Cautionary statement regarding 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 presentation contains certain forward-looking statements with respect to the operations, performance and financial condition of the Group. 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 presentation 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 patents, marketing exclusivity or trade marks, or the risk of failure to obtain patent protection; the risk of substantial adverse litigation/government investigation claims and insufficient insurance coverage; exchange rate fluctuations; the risk that R&D will not yield new products that achieve commercial success; the risk that strategic alliances and acquisitions will be unsuccessful; the impact of competition, price controls and price reductions; taxation risks; the risk of substantial product liability claims; the impact of any failure by third parties to supply materials or services; the risk of failure to manage a crisis; the risk of delay to new product launches; the difficulties of obtaining and maintaining regulatory approvals for products; the risk of failure to observe ongoing regulatory oversight; the risk that new products do not perform as we expect; the risk of environmental liabilities; the risks associated with conducting business in emerging markets; the risk of reputational damage; the risk of product counterfeiting; the risk of failure to successfully implement planned cost reduction measures through productivity initiatives and restructuring programmes; the risk that regulatory approval processes for biosimilars could have an adverse effect on future commercial prospects; and the impact of increasing implementation and enforcement of more stringent anti-bribery and anti-corruption legislation.

Nothing in this presentation should be construed as a profit forecast.
Introduction

Thomas Kudsk Larsen, Head of Investor Relations
Welcome, agenda & introduction

- Welcome
- PEGASUS-TIMI 54 trial
- BRILINTA® / BRILIQUE™ clinical & business status
- Q&A

Estimated duration up to one hour
PEGASUS-TIMI 54 trial

Dr. Marc Sabatine, PEGASUS TIMI-54 Primary Investigator

Brigham and Women’s Hospital, Massachusetts, USA
Prevention of Cardiovascular Events in Patients With Prior Heart Attack Using Ticagrelor Compared to Placebo on a Background of Aspirin

Marc S. Sabatine, MD, MPH
on behalf of the PEGASUS-TIMI 54 Executive & Steering Committees and Investigators

NCT00526474
Background

- Current guidelines recommend adding a P2Y\textsubscript{12} receptor antagonist to aspirin only for the first year after an acute coronary syndrome (ACS)

- However, several lines of evidence suggest more prolonged therapy may be beneficial in Pts w/ prior MI
  - Landmark analyses from 1-year ACS trials of P2Y\textsubscript{12} antag
  - Post-hoc MI subgroup analysis from CHARISMA

- Ticagrelor is a potent, reversibly-binding, direct-acting P2Y\textsubscript{12} antagonist with established efficacy for the first year after an ACS
Hypothesis

The addition of ticagrelor to standard therapy (including low-dose aspirin) would reduce the incidence of major adverse cardiovascular events during long-term follow-up in patients with a history of MI.
Trial Organization

TIMI Study Group
Eugene Braunwald (Chair)  Marc S. Sabatine (PI)
Marc P. Bonaca (Co-PI)    Stephen D. Wiviott (CEC Chair)
S Morin & P Fish (Operations)  SA Murphy & Kelly Im (Statistics)

Executive Cmte
Eugene Braunwald (Chair)  Marc S. Sabatine
Deepak L. Bhatt            Marc Cohen
Ph. Gabriel Steg            Robert Storey

Sponsor: AstraZeneca
Peter Held                   Eva Jensen
Per Johanson                 Ann Maxe Ahlbom
Barbro Boberg                Olof Bengtsson

Independent Data Monitoring Cmte
Jeffrey L. Anderson (Chair)  Terje R. Pedersen
Freek W.A.Verheugt            Harvey D. White
David L. DeMets
Steering Committee

Argentina
R. Diaz/E Paolasso

Australia
P Ayiward

Belgium
F Van der Werf

Brazil
J Nicolau

Bulgaria
A Goudev

Canada
P Theroux

Chile
R Corbalan

China
D Hu

Colombia
D Isaza

Czech Republic
J Spinar

France
G Montalescot/PG Steg

Germany
C Hamm

Hungary
R Kiss

Italy
D Ardissino

Japan
S Goto

Netherlands
T Oude Ophuis

Norway
F Kontry

Peru
F Medina

Philippines
MT Abola

Poland
A Budaj

Romania
D Dimulescu

Russia
M Ruda

S. Africa
A Dalby

S. Korea
K Seung

Slovakia
G Kamensky

Spain
J Lopez-Sendon

Sweden
M Dellborg

Turkey
S Guneri

UK
R Storey

Ukraine
A Parkhomenko

USA
Bonaca/Bhatt/Cohen
Trial Design

Stable pts with history of MI 1-3 yrs prior + ≥1 additional atherothrombosis risk factor

RANDOMIZED DOUBLE BLIND

Planned treatment with ASA 75 – 150 mg/d & Standard background care

Ticagrelor 90 mg bid

Ticagrelor 60 mg bid

Placebo

Follow-up Visits Q4 mos for 1st yr, then Q6 mos

Minimum 1 year follow-up Event-driven trial

Bonaca MP et al. Am Heart J 2014;167:437-44
**Key Inclusion & Exclusion Criteria**

**Key Inclusion**
- Age ≥50 years
- At least 1 of the following:
  - Age ≥65 years
  - Diabetes requiring medication
  - 2nd prior MI (>1 year ago)
  - Multivessel CAD
  - CrCl <60 mL/min
- Tolerating ASA and able to be dosed at 75-150 mg/d

**Key Exclusion**
- Planned use of P2Y<sub>12</sub> antagonist, dipyridamole, cilostazol, or anticoag
- Bleeding disorder
- History of ischemic stroke, ICH, CNS tumor or vascular abnormality
- Recent GI bleed or major surgery
- At risk for bradycardia
- Dialysis or severe liver disease

Bonaca MP et al. Am Heart J 2014;167:437-44
Endpoints

• Efficacy: hierarchical testing
  – Primary: cardiovascular (CV) death, MI, or stroke
  – Secondary: CV death; all-cause mortality
  – Prespecified exploratory: substituting coronary for CV death; other individual coronary and cerebrovascular ischemic outcomes; pooling ticagrelor doses

• Safety
  – Primary: TIMI Major Bleeding
  – Other: intracranial hemorrhage (ICH), fatal bleeding
  – AEs/SAEs

• TIMI Clinical Events Committee (CEC)
  – Adjudicated all efficacy endpoints & bleeding events
  – Members unaware of treatment assignments
21,162 patients randomized at 1161 sites in 31 countries between 10/2010 – 5/2013
Follow-Up

Randomized 21,162 patients

- Ticagrelor 90 mg bid (N=7050)
- Ticagrelor 60 mg bid (N=7045)
- Placebo (N=7067)

Follow-up median 33 months (IQR 28-37)
Minimum 16 months, maximum 47 months

<table>
<thead>
<tr>
<th></th>
<th>12%/yr</th>
<th>11%/yr</th>
<th>8%/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature perm. drug discontinuation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrew consent</td>
<td>0.7% total</td>
<td>0.7% total</td>
<td>0.7% total</td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>3 patients</td>
<td>6 patients</td>
<td>1 patient</td>
</tr>
</tbody>
</table>

Ascertainment for primary endpoint was complete for 99% of potential patient-years of follow up
### Baseline Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age – yr, mean (SD)</td>
<td>65 (8)</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
</tr>
<tr>
<td>Hypertension</td>
<td>78</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>77</td>
</tr>
<tr>
<td>Current smoker</td>
<td>17</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>32</td>
</tr>
<tr>
<td>Estimated GFR &lt;60 mL/min/1.73m²</td>
<td>23</td>
</tr>
<tr>
<td>History of PCI</td>
<td>83</td>
</tr>
<tr>
<td>Multivessel coronary disease</td>
<td>59</td>
</tr>
<tr>
<td>History of more than 1 prior MI</td>
<td>17</td>
</tr>
</tbody>
</table>

No difference between treatment arms. Values for categorical variables are %. 
# Baseline Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualifying Event</strong></td>
<td></td>
</tr>
<tr>
<td>Years from MI – median (IQR)</td>
<td>1.7 (1.2 – 2.3)</td>
</tr>
<tr>
<td>History of STEMI</td>
<td>53</td>
</tr>
<tr>
<td>History of NSTEMI</td>
<td>41</td>
</tr>
<tr>
<td>MI type unknown</td>
<td>6</td>
</tr>
</tbody>
</table>

![Bar chart showing years from qualifying MI to end of follow-up](chart.png)

- **No difference between treatment arms.**
- **Values for categorical variables are %**.
# Baseline Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualifying Event</strong></td>
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<tr>
<td>History of STEMI</td>
<td>53</td>
</tr>
<tr>
<td>History of NSTEMI</td>
<td>41</td>
</tr>
<tr>
<td>MI type unknown</td>
<td>6</td>
</tr>
<tr>
<td><strong>Medications at enrollment</strong></td>
<td></td>
</tr>
<tr>
<td>Aspirin (any dose)</td>
<td>99.9</td>
</tr>
<tr>
<td>Dose 75-100 mg/d</td>
<td>97.3</td>
</tr>
<tr>
<td>Statin</td>
<td>93</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>82</td>
</tr>
<tr>
<td>ACEI or ARB</td>
<td>80</td>
</tr>
</tbody>
</table>

No difference between treatment arms. Values for categorical variables are %.
Primary Endpoint

N = 21,162
Median follow-up 33 months

- Placebo (9.0%)
- Ticagrelor 90 (7.8%)
- Ticagrelor 60 (7.8%)

Ticagrelor 90 mg
HR 0.85 (95% CI 0.75 – 0.96)
P=0.008

Ticagrelor 60 mg
HR 0.84 (95% CI 0.74 – 0.95)
P=0.004
## Components of Primary Endpoint

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>HR (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CV Death, MI, or Stroke (1558 events)</td>
<td>0.85 (0.75-0.96)</td>
<td>0.008</td>
</tr>
<tr>
<td>CV Death (566 events)</td>
<td>0.84 (0.74-0.95)</td>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td>0.84 (0.76-0.94)</td>
<td>0.001</td>
</tr>
<tr>
<td>Myocardial Infarction (898 events)</td>
<td>0.87 (0.71-1.06)</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>0.83 (0.68-1.01)</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>0.85 (0.71-1.00)</td>
<td>0.06</td>
</tr>
<tr>
<td>Stroke (313 events)</td>
<td>0.81 (0.69-0.95)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>0.84 (0.72-0.98)</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>0.83 (0.72-0.95)</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>0.82 (0.63-1.07)</td>
<td>0.14</td>
</tr>
<tr>
<td></td>
<td>0.75 (0.57-0.98)</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>0.78 (0.62-0.98)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

- **Ticagrelor 90 mg**
- **Ticagrelor 60 mg**
- **Placebo better**
- **Pooled**
## Other Efficacy Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Ticagrelor 90 mg bid (N=7050)</th>
<th>Ticagrelor 60 mg bid (N=7045)</th>
<th>Placebo (N=7067)</th>
<th>Ticagrelor 90 vs Placebo p-value</th>
<th>Ticagrelor 60 vs Placebo p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-yr KM rate (%)</td>
<td></td>
<td></td>
<td></td>
<td>HR 0.82 P=0.002</td>
<td>HR 0.83 P=0.003</td>
</tr>
<tr>
<td>Coronary Death, MI, or Stroke</td>
<td>7.0</td>
<td>7.1</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Death or MI</td>
<td>5.6</td>
<td>5.8</td>
<td>6.7</td>
<td>HR 0.81 P=0.004</td>
<td>HR 0.84 P=0.01</td>
</tr>
<tr>
<td>Coronary Death</td>
<td>1.5</td>
<td>1.7</td>
<td>2.1</td>
<td>HR 0.73 P=0.02</td>
<td>HR 0.80 P=0.09</td>
</tr>
<tr>
<td>Death from any cause</td>
<td>5.2</td>
<td>4.7</td>
<td>5.2</td>
<td>HR 1.00 P=0.99</td>
<td>HR 0.89 P=0.14</td>
</tr>
</tbody>
</table>
## Efficacy for 1° EP in Subgroups

### Hazard Ratio (95% CI)

#### Ticagrelor 90 mg vs Placebo

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>21,162</td>
</tr>
<tr>
<td>Age at Randomization</td>
<td></td>
</tr>
<tr>
<td>Age &lt; 75</td>
<td>18,079</td>
</tr>
<tr>
<td>Age ≥ 75</td>
<td>3,083</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5,060</td>
</tr>
<tr>
<td>Male</td>
<td>16,102</td>
</tr>
<tr>
<td>Qualifying MI</td>
<td></td>
</tr>
<tr>
<td>NSTEMI</td>
<td>8,583</td>
</tr>
<tr>
<td>STEMI</td>
<td>11,329</td>
</tr>
<tr>
<td>Unknown</td>
<td>1,223</td>
</tr>
<tr>
<td>Time from Qualifying MI</td>
<td></td>
</tr>
<tr>
<td>&lt; 2 years</td>
<td>12,980</td>
</tr>
<tr>
<td>≥ 2 years</td>
<td>8,155</td>
</tr>
<tr>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>North America</td>
<td>3,907</td>
</tr>
<tr>
<td>South America</td>
<td>2,458</td>
</tr>
<tr>
<td>Europe</td>
<td>12,428</td>
</tr>
<tr>
<td>Asia</td>
<td>2,369</td>
</tr>
</tbody>
</table>

*All P values for heterogeneity >0.05*
Bleeding

Ticag 90: HR 2.69 (1.96-3.70)
Ticag 60: HR 2.32 (1.68-3.21)

P<0.001

3-Year KM Event Rate (%)

- TIMI Major
- TIMI Minor
- Fatal bleeding or ICH
- ICH
- Fatal Bleeding

- Ticagrelor 90 mg
- Ticagrelor 60 mg
- Placebo

P=NS
# Other Adverse Events

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Ticagrelor 90 mg bid (N=6988)</th>
<th>Ticagrelor 60 mg bid (N=6958)</th>
<th>Placebo (N=6996)</th>
<th>Ticagrelor 90 vs Placebo p-value</th>
<th>Ticagrelor 60 vs Placebo p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyspnea AE</td>
<td>18.9</td>
<td>15.8</td>
<td>6.4</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Leading to study drug d/c</td>
<td>6.5</td>
<td>4.6</td>
<td>0.8</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Severe</td>
<td>1.2</td>
<td>0.6</td>
<td>0.2</td>
<td>P&lt;0.001</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Bradyarrhythmia</td>
<td>2.0</td>
<td>2.3</td>
<td>2.0</td>
<td>P=0.31</td>
<td>P=0.10</td>
</tr>
<tr>
<td>Gout</td>
<td>2.3</td>
<td>2.0</td>
<td>1.5</td>
<td>P&lt;0.001</td>
<td>P=0.01</td>
</tr>
</tbody>
</table>
Summary

- Adding ticagrelor to low-dose aspirin in stable patients with a history of MI reduced the risk of CV death, MI or stroke

- The benefit of ticagrelor was consistent
  - For both fatal & non-fatal components of primary endpoint
  - Over the duration of treatment
  - Among major clinical subgroups

- Ticagrelor increased the risk of TIMI major bleeding, but not fatal bleeding or ICH

- The two doses of ticagrelor had similar overall efficacy, but bleeding and other side effects tended to be less frequent with 60 mg bid dose
Conclusion

Long-term dual antiplatelet therapy with low-dose aspirin and ticagrelor should be considered in appropriate patients with a myocardial infarction.
BRILINTA® / BRILIQUE™
Clinical & business status

Tom Keith-Roach, BRILINTA® Task Force leader
Global #1 cause of death\textsuperscript{1,2}, >17m per year\textsuperscript{1}

Cardiovascular disease (CVD) worldwide

- 4.6 million Europe
- 3.6 million South East Asia
- 1.2 million Middle East & North Africa
- 4.7 million Western Pacific
- 1.9 million Americas
- 1.3 million Africa

17.3 million to 23.3 million

\begin{tabular}{|c|c|}
\hline
\textbf{Year} & \textbf{Low-to-Middle Income} & \textbf{High Income} \\
\hline
2008 & & \\
\hline
2030 & & \\
\hline
\end{tabular}

35% growth

\approx 70\%

of total global CVD deaths are due to ischaemic heart disease and cerebrovascular disease\textsuperscript{3}

Indicated for the treatment of ACS

- Indicated to reduce the rate of thrombotic CVD events in patients with ACS
- Shown to reduce the rate of a combined end point of CVD death, MI, or stroke compared to clopidogrel

**Definitions:** ACS – Acute Coronary Syndrome; MI – Myocardial Infarction; STEMI – ST Segment Elevation Myocardial Infarction; NSTEMI – Non-ST Segment Elevation myocardial Infarction; and ASA – Aspirin. **Notes:** 1. Markets include Australia, China, EU5, Japan, Russia and United States only. **Source:** Kantar Health (2010), GRACE registry (2007), National Health & Wellness Survey (2013), medical literature, internal data
US performance
Momentum has led to branded NBRx leadership

Branded oral anti-platelet (OAP) retail new-to-brand prescription (NBRx) share\(^1\)

Monthly brand total prescriptions (TRx) and NBRx share, OAP class\(^2\)

Source, Notes: 1. IMS Health NPA through w/e February 20, 2015. 2. IMS Health NPA, Monthly data through January 2015.
Global performance
Positive momentum continues through FY 2014

OAP share, volume: Retail + hospital\(^1\)

![Graph showing market share over time for different countries.]

Monthly brand share, OAP class\(^3\)

- US: 7%
- UK: 5%
- Spain: 12%
- Italy: 3%
- Germany: -5%
- France: 4%
- Australia: 4%

Source, Notes: 1. IMS MIDAS. Spain retail only. 2. Month 1 = month of 1st external sales data for product (does not reflect commercial launch timing). 3. IMS Hospital Discharge Tracker, AstraZeneca commissioned report.
Significant future opportunities
International guidelines support *BRILINTA® / BRILIQUE™* for >65% patients treated for 12 months

**ACS discharge share¹**

<table>
<thead>
<tr>
<th>Country</th>
<th>% patients at 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>67%</td>
</tr>
<tr>
<td>Australia</td>
<td>51%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>50%</td>
</tr>
<tr>
<td>France</td>
<td>41%</td>
</tr>
<tr>
<td>Spain</td>
<td>34%</td>
</tr>
<tr>
<td>Germany</td>
<td>30%</td>
</tr>
<tr>
<td>United States</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Rolling three waves ending**

Source: 1. IMS Hospital discharge tracker, AstraZeneca commissioned. 2. AstraZeneca.
Beyond 12 months
Patients remain at a significant risk

APOLLO; late-breaking registry presentation at the 2014 European Society of Cardiology

~1 in 5 patients who are event free for the first year post-MI, will suffer an MI, stroke or death within 3 years

APOLLO 4-country analysis: Adjusted Incidence

Patients who are event free in first year after their index event will suffer a MI, stroke or death in the subsequent three years
PEGASUS-TIMI 54 study of BRILINTA® / BRILIQUE™ meets primary endpoint in both 60mg and 90mg doses

• Investigated 60mg and 90mg ticagrelor vs. placebo in patients (low-dose aspirin) aged 50 and older with a history of heart attack and one additional CVD risk factor\(^1\)

• Designed to better understand the management of patients more than 12 months after their heart attack, who remain at high risk for major thrombotic events

Definitions: ACS – Acute Coronary Syndrome; MI – myocardial Infarction; STEMI – ST Segment Elevation myocardial Infarction; NSTEMI – Non-ST Segment Elevation myocardial Infarction; and ASA – Aspirin


Prior MI 13-36 months
4.5 million

P2Y\(_{12}\) treated
0.95 million

ASA treated/no therapy
3.6 million
### Outstanding collaboration with TIMI Study Group

**Publication, regulatory, prepare to launch**

#### Study metrics
- 21,000 patients in 31 countries
- >210,000 patient visits
- <0.1% patients lost to follow-up

#### Publication, regulatory
- FDA and EMA submissions complete
- Parallel presentation and publication ACC/NEJM\(^1\)

#### Towards launch
- Regulatory submission
- Pre-launch planning
- Disease and risk education

---

\(^1\) The New England Journal of Medicine
**PARTHENON programme**

Four regulatory submissions expected in three years

<table>
<thead>
<tr>
<th>Programme</th>
<th>Patients enrolled</th>
<th>Comparator</th>
<th>OAP access</th>
<th>Billion Days of Therapy</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PLATO</strong> Acute Coronary Syndrome</td>
<td>18,624</td>
<td>clopidogrel</td>
<td>20%</td>
<td>1.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PEGASUS</strong> Prior MI</td>
<td>21,162</td>
<td>placebo</td>
<td>20%</td>
<td>1.4%</td>
<td>Data</td>
<td></td>
<td></td>
<td>Expected launch</td>
</tr>
<tr>
<td><strong>SOCRATES</strong> Stroke/TIA</td>
<td>9,600</td>
<td>ASA</td>
<td>31%</td>
<td>2.3%</td>
<td>Data</td>
<td></td>
<td></td>
<td>Expected launch</td>
</tr>
<tr>
<td><strong>EUCLID</strong> Peripheral Arterial Disease</td>
<td>13,500</td>
<td>clopidogrel</td>
<td>69%</td>
<td>5.3%</td>
<td>Data</td>
<td></td>
<td></td>
<td>Expected launch</td>
</tr>
<tr>
<td><strong>THEMIS</strong> Diabetes</td>
<td>17,000</td>
<td>placebo</td>
<td>84%</td>
<td>6.8%</td>
<td></td>
<td></td>
<td></td>
<td>Exp. launch</td>
</tr>
</tbody>
</table>

- Increase in access to OAP market volume: >4.2x
- Increase in access to billion Days of Therapy: >5.5x
2015 priorities: Execution and launch

1. Guideline implementation in ACS

2. Launch BRILINTA® / BRILIQUE™ into post MI

3. Build the franchise – three world-class business units in coronary, stroke and PAD¹
Summary

• Worldwide 2014 sales for BRILINTA® / BRILIQUE™ were $476m up 70%\(^1\)

• Strong brand momentum in the United States continues

• PEGASUS-TIMI 54 met its primary endpoint in both 60mg and 90mg doses

• Upcoming SOCRATES study in stroke: From indication to franchise

\(^1\) At constant exchange rates
Questions & Answers

Participants

• **Dr. Marc Sabatine**, PEGASUS-TIMI 54 Primary Investigator (P.I.)
• **Tom Keith-Roach**, *BRILINTA® / BRILIQUE™* Task Force leader
• **Elisabeth Björk**, Head of Global Medicines Development for Cardiovascular and Metabolic Disease
• **Marc Ditmarsch**, *BRILINTA® / BRILIQUE™* Clinical Development Lead
• **Tomas Andersson**, *BRILINTA® / BRILIQUE™* Medical Science Director

Please press *1 on your phone to indicate that you wish to ask a question