

SECOND QUARTER RESULTS 2023
INVESTORS & ANALYSTS CALL
Wednesday, 26 July 2023 @ 12.00 hrs

Introduction | Nick Stone, SVP, Head of Investor Relations

Hello everyone. Welcome to our half-year and Q2 2023 conference call and webcast for investors and analysts. The presentation was sent to our distribution list via email and you can find us on GSK.com. Please turn to slide 2.

Cautionary statement regarding forward-looking statements

This is the usual safe harbour statement. We will comment on our performance using constant exchange rates (CER) unless stated otherwise. As a reminder, following the Consumer Healthcare demerger in 2022 to form Haleon, we are presenting performance and growth on the continuing operations for GSK.

Agenda

Today's call will last approximately one hour and management presentation will take between 30-35 minutes, with the remaining time for your questions. For those who wish to ask the question, please join the queue by raising your hand. We would request that you ask one question so that everyone has a chance to participate. Our speakers today are Emma Walmsley, Tony Wood, Luke Miels, Deborah Waterhouse and Julie Brown, with David Redfern joining the rest of the team for the Q&A portion of the call. I shall now hand the call over to Emma.

Strong performance drives momentum | Emma Walmsley, CEO

Thanks, Nick, and a very warm welcome to everyone joining us today. I am delighted to be presenting to you all another set of excellent results for GSK. Please turn to the next slide.

Slide 5

Sales and profits grew at double digit levels for the quarter, our sixth consecutive quarter of strong growth. Sales were £7.2 billion, up 11% excluding pandemic solutions. Adjusted operating profit was up 12% to £2.2 billion and adjusted EPS was up 17% to 38.8 pence. This is further evidence of a sustained step-change in GSK's performance and this momentum supports our decision to upgrade our guidance for the year. Our performance also demonstrates the delivery of the strategic choices we have made to develop the portfolio and the R&D pipeline.

New products, notably in Vaccines and HIV, all made healthy contributions to growth and reflect the investments we have made to prioritise these parts of our business. Sixty-two percent of sales are now coming from Vaccines and Specialty Medicines, which we expect to provide durable and profitable growth through the decade, and New Products launched since 2017 have contributed sales of £4.6 billion so far this year, adding nearly one billion pounds of additional turnover compared to 2022. Equally, our General Meds business continues to perform alongside the other parts of our portfolio.

Delivering our commitments for attractive medium-term growth

We are deploying capital in a financially disciplined way to invest in growth and deliver stronger returns to shareholders. We are delivering on our commitments and, as you can see from the slide, we are on track to hit all the targets we set out in 2021.

As you all know, our very first priority for capital remains to invest in continued pipeline progress, and we know this is the key question for shareholders. At the core of our work is an aggressive pursuit of organic pipeline delivery and targeted business development. We are making good progress on both and there is more to come.

The approval of *Arexvy* this quarter is, we believe, transformational and set to bring enormous benefit to people aged over 60 who are at annual exposure to RSV. *Arexvy* is spearheading the next wave of vaccine innovation at GSK. This quarter we presented positive clinical data for our pentavalent meningitis vaccine, secured regulatory approval for *Shingrix* in Japan in at-risk populations and achieved US FDA fast-track designation for our candidate vaccine to prevent gonorrhoea, a bacterium that is considered a high priority pathogen by the WHO.

As you will have seen at our recent Meet the Management event, we have substantial innovation to come with potential new vaccines to prevent influenza, pneumococcal disease and herpes simplex

virus. This all sits alongside other innovation in infectious diseases like bepirovirsen for Hep B and a new portfolio of much-needed anti-infectives.

We are also very pleased with the progress we are making in our HIV portfolio. A key aspect here is, of course, to develop the portfolio to replace the loss of exclusivity for dolutegravir which, as a reminder, is not expected to start until 2028 in the US and 2029 in Europe. We are well on track to do this.

We expect sales from our new long-acting regimens of around £2 billion by 2026 and, to add to this, clinical development plans are advancing very well to support new ultra long-acting options launching from 2026. With these innovations, we aim to replace the majority of revenues from dolutegravir and support profitable growth for GSK well into the next decade. We are looking forward to talking to you more about all of this at our HIV Meet the Management event in late September.

Equally, we continue to make good progress in our business development. Here we are targeting acquisitions and partnerships to strengthen and complement our core therapy areas, to help deliver above and beyond our current long-term outlooks. You will expect to see us keep up broadly the same levels and pace of BD as we have in the last 18 months.

This quarter we completed the acquisition of BELLUS Health, building upon our Respiratory expertise with the addition of camlipixant, a Phase III potential best-in-class treatment for refractory chronic cough. Our pipeline in broader Respiratory is developing well too across all three product areas and we are increasingly confident that we shall be a major source of new long-term growth.

Strong momentum supports confidence in short, medium and long-term commitments to profitable growth

Our focus is to deliver competitive performance and improved shareholder value in the short, medium and long term. With our current momentum and further successful execution of our priorities, we are very confident in our ability to deliver profitable sales growth in all three of these timeframes.

In 2023, we now expect to deliver sales growth of 8-10% and adjusted operating profit growth of 11-13%. For 2026, we expect to deliver sales of more than 5%, and adjusted operating profit of more than 10% on a CAGR basis; and by 2031 we are confident that we will have effectively absorbed any impact from the loss of exclusivity across the portfolio, to deliver our stated ambition of more than £33 billion in sales.

We know this ambition is significantly higher than current market expectations, and over the next year we will continue to give you more clarity and specificity on our building blocks to deliver profitable results, through a series of Meet the Management events, data readouts and more comprehensive updates against our 2021 long-term plan.

Let me now hand over to Tony, who will talk you through his latest thoughts on R&D priorities and performance.

Thank you, Emma and hello everyone, it's great to be with you today. Please turn to slide 9.

Three key R&D priorities

I'm pleased to report that we are making good progress in strengthening the pipeline, and we know there is more to come. Our absolute focus is to develop a robust programme that can drive sustainable, profitable growth.

I see this being achieved through a combination of organic delivery and disciplined business development, overlaid with continuous improvement in R&D productivity. This is reflected in my three priorities for R&D, shown on this slide, and in the delivery of our strategy, which is focused across four therapeutic areas, and they're used to leverage our deep understanding of the immune system and use of advanced technologies.

Effective capital allocation to support R&D investment priorities

It's important that we allocate our capital and resources effectively. I think about this from two perspectives: first, from a therapeutic area standpoint. Our priority is to build on our strengths and leadership in infectious diseases, HIV, respiratory, immunology and our emerging capabilities in oncology. This is by investing in both organic and targeted business development to deliver first- or best-in-class innovation, balancing probabilities of success and sales potential; and we apply the same discipline in returns criteria for both approaches. In addition, we also seek platform and data technology-enabled opportunities.

Second, from a time perspective, to develop, partner or acquire vaccines, specialty medicines and technologies with significant commercial potential that can meaningfully contribute to sales and profit growth in the latter part of this decade and beyond.

Ultimately, I want a portfolio of R&D innovation that offers a good balance of risk and return, and which can drive growth for GSK above and beyond the ambition Emma just talked about.

Four focused therapeutic areas

Our pipeline today comprises 68 assets in clinical development. Two-thirds of the assets within our development portfolio are focused on infectious diseases and HIV. In infectious diseases, we are focused on seasonal respiratory viruses, bacterial, fungal and chronic viral infections. Vaccines are front and centre of this effort.

Emma has already mentioned *Arexvy* and some of the innovation that is behind it. Our pentavalent meningococcal vaccine candidate recently met all primary endpoints in the Phase III trial, and demonstrated immunological effectiveness against 110 diverse MenB strains. These count for 95% of circulating strains in the US. Five serogroups are responsible for most meningococcal infections and no single approved vaccine can yet protect against all five. If approved, MenABCWY would do so, offering a simplified immunisation schedule and supporting increased vaccine uptake. This is important when you consider that only 30% of adults currently receive full protection from all five meningococcal serogroups. We're on track to submit the vaccine to regulators in 2024.

Our novel 24-valent pneumococcal vaccine candidate, acquired through the Affinivax transaction, has also shown very positive immune response across serotypes. We continue to examine the potential acceleration options in the 24- and 30-valent programmes in infants and adults.

With CureVac we are looking to disrupt the influenza market and deliver new multivalent combination vaccines, using next generation and RNA technology. Multivalent Phase 1 and 2 flu and cold trials are under way, and we expect data from these towards the end of this year and the start of 2024.

In chronic viral infections, in addition to geographic expansion we are looking at new growth opportunities for *Shingrix*. These include extending the population who might benefit from protection to a younger cohort, such as the recent Japanese approval to include adults aged 18 to 49, and we continue to review the potential need for a booster. Additionally, a growing body of evidence suggests the shingles vaccination may reduce the risk of dementia.

We are leveraging our expertise in herpes virus, varicella zoster virus, to develop a promising injectable treatment for the control of herpes simplex virus reactivation. Our plan is to initiate proof of concept studies later this year.

In anti-infectives, we have now signed a promising portfolio of new medicines. Gepotidacin, which we stopped early for efficacy and is anticipated to launch next year, has the potential to be the first oral antibiotic to treat uncomplicated urinary tract infections in more than 20 years.

Complementing this is tebipenem from Spero Therapeutics which, if approved, will provide us with access to a late-stage antibiotic with the potential to treat *complicated* urinary tract infections.

Rexifen, a novel first-in-class medicine to treat fungal infection, acquired through an exclusive licence agreement with Senexis, completes this trio.

Bepirovirsen is another potentially transformative treatment which could help patients achieve a functional cure for chronic hepatitis B. We look forward to presenting data from our Phase IIB trial, B-Together, later this year. This trial is designed to answer whether interferons are needed to improve the durability of functional cure following bepi treatment.

In HIV, we are entering an important period in our clinical development plans for potential ultra-long acting treatments and prevention options. These spearhead the transition we expect to deliver an HIV portfolio over the next five years. We will be setting out more detail on these in our third quarter Investor Day.

In Respiratory and Immunology, we are prioritising late-stage development of our IL-5 medicine, depemokimab. The addition of camlipixant, a highly selective P2X3 antagonist for the treatment of refractory chronic cough also provides us with another asset for Phase III development. Luke and I expect to be sharing more with you on our plans and opportunities in Respiratory before the year end.

In Oncology, we are progressing the regulatory submission for momelotinib following the US FDA's recently extended review date to September. We are confident that this new medicine will help tackle the significant and debilitating medical needs of myelofibrosis patients with anaemia.

Given the make-up of our current portfolio and capabilities, our approach in Oncology is to prioritise the development of novel medicines to treat blood and women's cancers and to explore other potential breakthroughs in immune-oncology. *Jemperli*, our highly effective PD-1 inhibitor, is central to this approach, and exploration as a back-up treatment used in combination with other proven or promising therapies is in development.

68 assets in clinical development: upcoming pipeline catalysts

You can see how many of the elements I have just touched on are expected to play out over the next 12 to 18 months. I believe that these, together with targeted business development and a series of important Phase I and Phase II investment decisions, will lead to significant progression of this pipeline in the short term.

Continuous improvement in R&D productivity

Alongside allocating resources to prioritise and accelerate clinical development, I want us to continue to improve overall R&D productivity. We have made progress. Success rates will help our improvement, but more needs to be done. For me, this really means two things: first, doubling down on leveraging our scientific capabilities with the use of new platform and data technologies, and second, developing our partnering and external sourcing capabilities. With AI and machine learning applications now rapidly

maturing, access to proprietary data to keep models and to generate novel insights is a key strategic differentiator.

For example, we recently presented data in ESOF for bepirovirsen, from the Phase II/Phase IIIB trial. This deep, multi-modal analysis helped us to develop a clear heterogeneity map in chronic hepatitis B, stratifying individuals treated with bepirovirsen into three subtypes – a highly enriched response, a mixed response and a non-response, each defined by the state of clinical, virological and molecular trajectories and associated with a number of markers. These predictive models provide greater precision than existing markers, and suggests potential enriching strategies.

We are competitively placed in platform technologies and have laid strong foundations in data technologies. I want us now vigorously to scale and build on these foundations to better de-risk targets and rapidly test and progress high-quality first-in-class candidates – all with the aim of accelerating and improving the success rates of our development programmes.

In summary, let me close by saying that I am pleased with the progress that we have made so far this year and that we have clear plans in place to move forward at pace to deliver on our key objectives through R&B and support the overall growth ambitions for GSK.

I will now hand over to Luke, with Slide 14..

Thanks, Tony. Please turn to the next slide.

Continued strong commercial execution

I am pleased to say that Quarter 2 was another quarter of continued strong commercial execution, right across the business. All three of our product groups – Vaccines, Specialty and General Medicines – were up in the quarter, with growing contributions across all three regions. Please turn to slide 16.

Q2 2023 sales £7.1 billion, +11%

In Quarter 2, we delivered £7.1 billion of sales, up 11% versus last year, excluding pandemic solutions. In Vaccines, strong growth of 15%, excluding pandemic solutions, was supported by *Shingrix*, which was up 20%, and *Bexsero*, which was up 18%. *Shingrix* delivered another record quarter of sales and it is the sixth consecutive quarter of growth.

In the US, we have now reached the motivated consumers, with about 32% penetration of eligible people receiving at least one dose. Moving forward in the US, we are resourcing for success by raising awareness about the importance of shingles prevention, especially among consumers who are less motivated to get vaccines. We remain confident in the US opportunity and believe that we can reach flu-like penetration of around 60% to 65% over time.

Ex-US remains an important growth driver for *Shingrix* and represented 46% of the revenue in the quarter. *Shingrix* is now available in 33 countries, with most with less than 3% penetration, indicating the potential of further expansion in these populations. We have unconstrained supply and strong global demand and we continue to retain high-value US-like pricing as we launch in private pay settings globally.

In Speciality Medicines including HIV which Deborah will speak about shortly, we increased sales by 12%, excluding *Xevudy* to £2.5 billion. Our market leading blockbuster medicines especially *Benlysta* and *Nucala*, continued to deliver double-digit growth. *Benlysta* was up 19% in the quarter with sustained growth across all major markets, with further opportunity to drive increased penetration in both SLE and lupus nephritis with about 25% bio-penetration in the US and other key markets.

We are focused on life-cycle management opportunities of *Benlysta* as we explore further indications including systemic sclerosis, associated interstitial lung disease which will be important for patients as well as payback across the entire product.

Nucala was up 15% in the quarter and remains the first and only biologic approved in eosinophilic diseases with new indications driving growth and differentiation. The severe asthma market continues

to grow in the US for opportunity for *Nucala* to drive bio-penetration with our clearly differentiated profile in hyper-eos patients. We look forward to having COPD data in 2024.

In oncology, down 3%, in line with expectations. However, *Jemperli* continues to be a growing contributor and we are excited about the potential for our PD1 as our development programme investigates the opportunity to help all patients with endometrial, ovarian and potentially other indications.

Our General Medicines portfolio grew 8%, grown primarily by *Trelegy* which was up 30% in the quarter. *Trelegy* continues to have a best in class profile across access versus competitors and there is a leading share of key specialty medicines for pulmonologists.

Considering this strong Q2 and H1 performance, we now expect Speciality Medicines to grow high single digit and General Medicines to grow at low single digit in the full year. We still expect vaccines to grow in routine.

Arexvy approved ahead of 2023/24 RSV season Adults aged 60 and older can be protected from RSV disease for the first time

We are very excited about the upcoming launch of *Arexvy*. We believe *Arexvy*'s profile recommendation to support our market leadership with multi-billion sales potential. Additionally the CDC has now adopted last month's ACIP recommendation and is being communicated broadly to healthcare providers, an important step that sets permanent guidance and established the trigger for patent coverage.

The launch is now underway as we speak and we have a clear understanding of what is required for successful commercial execution. We are also building our relationships with retailers given our expertise in the older adult population through *Shingrix* and we are playing to our strength using our deep respiratory equities and our experienced primary care sales force.

We have now shipped doses to distribution centres and we look forward the impact that this important medicine will have to help prevent the severe consequences of RSV in the US and globally as we also prepare for to launch the season across Europe.

With that let me handover to Deborah.

HIV +12% growth in Q2 2023 driven by oral 2DR1 and long-acting regimens

Our HIV business delivered sales of £1.6 billion in the second quarter of 2023, growing 12%. This growth was primarily driven by demand which contributed 8% points growth and US pricing favourability which contributed a further 2% points of growth.

Our performance benefitted from strong patient demand for our oral two-drug regimens and long acting injecting medicine which now constitute more than 50% of our total portfolio. This demand helped grow our global market share by 2% points versus last year.

The inventory build that we saw in the US at the end of last year has now materially burned and we don't anticipate any further significant burn this year.

Dovato delivered £430 million in the quarter. Market performance reflects HCP belief in *Dovato* which is now our number one selling HIV medicine. We were also pleased that dolutegravir received US FDA paediatric exclusivity in the quarter which extends the dolutegravir loss of exclusivity in the US by a further six months to April 2028, and as a reminder Europe is April 2029.

We aim to further consolidate our leadership in paediatric HIV by following a similar approach with our foundational medicine, cabotegravir.

Turning to *Cabenuva*, sales for the quarter were £176 million reflecting strong patient demand with high levels of market access and reimbursements across the US and Europe. Growth has been driven by positive sentiment towards the SOLAR data presented at CROI earlier in the year. and strong commercial execution, and it is particularly pleasing to see that more than 70% of *Cabenuva* sales are originating from competitor regimens.

Moving onto prevention, sales of *Apretude*, the world's first long acting injectable for the prevention of HIV delivered £36 million in the quarter and we are pleased by the growing momentum across the US. We were delighted that earlier this week the European Medicines Agency granted positive opinion for this medicine. With more than 100,000 new infections every year across the continent we very much look forward to the approval of *Apretude* which has the potential to significantly reduce the transmission of HIV in Europe.

We are encouraged by the progress of our pipeline which is focused on innovative long-acting regimens. We have three target medicine profiles, to provide the world's first self-administered long-acting regimen and treatment and to provide ultra-long acting regimens with treatment and prevention with dosing intervals of three months or longer.

I am pleased to confirm that next month, we shall begin our Phase IIb study in cabotegravir in combination with our broadly neutralising antibody N6LS which offers the potential for ultra long-acting dosing. We are very excited about the potential of these medicine profiles and will be ready for two regimens in 2024.

We remain very confident in our ambition to achieve a five-year mid single digit sales CAGR to 2026, and our strong future performance means we are in a position to raise our outlook for 2023 from mid single digit to a high single digit growth rate.

With that, I shall hand over to Julie on slide 19.

Performance: CFO priorities, capital allocation and financial results | Julie Brown, Chief Financial Officer

Slide 19

Good afternoon, everyone. I am delighted to be here at my first set of results as the CFO for GSK. The Biopharma industry is incredibly special to me, it is where I have spent most of my career, and it is a sector that can create enormous value for patients and shareholders.

GSK is a company that I have long admired and it has a clear purpose to impact positively the health of billions over the next decade. I am really pleased to be part of the team that is going to deliver this.

As this is the first time speaking to you and before we cover the financials, I want to take the opportunity to highlight three areas of focus that will be important to me as CFO.

First, disciplined capital allocation with two clear priorities: to invest for growth and to deliver improved returns to shareholders. Secondly, partnering with Tony to enhance returns on investment and to improve R&D productivity with a strong focus on resource optimisation and efficient funding. Thirdly, identifying sources of business efficiency to fund investments and deliver a competitive P&L.

Capital allocation framework

Turning to capital allocation. Our first priority is investment in the business, driven towards development of the pipeline through both organic and targeted business development. We shall also invest to support new product launches. My intention here is to be laser-focused on prioritising and accelerating investment in those assets and technologies that will help us to deliver growth. I intend to achieve this through an increased focus on ROI for organic and BD-related investments and this will include: an assessment of the market opportunity; first-in-class potential and best-in-class potential; peak year sales; probability of success and expected financial returns.

The returns to shareholders, our primary mechanism for cash distributions, will remain through the delivery of a progressive dividend and last year the payout ratio of 40-60% over the cycle was established. We expect to maintain dividends within this range as earnings increase over time.

For completeness, in the event of surplus, excess cash would be returned to shareholders using the most efficient mechanism available. However, we do not expect excess cash in the medium term given our priority is to invest in growth.

Finally, and very importantly, we remain committed to maintaining a balance sheet with a strong investment grade credit rating.

Taken together, I believe this represents a sensible capital allocation framework for GSK, consistent with our strategic priorities and supportive of our commitment to deliver profitable growth through this decade.

Delivered a strong Q2 2023 financial performance

Turning now to the quarter, as I cover the financials, reference to growth are at constant exchange rates unless otherwise stated, and I shall focus my comments on adjusted results.

Starting with the income statement, sales increased 11%, excluding COVID solutions, and were up 4% overall, reflecting the strong delivery that Luke and Deborah have covered. Operating leverage, primarily in COGS, drove adjusted operating profit growth 11% with the margin increasing to 30.2%. Excluding COVID solutions, adjusted operating profit grew 12%.

Turning to the reported results, the growth in total profit was driven by a strong operating performance and favourable contingent consideration liability remeasurements.

Improved Q2 2023 adj. operating margin by 200 bps at CER

Turning to margin dynamics, as mentioned the adjusted operating margin was 30.2%, a 200 basis points increase versus the prior year at constant rates. Excluding the impact of COVID solutions, the margin increased 20 basis points. Cost of goods sold decreased, primarily reflecting reduced sales of low margin *Xevudy* in Q2, which resulted in a gross profit increase of 11%. Excluding COVID solutions, COGS increased in line with sales with a neutral growth margin impact, with favourable mix and efficiencies offset by higher freight and energy costs.

SG&A reflects investment behind product launches such as *Shingrix* geographic expansion, HIV and preparations for *Arexvy*'s imminent launch. We expect the SG&A growth to reduce in the fourth quarter as investment levels stabilise and to be broadly in line with sales growth for the full year.

In R&D, there was increased investment across a range of early and late-stage programmes, including a number that Deborah and Tony discussed earlier. Our royalties benefitted from *Gardasil*, *Biktarvy* and *Kesimpta*, and there was a 70 basis point adverse move from foreign exchange.

Efficient delivery of profit attributable to shareholders

Earnings per share benefited from no net finance expense and no controlling interests, and now we are turning to the adjusted compared with our total results.

Q2 2023 Total to adjusted profit reconciliation

Overall, total unadjusted operating profit was similar in the second quarter, at £2.1 and £2.2 billion respectively. In addition to CCL remeasurements, the main other adjusting items of note were within divestments, significant legal and other, and this reflected dividend and distribution income received,

including Haleon dividends, and the fair value movements of Haleon shares, which was partly offset by significant legal charges. Legal fees primarily reflected increased charges for *Zantac*, of which the vast majority relate to prospective legal costs for the defence.

H1 2023 free cash outflow of £0.3bn

Cash generated from operations was £1.9 billion in the first half, £2 billion lower than the prior year, and the key drivers are similar to those covered at Q1, and relate to the Gilead settlement and timing of *Xevudy* collections received last year, together with pension payments and increased working capital this year. There was no change to our expectation that 2023 cash generated from operations will be slightly lower than 2022, and we remain committed to our 2026 projection of more than £10 billion.

Net debt increased to £18.2 billion, reflecting the free cash outflow and net acquisition costs of BELLUS Healthcare, partly offset by disposal of investments, including the monetisation of part of our equity holding in Haleon.

2023 guidance upgraded

Turning now to guidance, on slide 26. We have delivered a very strong first half, and as Emma mentioned, we are upgrading our guidance for the year. As a reminder, all of this guidance excludes the influence of COVID-19 solutions.

We now expect sales to increase between 8 and 10%, up two percentage points. We expect adjusted operating profit to increase between 11 and 13%, and adjusted earnings per share to increase between 14 and 17%. Within sales we are maintaining our full-year vaccines expectation of a mid-teens percentage growth, and are upgrading our expectations for Specialty and General Med. We now anticipate Specialty Medicines, and HIV within it, to grow a high single-digit per cent, and for Gen Med to grow a low single-digit per cent.

Turning to phasing, firstly on sales: we expect that the second half growth will be below the first half, informed by the comparators. We would also expect sales growth to be slightly higher in Q3 relative to Q4. Secondly, on operating profit, we expect that the second half growth will be stronger than the first, with a broadly similar growth rate in each quarter, primarily reflecting SG&A growth expectations, as mentioned earlier.

Investor roadmap over next 18 months

In summary, business is performing well and with strong momentum. I look forward to connecting with you and updating you on our progress and continued delivery towards our '26 and '31 goals in the quarters to come.

With that in mind, slide 27 shares how we plan to keep you informed in four key areas: execution, portfolio, capital allocation and investor events. Execution shares our major earnings and reviews; the portfolio component builds on the R&D catalysts shared in Tony's presentation; capital allocation has been clarified further today; and the investor relations programme shares how we plan to provide you with the building blocks underpinning our pipeline, and the opportunity to meet the management at two more events this year. The first will focus on HIV in September, followed by Respiratory and Immunology in the fourth quarter. We will also continue to run a comprehensive programme of meetings, participation in investor conferences, and updates from key medical events.

Thank you, and with that I will hand you back to Emma.

Trust: delivering health impact sustainably | Emma Walmsley, CEO

Thanks, Julie. It's great to have you with us.

Purpose: to get ahead of disease together

We continue to build trust by delivering in the six key areas we prioritise for ESG performance.

This quarter we made progress on several fronts, but I want to highlight one in particular.

Of the more than two and a half billion people we will reach this decade, the majority will be through our infectious disease portfolio of vaccines, antibiotics, anti-virals and global health products.

So we were delighted to see new third-party funding announced to advance M72, a tuberculosis vaccine candidate discovered and developed by GSK into Phase III development. This could potentially become the first new vaccine to help prevent pulmonary TB in more than one hundred years. It's a true testament to GSK's vaccine scientists and our ability to partner with others to develop innovative global health assets in an economically viable and sustainable way.

With more than 10 million people falling ill and more than one and a half million people dying from TB every year, and increasing evidence of drug resistance, successful development of this vaccine could have a profound impact on human health.

A focused global biopharma company with momentum and bold ambitions

In summary, we are seeing strong momentum in our performance with continued delivery of competitive sales and profit growth.

We remain very focused on continuing to progress our pipeline through organic development, targeted complementary business development, and our progress is providing us with high confidence to deliver our outlooks and ambitions for shareholders through the decades.

With that, let's move to the Q&A with the team.

Question & Answer Session

James Gordon (JP Morgan): Thank you for taking my question – I will keep to one. My question is about *Shingrix* in the US. I think the sales declined 10% this quarter, although perhaps it is flat-ish when we adjust for stocking, but I saw that you have refined the *Shingrix* global guidance and so it is now high teens this year and I think it was double-digit before. Luke made some comments about having reached the most motivated patients in the US and further penetration increases – it sounds as though that may be tough with the less motivated patients.

The question is, where are we on *Shingrix* and the US growth, specifically? Could we be running out of road for the US growth, and will it be more ex-US growth, with the US perhaps flat this year and then could even decline? Or is Q2 a bit of a blip with stocking and other one-off factors, with plenty of US growth still to come?

Emma Walmsley: Thanks, James. Obviously, we are still very ambitious for the scale and reach of *Shingrix*, but can I ask Luke to comment about the US?

Luke Miels: Sure, James. I suspect you are probably not the only person with that question, so I will take a little longer to cover all those points.

The short answer is, not yet. We have covered this in parts of calls: there will be a point, which we are entering now, where we need to work harder to go up what is essentially a logarithmic growth curve. I will tell you a little bit about the dynamics, because it is very much a non-retail effect right now and, as you have said, there is some stock movement.

On retail first, we actually saw an 8% growth, up 8% versus last year, and that was very much driven by 65-year old individuals coming in following the removal of the co-pay into the IRA. It is interesting that in Q4 and Q1, we added about 2% to the total vaccination rate each time and we are now at a penetration of around 32% on the latest data that we have, which is Q1. If you then subtract that, there are about 80 million more people to go, if we were to get to 100%, and we add around a 4 million who turn 50 each year.

The other important element on stocking – we actually changed the rules in terms of how much stock wholesalers could hold. We have two categories: category A and category B. Historically, *Shingrix* had been classified in category B, which just gave wholesalers more room and more flexibility in terms of the volumes that they hold. We have now tightened that up and tried to remove some of this volatility. If you remember, last year, we had stock movements which were 1.3 and 1.8, and then down to 0.9 and so, by this year, we have tightened to around 0.6 or 0.7. I expect it will go up a little at the end of Q3 in the flu season, but we are trying to keep a tighter column on that, and so that has an effect as well.

If we go to the non-retail, which is the important component in the US, this is the key shift. Historically, non-retail has been around 45% to 50% of the business but, in Q1, that went down to 34% and in Q2 it is around 31%. It is very specific. We have a very small number of key customers who are now approaching 60% of the target population in vaccination. We have about 197 other key customers that

we can work for and so I guess that the 'glass half full' in this is that we can get to the types of penetration that we are targeting in these centres, and that is an opportunity with the other ones. But you are right: we need to work harder to get to the less motivated patients, but we have always known that was coming and we have plans to do that.

If we look outside of the US, just to conclude, we try to explain this to everybody that we have three places. We have the US, which is down on that curve, and we are now starting in Europe, and it is very early days in markets like China. As we said, there is about 3% penetration if we exclude the US and Germany, which are ahead of the curve with penetration.

We are in good shape overall and we look forward to updating you on Q3.

Emma Walmsley: Thanks, Luke. The other point to emphasise – as Luke referred to – is that the cost of reaching deeper into the US obviously goes up and actually, in the other markets we're in, because we don't have advertising, and because price has been successfully globalised, it remains a very appealing business in adult immunisations and of course we are now adding to with RSV and we have the additional pipeline on that.

Jo Walton (Credit Suisse): Thank you. I would like to ask a question about IRA, and two aspects of that. I wonder if you have a view about increased volume in anything other than vaccines given the change in patient co-pay going down, and also if you could talk about penny pricing and how we should think about that. You have some old products which will have accumulated very large rebates which in theory would become a problem next year. We have seen the insulin companies talk about it, how are you going to handle that in Respiratory?

Emma Walmsley: Thank you Jo, you are absolutely right, there are some really good things about the IRA that we are very supportive of, the co-pay removal in vaccines is important for our portfolio. There are some other things that alongside others in the sector we are concerned about in terms of unintended consequences, and for two parts of the portfolio, HIV probably more likely in 2025 and then in Gen Meds probably from next year there is some impact, all of which is explicitly absorbed in our guidance and in our outlooks. You will see some volatility there, but Luke, I don't know if you wanted to comment more on the specifics in established respiratory.

Luke Miels: Jo, you are bang-on in terms of some effects in terms of compliance. We see patients drop out of products like *Trelegy*, in terms of that historic coverage gap so that should help the volume. As Emma said, there are other aspects of the programme that we are less enamoured of and we need to see how that affects.

In terms of AMP cap, we have a very clear list of products, exactly as you said, that have had pretty intensive discounting and historical price increases which have been ahead of inflation and those will have an effect. The total exposure, this is just total revenue, not impact, I want to really stress this, about \$700 million. So that's, *Flovent HFA*, *Flovent diskus*, *Advair HFA*, *Advair diskus*, *Serevent* and *Lamictal*, and the biggest of those is *Lamictal*. We have had a lot of warning that this is coming and the work in

the US has done a great job in terms of developing authorised generics, partnerships. We have options to divest selected products and where we can't bring in an authorised generic, or if we are unable to divest, of course we can always lower the WAC to adjust that. So that is a collection of approaches that we are doing to protect the bulk of our business.

James Quigley (Morgan Stanley): Thank you very much. Maybe a question for Julie, picking up on one of her comments. You mentioned building a competitive P&L, what is your definition of a competitive P&L and what would be the focus areas to generate better competitiveness in terms of margin ranges or growth potential? Are there any early areas that could drive efficiencies or levers that you can use to get you into these competitive ranges? Thank you.

Julie Brown: Thanks, James. I see a competitive P&L as one that is operating to full capacity and making optimal use of the resources in the business and capital allocation in the business. Good progress has been made in GSK already following the separation with the future ready programme. Clearly at the moment we are in the launch cycle with a number of important medicines and vaccines being brought to the market as Luke and Deborah both mentioned.

As we move beyond this of course we will continue to look for efficiencies and we do anticipate once we are through the launch cycle that SG&A will grow at a lower rate than sales, thereby improving that particular margin. Working with Tony closely, because obviously I have been in the Pharma industry for a long time, I worked with R&D for a long time, clearly investment and productivity and resource allocation in R&D is critical to a pharmaceutical business. As you can imagine, I will spend some time looking for continuous improvement and opportunities to fuel business efficiencies to fuel further growth.

Emily Field (Barclays): I know that you had previously guided for a down year but you didn't expect that to be down 20%. If you could give any colour on what the driver is for that? Then I believe on the pipeline side you indicated that we could get an update on the 'go forward' plans for the mRNA seasonal flu vaccine, and if you could just give any sort of high-level thoughts on what we could expect from that decision in the back-half of this year, thank you.

Emma Walmsley: As you know, our current flu business is in, let's call it, not the most modern technology platform and we are expecting a decline in sales. I'll ask Luke to comment very briefly on why we see that, but once again to reiterate, our overall outlook on vaccines overall remains very strong for the year. Then, Tony, perhaps you can update and I know we are excited about the potential doublet that we can go after with mRNA.

Luke Miels: Thank you for your question. You have a comparator issue as the demand around the time of COVID was very high, so there is pressure there. The fact is that there are a lot of doses around and people were motivated to discount to offload them, so we have seen pricing pressure. In terms of

volumes, we expect around 43 million doses this year versus around 51 million that we sold in 2022. Our goal remains to evolve this technology and I shall hand over to Tony.

Tony Wood: First of all, Emily, as I said, we are now moving with the mRNA partnership in flu and COVID - into the evaluation of multivalent options, and we continue to be encouraged by the data that we see there and the plans to move into Phase I and Phase II studies we expect in the case of both instances. We will see read-out on those towards the end of the year and the beginning of next year.

Probably the only other point I would add, and I am sure you follow this as well, is that the field continues to encounter difficulties with regards to coverage particularly in B strains. What I would say at this point is that our studies are designed to account for B strain coverage and looking at a broader range of antigens, so all of that will come together when we have an opportunity to update you in more detail at the beginning of next year. We are very pleased with the progress on the platform.

Peter Welford (Jefferies): Thanks. I want to come back to US *Shingrix* for a minute to try to understand the cadence here that we are talking about. Presumably, the retail segment is typically the segment that we would anticipate to increase towards the end of the year. I am trying to understand, in that segment you are saying that demand is still robust but, presumably, we will see the usual detailing that you do together with flu or is there any issue with *Arexvy* perhaps taking over priority there going into the flu season for the retail channel this year?

For the non-retail, I am trying to understand. The issue is that the majority of the non-retail segment has yet to reach that 60-65% but can you talk about what is the challenge perhaps to get doctors there? Is it coverage, as insurance coverage, or is it just getting these people back in to see the physician? What exactly is the ceiling there with the doctors please?

Luke Miels: Peter, I'll start with non-retail first. We have had a couple of very, very large players that we have intensively worked with. It's natural when you have momentum, you try to go with that and we really wanted to see how high the penetration would get. We still expect those large centres to keep vaccinating and our aim is to go beyond 60% but the curve does tend to flatten out at 60%.

If we think long term, this is why I am personally fascinated by the relationship that we have seen in the Welsh study around vaccination, *Shingrix* and a potential relationship with dementia, and we are going to be very busy with life-cycle work on that one both prospectively and retrospective analysis.

There are another 197 key customers that we have that are in the range of 30-60 behind which we are now putting more work. We also pulled back on the primary care promotion on *Shingrix* in these centres and we are concentrating on *Trelegy* to give that a hard push along with *Nucala* as an experiment, to see if PCPs would respond. We are now switching that team back to *Shingrix*, so that is all pointing in the right direction. It is more a case of prioritisation and just moving that up, these larger centres putting a flag in the system and we saw one of them is really moving. We just need to do the hard work to pick up the other ones now and I feel very confident that we can do that.

As far as retail, you are right, there is still a seasonal relationship which we expect to continue. It is not as extreme as it was in the first couple of years of *Shingrix* but it still exists. The unknowns are that there is no push on COVID booster this year, so we don't know what effect that will have; it has been a drag historically. As you correctly point out, we are going to be very busy with *Arexvy*, targeting the high-risk individuals which is the subset of the *Shingrix* target universe. Let us see, we'll get some more colour, I unfortunately don't have a crystal ball but I remain very confident about the demand for this product in the US in 2023.

Emma Walmsley: Just to remind everyone again, ex-US and Germany, we are at less than 3% penetration, so there is plenty of runway for this asset. Next question please.

Eric Le Berrigaud (Stifel): Thank you, Nick, and good afternoon everyone. I have a question to get more clarity in terms of cash flow development. We are now getting into double digits in terms of earnings growth and you are raising the guidance here but you are still guiding in terms of cash flow declining this year.

Could you perhaps give us a little more detail about the push and pulls to make the difference between earnings growth and cash flow decline, even though we go beyond the Gilead settlement and the COVID impact, and whether getting into 2024 and beyond we might see cash flow development more in line with earnings? Thank you.

Emma Walmsley: Thanks, Eric. Over to you, Julie. We are reiterating our '26 outlook for operating cash flow. Over to you.

Julie Brown: Thanks for the question, Eric. This year clearly we've had an influence of a number of factors with the cash flow. A couple of things happened last year that have obviously affected the comparator: last year with the cash flow, we had the Gilead settlement, that occurred at the beginning of the year, and then we've also had *Xevudy* receivables coming in last year.

This year, the cash flow has been depressed somewhat, partly by movements in working capital - which we expect to resolve by the end of the year - and also, we've had an additional pension payment that's been made this year, which was reasonably sizeable, over £350 million. They are somewhat one-offs, you may call them, relating to the cash flow - this is where you see the £2 billion swing in the first half.

We are maintaining the guidance for the full year for cash flow, which is basically to be slightly lower than last year. Then major reason you do see this difference, usually our cash flow rating is very much towards the second half, and we normally have around 70-75% of the cash coming in in the second half of the year; last year was very unusual, it was 50:50 because of the things I mentioned. That's why you're seeing the difference.

In terms of 2024, obviously we will guide when we come to that at the end of the year, but you can be sure that we will care for cash, we will be very focused on cash conversion and the translated profit into cash. You can see us paying a lot of attention to that as we go forward.

Michael Leuchten (UBS): Thank you. A question on RSV and Luke's comment on prioritisation, please: I guess the ACIP recommendation could have been a little bit stronger than it was, just wondering how you reacted to that – will you throw more commercial resources at RSV, or is the plan to execute it as it was? Thank you.

Emma Walmsley: I know Luke is very excited about the pending launch, so if you could you add a bit of colour to that.

Luke Miels: I think on my Christmas wish list it would have been for a simpler label, but that's the label we have. To put it in perspective, our strategy has always been to focus on these high-risk individuals who naturally would engage in that type of discussion with their healthcare provider, are regular visitors to the pharmacy, because they are poly pharmacy and we have market research that clearly says that.

If you look at our label, that secondary claim, the 94% efficacy, etc., really plays to our strength. At the end of the day, it doesn't have an enormous impact in the first couple of years. We are now actively with Tony's team generating the data that the ACIP group want to see and we're confident that we can bring that, so I think if we look in the medium to long term we will see this fully supported, a simpler access process for these vaccines. Our discussions with insurers are very, very encouraging.

There is also some really good work published by our friends in New York that looked at rates of RSV created in the hospital setting, particularly the use of sputum-based tests, and they're looking at, it's really under-diagnosis by a factor of two. The demand is there, the willingness to recommend is there, so we remain encouraged, and the pricing and support is high. I think you'd have to see the full effect in terms of the multi-season label, but again, for these high-risk patients, I think this is more of a reassurance, and also, arguably lets us move this out of the seasonal collar that we would normally typically have with flu, because you have that longer timeframe in terms of occurrence.

Net/net, I think we remain very excited, as Emma said. We are very much looking forward to a scientific battle with Pfizer, and it's something that we relish. In the end, this is going to mean that physicians and pharmacists are better informed and patients are going to get a better vaccine.

Graham Parry (Bank of America): Hi, thanks for taking my question. I just want to follow up on what people asked about whether you can grow *Shingrix* in the US, I'll just throw that out but I think it's been answered; then I'll ask my question, which is on *Zantac*. With the Goetz settlement, you showed a willingness or even a desire to settle cases in California, but is that still the attitude that you have towards the upcoming case in November? Now the same lead plaintiffs' attorney is representing the plaintiffs both in California and the Delaware cases, would any settlement of the entirety of the *Zantac* litigation now need to include a Delaware settlement as well? Thank you.

Emma Walmsley: We'll come to Luke to see whether he wants to add anything more to his already reasonably comprehensive answer, but in terms of *Zantac* we remain very confident in our position. We continue to be guided by the science, the evidence that's been in place, we have a dedicated team managing this, we will continue to defend ourselves vigorously. We obviously won't comment on our

specific legal strategy ahead of its execution. I am happy to be where we are, and we will keep everybody updated as we progress through, obviously knowing that we have Delaware coming in the new year. Nothing more to add than that.

Luke's shaking his head, with nothing new to add on *Shingrix*.

Rajesh Kumar (HSBC): Hi there! Just on the capital allocation piece, you suggested that you are going to focus on deals as well as investing organically in R&D. Could you run us through some criteria that you look at when you deploy capital, when you pick between R&D versus external investment? How do you compare the two and what other internal metrics you look at? Are the management below the top management incentivised similarly for doing deals versus organic investment?

Emma Walmsley: I will comment on that and then see whether Julie wants to add anything further. It should be really clearly in our capital allocations framework that our No. 1 priority is investing in growth. As you saw both from Julie's slides and from Tony's slides, that is about the pipeline and our launches. Within the pipeline, it is organic and inorganic. You will know that, across the entire sector, about half the pipeline is sourced from outside, and that number is probably going up across the sector. We have been really pleased with the reset of our balance sheet to create the capacity to do that, and then we have a very focused track record of executing against deals at a reasonably swift pace – particularly over the last 18 months or so. You should expect to see it broadly the same.

The most important point is that because it is part of the way that we do R&D, our BD team reports into Tony. We have been very thoughtful about the incentive system and the goals that are set in terms of pipeline progression, to keep it neutral, regardless of whether it is sourced internally or externally. You are absolutely right – there were some slightly perverse incentives around that, which aren't helpful.

Our criteria are unchanged and I think they were laid out explicitly on Tony's opening slide. We like to look for assets that are best in class and first in class. We look at ROIs, NPVs. We look at contribution to sales growth – particularly in the latter half of the decade and beyond. We look across a balanced portfolio of risk across all therapeutic areas. We are obviously focused more on investing in our Specialty and Vaccines pipeline, but also in technology platforms that will allow us to continue to improve productivity – and that is where we like to see the tech enablement of what we bring through.

The really important point is that, regardless of whether it is internal or external, and regardless of TA, we use the same set of criteria. I don't know whether Tony or Julie would like to add to that.

Julie Brown: Yes, just an extra point. We also have a very vigorous governance process that runs through both BD assets, we get together regularly, looking at the BD pipeline, as well as the organic pipeline. As Emma mentioned, one of our jobs which we see as being very important is also to accelerate the key assets. So we identify the key assets and we look to accelerate them. We look to ensure that they have the right resources to do that and we remove any blocker that could be there in the organisation.

Finally, we also review assets – whether it be BD or organic – for success, so we do post-deal reviews also. There is a very rigorous process around this.

Richard Parkes (BNP Paribas Exane): I just wanted to push you a little more to talk about your expectations for the RSV launch, based on the initial outreach. With the new data on annual use looking uncertain, I think the market is sceptical on your previous *Shingrix*-like target but, given higher pricing, clearly it could be a more meaningful opportunity near-term if you can drive rapid uptake.

Looking at consensus, I think you have £180 million of sales this year, and going to £570. I just wondered whether you could give us your thoughts on whether you see the potential to exceed those numbers, or is the weaker ACIP recommendation and perhaps lower vaccine uptake you are factoring into flu vaccine going to be a headwind to that? I note that you have not upgraded the vaccines guidance, despite that higher pricing, so does that moderate your expectations in terms of volume? Thank you very much.

Emma Walmsley: Thanks. First of all, I will start and then come to Luke for any additional comments. There is absolutely no change to our outlook. We emphasised again at our Meet the Management Update on Infectious Diseases that we see the potential of this to be around £3 billion of sales. In that sense, it is a multi-billion asset. I think we have been clear right from the beginning that we didn't expect the start to be at the same rate as *Shingrix*, just for the simple facts, awareness of the virus, and of course we have some competitiveness for arm-space in there. Also, as you know, we had a very specific recommendation from ACIP for treatments which were remedial as well as – bizarrely – helpful. Initial shortness of stock – we are a long way from dealing with here, also taking a different pace of launching in multiple countries across the world.

We don't guide for individual quarters of sales, but I will let Luke comment on some more details around pricing aspects as well.

Luke Miels: Thanks, Richard. I think there was no solution for RSV historically, and so it didn't really make a lot of sense for statistics to focus on. Then, as you saw, COVID with PCR testing, often that was an accompanying test and better understanding and character and prevalence of RSV emerged. I think we are in a very different place that we were a couple of years ago and, as we start to promote and educate doctors and pharmacists, and pharmacist chains are very enthusiastic about this product, I think that is a very fair long term ambition. There is a heavy overlap if you look at high dose flu, and of course the *Shingrix* population and the pneumococcal population. I said in the past that I think there will be a steady build that people will be very strong, and this is outstanding data for a company that is very impactful for healthcare systems and individuals. We will get there and the data we have generated so far I think is quite exciting.

Pricing-wise, again, we went into ACIP with a core of \$270 to \$295 and we have been able to keep within that at \$280 so I think our credibility with ACIP is enhanced through that process, and the reception we have received so far from payors and pharmacy chains has been very encouraging. That is probably all I can say at this point, I very much look forward to updating everyone in Q3.

Andrew Baum (Citi): In relation to *Trelegy*, we are expecting to be included in the IRA price negotiation list being enacted in 2027. I am curious as to how Luke is thinking about the ability of GSK to claw back the rebate, in order to mitigate the impact of the list price reduction. My understanding is that PBMs cannot exclude a drug once it has been selected for price negotiations. Do you think you can take away the rebate or do you think that the PBMs will make you pay by creating hurdles to other products in your portfolio?

Then just following up on an earlier question in relation to the impact of the out-of-pocket cap in driving increased volumes. Still patients are going to have to pay \$2000 out of their own pocket. How meaningful do you think that really is in getting patients off your patient assistance programme onto pay drugs or do you actually think \$2000 is still a real barrier for many patients and therefore the volume impact isn't going to be that meaningful?

Luke Miels: Andrew, I think \$2000 is still a large amount of money for many people, particularly older individuals but it is an improvement, it's more predictable for those patients. I don't see a massive adjustment in some of our assistance programmes particularly in oncology and areas like that.

In terms of *Trelegy*, Q4 this year we will have a better idea in terms of how CMS is defined and how it is going to be managed, but we have as you said very high IRA rates on *Trelegy* already. I think PBMs, your second scenario is more likely to be reality and we are very rational to make that assumption but we are obviously starting to think about various combinations and initiate discussions with them. The other factor with *Trelegy* is whether you will see a generic emerge at some point because the technical challenges of encompassing or enclosing through inhaled medicines and validating that through a regulatory path is not simple, as we have seen with *Advair*, so I think that is also another factor we are starting to look at.

Kerry Holford (Berenberg): Question please for Deborah on long-acting HIV. Clearly *Cabenuva* had a strong performance in Q2 - just whether you can talk about that, whether that growth in this quarter truly reflective of underlying demand or were there any one-offs to be aware of when modelling sales in the second half of this year and beyond?

You also highlighted that together two-drug regimens, long-acting, represent I think you said around 50% of total ViiV, so I am interested to see whether that run-rate at this point is what you would have expected on the long-acting portfolio in particular. Are you are behind, in line or ahead of those internal expectations at this point in the year?

May I squeeze in a quick one just to remind us of the timelines for your three-monthly dosing formulation? Thank you.

Emma Walmsley: Obviously we are extremely pleased with the performance of ViiV through this year and to be able to upgrade our outlooks on it, and not least because of the innovation we have pioneered on coming through so strongly, so Deborah do you want to pick up on those?

Deborah Waterhouse: Thanks for the question, Kerry. Needless to say we were really pleased with the performance of our HIV business in the quarter. Really strong underlying growth for both our two-drug regimens and our long-acting injectables and that is absolutely being driven by demand.

Let's go into *Cabenuva*, it's all demand, we have seen really positive demand for our products from people who are living with HIV, and we know this is set to continue because we know that many doctor's offices have people on waiting lists, particularly in the US, to be starting on the drug. It's really strong underlying demand from people living with HIV. We expect that to continue, and this in turn gives us confidence that we can build this market and we can deliver greater and greater share of this market through our long-acting injectables.

In terms of expectation, it is ahead of where we expected, if I am completely honest, so to be at 51% of our overall portfolio in our two-drug regimens and long-acting injectables is ahead of expectation. We are really delighted by the underlying demand and particularly the long-acting injectable uptake from *Cabenuva*. It takes a long time to build a market and you are in this market on your own, so you always wonder how much will it take and can you unlock each stage of the journey, each barrier that you face, and the answer is, yes, we can. We are really optimistic about this opportunity.

Regarding the pipeline, we shall talk more about this at the Meet the Management session in September, but what we have said is that we are looking to target an ultra long-acting version of cabotegravir, so an ultra long-acting every three months plus, from 2027 onwards. We are making really good progress with our reformulation of cabotegravir, because that will be the backbone to the first wave of our innovation PrEP and in treatment. What you probably saw on some of the slides that Tony presented was us starting to move forward with the accompanying partners, be it maturation inhibitor, be it capsid or be it our bNAb. We are moving those assets forward so that we can make a choice in 2024 of the regimen that we shall take forward. The dates we have given in our previous investor update stand, but we hope to be able to give you a little more specificity when we do the Meet the Management in September. It is a very optimistic position in which to be, both from a pipeline and a performance perspective, in the HIV space.

Emma Walmsley: Thanks Deborah. I gather there are a few more questions, so we shall keep going and try to give some short answers, speaking for myself!

Luke Miels: Just one correction or clarification. The patent expiry or LoE for *Trelegy* is 2027 (for the molecule and 2027-2030 for the device) but the IRA effect is expected in 2027 [correction]. I just want to make sure everyone is clear on that.

Simon Baker (Redburn): Going back, Tony, to slide 13 on R&D, two related questions, so one really! First, on the reduced cycle times, could you give us an idea of how much that is down to therapeutic mix and how much is underlying reduction in non-vaccine R&D times? Also on the probability trend, you show a nice trend of improvement in Phase II/III and beyond probability of success, and normally that is matched by a reduction in success rates in Phase I, i.e. you are killing projects earlier. I wonder whether you can give us an idea as to how that trend has evolved over time? Thanks very much.

Tony Wood: To your first question regarding cycle planning, obviously there is a component of vaccines in that but we are seeing cycle times come down, particularly across our late stage portfolio, so a contribution from both. As far as success rates in Phase II, all we want to do throughout the portfolio is begin to take attrition earlier and earlier. One of the things that we are driving, coming from our focus on human genetics and functional genomics and, of course, the benefits we get from focusing on infectious diseases, is to be able to take attrition on efficacy terms much earlier than first time in humans. What we shall see in the future is the preservation of those Phase II success rates and it being accounted for by earlier attrition than necessarily from first time in humans. We will very much be more focused on the quality of agents driving survival at that stage.

Emmanuel Papadakis (Deutsche Bank): Perhaps just a quick follow-up. I believe, Luke, you said in response to the earlier question around rebates offsetting price negotiation, 'the second scenario', could you just clarify what you meant by that? Do you mean you think you will be able to reduce rebating to offset that price reduction?

The question that I want to ask is on momelotinib and the delay in the PDUFA: to what extent do you think any bolus will now be diminished in demand by the delay given the emerging data we have seen on anaemia benefit with pacritinib and to what extent is pacritinib's quarterly run rate of 20 million or so a better guide to how we should be thinking about the launch? Thank you.

Luke Miels: I just think we are going to have pressure and it is getting difficult to evade those structures which is minus any values with two options. I would expect the high pain scenario versus the low pain scenario with *Trelegy*, in terms of linkage to other products in the portfolio. Again, we are looking at options to offset that and we are making progress there.

In terms of momelotinib, I think the bolus will still be there. It is really interesting, in terms of recent market research we have it is quite encouraging. Some of the numbers, just for interest: 75% of doctors agree that there is an unmet need. This is quite interesting that around 60% of patients presented with anaemia within one year of diagnosis and about 46% needed transfusion.

The other interesting statistic that fits our strategy, is that about two-thirds of them are on that 10-5mg dose of vorasidenib.

Correct me if I don't think it is an accurate analogue, because really their label is within that platelet sub-group, versus the broader anaemia group, there have been some great posters etc., presented, but the NCCM guidelines, if you look at the minutes, they say they decline to review that broader recommendation, so that product is very much anchored in the low-50 platelet group, whereas we have a much broader opportunity, we believe, with anaemic patients. We'll wait and see what the FDA decides in terms of the label, we built the business case for the deal on a second line label, second line anaemia. I hope that helps.

Steve Scala (Cowen): Thank you. In adult RSV, how has your success in contracting thus far compared to your expectations, and versus what you think Pfizer has accomplished to date? Is your potentially superior data giving you the edge versus Pfizer, and if not, then why do you think that's the case? Thank you very much.

Emma Walmsley: In recognition that we are in a competitive commercial situation, I'll let Luke answer the final question.

Luke Miels: Steve, we're encouraged, but it's happening right now, literally as we speak, so we'll have more news for you in Q3 and hopefully that's good news. Sorry I can't give you any more.

Emma Walmsley: Thanks, Luke. Once again, thanks everyone for joining us. We've been very pleased to report another excellent quarter of performance with strong sales and earnings growth, driven by new product sales in HIV and vaccines, ongoing progress in our pipeline, including the approval of the world's first RSV vaccine, our BELLUS Health deal, and of course upgrading guidance. With this momentum behind us, a lot of confidence in delivering our short-, medium- and long-term targets, and we look forward to keeping you informed over the quarters ahead. Thank you.

[Ends]