Meet AZN Management: ERS 2026

Conference call and webcast for investors and analysts

8 September 2026

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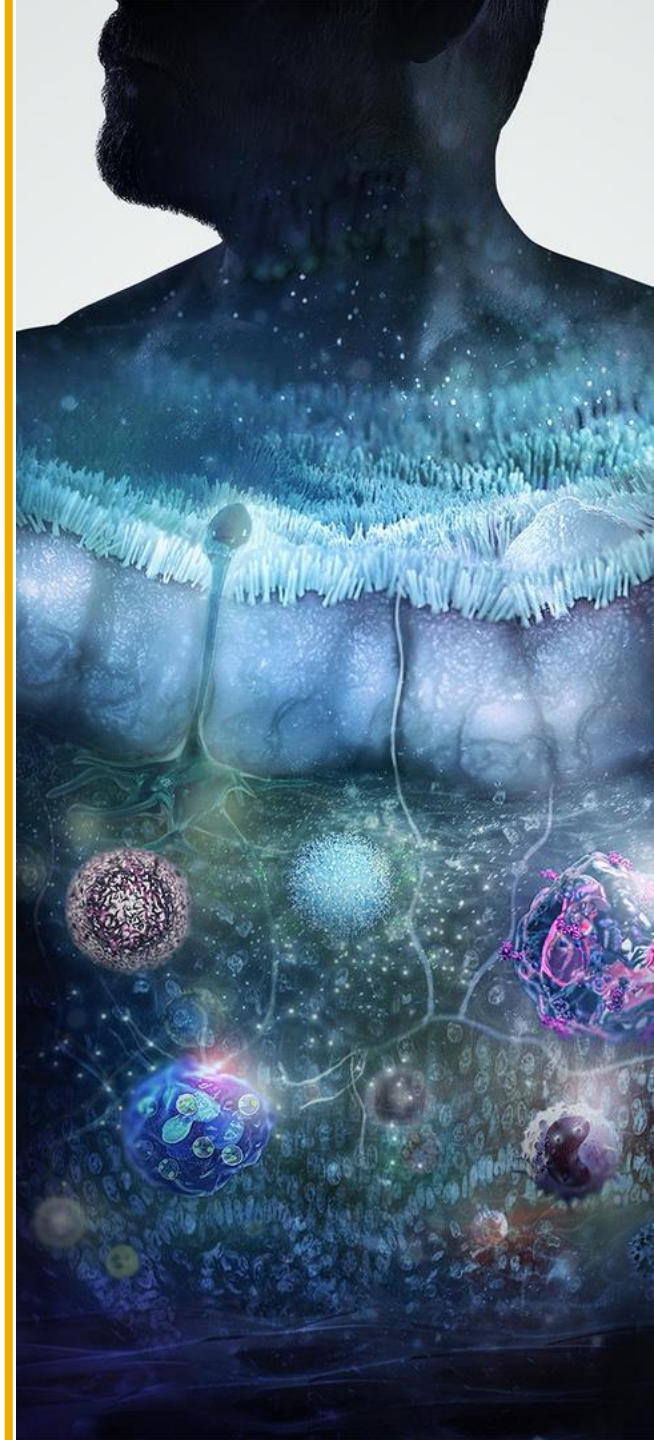
Meet AZN Management @ ERS – agenda

Furthering the AstraZeneca ambition with R&I	**Ruud Dobber,** EVP, BioPharmaceuticals Business **Sharon Barr,** EVP, BioPharmaceuticals R&D
Tozorakimab in COPD – Phase III: OBERON and TITANIA	**Frank C. Sciurba, MD** Professor of Pulmonary and Critical Care Medicine, University of Pittsburgh
Unlocking the potential of tozorakimab	**Sharon Barr,** EVP, BioPharmaceuticals R&D
Delivering growth to 2030 and beyond	**Pascal Soriot,** Chief Executive Officer
Q&A session	



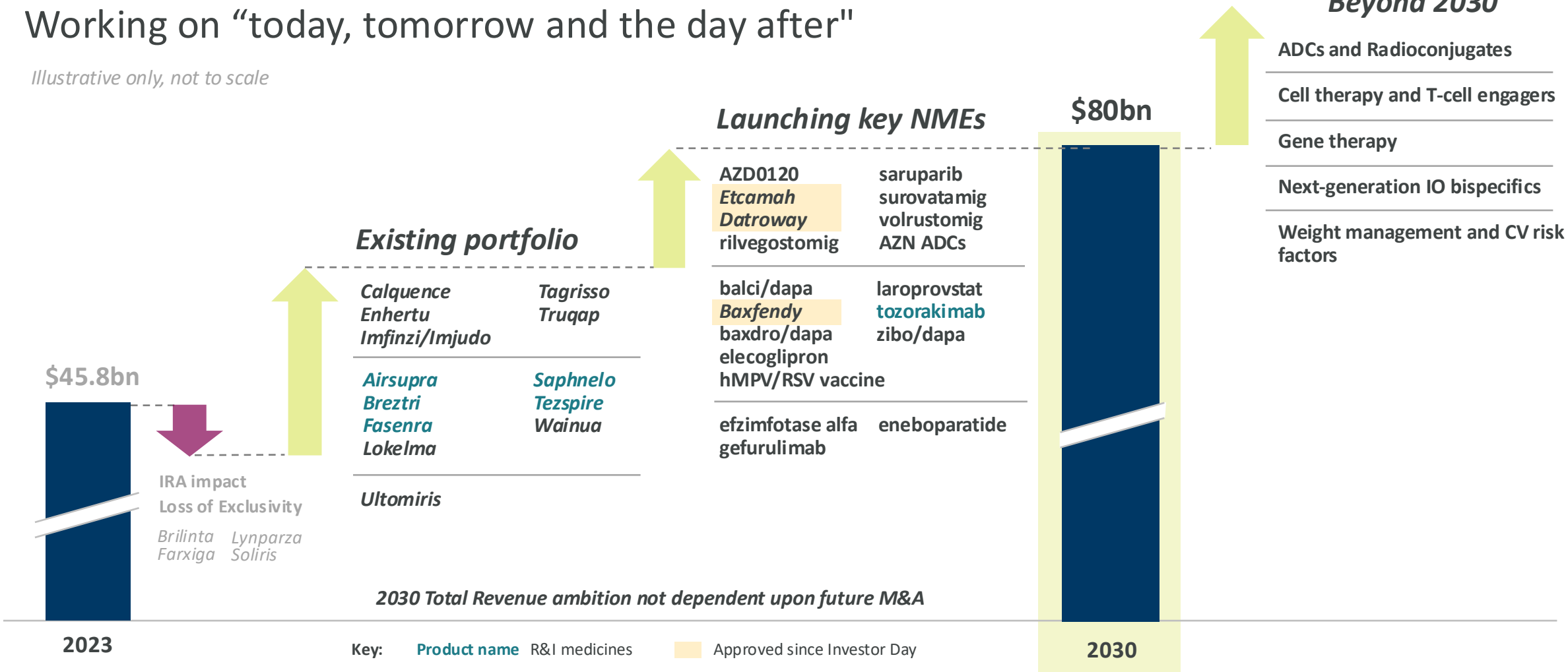
Furthering the AstraZeneca ambition with R&I

Ruud Dobber
EVP, BIOPHARMACEUTICALS BUSINESS
Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

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

R&I portfolio to contribute meaningfully to 2030 Ambition and growth thereafter

Six key growth drivers in R&I portfolio

Fasenra®

BREZTRI AEROSPHERE®

TEZSPIRE®

AIRSUPRA™

tozorakimab

Saphnelo™

Additional LCM indications in Phase III

CROSSING | *Tezspire* eosinophilic esophagitis	✓	**JASMINE** | *Saphnelo* idiopathic inflammatory myopathies — H2 2027
EMBARK / JOURNEY | *Tezspire* chronic obstructive pulmonary disease — >2027		**DAISY** | *Saphnelo* systemic sclerosis — H1 2027
TILIA | tozorakimab severe lower respiratory tract disease — H2 2027		**IRIS** | *Saphnelo* lupus nephritis — H1 2027
THARROS | *Breztri* cardiopulmonary outcomes in COPD — >2027		**LAVENDER** | *Saphnelo* cutaneous lupus erythematosus — H1 2027

R&I portfolio has **5 NMEs** in Phase II to drive additional growth

R&I portfolio has multiple recently launched products and deep pipeline to fuel future growth

Respiratory | Immunology

Appendix: Glossary

AstraZeneca respiratory portfolio spans the full spectrum of asthma and COPD care

Primary care-led — ***Increasing severity*** — *Specialty care-led*

	INHALED	NOVEL ORAL/INHALED	BIOLOGIC
Asthma	**~54M** patients ***Airsupra*** ***Breztri*** ***Symbicort***	**~3.6M** patients **sunakiment** — iTSLP Fab	***Fasenra*** ***Tezspire*** **tozorakimab** — IL-33 inhibitor
COPD	**~40M** patients ***Breztri*** ***Symbicort*** **TQC3721** — PDE3/4 inhibitor	**~4.6M** patients **AZD6793** — oIRAK4 inhibitor	**tezepelumab** — TSLP inhibitor **tozorakimab** — IL-33 inhibitor

Marketed Pipeline

Estimated epidemiology reflects maintenance-treated patients on inhaled therapies and biologic-eligible patients within novel oral/inhaled and biologic in Top 8 countries in 2026. Collaboration partners: Amgen (*Tezspire* / tezepelumab, sunakiment). Appendix: Glossary

COPD remains a disease with high unmet need which places significant burden on healthcare systems

Remaining high unmet need in COPD globally

~40 million

patients with COPD on maintenance therapy

3rd

leading cause of death[1]

Exacerbations are a leading cause of death and healthcare system costs

50%

of patients on inhaled SoC still experience exacerbations[2]

1 in 2

Patients die within 3.5 years after first severe exacerbation[3]

$4T

estimated cost to global health systems of COPD from 2020 to 2050[4]

Prevention of COPD exacerbations is a critical goal in the treatment of COPD to improve patient outcomes and reduce healthcare costs

1. World Health Organization (WHO). The top 10 causes of death. 2024. Excluding COVID-19. 2. Chen S, Small M, Lindner L, Xu X. Symptomatic burden of COPD for patients receiving dual or triple therapy. Int J Chron Obstruct Pulmon Dis 2018;13:1365–1376. 3. Suissa S, Dell'Aniello S, Ernst P. Long-term natural history of chronic obstructive pulmonary disease: severe exacerbations and mortality. Thorax 2012;67:957–963. 4. Chen S, Kuhn M, Prettner K, et al. 2023. The global economic burden of chronic obstructive pulmonary disease for 204 countries and territories in 2020-2050. Lancet Glob Health 11(8): e1183-e93. Appendix: Glossary

tozorakimab – Phase III OBERON and TITANIA

Frank C. Sciurba, MD
Professor of Pulmonary and Critical Care Medicine, University of Pittsburgh

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Tozorakimab to prevent COPD exacerbations: results from the replicate OBERON and TITANIA phase 3 studies

Frank C Sciurba,* Henrik Watz,* Arnaud Bourdin, Wim Janssens, Fernando J Martinez, Jinping Zheng, Maarten van den Berge, Matteo Bonini, MeiLan K Han, Dave Singh, Gerard J Criner, Christopher E Brightling, Alberto Papi, Surya P Bhatt, Martin Jenkins, Marta Mikosz, Piotr Chołbiński, Monika Ziemiecka, Magnus Löfdahl, Deepa Arya, Madhavi Yadavalli, Bryan H Brodek, Malin Fagerås, Samuel Bardsley, Neil Martin, Rajesh Patel, Ioannis Psallidas

**Co-first authors who contributed equally to this work*

COPD is associated with a high disease burden and high unmet need

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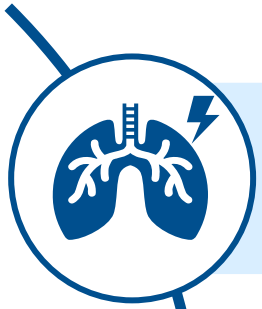
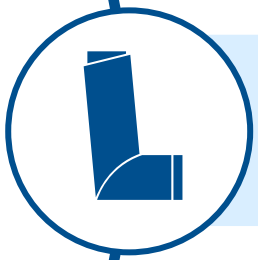


COPD exacerbations accelerate lung function decline, reduce quality of life, and increase risks of hospitalization and death[1,2]



Over 50% of patients remain at a **high risk of exacerbations** while on standard-of-care inhaled maintenance therapy[3]

Approved biologics are **limited** to adults with inadequately controlled COPD and an **eosinophilic phenotype**[4–8]

BEC, blood eosinophil count; COPD, chronic obstructive pulmonary disease. **1.** Donaldson GC *et al. Thorax* 2002;57:847–52. **2.** Daniels K *et al. Int J Chron Obstruct Pulmon Dis* 2024;19:225–41. **3.** Nordon C *et al. Int J Chron Obstruct Pulmon Dis* 2025;20:1851–64. **4.** Bhatt SP *et al. N Engl J Med* 2023;389:205–14. **5.** Bhatt SP *et al. N Engl J Med* 2024;390:2274–83. **6.** Sciurba FC *et al. N Engl J Med* 2025;392:1710–20. **7.** Regeneron Pharmaceuticals. Dupixent, Prescribing information. FDA, 2026. https://www.regeneron.com/downloads/dupixent_fpi.pdf (Accessed 22 July 2026). **8.** GlaxoSmithKline. Prescribing information, Nucala. FDA, 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125526s007lbl.pdf (Accessed 22 July 2026)

IL-33 is an upstream cytokine with two distinct bioactive forms that contribute to the pathophysiology of COPD[9,10]

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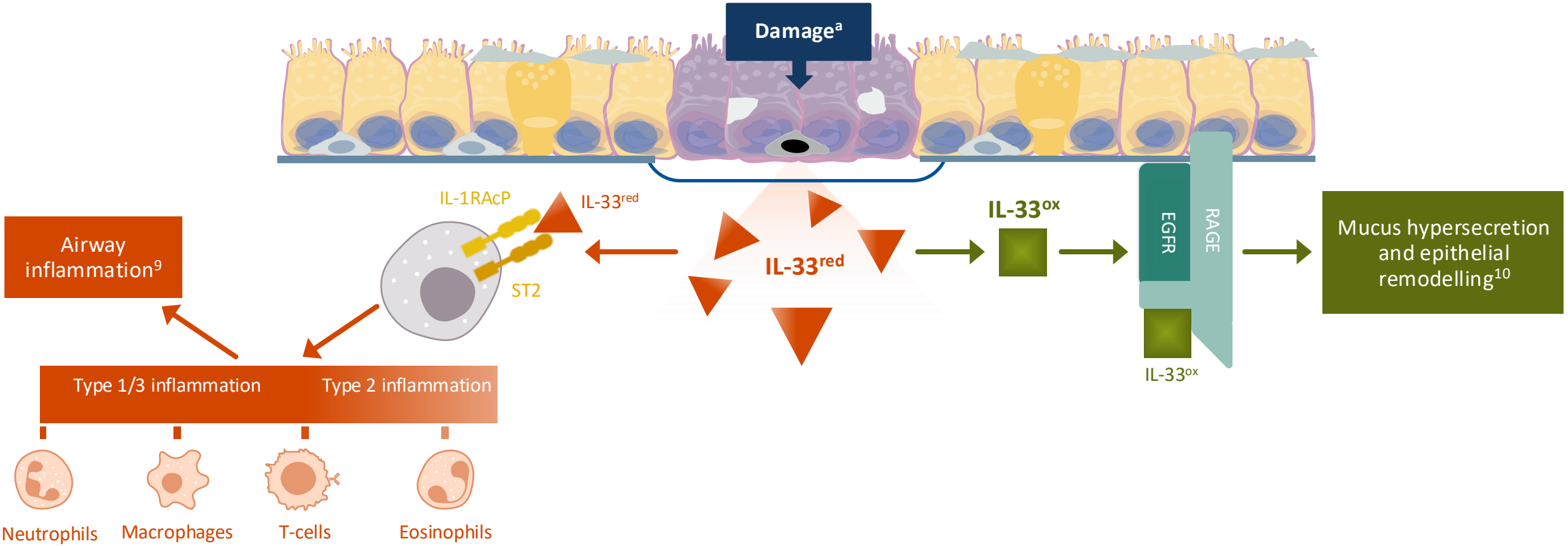

[a]Damage induced by smoke, pollutants, and viral or bacterial exposure. EGFR, epidermal growth factor receptor; IL-1RAcP, interleukin-1 receptor accessory protein; IL-33, interleukin-33; ox, oxidized; RAGE, receptor for advanced glycation end products; red, reduced; ST2, serum stimulation-2. **9.** England E *et al. Sci Rep* 2023;13:9825. **10.** Strickson S *et al. Eur Respir J* 2023;62:2202210

Tozorakimab is a monoclonal antibody that inhibits the activity of both IL-33^{red} and IL-33^{ox},[9]

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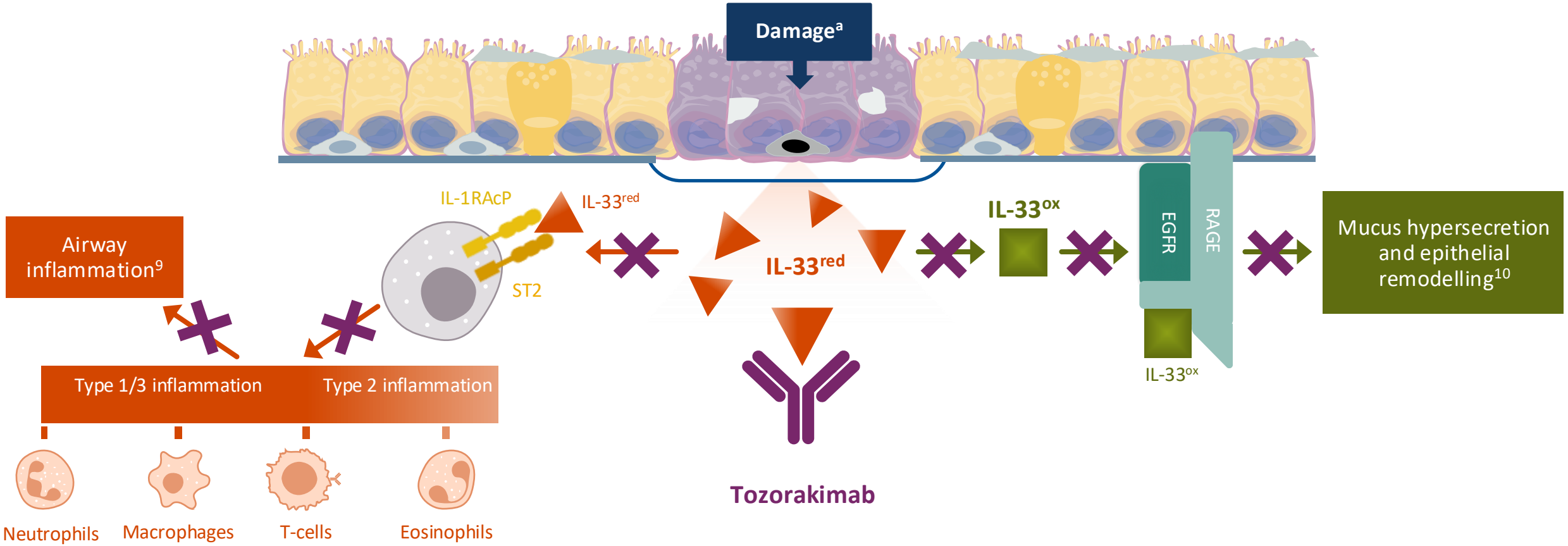

Aim: **Evaluate the efficacy and safety of tozorakimab compared with placebo when added to standard of care in patients with COPD with a history of exacerbations**

[a]Damage induced by smoke, pollutants, and viral or bacterial exposure. EGFR, epidermal growth factor receptor; IL-1RAcP, interleukin-1 receptor accessory protein; IL-33, interleukin-33; ox, oxidized; RAGE, receptor for advanced glycation end products; red, reduced; ST2, serum stimulation-2. **9.** England E *et al. Sci Rep* 2023;13:9825. **10.** Strickson S *et al. Eur Respir J* 2023;62:2202210

OBERON and TITANIA were replicate, phase 3, randomized, double-blind, placebo-controlled studies

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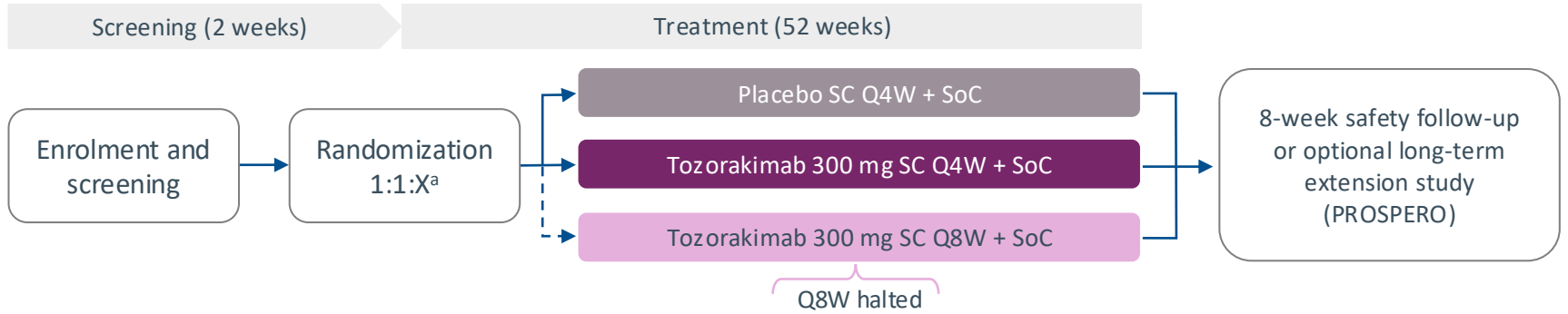
Patient population

- Adults (aged ≥ 40 yr) with COPD for ≥ 1 yr
- ≥ 2 moderate or ≥ 1 severe COPD exacerbations (past 12 months)
- On stable SoC inhaled therapy (triple or dual)
- Current or former smokers
- Post-bronchodilator FEV_1 > 20% of predicted normal
- CAT total score ≥ 10 (phlegm and cough item scores of ≥ 2)
- Any blood eosinophil count (BEC)

Study design[11]



Primary endpoint

Annualized rate of moderate/severe exacerbations[b] in former smokers

Key secondary and safety endpoints in hierarchical order

- **Annualized rate of moderate/severe exacerbations[b] in the overall population (current and former smokers)**
- SGRQ total score[c]
- Pre-bronchodilator FEV_1[c]
- Post-bronchodilator FEV_1[d]
- E-RS:COPD total score[c]
- Annualized rate of hospitalization and or ER/ED visits[e]
- **Adverse events and MACE**

[a]Before the protocol amendment X = 1; following the protocol amendment X = 0. [b]Moderate exacerbations: worsening COPD symptoms resulting in treatment with systemic glucocorticoids for at ≥ 3 days and/or antibiotics, or an ER/ED visit of < 24 hours with intensive treatment; severe exacerbations: worsening COPD symptoms resulting in hospitalization for ≥ 24 hours or death. [c]Change from baseline over 52 weeks. [d]Change from baseline at week 52. [e]COPD exacerbations resulting in hospitalization and/or an ER/ED visit (of any duration), or death. CAT, COPD Assessment Test; ED, emergency department; ER, emergency room; E-RS:COPD, Evaluating Respiratory Symptoms in COPD; FEV_1, forced expiratory volume in one second; MACE, major adverse cardiovascular event; Q4W, every 4 weeks; Q8W, every 8 weeks; SC, subcutaneously; SGRQ, St. George's Respiratory Questionnaire; SoC, standard of care; yr, years.

11. Watz H *et al. BMJ Open Respir Res* 2026;13:e004145

Baseline characteristics were balanced between treatment groups and trials, and representative of the COPD population studied

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	OBERON		TITANIA	
	Tozorakimab Q4W (n = 446)	Placebo (n = 431)	Tozorakimab Q4W (n = 438)	Placebo (n = 435)
Age, years, mean (SD)	67.3 (7.8)	67.1 (7.8)	68.0 (7.3)	67.8 (7.2)
Male, n (%)	296 (66.4)	273 (63.3)	301 (68.7)	293 (67.4)
Smoking status, n (%)				
Former	342 (76.7)	337 (78.2)	350 (79.9)	344 (79.1)
Current	104 (23.3)	94 (21.8)	88 (20.1)	91 (20.9)
Triple therapy,[a] n (%)	406 (91.0)	393 (91.2)	396 (90.4)	390 (89.7)
No. of moderate/severe exacerbations in the past 12 months,[b] mean (SD)	2.5 (1.2)	2.4 (1.2)	2.3 (1.0)	2.3 (1.2)
BEC at screening,[b] n (%)				
< 150 cells/µL	165 (37.0)	166 (38.5)	178 (40.6)	184 (42.3)
150 to 300 cells/µL	160 (35.9)	152 (35.3)	162 (37.0)	151 (34.7)
≥ 300 cells/µL	121 (27.1)	113 (26.2)	98 (22.4)	100 (23.0)
Severity of airflow obstruction (GOLD criteria),[c] n (%)				
Mild (1)	12 (2.7)	21 (4.9)	17 (3.9)	21 (4.8)
Moderate (2)	154 (34.5)	134 (31.1)	137 (31.3)	152 (34.9)
Severe (3)	198 (44.4)	185 (42.9)	193 (44.1)	182 (41.8)
Very severe (4)	82 (18.4)	89 (20.6)	91 (20.8)	80 (18.4)
Post-bronchodilator FEV_1/FVC, % – mean (SD)	43.4 (11.8)	44.0 (13.1)	43.2 (12.6)	44.1 (12.3)
CAT total score,[d] mean (SD)	21.7 (5.8)	21.5 (5.6)	21.7 (5.5)	22.0 (5.7)

Data are reported for the overall populations (current and former smokers). [a]Patients were receiving stable COPD inhaled maintenance triple therapy (inhaled corticosteroid/long-acting beta-agonist/long-acting muscarinic antagonist) at screening or dual therapy when triple therapy was not considered appropriate. [b]Before enrolment. [c]Severity of airflow obstruction was classified according to GOLD criteria as mild ($FEV_1 \geq 80\%$ predicted), moderate ($50\% \leq FEV_1 < 80\%$ predicted), severe ($30\% \leq FEV_1 < 50\%$ predicted), or very severe ($FEV_1 < 30\%$ predicted), using Global Lung Function Initiative spirometry reference equations. [d]CAT total score ranges from 0 to 40, with higher scores indicating a greater impact of COPD on health status. FVC, forced vital capacity; GOLD, Global Initiative for Chronic Obstructive Lung Disease; SD, standard deviation

Tozorakimab Q4W significantly reduced the annualized rate of moderate/severe exacerbations versus placebo

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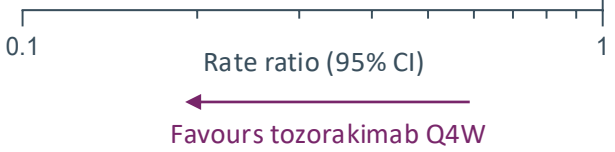
OBERON	Treatment group	Adjusted annualized rate (95% CI)	Rate ratio (95% CI)	*p* value
Primary endpoint: Former smokers	Tozorakimab Q4W (n = 342)	1.34 (1.14, 1.58)	**0.71 (0.57, 0.88)**	0.002
	Placebo (n = 337)[a]	1.90 (1.63, 2.21)	***29% reduction***	
First key secondary endpoint: Overall population	Tozorakimab Q4W (n = 446)	1.41 (1.22, 1.62)	**0.70 (0.58, 0.85)**	<0.001
	Placebo (n = 431)[a]	2.00 (1.74, 2.30)	***30% reduction***	

TITANIA	Treatment group	Adjusted annualized rate (95% CI)	Rate ratio (95% CI)	*p* value
Primary endpoint: Former smokers	Tozorakimab Q4W (n = 350)	1.37 (1.19, 1.57)	**0.66 (0.55, 0.80)**	<0.001
	Placebo (n = 344)	2.07 (1.81, 2.37)	***34% reduction***	
First key secondary endpoint: Overall population	Tozorakimab Q4W (n = 438)	1.44 (1.27, 1.63)	**0.71 (0.59, 0.84)**	<0.001
	Placebo (n = 435)	2.03 (1.80, 2.30)	***29% reduction***	



[a]Patients included in analysis: n = 336 (former smokers); n = 429 (overall population). CI, confidence interval

Cumulative counts of moderate/severe exacerbations were lower with tozorakimab Q4W than placebo from baseline through week 52

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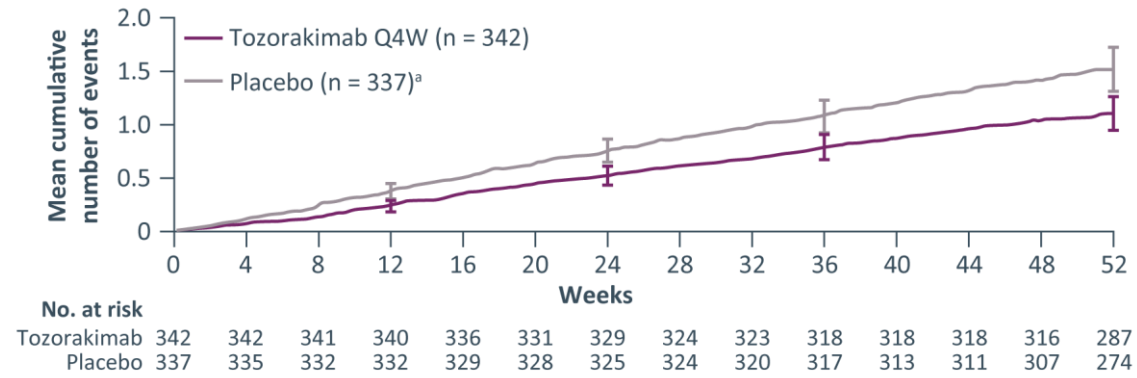
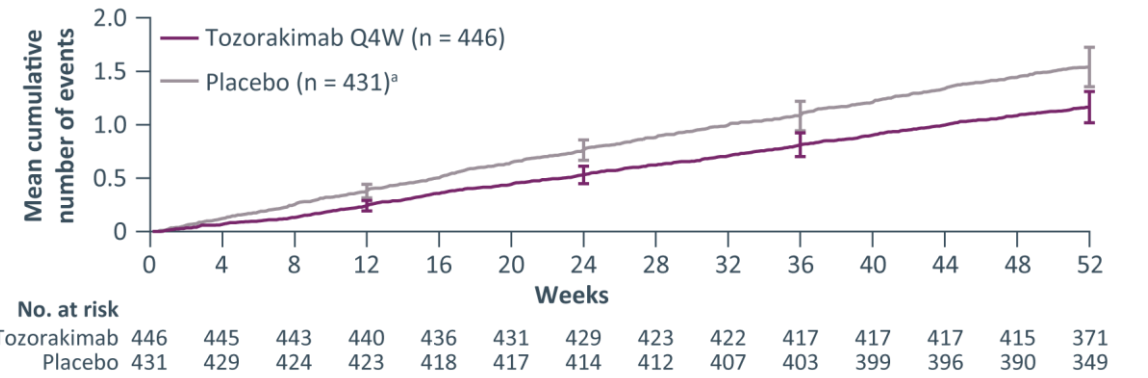
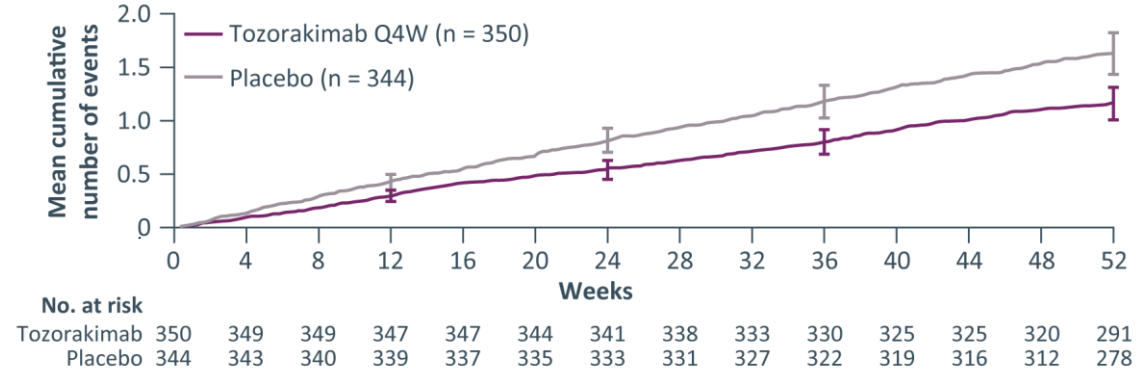
OBERON: former smokers



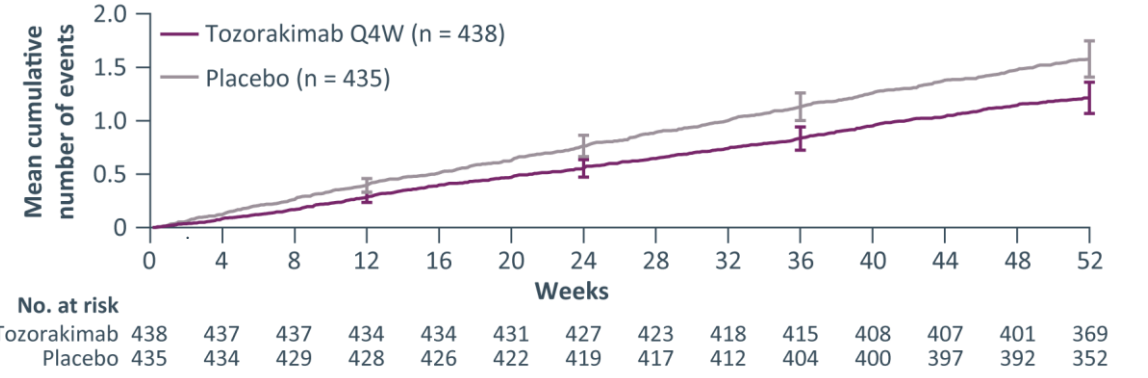
OBERON: overall population



TITANIA: former smokers

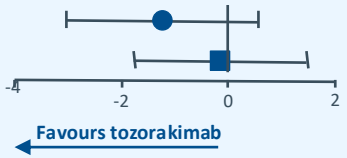
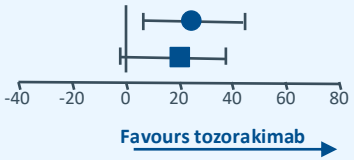
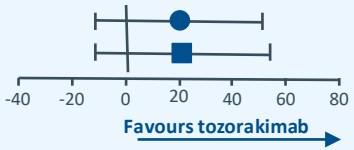
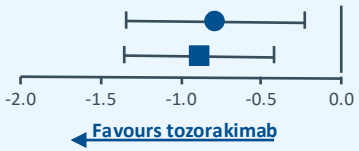
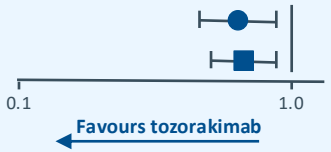


TITANIA: overall population



[a]Patients included in the analysis: n = 336 (former smokers); n = 429 (overall population)

Other key secondary endpoints in the overall population as described in NEJM

Change in SGRQ Total Score		**LS Mean Diff (95% CI)** OBERON −1.23 (−3.04 to 0.57) TITANIA −0.16 (−1.79 to 1.47)
Change in prebronchodilator FEV_1		**LS Mean Diff (95% CI)** OBERON 25 (4 to 46) TITANIA 20 (−1 to 40)
Change in postbronchodilator FEV_1		**LS Mean Diff (95% CI)** OBERON 20 (−11 to 51) TITANIA 21 (−11 to 54)
Change in E-RS:COPD Total Score		**LS Mean Diff (95% CI)** OBERON −0.79 (−1.34 to −0.23) TITANIA −0.89 (−1.36 to −0.42)
Annualised rate of exacerbations resulting in hospitalisation, ED visit, or both		**Rate Ratio (95% CI)** OBERON 0.64 (0.46 to 0.89) TITANIA 0.67 (0.51 to 0.88)

Sciurba, F. C., Watz H. et. al. Tozorakimab to Prevent COPD Exacerbations. N Engl J Med 8 September 2026.

Prespecified pooled analysis: a reduction in the rate of moderate/severe exacerbations was consistently seen across subgroups of the overall population

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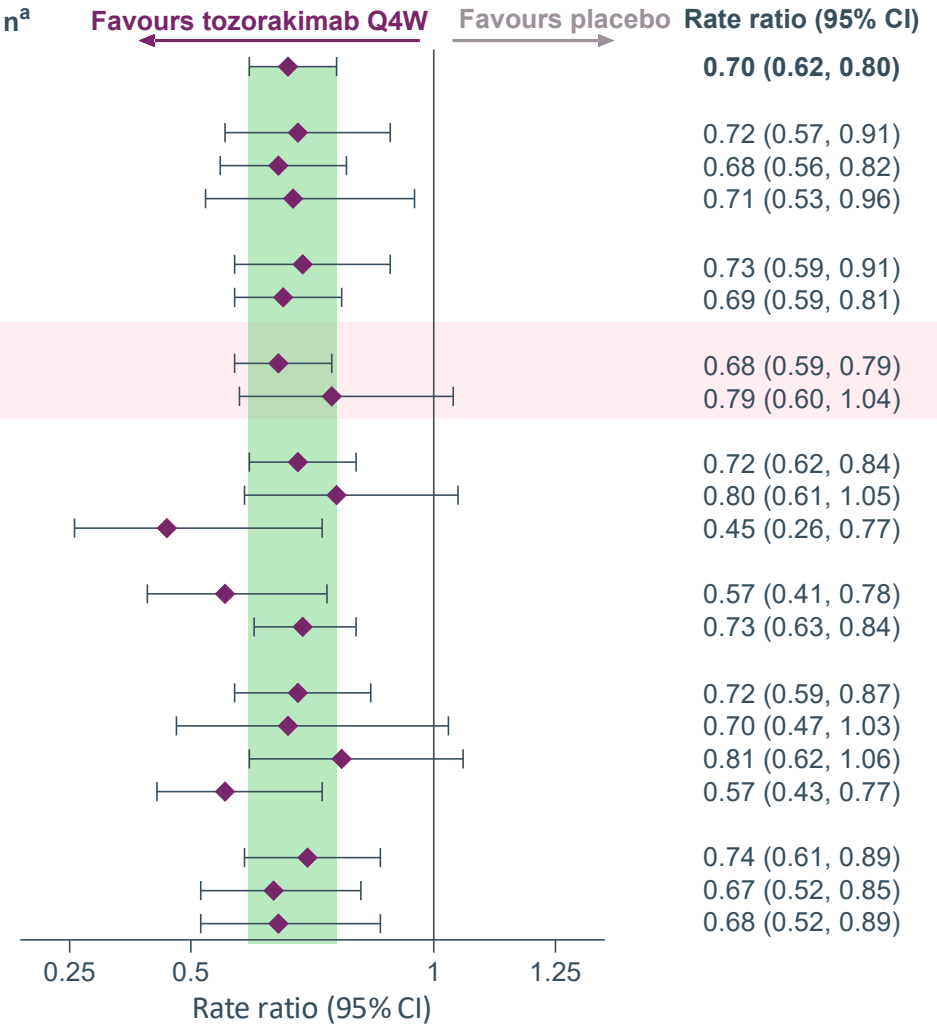
	Tozorakimab, n[a]	Placebo, n[a]	Rate ratio (95% CI)
Overall[b]	**884**	**864**	**0.70 (0.62, 0.80)**
Age			
<65	283	296	0.72 (0.57, 0.91)
65 to 75	429	413	0.68 (0.56, 0.82)
≥75	172	155	0.71 (0.53, 0.96)
Sex			
Female	287	298	0.73 (0.59, 0.91)
Male	597	566	0.69 (0.59, 0.81)
Smoking status			
Former	692	680	0.68 (0.59, 0.79)
Current	192	184	0.79 (0.60, 1.04)
OMB race category[c]			
White	618	609	0.72 (0.62, 0.84)
Asian	205	193	0.80 (0.61, 1.05)
Other	46	42	0.45 (0.26, 0.77)
OMB ethnicity category			
Hispanic or Latino	154	166	0.57 (0.41, 0.78)
Not Hispanic or Latino	725	692	0.73 (0.63, 0.84)
Region			
Europe	402	400	0.72 (0.59, 0.87)
North America	98	91	0.70 (0.47, 1.03)
Asia	208	196	0.81 (0.62, 1.06)
Rest of world	176	177	0.57 (0.43, 0.77)
Baseline body mass index			
≤25 kg/m^2	410	407	0.74 (0.61, 0.89)
>25 to 30 kg/m^2	266	257	0.67 (0.52, 0.85)
>30 kg/m^2	208	200	0.68 (0.52, 0.89)



[a]Number of patients included in the analysis. [b]Pooled overall population (current and former smokers) from OBERON and TITANIA. [c]Subgroup analyses were not calculated for OMB race categories 'Black or African American' and 'American Indian or Alaska Native' owing to the low n numbers for these groups (n = 6–10). OMB, Office of Management and Budget

Prespecified pooled analysis: a reduction in the rate of moderate/severe exacerbations was consistently seen across subgroups of the overall population

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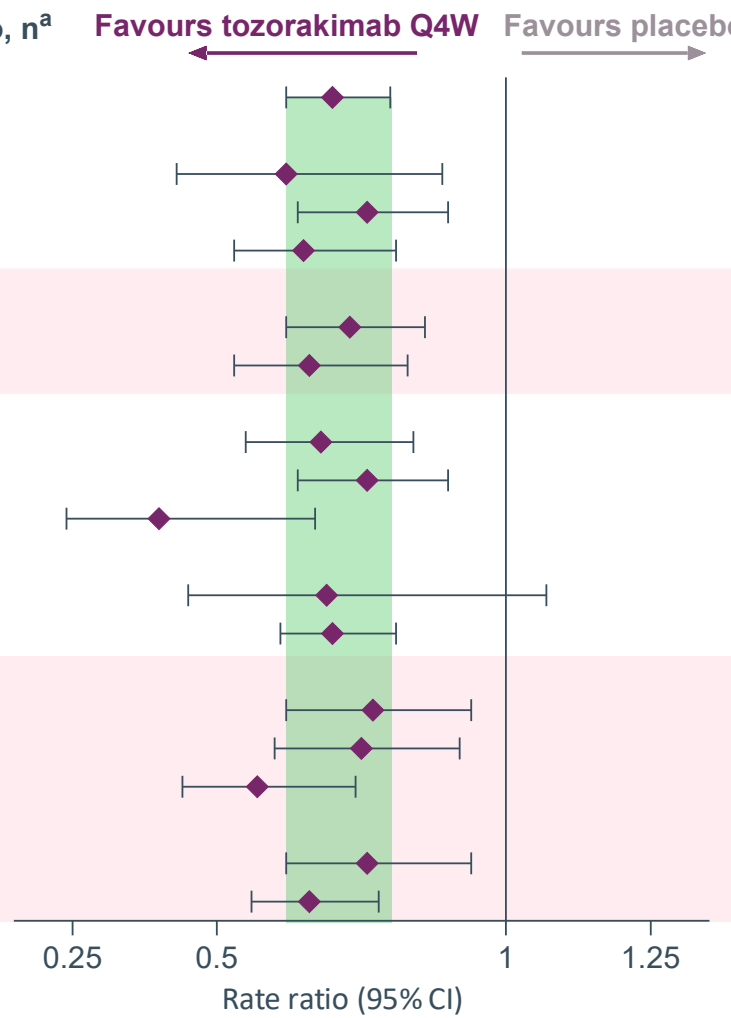
	Tozorakimab, n[a]	Placebo, n[a]	Rate ratio (95% CI)
Overall[b]	**884**	**864**	**0.70 (0.62, 0.80)**
No. of moderate/severe exacerbations in the past 12 months[c]			
1	111	115	0.62 (0.43, 0.89)
2	518	524	0.76 (0.64, 0.90)
≥ 3	255	225	0.65 (0.53, 0.81)
Severity of airflow obstruction			
FEV_1 ≤ 50% predicted	564	536	0.73 (0.62, 0.86)
FEV_1 > 50% predicted	320	328	0.66 (0.53, 0.83)
CAT total score			
< 20	327	314	0.68 (0.55, 0.84)
20 to 30	495	484	0.76 (0.64, 0.90)
> 30	62	66	0.40 (0.24, 0.67)
Prior maintenance inhaled therapy			
Dual therapy	82	83	0.69 (0.45, 1.07)
Triple therapy	802	781	0.70 (0.61, 0.81)
Screening blood eosinophil count			
< 150 cells/µL	343	349	0.77 (0.62, 0.94)
150 to < 300 cells/µL	322	303	0.75 (0.60, 0.92)
≥ 300 cells/µL	219	212	0.57 (0.44, 0.74)
Screening blood eosinophil count[d]			
< 150 cells/µL	343	349	0.76 (0.62, 0.94)
≥ 150 cells/µL	541	515	0.66 (0.56, 0.78)



[a]Number of patients included in the analysis. [b]Pooled overall population (current and former smokers) from OBERON and TITANIA. [c]Before enrolment. [d]All subgroups were predefined except BEC < 150/≥ 150 cells/µL at screening, which combined the predefined BEC 150 to < 300 and ≥ 300 cells/µL subgroups. The modelled estimate among patients with a BEC of <150 cells/µL differs slightly between these analyses due to rounding of values close to 23.5%. RR, rate ratio

Prespecified pooled analysis: a reduction in the rate of moderate/severe exacerbations was consistently seen across subgroups of the overall population

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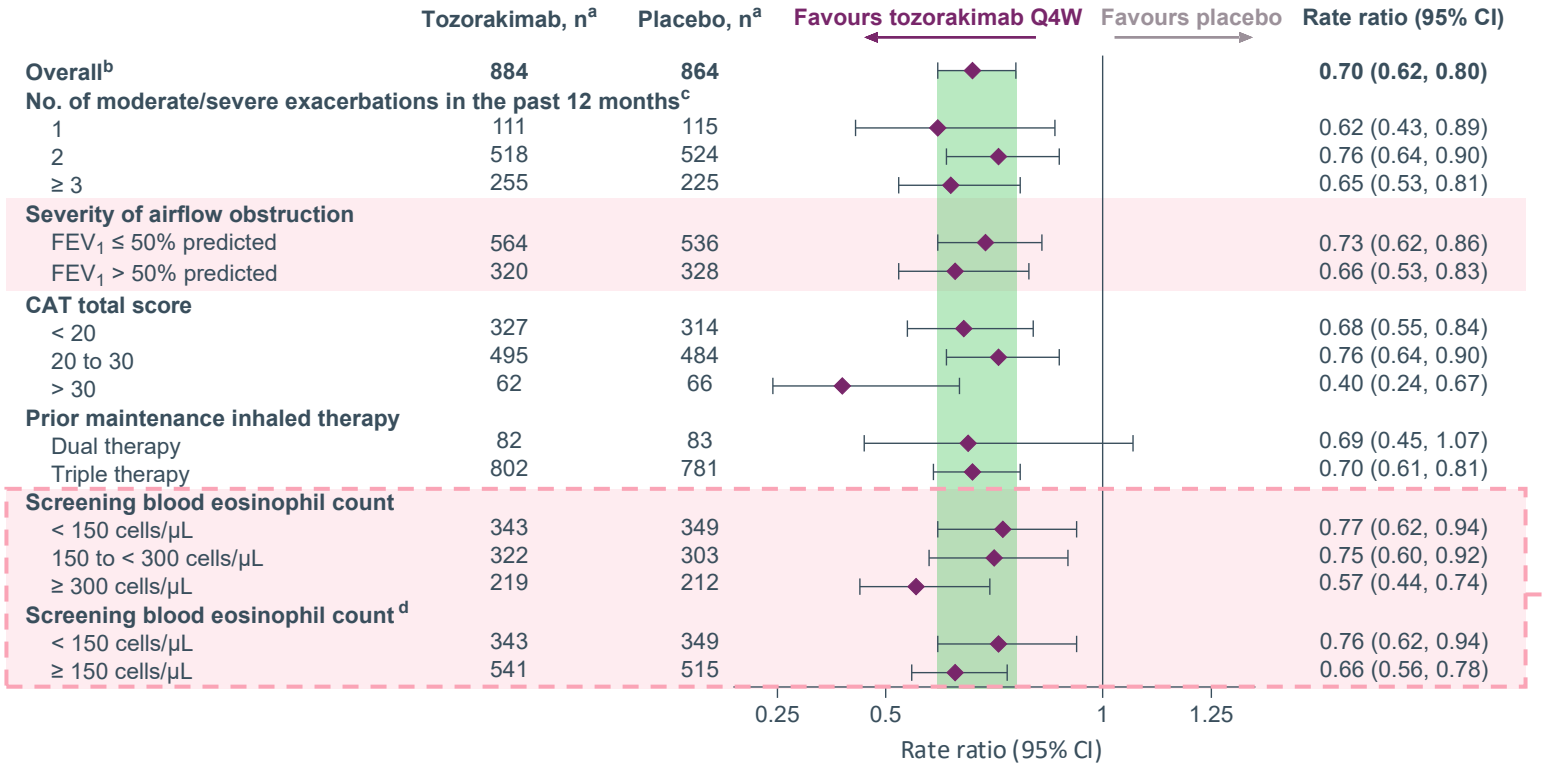

BEC < 150 cells/µL	BEC ≥ 150 cells/µL[d]	BEC ≥ 300 cells/µL
23% reduction	**34% reduction**	**43% reduction**
RR (95% CI): 0.77 (0.62, 0.94)	RR (95% CI): 0.66 (0.56, 0.78)	RR (95% CI): 0.57 (0.44, 0.74)

[a]Number of patients included in the analysis. [b]Pooled overall population (current and former smokers) from OBERON and TITANIA. [c]Before enrolment. [d]All subgroups were predefined except BEC < 150/≥ 150 cells/µL at screening, which combined the predefined BEC 150 to < 300 and ≥ 300 cells/µL subgroups. The modelled estimate among patients with a BEC of <150 cells/µL differs slightly between these analyses due to rounding of values close to 23.5%. RR, rate ratio

Tozorakimab Q4W was well tolerated with AEs generally similar across treatment groups

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Patients, n (%)	OBERON		TITANIA	
	Tozorakimab (n = 446)	Placebo (n = 430)	Tozorakimab (n = 438)	Placebo (n = 435)
Any AE	314 (70.4)	332 (77.2)	351 (80.1)	347 (79.8)
Any serious AE	104 (23.3)	116 (27.0)	136 (31.1)	141 (32.4)
Any AE leading to treatment discontinuation	14 (3.1)	12 (2.8)	16 (3.7)	23 (5.3)
Any AE leading to death	6 (1.3)	5 (1.2)	11 (2.5)	4 (0.9)
Major adverse cardiovascular event[a]	2 (0.4)	0 (0.0)	11 (2.5)	5 (1.1)
AEs occurring in ≥ 5% of patients receiving tozorakimab or placebo in either trial[b]				
COPD	56 (12.6)	76 (17.7)	89 (20.3)	108 (24.8)
Nasopharyngitis	45 (10.1)	46 (10.7)	37 (8.4)	35 (8.0)
Upper respiratory tract infection	27 (6.1)	22 (5.1)	38 (8.7)	38 (8.7)
Injection-site reaction	23 (5.2)	6 (1.4)	29 (6.6)	7 (1.6)
Fall	21 (4.7)	24 (5.6)	28 (6.4)	24 (5.5)
COVID-19	23 (5.2)	16 (3.7)	25 (5.7)	39 (9.0)
Pneumonia	17 (3.8)	17 (4.0)	24 (5.5)	36 (8.3)
Headache	23 (5.2)	19 (4.4)	18 (4.1)	22 (5.1)
Respiratory failure	9 (2.0)	19 (4.4)	24 (5.5)	25 (5.7)
Urinary tract infection	21 (4.7)	24 (5.6)	12 (2.7)	17 (3.9)
Lower respiratory tract infection	11 (2.5)	11 (2.6)	21 (4.8)	22 (5.1)
Acute respiratory failure	7 (1.6)	11 (2.6)	9 (2.1)	23 (5.3)

Data are from the safety population and show AEs with an onset date on or after the date of the first dose of tozorakimab Q4W or placebo, up to and including the date of the last dose + 84 days, or up to the date of study withdrawal, or enrolment in the long-term extension study (PROSPERO). aPositively adjudicated AEs assessed by independent adjudication committee for each trial. bCoded according to the Preferred Terms of the Medical Dictionary for Regulatory Activities, version 28.1, and ordered by decreasing frequency in the combined tozorakimab Q4W groups in both trials. AE, adverse event

Conclusions

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Tozorakimab significantly **reduced the annualized rate of moderate/severe exacerbations by up to 34%** versus placebo

In a prespecified pooled analysis, tozorakimab **reduced the rate of moderate/ severe exacerbations across subgroups** defined by screening BEC, baseline airflow obstruction and smoking status (current/former)

Tozorakimab was **generally well tolerated**, with a safety profile similar to placebo, apart from injection-site reactions

Tozorakimab is a **first-in-class biologic with replicated efficacy in a broad population of patients** with COPD and a history of exacerbations

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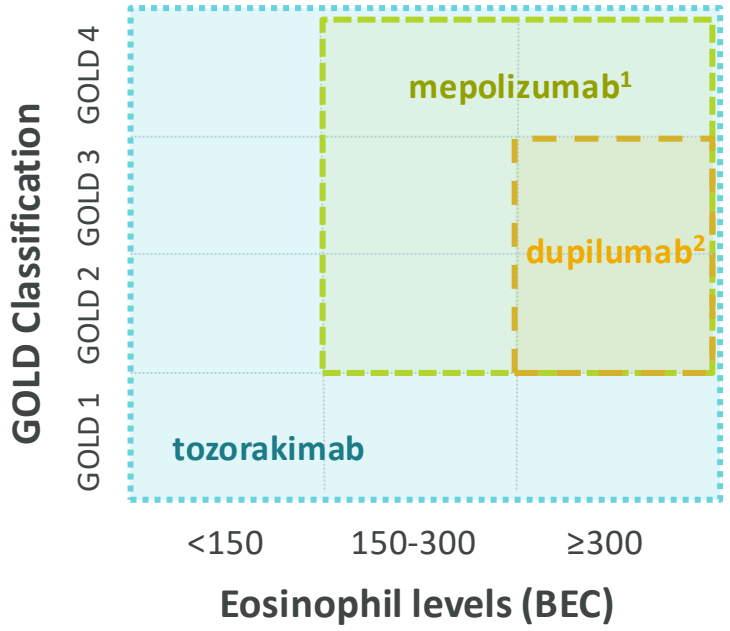
Unlocking the potential of tozorakimab

Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

Tozorakimab – best-in-biologic efficacy in high-EOS and first biologic to benefit low-EOS patients

Studied in broadest COPD population for a biologic



Exacerbation reduction independent of EOS levels[3]

<150 EOS 35% of patients	**23%**
≥150 EOS 65% of patients	**34%**
≥300 EOS 30% of patients	**43%**

Highly clinically meaningful efficacy in broad population

Up to **34%** reduction in exacerbations in **former smokers**[4]

Up to **30%** reduction in exacerbations in **all comers**[5]

Priority Review granted in the United States with Q1 2027 PDUFA date

1. Based on MATINEE and METREX Phase III studies. *N Engl J Med*. 2025;392:1710-1720; *N Engl J Med*. 2017;377(17):1613-1629. 2. Based on NOTUS and BOREAS Phase III trials; *N Engl J Med*. 2023;389(3):205-214; *N Engl J Med*. 2024; 390(24):2274-2283. 3. Exacerbation reductions based on pooled data for tozorakimab from OBERON and TITANIA trials. Percentage of patients with each EOS level based on analysis of Vogelmeier et al. Respiratory Research (2019) 20:178 and an analysis of Optum Clinformatics Datamart, 2021. 4. Annualised reduction in moderate to severe exacerbations based on the primary endpoint. 5. Annualised rate of moderate to severe exacerbations based on a key secondary endpoint.
Sciurba, F et. al ALERT 2 Session RCT6571 presented at the 2026 European Respiratory Society Congress. Appendix: Glossary

Tozorakimab: a potential $5bn+ asset anchored by Phase III OBERON and TITANIA trials

Large, differentiated COPD opportunity

6 million biologic-eligible COPD patients expected by 2030[1]

35% of patients	35% of patients	30% of patients
EOS <150	150 ≤ EOS <300	EOS ≥300
No approved biologics	1 approved biologic	2 approved biologics

tozorakimab is the only biologic to show efficacy across all EOS thresholds

Lifecycle expansion provides upside beyond COPD

- IL-33 is implicated in numerous respiratory diseases
- Ambition to build leading respiratory franchise

Ongoing tozorakimab trials	Actively exploring potential indications
Asthma	Bronchiectasis
sLRTD	Chronic Rhinosinusitis
	CTD-ILD

Ongoing trial | Potential future trial

1. In US, EU5, JP and CN. Based on IQVIA data with internal analysis. Appendix: Glossary.

Delivering growth to 2030 and beyond

Pascal Soriot
CHIEF EXECUTIVE OFFICER

Tozorakimab is one of several high-value NMEs in a diverse portfolio to drive growth into next decade

>$5bn

- DATROWAY®[1] ✓
- AZD0120
- saruparib
- surovatamig
- rilvegostomig
- Wholly-Owned ADCs[2]
- ETCAMAH™ ✓
- BAXFENDY™ ✓
- balcinrenone | zibotentan + dapagliflozin
- elecoglipron | AZD6234 | AZD9550
- laroprovstat franchise
- tozorakimab ✓

$3-5bn

- sonesitatug vedotin[2] ✓
- volrustomig
- cliramitug
- efzimfotase alfa ✓

Deep late-stage pipeline of multi-blockbuster opportunities

Represents non-risk adjusted peak year revenue, as provided during Investor Day, May 2024 except for tozorakimab and sonesitatug vedotin which were updated at H1 and Q2 2026 results and volrustomig which was updated in September 2026. 1. Peak Year Revenue, non-risk adjusted (Product Sales and Alliance Revenue) across all indications 2. At Investor Day, total wholly-owned ADC portfolio was presented as a >$5bn NRA PYR opportunity. Includes puxitatug samrotecan and torvutatug samrotecan, wholly-owned ADCs planned to launch by 2030. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

✓ Positive Phase III readout

Oncology | BioPharma | Rare

Pipeline momentum continues through 2027 to fuel growth

Key readouts for NMEs will drive growth beyond 2030

laroprovstat | **$5bn+**

AZURE-LDL/AZURE-HeFH
Dyslipidaemia | H1 2027

- Novel oral small-molecule PCSK9i
- Once-daily, no food effect, no known DDI, combinable
- CVOT >2027 reinforces value proposition

balcinrenone + dapagliflozin | **zibotentan + dapagliflozin** | **$5bn+**

BalanceD-HF | ZENITH High Proteinuria
HF + renal impairment | CKD + high proteinuria | H1 2027

- Balci-dapa: Foundational HF/CKD therapy (SGLT2i/MRA) with reduced hyperkalaemia risk
- Zibo-dapa: ERA + SGLT2i combination addressing rapid CKD progression while mitigating fluid retention risk

Etcamah | **$5bn+**

CAMBRIA-1 | adj. switch HR+/HER2− eBC | H2 2027

- Efficacy of oSERD in eBC already established
- Switch design enriches for endocrine-sensitivity
- 2-5 yr switch focuses on large prevalent pool

saruparib | **$5bn+**

EvoPAR-Prostate01 | 1L mCSPC | H2 2027

- Benefit of PARPi in mHSPC and in combination with NHA already established
- PARP1-selective may offer improved tolerability and combinability

>10 other high-value readouts also in 2027

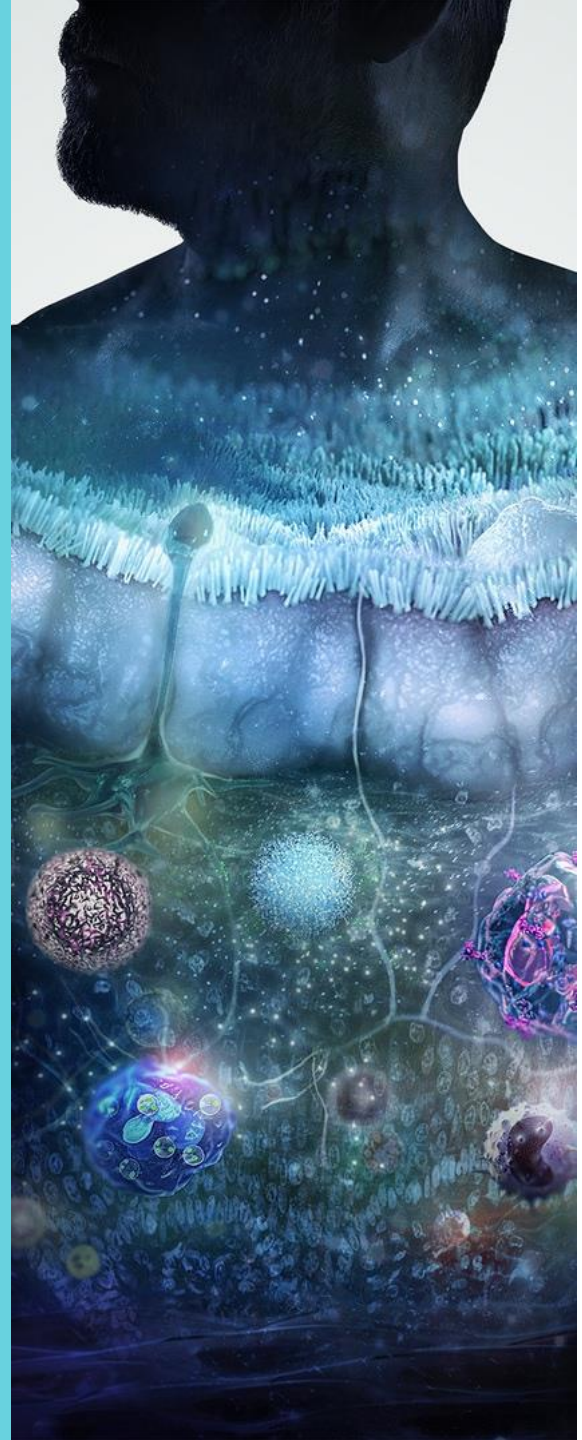
H1 2027

TROPION-Lung07 | *Datroway*
DAISY | *Saphnelo*
IRIS | *Saphnelo*
LAVENDER | *Saphnelo*

H2 2027

TROPION-Breast03 | *Datroway + Imfinzi*
TROPION-Breast05 | *Datroway + Imfinzi*
PACIFIC-4 | *Imfinzi*
CAPItello-292 | *Truqap*
Bluestar-Endometrial01 | puxi-sam
eVOLVE-Cervical | volrustomig
BaxPA | *Baxfendy*
JASMINE | *Saphnelo*
TILIA | tozorakimab

Represents non-risk adjusted peak year revenue, as provided during Investor Day, May 2024. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.



Q&A Session

Key External Expert

Frank C. Sciurba, MD
PROFESSOR OF PULMONARY AND CRITICAL CARE MEDICINE, UNIVERSITY OF PITTSBURGH

AstraZeneca Leadership

Pascal Soriot
CHIEF EXECUTIVE OFFICER

Ruud Dobber
EVP, BIOPHARMACEUTICALS BUSINESS

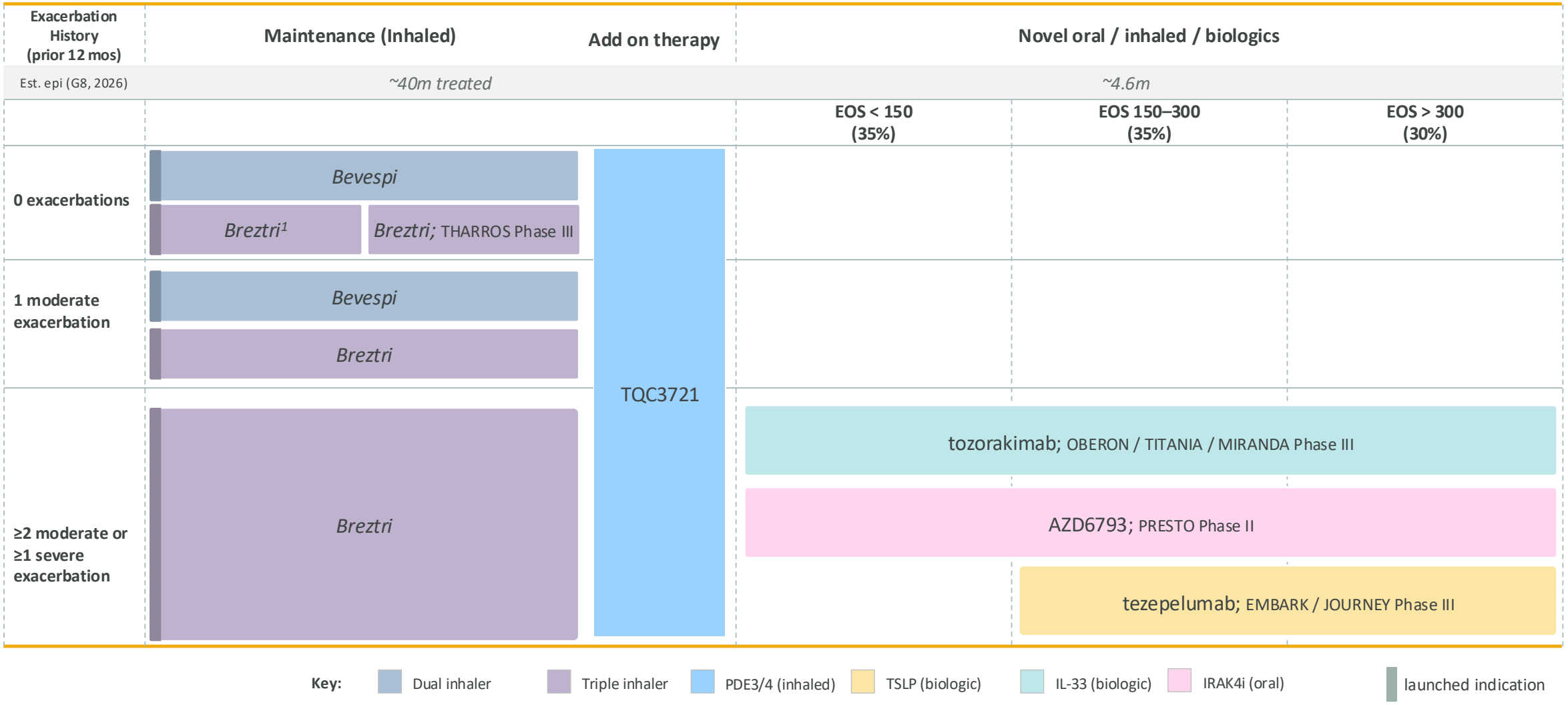
Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

Anne-Laure Dreno
SVP, GLOBAL R&I BUSINESS

Caterina Brindicci
SVP, GLOBAL HEAD RESPIRATORY R&D

Appendix

AstraZeneca in COPD

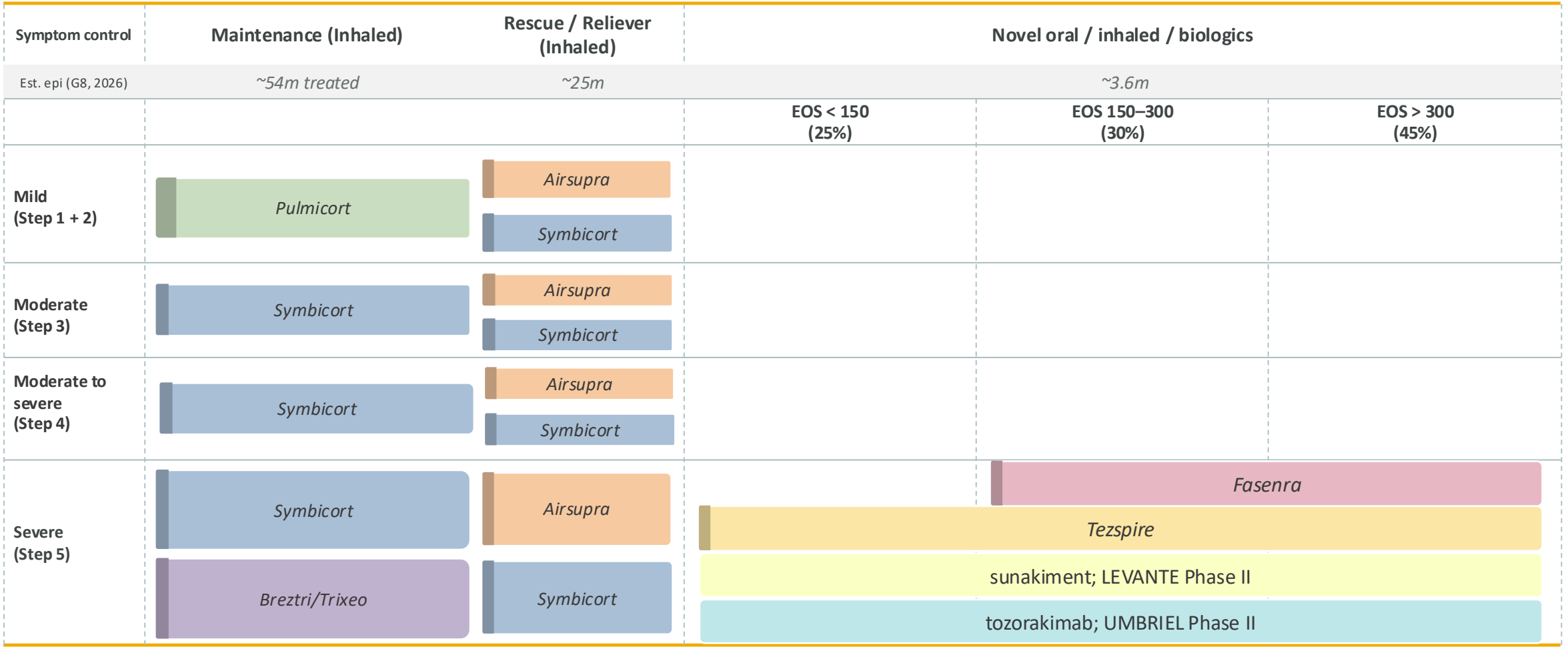


All numbers are approximate. Illustrative settings and populations, not to scale. COPD map reflects Phase II or Phase III /pivotal trials. Approved product categorisation based on GOLD 2026 treatment guidelines

1. *Breztri* currently recommended to be used in patients on ICS/LABA therapy with no exacerbations in prior 12m who are still symptomatic. Collaboration partners: Amgen (*Tezspire* / tezepelumab).

Appendix: Glossary.

AstraZeneca in Asthma



All numbers are approximate. Illustrative settings and populations, not to scale, based on 2026 GINA recommendation. Patient population and treatment recommendation is defined as per GINA recommendation. However, in some jurisdiction, biologics can be approved to be used at the moderate to severe step (ie: US, and China). Asthma map reflects Phase III/pivotal trials and selected phase II programmes.
Collaboration partners: Amgen (*Tezspire,* sunakiment).
Appendix: Glossary.

Glossary

1L	first-line
ADC	antibody-drug conjugate
AE	adverse event
AZN	AstraZeneca
BEC	blood eosinophil count
BMJ	British Medical Journal
CAT	COPD Assessment Test
CI	confidence interval
CKD	chronic kidney disease
CN	China
COPD	chronic obstructive pulmonary disease
COVID-19	coronavirus disease 2019
CTD-ILD	connective tissue disease-associated interstitial lung disease
CV	cardiovascular
CVOT	cardiovascular outcomes trial
DDI	drug-drug interaction
E-RS:COPD	Evaluating Respiratory Symptoms in Chronic Obstructive Pulmonary Disease
eBC	early breast cancer
ED	emergency department
EGFR	epidermal growth factor receptor
EOS	eosinophils
ER	emergency room
ERA	endothelin receptor antagonist
ERS	European Respiratory Society
EU5	France, Germany, Italy, Spain and the UK
EVP	executive vice president
Fab	antigen-binding fragment
FDA	US Food and Drug Administration
FEV1	forced expiratory volume in one second
FVC	forced vital capacity
G8	EU5, China, Japan and the US
GINA	Global Initiative for Asthma
GOLD	Global Initiative for Chronic Obstructive Lung Disease
H1/H2	first/second half of the year
HeFH	heterozygous familial hypercholesterolaemia
HF	heart failure
hMPV/RSV	human metapneumovirus/respiratory syncytial virus
HR+/HER2–	hormone receptor-positive/human epidermal growth factor receptor 2-negative
ICS	inhaled corticosteroid
IL-1RAcP	interleukin-1 receptor accessory protein
IL-33	interleukin-33
IL-5	interleukin-5
IO	immuno-oncology
IRA	Inflation Reduction Act
IRAK4i	interleukin-1 receptor-associated kinase 4 inhibitor
iTSLP	inhaled TSLP
JP	Japan
LABA	long-acting beta-agonist
LAMA	long-acting muscarinic antagonist
LCM	life-cycle management
LDL	low-density lipoprotein
LS	least squares
M&A	mergers and acquisitions
MACE	major adverse cardiovascular events
mCSPC/mHSPC	metastatic castration-sensitive/metastatic hormone-sensitive prostate cancer
MD	Doctor of Medicine
MRA	mineralocorticoid receptor antagonist
NEJM	New England Journal of Medicine
NHA	novel hormonal agent
NRA	non-risk-adjusted
oIRAK4	oral interleukin-1 receptor-associated kinase 4 inhibitor
OMB	Office of Management and Budget
oSERD	oral selective estrogen receptor degrader
PARP1/PARPi	poly(ADP-ribose) polymerase 1/poly(ADP-ribose) polymerase inhibitor
PCSK9i	proprotein convertase subtilisin/kexin type 9 inhibitor
PDE3/4	phosphodiesterase 3 and 4
PDUFA	Prescription Drug User Fee Act
PYR	peak year revenue
Q&A	questions and answers
Q1/Q2	first/second quarter
Q4W/Q8W	every four/eight weeks
R&D	research and development
R&I	Respiratory & Immunology
RAGE	receptor for advanced glycation end products
RR	rate ratio
SC	subcutaneously
SD	standard deviation
SGLT2i	sodium-glucose cotransporter 2 inhibitor
SGRQ	St. George's Respiratory Questionnaire
sLRTD	severe lower respiratory tract disease
SoC	standard of care
ST2	suppression of tumorigenicity 2
SVP	senior vice president
TSLP	thymic stromal lymphopoietin
US	United States
WHO	World Health Organization

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