Oncology Pipeline

Data highlights from ESMO 2025 and
AACR-NCI-EORTC International Conference on
Molecular Targets and Cancer Therapeutics 2025

October 24, 2025 (JST)

Cautionary statement regarding forward-looking information

In this material, statements made with respect to current plans, estimates, strategies and beliefs and other statements that are not historical facts are forward-looking statements about the future performance of Astellas Pharma. These statements are based on management's current assumptions and beliefs in light of the information currently available to it and involve known and unknown risks and uncertainties. A number of factors could cause actual results to differ materially from those discussed in the forward-looking statements. Such factors include, but are not limited to: (i) changes in general economic conditions and in laws and regulations, relating to pharmaceutical markets, (ii) currency exchange rate fluctuations, (iii) delays in new product launches, (iv) the inability of Astellas to market existing and new products effectively, (v) the inability of Astellas to continue to effectively research and develop products accepted by customers in highly competitive markets, and (vi) infringements of Astellas' intellectual property rights by third parties.

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The data presented here are based on data presented at scientific congress.

Contents

Presenter

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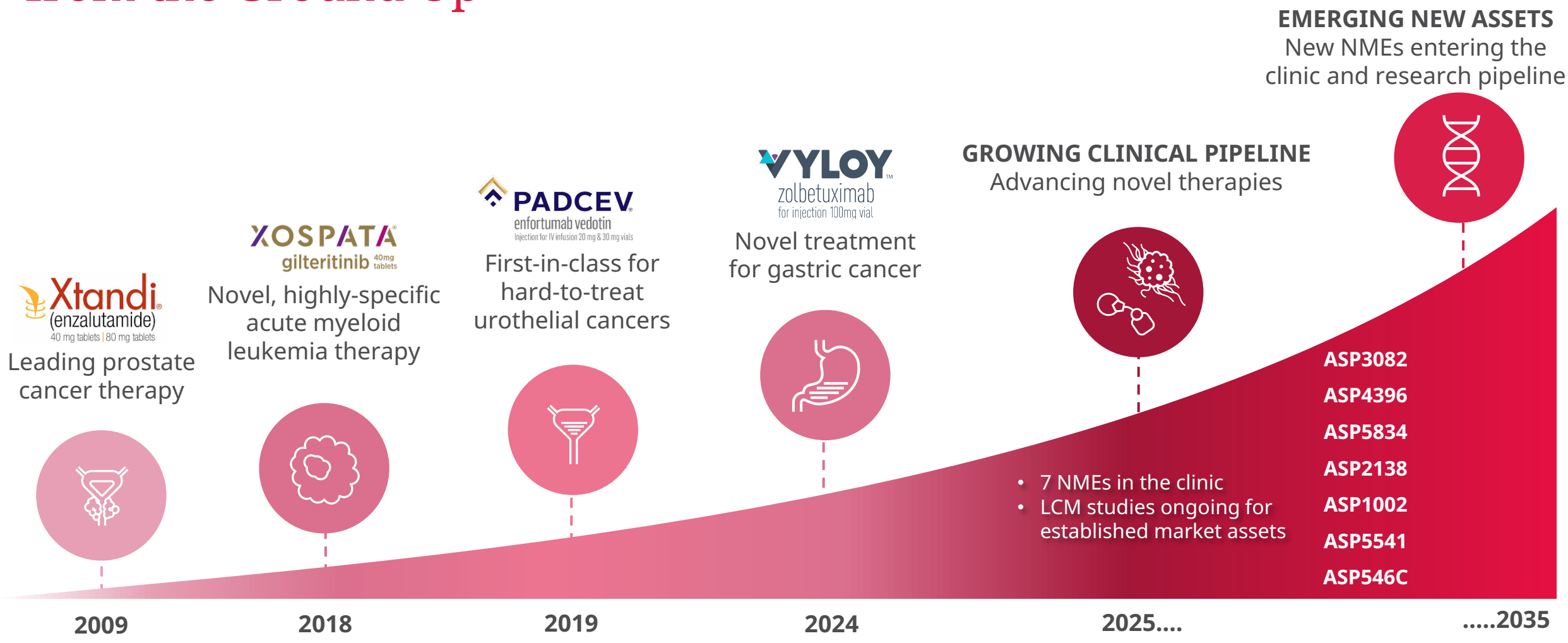
TPD, Targeted Protein Degradation; IO, Immuno-Oncology

At Astellas, we are **pioneering science to deliver the oncology medicines of tomorrow.**

By bringing together our deep disease area expertise, understanding of biology and cutting-edge capabilities, **we are advancing novel, next-generation therapies for hard-to-treat cancers where few or no therapeutic options currently exist.**

In Just Over a Decade, We Have Built a Leading Oncology Pipeline from the Ground Up



Astellas Had Several Major Oncology Achievements Across Multiple Cancer Types in October Alone

Prostate Cancer

- Positive overall survival analysis of Phase 3 EMBARK study showing XTANDI plus leuprolide significantly improves survival outcomes in men with non-metastatic hormone-sensitive prostate cancer with high-risk biochemical recurrence (oral presentation at ESMO 2025)

Today's topics

Bladder Cancer

- Phase 3 EV-303 study shows PADCEV in combination with pembrolizumab reduces the risk of death and recurrence by at least half for patients with cis-ineligible MIBC when given before and after surgery (Presidential Symposium at ESMO 2025)
- The US FDA has granted Priority Review for sBLA (PDUFA date: April 7, 2026)

Lung Cancer

- First non-small cell lung cancer data from KRAS G12D degrader ASP3082 demonstrate encouraging safety and efficacy (oral presentation at AACR-NCI-EORTC 2025)

GI Cancer

- First clinical data from ASP2138 demonstrate encouraging safety and efficacy in gastric cancer, with potential to be the first subcutaneously delivered T cell engager approved for solid tumors (poster presentation at ESMO 2025)

PADCEV (enfortumab vedotin)

EV-303 study results

Data from presentation at ESMO 2025

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Stages of Bladder/Urothelial Cancer

NON-MUSCLE INVASIVE (NMIBC)

Stage 0-1

5-year survival: 97%

Recurrence rate: 70%

MUSCLE INVASIVE (MIBC)

Stage 2-4

5-year survival: 71%

Recurrence rate: 50%

LOCALLY ADVANCED OR METASTATIC (la/mUC)

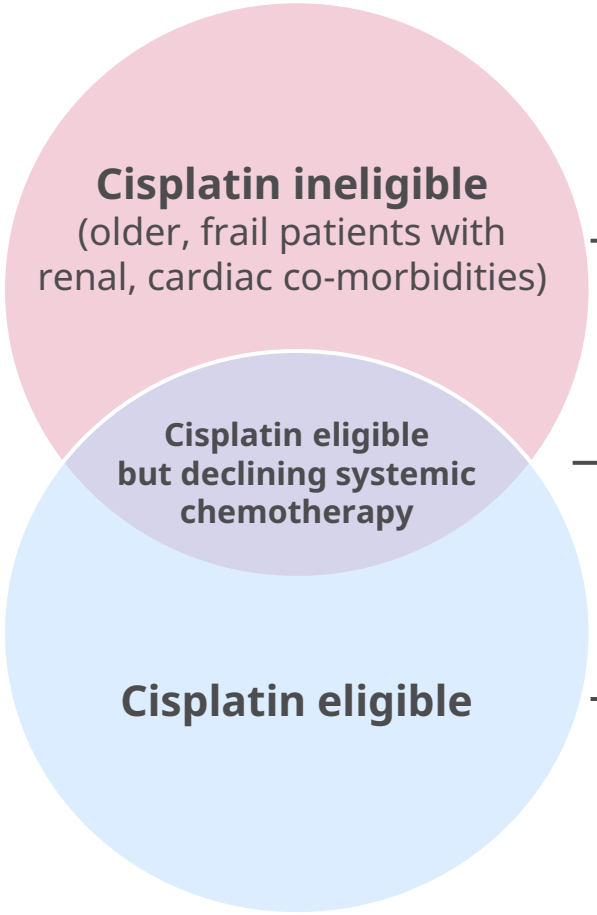
Stage 4

5-year survival: 8-39%

Recurrence rate: 50%

National Cancer Institute. Bladder Cancer Prognosis and Survival Rates. Available at: https://www.cancer.gov/types/bladder/survival. Last accessed: August 2025; Wallerand H, et al. Urol Oncol 29:4-11 (2011); Hensley PJ, et al. Eur Urol 85(1):32-34 (2024)

PADCEV + Pembrolizumab in MIBC: Potential to Shift Care and Address Key Unmet Needs

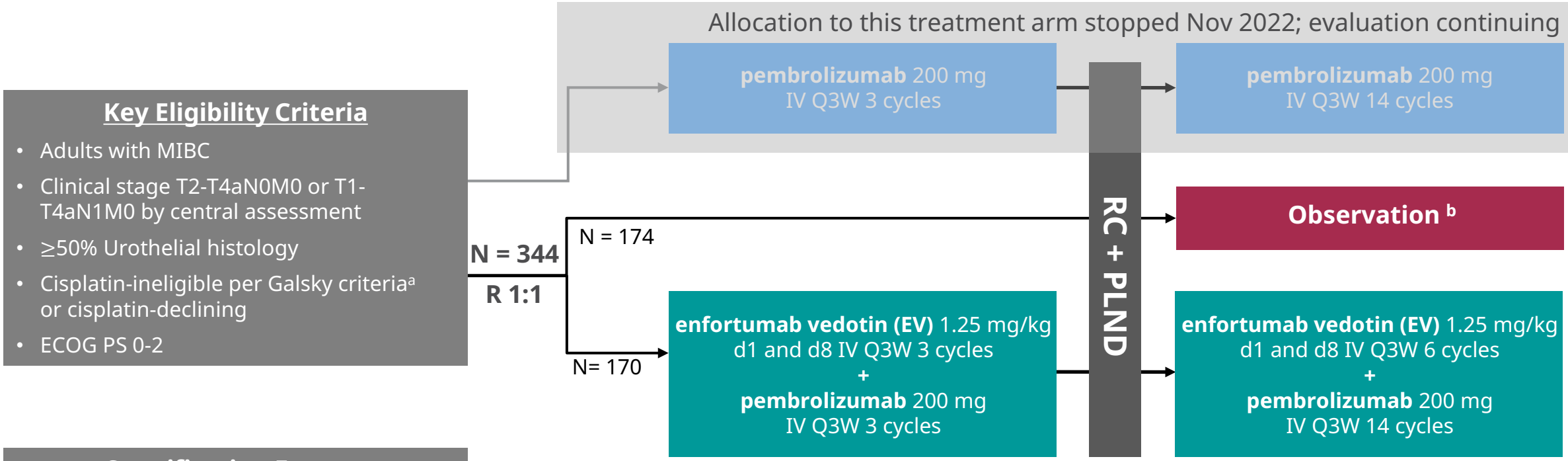


Neo-adjuvant/ peri-operative therapy	Surgery	Adjuvant therapy
• Non-cisplatin based chemotherapy (carbo-gem) **PADCEV + pembrolizumab (EV-303)**		• Non-cisplatin based chemotherapy (carbo-gem) • Nivolumab **PADCEV + pembrolizumab (EV-303)**
• None **PADCEV + pembrolizumab (EV-303)**		• None **PADCEV + pembrolizumab (EV-303)**
• Cisplatin based chemotherapy (gem-cis, ddMVAC) +/- durvalumab **PADCEV + pembrolizumab (EV-304)**		• Cisplatin based chemotherapy (gem-cis, ddMVAC) +/- durvalumab • Nivolumab **PADCEV + pembrolizumab (EV-304)**

Shorter time to recurrence and death

May benefit from more targeted therapy options

EV-303/KEYNOTE-905 Phase 3 Trial in Cis-Ineligible MIBC



Key Eligibility Criteria

- Adults with MIBC
- Clinical stage T2-T4aN0M0 or T1-T4aN1M0 by central assessment
- ≥50% Urothelial histology
- Cisplatin-ineligible per Galsky criteria[a] or cisplatin-declining
- ECOG PS 0-2

Stratification Factors

- Cisplatin ineligibility (ineligible vs. eligible but declining)
- Clinical stage (T2N0 vs. T3/T4aN0 vs. T1-4aN1)
- Region (US vs. EU vs. Most of World)

Primary endpoint: Event-free survival (EFS) by BICR

Key secondary endpoints: OS and pathological complete response (pCR; pT0N0, i.e. absence of viable tumor in examined tissue from surgery) by central pathologist review

Other secondary endpoints include Safety

Exploratory endpoints include: EFS by pCR status

BICR, blinded independent central review; IV, intravenous; Q3W, every 3 weeks; RC + PLND, radical cystectomy with standard pelvic lymph node dissection.
[a]Protocol-defined as having ≥1 of the following: impaired renal function (creatinine clearance 30–59 ml/min), ECOG PS 2, gr ≥2 audiometric hearing loss, or NYHA class III heart failure;
[b]As of Nov 2022, adjuvant nivolumab was permitted when clinically indicated and regionally available.

Baseline Characteristics of Patients Entering the EV-303 Trial
Older, More Frail Patients with Poor Prognosis

Characteristic, n (%)	EV + pembro (N = 170)	Control (N = 174)
Median age (range), years	74.0 (47–87)	72.5 (46–87)
≥65 to <75 years	63 (37.1)	77 (44.3)
≥75 years	78 (45.9)	68 (39.1)
Male	137 (80.6)	131 (75.3)
ECOG PS		
0	102 (60.0)	95 (54.6)
1	47 (27.6)	53 (30.5)
2	21 (12.4)	26 (14.9)
Region		
United States	21 (12.4)	23 (13.2)
European Union	78 (45.9)	77 (44.3)
Most of World	71 (41.8)	74 (42.5)
Cisplatin eligibility status (per Galsky criteria)		
Ineligible	142 (83.5)	139 (79.9)
Eligible but declining	28 (16.5)	35 (20.1)
PD-L1 combined positive score (CPS) ≥10[a]	80 (47.1)	83 (47.7)
Tumor stage at baseline (*centrally assessed using both pathology of TURBT specimen and imaging*)[b]		
T2N0	30 (17.6)	32 (18.4)
T3/T4aN0	133 (78.2)	132 (75.9)
T1-4aN1	7 (4.1)	10 (5.7)
Creatinine clearance		
≥60 mL/min	68 (40.0)	72 (41.4)
≥30 and <60 mL/min	102 (60.0)	101 (58.0)
<30 mL/min	0	1 (0.6)
Pure urothelial carcinoma histology	152 (89.4)	161 (92.5)

TURBT, transurethral resection of bladder tumor. aBy PD-L1 IHC 22C3 pharmDx (Agilent, Carpinteria, CA); CPS = # PD-L1–staining cells (tumor cells, lymphocytes, and macrophages) ÷ total # viable tumor cells × 100. bBy investigator assessment, 124 pts (72.9%) in the EV + pembro arm and 119 pts (68.4%) in the control had T2N0 stage MIBC at baseline. Data cutoff date: 6 June 2025

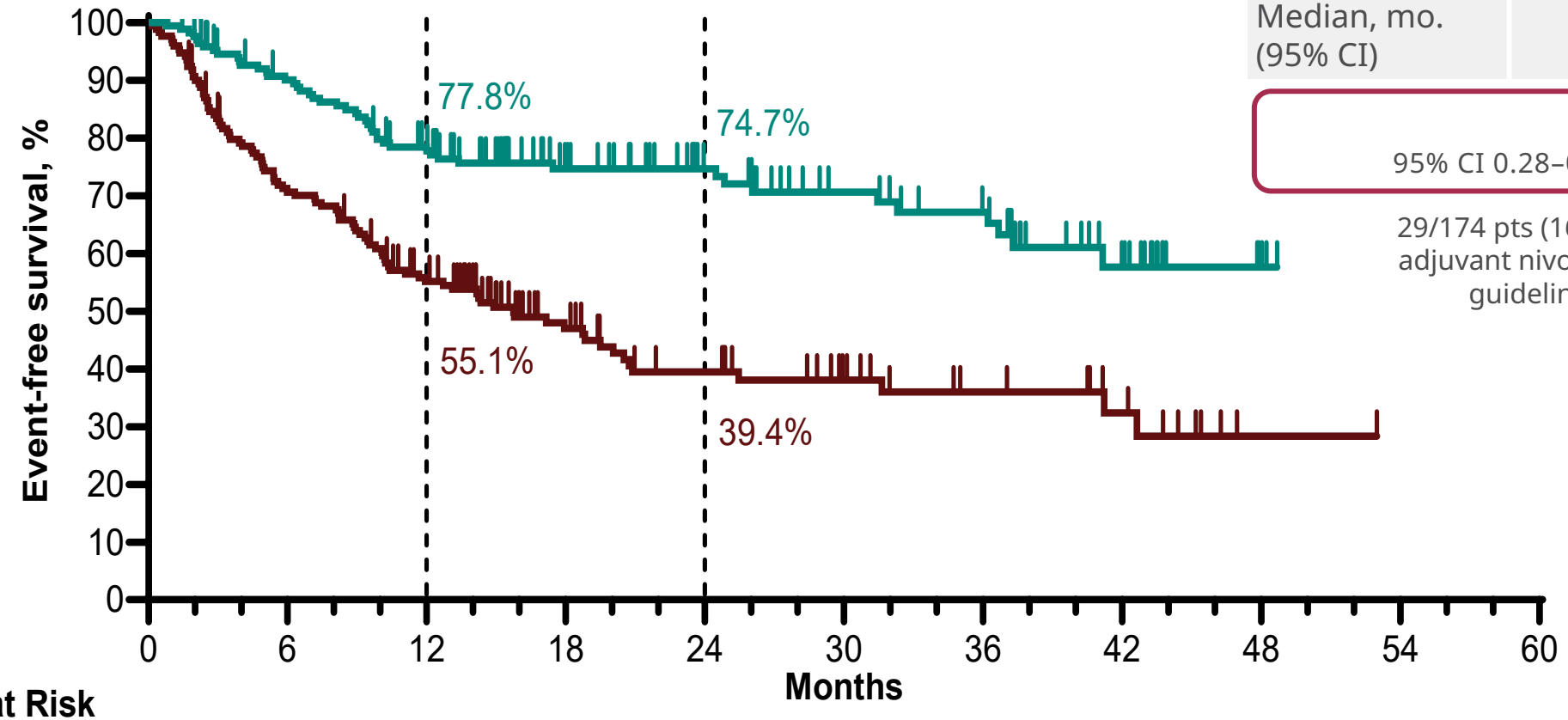
EV-303 Achieved its Primary Endpoint at Interim Analysis 1

Event-Free Survival

	EV + pembro (N = 170)	Control (N = 174)
Events, n (%)	48 (28.2)	95 (54.6)
Median, mo. (95% CI)	**NR (37.3–NR)**	15.7 (10.3–20.5)

HR 0.40
95% CI 0.28–0.57, one-sided *P* <.0001*

29/174 pts (16.7%) in the control arm received adjuvant nivolumab as of data cutoff per local guidelines/prescribing information



No. at Risk

EV + pembro	170	140	116	73	56	42	35	16	3	0	0
Control	174	116	84	48	33	22	14	9	1	0	0

NR, not reached. * denotes statistical significance (one-sided boundary 0.0097). [a]Time from randomization to first occurrence of: radiographic PD precluding surgery; biopsy-proven residual MIBC (pts who did not undergo surgery); gross residual disease post-surgery or newly detected metastatic disease at surgery; local/distant recurrence post-surgery (imaging or biopsy); or death (any cause). High-risk NMIBC of the residual urothelium after surgery also considered an event. Pts who did not undergo surgery were considered EFS event if they met criteria for EFS at any point in time or were censored within ≤16 wks from last dose of neoadjuvant therapy or surgery. Data cutoff date: 6 June 2025

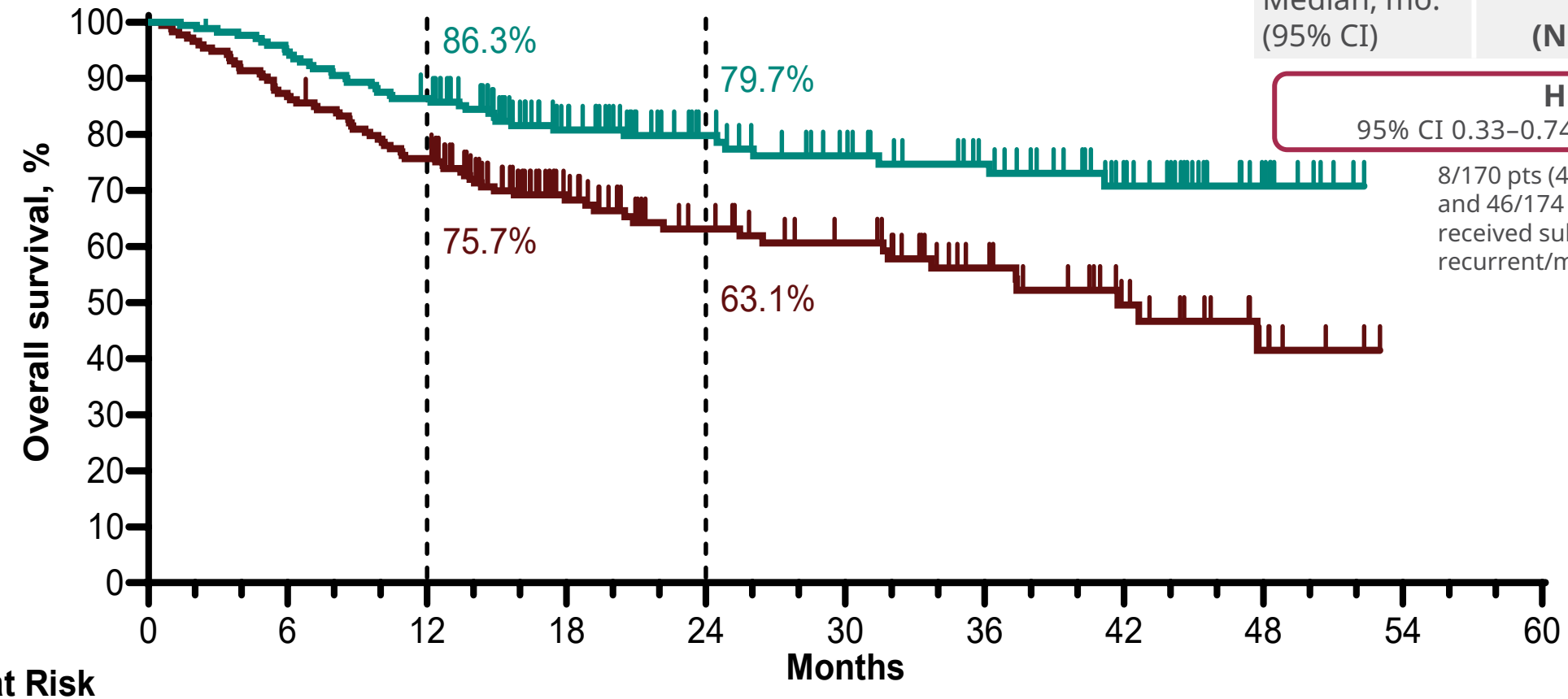
EV-303 Also Achieved a Key Secondary Endpoint at Interim Analysis 1

Overall Survival

	EV + pembro (N = 170)	Control (N = 174)
Events, n (%)	38 (22.4)	68 (39.1)
Median, mo. (95% CI)	**NR (NR–NR)**	41.7 (31.8–NR)

HR 0.50
95% CI 0.33–0.74, one-sided *P* =.0002*

8/170 pts (4.7%) in the EV + pembro arm and 46/174 (26.4%) in the control arm received subsequent therapy for recurrent/metastatic disease

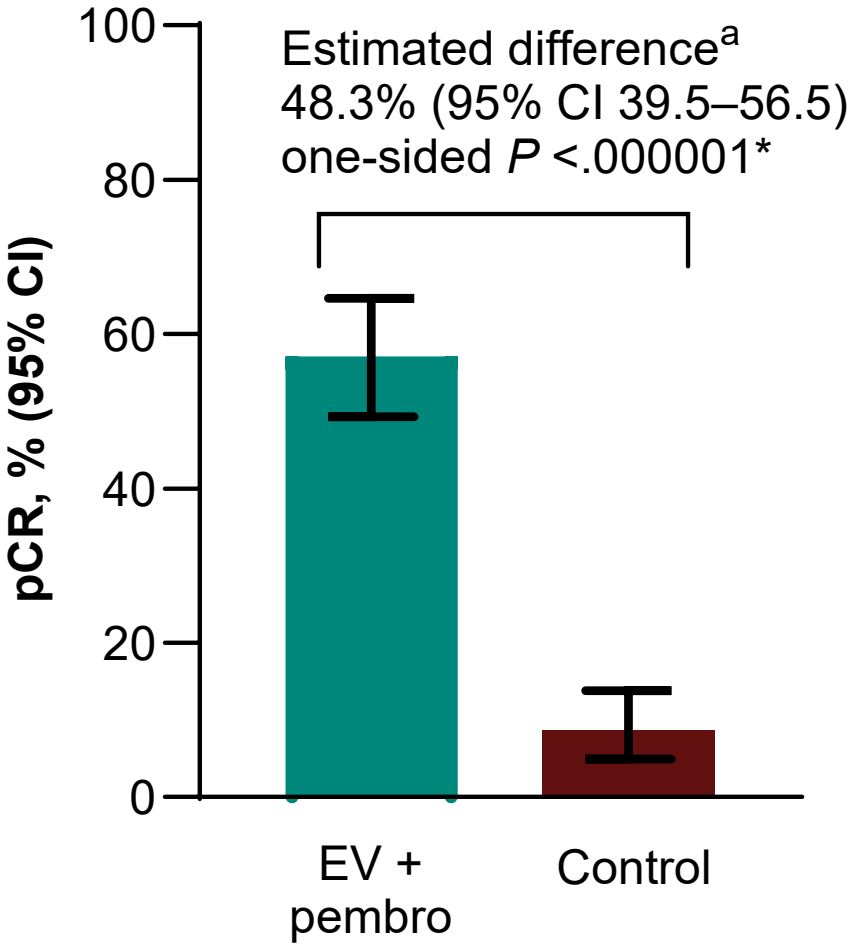


No. at Risk

EV + pembro	170	159	144	94	68	56	45	28	10	0	0
Control	174	150	130	75	54	45	30	18	6	0	0

NR, not reached. * denotes statistical significance (one-sided boundary 0.00488). Data cutoff date: 6 June 2025

EV-303 Achieved Other Key Secondary Endpoints at Interim Analysis 1
Pathological Complete Response (pCR) by Central Pathology Review



	EV + pembro (N = 170)	Control (N = 174)
pCR, n	97	15
pCR rate, % (95% CI)	**57.1 (49.3–64.6)**	8.6 (4.9–13.8)

- **pCR:** absence of viable tumor (pT0N0) in examined tissue from RC + PLND
- Pts who did not undergo surgery, including those with clinical complete response after neoadjuvant therapy, were considered non-responders

* denotes statistical significance (one-sided boundary 0.00025). Data cutoff date: 6 June 2025
[a]Based on stratified Miettinen and Nurminen method.
RC + PLND, radical cystectomy with standard pelvic lymph node dissection.

Summary of Adverse Events Observed in EV-303

- Median (range) duration of **neoadjuvant therapy** in the EV + pembro arm (N = 167): 1.6 months (0.03–2.8)
  - Median cycles of neoadjuvant EV + pembro: 3.0 (range, 1.0–3.0)
- Median (range) duration of **adjuvant therapy** in the EV + pembro arm (N = 100): 8.0 months (0.03–12.9)
  - Median (range) number adjuvant cycles of EV was 6.0 (1.0–6.0) and of pembro was 12.0 (1.0–14.0)

	EV + pembro (N = 167)	Control (N = 159)
Any grade TEAE[a]	167 (100)	103 (64.8)
Surgery phase only[b]	99/146 (67.8)	103 (64.8)
Grade ≥3 TEAE	119 (71.3)	73 (45.9)
Surgery phase only	52/146 (35.6)	73 (45.9)
Serious TEAE	97 (58.1)	65 (40.9)
Surgery phase only	42/146 (28.8)	65 (40.9)
AE leading to surgery delay[c]	6/149 (4.0)	1/159 (0.6)
TEAE leading to dose reduction of EV	28 (16.8)	NA
TEAE leading to discontinuation of EV	69 (41.3)	NA
TEAE leading to discontinuation of pembro	57 (34.1)	NA
TEAE leading to death	13 (7.8)*	9 (5.7)
Surgery phase only	4/146 (2.7)	9 (5.7)

TEAE, treatment-emergent adverse event. Data are n (%) when denominator matches header, and n/N (%) when denominator is different.
*Included 2 drug-related deaths (both during neoadjuvant phase: n=1 myasthenia gravis and n=1 toxic epidermal necrolysis).

[a]Collected up to 30 days after cessation of study treatment (serious AEs collected up to 90 days, or 30 days after if pt started a new anticancer therapy).
[b]Defined as time from date of surgery to 30 days post-surgery for nonserious events (90 days for serious events) and prior to date of first postoperative study drug (if applicable).
[c]Surgery delay defined as >8 weeks from last preoperative drug dose (or randomization if no preoperative drug received) to surgery for the EV + pembro arm (18/149 pts; 12.1%); and >8 weeks from randomization to surgery for the control arm (25/159 pts; 16.0%). Data cutoff date: 6 June 2025

EV-303 Provides an Opportunity to Continue to Shift the Paradigm in the Management of Bladder Cancer, particularly the ~50% MIBC Patients Who are Ineligible[1], or Decline Cisplatin Based Chemotherapy

Patient segment		Pivotal study Regimen	Number of eligible patients*
MIBC	**Cis-eligible****	**EV-304** EV + pembrolizumab	**32,000*****
	Cis-ineligible**	**EV-303** EV + pembrolizumab	**20,000*****
1L metastatic urothelial Cancer (mUC)		**EV-302** EV + pembrolizumab **Approved**	**102,000**
2L+ mUC (platinum & PD-1/L1 inhibitor pretreated)		**EV-301** EV monotherapy **Approved**	**44,000**

*US, Germany, France, Italy, Spain, UK, Japan, China (based on internal estimates)
**Ineligible for or declined cisplatin-based chemotherapy
***Excluding China

1. Per Galsky criteria

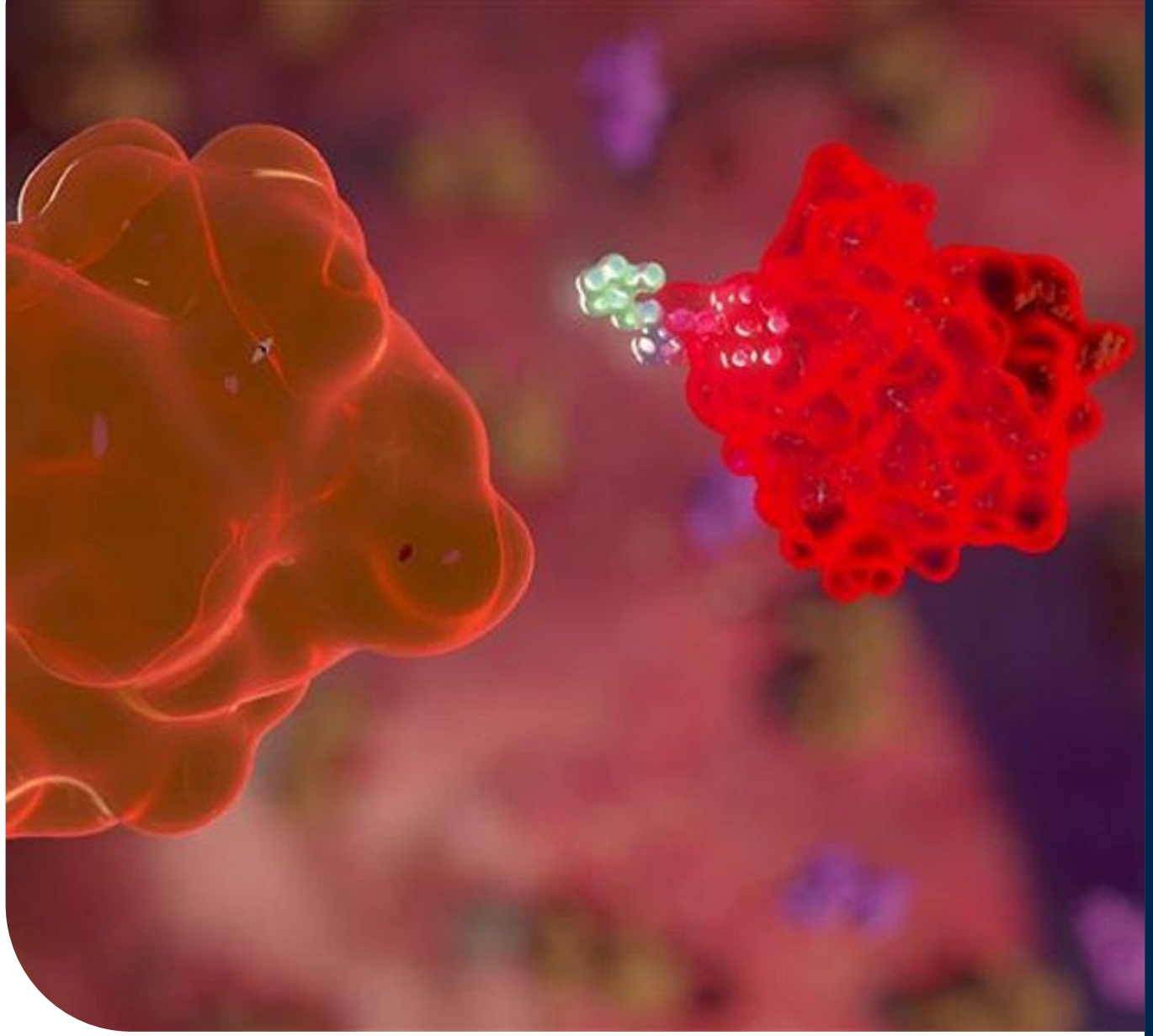
Summary & Next Steps

1. **The EV-303 trial data demonstrates a 60% reduction in the risk of disease progression or recurrence and a 50% reduction in the risk of death** with neoadjuvant and adjuvant EV + pembro as compared to SoC surgery alone in cisplatin-ineligible MIBC patients
2. EV + pembro combination has the potential to become a new standard of care for cisplatin-ineligible MIBC patients
3. The US FDA has granted Priority Review for sBLA (PDUFA date: April 7, 2026)
4. Interim analysis from EV-304 trial in cisplatin-eligible MIBC patients is anticipated in 2H/FY2025

Advancing our TPD Pipeline

Progress on ASP3082

Data from abstract at AACR-NCI-EORTC 2025



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Through **Primary Focus Targeted Protein Degradation**, we are working to target “undruggable” proteins and transform treatment of cancer and other diseases

80% of disease-related proteins are considered ‘undruggable’ because traditional therapies cannot target them. [1]

Targeted Protein Degraders could overcome this by **harnessing the body’s natural protein disposal process,** to locate and eliminate these targets.

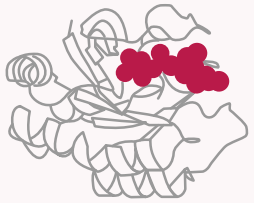
Through our work with TPDs, **we’re reshaping expectations for treating many diseases**.

Starting with cancer, we plan to expand to other diseases that need better treatment options.

Historically, the efficacy of small molecule inhibitors has been limited by target selectivity, difficulty binding to disease-related or multi-domain proteins and development of resistance. [1]

ADVANTAGES OF PROTEIN DEGRADERS

1



TARGETING UNDRUGGABLES

2

SPECIFICITY

3

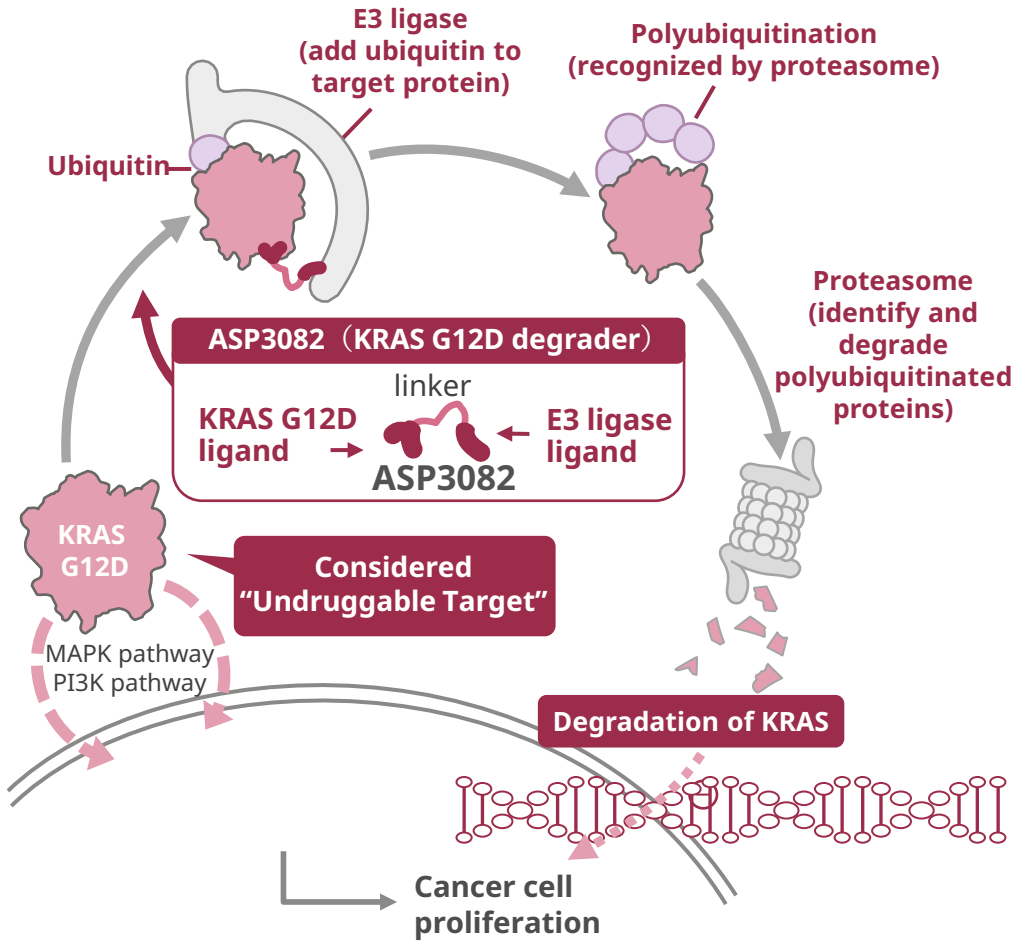
OVERCOME RESISTANCE

1. Verdine, G.L. Drugging the "Undruggable". The Harvey Lectures. 2006;102:1-15

Our Lead TPD Program, ASP3082, is a Potential First-in-Class Therapy

ASP3082 FOR KRAS G12D+ SOLID TUMORS

- **KRAS has been considered an undruggable target** with less druggable pockets, making it difficult to develop inhibitors
- Multiple types of KRAS mutations are known. **G12D mutation occurs most frequently**: More than 51,000 new cancer cases annually in the US[1]
- **ASP3082 is a KRAS G12D targeted protein degrader.** It binds KRAS G12D on tumor cells and directs them for degradation



Cancer Discov 12:924 (2022)
KRAS, Kirsten rat sarcoma viral oncogene homologue; MAPK, Mitogen-activated protein kinase; PI3K, Phosphatidylinositol-3 kinase

There is High Unmet Need in Non-Small Cell Lung Cancer (NSCLC)

4% of NSCLC patients have KRAS G12D mutations; usually associated with poor response to front line immunotherapy or chemo-immunotherapy [1]

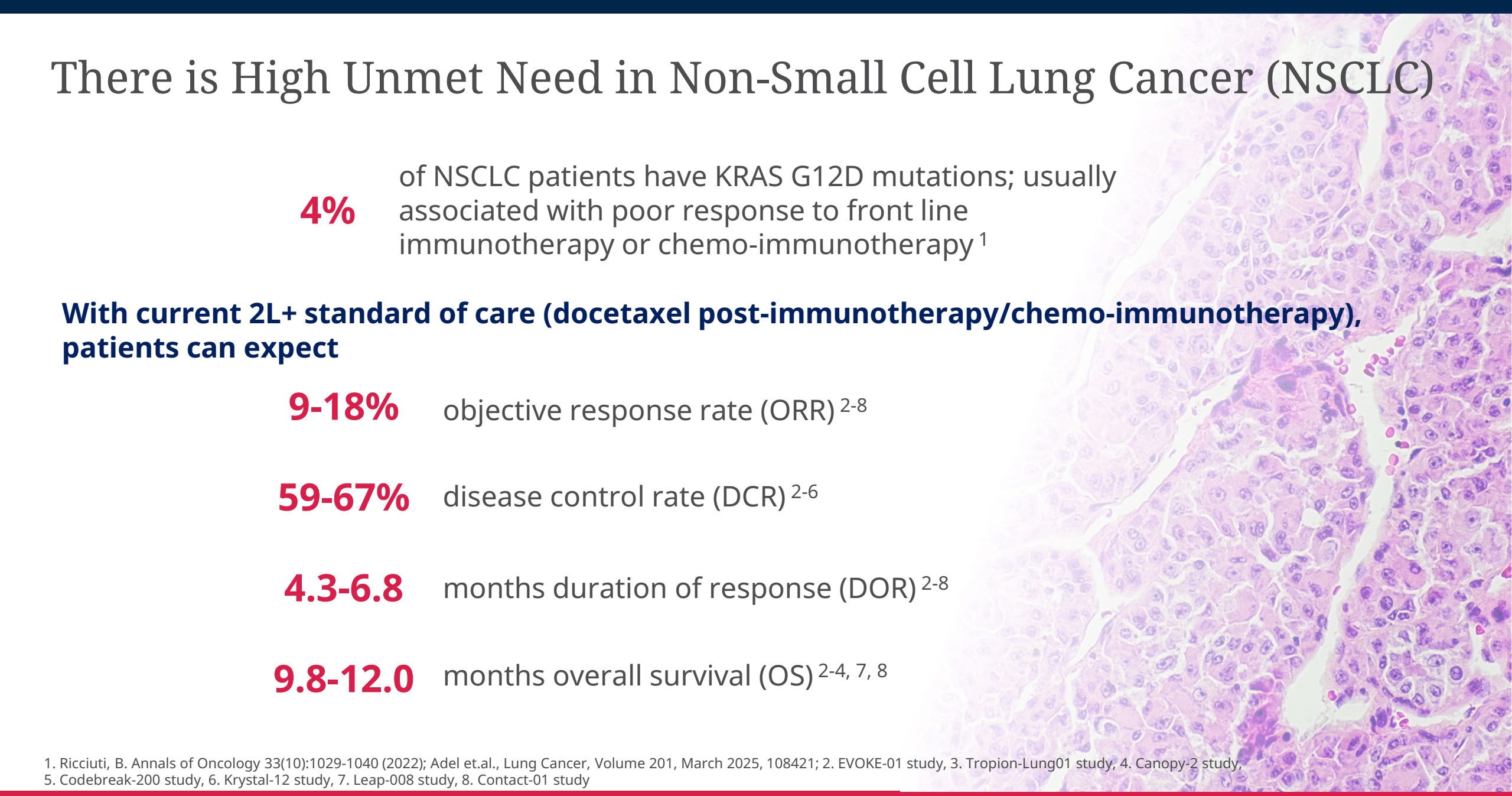
With current 2L+ standard of care (docetaxel post-immunotherapy/chemo-immunotherapy), patients can expect

9-18% objective response rate (ORR) [2-8]

59-67% disease control rate (DCR) [2-6]

4.3-6.8 months duration of response (DOR) [2-8]

9.8-12.0 months overall survival (OS) [2-4, 7, 8]

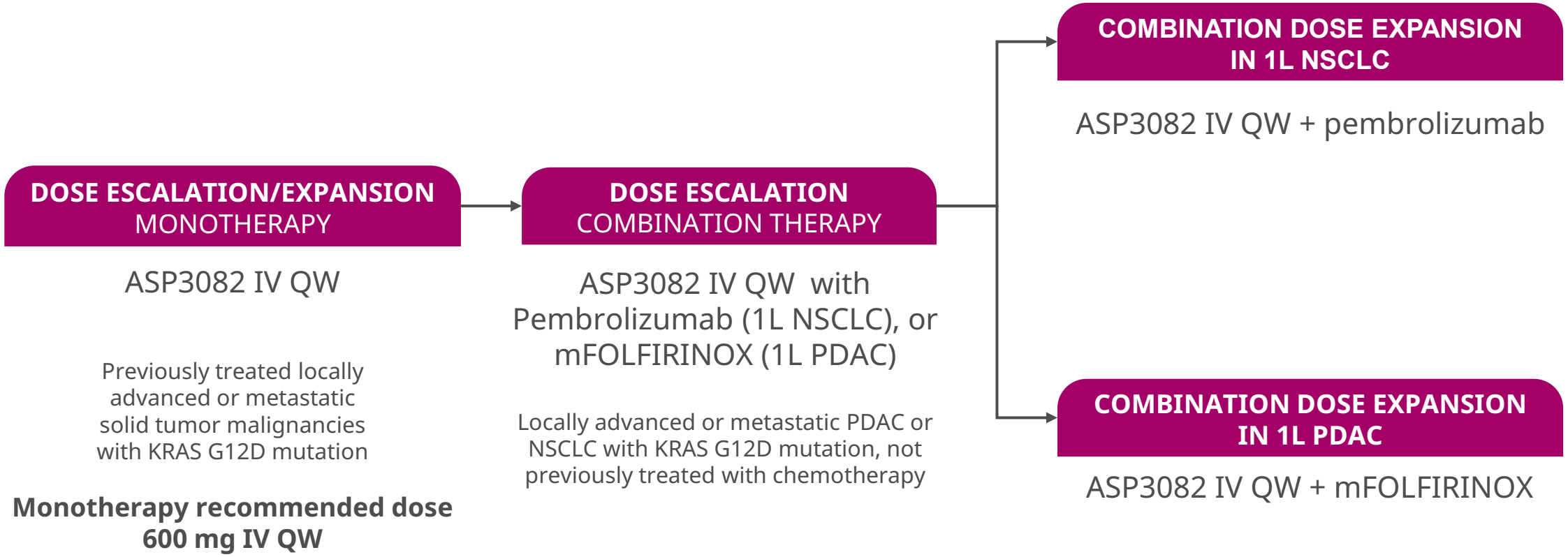


1. Ricciuti, B. Annals of Oncology 33(10):1029-1040 (2022); Adel et.al., Lung Cancer, Volume 201, March 2025, 108421; 2. EVOKE-01 study, 3. Tropion-Lung01 study, 4. Canopy-2 study, 5. Codebreak-200 study, 6. Krystal-12 study, 7. Leap-008 study, 8. Contact-01 study

ASP3082 is Being Studied as Monotherapy and in Combination with SOC Therapies in a Phase 1 Open Label Trial

Clinical Trial Design

A phase 1, open-label study of ASP3082 in patients with previously treated locally advanced or metastatic solid tumor malignancies with KRAS G12D mutation



NSCLC patients with KRAS G12D mutations tend to be non-smokers and usually progress rapidly on standard of care therapies

ASP3082 Phase 1 NSCLC monotherapy dose expansion - Patient Demographics (n=25)				
Sex	**Tobacco Use**	**Age** (Median, yrs)	**PD-L1+** (≥1% tumor proportion score)	**Prior anticancer therapy** (median # lines)
72% female	**32% never used tobacco**	62 (range, 36-81)	15/22 (68.2%)	2 lines (range, 1-5) **Most patients 3-4L**

Median duration of ASP3082 exposure: 17.1 weeks (range, 1-60)
Median follow-up: 6.83 months (95% CI, 5.03-8.74)

Initial Results from ASP3082 as Monotherapy in Patients with NSCLC - Safety

Treatment-related adverse events (TRAEs)	Grade ≥3 TRAEs	Serious AEs	Serious TRAEs	Infusion-related reactions (IRR)	Other TRAEs (≥20% pts)
24/25 (96.0%) **No treatment-related deaths**	**2/25 (8.0%)**	**7/25 (28.0%)**	**2/25 (8.0%)**	**19/25 (76.0%) (all grade 1-2)** • **Manageable with a short pause during infusion and antihistamines** • 1 patient (4.0%) required dose reduction due to IRR but later resumed 600 mg • None led to drug discontinuation	• Pruritus (36.0%) • Rash (36.0%) • Nausea (28.0%) • Diarrhea (20.0%) • Urticaria (20.0%).

Initial Efficacy from ASP3082 as Monotherapy in Patients with 2+ line NSCLC

Objective Response Rate (ORR)* in patients with ≥1 post-baseline scan	Partial Response (PR)	Disease Control Rate (DCR)	Median Duration of Response (DOR)
37.5% (95% CI, 18.8–59.4%)	**9/24**	**91.7%** (95% CI, 73.0–99.0%)	**9.72 months** (95% CI, 2.33–NE) in 8 pts who achieved confirmed response (n=3 events; 5 censored)

*8 patients had confirmed PR and 1 patient had unconfirmed PR as of data cutoff

Ci, confidence interval; NE, not estimable

Result Support Further Evaluation of ASP3082 as a New First-in-Class Treatment for Patients with KRAS G12D-mutant Solid Tumors

- ✓ ASP3082 monotherapy showed promising antitumor activity in a heavily pretreated patient population with NSCLC
- ✓ Safety events were generally manageable
- ✓ Findings support continued evaluation of ASP3082 monotherapy in 2L+ NSCLC

NEXT STEPS

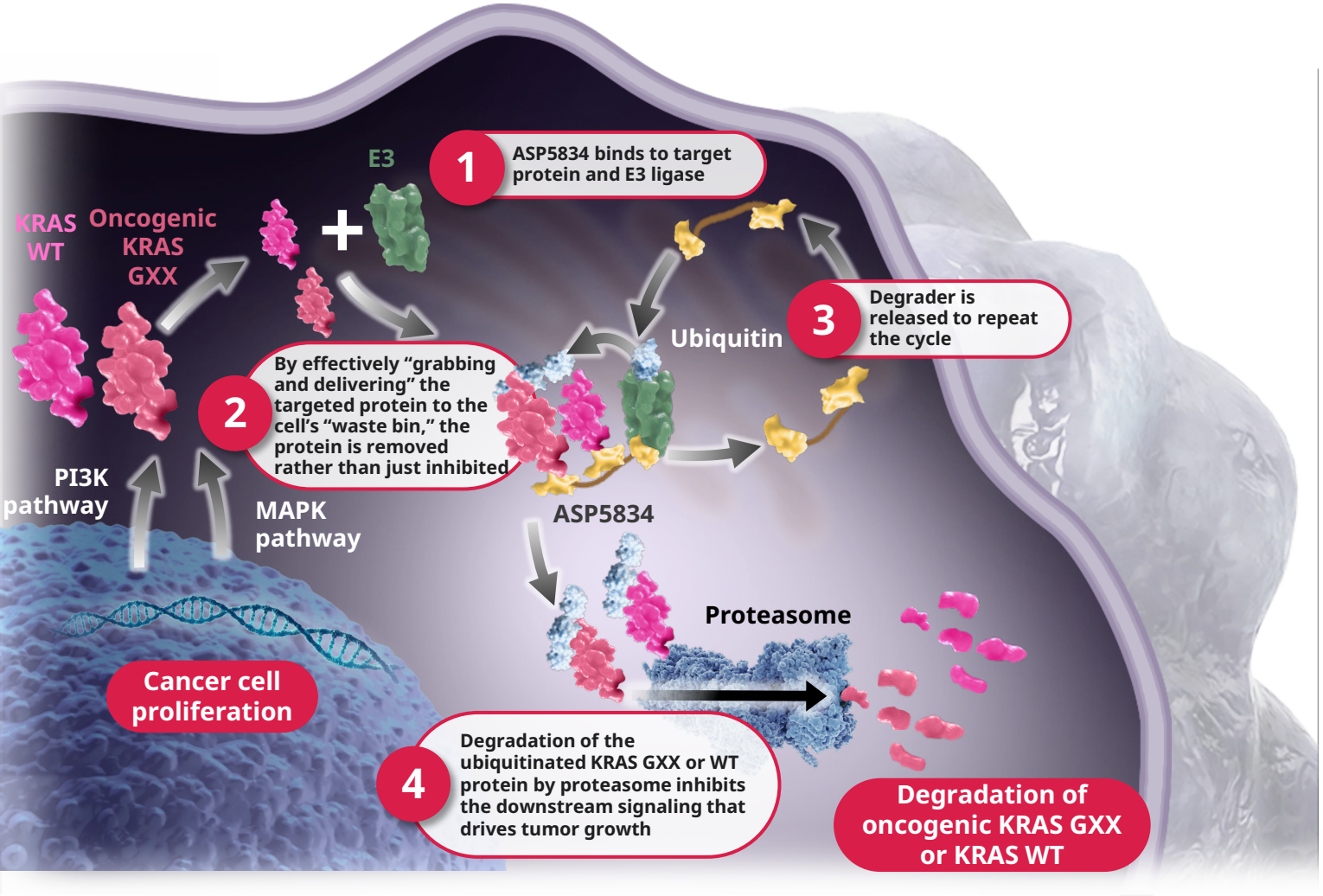
- Ongoing work to understand the benefit of ASP3082 in other tumor types, earlier lines of treatment, and in combination with other novel therapies
- **Aiming to initiate registrational study for 1L PDAC in 2H FY2025**
- Planning is ongoing for registrational studies in NSCLC

We Are Advancing a Robust TPD Pipeline

Program	Mechanism of Action	Target Disease	Origin/Partner	Current Phase	Recent Updates
ASP3082	KRAS G12D degrader	KRAS G12D+ solid tumor		**Phase 1** Discussion ongoing toward registrational studies	• PoC achieved in PDAC (based on 2/3L data) and NSCLC (based on 2L+ data) • PoC judgment in CRC anticipated for 2H/FY2025 • Data presentation aiming for 2H/FY2025
ASP4396	KRAS G12D degrader (different E3 from ASP3082)	KRAS G12D+ solid tumor		**Phase 1**	
ASP5834	Pan-KRAS degrader	KRAS+ solid tumor		**Phase 1**	• FSD in August 2025
ASPxxxx	KRAS degrader + antibody (DAC: degrader-antibody conjugate)	KRAS+ solid tumor		**IND enabling**	
Undisclosed	Undisclosed	Cancer	FIMECS	**Discovery**	
Undisclosed	Cell cycle protein degrader	Cancer	cullgen	**Discovery**	
Undisclosed	Undisclosed	Cancer	PeptiDream	**Discovery**	
Undisclosed programs	Degrader / DAC / etc.	Cancer / Non-oncology		**Discovery**	

KRAS, Kirsten rat sarcoma viral oncogene homologue; PoC, proof of concept; PDAC, pancreatic ductal adenocarcinoma; 2/3L, second and third line; NSCLC, non-small cell lung cancer; 2L+, second or later line; CRC, colorectal cancer; FSD, first subject dosed

ASP5834 is a Potential First-in-Class Therapy Designed to Degrade Multiple Different KRAS Mutant Proteins



ASP5834 – A PAN-KRAS TARGETED PROTEIN DEGRADER

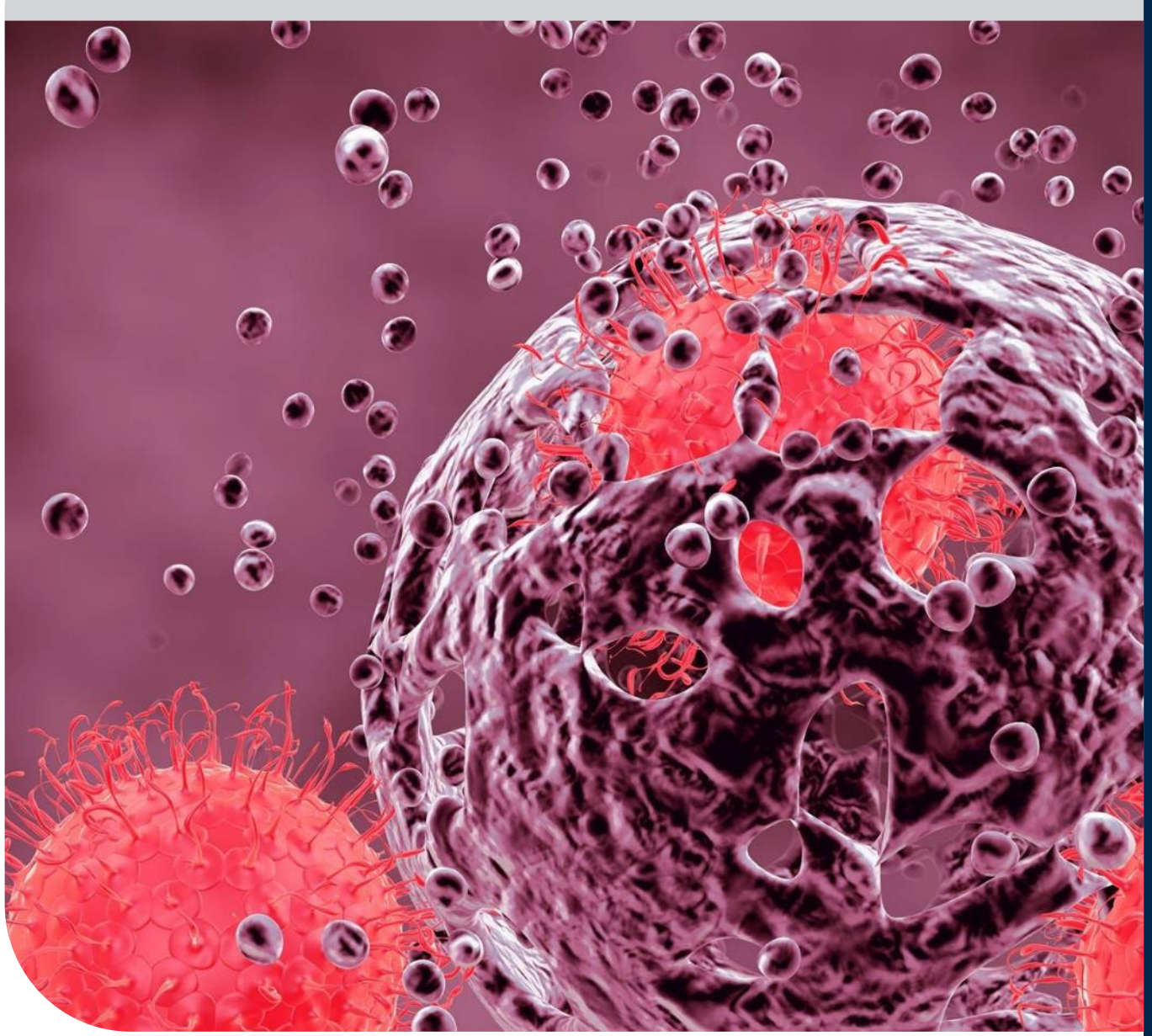
- 11.6% of all cancer patients have a KRAS mutation [1,2]
- **ASP5834 is a degrader that targets multiple KRAS alterations**: KRAS G12V/D/C/R/A, G13D mutations and KRAS WT amplification
- **First patient in Phase 1 study of ASP5834 dosed in Aug 2025** (27 days after IND clearance)

1. American Cancer Society. Cancer Facts & Figures (2020), 2. Hofmann, M.H. et al. Cancer Discovery 12(4):924-937 (2022)

Advancing our IO Pipeline

Progress on ASP2138

Data from presentation at ESMO 2025



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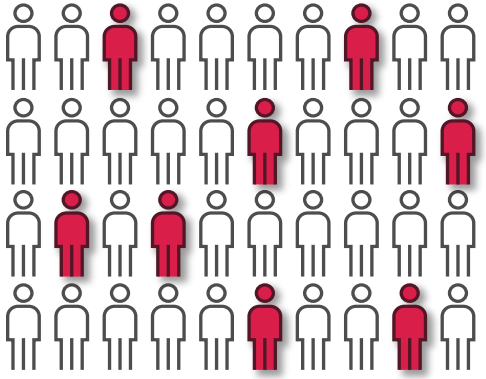
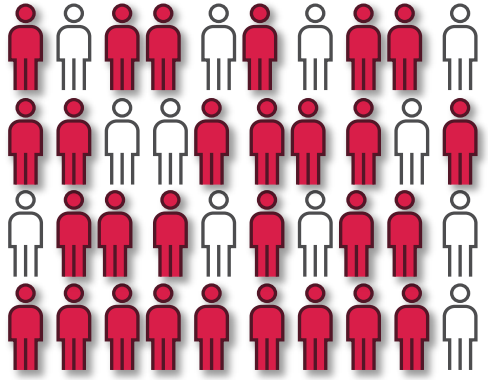
Through Primary Focus Immuno-Oncology, our goal is to arm the immune system to discover, disarm and destroy hard-to-treat cancers

Currently only **approximately 20% of cancers** respond to existing cancer immunotherapy treatments [1]



With our innovative pipeline we are striving for a future where immunotherapies make a difference in the lives of **many more cancer patients**



We are building on our foundation of

EXPERTISE and EXPERIENCE in cancer biology and cancer drug development

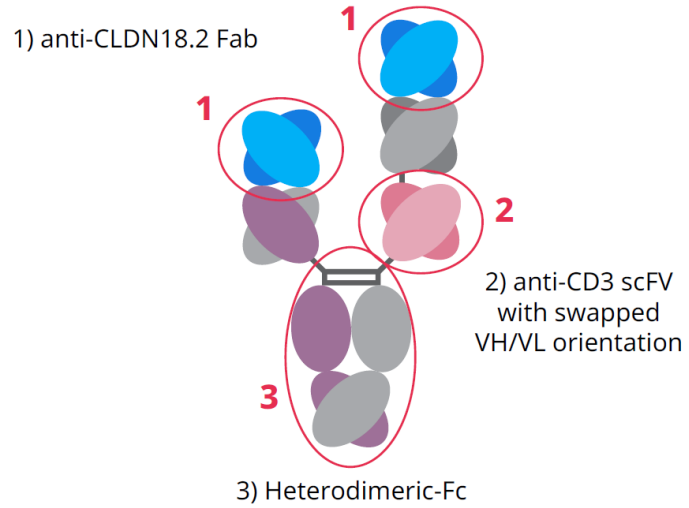
ADVANCED TECHNOLOGY capabilities to develop and improve novel modality platforms, and

PARTNERS with the best minds in immuno-oncology research and development to create new ways to treat cancer

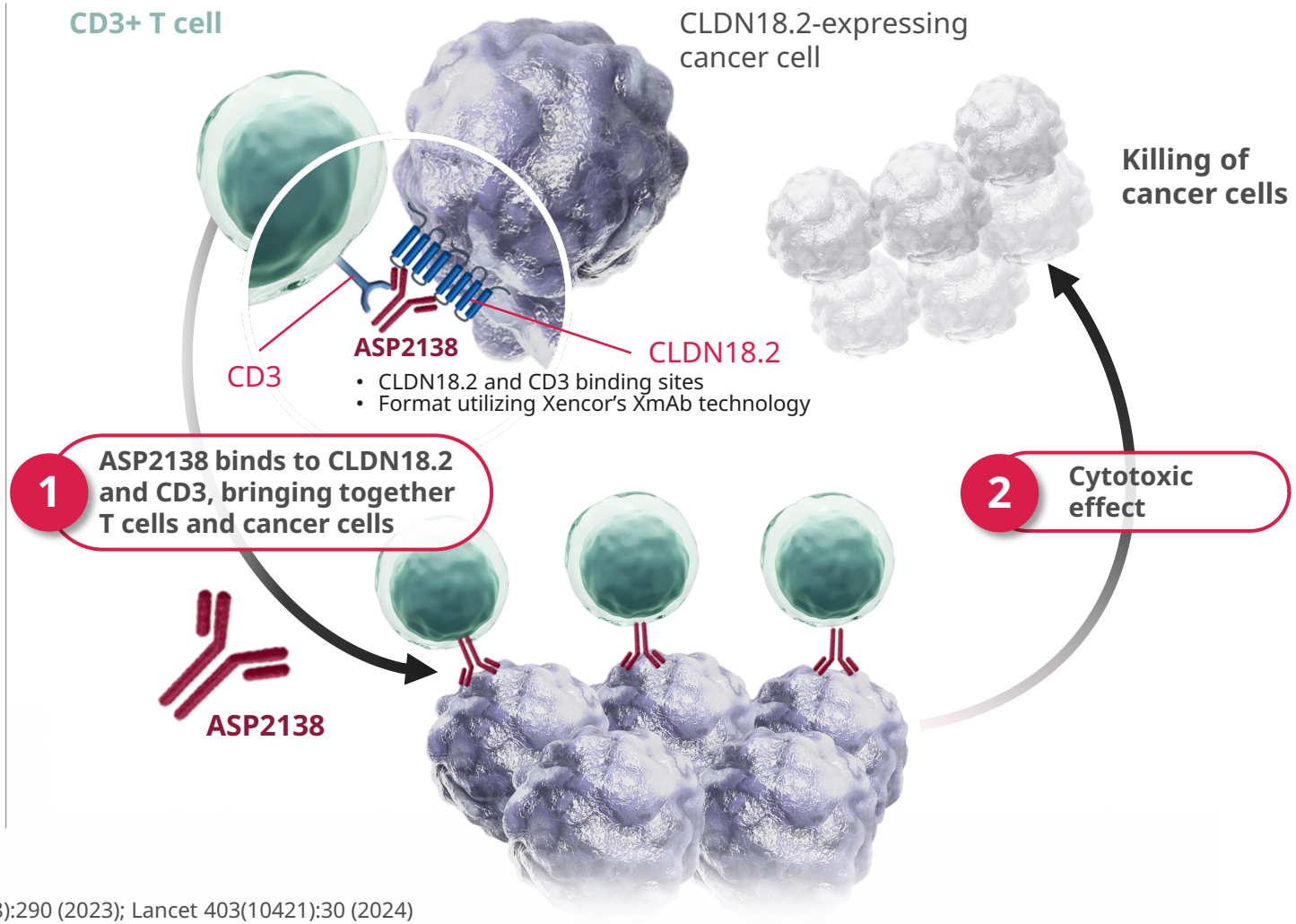
1. Ventola CL. Cancer Immunotherapy 42(8):514-521 (2017)

ASP2138 is a Next-Generation Bispecific T cell Engager Targeting Claudin 18.2, Building on our Expertise from VYLOY

ASP2138
NEXT GENERATION BISPECIFIC T CELL ENGAGER



- ASP2138 is a bispecific antibody designed to bind Claudin 18.2 (CLDN18.2) and CD3, forming a link between tumor cells and T cells, and helping to activate T cells and enhance their ability to kill tumor cells
- ASP2138 has a novel design that may reduce risk of off-tumor immune activation and related toxicities.



1. Sung H, et al. CA Cancer J Clin 71(3):209-249 (2021),
2. Shitara K, Lordick F, Bang YJ, et al. Lancet 401(10389):1655-1668 (2023); Lancet 402(10398):290 (2023); Lancet 403(10421):30 (2024)
3. Shah MA, Shitara K, Ajani JA, et al. Nat Med 29(8):2133-2141 (2023)

There is High Unmet Need in Gastric/GEJ Cancer

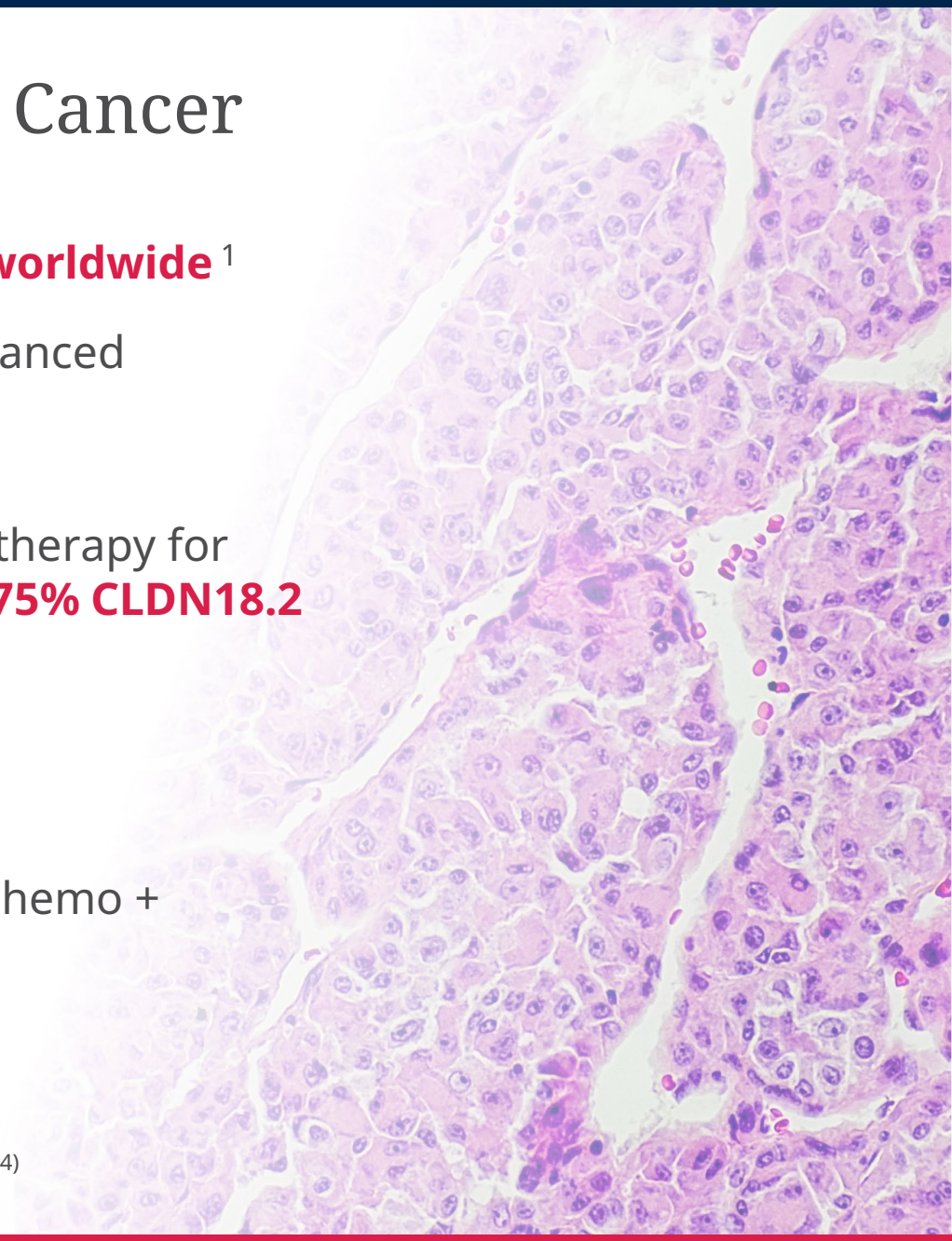
Gastric cancer is the **fifth most commonly diagnosed cancer worldwide** [1]

Studies establish **CLDN18.2 as a novel biomarker** in locally advanced unresectable or metastatic gastric/GEJ adenocarcinoma [2,3]

VYLOY is now approved in many countries as the first targeted therapy for gastric/GEJ adenocarcinoma patients whose **tumors express ≥75% CLDN18.2** (SPOTLIGHT, GLOW)

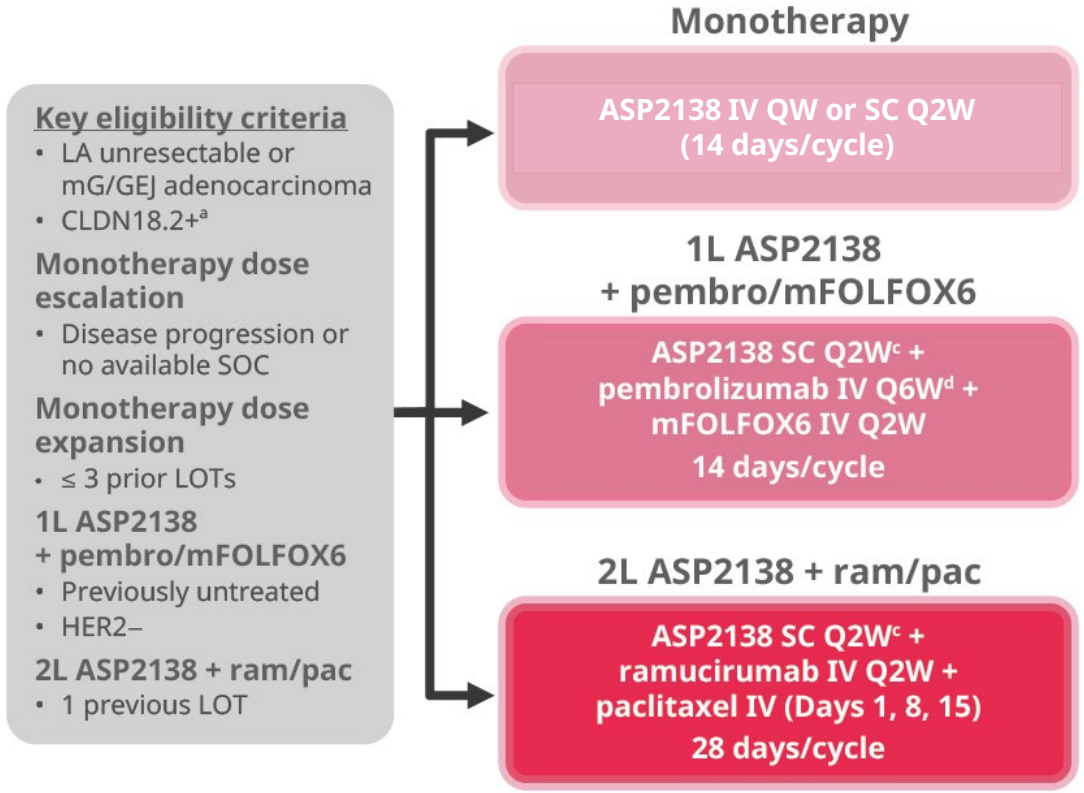
Patients whose tumor expresses <75% CLDN18.2

- Have no approved Claudin 18.2 targeted therapies available
- Median progression-free survival (PFS) with chemo alone or chemo + checkpoint inhibitor is 6-7 months [4]



1. Sung H, et al. CA Cancer J Clin 71(3):209-49 (2021)
2. Shitara K, Lordick F, Bang YJ, et al. Lancet 401(10389):1655-1668 (2023); Lancet 402(10398):290 (2023); Lancet 403(10421):30 (2024)
3. Shah MA, Shitara K, Ajani JA, et al. Nat Med 29(8):2133-2141 (2023)
4. Rha et al. The Lancet Oncology 24(11):1181-1195 (2023)

ASP2138 is Being Investigated as Monotherapy and in Combination with SOC Therapies in CLDN18.2+ Gastric/GEJ Adenocarcinoma

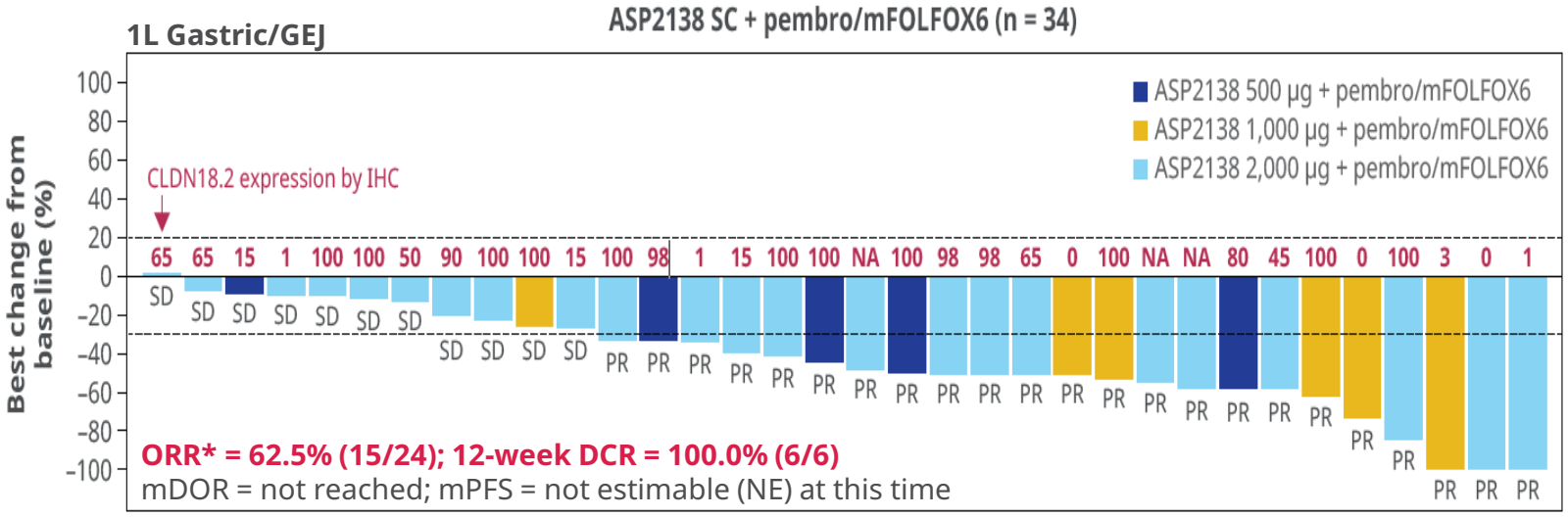


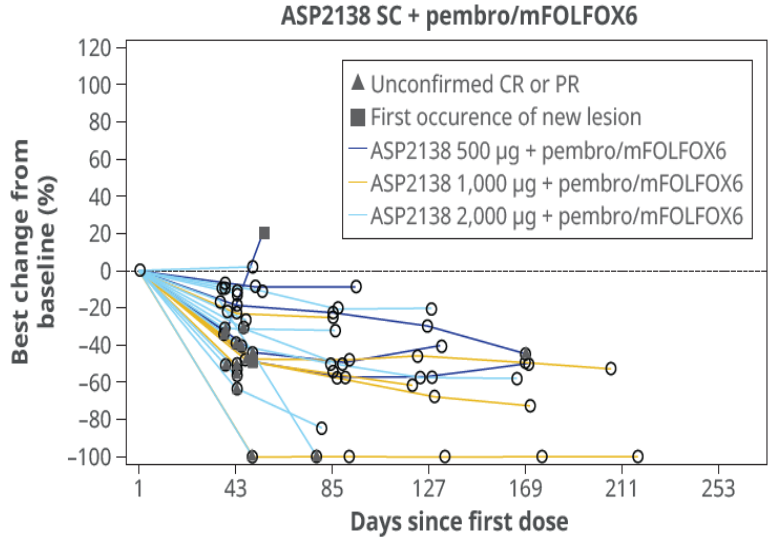
[a]≥ 1% of tumor cells with ≥ 1+ membranous CLDN18 staining by IHC

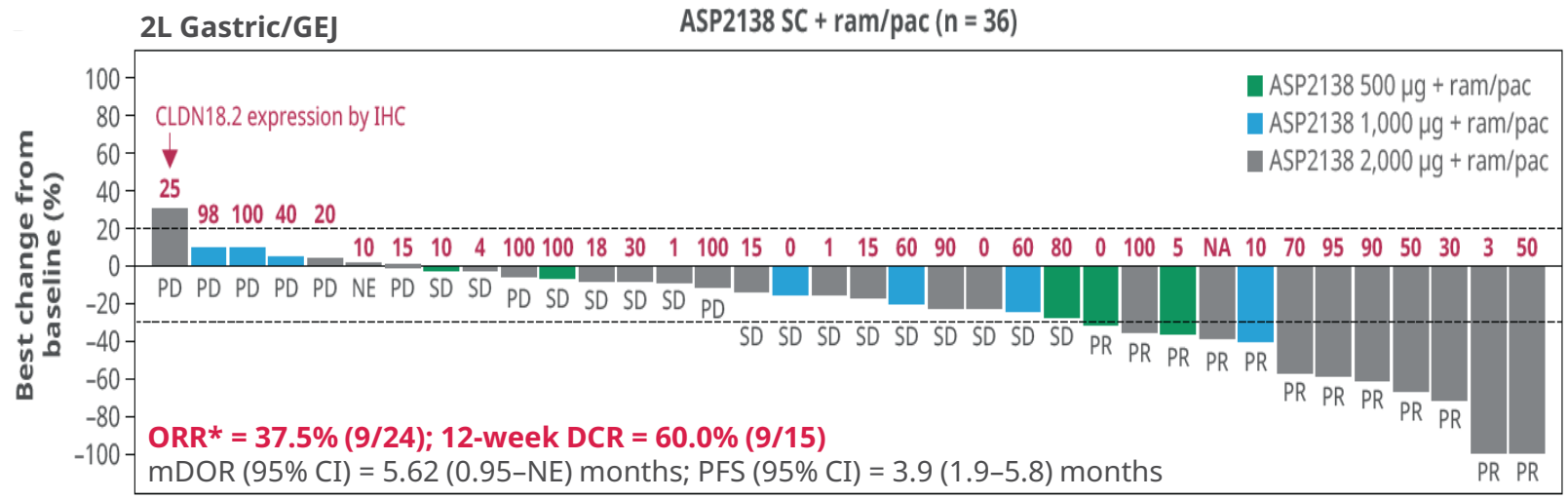
- **Monotherapy dose escalation and optimization (IV and SC) has been completed,** MTD was not reached
  - Most treatment emergent adverse events (TRAEs) with ASP2138 Sub-cutaneous (SC) monotherapy were grade 1–2
    - no grade ≥ 3 cytokine release syndrome (CRS)
    - no grade ≥ 3 nausea, vomiting, or gastritis
- Preliminary TME (tumor microenvironment) data from ASP2138 IV monotherapy shows increase in T-cell infiltration into the tumor and upregulation of PD-L1 expression
- Antitumor activity was observed in patients with both high and medium-to-low CLDN18.2 expression levels
- At 2,000 µg SC: ORR* = 14.3% (3/21); 12-week DCR = 33.3% (7/21)
  - Similar to checkpoint inhibitors in this setting
    - Nivolumab (Attraction-2) – ORR: 11%, DCR: 40%
    - Pembrolizumab (KEYNOTE-059) – ORR: 11.6%, DCR: 27%

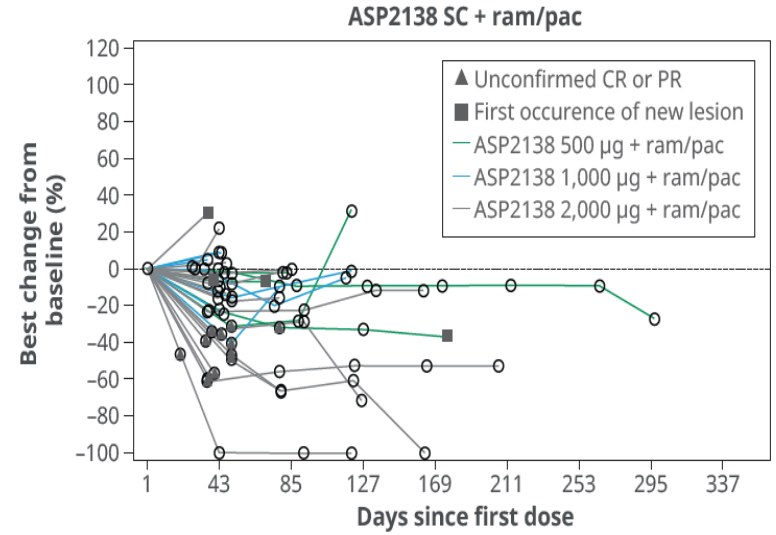
CLDN, claudin; LA, locally advanced; mG/GEJ, metastatic gastric or gastroesophageal junction; SOC, standard of care; LOT, line of therapy; 1L, first-line; mFOLFOX6, modified folinic acid, fluorouracil, and oxaliplatin regimen; HER2, human epidermal growth factor receptor 2; 2L, second-line; IV, intravenous; QW, every week; SC, subcutaneous; Q2W, every 2 weeks; Q6W, every 6 weeks; MTD, maximum tolerated dose: IHC, immunohistochemistry; ORR, objective response rate; DCR, disease control rate

Anti-tumor Activity Observed in 1L and 2L G/GEJ Adenocarcinoma with ASP2138 in Combination with SOC Irrespective of Claudin 18.2 Expression









*unconfirmed ORR, at 2,000 µg SC

Results Support Further Development of ASP2138 in G/GEJ Adenocarcinoma

- ✓ Safety and tolerability of ASP2138 supports combination with standard of care (SOC) chemotherapy and checkpoint inhibitors
- ✓ Sub-cutaneous (SC) administration retained efficacy, demonstrated favorable safety and tolerability (CRS and gastric toxicity), and improved convenience compared with IV administration
- ✓ ASP2138 SC demonstrated clinically meaningful antitumor activity in combination with a SOC chemotherapy and a checkpoint inhibitor; durability data is maturing
- ✓ Compelling responses were observed in patients with both high and medium-to-low CLDN18.2 expression levels

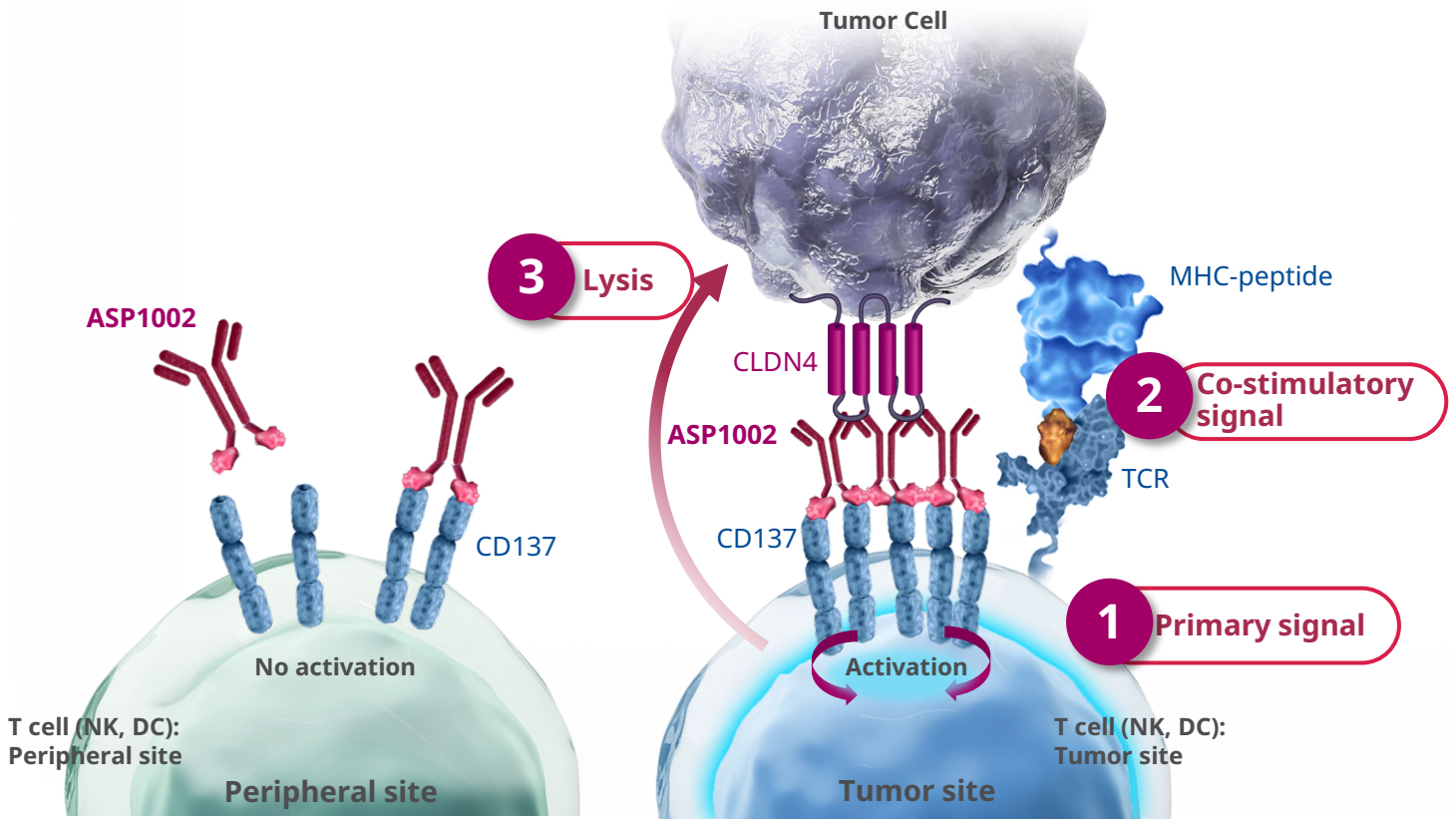
NEXT STEPS

- Preliminary data indicates that ASP2138 is progressing toward the pre-specified POC criteria in G/GEJ adenocarcinoma
- Planning is ongoing in parallel to initiate registrational studies
- Assessment of ASP2138 in combination with SOC chemotherapy in 1L pancreatic ductal adenocarcinoma (PDAC) is ongoing

We Have Established a Robust and Competitive Engineered Antibody Pipeline

Program	Modality	Mechanism of Action	Current Phase	Origin/Partner
ASP2138	Bispecific Immune Cell Engager	Anti-Claudin 18.2 and Anti-CD3 Bispecific Antibody	Phase 1	xencor
ASP1002		Anti-Claudin 4 and Anti-CD137 Bispecific Antibody	Phase 1	
(Not disclosed)		Probody® T Cell Engagers	Preclinical	CytomX
(Not disclosed)		Anti-PD-L1 x Anti-SIRPα Bispecific Antibody	Discovery	Elpiscience
(Not disclosed)	Immunostimulatory Antibody Drug Conjugate (iADC)	Direct Cancer Cell Killing & Immune Activation	Preclinical	SUTRO BIOPHARMA
ASP546C **Not part of IO pipeline*	Antibody Drug Conjugate	Anti-Claudin 18.2 Antibody Drug Conjugate	Phase 1	EVOPOINT Biosciences

ASP1002 is a Bispecific Antibody Targeting CLDN4



ASP1002 – CLDN4-TARGETED BISPECIFIC ANTIBODY

- ASP1002 is a bispecific antibody designed to target claudin 4 (CLDN4) and CD137, potentially enhancing the antitumor response of T cells against CLDN4-expressing tumor cells
- CLDN4 is highly expressed in multiple tumor types and is usually associated with poor prognosis
- CD137 is widely expressed in immune cells and provides a co-stimulatory signal following primary T-cell activation that enhances T-cell proliferation and cytokine production
- Phase 1 study is ongoing

DC, dendritic cell; MHC, major histocompatibility complex; NK, natural killer cell; TCR, T-cell receptor

Immunostimulatory Antibody Drug Conjugates Build on the Efficacy of Traditional ADCs

Immunostimulatory antibody-drug conjugate (iADC)

- iADCs build on the structure of ADCs but include an immune-stimulating drug payload in addition to a traditional cytotoxic payload.
- By not only directly killing cancer cells but also stimulating the immune system, iADCs are expected to enhance the body's ability to recognize and attack tumors.
- We are working with Sutro Biopharma to develop and advance iADC candidates.

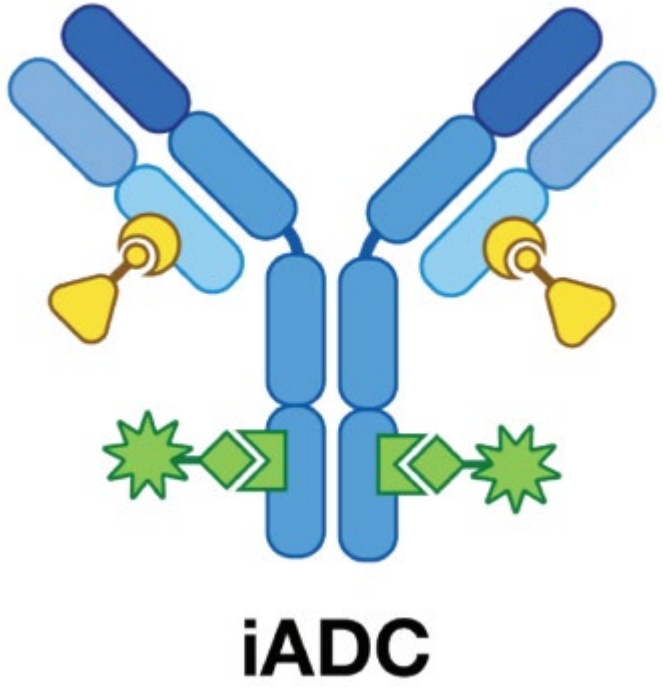


Image from Sutro Biopharma

We're reshaping the future for patients through bold science, purposeful collaboration and next-generation capabilities

Targeting breakthroughs that matter

We focus our R&D on serious, underserved diseases to deliver meaningful outcomes for patients.

Building the future of medicine

From advanced cell and gene manufacturing to digital innovation, we invest in end-to-end capabilities that will power breakthroughs for generations.

Acting with purpose

Our long-term mindset drives pioneering science, grounded in doing good for patients, partners and the future of healthcare.

Collaborating for impact

We work with innovators who share our vision to move faster, think bigger, and deliver more value together.

Science can ***guide us***

Science can ***inspire us***

Science can ***surprise us***

Together, we will pioneer science to change tomorrow.

Q&A