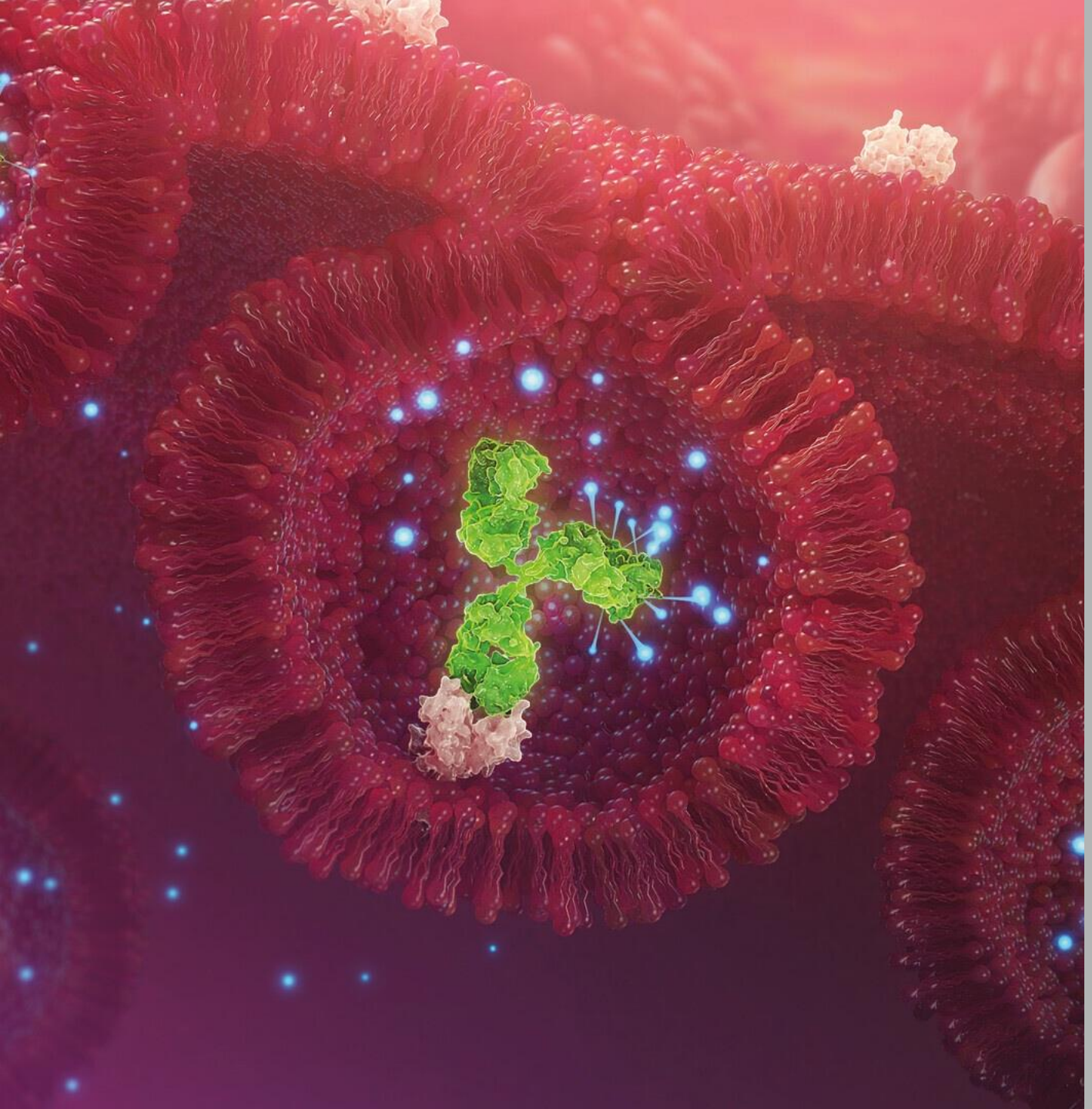


Meet AZN Management: ASCO

Investor Event

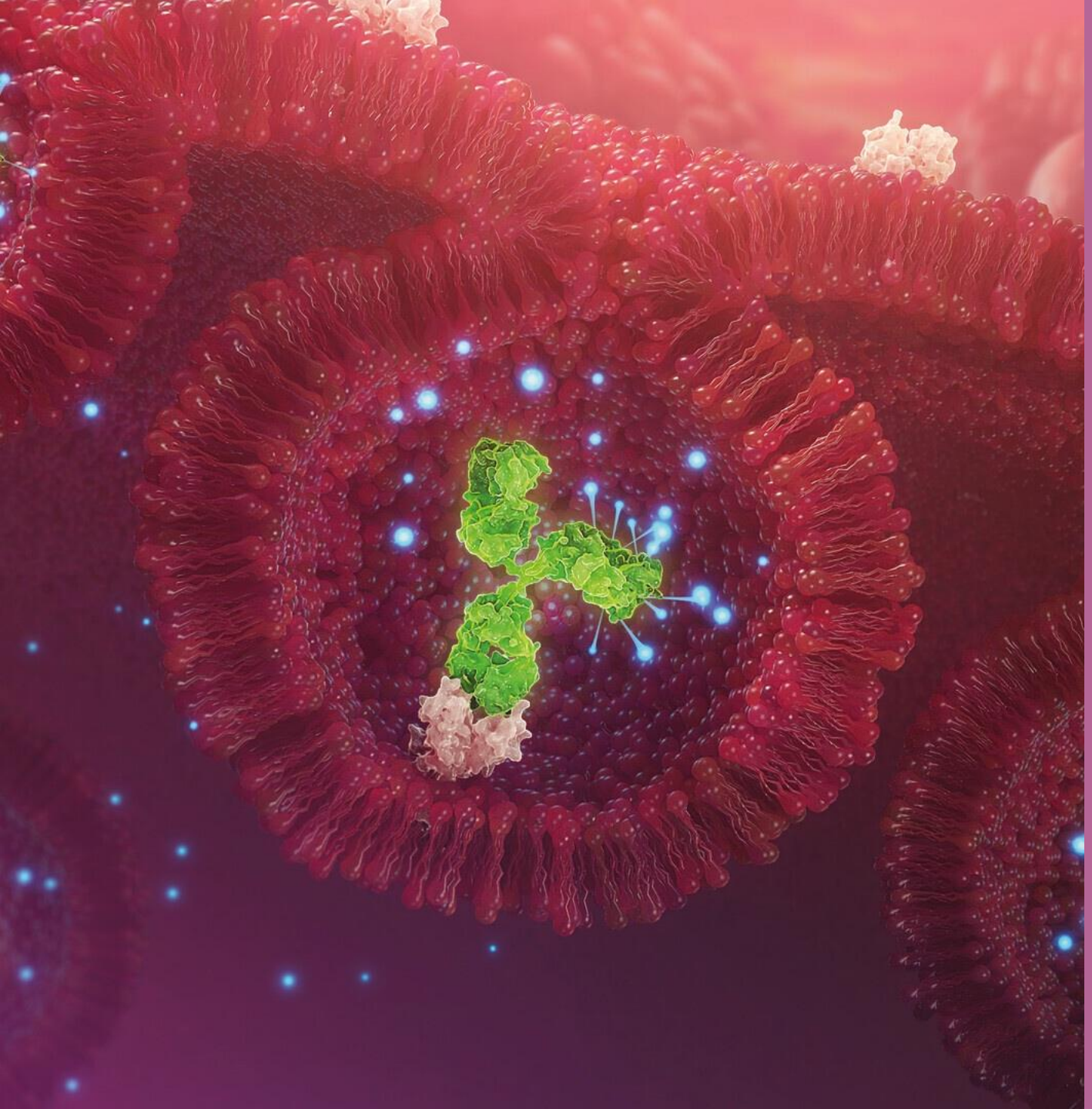
2 June 2025

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 AI 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; the risk of unexpected deterioration in the Group's financial position; the risk of foreign exchange rate movements impacting our financial condition or results of operations; and 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. Nothing in this document, or any related presentation/webcast, should be construed as a profit forecast.

AstraZeneca @ ASCO 2025

Furthering the AstraZeneca ambition	**Pascal Soriot,** Chief Executive Officer
Key Oncology themes at ASCO	**Susan Galbraith,** EVP, Oncology Haematology R&D
Redefining the breast cancer landscape • SERENA-6 • DESTINY-Breast09 • Integrating into clinical practice • Q&A	**Prof. Nick Turner**, Consultant Medical Oncologist, Royal Marsden **Dr Sara Tolaney**, Chief of the Division of Breast Oncology, Dana-Farber Cancer Institute **Sunil Verma,** SVP, Global Head, Oncology Franchise **Dave Fredrickson,** EVP, Oncology Haematology Business
Expanding leadership in GI cancers • MATTERHORN, DESTINY-Gastric04, GEMINI-Hepatobiliary • Integrating into clinical practice	**Cristian Massacesi,** Chief Medical Officer & Oncology Chief Development Officer **Dave Fredrickson,** EVP, Oncology Haematology Business
Closing Remarks and Q&A Session	**Dave Fredrickson,** EVP, Oncology Haematology Business



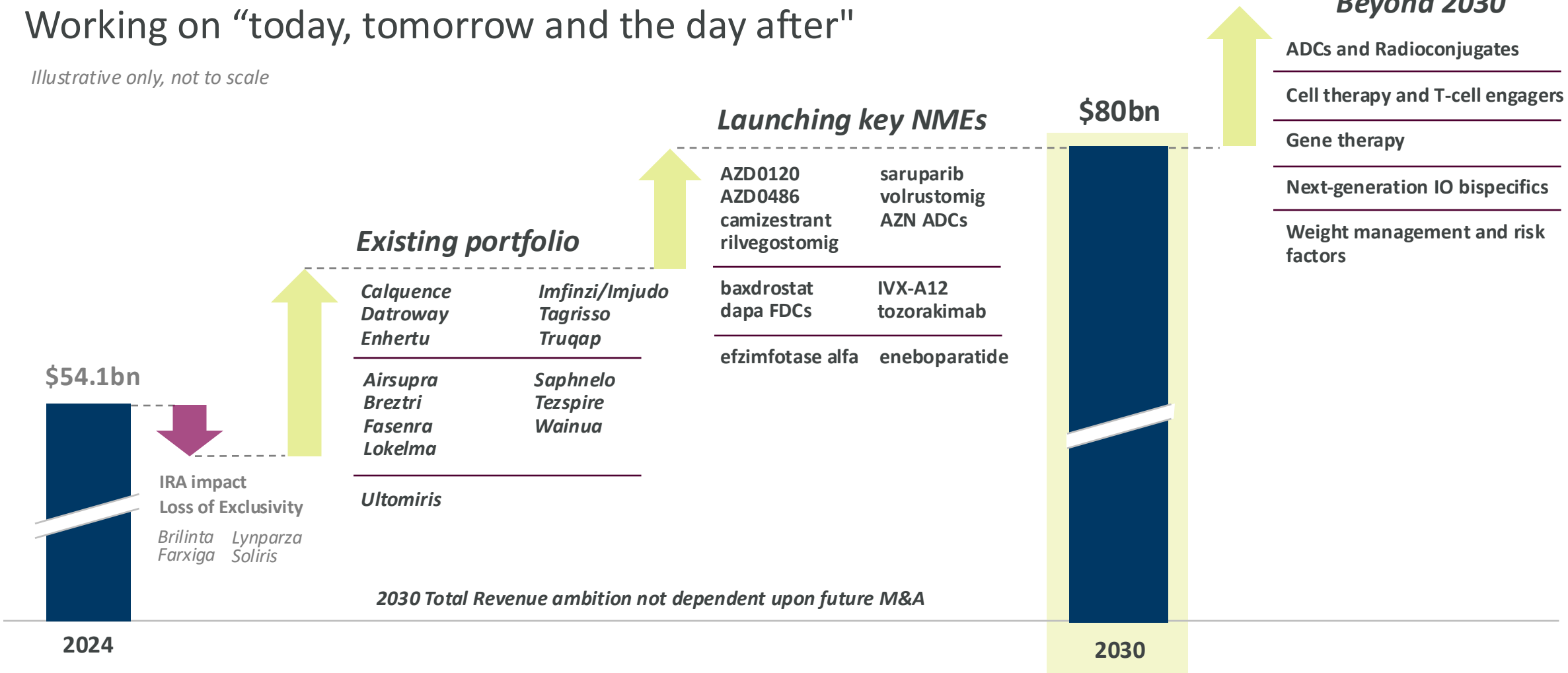
Furthering the AstraZeneca ambition

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 latest long-range plan.
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.
Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Amgen (*Tezspire*), Ionis (*Wainua*), Compugen (rilvegostomig), Merck & Co., Inc. (*Lynparza*). Appendix: Glossary.

Pipeline advancing at pace and significant progress with transformative technologies

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 initiating with **AZD0780 (oPCSK9)** Multiple Phase II dose optimisation trials ongoing **AZD5004 (oGLP-1)** **AZD6234 (SARA)**	6 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	**13 Phase III trials** with rilvegostomig and volrustomig initiated **First ADC combination** data at ASCO 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**

Strong clinical trial execution across the pipeline in 2025 with recruitment significantly ahead of plan in >50% of trials

Collaboration partners: Compugen (rilvegostomig).
Appendix: Glossary.

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

H1 2025

- **CALYPSO** | eneboparatide
  hypoparathyroidism
- **DESTINY-Breast09** | *Enhertu*
  1L HER2+ breast cancer
- **DESTINY-Breast11** | *Enhertu*
  early-stage HER2+ breast
- **KALOS/LOGOS** | *Breztri*
  uncontrolled asthma
- **MATTERHORN** | *Imfinzi*
  resectable GC/GEJC
- **POTOMAC** | *Imfinzi*
  non-muscle invasive bladder cancer
- **SERENA-6** | camizestrant
  1L *ESR1*m HR+ HER2- adv. breast cancer
- **TROPION-Breast02** | *Datroway*
  1L TNBC

H2 2025

- **AVANZAR** | *Datroway* + *Imfinzi*
  1L NSQ/NSQ TROP2+ NSCLC
- **DESTINY-Breast05** | *Enhertu*
  early HER2+ breast cancer
- **VOLGA** | *Imfinzi*
  muscle-invasive bladder cancer
- **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)
- **CAEL101-301/2** | anselamimab
  light-chain amyloidosis
- **HICKORY/CHESTNUT** | efzimfotase alfa hypophosphatasia
- **MG-301** | gefurulimab
  generalised myasthenia gravis

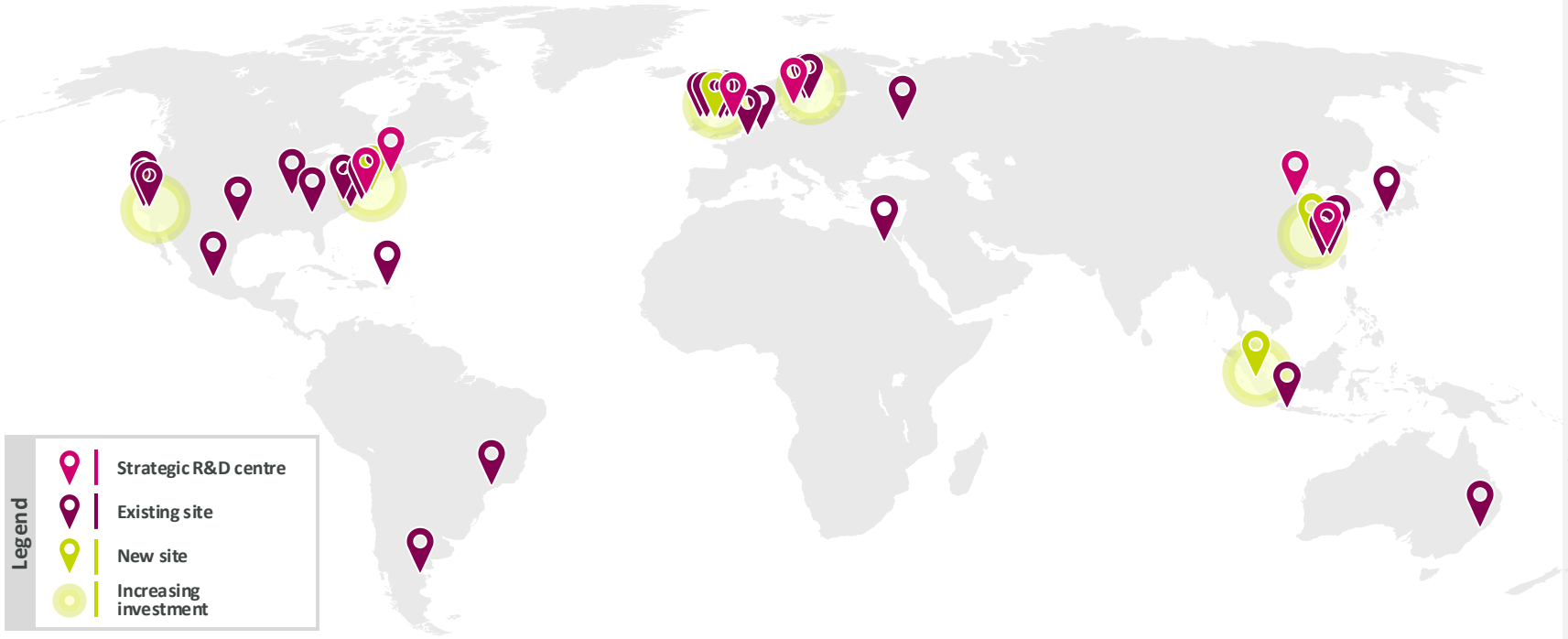
2026

- **TROPION-Lung07** | *Datroway*
  1L NSQ NSCLC
- **TROPION-Lung15** | *Datroway* ± *Tagrisso* 2L NSQ NSCLC
- **TROPION-Breast05** | *Datroway*
  1L PD-L1+ met. TNBC
- **EMERALD-2** | *Imfinzi*
  early HCC
- **EMERALD-3** | *Imfinzi*
  locoregional HCC
- **SAFFRON** | *Tagrisso* + *Orpathys*
  *EGFR*m NSCLC
- **SERENA-4** | camizestrant
  1L HR+ HER2- met. breast cancer
- **CLARITY-Gastric01** | sonesitatug vedotin 2L+ CLDN18.2+ gastric cancer
- **IRIS** | *Saphnelo*
  lupus nephritis
- **DAISY** | *Saphnelo*
  systemic sclerosis
- **CARDIO-TTRansform** | *Wainua*
  ATTR-CM
- **OBERON/TITANIA** | tozorakimab
  COPD
- **MIRANDA** | tozorakimab
  COPD
- **TILIA** | tozorakimab
  lower respiratory tract disease
- **ARTEMIS** | *Ultomiris*
  CSA-AKI
- **MULBERRY** | efzimfotase alfa
  hypophosphatasia

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

A growing broad-based global footprint

Resilient, dual-source supply chain with strategic investments in new technologies and R&D



Cambridge, UK

Gothenburg, Sweden

Gaithersburg, US

Boston, US – Kendall Sq.

Shanghai, China

Beijing, China

31 production facilities

11 US sites

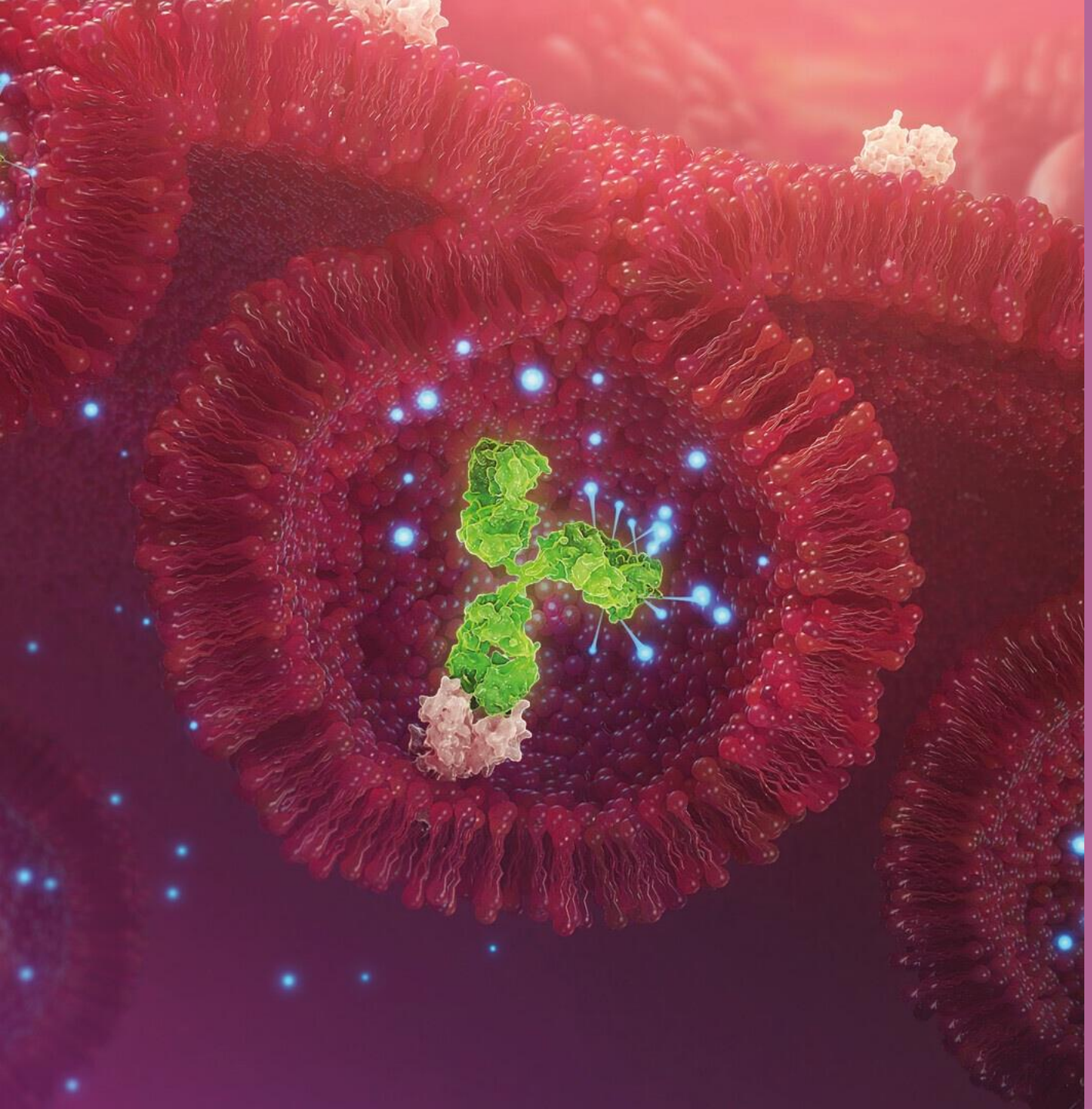
Vast majority of products sold in US are manufactured in US

6 strategic R&D centres

Appendix: Glossary.

Remarkable series of ASCO plenaries since 2020

Count of plenary sessions by pharmaceutical company since 2020 based on trial active arm.
Appendix: Glossary.



Key Oncology themes at ASCO

Susan Galbraith
EVP, ONCOLOGY
HAEMATOLOGY R&D

Focused strategy to redefine cancer care

Novel ADCs and Radioconjugates	1	Replace the backbone of chemotherapy and radiotherapy
Novel IO	2	Next wave of IO agents will segment the IO-sensitive space
Cell therapy and T-cell engagers	3	Scalable, accessible therapies in both liquid and solid tumours
Powerful combinations	4	Transform outcomes with novel ADC, Radio-conjugate and next-generation IO combinations
Early intervention	5	Improve long-term outcomes with neoadjuvant combinations

7 consecutive years of ASCO plenaries

Demonstrates value of AstraZeneca R&D engine

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

AstraZeneca

2025 ASCO® ANNUAL MEETING

82 abstracts accepted

43 poster presentations

19 oral presentations

2 plenary presentations

1 special LBA session

- SERENA-6 — Plenary, US BTD
- DESTINY-Breast09 — Special session
- MATTERHORN — Plenary
- DESTINY-Gastric04
- GEMINI-HPB
- NeoADAURA
- TROPION-Lung02
- TROPION-Lung04
- NeoCOAST-2
- SACHI, SAVANNAH

Eight simultaneous publications during ASCO, including three in *NEJM*

Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Hutchmed (*Orpathys*), Compugen (rilvegostomig). Appendix: Glossary.

AstraZeneca ground-breaking data across tumour types

Redefining care in breast cancer

Establishing a new endocrine backbone with camizestrant

SERENA-6

Phase III switch to cami with CDK4/6i in 1L *ESR1*m HR+/HER2- aBC

Moving *Enhertu* earlier in HER2+ mBC

DESTINY-Breast09

Phase III *Enhertu* + pertuzumab in 1L HER2+ mBC

Transforming outcomes in gastrointestinal cancers

New perioperative regimen for gastric/GEJ cancers

MATTERHORN

Phase III *Imfinzi* + FLOT in resectable GC/GEJC

Confirming *Enhertu* benefit in gastric/GEJ cancers

DESTINY-Gastric04

Phase III *Enhertu* in 2L HER2+ GC/GEJC

Building role of rilvegostomig in BTC

GEMINI-HPB

Phase II rilvegostomig + CTx in BTC

Ambition to treat 1 in 2 lung cancers by 2030

***Tagrisso* backbone across *EGFR*m NSCLC**

NeoADAURA

Phase III neoadjuvant *Tagrisso* ± CTx in resectable *EGFR*m NSCLC

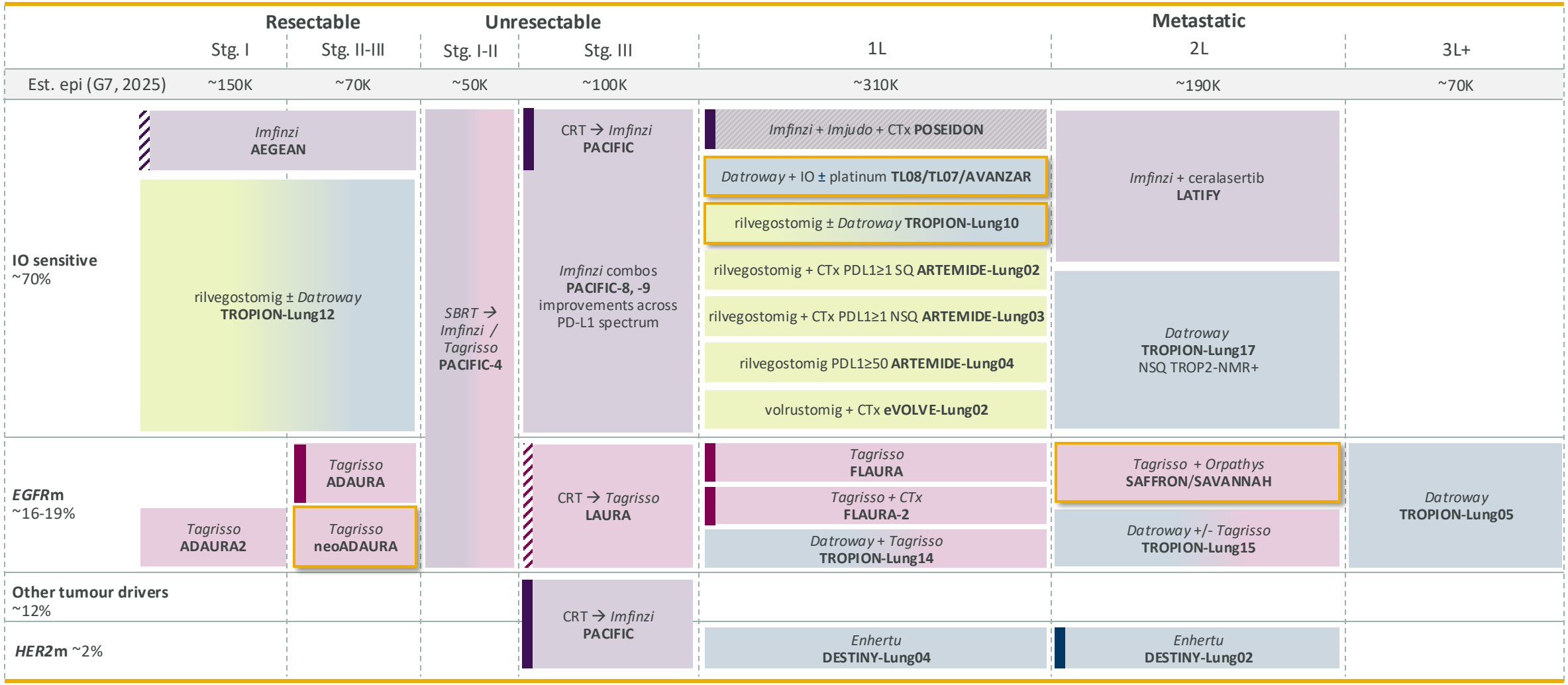
Potential for *Datroway* + IO to transform treatment expectations in lung cancer

NeoCOAST-2, TROPION-Lung02, TROPION-Lung04

Phase Ib and II trials of *Datroway* + IO ± CTx

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

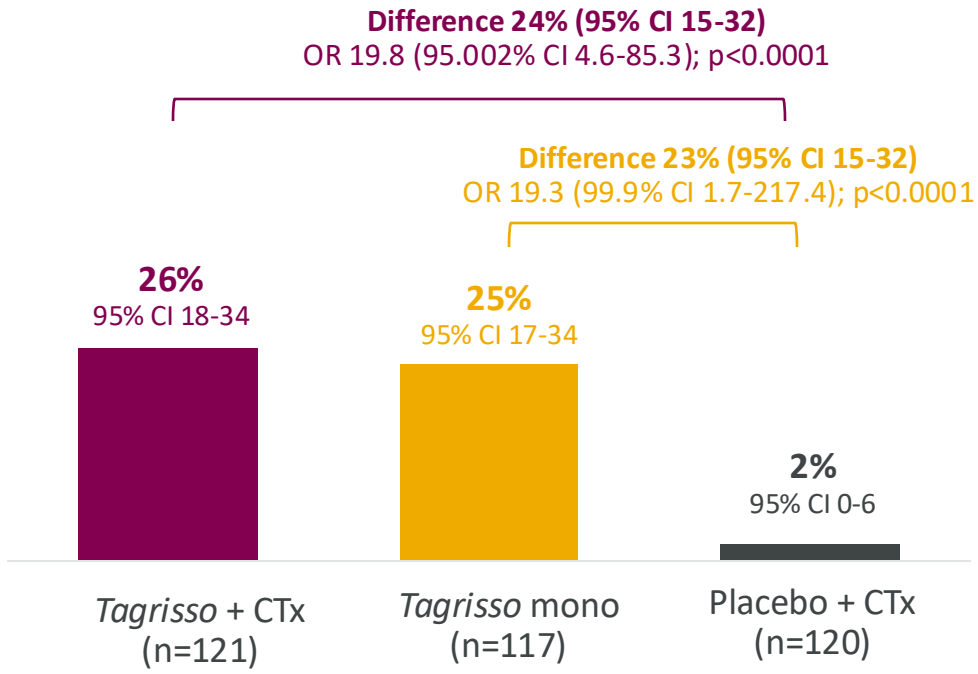
Leading development programme in lung cancer



Lung Cancer map reflects Phase III/pivotal trials. Collaboration partners: Daiichi Sankyo (*Enhertu*, *Datroway*), Hutchmed (*Orpathys*), Compugen (rilvegostomig). Appendix: Glossary.

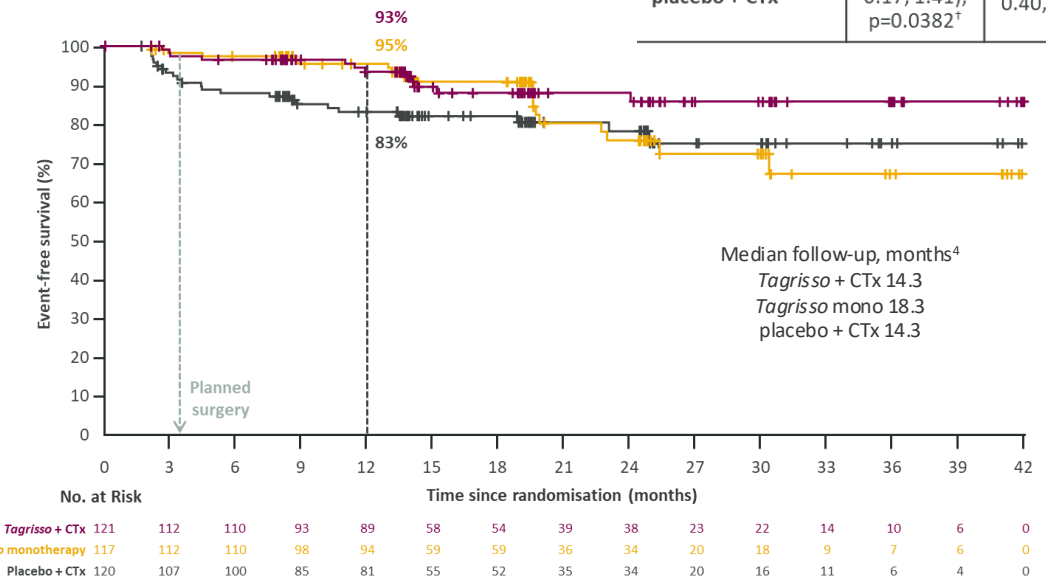
NeoADAURA: Reinforces ADAURA and LAURA with *Tagrisso* as a backbone in curative settings for *EGFR*m NSCLC

Significant improvement in MPR rate[1]



Favourable EFS trend[2]

	Tagrisso + CTx	*Tagrisso* mono.
EFS HR vs. placebo + CTx	**0.50** (99.8% CI 0.17, 1.41); p=0.0382[†]	**0.73** (95% CI 0.40, 1.35)[3]



No. at Risk

Tagrisso + CTx	121	112	110	93	89	58	54	39	38	23	22	14	10	6	0
Tagrisso monotherapy	117	112	110	98	94	59	59	36	34	20	18	9	7	6	0
Placebo + CTx	120	107	100	85	81	55	52	35	34	20	16	11	6	4	0

Underscores importance of early biomarker testing

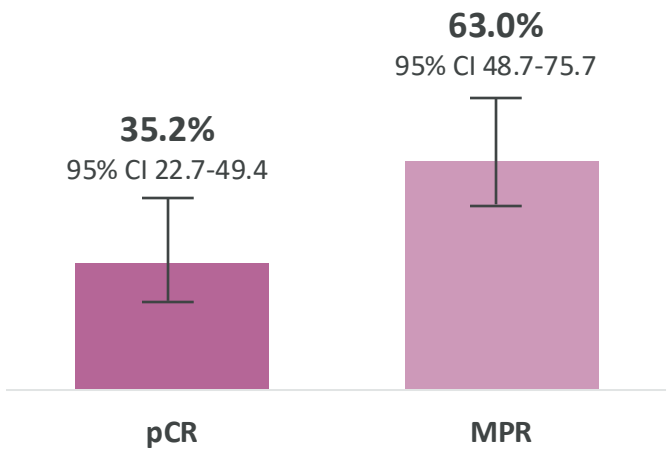
Trial conducted in patients with Stage II-IIIb resectable NSCLC. Data cut-off: October 15, 2024. 1. MPR defined as ≤10% residual viable tumour cells in the lung primary tumour at resection. 2. Interim investigator-assessed EFS at 15% maturity. 3. EFS analysis performed using a log-rank test stratified by disease stage (II vs III), race (Chinese vs other Asian vsnon-Asian) and EGFR mutation type (Ex19del vs L858R). p-value ≤0.002 required for statistical significance at interim analysis. No p-value calculated for *Tagrisso* mono comparison. The pre-specified sequential multiple testing procedure required a statistically significant improvement in EFS to be demonstrated for the comparison of *Tagrisso* + CTx vs placebo + CTx before formal testing for the comparison of *Tagrisso* mono vs placebo + CTx could be performed. 4. All patients. Chaft JE et al. Abstract #8001 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

Potential for *Datroway* + IO to transform treatment expectations in advanced and early-stage NSCLC

pCR and MPR doubled with triplet vs SoC AEGEAN

Phase II NeoCOAST-2

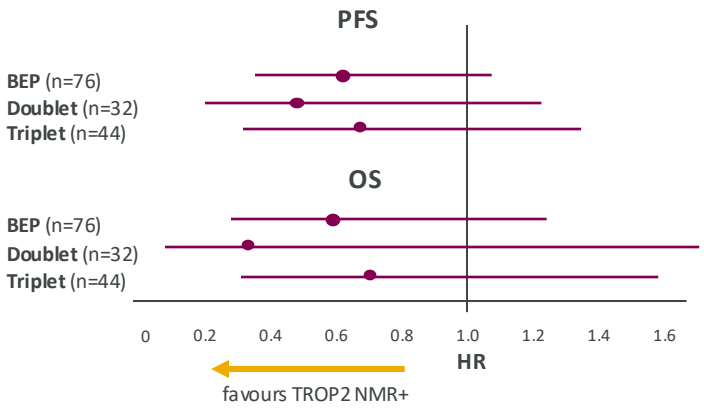
***Datroway* + *Imfinzi* + CTx (N=54)[1]**



Trend to PFS and OS benefit with TROP2 NMR biomarker in 1L NSCLC

Phase Ib TROPION-Lung02

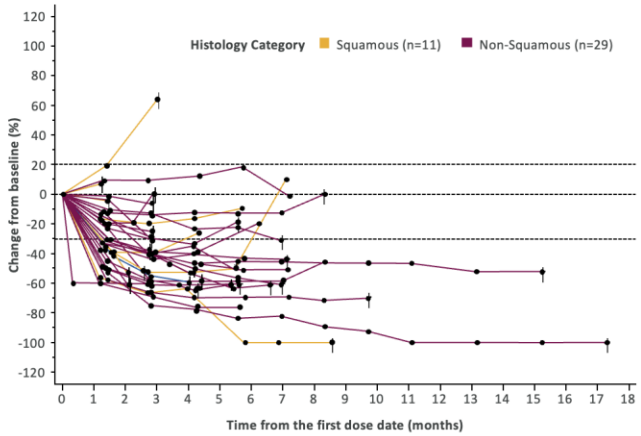
***Datroway* + pembrolizumab ± CTx (N=76)[2]**



Ability to combine *Datroway* with next generation IO

Phase Ib TROPION-Lung04

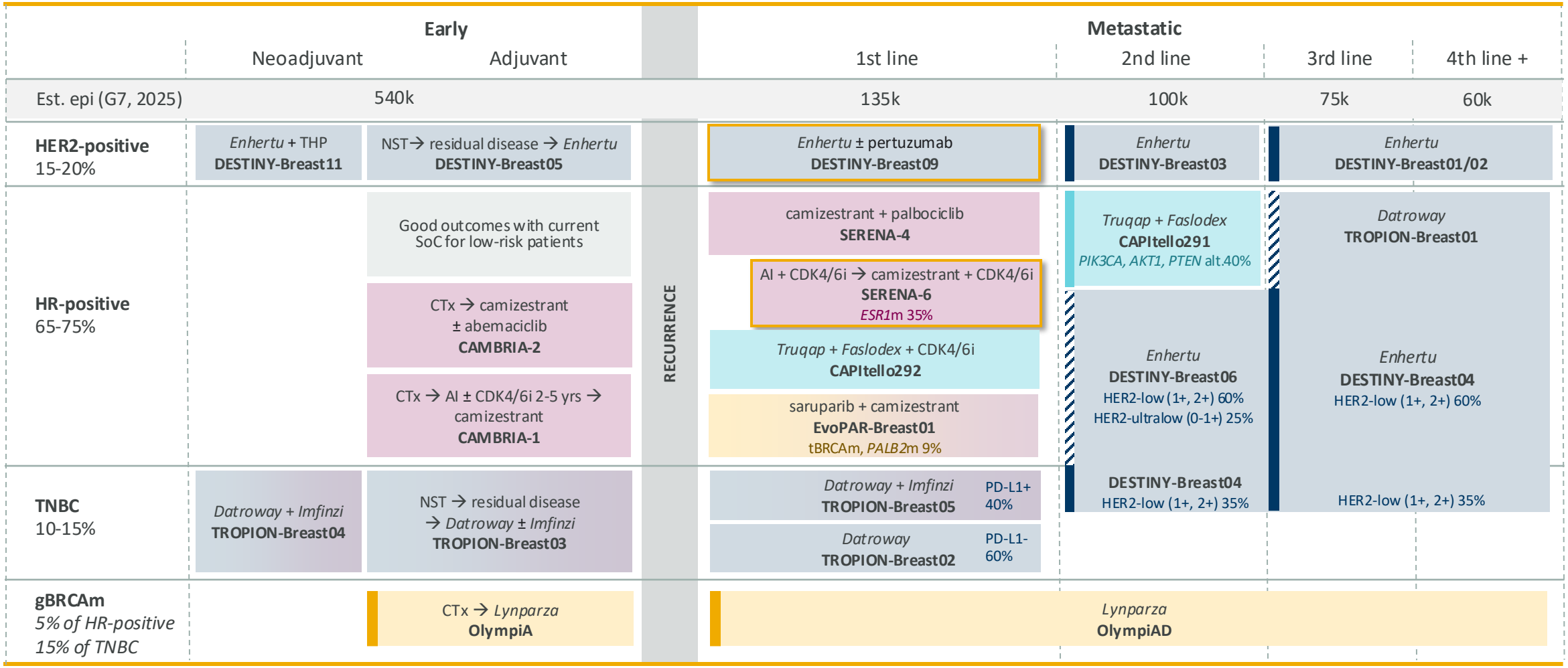
***Datroway* + rilvegostomig (N=40)[3,4]**



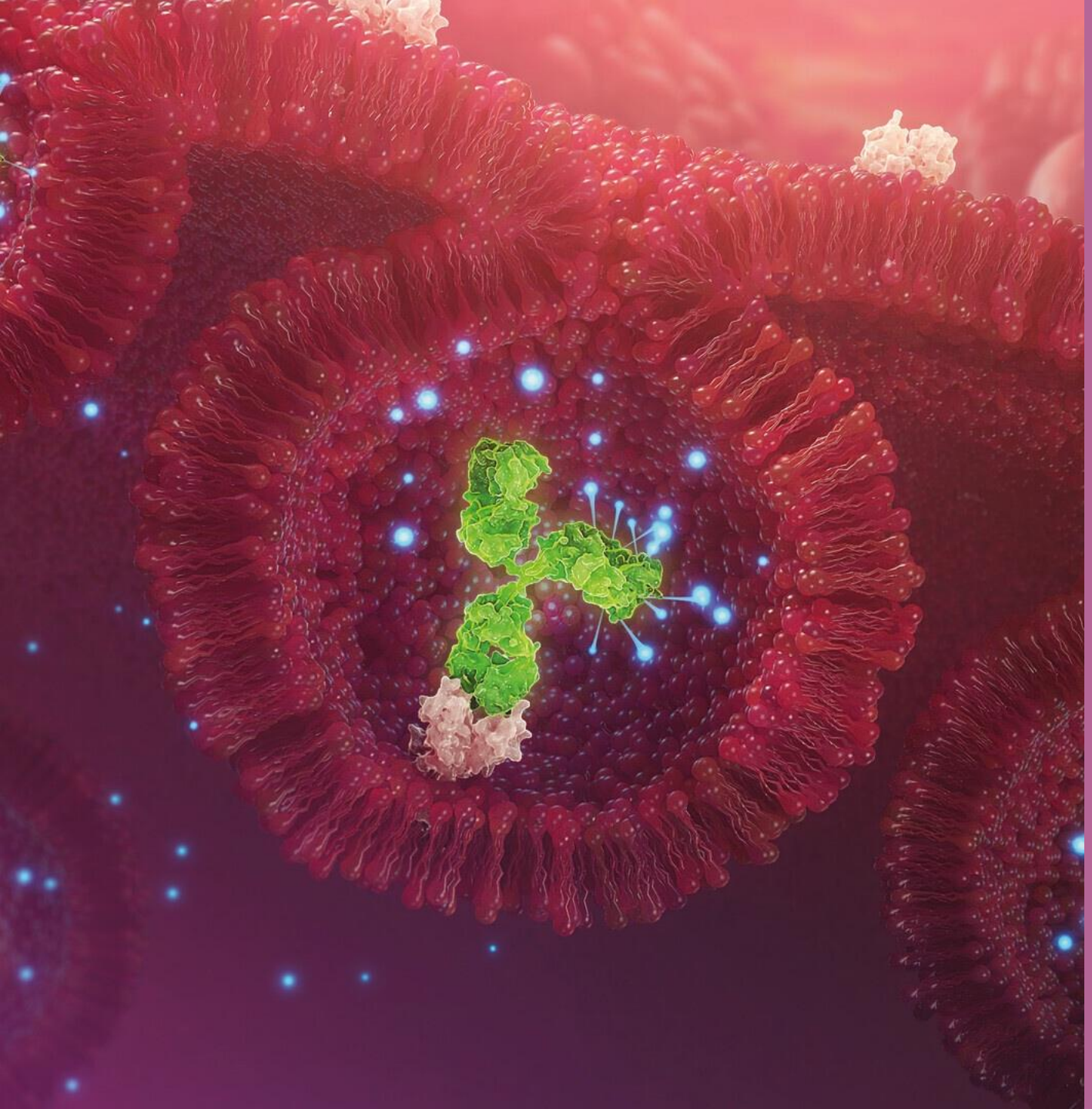
Data support ongoing robust Phase III programme for *Datroway* + IO

1. NeoCOAST-2 Arm 4. 2. Exploratory QCS analysis. 3. TROPION-Lung04 Cohort 5. 4. Investigator assessed per RECIST v1.1.
Cascone, T et al. Abstract #8046 presented at the American Society of Clinical Oncology 2025. Levy, BP et al. Abstract #8501 presented at the American Society of Clinical Oncology 2025. Waqar, SN et al. Abstract #8521 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Datroway*), Compugen (rilvegostomig). Appendix: Glossary.

Leading development programme 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.

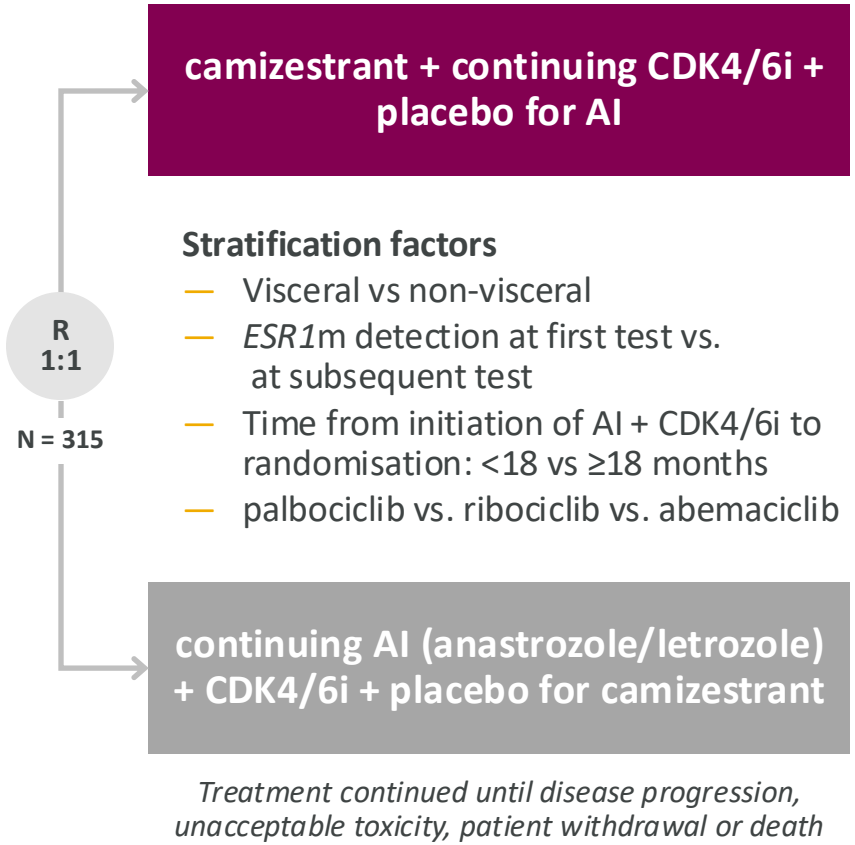


SERENA-6

Prof. Nicolas Turner
CONSULTANT MEDICAL ONCOLOGIST, ROYAL MARSDEN

SERENA-6: Innovative trial design leveraging ctDNA to inform treatment switch in 1L HR+ advanced BC

- ER+ HER2- advanced breast cancer (aBC)[1]
- ≥6 months of AI + CDK4/6i (palbociclib, ribociclib, or abemaciclib) as initial endocrine-based therapy for aBC
- *ESR1*m detected in ctDNA with no evidence of disease progression
  - Testing carried out every 2-3 months



Primary endpoint:

PFS by investigator assessment (RECIST v1.1)

Key secondary endpoints:

- Progression-free survival 2
- Overall survival

Secondary endpoints:

- Safety
- Objective response

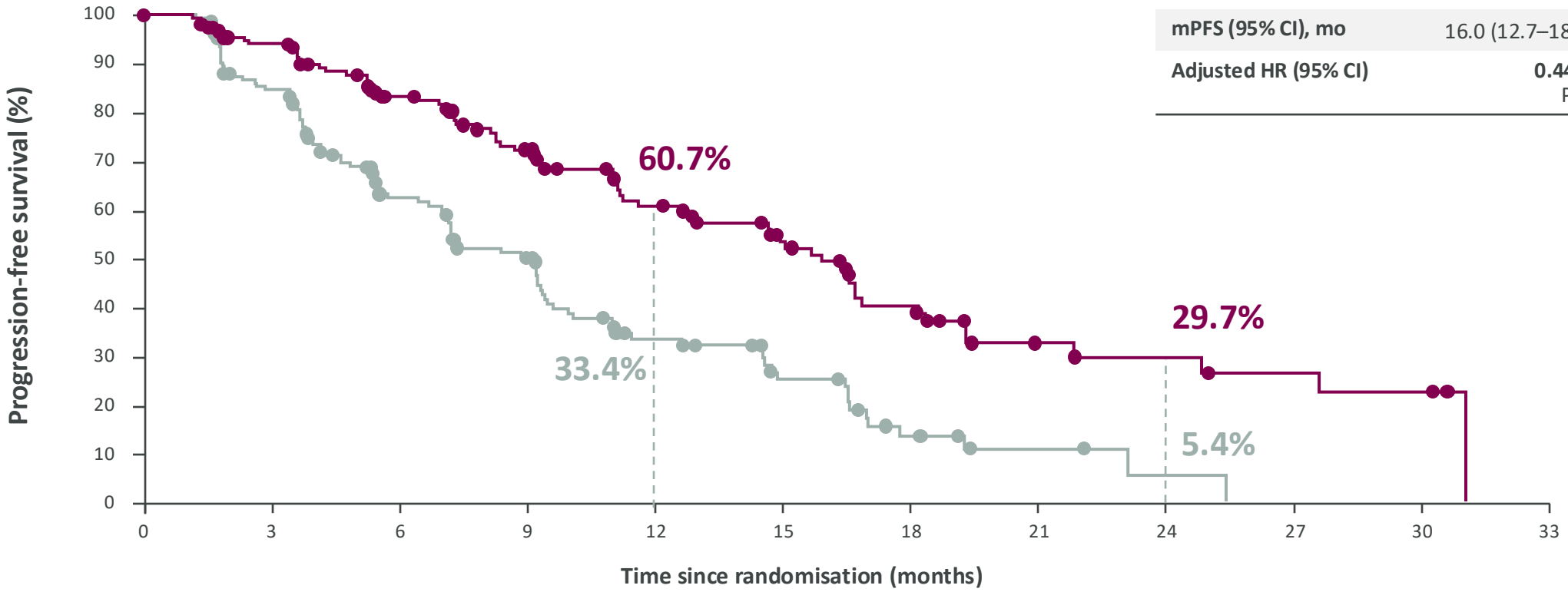
Exploratory endpoints:

- Time to deterioration in global health status/quality of life

1. Pre- or perimenopausal women, and men received a luteinizing hormone–releasing hormone agonist per clinical guidelines.
Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025.
Appendix: Glossary.

SERENA-6: Camizestrant + CDK4/6i reduced the risk of progression or death by 56%

	camizestrant + CDK4/6i (N=157)	AI + CDK4/6i (N=158)
PFS events	71	100
mPFS (95% CI), mo	16.0 (12.7–18.2)	9.2 (7.2–9.5)
Adjusted HR (95% CI)	**0.44** (0.31–0.60) P<0.00001	

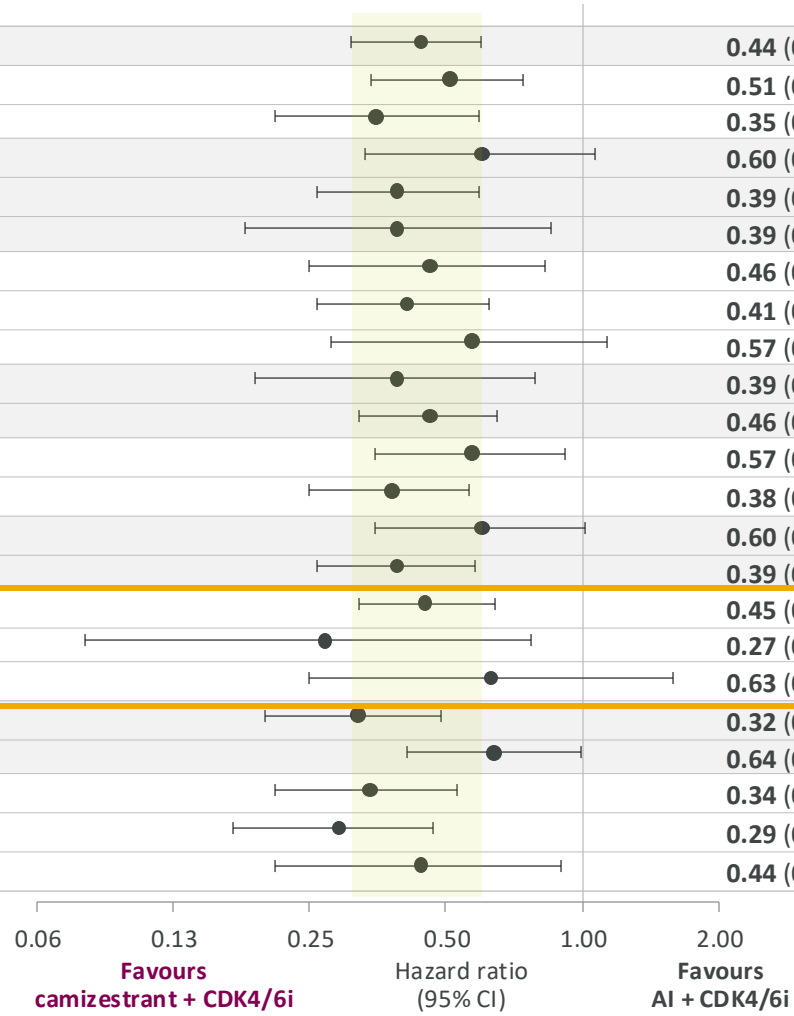


No. at risk												
camizestrant + CDK4/6i	157	138	105	82	55	41	26	11	9	7	6	0
AI + CDK4/6i	158	124	73	55	29	17	7	3	1	0	0	0

Planned interim analysis of investigator-assessed PFS. P-value crossed the threshold for significance (P=0.0001). PFS was defined per RECIST v1.1. HR was estimated using the Cox proportional hazard model adjusted for stratification factors.
Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025.
Appendix: Glossary.

SERENA-6: Consistent benefit across subgroups for camizestrant + CDK4/6i

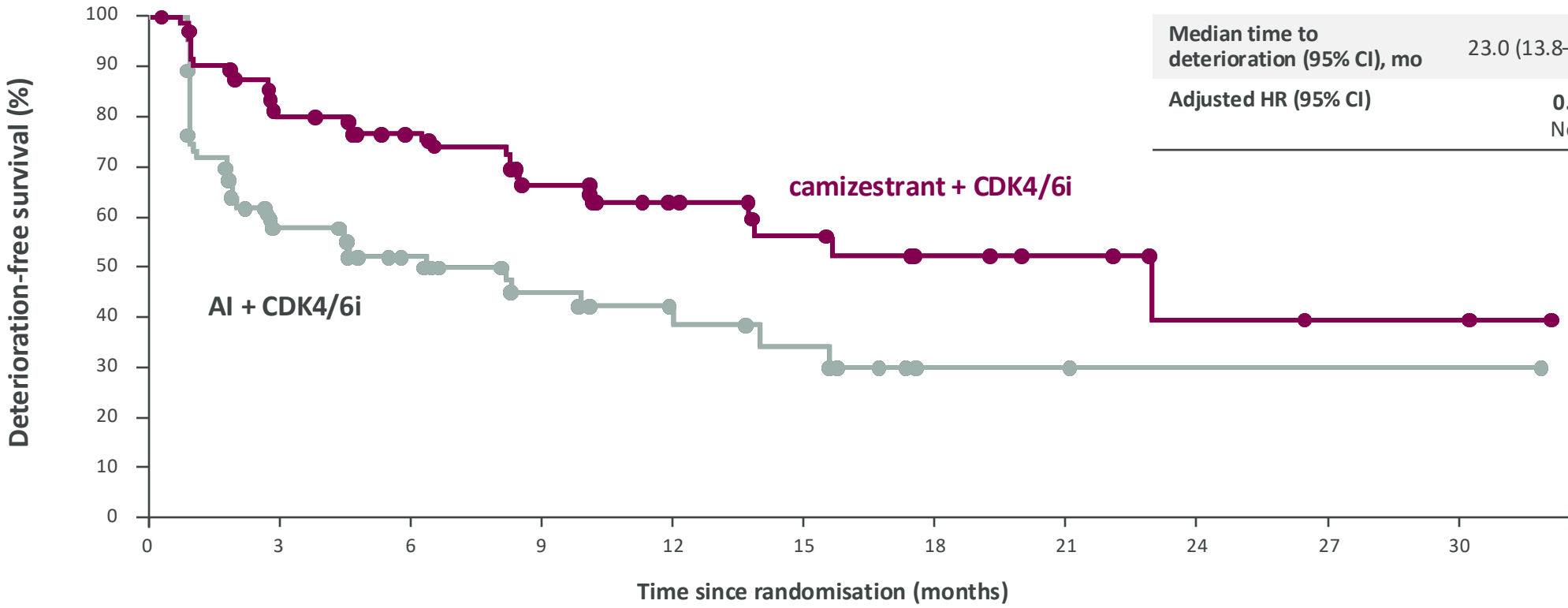
	Subgroup	camizestrant + CDK4/6i	AI + CDK4/6i	Hazard ratio (95% CI)
		# of events/total		
	All patients	71/157	100/158	**0.44** (0.31–0.60)
Age	<65 years	44/95	67/104	**0.51** (0.34–0.74)
	≥65 years	27/62	33/54	**0.35** (0.21–0.59)
Race	Asian	22/39	25/34	**0.60** (0.33–1.07)
	White	37/97	61/102	**0.39** (0.26–0.59)
	Other	12/21	14/21	**0.39** (0.18–0.85)
Region	Asia	19/40	28/39	**0.46** (0.25–0.83)
	Europe	37/89	54/91	**0.41** (0.26–0.62)
	North America	15/28	18/28	**0.57** (0.28–1.13)
Menopausal status	Pre- and perimenopausal women, and men	14/34	18/31	**0.39** (0.19–0.79)
	Postmenopausal	57/123	82/127	**0.46** (0.32–0.65)
Disease site[1]	Visceral	32/65	37/64	**0.57** (0.35–0.92)
	Non-visceral	39/92	63/92	**0.38** (0.25–0.56)
Time from initiation of AI+CDK4/6i to randomisation[1]	<18 months	28/50	29/46	**0.60** (0.35–1.01)
	>18 months	43/105	69/110	**0.39** (0.26–0.58)
CDK4/6i[1]	Palbociclib	57/117	78/118	**0.45** (0.32–0.64)
	Ribociclib	4/23	13/23	**0.27** (0.08–0.77)
	Abemaciclib	10/15	9/15	**0.63** (0.25–1.59)
Time of *ESR1*m detection[1]	First test	36/82	56/79	**0.32** (0.20–0.49)
	A subsequent test	35/75	44/79	**0.64** (0.41–0.99)
Type of *ESR1*m	D538G	29/70	52/82	**0.34** (0.21–0.53)
	Y537S	24/61	46/60	**0.29** (0.17–0.47)
	Y537N	13/29	18/25	**0.44** (0.21–0.90)



Investigator-assessed PFS. 1. Stratification factors at randomisation. HRs and 95% CIs were not calculated for subgroups with <20 events, except for the CDK4/6i subgroup. HRs and 95% CIs were calculated from a Cox proportional hazards model with treatment, factor and treatment-by-factor as covariates. Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

SERENA-6: Camizestrant + CDK4/6i reduced the risk of deterioration of HRQoL

	camizestrant + CDK4/6i (N=107)	AI + CDK4/6i (N=95)
Events	36	49
Median time to deterioration (95% CI), mo	23.0 (13.8–NC)	6.4 (2.8, 14.0)
Adjusted HR (95% CI)	**0.53** (0.33–0.82) Nominal P<0.001	



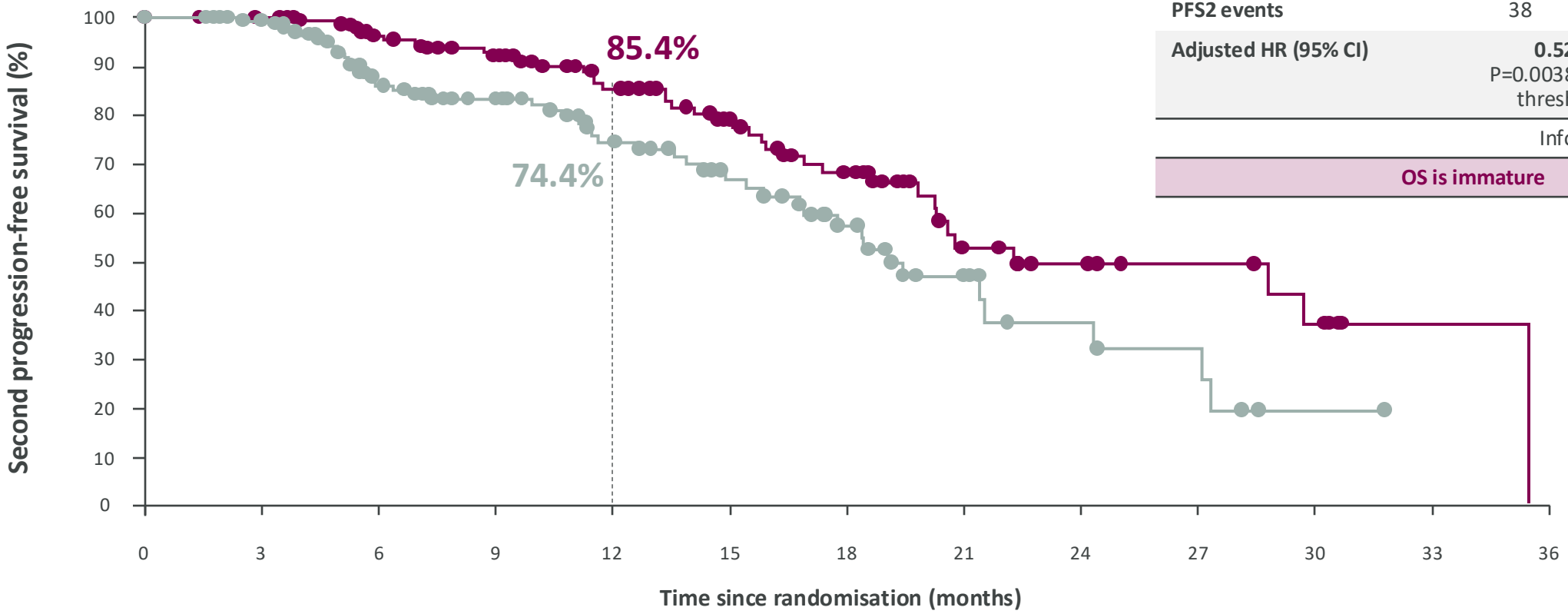
No. at risk												
camizestrant + CDK4/6i	107	72	59	40	24	16	9	6	3	2	2	0
AI + CDK4/6i	95	42	26	16	11	8	2	2	1	1	1	0

Camizestrant + CDK4/6i also delayed the time to deterioration in pain compared with AI + CDK4/6i

Assessments were conducted at baseline, weeks 4, 8 and 12 and then every 8 weeks until PFS2. Analysis conducted in patients with a baseline score and at least one post-baseline assessment. TTD in global health status/quality of life, an exploratory endpoint, was defined as the time from randomisation to first deterioration that was confirmed at a subsequent timepoint measured using the European Organisation for Research and Treatment of Cancer 30-item quality-of-life questionnaire. Deterioration was defined as a decrease from baseline ≥16.6. HR was estimated using the Cox proportional hazard model stratified by time of ESR1m detection (one test vs more than one test), and time from initiation of AI + CDK4/6i torandomisation (<18 months vs. ≥18 months). Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

SERENA-6: Consistent benefit in second progression-free survival (PFS2)

	camizestrant + CDK4/6i (N=157)	AI + CDK4/6i (N=158)
PFS2 events	38	47
Adjusted HR (95% CI)	**0.52** (0.33–0.81) P=0.0038 [interim analysis threshold p=0.0001]	
	Information fraction: 54%	
OS is immature		



No. at risk													
camizestrant + CDK4/6i	157	146	120	103	74	55	39	17	12	9	6	1	0
AI + CDK4/6i	158	144	98	78	55	38	25	12	7	5	1	0	0

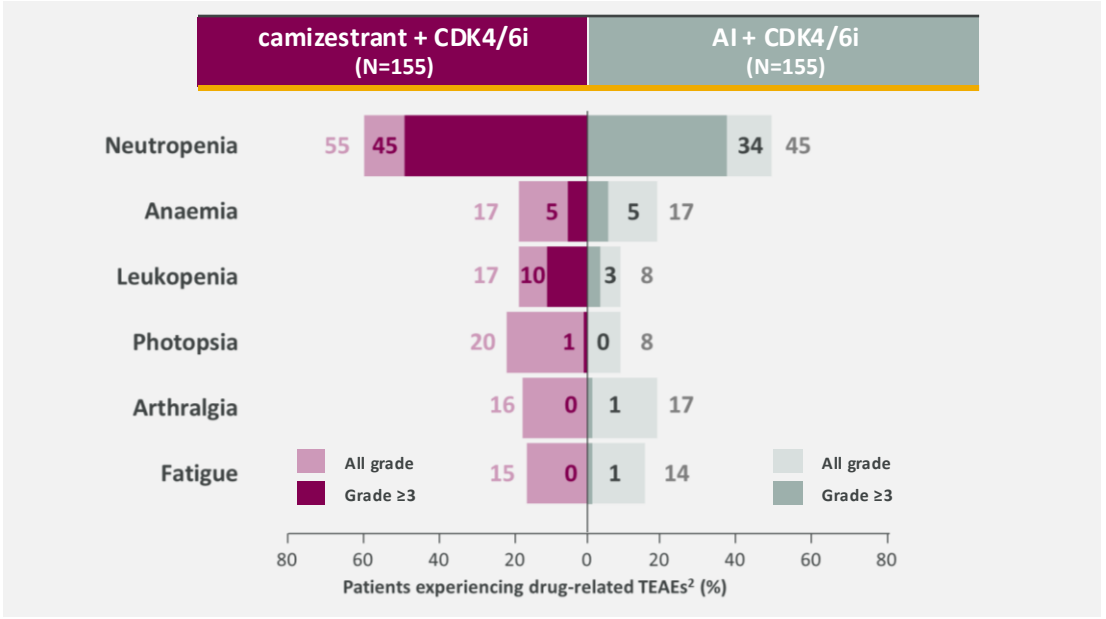
HR was estimated using the Cox proportional hazard model adjusted for stratification factors. Final PFS2 analysis will occur at 158 PFS2 events.
Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025.Appendix: Glossary.

SERENA-6: Camizestrant + CDK4/6i is well-tolerated with a very low discontinuation rate (<1.5%)

Very low discontinuation rates

n (%)	camizestrant + CDK4/6i (N=155)	AI + CDK4/6i (N=155)
Any adverse event	145 (93.5)	135 (87.1)
Any serious adverse event	16 (10.3)	19 (12.3)
Any adverse event leading to discontinuation		
Discontinuation of camizestrant/AI	2 (1.3)	3 (1.9)
Discontinuation of both camizestrant/AI and CDK4/6i	1 (0.6)	2 (1.3)
Any adverse event leading to dose modification of camizestrant/AI[1]	39 (25.2)	23 (14.8)
Treatment exposure (months)		
camizestrant/AI	10.1	6.3
CDK4/6i	9.8	6.1

Compelling AE profile



Exposure-adjusted incidence rates similar between treatment arms for neutropenia
Photopsia did not impact daily activities and was reversible
No discontinuations due to bradycardia or photopsia

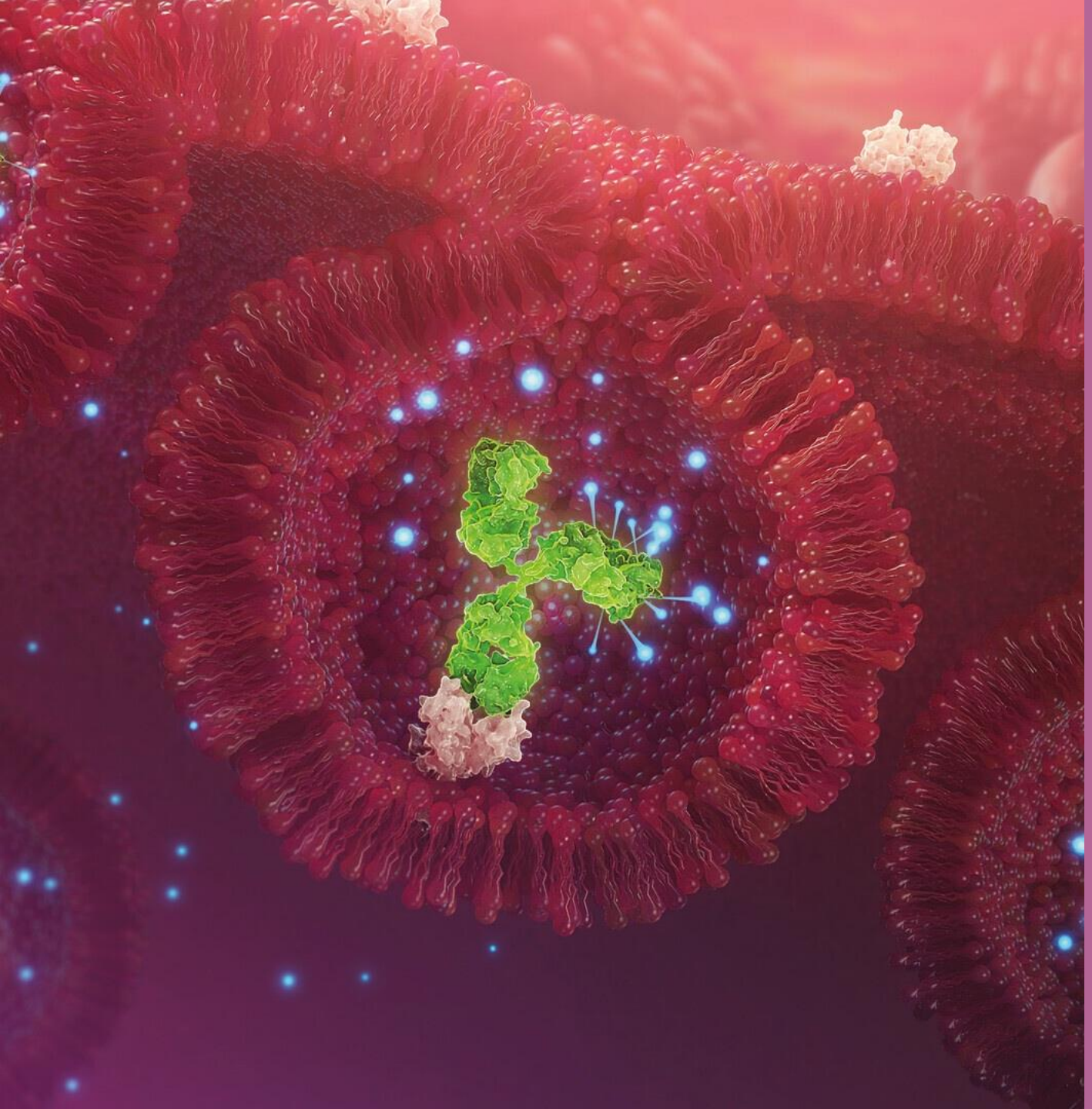
1. Percentage of the actual dose intensity received by the patient relative to the intended dose intensity until treatment discontinuation. 2. AEs in ≥15% of patients (either arm).
Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

SERENA-6: Camizestrant first next generation oral SERD to demonstrate benefit in 1L HR+ advanced BC

- Switching AI to camizestrant with continuation of CDK4/6i, guided by the emergence of *ESR1*m during 1L therapy ahead of disease progression, significantly improved PFS in patients with HR+/HER2- aBC
- PFS benefit was consistent across the CDK4/6i and clinically relevant subgroups
- Camizestrant + CDK4/6i delayed time to deterioration in quality of life vs. continuing AI + CDK4/6i, and was well tolerated with a very low rate of treatment discontinuations due to AEs
- SERENA-6 is the first global registrational Phase III study to demonstrate the clinical utility of ctDNA monitoring to detect and treat emerging resistance in breast cancer

SERENA-6 presents the opportunity to re-shape the 1L treatment paradigm through significantly improving outcomes for patients with HR+ advanced BC

Turner, NC et al. Abstract #LBA4 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

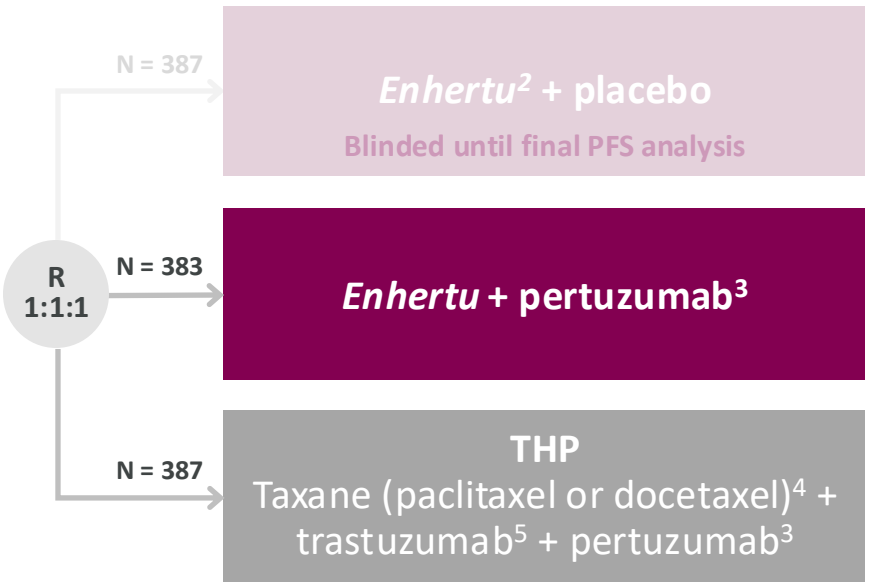


DESTINY-Breast09

Dr Sara Tolaney
CHIEF OF THE DIVISION OF BREAST ONCOLOGY, DANA-FARBER CANCER INSTITUTE

DESTINY-Breast09: Moving *Enhertu* into 1L with potential to displace established standard of care THP

- HER2+ a/mBC
- Asymptomatic/inactive brain mets allowed
- DFI >6 mo from last CTx or HER2-targeted therapy in neoadj./ adj. setting
- 1 prior line of ET for mBC permitted
- No other prior systemic treatment for mBC[1]



Primary endpoint:

PFS (BICR)

Key secondary endpoints:

OS

Secondary endpoints:

- PFS (INV)
- ORR (BICR/INV)
- DOR (BICR)
- Safety and tolerability

Stratification factors

- De-novo vs recurrent mBC
- HR+ or HR−
- *PIK3CA*m (detected vs non-detected)

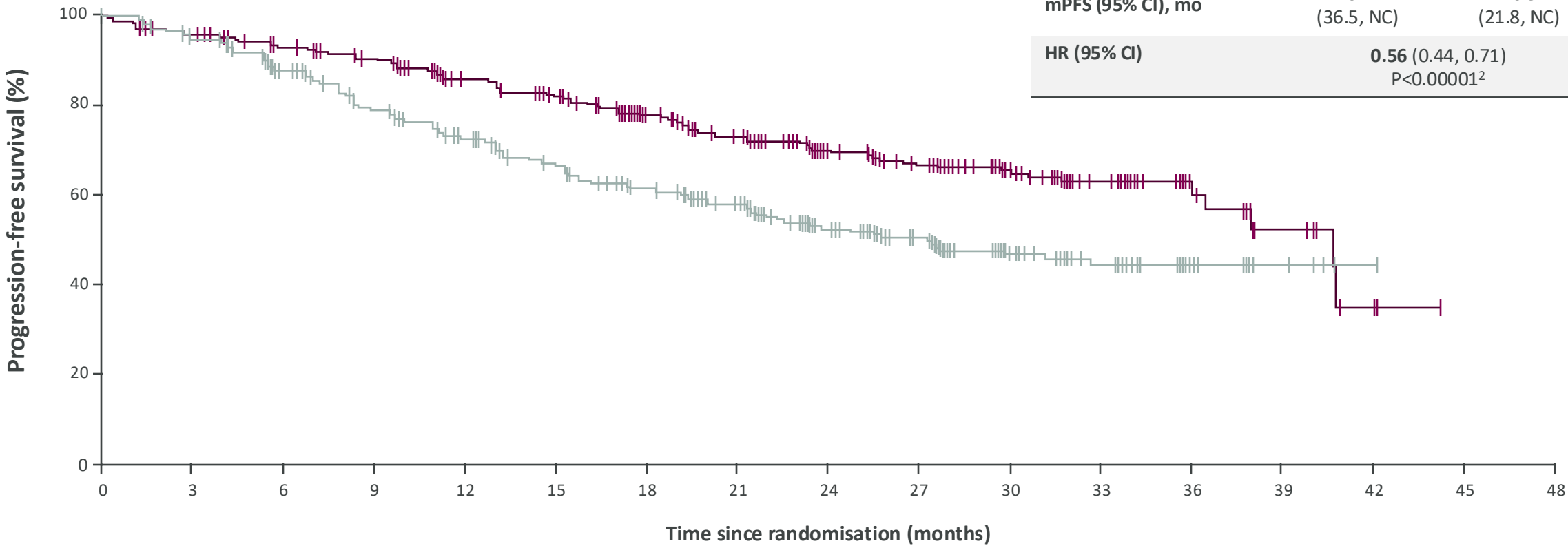
Planned interim analysis: At this data cutoff (Feb 26, 2025), the criterion for PFS superiority (P-value <0.00043) was met for *Enhertu* + pertuzumab vs THP

Open label for THP arm. Double blinded for pertuzumab in experimental arms; 1. HER2-targeted therapy or chemotherapy; 2. 5.4 mg/kg Q3W; 3. 840 mg loading dose, then 420 mg Q3W; 4. paclitaxel 80 mg/m2 QW or 175 mg/m2 Q3W, or docetaxel 75 mg/m2 Q3W for a minimum of six cycles or until intolerable toxicity; 8 mg/kg loading dose, then 6 mg/kg Q3W.

Tolaney, SM et al. Abstract #LBA1008 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast09: *Enhertu* + pertuzumab reduced risk of disease progression death by 44%

	Enhertu + P (N=383)	THP (N=387)
mPFS (95% CI), mo	40.7[1] (36.5, NC)	26.9 (21.8, NC)
HR (95% CI)	**0.56** (0.44, 0.71) P<0.00001[2]	



No. at risk																
Enhertu + P	383	358	355	321	293	275	242	208	175	153	82	49	21	10	3	0
THP	387	353	312	273	241	215	187	160	124	106	51	32	12	5	1	0

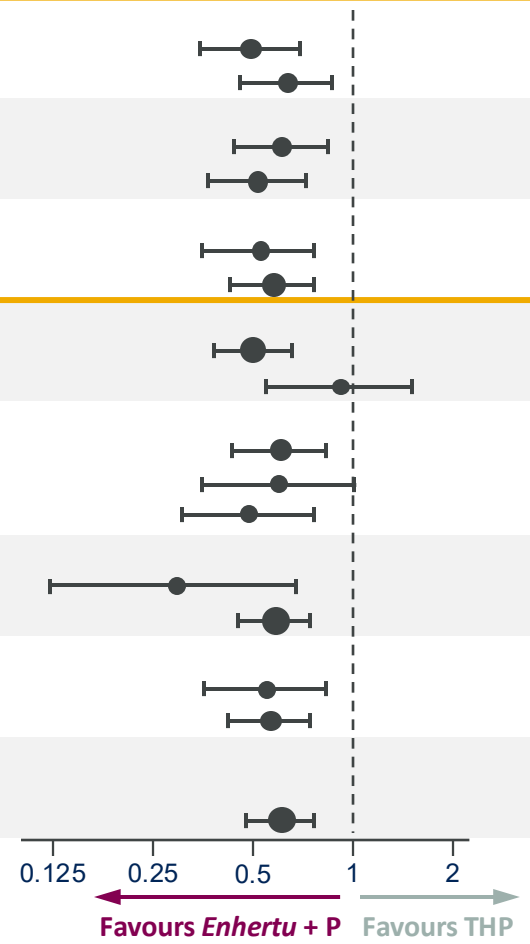
38% maturity; BICR assessment.

1. Median PFS estimate for *Enhertu* + P is likely to change at updated analysis 2. Stratified log-rank test. A P-value of <0.00043 was required for interim analysis superiority.

Tolaney, SM et al. Abstract #LBA1008 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast09: Consistent benefit for *Enhertu* + pertuzumab observed across subgroups

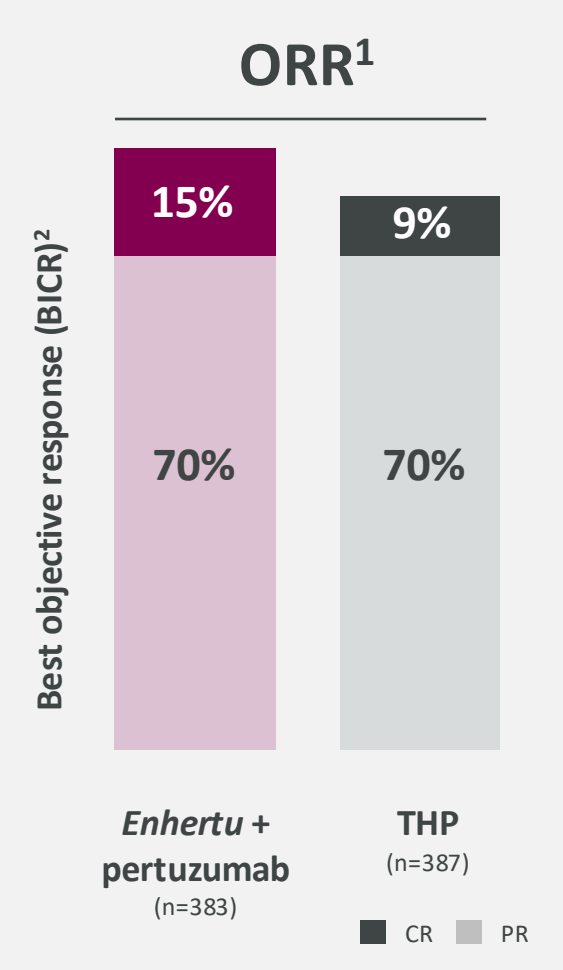
	No. of events / no. of patients		mPFS, months (95% CI)		Hazard ratio (95% CI)
	Enhertu + P	THP	*Enhertu* + P	THP	
Prior treatment status					
De novo	52/200	85/200	NC (36.5, NC)	31.2 (23.5, NC)	0.49 (0.35, 0.70)
Recurrent	66/183	87/187	38.0 (26.9, NC)	22.5 (18.1, NC)	0.63 (0.46, 0.87)
HR status					
Positive	65/207	87/209	38.0 (36.0, NC)	27.7 (22.4, NC)	0.61 (0.44, 0.84)
Negative	53/176	85/178	40.7 (40.7, NC)	22.6 (17.3, 32.7)	0.52 (0.37, 0.73)
***PIK3CA* mutation status**					
Detected	41/116	64/121	36.0 (29.7, NC)	18.1 (15.1, 25.6)	0.52 (0.35, 0.77)
Not detected	76/266	108/266	40.7 (38.0, NC)	32.7 (24.4, NC)	0.57 (0.43, 0.77)
Age at randomisation					
<65 years	90/315	139/315	40.7 (36.5, NC)	27.4 (22.4, NC)	0.50 (0.38, 0.65)
≥65 years	28/68	33/72	27.6 (14.9, NC)	21.5 (13.9, NC)	0.92 (0.55, 1.51)
Geographical region					
Asia	62/188	87/191	40.7 (36.5, NC)	27.2 (21.5, NC)	0.60 (0.43, 0.83)
Western Europe and North America	27/87	31/78	36.0 (30.6, NC)	31.2 (15.8, NC)	0.60 (0.35, 1.01)
Rest of World	29/108	54/118	NC (38.0, NC)	24.4 (14.8, NC)	0.48 (0.30, 0.76)
Brain metastases at baseline					
Present	10/25	15/22	31.8 (18.5, NC)	9.5 (5.6, 13.3)	0.30 (0.12, 0.68)
Not present	108/358	157/365	40.7 (36.5, NC)	27.6 (22.6, NC)	0.58 (0.45, 0.74)
Prior exposure to anti-HER2 therapies					
Yes	39/115	51/112	38.0 (26.9, NC)	21.5 (15.3, NC)	0.55 (0.36, 0.83)
No	79/268	121/275	40.7 (36.5, NC)	27.6 (22.5, NC)	0.56 (0.42, 0.74)
Prior exposure to pertuzumab					
Yes	5/31	12/26	40.8 (25.4, NC)	19.8 (7.5, NC)	NC
No	113/352	160/361	40.7 (36.0, NC)	27.4 (22.4, NC)	0.61 (0.48, 0.77)

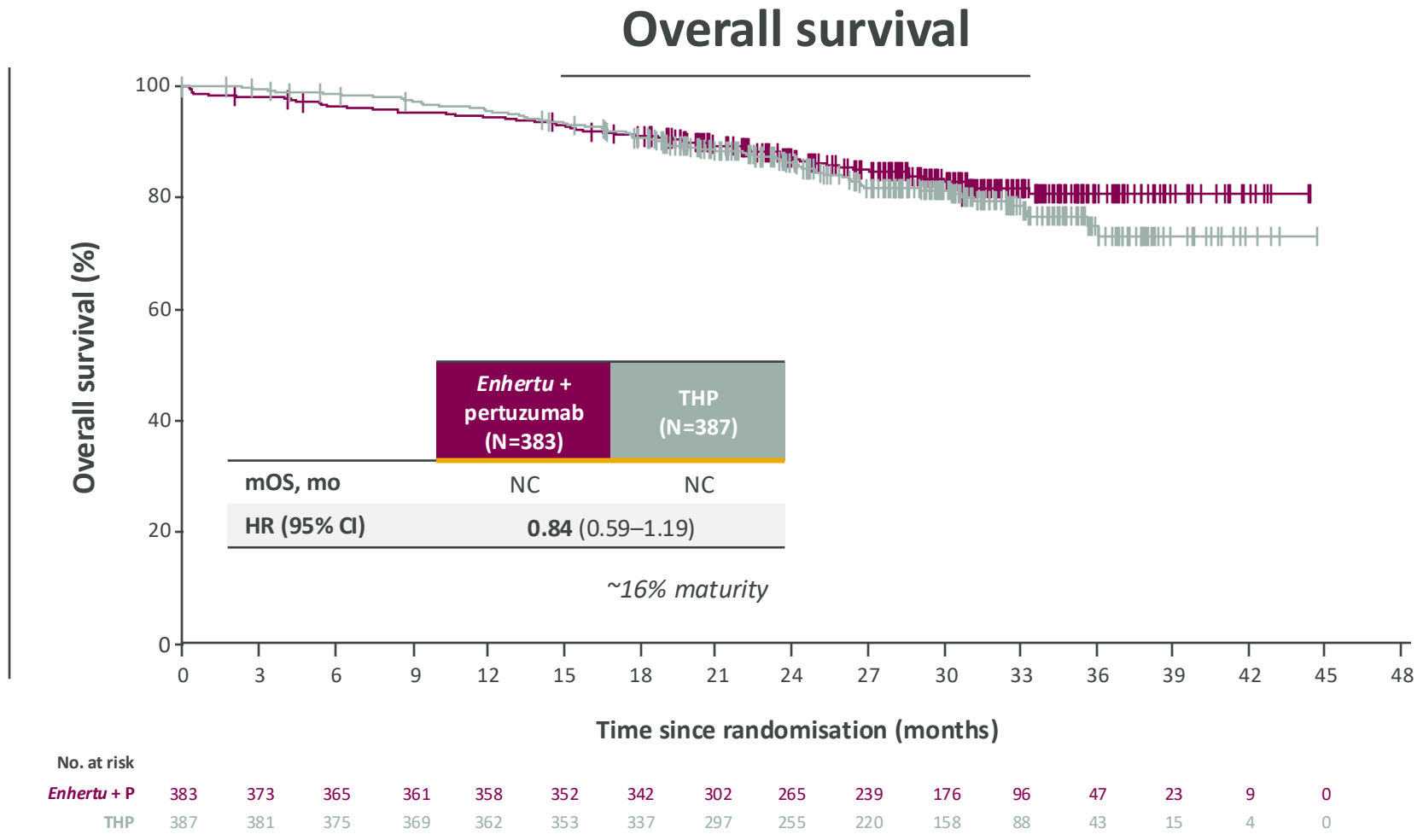


Size of circle is proportional to the number of events.

Tolaney, SM et al. Abstract #LBA1008 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast09: High durable response rate and early trend to OS for *Enhertu* + pertuzumab





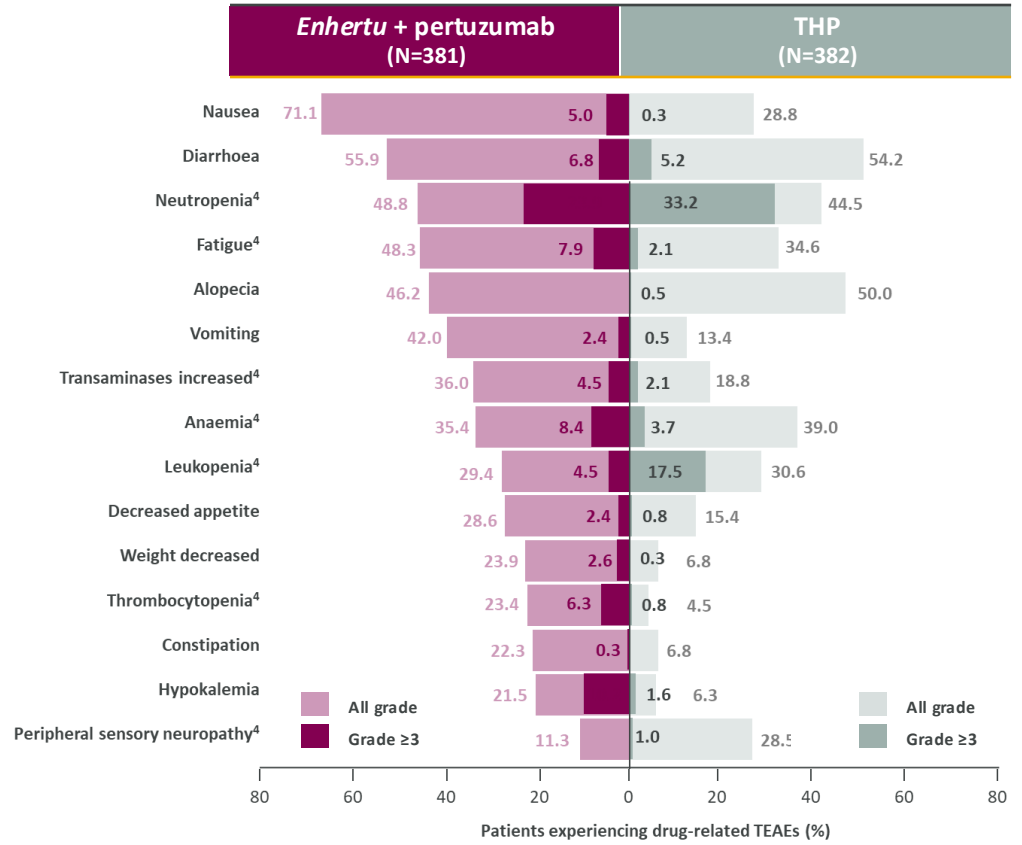
1. Confirmed ORR by BICR. 2. Based on RECIST v1.1; response required confirmation after 4 weeks.
Tolaney, SM et al. Abstract #LBA1008 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast09: Safety profile consistent with known profiles of *Enhertu* and pertuzumab

Lower rate of discontinuations due to AEs

	Enhertu + P (N=381)	THP (N=382)
Total exposure, patient years	659.7	564.0
Any TEAE, n (%)	380 (99.7)	378 (99.0)
Possibly TRAEs (inv.-assessed), n (%)	373 (97.9)	369 (96.6)
Grade ≥3	209 (54.9)	200 (52.4)
Serious TEAEs, n (%)	103 (27.0)	96 (25.1)
TEAEs associated with any treatment discontinuation,[1] n (%)	79 (20.7)	108 (28.3)
TEAEs associated with any dose interruptions,[1] n (%)	262 (68.8)	187 (49.0)
TEAEs associated with any dose reductions,[1] n (%)	175 (45.9)	76 (19.9)
TEAEs with outcome of death, n (%)	13 (3.4)	3 (0.8)
Possibly treatment related (inv.-assessed)[2]	5 (1.3)	1 (0.3)

Manageable AE profile[3]



1. Dose modifications or discontinuations relate to any component of each arm. 2. Treatment-related TEAEs with outcome of death were pneumonitis (n=1), sepsis (n=1), septic shock (n=1), febrile neutropenia (n=1), and dyspnea (n=1) in the *Enhertu* + P arm, and anaemia (n=1) in the THP arm. 3. Drug-related TEAEs in ≥20% of patients (either treatment arm). 4. Grouped term.
Tolaney, SM et al. Abstract #LBA1008 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

DESTINY-Breast09: First improvement in over a decade vs current 1L SoC across broad HER2+ mBC population

- *Enhertu* + pertuzumab demonstrated a statistically significant and clinically meaningful PFS benefit vs. THP
- mDOR >3 years with *Enhertu* + pertuzumab, CR in 15.1% vs 8.5%
- OS data showed an early trend favouring the *Enhertu* + pertuzumab arm with a supportive hazard ratio of 0.60 for PFS2
- Safety data consistent with known profiles of individual treatments, with a longer treatment duration vs THP

PFS by BICR

44%

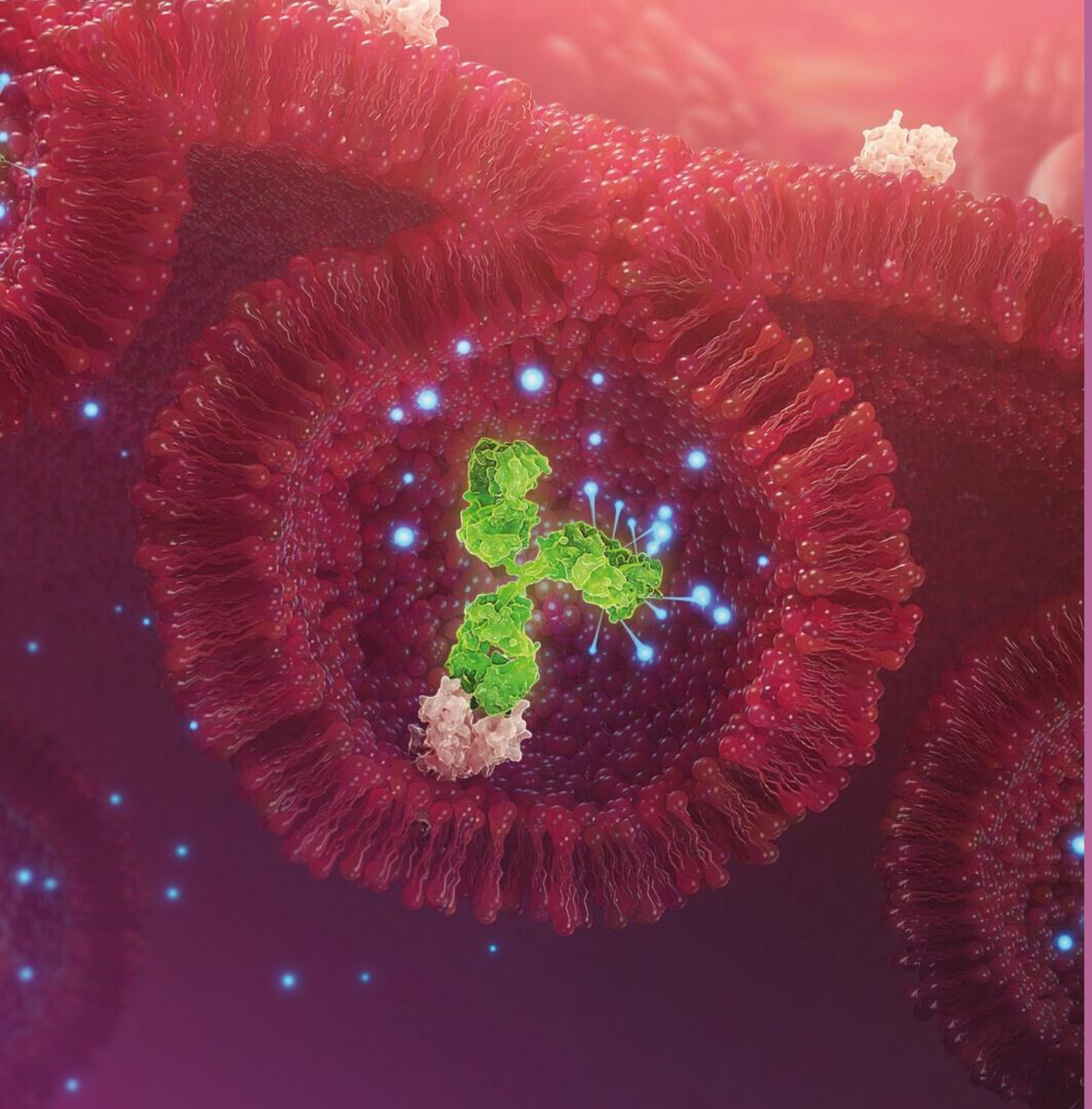
reduction in risk of disease progression or death with *Enhertu* + pertuzumab vs THP

>3 years mPFS with *Enhertu* + pertuzumab

DESTINY-Breast09 to move *Enhertu* one line earlier and has the potential to transform management of 1L HER2+ mBC

1. By BICR.

Tolaney, SM et al. Abstract #LBA1008 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.



Realising our ambition in breast cancer

Sunil Verma
SVP, GLOBAL HEAD,
ONCOLOGY FRANCHISE

Major progress towards establishing camizestrant as the new backbone endocrine therapy in HR+ BC

SERENA-6 | Only oral next generation SERD with Phase III data in 1L HR+ aBC

85k patients in G7 | 1L HR+ aBC

↳ **50%** | currently receiving AI + CDK4/6i as SoC

↳ **75%** | >6 months on CDK4/6i

↳ **30%** | detected *ESR1*m prior to progression

Established *ESR1*m testing using ctDNA can be integrated into **routine blood test schedule**

Differentiated programme

Broaden camizestrant across 1L HR+ aBC

SERENA-4 | 2026

Introduce camizestrant in the early stages of the disease

CAMBRIA-1 | >2026

CAMBRIA-2 | >2026

camizestrant | $5bn+ PYR potential[1]

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

Transforming treatment in HER2+ breast cancer

DESTINY-Breast09 | *Enhertu* + pertuzumab to become a potential 1L SoC for HER2+ mBC

~23k | 1L HER2+ mBC patients eligible in G7

↳ Demonstrated benefit across broad spectrum of 1L HER2+ disease including both HR+ and HR- patients

~1 in 3 | patients never receive further treatment after 1L

↳ Target HER2, underlying driver of the disease, at earliest opportunity with most efficacious anti-HER2 therapy upfront

1L HER2+ breast cancer represents multi-blockbuster opportunity[1] for *Enhertu* across the AstraZeneca Daiichi Sankyo Alliance

Moving into early stage

Neoadjuvant approach, high-risk at diagnosis

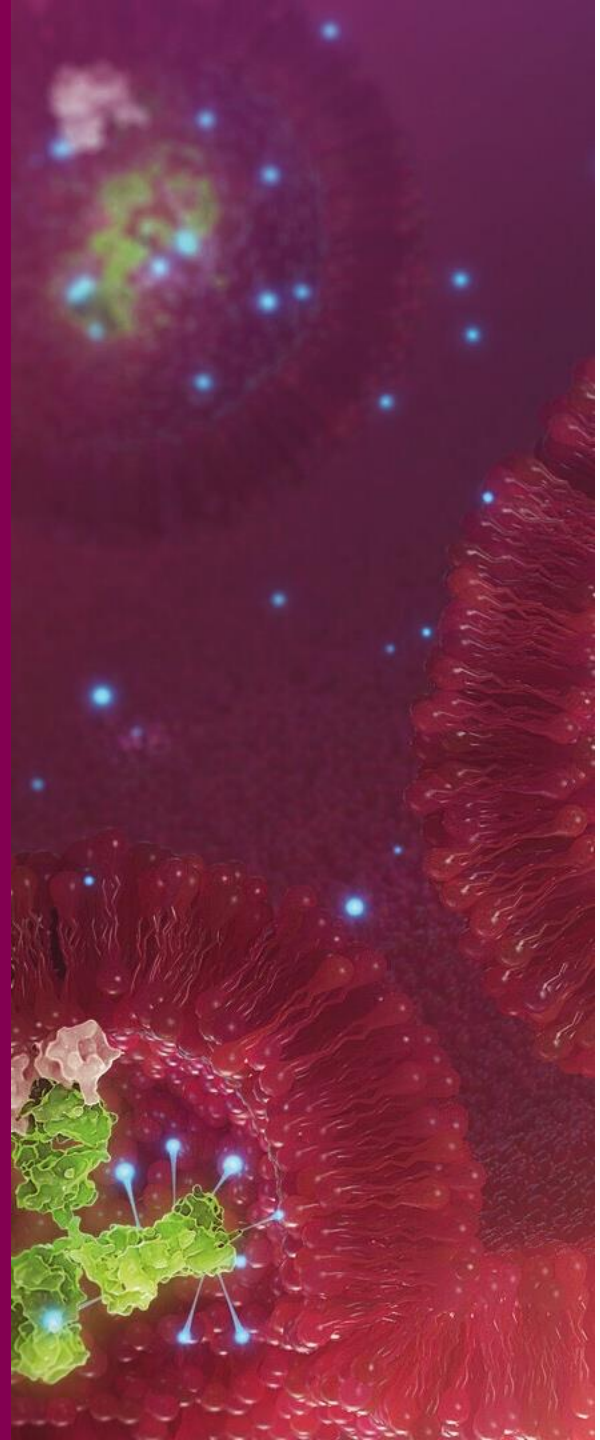
DESTINY-Breast11 | Positive data May 2025

Adjuvant treatment, high-risk post-surgery

DESTINY-Breast05 | H2 2025

Potential to redefine treatment for early stage HER2+ patients

1. Peak Year Revenue, non-risk adjusted. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.



Opportunity for Q&A

Key External Experts

Prof. Nick Turner
CONSULTANT MEDICAL ONCOLOGIST, ROYAL MARSDEN

Dr Sara Tolaney
CHIEF OF THE DIVISION OF BREAST ONCOLOGY, DANA-FARBER CANCER INSTITUTE

AstraZeneca Leadership

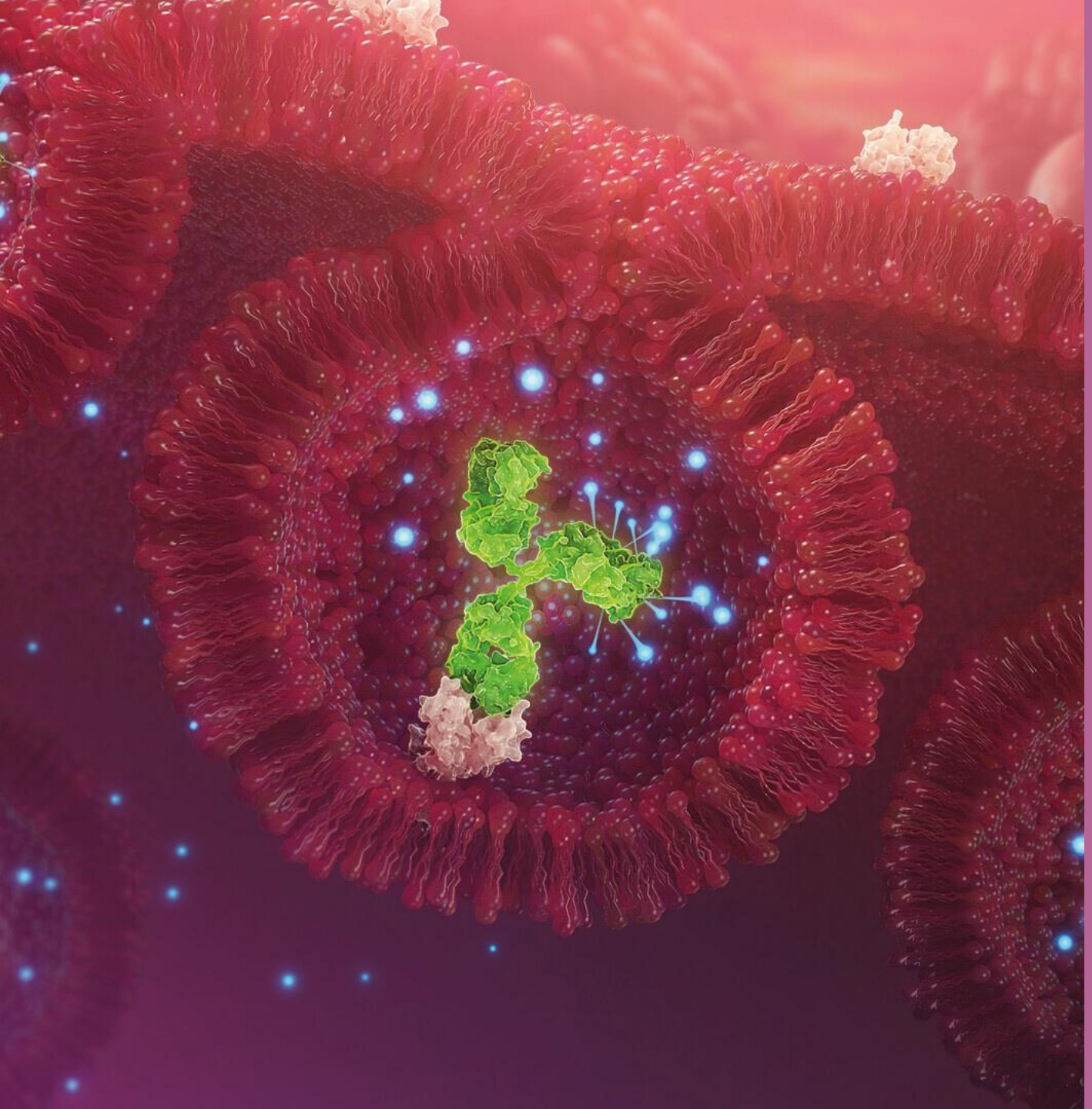
Pascal Soriot
CHIEF EXECUTIVE OFFICER

Dave Fredrickson
EVP, ONCOLOGY HAEMATOLOGY BUSINESS

Susan Galbraith
EVP, ONCOLOGY HAEMATOLOGY R&D

Cristian Massacesi
CHIEF MEDICAL OFFICER & ONCOLOGY CHIEF DEVELOPMENT OFFICER

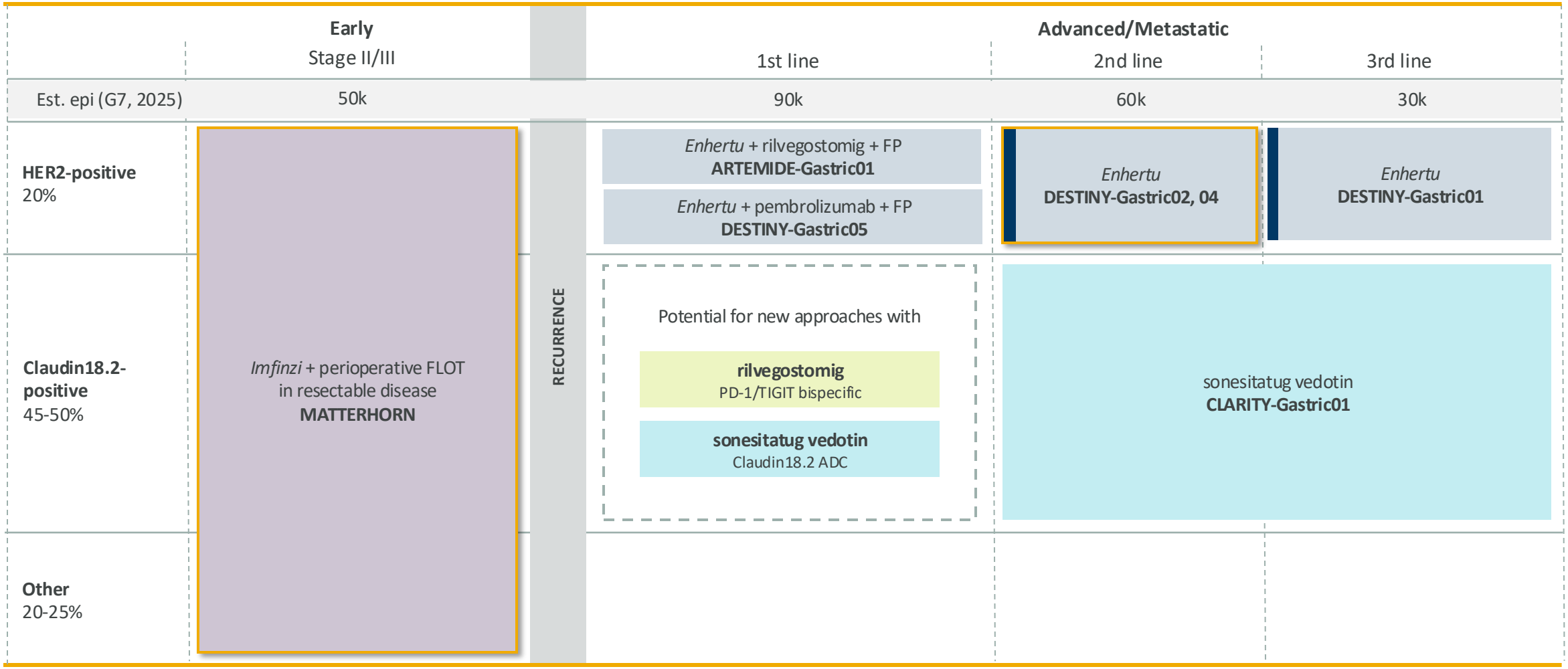
Sunil Verma
SVP, GLOBAL HEAD, ONCOLOGY FRANCHISE



Expanding leadership in GI cancers

Cristian Massacesi
CHIEF MEDICAL OFFICER & ONCOLOGY CHIEF DEVELOPMENT OFFICER

Building a leading development programme in gastric cancer



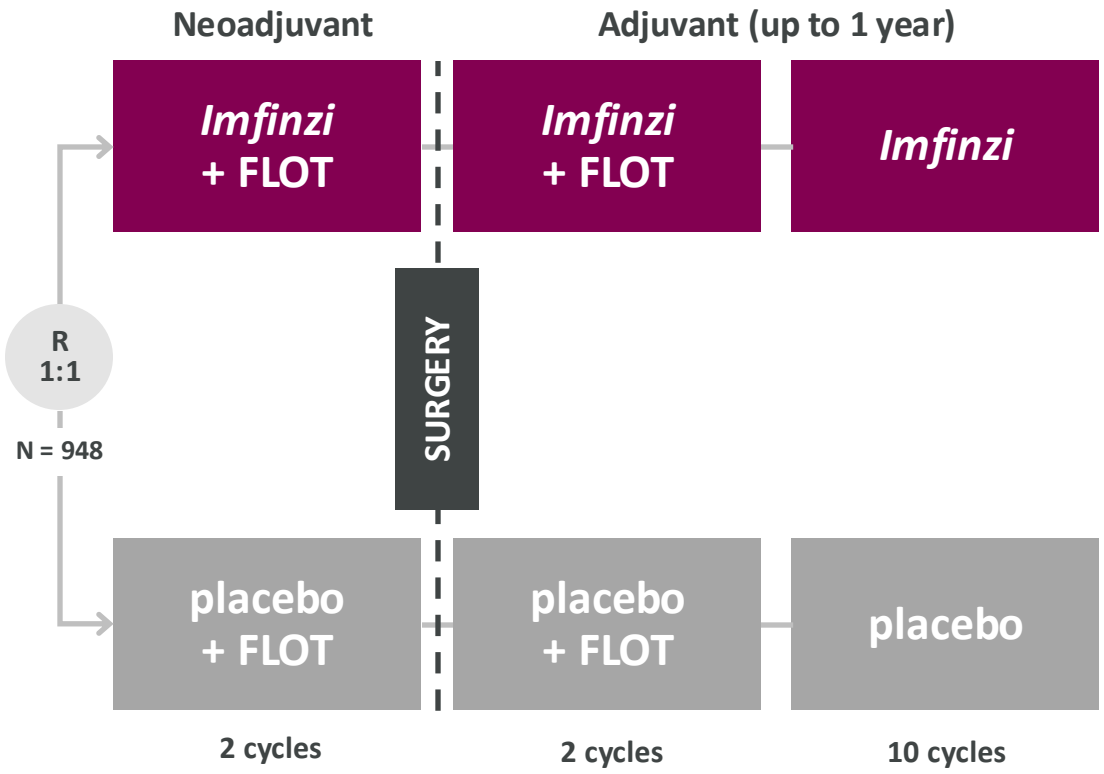
sonesitatug vedotin previously AZD0901.
All numbers are approximate. Illustrative settings and populations, not to scale. Gastric cancer map reflects ongoing active Phase III/pivotal trials.
Collaboration partners: Daiichi Sankyo (*Enhertu*), Compugen (rilvegostomig). Appendix: Glossary.

MATTERHORN: Third positive perioperative trial for *Imfinzi,* building on NIAGARA and AEGEAN success

- Stage II–IVa gastric and GEJ cancer
- No evidence of metastasis
- No prior therapy
- ECOG PS 0 or 1
- Global enrollment from Asia, Europe, North and South America

Stratification factors

- Asia vs non-Asia
- Clinical lymph node positive vs negative
- PD-L1 : TAP <1% vs TAP ≥1%[1]



Primary endpoint:

EFS

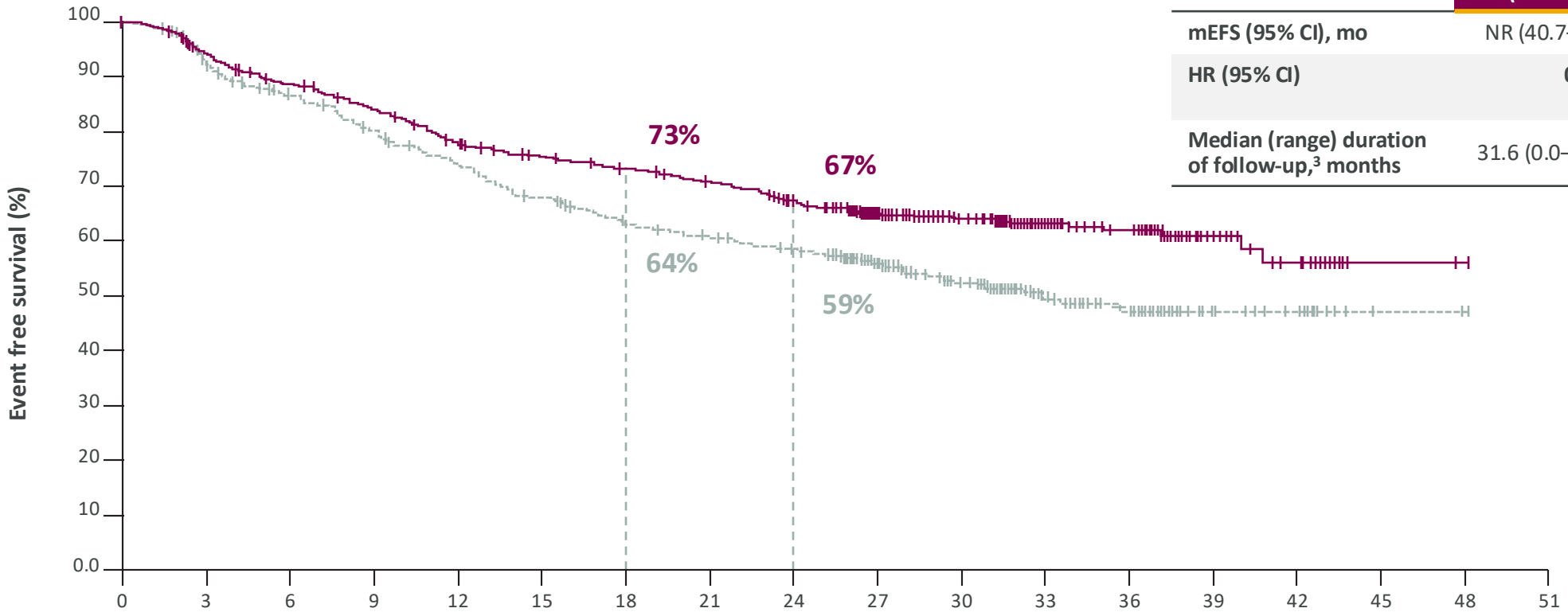
Key secondary endpoints:

- OS
- pCR

FLOT: 5-fluorouracil 2600 mg/m2, leucovorin 200 mg/m2, oxaliplatin 85 mg/m2, docetaxel 50 mg/m2, on Days 1 and 15 Q4W, 4 doses (two cycles) pre- and post-operative; *Imfinzi*: 1500 mg on Day 1 Q4W, 2 doses (two cycles) of *Imfinzi* or placebo pre- and post-operative, followed by 10 doses of post-operative *Imfinzi* or placebo monotherapy. Participants underwent surgery 4–8 weeks after last dose of neoadjuvant therapy. Adjuvant therapy began 4–12 weeks post-surgery. *Imfinzi*/placebo monotherapy may be continued if FLOT is discontinued due to toxicity. 1. Measured by IHC using VENTANA PD-L1 (SP263) CDx Assay (Roche Diagnostics; IUO).
Janjigian, YY et al. Abstract #LBA5 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

MATTERHORN: Statistically significant EFS benefit for *Imfinzi* + FLOT

	Imfinzi + FLOT (n=474)[1]	Placebo + FLOT (n=474)[1]
mEFS (95% CI), mo	NR (40.7–NR)	32.8 (27.9–NR)
HR (95% CI)	**0.71** (0.58–0.86) P[2]<0.001	
Median (range) duration of follow-up,[3] months	31.6 (0.0–48.1)	31.4 (0.0–48.1)

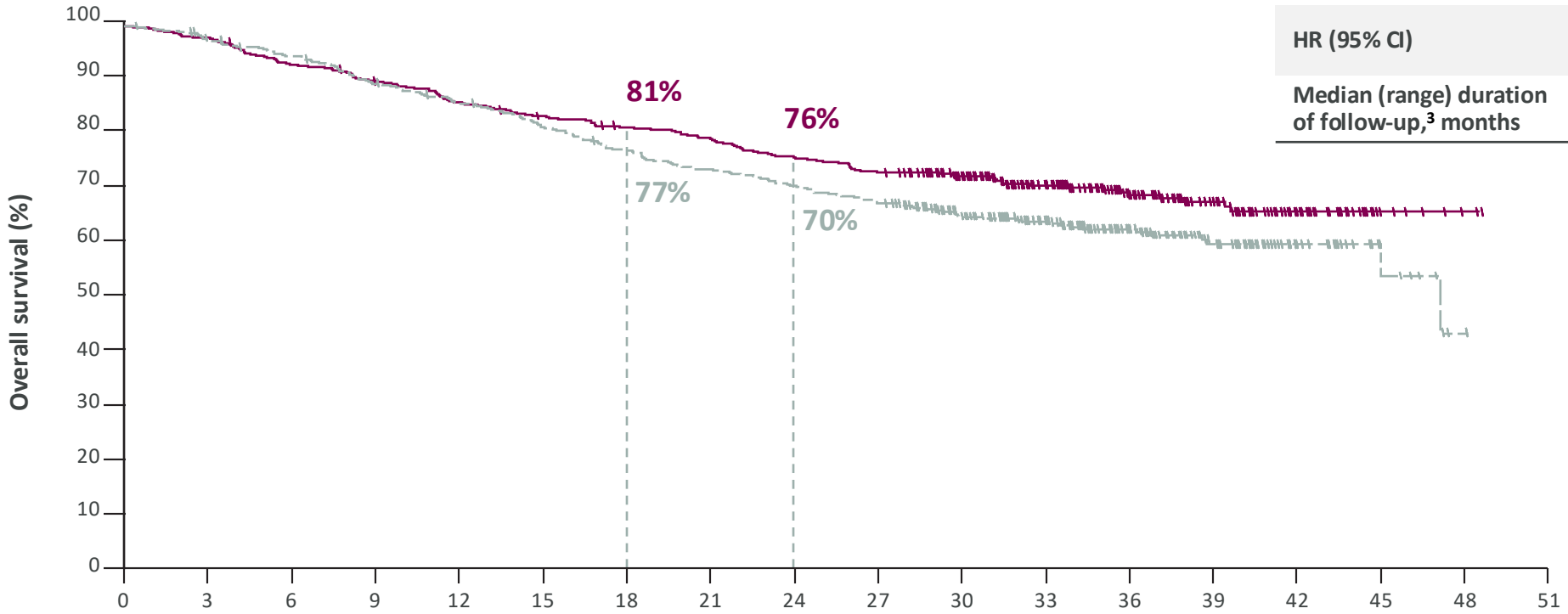


No. at risk																		Total events
Imfinzi + FLOT	474	436	404	381	351	334	320	307	288	234	187	107	88	33	20	2	1	0	167
Placebo + FLOT	474	429	392	360	329	302	278	264	249	202	160	89	65	26	21	2	1	0	218

Events were defined as the earliest of RECIST v1.1 events, non-RECIST v1.1 events, or deaths of any cause. Analysis was based on BICR assessments and / or locally by pathology testing if clinically required. The HR and its CI were estimated from a Cox proportional hazards model, adjusted for geographic region, clinical lymph node status, and PD-L1 expression. The CI for the HR was calculated using a profile likelihood approach. The two-sided p-value was calculated using a stratified log-rank test adjusted for geographic region, clinical lymph node status, and PD-L1 expression. 1. Full analysis set (all randomised participants, regardless of treatment received). 2. The threshold of significance for this analysis was 0.0239. 3. In censored participants.
Janjigian, YY et al. Abstract #LBA5 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

MATTERHORN: Trend to OS benefit with *Imfinzi* + FLOT

	Imfinzi + FLOT (n=474)[1]	Placebo + FLOT (n=474)[1]
Median OS (95% CI), mo	NR (NR–NR)	47.2 (45.1–NR)
HR (95% CI)	**0.78** (0.62–0.97) P[2]=0.025	
Median (range) duration of follow-up,[3] months	34.6 (3.5-48.6)	34.6 (0.0-48.1)



No. at risk																			Total events
Imfinzi + FLOT	474	464	438	422	403	389	376	367	351	338	293	205	143	80	38	8	2	0	145
Placebo + FLOT	474	457	439	414	395	374	354	337	323	309	262	197	128	72	33	11	2	0	176

MATTERHORN is ongoing for OS (33.9% maturity at this interim analysis). Events were defined as time from randomisation until the date of death due to any cause. The HR and its CI were estimated from a Cox proportional hazards model, adjusted for geographic region, clinical lymph node status, and PD-L1 expression. The CI for the HR was calculated using a profile likelihood approach. The two-sided p-value was calculated using a stratified log-rank test adjusting for geographic region, clinical lymph node status, and PD-L1 expression. 1. Full analysis set (all randomised participants, regardless of treatment received). 2. Threshold of significance for this analysis was 0.0001. 3. In censored participants.

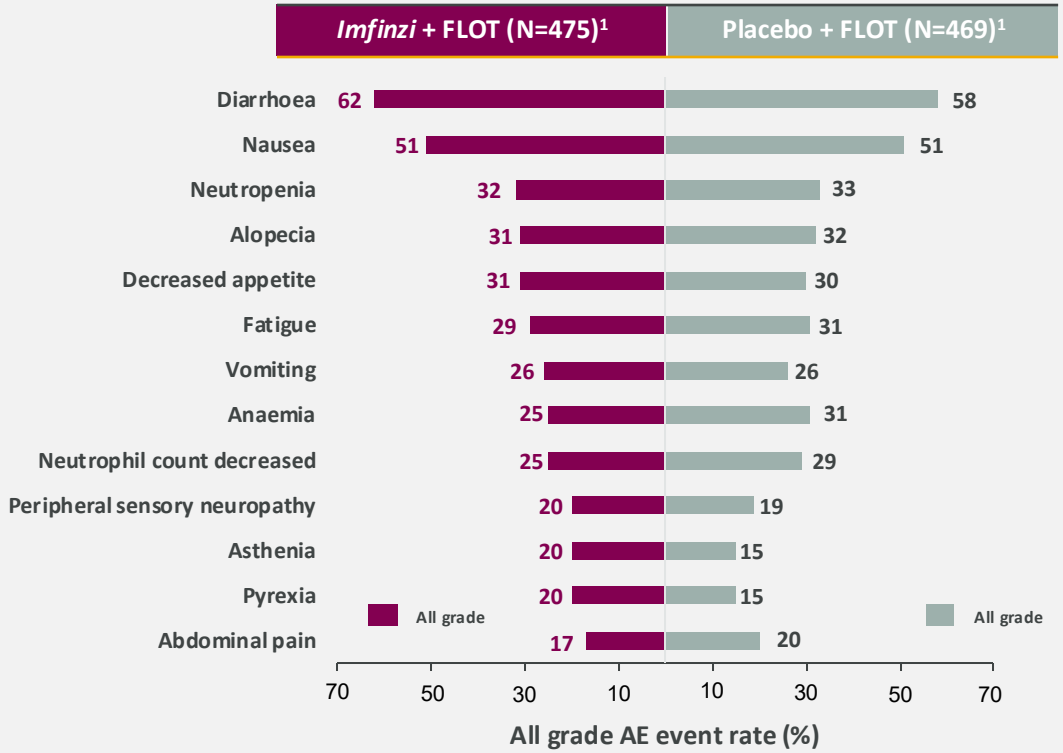
Janjigian, YY et al. Abstract #LBA5 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

MATTERHORN: AE profile consistent with known safety profiles of *Imfinzi* and FLOT

AEs did not result in a delay to surgery

	Imfinzi + FLOT (n=475)[1]	Placebo + FLOT (n=469)[1]
Any grade TRAE, %	95	95
Grade 3 or 4 TRAE, %	60	59
Serious AE, %	48	44
AE leading to discontinuation of any study treatment, %	30	23
AE with outcome of death, %	5	4
Any AE leading to surgery not being performed, %	1	<1
Any AE leading to a delay in surgery, %[2]	2	3

No new safety signals[3]



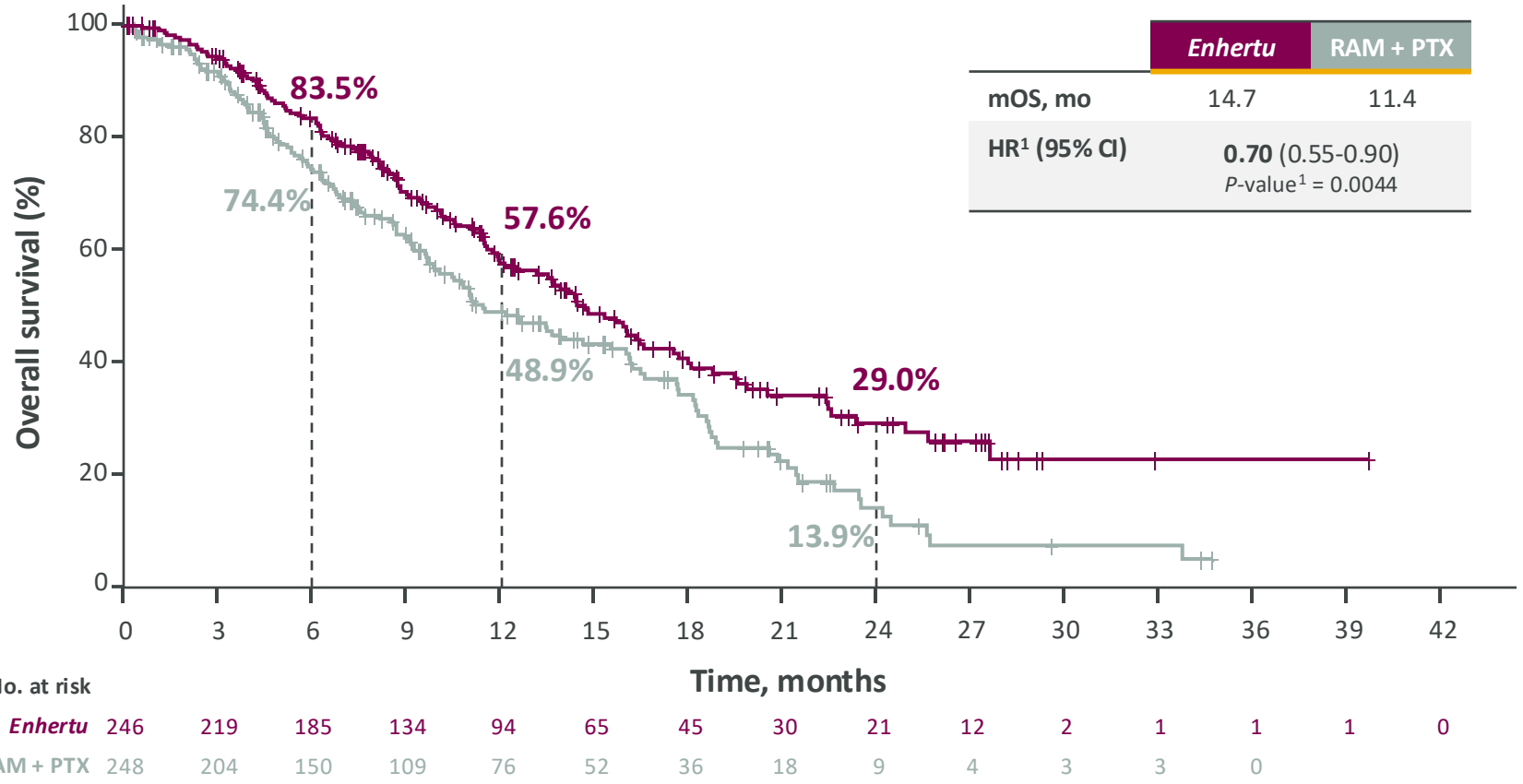
Includes AEs in the overall treatment period, with onset date on or after the first dose of investigational treatment, or pre-treatment AEs that increase in severity on or after the first dose of investigational treatment up to and including 90 days following the last dose or until initiation of the first subsequent anticancer therapy (excluding palliative radiotherapy), whichever occurs first.

1. Safety analysis set (participants who received at least one dose of study treatment); one participant in the placebo + FLOT group received a single dose of *Imfinzi* and is, therefore, included in the *Imfinzi* + FLOT group for the safety analysis. 2. A surgical delay is defined as surgery occurring >8 weeks (56 days) after the last dose of neoadjuvant treatment. 3. AEs occurring in ≥20% of participants in any treatment group.

Janjigian, YY et al. Abstract #LBA5 presented at the American Society of Clinical Oncology 2025. Appendix: Glossary.

DESTINY-Gastric04: Phase III data confirm *Enhertu* benefit in 2L HER2+ metastatic gastric/GEJ cancer

Significant survival benefit with *Enhertu*



	Enhertu	RAM + PTX
mOS, mo	14.7	11.4
HR[1] (95% CI)	**0.70** (0.55-0.90) *P*-value[1] = 0.0044	

- *Enhertu* 6.4 mg/kg toxicity profile generally manageable
- Consistent with *Enhertu* known safety profile
- Patient-reported QoL was maintained with *Enhertu*

Reinforces *Enhertu* as global 2L SoC for patients with HER2+ metastatic gastric/GEJ cancer

1. Two-sided P value from stratified log-rank test and stratified Cox proportional hazards model adjusted for stratification factor: HER2 status (IHC 3+ or IHC 2+/ISH+).
Shitara, K et al. Abstract #LBA4002 presented at the American Society of Clinical Oncology 2025. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

GEMINI-HBP in advanced biliary tract cancer: Encouraging efficacy for rilvegostomig + CTx in Phase II trial

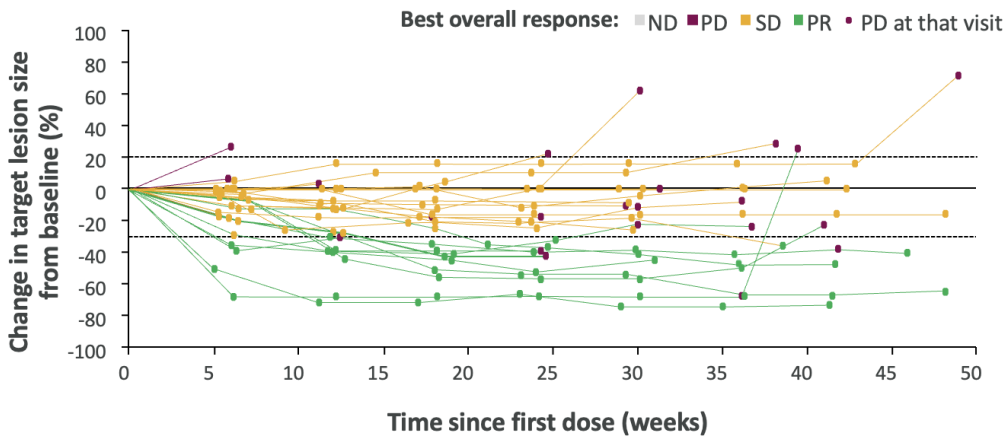
***Imfinzi* has transformed management of aBTC**

2x survival rate at 3 years for *Imfinzi* + CTx vs CTx alone[1]

Despite this unmet need in these patients remains

<15% alive at 3 years even with *Imfinzi* + CTx[1]

Promising early efficacy for rilvegostomig + CTx[2]



N=29

- **mPFS 8.3 mo**
- **ORR 31%**
- **mDoR 6.9 mo**

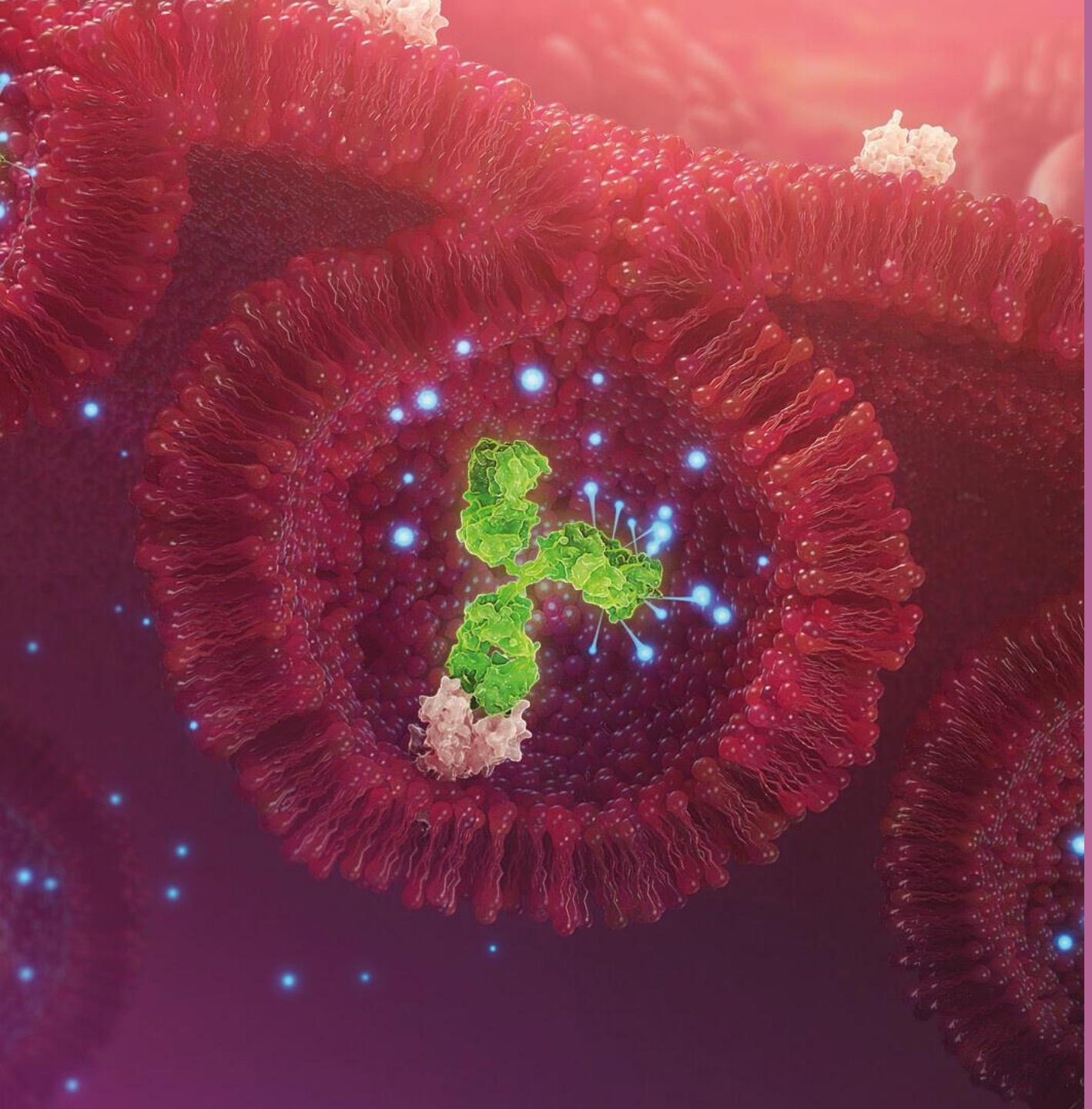
Manageable safety profile for combination[2]

AEs driven by CTx combination, in line with previous trials

No rilvegostomig-related AEs leading to treatment discontinuation

Data support ongoing Phase III ARTEMIDE-Biliary01 and DESTINY-BTC01 trials

Response based on RECIST v1.1 (response and progression defined as –30% and +20% change from baseline, respectively). Dots represent study visits. One patient was found to not have a target lesion after baseline and thus was not response-evaluable. Safety cohort N=30. 1. Oh DY et al. Abstract presented at AMMF's Hybrid 2024 European Cholangiocarcinoma Conference 2024. 2. Zhou, J et al. Abstract #4080 presented at the American Society of Clinical Oncology 2025.
Collaboration partners: Compugen (rilvegostomig). Appendix: Glossary.



Realising our ambition in GI cancers

Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS

Building a leading gastrointestinal cancers portfolio to transform patient outcomes

MATTERHORN | Third perioperative opportunity for *Imfinzi*

Potential to be first and only perioperative IO-based regimen in Stage II-IVa gastric/GEJ cancer

43k patients in G7 | drug-treated resectable gastric/GEJ cancer

50% | undergo perioperative Tx in US/EU

55% | currently receive FLOT

MATTERHORN data to increase perioperative FLOT utilisation

MATTERHORN potential blockbuster opportunity[1]

DESTINY-Gastric04 | Supports existing *Enhertu* indications

Already established SoC in 2L+ HER2+ gastric and GEJ cancers in many countries

- Reinforces confidence in *Enhertu*
- Converts conditional to full approvals
- Enables move from 3L to 2L[2]
- Supports reimbursement

Moving *Enhertu* to 1L gastric cancer

DESTINY-Gastric05 | >2026
ARTEMIDE-Gastric01 | >2026

1. Peak Year Revenue, non-risk adjusted. 2. Key opportunities in Japan and China. Collaboration partners: Daiichi Sankyo (*Enhertu*). Appendix: Glossary.

Opportunity for Q&A

AstraZeneca Leadership

Pascal Soriot
CHIEF EXECUTIVE OFFICER

Dave Fredrickson
EVP, ONCOLOGY
HAEMATOLOGY BUSINESS

Susan Galbraith
EVP, ONCOLOGY
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Cristian Massacesi
CHIEF MEDICAL OFFICER
& ONCOLOGY CHIEF
DEVELOPMENT OFFICER

Sunil Verma
SVP, GLOBAL HEAD,
ONCOLOGY FRANCHISE

Glossary

1L, 2L, 3L	first-, second-, third-line
a/mBC	advanced/metatistic breast cancer
aBC	advanced breast cancer
aBTC	advanced biliary tract cancer
ADC	antibody conjugate
adj.	adjuvant
AE	adverse event
AI	aromatase inhibitors
AKT1	AKT serine/threonine kinase 1
ASCO	American Society of Clinical Oncology
AZN	AstraZeneca
BC	breast cancer
BCMA	B-cell maturation antigen
BICR	blinded independent central review
BTC	biliary tract cancer
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
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
DFI	disease-free interval
DOR	duration of response
DXd	deruxtecan
ECOG	Eastern Cooperative Oncology Group
EFS	event-free survival
EGFRm	epidermal growth factor receptor-mutant
ER+	estrogen receptor-positive
ERoW	Established Rest of World
ESR1m	estrogen receptor alpha-mutated
FL	follicular lymphoma
FLOT	luorouracil, leucovorin, oxaliplatin and docetaxel
FP	fluoropyrimidine
G7	US, Japan, EU5
gBRCAm	germline BRCA-mutant
GC	gastric cancer
GEJ	gastroesophageal junction
GEJA	gastroesophageal junction adenocarcinoma
gMG	generalised myasthenia gravis
HER2	human epidermal growth factor receptor 2
HER2-/negative	human epidermal growth factor receptor 2-negative
HER2+/positive	human epidermal growth factor receptor 2-positive
HER2-low/ultralow	human epidermal growth factor receptor 2-low/ultralow
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
HSCT-TMA	hematopoietic stem cell transplantation-associated thrombotic microangiopathy
INV	invasive
IO	immuno-oncology
IRA	Inflation Reduction Act
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
mPFS	median progression-free survival
MPR	major pathological response
NC	non-calculable
NEJM	New England Journal of Medicine
neoadj.	Neoadjuvant
NMIBC	non-muscle invasive bladder cancer
NMR	normalised membrane ratio
NMR+	nuclear magnetic resonance-positive
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-1	programmed cell death protein-1
PDL1/PD-L1	programmed cell death-ligand 1
PFS	progression free survival
PFS2	second progression-free survival
PIK3CA	phosphatidylinositol-4,5-biphosphate 3-kinase catalytic subunit
PIK3CAm	phosphatidylinositol-4,5-biphosphate 3-kinase catalytic subunit-mutant
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
TAP	tumour area positivity
tBRCAm	tumor BRCA mutation
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	Therapy
V&I	Vaccines & Immune Therapies

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