Investor Science Event

Getting ahead of anaemia due to chronic kidney disease

ASN Kidney Week 2021

7 November 2021

Cautionary statement regarding forward-looking statements

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.

Other than in accordance with its legal or regulatory obligations (including under the Market Abuse Regulations, UK Listing Rules and the Disclosure Guidance and Transparency Rules of the Financial Conduct Authority), the Group undertakes no obligation to update any forward-looking statements, whether as a result of new information, future events or otherwise. Investors should, however, consult any additional disclosures that the Group may make in any documents which it publishes and/or files with the US Securities and Exchange Commission (SEC). All investors, wherever located, should take note of these disclosures. Accordingly, no assurance can be given that any particular expectation will be met and investors are cautioned not to place undue reliance on the forward-looking statements.

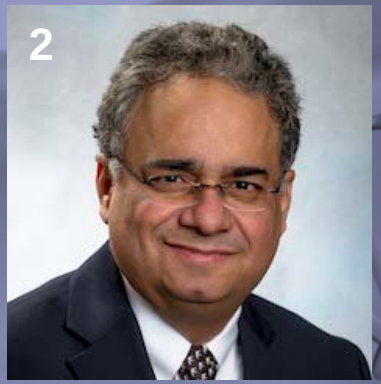
Forward-looking statements are subject to assumptions, inherent risks and uncertainties, many of which relate to factors that are beyond the Group's control or precise estimate. The Group cautions investors that a number of important factors, including those in this presentation, could cause actual results 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 FY 2020 and any impacts of the COVID-19 pandemic. 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 our third quarter 2021 earnings release and Annual Report on Form 20-F for FY 2020.

All expectations and targets regarding future performance and the dividend should be read together with the section "Outlook, assumptions and cautionary statements" on pages 60 and 61 of our third quarter 2021 earnings release.

Speakers

1. Dr Hal Barron
2. Dr Ajay Singh
3. Luke Miels



Agenda

Daprodustat: a potential best-in-class treatment	Dr Hal Barron
ASCEND Phase III programme	Dr Ajay Singh
Commercial opportunity	Luke Miels
Q&A	Dr Hal Barron Luke Miels Chris Corsico Dr Ajay Singh John Lepore

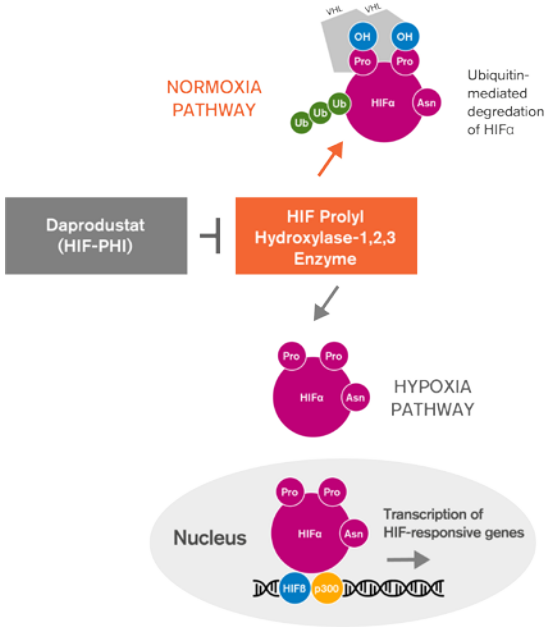
Daprodustat: a potential best-in-class treatment

Dr Hal Barron, Chief Scientific Officer and President, R&D

Daprodustat

Potential best-in-class treatment for patients with anaemia due to CKD[1]

Nobel prize-winning science



ASCEND[2]: Phase III clinical development programme with large geographical reach

- >8,000 patients with anaemia due to CKD[3] in five Phase III trials
- Consistent clinical trial programme:
  - Active control (injectable ESA[4])
  - One global Hb[5] target range (10-11 g/dl)
  - Standardised patient management methods[6]
- Trial design and primary MACE[7] end-point aligned with global regulators
- No meta-analysis required
- Studies in dialysis (peritoneal, and haemodialysis) and non-dialysis

High unmet medical need

>700 million

people suffer from chronic kidney disease worldwide[8]

One in seven patients suffer from anaemia of CKD where the current standard of care is administered via subcutaneous injection or as part of dialysis

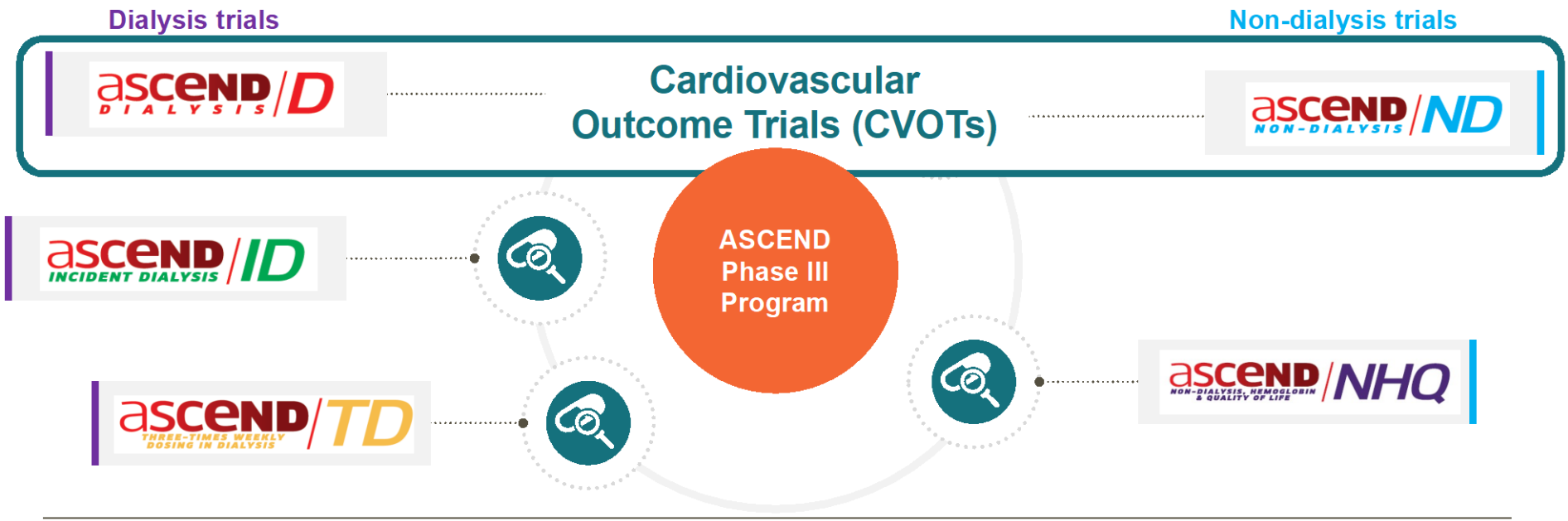
1. Chronic kidney disease 2. Anaemia Studies in Chronic Kidney Disease: Erythropoiesis via a Novel prolyl hydroxylase inhibitor Daprodustat 3. Presented at American Society of Nephrology Kidney Week 2021: Singh AK, et al. FR-OR66 and PO0465; Coyne DM, et al PO0487; and Johensen KL, et al FR-CR53 4. Erythropoiesis-stimulating agents 5. Haemoglobin 6. Dose adjustment algorithms, iron management criteria and anaemia rescue algorithms 7. Evaluating a composite of all-cause mortality, stroke and myocardial infarction 8. *The Lancet*, The Global Burden of Chronic Kidney Disease published in February 2020.

ASCEND Phase III programme

Dr Ajay K. Singh, Senior Associate Dean for Postgraduate Medical Education from Harvard Medical School, and Principal Investigator

ASCEND Clinical Trial Program

The **A**nemia **S**tudies in **C**hronic Kidney Disease: **E**rythropoiesis via a **N**ovel prolyl hydroxylase inhibitor **D**aprodustat (**ASCEND**) Phase III program investigated the efficacy and safety profile of daprodustat across a spectrum of patients with CKD

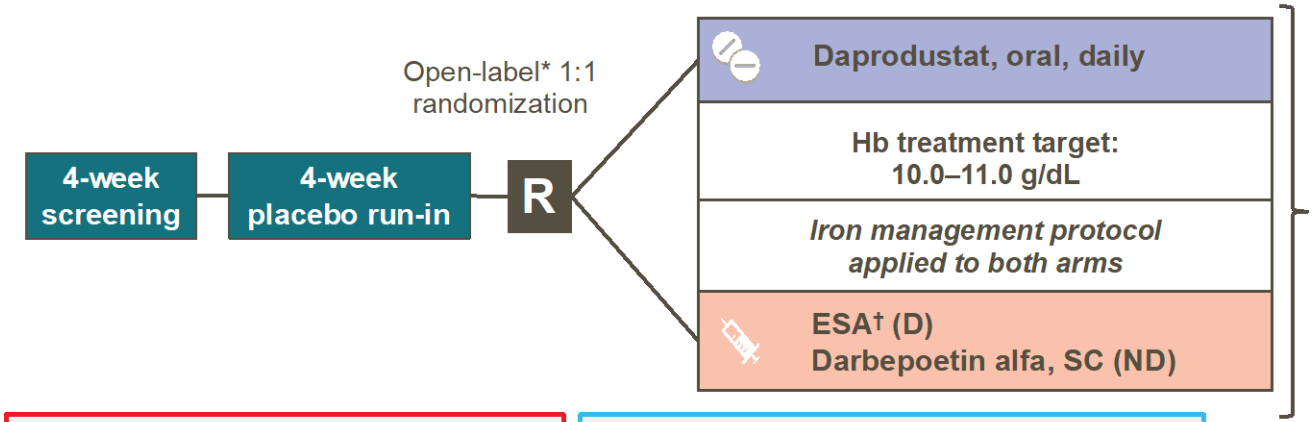


CKD, chronic kidney disease; D dialysis; Hb, hemoglobin; ID, incident dialysis; ND, non-dialysis; NHQ, TD, three times a week dosing.

ASCEND-D and -ND: Trial Design

Event-driven, open-label, randomized, active-controlled, parallel-group, multicenter, Phase 3 trials

ASCEND-D and ASCEND-ND accepted for publication



Co-primary Endpoints

Mean change in Hb from baseline to the average during the primary evaluation period (Week 28 through Week 52)

Time to first MACE‡ (target 664 adjudicated first events)

ASCEND-D: Key Entry Criteria

- ≥18 years of age
- Randomization Hb criteria:
  - Hb 8.0–11.5 g/dL
- ESA users
- Dialysis (HD/PD) >90 days prior to screening
- Iron replete: Ferritin >100 ng/mL; TSAT >20%

ASCEND-ND: Key Entry Criteria

- ≥18 years of age
- CKD Stage 3–5
- Randomization Hb criteria:
  - Hb 8.0–10.0 g/dL, if not using ESAs
  - Hb 8.0–11.0 g/dL, if using ESAs
- Not on dialysis and no plans to start within 90 days
- Iron replete: Ferritin >100 ng/mL; TSAT >20%

*The sponsor, steering committee and endpoint adjudication committee remained blind to aggregate treatment assignment throughout the trial.
†Epoetin alfa (IV; HD patients) or darbepoetin alfa (SC; PD patients). ‡MACE: composite of all-cause mortality, a non-fatal myocardial infarction, or a non-fatal stroke.
CKD, chronic kidney disease; ESA, erythropoiesis-stimulating agent; Hb, hemoglobin; HD, hemodialysis; IV, intravenous; MACE, major adverse cardiovascular event; PD, peritoneal dialysis; R, randomization; SC, subcutaneous; TSAT, transferrin saturation.

Patient Disposition

ITT Population

Few patients withdrew and withdrawal rates were similar across treatment groups
Premature discontinuation of randomized treatment was balanced across treatment groups
Known vital status was high in both trials across both treatment groups

ASCEND-D DIALYSIS	Daprodustat	ESA
Randomized, n	**2964**	
Intent-to-treat, n	1487	1477
Withdrew from trial, %	**8**	**8**
Completed the trial	92	92
Prematurely discontinued RT, %	**53**	**53**
Did not prematurely discontinue RT	47	47
Known vital status, %	**98**	**98**
Unknown vital status	2	2

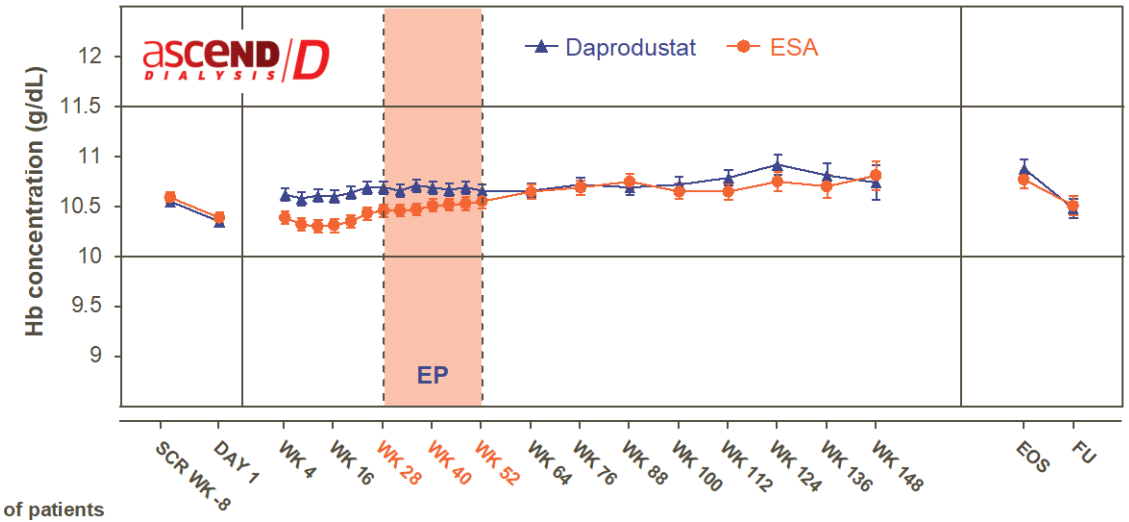
ASCEND-ND NON-DIALYSIS	Daprodustat	Darbepoetin alfa
Randomized, n	**3872**	
Intent-to-treat, n	1937	1935
Withdrew from trial, %	**3**	**3**
Completed the trial	97	97
Prematurely discontinued RT, %	**38**	**38**
Did not prematurely discontinue RT	62	62
Known vital status, %	**99**	**99**
Unknown vital status	<1	<1

ITT, intent-to-treat; RT, randomized treatment.
Note: In ASCEND-D, 5 daprodustat and 3 ESA patients were randomized but never treated. In ASCEND-ND, 2 darbepoetin alfa patients were randomized but never treated.

Co-primary Efficacy Endpoint: ASCEND-D

Mean Hb change from baseline to the evaluation period (Weeks 28–52) – ITT Population

Daprodustat was noninferior to ESA for mean change in Hb from baseline to the evaluation period (Weeks 28–52)



No. of patients	SCR WK -8	DAY 1	WK 4	WK 16	WK 28	WK 40	WK 52	WK 64	WK 76	WK 88	WK 100	WK 112	WK 124	WK 136	WK 148	EOS	FU
Daprodustat	1487	1485	1453	1403	1336	1274	1241	1191	1138	1092	1039	863	612	432	248	862	639
ESA	1477	1475	1449	1381	1323	1270	1225	1175	1125	1059	998	838	601	419	230	839	628

Prespecified NI margin:
-0.75 g/dL

Adjusted Mean Treatment Difference (95% CI)*
0.18 (0.12, 0.24)

Noninferiority was achieved because the lower limit of the 95% CI of the treatment difference was greater than the prespecified noninferiority margin of **−0.75 g/dL**

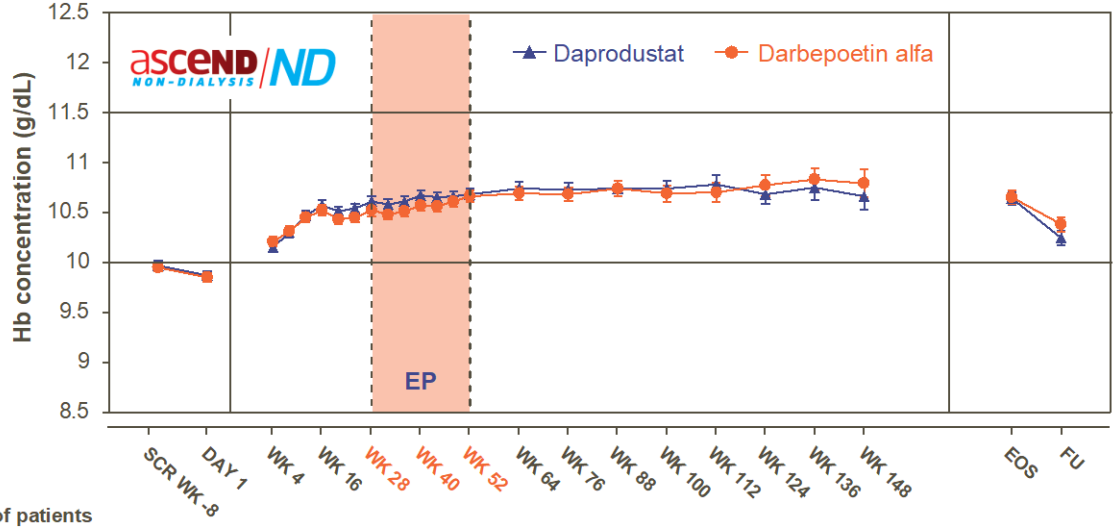
*Based on an ANCOVA model using observed and imputed data with terms for treatment, baseline hemoglobin, dialysis type and region. Error bars indicate 95% CI. Post-randomization values include on- and off-treatment values. Visits on or before Day 1 include only pre-treatment values. Horizontal reference lines represent the Hb analysis range (10–11.5g/dL). The Hb target range for dose changes is 10–11g/dL. Vertical dotted lines represent the EP.

CI, confidence interval; EP, evaluation period; EOS, end of study; ESA, erythropoiesis-stimulating agent; FU, follow up; Hb, hemoglobin; ITT, intent-to-treat; NI noninferiority; SCR screening; Wk, week.

Co-primary Efficacy Endpoint: ASCEND-ND

Mean Hb change from baseline to the evaluation period (Weeks 28–52) – ITT Population

Daprodustat was noninferior to darbepoetin alfa for mean change in Hb from baseline to the evaluation period (Weeks 28–52)



No. of patients																	
Daprodustat	1936	1932	1866	1705	1511	1364	1254	1100	961	832	725	587	453	349	243	1276	1056
Darbepoetin alfa	1935	1933	1867	1697	1506	1398	1243	1100	952	835	727	602	482	378	272	1278	1043

Prespecified NI margin:
-0.75 g/dL

Adjusted Mean Treatment Difference (95% CI)*
0.08 (0.03, 0.13)

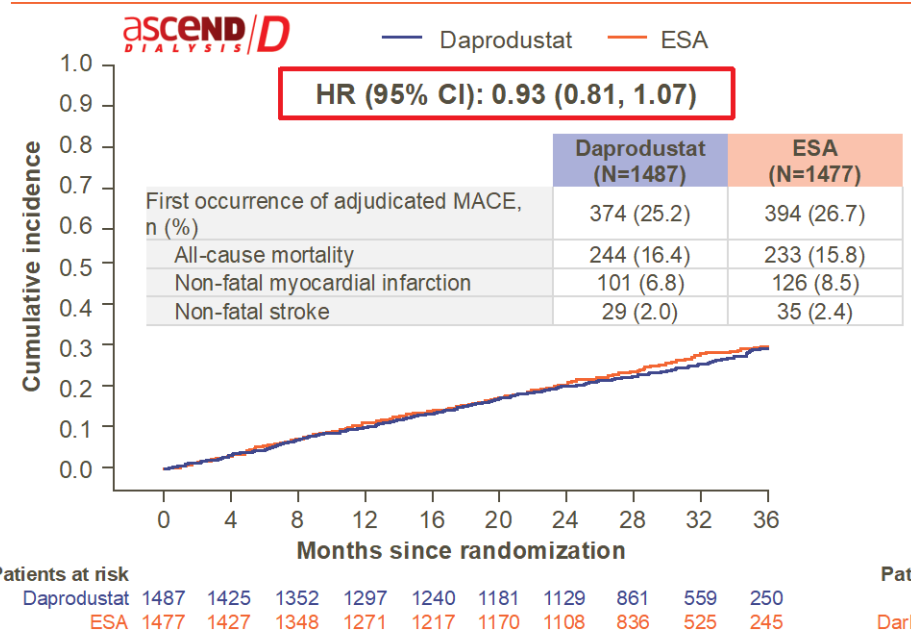
Noninferiority was achieved because the lower limit of the 95% CI of the treatment difference was greater than the prespecified noninferiority margin of **–0.75 g/dL**

*Based on an ANCOVA model using observed and imputed data with terms for treatment, baseline hemoglobin, current ESA use and region. Error bars indicate 95% CI. Post-randomization values include on- and off-treatment values. Visits on or before Day 1 include only pre-treatment values. Horizontal reference lines represent the Hb analysis range (10–11.5g/dL). The Hb target range for dose changes is 10–11g/dL. Vertical dotted lines represent the EP.

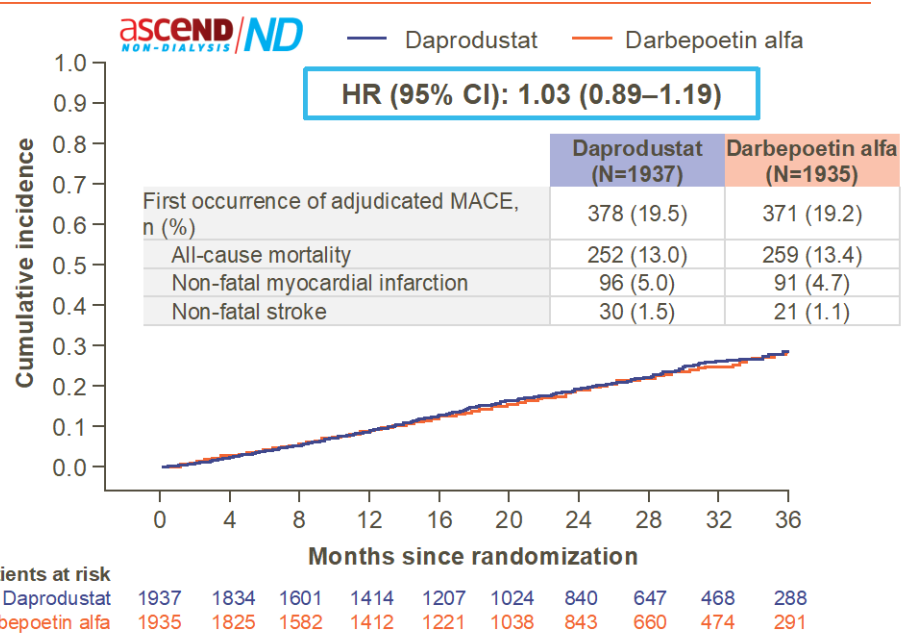
CI, confidence interval; EP, evaluation period; EOS, end of study; ESA, erythropoiesis-stimulating agent; FU, follow up; Hb, hemoglobin; ITT, intent-to-treat; NI noninferiority; SCR screening; Wk, week.

First Occurrence of Adjudicated MACE

During the Time Period for Follow-up of CV Events – ITT Population



	Daprodustat (N=1487)	ESA (N=1477)
First occurrence of adjudicated MACE, n (%)	374 (25.2)	394 (26.7)
All-cause mortality	244 (16.4)	233 (15.8)
Non-fatal myocardial infarction	101 (6.8)	126 (8.5)
Non-fatal stroke	29 (2.0)	35 (2.4)



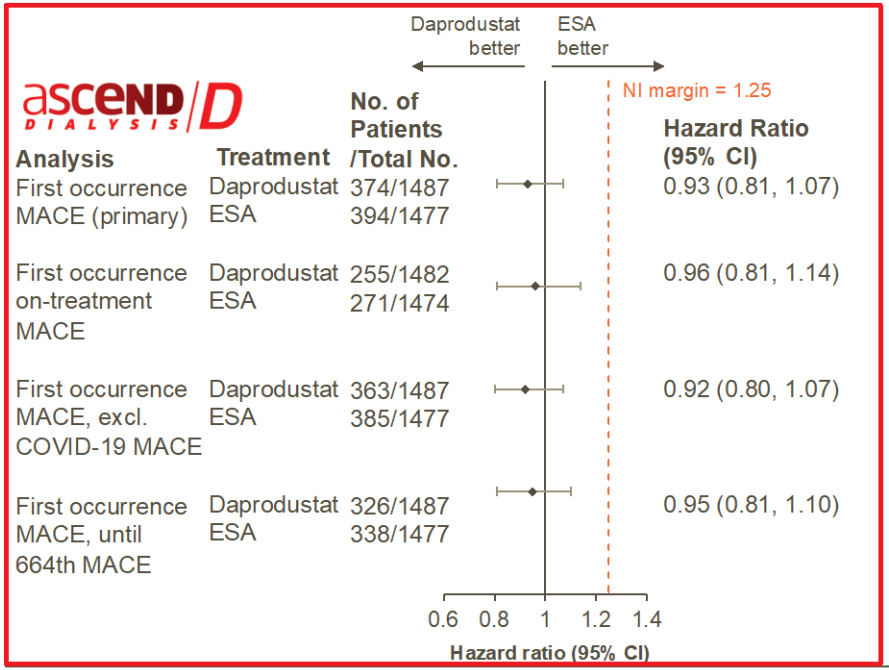
	Daprodustat (N=1937)	Darbepoetin alfa (N=1935)
First occurrence of adjudicated MACE, n (%)	378 (19.5)	371 (19.2)
All-cause mortality	252 (13.0)	259 (13.4)
Non-fatal myocardial infarction	96 (5.0)	91 (4.7)
Non-fatal stroke	30 (1.5)	21 (1.1)

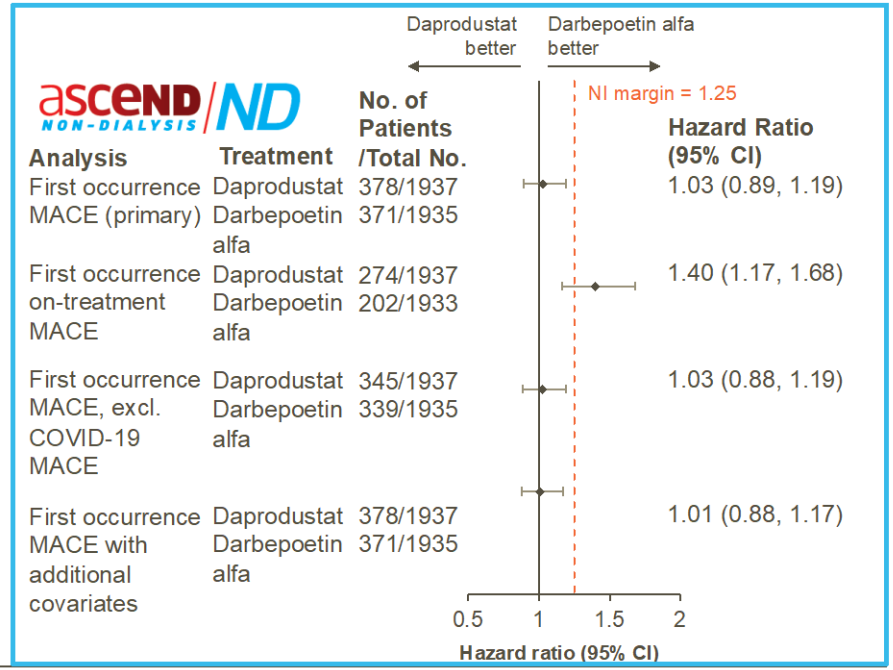
Noninferiority was achieved because the upper boundary of the 95% CI of the HR was lower than the pre-specified NI margin of **1.25**

HR estimated using a Cox proportional hazards regression model with treatment group, dialysis type (ASCEND-D) or baseline ESA use (ASCEND-ND) and region as covariates.
A HR <1 indicates a lower risk with daprodustat compared with ESA/darbepoetin alfa. Note: y-axis scale may differ from those in the primary publications.
CI, confidence interval; CV, cardiovascular; ESA, erythropoiesis-stimulating agent; HR, hazard ratio; ITT, intent-to-treat; MACE, major adverse cardiovascular event.

MACE Supplementary Analyses

Supplementary MACE analyses were generally consistent with noninferiority conclusions from the primary analysis, except the ASCEND-ND on-treatment MACE analysis





Note: With the exception of the on-treatment analyses, all analyses follow the "ITT approach" and use both on- and off-treatment MACE events. On-treatment: from treatment start to the earlier of [28 days after the participant's last dose of randomized treatment (last dose date + 28 days), or date of study completion/withdrawal]. HR estimated using a Cox proportional hazards regression model with treatment group, dialysis type (ASCEND-D) or baseline ESA use (ASCEND-ND) and region as covariates. A HR <1 indicates a lower risk with daprodustat compared with ESA/darbepoetin alfa. CI, confidence interval; ESA, erythropoiesis-stimulating agent; MACE, major adverse cardiovascular event; NI, noninferiority.

Principal Secondary Endpoints

Principal secondary endpoints did not meet multiplicity-adjusted statistical significance for superiority*

ASCEND-D DIALYSIS	Hazard ratio (95% CI)†
MACE (superiority)	0.93 (0.81, 1.07)
MACE + thromboembolic events (DVT, PE, VAT)	0.88 (0.78, 1.00)
MACE + hospitalization for heart failure	0.97 (0.85, 1.11)
	Adjusted Mean Treatment Difference daprodustat-ESA (95% CI)‡
On-treatment average monthly IV iron dose (mg) from baseline to Week 52	-9.1 (-18.4, 0.2)

ASCEND-ND NON-DIALYSIS	Hazard ratio (95% CI)†
MACE (superiority)	1.03 (0.89, 1.19)
MACE + thromboembolic events (DVT, PE, VAT)	1.06 (0.93, 1.22)
MACE + hospitalization for heart failure	1.09 (0.95, 1.24)
	Hazard ratio (95% CI)§
CKD progression *(40% decline in eGFR OR ESRD, i.e., chronic dialysis, not initiating dialysis when indicated or kidney transplant)*	0.98 (0.84, 1.13)

*Holm-Bonferroni multiplicity adjustment used for principal secondary endpoints. †HR estimated using a Cox proportional hazards regression model with treatment group, dialysis type (ASCEND-D) or baseline ESA use (ASCEND-ND) and region as covariates. ‡Based on an ANCOVA model with terms for treatment, baseline monthly IV iron dose, dialysis type and region; §Subdistribution hazard ratio estimated using Fine & Gray's proportional subdistribution hazard regression model with treatment group, baseline ESA use, and region as covariates. A HR <1 indicates a lower risk with daprodustat compared with ESA/darbepoetin alfa. CI, confidence interval; CKD, chronic kidney disease; DVT, deep vein thrombosis; eGFR, estimated glomerular filtration rate; ESA, erythropoiesis-stimulating agent; ESRD, end stage renal disease; HR, hazard ratio; IV, intravenous; MACE, major adverse cardiovascular event; PE, pulmonary embolism; VAT, vascular access thrombosis.

Adverse Events

Safety population reporting treatment-emergent events

AE and SAE rates were similar between treatment groups in both studies
Rates of AESIs were generally similar between treatment groups in both studies

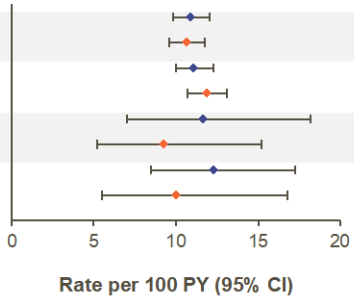
ascend D DIALYSIS	Daprodustat (N=1482)	ESA (N=1474)	ascend ND NON-DIALYSIS	Daprodustat (N=1937)	Darbepoetin alfa (N=1933)
Rate of AEs	88%	85%	**Rate of AEs**	80%	77%
Rate of SAEs	52%	51%	**Rate of SAEs**	44%	36%
Adverse Events of Special Interest (AESIs) undergoing further investigation:					
Esophageal and gastric erosions, % [n]	4.0% [60]	**5.5%** [81]	Esophageal and gastric erosions, % [n]	**3.6%** [70]	2.1% [41]
Cancer-related mortality and tumor progression and recurrence, % [n]	3.2% [47]	**3.5%** [51]	Cancer-related mortality and tumor progression and recurrence, % [n]	**3.7%** [72]	2.5% [49]

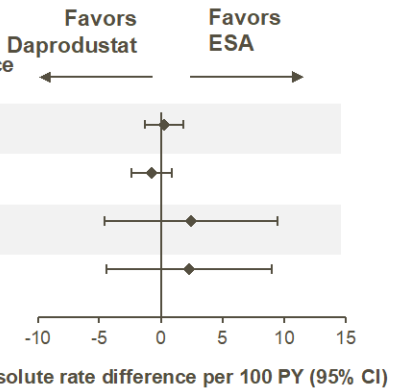
Safety population: all randomized patients who received at least one dose of randomized treatment. Treatment-emergent adverse events are reported which start or worsen on or after the participant's treatment start date and on or before the day after the participant's last dose of randomized treatment. Adverse events of special interest were investigator reported events and were not adjudicated. They were defined for daprodustat based on data from non-clinical and clinical studies, current information about HIF-associated pathophysiology, and identified risks for ESAs. A programmatic approach for these potential events was implemented using a broad set of terms of interest. AE, adverse event; AESI, adverse event of special interest; ESA, erythropoiesis-stimulating agent; HIF, hypoxia-inducible factor; SAE, serious adverse event.

ASCEND Program-Level Cardiovascular Safety Data

MACE profile was generally consistent across treatment groups in all trials*

MACE	Patients with events n/N (%)		Rate per 100 PY (95% CI)		Absolute rate difference per 100 PY (95% CI)
	Daprodustat	ESA†	Daprodustat	ESA†	
ASCEND-ND	378/1937 (19.5)	371/1935 (19.2)	10.86 (9.80, 12.02)	10.63 (9.58, 11.77)	0.23 (-1.31, 1.77)
ASCEND-D	374/1487 (25.2)	394/1477 (26.7)	11.07 (9.98, 12.26)	11.86 (10.72, 13.09)	-0.78 (-2.41, 0.84)
ASCEND-ID	19/157 (12.1)	15/155 (9.7)	11.65 (7.02, 18.20)	9.24 (5.17, 15.24)	2.41 (-4.61, 9.43)
ASCEND-TD	33/270 (12.2)	14/137 (10.2)	12.30 (8.46, 17.27)	10.02 (5.48, 16.81)	2.28 (-4.44, 9.00)





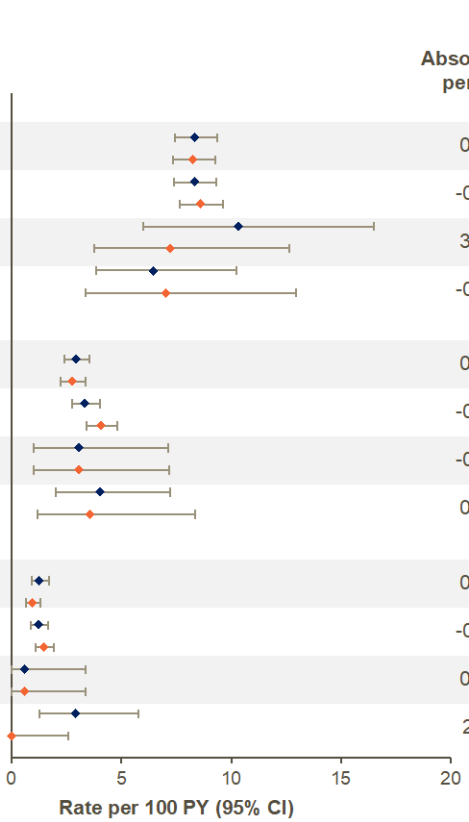
First MACE rates in ASCEND-NHQ (28 weeks): 4.9% daprodustat; 6.2% placebo

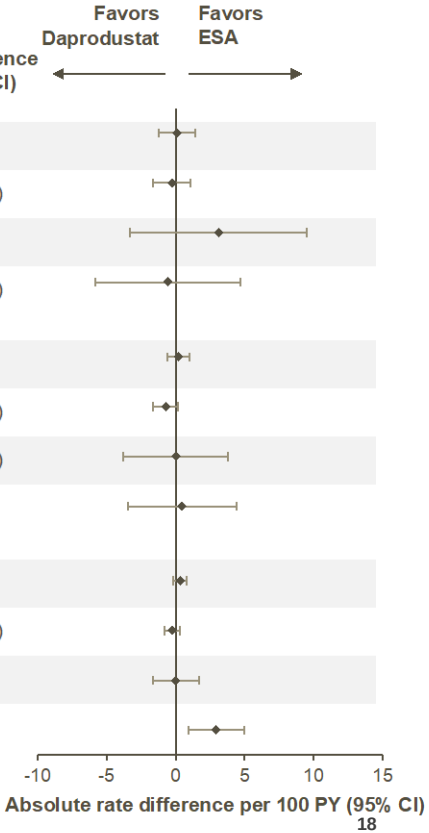
*Smaller trials (ASCEND-ID, ASCEND-TD and ASCEND-NHQ) reported MACE but were not designed for formal MACE evaluation; †Darbepoetin alfa (ASCEND-D, -ND, -ID), epoetin alfa (ASCEND-D, -TD).

ASCEND Program-Level Cardiovascular Safety Data

MACE components were generally consistent across treatment groups in all trials*

	Patients with events n/N (%)		Rate per 100 PY (95% CI)		Absolute rate difference per 100 PY (95% CI)
	Daprodustat	ESA†	Daprodustat	ESA†	
All-cause mortality					
ASCEND-ND	301/1937 (15.5)	298/1935 (15.4)	8.35 (7.43, 9.35)	8.27 (7.35, 9.26)	0.08 (-1.25, 1.41)
ASCEND-D	294/1487 (19.8)	300/1477 (20.3)	8.32 (7.39, 9.32)	8.59 (7.65, 9.62)	-0.28 (-1.63, 1.08)
ASCEND-ID	17/157 (10.8)	12/155 (7.7)	10.32 (6.01, 16.52)	7.23 (3.74, 12.63)	3.08 (-3.30, 9.47)
ASCEND-TD	18/270 (6.7)	10/137 (7.3)	6.47 (3.84, 10.23)	7.04 (3.37, 12.94)	-0.56 (-5.85, 4.72)
Myocardial infarction					
ASCEND-ND	103/1937 (5.3)	97/1935 (5.0)	2.94 (2.40, 3.56)	2.76 (2.24, 3.36)	0.18 (-0.61, 0.97)
ASCEND-D	114/1487 (7.7)	137/1477 (9.3)	3.34 (2.76, 4.01)	4.08 (3.43, 4.83)	-0.74 (-1.66, 0.18)
ASCEND-ID	5/157 (3.2)	5/155 (3.2)	3.07 (1.00, 7.15)	3.08 (1.00, 7.19)	-0.01 (-3.82, 3.80)
ASCEND-TD	11/270 (4.1)	5/137 (3.6)	4.03 (2.01, 7.21)	3.58 (1.16, 8.35)	0.45 (-3.48, 4.39)
Stroke					
ASCEND-ND	45/1937 (2.3)	34/1935 (1.8)	1.26 (0.92, 1.69)	0.95 (0.66, 1.33)	0.31 (-0.18, 0.80)
ASCEND-D	43/1487 (2.9)	51/1477 (3.5)	1.23 (0.89, 1.66)	1.48 (1.10, 1.94)	-0.25 (-0.79, 0.30)
ASCEND-ID	1/157 (0.6)	1/155 (0.6)	0.61 (0.02, 3.38)	0.60 (0.02, 3.36)	0.00 (-1.67, 1.68)
ASCEND-TD	8/270 (3.0)	0/137 (0.0)	2.92 (1.26, 5.76)	0.00 (0.00, 2.60)	2.92 (0.90, 4.95)





*Smaller trials (ASCEND-ID, ASCEND-TD and ASCEND-NHQ) reported MACE but were not designed for formal MACE evaluation; †Darbepoetin alfa (ASCEND-D, -ND, -ID), epoetin alfa (ASCEND-D, -TD).

Summary and Conclusions

- Daprodustat was as effective as conventional ESA therapy in treating anemia of CKD
- Daprodustat was noninferior to ESA with respect to CV safety and no new safety signals were observed

Daprodustat could represent an oral alternative to ESA for treating anemia of CKD in both dialysis and non-dialysis patients

AE, adverse events; CKD, chronic kidney disease; CV, cardiovascular; MACE, major adverse cardiovascular event

Commercial opportunity

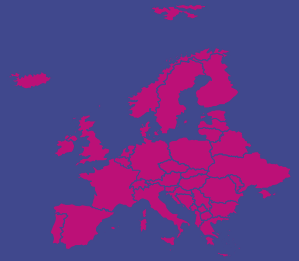
Luke Miels, Chief Commercial Officer

The prevalence of anaemia increases as CKD progresses; it is associated with an increased risk of hospitalisation, cardiovascular complications and death

North America

30 million
CKD prevalence

19 million
Stages 3-5



Europe

25 million
CKD prevalence

16 million
Stages 3-5

Asia

367 million
CKD prevalence

123 million
Stages 3-5

Treating patients with anaemia due to CKD

	Stage of CKD	Kidney function %	Diagnosed patients (m)	Average treatment duration (years)
Primary care physician and Nephrologist	Stage 3a	45-59	**4.4**	7.9
	Stage 3b	30-44	**5.6**	5.0
Nephrologist	Stage 4	15-29	**1.3**	4.2
	Stage 5	<15%	**0.5**	0.8

Source: 1. NHANES 2016 data accessed via Centers for Disease Control and Prevention. CKD Surveillance System—United States; website: http://www.cdc.gov/ckd; 2. 2018 USRDS Annual data report – Volume 2: ESRD in the US 3. Lancet: Global, regional and national burden of chronic kidney disease, 1990–2017; 4. The prevalence of Chronic Kidney Disease in Asia, Liyanage T, Toyama T, ISN WCN 2020. 5 Spherix RealWorld Dynamix ND Patient Audit Neph and PCP – 2019, 6: GSK internal materials, 7. Dowling TC. Am J Health Syst Pharm 2007;64(13 Suppl 8):S3–7., Schmidt RJ, Dalton CL. Osteopath Med Prim Care 2007;1:14.

HIF-PHI[1] class could become the new standard of care

Daprodustat has the potential to deliver patient benefit across populations

Non-dialysis dependent

>1 million

Patients treated in the US and Europe

c.30%

Patients with Hb <10g/dl treated with ESA

54%

Treatment discontinuation in one year

Dialysis dependent

>850 thousand

Patients treated in the US and Europe

c.12%

Patients treated with home dialysis
(expected to grow to 25% by 2025)

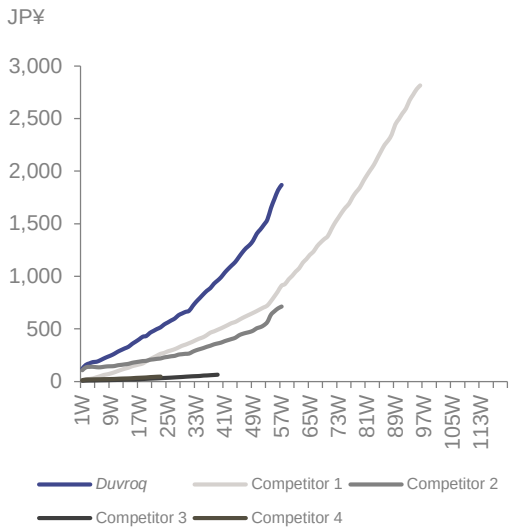
c.12%

ESA hypo responders

1. Hypoxia-inducible factor prolyl hydroxylase Inhibitors. Source: Epidemiology data derived from multiple sources, including: 1. https://www.thelancet.com/article/S0140-6736(20)30045-3/fulltext 2. Prevalence of Anemia in Chronic Kidney Disease in the United States (nih.gov) 3. Nephrol Dial Tranplant 2002, Suppl11:44-6 4. https://www.nature.com/articles/s41598-020-79254-6, 5CKDopps. Sci Rep 11, 1784 (2021). https://doi.org/10.1038/s41598-020-79254-6, Spherix RealWorld Dynamix 20Q2 report.

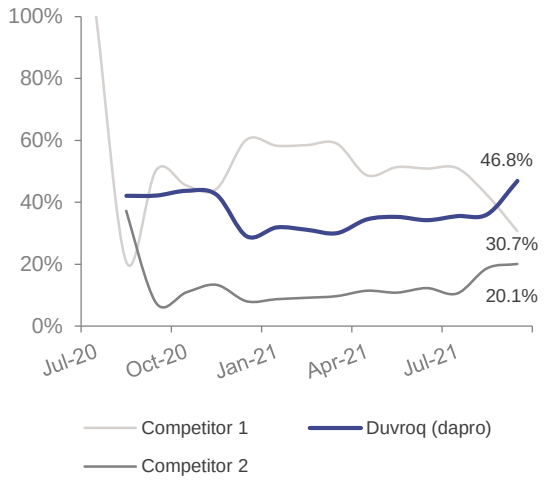
Japan: *Duvroq* has achieved market-leading share

Encouraging launch despite being second to market



Source: IQVIA JPM Monthly model, September flash data from IQVIA JPM flash.

Leading market share



Source: IQVIA JPM Monthly model, September flash data from IQVIA JPM flash.

Translating success in Japan to global expansion

Strong momentum across populations

- 75% of patients switching from ESA to *Duvroq*
- 25% new to treatment
- Rx to patients in both DD (40%) and NDD (60%)

Early engagement enabled smooth commercial transition

- Started early conversations with US commercial providers and large dialysis centers
- Encouraged by positive initial feedback and intent to include PHIs in treatment paradigm
- Will continue dialogue as we move closer to filing

Daprodustat: an innovative, convenient oral treatment for patients with anaemia due to CKD

Strong clinical data supports competitive commercial profile

- Convenient oral option for non-dialysis and dialysis patients
- Flexible dosing: QD[1] or TIW[2] with iron and phosphate binders
- Predictable Hb increase and maintenance within target level
- Improvements in QOL[3] including fatigue (SF-36 vitality score)

Significant market opportunity

>£2 billion

US ESA CKD market

>£1 billion

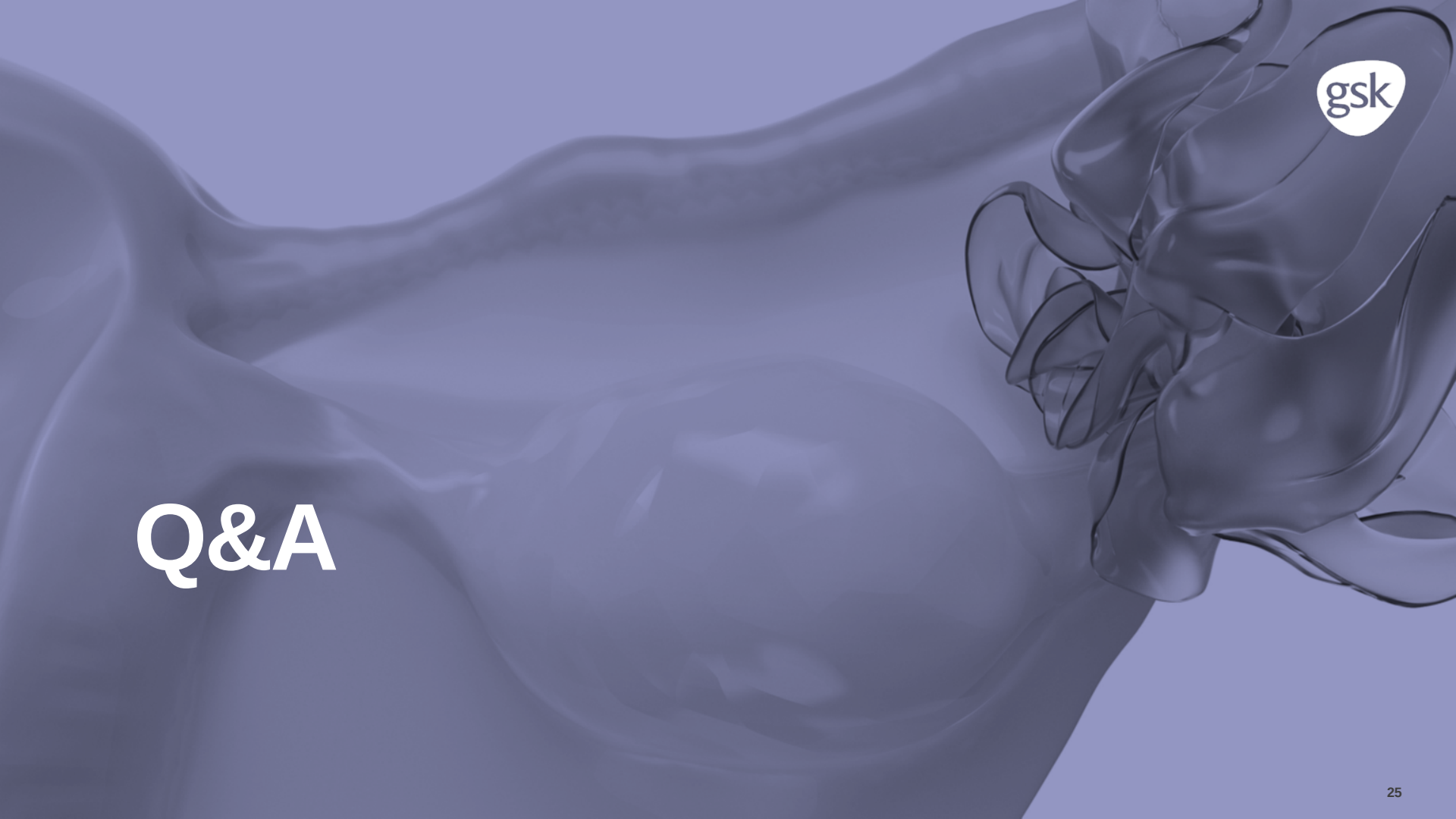
Europe ESA CKD market

Leveraging experience to deliver commercial success

- Investing behind internal capabilities
- >900 specialty experts hired since 2017
- Established leadership position with nephrologists from *Benlysta* LN launch

H1 2022: regulatory submissions (US, EU)

1. Once daily 2. Three times weekly 3. Quality of life.



Q&A