Investor science conference call: European Society for Medical Oncology (ESMO) Congress 2019

Conference call for investors and analysts

30 September 2019
Forward-looking statements

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

Pascal Soriot  
Executive Director and  
Chief Executive Officer

Dave Fredrickson  
Executive Vice President,  
Oncology Business Unit

Dr. Isabelle Ray-Coquard  
Primary investigator of the  
*Lynparza* Phase III PAOLA-1 trial

José Baselga  
Executive Vice President,  
Oncology R&D
Agenda

Introduction

*Lynparza*’s Phase III PAOLA-1 trial (ovarian cancer)

Other Phase III data at ESMO 2019

- *Lynparza*’s PROfound trial (prostate cancer)
- *Tagrisso*’s FLAURA trial (lung cancer)

Closing and Q&A
### Oncology: strategy
A leading, diversified oncology business

<table>
<thead>
<tr>
<th>Lung cancer</th>
<th>Multiple cancers</th>
<th>Multiple cancers</th>
<th>Haematology</th>
</tr>
</thead>
</table>
| **Stage IV NSCLC**<sup>1</sup>  
T790M<sup>2</sup> / EGFR<sup>3</sup>  
Next: adjuvant, Stage III | **Unresectable, Stage III NSCLC**  
Next: early/advanced stages in several cancers | **Ovarian, breast cancers**  
MRK collaboration  
Next: pancreatic, prostate cancers | **trastuzumab deruxtecan** |
| **Next: adjuvant, Stage III NSCLC**  
Next: early/advanced stages in several cancers | **Ovarian, breast cancers**  
MRK collaboration  
Next: pancreatic, prostate cancers | **DS<sup>4</sup> collaboration**  
Next: HER2+<sup>5</sup> breast, gastric cancers; HER2-low cancers | **First medicine in haematology**  
**MCL<sup>6</sup> launched**  
**CLL<sup>7</sup> data started**  
**Next: combinations** |
| **IMFINZI**<sup>8</sup> durvalumab  
Injection for Intravenous Use 50 mg/mL | **Lynparza**<sup>9</sup> olaparib  
Injection for Intravenous Use 30 mg/mL | **CALQUENCE**<sup>10</sup> (acalabrutinib) 100 mg capsules | |

‘What’s next’: rich early to mid-stage pipeline, including combinations

1. Non-small cell lung cancer  
2. Substitution of threonine (T) with methionine (M) at position 790 of exon 20 mutation  
3. Epidermal growth factor receptor mutation  
4. Daiichi Sankyo  
5. Human epidermal growth factor receptor 2 positive  
6. Mantle cell lymphoma  
7. Chronic lymphocytic leukaemia
AstraZeneca redefines cancer treatment at ESMO 2019

>60 abstracts accepted, five presidential and seven oral presentations

Key Phase III presentations

- **Tagrisso**
  FLAURA OS\(^1\) - EGFRm NSCLC

- **Lynparza**
  PAOLA-1 - ovarian cancer
  PROfound - prostate cancer

- **Imfinzi**
  CASPIAN - SCLC\(^2\)

- **Faslodex OS**
  MONARCH2 - breast cancer
  MONALEESA-3 - breast cancer

ESMO abstracts

- Over 60 abstracts, including **five presidential** and **seven oral presentations**
- Five late-breaking abstracts
- Externally sponsored c. 40% of total

\(^1\) Overall survival  \(^2\) Small cell lung cancer.
Agenda

Introduction

**Lynparza’s Phase III PAOLA-1 trial (ovarian cancer)**

Other Phase III data at ESMO 2019

- **Lynparza’s PROfound trial (prostate cancer)**
- **Tagrisso’s FLAURA trial (lung cancer)**

Closing and Q&A
**Study design**

Newly diagnosed FIGO stage III–IV high-grade serous/endometrioid ovarian, fallopian tube or primary peritoneal cancer*

**FIRST LINE**
- Surgery (upfront or interval)
- Platinum–taxane based chemotherapy
- ≥3 cycles of bevacizumab†

**Randomization**

- NED/CR/PR

**Maintenance therapy**

- Olaparib (300 mg BID) x2 years
  - + bevacizumab†

- Placebo x2 years
  - + bevacizumab†

**Stratification**
- Tumour BRCAm status‡
- First-line treatment outcome¶

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*Patients with other epithelial non-mucinous ovarian cancer were eligible if they had a germline BRCA1 and/or BRCA2 mutation

†Bevacizumab: 15 mg/kg, every 3 weeks for a total of 15 months, including when administered with chemotherapy; ‡By central labs; ¶According to timing of surgery and NED/CR/PR BID, twice daily; BRCAm, BRCA1 and/or BRCA2 mutation; CR, complete response; NED, no evidence of disease; PR, partial response
## Patient disposition

<table>
<thead>
<tr>
<th></th>
<th>Olaparib + bevacizumab</th>
<th>Placebo + bevacizumab</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Randomized, n</strong></td>
<td>537</td>
<td>269</td>
</tr>
<tr>
<td><strong>Treated, n (%)</strong></td>
<td>535 (99.6)</td>
<td>267 (99.3)</td>
</tr>
<tr>
<td><strong>Discontinued study treatment,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease progression per RECIST</td>
<td>182 (34)</td>
<td>155 (58)</td>
</tr>
<tr>
<td>Disease progression non-RECIST</td>
<td>14 (3)</td>
<td>13 (5)</td>
</tr>
<tr>
<td>TEAE</td>
<td>109 (20)</td>
<td>13 (5)</td>
</tr>
<tr>
<td>Patient decision</td>
<td>17 (3)</td>
<td>10 (4)</td>
</tr>
<tr>
<td>Death</td>
<td>1 (&lt;1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Other*</td>
<td>8 (1)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Median duration of treatment,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>months (range)</td>
<td>Olaparib/placebo</td>
<td>17.3 (0.03–33.0)</td>
</tr>
<tr>
<td></td>
<td>Bevacizumab</td>
<td>11.0 (0.69–21.4)</td>
</tr>
<tr>
<td><strong>Median duration of follow-up,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>months</td>
<td></td>
<td>24.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22.7</td>
</tr>
</tbody>
</table>

*Other includes lost to follow up, surgery, new comorbidities and other*  
TEAE, treatment-emergent adverse event
Summary of AEs

<table>
<thead>
<tr>
<th></th>
<th>Olaparib + bevacizumab (N=535)</th>
<th>Placebo + bevacizumab (N=267)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All grade TEAEs, n (%)</td>
<td>531 (99)</td>
<td>256 (96)</td>
</tr>
<tr>
<td>Grade ≥3 TEAEs, n (%)</td>
<td>303 (57)</td>
<td>136 (51)</td>
</tr>
<tr>
<td>SAEs, n (%)</td>
<td>167 (31)</td>
<td>83 (31)</td>
</tr>
<tr>
<td>Deaths, n (%)</td>
<td>1 (&lt;1)</td>
<td>4 (1)</td>
</tr>
<tr>
<td>Dose interruptions due to AEs, n (%)</td>
<td>291 (54)</td>
<td>65 (24)</td>
</tr>
<tr>
<td>Dose reductions due to AEs, n (%)</td>
<td>220 (41)</td>
<td>20 (7)</td>
</tr>
<tr>
<td>Discontinuations due to AEs, n (%)</td>
<td>109 (20)</td>
<td>15 (6)</td>
</tr>
</tbody>
</table>

Dose interruptions, reductions and discontinuations reported are for olaparib and placebo.
SAE, serious adverse event.
**Lynparza’s Phase III PAOLA-1 trial**

**PFS by investigator assessment: ITT population**

- **Events, n (%) [59% maturity]**
  - Olaparib + bevacizumab (N=537) 280 (52)
  - Placebo + bevacizumab (N=269) 194 (72)
- **Median PFS, months**
  - Olaparib + bevacizumab: 22.1
  - Placebo + bevacizumab: 16.6
- **HR 0.59 (95% CI 0.49–0.72; P<0.0001)**

**No. at risk**
- Olaparib: 537, 513, 461, 433, 403, 374, 279, 240, 141, 112, 55, 37, 12, 3, 0
- Placebo: 269, 252, 226, 205, 172, 151, 109, 83, 50, 35, 15, 9, 1, 1, 0

**Median time from first cycle of chemotherapy to randomization = 7 months**

**ITT, intent-to-treat population**
Biomarker subgroups in PAOLA-1/ENGOT-ov25

- HRD negative: n=277; 34%
- HRD status unknown: n=142; 18%
- HRD positive: n=387; 48%
- tBRCAm: n=235; 29%
- HRD positive, excluding tBRCAm: n=152; 19%

HRD positive is either tumour BRCA mutation and/or HRD score ≥42 by Myriad MyChoice® HRD Plus
Reasons for HRD status unknown: 4.2% missing; 2.1% fail; 11.3% inconclusive
Lynparza’s Phase III PAOLA-1 trial | 6

PFS by HRD status

HRD positive, including tBRCAm

HRD positive, excluding tBRCAm

HRD negative/unknown

The percentages of patients progression-free at 12 months and 24 months have been calculated based on Kaplan-Meier estimates. HRD positive is an HRD score ≥42. *This median is unstable due to a lack of events – less than 50% maturity.
PFS by tBRCA mutation status

The percentages of patients progression-free at 12 months and 24 months have been calculated based on Kaplan-Meier estimates. *This median is unstable due to a lack of events – less than 50% maturity; †Includes tBRCA unknown
Conclusions

• PAOLA-1/ENGOT-ov25 included a broad, front-line population of advanced ovarian cancer patients which was not restricted by surgical outcome or BRCA mutation status

• PAOLA-1/ENGOT-ov25 met its primary objective, demonstrating a statistically significant improvement in PFS in the ITT population when olaparib compared with placebo was added to first-line standard-of-care bevacizumab maintenance treatment

• Prespecified subgroup analyses showed that patients with tBRCA mutations and patients with a positive HRD status had the greatest PFS benefits
  – The results reveal a patient population beyond tBRCAm patients, who are HRD positive, that experiences substantial benefit from maintenance treatment with olaparib and bevacizumab

• The safety profile of olaparib in combination with bevacizumab was generally consistent with previous trials of each drug and the addition of olaparib did not impact on bevacizumab tolerability and HRQoL
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Closing and Q&A
**STUDY DESIGN**

**Key eligibility criteria**
- mCRPC with disease progression on prior NHA, e.g., abiraterone or enzalutamide
- Alterations in ≥1 of any qualifying gene with a direct or indirect role in HRR*

**Stratification factors**
- Previous taxane
- Measurable disease

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**Cohort A:**
- BRCA1, BRCA2 or ATM
- N=245

**Cohort B:**
- Other alterations
- N=142

**2:1 randomization Open-label**

- Olaparib 300 mg bid
  - Cohort A: n=162
  - Physician’s choice‡ n=83
- Olaparib 300 mg bid
  - Cohort B: n=94
  - Physician’s choice‡ n=48

**Primary Endpoint**
- Radiographic progression-free survival (rPFS) in Cohort A
  - (RECIST 1.1 & PCWG3 by BICR)

**Secondary Endpoints**
- rPFS in Cohorts A+B
- Confirmed radiographic objective response rate (ORR) in Cohort A
- Time to pain progression (TTPP) in Cohort A
- Overall survival (OS) in Cohort A

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*An investigational Clinical Trial Assay, based on the FoundationOne® CDx next-generation sequencing test, and developed in partnership with Foundation Medicine Inc, was used to prospectively select patients harboring alterations in the following genes in their tumor tissue: BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, PPP2R2A, RAD51B, RAD51C, RAD51D or RAD54L

‡Physician’s choice of either enzalutamide (160 mg qd) or abiraterone (1000 mg qd plus prednisone [5 mg bid])

BICR, blinded independent central review
### SAFETY SUMMARY IN THE OVERALL POPULATION (COHORTS A+B)

**Median treatment duration:** Olaparib, 7.4 months; Physician’s choice 3.9 months

<table>
<thead>
<tr>
<th></th>
<th>Olaparib (N=256)</th>
<th>Physician’s choice (N=130)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any AE, n (%)</td>
<td>244 (95.3)</td>
<td>114 (87.7)</td>
</tr>
<tr>
<td>Any AE of CTCAE grade 3 or higher, n (%)</td>
<td>130 (50.8)</td>
<td>49 (37.7)</td>
</tr>
<tr>
<td>Dose reduction due to AE, n (%)</td>
<td>57 (22.3)</td>
<td>5 (3.8)</td>
</tr>
<tr>
<td>Discontinuation due to AE, n (%)</td>
<td>42 (16.4)</td>
<td>11 (8.5)</td>
</tr>
<tr>
<td>Death due to AE, n (%)</td>
<td>10 (3.9)</td>
<td>5 (3.8)</td>
</tr>
<tr>
<td>Reported to be related to study treatment</td>
<td>1 (0.4)</td>
<td>1 (0.8)</td>
</tr>
</tbody>
</table>

AEs are reported irrespective of attribution, unless otherwise stated.
Primary endpoint

**rPFS BY BICR IN PATIENTS WITH ALTERATIONS IN BRCA1, BRCA2, OR ATM (COHORT A)**

- **Events (%)**
  - Olaparib (N=162): 106 (65.4)
  - Physician's choice (N=83): 68 (81.9)

- **Median PFS (months)**
  - Olaparib: 7.39
  - Physician's choice: 3.55

- **Hazard ratio (95% CI)**
  - 0.34 (0.25, 0.47)
  - *P* < 0.0001

Prespecified sensitivity analysis based on investigator assessment: Hazard ratio 0.24 (95% CI 0.17, 0.34); *P* < 0.0001
Key secondary endpoint
rPFS BY BICR IN THE OVERALL POPULATION (COHORTS A+B)

<table>
<thead>
<tr>
<th>Time from randomization (months)</th>
<th>Probability of rPFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>4</td>
<td>0.6</td>
</tr>
<tr>
<td>5</td>
<td>0.5</td>
</tr>
<tr>
<td>6</td>
<td>0.4</td>
</tr>
<tr>
<td>7</td>
<td>0.3</td>
</tr>
<tr>
<td>8</td>
<td>0.2</td>
</tr>
<tr>
<td>9</td>
<td>0.1</td>
</tr>
<tr>
<td>10</td>
<td>0.0</td>
</tr>
</tbody>
</table>

6-mo rate
- Olaparib: 49.66%
- Physician's choice: 23.67%

12-mo rate
- Olaparib: 22.13%
- Physician's choice: 13.47%

Events (%)
- Olaparib (N=256): 180 (70.3)
- Physician's choice (N=131): 99 (75.6)

Median PFS (months)
- Olaparib: 5.82 months
- Physician's choice: 3.52 months

Hazard ratio (95% CI)
- Olaparib vs Physician's choice
  - Hazard ratio: 0.49 (0.38, 0.63)
  - P-value: <0.0001

No. at risk
- Olaparib: 256, 188, 145, 106, 67, 48, 31, 21, 11, 2, 0
- Physician's choice: 131, 73, 38, 20, 9, 5, 5, 3, 2, 1, 0

Lynparza’s Phase III PROfound trial | 4
Tagrisso’s Phase III FLAURA trial

OVERALL SURVIVAL

Median OS, months (95% CI)
- Osimertinib: 38.6 (34.5, 41.8)
- Comparator EGFR-TKI: 31.8 (26.6, 36.0)

HR (95.05% CI): 0.799 (0.641, 0.997); p=0.0462

321 deaths in 556 patients at DCO: 58% maturity

For statistical significance, a p-value of less than 0.0495, determined by O'Brien-Fleming approach, was required.
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Closing and Q&A
### Summary | 1

**Median PFS (mPFS) from PRIMA and PAOLA-1 trials**

<table>
<thead>
<tr>
<th></th>
<th>PFS Hazard Ratio</th>
<th>Difference in mPFS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ITT (BICR)</td>
<td>0.62 (BICR)</td>
<td>5.6m (BICR)</td>
</tr>
<tr>
<td>HRD-ve</td>
<td>0.68</td>
<td>2.7m</td>
</tr>
<tr>
<td>HRD+ve</td>
<td>0.43</td>
<td>11.2m</td>
</tr>
<tr>
<td>BRCAm</td>
<td>0.40</td>
<td>11.0m</td>
</tr>
<tr>
<td><strong>PAOLA-1</strong></td>
<td>0.92*</td>
<td>5.5m (BICR: 7.8m)</td>
</tr>
<tr>
<td>ITT (inv)</td>
<td>0.59 (BICR: 0.63)</td>
<td></td>
</tr>
<tr>
<td>HRD-ve/unknown</td>
<td>0.92*</td>
<td>0.9m</td>
</tr>
<tr>
<td>HRD+ve</td>
<td>0.33</td>
<td>19.5m</td>
</tr>
<tr>
<td>BRCAm</td>
<td>0.31</td>
<td>15.5m</td>
</tr>
</tbody>
</table>

**PFS months**

- Placebo
- Niraparib
- Bevacizumab
- Bevacizumab + Lynparza

*Inv: investigator assessed.  * Unadjusted.

Source: ESMO 2019.
### Summary | 2

**Lynparza safety supports general combinability with other medicines**

<table>
<thead>
<tr>
<th></th>
<th>PRIMA</th>
<th></th>
<th></th>
<th>PAOLA-1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>niraparib</td>
<td>placebo</td>
<td>bevacizumab +</td>
<td>bevacizumab</td>
</tr>
<tr>
<td><strong>Duration of follow up</strong></td>
<td>13.8months*</td>
<td></td>
<td>24.0m</td>
<td>22.7m</td>
</tr>
<tr>
<td><strong>Discontinuation rates for reasons other than disease progression</strong></td>
<td>18%*</td>
<td>5%*</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>Due to AE</td>
<td>12%</td>
<td>2%</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>Withdrew / Other Reasons</td>
<td>6%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Dose reductions</strong></td>
<td>71%</td>
<td>8%</td>
<td>41%</td>
<td>7%</td>
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<tr>
<td><strong>Dose interruptions</strong></td>
<td>80%</td>
<td>18%</td>
<td>54%</td>
<td>24%</td>
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<tr>
<td><strong>AE rates</strong></td>
<td>&gt; Grade 3 (with &gt;10% pts in either trial)</td>
<td>71%</td>
<td>19%</td>
<td>57%</td>
</tr>
<tr>
<td>Anaemia</td>
<td>31%</td>
<td>2%</td>
<td>17%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>13%</td>
<td>1%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>29%</td>
<td>&lt;1%</td>
<td>2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Platelet count decrease</td>
<td>13%</td>
<td>&lt;1%</td>
<td>Grouped as thrombocytopenia</td>
<td>Grouped as thrombocytopenia</td>
</tr>
<tr>
<td>Hypertension</td>
<td>NR</td>
<td>NR</td>
<td>19%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Source:** ESMO 2019, González-Martín et al. NEJM; 28 September 2019.
**Summary | 3**

New options for 1st-line ovarian cancer maximising chance of cure or long-term remission

<table>
<thead>
<tr>
<th>BRCAm/HRD+ve and HRD unknown (~65%)</th>
<th>Bevacizumab eligible ~70 to 80%</th>
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</thead>
<tbody>
<tr>
<td>Lynparza + bevacizumab</td>
<td>Lynparza / niraparib monotherapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Known HRD-ve (~35%)</th>
<th>Bevacizumab ineligible ~20 to 30%</th>
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</thead>
<tbody>
<tr>
<td>bevacizumab monotherapy</td>
<td>niraparib monotherapy</td>
</tr>
</tbody>
</table>

Illustrative; AstraZeneca estimates.
Continuing to improve standards of care for oncology patients

Summary | 4
Phase III data presented at ESMO 2019

• **Lynparza** Phase III PAOLA-1 trial (ovarian cancer)
  • Bevacizumab + *Lynparza* demonstrated unprecedented median PFS in 1st-line maintenance OC\(^1\) of >22 months in a representative ovarian cancer population not restricted by surgical outcome, with additional benefit in HRD positive patients
  • *Lynparza* is the only PARPi\(^2\) with Phase III OC data as monotherapy in BRCAm or when combined with bevacizumab in all-comers patients
  • *Lynparza* is generally well tolerated with or without bevacizumab; safety was consistent with previous trials and the addition of *Lynparza* to bevacizumab did not impact on bevacizumab tolerability and health-related quality of life

• **Lynparza** Phase III PROfound trial (prostate cancer)
  • First time a positive Phase III in biomarker-selected mCRPC, in patients with BRCA1, BRCA2 and/or ATM alterations

• **Tagrisso** Phase III FLAURA trial (lung cancer)
  • Unprecedented ORR, PFS and now OS reinforces *Tagrisso* as the standard of care in 1st-line EGFRm NSCLC patients

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\(^1\) Ovarian cancer. \(^2\) Poly (ADP-ribose) polymerase inhibitor.
Q&A
Appendix: Tagrisso’s Phase III FLAURA trial

SECOND-LINE TREATMENT FOLLOWING PROGRESSION

- Of the 180 patients in the comparator EGFR-TKI arm who received a first subsequent treatment, 85 patients (47%) crossed over to osimertinib (31% of all patients randomised from the comparator EGFR-TKI arm)

Patient disposition:
- Received first subsequent (second-line) anticancer treatment
- No subsequent anti-cancer treatment
- Still on study treatment

First subsequent (second-line) anticancer therapies:
- Other*
- Cytotoxic chemotherapy†
- Osimertinib
- EGFR-TKI containing regimen, other than osimertinib

Data cut-off: 25 June 2019

*Refers to those patients who did not receive either chemotherapy or an EGFR-TKI; †The majority of patients who received cytotoxic chemotherapy received a platinum-based chemotherapy regimen

FST, first subsequent treatment
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