

**GLAXOSMITHKLINE
FULL YEAR & Q4 2021 Results**

**ANALYSTS PRESENTATION
Wednesday, 9 February 2022**

Nick Stone (Head of Investor Relations): Hello everyone and welcome to our full year and Q4 conference call and webcast for investors and analysts. The presentation was posted on gsk.com and it was sent out by email to our distribution list earlier today.

Cautionary statement regarding forward-looking statements

This is the usual safe harbour statement and we shall be making comments on constant exchange rates or CER unless otherwise stated.

Agenda

This is today's schedule and we plan to cover all aspects of our full year results. The presentation will last around 35 minutes to maximise the opportunity for questions. For those on the phone, please join the queue by pressing *1 and we request, in the first instance, if you could ask one question so that everyone has the chance to participate in today's call.

Today, our speakers are Emma Walmsley, Luke Miels, Deborah Waterhouse, Brian McNamara, Iain Mackay and Hal Barron. The Q&A portion of the call will be joined by Roger Connor and David Redfern. With that, I will now hand the call over to Emma.

Accelerating progress

Emma Walmsley (CEO): Thanks, Nick, and a very warm welcome to everyone.

2021: strong results and accelerating momentum

I am delighted to announce our 2021 full year results. They demonstrate strong financial performance and continued progress against our strategic priorities. For the full year, sales increased 5% and adjusted EPS increased 9%. Excluding the contribution from COVID Solutions, we exceeded our raised guidance with adjusted EPS stable for the full year.

Sales growth was driven by first class commercial execution and strong uptake of new products. Pharma delivered 10% growth, New and Specialty Medicines growing 26%, double digit sales in Immuno-inflammation, Respiratory and Oncology, together with sales from *Xevudy* for COVID-19, all drove this performance. Vaccines sales increased 2% and Consumer Healthcare finished the year with 4% growth overall, notably accelerating again in the fourth quarter with sales up 11%.

Alongside this, we increased investment for key R&D pipeline programmes, expanded support for new and ongoing launches and maintained a strong focus on cost optimisation. This is also reflected in adjusted operating profit growth, which increased 9% for the full year.

We see these results as very encouraging and a demonstration of the accelerating momentum we now have at GSK. As we said, 2022 marks a step-change in growth for the company and is underscored by the guidance for New GSK, the Biopharma business, we are giving today of 5-7% sales growth and 12-14% adjusted operating profit growth at CER. This includes the anticipated benefit of *Biktarvy*-related royalties but excludes any contribution from Pandemic Solutions, and Iain will provide more detail on this and our overall financial performance in his section.

Excellent progress across all three strategic priorities

2021 was a year of excellent progress across all three of our long-term strategic priorities. In Innovation, we delivered three major product approvals: *Jemperli* for endometrial cancer, *Xevudy* for COVID-19 and *Apretude*, our new long-acting medicine for HIV prevention. We also presented positive Phase III data for daprodustat, a potential best-in-class medicine for treating anaemia of chronic kidney disease. We expect to file this new and exciting medicine with regulators in the first half of 2022.

These new medicines are at the forefront of an exciting, high-value pipeline we continue to build across prevention and treatment of disease through organic and inorganic delivery. We now have a pipeline of 21 vaccines and 43 medicines, 22 of which are in pivotal studies. This year we anticipate data readouts on up to seven of the 11 new vaccines and medicines we have identified as key future growth drivers. This includes our RSV vaccine for older adults in the first half of 2022 and several new potential specialty treatments, including those for rheumatoid arthritis, cancer and hepatitis B.

In Performance, our decision to prioritise investment in commercial execution to specialty medicines and vaccines is evident in our improving sales growth. *Shingrix* sales clearly reflected the adverse impact of COVID-19 last year, particularly in the US, but we

exceeded our expectations highlighted at Q3 to deliver sales of £1.7 billion. This year, we do expect to see strong recovery growth and Luke will give details on this in a moment.

Lastly, on Trust, we continue to maintain sector leadership in ESG, with our No. 1 ranking in the Dow Jones Sustainability Index and our longstanding leadership in the Access to Medicines index.

Looking ahead, we also aim to deliver ambitious environmental commitments, with targets of net zero on carbon and net-positive on nature by 2030, and we are also making good progress on diversity and inclusion. ESG will continue to be an integral part of New GSK's strategy and investment case.

Ready to unlock long-term value with the demerger in mid-2022

Turning to Slide 7, 2022 sees the biggest change in GSK's recent corporate history, with the creation of a new, unique world leader, dedicated to Consumer Healthcare, expected in the middle of this year. This will be the culmination of a series of progressive, strategic moves, successfully executed over the last few years to build significant value and a new Consumer Healthcare company. We are now in full countdown mode to demerger and, by doing so, our aim is to unlock the potential of both GSK and Consumer Health, strengthen GSK's balance sheet and to maximise value for all our shareholders.

As a new standalone company, the Consumer Healthcare business is a compelling prospect. It has an outstanding brand portfolio and will be a world leader in consumer health. For prospective investors, it will offer a highly attractive financial profile of above-category sales growth, sustainable margin expansion and high, stable cash generation. It will have a fantastic leadership team, led by CEO Brian McNamara and a Board with best-in-class international consumer sector experience, as is already evident with the recent appointment of Sir Dave Lewis, as Chairman designate. We will provide a great deal more detail on this business at our Capital Markets event later this month. Brian will give you more on this shortly.

For New GSK, as we have previously shared, we have set a new purpose and new ambitions for growth. Our purpose is to unite science, talent and technology, to get ahead of disease together – to deliver scale human health impacts, improved returns for shareholders and to be a company where outstanding people thrive. This is reflected in the growth commitments and ambition that we set out in our Investor Update in June last year and these represent a significant step-change in delivery for GSK. As I said earlier, they start now and are reflected in the guidance we are giving today and the exciting R&D catalyst ahead.

Before closing, I would like to say a very big thank you to the more than 94,000 GSK people who helped us to deliver our 2021 performance and the momentum they have built as we head into this landmark year. Let me now hand over to the team, who will take you through more of the detail. Luke, first of all, over to you.

Growth Drivers

Luke Miels: Thanks, Emma. Let us turn to slide 9.

New and Specialty: strong double-digit growth (+26%, +14% ex-*Xevudy*)

Let me start with New and Specialty, where we have made remarkable progress driven by excellent commercial execution. Excluding *Xevudy*, we delivered 14% sales growth for the year, and 10% in Q4, maintaining our double-digit track record. I am incredibly proud to report that two of our assets exceeded £1 billion sales for the first time: *Trelegy* and *Nucala*. And, as you have seen, we were able to respond quickly to the strong demand for *Xevudy*, delivering close to £1 billion in sales with this crucial COVID treatment. *Trelegy* had a fantastic year despite growing competition and our unique dual indication of COPD and asthma continues to drive high demand in the US and Japan.

We have also seen very positive trends for our launch in China, where the single inhaler therapy class is growing rapidly and we are winning share in Tier 1 and Tier 2 cities.

For *Nucala*, sales were up 22% and it remains the leading IL-5 for eosinophil disease across key markets. We are pleased to see that our robust approach to life-cycle innovation is driving incremental growth opportunities with the launch of three new indications: EGPA, HES and nasal polyps in Europe.

Benlysta also benefitted from label expansion, with sales up 29% as we reached more new patients with lupus nephritis. Against the backdrop of COVID, we continued to see the importance of having a subcut formulation available for at-home use. And, as expected, with competitors entering the market, we have seen an overall increase in biologic use, benefitting *Benlysta* as the leader.

In Oncology, we continued to make steady progress. *Blenrep* remains the only off-the-shelf anti-BCMA therapy, and we have expanded our presence in 13 markets. In the US, we are driving use in the community setting, where most multiple myeloma patients are treated, we are working to reach new physicians as prescribing increases perception of corneal adverse event management.

Closing with *Zejula*, COVID continues to impact the ovarian cancer market with diagnosis and debulking surgery still below pre-pandemic levels. Despite the constrained market, *Zejula* has delivered its strongest quarter of sales today and we continue to perform exceptionally well in market share terms with one in two new patients receiving a PARP being prescribed *Zejula*.

A very strong year for New and Specialty and we expect to grow Specialty sales by around 10% in 2022, even with *Trelegy* moving into the new General Medicines area and this is before we include the expected contributions of *Xevudy*.

Vaccines: *Shingrix* poised for 2022 recovery

Moving to Vaccines, full year sales increased by 2% but decreased by 5% excluding pandemic sales. The overall performance demonstrated the impact on several of our vaccines of COVID. Most impacted was *Shingrix* where sales were down by 9% in the year which was slightly better than the outlook we indicated at the nine-month stage. Based on the encouraging early momentum we are seeing, we continue to anticipate a strong sales recovery in 2022.

Since Q2 2021 *Shingrix* has delivered strong sequential growth reflecting improvement in trends in the US, including solid demand in the non-retail channel as well as contributions from new European launches and recovery of demand in Germany. We expect this momentum to continue in 2022, despite Omicron's short-term impact. We continue to launch in new markets supported by our unconstrained supply position and we believe there is a significant pent-up demand in the US. Consequently, we continue to expect *Shingrix* to deliver strong double-digit sales growth in 2022 with record annual sales. This will be a crucial driver of the expected low teen sales growth in vaccines this year, excluding pandemic solutions.

Looking further ahead, by 2024 we expect *Shingrix* to be available in 35 markets representing nearly 90% of the global vaccines market, underscoring our ambition to double *Shingrix* revenues by 2026.

Let me now hand over to Deborah on Slide 11.

HIV: innovation medicines accelerating growth

Deborah Waterhouse: Thank you, Luke. Our goal is to remain innovation leaders in HIV, achieve a mid single-digit sales CAGR to 2026 and digest the loss of exclusivity

of dolutegravir at the end of the decade through the changing mix of our portfolio and the success of our pipeline.

Our Q4 and full-year results demonstrate positive momentum towards delivering on these objectives. Sales grew 3% both for Q4 and for the year. Within this, we achieved a noticeable acceleration in our innovation sales which now stand at 34% of our portfolio and all regions reported growth.

This acceleration in growth results from strong commercial execution behind our two-drug regimens and *Dovato* in particular. Sales of *Dovato* more than doubled to £787 million and are fast approaching 20% of the total HIV sales.

Dolutegravir-based regimens now hold the number one position in the share of the switch market across the US and Europe. Based on this strong momentum, we believe *Dovato* is on track to deliver £1 billion of sales in 2022 with further significant growth potential beyond.

HIV: Shifting the paradigm towards long-acting regimens

Turning to our injectable portfolio, *Cabenuva* is our first in class long-acting regimen for the treatment of HIV for which we received FDA approval last week for every two month dosing.

As with any new class of medicine, sales of *Cabenuva* will take time to build and the COVID environment is constraining switch activity, particularly where a patient needs to visit a physician's office. Nevertheless, over 4500 people living with HIV are already taking *Cabenuva/Vocabria*, *Rekambys* and the outlook for this important new medicine is for strong brand recognition and market access exceeding 80%.

Moving on to prevention, we ended 2021 on a high with the FDA approval of *Apretude*, the world's first long-acting injectable for the prevention of HIV dosed every two months.

HIV prevention is a huge unmet need as current medical options are associated with stigma and adherence issues. *Apretude* not only addresses these concerns but it has demonstrated superior efficacy over daily oral tablets.

As a new paradigm, we need to educate physicians, patients and payers, so this year our focus is on building awareness and access for *Apretude*. The early signs are encouraging with positive feedback from patients and prescribers and with political will supportive of medicines for HIV prevention.

Consequently, we remain confident that *Apretude* will deliver significant benefits to patients in the years ahead, as well as significant commercial value beginning in 2023, and with that, I will hand over to Brian, and we will move onto slide 13.

Global leader in Consumer Healthcare

Brian McNamara: Thanks, Deborah. Now turning to Consumer Healthcare.

Sales for the full year, excluding brands divested and under review increased by 4% at constant exchange rates, despite a negative 1% impact of COVID on Cold and Flu sales, building on the 4% growth we delivered in 2020.

International grew 9%, with Emerging Markets performing particularly well, including China and Middle East Africa growing double digits.

US sales increased 2%, and Europe was broadly stable, with both regions building momentum through the year.

Q4 growth was strong, up 11% at constant exchange rates, albeit against a weaker comparator of 1% growth in 2020, with all categories performing well.

Cold and Flu sales rebounded in Q4, with European sales above 2019, and US sales only slightly below.

From a category perspective for the full year, Oral Health sales increased 5%, with broad-based growth in key markets reflecting brand strength, strong execution and successful innovation.

Pain Relief grew high-single digits. This was primarily driven by *Panadol*, which benefited from seasonal demand in the second half of the year.

Voltaren delivered mid-single digit growth, despite the expected introduction of US private label earlier in the year.

Vitamins, Minerals and Supplements grew 4%, continuing momentum on a very strong year-over-year comparator. *Centrum* growth in the second half was particularly strong due to the increased capacity and retail stocking.

Respiratory declined 1% with strong growth in Allergy offset by a mid-single digit decline of our Cold and Flu products.

Q4 rebounded, delivering 40% growth, giving a return of a more typical Cold and Flu demand, although it fell just short of offsetting the unprecedented market declines in Q1.

Digestive Health and other sales were up mid-single digits, with broad-based growth across Skin, Digestive Health and Smokers' Health.

On E-commerce, year-to-date sales grew in the [mid] 20% range, and is now 8% of sales, with good growth in key regions such as China.

Our on-going investment in digital capabilities continue to position us well for growth in this vital channel.

We have also delivered strong margin progressions for the year, up 200 basis points to constant exchange rates, while at the same time increasing investments in our brand.

Operational efficiencies on top of synergies, along with pricing have more than offset the impact of divestments and inflation in the year.

Overall, looking at sales growth over the last two years we have delivered a CAGR of over 4%, despite net COVID headwinds.

We were able to successfully capitalise on tailwinds created by increased Vitamin and Mineral Supplement demand. However, these were more than offset by the decline in Respiratory, as a result of the historically low cold and flu season.

This clearly demonstrates the strength and breadth of our portfolio, and the capabilities that we have built through the two most significant transactions in the industry, coupled with extensive portfolio rationalisation.

This positions us to deliver sustained market out-performance, with a 4-6% medium-term annual sales outlook.

Creating a world-leader in Consumer Healthcare

With regards to the upcoming separation, I am delighted that Dave Lewis was recently appointed as Chair Designate and my Executive Leadership Team has now been announced.

I hope you will join us at our Capital Markets Day, which will take place virtually on 28 February. We will lay out our strategic priorities, key growth drivers and detailed financial information. The team and I will share both a global and regional overview, including our innovation, digital and operational capabilities, as well as our capital allocation priorities as a newly listed company.

Most importantly, we will set out how we will deliver the growth, category outperformance, and attractive sustainable returns that we are confident this business can achieve in the medium term.

With that, I will hand it over to Iain.

Financial results and 2022 guidance

Iain Mackay: Thanks, Brian. As I cover financials, references to go through constant exchange rates, unless stated otherwise.

Headline results

On Slide 16 is a summary of the Group's results for the full year 2021. I will focus my comments on the full year performance. Turnover was £34.1 billion, up 5% and adjusted operating profit was £8.8 billion, up 9%. Total earnings per share were 87.6 pence, down 13%, while adjusted earnings per share was 113.2 pence, up 9%. Pandemic solutions contributed approximately 9 points of growth on adjusted earnings per share.

In currency there was a headwind of 5% in sales, and 11% in adjusted earnings per share, in particular due to the strengthening of sterling against the US\$, relative to 2020.

Results reconciliation 2021

Turning to the next slide, this slide summarises the reconciliation of our total to adjusted results. The main adjusting items of note for the year were in disposals and other, which primarily reflected profits across several divestments, including the gain on disposal of the rights of the royalty stream for cabozantinib in Q1, the gain on disposal of the cephalosporins business in Q4, and significant positive revaluation of deferred tax assets in the UK, resulting from the Q2 enactment of the 2021 UK Finance Bill.

Finally, in transaction related, the main factor was the movement on the ViiV CCL, which includes the impact of assessment of Gilead.

My comments from here onwards are on adjusted results, unless stated otherwise.

Group sales and adjusted operating margins 2021

Key drivers of revenues and profits for the group in 2021 compared to 2020 are set out here. Revenues grew 5% overall, revenues from our COVID solutions contributed around 4 percentage points of that growth. Positive operating leverage from higher sales in the year were supported by continued focus on cost control and the benefits and synergies resulting from restructuring across the group, with SG&A down 1%. This included favourable legal

settlements compared to increased legal costs in 2020, which primarily impacted Q1, and one-off benefits in pensions and insurance in Q4.

Alongside these benefits we continued to prioritise investing in our pipeline, and R&D expenditures increased by 8%. This resulted in an adjusted operating profit increase of 9%, with pandemic solutions contributing 7 percentage points of that growth. The full year margin was 25.8%, 90 basis points higher than 2020 at constant exchange rates.

Adjusted operating profit to net income

Moving to the bottom half of the P&L, and highlighting the effective tax rate of 17.5% was in line with expectations, and that interest expense of £753 million was slightly lower than expected, primarily due to favourable foreign exchange.

Free cash flow of £4.4 bn

Next I will briefly cover free cash flow for the year, before going into more detail on the financials of each business.

On Slide 20, in 2021 we generated £4.4 billion of free cash flow. This was a step down versus 2020 and consistent with our outlook given in February last year. The positive factors of increased adjusted operating profit at CER, and lower dividends to non-controlling interests, were more than offset by increased purchases of intangible assets, including our collaborations with Alector and iTeos from Q3, reduced proceeds following completion of the consumer brands disposal programme, adverse timing of returns and rebates compared to 2020, and adverse exchange impacts.

Net cash generated from operations for the Group was £8 billion. We expect to share comparators for New GSK cash flow later in the first half. In 2022 we expect cash generated from operations for New GSK, on a like for like basis, to be higher than 2021, as a result of the Gilead settlement and increased adjusted operating profit. This will be partly offset by lower cash generated from lower margin COVID solutions, and RAR headwinds related to the phasing of payments in 2021, and continued generics impact on the US respiratory portfolio.

Pharmaceuticals 2021

Turning to performance of the pharma business on Slide 21, overall pharmaceutical revenues grew 10%, driven by strong growth in New and Specialty medicines, favourable US return and rebate adjustments, and sales of *Xevudy*, which contributed 6 percentage points of

growth. Within this 10% growth, established pharma sales decreased 6% in 2021, which was slightly better than expected.

The pharma operating margin was 26.4% for 2021. The increase in profit margin primarily reflected the positive operating leverage from the increased sales, including favourable pricing in RAR, continued tight cost control and restructuring benefits. This was partly offset by continued investment in R&D, and HIV product launches.

Vaccines 2021

Turning to Slide 22, overall vaccines sales grew by 2%. Excluding pandemic adjuvant revenues, sales decreased 5%, primarily driven by *Shingrix* dynamics, which Luke has described. We continue to be very confident in the demand for our vaccines. Notably, during 2022 we expect *Shingrix* to deliver record sales with strong double digit growth. The operating margin was 33.3%, the decrease in operating profit and margin primarily reflected higher supply chain costs resulting from lower demand. This was accompanied by an increased R&D investment of 34% as we progressed our RSV and meningitis development programmes and invested in our mRNA platform. Higher royalty income and beneficial mix from pandemic adjuvant sales partly offset these factors. In Q4 sales were down 7%, reflecting a tough comparison with 2020 due to strong *Shingrix* sales.

Consumer Healthcare 2021

Revenues from Consumer Healthcare increased 4%, excluding brands either divested or under review; including those brands, turnover was flat. Brian outlined the main drivers earlier. The operating margin was 23.3%, up 200 basis points at CER versus last year due to sales growth, including favourable pricing and mix, and strong synergy delivery. This was partially offset by a 120 basis point impact from divested brands in addition to commodity and trade cost pressures. This strong 11% sales growth, excluding brands divested or under review, in Q4 is an encouraging sign of momentum as the business moves into 2022.

2022 guidance and 2021-26 outlooks

I will close out with guidance for New GSK in 2022, all of which excludes the commercial impact of our COVID solutions. Our guidance is predicated on the Consumer Healthcare business being demerged in mid-2022, and we expect the formal criteria for

treating Consumer Healthcare as a discontinued operation to be satisfied in Q2. GSK will continue to consolidate the business for reporting purposes until the planned demerger.

As Brian mentioned earlier, the Consumer Healthcare Capital Markets Day will set out the strategic priorities, key growth drivers and detailed financial information that underpin our confidence in compelling medium-term outlooks for that company.

For New GSK, 2022 will see a step-change in growth. We expect New GSK sales growth to be between 5-7% in 2022. Investment in the business for growth will continue in a focused and controlled fashion, so we expect SG&A and R&D to increase at a rate similar to sales, while we expect cost of goods sold to increase at a slower rate than sales. As a result, our guidance for adjusted operating profit is for between 12-14% growth. This includes the anticipated benefit of related royalties contributing around two percentage points of adjusted operating profit growth.

Regarding our outlook for COVID Solutions in 2022 based on known binding agreements with governments, we expect that COVID Solutions will contribute a similar sales level to that of 2021 by a substantially reduced profit contribution due to the increased proportion of lower margin *Xevudy* sales. We expect this to reduce New GSK adjusted operating profit growth, including COVID Solutions in both years, by between 5-7%. We shall provide quarterly updates as future contracting and binding agreements progress.

With regard to dividend policy in 2022, the total expected cash distribution and the respective dividend payout ratios for each company are unchanged from what we communicated at our Investor Update last June. GSK expects to pay 49p per share, comprising 44p per share for New GSK and 5p per share representing Consumer Healthcare while still part of the Group. Consumer Healthcare's dividend in the second half of 2022 is subject to review and approval by the Consumer Healthcare Board. This is expected to be around 3p per share and has been adjusted to reflect the total number of Consumer shares that are expected to be an issue upon demerger. More details are provided in the Appendix.

Given the complexities associated with demerging a significant operating segment of the company, we'll provide adjusted earnings per share guidance at our Q2 results following the demerger. To help with modelling New GSK, a reconciliation of the 2021 results to reflect the new reporting format is expected to become available later in the first half.

As a reminder, we shall be presenting a single New GSK operating margin in the future.

In summary, we believe the business momentum built from the excellent work of our teams in 2021 sets us up for a step-change in growth for New GSK in 2022. With that, I shall hand over to Hal.

R&D update

Hal Barron: I'll provide a short update on our progress in R&D over the past year and highlight some of the key upcoming pipeline milestones.

2021: significant R&D progress across the pipeline

As we set out last June, the transformation of our R&D approach since 2018 has resulted in a significantly stronger pipeline and improved productivity across multiple metrics, and in 2021 we continued to build on this momentum.

In terms of late-stage pipeline advancements, we achieved the first regulatory approval for three new medicines in 2021 - *Apretude*, *Xevudy* and *Jemperli* - as well as seven regulatory submissions. As Luke mentioned earlier, our approach to life cycle innovation is also delivering with five additional approvals in 2021 for *Nucala* and *Benlysta*.

We also reported positive pivotal data on three assets, including daprodustat which I will cover in more detail in a moment and started eight new Phase III trials. In total, we have delivered 13 major regulatory approvals since 2017 which is top quartile performance for the industry and four of these assets have already achieved so-called blockbuster status.

As a reminder, we expect the medicines and vaccines approved between 2017 and 2021 to contribute around 60% of New GSK's '21 to '26 sales growth with the anticipated pipeline approvals contributing another 40%. We are also bringing forth the next generation of innovative assets into our pipeline, driven by our focus on the science of the immune system, human genetics and advanced technologies.

In 2021 we moved 19 assets into Phase I or Phase II trials which are as a direct result of our focus on human genetics and functional genomics with our overarching vision to use the human as the model organism.

An excellent example of this is our anti-IL-18 neutralising antibody, so-called GSK 806, which is being developed to treat patients with atopic dermatitis where there is strong genetic rationale for this target.

The second example is GSK 130, a monoclonal antibody that just entered Phase I and targets IL-7 which is genetically associated with developing multiple sclerosis.

In Oncology, our internal work on functional genomics has identified more than ten target candidates in research for evaluation in the field of synthetic lethality.

Our collaboration with IDEAYA has three synthetic lethal targets. The most advanced is our MAT2A inhibitor which is in Phase I for patients with tumours where MTAP is deleted

which is common in solid tumours. Overall, I am very excited about the potential of this next wave of medicines and vaccines in our pipeline.

H2 2021: two major pipeline achievements demonstrate R&D momentum

This slide highlights two major pipeline achievements delivered towards the end of 2021.

I have previously spoken before about daprodustat, our HIF prolyl hydroxylase inhibitor, a target we chose to pursue because again genetics strongly suggested a role in stimulating erythropoiesis.

The ASCEND Phase III programme recruited over 8,000 patients in well-designed studies using active controls and delivered very consistent efficacy and safety results in both dialysis and non-dialysis patients. The results uniquely demonstrated that daprodustat met the primary endpoint of non-inferiority to another erythropoiesis stimulating agent in terms of cardiovascular safety and was shown to be as effective as standard of care in treating to a target haemoglobin range.

We believe these data position daprodustat as the best in class oral agent for treating patients with anaemia chronic to kidney disease and are on track to submit this data in the first half of this year.

The second key pipeline achievement was the approval of *Apretude* for the prevention of HIV based on extremely impressive efficacy results. This exciting milestone was well covered by Deborah earlier so let's turn to Slide 28.

H1 2022: pivotal data expected for differentiated RSV vaccine candidate

Looking to the year ahead, this slide focuses on the important pipeline milestones we anticipate in the first half of 2022. RSV disease represents a significant unmet medical need with RSV infections accounting for around 180,000 hospitalisations each year and about 14,000 deaths in the over-65 population in the United States alone.

The unique design of our antigen/adjuvant combination induces strong neutralising antibody titres and T-cell responses against both RSV A and B in the Phase II trial which is critical to protect an older adult population who are at increased risk for RSV disease.

From the literature and our trial data we know that older adults typically have a lower T-cell response when compared to younger populations and our RSV older adult vaccine utilises our AS01 adjuvant to overcome this deficiency. Our RSV older adult trial is expected

to read out ahead of our original timelines with headline data expected during the first half of 2022 and filing is anticipated before year-end, potentially putting us on a path for inclusion in the June 2023 ACIP meeting.

Significant R&D pipeline news flow continues

The next two years will see R&D continue to deliver important news flow on several potential new medicines and vaccines within our late stage pipeline. In 2022, we anticipate late stage milestones from up to seven of the 11 new vaccines and medicines we have highlighted at the Investor Update in June last year, including those I have already mentioned.

I will take two minutes to highlight some of the other read-outs that I am most excited about. I will start with otilimab, where we have three Phase III trials reading out in 2022: CONTRAST 1, 2 and 3. These data will define the efficacy and safety of our anti-GMCSF antibodies which has a potential to deliver an entirely new mechanism of action for patients with rheumatoid arthritis. Data from the Phase IIB trial suggested a unique reduction in pain which, we believe, could be driven by CCL17 – the most over-expressed protein by monocytes when stimulated by GMCSF. Based on this finding, we moved GSK-279, a CCL17 monoclonal antibody, into development to treat patients with osteoarthritic pain and we expect initial data to be available later this year.

In addition, we expect data on Blenrep, the pivotal DREAMM-3 read-out in patients with third-line multiple myeloma. This is an important study because it will give us the first progression-free survival and overall survival data on Blenrep in a randomised setting.

We also anticipate presenting data around the middle of this year on Blenrep in combination with a gamma secretase inhibitor. These data will also help inform our strategy for treating patients in the frontline setting.

I also want to mention our HBV-ASO, which we plan to present data on in the middle of the year, from our Phase IIB trial investigating the treatment of patients with chronic Hep B. There is a significant unmet medical need for these patients: there are around 300 million patients living with Hep B and the disease is responsible for over 900,000 deaths each year. In addition to these late-stage read-outs, we plan at least three major regulatory submissions in 2022, including daprodustat, RSV for older adults, and Blenrep in the third-line setting.

Lastly, we have recently announced several impressive leadership appointments, including Phil Dormitzer, as the Head of Vaccines R&D, who joins us from Pfizer, and Hesham Abdullah, who was promoted to the Head of Clinical Oncology.

In January, we also announced that Tony Wood would be our new Chief Scientific Officer from 1 August and I am delighted about his appointment. Tony is a person and scientist of the highest quality, who is integral to building our new approach to R&D. His appointment and expertise deepen our commitment to the strategy and I am positive that Tony will be an outstanding leader for GSK R&D. I am also pleased to remain part of GSK beyond August as I transition to a non-executive Board member and to support Tony and the team to deliver on the promise of our exciting pipeline.

In summary, 2022 will be an exciting year for a high-quality pipeline. I remain very confident that we will continue to advance the standard of care for patients and deliver value to shareholders.

With that, I will hand back to Emma.

Emma Walmsley: Thank you. Let's move to the Q&A, please.

Question & Answer Session

James Gordon (JP Morgan): Thank you for taking my questions. I have one question about Specialty Pharma. I saw Specialty Pharma sales were a little bit light versus expectations today. I know that growth will be approximately 10% in 2022, which sounds a little more cautious than the double-digit medium-term outlook that you issued in June last year. Have things it got any tougher for these assets? Is it going to be back-end weighted CAGR for Specialty Pharma? What could drive an inflection, particularly in Oncology? Do we need more data or is it really about COVID diagnoses, or COVID getting better and then more diagnoses for these conditions?

Then – and this is not another question, just a clarification – if I look at the guidance, the 5-7% core EBIT headwind for COVID-19 product contribution, it looks like it is effectively assuming that you sold the 1 million doses of *Xevudy* that you already have an order for, but there are no more sales at all for the rest of the year. Just for clarification, is that right? The assumption is that beyond the orders that you already have, you won't sell any more *Xevudy* this year.

Emma Walmsley: Thanks James, for that one question and clarification. I will ask Iain to pick up first on the forecast forward for COVID solutions – just remembering that it is not in any of our guidance either for this year or for the year ahead and that there is obviously still some uncertainty about how that market will play out. We will come to Iain first.

Just more broadly on the total outlook, obviously we guided more than 5% topline on a five-year outlook and, as you said, double-digit for Specialty and high single-digits for

Vaccines. We are very clear that that is not, at an overall level, something that we are expecting anyone to wait for – which is why we are starting strong and starting now in 2022, with 5% to 7%. Clearly, the mix of that is dependent on some of the pipeline coming, and recent launches maturing into more scale contributions in Specialty.

I will ask Luke to comment a bit more on some of the shape of that, and then perhaps, Hal, we can come back to you to talk about some of the pipeline catalysts further out in Specialty medicines more broadly, but, first of all, Iain.

Iain Mackay: Yes, it is an easy answer, James, pretty much exactly what we wrote in our earnings release, which we expect pandemic sales for around £1.4 billion from *Xevudy*. That reflects binding agreements that we have in place at this point in time. To the extent there are any further binding agreements that would inform any updates, we will provide those on a quarterly basis.

Emma Walmsley: Luke, in terms of momentum and outlook on Specialty?

Luke Miels: Yes, thanks, James.

I think the momentum, for example, on *Trelegy* is very strong. We are getting five scripts for every one that *Breztri* gets. *Benlysta* is very healthy.

I think the primary challenge is - and we have placed this in the backup in the appendix - is just the continued slow recovery of ovarian cancer diagnoses, which is still down by 22%, and debulking surgeries are down by 17%, so that is taking longer to resolve than we were expecting, which is obviously very sad, and we expect that when those women present the disease is going to be more advanced, and so that is having an impact.

There was also some pricing pressure emerging in the IL-5 class in Q4.

Emma Walmsley: Thanks, Luke, and perhaps, Deborah, just before we go to Hal, obviously, one of the areas that is going to continue to build in contribution is the innovation in HIV, so, Deborah, to you first.

Deborah Waterhouse: At the Business Investor Update at the end of November we committed to mid-single digit CAGR between now and 2026, and that's an acceleration of growth from where we have been over the last few years, where if you remember, we have had over the last three, 1%, 1%, and then obviously in 2021 we are at 3%, so you can see that progressive growth acceleration, and we feel very positive about our ability to deliver that mid-single digit CAGR on the back of the tremendous progress that we have made with *Dovato*, but also the fact that you will get more material contribution from *Cabenuva*, certainly 2022 and beyond, and *Apretude* 2023 and beyond, so I am feeling really excited and confident about the future in the HIV part of Specialty.

Emma Walmsley: Thank you. Hal, do you have anything to add on catalysts to follow?

Hal Barron: Yes, there has been a lot of catalysts in the last 12 months, as I pointed out with the three regulatory approvals and the seven major filings, three pivotal data readouts in the eight Phase 3 starts.

I think it is important, now that we have 64 medicines and vaccines in the pipeline, 22 of which are in late-stage pivotal studies, so we are going to be seeing a lot of readouts, most importantly, in 2022 we have talked about the 11 key assets, and in 2022 we are hoping that up to seven of those will actually have readouts, including *RSV* out of the way in the first half; *otilimab*, as I mentioned, the second half; *Blenrep*, DREAMM-3 in the second half; *RSV Maternal*, which we should get data on the second half; the Meninge pentavalent, ABCWY in the second half. *Jemperli* we will have readout both in the conversion of the GARNET study, as well as data in RUBY, and as I mentioned a little earlier, Phase IIb bepirovirsen for the B-Clear in HPV, and that, of course, complements the wonderful data that we received earlier with the *Apretude* and the recent approval, so, really, quite a lot to count on.

Emma Walmsley: I think fundamentally, James, it is just worth reminding ourselves that in New and Specialty our growth last year was 26%, and even excluding the contribution from *Xevudy* it's 14%, so there are a lot of reasons for confidence in strong executional performance of growth, and, of course, all the pipeline to add to that.

Keyur Parekh (Goldman Sachs): Hi, thank you. I have two questions, please.

The first one is for Deborah. Just following up on your comments about the HIV, and I see that you are guiding to about £2 billion in revenue contributions from the long-acting regimens by 2026, but what I would be interested in, Deborah, is your perspectives on how do you see that long-acting market developing beyond 2026 into the 2030s, given that the news flow that you have had from *islatravir* and just the early feedback that you had on the PrEP launch, so how are you framing that longer-term outlook for that business?

Then, secondly, Hal, many congratulations on all your successes and best of luck in your role, but as you sit here today and look at the progress Glaxo has made from an R&D perspective over the last few years, how much of what you set out to do at the start have you achieved so far, and how much more do you think the company needs to achieve and what role do you think you might be playing in that from a non-executive perspective? Thank you.

Emma Walmsley: Thank you very much, I will direct you to Deborah and Hal.

Deborah Waterhouse: Thanks very much for the question. We see the long-acting market from a treatment perspective to be about £4-5 billion in value by the end of the 2030s. By the end of the 2020s, we see £4-5 billion in value for the PrEP market, so both have the same kind of value from a long-acting perspective in the 2020s decade. Despite the fact that we have seen islatravir have some challenges, we have seen that Gilead are also extremely committed to long-acting themselves with lenacapavir and they outlined in their results all the partners they are looking at for lenacapavir. Therefore, what you are hearing from both of the big players in the market is that there is a big opportunity to serve the needs of patients by delivering innovative new medicines into both the prevention and treatment parts of the market.

Obviously, Merck will continue to look at islatravir but the piece I think is really encouraging is the real energy around the evolution of the PrEP market in the United States. If you remember, ending the epidemic is a commitment that there will be significantly less new infections as the decade progresses to the point at which there is a 90% reduction by 2030 and the government in the US is extremely energised at the moment around how they are going to deliver against that target. There is a lot of dialogue occurring and a lot of encouraging sounds about how we could see that PrEP market evolve, given that only 23% of those who could benefit from PrEP are getting a medicine today.

The numbers that we talked about at the BIU in June and again in November are still what we are expecting as far as the long-acting treatment market and the long-acting PrEP market each being around £4-5 billion by the end of 2020s.

Emma Walmsley: The other thing that may be worth mentioning is the very exciting next gen pipeline that is coming through in longer-acting that you and Kim covered off in November where we get into longer-acting, longer-acting, beyond the near term.

Deborah Waterhouse: Yes, we are really excited about that. There are, if you remember, three areas where we are really focusing: an at-home treatment, an ultra long-acting treatment which will be clinic delivered and then obviously we are focusing on cure. Where we are today with *Apretude* and *Cabenuva* - we are absolutely not stopping there. That is why we are so confident about our ability to move past the dolutegravir loss of exclusivity, and still replace a lot of that revenue that is lost and have a very vibrant HIV business at the end of the decade and beyond. We have integrases at the core, both with cabotegravir and the next generation, that we have agreed to in-licence from Shionogi. Then we have the partner options we are looking at and we should be able to pick a partner for cabotegravir for at-home and long-acting in 2024 as data reads out and inform our choices. Therefore, we are

really excited about the pathway which is very clear before us and the choice points and when data will be available are also very clear and we shall keep you all updated.

Hal Barron: Thanks for the question, Keyur. I am very proud of what we in the R&D organisation have accomplished over the past four years. There are so many different metrics that one can use to highlight that. Today the pipeline has 64 medicines and vaccines, 22 of which are in pivotal studies. We have 13 novel assets in Phase III and, as Emma mentioned earlier, we have doubled the number of Phase III assets over the last couple of years.

Probably the most important metric that I look at is how much of the R&D success and the pipeline are driving the CAGRs we are proposing which are top quartile relative to our peers. When you look back, there have been 13 new medicines and vaccines approved over the last four and a quarter years or so, and that is driving about 60% of the terrific performance to which we have committed to. Importantly, on a risk-adjusted basis, the late stage pipeline - and this again excludes all of Phase I and Phase II - is expected on an adjusted basis to drive another 40% of that growth. Those are important metrics to point out, there are other metrics, but we have made quite a bit of progress.

You asked what's not finished. Well, I think if you think about being the Head of R&D of any pharma company or biotech company, you never leave the job finished, there is always more assets you can progress, there's more programmes, there's more lifecycle innovation. As long as the success rate is where it is there is an enormous opportunity to transform how targets are discovered, and I'm very excited about how much progress we've made on using the human as the model organism, using human genetics, functional genomics and machine learning to evolve our strategy.

In fact, if you think about what's coming, we have around 40 collaboration projects with 23andMe on human genetically validated targets, we have 10 synthetic lethal programmes that we've internally developed, we have three with IDEAYA, we have programmes with the Broad, we have programmes with Adrestia, a number of collaboration programmes, the anti-sortilin programme, so a number of genetically validated targets that over the next five to ten years are going to evolve.

I'm looking forward to my transition from being the CSO to the Board member, to help Tony Wood, who is an outstanding leader and outstanding scientist and outstanding person, and I'm hoping that I can play some role in helping him evolve our strategy to be able to accomplish all these things that we're hoping to do.

Emma Walmsley: I would just reiterate that what matters most in these transitions is extremely well planned and strategic and thoughtful succession. We are all very

confident we're going to accelerate the momentum of the execution of this strategy that objectively and quantitatively can really be seen to be bearing results already. We're absolutely thrilled that Hal is still going to be part of that adventure as a Board member, as a Science Committee member, and with some additional commitments that I know that he has more that happily made to support the R&D organisation, its Advisory Boards, some connectivity in his part of the world, and we are obviously very proud of him for his next step, too, and excited for the path ahead.

Graham Parry (Bank of America): Thanks for taking my question. Firstly, on the RSV vaccine, it looks like Pfizer's on track to publish RSV older adults vaccine data Q1 or Q2, possibly ahead of GSK. Are you seeing that the hurdle rates of both their vaccine and yours is the same level of protection you saw in J&J's Cyprus Phase 2 trial? How confident are you that your vaccine can match those levels? Do you see that by not waiting for a full RSV season that Pfizer could gain any sort of time advantage to the market to you, or is it just a seasonal issue?

Then secondly on COGS, that was negatively impacted by both *Xevudy* and write downs in the quarter, I just wonder if you could quantify how much for each in basis points, and just what the right longer-term COGS ratio ex-pandemic we should be thinking about?

Emma Walmsley: Briefly, Iain, could you comment on COGS and then Hal on RSV?

Iain Mackay: Graham, again, we've provided a little bit of a steer in terms of the impact of *Xevudy* in terms of operating margin. We participate in about 27.3% of the economics from sales in *Xevudy*, so when you translate that through to the overall profitability we provide some steer in our release earnings in terms of what that means. There is within the team a very strong focus on continuing to drive productivity and efficiency across the supply chain through COGS, and as we talked about in the Investor update in June, that focus remains consistent and is part of what informs our progress in operating profit growth in 2022 and beyond.

Hal Barron: Thanks, Graham. Our RSV programme is actually ahead of schedule, as I mentioned. Enrolment is completed and we expect the data for the trial to read out this half, H1 22.

It's important to keep in mind that we have a pretty unique vaccine, because we, as you know, have the protein with the AS01 adjuvant, and we think this is a very important component, because as I mentioned earlier, the elderly, who are obviously at risk for the

complications of this infection, over time lose their both adaptive and innate sense of being able to combat this infection, and particularly you see an abnormality in their T-cell response. We are optimistic that the combination of the right protein which neutralises both the RSV A and B isoforms of the virus, as well as having the T-cell modulatory component with the adjuvant will give us the highest chance of success for this vaccine.

Emma Walmsley: Thanks. The next question, please.

Simon Baker (Redburn): Thank you for taking my question. Just going back to Graham's question on COGS, Iain, you pointed out the impact of *Xevudy* but also in the press release you discussed other headwinds on the gross margin in 2021. Presumably in light of the comments you made on R&D, SG&A, and the guidance for operating profit, they will fall away in their entirety in 2022, but I just wondered if you could give us any other non-*Xevudy* tailwinds and headwinds we should be thinking about for COGS in 2022. Thanks very much.

Iain Mackay: What I was referring to in '21 was specifically some higher inventory costs within COGS and lower demand, particularly within the Vaccines business. That was one key driver.

Another factor which was possibly more noticeable within our Consumer business but as well as it was managed there, it was equally managed within the Biopharma business around input costs, so freight as an example where I think the team was incredibly successful in driving productivity to offset some of that inflationary pressure.

That focus and capability continues through 2022. There are a couple of factors that were unique to 2021 that I have mentioned that we do not see at this point in time recurring in 2022 and then just that overall focus and driving efficiency, productivity through the commercial cycle across our businesses in managing COGS overall where we have built a good track record over the course of the last couple of years and we expect to be able to sustain over the coming year.

It's good old-fashioned productivity through the supply chain, the procurement channels, good linkage with the commercial cycle in terms of understanding demand in the market and managing inventory accordingly.

Emma Walmsley: Thank you.

Tim Anderson (Wolfe Research): Thank you. I have a question, just a pipeline question. Otilimab, you call out the Phase II read-out in RA in the second half as an important 2022 catalyst.

To me that Phase II data always looked a little questionable and I note Glaxo is the only company chasing this mechanism. Sometimes that is a red flag because most of the time other companies crowd into new and exciting areas.

My question is your confidence in that read-out and in this being a commercially meaningful asset, I am trying to figure out how much this sort of thing is in your kind of longer term forecast and how much risk adjusting you do on this particular asset. Thank you.

Hal Barron: Yes, you know, Tim, thanks for the question. Otilimab is a pretty interesting pathway. It's very novel, so typically when you have such a novel pathway you don't see the so-called crowding until of course the data it reads out positively which then results in crowding.

I am pretty optimistic this trial will hit, to be honest. You have to remember that there is a design or it's against placebo for the first 12 weeks and then active comparator against IL-6 in one study and the JAK class in the other.

The signal for efficacy was pretty clear, but your point is well taken that not every endpoint in the Phase IIb was positive, but quite a few were.

I think the area that is a little more speculative but again I am cautiously optimistic is where we saw signals to a more significant reduction in the clinical pain scores than one would expect for the reduction in things like sed rate and CRP levels that are chemistry measures of the disease severity.

We have looked at that data carefully and overlaid it with the pre-clinical data where we had mouse data with the CCL17 knockout which as I mentioned earlier is the most over-expressed protein when GM-CSF is applied to monocytes. In that CCL17 knockout mouse study in an osteoarthritic neuropathic pain model, there was a dramatic reduction in pain with the knockout, so that gave us more credibility that that signal, if you will, in Phase IIb might be real.

Again we are going to have readout from the CCL17 mAb data probably in Q2, maybe Q3, and I think that will give us further confidence in the programme, but again just to highlight, I am reasonably optimistic that this will actually benefit patients. It will be a novel class and hopefully we will see some important reductions in pain.

Maybe I can just turn it over to Luke to comment on his interest in the commercial component and how he sees this in the landscape of RA patients.

Luke Miels: Thanks Hal, and thanks, Tim, for the question. The numbers of patients here are enormous, right? There are about one million in the US on biologics and JAKs and many of them are cycling, as we know. What is interesting if you look at the data with JAKs, we have market research which indicates that about 65% of doctors want to reduce their usage of JAKs and that there could be an opportunity for alternative non-JAK/non-TNF mechanisms for about 40%. There is clearly a demand for patients. I think the genericisation in biosimilars will also move patients onto targeted therapies earlier, and therefore they will cycle earlier.

For the other programmes, there has been GMCSF in the past, and a number of them have had some issues in preclinical, non-human primate models, etc. Again, hopefully we can thread the needle here. As Hal said, contRAst-3 is really interesting against the IL-6, which is naturally a primary competitor, and then of course we have contRAst-1 and -2, against tofa, and methotrexate by itself. I think it is an interesting programme.

Emmanuel Papadakis (DB): Thank you for taking the question. I have a question on Vaccines, please. The flu market has been pretty topical of late. We have heard market leaders talk at length about reasons to believe in the resilient outlet for egg-based quadrivalent vaccines. I would love to hear your perspective on mRNA-based vaccines to improve upon both production aspects and risk/benefits of currently based vaccines over coming years, given that you have some involvement on both sides of that equation. Perhaps you could also take the opportunity to give us a quick update on the CureVac partnership on both the second gen COVID programmes. Thank you.

Emma Walmsley: Thank you. Why don't we hear from Roger, just on the more strategic outlook for flu, because I know that we also covered that at the Capital Markets Update briefly. Then Hal, I will come back to you in terms of the mRNA approach.

Roger Connor: Thank you very much for the question. As we covered last year in the update, we think there is a real opportunity area, to be honest. It is a significant disease burden, as you well know, but also, when you look at influenza vaccine efficacy, it is the one area that stands out as crying out for innovation, to move an on-average efficacy level of 50% some way higher. I think mRNA is a very exciting technology and it is one in which we are investing significantly. It is one that we think could potentially differentiate us as well. The opportunity is in that differentiation. With our CureVac partnership which Hal will go into, we are looking at both flu and also looking at a universal flu option as well.

I wouldn't forget egg. Egg is something that will be around as a technology for a number of years and we will continue to maximise that, but we are allocating significant capital

into the mRNA play, to ensure that we look to differentiate that. Obviously, the challenge with mRNA in a multi-valent vaccine which flu is, is in trying to solve this reactogenicity ceiling, which you can hit with mRNA. It will take a little time to optimise any mRNA platform to be able to deliver that as well but our strategy is clear: continue to maximise flu in the egg base, and develop at pace an mRNA platform that can give us a flu solution to deliver a higher-performing flu efficacy.

Hal Barron: Thanks, Roger, and thank you, Emmanuel, for your question. It is pretty clear to the world now that mRNA is a disruptive technology that will really transform, to some extent, how we think about vaccines – both because of its advantage in terms of its speed from sequence of the virus, or the knowledge of what virus is going to be endemic at that stage, as in flu. The longer you have to figure that out, the more likely you are to get the right valence in your vaccines. That will be a unique opportunity and, as alluded to by Roger, the other point is that you can if you can have a polyvalent vaccine, the efficacy is likely to go up, relative to a monovalent vaccine. So mRNA has a significant potential in flu and we should be in the clinic with a multivalent mRNA vaccine in 2022 with CureVac.

The key thing with multivalent vaccines and mRNA is that the more transcript you put into a patient, the higher the reactogenicity. Some of that is somewhat solved by modifying the bases but, even with that, as we saw from some of the Moderna data, we will have to continue to work on that. One of the strategies that we are pursuing, and which we are excited about, is whether we can lower the dose of the transcript by optimising its stability and how effectively it is translated – the more protein for a given amount of mRNA. We think that the proprietary technology developed by CureVac with this optimisation of the codon flanking the transcript, the five prime and three prime regions that were done through some pretty sophisticated machine learning, we think this will allow us to lower the dose, or if you could think of it as keeping the same dose but with a larger number of valents, and have a both immunogenic and well-tolerated limited reactogenicity to be able to develop a best-in-class flu vaccine.

Emma Walmsley: Thanks, Hal.

Hal Barron: I should also mention, just to complete this, we will have two other mRNA vaccines in the clinic this year as well for COVID, so at least three mRNA vaccines for 2023.

Emma Walmsley: Yes, that sounds great under the new Vaccines leadership as well, so we have confidence in that.

Hal Barron: Yes.

Jo Walton (Credit Suisse): Thank you. I am afraid I am going to go back to the margins question. On page 24 you tell us that you are going to have 5-7% top-line growth, 12-14% adjusted growth, all excluding COVID, and we know that that includes two points from Gilead.

On page 36 you tell us that SG&A and R&D are going to go up in line with sales, and it is the COGS that is going to go up less than sales, so there's a very big COGS improvement that we should expect in 2022. My question is if we were, and we obviously don't have this data, to look just at COGS of New GSK how far adrift of your peer group do you think you are so that we can get some guide as to whether the majority of the margin gains that we are expecting, not just in 2022, but in '23, '24, etc., are going to come from COGS, and how much are going to be able to come from a winding down of SG&A? I am assuming that R&D will continue to grow strongly. Thank you.

Iain Mackay: Yes, what we said and we say it again, Jo, is that we would expect to grow SG&A, and this is very much customer-facing SG&A, so it is focussed on supporting top-line growth and engagement with patients and customers. If you like, the component that is orientated around functional support still has a trajectory that is flat to down, SG&A we would expect to be similar levels, but slightly below revenue growth, and the same is true from an R&D perspective. Although we will continue to grow it is going to be similar to, but possibly slightly below revenue growth.

In terms of productivity coming through COGS, part of this is driven by top-line, so we are seeing a change in the mix in the portfolio over the period 2022 to '26, moving to about 75% of the revenues coming from Specialty and Vaccines, moving to 25% coming from the General Medicines portfolio, and that mix change is an important part of the change overall. Now, when you talk about geographic mix, we remain broadly stable to where we are, so we have about 40% for revenues in the US now. By '26 we would expect about 40% for revenues per US as well from Biopharma perspective, but that change in mix of Specialty Medicines and Vaccines to 75% versus 25% is an important component of the overall gross margin story, notwithstanding the continued delivery of productivity and synergies coming through the supply chain, so those are key dynamics that are coming through there.

Emma Walmsley: We are also having a bit of a one-year recovery of COVID T&E, and I know we are keeping costs very much under control on that, but we are expecting to go back on that.

Iain Mackay: Absolutely, but very much within the guidance that we provided there, Emma.

Emma Walmsley: Yes.

Steve Scala (Cowen): Thank you very much. It looks as though the contrast 1, 2 and 3 trials of otilimab are well past their primary completions. They have conventional endpoints, so there are no events to wait for, so is the data inhouse - and, Hal, I have to say, you do sound more confident today than you have been in the past - or is there a delay? Why won't the filing be earlier than 2023? Thank you.

Hal Barron: Thanks, Steve. No, I have not seen the data. I would love to see the data but I have not, and the reason is, and you are absolutely right that it is a 12-week endpoint, it is not event-driven, so that shouldn't be the problem. The issue is the data remains blinded with all these studies for the 52-week follow-up because of the interest in secondary endpoints of having the active converter phase of the programme, so in order to maintain the integrity of the trial it is blinded for a longer period of time.

Andrew Simon Baum (Citi): I have a question on BCMA in two parts. Firstly, on DREAMM-5 with the gamma secretase, you recently expanded that cohort. It is an open label trial and GSK has, of late, talked more about scheduling dose fractionation and less focus on the benefits of GSI. Given that is open label and given that you have expanded the cohort, perhaps you could share what you are seeing?

Secondly, also on BCMA, there have been some recent data published with a CAR-T, suggesting that BCMA CAR-T were associated with Parkinson's type syndrome with BCMA expression on substantia nigra. The question is, do you have any evidence that belantamab crosses the blood-brain barrier? I shall stop there, thank you.

Hal Barron: Thank you, Andrew. Let me try to address that really interesting question about Parkinson's. We have no evidence to suggest - and I am reasonably confident that it doesn't - the antibody crosses the blood-brain barrier. So, to the extent that it is a non-target effect, we are not observing that clinically and I wouldn't expect us to. I can look into a little more detail about that later but I am pretty confident that it is not crossing the blood-brain barrier, but it is an interesting point that you make about the CARs.

As you know, the rationale for the combination of the GSI with *Blenrep* is that it should be able to increase the density of BCMA on the plasma cells or perhaps any cell but the plasma cells are of interest and, therefore, be able to obtain responses at lower doses. We hope that at lower doses there would be less ocular toxicity. It is one of the four levers that we are using to try to improve the benefit/risk ratio, and I shall go over the other three in a second.

We have seen some open label data and, as we said, it is encouraging. It is small numbers and we have all seen examples where small numbers of encouraging data doesn't always translate. However, the data were definitely encouraging enough that we moved into a randomised setting, using the DREAMM-5 platform to begin a more robust programme where we not only have a larger number of patients but also a control arm to make sure it is

not confounded by baseline coverts that can occasionally happen. I can tell you that our optimism was based on seeing data and we, as you know, were using doses at the 0.92mg/kg level, which at least in the DREAMM-1 and 2 studies was inactive. We think that is a reasonable way of assessing our level of optimism but by mid-year this year, we should have a much more robust dataset, hopefully with some control patients, and be able to be clear as to what the value is that this could provide to move into frontline.

As you know, the other three levers we are looking at to optimise this programme are to see if the combination of *Blenrep* with the standard of care, whether it be with pomalidomide, or Darzalex, or Velcade or various other standard of care reagents would allow us to be able to reduce the dose to further maximise its benefit risk.

We are also looking at something relatively simple which is in the phased pivotal DREAMM-2 study, the protocol had dose-holding when grade 3 ocular tox was identified, the ability to reduce grade 3 and above ocular toxicity is limited if that is when you hold the dose. With the profound efficacy that we are observing in multiple different trials now, we have decided to hold the dose when reaching grade 2 ocular tox, which in theory and in observed data from ASH suggest that the ocular tox is going down further.

Perhaps even the most important of all of these, who knows, is going to be that we are altering and exploring different schedules. As you know, in DREAMM-2 and the approved dose for later line therapy was using 2.5 mg/kg at Q3 weeks. We are looking at Q4, Q6 and even at Q8 dosing at doses of 2.5, 1.9 and even lower to see whether Cmax versus trough will have an impact on both efficacy and hopefully reduce ocular tox. Those four levers are all being studied independently and the ability to use them as modules and combine them to move us into third/secondline, which we are reasonably confident in, and perhaps even frontline. A lot of data are there to help you understand that.

Laura Sutcliffe (UBS): Hello, thank you. Could we go back to HIV please? There has been some commentary in recent days from Gilead talking about a tougher first quarter 2022 than 2021 based on copay scheme resets in the US and other gross to net dynamics. Is there anything we should be thinking about along those lines for your portfolio in terms of it being more aggressive this year than it was last year?

And then just related given the wider importance of the access to medicines piece at group level, is there anything you see changing on your ESG profile or external rankings, whichever ones you consider to be most meaningful, when Consumer leaves the Group later this year? Thanks.

Emma Walmsley: Thanks. On the broader ESG, you are continuing to see us make leadership in ESG a priority for GSK and we will be updating our reporting on that frankly to make it ever simpler, more transparent and easier for us to be held to account across

the six key areas we have identified as the priority for ESG, whether that be in access, in environment, in diversity and inclusion, and so we are really looking forward to discussing that with you. You will also be familiar with the fact that this is as I would say a focussed level, it's included in the accountabilities from an incentive point of view as well. It really is something that has long been at the core of who we are as a company. It never replaces TSR but I am hoping that we are able to continue to get the recognition for our very much leading rankings we have but also transparency and simplicity of reporting in a way that is of course validated by third parties as opposed to us just marking our own homework.

But maybe we'll come back to Deborah, please, for the HIV question.

Deborah Waterhouse: Thanks, Laura. If I think about the PrEP market and treatment as two separate markets, in the treatment market it continues to be guideline-driven, choice of access are absolutely crucial and we see that market as continuing to be relatively stable. Obviously the Build Back Better Bill will affect the whole industry, so let's see how that plays out but in terms of if you assume that's taken to one side, the treatment market looks fairly stable and continues to be guideline-driven, but choice and access is at the core.

In the PrEP market it's a little bit different to that because obviously you've a generic of Truvada in the market. Gilead have moved quite a lot of the market away from Truvada into Descovy, but I think that has taken obviously some negotiation with payers to make that happen and we are in dialogue with payers at the moment over ensuring that we can get broad access to *Apretude* at a price that rewards our innovation, so I think that you should look at treatment and PrEP as a little bit separate. But in the main, the treatment market is five times bigger than the PrEP market, so the core of where our revenue and our profit comes from remains stable.

Emma Walmsley: And the other core is having truly differentiated medicines and medicines to get approved and stopped in their trials for being so significantly better than existing standard of care. It delivers a value that is worth paying for.

Deborah Waterhouse: Absolutely.

Seamus Fernandez (Guggenheim): Thanks very much. My question is actually on HBV. Hal, I just wondered if you could give us your thoughts on the HBV ASO versus antibody-based approaches as well as just your general thoughts on how we are likely to ultimately see a real break in HBV cures. Is that going to require a combination of a treatment-based approach followed by a vaccine in your view or when we see these data later this year, do you think that either an ASO or perhaps an RNAi-based approach will really be viewed as the preferred way to then pursue cures? Thanks.

Hal Barron: Thanks for the question, it's a really good question. It's really hard to predict the future on this but it is likely that what we will see with the ASOs is a couple

of things. First, I think it's pretty clear that not all ASOs are behaving the same way, so I think over the next six to 12 months we will get more clarity on the value of the various approaches of ASOs, GalNAc or unmodified. We will get a good sense and I am optimistic from our Ila data that the ASO approach will deliver efficacy as it relates to lowering the surface antigen. One of the hypotheses is that this virus makes a massive amount of surface antigen, and one compelling hypothesis that's pretty well supported from preclinical data is that that overwhelms the T-cell, and it results in T-cell exhaustion, and that by lowering the HBV surface antigens' levels the immune system may be able to kick in.

My guess is that that will work in some people, but probably a very small minority, and what's going to be needed is combinations. Whether that's a combination with a nuke, an interferon, or possibly even something like a checkpoint blockade like PD-1, or maybe even a STING agonist – things that are going to increase the interferon production from the Kupffer cells and other cells responsible for the [inaudible].

I do think, though, that in the end, after we figure all of this out, and hopefully we will have some compelling data mid-year with the B-Clear study that we will be able to embark on these combination studies in a thoughtful manner and ultimately reduce the really enormous burden – 250 million people living with chronic HepB infection, and 100,000 people dying from it annually, and if we can make a dent in the functional cure rate, which is a very high bar, that will be one of the more significant advances in medicine.

Emma Walmsley: Thanks, Hal.

Kerry Holford (Berenberg): Two questions to follow up on RSV for Older Adults, please.

Hal, you mentioned targeting the June ACIP meeting. I guess you are working on the assumption of a launch next year, and I would just like to understand what gives you the confidence in the regulators accepting data package from one RSV season only, given your and competitor studies will continue further? Is there a risk that the regulators will want to see more data across more seasons before moving to a proven vaccine here, and do you think that decision will ultimately be influenced by the clinical efficacy you and your peers deliver? Thank you.

Hal Barron: Thanks, Kerry. I think we are pretty confident in our strategy, but, of course, any approval and any recommendation for use is going to depend on the risk/benefit. We are expecting a reasonably high success rate and effectiveness rate from this vaccine, and being able to show it works well in the various subgroups of interest, as well as determining whether this is going to be effective in an equally significant way across the season, in other words, how effective the duration of efficacy relates.

So when we have all that data I think we will be able to have a better sense, but we are pretty confident in our strategy of the trial design, the sample size, the effect rate, and the risk/benefits that that would endure.

I should mention that, of course, the ASO1 is something that we have enormous amount of experience with and a very, very large database with, so it is really going to be driven by the efficacy and probably viewed by ACIP in aggregate all the data, as well as helping regulators reach an individual company.

Emma Walmsley: Thanks.

Mark Purcell (Morgan Stanley): Yes, thank you for taking my questions. Just, again, on RSV Older Adults and getting a bit more perspective. I wonder if you could sort of help us understand how we can assess whether the ASO1 adjuvant will provide a potential durability advantage from the initial datasets, your own datasets, RENOIR and EVERGREEN? What should we be looking out for which suggests you might have a T-cell restoration benefit? Then, just a related question: are there any IP considerations around the prefusion F subunit target? Clearly, you were a first mover when it came to HPV and you secured a royalty stream. Is there something such that we should think that that situation could occur with RSV?

Hal Barron: Yes, thanks, Mark. Why don't I tackle the first part. I don't think there's any IP issues that I were unaware of, but I will ask Roger to jump in if he knows of something I don't.

I think it is going to be challenging to figure out the impact of the adjuvant on duration as it relates to multi-year, because, of course, we only go by a multi-year, and back when you look at *Shingrix* it obviously took eight years to figure out that it worked so well for eight years. I do think there is going to be hints potentially one could look for to be underpowered for these, but I think that it might be directionally useful. First of all, is the point estimate of benefit greater than other trials? I think that is one thing to look for. That would suggest that the adjuvant is doing something unique.

It could also be that in subgroups, particularly the older-75s, and particularly the immunosuppressed patients, one might see a signal that looks more prominent than non-adjuvant, and that might give you a signal, and as I said a few minutes ago, there is a way of looking at the duration of efficacy of the season, so if the efficacy with a non-adjuvanted vaccine, for instance, is pretty significant in the beginning of the season but wanes during the end of the season - and for instance ours would have a treatment effect that's impressive and constant over that period of time - one might be more confident that there could be a duration effect when one looks longer. But at the end of the day we're going to have to look for a longer-term follow-up, and we have studies already under way, but I'll explore that.

Roger, did you want to add anything?

Roger Connor: Yes, just on the IP, there's no IP restrictions on the PreF, nor is there any IP direct ownership from our perspective that would generate income, so that's not something that we should be thinking of and worrying about.

Emma Walmsley: We have time for one more question.

Peter Welford (Jefferies): Thanks for squeezing mine in. A question just on RSV vaccine again in the Older Adults. Can I just ask, when we think about the COVID data, have we all been spoiled with hospitalisation and decreases that we saw there of 90% plus in some cases; and perhaps, could you give us some sort of idea of what we should be thinking about for the RSV Phase III, with regard to what is a reasonable reduction in hospitalization. Is the nirsevimab 80% or so reduction a sensible ballpark that we should regard as clinically meaningful?

And perhaps just a comment: I think you should win an award for masters of understatement! From my calculations, it seems as though your strong double-digit growth was probably over 40% for *Shingrix*, and can you just remind us if the £2.5 billion, if that's roughly where I get to from your guidance, entirely can be met with existing manufacturing, and should we then consider future growth from that, again, are you confident that you can sustain that level of growth and that level of demand with your existing capacity that you have, without the need for a new facility?

Emma Walmsley: Let me be utterly unequivocal: we are not supply constrained, and we are very confident on doubling our *Shingrix* sales from their 2020 levels. In terms of the outlook that we gave at the update last year, we feel very good about getting a bounce back. Obviously there has been a bit of COVID disruption, but as Luke outlined, the momentum is very good.

I don't know, Hal, if there is anything further we want to add?

Hal Barron: Obviously it's very hard to predict the efficacy, but as we look around immunities and the aggregate packages that have been presented, and in discussions with clinicians, we're pretty confident that any effect more than 50% is clinically meaningful, an effect greater than 70% is a very good response and it will be a very successful vaccine, and should we get efficacy above 80, that's outstanding.

Emma Walmsley: With that, thank you very much everybody, we shall look forward to gathering with some of you over the next few days, and we are really looking forward to an extremely exciting year ahead for GSK, whether that's doing everything we said we were going to do, the delivery of the step-change in growth, reading out these very exciting pipeline

milestones, continuing to accelerate the execution of all that we already have in hand, and plans for very competitive execution of what's to come, and of course the tremendous unlock of value that's going to come with the creation of a completely unique, FTSE-leading world leader dedicated to consumer healthcare, and I know Brian is enormously looking forward to the long Q&A session on that at that end of this month.

Thanks everybody, catch up soon.

[Ends]