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ASCO 2007 Investor Event
Chicago, June 4, 2007

Introduction

Karl Mahler, Head Investor Relations



Moving the standards of care

Making a difference for patients

- **Introduction**

Dr. Karl Mahler - Head of Investor Relations, Roche

- **Pertuzumab Phase II in mBC**

Prof. Dr. José Baselga - Vall d'Hebron University Hospital, Barcelona

- **Setting the standards of care for treatment of cancer**

Dr. Kapil Dhingra - VP Medical Science, Roche

- **AVOREN: The role of Avastin in Renal Cancer**

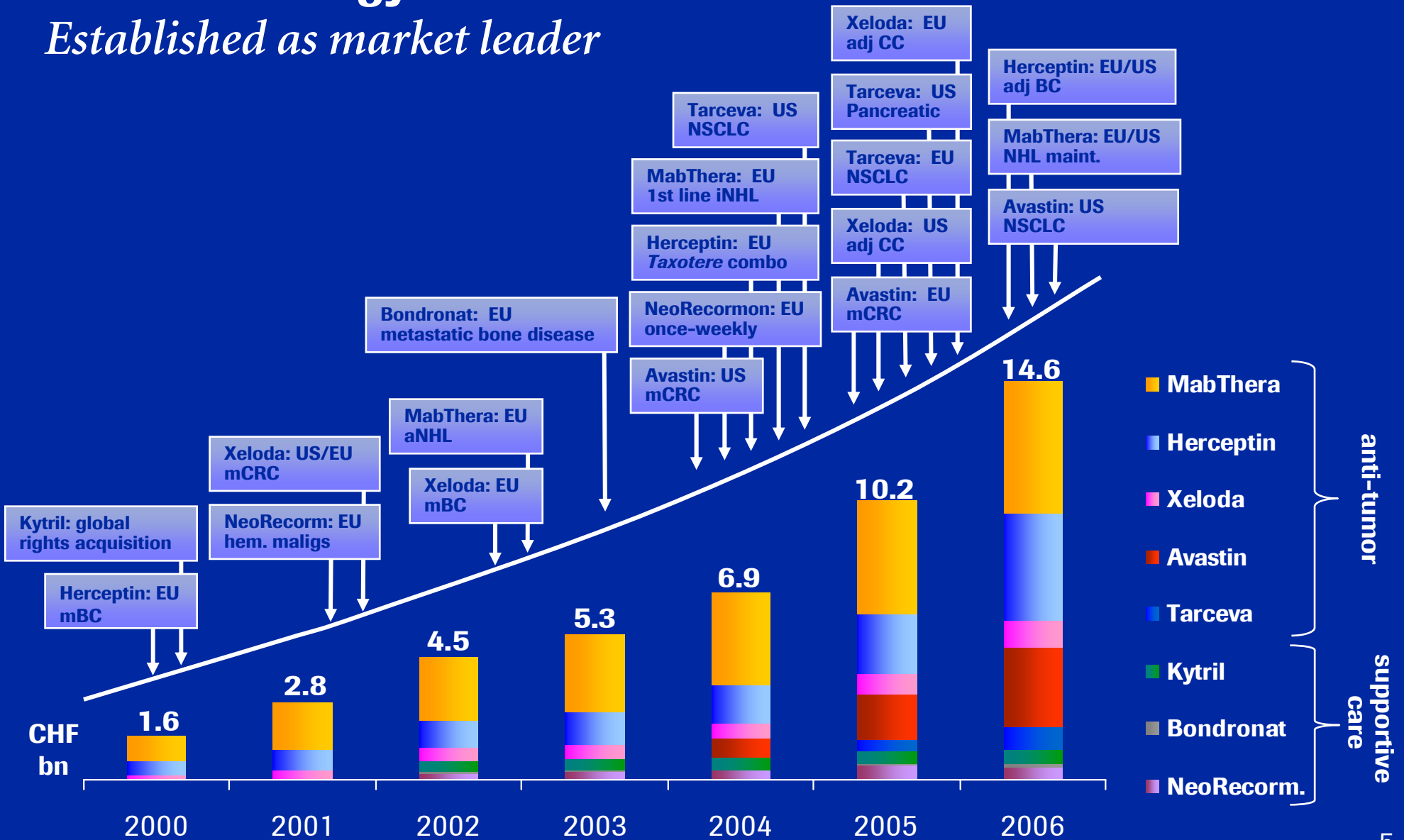
Prof. Dr. Bernard Escudier - Institut Gustave Roussy, Paris

- **Q&A**



Roche oncology 2000-2006

Established as market leader



Changes in the oncology market

Significant therapeutic progress over the last decade

- Research activities over the past years have resulted in substantial increases in approved oncology drugs
 - 1950- 1960: 11
 - 1990-2000: > 50
 - 2000-2005: > 80
- New generation of oncology products: biologics and targeted therapies
- Roche has set the standard

Our strategy

- Build on our excellent products with proven safety and efficacy
- Improve the standard of care
 - With new combinations
 - In multiple cancer types
- Move products from 'potentially life extending' to 'potentially life saving'
- Make use of our first mover advantage - keep the lead



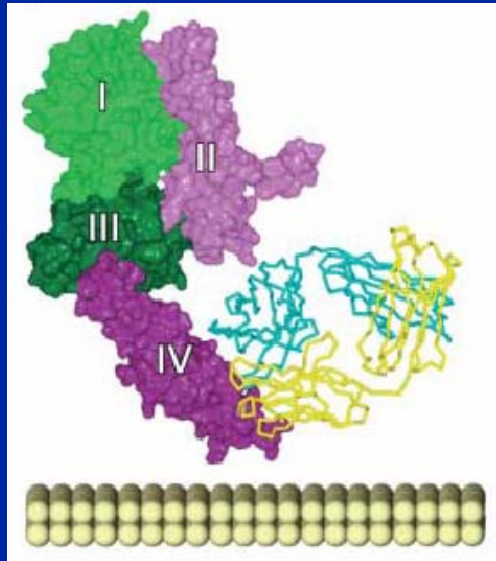
ASCO 2007 Investor Event
Chicago, June 4, 2007

Pertuzumab in HER2-positive metastatic breast cancer
J. Baselga, Vall d'Hebron University Hospital, Barcelona

Trastuzumab and pertuzumab

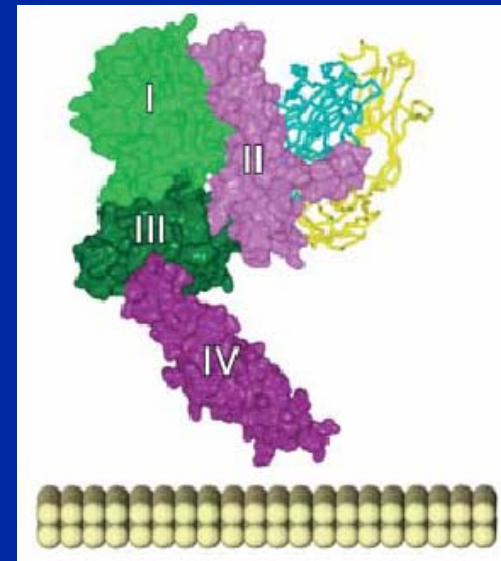
Binding to distinct epitopes on HER2 extracellular domain

Trastuzumab



- Activates antibody-dependent cellular cytotoxicity
- Enhances HER2 internalization
- Inhibits shedding and therefore formation of p95
- Inhibits HER2-regulated angiogenesis

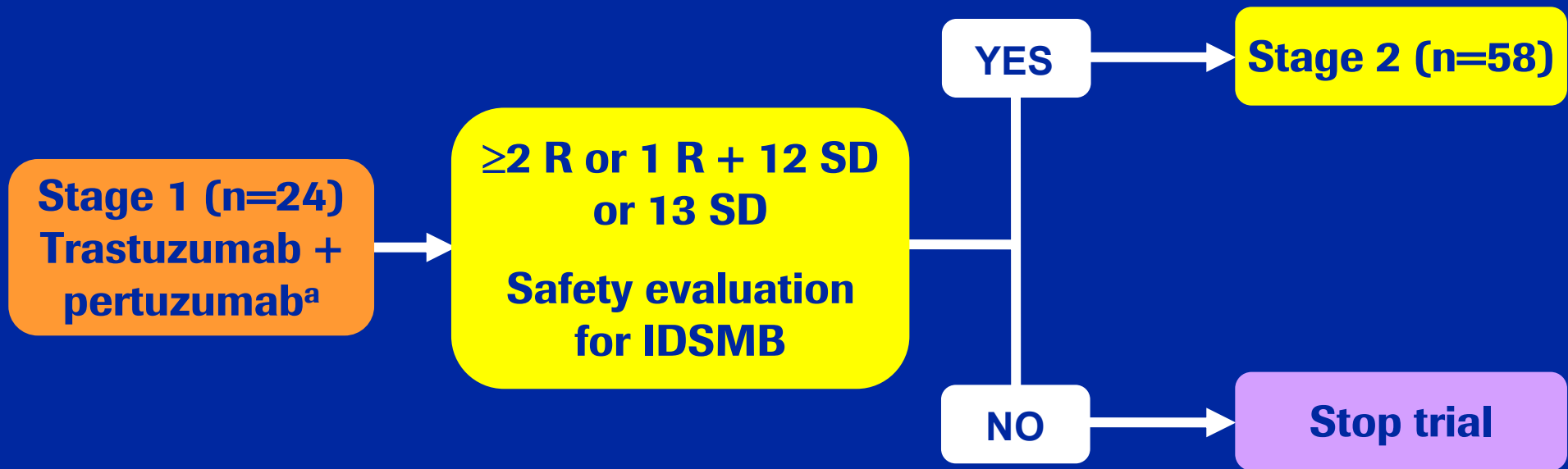
Pertuzumab



- Activates antibody-dependent cellular cytotoxicity
- Prevents receptor dimerization
- Potent inhibitor of HER-mediated signaling pathways

Phase II Trial of pertuzumab + trastuzumab in HER2-positive patients progressing on trastuzumab

Two-stage design



^aT: 4 mg/kg loading dose → 2 mg/kg qw or 8 mg/kg loading dose → 6 mg/kg q3w;

P: 840 mg loading dose → 420 mg q3w

IDSMB, International Data and Safety Monitoring Board

Study objectives

Primary

- Efficacy
 - response rate + stabilization of disease = clinical benefit rate
- Safety
 - evaluate safety of combined antibody treatment

Secondary

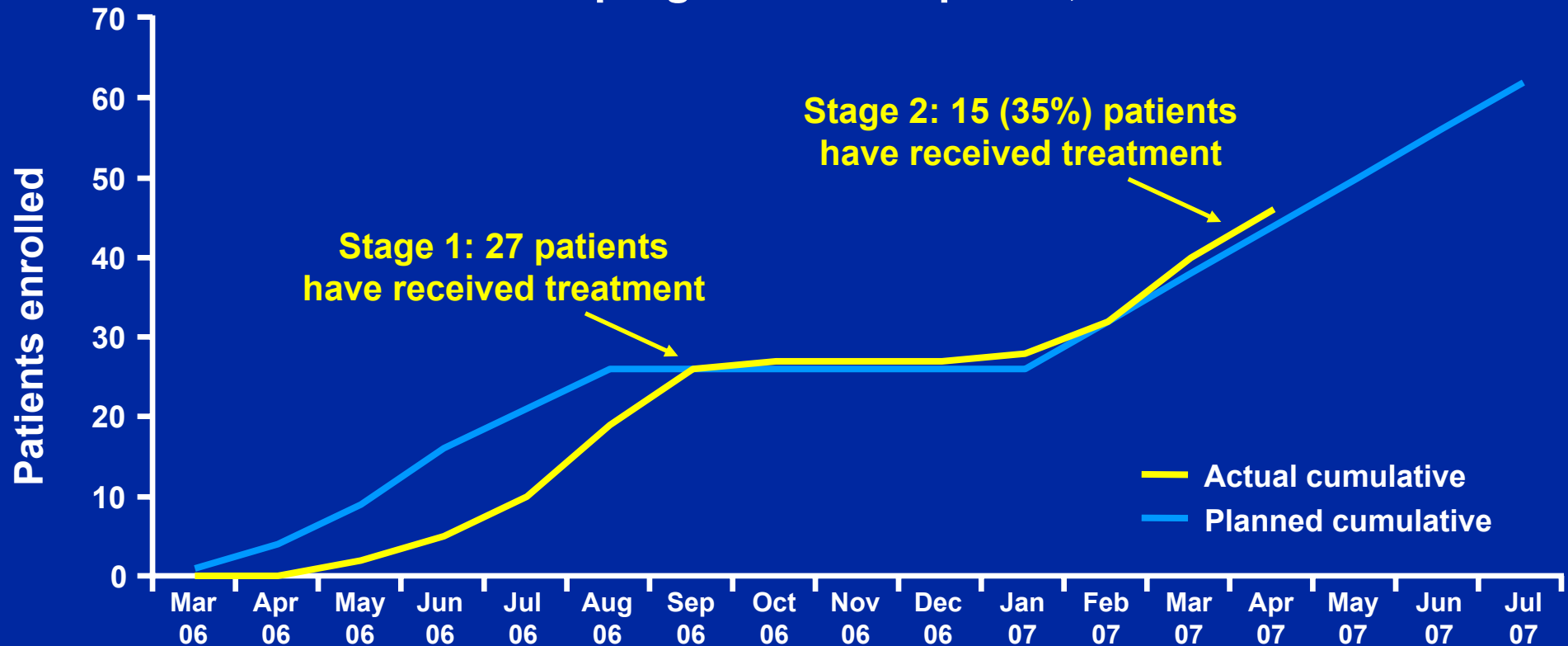
- Biomarker evaluation
 - qRT-PCR panel: EGFR, HER2, HER3, beta-cellulin, amphiregulin
 - serum marker panel: HER2 extracellular domain, TGF-alpha, EGF, amphiregulin

Main eligibility criteria

- HER2-positive breast cancer (IHC 3+ / FISH+ centrally confirmed) and availability of tumor samples for biomarker assessment
- Measurable disease according to RECIST
- Up to 3 lines of prior therapies or chemotherapy and / or trastuzumab (including in the adjuvant setting)
- Disease progression during trastuzumab as most recent treatment for metastatic disease
- Study treatment initiated within 9 weeks of the last dose of trastuzumab
- Baseline LVEF $\geq 55\%$ and no decrease of LVEF to $< 50\%$ during prior trastuzumab treatment

Current status

Recruitment progress as at April 30, 2007



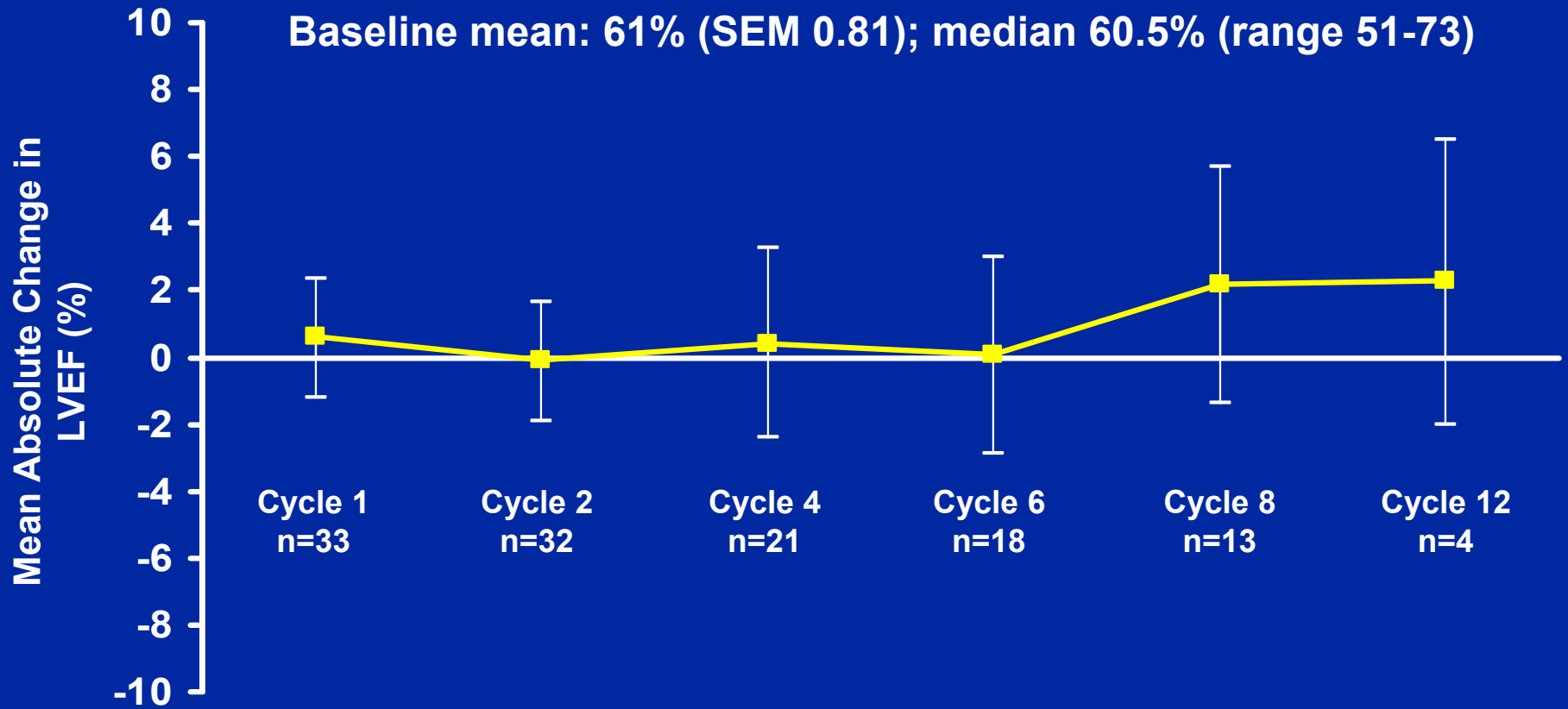
- 44 patients randomized, 2 yet to receive treatment
- Safety population n=42 (all patients randomized and received study treatment)
- Efficacy population n=33 (all patients in safety population and had a post-baseline tumor assessment)

Overall adverse events

Adverse event	Incidence (%)
Diarrhea	24 (57)
Skin (other than rash)	15 (35)
Nausea / vomiting	14 (33)
Mucositis	14 (33)
Pain	14 (33)
Rash	12 (28)
Fatigue	13 (31)
Deep vein thrombosis, ejection fraction decreased, hypersensitivity, hypertension, hypomagnesemia	1 each (2)

Total number of AEs = 233; patients with at least 1 AE = 34 (81%)

Cardiac safety



Efficacy data

Best overall response

Response	n (%) n=33
Complete response	1 (3.0)
Partial response	5 (15.1)
Overall response rate	6 (18.2)
Stable disease for 6 months (\geq cycle 8)	7 (21.2)
Clinical benefit rate	13 (39.4)
Stable disease (<6 months)	10 (30.3)
Progressive disease	10 (30.3)

Efficacy data

Best overall response over time

	Cycle					
	BL	2	4	6	8	12
Tumor assessments completed (n)	42	33	20 ^a	19	12	4
Best confirmed overall response						
Complete response				1		
Partial response		3	1	1		
Stable disease		6	4		6	1

^aEarliest scheduled opportunity for confirmed response
BL, baseline

Responding patients

Characteristics

Age (years)	76	54	55	45	49	57
ER / PgR status	+ / -	- / NK	+ / +	- / -	+ / NK	- / -
Previous chemotherapy	2	1	1	2	2	2
Site of target lesions	LN	Liver	LN	Liver LN	LN	Skin
Sum of lesions at BL (mm)	27	105	28	103	61	588
Site of non-target lesions	LN	Liver Bone	LN	Liver Bone	Skin	
Response status	PR	PR	CR	PR	PR	PR

CR, complete response; LN, lymph nodes; NK, not known; PgR, progesterone receptor; PR, partial response

Conclusions

- Pertuzumab, the first HER2 dimerization inhibitor, a new class of anti-HER2 therapies
- Pertuzumab is active and well tolerated when given with trastuzumab in patients with HER2 overexpressing breast cancer with documented progression on trastuzumab as last therapy
- Accrual is ongoing (planned recruitment: 58 evaluable patients)
- Biomarker research is being conducted and may help to identify patients most likely to benefit
- Pertuzumab is a valuable addition to anti-HER2 agents. Further studies are being planned in early and advanced HER2-overexpressing breast cancer



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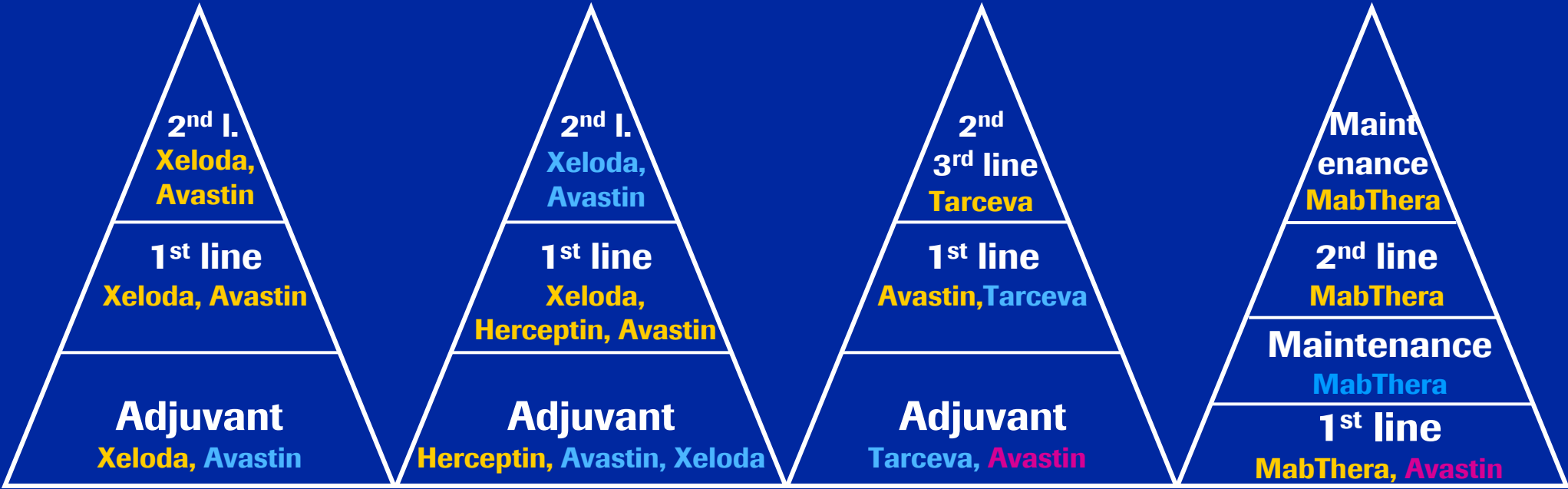
**Setting the standards of care for treatment of cancer
*Dr. Kapil Dhingra, VP Medical Science***





Roche products

Key components of the standards of care in major indications



CRC

BC

NSCLC

NHL

Proven efficacy
In development
Development in preparation

Breast Cancer

Colorectal Cancer

Non-Small Cell Lung Cancer

Non Hodgkin's Lymphoma

Renal Cell Carcinoma

Outlook



Herceptin

Standard of care for HER2-positive breast cancer

Proven overall survival benefit in metastatic BC

- 4.8 months median survival for H + all chemotherapy (from 20.3 to 25.1 months)
- 8.5 months median survival benefit for H + Docetaxel (from 22.7 to 31.2 months)

Unprecedented benefit in early BC

- Risk of disease recurrence halved
- Risk of death reduced by a third
- Consistent across four large trials

Well-established safety record

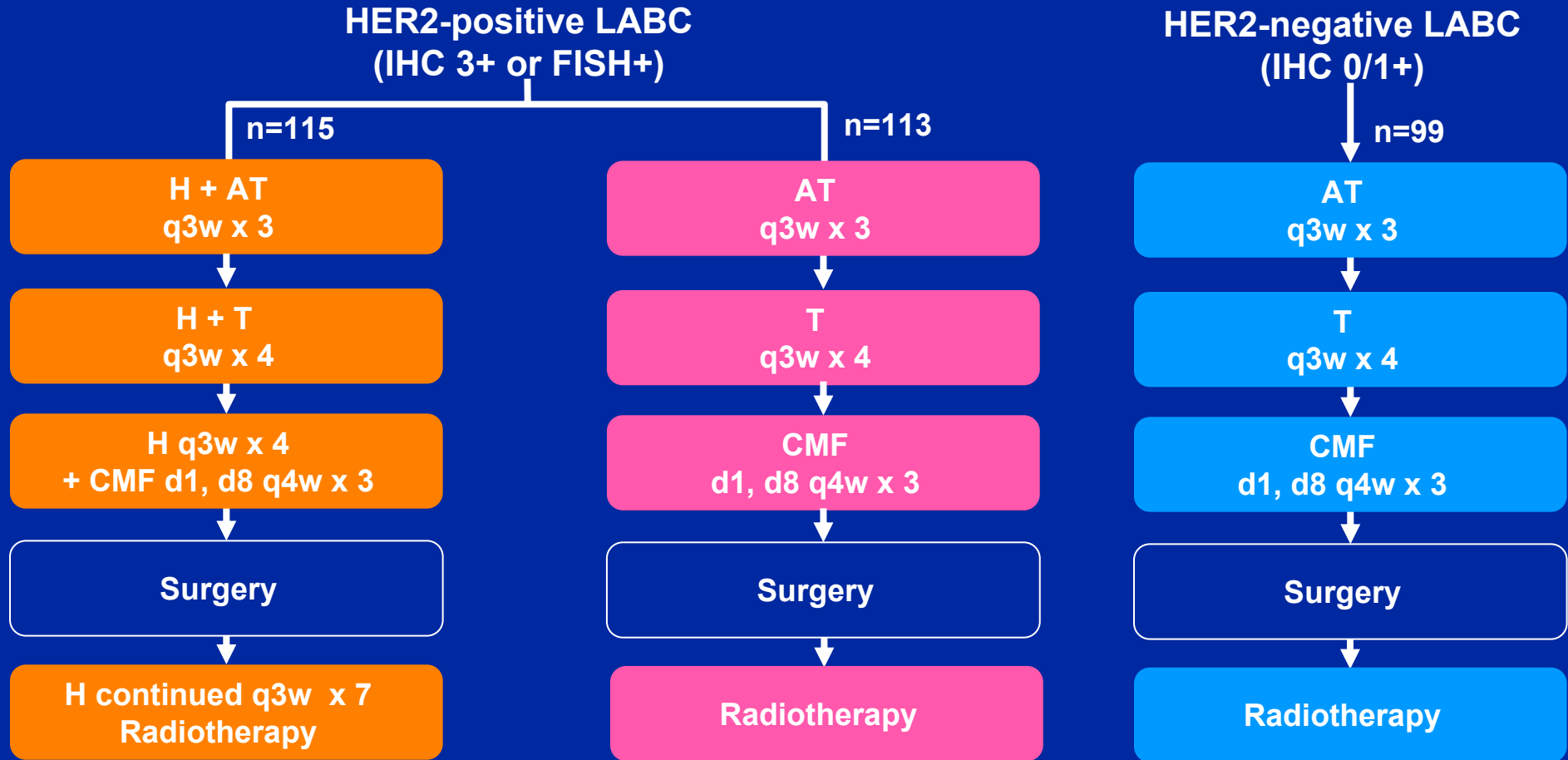
- 10 years of clinical experience in nearly 400,000 patients

Most effective HER2-targeting agent



Neoadjuvant Herceptin (NOAH)

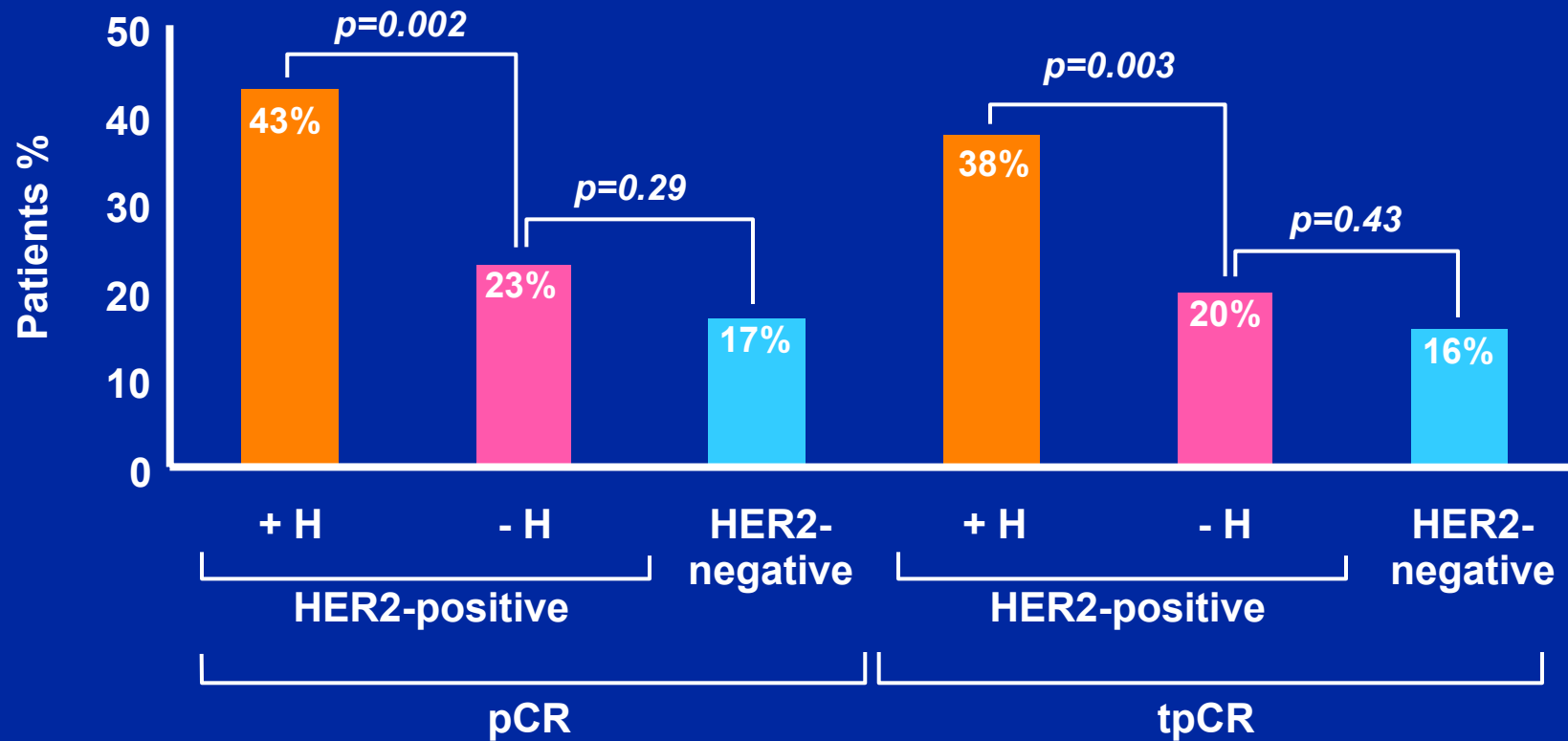
Improve outcome by reducing tumor size prior to surgery



L. Gianni et al. ASCO 2007

NOAH

Near doubling of pathological complete response



Safety: only one patient with >10% decrease from baseline and <45% absolute LVEF

pCR, pathological complete response; tpCR, total pathological complete response in breast and nodes

L. Gianni et al. ASCO 2007

NOAH conclusion

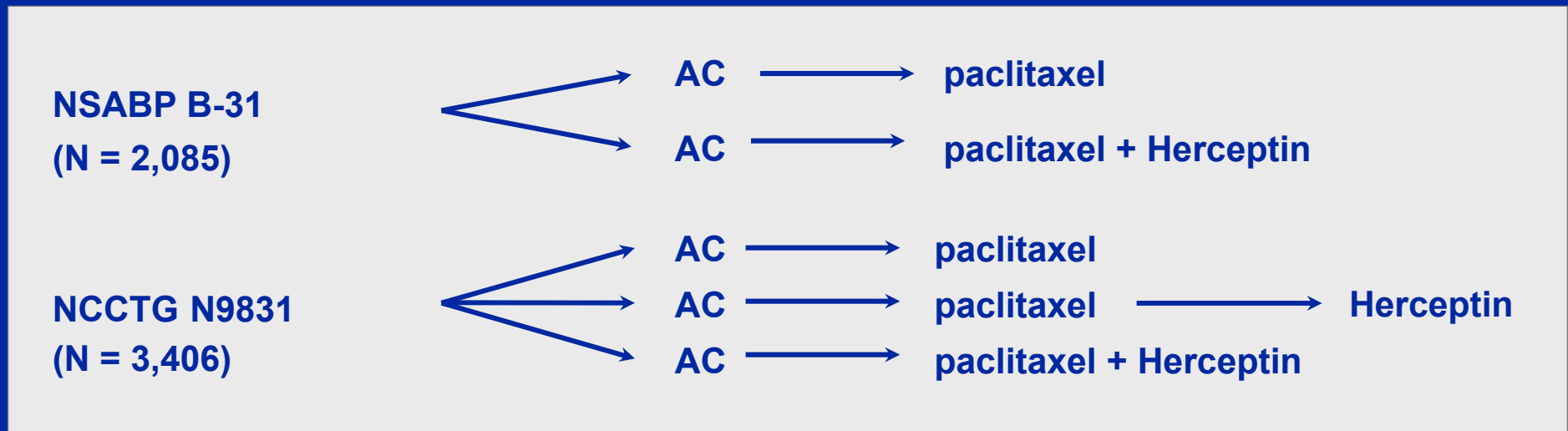
Herceptin's value in neoadjuvant therapy confirmed

- Compelling anti-tumor activity in primary breast cancer
- Well tolerated
- Patient benefit:
 - Renders inoperable tumors removable
 - Results in less invasive & breast-conserving surgery in the majority of cases
 - Likely to improve survival in a difficult-to-treat population

Update on adjuvant trials

NCCTG N9831 / NSABP B-31 joint efficacy analysis

- Adjuvant chemotherapy with or without Herceptin in HER2-positive early BC



Patients randomized to AC → T and less than 6 months from completion of chemo were eligible to receive Herceptin

NCCTG N9831 / NSAPB B-31

Joint efficacy analysis of adjuvant trials

2.9 years median follow-up; combined analysis:

- Risk of relapse reduced by 52%
- Risk of death reduced by 35%

Cumulative incidence of cardiac events unchanged

Conclusion

- Substantial improvement in outcomes with the addition of Herceptin to chemo
- Improvement continues despite cross-over after initial results reported
- No increase in cardiac events with longer follow-up

Further reinforce the use of Herceptin as the foundation of care



Attacking the HER2 pathway from multiple angles

Two next generation products in development

	Herceptin	Pertuzumab	Trastuzumab-DM1
Mechanism	Specifically targeting HER2 Inhibits HER2-mediated signalling	First in class HER dimerization inhibitor Inhibits multiple HER-mediated pathways	Binds to HER2 and delivers a potent cytotoxic agent in a targeted manner
Phase of development	Approved for adjuvant and mBC (HER2+)	Phase III 'go' decision For mBC (HER2+)	Phase I
Efficacy data	Survival benefit In adjuvant and metastatic HER2+ BC	18% response rate 39% clinical benefit rate	Poster at ASCO 2007

Key clinical trials in mBC

	Herceptin+ Avastin	Avastin			Herceptin+ Pertuzumab
Study	Roche phase III	AVADO phase III	RIBBON-1 phase III	RIBBON-2 phase III	Phase II
Patient population	1 st line	1 st line	1 st line	2 nd line	2 nd line Ph II 1 st line Ph III
Treatment regimen	Herceptin + Docetaxel ± Avastin	Taxotere ± Avastin	CT ± Avastin	CT ± Avastin	Herceptin ± Pertuzumab
Status	Started 3Q 2006	Completed recruitment	Started 4Q 2005	Started 1Q 2006	Ph II results available

Continuous commitment to advancing the standard of care in mBC

Key ongoing/planned clinical trials in adjuvant BC



	Xeloda	Avastin		Avastin + Herceptin
Study	NO17629 phase III	E5103 phase III	Roche phase III	Roche phase III
Patient population	HER2-	HER2-	HER2- ER/PR-	HER2+
Treatment regimen	AC → Docetaxel ± Xeloda	AC → P vs. AC/Avastin → P/Avastin vs. AC/Avastin → P/Avastin → Avastin up to 12 months	Standard chemo +/- Avastin for 12 months	tbd
Status	Recruitment completed	FPI pending	FPI planned for 4Q 2007	Protocol in preparation

Broad program to redefine adjuvant BC treatment

Breast Cancer

Colorectal Cancer

Non-Small Cell Lung Cancer

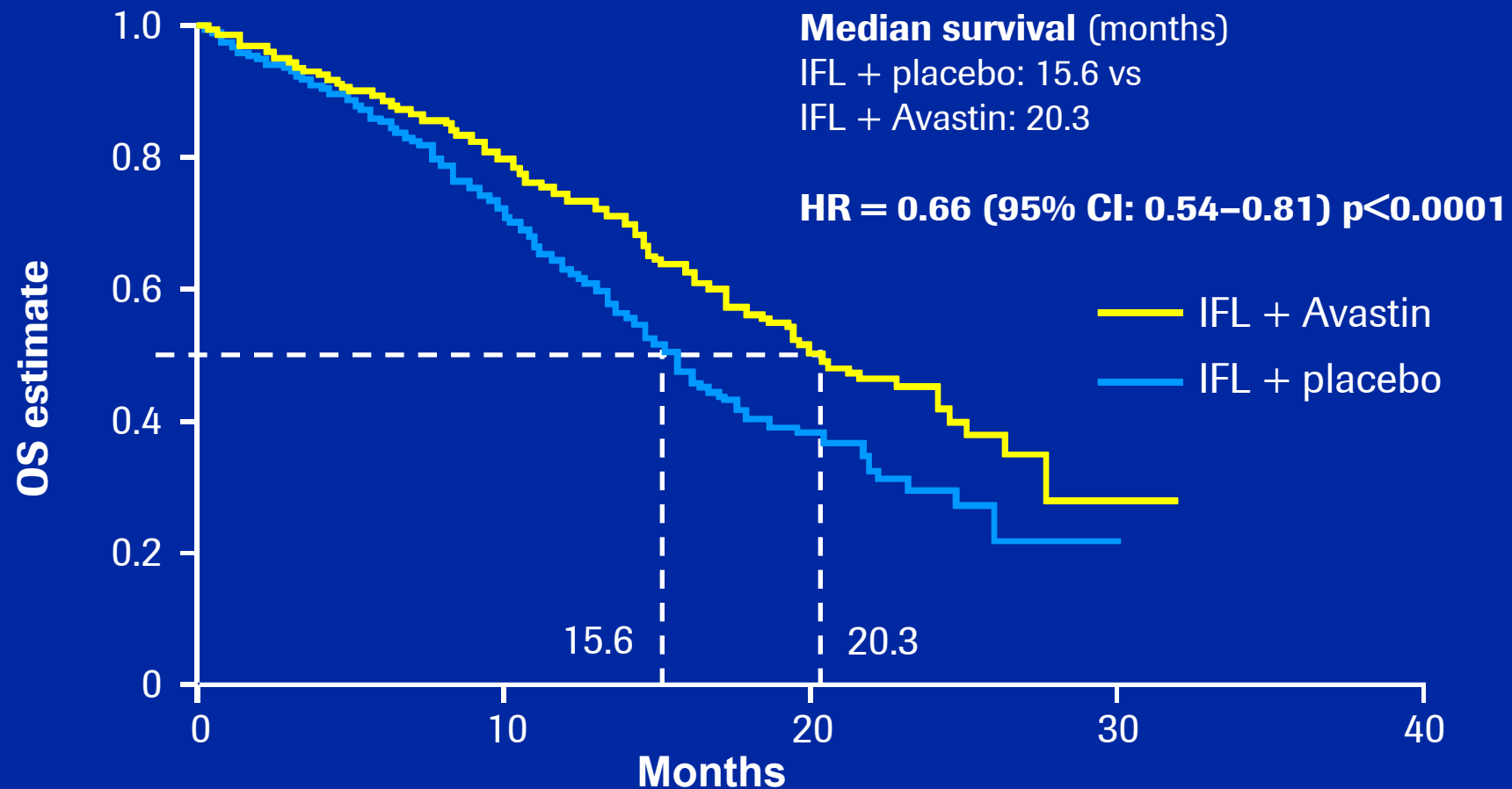
Renal Cell Carcinoma

Non Hodgkin's Lymphoma

Outlook

Avastin in 1st line mCRC

Largest improvement in overall survival in phase III





Key phase III/IV Avastin trials in mCRC

At ASCO 2007

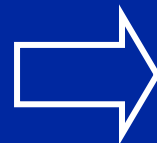
	Avastin+ FOLFIRI	Avastin+ various chemos	Avastin+ various chemos	Avastin + oxaliplatin based chemos
Study	AVIRI	BEAT	BRiTE	NO16966
Patient population	1 st line mCRC	1 st line mCRC	1 st line mCRC	1 st line mCRC
Treatment regimen	FOLFIRI+Avastin	Avastin + current standard regimens	Avastin + current standard regimens	FOLFOX or XELOX + Avastin vs placebo
Status	PFS data at ASCO 2007	Efficacy update ASCO 2007	Efficacy update ASCO 2007	Primary endpoint met ESMO 2006

NO16966

Study design

Recruitment
June 2003 – May 2004

XELOX N=317
FOLFOX4 N=317



Recruitment
Feb 2004 – Feb 2005

XELOX + placebo N=350	XELOX + Avastin N=350
FOLFOX4 + placebo N=351	FOLFOX4 + Avastin N=349

Initial 2-arm
open-label study (N=634)

Protocol amended to 2x2 placebo-controlled design
after Avastin phase III data became available
(N=1400)

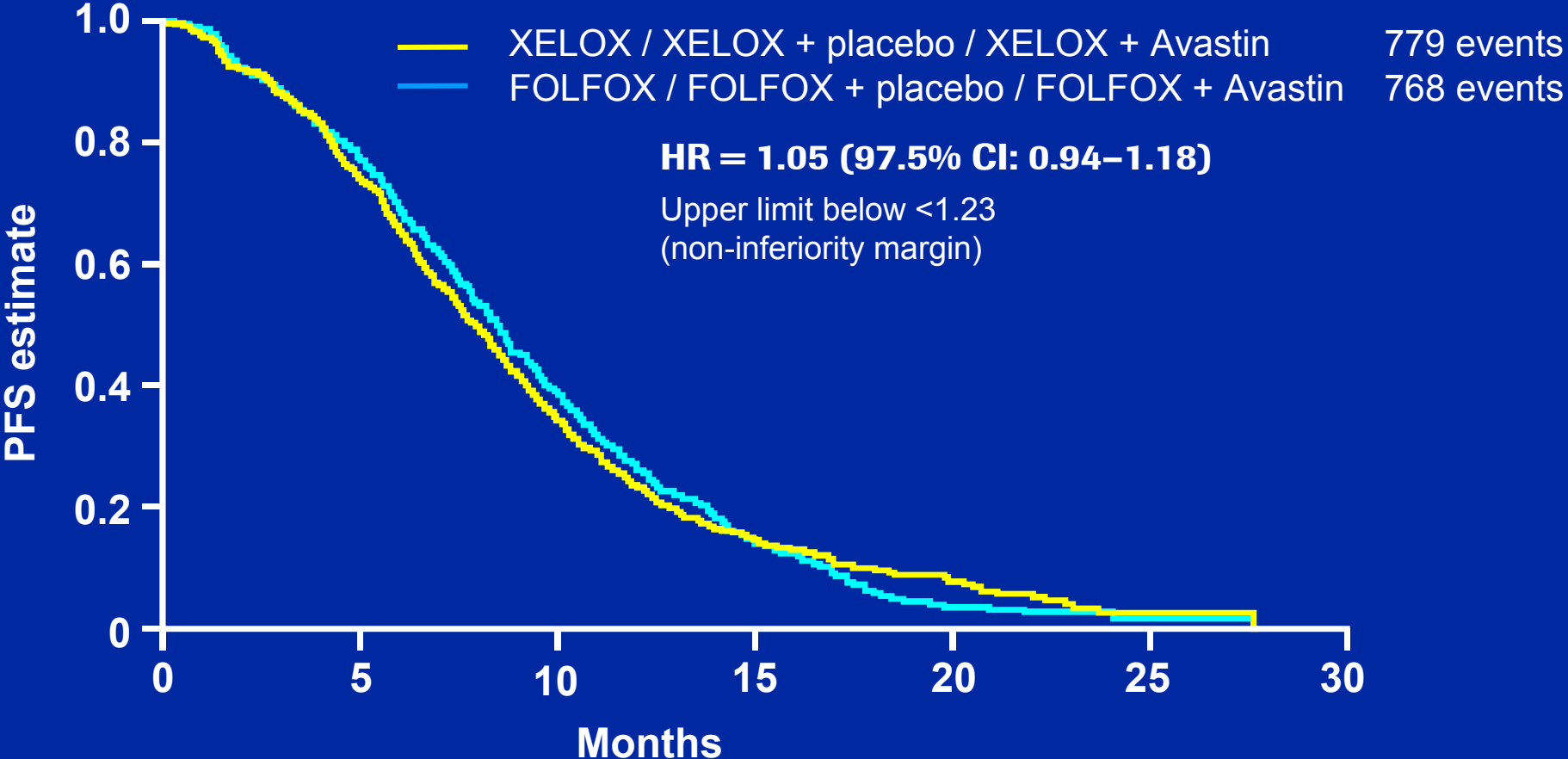
NO16966

Primary objectives

1. Non-inferiority of XELOX vs. FOLFOX-4
2. Superiority of Avastin + chemo (XELOX or FOLFOX-4) vs. placebo + chemo
 - Primary endpoint: PFS

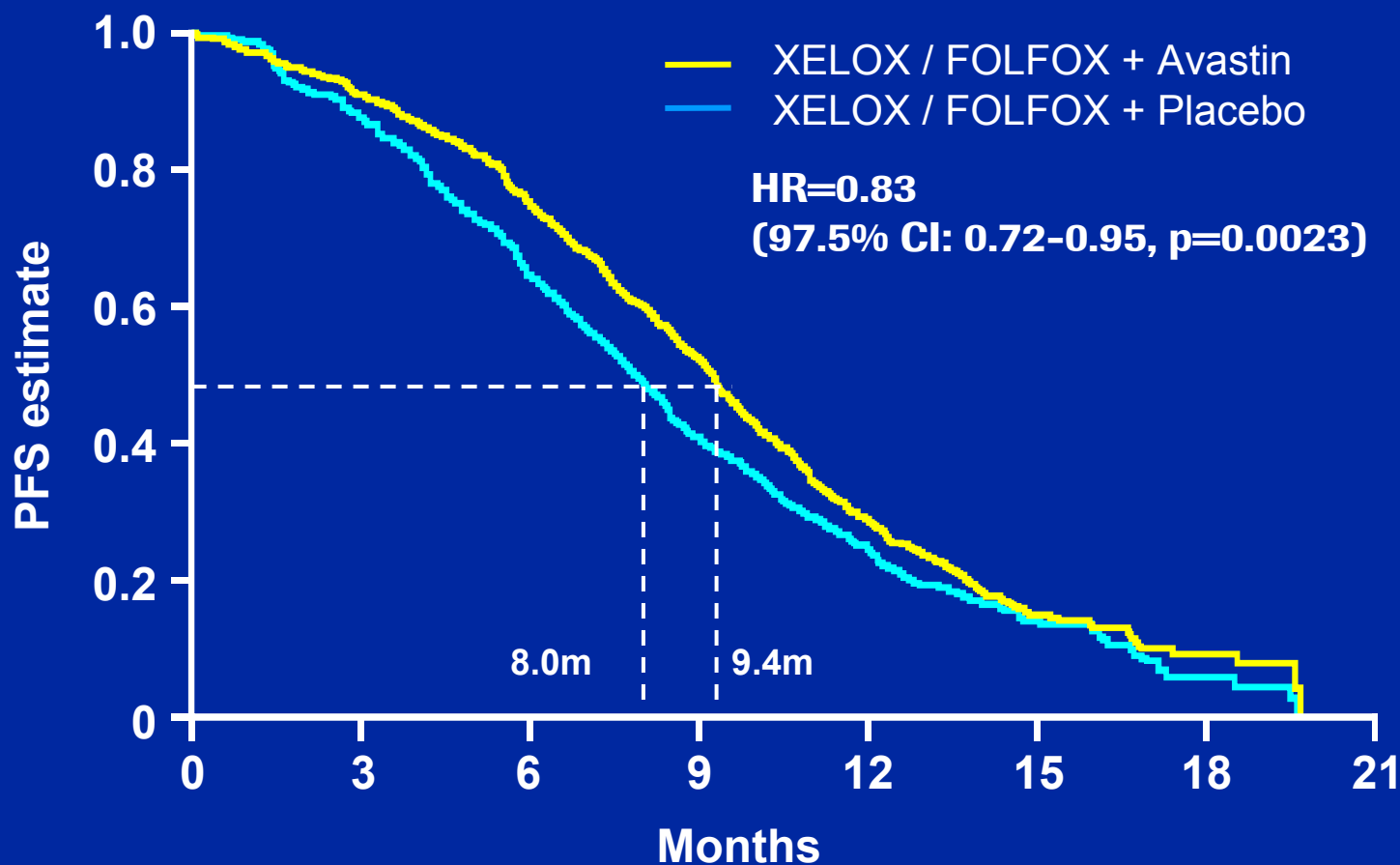
XELOX non-inferiority

Primary objective met



Avastin superiority

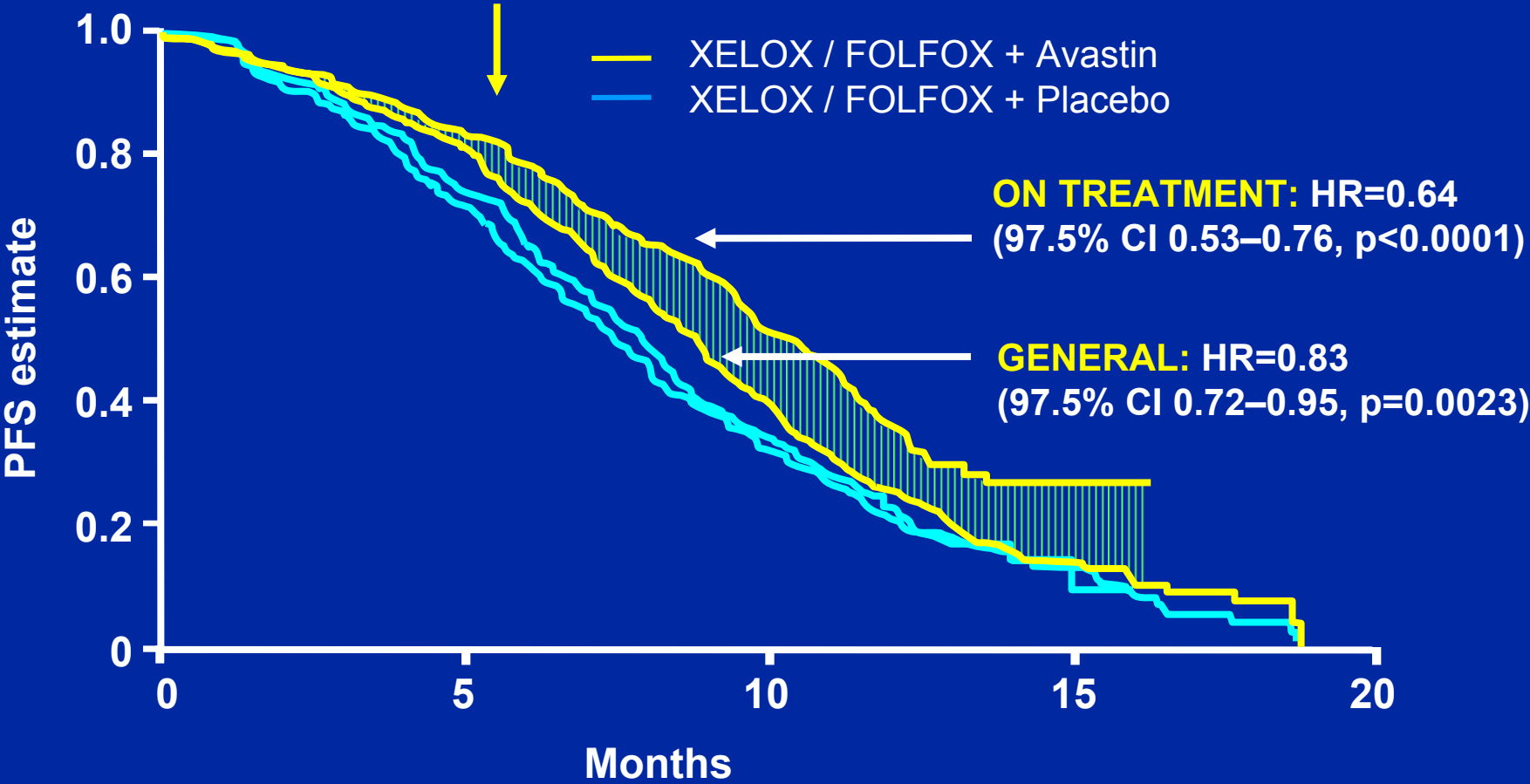
Primary objective met



513 events
547 events

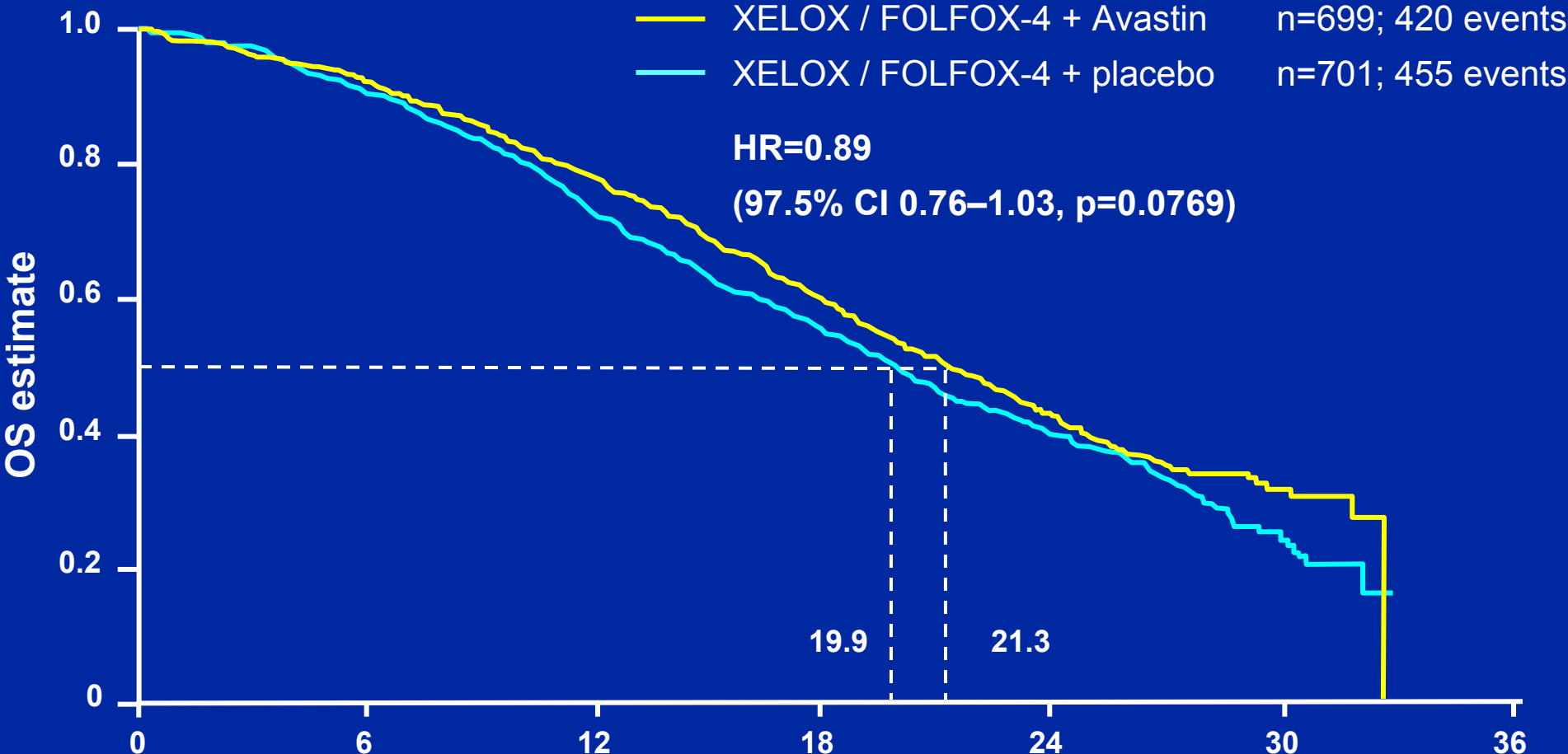
Avastin superiority

Strong benefit from treatment until progression





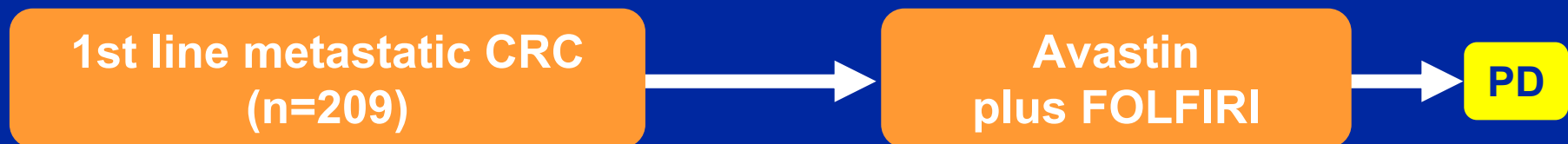
NO16966: Secondary endpoint OS



Strong survival trend despite suboptimal use of Avastin

The AVIRI study

FOLFIRI + Avastin in mCRC



International multicenter trial, open label,
31 centres

Primary endpoint: progression-free survival



The AVIRI study

Excellent efficacy for Avastin + FOLFIRI

Parameter	All pts (n=209)
Progression-free survival	11.1 months
Overall response rate	53.1%
Overall tumor control	85.6%



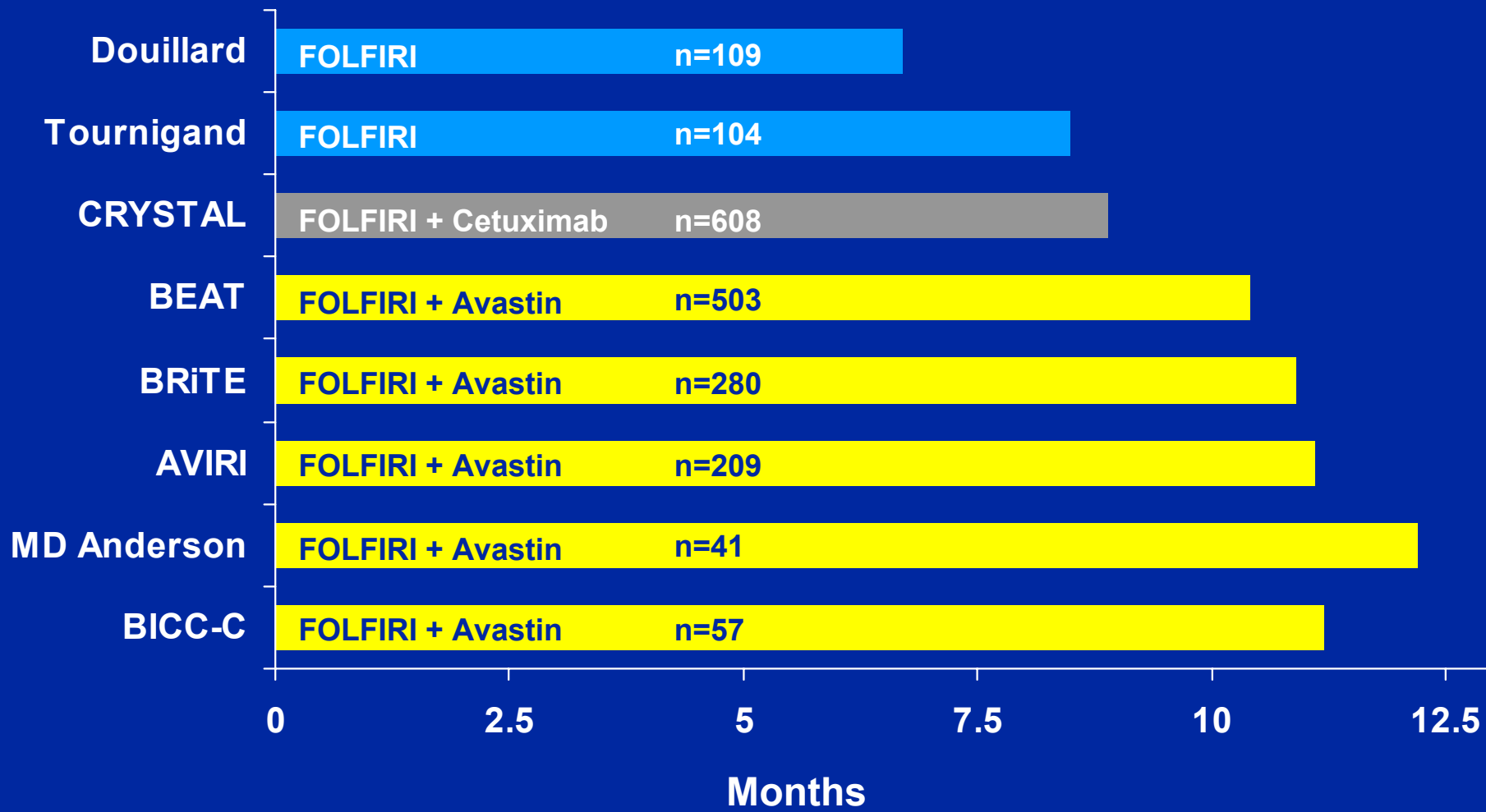
FOLFIRI in 1st line mCRC

High response rates with Avastin

Parameter	Overall Response Rate
FOLFIRI + Avastin (AVIRI)	53.1%
FOLFIRI + Avastin (MD Anderson)	62.0%
FOLFIRI + Avastin (BICC-C)	47.0%
FOLFIRI + Cetuximab (CRYSTAL)	46.9%

FOLFIRI in 1st line mCRC

Excellent progression free survival with Avastin



Avastin in 1st line mCRC

BRiTE – A large observational study



Multicenter trial, open label, US territory

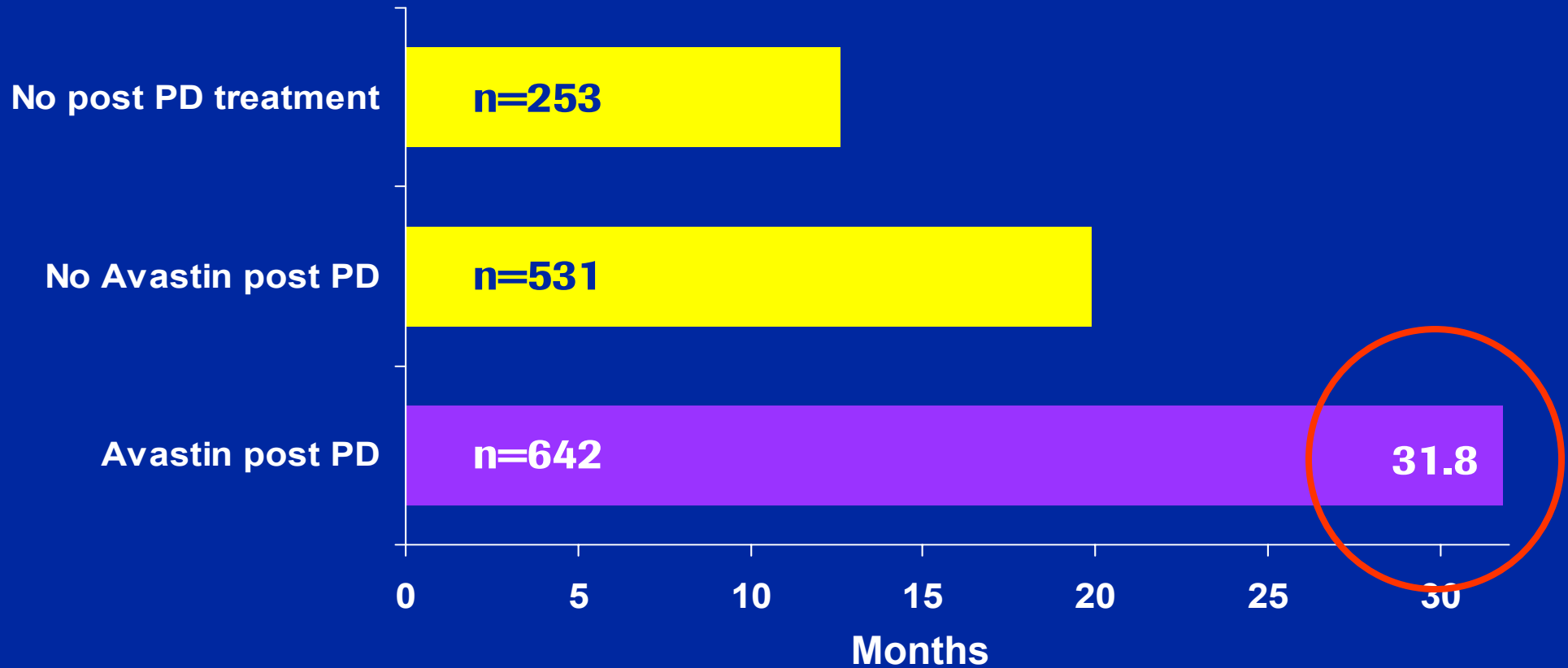
Chemotherapy backbone at discretion of investigator

Objectives: Safety and efficacy

Option to continue Avastin beyond progression at the discretion of the investigator

BRiTE: post 1st progression therapy

Avastin beyond progression: potential to increase survival



Superior survival in patients continuing Avastin beyond progression demonstrated in a multivariate analysis (HR=0.53, $p < 0.001$)

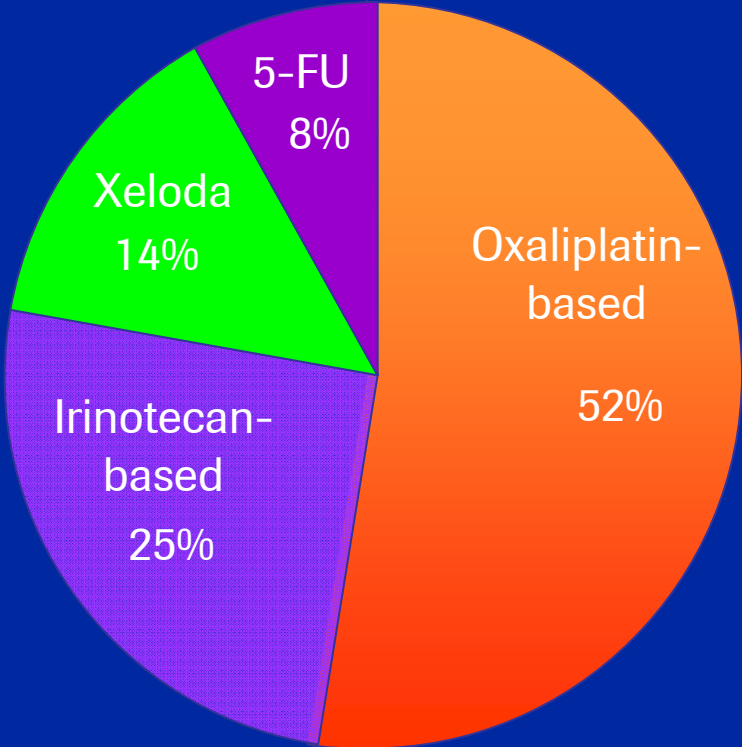
Combinations in metastatic colorectal cancer

Expanding the market for Xeloda and Avastin

Avastin

Current EU label: iv 5-FU or 5-FU + Irinotecan-based tx

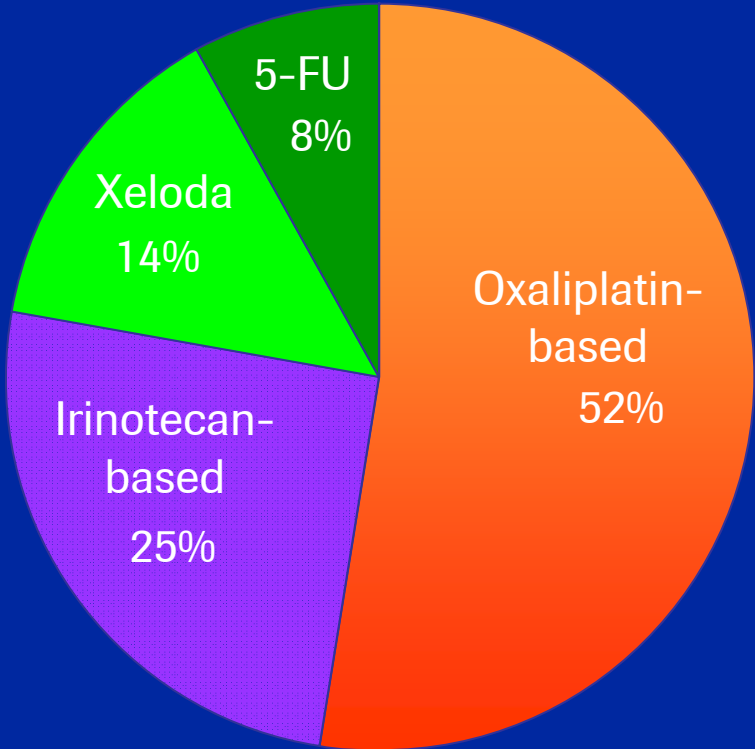
Future label: + any combination



Xeloda

Current label: Monotherapy

Future label: extended to oxaliplatin-based therapy plus/minus Avastin



Avastin: aiming for cure in mCRC



Excellent safety and efficacy results in patients not optimal candidates for primary liver resection

Response	Patients (n=54)
Overall response rate	74%
Complete pathological response	9%
Resection rate	90%

Peri- and post-operative events:

- No increased bleeding
- Normal liver regeneration
- One patient required further surgery

Avastin in mCRC

Strong and clinically meaningful efficacy

Four randomized phase III trials show compelling efficacy

- AVF2107g
- E3200
- AVF2192
- NO16966

AVIRI / BICC-C / MD Anderson

- Avastin + FOLFIRI investigated in more than 1000 patients
- Demonstrates excellent PFS results and response rates

BRiTE

- Initial evidence of benefit from Avastin in multiple lines of therapy

Aiming for cure

- Excellent safety and efficacy results in patients not optimal candidates for primary liver resection

Breast Cancer

Colorectal Cancer

Non-Small Cell Lung Cancer

Non Hodgkin's Lymphoma

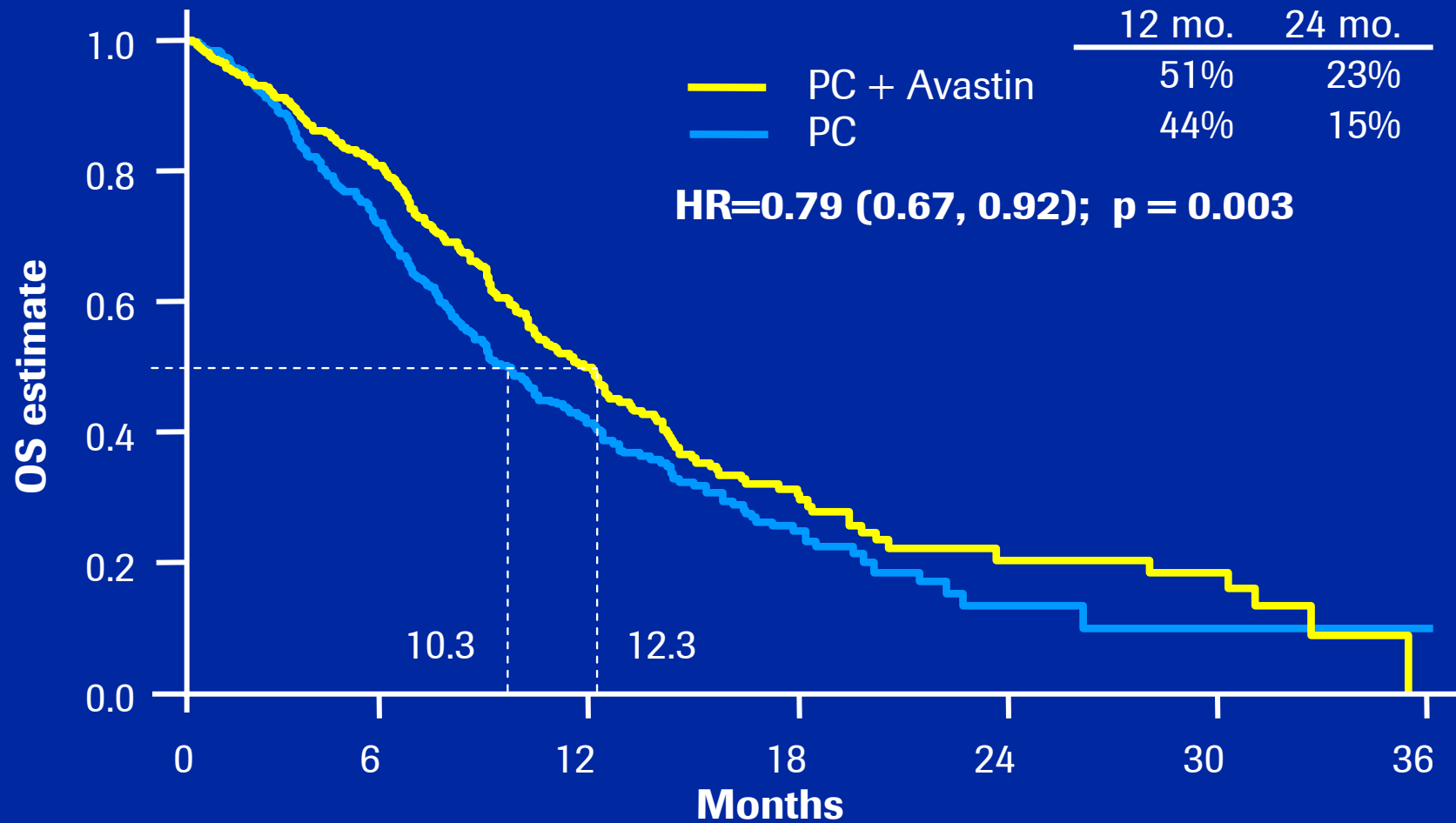
Renal Cell Carcinoma

Outlook



Avastin in 1st line NSCLC (E4599)

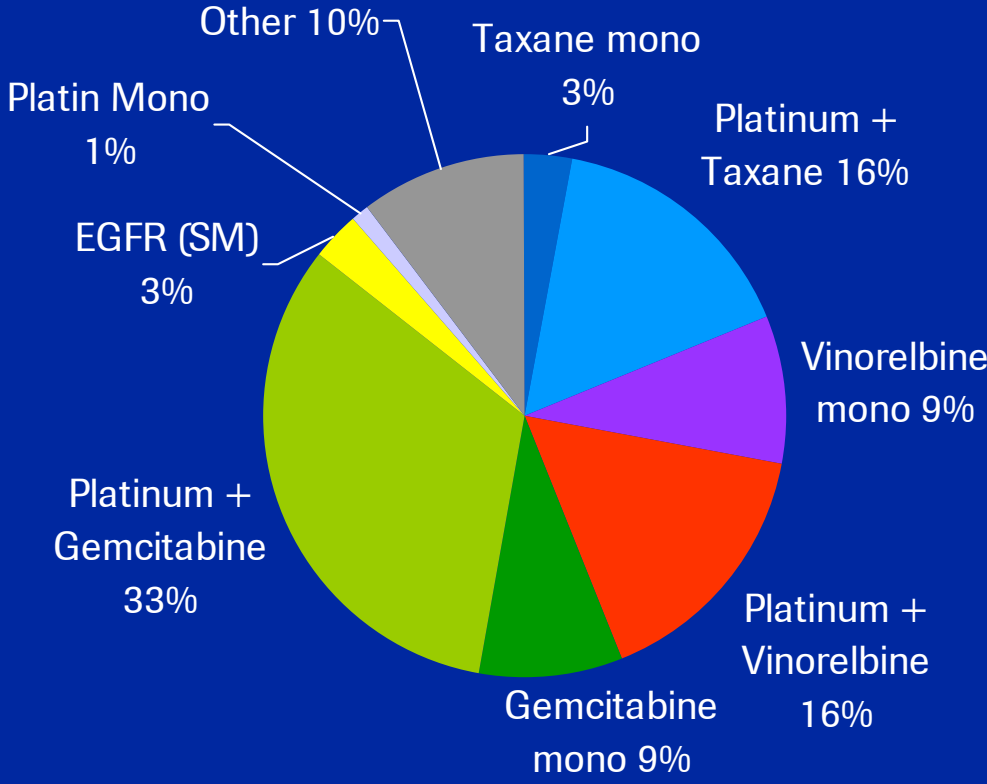
First drug in a decade to show an overall survival benefit



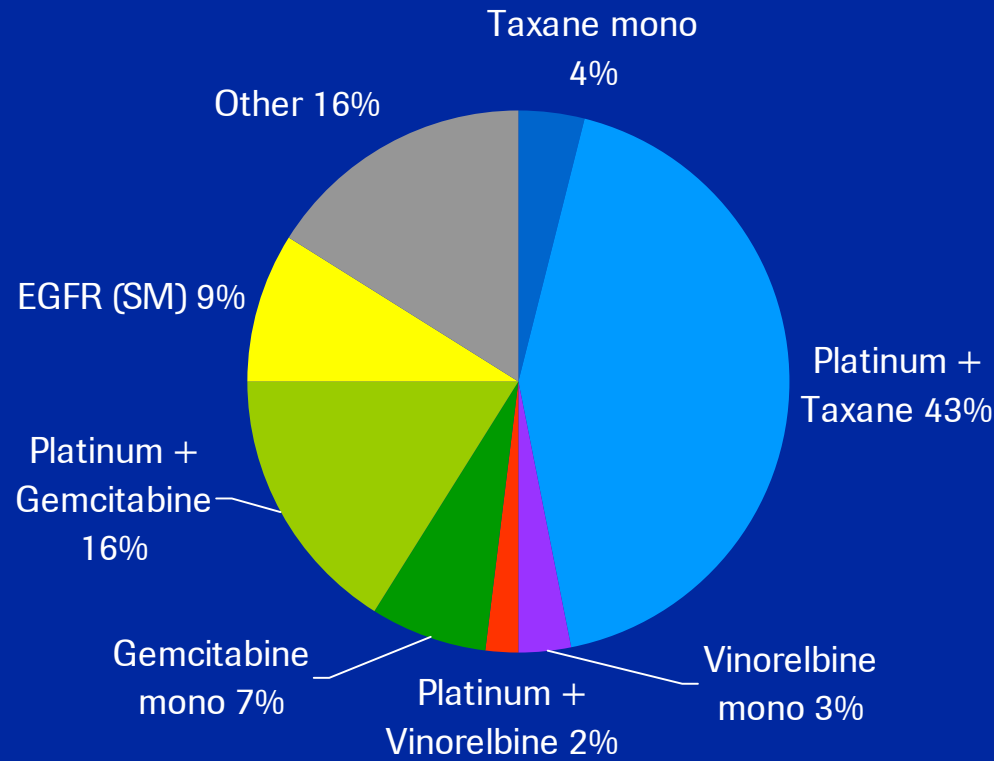
The 1st line NSCLC market

Different treatment algorithms in US & EU

EU



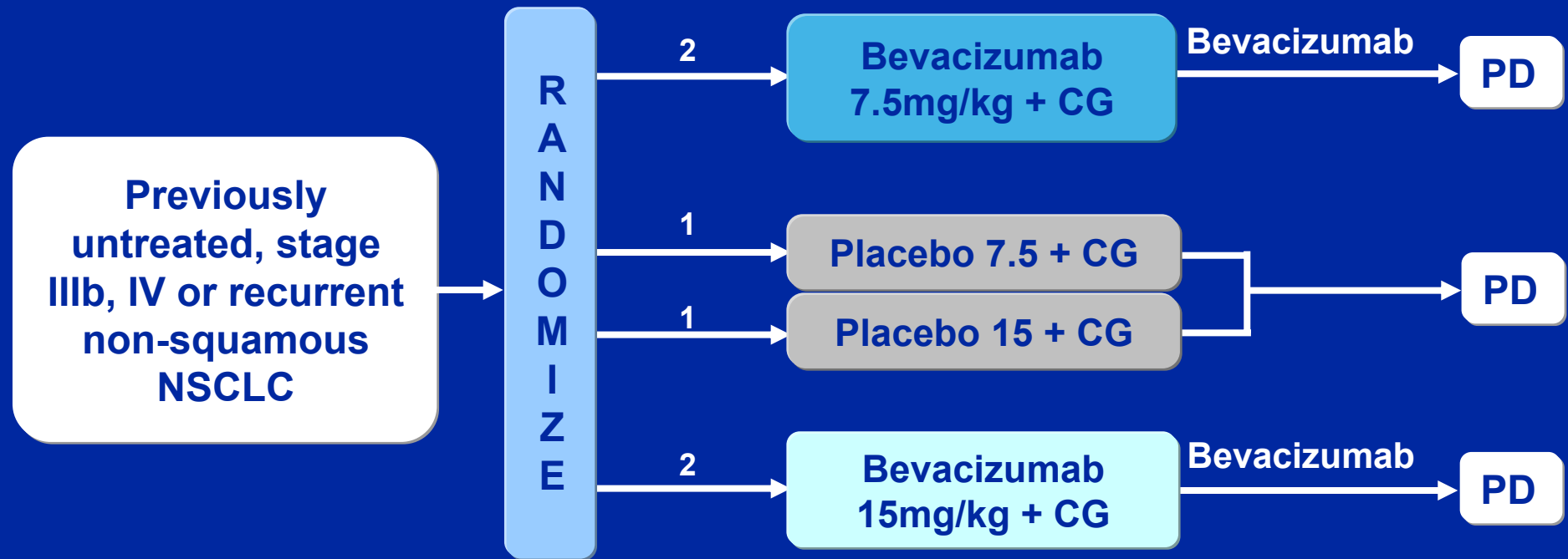
US



Source: Synovate Healthcare 2005

AVAIL 'Avastin in Lung'

Study design



Primary endpoint

- Progression-free survival (PFS)

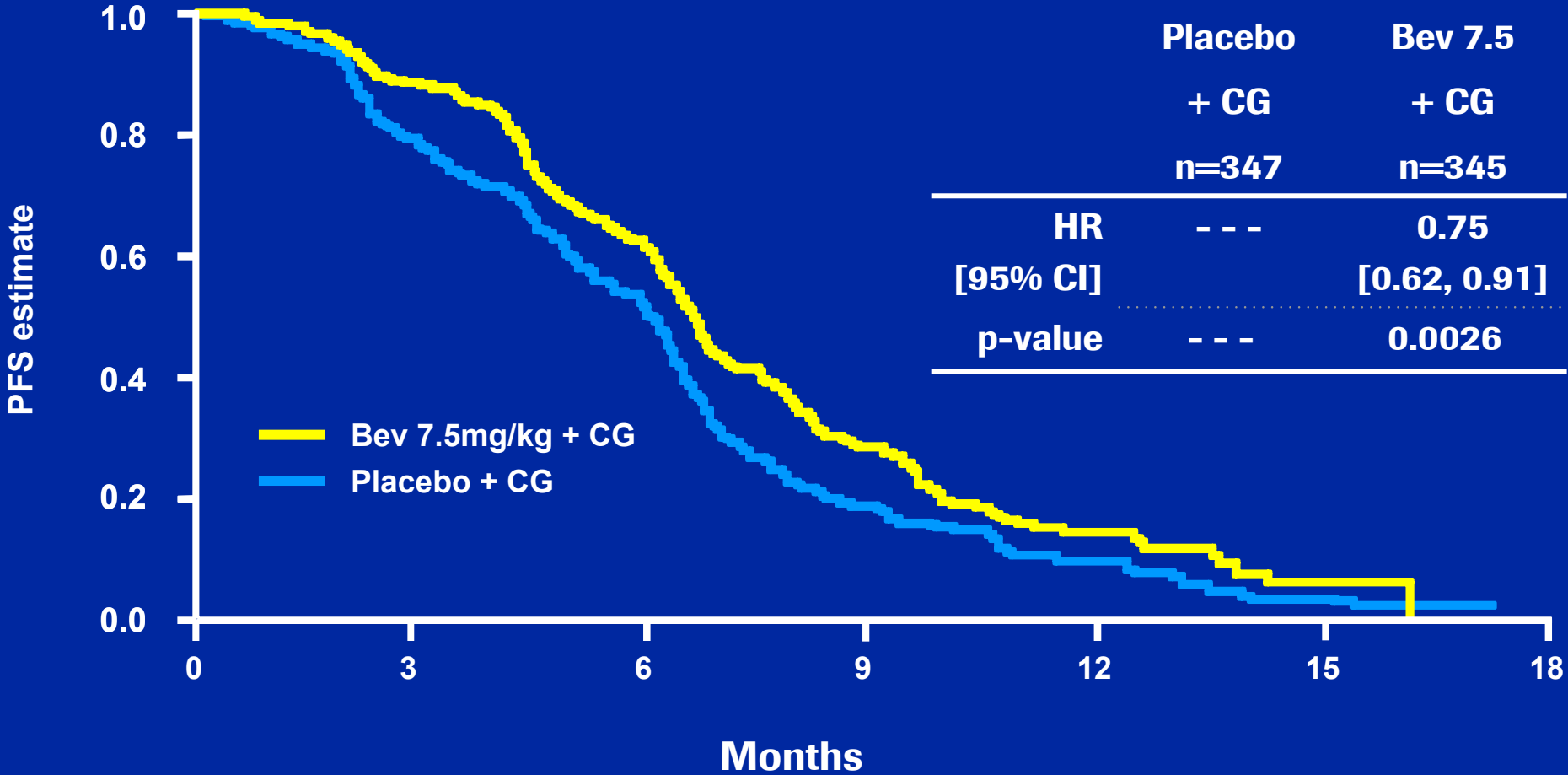
Secondary endpoints

- Overall survival
- Response rates
- Duration of response
- Safety



Progression-free survival

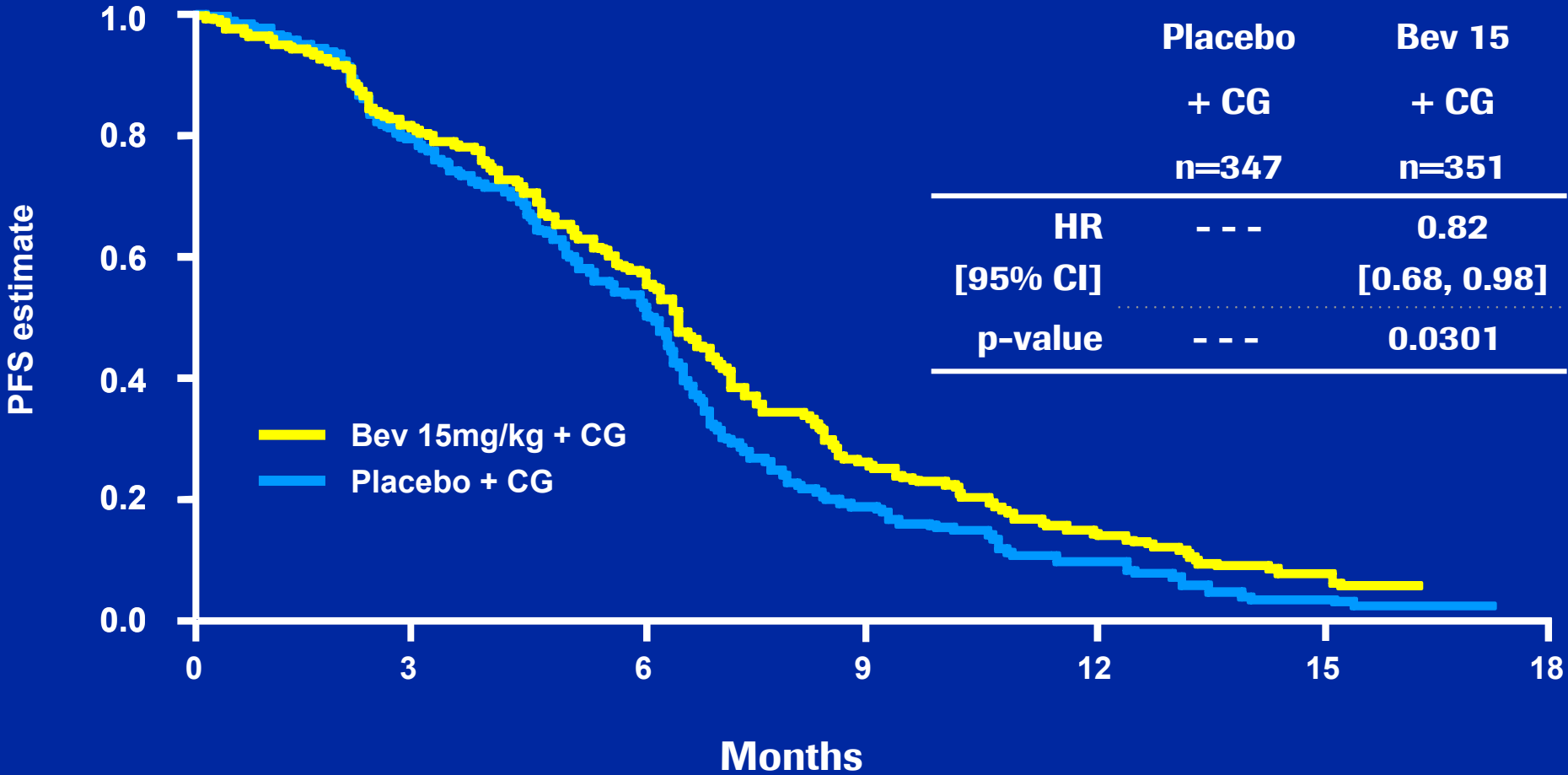
Primary analysis (ITT) of Avastin 7.5mg/kg versus placebo





Progression-free survival

Primary analysis (ITT) of Avastin 15mg/kg versus placebo





Primary censoring for the PFS endpoint

Difference between US and European trials

- Pre-planned analysis to correct for 7% of patients in the trial who received antineoplastic therapy before documented PD

	With NPT censoring		
	Placebo + CG n=347	Bevacizumab 7.5mg/kg + CG n=345	Bevacizumab 15mg/kg + CG n=351
Hazard ratio		0.68	0.74
95% CI		[0.56, 0.83]	[0.60, 0.90]
p value		0.0001	0.0021

Hazard ratio similar to E4599 (with censoring)



Tumor response and response duration

Patients with measurable disease at baseline

	Placebo + CG n=324	Bevacizumab 7.5mg/kg + CG n=323	Bevacizumab 15mg/kg + CG n=332
Response rate %	20	34	30
		p<0.0001	p=0.0017
Duration of response			
Median (months)	4.7	6.1	6.1
(95% CI)	[4.6, 5.6]	[5.1, 7.0]	[5.0, 6.6]

Number of events required for survival analysis not yet reached



Safety summary

All treated patients

	Placebo + CG n=327	Bevacizumab 7.5mg/kg + CG n=330	Bevacizumab 15mg/kg + CG n=329
Any grade 3–5 adverse event	75%	76%	81%
Serious adverse events	35%	35%	44%
Adverse events leading to death	4%	4%	5%



Severe (Gr ≥ 3) adverse events

	Placebo + CG n=327	Bevacizumab 7.5mg/kg + CG n=330	Bevacizumab 15mg/kg + CG n=329
Bleeding	2%	4%	4%
Hypertension	2%	6%	9%
Proteinuria	–	0.3%	1%
Gastrointestinal perforation	0.6%	–	0.3%
Ischemic events (includes arterial thromboembolic events)	5%	2%	3%
Venous thromboembolic events	6%	7%	7%



Pulmonary hemorrhage events

	Placebo + CG n=327	Bevacizumab 7.5mg/kg + CG n=330	Bevacizumab 15mg/kg + CG n=329
	n (%)		
Pulmonary hemorrhage (all grades)	17 (4.9%)	23 (7.0%)	32 (9.7%)
Pulmonary hemorrhage (Gr ≥ 3)	2 (0.6%)	5 (1.5%)	3 (0.9%)
Fatal pulmonary hemorrhage	1 (0.3%)	4 (1.2%)	3 (0.9%)

- 38% of patients in AVAiL had central lesions
 - 4/10 patients with severe pulmonary hemorrhage had central lesions
- 9% of patients in AVAiL had therapeutic anticoagulation
 - but none of them had a severe pulmonary hemorrhage

Avastin in 1st line NSCLC

Conclusions

- Only first-line treatment to demonstrate extended survival in over a decade
- Efficacy demonstrated in two randomized phase III trials, supporting Avastin as part of standard therapy
- Generally well tolerated
- AVAiL data: part of the EU registration dossier – should allow, together with E4599, for a broad label



Key clinical trials

Metastatic NSCLC

	Avastin	Avastin			Avastin + Tarceva		Tarceva
Study	E4599 phase III	AVAiL phase III	GNE 3744 BRIDGE phase II	GNE phase II	ATLAS phase III	BETA Lung phase III	SATURN phase III
Patient population	1 st line, non-squamous	1 st line, non-squamous	1 st line, squamous	1 st or 2 nd line, treated CNS metastases	1 st line maintenance non-squamous	2 nd line	1 st line maintenance
Treatment regimen	Carboplatin/ Taxol ± Avastin	Cisplatin/ Gemcitabine ± Avastin	RT→CT→CT + Avastin	CT + Avastin or Tarceva + Avastin	CT + Avastin →Avastin ± Tarceva	Tarceva ± Avastin	CT→ Tarceva vs. placebo
Status	Data at ASCO 2005	Data at ASCO 2007	Started 2Q 2006	Started 1Q 2006	Started 4Q 2005	Started 2Q 2005	Started 4Q 2005

Phase III in adjuvant NSCLC with Avastin in preparation

Breast Cancer

Colorectal Cancer

Non-Small Cell Lung Cancer

Non Hodgkin's Lymphoma

Renal Cell Carcinoma

Outlook

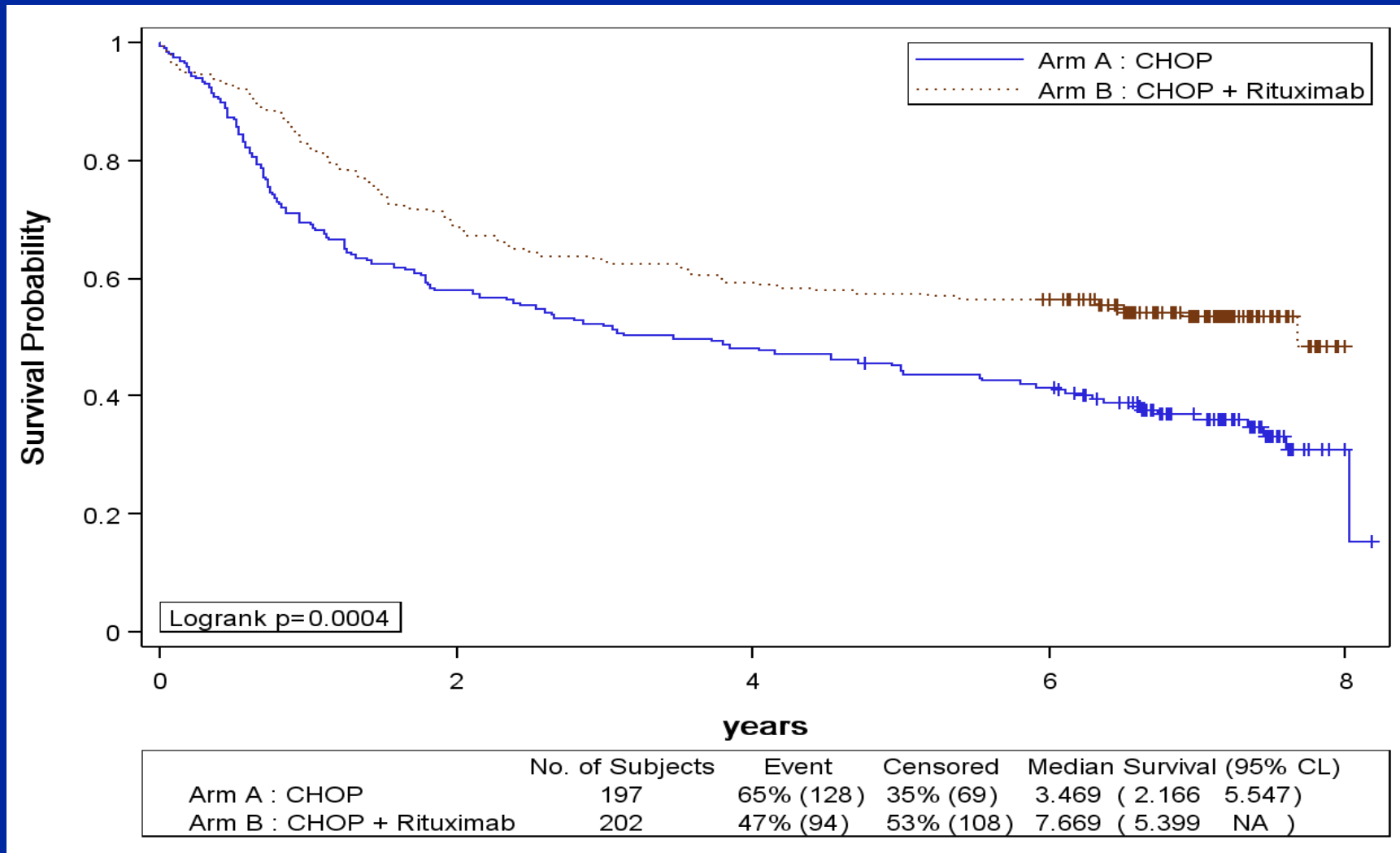
MabThera

GELA R-CHOP study

- Phase III trial to investigate efficacy and safety of R-CHOP combination
- Multicenter, randomized, open-label study evaluated 399 previously untreated elderly patients (60-80 years) with diffuse large B-cell lymphoma (DLBCL)
- Treatment consisted of 8 cycles of CHOP every 3 weeks, either alone or combined with rituximab

Overall Survival

Median follow-up 7 years



GELA R-CHOP Study

Conclusions

- MabThera has dramatically changed the natural history of diffuse large cell lymphoma
- R-CHOP the definitive standard of care in aggressive NHL
- Offers patients the best chance of cure

Breast Cancer

Colorectal Cancer

Non-Small Cell Lung Cancer

Non Hodgkin's Lymphoma

Renal Cell Carcinoma

Outlook



ASCO 2007 Investor Event
Chicago, June 4, 2007

AVOREN Avastin in 1st line renal cell carcinoma
B. Escudier, Institut Gustave Roussy, Paris

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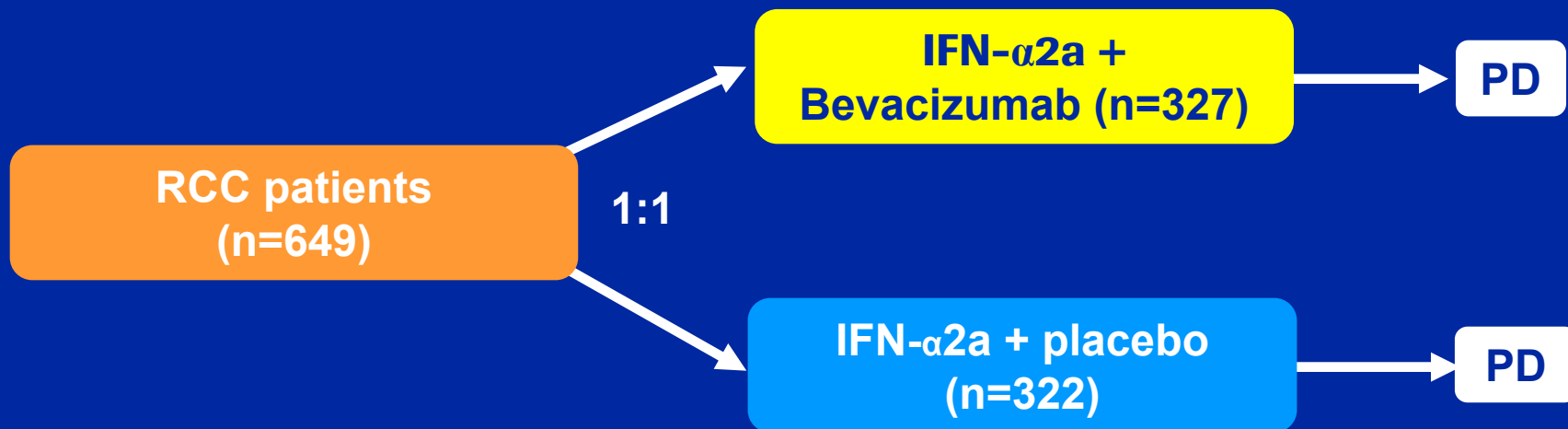
Trial rationale

- Until recently, treatment of metastatic RCC included immunotherapy as standard of care
- Treatment with interferon (IFN) provided modest clinical benefit and toxicity with an expected median progression-free survival of 4.7 months and median overall survival of 13–14 months¹
- VEGF has become a critical target in this disease and agents that target this pathway have recently been approved
- The bevacizumab dose of 10mg/kg q2w has shown an acceptable safety profile as monotherapy in RCC

¹Motzer et al JCO 2002;20:289–96

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Study design



- Bevacizumab/placebo 10mg/kg i.v. q2w until progression
- IFN- α 2a 9MIU s.c. three times/week (maximum of 52 weeks) (dose reduction allowed)
- Multinational ex-US study: 101 study sites in 18 countries
- Stratification factors: country and Motzer score

PD = progression of disease; i.v. = intravenous; s.c. = subcutaneous

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Objectives

Primary objective

- To evaluate the efficacy of the combination of IFN- α 2a plus bevacizumab as compared with IFN- α 2a alone based on overall survival

Secondary objectives

- Progression-free survival, time to disease progression, time to treatment failure and objective response rates of IFN- α 2a plus bevacizumab compared with IFN- α 2a alone
- Safety profile of IFN- α 2a plus bevacizumab versus IFN- α 2a alone
- Pharmacokinetics and pharmacodynamics of bevacizumab



Tumor response

Investigator assessed

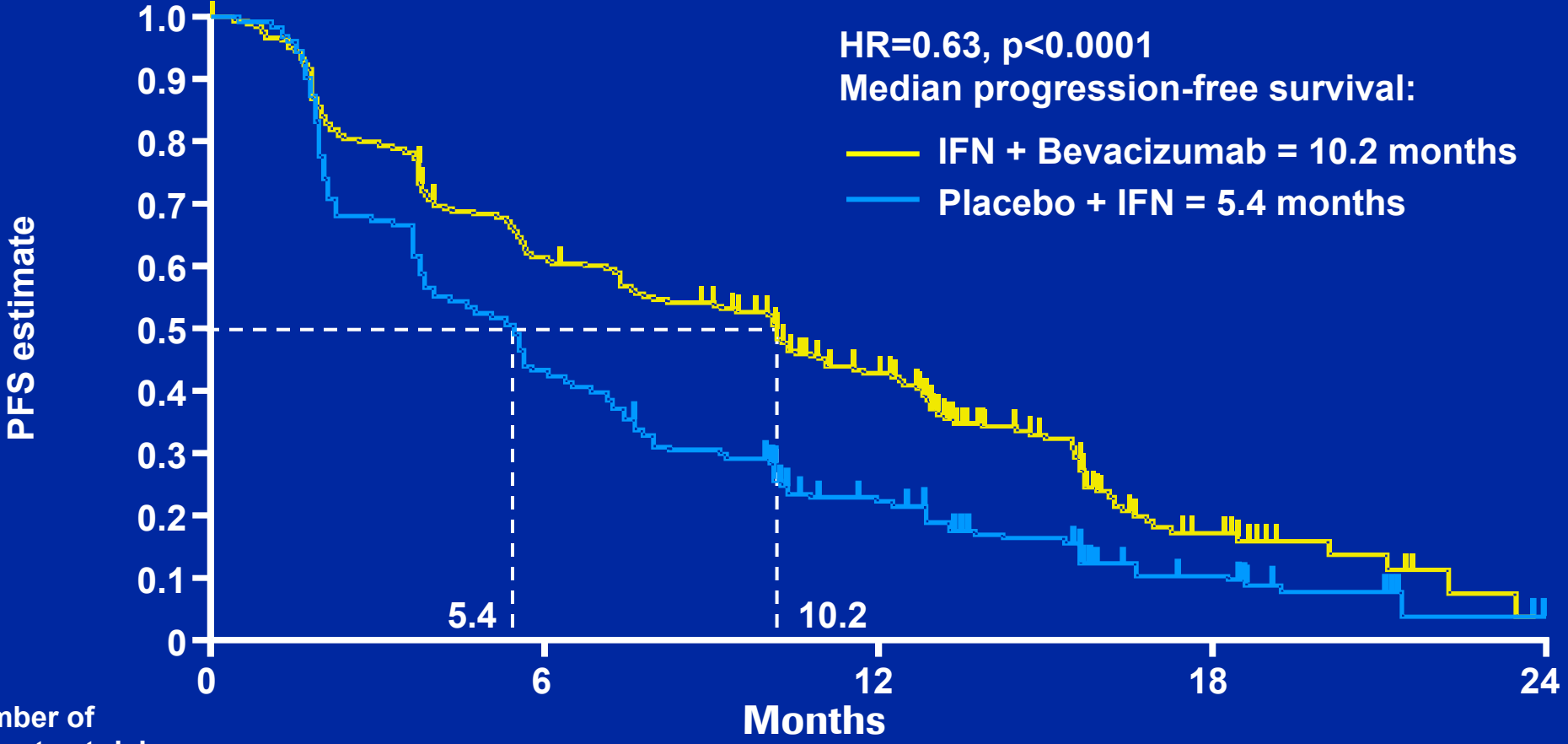
Response	IFN + placebo (n=289)	IFN + Bevacizumab (n=306)
Overall response rate (%)*	13	31
Complete response	2	1
Partial response	11	30
	p<0.0001	
Median duration of response (months)	11	13
Median duration of stable disease (months)	7	10

*Patients with measurable disease only



Progression-free survival

Investigator assessed

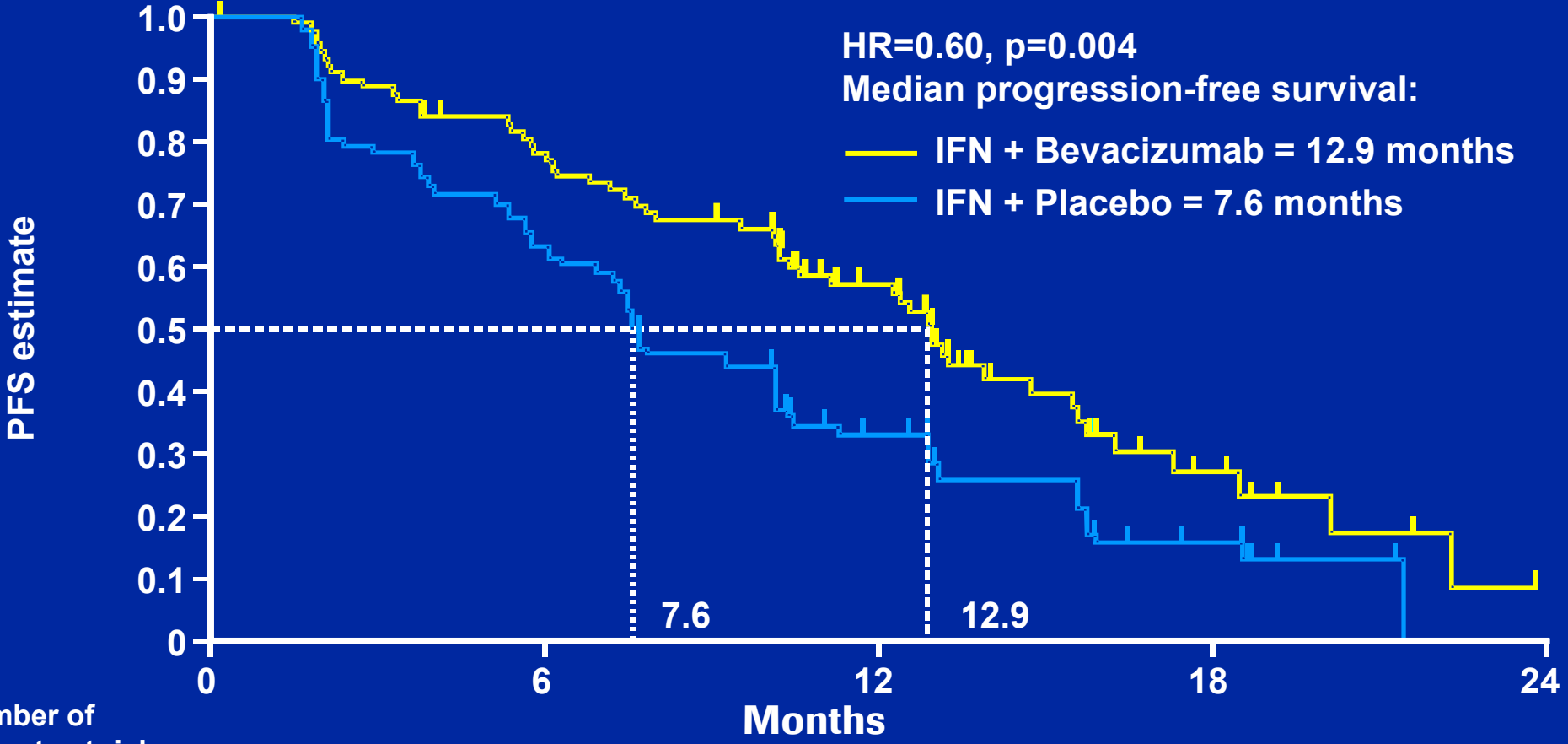


Number of patients at risk		Months				
	0	6	12	18	24	
Placebo + IFN	322	137	59	15	0	
IFN + Bevacizumab	327	196	107	18	0	



Motzer subgroup

Favorable

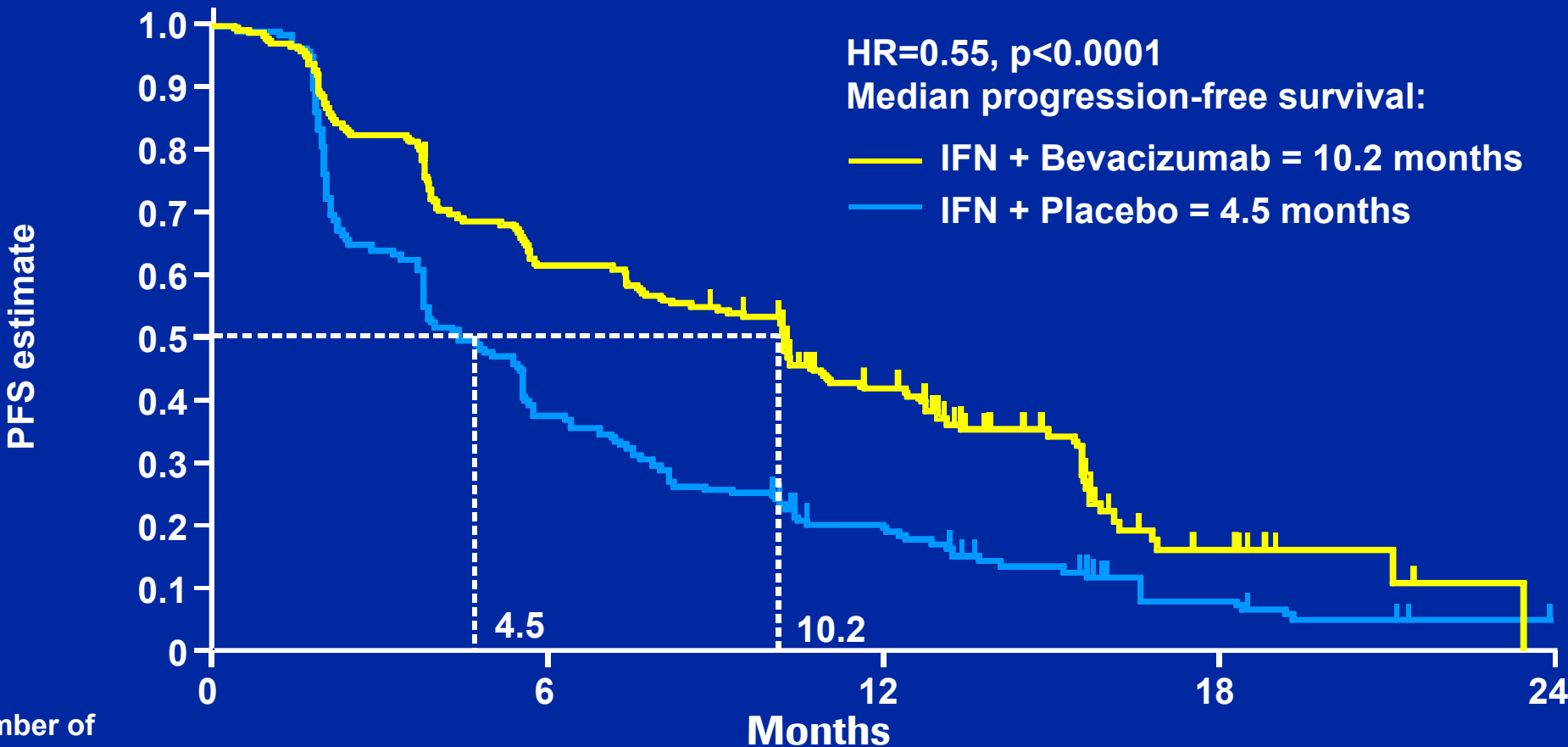


Number of patients at risk

IFN + Placebo	93	57	25	7	0
IFN + Bevacizumab	87	65	39	8	0

Motzer subgroup

Intermediate

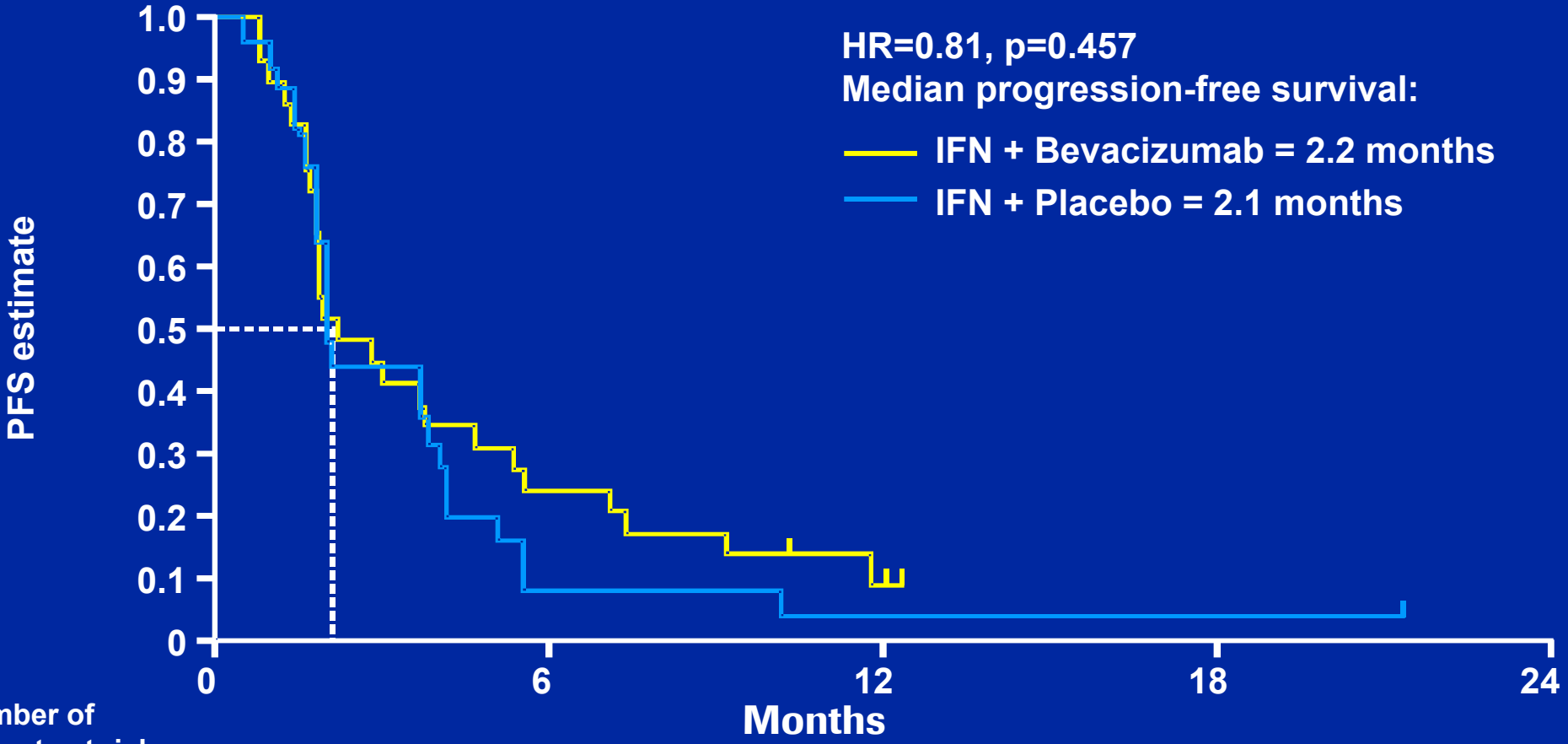


Number of patients at risk

IFN + Placebo	180	67	28	6	0
IFN + Bevacizumab	183	112	60	9	0

Motzer subgroup

Poor



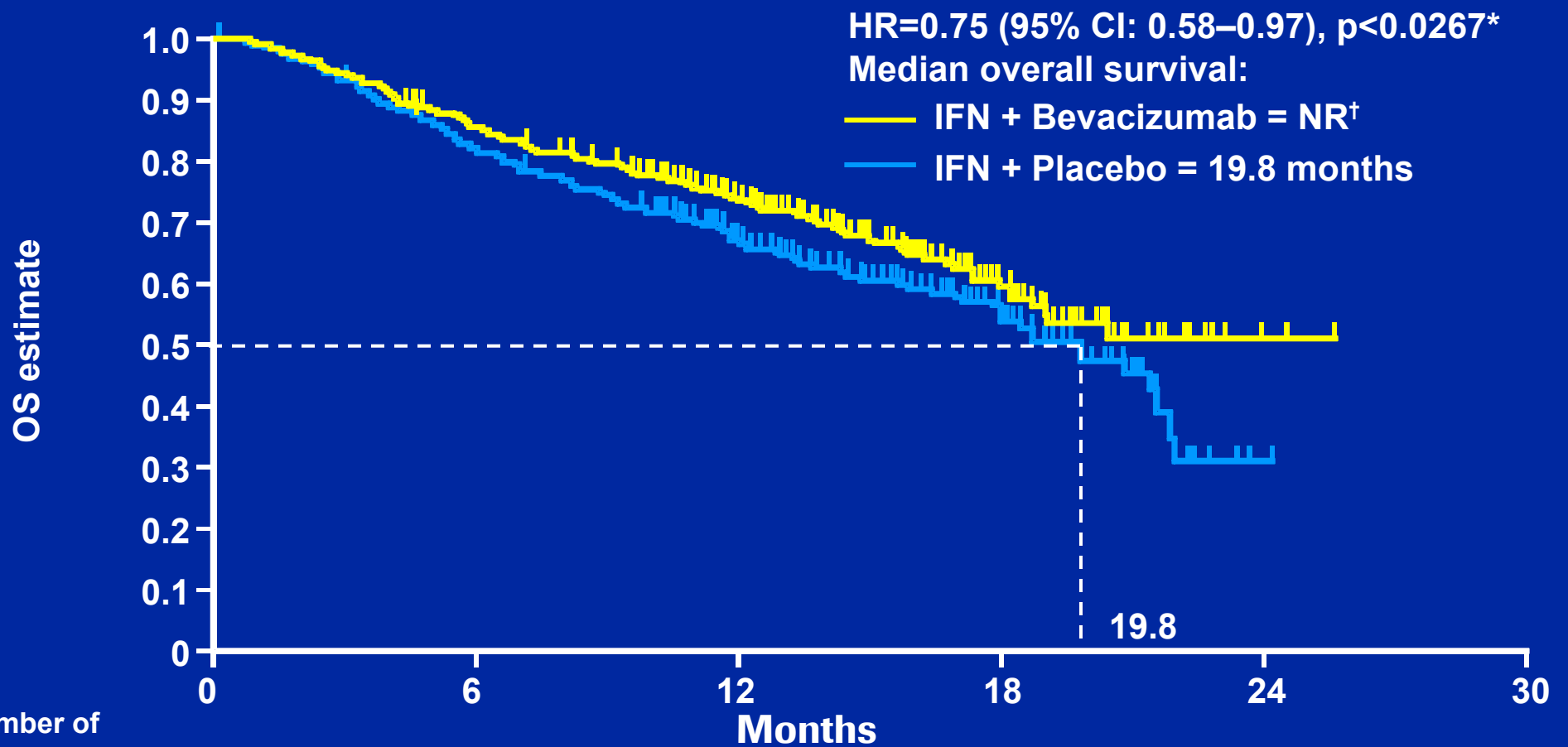
Number of patients at risk

IFN + Placebo	25	2	1	1	0
IFN + Bevacizumab	29	7	1	0	0



Interim analysis of overall survival

251 of 450 scheduled events



Number of patients at risk

	0	6	12	18	24	30
IFN + Placebo	322	262	176	53	1	0
IFN + Bevacizumab	327	275	197	60	2	0

77

*Stratified by Motzer score and region category; prespecified level of significance $p=0.0056$ †Not reached



Overview of adverse events*

	Number of patients	
	IFN + placebo (n=304)	IFN + Bevacizumab (n=337)
Median duration of treatment		
Bevacizumab/placebo (months)	5	10
Dose intensity (%)	96	92
IFN (months)	5	8
Dose intensity (%)	96	91
Grade ≥ 3 adverse event (%)	45	60
Serious adverse event	16	29
Discontinuation due to adverse event (%)		
Any study drug	12	28
Bevacizumab/placebo	6	19
IFN	12	23
Death not due to PD (%)	2	2 [†]

*Based on safety population; [†]3/8 deaths were possibly related to bevacizumab



Selected grade 3/4 adverse events*

Adverse event	Number of patients (%)	
	IFN + placebo (n=304)	IFN + Bevacizumab (n=337)
Any grade 3/4 adverse event	137 (45)	203 (60)
Fatigue/asthenia/malaise	46 (15)	76 (23)
Proteinuria	0 (0)	22 (6.5)
Hypertension	2 (0.7)	13 (3.9)
Hemorrhage	1 (0.3)	11 (3.3)
Venous thromboembolism	2 (0.7)	6 (1.8)
Gastrointestinal perforation	0 (0)	5 (1.5)
Arterial ischemia	1 (0.3)	4 (1.2)

*Based on safety population

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Conclusions

- In this placebo-controlled study, the addition of bevacizumab to IFN results in clinically important and statistically significant improvement in progression-free survival and tumor response
- Trend in favor of improved survival exists
- The treatments were well tolerated and no new toxicities emerged outside of those known with IFN and bevacizumab

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Outlook

Building the standard of care

Phase III trials in major indications and cancer types



	Adjuvant	Maintenance	1 st Line		2 nd Line
Filed			Tarceva pancreatic Ca ✓	Avastin NSCLC ✓	Avastin mBC ✓
			Xeloda gastric Ca ✓	Avastin mCRC 1 st line ext. ✓	Avastin RCC ✓
			Herceptin mBC combo hormonal ✓	Xeloda mCRC 1 st line combo ✓	Xeloda mCRC 2 nd line combo ✓
Ongoing	Xeloda adjuvant BC	Tarceva & Avastin NSCLC maintenance	Avastin mBC 1 st line ext.	Avastin NSCLC 1 st line ext.	Avastin prostate Ca
	Xeloda adjuvant CC combo	MabThera iNHL maintenance	Avastin pancreatic Ca	Avastin ovarian Ca	Tarceva & Avastin NSCLC 2 nd line
	Avastin adjuvant CC		Avastin & Herceptin mBC 1 st line ext.		Avastin mBC 2 nd line
	Avastin adjuvant rectal Ca		Herceptin gastric Ca	Tarceva NSCLC 1 st line	MabThera relapsed CLL
	Tarceva adjuvant NSCLC		MabThera 1 st line CLL		
Starting soon	Avastin adjuvant NSCLC	Avastin adjuvant BC	Herceptin & Pertuzumab HER2+ mBC		

The future

Targeted therapy combinations

	NSCLC			Breast Cancer			
Study	ATLAS (Phase III)	BETALung (Phase III)	Phase II	AVEREL (Phase III)	Pegram (Phase II)	Phase III	Phase II
Patient population	1 st line maintenance non-squam.	2nd line	2nd line	1st line	1st line	Adjuvant	2nd line
Treatment regimen	CT + Avastin → Avastin ± Tarceva	Tarceva ± Avastin	Avastin + Tarceva vs. Avastin + CT vs. CT	Herceptin + Taxotere ± Avastin	Herceptin + Avastin	Herceptin ± Avastin tbd	Herceptin + Pertuzumab
Status	Started 4Q 2005	Started 2Q 2005	Presented ASCO 2006	Started 3Q 2006	Presented SABC 2006	Planned	Presented at ASCO 2007

Roche setting the standards of care in combined targeted therapies



Summary

Keeping the lead

Roche - five targeted cancer medicines with

- Proven survival benefit in several cancer types
- Good tolerability
- Broad potential for combination therapies

All five drugs define or are developing into standard of care

Roche has a leading late-stage development program

Roche - uniquely positioned to maintain and expand its lead in oncology



ASCO 2007 Investor Event Chicago, June 4, 2007

Q&A

Karl Mahler, Head Investor Relations





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