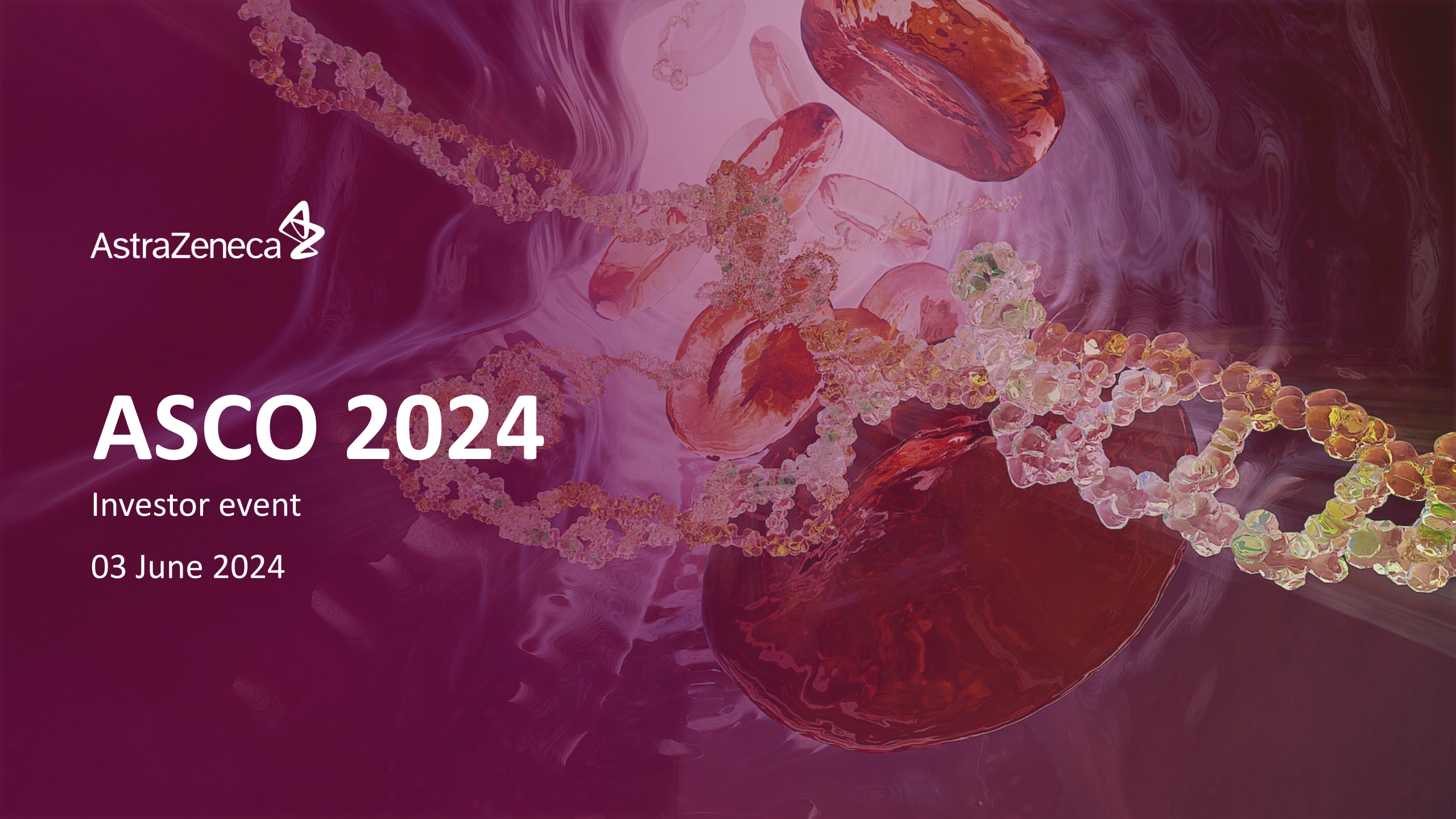

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ASCO 2024

Investor event

03 June 2024

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 or targeted revenues, margins, earnings per share or other financial or other measures (including the Financial Ambition Statements described in this presentation). Although the Group believes its expectations and targets are based on reasonable assumptions and has used customary forecasting methodologies used in the pharmaceutical industry and risk-adjusted projections for individual medicines (which take into account the probability of success of individual clinical trials, based on industry-wide data for relevant clinical trials at a similar stage of development), 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 impact 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 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 regulatory or ethical expectations on environmental impact, including climate change; 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-related risks to the Group's products; the risk of failure to achieve strategic plans or meet targets or expectations; the risk of failure in financial control or the occurrence of fraud; the risk of unexpected deterioration in the Group's financial position; the impact that global and/or geopolitical events may have, or continue to have, on these risks, on the Group's ability to continue to mitigate these risks, and on the Group's operations, financial results or financial condition There can be no guarantees that the conditions to the closing of the proposed transaction with Fusion will be satisfied on the expected timetable, or at all, or that "FPI-2265" (Ac225-PSMA I&T) or any combination product will receive the necessary regulatory approvals or prove to be commercially successful if approved. There can be no guarantees that the conditions to the closing of the proposed transaction with Amolyt Pharma will be satisfied on the expected timetable, or at all, or that eneboparatide ('AZP-3601') will receive the necessary regulatory approvals or prove to be commercially successful if approved.

This presentation includes references to new molecular entities and life-cycle management programmes that are being investigated in current or future clinical trials, and as such have not been approved by any regulatory agency. For a list of new molecular entities and indications in development, see pages 7-11 of the Clinical Trials Appendix that accompanied AstraZeneca's Q1 2024 results.

Basis of AstraZeneca ambitions, forecasts and targets

AstraZeneca ambitions, forecasts and targets in this presentation (the "Financial Ambition Statements") are derived from AstraZeneca's most recent risk-adjusted mid- and long-term plans, adjusted for developments in the business since those plans were finalised. Financial Ambition Statements presented are based on management's risk-adjusted projections for individual medicines and individual clinical trials. Estimates for these probabilities are based on industry-wide data for relevant clinical trials in the pharmaceutical industry at a similar stage of development adjusted for management's view on the risk profile of the specific asset. The peak year revenue (PYR) potential for individual medicines referred to in this presentation are the maximum estimated Total Revenue to be recognised by AstraZeneca in a single calendar year, during the lifecycle of the medicine, and are based on management's latest non-risk adjusted forecast estimates. Estimates are based on customary forecasting methodologies used in the pharmaceutical industry. Peak year revenue may occur in different years for each NME depending on trial outcomes, approval label, competition, launch dates and exclusivity periods, amongst other variables. The peak year revenue figures are derived from net sales at nominal values and are not risk-adjusted or time-value discounted. The development of pharmaceutical products has inherent risks given scientific experimentation and there are a range of possible outcomes in clinical results, safety, efficacy and product labelling. Clinical results may not achieve the desired product profile and competitive environment, pricing and reimbursement may have material impact on commercial revenue forecasts. By their nature, forecasts are based on a multiplicity of assumptions and actual performance in future years may vary, significantly and materially, from these assumptions. The Financial Ambition Statements in this presentation are based on Q1 2024 exchange rates; AZ undertakes no obligation to update those statements based on future currency movements

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AstraZeneca @ ASCO 2024

Agenda

CEO opening remarks – ***Pascal Soriot**, CEO*

AstraZeneca presence at ASCO 2024 – ***Susan Galbraith**, EVP, Oncology R&D*

Clinical Impressions Lung – ***Leora Horn,** Late Clinical Development and Global Clinical Strategy Lead, Lung Cancer, R&D (moderator)*

***Dr Charu Aggarwal,** University of Pennsylvania*

Clinical Impressions Breast – ***Ingrid Mayer,** VP, Breast and Gynecologic Cancers, R&D (moderator)*

***Dr Rebecca Dent,** National Cancer Center Singapore*

Strengthening leadership in lung and breast cancer – ***Dave Fredrickson**, EVP, Oncology*

Q&A session

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AstraZeneca @ ASCO 2024

Speakers and panelists

ASTRAZENECA LEADERSHIP

Pascal Soriot
CHIEF EXECUTIVE OFFICER

Dave Fredrickson
EXECUTIVE VICE PRESIDENT, ONCOLOGY BUSINESS

Susan Galbraith
EXECUTIVE VICE PRESIDENT, ONCOLOGY R&D

Leora Horn
LATE CLINICAL DEVELOPMENT AND GLOBAL CLINICAL STRATEGY LEAD, LUNG CANCER

Ingrid Mayer
VICE PRESIDENT, BREAST AND GYNECOLOGIC CANCERS, R&D

KEY EXTERNAL EXPERTS

Dr Charu Aggarwal
THORACIC MEDICAL ONCOLOGIST, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE

Dr Rebecca Dent
HEAD OF THE DEPARTMENT OF MEDICAL ONCOLOGY AND CHIEF OF THE BREAST MEDICAL ONCOLOGY SERVICE AT THE NATIONAL CANCER CENTER SINGAPORE

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Furthering our oncology ambition at ASCO 2024

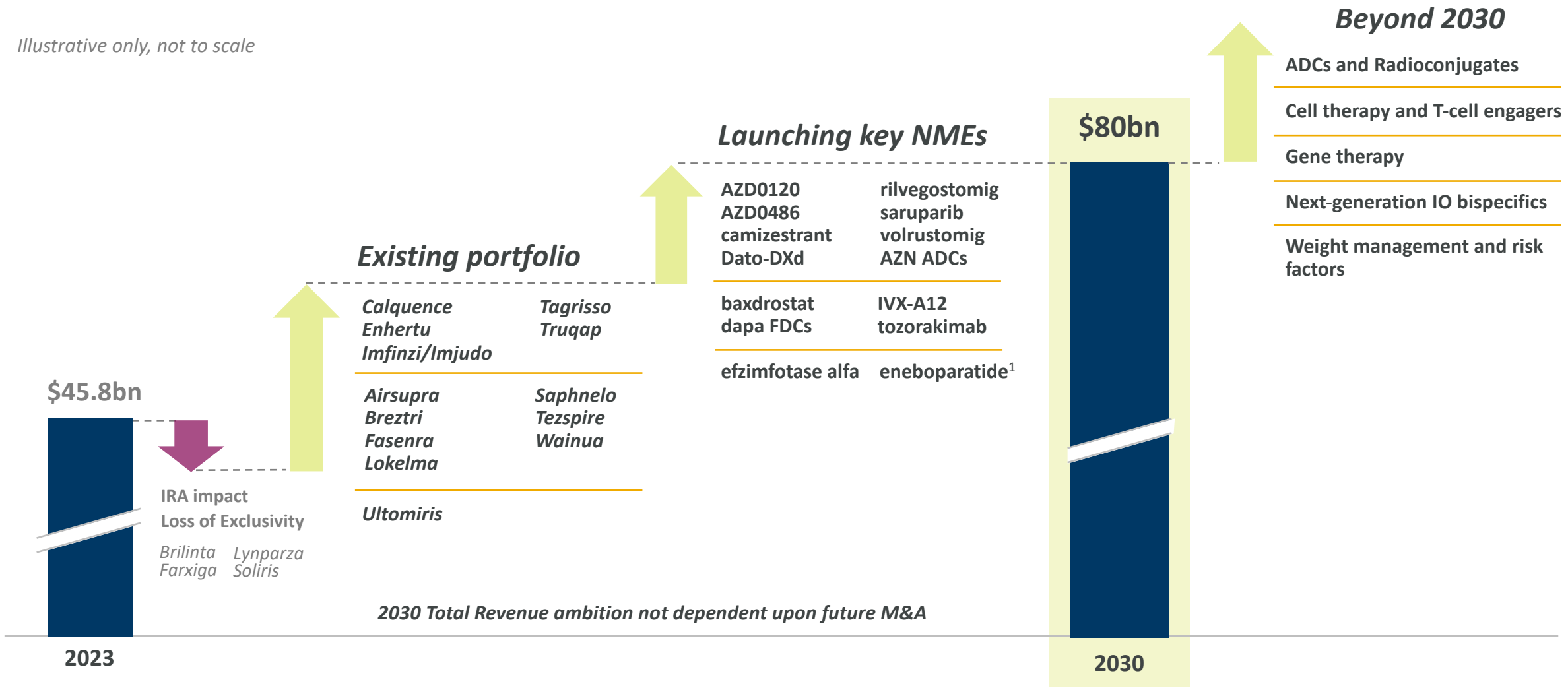
Pascal Soriot

CHIEF EXECUTIVE OFFICER

AstraZeneca

Ambition – $80bn Total Revenue by 2030 & sustained 2030+ growth

Working on “today, tomorrow and the day after"



Note: Ambition to achieve $80bn in Total Revenue by 2030 is risk-adjusted, based on latest long-range plan – see slide 3 for details.
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.
1. Amolyt Pharma acquisition remains subject to customary external clearances; all clinical development plans mentioned herein subject to deal closure.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Amgen (*Tezspire*), Ionis (*Wainua*), Compugen (rilvegostomig), Merck & Co., Inc. (*Lynparza).*

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Investing in disruptive categories to drive 2030+ growth

Weight management and risk factors	ADCs and Radioconjugates	Next-gen IO bispecifics	Cell therapy and T-cell engagers	Gene therapy and gene editing
Establish and lead in new weight management paradigm	Replace systemic chemotherapy and radiotherapy	Replace existing PD-1/ PD-L1 inhibitors	Develop scalable cell therapies and T-cell engagers across therapy areas	Make cure possible for a range of rare diseases
oGLP-1 mono and FDCs **Long-acting amylin** **GLP-1/glucagon**	**Six clinical-stage ADCs** **FPI-2265**[1]	**volrustomig** (PD-1/CTLA-4) **rilvegostomig** (PD-1/TIGIT)	**AZD0120** (BCMA/CD19) **Solid tumour cells** **AZD0486** (CD19/CD3 TCE)	**sAAVy and AAV capsid** **TALEN technology**

1. Fusion Pharmaceuticals acquisition remains subject to customary external clearances; all clinical development plans mentioned herein subject to deal closure. Collaboration partners: Compugen (rilvegostomig).

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AstraZeneca – six years in a row of plenary presentations

ASCO 2024 | DESTINY-Breast06 granted special oral LBA session

Collaboration partners: Daiichi Sankyo (*Enhertu*), Merck & Co., Inc. (*Lynparza*).

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Significant news flow across key medicines through 2025

2024

- ***Imfinzi*** ✓
  ADRIATIC
  ASCO plenary (June 2024)
- ***Tagrisso*** ✓
  LAURA
  ASCO plenary (June'24)
- ***Enhertu*** ✓
  DESTINY-Breast06
  ASCO LBA (June 2024)
- ***Calquence*** ✓
  ECHO
  MCL updated data cut
- **Dato-DXd** ✓
  TROPION-Lung01
  OS data, regulatory decision[1]
- **Dato-DXd**
  TROPION-Breast02
  1L TNBC data readout
- ***Truqap***
  CAPitello-281
  d*PTEN* prostate data readout
- ***Imfinzi***
  BR.31
  Adjuvant NSCLC data readout
- **volrustomig + CTx**
  AZ FIH Phase I/II
  updated data cut
- **rilvegostomig**
  Phase I/II ARTEMIDE-01
  1L PD-L1>1% NSCLC update
- **rilvegostomig + CTX**
  Phase I/II GEMINI
  1L gastric data cut

2025

- **Dato-DXd**
  TROPION-Breast01
  regulatory decision
- **Dato-DXd + *Imfinzi***
  AVANZAR
  1L NSCLC data readout
- ***Imfinzi* + ceralasertib**
  LATIFY
  2L NSCLC data readout
- ***Imfinzi***
  MATTERHORN
  early-stage gastric data readout
- ***Imfinzi***
  EMERALD-2
  adj. HCC data readout (≥2025)
- ***Imfinzi***
  EMERALD-3
  locoregional HCC data readout (>2025)
- ***Enhertu***
  DESTINY-Breast09
  1L HER2+ breast data readout
- ***Enhertu***
  DESTINY-Breast11
  early-stage HER2+ breast data readout
- **camizestrant**
  SERENA-4/6
  1L HR+ HER2- breast data readout (>2025)
- ***Enhertu***
  DESTINY-Lung04
  1L *HER2*m NSCLC data readout
- ***Calquence***
  AMPLIFY
  1L CLL data readout
- ***Tagrisso* + savolitinib**
  SAFFRON
  2L MET+ *EGFR*m data readout

Multiple Phase III trial initiations planned with IO bispecifics and ADC combinations over next 12-18 months

1. Regulatory decision anticipated H2 2024.

Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Compugen (rilvegostomig).

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AstraZeneca presence at ASCO 2024

Susan Galbraith
EVP, HEAD OF ONCOLOGY R&D

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2024 ASCO® ANNUAL MEETING

119 abstracts accepted

73 poster presentations

16 oral presentations

2 Plenary presentations

1 special LBA session

Key data highlights

- LAURA (Plenary LBA4)
- ADRIATIC (Plenary LBA5)
- DESTINY-Breast06 (LBA1000)
- AZD7003[1] Phase I (4019)
- TROPION-Lung02 additional follow-up (8617)
- I-SPY 2.2 (LBA501 and LBA509)
- TROPION-Breast01 PROs (1006)

1. Also known as C-CAR031. PROs = patient reported outcomes.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd).

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Key ASCO 2024 data furthers our ambition to become the leading Oncology company by 2030

Strengthening tumour area leadership

BREAST • LUNG

LAURA

Tagrisso Stg III u/r *EGFR*m NSCLC

DESTINY-Breast06

Enhertu 2L HR+, HER2-low and -ultralow

ADRIATIC

Imfinzi post-CRT LS-SCLC

TROPION-Breast01

Dato-DXd in HR+ HER2- adv. BC

Powerful combinations

ADC + IO

I-SPY 2

Dato-DXd + *Imfinzi* neoadjuvant TNBC

TROPION-Lung02

Dato-DXd + IO ± CTx

Advancing medicines in disruptive categories

CAR-T • ADCs

AZD7003[1] | armoured GPC3 CAR-T

FIH in late line liver cancer

AZD0901 | CLDN18.2

Pre-treated CLDN18.2+ gastric/GEJ

1. Also known as C-CAR031.

Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd).

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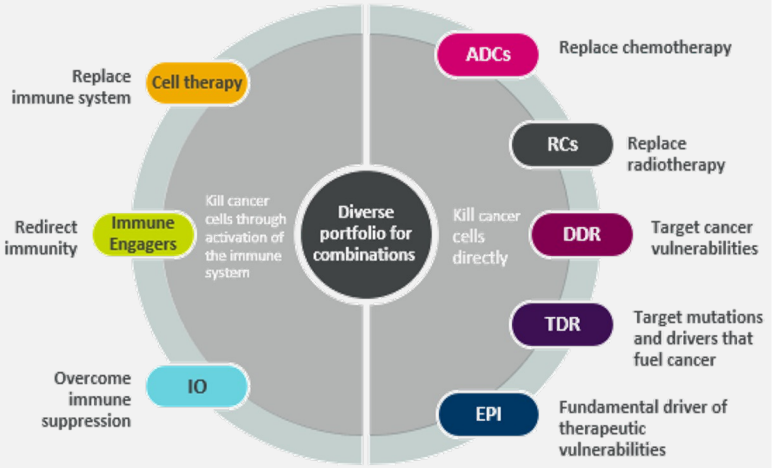
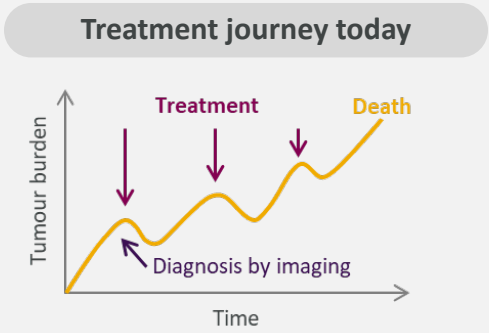
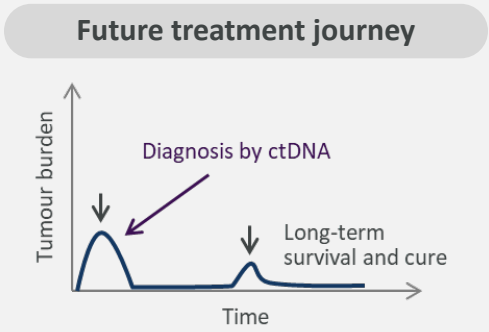
Our R&D strategy to transform patient outcomes

Attack cancer from multiple angles

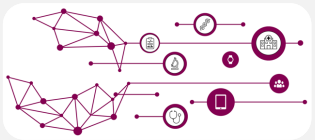


Treat earlier and smarter





Lead with innovative technology



Data and AI in clinical trials

HER2

TROP2

Accelerating computational pathology

Improving patient outcomes through digital health

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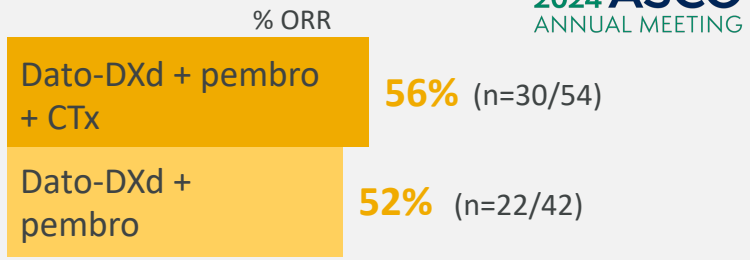
Phase I/II efficacy data reinforce Dato-DXd + IO potential in Phase III combination trials

Strong efficacy demonstrated across doublet and triplet combinations in NSCLC

2024 ASCO ANNUAL MEETING

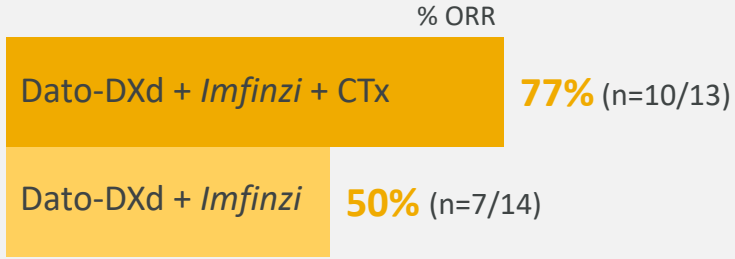
TROPION-Lung02[1]

1L advanced NSCLC



TROPION-Lung04[2]

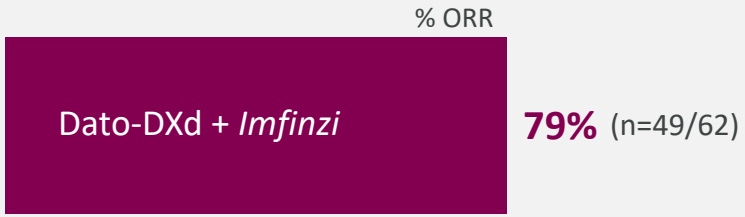
1L advanced NSCLC



Strong and consistent efficacy observed in breast cancer

BEGONIA[3]

Advanced or metastatic TNBC



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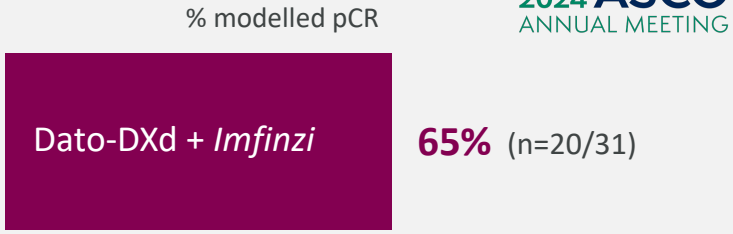
I-SPY2[4]

High-risk eBC – HER2-immune+ cohort



Data for neoadjuvant/adjuvant Dato-DXD + *Imfinzi* + platinum from NeoCOAST2.0 to be presented at upcoming 2024 congress

1. Levy BP et al. Abstract 8617 presented at American Society of Clinical Oncology 2024. 2. Papadopoulos KP et al. Abstract OA05.06 presented at World Conference on Lung Cancer 2023. 3. Schmid P et al. Abstract 379MO presented at European Society of Medical Oncology 2023. 4. Shatsky RA et al. Abstract LBA501 presented at American Society of Clinical Oncology 2024.
Collaboration partner: Daiichi Sankyo (Dato-DXd).

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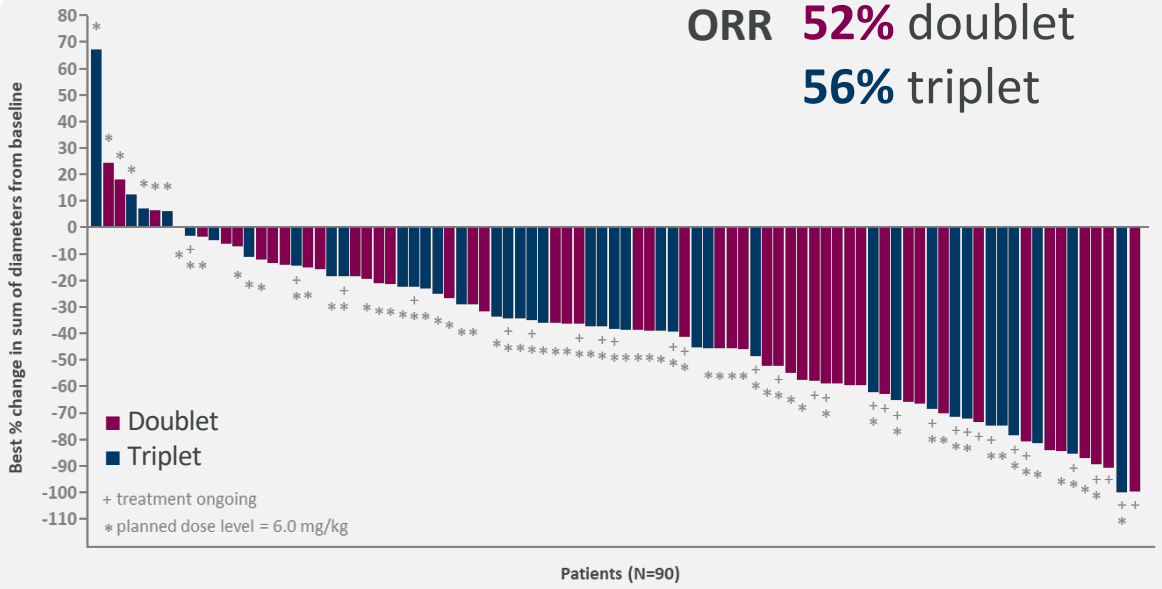
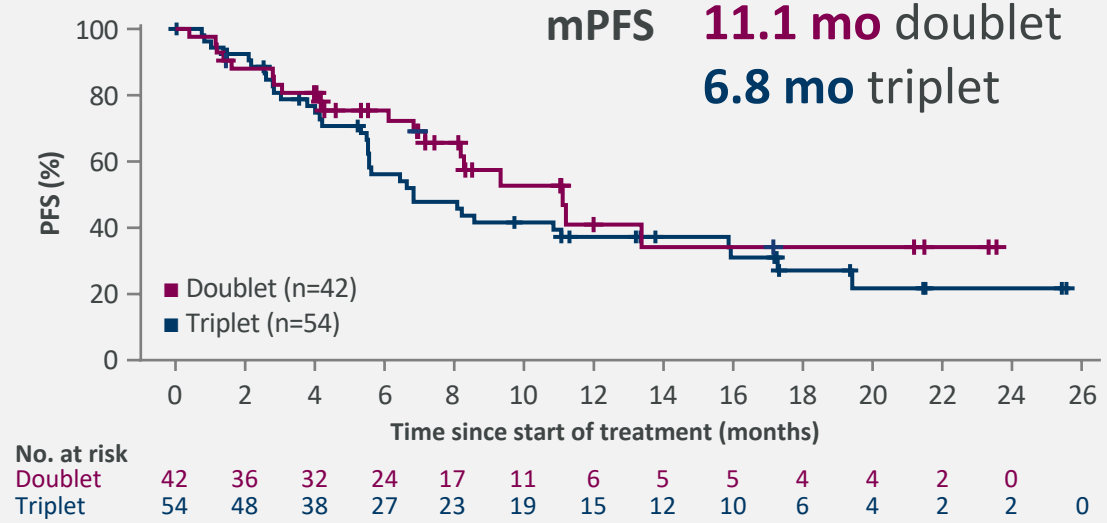
TROPION-Lung02 – Updated data support ongoing Phase III trials of Dato-DXd + IO ± CTx in 1L setting

Durable clinical response for both doublet and triplet



Encouraging PFS for doublet and triplet independent of PD-L1 status



No. at risk													
Doublet	42	36	32	24	17	11	6	5	5	4	4	2	0
Triplet	54	48	38	27	23	19	15	12	10	6	4	2	2	0

- All grade TRAEs in 93% of patients in doublet and 100% of patients in triplet arm
- Grade ≥3 TRAEs in 33% of patients in doublet and 56% of patients in triplet arm

69% patients with non-squamous histology

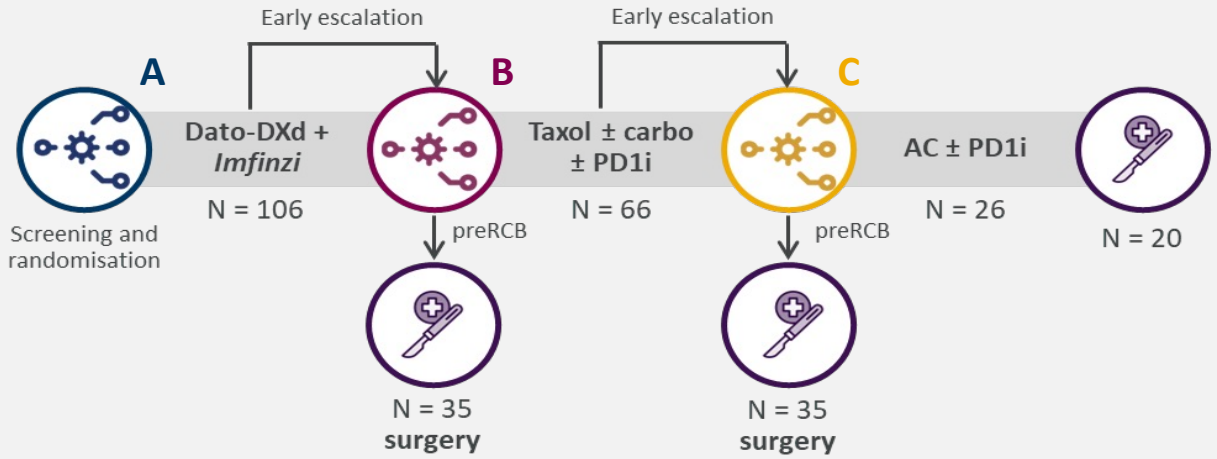
43% of patients in the doublet and 30% in the triplet arm had PD-L1 expression <1%

Patients with no baseline target lesions or no post-baseline tumour assessments were excluded from the waterfall plot. Median PFS follow-up: 8.5 months (doublet); 17.2 months (triplet).

Levy BP et al. Abstract 8617 presented at American Society of Clinical Oncology 2024.

Collaboration partner: Daiichi Sankyo (Dato-DXd).

I-SPY 2 – First IO + ADC combination showing strong pCR rates in HR+ and HR- patients with breast cancer



Efficacy of Block A only (4 cycles of Dato-DXd + *Imfinzi*)

Subtype[1]	N	pCR	Non-pCR	Modeled Rate (95% CI)	Threshold	P (>Thr)
HER2-Immune+	47	20	11	65% (47%-83%)	40%	0.99

- Phase II trial in neoadjuvant breast cancer
- Strong efficacy in neoadjuvant, Immune+ breast cancer with only 4 cycles of Dato-DXd + *Imfinzi*
- ~30% patients went to surgery at end of Block A for Dato-DXd ± *Imfinzi* cohorts, sparing subsequent chemo
- No new safety signals were observed
- Together with BEGONIA, supportive of ongoing Phase III Dato-DXd + *Imfinzi* trials
  - TROPION-Breast04, -03, -05

Reinforces potential to replace chemotherapy with Dato-DXd + IO, with reduced toxicity

Shatsky RA et al. Abstract LBA501 presented at American Society of Clinical Oncology 2024; Meisel J et al. Abstract LBA509 presented at American Society of Clinical Oncology 2024.
Collaboration partner: Daiichi Sankyo (Dato-DXd).

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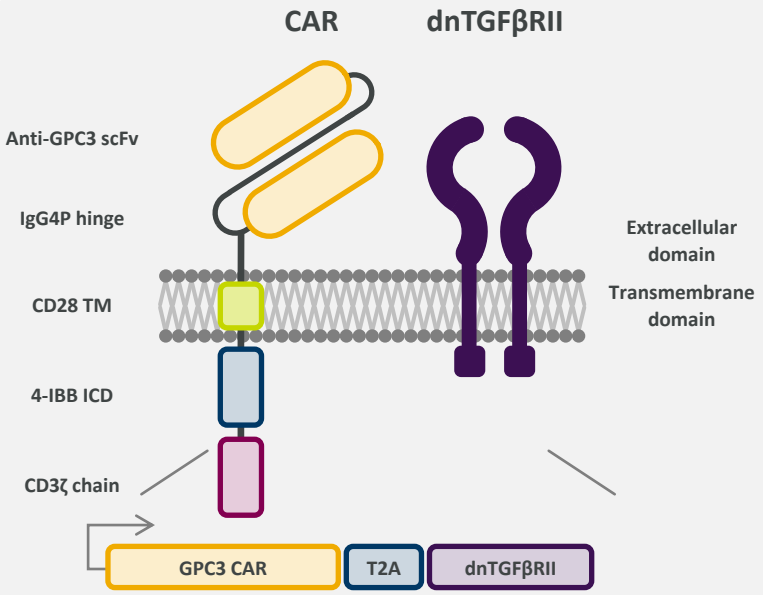
AZD7003 – GPC3-specific TGFβRIIDN armoured CAR-T

First clinical data in liver cancer, highlights potential of CAR-T in solid tumours

Differentiated vs other GPC3 CAR-Ts

Only clinical-stage CAR-T armoured with TGFβRIIDN



TGFβRIIDN armouring:

- Resists the immuno-suppressive tumour microenvironment
- Enhances the potential effectiveness CAR-T in solid tumours

FIH data from Phase I, open-label, dose escalation and expansion study conducted in China

GPC3-positive HCC

Heavily pre-treated patients
Relapsed/progressed/ intolerant to HCC systemic therapies (≥1 line)

Summary of baseline characteristics	N = 24
ECOG PS, n (%)	
0	2 (8.3)
1	22 (91.7)
Median SLD (mm)[1], (range)	73.8 (12.9, 179.4)
Median number of prior lines of therapies, (range)	3.5 (1,6)
≥ 3, n (%)	18 (75)
Received both IO and VEGF(R) inhibitors[2]	23 (95.8)

Part of AstraZeneca's innovative in-house CAR-T programme for solid tumours

AZD7003 | GPC3 | **AZD0754** | STEAP2 | **AZD4622** | Claudin 18.2

1. Per RECIST 1.1. 2. IO defined as immune checkpoint inhibitors and VEGF(R) inhibitors defined as anti-angiogenesis agents such as Bevacizumab (or its biosimilars), Tyrosine kinase inhibitors such as sorafenib, Lenvatinib, apatinib and etc.
Zhang Q et al. Abstract 4019 presented at American Society of Clinical Oncology 2024.

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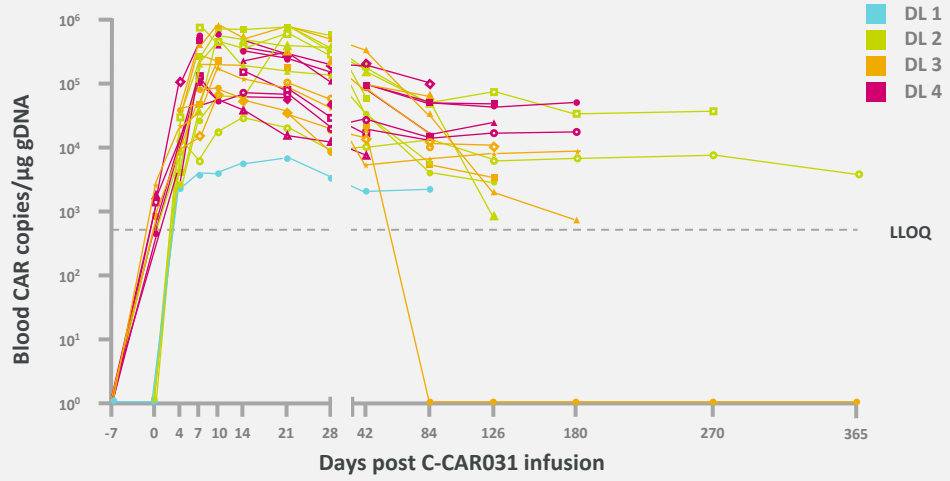
AZD7003 – Encouraging early efficacy in heavily pre-treated HCC patients with ORR 56.6% across dose levels

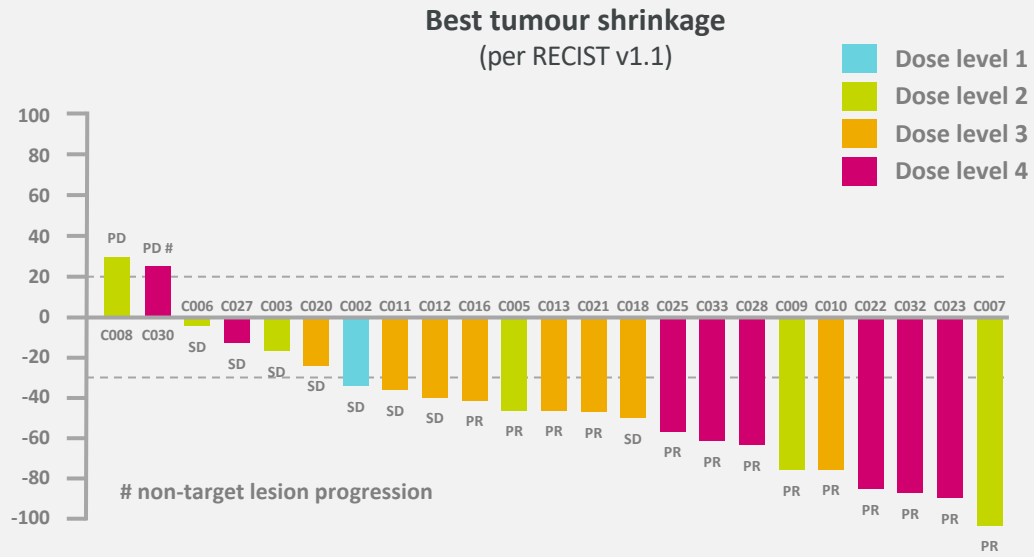
Robust cellular expansion and persistence in patients



Median CK parameters (range)

N	$AUC_{0\text{-}28\ day}$ (CAR copies/µg gDNA*day)	C_{max} (CAR copies/µg gDNA)	T_{max} (day)	T_{last} (day)
N=23	$4.5x10^6$ ($1.3x10^6$, $14.3x10^6$)	$3.9x10^5$ ($7.1x10^3$, $8.3x10^5$)	10 (7, 21)	125+ (43, 271+)

Encouraging tumour responses with mDoR of 7.36 months after median follow-up of 9.03 months



Well tolerated across all four dose levels – no incidence of ICANS and only one case of Grade 3 CRS in dose level 4

Zhang Q et al. Abstract 4019 presented at American Society of Clinical Oncology 2024.

Clinical impressions

Lung cancer

Physician fireside

Leora Horn

Global Clinical Head for Lung Cancer and Lung Cancer Strategy, AstraZeneca

Charu Aggarwal

Thoracic Medical Oncologist, University of Pennsylvania School of Medicine

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ADRIATIC

Randomised, double-blind, placebo-controlled, multi-centre global Phase III trial evaluating *Imfinzi* monotherapy and *Imfinzi* plus *Imjudo* vs placebo in limited stage SCLC

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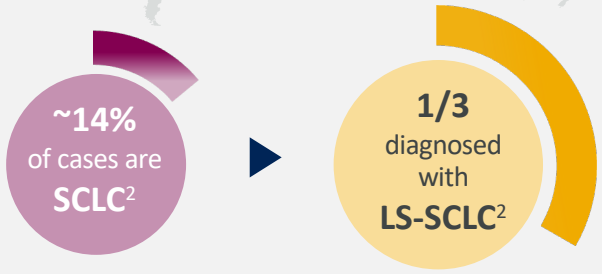
ADRIATIC Phase III first potential major advancement in systemic treatment for LS-SCLC for several decades

High unmet need in SCLC

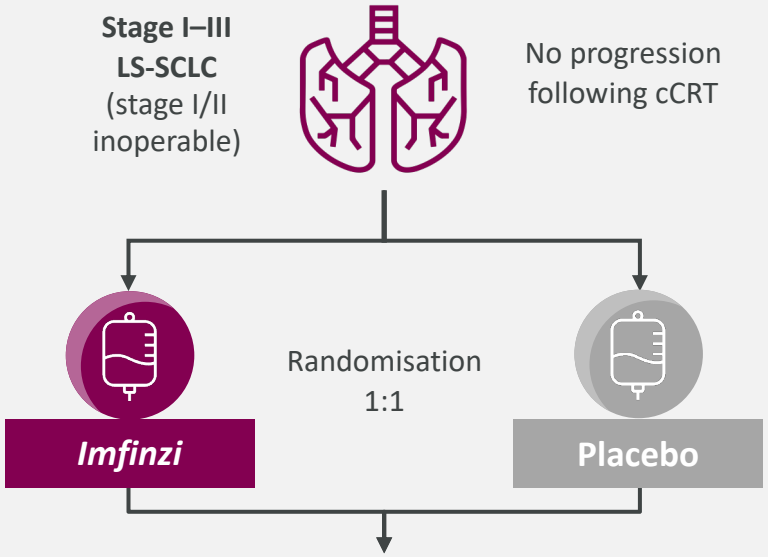
>2.4 million
new lung cancer cases
per year, globally[1]



SoC is cCRT, followed by PCI if indicated, then observation[3]

Majority experience disease relapse within 2 years[4,5]

ADRIATIC Phase III addresses limited stage-SCLC



1. Global Cancer Observatory. https://gco.iarc.who.int/media/globocan/factsheets/cancers/15-trachea-bronchus-and-lung-fact-sheet.pdf. Accessed May 2024.. 2. Cittolin-Santos GF, et al. Cancer 2024 [Epub]. 3. Dingemans, A-MC, et al. Ann Oncol 2021;32:839–53. 4. Faivre-Finn C, et al. Lancet Oncol 2017;18:1116–25; 5. Bogart J, et al. J Clin Oncol 2023;41:2394-402.
Spigel DR et al. Abstract LBA5 presented at American Society of Clinical Oncology 2024.

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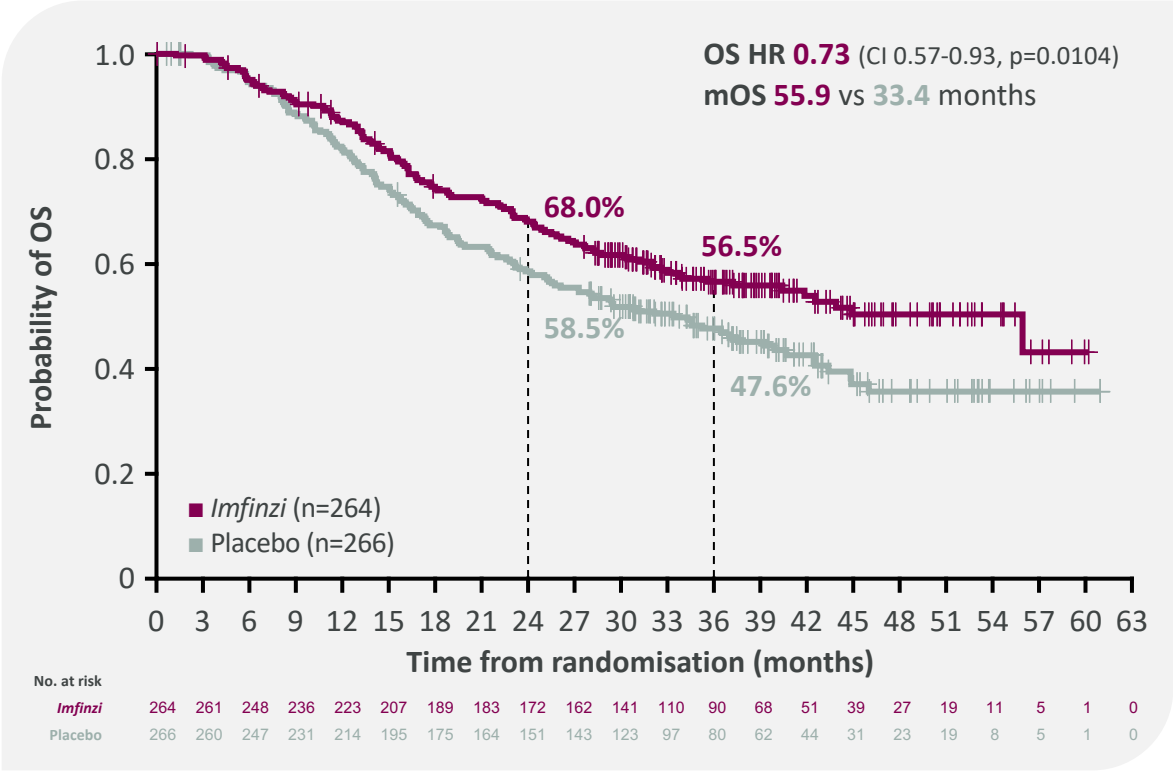
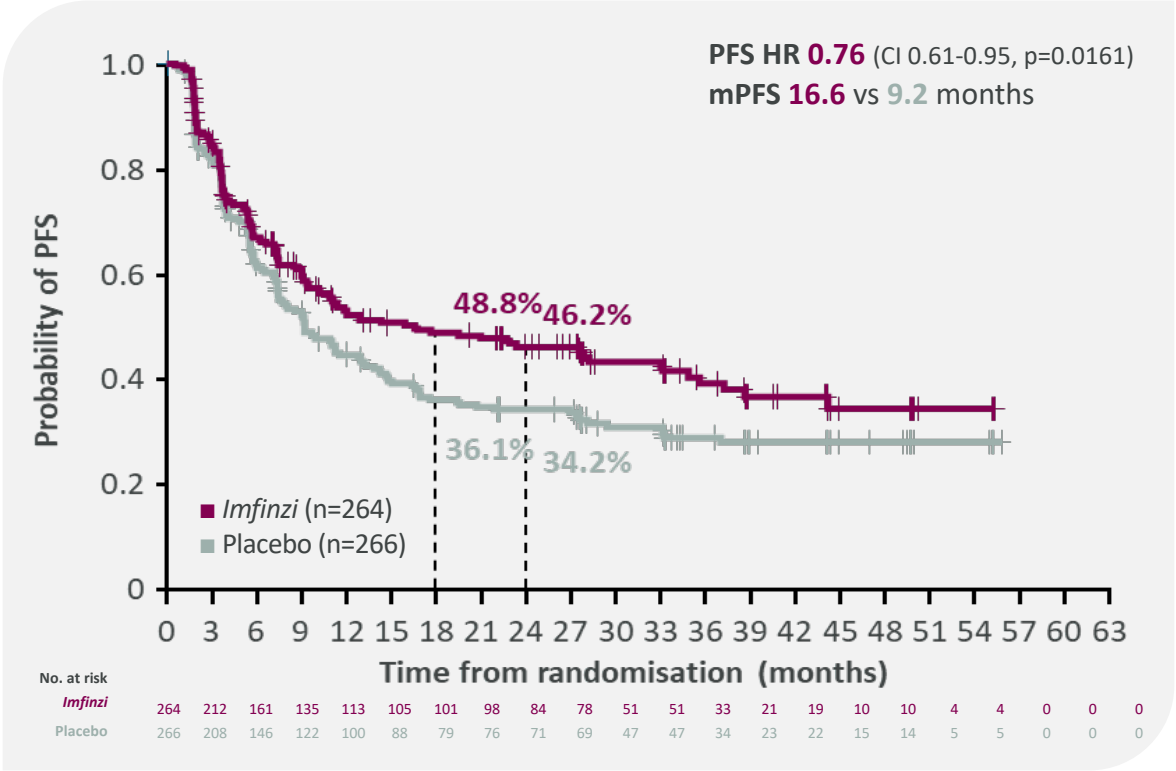
Imfinzi first and only immunotherapy to show survival benefit in limited-stage SCLC in global Phase III trial

~57% of patients treated with *Imfinzi* alive at three years



~46% of patients treated with *Imfinzi* had not experienced disease progression at two years



OS was analysed using a stratified log-rank test adjusted for receipt of PCI (yes vs no). The significance level for testing OS at this interim analysis was 0.01679 (2-sided) at the overall 4.5% level, allowing for strong alpha control across interim and final analysis timepoints. PFS assessed by BICR per RECIST, v1.1. PFS was analysed using a stratified log-rank test adjusted for disease stage (stage I/II vs III) and receipt of PCI (yes vs no). The significance level for testing PFS at this interim analysis was 0.00184 (2-sided) at the 0.5% level, and 0.02805 (2-sided) at the overall 5% level. Statistical significance for PFS was achieved through the recycling MTP framework and testing at the 5% (2-sided) alpha level (adjusted for an interim and final analysis).

Spigel DR et al. Abstract LBA5 presented at American Society of Clinical Oncology 2024.

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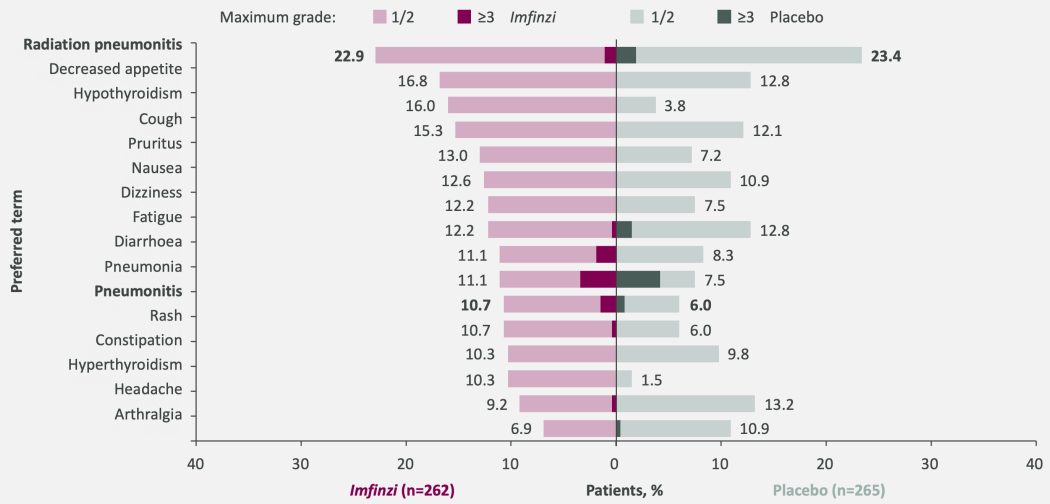
Safety profile for *Imfinzi* generally manageable and consistent with known profile

Similar rate of Grade ≥3 AEs between arms

AEs, n (%)	*Imfinzi* (n=263)	Placebo (n=265)
All grade	247 (94.3)	234 (88.3)
Grade ≥3	64 (24.4)	64 (24.2)
	78 (29.8)	64 (24.2)
Serious	43 (16.4)	28 (10.6)
Leading to discontinuation	7 (2.7)	5 (1.9)
Leading to death	2 (0.8)[3]	0
Treatment-related[1] leading to death	84 (32.1)	27 (10.2)
Grade ≥3 immune-mediated[2]	14 (5.3)	4 (1.5)

Common AEs[4] consistent with previous trials of *Imfinzi*



- Pneumonitis[5] leading to death was 0.4% in *Imfinzi* arm vs 0 in placebo arm
- Pneumonitis[5] leading treatment discontinuation was 9% in the *Imfinzi* arm vs 3% in the placebo arm

1. Assessed by investigator. 2. Defined as an AE of special interest (excluding infusion related/hypersensitivity/anaphylactic reaction) that is consistent with an immune-mediated mechanism that required treatment with systemic corticosteroids, other immunosuppressants, or endocrine therapy. 3. Causes of death were encephalopathy and pneumonitis. 4. Displayed are most common AEs occurring in ≥10% of patients in either treatment arm. 5. Includes radiation pneumonitis. Includes the preferred terms of immune-mediated lung disease, interstitial lung disease, pneumonitis, radiation fibrosis – lung, and radiation pneumonitis. Events are included irrespective of aetiology and AE management. Spigel DR et al. Abstract LBA5 presented at American Society of Clinical Oncology 2024.

LAURA

Randomised, double-blind, placebo-controlled, multi-centre, global Phase III trial evaluating *Tagrisso* vs placebo in patients with unresectable, Stage III *EGFR*m NSCLC whose disease has not progressed following definitive platinum-based CRT

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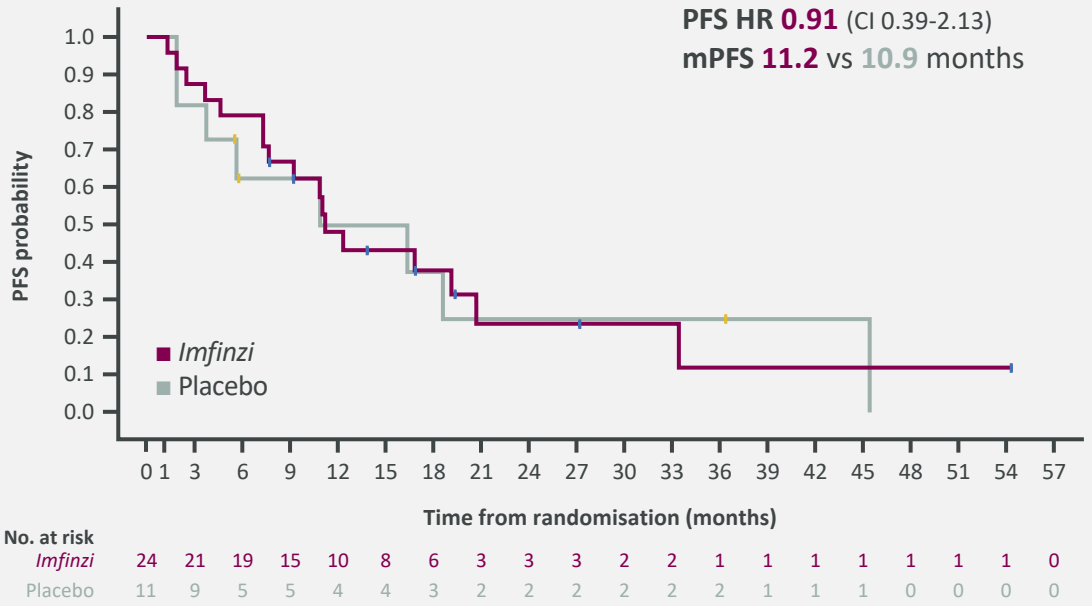
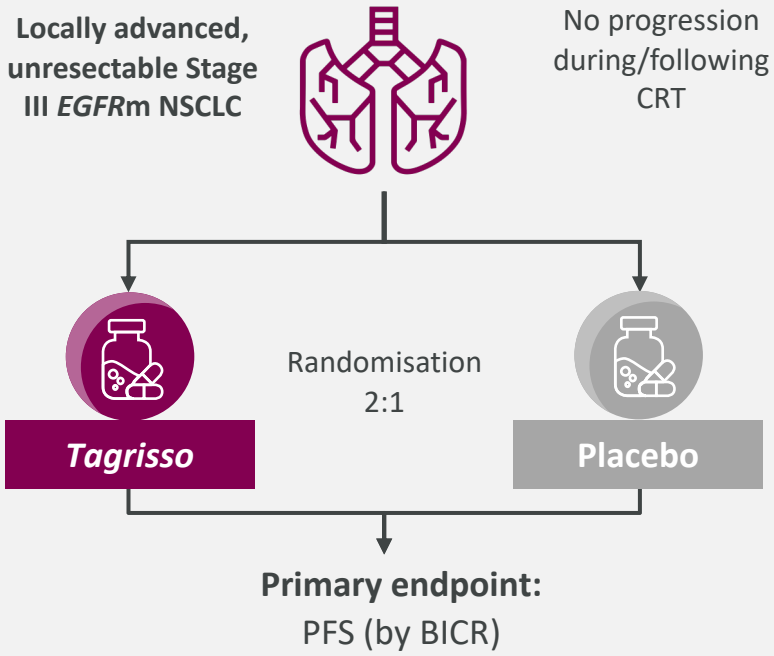
LAURA Phase III opportunity to bring *Tagrisso* to population with poorer outcomes on current SoC

Unmet need in unresectable Stage III *EGFR*m NSCLC

PACIFIC *EGFR*m post-hoc subgroup analysis[1]



LAURA Phase III addresses Stage III unresectable setting



1. Naidoo et al. J Thorac Oncol 2023;18:657–663.
Ramalingam SS et al. Abstract LBA4 presented at American Society of Clinical Oncology 2024.

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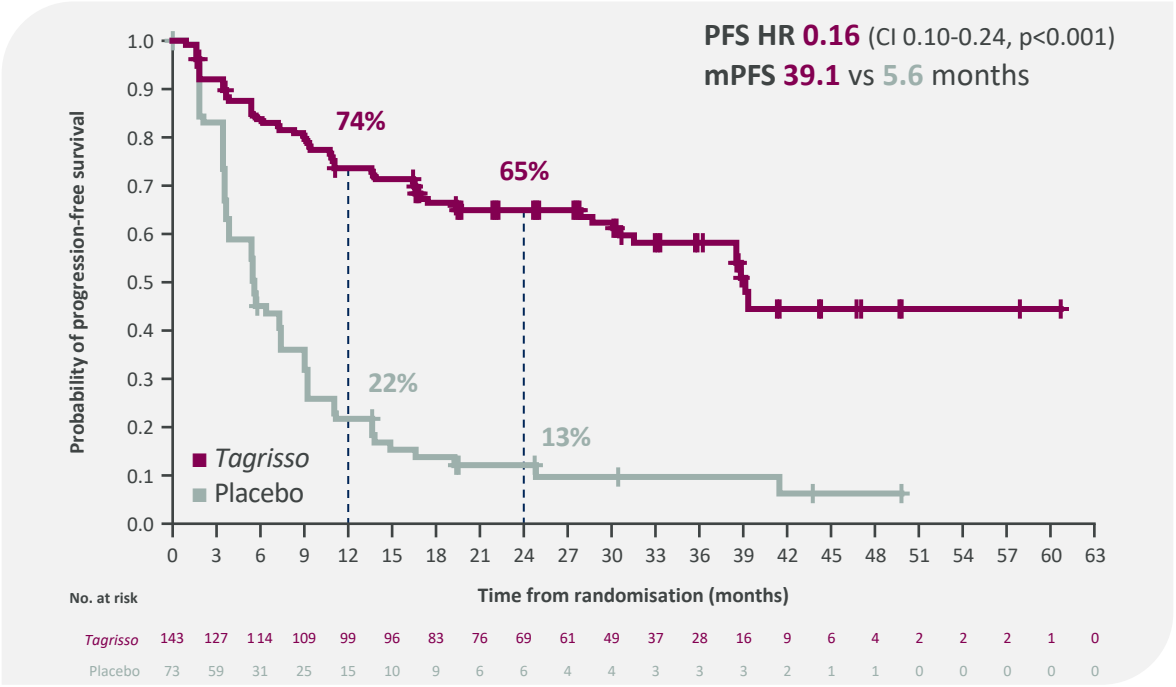
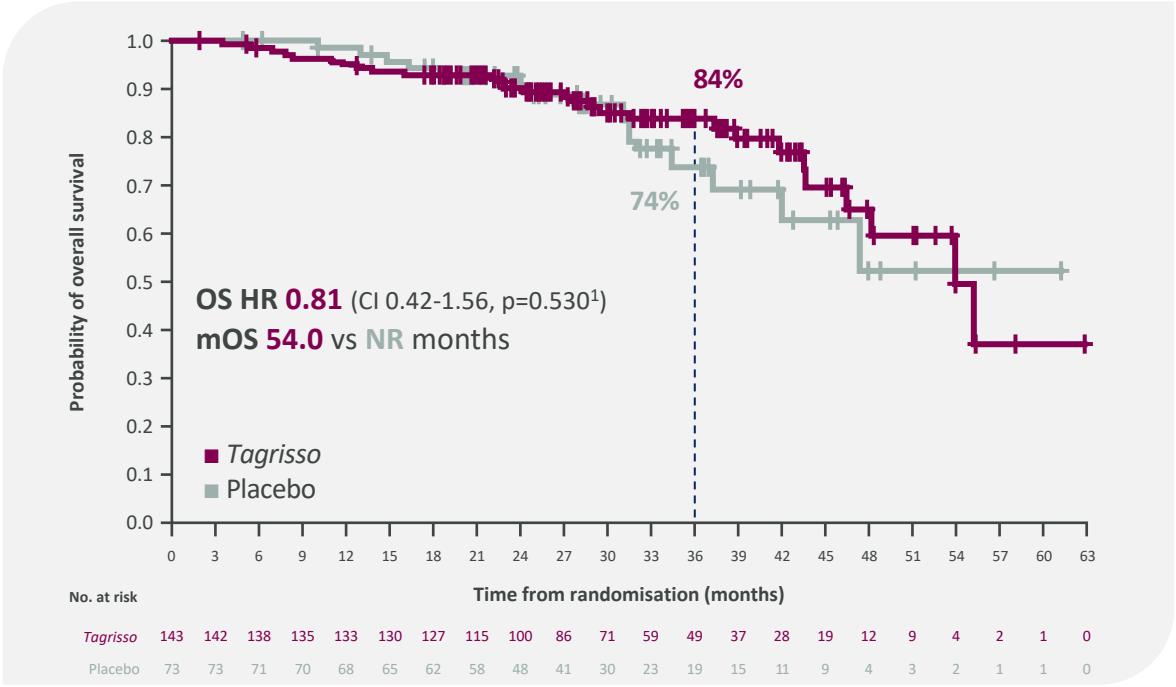
Tagrisso demonstrated overwhelming efficacy benefit in LAURA Phase III trial

Statistically significant and clinically meaningful improvement in PFS with *Tagrisso* vs placebo



Early trend to OS benefit with *Tagrisso* vs placebo



81% of patients in the placebo arm with BICR-confirmed progression crossed over to *Tagrisso*

1. For statistical significance at this interim analysis, a p-value of <0.00036 was required.

Ramalingam SS et al. Abstract LBA4 presented at American Society of Clinical Oncology 2024.

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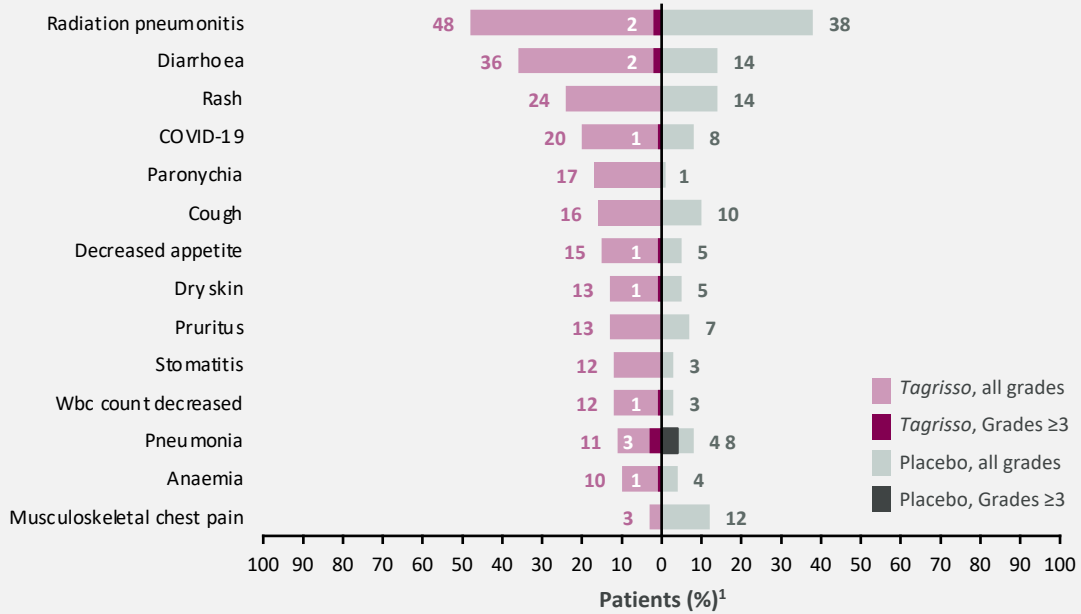
Safety profile of *Tagrisso* post-CRT was as expected and manageable

Low discontinuation rate for *Tagrisso*

	Tagrisso (n=143)	Placebo (n=73)
Any AE	140 (98)	64 (88)
Any AE Grade ≥3	50 (35)	9 (12)
Any AE leading to death	3 (2)	2 (3)
Any serious AE	55 (38)	11 (15)
Any AE leading to discontinuation	18 (13)	4 (5)
Any AE leading to dose reduction	12 (8)	1 (1)
Any AE leading to dose interruption	80 (56)	18 (25)

Consistent AE profile with previous *Tagrisso trials*



- ILD[2] was reported in 11 (8%) patients in the *Tagrisso* arm. The majority were Grades 1/2; Grade 5 (n=1)

1. Median duration of exposure: *Tagrisso* 24.0 months, placebo 8.3 months. AEs with incidence of 10% or more in either treatment arm are shown. Patients with multiple events in the same category counted only once in that category. Patients with events in more than one category are counted once in each of those categories. Includes AEs with an onset date on or after the date of first dose and up to and including 28 days following the discontinuation of study treatment and before starting subsequent cancer therapy.
2. Interstitial lung disease (grouped term) was reported in 1 patient (1%) in placebo arm; AE was pneumonitis, Grade 1.
Ramalingam SS et al. Abstract LBA4 presented at American Society of Clinical Oncology 2024.

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Clinical impressions

Breast cancer

Physician fireside

Ingrid Mayer

Global Clinical Strategy Head,
Breast and Gynaecological Cancers
AstraZeneca

Rebecca Dent

Head of the Department of Medical Oncology and Chief of the Breast Medical Oncology Service at the National Cancer Center Singapore

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DESTINY-Breast06

Randomised, open-label, Phase III trial in patients with HR-positive, HER2-low or HER2-ultralow advanced or metastatic breast cancer evaluating *Enhertu* vs investigator's choice of chemotherapy

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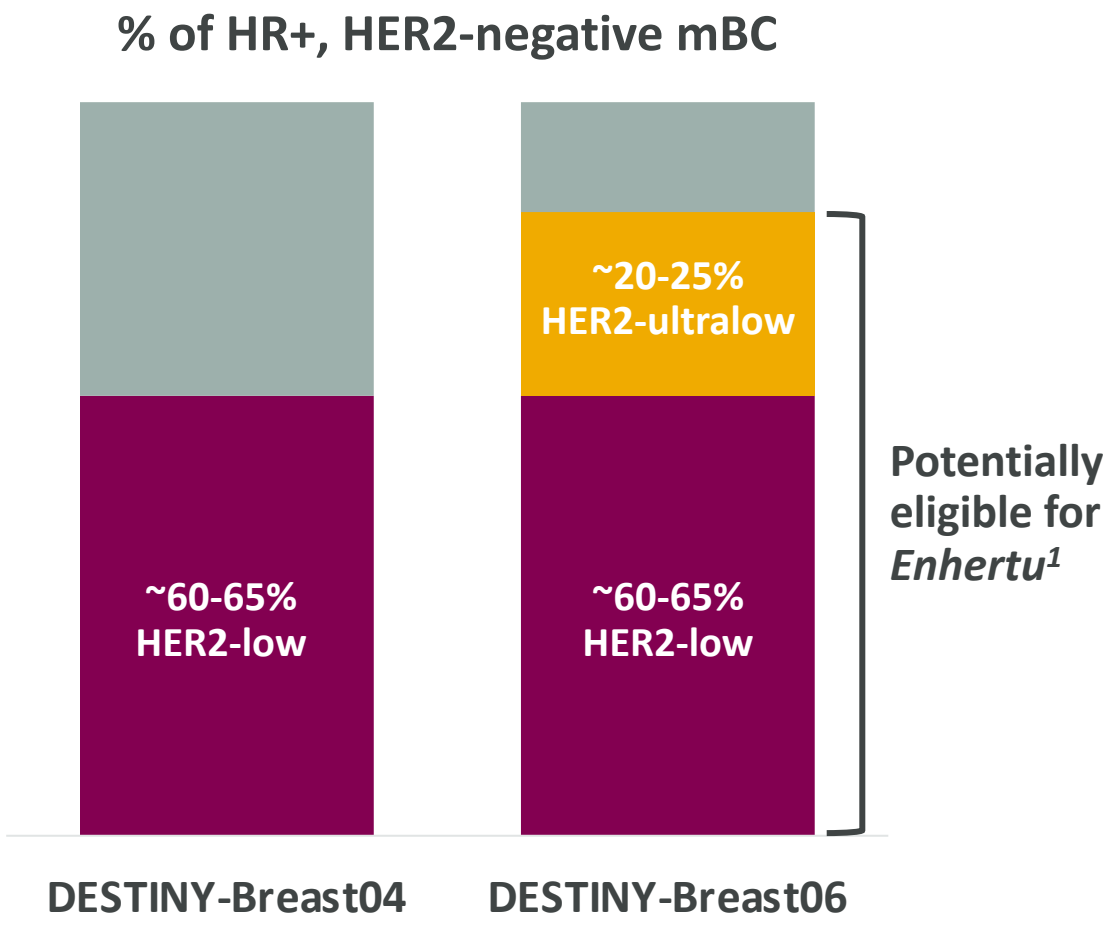
Enhertu demonstrated efficacy in HER2-low mBC in an earlier line of treatment to DESTINY-Breast04



- *Enhertu* demonstrated efficacy in **HER2-low mBC** in an **earlier line of treatment** to DESTINY-Breast04
- Including HER2-ultralow, the proportion of patients who could benefit from *Enhertu* is **~85% of HR+, HER2-negative mBC** after DESTINY-Breast06

In DESTINY-Breast06, *Enhertu* demonstrated a statistically significant and clinically meaningful PFS benefit vs TPC (CTx) in HR+, HER2-low mBC after ≥1 endocrine-based therapy, with consistent results in HER2-ultralow mBC

1. As a percentage of HR+, HER2-negative mBC.

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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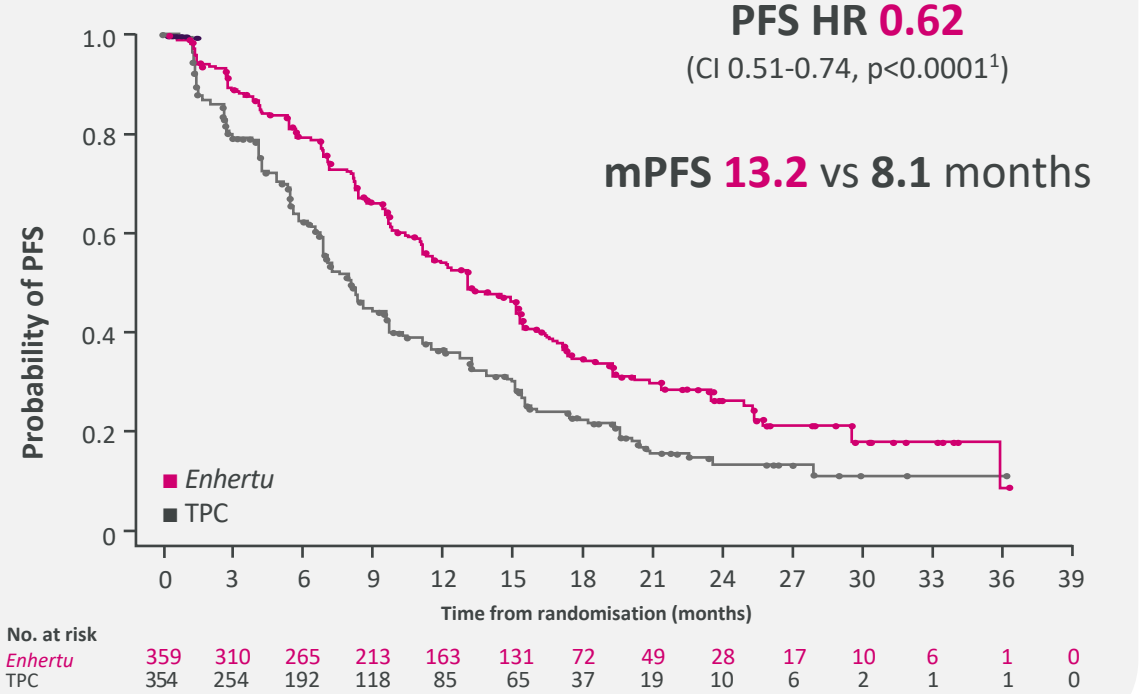
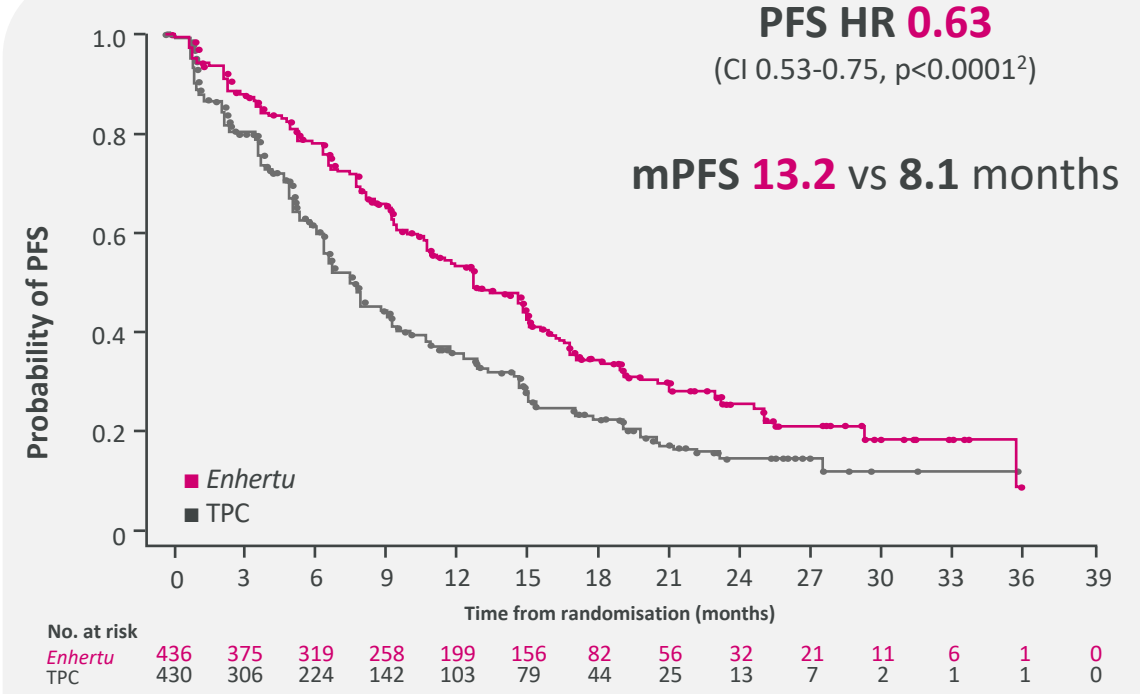
Statistically significant and clinically meaningful PFS improvement with *Enhertu* vs TPC in HER2-low and ITT

HER2-low PFS



ITT PFS (HER2-low + HER2-ultralow)



1. P-value of <0.05 required for statistical significance. 2. P-value of <0.015 required for statistical significance.

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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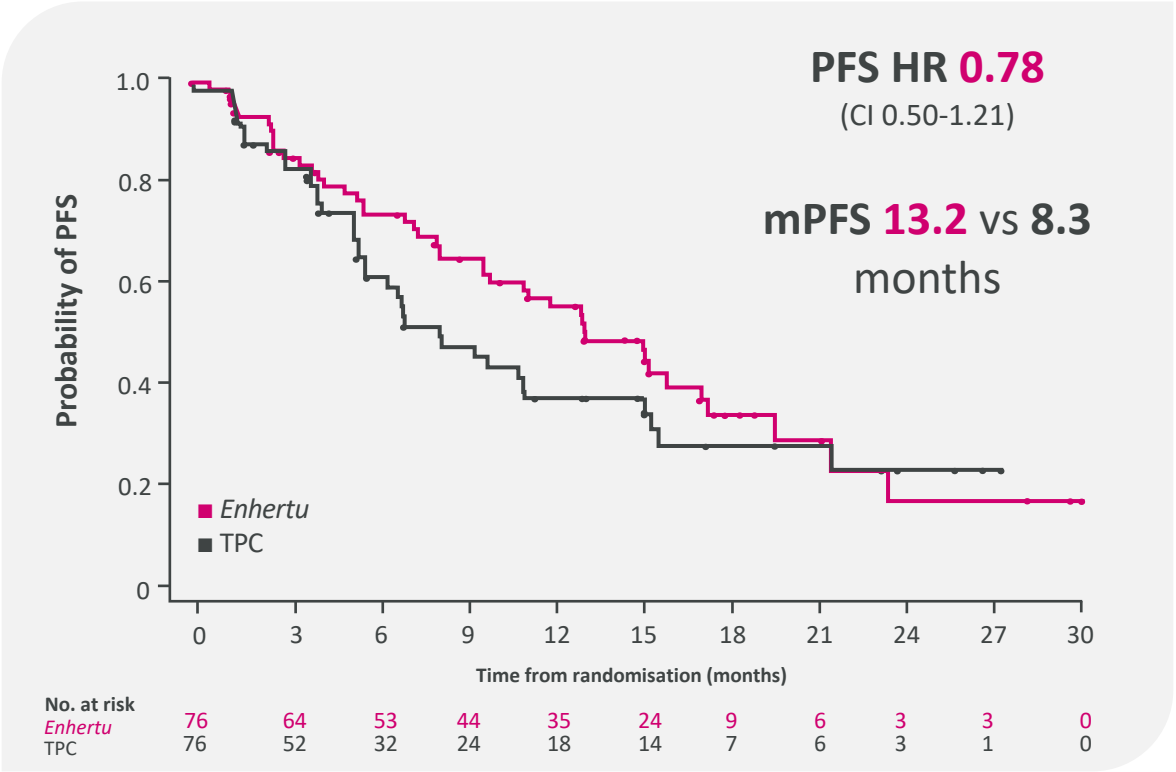
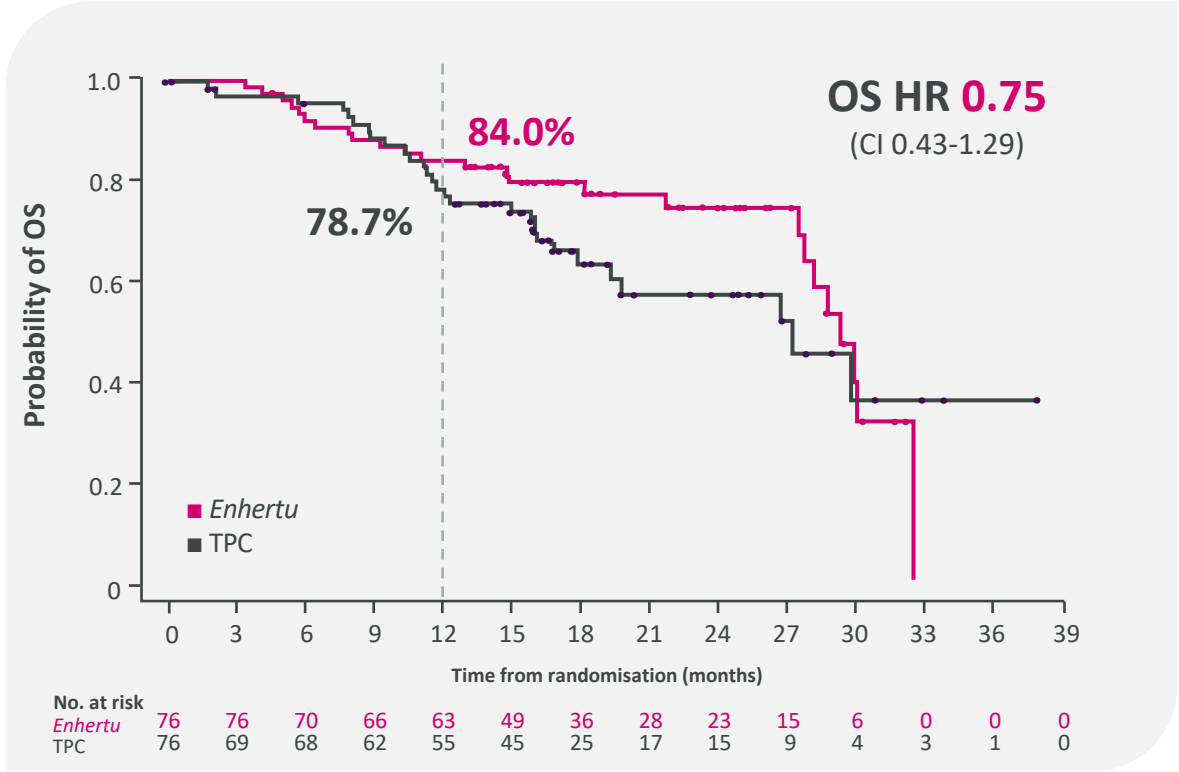
Clinically meaningful PFS improvement with *Enhertu* vs TPC consistent between HER2-low and -ultralow disease

HER2-ultralow PFS (BICR) (N=152)



HER2-ultralow OS[1] (N=152)



1. 34.9% maturity (of total N for population) at this first interim analysis; median duration of follow up was 16.8 months.

Enhertu safety profile consistent with known profile; details of the *Enhertu* safety and tolerability profile in DESTINY-Breast06 can be found in the Appendix of this presentation.

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

AstraZeneca

Strengthening our leadership in lung and breast

Dave Fredrickson

EVP, HEAD OF ONCOLOGY

AstraZeneca

Our commercial strategy to transform cancer outcomes

Medicines that matter
Building transformative brands

TAGRISSO®
Lynparza®
IMFINZI® / IMJUDO™
CALQUENCE®
ENHERTU®
Zoladex
Truqap™

Leveraging scale
Tumour area leadership

- Lung
- Haematology
- GYN/GU
- Breast
- Gastrointestinal

Transforming patient care
Closing the care gap

- Early detection
- Precision diagnostics
- Guideline-based treatment
- Patient experience

Collaboration partner: Daiichi Sankyo (*Enhertu*, Dato-DXd).

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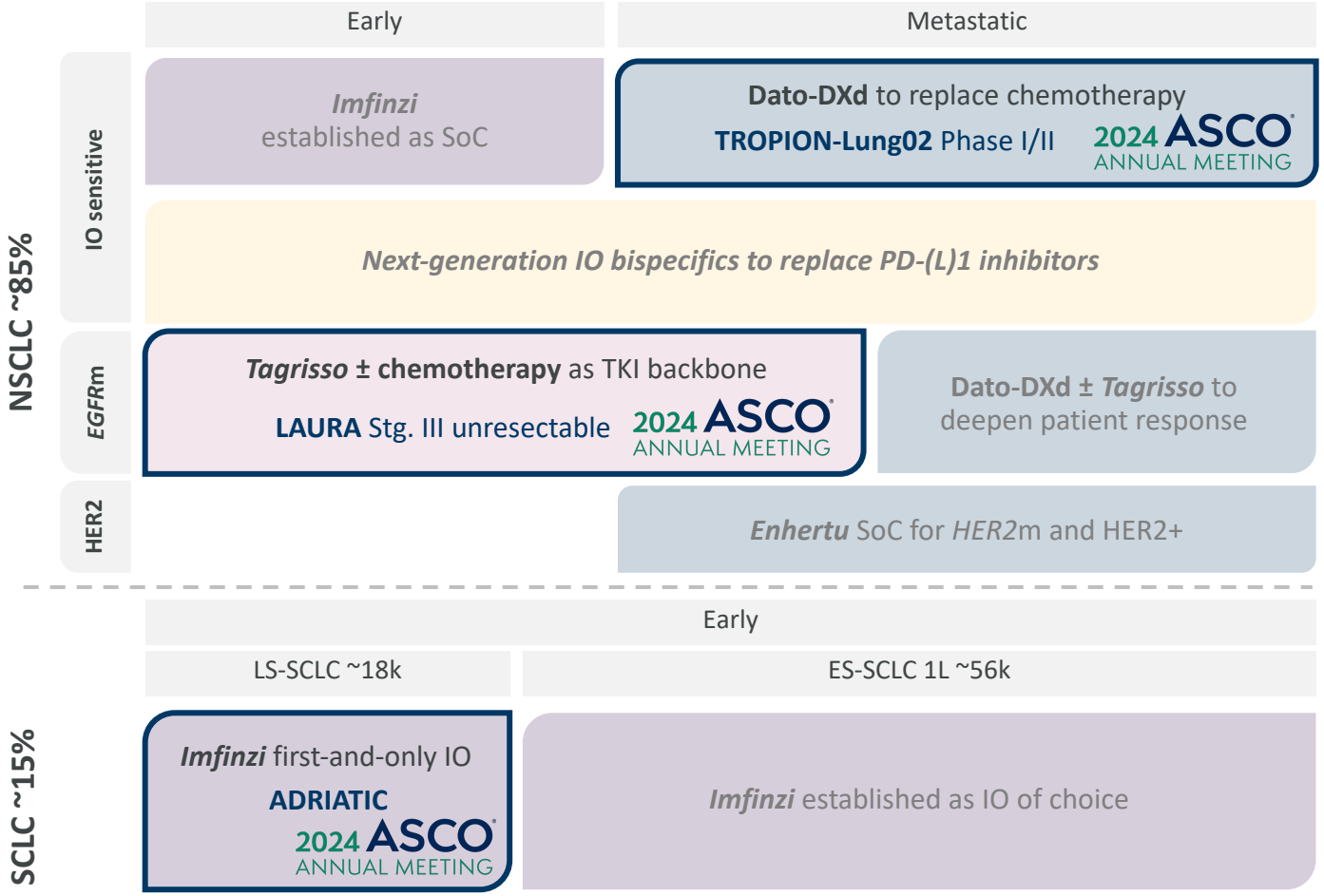
AstraZeneca @ ASCO 2024

Key data furthers ambition to redefine treatment of lung cancer



I. Replace systemic chemotherapy with ADCs
   - **TROPION-Lung02 updated data cut reinforce confidence in 1L Phase III trials**

II. Replace PD-(L)1 with next-generation IO bispecifics

III. Leverage biomarker understanding to drive adoption of targeted medicines
   - **LAURA expands in early-stage and strengthens *Tagrisso* as backbone TKI**

IV. Establish *Imfinzi* as IO of choice in SCLC
   - **ADRIATIC first innovation in >3 decades, establishes IO post-CRT**

Illustrates abbreviated tumour map featuring key data at ASCO 2024; full lung cancer tumour map available in Appendix of this presentation.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd).

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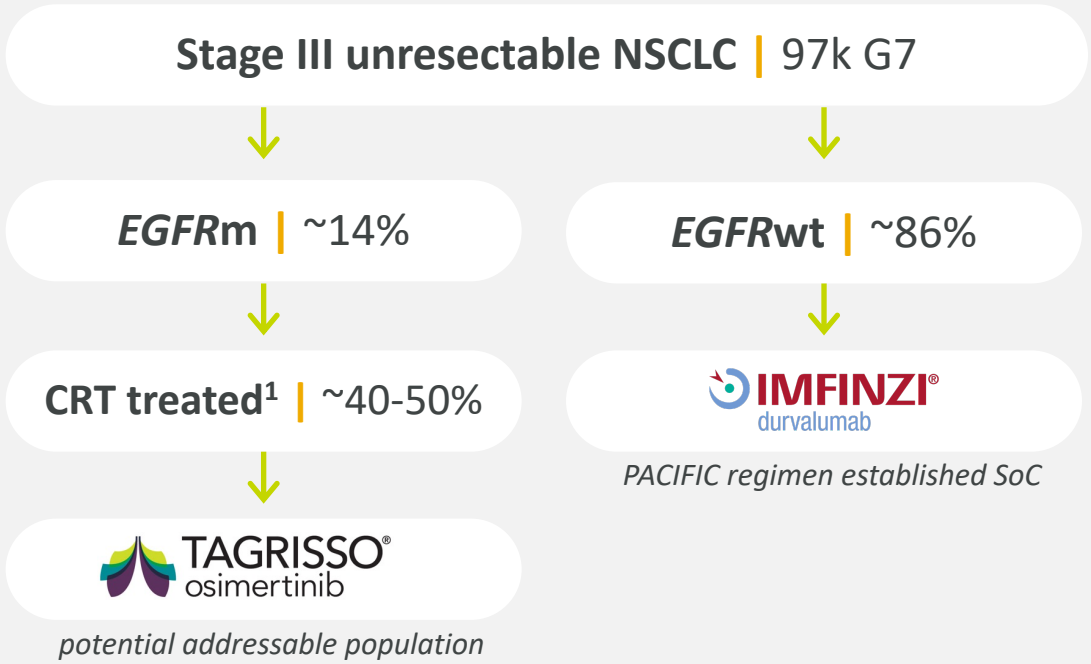
LAURA – *Tagrisso* expanding presence in early-stage, potential SoC Stg. III unresectable EGFRm NSCLC



- **Significant unmet need in *EGFR*m patients**
  - CRT alone has increased risk of distant recurrence
  - IO post-CRT limited additional benefit in *EGFR*m
- **Clear path to unlock value and drive new SoC**
  - Maximise *EGFR*m testing rates at diagnosis
  - Drive engagement and LAURA adoption across multi-disciplinary teams
  - Reinforce treatment to progression, maximise patient adherence

LAURA represents potential blockbuster opportunity

1. Includes % patients eligible for CRT treatment, % patients successfully completing CRT and % patients treated with maintenance therapy.

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ADRIATIC – *Imfinzi* first-and-only IO in LS-SCLC and first novel innovation in over three decades

>2.4 million
new lung cancer cases diagnosed globally[1]

~14%
of cases are **SCLC**[2]

1/3
diagnosed with **LS-SCLC**[2]

cCRT is SoC, survival outcomes remain poor

50% thoracic recurrence at 2 years[3]

19% CNS recurrence at 2 years[3]

ADRIATIC reinforces *Imfinzi* foundation in SCLC, built on support from CASPIAN, PACIFIC

CASPIAN established SoC

ADRIATIC

- **PACIFIC** (u/r Stg. III NSCLC) *Imfinzi* post-CRT showed significant improvement in OS
- **CASPIAN** (ES-SCLC) supported rationale for *Imfinzi* monotherapy arm in ADRIATIC
- **ADRIATIC (OS HR, 0.73, PFS HR, 0.76) *Imfinzi* potential SoC in LS-SCLC**

1. Global Cancer Observatory. https://gco.iarc.who.int/media/globocan/factsheets/cancers/15-trachea-bronchus-and-lung-fact-sheet.pdf.. Accessed May 2024. 2. Cittolin-Santos GF, et al. Cancer 2024 [Epub]. 3. Ellis PM, et al. Curr Oncol. 2021;28:2778-2788.

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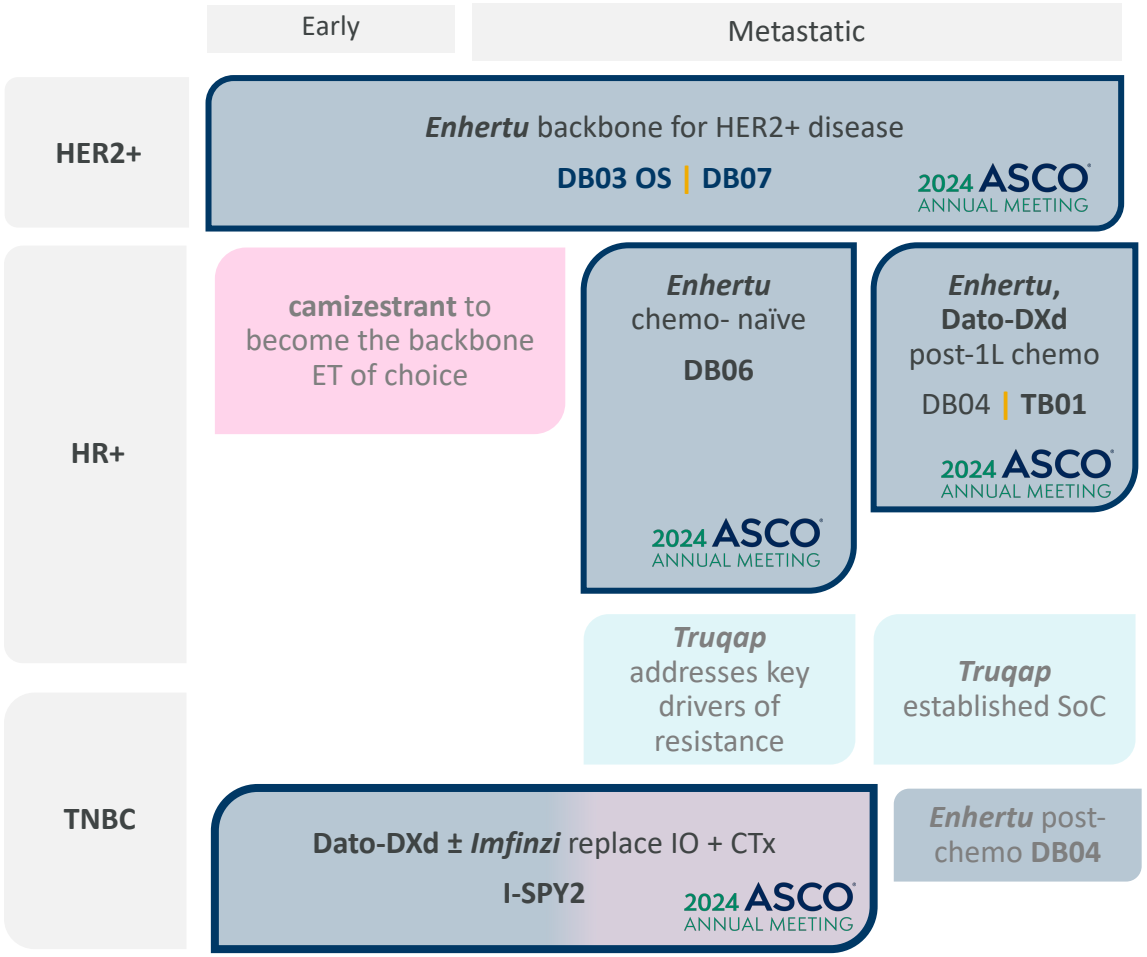
AstraZeneca @ ASCO 2024

Key data furthers ambition to redefine treatment of breast cancer



I. Address full spectrum of HR+ disease through targeted medicines and novel combinations
   - ER drive exists – deliver best-in-class ET, seek to extend benefit of ET
   - ER-driven disease is absent – replace systemic chemotherapy with ADCs
     - **DESTINY-Breast03** OS
     - **DESTINY-Breast07** benefit in HER2+ mBC, support for ongoing DESTINY-Breast09
     - **DESTINY-Breast06** moves *Enhertu* earlier, expands into HER2-ultralow
     - **TROPION-Breast01** Patient Reported Outcomes

II. Redefine TNBC – identifying subsets of patients with actionable features
   - **I-SPY 2** benefit of *Imfinzi* ± Dato-DXd in neoadjuvant, support for TROPION-Breast04

Illustrates abbreviated tumour map featuring key data at ASCO 2024; full breast cancer tumour map available in Appendix of this presentation.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd).

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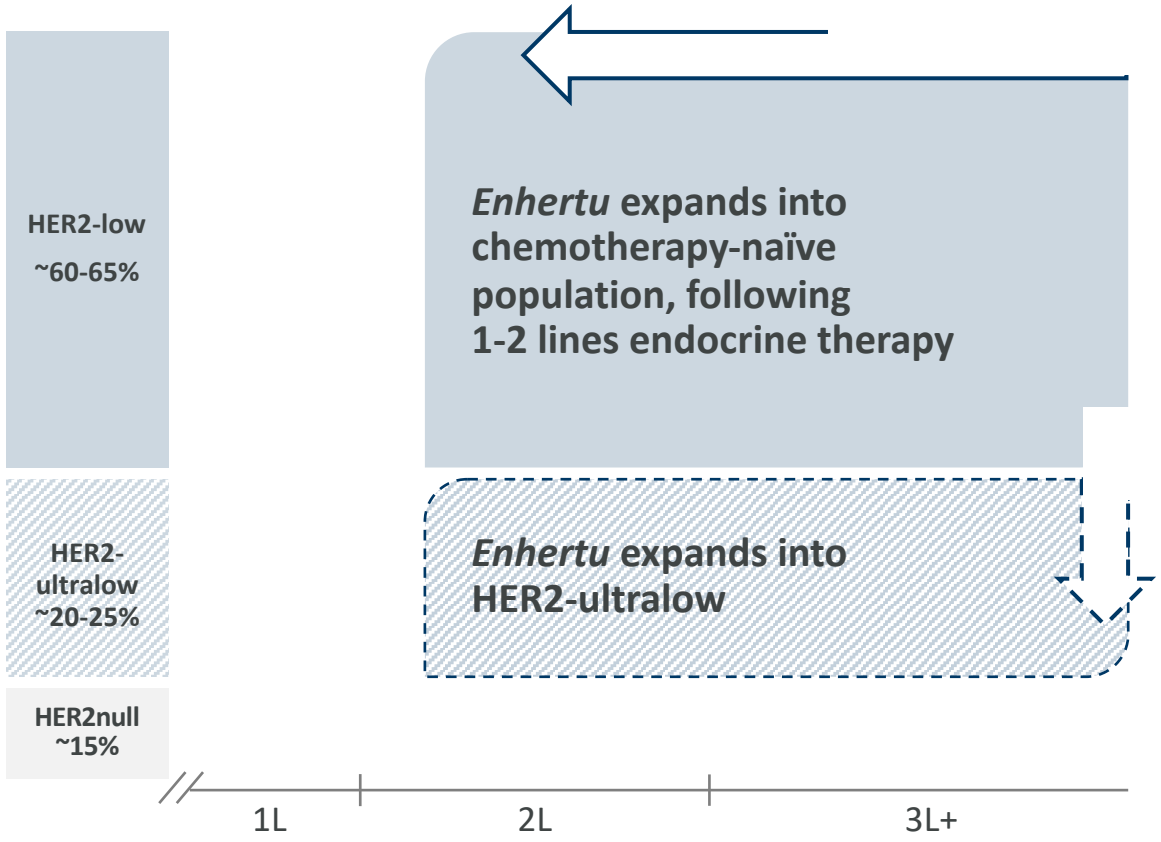
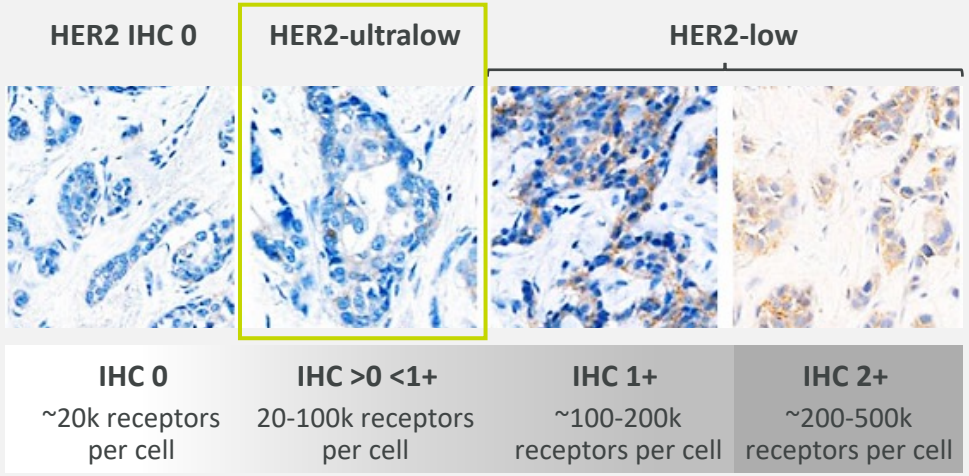
DESTINY-Breast06 – *Enhertu* moving into 2L and expanding into HER2-ultralow breast cancer





Opportunity to build understanding of HER2-ultralow pathology to reach full addressable population

55-60k patients with HER2-low or -ultralow HR+ mBC that have received prior ET and are chemotherapy-naïve[1]

1. Estimated for G7 countries. All numbers are approximate. Illustrative settings and populations, not to scale.
AstraZeneca data on file; Tarantino P, et al. J Clin Oncol. 2020; Schettini F, et al. NPJ Breast Cancer. 2021; Owens et al., Clinical Breast Cancer 2004; Lambein et al., American Journal of Clinical Pathology 2013, CAncerMPACT (2017); Schettini et al. ESMO BC 2020; Nuciforo et al., Molec Onc. 10, 2016; Scott et al. ASCO 2021 Abstract #1021.
Collaboration partner: Daiichi Sankyo (*Enhertu*).

Q&A session

ASTRAZENECA LEADERSHIP

Pascal Soriot
CEO, ASTRAZENECA

Susan Galbraith
EVP, ONCOLOGY R&D

Dave Fredrickson
EVP, ONCOLOGY

Cristian Massacesi
CHIEF MEDICAL OFFICER AND ONCOLOGY CHIEF DEVELOPMENT OFFICER

Sunil Verna
SVP, GLOBAL HEAD OF ONCOLOGY, MEDICAL

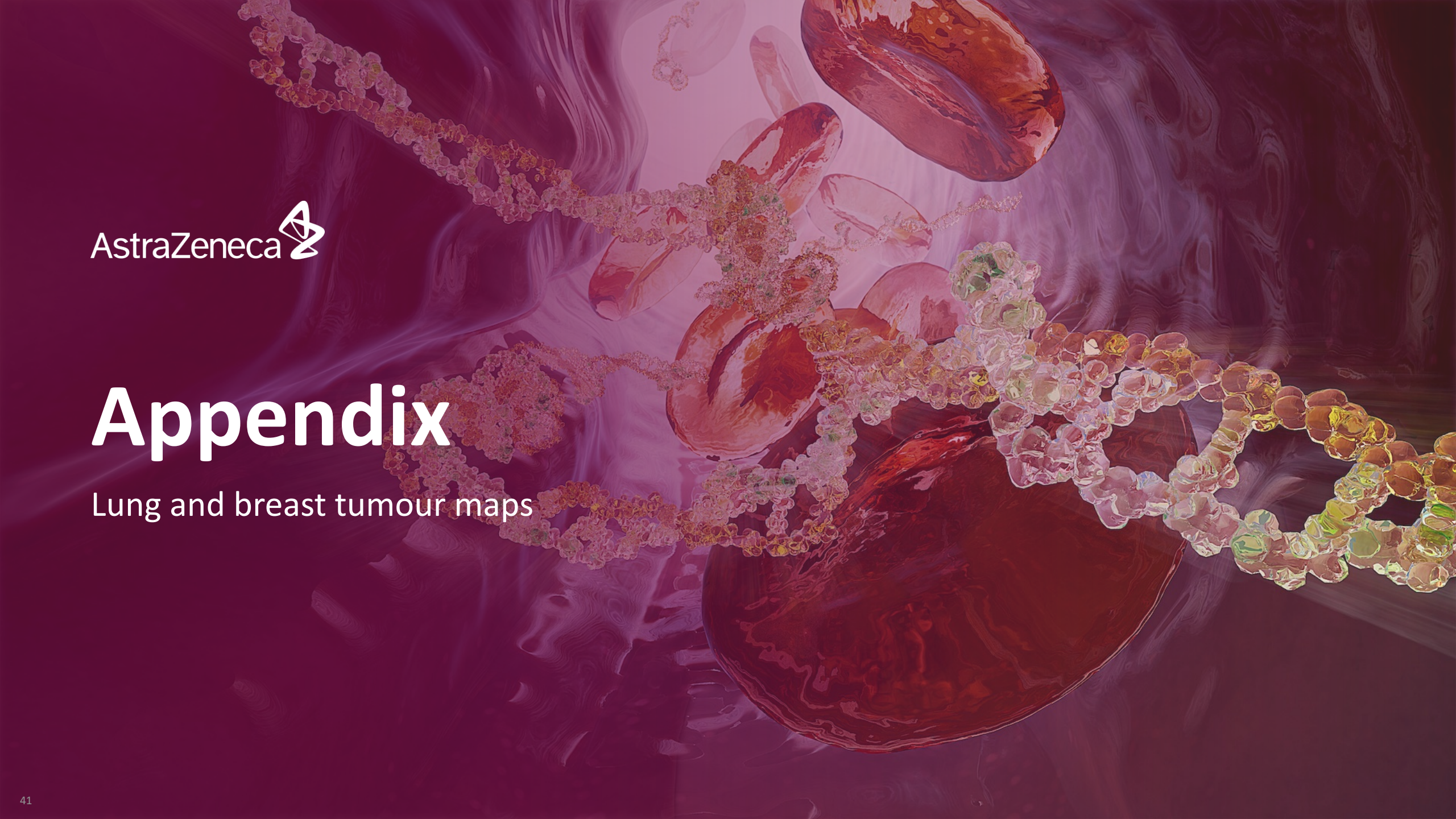
Leora Horn
LATE CLINICAL DEVELOPMENT AND GLOBAL CLINICAL STRATEGY LEAD, LUNG CANCER

Ingrid Mayer
VP, BREAST AND GYNECOLOGIC CANCERS, R&D

KEY EXTERNAL EXPERTS

Dr Charu Aggarwal
MEDICAL ONCOLOGIST, LUNG CANCER

Dr Rebecca Dent
MEDICAL ONCOLOGIST, BREAST CANCER

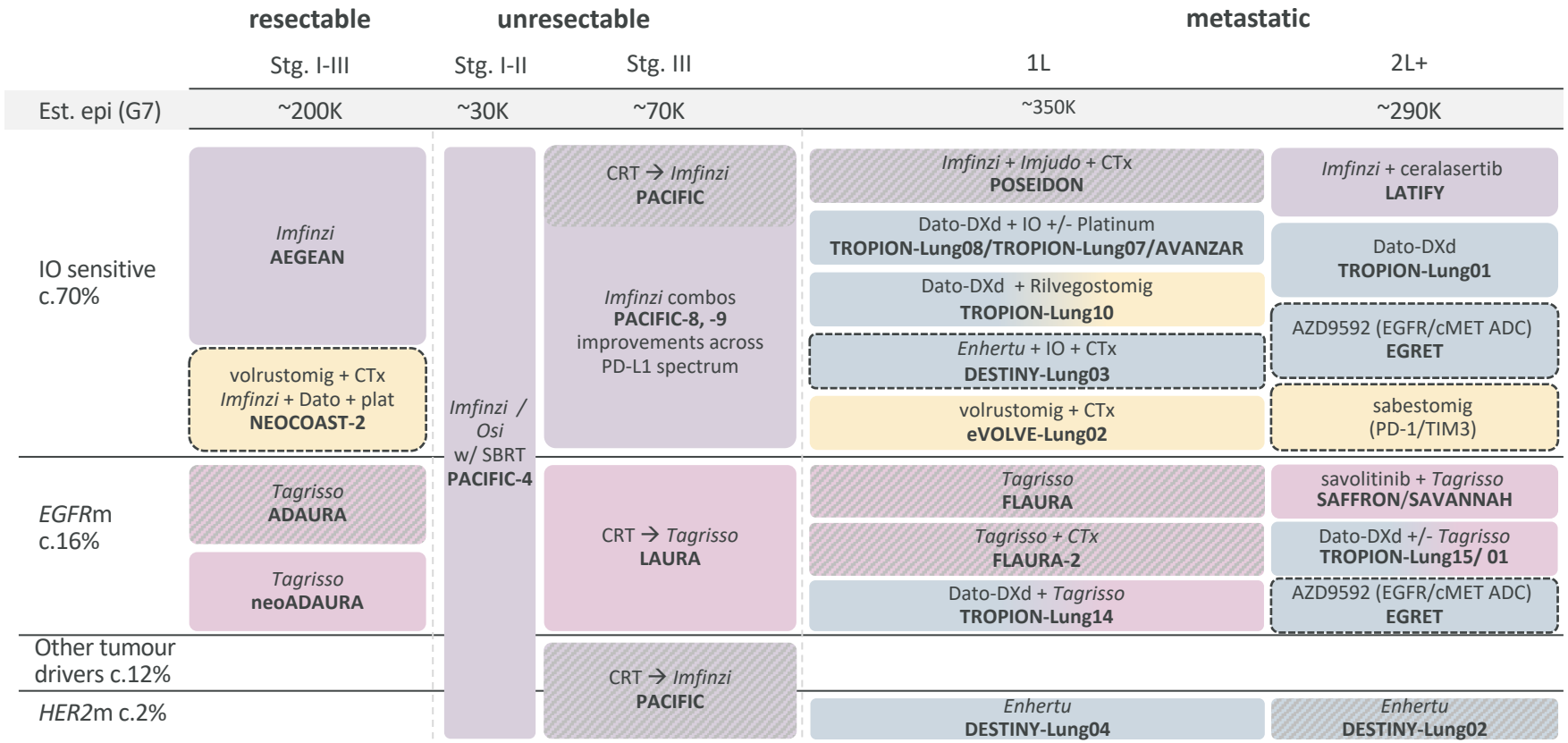


Appendix

Lung and breast tumour maps

AstraZeneca in lung cancer

Ambition for >50% of lung cancer patients to be eligible for AZN medicine by 2030



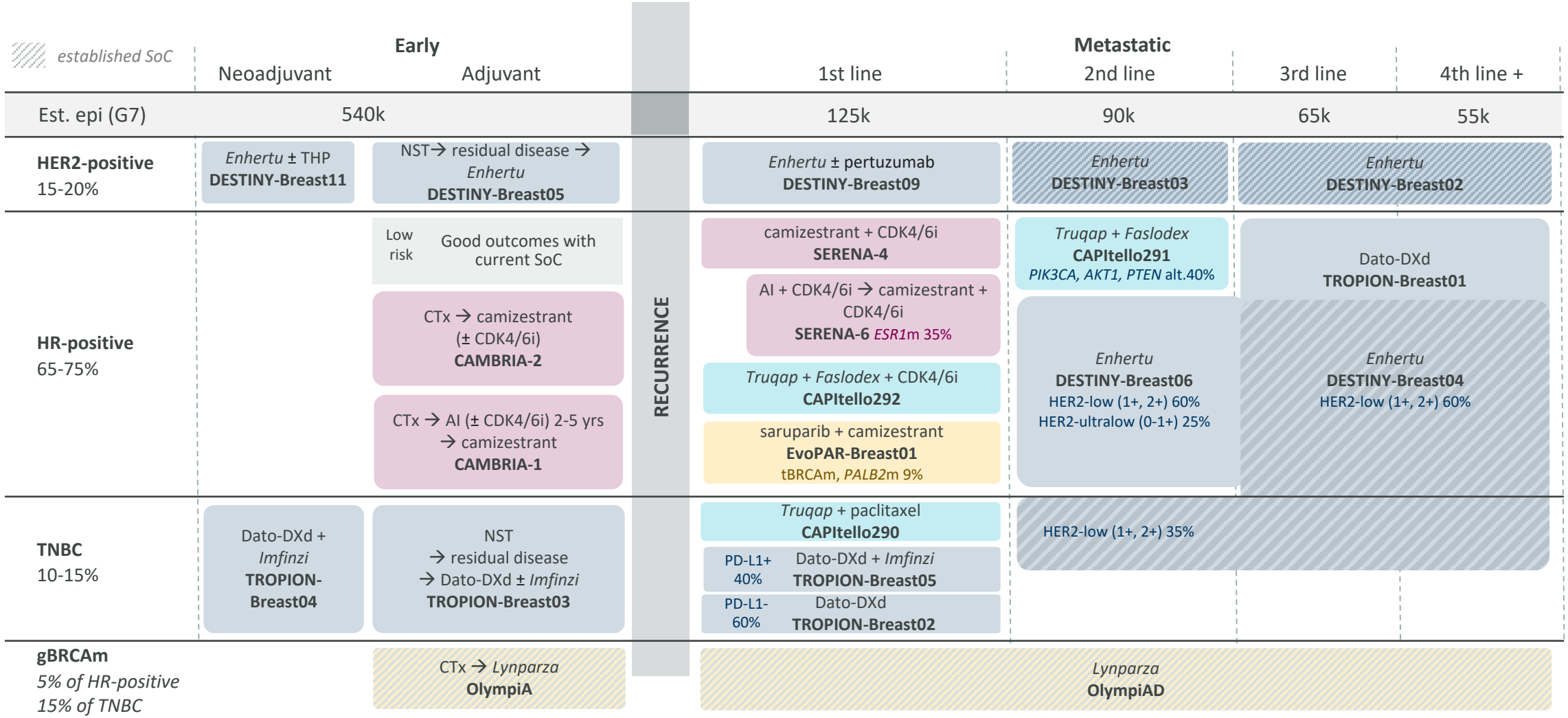
Leading the future of lung cancer treatment

- Establishing *Tagrisso* as backbone TKI in *EGFR*m
- *Imfinzi* leading IO in unresectable
- Advancing best-in-class ADCs to replace systemic chemotherapy
- Delivering next-wave bispecifics to improve on PD-(L)1
- Developing novel combinations, including IO & *Tagrisso* + ADCs
- Investing behind new technologies and platforms, including cell therapy and testing/screening

All numbers are approximate. Illustrative settings and populations, not to scale. Acronym definitions can be found in Glossary.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Compugen (rilvegostomig).

AstraZeneca in breast cancer

Ambition to eliminate breast cancer as a cause of death



All numbers are approximate. Illustrative settings and populations, not to scale.
Collaboration partners: Daiichi Sankyo (*Enhertu*, Dato-DXd), Merck & Co., Inc. (*Lynparza*).

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Appendix

Key data at ASCO 2024

TROPION-Breast01

Randomised, open-label, Phase III trial evaluating *Enhertu* vs T-DM1 in patients with HER2-positive unresectable and/or metastatic breast cancer previously treated with trastuzumab and a taxane

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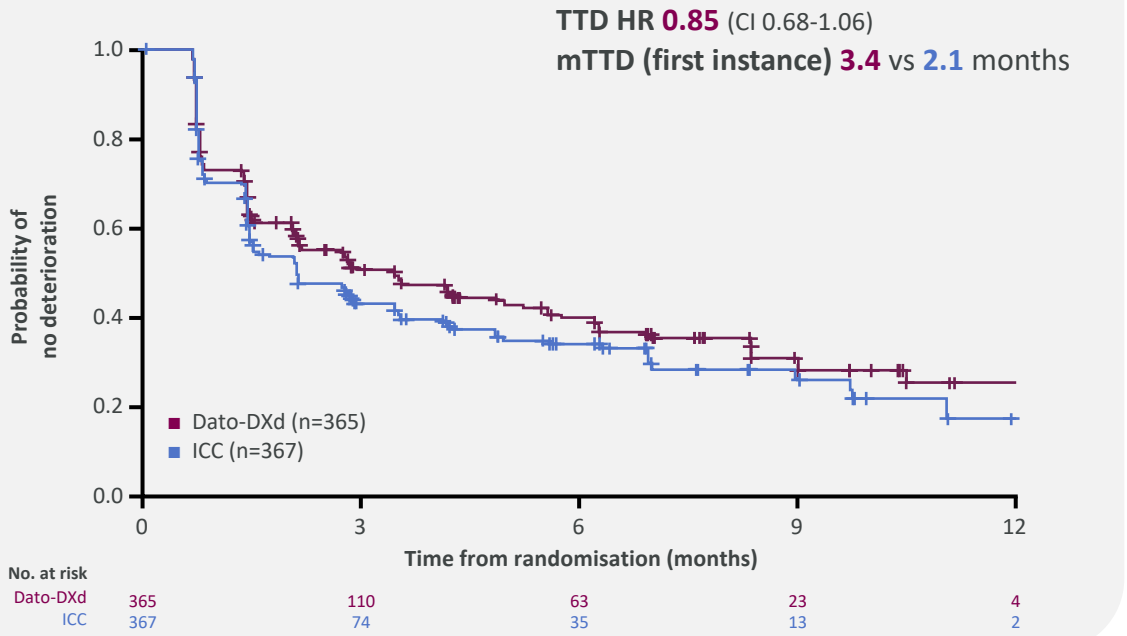
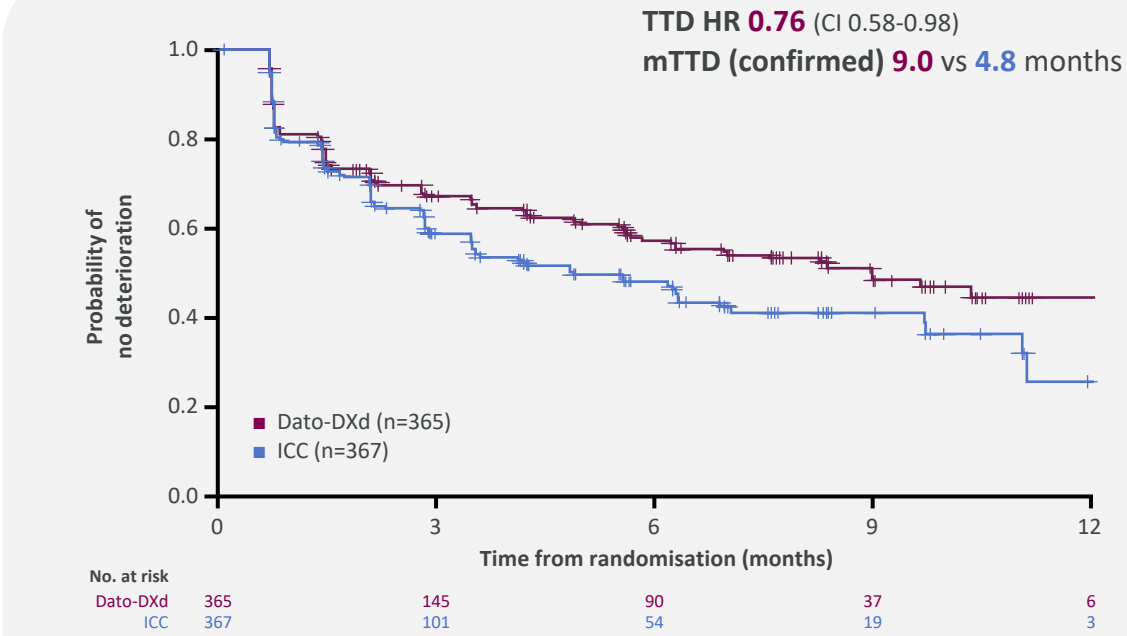
PRO data support Dato-DXd as a potential new, well-tolerated therapeutic option for HR+ HER2- adv. BC

Time to deterioration[1] in GHS/QoL (first instance)



Time to deterioration[1] in GHS/QoL (confirmed)



Patient-reported symptomatic AEs generally consistent with clinician-reported safety data, without showing major impact on patients' functioning and health-related quality of life

1. TTD in GHS/QoL, pain, and physical functioning are secondary endpoints and were measured using EORTC QLQ-C30. Time to first deterioration (primary analysis) was defined as the time from date of randomization to date of first deterioration. Time to confirmed deterioration (sensitivity analysis) required deterioration to be confirmed at a subsequent timepoint. Deterioration was defined as a change from baseline that reached a clinically meaningful deterioration threshold of 16.6.

Pernas S et al. Abstract 1006 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (Dato-DXd).

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DESTINY-Breast06

Randomised, open-label, Phase III trial in patients with HR-positive, HER2-low or HER2-ultralow advanced or metastatic breast cancer evaluating *Enhertu* vs investigator's choice of chemotherapy

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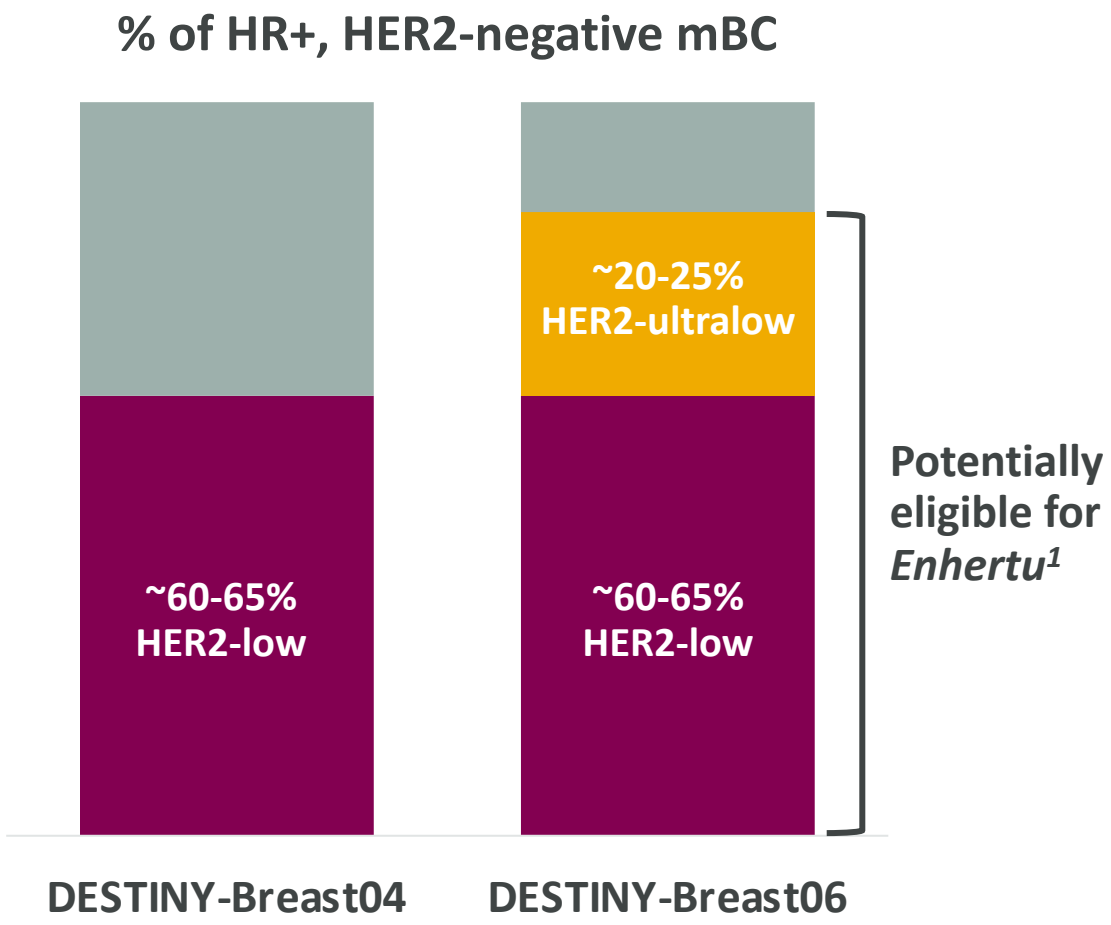
Enhertu demonstrated efficacy in HER2-low mBC in an earlier line of treatment to DESTINY-Breast04



- *Enhertu* demonstrated efficacy in **HER2-low mBC** in an **earlier line of treatment** to DESTINY-Breast04
- Including HER2-ultralow, the proportion of patients who could benefit from *Enhertu* is **~85% of HR+, HER2-negative mBC** after DESTINY-Breast06

In DESTINY-Breast06, *Enhertu* demonstrated a statistically significant and clinically meaningful PFS benefit vs TPC (CTx) in HR+, HER2-low mBC after ≥1 endocrine-based therapy, with consistent results in HER2-ultralow mBC

1. As a percentage of HR+, HER2-negative mBC.

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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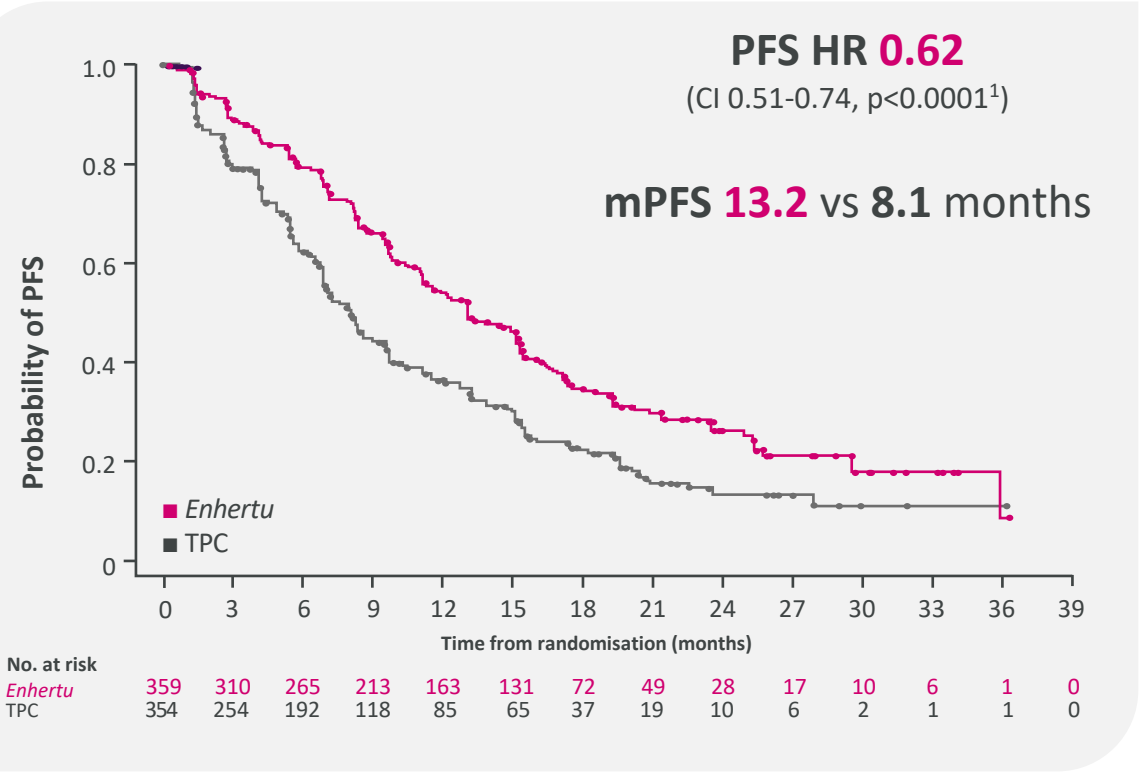
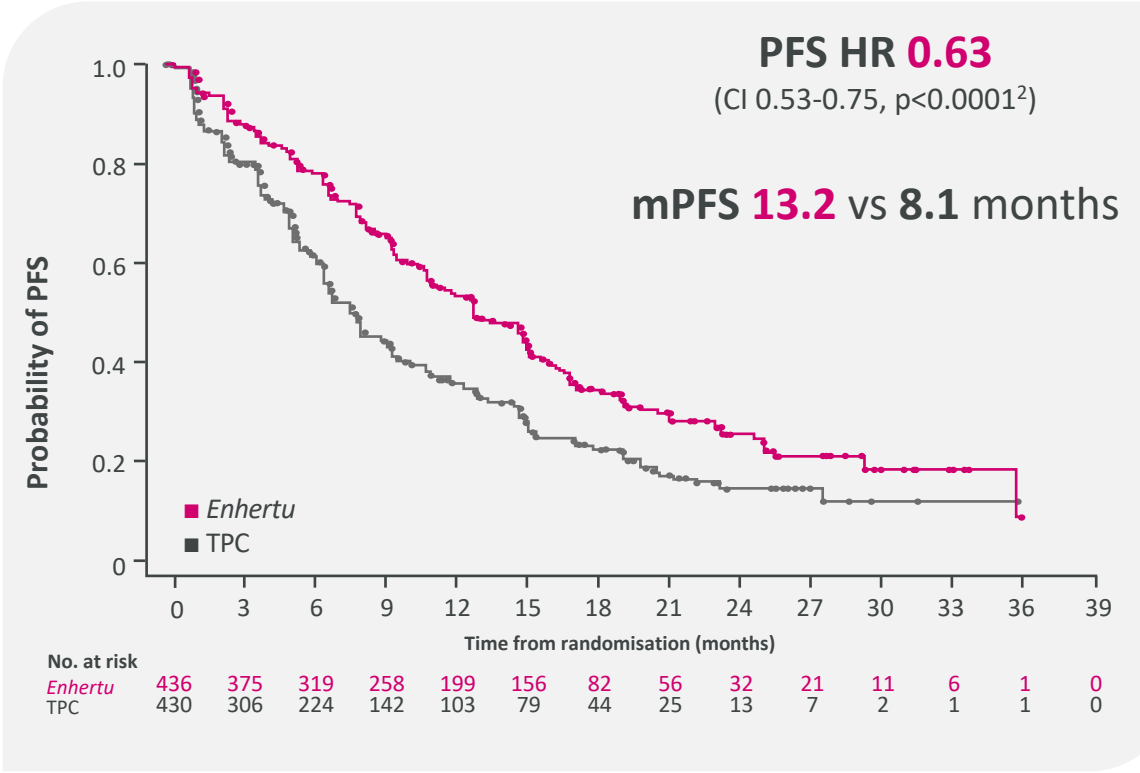
Statistically significant and clinically meaningful PFS improvement with *Enhertu* vs TPC in HER2-low and ITT

HER2-low PFS



ITT PFS (HER2-low + HER2-ultralow)



1. P-value of <0.05 required for statistical significance. 2. P-value of <0.015 required for statistical significance.

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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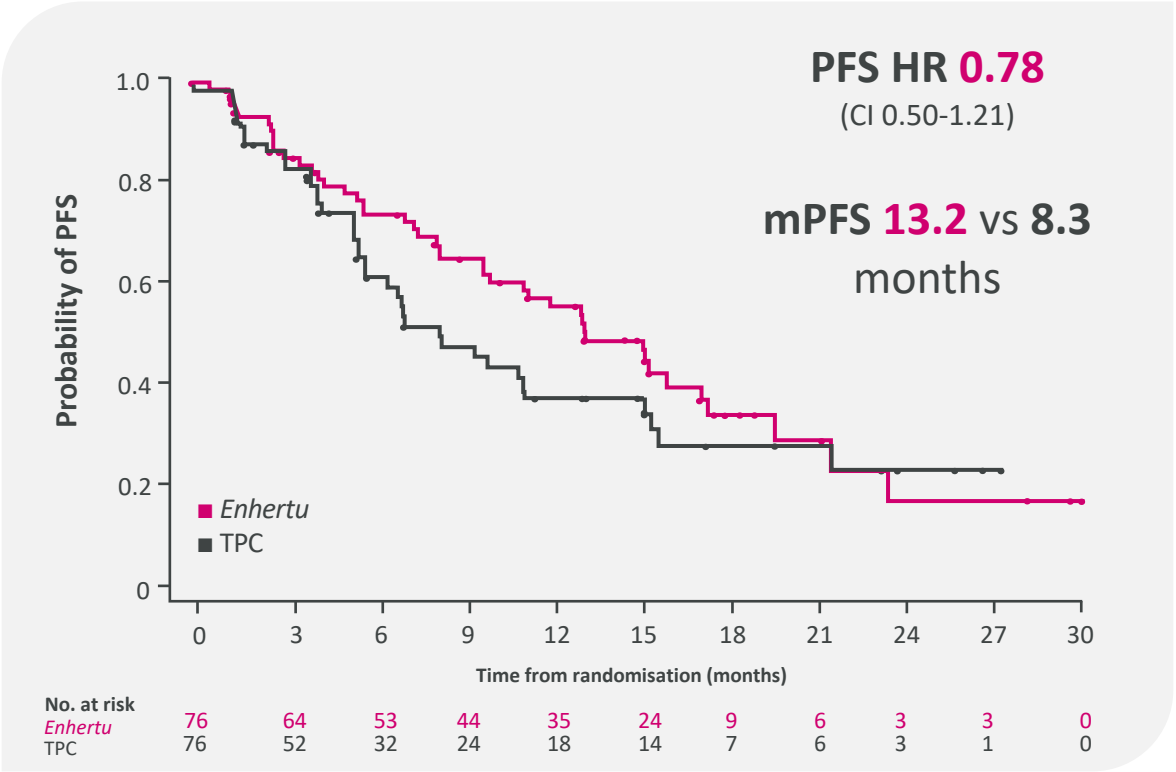
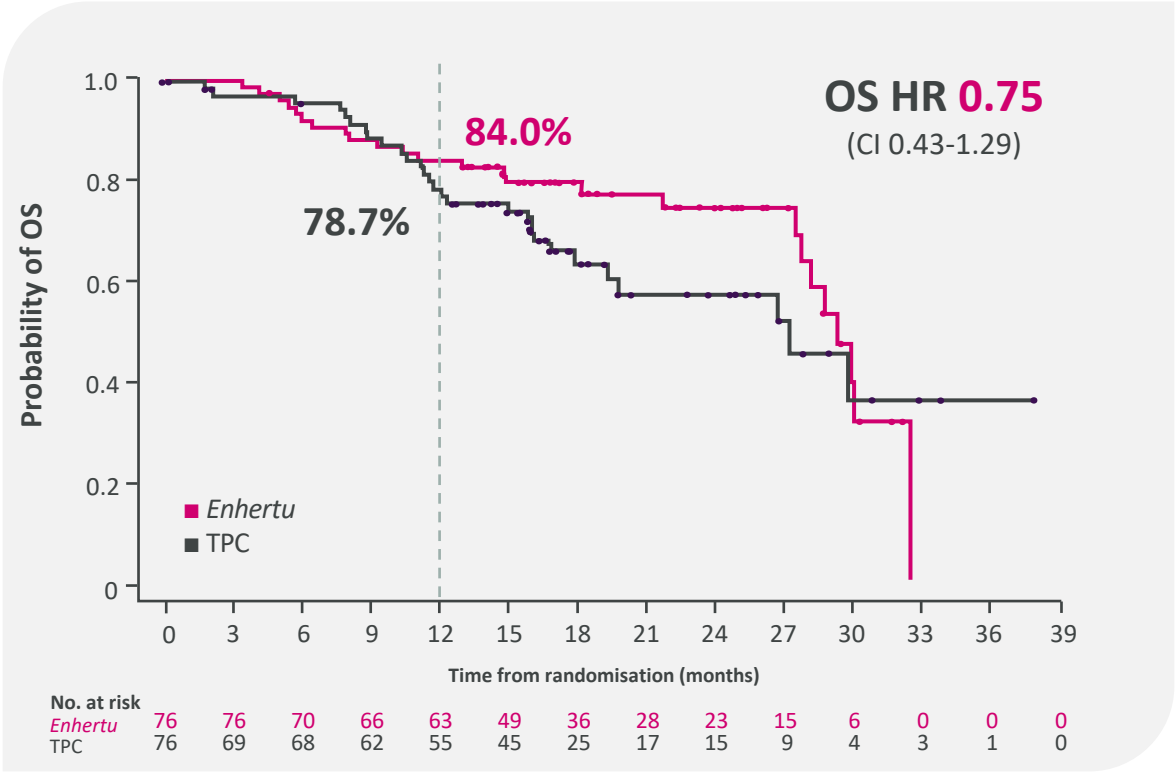
Clinically meaningful PFS improvement with *Enhertu* vs TPC consistent between HER2-low and -ultralow disease

HER2-ultralow PFS (BICR) (N=152)



HER2-ultralow OS[1] (N=152)



1. 34.9% maturity (of total N for population) at this first interim analysis; median duration of follow up was 16.8 months.

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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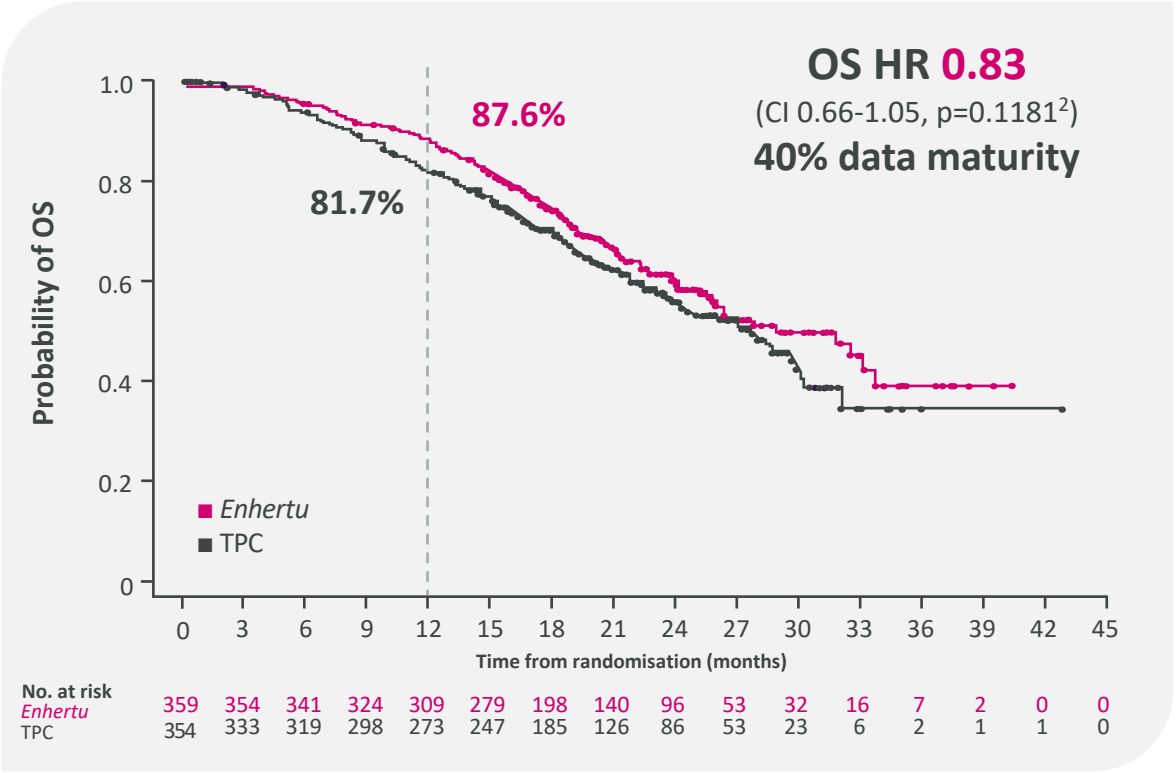
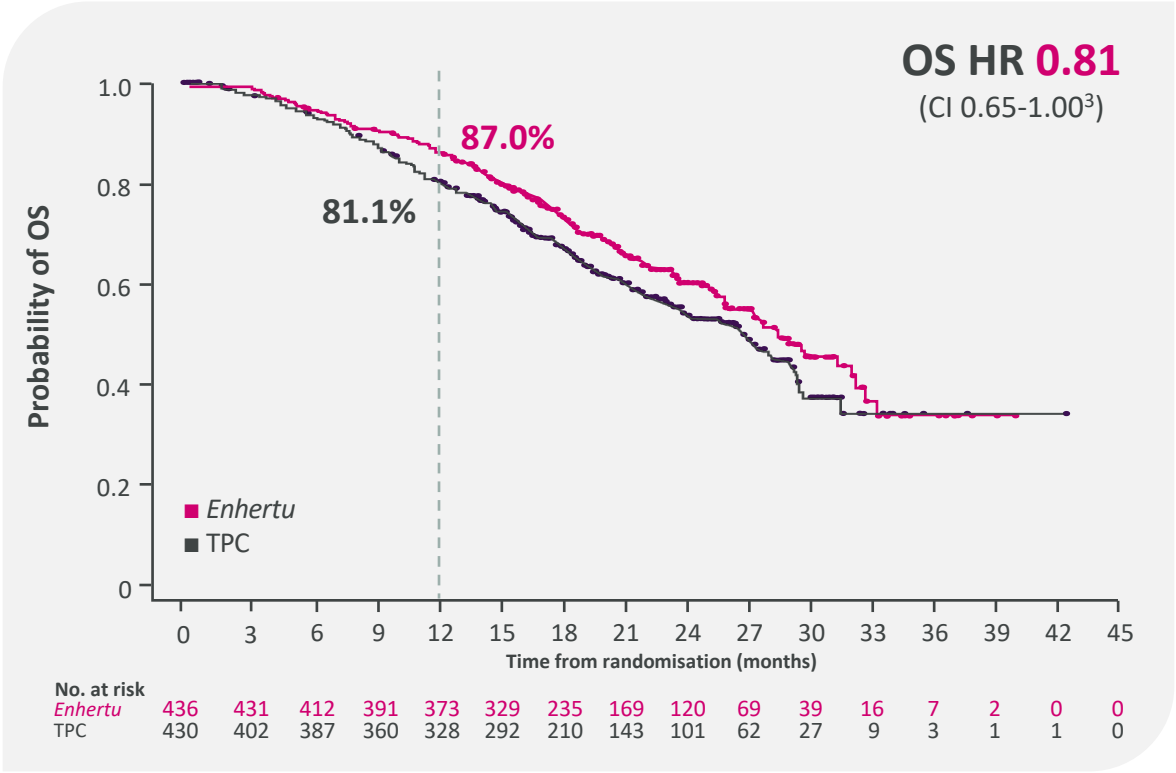
Trend to overall survival benefit with *Enhertu* vs TPC (~40% maturity)

HER2-low OS[1] (N=713)



ITT OS (HER2-low + HER2-ultralow) (N=866)



1. 39.6% maturity (of total N for population) at this first interim analysis; median duration of follow up was 18.6 months (HER2-low). 2. P-value of <0.0046 required for statistical significance. 3. No test of significance was performed in line with the multiple testing procedure; median duration of follow up was 18.2 months (ITT)

Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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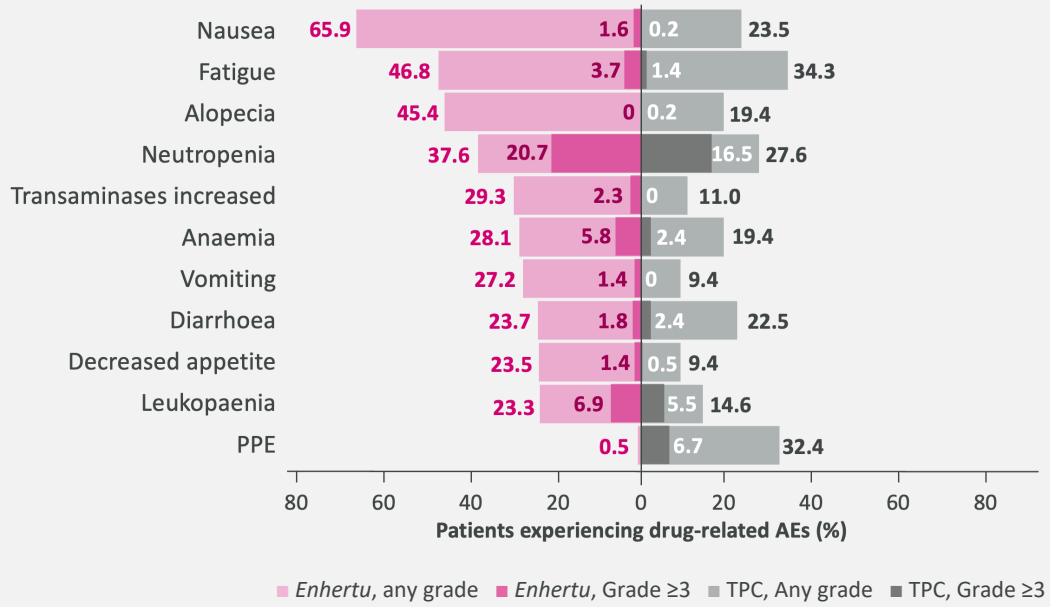
Enhertu safety profile consistent with known profile

Enhertu AE profile generally manageable through dose interruptions and reductions

TEAEs, n (%)	*Enhertu* (n=434)	TPC (n=417)
Any TEAE	438.5	263.5
	429 (98.8)	397 (95.2)
Treatment-related TEAEs	417 (96.1)	373 (89.4)
Grade ≥3	176 (40.6)	131 (31.4)
Serious TEAEs	88 (20.3)	67 (16.1)
Associated with treatment discontinuation	62 (14.3)	39 (9.4)
Associated with dose interruptions	210 (48.4)	160 (38.4)
Associated with dose reductions	107 (24.7)	161 (38.6)
Leading to death	11 (2.5)	6 (1.4)
Treatment related[1]	5 (1.2)	0

Common AEs consistent with previous trials of *Enhertu*



- Three cases (0.7%) of adjudicated Grade 5 drug-related interstitial lung disease/pneumonitis[1] in *Enhertu* arm (vs 0 in TPC arm)

1. Reasons were interstitial lung disease (n=2), sepsis (n=1), neutropenic sepsis (n=1) and general physical health deterioration (n=1). 2. Grouped term. Median time to first onset of interstitial lung disease / pneumonitis for patients with *Enhertu* was 141 days (range 37–835). No pending cases of drug-related interstitial lung disease / pneumonitis to be adjudicated. One interstitial lung disease–related death per investigator assessment was upheld by the adjudication committee. An additional two deaths were adjudicated as interstitial lung disease–related by the adjudication committee.
Tornado plot displays drug-related TEAEs in ≥20% of patients (either treatment group).
Curigliano G et al. Abstract LBA1000 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

DESTINY-Breast03

Randomised, open-label, Phase III trial evaluating *Enhertu* vs T-DM1 in patients with HER2-positive unresectable and/or metastatic breast cancer previously treated with trastuzumab and a taxane

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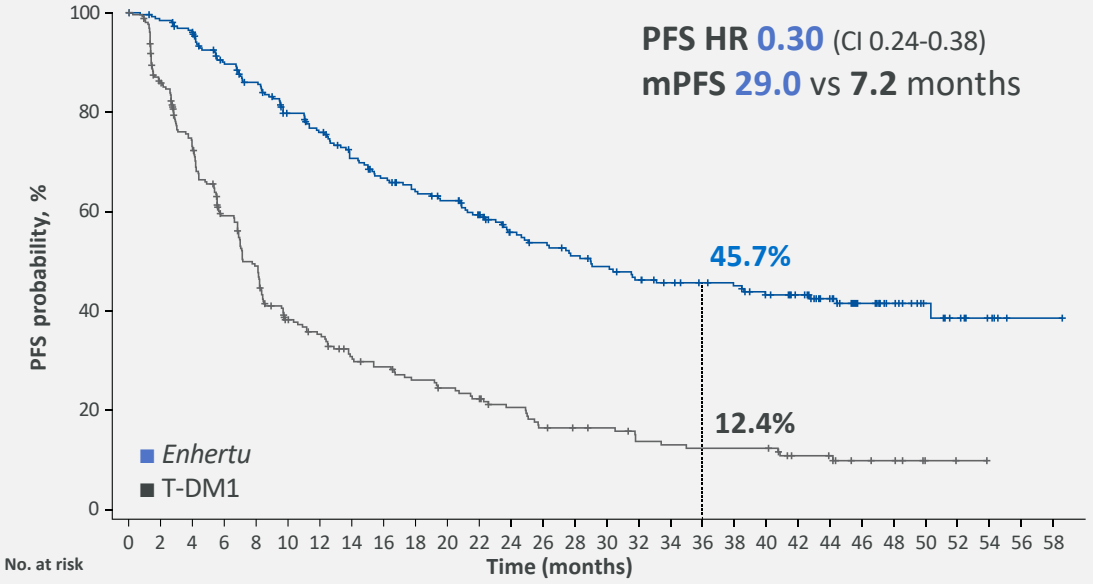
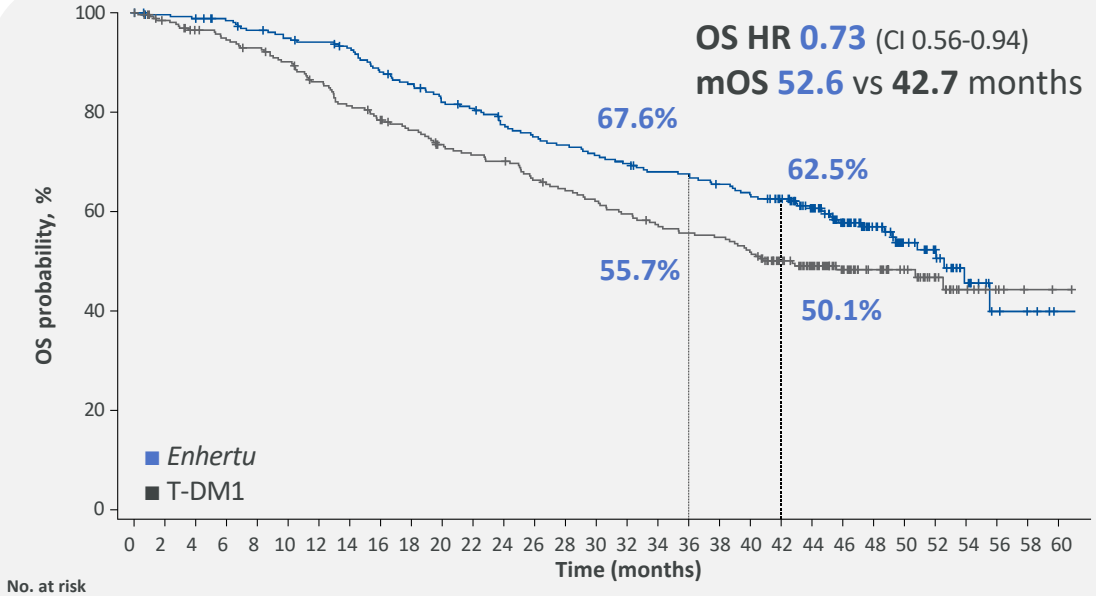
Long-term follow-up from DESTINY-Breast03 further support superiority of *Enhertu* over T-DM1 2L+ HER2+ mBC

Investigator-assessed mPFS ~4 times longer for *Enhertu* vs T-DM1



With longer follow-up *Enhertu* safety profile remained consistent[1] and manageable, with no cumulative toxicities

Over 4 years median overall survival for patients on *Enhertu*



With longest OS in this setting, data reinforce use of *Enhertu* as SoC for 2L+ HER+ mBC

1. With previous analyses.

Hamilton EP et al. Abstract 1025 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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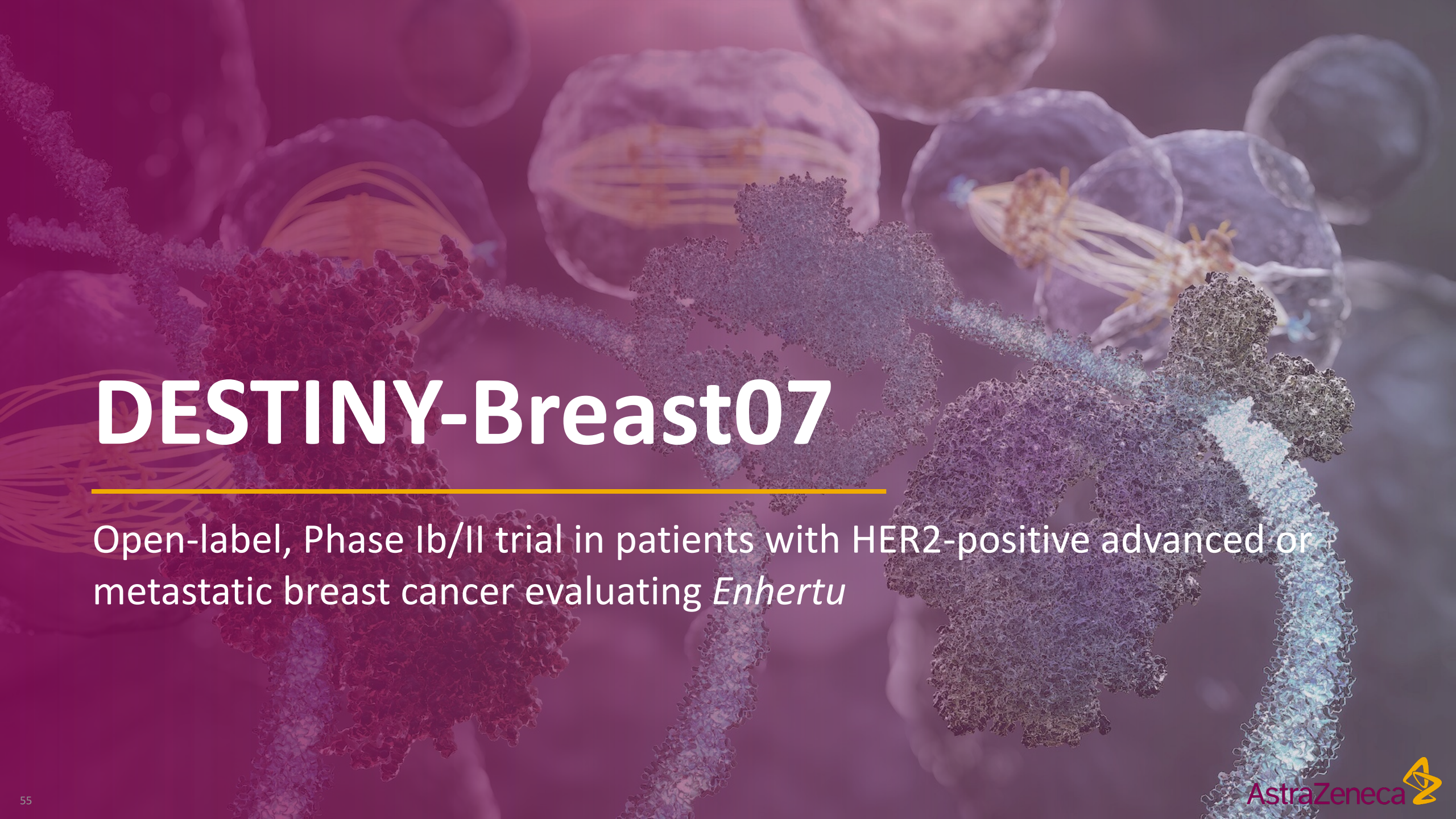

DESTINY-Breast07

Open-label, Phase Ib/II trial in patients with HER2-positive advanced or metastatic breast cancer evaluating *Enhertu*

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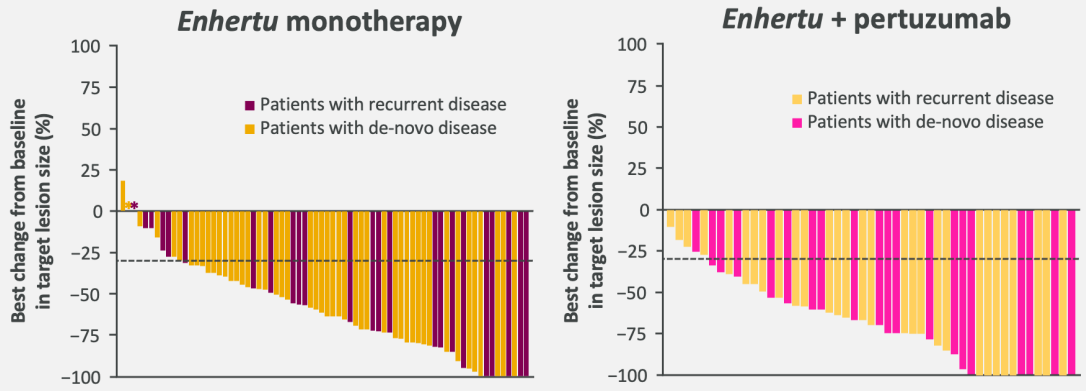
DESTINY-Breast07 – first dataset of *Enhertu* ± pertuzumab as 1L treatment for HER2+ mBC

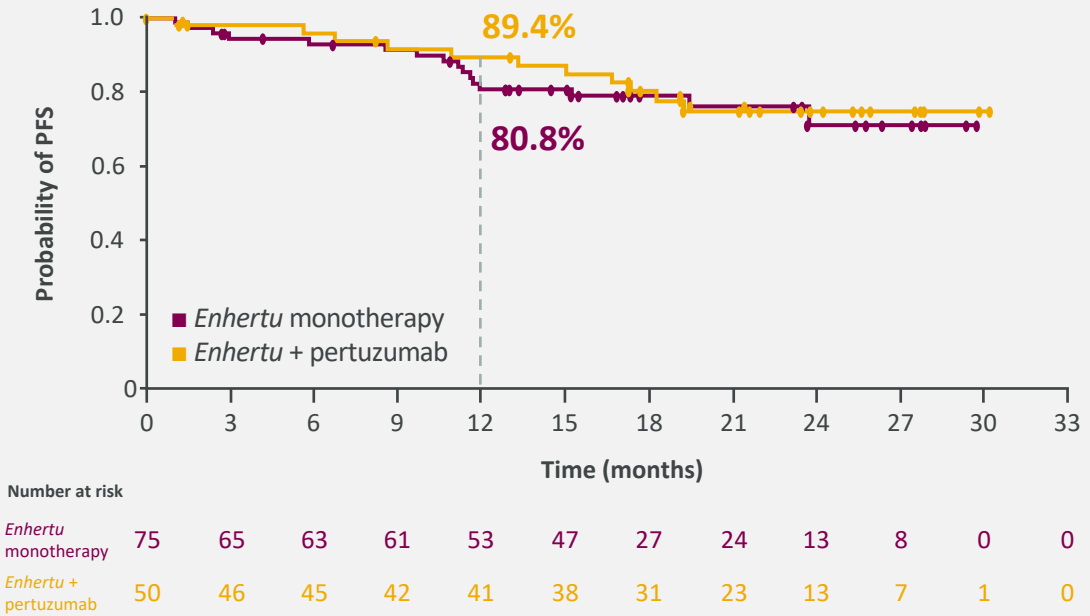
Robust efficacy demonstrated by ORR and mDOR[1]



- Confirmed ORR of 76.0% and 84.0% for *Enhertu* monotherapy *Enhertu* + pertuzumab, respectively
- Median DoR not reached for *Enhertu* monotherapy or *Enhertu* + pertuzumab

Safety profiles of *Enhertu* and pertuzumab consistent with their individual known profiles

Improved PFS rate at 12 months, further follow-up required[2]



Enhertu ± pertuzumab being evaluated in patients with 1L HER2+ mBC in the Phase III DESTINY-Breast09 trial

*Patients had 0% change from baseline.

1. Dashed reference line at −30% indicates the threshold for partial response. DCO was December 22, 2023. Median duration of follow up was 23.9 months for *Enhertu* monotherapy and 25.3 months for *Enhertu* + pertuzumab. 2. Number of PFS events is small and most patients were censored.

Andre F et al. Abstract 1009 presented at American Society of Clinical Oncology 2024. Collaboration partners: Daiichi Sankyo (*Enhertu*).

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AZD0901

Multi-centre, open-label Phase I trial evaluating AZD0901 in relapsed and/or refractory advanced solid tumours

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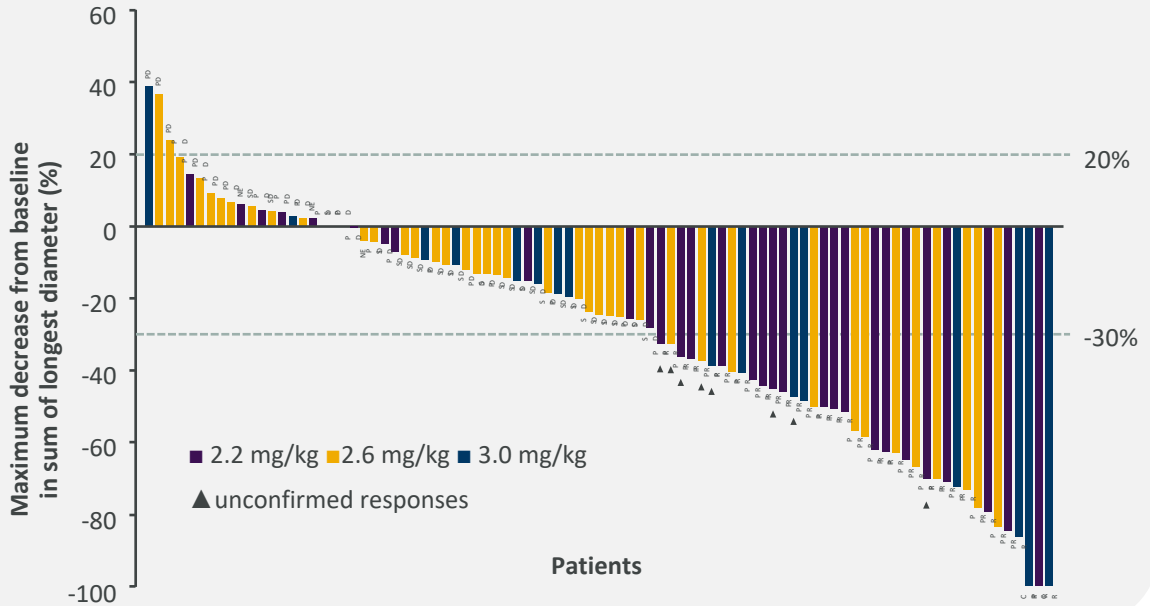
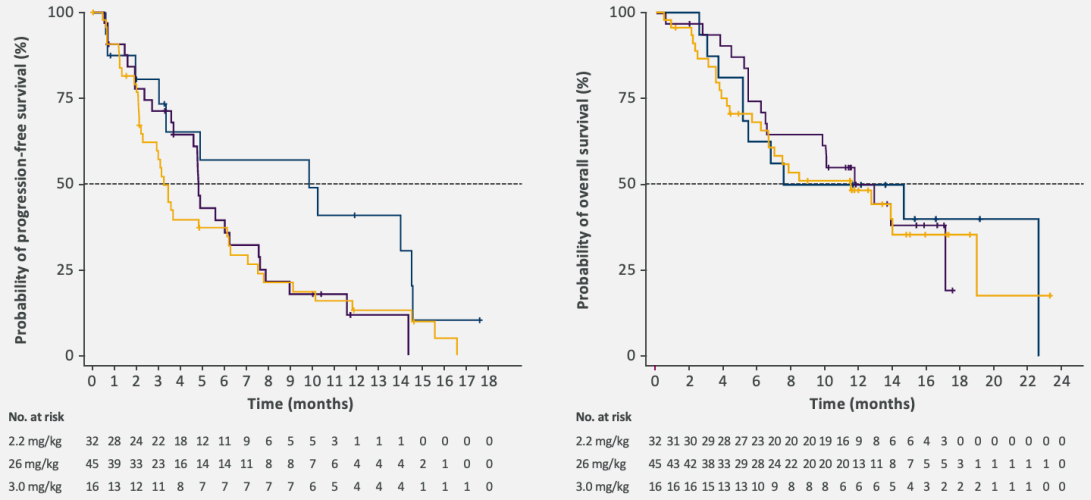
AZD0901[1] – Promising clinical efficacy in pretreated patients with CLDN18.2-high gastric/GEJ cancer

Robust ORR of 48% in 2.2 mg/kg cohort



AZD0901 was generally well-tolerated, with a manageable safety profile

Encouraging mPFS of 4.8 months and mOS of 11.8 months in 2.2 mg/kg cohort



The current clinical program for AZD0901 is expanding for advanced solid tumours expressing CLDN18.2

1. Also know as CMG901

Zhang Q et al. Abstract 4019 presented at American Society of Clinical Oncology 2024.

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Glossary

1L, 2L, 3L	first-, second-, third-line
4-IBB	tumour necrosis factor ligand superfamily member 9
AAV	adeno-associated virus
AC	doxorubicin/cylophosphamide
ADC	antibody-drug conjugate
AE	adverse event
AI	artificial intelligence
ASCO	American Society of Clinical Oncology
BC	breast cancer
BCMA	B-cell maturation antigen
BICR	Blinded Independent Central Review
CAR	chimeric antigen receptor
carbo	carboplatin
CAR-T	chimeric antigen receptor T-cells
cCRT	concurrent chemoradiotherapy
CD19	cluster of differentiation 19
CD28	cluster of differentiation 28
CD3	cluster of differentiation 3
CD3ζ	T-cell surface glycoprotein CD3 zeta chain
CI	confidence interval
CLDN 18.2	Claudin 18.2
CRS	cytokine release syndrome
CRT	chemoradiotherapy
ctDNA	circulating tumour DNA
CTLA-4	cytotoxic T-lymphocyte associated protein-4
CTx	chemotherapy
Dato-DXd	datopotamab deruxtecan
DB03	DESTINY-Breast03
DB04	DESTINY-Breast04
DB06	DESTINY-Breast06
DB07	DESTINY-Breast07
DDR	DNA damage response
DL	dose level
dnTGFβRII	dominant-negative transforming growth factor-beta type II receptor
dPTEN	de novo phosphatase and tensin homolog deficient
eBC	early breast cancer
ECOG	Eastern Cooperative Oncology Group
EGFR	epidermal growth factor receptor
EGFRm	epidermal growth factor receptor-mutant
EPI	epigenetics
ES-SCLC	early stage small-cell lung cancer
ET	endocrine therapy
exp.	expressing
FDC	fixed dose combination
FIH	first-in-human
G7	US, Japan, EU5
GEJ	gastroesophageal junction
GLP-1	glucagon-like receptor peptide-1
GPC3	glypican-3
GU	genitourinary
GYN	gynaecological
HCC	hepatocellular carcinoma
HER2	human epidermal growth factor receptor 2
HER2-	human epidermal growth factor receptor 2-negative
HER2-immune+	human epidermal growth factor receptor 2-immune-positive
HER2-low	human epidermal growth factor receptor 2-low
HER2-negative	human epidermal growth factor receptor 2-negative
HER2-positive	human epidermal growth factor receptor 2-positive
HER2-ultralow	human epidermal growth factor receptor 2-ultralow
HR	hazard ratio
HR-	hormone receptor-negative
HR+	hormone receptor-positive
ICANS	immune effector cell-associated neurotoxicity syndrome
ICD	International Classification of Diseases
IgG4P	immunoglobulin G4 protein
IHC	immunohistochemistry
ILD	interstitial lung disease
IO	immuno-oncology
ISH	in situ hybridisation
ITT	intent to treat
LBA	late-breaking abstract
LS	late-stage
LS-SCLC	limited stage small-cell lung cancer
mBC	metastatic breast cancer
mDoR	median duration of response
mo	month
mOS	median overall survival
mPFS	median progression-free survival
mTTD	median time to treatment discontinuation
NME	new molecular entity
no.	number
NSCLC	non-small cell lung cancer
oGLP-1	oral glucagon-like receptor peptide-1
ORR	overall response rate
OS	overall survival
PCI	prophylactic cranial irradiation
pCR	pathological complete response
PD	Progressive disease
PD-1	programmed cell death protein-1
PD-1i	programmed cell death protein-1 inhibitor
PD-L1	programmed cell death ligand-1
pembro	pembrolizumab
PFS	progression-free survival
PPE	palmar-plantar erythrodysesthesia
PR	partial response
preRCB	pre-residual cancer burden
RC	radioconjugate
RECIST	Response Evaluation Criteria in Solid Tumours
scFv	single-chain fragment variable
SCLC	small-cell lung cancer
SD	standard deviation
SD	stable disease
SLD	sum of lesion diameters
SoC	standard-of-care
STEAP2	six-transmembrane epithelial antigen of prostate-2
Stg.	stage
T2A	tumor is between 3cm and 4cm
taxol	paclitaxel
TB01	TROPION-Breast01
TCE	T-cell engager
TDR	tumour drivers and resistance
T-DxD	trastuzumab deruxtecan (Enhertu)
TEAE	treatment emergent adverse event
TIGIT	T-cell immunoreceptor with immunoglobulin and ITIM domains
TKI	tyrosine kinase inhibitor
TNBC	triple negative breast cancer
TPC	docetaxel, cisplatin and irinotecan
TROP2	trophoblast cell surface antigen 2
TTD	time to treatment discontinuation
u/r	unresectable
unresect.	unresectable
VEGF(R)	vascular endothelial growth factor (receptor)

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