



ESMO Analyst briefing

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Speakers



Nina Mojas
President, Global
Product Strategy



Hesham
Abdullah
SVP, Global Head
Oncology R&D



Ahmed Rabie
SVP Global
Product Strategy,
Oncology

Agenda

ESMO review

Hesham Abdullah, Global Head, Oncology R&D

Closing remarks

Nina Mojas, President, Global Product Strategy

Q&A

Hesham, Nina and Ahmed Rabie, Head Oncology Global Product Strategy



ESMO review

Hesham Abdullah, Global Head, Oncology R&D



2L+ SCLC: Emerging global data appear consistent with data generated in China

3841P

EMBOLD PanTumor-101: Risvutatug rezetecan dose optimisation in patients with extensive-stage small cell lung cancer

Hye Ryun Kim¹, Javier García-Corbacho², Enriqueta Felip³, Jon Zugazagoitia Fraile⁴, María Eugenia Olmedo García⁵, Sanjay Goel⁶, Antoine Italiano⁷, Shigehiro Koganemaru⁸, Young Joo Lee⁹, Yohann Loriaut¹⁰, Patricia M. LoRusso¹¹, Kei Muro¹², Noboru Yamamoto¹³, Lucia Archibale¹⁴, Fernando Carreño¹⁵, Matthew Gibb¹⁶, John LaMacchia¹⁷, Ishara Thahir¹⁸, Danielle Wanik¹⁹, Dong-Wan Kim²⁰

	n	End points
EMBOLD Pan-Tumour 101 2L+ SCLC: 8mg/kg q3w	18	ORR: 61%

IASLC





**2026 World Conference
on Lung Cancer**

SEPTEMBER 12 – 15, 2026

SEOUL, REPUBLIC OF KOREA

**Risvutatug Rezetecan vs Topotecan in Relapsed SCLC:
Primary Results of Phase 3 ARTEMIS-008**

	n	End points
ARTEMIS-008 China phase III pivotal 2L+ SCLC	461	- ORR 58.3% - OS HR 0.46; mOS 18.5m



2026 World Conference on Lung Cancer

SEPTEMBER 12 – 15, 2026 | SEOUL, REPUBLIC OF KOREA

Risvutateg Rezetecan vs Topotecan in Relapsed SCLC: Primary Results of Phase 3 ARTEMIS-008

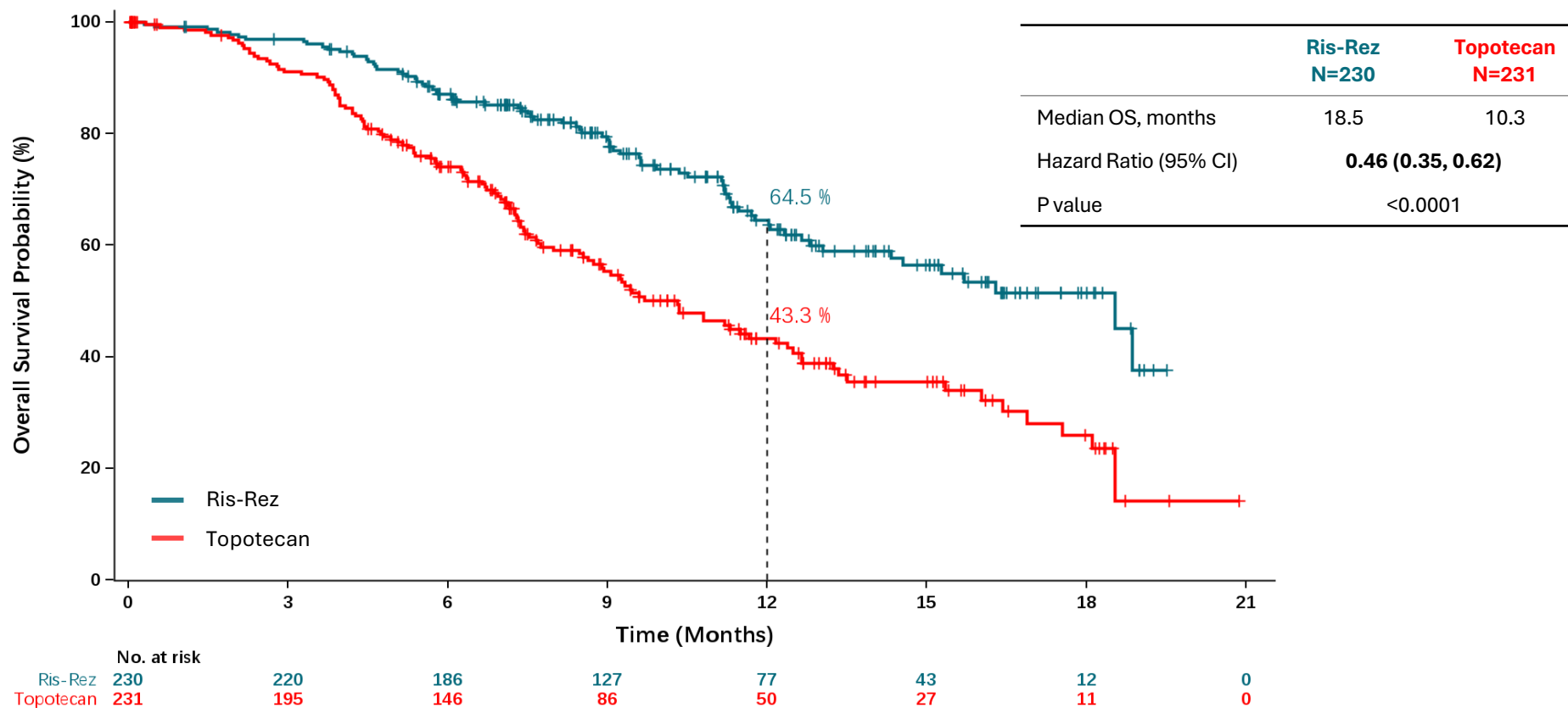
J. Wang¹, L. Wang², J. Duan¹, H. Liu³, Q. Wang⁴, H. Wang², L. Sun⁵, S. Huang⁶, Y. Huang⁷, F. Tong⁸, W. Zheng⁹, T. Chu¹⁰, Y. Fan¹¹, D. Huang¹², P. Zhang¹³, W. Guo¹⁴, B. Liu¹⁵, J. Zhou¹⁶, Q. Li¹⁷, Y. Dong¹⁸, Q. Liu¹⁸, M. Zhang¹⁸, X. Zhang¹⁸, J. Yu²

¹National Cancer Center/National Clinical Research Center for Cancer/Cancer Hospital, Chinese Academy of Medical Sciences Peking Union Medical College, Beijing/CN, ²Shandong Cancer Hospital and Institute, Shandong First Medical University, Shandong Academy of Medical Sciences, Jinan/CN, ³Jilin Cancer Hospital, Changchun/CN, ⁴The Affiliated Cancer Hospital of Zhengzhou University & Henan Cancer Hospital, Institute of Cancer Research, Henan Academy of Innovations in Medical Science, Zhengzhou/CN, ⁵The First Affiliated Hospital of Nanchang University, Nanchang/CN, ⁶The First Affiliated Hospital of Zhengzhou University, Zhengzhou/CN, ⁷Fujian Cancer Hospital, Fuzhou/CN, ⁸Union Hospital, Tongji Medical College, Huazhong University of Science and Technology, Wuhan/CN, ⁹Shengjing Hospital of China Medical University, Shenyang/CN, ¹⁰Shanghai Chest Hospital, Shanghai Jiao Tong University, School of Medicine, Shanghai/CN, ¹¹Zhejiang Cancer Hospital, Hangzhou/CN, ¹²Cancer Institute & Hospital, Tianjin Medical University, Tianjin/CN, ¹³Shanghai Pulmonary Hospital Affiliated to Tongji University, Shanghai/CN, ¹⁴Shanxi Provincial Cancer Hospital, Taiyuan/CN, ¹⁵Harbin Medical University Cancer Hospital, Harbin/CN, ¹⁶Sichuan Clinical Research Center for Cancer, Sichuan Cancer Hospital & Institute, Sichuan Cancer Center, University of Electronic Science and Technology of China, Chengdu/CN, ¹⁷Xiangyang Center Hospital, Affiliated Hospital of Hubei University Arts and Science, Xiangyang/CN, ¹⁸Shanghai Hansoh BioMedical Co., Ltd, Shanghai/CN

Presenter: Jie Wang

Primary Endpoint: OS

- At this IA (DCO June 6, 2026), 77 (33.5%) OS events in Ris-Rez arm and 121 (52.4%) in Topotecan arm.
- With a median follow-up of 12.2 months, Ris-Rez demonstrated statistically significant and clinically meaningful survival benefit over topotecan.

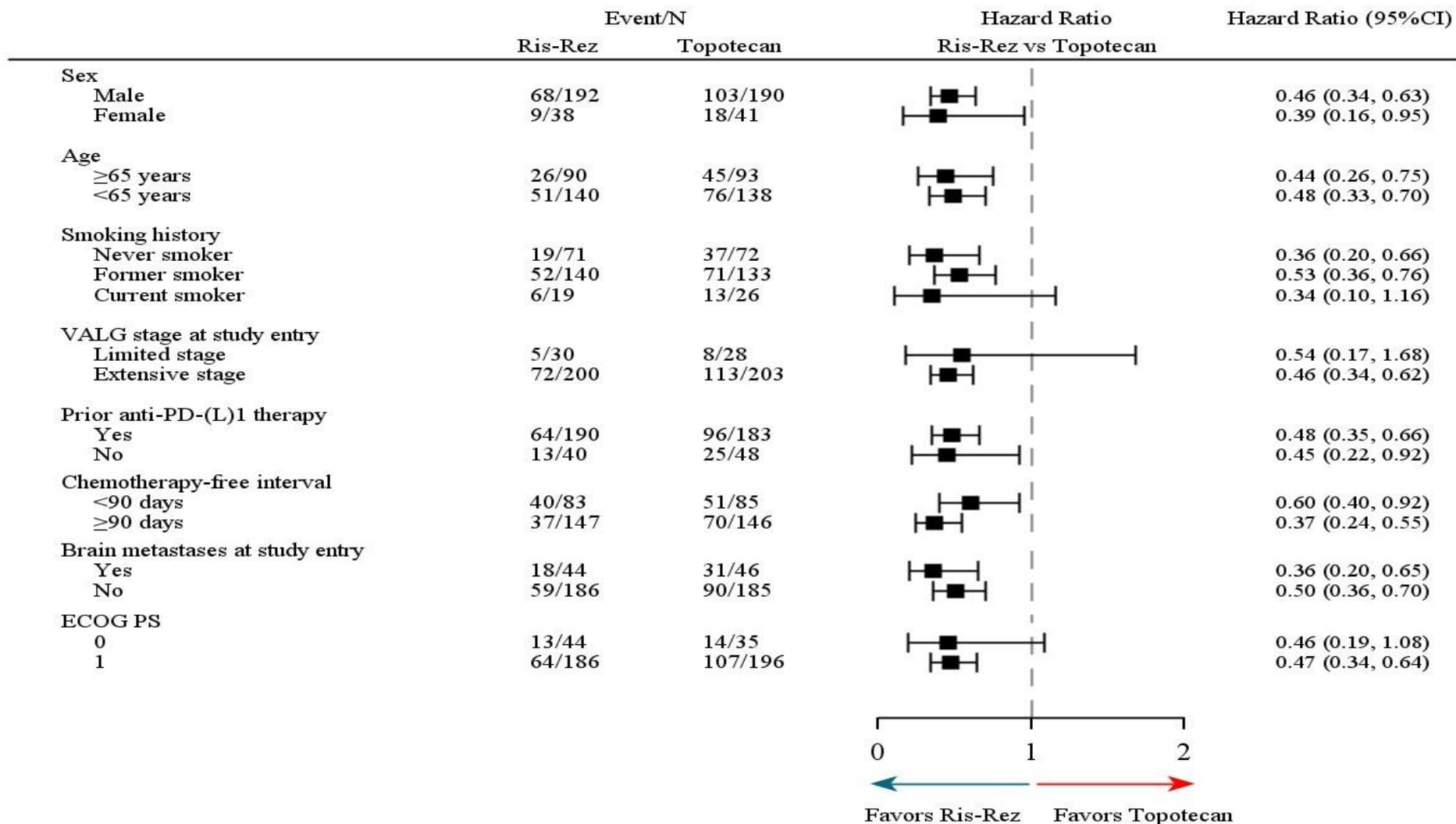


Hazard ratio and P value were estimated using a Cox proportional hazards model and Log-rank test, stratified by baseline brain metastasis status, CTFI, and VALG stage at study entry.

Censoring rule for OS: patients were censored at their last known survival time; for the 15 untreated patients who withdrew consent in topotecan group, censoring occurred at the withdrawal date.

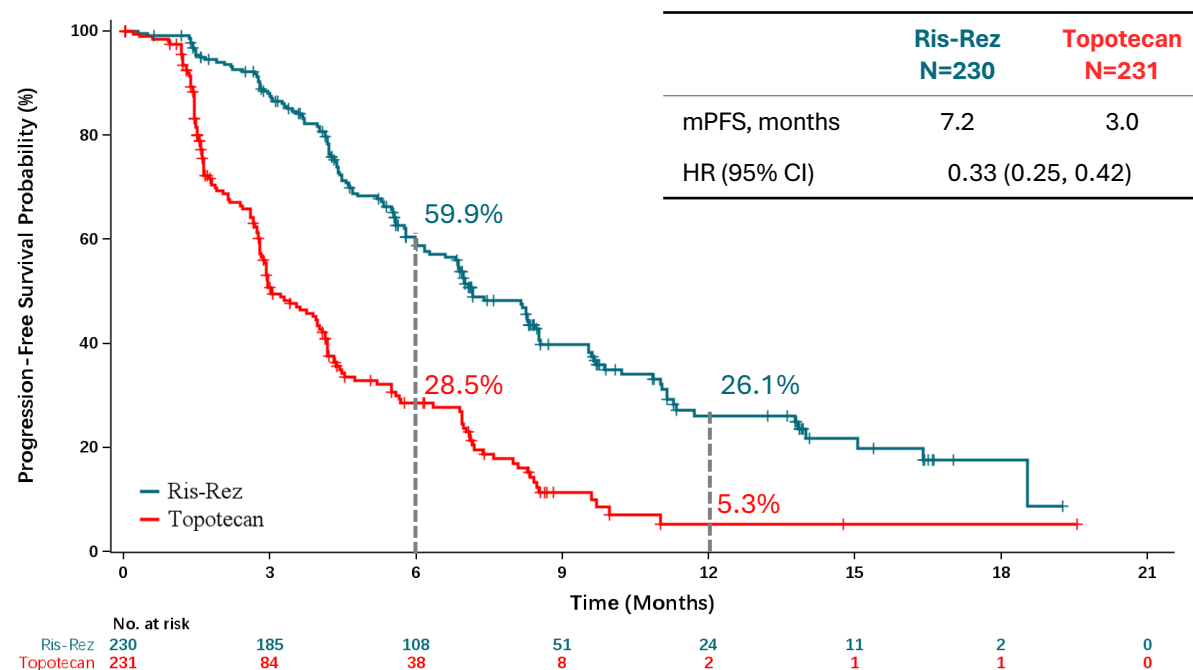
Abbreviation: CI, confidence interval; CTFI, chemotherapy-free interval; IA, interim analysis; OS, overall survival; VALG, Veterans Administration Lung Study Group

Overall Survival – Benefit Across Pre-defined Subgroups

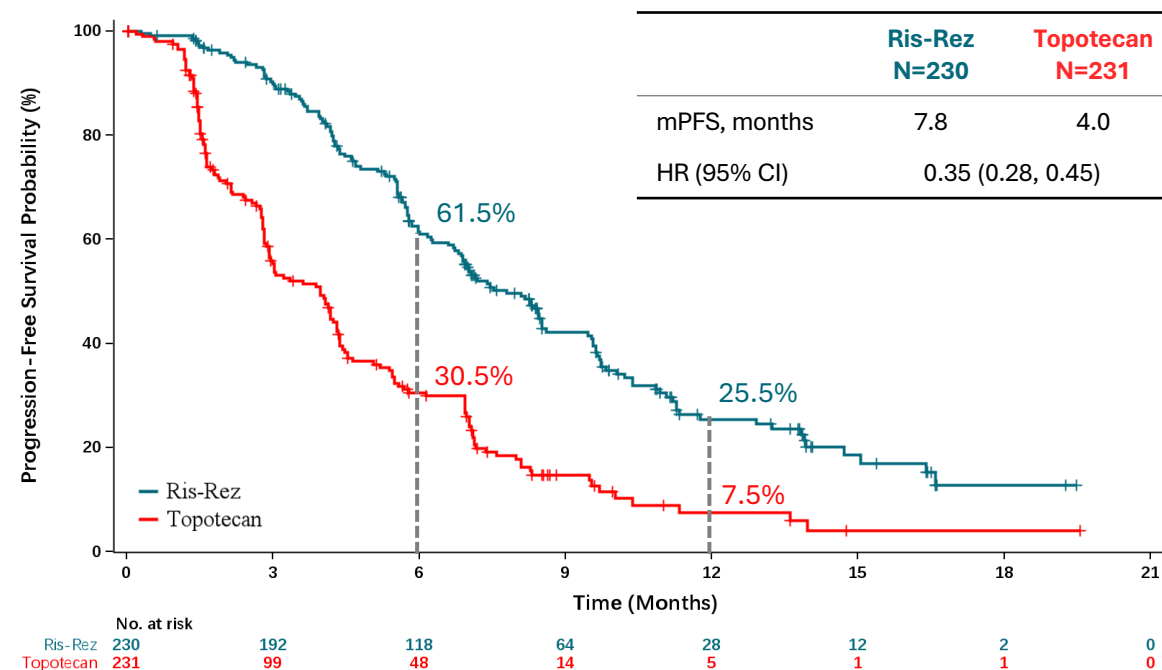


Secondary Endpoints: PFS by BICR and investigator

BICR-assessed PFS

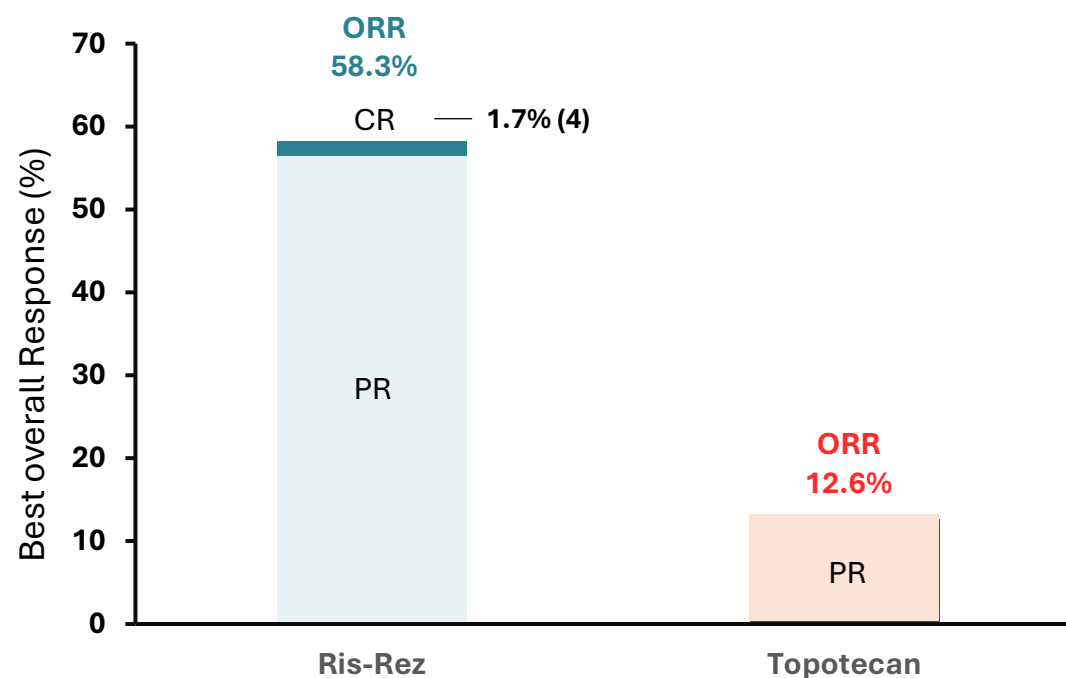


Investigator-assessed PFS



Secondary Endpoints: ORR, DCR and DoR by BICR

- Ris-Rez demonstrated consistent benefit across secondary efficacy endpoints



	Ris-Rez (N= 230)	Topotecan (N= 231)
ORR, % (95% CI)	58.3 (51.6, 64.7)	12.6 (8.6, 17.5)
DCR, % (95% CI)	90.4 (85.9, 93.9)	60.2 (53.5, 66.5)
Median DoR, months (95% CI)	6.9 (5.6, 8.2)	5.6 (3.0, 8.3)

Recent phase III SCLC datasets

Ris-Rez
ARTEMIS-008

(China only)

18.5 mo.

mOS vs 10.2 for topotecan¹

HR:0.46, 48.3 mos, 12 mos follow-up

Tam-peli
TAISHAN-302

(China only)

13.3 mo.

mOS vs 9.4 for topotecan²

HR:0.46, 43.9 mos, 9 mos follow-up

tarlatamab
USPI

Global phase III

13.6 mo.

mOS vs 8.3 for plt-based chemo³

HR:0.6, 45.3 mo.[†]

EMBOLD SCLC 301
2L+ SCLC

Recruiting

EMBOLD SCLC 303
1L SCLC

Q4 '26 start

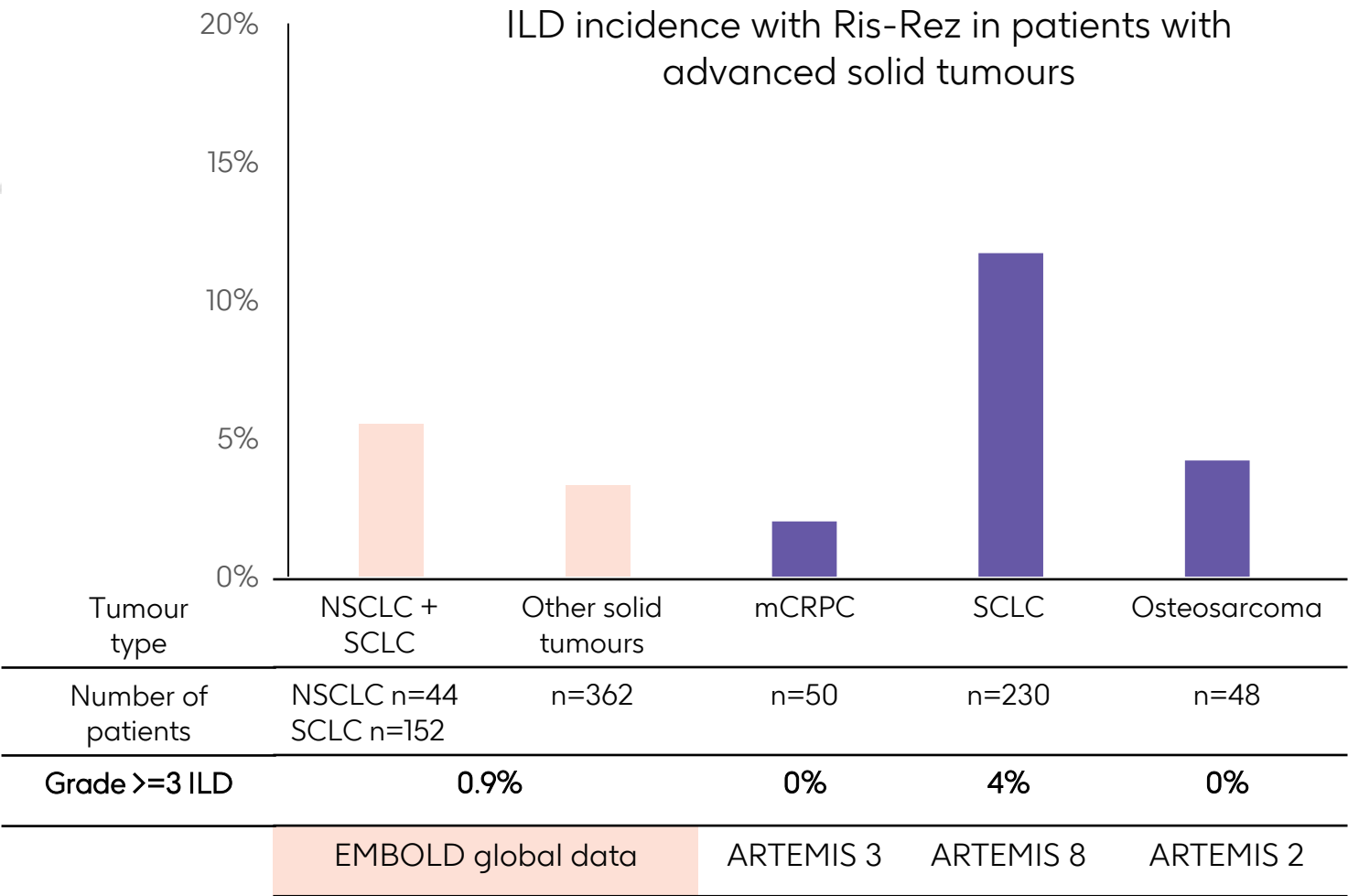
Notes: [†]versus investigators choice chemotherapy., mOS: median overall survival.

Sources: 1. Hansoh WCLC presentation 2. Medilink TAISHAN-302 Presentation at WCLC 3. IMDELLTRA FDA label

Ris-Rez global pooled analysis: ILD rates ca4% with most events <Grade 3

Pooled analysis of interstitial lung disease cases among patients with advanced solid tumours who received risvutaturg rezetecan monotherapy

Jon Zuazuaortia Fraile¹, Patricia M. LaRusso², Li-Yuan Bai³, Elena Élez⁴, María Eugenia Olmedo García⁵, Javier García-Corbacho⁶, Sanjay Goel⁷



Risvutatumab Versus Gemcitabine and Docetaxel in Heavily Pretreated Patients With Relapsed or Refractory Osteosarcoma: Primary Results From the Phase 3 ARTEMIS-011 Study

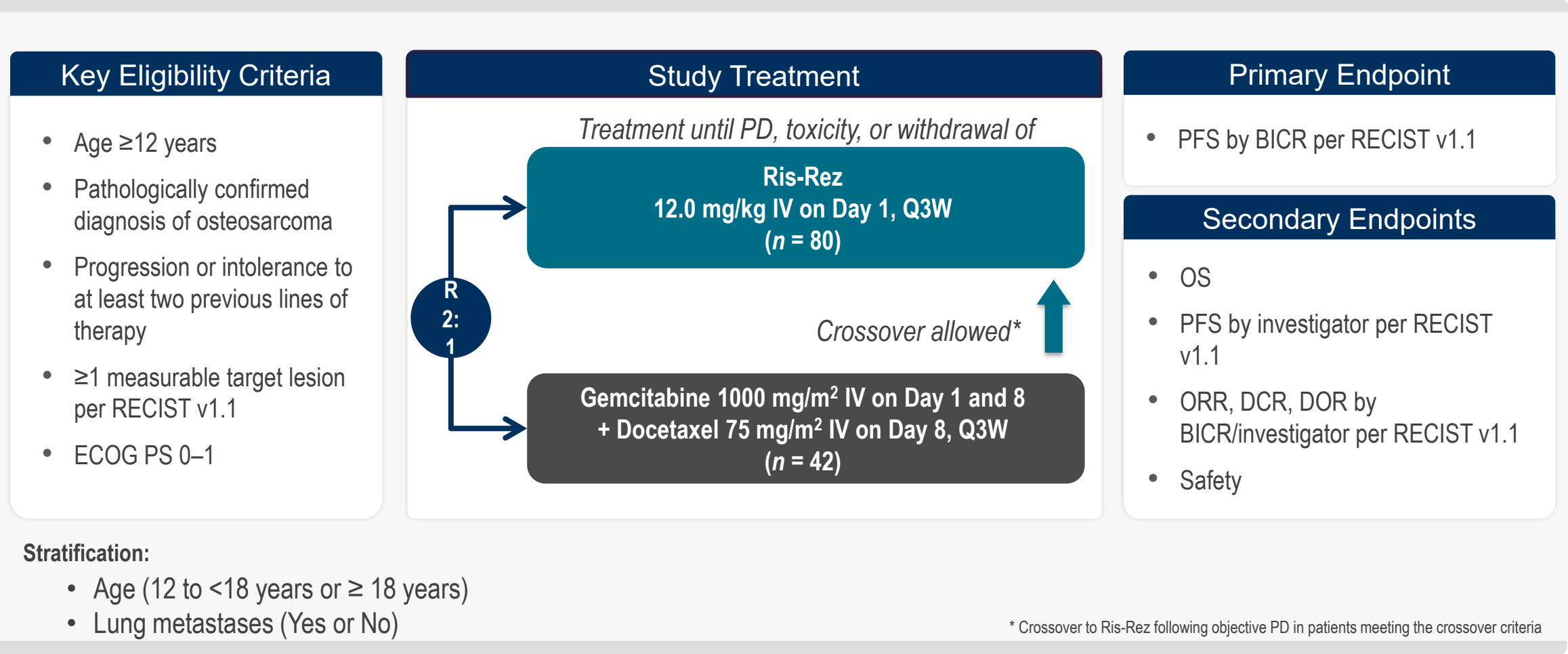
L. Xie¹; W. Yao²; Y. Hua³; W. Luo⁴; C. Tu⁵; J. Wang⁶; J. Chen⁷; B. Li⁸; D. Zhu⁹; X. Li¹⁰; Y. Xiao¹¹; J. Ma¹²; H. Hu¹³; M. Fang¹⁴; H. Wang¹⁵; Q. Liu¹⁵; Y. Jin¹⁵; X. Zhang¹⁵; X. Niu¹⁶; X. Tang¹

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Presented by: Lu Xie, MD

Musculoskeletal Tumor Center, Peking University
People's Hospital (PKUPH), Beijing, China
Madrid, Spain; October 26, 2026

ARTEMIS-011: A Multi-Centre, Open-Label, Randomised, Controlled Phase 3 Study



BICR, blinded independent central review; DCR, disease control rate; DOR, duration of response ECOG PS, Eastern Cooperative Oncology Group performance status; IV, intravenous; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; Q3W, every 3 weeks; R, randomisation; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1; Ris-Rez, risvutag rezetecan

Patient Demographics and Disease Characteristics

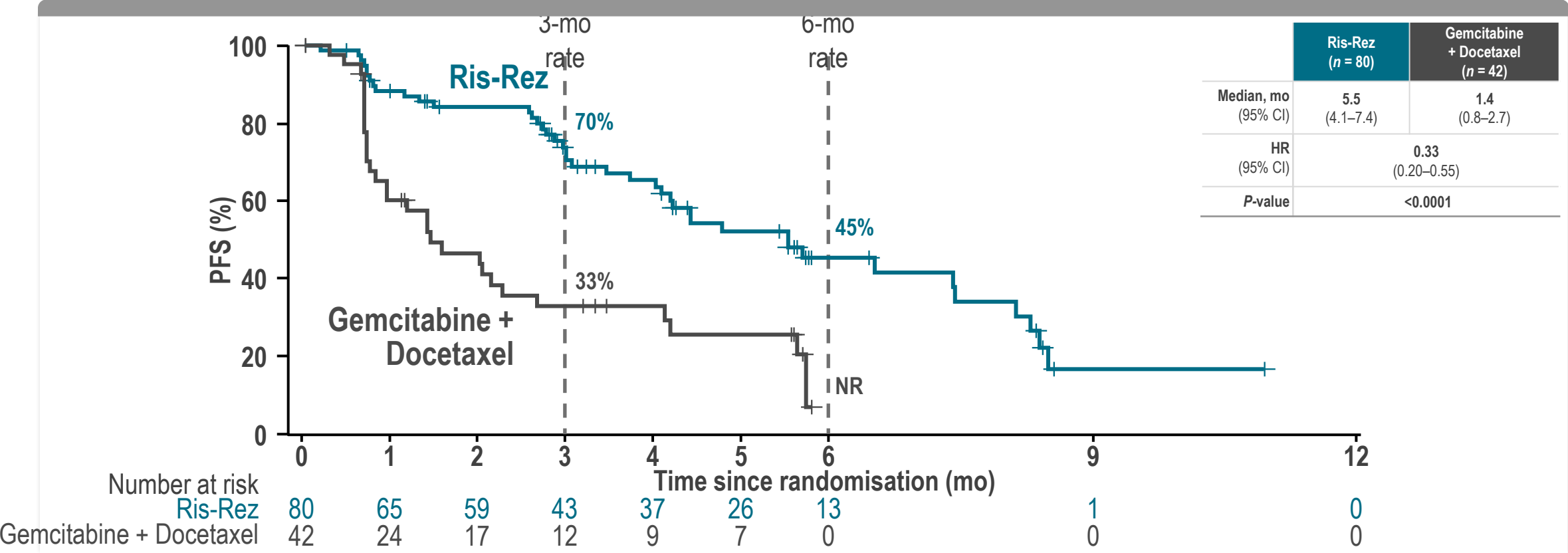
- A total of 122 patients were randomised and received ≥ 1 dose of study drug
- Median follow-up time was 7.1 months

	Ris-Rez (n = 80)	Gemcitabine + Docetaxel (n = 42)
Age		
Median (IQR), years	22.0 (17.5–33.0)	21.0 (17.0–37.0)
12 to <18 years, n (%)	20 (25)	11 (26)
≥ 18 years, n (%)	60 (75)	31 (74)
Male, n (%)	55 (69)	24 (57)
BMI, median (range), kg/m²	22.3 (12.2–36.8)	22.8 (15.1–31.5)
Time from initial diagnosis to randomisation, median (range), mo	23.1 (5.7–116.9)	23.6 (7.0–107.6)
ECOG PS, n (%)		
0	26 (33)	9 (21)
1	54 (68)	33 (79)
Patients with metastasis, n (%)		
Lung metastasis	79 (99)	40 (95)
Liver metastasis	3 (4)	3 (7)
Sum of diameters of target lesions at baseline, mean (SD), mm	74.4 (59)	81.1 (66)
Prior lines of systemic anticancer therapy		
Number of prior lines, median (range)	2.5 (2, 6)	3.0 (2, 5)
Chemotherapy, n (%)	80 (100)	42 (100)
Immunotherapy, n (%)	21 (26)	11 (26)
Targeted therapy, n (%)	55 (69)	33 (79)

BMI, body-mass index; ECOG PS, Eastern Cooperative Oncology Group performance status; IQR, interquartile range; mo, months; Ris-Rez, risvututug rezetecan; SD, standard deviation

Primary Endpoint: BICR-assessed PFS with Ris-Rez vs Gemcitabine + Docetaxel

- At data cutoff date, there were 41 PFS events per BICR (41/80; 51%) in the Ris-Rez arm and 31 (31/42; 74%) in the Gemcitabine + Docetaxel arm
- Ris-Rez demonstrated a **statistically significant and clinically meaningful improvement** in BICR-PFS vs Gemcitabine + Docetaxel



DCO: 17 June 2026.

BICR, blinded independent central review; CI, confidence interval; DCO, data cutoff; HR, hazard ratio; mo, months; NR, not reached; PD, progressive disease; PFS, progression-free survival; Ris-Rez, risvutaturg rezetecan

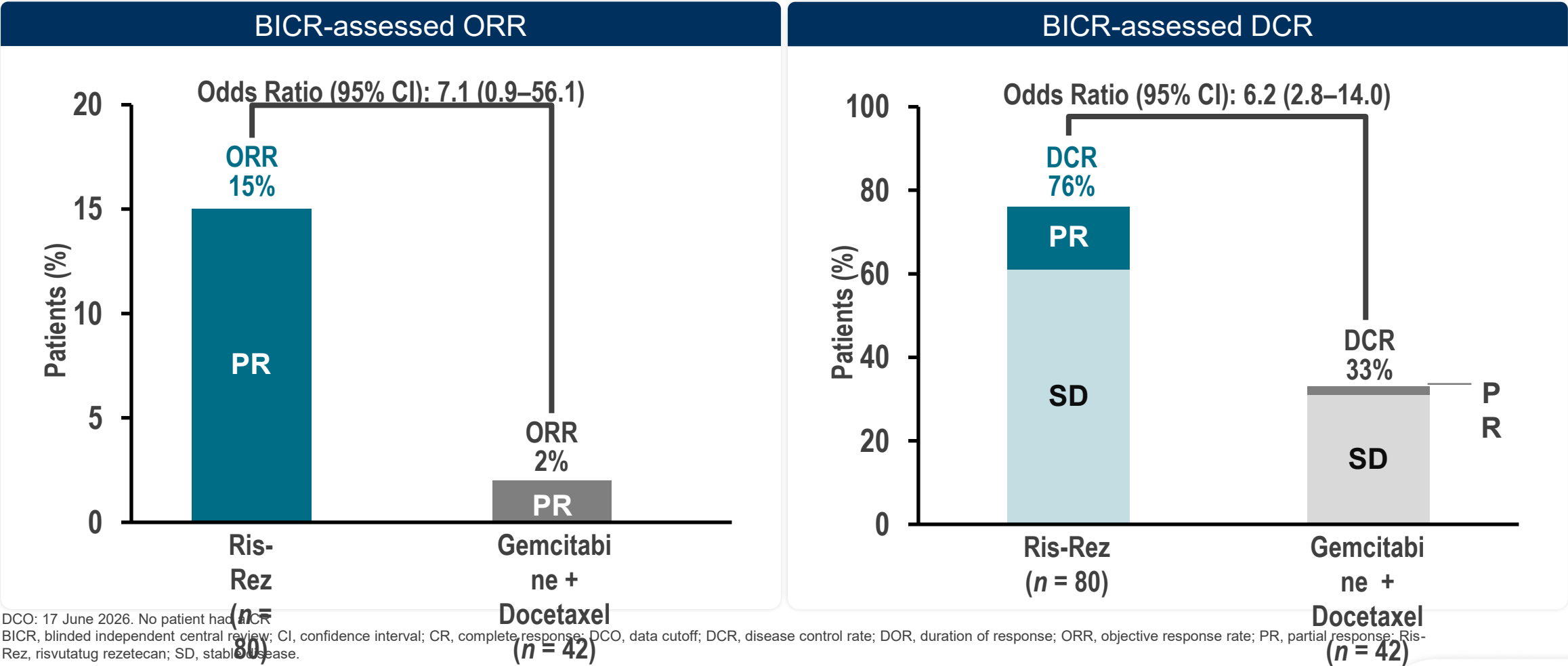
Presented by: Lu Xie, MD, PKUPH

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Tumour Response Assessed by BICR

- BICR-assessed ORR and DCR were markedly higher with Ris-Rez vs Gemcitabine + Docetaxel
- Median DOR by BICR was 7.6 months with Ris-Rez and was not reached in the Gemcitabine + Docetaxel arm (only one patient achieved PR)



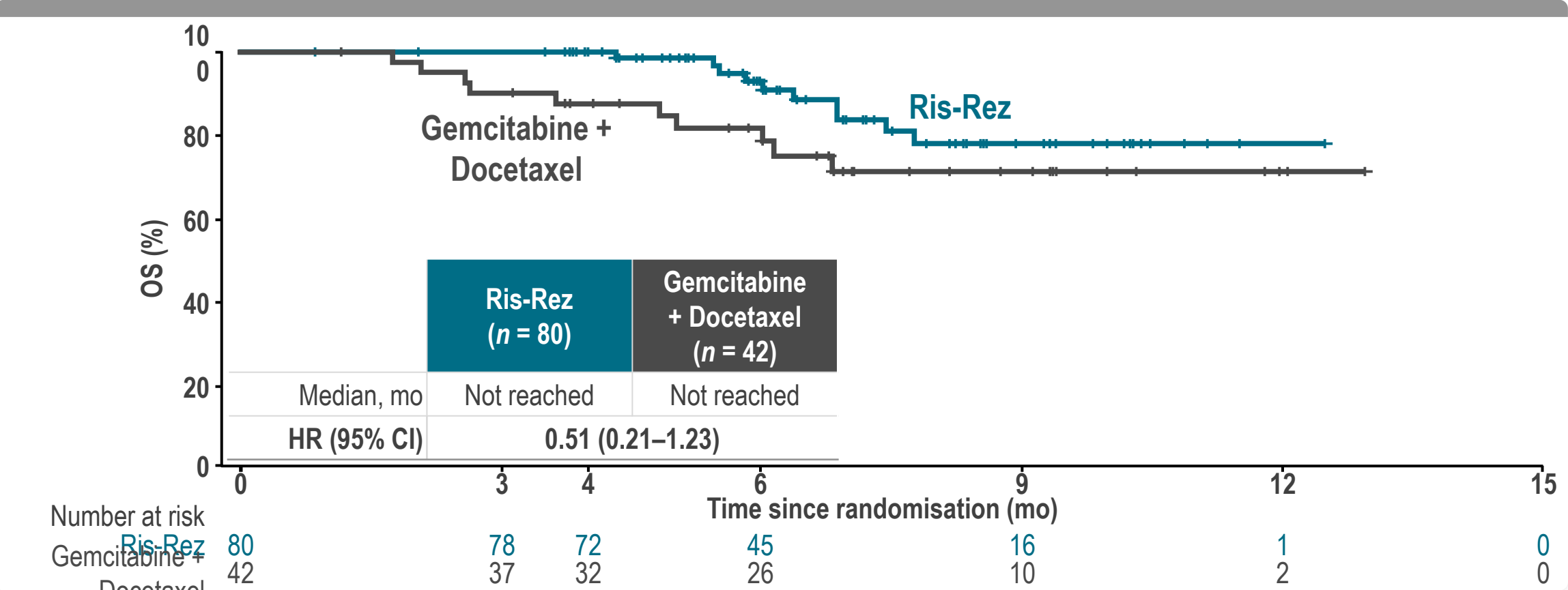
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OS in R/R Osteosarcoma with Ris-Rez vs Gemcitabine + Docetaxel

- OS data were immature but suggested a **favourable trend towards an OS benefit** with Ris-Rez
- 10 events had occurred in each arm: 13% with Ris-Rez and 24% with Gemcitabine + Docetaxel
- 17 patients* in the Gemcitabine + Docetaxel arm crossed over to Ris-Rez following PD



DCO: 17 June 2026. Symbols show censoring. *Crossover criteria were met.
BICR, blinded independent central review; CI, confidence interval; DCO, data cutoff; HR, hazard ratio; mo, month; OS, overall survival; PD, progressive disease; Ris-Rez, risvutaturg rezetecan; R/R, relapsed/refractory

Presented by: Lu Xie, MD, PKUPH

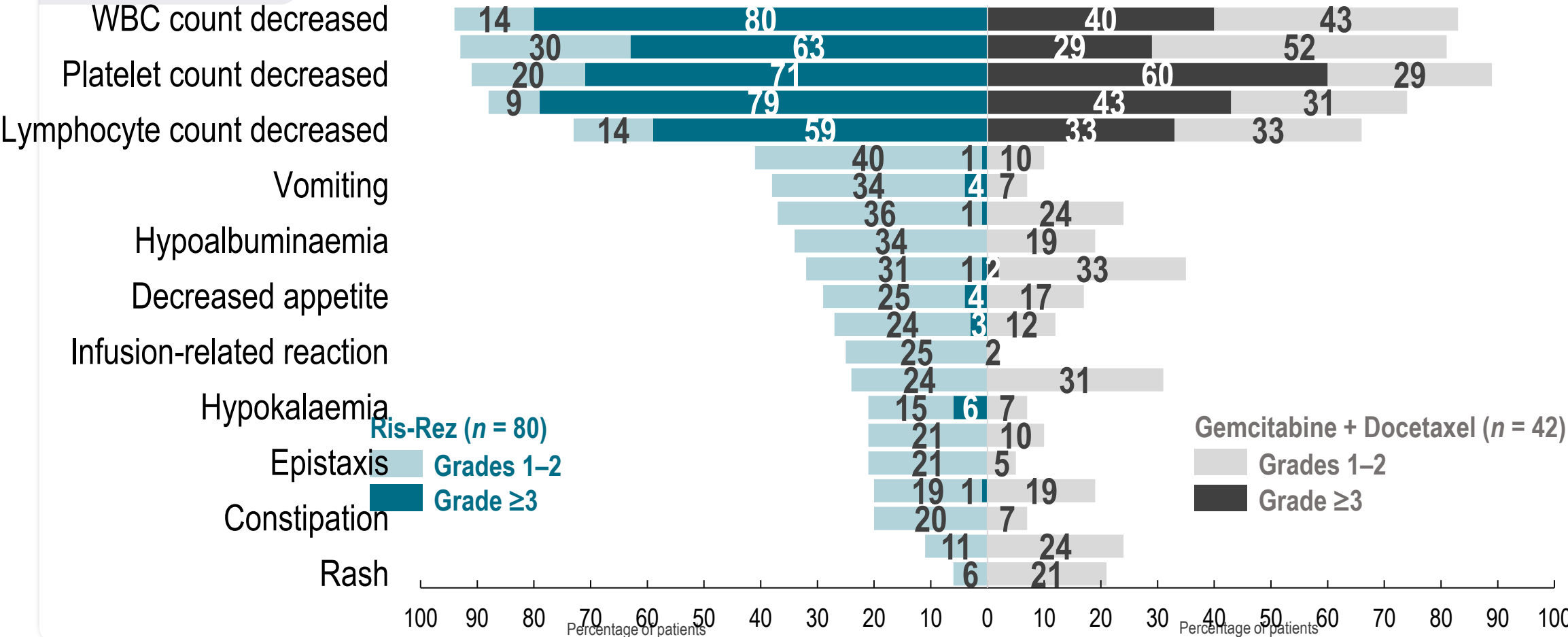
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Safety Profile

TRAEs reported in ≥20% of patients (in either treatment arm)

Incidence, %



ALT, alanine aminotransferase; AST, aspartate aminotransferase; GGT, gamma glutamyltransferase; LDH, lactate dehydrogenase; Ris-Rez, risvutag rezetecan; R/R, relapsed/refractory; TRAE, treatment-related adverse event; WBC, white blood cell

Presented by: Lu Xie, MD, PKUPH

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Mocertatug Rezetecan (Mo-Rez) in Patients With Platinum-Resistant Ovarian Cancer (PROC): Updated Results With Longer Follow-Up From the Global BEHOLD-1 Study

Vanda Salutari¹, Stephanie Lheureux², Myong Cheol Lim³, Isabelle Ray-Coquard⁴, Marloes G van Dongen⁵, William McKean⁶, Jung-Yun Lee⁷, Victor Moreno⁸, Rowan E Miller^{9,10}, Toon Van Gorp¹¹, Jean-Sébastien Frenel¹², Joo Ern Ang¹³, Lisa Liu Burström¹⁴, Katriina Jalkanen¹⁵, Shruti D Shah¹⁶, Evi Bakirtzi¹⁷, Sybil Zildjian¹⁸, Morrys C Kaisermann¹⁹, Ana Oaknin²⁰

¹Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; ²University Health Network, Princess Margaret Cancer Centre, Toronto, ON, Canada; ³Center for Gynecologic Cancer, National Cancer Center, Goyang-si, Republic of Korea; ⁴Centre Léon Bérard, Université Claude Bernard Lyon 1, Lyon, France; ⁵The Netherlands Cancer Institute, Amsterdam, The Netherlands; ⁶The START Center for Cancer Research, Mountain Region, West Valley City, UT, USA; ⁷Yonsei University College of Medicine, Seoul, Republic of Korea; ⁸START Madrid-FJD, Hospital Fundación Jiménez Díaz, Madrid, Spain; ⁹University College London Hospitals NHS Foundation Trust, London, UK; ¹⁰St Bartholomew's Hospital, London, UK; ¹¹Division of Gynaecological Oncology, University Hospital Leuven and KU Leuven, Leuven Cancer Institute, Leuven, Belgium; ¹²Institut de Cancérologie de L'ouest, Site René Gauducheau, Saint-Herblain, France; ¹³Department of Oncology, Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK; ¹⁴Theme Cancer, Karolinska University Hospital, Stockholm, Sweden; ¹⁵Helsinki University Hospital, Comprehensive Cancer Center, Helsinki, Finland; ¹⁶CMPS Oncology, GSK, Waltham, MA, USA; ¹⁷Oncology Statistics, GSK, London, UK; ¹⁸Oncology Clinical Development, GSK, Waltham, MA, USA; ¹⁹Oncology Clinical Development, GSK, Philadelphia, PA, USA; ²⁰Medical Oncology Department, Hospital Universitario Puerta de Hierro Majadahonda, Madrid, Spain

BEHOLD-1 is a two-part, open-label Phase 1 study

Eligibility Criteria

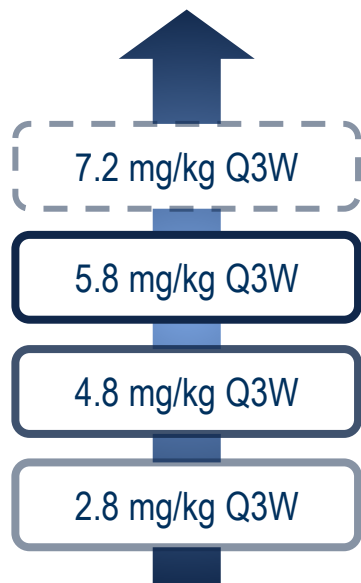
- Aged ≥18 years
- Histologically confirmed advanced solid tumour
- ECOG PS 0–2
- ≥1 measurable target lesion per RECIST v1.1
- No prior B7-H4 therapy

Phase 1b only:

- 1–3 prior LOT[‡]
- No prior TOP1i

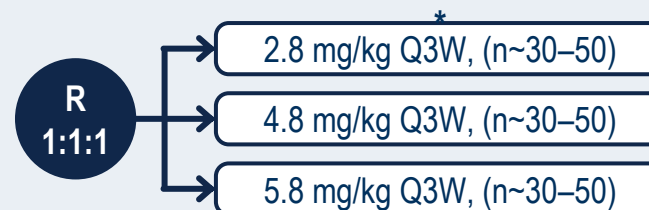
Phase 1a Dose Escalation

Advanced solid tumours

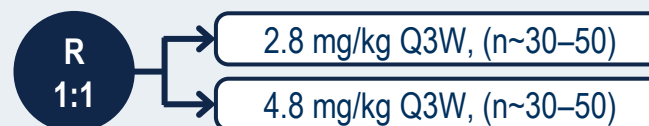


Phase 1b Dose Optimisation/Expansion

PROC^{*}



Advanced/recurrent EC



Key Endpoints

Primary: cORR assessed by INV according to RECIST v1.1

Secondary: DoR and PFS assessed by INV according to RECIST v1.1, safety

Expansion phase at Mo-Rez 5.8 mg/kg Q3W is ongoing[†]

^{*}For patients with advanced high-grade serous/endometrioid ovarian, primary peritoneal, or fallopian tube cancer. [†]Mo-Rez 5.8 mg/kg Q3W selected as the recommended dose for both PROC and advanced/recurrent EC cohorts. [‡]Current protocol amendment allows for 1–4 prior LOT. B7-H4, B7 homologue 4 protein; cORR, confirmed objective response rate; DoR, duration of response; EC, endometrial cancer; ECOG PS, Eastern Cooperative Oncology Group Performance Status; INV, investigator; LOT, lines of therapy; Mo-Rez, mocertatug rezetecan; PFS, progression-free survival; PROC, platinum-resistant ovarian cancer; Q3W, every 3 weeks; R, randomisation; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1; TOP1i, topoisomerase 1 inhibitor.

Baseline characteristics

PROC	Total (N=136)
Age, median (range), years	60.5 (38, 79)
Race, n (%)	
White / Asian	112 (82) / 23 (17)
Black or African American	1 (<1)
BMI, median (range), kg/m ²	25.8 (16, 50)
ECOG PS, n (%)	
0 / 1 / 2	68 (50) / 67 (49) / 1 (<1)
Histology at diagnosis, n (%)	
High-grade serous carcinoma / serous adenocarcinoma*	134 (99) / 1 (<1)
Endometrioid	1 (<1)
Number of prior LOT, median (range)	2 (1, 5)
Prior LOT, n (%)	
1 / 2 / ≥3†	28 (21) / 58 (43) / 49 (36)
Prior therapies, n (%)	
Bevacizumab	105 (77)
PARP inhibitor	79 (58)
FRα ADC	6 (4)
B7-H4-evaluable tumour sample, n	122
B7-H4 tumour membrane positivity, n (%)‡	118 (97)

36% of patients received >2 prior LOT

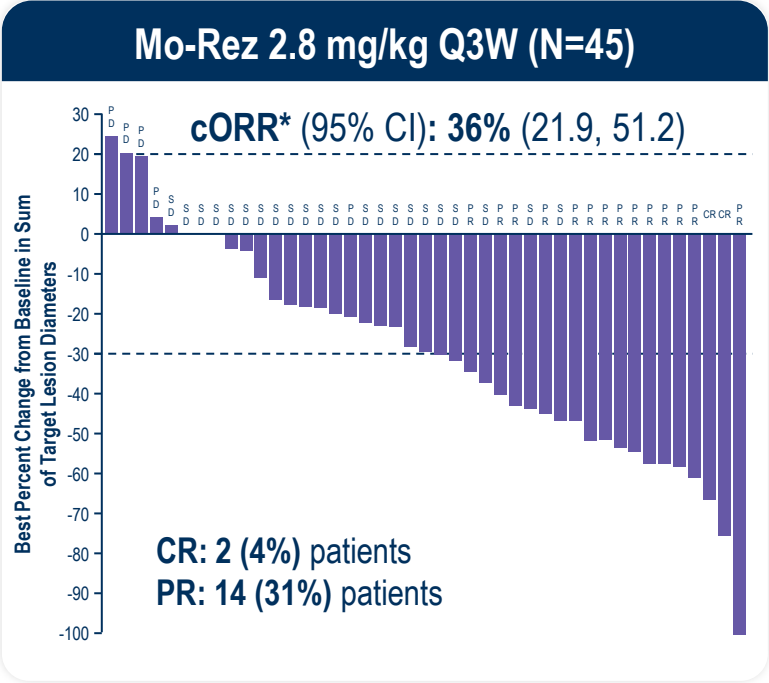
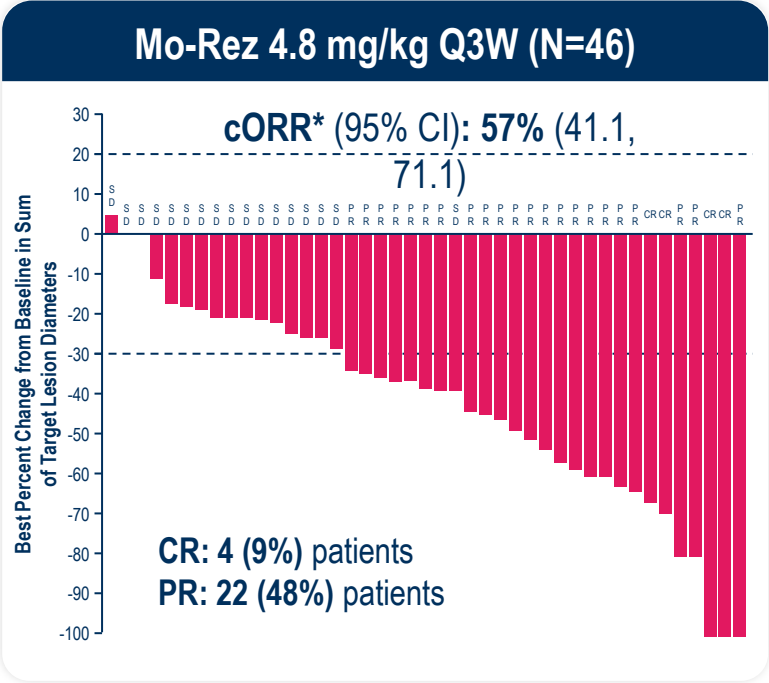
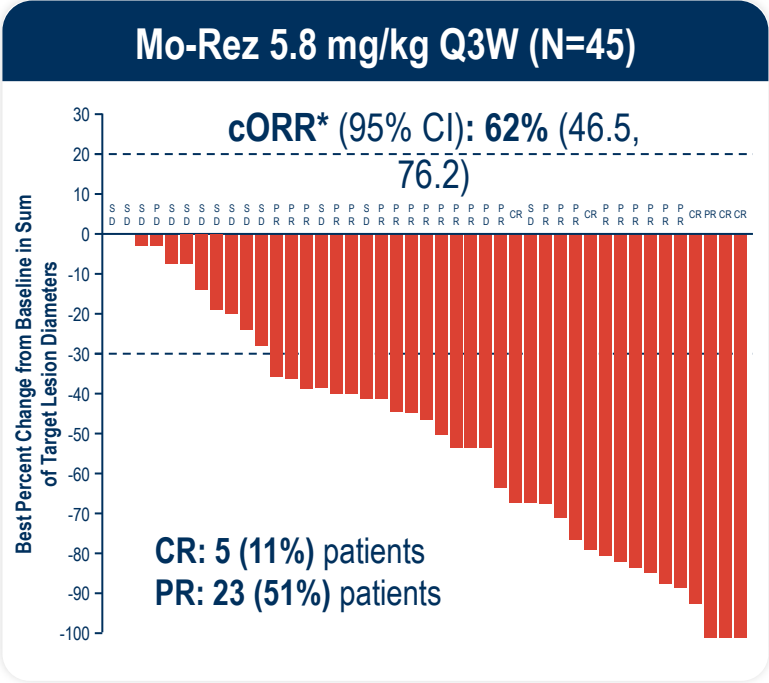
Most patients received prior bevacizumab or PARPi

97% of evaluable patients showed B7-H4 tumour membrane positivity

Mo-Rez was associated with rapid and deep responses at the 5.8 mg/kg Q3W dose



Scan Me



	Mo-Rez dose, mg/kg Q3W		
	2.8	4.8	5.8
mTTR, days (IQR)	80.0 (42.5, 85.5)	80.0 (43.0, 121.0)	42.0 (41.5, 50.5)
mDpR [†] , % (IQR)	-28.6 (-51.1, -11.1)	-38.2 (-60.0, -21.4)	-45.5 (-78.3, -27.3)



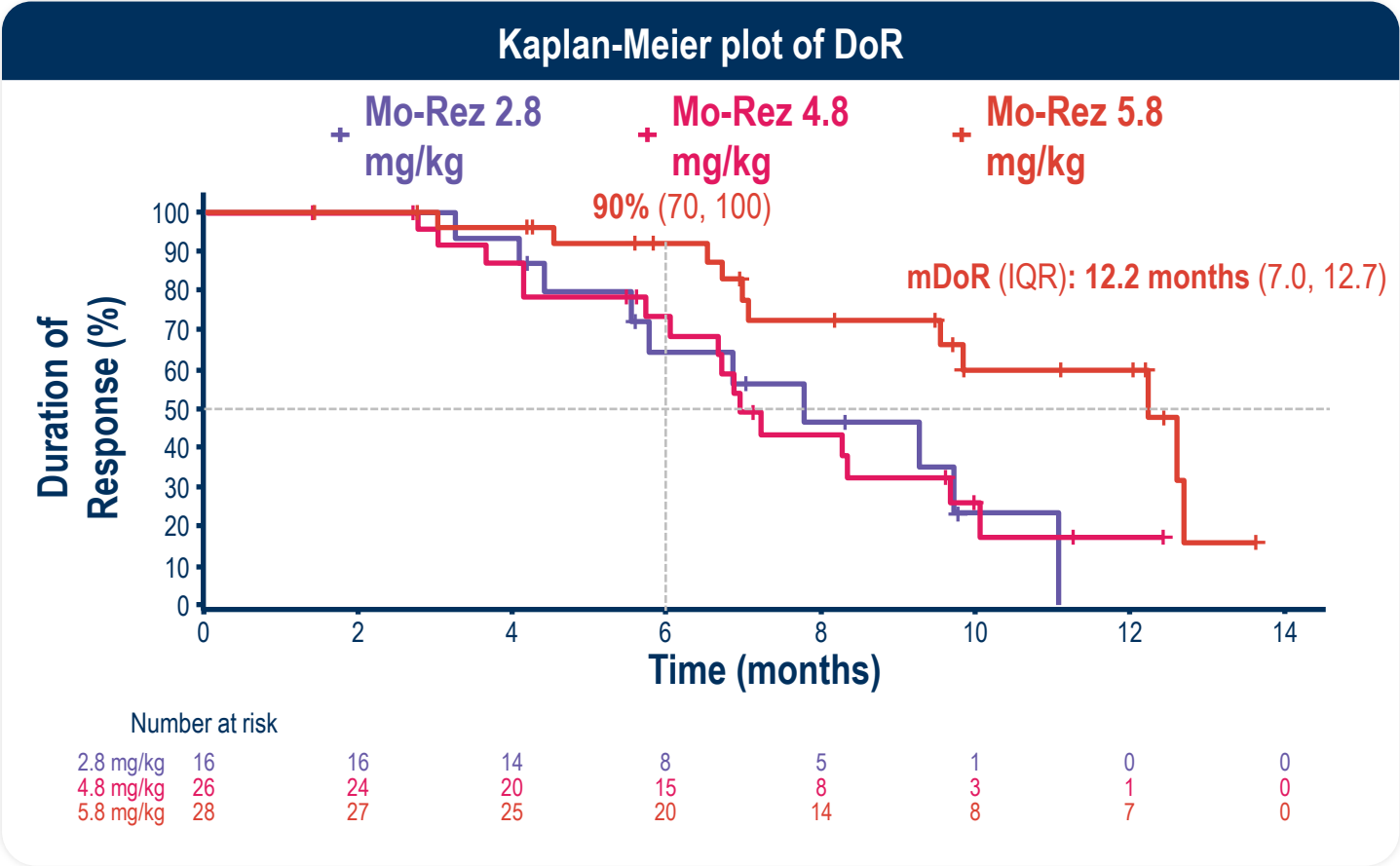
Responses were observed across a range of B7-H4 expression levels (scan QR code)

DCO: 30 June 2026. Efficacy analysed in all randomised patients. Waterfall plots show confirmed best overall response for patients with at least one post-baseline tumour assessment. *Two out of four patients who received prior mirvetuximab soravtansine had a confirmed objective response to Mo-Rez (all dose levels). [†]DpR refers to best change from baseline in SLD of target lesions. B7-H4, B7 homologue 4 protein; CI, confidence interval; cORR, confirmed objective response rate; CR, complete response; DCO, data cut-off; IQR, interquartile range; mDpR, median depth of response; Mo-Rez, mocretatug rezetecan; mTTR, median time to response; PD, progressive disease; PR, partial response; Q3W, every 3 weeks; SD, stable disease; SLD, sum of lesion diameters.

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Mo-Rez was associated with durable responses at 5.8 mg/kg Q3W

	Mo-Rez dose, mg/kg Q3W		
	2.8 (N=45)	4.8 (N=46)	5.8 (N=45)
Events, n (%)	10 (63%)	16 (62%)	11 (39%)
Median DoR, months (IQR)*	7.8 (4.4, NE)	6.9 (5.7, 9.7)	12.2 (7.0, 12.7)
Probability of DoR at 6 months, % (95% CI)†	60% (30, 80)	70% (50, 90)	90% (70, 100)

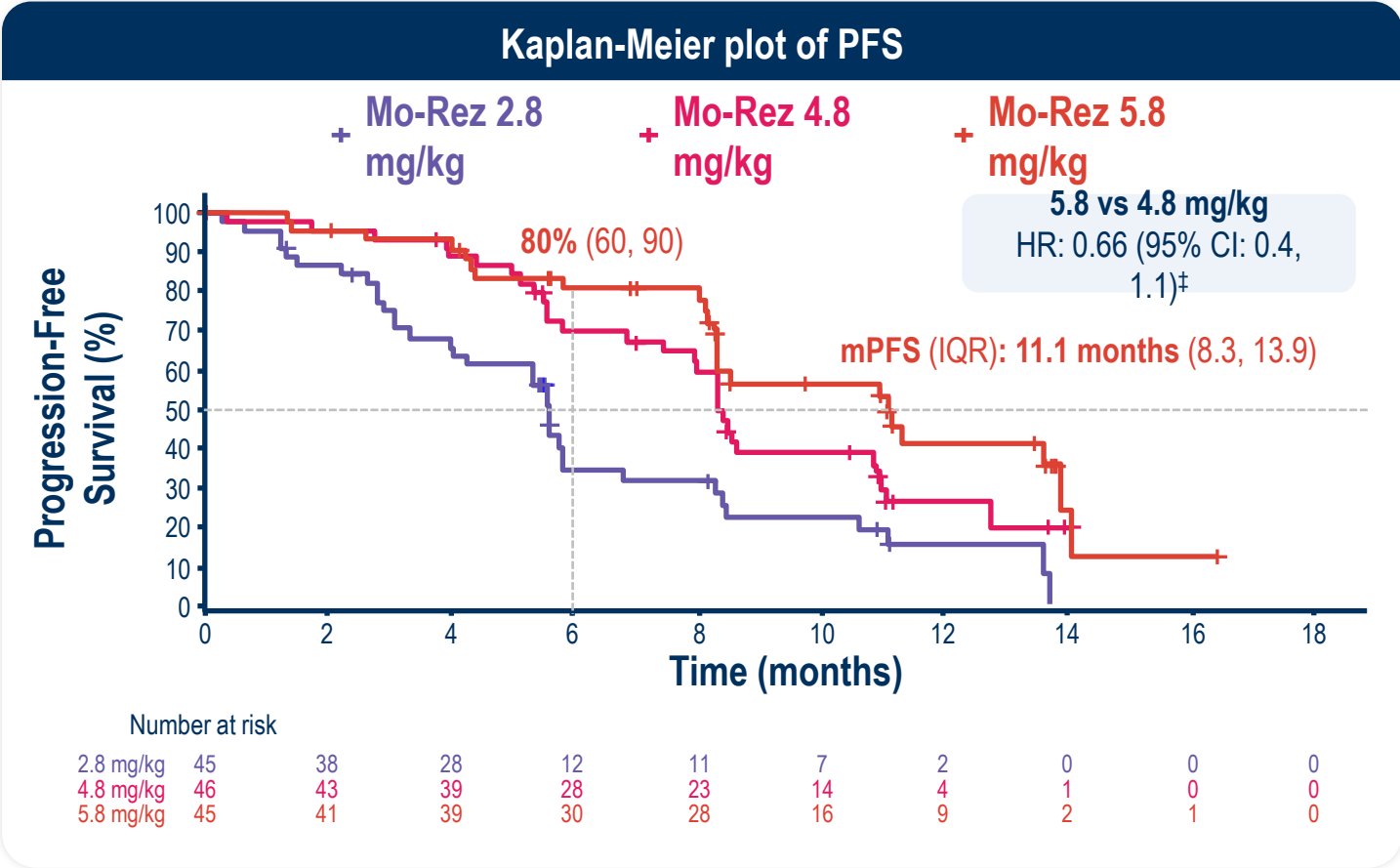


Median (IQR) follow-up: 13.4 (10.4, 13.9) months

DCO: 30 June 2026. Efficacy analysed in all randomised patients. *Estimation was conducted using the Kaplan-Meier method and CIs were estimated using the Brookmeyer-Crowley method. †Estimation was conducted using the Kaplan-Meier method and CIs were calculated using Greenwood's formula for the standard errors, with a log-log transformation to derive the bounds. CI, confidence interval; DCO, data cut-off; DoR, duration of response; IQR, interquartile range; mDoR, median duration of response; Mo-Rez, mocertatug rezetecan; NE, not estimable; Q3W, every 3 weeks.

PFS was longest at the 5.8 mg/kg Q3W Mo-Rez dose

	Mo-Rez dose, mg/kg Q3W		
	2.8 (N=45)	4.8 (N=46)	5.8 (N=45)
Events, n (%)	35 (78%)	30 (65%)	23 (51%)
Median PFS, months (IQR)*	5.6 (4.0, 5.8)	8.3 (7.4, 10.9)	11.1 (8.3, 13.9)
Probability of PFS at 6 months, % (95% CI)†	30% (20, 50)	70% (50, 80)	80% (60, 90)



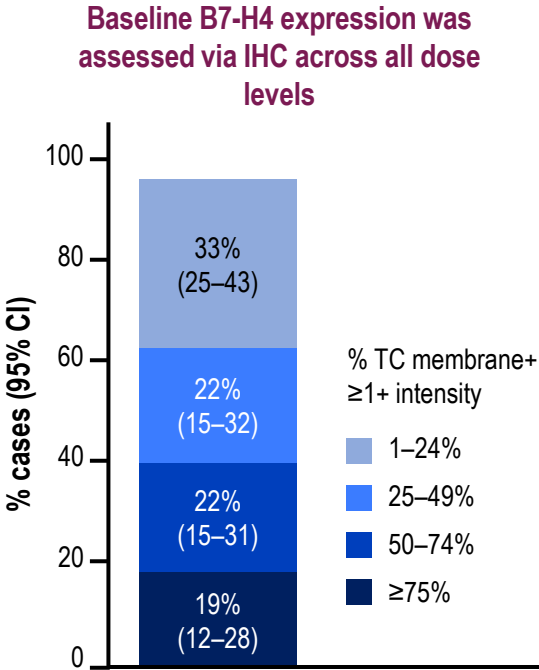
Median (IQR) follow-up: 13.4 (10.4, 13.9) months

DCO: 30 June 2026. Efficacy analysed in all randomised patients. *Estimation was conducted by using the Kaplan-Meier method and CIs estimated using the Brookmeyer-Crowley method. †Estimation was conducted by using the Kaplan-Meier method and CIs calculated using Greenwood's formula for the standard errors, with a log-log transformation to derive the bounds. ‡HR and 95% CIs were estimated using a Cox proportional hazards model with Efron's method for tie handling and randomised treatment arm (dose level) as the single covariate. CI, confidence interval; DCO, data cut-off; HR, hazard ratio; IQR, interquartile range; Mo-Rez, mocertatug rezetecan; PFS, progression-free survival; Q3W, every 3 weeks.

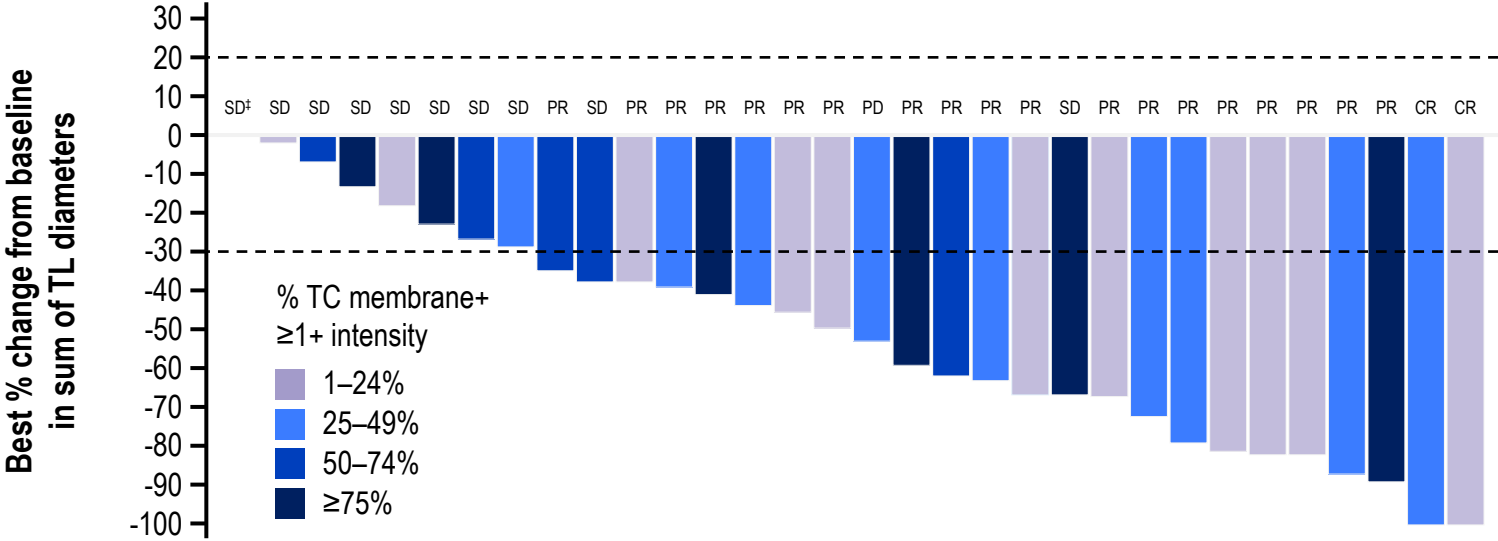
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B7-H4 is widely expressed in PROC, enabling tumour selective payload delivery

96% of patients with PROC had B7-H4⁺ tumours (n=107/111)*



Responses were observed across a range of B7-H4 expression levels at the 5.8 mg/kg dose (n=34; data cut-off Nov 2025)[†]

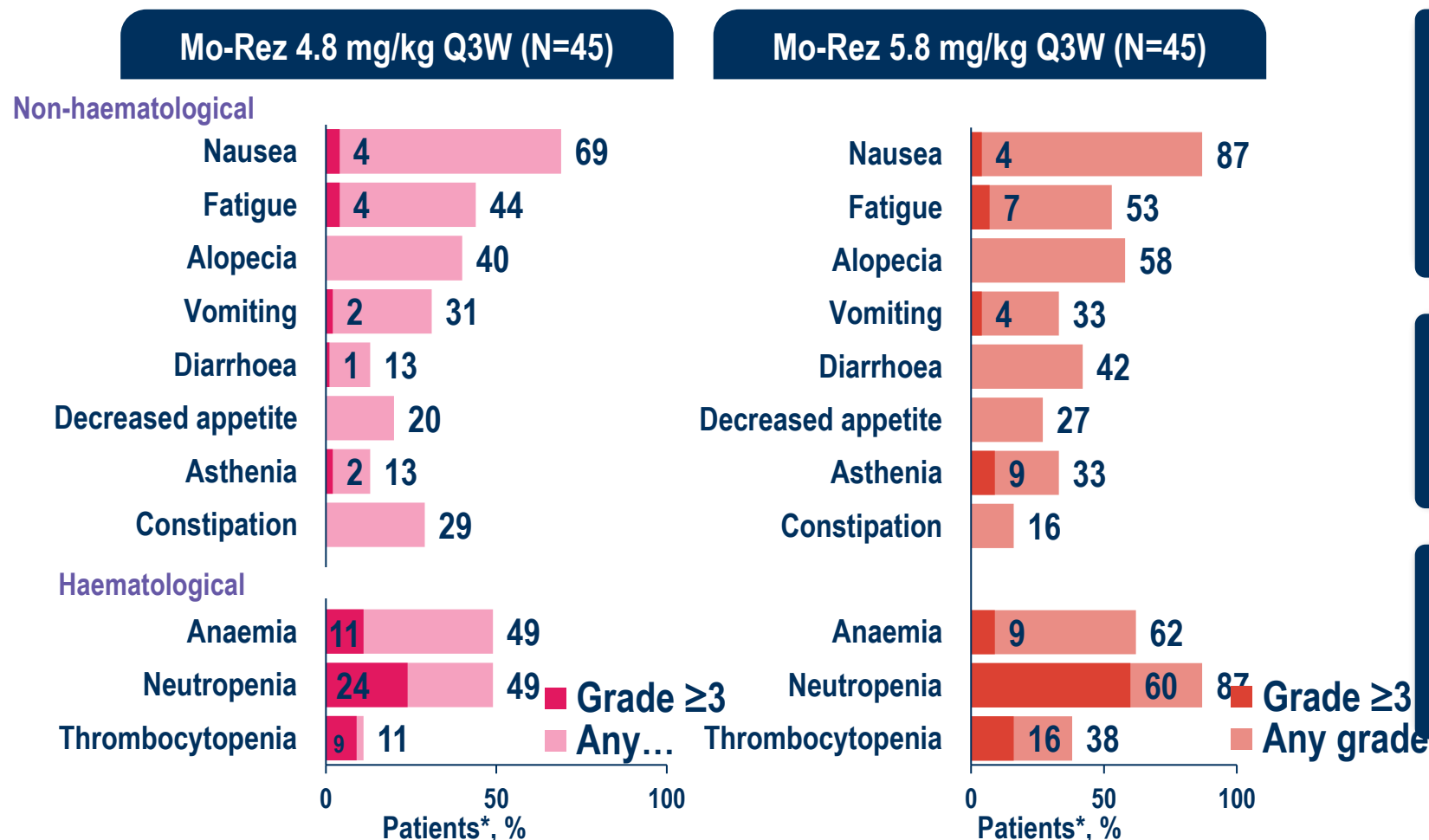


*Baseline TC B7-H4 expression levels in patients with PROC enrolled in BEHOLD Phase 1b and with evaluable tissue samples. [†]Waterfall plot shows best change for patients with baseline, and at least one post-baseline, tumour assessment receiving Mo-Rez 5.8 mg/kg by the percentage of B7-H4 TC membrane+. [‡]TC membrane+ ≥1+ intensity of <25%.
B7-H4, B7 homologue 4 protein; CI, confidence interval; cORR, confirmed objective response rate; CR, complete response; IHC, immunohistochemistry; Mo-Rez, mocertatug rezetecan; PD, progressive disease; PR, partial response; PRO, platinum-resistant ovarian cancer; SD, stable disease; TC, tumour cell; TL, target lesion.

The most common treatment-related AEs were gastrointestinal and haematological



Scan Me



ILD/pneumonitis occurred in 9 patients (7%): 8 at 4.8 mg/kg and 1 (2%) at the 5.8 mg/kg dose[†]

- 8 of 9 events were Grade 1–2

Primary G-CSF prophylaxis was used in 8% of patients at the 5.8 mg/kg dose[‡]

G-CSF prophylaxis is now strongly recommended across the BEHOLD study programme

DCO: 30 June 2026. Scan QR code for data on Mo-Rez 2.8 mg/kg dose. Safety analysis set included patients who received ≥1 dose of study treatment. AEs assessed using MedDRA 29.0 and CTCAE 5.0. *TRAEs occurring in ≥15% of patients in the PROC cohort are shown. †These AESI were investigator-assessed, not adjudicated, and based on a search of the Interstitial Lung Disease Standardised Medical Dictionary for Regulatory Activities Query (Narrow). ‡Including PROC and EC patients receiving Mo-Rez 5.8 mg/kg Q3W. Primary prophylactic therapy with G-CSF defined as that administered within four days of the first Mo-Rez dose during Cycle 1 (GSK data on file). Febrile neutropenia occurred in three patients (7%) at 5.8 mg/kg dose (all Grade 3). AE, adverse event; AESI, AE of special interest; CTCAE, Common Terminology Criteria for Adverse Events; DCO, data cut-off; EC, endometrial cancer; G-CSF, granulocyte colony-stimulating factor; ILD, interstitial lung disease; MedDRA, Medical Dictionary for Regulatory Activities; Mo-Rez, mocertatug rezetecan; PROC, platinum-resistant ovarian cancer; Q3W, every 3 weeks; TRAE, treatment-related AE.

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Mo-Rez is being investigated in five global Phase 3 trials spanning ovarian and endometrial cancer



Mo-Rez vs SoC in 2L+ PROC

NCT07286266 | GOG-3132 | ENGOT-ov98 | APGOT-OV24



Scan Me



Mo-Rez + BEV vs CT + BEV in PSOC

NCT07684612 | GOG-3136 | ENGOT-ov99 | APGOT-OV19



Mo-Rez ± BEV vs active observation ± BEV as 1L maintenance in non-HRd OC

NCT07694427 | ENGOT-ov105 | GOG-3135 | APGOT-OV20



Mo-Rez vs CT in 2L+ advanced or recurrent EC

NCT07286331 | ENGOT-en34 | GOG-3131 | APGOT-EN4



Scan Me



Mo-Rez + anti-PD-1 vs anti-PD-1 as 1L maintenance in MMRp EC

NCT07684599 | ENGOT-en33 | GOG-3130 | APGOT-EN5

Clinical Complete Response with Dostarlimab Monotherapy in dMMR/MSI-H Locally Advanced Rectal Cancer: First Results from the Global Registrational AZUR-1 Trial

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of Valencia, Valencia, Spain; ¹⁸GSK, Baar, Switzerland; ¹⁹GSK, London, UK;

²⁰University Medical Center Utrecht, Utrecht University, Utrecht, The Netherlands



Background

Locally advanced rectal cancer (LARC) has historically been treated with multimodal SOC^{1,2}

- CRT and surgical approaches are associated with substantial toxicity, morbidity, and QoL burden^{3,4}
- There has been growing interest in organ preservation strategies^{5,6}
- While data are limited, cCR rates post-SOC in dMMR/MSI-H locally advanced rectal cancer are approximately 20–25%^{7–9}

Dostarlimab, a PD-1 inhibitor, has demonstrated compelling durable responses as monotherapy in patients with dMMR/MSI-H locally advanced rectal cancer in a single-centre study, supporting a non-operative management (NOM) approach that may also allow patients to avoid chemotherapy and radiation¹⁰

AZUR-1 (NCT05723562) is the first global registrational study to evaluate the clinical benefit of dostarlimab monotherapy in patients with dMMR/MSI-H locally advanced rectal cancer¹¹

We report interim results from the AZUR-1 trial, focusing on clinical complete response (cCR) and safety outcomes

CRT, chemoradiotherapy; dMMR, mismatch repair deficient; MSI-H, microsatellite instability high; PD-1, programmed cell death protein 1; QoL, quality of life; SOC, standard of care; TNT, total neoadjuvant therapy. 1. Conroy T, et al. Lancet. 2021;22(5):702-15; 2. Bahadoer RR, et al. Lancet Oncol. 2021;22(1):29-42; 3. Conces ML, et al. Curr Oncol. 2024;31(1):366–382; 4. Wyatt J, et al. Clin Oncol. 2023;35(2):117–123; 5. Williams H, et al. Front Oncol. 2024;12:1477510; 6. Cercek A, et al. NEJM. 2022;386(25):2362–2378; 7. Audisio A, et al. Jama Oncol. 2025;11(9):1045–1054; 8. Habr-Gama A, et al. Ann Surg. 2004;240(4):711–717; 9. Lunenberg RA, et al. Int J Cancer. 2025;158(4):963–976; 10. Cercek A, et al. NEJM. 2025;392(23):2297–2308; 11. Cercek A, et al. Clin Colorectal Cancer. 2025;24(2):325-330.

Baseline characteristics

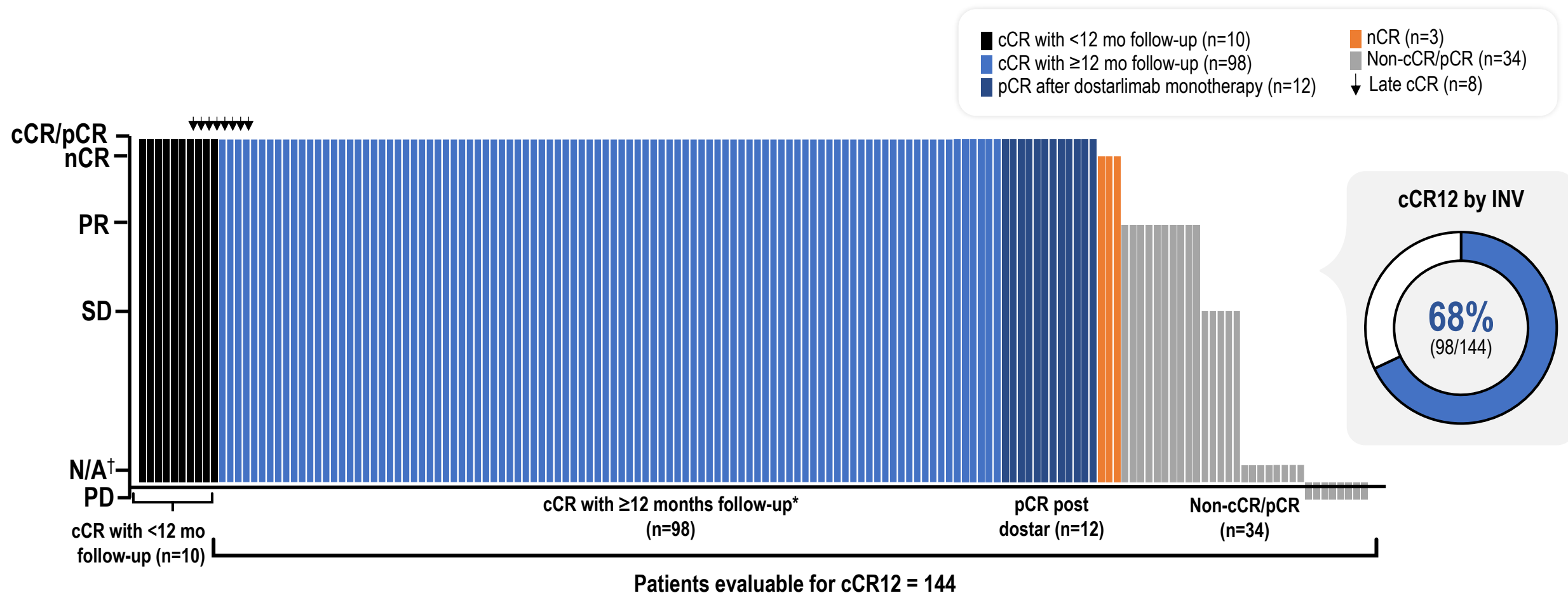
Dostarlimab monotherapy (N=154)	
Age, median (range), years	61.5 (23–92)
≥65, n (%)	65 (42)
Sex, n (%)	
Male	95 (62)
Female	59 (38)
ECOG performance status, n (%)	
0	109 (71)
1	45 (29)
dMMR/MSI-H status, n (%)	
dMMR	138 (90)
MSI-H	16 (10)
Lynch syndrome, n (%)	
Yes	35 (23)
No	18 (12)
Not tested	101 (66)

Dostarlimab monotherapy (N=154)	
Disease stage at screening, n (%)	
Stage II	22 (14)
Stage III	132 (86)
Clinical tumour stage, n (%)	
T1–T2	14 (9)
T3	100 (65)
T4	40 (26)
Clinical node stage positive, n (%)	132 (86)
Tumour location [†] , n (%)	
High	24 (16)
Middle	67 (44)
Low	62 (40)
Unknown	1 (<1)
Mucinous tumour [‡] , n (%)	
Yes	23 (15)
No	131 (85)

DCO 20 Apr 2026. *Data de-identified for demographic variables if n≤10. [†]Tumour location was determined by the distance from interior border primary tumour to anal verge (cm) based on imaging. High, middle, and low are >10–15 cm, >5–10 cm, and 0–5 cm from anal margin;

[‡]Mucinous tumour defined as >50% mucin within the tumour, determined by imaging. dMMR, mismatch repair deficient; ECOG, Eastern Cooperative Oncology Group; MSI-H, microsatellite instability-high

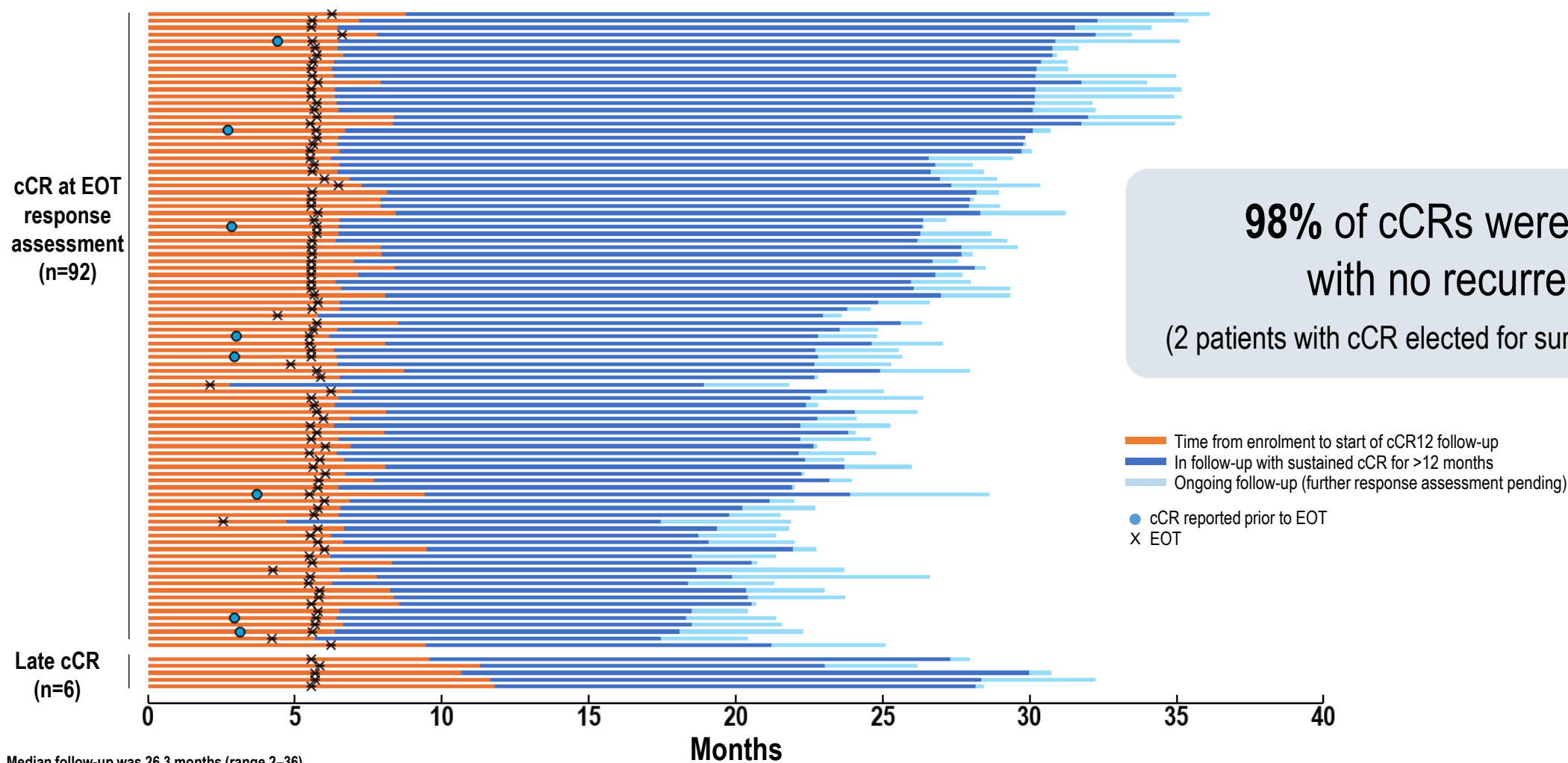
High rate of cCR12 observed with dostarlimab alone



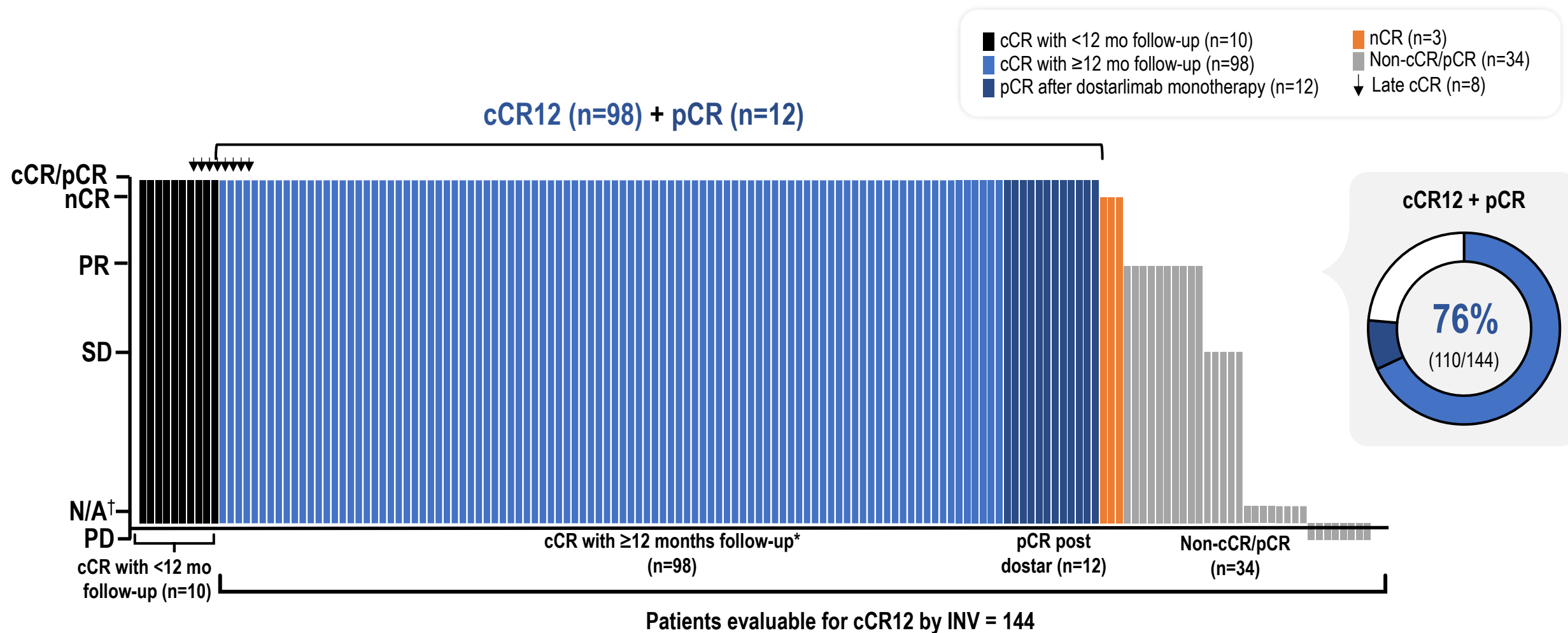
*Sufficient follow-up for cCR12 analyses required 12 months of follow-up and adequate disease assessments according to the scheduled assessment plan (i.e., a patient with a cCR may have completed 12 months of follow-up but would still not be cCR12-evaluable if the required disease assessments were not performed); †Patients who were not evaluable (n=4) have been pooled with those who were N/A (n=6): four patients did not reach end of treatment response assessment and did not initiate SoC treatment; six patients did not undergo end of treatment response assessment but were recorded as continuing on study and received SoC. cCR, clinical complete response; N/A, not available; nCR, near complete response; pCR, pathologic complete response; PD, progressive disease; PR, partial response; SD, stable disease.

Durable responses were observed in patients who achieved cCR

Patients achieving cCR12 (INV) after dostarlimab alone (n=98)



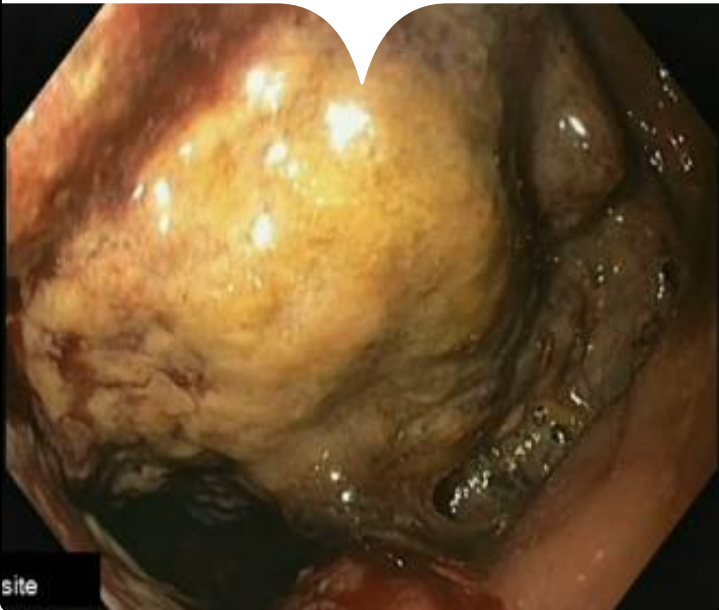
cCR12 + pCR shows high overall benefit of dostarlimab alone



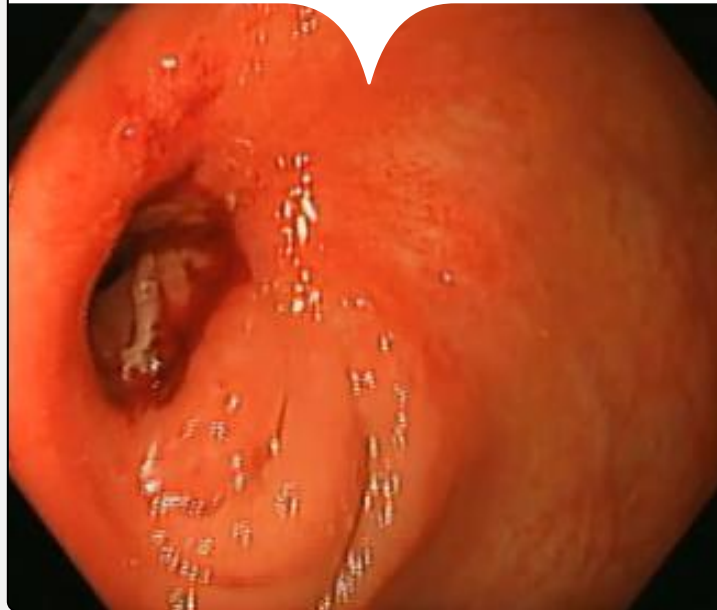
*No subsequent systemic treatment or radiotherapy after completing dostarlimab; †Patients who were not evaluable (n=4) have been pooled with those who were N/A (n=6): four patients did not reach end of treatment response assessment and did not initiate SoC treatment; six patients did not undergo end of treatment response assessment but were recorded as continuing on study and received SoC. cCR, clinical complete response; iCR, incomplete response; nCR, near complete response; NE, not evaluable; ORR, overall response rate; pCR, pathologic complete response; PD, progressive disease; PR, partial response; SD, stable disease.

Image of complete response after Dostarlimab monotherapy
in LA dMMR/MSI-H rectal cancer

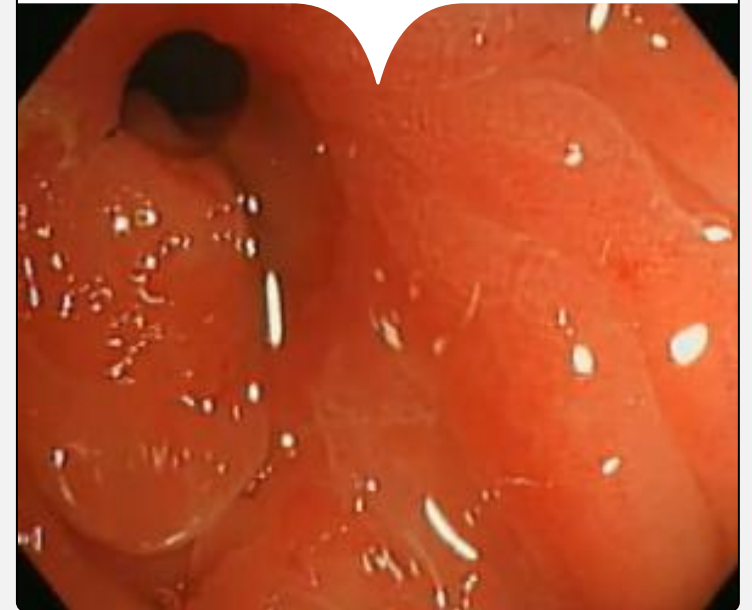
Before
Dostarlimab



Baseline evaluation after
Dostarlimab completion



2nd follow-up after
Dostarlimab completion



Safety profile consistent with prior studies of dostarlimab

Dostarlimab median number of cycles 9 (range 2–9) N=154

AEs (≥10% of patients)	Gr1–2	≥Gr3
Any dostarlimab-related AE, n (%)	98 (64)	15 (10)
Pruritus	21 (14)	0
Hypothyroidism	19 (12)	0
Fatigue	16 (10)	1 (<1)

Immune-mediated AEs (≥2% of patients)	Gr1–2	≥Gr3
Any immune-mediated AE, n (%)	32 (21)	4 (3) [¶]
Hypothyroidism	12 (8)	0
Arthralgia	3 (2)	0
Hyperthyroidism	3 (2)	0

SAEs*	Any causality	Dostarlimab related [†]
Any treatment emergent SAE, n (%)	31 (20)	8 (5)
SAEs of clinical interest		
Intestinal obstruction [‡]	3 (2)	0
Rectal stenosis	2 (1)	0
Intestinal perforation [§]	2 (1)	0

Among adverse events related to dostarlimab:

- 3 (2%) patients discontinued treatment^{¶¶}
- No fatal AEs

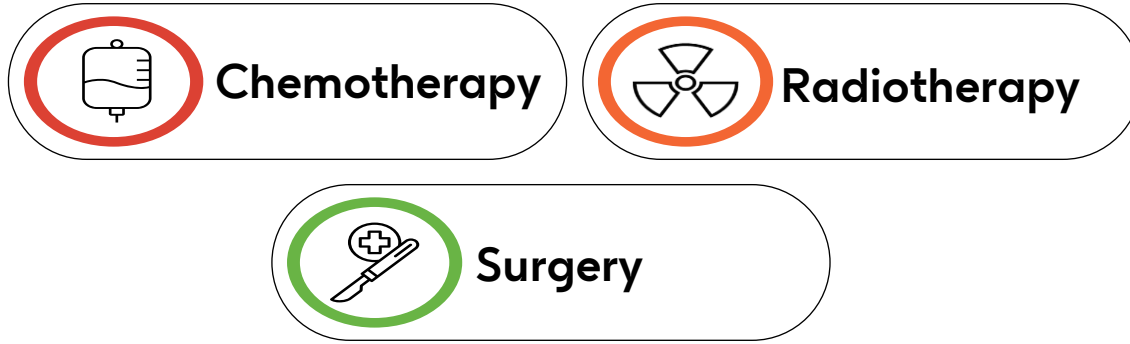
DCO 20 April 2026

*Results in death, is life-threatening, requires or prolongs hospitalization, causes persistent disability, results in a birth defect, or other medically important event; †AEs considered related to dostarlimab were at the discretion of the investigator; ‡In 2 patients with response to dostarlimab the obstruction was at primary tumor site, one of whom died due to sepsis with complications post surgery; §Includes large intestinal perforation (n=1) and procedural intestinal perforation (n=1); ¶Includes Grade 3 adrenal insufficiency (n=1), Grade 4 diabetic ketoacidosis (n=1), Grade 3 lichen planus (n=1) and Grade 3 hepatitis;

¶Hepatitis (n=1), amylase increase (n=1), and lichen planus (n=1). AE, adverse event; SAEs, serious adverse event.

Locally advanced rectal cancer (LARC) is typically treated with multi-modal standard of care

Current Standard of Care



Outcomes	Adverse events
<ul style="list-style-type: none">• cCR rate 20-25%• Death due to disease ca30%	<ul style="list-style-type: none">• Surgery related complications (bleeding, infection, injury to neighbouring organs)• Bowel, urinary sexual dysfunction• Colostomy bags• Chemo/radio related toxicities

AZUR-1 data

- Single agent dostarlimab for 9 cycles
- cCR rate 68% per investigator
- 76% cCR12 + pCR
- 98% of cCRs were durable, with no recurrences

Adverse events

- 5% SAE considered dostar related
- No fatal AEs
- 2% of patients discontinued treatment



2026 World Conference on Lung Cancer

SEPTEMBER 12 – 15, 2026 | SEOUL, REPUBLIC OF KOREA

Zidesamtinib in TKI-naïve patients with advanced/metastatic **ROS1+ NSCLC: ARROS-1 efficacy and safety data**

Alexander E. Drilon, Adrianus Johannes de Langen, Benjamin Besse, Aurélie Swalduz, Christina S. Baik, Elaine Shum, Tatsuya Yoshida, Geoffrey Liu, Stephen V. Liu, Julien Mazieres, Joel W. Neal, Benjamin J. Solomon, Daniel Tan, A. J. van der Wekken, Ryo Ariyasu, Jessica R. Bauman, Ji-Youn Han, Dong-Wan Kim, Lorenza Landi, Jessica J. Lin, Dwight H. Owen, Hiroaki Akamatsu, Rossana Berardi, Antonio Calles, Gilberto de Lima Lopes, Enriqueta Felip, Marina Chiara Garassino, Gee-Chen Chang, Hidetoshi Hayashi, Melissa Johnson, Steven Kao, Chia-Chi Lin, Chien-Chung Lin, Kiichiro Ninomiya, Sehhoon Park, Giulia Pasello, Elvire Pons-Tostivint, Alice T. Shaw, Ross Andrew Soo, Shuhei Teranishi, Saiama N. Waqar, Manoj Samant, Junwu Shen, Vivek A. Upadhyay, Byoung Chul Cho

Memorial Sloan Kettering Cancer Center and Weill Cornell Medical Center, New York, NY, USA

ARROS-1: Patient Population

Data cut-off: 16 April 2026

Total Enrolled: N = 629

Any ROS1+ solid tumor, any dose
Phase 1 + Phase 2 pooled



Safety Population: N = 532

Advanced ROS1+ NSCLC
Zidesamtinib 100 mg QD (any line of therapy)



ROS1 TKI-Naive ^a

n = 183



ROS1 TKI-Naive Efficacy Population: ^b

n = 94

with measurable disease by BICR
Treated by 15 June 2025 (≥ 9 months DOR follow up)

**Median duration follow-up:
15.2 months (range 1.1 – 30.5)**

Patient Characteristic

All data shown as n (%) unless otherwise specified

ROS1 TKI-Naive Efficacy Population n = 94

Age, median (range), years	59 (26, 87)
Female	55 (59%)
Never smoker	55 (59%)
Geographic region	
Asia Pacific	29 (31%)
Europe	27 (29%)
North America	38 (40%)
ECOG PS	
0	56 (60%)
1	38 (40%)
Baseline CNS metastases ^c	16 (17%)
Tumor stage at study entry	
III	7 (7%)
IV	87 (93%)

Treatment History

Prior platinum-based chemotherapy ± immunotherapy ^d	25 (27%)
--	----------

^a Includes TKI-naïve patients enrolled across any cohort. ^b Includes patients with ≤1 prior line of chemotherapy with or without immunotherapy from the registrational intent ROS1 TKI-naïve cohort.

^c Measurable or non-measurable lesions by BICR. ^d 16/25 patients with prior chemotherapy also received prior immunotherapy.

BICR, blinded independent central review; **CNS**, central nervous system; **DOR**, duration of response; **ECOG PS**, Eastern Cooperative Oncology Group Performance Status; **QD**, once daily; **NSCLC**, non-small cell lung cancer; **ROS1**, c-ros oncogene 1; **TKI**, tyrosine kinase inhibitor.

ARROS-1: Objective Response in ROS1 TKI-Naive Patients with NSCLC

Advanced *ROS1*+ NSCLC

RECIST v1.1 by BICR

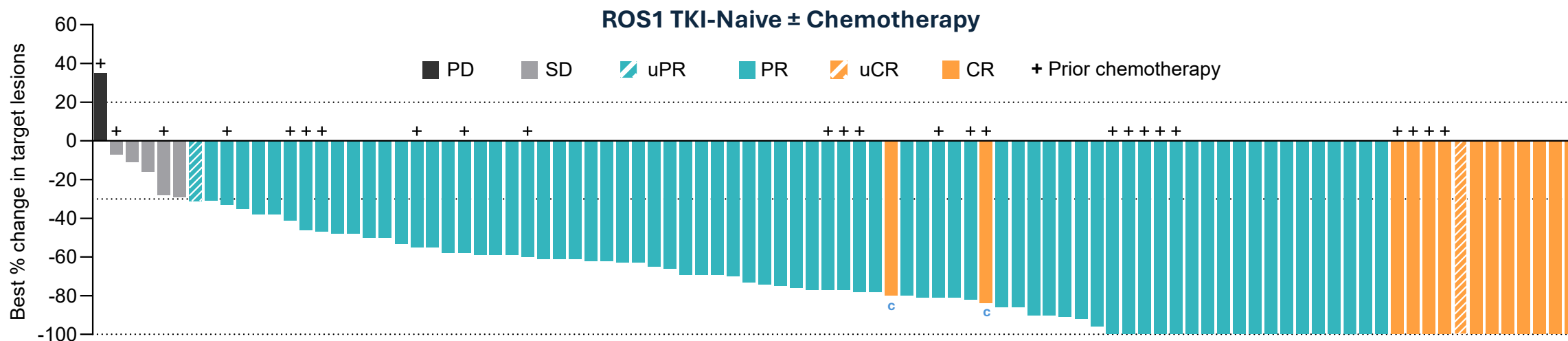
ORR, % (n/N) ^a

[95% CI]

ROS1 TKI-Naive ± Prior Chemotherapy (n = 94)

94% (88/94)

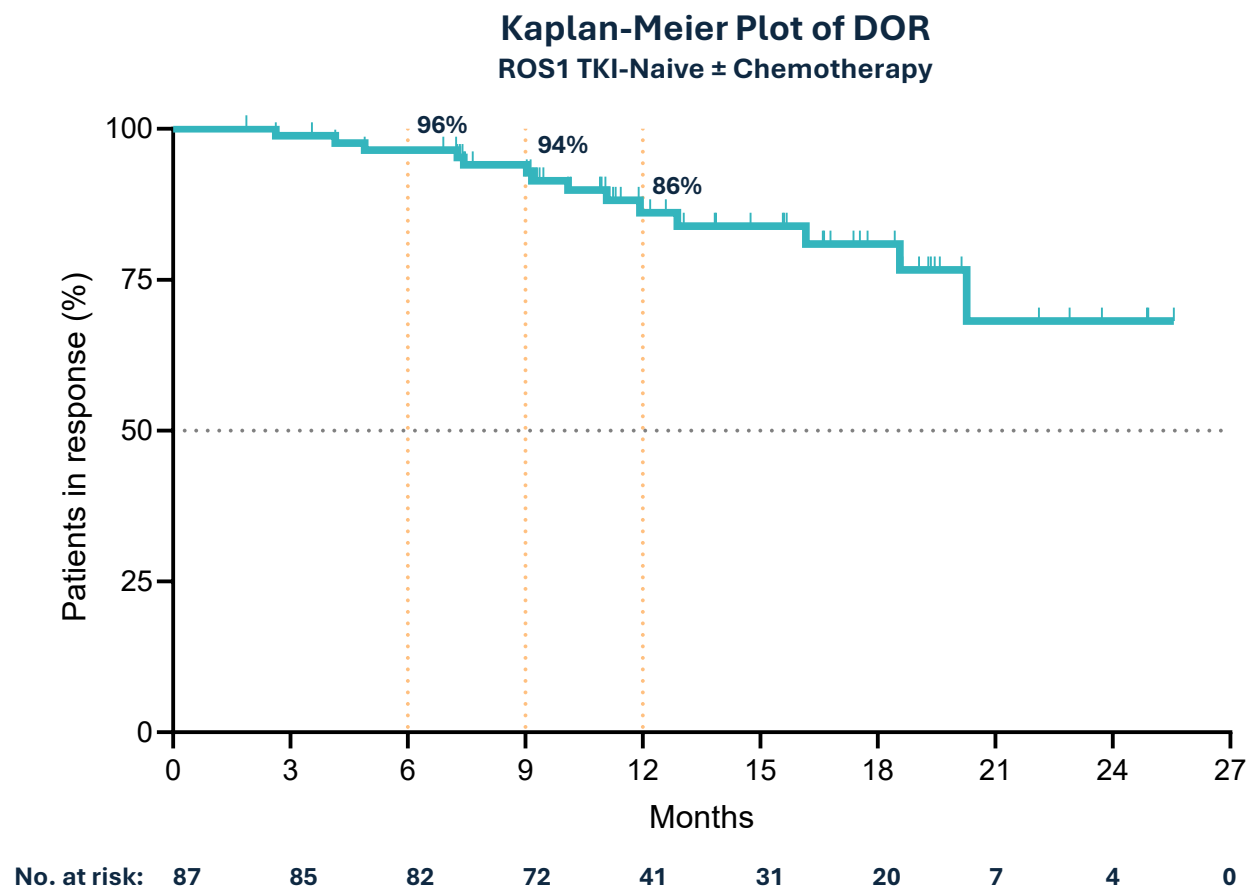
[87, 98]

CR, % (n/N) ^b**15% (14/94)**^a Includes 1 single-timepoint PR pending confirmation in ongoing patient.^b Includes 1 single-timepoint CR pending confirmation in ongoing patient with prior confirmed PR.^c CR with <100% shrinkage due to residual non-pathologic lymph node.

BICR, blinded independent central review; **CR**, complete response; **NSCLC**, non-small cell lung cancer; **ORR**, objective response rate; **PD**, progressive disease; **PR**, partial response; **RECIST**, Response Evaluation Criteria in Solid Tumor; **ROS1**, c-ros oncogene 1; **SD**, stable disease; **TKI**, tyrosine kinase inhibitor; **uCR**, unconfirmed CR (single-timepoint CR pending confirmation in ongoing patient with prior confirmed PR); **uPR**, unconfirmed PR (single-timepoint PR pending confirmation in ongoing patient).

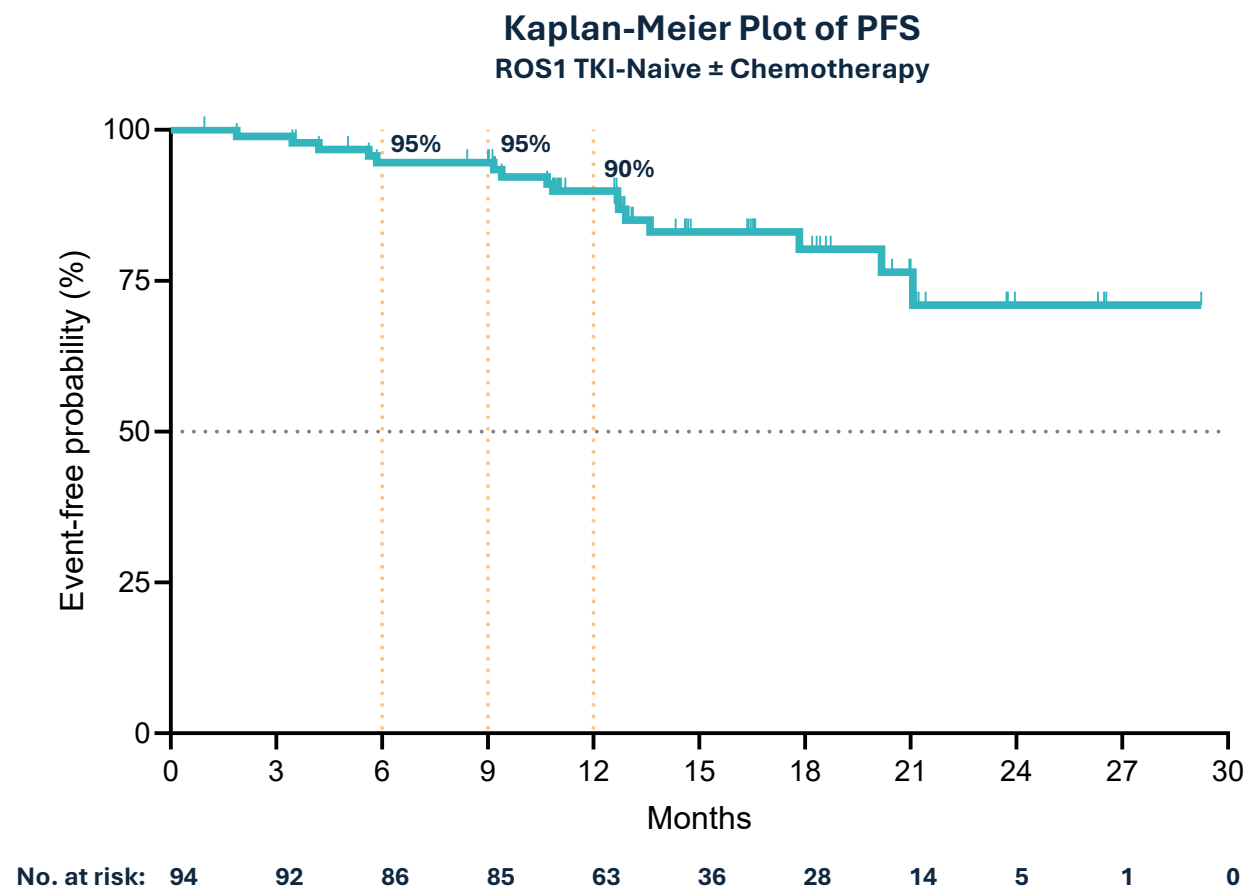
ARROS-1: Duration of Response in ROS1 TKI-Naïve Patients with NSCLC

Advanced <i>ROS1</i> + NSCLC Kaplan-Meier Estimate	ROS1 TKI-Naïve ± Prior Chemotherapy n = 87
% DOR ≥ 6 months [95% CI]	96% [89, 99]
% DOR ≥ 9 months [95% CI]	94% [86, 97]
% DOR ≥ 12 months [95% CI]	86% [75, 92]
Median DOR, months [95% CI]	NR [20, NE]



ARROS-1: Progression-Free Survival in ROS1 TKI-Naive Patients with NSCLC

Advanced <i>ROS1</i> + NSCLC Kaplan-Meier Estimate	<i>ROS1</i> TKI-Naive ± Prior Chemotherapy n = 94
% PFS ≥ 6 months [95% CI]	95% [87, 98]
% PFS ≥ 9 months [95% CI]	95% [87, 98]
% PFS ≥ 12 months [95% CI]	90% [81, 95]
Median PFS, months [95% CI]	NR [NE, NE]



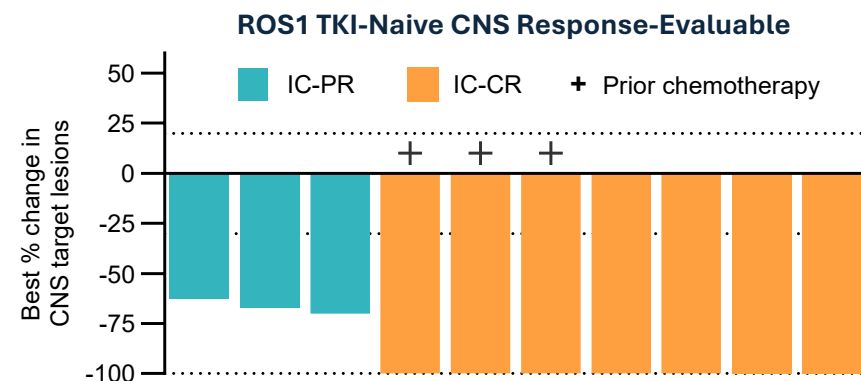
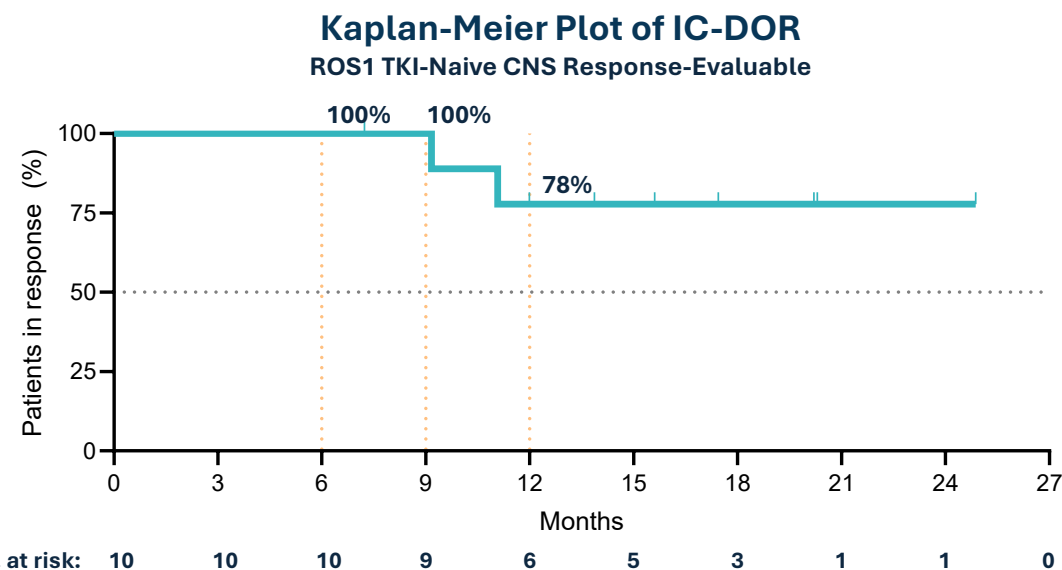
ARROS-1: CNS Activity in ROS1 TKI-Naive Patients with NSCLC

CNS Response-Evaluable Population ^a RECIST v1.1 by BICR	ROS1 TKI-Naive ± Prior Chemotherapy n = 10
IC-ORR, % (n/N) [95% CI]	100% (10/10) [69, 100]
IC-CR, % (n/N)	70% (7/10)
% IC-DOR ≥ 6 months^b [95% CI]	100% [100, 100]
% IC-DOR ≥ 9 months^b [95% CI]	100% [100, 100]
% IC-DOR ≥ 12 months^b [95% CI]	78% [36, 94]
Median IC-DOR, months^b [95% CI]	NR [9, NE]

^a Includes patients without brain radiation within 2 months of the first dose of zidesamtinib with measurable (≥5 mm) CNS lesions at baseline by BICR.

^b Analyses of DOR based on Kaplan-Meier estimates.

No CNS progression events observed among the 78 ROS1 TKI-naive patients who entered the study without brain metastases at baseline per BICR



BICR, blinded independent central review; **CNS**, central nervous system; **IC-CR**, intracranial complete response; **IC-DOR**, intracranial duration of response; **IC-ORR**, intracranial objective response rate; **IC-PR**, intracranial partial response; **NE**, not estimable; **NR**, not reached; **NSCLC**, non-small cell lung cancer; **RECIST**, Response Evaluation Criteria in Solid Tumor; **ROS1**, c-ros oncogene 1; **TKI**, tyrosine kinase inhibitor.

ARROS-1: Safety in Advanced *ROS1*+ NSCLC

TEAEs in ≥ 15% of TKI-Naive or TKI-Pretreated Patients with Advanced *ROS1*+ NSCLC Receiving Zidesamtinib 100 mg QD (N = 532)

Preferred Term	Any Grade	Grade ≥3
Peripheral edema	42%	1%
Blood CPK increased	23%	5%
Constipation	23%	<1%
Weight increased	22%	7%
AST increased	19%	1%
ALT increased	18%	2%
Dysgeusia	18%	0
Dyspnea	17%	4%
Arthralgia	17%	1%
Peripheral sensory neuropathy	17%	1%
Hypertriglyceridemia	16%	3%
Headache	15%	<1%

- Treatment-related AEs in ≥15% of patients (any grade; grade ≥3):**

- Peripheral edema (34%; 0.6%)
- Weight increased (18%; 4%)
- Blood CPK increased (18%; 3%)
- Dysgeusia (17%; 0%)
- AST increased (15%; 1%)

- Dose reduction due to TEAE: 12%; TRAE: 11%**

- TEAEs leading to dose reduction in ≥1% of patients: peripheral edema (2.4%), peripheral sensory neuropathy (1.5%), blood CPK increased (1.1%), weight increased (1.1%)

- Discontinuation due to TEAE: 4%; TRAE: 1%**

- TEAEs leading to discontinuation in ≥2 patients: pneumonia (n=3), pneumonitis (n=3), weight increased (n=2)

ALT, alanine aminotransferase; **AST**, aspartate aminotransferase; **CPK**, creatine phosphokinase; **NSCLC**, non-small cell lung cancer; **QD**, once-daily; ***ROS1***, c-ros oncogene 1; **TEAE**, treatment emergent adverse event; **TKI**, tyrosine kinase inhibitor.



Closing remarks

Nina Mojas, President Global Product Strategy



ESMO and WCLC 2026 data summary

Ris-Rez: 2L+ SCLC
EMBOLD pan-tumour 101

61% ORR

ARTEMIS-008 ORR 58%

Ris-Rez: 2L+ SCLC
ARTEMIS-008

18.5m mOS vs 10.3m
topotecan (HR 0.46)

54% reduction in risk of death

Ris-Rez: r/r osteosarcoma
ARTEMIS-011

0.33 PFS HR

mPFS 5.5m vs 1.4m
for current standard of care

Jemperli: dMMR LARC
AZUR-1

68% cCR;
98% durable at 26m

SoC achieves cCR in only 20-25% of cases

Jideytr: TKI-naïve ROS-1+ NSCLC
ARROS-1

94% ORR

90% progression free at 12mo
IC-ORR= 100% (n=10)

Mo-Rez: PROC
BEHOLD Ovarian 01

62% cORR

Median duration of response 12.2m
11.1month mPFS

Q&A



Nina Mojas
President, Global
Product Strategy



Hesham Abdullah
SVP, Global Head
Oncology R&D



Ahmed Rabie
SVP Global Product
Strategy, Oncology



Klaas Bakker
MDL
Ris-Rez



Eric Richards
SVP Oncology
Product Leadership



Richard Davidson
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