Meet GSK management Oncology
Getting ahead of cancer
Interactive event for investors and analysts. This webinar is being recorded.
Cautionary statement regarding forward-looking statements

This presentation may contain forward-looking statements. Forward-looking statements give the Group’s current expectations or forecasts of future events. An investor can identify these statements by the fact that they do not relate strictly to historical or current facts. They use words such as ‘anticipate’, ‘estimate’, ‘expect’, ‘intend’, ‘will’, ‘project’, ‘plan’, ‘believe’, ‘target’ and other words and terms of similar meaning in connection with any discussion of future operating or financial performance. In particular, these include statements relating to future actions, prospective products or product approvals, future performance or results of current and anticipated products, sales efforts, expenses, the outcome of contingencies such as legal proceedings, dividend payments and financial results.

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A number of adjusted measures are used to report the performance of our business, which are non-IFRS measures. These measures are defined and reconciliations to the nearest IFRS measure are available in the Group’s Q1 2024 Results and the Group’s Annual Report on Form 20-F for FY 2023.

All expectations, guidance and outlooks regarding future performance and the dividend should be read together with the section “Guidance and outlooks, assumptions and cautionary statements” on page 49 of our stock exchange announcement of GSK’s Q1 2024 Results, the section “Assumptions and basis of preparation related to 2024 guidance” in the Appendix of this presentation and the statements on page 317 of GSK’s Annual Report on Form 20-F for FY 2023.
Today’s focus

- **Material growth opportunities** across haematology, gynaecologic cancers and other tumour types
- **Multi-blockbuster potential of Blenrep** delivering statistically significant, robust efficacy with manageable toxicity profile
  - Regulatory filing in all major markets in H2 2024
  - Future opportunity for Blenrep in 1L
- **High potential, early stage oncology pipeline**
  - Differentiated immuno-oncology combinations with Jemperli
  - Gated investment in ADCs to unlock potential opportunity across solid tumours
- **Key oncology data readouts 2024-2026**

1L: first line, ADC: antibody-drug conjugate.
Participants

Dr Evangelos Terpos
Professor of Haematology
National and Kapodistrian University of Athens
DREAMM-8 Principal Investigator

Dr Tony Wood
Chief Scientific Officer

Dr Hesham Abdullah
SVP, Global Oncology R&D

Dr Nina Mojas
SVP, Global Product Strategy

Luke Miels
Chief Commercial Officer

Dr Mondher Mahjoubi
Chief Patient Officer

Speakers

Q&A
Focused on core therapy areas
Emerging oncology portfolio focused on blood and gynaecologic cancers, and are seeking to make transformative breakthroughs

Infectious Diseases
- Arexvy
- MenABCWY
- Pneumococcal 24-valent
- mRNA Seasonal influenza/COVID-19
- Shingrix
- GSK3943104 (Herpes simplex virus)
- GSK438413 (gonorrhoea)
- gepotidacin
- Brexafemme
- tebipenem
- bepiroviren

HIV
- Long-acting and ultra-long-acting
- N6LS (bNAb)
- 3rd generation INSTI
- Capsid inhibitor

Respiratory/Immunology
- depemokimab
- camlipixant
- Nucala (COPD)
- GSK4532990 (NASH)
- GSK3858279 (osteoarthritis pain)
- GSK1070806 (atopic dermatitis)

Oncology
- Blenrep
- Ojaara
- Zejula
- Jemperli
- cabolinab
- belrestatug/CD226 axis
- Antibody-drug conjugates

Enabled by advanced technology and data platforms with targeted business development

Note: select pipeline programmes shown.
Oncology is a significant, emerging contributor to our long-term ambitions.


Illustrative. 1. Blenrep is excluded from guidance.

Oncology growth drivers

2024-26
- Jemperli in endometrial
- Zejula in ovarian
- Oijaara in myelofibrosis
- Blenrep in multiple myeloma

2027-31
- Blenrep in multiple myeloma
- Jemperli monotherapy or IO combinations in CRC, HNSCC and NSCLC
- CD226 axis combinations in solid tumours
- GSK5764227 (B7-H3 ADC) & GSK5733584 (B7-H4 ADC) in various tumour types
### Focused oncology strategy with potential for expansion

**Significantly differentiated medicines with heavily gated investments**

<table>
<thead>
<tr>
<th>Haematology</th>
<th>Haematology cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ojaara (montelukast)</td>
<td>myelofibrosis</td>
</tr>
<tr>
<td>belantamab mafodotin (belamafr)</td>
<td>multiple myeloma (DREAMM)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gynaecologic cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jemperli (trifluridine/tiygibenulin)</td>
</tr>
<tr>
<td>Zejula (niraparib)</td>
</tr>
<tr>
<td>dostarlimab + niraparib</td>
</tr>
<tr>
<td>GSK5733584 (B7-H4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other tumour types</th>
</tr>
</thead>
<tbody>
<tr>
<td>dostarlimab</td>
</tr>
<tr>
<td>niraparib</td>
</tr>
<tr>
<td>belrestotug/CD226 axis</td>
</tr>
<tr>
<td>cobolimab</td>
</tr>
<tr>
<td>GSK5764227 (B7-H3)</td>
</tr>
</tbody>
</table>

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CRC: colorectal cancer, GBM: glioblastoma, HNSCC: head and neck squamous cell carcinoma, NSCLC: non-small cell lung cancer, SCS: supported collaborative study (with the Ivy Brain Institute). All assets shown are in-licensed or within an alliance relationship with a third party.
Blenrep (belantamab mafodotin)
Potential standard of care treatment for 2L multiple myeloma
Significant patient burden

- Life expectancy
- Time in remission
- Treatment burden
- Patient eligibility for novel medicines
- Treatment accessibility, particularly in the community setting

Achievable progression-free survival in 2L+, post-1L lenalidomide

1L patients receive lenalidomide

High unmet medical needs remain

Multiple myeloma market by 2031

~£36bn

+10% compound growth rate

~160k patients worldwide suffer from this complex disease

5-year survival rate

<60%

Treatment dynamics, US

70%

Treatment intensification (combinations) with adverse events

Treatment dynamics, US

12-28 months

Achievable progression-free survival in 2L+, post-1L lenalidomide

Achievable progression-free survival in 2L+ post-1L

Unspecified

DKd

Other carfilzomib regimens

Other daratumumab regimens

Other doublets or triplets

% of patients who achieve

- 28 months PFS
- 19 months PFS
- 12 months PFS
Blenrep (belantamab mafodotin): Data from DREAMM-7, DREAMM-8 and a NDMM study

Dr. Evangelos Terpos, MD, PhD
Professor of Haematology, National and Kapodistrian University of Athens, and DREAMM-8 Principal Investigator
**Eligibility criteria**
- Adults with MM
- ≥1 prior line of MM therapy and documented PD during or after most recent therapy
- No prior treatment with anti-BCMA
- Not refractory to or intolerant of daratumumab or bortezomib

**Recruitment period**
- 13 months from FPI (May 7, 2020) to LPI (June 28, 2021)

**Treatment period**
- Cycles 1-8
  - Belamaf monotherapy
    - 2.5 mg/kg IV q3w
    - bortezomib 1.3 mg/m² SC on days 1, 4, 8, and 11 of cycles 1-8 (21-day cycles)
    - dexamethasone 20 mg on the day of and day after bortezomib in cycles 1-8
  - Daratumumab
    - 16 mg/kg IV qw in cycles 1-3; and q3w in cycles 4-8
  - bortezomib 1.3 mg/m² SC on days 1, 4, 8, and 11 of cycles 1-8 (21-day cycles)
  - dexamethasone 20 mg on the day of and day after bortezomib in cycles 1-8
- Cycle 9+
  - Belamaf monotherapy
    - 2.5 mg/kg IV q3w
  - Daratumumab monotherapy
    - 16 mg/kg IV qw in cycle 9+
  - End-of-treatment visit

**Follow-up period**
- Follow-up for PFS q3w (for patients who discontinue due to reasons other than PD)
  - Disease assessments q3w
- Follow-up for OS q12w (for patients who discontinue due to PD or other reasons)

**Primary endpoint:**
- PFS (IRC assessed)

**Key secondary endpoints:**
- OS, DOR, and MRD

**Additional secondary endpoints:**
- CRR, ORR, CBR, TTR, TTP, PFS2, AEs, ocular findings, and QOL

**Disease assessment visits:** q3w from cycle 1 day 1 until PD

**Stratification:**
- Prior lines of treatment (1 vs 2 or 3 vs ≥4)
- R-ISS stage (I vs II/III)
- Prior bortezomib (yes vs no)

AE, adverse event; BCMA, B-cell maturation antigen; CBR, clinical benefit rate; CRR, complete response rate; DOR, duration of response; FPI, first patient in; IRC, independent review committee; ITT, intent-to-treat; IV, intravenous; LPI, last patient in; MM, multiple myeloma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; q3w, every 3 weeks; q4w, every 4 weeks; q12w, every 12 weeks; QOL, quality of life; qw, once weekly; R-ISS, Revised International Staging System; SC, subcutaneous; TTP, time to progression; TTR, time to response.

-starting dose of dexamethasone may be reduced to 10 mg for patients aged >75 years, who have a body-mass index of less than 18.5, who had previous unacceptable side effects associated with glucocorticoid therapy, or who are unable to tolerate the starting dose.
DREAMM-7: BVd led to a significant increase in PFS vs. DVd

BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; HR, hazard ratio; ITT, intent to treat; NR, not reached; PFS, progression-free survival; PFS2, progression-free survival 2.

a Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output.

b CIs were estimated using the Brookmeyer-Crowley method.

c HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III), with a covariate of treatment.

d P value from 1-sided stratified log-rank test.

BVd demonstrated a statistically significant and clinically meaningful PFS benefit, with a median PFS that was 23 months longer than that with DVd.

PFSa | BVd (N=243) | DVd (N=251) |
--- | --- | --- |
Events, n (%) | 91 (37) | 158 (63) |
PFS, median (95% CI), monthsb | 36.6 (28.4-117.5) | 13.4 (11.1-17.5) |
HR (95% C) | 0.41 (0.31-0.53) | <.00001
OS showed an early, strong, and clinically meaningful trend favoring the BVd arm; additional OS follow-up is ongoing.

BVD, belantamab mafodotin, bortezomib, and dexamethasone; DVD, daratumumab, bortezomib, and dexamethasone; HR, hazard ratio; ITT, intent to treat; NR, not reached; OS, overall survival; R-ISS, Revised International Staging System.

* Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. * CIs were estimated using the Brookmeyer-Crowley method. * HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III), with a covariate of treatment. * P value is from 1-sided stratified log-rank test. * The P value has not yet reached criteria for statistical significance (P < 0.00037) at this interim analysis. Follow-up for OS is ongoing.
DREAMM-7: deeper responses with BVd vs. DVd\textsuperscript{a}

\[ \geq \text{CR MRD negativity}\textsuperscript{b} \]

<table>
<thead>
<tr>
<th></th>
<th>BVd (n=243)</th>
<th>DVd (n=251)</th>
</tr>
</thead>
<tbody>
<tr>
<td>sCR:14</td>
<td>24.7% (95% CI, 19.4%-30.6%)</td>
<td>9.6% (95% CI, 6.2%-13.9%)</td>
</tr>
<tr>
<td>CR:20.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VGPR:31.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PR:16.9</td>
<td></td>
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</tbody>
</table>

\[ \geq \text{VGPR MRD negativity}\textsuperscript{b} \]

<table>
<thead>
<tr>
<th></th>
<th>BVd (n=243)</th>
<th>DVd (n=251)</th>
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</thead>
<tbody>
<tr>
<td>sCR:5.2</td>
<td>38.7% (95% CI, 32.5%-45.1%)</td>
<td>17.1% (95% CI, 12.7%-22.4%)</td>
</tr>
<tr>
<td>CR:12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VGPR:29.1</td>
<td></td>
<td></td>
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<tr>
<td>PR:25.1</td>
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</tbody>
</table>

BVd was associated with a greater depth of response, with double the \( \geq \) CR rate and more than double the MRD negativity rates (sensitivity of \( 10^{-5} \)) of DVd (\( P<.00001 \))\textsuperscript{c}.

\textsuperscript{a}CIs were based on the exact method. Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output.

\textsuperscript{b}MRD negativity rate was defined as percentage of patients who were MRD negative by NGS based on a sensitivity of \( 10^{-5} \).

\textsuperscript{c}Nominal \( P \) value. Cochran–Mantel–Haenszel test was used and adjusted for stratification factors, including number of prior lines of therapy (1 vs 2 or 3 vs \( \geq 4 \)), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III).

ORR, 82.7% (95% CI, 77.4%-87.3%)

\( \geq \) CR: 20.6 (95% CI, 16.9%-24.2%)

\( \geq \) VGPR: 31.3 (95% CI, 27.6%-35.0%)

ORR, 71.3% (95% CI, 65.3%-76.8%)

\( \geq \) CR: 12 (95% CI, 8.7%-16.2%)

\( \geq \) VGPR: 29.1 (95% CI, 24.4%-33.9%)

BVd, belantamab mafodotin, bortezomib, and dexamethasone; CR, complete response; DVd, daratumumab, bortezomib, and dexamethasone; ITT, intent to treat; MRD, minimal residual disease; NGS, next-generation sequencing; PR, partial response; R-ISS, Revised International Staging System; sCR, stringent complete response; VGPR, very good partial response.

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**Categories** | **BVd n/N** | **DVd n/N** | **Favors BVd** | **HR (95% CI)** | **Favors DVd** |
<table>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (stratified)^a</td>
<td>91/243</td>
<td>158/251</td>
<td></td>
<td>0.41 (0.31-0.53)</td>
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</tr>
<tr>
<td>No. of prior LOT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>46/125</td>
<td>76/125</td>
<td></td>
<td>0.52 (0.36-0.76)</td>
<td></td>
</tr>
<tr>
<td>2 or 3</td>
<td>29/88</td>
<td>62/89</td>
<td></td>
<td>0.34 (0.22-0.53)</td>
<td></td>
</tr>
<tr>
<td>≥4</td>
<td>20/27</td>
<td></td>
<td></td>
<td>0.38 (0.19-0.75)</td>
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<tr>
<td>No. of prior LOT</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>46/125</td>
<td>76/125</td>
<td></td>
<td>0.52 (0.36-0.76)</td>
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<tr>
<td>&gt;1</td>
<td>45/118</td>
<td>82/126</td>
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<td>Prior bortezomib</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>Yes</td>
<td>79/210</td>
<td>132/211</td>
<td></td>
<td>0.45 (0.34-0.59)</td>
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<td>26/40</td>
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<td>0.42 (0.21-0.84)</td>
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<td>Prior lenalidomide</td>
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<td>Yes</td>
<td>44/127</td>
<td>88/130</td>
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<td>0.33 (0.23-0.48)</td>
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<tr>
<td>No</td>
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<td>70/121</td>
<td></td>
<td>0.57 (0.39-0.83)</td>
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<tr>
<td>Disease refractory to lenalidomide</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>33/79</td>
<td>64/87</td>
<td></td>
<td>0.37 (0.24-0.56)</td>
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<tr>
<td>No</td>
<td>58/164</td>
<td>94/164</td>
<td></td>
<td>0.48 (0.34-0.67)</td>
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<tr>
<td>ISS stage at screening</td>
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</tr>
<tr>
<td>I/II</td>
<td>37/102</td>
<td>64/103</td>
<td></td>
<td>0.42 (0.28-0.64)</td>
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<tr>
<td>III</td>
<td>53/139</td>
<td>94/146</td>
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<td>0.45 (0.32-0.64)</td>
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<td>Age</td>
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</tr>
<tr>
<td>&gt;65 years</td>
<td>42/121</td>
<td>84/126</td>
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<td>0.39 (0.27-0.56)</td>
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<tr>
<td>65 to &lt;75 years</td>
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<td>61/85</td>
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<td>0.48 (0.32-0.73)</td>
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<tr>
<td>&lt;75 years</td>
<td>12/37</td>
<td>13/30</td>
<td></td>
<td>0.62 (0.28-1.38)</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Female</td>
<td>48/115</td>
<td>59/107</td>
<td></td>
<td>0.59 (0.40-0.87)</td>
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<tr>
<td>Male</td>
<td>43/128</td>
<td>99/144</td>
<td></td>
<td>0.35 (0.25-0.50)</td>
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<td>Time to relapse after completion of 1L treatment</td>
<td></td>
<td></td>
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<tr>
<td>≤12 months</td>
<td>23/49</td>
<td>31/50</td>
<td></td>
<td>0.46 (0.26-0.79)</td>
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<tr>
<td>&gt;12 months</td>
<td>68/194</td>
<td>127/201</td>
<td></td>
<td>0.43 (0.32-0.58)</td>
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</tr>
<tr>
<td>Cyogenetic risk</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High risk^c</td>
<td>26/67</td>
<td>48/69</td>
<td></td>
<td>0.36 (0.22-0.58)</td>
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</tr>
<tr>
<td>Standard risk^d</td>
<td>68/175</td>
<td>106/175</td>
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<td>0.48 (0.35-0.65)</td>
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</tr>
<tr>
<td>Missing or not evaluable</td>
<td>0/1</td>
<td>4/7</td>
<td></td>
<td>NE</td>
<td></td>
</tr>
<tr>
<td>Extramedullary disease at baseline</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>8/13</td>
<td>18/25</td>
<td></td>
<td>0.57 (0.24-1.34)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>83/230</td>
<td>140/226</td>
<td></td>
<td>0.44 (0.34-0.58)</td>
<td></td>
</tr>
</tbody>
</table>

**PFS benefit consistently favored BVd vs DVd across prespecified subgroups, including patients with lenalidomide-refractory or high-risk cytogenetic MM**

1. 1L, first line; BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; HR, hazard ratio; IRC, independent review committee; IVRS, interactive voice response system; LOT, line of therapy; MM, multiple myeloma; NE, not evaluable; PFS, progression-free survival; R-ISS, Revised International Staging System.

^a HRs for subgroups were only plotted if the number of events was ≥20 across both treatments. HRs for subgroups were estimated using Cox proportional hazards model, without adjustment for stratification variables.

^b Stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III) according to IVRS stratum, with a covariate of treatment.

^c A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13).

^d A patient was considered standard risk if they had negative results for all high-risk abnormalities: t(4;14), t(14;16), or del(17p13).

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Lenalidomide Refractory

<table>
<thead>
<tr>
<th>PFS b</th>
<th>BVd (N=79)</th>
<th>DVd (N=87)</th>
<th>HR c (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events, n (%)</td>
<td>33 (42)</td>
<td>64 (74)</td>
<td>0.31 (0.19-0.48)</td>
</tr>
<tr>
<td>mPFS (95% CI), mo</td>
<td>25.0 (18.1-NR)</td>
<td>8.6 (6.4-13.5)</td>
<td></td>
</tr>
<tr>
<td>1 prior LoT, n (%)</td>
<td>22 (29)</td>
<td>27 (33)</td>
<td></td>
</tr>
<tr>
<td>2 prior LoT, n (%)</td>
<td>24 (30)</td>
<td>21 (24)</td>
<td></td>
</tr>
<tr>
<td>3+ prior LoT, n (%)</td>
<td>33 (42)</td>
<td>39 (45)</td>
<td></td>
</tr>
</tbody>
</table>

Not Lenalidomide Refractory a

<table>
<thead>
<tr>
<th>PFS b</th>
<th>BVd (N=164)</th>
<th>DVd (N=164)</th>
<th>HR c (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events, n (%)</td>
<td>58 (35)</td>
<td>94 (67)</td>
<td>0.48 (0.34-0.68)</td>
</tr>
<tr>
<td>mPFS (95% CI), mo</td>
<td>36.6 (30.5-NR)</td>
<td>18.0 (12.5-23.5)</td>
<td></td>
</tr>
<tr>
<td>1 prior LoT, n (%)</td>
<td>103 (64)</td>
<td>98 (60)</td>
<td></td>
</tr>
<tr>
<td>2 prior LoT, n (%)</td>
<td>30 (18)</td>
<td>42 (26)</td>
<td></td>
</tr>
<tr>
<td>3+ prior LoT, n (%)</td>
<td>31 (19)</td>
<td>24 (15)</td>
<td></td>
</tr>
</tbody>
</table>

BVD was associated with clinically meaningful PFS benefit in both lenalidomide refractory and non-lenalidomide refractory patients

a Includes patients who are lenalidomide exposed but not refractory and patients who have not been exposed to lenalidomide. b Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. c CIs were estimated using the Brookmeyer-Crowley method. 95% CIs were not adjusted for multiplicity and cannot be used for hypothesis testing. d HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib, and R-ISS stage at screening (I vs II/III), with a covariate of treatment.

ASCO 2024 oral presentation.
DREAMM-7: subgroup by cytogenetic risk
Progression-free survival (high risk and standard risk)

No. at Risk

High Risk

<table>
<thead>
<tr>
<th>PFS*</th>
<th>BVD (N=67)</th>
<th>Dvd (N=69)</th>
<th>HRc (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events, n (%)</td>
<td>26 (39)</td>
<td>48 (70)</td>
<td>0.31 (0.18-0.52)</td>
</tr>
<tr>
<td>mPFS (95% CI)</td>
<td>33.2 (20.3-NR)</td>
<td>10.5 (7.6-13.4)</td>
<td></td>
</tr>
</tbody>
</table>

---

Standard Risk

<table>
<thead>
<tr>
<th>PFS*</th>
<th>BVD (N=175)</th>
<th>Dvd (N=175)</th>
<th>HRc (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events, n (%)</td>
<td>65 (37)</td>
<td>106 (61)</td>
<td>0.44 (0.32-0.60)</td>
</tr>
<tr>
<td>mPFS (95% CI)</td>
<td>36.6 (28.4-NR)</td>
<td>15.3 (11.8-20.1)</td>
<td></td>
</tr>
</tbody>
</table>

---

BVD led to strong PFS benefit (more than double to triple the median PFS) regardless of cytogenetic risk status compared with Dvd

* Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. b CIs were estimated using the Brookmeyer-Crowley method. 95% CIs were not adjusted for multiplicity and cannot be used for hypothesis testing. c HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib, and R-ISS stage at screening (I vs II/III), with a covariate of treatment.
DREAMM-8: study design

Eligibility criteria
- Adults with MM
- ≥1 prior line of MM therapy including LEN
- Documented PD during or after their most recent therapy
- No prior treatment with anti-BCMA or pomalidomide; not refractory/intolerant to bortezomib

Stratification:
- Prior lines of treatment (1 vs 2 or 3 vs ≥4)
- Prior bortezomib (yes vs no)
- Prior anti-CD38 therapy (yes vs no)

Recruitment period
October 2020 to December 2022

N=302

Belantamab mafodotin
2.5 mg/kg IV (cycle 1) then 1.9 mg/kg IV Q4W from cycle 2 onward
+ Pomalidomide 4 mg orally on days 1-21 (28-day cycles)
+ Dexamethasone 40 mg on days 1, 8, 15, and 22

Bortezomib
1.3 mg/m² SC on days 1, 4, 8, and 11 of cycles 1-8 then days 1 and 8 (21-day cycles)
+ Pomalidomide 4 mg orally on days 1-14 (21-day cycles)
+ Dexamethasone 20 mg on the day of and day after bortezomib

Treatment period
Until PD, death, unacceptable toxicity, end of study, or withdrawal of consent

Primary endpoint:
PFS (IRC assessed per IMWG)

Key secondary endpoints:
OS, MRD negativity, DOR

Additional secondary endpoints include:
ORR, CRR, ≥VGPR, TTBR, TTR, TTP, PFS2, AEs, ocular findings, HRQOL, and PROs

AE, adverse event; BCMA, B-cell maturation antigen; BPd, belamaf, pomalidomide, and dexamethasone; CD, cluster of differentiation; CRR, complete response rate; DOR, duration of response; HRQOL, health-related quality of life; IMWG, International Myeloma Working Group; IRC, independent review committee; ISS, International Staging System; IV, intravenous; LEN, lenalidomide; MM, multiple myeloma; MRD, minimal residual disease; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PFS2, progression-free survival on subsequent line of therapy; PRO, patient-reported outcome; PVd, pomalidomide, bortezomib, and dexamethasone; Q3W, every 3 weeks; Q4W, every 4 weeks; SC, subcutaneous; TTBR, time to best response; TTP, time to progression; TTR, time to response; VGPR, very good partial response.

* Patients aged ≥75 years, with comorbidities, or intolerant to 40 mg dose in Arm A or 20 mg dose in Arm B could have dose level reduced to half per investigator discretion.

+ Some patients were stratified by ISS status I vs II/III; the protocol was amended on 20 April 2021 to replace this randomization factor with prior anti-CD38 treatment (yes vs no).
DREAMM-8: BPd led to a significant PFS benefit vs. PVd

The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model, and the P value was produced based on the 1-sided stratified log-rank test. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.

BPd, belamaf, pomalidomide, and dexamethasone; HR, hazard ratio; NR, not reported; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

BPd led to a statistically significant and clinically meaningful reduction in risk of disease progression or death vs PVd (HR, 0.52; 95% CI, 0.37-0.73; P<.001)

Median follow-up, 21.8 months (range, 0.03-39.23 months)

The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model, and the P value was produced based on the 1-sided stratified log-rank test. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.

BPd, belamaf, pomalidomide, and dexamethasone; HR, hazard ratio; NR, not reported; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

ASCO 2024 oral presentation.
DREAMM-8: PFS benefit was seen consistently across all prespecified subgroups

HRs for subgroups were only plotted if the number of events was ≥20 in total across both treatments and were estimated using Cox proportional hazards models, without adjustments for stratification variables. A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13) and considered standard risk if they had negative results for all high-risk cytogenetics listed above.

All patients (stratified)  
Age, years  
<65  
65 to <75  
≥75  
Baseline ECOG PS  
0  
1 or 2  
Time to relapse after initiation of 1L treatment  
≤12 months  
>12 months  
Cytogenetics risk  
High risk  
Standard risk  
ISS stage at screening  
I  
II/III  
EMD at baseline  
Yes  
No

<table>
<thead>
<tr>
<th>Categories</th>
<th>BPd n/N</th>
<th>PVD n/N</th>
<th>Favor BPd Hazard ratio (95% CI)</th>
<th>Favor PVD Hazard ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (stratified)</td>
<td>62/155</td>
<td>80/147</td>
<td>0.52 (0.37-0.73)</td>
<td></td>
</tr>
<tr>
<td>Age, years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;65</td>
<td>28/64</td>
<td>27/53</td>
<td>0.64 (0.37-1.09)</td>
<td></td>
</tr>
<tr>
<td>65 to &lt;75</td>
<td>29/72</td>
<td>34/59</td>
<td>0.48 (0.29-0.79)</td>
<td></td>
</tr>
<tr>
<td>≥75</td>
<td>5/19</td>
<td>19/35</td>
<td>0.40 (0.15-1.07)</td>
<td></td>
</tr>
<tr>
<td>Baseline ECOG PS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>34/82</td>
<td>48/85</td>
<td>0.59 (0.38-0.92)</td>
<td></td>
</tr>
<tr>
<td>1 or 2</td>
<td>28/73</td>
<td>32/62</td>
<td>0.46 (0.28-0.76)</td>
<td></td>
</tr>
<tr>
<td>Time to relapse after initiation of 1L treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤12 months</td>
<td>8/22</td>
<td>12/20</td>
<td>0.26 (0.10-0.68)</td>
<td></td>
</tr>
<tr>
<td>&gt;12 months</td>
<td>54/133</td>
<td>68/127</td>
<td>0.58 (0.40-0.83)</td>
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</tr>
<tr>
<td>Cytogenetics risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>29/52</td>
<td>31/47</td>
<td>0.57 (0.34-0.95)</td>
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</tr>
<tr>
<td>Standard risk</td>
<td>24/72</td>
<td>35/75</td>
<td>0.51 (0.30-0.86)</td>
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</tr>
<tr>
<td>ISS stage at screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>33/93</td>
<td>46/85</td>
<td>0.48 (0.30-0.75)</td>
<td></td>
</tr>
<tr>
<td>II/III</td>
<td>29/61</td>
<td>34/62</td>
<td>0.62 (0.38-1.02)</td>
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<tr>
<td>EMD at baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13/20</td>
<td>9/11</td>
<td>0.67 (0.28-1.59)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>49/135</td>
<td>71/136</td>
<td>0.48 (0.33-0.70)</td>
<td></td>
</tr>
</tbody>
</table>

HRs for subgroups were only plotted if the number of events was ≥20 in total across both treatments and were estimated using Cox proportional hazards models, without adjustments for stratification variables. A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13) and considered standard risk if they had negative results for all high-risk cytogenetics listed above.

HR for all patients was stratified by the number of lines of prior therapy (1 vs 2/3 vs ≥4) and prior bortezomib (yes or no) according to interactive voice response system strata with a covariate of treatment.

1L, first line; BPd, bempalutam, pomalidomide, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; EMD, extramedullary disease; HR, hazard ratio; ISS, International Staging System; LOT, line of therapy; PFS, progression-free survival; PVD, pomalidomide, bortezomib, and dexamethasone.

ASCO 2024 oral presentation.
DREAMM-8: PFS benefit was seen consistently across all prespecified subgroups

### Categories

<table>
<thead>
<tr>
<th>Categories</th>
<th>BPd n/N</th>
<th>PVd n/N</th>
<th>Hazard ratio (95% CI)</th>
<th>Favors BPd</th>
<th>Favors PVd</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior stem cell transplant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42/99</td>
<td>41/82</td>
<td>0.61 (0.39-0.94)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>20/56</td>
<td>39/65</td>
<td>0.45 (0.26-0.78)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of prior lines of therapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>25/82</td>
<td>34/77</td>
<td>0.52 (0.31-0.88)</td>
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<tr>
<td>&gt;1</td>
<td>37/73</td>
<td>46/70</td>
<td>0.52 (0.33-0.80)</td>
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<tr>
<td><strong>Triple class exposed (PI, Immunomodulator, anti-CD38)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21/34</td>
<td>24/39</td>
<td>0.76 (0.42-1.37)</td>
<td></td>
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<tr>
<td>No</td>
<td>41/121</td>
<td>56/108</td>
<td>0.47 (0.31-0.70)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prior bortezomib treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>54/134</td>
<td>70/130</td>
<td>0.55 (0.38-0.78)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>8/21</td>
<td>10/17</td>
<td>NE</td>
<td></td>
<td></td>
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<tr>
<td><strong>Refractory to lenalidomide</strong></td>
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<tr>
<td>Refractory</td>
<td>54/125</td>
<td>70/111</td>
<td>0.45 (0.31-0.65)</td>
<td></td>
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<tr>
<td>Nonrefractory</td>
<td>8/30</td>
<td>10/38</td>
<td>NE</td>
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</tr>
<tr>
<td><strong>Refractory to anti-CD38 treatment</strong></td>
<td></td>
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<tr>
<td>Refractory</td>
<td>20/35</td>
<td>25/36</td>
<td>0.65 (0.36-1.18)</td>
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<tr>
<td>Nonrefractory</td>
<td>42/120</td>
<td>55/111</td>
<td>0.49 (0.33-0.74)</td>
<td></td>
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</tr>
</tbody>
</table>

HRs for subgroups were only plotted if the number of events was ≥20 in total across both treatments and were estimated using Cox proportional hazards models, without adjustments for stratification variables. A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13) and considered standard risk if they had negative results for all high-risk cytogenetics listed above.

BPd, b雷马/mary, pomalidomide, and dexamethasone; CD, cluster of differentiation; HR, hazard ratio; LOT, line of therapy; NE, not evaluable; PI, proteasome inhibitor; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.
DREAMM-8: deeper responses with BPd vs. PVd

The CR or better rate in the BPd arm was more than double that reported in the PVd arm.

The CR or better rate in the BPd arm was more than double that reported in the PVd arm.

CIs were based on the exact method. All percents are based on the ITT population.
BPd, belamaf, pomalidomide, and dexamethasone; CR, complete response; ITT, intent to treat; ORR, objective response rate; PR, partial response; PVd, pomalidomide, bortezomib, and dexamethasone; sCR, stringent complete response; VGPR, very good partial response.
DREAMM-8: higher MRD negativity rates with BPd vs. PVd

CIs were based on the exact method. MRD negativity rate was defined as the percentage of total intent-to-treat patients who were MRD negative by NGS based on sensitivity of $10^{-5}$. All percents including MRD negativity are based on the ITT population.

BPd, belamaf, pomalidomide, and dexamethasone; CR, complete response; ITT, intent to treat; MRD, minimal residual disease; NGS, next-generation sequencing; PR, partial response; PVd, pomalidomide, bortezomib, and dexamethasone; sCR, stringent complete response; VGPR, very good partial response.

The proportion of patients with a response of CR or better and MRD negative status (sensitivity of $10^{-5}$) was 5× greater in the BPd arm compared to the PVd arm (24% vs 5%).

CIs were based on the exact method. MRD negativity rate was defined as the percentage of total intent-to-treat patients who were MRD negative by NGS based on sensitivity of $10^{-5}$. All percents including MRD negativity are based on the ITT population.

BPd, belamaf, pomalidomide, and dexamethasone; CR, complete response; ITT, intent to treat; MRD, minimal residual disease; NGS, next-generation sequencing; PR, partial response; PVd, pomalidomide, bortezomib, and dexamethasone; sCR, stringent complete response; VGPR, very good partial response.
DREAMM-8: positive OS trend favouring BPd vs. PVd

Positive OS trend favoring BPd was seen despite the use of effective anti-MM therapies after progression with PVd; additional OS follow-up is ongoing.

Median follow-up, 21.8 months (range, 0.03-39.23 months). Minimum ongoing follow-up, 12.8 months.

BCMA, B-cell maturation antigen; BPd, belanfim, pomalidomide, and dexamethasone; HR, hazard ratio; ITT, intent to treat; NR, not reached; OS, overall survival; PVd, pomalidomide, bortezomib, and dexamethasone.

a Includes patients who died after study withdrawal when permitted per local laws.

b The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.

c Includes any subsequent antimyeloma therapy. Selected categories of interest are included.

d Identified by posthoc analysis. e Includes belanfim, teclistamab, elranatamab, REGN5458, and EMB-06.

Proportion alive

Time since randomization, months

No. at risk (no. of events)

BPd

PVd

12 months

83%

76%

Interim OS

BPd (N=155)

PVd (N=147)

Events, n (%)

49 (32)

56 (38)

Median OS (95% CI), months

NR (33.0-NR)

NR (25.2-NR)

HR (95% CI)

0.77 (0.53-1.14)

Subsequent antimyeloma therapy, n (%)c

ITT population

BPd (N=155)  PVd (N=147)

Steroids

37 (24)  59 (40)

Anti-CD38 antibodies

23 (15)  49 (33)

Proteasome inhibitor

26 (17)  36 (24)

Immunomodulator

14 (9)  29 (20)

BCMA-targeting therapyd,e

1 (<1)  20 (14)

Chemotherapy

16 (10)  25 (17)

Transplant

1 (<1)  5 (3)

- Includes patients who died after study withdrawal when permitted per local laws.
- The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.
- Includes any subsequent antimyeloma therapy. Selected categories of interest are included.
- Identified by posthoc analysis. Includes belanfim, teclistamab, elranatamab, REGN5458, and EMB-06.
DREAMM-7: changes in BCVA

Among all patients who received BVd, 44% had dose reductions, 78% had dose delays/interruptions, and 9% discontinued due to any ocular event.

BCVA, best-corrected visual acuity; BVd, belantamab mafodotin, bortezomib, and dexamethasone.

a Only patients with baseline visual acuity of 20/25 or better in ≥1 eye with on-trial worsening to 20/50 or 20/200 in each eye at the same visit.

b Resolution (post hoc) was defined as returning to baseline visual acuity (20/25 or better in ≥1 eye).

c Improvement was defined as bilateral improvement to better than 20/50 (or 20/200).

DREAMM-7: impact of dose modifications on PFS and ocular management

- Median time between doses increased the longer patients were on therapy
- Dose delays did not have an impact on PFS
  - BVd patients with ≥1 dose delay of ≥12 weeks (N=126), mPFS 36.6 months
  - 23% of patients experienced 20/50 or worse events in first 3 months; prevalence decreased thereafter
  - Rate of treatment discontinuation due to ocular events were low

<table>
<thead>
<tr>
<th>Time since first belantamab mafodotin dose, months</th>
<th>No. of patients with bilateral 20/50 or worse</th>
<th>No. of patients on treatment</th>
<th>No. of patients with bilateral 20/50 or worse</th>
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</thead>
<tbody>
<tr>
<td>≤3</td>
<td>23.2</td>
<td>211</td>
<td>49</td>
</tr>
<tr>
<td>&gt;3 to ≤6</td>
<td>15.9</td>
<td>170</td>
<td>27</td>
</tr>
<tr>
<td>&gt;6 to ≤9</td>
<td>15.6</td>
<td>147</td>
<td>23</td>
</tr>
<tr>
<td>&gt;9 to ≤12</td>
<td>11.5</td>
<td>131</td>
<td>15</td>
</tr>
<tr>
<td>&gt;12 to ≤15</td>
<td>9.4</td>
<td>117</td>
<td>11</td>
</tr>
<tr>
<td>&gt;15 to ≤18</td>
<td>12.7</td>
<td>110</td>
<td>14</td>
</tr>
<tr>
<td>&gt;18 to ≤21</td>
<td>11.8</td>
<td>102</td>
<td>12</td>
</tr>
<tr>
<td>&gt;21 to ≤24</td>
<td>7.2</td>
<td>97</td>
<td>7</td>
</tr>
<tr>
<td>&gt;24 to ≤27</td>
<td>10.8</td>
<td>93</td>
<td>10</td>
</tr>
<tr>
<td>&gt;27 to ≤30</td>
<td>4.3</td>
<td>69</td>
<td>3</td>
</tr>
<tr>
<td>&gt;30</td>
<td>11.9</td>
<td>42</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Median of average weeks between doses</th>
</tr>
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<tbody>
<tr>
<td>≤3</td>
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<tr>
<td>&gt;3 to ≤6</td>
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<tr>
<td>&gt;6 to ≤9</td>
</tr>
<tr>
<td>&gt;9 to ≤12</td>
</tr>
<tr>
<td>&gt;12 to ≤15</td>
</tr>
<tr>
<td>&gt;15 to ≤18</td>
</tr>
<tr>
<td>&gt;18 to ≤21</td>
</tr>
<tr>
<td>&gt;21 to ≤24</td>
</tr>
<tr>
<td>&gt;24 to ≤27</td>
</tr>
<tr>
<td>&gt;27 to ≤30</td>
</tr>
<tr>
<td>&gt;30</td>
</tr>
</tbody>
</table>

- Only belantamab mafodotin treatment period considered in these post hoc analyses.
- Only patients with 20/25 or better in either or both eyes at baseline are considered.
- Mean of days between doses, for each patient, per interval is used.
- Only patients receiving ≥6 months of treatment included in analysis to exclude early discontinuations (e.g., rapid PDs)
DREAMM-8: bilateral worsening in best corrected visual acuity

![Image](image-url)


<table>
<thead>
<tr>
<th>BPd</th>
<th>Bilateral worsening of BCVA in patients with normal baseline (20/25 or better in ≥1 eye)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20/50 or worse&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Patients, n/N (%)</td>
<td>51/150 (34)</td>
</tr>
<tr>
<td>Time to onset of first event, median (range), days</td>
<td>112 (28-761)</td>
</tr>
<tr>
<td>Time to resolution of first event to normal baseline, median (range), days&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>57 (14-451)</td>
</tr>
<tr>
<td>Time to improvement of first event, median (range), days&lt;sup&gt;e&lt;/sup&gt;</td>
<td>29 (7-196)</td>
</tr>
<tr>
<td>First event resolved to normal baseline, n/N (%)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>43/51 (84)</td>
</tr>
<tr>
<td>First event improved, n/N (%)&lt;sup&gt;e&lt;/sup&gt;</td>
<td>47/51 (92)</td>
</tr>
<tr>
<td>Follow-up ended with event ongoing, n/N (%)&lt;sup&gt;c,f&lt;/sup&gt;</td>
<td>4/51 (8)</td>
</tr>
</tbody>
</table>

**Visual acuity changes that could affect activities of daily living were reversible in most patients**

BCVA, best corrected visual acuity; BPd, bapaftomab, pomalidomide, and dexamethasone; NA, not available.

<sup>a</sup> Only patients with baseline visual acuity of 20/25 or better in ≥1 eye with on-study worsening to 20/50 or 20/200 in each eye at the same visit.  
<sup>b</sup> Defined as time from onset to resolution to normal baseline.  
<sup>c</sup> Posthoc analyses.  
<sup>d</sup> One event resolved to normal baseline after 57 days, while for the other event, patient follow-up ended prior to resolution; median not available.  
<sup>e</sup> “Improved” was defined as no longer 20/50 (or 20/200) or worse in both eyes.  
<sup>f</sup> Ongoing events were defined as events that had not resolved to normal baseline. Shi C, et al. bioRxiv. Published online May 22, 2018.
**Blenrep efficacy data is potentially transformational vs. 2L+ SoC triplets**

Independent, H2H confirmation vs. daratumumab and bortezomib with consistent, manageable safety

**DREAMM-7**

**mPFS 36.6 months**

(HR 0.41; P<0.0001) compared to 13.4 months, median follow-up (ITT) of 28.2 months

- PFS consistent across subgroups associated with poor prognosis, including patients with lenalidomide-refractory disease or high-risk cytogenetics
- Strong and clinically meaningful OS
- Greater ORR and depth (≥CR, ≥VGPR, MRD negativity) and durability of response

**DREAMM-8**

**mPFS NR**

(HR 0.52; P<0.001) compared to 12.7 months, median follow-up (ITT) of 21.8 months

- 100% lenalidomide-exposed patients
- PFS consistent across all prespecified subgroups, including patients with high-risk cytogenetics or lenalidomide- or anti-CD38-refractory disease
- Greater depth (≥CR; ≥CR and MRD negativity) and durability of response
- Early OS trend with ongoing follow-up

**Safety**

- Safety and tolerability of BVd and BPd regimens in DREAMM-7/-8 consistent with the known safety profile of the individual agents
- Dose modifications were effective in enabling patients with ocular adverse events to achieve PFS outcomes and low treatment discontinuation rates, consistent with that of the overall study population

**Blenrep triplets can potentially be a new SoC in 2L+ RRMM owing to the robust efficacy, manageable safety and ease of administration**

\[2L+: \text{second line or later, B: belamaf, CR: complete response, d: dexamethasone, H2H: head-to-head, HR: hazard ratio, mPFS: median progression-free survival, MRD: minimal residual disease, NR: not reached, ORR: overall response rate, OS: overall survival, P: pomalidomide, PFS: progression-free survival, RRMM: relapsed/refractory multiple myeloma, SoC: standard of care, V: bortezomib, VGPR: very good partial response.}\]

ASCO 2024 oral presentations for DREAMM-7 (BVd vs. DVd) and DREAMM-8 (BPd vs. PVd).
Study of BRd in 1L MM evaluates optimal dosing and dosing schedules

**Key eligibility criteria**
- Documented MM
- Ineligible for high-dose chemotherapy with ASCT
- ECOG PS 0–2
- Adequate organ system function
- eGFR ≥30 mL/min/1.73 m²

**Belamaf**
- Cohort 1: 2.5 mg/kg Q8W
- Cohort 2: 1.9 mg/kg Q8W
- Cohort 3: 1.4 mg/kg Q8W

**Lenalidomide**: 25 mg/d PO, days 1–21 of every 28-day cycle

**Dexamethasone**: 40 mg/day PO or IV, days 1, 8, 15, 22 of every 28-day cycle*

**Part 1**
(36 patients randomized 1:1:1)

**Belamaf** modifications

<table>
<thead>
<tr>
<th>Cohort 1</th>
<th>Cohort 2</th>
<th>Cohort 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose +1</td>
<td>2.5 Q4W</td>
<td>1.9 Q4W</td>
</tr>
<tr>
<td>Dose -1</td>
<td>2.5 Q12W</td>
<td>1.9 Q12W</td>
</tr>
</tbody>
</table>

**Starting dose**
- Cohort 1: 2.5 Q8W
- Cohort 2: 1.9 Q8W
- Cohort 3: 1.4 Q8W

**Part 1**
(BelaRd safety, tolerability, belamaf RP2D)

**Secondary endpoints**
- BelaRd efficacy
- Corneal AE management
- PK profile
- Ocular AEs by OSDI

**Primary endpoint**
- Part 1: BelaRd safety, tolerability, belamaf RP2D

*For participants ≥75 years, 20 mg/day on days 1, 8, 15, 22 of every 28-day cycle. AE: adverse event, ASCT: autologous stem cell transplantation, belamaf: belantamab mafodotin, BelaRd: belamaf + lenalidomide + dexamethasone, ECOG PS: Eastern Cooperative Oncology Group Performance Status, eGFR: estimated glomerular filtration rate, IV: intravenously, MM: multiple myeloma, NDMM: newly diagnosed multiple myeloma, OSDI: Ocular Surface Disease Index, PD: progressive disease, PK: pharmacokinetic, PO: per os, Q4/8/12W: once every four/eight/twelve weeks, RP2D: recommended phase II dose.

*Presented at 5th European Myeloma Network Meeting (April 2024)*
Clinical activity observed across doses with no disease progression to date

Overall Response Rate

<table>
<thead>
<tr>
<th>Patients (%)</th>
<th>CR</th>
<th>VGPR</th>
<th>PR</th>
<th>sCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8  (22.2%)</td>
<td>4 (33.3%)</td>
<td>2 (16.7%)</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>Cohort 1</td>
<td>11 (30.6%)</td>
<td>3 (25.0%)</td>
<td>4 (33.3%)</td>
<td>4 (33.3%)</td>
</tr>
<tr>
<td>Cohort 2</td>
<td>13 (36.1%)</td>
<td>3 (25.0%)</td>
<td>5 (41.7%)</td>
<td>5 (41.7%)</td>
</tr>
<tr>
<td>Cohort 3</td>
<td>4 (11.1%)</td>
<td>2 (16.7%)</td>
<td>1 (8.3%)</td>
<td>1 (8.3%)</td>
</tr>
</tbody>
</table>

Progression Free Survival

- PFS Events: 8 deaths
  - COVID-19: 4 patients
  - Pneumonia: 2 patients
  - Sudden death: 1 patient
  - Intracranial hemorrhage: 1 patient
- Median PFS was not reached

Median time to first response: ~1 month

Rapid, deep, and durable responses across cohorts were observed.
At median follow-up of 24.8 months, no disease progression was observed.
Low frequency of ≥Gr3 OAEs and meaningful BCVA decline were observed. Times to OAE resolution were rapid.

<table>
<thead>
<tr>
<th></th>
<th>Cohort 1 (2.5 mg/kg)</th>
<th>Cohort 2 (1.9 mg/kg)</th>
<th>Cohort 3 (1.4 mg/kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of ocular assessments</td>
<td>268</td>
<td>295</td>
<td>241</td>
</tr>
<tr>
<td>Assessments with OAE, n (%)&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild (Grade 0-1)</td>
<td>103 (38.4)</td>
<td>155 (52.5)</td>
<td>129 (53.5)</td>
</tr>
<tr>
<td>Moderate (Grade 2)</td>
<td>108 (40.3)</td>
<td>100 (33.9)</td>
<td>85 (36.3)</td>
</tr>
<tr>
<td>Severe (Grade ≥ 3)</td>
<td>57 (21.3)</td>
<td>40 (13.6)</td>
<td>27 (11.2)</td>
</tr>
<tr>
<td>Assessments with BCVA change from baseline, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild (Grade 0-1)</td>
<td>107 (39.9)</td>
<td>167 (56.6)</td>
<td>134 (55.6)</td>
</tr>
<tr>
<td>Moderate (Grade 2)</td>
<td>113 (42.2)</td>
<td>89 (30.2)</td>
<td>81 (33.6)</td>
</tr>
<tr>
<td>Severe (Grade ≥ 3)</td>
<td>48 (17.9)</td>
<td>39 (13.2)</td>
<td>26 (10.8)</td>
</tr>
<tr>
<td>Assessments with keratopathy findings, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild (Grade 0-1)</td>
<td>222 (82.8)</td>
<td>257 (87.1)</td>
<td>213 (88.4)</td>
</tr>
<tr>
<td>Moderate (Grade 2)</td>
<td>33 (12.3)</td>
<td>37 (12.5)</td>
<td>27 (11.2)</td>
</tr>
<tr>
<td>Severe (Grade ≥ 3)</td>
<td>13 (4.9)</td>
<td>1 (0.3)</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>Time to resolution in months, median (range)&lt;sup&gt;†&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to resolution of meaningful BCVA decline&lt;sup&gt;‡&lt;/sup&gt; with ≥3 lines drop in better seeing eye&lt;sup&gt;§&lt;/sup&gt;</td>
<td>11 (1.0-5.8)</td>
<td>14 (0.8-2.4)</td>
<td>16 (0.9-5.5)</td>
</tr>
<tr>
<td>Time to resolution of BCVA change from baseline</td>
<td>2.1 (0.3-17.7)</td>
<td>1.9 (0.9-6.2)</td>
<td>1.9 (0.9-11.3)</td>
</tr>
<tr>
<td>Time to resolution of keratopathy</td>
<td>1.1 (0.5-12.2)</td>
<td>1.4 (0.9-3.4)</td>
<td>11 (0.9-3.7)</td>
</tr>
</tbody>
</table>

BCVA: best corrected visual acuity. OAE: ocular adverse event.

<sup>*</sup> For OAEs, the maximum grade of keratopathy or BCVA change from baseline is presented. § Meaningful BCVA decline is defined as BCVA decrease worse than 20/50 in the better-seeing eye. Better seeing eye was considered the eye that presented higher visual acuity at screening (based on BCVA). Patients with BCVA worse than 20/50 in both eyes at baseline are excluded from this analysis. ¶ Meaningful BCVA decline resolution was considered, when BCVA became better than 20/50 or line drops < 3 lines, while for keratopathy and BCVA change from Baseline resolution, was considered when Grade became ≤ 1. Time to resolution is presented for the resolved events.
Ocular symptoms had minimal impact on activities of daily living
No patients discontinued due to ocular adverse events

Across cohorts, a minor impairment in eyesight-associated daily functioning was observed, as “all/most/half of the time” responses in OSDI ADL category were <10.0% across cohorts.
Appropriate belamaf dose administration critical to avoiding ocular events

Inappropriate dose administration

Appropriate dose administration

Inappropriate dosing (i.e., when substantial ocular symptoms are present) may lead to significant drop in visual acuity

Appropriate administration (i.e., without substantial ocular symptoms) may minimize ocular peak toxicities

B: appropriate belamaf administration
B: inappropriate belamaf administration
Summary of BRd in 1L multiple myeloma

Dosing and efficacy

• Extension of belamaf dosing to Q8W/Q12W did not lead to reduced efficacy compared to previous studies implementing the Q3W schedule

• Results show that the efficacy of belamaf is maintained, even when administered in extended time intervals

Dosing and vision-related functioning

• Extended dosing schedule had only a minimal impact on vision-related functioning, with “all/most of the time” OSDI ADL responses recorded in <2.5% of assessments

• Frequency of clinically relevant impairment in vision was low, as meaningful BCVA decline was observed in less than 10% of assessments, with a rapid time to resolution
Eye-related side effects experienced on Blenrep can be manageable.
Blenrep may have potential to improve upon standard of care in 2L MM
Favourable comparison to standard of care regimens on efficacy, convenience and access

<table>
<thead>
<tr>
<th>Population</th>
<th>Regimen</th>
<th>lenalidomide exposed (%)</th>
<th>PFS ITT (months)</th>
<th>Key constraint</th>
<th>Treatment visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>belamaf-Vd(^1)</td>
<td>52</td>
<td>37</td>
<td>-</td>
<td>Weekly 6-12 weeks(^9)</td>
</tr>
<tr>
<td></td>
<td>dara-Kd(^2)</td>
<td>39</td>
<td>28</td>
<td>CV exclusion</td>
<td>Weekly Weekly</td>
</tr>
<tr>
<td></td>
<td>dara-Vd(^3)</td>
<td>36</td>
<td>17</td>
<td>-</td>
<td>Weekly Monthly</td>
</tr>
<tr>
<td></td>
<td>dara-Rd(^4)</td>
<td>18</td>
<td>45</td>
<td>1L SoC</td>
<td>Monthly Monthly</td>
</tr>
<tr>
<td>Heavily pre-treated</td>
<td>belamaf-Pd(^5)</td>
<td>100</td>
<td>NR(^8)</td>
<td>-</td>
<td>Monthly 8-12 weeks(^10)</td>
</tr>
<tr>
<td></td>
<td>dara-Pd(^6)</td>
<td>100</td>
<td>12</td>
<td>-</td>
<td>Weekly Monthly</td>
</tr>
<tr>
<td></td>
<td>bortezomib-Pd(^7)</td>
<td>100</td>
<td>11</td>
<td>-</td>
<td>Weekly Weekly</td>
</tr>
</tbody>
</table>

*Blenrep* is the only anti-BCMA expected to:
- be available also outside of excellence/academic centers
- offer anti-BCMA efficacy with low treatment burden
- offer early and sustained survival benefit*
- not be associated with life-threatening side-effects

Filing expected in all major markets by end of 2024

---

**Notes:**
- Subject to regulatory approvals and based on early separation of OS curves in DREAMM-7 (confirmatory pattern in DREAMM-8) vs. early detriment in Cartitude-4 and Karmma-3.

Blenrep may have a role in all patient segments and sites of care in 2L MM. Eligibility may span patient age and fitness.

<table>
<thead>
<tr>
<th>Current SoC</th>
<th>Future anti-BCMA agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young / Fit</td>
<td>Patient Age / Fitness</td>
</tr>
<tr>
<td>All sites of care</td>
<td>Old / Frail</td>
</tr>
<tr>
<td>DKd, KPd (no cardiac nor other comorbidity)</td>
<td>DPd, PVd</td>
</tr>
<tr>
<td>CAR-Ts (hospitalization required in US)</td>
<td>Bispecifics (hospitalization required in US)</td>
</tr>
</tbody>
</table>

Blenrep

Multiple datasets support opportunity for *Blenrep* in 1L (NDMM)

*Blenrep* outperforms daratumumab through direct or indirect comparisons

Potential evidence for superiority of *Blenrep* in 1L multiple myeloma (newly diagnosed)

<table>
<thead>
<tr>
<th>DREAMM-7 (vs. daratumumab-based SoC), 2L MM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PFS</td>
<td>36.6 vs. 13.4 months</td>
</tr>
<tr>
<td>OS</td>
<td>Trend with HR 0.51</td>
</tr>
<tr>
<td>mDoR</td>
<td>35.6 vs. 17.8 months</td>
</tr>
<tr>
<td>≥CR</td>
<td>34.6 vs. 17.1%</td>
</tr>
<tr>
<td>MRD-</td>
<td>38.7% vs. 17.1%</td>
</tr>
</tbody>
</table>

DREAMM-8, 2L MM Cross-trial comparison vs. daratumumab (APOLLO trial*)

| PFS                                        | NR vs. 12.4 |

1L (NDMM) BelaRd Ph2 trial (Terpos)

At a median follow-up of 24.8 months, no disease progression was observed across 3 dose cohorts of belantamab

DREAMM-10 (phase III): *Blenrep* in 1L multiple myeloma

**belamaf + SoC/backbone regimen**

**Primary endpoints:**
- MRD negativity
- PFS

**Newly diagnosed multiple myeloma**

**DRd** (daratumumab, lenalidomide, dexamethasone)

Trial to initiate in 2025

The Oncologic Drugs Advisory Committee (ODAC) have voted unanimously in favour of minimal residual disease (MRD) testing as an early endpoint in multiple myeloma

---

**1L:** first line, **2L:** second line, **CR:** complete response, **D:** daratumumab, **d:** dexamethasone, **mDoR:** median duration of response, **MM:** multiple myeloma, **mPFS:** median progression-free survival, **MRD(-):** minimal residual disease (negativity), **NDMM:** newly diagnosed multiple myeloma, **NR:** not reached, **OS:** overall survival, **PFS:** progression-free survival, **R:** lenalidomide, **SoC:** standard of care.

* Dimopoulos MA, et al. Lancet Oncol. 2021;22(6):801–812. mPFS for ITT of 12.4 months vs. 6.9 months for DPd vs. Pd, respectively, in a 100% lenalidomide-exposed population.
Ojjaara/Omjjara (momelotinib)

Only asset demonstrating durable clinical benefit on spleen response, symptoms and anemia for patients with myelofibrosis
Myelofibrosis patients with anaemia have poor OS and limited options
~40% of patients are anaemic at diagnosis, while nearly all become anaemic over time

Myelofibrosis market by 2031^1,2

~£3bn
+7% compound growth rate

~53k drug-treated patients^6,7 in developed markets

High unmet medical needs remain
- Extending overall survival
- Disease-modifying treatments
- Treatments that address the totality of myelofibrosis manifestations, i.e., splenomegaly, constitutional symptoms, anaemia, and thrombocytopenia

Significant patient burden^3 with nearly all patients becoming anaemic over time

Treatment dynamics^4,5,6

~50%

Patients that require RBC transfusions within one year after diagnosis

- Treatment with JAK inhibitors is initiated due to splenomegaly and constitutional symptoms; ~40% of patients are already anaemic at diagnosis
- Anaemia worsens due to disease progression or myelosuppressive therapies that exacerbate anaemia
- Symptoms of myelofibrosis and transfusion burden severely impact quality of life

Hb: haemoglobin, JAK: Janus kinase, OS: overall survival, RBC: red blood cell. * Severe anaemia defined as either Hb<8 or transfusion-dependent.

**Strong Ojjaara launch uptake; establishing share in 1L and 2L settings**

**Ojjaara: fastest US launch uptake in value for a JAKi in MF**

---

**Strong commercial performance**

- Driven by strong execution
- US share in patients with anaemia: **14%** in 1L and **28%** in 2L
- ~60% of US physicians expect to increase prescribing Ojjaara in the next six months
- Line-agnostic label in EU, with ongoing launches in the UK and Germany

---

**Next steps**

- H2 2024: Japan approval
- Exploring further indications at the overlap of oncology and inflammation

---

1L: first line, 2L: second line, JAKi: Janus kinase inhibitor, MF: myelofibrosis.

1. GSK quarterly financial results; EvaluatePharma (March 2024).
2. Quarterly chart audits, March 2024.
3. US Oncology ATU, Feb/Mar 24, n=102.
Zejula (niraparib)

Continued impact on ovarian cancer outcomes and promising data in glioblastoma
Zejula development is mainly focused within ovarian cancer and GBM

Ovarian cancer market by 2031\(^2\)

\(~\£7bn\)  
+16% compound growth rate  
~65k drug-treated patients\(^3\) in developed markets

High unmet medical needs remain\(^5,6\)
- Over 70% recurrence within 3-5 years in the absence of 1L maintenance therapy  
- 1 of 2 patients in the US (vs. 1 of 4 in EU) remain untreated after chemotherapy

Glioblastoma market by 2031\(^2\)

\(~\£1bn\)  
+45% compound growth rate  
~26k patients diagnosed in developed markets by 2032\(^4\)

High unmet medical needs remain\(^5\)
- Only 2% of patients achieve 5-year survival for unmethylated MGMT (~60% of total population)  
- Over 40 years with no meaningful treatment improvement

---

Poly (ADP-ribose) polymerase inhibitor (PARPi) class

- Established therapy option for platinum-sensitive patients, particularly for BRCAm and BRCAwt HRd  
- Demonstrated overall clinical impact on ovarian cancer outcomes over the last decade  
- Efficacy of PARPi that can cross the blood-brain barrier is being explored in CNS tumours (GBM), with potential for meaningful improvement in an area of high unmet need

Overcoming PARPi resistance

- Inhibition of POL\(\theta\) activity may deepen PARPi response  
- More information on clinical programme forthcoming

---

Promising data in glioblastoma is a compelling opportunity

Zejula crosses the blood-brain barrier to penetrate brain tumours

No clinically meaningful improvement in unmethylated MGMT population since 1978

• Based upon pre-clinical data, Zejula crosses the blood-brain barrier, unlike other PARPi studied, showing favourable brain tumour penetration

Phase II\(^1\) data presented at 2024 ASCO

• Showed promising overall and progression-free survival in unmethylated MGMT

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Zejula phase II (n=20)</th>
<th>Historic SoC data (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mPFS (months)</td>
<td>14.9</td>
<td>5.3</td>
</tr>
<tr>
<td>mOS (months)</td>
<td>20.3</td>
<td>12.8</td>
</tr>
</tbody>
</table>

Zejula (phase III) in glioblastoma, Ivy Brain Institute supported collaborative study

**Induction**
- Newly diagnosed unMGMT GBM
- niraparib + RT
- 6-7 weeks

**Adjuvant**
- niraparib
- 4 week break

**Primary endpoints:** PFS, OS

**TMZ + RT**
- TMZ max 6 cycles

**TMZ**

**Next steps**

• 2024: Phase III initiated
• 2027: data anticipated

GBM: glioblastoma, mPFS: median progression-free survival, mOS: median overall survival, PARPi: poly (ADP-ribose) polymerase inhibitor, RT: radiotherapy, SoC: standard of care, TMZ: temozolomide, unMGMT GBM: unmethylated O6-methylguanine-DNA methyltransferase glioblastoma.

1. Single arm study.
Immuno-oncology: *Jemperli* (dostarlimab) and CD226 axis assets

Development of monotherapy and combinations across select solid tumours
Jemperli development is focused across endometrial, CRC and HNSCC
dMMR-driven tumour opportunities with expansion into highly PD-L1 positive HNSCC

Endometrial cancer market by 2031

~£2bn
+13% compound growth rate
~125k patients diagnosed in developed markets

Treatment dynamics: ~70% MMRp, and 30% dMMR/MSI-H

High unmet medical needs remain
- IO has transformed outcomes in dMMR
- While there have been improvements in MMRp patients, unmet need remains
- Poor long-term outcomes with chemotherapy alone

Colorectal cancer market by 2031

~£9bn
+7% compound growth rate
>1 million patients diagnosed in developed markets by 2032

Treatment dynamics: Stage II/III 85-90% MMRp, and 10-15% dMMR/MSI-H

High unmet medical needs remain
- Chemotherapy with current standard-of-care has quality of life impact, toxicity, marginal efficacy and continues to be a compliance burden for patients
- PD-1 monotherapy is not currently being studied

Head and neck cancer market by 2031

~£4bn
+5% compound growth rate
~300k patients diagnosed in developed markets

Treatment dynamics: ~85% PD-L1 positive patients

High unmet medical needs remain
- Locally advanced setting and standard-of-care has not improved for >20 years
- Benefits of anti-PD-(L)1 therapy have not yet been realised in early-stage disease


Jemperli & chemo showed significant OS benefit in 1L endometrial cancer
Unprecedented data builds upon current approval in 1L primary advanced/recurrent dMMR population

RUBY 1: statistically significant PFS benefit in dMMR/MSI-H\(^1\) (\(mPFS \text{ NE} (30) \text{ vs. } 7.7 \text{ months}\))

<table>
<thead>
<tr>
<th>Time since randomization (mo)</th>
<th>0</th>
<th>4</th>
<th>8</th>
<th>12</th>
<th>16</th>
<th>20</th>
<th>24</th>
<th>28</th>
<th>32</th>
<th>36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of PFS (%)</td>
<td>100</td>
<td>80</td>
<td>60</td>
<td>40</td>
<td>20</td>
<td>0</td>
<td>24.4%</td>
<td>63.5%</td>
<td>61.4%</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

- Launch of 1L dMMR indication has shown rapid uptake
  - 33% new patient share (NPS) in US
  - >35% NPS in Germany and strong UK performance since March launch
  - £800-900m in anticipated PYS

RUBY 1: statistically significant OS benefit in all-comers\(^2\) (\(mOS 44.8 \text{ vs. } 28.2 \text{ months}\))

<table>
<thead>
<tr>
<th>Time since randomization (mo)</th>
<th>0</th>
<th>4</th>
<th>8</th>
<th>12</th>
<th>16</th>
<th>20</th>
<th>24</th>
<th>28</th>
<th>32</th>
<th>36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of OS (%)</td>
<td>100</td>
<td>80</td>
<td>60</td>
<td>40</td>
<td>20</td>
<td>0</td>
<td>54.9%</td>
<td>70.1%</td>
<td>54.3%</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

- RUBY 1 all-comers indication accepted for US FDA priority review (Aug 2024 PDUFA), and EMA submission completed
- Jemperli to serve as a backbone for B7-H4 ADC combination in endometrial cancer

1. SGO 2023 presentation. 2. SGO 2024 presentation.
Jemperli has shown transformative data in LA dMMR rectal cancer
Data ungated further investment in registration-enabling gastrointestinal indications

Continued benefit in locally advanced dMMR rectal cancer\(^1\)

- 100% complete clinical response (cCR) (N=42 patients)
- Durable complete responses with monotherapy at 12 months of follow-up, as no progression evidenced
- No Gr3/4 adverse events were observed
- No patients have required chemotherapy, radiation nor surgery

AZUR-1 (phase II): Jemperli monotherapy in dMMR rectal cancer

- LA, unresected Stage II/III LA dMMR/MSI-H rectal (N=150)
- dostarlimab 500mg IV Q3W x 9 cycles
- < cCR
- SoC ± surgery
- Primary endpoint: cCR12
- Non-operative management

- Current SoC: CRT and/or surgery
- Dostarlimab being explored as a chemo- and surgery-sparing treatment option to replace SoC
- Data expected in 2026+

AZUR-2 (phase III) Jemperli monotherapy in dMMR colon cancer

- Perioperative Stage II/III dMMR/MSI-H colon (N=711)
- R2:1
- dostarlimab 500mg IV Q3W x 4 cycles
- surgery
- dostarlimab 1000mg IV Q6W x 6 cycles
- surgery
- SoC (chemo 12-24 wks or surveillance)
- Primary endpoint: EFS

- IO shown to provide clinical benefit vs. chemo
- Dostarlimab being explored as a chemo-free treatment option to replace chemo
- Data expected in 2026+

1. ASCO 2024 presentation (supported collaborative study).

Jemperli data shows unprecedented response in locally advanced dMMR rectal cancer

Dr. Andrea Cercek, medical oncologist

Memorial Sloan Kettering Cancer Center and Principal Investigator, GSK-supported dostarlimab study in dMMR rectal cancer
Jemperli being explored in locally advanced head and neck cancer
Investigating potential as new standard of care in post-chemoradiotherapy setting

- PD-(L)1 drug class has shown efficacy improvements over standard of care in the relapsed/metastatic setting, as well as in certain locally advanced, unresected settings

- Patients with locally advanced HNSCC do not currently receive any follow-on treatment after initial chemoradiotherapy

- JADE phase III study investigates efficacy of Jemperli post-chemoradiotherapy in patients most likely to benefit

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**JADE (phase III): Jemperli monotherapy in HNSCC**

- Primary endpoint: EFS
- Data expected in 2026+

**LA, unresected, newly diagnosed HNSCC (N=864)**
- dostarlimab
- placebo

**12 months**

- Only newly diagnosed, treatment-naïve patients with locally advanced, unresected HNSCC
- PD-L1 CPS ≥1 (CPS <1 unlikely to respond)

- Post-cisplatin-based CRT
GSK and iTeos initiated phase III GALAXIES Lung-301 study in NSCLC
First registrational study of the Jemperli-belrestotug combination

Advancing CD226 axis combinations in NSCLC

GALAXIES Lung-301 (phase III): belrestotug in NSCLC

Previously untreated, PD-L1 high (TC≥50%) in current/former smokers in LA, unresectable or metastatic NSCLC (N=1000)

Data from phase II randomised study of Jemperli + belrestotug vs. Jemperli alone (GALAXIES Lung-201) planned to be presented in H2 2024

Compelling science

- **Fc-functional domain**: Preclinical evidence suggests Fc engagement may be important for optimal antitumor responses by TIGIT mAbs\(^2\)

- **Potency**: Cell-based assays demonstrated higher potency of belrestotug relative to other Fc-functional and Fc-silent anti-TIGIT mAbs providing basis for selection as a therapeutic candidate\(^3\)

- **Treg depletion**: Treatment of patients with belrestotug demonstrated depletion of exhausted Treg cells while enhancing population of active CD8 cells\(^4\)

- **In combination with proven anti-PD-1 profile**: Findings from the PERLA trial support the use of dostarlimab as a treatment backbone in trials of the combinations with belrestotug and other mAbs targeting the CD226 axis\(^5\)

4. iTeos corporate presentation – April 2022.
Jemperli programme explores monotherapy and combinations
Endometrial cancer foundation with potential for growth across solid tumours

**Illustrative timeline**

<table>
<thead>
<tr>
<th>Year</th>
<th>Study</th>
<th>Disease</th>
<th>Treatment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2024</td>
<td>RUBY 1 (phase III)</td>
<td>1L EC (+chemo)</td>
<td></td>
<td><em>Approved in dMMR/MSI-H (2023); all-comers indication PDUFA Aug 2024</em></td>
</tr>
<tr>
<td>2025</td>
<td>DOMENICA (phase III)</td>
<td>1L dMMR endometrial cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2026</td>
<td>AZUR-1 (phase II registrational)</td>
<td>locally advanced dMMR/MSI-high rectal cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2027</td>
<td>AZUR-2 (phase III)</td>
<td>locally advanced dMMR/MSI-high colon cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2028</td>
<td>JADE (phase III)</td>
<td>locally advanced, unresected, PD-L1+ HNSCC post-CRT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>RUBY 2 (phase III)</td>
<td>1L endometrial cancer (+chemo → +Zejula)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>FIRST (phase III)</td>
<td>1L ovarian cancer (+chemo → +Zejula)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>GALAXIES H&amp;N-202 (phase III platform)</td>
<td>1L PD-L1 CPS≥1 HNSCC (+belrestotug ± nelistotug)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>GALAXIES Lung-201 (phase III platform)</td>
<td>1L PD-L1 high NSCLC (+belrestotug ± nelistotug)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2026</td>
<td>GALAXIES Lung-301 (phase III)</td>
<td>1L PD-L1 high NSCLC (+belrestotug)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>COSTAR Lung (phase III)</td>
<td>2L NSCLC (+chemo ± cobolimab)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Monotherapy†**

- RUBY 1 investigated Jemperli plus chemotherapy.
- Combination agents: belrestotug (TIM3 inhibitor), cobolimab (TIGIT inhibitor), nelistotug (CD96 inhibitor), Zejula (PARP inhibitor).

**Novel combinations*†**

- Approved in dMMR/MSI-H (2023); all-comers indication PDUFA Aug 2024.

---


† RUBY 1 investigated Jemperli plus chemotherapy. * Combination agents: belrestotug (TIGIT inhibitor), cobolimab (TIM3 inhibitor), nelistotug (CD96 inhibitor), Zejula (PARP inhibitor).
Antibody-drug conjugates (GSK5733584 (B7-H4), GSK5764227 (B7-H3))
Blockbuster potential across focused tumour indications
GSK5733584 (B7-H4 ADC) builds on presence in gynaecologic cancers

B7-H4 is highly expressed in solid tumours with high unmet need

<table>
<thead>
<tr>
<th>Tumour Type</th>
<th>% B7-H4 positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endometrial</td>
<td>100%</td>
</tr>
<tr>
<td>Cholangiocarcinoma</td>
<td>80%</td>
</tr>
<tr>
<td>Ovarian</td>
<td>60%</td>
</tr>
<tr>
<td>TNBC</td>
<td>20%</td>
</tr>
</tbody>
</table>

5-year survival for patients with distant metastasis:
- Endometrial: 18%
- Cholangiocarcinoma: 4%
- Ovarian: 32%
- TNBC: 13%

ESMO 2023: HS-20089 showed an ORR of 33.3% (4.8 mg/kg) and 27.3% (5.8 mg/kg) in TNBC patients

Well-positioned to potentially bring transformational value to patients and to drive GSK growth
- High tumour expression coupled with limited healthy tissue expression creates potential for a broad therapeutic index
- Clinically validated TOPO1i payload and linker
- Development focus on GSK proprietary combinations, including dostarlimab
- Proof of concept studies to begin H2 2024 to support accelerated registrational pathway


Ex-China licensing: includes China, Macau, Hong Kong and Taiwan.
GSK5764227 (B7-H3) has multi-indication, transformational potential

B7-H3 is broadly expressed across numerous tumour types with high unmet need

ASCO 2023: HS-20093 showed an ORR of 63.6% in SCLC patients (N=11)

ASCO 2024: ORR of 17.4%/25% in osteosarcoma/sarcoma

No new safety signal (12mg/kg)

- Clinical activity observed in a broad range of tumours, including non-small lung cancer, small cell lung cancer and sarcoma
- Clinically validated TOPO1i payload and linker
- Development opportunity in lung, genitourinary, gastrointestinal and beyond
- Opportunity for monotherapy use in relapsed/refractory disease and acceleration of paradigm-changing combination in early lines of therapy (i.e., dostarlimab combination)
- Potential for first-to-market in a variety of tumours
- Proof of concept studies to begin H2 2024 to support accelerated registrational pathway


1. Adapted from Yamato, Mol Cancer Ther (2022) 21 (4): 635–646; dataset represents tested tumors and is not a complete list of all tumors that express B7-H3.

Ex-China licensing: includes China, Macau, Hong Kong and Taiwan.
Delivering upon our future ambition
Select oncology growth drivers

<table>
<thead>
<tr>
<th><strong>Ojjaara</strong></th>
<th><strong>£1bn</strong> in peak year sales¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anaemia burden increasingly at forefront of treatment decisions</td>
<td></td>
</tr>
<tr>
<td>• 56%/66% of US/EU physicians likely to switch to Ojjaara/Omjjara within next 6 months</td>
<td></td>
</tr>
<tr>
<td>• Geographic launch expansion</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Jemperli</strong></th>
<th><strong>£2bn</strong> in peak year sales¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Further uptake in 1L endometrial cancer</td>
<td></td>
</tr>
<tr>
<td>• Development beyond dMMR tumours</td>
<td></td>
</tr>
<tr>
<td>• Proprietary IO backbone being developed across a range of solid tumours</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>belrestotug &amp; CD226 axis assets</strong></th>
<th><strong>£2bn</strong> in peak year sales¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Novel combination strategies with all major targets of CD226 axis: TIGIT, CD96, PVRIG</td>
<td></td>
</tr>
<tr>
<td>• Current development focused in NSCLC and HNSCC, including doublets and triplets</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GSK5764227 (B7-H3) &amp; GSK5733584 (B7-H4) ADCs</strong></th>
<th><strong>Blockbuster potential</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Antigen overexpression in tumours with high unmet need</td>
<td></td>
</tr>
<tr>
<td>• Proprietary combinatorial potential, particularly with dostarlimab</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Blenrep²</strong></th>
<th><strong>£3bn</strong> in peak year sales¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Growth of BCMA class</td>
<td></td>
</tr>
<tr>
<td>• Broad patient eligibility</td>
<td></td>
</tr>
<tr>
<td>• HCP and patient desire for treatment use in outpatient, community setting</td>
<td></td>
</tr>
</tbody>
</table>

¹ Non-risk adjusted peak year sales potential is subject to certain assumptions consistent with those for previous outlooks, ambitions and expectations. 2. Blenrep is not included in current GSK guidance.
### Forthcoming catalysts

<table>
<thead>
<tr>
<th></th>
<th>Remainder of 2024</th>
<th>2025</th>
<th>2026+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blenrep</strong></td>
<td><strong>Regulatory filings</strong></td>
<td><strong>Regulatory decisions</strong></td>
<td><strong>Regulatory decisions</strong></td>
</tr>
<tr>
<td></td>
<td>US, EU, JP &amp; CHN (2L+ MM)</td>
<td>US, EU &amp; JP (2L+ MM)</td>
<td>CHN (2L+ MM)</td>
</tr>
<tr>
<td><strong>DREAMM-10</strong></td>
<td><strong>Phase III initiation</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(1L MM)</td>
<td></td>
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<tr>
<td><strong>Regulatory decision</strong></td>
<td>US (1L EC all-comers)</td>
<td><strong>Regulatory decision</strong></td>
<td><strong>AZUR-1</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EU (1L EC all-comers)</td>
<td>Phase II data readout</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(locally advanced rectal)</td>
</tr>
<tr>
<td><strong>COSTAR Lung</strong></td>
<td><strong>Phase III data readout</strong></td>
<td></td>
<td><strong>AZUR-2</strong></td>
</tr>
<tr>
<td>(with cobolimab)</td>
<td>(2L NSCLC)</td>
<td></td>
<td>Phase III data readout</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(peri-operative colon)</td>
</tr>
<tr>
<td><strong>Jemperli</strong></td>
<td><strong>Initiation of new</strong></td>
<td></td>
<td><strong>JADE</strong></td>
</tr>
<tr>
<td></td>
<td>opportunities**</td>
<td></td>
<td>Phase III data readout</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(unresected HNSCC)</td>
</tr>
<tr>
<td><strong>GSK5764227</strong> (B7-H3 ADC), GSK5733584 (B7-H4 ADC)**</td>
<td><strong>Regulatory decision</strong></td>
<td>Initiation of new opportunities**</td>
<td></td>
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<tr>
<td></td>
<td>Japan (MF)</td>
<td></td>
<td><strong>GALAXIES H&amp;N-202</strong></td>
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<td></td>
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<td></td>
<td>Phase II data readout</td>
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<tr>
<td></td>
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<td></td>
<td>(IL HNSCC)</td>
</tr>
<tr>
<td><strong>Oijaara</strong></td>
<td><strong>Regulatory decision</strong></td>
<td>Initiation of new opportunities**</td>
<td></td>
</tr>
<tr>
<td>belrestotug &amp; CD226 assets</td>
<td><strong>GALAXIES Lung-201</strong></td>
<td></td>
<td><strong>GALAXIES H&amp;N-202</strong></td>
</tr>
<tr>
<td></td>
<td>Phase II data readout (IL NSCLC)</td>
<td></td>
<td>Phase II data readout</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(IL HNSCC)</td>
</tr>
<tr>
<td></td>
<td><strong>GALAXIES Lung-301</strong></td>
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<tr>
<td></td>
<td>Phase III initiation (1L NSCLC)</td>
<td></td>
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<tr>
<td><strong>FIRST (with dostarlimab)</strong></td>
<td><strong>Phase III data readout</strong></td>
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<td></td>
<td>(1LM OC)</td>
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<tr>
<td><strong>ZEAL-1L</strong></td>
<td><strong>Phase III data readout</strong></td>
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<tr>
<td></td>
<td>(1LM NSCLC)</td>
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<tr>
<td><strong>IVY supported collaborative study</strong></td>
<td><strong>Phase III initiation</strong></td>
<td></td>
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<tr>
<td></td>
<td>(GBM)</td>
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</tbody>
</table>

**Notes:**
- 1L: first line
- 2L: second line
- EC: endometrial cancer
- GBM: glioblastoma
- HNSCC: head and neck squamous cell carcinoma
- MF: myelofibrosis
- MM: multiple myeloma
- NSCLC: non-small cell lung cancer
- OC: ovarian cancer.
Q&A participants

Dr Evangelos Terpos
Professor of Haematology
National and Kapodistrian University of Athens
DREAMM-8 Principal Investigator

Luke Miels
Chief Commercial Officer

Dr Tony Wood
Chief Scientific Officer

Dr Nina Mojas
SVP, Global Product Strategy

Dr Hesham Abdullah
SVP, Global Oncology R&D

Dr Mondher Mahjoubi
Chief Patient Officer
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