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EDITED TRANSCRIPT

PFE.N - Pfizer Inc at Citi BioPharma Conference

EVENT DATE/TIME: SEPTEMBER 07, 2022 / 2:30PM GMT

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PRESENTATION

Christopher J. Stevo - *Pfizer Inc. - Senior VP & Chief IR Officer*

All right. Before Andrew and Mikael will get started, I need to read a quick forward-looking statement.

I'd like to point out that our discussion today may include forward-looking statements. Forward-looking statements -- forward-looking information is subject to substantial risks and uncertainties that could cause actual results to differ materially from those projected in such statements. Additional information regarding forward-looking statements is available in our SEC Forms 10-K and 10-Q under Risk Factors and forward-looking Information and factors that may affect future results. Please note, forward-looking statements on today's webcast speak only as of the webcast's original date, and we undertake no obligation to update or revise any of these statements.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

So welcome back. Thank you, Chris. So delighted to introduce our next speakers from Pfizer. So Chris, Head of IR, you already heard and seen.

The main event: The President, Head of R&D and Medical and CSO of Pfizer, Mikael Dolsten, Mikael. Thank you so much for joining us today.

First thing. Look, I haven't seen you in person since COVID, so we owe you a debt of gratitude for both the vaccine, execution and also discovery and development of PAXLOVID, and we'll come and talk a little bit about that later on the conversation.

But given the recency of the news flow on RSV, perhaps you could talk to the data that you have shared. The nature of the data points because there's a little bit of complexity there. And we can contrast it to what GSK seems to be suggesting they have delivered in terms of efficacy with their competing vaccine. So let's start there.

QUESTIONS AND ANSWERS

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Thank you. We're obviously very excited about the data that we shared, the top line of RSV, and it gives us an opportunity to expand our strong leadership on the currently most common respiratory virus, SARS-CoV-2, or COVID-19, and now with an RSV vaccine.

And I would like to say we take a real science franchise approach in this area, where we are the leaders of the world when it comes now to treating the most burdensome and difficult respiratory virus. As you said, Andrew, we developed Comirnaty with BioNTech, PAXLOVID, and now we're developing the RSV vaccine for adults and maternal and sisunatovir. We have acquired a viral drug.

Now specifically to the adult trial, I feel very excited about these, I would say, spectacular results. The study looks at lower respiratory tract symptoms, and either 2-plus items or 3-plus symptoms. The 3-plus symptoms are those patients with the more medically burdensome, impactful disease. And

that's where we reported out 86% reduction of that symptom score. It's a very strong data set. And we had 66% reduction in the more milder cases, still a very nice results.

It's underpinned by our immunogenicity data, which is really the data that's more easier to compare across trials. In our hands, it's not that easy to compare how symptoms are scored in different index that describe them, in different studies with different sites. I can only say that 86% reduction of the disease events of the more severe is just outstanding to me.

Immunogenicity-wise, we have been the top-notch -- and I think the only one that have kept both activity against RSV A and B at the upper range of fold increase over baseline. And we believe that relates to that we are the only vaccine that have both the RSV A and B pre-fusion protein expressed and included.

So all in, I think this result just stands out, and it will be a transformative vaccine. I think there is room for, obviously, more than 1 vaccine. And I look forward to the GSK's results for the benefit of patients. But I think it would be very hard to cross-trial comparison and feel that you can do much better than the 86%. And we'll just see how we can make sure, after regulatory review, that the vaccine can really be advanced in the population.

And I should end, Andrew, by saying we will have the unique opportunity, of course, to have the leading pneumococcal, bacterial vaccines for respiratory infection by bacteria, the leading COVID-19 vaccine for viruses, I think the leading RSV vaccine, and we are on our way to start also pivotal studies with a flu vaccine. So a very comprehensive approach from us here.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

So it's tough to benchmark because, of course, GSK hasn't shared the data. But they seem to be intimating, for the equivalent of 3-plus symptoms, somewhere around the 80% mark, which would put them in a certainly competitive, if not stronger position than you. But obviously, we need to see the data, and we can't make judgments there.

One might imagine that the presence of the adjuvant may result in 2 impacts. Number one, a greater level of protection in the older, whether they're immunosenescence. So I was curious as if you could share a little bit of information about how many patients in your trial were above the age of 65, 70, and whether you saw the same VE as you did in younger patients.

And then second, that may also translate into the duration of protection. And obviously, we can't comment yet, but data will on that will emerge in the fullness. Again, any thoughts there?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Well, we will share more data at conferences. And I can only say that the data I've looked at looks really strong. I would have been having difficulties to imagine a better outcome than what we saw. And I think it will be seen as a premier vaccine, all the older adult population, particularly that's the most vulnerable. And then we are the only one that have a maternal vaccine. I think the company referred to failed in that area.

I tend to say that having an adjuvant is a liability if not needed. And we did study some adjuvants and found that our 2 RSV pre-fusion F antigens did so well by themselves, and our tolerability is phenomenal. If you can avoid adjuvants, you are usually on a positive side because with each adjuvant, you elevate the risk for rare adverse events, particularly immunological rare events, that may be seen as you accumulate more patients on your product.

Now we also view that, over time, we will see a lot of combination vaccines evolve in this space. We don't know exactly when would be a nice rhythm to revaccinate for RSV. But we certainly know there will be annual vaccinations, probably very likely, for COVID, for flu. And in some way, RSV will likely be integrated. Having quite strong adjuvants as the other company will hamper your ability to build a comprehensive combination franchise as we see has been so important in adult and infant vaccination schedule.

So this was part of our overall strategy. But of course, you may think differently if you have success in pneumococcal, in COVID, in RSV, than if you have more of a lonely stand-alone effort. But that's really the strength of Pfizer. We go in all in and we want to offer patient-friendly solutions to deal with the total burden of respiratory infections here.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Yes. It's -- when you say the other company, I can't help thinking about Voldemort, he who shall not be named.

But just staying on the vaccines front, thinking about COVID. China recently approved the first inhaled vaccine. And there is not sterilizing immunity with the existing systemic vaccines. There has been a lot of academic research with inhaled vaccines and IGM and the potential world of IGM, but seemingly, industry has not been that interested despite the strong scientific rationale. So where is Pfizer on inhaled vaccines? If not, why not? Over to you.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Andrew, I appreciate you use characters from British literature in our discussion. We tend just to be careful to speak about other companies. That's why I...

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

I know. I was just teasing.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

I like your familiarity with some of the great British writers.

Now when you think about COVID, where it's going. We are, on one hand, thrilled for the BA.4/5 EUA approval in the United States. And I think as we speak, you can start to get slots for vaccination at many vaccination centers in United States, and we are making great progress also in Europe and other places to get this new updated variant vaccine. From the science that's available today, I think it will provide much desirable upgrade of the protection as the virus has evaded the first generation of vaccines.

We are working on additional improvement to make vaccination more durable with proprietary engineering of the vaccine. We think that can improve the overall protection of the vaccine, including symptoms. And then we are planning later this year for a study that includes more of a pan-SARS-COV-2 variant vaccines that should allow you to be less vulnerable as new strains evade.

Now you come to the approaches to deal with upper respiratory symptoms of, let's say, more mild to moderate character, which are still a nuisance, even though we feel very good about how we have changed the outcome of severe disease, mortality and keeping people away from the emergency rooms.

I don't think that inhaled or intranasal is going to be an alternative for an intramuscular vaccine. I think the learning we have done in immunology vaccines tells us those are the most reliable, most potent ways to get the systemic protection.

I am intrigued that, for example, intranasal, which is a much more, I would say, local delivery than going deep into the line, intranasal may be in adjunct approach. What do I mean by adjunct? It may be an opportunity to augment, particularly if there is a rapid, surprising strain shift, augment your protection from the milder symptoms.

So this is something we are intrigued and monitor to see if it could be an adjunct, but not a replacement, substitution for the intramuscular. I think it would be just a top-of in order to maybe remove or attenuate some of the upper airway symptoms, which could benefit from delivery of possibly mRNA-based technologies into the nose.

So something we are looking at, but right now, I think you should see them more as an add-on. And I have no reason to believe that they would ever replace an intramuscular.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

I ask from as much as a public health perspective because I'm concerned about high replication rates and reducing transmission and anything that seems to have a role in that. And clearly, systemic vaccines do. But the potential for an inhaled vaccine to do so to a greater extent seems to have an important role. But I understand what you're saying, and I guess we'll see the data.

I want to segue a bit to a completely different topic. So nitrosamines. And in your parlance, some of the other companies are struggling and their share price has been sorely impacted by the feared liability risk. You've had a couple of withdrawals. In fact, 3, I think, but unless I've missed 1 or 2, namely, Chantix, but -- Accuretic. Could you talk to what you see as the potential levels of exposure? Ongoing lawsuits? Anything you can add would just be helpful.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

I know, Chris, you have some remarks given this area.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Hang on a second, we'll just give...

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Maybe you use the mic there, Chris.

Christopher J. Stevo - *Pfizer Inc. - Senior VP & Chief IR Officer*

So what we said specifically regarding Zantac on our August 11 statement is that, given agreements we have with other companies and given the science and the facts and circumstances of the legal cases, we're very comfortable both with our scientific and legal case as well as limitations to our liabilities. So it's unlikely to represent a material financial impact to Pfizer.

More broadly regarding nitrosamines in general, as you know, we just like many companies, have worked very expeditiously to test our products, and where necessary, to make changes in our supply chain or to remove products from the market where that's not possible. So again, worked with a lot of diligence and a lot of speed where possible, and we feel like we substantially mitigated the issue.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

And the activity in all cases you're seeing on either Chantix or Accuretic?

Christopher J. Stevo - *Pfizer Inc. - Senior VP & Chief IR Officer*

I'm sorry?

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

In terms of the lawsuits that have been filed for both your smoking cessation drug, Chantix, but also Accuretic?

Christopher J. Stevo - *Pfizer Inc. - Senior VP & Chief IR Officer*

No. I was regarding the -- I was speaking regarding the legal liability for Zantac. I wasn't saying anything...

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

No, my question was specifically away from Zantac, on those 2 other products.

Christopher J. Stevo - *Pfizer Inc. - Senior VP & Chief IR Officer*

Yes. We haven't spoken to that at this point.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Got it. Okay. So perhaps moving to some of the internally discovered pipeline products, and Pfizer's background is one of deep medicinal chemistry, right? I mean, you are a medicinal chemistry. And where you have delivered drugs, such as ALK inhibitors or XELJANZ or IBRANCE, it is in medicinal chemistry. It's your core competence. And I'm a great believer in institutional knowledge and that panning out over sort of generations.

So perhaps you could talk about your GLP-1, your -- or GLP-1 analogs. And I know you have a lead compound which is twice a day, and you have a once-a-day compound. And I think initially, the plan was to take both quickly into Phase 3. Could you talk to, given the rapidly evolving landscape with the parenterals, how the profile of these drugs looks and how you see the commercial opportunity and the clinical trial design and the timelines as you look to take these drugs forward?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Could you specify these drugs? What...

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

What you -- so I'm talking to, number one, semaglutide, so Ozempic. And then you've also got the GLP-1/GIP analogs as well. So that's what I'm thinking. I'm not talking about the triple Gs and some of the [auxins and motilins], just the current next-gen agents.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

I think 1 very important part of our success has been the focus of having excellence in how we design medicines and vaccines. And clearly, small molecules, where we have probably the largest in the world knowledge base about structure activity. We have a leading structure-based drug design, virtual screening, AI-powered technology, all of that were example behind PAXLOVID. They are example that helped us to design I think the only in-house pharma oral GLP-1, that's a true small molecule based on that unique small molecule capability.

We are blessed to have 2 different drugs. Many of you may be familiar with danuglipron that have been shown in repeat Phase 2 studies to have a very nice effect on both lowering of HbA1c and body weight. As we refined our drug design, we have been able to move a second one with the Pfizer #1532, which has, beyond what danuglipron has, a once-a-day, very optimal half-life with a sustaining, a very nice active dose over the entire 24 hours in patients.

And that 1532 is now entering Phase 2b studies. We will share later at conferences how we were able to normalize studies of only 4 to 6 weeks titration studies. We will normalize fasting plasma glucose, have a remarkable effect on HbA1c and robust short-term effect on body weight reduction. So that looks to me as a potential, really premier, best-in-class oral small molecule.

Why is that so important? Well, the GLP, and to come, the GIP/GLP class, is the most powerful antidiabetics, and today by far, maybe the only really persuasive anti-obesity medicines.

But still, they are used among patients that need -- in just the low number of percentage. And whether you have diabetes or obesity there, you could say, in diabetes, they have still moderate market share because they are injectable and not oral. In obesity, they have a higher market share, but very few patients are treated because they're injectable and not oral.

So we see a tremendous opportunity, based on 1532 and danuglipron as an alternative over the next year, maybe 1.5 years, to cherry pick the dose and move swiftly with 1 of them into pivotal studies. And our vision here is really to, within the oral segment, be by far the most efficacious drugs. And within the segment of any diabetic obesity drug, be as good, but the most convenient opportunity for patients to really capitalize on the great story so far, how these drugs have, near-term, improved glucose and weight control; and long term, really good vascular outcomes.

I think there will also be on cardiovascular outcomes, powerful drugs or other diseases, such as NASH. So it's one of our big next efforts. We kind of now label it Lightspeed project, and we're bringing all our knowledge we had from many other Lightspeed programs. It started, of course, with the way we develop Comirnaty and PAXLOVID. And you will see a tremendous focus from us in building what we think would be one of the big next oral drug segments.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

So listening to what I'm saying, it's less about trying to match the efficacy of the next-gen parenterals. It's more about dominating the oral class?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

No. It's an and.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Do you think you can deliver Hba1c and obesity?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Our data suggests we can be as good as any of the injectables, but have a much more convenient profile, much more patient-friendly way of titrating. That's the vision. It's an and: To be the preferred drug where you're going for the most efficacious, but much more convenient. And an even larger segment, the oral segment, that's probably 80% today of the medicine used in diabetes are oral.

Why do we still treat with many old poly effectives? It's because people prefer oral in the cardiometabolic sector, but there hasn't been as powerful agent yet. And we think 1532 and/or danuglipron could have that property. But for those that want to have the best, we think this would offer efficacy as good as injectable, but with much better convenience.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

And you're starting the Phase 2b this year?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

We are moving very swiftly to start it this year.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

And the duration of that program will be, what, 16 weeks, in terms of?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

We will share the design soon. But it will be a study that will allow us to feel absolutely confident in the dose. And this drug class have usually dose titration to reach the highest tolerable dose that allow you to be able to drop Hba1c and body weight that continues to drop, over time, more and more, in this balance between tolerability, convenience and efficacy. So we'll probably do trials that allow us also to follow a little bit longer, the time points.

I estimated that we will have data within 18 months, to then share those and of course I'm leaning toward that 1532, just look so spectacular. But I was very excited about danuglipron, too. So we are maybe in the fortunate situation to have 2 such great drugs to choose among.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

I do want to spend some time talking about oncology.

But before we go there, there's one question that I forgot to ask when we were talking about vaccines, was the pneumococcal vaccines. And GSK, the other company, made an acquisition of Affinivax, which offers higher number of serotype targeting, they would claim, raising the bar again.

Obviously, you were prohibited from looking at that transaction, I assume, given antitrust reasons. How do you think about the technology that's there in their hands now? I believe they have got Breakthrough status.

Their timelines are fairly aggressive in pursuing Phase 3 trials. How should we think about this? Is this perennially changing hands? Or is Pfizer confident that they can expand the serotypes? So in fact, the serotype expansion is going to be clinically irrelevant because it's going to be addressed in serotypes, which are not associated with severe disease.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Well, I recall that company made an attempt earlier to break in with their 10-valent. And I think it's a hardly used vaccine. I think it's a very late entrant, with Pfizer being by far the leader with our 20-valent. Merck being a long-term player as a second company there.

We have monitored this technology that you referred to, and we didn't think it had the technological sophistication that was interesting to us. And I think you need a very deep knowledge base on how many different serotype you can put into one single vaccination campaign, to design and get the data that allow you to establish a new vaccine as the preferred standard.

We're working on numerous follow-on vaccines. This is a game where you never can relax in a comfortable chair like this. You always need to lean forward and push the frontier. And believe me, I think there's little room for the company referred to. And I wish them the same luck as they had in the COVID. And hopefully, they will do better here.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

I will put that to the other company's head of vaccines when I see them later or tomorrow.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

I know -- well, obviously, he trained with us.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Well, that's the new head. Yes. So the new Head of R&D, absolutely.

So going to oncology. So IBRANCE is approaching its LOE. You have licensed the Arvinas degrader. There's obviously been, with one exception, a stream of negative data with SERDs. Now in your view, is this a patient selection trial design issue? Does it undermine the potential role for ER degrading within this category? Obviously, you all have ADCs coming in, but I'm assuming people are going to hit the ER access until it gives up before they turn to an ADC. So how is your prior being adjusted for the commercial potential of the Arvinas degrader, given the data sets we're seeing from competing molecules?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

You know it's a very exciting question and similar to the other areas we discussed, this is an area where we are deploying a lot of our best resources, technologies, and effort [inaudible] cancer, particular now we are speaking about estrogen receptor dependent breast cancer and we have a very large R&D effort ongoing and I'll start by commenting on our ARV-471, why we got excited about it. It's not a standalone asset for us. We have multiple assets that we like in combination. It has the best pre-clinical data on degrading the estrogen receptor which is very important. Some of the other drugs out there which we reviewed and to be certain about taking what seems to be the most unique opportunity here were less potent degraders. It acts on the estrogen receptor limitations and particular when you progress for example on CDK 4/6 drugs maybe up to 40% of the patients carry estrogen receptor limitations. So if you don't have a good effect on that your drug is not going to do well. And it's very important also to make sure that you enrich for those patients because that's really where a degrader of this type will come to its best use. For us, it was very important to combine well with CDK 4/6 including palbociclib IBRANCE which it does. We also have now a new generation CDK4 that's starting to generate very exciting clinical data. And we are moving now our attention to that to an equal degree of enthusiasm as ARV-471, and you may notice us pushing both the axis of new, improved estrogen receptor degrader as well as next generation CDK4 that can deliver more durable and more extensive responses, and behind them we are also working on drugs related to resistance in this class such as our CDK2 drug, our KAT6. So this is a very powerful collection of molecules. Each by themselves like 471 has differentiated properties. But the way it will evolve over time is going to be combinations. So for us, I think we will have a lot of 1+1 becomes 4. And of course, I'm eager not to just win in the metastatic segment but improve even further outcomes in also early breast cancers with so many new treatment regimens available in our hands, in our portfolio.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Remind me where your CDK4 inhibitor is?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

It's now in I would say Phase 1b/2 studies. Both on CDK 4/6-progressed patients showing interesting data and also on CDK4-naïve patients. And having been really inspired by the Lightspeed spirit coming from Albert's way of challenging R&D to think differently, you could just imagine what's going on in my head about those data that so, starting week-by-week, look very intriguing, working out Lightspeed scenario, how we possibly could be in both CDK4 ARV-471 on a relatively short time frame into pivotal studies. So these are some of the scenario I see coming up based on, again, our unique ability to design molecules, pick partners and to be able to execute with enormous resources behind the drugs that matters.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

And then as we think within oncology, this time on hematology. So you have an entree drug into heme with elranatamab in BCMA, and you've got your CD47 from Trillium, which we believe may not share the hemolytic anemia associated with competing Fc-enabled approaches.

Maybe starting with elranatamab. So from memory, it's subcu, right?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

It has unique subcu properties, absolutely. It's, again, designed inside Pfizer with proprietary technology. And I say that mainly because of our focus on having the best platforms. We love to collaborate with other companies to augment them further. But truly, we combine platforms with deep understanding of the diseases we're going into.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

And I'm assuming that you've got a -- you're going to file or you are looking to file on the Phase 2 data in refractory MM, correct?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

That's our view. We have a very strong, very strong data sets. You have seen responses in the 60% to 70%, long-lasting responses, patients that have been through CAR-Ts, ADCs. All types of patient sub-classes respond dramatically.

What we think may be unique with this compared to teclistamab is that the profile of this drug also shows a very nice balance between strong efficacy and manageable cytokine release syndrome, and that was really part of the design when you designed the affinity for the 2 arms. It's a 2-arm antibodies. The arm for the T cell versus the myeloma was particularly refined for what we think is the recipe to get this very high efficacy and moderate the cytokine release syndrome, which put this class, I think, way ahead of CAR-T.

There was early -- the first targeted therapy that went in into BCMA, I think, was an ADC coming from the company we spoke so much about before. And that data set, of course, looks very dismal if you compare it to the bifunctional antibodies. So it really shows the power of immunotherapies for liquid tumor based on bifunctional antibodies. And we're super excited about establishing this drug class.

While you spoke about the triple class refractory, where we're on our way, plans to file, we have a very comprehensive program. We think we can be absolute in the first wave of first for double-class exposed, naive patients that are coming back after cell transplant, et cetera.

And we're running a big basket of combination, among which, I think the CD47 has a unique interest. We think it's really unique within all the CD47s that are around. And I'm happy later to say why. And it acts with another arm of the immune system, the myeloid macrophage, which we think will do very well as a supplement to the T cells. So really an area where we're now in blood cancers, myeloma particularly, but other blood cancers, are tripling down with this type of new immunotherapy.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

And when you think about the -- because, and Albert always reproaches me for this, reminds me that he ran oncology for many years. But rightly or wrongly, my view is that Pfizer is not among the leading oncology players. And while you have had notable successes, for example, with targeting ALK and IBRANCE, the breadth of technologies and competencies and the translation into drugs from discovery hasn't been as what it could have been.

And the question is, how do you get there? And one is there's ways to add molecules as you have done? And the other way is to add the right individuals so that you can identify technologies early and then either develop them, discover them internally or bring them in.

Anyway, where I'm going with this is another company has gone out of its way to build very deep relationships. They brought in an academic oncologist. So I'm talking about the late José at Astra. But they have become an oncology powerhouse. Now yes, they did have a legacy in oncology to build on, so they were coming from a stronger base.

When you look at where Pfizer is, do you see there's something that Pfizer needs to do? Do they need to grow the academic relationships, build that base? Or do you think that, with the systemic process of adding high-profile assets in certain large areas, it's going to get you there?

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Well, I'm glad for their success. Early in my career, I worked with the company, and it was started, as you know, an anti-hormonals as per legacy.

I think it just illustrates that it's technology-driven. And those that were the old large oncology companies who figured it out, have vanished. Those that were in the taxol era, those that were in the CML era have lost presence. All of them had all these wonderful connections, and being overrun with other companies that have picked up new technology.

We have built a tremendous leadership in the new era of targeted treatment for hormone-dependent cancer, whether we spoke about breast cancer and alluded to the many drugs, or prostate cancer. We were a leader with XTANDI. We have multiple drugs coming into combinations. We just spoke about new technology disrupting the blood cancer myeloma and how maybe the previous innovations around proteasome inhibitor, IMiDs, are now likely going to be displaced by the immunotherapies coming in.

And I feel pleased that we, with another company, J&J, that neither used to be the oncology companies over the past, are taking the lead in breaking up that. We have been one of the premier in precision medicine through our work with the ALK oncogene, LORBRENA, I think, is a very powerful agent. They're now through our acquisition of Array and BRAF and the whole family of RAF/RAS opportunities, in lung, in colorectal, in melanoma.

So that's our 3 legs: The hormone-dependent cancer, the blood cancers, the precision medicine. And we have built a very strong relationship in those areas, and it's based on new, powerful technologies.

Oncologists are not people that look to old family relationship. They look to the best for the patients, and the best for the patient is to have the new medicines from the company that have used the newest technologies and are able to run those studies. We have felt that we are having a premier place whenever oncologists are looking for companies, whether it's going to invite to conferences or reaching out for knowledge and getting together.

So I think we have everything we need, particularly in those areas where we go deep, as I alluded to: Breast, prostate/urology, blood, precision medicine. And that's how we win. You select where to win and how to play, and you go for it based on understanding the patients, designing the best medicines.

Oncology is a huge area. It's hard for anyone to be everywhere, and different companies are carving out their niche. I feel very comfortable that we're going to grow our place in oncology through both organic and acquisitions. There are lots of things, and you will see us cluster among those areas where we really already are the big player.

Andrew Simon Baum - *Citigroup Inc., Research Division - Global Head of Healthcare Research and MD*

Excellent. Well, I'm afraid we have run out of time and there was a lot we could have spoken about, but we didn't. But Mikael, thank you so much for joining us today. Thank you, again.

Mikael Dolsten - *Pfizer Inc. - Chief Scientific Officer and President of Worldwide Research, Development & Medical*

Thank you.