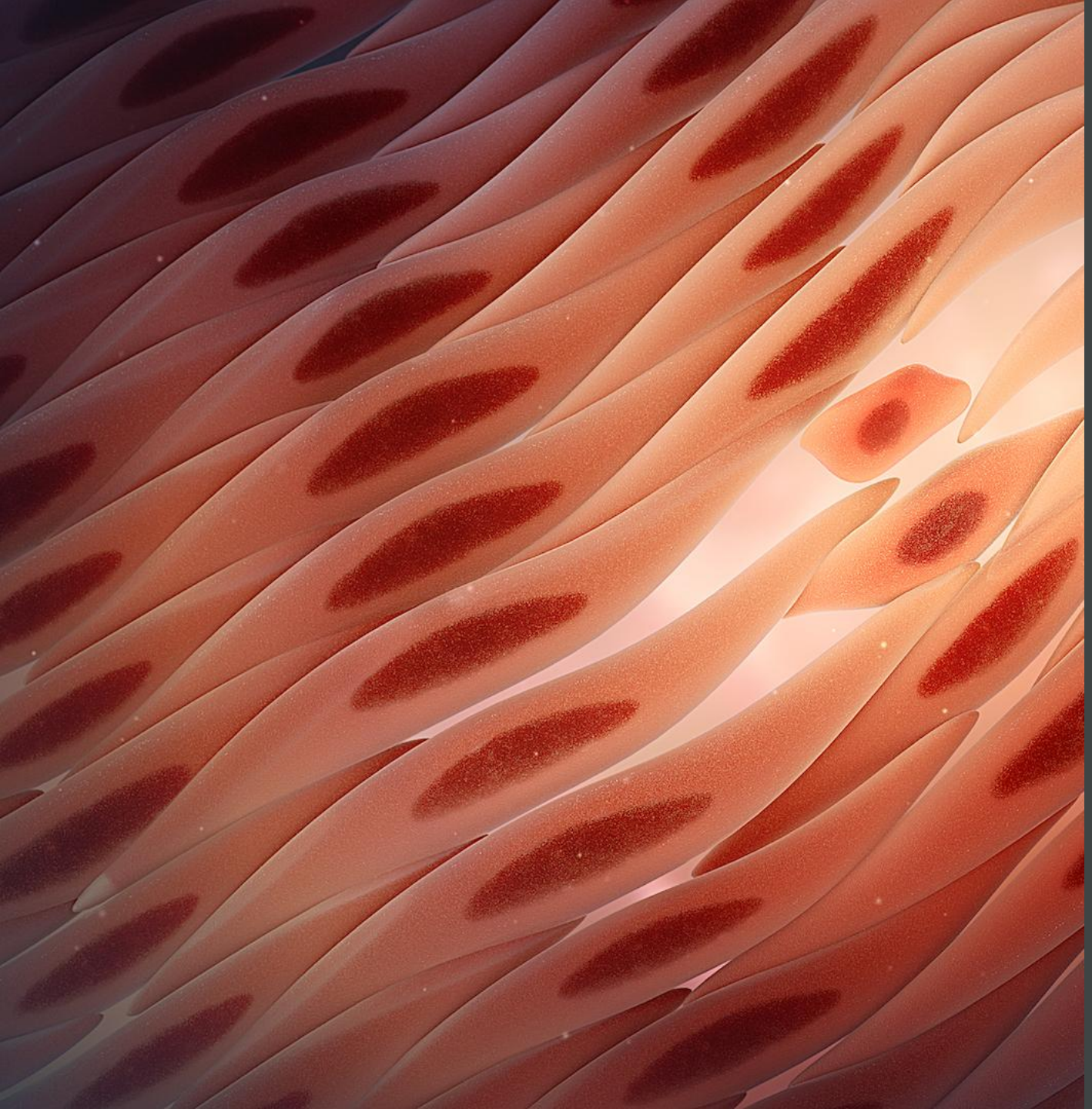


Meet AZN Management: ESC 2025

Conference call and webcast for investors and analysts

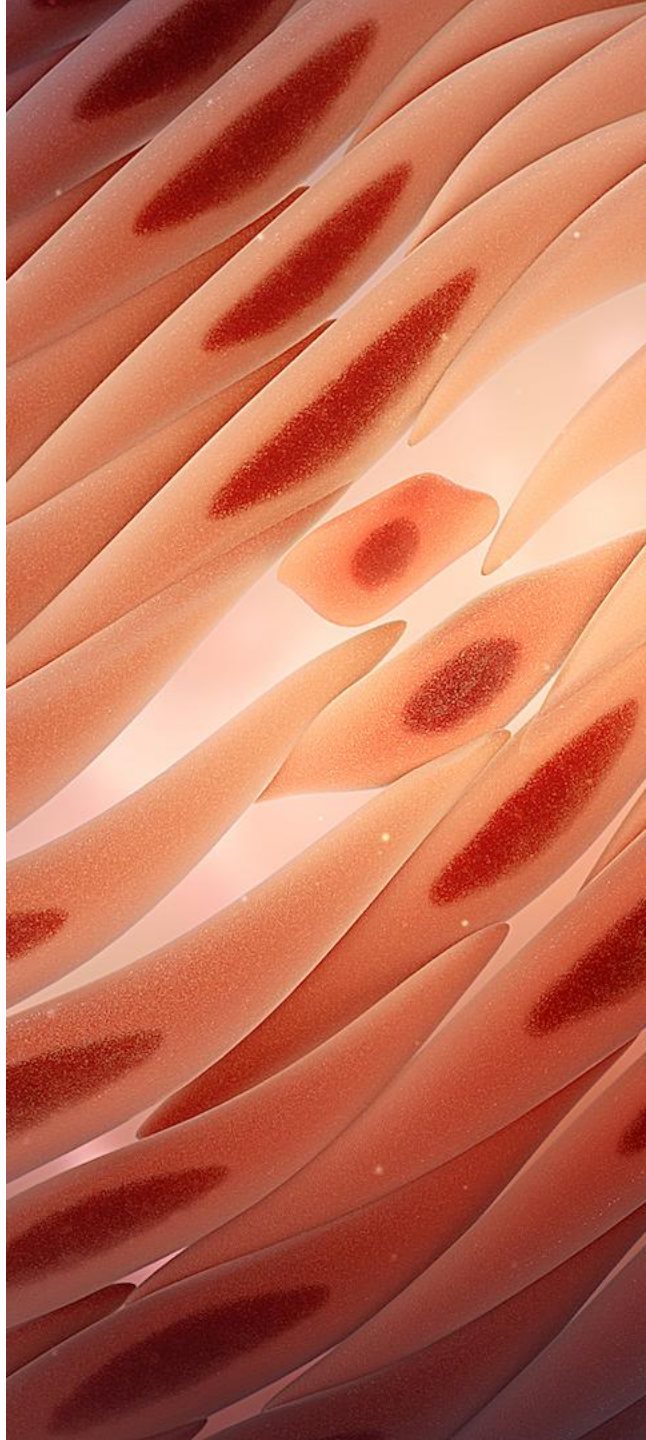
31 August 2025

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.

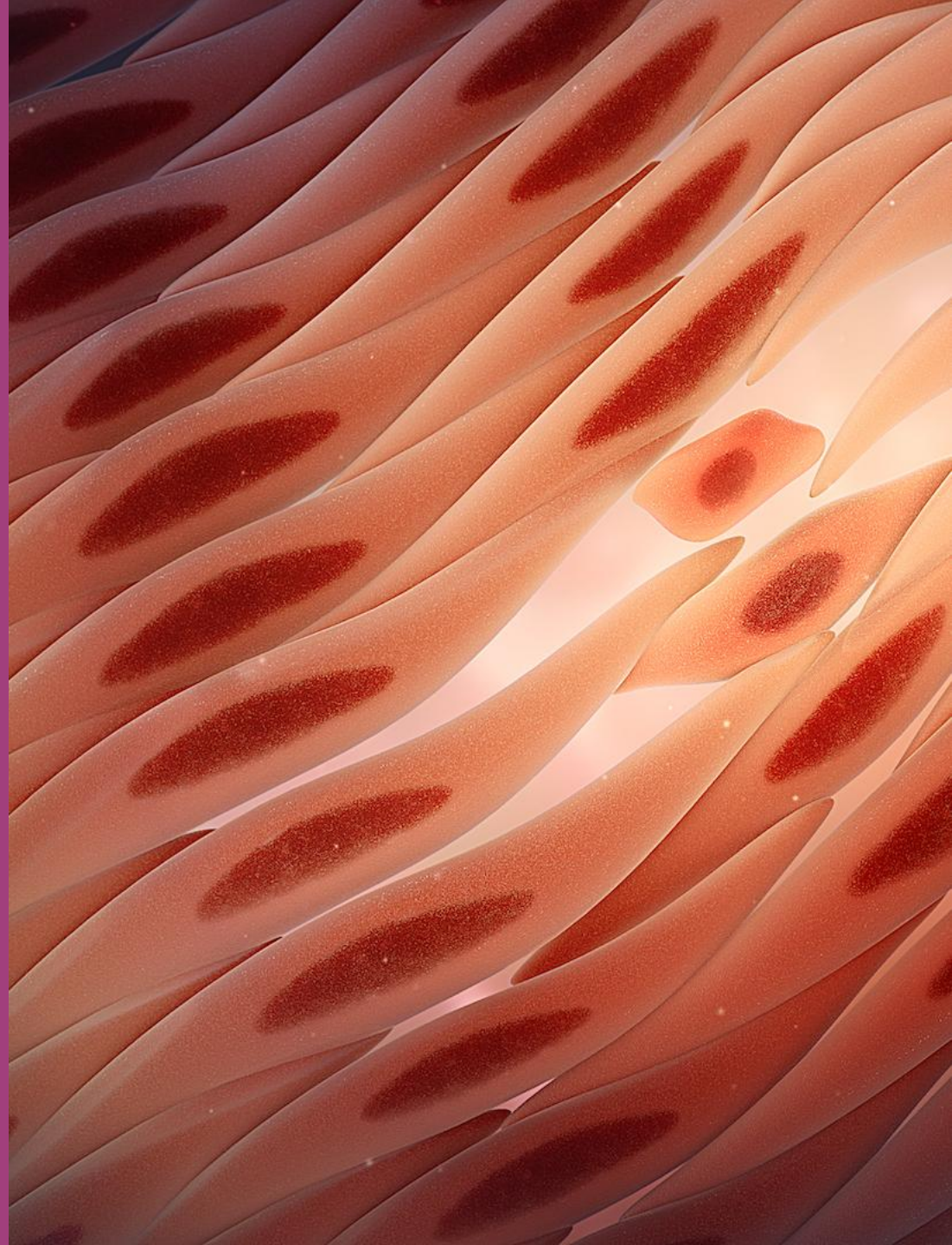
Meet AZN Management @ ESC – agenda

Furthering the AstraZeneca ambition	**Ruud Dobber,** EVP, BioPharmaceuticals Business
Addressing unmet need in cardiometabolic diseases	**Sharon Barr,** EVP, BioPharmaceuticals R&D
baxdrostat – Phase III BaxHTN: baxdrostat in hard-to-control hypertension	**Dr Bryan Williams,** Chair of Medicine, University College London
Delivering next-wave of CVRM growth with baxdrostat	**Sharon Barr,** EVP, BioPharmaceuticals R&D **Ruud Dobber,** EVP, BioPharmaceuticals Business
Closing remarks and Q&A session	



Furthering the AstraZeneca ambition

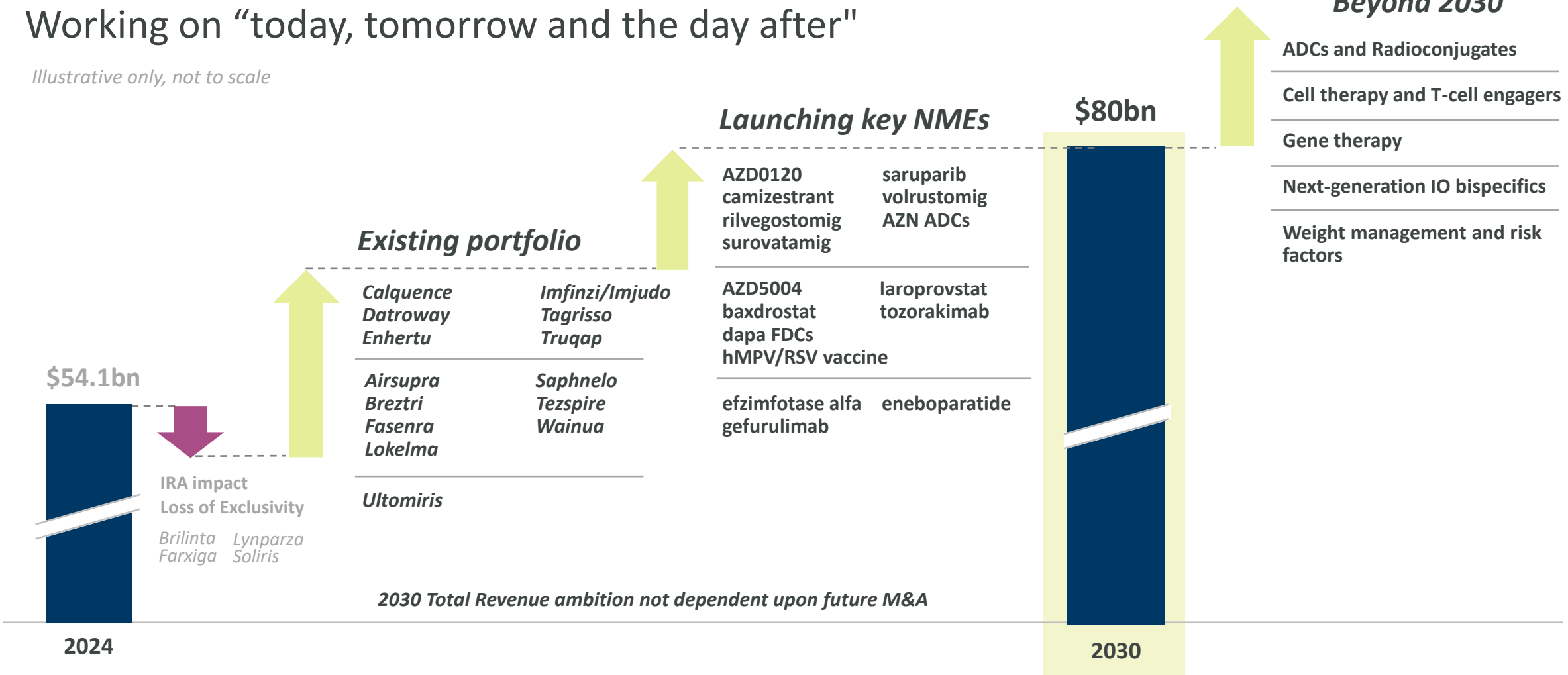
Ruud Dobber
EVP, BIOPHARMACEUTICALS BUSINESS



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

Working on “today, tomorrow and the day after"

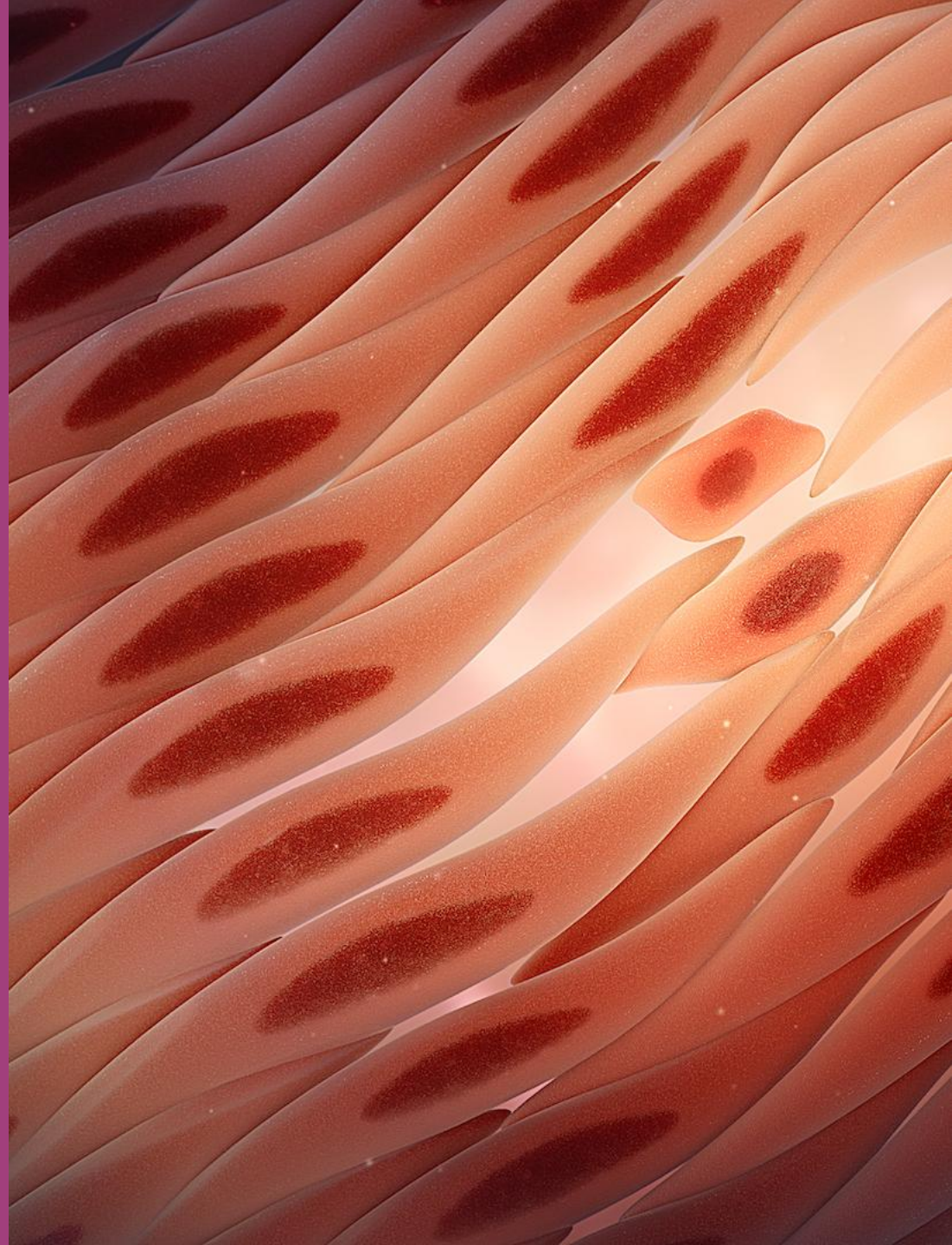
Illustrative only, not to scale



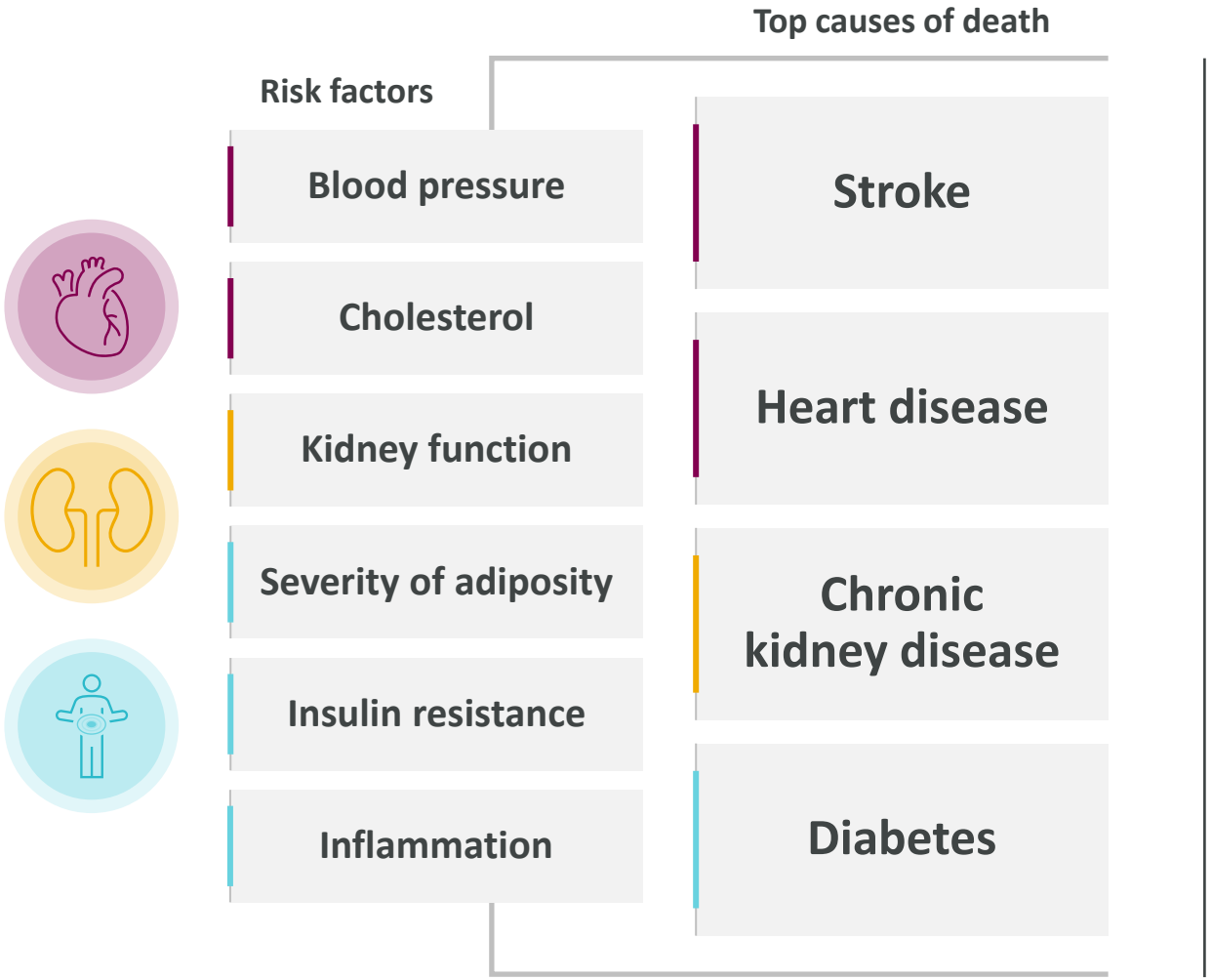
Note: Ambition to achieve $80bn in Total Revenue by 2030 is risk-adjusted, based on long-range plan as of AstraZeneca Investor Day May 2024. Medicines and assets listed reflect key contributors to 2030 Total Revenue ambition; however, this list is not exhaustive. Medicines and assets listed in alphabetical 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*).

Addressing unmet need in cardiometabolic diseases

Sharon Barr
EVP, BIOPHARMACEUTICALS R&D



Uniquely positioned to address risk factors and interconnectedness of cardiometabolic disease



Increasing need for novel mechanisms and combination therapies to address multi-organ and multi-risk factor diseases

Up to 80%
of adults 65+ have two or more chronic diseases[1]

>50%
causes of death globally by 2040[2]

1. Xiaopeng Cui, Yunsheng Zhang, Yujing Jin, Zhuolin Wu, Ying Gao, Haiyan Su, Qing Zhang, Liang Wang, Xinyu Yang, Association of cardiometabolic index and depressive symptoms with cardiovascular and cerebrovascular diseases in middle-aged and older adults: A national prospective cohort study, Journal of Affective Disorders, **391**, (119940), (2025).] 2. Internal estimates. Appendix: Glossary.

Ambition to transform care across cardiometabolic diseases where large unmet need remains

Dyslipidaemia and ASCVD

Eliminate LDL-C as a cardiovascular risk factor

2bn[1]

c.70% not at LDL-C goal despite statin use[2]

Hypertension

Address hard-to-control hypertension and advance cardiorenal risk reduction

1.3bn[3]

c.50% treated remain uncontrolled[4]

Heart failure and amyloidosis

Drive prevention of end-stage disease

300-500k[5]

with 2- to 5-year average mortality post-ATTR-CM diagnosis[6]

Kidney disease

Prevent or slow kidney failure across entire spectrum of disease

Millions across distinct populations

30m | heart failure[7]

>50m | high proteinuria[8,9]

600m | hypertension[10,11]

Weight management and diabetes

Reduce or reverse weight-related comorbidities and advance organ protection

2.5bn[12]

majority of those suffering from obesity and overweight have at least one co-morbidity[13]

1. World Health Organization – Global Health Observatory Raised Cholesterol. 2. World Heart Federation. Cholesterol. 3. World Health Organization – Hypertension Fact Sheet. 4. NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in hypertension prevalence and progress in treatment and control from 1990 to 2019: a pooled analysis of 1201 population-representative studies with 104 million participants. Lancet. 2021 Sep 11;398(10304):957-980. doi: 10.1016/S0140-6736(21)01330-1. Epub 2021 Aug 24. 5. Ionis 2024 Annual Report. 6. Nativi-Nicolau JN, Karam C, Khella S, Maurer MS. Screening for ATTR amyloidosis in the clinic: overlapping disorders, misdiagnosis, and multiorgan awareness. Heart Fail Rev. 2022 May;27(3):785-793. 7. Lala et AL. The interplay between heart failure and chronic kidney disease; Diabetes Obes Metab. 2025;27:3568–3582. 8. LabCorp data. 9. Internal estimates. 10. Foti KE, Wang D, Chang AR, Selvin E, Sarnak MJ, Chang TI, Muntner P, Coresh J. Potential implications of the 2021 KDIGO blood pressure guideline for adults with chronic kidney disease in the United States. Kidney Int. 2021 Mar;99(3):686-695. doi: 10.1016/j.kint.2020.12.019. PMID: 33637204; PMCID: PMC7958922. 11. Jager KJ, Kovesdy C, Langham R, Rosenberg M, Jha V, Zoccali C. A single number for advocacy and communication-worldwide more than 850 million individuals have kidney diseases. Kidney Int. 2019 Nov;96(5):1048-1050. doi: 10.1016/j.kint.2019.07.012. Epub 2019 Sep 30. PMID: 31582227. 12. World Health Organization – Obesity Fact Sheet. 13. TriNetX (US EHR data), November 2020 and Optum claims data. Obesity defined as ICD10 codes E66.0, E66.1 , E66.2, E66.8, E66.9. Obesity defined as BMI > 30, Overweight as BMI 25-29.9. Appendix: Glossary.

Addressing unmet need with novel mechanisms and combinations to drive next wave of growth

Dyslipidaemia and ASCVD

laroprovstat
oPCSK9

Additional potential combinations

laroprovstat/rosuvastatin
oPCSK9/statin

laroprovstat/ezetimibe
oPCSK9/NPC1L1i

Hypertension

baxdrostat
ASI

Heart failure and amyloidosis

Wainua
TTR silencer

cliramitug
TTR fibril depleter

baxdrostat/dapa
ASI/SGLT2i

balcinrenone/dapa
MRM/SGLT2i

Kidney disease

baxdrostat/dapa
ASI/SGLT2i

zibotentan/dapa
ET_A RA/SGLT2i

balcinrenone/dapa
MRM/SGLT2i

Weight management and diabetes

AZD5004
oGLP-1 RA

Additional potential combinations

AZD5004/dapa
oGLP-1 RA/SGLT2i

AZD5004/laroprovstat
oGLP-1 RA/oPCSK9

Additional mechanisms

AZD6234
SARA

AZD6234/AZD9550
SARA/GLP-1/GCG

+ other mechanisms

Includes featured pipeline assets and combinations. Laroprovstat previously AZD0780. Cliramitug previously ALXN2220. Appendix: Glossary.

baxdrostat – potential first-in-class opportunity to set foundation in hard-to-control hypertension

Significant proportion of patients remain uncontrolled

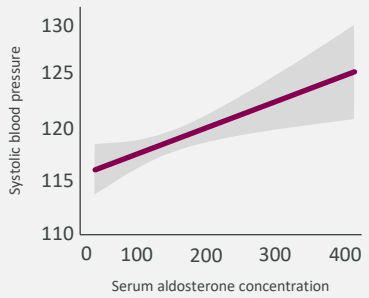
1.3bn
patients globally with hypertension[1]

c.50%
of those treated remain uncontrolled[2]

Addressing critical unmet need by targeting aldosterone dysregulation with baxdrostat

Highly selective, potent aldosterone synthase inhibition

Higher aldosterone leads to higher blood pressure[3]



Robust safety and efficacy at low doses

- Once-daily dosing with no off-target hormonal effects
- No clinically relevant drug-drug interactions
- Ability to combine while maintaining efficacy at low doses

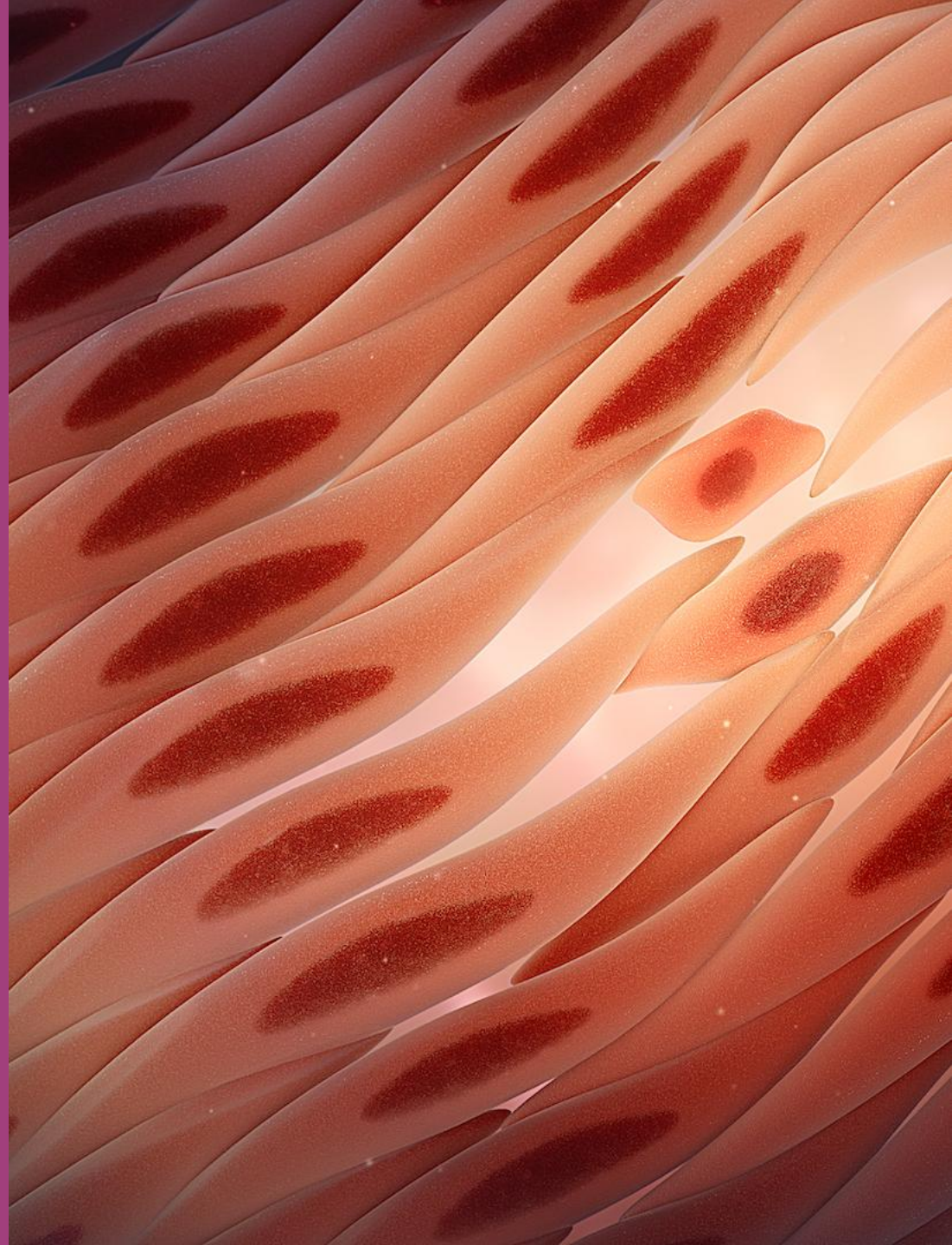
24-hour control supported by long half-life

- Early morning hypertension may cause increase in cardiac events
- **Bax24** H2 2025 — Extended half-life with potential to deliver 24-hour SBP control

1. World Health Organization – Hypertension Fact Sheet. 2. NCD Lancet 2021; 398: 957–80. Shown as percentage of treated that are uncontrolled. 3. Azra Mahmud, John Feely, Aldosterone-to-renin ratio, arterial stiffness, and the response to aldosterone antagonism in essential hypertension, *American Journal of Hypertension*, Volume 18, Issue 1, January 2005, Pages 50–55, https://doi.org/10.1016/j.amjhyper.2004.08.026. Appendix: Glossary.

baxdrostat – Phase III BaxHTN

Dr Bryan Williams
CHAIR OF MEDICINE,
UNIVERSITY COLLEGE LONDON



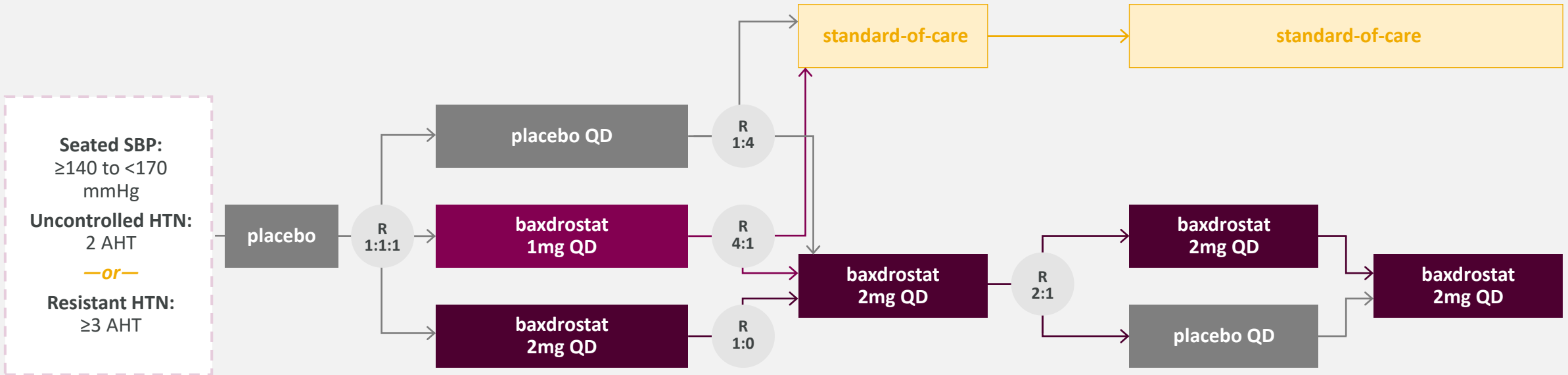
Background

- Patients with uncontrolled and resistant hypertension are at high risk of cardiovascular morbidity and mortality and adverse renal outcomes[1-4]
- Aldosterone dysregulation is a key driver of uncontrolled and resistant hypertension and hypertension-mediated organ damage[5-7]
- MRAs can block the mineralocorticoid receptor-mediated effects of aldosterone, but their clinical utility is limited by dose-dependent adverse effects[8]
- **baxdrostat is a highly selective and potent aldosterone synthase inhibitor[9,10]**

BaxHTN Phase III trial objective: assess the efficacy and safety of baxdrostat in patients with uncontrolled or resistant hypertension

1. Daugherty SL, et al. Circulation 2012;125:1635–42. 2. de la Sierra A, et al. Hypertension 2024;81:2350–56. 3. Sim JJ, et al. Kidney Int 2015;88:622–32. 4. Zhou D, Xi B, Zhao M, et al. Sci Rep 2018;8:9418. 5. Brown JM, et al. Hypertension 2014;63:1205–11. 6. Monticone S, et al. Lancet Diabetes Endocrinol 2018;6:41–50. 7. Brown JM, et al. Ann Intern Med 2020;173:10–20. 8. Kallistratos MS, et al. Curr Pharm Des 2018;24:5537–41. 9. Azizi M, et al. J Clin Endocrinol Metab 2025;110:e557–65. 10. Freeman MW, et al. Hypertens Res 2023;46:108–18. Appendix: Glossary.

Phase III trial design



Efficacy: parts of trial presented (1 and 3)

Appendix: Glossary.

Trial population

Adults ≥18 years of age with uncontrolled or resistant hypertension

Key inclusion criteria

- **Mean seated-SBP ≥140 and <170 mmHg despite treatment with maximally tolerated doses of either 2 (uncontrolled HTN) or ≥3 (resistant HTN) anti-hypertensive medications, including a diuretic, for ≥4 weeks before screening**
- eGFR ≥45 mL/min/1.73m^2
- Serum potassium ≥3.5 and <5 mmol/L

Key exclusion criteria

- Current use of MRAs or potassium-sparing diuretics
- Secondary hypertension (except for obstructive sleep apnoea or primary aldosteronism)
- Uncontrolled diabetes (HbA_{1c} >10%)
- Cardiovascular or cerebrovascular events within 6 months, or persistent atrial fibrillation

Seated office systolic BP at randomisation ≥135 mmHg

Appendix: Glossary.

Trial endpoints

Primary endpoint: change in seated office systolic BP from baseline to Week 12

- 98% power to detect a mean (SD) difference of 6 (15) mmHg for a change from baseline in seated-SBP at Week 12 in favour of baxdrostat (1mg or 2mg versus placebo)

Secondary endpoints (hierarchical order):

- Change in seated-SBP from **RWD period** baseline (Week 24) to Week 32 (baxdrostat 2mg versus placebo)
- Change from baseline in seated-SBP at Week 12 in the **resistant hypertension subpopulation**
- Change from baseline in **seated-DBP** at Week 12
- **Achieving seated-SBP <130 mmHg** at Week 12

Exploratory endpoints:

- **Serum aldosterone concentrations** and **plasma renin activity**
- **Mean 24-hour** and **night-time ambulatory SBP**

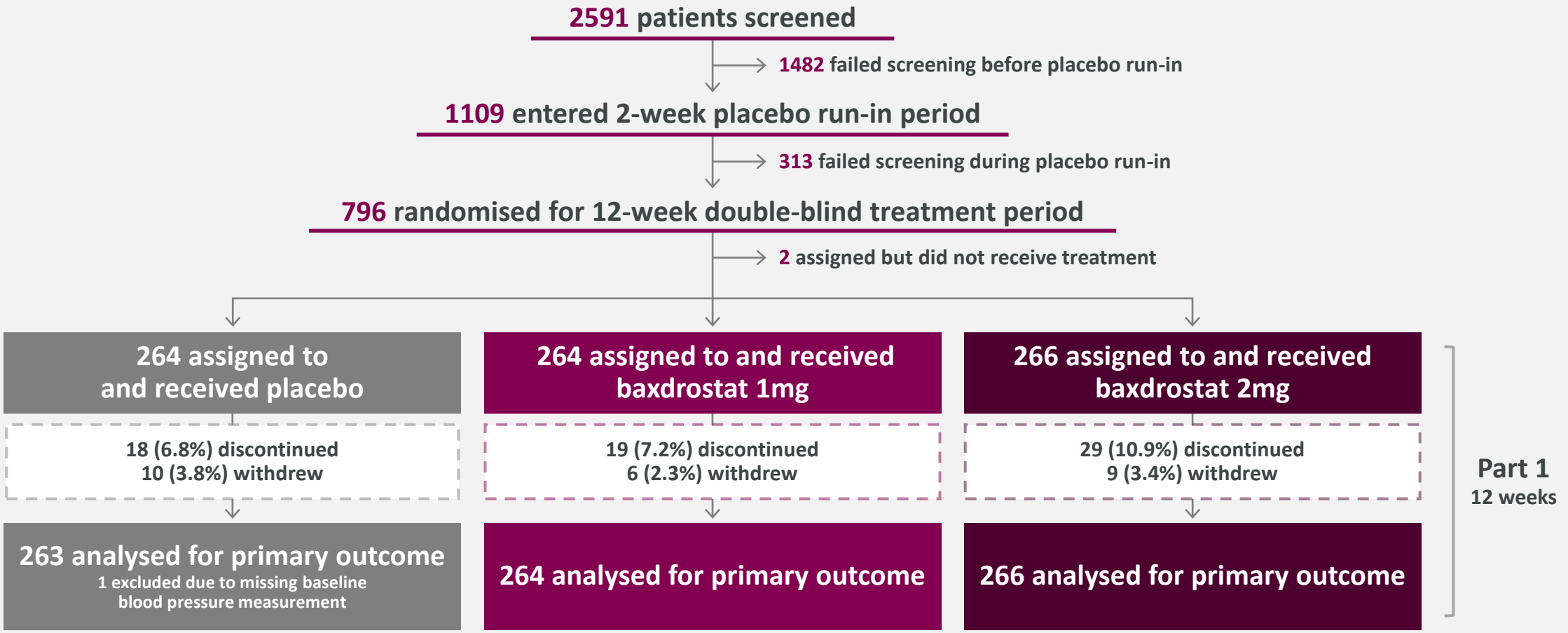
Safety endpoints:

- AEs, vital signs, laboratory tests, and adjudicated major adverse cardiovascular events
- AEs of special interest including hyperkalaemia requiring medical intervention

Appendix: Glossary.

Trial disposition – primary outcome

12-week double-blind period



Appendix: Glossary.

Participant characteristics

794 participants
27% uncontrolled HTN
73% resistant HTN

- Participants were 62% male and 63% White
  - 26% Asian; 7% Black
- Mean (SD) age was 61 (12) years
- Participants were from:
  - The Americas (27%)
  - Europe (43%)
  - Asia Pacific, Middle East, and Africa (30%)

Characteristic	placebo (n=264)	baxdrostat 1mg (n=264)	baxdrostat 2mg (n=266)
Age, mean ± SD, years	61.9 ± 11.6	59.8 ± 11.8	61.8 ± 11.7
Male sex, n (%)	162 (61.4)	169 (64.0)	163 (61.3)
Race, n (%)[1]			
White	167 (63.3)	165 (62.5)	168 (63.2)
Black	15 (5.7)	23 (8.7)	21 (7.9)
Asian	72 (27.3)	65 (24.6)	72 (27.1)
Native Hawaiian or Pacific Islander	1 (0.4)	1 (0.4)	0 (0.0)
Other	9 (3.4)	10 (3.8)	5 (1.9)

1. Reported by the participant. Appendix: Glossary.

Participant characteristics

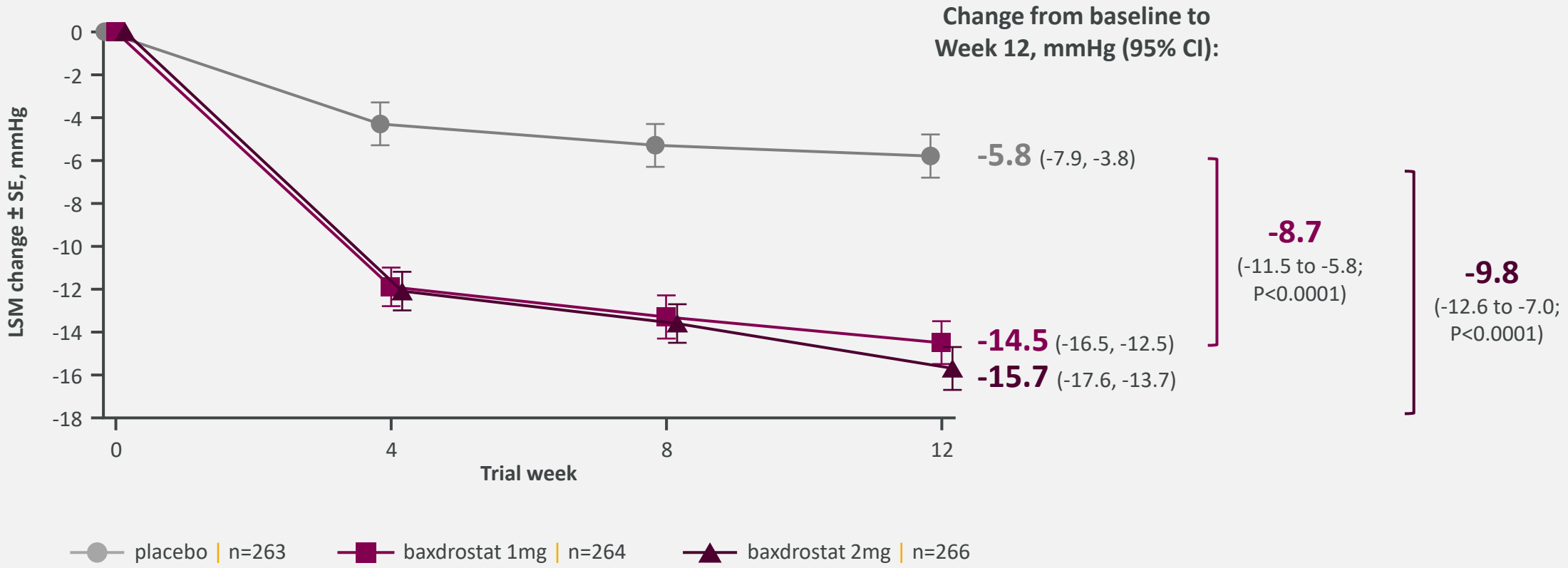
- Clinical characteristics at baseline were similar across treatment arms
- Baseline BP: 149/87 mmHg
  - Median number of background AHT medications: 3 (for each treatment group)
  - Almost all on a diuretic (99.6%)
  - 90% on an ACEi or ARB
  - 70% on a calcium channel blocker
  - 34% on a beta blocker
- 52% had obesity, 38% had diabetes
- Baseline potassium: 4.2 mmol/L
- Baseline eGFR: 85.0 mL/min/1.73m^2

Characteristic	placebo (n=264)	baxdrostat 1mg (n=264)	baxdrostat 2mg (n=266)
Seated BP, mmHg*			
Systolic, mean ± SD	149.0 ± 8.7	149.7 ± 10.1	149.1 ± 9.1
Diastolic, mean ± SD	85.8 ± 10.5	88.0 ± 10.5	85.8 ± 10.5
eGFR, mL/min/1.73m^2			
Mean	84.1 ± 18.0	86.6 ± 18.5	84.3 ± 17.9
<60, n (%)	29 (11.0)	27 (10.2)	30 (11.3)
Serum sodium, mmol/L			
Mean ± SD	139.6 ± 2.5	139.9 ± 2.6	139.8 ± 2.5
Serum potassium, mmol/L			
Mean ± SD	4.2 ± 0.5	4.2 ± 0.4	4.2 ± 0.4
Serum aldosterone, ng/dL†			
Median (IQR)	7.5 (4.2,10.3)	7.9 (4.7, 10.8)	7.2 (4.5, 10.9)
PRA, ng/mL/h‡			
Median (IQR)	1.4 (0.6, 4.0)	1.8 (0.7, 4.7)	1.5 (0.6, 5.0)

*n= 1; placebo had a missing SBP value at baseline. †placebo: n= 224; baxdrostat 1mg: n=228; baxdrostat 2mg: n=227; ‡placebo: n=178; baxdrostat 1mg: n= 197; baxdrostat 2mg: n=179. Appendix: Glossary.

Primary outcome – change in seated-SBP

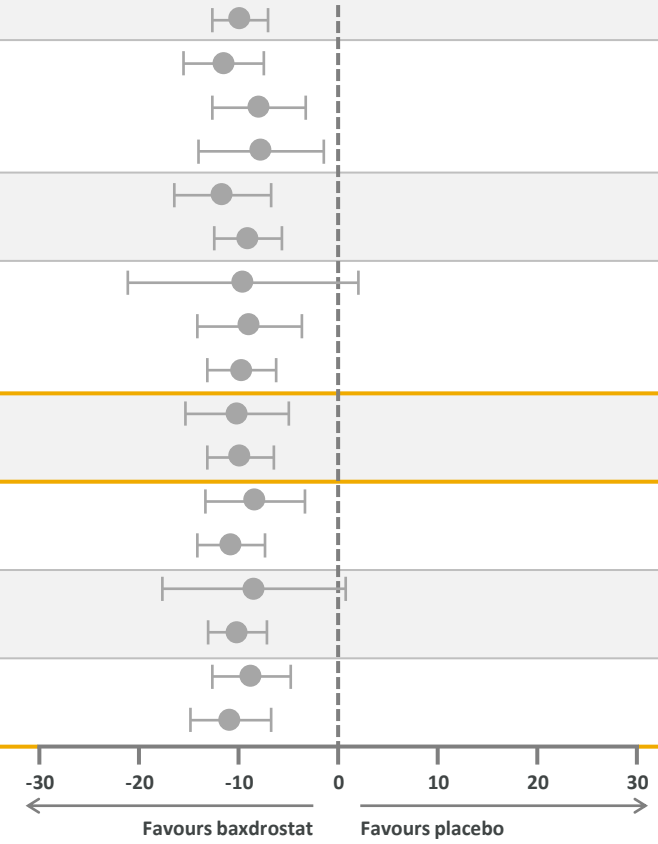
baxdrostat versus placebo, baseline to Week 12



Appendix: Glossary.

Changes in seated SBP at Week 12 were consistent across all pre-specified subgroups with baxdrostat 2mg

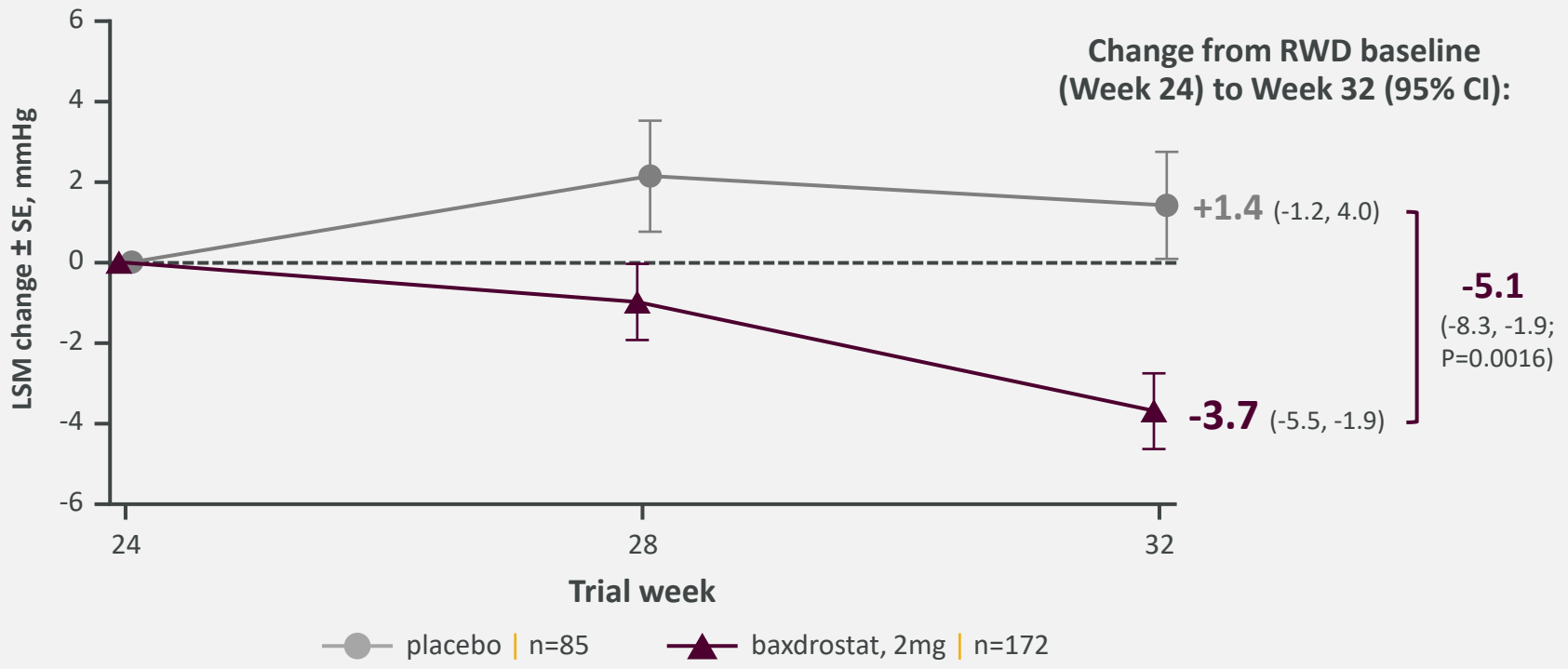
Subgroup		baxdrostat 2mg n	placebo n	Least-squares mean difference (95% CI) in seated systolic blood pressure, mmHg
Overall		266	263	
Age, years	<65	145	138	
	≥65 to <75	88	91	
	≥75	33	34	
Sex	Female	103	102	
	Male	163	161	
Race	Black or African American	21	15	
	Asian	72	72	
	White	168	166	
Baseline hypertension	Uncontrolled hypertension	67	71	
	Resistant hypertension	199	192	
Baseline systolic blood pressure, mmHg	<145	92	92	
	≥145	174	171	
Baseline eGFR, mL/min/1.73m²	<60	30	29	
	≥60	236	234	
Baseline body-mass index, kg/m²	<30	126	128	
	≥30	140	135	



Appendix: Glossary.

Impact of 8-week randomised withdrawal period of baxdrostat 2mg on seated SBP

Seated-SBP at the start of the RWD period (Part 3): 133 mmHg in both groups



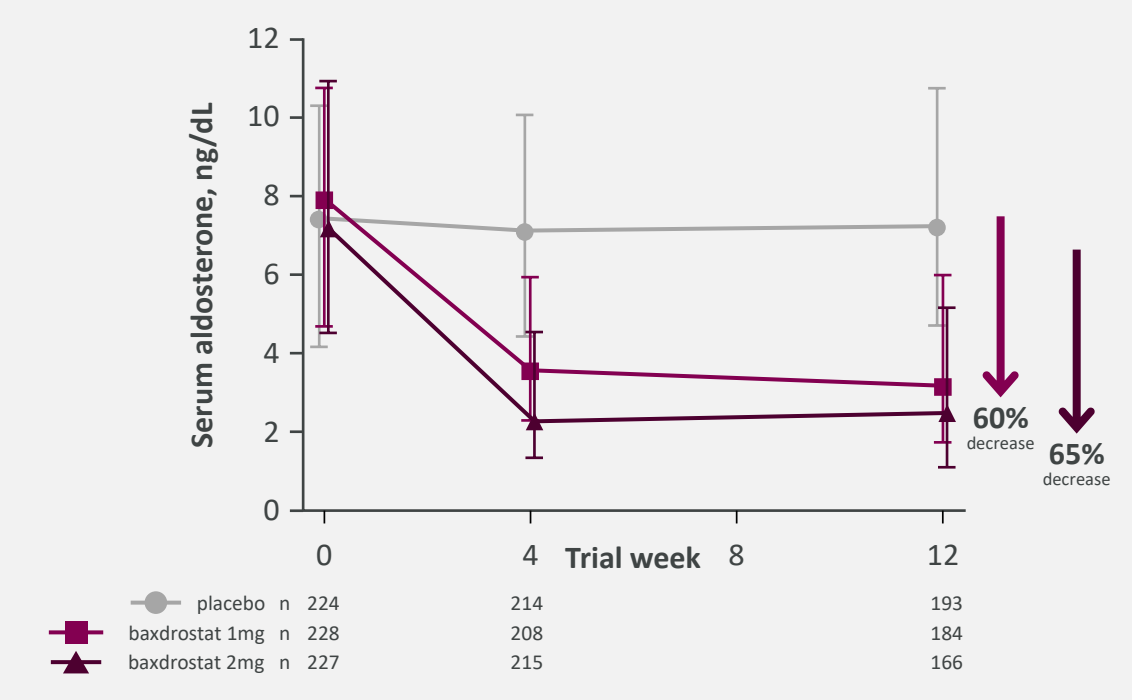
Slow offset of effect on baxdrostat on SBP

Continued BP lowering with baxdrostat 2mg out to 32 weeks

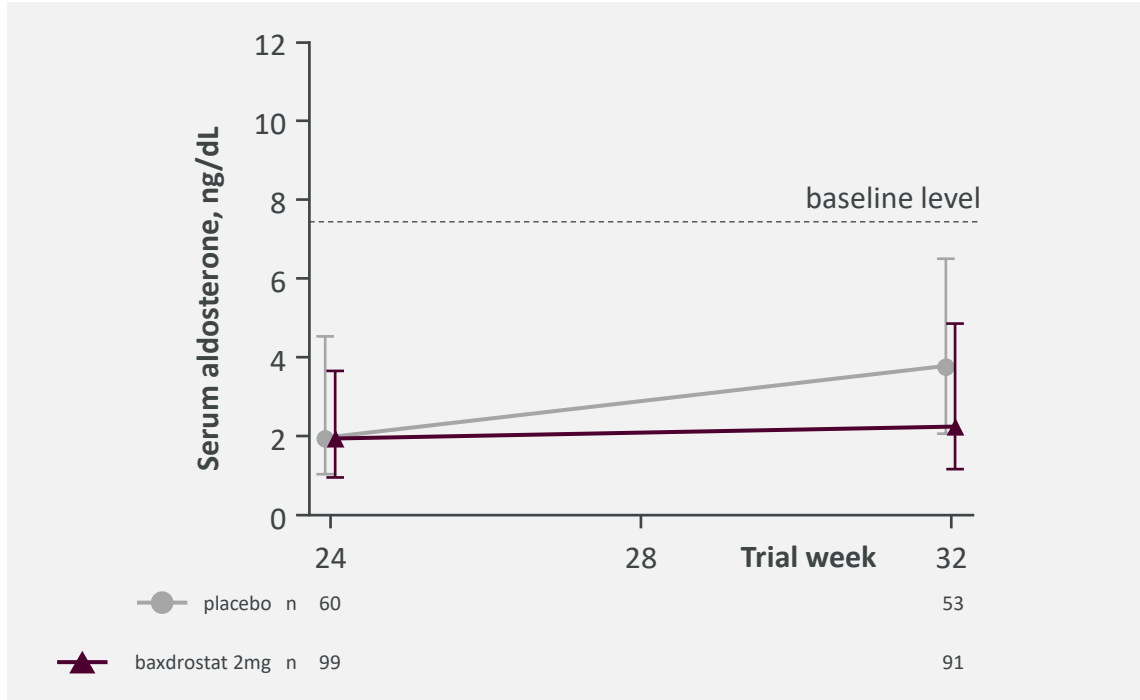
Appendix: Glossary.

Impact on serum aldosterone concentrations during Part 1 and Part 3 (randomised withdrawal period)

Part 1: double-blind period



Part 3: double-blind RWD period



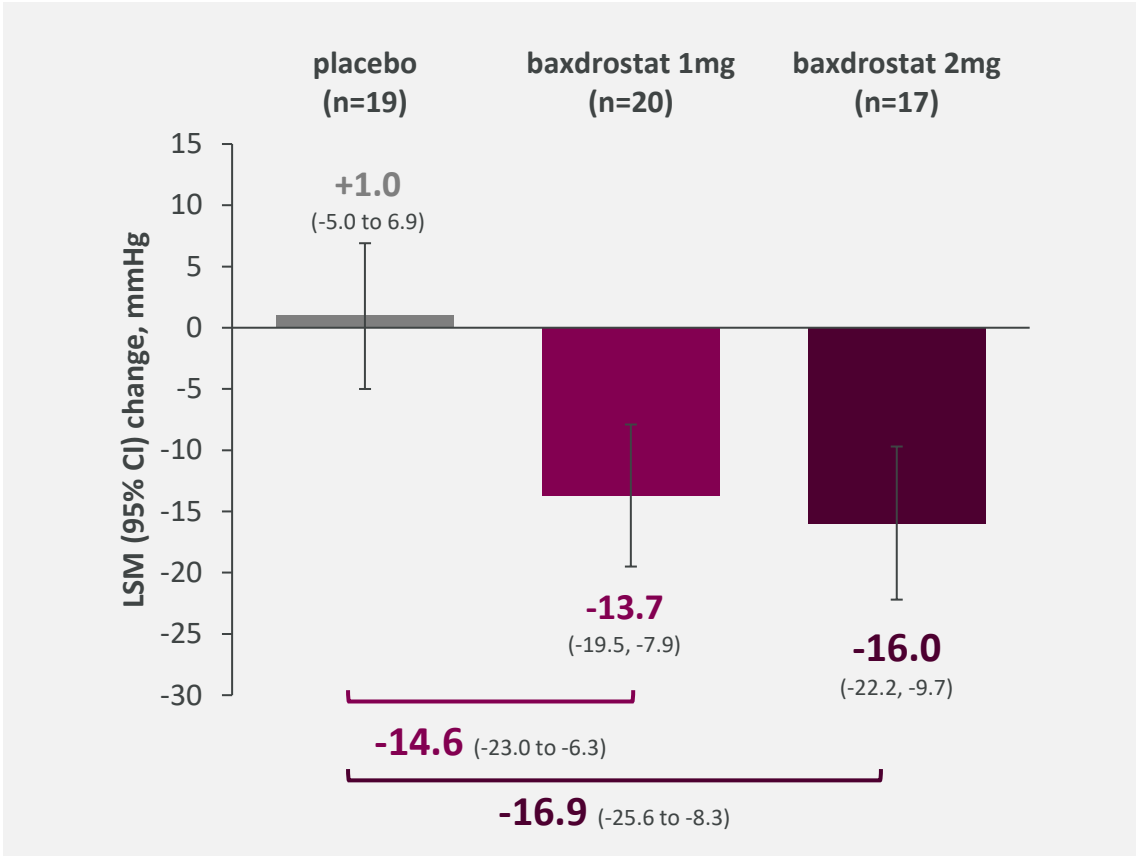
Serum aldosterone concentration (median) decreased from baseline to Week 12 with:

baxdrostat 1mg from 7.9 to 3.2 ng/dL: 60% decrease | baxdrostat 2mg from 7.2 to 2.5 ng/dL: 65% decrease

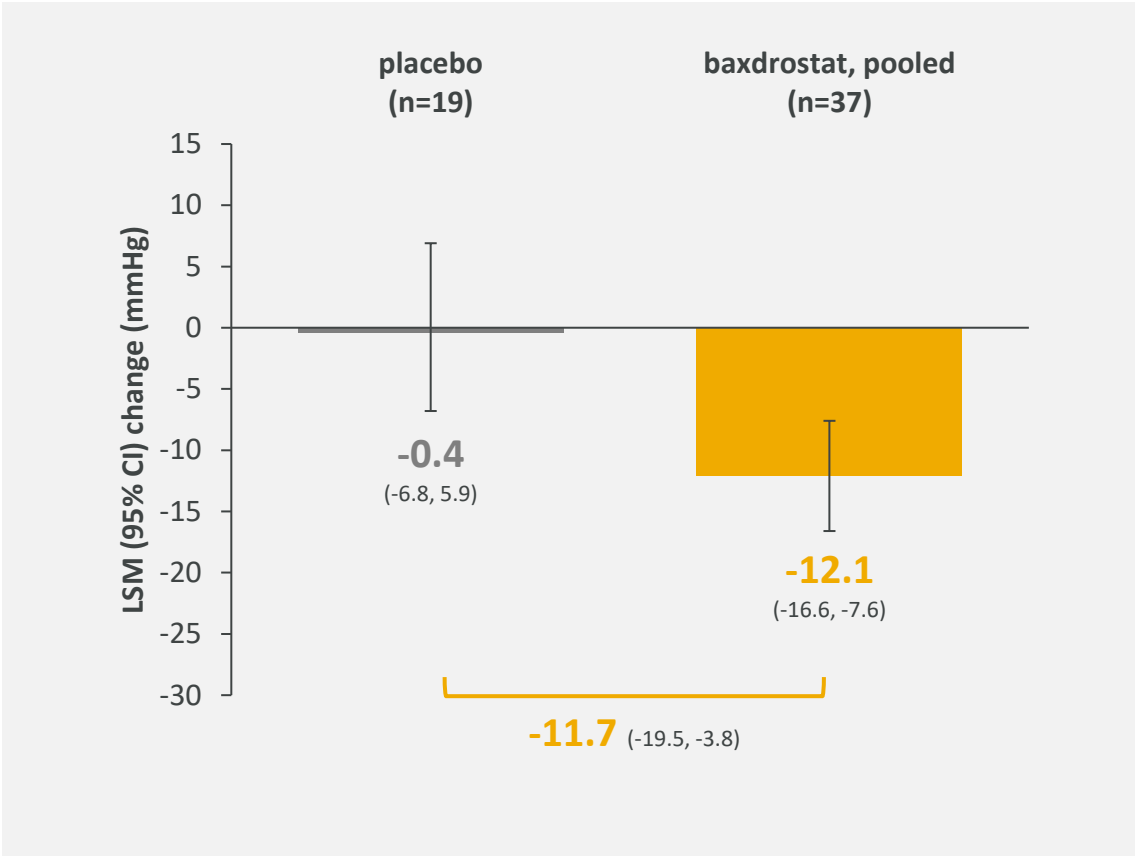
Data are median and interquartile range. Appendix: Glossary.

ABPM sub-study – baxdrostat impact on mean 24-hour and night-time SBP versus placebo at Week 12

Ambulatory 24-hour average SBP



Ambulatory night-time average SBP



Baseline was captured during the run-in visit. Appendix: Glossary.

Safety data – Part 1 to 12 weeks

- AEs were mostly mild
- One death in the placebo group
- No reports of adrenal insufficiency
- Most common AEs – numerically higher for baxdrostat versus placebo:
  - Hyperkalaemia
  - Hyponatraemia
  - Hypotension
  - Muscle spasms
  - Dizziness
- There were low rates of:
  - Confirmed serum potassium >6.0 mmol/L
  - Hyperkalaemia leading to discontinuation

n (%)	placebo (n=264)	baxdrostat 1mg (n=264)	baxdrostat 2mg (n=266)
Any adverse event	109 (41.3)	125 (47.3)	119 (44.7)
Moderate/severe	23 (8.7)	27 (10.2)	37 (13.9)
Severe	5 (1.9)	3 (1.1)	7 (2.6)
Any adverse event leading to discontinuation	5 (1.9)	7 (2.7)	12 (4.5)
Hyperkalaemia leading to discontinuation	0 (0.0)	2 (0.8)	4 (1.5)
Any serious adverse event[1]	7 (2.7)	5 (1.9)	9 (3.4)
Death	1 (0.4)	0 (0.0)	0 (0.0)
Adverse event of special interest[2]			
Hyperkalaemia	0 (0.0)	7 (2.7)	21 (7.9)
Hyponatraemia	1 (0.4)	2 (0.8)	6 (2.3)
Hypotension	2 (0.8)	5 (1.9)	6 (2.3)
Serum potassium – mmol/L			
>5.5 mmol/L	1/260 (0.4)	16/262 (6.1)	29/261 (11.1)
>6.0 mmol/L	1/262 (0.4)	6/262 (2.3)	8/263 (3.0)
Confirmed >6.0 mmol/L[3]	0/262 (0.0)	3/262 (1.1)	3/263 (1.1)

1. One case of hyperkalaemia (baxdrostat 1mg) and two cases of hyponatraemia (baxdrostat 1mg and 2mg) were deemed by investigators to be possibly related to baxdrostat. 2. Elevated potassium levels, low sodium levels and low blood pressure were adverse events of special interest if they required clinical intervention. 3. Central laboratory measurement >6.0 mmol/L confirmed with a local laboratory potassium measurement from the same day.
Appendix: Glossary.

Summary

- In participants with uncontrolled or resistant hypertension, the addition of baxdrostat 1mg or 2mg once daily to background anti-hypertensive therapy led to **placebo-adjusted reductions in seated-SBP of 8.7 mmHg and 9.8 mmHg**, respectively, after 12 weeks of treatment
- BP responses were consistent across **all pre-specified subgroups**
- Efficacy of baxdrostat persisted up to **at least 32 weeks**
- **Ambulatory 24-hour and night-time SBP were reduced** substantially with baxdrostat
- baxdrostat was generally **well tolerated**, with no unanticipated safety findings
- Rates of **confirmed serum potassium >6.0 mmol/L** were low (1% in both baxdrostat groups)

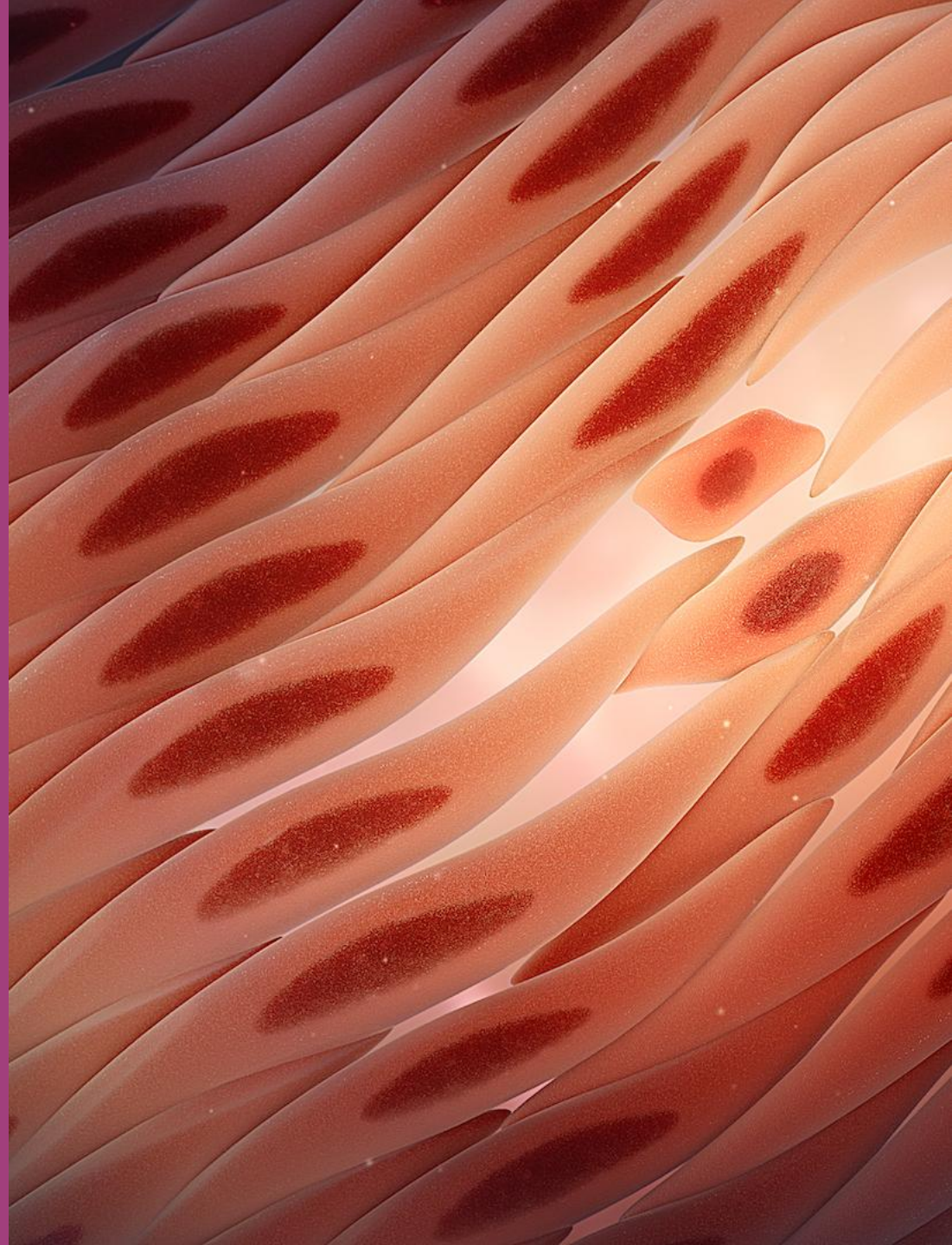
The Phase III BaxHTN trial demonstrated the efficacy and safety of baxdrostat for reducing BP in a broad population of patients with uncontrolled and resistant hypertension

Appendix: Glossary.

Delivering next-wave of CVRM growth with baxdrostat

Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

Ruud Dobber
EVP, BIOPHARMACEUTICALS BUSINESS

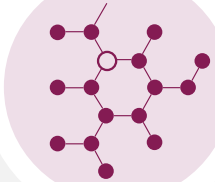


baxdrostat – potential first- and best-in-class aldosterone inhibitor to address hard-to-control hypertension

Largest mmHg reduction reported in primary analysis

Robust Hg reduction in hard-to-control population at Week 12[1]

9.8 mmHg reduction with 2mg
8.7 mmHg reduction with 1mg



Differentiated profile

Powerful aldosterone synthase inhibition
with 60-65% plasma aldosterone reduction

Favourable tolerability profile
with no off-target hormonal effects or clinically relevant drug-drug interactions

Additional supportive analyses

Long half-life for potential 24-hour control

BaxHTN encouraging exploratory data
Bax24 trial ongoing | H2 2025

1. Placebo-adjusted. Appendix: Glossary.

Leveraging existing foundation to transform hard-to-control hypertension globally with baxdrostat

Significant unmet need across regions

US: >20m
2L+ hypertension patients remain uncontrolled

ex-US: >75m
2L+ hypertension patients remain uncontrolled

Maximising strength of AstraZeneca in specialty and primary care to reach more patients with baxdrostat

c.85%

of 2L+ hypertension patients managed by primary care physicians and specialists[1,2]

>90%

of cardiologists and majority of primary care physicians reached with current AstraZeneca CVRM presence[1,2]

>115

countries currently reached with *Forxiga* and *Lokelma*

forxiga
LOKELMA

1. In the US. 2. Internal estimates. Appendix: Glossary.

$5bn+ potential with baxdrostat across monotherapy and combination opportunities

Monotherapy

to address aldosterone-driven diseases

BaxHTN	Bax24	BaxPA
hard-to-control hypertension	24-hour control in resistant hypertension	primary aldosteronism
Primary and all secondary endpoints met	**H2 2025**	***Initiating***

Combination with dapagliflozin

to transform treatment paradigm and further improve cardiorenal outcomes

BaxDUO-Arctic	BaxDUO-Pacific	PREVENT-HF
CKD and hypertension (*eGFR slope*)	CKD and hypertension (*outcomes*)	heart failure prevention
Ongoing Phase III with data anticipated >2026		

Peak Year Revenue, non-risk adjusted. Appendix: Glossary.

Q&A Session

Key External Expert

Dr Bryan Williams
CHAIR OF MEDICINE,
UNIVERSITY COLLEGE LONDON

AstraZeneca Leadership

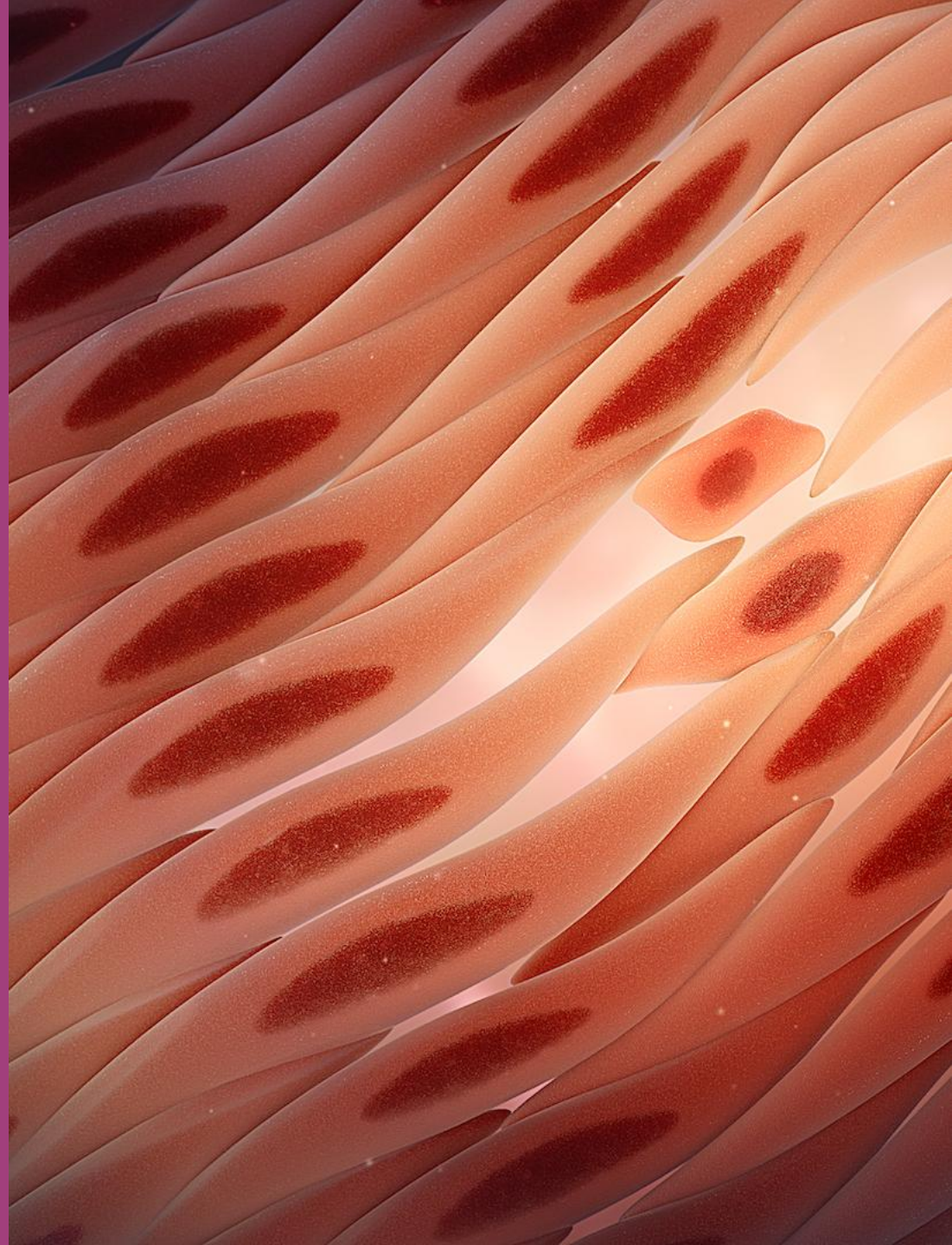
Sharon Barr
EVP, BIOPHARMACEUTICALS R&D

Ruud Dobber
EVP, BIOPHARMACEUTICALS BUSINESS

Mikhail Kosiborod
SVP, LATE CVRM R&D

Mina Makar
SVP, GLOBAL CVRM BUSINESS

Appendix



Glossary

2L+	second-line plus
ABPM	ambulatory blood pressure monitoring
ACEi	angiotensin-converting enzyme inhibitor
ADC	antibody-drug conjugate
AE	adverse event
AHT	anti-hypertensive medication
ARB	angiotensin-receptor blocker
ASCVD	atherosclerotic cardiovascular disease
ASI	aldosterone synthase inhibitor
ATTR-CM	transthyretin amyloid cardiomyopathy
BP	blood pressure
CI	confidence interval
CKD	chronic kidney disease
CVRM	cardiovascular, renal and metabolism
DBP	diastolic blood pressure
eGFR	estimated glomerular filtration rate
ESC	European Society of Cardiology
ETA	endothelin A
GCG	glucagon
GLP-1	glucagon-like peptide-1
HbA$_{1c}$	glycated hemoglobin
hMPV/RSV	human metapneumovirus/respiratory syncytial virus
HTN	hypertension
IO	immuno-oncology
IQR	interquartile range
IRA	Inflation Reduction Act
LDL-C	low-density lipoprotein cholesterol
LSM	least-squares mean
M&A	mergers and acquisitions
MRA	mineralocorticoid receptor antagonist
MRM	mineralocorticoid receptor modulator
NME	new molecular entity
NPC1L1i	Niemann-Pick C1-like 1 protein
oGLP-1	oral glucagon-like peptide-1
oPCSK9	oral proprotein convertase subtilisin/kexin type 9
PRA	plasma renin activity
QD	once-daily
R	randomised
RA	receptor agonist
RWD	randomised withdrawal
SARA	selective amylin receptor agonist
SBP	systolic blood pressure
SD	standard deviation
SE	standard error
SGLT2i	sodium-glucose cotransporter 2 inhibitor
TTR	transthyretin

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