ASCO 20 Virtual

Roche Analyst Event

Friday, 29 May 2020
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Welcome
Karl Mahler, Head of Investor Relations and Group Planning

Cancer immunotherapy pipeline overview
Targeting the cancer immunity cycle and tiragolumab (Anti-TIGIT) overview
Ira Mellman, Ph.D., Vice President, Cancer Immunology, Genentech Research and Early Development

ASCO 2020 Key readouts across tumor types
CITYSCAPE: Primary analysis of tiragolumab + Tecentriq in 1L NSCLC
Updated data from Alecensa, Rozlytrek and Tecentriq in lung, liver cancer & tumor-agnostic indications
Alan Sandler, M.D., Global Head of Product Development Oncology - Solid Tumors

Q&A
Welcome

Karl Mahler | Head of Investor Relations and Group Planning
Establishing Tecentriq as standard of care in major tumor types

1. **First wave**
   - Checkpoint Inhibitors Monotherapy
   - Tecentriq in NSCLC: Impower110

2. **Second wave**
   - Combine with Existing Medications
   - Tecentriq + chemo/ targeted therapies in SCLC, TNBC, ovarian, HCC, bladder, etc.

3. **Third wave**
   - Expand to novel CITs
   - Immune doublets: Tecentriq + Bi-specifics, tiragolumab, etc.

4. **Fourth wave**
   - Personalized CIT, RNAseq, etc.
   - Combos/ NMEs: defined immune profiles

5. **Wave 3**
   - Tecentriq and tiragolumab in various cancer types have started Ph III development
   - SKYSCRAPER-01 Ph III in PD-L1+ NSCLC
   - SKYSCRAPER-02 Ph III in ES-SCLC
   - SKYSCRAPER-04 Ph II in PD-L1+ cervical cancer

6. **Wave 4**
   - Tecentriq and Avastin in HCC
   - Medically meaningful improvement

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NSCLC=non-small cell lung cancer; SCLC=small cell lung cancer; TNBC=triple-negative breast cancer; HCC=hepatocellular carcinoma
Overview of tiragolumab (Anti-TIGIT)

Ira Mellman, Ph.D. | Vice President, Cancer Immunology (gRED)
All tumors exhibit one of three basic immune phenotypes

*Provides mechanistic context for response and lack of response to CIT*

<table>
<thead>
<tr>
<th>Incidence</th>
<th>CRC</th>
<th>Lung</th>
<th>TNBC</th>
<th>CRC</th>
<th>PDAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC</td>
<td>12%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NSCLC</td>
<td>31%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>mUC</td>
<td>26%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TNBC</td>
<td>36%</td>
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**IMMUNE INFLAMED**
CD8+ T cells infiltrated, but insufficient

**IMMUNE EXCLUDED**
CD8+ T cells do not efficiently infiltrate out from stroma

**IMMUNE DESERT**
CD8+ T cells absent from tumor and periphery

CRC: colorectal cancer, NSCLC: non small cell lung cancer; mUC metastastic urothelial carcinoma, TNBC: triple negative breast cancer, CIT: cancer immunotherapy
Strategies to promote an antitumor immune response by phenotype
Target “rate limiting steps” associated with primary and secondary resistance

**IMMUNE DESERT**
- Generate/release/deliver antigens
- Enhance antigen presentation and T-cell priming
- Redirect and engage T cells

**IMMUNE EXCLUDED**
- Recruit T cells to tumour
- Address stromal barrier
- Redirect and engage T cells

**INFLAMED**
- Invigorate T cell response
- Redirect and engage T cells

Some patients may only require targeting of negative regulator (aPD-L1 monotherapy) to enable cancer immunity

Some patients will need two or more therapies to enable cancer immunity (e.g., to drive infiltration, boost MHC expression, etc)

Targeting the cancer immunity cycle requires a methodologically coordinated approach.

Immune profiles may limit the effectiveness even of synthetic approaches.
Neoantigen specific therapies: two complimentary approaches

Personalized Cancer Vaccines (iNeST)

Tumor biopsy → Mutation identification → Neoantigen prediction → TCR identification → TCR insertion in patient’s T cells & Expansion → Vaccine manufacture

iNEST: individualized neoantigen specific immunotherapy, TCR: T cell receptor, MHCI: major histocompatibility complex class I
Neoantigen-specific T cells can be shared or individual

**Shared Neoantigens**

- Determine patient mutation and HLA
- Access “warehouse” of conserved neo-AgTCRs*

**Individual Neoantigens**

- Patient tumor sequence

**Steps:**

1. **Apheresis**
2. **Isolate & stimulate T cells**
3. **TCR gene editing (CRISPR)**
4. **Expand T cells**
5. **Infuse**

**Additional Steps:**

- **TCR identification/Selection***
- **Produce TCR encoding DNA**

*from patient PBLs or naïve TCR library

**Key Terms:**

- TCR: T cell receptor
- HLA: human leukocyte antigen
- PBL: peripheral blood leukocytes
- neo-Ag: neoantigen
There are many T cell checkpoints, including TIGIT

**T-cell regulation**

- Activating receptors: CD26, OX40, GITR, CD137, CD27, HVEM
- Inhibitory receptors: CTLA-4, PD-1, TIM-3, BTLA, VISTA, LAG-3

**About TIGIT**

- **TIGIT** (T cell immunoreceptor with Ig and ITIM domains) is an _inhibitory receptor_, discovered at Genentech
- **TIGIT** acts as a specific negative regulator of the CD226 costimulatory receptor
- **TIGIT** is expressed on multiple immune cells, including **CD8+ T cell** (effector memory), **CD4+ T cells** (effector memory and regulatory), **Tfh cells**, and **NK cells**
- **TIGIT** is expressed on a new population of T cells, _stem-like memory cells_, that may be the preferred targets for anti-PDx efficacy

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**Ig, immunoglobulin; ITIM, immunoreceptor tyrosine-based inhibition motif; Tfh, T follicular helper cell; NK, natural killer**

TIGIT – expressed in multiple tumor types

Model for TIGIT regulation of T cell responses

1. Competes with CD226 for PVR
2. Directly inhibits T cell in cis
3. Disrupts CD226 activation

TIGIT is highly expressed in T-cell infiltrated tumors

Lung squamous cell cancer
Colon cancer
Uterine endometrioid carcinoma
Breast cancer

Johnson et al. Cancer Cell 2014
Evolving understanding of how checkpoint inhibitors work: Reversing exhaustion vs expanding stem cell-like anti-tumor T cells

Original view: exhaustion reversal

- **Exhausted T cell**
  - Tumor cell
  - PD-L1
  - PD-1
  - Antigen
  - T cell receptor

- **Rejuvenated T cell**
  - Tumor cell death
  - Anti PD-L1
  - PD-L1
  - Anti PD-1
  - PD-1
  - Antigen
  - T cell receptor
Evolving understanding of how checkpoint inhibitors work: Reversing exhaustion vs expanding stem cell-like anti-tumor T cells

Revised view: $T_{SCM}$ expansion


- **LCMV**: Im et al. 2016. PMID 27501248, Utschneider et al 2016. PMID 27533016
Expansion of stem cell-like anti-tumor T cells will drive the production of more tumor-specific effectors

Steady state equilibrium

Key CIT questions
1) How do we generate more tumor reactive T_{SCM} cells?
2) How do we promote their self renewal?
3) How do we promote their differentiation and effector function?

PDx blockade

Gattinoni et al 2012 Nature Rev Cancer
T_{EM}: T effector memory cells; T_{EFF}: effector T cells; T_{CM}: central memory T cells; T_{SCM}: stem-cell like T cells
T stem like memory cells ($T_{scm}$) express PD-1 and TIGIT… not Tim-3 or other negative regulators

$T_{scm}$ are also CD226+

Raj Valanparambil, Eugene Chiang, Ira Mellman & Rafi Ahmed, Emory University & Genentech

$T_{SCM}$: stem-cell like T cells
Rationale for Tecentriq + TIGIT

**PD1 and TIGIT are co-expressed on stem-like T-cells**

Anti-PD-L1 expands a key population of PD-1-positive T stem-like cells, which also express TIGIT but no other negative regulator

- **T-cell expansion**
- **Prevent/reverse T-cell exhaustion**

Other potential MOA:
- Myeloid cell reprogramming
- T regulatory cell reprogramming
- NK effector function

Modified from Chen and Mellman Nature 2017
Additional mechanistic roles for TIGIT

Role of specific cells, CD226, and antibody format

CD8 T cell effector function driven by CD226 signaling

Modulation of myeloid cells creates proinflammatory tumor microenvironment

CD226 signaling may dampen Treg suppression, promote effector phenotype

TIGIT is also expressed by NK cells, unlike PD-1

Anti-TIGIT Fc:FcyR interaction may sequester TIGIT away from the synapse, and play a role in reprogramming of myeloid cells

1. Dahan Cancer Cell 2015
NK: natural killer cell; Fc: Fragment crystallizable region
Anti-TIGIT activity may be dependent on antibody design

Preclinical data supports the hypothesis that Anti-TIGIT activity may be dependent on Fc effector function.

Anti-TIGIT monotherapy

- aTIGIT Attenuated Fc
  - 03 - Mu IgG2a anti-TIGIT LALAPG
- aTIGIT Intact Fc
  - 02 - Mu IgG2a anti-TIGIT

Tumor Volume (mm^3) on log scale

Day

Anti-TIGIT + Anti PD-1

- aTIGIT Attenuated Fc
  - 05 - Mu IgG2a anti-TIGIT LALAPG - Mu IgG2a anti-PD1 (GNE 9899) LALAPG
- aTIGIT Intact Fc
  - 06 - Mu IgG2a anti-TIGIT + Mu IgG2a anti-PD1 (GNE 9899) LALAPG

Day

E0771 cell line

Fc: Fragment crystallizable region
TIGIT and PD-L1 blockade synergistically improves tumor control
Prolongs survival in CT26 models

Blockade of TIGIT and PD-L1 showed a 75% decrease in mean tumor volume after 16 days of treatment

An evolving paradigm: PD1/TIGIT blockade induce T cell expansion in dLN to achieve therapeutic anti-tumor immunity
ASCO 2020 Key readouts across tumor types

Alan Sandler, M.D. | Global Head of Product Development Oncology - Solid Tumors
Lung cancer

- **CITYSCAPE**: Tiragolumab + Tecentriq in 1L NSCLC
- **ALEX**: Alecensa in 1L Alk-mut. NSCLC

Tumor agnostic indications

- Rozlytrek updated analyses in pediatrics and adults with solid tumors

Liver cancer

- **IMbrave150**: Tecentriq + Avastin in 1L HCC
CITYSCAPE: Primary analysis of a randomized, double-blind, phase II study of the anti-TIGIT antibody tiragolumab plus Tecentriq versus placebo plus Tecentriq as 1L treatment in patients with PD-L1-selected NSCLC
CITYSCAPE rPh II: Tiragolumab plus Tecentriq in 1L NSCLC

Study design

1L Stage IV NSCLC EGFR/ALK wild-type
Tumor PD-L1 TPS ≥ 1% by 22C3 IHC by local or central assay
N=135

- Co-primary endpoints: ORR and PFS in ITT
- Key secondary endpoints: Safety, DOR, OS
- Exploratory endpoints: Efficacy analysis by PD-L1 status

Stratification factors by baseline: ITT

<table>
<thead>
<tr>
<th></th>
<th>Tiragolumab + Tecentriq (n=67)</th>
<th>Placebo + Tecentriq (n=68)</th>
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<tbody>
<tr>
<td>Never used tobacco*</td>
<td>7 (10%)</td>
<td>7 (10%)</td>
</tr>
<tr>
<td>Non-squamous histology*</td>
<td>40 (60%)</td>
<td>40 (59%)</td>
</tr>
<tr>
<td>PD-L1 TPS ≥ 50%*</td>
<td>29 (43%)</td>
<td>29 (43%)</td>
</tr>
<tr>
<td>PD-L1 TPS 1-49%*</td>
<td>38 (57%)</td>
<td>39 (57%)</td>
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</tbody>
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Primary data cut-off: 30 June, 2019; ITT=intention-to-treat; DOR = duration of response; IHC = immunohistochemistry; ORR = confirmed overall response rate; OS = overall survival; PD = progressive disease; PFS = progression free survival; q3w = every 3 weeks; R = randomized; TPS = tumor proportion score; *stratification factors
CITYSCAPE rPh II: Tiragolumab plus Tecentriq in 1L NSCLC
Primary analysis with 5.9 months median follow-up

ITT: Overall response rate

Response (95% CI)

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<thead>
<tr>
<th></th>
<th>Response</th>
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<tbody>
<tr>
<td>Tiragolumab + Tecentriq (n=67)</td>
<td>31%</td>
</tr>
<tr>
<td>Placebo + Tecentriq (n=68)</td>
<td>16%</td>
</tr>
</tbody>
</table>

ITT: Primary Investigator-Assessed PFS after ~80 PFS events

Progression-Free Survival (%)

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiragolumab + Tecentriq</td>
<td>5.42 mo (95% CI: 4.21-NE)</td>
<td>0.57</td>
</tr>
<tr>
<td>Placebo + Tecentriq</td>
<td>3.58 mo (95% CI: 2.73, 4.44)</td>
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Tiragolumab plus Tecentriq met both co-primary endpoints in the ITT population, showing an improvement in ORR and PFS

Primary data cut-off: 30 June, 2019; ITT=intention-to-treat; ORR = confirmed overall response rate; PFS = progression free survival; NE = non-evaluable; *stratified HR
CITYSCAPE rPh II: Tiragolumab plus Tecentriq in 1L NSCLC
Updated ORR analysis with 10.9 months median follow-up

Consistent and clinically meaningful overall response rate (ORR), mainly driven by the PD-L1 high population (TPS>50%)

Follow-up data cut-off: 02 December, 2019; ITT=intention-to-treat; TPS=tumor proportion score
CITYSCAPE rPh II: Tiragolumab plus Tecentriq in 1L NSCLC
Updated PFS analysis with 10.9 months median follow-up

Updated investigator-assessed PFS: ITT

Updated Investigator-Assessed PFS: PD-L1 TPS ≥ 50%

Consistent and clinically meaningful PFS at longer follow-up with greater magnitude of improvement in the PD-L1 high population

Follow-up data cut-off: 02 December, 2019; NE = non-evaluable; PFS = progression free survival; ITT=intention-to-treat; TPS = tumor proportion score *unstratified HR
CITYSCAPE: All-cause adverse events (updated analysis)

Combining tiragolumab and Tecentriq was well-tolerated with similar rates of all Grade 3+ AEs compared with Tecentriq alone.

Updated data cutoff: 2 Dec 2019
**CITYSCAPE: Immune-mediated adverse events (updated analysis)**

<table>
<thead>
<tr>
<th>Immune-Mediated Adverse Event*, n (%)</th>
<th>Tiragolumab + Tecentriq (n=67)</th>
<th>Placebo + Tecentriq (n=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46 (69%)</td>
<td>32 (47%)</td>
</tr>
<tr>
<td>Grade 3-4</td>
<td>12 (18%)</td>
<td>9 (13%)</td>
</tr>
</tbody>
</table>

More frequent immune-related AEs with the combination of tiragolumab and Tecentriq, but primarily Grade 1-2 IRR and rash

*imAE's captured using Atezo AESI basket strategy to identify possibly immune related PT's

Updated data cutoff: 2 Dec 2019
CITYSCAPE: Conclusions

• Tiragolumab + Tecentriq showed clinically meaningful improvement in ORR and PFS in the ITT population compared to placebo + Tecentriq

• With longer follow-up, the treatment benefit of tiragolumab + Tecentriq remained consistent, with a greater magnitude of improvement seen in the PD-L1 TPS ≥ 50% subgroup

• Tiragolumab + Tecentriq was well-tolerated, with a safety profile similar to placebo + Tecentriq
  - Immune-mediated adverse events (imAEs) were more frequent with tiragolumab + Tecentriq but were primarily Grade 1-2 imAEs (mostly IRR and rash) and were manageable

• The observed activity and safety of tiragolumab + Tecentriq is to be confirmed in an ongoing Phase III study (SKYSCRAPER-01) in first-line PD-L1 TPS ≥ 50% NSCLC (NCT04294810)
Tiragolumab: Broad clinical development program
Further studies to be started over the course of next 12 months

| Phase 1 GO30103 | Solid tumors | Ongoing |
| Phase 1 GO41036 | R/R Multiple myeloma or NHL | Ongoing |
| Phase 2 CITYSCAPE | Non-small cell lung cancer PD-L1 TPS ≥ 1% | Ongoing |
| Phase 3 SKYSCRAPER-01 | Non-small cell lung cancer PD-L1 TPS>50% | Ongoing |
| Phase 3 SKYSCRAPER-02 | Extensive stage small-cell lung cancer | Data at ASCO 2020 |
| Phase 2 SKYSCRAPER-04 | Cervical cancer PD-L1-selected | FPI exp. Q2 ‘20 |
| Phase 1b/2 YO39609 | MORPHEUS GI cancer | Ongoing |
| Phase 1b/2 WO39608 | MORPHEUS pancreatic cancer | Ongoing |
| Phase 1b/2 WO39613 | MORPHEUS urothelial carcinoma | Ongoing |

Data from NSCLC cohort at AACR 2020

Signal-seeking in various tumor types ongoing; four additional phase 3 studies including chemo-free immune doublets to be initiated in 2020
Lung cancer

• CITYSCAPE: Tiragolumab + Tecentriq in 1L NSCLC
• ALEX: Alecensa in 1L Alk-mut. NSCLC

Tumor agnostic indications
• Rozlytrek updated analyses in pediatrics and adults with solid tumors

Liver cancer
• IMbrave150: Tecentriq + Avastin in 1L HCC
Alecensa in 1L ALK+ NSCLC (ALEX): Greater than 60% of patients alive after 5 years

5-year OS rate (ITT) of 62.5% independent of CNS metastases at BL

The updated analysis confirms the superior OS efficacy and tolerability of Alecensa in comparison to crizotinib

*Data cut-off 29 Nov 2019; ECOG = Eastern Cooperative Oncology Group; PS = performance status; IHC = immunohistochemistry; ITT=intention-to-treat; OS = overall survival; NR = not reached
Lung cancer

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Rozlytrek activity in children and adolescents in tumors with and without NTRK1/2/3, ROS1 or ALK fusions: STARTK-NG update

Response rate in pediatric solid tumors - ORR in fusion-positive tumors: 76% (13/17)

- Efficacy data, with longer follow-up, confirm the rapid and durable objective responses seen in both high-grade CNS tumors and extracranial solid tumors
- Median confirmed DoR not reached: (95% CI 14.3mo, NE)
- Safety profile was consistent with prior reports

Today: Positive CHMP opinion for Rozlytrek in NTRK fusion-positive solid tumors and ROS1-positive, advanced NSCLC in patients 12 years of age and older

Data cut-off: 1 July 2019. Investigator assessed. HGG, high-grade glioma; IMT, inflammatory myofibroblastic tumor; LGG, low-grade glioma; NBL, neuroblastoma; SLD, sum of longest diameter; SPD, sum of product diameters; 2 fusion-positive patients are not depicted as they had non-measurable disease
Rozlytrek in adult patients with \textit{NTRK} fusion-positive solid tumors: Updated integrated analysis\textsuperscript{1}

Best individual response per BICR, by tumor type; N=74

Clinically meaningful responses and survival outcomes in \textit{NTRK}-fp solid tumors

ORR 63.5%  
mPFS 11.2 mo  
mOS 23.9 mo

Systemic efficacy irrespective of presence or absence of CNS metastases at baseline

\textbf{ORR}  

\textbf{62.5\%}  

\textbf{ORR}  

\textbf{63.8\%}

Strong intracranial efficacy in patients with CNS metastases at baseline

\textbf{Intracranial ORR 50.0\%}

Durable disease control

\textbf{DoR 12.9 months vs previous 10.4}

1.Integrated analysis of phase 1/2 studies (ALKA-372-001, STARTRK-1, STARTRK-2; EudraCT 2012-000148-88; NCT02097810; NCT02568267)

Patients with missing SLD percent change are excluded from the plot. SLD, sum of longest diameters. GI, gastrointestinal. CRC, colorectal cancer. NSCLC, non-small-cell lung cancer. MASC, mammary analogue secretory carcinoma.
### Broadest NSCLC portfolio with the potential for chemo-free combos

**Newly added tiragolumab complements activity of Tecentriq**

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

#### Neo-/Ad夹

- **Alecensa**
- **Tiragolumab + Tecentriq**

#### 1L

- **Alecensa**
- **Tarceva + Avastin**
- **Rozlytrek**

**IMpower110**

- **Tecentriq**
- **Avastin + CP**

**IMpower150**

- **Tecentriq + Avastin + CP**
- **Tecentriq + CnP**
- **Tecentriq + pemetrexed**

**IMpower130**

- **Tecentriq**

**IMpower132**

- **Tecentriq**
- **Avastin + CP**

**IMpower131**

- **Tecentriq + CnP**

**IMpower133**

- **Tecentriq + carboplatin + etoposide**

#### SKYSCRAPER-01

**Tiragolumab + Tecentriq**

#### SKYSCRAPER-02

**Tiragolumab + TCQ + chemo**

#### 2L

- **IMpower150**

**Avastin + CP**

**OAK, POPLAR, BIRCH**

**Tecentriq**

**Tarceva**

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*IMpower132 approved in Japan*
Lung cancer

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Liver cancer
- IMbrave150: Tecentriq + Avastin in 1L HCC
**Tecentriq + Avastin in 1L HCC**

*A new standard of care in unresectable HCC*

- Statistically significant and clinically meaningful improvement in both OS and PFS with Tecentriq + Avastin vs sorafenib in patients with unresectable HCC who had not received prior systemic therapy
- Tecentriq + Avastin may be a practice-changing treatment for patients with unresectable HCC who have not received prior systemic treatment

**IMbrave150: Overall survival primary analysis**

- 6-mo OS rate: 85%
- 6-mo OS rate: 72%
- HR 0.58 (95% CI: 0.42, 0.79)<sup>b</sup>
- p=0.0006<sup>b,c</sup>
- mOS: 13.2 mo (95% CI: 10.4, NE)

**IMbrave150: Confirmed progression-free survival<sup>a</sup>**

- 6-mo PFS rate: 55%
- 6-mo PFS rate: 37%
- HR 0.59 (95% CI: 0.47, 0.76)<sup>b</sup>
- p<0.0001<sup>b,c</sup>
- mPFS: 6.8 mo (95% CI: 5.7, 8.3)

NE, not estimable;<sup>a</sup>assessed by IRF per RECIST 1.1;<sup>b</sup> HR and P value were from Cox model and log-rank test and were stratified by geographic region (Asia vs rest of world, including Japan), AFP level (< 400 vs ≥ 400 ng/mL) at baseline and MVI and/or EHS (yes vs no) per IxRS. <sup>c</sup>The 2-sided P value boundary based on 161 events is 0.0033. Data cutoff, 29 Aug 2019; median survival follow-up, 8.6 mo.
### Tecentriq + Avastin in 1L unresectable HCC: Complete responses regardless of poorer prognostic factors or HCC etiology

<table>
<thead>
<tr>
<th></th>
<th>IRF RECIST 1.1</th>
<th>IRF HCC mRECIST</th>
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<tbody>
<tr>
<td></td>
<td>Atezo + Bev (n = 326)</td>
<td>Sorafenib (n = 159)</td>
</tr>
<tr>
<td><strong>Confirmed ORR, n (%)</strong></td>
<td>89 (27)</td>
<td>19 (12)</td>
</tr>
<tr>
<td>(95% CI)</td>
<td>(23, 33)</td>
<td>(7, 18)</td>
</tr>
<tr>
<td><strong>CR</strong></td>
<td>18 (6)</td>
<td>0</td>
</tr>
<tr>
<td><strong>PR</strong></td>
<td>71 (22)</td>
<td>19 (12)</td>
</tr>
<tr>
<td><strong>Stratified P value</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>&lt; 0.0001</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>SD, n (%)</td>
<td>151 (46)</td>
<td>69 (43)</td>
</tr>
<tr>
<td>PD, n (%)</td>
<td>64 (20)</td>
<td>39 (25)</td>
</tr>
<tr>
<td><strong>DCR, n (%)</strong></td>
<td>240 (74)</td>
<td>88 (55)</td>
</tr>
<tr>
<td><strong>Ongoing response, n (%)</strong>&lt;sup&gt;c&lt;/sup&gt;</td>
<td>77 (87)</td>
<td>13 (68)</td>
</tr>
<tr>
<td><strong>Median DOR, months</strong>&lt;sup&gt;c&lt;/sup&gt; (95% CI)</td>
<td>NE</td>
<td>6.3 (4.7, NE)</td>
</tr>
<tr>
<td><strong>Event-free rate at 6 months, n (%)</strong></td>
<td>88</td>
<td>59</td>
</tr>
</tbody>
</table>

- Six % of patients achieved a CR per RECIST1.1 with Tecentriq+Avastin vs 0% with sorafenib despite historically low CR rates
- Significantly higher ORR with Tecentriq+Avastin (although similar TTR as sorafenib): median TTR per RECIST1.1 of 2.8 months with 27% of patients responding, compared with TTR of 2.7 months for sorafenib with 12% of patients responding
- In the vast majority of patients, CR was still ongoing at 6 months and a median duration of CR has not yet been reached

<sup>a</sup> IRF HCC mRECIST–evaluable population was based on patients who presented with measurable disease at baseline per HCC mRECIST criteria.

<sup>b</sup> Stratification factors included geographic region (Asia vs rest of world, including Japan), AFP level (< 400 vs ≥ 400 ng/mL) at baseline and MVI and/or EHS (yes vs no) per IxRS.

<sup>c</sup> Denominator is patients with confirmed CR/PR. Data cutoff, 29 Aug 2019; median survival follow-up, 8.6 mo.
# Overview CIT adjuvant program

*Liver cancer added, lung and breast studies starting to read out in 2020*

<table>
<thead>
<tr>
<th>TNBC</th>
<th>Neoadjuvant</th>
<th>IMpassion 031</th>
<th>Tecentriq + nab-paclitaxel</th>
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<tbody>
<tr>
<td>Neoadjuvant + adjuvant</td>
<td>NCT02620280 (sponsor Fondazione Michelangelo)</td>
<td>Tecentriq + nab-paclitaxel + carboplatin</td>
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</tr>
<tr>
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<td>Tecentriq + carboplatin + paclitaxel</td>
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<tr>
<td>Adjuvant</td>
<td>IMpassion 030</td>
<td>Tecentriq + paclitaxel followed by AC followed by Tecentriq</td>
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<th>HER2+ BC</th>
<th>Neoadjuvant</th>
<th>IMpassion 050</th>
<th>H+P + chemo + Tecentriq / surgery / Tecentriq + chemo</th>
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<tr>
<th>NSCLC</th>
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<th>Tecentriq + platinum based chemo</th>
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<tbody>
<tr>
<td>Adjuvant</td>
<td>IMpower 010</td>
<td>Tecentriq following adjuvant cisplatin based chemo</td>
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<td>Adjuvant</td>
<td>ALINA Alecensa</td>
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<th>IMbrave050</th>
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<th>2020</th>
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**Legend:**
- **Tecentriq Ph III (Roche sponsored)**
- **Tecentriq Ph III (Roche supported)**
Doing now what patients need next