

Q3 2023 results presentation  
Wednesday, 1 November 2023

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Introduction | Nick Stone

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**Slide 1**

Hello everyone. Welcome to our year-to-date and Q3 2023 results conference call and webcast for investors and analysts. The presentation was sent to our distribution list by email, and you can also find it on [gsk.com](https://www.gsk.com). Please turn to slide 2.

**Slide 2**

This is the usual safe-harbour statement - we will comment on our performance using constant exchange rates or CER unless stated otherwise.

As a reminder, following the Consumer Healthcare demerger in 2022 to form Haleon, we are presenting performance and growth of the continuing operations for GSK.

Please turn to slide 3.

**Slide 3**

Today's call will last approximately one hour, with the management presentation taking around [30] minutes and the remaining time for your questions. For those who wish to ask questions, please join the queue by raising your hand. Press \*9 to raise and lower your hand if you are on the phone. And we request that you ask 1-2 questions so that everyone has a chance to participate.

Our speakers 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.

Turning to slide 4, I will now hand the call to Emma.

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## Strategic summary | Emma Walmsley

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### Slide 4 | Strong and sustained performance heading into 2024

Thanks, Nick, and welcome to everyone joining us today. I'm delighted to be presenting to you all with *another set* of excellent quarterly results.

Please turn to the next slide.

### Slide 5 | Clear momentum driving strong year-to-date performance

Sales and profits grew double digits for the quarter, with sales up 16% to 8.1 billion pounds, adjusted operating profit up 22% to 2.8 billion pounds and adjusted earnings per share up 25% to 50.4p (all excluding pandemic solutions).

Our strong performance was broadly based and benefited particularly from the outstanding US launch of our RSV vaccine *Arexvy*, on track to be a blockbuster in its first year on the market.

This excellent execution, together with our drive for efficiency and margin accretion, means we can upgrade our 2023 sales, adjusted operating profit and adjusted EPS guidance. For the year, we now expect sales to increase between 12 and 13%, adjusted operating profit to increase between 13 and 15%, and adjusted EPS to increase between 17 and 20%.

Within sales, we are upgrading the outlooks across all segments for this year, reflecting our clear momentum.

Our performance also clearly demonstrates delivery of the strategic choices we've made to invest in prevention, as well as treatment of disease. New products - launched since 2017 – have contributed sales of 7.8 billion pounds so far this year, with nearly 80% coming from Vaccines and Specialty Medicines.

Approvals this year for *Arexvy* and *Apretude*, together with two important oncology medicines, *Jemperli* and, most recently, *Ojjaara*, further strengthen this new product portfolio and offer meaningful sources of profitable growth. Taken altogether, this is a strong and sustained performance heading into 2024.

Next slide, please.

## Slide 6 | Spotlight on prevention: Vaccines are a strong, durable growth business

This quarter further underscored the importance and strength of our vaccines business.

Prevention is an increasing focus for healthcare systems all around the world; GSK is a world leader in vaccines and is extremely well-placed to deliver innovation and offer value to both individuals and payers.

The introduction of *Arexvy* in the US is evidence of this - demonstrating our strong launch capabilities with over 700 million pounds of sales in its very first quarter – as we protect people at scale from this life-threatening disease, especially those with comorbidities.

Generating further clinical evidence for *Arexvy* remains a clear priority, and we were pleased to present positive data in adults aged 50 – 59 years at the CDC’s Advisory Committee on Immunisation Practices last month.

We also added to the outstanding clinical profile for *Shingrix* this quarter. Results of a large post-marketing study in China demonstrating 100% efficacy.

And alongside this, we are additionally significantly expanding availability of *Shingrix* in China. Our exclusive partnership with Zhifei, signed last month, will support and accelerate our goal for *Shingrix* annual sales of more than £4 billion by 2026, and with opportunities to expand the partnership further, including potentially with *Arexvy*.

Our innovation in RSV, shingles, meningitis, and paediatrics all demonstrate our world-leading vaccines capabilities.

And we have further substantial innovation in the pipeline where we have our comprehensive and leading suite of vaccine platform technologies, including next-generation mRNA, our multiple antigen presenting system or MAPS, as well as our adjuvant systems. All of these offer exciting new opportunities in seasonal respiratory, bacterial, and chronic viral infections, and we continue to explore the science beyond infectious diseases.

Next slide, please.

## Slide 7 | Trust: Delivering health impact sustainably

Alongside delivering stronger shareholder returns, we also continue to build trust by delivering across the 6 key areas we prioritise for ESG.

This quarter, I'm highlighting our continued commitment to fight malaria with innovation. GSK scientists, working with the Johns Hopkins Institute and others, published their ground-breaking discovery of a naturally occurring bacterium that can significantly reduce the malaria parasite load in mosquitoes, indicating the potential to inhibit transmission of malaria to humans.

And we also continue to deliver our Environment and Diversity, Equity and Inclusion goals. Further details along with more on all six key areas are included in the Q3 results announcement.

Now, let's hear more from the team on our progress, starting with Tony and R&D.

### Slide 8 | Innovation

Thank you, Emma. Please turn to slide 9.

### Slide 9 | Focused on core therapy areas

My priority is investing in our pipeline and accelerating R&D to deliver new vaccines and medicines for patients. Today, the pipeline comprises 67 assets in clinical development. Two-thirds of these prevent and treat infectious diseases and HIV.

During the quarter, we have seen continued progress.

In Infectious Diseases, we are focused on seasonal respiratory viruses, bacterial, fungal, and chronic viral infections.

- In seasonal respiratory viruses, *Arexvy* received approval in Japan as the country's first RSV vaccine for older adults, and we also shared positive data for 50-59-year-olds with The Advisory Committee on Immunization Practices in the US.
- In chronic viral infections, we will present data later this month on bepirovirsen, a potentially transformative treatment for chronic hepatitis B - I will talk more about these data shortly.

In HIV, the European Medicines Agency approved *Apretude* as the first and only HIV prevention option in combination with safer sex practices to reduce the risk of sexually acquired HIV infection in high-risk adults and adolescents.

For Respiratory, Japan accepted the regulatory submission of *Nucala* for chronic rhinosinusitis with nasal polyps. And later this month, alongside Luke, I look forward to providing you with insights into our respiratory strategy and medicines at the next focused Meet the Management event.

For Oncology, the European Medicines Agency recommended not renewing conditional marketing authorisation for *Blenrep*. As a reminder, given the changing regulatory environment, our expectations remain low for the event-driven DREAMM-7 and DREAMM-8 phase 3 trials, which we now expect to read these out in 2024.

This quarter, we also reached an exclusive licensing agreement with Hansoh for a phase 1, B7-H4 targeted antibody-drug conjugate (ADC), we believe has best-in-class potential in ovarian and endometrial cancer with opportunities in other solid tumours.

Lastly, we were delighted with the US FDA approval of *Ojjaara* (mometinib), which is indicated for treating myelofibrosis in adults with anaemia. And the approval of *Jemperli*, our highly effective PD1 inhibitor, as the first new frontline treatment for patients with dMMR/MSI-high primary advanced or recurrent endometrial cancer. The profile for *Jemperli* was strengthened by the recent interim analysis of RUBY Part 1, which reported a statistically significant and clinically meaningful survival benefit in the overall population enrolled. We aim to present these OS data at a conference early next year.

Next slide, please.

### Slide 10 | Delivering important new data to prevent infectious disease

Last week, we presented further safety and immunogenicity data for *Arexvy* to ACIP. The vaccine met its co-primary endpoints and demonstrated non-inferiority in people aged 50-59 years of age, when compared with adults of 60 years and older, including those at increased risk of RSV lower respiratory tract disease. These data continue to demonstrate the consistent strength of *Arexvy*'s profile in protecting the most vulnerable. We will make a supplementary biological licenses application to the US FDA before the end of this year in time for next year's ACIP to further support potential label updates.

For *Shingrix*, we continue to build our knowledge with new data demonstrating 100% efficacy in the prevention of shingles in China for adults aged 50 and over – a remarkable result. We expect to publish these data in a peer-reviewed scientific journal before the end of the year.

Slide 11, please.

### Slide 11 | Bepirovirsen a triple-action antisense oligonucleotide

Continuing with infectious diseases. Bepirovirsen, our triple-action antisense oligonucleotide, has the potential to be the cornerstone of functional cure for patients with chronic hepatitis B. It inhibits viral replication, reducing viral DNA, and thus the production of viral proteins, including the hepatitis B surface antigen. And importantly, it stimulates the body's innate immune system. We believe this triple mechanism of action is the reason for bepi's unique profile.

There are more than 300 million people living with hepatitis B, our goal is to provide patients with the first clinically meaningful functional cure for hepatitis B, eliminating the need for continued therapy and ultimately reducing the long-term risk of developing liver cirrhosis and cancer.

We now have two completed phase II trials for which data are consistent and demonstrate that patients with low surface antigen have the greatest chance of a functional cure when treated with bepi. In the case of B-Together, this is not significantly improved by sequential Peg-IFN treatment.

However, the recent exclusive license of Janssen's phase 2 small interfering RNA-based therapeutic provides a complementary opportunity to develop a potential novel sequential regimen to benefit a broader patient population and potentially drive higher functional cure rates.

Lastly, we hope data from B-Sure will be presented later this month at AASLD. This will demonstrate a durable response for a significant proportion of patients treated with bepi. Our phase III trials, B-Well 1 and B-Well 2, are progressing as planned in 31 countries, with data anticipated in 2025.

Turning to my final slide.

### Slide 12 | 67 assets in clinical development: upcoming pipeline catalysts

This slide highlights important clinical data readouts and regulatory events over the upcoming months. You can find a comprehensive overview in the appendix.

In summary, I am pleased with our progress so far this year. We have clear plans to move forward at pace, deliver on our key objectives for R&D, and support GSK's overall growth ambitions.

I will now hand it over to Luke on slide 13.

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## Performance | Luke Miels

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### Slide 13 | Performance: growth drivers

Thanks, Tony. Please turn to the next slide.

### Slide 14 | Delivering growth across portfolio

In Q3, we again delivered growth across Vaccines and Specialty Medicines and in each region with £8.1 billion of sales, up 16% versus last year, excluding pandemic solutions.

Please turn to Slide 15.

### Slide 15 | Vaccines: +34%<sup>1</sup> with strong Arexvy launch contributing £709m

In Vaccines, we saw strong growth of 34% in the quarter, excluding pandemic solutions, led by the excellent launch of Arexvy, which contributed £709m. On the same basis, we now expect full-year Vaccines sales growth to be around 20%.

On Arexvy, I want to highlight the excitement our organisation has had behind the launch we've seen in the US. Following an initial inventory build, we saw high demand and received two of every three retail prescriptions. In the quarter, we saw around 50% of Arexvy doses were co-administered with flu. We're very pleased with our commercial positioning in all major pharmacies, including competitive contracts with 11 key accounts. We strategically chose to highlight our 94.6% efficacy in the co-morbid population, and that message seems to resonate well with strong HCP brand recognition.

There's a long runway for Arexvy in the US, where during the quarter, we vaccinated more than 1.4 million adults of the 83m at risk and ex-US, as launches are underway across Europe and Canada. In September, we also received approval in Japan.

We remain confident in our peak sales being greater than £3bn. For the full year, we expect sales to be between 0.9 and 1 billion pounds, based on an analogue of flu vaccination seasonality. However, there continue to be unknown factors, including annual vaccination patterns, duration of protection, and what revaccination recommendations might be. We will continue to keep you informed, of course, as we learn more.

Next slide, please.



### Slide 16 | Vaccines: Strong *Shingrix* momentum driven by geographic expansion

Moving to *Shingrix*, this remains an important vaccine for our portfolio, up 15% vs last year, with the ex-US contribution now representing 50% of sales. In addition to the US, *Shingrix* is available in 38 additional countries, with less than 3% penetration in most markets, and we continue to have unconstrained supply.

In the US, we have reached the most motivated consumers, with 33% penetration of more than 120 million adults recommended to receive *Shingrix*. We remain encouraged by the growth in retail, which was up 4% in the quarter, and are investing in strategic initiatives to actively target consumers and HCPs to access the next tranche of customers.

In October, we announced a deal with Zhifei to co-promote *Shingrix* in China. This partnership materially expands the number of Chinese adults who can benefit from *Shingrix* over the next three years through a company with a track record of driving access to innovative medicines and vaccines in China. Zhifei has a significant reach across China with an extensive service network covering more than 30,000 points of vaccination vs the current 9,500 we have now. As Emma mentioned, we expect this partnership to support and accelerate our expectations for *Shingrix* sales to reach more than £4bn by 2026.

Next slide, please.

### Slide 17 | Specialty Medicines: +17%<sup>1</sup> with durable growth drivers

In Speciality Medicines, including HIV, which Deborah will cover shortly, we increased sales by 17%, excluding *Xevudy*. For the full year, we now expect low double-digit sales growth.

Our market-leading medicines, *Benlysta* and *Nucala*, continued to deliver double-digit growth. *Benlysta* was up 20% in the quarter, with growth across all major markets and a promising opportunity with updated EULAR guidelines now recommending use earlier as part of standard of care for Lupus and Lupus Nephritis. *Nucala* was up 19% in the quarter and remains the first and only biologic approved in four eosinophilic diseases. We expect to see COPD data for *Nucala* in the second half of next year. Both of these medicines continue to have room to grow with relatively low bio-penetration and life cycle opportunities, underscoring our confidence in the long-term opportunity for both.

In oncology, sales were up 26% in the quarter, with *Jemperli* now being used in the first line for appropriate endometrial cancer patients. And *Zejula* is up 22% due to stocking of our new tablet formulation, providing an improved patient experience. We expect this stock will be utilised by the end of the year.

On this slide, I wanted to highlight the recent approval of our myelofibrosis medicine, *Ojjaara*. In addition to a line agnostic label in the US, regulators acknowledged our unique benefit in anaemia – an especially important characteristic for these patients as we know that anaemia status and requirements of transfusion directly correlate with poor survival prognosis and quality of life. And as you can see on this chart, if you're a myelofibrosis patient with no anaemia, you have a median 8-year life expectancy. Conversely, you have a 2-year life expectancy if you are severely anaemic.

We look forward to making this medicine available to patients and have already recorded sales in September.

And with these updates, we are raising our full-year oncology sales expectations to increase low single digit.

Please turn to slide 18.

### Slide 18 | General Medicines: anticipate low to mid single-digit growth in 2023

Finally, our General Medicines portfolio continues to contribute more than £2 billion in the quarter, led by *Trelegy*, which was up 23%. *Trelegy* is the fastest-growing triple therapy for COPD and asthma, with room to grow as the SITT class still only has 28% penetration of the COPD patient class share in the US.

Overall, General Medicines was down 2% for the quarter due to negative RAR impacts slightly offset by *Trelegy* demand and continued post-pandemic recovery of the EU and International antibiotic market. Taking everything into account, we now anticipate low to mid-single-digit growth this year.

With that, I will now hand over to Deborah to cover HIV.

**Slide 19 | HIV: 15% growth in Q3 primarily driven by oral 2DR<sup>1</sup> and long-acting regimens**

Thank you, Luke.

Our HIV business delivered sales of one point six billion pounds in the third quarter, growing fifteen per cent. This growth was primarily driven by patient demand which contributed ten percentage points of growth with the majority of the remaining five points from tender phasing in our International business. Our continued strong performance through this quarter means we are now increasing our guidance for full year growth to around ten per cent.

Our performance benefited from strong patient demand for our oral two-drug regimens and long-acting injectable medicines which are now fifty-three per cent of our total portfolio value.

Dovato delivered four hundred and seventy-seven million pounds in the quarter. Market performance reflects HCP belief in Dovato which has firmly consolidated its position as the leading oral two-drug regimen.

I would like to spend a few moments describing our expectations around dolutegravir's loss of exclusivity. In Europe, the composition of matter patent expires in July 2029. In the US, dolutegravir is protected by a composition of matter patent until April 2028, which includes an additional six months of exclusivity following the completion of our paediatric studies. Dovato and Juluca are also protected by formulation and other patents in the US which have expiry dates after the composition of matter patent. Therefore, we anticipate a longer exclusivity period in the US for Dovato until December 2029 and Juluca until July 2030.

Turning to our long-acting injectable portfolio. Cabenuva sales for the quarter were one hundred and eighty-two million pounds, reflecting strong patient demand with high levels of market access and reimbursement across the US and Europe. Cabenuva continues to be supported by strong label evolution and data which underpins confidence. Patient awareness of Cabenuva is high at over seventy per cent and around two thirds of switches are coming from competitor products.

Moving on to prevention. Sales of Apretude, the world's first long-acting injectable for the prevention of HIV, delivered thirty-seven million pounds in the quarter, and we are pleased by the momentum across the US. This, alongside a desire by prescribers, payers and Governments for a new solution to help end the HIV epidemic gives confidence that the PrEP market in the US will continue to grow strongly. We were also pleased to receive European approval for Apretude in September.

We're also pleased by the progress of our pipeline which is focused on innovative long-acting regimens. We have three clear target medicine profiles: to provide the world's first self-administered

long-acting regimen for treatment, and to provide ultra-long-acting regimens for treatment and prevention.

In our recent HIV meet the management event, we confirmed that we are currently on track to deliver an every four-month injectable regimen. This would enable us to double the dosing interval, enabling clinic visits to be halved to just three per year, meaningfully increasing the benefit of long-acting regimens for patients and healthcare systems. For four-monthly dosing in prevention, we said we currently expect approval in the 2026 timeframe and for four-monthly treatment in 2027. We also provided greater clarity on our roadmap to further extend the dosing interval of our long-acting regimens in treatment and prevention to enable every-six monthly dosing towards the end of the decade.

To conclude, we remain very confident in our ambition to achieve a five-year sales CAGR to 2026 of six to eight per cent and to maintain our innovation leadership in HIV. This, combined with the continued growth of the long-acting market, gives us the potential to significantly replace the revenue from the dolutegravir loss of exclusivity.

I will now handover to Julie.

**Slide 20 | Performance: financial results**

Thank you Deboarh and good afternoon everyone.

**Slide 21 | Investor roadmap to end of 2024**

As you have heard from the team, we have made great progress on our roadmap since our second-quarter results, and we are well-positioned heading into the end of the year. We continue to be focused on execution, our pipeline, capital allocation and investor engagement. And as Tony mentioned, we've had several regulatory approvals, including for *Ojjaara* and *Jemperli* during Q3, and following our HIV Meet the Management event in September, we look forward to holding a similar event focused on Respiratory on 30th November.

Please now turn to slide 22.

**Slide 22 | Delivered a very strong Q3 2023 financial performance**

Turning to the quarter. As I cover the financials, references to growth are at constant exchange rates, and I will focus my comments on Adjusted results.

Starting with the income statement:

**Sales increased 16%, excluding COVID solutions**, and were up 10% overall, reflecting continued strong execution with the extremely successful launch of *Arexvy*.

**Gross margin** improved 80bps excluding COVID and 360 bps CER (incl. the impact of lower sales of *Xevudy*).

**SG&A growth** was +14%, excluding COVID. And as a reminder, in Q3 last year, we had foreign exchange gains on the Vir collaboration, which contributed 3 points of reported SG&A growth this quarter due to the credit last year.

**Adjusted operating profit grew 22%, excluding COVID solutions, and 15% overall**. The margin increased to 34%, driven largely by COGs improvements and operating leverage.

Turning to the **Reported results**, total operating profit increased 83% to £1.9 billion, which was driven by overall performance, as well as favourable CCL movements and fair value gains on our stake in Haleon. The reconciliation of Total to Adjusted results is included in the appendix.

On currency, there was an adverse 6-point impact on sales and 9 points on adjusted operating profit, primarily due to the strengthening of Sterling against the US dollar.

Please now turn to slide 23.

### Slide 23 | Improved Q3 2023 adj. operating margin by 170 bps at CER

Moving to the **adjusted operating margin** dynamics in the quarter.

The **margin** increased by 170 basis points to 35% at CER and improved 180bps excluding COVID solutions.

Overall, cost of goods has been favourable, primarily reflecting reduced sales of lower-margin *Xevudy* and an improvement in mix towards Specialty and Vaccines.

**Regarding SG&A**, we are in an investment cycle, supporting our priority products. Our spend is focused on maximising the launch of *Arexvy*, building awareness of RSV and catalysing the global market expansion opportunity for *Shingrix*. We now have approval in 39 countries for *Shingrix* and 18 countries for *Arexvy*.

Specialty Medicines is also a targeted investment area, with clear opportunities for the long-acting HIV franchise and the launch of *Ojjaara* in Oncology.

We confirm our guidance for SG&A this year, with growth broadly in line with sales.

It is important to say that following a period of investment, we now expect to move to a period of delivering returns on that investment and building on a great foundation of performance. In this new cycle, SG&A growth will step down and will be accretive to profits from 2024.

Next slide, please.

### Slide 24 | Improved adj. earnings per share, with 17% CER growth

Adjusted earnings per share grew 17% overall and benefitted from lower net finance expense, following debt restructuring and a favourable tax rate, partly offset by higher ViiV profits leading to an increase in non-controlling interests.

Next slide, please.

### Slide 25 | 9M 2023 free cash flow of £1.3bn

**Cash generated from operations** was £4.4 billion in the year to date, £1.4 billion lower than the prior year.

Two major items to call out:

- Firstly, the receipt of the Gilead settlement last year of £0.9bn, and
- Secondly, the increase in working capital influenced by strong *Arexvy* sales in Q3 and lower *Xevudy* collections. The *Arexvy* sales will come through in the fourth quarter cash flow.

**Free cash flow more than doubled to** £1.7 billion in the 3rd quarter and brought the 9-month year-to-date to an inflow of £1.3 billion.

Cash expectations for the year have improved, but we still anticipate that 2023 cash generated from operations will be slightly lower than 2022 due to the one-off receipt from Gilead last year. We confirm our commitment of more than £10bn of cash generated from operations by 2026.

**Net debt** stands at £17.6 billion, with the free cash inflow and proceeds from the Haleon stake partly deployed through business development including the acquisition of Bellus Healthcare.

Turning now to guidance on slide 26.

### Slide 26 | 2023 guidance at CER upgraded (excl. COVID-19 solutions)

Given our sustained strong performance across all segments of the business, we are upgrading our guidance at CER for the full year, and, as a reminder, guidance excludes the impact of COVID-19.

We now expect **sales** to increase between **12 and 13 per cent**.

We expect **Adjusted operating profit** to increase between **13 and 15 per cent**; and

For **adjusted earnings per share** to increase between **17 and 20 per cent**.

The strength of the *Arexvy* launch has been ahead of our initial expectations and is the main source of the guidance upgrade.

Q3 sales of *Arexvy* benefitted from strong demand and initial channel inventory build, with TRx volumes representing around one-third of volumes sold.

As Luke referenced, we are projecting our forecasts for this season in line with high-dose flu analogues and, therefore, expect full-year sales of around 0.9 to 1 billion pounds. There is, however, still much to learn, given the novel nature of this new vaccine, including annual vaccination patterns, duration of protection, competitor dynamics and what expert recommendations might be. And we

anticipate further insight following the end of the US flu season, which will inform our outlook for 2024. We look forward to updating you further as part of our FY results and remain confident in our longer-term revenue ambition for *Arexvy*.

Turning to the dynamics within the upgraded guidance. Within sales, we're increasing our expectations across all product groups:

- We now anticipate Vaccines growth of around 20%,
- Specialty Medicines to grow low double-digit, and within this, HIV to grow around 10%
- And General Medicines to grow low to mid-single digits.

Moving down the P&L to operating profit, we now expect Royalties to be around £900 million, with no change in our expectations for the other lines of the P&L.

To EPS, we expect lower interest expense of between £650 and £700 million.

In terms of currency, if exchange rates were to hold at the closing rates on 30 September for the rest of the year, the estimated adverse impact on Sterling turnover growth for the full year would be -2% and on adjusted operating profit growth, it will be -4%.

Finally, I will remind you of a few modelling considerations for 2024, namely the impact of AMP Cap, loss of Gardasil royalties, and the tax rate likely being a couple of percentage points higher due to OECD legislation. More details on these are included in our pre-quarterly Aide Memoire, and I look forward to guiding more fully at the end of the year.

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



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## Summary | Emma Walmsley

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Thanks, Julie. Turning lastly to Slide 27.

### Slide 27 | A focused global biopharma company with clear momentum that is delivering

So, in summary:

We are seeing strong and sustained improvements in our performance. This quarter marks the seventh consecutive quarter of competitive sales and profit growth, which supports an upgrade to our guidance for the year.

We also remain very focussed on strengthening our pipeline and our longer-term outlooks, with progress in Vaccines, development of our long-acting HIV portfolio and new prospects in Respiratory, all pointing to new growth opportunities for GSK.

We have strong performance as we enter 2024, and we look forward to keeping you updated on our progress.

Thank you for listening; let's now please move to the Q&A.

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- Question & Answer Session -

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**Graham Parry (Bank of America):** Great, thanks for taking my questions. I'll start with *Arexvy*, the question on the level of discounting in the initial launch, so two-thirds of your £709 million was inventory and you have administered somewhere between 1.4-1.5 million doses. That means underlying sales are in the 230-240 range and that would imply a net price probably more than 30% below the list price, so can I just check that is the right ballpark? Is that mostly wholesaler discounting or retail pharmacy discounting to drive the initially inventory build and something which we might see ameliorate a little bit over time, or is that just kind of where the competitive nature of the market is at the moment?

And then secondly, I know Julie touched on this, but the dynamics into next year, I would just be interested in what you are internally planning at the moment for 2024. You obviously won't have the initial inventory build, but how much of that inventory do you think is just seasonal inventory build as opposed to initial inventory build. Of course you don't have the return of the people who have been vaccinated this year, so any thoughts you have so far on how far penetrated you are into the easy wins of the more elderly, comorbid, etc., and how much tougher it might be to get return or new people to get vaccinated next year. Thank you.

**Emma Walmsley:** Thanks, Graham. We will come to Julie in a minute on guidance and thoughts around next year, although obviously we will mainly be giving you thoughts around next year when we come to February 2024. I would just remind everybody that whilst we are absolutely delighted with the fast and competitive start here on RSV, it is just the start. It is the first season and we remain very ambitious for the £3 billion, at least, that we expect this asset to represent.

Now let's go to Luke first, noting, Graham, you will fully understand that we are not going to be declaring all our commercial details on this call, but Luke, do you want to comment more broadly?

**Luke Miels:** Yes, Graham, thank you. I think we have been quite disciplined taking a longer-term around pricing and contracting, and it's landed quite well. I won't give you any more colour than that in terms of the stages at this point because I am sure our friends in New York have probably got up a little bit earlier this morning, but what I would say is to build on Emma's point, in the short-term things are uncertain. We are very happy with the launch. In the long-term we are very certain. I think so far if we look at some of the metrics which I can try and help you with, it's about 50% co-administration with flu. There is a very large overlap with that population and, interestingly, around 15% of people are getting three shots when they come into the pharmacy. 85% is that 65 to 84 age population, so again very similar to high dose flu and, yes, I think for the rest of the year in terms of demand, you are still seeing good market research in terms of HCPs recommending it, so it's about 64% based on our latest market research which is encouraging, and of course the CDC is advising doctors to keep going, so that's on the positive side of the ledger.

But the fact is our working hypothesis is this is more of a flu-like trajectory, and as people start coming into pharmacies and we see a reduction in staffing levels in pharmacies who actually deliver

these vaccines, then we are going to see a drop off in demand. That's our hypothesis at this point. We will obviously have a lot more colour in Q4 and will give you an update and as Emma said, I think we are very, very confident in terms of the £3 billion number that we have outlined in the past.

**Emma Walmsley:** And obviously looking forward to running forward with that with that 50 to 59 data too which is another potentially meaningful cohort.

Julie, anything else you want to add?

**Julie Brown:** No, I think actually Luke has covered it extremely well. We have obviously looked at the levels of stock in the channel, we have looked at the rate of immunisations, we have seen the correlation with flu, as Luke mentioned, very, very close, and that has really informed our guidance.

And in terms of 2024, as we come through the US flu season we are going to have a much clearer view of 2024 when we give our full year results, so we will definitely update you at that stage more fully.

**Emma Walmsley:** Thanks.

**Kerry Holford (Berenberg):** Thank you. I have a couple of questions for Tony, please, within R&D. Firstly on the bepirovirsen, now you have the full suite of your Phase II data and you have recently signed that deal with J&J to look at sequential therapy, do you still remain confident you can offer Hep B patients a functional cure, at least a proportion of them, and what do you expect that J&J siRNA to add here? And do you stand by your more £2 billion sterling peak sales target for that asset?

And then secondly a broader question on R&D budget. Here we have seen significant growth in your budget over the past 18 months or so and, based on the guideline you have ahead of you, are you broadly happy with the annual budget that you have effectively been given this year - the run rate looks to be about £5.5 billion, or should we expect that R&D budget to continue to grow in the low double-digit range that we have seen, year-to-date, going forward?

**Tony Woods:** Thanks, Kerry. Let's get started with HBV and then I will comment on the pipeline and perhaps, Emma, you might want to make a comment on the R&D budget.

First of all, I am really pleased with this deal, Kerry. Let me just remind you because I am going to anchor this in what we know about bepi and becoming increasingly confident about, and that is in the context of monotherapy on top of nucleoside treatment, that we achieve a durable, functional cure for a significant proportion of the chronic HBV patient population. That is for individuals who have a surface antigen count of less than 3,000, just as a reminder, that is about 40% of the 300 million individuals who are living chronic Hepatitis B.

To put it in a nutshell, what the new deal with J&J siRNA does is that it takes the broader population down to that target population of about 3,000 and below. You should expect – and we are excited about the prospects therefore – of seeing increased both an increased coverage in an ITT population and also a deepening of the therapeutic effect. This is important, if you look at the

mechanism of action of the J&J siRNA: it works in a complementary fashion to bepi, further lowering viral DNA and the consequences of that, as I mentioned in the presentation.

The other important thing is that we have built a complex PK/PD model around response, which this will add to. In addition, using AIML and some really deep phenotyping on the 500 patients, established an understanding of the immune status required at the beginning of treatment for response.

We will continue to add that with the deal in question, we get a number of ongoing Phase II studies. I am really very pleased about where we are with that particular deal: for me, it strengthens my expectations in terms of our ability to deliver a functional cure for a broader population of patients living with this disease.

In terms of the question about R&D budget and growth, perhaps I could just say a few brief things about the portfolio and then hand over to Emma. I am really very pleased with where we are in the portfolio. Emma mentioned the strength that we have in our growing vaccines portfolio, particularly next year as you will see more data coming from our mRNA platform, from MAPS. We have a number of important studies, like, for example, the therapeutic arm of the herpes simplex vaccine readout on POC, that will again continue hopefully to deepen the importance of our adjuvant technology that is underscoring the fantastic clinical performance that we see for *Shingrix* and for *Arexvy*.

Luke and I will say more at the meet the management about the cornerstones of depemokimab, *Nucala* and camlipixant in our Respiratory portfolio – of course, I just mentioned bepi - and moving just briefly into Oncology, *Jemperli* most recently through the OS data that I mentioned earlier, continues to show its credentials as a very highly effective PD-1 inhibitor. With all of that in place, I think we are well set with regard to our future ambitions and the budget required for that ambition. We're in good shape with that.

**Emma Walmsley:** Thanks, Kerry. There are two important things to emphasise strongly here. First of all, we have been very clear in our capital allocation framework that the No. 1 priority for the company is to invest in the pipeline – organically and inorganically. That is why, over the last five years, you have seen a significant step-up in our R&D spending. What matters is not how much you spend but that you spend it super-smartly, and that is ever improving, and that we continue to fuel competitive, profitable growth for our shareholders.

The first thing is that it is a priority, but it is about how we spend it. I think we are broadly at more industry-norm levels in terms of spending, but very much focused on the returns of that.

The second point is that we are absolutely committed to profitable growth. We are in that chapter now: we are in seven consecutive quarters of competitive growth and glad to upgrade guidance for the year. We are very confident about our '26 outlooks and our double-digit profit CAGR. This year, we expect R&D spend to increase slightly below our turnover levels: we are not going to set an explicit target around that but you can be very confident that the outlooks we previously laid out we are completely committed to, and delighted about our progress against those.

**Simon Baker (Redburn):** Thank you for taking my questions – I have two, if I may please, both on the pipeline. Apologies if I missed this, but I lost sound at one point.

It looks like depemokimab is running slightly ahead of previous expectations: perhaps you could give us update there on the shift in the SWIFT-2 study timeline?

And then secondly on the Hansoh ADC, I wondered if you could just elaborate a bit on what attracted you to that asset. Obviously we have not seen much data, you will have seen more than us, and I was wondering if it was data-driven or whether it was driven by the fact that the payload and the link of one or two carbons is identical to Dato-DXd and therefore gives you a high level of confidence in the potential of that ADC. Thanks so much.

**Emma Walmsley:** Thanks. I will come to Tony on both of those, but just to flag, please do join us, or at least Tony and Luke I should say, on 30 November when they will update you on the very exciting scale assets we have in Respiratory, obviously our homeland and our heartland, including depe and camlipixant as well, but Tony might want to comment a bit more on the trials that are ongoing and then also on the ADC, which is obviously completely in line with our Onc strategy.

**Tony Wood:** Sure, thanks, Emma. Hi, Simon. Yes, I am pleased with the progress we are making on SWIFT-1 and 2. As you have spotted, we have seen a slight acceleration in that. That was associated with also an acceleration in the ANCHOR study for nasal polyps. What that means is that the safety database that we need to end up in the file is now complete. You should expect though that we will stay on schedule with regards to the analysis and publication of the data, and I won't be doing that until we get the results for the second SWIFT analysis which still places us in the first half of next year.

As far as the ADC deal is concerned, Simon, yes, as you quite rightly point out in terms of link and payload, there are similarities to Dato-DXd and therefore we derive confidence from the improved profile that you see for ADCs carrying that link of payload.

Two important things though to stress in the context of this deal. One, the antigen, B7-H4, is selectively expressed on gynaecological cancers. That's why we went after the mechanism in line with our strategy to focus on women's cancers and haem. And lastly in that area as well, there is ample evidence of the use of topoisomerase inhibitors, so standard of care for chemotherapy. That's related in part probably to the fact that you see a lot of DNA instability in those cancers and as I am sure you are aware, topoisomerases work on that mechanism.

**Andrew Baum (Citi):** Two questions please, one for Luke and the other one for Tony. For Luke, could you talk to the impact of the removal of the Medicaid cap, the AMP cap, on your Gen Med business, particularly Respiratory next year in terms of quantifying the impact on revenue and earnings?

And then for Tony, or I guess Kim if she's on, there was recently reported the ATHENA cohort with cabotegravir with rilpivirine, there was a number of cases of viral rebound resistance, particularly in patients with high BMI or weight gain.

Should we expect any label change as a function of observations in that cohort? It was a limited number, but still it was notable and remarked upon. Thank you.

**Emma Walmsley:** We will come to Deborah on the HIV pipeline first and then Luke, back to you.

**Deborah Waterhouse:** Thanks Andrew, the ATHENA is a cohort study, it was presented at the ACS eight to ten days ago. Actually the finding is exactly in line with our clinical studies, so as you know there are three characterised things that give you a higher likelihood of failing with cab plus rilpivirine. Weight is one, so high BMI is one, and then obviously A6, A1 subtypes, and then lastly, if you are resistant to rilpivirine, so we clearly guide that those patients - if you have two of those risk factors you are more likely to fail.

We guide that and that's exactly what we saw in the ATHENA study in terms of the characteristics of those that failed and it was in proportion with what we saw in the clinical study which is obviously less than 1%, so no surprises whatsoever. Exactly what you would expect, and it just makes it more important that we continue to communicate through our multivariate analysis data for whom *Cabenuva* is right and who probably shouldn't be taking the medicine, but it's a tiny proportion of the overall patient base that will get benefit from this medicine.

**Emma Walmsley:** And nothing new. Luke.

**Luke Miels:** Thanks, Andrew. As I said at Q2, the exposure is US\$700 million, but of course we have had notice so we have authorised generics in place, we have done some withdrawals that we have announced, we have done WAC adjustment with *Lamictal*. The other products impacted of course are *Advair* and *Flovent* and *Serevent*.

I think the impact is going to be sizeable. We have started to reflect that in our adjustments now but we need to judge to see what level of returns ultimately come back. There is also some variables in terms of the percentage of switch to authorised generics but we do have competitive generics, for example, with *Flovent*, so they may pick up more volume and make it hard to forecast. Long story short, we have been prepared for this and we have been working on it for a couple of years and I think we are in the strongest position possible, but there will be a material impact on that \$700 million and that is why it is reflected in the outlook for General Medicines next year.

**Emma Walmsley:** That is a really important point. It is a 24-hit, but it is all included in our medium-term guidance, and then broadly flat in this business where we have obviously seen a nice uptick in performance, not least as *Trelegy* continues to power forward and lead the way. It is all factored in and planned for.

**Richard Bath (BNP Paribas):** I just have a couple of questions, firstly on *Arexvy*. Can you talk about the unmet need in terms of severe disease in the 50 to 60-year old patient population, just so that we can have a sense of that, and also what you would expect in terms of ACIP recommendations

so that we can have a sense of how that label update might impact the opportunity going into next year?

My second question is on *Jemperli*. Could you talk about your confidence in expanding the approval into the MMR proficient population? Obviously, I think there are two options there: one is the overall survival data from Part 1 of the studies. Could you talk about consistency of that benefit across those subgroups? And then the PARP inhibitor arm of Part 2 of the trial – I notice you don't include *Zejula* when you talk about Part 2 as an opportunity, so I just wondered about your confidence in the PARP inhibitor maintenance arm of that study as well. Thank you.

**Emma Walmsley:** Thank you. We will come to Tony in a minute on Oncology but Luke, perhaps you could talk about the 50-59 opportunity – which is another 40 million people by the way in the USA.

**Luke Miels:** There are two advantages. One is just the access to the 40 million people, and, again, that lines up nicely with the overall *Shingrix* cohort, so there are lots of synergies there that we can achieve. And then there is the broader advantage when we are contracting in the retail and non-retail settings, because we will be the only one there. Our expectation at this point is that it will be shared clinical decision-making but, as we speculated before the launch, and I think so far that is holding up, that has not been a barrier during this initial phase of adoption.

If you look at the 50 to 60-plus population, there is a sizeable proportion within that who also have one or more co-morbidities, so it is attractive and certainly resonates well with primary care doctors in terms of their support for the brand, which is around 71% in terms of their preference overall for *Arexvy*.

**Tony Wood:** Okay. In terms then of RUBY and particularly RUBY-Part 2, and indeed the MMR-P population from the results that we described earlier this week, it is important to recognise that the RUBY-Part 1 study was not powered to look at OS in the MMR-P population, but rather OS for the overall population. The way to think about this in the context of both Part 1 and Part 2 is definitely isolating out the MMR-P population and asking under what circumstances are we likely to see the most meaningful therapeutic effect for those. There are, for example, genotype considerations associated with part response in the Part 2 population that are important. I don't want to get into the details of that at this point in time because we are still waiting for the read-outs, but it is fair to say that the filing strategy that we will put around *Jemperli* in first-line EC will take account of all the factors that I have just described, as well as the competitor position.

**Luke Miels:** Yes, and I think to build on that competitive position, we are optimistic in terms of how the NCCN may read that. Of course, as you know, GY18 is not designed around an overall survival signal, and it is very interesting that since that initial label we have gone from 300 to 900 accounts now stocking *Jemperli* in the US, so that has a flow-on effect, and sales are 10 times up after SGO. It is intriguing, just looking at the market shares, if you look at that first-line setting where it was obviously non-promoted initially, Keytruda was picking up around 40% of that business. Chemo had dropped from 40% down to 27% and we had around 13% of that market, so I think there is an

opportunity now to start to make the case versus GY18, with the elements of the design and the survival signal, to try to expand the use of *Jemperli* in that setting. This is something we are quite excited about, and then of course DUO-E helps to inform the thinking around RUBY-2.

**Tony Wood:** There are just a couple of things to underscore, to Luke's point, to remind you about GY18, different patient populations. We had a larger degree of carcinosarcoma patients, which are harder to treat and, importantly as well, the RESIST sampling frequency for our study was smaller, which will obviously be going to pick up failures more quickly than the GY18 case does. It is important to bear those two things in mind when you consider the comparison of the two studies.

I think Luke has guided you correctly in thinking about DUO-E as being informative, as regards to how we might interpret the Part 2.

**Emma Walmsley:** Thank you.

**James Gordon (JP Morgan):** Thank you for taking the questions. I will stick to *Arexvy* for my two.

The first one is about *Arexvy* and stocking. It looks as though £460 million of *Arexvy* was stock in this quarter and the guide for this year implies about £200 to £300 million of sales in Q4. What does this assume in terms of stocking unwind in Q4? How much stock do you need to keep in the market to support the product as an ongoing run rate?

And also, what are you thinking about ex-US stocking in Q4? Could there be a US sized stock up that we saw in Q3 in Q4?

And the second question links into that which is *Arexvy* and the ex-US launch, so ex-US sales were only around £9 million in this quarter but the product was approved in the EU back in June and my understanding is you are not capacity constrained, so could ex-US stocks ramp in Q4 this year and, looking into next year, could we see a big launch for ex-US *Arexvy*? Could that be a big growth driver for next year or is it going to take a bit longer in Europe to get this going and what are the gating factors to get ex-US *Arexvy* ramp like what we have seen this quarter in the US?

**Emma Walmsley:** Okay, we will go to Julie first just to deconstruct the guidance for Q4, and then Luke around the globalisation, but you are absolutely right, this is a global opportunity and I will even include in that the recent commercial deals we have been doing in the second biggest market in the world. There could be an option on that for the future. Just to repeat, we are very ambitious for this being a multi-billion asset as we've committed before, but in terms of the very short-term in its first season, Julie, do you want to comment on the guidance?

**Julie Brown:** Yes, thanks very much, Emma. What we have definitely found so far is of the sales of £709 million in terms of immunisations into people's arms we have around the equivalent of about 230 million to 250 million. The launch has been massively successful. We were expecting a stock-in at this point because it's very, very analogous to what is happening with flu, so I think I will hand over to Luke in terms of the amount of inventory we expect to carry. The figure for Q4, by the way, was



absolutely spot on in terms of the level of sales we expect to see in the remainder, 200 to 300, and it's all to do with the stocking, so over to Luke.

**Luke Miels:** Yes, if you look at the total market it's about 2.71 and we have 1.7 of that in arm. Yes, I won't give too much more colour. As Julie says, it's two-thirds of sales so far and we will obviously try and burn through that towards the end of the year to position ourselves well. What we don't want is empty shelves or any window where Pfizer can get in there. That's why I am being a little bit cute with the numbers here because it's very dynamic at this point.

In terms of EU, look, it's very early days, it's private, we have kept the price in a very tight collar with the US like we have done with *Shingrix*, and our expectation is that we need to now navigate access. We have early wins in Canada, we have some very encouraging signs coming in in Europe and other markets, so we will see the full effect of that in 2024. Of course, the advantage in the European, much like Japan, and other international markets is once we get the NIP, then the level of resourcing we need to do to drive patients is significantly lower, and so from a P&L point of view it's also very attractive, so 2024 for rest of world for *Arexvy* and a quick start in the US.

**Emma Walmsley:** And just to repeat, we are definitely seeing increased openness and recognition of the value, literally, financial value of investing in prevention, and so that is definitely in part why we are seeing this faster rate, even if currently in the private market of approvals, because it's just a lot cheaper and there isn't a healthcare system or budget that isn't burdened at the moment, and they have more infrastructure in place, not least through pharmacy channels for distribution in many countries.

All of this underpins this broader confidence, but with phenomenally tight discipline from Luke and his team, as he has alluded to, around the shape of the financial contribution.

**Mark Purcell (Morgan Stanley):** Thank you, and thanks for taking my question. On *Arexvy*, a little bit more colour. I just wondered if there was any early indications of how the seasonal demand for RSV vaccination is doing and there may be more of a sort of *Prevnar/flu*-type of model. I know you will know more by the end of the year but any early indications there?

And in pharmacies where Pfizer is fully stocked alongside you, given that they talk about how they are not fully launched yet, what is your market share in those pharmacies where both products are present?

And then a quick one for Tony. In terms of the IRA considerations on R&D, where you have assets such as like your IL-18 where you could run parallel trials across a multiple number of indications, do you see the sort of pressure to do that, and on IL-5, could you do a bridge study or would you have to do a separate study in COPD?

**Luke Miels:** Thanks, Mark. We are beating them everywhere so far. The aim is to keep that happening. It's interesting, when you look at pharmacists' prioritisation, RSV is up there with flu and COVID, but you are seeing COVID volumes drop off, and last week we still kept growing with *Arexvy*

which is encouraging. I was wondering whether it would start to slow down, so this next couple of weeks, scrip data will really be interesting. It is more than 90% in the retail setting and that is another critical component in your assumptions and we do not expect that to change materially. We think vaccines for maternal, in OBGYN and PCP offices, will occur, which is something we will have to back up for future calculations, but we think the older adults market will be very much like flu, very much like *Shingrix*, heading in the direction of retail. We will just have to see what people's enthusiasm is over the next couple of weeks.

Clearly, awareness is very high and the intention to recommend is very high, and so, again, I am very happy to back the truck up with everything we know in Q4 and give you much more colour around the market research that we will have at that point.

**Emma Walmsley:** Great, thanks. Tony, is there anything to add?

**Tony Wood:** Yes, just two very quick points in terms of the IL-18 question. The key question we are asking with IL-18 is at the moment is about its efficacy relative to dupi in atopic dermatitis. For the medium-term, as we build out our biomarker strategy and look for markers of efficacy at Phase I – that is exactly the underpinnings that I would then want, to have the confidence to go forward into multiple indications.

You probably have in mind that, in the case of IL-18, the Mendelian randomisation also points to inflammatory bowel disease. There is obviously a range of other considerations there, beyond just IRA, in terms of whether or not that is a path to go.

Lastly, for MATINEE and a bridge for depe, let's see where we go when we get the MATINEE results. Obviously, we are focusing very much on the role of EOs in driving the morbidity and mortality associated with COPD, so that will be part of our strategy, but I am focused at the moment on making sure that we get the results out of MATINEE and delivering success for *Nucala* there.

**Emma Walmsley:** Yes, and of course any allocation of capital is a combination of progress and success and the assumed forecast, and that assumed forecast now has to take into account the area under the curve, or the format, or anything else.

**Stephen Scala (TD Cowen):** Thank you very much. I am curious if *Arexvy* shipments in October support your conservative guide for the full year. Were they essentially zero? I would note that in the first quarter of 2018, GSK called out stocking for *Shingrix* and then went on to beat in 10 of the next 12 quarters in the US.

Second, I know that you are beating Pfizer in RSV everywhere, but to what should be attribute the success they have had? Previously, you have said you have a better vaccine and you are stronger in the commercial setting, and yet they put up a big number as well. To what do we attribute that?

**Emma Walmsley:** I will ask Luke to overlay, Steve, but thanks for the questions. This is the first season that we have been through. We have our guidance for reasons that I will not repeat, since we are under some timing pressure, but we will know a great deal more at Q4. Obviously, we remain

extremely ambitious for this and our competitive focus is to make sure that not only the size of the market is big, which is why we welcome competition, but that we are able to effectively reach the patients who need us, which is this more vulnerable hospitalisation cohort.

Luke, is there anything you would like to add?

**Luke Miels:** I think *Shingrix* is a different case. I was in the middle of that: we cancelled the global launch and we redirected all of the volumes to the US and we also in the middle of the later year had some synergies in manufacturing, which were a surprising upside, in terms of loss rent and packaging. That is why we were able to get that volume ahead for *Shingrix*.

In terms of us versus Pfizer, first, it is great that two companies are out there driving volume, because this is an awareness game. No-one had heard of RSV – it was the first in the population before that – and so having two companies promote is good. We have enormous respect for Pfizer; we like competing with them and they are a strategic competitor for us, if you look across PCV, meningitis, RSV and potentially shingles at some point. It is nice to have this strong start and, again, we want to keep this going.

**Peter Welford (Jefferies):** I am afraid that I am sticking with *Arexvy*. You mentioned that retail was over 90% of volume so far. I am curious as to why you are so confident that that mix will continue. Obviously with *Shingrix* it has varied over time. I think your competitor made some comments that they think that potentially, in the 4<sup>th</sup> quarter in the back half of the season, it will switch more towards the non-retail segment, where they see perhaps a greater competitive advantage. I wondered if you could comment on both of those – both from the competitor advantage point of view, and also how potentially this could change during the course of the season.

Secondly, I wanted to stick with vaccines but wondered whether Tony could possibly give us an update on how you are thinking about mRNA. I know we come back to this almost every quarter, but there have obviously been some competitive developments in this, so could you give us a quick update on how you are looking at your strategy and give an update on the news flow we could get for your mRNA portfolio in 2024?

**Emma Walmsley:** Yes, we are very excited about mRNA so I will come to Tony first. Remember, the 90% is older asset adult, but we will come back to Luke on that in a minute. Tony, mRNA?

**Tony Wood:** Just very quickly, we are very pleased about the platform and how it is moving forward. We are now moving into Phase II, in both COVID and flu, and our Phase II programme for flu includes a range of options and doses that we have deduced from our Phase I study, looking at up to eight antigen components, which we feel is the path forward to, I presume, resolving the B-strain coverage question that exists. It is also worthwhile pointing out that that is likely to become a slightly simplified proposition as the B and the garter strain is probably going to be removed in '24, but more on this when I have the readout from the Phase II data.

**Emma Walmsley:** Luke, anything to add on?

**Luke Miels:** Yes, I just look at it at a macro level. You have 83 million who are over 60, you add the 50-59ers, that's another 40 million, so that's 120 million. We think 90% of those are going to still come through. If you look at a typical birth cohort, it's four million a year, so if I look at between now and the end of the year, that's about a million pregnant women and then it's unknown how many of those will get a vaccine. Then there is the influence of the antibody as well.

I think the other thing to keep in mind and we are seeing this with *Shingrix* is there are a lot of practices that are driving patients to a pharmacy because they don't want to navigate the IRA dimensions and then have a separate track for the commercial patients, so they are actually sending patients through to the pharmacy rather than persisting with that themselves, so that's a bit unknown but definitely those maternal vaccines will be given in OB-GYN offices where we don't have the label there so we will need to exclude that from our market share calculations going forwards.

**Emma Walmsley:** Thank you. We have time for one more.

**Emily Field (Barclays):** Thank you so much for fitting me in and maybe I will just ask one last one about *Ojjaara*. I was wondering if you could provide some context about how you are thinking about the speed of uptake of this launch, particularly now that you did get the line-agnostic label and if you are expecting more upfront usage versus second-line usage and any early indicators you could give us. Thank you.

**Luke Miels:** Thanks, Emily. We have about 132 patients on so far. The bulk of those are JAK failures, highly anaemic, so pretty severe cases so that initial bolus will work through.

Our working assumption is that between 40% and 50% of patients presenting are anaemic at diagnosis and as you know, we have an outstanding recommendation there in terms of 2A and the most competitive profile in that subgroup and we also know that around 46% of patients require a transfusion within one year of diagnosis, so that's our target market.

We think right now, yes, third-line is a couple of months but we will work our way up. Second-line typical treatment length is 18 months but we should be able to start to penetrate in 2024 that first-line where typical treatment is around 26 months of duration. We got the NCCN data into the two hours approval and we were very happy with the recommendation.

So far so good, a lot of academic interest, it's about 55% of the volume right now, 45% in the community. Of course we expect that to change in time, but a lot of excitement and this is clearly a visible problem for haematologists and they are very supportive of momelotinib, so, so far so good.

**Emma Walmsley:** Wonderful, thanks Luke. We will look forward to coming to more of your questions over coming days and weeks. I just want to leave you with the recap that we are

delivering strong and sustained performance momentum with another quarter of double-digit sales and earnings growth.

This is broadly based performance but of course benefitting specifically from the very fast start of Arexvy which we are looking forward to seeing its progress ahead.

Pleased to have an upgrade, but also really delighted with momentum as we look ahead to delivering our '26 results and continue to strengthen that longer-term outlook as we keep progressing the Vaccines pipeline, longer acting HIV and exciting prospects in Respiratory, so thank you to everybody and look forward to catching up soon.

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