AMG 160 DATA AT ESMO VIRTUAL CONGRESS 2020

SEPTEMBER 21, 2020

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SAFE HARBOR STATEMENT

This presentation contains forward-looking statements that are based on the current expectations and beliefs of Amgen. All statements, other than statements of historical fact, are statements that could be deemed forward-looking statements, including any statements on the outcome, benefits and synergies of collaborations, or potential collaborations, with any other company, including BeiGene, Ltd. or any collaboration or potential collaboration in pursuit of therapeutic antibodies against COVID-19 (including statements regarding such collaboration's, or our own, ability to discover and develop fully-human neutralizing antibodies targeting SARS-CoV-2 or antibodies against targets other than the SARS-CoV-2 receptor binding domain, and/or to produce any such antibodies to potentially prevent or treat COVID-19), or the Otezla® (apremilast) acquisition (including anticipated Otezla sales growth and the timing of non-GAAP EPS accretion), as well as estimates of revenues, operating margins, capital expenditures, cash, other financial metrics, expected legal, arbitration, political, regulatory or clinical results or practices, customer and prescriber patterns or practices, reimbursement activities and outcomes, effects of pandemics or other widespread health problems such as the ongoing COVID-19 pandemic on our business, outcomes, progress, or effects relating to studies of Otezla as a potential treatment for COVID-19, and other such estimates and results. Forward-looking statements involve significant risks and uncertainties, including those discussed below and more fully described in the Securities and Exchange Commission reports filed by Amgen, including our most recent annual report on Form 10-K and any subsequent periodic reports on Form 10-Q and current reports on Form 8-K. Unless otherwise noted, Amgen is providing this information as of the date of this presentation and does not undertake any obligation to update any forward-looking statements contained in this document as a result of new information, future events or otherwise.

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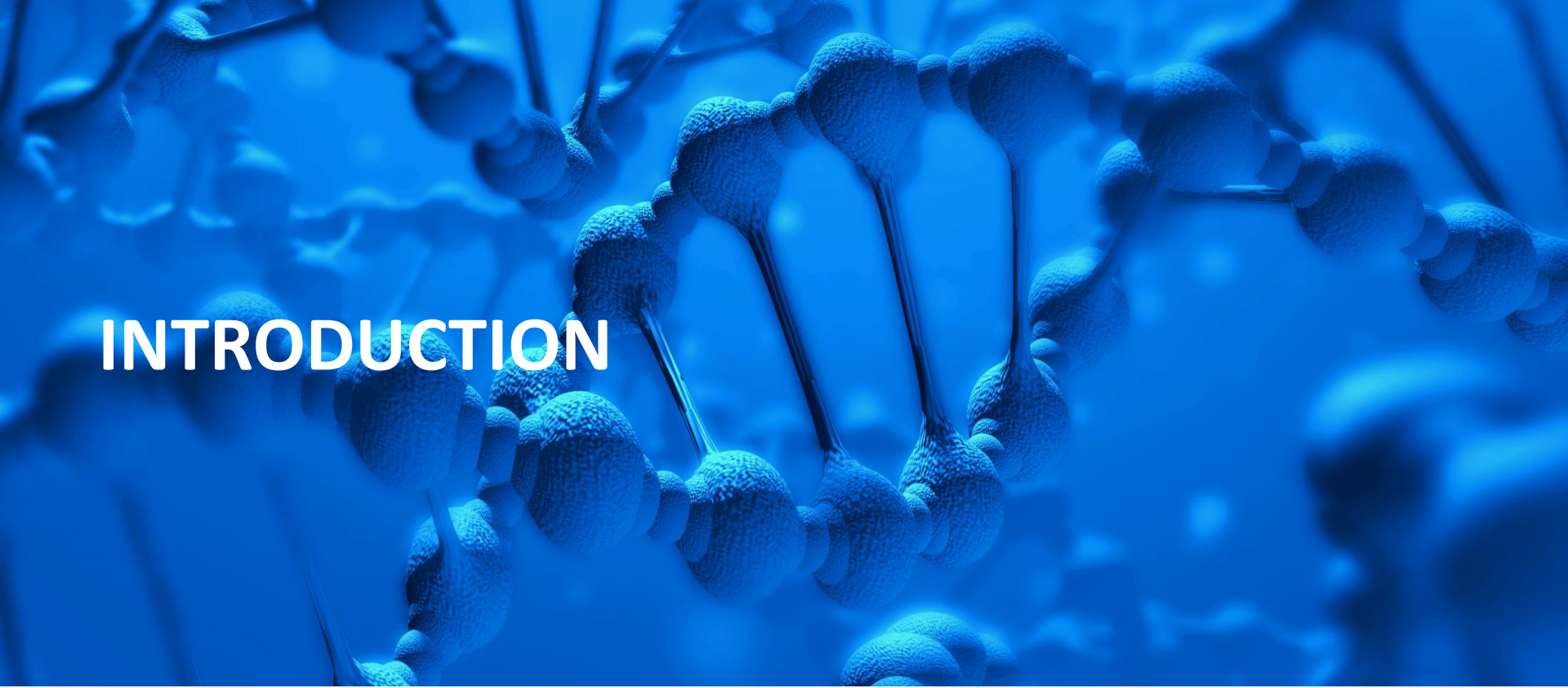
AGENDA

Introduction	**David Reese, M.D.—Executive Vice President, Research and Development**
AMG 160 Data Overview	**Gregory Friberg, M.D.—Vice President, Global Development and Oncology Therapeutic Area Head**
Q&A	**David Reese, M.D.** **Gregory Friberg, M.D.**



INTRODUCTION

DAVID REESE, M.D.

EXECUTIVE VICE PRESIDENT, RESEARCH AND DEVELOPMENT

AMGEN®

AMGEN IS THE LEADER IN BiTE® IMMUNO-ONCOLOGY

BLINCYTO® is the only FDA Approved BiTE® Therapy

Most robust pipeline with 10 investigational molecules across solid tumors and blood cancers

Most Patients Studied

To date, Amgen's BiTE® immuno-oncology platform has been investigated in more than 3,000 patients

BiTE® = bispecific T-cell engager

Provided September 21, 2020, as part of an oral presentation and is qualified by such, contains forward-looking statements, actual results may vary materially; Amgen disclaims any duty to update.

AMGEN'S BITE® PLATFORM: A CLINICALLY VALIDATED IMMUNO-ONCOLOGY THERAPY

- Clinically validated off-the-shelf immuno-oncology therapy
- Seamlessly integrated, scalable, industrialized platform
- Clinical activity demonstrated in both liquid and solid tumors
- Advancing half-life extended BiTE® constructs against high-quality targets in prostate cancer, SCLC, MM and gastric cancer
- Applying learnings across programs to optimize dose / schedule and mitigate adverse events
- Exploring strategies to prevent resistance
  - Combinations with PD-1 antibodies are ongoing
  - Additional combinations and rational sequences are planned

SCLC = small cell lung cancer; MM = multiple myeloma; PD-1 = programmed cell death protein 1

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AMG 160 UPDATE

GREGORY FRIBERG, M.D.

VICE PRESIDENT, GLOBAL DEVELOPMENT AND ONCOLOGY
THERAPEUTIC AREA HEAD

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PROSTATE CANCER IS A LEADING CAUSE OF MORTALITY IN MEN

- #1 diagnosed non-cutaneous cancer in men in the U.S. and EU, #2 worldwide[1-4]
- ~ 1.3 million new diagnoses and ~ 360,000 estimated deaths due to prostate cancer worldwide in 2018[5]
- Androgen-deprivation therapy (ADT) is the standard of care for regional or advanced prostate cancer, however most men progress to castrate resistant prostate cancer (CRPC)[6,7]
- ~ 1/3 of patients with CRPC develop metastases within two years of diagnosis[8]
- Metastatic CRPC (mCRPC) remains incurable despite current treatments, including ADT, chemotherapy, immunotherapy, radium isotope and palliative therapies[9]
- The five-year survival rate for mCRPC is 30%, representing a high unmet medical need[2]

1. Ferlay J, et al. Eur J Cancer. 2018;103:356-387. 2. SEER Cancer Stat Facts: Prostate Cancer. seer.cancer.gov/ statfacts/html/prost.html. Accessed March 14, 2019. 3. Bray F, et al. *CA Cancer J Clin*. 2018;68:394-424. 4. Gandaglia G, et al. *Prostate*. 2014;74:210-216. 5. The Global Cancer Observatory. https://gco.iarc.fr/today/data/factsheets/cancers/27-Prostate-fact-sheet.pdf. 6. Crawford ED, et al. Urol Oncol. 2017;355:S1-S13. 7. Nouri M, et al. Front Oncol. 2014;4:370. 8. Kirby M, et al. Int J Clin Pract. 2011;65:1180-1192. 9. Sumanasuriya S, et al. Cold Spring Harb Perspect Med. 2018;8:a030635.

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PROSTATE-SPECIFIC MEMBRANE ANTIGEN (PSMA): A COMPELLING TARGET FOR PROSTATE CANCER

- **PSMA is a type II transmembrane glycoprotein highly expressed on the surface of prostate cancer cells**
- **Considered an independent indicator of poor prognosis[1-5]**
  - **High expression on biopsy is associated with increased chance of disease recurrence**
  - **Expression increases with tumor aggressiveness, androgen independence, metastatic disease, and disease recurrence**
- **Low, predominantly cytoplasmic expression in some normal tissues, including prostate, brain, kidney, liver and small intestine**
- **Low membrane expression on select tumors: NSCLC, neuroendocrine, breast**

1. Chang SS. Rev Urol. 2004;6(suppl 10):S13-S18. 2. Bouchelouche K, et al. Discov Med. 2010;9:55-61. 3. Bravaccini S, et al. Sci Rep. 2018;8:4254. 4. Chang SS, et al. Cancer Res. 1999;59:3192-3198. 5. Hupe MC, et al. Front Oncol. 2018;8:623..

Interim results from a phase 1 study of AMG 160, a half-life extended (HLE), PSMA-targeted, bispecific T-cell engager (BiTE®) immune therapy for metastatic castration-resistant prostate cancer (mCRPC)

Ben Tran, MBBS, FRACP,[1] Lisa Horvath, PhD, MBBS, FRACP,[2] Tanya Dorff, MD,[3] Matthew Rettig, MD,[4] Martijn P. Lolkema, MD, PhD,[5] Jean-Pascal Machiels, MD,[6] Sylvie Rottey, MD, PhD,[7] Karen Autio, MD,[8] Richard Greil, MD,[9] Nabil Adra, MD, MSc,[10] Charlotte Lemech, MD, FRACP,[11] Mukul Minocha, PhD,[12] Fu-Chih Cheng, PhD,[12] Hosein Kouros-Mehr, MD, PhD,[12] Karim Fizazi, MD, PhD[13]

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Presented at European Society of Medical Oncology 2020 Virtual Congress, September 19-21, 2020

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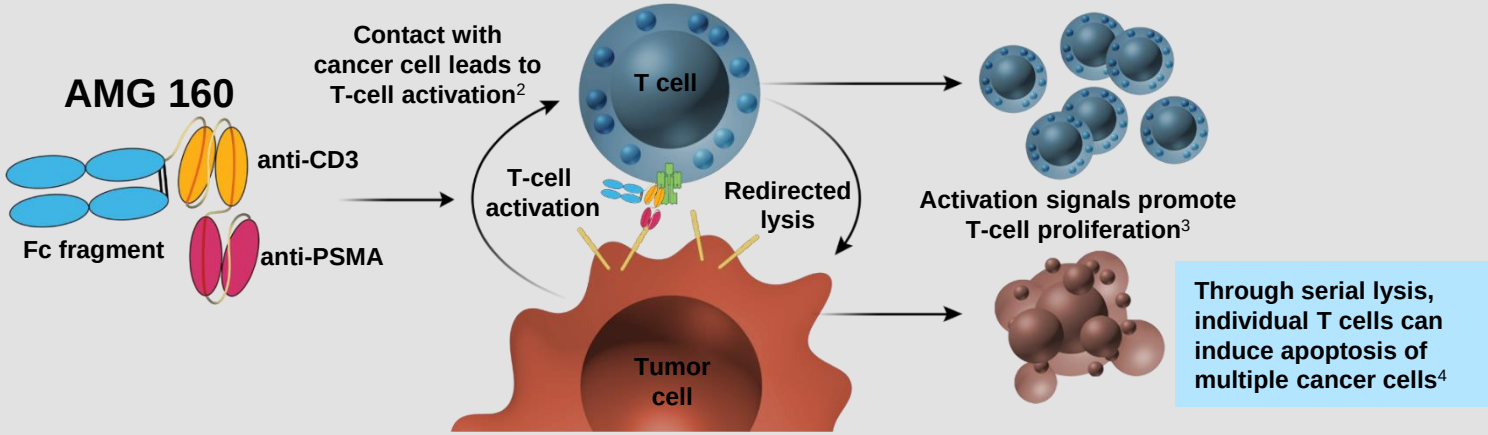
AMGEN BITE® (BISPECIFIC T-CELL ENGAGER) IMMUNOTHERAPY



- BiTE® molecules engage a patient's own T cells to attack and eradicate cancer cells[1]
  - T-cell activation induces transient cytokine release and tumor killing[1]
- Blinatumomab (BLINCYTO®, Amgen Inc.) is the first and only bispecific immunotherapy approved in oncology worldwide[1]
- AMG 160 is a half-life extended PSMA x CD3 BiTE® immunotherapy for mCRPC

1. Baeuerle PA, et al. Cancer Res. 2009;69:4941-4. 2. Klinger M, et al. Immun Rev. 2016;270(1):193-208. 3. Bargou R, et al. Science. 2008;321:974-7. 4. Stieglmaier J, et al. Expert Opin Biol Ther. 2015;15(8):1093-9.

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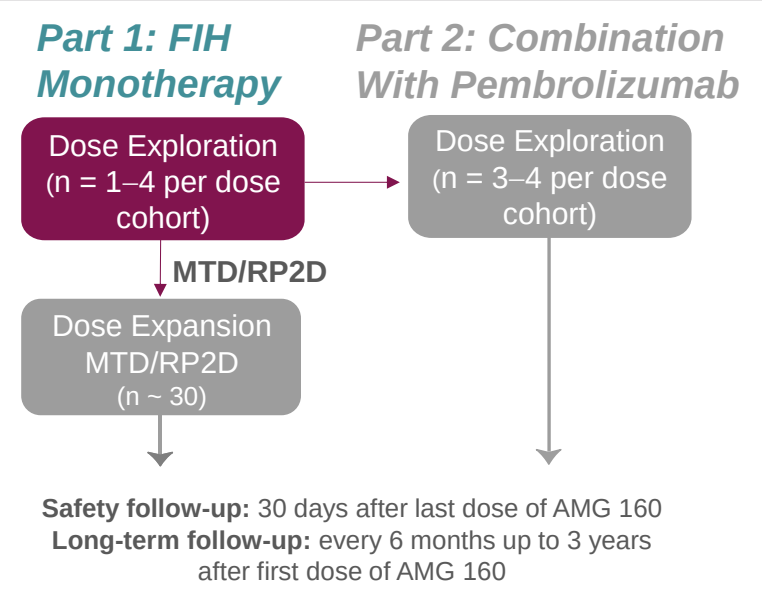
FIRST-IN-HUMAN DOSE EXPLORATION STUDY OF AMG 160



Primary Objectives

- Evaluate safety and tolerability in mCRPC
- Determine MTD or RP2D

Secondary Objectives

- Characterise PK
- Evaluate preliminary antitumor activity

Exploratory Objectives

- Evaluate biomarkers of PD activity
- Identify potential patient selection biomarkers

- **Study design – Phase 1, global, open-label study evaluating safety and tolerability of AMG 160 monotherapy (Part 1) or in combination with pembrolizumab (Part 2)**
- **Dosing schedule – IV infusion every 2 weeks (after target dose reached)**

FIH = first-in-human; IV = intravenous; mCRPC = metastatic castration-resistant prostate cancer; MTD = maximum tolerated dose; PD = pharmacodynamics; PK = pharmacodynamics; RP2D = recommended phase 2 dose

KEY ELIGIBILITY CRITERIA AND DEMOGRAPHICS

- **Inclusion Criteria**
  - **Histologically or cytologically confirmed mCRPC refractory to novel hormonal therapy and**
    - **Have failed 1–2 taxane regimens; or**
    - **Patient deemed unsuitable for or has refused taxanes**
  - **Evidence of progressive disease per PCWG3**
- **Exclusion Criteria**
  - **Active autoimmune disease or requiring immunosuppressive therapy**
  - **Prior PSMA–targeted therapy (patients treated with PSMA radionuclide therapy may be eligible)**
  - **CNS metastases, leptomeningeal disease, or spinal cord compression**

Baseline Demographics	All (N = 43)
Median (range) age, y	66.0 (49–78)
Race, n (%)	
Asian	2 (4.7)
Black	2 (4.7)
White	34 (79.1)
Other	5 (11.6)
Prior lines of therapy, n (%)	
1	2 (4.7)
2	4 (9.3)
3	9 (20.9)
≥ 4	26 (60.5)
Median (range)	4 (1–9)
Median (range) PSA at baseline, µg/L	79.2 (0.1–4035.0)
RECIST-measurable disease, n (%)	15 (34.9%)

CNS = central nervous system; PCWG3 = Prostate Cancer Clinical Trials Working Group 3; RECIST = Response Evaluation Criteria in Solid Tumors

ADVERSE EVENTS (AES) AND ANTIDRUG ANTIBODIES (ADAS)

- 43 patients received ≥ 1 dose of AMG 160 monotherapy
  - 41 (95.3%) patients experienced TEAEs
  - 19 (44.2%) patients remained on AMG 160 at the time of data analysis
    - 6 (14.0%) received treatment ≥ 6 months

TRAEs

- 41 (95.3%) patients experienced TRAEs
  - No grade 5 events, and none resulted in treatment discontinuation
- 3 reversible dose-limiting toxicities occurred
  - Grade 3 rash (n = 2)
  - Grade 3 GI hemorrhage (n = 1)

ADAs

- 6 of 30 (20.0%) patients assessed developed ADAs affecting drug exposure between cycles 1 and 10
  - No AEs associated with ADAs were observed

TRAEs in ≥ 20% of patients (N = 43)*

TRAE, n (%)	All Grade, n (%)	Grade 3, n (%)
CRS (Lee criteria)†	39 (90.7)	11 (25.6)
Fatigue	19 (44.2)	1 (2.3)
Vomiting†	19 (44.2)	0 (0)
Nausea†	17 (39.5)	0 (0)
Pyrexia†	16 (37.2)	0 (0)
Headache†	15 (34.9)	0 (0)
Diarrhoea†	14 (32.6)	2 (4.7)
Dry mouth	13 (30.2)	0 (0)
Rash†	12 (27.9)	4 (9.3)
Hypophosphataemia	11 (25.6)	4 (9.3)
Hypotension†	10 (23.3)	5 (11.6)
Chills†	10 (23.3)	0 (0)
Dysgeusia	10 (23.3)	0 (0)
Decreased appetite	9 (20.9)	0 (0)

* 8 patients experienced grade 4 laboratory abnormalities that were clinically non-significant;
† CRS-related

20 July 2020 cutoff; ADA = antidrug antibody; AE = adverse event; CRS = cytokine release syndrome; GI = gastrointestinal; TEAE = treatment-emergent adverse event; TRAE = treatment-related adverse event

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CHARACTERISTICS OF CYTOKINE RELEASE SYNDROME

- **CRS was reversible, manageable, most severe in cycle 1 and associated with fever, hypotension, transient transaminitis, nausea/vomiting and/or diarrhea (Lee 2014 grading)**
  - **No grade 4/5 CRS events or treatment discontinuations**
  - **26 (60.5%) patients had grade 2 CRS as worst grade (hypotension: 15 [34.9%]; transaminitis: 13 [30.2%])***
  - **11 (25.6%) patients had grade 3 CRS as worst grade (hypotension: 6 [14.0%]; transaminitis: 10 [23.3%])***
    - **Transaminitis events were short-term AST/ALT elevations not associated with long-term hepatic dysfunction**
  - **4 (9.3%) patients experienced reversible atrial fibrillation in setting of CRS/tachycardia**

CRS Grading (Lee 2014)			
Grade 1	**Grade 2**	**Grade 3**	**Grade 4†**
Fever, nausea, fatigue, etc, requiring symptomatic treatment only	Grade 1 CRS symptoms and • O_2 requirement $< 40\%$ • Intravenous fluids or low-dose vasopressor for hypotension • Grade 3 transaminitis	Grade 1 CRS symptoms and • O_2 requirement $\geq 40\%$ • High-dose or multiple vasopressors for hypotension • Grade 4 transaminitis	Grade 1 CRS symptoms and • Requirement for ventilator • Grade 4 organ toxicity (excluding transaminitis)

*** Data from investigators, database-reported AEs, and laboratories (20 July 2020); † No grade 4 CRS events were observed at the time of data cutoff (20 July 2020)**
AE = adverse event; ALT = alanine aminotransferase; AST = aspartate aminotransferase; CRS = cytokine release syndrome

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PROPHYLACTIC MITIGATIONS TO IMPROVE CRS PROFILE

Prophylactic Mitigations in Cycle 1 Priming Cohort		
Dose priming	**Dexamethasone premedication**	**Prophylactic IV hydration**
Lower run-in dose before maintenance target dose	8 mg PO and 8 mg IV before AMG 160 dose*	1L normal saline after AMG 160 dose

Safety Outcomes With Prophylactic Mitigation Strategy	
Cohort 5 (unoptimised), 0.3 mg (n = 4)	**Cohort 5 (optimised), 0.3 mg (n = 5)**
• **No DLTs** • **SAEs, (n = 4; including 3 CRS events)** • **Grade 2 CRS (n = 3)** • **Grade 3 CRS (n = 2)**	• **No DLTs** • **No SAEs** • **Grade 2 CRS (n = 3)** • **No Grade 3 CRS**

20 July 2020 data cutoff; CRS = cytokine release syndrome; DLT = dose limiting toxicity; IV = intravenous; PO = oral administration; SAE = serious adverse event
***Dexamethasone premedication: 8 mg PO (6–16 hours before) and 8 mg IV (1 hours before) before AMG 160 doses in cycle 1**

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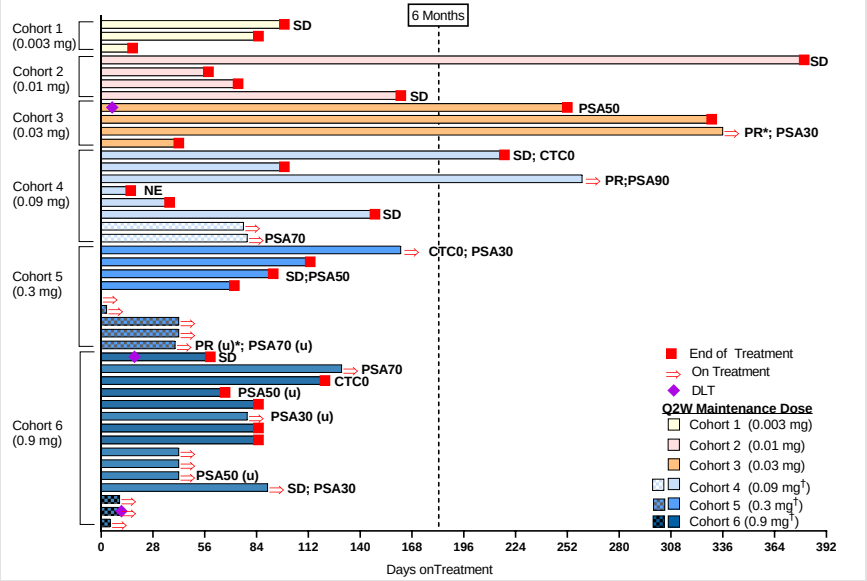
AMG 160 DEMONSTRATES EFFICACY WITH LONG-TERM RESPONSES

PSA/CTC Responses (n = 13–35)	
Response	**All, n (%)**
PSA response, confirmed*	8 (27.6)
PSA response, unconfirmed†	4 (11.4)
CTC0 response‡	3 (23.1)

RECIST Responses (n = 15)	
Response	**All, n (%)**
Partial response, confirmed	2§ (13.3)
Partial response, unconfirmed	1§ (6.7)
Stable disease	8 (53.3)

*** ≥ 30% reduction based on 29 patients with 2 postbaseline PSA results**
† ≥ 30% reduction based on 35 patients with measurable PSA at baseline
‡ Based on 13 patients with baseline CTC > 0 and postbaseline CTC assessment
§ 1 PR(u) and 1 PR confirmation occurred after 20 July 2020



CTC = circulating tumor cell; DLT = dose-limiting toxicities; NE = not evaluable; PSA = prostate-specific antigen; PR = partial response; Q2W = every 2 weeks; RECIST = Response Evaluation Criteria in Solid Tumors; SD = stable disease; (u) = unconfirmed
*** PR occurred before but reported after 20 July 2020 data cutoff; PR (u) reported after 20 July 2020 data cutoff**
† Checkered bars indicate cohorts with optimised cycle 1 priming strategies

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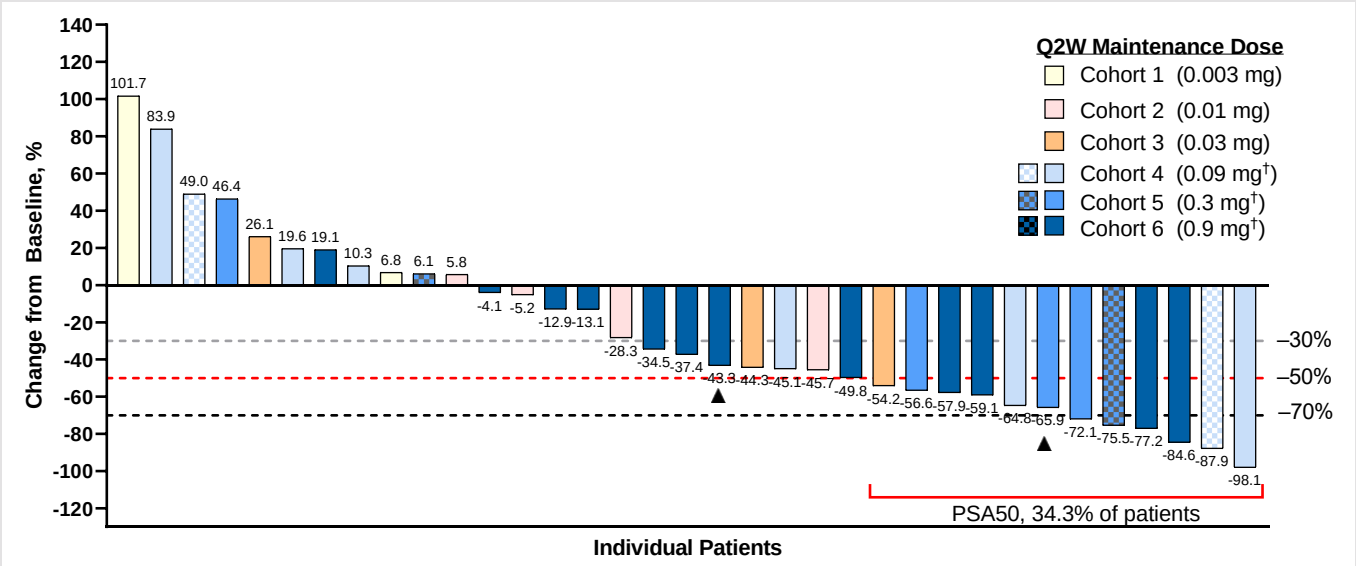
PSA REDUCTIONS IN THE MAJORITY OF EVALUABLE PATIENTS*

- **PSA reductions (best response) were dose dependent and occurred in 24/35 (68.6%) evaluable patients (20 July 2020)**
- **PSA reductions > 50% occurred in 12/35 (34.3%) evaluable patients**

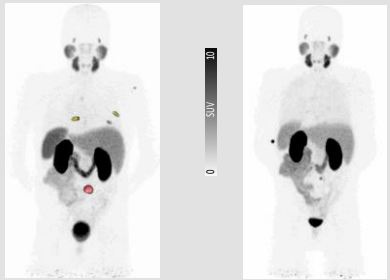


PSA50 = PSA decrease of ≥ 50%; Q2W = every 2 weeks; * Best PSA reductions at any time point in evaluable patients included those who had received ≥ 1 dose of AMG 160 and had measurable baseline PSA; † Checkered bars indicate cohorts with optimised cycle 1 priming strategies; ▲ Indicates patient who had failed prior LuPSMA treatment

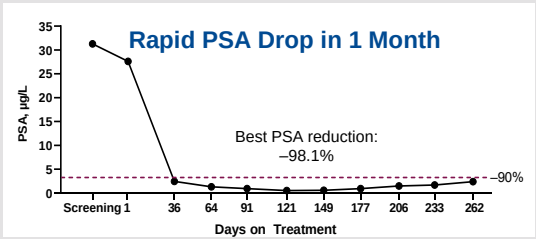
EXAMPLES OF DEEP RESPONSES TO AMG 160

Patient	10112001002
Prior Rx	Surgery, radiotherapy, docetaxel, enzalutamide, bicalutamide, and talazoparib
Cohort	4 (0.09 mg with cycle 1 priming)

PR by 3 Months
PSMA PET/CT

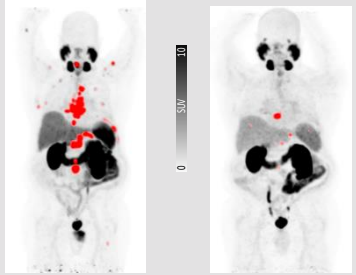


Baseline **Week 12**

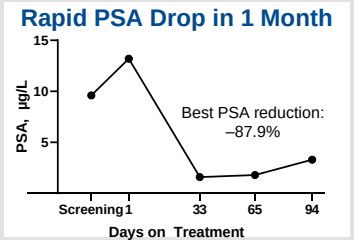


Patient	10166004005
Prior Rx	Surgery, docetaxel, enzalutamide, sipuleucel
Cohort	4 (0.09 mg with optimised cycle 1 priming)

Not RECIST evaluable
PSMA PET/CT

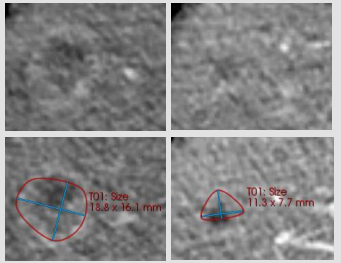


Baseline **Week 12**



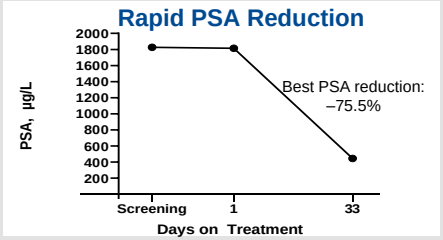
Patient	10166004006
Prior Rx	Radiotherapy, apalutamide, docetaxel, sipuleucel-T, radium-223
Cohort	5 (0.3 mg with optimised cycle 1 priming)

PR (u)* by 2.5 Months



Baseline
T01 Liver Segment VIII

Week 10
40% reduction vs baseline



PET/CT = positron emission tomography–computed tomography; PR = partial response; PSA = prostate-specific antigen; PSMA = prostate-specific membrane antigen; RECIST = Response Evaluation Criteria in Solid Tumors; u = unconfirmed; * PR (u) response reported after 20 July, 2020 data cutoff

CONCLUSIONS

- AMG 160 had a manageable safety profile as monotherapy
  - CRS was reversible and manageable with priming doses and standard mitigations
  - No grade 5 TRAEs or treatment-related discontinuations
- In heavily pretreated patients, AMG 160 showed preliminary evidence of efficacy
  - Overall, 68.6% of patients showed any PSA decline across all monotherapy dose cohorts
  - 34.3% of patients showed ≥ PSA50 reduction
  - Among the 15 patients with measurable disease, 3 PR (2 confirmed) and 8 SD were observed
- 44.2% of patients remained on AMG 160 at the time of data analysis, with 6 (14.0%) patients continuing treatment for ≥ 6 months
- MTD has not been reached and dosing optimisation of AMG 160 continues as study nears RP2D; investigation of AMG 160 in combination with pembrolizumab is in progress

For more information, please contact Amgen Medical Information: medinfo@amgen.com

CRS = cytokine release syndrome; MTD = maximum tolerated dose; PR = partial response; PSA = prostate-specific antigen; PSA50 = PSA decrease of ≥ 50%; RP2D = recommended phase 2 dose; SD = stable disease

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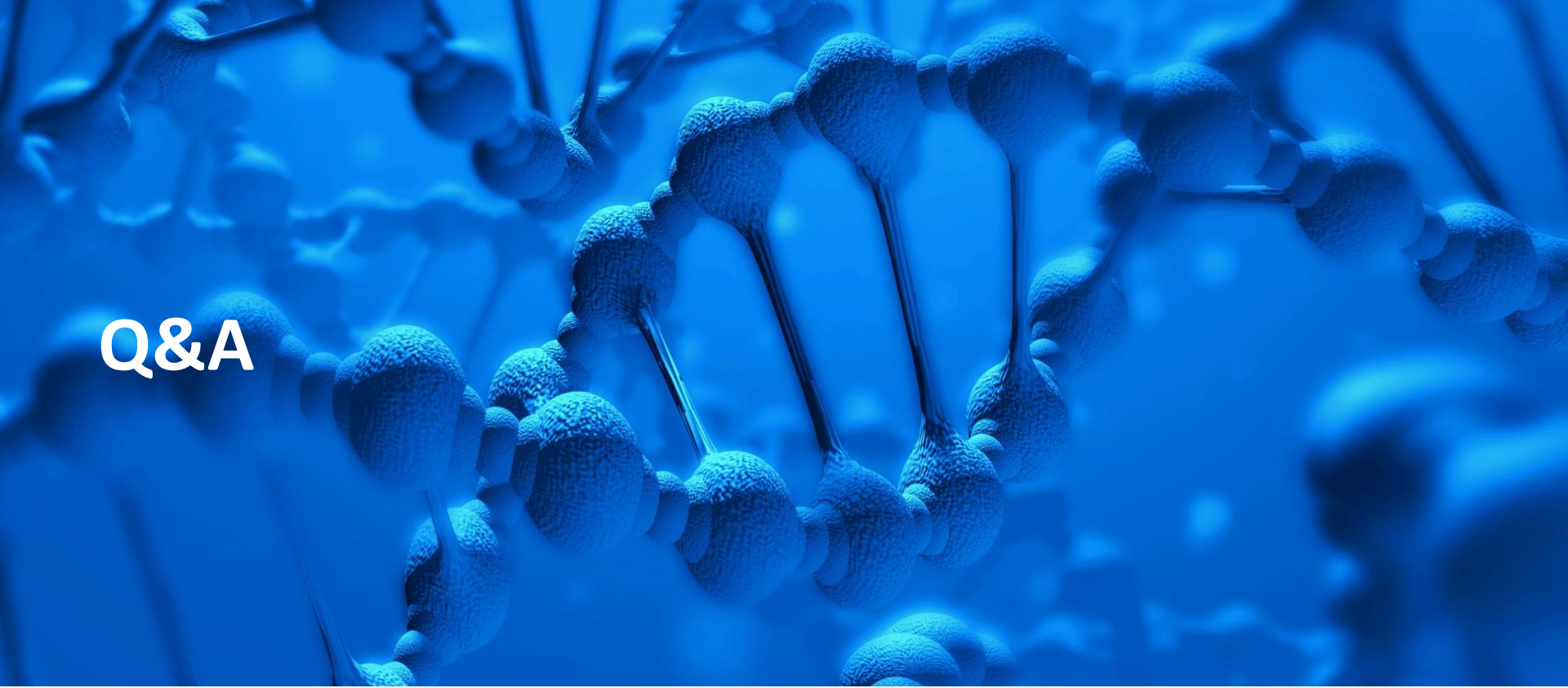
Q&A

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