Post-ASH Blenrep investor call
10 December 2024

Cautionary statement regarding forward-looking statements

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Forward-looking statements are subject to assumptions, inherent risks and uncertainties, many of which relate to factors that are beyond the Group's control or precise estimate. The Group cautions investors that a number of important factors, including those in this presentation, could cause actual results to differ materially from those expressed or implied in any forward-looking statement. Such factors include, but are not limited to, those discussed under Item 3.D 'Risk factors' in the Group's Annual Report on Form 20-F for the full year (FY) 2023. Any forward-looking statements made by or on behalf of the Group speak only as of the date they are made and are based upon the knowledge and information available to the Directors on the date of this presentation.

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 Q3 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 54 of our stock exchange announcement of the Group's Q3 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 the Group's Annual Report on Form 20-F for FY 2023.

Today's agenda and speakers

Luke Miels
Chief Commercial Officer

Strategic context for Blenrep

Paul G. Richardson, MD
Dana-Farber Cancer Institute

DREAMM-7 OS update, and Practical application in clinical practice

Nina Mojas
SVP, Global Product Strategy

Positioning of Blenrep in 2L Multiple Myeloma

Hesham Abdullah, MD
SVP, Global Oncology R&D

Development program in Newly Diagnosed Multiple Myeloma

Mondher Mahjoubi, MD
SVP, Chief Patient Officer

Q&A

Multiple Oncology approvals in the next 3-5 years, expanding into a range of solid tumours with significant unmet need

Estimated approval timelines across Oncology portfolio

	Launched	2025	2026	2027+
Haematologic	Ojjaara Myelofibrosis	Blenrep 2L+ MM (DREAMM-7/8)		Blenrep 1L MM (DREAMM-10)
Gynaecologic	Jemperli Endometrial (RUBY Part 1) Zejula Ovarian	Jemperli + Zejula (FIRST) Ovarian		B7H4 ADC Endometrial, Ovarian
Lung			cobolimab NSCLC (COSTAR+dostar)	B7H3 ADC SCLC belrestotug (TIGIT) Lung (GALAXIES 301 + dostar)
GI				B7H3 ADC CRC Jemperli Colon, rectal (AZUR 1&2)
Other tumours			belrestotug (TIGIT) (GALAXIES H&N + dostar)	B7H4 ADC Breast Jemperli HNSCC (JADE)

MM: multiple myeloma, CRC: colorectal cancer, HNSCC: head and neck squamous cell carcinoma, NSCLC: non-small cell lung cancer. SCLC: small cell lung cancer. Timelines are illustrative.

Blenrep summary

- Blenrep combination shows statistically significant and clinically meaningful overall survival benefit, reducing the risk of death by 42% in RRMM compared to daratumumab-containing standard of care[1]
- Blenrep could be transformational for patients and physicians across both community and the academic settings
- Confident in the initiation of NDMM program given the strength of the data in RRMM and early data in NDMM
- Seven completed regulatory filings for RRMM, including in the US (PDUFA 23 July 2025)

RRMM: relapsed-refractory multiple melanoma; NDMM: Newly diagnosed multiple myeloma

1 Hungria V., Presented at ASH 2024, December 7-10; San Diego, United States .

DREAMM-7 OS update

Paul G. Richardson, MD
Dana-Farber Cancer Institute

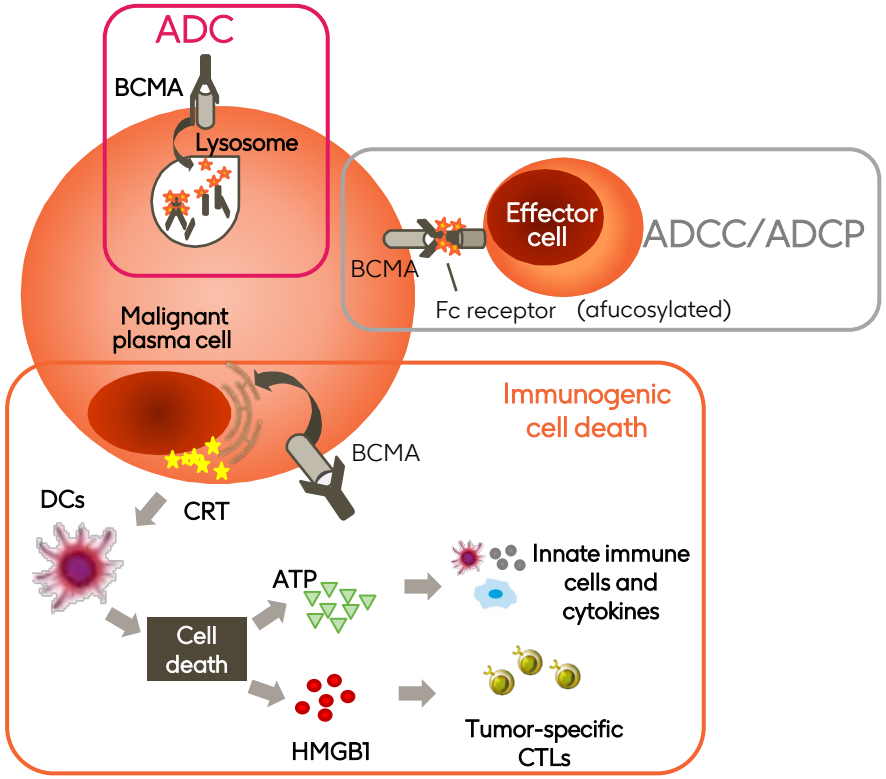
gsk.com

https://annualmeeting.hematology.org/session/250891

Blenrep multimodal mechanism of action

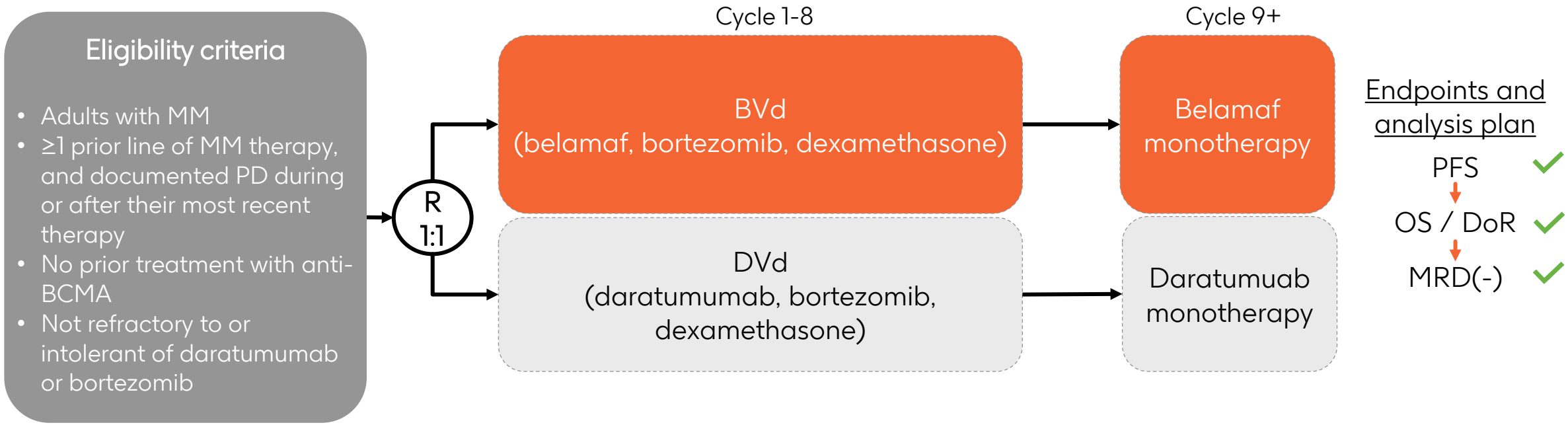
BCMA-targeting monoclonal antibody conjugated with a cytotoxic payload (MMAF)

- Payload induced direct cell death
- Antibody engineered to have ADCC
- MMAF induces immunogenic cell death, eliciting an immune response



ADC, antibody-drug conjugate; ADCC, antibody-dependent cellular cytotoxicity; ADCP, antibody-dependent cellular phagocytosis; ATP, adenosine triphosphate; BCMA, B-cell maturation antigen; CTL, cytotoxic T-lymphocyte; DC, dendritic cell; HMGB1, high-mobility group box 1; MM, multiple myeloma; MMAF,maleimidocaproyl monomethyl auristatin-F; SCT, stem cell transplant

DREAMM-7: Study design and endpoints



DOR, duration of response; MRD, minimal residual disease; OS, overall survival; PFS, progression-free survival; MM: Multiple myeloma; PD progressive disease; BCMA B-cell maturation antigen

Hungria V, et al. *N Engl J Med.* 2024;391(5):393-407.

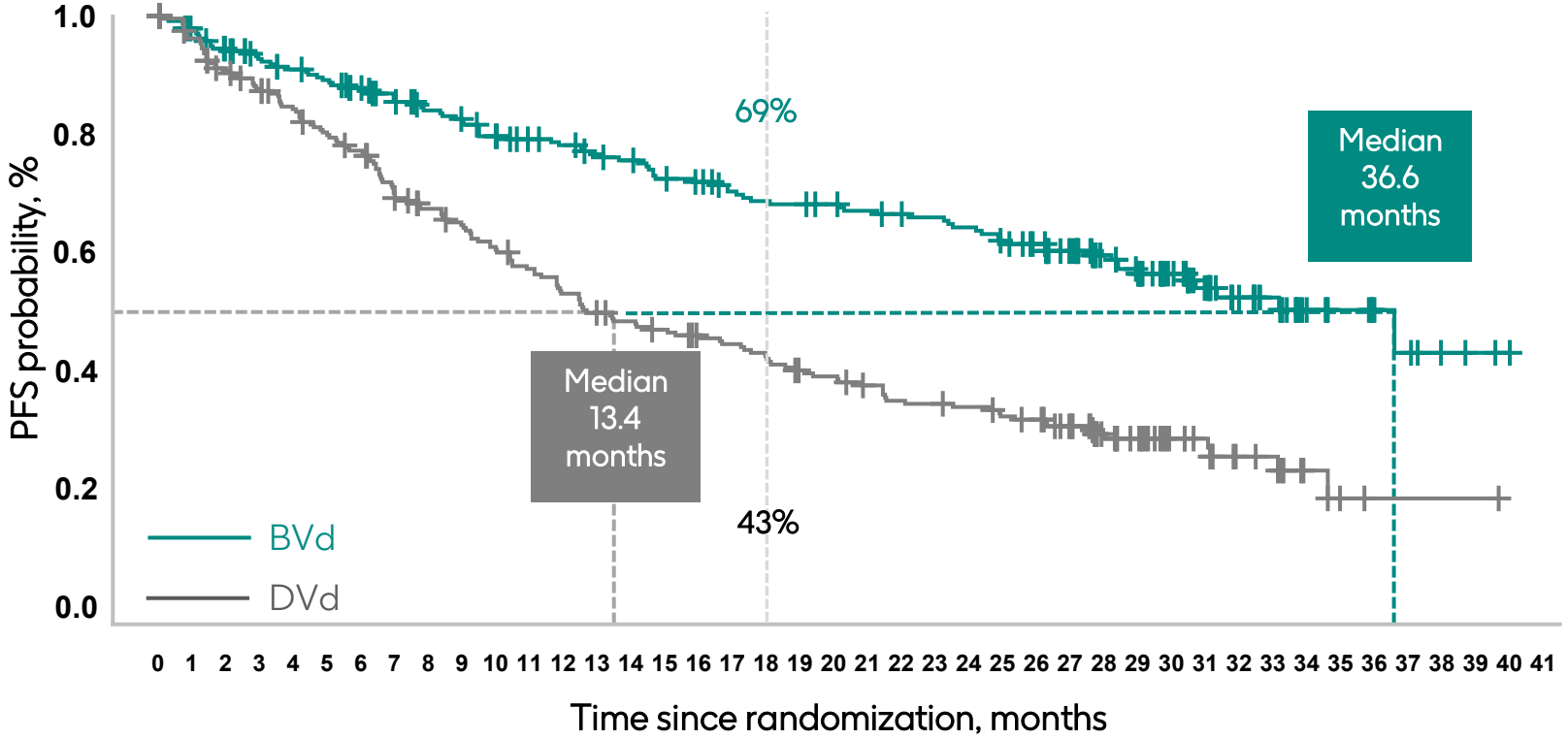
Baseline characteristics and prior treatments received were balanced across both arms

Baseline characteristics	ITT population	
	BVd (N=243)	DVd (N=251)
Age, median (range), years	65.0 (34-86)	64.0 (32-89)
Male, n (%)	128 (53)	144 (57)
ECOG PS ≤1, n/N (%)	232/242 (96)	235/246 (96)
R-ISS stage at screening, n (%)		
I	102 (42)	103 (41)
II	130 (53)	132 (53)
III	9 (4)	14 (6)
Cytogenetic abnormalities, n (%		
High risk	67 (28)	69 (27)
Standard risk	175 (72)	175 (70)
Prior lines of therapy		
1	125 (51)	125 (50)
2 or 3	88 (36)	99 (39)
4+	30 (12)	27 (11)
Prior proteasome inhibitor	218 (90)	216 (86)
Prior bortezomib	210 (86)	211 (84)
Prior immunomodulatory drugs	198 (81)	216 (86)
Prior lenalidomide	127 (52)	130 (52)
Refractory to lenalidomide	79 (33)	87 (35)
Prior daratumumab	3 (1)	4 (2)

BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; ITT, intent to treat; R-ISS, Revised International Staging System.

Hungria V, et al. *N Engl J Med.* 2024;391(5):393-407.

BVd nearly tripled median PFS vs DVd (36.6 vs 13.4 months)

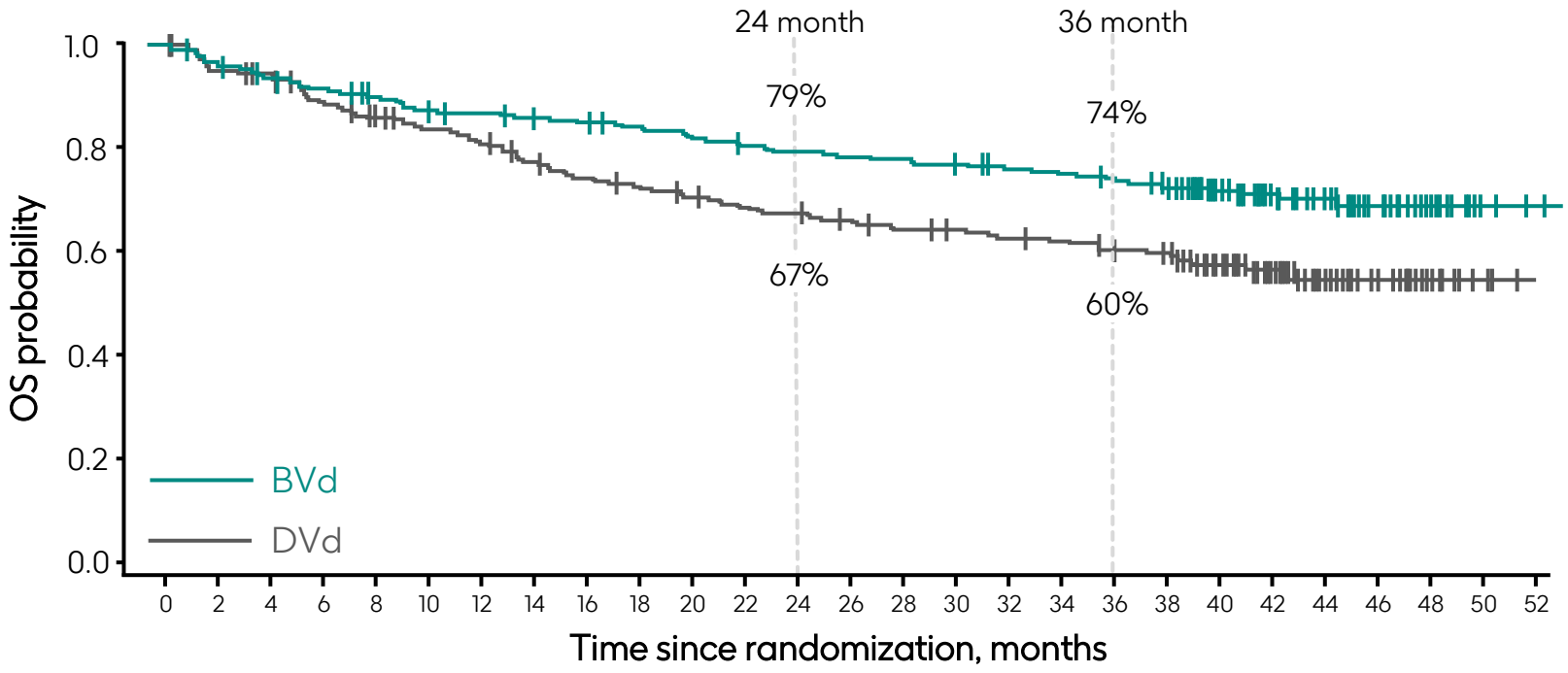


PFS	BVd (N=243)	DVd (N=251)
Events, n (%)	91 (37)	158 (63)
PFS, median (95% CI), mo	36.6 (28.4-NR)	13.4 (11.1-17.5)
HR (95% CI)	0.41 (0.31-0.53)	
P value	<0.00001	

BVd, belantamab mafodotin, bortezomib, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone, PFS progression free survival, HR Hazard ratio, CI confidence internal

Hungria V, et al. N Engl J Med. 2024;391(5):393-407

BVd had an early, sustained, and statistically significant Overall Survival benefit vs DVd



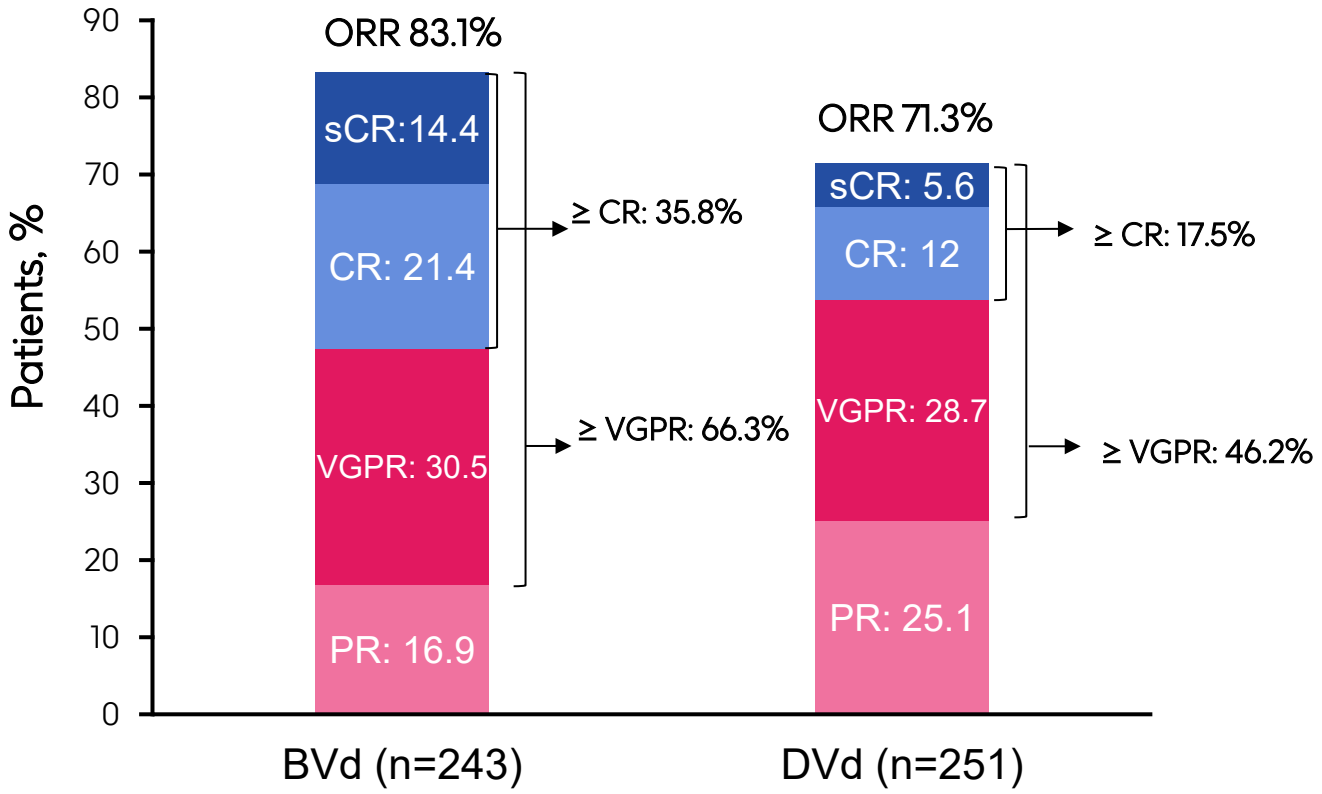
OS	BVd (N=243)	DVd (N=251)
Events, n (%)	68 (28)	103 (41)
OS, median (95% CI), months	NR (NR, NR)	NR (41.0,NR)
HR (95% CI)	0.58 (0.43-0.79)	
P value	0.00023	
24-month survival, % (95% CI)	79 (73-84)	67 (61-73)
36-month survival, % (95% CI)	74 (68-79)	60 (54-66)

Median OS was not reached.
Predicted median OS based on modeling was 84 months for BVd and 51 months for DVd

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

Hungria V., Presented at ASH 2024, December 7-10; San Diego, United States

Deeper responses reported with BVd vs Dvd with statistically significant MRD(-) benefit

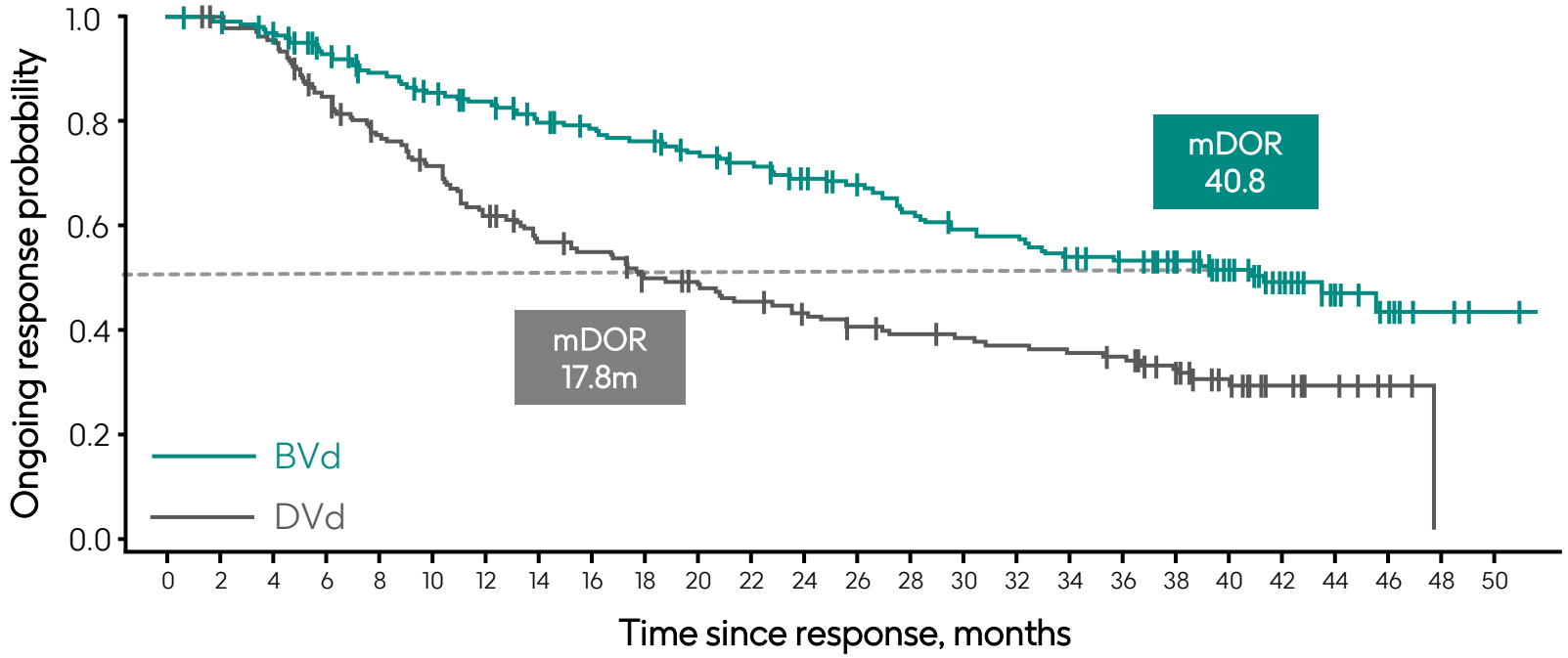


MRD(-) benefit

Patients, (95% CI), %	BVd (N=243)	DVd (N=251)
≥ CR and MRD negativity[b]	25.1 (19.8, 31.0)	10.4 (6.9, 14.8)
≥ VGPR and MRD negativity[b]	38.7 (32.5-45.1)	17.9 (13.2-23.2)

BVd, belantamab mafodotin, bortezomib, and dexamethasone; CR, complete response; DVd, daratumumab, bortezomib, and dexamethasone; ITT, intent to treat; MRD, minimal residual disease; PR, partial response; sCR, stringent complete response; VGPR, very good partial response.
Hungria V., Presented at ASH 2024, December 7-10; San Diego, United States

Duration of Response with BVd was more than double that of DVd



Duration of Response (DOR)	BVd (N=243)	DVd (N=251)
Responders, n	202	179
Events, n (%)	86 (43)	114 (64)
Patients with ongoing response, n (%)	79 (39)	39 (22)
DOR, median (95% CI), months	40.8 (30.5, NR)	17.8 (13.8-23.6)

- PFS2 also favored BVd vs DVd. HR 0.59 (95% CI, 0.45-0.77)

BVd, belantamab mafodotin, bortezomib, and dexamethasone;; DVd, daratumumab, bortezomib, and dexamethasone
Hungria V., Presented at ASH 2024, December 7-10; San Diego, United States

Eye-related side effects were manageable and reversible

Reprinted from Shi C, et al. *J Vis.* 2020;20(8):29. Copyright © 2020 The Authors.

BVd	Bilateral worsening of BCVA in patients with normal baseline 20/25 or better	
	20/50 or worse	20/200 or worse
Patients, n/N (%)	84/242 (35)	5/242 (2)
Time to onset of first event, median (range), days	79 (16-1320)	105 (47-304)
Time to resolution of first event to baseline, median (range), days	64 (8-908)	87 (22-194)
Time to improvement of first event, median (range), days	22 (6-257)	19 (8-26)
First event resolved, n/N (%)[b]	78/84 (93)	4/5 (80)
First event improved, n/N (%)	81/84 (96)	5/5 (100)
Follow-up ended with event ongoing, n/N (%)	3/84 (4)	0

Blurred vision was the most frequent eye-related side effects in the BVd arm with 24% Gr 3/4 events
Discontinuation due to any eye-related side effects was 10%

; BCVA, best-corrected visual acuity; BVd, belantamab mafodotin, bortezomib, and dexamethasone; CTCAE, Common Terminology Criteria for Adverse Events; DVd, daratumumab, bortezomib, and dexamethasone

Conclusions

- BVd is the only triplet combination compared with an anti-CD38 monoclonal antibody triplet (DVd) that has demonstrated
  - an early and sustained separation of OS KM curves
  - Statistically significant survival benefit; HR of 0.58, *p*=.00023
  - Predicted mOS based on modeling: 84 months for BVd vs 51 months for DVd
- BVd maintained durable and deep responses with more than double CR rates, MRD negativity rates, and median DOR, compared with DVd
- Safety profile was consistent with previous analysis and eye-related side effects were manageable and reversible with dose modifications
- Belamaf could be a new standard of care for patients with RRMM

BVd, belantamab mafodotin, bortezomib, and dexamethasone; CR, complete response; DOR, duration of response; DVd, daratumumab, bortezomib, and dexamethasone; MRD, minimal residual disease; OS, overall survival; HR, Hazard ratio; RRMM, relapsed or refractory multiple myeloma.

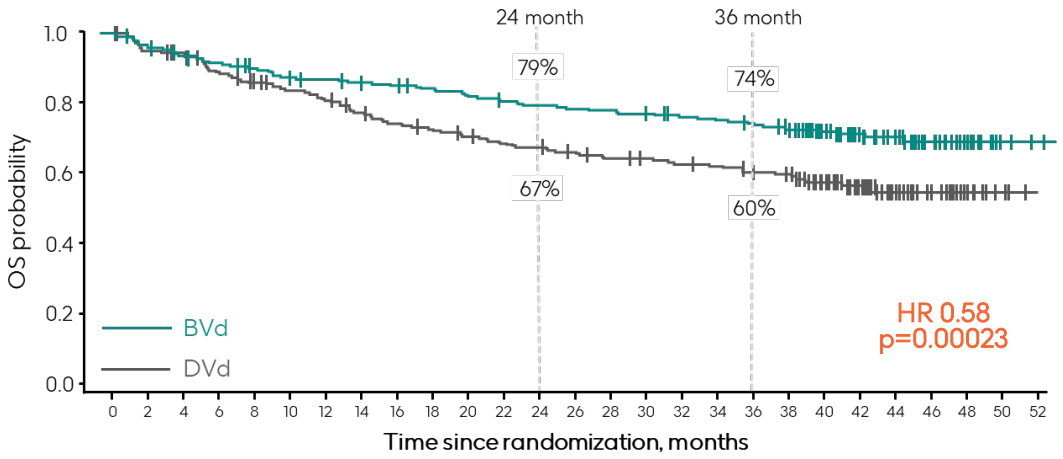
Relevance for clinical practice

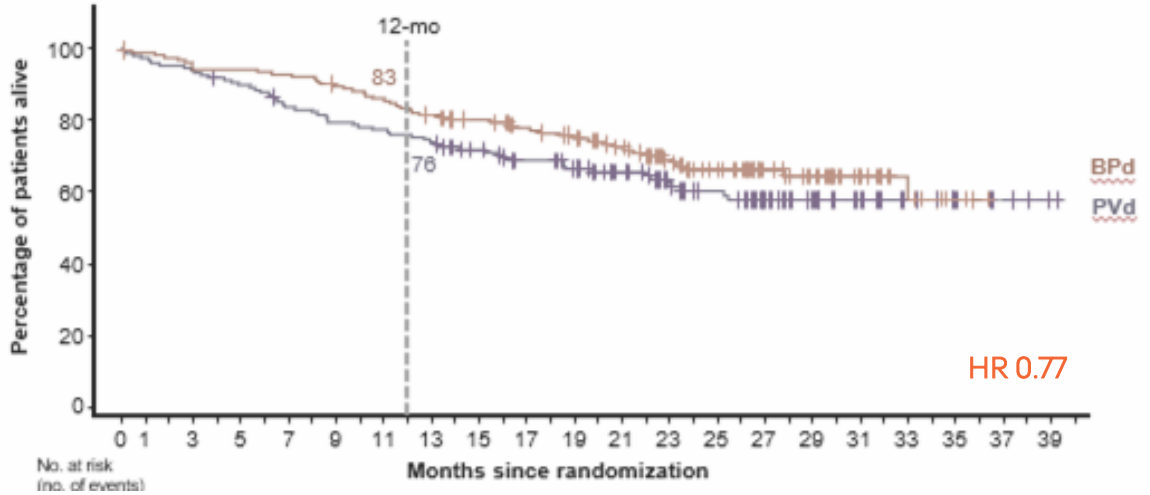
Paul G. Richardson, MD

Dana-Farber Cancer Institute

Blenrep is highly efficacious option for 2L MM

Overall Survival benefit across DREAMM-7[1] and DREAMM-8[2]





- Depth and durability of response: **CR/sCR rates and DoR doubled; 2.5-5x MRD(-) improvement**
- Eye-related side effects: 1) **Managed with dose modifications** without impacting efficacy
  2) **Reversible**

2L second line of therapy; MM Multiple myeloma; HR hazard ratio; CR complete response, sCR, DoR duration of response, MRD(-): minimal residual disease (negativity), sCR, stringent complete response

1 Hungria et al., ASH 2024, San Diego, United States, December 5-10
2 . Dimopoulos M, et al. NEJM 2024; 391: 408

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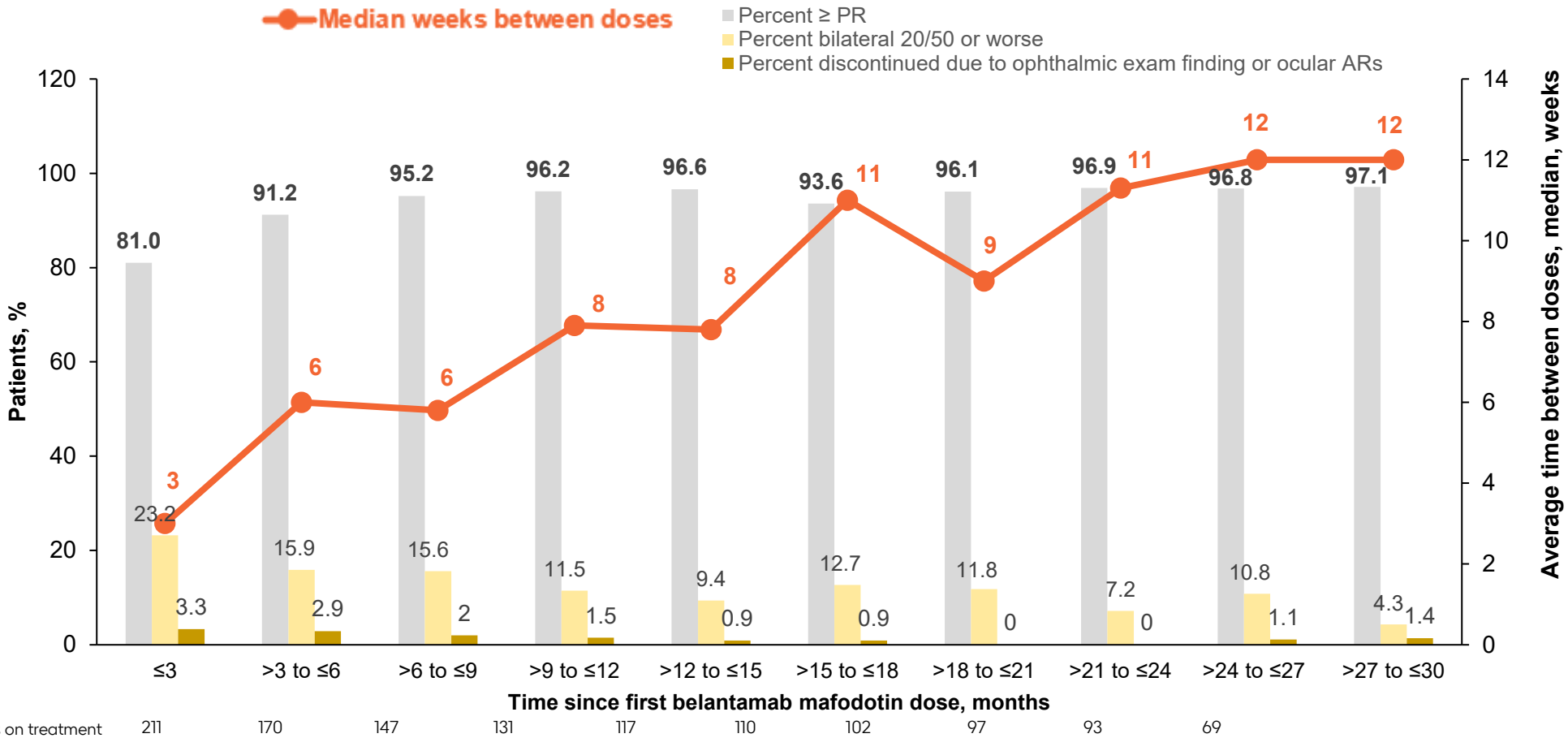
DREAMM-7: High response rates maintained with Blenrep dosing extended to ~8–12 weeks



Similar trends observed with extended dosing in DREAMM-8
Dosing frequency represents a low treatment burden, suitable for academic and community settings

AR, adverse reaction; BCVA, best-corrected visual acuity; BVd, belantamab mafodotin, bortezomib, and dexamethasone; CTCAE, Common Terminology Criteria for Adverse Events; KVA, Keratopathy and Visual Acuity; PD, progressive disease; PR, partial response.
Results from the primary analysis (data cutoff, October 2, 2023; Hungria et al., ASH 2024, San Diego, United States, December 5-10

- Blenrep is highly efficacious option for all 2L MM patient segments*
- Blenrep dosing in clinical studies extends to ~8-12weeks
- Majority of Grade3/4 eye-related side effects were blurred vision and were manageable and reversible
- Blenrep-based regimens can be used across all care settings without the need for hospitalizations

MM multiple myeloma; 2L second line of therapy
*once approved – Blenrep is not currently approved for treatment .

Positioning of Blenrep in RRMM

Nina Mojas
SVP, Oncology Global Product Strategy

1st relapse in MM is a critical moment in evolving treatment landscape

Need to use the most effective treatments at 1st relapse

2L 38k new patients per year

3L 21k new patients per year

17k patients lost

4L 12k new patients per year

9k patients lost

US + EU5 patient numbers

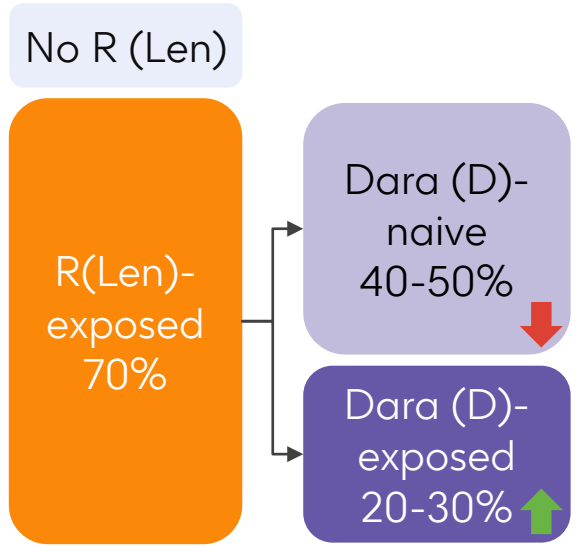
At 1st relapse, majority of 2L patients will be Len exposed

Historic 1L market (2022-2023)

- MAIA regimen (DRd)
- VRd
- Other

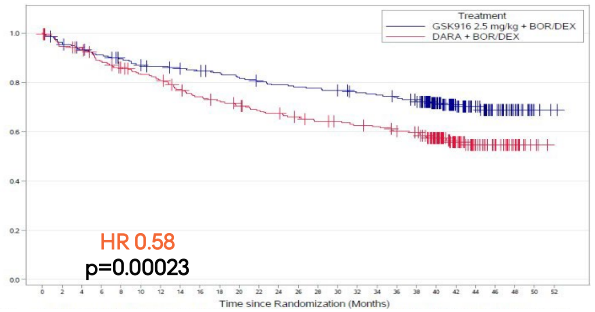
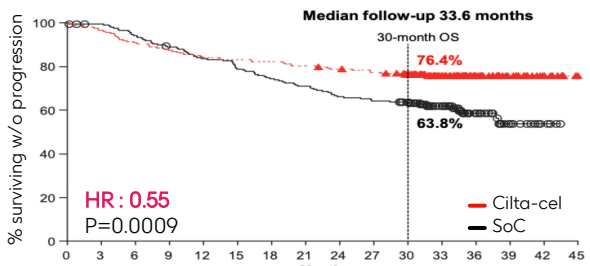
R: Revlimid (lenalidomide)
D: Darzalex (daratumumab)
V=Velcade (bortezomib)

Projected pretreatment profile for 2L patients in 2025



2L, second line therapy; 1L, first line of therapy; D/Dara, Darzalex/daratumumab; d, dexamethasone; R, Revlimid/lenalidomide; V, Velcade/bortezomib
US: drug treated estimates by line, 2021 Epiphany partners, EU5: Cerna Enviza patient metrics ; Fonseca R. et al. Impact of Treatment Sequencing on Overall Survival in Patients with Transplant-Ineligible Newly Diagnosed Myeloma, Oncologist 2023 May; 28(5): e263–e269; GSK Primary research US Q1 2024.

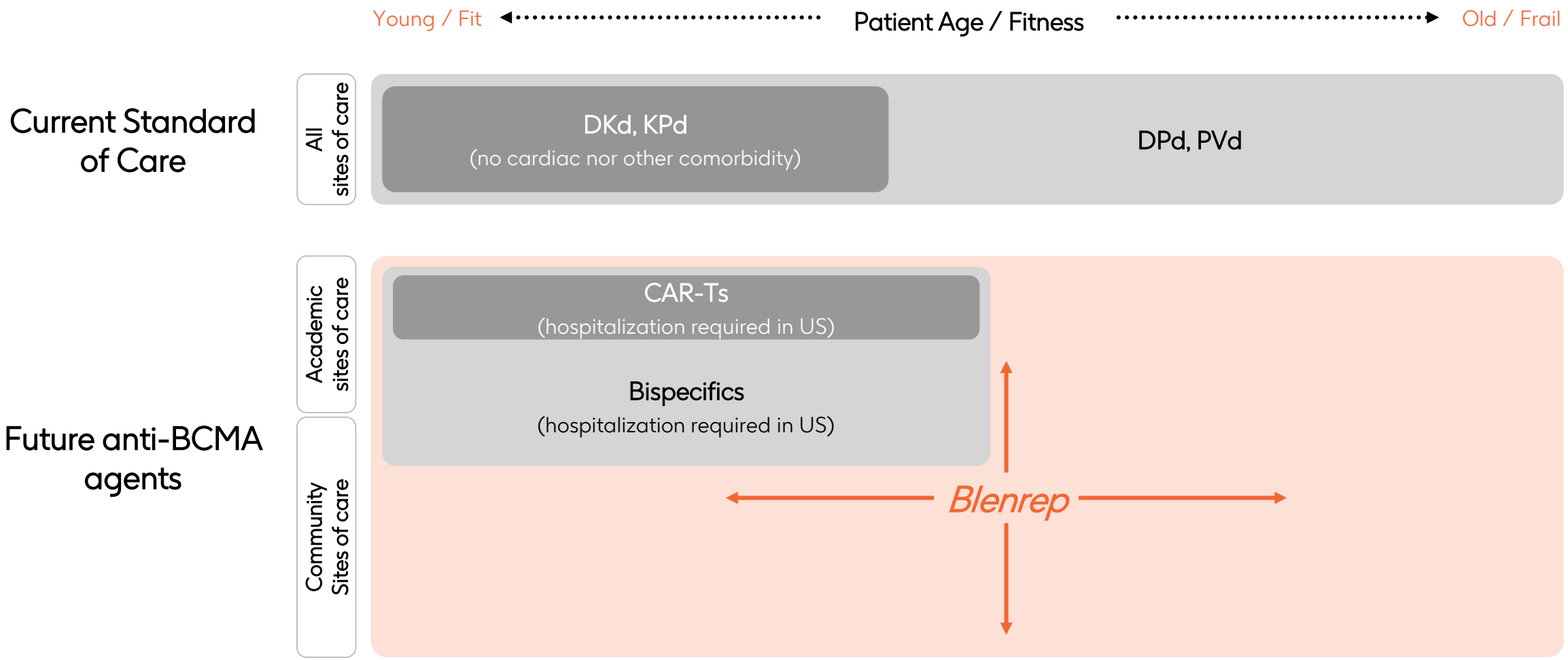
Blenrep offers option with Overall survival benefit and low treatment burden*

	Blenrep[3]	CAR-T (Cilta-cel)[1,2]	Bi-specific (Teclistamab)
OS			No OS data available
Response	Deep and durable response maintained through dose modification Statistically significant OS	Rapid, deep and durable response Statistically significant OS	High, rapid and deep response
Adverse events	Eye-related side effects, reversible and manageable	Parkinsonism and second primary malignancies[4,5,6]	Hospitalization to manage CRS and infections[7,8,9]
Ease of Use / Tx burden	Off-the-shelf, outpatient use 30 mins infusion DREAMM -7/8 indicate extended dosing	Highly specialised procedure Requires hospitalization & proximity to center of excellence	Off-the-shelf treatment with hospitalization Q4W IVIG; Teclistamab Q1-2W

B, BLENREP; D, darzalex; d, dexamethasone; HR, hazard ratio; IVIG, intravenous immunoglobulin; OS, overall survival; Q#W, every # weeks; Tx, treatment; V, Velcade; CRS Cytokine release syndrome
*once approved – Blenrep is not currently approved for treatment

1. San-Miguel J, et al. *N Eng J Med.* 2023;DOI: 10.1056/NEJMoa2303379; 2. Mateos MV, et al. IMS 2024, September 25–28; Rio de Janeiro, Brazil. OA-65;
3. Hungria V, et al. *N Engl J Med.* 2024;391(5):393-407; 4. Karschnia, P, *Blood*, 2023, 142(14), 1243–1248; 5. Hamilton, M. P., N Eng J Med. 2024, *390*(22), 2047–2060; 6. Ghilardi, G., *Nature Medicine*, 2024; 7. Gong Z. et al, *Blood* (2023) 142 (Supplement 1): 358; 8. Jourdes, A., *Clinical Microbiology and Infection*, 2024 30(6), 764–771; 9. Reynolds G., *Blood Adv*, 2023, 7 (19): 5898–5903.

Blenrep as an option for patient segments across care settings in 2L MM



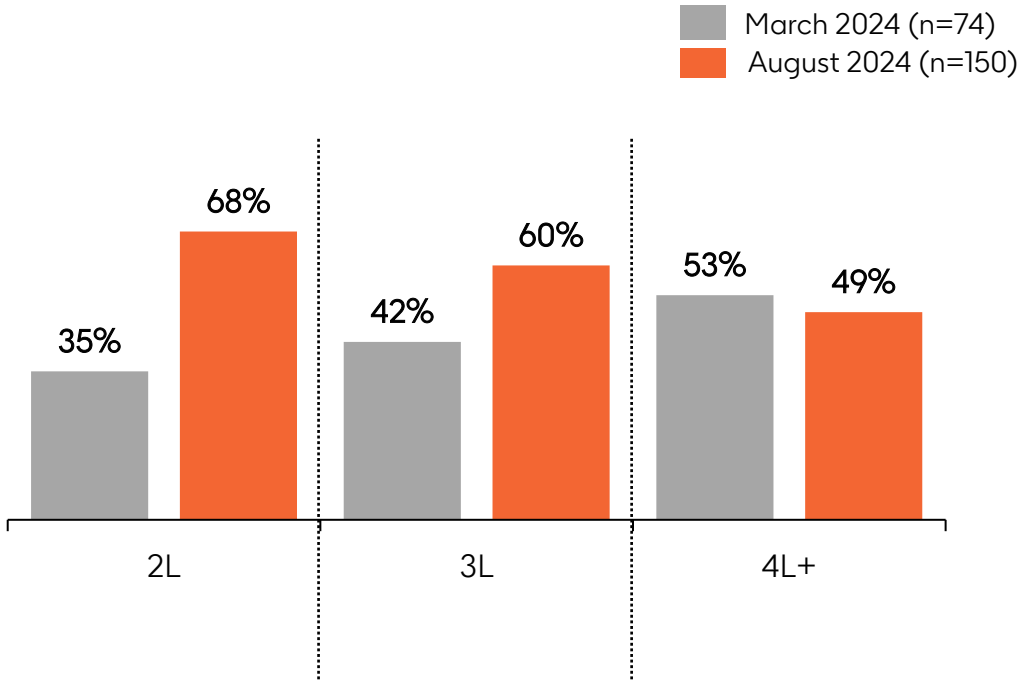
2L: second line, CAR-T: chimeric antigen receptor-T cell therapy, D: daratumumab, d: dexamethasone, K: carfilzomib, MM: multiple myeloma, P: pomalidomide, V: bortezomib;

Quantitative market research show strong momentum for anti-BCMA therapies and Blenrep

Anti-BCMAs expected to dominate across fit/intermediate fit populations

Line of therapy	Stated future BCMA shares
2L	52–66%
3L	51–69%
4L	51–71%

Proportion of US physicians who intend to prescribe BLENREP March[1] vs August 2024[2]



#L, number of treatment lines; BCMA, B-cell maturation antigen; HCP, healthcare professional; n= number of hematologists/oncologists
1. FirstWord conducted a survey of US-based hems/oncs, asking these providers how likely they would be to prescribe BLENREP for patients with both transplant-eligible and transplant-ineligible MM. The presented %s represent % who answered "Likely" or "Very Likely". 2. US Demand Research

Development program in Newly Diagnosed Multiple Myeloma (NDMM)

Hesham Abdullah, MD
SVP, Head of Oncology R&D

Ph1 DREAMM-9 **Blenrep Quad (BVRd)** in Transplant-Ineligible Newly Diagnosed Multiple Myeloma

Transplant-Ineligible Newly Diagnosed Multiple Myeloma (N=108)

Belamaf + VRd# bortezomib, lenalidomide, dexamethasone

- 1.9 mg/kg Q3/4W,
- 1.9 mg/kg Q6/8W
- 1.4 mg/kg Q3/4W
- 1.4 mg/kg Q6/8W
- 1.9 (9W) to 1.4 mg/kg Q9/12W
- 1.0 mg/kg Q3/4W
- 1.4 (9W) to 1.0 mg/kg Q9/12W
- 1.0 mg/kg Q12W

<u>Primary endpoint</u>
Safety

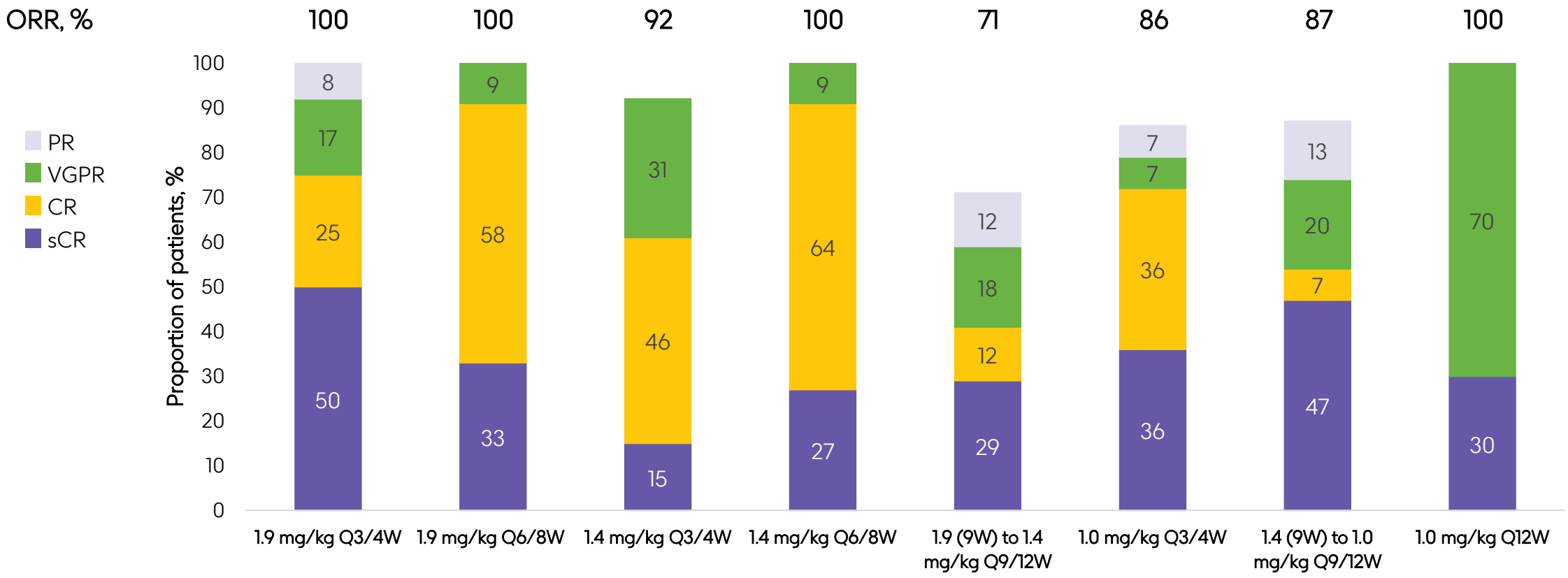
<u>Secondary endpoint</u>
Efficacy [ORR, MRD(-)]

Clinical pharmacokinetics

https://annualmeeting.hematology.org/session/251014

*Cohorts with longer rectangles opened earlier #(VRd Cycles 1–8, Rd [Cycles 9+])
belamaf, belantamab mafodotin; MM, multiple myeloma; MRD, minimal residual disease; QxW, every x weeks; VRd, bortezomib, lenalidomide and dexamethasone
Usmani S. et al, Presented at ASH 2024, December 7-10; San Diego, United States

Blenrep Quad achieved response of 100% at doses 1.4-1.9mg/kg and with schedules of 6-8 weeks

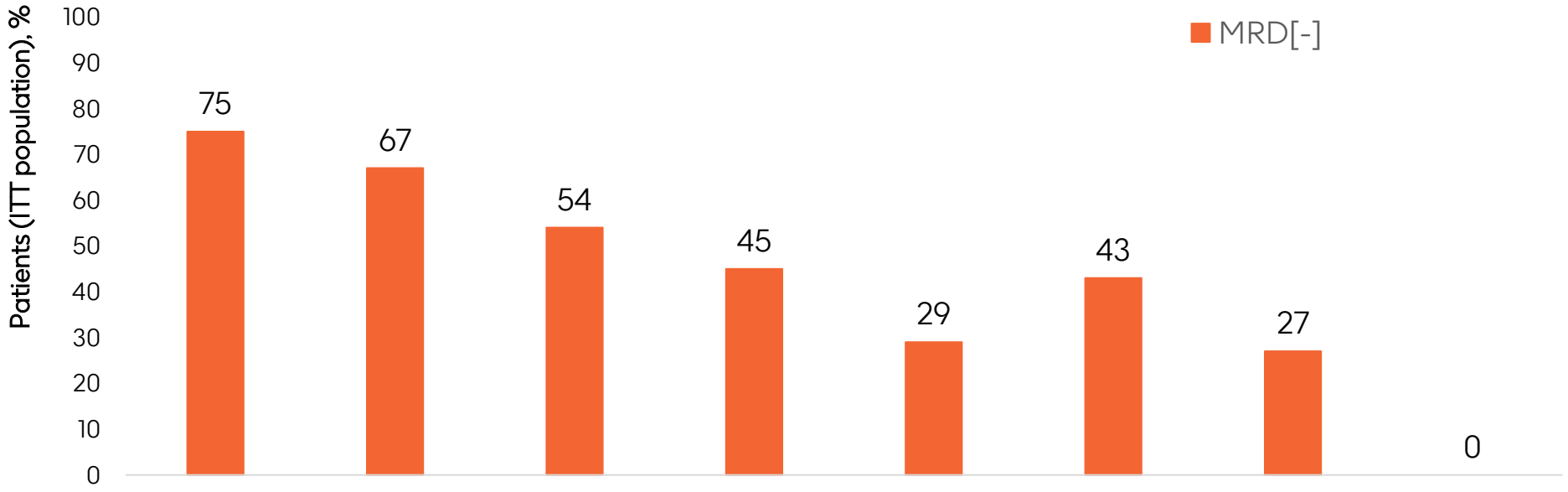


Number of patients	n=12	n=12	n=13	n=11	n=17	n=14	n=15	n=10
Median follow-up, months	37.6	32.3	20.2	32.4	17.1	31.0	18.2	7.8

CI, confidence interval; CR+, complete response or better; ORR, overall response rate; PR, partial response; QxW, every x weeks; sCR, stringent complete response; VGPR, very good partial response

Usmani S. et al, Presented at ASH 2024, December 7-10; San Diego, United States

High rates of MRD(-) achieved at doses 1.4-1.9mg/kg and with extended schedules of 6-8 weeks



	1.9 mg/kg Q3/4W	1.9 mg/kg Q6/8W	1.4 mg/kg Q3/4W	1.4 mg/kg Q6/8W	1.9 (9W) to 1.4 mg/kg Q9/12W	1.0 mg/kg Q3/4W	1.4 (9W) to 1.0 mg/kg Q9/12W	1.0 mg/kg Q12W
Median follow-up, months (MRD negativity typically assessed at ~18months	37.6	32.3	20.2	32.4	17	31.0	18.2	7.8

Belamaf, belantamab mafodotin; MRD[-], minimal residual disease negativity; QxW, every x weeks
Usmani S. et al, Presented at ASH 2024, December 7-10; San Diego, United States.

Preliminary DREAMM-9 Safety: Grade 3/4 event rates reduce with extended schedules

Belamaf schedule	1.9 mg/kg Q3/4W	1.9 mg/kg Q6/8W	1.4 mg/kg Q3/4W	1.4 mg/kg Q6/8W	1.9 (9W) to 1.4 mg/kg Q9/12W	1.0 mg/kg Q3/4W	1.4 (9W) to 1.0 mg/kg Q9/12W	1.0 mg/kg Q12W	Total
n	12	12	13	12	17	14	15	10	N=105
Median follow-up, months (range)	37.6 (7–50)	32.3 (6–38)	20.2 (1–37)	32.4 (5–37)	17.1 (1–23)	31.0 (0–38)	18.2 (2–22)	7.8 (5–10)	–
Grade 3/4 KVA events, n (%)	10 (83)	11 (92)	11 (85)	9 (75)	5 (29)	9 (64)	1 (7)	2 (20)	58 (55)
Grade 4 KVA events, n (%)	4 (33)	0	4 (31)	2 (17)	0	2 (14)	0	0	12 (11)
Total Grade 3/4 KVA events, no. of events (% of all assessments)	97 (26)	36 (10)	42 (14)	50 (18)	14 (6)	73 (22)	10 (4)	2 (3)	324 (15)
Total Grade 4 KVA events, no. of events (% of all assessments)	13 (3)	0	6 (2)	3 (1)	0	5 (2)	0	0	27 (1)
Discontinuation due to Grade ≥3 KVA events, n (%)	1 (8)	0	2 (15)	0	0	2 (14)	0	0	5 (5)

Belamaf, belantamab mafodotin; KVA, Keratopathy Visual Acuity; QxW, every x weeks
Usmani S. et al, Presented at ASH 2024, December 7-10; San Diego, United States

BLENREP quad could yield improved efficacy vs anti-CD38 quads in ALL NDMM patients, including high risk

BVRd (DREAMM-9) and Isa-VRd (IMROZ) in an all-comers population

	ORR	≥VGPR	MRD negativity (10^{-5})
BVRd[1] 1.9 mg/kg Q8W	100%	100%	67%

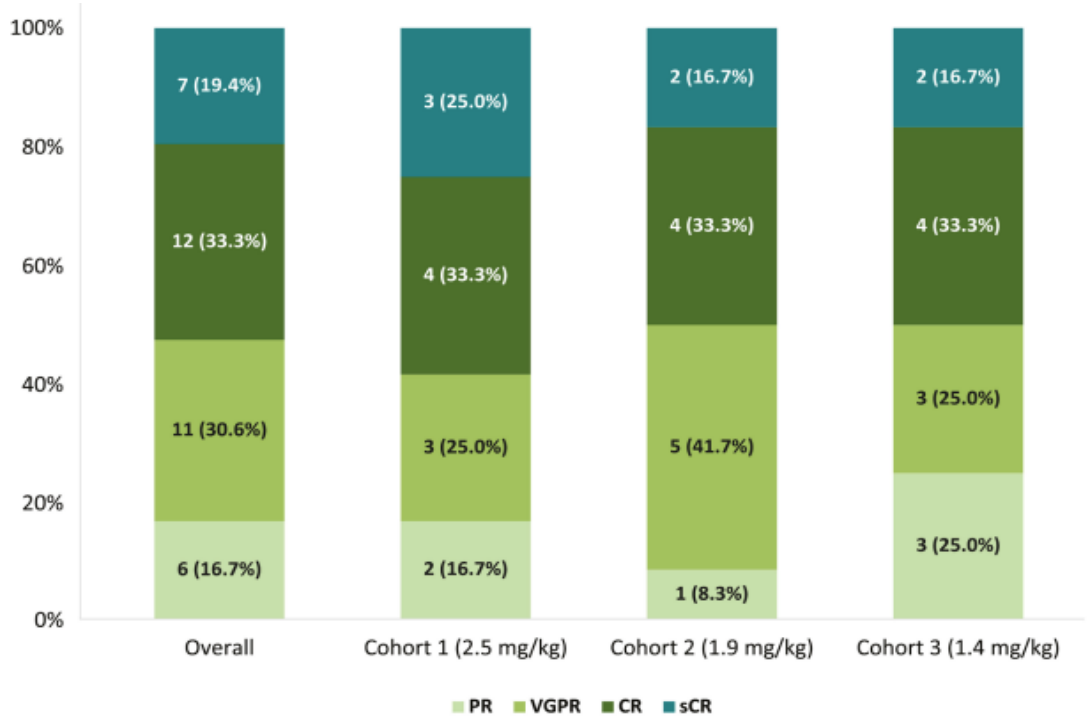
	ORR	≥VGPR	MRD negativity (10^{-5})
Isa-VRd[2] 10 mg/kg Q1/2W	91%	89%	56%

1L, first line of therapy; 2L second line of therapy; NDMM: newly diagnosed multiple myeloma; ORR overall response rate; VGPR: very good partial response; MRD(-): minimal residual disease (negativity); B, Belamaf; V, Velcade; R, Revlimid; d, dexamethasone; Isa, Isatuximab, Q#W, every # weeks

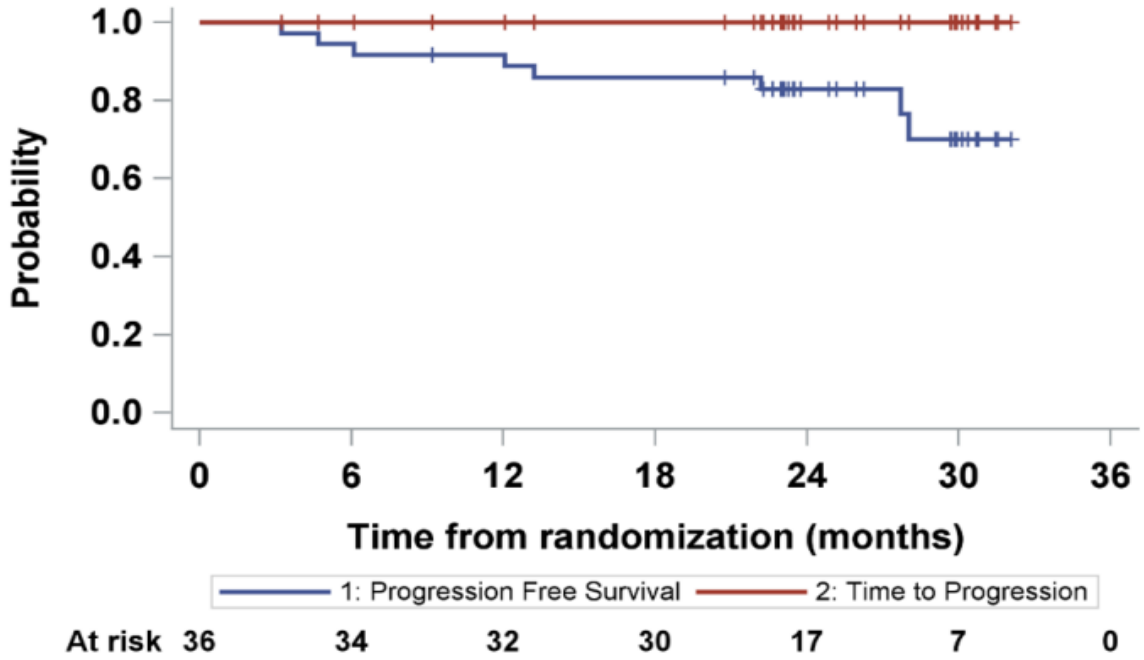
1. Usmani SZ, et al. Presented at the 66th American Society of Hematology Annual Meeting and Exposition, 2024; 2. Facon T, et al. *N Eng J Med.* 2024;391(17):1597–1609.

In addition, **Blenrep triplet** in NDMM showed 100% ORR and no disease progression to date

100% ORR across all cohorts
Median time to first response: ~1 month

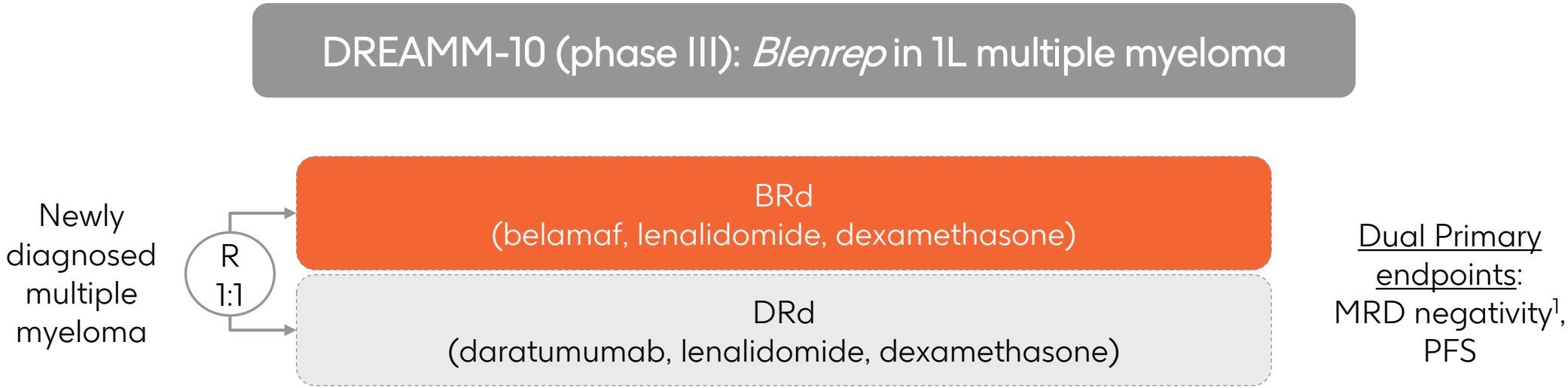


At median follow up of 24.8 months, no disease progression was observed*



*PFS Events: 8 deaths: COVID-19: 4 patients; Pneumonia: 2 patients; Sudden death: 1 patient; Intracranial haemorrhage: 1 patient
CR: complete response, PR: partial response, sCR: stringent complete response, VGPR: very good partial response.
Terpos et al., Haematologica. 2024 Aug 1;109(8):2594-2605; Terpos et al, 5" European Myeloma Network Meeting, April 18-20 2024., Turin

Study design for Blenrep triplet in 1L (DREAMM-10)



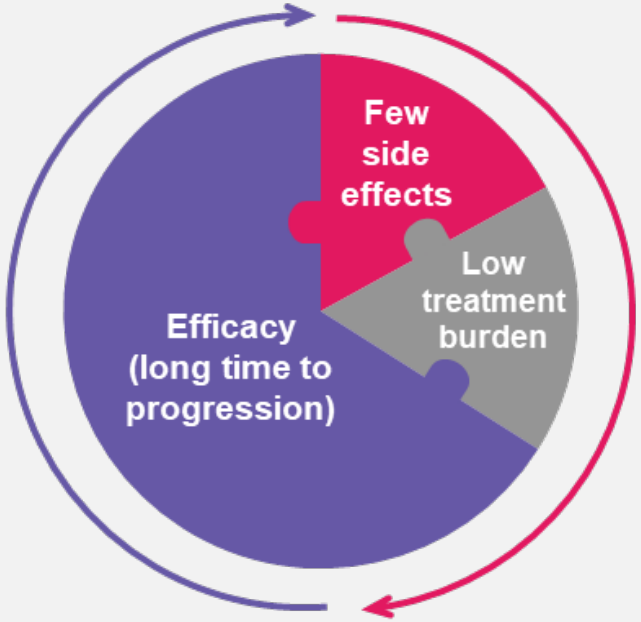
Trial expected to initiate imminently

1L: first line; PFS: Progression-free survival, MRD(-): minimal residual disease (negativity)
1 Oncology Drugs Advisory Committee (ODAC) has voted unanimously in favour of MRD testing as an early endpoint in multiple myeloma

Summary
Q&A

Blenrep is well positioned to improve outcomes in RRMM

Blenrep is the only anti-BCMA treatment that has the potential to address multiple patients' needs



>£3bn PYS potential

- Blenrep combination shows statistically significant and clinically meaningful overall survival benefit, reducing the risk of death by 42% in RRMM compared to daratumumab-containing standard of care
- Blenrep could be transformational for patients and physicians across both community and the academic settings
- Confident in the initiation of NDMM program given the strength of the data in RRMM and early data in NDMM

BCMA, B-cell maturation antigen; PYS, peak year sales; RRMM, relapsed or refractory multiple myeloma; NDMM newly diagnosed multiple myeloma

Appendix

Luke Miels

Chief Commercial Officer

Luke Miels joined GSK and the GLT in 2017. As Chief Commercial Officer he is responsible for our commercial portfolio of medicines and vaccines.

Luke also co-chairs the Portfolio Investment Board with Tony Wood and is a member of the ViiV Healthcare Board.

Outside of GSK, Luke is a member of the Singapore Economic Development Board.

He previously worked for AstraZeneca as Executive Vice President of their European business and, prior to that, was Executive Vice President of Global Product and Portfolio Strategy, Global Medical Affairs and Corporate Affairs. Before that, he was head of Asia for Roche, based in Shanghai and then Singapore. Prior to that he held roles of increasing seniority at Roche and Sanofi-Aventis in the US, Europe and Asia.

Luke holds a Bachelor of Science degree in Biology from Flinders University in Adelaide and a MBA from the Macquarie University, Sydney.

Paul G. Richardson, MD

Dana-Farber Cancer Institute

Paul Richardson, MD - After certification in Internal Medicine, Hematology and Medical Oncology, as well as working in Cancer Pharmacology and stem cell transplant from 1994 onwards at Dana-Farber Cancer Institute (DFCI), Dr. Richardson joined the Jerome Lipper Myeloma Center in 1999, was appointed Clinical Director in 2001, and led the study and development of several pivotal novel drugs including thalidomide, lenalidomide, bortezomib, pomalidomide, panobinostat, daratumumab, elotuzumab, and ixazomib. In this context, Dr. Richardson was appointed the inaugural RJ Corman Professor of Medicine at Harvard Medical School in 2012, and then became Clinical Program Leader and Director of Clinical Research in 2014.

Subsequent studies have focused on newer novel drugs including various small molecules, such as the third-generation proteasome inhibitor marizomib, next-generation monoclonal antibodies, histone deacetylase inhibitors, other small molecule inhibitors, targeted cytotoxics, and evolving strategies for new immunomodulatory therapy, including the groundbreaking oral CelMoD mezigdomide, all with the goal of further improving patient outcomes. Recent approvals have included selinexor (2019), isatuximab (2020), belantamab mafodotin (2020), and melflufen (2021), for all which Dr. Richardson has had a leadership role in clinical development, as well as contributions to the successful translation of these therapeutic agents from bench to bedside. Importantly, Dr. Richardson has made contributions toward the management of key side effects, including treatment-emergent neuropathy in myeloma, its characterization, and strategies to minimize it.

Honors include several Partners in Excellence Awards; the George Canellos Award for Excellence in Clinical Research and Patient Care, and The Tisch Outstanding Achievement Award for Clinical Research, as well as an honorary Fellowship of the Royal College of Physicians (UK), given in recognition for international contributions in multiple myeloma and stem cell transplantation.

Nina Mojas

SVP, Global Product Strategy

Nina Mojas is the Senior Vice President of Global Product Strategy, Oncology. Her extensive experiences, expertise in oncology, and her global, strategic mindset is an asset to the GSK commercial organisation as the focus is on delivering transformational medicines to patients living with cancer.

Nina joined GSK from AstraZeneca where she was the Oncology Business Unit Director for Switzerland and oversaw five new oncology launches in less than a year. Prior to this role, she was the Vice President and Global Medicines Lead for Lynparza (olaparib), based in Cambridge UK, leading the Global Product Team across Breast, Pancreatic, and Prostate indications. Before the Lynparza program expanded to additional indications, Nina was the sole Global Medicines Leader for the product. She started in AstraZeneca as the VP, Head of Oncology Search and Evaluation which established multiple external collaborations and inlicensing agreements, among others, the acquisition of Acerta Pharma which brought Calquence into AstraZeneca pipeline in 2016. She also built the team of Oncology Early Portfolio Directors who support early portfolio assets and provide commercial and strategic guidance. During this period, Nina actively supported Cancer Enterprise in establishing the new governance process for the Oncology programs.

Prior to AstraZeneca, Nina spent just over four years at Roche in Basel, Switzerland, where she worked in the Investor Relations (IR) team. Nina obtained her PhD from the University of Zurich, Switzerland in the field of DNA damage response. After finalising her postdoctoral studies, she worked in a sellside brokerage as a healthcare specialist.

Hesham Abdullah, MD

SVP, Global Oncology R&D

Hesham A. Abdullah, MD, is Senior Vice President and Global Head of Development, Oncology at GSK, where he oversees the end-to-end strategic development and delivery of GSK's oncology clinical-stage portfolio. Hesham is a proven global drug developer whose leadership and oversight responsibilities have led to multiple oncology product approvals including Iressa, Lynparza, Tagrisso, Imfinzi, Calquence, Lumoxiti, Zejula, Blenrep and Jemperli, while setting numerous drug development precedents along the way. Hesham is a seasoned researcher, clinician and senior executive with wide-ranging experiences in biopharmaceutical research and development, including small and large molecules, spanning across early and late stages of development, in both solid and haematological malignancies.

Hesham has an established track record of building high performing global teams in complex and highly matrixed environments, most recently re-establishing the role of Oncology Clinical Development in functional and strategic decision making at GSK. Prior to leading Oncology Development at GSK, Hesham rebuilt the Late Stage Immuno-Oncology Development and Oncology Global Regulatory Sciences functions at AstraZeneca.

Hesham originally started his biopharmaceutical career at Amgen and subsequently joined AstraZeneca in 2011. He has over 17 years of oncology and immunooncology drug development experience, with roles of increasing responsibility and leadership across Oncology Development functions. He holds an MD from the University of Cairo School of Medicine and is trained in internal medicine. Additionally, he holds a Master's degree in Regulatory Sciences from the University of Southern California (USC) and is currently a candidate for a Doctoral degree in Regulatory Sciences (DRSc) at USC.

Mondher Mahjoubi, MD

SVP, Chief Patient Officer

Dr. Mondher Mahjoubi is the Chief Patient Officer of GSK Pharma. He was previously chief executive officer and chairman of the executive board at Innate Pharma. Prior to joining Innate, Dr. Mahjoubi led AstraZeneca's oncology therapy area franchise, playing an instrumental role in driving its oncology strategy.

He also served as the senior vice president of global product strategy at Genentech; before that, he held marketing and medical affairs roles at Roche, Mayne Pharma, Sanofi-Aventis and Rhone Poulenc Rorer. Dr. Mahjoubi is a medical oncologist trained at the Institut Gustave Roussy (Paris-Villejuif).

He holds an M.D. from the University of Tunis and certifications in medical oncology from the University of Tunis and University of Paris Sud, as well as in clinical research and methodology from the University of Lariboisiere-Saint Louis.