of exposure: osimertinib: 22.3 months (range 0 to 43), placebo: 18.4 months (range 0 to 48)

- Grade 1/2 interstitial lung disease (grouped terms) was reported in 10 (3%) patients in the osimertinib arm*
- QTc prolongation was reported in 22 (7%) patients in the osimertinib arm and 4 (1%) patients in the placebo arm†

Diarrhea
Paronychia
Dry skin
Pruritus
Cough
Stomatitis
Nasopharyngitis
Decreased appetite
URTI
Dermatitis aciform
Mouth ulceration

Patients with adverse event (%)
Primary endpoint: DFS in patients with stage II/IIIA disease

- **Median DFS, months (95% CI)**
  - Osimertinib: NR (38.8, NC)
  - Placebo: 20.4 (16.6, 24.5)
  - HR (95% CI): 0.17 (0.12, 0.23); p<0.0001

Maturity 33%: osimertinib 11%, placebo 55%
Secondary endpoint: DFS in the overall population (stage IB/II/IIIA)

- Osimertinib: NR (NC, NC)
- Placebo: 28.1 (22.1, 35.8)
- HR (95% CI): 0.21 (0.16, 0.28); p<0.0001

Maturity 29%:
- Osimertinib 12%, placebo 46%
### DFS across subgroups in the overall population

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Stratified log-rank</th>
<th>Unadjusted Cox PH</th>
<th>HR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall (N=682)</td>
<td></td>
<td></td>
<td>0.21</td>
<td>0.16, 0.28</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td>0.20</td>
<td>0.14, 0.29</td>
</tr>
<tr>
<td>Male (n=204)</td>
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<td></td>
<td>0.21</td>
<td>0.11, 0.36</td>
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<tr>
<td>Female (n=478)</td>
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<td></td>
<td>0.20</td>
<td>0.12, 0.30</td>
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<tr>
<td>Age</td>
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<td></td>
<td>0.24</td>
<td>0.14, 0.38</td>
</tr>
<tr>
<td>&lt;65 (n=380)</td>
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<td></td>
<td>0.18</td>
<td>0.10, 0.28</td>
</tr>
<tr>
<td>≥65 (n=302)</td>
<td></td>
<td></td>
<td>0.24</td>
<td>0.14, 0.38</td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
<td></td>
<td>0.14</td>
<td>0.06, 0.27</td>
</tr>
<tr>
<td>Smoker (n=194)</td>
<td></td>
<td></td>
<td>0.23</td>
<td>0.15, 0.34</td>
</tr>
<tr>
<td>Non-smoker (n=488)</td>
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<td></td>
<td>0.22</td>
<td>0.14, 0.33</td>
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<tr>
<td>Race</td>
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<td>0.17</td>
<td>0.08, 0.31</td>
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<tr>
<td>Asian (n=434)</td>
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<td>0.17</td>
<td>0.08, 0.31</td>
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<tr>
<td>Non-Asian (n=248)</td>
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<td></td>
<td>0.17</td>
<td>0.08, 0.31</td>
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<tr>
<td>Stage</td>
<td></td>
<td></td>
<td>0.12</td>
<td>0.07, 0.20</td>
</tr>
<tr>
<td>Stage IB (n=212)</td>
<td></td>
<td></td>
<td>0.50</td>
<td>0.25, 0.96</td>
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<tr>
<td>Stage II (n=236)</td>
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<td></td>
<td>0.17</td>
<td>0.08, 0.31</td>
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<tr>
<td>Stage IIIA (n=234)</td>
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<td>0.12</td>
<td>0.07, 0.20</td>
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<tr>
<td>EGFRm</td>
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<td></td>
<td>0.12</td>
<td>0.07, 0.20</td>
</tr>
<tr>
<td>Ex19del (n=378)</td>
<td></td>
<td></td>
<td>0.35</td>
<td>0.21, 0.55</td>
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<tr>
<td>L858R (n=304)</td>
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<td>0.35</td>
<td>0.21, 0.55</td>
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<tr>
<td>Adjuvant chemotherapy</td>
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<td>0.18</td>
<td>0.11, 0.29</td>
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<tr>
<td>Yes (n=378)</td>
<td></td>
<td></td>
<td>0.18</td>
<td>0.11, 0.29</td>
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<tr>
<td>No (n=304)</td>
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<td></td>
<td>0.23</td>
<td>0.13, 0.38</td>
</tr>
</tbody>
</table>

Favors osimertinib  Favor placebo
Early snapshot: overall survival in patients with stage II/III A disease

- Osimertinib
  - Median OS, months (95% CI): NR (NC, NC)
  - HR (95% CI): 0.40 (0.18, 0.90)
  - Maturity 5%
    - Osimertinib 3%, placebo 7%

- Placebo
  - Median OS, months (95% CI): NR (NC, NC)

No. at risk

<table>
<thead>
<tr>
<th>Osimertinib</th>
<th>Placebo</th>
</tr>
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<tbody>
<tr>
<td>233</td>
<td>237</td>
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<tr>
<td>229</td>
<td>231</td>
</tr>
<tr>
<td>221</td>
<td>221</td>
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</table>

Time from randomization (months)

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<th>Osimertinib</th>
<th>Placebo</th>
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</thead>
<tbody>
<tr>
<td>192</td>
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<tr>
<td>137</td>
<td>127</td>
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</table>
Conclusions

- Adjuvant osimertinib is the first targeted agent in a global trial to show a statistically significant and clinically meaningful improvement in DFS in patients with stage IB / II / IIIA EGFRm NSCLC
  - Overall, there was a 79% reduction in the risk of disease recurrence or death with osimertinib (DFS HR 0.21 [95% CI 0.16, 0.28]; p<0.0001)
  - Osimertinib vs placebo DFS rates at 2 years were 89% vs 53%, respectively
- A consistent improvement in DFS was seen regardless of whether patients received prior adjuvant chemotherapy
- The safety profile was consistent with the established safety profile of osimertinib, with mild EGFR-TKI class effects reported; median duration of exposure to osimertinib was 22 months

Adjuvant osimertinib will provide a highly effective, practice changing treatment for patients with stage IB / II / IIIA EGFRm NSCLC after complete tumor resection.
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Virtual breakout sessions
Updated Overall Survival: D+EP vs EP

<table>
<thead>
<tr>
<th></th>
<th>D+EP</th>
<th>EP</th>
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<tbody>
<tr>
<td>Events, n/N (%)</td>
<td>210/268 (78.4)</td>
<td>231/269 (85.9)</td>
</tr>
<tr>
<td>mOS, months (95% CI)</td>
<td>12.9 (11.3–14.7)</td>
<td>10.5 (9.3–11.2)</td>
</tr>
<tr>
<td>HR (95% CI)</td>
<td>0.75 (0.62–0.91)</td>
<td>0.0032</td>
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<td>Nominal p-value</td>
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No. at risk

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</table>
Conclusions

- First-line durvalumab + EP continued to demonstrate sustained improvement in OS compared with a robust control arm that allowed up to 6 cycles of EP and the use of PCI
  - OS HR 0.75 (95% CI 0.62–0.91; nominal p=0.0032)
  - Sustained separation of OS curves with 22.2% vs 14.4% of patients alive at 24 months
  - Benefit was observed across all pre-specified subgroups and key secondary efficacy outcomes

- Addition of tremelimumab to durvalumab + EP did not significantly improve outcomes in CASPIAN

- Safety findings in all arms remained consistent with the known safety profiles of all agents

- These results further support durvalumab + EP as a new standard-of-care treatment for first-line ES-SCLC offering the flexibility of platinum choice
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Virtual breakout sessions
**DESTINY-Gastric01**

**Primary Endpoint: ORR**

<table>
<thead>
<tr>
<th></th>
<th>T-DXd (n = 119)</th>
<th>PC (n = 56)</th>
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</thead>
<tbody>
<tr>
<td><strong>ORR by ICR (CR + PR)</strong></td>
<td>51.3% (n = 61)</td>
<td>14.3% (n = 8)</td>
</tr>
<tr>
<td>95% CI, 41.9-60.5; P &lt; .0001</td>
<td>95% CI, 6.4-26.2</td>
<td></td>
</tr>
<tr>
<td><strong>Confirmed ORR by ICR (CR + PR)</strong></td>
<td>42.9% (n = 51)</td>
<td>12.5% (n = 7)</td>
</tr>
<tr>
<td>95% CI, 33.8-52.3</td>
<td>95% CI, 5.2-24.1</td>
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</tr>
<tr>
<td><strong>CR</strong></td>
<td>8.4% (n = 10)</td>
<td>0</td>
</tr>
<tr>
<td><strong>PR</strong></td>
<td>34.5% (n = 41)</td>
<td>12.5% (n = 7)</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>42.9% (n = 51)</td>
<td>50.0% (n = 28)</td>
</tr>
<tr>
<td><strong>PD</strong></td>
<td>11.8% (n = 14)</td>
<td>30.4% (n = 17)</td>
</tr>
<tr>
<td><strong>Not evaluable</strong></td>
<td>2.5% (n = 3)</td>
<td>7.1% (n = 4)</td>
</tr>
<tr>
<td><strong>Confirmed DCR (CR + PR + SD)</strong></td>
<td>85.7% (n = 102)</td>
<td>62.5% (n = 35)</td>
</tr>
<tr>
<td>95% CI, 78.1-91.5</td>
<td>95% CI, 48.5-75.1</td>
<td></td>
</tr>
<tr>
<td><strong>Median confirmed DOR</strong></td>
<td>11.3 months</td>
<td>3.9 months</td>
</tr>
<tr>
<td>95% CI, 5.6-NE</td>
<td>95% CI, 3.0-4.9</td>
<td></td>
</tr>
</tbody>
</table>

Includes data for the response evaluable set: all randomized patients who received ≥1 dose of study drug and had measurable tumors based on independent central review at baseline.
Enhertu gastric cancer - 2

DESTINY-Gastric01

Overall and Progression-Free Survival

**Overall Survival**

- **Events/n**: T-DXd 62/125, Physician’s choice 39/62
- **Median**: T-DXd 12.5 months (95% CI, 9.6-14.3), Physician’s choice 8.4 months (95% CI, 6.9-10.7)
- **HR**: T-DXd 0.59 (95% CI, 0.39-0.88), Physician’s choice 0.47 (95% CI, 0.31-0.71)

**Progression-Free Survival**

- **Events/n**: T-DXd 73/125, Physician’s choice 36/62
- **Median**: T-DXd 5.6 months (95% CI, 4.3-6.9), Physician’s choice 3.5 months (95% CI, 2.0-4.3)
Enhertu gastric cancer - 3

**DESTINY-Gastric01 Safety Summary**

- **TEAEs associated with:**
  - T-DXd (n = 125)
  - PC (n = 62)
  - Drug discontinuation: 15.2% vs. 6.5%
  - Dose reduction: 32.0% vs. 33.9%
  - Dose interruption: 62.4% vs. 37.1%

- There was 1 drug-related death due to pneumonia with T-DXd and none with PC.

- 12 patients (9.6%) had T-DXd-related ILD/pneumonitis as determined by an independent adjudication committee:
  - Median time to first onset, 84.5 days (range, 36-638 days)
  - Most were grade 1 or 2 (grade 1, n=3; grade 2, n=6; grade 3, n=2; grade 4, n=1; no grade 5 events)
Enhertu lung cancer - 1

DESTINY-Lung01 HER2-Mutated NSCLC

Best Change in Tumor Size

Based on independent central review. Baseline is last measurement taken before enrollment. Shown is best (minimum) percent change from baseline in the sum of diameters for all target lesions.

*One patient was missing a baseline assessment and 2 additional patients were missing post-baseline assessments.
Enhertu lung cancer - 2

DESTINY-Lung01 HER2-Mutated NSCLC

Treatment-Emergent Adverse Events in >15% of Patients

- Nausea
- Alopecia
- Anemia
- Decreased appetite
- Neutrophil count decreased*  
- Vomiting
- Diarrhea
- Weight decreased
- Constipation
- Fatigue
- WBC count decreased
- AST increased
- Malaise
- Lung infection
- Pyrexia

Patients (N = 42)
Grade 1 or 2
Grade ≥3

*2 patients had febrile neutropenia; grade ≥3 neutrophil count decreased, 26.2%.
Enhertu colorectal cancer - 1

DESTINY-CRC01 Cohort A

Best Change in Tumor Size

HER2+ Cohort A (N = 53)
- IHC3+
- IHC2+/ISH+
- Prior anti-HER2 treatment
- HER2 IHC2+/ISH+ with an NRAS mutation
Enhertu colorectal cancer - 2

DESTINY-CRC01

Treatment-Emergent Adverse Events in >15% of Patients

- Nausea
- Anemia
- Neutrophil count decreased\(^a\)
- Fatigue
- Decreased appetite
- Platelet count decreased
- Vomiting
- Diarrhea
- Alopecia
- Hypokalemia
- WBC count decreased

All Patients (N=78)

- Grade 1 & 2
- Grade ≥3

\(^a\) Grade ≥3 neutrophil count decreased, 25.6%, no patients had febrile neutropenia.
Agenda

Introduction and overview

Oncology strategy and growth

ASCO 2020 highlights

- Tagrisso adjuvant lung cancer (ADAURA trial)
- Imfinzi small cell lung cancer (CASPIAN trial)
- Enhertu gastric, lung and colorectal cancers (DESTINY trials)

Virtual breakout sessions
Meet AZN management: ASCO 2020
Four Q&A-focused, virtual breakout sessions

Opening session
16:00-16:25 BST
Pascal Soriot, Dave Fredrickson, José Baselga

https://astrazeneca.zoom.us/webinar/register/WN_hEt-K5tqRGOxefPVfBtTdg
Webinar ID: 957 3417 3925 | IR moderator: thomas.larsen@astrazeneca.com

Tagrisso and immuno-oncology
Session 1: 16:35 BST
Session 2: 17:15 BST
Dave Fredrickson, Cristian Massacesi
https://astrazeneca.zoom.us/webinar/register/WN_-ScpPmA9TRST-5NET3fEig
Webinar ID: 936 3943 3037 | IR moderator: craig.marks@astrazeneca.com

Enhertu and breast cancer
Session 1: 16:35 BST
Session 2: 17:15 BST
José Baselga, Mika Sovak, Jon Wildin
https://astrazeneca.zoom.us/webinar/register/WN_Mux3EqBhTmeTmtJ-UuhVYA
Webinar ID: 995 5382 4818 | IR moderator: tom.waldron@astrazeneca.com

Lynparza
Session 1: 16:35 BST
Session 2: 17:15 BST
Susan Galbraith, Greg Rossi
https://astrazeneca.zoom.us/webinar/register/WN_gvp6EHQ6TW29LiKUbnx3Q
Webinar ID: 989 7940 1118 | IR moderator: nick.stone@astrazeneca.com

Calquence and haematology
Session 1: 16:35 BST
Session 2: 17:15 BST
Michelle Werner, Andrew Mortlock
https://astrazeneca.zoom.us/webinar/register/WN_Tx4eYAyF5xi4nQ2x8iMkNA
Webinar ID: 933 8283 0734 | IR moderator: henry.wheeler@astrazeneca.com

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Event closes c. 17:45 BST
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