Farxiga’s DAPA-HF trial at ESC

Conference call for investors and analysts

1st 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 R&D 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 media platforms and new technology; and the risk of failure of information technology and cybercrime. Nothing in this presentation / webcast should be construed as a profit forecast.
Presenters

Pascal Soriot
Executive Director and Chief Executive Officer

Professor John McMurray
MB ChB (Hons), MD, FRCP, FESC, FACC, FAHA, FRSE, FmedSci, OBE
University of Glasgow, UK

Available for Q&A

Mene Pangalos
Executive Vice President, BioPharmaceuticals R&D

Ruud Dobber
Executive Vice President, BioPharmaceuticals Business Unit

Elisabeth Björk
Senior Vice President, Late CVRM
Agenda for today’s conference call

1. Introduction by Pascal Soriot
2. DAPA-HF presentation by Prof. John McMurray
3. Closing and Q&A
AstraZeneca @ ESC 2019

DAPA-HF another important milestone for Farxiga
THEMIS builds on positive Brilinta momentum

Farxiga

➢ Positive DECLARE data in a broad patient population in type-2 diabetes

➢ Ground breaking results in heart failure (HFrEF) in both patients with and without type-2 diabetes

➢ DELIVER (HFpEF), data 2020+

➢ US FDA Fast Track Designation in CKD

Brilinta

➢ THEMIS shows statistically significant benefit for Brilinta in patients with CAD and type-2 diabetes

Positive risk/benefit in PCI subgroup

Heart Failure:
Prevent & treat
High unmet medical need

- **425m** people affected with diabetes
- **64m** people with HF
- **17.9m** CV deaths per year
- **200m** people with chronic kidney disease

Sources:

$31bn$ estimated costs in the US alone in 2012
Innovative, complementary CVRM portfolio

**Diabetes**
- farxiga® (dapagliflozin) mg once
- BRILINTA® ticagrelor tablets
- Roxadustat roxadustat

**Heart Failure**
- farxiga® (dapagliflozin) mg once
- LOKELMA™ v

**Cardiovascular**
- farxiga® (dapagliflozin) mg once
- BRILINTA® ticagrelor tablets
- epanova® omega-3 carboxylic acids

**Kidney Disease**
- farxiga® (dapagliflozin) mg once
- LOKELMA™ v

* Enabling effective treatment for HF

Data 2020

Data 2020+
Farxiga’s Dapa-HF trial at ESC 2019

Dapagliflozin in Patients with Heart Failure and Reduced Ejection Fraction

John McMurray
BHF Cardiovascular Research Centre,
University of Glasgow & Queen Elizabeth
University Hospital, Glasgow
Farxiga’s Dapa-HF trial at ESC 2019

Trial leadership and data analysis

Executive Committee
John J.V. McMurray MD (Chairman), David L. DeMets, Silvio E. Inzucchi, Lars Køber, Mikhail N. Kosiborod, Anna Maria Langkilde, Felipe A. Martinez, Piotr Ponikowski, Marc S. Sabatine, Mikaela Sjöstrand, Scott D. Solomon

AstraZeneca leadership
Anna Maria Langkilde, Olof Bengtsson, Mikaela Sjöstrand, Kinga Kazanowska, Mikael Forsby, Yvonne Fox

Data analysis
Olof Bengtsson, Folke Folkvaljon, Samvel Gasparyan (AstraZeneca); Pardeep Jhund, Kieran Docherty, Alice Jackson, Jim Lewsey (University of Glasgow)
Farxiga’s Dapa-HF trial at ESC 2019

Background

- Sodium-glucose co-transporter 2 (SGLT2) inhibitors prevent the development of heart failure in patients with type 2 diabetes (T2D). Can they be used to treat patients with established heart failure?
- The benefits of SGLT2 inhibitors may be glucose-independent. Can SGLT2 inhibitors be used to treat patients without T2D?
- We tested the SGLT2 inhibitor dapagliflozin, 10 mg once daily, added to standard therapy, in patients with heart failure and reduced ejection fraction (HFrEF) both with and without T2D.
Farxiga’s Dapa-HF trial at ESC 2019

Trial Design

- **Key inclusion criteria:** Symptomatic HF; EF ≤40%; NT-proBNP ≥600 pg/ml (if hospitalized for HF within last 12 months ≥400 pg/mL; if atrial fibrillation/flutter ≥900 pg/mL)

- **Key exclusion criteria:** eGFR <30 ml/min/1.73 m²; symptomatic hypotension or SBP <95 mmHg; type 1 diabetes mellitus

- **Primary endpoint:** Worsening HF event or cardiovascular death (worsening HF event = unplanned HF hospitalization or an urgent heart failure visit requiring intravenous therapy)

*For full details see McMurray JJV et al Eur J Heart Fail. 2019;21:665-675*
Farxiga’s Dapa-HF trial at ESC 2019

DAPA-HF Design

Enrolment
- Informed consent
- Inclusion/exclusion
- Clinical assessment
- ECG
- NT-proBNP
- Laboratory assessments

Randomization
- N=2371
  - Placebo
- N=2373
  - Dapagliflozin 10 mg once daily

Visit 1 Visit 2 Visit 3 Visit 4 Visit 5 Visit 6 etc.
- Day -14 Day 0 Day 14 Day 60 Day 120 Every 120 days

≥844 Primary endpoints Composite of:
- CV death
- HF hospitalization
- Urgent HF visit
Farxiga’s Dapa-HF trial at ESC 2019

DAPA-HF - A global trial
4,744 patients  20 countries

North America
- Canada  223
- USA  454

Western Europe
- Denmark  99
- Germany  186
- Netherlands  135
- Sweden  68
- UK  62

Central/Eastern Europe
- Bulgaria  266
- Czech Rep.  210
- Hungary  250
- Poland  290
- Slovakia  166
- Russia  422

Latin America
- Argentina  297
- Brazil  520

Asia-Pacific
- China  237
- India  237
- Japan  343
- Taiwan  141
- Vietnam  138
Farxiga’s Dapa-HF trial at ESC 2019

Key baseline characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Dapagliflozin (n=2373)</th>
<th>Placebo (n=2371)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (yr)</td>
<td>66</td>
<td>67</td>
</tr>
<tr>
<td>Male (%)</td>
<td>76</td>
<td>77</td>
</tr>
<tr>
<td>NYHA class II/III/IV (%)</td>
<td>68/31/1</td>
<td>67/32/1</td>
</tr>
<tr>
<td>Mean LVEF (%)</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Median NT pro BNP (pg/ml)</td>
<td>1428</td>
<td>1446</td>
</tr>
<tr>
<td>Mean systolic BP (mmHg)</td>
<td>122</td>
<td>122</td>
</tr>
<tr>
<td>Ischaemic aetiology (%)</td>
<td>55</td>
<td>57</td>
</tr>
<tr>
<td>Mean eGFR (ml/min/1.73m²)</td>
<td>66</td>
<td>66</td>
</tr>
<tr>
<td>Prior diagnosis T2D (%)</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Any baseline T2D (%)*</td>
<td>45</td>
<td>45</td>
</tr>
</tbody>
</table>

*includes 82 dapagliflozin and 74 placebo patients with previously undiagnosed diabetes i.e. two HbA1c ≥6.5% (≥48 mmol/mol)
## Baseline treatment

<table>
<thead>
<tr>
<th>Treatment (%)</th>
<th>Dapagliflozin (n=2373)</th>
<th>Placebo (n=2371)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diuretic</td>
<td>93</td>
<td>94</td>
</tr>
<tr>
<td>ACE-inhibitor/ARB/ARNI*</td>
<td>94</td>
<td>93</td>
</tr>
<tr>
<td>ACE inhibitor</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>ARB</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Sacubitril/valsartan</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>MRA</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td>ICD*</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>CRT**</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

*ARNI = angiotensin receptor neprilysin inhibitor  
*ICD or CRT-D  **CRT-P or CRT-D  

For full details see McMurray JJV et al  
Eur J Heart Fail.2019 Jul 15. doi: 10.1002/ejhf.1548
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Patient disposition

8134 patients screened

3390 patients not randomized
Death 12
Adverse event 15
Participant choice 84
Eligibility criteria not met 3279

4744 patients randomized

2373 assigned to dapagliflozin
5 patients did not receive drug
249 discontinued treatment
14 incomplete follow-up for primary endpoint
0 unknown vital status

2371 assigned to placebo
3 patients did not receive drug
258 discontinued treatment
20 incomplete follow-up for primary endpoint
2 unknown vital status

Median follow-up 18.2 months
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Primary outcome
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Primary composite outcome
CV Death/HF hospitalization/Urgent HF visit

HR 0.74 (0.65,0.85)
p=0.00001
NNT=21

Number at Risk
Dapagliflozin 2373 2305 2221 2147 2002 1560 1146 612 210
Placebo 2371 2258 2163 2075 1917 1478 1096 593 210
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Components of primary outcome

Worsening HF event
HR 0.70 (0.59, 0.83); p=0.00003

Cardiovascular death
HR 0.82 (0.69, 0.98); p=0.029
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Primary Endpoint: Prespecified subgroups

<table>
<thead>
<tr>
<th>HR (95% CI)</th>
<th>NT-proBNP</th>
<th>Prior hospitalization for HF</th>
<th>MRA at baseline</th>
<th>Type 2 diabetes at baseline</th>
<th>Atrial fibrillation or flutter at enrolment ECG</th>
<th>Main Etiology of HF</th>
<th>BMI (kg/m²)</th>
<th>Baseline eGFR (mL/min/1.73m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall effect</td>
<td>0.74 (0.65, 0.85)</td>
<td>≤ Median</td>
<td>0.63 (0.49, 0.80)</td>
<td>Yes</td>
<td>0.75 (0.63, 0.90)</td>
<td>Ischemic</td>
<td>&lt;30</td>
<td>&lt;60</td>
</tr>
<tr>
<td>Age (years)</td>
<td>0.78 (0.63, 0.96)</td>
<td>&gt; Median</td>
<td>0.77 (0.65, 0.92)</td>
<td>No</td>
<td>0.74 (0.63, 0.90)</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
<td>≥60</td>
</tr>
<tr>
<td>≤65</td>
<td>0.72 (0.60, 0.85)</td>
<td>Yes</td>
<td>0.67 (0.56, 0.80)</td>
<td>Yes</td>
<td>0.75 (0.63, 0.90)</td>
<td>Baseline eGFR (mL/min/1.73m²)</td>
<td>&lt;60</td>
<td>0.72 (0.59, 0.86)</td>
</tr>
<tr>
<td>&gt;65</td>
<td>Male</td>
<td>0.73 (0.63, 0.85)</td>
<td>No</td>
<td>0.74 (0.63, 0.90)</td>
<td>&gt; Median</td>
<td>0.76 (0.63, 0.92)</td>
<td>≥60</td>
<td>0.76 (0.63, 0.92)</td>
</tr>
<tr>
<td>Female</td>
<td>0.79 (0.59, 1.06)</td>
<td>No</td>
<td>0.74 (0.63, 0.90)</td>
<td>No</td>
<td>0.73 (0.60, 0.88)</td>
<td>Baseline eGFR (mL/min/1.73m²)</td>
<td>≥60</td>
<td>0.76 (0.63, 0.92)</td>
</tr>
<tr>
<td>Race</td>
<td>0.78 (0.66, 0.91)</td>
<td>Yes</td>
<td>0.63 (0.60, 0.84)</td>
<td>Yes</td>
<td>0.73 (0.60, 0.88)</td>
<td>Main Etiology of HF</td>
<td>IS</td>
<td>0.72 (0.59, 0.86)</td>
</tr>
<tr>
<td>White</td>
<td>0.73 (0.37, 1.04)</td>
<td>No</td>
<td>0.64 (0.48, 0.86)</td>
<td>No</td>
<td>0.73 (0.60, 0.88)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>Black or African</td>
<td>0.64 (0.48, 0.86)</td>
<td>No</td>
<td>0.73 (0.60, 0.88)</td>
<td>No</td>
<td>0.73 (0.60, 0.88)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>Asian</td>
<td>0.64 (0.48, 0.86)</td>
<td>No</td>
<td>0.73 (0.60, 0.88)</td>
<td>No</td>
<td>0.73 (0.60, 0.88)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>Other</td>
<td>0.65 (0.49, 0.87)</td>
<td>Yes</td>
<td>0.75 (0.63, 0.90)</td>
<td>Yes</td>
<td>0.73 (0.60, 0.88)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>NYHA class</td>
<td>0.84 (0.69, 1.01)</td>
<td>No</td>
<td>0.72 (0.61, 0.84)</td>
<td>No</td>
<td>0.72 (0.61, 0.84)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>I</td>
<td>0.73 (0.51, 1.03)</td>
<td>Yes</td>
<td>0.82 (0.63, 1.06)</td>
<td>No</td>
<td>0.72 (0.61, 0.84)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>II or IV</td>
<td>0.64 (0.47, 0.88)</td>
<td>Yes</td>
<td>0.75 (0.63, 0.90)</td>
<td>Yes</td>
<td>0.73 (0.60, 0.88)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>≤ Median</td>
<td>0.63 (0.52, 0.75)</td>
<td>No</td>
<td>0.72 (0.61, 0.84)</td>
<td>No</td>
<td>0.72 (0.61, 0.84)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
<tr>
<td>&gt; Median</td>
<td>0.70 (0.59, 0.84)</td>
<td>Yes</td>
<td>0.82 (0.63, 1.06)</td>
<td>No</td>
<td>0.72 (0.61, 0.84)</td>
<td>Main Etiology of HF</td>
<td>Non-Ischemic/Unknown</td>
<td>≥30</td>
</tr>
</tbody>
</table>
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No diabetes/diabetes subgroup: Primary endpoint

<table>
<thead>
<tr>
<th></th>
<th>Dapagliflozin (n=2373)</th>
<th>Placebo (n=2371)</th>
<th>HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>386/2373</td>
<td>502/2371</td>
<td>0.74 (0.65, 0.85)</td>
</tr>
<tr>
<td>Type 2 diabetes at baseline*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>215/1075</td>
<td>271/1064</td>
<td>0.75 (0.63, 0.90)</td>
</tr>
<tr>
<td>No</td>
<td>171/1298</td>
<td>231/1307</td>
<td>0.73 (0.60, 0.88)</td>
</tr>
</tbody>
</table>

*Defined as history of type 2 diabetes or HbA1c ≥6.5% at both enrollment and randomization visits.
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**ARNI/no ARNI post hoc subgroup:**

**Primary endpoint**

<table>
<thead>
<tr>
<th>Group</th>
<th>Dapagliflozin (n=2373)</th>
<th>Placebo (n=2371)</th>
<th>HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>386/2373</td>
<td>502/2371</td>
<td>0.74 (0.65, 0.85)</td>
</tr>
<tr>
<td>Angiotensin Receptor Neprilysin Inhibitor (ARNI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>41/250</td>
<td>56/258</td>
<td>0.75 (0.50, 1.13)</td>
</tr>
<tr>
<td>No</td>
<td>345/2123</td>
<td>446/2113</td>
<td>0.74 (0.65, 0.86)</td>
</tr>
</tbody>
</table>

**Diagram:**

- Dapagliflozin Better
- Placebo Better
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Secondary outcomes
In order of hierarchical testing
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CV death or HF hospitalization

HR 0.75 (0.65, 0.85)
p=0.00002

Number at Risk
Dapagliflozin 2373 2306 2223 2153 2007 1563 1147 613 210
Placebo 2371 2264 2168 2082 1924 1483 1101 596 212
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Total HF hospitalizations and CV death
Including first and repeat hospitalizations

Rate Ratio 0.75 (0.65, 0.88)
p=0.0002

Number at Risk
<table>
<thead>
<tr>
<th>Dapagliflozin</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>2373</td>
<td>2371</td>
</tr>
<tr>
<td>2339</td>
<td>2330</td>
</tr>
<tr>
<td>2293</td>
<td>2279</td>
</tr>
<tr>
<td>2248</td>
<td>2230</td>
</tr>
<tr>
<td>2127</td>
<td>2091</td>
</tr>
<tr>
<td>1664</td>
<td>1636</td>
</tr>
<tr>
<td>1242</td>
<td>1219</td>
</tr>
<tr>
<td>671</td>
<td>664</td>
</tr>
<tr>
<td>232</td>
<td></td>
</tr>
</tbody>
</table>
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Kansas City Cardiomyopathy Questionnaire (KCCQ)

Total Symptom Score (TSS):
Change from baseline to 8 months

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dapagliflozin</td>
<td>+6.1 ± 18.6</td>
</tr>
<tr>
<td>Placebo</td>
<td>+3.3 ± 19.2</td>
</tr>
</tbody>
</table>

Difference
2.8 points (95% CI 1.6, 4.0)
p<0.001*

Increase in score indicates an improvement

*Calculated from win ratio, incorporating death. Win ratio = 1.18 (CI 1.11, 1.26). Win ratio >1 indicates superiority of dapagliflozin over placebo
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Kansas City Cardiomyopathy Questionnaire (KCCQ)

Total Symptom Score: Proportion with ≥5 point change from baseline to 8 months*

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Dapagliflozin</th>
<th>Placebo</th>
<th>Odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥5 point improvement</td>
<td>58%</td>
<td>51%</td>
<td>1.15 (1.08, 1.23)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>≥5 point deterioration</td>
<td>25%</td>
<td>33%</td>
<td>0.84 (0.78, 0.90)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>

*Taking account of death
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Worsening renal function endpoint

Composite of: Sustained* ≥50% reduction in eGFR, end-stage renal disease (ESRD) or death from renal causes

<table>
<thead>
<tr>
<th>Treatment</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dapagliflozin</td>
<td>28 (1.2)</td>
</tr>
<tr>
<td>Placebo</td>
<td>39 (1.6)</td>
</tr>
</tbody>
</table>

Hazard ratio (95% CI)
0.71 (0.44, 1.16)
p=0.17

ESRD consisted of sustained eGFR below 15 ml/min/1.73m², sustained dialysis or kidney transplantation

*Sustained = 28 days or more
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All-cause death

HR 0.83 (0.71, 0.97)
p=0.022*

Cumulative Percentage (%) vs. Months since Randomization

Placebo
Dapagliflozin

Number at Risk
Dapagliflozin 2373 2342 2296 2251 2130 1666 1243 672 233
Placebo 2371 2330 2279 2231 2092 1638 1221 665 235

*Nominal p value
**Farxiga’s Dapa-HF trial at ESC 2019**

### Safety/adverse events

<table>
<thead>
<tr>
<th>Patients exposed to at least one dose of study drug</th>
<th>Dapagliflozin (n=2368)</th>
<th>Placebo (n=2368)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse events (AE) of interest (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volume depletion⁺</td>
<td>7.5</td>
<td>6.8</td>
<td>0.40</td>
</tr>
<tr>
<td>Renal AE‡</td>
<td>6.5</td>
<td>7.2</td>
<td>0.36</td>
</tr>
<tr>
<td>Fracture</td>
<td>2.1</td>
<td>2.1</td>
<td>1.00</td>
</tr>
<tr>
<td>Amputation</td>
<td>0.5</td>
<td>0.5</td>
<td>1.00</td>
</tr>
<tr>
<td>Major hypoglycaemia</td>
<td>0.2</td>
<td>0.2</td>
<td>-</td>
</tr>
<tr>
<td>Diabetic ketoacidosis</td>
<td>0.1</td>
<td>0.0</td>
<td>-</td>
</tr>
<tr>
<td><strong>AE leading to treatment discontinuation (%)</strong></td>
<td>4.7</td>
<td>4.9</td>
<td>0.79</td>
</tr>
<tr>
<td><strong>Any serious adverse event (incl. death) (%)</strong></td>
<td>38</td>
<td>42</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

⁺Volume depletion serious AEs in 29 dapagliflozin patients (1.2%) and 40 placebo patients (1.7%), p=0.23
‡Renal serious AEs in 38 dapagliflozin patients (1.6%) and 65 placebo patients (2.7%), p=0.009
Farxiga’s Dapa-HF trial at ESC 2019

Summary and conclusions

- Dapagliflozin reduced the risk of worsening heart failure events and cardiovascular death, and improved symptoms, in patients with HFrEF, when added to standard therapy.
- The relative and absolute risk reductions in death and hospitalization were substantial, clinically important, and consistent across important subgroups, including patients without T2D.
- Dapagliflozin was well tolerated and the rate of treatment discontinuation was low.
- Dapagliflozin offers a new approach to the treatment of HFrEF.
Q&A
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