THOMSON REUTERS STREETEVENTS

EDITED TRANSCRIPT

PFE - Pfizer Inc at Goldman Sachs Biosimilars Conference

EVENT DATE/TIME: APRIL 02, 2015 / 12:30PM GMT

THOMSON REUTERS

CORPORATE PARTICIPANTS

Diem Nguyen *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

CONFERENCE CALL PARTICIPANTS

Jami Rubin *Goldman Sachs - Analyst*

PRESENTATION

Jami Rubin - *Goldman Sachs - Analyst*

I am delighted to introduce Diem Nguyen, who is the Regional President of North America for Pfizer's Global Established Products business, responsible for a portfolio with $6 billion in annual sales. Prior to her current new role, Diem led Pfizer's biosimilar and US brands business for Global Established Products.

So we're really excited to have you. I just want to make one note. Diem will be unable to address any questions related to the pending Hospira transaction.

But we have 20 minutes, and then we're going to open up to Q&A. So, thank you.

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

Good morning. So, as Jami mentioned, my name is Diem Nguyen. I am currently the North America Regional President for Pfizer's Global Established Pharma, but I have been part of Pfizer's biosimilars business since its inception, so I'm really thrilled today to come and talk about biosimilars.

Four years ago, there were hardly any questions about biosimilars. And as Jami mentioned, all of the events that have transpired over the last few years has really made this a dynamic and interesting topic to discuss today. And given the attendance in the audience today, I imagine that there's the same sentiments in terms of the interest in biosimilars.

Before I start, I think everybody knows I need to caveat any of our forward-looking statements. If you want to read in detail, it's always available, as you know, on our website.

As mentioned earlier, biosimilars market is still in its nascency today. We had roughly a range of less than $1 billion in 2012, and is growing to $20 billion by 2020. And one might ask, what is the driver of the growth? And I think there are a couple of things that came through. For the last two or three years, you've seen an evolution in the regulatory pathways.

Before 2012, the only way to get a biologic copy into the marketplace was to go through an innovative pathway. With the recent guidelines established with the EMA and then with the draft guidelines with the FDA, what you've seen is more clarity into what the expectations of the regulatory guidelines are.

What is causing this next wave of growth, from 2015 to 2020, is this perspective of innovative biologics going off-patent. If you look at -- there's two peaks of loss of patent expiry. The first is in the 2015 to 2017 time horizon, which is primarily dominated by the recombinant proteins. Then you move to a 2018 to 2020 time horizon, where a lot of the monoclonals start losing their patent expiry.

This is compounded by the regulatory pathways becoming more clear to manufacturers subsequently going into the market to develop biosimilars, and the patent expiration where the legal resolution is still being worked through, but certainly is becoming more clear as well, too. With that is the expectation where you're moving from a less than $3 billion market to quite a sizable market in 2020.

Before I get into a little bit of the details about extrapolation and comparability, I do think it's important to talk about the fundamentals of biosimilars. And forgive me if it's oversimplistic; or in terms of the scientific, it's not probably your number-one priority to hear. But it is important to understand, because it does then therefore drive the regulatory pathway and then ultimately the access platform.

The first title says, biosimilars are not generics. Reason for that is you're talking about generics as small molecules that are chemical entities. What drives the development of generics are, one, demonstrating proof of quality; two, PK data; and then being able to rely on existing clinical data from the innovator label.

Biosimilars, on contrast, are proteins, and these are proteins that are developed through live cell lines or a viral platform. And so what you have here is the requirements is, one, proof of quality and similarity. You can't have an identical biosimilar -- that would be called bioidentical -- those don't exist. You have the requirement of PK data, as well as clinical data to demonstrate comparability from a safety and efficacy perspective.

The contrast here, in terms of development of a biosimilar, is we're looking at a Phase 1 as well as a robust Phase 3 clinical trial based on most likely one or a few indications with some level of extrapolation. When I say robust, in general what we've seen from an FDA and EMA expectations is you are looking at patient numbers ranging from the 600- to 800-patient trials.

Why we're excited about biosimilars is because of the complexity that I just outlined to you, it really requires just to think differently how we make biosimilars, and ultimately how we want to commercialize the biosimilars. We think the potential is great. And you would appreciate that with the cell line development of proteins, I think many scientists would say it's challenging itself as an endeavor. But being able to make that protein consistently from a commercial supply perspective over the course of a year is not an easy task.

That's why I think Pfizer is extremely thrilled to be in the space because, one, we have built that capability from our Innovative portfolio from a biologics perspective. And we want to drive that capability, from a manufacturing perspective, to ultimately raise the expectations of what a biosimilar in the industry should be from a quality and similarity perspective.

Why I think that's important is because you have biosimilars that currently are not automatic substituted today. And so the ability to be able to drive physician and patient confidence is going to be driven based on data and quality.

There are a lot of unknowns at this place, because we're talking about 2015, and there are a lot of things that still need to be worked through, if you will, to get to the ultimate market potential. And I'd like to be able to just tackle through some of those components and what our perspectives are.

It's interesting, though, because the FDA has just -- I think they were the most productive when it came to the biosimilar development pathway last year. And it was interesting because it seems like we've had biosimilars for quite some time. But it just wasn't until last year where we started to get a little bit more clarity with the agencies.

The expectation is the totality of evidence. And that's a step-wise approach to development. And I think what you want to keep in mind is the first step is the preclinical analytical data, so a lot of the pharmaceutical sciences data, to demonstrate that you have a similar protein.

A way to explain it, just in common layman's terms, is if you have a 2 by 2 piece of wood, and you can cut that 2 by 2, and it looks identical. And I think of that as a generic. But then you have a tree, which is your biosimilar. It's a protein. And if you look afar, all those trees look the same, but the branches are actually quite different. And in some regards, you can compare that to the glycosylation pattern.

And what we have to decipher is, one, how do you make that tree look as identical and superimposable as possible? But then, two, say okay, when they aren't the same -- and there will be parts that aren't the same -- are they clinically meaningful? And that's that pre-analytical data that's necessary.

Just to give you a little of a sense, when you put a dossier together for a biosimilar, the preclinical part for a biosimilar is roughly 3 times what we generally put for an innovative biologic. So the amount of data that's required to demonstrate similarity is quite significant.

Then you move to the clinical trials, where you will have likely one or two indications that you would try to pick the most sensitive population to then be able to say, okay, in this indication, there is comparability from a similarity perspective.

And your argument here is based on the totality of the data you could therefore assume that that -- the molecule will behave the same in the other indications. From a biosimilar perspective, it would not be feasible to develop a -- conduct clinical trials for all the indications in the label. Some level of extrapolation is necessary for the viability of biosimilars.

I think where the difference is is which indication are you going to choose? And that is driven by science. There's a component of, if you are running a trial on a specific indication, the Agency wants you to pick the most sensitive population to detect differences. But what if the other indication runs through a different mechanism of action? And is that something that the Agency is going to feel comfortable, from a data extrapolation perspective?

So all of those pieces of information are necessary to be able to gain full label for a biosimilar. I think one of the important components of it is it is not going to be some cookie-cutter recipe that you follow, and therefore you get full label. It's going to be based on, one, the molecule; and then, two, what kind of data do you have to support the extrapolation?

Then you come to this perspective of naming. So again, we talked about the fact that the bioidentical doesn't exist. So how do you want to start tracking the naming, once that asset becomes commercialized? And it is a component of the pharmacovigilance being a necessary part of the services as provided.

And so there is a component being currently debated today in terms of, do you have -- did you take just the INN name? Do you use what we call a biologic qualifier? Is it a prefix versus a suffix? And on that regard, how does the actual system take place to be able to capture those qualifiers, if you will? So all of these things are currently being discussed with our distribution, our stakeholders, and whatnot, to be able to accommodate the differences between a biosimilar and a generic.

I mentioned the label component, and that's all driven by the extrapolation. As we see in Europe today with the infliximab biosimilar, the EMA took complete data from the innovator. And it remains to be determined what the FDA is going to do, and we have seen differences in terms of approaches. And, for example, in Canada, they did not take the full label. So what you are going to expect globally is there is going to be differences in opinions from an Agency perspective from a label.

As we've mentioned, interchangeability is one of those components where I think it needs to be driven by the science and the data. The FDA has been falling short in terms of how they define interchangeability at this point. But, certainly, it's one of those aspects that it's not going to be common, one decision for all of the biosimilars; but, rather, how do we demonstrate biosimilarity, or as close to similar as possible for a particular medicine? And then is that sufficient to determine interchangeability?

If you don't have interchangeability, automatic substitution doesn't necessarily come in play. And with that then drives this perspective of how do you drive adoption, potential switching, and then how do you distinguish between the brands? All of those aspects are certainly areas that we are still working through today.

And then, finally, I think the last part is the uncertainties associated with intellectual property. Biologics, whether they are biosimilars or innovative assets, they are still complex associated with the patent landscape. There has been a system established, which is called the IPR, for biosimilars in particular. That is a new process to move forward in. And so it's going to remain to be determined how that actually will look to resolve patent disputes in an efficient manner.

Because of all of those things I just outlined on the previous slide, I think it's really important to say, okay, what do you think you need to be successful in the biosimilars space? And I think there is the first component of because they're not identical, because you don't have automatic substitution, there will be some level of needing to drive physician and patient comfort. And that will be driven by, one, your clinical data; two, the relationships you have with the physicians to be able to describe the differences, and also be able to share the data and have a robust dialogue; and, three, be able to track post-marketing requirements.

Certainly we can't forget, though, that biologics are hard to make in general. And so the expectations of being able to develop a consistent supply of products, I think, will be equally as important as what we normally see with the sterile injectables; but even more important, given the fact that the complexity of biologics.

And finally, I think we would be remiss to say that it is still a multi-source environment. To rely just solely on branded and promotion, I think, is important. But it's only one half of the picture. The other half of the picture will certainly be on driving affordability and uptake through a payer strategy.

All of those components are some things that I think that Pfizer does well, particularly in the Global Established Pharma space. And I think that this is why we're extremely excited to be dedicating a lot of our efforts into the biosimilars portfolio.

You all might know currently today we have five assets that are in development in the spaces of Oncology and Inflammation: Herceptin, Rituxan, as well as Remicade are all in Phase 3. And then we have beva that's starting our Phase 3 this year, and Humira that's completing up their Phase 1. We feel very confident in terms of quality, as well as the development and manufacture of these assets to be competitive in the biosimilars space.

Our key takeaway is, one, I think that there is a strong potential in terms of the biosimilar growth. It is, as we mentioned earlier, small today, but certainly projected to grow to a significant size in the next five years for the number of the reasons I outlined earlier. Then because of the complexity of the proteins and the biologics, developing a high-quality, safe, and effective biosimilar I think will be critical, not just for Pfizer but actually for the industry as well, too.

I think one black swan that you might have is if there is one biosimilar that ends up having an adverse event, and then what does that do to the class effect of biosimilars? And I think that's a component where having dialogues with regulatory agencies to be able to have a productive discussion of what we believe is necessary to develop a safe biosimilar, I think it will be not good just for Pfizer but for the industry in general.

And then, finally, I think the adoption of biosimilars is something that is certainly needed in our healthcare system. But it will require more work than you would generally expect from a generic space. And that's driven by, one, the lack of identical, automatic substitution. Two, being able to just have dialogues with the payer, but also to be able to drive that pull-through with the physician and the patients as well, too. Finally, I think with our portfolio, we're very excited about this. And I'm happy to answer any questions you might have on our portfolio, as well as biosimilars' landscape in general.

QUESTIONS AND ANSWERS

Jami Rubin - *Goldman Sachs - Analyst*

Okay. I want to better understand your thinking behind your commercial strategy. If, for example, the innovator were to compete on price, lower their price, you're not better; you're similar. How will you differentiate your product and gain share under that scenario?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

Yes, I think that's a great question. I think there are two aspects. And I'm going to answer it from an innovative perspective and then also from the competitive biosimilar landscape.

When you look at the profitability of biosimilars, I think you take on many components. The first one is the price. But the second one is your cost of goods. And if you think just about the innovative assets, they were developed 10, 20 years ago with a mammalian platform that may not be as robust as the new state of technology that many are using today.

One of the clear components that we have is, our eyes are -- what we do think it's a hybrid branded model, we do understand it's multi-sourced. And with that, we developed our biosimilars to have a very strong cost of goods structure to allow us to effectively compete on price.

When you also then look at the profitability, though, it's the gross margins. But then you also look at how you want to promote and leverage the existing commercial infrastructure we have today. We believe that we have a good model that allows us to be as competitive as you could imagine from a pricing as well as a multi-source environment.

Jami Rubin - *Goldman Sachs - Analyst*

So if an innovator drops their price to where you are pricing, would you just keep lowering your price to maintain that advantage? Or (multiple speakers) apart from price, what are the other aspects that you would focus on to gain market share?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

I think that's a great question. There is a price component where we assume there will be an adjustment. When a product goes off-patent, you assume that there will be some level of adjustment in the price. I think the second assumption is how do you drive the production of your biosimilars to be as competitive from a cost of goods perspective? Which is very much a generic space, if you will.

The third component is in the therapeutic areas that we have, we would look to leverage our existing infrastructure in inflammation as well as in oncology. And those areas I think allows us to build the scale to be competitive to ultimately drive that profitability.

I think there are components in there -- and I think that that's where you'll see the distinctions with the biosimilar landscape as well, too, because some may be strong in one therapeutic area versus the others. We certainly have strength in both of the therapeutic areas that we're in, and I think leveraging our commercial infrastructure will be critical for us.

Jami Rubin - *Goldman Sachs - Analyst*

You have assets in both the oncology and the anti-TNF categories. How do you compare the commercial opportunities for the TNF biosimilars versus the cancer biosimilars? They're both very different. And are there any dynamics that make one class of drugs more conducive to biosimilars?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

Yes, I'm going to start with just a general, broad view. It's always going to be specific based on indication. But if you look at the oncology space, I think oncologists are generally comfortable with using a cocktail of medicines. And the cocktail medicines include older, established products with innovative products to then be able to comprehensively treat patients.

So if you think about biosimilars, that actually makes a lot of sense. And so the ease of using a biosimilar in combination with other innovative medicines, I think is something that oncologists may be more receptive to.

In the inflammation space, it's new, relatively new. So you basically had solid oral dose pills, and then you had a huge breakthrough with biologics when it came to the anti-TNF. And they haven't had much of anything besides that, and so the (multiple speakers).

Jami Rubin - *Goldman Sachs - Analyst*

[Not] having a massive impact yet.

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

I can't speak about that. But I think there's a component of saying, okay, with that, is it going to be harder to shift over? However, I'm going to just caveat that a little bit, saying, you have a life-threatening disease and you have a chronic disease; and so would there be a higher degree of flexibility to try a biosimilar in a chronic disease than a life-threatening?

So all of those components that balance each other out, that's a general nutshell. But I would say in terms of indications, it really is different based on -- in the inflammation space, you have RA, and then you have the IBD, you have psoriasis. And if you have those discussions with physicians, all of them have different perspectives of what they're willing to do and what they're willing not to do, and it will be driven by the data.

Jami Rubin - *Goldman Sachs - Analyst*

Question back here?

Unidentified Audience Member

So, you talked about the differences between innovative and biosimilars in the current constellation and just the difference in the molecules. If you look at -- using Remicade, as an example, Remicade from 15 years ago versus Remicade today -- how much different is the original Remicade versus the current Remicade, and what you have on the biosimilar? And do you think docs would appreciate the idea that the Remicade they have been prescribing for however long is much different than it is today?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

Remicade is not our product, so I can't very much give you a guidance in terms of the -- and some people call it manufacturing drifting of one lot versus the other. What I can say is that is one of the expertise and arts that you need to have as a biologic manufacturer, whereby biosimilars are biologics.

Why we feel that there is a high degree of comfort is we always look at our lot-to-lot to say, how much of that drifting takes place? And is that something that -- within the threshold from a clinical and safety perspective? Or is it something that causes us to be more alarmed, if you will?

And I think those are the components that's critical for us to be able to say, okay, the Enbrel, or the biologic that we've provided to you, is similar to the one that you are currently taking today, even though the span is quite different from a timing perspective.

Unidentified Audience Member

Do you think docs will be able to grasp the idea that biosimilars might actually be more similar than the original, innovative molecule? Or you have not -- know that yet?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

Yes, so I think the conversations we really generally have with physicians is not necessarily how the innovator biologic has shifted over time. It's more of how our biosimilar is comparable to the innovator. And I think that that is -- they do ask questions about the differences. And they do generally like to hear data, to say, is that difference meaningful or not?

Jami Rubin - *Goldman Sachs - Analyst*

Pfizer is likely to be the second or third entrant for certain biosimilars. Mentioned that Humira is completing Phase 1, will be entering Phase 3, I think. Amgen is late in Phase 3. So you are at least second, if not third, in that category. How will that impact your commercial strategy? Is speed to market important here, or how are you thinking about that?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

I think I would caution a bit, in terms of just finding time to market based on the stages of clinical development. And the reason I say that is because there is still a lot of data, and still a lot of information that you still have to provide to the Agency to be able to ultimately commercialize those medicines beyond just the Phase 3.

I will give you an example. When we develop our biosimilar, what we do is we actually build up, scale up to commercial supply first, before running the trial. Generally, some will go and scale up that clinical supply; once you are successful at Phase 3, then scale up to commercial supply.

It sounds very technical, but the reason why it's important is when you scale up from clinical to commercial, then you actually move to a process change. But then you have to see comparability because of that process change. And that's really a difficult component when you're thinking about biosimilarity, where you're looking at, one, the comparability of your product in clinical trials to the innovator; but then having to add a layer of complexity of determining the comparability of the clinical supply to the commercial. And that is something that we've taken completely away from the risk.

But then there is perspective of the other aspects that we talked about that are still driving uncertainty, and that's the patent landscape, how that will resolve. And because of that, I say that for our assets we're still striving to be the first wave in the US. In other, ex-US markets, I think that there is, depending on the patent expiry landscape, there are differences. But we still think that, one, we'll be extremely competitive. And two, there are other areas of differentiation that allows many players in the marketplace to be successful.

Jami Rubin - *Goldman Sachs - Analyst*

And to be even more specific on the timeline for Humira --.

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

For Humira, we don't do forward statements in terms of when we are expecting to launch Humira. I would say that what I can tell you is that we're completing our Phase 1, and we'd look to be as productive as possible in Phase 3.

Jami Rubin - *Goldman Sachs - Analyst*

But you talked about that extra layer, showing comparability to your commercial supplies with the innovator. How much time does that add to the process?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

It's dependent on how successful, because what if you have -- it could be pretty seamless. Or it could go to this component of scaling up to commercial supply could cause challenges that may, in the worst case scenario, require additional studies.

I would also look into this perspective of the pivotal trials that are being run; will that gave you a full label? So a lot of our strategies today are the expectation of full label. There certainly are manufacturers' strategies to say how do I get to the fastest recruitment? Whereas may not be able to

get full label, and then therefore have a partial opportunity. So I just wanted -- there's a lot of dynamics to think about. And I just don't want you to just overlook purely from a date perspective.

Jami Rubin - *Goldman Sachs - Analyst*

And then how is Pfizer thinking about interchangeability?

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

I think that there are components of, right now, we would be surprised if the Agency had, based on our conversations, have deemed interchangeability for the monoclonals that we're currently discussing today. In the future, or if there are data out there that suggests that there is a high degree of sensitivity, if you will, that shows that they are as close to identical as possible, one could imagine that interchangeability could happen. Not sure I could see that in the near future, but certainly as you evolve and drive more comfort in terms of (technical difficulty) not something that I would think that would be unreasonable.

Jami Rubin - *Goldman Sachs - Analyst*

So that you're not sensing that the FDA has changed its tune on the timing and requirements for interchangeability, based on your discussions now.

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

No, no. I think that the FDA is going to be cautious, and look at it on a data-by-data, asset-by-asset basis to say whether an actual medicine becomes interchangeable or not.

Jami Rubin - *Goldman Sachs - Analyst*

We are just out of time. So, thank you very much.

Diem Nguyen - *Pfizer Inc. - Regional President North America, Global Established Pharmaceuticals*

Thank you.

Jami Rubin - *Goldman Sachs - Analyst*

That was really, really helpful.
