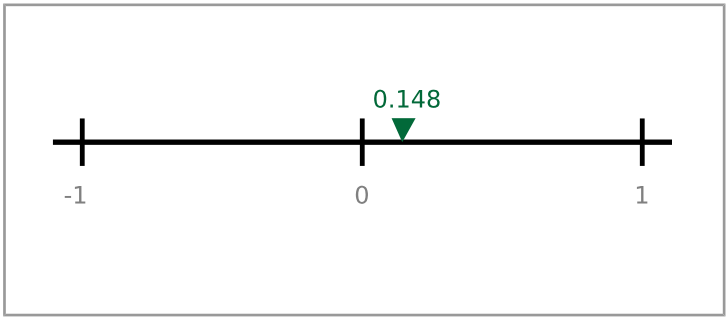
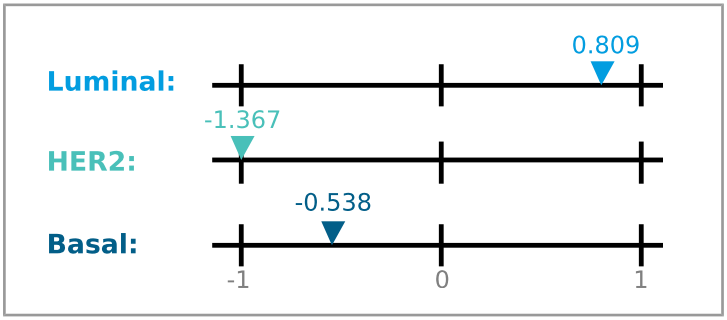
MammaPrint® and BluePrint® Technical Report

TEST RESULTS

MammaPrint: Low Risk



BluePrint: Luminal-type



If a FFPE sample's MammaPrint Index (MPI) falls within a pre-defined area around the classification cut-off between -0.058 and +0.058, the classification accuracy is less than 90%.

RUN INFORMATION

Samples in Run	Instrument Serial Number	Date of Data Submission	Date of Report Generation
28	@M02340	18-Mar-2026 06:19:19 UTC	18-Mar-2026 07:59:57 UTC
Human Assembly Version	**Software Version**		**QC Model Version**
GRCh37 (hg19)	Tulip v1.0.0		v3.1

DETAILED QUALITY CONTROL INFORMATION

Quality Control Metric	Value	Verdict
Total Read Counts (log_2)	20.389	Pass
Percent Mapped	88.5%	Pass
Percent On Target	71.5%	Pass
Percent Q30	87.7%	Pass
RNA Quality Metric	0.967	Pass
Additional NGS Run Quality Assessment		Pass
MammaPrint Quality Assessment		Pass
BluePrint Quality Assessment		Pass
Overall Assessment		**Pass**

Authorized Signature

AGENDIA
MAMMAPRINT+BLUEPRINT

MammaPrint® and BluePrint® Explanation of Results

AGENDIA
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GENOMIC TESTING RESULTS

MammaPrint Risk Group	MammaPrint Index	BluePrint Molecular Subtype
Low Risk	+0.148	Luminal A

CLINICAL IMPLICATIONS

This explanation of results assumes the patient's tumor is hormone-receptor positive. Clinical implications are based on observed outcomes from clinical research studies depicted below and further referenced on page 3. Results should be taken in the context of all other relevant clinico-pathological factors and standard practice of medicine.

Neoadjuvant Chemotherapy Planning

Probability of pCR with Neoadjuvant Chemotherapy

2%

NBRST[A]

Adjuvant Chemotherapy Planning

Absolute Chemotherapy Benefit

<1.0%

MINDACT[D]

5-Year Distant Metastasis Free Interval with Endocrine Therapy Alone

Lymph Node Negative	Lymph Node Positive
98%	96%

MINDACT[D]

Adjuvant Endocrine Therapy Planning

Standard Endocrine Therapy Benefit

Yes

STO-3[C]

Absolute Benefit from Extended Endocrine Therapy (DFS)

9.5%

Risk Reduction of Late Recurrence (Years 5-15)

NSABP B-42[E]

DFS: Disease Free Survival | **MPI:** MammaPrint Index | **pCR:** Pathologic Complete Response

Note: This summary is provided for general informational purposes. It is not part of any official diagnostic report. Please refer to the MammaPrint and BluePrint Technical Report and Instructions for Use for comments, assay information, and references.

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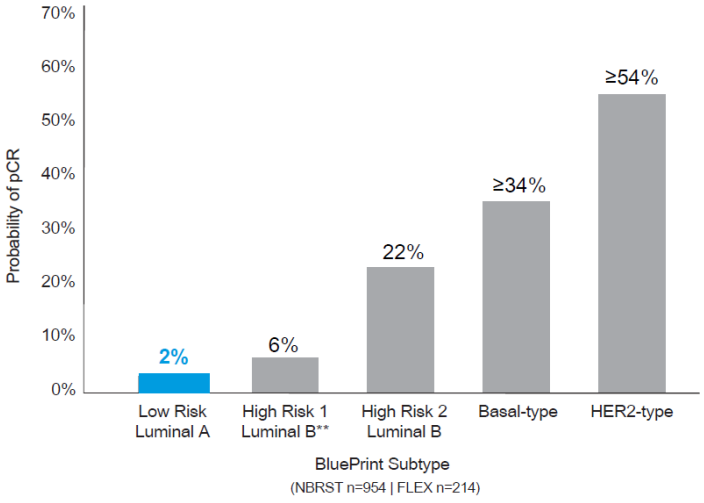
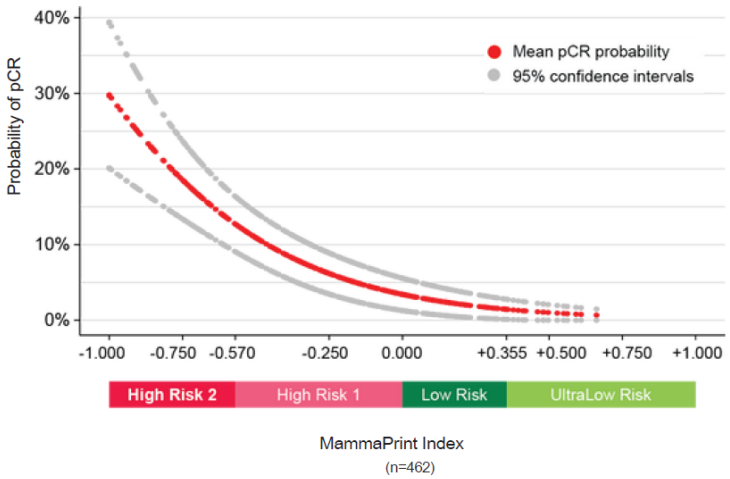
NEOADJUVANT CHEMOTHERAPY PLANNING DATA*

Probability of pCR Based on BluePrint Subtype and MP Risk Group
NBRST/FLEX[A,B]

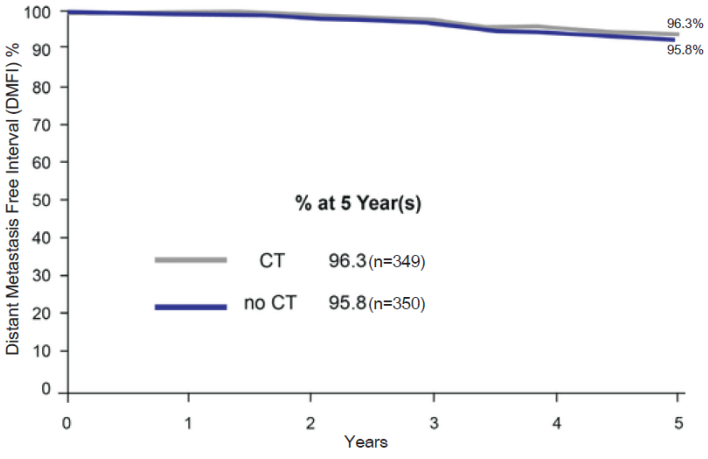


Probability of pCR Based on MPI and MP Risk Group
NBRST[A]

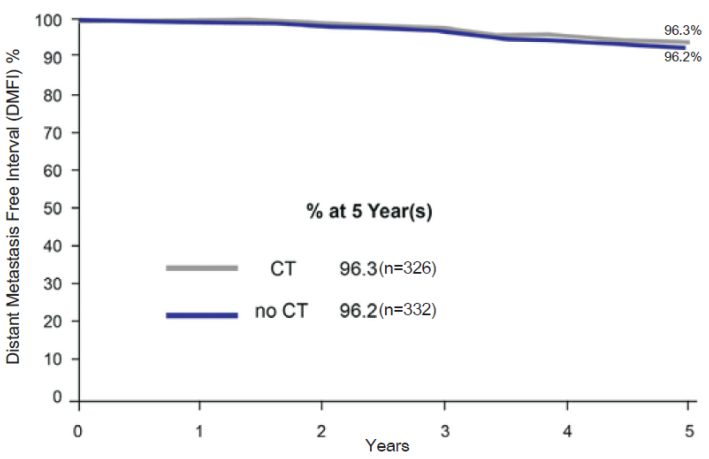


ADJUVANT CHEMOTHERAPY PLANNING DATA*

5-Year DMFI in C-High/MP Low Risk LN0 Patients with and without CT
MINDACT[D]



5-Year DMFI in C-High/MP Low Risk LN+ Patients with and without CT
MINDACT[D]



***Clinical implications are based on observed outcomes from clinical research studies depicted above and further referenced on page 3. Results should be taken in the context of all other relevant clinico-pathological factors and standard practice of medicine.**

**A pathologically ER+/HER2+ patient with a Luminal B-Type result has a 16% probability of pCR with neoadjuvant chemotherapy.

C-High: Clinically High Risk | **CT:** Chemotherapy | **LN:** Lymph node | **MP:** MammaPrint | **MPI:** MammaPrint Index | **pCR:** Pathologic Complete Response

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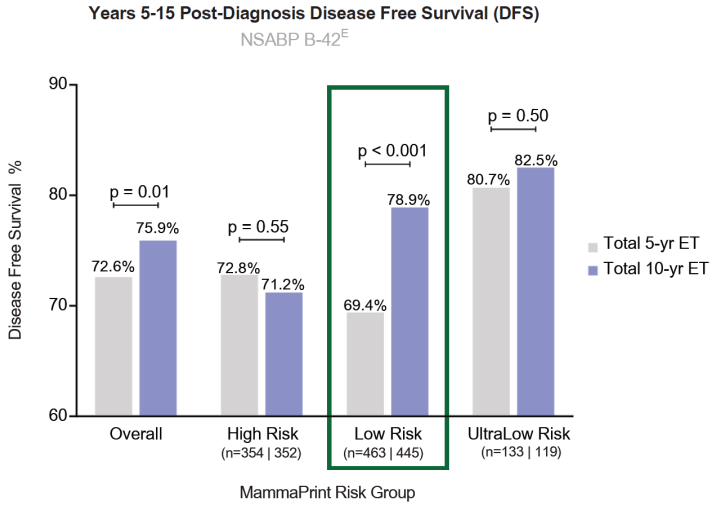
ADJUVANT ENDOCRINE THERAPY (ET) PLANNING DATA*



***Clinical implications are based on observed outcomes from clinical research studies depicted above and further referenced below. Data supporting adjuvant endocrine therapy planning were generated from studies composed of predominantly HR+, post-menopausal women (>50 years old). Menopausal status at 5 years post-diagnosis can be used to determine the application of data for adjuvant endocrine therapy planning. Results should be taken in the context of all other relevant clinico-pathological factors and standard practice of medicine.**

CLINICAL STUDY AND TRIAL REFERENCES

A. NBRST: A prospective study that included 1,069 patients with histologically proven early stage breast cancer (ESBC), aged 18-90 years, who were scheduled to receive neoadjuvant therapy. Patients were enrolled from 40 US institutions and received both MammaPrint and BluePrint genomic testing. Treatment was at the discretion of the physician adhering to NCCN-approved or other peer-reviewed, established regimens. Intrinsic preoperative chemosensitivity and long-term outcomes were precisely determined by MammaPrint and BluePrint regardless of patient age, supporting the utility of these assays to inform treatment and surgical decisions in ESBC.[1-4]

B. FLEX (NCT03053193): An ongoing prospective, observational trial that has enrolled >17,000 patients with ESBC who were tested with MammaPrint as standard of care, with or without BluePrint, and consented to clinically annotated full transcriptome data collection (data locked August 2024).[5-7]

C. STO-3: The prospective Stockholm tamoxifen trial included 1,780 lymph node-negative, HR+, post-menopausal patients with tumors smaller than or equal to 3 cm in diameter, randomized to 2 (65%) to 5 (35%) years of adjuvant tamoxifen vs no adjuvant treatment. MammaPrint was retrospectively assessed on a translational cohort of 652 patients; 313 had received tamoxifen (2-5 years) and 339 had not received adjuvant systemic therapy.[8,9]

D. MINDACT: A phase 3, prospective, randomized clinical trial that enrolled 6,693 patients at 112 academic and community hospitals in 9 European countries. Patients were eligible to enroll if they were women aged 18-70 years with histologically confirmed unilateral primary non-metastatic (M0) invasive breast cancer (clinical stage T1 or T2 or operable T3) with 0-3 positive axillary lymph nodes. For hormone-positive women ≤ 50 years, there was a 2.6% benefit in 5-year distant metastasis free survival for women who received chemotherapy (CT) vs those that received endocrine therapy (ET) alone. Although this difference is possibly due to CT-induced ovarian function suppression, it should be part of informed, shared decision making.[10,11]

E. NSABP B-42: A prospective adjuvant extended ET trial which included 3,966 post-menopausal women with stage I-IIIA hormone receptor-positive breast cancer, who were disease-free after 5 years of ET. Patients were randomized to receive either an additional 5 years of letrozole (EET) or placebo. MammaPrint was retrospectively analyzed on a translational cohort of 1,866 patients; 916 patients received EET and 950 patients received placebo.[12]

References:

1. Whitworth P et al. Ann Surg Oncol. 2017 Mar;24(3):669-675.| **2.** Whitworth P et al. JCO Precis Oncol. 2022 Apr;6(1):e2100463.| **3.** Whitworth P et al. AnnSurg Oncol. 2022 Apr 4;29(7):4141-4152.| **4.** Whitworth P et al. JCO Precis Oncol. 2022 Sep:6:e2200197.| **5.** O'Shaughnessy J et al. 2021. ASCO. Abstract#563.| **6.** O'Shaughnessy J et al. 2023. SABCS. Abstract PO5-15-04.| **7.** Audeh MW et al. 2024. MBCC. Poster #29.| **8.** van 't Veer L et al. Breast Cancer ResTreat. 2017;166(2):593-601.| **9.** Esserman LJ et al. JAMA Oncol. 2017;3(11):1503-1510.| **10.** Piccart M et al. Lancet Oncol. 2021;22(4):476-488.| **11.** Lopes-Cardozo J et al. J Clin Oncol. 2022;40(12):1335-1345.| **12.** Rastogi P et al. J Clin Oncol. 2024;00:1-9.