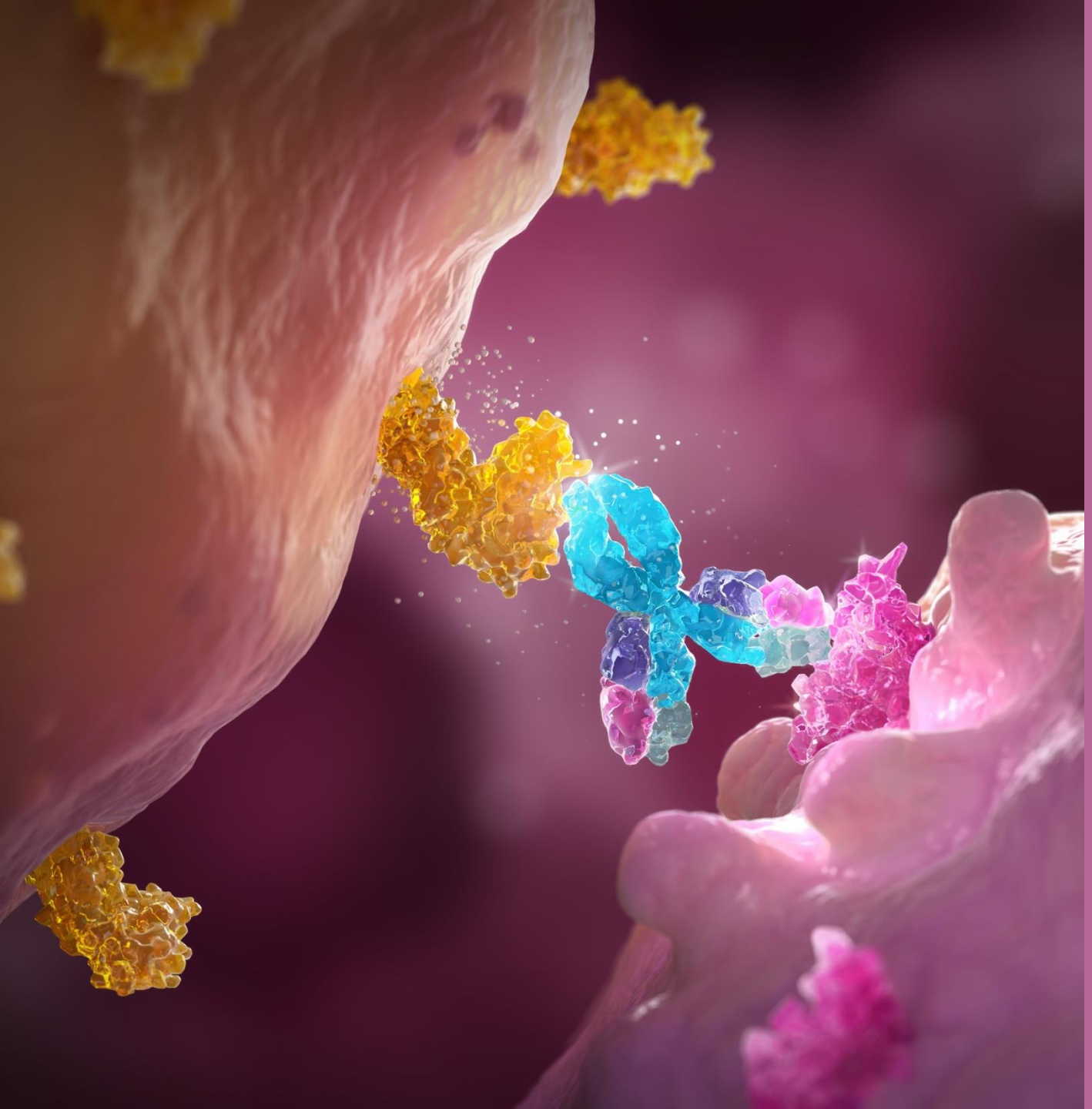


Meet AZN Management: ESMO

Investor Event

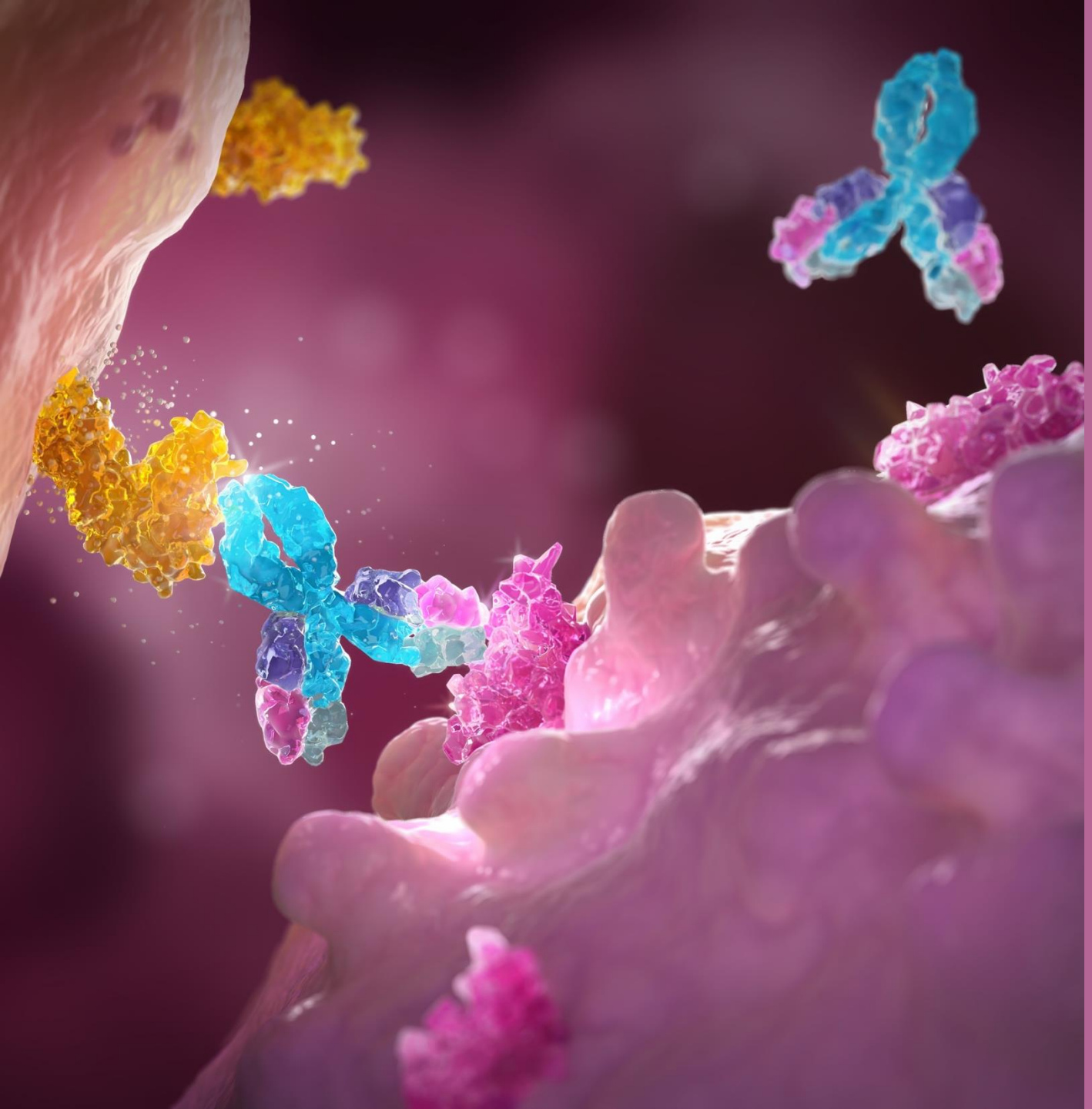
20 October 2025

Forward-looking statements

This document contains certain forward-looking statements with respect to the operations, performance and financial condition of the Group, including, among other things, statements about expected revenues, margins, earnings per share or other financial or other measures. Although the Group believes its expectations are based on reasonable assumptions, any forward-looking statements, by their very nature, involve risks and uncertainties and may be influenced by factors that could cause actual outcomes and results to be materially different from those predicted. The forward-looking statements reflect knowledge and information available at the date of preparation of this document and the Group undertakes no obligation to update these forward-looking statements. The Group identifies the forward-looking statements by using the words 'anticipates', 'believes', 'expects', 'intends' and similar expressions in such statements. Important factors that could cause actual results to differ materially from those contained in forward-looking statements, certain of which are beyond the Group's control, include, among other things: the risk of failure or delay in delivery of pipeline or launch of new medicines; the risk of failure to meet regulatory or ethical requirements for medicine development or approval; the risk of failures or delays in the quality or execution of the Group's commercial strategies; the risk of pricing, affordability, access and competitive pressures; the risk of failure to maintain supply of compliant, quality medicines; the risk of illegal trade in the Group's medicines; the 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 and artificial intelligence in line with legal and regulatory requirements and strategic objectives; the risk of failure to attract, develop, engage and retain a diverse, talented and capable workforce; the risk of failure to meet our sustainability targets, regulatory requirements and stakeholder expectations with respect to the environment; the risk of the safety and efficacy of marketed medicines being questioned; the risk of adverse outcome of litigation and/or governmental investigations; intellectual property risks related to the Group's products; the risk of failure to achieve strategic plans or meet targets or expectations; the risk of geopolitical and/or macroeconomic volatility disrupting the operation of our global business; the risk of failure in internal control, financial reporting or the occurrence of fraud; and the risk of unexpected deterioration in the Group's financial position. Nothing in this document, or any related presentation/webcast, should be construed as a profit forecast.

AstraZeneca @ ESMO 2025

Furthering the AstraZeneca ambition	**Pascal Soriot,** Chief Executive Officer
Key Oncology themes at WCLC and ESMO	**Susan Galbraith,** EVP, Oncology Haematology R&D
Redefining the breast cancer landscape	
• DESTINY-Breast11, DESTINY-Breast05	**Prof. Nadia Harbeck,** LMU University Hospital
• TROPION-Breast02	**Prof. Rebecca Dent,** National Cancer Center Singapore
• Integrating into clinical practice	**Sunil Verma,** SVP, Global Head, Oncology Franchise
• Q&A	**Dave Fredrickson,** EVP, Oncology Haematology Business
Realising our ambition in GU cancers and beyond	
• POTOMAC	**Dr Neal Shore,** Carolina Urologic Research Center
• Integrating into clinical practice	**Dave Fredrickson,** EVP, Oncology Haematology Business
Closing Remarks and Q&A Session	**Dave Fredrickson,** EVP, Oncology Haematology Business



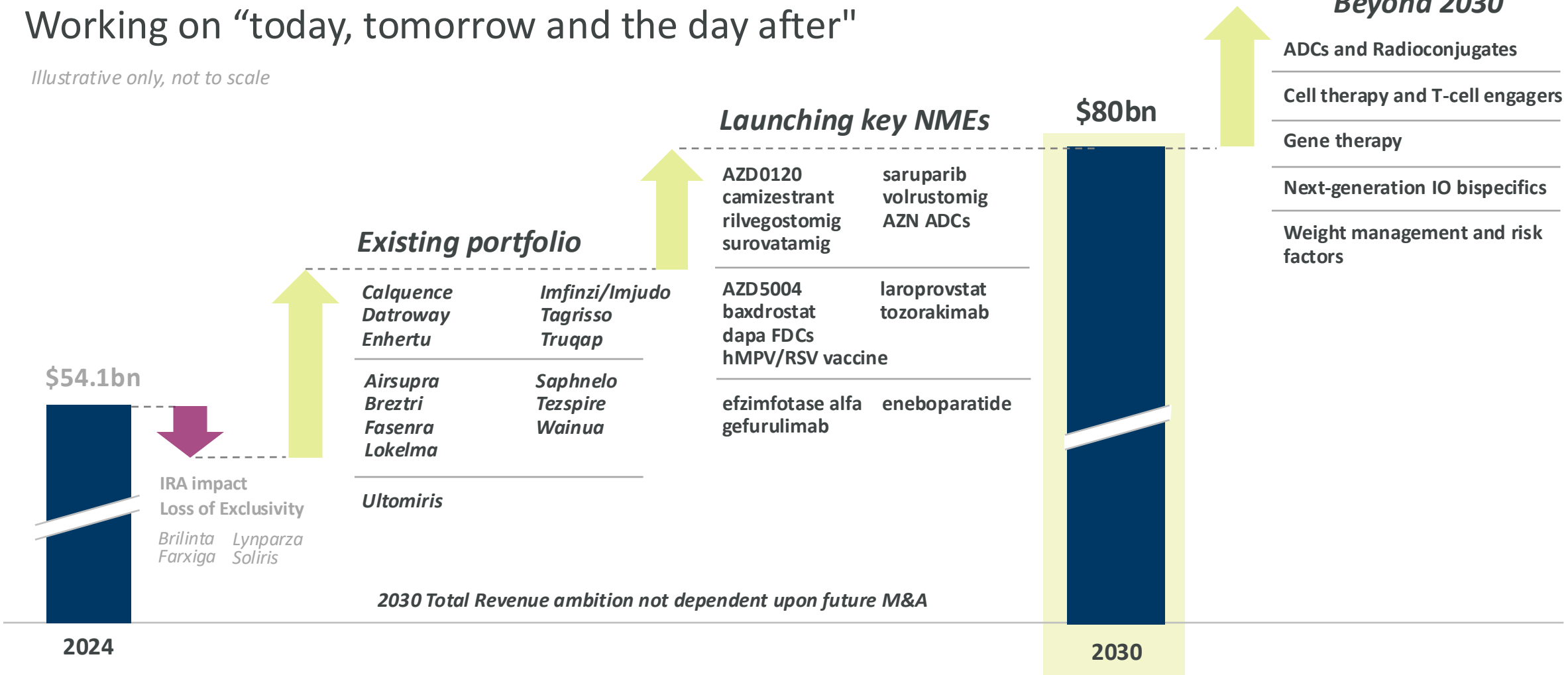
Furthering the AstraZeneca ambition

Pascal Soriot
CHIEF EXECUTIVE OFFICER

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

Working on “today, tomorrow and the day after"

Illustrative only, not to scale



Note: Ambition to achieve $80bn in Total Revenue by 2030 is risk-adjusted, based on long-range plan as of AstraZeneca Investor Day May 2024. Medicines and assets listed reflect key contributors to 2030 Total Revenue ambition; however, this list is not exhaustive. Medicines and assets listed in alphabetical order and sorted by therapy area. Laroprovstat previously AZD0780. Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Amgen (*Tezspire*), Ionis (*Wainua*), Compugen (rilvegostomig), Merck & Co., Inc. (*Lynparza*). Appendix: Glossary.

Unprecedented catalyst rich period with key Phase III readouts in 2025 and 2026

H1 2025

- **DESTINY-Breast09** | *Enhertu*
  1L HER2+ breast cancer
- **DESTINY-Breast11** | *Enhertu*
  early-stage HER2+ breast
- **CAPItello280** | *Truqap*
  mCRPC
- **MATTERHORN** | *Imfinzi*
  resectable GC/GEJC
- **POTOMAC** | *Imfinzi*
  non-muscle invasive bladder cancer
- **SERENA-6** | camizestrant
  1L *ESR1*m HR+ HER2- adv. breast cancer
- **KALOS/LOGOS** | *Breztri*
  uncontrolled asthma
- **CALYPSO** | eneboparatide
  hypoparathyroidism

H2 2025

- **TROPION-Breast02** | *Datroway*
  1L TNBC
- **DESTINY-Breast05** | *Enhertu*
  early HER2+ breast cancer
- **VOLGA** | *Imfinzi*
  muscle-invasive bladder cancer
- **FLAURA2 OS** | *Tagrisso*
  1L *EGFR*m NSCLC
- **LATIFY** | ceralasertib + *Imfinzi*
  post-IO NSCLC
- **RESOLUTE** | *Fasenra*
  moderate to severe COPD
- **TULIP-SC** | *Saphnelo*
  moderate to severe SLE
- **BaxHTN** | baxdrostat
  uncontrolled hypertension
- **TMA-313** | *Ultomiris*
  HSCT-TMA (adults)
- **CARES**[1] | anselamimab
  light-chain amyloidosis
- **MG-301** | gefurulimab
  generalised myasthenia gravis

H1 2026

- **AVANZAR** | *Datroway* + *Imfinzi*
  1L NSQ/NSQ TROP2+ NSCLC
- **TROPION-Lung07** | *Datroway*
  1L NSQ NSCLC
- **EMERALD-3** | *Imfinzi*
  locoregional HCC
- **SAFFRON** | *Tagrisso* + *Orpathys*
  *EGFR*m NSCLC
- **CLARITY-Gastric01** | sonesitatug vedotin 2L+ CLDN18.2+ gastric cancer
- **OBERON/TITANIA** | tozorakimab
  COPD
- **MIRANDA** | tozorakimab
  COPD
- **ICAN** | *Ultomiris*
  IgAN
- **HICKORY/CHESTNUT/MULBERRY** | efzimfotase alfa hypophosphatasia

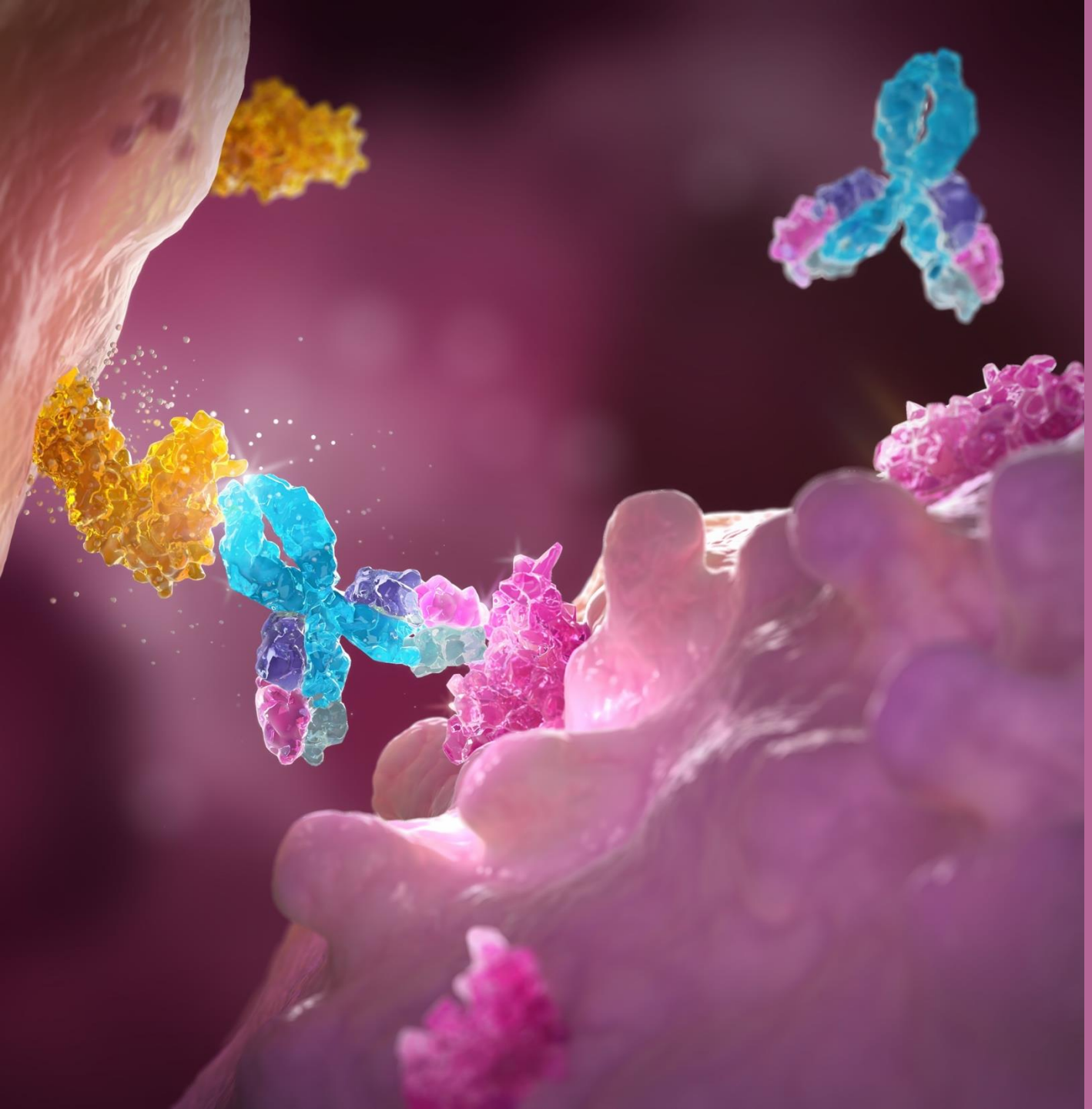
H2 2026

- **TROPION-Lung15** | *Datroway* ± *Tagrisso* 2L *EGFR*m NSCLC
- **EMERALD-2** | *Imfinzi*
  early HCC
- **SERENA-4** | camizestrant
  1L HR+ HER2- met. breast cancer
- **IRIS** | *Saphnelo*
  lupus nephritis
- **DAISY** | *Saphnelo*
  systemic sclerosis
- **CARDIO-TTRansform** | *Wainua*
  ATTR-CM
- **TILIA** | tozorakimab
  lower respiratory tract disease
- **ARTEMIS** | *Ultomiris*
  CSA-AKI

1. Primary endpoint not met in overall patient population; highly clinically meaningful improvement demonstrated in a prespecified subgroup of patients.

Key upcoming pipeline catalysts are defined by a threshold of non-risk adjusted global peak year revenue expectations as of 29 July 2025.

Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Hutchmed (*Orpathys*), Ionis (*Wainua*), Compugen (rilvegostomig), Merck & Co., Inc. (*Lynparza*). Appendix: Glossary.



Key Oncology themes at WCLC and ESMO

Susan Galbraith
EVP, ONCOLOGY
HAEMATOLOGY R&D

AstraZeneca

at WCLC and ESMO 2025

>160 abstract acceptances

98 poster presentations

35 oral presentations

4 plenary presentations[1]

Transforming care today

- **DESTINY-Breast11** (291O)
- **DESTINY-Breast05** (LBA1)
- **TROPION-Breast02** (LBA21)
- **POTOMAC** (LBA108)
- **FLAURA2 final OS[2]** (PL02.06)
- **MATTERHORN final OS** (LBA81)

Establishing the pipeline for tomorrow

- **rilvegostomig *ex vivo* data[2]** (OA03.03)
- **ARTEMIDE-01** (1853MO)
- **TROPION-PanTumor03** (3072MO)
- **FONTANA** (1065MO)
- **PETRANHA** (2384MO)

Five presidential plenary presentations in the past three years at ESMO

represents Plenary (WCLC) or Presidential (ESMO) session. All sessions except for FL

1. Plenary (WCLC) or Presidential (ESMO) session. 2. Data at WCLC 2025. All other listed datasets are at ESMO 2025. Appendix: Glossary.

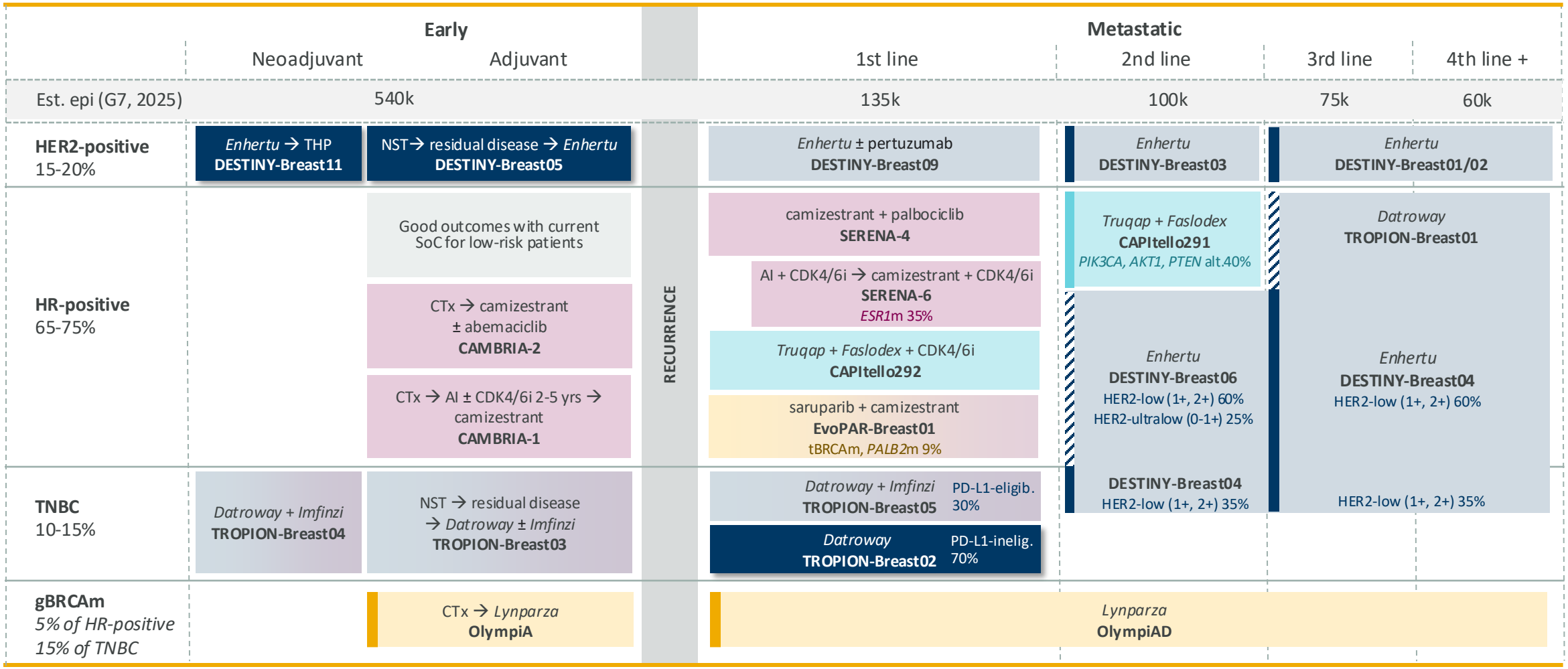
Focused strategy to redefine cancer care

		Significant progress at ESMO and WCLC 2025
Novel ADCs and Radioconjugates 1	Replace the backbone of chemotherapy and radiotherapy	DESTINY-Breast11 · DESTINY-Breast05 · TROPION-Breast02 · FONTANA · TROPION-PanTumor03 · QCS real world implementation
Novel IO 2	Next wave of IO agents will segment the IO-sensitive space	ARTEMIDE-01 · TROPION-PanTumor03
Cell therapy and T-cell engagers 3	Scalable, accessible therapies in both liquid and solid tumours	Upcoming data for surovatomig and AZD0120
Powerful combinations 4	Transform outcomes through new combinations including novel ADC, Radioconjugate and next-generation IO	FLAURA2 OS · TROPION-PanTumor03 · PETRANHA
Early intervention 5	Improve long-term outcomes by acting at the earliest stages of disease	POTOMAC · MATTERHORN OS

■ Phase III dataset
■ Early phase dataset

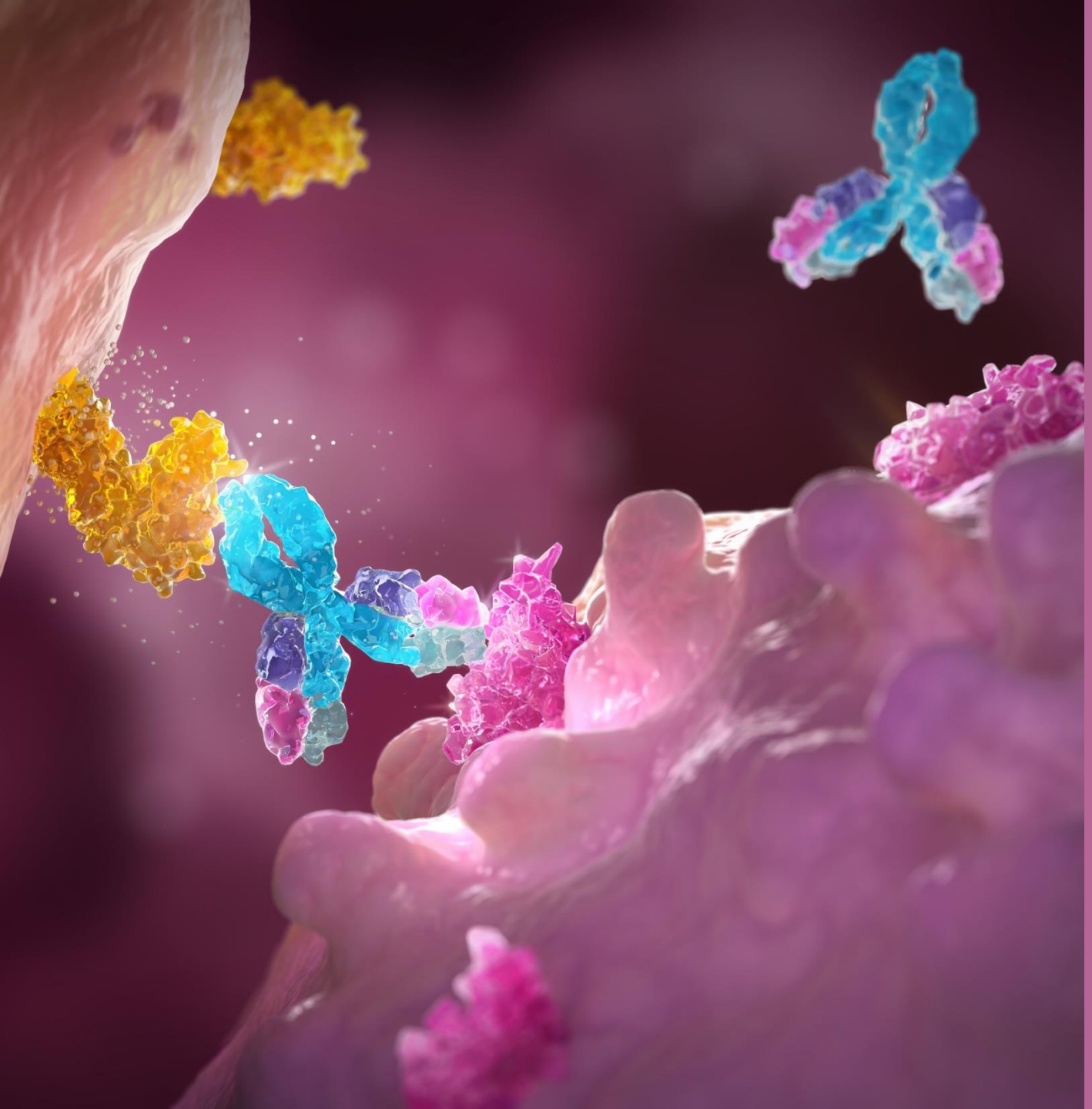
Collaboration partners: Daiichi Sankyo (*Enhertu*), Merck & Co., Inc. (*Lynparza*). Appendix: Glossary.

Leading development programme in breast cancer



Darker boxes denote trials of focus for ESMO 2025

All numbers are approximate. Illustrative settings and populations, not to scale. Breast Cancer map reflects Phase III/pivotal trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Merck & Co., Inc. (*Lynparza*).
Appendix: Glossary.

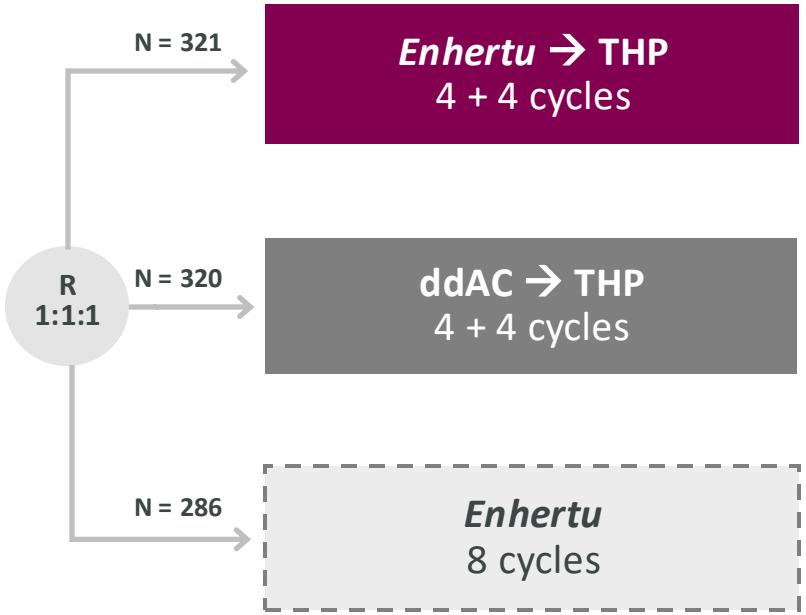


DESTINY-Breast11

Prof. Nadia Harbeck
BREAST CENTER DIRECTOR,
LMU UNIVERSITY HOSPITAL,
MUNICH

DESTINY-Breast11: Advancing *Enhertu* into curative early breast cancer setting

- Previously untreated HER2+ eBC
- HR+ or HR-
- High-risk defined as:
  - ≥cT3 and N0–3 or cT0–4 and N1–3
  - Inflammatory BC



Surgery

Recommended post-neoadjuvant treatment per study protocol[1]

The *Enhertu* monotherapy alone arm closed following IDMC recommendation on 12 March 2024[2]

Primary endpoint:

pCR (ypT0/is ypN0) (BICR)

Secondary endpoints:

- pCR (ypT0 ypN0) (BICR)
- EFS, safety, PK and immunogenicity, IDFS, OS, HRQOL

Additional outcome measures

- Residual cancer burden

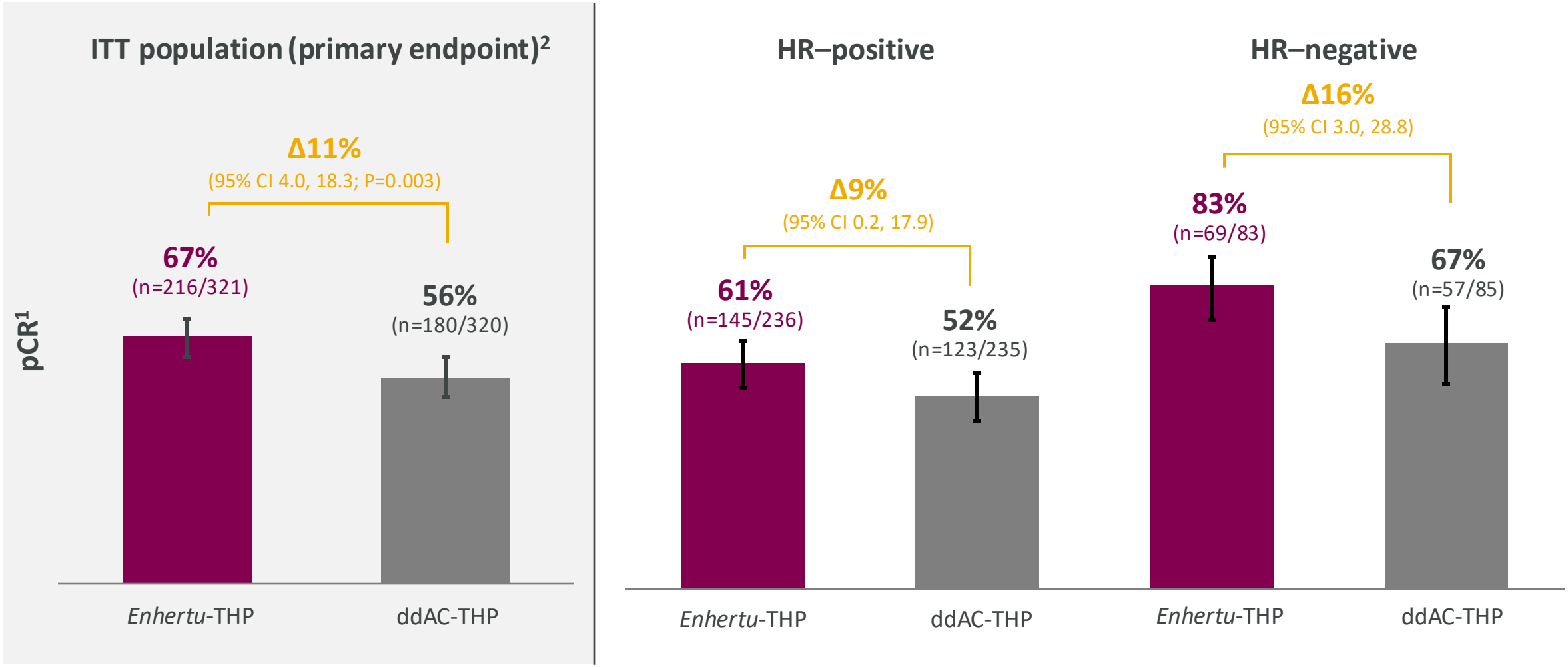
Stratification factors

- HR status: ER and/or PR–positive or negative
- HER2 status (IHC 3+ or ISH+ in the absence of IHC 3+ status)

ypT0/is ypN0, absence of invasive cancer in the breast and axillary nodes; ypT0 ypN0, absence of invasive and in-situ cancer in the breast and axillary nodes.

1. pCR: radiotherapy and concomitant trastuzumab ± pertuzumab for up to 1 year; no pCR: radiotherapy and T-DM1 for up to 14 cycles; HR–positive: endocrine therapy. 2. The reasons for closure were multifactorial, including a lower pCR rate, low likelihood that *Enhertu* alone would be superior to ddAC-THP, and the timing of surgery. The recommendation was not based on new safety findings. Harbeck N et al. Abstract 291O presented at the European Society of Medical Oncology 2025.
Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

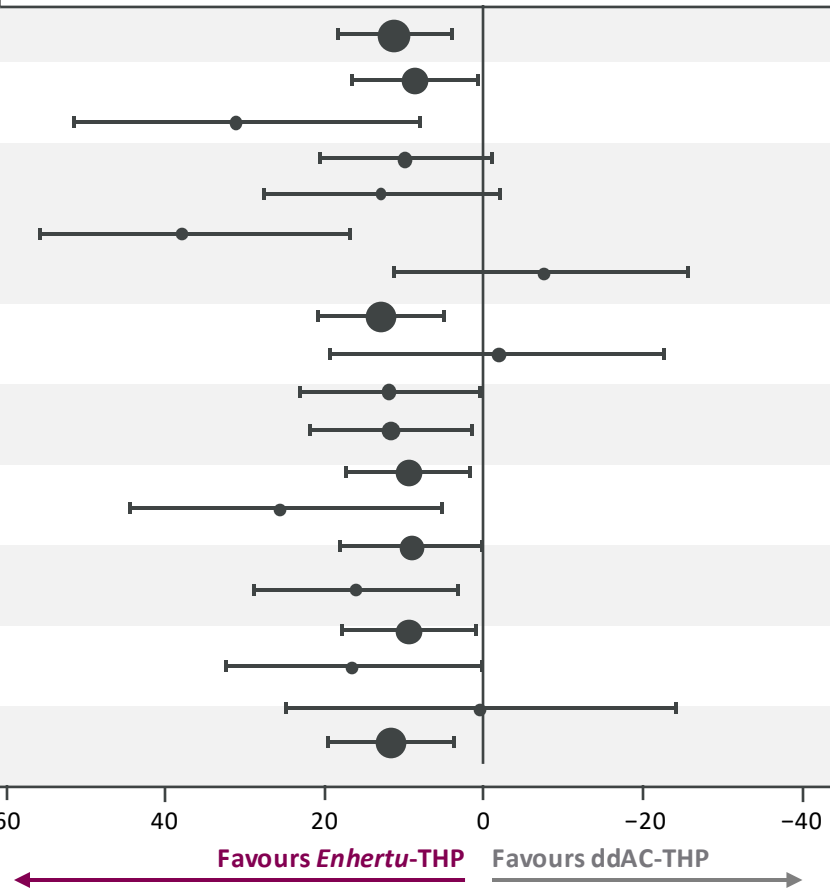
DESTINY-Breast11: Highest reported pCR rate in registrational neoadjuvant HER2+ eBC trial



1. By blinded central review.2. pCR responders were defined as patients who only received randomised study treatment (at least one dose) and had pCR.
Harbeck N et al. Abstract 291O presented at the European Society of Medical Oncology 2025. Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

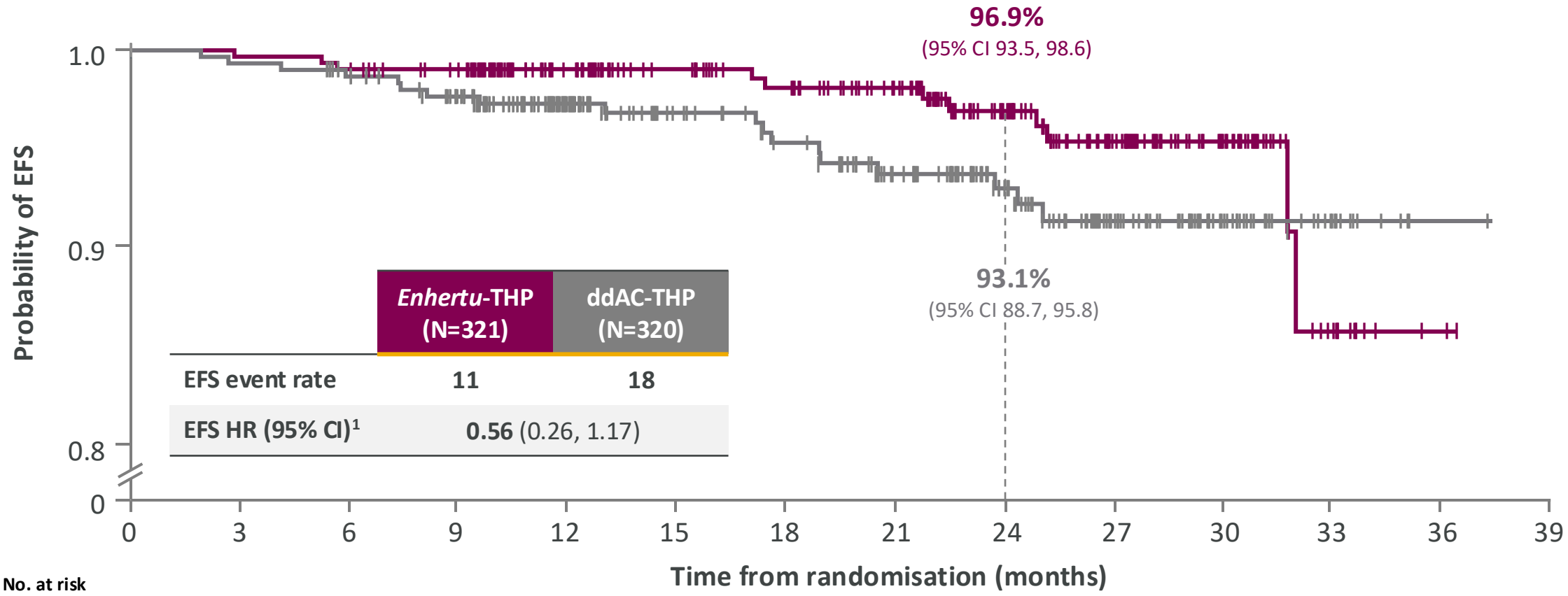
DESTINY-Breast11: Consistent benefit for *Enhertu*-THP observed across subgroups

		pCR rate, % (n/N)		ΔpCR, % (95% CI)
		***Enhertu*-THP (n=321)**	**ddAC-THP (n=320)**	
All patients		**67.3** (216/321)	**56.3** (180/320)	**11.2** (4.0, 18.3)
Age at baseline	<65 years	**66.7** (188/282)	**58.0** (167/288)	**8.7** (0.7, 16.5)
	≥65 years	**71.8** (28/39)	**40.6** (13/32)	**31.2** (8.0, 51.4)
Geographical region	Asia	**66.4** (101/152)	**56.6** (86/152)	**9.9** (−1.1, 20.6)
	Western Europe	**75.4** (52/69)	**62.3** (48/77)	**13.0** (−2.2, 27.5)
	North America	**74.4** (32/43)	**36.6** (15/41)	**37.8** (16.8, 55.7)
	Rest of world[1]	**54.4** (31/57)	**62.0** (31/50)	**−7.6** (−25.7, 11.2)
Eastern Cooperative Oncology Group performance status score	0	**68.7** (191/278)	**55.7** (156/280)	**13.0** (5.0, 20.9)
	1	**58.1** (25/43)	**60.0** (24/40)	**−1.9** (−22.6, 19.1)
Menopausal status	Post	**68.8** (86/125)	**56.9** (87/153)	**11.9** (0.5, 23.0)
	Pre	**66.8** (123/184)	**55.2** (90/163)	**11.6** (1.4, 21.7)
HER2 status	IHC 3+	**71.1** (199/280)	**61.5** (174/283)	**9.6** (1.8, 17.3)
	Other	**42.5** (17/40)	**16.7** (6/36)	**25.8** (5.2, 44.4)
HR status	Positive	**61.4** (145/236)	**52.3** (123/235)	**9.1** (0.2, 17.9)
	Negative	**83.1** (69/83)	**67.1** (57/85)	**16.1** (3.0, 28.8)
American Joint Committee on Cancer clinical stage	II–IIIA	**65.7** (163/248)	**56.4** (146/259)	**9.4** (0.9, 17.7)
	IIIB–IIIC	**72.2** (52/72)	**55.7** (34/61)	**16.5** (0.1, 32.3)
Nodal status	N0	**57.7** (15/26)	**57.1** (20/35)	**0.6** (−24.2, 24.8)
	N+	**68.3** (196/287)	**56.6** (159/281)	**11.7** (3.8, 19.5)



Size of circle is proportional to the number of patients. 1. Brazil, Bulgaria, Peru, Poland, Russia, and Saudi Arabia.
Harbeck N et al. Abstract 291O presented at the European Society of Medical Oncology 2025. Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast11: Promising early EFS trend for *Enhertu*-THP



No. at risk

Enhertu-THP	321	315	313	305	248	220	208	189	141	93	50	14	2	0
ddAC-THP	320	303	296	285	231	199	187	163	124	72	35	14	1	0

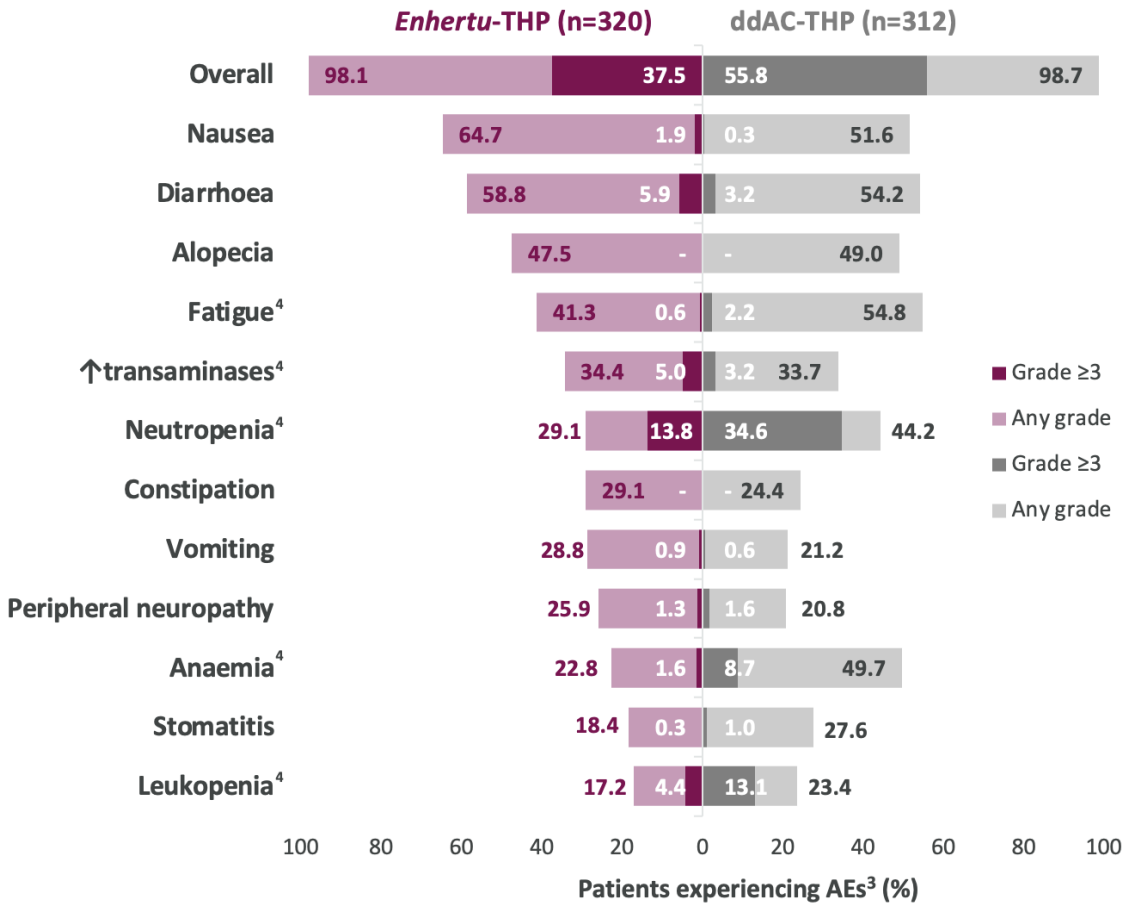
The median duration of follow up was 24.3 months with *Enhertu*-THP and 23.6 months with ddAC-THP.

1. At data cutoff (March 12, 2025) EFS event maturity was 4.5%; at final cutoff, maturity is predicted to be ~10%.

Harbeck N et al. Abstract 291O presented at the European Society of Medical Oncology 2025. Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast11: *Enhertu*-THP demonstrates a favourable safety profile vs ddAC-THP

Events, n (%)	*Enhertu*-THP (n=320)[1]	ddAC-THP (n=312)[1]
Any AE	314 (98.1)	308 (98.7)
Grade ≥3	120 (37.5)	174 (55.8)
Any serious AE	34 (10.6)	63 (20.2)
AE leading to any dose reduction	58 (18.1)	60 (19.2)
AE leading to any drug interruption	121 (37.8)	170 (54.5)
AE leading to any treatment discontinuation	45 (14.1)	31 (9.9)
Any AE with outcome of death[1]	2 (0.6)	2 (0.6)
AE of special interest		
Drug-related adjudicated ILD/pneumonitis	14 (4.4)	16 (5.1)
Grade ≥3	2 (0.6)	6 (1.9)
Left ventricular dysfunction	4 (1.3)	19 (6.1)
Grade ≥3	1 (0.3)	6 (1.9)
AE leading to surgical delay[2]	11 (3.4)	8 (2.6)



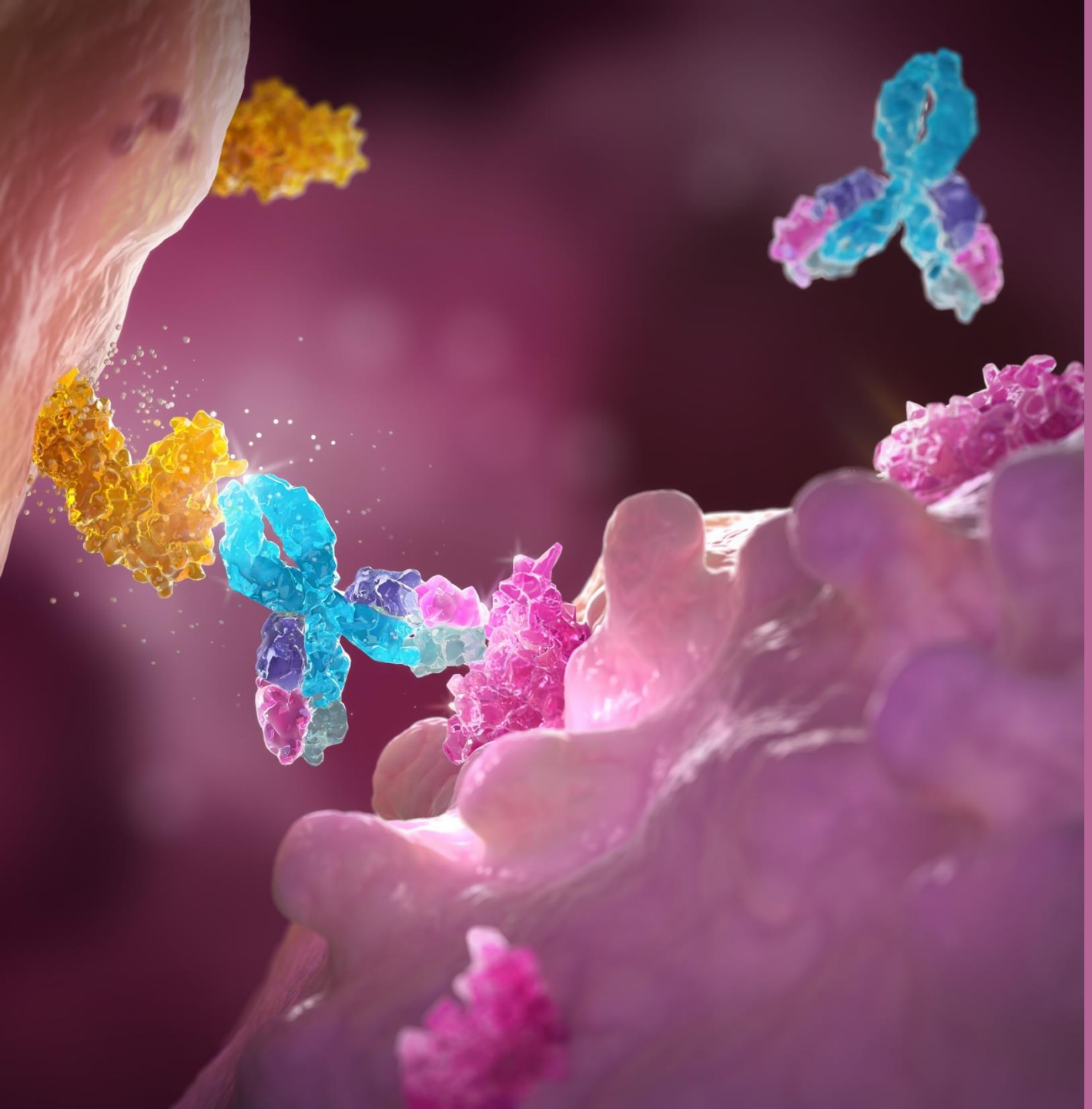
Median total treatment duration of whole regimen was 24.1 months (*Enhertu*-THP), and 21.0 months (ddAC-THP). 1. Safety analyses included all patients who received at least one dose of any study treatment; 1. *Enhertu*-THP arm: death of unknown cause (n=1), drug-related pneumonitis adjudicated by the Independent ILD Adjudication Committee (n=1); ddAC-THP arm: investigator-determined drug-related bacterial encephalitis (n=1), drug-related pneumonitis adjudicated by the ILD Adjudication Committee (n=1). 2. Defined as surgery not occurring within 3–6 weeks after the last cycle of neoadjuvant treatment. 3. Treatment-emergent AEs in at least 20% of patients in either arm. 4. Grouped term.
Harbeck N et al. Abstract 291O presented at the European Society of Medical Oncology 2025. Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast11: *Enhertu*-THP potential to be preferred regimen for patients with high-risk HER2+ eBC

- *Enhertu*-THP showed a 67% pCR rate, the highest reported in a HER2+ eBC registrational study in the neoadjuvant setting, despite a high-risk, predominantly HR+ population
- Early positive trend in EFS was observed, favouring *Enhertu*-THP vs ddAC-THP (HR 0.56)
- Safety profile of *Enhertu*-THP was favourable vs ddAC-THP
  - Lower rates of Grade ≥3 AEs, serious AEs, and AEs leading to dose reductions/interruptions
  - Lower rates of haematological AEs, left-ventricular dysfunction, and fatigue
  - Similar and low ILD rates between arms

Enhertu-THP has the potential to transform the neoadjuvant treatment landscape, underscoring the importance of bringing _Enhertu_ into earlier stages of HER2+ disease

Harbeck N et al. Abstract 291O presented at the European Society of Medical Oncology 2025. Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

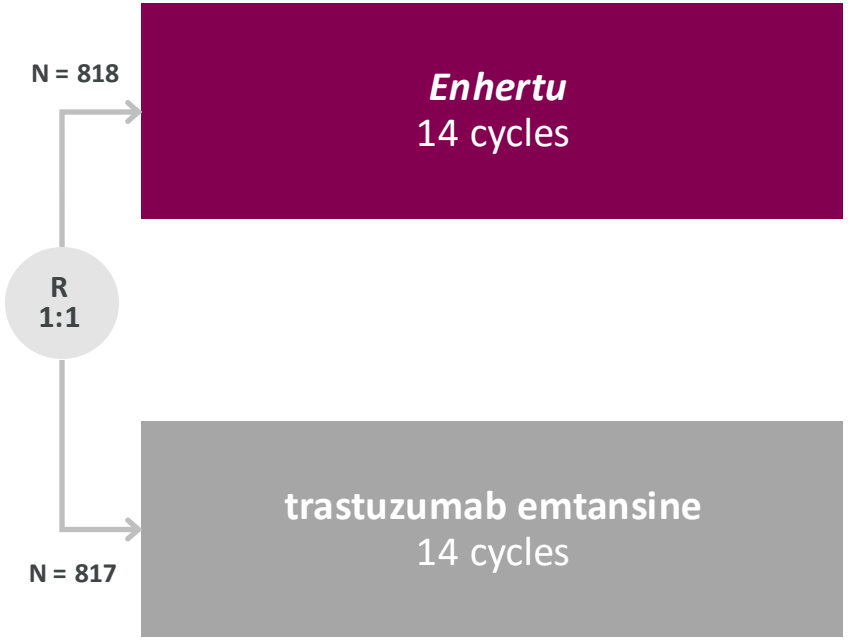


DESTINY-Breast05

Prof. Nadia Harbeck
BREAST CENTER DIRECTOR,
LMU UNIVERSITY HOSPITAL,
MUNICH

DESTINY-Breast05: Moving *Enhertu* into high-risk post-neoadjuvant setting

- High-risk[1] HER2+ eBC
- Residual disease after neoadjuvant chemotherapy and preoperative HER2-directed treatment
- ECOG PS 0 or 1



Primary endpoint:
IDFS (inv)

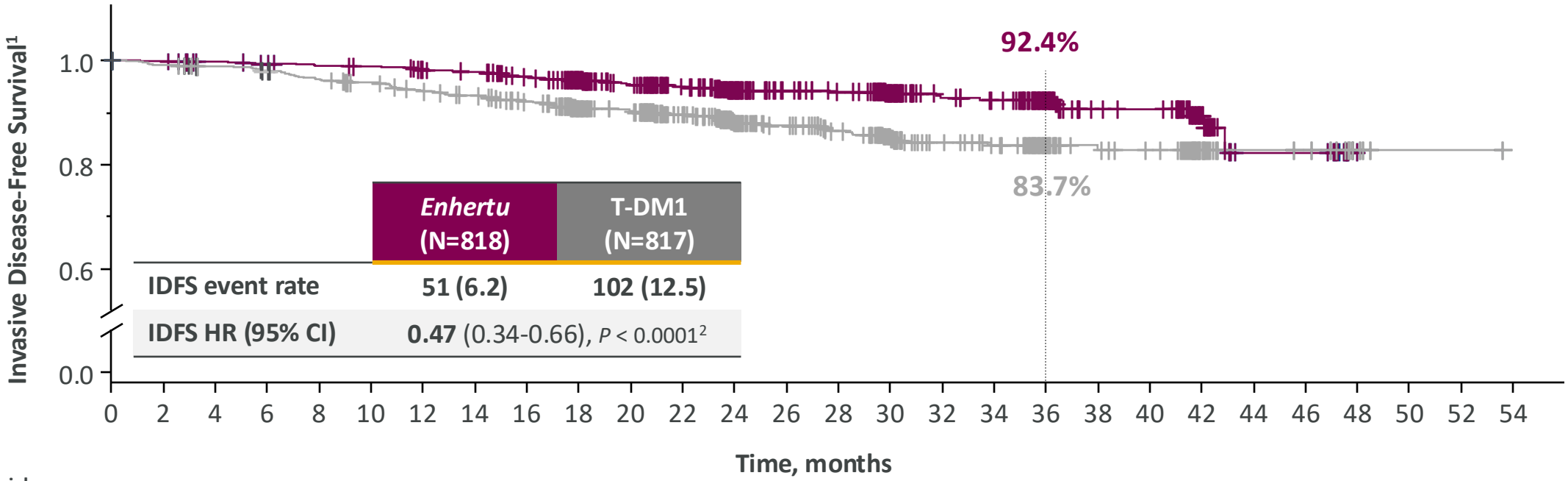
Key secondary endpoint:
DFS (inv)

Secondary endpoints:
- OS
- DRFI (inv)
- BMFI (inv)
- Safety

Stratification factors
- Extent of disease status at presentation
- HER2-targeted NAT (single, dual)
- Hormone receptor status
- Post-NAT pathologic nodal status

1. High risk is defined as clinical stages T4, N0-3, M0 or T1-3, N2-3, M0 at presentation (prior to NAT) or clinical stages T1-3, N0-1, M0, with axillary node-positive disease (ypN1-3) following NAT.
Geyer C et al. Abstract LBA1 presented at the European Society of Medical Oncology 2025.
Collaboration partner: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast05: *Enhertu* reduced the risk of invasive disease recurrence or death by 53% vs T-DM1



No. at risk:

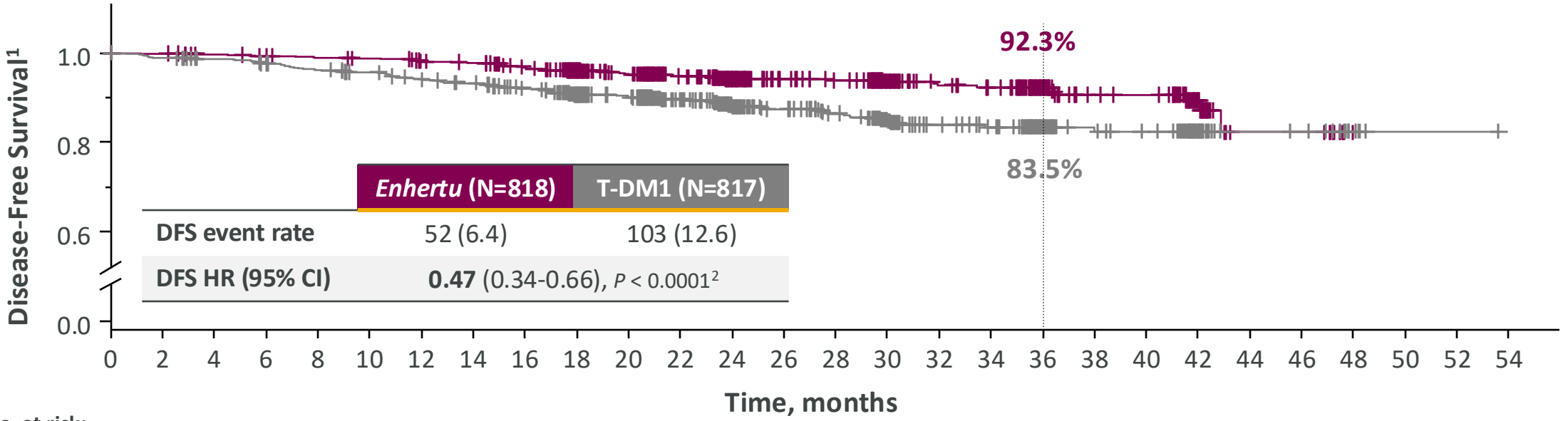
Enhertu	818	788	781	776	771	768	758	753	731	684	634	544	440	380	370	275	218	212	129	92	90	46	14	14	0	0	0	0
T-DM1	817	781	769	760	745	734	719	708	687	632	599	527	417	355	337	233	186	177	120	84	79	38	14	13	4	1	1	0

Consistent benefit across all pre-specified subgroups including extent of disease status at presentation, HR status, post-NAT pathologic nodal status, and HER2-targeted NAT approach

Efficacy stopping boundary, P = 0.0183.

1. IDFS is defined as the time from randomization until the date of first occurrence of one of the following events: recurrence of ipsilateral invasive breast tumor, recurrence of ipsilateral locoregional invasive breast cancer, contralateral invasive breast cancer, a distant disease recurrence, or death from any cause. 2. Two-sided P value from stratified log-rank test. Hazard ratio and 95% CI from stratified Cox proportional hazards model with stratification factor of operative status at disease presentation.
Geyer C et al. Abstract LBA1 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast05: Secondary endpoints supportive of Enhertu benefit vs T-DM1



No. at risk:

Enhertu	818	788	781	776	771	768	758	753	731	683	633	543	440	380	370	275	218	212	129	92	90	46	14	14	0	0	0	0
T-DM1	817	779	767	757	743	733	718	707	686	631	598	526	416	354	336	233	186	177	120	84	79	38	14	13	4	1	1	0

Consistent benefit across DRFI, BMFI and early trend to OS improvement (HR 0.61) at 2.9% maturity

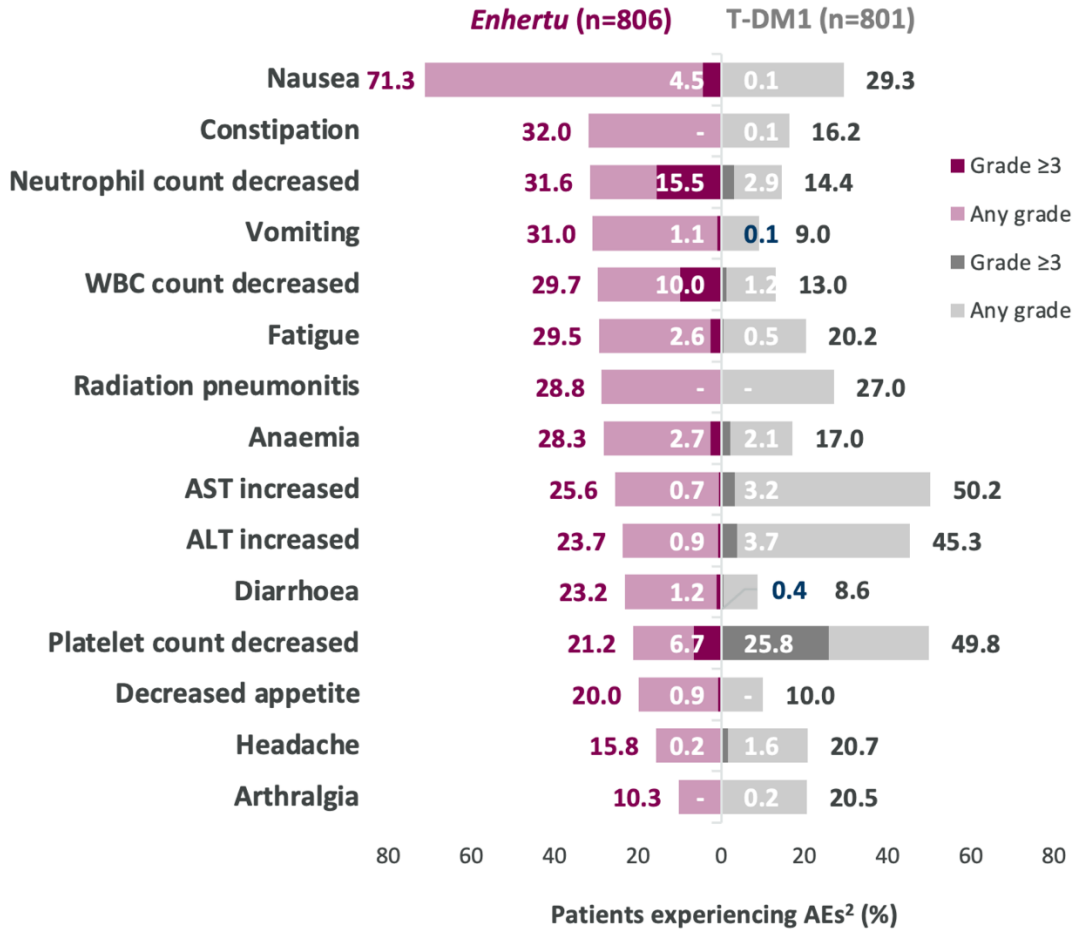
1. DFS defined as the time between randomization and the date of the first occurrence of an IDFS event per STEEP criteria, including second primary non-breast cancer event or contralateral or ipsilateral ductal carcinoma in situ. 2. Two-sided P value from stratified log-rank test. Hazard ratio and 95% CI from stratified Cox proportional hazards model with stratification factor of operative status at disease presentation.

Geyer C et al. Abstract LBA1 presented at the European Society of Medical Oncology 2025.

Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast05: Generally manageable AE profile consistent with prior trials of *Enhertu*

TEAEs, n (%)	*Enhertu* n=806[1]	T-DM1 n=801[1]
Any-grade	802 (99.5)	788 (98.4)
Grade ≥3	408 (50.6)	416 (51.9)
Serious	140 (17.4)	109 (13.6)
Associated with drug discontinuation	144 (17.9)	103 (12.9)
Related to drug-related ILD	30 (3.7)	8 (1.0)
Associated with drug interruptions	400 (49.6)	329 (41.1)
Associated with dose reductions	213 (26.4)	213 (26.6)
Associated with deaths	3 (0.4)	5 (0.6)



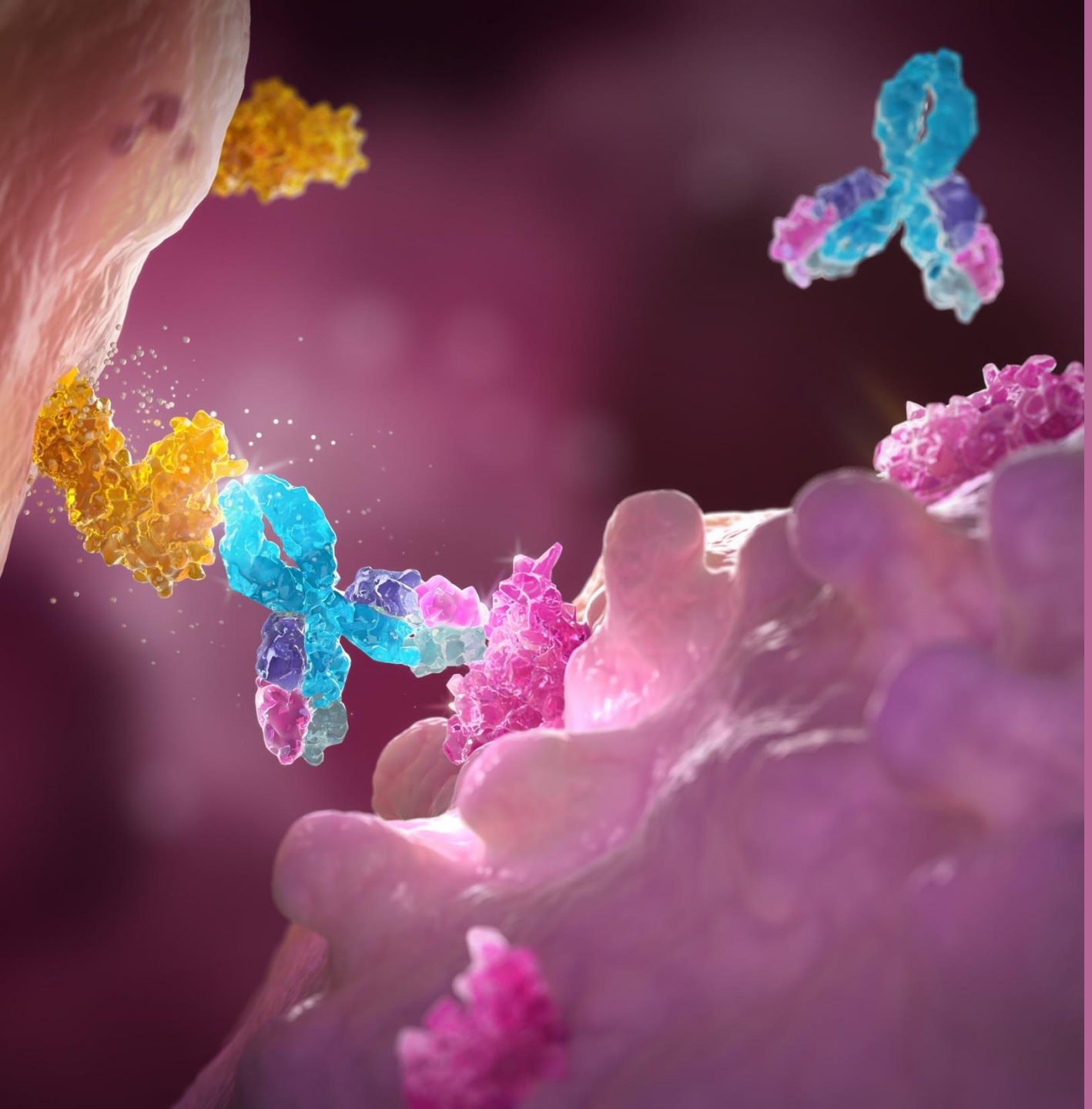
1. All patients who received at least 1 dose of study treatment. 2. TEAEs in ≥20% of patients (either arm).
Geyer C et al. Abstract LBA1 presented at the European Society of Medical Oncology 2025.
Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast05: Post-neoadjuvant *Enhertu* potential new standard-of-care in high-risk HER2+ eBC

- *Enhertu* showed a statistically significant and clinically meaningful IDFS and DFS benefit versus T-DM1 in patients with HER2+ eBC with residual invasive disease and high risk of recurrence after neoadjuvant therapy
- Efficacy benefit was consistent across all prespecified subgroups
- Clinically meaningful benefit was observed in additional secondary endpoints
- The overall safety profiles of *Enhertu* and T-DM1 were generally manageable with no new safety signals

Opportunity to transform clinical practice in the post-neoadjuvant setting for patients with high-risk disease

Geyer C et al. Abstract LBA1 presented at the European Society of Medical Oncology 2025.
Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

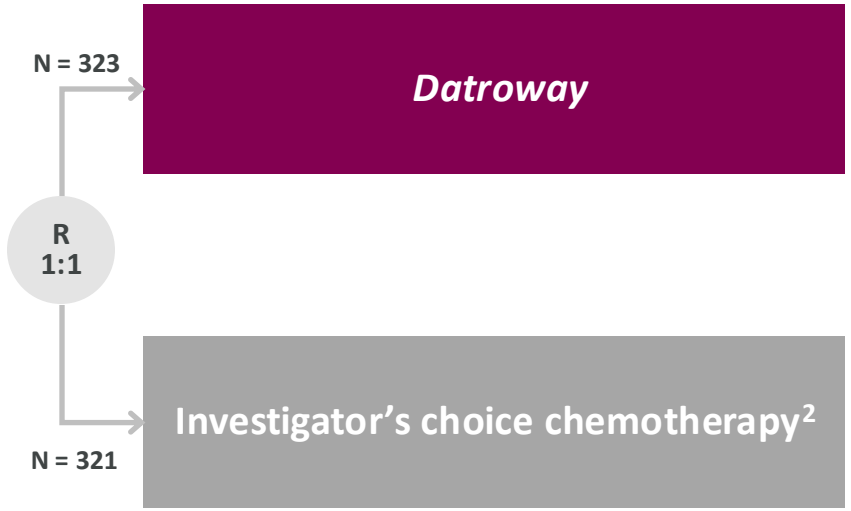


TROPION-Breast02

Prof. Rebecca Dent
HEAD OF DEPARTMENT OF MEDICAL ONCOLOGY, CHIEF OF BREAST MEDICAL ONCOLOGY, NATIONAL CANCER CENTER SINGAPORE

TROPION-Breast02: Establishing *Datroway* in 1L TNBC with positive overall survival data

- Locally recurrent inoperable or metastatic TNBC
- No prior chemotherapy or targeted systemic therapy in the locally recurrent inoperable or metastatic setting
- Immunotherapy not an option[1]
- ECOG PS 0 or 1
- No minimum DFI



Dual primary endpoints:

PFS (BICR), OS

Secondary endpoints included:

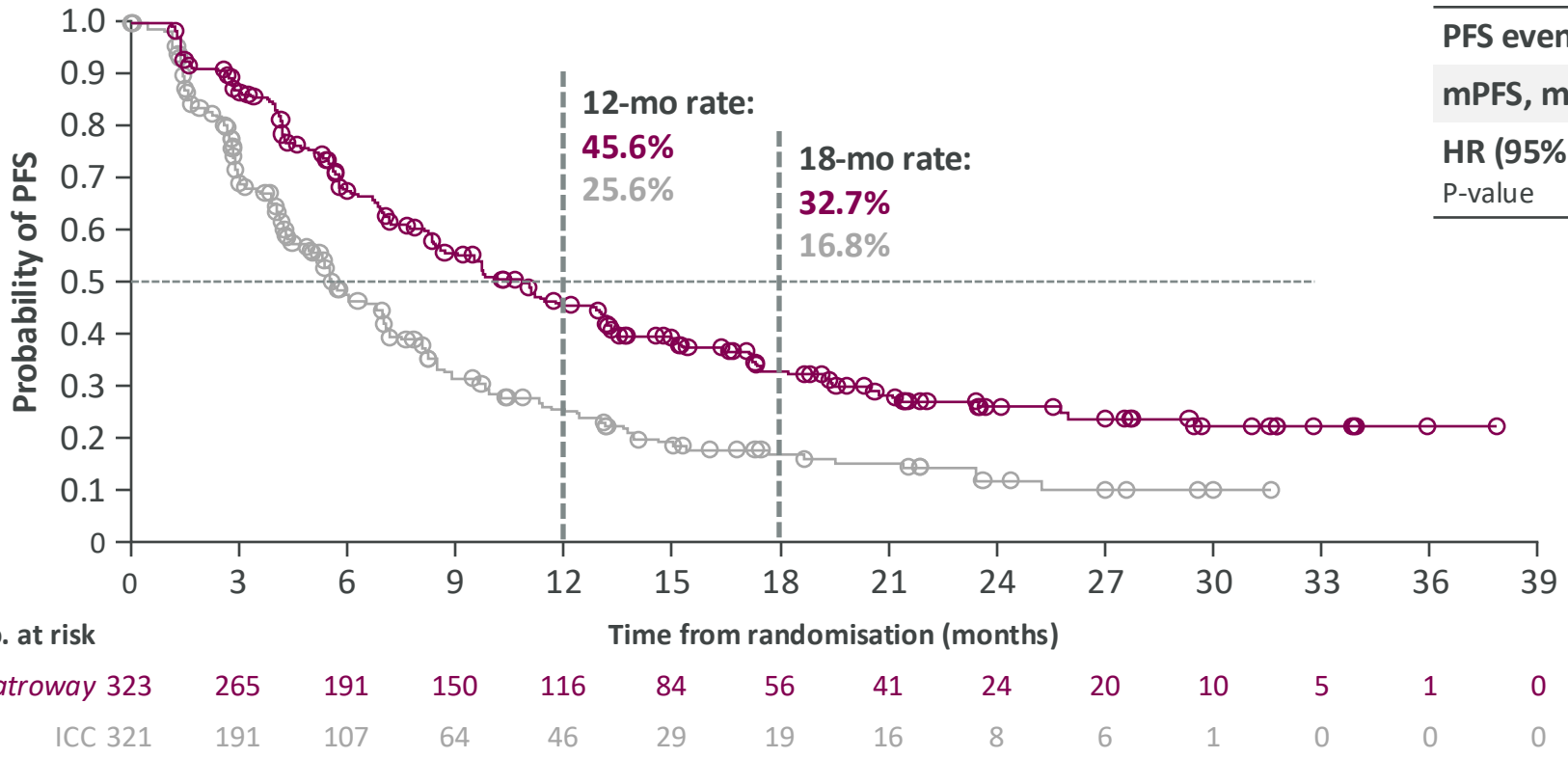
- ORR, DoR
- PFS (inv)
- Safety

Stratification factors

- Geographic region (US/Canada/Europe vs other geographic regions)
- DFI history (*de novo* vs prior DFI 0-12 months vs prior DFI >12 months)
- PD-L1 status (high [CPS ≥10] vs low [CPS <10])

1. Including patients with PD-L1 low tumours, or patients with PD-L1 high tumours with (a) disease relapse after prior PD-(L)1 inhibitor therapy for early-stage breast cancer, (b) comorbidities precluding PD-(L)1 inhibitor therapy, or (c) no regulatory access to PD-(L)1 inhibitor therapy. 2. If no prior taxane, or prior taxane in the (neo)adjuvant setting and DFI >12 months: paclitaxel 80 mg/m² IV, D1, 8, 15, Q3W, or nab-paclitaxel 100mg/m² IV, D1, 8, 15, Q4W; if prior taxane and DFI 0–12 months: capecitabine 1000 or 1250 mg/m² orally twice daily, D1–14, Q3W (dose determined by standard institutional practice), or eribulin mesylate 1.4 mg/m² / eribulin 1.23 mg/m² IV, Day 1, 8, Q3W, or carboplatin AUC6 IV, D1, Q3W. Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

TROPION-Breast02: *Datroway* reduced the risk of progression or death by 43% vs chemotherapy

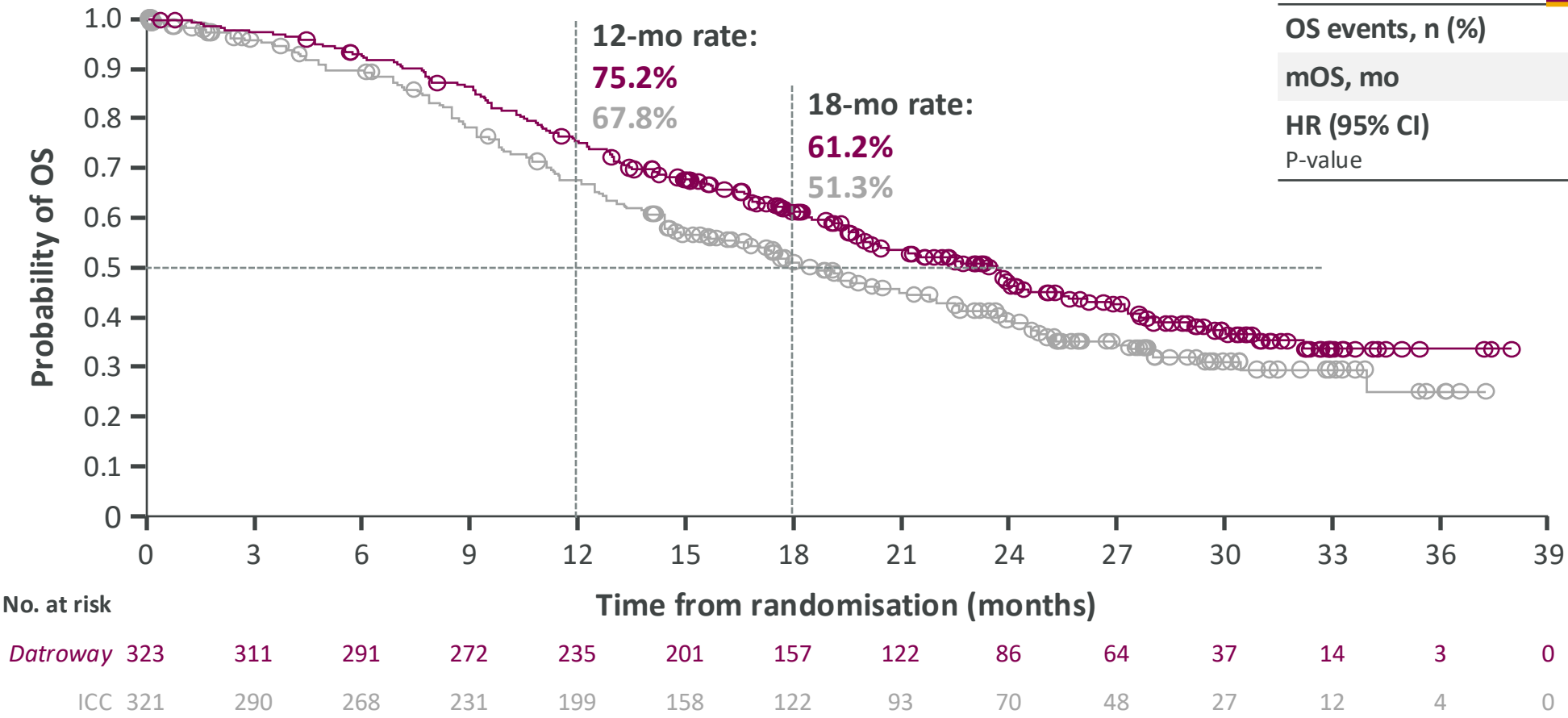


	Datroway	ICC
PFS events, n (%)	199 (62)	209 (65)
mPFS, mo	10.8	5.6
HR (95% CI)	**0.57 (0.47–0.69)**	
P-value	<0.0001	

PFS by investigator assessment was consistent with PFS by BICR

Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

TROPION-Breast02: *Datroway* improved overall survival by 5 months vs chemotherapy

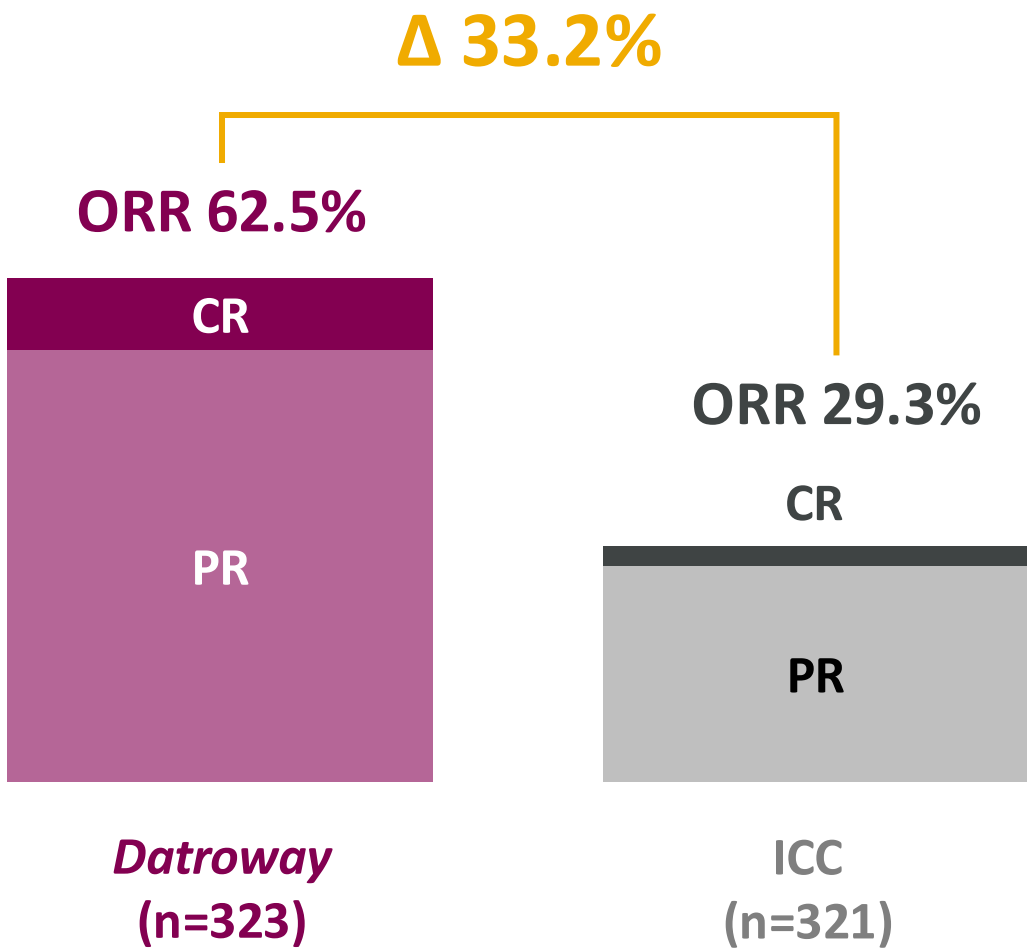


	Datroway	ICC
OS events, n (%)	168 (52)	181 (56)
mOS, mo	23.7	18.7
HR (95% CI)	**0.79 (0.64–0.98)**	
P-value	0.0291	

No. at risk														
Datroway	323	311	291	272	235	201	157	122	86	64	37	14	3	0
ICC	321	290	268	231	199	158	122	93	70	48	27	12	4	0

Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

TROPION-Breast02: *Datroway* improved objective response rate by 33% vs chemotherapy



	Datroway (n=323)	ICC (n=321)
Confirmed ORR, n (%)	202 (62.5)	94 (29.3)
Odds ratio (95% CI)	4.24 (3.03–5.95)	
Best confirmed objective response, n (%)		
Complete response	29 (9.0)	8 (2.5)
Partial response	173 (53.6)	86 (26.8)
Stable disease	87 (26.9)	151 (47.0)
Progressive disease	27 (8.4)	52 (16.2)
Not evaluable	7 (2.2)	24 (7.5)

Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

TROPION-Breast02: Manageable and tolerable safety profile throughout longer duration of therapy

	Datroway (n=319)	ICC (n=309)
Median total treatment duration, mo (range)	8.5 (0.7–38.0)	4.1 (0.1–32.0)
Total exposure >12 months, %	35.1	9.4
Treatment-related AEs, n (%)		
Any grade TRAEs	296 (93)	257 (83)
Grade ≥3 TRAEs	105 (33)	89 (29)
Serious TRAEs	29 (9)	26 (8)
TRAEs associated with discontinuation	14 (4)	23 (7)
TRAEs associated with death	0	0

Treatment-related AEs[1], n (%)	*Datroway* (n=319)		ICC (n=309)	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Dry eye[2]	76 (24)	4 (1)	9 (3)	0
Stomatitis	182 (57)	27 (8)	27 (9)	0
Nausea	142 (45)	2 (<1)	53 (17)	2 (<1)
Constipation	72 (23)	1 (<1)	31 (10)	0
Vomiting	65 (20)	4 (1)	23 (7)	1 (<3)
Decreased appetite	49 (15)	1 (<1)	20 (6)	1 (<1)
Neutropenia[3]	39 (12)	10 (3)	90 (29)	40 (13)
Anaemia[3]	48 (15)	6 (2)	64 (21)	10 (3)
Leukopenia[3]	27 (8)	3 (<1)	55 (18)	13 (4)
Peripheral neuropathy[3]	14 (4)	0	75 (24)	5 (2)
Alopecia	130 (41)	0	96 (31)	1 (<3)‖
Fatigue[3]	101 (32)	8 (3)	86 (28)	9 (3)

1. Most common treatment-related AEs (≥15% of patients). 2. In the *Datroway* arm only, ophthalmologic assessments were required every 3 cycles while on therapy; this was not required in the ICC arm. For all patients in both arms, ophthalmologic assessments were required at baseline, as clinically indicated, and at end of therapy. 3. Grouped term.

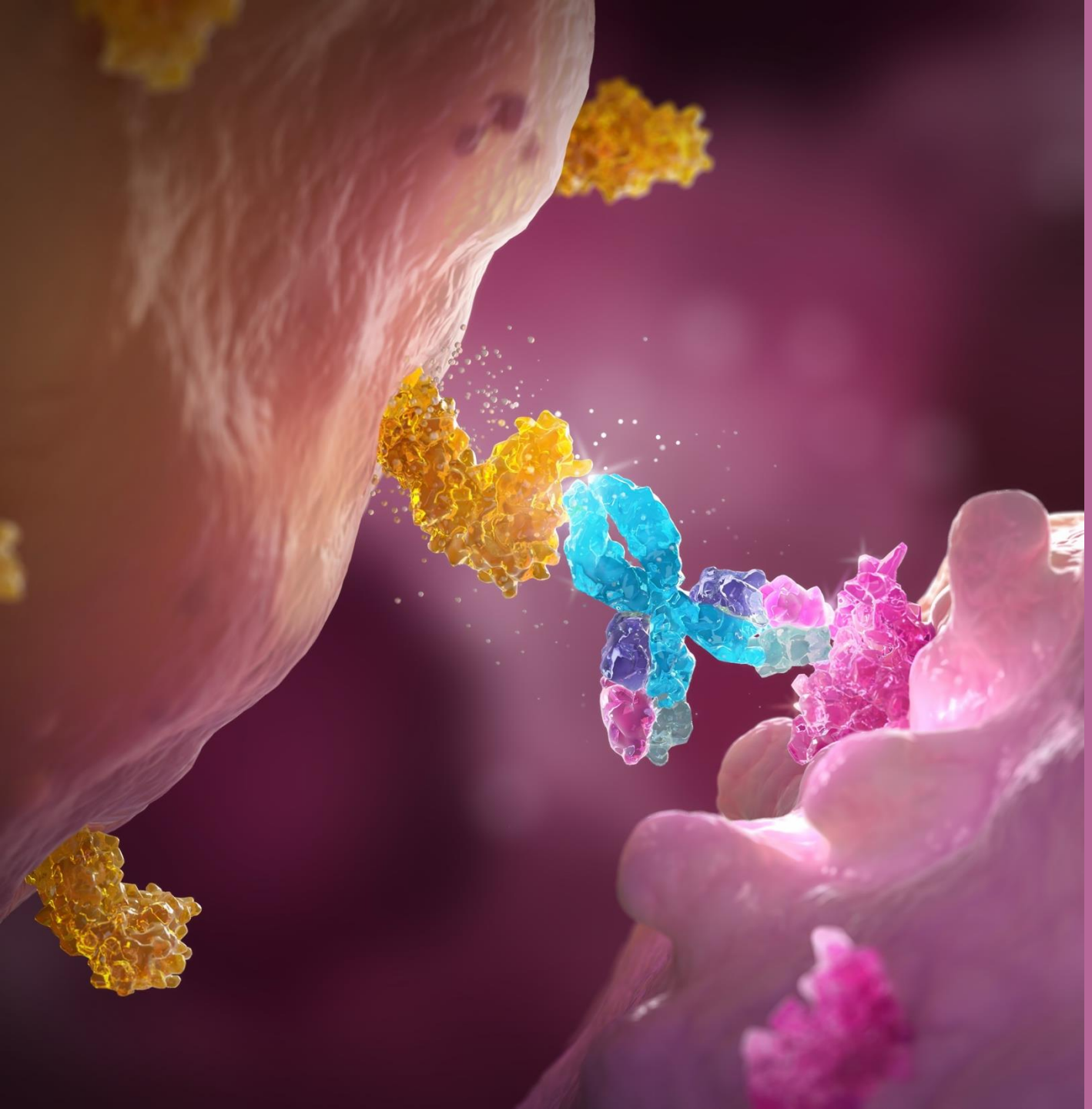
Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

TROPION-Breast02: *Datroway* to be potential new 1L SoC for patients with TNBC for whom IO is not an option

- TROPION-Breast02 met both dual primary endpoints: first-line *Datroway* demonstrated statistically significant and clinically meaningful improvement in OS and PFS over CTx
  - 5 mo improvement in mOS, HR 0.79
  - ≥5 mo improvement in mPFS by BICR, HR 0.57
- Despite more than double the duration of treatment in the *Datroway* arm, rates of Grade ≥3 TRAEs were similar, and discontinuations were lower with *Datroway* vs CTx

Datroway is the first and only therapy to significantly improve overall survival vs CTx in this patient population

Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*). Appendix: Glossary.



Realising our ambition in breast cancer

Sunil Verma
SVP, GLOBAL HEAD,
ONCOLOGY FRANCHISE

Moving *Enhertu* into early HER2+ disease increasing probability of cure

Potential new early breast cancer treatment paradigm

DESTINY-Breast11

34k patients in G7 | neoadj. HER2+ eBC[1]

80% | high-risk disease (prior to neoadjuvant Tx)

DESTINY-Breast11
4 cycles *Enhertu* → 4 cycles THP

DESTINY-Breast05

34k patients in G7 | neoadj. HER2+ eBC[1]

50% | residual disease after neoadjuvant Tx (*Enhertu*-naïve)

55% | high-risk characteristics

DESTINY-Breast05
14 cycles *Enhertu*

DESTINY-Breast11 and DESTINY-Breast05 combined blockbuster opportunity across the Alliance

1. Estimated epidemiology for drug-treated patients in G7 in 2024. Appendix: Glossary.

Enhertu opportunity to span continuum of HER2+ breast cancer

Early			Metastatic		
Neoadjuvant	Post-neoadjuvant		1st line	2nd line	3rd line +
Est. epi (G7, 2024)	34k		23k	17k	11k
Regulatory decision H1'26	**To be shared with regulatory authorities**	RECURRENCE	**Regulatory decision H1'26**	**Approved**	**Approved**
Enhertu → THP	neoadjuvant systemic Tx → residual disease → *Enhertu*		*Enhertu* + pertuzumab	*Enhertu*	*Enhertu*
DESTINY-Breast11	**DESTINY-Breast05**		**DESTINY-Breast09**	**DESTINY-Breast03**	**DESTINY-Breast01/02**
high-risk early-stage disease	post-neoadjuvant, residual disease				

Epidemiology in the G7 countries (US, Europe 5, Japan). All consider epidemiology for drug-treated patients. Appendix: Glossary.

Datroway redefining treatment in high unmet need TNBC population

TROPION-Breast02 | First and only therapy to significantly improve overall survival vs CTx in TNBC where IO is not an option[1]

24k patients in G7 | 1L TNBC, drug treated

↳ **70%** | not candidates for IO

↳ **TROPION-Breast02**

Efficacy including OS as well as safety demonstrate clear differentiation from other possible treatment regimens

Broadening *Datroway* impact in TNBC with *Imfinzi* combinations

BEGONIA Phase Ib/II data drive confidence in combinations

79% ORR in adv./ metastatic TNBC[2]

Ongoing Phase III programme | >2026

TROPION-Breast03	TROPION-Breast04	TROPION-Breast05
Residual disease post-neoadjuvant Tx	Neoadjuvant + adjuvant Tx	1L metastatic candidates for IO
Early disease		Metastatic

1. Dent R et al. Abstract LBA21 presented at the European Society of Medical Oncology 2025. 2.n=46/62, from Schmid P et al. Abstract #555MO presented at the European Society of Medical Oncology 2025.
Collaboration partner: Daiichi Sankyo (*Datroway*). Appendix: Glossary.

Opportunity for Q&A on breast cancer

Key External Experts

Prof. Nadia Harbeck
BREAST CENTER DIRECTOR, LMU UNIVERSITY HOSPITAL, MUNICH

Dr Rebecca Dent
HEAD OF DEPARTMENT OF MEDICAL ONCOLOGY, CHIEF OF BREAST MEDICAL ONCOLOGY, NATIONAL CANCER CENTER SINGAPORE

AstraZeneca Leadership

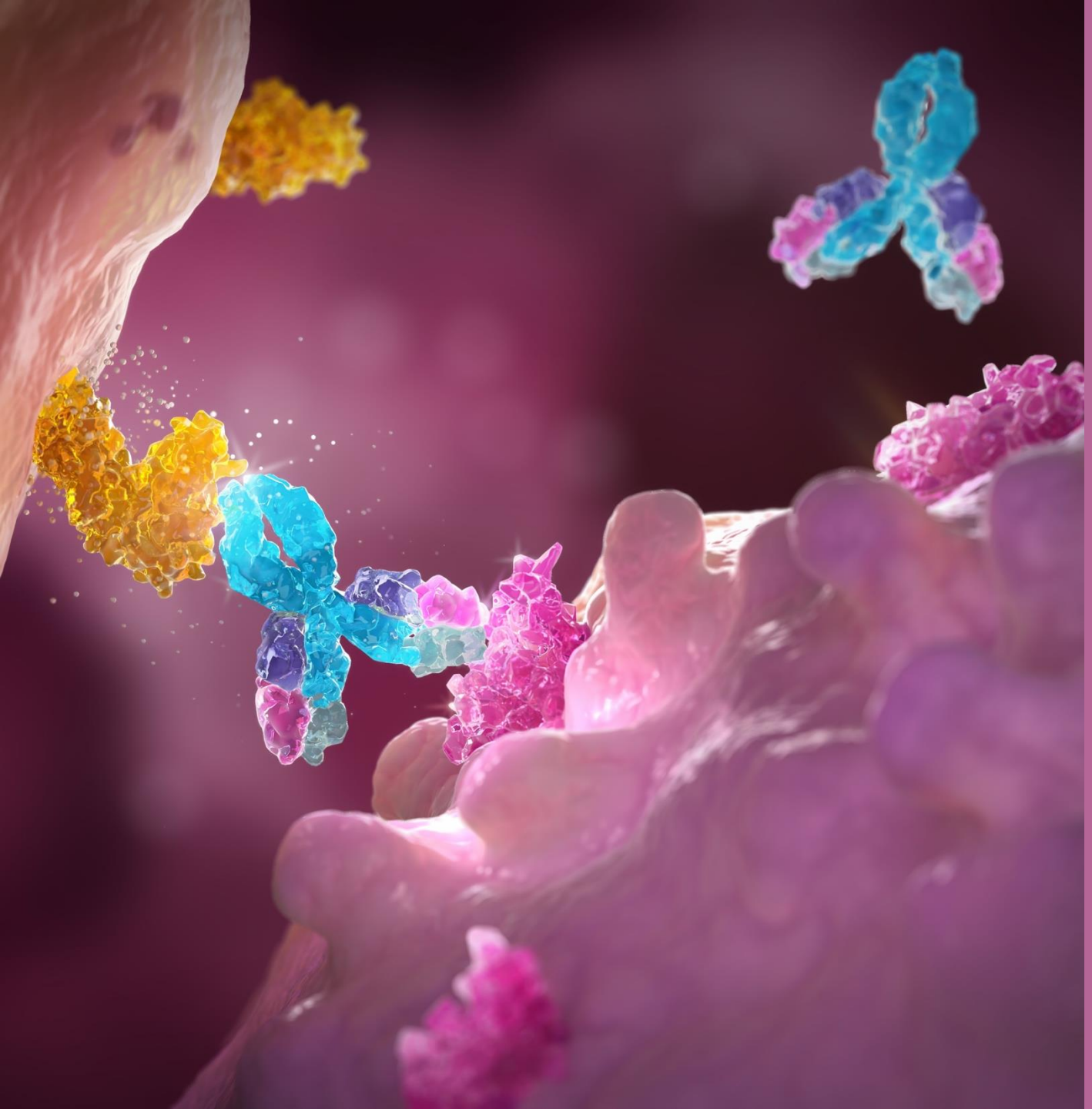
Pascal Soriot
CHIEF EXECUTIVE OFFICER

Dave Fredrickson
EVP, ONCOLOGY HAEMATOLOGY BUSINESS

Susan Galbraith
EVP, ONCOLOGY HAEMATOLOGY R&D

Leora Horn
SVP, LATE DEVELOPMENT ONCOLOGY

Sunil Verma
SVP, GLOBAL HEAD, ONCOLOGY FRANCHISE



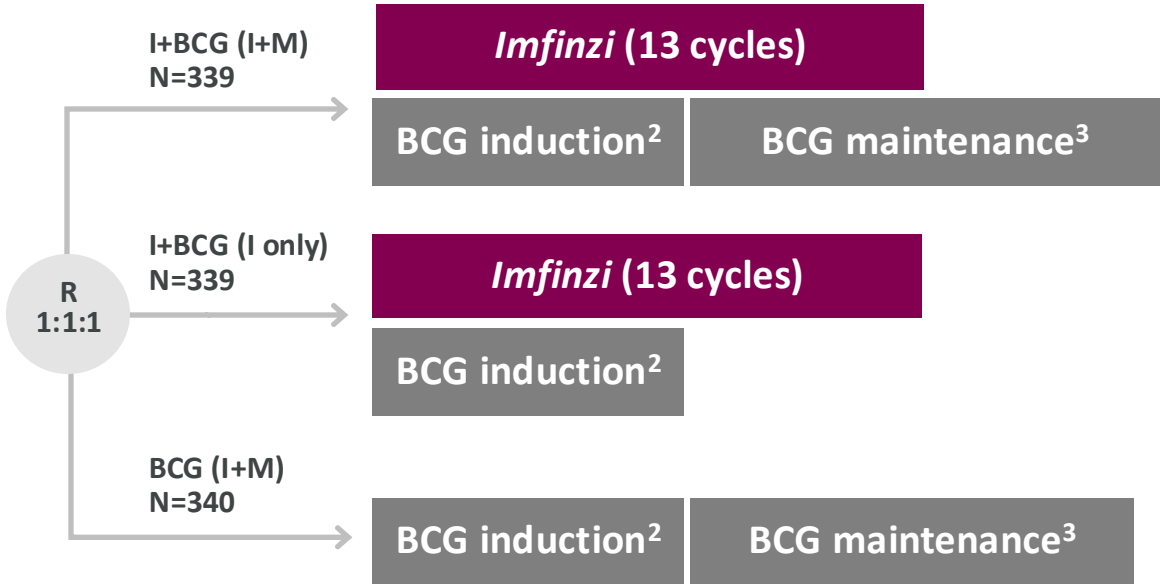
POTOMAC

Dr Neal Shore

MEDICAL DIRECTOR, START-CAROLINA UROLOGIC RESEARCH CENTER

POTOMAC: Transforming patient outcomes in a curative intent setting

- NMIBC
- BCG-naïve
- High-risk tumour defined as any of the following:
  - T1
  - High-grade/G3
  - CIS
  - Multiple and recurrent and large (≥3 cm)



Primary endpoint:

DFS: I+BCG (I+M) vs BCG (I+M)

Key secondary endpoints:

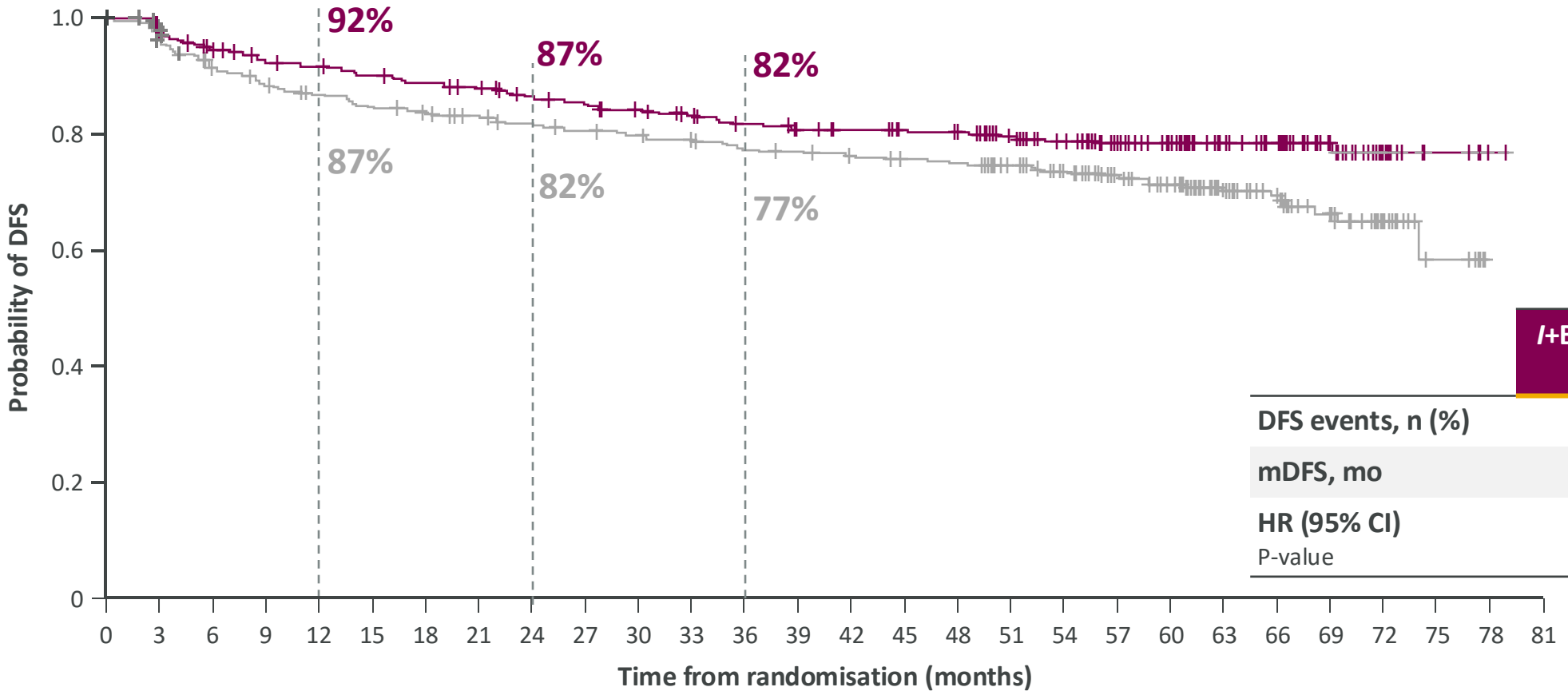
- DFS: I+BCG (I only) vs BCG (I+M)
- DFS at 24 months
- CRR at 6 months

Stratification factors

- Higher-risk papillary disease (yes vs no)[1]
- CIS (yes vs no)

1. Defined as T1G3/T1 high-grade or multiple and recurrent and large tumours (those with a diameter of ≥3 cm). 2. Weekly for 6 weeks. 3. 3 weekly doses at 3 mo, 6 mo, 12 mo, 18 mo and 24 mo.
De Santis M et al. Abstract LBA108 presented at the European Society of Medical Oncology 2025.
Appendix: Glossary.

POTOMAC: *Imfinzi* + BCG (I+M) reduced the risk of a DFS event by 32%, with an early and sustained benefit



	I+BCG (I+M) N=339	BCG (I+M) N=340
DFS events, n (%)	67 (20)	98 (29)
mDFS, mo	NR	NR
HR (95% CI)	**0.68 (0.50–0.93)**	
P-value	0.0154	

No. at risk:

***I*+BCG (I+M)**	339	321	304	292	289	283	278	273	262	257	250	245	235	229	226	222	220	204	195	156	145	108	94	57	26	9	1	0
BCG (I+M)	340	322	303	292	283	276	271	265	258	254	249	244	237	235	231	227	225	209	196	160	150	101	86	50	20	8	0	0

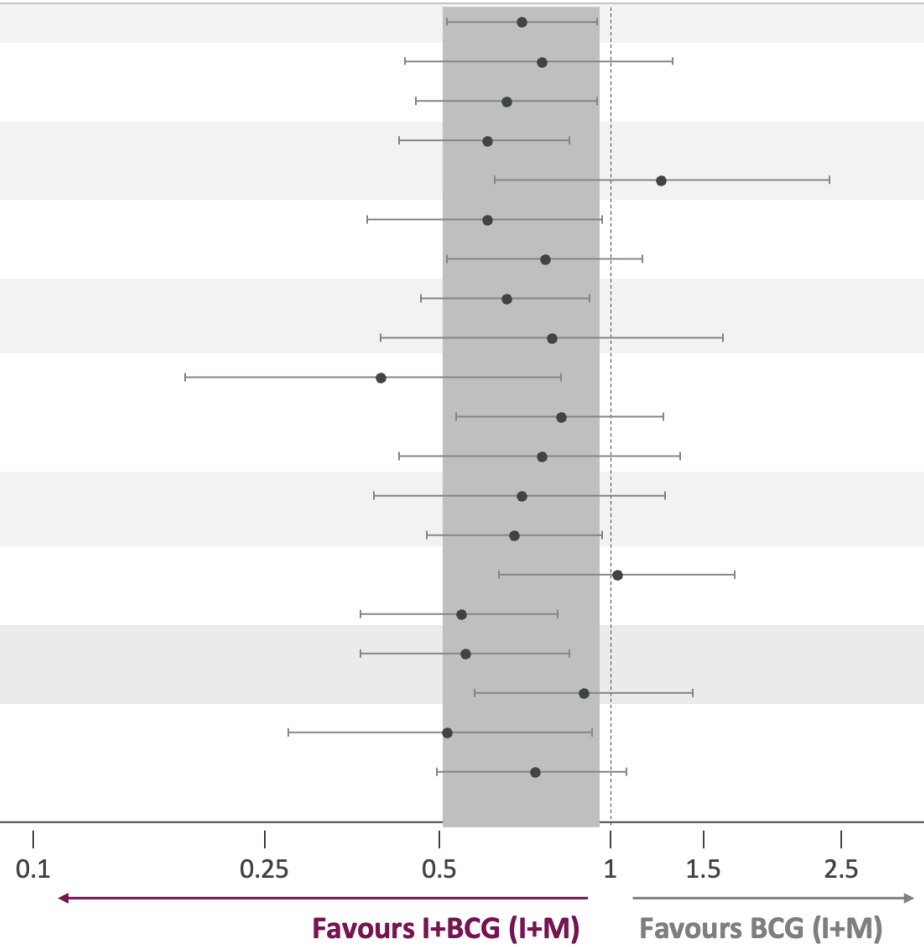
Median follow-up 60.7 months; DFS maturity 24%.

De Santis M et al. Abstract LBA108 presented at the European Society of Medical Oncology 2025.

Appendix: Glossary.

POTOMAC: Generally consistent DFS benefit across subgroups for *Imfinzi* + BCG (I+M)

Subgroup	Category	N	Hazard Ratio (95% CI)
All patients		679	0.68 (0.50–0.93)
Age	<65 years	258	0.74 (0.42–1.27)
	≥65 years	421	0.64 (0.44–0.93)
Sex	Male	547	0.59 (0.41–0.83)
	Female	132	1.21 (0.61–2.42)
Region	Western Europe	278	0.59 (0.36–0.95)
	Rest of world	401	0.75 (0.50–1.12)
ECOG PS	0	598	0.64 (0.45–0.90)
	1	81	0.77 (0.38–1.56)
Smoking status	Current	125	0.38 (0.17–0.80)
	Former	348	0.80 (0.52–1.22)
	Never	206	0.74 (0.41–1.31)
BCG strain	TICE®	162	0.68 (0.37–1.23)
	Other	513	0.66 (0.46–0.95)
CIS[1]	Yes	250	1.01 (0.62–1.64)
	No	429	0.53 (0.34–0.79)
Higher risk papillary disease[2]	Yes	346	0.54 (0.35–0.83)
	No	333	0.88 (0.56–1.38)
PD-L1 expression[3]	High (≥TC/IC25%)	166	0.50 (0.26–0.91)
	Low/negative	467	0.72 (0.48–1.05)
	Missing/not evaluable	46	NC (NC–NC)

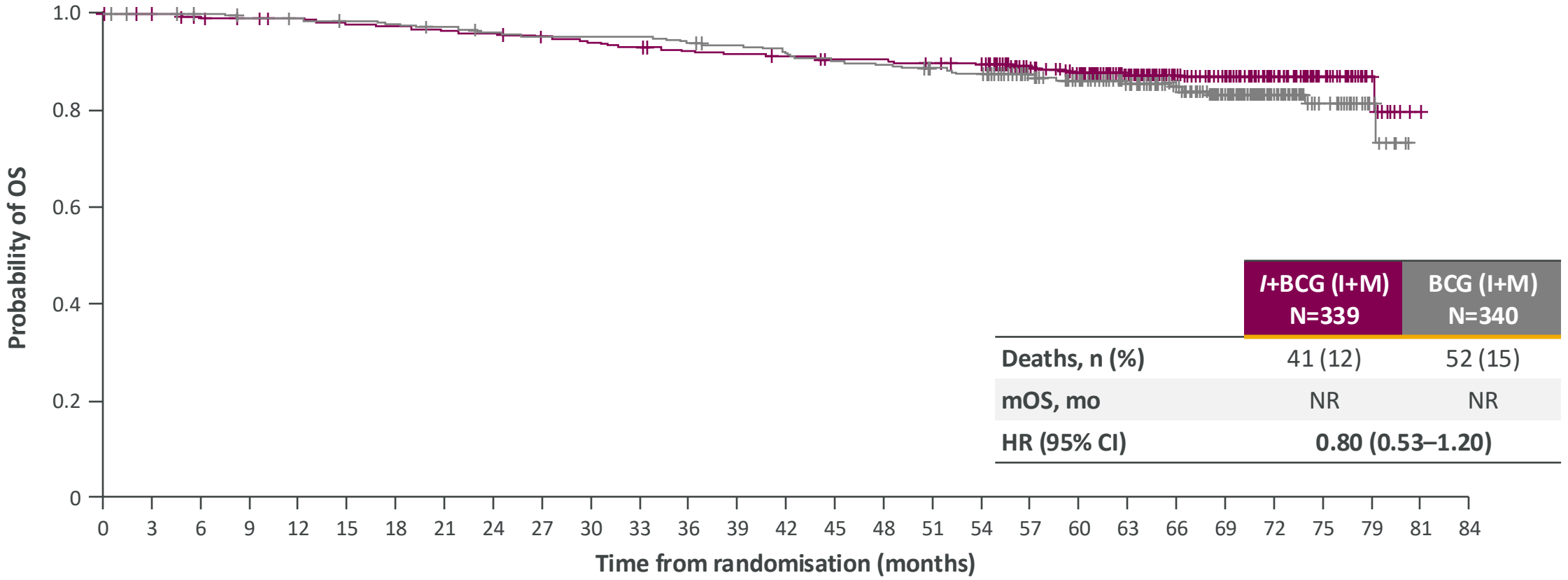


1. With or without papillary disease as recorded per interactive voice response system. 2. Defined as T1G3/T1 high-grade or multiple and recurrent and large tumours (those with a diameter of ≥3 cm). 3. Assessed with the investigational VENTANA PD-L1 (SP263) Assay; high PD-L1 expression was defined as any of the following: ≥25% of TC exhibit membrane staining; or ICP >1% and IC+ ≥25%; or ICP=1% and IC+=100%. Data cutoff 03 April 2025.

De Santis M et al. Abstract LBA108 presented at the European Society of Medical Oncology 2025.

Appendix: Glossary.

POTOMAC: No evidence of OS detriment with *Imfinzi* + BCG (I+M)



	I+BCG (I+M) N=339	BCG (I+M) N=340
Deaths, n (%)	41 (12)	52 (15)
mOS, mo	NR	NR
HR (95% CI)	0.80 (0.53–1.20)	

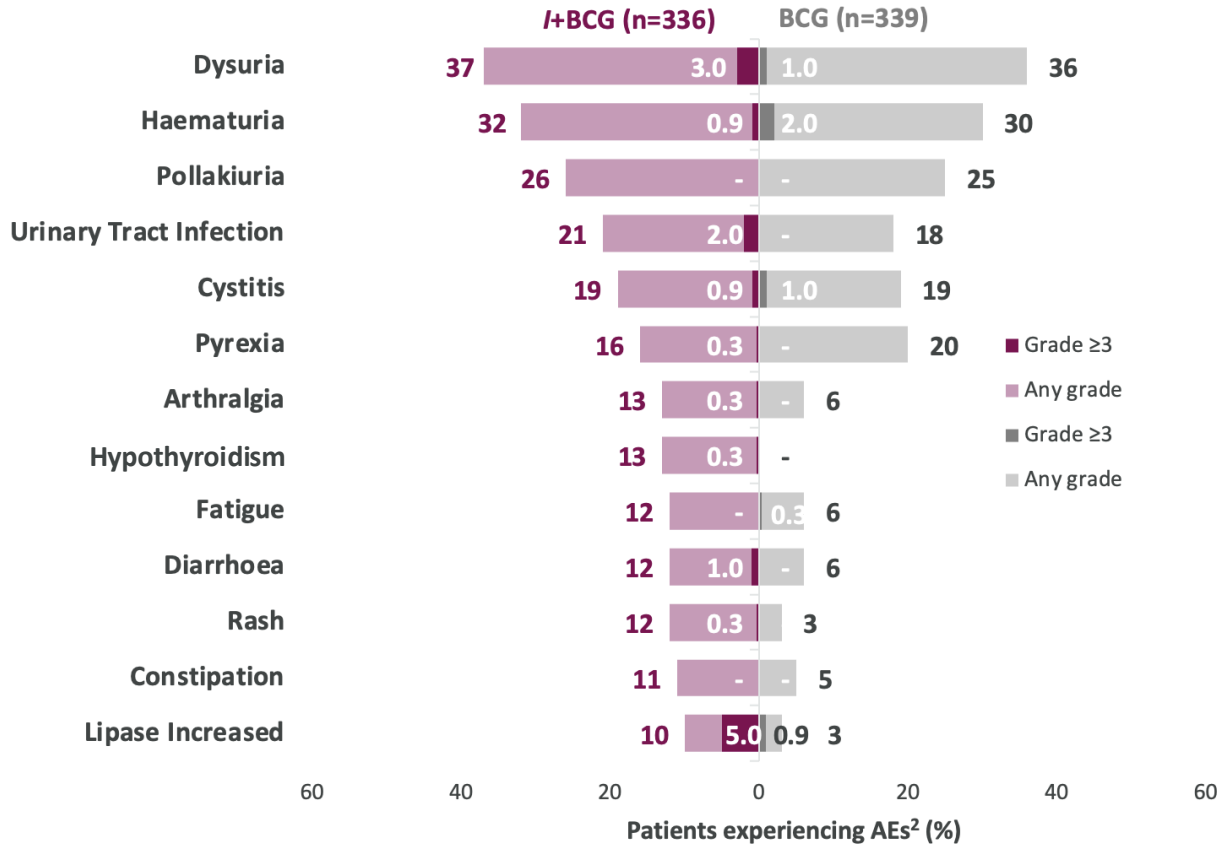
No. at risk:

***I*+BCG (I+M)**	339	336	328	325	323	319	318	314	313	310	305	302	297	295	292	289	289	285	282	246	222	184	144	115	73	34	14	1	0
BCG (I+M)	340	338	336	333	330	328	326	323	318	315	315	315	311	307	303	297	294	289	285	249	228	195	147	111	71	33	12	0	0

Median follow-up 65.6 mo in the I+BCG (I+M) arm and 65.9 mo in the BCG (I+M) arm; OS maturity 14%.
De Santis M et al. Abstract LBA108 presented at the European Society of Medical Oncology 2025.
Appendix: Glossary.

POTOMAC: AE profile was tolerable and manageable, and consistent with known profiles of individual therapies

Events, n (%)	*I*+BCG (I+M) n=336	BCG (I+M) n=339
TRAEs of any cause	325 (97)	307 (91)
Maximum Grade 3 or 4 TRAE	71 (21)	13 (4)
Serious TRAEs	45 (13)	13 (4)
TRAEs leading to death	0	0
AEs leading to discontinuation of study treatment	105 (31)	68 (20)
Possibly related to *Imfinzi*	54 (16)	1 (0.3)[1]
Possibly related to BCG	55 (16)	55 (16)
Any grade immune-mediated AEs	91 (27)	4 (1)
Maximum grade 3 or 4	27 (8)	1 (0.3)
Leading to death	0	0



The safety population includes all patients who received treatment. Causality per investigator assessment. 1. Patient assigned to the BCG (I+M) arm due to a data entry error. 2. All-causality AEs reported for ≥10% of patients in the safety population for either arm. Data cutoff 03 April 2025.

De Santis M et al. Abstract LBA108 presented at the European Society of Medical Oncology 2025.

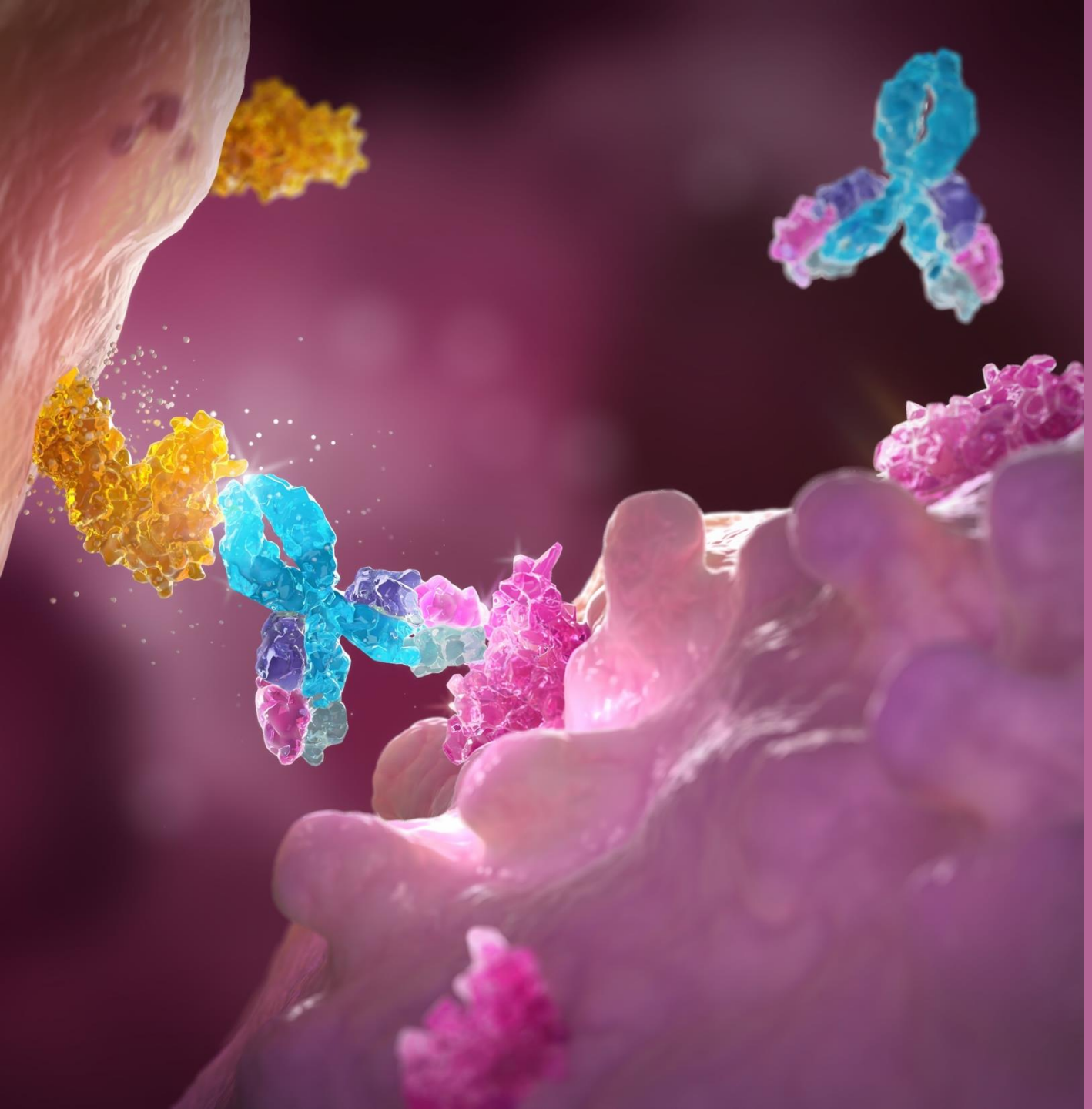
Appendix: Glossary.

POTOMAC: *Imfinzi* + BCG potential to change the course of high-risk non-muscle-invasive bladder cancer

- *Imfinzi* in combination with BCG induction and maintenance resulted in a statistically significant and clinically meaningful improvement in DFS vs BCG induction and maintenance alone in patients with BCG-naïve, high-risk NMIBC at a median of 5 years follow-up
  - 32% reduction in risk of a DFS event
  - Early and sustained DFS benefit with *Imfinzi* (starting at <4 months)
- Descriptive OS analysis showed no negative impact on OS with the addition of Imfinzi (HR 0.80 at 14% maturity)
- *Imfinzi* plus BCG induction and maintenance had a tolerable and manageable safety profile that was consistent with the known safety profiles of the individual agents

POTOMAC supports 1 year of *Imfinzi* in combination with BCG induction and maintenance as a new treatment option for patients with BCG-naïve, high-risk NMIBC

De Santis M et al. Abstract LBA108 presented at the European Society of Medical Oncology 2025.
Appendix: Glossary.



Realising our ambition in GU cancers and beyond

Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS

Building *Imfinzi* as a backbone in bladder cancer

POTOMAC | Moving *Imfinzi* into earlier stages of bladder cancer

96k

Drug-treated patients with high-risk NMIBC across G7

High unmet need |
Up to **80%**[1] will have disease recurrence with current SoC within 5y

Imfinzi CDP covers key stages of bladder cancer

High-risk NMIBC	MIBC	1L mUC
96k[2]	68k[2]	46k[2]

POTOMAC
Imfinzi + BCG induction and maintenance

NIAGARA
Neoadj. *Imfinzi* + CTx → adj. *Imfinzi*
~50% cis-eligible

VOLGA
Neoadj. *Imfinzi* + EV ± *Imjudo* → adj. *Imfinzi* ± *Imjudo*
~50% cis-ineligible/ refusal

NILE
Imfinzi + CTx ± *Imjudo*

***Imfinzi* bladder cancer programme combined blockbuster opportunity[3]**

1. Porten SP et al. Curr Opin Urol. 2012 Sep;22(5):385-9. 2. Estimated epidemiology in G7 (2024). All numbers are approximate. Illustrative settings and populations, not to scale. 3. Peak Year Revenue, non-risk adjusted. Appendix: Glossary.

AstraZeneca commercial strategy to transform patient outcomes

Medicines that matter

Building transformative brands

CALQUENCE® acalabrutinib 100 mg tablets

Lynparza™ olaparib

DATROWAY® datopotamab deruxtecan

TAGRISSO® osimertinib

ENHERTU® trastuzumab deruxtecan

Truqap® capivasertib

IMFINZI® durvalumab

Zoladex® (goserelin implant)

IMJUDO® tremelimumab-actl

Leveraging scale

Tumour area leadership

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

Transforming patient care

Closing the care gap

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

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

Opportunity for Q&A

Key External Expert

Prof. Neal Shore
MEDICAL DIRECTOR, START-CAROLINA UROLOGIC RESEARCH CENTER

AstraZeneca Leadership

Pascal Soriot
CHIEF EXECUTIVE OFFICER

Dave Fredrickson
EVP, ONCOLOGY HAEMATOLOGY BUSINESS

Susan Galbraith
EVP, ONCOLOGY HAEMATOLOGY R&D

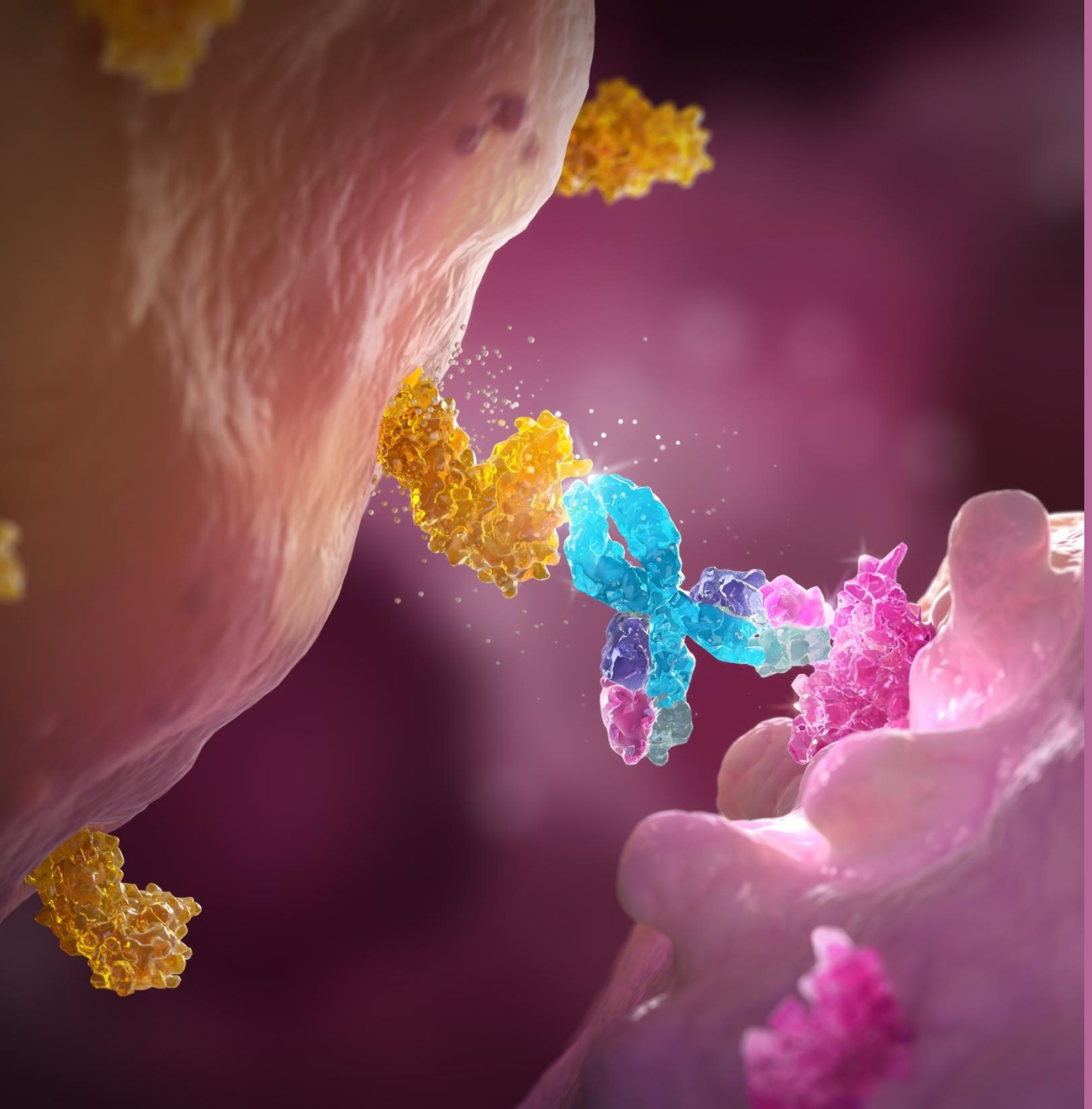
Leora Horn
SVP, LATE DEVELOPMENT ONCOLOGY

Sunil Verma
SVP, GLOBAL HEAD, ONCOLOGY FRANCHISE

Glossary

(a)BTC	(advanced) biliary tract cancer
1L, 2L, 3L	first-, second-, third-line
a/mBC	advanced/metastatic breast cancer
ADC	antibody conjugate
adj.	adjuvant
AE	adverse event
AI	aromatase inhibitor
AKT1	AKT serine/threonine kinase 1
ALT	alanine aminotransferase
ASCO	American Society of Clinical Oncology
AST	aspartate aminotransferase
AZN	AstraZeneca
BCMA	B-cell maturation antigen
BICR	blinded independent central review
BMFI	brain metastasis–free interval
BTD	Breakthrough Designation
CAR-T	chimeric antigen receptor T-cells
CD19	Cluster of differentiation 19
CD3	Cluster of differentiation 3
CDK4/6i	cyclin-dependent kinase 4/6 inhibitor
CFS	combined positive score
CI	confidence interval
CLDN18.2	Claudin-18.2
COPD	chronic obstructive pulmonary disease
CRT	chemoradiotherapy
ctDNA	circulating tumour DNA
CTx	chemotherapy
CVRM	Cardiovascular, Renal and Metabolism
DB04	DESTINY-Breast04
DCO	data cut-off
ddAC	dose-dense doxorubicin-cyclophosphamide
DFI	disease-free interval
DFS	disease-free survival
DOR	duration of response
DRFI	distant recurrence–free interval
DXd	deruxtecan
eBC	early breast cancer
ECOG	Eastern Cooperative Oncology Group
EFS	event-free survival
EGFRm	epidermal growth factor receptor-mutant
ER+	estrogen receptor-positive
ERoW	Established Rest of World
ESMO	European Society for Medical Oncology
ESR1m	estrogen receptor alpha-mutated
FL	follicular lymphoma
FLOT	fluorouracil, leucovorin, oxaliplatin and docetaxel
FP	fluoropyrimidine
G7	US, Japan, EU5
gBRCAm	germline BRCA-mutant
GC	gastric cancer
GEJ(A)	gastroesophageal junction (adenocarcinoma)
gMG	generalised myasthenia gravis
HER2	human epidermal growth factor receptor 2
HER2-/negative	human epidermal growth factor receptor 2-negative
HER2-low/ultralow	human epidermal growth factor receptor 2-low/ultralow
HER2+/positive	human epidermal growth factor receptor 2-positive
HER2m	human epidermal growth factor receptor 2-mutant
HLR	high-level results
HPP	hypophosphatasia
HR	hazard ratio
HR-/negative	hormone receptor-negative
HR+/positive	hormone receptor-positive
HRQOL	health-related quality of life
HSCT-TMA	hematopoietic stem cell transplantation-associated thrombotic microangiopathy
ICC	investigator's choice of chemotherapy
IDFS	invasive disease–free survival
IDMC	Independent Data Monitoring Committee
ILD	interstitial lung disease
INV	invasive
inv	investigator assessment
IO	immuno-oncology
IRA	Inflation Reduction Act
ITT	intention-to-treat
m(PFS/OS)	median (PFS/OS)
M&A	mergers & acquisitions
mBC	metastatic breast cancer
mCRPC	metastatic castration-resistant prostate cancer
mDOR	median duration of response
mg	milligram
MIBC	muscle invasive bladder cancer
mo	month
mono	monotherapy
mOS	median overall survival
MPR	major pathological response
NAT	neoadjuvant therapy
NC	non-calculable
NEJM	New England Journal of Medicine
neoadj.	Neoadjuvant
NMIBC	non-muscle invasive bladder cancer
NMR	normalised membrane ratio
no.	Number
NSCLC	non-small cell lung cancer
NSQ	non-squamous
NST	neoadjuvant systemic treatment
oGLP-1	oral glucagon-like peptide-1
oPCSK9	oral protein convertase subtilisin/kexin type 9
OR	odds ratio
ORR	objective response rate
OS	overall survival
P	pertuzumab
PALB2m	partner and localizer of BRCA2
pCR	pathologic complete response
PD-(L)1/PD-L1	programmed cell death-(ligand) 1
PFS	progression free survival
PFS2	second progression-free survival
PIK3CA(m)	phosphatidylinositol-4,5-biphosphate 3-kinase catalytic subunit (mutated)
PK	pharmacokinetics
PS	performance status
PSMA	prostate-specific membrane antigen
PTEN	phosphatase and TENsin homolog deleted on chromosome 10
PTX	paclitaxel
PYR	peak year revenue
Q2W	every 2 weeks
Q4W	every 4 weeks
QoL	quality of life
R	randomised
R&D	Research & Development
R&I	Respiratory & Immunology
RAM	ramucirumab
RC	radioconjugate
RECIST v1.1	Response Evaluation Criteria in Solid Tumors v1.1
SARA	selective amylin receptor agonist
SBRT	stereotactic brain radiotherapy
SERD	selective estrogen receptor degrader
SoC	standard-of-care
SQ	squamous
Stg.	stage
T-DM1	trastuzumab emtansine
TAP	tumour area positivity
tBRCAm	tumor BRCA mutation
TEAE	treatment-emergent adverse event
THP	docetaxel, trastuzumab and pertuzumab
TIGIT	T-cell immunoreceptor with immunoglobulin and ITIM domains
TKI	tyrosine kinase inhibitor
TNBC	triple negative breast cancer
TRAE	treatment-related adverse event
TROP2	trophoblast cell surface antigen 2
TTD	time-to-treatment discontinuation
Tx	treatment
V&I	Vaccines & Immune Therapies
WBC	white blood cells
WCLC	World Conference on Lung Cancer
ypT0 ypN0	absence of invasive and in-situ cancer in the breast and axillary nodes
ypT0/is ypN0	absence of invasive cancer in the breast and axillary nodes

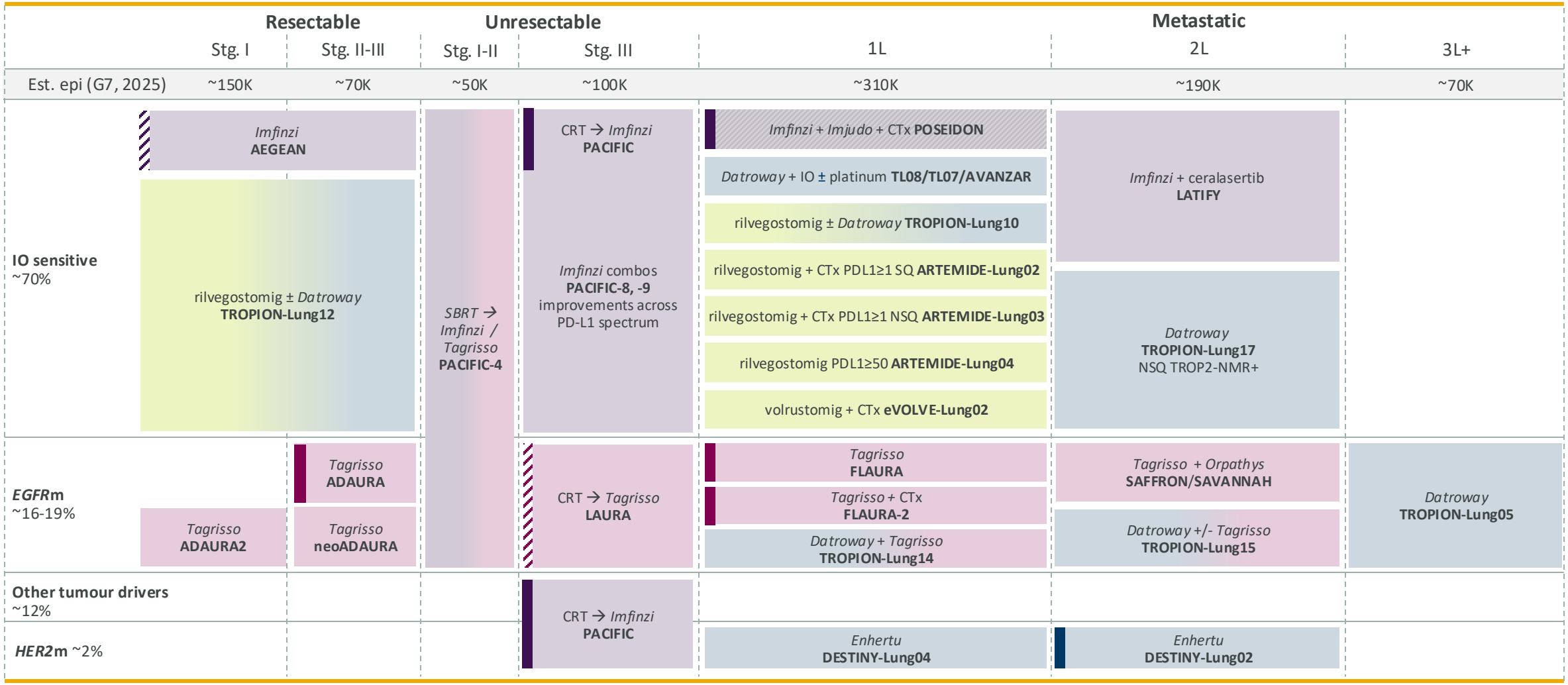
AstraZeneca PLC, 1 Francis Crick Avenue, Cambridge Biomedical Campus, Cambridge, CB2 0AA, UK
+44(0)203 749 5000
www.astrazeneca.com



Meet AZN Management: WCLC and ESMO

APPENDIX

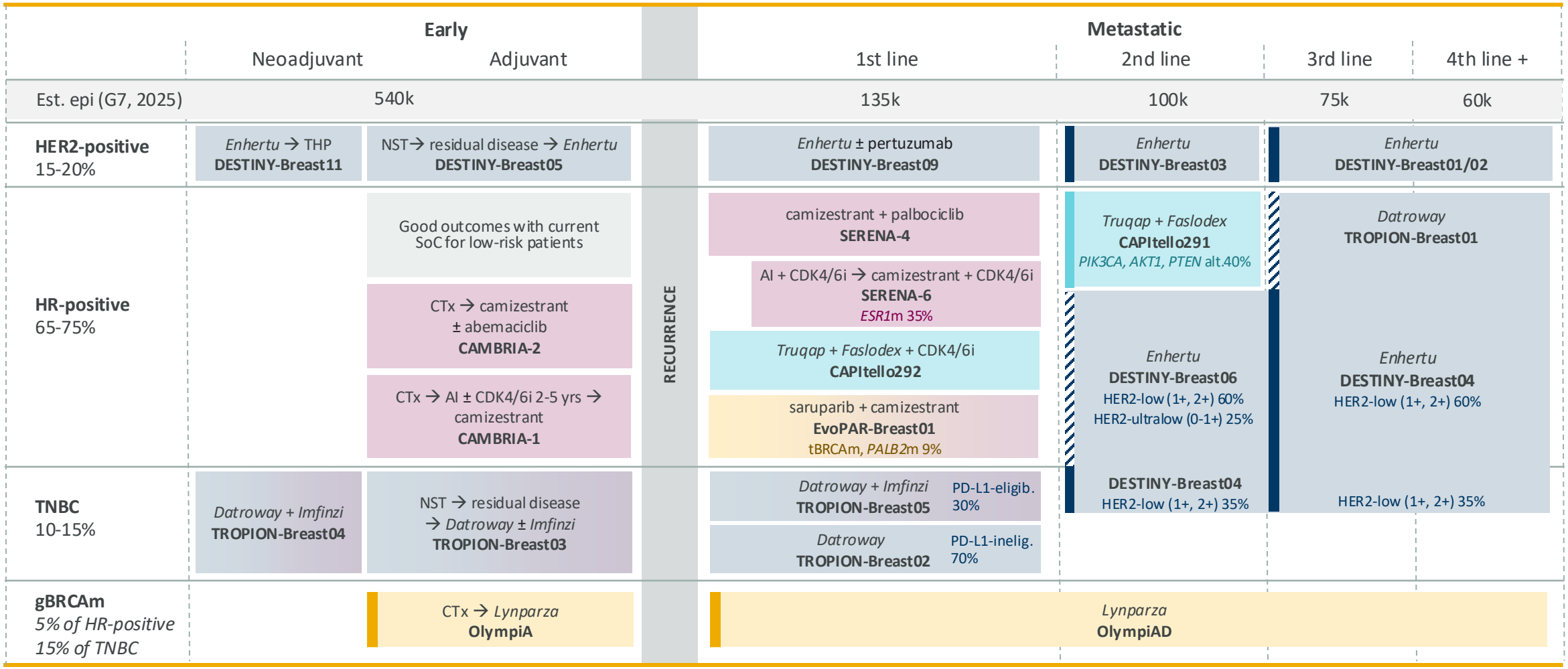
AstraZeneca in non-small cell lung cancer



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

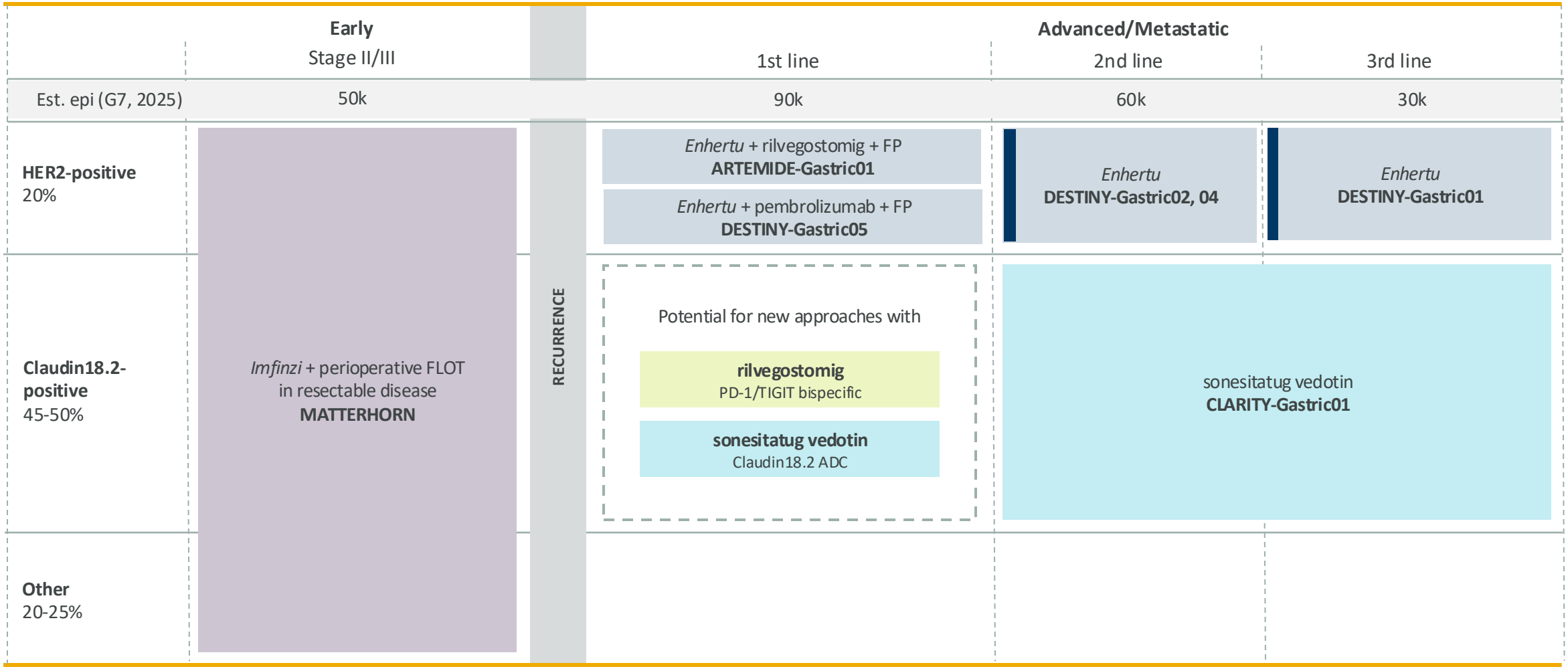
All numbers are approximate. Illustrative settings and populations, not to scale. Lung Cancer map reflects Phase III/pivotal trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Hutchmed (*Orpathys*), Compugen (rilvegostomig).
Appendix: Glossary.

AstraZeneca in breast cancer



All numbers are approximate. Illustrative settings and populations, not to scale. Breast Cancer map reflects Phase III/pivotal trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Merck & Co., Inc. (*Lynparza*).
Appendix: Glossary.

AstraZeneca in gastric cancer



sonesitatug vedotin previously AZD0901.

All numbers are approximate. Illustrative settings and populations, not to scale. Gastric cancer map reflects ongoing active Phase III/pivotal trials.

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

Appendix: Glossary.

Significant progress with transformative technologies 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
3 Phase III trials initiated with **laroprovstat (oPCSK9)** Multiple Phase II dose optimisation trials ongoing **AZD5004 (oGLP-1)** **AZD6234 (SARA)**	7 AZN ADCs in clinic, including **sonesitatug vedotin (CLDN18.2) in Phase III** for 2L+ GC/GEJA FPI-2265 (PSMA-targeted RC) in **Phase II** for pre-treated mCRPC	**14 Phase III trials** with rilvegostomig and volrustomig initiated[1] Encouraging early evidence for **ADC combination** presented at ASCO and ESMO 2025	**AZD0120 (BCMA/CD19) CAR-T Phase III** planned in multiple myeloma **surovatamig** (CD19/CD3) in **Phase III** for 1L FL **EsoBiotec** acquired	Preclinical and Phase I development ongoing across multiple platforms **sAAVy and AAV capsid** **TALEN technology**

ADCs/RCs, next-gen IO and cell therapy/TCE progressed to Phase III

1. Does not include eVOLVE-RCC02 which remains in Phase Ib.
Updated as of 20 October 2025.
Collaboration partners: Compugen (rilvegostomig).
Appendix: Glossary.