European Society for Medical Oncology (ESMO) 2019 Congress
Highlights from Roche

Saturday, 28 September 2019
Welcome
Karl Mahler, Head of Investor Relations

ESMO 2019 key readouts

IMvigor130: Tecentriq + Pt-doublet in 1L advanced or metastatic urothelial cancer

IMpower110: Tecentriq monotherapy in 1L PD-L1-selected non-sq NSCLC
B-FAST: Alecensa blood-first assay in 1L ALK+ NSCLC

GO30140: Tecentriq + Avastin in 1L HCC, randomized phase 1 data

Alan Sandler, M.D., Global Head of Product Development – Oncology, Solid Tumors

Q&A
Welcome
Karl Mahler
Head of Investor Relations
Roche transitioning: Replace and extend the business

<table>
<thead>
<tr>
<th>Replace/extend existing businesses</th>
<th>Entering new franchises</th>
</tr>
</thead>
<tbody>
<tr>
<td>MabThera/Rituxan</td>
<td>Gazyva, Venclexta, Polivy, mosunetuzumab, CD20 x CD3, idasanutlin</td>
</tr>
<tr>
<td>Herceptin</td>
<td>Perjeta, Kadcyla, Herceptin + Perjeta FDC-SC</td>
</tr>
<tr>
<td>Avastin</td>
<td>Tecentriq, Alecensa, Rozlytrek, ipatasertib</td>
</tr>
<tr>
<td>Lucentis</td>
<td>faricimab Port delivery system (PDS)</td>
</tr>
<tr>
<td>Tamiflu</td>
<td>Xofluza</td>
</tr>
</tbody>
</table>

Sales mix (100%) (Conceptual)

- **New products launched before mid 2019**
- **Other products**
- **Herceptin + Rituxan + Avastin**

FDC=fixed dose combination; NMOSD=neuromyelitis optica spectrum disorder; SMA=spinal muscular atrophy
Oncology: Focus on leadership across established core areas, while still investing in differentiated growth opportunities

**Lead in Hematology**
- NHL: Rituxan, Gazyva, Venclexta, Polivy, mosunetuzumab, CD20xCD3
- CLL: Venclexta, Gazyva
- AML: Venclexta, idasanutlin
- MM: Venclexta
- Hemophilia A: Hemlibra

**Lead in Breast Cancer**
- HER2+ BC: Herceptin, Perjeta, Kadcyla, H+P FDC SC
- TNBC: Tecentriq, ipatasertib
- HR+ BC: ipatasertib, PI3Kα inhibitor (RG6114); SERD (RG6171)

**Growth in Lung**
- ALK+/ROS1+/NTRK+: Alectinib, Rozlytrek
- SCLC: Tecentriq
- NSCLC: Tecentriq, Avastin

**Establish presence (with Tecentriq and combos)**
- mUC: Expand in 1L; Move into adjuvant
- HCC: Potential new SOC
- CRPC: Potential new SOC
- OC: Potential new SOC
- RCC and CRC: Explore opportunities

**High medical need in later lines, aNHL and AML**

> 80% patients in adjuvant

>70% still metastatic
Transforming standard of care in immuno-oncology

Earlier lines, new indications, combinations

Opportunity

Launch / catch up with competition

- 2L NSCLC Dx+
- 2L bladder Dx

Expand / lead aim for first in class

- 1L NSCLC (liver mets, etc.)
- 1L SCLC
- 1L mUC
- 1L TNBC
- 1L HCC
- 1L Ovarian Cancer

Transform / first and best in class

- Neo-/Adjuvant NSCLC
- Adjuvant Bladder Cancer
- Neo-/Adjuvant TNBC
- Neo-adjuvant HER2+
- Adjuvant RCC
- Adjuvant SCCHN

Novel CI combinations (e.g. bi-specifics, aTIGIT, etc.)
ESMO 2019 Key readouts
Alan Sandler, M.D.
Global Head of Product Development – Oncology, Solid Tumors
IMvigor130: Tecentriq + Pt-doublet in 1L advanced or metastatic urothelial cancer

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GO30140: Tecentriq + Avastin in 1L HCC, randomized phase 1 data
Bladder cancer diagnostic and treatment today

High unmet need remains in MIBC and mUC

<table>
<thead>
<tr>
<th>Non-metastatic</th>
<th>Locally advanced / metastatic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMIBC (51-75%)</strong></td>
<td><strong>MIBC (20-40%)</strong></td>
</tr>
<tr>
<td>low-risk</td>
<td>high-risk</td>
</tr>
<tr>
<td>Local therapy</td>
<td>Surgery 5 yr OS ~ 45%</td>
</tr>
<tr>
<td>5 yr OS of 95%</td>
<td>IMvigor130</td>
</tr>
<tr>
<td>high-risk</td>
<td>Surgery + chemo 5 yr OS ~50%</td>
</tr>
<tr>
<td>Local therapy</td>
<td>ALBAN</td>
</tr>
<tr>
<td>5 yr OS of 87%</td>
<td>&lt;</td>
</tr>
</tbody>
</table>

= positive readout  = approved

NMIBC=non-muscle invasive bladder cancer; MIBC=muscle invasive bladder cancer; epidemiology data Roche internal estimates EU5/US (2018)

Ongoing Tecentriq phase 3 studies in high-risk NMIBC and MIBC

IMvigor010: TECENTRIQ in high-risk muscle-invasive UC patients after surgery

- High-risk muscle-invasive UC after surgical resection
- No prior chemo for locally advanced MIBC
- ECOG PS ≤ 2
- N = 811

Primary endpoint: INV-assessed DFS

Arm A
Atezo monotherapy 1200 mg q3w
16 cycles, up to 1 year

Arm B
Observation
16 cycles, up to 1 year

Assessment every 12 weeks in the first 3 years, every 24 weeks thereafter

Data expected 1H 2020

ALBAN: TECENTRIQ in high-risk non-muscle-invasive UC patients

- High-risk non-muscle-invasive UC as determined by TURBT (Ta G3, T1 any grade or carcinoma in situ (CIS))
- No metastasis
- ECOG PS ≤ 2
- N = 614

Primary endpoint: INV-assessed RFS

Arm A
BCG induction + maintenance (control)
BCG induction instillations qw x 6 wks + BCG maintenance 3 instillations qw at Wk 13, 26, 52

Arm B
BCG induction and maintenance + 1 yr Atezo maintenance
BCG induction instillations qw x 6 wks + BCG maintenance 3 instillations qw at Wk 13, 26, 52 + Atezo 1200 mg q3w

Follow-up for 5 years as of randomization

Data expected 2022

NMIBC = non-muscle invasive bladder cancer; MIBC = muscle invasive bladder cancer
IMvigor130: Efficacy of Tecentriq+chemo in previously untreated locally advanced / metastatic UC

First positive Ph III of CIT combination in this setting

- Locally advanced or mUC
- No prior systemic therapy in the metastatic setting
- ECOG PS ≤ 2
- 1L platinum-eligible
- N = 1200
- Randomised 1:1:1

Stratification factors:
- PD-L1 IC status (IC0 vs IC1 vs IC2/3)
- Investigator choice of plt/gem\(^a\)

Co-primary endpoints:
- INV-assessed PFS\(^b\) and OS (Arm A vs C)
- OS (Arm B vs C, hierarchical approach)

Key secondary endpoints:
- INV-ORR\(^b\) and DOR
- PFS\(^b\) and OS (Arm B vs C; PD-L1 IC2/3 subgroup)
- Safety

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*The first 129 patients were randomized 2:1 to Arm A and Arm C per initial study design; Arm B enrolled later. PD-L1 status was unblinded in the final protocol amendment per IMDC recommendation, such that IC0/1 patients received atezo + plt/gem and IC2/3 patients received atezo monotherapy (n = 6). ^carbo/gem = carboplatin + gemcitabine or cis/gem = cisplatin + gemcitabine; ^b per RECIST 1.1.
**IMpower110: Tecentriq monotherapy in 1L PD-L1-selected non-sq NSCLC**

**B-FAST: Alecensa blood-first assay in 1L ALK+ NSCLC**

**GO30140: Tecentriq + Avastin in 1L HCC, randomized phase 1 data**

**IMvigor130: Tecentriq + Pt-doublet in 1L advanced or metastatic urothelial cancer**
Broadest NSCLC portfolio with the ability to cover all key segments

<table>
<thead>
<tr>
<th>NSCLC (NSq)</th>
<th>NSCLC (Sq)</th>
<th>SCLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALK EGFR ROS NTRK</td>
<td>Non-Driver</td>
<td>PD-L1+</td>
</tr>
</tbody>
</table>

**Neo- Adj**
- **ALK**
- **EGFR**
- **ROS**
- **NTRK**

<table>
<thead>
<tr>
<th></th>
<th>Alecensa</th>
<th>Entrectinib</th>
<th>IMpower110 Tecentriq</th>
<th>IMpower150 Tecentriq + Avastin + CP</th>
<th>IMpower130 Tecentriq + CnP</th>
<th>IMpower132 Tecentriq + pemetrexed</th>
<th>IMpower131 Tecentriq + CnP</th>
<th>IMpower110 Tecentriq</th>
<th>IMpower133 Tecentriq + carboplatin + etoposide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1L</strong></td>
<td>Alecensa</td>
<td>Entrectinib</td>
<td>IMpower110 Tecentriq</td>
<td>IMpower150 Tecentriq + Avastin + CP</td>
<td>IMpower130 Tecentriq + CnP</td>
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<td>IMpower110 Tecentriq</td>
<td>IMpower133 Tecentriq + carboplatin + etoposide</td>
</tr>
<tr>
<td><strong>2L</strong></td>
<td>IMpower150</td>
<td>IMpower150</td>
<td>IMpower150</td>
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<td>IMpower150</td>
</tr>
<tr>
<td><strong>Avastin + CP</strong></td>
<td>OAK, POPLAR, BIRCH</td>
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**Positive readout**

**Approved**
**IMpower110 Study Design**

- Primary endpoint: OS in WT population
- Key secondary endpoints: investigator-assessed PFS, ORR and DOR (per RECIST 1.1)

IC, tumour-infiltrating immune cells; Nsq, non-squamous; Sq, squamous; TC, tumour cells; WT, wild-type.

- PD-L1 expression (SP142 IHC assay) ≥ 1% on TC or IC.
- TC1/2/3 and any IC vs TC0 and IC1/2/3.
- 554 patients in the WT population.
- Cisplatin 75 mg/m² or carboplatin AUC 6 + pemetrexed 500 mg/m² IV q3w.
- WT population excludes patients with EGFR+ and/or ALK+ NSCLC.

Chemotherapy-naive, PD-L1–selected patients with Stage IV nsq or sq NSCLC

Stratification factors:
- Sex
- ECOG PS
- PD-L1 IHC expression
- Histology

n = 572

Arm A
Atezolizumab 1200 mg q3w

Arm B
- Nsq: cisplatin/carboplatin + pemetrexed
- Sq: cisplatin/carboplatin + gemcitabine
  - 4 or 6 cycles

Maintenance therapy (no crossover permitted)

PD or loss of clinical benefit

Survival follow-up

PD

Nsq: pemetrexed
Sq: best supportive care
IMpower110: Clinically meaningful OS benefit with Tecentriq monotherapy in 1L NSCLC patients with high PD-L1 (TC3/IC3)

**Overall survival (%)**

<table>
<thead>
<tr>
<th>Landmark</th>
<th>Arm A (atezo)</th>
<th>Arm B (chemo)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 107</td>
<td>n = 98</td>
</tr>
<tr>
<td>12-mo OS, % (95% CI)</td>
<td>64.9 (55.4, 74.4)</td>
<td>50.6 (40.0, 61.3)</td>
</tr>
</tbody>
</table>

**HR,\textsuperscript{a} 0.59 (95% CI: 0.40, 0.89); \textit{P} = 0.0106\textsuperscript{b}**

**Median follow-up, 15.7 mo (range, 0-35)**

**NE, not estimable. \textsuperscript{a} Stratified. \textsuperscript{b} Stratified log-rank.**

Date cutoff: 10 September 2018.
### IMpower110: OS in Key Subgroups for PD-L1 TC3 or IC3 WT

#### Subgroup

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>n (%)</th>
<th>OS HR (95% CI)</th>
<th>Median OS, mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 65 years</td>
<td>102 (49.8)</td>
<td>0.59 (0.34, 1.04)</td>
<td>NE</td>
</tr>
<tr>
<td>65-74 years</td>
<td>80 (39.0)</td>
<td>0.63 (0.34, 1.19)</td>
<td>17.8</td>
</tr>
<tr>
<td>75-84 years</td>
<td>22 (10.7)</td>
<td>1.04 (0.19, 5.70)</td>
<td>NE</td>
</tr>
<tr>
<td>Male</td>
<td>143 (69.8)</td>
<td>0.57 (0.35, 0.93)</td>
<td>23.1</td>
</tr>
<tr>
<td>Female</td>
<td>62 (30.2)</td>
<td>0.69 (0.34, 1.39)</td>
<td>17.8</td>
</tr>
<tr>
<td>White</td>
<td>169 (82.4)</td>
<td>0.67 (0.44, 1.03)</td>
<td>17.8</td>
</tr>
<tr>
<td>Asian</td>
<td>35 (17.1)</td>
<td>0.38 (0.13, 1.13)</td>
<td>NE</td>
</tr>
<tr>
<td>Never used tobacco</td>
<td>24 (11.7)</td>
<td>1.83 (0.63, 5.31)</td>
<td>8.0</td>
</tr>
<tr>
<td>Current tobacco user</td>
<td>49 (23.9)</td>
<td>0.35 (0.14, 0.93)</td>
<td>NE</td>
</tr>
<tr>
<td>Previous tobacco user</td>
<td>132 (64.4)</td>
<td>0.60 (0.36, 1.00)</td>
<td>23.1</td>
</tr>
<tr>
<td>Non-squamous histology</td>
<td>155 (75.6)</td>
<td>0.62 (0.40, 0.96)</td>
<td>20.2</td>
</tr>
<tr>
<td>Squamous histology</td>
<td>50 (24.4)</td>
<td>0.56 (0.23, 1.37)</td>
<td>NE</td>
</tr>
<tr>
<td>ECOG PS 0</td>
<td>73 (35.6)</td>
<td>0.42 (0.20, 0.92)</td>
<td>NE</td>
</tr>
<tr>
<td>ECOG PS 1</td>
<td>132 (64.4)</td>
<td>0.69 (0.43, 1.10)</td>
<td>16.5</td>
</tr>
<tr>
<td>All TC3 or IC3 WT patients</td>
<td>205 (100)</td>
<td>0.59 (0.40, 0.89)</td>
<td>20.2</td>
</tr>
</tbody>
</table>

- The patient in the ≥ 85 years subgroup is not included.
IMpower110: OS by PD-L1 status

Encouraging trend seen in PD-L1 TC2/3 or IC2/3

TC2/3 or IC2/3 WT

TC1/2/3 or IC1/2/3 WT

NE, not estimable. a Stratified. b Stratified log-rank. c For descriptive purposes only.

Date cutoff: 10 September 2018.
**IMpower110: TC3 or IC3 WT PFS and ORR**

*Strong benefit of Tecentriq in TC3/IC3 WT patients*

### Progression free survival

![Progression free survival chart](chart.png)

- **Median PFS, 5.0 mo** (95% CI: 4.2, 5.7)
- **Median PFS, 8.1 mo** (95% CI: 6.8, 11.0)

<table>
<thead>
<tr>
<th>Landmark</th>
<th>Arm A (atezo) (n = 107)</th>
<th>Arm B (chemo) (n = 98)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-mo PFS (95% CI), %</td>
<td>36.9 (27.0, 46.9)</td>
<td>21.6 (12.6, 30.6)</td>
</tr>
</tbody>
</table>

**HR**, 0.63 (95% CI: 0.45, 0.88); **P = 0.007**

### Overall response data

- **Arm A (atezo)**: PR 38.3%, CR 28.6%
- **Arm B (chemo)**: PR 28.6%, CR 38.3%

- **Median DOR** (range), mo
  - Arm A: NE (1.8–29.3+)
  - Arm B: 6.7 (2.6–23.9+)
Urgent need for new diagnostic approaches in oncology to optimise patient outcomes

In patients with metastatic NSCLC, current clinical practice guidelines recommend testing for:

- **EGFR and BRAF mutations**
- **ALK and ROS1 rearrangements**
- **PD-L1 expression**

Diagnostic testing mutations can identify patients more likely to benefit from a targeted therapy:

- However, 30% of patients have inadequate tumour tissue for molecular analysis at diagnosis.
- Repeat biopsies are not feasible in almost 20% of patients with advanced NSCLC.
- Almost 25% of repeat biopsies fail to yield sufficient material for genomic analysis.

Blood-based NGS has the potential to overcome some of the limitations associated with tissue collection and testing, which may enable clinicians to offer more effective personalised therapies.

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BFAST: Phase II/III study in 1L NSCLC using blood-based testing

Ph III trial design (B-FAST) for 1L treatment naive NSCLC

Blood based biomarkers:

- Only 17ml blood needed
- A single liquid biopsy test that detects the 4 main classes of genomic alterations (70 genes)
- Comprehensive genomic profile including resistance mutations or fusions in NSCLC
- Includes MSI status
- Guides therapy selection and clinical trials

Data to be presented in the Oral lung cancer session at 9:15 on 30 Sep (Abstract LBA81)

Mok T. et al., WCLC 2017; NGS=next generation sequencing; ctDNA=circulating tumor DNA; RWD=real world data
IMpower110: Tecentriq monotherapy in 1L PD-L1-selected non-sq NSCLC

B-FAST: Alecensa blood-first assay in 1L ALK+ NSCLC

IMvigor130: Tecentriq + Pt-doublet in 1L advanced or metastatic urothelial cancer

GO30140: Tecentriq + Avastin in 1L HCC, randomized phase 1 data
Liver cancer is the 6th most common cancer in the world

HCC accounts for 90% of primary liver cancer cases

Globally, >750,000 people are diagnosed with HCC each year, most often in late stages of the disease.

Almost 50% of all cases are diagnosed in China, in large part due to the prevalence of hepatitis B and C.

The incidence and number of deaths from liver cancer is rising across the globe

One of the factors of this is the rising prevalence of fatty foods and obesity.

There hasn’t been an improvement in treatments in over a decade.
In the absence of efficacious and tolerable systemic HCC treatments, surgical or loco-regional approaches are frequently used in EU/US.
Phase Ib GO30140 Study (NCT02715531)

Eligibility Criteria:
- Measurable disease per RECIST 1.1
- ECOG PS 0/1
- Up to Child-Pugh score B7 for Arm A and score A for Arm F
- No prior systemic therapy

Arm A: 1L HCC
Atezolizumab 1200 mg IV q3w + bevacizumab 15 mg/kg IV q3w

Arm F: 1L HCC
Atezolizumab 1200 mg IV q3w + bevacizumab15 mg/kg IV q3w

Until loss of clinical benefit or unacceptable toxicity
Survival follow-up

<table>
<thead>
<tr>
<th>Arm A – Median duration of follow up, 12.4 mo</th>
<th>Arm F – Median duration of follow up, 6.6 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary endpoints</td>
<td>Primary endpoints</td>
</tr>
<tr>
<td>• ORR per IRF-assessed RECIST 1.1</td>
<td>• ORR per IRF-assessed RECIST 1.1</td>
</tr>
<tr>
<td>• Safety</td>
<td>• PFS per IRF-assessed RECIST 1.1</td>
</tr>
<tr>
<td></td>
<td>• Safety</td>
</tr>
</tbody>
</table>

Arm A: Primary endpoint ORR by IRF RECIST 1.1 met
Clinically meaningful and durable responses with atezolizumab +
bevacizumab combination

### Atezolizumab + bevacizumab (N=104)

<table>
<thead>
<tr>
<th><strong>ORR IRF RECIST 1.1</strong>*</th>
<th><strong>PFS IRF RECIST 1.1</strong>*</th>
<th><strong>OS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confirmed ORR, n (%)</strong></td>
<td><strong>No. of events (%)</strong></td>
<td><strong>No. of deaths (%)</strong></td>
</tr>
<tr>
<td>CR, n (%)</td>
<td>12 (12)</td>
<td>69 (66)</td>
</tr>
<tr>
<td>PR, n (%)</td>
<td>25 (24)</td>
<td>47 (45)</td>
</tr>
<tr>
<td><strong>DCR, n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>74 (71)</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing response, n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=37</td>
<td></td>
<td></td>
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<tr>
<td>28 (76)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Median DoR (months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NE (11.8-NE)</td>
<td></td>
</tr>
<tr>
<td><strong>Median duration of follow-up: 12.4 months</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>mPFS (95% CI, months)</strong></th>
<th><strong>mOS (95% CI, months)</strong></th>
<th><strong>12-month PFS rate (%)</strong></th>
<th><strong>12-month OS rate (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3 (5.4–9.9)</td>
<td>17.1 (13.8–NE)</td>
<td>35</td>
<td>63</td>
</tr>
</tbody>
</table>

* IRF RECIST 1.1 similar to INV RECIST 1.1 and IRF HCC mRECIST


ORR – objective response rate, CR – complete response, PR - partial response, DCR – Disease control rate = CR + PR + SD; NE, not estimable. +, censored.
Arm F: Primary Endpoint of PFS\textsuperscript{a} by IRF RECIST 1.1 met
Single-agent contribution of atezolizumab and bevacizumab to the overall treatment effect

\textbf{Median duration of follow-up: 6.6 months}

\textsuperscript{a}IRF RECIST 1.1. \textsuperscript{b}Stratification factors included for analysis are geographic region (Asia excluding Japan vs. Rest of World) and AFP level (<400 ng/mL vs. ≥ 400 ng/mL) at baseline. DCR, CR + PR + SD. Missing/unevaluable: 3 patients for atezo + bev; 4 patients for atezo.

IMbrave150 pivotal Tecentriq phase III trial in 1L unresectable HCC

Inclusion criteria:
- Not eligible for surgical/locoregional Tx
- Child-Pugh Class A
- No CNS mets, no HIV
- HBV DNA <500 IU/ml
- ECOG PS 0 – 1
N = 480

Atezo 1200 mg IV q3w + bev 15 mg/kg IV q3w

Sorafenib 400 mg BID

Until loss of clinical benefit or unacceptable toxicity

Survival follow-up

Stratification factors:
- ECOG status
- Baseline AFP level
- Presence of macrovascular invasion and/or extrahepatic spread
- Geographic region

Co-primary endpoints:
- OS
- INV-assessed ORR (RECIST v1.1)

Key secondary endpoints:
- INV-assessed DoR, PFS and TTP (RECIST v1.1)
- IRF-assessed ORR, DOR, PFS and TTP (RECIST v1.1 & HCC mRECIST)
- OS and ORR by baseline AFP

IMbrave150 results expected Q4 2019
ESMO 2019 highlights - conclusions

1L Bladder: IMvigor130

• Tecentriq + plt/gem met its co-primary endpoint of PFS vs plt/gem in ITT population with clinically meaningful improvement in OS observed with atezolizumab combination

• IMvigor130 results support Tecentriq + plt/gem as an important new treatment option for patients with untreated mUC

1L Lung: IMpower110

• Tecentriq showed statistically significant and clinically meaningful OS improvement in the TC3 or IC3 WT population vs platinum-based chemotherapy (HR, 0.59 [95% CI: 0.40, 0.89]; P = 0.0106) as well as meaningful improvement in PFS, ORR and DOR

• Tecentriq represents a promising 1L treatment option in patients with PD-L1–high NSCLC
ESMO 2019 highlights – conclusions (cont’d)

1L Lung: B-FAST

- Results demonstrate the clinical utility of blood-based NGS as a method to inform clinical decision-making in ALK+ NSCLC

1L Liver: GO30140 study (Ph1b)

- Arm A: Clinically meaningful and durable responses achieved with Tecentriq + Avastin with ORR of 36% by IRF RECIST 1.1 and 76% of responses ongoing after median follow up of 12.4 months
- Arm F: Statistically significant and clinically meaningful improvement of PFS with Tecentriq + Avastin vs Tecentriq monotherapy with mPFS of 5.6 vs 3.4 mo, respectively (HR 0.55, p = 0.0108) by IRF RECIST 1.1 demonstrating single-agent contribution to overall treatment effect
- Tecentriq + Avastin may become a promising treatment option for patients with unresectable HCC, Phase III study IMbrave150 data expected Q4 2019
Doing now what patients need next