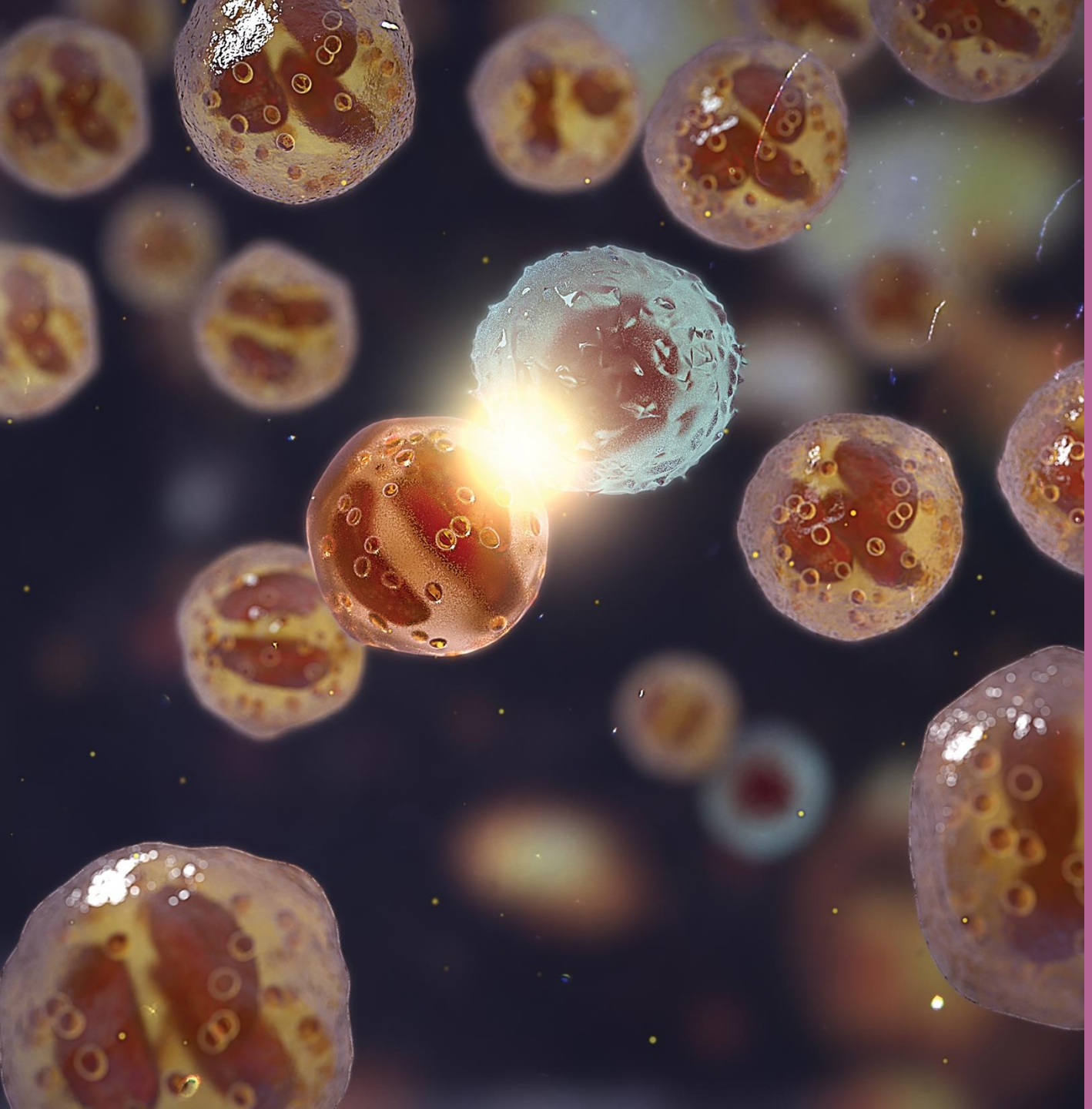


Meet AZN Management: ESMO 2026

Investor Event

26 October 2026

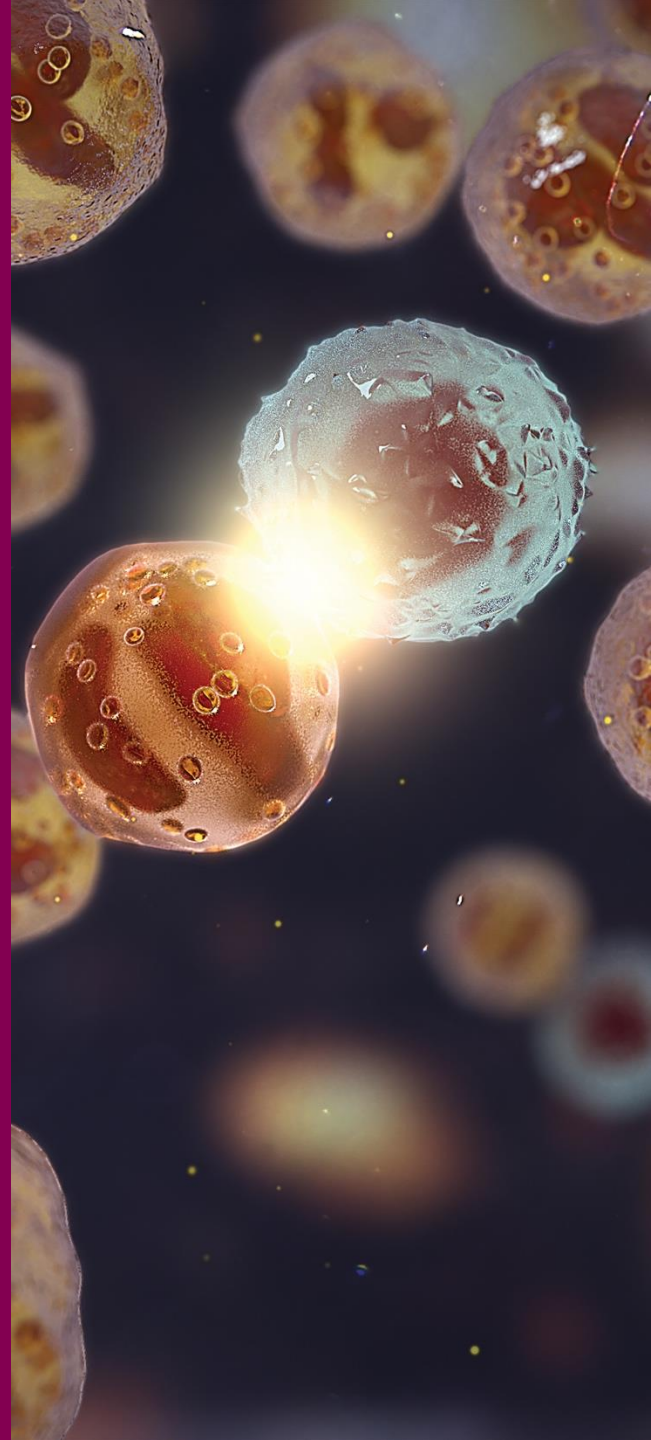
Cautionary statements regarding forward-looking statements

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

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

AstraZeneca @ ESMO 2026

Opening remarks	**Dave Fredrickson** EVP, Oncology Haematology Business
Bladder cancer: Expanding the foundational role of *Imfinzi* across MIBC Including Q&A session	**Prof. Thomas Powles** Professor of Genitourinary Oncology, Barts Cancer Institute
***EGFR*m lung cancer: Extending *Tagrisso* as backbone therapy**	**Prof. Yi-Long Wu** Professor of Oncology, Guangdong Lung Cancer Institute
Small cell lung cancer: Reinforcing *Imfinzi* as backbone therapy across SCLC	**Leora Horn** SVP, Late Development Oncology
Gastric cancer: Unlocking the power of ADCs with sone-ve	**Susan Galbraith** EVP, Oncology Haematology R&D
Realising our ambition in Oncology	**Dave Fredrickson** EVP, Oncology Haematology Business
Looking to the future of AstraZeneca	**Pascal Soriot** Chief Executive Officer
Q&A	**Chaired by Dave Fredrickson** EVP, Oncology Haematology Business



AstraZeneca

at ESMO and WCLC 2026

>140 abstract acceptances

>110 poster presentations

38 oral presentations

Unprecedented 4 Presidential datasets at ESMO

VOLGA	SAFFRON	DeLLphi-305	CLARITY-Gastric01
Imfinzi	*Tagrisso + Orpathys*	*Imfinzi*	sone-ve
LBA2	LBA6	LBA3	LBA7

2 practice-changing Phase III datasets

- **DESTINY-Lung04** | ***Enhertu*** PL03.08[1]
- **SANOVO** | ***Tagrisso + Orpathys*** LBA69

Additional early data driving 2030+ pipeline

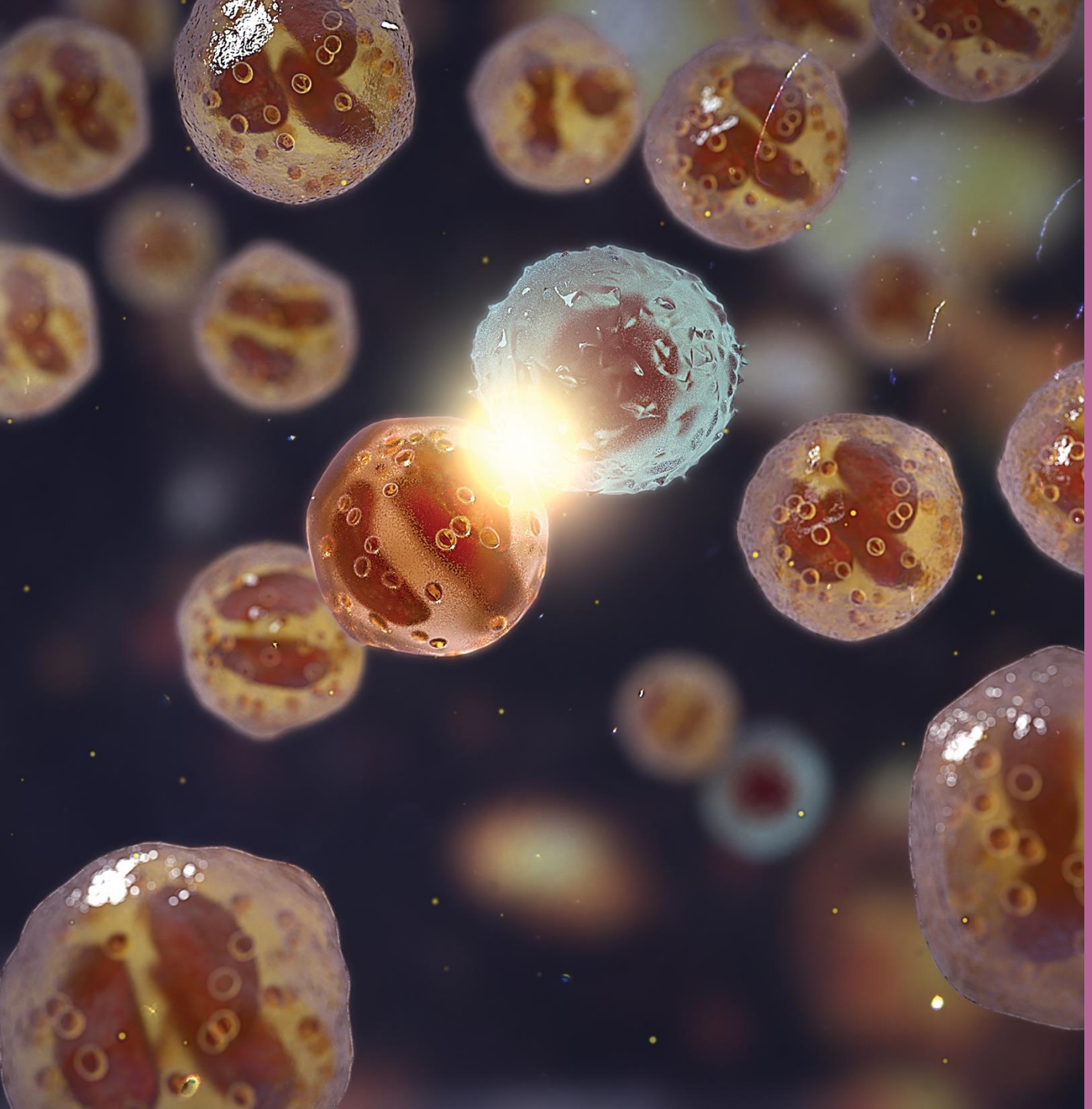
- **torvu-sam** FRα ADC | **FONTANA** 1245RO
- **rilvegostomig** PD-1/TIGIT mAb | **ARTEMIDE-01** MO07.10[1]
- **AZD7003** GPC3 CAR-T | **Phase I update** 1680RO

Data spans 27 approved and potential medicines across >15 tumour types

1. Data at WCLC 2026. All other listed datasets are at ESMO 2026. Collaboration partners: Daiichi Sankyo (*Enhertu*), Hutchmed (*Orpathys*). DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.

Appendix: Glossary.

Featured in Presidential session at congress



Bladder cancer: Expanding the foundational role of *Imfinzi* across MIBC

Prof. Thomas Powles
PROFESSOR OF GENITOURINARY ONCOLOGY, BARTS CANCER INSTITUTE

VOLGA – expanding the role of *Imfinzi* in MIBC

- MIBC (cT2-T4aN0/1M0 or cT1N1M0) by local assessment
- Ineligible for or refused cisplatin
- UC or UC with divergent differentiation or histological subtypes
- Evaluated and confirmed for cystectomy

R 1:1:1

N=695

	Neoadjuvant	Adjuvant
***Imfinzi* + EV N=233**	***Imfinzi*** **Q3W × 3 cycles**; **Enfortumab vedotin Q3W** × 3 cycles	***Imfinzi* Q4W × 9 cycles**
***Imfinzi* + *Imjudo* + EV N=233**	***Imfinzi*** **Q3W × 3 cycles**; ***Imjudo*** Q3W × 2 cycles; **Enfortumab vedotin Q3W** × 3 cycles	***Imfinzi* Q4W × 9 cycles**; ***Imjudo*** Q4W × 1 cycle
Control N=229	**No treatment** → Straight to RC	**Observation/locally approved treatment**

RC

Dual primary endpoint:
- EFS[1]: *Imfinzi* + EV vs control
- EFS[1]: *Imfinzi* + *Imjudo* + EV vs control

Key secondary endpoint:
- OS: *Imfinzi* + EV vs control
- OS: *Imfinzi* + *Imjudo* + EV vs control

Other secondary endpoints:
- pCR
- EORTC QLQ-C30

Exploratory endpoints:
- ctDNA analysis

Safety

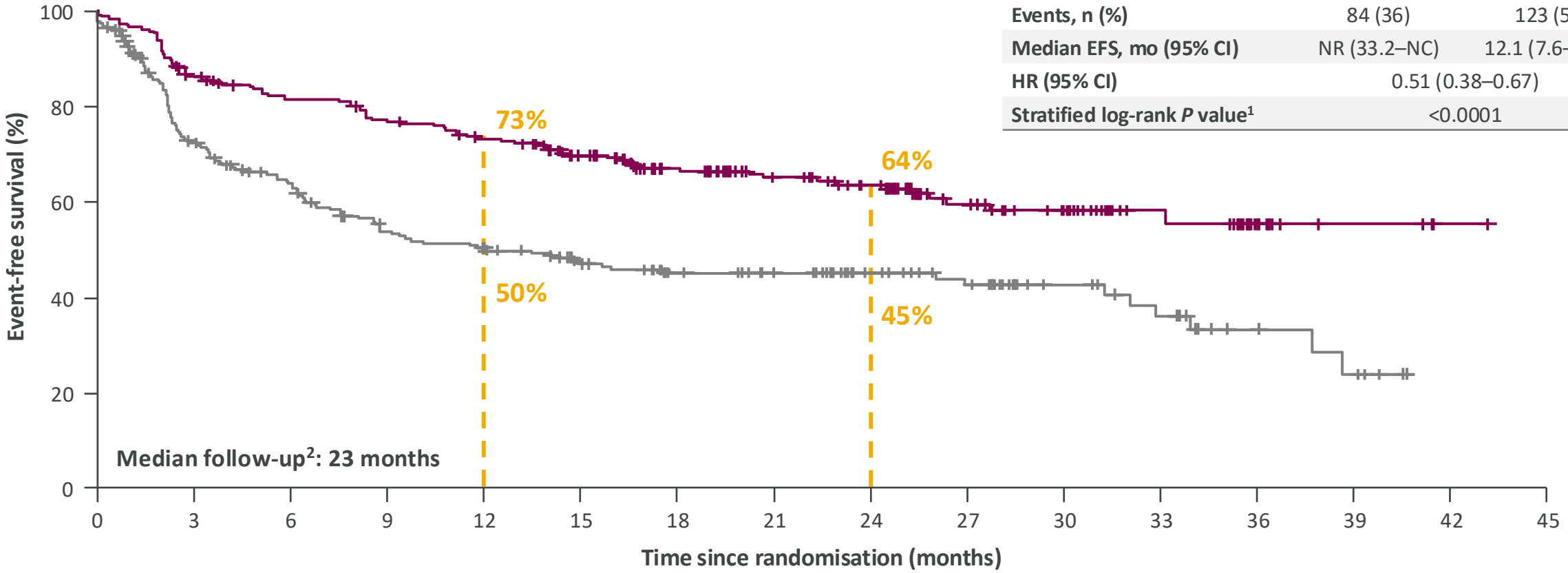
Stratification factors
- PD-L1 status (high vs low/negative)
- Clinical tumour stage (T2N0M0 vs T3-4aN0M0 vs T1-4aN1M0)
- Cisplatin status (ineligible vs refusal)

EFS was defined as time from randomisation to the first:
- Recurrence after RC
- Progression in patients who did not receive RC
- Failure to undergo RC in patients with residual disease
- Death due to any cause

Imfinzi dose was 1500 mg, *Imjudo* dose was 75 mg, and EV dose was 1.25 mg/kg body weight. 1. Evaluated by BICR or central pathology review (if a biopsy was required for a suspected new lesion).
Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.
Appendix: Glossary.

VOLGA – *Imfinzi +* EV demonstrated a statistically significant improvement in EFS vs control

	Imfinzi + EV N=233	Control N=229
Events, n (%)	84 (36)	123 (54)
Median EFS, mo (95% CI)	NR (33.2–NC)	12.1 (7.6–27.0)
HR (95% CI)	0.51 (0.38–0.67)	
Stratified log-rank *P* value[1]	<0.0001	

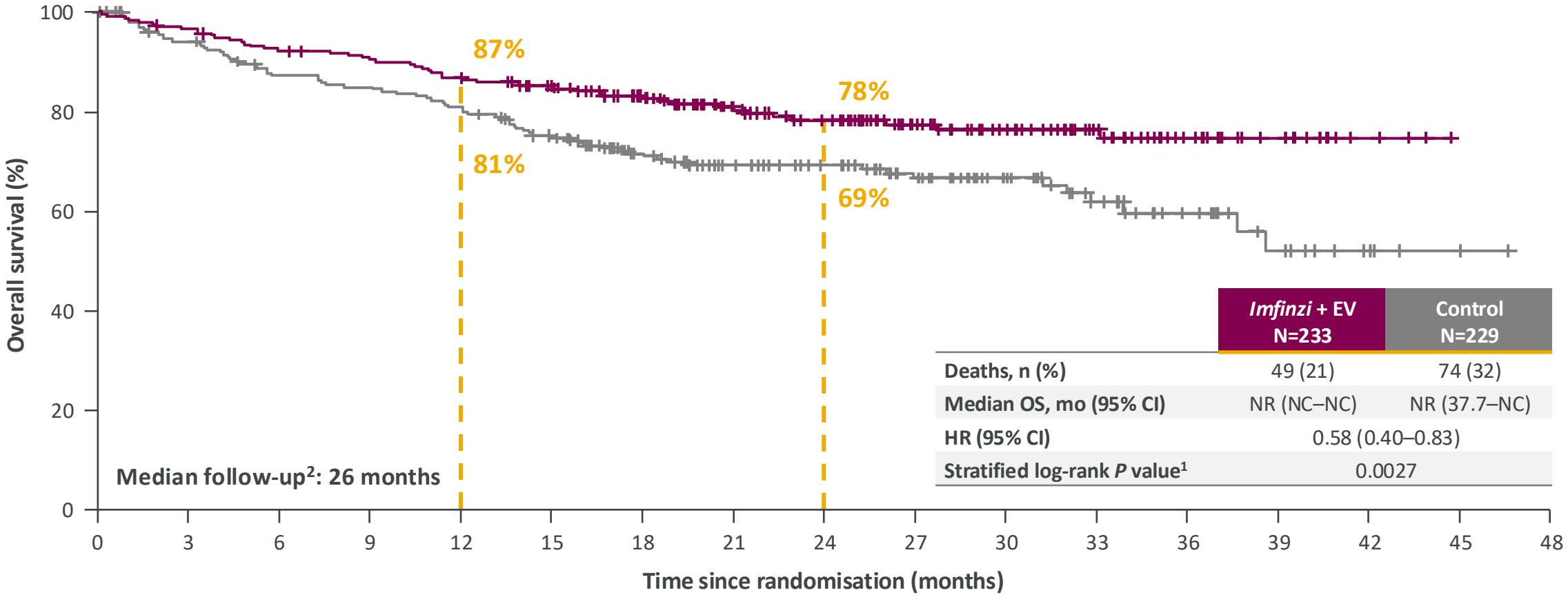


No. at risk																
Imfinzi + EV	233	197	180	170	158	136	111	93	80	51	38	21	11	4	1	0
Control	229	157	131	106	98	80	66	59	43	35	22	16	8	5	0	0

EFS is the time from randomisation to the first: 1) recurrence after RC, 2) progression in patients who did not receive RC, 3) failure to undergo RC in patients with residual disease, or 4) death due to any cause. 1. The threshold to declare statistical significance was based on a Lan-DeMets alpha spending function with O'Brien-Fleming boundary – with the observed number of events, the boundary for declaring statistical significance was 0.0218 for a 2.7% overall 2-sided alpha. 2. In censored patients across all study arms. Data cut-off 02 March 2026. Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.

Appendix: Glossary.

VOLGA – *Imfinzi* + EV demonstrated a statistically significant improvement in OS vs control



	Imfinzi + EV N=233	Control N=229
Deaths, n (%)	49 (21)	74 (32)
Median OS, mo (95% CI)	NR (NC–NC)	NR (37.7–NC)
HR (95% CI)	0.58 (0.40–0.83)	
Stratified log-rank *P* value[1]	0.0027	

No. at risk

Imfinzi + EV	233	224	212	207	198	185	160	128	110	82	66	45	27	15	4	0	0
Control	229	208	190	185	176	157	128	110	96	72	53	34	22	13	5	2	0

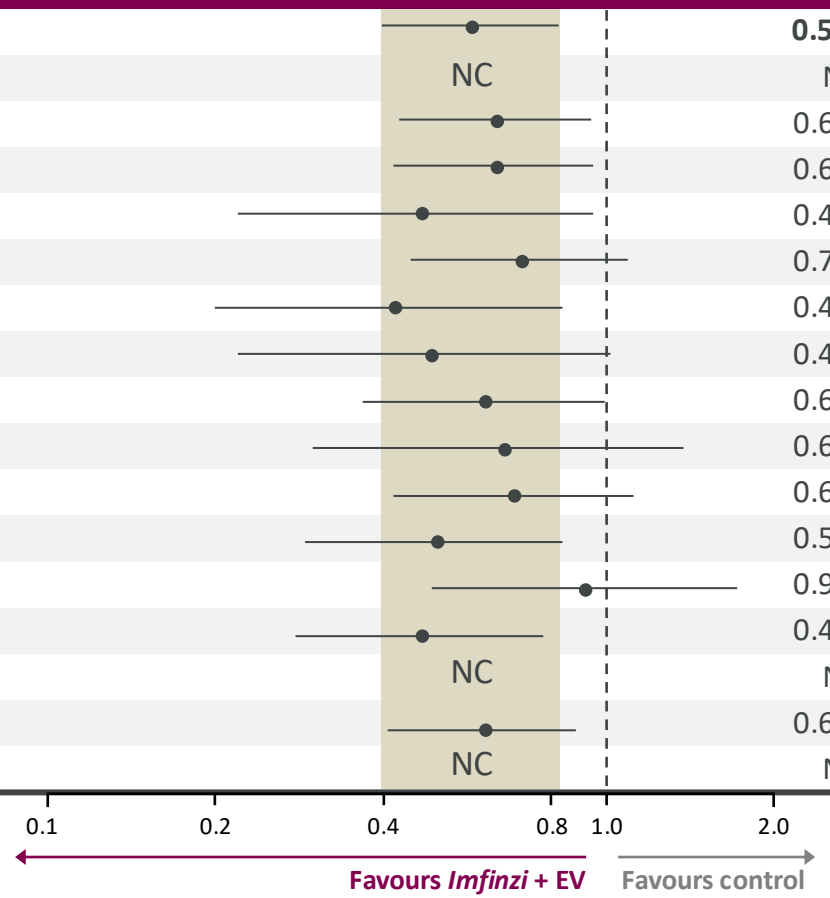
OS is the time from randomisation until death due to any cause, regardless of whether the patient withdraws from randomised therapy or receives another anticancer therapy. 1. The threshold to declare statistical significance was based on a Gamma family (-3) spending function – with the observed number of events, the boundary for declaring statistical significance was 0.0104 for a 5% overall 2-sided alpha. 2. In censored patients across all study arms. Data cut-off 02 March 2026.

Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.

Appendix: Glossary.

VOLGA – consistent OS benefit across subgroups

Subgroup	Category	Events/patients *Imfinzi* + EV	Events/patients Control	HR (95% CI)
All patients		49/233	74/229	**0.58 (0.40–0.83)**
Age at randomisation	<65 years	6/49	11/40	NC (NC–NC)
	≥65 years	43/184	63/189	0.64 (0.43–0.95)
Sex	Male	38/191	53/187	0.64 (0.42–0.96)
	Female	11/42	21/42	0.47 (0.22–0.96)
Race	White	34/153	45/158	0.71 (0.45–1.10)
	Non-White	11/56	23/54	0.42 (0.20–0.84)
Geographic region	Asia	10/44	19/46	0.49 (0.22–1.03)
	Europe	28/139	37/129	0.61 (0.37–1.00)
	Americas	11/50	18/54	0.66 (0.30–1.39)
Tumour PD-L1 expression[1–2]	High	27/120	38/120	0.69 (0.42–1.13)
	Low/negative	22/113	36/109	0.50 (0.29–0.84)
Tumour stage[1]	T2N0M0	19/82	20/83	0.92 (0.49–1.74)
	T3-4aN0M0	23/113	41/109	0.47 (0.28–0.78)
	T1-4aN1M0	7/37	12/35	NC (NC–NC)
Cisplatin status[1]	Ineligible	43/175	63/176	0.61 (0.41–0.89)
	Refusal	6/58	11/53	NC (NC–NC)



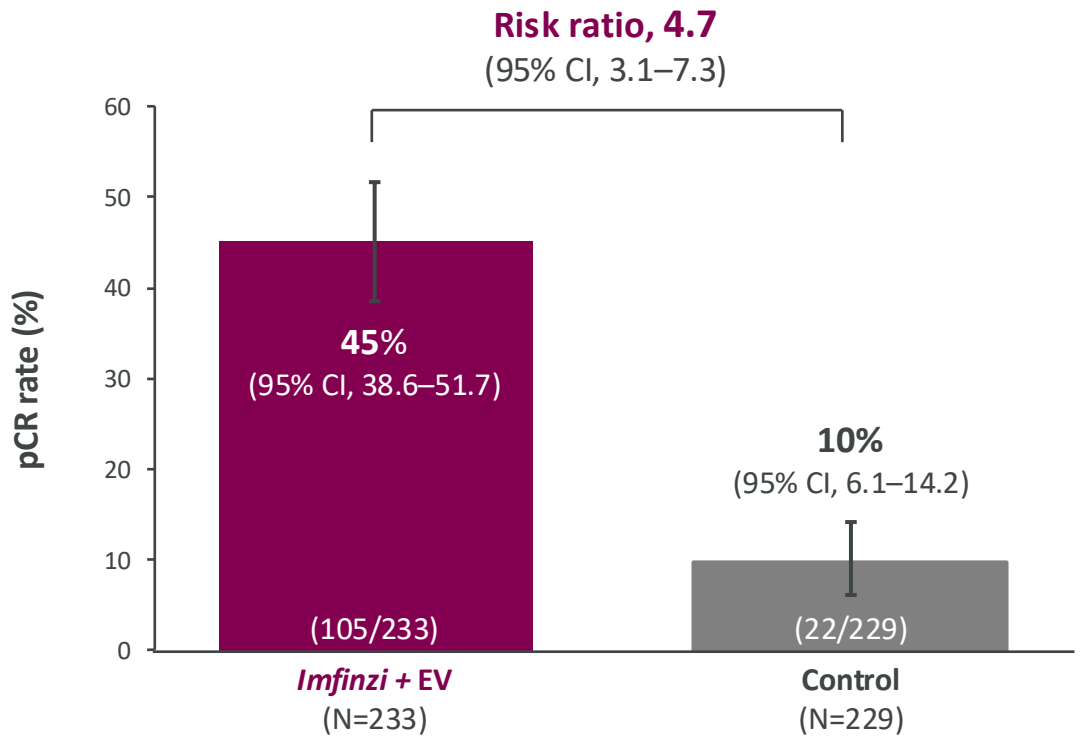
OS HR and CI were not calculated for subgroups with <20 events across both treatment arms. 1. As reported by electronic casereport form. 2. Assessed with the clinical trial assay for PD-L1 (SP263) (Roche Diagnostics); high PD-L1 expression was defined as any of the following: ≥25% of tumour cells exhibited membrane staining; or ICP >1% and IC+ ≥25%; or ICP=1% and IC+=100%. Data cutoff 02 March 2026.

Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.

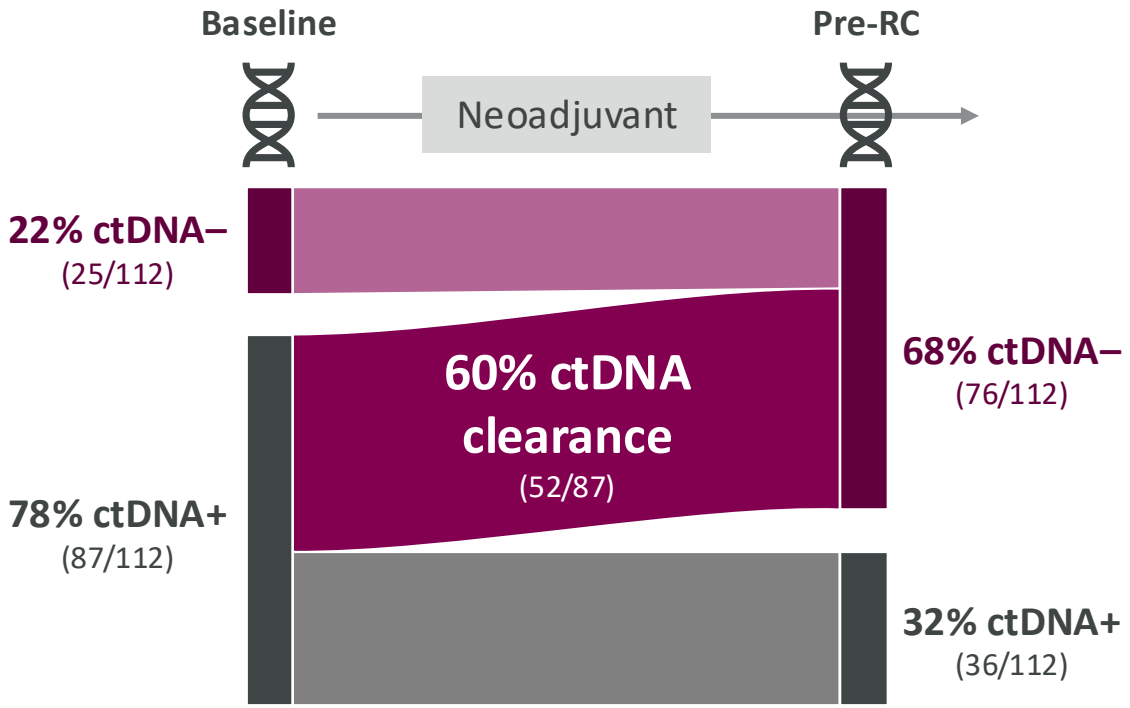
Appendix: Glossary.

VOLGA – *Imfinzi* + EV improved pCR rate vs control, with 60% ctDNA clearance in baseline ctDNA+ patients

Local pathology review (ITT)[1]



Exploratory analysis: ctDNA status in matched evaluable samples at baseline and pre-RC = 112 patients[2]



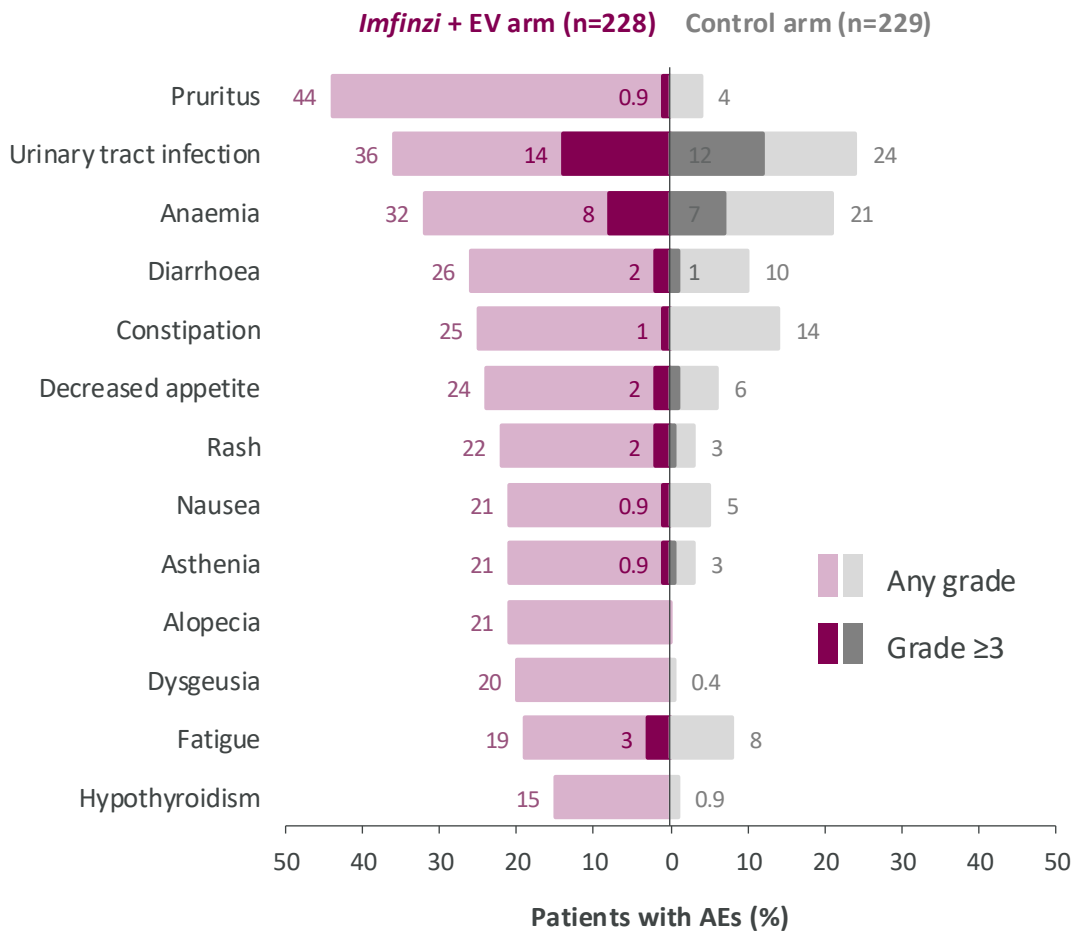
1. Analysis performed using log-binomial models adjusted using stratification factors: PD-L1 status, tumour stage and cisplatin status per interactive-response technology. Patients who did not undergo surgery or those with a missing or non-evaluable assessment were considered non-responders. Data cut-off 02 March 2026. 2. As assessed using Natera's ultrasensitive Signatera™ Genome with Phased and Structural Variants Assay. Analysis based on currently available ctDNA biomarker evaluable population as of July 2026; additional patient data pending. One patient with ctDNA– to ctDNA+ status is not shown in the Sankey plot.

Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.

Appendix: Glossary.

VOLGA – safety profile for *Imfinzi* + EV consistent with the safety profiles of the individual agents

Events, n (%)	*Imfinzi* + EV n=228	Control n=229
AEs of any cause	227 (>99)	170 (74)
Maximum Grade 3 or 4 AEs	145 (64)	101 (44)
Serious AEs	143 (63)	101 (44)
Leading to death	17 (7)	14 (6)
Leading to discontinuation of any study treatment	48 (21)	NA
Leading to discontinuation of *Imfinzi*	37 (16)	NA
Leading to discontinuation of *Imjudo*	NA	NA
Leading to discontinuation of enfortumab vedotin	26 (11)	NA
Leading to cancellation of surgery	2 (0.9)	0
Leading to delay in surgery[1]	8 (4)	1 (0.4)
AEs possibly related to any treatment	207 (91)	NA
Maximum Grade 3 or 4 AEs	69 (30)	NA
Serious AEs	45 (20)	NA
Leading to death	1 (0.4)	NA
Any-grade immune-mediated AEs	75 (33)	8 (3)
Maximum Grade 3 or 4	24 (11)	2 (0.9)
Leading to death	0	0



LHS: The safety population includes all patients who received study treatment (*Imfinzi* + EV arm) or who were randomised (control arm). Investigator-assessed causality. 1. Recommended timeframe for surgery was within 56 days after the last dose of neoadjuvant treatment (*Imfinzi* + EV arm), and within 12 weeks of diagnosis (control arm). Data cut-off 02 March 2026.

RHS: Shows all-causality AEs reported for ≥15% of patients in the safety population for either arm. Data cut-off 02 March 2026. Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.

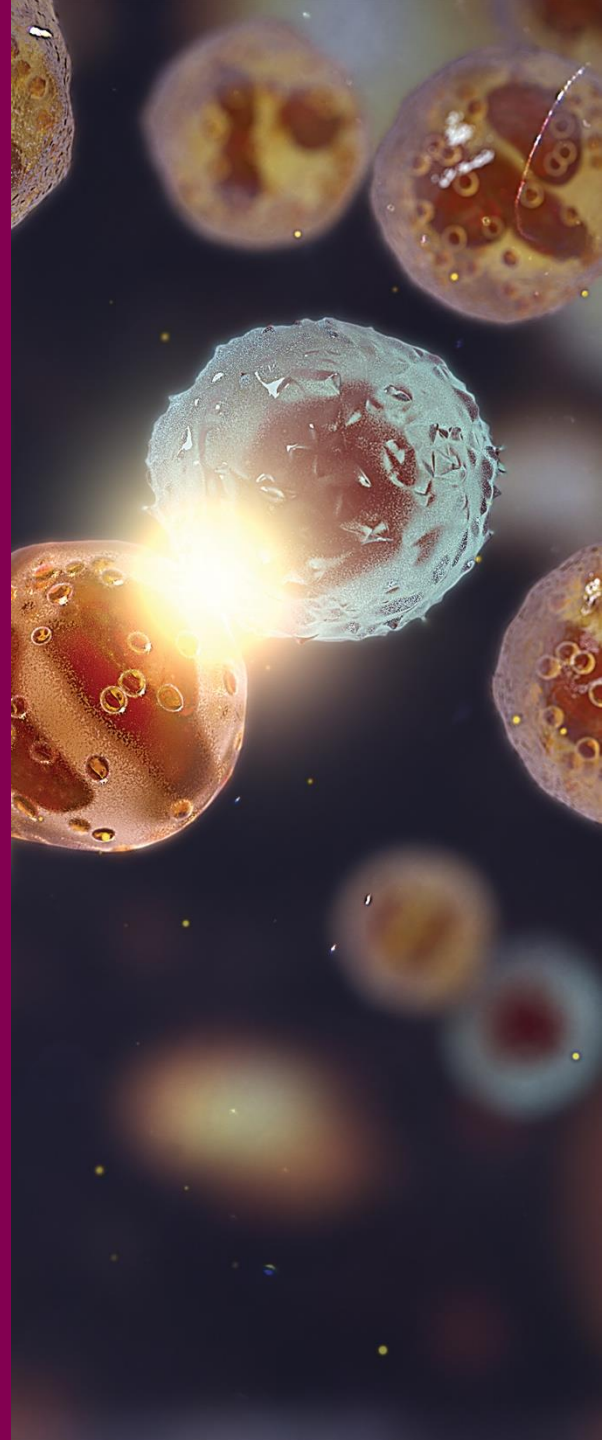
Appendix: Glossary.

VOLGA – *Imfinzi* as a foundational treatment across early bladder cancer

- Perioperative *Imfinzi* + 3 cycles of neoadjuvant enfortumab vedotin significantly improved EFS and OS vs control
- EFS HR 0.51 (95% CI, 0.38–0.67) *P*<0.0001, and OS HR 0.58 (95% CI, 0.40–0.83) *P*=0.0027
- Benefits were consistent across subgroups
- Manageable safety consistent with known profiles, with quality of life maintained after surgery

VOLGA supports *Imfinzi* + enfortumab vedotin as a potential new standard of care for MIBC patients ineligible for, or who refused, cisplatin-based chemotherapy

Powles T et al. Abstract LBA2 presented at the European Society of Medical Oncology 2026.
Appendix: Glossary.



Opportunity for Q&A

Key External Expert



Prof. Thomas Powles
PROFESSOR OF GENITOURINARY ONCOLOGY, BARTS CANCER INSTITUTE

AstraZeneca Leadership



Pascal Soriot
CHIEF EXECUTIVE OFFICER



Dave Fredrickson
EVP, ONCOLOGY HAEMATOLOGY BUSINESS



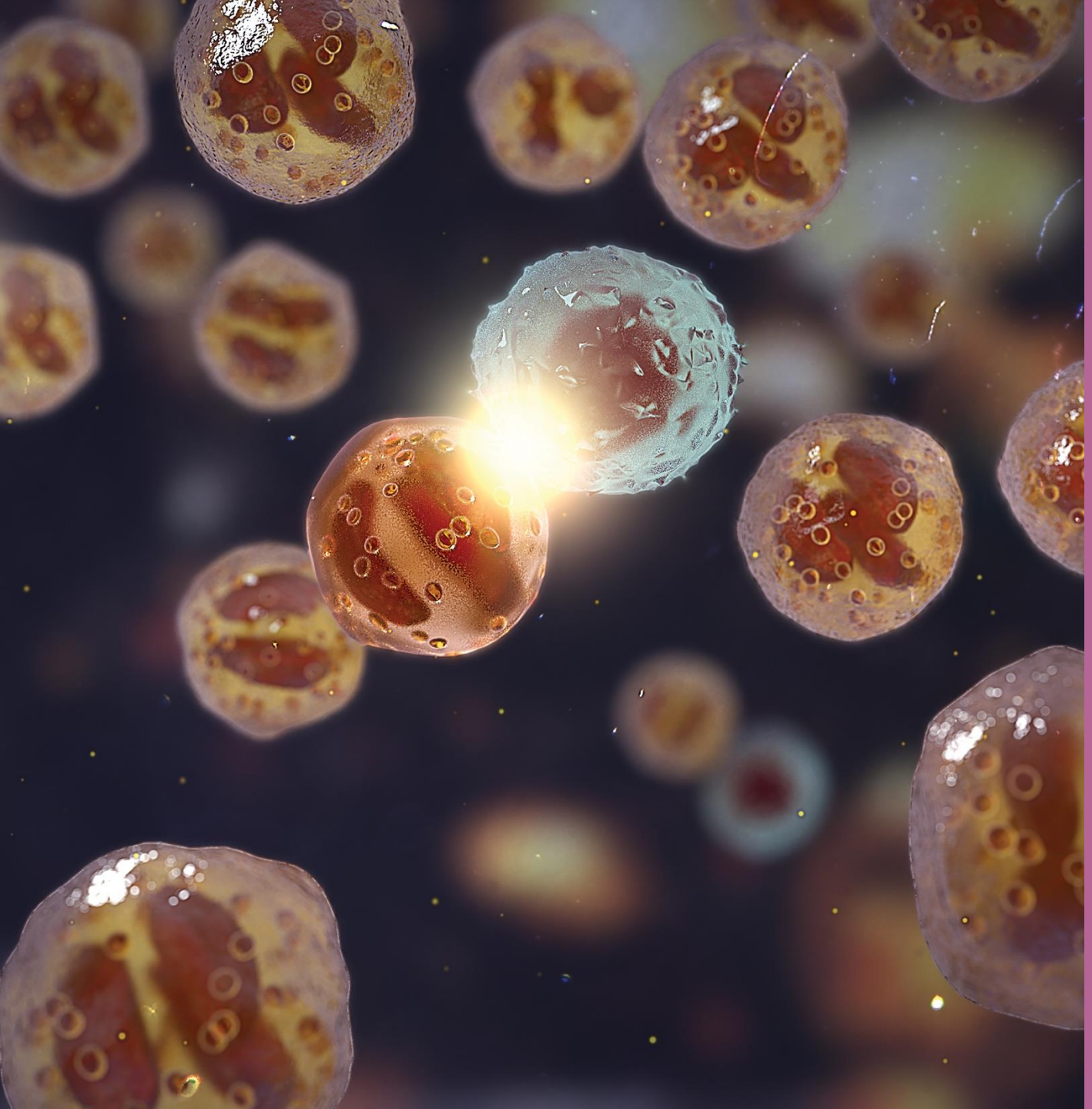
Susan Galbraith
EVP, ONCOLOGY HAEMATOLOGY R&D



Leora Horn
SVP, LATE DEVELOPMENT ONCOLOGY



Sunil Verma
SVP, GLOBAL HEAD, ONCOLOGY FRANCHISE

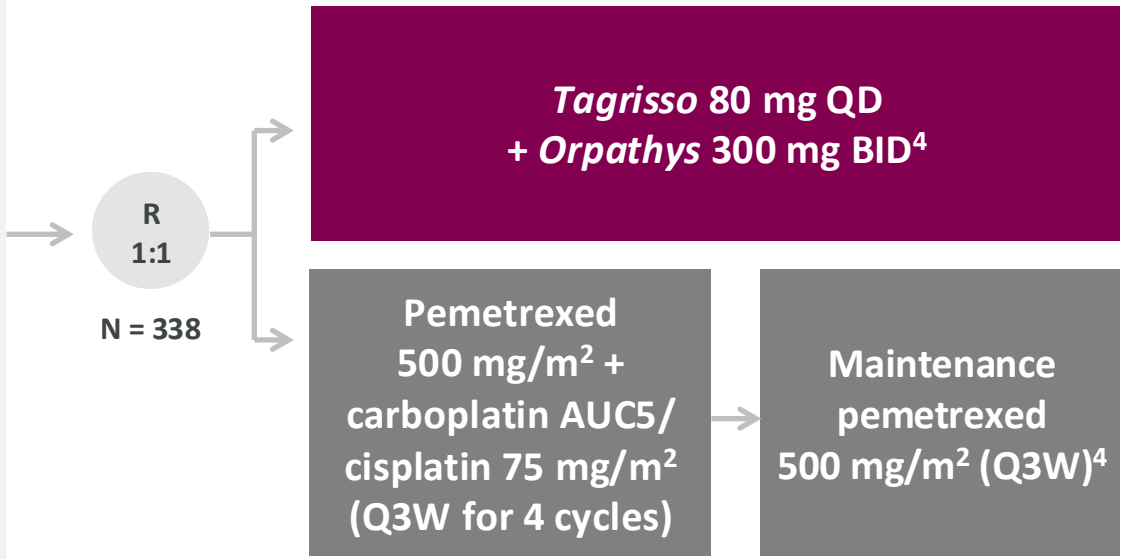


***EGFR*m lung cancer:** Extending *Tagrisso* as backbone therapy

Prof. Yi-Long Wu
PROFESSOR OF ONCOLOGY, GUANGDONG LUNG CANCER INSTITUTE

SAFFRON – *Tagrisso* + *Orpathys* potential first biomarker-driven, all-oral therapy for post-TKI *EGFR*m NSCLC

- *EGFR*m[1] locally advanced or metastatic NSCLC
- MET overexpression (MET IHC3+≥90%) and/or amplification (FISH10+)[2]
- Progression on 1L or 2L *Tagrisso* as the most recent anti-cancer treatment[3]



Investigator-assessed PD (per RECIST v1.1) or discontinuation

Treatment beyond PD allowed per investigator discretion[5]

Primary endpoint:

- PFS (BICR) in the FAS

Key secondary/exploratory endpoints:

- PFS (inv.), OS, ORR, DoR, DCR and tumour shrinkage in the FAS
- PFS in the MET-overexpressed and MET-amplified analysis sets
- Safety in the SAS

Stratification factors

- Race (Asian/non-Asian)
- Baseline brain metastases (Yes/no)
- Line of treatment (2L/3L)

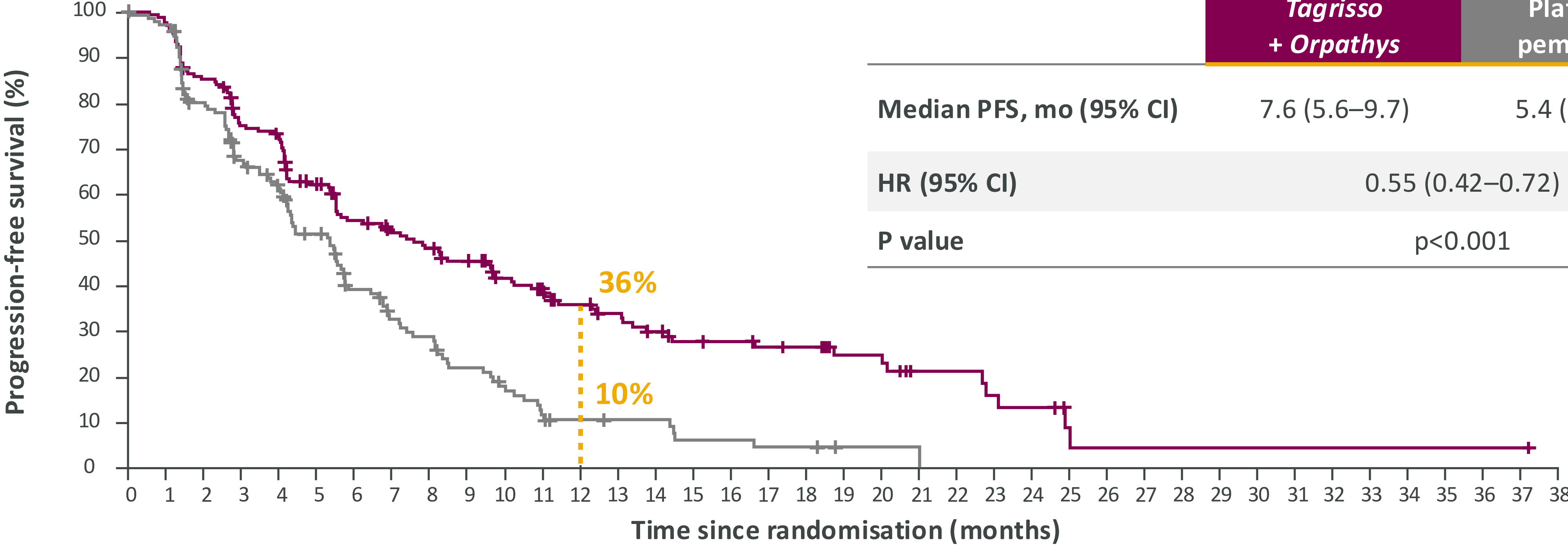
35% of patients evaluable for MET testing had MET overexpression (IHC3+≥90%) and/or *MET* amplification (FISH10+)

1. Ex19del, L858R, and/or T790M. 2. Centrally confirmed with post-progression tissue biopsy. MET IHC and FISH cut-offs were identified in preliminary analyses of the Phase II SAVANNAH study. IHC test: Investigational assay for MET (SP44; Roche Diagnostics, Tucson, AZ, USA); FISH test: investigational assay for MET (Vysis MET FISH Kit; Abbott Molecular, Inc., Des Plaines, IL, USA); 3. Patients treated with *Tagrisso* in adjuvant spetting were included if progression occurred <6 months after the last dose; 4. Patients received treatment until objective progressive disease by RECIST v1.1 as assessed by investigator, unacceptable toxicity, withdrawn consent, or another discontinuation criterion was met; 5. Patients continued to receive *Tagrisso* plus *Orpathys* or *Tagrisso* monotherapy (if *Orpathys* was stopped earlier) or pemetrexed maintenance beyond RECIST v1.1-defined progressive disease (if eligible) if they continued to receive clinical benefit in the opinion of the investigator. Crossover between treatment arms was not allowed.

Lu S et al. Abstract LBA6 presented at the European Society of Medical Oncology 2026. Collaboration partner:Hutchmed (*Orpathys*).

Appendix: Glossary.

SAFFRON – *Tagrisso* + *Orpathys* significantly improved PFS vs SoC



	Tagrisso + *Orpathys*	Platinum–pemetrexed
Median PFS, mo (95% CI)	7.6 (5.6–9.7)	5.4 (4.2–5.8)
HR (95% CI)	0.55 (0.42–0.72)	
P value	p<0.001	

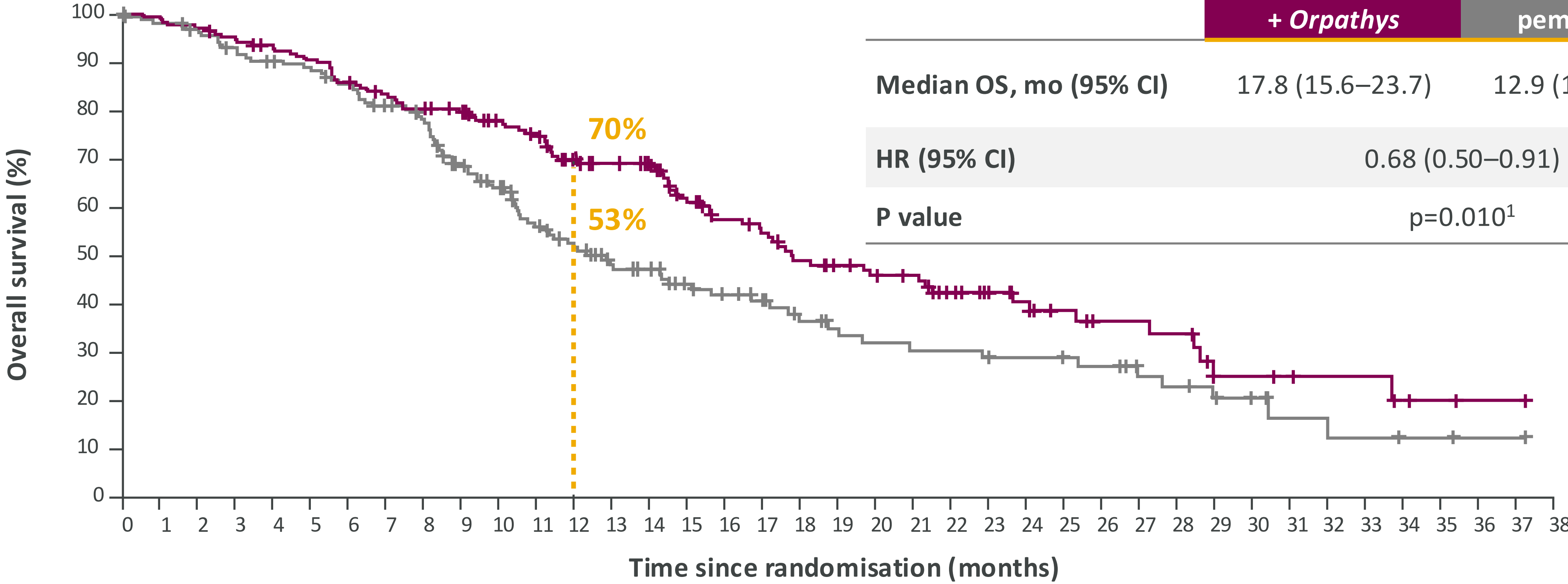
No. at risk

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	Number of patients/number of events
Tagrisso + Orpathys	171	166	144	124	120	98	82	75	70	64	54	49	39	34	29	25	24	22	21	14	14	8	8	6	5	2	1	1	1	1	1	1	1	1	1	1	1	1	0	171/117
Platinum–pemetrexed	167	139	109	87	77	61	43	34	30	22	17	12	8	7	7	4	4	3	3	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	167/113

Consistent PFS benefit across subgroups

Data cut-off: 06 July 2026. Median follow-up for PFS by BICR: *Tagrisso* + *Orpathys* 5.6 months, platinum–pemetrexed 3.5 months. Overall maturity: 68%.
Lu S et al. Abstract LBA6 presented at the European Society of Medical Oncology 2026. Collaboration partner:Hutchmed (*Orpathys*).
Appendix: Glossary.

SAFFRON – significant 4.9-month OS improvement with *Tagrisso* + *Orpathys* vs SoC



	Tagrisso + *Orpathys*	Platinum–pemetrexed
Median OS, mo (95% CI)	17.8 (15.6–23.7)	12.9 (10.6–16.8)
HR (95% CI)	0.68 (0.50–0.91)	
P value	p=0.010[1]	

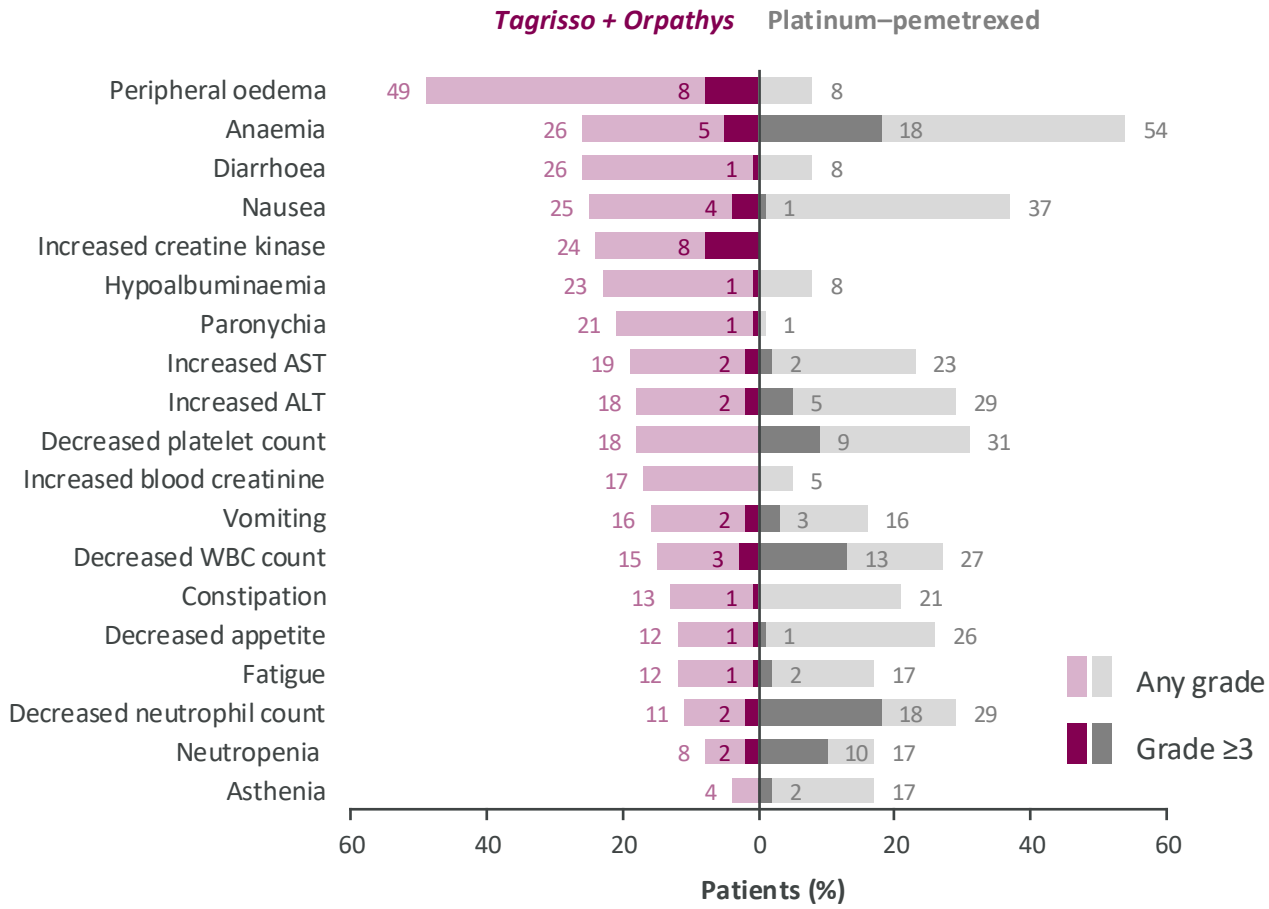
No. at risk

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	Number of patients/number of events
Tagrisso + Orpathys	171	170	166	162	157	152	144	138	133	130	119	114	98	93	89	74	63	59	51	46	43	39	31	27	22	17	14	14	13	9	7	6	5	5	3	2	1	1	0	171/87
Platinum–pemetrexed	167	154	150	142	137	134	128	119	113	96	86	70	62	51	48	40	36	32	27	23	21	20	20	19	18	18	16	12	11	9	7	4	4	3	2	2	1	1	0	167/93

Data cut-off: 06 July 2026. Median follow-up for OS: *Tagrisso* + *Orpathys* 14.2 months, platinum–pemetrexed 10.2 months. Overall maturity: 53%.
1. Boundary to declare statistical significance p<0.03047.
Lu S et al. Abstract LBA6 presented at the European Society of Medical Oncology 2026. Collaboration partner:Hutchmed (*Orpathys*).
Appendix: Glossary.

SAFFRON – safety profile for *Tagrisso* + *Orpathys* consistent with the known profiles of each medicine

	Tagrisso + *Orpathys* (n = 170)	Platinum–pemetrexed (n = 145)
Median total duration of exposure, mo (range)	8.5 (0.7–37.9)	3.5 (0–20.3)
TEAEs (all causality), n (%)	169 (99)	140 (97)
Any TEAE Grade ≥3	108 (64)	91 (63)
Any serious TEAE	69 (41)	40 (28)
Any fatal TEAE	12 (7)[1]	0
Any TEAE leading to discontinuation	23 (14)	12 (8)
Any TEAE leading to dose modification	104 (61)	64 (44)
TRAEs[2], n (%)	158 (93)	134 (92)
Any TRAE Grade ≥3	68 (40)	75 (52)
Any serious TRAE	24 (14)	23 (16)
Any fatal TRAE	1 (1)	0
Any TRAE leading to discontinuation	21 (12)	9 (6)
Any TRAE leading to dose modification	82 (48)	55 (38)



LHS: Data cut-off: 06 July 2026. 1. Nine of 12 patients in the *Tagrisso* + *Orpathys* arm who experienced fatal AEs had either documented disease progression before death or disease progression/NSCLC cited as a primary or secondary cause of death. 2. TRAEs were defined as AEs considered by the investigator to have a reasonable possibility of being caused by the study treatment. RHS: Shows all-causality TEAEs reported for ≥15% of patients in either arm. TEAEs are shown by preferred term. Muscle spasms occurred in 10% of patients in the *Tagrisso* + *Orpathys* arm (Grade ≥3: 0%) and no patients in the platinum–pemetrexed arm. Lu S et al. Abstract LBA6 presented at the European Society of Medical Oncology 2026. Collaboration partner: Hutchmed (*Orpathys*).
Appendix: Glossary.

SANOVO – exploring potential of *Tagrisso* + *Orpathys* in 1L setting

- *EGFR*m untreated unresectable or metastatic NSCLC[1]
- Centrally confirmed MET overexpression[2]
  - IHC 3+ ≥90%[3] or
  - IHC 2+ (H-score≥220 and <90%)[4]

CHINA ONLY TRIAL

R 1:1

N = 326

***Orpathys* 300 mg/200 mg BID (by BW) + *Tagrisso* 80 mg QD**

Placebo 300 mg/200 mg BID (by BW) + *Tagrisso* 80 mg QD

Until PD or intolerable toxicity[5]

Primary endpoint:

- PFS (inv.)

Secondary endpoints:

- PFS (IRC), ORR, DoR, DCR (inv. and IRC), OS
- Safety

Stratification factors

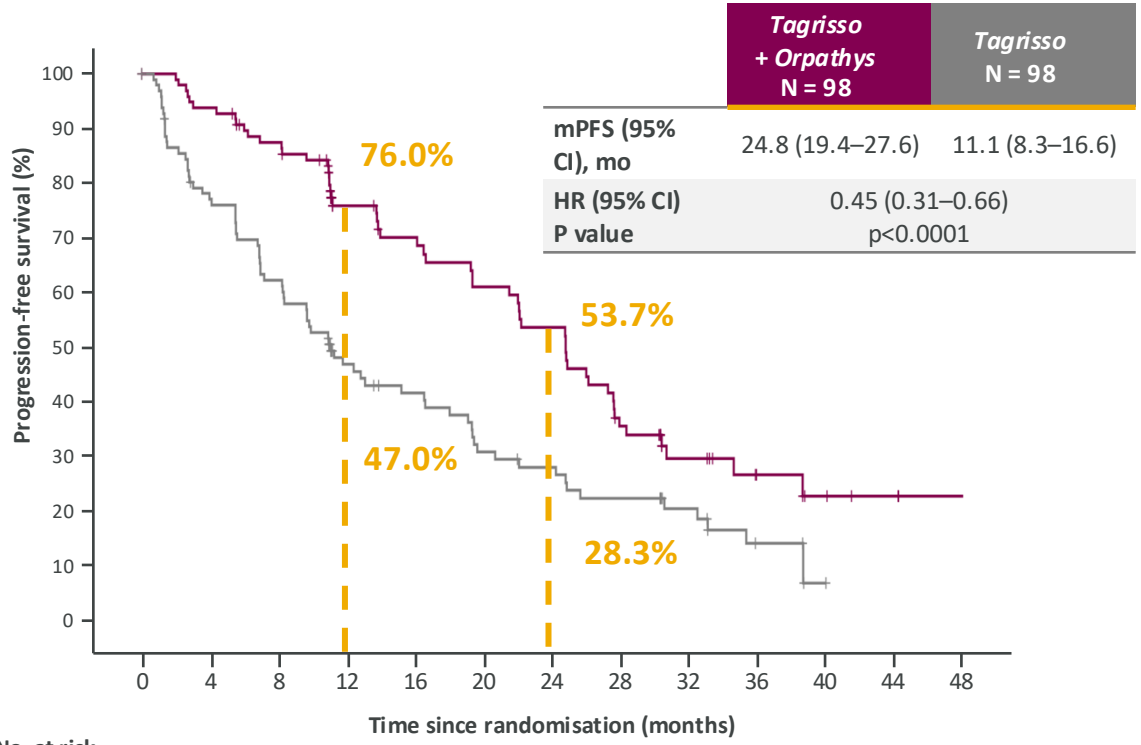
- *EGFR*m type (ex19del vs L858R)
- MET status (IHC 3+ vs IHC 2+)
- Brain metastases (yes vs no)

60% of the enrolled population had IHC 3+, the remainder were IHC 2+

1. Patients treated with chemotherapy in neoadjuvant/adjuvant setting were included if progression occurred ≥6 months after the last dose. EGFRm for inclusion were 19del or L858R. 2. MET IHC kit (D1C2, Amoy Diagnostics, Xiamen, China); 3. IHC 3+: ≥90% of tumour cells demonstrating strong staining; 4. IHC 2+: H-score≥220 and <90% of tumour cells demonstrating strong staining; 5. Patients received treatment until objective progressive disease by RECIST 1.1 as assessed by investigator, unacceptable toxicity, withdrawn consent, or another discontinuation criterion was met. Crossover between treatment groups was not allowed; patientswere followed up for safety outcomes 28 days after the last dose of study treatment.
Wu Y-L et al. Abstract LBA69 presented at the European Society of Medical Oncology 2026. Collaboration partner: Hutchmed (*Orpathys*).
Appendix: Glossary.

SANOVO – *Tagrisso + Orpathys* significantly improved PFS[1]

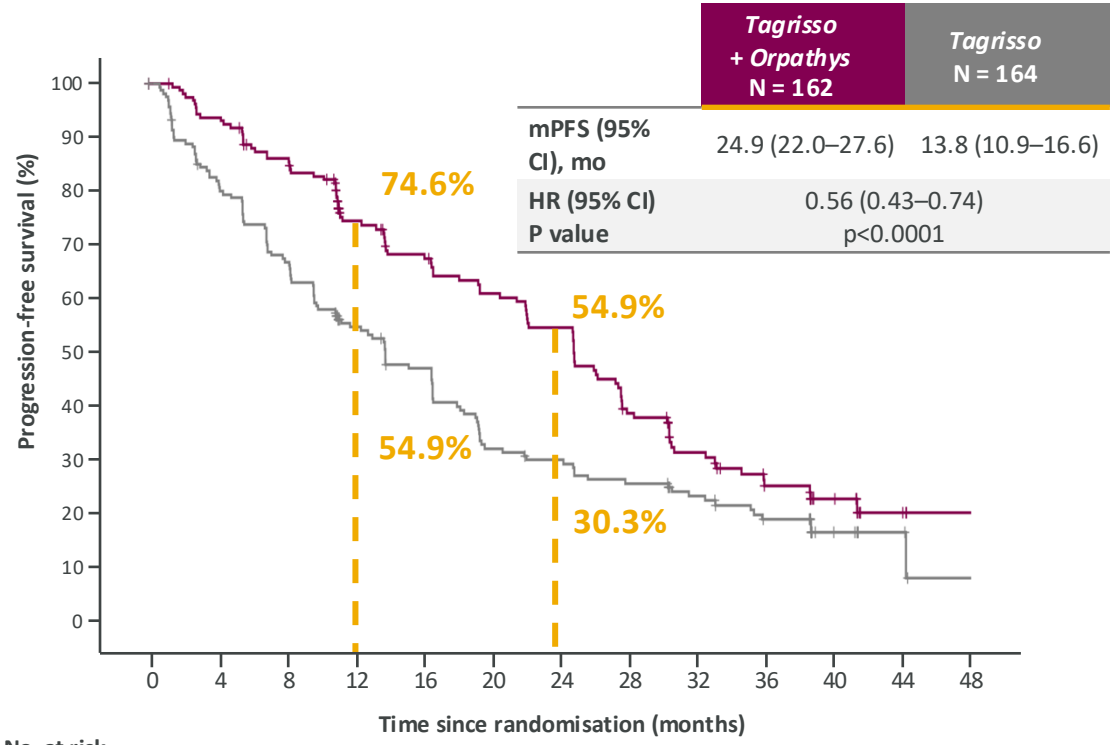
MET IHC 3+ population



	Tagrisso + Orpathys N = 98	*Tagrisso* N = 98
mPFS (95% CI), mo	24.8 (19.4–27.6)	11.1 (8.3–16.6)
HR (95% CI)	0.45 (0.31–0.66)	
P value	p<0.0001	

No. at risk													
Tagrisso + Orpathys	98	91	82	53	47	41	36	23	13	7	4	2	0
Tagrisso	98	74	59	37	31	23	20	16	11	5	0		

ITT population



	Tagrisso + Orpathys N = 162	*Tagrisso* N = 164
mPFS (95% CI), mo	24.9 (22.0–27.6)	13.8 (10.9–16.6)
HR (95% CI)	0.56 (0.43–0.74)	
P value	p<0.0001	

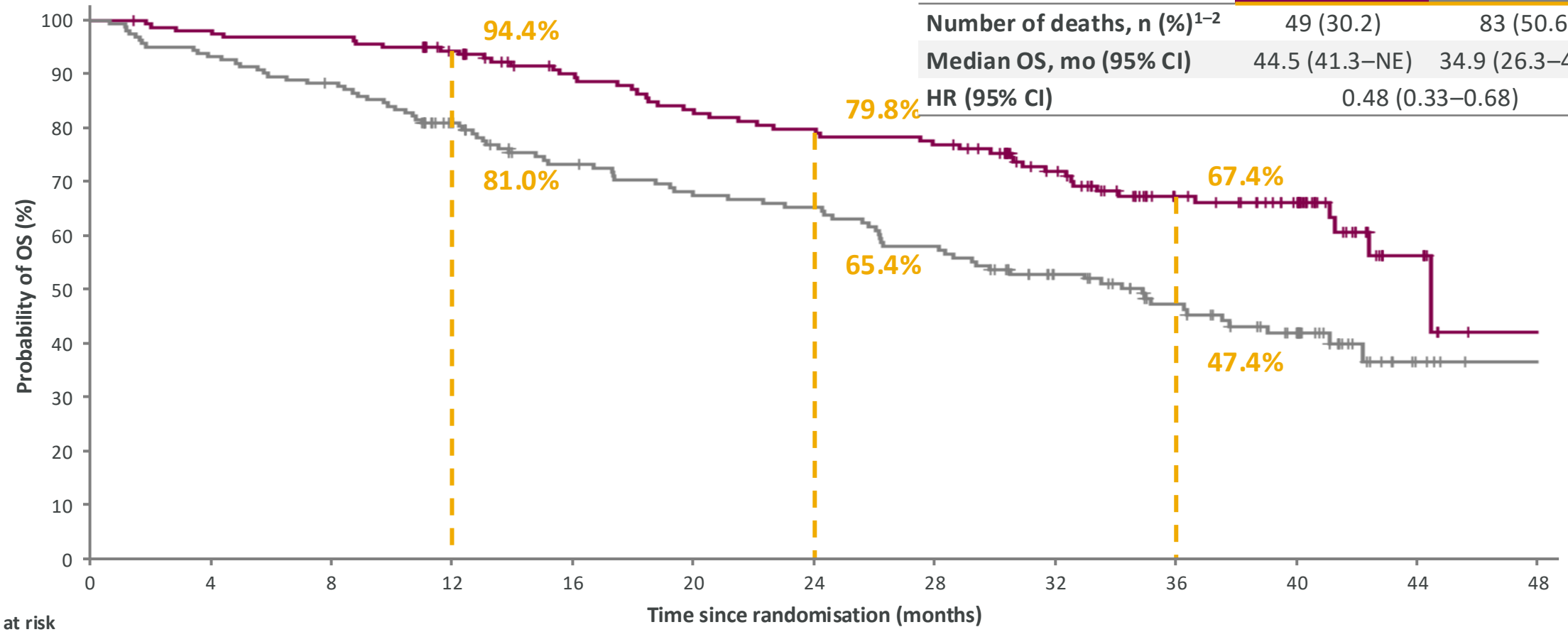
No. at risk													
Tagrisso + Orpathys	162	149	134	98	87	77	69	48	33	22	13	3	0
Tagrisso	164	132	107	80	67	46	42	36	29	21	7	3	0

IRC-assessed PFS benefit was consistent with investigator assessment

1. PFS by investigator assessment. Median follow-up for PFS: 30.4 months in the MET IHC 3+ population and 38.6 months in the ITT population.
Wu Y-L et al. Abstract LBA69 presented at the European Society of Medical Oncology 2026. Collaboration partner: Hutchmed (*Orpathys*).
Appendix: Glossary.

SANOVO – very encouraging clinical benefit in overall survival with *Tagrisso* + *Orpathys*

	Tagrisso + *Orpathys* N = 162	*Tagrisso* N = 164
Number of deaths, n (%)[1–2]	49 (30.2)	83 (50.6)
Median OS, mo (95% CI)	44.5 (41.3–NE)	34.9 (26.3–41.1)
HR (95% CI)	0.48 (0.33–0.68)	

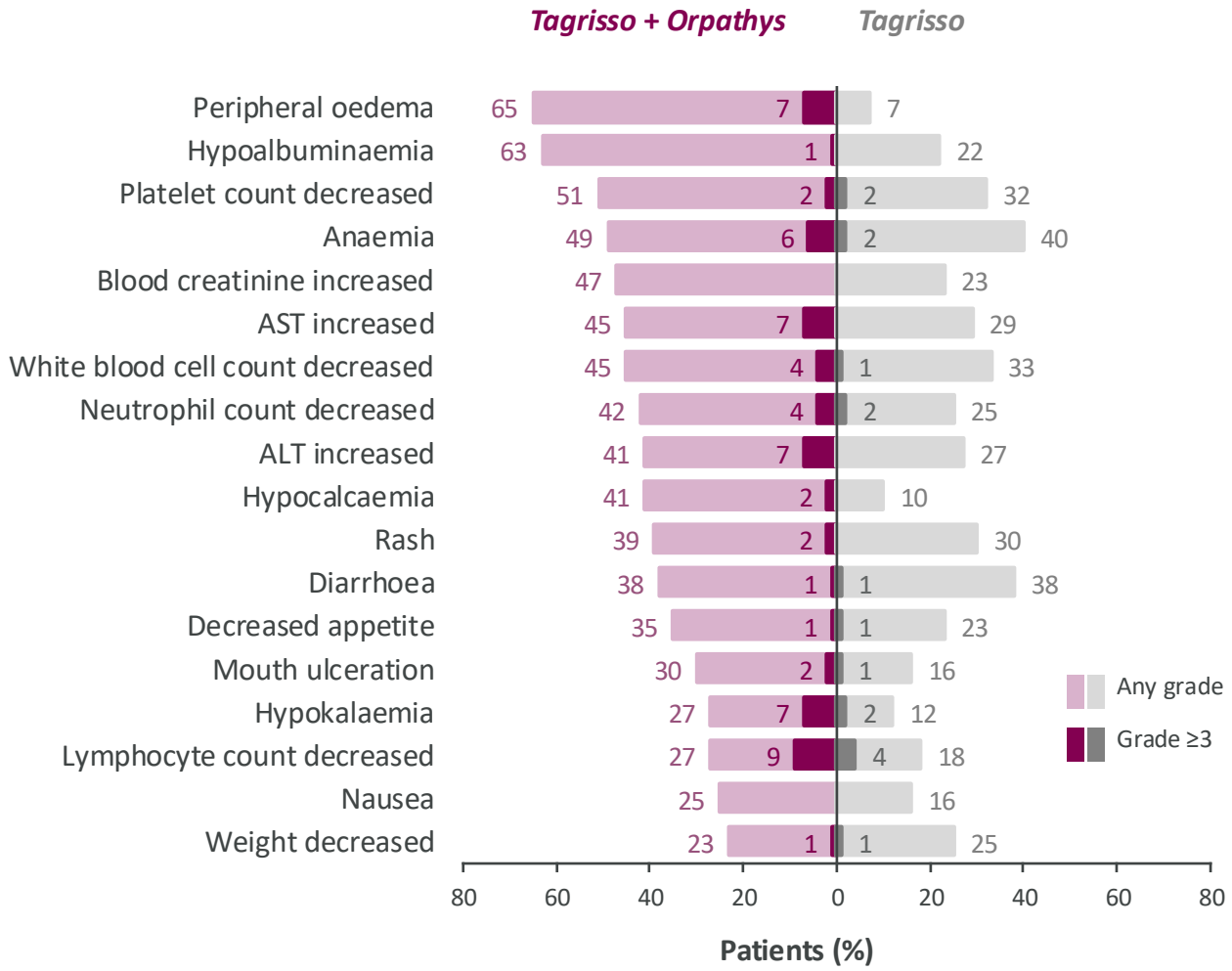


No. at risk												
Tagrisso + *Orpathys*	162	158	156	142	123	114	109	105	82	57	45	8	0
Tagrisso	164	153	144	121	102	93	90	80	62	47	33	4	0

1. At the data cut-off date, the overall survival maturity was 40.5%. 2. Median follow-up for OS: 38.7 months (ITT population). Wu Y-L et al. Abstract LBA69 presented at the European Society of Medical Oncology 2026. Collaboration partner: Hutchmed (*Orpathys*). Appendix: Glossary.

SANOVO – safety remains consistent with known profiles

	Tagrisso + Orpathys N = 162	*Tagrisso* N = 164
Median exposure, mo (range)	22.1 (0.4–44.2)	12.9 (0.4–45.5)
Any TEAE, n (%)	162 (100.0)	163 (99.4)
Grade ≥3 TEAE	125 (77.2)	63 (38.4)
TEAE leading to dose modification	119 (73.5)	57 (34.8)
TEAE leading to discontinuation	24 (14.8)	7 (4.3)
Serious TEAE	89 (54.9)	47 (28.7)
Fatal TEAE (excluding PD)	7 (4.3)	8 (4.8)



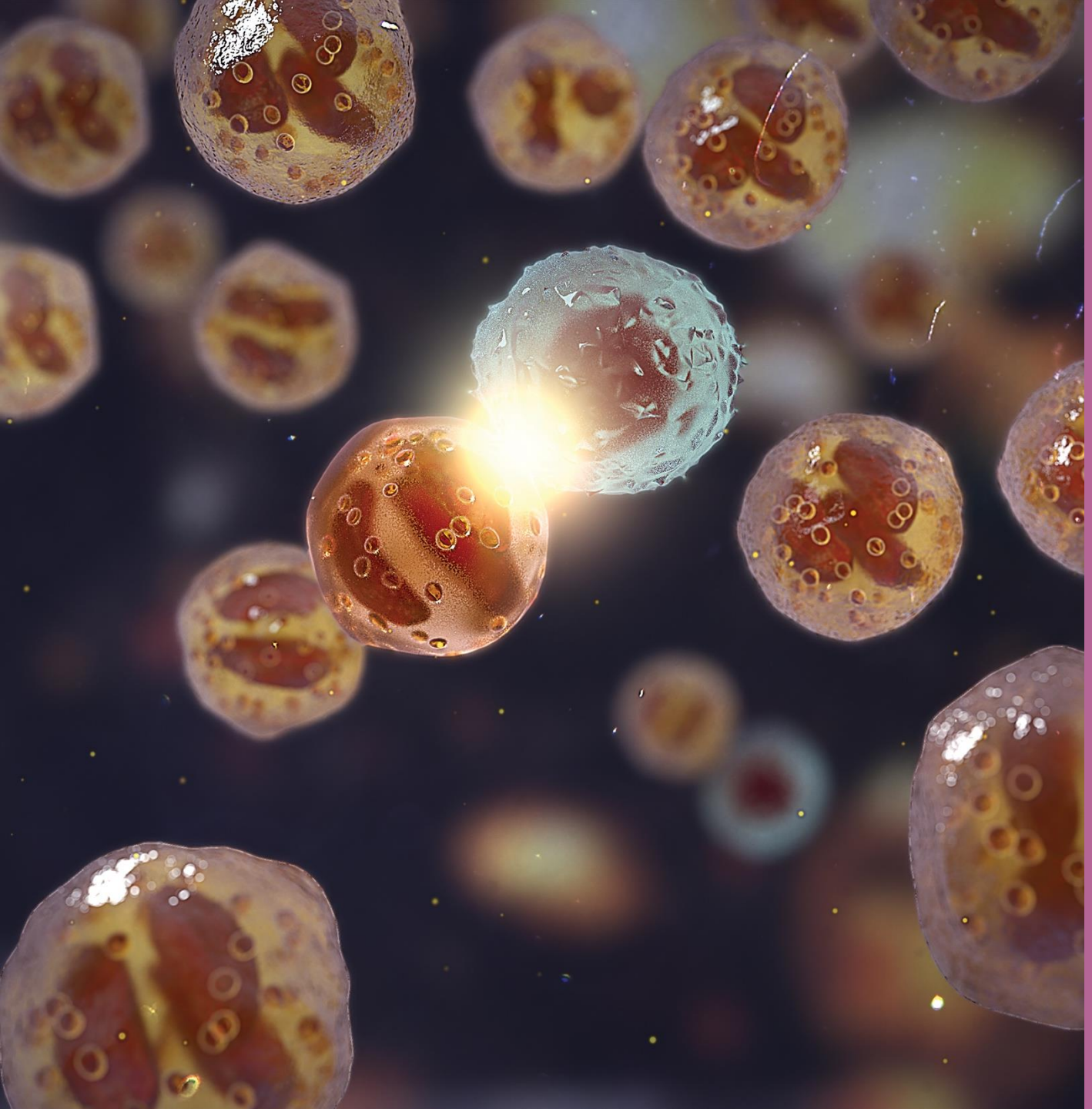
RHS: Shows all-causality TEAEs reported for ≥25% of patients in either arm.
Wu Y-L et al. Abstract LBA69 presented at the European Society of Medical Oncology 2026. Collaboration partner: Hutchmed (*Orpathys*).
Appendix: Glossary.

SAFFRON and SANOVO – reinforcing role of backbone *Tagrisso* across lines of treatment for *EGFR*m NSCLC

- **SAFFRON:** *Tagrisso* + *Orpathys* demonstrated statistically significant and clinically meaningful improvements in PFS and OS vs platinum–pemetrexed in *EGFR*m MET-overexpressed and/or -amplified post-TKI advanced NSCLC[1]
- **SANOVO:** *Tagrisso* + *Orpathys* showed statistically significant and clinically meaningful improvements in PFS vs *Tagrisso* alone in untreated advanced NSCLC patients harbouring activating *EGFR*m and MET overexpression in China-only trial[2]
- Combination in both trials demonstrated a tolerable safety profile, which was consistent with the established profiles for each treatment[1,2]

***Tagrisso + Orpathys* establishes a potential new oral standard-of-care for biomarker-directed *EGFR*m advanced NSCLC**

1. Lu S et al. Abstract LBA6 presented at the European Society of Medical Oncology 2026. 2. Wu Y-L et al. Abstract LBA69 presented at the European Society of Medical Oncology 2026.
Collaboration partner: Hutchmed (*Orpathys*).
Appendix: Glossary.



Small cell lung cancer: Reinforcing *Imfinzi* as backbone therapy across SCLC

Leora Horn
SVP, LATE DEVELOPMENT
ONCOLOGY

DeLLphi-305 – further reinforcing key role of *Imfinzi* in ES-SCLC with new data in combination with *Imdelltra*®

Imfinzi[1] + platinum-etoposide induction therapy (4 cycles)

- Age ≥18 years
- No disease progression
- ECOG PS 0–1
- Asymptomatic untreated or treated brain metastases

R 1:1

N=563

Until progression or unacceptable toxicity

***Imfinzi* (1500 mg Q4W)[3] + *Imdelltra*® (tarlatamab) (10 mg Q2W)[2] | n=282**

***Imfinzi* (1500 mg Q4W)[3] n=281**

Primary endpoint
- OS

Key secondary endpoint
- PFS

Secondary endpoints
- ORR
- DoR
- Safety

Stratification factors
- Brain and/or liver metastases (yes/no)
- Response to 1L CTx–IO (PR/CR vs SD)
- Prior platinum type (cisplatin vs carboplatin)

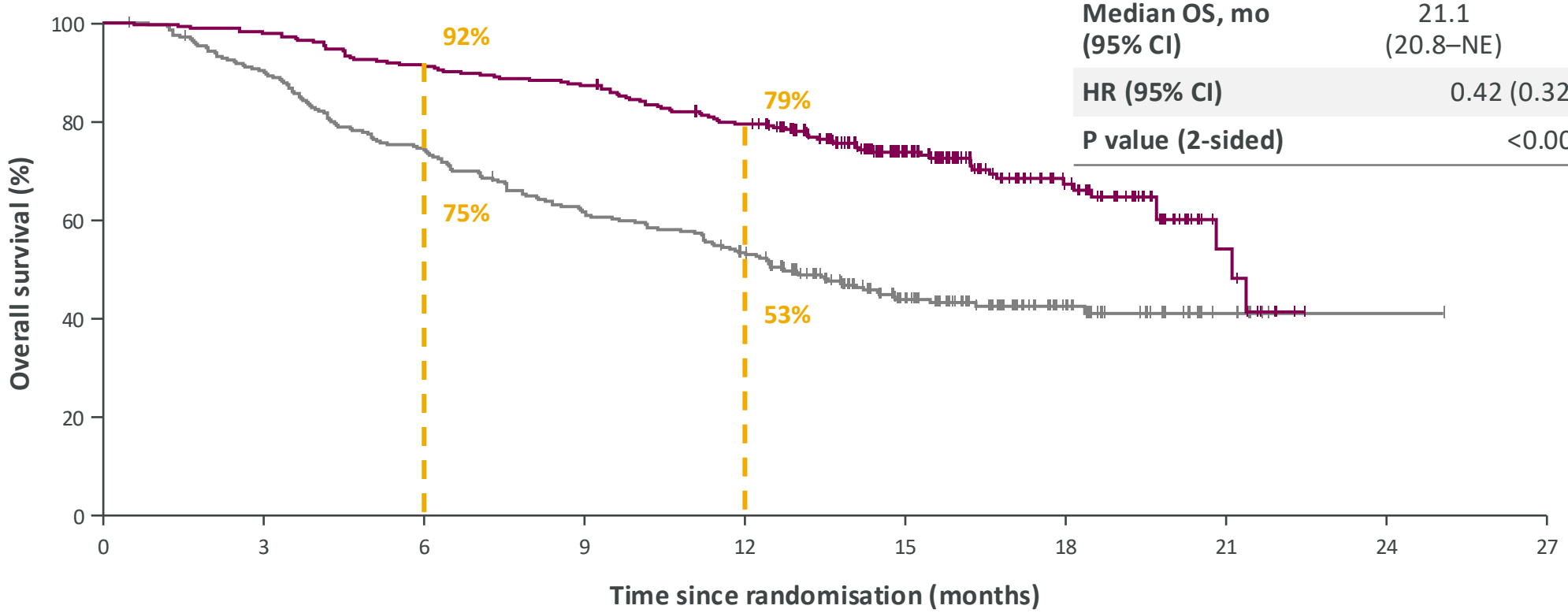
Interim OS analysis: 243 (61% IF)
OS events
Two-sided P-value boundary: 0.008

Endpoints were tested sequentially according to prespecified hierarchical testing strategy: OS, then PFS, then ORR

Data cut-off date: 7 July 2026. 1. Eligible patients must have received ≥3 cycles of concomitant *Imfinzi* as 1L treatment of ES-SCLC. 2. Patients were monitored on site for a minimum of 1 to 2 hours, or 6 to 8 hours in certain regions after the first two doses of *Imdelltra*®. 3. Each treatment cycle consists of 28 days.
Sands J et al. Abstract LBA3 presented at the European Society of Medical Oncology 2026. DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.
Appendix: Glossary.

DeLLphi-305 – significant OS improvement with *Imfinzi + Imdelltra®* vs *Imfinzi* alone

	Imfinzi + Imdelltra® (n=282)	*Imfinzi* (n=281)
Median OS, mo (95% CI)	21.1 (20.8–NE)	12.7 (11.2–14.8)
HR (95% CI)	0.42 (0.32–0.54)	
P value (2-sided)	<0.001	

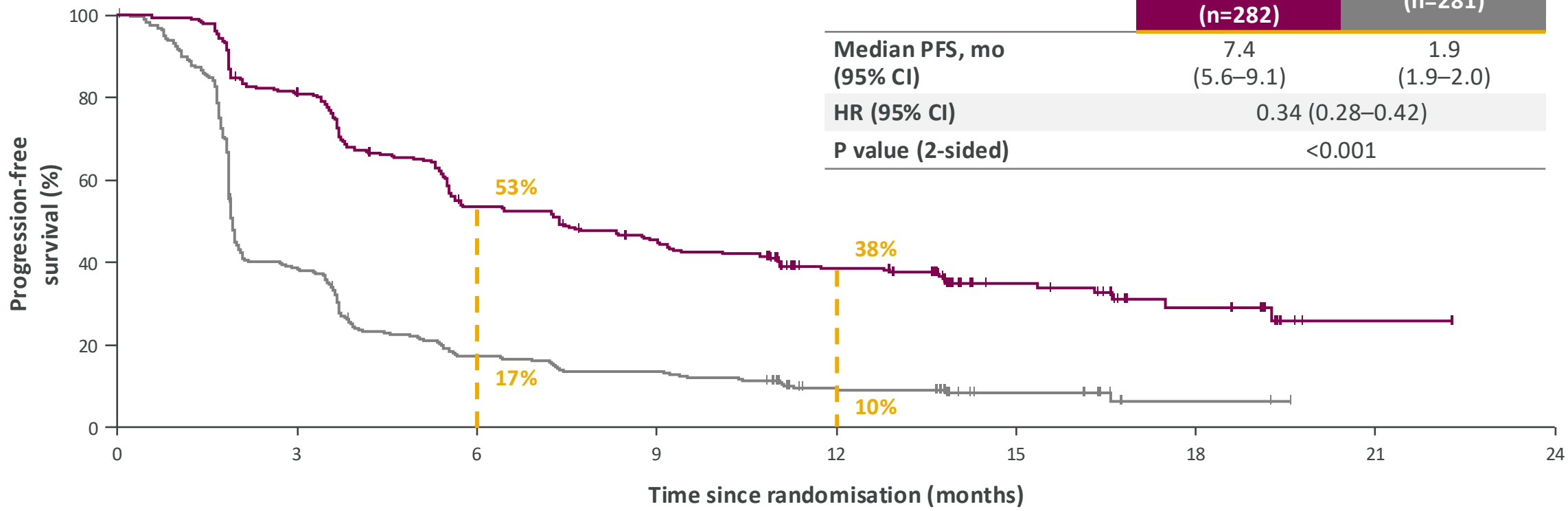


No. at risk									
Imfinzi + Imdelltra®	282	276	258	246	222	132	55	9	0
Imfinzi	281	252	208	171	146	81	33	8	1	0

Data cut-off date: 7 July 2026.
At the time of data cut-off, 87 events had occurred in the *Imfinzi-Imdelltra®* arm, and 156 events had occurred in the *Imfinzi* arm. Median follow-up 15.9 mo for *Imfinzi + Imdelltra®* and 16.1 mo for *Imfinzi*. P-value calculated using a stratified log-rank test.
Sands J et al. Abstract LBA3 presented at the European Society of Medical Oncology 2026. DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.
Appendix: Glossary.

DeLLphi-305 – more than 5-month PFS improvement with *Imfinzi + Imdelltra®* vs *Imfinzi* alone

	Imfinzi + Imdelltra® (n=282)	*Imfinzi* (n=281)
Median PFS, mo (95% CI)	7.4 (5.6–9.1)	1.9 (1.9–2.0)
HR (95% CI)	0.34 (0.28–0.42)	
P value (2-sided)	<0.001	



No. at risk								
Imfinzi + Imdelltra®	282	225	147	122	86	32	14	1	0
Imfinzi	281	106	46	36	18	8	2	0	

Data cut-off date: 7 July 2026.
At the time of data cut-off, 182 events had occurred in the *Imfinzi-Imdelltra®* arm, and 250 events had occurred in the *Imfinzi* arm. Median follow-up 13.9 mo for *Imfinzi + Imdelltra®* and 13.9 mo for *Imfinzi*. P-value calculated using a stratified log-rank test.
Sands J et al. Abstract LBA3 presented at the European Society of Medical Oncology 2026. DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.
Appendix: Glossary.

DeLLphi-305 – manageable safety profile consistent with the individual agents

Events, n (%)	*Imfinzi* + *Imdelltra*® (n=282)	*Imfinzi* (n=278)
Median treatment duration, weeks (IQR)	46.9 (16.4–65.6)	8.1 (4.1–20.1)
Any TEAE	281 (99.6)	258 (92.8)
Grade ≥3 TEAE	132 (46.8)	113 (40.6)
Serious TEAE	118 (41.8)	88 (31.7)
Fatal TEAE	13 (4.6)	13 (4.7)
TEAE leading to *Imdelltra*® discontinuation	16 (5.7)	NA
TEAE leading to *Imfinzi* discontinuation	16 (5.7)	16 (5.8)
Any TRAE[1]	268 (95.0)	145 (52.2)
Grade ≥3 TRAE	59 (20.9)	30 (10.8)
Serious TRAE	63 (22.3)	26 (9.4)
Fatal TRAE	0 (0.0)	2 (0.7)
TRAE leading to *Imdelltra*® discontinuation	9 (3.2)	NA
TRAE leading to *Imfinzi* discontinuation	9 (3.2)	10 (3.6)

- **CRS and ICANS consistent with the known safety profile of *Imdelltra*®[2]**
- Most CRS events resolved with supportive care and antipyretics
- Interventions included corticosteroids (21.6%), tocilizumab (3.9%) and low-flow oxygen (1.4%)

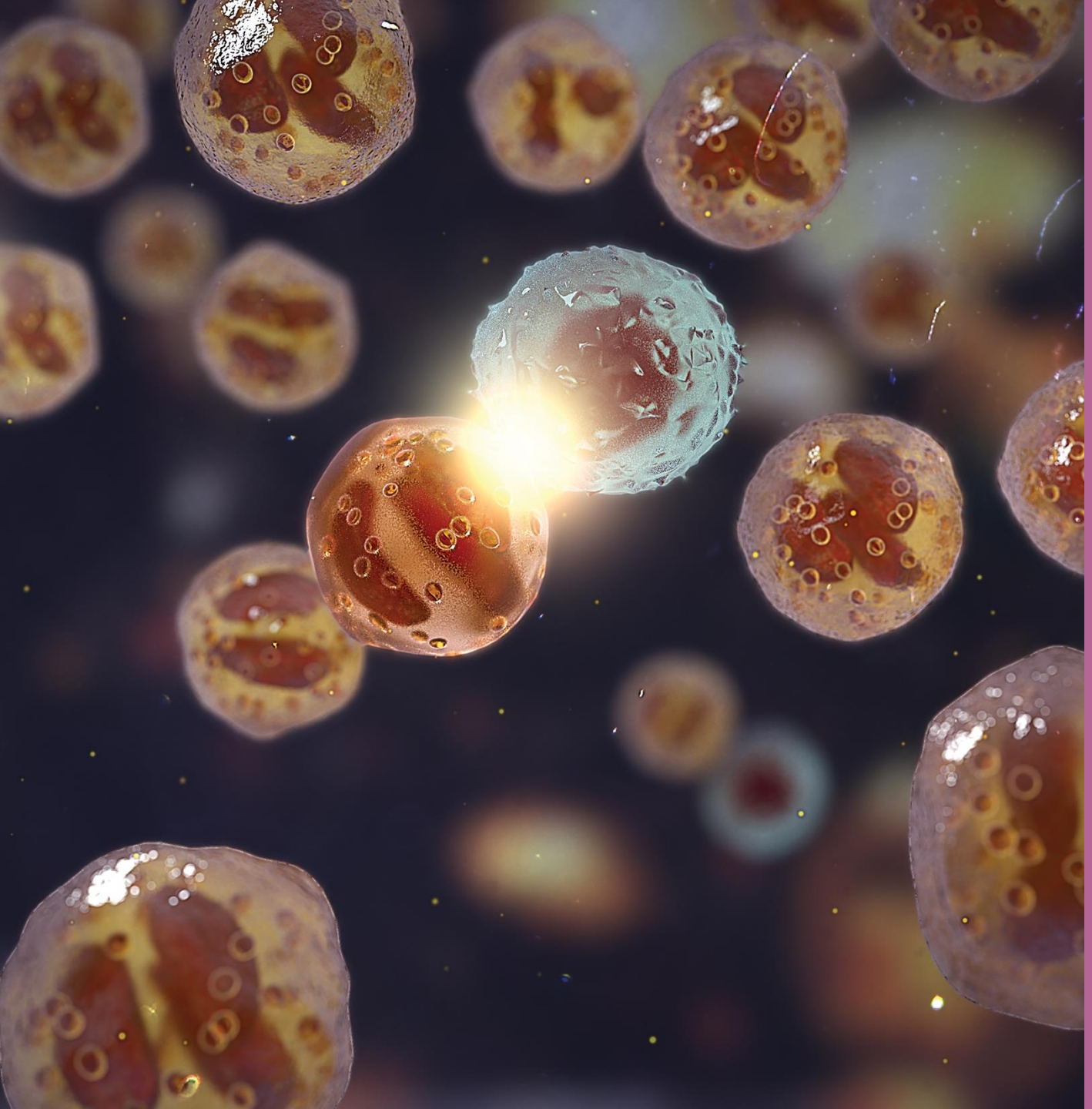
1. Related to any treatment. 2. CRS and ICANS events were graded using ASTCT 2019 criteria.
Data cut-off date: 7 July 2026. Assessed by investigator. Grade ≥3 TRAEs in ≥1% included decreased neutrophil count, neutropenia and decreased appetite with *Imfinzi* + *Imdelltra*®, and pneumonitis, increased AST and increased lipase with *Imfinzi*. Treatment discontinuations were infrequent, with no treatment-related fatalities in the combination arm.
Sands J et al. Abstract LBA3 presented at the European Society of Medical Oncology 2026. DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.
Appendix: Glossary.

DeLLphi-305 – *Imfinzi* + *Imdelltra*® first dual IO regimen in ES-SCLC, reinforcing the role of *Imfinzi* in this setting

- *Imfinzi* + *Imdelltra*® significantly improved OS, PFS and ORR vs *Imfinzi* in patients with ES-SCLC without progression after initial CTx + *Imfinzi*
  - 58% reduction in the risk of death
  - 66% reduction in the risk of disease progression or death
- Survival benefit extended to all predefined subgroups, including patients with brain metastases, liver metastases or minimal response to initial CTx + *Imfinzi*
- *Imfinzi* + *Imdelltra*® demonstrated a manageable safety profile with low rates of treatment discontinuation due to adverse events

DeLLphi-305 outcomes support maintenance therapy with *Imfinzi* + *Imdelltra*® as a new standard of care for first-line patients post-induction with *Imfinzi* + chemotherapy

Sands J et al. Abstract LBA3 presented at the European Society of Medical Oncology 2026. DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.
Appendix: Glossary.

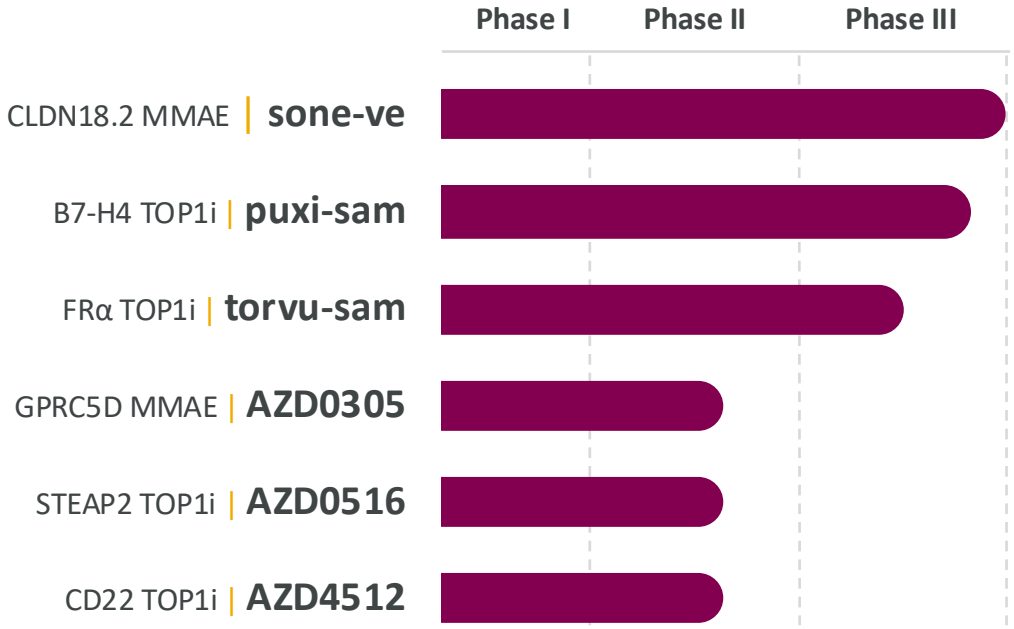


Gastric cancer: Unlocking the power of ADCs with sone-ve

Susan Galbraith
EVP, ONCOLOGY
HAEMATOLOGY R&D

Rapidly advancing broad high-value portfolio of ADCs

Clinical-stage ADC pipeline spans multiple targets across solid and haematologic tumour types



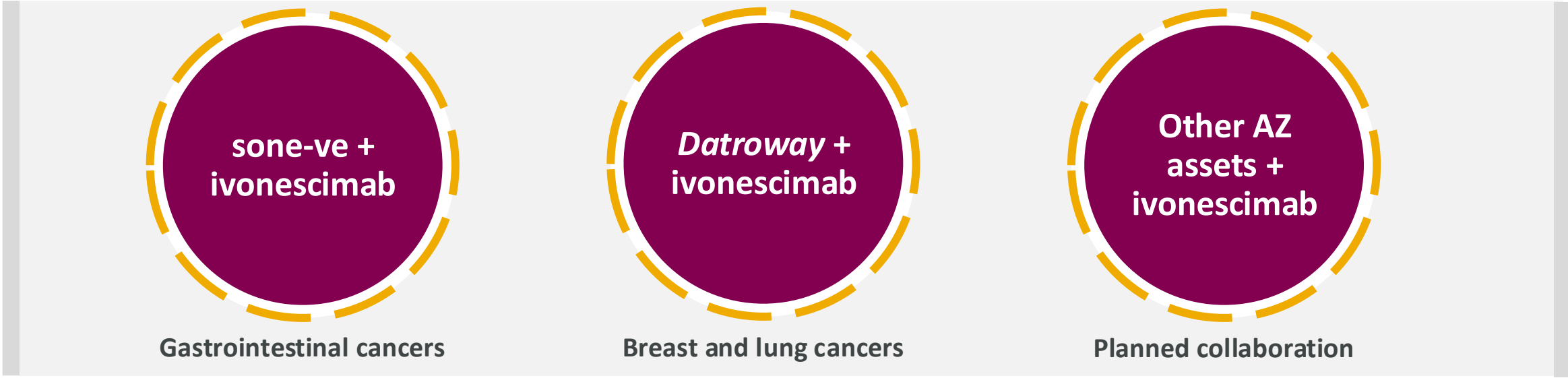
6 wholly owned ADCs in clinic
Preclinical pipeline including dual payload ADCs

Expanding Phase III development for late-stage ADCs

sone-ve	**CLARITY-Gastric01** 2L+ Claudin 18.2+ gastric cancer	✓
	CLARITY-Gastric02 1L Claudin 18.2+ gastric cancer	Ongoing
	+ ivonescimab GI cancers	To be initiated
puxi-sam	**Bluestar-Endometrial01** 2L+ B7-H4 endometrial cancer	HLR H2'27
torvu-sam	**TREVI-OC-01** FRα-high and -low PRR ovarian cancer	Ongoing
	TREVI-OC-03 PSR ovarian cancer (maintenance)	NEW FSI Q3'26
	TREVI-OC-02 1L HRD-ve ovarian cancer (maintenance)	NEW FSI Q3'26

Appendix: Glossary.

Enhancing the value of AstraZeneca's ADC portfolio through strategic collaboration with Summit



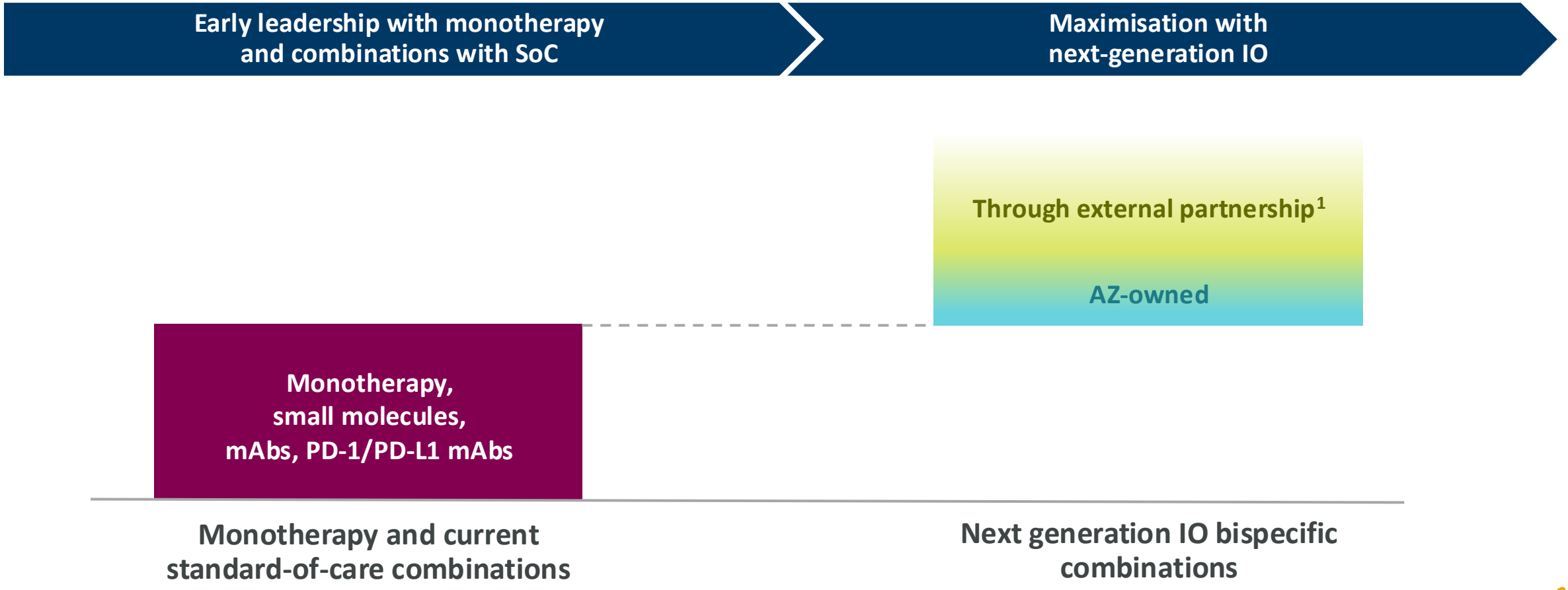
- Broadens and maximises AZ assets across key tumour types by addressing segmented treatment approaches
- Strategic investment in Summit accelerates development of ivonescimab + ADCs across tumour types

Positions AstraZeneca as a leader in the ADC + next-generation IO bispecific space

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

Maximising the potential of AstraZeneca ADCs through combinations with next-generation IO bispecifics

Illustrative of ADC value only; not to scale



1. External collaboration with Summit Therapeutics to investigate combinations ofivonescimab and AZ ADCs. Signed collaborations for *Datroway* and sone-ve.
Appendix: Glossary.

CLARITY-Gastric01 – establishing sone-ve in gastric cancer with positive overall survival data

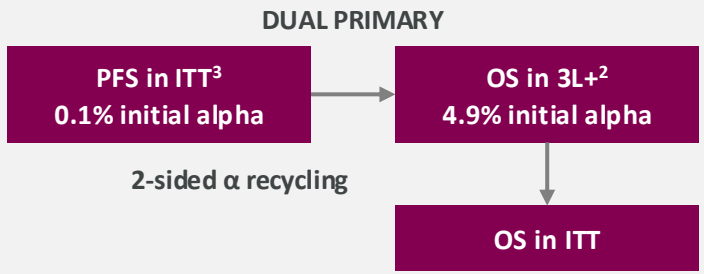
Study population:

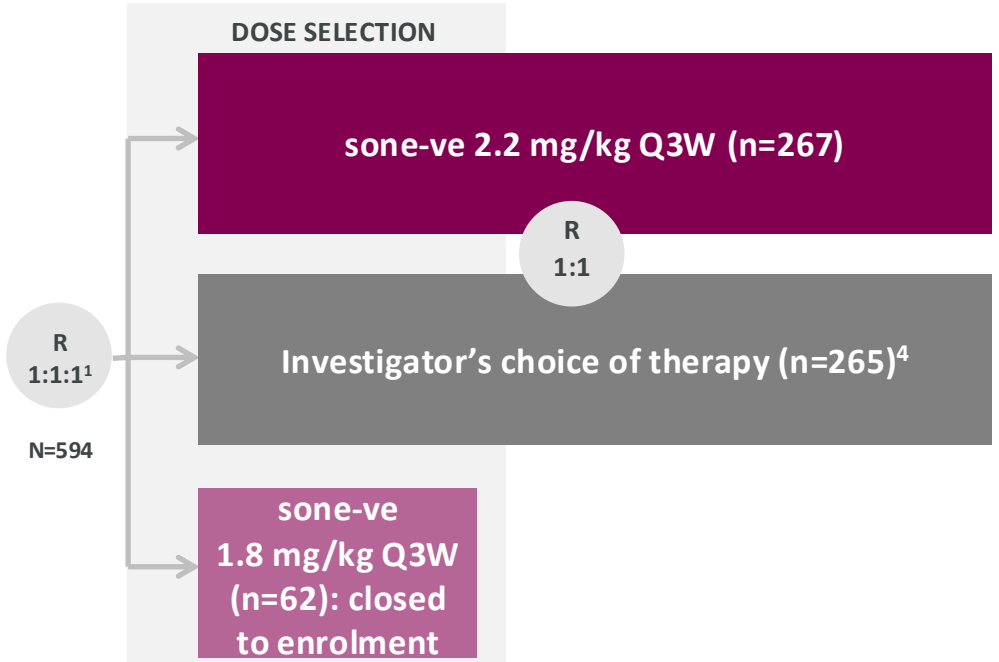
- 2L+ GEC expressing CLDN18.2 (≥25% tumour cells with any intensity membranous staining)

Stratification factors

- Region
- Prior gastrectomy
- Treatment line

Multiple testing procedure





Dual primary endpoints:

- OS (3L+[2])
- PFS by BICR (ITT[3])

Key secondary endpoint:

- OS (ITT)

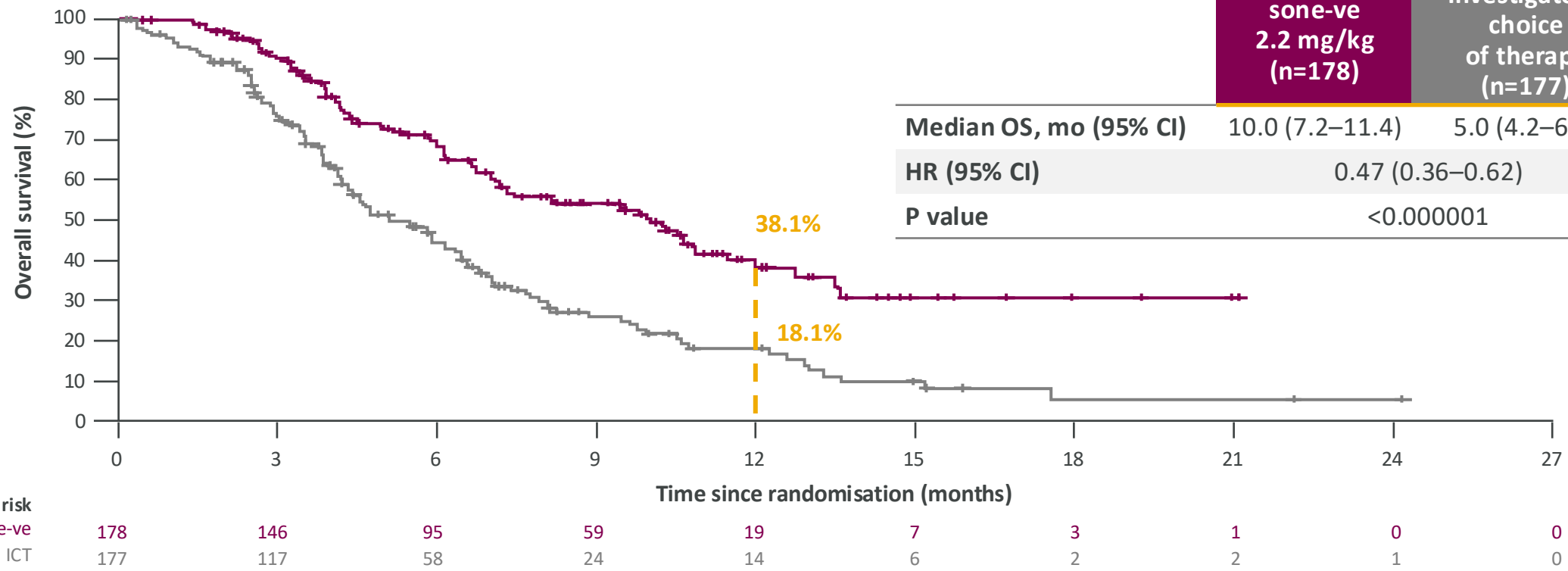
Additional secondary /exploratory endpoints:

- PFS by BICR (3L+)
- ORR and DoR by BICR (ITT, 3L+)
- Safety
- OS by CLDN18.2 expression (ITT)
- PFS, ORR and DoR by Investigator (ITT, 3L+)
- OS in prespecified subgroups (ITT, 3L+)

1. Patients were randomised 1:1:1 to sone-ve 2.2 mg/kg Q3W, sone-ve 1.8 mg/kg Q3W, or investigator's choice of therapy. As of January 2025, the optimal sone-ve monotherapy dose was determined to be 2.2 mg/kg IV Q3W and the 1.8 mg/kg arm was closed to enrolment. Randomisation continued in a 1:1 ratio sone-ve 2.2 mg/kg Q3W or investigator's choice of therapy. 2. All randomised patients who had received ≥2 prior lines of systemic therapy; 3. All randomised patients who had received ≥1 prior line of systemic therapy. 4. Investigator's choice of therapy in 2L: ramucirumab plus paclitaxel, paclitaxel (patients with contraindication to ramucirumab only), docetaxel (patients with contraindication to ramucirumab only); Investigator's choice of therapy in 3L: irinotecan, trifluridine/tipiracil (except China), apatinib (China only). Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026.

Appendix: Glossary.

CLARITY-Gastric01 – sone-ve reduced the risk of death by 53% vs investigator's choice of therapy in 3L+



	sone-ve 2.2 mg/kg (n=178)	Investigator's choice of therapy (n=177)
Median OS, mo (95% CI)	10.0 (7.2–11.4)	5.0 (4.2–6.4)
HR (95% CI)	0.47 (0.36–0.62)	
P value	<0.000001	

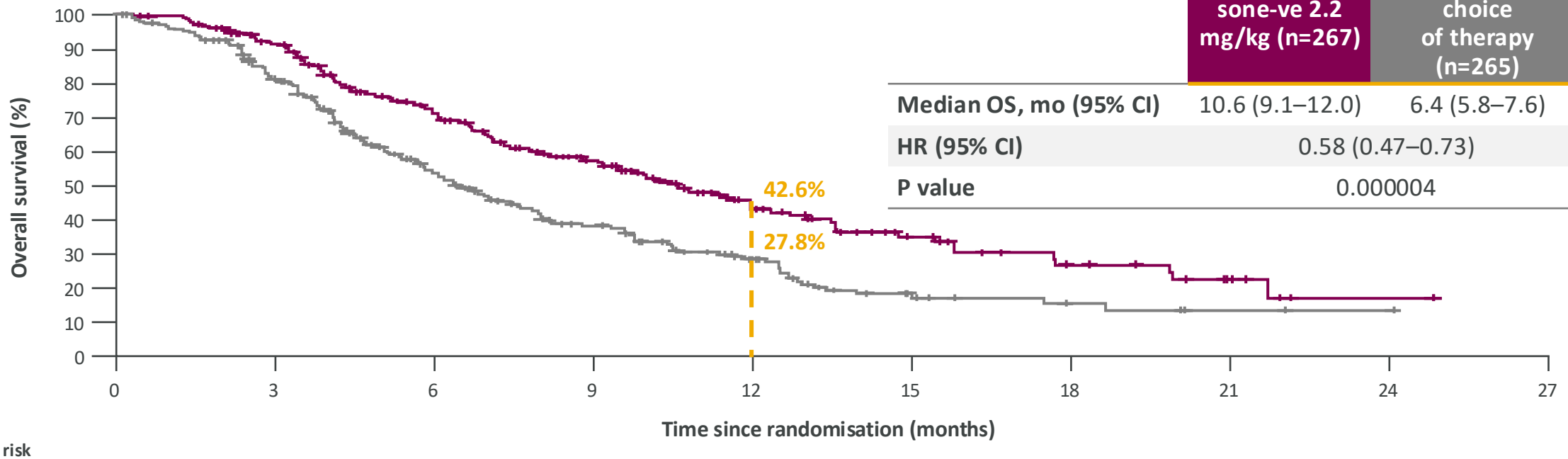
OS HR point estimates favoured sone-ve vs ICT across all clinically relevant subgroups in the 3L+ population

The HR for event or death and CI were estimated from a stratified Cox proportional-hazards model with ties = Efron. Stratification variables included geographical region, prior gastrectomy and line of therapy. The CI was calculated using a profile likelihood approach. An HR of less than 1 favours sone-ve. Tick marks indicate censored observations.

Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026.

Appendix: Glossary.

CLARITY-Gastric01 – sone-ve reduced the risk of death by 42% vs investigator's choice of therapy in 2L+



	sone-ve 2.2 mg/kg (n=267)	Investigator's choice of therapy (n=265)
Median OS, mo (95% CI)	10.6 (9.1–12.0)	6.4 (5.8–7.6)
HR (95% CI)	0.58 (0.47–0.73)	
P value	0.000004	

No. at risk										
sone-ve	267	227	159	107	49	26	14	6	1	0
ICT	265	197	114	67	37	14	8	5	1	0

Consistent OS benefit across CLDN18.2 expression levels (≥75% and ≥25% to <75%) in 2L+ population (exploratory endpoint)

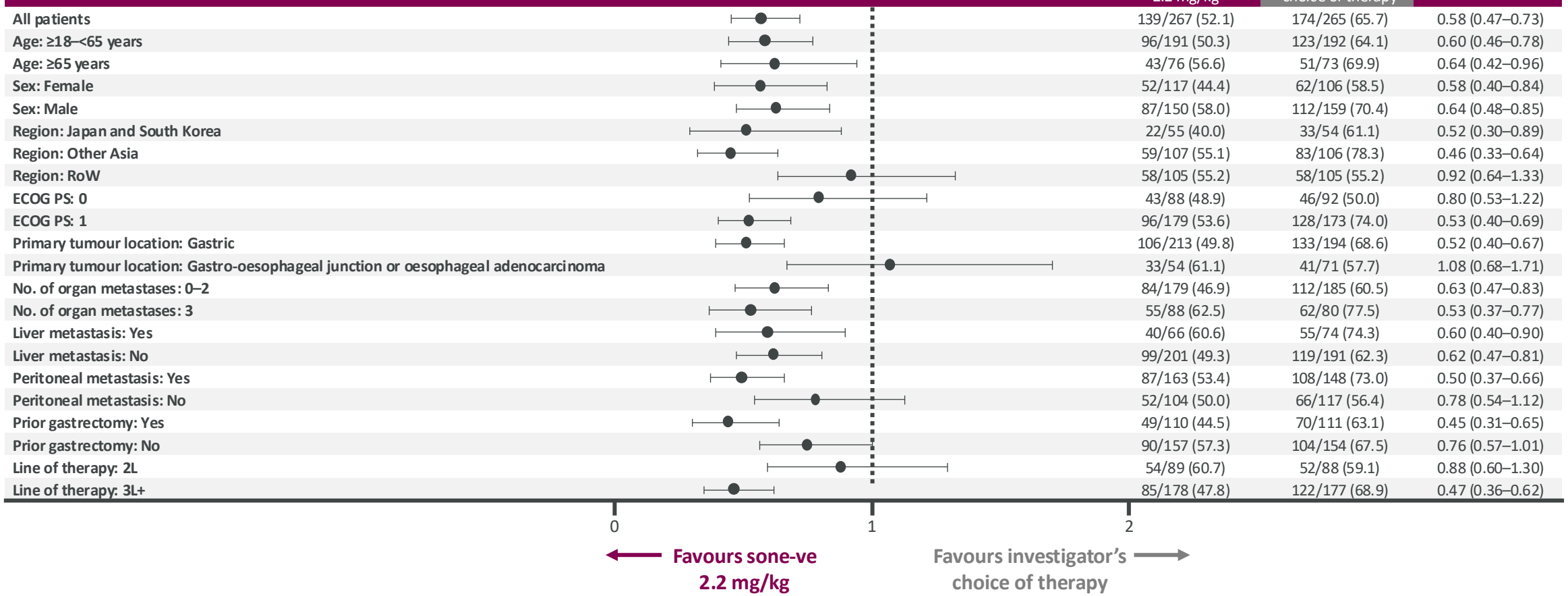
The HR for event or death and CI were estimated from a stratified Cox proportional-hazards model with ties = Efron. Stratification variables included geographical region, prior gastrectomy and line of therapy. The CI was calculated using a profile likelihood approach. An HR of less than 1 favours sone-ve. Tick marks indicate censored observations.

Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026.

Appendix: Glossary.

CLARITY-Gastric01 – exploratory analysis shows favourable OS HR point estimates across most subgroups in 2L+

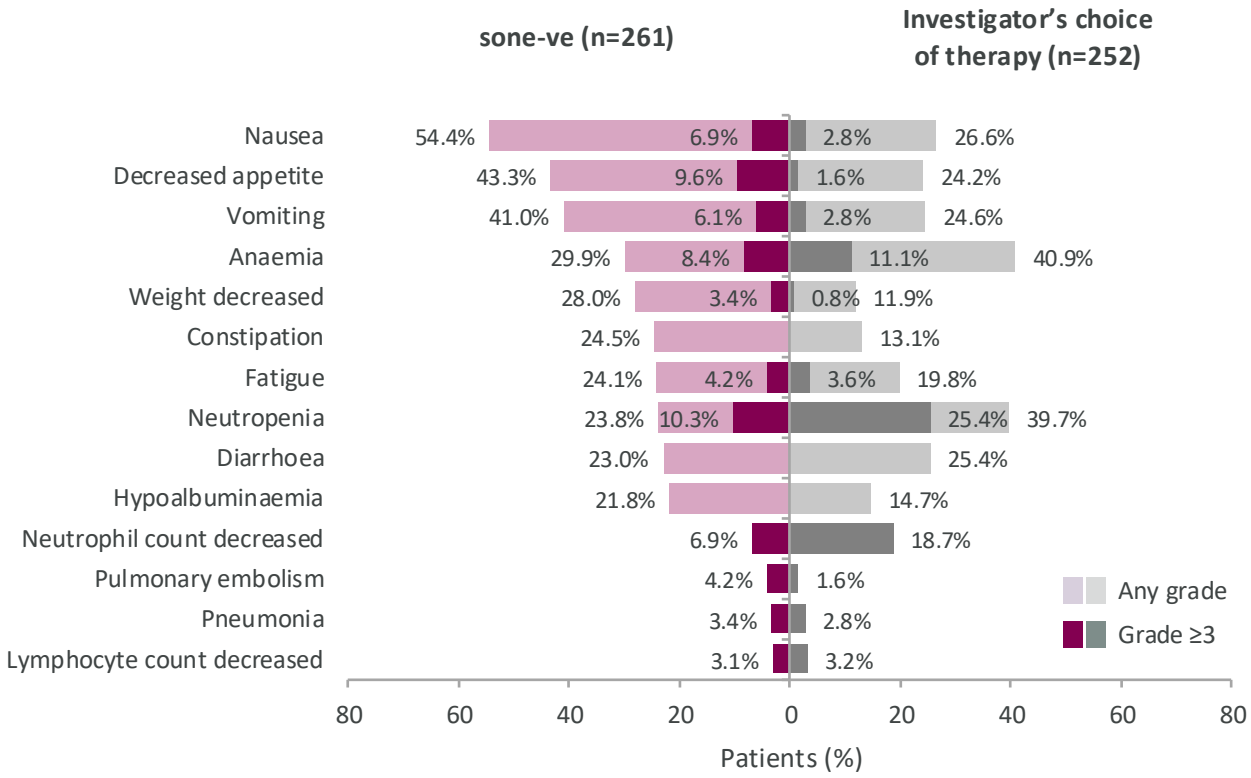
Subgroup	No. of events/total no. of patients: sone-ve 2.2 mg/kg	No. of events/total no. of patients: Investigator's choice of therapy	HR (95% CI)
All patients	139/267 (52.1)	174/265 (65.7)	0.58 (0.47–0.73)
Age: ≥18–<65 years	96/191 (50.3)	123/192 (64.1)	0.60 (0.46–0.78)
Age: ≥65 years	43/76 (56.6)	51/73 (69.9)	0.64 (0.42–0.96)
Sex: Female	52/117 (44.4)	62/106 (58.5)	0.58 (0.40–0.84)
Sex: Male	87/150 (58.0)	112/159 (70.4)	0.64 (0.48–0.85)
Region: Japan and South Korea	22/55 (40.0)	33/54 (61.1)	0.52 (0.30–0.89)
Region: Other Asia	59/107 (55.1)	83/106 (78.3)	0.46 (0.33–0.64)
Region: RoW	58/105 (55.2)	58/105 (55.2)	0.92 (0.64–1.33)
ECOG PS: 0	43/88 (48.9)	46/92 (50.0)	0.80 (0.53–1.22)
ECOG PS: 1	96/179 (53.6)	128/173 (74.0)	0.53 (0.40–0.69)
Primary tumour location: Gastric	106/213 (49.8)	133/194 (68.6)	0.52 (0.40–0.67)
Primary tumour location: Gastro-oesophageal junction or oesophageal adenocarcinoma	33/54 (61.1)	41/71 (57.7)	1.08 (0.68–1.71)
No. of organ metastases: 0–2	84/179 (46.9)	112/185 (60.5)	0.63 (0.47–0.83)
No. of organ metastases: 3	55/88 (62.5)	62/80 (77.5)	0.53 (0.37–0.77)
Liver metastasis: Yes	40/66 (60.6)	55/74 (74.3)	0.60 (0.40–0.90)
Liver metastasis: No	99/201 (49.3)	119/191 (62.3)	0.62 (0.47–0.81)
Peritoneal metastasis: Yes	87/163 (53.4)	108/148 (73.0)	0.50 (0.37–0.66)
Peritoneal metastasis: No	52/104 (50.0)	66/117 (56.4)	0.78 (0.54–1.12)
Prior gastrectomy: Yes	49/110 (44.5)	70/111 (63.1)	0.45 (0.31–0.65)
Prior gastrectomy: No	90/157 (57.3)	104/154 (67.5)	0.76 (0.57–1.01)
Line of therapy: 2L	54/89 (60.7)	52/88 (59.1)	0.88 (0.60–1.30)
Line of therapy: 3L+	85/178 (47.8)	122/177 (68.9)	0.47 (0.36–0.62)



All subgroups were pre-specified in the protocol. The analysis was based on the Kaplan-Meier technique and was performed using an unstratified Cox proportional hazards model. The overall HR was calculated using a stratified Cox proportional hazards model, adjusting for Interactive Response Technology strata, including prior gastrectomy, region and line of therapy and using an implemented pooling strategy per the statistical analysis plan with treatment as the only covariate. Ties were handled by the Efron approach. CIs were calculated using a profile likelihood approach. An HR below 1 favours sone-ve. Because PFS and OS were the only endpoints that were part of the multiple testing procedure, the widths of the CIs for subgroups have not been adjusted for multiplicity and may not be used in place of hypothesis testing. The grey band represents the 95% CI for the HR calculated for all patients. Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026.
Appendix: Glossary.

CLARITY-Gastric01 – differentiated and manageable safety profile vs ICT

	Sone-Ve 2.2 mg/kg (n=261)	Investigator's choice of therapy (n=252)
Median (range) duration of exposure, months	3.9 (0.2–24.7)	2.1 (0.2–22.0)
Any AE, n (%)	254 (97.3)	237 (94.0)
Possibly related to treatment,* n (%)	224 (85.8)	205 (81.3)
Any AE of CTCAE Grade ≥3, n (%)	138 (52.9)	154 (61.1)
Possibly related to treatment,* n (%)	95 (36.4)	113 (44.8)
Any SAE, n (%)	91 (34.9)	79 (31.3)
Any AE leading to discontinuation of study treatment, n (%)	13 (5.0)	11 (4.4)
Possibly related to study treatment,* n (%)	8 (3.1)	11 (4.4)
Any AE leading to interruption of study treatment or dose delay, n (%)	95 (36.4)	102 (40.5)
Any AE leading to dose reductions, n (%)	55 (21.1)	58 (23.0)
Any AE with outcome of death, n (%)	11 (4.2)	6 (2.4)
Possibly related to treatment,*† n (%)	3 (1.1)	2 (0.8)



sone-ve was associated with a manageable safety profile with a lower incidence of Grade ≥3 AEs than investigator's choice of therapy

Safety was assessed in all patients who received ≥1 treatment dose. Treatment-emergent AEs began or worsened from first dose through 97 days after the last dose, or until the day before subsequent cancer therapy, whichever occurred first; patients were counted once per AE category. The 10 most common any-Grade and Grade ≥3 AEs are shown. *Possibly treatment-related AEs were those considered by the investigator to have a reasonable possibility of being caused by treatment; missing responses were counted as possibly related. †Fatal AEs: sone-ve—pneumonia, cholestatic jaundice and cardiac failure; investigator's choice—pulmonary embolism and abdominal infection. Peripheral neuropathy occurred in 21.5% versus 14.3% of patients (Grade ≥3: 0.8% versus 0.4%), and alopecia in 5.0% versus 14.3%, respectively. AE, adverse event; CTCAE, Common Terminology Criteria for Adverse Events; SAE, serious adverse event.

Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026.

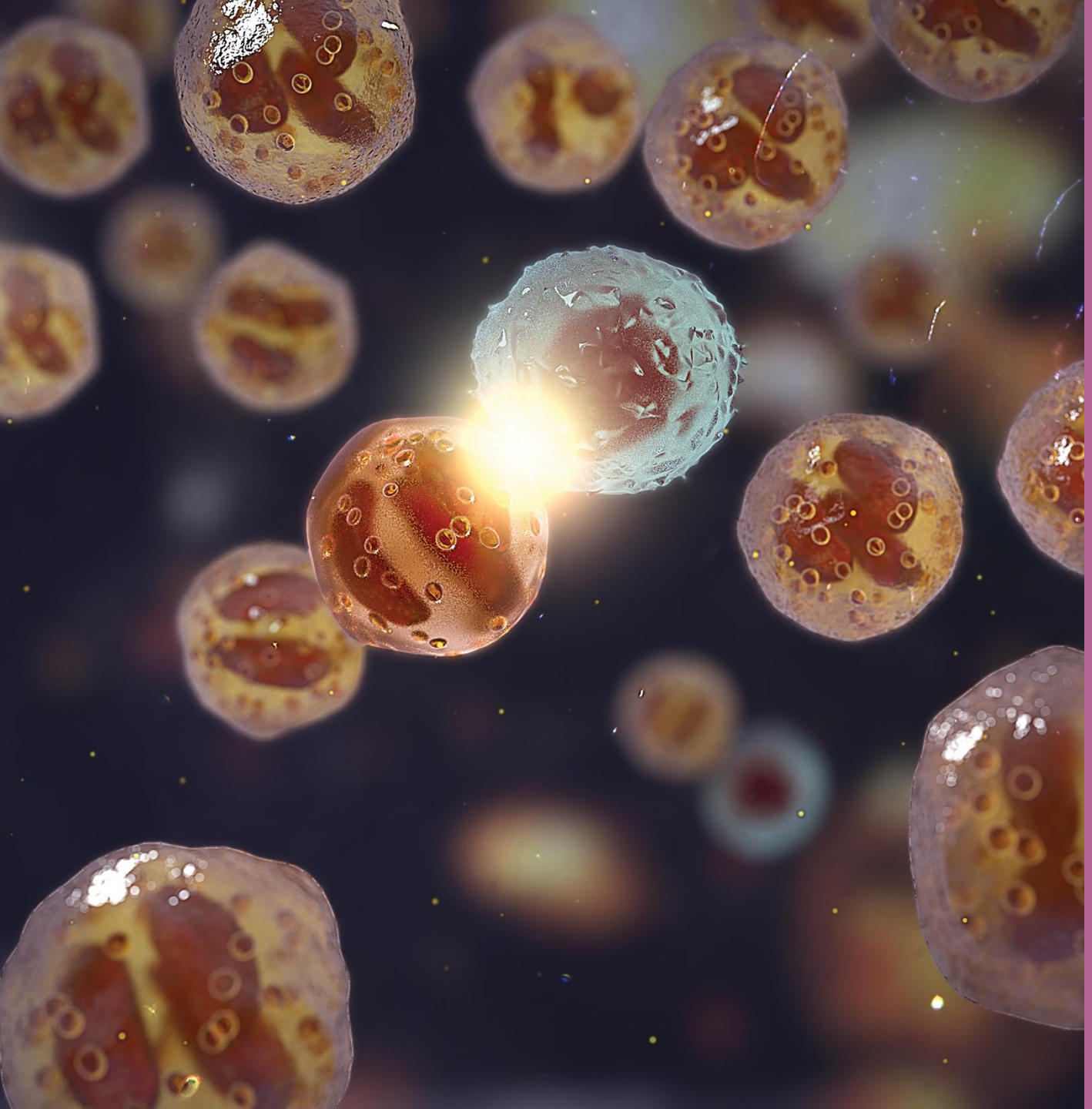
Appendix: Glossary.

CLARITY-Gastric01 – sone-ve improves OS with a manageable safety profile in the 2L+ setting

- sone-ve significantly improved OS vs investigator's choice of therapy in advanced or metastatic CLDN18.2-positive gastro-oesophageal carcinoma
  - 53% reduction in the risk of death in 3L+ and 42% in 2L+
  - Median OS improved by over 4 months to 10.6 months in 2L+ and doubled to 10.0 months in 3L+
- Consistent OS benefit across CLDN18.2 expression levels (≥75% and ≥25% to <75%)
- PFS by BICR in 2L+ did not reach statistical significance; PFS by investigator (exploratory) showed pronounced treatment effect (HR 0.59)
- sone-ve demonstrated a differentiated, manageable safety profile with lower rates of Grade ≥3 AEs and haematologic toxicities vs ICT

sone-ve may set a new standard of care in the 2L+ setting for patients with advanced or metastatic CLDN18.2-positive (≥25%) gastro-oesophageal carcinoma

Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026.
Appendix: Glossary.



Realising our ambition in Oncology

Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS

Transforming treatment in CLDN18.2+ gastric cancers

CLARITY-Gastric01 | First global study to show OS benefit in broad 2L+ CLDN18.2+ population

>50k patients across the G7
>200k patients in China

2L+ HER2-negative gastric cancer

60% | CLDN18.2 expression ≥25%

CLARITY-Gastric01
sone-ve

Lower CLDN18.2+ cut-off doubles eligibility vs existing therapies

>40% OS risk reduction vs SoC in 2L+[1] » Data support rapid adoption upon approval, with first-mover advantage in G7 markets

CLARITY-Gastric01 represents potential blockbuster opportunity[2]

Moving earlier and broader with sone-ve

1L metastatic gastric cancer
CLARITY-Gastric02
Phase III ongoing | >2027

BTC and pancreatic cancer
CLARITY-PanTumour01
Phase II ongoing | H1 2027

+ ivonescimab[3] | GI cancers

$3-5bn PYR opportunity across indications[2]

1. Xu R-H et al. Abstract LBA7 presented at the European Society of Medical Oncology 2026. 2. Peak Year Revenue, non-risk-adjusted. 3. External collaboration with Summit Therapeutics to investigate combinations of ivonescimab and AZ ADCs. Signed collaborations for *Datroway* and sone-ve.
Appendix: Glossary.

VOLGA reinforces *Imfinzi* as a backbone in bladder cancer

VOLGA | Consolidating the role of *Imfinzi* across the spectrum of MIBC

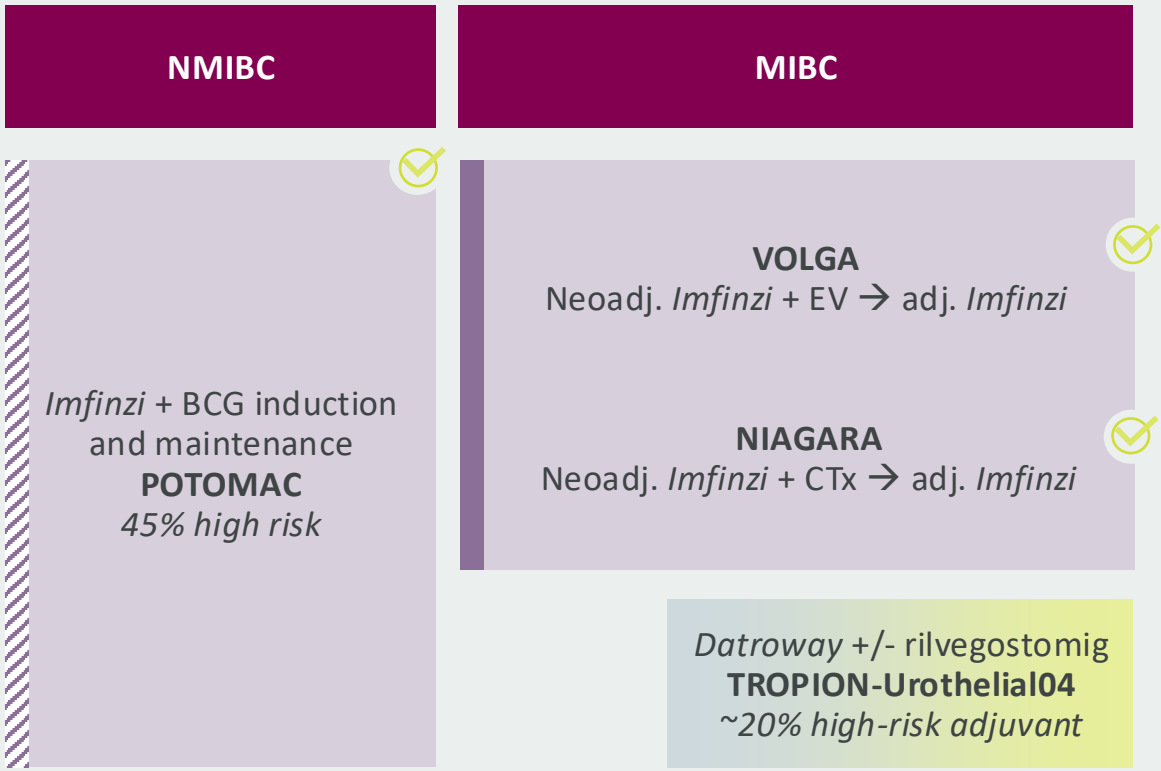
Patient-focused, differentiated regimen
Strong efficacy with EV exposure only in neoadjuvant setting

Established HCP base
HCP experience built on NIAGARA's first-to-market approval in cis-eligible MIBC

Competitive space with multiple options
Large MIBC market with >100k patients[1]

***Imfinzi* in bladder cancer represents blockbuster opportunity[2]**

Expanding presence in bladder cancer with broad *Imfinzi* coverage



1. Top 8 countries. 2. Non-risk adjusted peak year revenue opportunity for *Imfinzi* bladder programme.
Appendix: Glossary.

Strengthening position in *EGFR*m NSCLC with *Tagrisso* + *Orpathys* combinations

SAFFRON | Only global trial to demonstrate significant OS in this setting

45k patients across the G7
210k patients in China | 2L+ NSCLC

→ **34%** | MET overexpression IHC 3+ or amplification FISH 10+

→ **SAFFRON** *Tagrisso + Orpathys* — Biomarker-directed, all-oral therapy

Tagrisso combination pipeline ensures continued leadership

Establishing novel combinations in 2L+

TROPION-Lung15	*Datroway* ± *Tagrisso*	H1 2027

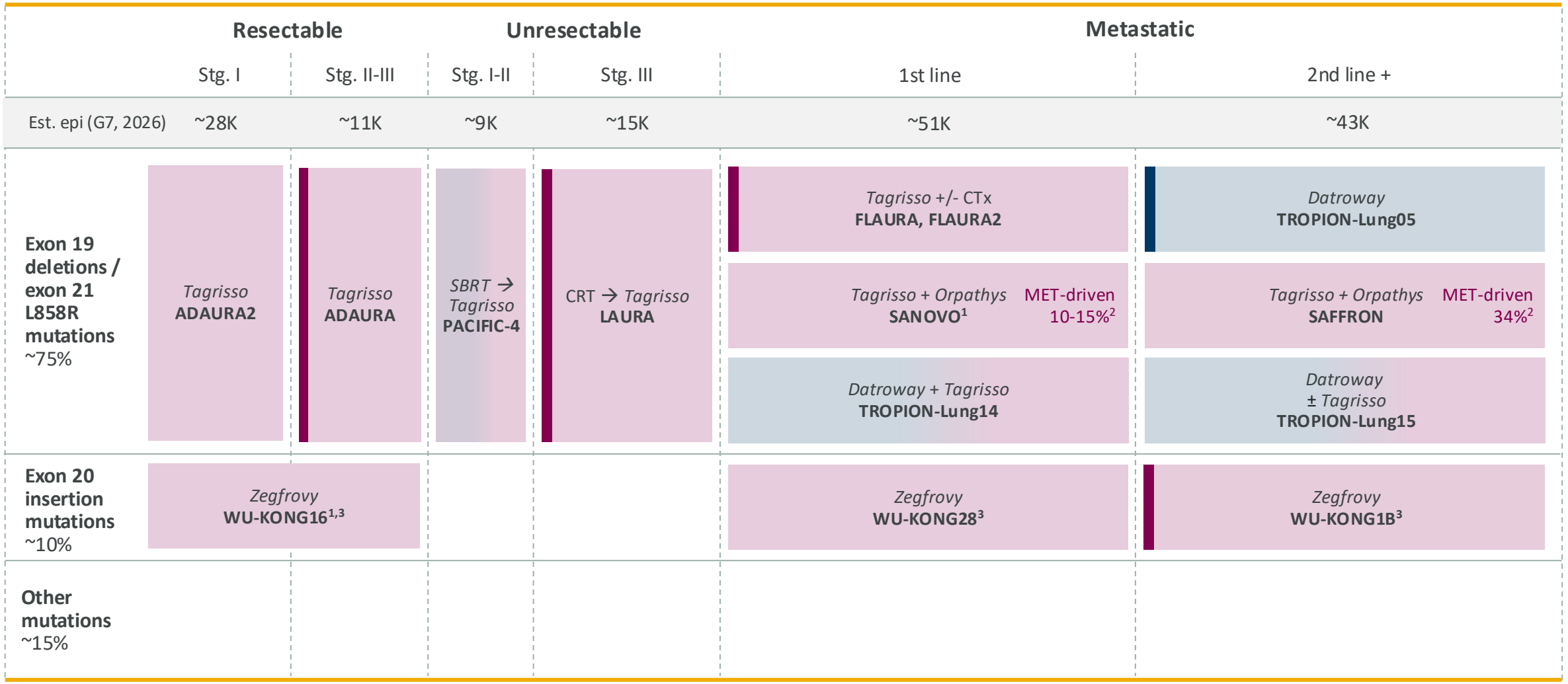
Expanding 1L disease leadership

SANOVO	*Tagrisso + Orpathys*	✓
TROPION-Lung14	*Datroway + Tagrisso*	>2027

Results reinforce *Tagrisso* as the backbone therapy across *EGFR*m lung cancer supporting continued *EGFR*m franchise growth

All numbers are approximate. Illustrative settings and populations, not to scale.
Collaboration partners: Daiichi Sankyo (*Datroway*), Hutchmed (*Orpathys*).
Appendix: Glossary.

AstraZeneca in *EGFR*m non-small cell lung cancer



1. China-only trial. 2. MET-driven defined as MET IHC 3+ in 1L and MET IHC 3+ or FISH 10+ in 2L. 3. Trial sponsored by Dizal Pharma. 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.

Continuing to reshape management of SCLC with *Imfinzi*-based regimens

DeLLphi-305 | First dual IO regimen and potential new SoC in ES-SCLC

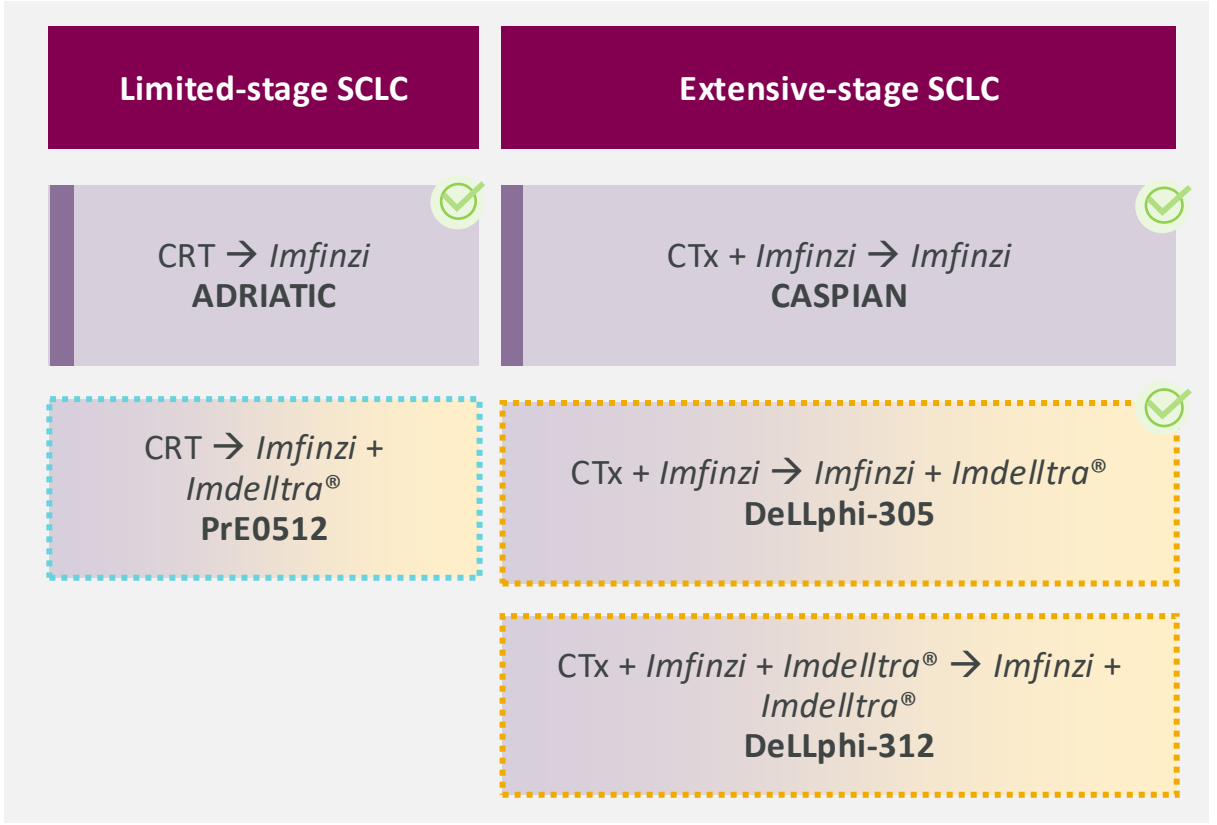
High unmet need
Current survival outcomes remain ~1 year

Significant patient population
195k patients with 1L ES-SCLC[1]

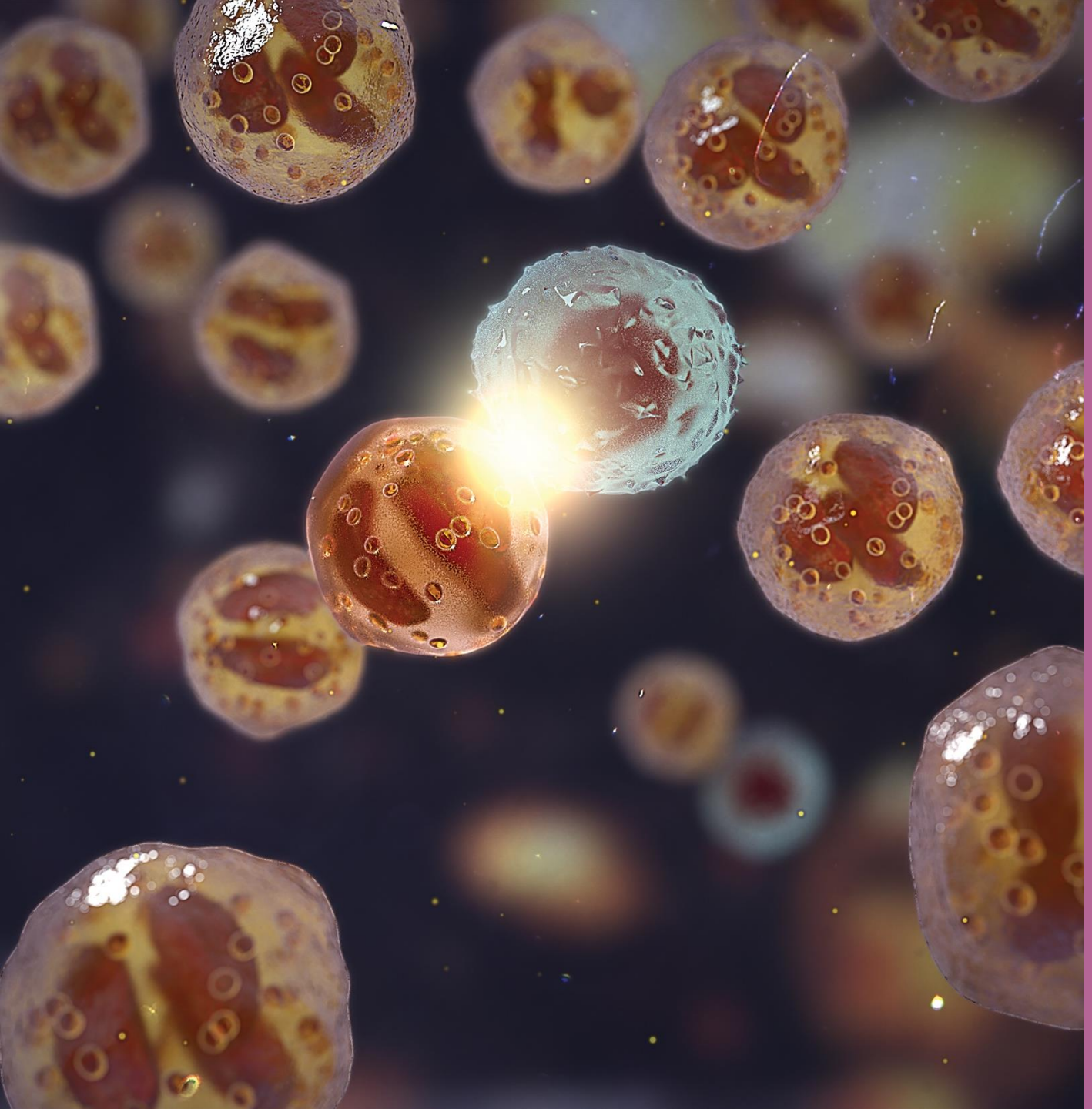
Blockbuster opportunity for *Imfinzi*
Incremental to CASPIAN

***Imfinzi* only IO with proven OS benefit across all stages of SCLC**

Ongoing development programme for *Imfinzi* in SCLC



1,. Top 8 countries.
DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca.
Appendix: Glossary.



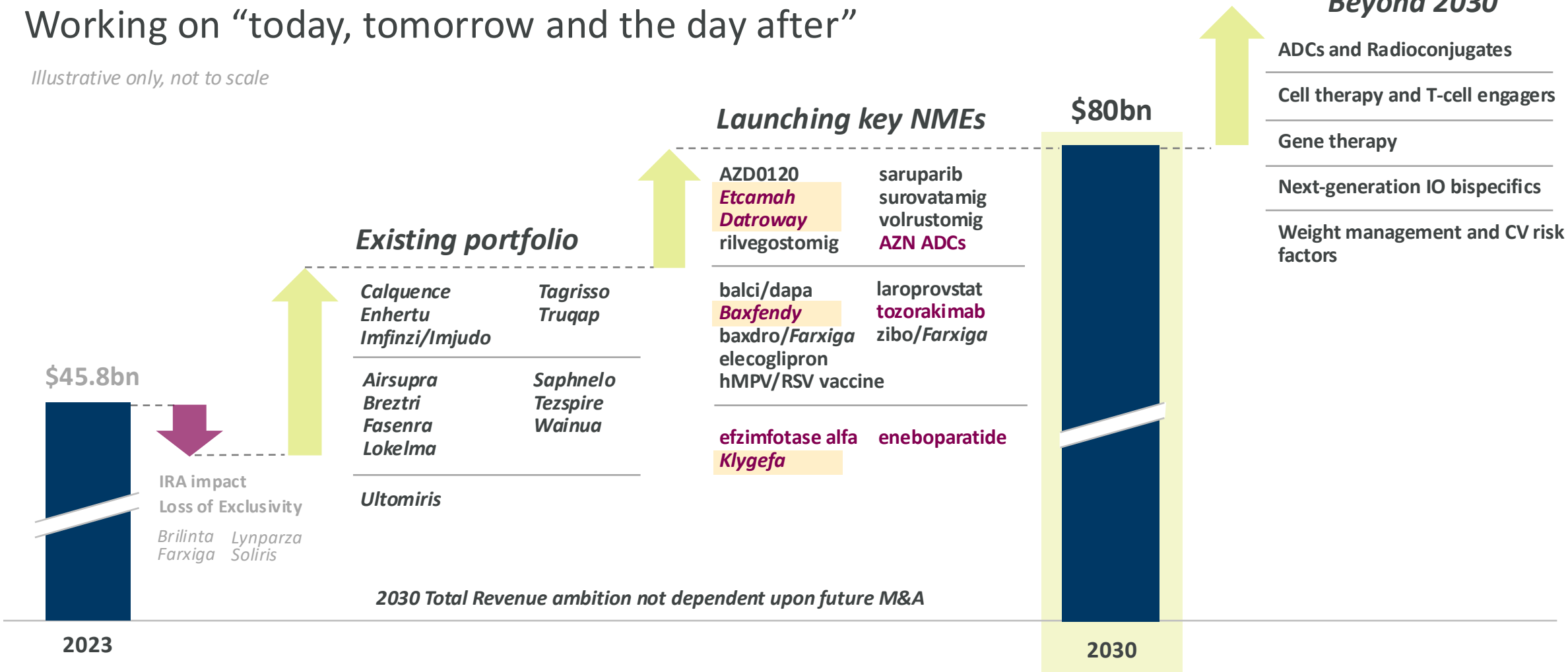
Looking to the future of AstraZeneca

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



Launched NME Positive Phase III data for NME Note: Ambition to achieve $80bn in Total Revenue by 2030 is riskadjusted, 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.

Twelve positive Phase III programme readouts YTD

tozorakimab COPD	OBERON TITANIA MIRANDA	**efzimfotase alfa** HPP	CHESTNUT MULBERRY HICKORY	***Imfinzi*** locoregional HCC	EMERALD-3
Ultomiris IgAN	ICAN	***Imfinzi*** MIBC	VOLGA	**sone-ve** CLDN18.2+ 2L+ gastric cancer	CLARITY-Gastric01
Imfinzi 1L urothelial cancer	NILE	***Tagrisso + Orpathys*** 2-3L *EGFR*m NSCLC	SAFFRON	***Enhertu*** *HER2*m NSCLC	DESTINY-Lung04
Tezspire EoE	CROSSING	***Tagrisso + Orpathys*** 1L *EGFR*m NSCLC	SANOVO[1]	***Imfinzi*** ES-SCLC	DeLLphi-305[2]

2026 positive Phase III readouts represent >$10bn in peak year revenue[3]

1. SANOVO trial conducted in China. 2. DeLLphi-305 trial is sponsored by Amgen, with partial funding and *Imfinzi* provided by AstraZeneca. 3. Combined risk-adjusted Peak-Year Revenue of all positive Phase III programmes in 2026, including those depicted on the slide. Individual PYR may occur at different time points for different trials. Collaboration partners: Daiichi Sankyo (*Enhertu*), Amgen (*Tezspire*), Hutchmed (*Orpathys*).
Appendix: Glossary.

NMEs with pivotal data readouts before 2030 drive growth into and through the 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

Key readouts support NME growth outlook

	NME NRA PYR[1]		
Datroway	$5bn+	**AVANZAR** 1L NSQ/NSQ TROP2+ NSCLC	H1
laroprovstat	$5bn+	**AZURE-LDL/AZURE-HeFH** Dyslipidaemia	H1
balcinrenone/ *Farxiga*	$5bn+	**BalanceD-HF** HF + renal impairment	H1
zibotentan/ *Farxiga*		**ZENITH High Proteinuria** CKD + high proteinuria	H1
Etcamah	$5bn+	**CAMBRIA-1** HR+ eBC (adjuvant switch)	H2
saruparib	$5bn+	**EvoPAR-Prostate01** HSPC	H2

>15 other high-value readouts

H1

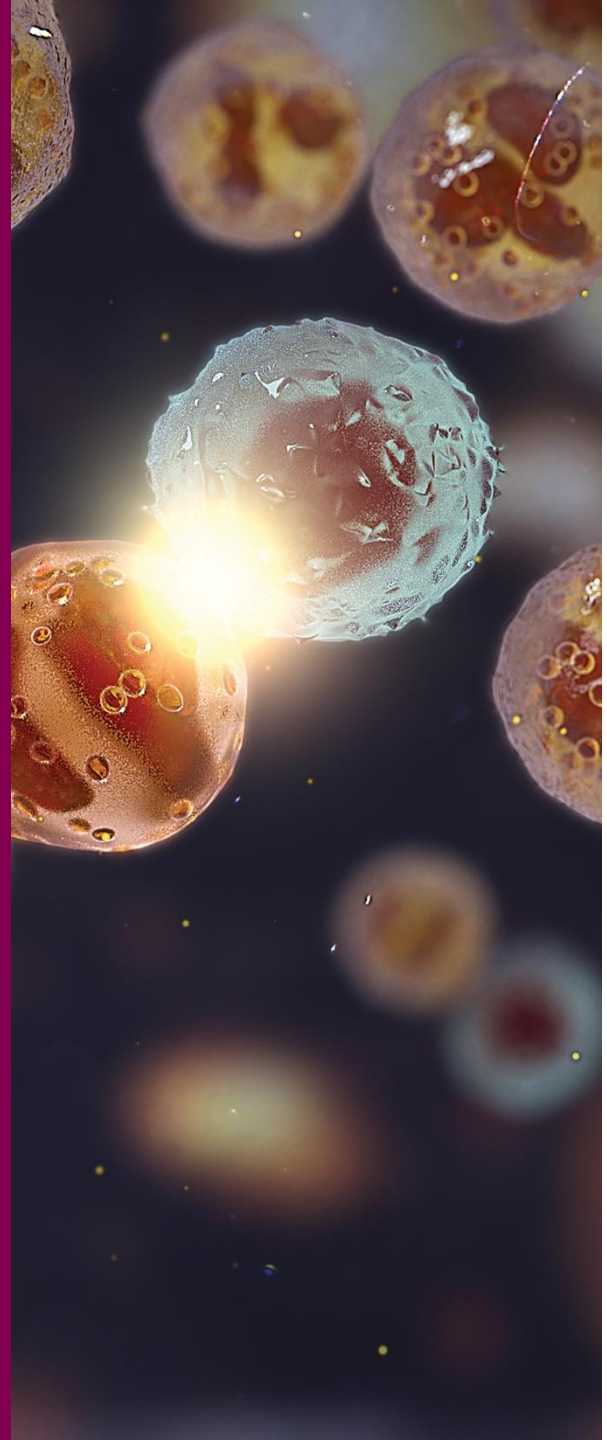
- **TROPION-Lung07** | *Datroway*
- **TROPION-Lung15** | *Datroway ± Tagrisso*
- **PACIFIC-9** | *Imfinzi* + oleclumab/monalizumab
- **reAZURE-PLUS** | laroprovstat + rosuvastatin
- **DAISY** | *Saphnelo*
- **IRIS** | *Saphnelo*
- **LAVENDER** | *Saphnelo*

H2

- **TROPION-Breast03** | *Datroway + Imfinzi*
- **TROPION-Breast05** | *Datroway + Imfinzi*
- **PACIFIC-4** | *Imfinzi*
- **CAPItello-292** | *Truqap*
- **Bluestar-Endometrial01** | puxi-sam
- **ARTEMIDE-Biliary01** | rilvegostomig
- **eVOLVE-Cervical** | volrustomig
- **BaxPA** | *Baxfendy*
- **reAZURE-NAIVE** | laroprovstat + rosuvastatin
- **TILIA** | tozorakimab

2027 Phase III readouts represent potential >$20bn in non-risk-adjusted peak year revenue[2]

1. Represents non-risk adjusted peak year revenue for the asset, as provided during Investor Day, May 2024. 2. Combined non-risk-adjusted Peak-Year Revenue of all Phase III programmes in 2027, including those depicted on the slide. Individual PYR may occur at different time points for different trials. Collaboration partners: Daiichi Sankyo (*Datroway*), Innate Pharma (monalizumab).
Appendix: Glossary.



Opportunity for Q&A



Pascal Soriot
CHIEF EXECUTIVE OFFICER



Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS



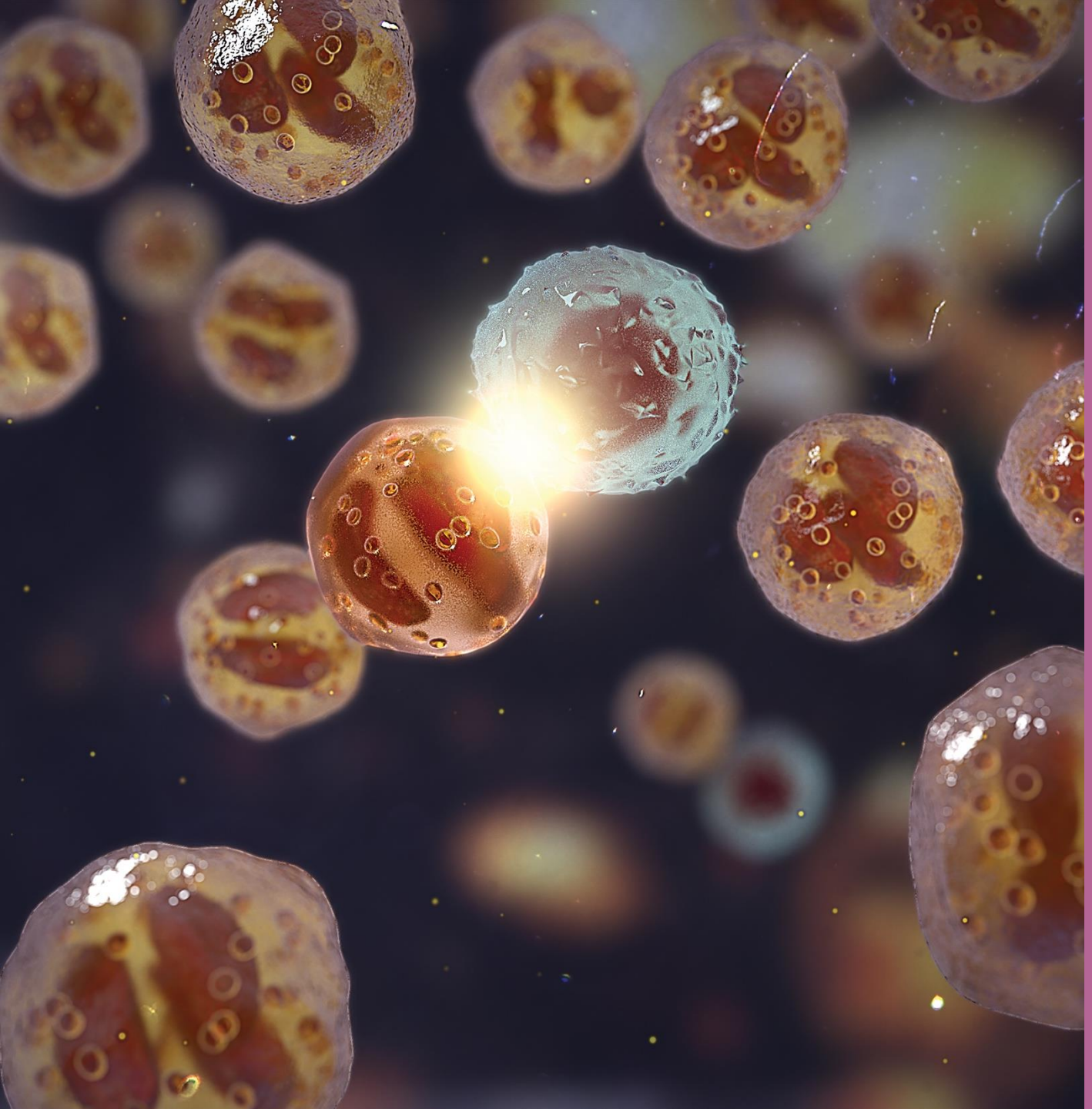
Susan Galbraith
EVP, ONCOLOGY
HAEMATOLOGY R&D



Leora Horn
SVP, LATE DEVELOPMENT
ONCOLOGY



Sunil Verma
SVP, GLOBAL HEAD,
ONCOLOGY FRANCHISE



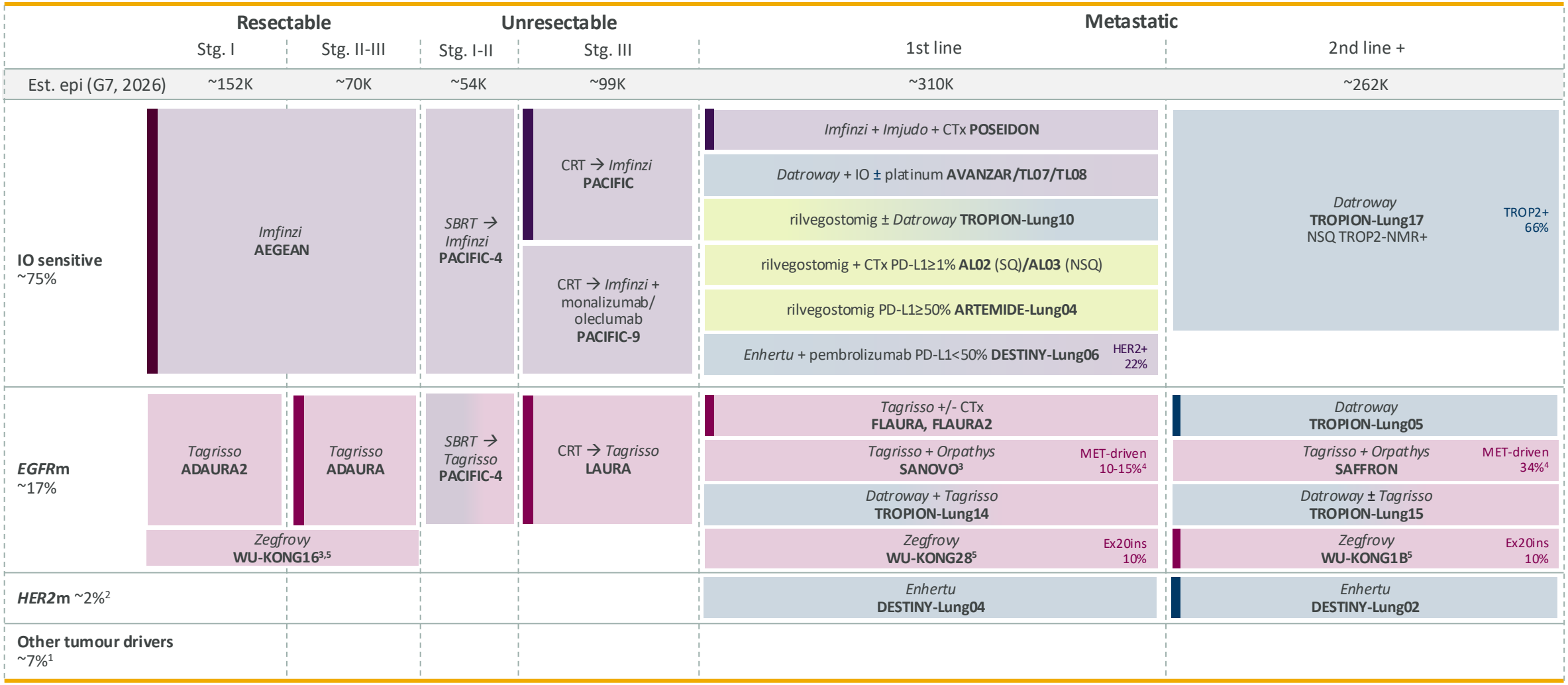
Meet AZN Management: ESMO 2026

APPENDIX

Glossary

1L, 2L, 3L	first-, second-, third-line
(a)BTC	(advanced) biliary tract 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
a/mBC	advanced/metastatic breast cancer
AST	aspartate aminotransferase
ASTCT	American Society for Transplantation and Cellular Therapy
ATTR-CM	Transthyretin Amyloid Cardiomyopathy
BCG	Bacillus Calmette–Guérin
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
CRS	cytokine release syndrome
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
EAC	oesophageal adenocarcinoma
ECOG	Eastern Cooperative Oncology Group
ee	embolisation-eligible
EFS	event-free survival
***EGFR*m**	epidermal growth factor receptor-mutant
EoE	eosinophilic oesophagitis
EORTC QLQ-C30	European Organisation for Research and Treatment of Cancer 30-item Core Quality of Life Questionnaire
***ESR1*m**	oestrogen receptor alpha-mutated
ES-SCLC	extensive-stage small-cell lung cancer
EV	enfortumab vedotin
Ex19del / Ex20ins	exon 19 deletion / exon 20 insertion
FISH	fluorescence in situ hybridisation
FLOT	fluorouracil, leucovorin, oxaliplatin and docetaxel
FP	fluoropyrimidine
FRα	folate receptor alpha
FSI	first subject in
G7	Group of Seven (major pharmaceutical markets)
gBRCAm	germline BRCA mutation
GC	gastric cancer
GCG	glucagon
GEJ(A) / GEJC	gastro-oesophageal junction (adenocarcinoma / carcinoma)
GI	gastrointestinal
GPC3	glypican-3
HCC	hepatocellular carcinoma
HER2	human epidermal growth factor receptor 2
HER2-low/ultralow	human epidermal growth factor receptor 2-low/ultralow
HER2m	human epidermal growth factor receptor 2-mutant
HER2-/negative	human epidermal growth factor receptor 2-negative
HER2+/positive	human epidermal growth factor receptor 2-positive
HLR	high-level results
HNSCC	head and neck squamous cell carcinoma
HPP	hypophosphatasia
HR	hazard ratio
HR-/negative	hormone receptor-negative
HR+/positive	hormone receptor-positive
ICANS	immune effector cell-associated neurotoxicity syndrome
ICP	tumour-associated immune cells present
ICT	investigator's choice of therapy
IF	information fraction
IgA	immunoglobulin A
IgAN	immunoglobulin A nephropathy
IHC	immunohistochemistry
IO	immuno-oncology
IQR	interquartile range
ITT	intention-to-treat
M&A	mergers & acquisitions
mAb	monoclonal antibody
mBC	metastatic breast cancer
mDOR	median duration of response
MET	mesenchymal–epithelial transition factor
MIBC	muscle-invasive bladder cancer
mNSCLC	metastatic non-small cell lung cancer
mOS	median overall survival
mPFS	median progression-free survival
m(PFS/OS)	median (PFS/OS)
mUC	metastatic urothelial carcinoma
NC	not calculated
NE	not evaluable
neoadj.	neoadjuvant
ngSERD	next-generation selective oestrogen receptor degrader
NME	new molecular entity
NMIBC	non-muscle-invasive bladder cancer
NMR	normalised membrane ratio
NR	not reached
NSCLC	non-small cell lung cancer
NSQ	non-squamous
NST	neoadjuvant systemic treatment
ORR	objective response rate
OS	overall survival
***PALB2*m**	partner and localiser of BRCA2
PARPi	PARP inhibitor
pCR	pathological complete response
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-bisphosphate 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
PSR	platinum-sensitive recurrent
PTEN	phosphatase and TENsin homolog deleted on chromosome 10
PYR	peak-year revenue
Q2W	every 2 weeks
Q3W / Q4W	every 3 weeks / every 4 weeks
QoL	quality of life
R	randomised
RC	radical cystectomy
RECIST v1.1	Response Evaluation Criteria in Solid Tumours v1.1
r/r	relapsed/refractory
SAE	serious adverse event
SAS	safety analysis set
SBRT	stereotactic body radiotherapy
SCLC	small-cell lung cancer
SD	stable disease
SERD	selective oestrogen receptor degrader
SoC	standard-of-care
SQ	squamous
Stg.	stage
tBRCAm	tumour BRCA mutation
TC	tumour cells
TCE	T-cell engager
TEAE / TRAE	treatment-emergent / treatment-related adverse event
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
UC	urothelial carcinoma
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

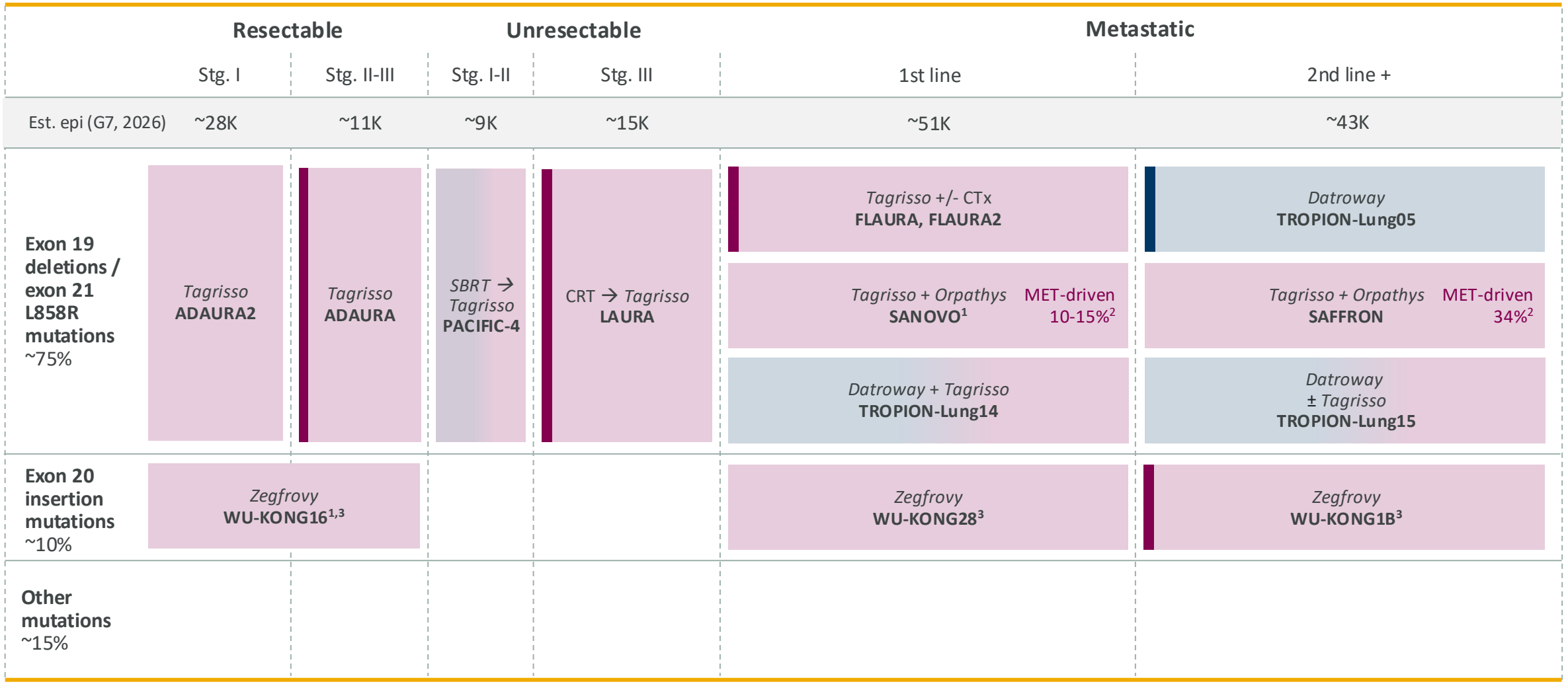


Key: DXd ADC | IO | TKI | IO bispecific

launched and established SoC | launched indication

1. Among total NSCLC patients. 2. Among mNSCLC patients. 3. China-only trial. 4. MET-driven defined as MET IHC 3+ in 1L and MET IHC 3+ or FISH 10+ in 2L. 5. Trial sponsored by Dizal Pharma. 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.

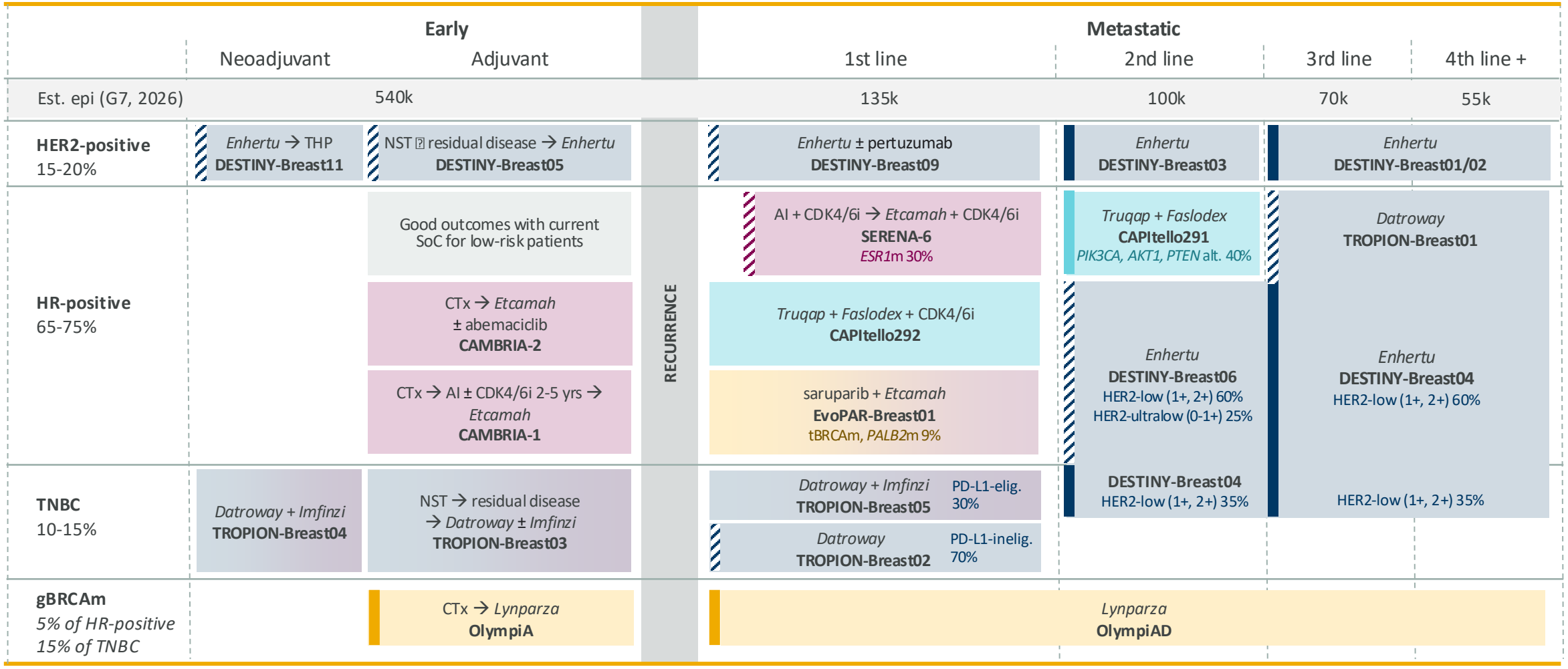
AstraZeneca in *EGFR*m non-small cell lung cancer



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

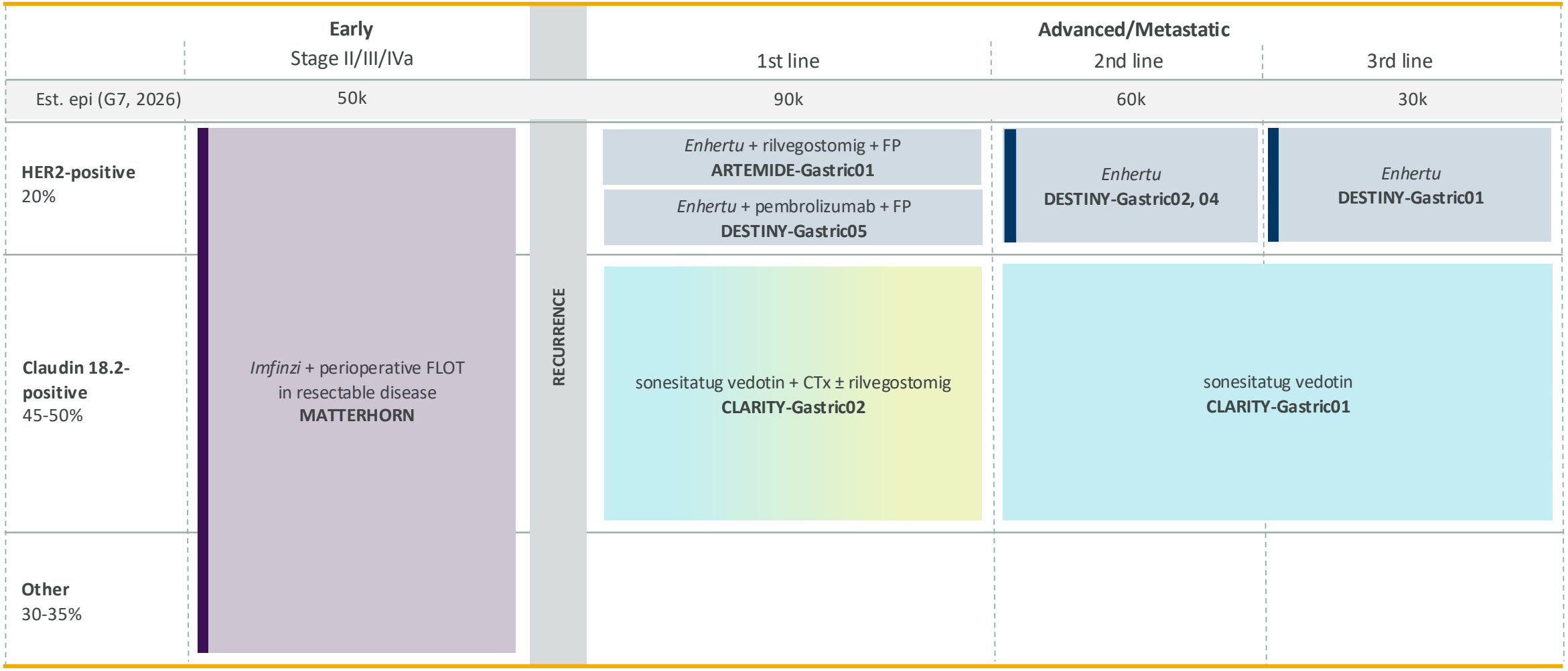
1. China-only trial. 2. MET-driven defined as MET IHC 3+ in 1L and MET IHC 3+ or FISH 10+ in 2L. 3. Trial sponsored by Dizal Pharma. All numbers are approximate. Illustrative settings and populations, not to scale. Lung Cancer map reflects Phase III/pivotal trials. Collaboration partners: Daiichi Sankyo (*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/pivotá trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Merck & Co., Inc. (*Lynparza*).
Appendix: Glossary.

AstraZeneca in gastric cancer



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. Gastric cancer map reflects ongoing activePhase III/pivotal trials and includes GC, EAC and GEJC epidemiology.
Collaboration partner: Daiichi Sankyo (*Enhertu*).
Appendix: Glossary.

AstraZeneca in bladder cancer

	High-risk NMIBC	MIBC	1L mUC
Est. epi (G7, 2026)	149k	81k	63k

Imfinzi + BCG induction and maintenance
POTOMAC

Neoadjuvant *Imfinzi* + EV ± *Imjudo* → adjuvant *Imfinzi* ± *Imjudo*
VOLGA

Neoadjuvant *Imfinzi* + CTx → adjuvant *Imfinzi*
NIAGARA

Datroway +/- rilvegostomig
TROPION-Urothelial04
~20% high-risk adjuvant

Imfinzi + CTx ± *Imjudo*
NILE

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.

Confidentiality Notice

This file is private and may contain confidential and proprietary information. If you have received this file in error, please notify us and remove it from your system and note that you must not copy, distribute or take any action in reliance on it. Any unauthorised use or disclosure of the contents of this file is not permitted and may be unlawful.

AstraZeneca PLC, 1 Francis Crick Avenue, Cambridge Biomedical Campus, Cambridge, CB2 0AA, UK
+44(0)203 749 5000
www.astrazeneca.com