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Agenda

Welcome
Karl Mahler, Head of Investor Relations

Roche hematology strategy
Tom Fuchs, Vice President, Hematology Franchise Head, Global Product Strategy

Key data presented at ASH: CLL, NHL
Ginna Laport, MD - Vice President & Global Head of Hematology NHL/CLL

Key data presented at ASH: MM, MDS
Marion Ott, MD, PhD – Global Franchise Head AML, Multiple Myeloma and Pediatric

Q&A
Welcome

Karl Mahler  |  Head of Investor Relations
# Broadest portfolio in hematology

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<th>Bispecific</th>
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<td><strong>CLL</strong></td>
<td>Gazyva</td>
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<td><strong>iNHL/FL</strong></td>
<td>Gazyva</td>
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<td>Mosunetuzumab</td>
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<td><strong>DLBCL</strong></td>
<td>Tiragolumab</td>
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<td><strong>MM</strong></td>
<td>Tiragolumab</td>
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<td>Cevostamab</td>
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<td><strong>AML</strong></td>
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<td>Venclexta</td>
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<td><strong>MDS</strong></td>
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<td><strong>Non-Malignant</strong></td>
<td>Crovalimab</td>
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<td>HemiLibra</td>
<td>Spark SPK-8011</td>
</tr>
</tbody>
</table>

- **CLL** = Chronic lymphoid leukemia; **iNHL** = Indolent Non-Hodgkin's lymphoma; **FL** = Follicular lymphoma; **DLBCL** = Diffuse large B-cell lymphoma; **MM** = Multiple myeloma; **AML** = Acute myeloid leukemia; **MDS** = Myelodysplastic syndrome; **Venclexta** in collaboration with AbbVie

- = approved
- Indications where Rituxan approved
- Heme-onc indications where Rituxan not approved
- Non-malignant hematolgy
Roche hematology strategy

Tom Fuchs | Vice President, Hematology Franchise Head, Global Product Strategy
**Innovation and acceleration of our hematology portfolio**

### Developing novel endpoints and prognostic factors
- MRD-negativity: primary endpoint in Ph 3 CristaLLo trial of Venclexta + Gazyva in 1L CLL
- ctDNA: being explored as prognostic risk factor in DLBCL

### Bringing medicines to market faster
- RTOR for Venclexta in 1L CLL and 1L AML and AA for Polivy in R/R DLBCL
- Engaging with health authorities on accelerated pathways for mosunetuzumab, glofitamab, and cevostamab, and crovalimab

### Reducing cost to society
- Focus on off-the-shelf medicines which can be administered in a variety of settings
- Fixed duration treatments avoid long term side effects of chronic therapy and generate savings to the healthcare system

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MRD = minimal residual disease; ctDNA = circulating tumor DNA; RTOR = real time oncology review; AA = accelerated approval; R/R = relapsed/refractory; DLBCL = Diffuse large B-cell lymphoma; CLL = Chronic lymphoid leukemia; AML = Acute myeloid leukemia; Venclexta in collaboration with AbbVie
Polivy readout in 1L DLBCL expected in 2021
Opportunity to establish Polivy as standard of care in curative setting

**Strong efficacy**: only agent in R/R DLBCL with OS benefit in randomized trial

**Well tolerated**: combines with standard of care (R-chemo) with no unique safety monitoring requirements

**Off the shelf**: readily available; administered in any oncology facility, with no hospitalization required

**Fixed duration**: administered for 6 cycles

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Polivy in collaboration with Seattle Genetics; R/R = relapsed/refractory; DLBCL=diffuse large B-cell lymphoma; BR = Rituxan + Bendamustine; GemOx=gemcitabine+oxaliplatin; R=Rituxan; OS=overall survival; CHP=cyclophosphamide + hydroxydaunorubicin + prednisone

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### Additional combinations with mosunetuzumab and glofitamab initiated in 1L and R/R DLBCL

<table>
<thead>
<tr>
<th>1L DLBCL</th>
<th>Approval</th>
<th>Ph1</th>
<th>Ph2</th>
<th>Ph3</th>
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</thead>
<tbody>
<tr>
<td>Polivy + R-CHP</td>
<td>POLARIX</td>
<td>✔️</td>
<td>✔️</td>
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R/R DLBCL

| Polivy + BR | ✔️ |
| Polivy + R-GemOx |
| Polivy + Venclexta + R |

>3.5 years ahead of competitors in 1L DLBCL
Mosunetuzumab and Glofitamab are differentiated CD20xCD3 bispecific antibodies

<table>
<thead>
<tr>
<th></th>
<th><strong>Mosunetuzumab (‘1:1’ format)</strong></th>
<th><strong>Glofitamab (‘2:1’ format)</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Efficacy</strong></td>
<td>• High/durable responses as single-agent and in combination across NHL subtypes</td>
<td>• Best in class efficacy potential with high CR rates in heavily pretreated R/R DLBCL</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>• Low grade 2 and no grade ≥3 CRS</td>
<td>• New step-up dosing schedule has allowed higher target doses with manageable CRS (mostly gr 1-2)</td>
</tr>
</tbody>
</table>
| **Administration** | • No protocol-required hospitalization  
                           • Potential to further improve safety profile and convenience with SC formulation | • Combinable with Rituxan and Gazyva  
                           • SC development to be started in 2021 |

R/R=relapsed/refractory; NHL=non-hodgkin’s lymphoma; DLBCL=diffuse large B-cell lymphoma; CR=complete response; CRS=cytokine release syndrome; SC=subcutaneous
Roche CD20 x CD3 bispecific portfolio can be tailored to address diverse patient and customer needs

**Mosunetuzumab**
Attractive profile for the outpatient setting and across a broad range of indications and settings

**Glofitamab**
Potential to offer CAR-T like efficacy “off-the-shelf”, for patients with aggressive disease

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<thead>
<tr>
<th>Patients</th>
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<tbody>
<tr>
<td>• FL/DLBCL/other histologies</td>
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<tr>
<td>• 1L or R/R disease</td>
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<tr>
<td>• Patient characteristics, including risk/prognostic factors</td>
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<tr>
<td>• Single agent vs combination</td>
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<tr>
<th>Providers</th>
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<tbody>
<tr>
<td>• Academic centers vs. community</td>
</tr>
<tr>
<td>• SC or IV administration</td>
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<tr>
<td>• Off-the-shelf administration</td>
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<tr>
<th>Payers</th>
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<tr>
<td>• Fixed duration vs. continuous</td>
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R/R = relapsed/refractory; DLBCL = diffuse large B-cell lymphoma; FL = follicular lymphoma; SC = subcutaneous; IV = intravenous
Most advanced CD20xCD3 bispecific portfolio
Potential to be first-in-class in FL and DLBCL

- Over 1,000 patients treated; multiple monotherapy and combination studies ongoing across lines in NHL
- Pursuing initial registration of mosun in 3L+ FL (FDA BTD) and glofit in 3L+DLBCL
- Phase 3 trials in 2L+ FL and 2L+ DLBCL planned to start in 2021
- Combination trials with Polivy ongoing/planned in 1L DLBCL, 1L elderly/unfit DLBCL and R/R DLBCL
- First ever bispecific data in front-line DLBCL (mosun)

<table>
<thead>
<tr>
<th>1L DLBCL</th>
<th>Ph1</th>
<th>Ph2</th>
<th>Ph3</th>
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<tbody>
<tr>
<td>Mosun + CHOP</td>
<td>✔️</td>
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<tr>
<td>Mosun + Polivy + CHP</td>
<td>✔️</td>
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<tr>
<td>Glofit + R-CHOP</td>
<td>✔️</td>
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<tr>
<td>Glofit + Polivy + R-CHOP*</td>
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<tr>
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<th>Ph1</th>
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<th>Ph3</th>
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<tbody>
<tr>
<td>Mosun</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Mosun + Polivy*</td>
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<td>✔️</td>
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<tr>
<th>R/R DLBCL</th>
<th>Ph1</th>
<th>Ph2</th>
<th>Ph3</th>
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<tbody>
<tr>
<td>Glofit + GemOx*</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Glofit + Polivy</td>
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<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Mosun + Polivy</td>
<td>✔️</td>
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<tr>
<td>Glofit</td>
<td>✔️</td>
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<tr>
<td>Mosun</td>
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<tr>
<th>R/R FL</th>
<th>Ph1</th>
<th>Ph2</th>
<th>Ph3</th>
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<tbody>
<tr>
<td>Mosun + Len*</td>
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<td>✔️</td>
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<tr>
<td>Mosun</td>
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<tr>
<td>Glofit +/- G</td>
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<th>R/R NHL</th>
<th>Ph1</th>
<th>Ph2</th>
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<tr>
<td>Mosun SC</td>
<td>✔️</td>
<td>✔️</td>
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* Planned trial

R/R = relapsed/refractory; DLBCL=diffuse large B-cell lymphoma; NHL=non-hodgkin’s lymphoma; SC=subcutaneous; FL=follicular lymphoma; BR= Ritusan + Bendamustine; GemOx=gemcitabine+oxaliplatin; R=Ritusan; G=Gazyva; CHOP=cyclophosphamide+hydroxydaunorubicin+vincristine+prednisone; Len=lenalidomide; BTD=breakthrough therapy designation
Venclexta

5 Breakthrough Therapy Designations, 2 approvals under RTOR

CLL = Chronic lymphoid leukemia; DLBCL = Diffuse large B-cell lymphoma; iNHL = Indolent Non-Hodgkin’s lymphoma; AML = Acute myeloid leukemia; MM = Multiple myeloma; MDS = Myelodysplastic syndrome; MRD = minimal residual disease; SCT = stem cell transplant; NCCN = National Comprehensive Cancer Network; RTOR = real time oncology review; Venclexta in collaboration with AbbVie

**CLL**
- Venclexta + Gazyva approved in 1L CLL: fixed dose, chemo free regimen
- Ph III (CristaLLo) in 1L fit CLL initiated in Q2’20; primary endpoint: MRD-negativity

**AML**
- US: Full approval in 1L unfit AML; >40% US market share; NCCN Category 1 listed
- Additional Ph III studies in AML initiated (1L maintenance, post-SCT maintenance)

**Multiple Myeloma**
- Ph III CANOVA trial underway in ~20% of patients with t(11;14) translocation

**MDS**
- Ph III VERONA trial in 1L MDS initiated Oct 2020

Developing broadly across multiple indications

CLL = 13%  
MM = 17%  
iNHL = 37%  
DLBCL = 14%  
ALL = 3%  
AML = 9%  
MDS = 7%  

CLL = Chronic lymphoid leukemia; DLBCL = Diffuse large B-cell lymphoma; iNHL = Indolent Non-Hodgkin’s lymphoma; AML = Acute myeloid leukemia; MM = Multiple myeloma; MDS = Myelodysplastic syndrome; MRD = minimal residual disease; SCT = stem cell transplant; NCCN = National Comprehensive Cancer Network; RTOR = real time oncology review; Venclexta in collaboration with AbbVie
Hemlibra

The most prescribed prophylactic treatment in the US for Hemophilia A

Source: Treated patients, Hemlibra Epidemiology models 2018; PWHA=People with Hemophilia A

~85% Hemlibra target population
US: Nearly 25% total market share in Q3

Significant experience and exposure to Hemlibra since it’s initial approval more than three years ago
• >8,200 people have received Hemlibra globally

Additional studies planned/initiated to continue to build evidence supporting the profile of Hemlibra:
• HAVEN6 (Mild to moderate patients)
• HAVEN7 (pediatric/infant patients)
Hemlibra long-term safety and efficacy

- The percentage of participants with zero treated bleeds increased over the first year and remained above 80% thereafter
- >95% of target joints in evaluable patients were resolved* with Hemlibra prophylaxis
- Favorable long-term safety profile: well tolerated over long-term follow-up with >970 patient years of exposure in HAVEN1-4

Callaghan, et al, ASH 2020; ABR=annualized bleed rate * Mean ABR calculated using a negative-binomial regression model
Crovalimab in PNH
Recycling Ab for maximal inhibition of C5

Anti-C5 mAb

1. High affinity binding
2. Preferential Ab uptake of antigen-bound Ab (Pi engineering)
3. Acid-sensitive antigen release
4. C5 degradation in the endosome
5. Ab recycling by FcRn engineering, protecting Abs from degradation

Ph III COMMODORE 1/2 trials initiated in PNH (switch and naive)

**COMMODORE1**

**Switch**
Patients with PNH aged ≥18 yrs on eculizumab ≥6m
- R 1:1
- Primary efficacy analysis
- crovalimab continuation
- eculizumab
- Descriptive arm

Adolescents, C5 SNP pts, pts on ravulizumab, pts > labeled dose of ecu
- crovalimab
- crovalimab continuation

**COMMODORE2**

**Naive**
Patients with PNH aged ≥12 yrs not previously tx with C5i
- R 1:1
- Primary efficacy analysis
- crovalimab continuation
- eculizumab

Additional study planned for PNH patients in China (COMMODORE 3)
Development of crovalimab in additional complement-mediated diseases is being explored

Key data presented at ASH: CLL, NHL

Ginna Laport, MD | Vice President & Global Head of Hematology NHL/CLL
Venclexta benefit maintained over long term follow-up with fixed duration dosing

MURANO: 5-year update (VenR in R/R CLL)\(^1\)

- 5-yr OS: 82.1% vs. 62.2% (HR: 0.40, p<0.001)

CLL14: 4-year update (VenG in 1L CLL)\(^2\)

- 4-yr OS: 85.3% vs. 83.1% (HR: 0.85, p=0.49)

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1. Kater, et al, ASH 2020; 2. Al Sawaf et al, ASH 2020; Venclexta in collaboration with AbbVie; CLL=Chronic lymphoid leukemia; VenR = Venclexta+Rituxan; VenG=Venclexta+Gazyva; BR= Bendamustine+Rituxan; G-Clb=Gazyva+Chlorambucil; mPFS=median progression free survival; OS: overall survival; NR=not reached
Polivy OS benefit in R/R DLBCL maintained with longer follow-up and consistent across cohorts

Main study

Phase Ib: Safety run-in
Pola+BR

R/R DLBCL

Pola+BR (n=6)

Phase II: Randomization
Pola+BR vs BR

R/R DLBCL

Randomized

Median follow-up: 48.9 months

Pola+BR (n=40)

BR (n=40)

Extension cohort

Phase II: Extension
Pola+BR

R/R DLBCL

Median follow-up: 15.2 months

Pola+BR (n=106)

Pooled Pola+BR cohorts (N=152)

Randomized

\[ \text{Median OS (95\% CI)} \]

Pola+BR (N=40): 12.4 months (9.0, 32.0)

BR (N=40): 4.7 months (3.7, 8.3)

Extension cohort

\[ \text{Median OS (95\% CI)} \]

Pola+BR (N=106): 12.5 months (8.3, 23.1)

1. Sehn et al, ASH 2020; Clinical cut-off date: July 07, 2020; Polivy in collaboration with Seattle Genetics; R/R = relapsed/refractory; DLBCL=diffuse large B-cell lymphoma; BR=Rituxan+Bendamustine; OS=overall survival
Polivy R/R DLBCL subgroup analysis demonstrates strong efficacy in 2L and non-refractory patients

Patients in Polivy randomized Ph 2 were highly pretreated and highly refractory, limiting the utility of cross-trial comparisons

- 72% of patients with ≥2 lines of prior therapy
- 75% refractory to last prior therapy
- 53% primary refractory

Subgroup analyses from pooled data demonstrate strong efficacy in 2L and non-refractory patients

**Best CR**

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate</th>
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<tbody>
<tr>
<td>2L</td>
<td>74%</td>
</tr>
<tr>
<td>Non-refractory to last tx</td>
<td>92%</td>
</tr>
<tr>
<td>Non-primary refractory</td>
<td>87%</td>
</tr>
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**Pooled data from randomized Ph 2 and expansion cohort**

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<thead>
<tr>
<th>Category</th>
<th>mPFS</th>
<th>mOS</th>
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<tbody>
<tr>
<td>2L (n=50)</td>
<td>5.4m</td>
<td>10.4m</td>
</tr>
<tr>
<td>3L+ (n=102)</td>
<td>4.9m</td>
<td>12.6m</td>
</tr>
<tr>
<td>Non-refractory* (n=36)</td>
<td>2.8m</td>
<td>12.6m</td>
</tr>
<tr>
<td>Refractory* (n=116)</td>
<td></td>
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</tr>
<tr>
<td>Non-primary refractory (n=55)</td>
<td>2.8m</td>
<td>12.6m</td>
</tr>
<tr>
<td>Primary refractory (n=97)</td>
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Median OS NE

Sehn et al, ASH 2020; Clinical cut-off date: July 07, 2020; Polivy in collaboration with Seattle Genetics; R/R = relapsed/refractory; DLBCL = diffuse large B-cell lymphoma; BR = Rituxan + Bendamustine; PFS = progression free survival; CR = complete response; OS = overall survival; refractory defined as no response or progression or relapse within 6 months of first anti-lymphoma therapy end date (primary refractory), or within 6 months of last anti-lymphoma therapy end date; PFS is IRC assessed
Mosunetuzumab: durable responses in patients with R/R FL
Outpatient regimen with only grade 1 and 2 CRS observed

**DOR in patients who achieved CR (efficacy population)**

Median duration of CR:
21 mos (95% CI: 16.0–22.7)

**High response rates in high risk subsets**

- **Complete response**
  - All FL patients: 67.7%
  - Refractory to last prior therapy: 16.1%
  - Refractory to first line therapy: 47.8%
  - Double refractory to first and second line therapy: 51.6%
  - POD24: 71.1%
  - Prior CAR-T therapy: 84.6%

- **Partial response**
  - All FL patients: 51.8%
  - Refractory to last prior therapy: 17.4%
  - Refractory to first line therapy: 50.0%
  - Double refractory to first and second line therapy: 50.0%
  - POD24: 75.9%
  - Prior CAR-T therapy: 50.0%

**Randomized Ph 3 trial planned in 2L+ FL: mosun+len vs. Rituxan+len**

Assouline et al, ASH 2020; FL = follicular lymphoma; R/R = relapsed/refractory; CR=complete response; CRS=cytokine release syndrome; DOR= duration of response; len=lenalidomide
Mosunetuzumab: durable CRs in elderly/unfit 1L DLBCL
Up to 30% of 1L patients do not receive standard dose R-CHOP

Median age, range: 82 yo (67 -100) All CRS events were Grade 1, except one (Grade 2)

1. Olszewski et al, ASH 2020; Data are presented for the secondary efficacy population (patients enrolled in the study for at least three months); DLBCL=Diffuse large B-cell lymphoma; CRS=cytokine release syndrome; R=Rituxan; CHOP=cyclophosphamide+hydroxydaunorubicin+vincristine+prednisone
Mosunetuzumab + CHOP (M-CHOP)
First ever bispecific combination data in 1L DLBCL

Primary response assessment (End of Treatment)¹

1L DLBCL

- ORR: 28/34 (82.4%)
- CR: 27/34 (79.4%)

R/R NHL

- ORR: 6/7 (85.7%)
- CR: 6/7 (85.7%)

- Primary response assessment compares favorably to historical standard of care (R-CHOP) in 1L DLBCL²
  - ORR (EOT): 78%
  - CR (EOT): 59%

- All CRS was grade 1-2, and all occurred in cycle 1

Multiple combination regimens with mosun and glofit being explored in 1L fit DLBCL

1. Phillips et al, ASH 2020; 2. Sehn et al, Blood 2019; DLBCL=Diffuse large B-cell lymphoma; CR=complete response; ORR=overall response rate; CR=Complete response; R= Rituxan; CRS=cytokine release syndrome; CHOP=cyclophosphamide+hydroxydaunorubicin+vincristine+prednisone; EOT=end of treatment
Mosunetuzumab Subcutaneous (SC) Ph I/Ib dose escalation

Preliminary data supports further SC development

Promising efficacy in fixed-dose escalation
- Anti-tumor activity observed in highly pre-treated aNHL and iNHL patients

CRS was infrequent, mild, and transient
- Less frequent Grade 2 CRS than IV at 7-fold higher dose
- No Grade 2 CRS observed at doses below 13.5 mg

Favorable PK profile with SC dosing
- High bioavailability (>95%)
- Slow absorption rate
- Lower peak IL-6 levels, with delayed onset

SC step up dosing will be explored to further optimize profile

Matasar et al, ASH 2020; *SPD data from one patient is missing in the waterfall plot due to delayed data entry on lesion measurement; aNHL= aggressive non-Hodgkins lymphoma; iNHL=indolent non-hodgkins lymphoma; CR=complete response; OR= overall response; SC=subcutaneous; IV= intravenous; CRS=cytokine release syndrome; PK=pharmacokinetic
Glofitamab shows high CR rates in heavily pre-treated DLBCL
“Off-the shelf” option with manageable CRS rates

Glofitamab step-up dosing* (2.5/10/16mg or 2.5/10/30mg)

- Partial metabolic response
- Complete metabolic response

<table>
<thead>
<tr>
<th>Dose</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>53.8%</td>
</tr>
<tr>
<td>Aggressive NHL</td>
<td>63.5%</td>
</tr>
<tr>
<td>Indolent NHL</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

Median prior lines of therapy: 3; Refractory to most recent therapy: 76.9%

Aggressive NHL

Randomized Ph III trial planned in 2L+ DLBCL: Glofit+GemOx vs. Rituxan+GemOx

Hutchings et al, ASH 2020; *Patients with missing or no response assessment are included as non-responders. Two aNHL and six iNHL patients did not have a response assessment reported at time of CCOD; DLBCL=Diffuse large B-cell lymphoma; CRS=cytokine release syndrome; CR=complete response; GemOx=gemcitabine+oxaliplatin; CCOD=clinical cut-off date
Key data presented at ASH: MM, MDS

Marion Ott, MD, PhD | Global Franchise Head AML, Multiple Myeloma and Pediatric
Cevostamab (FcRH5 x CD3)

- Humanized IgG-based T-cell-engaging bispecific ab
- Targets the most membrane-proximal domain of FcRH5 on myeloma cells and CD3 on T cells
- Resulting in T-cell activation and potent killing of myeloma cells

FcRH5 x CD3

FcRH5 protein expression in normal B cells, normal plasma cells and myeloma cells

- FcRH5 expressed exclusively in the B-cell lineage and across all maturation stages (elevated in myeloma cells and normal plasma cells vs normal B cells)
- Expressed on myeloma cells with near 100% prevalence

1. Li et al. Cancer Cell 2017;31:383–95; Ig=immunoglobulin; MM=multiple myeloma; ab=antibody
Cevostamab Ph 1 dose escalation in R/R MM

Patients were highly pretreated and highly refractory

**Baseline Characteristics**

- Median prior lines of therapy: 6 (2–15)
- Prior PI: 100%
- Prior IMiD: 100%
- Prior anti-CD38 mAb: 81%
- Prior anti-BCMA†: 21%
- Triple class refractory: 72%
- Penta-drug refractory: 45%
- Refractory to last therapy: 94%
- High-risk cytogenics*: 88%

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*Cohen et al ASH, 2020; BCMA=B-cell maturation antigen; PI=proteasome inhibitor; IMiD=immunomodulatory imide drug; R/R=relapsed/refractory; MM=multiple myeloma

*1q21, 21/29 (72%); t(4;14), 5/30 (17%); t(14;16), 0/29; del(17p), 10/35 (29%)
Cevostamab monotherapy demonstrates promising activity in heavily pretreated R/R Multiple Myeloma patients

- MRD negativity by NGS ($<10^{-5}$) detected in 6/7 evaluable pts with ≥VGPR
- Responses in penta-drug refractory pts (7/17, ORR:41%) and patients with prior BCMA (5/8, ORR:63%)
- Responses observed across all FcRH5 expression levels (FcRH5 expression on myeloma cells detected in all patients)
- Manageable toxicities with step-up dosing (CRS most common in C1; nearly all grade 1-2; one patient with grade 3 CRS)

Planning to engage with health authorities on accelerated approval pathways; initiating trials in combination with existing SOC

Cohen et al ASH, 2020; BCMA=B-cell maturation antigen; MRD=minimal residual disease; ORR=overall response rate; CR=complete response; VGPR=very good partial response; PR=partial response; R/R = relapsed/refractory; MM = multiple myeloma; ‡CAR-T, 6/11; ADC, 5/11

8 patients with duration of response ≥6m

Response rate in ≥3.6/20mg cohorts
**Response Rates**

- Historical azacitidine ORR: 38%\(^1\)

**Transfusion Independence**

<table>
<thead>
<tr>
<th>Transfusion independence rate</th>
<th>n (% of N=78)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC and platelet</td>
<td>51 (65)</td>
</tr>
<tr>
<td>RBC</td>
<td>52 (67)</td>
</tr>
<tr>
<td>Platelet</td>
<td>60 (77)</td>
</tr>
</tbody>
</table>

**Overall Survival**

- Median time on study: 16.4m

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>mOS</th>
<th>12m</th>
<th>24m</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ven + Aza patients</td>
<td>78</td>
<td>27.5m</td>
<td>77%</td>
<td>60%</td>
</tr>
<tr>
<td>All Ven + Aza patients receiving RP2D (400mg)</td>
<td>51</td>
<td>NR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Historical azacitidine mOS estimated ~15 months\(^1\)

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Garcia et al, ASH 2020; 1. Sekeres MA, et al. *J Clin Oncol*. 2017;35(24):2745–53; MDS=myelodysplastic syndrome; aza=azacitidine; ORR=overall response rate; CR=complete response; mCR=marrow complete response; SD=stable disease; PR=partial response; PD=progressive disease; NE=not evaluable; mOS=median overall survival; NR=not-reached; RBC=red blood cell
Doing now what patients need next