Disclaimer

This presentation contains forward-looking statements within the meaning of the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements can generally be identified by words such as “potential,” “can,” “will,” “plan,” “may,” “could,” “would,” “expect,” “anticipate,” “seek,” “look forward,” “believe,” “committed,” “investigational,” “pipeline,” “launch,” or similar terms, or by express or implied discussions regarding potential marketing approvals, new indications or labeling for the investigational or approved products described in this presentation; or regarding potential future revenues from such products; or regarding our transformation into a pure-play innovative medicines company; or regarding our mid-term sales guidance; or regarding potential future, pending or announced transactions; or regarding our approximate estimated peak sales, sales potential and other financial information; or regarding our commitment to operational excellence; or regarding our expanding use of our technology platforms across core therapeutic areas; or by discussions of strategy, plans, expectations or intentions. You should not place undue reliance on these statements. Such forward-looking statements are based on our current beliefs and expectations regarding future events, and are subject to significant known and unknown risks and uncertainties. Should one or more of these risks or uncertainties materialize, or should underlying assumptions prove incorrect, actual results may vary materially from those set forth in the forward-looking statements. There can be no guarantee that the investigational or approved products described in this presentation will be submitted or approved for sale or for any additional indications or labeling in any market, or at any particular time. Nor can there be any guarantee that such products will be commercially successful in the future, or that any estimated peak sales or other estimated financial figures referenced will be reached. In particular, our expectations regarding such products could be affected by, among other things, the uncertainties inherent in research and development, including clinical trial results and additional analysis of existing clinical data; regulatory actions or delays or government regulation generally; global trends toward health care cost containment, including government, payor and general public pricing and reimbursement pressures and requirements for increased pricing transparency; our ability to obtain or maintain proprietary intellectual property protection; the particular prescribing preferences of physicians and patients; general political, economic and business conditions, including the effects of and efforts to mitigate pandemic diseases; safety, quality, data integrity or manufacturing issues; potential or actual data security and data privacy breaches, or disruptions of our information technology systems, and other risks and factors referred to in Novartis AG’s current Form 20-F on file with the US Securities and Exchange Commission. Novartis is providing the information in this presentation as of this date and does not undertake any obligation to update any forward-looking statements contained in this presentation as a result of new information, future events or otherwise.
Participants

Shreeram Aradhye, MD
President, Development and Chief Medical Officer

Jeff Legos, PhD
EVP, Global Head of Oncology & Hematology Development

Reshema Kemps-Polanco
EVP, Chief Commercial Officer - US
1. Novartis legacy in CML and current unmet needs

2. *Scemblix*® ASC4FIRST results

3. *Scemblix*®: Establishing the 1L CML treatment of choice

4. Q&A
Novartis has a 20+ year legacy of innovation in CML, transforming a once deadly disease into a chronic condition

**Novartis legacy in CML**

**2001**
Introduction of **first targeted therapy** improves survival for CML patients

**2007**
Continued focus on **deeper levels of response** and disease control: MMR → DMR → TFR

**Today**
Goal of **transforming SoC once again** by potentially enabling more patients to meet treatment goals with better tolerability

**CML is now a chronic cancer**

~17k newly diagnosed patients/year

10-year survival rate of ~95%

Most patients have a life expectancy comparable to the general population

Vast majority take daily TKI therapy for the rest of their lives

---

However, treatments that optimize efficacy and safety are still needed

Inadequate control of CML and TKI-related AEs can increase risk of progression

- ~40% of 1L CML patients need to change therapy by 5 years due to either resistance, intolerance and treatment related complications\(^1\);\(^4\); \(~30\%\) of patients switch within the first year of their second therapy\(^5\)

- ~50% of patients do not achieve DMR even after 4 years of switching from their first treatment\(^6\)

- ~25% of treated CML patients manage to achieve TFR, with some requiring ~8 years to qualify for TFR\(^7\)

- Long-term use of 2G TKIs is associated with AEs such as pleural effusion, GI and CV events due to off-target effects\(^8,10\)

- Persistent AEs remain the most common reason for intentional non-adherence to TKI treatment\(^9\)

Novel treatments with differentiated mechanism of action may allow patients to stay on therapy longer and better achieve treatment goals
Scemblix was designed for enhanced efficacy and minimized off-target activity vs current standard-of-care TKIs\(^4\)

ATP-competitive TKIs\(^1,4\)

Scemblix: 1\(^{st}\) BCR::ABL1 inhibitor specifically targeting ABL myristoyl pocket\(^2,3,4\)

ATP-binding site\(^1\)  

ATP – adenosine triphosphate.  
CAMK – calcium/calmodulin-dependent protein kinases; CK1, cell kinase.  
STAMP – Specifically Targeting the ABL Myristoyl Pocket. STE, serine/threonine kinases.  
TKL – tyrosine kinase-like.

1. Each ATP-competitive TKIs inhibit multiple kinases due to similarities between ATP binding pockets.  
2. Myristoyl binding site unique for ABL-1 protein.  
3. BCR-ABL1 fusion protein kinase activity leads to uncontrolled growth of myeloid cells.  
4. Please refer to the appendix for references.
In the Ph3 ASCEMBL study, Scemblix more than doubled MMR rate vs bosutinib with a favorable safety profile in 3L+ CML...

Efficacy¹

- Scemblix is the 1st agent to show superiority vs 2G TKI, more than doubling the MMR rate vs bosutinib

Major Molecular Response (MMR) Rates at week 96

<table>
<thead>
<tr>
<th></th>
<th>Sceblux (n=156)</th>
<th>Bosutinib (n=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, %</td>
<td>37.6</td>
<td>15.8</td>
</tr>
<tr>
<td>21.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safety and tolerability¹,²

- AEs leading to treatment discontinuation were ~4x lower with Scemblix vs bosutinib
- Median duration of exposure was over 3x longer
- Scemblix showed improvements in symptoms and health-related QoL²

Durability³,⁴

- Sustained efficacy and safety with ~4 years median follow-up in ASCEMBL³
- Up to 8 years of follow-up in X2101 FIH study⁴

1. ASCEMBL Ph3 week 96: Hochhaus A. et al., Leukemia 2023; 37:617–626.
3. ASCEMBL Ph3 end of study: Mauro MJ et al., ASH2023, poster 4536.
4. X2101 FIH final results: Hochhaus A. et al., ASH2023, oral presentation 450.
...which has led to rapid uptake in clinical practice, and the opportunity to study Scemblix in earlier lines of treatment

**Scemblix uptake in 3L+ CML**

- >70 approvals around the world
- Conversion of accelerated approval to full approval in US
- Included in NCCN guidelines
- Leading share in both new starts and total TRx in 3L+
- Use across academic centers and the community setting
- Switches from all other TKIs

---

1. Novartis internal data on file.  
2. Scemblix Label FDA dated October 12th 2022 — Efficacy-Labeling Change With Clinical Data— from conditional to full approval.  
5. Atallah et al., Blood 2023; 142 (Supplement 1):1809.
Agenda

1. Novartis legacy in CML and current unmet needs
2. *Scemblix* ASC4FIRST results
3. *Scemblix*: Establishing the 1L CML treatment of choice
4. Q&A
Many newly diagnosed CML patients still do not reach efficacy goals with current standard-of-care TKIs

1L CML treatment landscape\textsuperscript{1,2,3}

Newly diagnosed
17k/year

1L

1%

20%

46%

28%

4%

On 1L treatment
55k

Roughly 50/50 imatinib vs 2G TKIs (reflected in ASC4FIRST comparator arm)

Remaining unmet need in 1L CML

\(~25\%\) of 1L patients \textit{switch treatments in the 1st year}\textsuperscript{4}

\(~50\%\) of 1L patients \textit{do not meet efficacy goals} (MMR) at 1 year; even fewer achieve deep responses by 2 years\textsuperscript{5-7}

Persistent AEs (such as diarrhea, edema, rash) remain the \textbf{most common reason for intentional non-adherence} to TKI treatment\textsuperscript{8}

Faster and deeper molecular response with favorable safety and tolerability remains the key unmet need for newly diagnose patients with CML

---

\textbf{MMR} – Major molecular response (BCR-ABL 1S ≤0.1%).

\textsuperscript{1} Newly diagnosed: Kantar health CML incidence in G7 (US, EU5, JP), patients in 2024.

\textsuperscript{2} CML prevalence in G7, 2024: Kantar health.

\textsuperscript{3} IQVIA Market Sizing, IPSOS & IQVIA Oncology Dynamics (G7, MAT Jun 2023). Please refer to appendix for references 4-8.
The Ph3 ASC4FIRST study was designed to reflect current clinical practice and unmet needs in newly diagnosed CML patients.

**ASC4FIRST:** Adult patients with newly diagnosed Ph+ CML-CP with no prior TKIs (n=405)

**Primary endpoints:**
- MMR week 48 vs all IS-TKIs
- MMR at week 48 vs imatinib

**Key secondary endpoints:**
- MMR at week 96 vs all IS-TKIs
- MMR at week 96 vs imatinib

**Other endpoints include:**
- MMR vs 2G TKIs
- DMR (MR4/MR4.5)
- Type, frequency and severity of AEs including discontinuation due to AEs
- Change in QoL

---

**Pre-randomization TKI selection**
- TKI a patient will take if randomized to IS-TKI arm
- Selected by physician in consultation with patient

**Stratification:**
- **Pre-randomization TKI selection**
  - Imatinib or 2G-TKI
- **ELTS**
  - High/intermediate/low

---

**Ph+ CML-CP** – Philadelphia positive chronic myeloid leukemia in chronic phase.  
**MMR** – Major molecular response (BCR-ABL 1IS ≤0.1%).  
**MR4** – at least a 4-log reduction i.e., BCR-ABL 1IS ≤0.01%.  
**MR4.5** – at least a 4.5 log reduction i.e., BCR-ABL 1IS ≤0.0032%.  
**MR5** – at least a 4 log reduction i.e., BCR-ABL 1IS ≤0.001%  
**TKI** – Tyrosine kinase inhibitor.  
**IS** – Investigator-selected.  
**ELTS** – EUTOS long-term survival score.  
**ASC** – asciminib.  
**QoL** – Quality of life.
Baseline characteristics were similar between the arms and representative of the CML population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Scemblix Imatinib stratum (n=101)</th>
<th>2G TKI(^1) stratum (n=100)</th>
<th>IS-TKI Imatinib stratum (n=102)</th>
<th>2G TKI(^1) stratum (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age (range), years</td>
<td>56.0 (21.0-79.0)</td>
<td>43.0 (18.0-76.0)</td>
<td>54.5 (20.0-86.0)</td>
<td>43.0 (19.0-83.0)</td>
</tr>
<tr>
<td>Age group, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 to &lt;65 years</td>
<td>68.3</td>
<td>86.0</td>
<td>68.6</td>
<td>83.3</td>
</tr>
<tr>
<td>65 to &lt;75 years</td>
<td>23.8</td>
<td>12.0</td>
<td>21.6</td>
<td>11.8</td>
</tr>
<tr>
<td>≥75 years</td>
<td>7.9</td>
<td>2.0</td>
<td>9.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Male, %</td>
<td>61.4</td>
<td>69.0</td>
<td>63.7</td>
<td>58.8</td>
</tr>
<tr>
<td>Framingham estimated 10-year cardiovascular disease risk categories, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk (&lt;10%)</td>
<td>40.6</td>
<td>68.0</td>
<td>39.2</td>
<td>70.6</td>
</tr>
<tr>
<td>Intermediate risk (10%–20%)</td>
<td>20.8</td>
<td>11.0</td>
<td>28.4</td>
<td>14.7</td>
</tr>
<tr>
<td>High risk (≥20%)</td>
<td>38.6</td>
<td>21.0</td>
<td>32.4</td>
<td>14.7</td>
</tr>
<tr>
<td>ELTS, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>61.4</td>
<td>60.0</td>
<td>62.7</td>
<td>59.8</td>
</tr>
<tr>
<td>Intermediate</td>
<td>29.7</td>
<td>26.0</td>
<td>29.4</td>
<td>26.5</td>
</tr>
<tr>
<td>High</td>
<td>8.9</td>
<td>14.0</td>
<td>7.8</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Patients pre-selected to receive imatinib (“imatinib stratum”) had more patients >65 years old and more patients with higher CV disease risk than those pre-selected to receive 2G TKI\(^1\) (“2G TKI\(^1\) stratum”)

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500. IS-TKIs – Investigator selected TKIs. CV – Cardiovascular. 1. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
Scemblix demonstrated clinically meaningful and statistically significant MMR benefit of nearly 20% vs investigator-selected TKIs (IS-TKIs)

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500. IS-TKIs – Investigator selected TKIs. CI – Confidence interval. CMH – Cochran-Mantel-Haenszel. 1. Clopper-Pearson 95% CI. 2. The common risk difference and its 95% CI estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data). 3. Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value ≤0.025.
MMR rate at week 48 was superior vs all IS-TKIs and vs imatinib, meeting both primary endpoints with high statistical significance.
Higher MMR rates were consistent across all demographic and prognostic subgroups

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500. IS-TKIs – Investigator selected TKIs. CI – Confidence interval. CMH – Cochran-Mantel-Haenszel. NA – Not applicable. 1. Clopper-Pearson 95% CI. 2. The common risk difference and its 95% CI estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data). 3. Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value ≤0.025. 4. Unstratified risk difference.
Scemblix patients also achieved earlier and deeper molecular responses vs all IS-TKIs...

Reduced Time to MMR by 1/3

<table>
<thead>
<tr>
<th></th>
<th>Median time to MMR (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scemblix (n=201)</td>
<td>24.3 (95% CI: 24.1-24.6)</td>
</tr>
<tr>
<td>All IS-TKIs (n=204)</td>
<td>36.4 (95% CI: 36.1-48.6)</td>
</tr>
</tbody>
</table>

Nearly doubled deep molecular responses at 1 year

- **Scemblix (n=201)**
  - MR4: 38.8%
  - MR4.5: 16.9%

- **All IS-TKIs (n=204)**
  - MR4: 20.6%
  - MR4.5: 8.8%

Hughes TP et al., 2024 ASCO Annual Meeting LBA500. CI – Confidence interval. CMH – Cochran-Mantel-Haenszel. NA – Not applicable. 1. Clopper-Pearson 95% CI. 2. The common risk difference and its 95% CI estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data). 3. Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value ≤0.025.
... as well as earlier and deeper molecular responses vs imatinib

### Median Time to MMR (weeks)

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=101)</th>
<th>Imatinib (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24.1 (95% CI: 24.0-24.6)</td>
<td>48.6 (95% CI: 36.1-59.6)</td>
</tr>
</tbody>
</table>

### Patients, %

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=101)</th>
<th>Imatinib (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MR4</td>
<td></td>
<td>42.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17.8</td>
</tr>
<tr>
<td>MR4.5</td>
<td></td>
<td>17.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.9</td>
</tr>
</tbody>
</table>

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500.  CI – Confidence interval.  CMH – Cochran-Mantel-Haenszel.  NA – Not applicable.  1. Clopper-Pearson 95% CI.  2. The common risk difference and its 95% CI estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data).  3. Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value ≤0.025.
Compared to 2G TKIs\textsuperscript{4}, Scemblix showed numerically higher MMR rates, earlier achievement of MMR, and deeper responses.

**MMR (not powered)**

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=100)</th>
<th>2G TKIs\textsuperscript{5} (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, %</td>
<td>66.0% (95% CI, 55.9, 75.2)\textsuperscript{1}</td>
<td>57.8% (95% CI, 47.7, 67.5)\textsuperscript{1}</td>
</tr>
<tr>
<td></td>
<td>(8.2%)\textsuperscript{2} (95% CI: -5.1, 21.5)</td>
<td></td>
</tr>
</tbody>
</table>

**Median Time to MMR (weeks)**

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=100)</th>
<th>2G TKIs\textsuperscript{4} (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, %</td>
<td>66.0% (95% CI: 24.1-35.6)</td>
<td>57.8% (95% CI: 24.4-48.1)</td>
</tr>
<tr>
<td></td>
<td>24.3</td>
<td>36.1</td>
</tr>
</tbody>
</table>

**MR4**

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=100)</th>
<th>2G TKIs\textsuperscript{5} (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, %</td>
<td>16.0% (95% CI: 9.3, 25.9)</td>
<td>12.8% (95% CI: 5.9, 23.7)</td>
</tr>
</tbody>
</table>

**MR4.5**

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=100)</th>
<th>2G TKIs\textsuperscript{5} (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, %</td>
<td>66.0% (95% CI: 35.9, 88.9)</td>
<td>57.8% (95% CI: 37.1, 69.8)</td>
</tr>
<tr>
<td></td>
<td>24.3</td>
<td>36.1</td>
</tr>
</tbody>
</table>

Hughes TP et al., 2024 ASCO Annual Meeting LBA8500. CI – Confidence interval. CMH – Cochran-Mantel-Haenszel. NA – Not applicable. 1. Clopper-Pearson 95% CI. 2. The common risk difference and its 95% CI estimated using the Mantel-Haenszel method after stratifying for (a) pre-randomization selected TKI, and (b) baseline ELTS risk groups (both IRT data). 3. Adjusted 1-sided p-value calculated based on the graphical gatekeeping procedure. The null hypothesis is rejected if the adjusted p-value ≤0.025. 4. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
Scemblix showed favorable safety and tolerability vs all IS-TKIs...

### Fewer grade ≥3 AEs vs all IS-TKIs

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=200)</th>
<th>Imatinib (n=99)</th>
<th>2G TKIs (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade ≥3 AEs</td>
<td>38.0</td>
<td>44.4</td>
<td>54.9</td>
</tr>
</tbody>
</table>

### Fewer AEs leading to interruptions/discontinuations

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=200)</th>
<th>Imatinib (n=99)</th>
<th>2G TKIs (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEs leading to discontinuation</td>
<td>4.5</td>
<td>11.1</td>
<td>9.8</td>
</tr>
<tr>
<td>AEs leading to dose adjustment/interruption</td>
<td>30.0</td>
<td>39.4</td>
<td>52.9</td>
</tr>
</tbody>
</table>

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500.  
IS-TKIs – Investigator selected TKIs.  
AEs – Adverse events.  
1. Safety analyses consisted of patients who received ≥1 dose of study drug. Patients were analyzed according to the study treatment received. The most common AEs leading to treatment discontinuation were lipase increases with Scemblix (1.5%), diarrhea and lymphopenia with imatinib (2.0% each), and pleural effusion with 2G TKIs (2.0%).  
2. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
... with lower rates of non-hematological AEs impacting patient quality of life

<table>
<thead>
<tr>
<th></th>
<th>Scemblix (n=200)¹</th>
<th>Imatinib (n=99)¹</th>
<th>2G TKIs² (n=102)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>15.5</td>
<td>21.5</td>
<td>26.3</td>
</tr>
<tr>
<td>Fatigue</td>
<td>14.0</td>
<td>17.6</td>
<td>14.1</td>
</tr>
<tr>
<td>Headache</td>
<td>13.5</td>
<td>14.7</td>
<td>17.2</td>
</tr>
<tr>
<td>Myalgia</td>
<td>13.0</td>
<td>13.1</td>
<td>10.1</td>
</tr>
<tr>
<td>Rash</td>
<td>13.0</td>
<td>10.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Lipase increased</td>
<td>11.5</td>
<td>12.7</td>
<td>17.2</td>
</tr>
<tr>
<td>Constipation</td>
<td>9.5</td>
<td>17.6</td>
<td>14.1</td>
</tr>
<tr>
<td>Nausea</td>
<td>9.0</td>
<td>21.2</td>
<td>21.2</td>
</tr>
<tr>
<td>Increased alanine aminotransferase</td>
<td>7.0</td>
<td>7.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>7.0</td>
<td>7.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Increased blood alkaline phosphatase</td>
<td>5.5</td>
<td>5.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Vomiting</td>
<td>5.5</td>
<td>5.9</td>
<td>11.3</td>
</tr>
<tr>
<td>Increased blood bilirubin</td>
<td>2.5</td>
<td>2.0</td>
<td>21.2</td>
</tr>
<tr>
<td>Increased aspartate aminotransferase</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Muscle spasms</td>
<td>2.0</td>
<td>4.9</td>
<td>6.1</td>
</tr>
<tr>
<td>Periorbital/face edema</td>
<td>1.0</td>
<td>1.0</td>
<td>19.2</td>
</tr>
</tbody>
</table>

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500. 1. Safety analyses consisted of patients who received ≥1 dose of study drug. Patients were analyzed according to the study treatment received. The most common AEs leading to treatment discontinuation were lipase increases with Scemblix (1.5%), diarrhea and lymphopenia with imatinib (2.0% each), and pleural effusion with 2G TKIs (2.0%). 2. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
**Better benefit-risk profile vs current SoC TKIs positions Scemblix as a potential therapy of choice for newly diagnosed CML patients upon approval**

<table>
<thead>
<tr>
<th>Scemblix demonstrated superior efficacy...</th>
<th>...with a favorable safety and tolerability profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Superior MMR rates vs IS-TKIs and vs imatinib alone</td>
<td>✓ Fewer grade ≥3 AEs</td>
</tr>
<tr>
<td>✓ Consistent results regardless of baseline characteristics</td>
<td>✓ Fewer dose adjustments/interruptions needed to manage AEs</td>
</tr>
<tr>
<td>✓ Earlier achievement of MMR and greater depth of responses</td>
<td>✓ Half the rate of all-grade AEs leading to discontinuation</td>
</tr>
<tr>
<td>✓ Improvement vs 2G TKI(^1) in MMR rate, speed and depth of responses</td>
<td>✓ Lower rates and severity of most AEs associated with 2G TKI(^1) class and impacting patient lives</td>
</tr>
</tbody>
</table>

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500.  
SoC – Standard of care.  
1. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
ASC4FIRST data recognized as a major advancement in CML innovation by regulators and the scientific community

FDA Breakthrough designation in 1L CML

- Granted based on positive data from ASC4FIRST study
- Previously received BTD in patients with 3L+ CML and T315I mutation

NEJM publication


ASCO and EHA presentations

- Official Press Program at ASCO, given to <1% of abstracts
- Plenary presentation at EHA, as one of the six best abstracts

FDA submission under RTOR; global submissions planned H2 2024-2025

Agenda

1. Novartis legacy in CML and current unmet needs

2. *Scemblix* ASC4FIRST results

3. *Scemblix*: Establishing the 1L CML treatment of choice

4. Q&A
ASC4FIRST results position Scemblix to be the treatment of choice for newly diagnosed CML patients upon approval

Superior\(^1\) benefit-risk profile vs SoC TKIs

- Better efficacy with fewer AEs and treatment discontinuations
- Numerically higher MMR rate vs 2G TKIs
- Half the discontinuation rate of imatinib or 2G TKIs

---

1. ASC4FIRST trial met both primary endpoints with clinically meaningful and statistically significant results; Scemblix\(^\circ\) (asciminib) shows superior MMR rates at week 48 vs standard-of-care TKIs (imatinib, nilotinib, dasatinib, and bosutinib) in newly diagnosed Ph+CML-CP patients. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
By combining a differentiated clinical profile with strong execution, Scemblix has been firmly established as the market leader in 3L+

Continued momentum in 3L+

Global sales
USD m, % cc

>2x NBRx share vs any other competitor in 3L+

US 3L+ NBRx share¹
FY 2023, %

NBRx – new to brand prescription. ¹ IQVIA Market Sizing Report, 2024.
1L CML opportunity represents ~3x the patient population of 3L+; nearly all prescribers covered by current Novartis Hematology FF

2023 US CML New Patient Population¹

- 3L+: ~2.0K (~18%)
- 2L: ~2.7K (~25%)
- 1L: ~6.2K (~57%)

US 1L CML Prescriber Population²

- All CML: ~10,500 HCPs ~100% of 1L TRxs
- High-volume: ~3,600 HCPs ~75% of 1L TRxs

Current Novartis Hematology FF covers ~90% of all CML HCPs and 100% of high-volume HCPs
~20% of high-volume HCPs already have experience with Scemblix in 3L+

TKI - tyrosine kinase inhibitor.  MMR – Major molecular response.  DMR – Deep molecular response.  TFR – Treatment-free remission.  ¹IQVIA Market Sizing Report, 2024.  ²Novartis internal market research and claims analysis
Leveraging our experience in CML to deliver against three critical elements of 1L launch readiness

1. **Empower patients**
   in decision-making

2. **Reduce access barriers**
   to allow optimal care

3. **Target potential early adopters**
   on differentiated clinical profile

CML-experienced field sales, market access and medical teams already in place, to appropriately raise awareness of Scemblix clinical profile upon approval
Empower patients: Elevating the patient perspective on their experience and unmet needs in CML

Many patients are dissatisfied with current treatment options¹

<table>
<thead>
<tr>
<th>Side effects of current 1L treatment</th>
<th>Satisfied</th>
<th>Neutral-to-dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>43%</td>
<td>57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety profile current 1L treatment</th>
<th>Satisfied</th>
<th>Neutral-to-dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>68%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Empower patients to advocate for a treatment with a tolerability profile that works for them

- Develop tools and resources to onboard newly diagnosed patients and support HCP discussion
- Continue strong engagement with key patient advocacy groups to facilitate active patient/HCP shared treatment decision-making
- Amplify conversations in the community among treatment-naive patients via CML advocates

¹ Novartis ATU market research (April 2024).
Reduce access barriers: CML is a managed category, presenting challenges and opportunities for Scemblix anticipated launch

Challenges

- ~40% of covered lives are managed by payers today (PAs, preferred brands, and/or step edits)
- 2G TKIs expected to lose exclusivity in 2024-2025

Opportunities

- HCPs accustomed to advocating for coverage and gaining payer approvals
- Less branded competition

Imperatives for a successful launch

- **Highlight value proposition** with population health decision-makers and payers to support 1L coverage upon approval
- **Educate HCPs about coverage**, PA criteria, and supporting data to foster successful approvals
- **Ensure robust patient services** to minimize patient OOP cost burden, facilitate on-boarding, and provide ongoing support
Target potential early adopters: Understanding ingrained behaviors, initial focus on physicians representing ~60% of 1L opportunity at launch

Current prescribing behavior in 1L

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>% of HCPs</th>
<th>% of 1L TRx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive treaters</td>
<td>&gt;75% of 1L TRx are 2G TKIs, ~20% of 1L opportunity</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>Splitters</td>
<td>Mixed use of 2G TKIs, imatinib, Higher CML patient volume than other cancer types, ~40% of 1L opportunity</td>
<td>48%</td>
<td>54%</td>
</tr>
<tr>
<td>Imatinib loyalists</td>
<td>&gt;75% of 1L TRx are imatinib, ~15% of 1L opportunity</td>
<td>22%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Key attributes of Scemblix prescribers at launch
- Understand tolerability as an unmet need
- Prioritize efficacy but dose adjust for AEs
- Willing to advocate for coverage

1. Novartis internal market research and claims analysis (2023, 2024).
2. Aggressive treaters (~20%), Splitters (~40%), and imatinib loyalists (~15%) make up the ~75% of the 1L TRxs prescribed by ~3600 high-volume HCPs. The remaining ~25% 1L TRxs are widely distributed across ~7000 other HCPs who also treat CML patients (please refer to slide 27).
Differentiated clinical profile, strong commercial readiness and a long patent life sets up Scemblix as a key growth driver for the future

**Differentiated clinical profile**
- Better efficacy with fewer AEs and treatment discontinuations
- Numerically higher MMR rate vs 2G TKIs¹
- Half the discontinuation rate of imatinib or 2G TKIs¹

**Strong commercial readiness**
- Deep disease expertise
- Strong engagement with CML experts and patients
- Field teams already in place
- Targeted approach at launch

**Long patent protection in a rare disease population**
- US compound patent plus expected PTE until 2035²
- FDA Orphan Drug Designation granted for treatment of CML³
- Excluded from IRA negotiations as a rare disease therapy

Confident in Scemblix USD 3bn+ global peak sales across lines

Agenda

1. Novartis legacy in CML and current unmet needs
2. *Scemblix* ASC4FIRST results
3. *Scemblix*: Establishing the 1L CML treatment of choice
4. Q&A
**Better benefit-risk profile vs current SoC TKIs positions Scemblix as a potential therapy of choice for newly diagnosed CML patients upon approval**

<table>
<thead>
<tr>
<th>Scemblix demonstrated superior efficacy...</th>
<th>...with a favorable safety and tolerability profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Superior MMR rates vs IS-TKIs and vs imatinib alone</td>
<td>✓ Fewer grade ≥3 AEs</td>
</tr>
<tr>
<td>✓ Consistent results regardless of baseline characteristics</td>
<td>✓ Fewer dose adjustments/interruptions needed to manage AEs</td>
</tr>
<tr>
<td>✓ Earlier achievement of MMR and greater depth of responses</td>
<td>✓ Half the rate of all-grade AEs leading to discontinuation</td>
</tr>
<tr>
<td>✓ Improvement vs 2G TKI(^1) in MMR rate, speed and depth of responses</td>
<td>✓ Lower rates and severity of most AEs associated with 2G TKI(^1) class and impacting patient lives</td>
</tr>
</tbody>
</table>

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500.  
SoC – Standard of care.  
1. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
“Scemblix is the first CML treatment to show significantly better efficacy compared to investigator-selected standard-of-care TKIs. When you combine superior response with the excellent safety and tolerability profile of Scemblix, we have a very promising potential frontline option for newly diagnosed patients to support them in achieving their treatment goals.”

Prof. Tim Hughes, MD,
South Australian Health & Medical Research Institute (SAHMRI)
Current treatment landscape for 1L CML is roughly evenly split between imatinib and 2nd generation (2G) TKIs

CML treatment landscape in G7\textsuperscript{1,2,3}

1. Newly diagnosed: Kantar health CML incidence in G7 (US, EU5, JP), patients in 2024.
2. CML prevalence in G7, 2024: Kantar health.
3. IQVIA Market Sizing, IPSOS & IQVIA Oncology Dynamics (G7, MAT Jun 2023).

Although Scemblix is not approved nor promoted in 1L or 2L, some HCPs are choosing to prescribe it in these lines.

1. Newly diagnosed: Kantar health CML incidence in G7 (US, EU5, JP), patients in 2024.
2. CML prevalence in G7, 2024: Kantar health.
3. IQVIA Market Sizing, IPSOS & IQVIA Oncology Dynamics (G7, MAT Jun 2023).

Although Scemblix is not approved nor promoted in 1L or 2L, some HCPs are choosing to prescribe it in these lines.
Most hematologic toxicities occurred at lower severities with Scemblix vs imatinib and 2G TKIs

Hughes TP et al., 2024 ASCO Annual Meeting LBA6500.

1. The safety set comprised all patients with ≥1 dose of a study drug; numbers represent counts of patients. Shown are AEs that occurred during treatment or within 30 days after receiving the last dose of study medication. A patient with multiple severity grades for an AE is only counted under the maximum grade. Leukopenia rates are not shown.

2. Thrombocytopenia includes thrombocytopenia and decreased platelet count; neutropenia includes neutropenia and decreased neutrophil count; lymphopenia includes lymphopenia and decreased lymphocyte count.

3. Investigator selected 2G TKIs – nilotinib, dasatinib, bosutinib.
References

Page 4 – Current unmet need:


Page 6 – BCR ABL binding and Scemblix design:


Page 14 – 1L unmet need: