

FINAL TRANSCRIPT

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PFE - Pfizer Inc at Goldman Sachs Global Healthcare Conference

Event Date/Time: Jun. 07. 2011 / 10:30PM GMT



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PRESENTATION

Jami Rubin - Goldman Sachs - Analyst

Good afternoon, everybody. I've got to now take off my generic hat and put on my pharma hat. But I'm very pleased to introduce Mace Rothenberg, the Senior VP, Clinical Development and Medical Affairs, of Pfizer's Oncology Business. And timing could not have been better, just given that he's right off the plane from ASCO and obviously has a lot of good news to share from over the weekend.

So, maybe -- my first question was going to be what is your oncology business worth if you spin it off, but I'm not going to ask you that question. Instead, I'm going to ask you to talk about what was the big news that came out of ASCO this weekend, and how is it going to impact Pfizer's oncology business?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Well, first, thanks for inviting me. This is the first ones of these kinds of events I've had a chance to attend, and from the sessions I've sat in on I've been very impressed.

This was a great week for us, because it really allowed us to evolve the story of Pfizer Oncology. Over the past three years we've really seen an evolution where when I started we were seeing the maturation of some studies that were done previously, that was adding Sutent to chemotherapy, we had more disappointments than we had successes there. Last year and the past two years we began to see very promising, extraordinary results from crizotinib. And this year that story continues, where we presented for the very first time survival data with crizotinib in non-small cell lung cancer.

What we also saw was an evolution of another compound in our late-stage portfolio, axitinib, which is a VEGFR tyrosine kinase inhibitor that had positive Phase III trial results in second-line treatment of renal cell cancer. We also updated information on bosutinib, which is a second-generation CML drug, and both in the first line and relapsed and refractory patients.

And we also saw signals from other compounds earlier in our development, a drug inotuzumab, which is an antibody drug conjugate that came over from legacy Wyeth, where, in an investor-initiated trial in refractory acute lymphocytic leukemia, the drug was observed to have a 50% plus complete remission rate in patients with refractory ALL. In the words of the principal investigator, Hagop Kantarjian at MD Anderson, this was the single most effective drug he had ever seen for ALL.

And we even had some reports of drugs that are in Phase I, where you really don't expect to see much activity but we are actually seeing activity for a monoclonal antibody that we have called activin like receptor kinase, which is an antibody to ALK1 that showed some activity in objective responses. We've also seen objective responses in some of our other Phase I compounds. So, when we now look at the emerging portfolio, I'm very optimistic.

Jami Rubin - Goldman Sachs - Analyst

Before we talk about those new opportunities for Pfizer, I wanted just to get a sense from you, from where you sit as head of the Oncology Business, how has the new CEO, who's obviously sort of reenergized the Company, certainly reenergized Wall Street with respect to its perception of change at Pfizer, but part of that change relates to the R&D budget, which was cut by



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30% to 40% by 2012, how does that affect your part of the world, your decisionmaking process? And if you could talk about just the changes that you've seen internally from Ian's focus on fixing the innovative core.

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Right. Well, that has a huge impact, because we are the largest expenditure in our budget. We are the people who actually spend all the money on research and development clinically. But even before his announcement in February we had already begun a process of looking at our portfolio, which, in the beginning of 2010, consisted of 32 drugs in clinical development in oncology.

Now, while Pfizer is the largest pharma company, even that size is not sufficient to support appropriate and aggressive development of 32 compounds. So we took and undertook a systematic review of those compounds to identify those that really fell into the highest categories, those that had clear lines forward towards registration, those with clear endpoints for success or failure, and then began to identify those that may be promising drugs but had a little more complex development path or may not have had the kind of future that we would've wanted, and so we began to look to find other homes for that or just to cease clinical development on those.

Jami Rubin - Goldman Sachs - Analyst

Can you give us some examples of where that happened?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Yes. So, we had backup compounds for many of our drugs. We had a backup compound for axitinib. We had a backup compound for Sutent. Both of these were successful compounds, and when we stepped back and asked ourselves, "Do we need yet two more drugs in this category?" the answer was, "Probably not," and it certainly didn't prioritize sufficiently for us to pursue development of those. We had other drugs that had been in Phase I for protracted periods of time and really with no clear movement towards Phase II and beyond.

So, and we've also had some late-stage disappointments with drugs like figitumumab, which was a compound we were very excited about just two years ago. It was first in class. We felt it was best in class. And we had very promising early data from a randomized Phase II trial in non-small cell lung cancer. So, we embarked on two Phase III trials, and lo and behold neither one of those made it to completion of accrual and were stopped early for futility.

So, we were able to look at this and ask ourselves, "What did we miss?" And we did an after-action review, as we call it, and were able to identify things that might've influenced this outcome. And then the question was, what do we do with this compound that was Phase III and we thought we knew what the drug could do in what disease, and we had to step back and realize we didn't know as much as we thought we did. So, the team came together in New York for a week in February and did a very rigorous self-examination, and at the end of that week their recommendation was to halt clinical development of this drug.

And, now, it's fairly uncommon, for those of you who are very experienced in the pharma world, for a team, many of whom have devoted years of their lives to the clinical development of this compound, to make a recommendation to discontinue that. People fear for loss of their jobs. But what we were able to convey to them was that we had a large enough portfolio that we needed their skills in other compounds that were maybe more promising. And it really gave them permission to do this, and no one lost their job based on that decision. So, I think it really has created a very good environment for us to rigorously evaluate compounds, be honest with ourselves, and recognize, when there really is a [signal], how we can accelerate that, bring the right people, right resources to really move that close to the market.



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Jami Rubin - Goldman Sachs - Analyst

So, those 32 drugs, what has that number been brought down to now?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Twenty.

Jami Rubin - Goldman Sachs - Analyst

Twenty.

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, we've pared -- we've done this ourselves. We've pared this by a third. And so Ian's decision to really focus on the innovative core, which includes Oncology, thankfully, was something that was very much in line with what we were doing already but yet really ratcheted tighter on the restrictions. So, we've had to set the bar higher for what we expect of our compounds at certain points in development, go, no-go signals. And what we recognize, the fact that there are some compounds that we believe have a future, that are going to help cancer patients, but we just didn't have the resources to develop them internally, so we undertook a very ambitious program to look for partners for them.

And on Tuesday it was announced, on June 2 it was announced that we had out-licensed our PARP inhibitor to Clovis. And this is a drug that has a fairly long and storied history at Pfizer. It was the first into clinical development. We thought it really had certain characteristics that made it potentially best in class. But more than any other compound, more than any other field, there were just extreme changes in the landscape over a very short period of time. It really was moving in one direction aggressively, and then either something internally or externally hit and we had to change direction. And that happened so many times that we really weren't able to make the forward movement that we wanted to in the time frame that was needed.

So, we felt almost like a child that you really can't take care of adequately, that we decided to look to put it up for adoption and find a good home for it. And so we interviewed prospective parents, and we found that Clovis had great insight into this mechanism. They appreciated the characteristics of the drug. And their plan was very in line with what ours was going to be. So we think we've found a good home for it, and we hope that Clovis can bring this drug to market where it can help people.

Jami Rubin - Goldman Sachs - Analyst

Has your specific Oncology budget changed?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Yes, it's changed in line with reduction, the overall (inaudible).

Jami Rubin - Goldman Sachs - Analyst

So, it, too, is down by 30%, 40%.



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Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Not that much, but it's still down a lot.

Jami Rubin - Goldman Sachs - Analyst

The trend in oncology research is to develop drugs based on gene mutations, and, obviously, crizotinib, which appears to show remarkable activity in non-small cell lung cancer when the tumor is positive for a particular ALK fusion mutation, is a great example of this. We had a lunchtime panel on personalized medicine, and it seems that that -- personalized medicine in oncology is an exciting opportunity. Can you talk about what Pfizer is doing with biomarker-driven targeted drug therapy? Do you have all of the inhouse expertise to make this a reality, or do you need to make acquisitions?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, the idea of personalized cancer therapy has been an aspiration for decades, and the idea of using characteristics of the tumor to help guide therapy is not a new one, because when you think about hormonal therapy for breast cancer we've been doing it for 30, 35 years. Women whose tumors are ER/PR positive have hormonal therapy as an option. Those who are negative don't. And that's happened with HER2. It's happened now with EGFR tyrosine kinase mutations. So, this is not a totally new concept in oncology.

What I think is new is that we're now seeing more of these opportunities emerge at a faster rate and begin to segment diseases more quickly into smaller groups, and that's really challenged the model that many pharma companies have had of going after the big five diseases, because that was where the biggest market was. And so what we really expect to see, and I think the genie is out of the bottle, there's really no going back, is that as we go forward and understand the genetic drivers of different tumors, the tumors that look identical under the microscope but are driven by different pathways will have different therapies.

At this ASCO, Mark Kris from Memorial Sloan-Kettering reported on behalf of the Lung Cancer Molecular Consortium, where they genotyped 1,000 lung cancers. And this was a consortium of centers from around the US, and they were looking for 10 mutations that they considered driving mutations -- EGFR, ALK, RAS and others. And what they were able to do was to identify that 54% of non-small cell lung cancers had a driving mutation that was detectable. So, we've gone from a black box, if you will, of non-small cell lung cancer as being a single entity to now being able to characterize more than half of them into a specific category where we can then potentially treat patients with known effective therapies or bring those patients into clinical trials with drugs that target that particular driving mutation.

So, I think that this is really the wave of the future. I think we're now seeing a closing of the gap between what we know about the biology of cancer and the genetics of cancer and what we can do about it. And a good example is the ALK fusion protein. When you think about CML and the effective therapy for CML, the first one being Gleevec, the gap was 41 years that they first identified the Philadelphia chromosome in 1960 and Gleevec was approved in 2001. The ALK fusion gene that's responsible for this cohort of non-small cell lung cancer patients was identified in 2007, and we've now filed for registration in 2011. So, we're really truncating that.

And it's really going to be a challenge. It's going to be a challenge for clinical trials mechanism, to be able to gear up and do these trials quickly. It's going to be a challenge for (inaudible) groups, a challenge for IRBs and a challenge for regulators. But everyone has identified this as being a desirable future state, and it's really up to us to make this happen.

Jami Rubin - Goldman Sachs - Analyst

Can you be a big player in personalized oncology or targeted therapeutics without owning a diagnostics company?



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Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

I think we can. I think it's really critically important for us to be able to be opportunistic and be able to identify what the best diagnostic technique is for a particular subgroup. And it is tempting to bring in a diagnostics company and say, "Now we've got it all. It's all inhouse." The problem is that the day you acquire it some element of that technology may become outdated because another company is developing something. So, now how do you resolve that? So, I think it's really important to be flexible and to recognize the opportunities it has to go with the best diagnostic at that moment, but also the challenges of having to coordinate efforts between another company and your own. And we feel we've done that very well with Abbott molecular diagnostics on the ALK FISH assay.

Jami Rubin - Goldman Sachs - Analyst

How does that partnership work?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

They actually were the company that were making the diagnostic kits for the laboratory-developed tests. So, they were the company that was most likely to be able to bring that forward. We knew some things about the test characteristics, the sensitivity of that. We knew it wasn't the easiest platform in which to perform a diagnostic test, but we knew -- we had the most experience and we knew it was very sensitive. So, we work with them. We have had a very good collaboration in terms of being able to support the studies that were needed to bring the diagnostic along, to help with interactions with regulators, and, really, to bring both applications along in tandem. It's never been done before. It's taken a lot of work, but we really feel we're where we need to be right now.

Jami Rubin - Goldman Sachs - Analyst

Question in the back?

Unidentified Audience Member

Hi. Thank you. Assuming that you had an unlimited R&D budget, what areas within oncology do you view as most attractive, and are there any areas in your portfolio, whether it be in lung, colon, breast and those sorts of therapeutic treatment areas, do you feel like you could perhaps bolster your position? And, I guess, second to that, what does the market look like now for kind of the small biotech companies? Are there a lot of attractive opportunities out there for maybe partnerships or compound development joint arrangements? If you could comment on kind of external opportunities, that'd be great.

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, we're always looking for good opportunities. Let's start with that. I think that it would really have to be a good match, because any opportunity, any compound we bring in, we're going to have to make sure that that can prioritize adequately to garner funds in a highly competitive space within our own portfolio. So, there -- we've been looking, and we really haven't found any as of yet.

In terms of gaps, we are actually quite broad in the classes of drugs we're working with. We're working with small molecules and monoclonal antibodies. We're working with immunotoxins and antibody drug conjugates. We're working with signal transduction inhibitors, self-cycle inhibitors, antiangiogenic agents. So, we really feel that we have a good breadth of portfolio, and we actually have active preclinical research programs using all those technologies, because we think that is going to be



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important, moving away from the small molecule platform as being the one and only one to more complex molecules that can actually affect tumors in different ways and more -- with greater potency than small molecules can.

Jami Rubin - Goldman Sachs - Analyst

(Inaudible)?

Unidentified Audience Member

Given that Pfizer spent roughly about \$1 billion plus or minus a few hundred million here and there on oncology R&D over each of the last five, six years, what sort of revenue base do you think justifies that level of investment in five years' time frame? Is it \$5 billion, is it \$6 billion, is it \$10 billion? And do you think the products that are in late stage today will allow you to get there?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

I don't know if I can speak exactly to the numbers, but what I can say from a conceptual perspective is that given the aging of the population and given control of other diseases like cardiovascular disease and infectious diseases that cancer is going to become a more important disease to deal with in our society. So, unfortunately, even though the cancer death rate is declining, the absolute number of deaths is increasing. So, this is an area where we still have a lot of opportunity, and when you look at the compound annual growth rate projections for all therapeutic areas oncology leads that. So I think it is a good area to be in.

I think we have a very good platform to begin with. There's a commitment on the part of the Company. Even during the dark days when we were having a lot of negative trials it was wonderful to talk with senior management and to hear them voice their confidence that we have what it takes to be able to really become successful in that area. And I think what we're seeing this year is a delivery on that promise. And if my insights are correct we'll see that continued success going into the future. So, I think the answer to that question is yes, it's an investment, but it's an investment that has a long payoff, not a short one.

Jami Rubin - Goldman Sachs - Analyst

But just if I could follow up, you're relatively small right now in oncology. Your only major drug is Sutent, which is about \$1 billion or so in sales. The next opportunities are crizotinib, axitinib and bosutinib, and, just to (inaudible) question, are those three molecules, are we talking \$3 billion to \$5 billion in revenues from those drugs, or what's the sort of revenue opportunity for the next wave of oncology drugs that Pfizer is developing now, or do we have to wait for that next wave following those three drugs to really get to multiple billions of dollars to justify the kind of investments that you've been making?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

It's hard for me to say. And I'm not playing coy, I just really don't know. I think that one of the things that I've realized because I've been in oncology research for 25 years is what we think we know about the biology of cancer is often not what's really there. And, while we may see a very small niche initially, as we learn about the drug, as we learn about biological pathways that that drug may hit, we actually may see a very different kind of profile emerge over time, that what started out with one niche may actually extend.

So, a lot of people consider or characterize crizotinib as a drug for ALK mutated non-small cell lung cancer. But don't forget that this was brought into the clinic as a MET inhibitor. And there were a number of other compounds that were and still are being developed against this target, and we're seeing that that is a tractable target, that you can have effective therapies for that, very often in combination with other therapies. So, that is a whole other group of tumors that this drug can actually hit.



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And we, as everyone knows, have filed submissions for crizotinib simultaneously in the US and Japan. Korea and Switzerland have also been filed. Others are to follow. And so this actually may be one of the first not only ALK inhibitors but drug that has MET inhibitory activities, as well, to hit the market. And then the issue there is now can we incorporate that into clinical trials, pursuing both those avenues? So, that's a dual purpose.

In addition, we know that other cancers also have ALK gene rearrangements, tumors like pediatric neuroblastoma, a rare soft tissue sarcoma called IMT and a rare lymphoma called anaplastic lymphoma, for which the gene was named. But we also know that there are a number of other tumors, more common tumors, like gastroesophageal cancer, breast cancer, other GI cancers, where this pathway is activated, overexpressed or amplified, not rearranged. And so the question there is what activity can crizotinib have in those tumors and will it be as robust as we're seeing now in the translocated tumors? Those trials are just beginning now.

Jami Rubin - Goldman Sachs - Analyst

So, can you remind us how many patients in the US and worldwide would be candidates to receive crizotinib in non-small cell lung cancer?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, the estimates, it depends on the different sources, have gone from a low of 3% to actually in one paper in China 16%. But the numbers that we've seen most often are around 5%. So, that would translate to about 8,000 patients in the US each year and 40,000 worldwide each year in the developed countries. Now, before you say, "That's a pretty small number," keep in mind that that number is larger than the patients who are diagnosed with testicular cancer or CML or Hodgkin's disease each year. So, even though we're talking about a subset of patients within a category, that category is so big that that subset is still substantial.

Jami Rubin - Goldman Sachs - Analyst

So, you would expect the penetration rate of those 8,000 patients to be fairly high, I would imagine.

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

We certainly hope so.

Jami Rubin - Goldman Sachs - Analyst

Can you -- you talked about other malignancies or other uses of the ALK gene that the ALK gene might respond to with crizotinib therapy. What sort of specific trials do you have planned now and what would the timelines be for that going forward?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, we have an ongoing trial in pediatric disease, and it's going for the Phase I, where it's refractory pediatric malignancies of all types, and then to focus on neuroblastoma. We also have a study in the US and a study in Europe that are looking for non-lung cancers where the ALK gene is overexpressed or amplified, and those are a variety of other tumors, but some of the more common ones.



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Jami Rubin - Goldman Sachs - Analyst

Let's move on to axitinib. How should we think about the positioning of this drug in second-line treatment of advanced renal cell carcinoma, and do you think that physicians will choose axitinib as a second line RCC over Nexavar, which they're already very familiar with?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

I hope so. I think that the fact that the -- there was a statistically and clinically meaningful improvement in progression-free survival for axitinib over sorafenib, Nexavar, in second-line therapy, is a clear signal of its superiority in that space. These data are now in discussions with regulatory agencies. It's been filed in Europe. We're in the process of doing that in the United States. And we also recognize the fact that each drug, even though we have a number of drugs that have activity in renal cell carcinoma, despite how well we've done, 13,000 Americans will still die this year from renal cell cancer. So, we still have progress to make, and we think axitinib is going to be important in that progress.

So, I think it's going to be -- even though we have two other drugs in this space, we have Sutent that has more than five years' experience clinically. More than 100,000 people have been treated with it worldwide during that time, more than 10,000 in clinical trials. We have a lot of experience with that drug in first-line therapy. Physicians have become familiar with it. They know how to manage patients who have side effects from it effectively and keep the patients on therapy. We have Torisel, which has been developed in high-risk patients. So, when the patient comes in with certain high-risk characteristics we have the greatest experience and knowledge of how well Torisel works in that group. And now we have axitinib, which we know has activity in second line, whether patients have received cytokines first line or Sutent first line it has meaningful activity. So, we think that this fits together very well.

Jami Rubin - Goldman Sachs - Analyst

How about the first-line therapy for advanced RCC? Is this something that -- would you expect to see activity there, as well?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, we have a trial that has completed accrual in first-line therapy, again compared to Nexavar. And we just have to wait for those data to mature.

Jami Rubin - Goldman Sachs - Analyst

And my understanding is axitinib is also being studied for melanoma. Can you talk about -- and there was a lot of news, melanoma news over the weekend at ASCO with Yervoy and the Roche drug -- will Pfizer pursue axitinib in advanced melanoma, and how do you expect this drug to compete effectively with Yervoy and the BRAF inhibitor, or would you expect to use it in second-line or third-line therapy? Where does it fit in, in your mind?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

The data is much less mature in melanoma for axitinib as it is for diseases like thyroid cancer, where there are some very -- we have Phase II data showing a very high response rate in that disease. We also have a trial that's just been initiated, a Phase II trial, in hepatocellular cancer with axitinib, given the activity of another VEGFR inhibitor, sorafenib, in that space. So, we're really focusing more in development of the drug in those areas. We're not -- axitinib in melanoma is not one of the areas that we're going to be pursuing actively right now.



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Jami Rubin - Goldman Sachs - Analyst

Are you still pursuing tremelimumab in melanoma?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Actually, we came that close to having a positive trial, and, unfortunately, it wasn't, and we had to be honest with ourselves and step away from that. But my feeling about immunotherapy has been that, while we see activity with single-agent immunotherapy for the last two decades with IL-2 in melanoma and renal cell, more recently with Provenge, now ipilimumab, we have a mechanism of action and we have a tumor that's sensitive to that, but is that all there is? When you talk to experts in the field the unanimous sentiment is that the way to get the most out of immunotherapy is to really help to not only unleash the immune system but to train it to be able to focus on that cancer, and that will require more than one element. And so I think that combination immunotherapy is really where we're going to see the next big leap.

Jami Rubin - Goldman Sachs - Analyst

Questions from the audience? Bosutinib is the third of the trio of new oncology opportunities that will drive your oncology business to \$5 billion in the next five years. Where does Pfizer expect bosutinib to compete in the CML landscape given the dominance of Gleevec, Gleevec's going generic by 2015, the rise of (inaudible).

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

We have data that are now complete in first-line as well as in second- and third-line CML. As you know, in the first-line trial the drug showed activity in many ways, but in the one element that was selected as the primary endpoint of that trial, called the BELA trial, it was numerically superior to imatinib but not statistically superior. So, we've had discussions with regulatory agencies about that and about how we interpret a trial where the negative endpoint was missed but important secondary endpoints were hit.

I think with CML what we're seeing is the evolution of understanding about how to measure effective drugs there, because when you look at different ways of measuring that you have hematologic remissions, so you don't see any blasts under the microscope on a blood smear; you have cytogenetic remissions, where you don't -- you can no longer detect on a karyotype the presence of the Philadelphia chromosome; and then you have molecular responses, where you use RT-PCR and you can't detect that transcript anywhere.

In the molecular responses, an assessment is 10 times more sensitive at detecting residual disease than cytogenetics. So, on the molecular endpoint, we were statistically significantly better than Gleevec. So, we have been in discussion with regulators about how to interpret that, because when we look at that and we talk to experts in the field and we talk to investigators who have had experience not only with bosutinib but with some of the other compounds that you've mentioned, they think it's a very effective drug. So, it's a frustrating situation to be in now, but we're working with regulators to define the path forward.

In the other trial where patients had already received at least imatinib and were either progressing or intolerant of that drug and then received bosutinib we saw significant activity in terms of cytogenetic, molecular response, as well as the ability to delay transformation into accelerated or blast phase. In fact, in the same trial we also evaluated patients who had not only received imatinib, but some who had received dasatinib and/or nilotinib, and we were still seeing activity in that group. And we took the opportunity in some patients to be able to do mutational analysis of those cases, and we saw that certain mutations in that CML kinase actually that rendered the tumors resistant to the other drugs still allowed those cells to be sensitive to bosutinib. So, we think that there is a place for the drug in refractory disease, as well, but, again, it's a dialog with the regulators about the evidence that's needed to be able to bring this to market.



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Jami Rubin - Goldman Sachs - Analyst

So, when do you think you will have answers to take back to redesign the trial? Where are we in clinical development?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

So, we're working with the regulators, and our hope is to have regulatory submissions submitted this year.

Jami Rubin - Goldman Sachs - Analyst

I just, I want to, we only have a couple more minutes -- oh, right here, Chris.

Unidentified Audience Member

You do bring up in that last question the issue of sort of the standards that regulators are defining. Kind of two questions. One would be do you feel as if as the field is evolving and you're having more of the kind of targeted drugs coordinated with biomarkers that the FDA is currently adequately equipped so that these, quote, "dialogs" that you're having are actually occurring in real time, or is there frustration in that regard? Second question is, amongst the various targets that we've seen more broadly, not necessarily with the Pfizer compound, is the question of using endpoints, PFS, versus overall survival, and, just from your standpoint as a medical director in oncology, do you have a perspective on that?

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Great questions. The first one regarding the FDA and how equipped it is, actually two or three years ago the FDA announced that it was creating an office of personalized medicine, and we were all very excited by that. And then when we brought crizotinib forward with a companion diagnostic and we said, "Where is the Office of Personalized Medicine?" they said, "Well, it's really not up and running yet." And so, what we realized, not only from this experience but from others, as well, is that sometimes you have a concept that remains a concept until you have a catalyst, an event that forces it to reduce that concept into practice, and that's what we're seeing here.

And, actually, what we've seen is that when we have meetings we're bringing two parts of the FDA that normally did not interact, CDER and CDRH, together. And at the first meeting we walked and introduced ourselves and then they walked in and introduced themselves to each other. So, it was really new for them, as well. But I have to say that there really has been a good coordination of this focus on crizotinib. I think there are a lot of lessons being learned that will be applicable to others that follow in this pathway, and they'll refine that and improve that.

In terms of endpoints, it's interesting, because I think people are frustrated because there is an ODAC and an FDA decision that this endpoint, PFS, is sufficient with this drug in this tumor. And then a few months later that same endpoint is found to be insufficient for another disease. And what's going on here? And, actually, it is because each of the situations is different. If you're looking at first-line versus salvage therapy, if you're looking at a disease that has a long history, if you're looking at a situation where there might be crossover effect, what can you do to really capture the value of that drug? And that really is our focus when we design clinical trials is not to use a cookie cutter approach -- this worked for another sponsor, or this worked for us last time -- but to say, "What's the clinical trial design that has the best chance of capturing the particular characteristics of this drug in this disease in a way that's not only compelling to regulators but to payers and clinicians and patients, as well?"



Jun. 07. 2011 / 10:30PM, PFE - Pfizer Inc at Goldman Sachs Global Healthcare Conference

Jami Rubin - Goldman Sachs - Analyst

Actually, just one more question and then we have to (inaudible) over time.

Unidentified Audience Member

You mentioned earlier on the move towards more segmentation of each of the cancer markets, but the necessary evil there is higher pricing in order to justify -- at least that's the perception on Wall Street -- in order to justify the investment because the regulatory hurdles are still high and the market opportunities are smaller. And this year in particular there's been significant scrutiny of high-priced agents, and wanted to get your thoughts on whether you think that high prices for oncology assets will be sustainable.

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Well, let me start by saying there's nothing evil about personalized medicine. This is good. And I think all of you, if you were in the position of having a drug being administered to you, would want to know that the chances of that drug helping you were better than 10% or 20% or 30%. So, this is a good thing from a patient's point of view. It's a good thing from a payer's point of view, believe it or not, because this will allow physicians to be able to direct the therapy to the subset of patients who are most likely to benefit. So, and after you realize that and you're not -- you're excluding a large number of patients who aren't likely to benefit, the overall costs to the healthcare system go down. So, I think we have to begin thinking of things in that way, so the patient wins, the payer wins, and by being able to show a bigger impact on a smaller number of patients we're able to do the clinical trials faster and get the drug to market, and so society and the sponsor win, as well.

Jami Rubin - Goldman Sachs - Analyst

And we have to end with that, so thank you very much.

Mace Rothenberg - Pfizer - SVP, Clinical Development & Medical Affairs, Oncology Business Unit

Thank you.

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