LUMAKRAS UPDATE
ESMO 2022

SEPTEMBER 12, 2022

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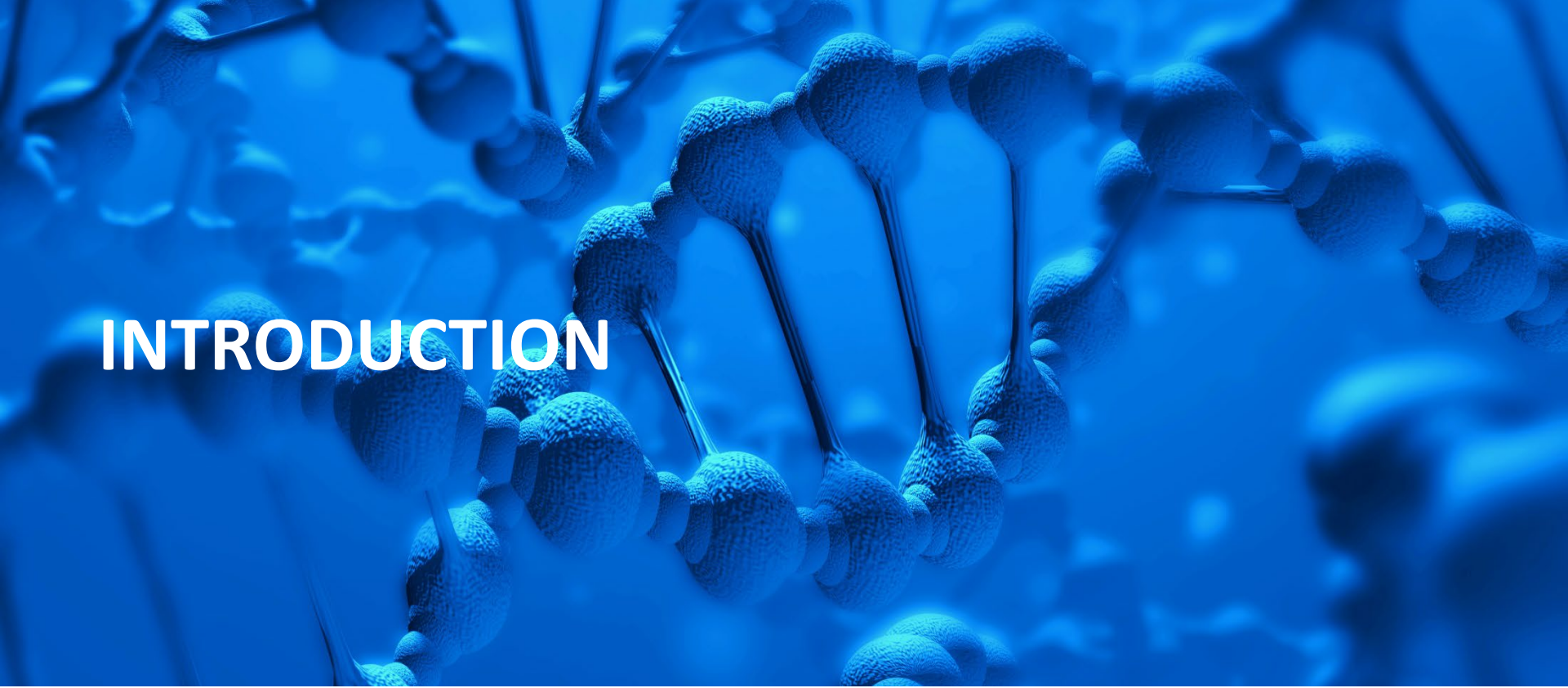

INTRODUCTION

DAVID REESE, MD

EXECUTIVE VICE PRESIDENT RESEARCH AND DEVELOPMENT

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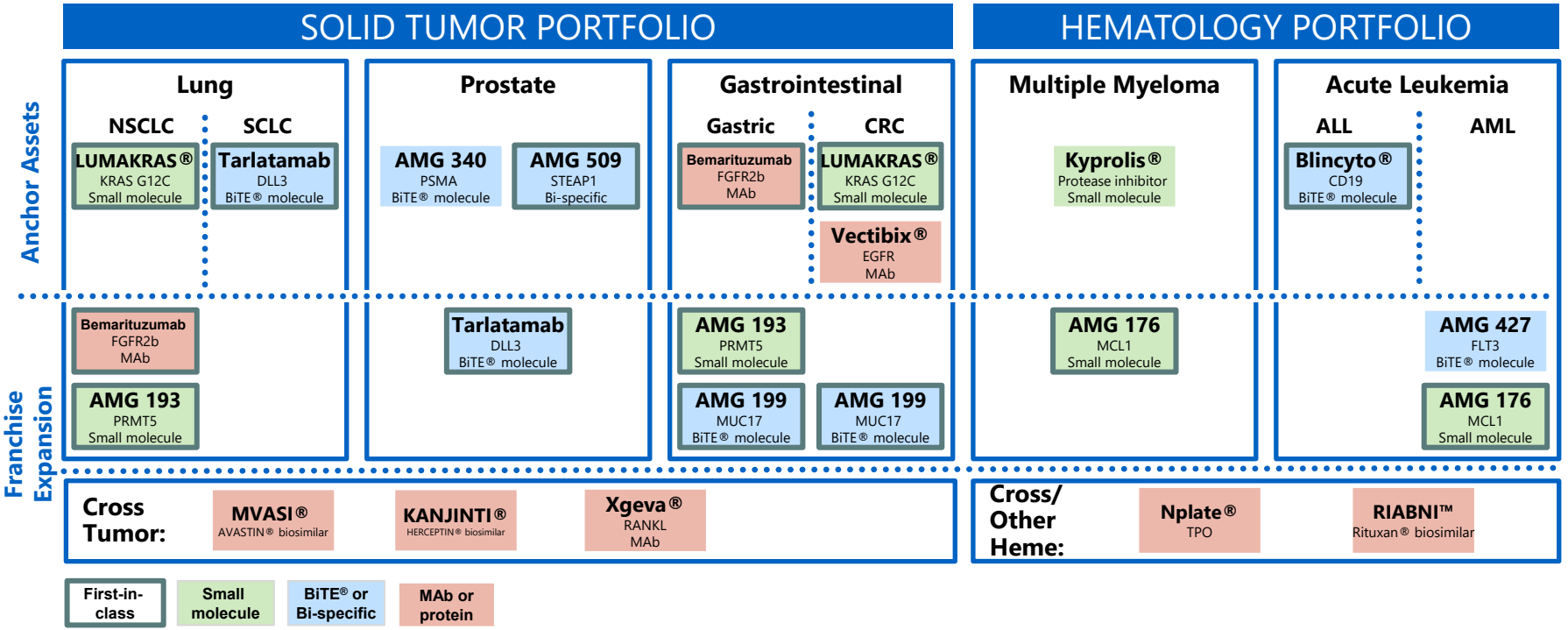
Agenda

Topic	Presenter
Introduction	David Reese, MD – Executive Vice President, Research and Development, Amgen
LUMAKRAS® + Vectibix Phase 1b, Colorectal Cancer	John Strickler MD Duke Cancer Institute
LUMAKRAS® Phase 3 CodeBreaK 200, Non-small Cell Lung Cancer	Ferdinandos Skoulidis, MD, PhD, MRCP MD Anderson Cancer Center
Concluding Remarks	Jean-Charles Soria, MD – Senior Vice President Development, Amgen
Q&A	All

Broad Oncology Portfolio With Multiple First-In-Class Programs



KRAS= Kirsten Rat Sarcoma; FGFR2b= fibroblast growth factor receptor 2b; BiTE®= bispecific T-cell engager; DLL3= delta-like ligand 3; PSMA= prostate-specific membrane antigen; STEAP1= Six-transmembrane epithelial antigen of prostate 1; MAb= monoclonal antibody; PRMT5= protein arginine methyltransferase 5; MUC17= Mucin 17; EGFR= epidermal growth factor receptor; MCL1= myeloid cell leukemia-1; CD19= cluster of differentiation 19; FLT3= fms-like tyrosine kinase 3; CRC= colorectal cancer; ALL= acute lymphoblastic leukemia; AML= Acute myeloid leukemia; NSCLC= non small cell lung cancer; SCLC= small cell lung cancer; RANKL= Receptor activator of nuclear factor kappa-B ligand; TPO= thrombopoietin

SOTORASIB IN COMBINATION WITH PANITUMUMAB IN REFRACTORY KRAS G12C-MUTATED COLORECTAL CANCER: SAFETY AND EFFICACY FOR PHASE 1B FULL EXPANSION COHORT

JOHN STRICKLER, MD
DUKE UNIVERSITY MEDICAL CENTER

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Current Standard of Care in mCRC

Standard of care treatments in chemotherapy refractory *KRAS G12C*-mutated mCRC have shown minimal benefit, with mPFS of only 2 months and response rates less than 2%, highlighting the need for additional therapies

	mOS (months)	mPFS (months)	ORR
Regorafenib vs placebo Phase 3 CORRECT[1]	6.4 vs 5.0	1.9 vs 1.7	1.0% vs 0.4%
Trifluridine/tipiracil vs placebo Phase 3 RECOURSE[2]	7.1 vs 5.3	2.0 vs 1.7	1.6% vs 0.4%

KRAS= Kirsten rat sarcoma; mCRC, metastatic colorectal cancer; ORR, objective response rate; mOS, median overall survival;; mPFS, median progression-free survival

1. Grothey A, Van Cutsem E, Sobrero A, et al. Regorafenib monotherapy for previously treated metastatic colorectal cancer (CORRECT): an international, multicentre, randomised, placebo-controlled, phase 3 trial. Lancet. 2013;381(9863):303-312.
2. Mayer RJ, Van Cutsem E, Falcone A, et al. Randomized trial of TAS-102 for refractory metastatic colorectal cancer. N Engl J Med. 2015;372(20):1909-1919.

CodeBreaK 101 Subprotocol H Study Design

Phase 1b, multicenter study*:
Sotorasib + panitumumab in chemorefractory *KRAS G12C*-mutated mCRC

Screening/enrolment	Part 1: Cohort A dose exploration‡	Part 2: Cohort A dose expansion (N=40)
Key eligibility criteria (Part 2 Cohort A) • *KRAS G12C*-mutated mCRC, identified through molecular testing • $KRAS^{G12C}$ inhibitor-naive • ≥1 prior treatment for advanced disease† • Progressed on or after fluoropyrimidine, oxaliplatin, irinotecan, and an anti-angiogenic agent	Sotorasib PO daily + Panitumumab 6 mg/kg IV Q2W	**Sotorasib: 960 mg PO daily** + **Panitumumab: 6 mg/kg IV Q2W** Treatment until disease progression, withdrawal of consent, or end of study

Primary endpoint: Safety/tolerability
Secondary endpoints: Anti-tumor efficacy (ORR, DCR, DOR, TTR, PFS per RECIST v1.1, and OS) **and PK**

*NCT04185883; EudraCT 2020-004721-23.
†For patients with tumors known to be microsatellite instability high, prior checkpoint inhibitor therapy is required if clinically appropriate and locally available for that indication.
‡Dose exploration is completed.
DCR= disease control rate; DOR= duration of response; IV= intravenous; *KRAS*= Kirsten rat sarcoma; mCRC= metastatic colorectal cancer; ORR= objective response rate; OS= overall survival; Q2W= every 2 weeks; PFS= progression-free survival; PK= pharmacokinetics; PO= orally; RECIST= Response Evaluation Criteria in Solid Tumors; TTR= time to response

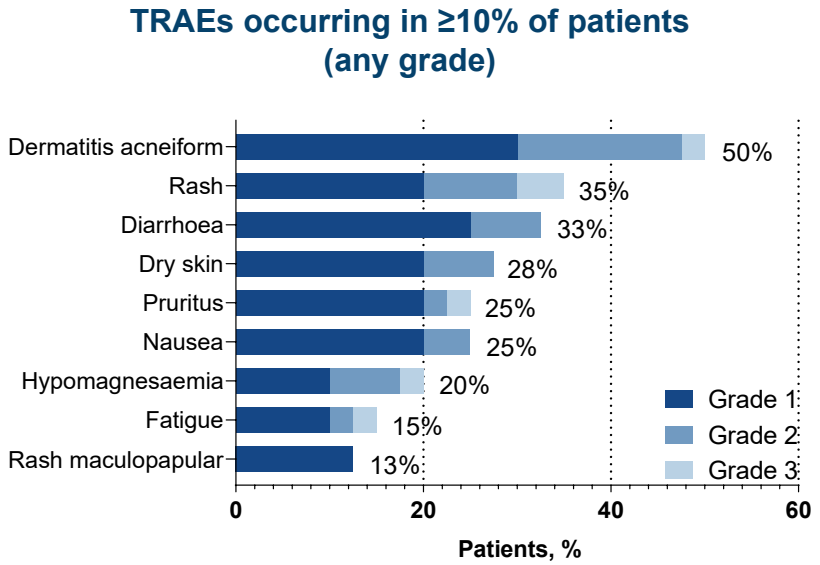
Baseline Characteristics

Characteristic	N = 40
Median age, years (range)	58 (30, 78)
Female, n (%)	30 (75)
ECOG performance status, n (%)	
0	13 (33)
1	26 (65)
2	1 (3)
Primary tumor location, n (%)	
Left	27 (68)
Right	13 (33)
Liver metastasis, n (%)	27 (68)
Median lines of prior therapy for metastatic disease, n (range)	2 (1, 7)
Prior regorafenib, n (%)	7* (18)
Prior trifluridine/tipiracil, n (%)	7* (18)

*One patient had both regorafenib as a third-line therapy and trifluridine/tipiracil as a fourth-line therapy.
ECOG= Eastern Cooperative Oncology Group

Treatment-Related Adverse Events (TRAEs)

TRAE	N = 40 n (%)
TRAE, any grade	37 (93)
Attributed to sotorasib	26 (65)
Attributed to panitumumab	37 (93)
Grade 3 TRAE*	9 (23)
Grade 4 TRAE	0
Fatal TRAE	0
TRAE leading to dose interruptions/reductions	
Attributed to sotorasib	6 (15)
Attributed to panitumumab	10 (25)
TRAE leading to discontinuation of either drug	0



Data cutoff: June 24, 2022.

*Grade 3 TRAEs were rash (n=2, 5%), anemia, fatigue, peripheral oedema, cellulitis, pustular rash, salmonellosis, skin infection, hypomagnesaemia, malignant neoplasm progression, pulmonary embolism, dermatitis acneiform, and pruritus (n=1 patient each, 3%).

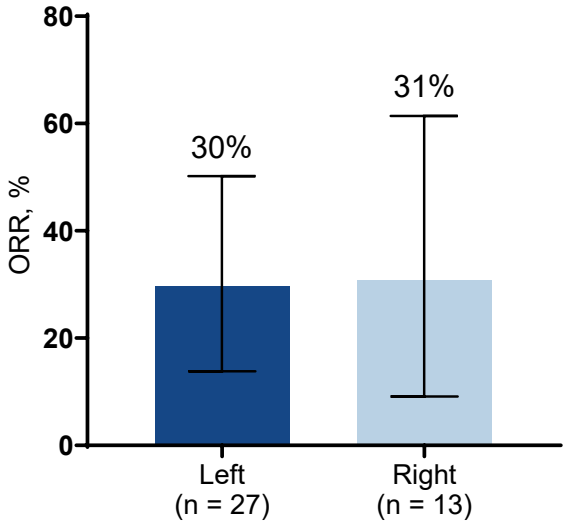
- **Sotorasib/panitumumab was well tolerated; no TRAEs resulted in discontinuation of either drug**
- **TRAEs were consistent with known safety profiles of the individual drugs**

Efficacy

Response by investigator assessment	N = 40 n (%)
ORR confirmed (95% CI)	**12 (30)** (16.6, 46.5)
Complete response	0
Partial response	12 (30)
Stable disease*	25 (63)
Progressive disease	3 (8)
DCR (95% CI)	**37 (93)** (79.6, 98.4)

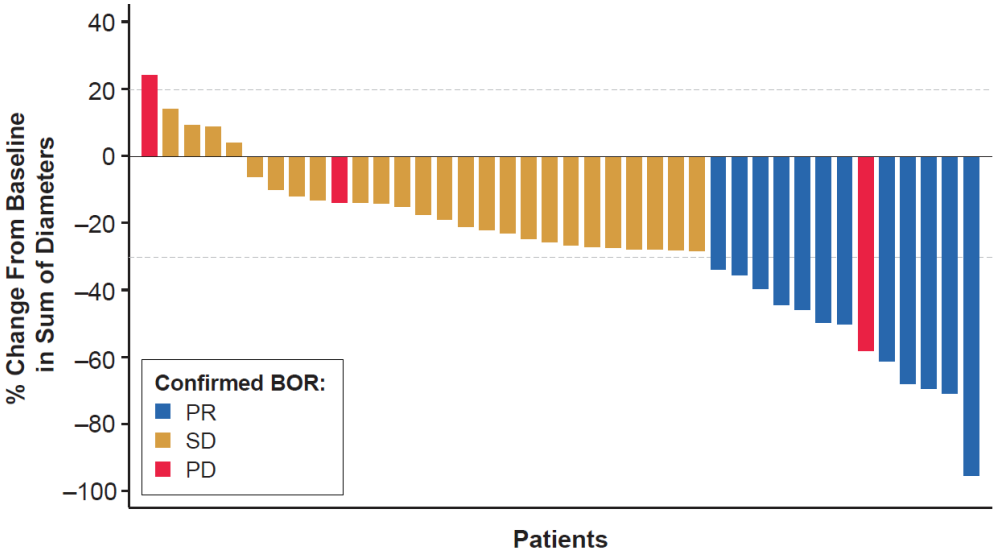
Data cutoff: June 24, 2022.
*Minimum requirement for stable disease was 5 weeks.
DCR= disease control rate; mCRC= metastatic colorectal cancer; ORR= objective response rate.

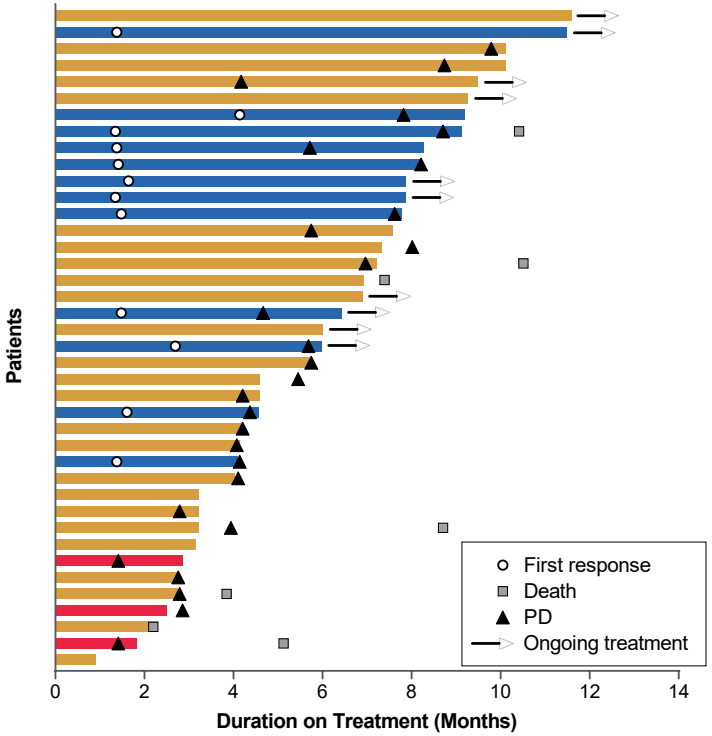
ORR subgroup analysis by primary tumor location



- **30% confirmed response rate for sotorasib + panitumumab in patients with chemorefractory mCRC, with disease control rate of 93%**
- **No obvious differences in response based on tumor location**

Tumor Response



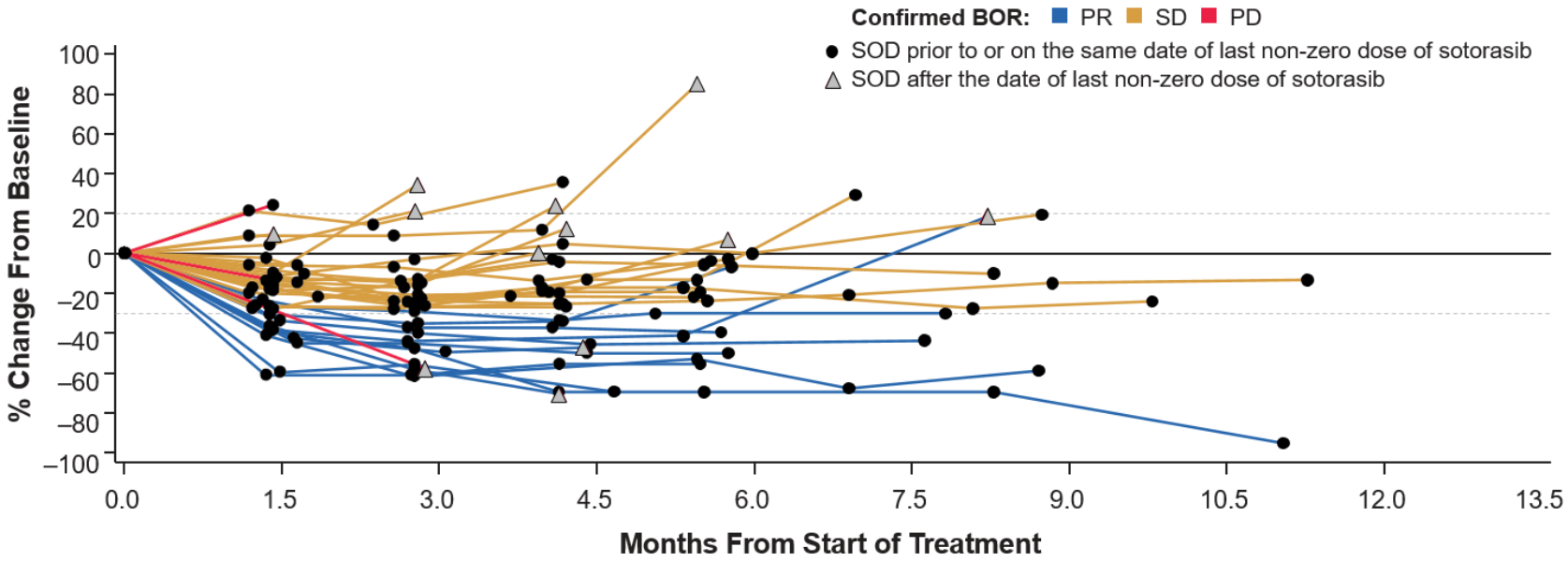


- **Reduction in RECIST target lesions observed in 88% of patients**
- **Median (range) duration of treatment was 5.9 (0.5, 11.3) months, with 25% of patients remaining on treatment**
- **Median duration of response was 4.4 months (range, 2.8–7.4 months)**

Data cutoff: June 24, 2022.

BOR= best overall response; PD= progressive disease, PR= partial response; RECIST= Response Evaluation Criteria in Solid Tumors; SD= stable disease.

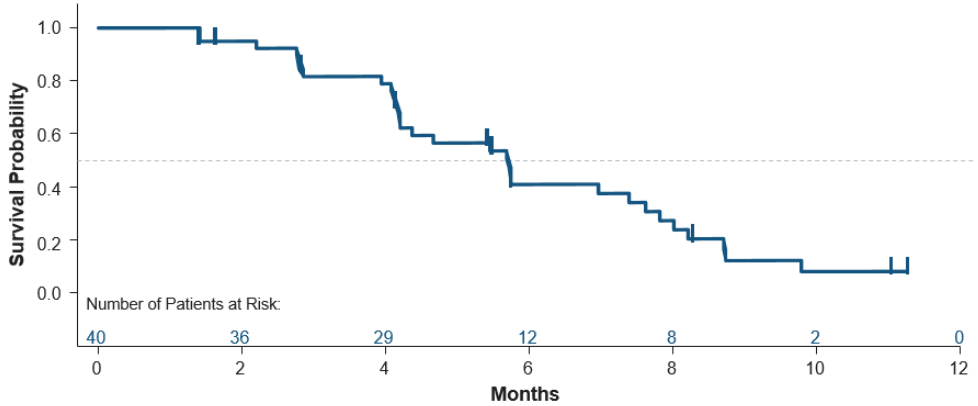
Change in Target Lesions Over Time



Median duration of response was 4.4 months (range, 2.8–7.4 months)

Data cutoff: June 24, 2022.
BOR, best overall response; PD, progressive disease, PR, partial response; SD, stable disease; SOD, sum of diameter.

Progression-Free Survival (PFS)



Kaplan-Meier estimate of PFS	N = 40
Median PFS, months (95% CI)	5.7 (4.2, 7.6)
Left primary tumor	5.8 (4.2, 7.8)
Right primary tumor	5.5 (3.9, 8.2)
PFS rate, % (95% CI)	
At 3 months	81.7 (65.4, 90.9)
At 6 months	41.1 (24.7, 56.7)
At 9 months	12.3 (3.4, 27.2)

With median follow-up of 11.0 months, median PFS was 5.7 months

With median follow-up of 8.8 months, the median OS is not yet reached (95% CI: 10.4, NE)

Conclusions

- Sotorasib plus panitumumab was safe and tolerable in these chemorefractory patients with *KRAS G12C*-mutated mCRC
  - TRAEs were consistent with known safety profiles of sotorasib and panitumumab
- The confirmed 30% ORR is 3-fold higher than previously reported with sotorasib monotherapy,[3] with a DCR of 93%
  - No apparent difference based on tumor location
- Median PFS of 5.7 months appears clinically meaningful and longer than that reported for sotorasib monotherapy (median PFS: 4.0 months),[3] and OS data appear promising

The currently enrolling CodeBreaK 300 global Phase 3 study (NCT05198934; EudraCT: 2021-004008-16) is exploring sotorasib plus panitumumab vs investigator's choice of standard care for treatment of *KRAS G12C*-mutated mCRC

KRAS= Kirsten rat sarcoma; TRAEs= treatment related adverse events; DCR= disease control rate; mCRC= metastatic colorectal cancer; ORR= objective response rate; PFS= progression free survival; OS= overall survival

[3]Fakih M, et al. Lancet Oncol. 2022;23:115-124.

SOTORASIB VERSUS DOCETAXEL FOR PREVIOUSLY TREATED NON-SMALL CELL LUNG CANCER WITH KRAS G12C MUTATION: CODEBREAK 200 PHASE 3 STUDY

FERDINANDOS SKOULIDIS, MD, PHD, MRCP
MD ANDERSON CANCER CENTER

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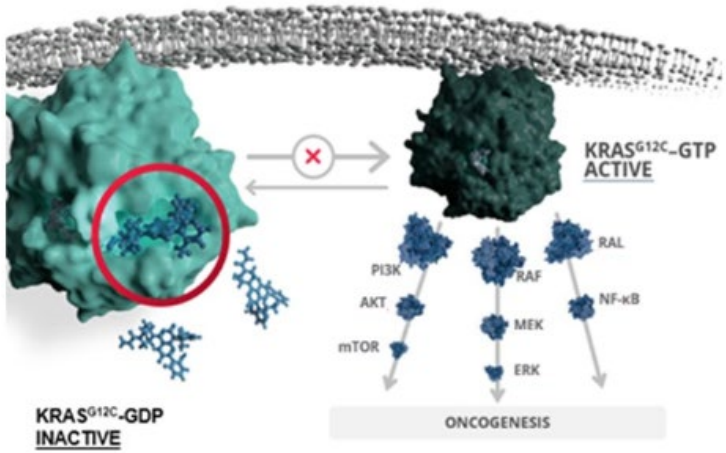
Background

- In the CodeBreaK 100 Phase 1/2 study, treatment with sotorasib in advanced *KRAS* G12C-mutated NSCLC led to an ORR of 41%, mPFS of 6.3 months and mOS of 12.5 months[2-5]

- Historically, docetaxel has been the preferred treatment option following progression on platinum-based chemotherapy and/or IO based on ORR of 12-14%, mPFS of 2.8-4.2 months, and mOS of 7.9-9.4 months[6-8]
  - Recent retrospective data suggest an improvement in outcomes when patients receive prior IO, likely due to a chemo-sensitization effect post IO[9,10]

Sotorasib is a first-in-class, oral, once daily irreversible KRAS^{G12C} inhibitor[1]

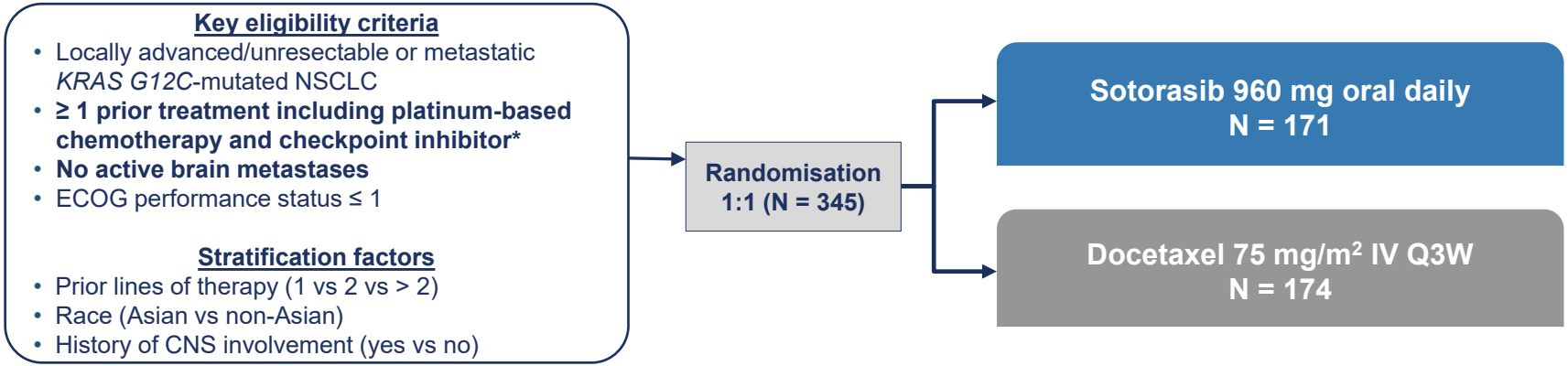


In the first phase 3 study for a KRAS^{G12C} inhibitor (CodeBreaK 200), we evaluate sotorasib compared with docetaxel in previously treated *KRAS G12C*-mutated advanced NSCLC

KRAS= Kirsten rat sarcoma; NSCLC= Non-small cell lung cancer; ORR= objective response rate; mPFS= median progression free survival; mOS= median overall survival; IO= immunotherapy

[1]Canon J, et al. Nature. 2019;575:217-223. [2]Lumakras (sotorasib). Full Prescribing Information, Amgen Inc., Thousand Oaks, CA, 2021. [3]Lumykras (sotorasib). Summary of Product Characteristics, Amgen Ltd., Cambridge, UK, 2021. [4]Lumykras (sotorasib). European Medicines Agency. Available at https://www.ema.europa.eu/en/medicines/human/EPAR/lumykras. Accessed June 6, 2022. [5]Dy GK, et al. Long-term Outcomes With Sotorasib in Pre-treated KRAS p.G12C Mutated NSCLC: 2-year Analysis of CodeBreaK 100. AACR 2022. [6]Borghaei H, et al. N Engl J Med. 2015;373(17):1627-39. [7]Garon EB, et al. Lancet. 2014;384(9944):665-673. [8]Janne PA, et al. JAMA. 2017; 317(18):1844-1853. [9]Yasuda Y, et al. Efficacy of single-agent chemotherapy after exposure to nivolumab in advanced NSCLC. WCLC 2017. [10]Schvartsman G, et al. Response rates to single-agent chemotherapy after exposure to immune checkpoint inhibitors in advanced non-small cell lung cancer. Lung Cancer. 2017 Oct;112:90-95.

CodeBreaK 200 Phase 3 Study Design



Primary Endpoint: PFS by BICR

Secondary Endpoints: Efficacy (OS†, ORR, DOR, TTR, DCR)**, safety/tolerability, PRO**

ITT population analysis included all randomized patients

Per regulatory guidance, protocol was amended to reduce planned enrolment from 650 to ~330 patients, and crossover from docetaxel to sotorasib was permitted.

Enrollment period: June 4, 2020 to April 26, 2021; protocol amendment: February 15, 2021; data cutoff: August 2, 2022.

NCT04303780; EudraCT: 2019-003582-18.
*Treatment with chemotherapy and checkpoint inhibitor could be concurrent or sequential; patients with medical contraindication to these therapies could be included with approval.
†Analysis of OS planned if PFS was found to be statistically significant and when ~198 OS events have been reached.
KRAS= Kirsten rat sarcoma; NSCLC= non-small cell lung cancer; ECOG= Eastern Cooperative Oncology Group; CNS= central nervous system; IV= intravenous; Q3W= every three weeks; PFS= progression free survival; BICR= blinded independent central review; OS= overall survival; ORR= objective response rate; DOR= duration of response; TTR= time to response; DCR= disease control rate; PRO= patient reported outcome; ITT= intent to treat

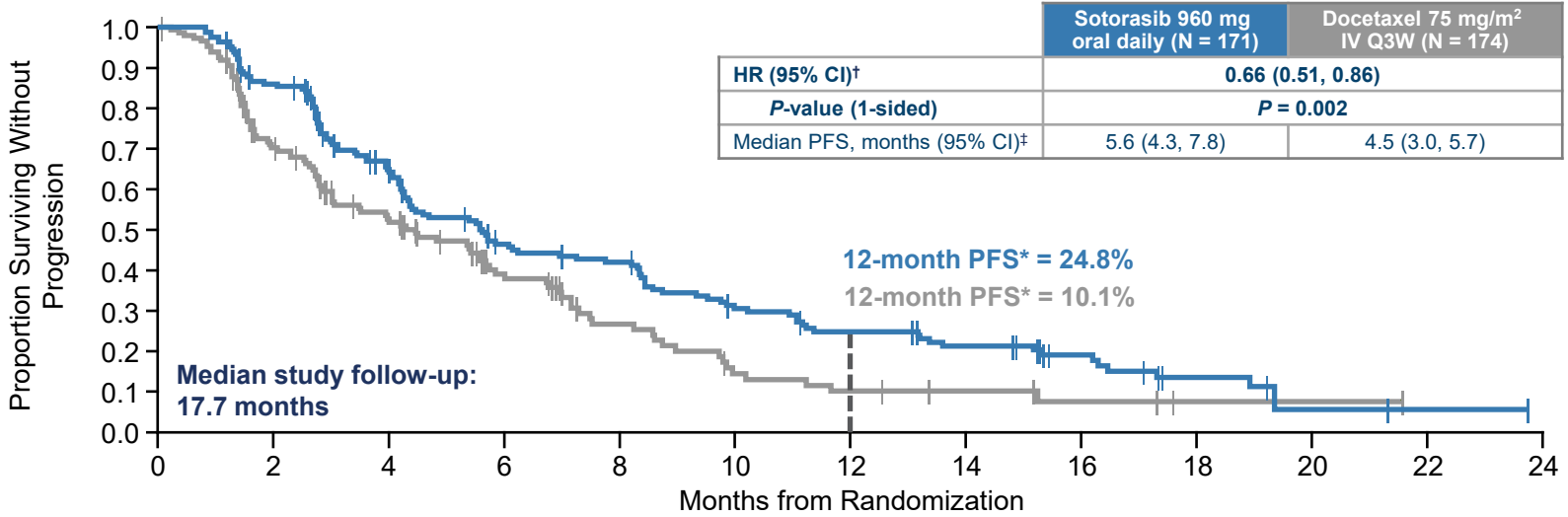
Baseline Characteristics

	Sotorasib 960 mg oral daily (N = 171)	Docetaxel 75 mg/m^2 IV Q3W (N = 174)
Age, median (range), years	64.0 (32, 88)	64.0 (35, 87)
Female, n (%)	62 (36.3)	79 (45.4)
North America/Europe/Other*, %	11.7 / 73.7 / 14.6	12.6 / 72.4 / 14.9
Race, Asian, n (%)	21 (12.3)	22 (12.6)
Smoking history (current or former), n (%)	166 (97.1)	166 (95.4)
ECOG performance status 1, n (%)	112 (65.5)	115 (66.1)
History of CNS involvement, n (%)	58 (33.9)	60 (34.5)
Liver metastasis, n (%)	30 (17.5)	35 (20.1)
Prior lines of therapy†, n (%)		
1	77 (45.0)	78 (44.8)
2	65 (38.0)	69 (39.7)
>2	29 (17.0)	27 (15.5)
PD-L1 expression, n (%)		
<1%	57 (33.3)	55 (31.6)
≥1–<50%	46 (26.9)	70 (40.2)
≥50%	60 (35.1)	40 (23.0)

*Other includes South America, Asia, and Australia. †Prior lines of therapy for advanced disease
ECOG= Eastern Cooperative Oncology Group; CNS= central nervous system; PD-L1= programmed death ligand 1; IV= intravenous; Q3W= every three weeks

Primary Endpoint: PFS by BICR

	Sotorasib 960 mg oral daily (N = 171)	Docetaxel 75 mg/m² IV Q3W (N = 174)
HR (95% CI)†	0.66 (0.51, 0.86)	
P-value (1-sided)	*P* = 0.002	
Median PFS, months (95% CI)‡	5.6 (4.3, 7.8)	4.5 (3.0, 5.7)



Number of Patients at Risk:

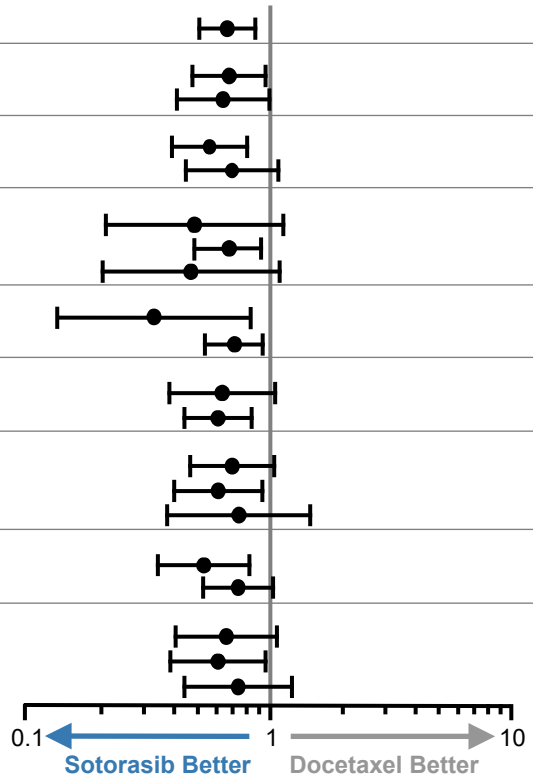
Sotorasib	171	139	93	63	56	38	30	24	14	6	2	1	0
Docetaxel	174	93	62	36	20	10	7	5	3	1	1	0	

CodeBreaK 200 met its primary endpoint with sotorasib demonstrating superior PFS over docetaxel (HR 0.66, *P* = 0.002); 12-month PFS rate was 24.8% for sotorasib and 10.1% for docetaxel

*PFS rates estimated using Kaplan-Meier method; ITT population.
†HR and 95% CIs estimated using a stratified Cox proportional hazards model; *P*-value calculated using a stratified log-rank test.
‡Medians estimated using Kaplan-Meier method; 95% CIs estimated using the method by Klein and Moeschberger with log-log transformation
PFS= progression free survival; BICR= blinded independent central review; IV= intravenous; Q3W= every three weeks; HR= hazard ratio; .

PFS Across Subgroups

Subgroup	Number of Patients: Sotorasib	Number of Patients: Docetaxel	Median PFS, months: Sotorasib	Median PFS, months: Docetaxel	Hazard Ratio (95% CI)
All randomised patients	171	174	5.6	4.5	0.66 (0.51, 0.86)
Age, at baseline (years)					
< 65	91	95	4.4	3.1	0.68 (0.48, 0.96)
≥ 65	80	79	5.9	5.6	0.64 (0.41, 0.99)
Sex					
Male	109	95	5.7	4.5	0.56 (0.39, 0.80)
Female	62	79	4.6	4.2	0.69 (0.45, 1.08)
Region					
North America	20	22	5.9	6.8	0.49 (0.21, 1.13)
Europe	126	126	5.6	4.0	0.68 (0.50, 0.92)
Other*	25	26	5.7	5.6	0.47 (0.20, 1.09)
Race					
Asian	21	22	8.3	5.6	0.33 (0.14, 0.80)
Non-Asian	149	151	5.6	4.2	0.71 (0.54, 0.95)
Baseline ECOG status					
0	59	59	8.4	6.7	0.63 (0.38, 1.05)
1	112	115	4.4	2.8	0.61 (0.44, 0.84)
Number of prior lines in advanced disease					
1	77	78	4.2	4.2	0.70 (0.47, 1.04)
2	65	69	5.7	4.8	0.61 (0.40, 0.92)
> 2	29	27	4.7	4.0	0.74 (0.37, 1.46)
History of CNS involvement					
Yes	58	60	4.4	2.9	0.53 (0.34, 0.82)
No	113	114	5.7	5.7	0.74 (0.53, 1.03)
PD-L1 protein expression					
< 1%	57	55	8.3	5.9	0.66 (0.41, 1.06)
≥ 1% and < 50%	46	70	4.6	3.0	0.61 (0.39, 0.96)
≥ 50%	60	40	5.7	5.4	0.74 (0.44, 1.23)

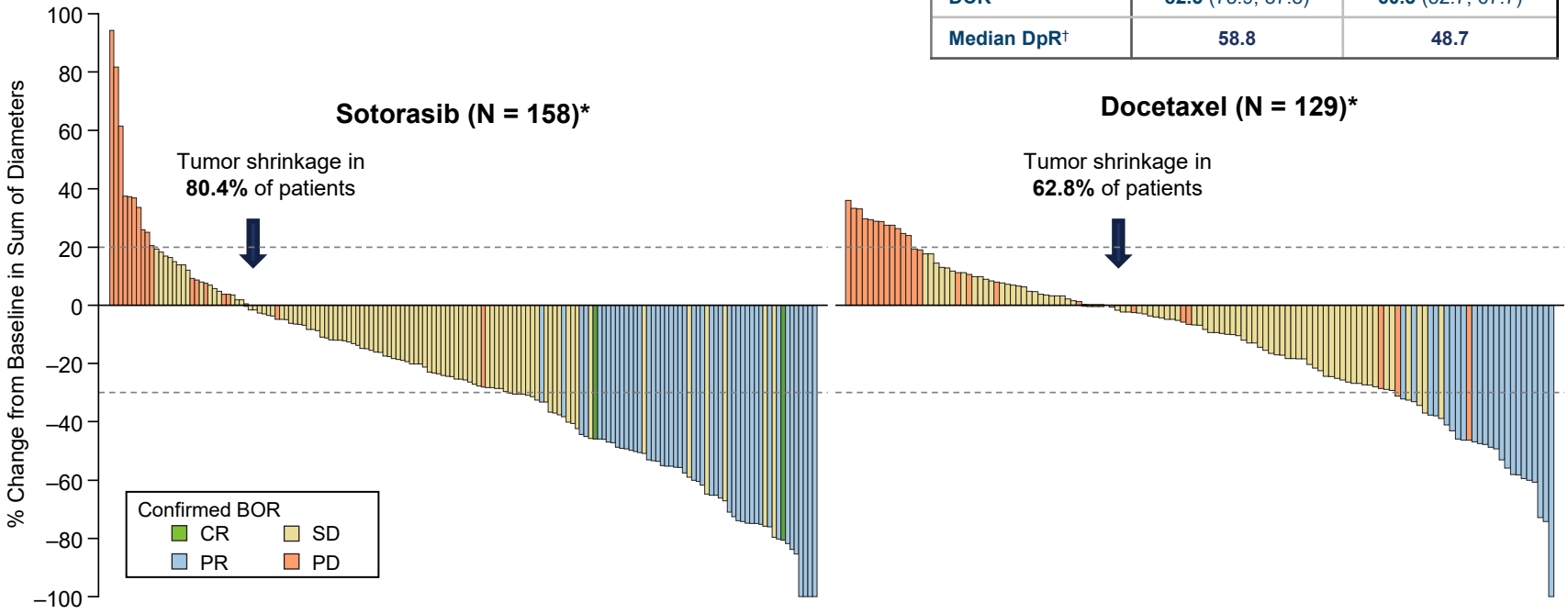


*Other includes South America, Asia, and Australia; PFS= progression free survival; ECOG= Eastern Cooperative Oncology Group; CNS= central nervous system; PD-L1= programmed death ligand 1.

PFS favored sotorasib versus docetaxel across subgroups

Tumor Response by BICR

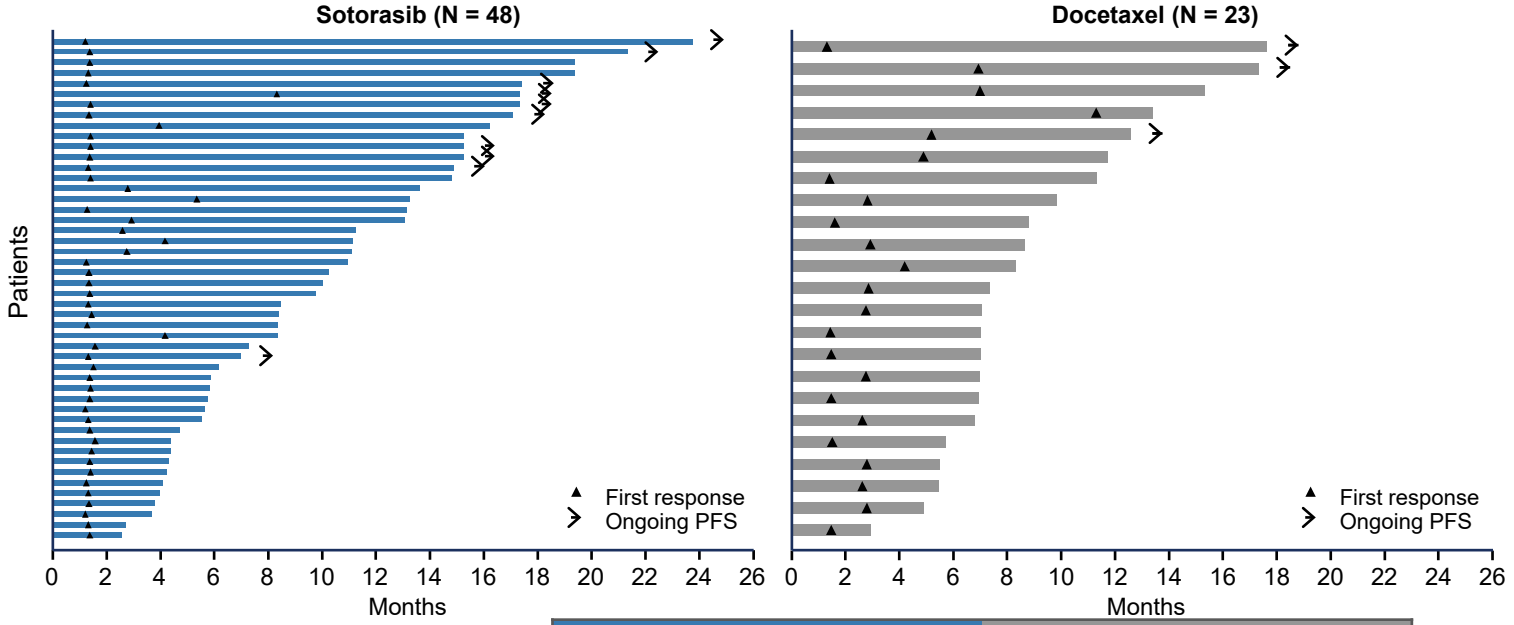
% (95% CI)	Sotorasib	Docetaxel
ORR	**28.1** (21.5, 35.4)	**13.2** (8.6, 19.2)
DCR	**82.5** (75.9, 87.8)	**60.3** (52.7, 67.7)
Median DpR†	**58.8**	**48.7**



Response rate was significantly higher with sotorasib versus docetaxel ($P < 0.001$)

*Patients without baseline target lesions or post-baseline percent changes, or with BOR of NE are not shown.
†Median of best percent change from baseline in sum of diameters for confirmed responders
BICR= blinded independent central review; ORR= objective response rate; DCR= disease control rate; BOR= best overall response; CR= complete response; SD= stable disease; PR= partial response; PD= progressive disease.

Duration of Response: Sotorasib vs Docetaxel*



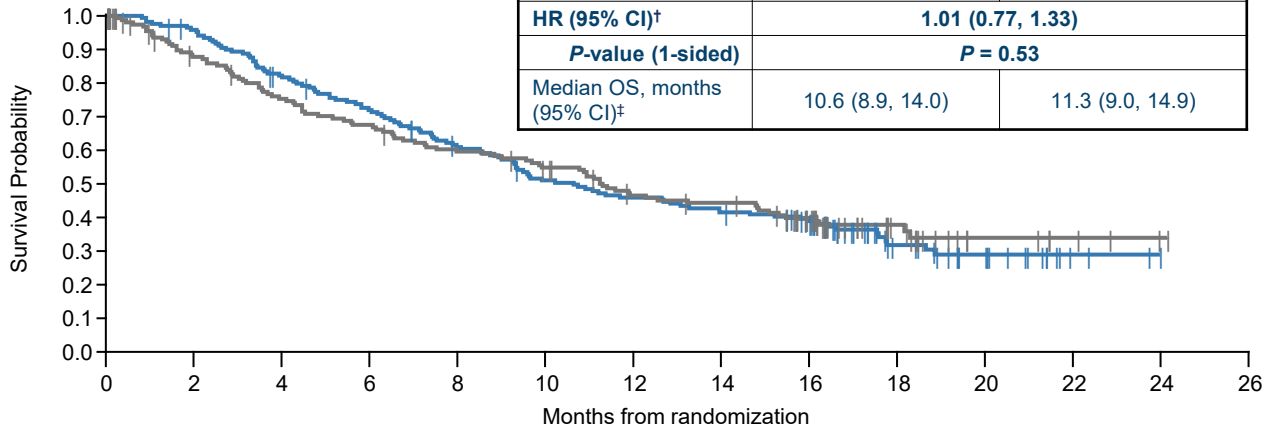
	Sotorasib 960 mg oral daily (n = 48)†	Docetaxel 75 mg/m² IV Q3W (n = 23)†
Median TTR, months (range)‡	1.4 (1.2, 8.3)	2.8 (1.3, 11.3)
Median DOR, months (95% CI)‡	8.6 (7.1, 18.0)	6.8 (4.3, 8.3)

Sotorasib was associated with both faster time to response and longer duration of response

*DOR and TTR calculated only for patients who achieved a confirmed best overall response of PR or CR; ITT population. †Number of responders. ‡Medians and 95% CIs estimated using Kaplan-Meier method.
PFS= progression free survival; IV= intravenous; Q3W= every three weeks; TTR= time to response; DOR= duration of response

OS: Sotorasib vs Docetaxel*

	Sotorasib 960 mg oral daily (N = 171)	Docetaxel 75 mg/m² IV Q3W (N = 174)
Deaths, n (%)	109 (63.7)	94 (54)
HR (95% CI)†	**1.01 (0.77, 1.33)**	
***P*-value (1-sided)**	***P* = 0.53**	
Median OS, months (95% CI)‡	10.6 (8.9, 14.0)	11.3 (9.0, 14.9)



Number of Patients at Risk:

Sotorasib	171	162	137	119	98	81	73	66	56	25	15	3	0
Docetaxel	174	135	115	103	90	81	65	61	44	20	7	4	1	0

§

	Sotorasib	Docetaxel
Any subsequent treatment	36%	42%
Subsequent $KRAS^{G12C}$ inhibitor, including crossover	4%	34%
Subsequent chemo	21%	12%
Subsequent IO	9%	6%

*OS rates estimated using Kaplan-Meier method; ITT population. †HR and 95% CIs estimated using a stratified Cox proportional hazards model; *P*-value calculated using a stratified log-rank test. ‡Medians estimated using Kaplan-Meier method; 95% CIs estimated using the method by Klein and Moeschberger with log-log transformation. §Patients (16.4% in sotorasib arm, 5.2% in docetaxel arm) were treated beyond progression
IV= intravenous; Q3W= every three weeks; HR= hazard ratio; OS= overall survival; KRAS= Kirsten rat sarcoma; IO= immunotherapy

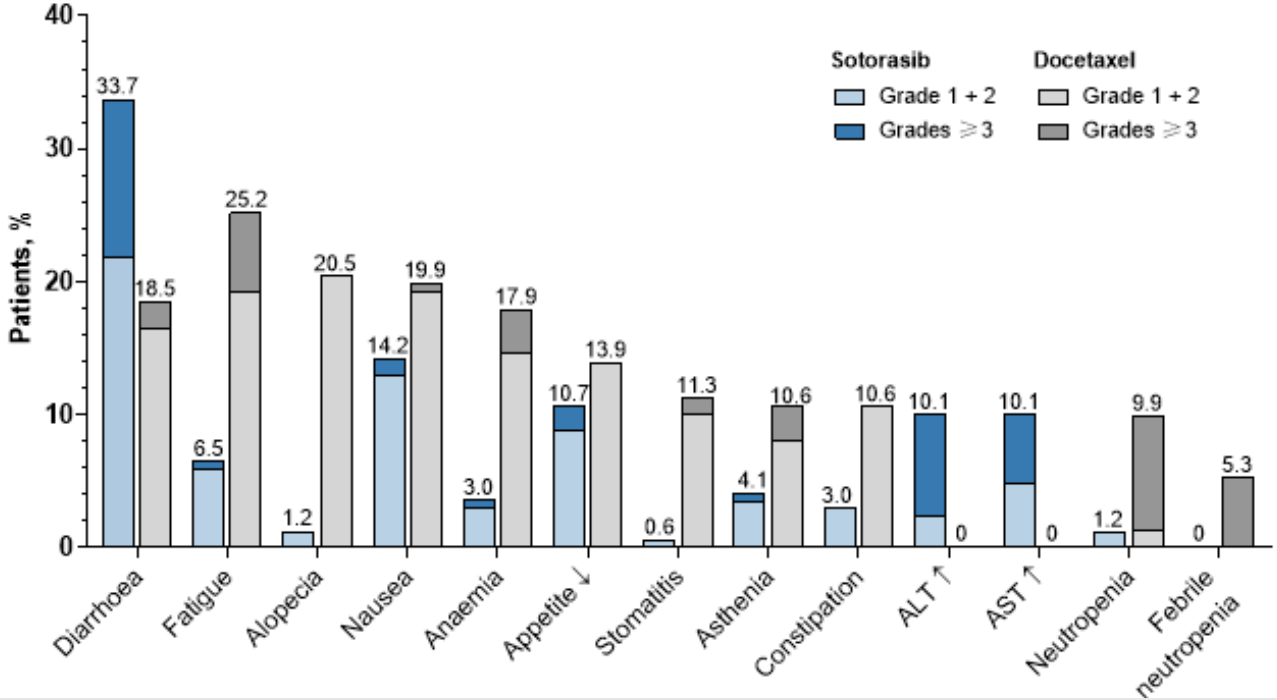
Safety Profile for Sotorasib Versus Docetaxel

	Sotorasib 960 mg oral daily (N = 169)	Docetaxel 75 mg/m^2 IV Q3W (N = 151)
TEAEs, n (%)	**166 (98.2)**	**148 (98.0)**
Grade ≥3	121 (71.6)	91 (60.3)
TRAEs, n (%)	**119 (70.4)**	**130 (86.1)**
Grade ≥3	56 (33.1)	61 (40.4)
Serious	18 (10.7)	34 (22.5)
Leading to dose interruption*	60 (35.5)	23 (15.2)
Leading to dose reduction†	26 (15.4)	40 (26.5)
Leading to discontinuation‡	16 (9.5)	17 (11.3)
Fatal TRAEs§, n (%)	**1 (0.6)**	**2 (1.3)**
Duration of treatment, weeks, median (range)	**20 (0.4, 101)**	**12 (3, 101)**

Sotorasib was well-tolerated with a lower incidence of grade ≥3 and serious TRAEs vs docetaxel

*For sotorasib, diarrhea (n=22), ALT increased (n=9), and AST increased (n=7), and for docetaxel, include fatigue and pneumonia (both n=3), and hypersensitivity and myalgia (both n=2) are the most common.
†For sotorasib, diarrhea (n=14), ALT increased (n=6), and AST increased (n=3), and for docetaxel, include neutropenia (n=7), fatigue (n=6), and febrile neutropenia, neuropathy peripheral, and asthenia (n=4 each) are the most common.
‡For sotorasib, increased ALT (n=6), blood bilirubin (n=4), AST, or blood alkaline phosphatase, and drug-induced liver injury (n=2 each), and for docetaxel, include fatigue (n=3) and febrile neutropenia (n=2) are the most common.
§Fatal TRAEs were observed in 1 patient in the sotorasib group (interstitial lung disease), and 2 patients in the docetaxel group (ileus and multiorgan failure)
IV= intravenous; Q3W= every three weeks; TEAEs= Treatment emergent adverse events; TRAEs= treatment related adverse events; AST= aspartate transaminase; ALT= alanine transaminase

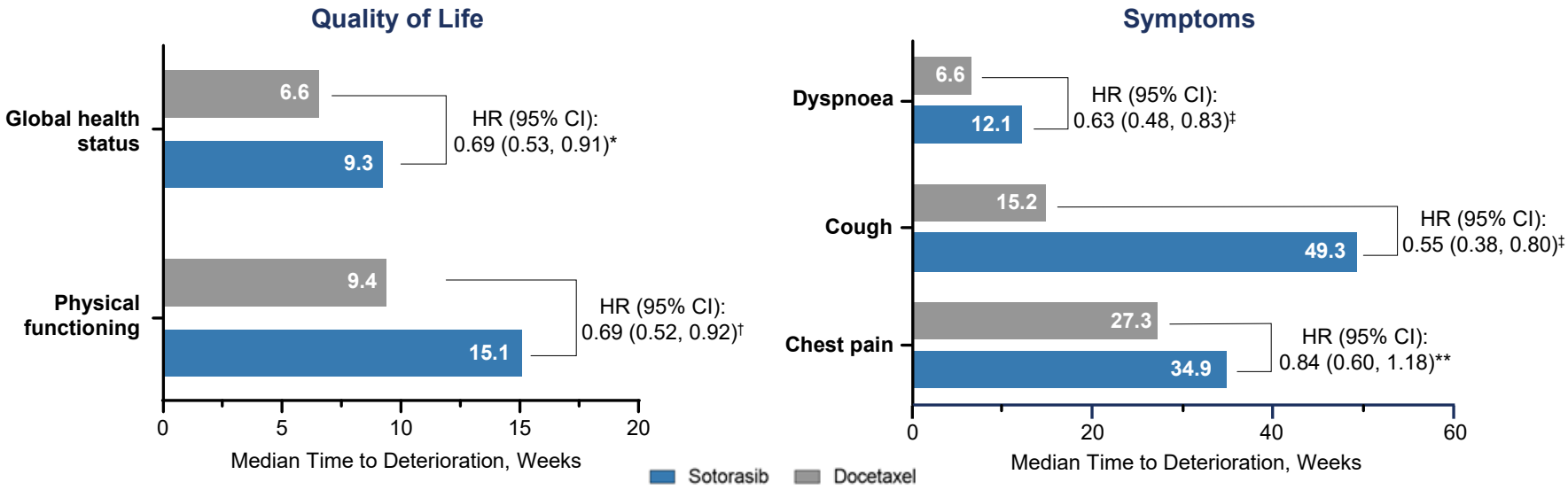
Most Common TRAEs
Any Grade TRAEs (≥ 10%) or Grade ≥ 3 (≥ 5%)



Most common Grade 3+ TRAEs with sotorasib were diarrhea and elevated liver enzymes, and with docetaxel were neutropenia, fatigue, and febrile neutropenia

*Highest-level TRAE per preferred term reported; TRAEs= treatment related adverse events; ALT= alanine transaminase; AST= aspartate transaminase

Patient-Reported Outcomes:
Time to Deterioration



Time to deterioration in global health status, physical functioning, and cancer-related symptoms (dyspnea and cough) were delayed with sotorasib compared to docetaxel

Baseline threshold: global health status: ≥ 8; physical functioning : ≥ 13; dyspnea (composite score): ≤ 92, cough: ≤ 67, chest pain: ≤ 67.

- $P = 0.005$; † $P = 0.007$; ‡ $P < 0.001$; ** $P = 0.17$.

HR= hazard ratio

Conclusions: CodeBreaK 200 Phase 3 Trial

- Sotorasib, a first-in-class KRAS^{G12C} inhibitor, showed significant improvement in the primary endpoint of PFS versus docetaxel (median 5.6 vs 4.5 months, HR=0.66, *P* = 0.002) in previously treated *KRAS G12C*-mutated NSCLC
  - 12-month PFS rate was 24.8% for sotorasib vs 10.1% for docetaxel
  - PFS benefit was consistent across subgroups
- ORR, DCR, TTR, and DOR were improved for sotorasib versus docetaxel
- No difference in OS, though study was not powered to detect a statistical difference
- Sotorasib was well-tolerated with fewer grade 3+ TRAEs than docetaxel
- Clinically meaningful patient-reported outcomes were superior for sotorasib vs docetaxel
- These findings support sotorasib as an important treatment option in this setting and reinforce the importance of NGS testing for *KRAS* G12C

KRAS= Kirsten rat sarcoma; PFS= progression free survival; NSCLC= non-small cell lung cancer; ORR= objective response rate; DCR= disease control rate; TTR= time to response; DOR= duration of response; OS= overall survival; TRAEs= treatment related adverse events; NGS= next generation sequencing

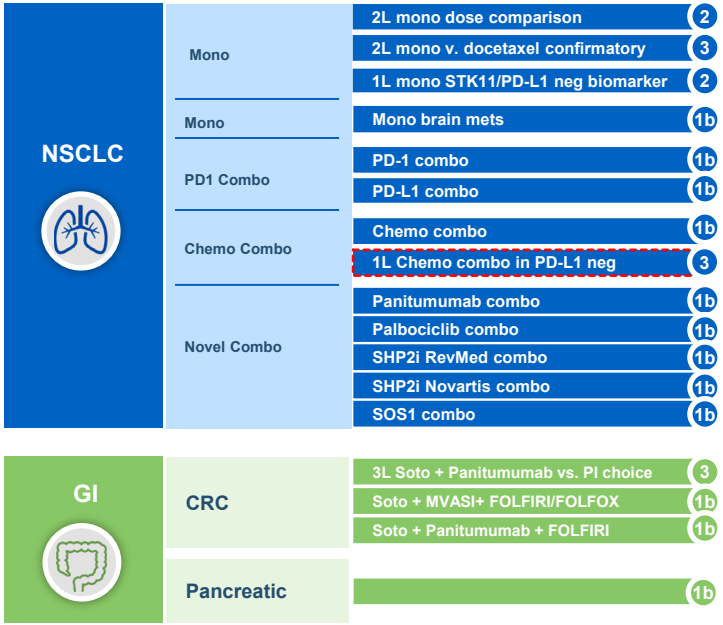
CONCLUDING REMARKS

JEAN-CHARLES SORIA, MD

SENIOR VICE PRESIDENT GLOBAL DEVELOPMENT ONCOLOGY

AMGEN®

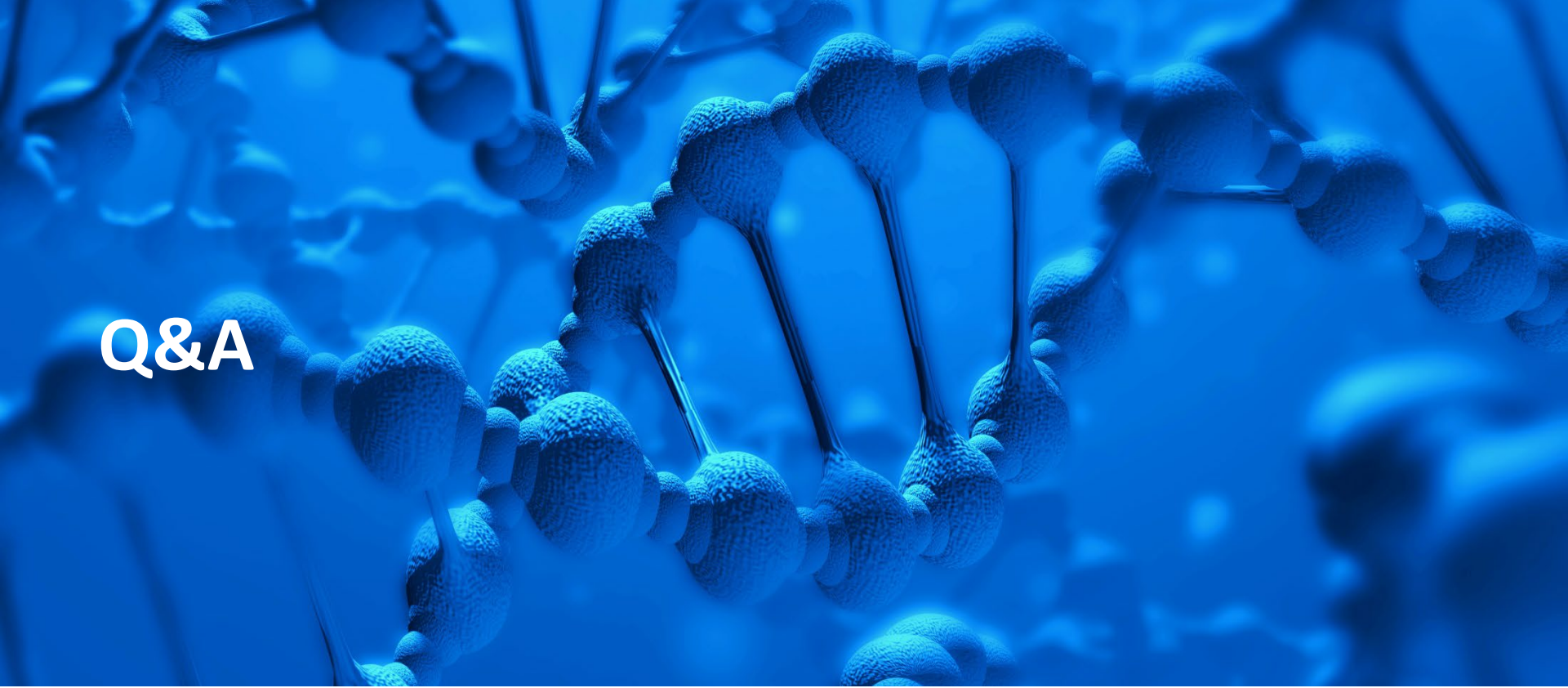
Investigating LUMAKRAS® in multiple combinations, different tumor types, and earlier lines of therapy



- Largest and broadest clinical program
- Only positive Phase 3 trial
- Pursuing NSCLC, CRC, and pancreatic cancers
- Exploring 10+ combinations
- Multiple potential paths to first-line NSCLC

Planned
Does not include deprioritized cohorts MEK +/- panitumumab, EGFR (afatinib), mTORi (everolimus), Chemo Docetaxel and Carbo/Pac

Mono= monotherapy; combo= combination therapy; mets= metastasis; STK11= serine/threonine kinase 11; chemo= chemotherapy; SHP2i= Src homology region 2-containing protein tyrosine phosphatase 2 inhibitor; RevMed= Revolution Medicines; SOS1= son of sevenless 1; Soto= sotorasib; PI= principle investigator; FOLFIRI= Folinic acid, fluorouracil and irinotecan; GI= gastrointestinal; NSCLC= non small cell lung cancer; CRC= colorectal cancer; 1L= first line; 2L= second line; 3L= third line; PD1= programmed cell death protein 1; FOLFOX= fluorouracil, leukovorin, and oxaliplatin; mTORi = mammalian target of rapamycin inhibitor; MEK= mitogen-activated protein kinase kinase; EGFR= epidermal growth factor receptor


Q&A