17 June 2024

Meet GSK management Oncology
Getting ahead of cancer

Interactive event for investors and analysts. This webinar is being recorded.

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This presentation may contain forward-looking statements. Forward-looking statements give the Group's current expectations or forecasts of future events. An investor can identify these statements by the fact that they do not relate strictly to historical or current facts. They use words such as 'anticipate', 'estimate', 'expect', 'intend', 'will', 'project', 'plan', 'believe', 'target' and other words and terms of similar meaning in connection with any discussion of future operating or financial performance. In particular, these include statements relating to future actions, prospective products or product approvals, future performance or results of current and anticipated products, sales efforts, expenses, the outcome of contingencies such as legal proceedings, dividend payments and financial results.

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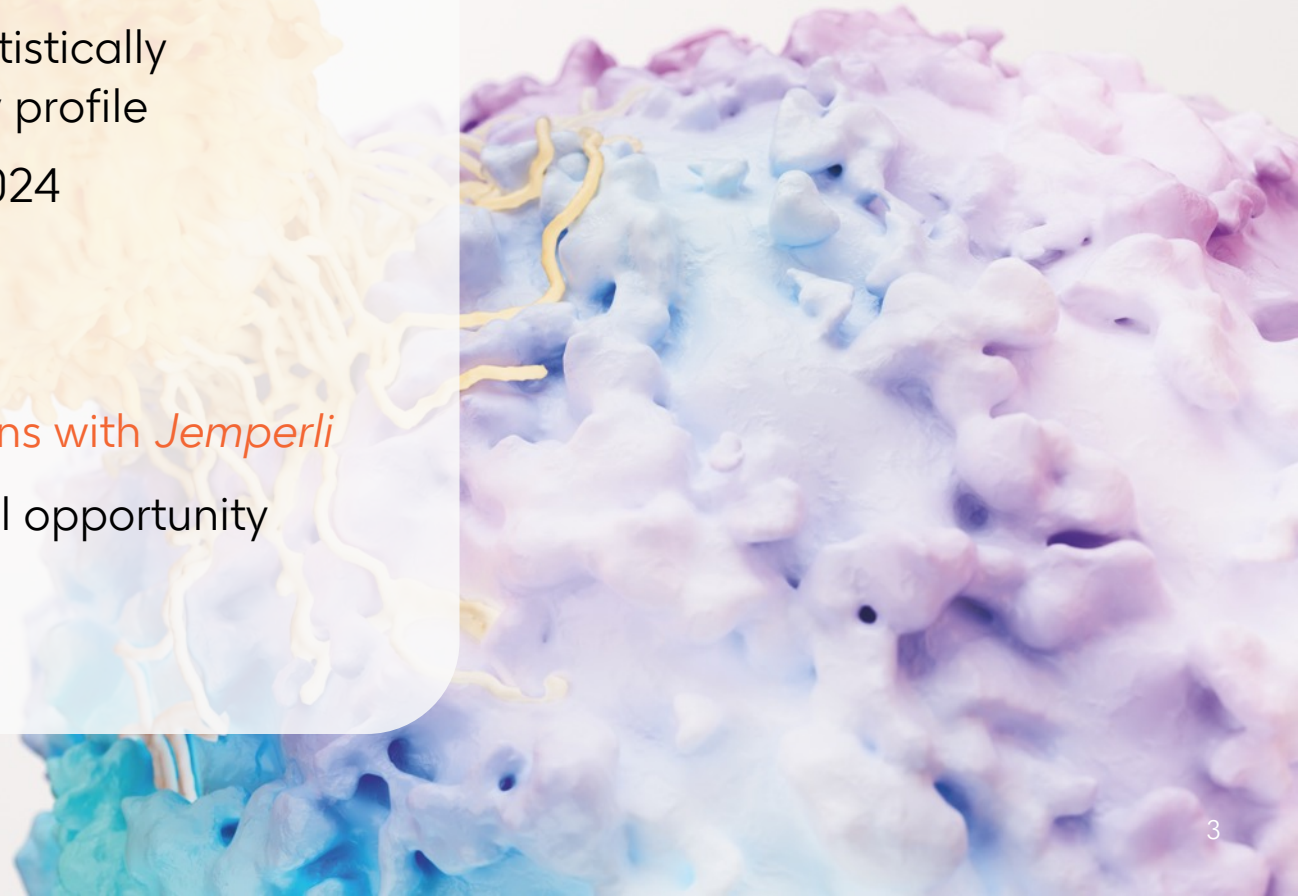
A number of adjusted measures are used to report the performance of our business, which are non-IFRS measures. These measures are defined and reconciliations to the nearest IFRS measure are available in the Group's Q1 2024 Results and the Group's Annual Report on Form 20-F for FY 2023.

All expectations, guidance and outlooks regarding future performance and the dividend should be read together with the section "Guidance and outlooks, assumptions and cautionary statements on page 49 of our stock exchange announcement of GSK's Q1 2024 Results, the section "Assumptions and basis of preparation related to 2024 guidance" in the Appendix of this presentation and the statements on page 317 of GSK's Annual Report on Form 20-F for FY 2023.

Today's focus

- Material growth opportunities across haematology, gynaecologic cancers and other tumour types
- Multi-blockbuster potential of *Blenrep* delivering statistically significant, robust efficacy with manageable toxicity profile
    - Regulatory filing in all major markets in H2 2024
    - Future opportunity for *Blenrep* in 1L
- High potential, early stage oncology pipeline
    - Differentiated immuno-oncology combinations with *Jemperli*
    - Gated investment in ADCs to unlock potential opportunity across solid tumours
- Key oncology data readouts 2024-2026+



1L: first line, ADC: antibody-drug conjugate.

Participants

Speakers

Luke Miels
Chief Commercial Officer

Dr Tony Wood
Chief Scientific Officer

Dr Evangelos Terpos
Professor of Haematology
National and Kapodistrian University of Athens
DREAMM-8 Principal Investigator

Q&A

Dr Nina Mojas
SVP, Global Product Strategy

Dr Hesham Abdullah
SVP, Global Oncology R&D

Dr Mondher Mahjoubi
Chief Patient Officer

GSK

Focused on core therapy areas

Emerging oncology portfolio focused on blood and gynaecologic cancers, and are seeking to make transformative breakthroughs

Arexvy
MenABCWY
Pneumococcal 24-valent
mRNA Seasonal influenza/COVID-19
Shingrix
GSK3943104 (Herpes simplex virus)
GSK4348413 (gonorrhoea)
gepotidacin
Brexafemme
tebipenem
bepirovirsen

Long-acting and ultra-long-acting
N6LS (bNAb)
3rd generation INSTI
Capsid inhibitor

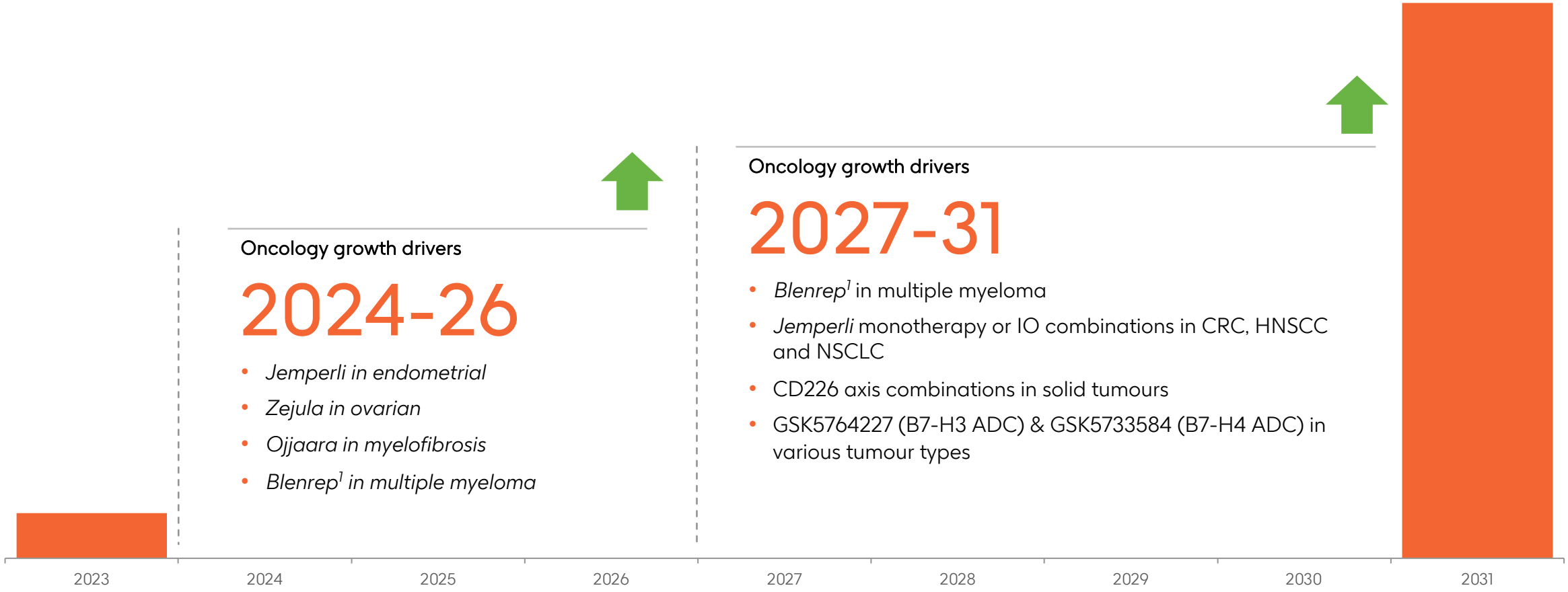
depemokimab
camlipixant
Nucala (COPD)
GSK4532990 (NASH)
GSK3858279 (osteoarthritis pain)
GSK1070806 (atopic dermatitis)

Blenrep
Ojjaara
Zejula
Jemperli
cobolimab
belrestotug/CD226 axis
Antibody-drug conjugates

Enabled by advanced technology and data platforms with targeted business development

bNAB: broadly neutralising antibody, COPD: chronic obstructive pulmonary disease, INSTI: integrase strand transfer inhibitor, NASH: non-alcoholic steatohepatitis.
Note: select pipeline programmes shown.

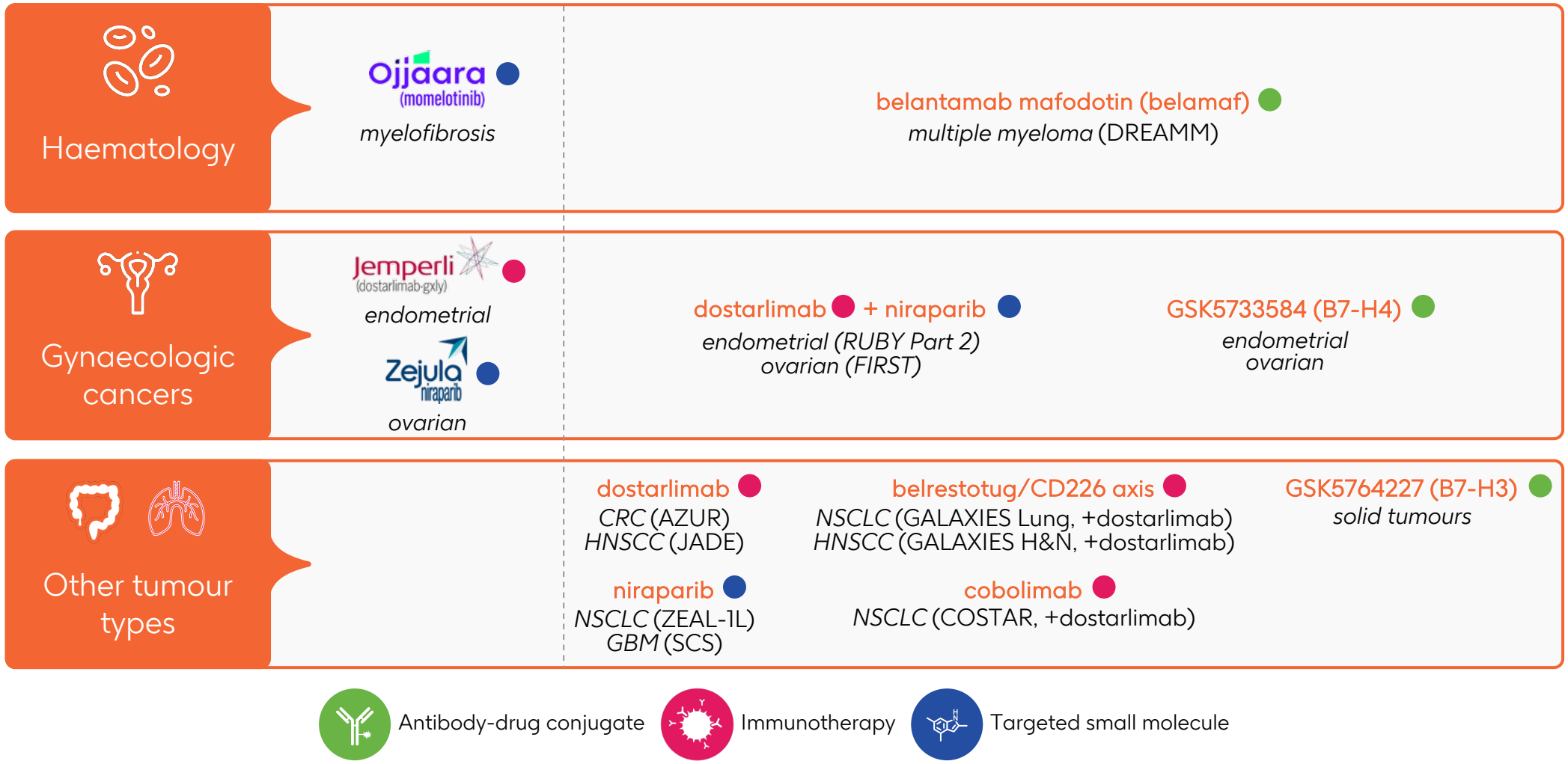
Oncology is a significant, emerging contributor to our long-term ambitions



CRC: colorectal, HNSCC: head and neck squamous cell carcinoma, IO: immuno-oncology, NSCLC: non-small cell lung cancer.
Illustrative. 1. Blenrep is excluded from guidance.

Focused oncology strategy with potential for expansion

Significantly differentiated medicines with heavily gated investments



CRC: colorectal cancer, GBM: glioblastoma, HNSCC: head and neck squamous cell carcinoma, NSCLC: non-small cell lung cancer, SCS: supported collaborative study (with the Ivy Brain Institute).
All assets shown are in-licensed or within an alliance relationship with a third party.

Blenrep (belantamab mafodotin)

Potential standard of care treatment for 2L multiple myeloma

Multiple myeloma patients cycle through treatment combinations

Time to next relapse is short with many therapies limited by tolerability and practicality of administration

Multiple myeloma market by 2031[1,2]

~£36bn

+10% compound growth rate

~160k patients[4] worldwide suffer from this complex disease

High unmet medical needs remain

- Life expectancy
- Time in remission
- Treatment burden
- Patient eligibility for novel medicines
- Treatment accessibility, particularly in the community setting

Treatment dynamics, US[3]

70%

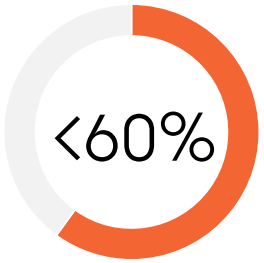
1L patients receive lenalidomide

Treatment dynamics, US[3]

12-28 months

Achievable progression-free survival in 2L+, post-1L lenalidomide

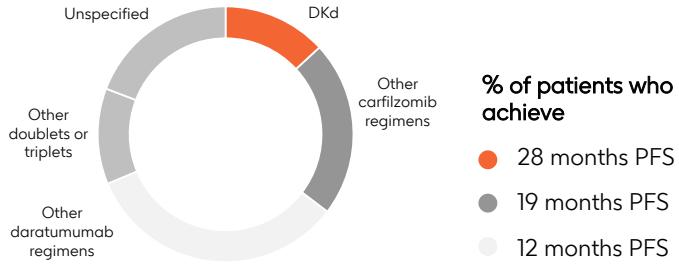
Significant patient burden[5]



5-year survival rate

- Treatment intensification (combinations) with adverse events
- Novel modalities often necessitate hospitalisation or inpatient care (CAR-Ts and bispecifics)

Treatment dynamics, US[3]



Achievable progression-free survival in 2L+ post-1L

1L: first line, 2L+: second line or later, CAR-T: chimeric antigen receptor-T cell therapy, D: daratumumab, d: dexamethasone, K: carfilzomib, PFS: progression-free survival.

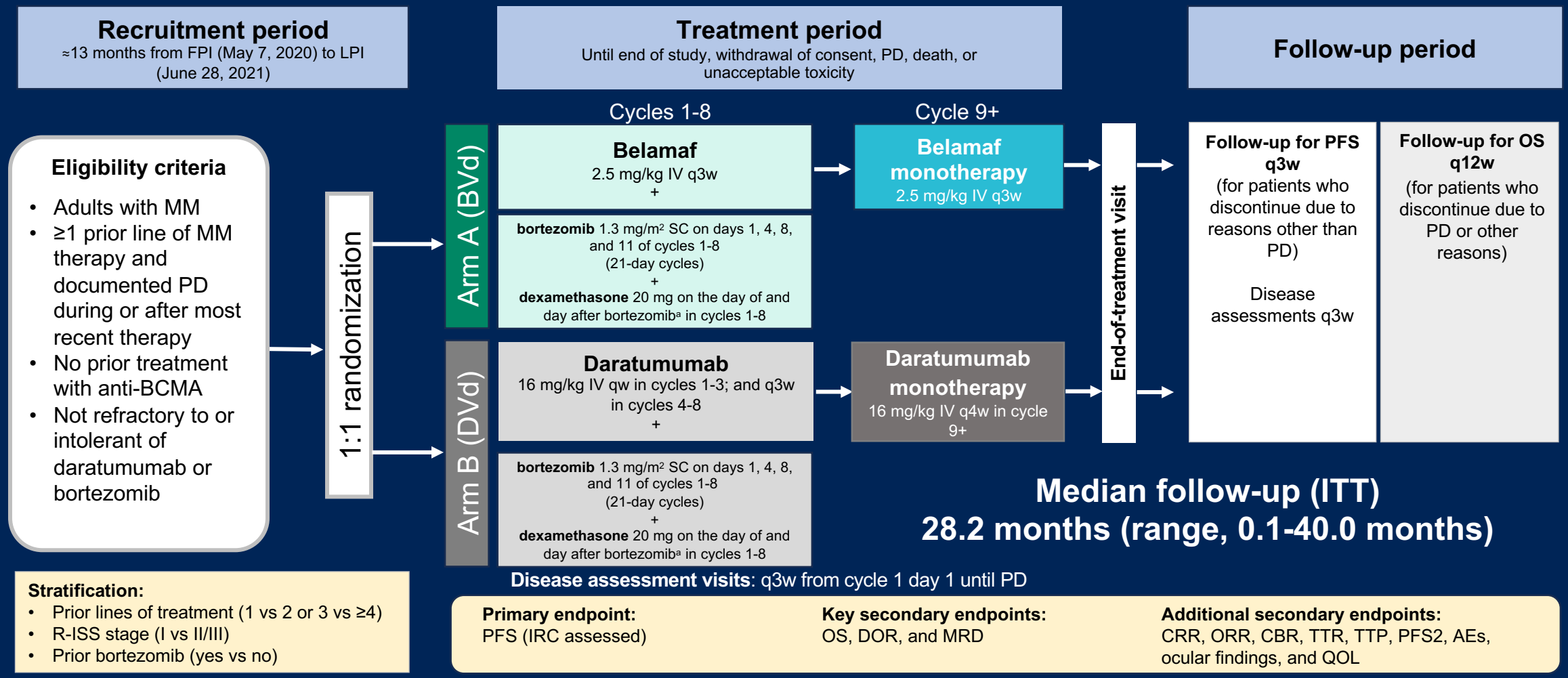
1. Evaluate Pharma (May 2024) based on forecasted sales. 2. Compound annual growth rate 2024-2031 based on forecasted sales. 3. A+A and IQVIA APLD US. 4. Ludwig, et al. Multiple myeloma incidence and mortality around the globe, Oncologist 2020. 5. Rosenberg PS, et al. Blood. 2015;125(2):410-2. doi: 10.1182.

Blenrep (belantamab mafodotin): Data from DREAMM-7, DREAMM-8 and a NDMM study

Dr. Evangelos Terpos, MD, PhD

Professor of Haematology, National and Kapodistrian University of Athens, and DREAMM-8 Principal Investigator

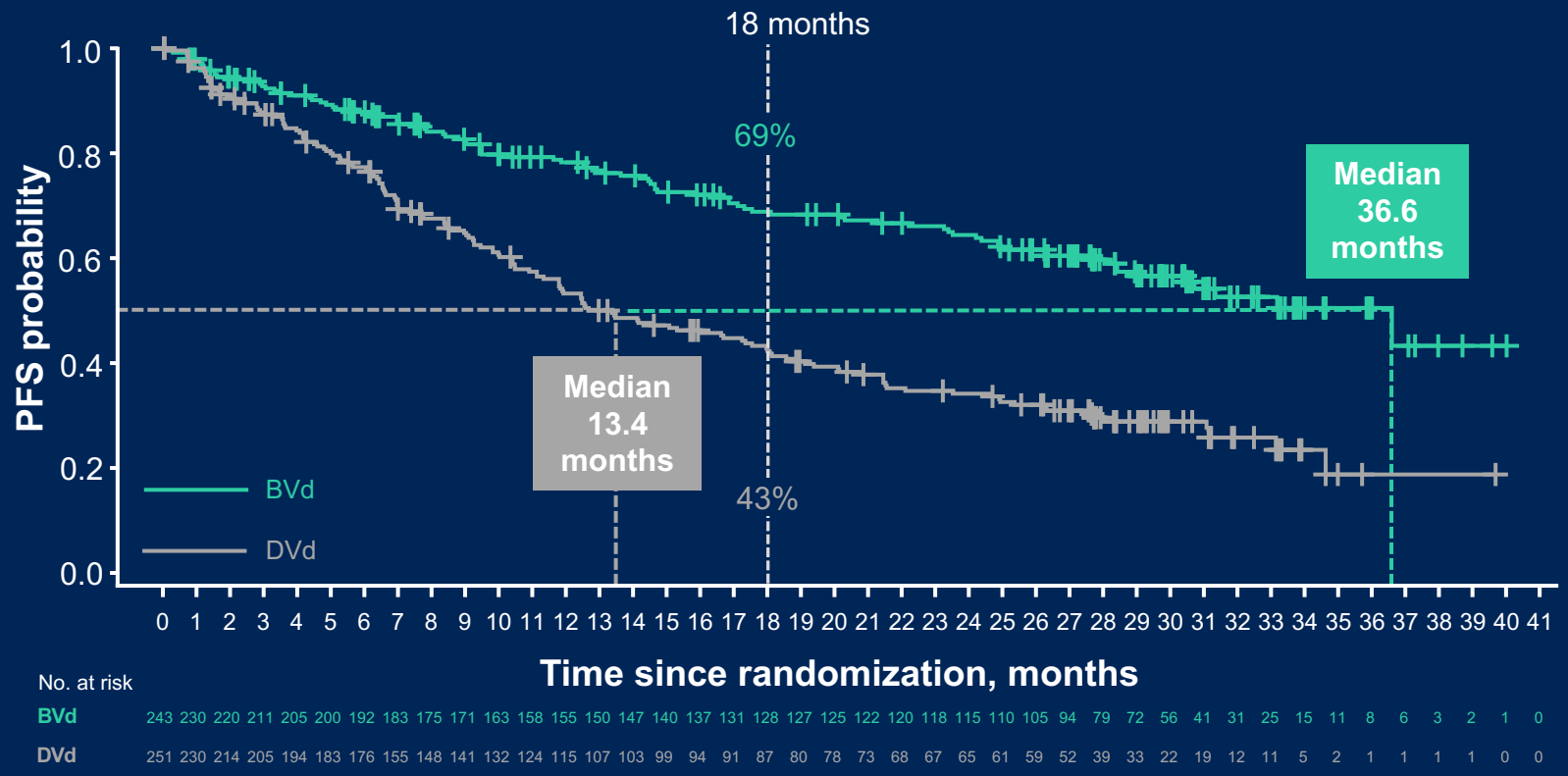
DREAMM-7 study design



AE, adverse event; BCMA, B-cell maturation antigen; CBR, clinical benefit rate; CRR, complete response rate; DOR, duration of response; FPI, first patient in; IRC, independent review committee; ITT, intent-to-treat; IV, intravenous; LPI, last patient in; MM, multiple myeloma; MRD, minimal residual disease; ORR, overall response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; q3w, every 3 weeks; q4w, every 4 weeks; q12w, every 12 weeks; QOL, quality of life; qw, once weekly; R-ISS, Revised International Staging System; SC, subcutaneous; TTP, time to progression; TTR, time to response.

[a] Starting dose of dexamethasone may be reduced to 10 mg for patients aged >75 years, who have a body-mass index of less than 18.5, who had previous unacceptable side effects associated with glucocorticoid therapy, or who are unable to tolerate the starting dose.

DREAMM-7: BVd led to a significant increase in PFS vs. DVd

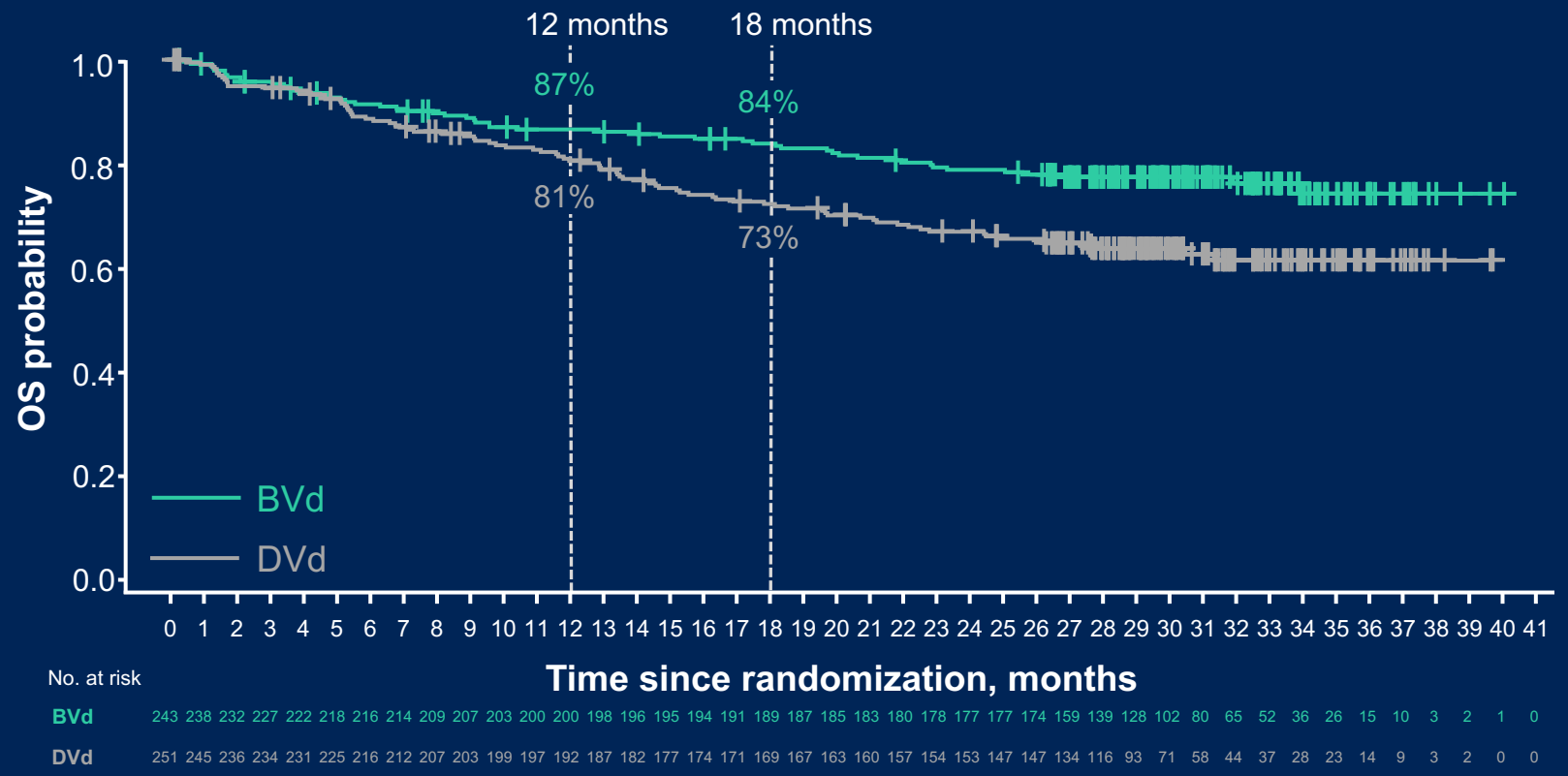


PFS[a]	BVd (N=243)	DVd (N=251)
Events, n (%)	91 (37)	158 (63)
PFS, median (95% CI), months[b]	36.6 (28.4-NR)	13.4 (11.1-17.5)
HR (95% CI)[c]	0.41 (0.31-0.53)	
P value[d]	<.00001	

BVd demonstrated a statistically significant and clinically meaningful PFS benefit, with a median PFS that was 23 months longer than that with DVd

BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; HR, hazard ratio; ITT, intent to treat; NR, not reached; PFS, progression-free survival; PFS2, progression-free survival 2.
[a] Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. [b] CIs were estimated using the Brookmeyer-Crowley method. [c] HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III), with a covariate of treatment. [d] *P* value from 1-sided stratified log-rank test.

DREAMM-7: early OS trend favouring BVd vs. DVd



OS[a]	BVd (N=243)	DVd (N=251)
Events, n (%)	54 (22)	87 (35)
OS, median (95% CI), months[b]	NR	NR
HR (95% CI)[c]	0.57 (0.40-0.80)	
P value[d]	.00049[e]	

OS showed an early, strong, and clinically meaningful trend favoring the BVd arm; additional OS follow-up is ongoing

BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; HR, hazard ratio; ITT, intent to treat; NR, not reached; OS, overall survival; R-ISS, Revised International Staging System. [a] Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. [b] CIs were estimated using the Brookmeyer-Crowley method. [c] HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III), with a covariate of treatment. [d] *P* value is from 1-sided stratified log-rank test. [e] The *P* value has not yet reached criteria for statistical significance (*P*≤00037) at this interim analysis. Follow-up for OS is ongoing.

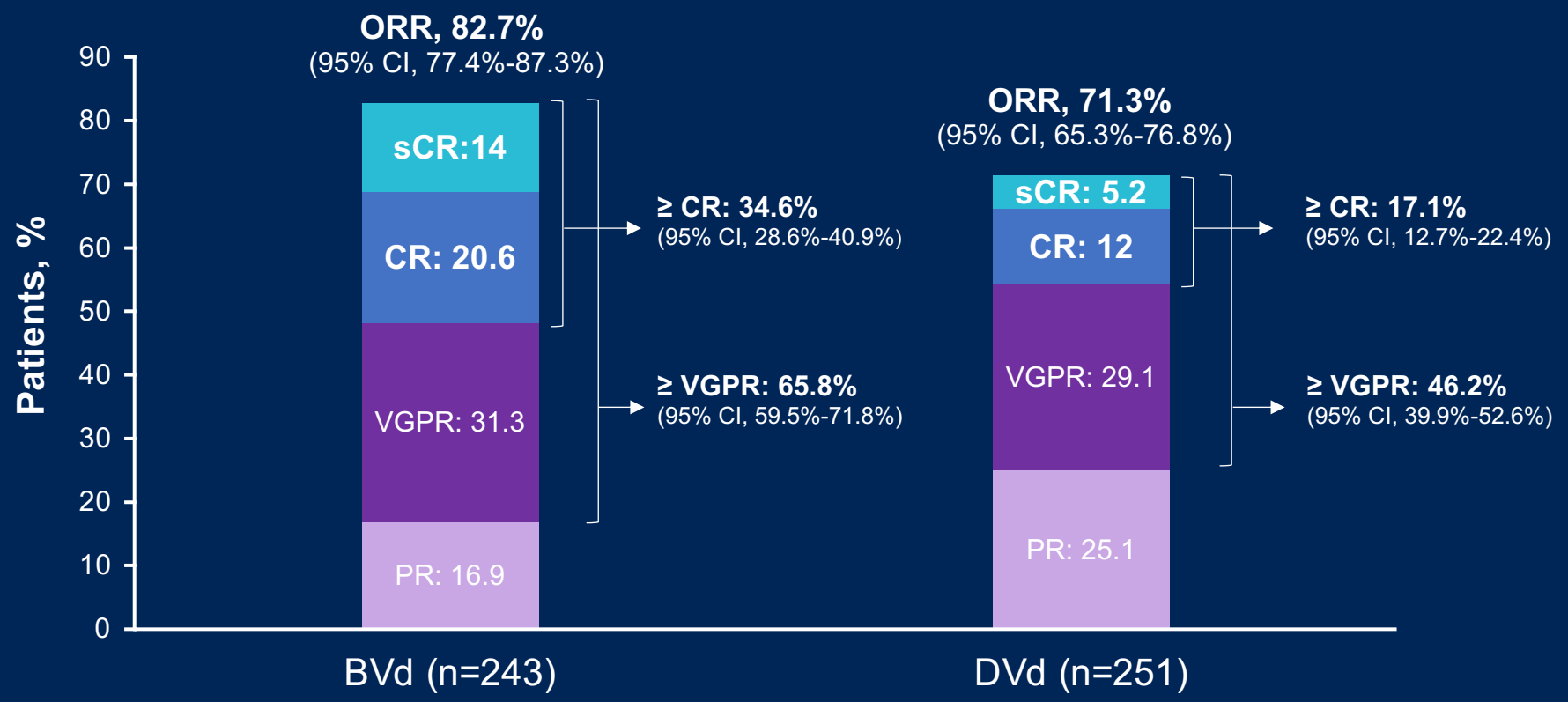
DREAMM-7: deeper responses with BVd vs. DVd[a]

≥ CR MRD negativity[b]

24.7% (95% CI, 19.4%-30.6%) **vs** **9.6%** (95% CI, 6.2%-13.9%)

≥ VGPR MRD negativity[b]

38.7% (95% CI, 32.5%-45.1%) **vs** **17.1%** (95% CI, 12.7%-22.4%)



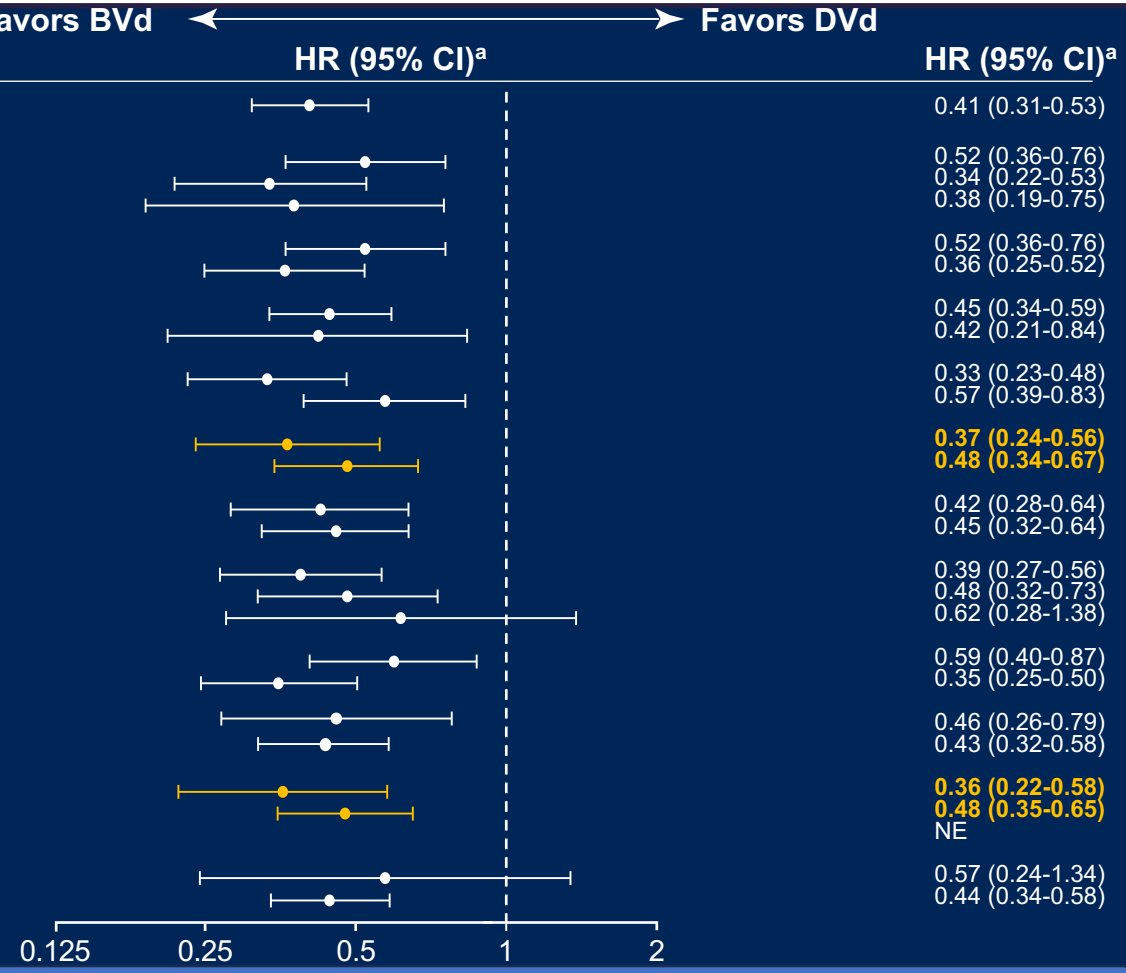
BVd was associated with a greater depth of response, with double the ≥ CR rate and more than double the MRD negativity rates (sensitivity of 10^{-5}) of DVd (P<.00001)[c]

BVd, belantamab mafodotin, bortezomib, and dexamethasone; CR, complete response; DVd, daratumumab, bortezomib, and dexamethasone; ITT, intent to treat; MRD, minimal residual disease; NGS, next-generation sequencing; PR, partial response; R-ISS, Revised International Staging System; sCR, stringent complete response; VGPR, very good partial response.

[a] CIs were based on the exact method. Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. [b] MRD negativity rate was defined as percentage of patients who were MRD negative by NGS based on a sensitivity of 10^{-5}. [c] Nominal P value. Cochran–Mantel–Haenszel test was used and adjusted for stratification factors, including number of prior lines of therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III).

DREAMM-7: prespecified subgroup analysis of IRC-assessed PFS

Categories	BVd n/N	DVd n/N	HR (95% CI)[a]
All patients (stratified)[b]	91/243	158/251	0.41 (0.31-0.53)
No. of of prior LOT			
1	46/125	76/125	0.52 (0.36-0.76)
2 or 3	30/88	62/99	0.34 (0.22-0.53)
≥4	15/30	20/27	0.38 (0.19-0.75)
No. of prior LOT			
1	46/125	76/125	0.52 (0.36-0.76)
>1	45/118	82/126	0.36 (0.25-0.52)
Prior bortezomib			
Yes	79/210	132/211	0.45 (0.34-0.59)
No	12/33	26/40	0.42 (0.21-0.84)
Prior lenalidomide			
Yes	44/127	88/130	0.33 (0.23-0.48)
No	47/116	70/121	0.57 (0.39-0.83)
Disease refractory to lenalidomide			
Yes	**33/79**	**64/87**	**0.37 (0.24-0.56)**
No	**58/164**	**94/164**	**0.48 (0.34-0.67)**
R-ISS stage at screening			
I	37/102	64/103	0.42 (0.28-0.64)
II/III	53/139	94/146	0.45 (0.32-0.64)
Age			
<65 years	42/121	84/126	0.39 (0.27-0.56)
65 to <75 years	37/85	61/95	0.48 (0.32-0.73)
≥75 years	12/37	13/30	0.62 (0.28-1.38)
Sex			
Female	48/115	59/107	0.59 (0.40-0.87)
Male	43/128	99/144	0.35 (0.25-0.50)
Time to relapse after completion of 1L treatment			
≤12 months	23/49	31/50	0.46 (0.26-0.79)
>12 months	68/194	127/201	0.43 (0.32-0.58)
Cytogenetic risk			
High risk[c]	**26/67**	**48/69**	**0.36 (0.22-0.58)**
Standard risk[d]	**65/175**	**106/175**	**0.48 (0.35-0.65)**
Missing or not evaluable	0/1	4/7	NE
Extramedullary disease at baseline			
Yes	8/13	18/25	0.57 (0.24-1.34)
No	83/230	140/226	0.44 (0.34-0.58)



PFS benefit consistently favored BVd vs DVd across prespecified subgroups, including patients with lenalidomide-refractory or high-risk cytogenetic MM

1L, first line; BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; HR, hazard ratio; IRC, independent review committee; IVRS, interactive voice response system; LOT, line of therapy; MM, multiple myeloma; NE, not evaluable; PFS, progression-free survival; R-ISS, Revised International Staging System.

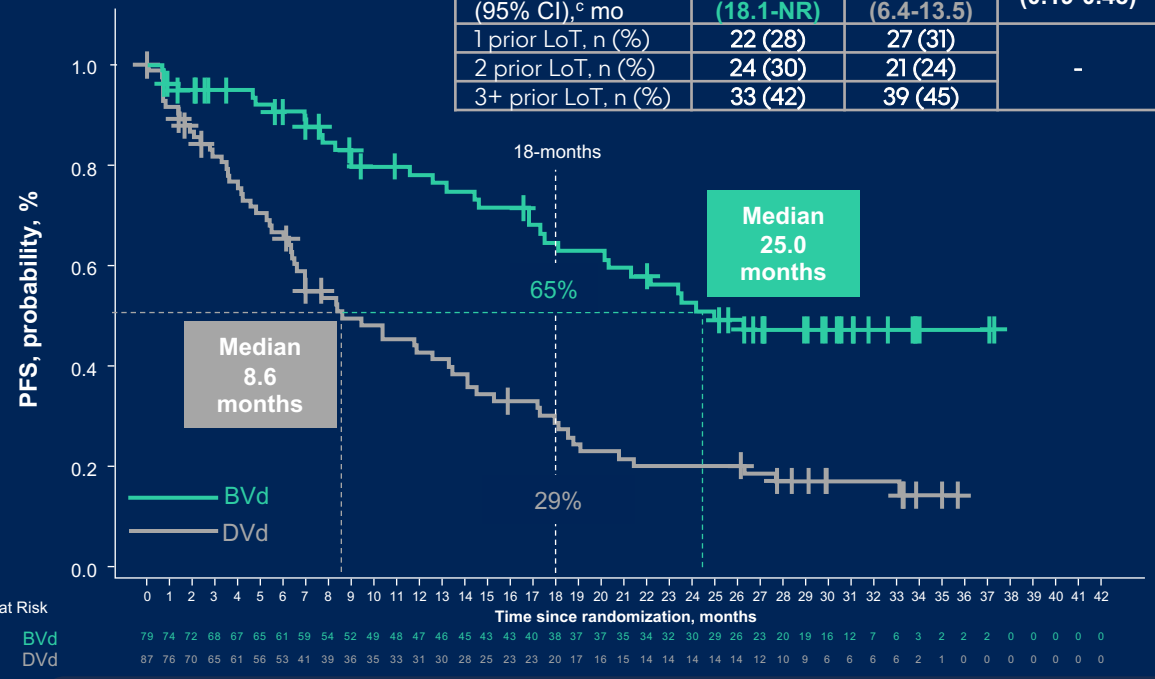
[a] HRs for subgroups were only plotted if the number of events was ≥20 across both treatments. HRs for subgroups were estimated using Cox proportional hazards model, without adjustment for stratification variables. [b] Stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib (no vs yes), and R-ISS stage at screening (I vs II or III) according to IVRS stratum, with a covariate of treatment. [c] A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13). [d] A patient was considered standard risk if they had negative results for all high-risk abnormalities: t(4;14), t(14;16), or del(17p13).

DREAMM-7: subgroup by lenalidomide refractory status

Progression-free survival (lenalidomide refractory and not refractory)

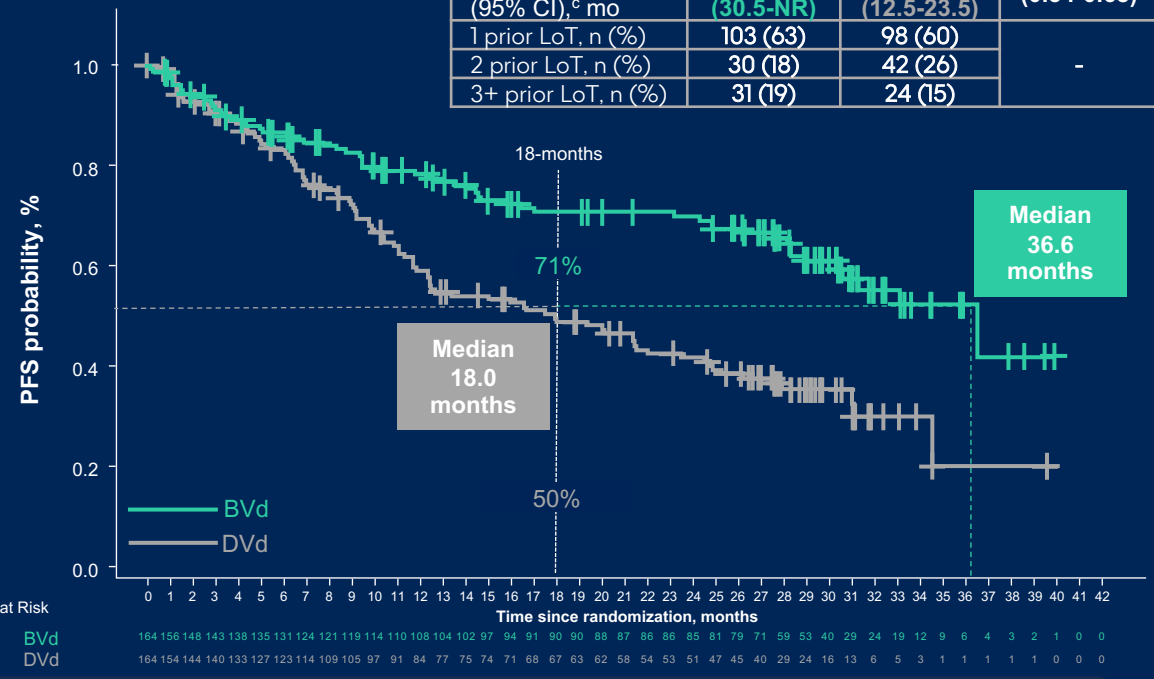
Lenalidomide Refractory

PFS[b]	BVd (N=79)	DVd (N=87)	HR[d] (95% CI)
Events, n (%)	33 (42)	64 (74)	0.31 (0.19-0.48)
mPFS (95% CI),[c] mo	25.0 (18.1-NR)	8.6 (6.4-13.5)	
1 prior LoT, n (%)	22 (28)	27 (31)	-
2 prior LoT, n (%)	24 (30)	21 (24)	
3+ prior LoT, n (%)	33 (42)	39 (45)	



Not Lenalidomide Refractory[a]

PFS[b]	BVd (N=164)	DVd (N=164)	HR[d] (95% CI)
Events, n (%)	58 (35)	94 (57)	0.48 (0.34-0.68)
mPFS (95% CI),[c] mo	36.6 (30.5-NR)	18.0 (12.5-23.5)	
1 prior LoT, n (%)	103 (63)	98 (60)	-
2 prior LoT, n (%)	30 (18)	42 (26)	
3+ prior LoT, n (%)	31 (19)	24 (15)	



BVd was associated with clinically meaningful PFS benefit in both lenalidomide refractory and non-lenalidomide refractory patients

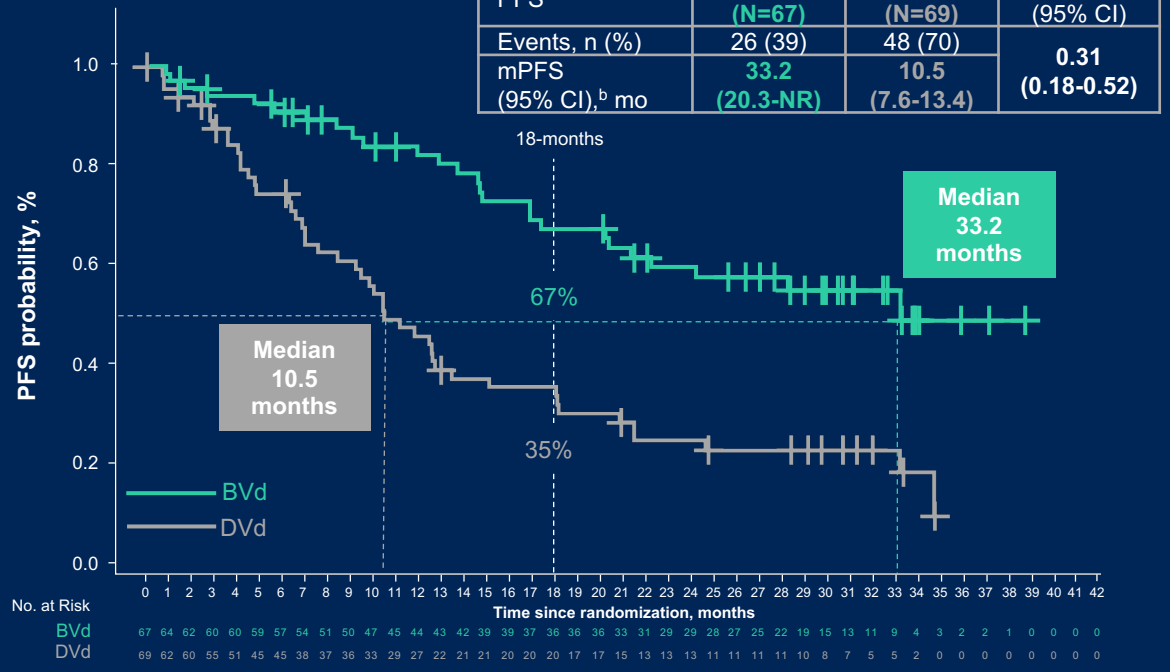
[a] Includes patients who are lenalidomide exposed but not refractory and patients who have not been exposed to lenalidomide. [b] Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. [c] CIs were estimated using the Brookmeyer-Crowley method. 95% CIs were not adjusted for multiplicity and cannot be used for hypothesis testing. [d] HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib, and R-ISS stage at screening (I vs II/III), with a covariate of treatment.

DREAMM-7: subgroup by cytogenetic risk

Progression-free survival (high risk and standard risk)

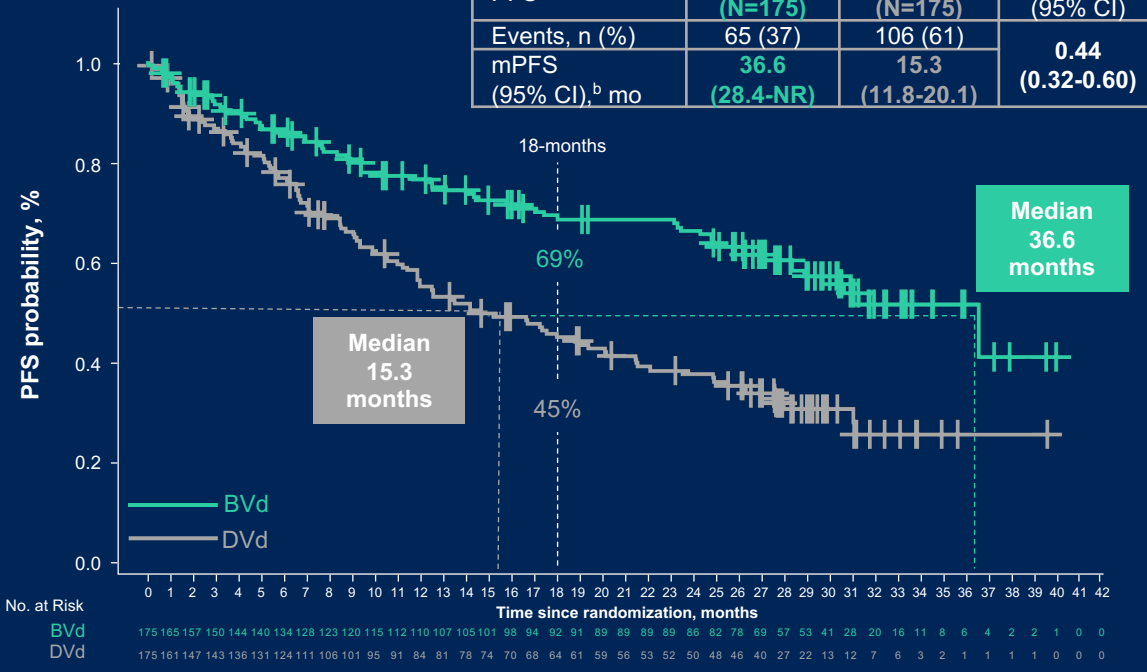
High Risk

PFS[a]	BVd (N=67)	DVd (N=69)	HR[c] (95% CI)
Events, n (%)	26 (39)	48 (70)	**0.31 (0.18-0.52)**
mPFS (95% CI),[b] mo	**33.2 (20.3-NR)**	**10.5 (7.6-13.4)**	



Standard Risk

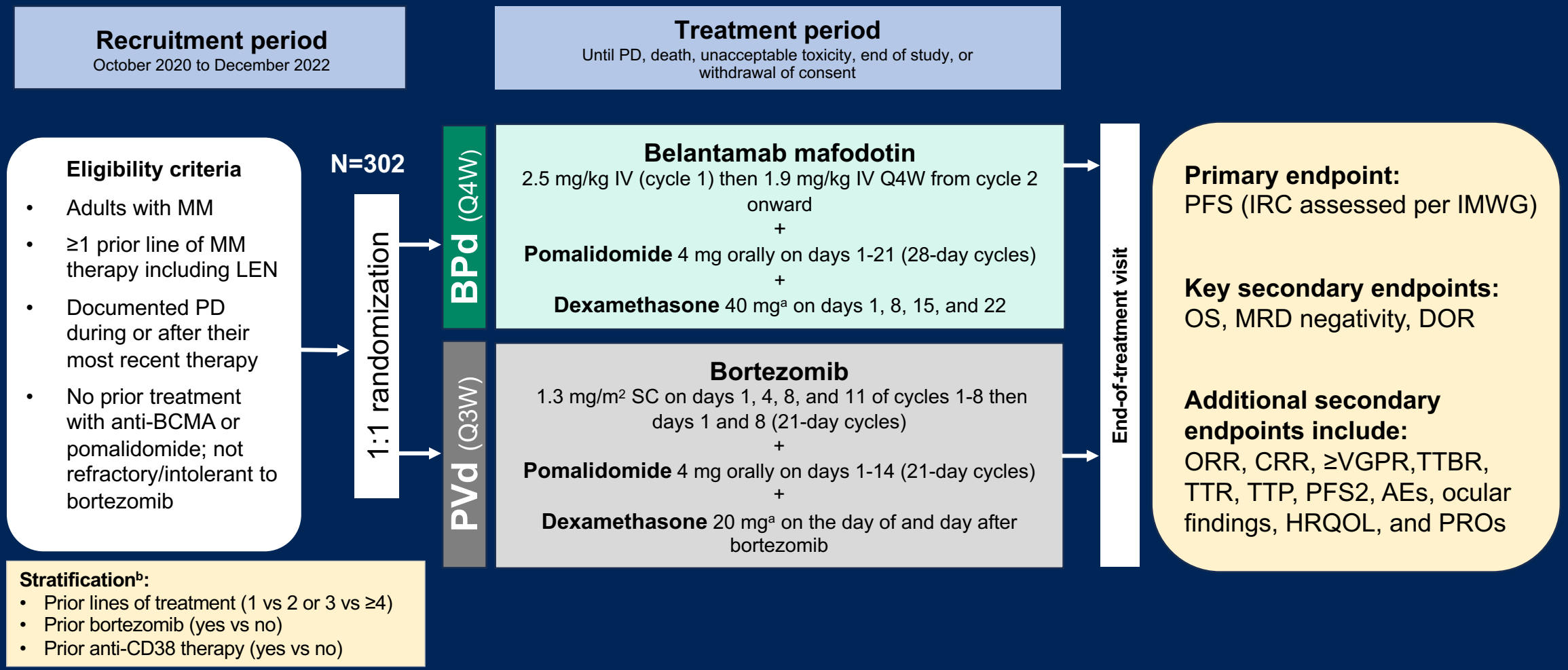
PFS[a]	BVd (N=175)	DVd (N=175)	HR[c] (95% CI)
Events, n (%)	65 (37)	106 (61)	**0.44 (0.32-0.60)**
mPFS (95% CI),[b] mo	**36.6 (28.4-NR)**	**15.3 (11.8-20.1)**	



BVd led to strong PFS benefit (more than double to triple the median PFS) regardless of cytogenetic risk status compared with DVd

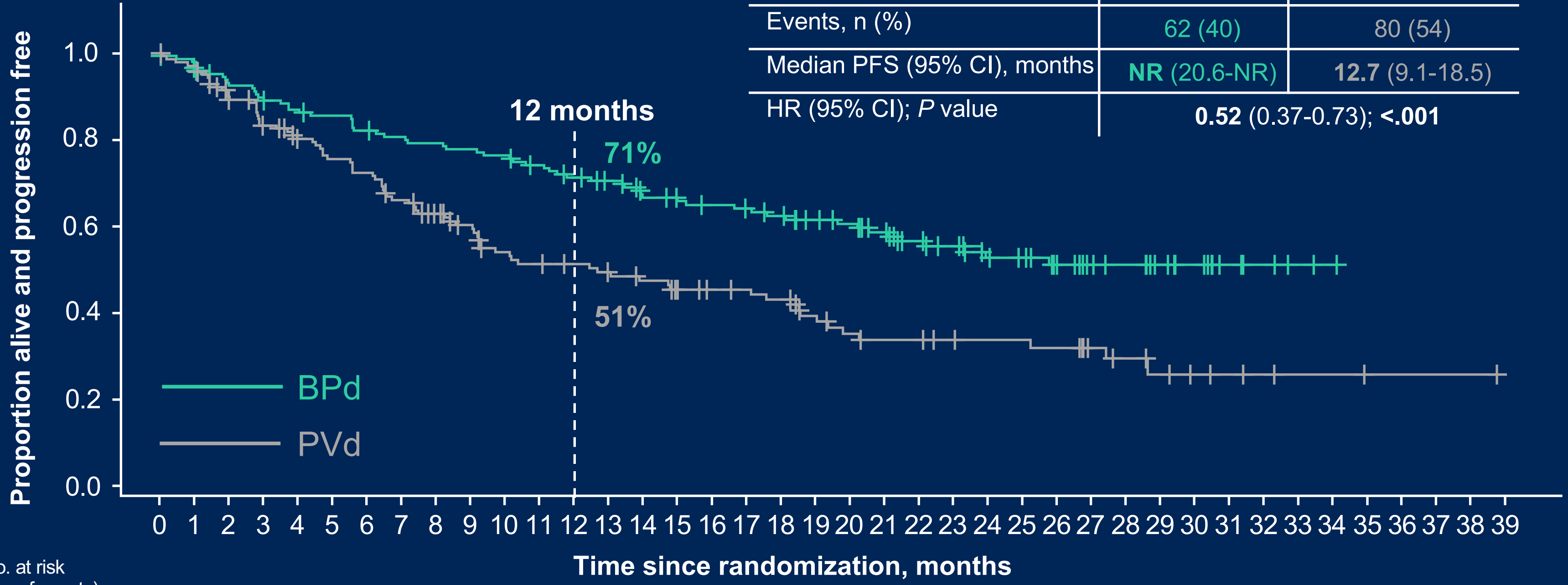
[a] Two patients in the ITT population were randomized, not treated, rescreened, and rerandomized. They are counted as 4 unique patients in this output. [b] CIs were estimated using the Brookmeyer-Crowley method. 95% CIs were not adjusted for multiplicity and cannot be used for hypothesis testing. [c] HRs were estimated using a Cox proportional hazards model stratified by the number of lines of prior therapy (1 vs 2 or 3 vs ≥4), prior bortezomib, and R-ISS stage at screening (I vs II/III), with a covariate of treatment.

DREAMM-8: study design



AE, adverse event; BCMA, B-cell maturation antigen; BPd, belamaf, pomalidomide, and dexamethasone; CD, cluster of differentiation; CRR, complete response rate; DOR, duration of response; HRQOL, health-related quality of life; IMWG, International Myeloma Working Group; IRC, independent review committee; ISS, International Staging System; IV, intravenous; LEN, lenalidomide; MM, multiple myeloma; MRD, minimal residual disease; ORR, objective response rate; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PFS2, progression-free survival on subsequent line of therapy; PRO, patient-reported outcome; PVd, pomalidomide, bortezomib, and dexamethasone; Q3W, every 3 weeks; Q4W, every 4 weeks; SC, subcutaneous; TTBR, time to best response; TTP, time to progression; TTR, time to response; VGPR, very good partial response.
[a] Patients aged >75 years, with comorbidities, or intolerant to 40 mg dose in Arm A or 20 mg dose in Arm B could have dose level reduced to half per investigator discretion. [b] Some patients were stratified by ISS status (I vs II/III); the protocol was amended on 20 April 2021 to replace this randomization factor with prior anti-CD38 treatment (yes vs no).

DREAMM-8: BPd led to a significant PFS benefit vs. PVd



PFS	BPd (N=155)	PVd (N=147)
Events, n (%)	62 (40)	80 (54)
Median PFS (95% CI), months	**NR** (20.6-NR)	**12.7** (9.1-18.5)
HR (95% CI); *P* value	**0.52** (0.37-0.73); **<.001**	

No. at risk
(no. of events)

BPd	155	143	135	130	125	122	117	113	111	109	107	102	97	93	82	80	77	75	72	67
	(0)	(5)	(10)	(15)	(19)	(21)	(26)	(28)	(30)	(32)	(34)	(37)	(41)	(42)	(47)	(47)	(49)	(50)	(52)	(53)
PVd	147	138	123	111	102	96	92	83	75	68	59	56	54	51	47	43	40	39	37	30
	(0)	(4)	(14)	(23)	(27)	(33)	(37)	(45)	(49)	(52)	(59)	(62)	(62)	(64)	(66)	(68)	(68)	(68)	(70)	(73)

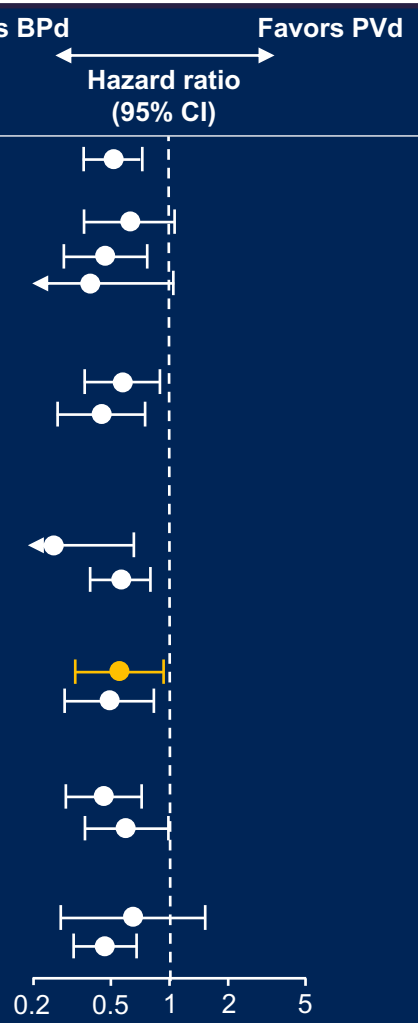
BPd	64	59	50	45	38	36	28	23	21	16	13	8	4	2	1	0	0	0	0	0
	(54)	(56)	(58)	(59)	(61)	(61)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)	(62)
PVd	25	22	22	19	18	18	17	13	11	7	5	4	3	2	2	1	1	1	1	0
	(76)	(77)	(77)	(77)	(77)	(77)	(78)	(78)	(79)	(80)	(80)	(80)	(80)	(80)	(80)	(80)	(80)	(80)	(80)	(80)

BPd led to a statistically significant and clinically meaningful reduction in risk of disease progression or death vs PVd (HR, 0.52; 95% CI, 0.37-0.73; *P*<.001)

Median follow-up, 21.8 months (range, 0.03-39.23 months)
The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model, and the *P* value was produced based on the 1-sided stratified log-rank test. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use.
BPd, belamaf, pomalidomide, and dexamethasone; HR, hazard ratio; NR, not reported; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

DREAMM-8: PFS benefit was seen consistently across all prespecified subgroups

Categories	BPd n/N	PVd n/N	Hazard ratio (95% CI)
All patients (stratified)[a]	**62/155**	**80/147**	**0.52 (0.37-0.73)**
Age, years			
<65	28/64	27/53	0.64 (0.37-1.09)
65 to <75	29/72	34/59	0.48 (0.29-0.79)
≥75	5/19	19/35	0.40 (0.15-1.07)
Baseline ECOG PS			
0	34/82	48/85	0.59 (0.38-0.92)
1 or 2	28/73	32/62	0.46 (0.28-0.78)
Time to relapse after initiation of 1L treatment			
≤12 months	8/22	12/20	0.26 (0.10-0.68)
>12 months	54/133	68/127	0.58 (0.40-0.83)
Cytogenetics risk			
High risk	29/52	31/47	0.57 (0.34-0.95)
Standard risk	24/72	35/75	0.51 (0.30-0.86)
ISS stage at screening			
I	33/93	46/85	0.48 (0.30-0.75)
II/III	29/61	34/62	0.62 (0.38-1.02)
EMD at baseline			
Yes	13/20	9/11	0.67 (0.28-1.59)
No	49/135	71/136	0.48 (0.33-0.70)



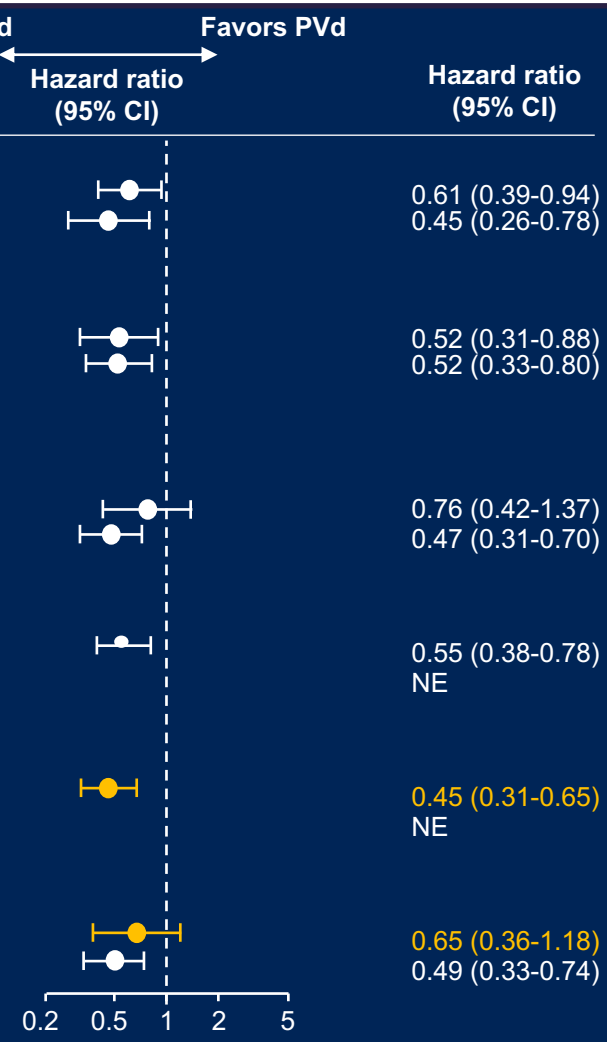
HRs for subgroups were only plotted if the number of events was ≥20 in total across both treatments and were estimated using Cox proportional hazards models, without adjustments for stratification variables. A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13) and considered standard risk if they had negative results for all high-risk cytogenetics listed above.

[a] HR for all patients was stratified by the number of lines of prior therapy (1 vs 2/3 vs ≥4) and prior bortezomib (yes or no) according to interactive voice response system strata with a covariate of treatment.

1L, first line; BPd, belamaf, pomalidomide, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; EMD, extramedullary disease; HR, hazard ratio; ISS, International Staging System; LOT, line of therapy; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

DREAMM-8: PFS benefit was seen consistently across all prespecified subgroups

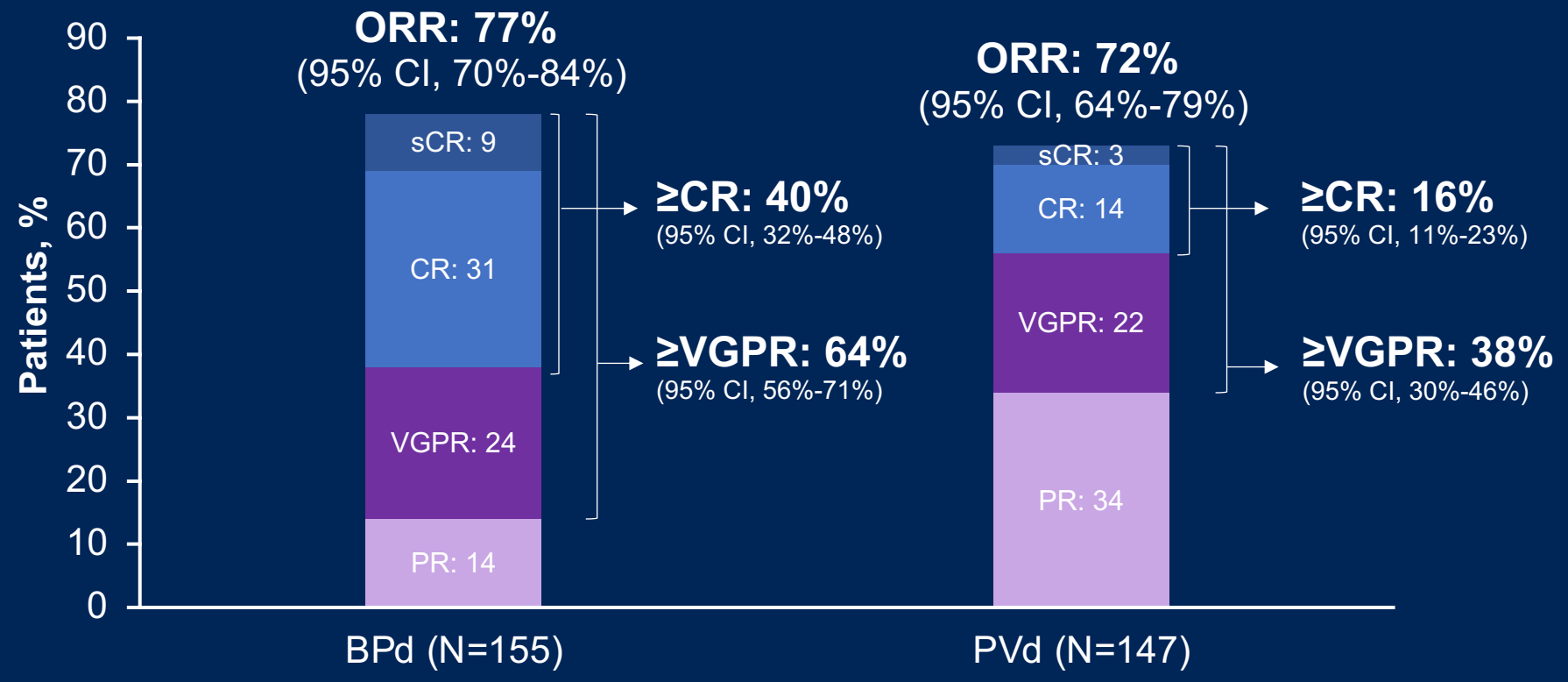
Categories	BPd n/N	PVd n/N	Hazard ratio (95% CI)
Prior stem cell transplant			
Yes	42/99	41/82	0.61 (0.39-0.94)
No	20/56	39/65	0.45 (0.26-0.78)
Number of prior lines of therapy			
1	25/82	34/77	0.52 (0.31-0.88)
>1	37/73	46/70	0.52 (0.33-0.80)
Triple class exposed (PI, Immunomodulator, anti-CD38)			
Yes	21/34	24/39	0.76 (0.42-1.37)
No	41/121	56/108	0.47 (0.31-0.70)
Prior bortezomib treatment			
Yes	54/134	70/130	0.55 (0.38-0.78)
No	8/21	10/17	NE
Refractory to lenalidomide			
Refractory	54/125	70/111	0.45 (0.31-0.65)
Nonrefractory	8/30	10/36	NE
Refractory to anti-CD38 treatment			
Refractory	20/35	25/36	0.65 (0.36-1.18)
Nonrefractory	42/120	55/111	0.49 (0.33-0.74)



HRs for subgroups were only plotted if the number of events was ≥20 in total across both treatments and were estimated using Cox proportional hazards models, without adjustments for stratification variables. A patient was considered high risk if they had any of the following cytogenetics: t(4;14), t(14;16), or del(17p13) and considered standard risk if they had negative results for all high-risk cytogenetics listed above.

BPd, belamaf, pomalidomide, and dexamethasone; CD, cluster of differentiation; HR, hazard ratio; LOT, line of therapy; NE, not evaluable; PI, proteasome inhibitor; PFS, progression-free survival; PVd, pomalidomide, bortezomib, and dexamethasone.

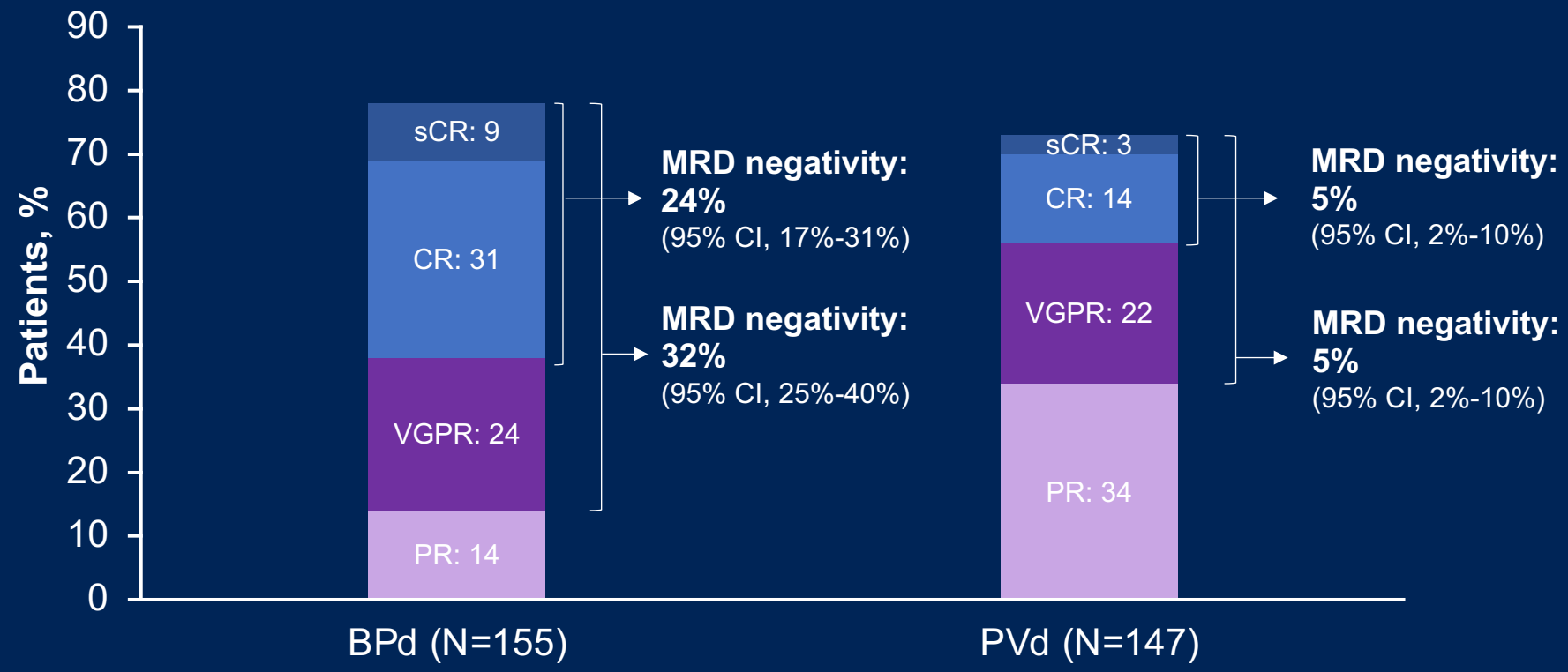
DREAMM-8: deeper responses with BPd vs. PVd



The CR or better rate in the BPd arm was more than double that reported in the PVd arm

CIs were based on the exact method. All percents are based on the ITT population.
BPd, belamaf, pomalidomide, and dexamethasone; CR, complete response; ITT, intent to treat; ORR, objective response rate; PR, partial response; PVd, pomalidomide, bortezomib, and dexamethasone; sCR, stringent complete response; VGPR, very good partial response.

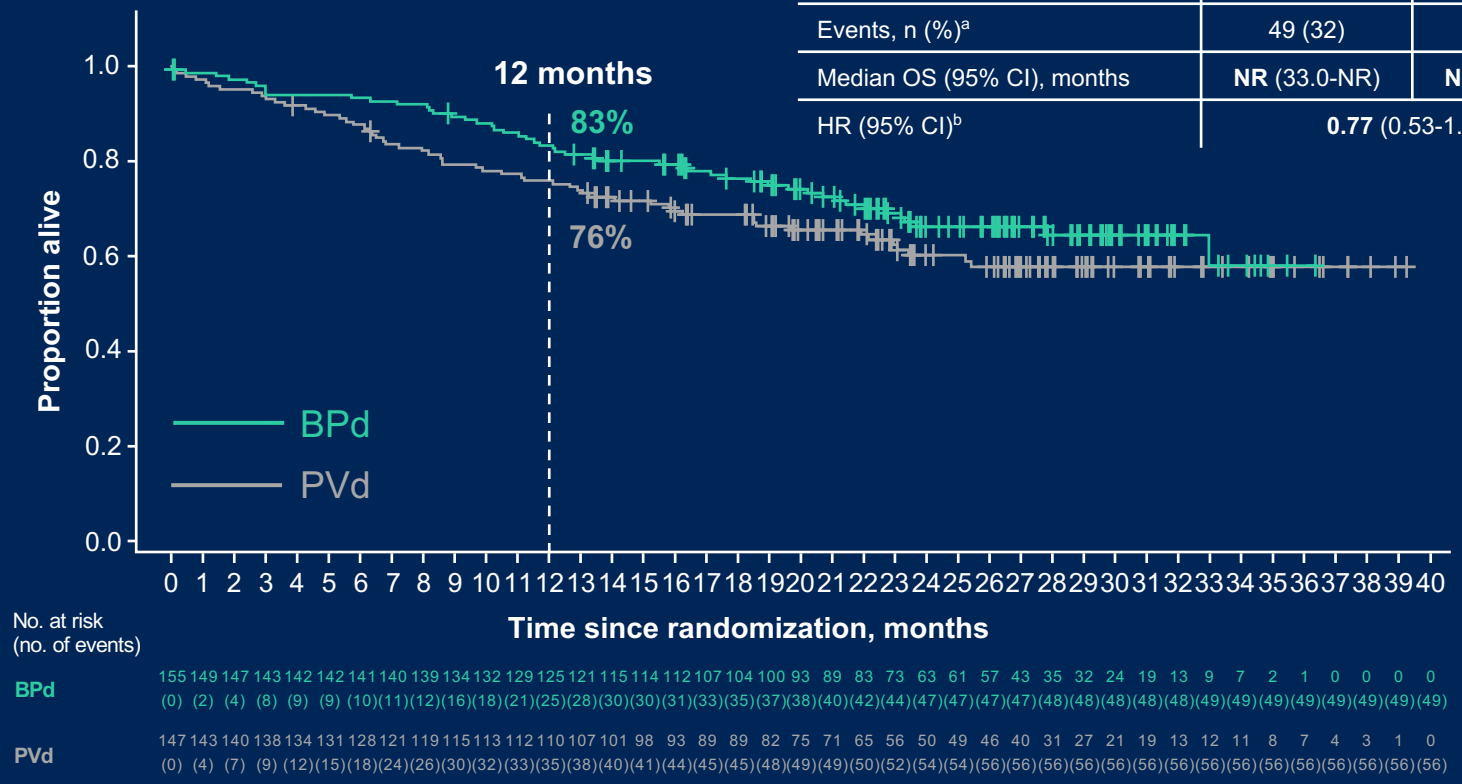
DREAMM-8: higher MRD negativity rates with BPd vs. PVd



The proportion of patients with a response of CR or better and MRD negative status (sensitivity of 10^{-5}) was 5× greater in the BPd arm compared to the PVd arm (24% vs 5%)

CIs were based on the exact method. MRD negativity rate was defined as the percentage of total intent-to-treat patients who were MRD negative by NGS based on sensitivity of 10^{-5}. All percents including MRD negativity are based on the ITT population.
BPd, belamaf, pomalidomide, and dexamethasone; CR, complete response; ITT, intent to treat; MRD, minimal residual disease; NGS, next-generation sequencing; PR, partial response; PVd, pomalidomide, bortezomib, and dexamethasone; sCR, stringent complete response; VGPR, very good partial response.

DREAMM-8: positive OS trend favouring BPd vs. PVd



Interim OS	BPd (N=155)	PVd (N=147)
Events, n (%)[a]	49 (32)	56 (38)
Median OS (95% CI), months	**NR** (33.0-NR)	**NR** (25.2-NR)
HR (95% CI)[b]	**0.77** (0.53-1.14)	

Subsequent antimyeloma therapy, n (%)[c]	ITT population	
	BPd (N=155)	PVd (N=147)
Steroids	37 (24)	59 (40)
Anti-CD38 antibodies	23 (15)	49 (33)
Proteasome inhibitor	26 (17)	36 (24)
Immunomodulator	14 (9)	29 (20)
BCMA-targeting therapy[d,e]	1 (<1)	20 (14)
Chemotherapy	16 (10)	25 (17)
Transplant	1 (<1)	5 (3)

Positive OS trend favoring BPd was seen despite the use of effective anti-MM therapies after progression with PVd; additional OS follow-up is ongoing

Median follow-up, 21.8 months (range, 0.03-39.23 months). Minimum ongoing follow-up, 12.8 months.
BCMA, B-cell maturation antigen; BPd, belamaf, pomalidomide, and dexamethasone; HR, hazard ratio; ITT, intent to treat; NR, not reached; OS, overall survival; PVd, pomalidomide, bortezomib, and dexamethasone.
[a] Includes patients who died after study withdrawal when permitted per local laws. [b] The treatment effect (HR and corresponding 95% CIs) was estimated using the stratified Cox proportional hazards model. Stratified analyses were adjusted for number of prior lines of therapy and prior bortezomib use. [c] Includes any subsequent antimyeloma therapy. Selected categories of interest are included. [d] Identified by posthoc analysis. [e] Includes belamaf, teclistamab, elranatamab, REGN5458, and EMB-06.

DREAMM-7: changes in BCVA

20/20

20/50

20/200

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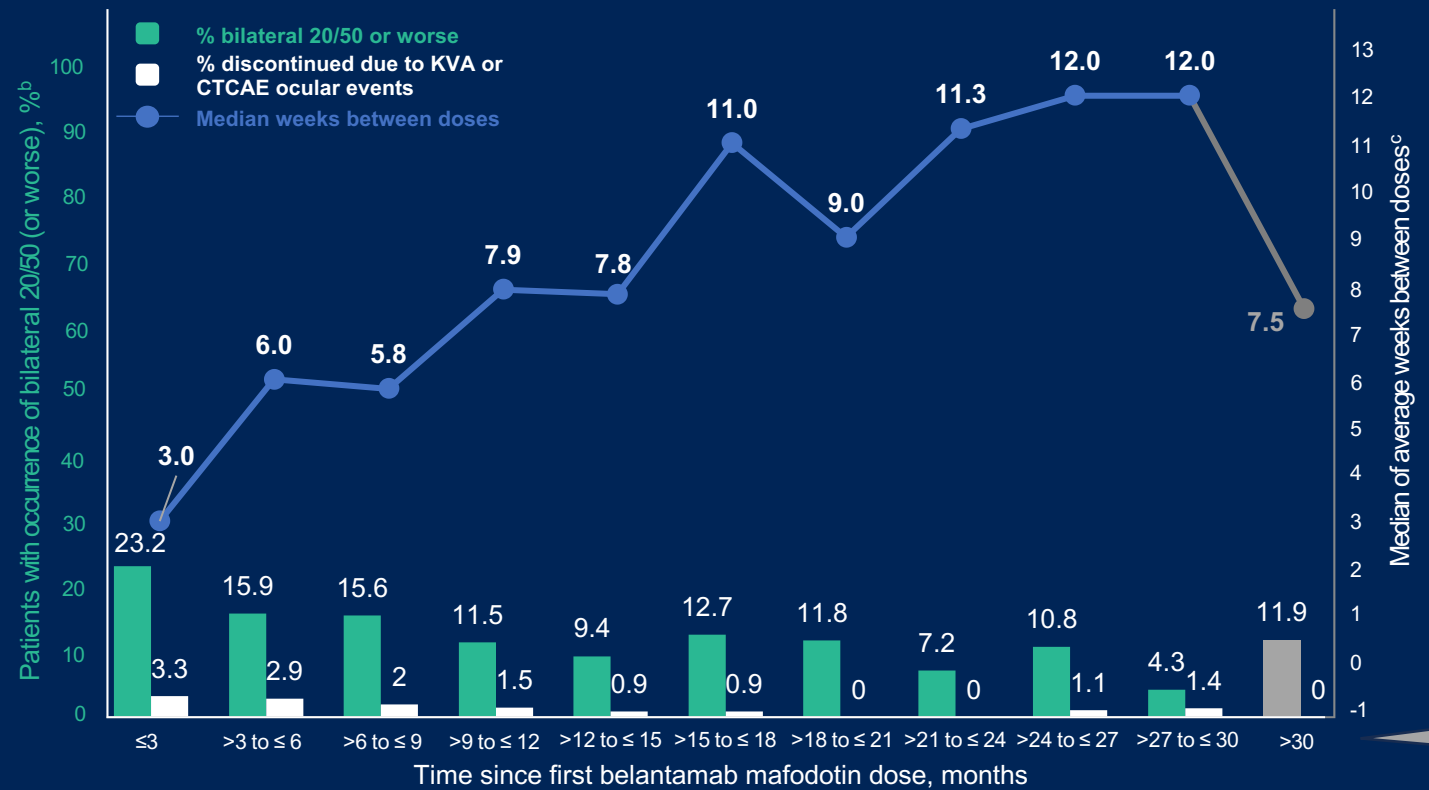
BVd	Bilateral worsening of BCVA in patients with normal baseline 20/25 or better	
	20/50 or worse[a]	20/200 or worse[a]
Patients, n/N (%)	82/242 (34)	5/242 (2)
Time to onset of first event, median (range), days	73.5 (16-753)	105 (47-304)
Time to resolution of first event to baseline, median (range), days[b]	64 (8-908)	86.5 (22-194)
Time to improvement of first event, median (range), days[c]	22 (6-257)	19 (8-26)
First event resolved, n/N (%)[b]	77/82 (94)	4/5 (80)
First event improved, n/N (%)[c]	80/82 (98)	5/5 (100)
Follow-up ended with event ongoing, n/N (%)	2/82 (2)	0

Among all patients who received BVd, 44% had dose reductions, 78% had dose delays/interruptions, and 9% discontinued due to any ocular event

BCVA, best-corrected visual acuity; BVd, belantamab mafodotin, bortezomib, and dexamethasone.
[a] Only patients with baseline visual acuity of 20/25 or better in ≥1 eye with on-trial worsening to 20/50 or 20/200 in each eye at the same visit. [b] Resolution (post hoc) was defined as returning to baseline visual acuity (20/25 or better in ≥1 eye). [c] Improvement was defined as bilateral improvement to better than 20/50 (or 20/200).

DREAMM-7: impact of dose modifications on PFS and ocular management[a]



No. of patients on treatment	211	170	147	131	117	110	102	97	93	69	42
No. of patients with bilateral 20/50 or worse	49	27	23	15	11	14	12	7	10	3	5
Median days between doses	21	42	41	55	54	77	63	79	84	84	53
No. of patients who discontinued due to KVA or ocular CTCAE event	7	5	3	2	1	1	0	0	1	1	0

- Median time between doses increased the longer patients were on therapy
- **Dose delays did not have an impact on PFS[d]**
  - BVd patients with ≥1 dose delay of ≥12 weeks (N= 126), **mPFS 36.6 months**
- 23% of patients experienced 20/50 or worse events in first 3 months; prevalence decreased thereafter
- Rate of treatment discontinuation due to ocular events were low

Data beyond 30 months is cumulative

[a] Only belantamab mafodotin treatment period considered in these post hoc analyses. [b] Only patients with 20/25 or better in either or both eyes at baseline are considered. [c] Mean of days between doses, for each patient, per interval is used. [d] Only patients receiving ≥6 months of treatment included in analysis to exclude early discontinuations (e.g., rapid PDs)

DREAMM-8: bilateral worsening in best corrected visual acuity

20/20

20/50

20/200

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BPd	Bilateral worsening of BCVA in patients with normal baseline (20/25 or better in ≥1 eye)	
	20/50 or worse[a]	20/200 or worse[a]
Patients, n/N (%)	51/150 (34)	2/150 (1)
Time to onset of first event, median (range), days	112 (28-761)	351 (29-673)
Time to resolution of first event to normal baseline, median (range), days[b,c]	57 (14-451)	NA[d]
Time to improvement of first event, median (range), days[e]	29 (7-196)	25.5 (22-29)
First event resolved to normal baseline, n/N (%)[c]	43/51 (84)	1/2 (50)
First event improved, n/N (%)[e]	47/51 (92)	2/2 (100)
Follow-up ended with event ongoing, n/N (%)[c,f]	4/51 (8)	1/2 (50)

Visual acuity changes that could affect activities of daily living were reversible in most patients

BCVA, best corrected visual acuity; BPd, belamaf, pomalidomide, and dexamethasone; NA, not available.
[a] Only patients with baseline visual acuity of 20/25 or better in ≥1 eye with on-study worsening to 20/50 or 20/200 in each eye at the same visit. [b] Defined as time from onset to resolution to normal baseline. [c] posthoc analyses. [d] One event resolved to normal baseline after 57 days, while for the other event, patient follow-up ended prior to resolution; median not available. [e] "Improved" was defined as no longer 20/50 (or 20/200) or worse in both eyes. [f] Ongoing events were defined as events that had not resolved to normal baseline. Shi C, et al. *bioRxiv.* Published online May 22, 2018.

Blenrep efficacy data is potentially transformational vs. 2L+ SoC triplets

Independent, H2H confirmation vs. daratumumab and bortezomib with consistent, manageable safety

DREAMM-7

mPFS 36.6 months

(HR 0.41; P<.00001) compared to 13.4 months, median follow-up (ITT) of 28.2 months

- PFS consistent across subgroups associated with poor prognosis, including patients with lenalidomide-refractory disease or high-risk cytogenetics
- Strong and clinically meaningful OS
- Greater ORR and depth (≥CR, ≥VGPR, MRD negativity) and durability of response

DREAMM-8

mPFS NR

(HR 0.52; P<.001) compared to 12.7 months, median follow-up (ITT) of 21.8 months

- 100% lenalidomide-exposed patients
- PFS consistent across all prespecified subgroups, including patients with high-risk cytogenetics or lenalidomide- or anti-CD38-refractory disease
- Greater depth (≥CR; ≥CR and MRD negativity) and durability of response
- Early OS trend with ongoing follow-up

Safety

- Safety and tolerability of BVd and BPd regimens in DREAMM-7/-8 consistent with the known safety profile of the individual agents
- Dose modifications were effective in enabling patients with ocular adverse events to achieve PFS outcomes and low treatment discontinuation rates, consistent with that of the overall study population

Blenrep triplets can potentially be a new SoC in 2L+ RRMM owing to the robust efficacy, manageable safety and ease of administration

2L+: second line or later, B: belamaf, CR: complete response, d: dexamethasone, H2H: head-to-head, HR: hazard ratio, mPFS: median progression-free survival, MRD: minimal residual disease, NR: not reached, ORR: overall response rate, OS: overall survival, P: pomalidomide, PFS: progression-free survival, RRMM: relapsed/refractory multiple myeloma, SoC: standard of care, V: bortezomib, VGPR: very good partial response.

ASCO 2024 oral presentations for DREAMM-7 (BVd vs. DVd) and DREAMM-8 (BPd vs. PVd).

Study of BRd in 1L MM evaluates optimal dosing and dosing schedules

A Prolonged Dosing Schedule of Belantamab Mafodotin Plus Lenalidomide and Dexamethasone Significantly Reduced Ocular Adverse Events without Compromising Clinical Activity in Transplant Ineligible Patients with Newly Diagnosed Multiple Myeloma

Presented at 5th European Myeloma Network Meeting (April 2024)

Key eligibility criteria

- Documented MM
- Ineligible for high-dose chemotherapy with ASCT
- ECOG PS 0–2
- Adequate organ system function
- eGFR ≥30 mL/min/1.73 m^2

Part 1
(36 patients randomized 1:1:1)

Belamaf

- **Cohort 1**: 2.5 mg/kg Q8W
- **Cohort 2**: 1.9 mg/kg Q8W
- **Cohort 3**: 1.4 mg/kg Q8W

Lenalidomide: 25 mg/d PO, days 1–21 of every 28-day cycle

Dexamethasone: 40 mg/day PO or IV, days 1, 8, 15, 22 of every 28-day cycle*

Until PD or unacceptable toxicity

Primary endpoint

- **Part 1**: BelaRd safety, tolerability, belamaf RP2D

Secondary endpoints

- BelaRd efficacy
- Corneal AE management
- PK profile
- Ocular AEs by OSDI

Permitted dose (mg/kg) modifications

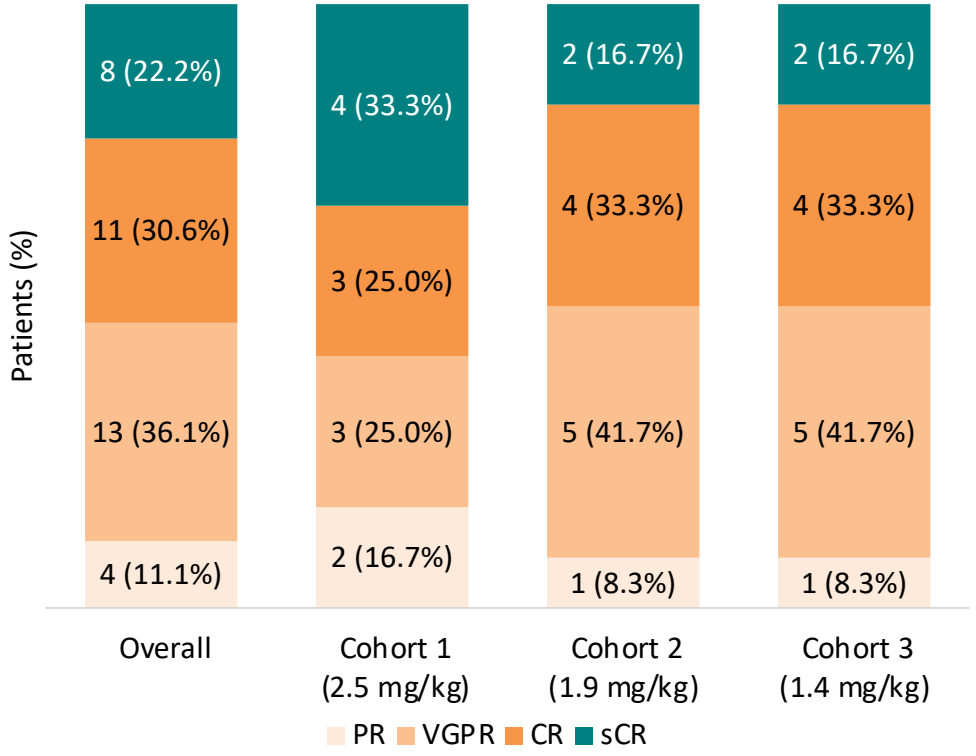
	Cohort 1	Cohort 2	Cohort 3
Dose +1	2.5 Q4W	1.9 Q4W	1.4 Q4W
Starting dose	2.5 Q8W	1.9 Q8W	1.4 Q8W
Dose -1	2.5 Q12W	1.9 Q12W	1.4 Q12W

*For participants ≥75 years, 20 mg/day on days 1, 8, 15, 22 of every 28-day cycle. AE: adverse event, ASCT: autologous stem cell transplantation, belamaf: belantamab mafodotin, BelaRd: belamaf + lenalidomide + dexamethasone, ECOG PS: Eastern Cooperative Oncology Group Performance Status, eGFR: estimated glomerular filtration rate, IV: intravenously, MM: multiple myeloma, NDMM: newly diagnosed multiple myeloma, OSDI: Ocular Surface Disease Index, PD: progressive disease, PK: pharmacokinetic, PO: per os, Q4/8/12W: once every four/eight/twelve weeks, RP2D: recommended phase II dose.

5th European Myeloma Network Meeting – April 2024.

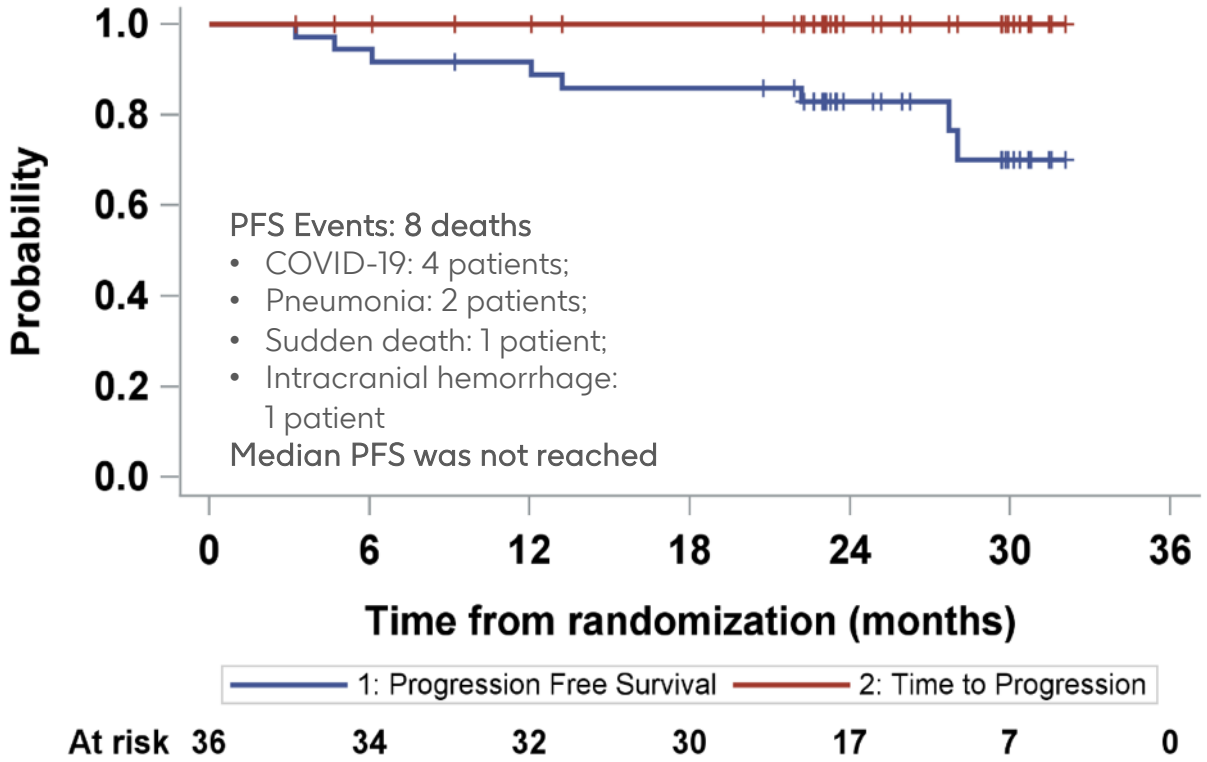
Clinical activity observed across doses with no disease progression to date

Overall Response Rate



Median time to first response: ~1 month

Progression Free Survival



Rapid, deep, and durable responses across cohorts were observed.
At median follow-up of 24.8 months, no disease progression was observed

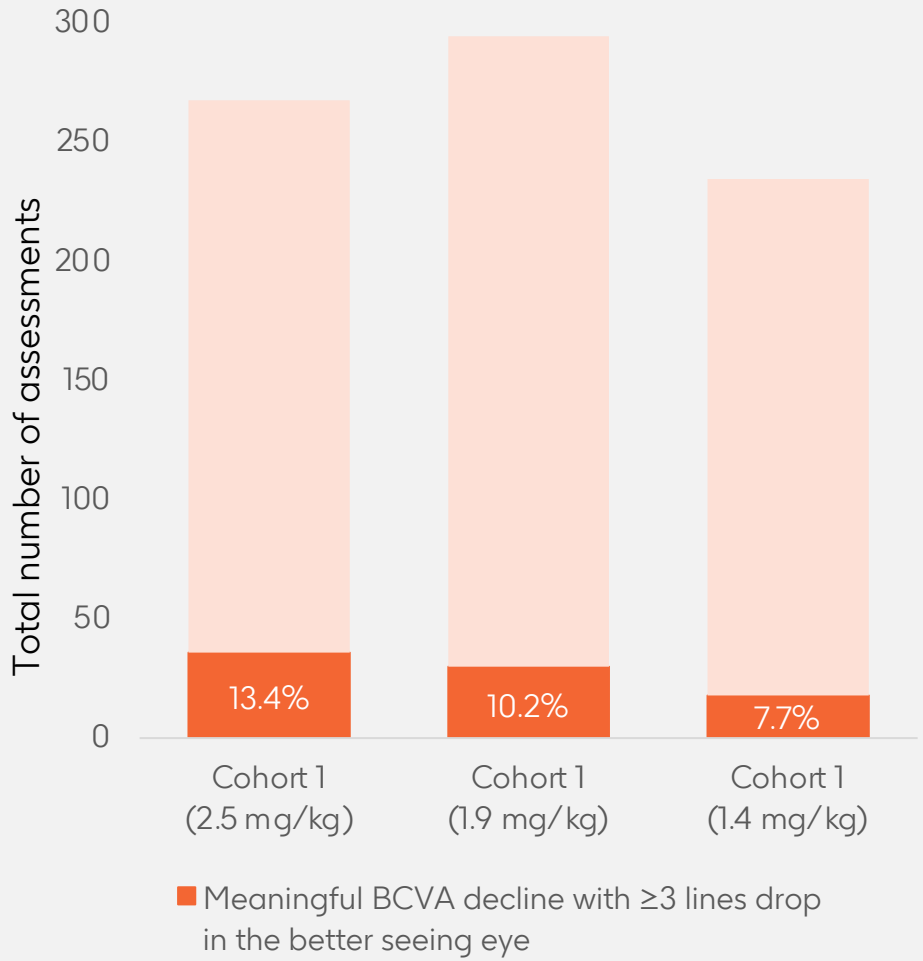
CR: complete response, PR: partial response, sCR: stringent complete response, VGPR: very good partial response.
5th European Myeloma Network Meeting – April 2024.

Low frequency of ≥Gr3 OAEs and meaningful BCVA decline were observed

Times to OAE resolution were rapid

	Cohort 1 (2.5 mg/kg)	Cohort 2 (1.9 mg/kg)	Cohort 3 (1.4 mg/kg)
Total number of ocular assessments	268	295	241
Assessments with OAE, n (%)*			
Mild (Grade 0-1)	103 (38.4)	155 (52.5)	129 (53.5)
Moderate (Grade 2)	108 (40.3)	100 (33.9)	85 (35.3)
Severe (Grade ≥ 3)	57 (21.3)	40 (13.6)	27 (11.2)
Assessments with BCVA change from baseline, n (%)			
Mild (Grade 0-1)	107 (39.9)	167 (56.6)	134 (55.6)
Moderate (Grade 2)	113 (42.2)	89 (30.2)	81 (33.6)
Severe (Grade ≥ 3)	48 (17.9)	39 (13.2)	26 (10.8)
Assessments with keratopathy findings, n (%)			
Mild (Grade 0-1)	222 (82.8)	257 (87.1)	213 (88.4)
Moderate (Grade 2)	33 (12.3)	37 (12.5)	27 (11.2)
Severe (Grade ≥ 3)	13 (4.9)	1 (0.3)	1 (0.4)
Time to resolution in months, median (range) ¶			
Time to resolution of meaningful BCVA decline with ≥3 lines drop in better seeing eye§	1.1 (1.0-5.8)	1.4 (0.8-2.4)	1.6 (0.9-5.5)
Time to resolution of BCVA change from baseline	2.1 (0.3-17.7)	1.9 (0.9-6.2)	1.9 (0.9-11.3)
Time to resolution of keratopathy	1.1 (0.5-12.2)	1.4 (0.9-3.4)	1.1 (0.9-3.7)

Frequency in clinically relevant vision impairments

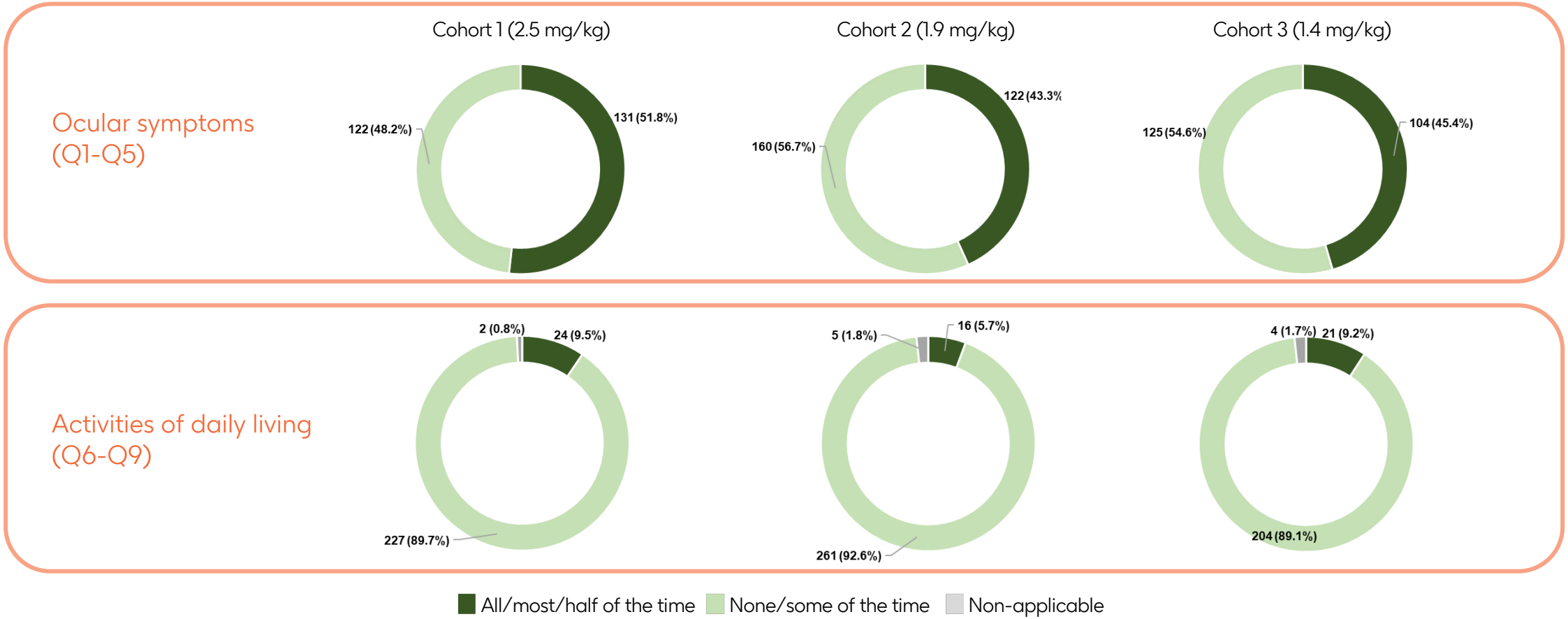


BCVA: best corrected visual acuity, OAE: ocular adverse event.

* For OAEs, the maximum grade of keratopathy or BCVA change from baseline is presented. § Meaningful BCVA decline is defined as BCVA decrease worse than 20/50 in the better-seeing eye. Better seeing eye was considered the eye that presented higher visual acuity at screening (based on BCVA). Patients with BCVA worse than 20/50 in both eyes at baseline are excluded from this analysis. ¶ Meaningful BCVA decline resolution was considered, when BCVA became better than 20/50 or line drops < 3 lines, while for keratopathy and BCVA change from Baseline resolution, was considered when Grade became ≤ 1. Time to resolution is presented for the resolved events.

Ocular symptoms had minimal impact on activities of daily living

No patients discontinued due to ocular adverse events

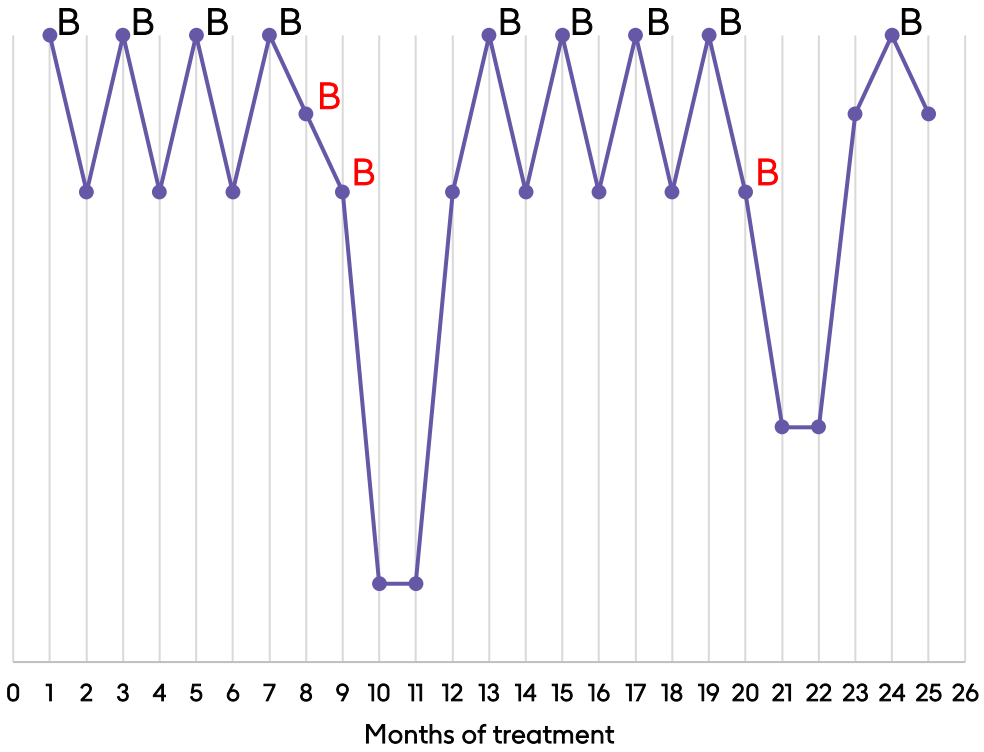


Across cohorts, a minor impairment in eyesight-associated daily functioning was observed, as "all/most/half of the time" responses in OSDI ADL category were <10.0% across cohorts

ADL: activities of daily living, OSDI: Ocular Surface Disease Index.

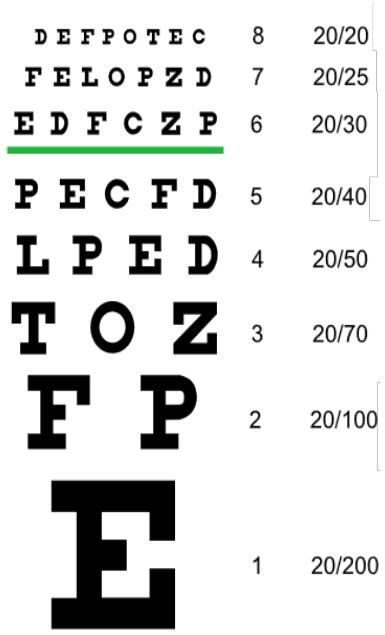
Appropriate belamaf dose administration critical to avoiding ocular events

Inappropriate dose administration

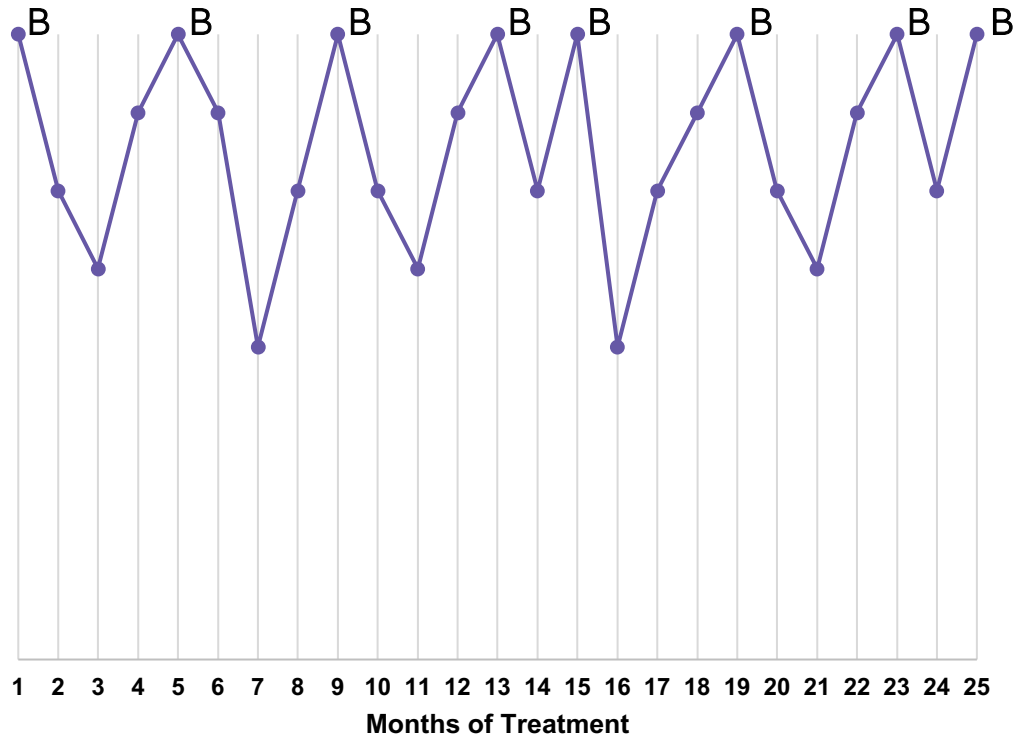


Inappropriate dosing (*i.e.*, when substantial ocular symptoms are present) may lead to significant drop in visual acuity

Visual acuity - Snellen chart



Appropriate dose administration



Appropriate administration (*i.e.*, without substantial ocular symptoms) may minimize ocular peak toxicities

B: appropriate belamaf administration
B: inappropriate belamaf administration

Summary of BRd in 1L multiple myeloma

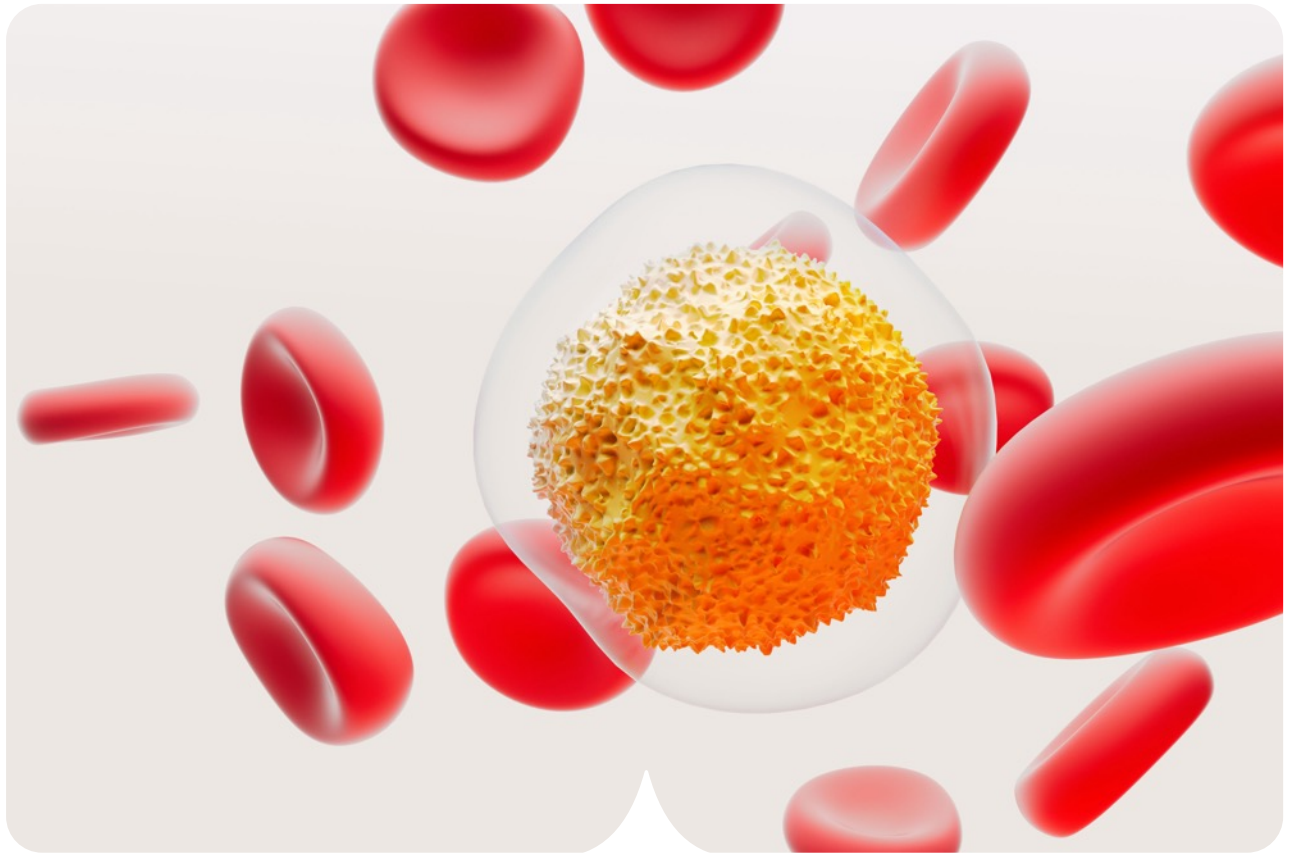
Dosing and efficacy

- Extension of belamaf dosing to Q8W/Q12W did not lead to reduced efficacy compared to previous studies implementing the Q3W schedule
- Results show that the efficacy of belamaf is maintained, even when administered in extended time intervals

Dosing and vision-related functioning

- Extended dosing schedule had only a minimal impact on vision-related functioning, with "all/most of the time" OSDI ADL responses recorded in <2.5% of assessments
- Frequency of clinically relevant impairment in vision was low, as meaningful BCVA decline was observed in less than 10% of assessments, with a rapid time to resolution

1L: first line, ADL: activities of daily living, BCVA: best corrected visual acuity, OSDI: Ocular Surface Disease Index, Q12W: every 12 weeks, Q8W: every 8 weeks.
5th European Myeloma Network Meeting – April 2024.



Eye-related side effects experienced on *Blenrep* can be manageable

Blenrep may have potential to improve upon standard of care in 2L MM

Favourable comparison to standard of care regimens on efficacy, convenience and access

Population	*Regimen*	*lenalidomide exposed (%)*	*PFS ITT (months)*	*Key constraint*	*Treatment visits*	
					Start	*6 months+*
Standard	belamaf-Vd[1]	52	37	-	Weekly	6-12 weeks[9]
	dara-Kd[2]	39	28	CV exclusion	Weekly	Weekly
	dara-Vd[3]	36	17	-	Weekly	Monthly
	dara-Rd[4]	18	45	1L SoC	Weekly	Monthly
Heavily pre-treated	belamaf-Pd[5]	100	NR[8]	-	Monthly	8-12 weeks[10]
	dara-Pd[6]	100	12	-	Weekly	Monthly
	bortezomib-Pd[7]	100	11	-	Weekly	Weekly

Blenrep is the only anti-BCMA expected to:

- be available also outside of excellence/academic centers
- offer anti-BCMA efficacy with low treatment burden
- offer early and sustained survival benefit*
- not be associated with life-threatening side-effects

Filing expected in all major markets by end of 2024

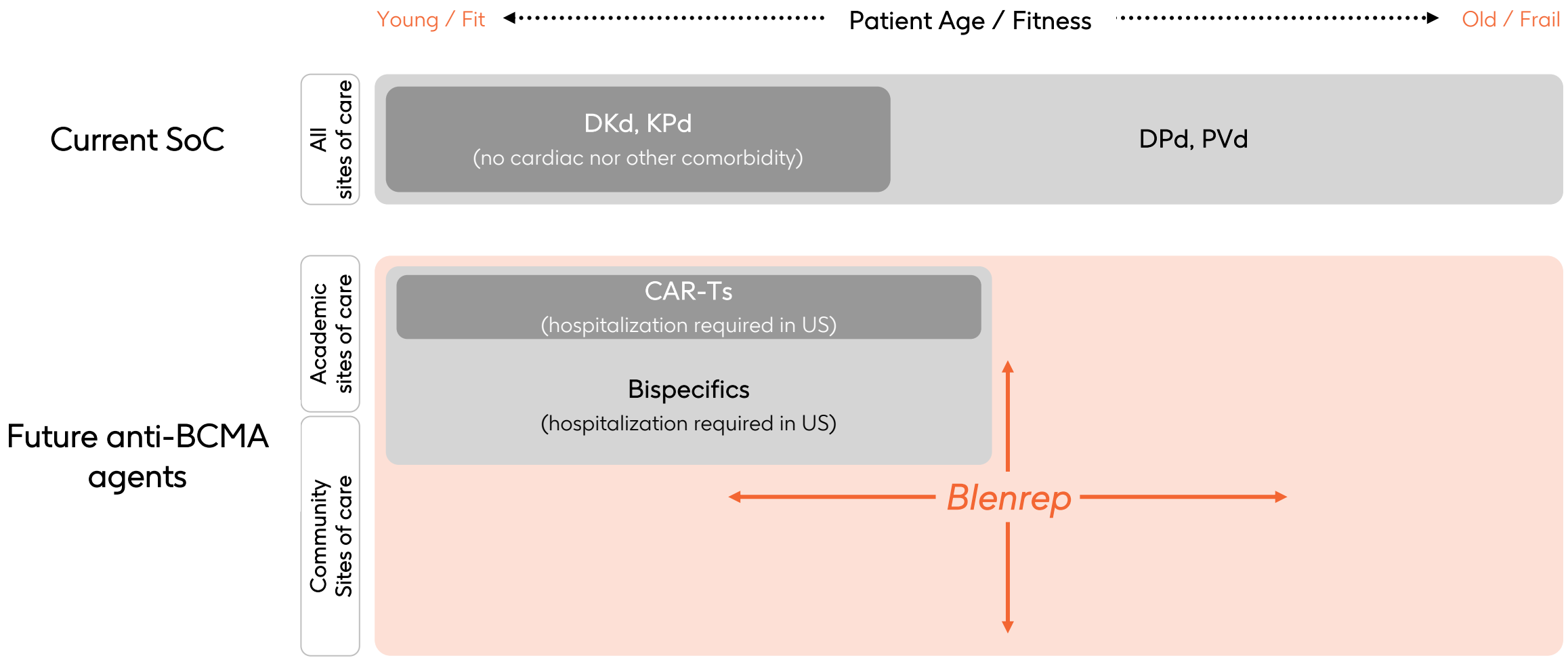
BCMA: B cell maturation antigen, CV: cardiovascular, d: dexamethasone, dara: daratumumab, ITT: intent-to-treat, K: carfilzomib, MM: multiple myeloma, NR: not reached, P: pomalidomide, PFS: progression-free survival, R: lenalidomide, SoC: standard of care, V: bortezomib.

* Subject to regulatory approvals and based on early separation of OS curves in DREAMM-7 (confirmatory pattern in DREAMM-8) vs. early detriment in Cartitude-4 and Karmma-3.

1. Mateos et al. New England Journal of Medicine. 2024 online. 2. Usmani SZ, et al. Lancet Oncol. 2022;23(1):65–76. 3. Weisel KC et al. Blood. 2019; 134 (Supp 1): 3192. 4. Bahlis NJ, et al. Leukemia. 2020;34(7):1875–1884. 5. Dimopoulos et al. New England Journal of Medicine. 2024 online. 6. Dimopoulos MA, et al. Lancet Oncol. 2021;22(6):801–812. 7. Richardson PG, et al. Lancet Oncol. 2019;20(6):781–794. 8. Median follow-up (ITT) of 21.8 months. 9. Data on file. 10. Data on file.

Blenrep may have a role in all patient segments and sites of care in 2L MM

Eligibility may span patient age and fitness



2L: second line, CAR-T: chimeric antigen receptor-T cell therapy, D: daratumumab, d: dexamethasone, K: carfilzomib, MM: multiple myeloma, P: pomalidomide, SoC: standard of care, V: bortezomib.

Multiple datasets support opportunity for *Blenrep* in 1L (NDMM)

Blenrep outperforms daratumumab through direct or indirect comparisons

Potential evidence for superiority of *Blenrep* in 1L multiple myeloma (newly diagnosed)

DREAMM-7 (vs. daratumumab-based SoC), 2L MM

PFS	36.6 vs. 13.4 months	Nearly tripling
OS	Trend with HR 0.51	p < 0.0005 (nominal)
mDoR	35.6 vs. 17.8 months	Doubling
≥CR	34.6 vs. 17.1%	≥VGPR 65.8% vs. 46.2%
MRD-	38.7% vs. 17.1%	More than doubled

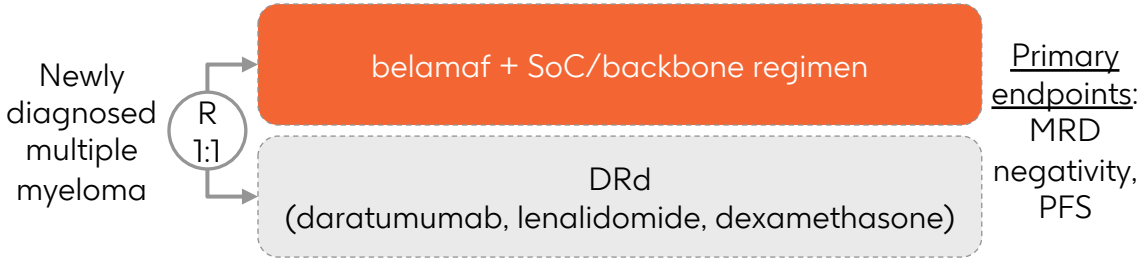
DREAMM-8, 2L MM
Cross-trial comparison vs. daratumumab (APOLLO trial*)

PFS	NR vs. 12.4	Almost doubling PFS

1L (NDMM) BelaRd Ph2 trial (Terpos)

At a median follow-up of 24.8 months, no disease progression was observed across 3 dose cohorts of belantamab

DREAMM-10 (phase III): *Blenrep* in 1L multiple myeloma



Trial to initiate in 2025

The Oncologic Drugs Advisory Committee (ODAC) have voted unanimously in favour of minimal residual disease (MRD) testing as an early endpoint in multiple myeloma

1L: first line, 2L: second line, CR: complete response, D: daratumumab, d: dexamethasone, mDoR: median duration of response, MM: multiple myeloma, mPFS: median progression-free survival, MRD(-): minimal residual disease (negativity), NDMM: newly diagnosed multiple myeloma, NR: not reached, OS: overall survival, PFS: progression-free survival, R: lenalidomide, SoC: standard of care.

* Dimopoulos MA, et al. Lancet Oncol. 2021;22(6):801–812. mPFS for ITT of 12.4 months vs. 6.9 months for DPd vs. Pd, respectively, in a 100% lenalidomide-exposed population.

Ojjaara/Omjjara (momelotinib)

Only asset demonstrating durable clinical benefit on spleen response, symptoms and anemia for patients with myelofibrosis

Myelofibrosis patients with anaemia have poor OS and limited options

~40% of patients are anaemic at diagnosis, while nearly all become anaemic over time

Myelofibrosis market by 2031[1,2]

~£3bn

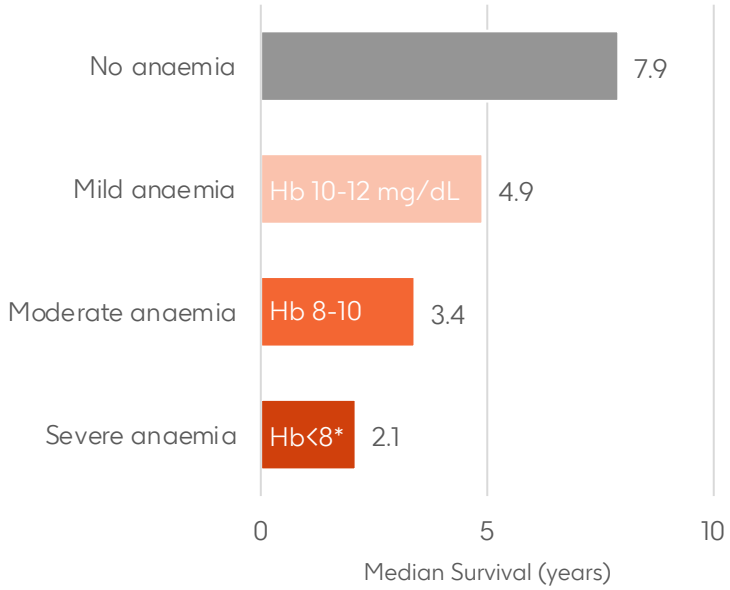
+7% compound growth rate

~53k drug-treated patients[6,7] in developed markets

High unmet medical needs remain

- Extending overall survival
- Disease-modifying treatments
- Treatments that address the totality of myelofibrosis manifestations, *i.e.*, splenomegaly, constitutional symptoms, anaemia, and thrombocytopenia

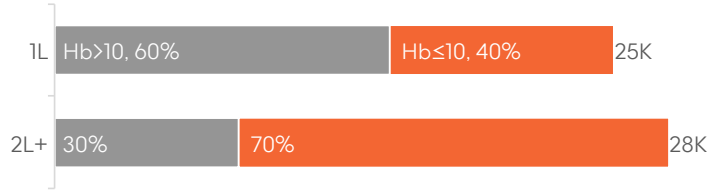
Significant patient burden[3] with nearly all patients becoming anaemic over time



Treatment dynamics[4,5,6]

~50%

Patients that require RBC transfusions within one year after diagnosis



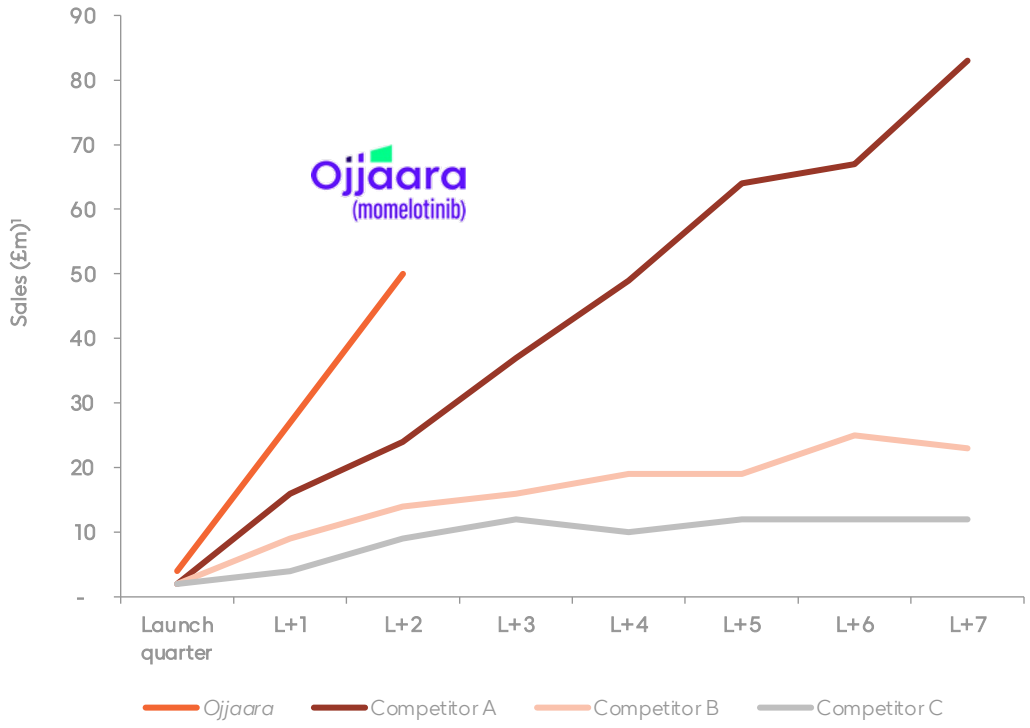
- Treatment with JAK inhibitors is initiated due to splenomegaly and constitutional symptoms; ~40% of patients are already anaemic at diagnosis
- Anaemia worsens due to disease progression or myelosuppressive therapies that exacerbate anaemia
- Symptoms of myelofibrosis and transfusion burden severely impact quality of life

Hb: haemoglobin, JAK: Janus kinase, OS: overall survival, RBC: red blood cell.* Severe anaemia defined as either Hb<8 or transfusion-dependent.

1. Evaluate Pharma (May 2024); GSK internal analysis. 2. Compound annual growth rate 2024-2031 based on forecasted sales. 3. Nicolosi M et al. Leukemia. 2018;32(5):1254-1258. 4. GSK trial populations and internal analysis. 5. Tefferi A, et al. Mayo Clin Proc. 2012;87(1):25-33. 6. Masarova et al, Cancer. 2022;128(8):1658-1665 7. Sochaki et al, Blood Adv. 2022.

Strong *Ojjaara* launch uptake; establishing share in 1L and 2L settings

Ojjaara: fastest US launch uptake in value for a JAKi in MF[1]



Strong commercial performance

- Driven by strong execution
- US share in patients with anaemia[2]: 14% in 1L and 28% in 2L
- ~60% of US physicians expect to increase prescribing *Ojjaara* in the next six months[3]
- Line-agnostic label in EU, with ongoing launches in the UK and Germany

Next steps

- H2 2024: Japan approval
- Exploring further indications at the overlap of oncology and inflammation

1L: first line, 2L: second line, JAKi: Janus kinase inhibitor, MF: myelofibrosis.
1. GSK quarterly financial results; EvaluatePharma (March 2024). 2. Quarterly chart audits, March 2024. 3. US Oncology ATU, Feb/Mar 24, n=102.

Zejula (niraparib)

Continued impact on ovarian cancer outcomes and promising data in glioblastoma

Zejula development is mainly focused within ovarian cancer and GBM

Ovarian cancer market by 2031[1,2]

~£7bn

+16% compound growth rate

~65k drug-treated patients[3] in developed markets

High unmet medical needs remain[5,6]

- Over 70% recurrence within 3-5 years in the absence of 1L maintenance therapy
- 1 of 2 patients in the US (vs. 1 of 4 in EU) remain untreated after chemotherapy

Glioblastoma market by 2031[1,2]

~£1bn

+45% compound growth rate

~26k patients diagnosed in developed markets by 2032[4]

High unmet medical needs remain[5]

- Only 2% of patients achieve 5-year survival for unmethylated MGMT (~60% of total population)
- Over 40 years with no meaningful treatment improvement

Poly (ADP-ribose) polymerase inhibitor (PARPi) class

- Established therapy option for platinum-sensitive patients, particularly for BRCAm and BRCAwt HRd
- Demonstrated overall clinical impact on ovarian cancer outcomes over the last decade
- Efficacy of PARPi that can cross the blood-brain barrier is being explored in CNS tumours (GBM), with potential for meaningful improvement in an area of high unmet need

Overcoming PARPi resistance

- Inhibition of POLθ activity may deepen PARPi response
- More information on clinical programme forthcoming

1L(M): first line (maintenance), BRCAm: breast cancer gene mutation, BRCAwt: breast cancer gene wild type, CNS: central nervous system, GBM: glioblastoma, HRd: homologous recombination deficiency, MGMT: O6-methylguanine-DNA methyltransferase, NSCLC: non-small cell lung cancer, PARPi: poly (ADP-ribose) polymerase inhibitor.

1. Evaluate Pharma (May 2024); GSK internal analysis. 2. Compound annual growth rate 2024-2031 based on forecasted sales. 3. Epidemiology by tumour dashboard (internal). 4. Cerner/ClearView. 5. Evidera Live Tracker. 6. Flatiron R12M Feb 2024.

Promising data in glioblastoma is a compelling opportunity

Zejula crosses the blood-brain barrier to penetrate brain tumours

No clinically meaningful improvement in unmethylated MGMT population since 1978

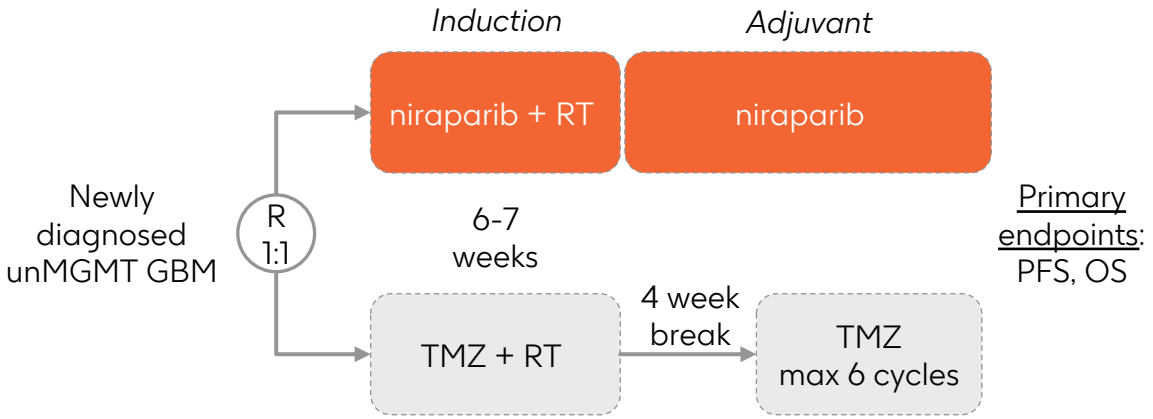
- Based upon pre-clinical data, *Zejula* crosses the blood-brain barrier, unlike other PARPi studied, showing favourable brain tumour penetration

Phase II[1] data presented at 2024 ASCO

- Showed promising overall and progression-free survival in unmethylated MGMT

Endpoint	*Zejula* phase II (n=20)	Historic SoC data (n=40)
mPFS (months)	**14.9**	5.3
mOS (months)	**20.3**	12.8

Zejula (phase III) in glioblastoma, Ivy Brain Institute supported collaborative study



Next steps

- 2024: Phase III initiated
- 2027: data anticipated

GBM: glioblastoma, mPFS: median progression-free survival, mOS: median overall survival, PARPi: poly (ADP-ribose) polymerase inhibitor, RT: radiotherapy, SoC: standard of care, TMZ: temozolomide, unMGMT GBM: unmethylated O6-methylguanine-DNA methyltransferase glioblastoma.

1. Single arm study.

Immuno-oncology: *Jemperli* (dostarlimab) and CD226 axis assets

Development of monotherapy and combinations across select solid tumours

Jemperli development is focused across endometrial, CRC and HNSCC

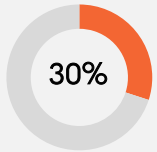
dMMR-driven tumour opportunities with expansion into highly PD-L1 positive HNSCC

Endometrial cancer market by 2031[1,2]

~£2bn

+13% compound growth rate

~125k patients[3] diagnosed in developed markets



Treatment dynamics: ~70% MMRp, and 30% dMMR/MSI-H[4]

High unmet medical needs remain

- IO has transformed outcomes in dMMR
- While there have been improvements in MMRp patients, unmet need remains
- Poor long-term outcomes with chemotherapy alone

Colorectal cancer market by 2031[1,2]

~£9bn

+7% compound growth rate

>1 million patients[3] diagnosed in developed markets by 2032

Treatment dynamics: Stage II/III 85-90% MMRp, and 10-15% dMMR/MSI-H[4]

High unmet medical needs remain

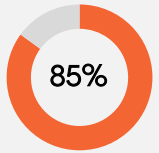
- Chemotherapy with current standard-of-care has quality of life impact, toxicity, marginal efficacy and continues to be a compliance burden for patients
- PD-1 monotherapy is not currently being studied

Head and neck cancer market by 2031[1,2]

~£4bn

+5% compound growth rate

~300k patients[3] diagnosed in developed markets



Treatment dynamics: ~85% PD-L1 positive patients[5]

High unmet medical needs remain

- Locally advanced setting and standard-of-care has not improved for >20 years
- Benefits of anti-PD-(L)1 therapy have not yet been realised in early-stage disease

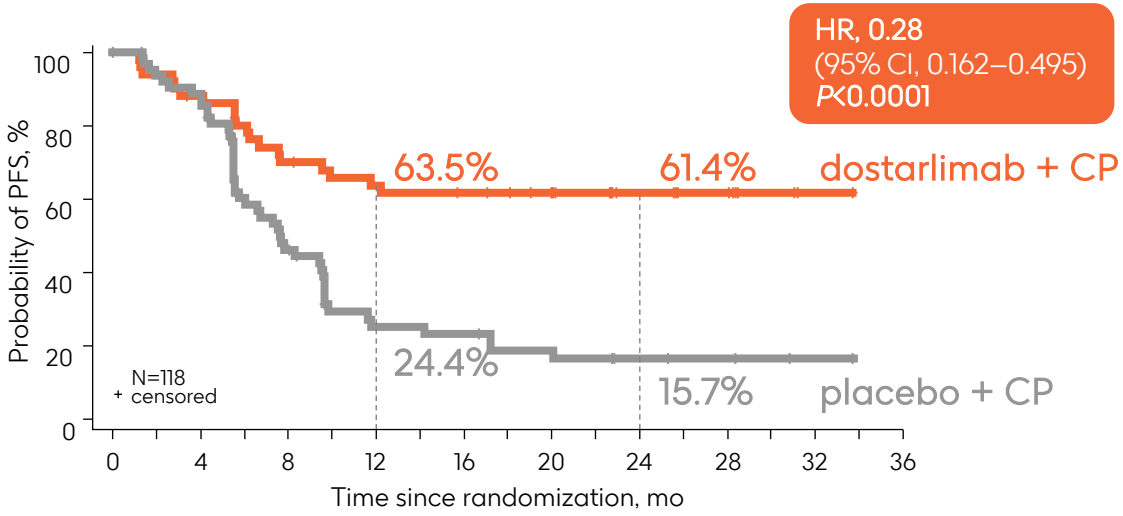
CRC: colorectal cancer, dMMR: deficient mismatch repair, HNSCC: head and neck squamous cell carcinoma, LA: locally advanced, MMRp: mismatch repair proficient, MSI-H: microsatellite instability-high, OS: overall survival, PD-1: programmed cell death protein 1, PD-L1: programmed cell death-ligand 1, SoC: standard of care.

1. Evaluate Pharma (May 2024); GSK internal analysis. 2. Compound annual growth rate 2024-2031 based on forecasted sales. 3. Oracle Life Sciences CancerMPact Patient Metrics, accessed May 2024. 4. Oracle Life Sciences CancerMPact® Treatment Architecture Reports, 2023. 5. Based on KN-412 clinical trial.

Jemperli & chemo showed significant OS benefit in 1L endometrial cancer

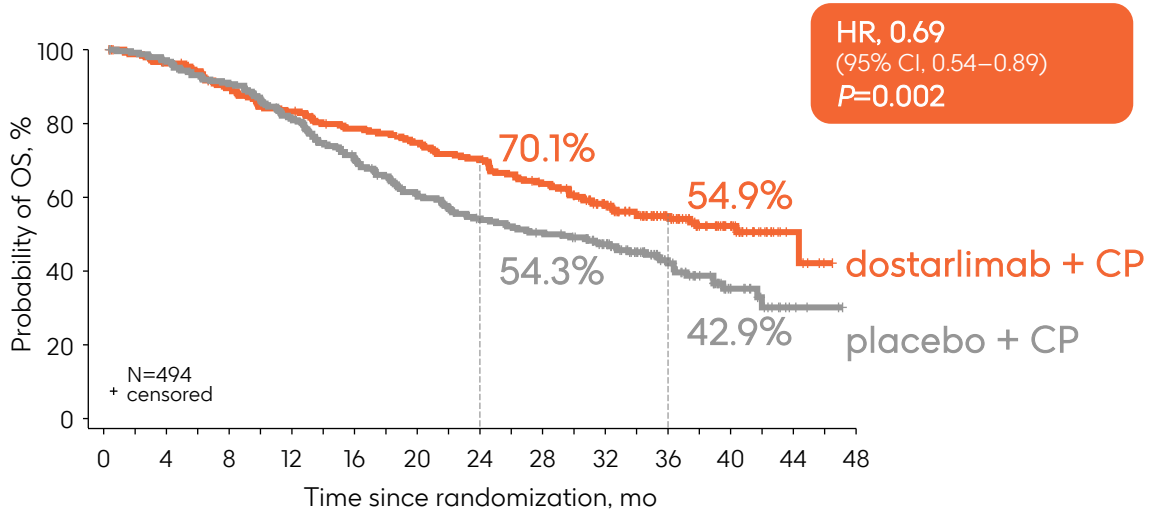
Unprecedented data builds upon current approval in 1L primary advanced/recurrent dMMR population

RUBY 1: statistically significant PFS benefit in dMMR/MSI-H[1] *(mPFS NE (30) vs. 7.7 months)*



- Launch of 1L dMMR indication has shown rapid uptake
  - 33% new patient share (NPS) in US
  - >35% NPS in Germany and strong UK performance since March launch
  - £800-900m in anticipated PYS

RUBY 1: statistically significant OS benefit in all-comers[2] *(mOS 44.8 vs. 28.2 months)*



- RUBY 1 all-comers indication accepted for US FDA priority review (Aug 2024 PDUFA), and EMA submission completed
- *Jemperli* to serve as a backbone for B7-H4 ADC combination in endometrial cancer

1L: first line, ADC: antibody-drug conjugate, CP: carboplatin-paclitaxel, dMMR: deficient mismatch repair, HR: hazard ratio, mPFS: median progression free survival, mOS: median overall survival, MSI-H: microsatellite instability-high, NE: not estimable, NPS: new patient share, OS: overall survival.

1. SGO 2023 presentation. 2. SGO 2024 presentation.

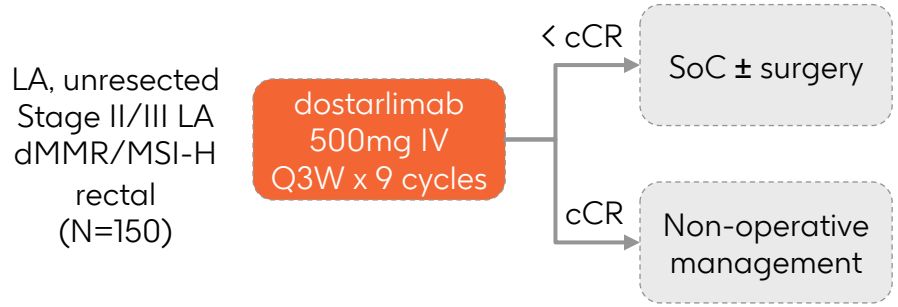
Jemperli has shown transformative data in LA dMMR rectal cancer

Data ungated further investment in registration-enabling gastrointestinal indications

Continued benefit in locally advanced dMMR rectal cancer[1]

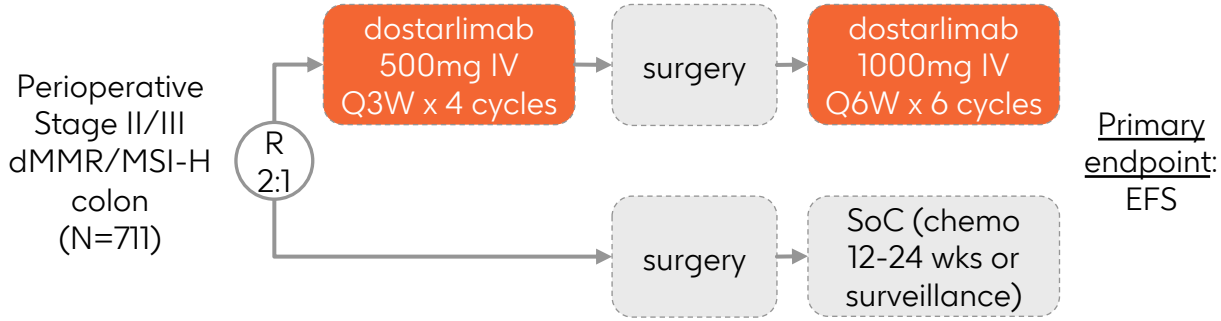
- 100% complete clinical response (cCR) (N=42 patients)
- Durable complete responses with monotherapy at 12 months of follow-up, as no progression evidenced
- No Gr3/4 adverse events were observed
- No patients have required chemotherapy, radiation nor surgery

AZUR-1 (phase II): *Jemperli* monotherapy in dMMR rectal cancer



- Current SoC: CRT and/or surgery
- Dostarlimab being explored as a chemo- and surgery-sparing treatment option to replace SoC
- Data expected in 2026+

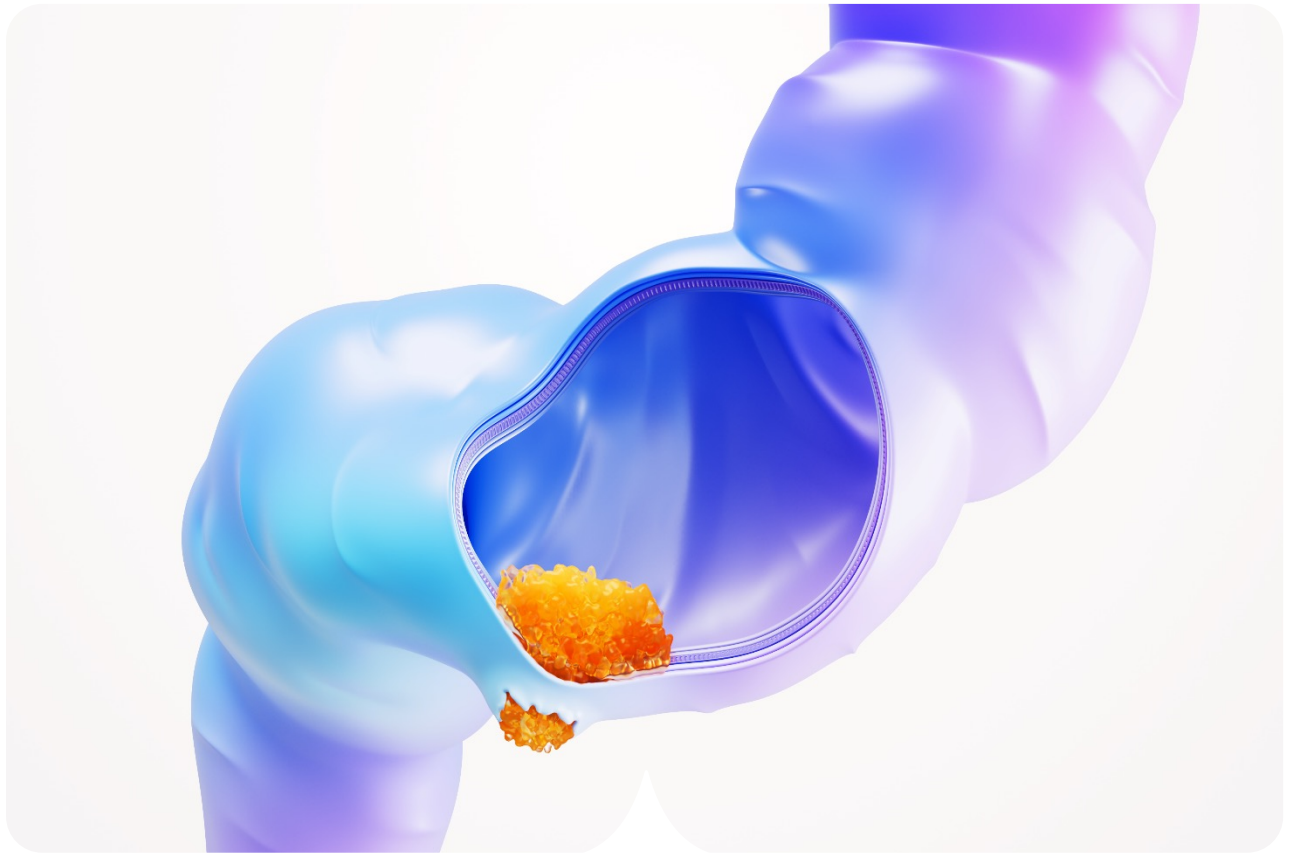
AZUR-2 (phase III) *Jemperli* monotherapy in dMMR colon cancer



- IO shown to provide clinical benefit vs. chemo
- Dostarlimab being explored as a chemo-free treatment option to replace chemo
- Data expected in 2026+

cCR12: complete clinical response for 12 months following post-intervention disease assessment, cCR: complete clinical response, CRT: chemoradiotherapy, dMMR: deficient mismatch repair, EFS: event-free survival, IO: immuno-oncology, IV: intravenous, LA: locally advanced, MSI-H: microsatellite instability-high, Q3W: once every 3 weeks, Q6W: once every 6 weeks, SoC: standard of care.

1. ASCO 2024 presentation (supported collaborative study).



Jemperli data shows unprecedented response in locally advanced dMMR rectal cancer

Dr. Andrea Cercek, medical oncologist

Memorial Sloan Kettering Cancer Center and Principal Investigator, GSK-supported dostarlimab study in dMMR rectal cancer

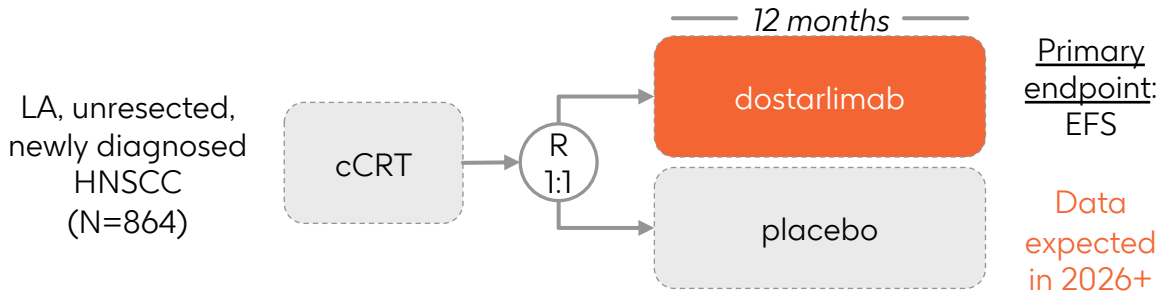
GSK

Jemperli being explored in locally advanced head and neck cancer

Investigating potential as new standard of care in post-chemoradiotherapy setting

- PD-(L)1 drug class has shown efficacy improvements over standard of care in the relapsed/metastatic setting, as well as in certain locally advanced, unresected settings
- Patients with locally advanced HNSCC do not currently receive any follow-on treatment after initial chemoradiotherapy
- JADE phase III study investigates efficacy of *Jemperli* post-chemoradiotherapy in patients most likely to benefit

JADE (phase III): *Jemperli* monotherapy in HNSCC



- ✓ Optimal patient selection
  - Only newly diagnosed, treatment-naïve patients with locally advanced, unresected HNSCC
  - PD-L1 CPS≥1 (CPS <1 unlikely to respond)
- ✓ Optimal timing of anti-PD-1 administration
  - Post-cisplatin-based CRT

cCRT: concurrent chemoradiotherapy, CPS: combined positive score, CRT: chemoradiotherapy, EFS: event-free survival, HNSCC: head and neck squamous cell carcinoma, LA: locally advanced, PD-L1: programmed cell death-ligand 1.

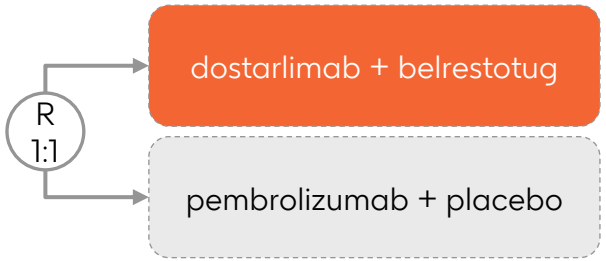
GSK and iTeos initiated phase III GALAXIES Lung-301 study in NSCLC

First registrational study of the *Jemperli*-belrestotug combination

Advancing CD226 axis combinations in NSCLC

GALAXIES Lung-301 (phase III): belrestotug in NSCLC

Previously untreated, PD-L1 high (TC≥50%) in current/former smokers in LA, unresectable or metastatic NSCLC (N=1000)



Primary endpoints: PFS, OS

Compelling science

- Fc-functional domain: Preclinical evidence suggests Fc engagement may be important for optimal antitumor responses by TIGIT mAbs[1,2]
- Potency: Cell-based assays demonstrated higher potency of belrestotug relative to other Fc-functional and Fc-silent anti-TIGIT mAbs providing basis for selection as a therapeutic candidate[3]
- Treg depletion: Treatment of patients with belrestotug demonstrated depletion of exhausted Treg cells while enhancing population of active CD8 cells[4]
- In combination with proven anti–PD-1 profile: Findings from the PERLA trial support the use of dostarlimab as a treatment backbone in trials of the combinations with belrestotug and other mAbs targeting the CD226 axis[5]

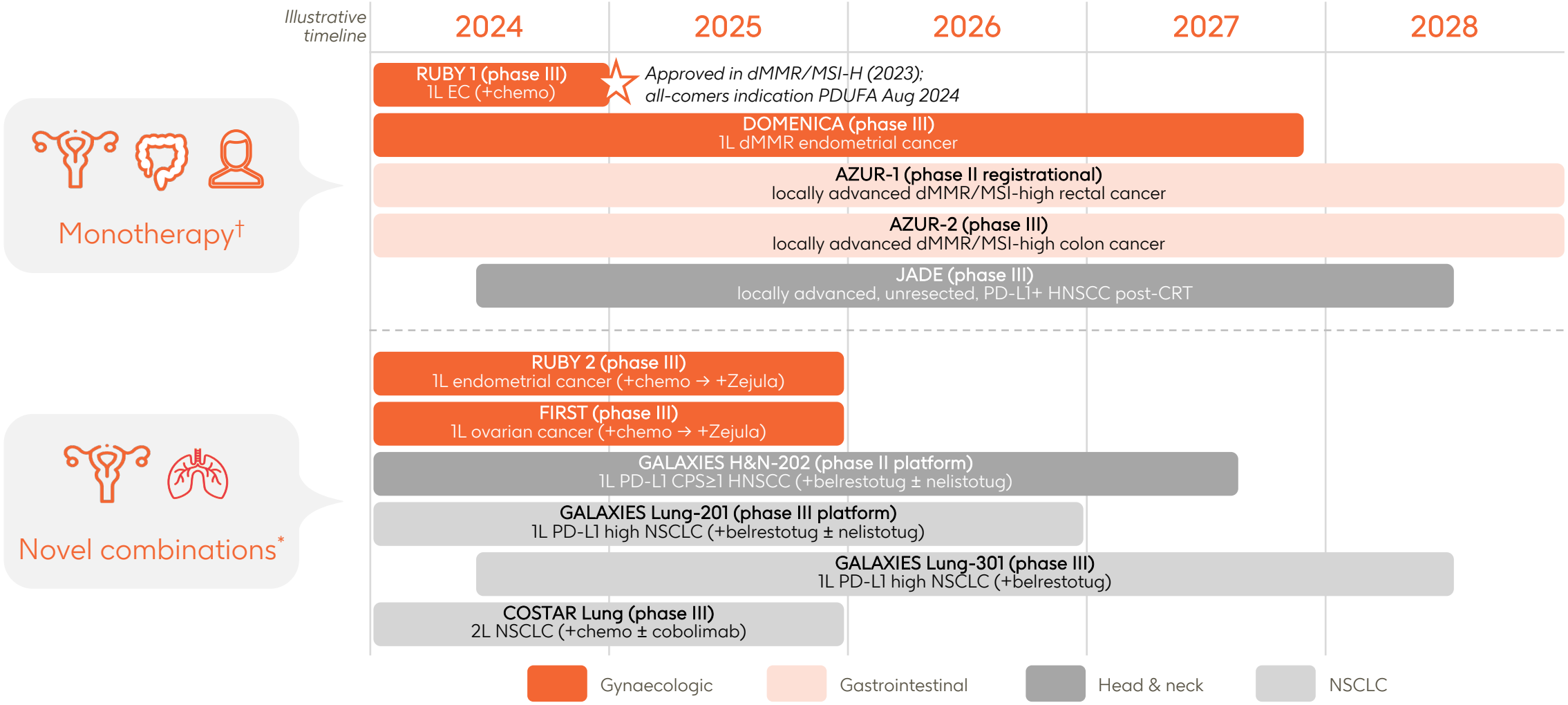
Data from phase II randomised study of *Jemperli* + belrestotug vs. *Jemperli* alone (GALAXIES Lung-201) planned to be presented in H2 2024

LA: locally advanced, mAbs: monoclonal antibodies, NSCLC: non-small cell lung cancer, OS: overall survival, PD-1: programmed cell death protein 1, PD-L1: programmed cell death-ligand 1, PFS: progression-free survival, TC: tumour cells.

1. Preillon J, et al. Mol Cancer Ther 2021;121-131. 2. Nguyen TL-A, et al. Presented at AACR II Apr 27-28 and Jun 22-24, 2020. 3. Cuende J, et al. Poster #LB189 presented at AACR Apr 8-13 2022. 4. iTeos corporate presentation – April 2022. 5. Lim SM, et al. Nat Commun 2023;14:7301.

Jemperli programme explores monotherapy and combinations

Endometrial cancer foundation with potential for growth across solid tumours



1L: first line, 2L: second line, CPS: combined positive score, CRT: chemoradiotherapy, dMMR: deficient mismatch repair, EC: endometrial cancer, HNSCC: head and neck squamous cell carcinoma, MSI-H: microsatellite instability-high, NSCLC: non-small cell lung cancer, PD-L1: programmed cell death-ligand 1, unHNSCC: unresected head and neck squamous cell carcinoma.

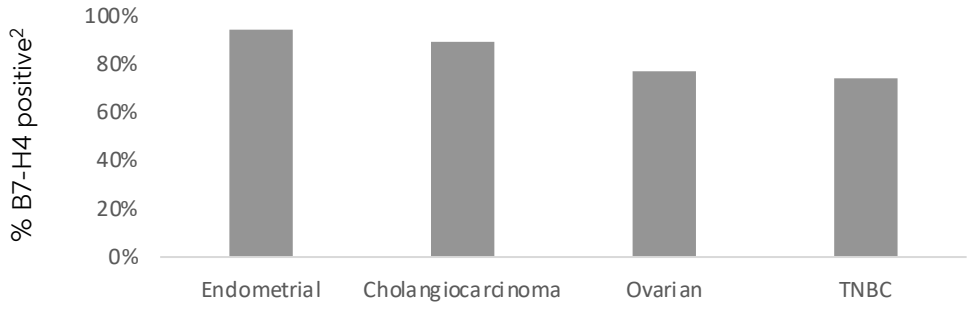
† RUBY 1 investigated Jemperli plus chemotherapy. * Combination agents: belrestotug (TIGIT inhibitor), cobolimab (TIM3 inhibitor), nelistotug (CD96 inhibitor), Zejula (PARP inhibitor).

Antibody-drug conjugates (GSK5733584 (B7-H4), GSK5764227 (B7-H3))

Blockbuster potential across focused tumour indications

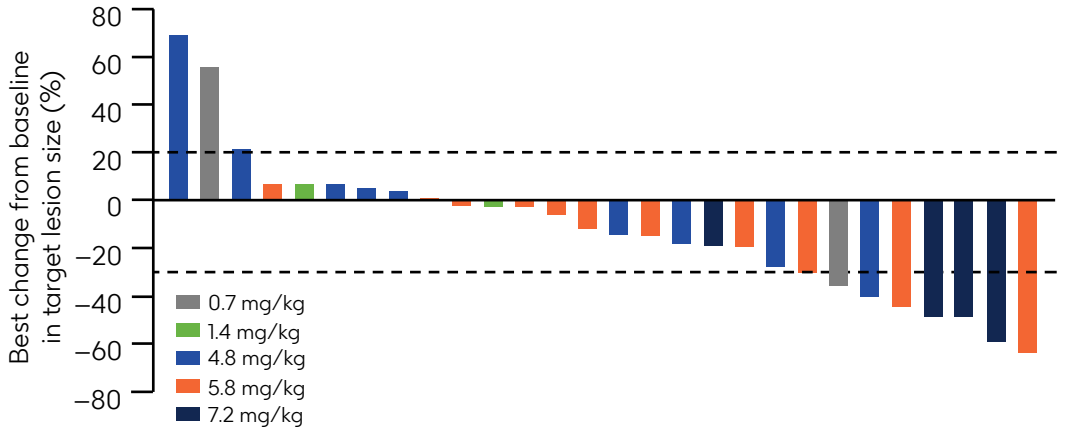
GSK5733584 (B7-H4 ADC) builds on presence in gynaecologic cancers

B7-H4 is highly expressed in solid tumours with high unmet need



5-year survival for patients with distant metastasis[1]	18%	4%	32%	13%

ESMO 2023: HS-20089 showed an ORR of 33.3% (4.8 mg/kg) and 27.3% (5.8mg/kg) in TNBC patients



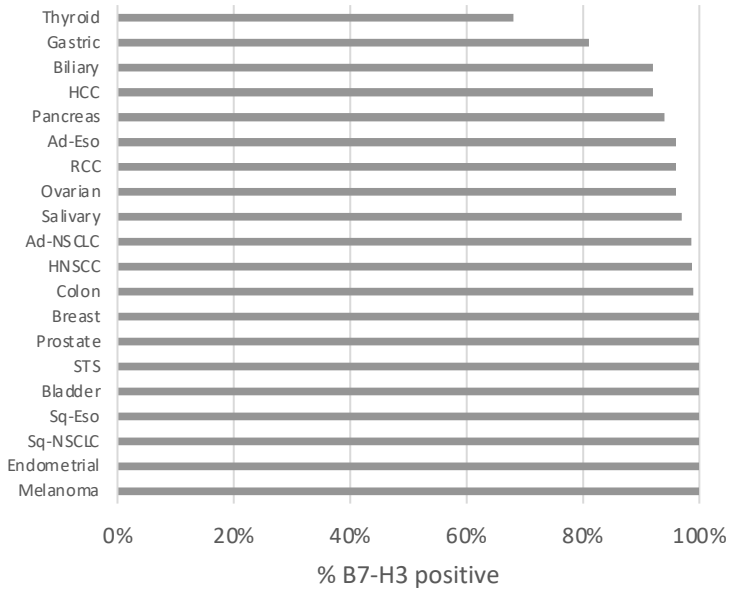
Well-positioned to potentially bring transformational value to patients and to drive GSK growth

- High tumour expression coupled with limited healthy tissue expression creates potential for a broad therapeutic index
- Clinically validated TOPO1i payload and linker
- Development focus on GSK proprietary combinations, including dostarlimab
- Proof of concept studies to begin H2 2024 to support accelerated registrational pathway

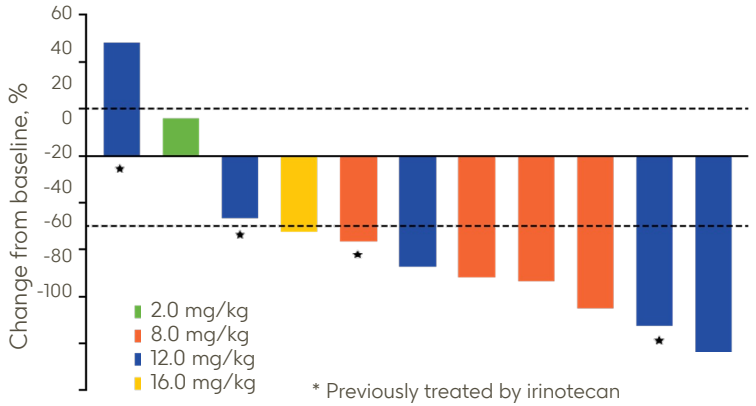
ADC: antibody-drug conjugate, ORR: overall response rate, TNBC: triple negative breast cancer.
1. SEER: 5 yr survival statistics for US. 2. Kinneer K, et al. Clin Cancer Res. 2023;29:1086–1101.
Ex-China licensing: includes China, Macau, Hong Kong and Taiwan.

GSK5764227 (B7-H3) has multi-indication, transformational potential

B7-H3 is broadly expressed across numerous tumour types with high unmet need[1]



ASCO 2023: HS-20093 showed an ORR of 63.6% in SCLC patients (N=11)



ASCO 2024: ORR of 17.4%/25% in osteosarcoma/sarcoma

No new safety signal *(12mg/kg)*

- Clinical activity observed in a broad range of tumours, including non-small lung cancer, small cell lung cancer and sarcoma
- Clinically validated TOPO1i payload and linker
- Development opportunity in lung, genitourinary, gastrointestinal and beyond
- Opportunity for monotherapy use in relapsed/refractory disease and acceleration of paradigm-changing combination in early lines of therapy (*i.e.*, dostarlimab combination)
- Potential for first-to-market in a variety of tumours
- Proof of concept studies to begin H2 2024 to support accelerated registrational pathway

Ad: adjuvant, ADC: antibody-drug conjugate, Eso: espohageal, HCC: hepatocellular carcinoma, HNSCC: head and neck squamous cell carcinoma, NSCLC: non-small cell lung cancer, ORR: overall response rate, RCC: renal cell carcinoma, SCLC: small cell lung cancer, STS: soft tissue sarcoma.

1. Adapted from Yamato, Mol Cancer Ther (2022) 21 (4): 635–646; dataset represents tested tumors and is not a complete list of all tumors that express B7-H3.

Ex-China licensing: includes China, Macau, Hong Kong and Taiwan.

Delivering upon our future ambition

Select oncology growth drivers

Ojjaara

>£1bn

in peak year sales[1]

- Anaemia burden increasingly at forefront of treatment decisions
- 56%/66% of US/EU physicians likely to switch to *Ojjaara/Omjjara* within next 6 months
- Geographic launch expansion

Jemperli

>£2bn

in peak year sales[1]

- Further uptake in 1L endometrial cancer
- Development beyond dMMR tumours
- Proprietary IO backbone being developed across a range of solid tumours

belrestotug & CD226 axis assets

>£2bn

in peak year sales[1]

- Novel combination strategies with all major targets of CD226 axis: TIGIT, CD96, PVRIG
- Current development focused in NSCLC and HNSCC, including doublets and triplets

GSK5764227 (B7-H3) & GSK5733584 (B7-H4) ADCs

Blockbuster potential

- Antigen overexpression in tumours with high unmet need
- Proprietary combinatorial potential, particularly with dostarlimab

Blenrep[2]

>£3bn

in peak year sales[1]

- Growth of BCMA class
- Broad patient eligibility
- HCP and patient desire for treatment use in outpatient, community setting

1L: first line, BCMA: B cell maturation antigen, ADC: antibody-drug conjugate, dMMR: deficient mismatch repair, HNSCC: head and neck squamous cell carcinoma, IO: immuno-oncology, NSCLC: non-small cell lung cancer.

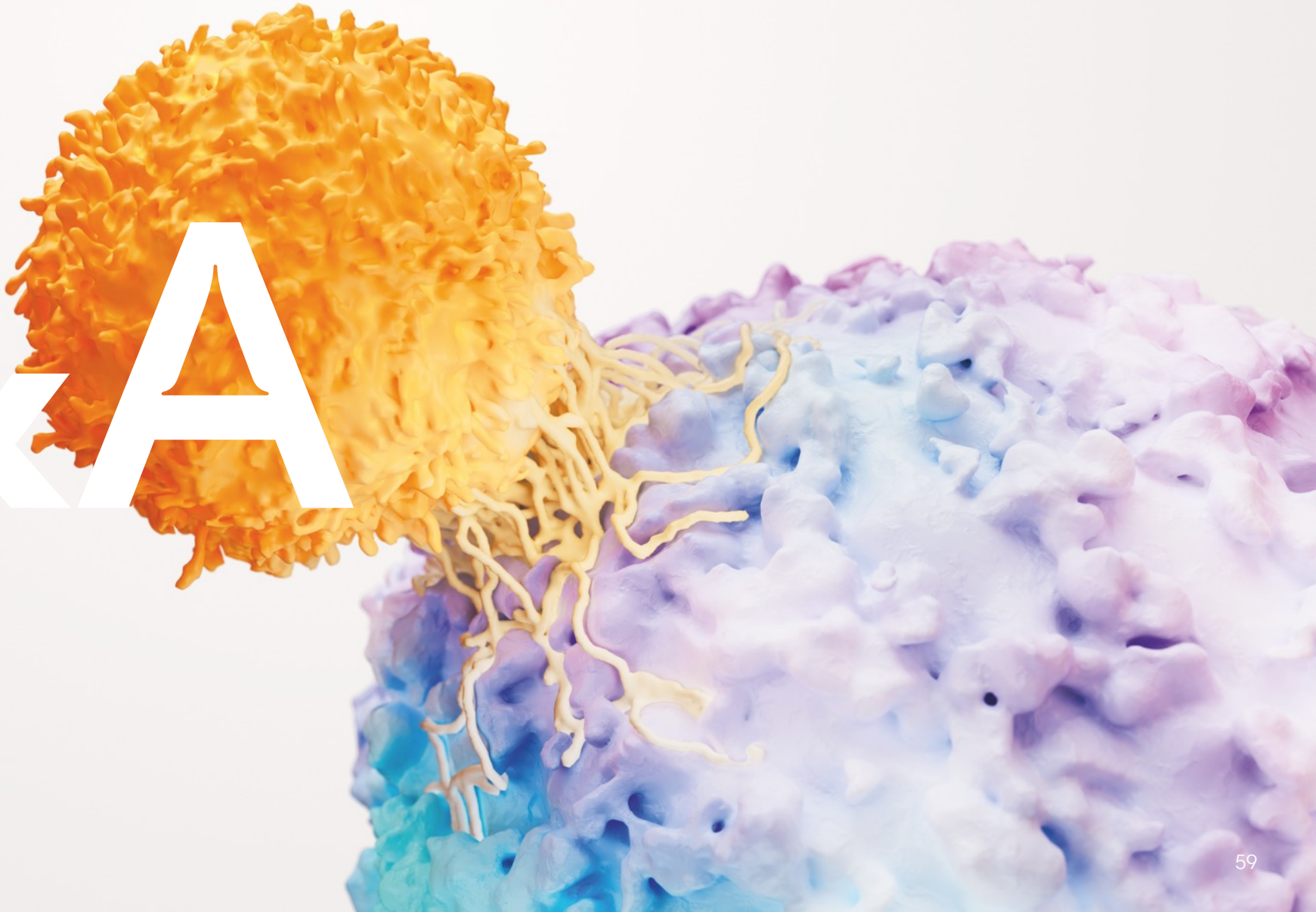
1. Non-risk adjusted peak year sales potential is subject to certain assumptions consistent with those for previous outlooks, ambitions and expectations. 2. *Blenrep* is not included in current GSK guidance.

Forthcoming catalysts

	Remainder of 2024	2025	2026+
Blenrep	**Regulatory filings** US, EU, JP & CHN (2L+ MM)	**Regulatory decisions** US, EU & JP (2L+ MM) **DREAMM-10** Phase III initiation (1L MM)	**Regulatory decisions** CHN (2L+ MM)
Jemperli	**Regulatory decision** US (1L EC all-comers)	**Regulatory decision** EU (1L EC all-comers) **COSTAR Lung *(with cobolimab)*** Phase III data readout (2L NSCLC)	**AZUR-1** Phase II data readout (locally advanced rectal) **AZUR-2** Phase III data readout (peri-operative colon) **JADE** Phase III data readout (unresected HNSCC)
GSK5764227 (B7-H3 ADC), GSK5733584 (B7-H4 ADC)	Initiation of new opportunities		
Ojjaara	**Regulatory decision** Japan (MF)	Initiation of new opportunities	
belrestotug & CD226 assets	**GALAXIES Lung-201** Phase II data readout (1L NSCLC) **GALAXIES Lung-301** Phase III initiation (1L NSCLC)		**GALAXIES H&N-202** Phase II data readout (1L HNSCC)
Zejula	**FIRST *(with dostarlimab)*** Phase III data readout (1LM OC) **ZEAL-1L** Phase III data readout (1LM NSCLC) **IVY supported collaborative study** Phase III initiation (GBM)		

1L: first line, 2L: second line, EC: endometrial cancer, GBM: glioblastoma, HNSCC: head and neck squamous cell carcinoma, MF: myelofibrosis, MM: multiple myeloma, NSCLC: non-small cell lung cancer, OC: ovarian cancer.

Q&A



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Use of GSK conference call, webcast and presentation slides

gsk.com