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## CORPORATE PARTICIPANTS

**Mikael Dolsten** *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

## CONFERENCE CALL PARTICIPANTS

**Jamilu E. Rubin** *Goldman Sachs Group Inc., Research Division - Equity Analyst*

## PRESENTATION

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

Okay. I think we're going to get going. Good morning, everyone, and welcome to our second day of our 38th Annual Healthcare Conference. And I am delighted to kick it off this morning with Dr. Mikael Dolsten, who is President of Worldwide R&D at Pfizer.

And Mikael is going to provide sort of a 5- to 10-minute overview, and then I'm going to launch right into Q&A. And remember, this is a fireside chat presentation. So please, if you have questions, raise your hand.

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Thank you very much, Jami. I apologize there are no slides. They are available though on our web page in the webcast. So before I give you just a brief overview of our pipeline and our exciting products, like always, I wanted to remind you about our forward-looking statements, that you'll also, of course, find in our filings and on our web page, that this conversation may include forward-looking statements about our products and other related things in the pipeline. And these are subject to uncertainties and risks that could cause actual results to differ materially from the statements expressed or implied during this conversation.

Right now, I believe Pfizer has one of the most interesting pipelines that we have seen over more than a decade. And it's a pipeline that positions us for growth over the next 5 years to come when it comes to new product launches into the marketplace. I wanted just to share a few perspectives on the quantity and the quality of this pipeline.

First, when it comes to the quantity. Over the last number of years from 2011 to year-to-date, we have had more than 20 -- we have had 22 key approvals, of which 14 has been new medical entities. We have had 42 pivotal study starts aimed for registrational intent. That gives us an annual productivity of about 3 to 4 approvals, of which, on average, 2 are NMEs and 6 to 7 new pivotal study starts with registration intent.

We have a pipeline of about 96 products with about 43 of them almost 45% in the Phase 3 registration phase. And as we project just for 2017 to '18, and you will hear a little bit more in a brief moment about the 5-year perspective, we see that we'll continue with the same rhythm in the pipeline and even enhance and augment the output over this period. And in '17 and '18, we expect and I project 15 pivotal study starts and 10 differentiated approvals over these 2 years.

Now to the quality. We have increasingly emphasized our pillar in the pipeline in addition to the breadth to build on anchor products or anchor assets. An anchor is an asset that we believe have an opportunity to grow its impact in medical practice and its commercial potential over many years in different indications, patient populations and in possibly different combinations. We are focusing on large unmet need. And we are aiming for market potential above $2 billion. It's also often related to breakthrough science pursued by findings in our laboratories or very unique drug design that allow us to create molecules with different and leading properties.

And we aim often to build a leadership that transcends several product generations, which allow us to establish a foothold with our first product and then expand through follow-on drugs or combinations to allow a much more impactful contribution both in the marketplace and to patients. And it really brings together a focus for science, R&D, commercial go-to-market models as well as it attracts many of our external partners to collaborate with us and establish unique anchor technologies and anchor assets.

So the first wave of anchor assets that started around 2011 to year-to-date. I just wanted to highlight a few because they give you a sense of how we're thinking and going. IBRANCE in breast cancer started with an approval 2015 in advanced breast cancer followed in 2016 by recurrent. We have built a tremendous knowledge about the target areas of CDKs, that is the mechanism of action of this product. And that led us to explore not only the combination in breast cancer with anti-hormonal but new combinations outside breast cancer.

And we have really the leading position when it comes to going from the more metastatic advanced into early breast cancer, where we have 2 large studies ongoing that have readouts possibly around the 2020 time period. We're also investing in looking at ways to intervene with resistance that occur for all cancer products over time. And we have initiated clinical studies on that. And next year, we expect to have a full-on CDK into human studies that have a unique design to deal with resistance patterns that may emerge.

Our second anchor in oncology is XTANDI that reflects the Medivation acquisition we did. And as you know, it has a leading position in metastatic castration-resistant prostate cancer. And more recently, we announced that we are able to accelerate one of the studies for XTANDI into the non-metastatic space, the PROSPER study, to have a readout already this year. Also in the XTANDI space, we are looking at numerous opportunities to combine it with drugs in our pipeline, whether in the potential immuno-oncology arena or with other targeted agents to deal with resistance.

Immuno-oncology, that I briefly touched upon, represents initially our alliance with Merck KGaA around avelumab or BAVENCIO, for which we got 2 approvals this year, Merkel cell carcinoma and second line urothelial or bladder cancer. We have a very large program ongoing across many indications, combinations and several different I/O type of compounds for targeted therapy that can fit with BAVENCIO.

The fourth anchor, and it's really the prototype of an anchor product, is the PREVNAR 13 vaccine. You may remember that already around year 2000, we were the company that brought forward the 7-valent Prevnar vaccine followed by 2010 and '11, the 13-valent for infants and adults. And right now, we have, in Phase 1, concluded a study that looks encouraging with a 20-valent pneumococcal next-generation vaccine. So that's suggest to you an opportunity for anchor assets to transcend, which could possibly be 3 decades of leadership in products in the marketplace for a multibillion dollar product.

XELJANZ represents the first JAK inhibitor for rheumatology in the United States, it was launched by us in 2012. And we have been the leading and only yet this far in rheumatology. And also here, we are expanding to new indications in gastroenterology, ulcerative colitis, psoriatic arthritis, in which we are in registration phase.

And EUCRISA is another example of a strategic acquisition not just of a product but of an anchor asset in the sense that EUCRISA, as you know, was approved late last year for moderate to mild atopic dermatitis as a topical treatment. We are now looking at ways to extend the whole topical platform with multiple additional new medical entities that may be delivered as monotherapy or possibly even combined with EUCRISA. And again, going from an initial product to build a leadership in a new space of dermatology, atopic dermatitis, and we aim also to explore new medical entities for psoriasis.

Now a little bit of perspective from tomorrow towards 2022. So we see in the anchor of immuno-oncology that we will enable a large set of combinations, including doublets and triplets as well as many different targeted combinations as well as exploring new ways to attack tumors, such as cancer vaccines. In rare disease, where we actually have a quite vibrant pipeline, Roche invested in our anchor technology gene therapy. And we have a pipeline now where we expect by 2018 to have 4 different novel gene therapies in the clinic. And this year, very soon, we have a readout in Phase 2 for our first proof-of-concept in the collaboration with Spark Therapeutics around our factor IX gene therapy. You may have noticed we recently made a deal with Sangamo for a factor VIII gene therapy. And we earlier acquired Bamboo biotech for gene therapies in neuromuscular disease. And that gave us also end-to-end pharmaceutical and manufacturing capability that we are expanding.

I briefly touched upon XELJANZ as the first JAK inhibitor. We will have within 12 months about 10 different JAK inhibitor studies with new JAK inhibitors that are designed to more sophisticated, based on new knowledge, deal with a variety of different immune conditions. We have just -- in the conclusion phase of a Phase 2 study for a novel JAK inhibitor for atopic dermatitis. To the best of my knowledge, a first Phase 2 readout in that indication with what looks like encouraging clinical efficacy (inaudible) with studies in alopecia, in inflammatory bowel disease and are broadening the use of this novel generation of JAK inhibitor across many indications.

In our franchise area of internal medicine, which includes neuroscience and also NASH, we expect to have this year 4 different compounds for NASH in the clinic. And we're building a presence in a highly select area of neurology. Our presence in vaccine with our anchor assets around the pneumococcal franchise is now expanded with a second anchor around novel bacterial vaccines with C. difficile in Phase 3 and staph aureus vaccine in Phase 2b in a pivotal study. And we're also starting a clinical study with a Group B streptococcal vaccine, building a large anchor around novel vaccines for bacterial diseases. And I briefly earlier mentioned our pneumococcal next-generation vaccine that, of course, primarily expands the conjugate Prevnar franchise.

Now coming to -- just concluding 1 or 2 remarks here. As we see our pipeline projects over the next 5 years, I believe we have a potential for the next 5 years for about 25 to 30 product approvals, which continues on our track record of 5 and possibly 6 product approvals per year. And of those, I can see an opportunity for up to 15, 1-5, blockbuster approvals over the next 5 years. And on the webcast, you can see a list of what constitutes the great example of what could be these 15 product approvals of blockbuster size.

Let me just quickly run through a few examples, and then I'll hand over to Jami. In oncology, we see an opportunity for 5 different blockbuster approvals over the next 5 years. Of course, with the near-term PROSPER readout followed by in the later period IBRANCE into early adjuvant breast cancer, we see for I/O-targeted or I/O-chemo opportunity, you may have noticed that as our avelumab INLYTA example. And we see for I/O doublets and triplets an opportunity to contribute in this period.

Inflammation and immunology, we see an opportunity to accelerate our next-generation JAKs within atopic dermatitis, alopecia. And of course, we are in registration phase with XELJANZ for psoriatic arthritis and ulcerative colitis. In vaccines, we see 3 opportunities for blockbusters: the Phase 3 Clostridium difficile, the Staphylococcus aureus in a pivotal Phase 2b and our pneumococcal next-generation 20-valent vaccine that we are accelerating forcefully.

And finally, in rare disease and internal medicine, we have a readout that's for our domagrozumab for Duchenne muscular disease, rivipansel for sickle cell, tafamidis for cardiomyopathy and tanezumab already next year likely for pain. So that's a pretty comprehensive list. And it is supplement that which wasn't included in the 15 opportunities for a handful of biosimilars across the major cancer inflammatory diseases that are really high-value opportunities.

Now I'll just end to say on the last slide, you can see our news flow in '17 and '18. In the late stage, of course, we are waiting for the action date for the XELJANZ submissions in psoriatic arthritis and ulcerative colitis, ertugliflozin, our partnership with the U.S. Merck in diabetes. And we're planning to submit a next-generation ALK lorlatinib, glasdegib, dacomitinib as additional cancer agents. And early next year, we have opportunities to have action dates for SUTENT, as well as generating data late this year for our I/O doublets, followed by I/O triplet next year. And we also look forward to communicate, over this 1-year period, our data of new drugs in NASH as well as additional novel modalities in immuno-oncology, such as bifunctional agent, P-cadherin.

I hope that gave you a sense about our pipeline's quantity to deliver this flow of up to 15 blockbuster drug approvals over the next 5 years and 25 to 30 approvals overall. And it's really an emphasis, not just on quantity but drilling down with quality and anchor assets in areas where we can deliver leadership over time. Thank you very much.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

That was great. Thank you very much. And unfortunately, we only have 20 minutes to really drill down on what I think are the most interesting assets, but I will do my best.

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## QUESTIONS AND ANSWERS

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

First, I just -- as kind of a high-level question, Mikael, you are responsible for an R&D budget of $7.5 billion to $8 billion. I think on an absolute basis, that's probably one of the largest, if not the largest, R&D budget in the industry. And you just rattled off a whole bunch of assets in many different therapeutic categories. How do you allocate your investment spending? How do you decide how much to spend in which therapeutic category? Is cancer really dominating most of your time now in your investment views? Or how do you think about it?

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes, thank you. Of course, we work as an extended leadership team across many colleagues together here to do a thoughtful allocation based on the scientific prospects and the commercial opportunity to win for us. Oncology constitutes a large area for us. And you can note in our pipeline, it's kind of 40% to 50% of the activities we have. But I think a strength for Pfizer is the presence in 5 categories, including 6 therapeutic areas. And that allow us to be a company that can contribute across many areas with a number of these anchor drugs. And we try to, on one hand, allocate funds where we have a strategic direction, like you heard some of these anchor technologies and assets. But also of course, we look at products one-by-one. And we are willing to put a lot of effort in a space when we want to expand it, such as we did around IBRANCE and as we tried to accelerate our position in immuno-oncology and gene therapy. And to sum up what I think we have as a real advantage is this consistent flow of products coming through, including blockbusters. And we are not a company that's dependent on a binary outcome of a single trial or a single product. But it's much more of a broader portfolio with a lot of upsides in some of these drugs, as I mentioned.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

So what I think is really interesting is that when I started my career, which was a long time ago, and following Pfizer, Pfizer was a big cardiovascular company. You were also big in diabetes, arthritis. And so many of the key areas you focus on today bear no resemblance to what the company was even just a decade ago. So how confident are you that you have the right teams in place? I mean, companies take decades to change. And Pfizer is a big company. So in each of these big therapeutic categories, these were not the areas of key competencies that you had just 5, 10 years ago. So how can you be confident that you have the right people in place, the right teams in place to execute on some of these very ambitious goals?

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. We have been, I think, in a very exciting journey of creating growth for the company, of course, led by Ian Read, our CEO. I started to work with Ian around 2009. And it's been a really strategic focus on moving the company to the phase where you see the best growth and where you can create more transformative products. We have retained a presence also in some of the classical areas, although at smaller scale. You heard about ertugliflozin in diabetes and NASH, which is kind of a new disease, coming from the cardiometabolic epidemic, is a space we contribute. We have built talent in the company and capabilities both by internal recruitment and a lot of external collaborations, acquisitions. And I think that has created really a very seasoned, experienced team, colleagues that have been long with Pfizer, other colleagues that have come from other companies. I joined Pfizer after the Wyeth acquisition, which gave Pfizer, of course, a very solid and industry-leading vaccines. And going forward, a new Pfizer, through some of the acquisitions I mentioned, Medivation, Anacor, boosted areas around oncology, inflammation. And we have attracted talent across the industry that have supplemented a lot of really institutional knowledge we have, how to develop drugs and how to launch them successfully.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

So we just came off ASCO last weekend and you recently hosted an oncology update. So I wanted to focus some of my questions on your broader oncology pipeline, which I do think is really exciting. On the I/O market, obviously I think one of the big takeaways from ASCO is just how dizzyingly crowded this market has become and with dozens of PD-1, PD-L1 drugs either on the market or in development. And as you know, Pfizer is well behind the frontrunners, Bristol-Myers, Merck, and behind the next wave of competitors, Roche and AstraZeneca, in the big tumor market. But you

-- avelumab is now available in 2 approvals, Merkel cell and second line bladder, which are relatively small markets. So I think it's not debatable that Pfizer is still well behind in what is a huge market. And clearly, this is an area of focus for the company. So I guess the first question is how do you tackle this massive market opportunity where you're coming from behind, but clearly you have some really interesting assets internally? How do you deal with the complexity of this field? And the competitive dynamics that it used to be that it took a decade to develop a new cancer drug, now it takes weeks. There's new information about biomarkers every other week. So how do you, coming from behind, play catch-up in a big way? And how do you think about that?

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. I think the immuno-oncology space has a complexity that's far larger than, for example, the CDK space, where we established a leadership and have, I think, a really strong position. The immuno-oncology space is so vast and complex that being the first entrant doesn't necessarily mean that you will be able to cover lots of the growth opportunities over the next decade. Of course, we acknowledge that companies like you mentioned, BMS, Merck, were early into some of the large indications, such as lung. But we also start to learn that monotherapy, which is currently the approach, is likely not going to prevail as the long-term approach. And you will see opportunities for different types of combinations and segmentation to curing those diseases. And that's where, I think, the breadth of our pipeline has a real advantage. We shared, for example, at ASCO tremendous promising data around combining INLYTA, a targeted agent in renal cell cancer with BAVENCIO avelumab, showing the opportunity to cross-targeted immuno-oncology agents. And you will see our significant (inaudible) of targeted agents, whether in ALK tumors or in EGFR tumors or PARP inhibitors or type of extended drugs combined with I/O and strengthen our position in the target I/O space. And then in the I/O-I/O space, we have 11 different types of I/O drugs in clinical studies. And we see lots of opportunities to learn which ones have the best position in tumors that are highly amenable to immuno-intervention, the hot tumors versus tumors that need some more inflammatory thing that are currently cold tumors. And near term, I'm particularly excited about our triple I/O drug, the 4-1BB, OX40, and BAVENCIO avelumab and look forward to see if we can break through into some of the large indications with that or some of the other approaches we're taking. So that's really how we see that this field will have numerous changes here over the next few years. And we aim to carve out some leadership role in there.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

Are you planning to compete head-to-head in some of the larger tumor markets where there's already a lot of activity? Or is the plan to sort of segment targets or tumors where there's been less focus?

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. In some areas, we think we can compete with monotherapy. There are certain aspects of gastric, ovarian, head and neck, where we think we can be among the top 2 when it comes to initial monotherapy. In lung, as you exemplified, we certainly will compete very well in the targeted lung combinations. But otherwise, our bet is for the larger lung segment, really the combination with doublet and triplet I/O that we think and hope for the patients' benefit it will surpass the mono I/Os, the PD-1 alone, which although has encouraging data, it's still a very narrow amount of the patients that respond.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

What are the doublets that you're developing for frontline lung?

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. So the doublets that we have now in the kind of Phase 1b basket studies, and they go across many indications. So it's not specifically for lung, but we're looking for signals, includes BAVENCIO with OX40, BAVENCIO with 4-1BB, BAVENCIO, OX40, 4-1BB. And we're also concluding studies now with our IDO1 inhibitor that could potentially also move into this setting. So this gives you just the kind of a feel for the near-term opportunities, how we're thinking in this space.

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

So I don't think we have so much data on OX40 or 4-1BB this year at ASCO.

**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

No, I think they are not really drugs for monotherapy. You really need to combine them in doublets and triplets. And we expect to have data on those later this year and triplet possibly late or early next year. I do see, however, that there would be additional combinations that would come, some from our internal research. We will put into human studies every year 1 to 2 novel agents that will be able to combine with BAVENCIO and go into some of these large tumors. So it's not kind of a one approach, that's it, it's a continuous flow of small and large molecules that will combine with BAVENCIO from our own labs and from external acquisitions and partnerships.

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

What are the next indications you expect for avelumab?

**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

The next one will be the type of late lines of gastric, lung, ovarian. And when you look over a 2-years period, we also expect to get close to a -- the INLYTA avelumab in RCC, which I think looks very promising.

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

IBRANCE is clearly your largest and most exciting and important cancer drug. But obviously, competition is coming. Can you talk about what's next for IBRANCE? And are there opportunities in other tumors, such as lung? I know that Lilly is pursuing lung, and I don't think that Pfizer is.

**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. So first, we feel really good about IBRANCE's position in breast and growth opportunity in breast. And it's been used by some 60,000 breast cancer patients and has been seen as an effective, tolerable drug and has really high quality of life and impactful efficacy on progression-free survival. We haven't really seen in any of the competitors that are 2 to 3 years behind us in the marketplace anything that looks different on the positive side. In contrast, we see some of them, like the Novartis drug, has need for monitoring of cardiovascular, of liver, of electrolytes. We've seen the Lilly drug having issues with a high frequency of diarrhea. And our experience tells us, these are things that matters for physicians and patients in this disease. We are way ahead of anyone when it comes to studies in early breast cancer, which is the real growth segment. It's an area probably as we go even larger than the metastatic and recurrent because of the number of patients and the long time you treat. Now in other indications, we'll have readouts within a year or so in head and neck, combining IBRANCE with ERBITUX. We'll have readouts in pancreatic cancer. These are Phase 1, Phase 2 studies. But of course, if data is promising, we can accelerate in head and neck cancer. And we do have studies that are in other -- launching new studies also in lung, since you ask. We're not really developing IBRANCE as monotherapy. We do think -- our science tells us that CDK drugs do much better in combination, giving more sustained efficacy. So for example, we're going to study IBRANCE together with our own EGFR inhibitors in lung as one example.

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

What are your thoughts on -- Lilly has been pitching abemaciclib as potentially best-in-class based on single agent activity, which they did demonstrate in refractory patients in MONARCH 1, continuous dosing and crossing the blood-brain barrier. What are your thoughts on that?

**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. I think it's good if there is a drug that can help for very advanced patients as monotherapy. It is a very small segment of patients and not at all applicable or comparable to where we are with our combination with anti-hormonals. Otherwise, the data I've seen hasn't shown to me that abemaciclib has any efficacy signals that would be different from IBRANCE. It's hard to compare across trials. In some of our trials, we may have more patients with prior experience of multiple line of estrogen receptor blockade or chemo experience versus another competitor drug. So that's very difficult to do. But overall, I think when you look at our hazard rates, they are very robust. And I haven't really seen any of the other CDKs, including Lilly, having data that suggests anything of really different magnitude. In contrast, as I alluded to, we see the adverse events profile and intolerabilities to be less preferable for patients. When it comes to brain mets, we haven't yet seen any data on which of the drug is effective. But I want to punctuate that brain met, fortunately, it's relatively uncommon in breast cancer. It's single-digit percent of the patients that tend to suffer from it. So I don't think that's the major space to go. And we're pushing ahead, not just with early breast cancer, which is an even more important space not to have a need for monitoring or GI side effect, but we also aspire to have a number of combination studies for patients that get resistance to these drugs and including a new CDK for IBRANCE or any CDK4/6-resistant patient into the clinic next year.

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

I just quickly want to ask, do you expect that we will see overall survival with any of these CDK4 inhibitors because of the crossover risk?

**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

I think for the kind of first line metastatic breast cancer, that will be -- you will see survival data, but it will be hard as it is across many different cancer types to get a really good understanding of the efficacy of the drug when you look at survival because the patients do cross over to other types of therapies. That's why I think regulators tend to focus in early line, where patients live longer on progression-free survival and where we have very strong data.

**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

I want to touch upon XTANDI because obviously it's an area of focus. You've spent $14 billion to buy Medivation. And sales growth over the past couple of quarters have not been great. So can you talk about what's going on with XTANDI? How do you plan to turn it around? Is it all dependent on the success of the new PROSPER trial in the pre-metastatic market that drives the growth? But just remind us what the value proposition was of Medivation and just how important the earlier lines of treatment are to support the deal size.

**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Yes. So the value proposition was dominated by XTANDI and including growth into the non-metastatic setting, which was very important for us. And there was some value also in talazoparib, particularly for BRCA in breast. These were the main things, the prostate franchise of XTANDI. So you may have heard my colleague, Albert Bourla, speak about that we think we will stabilize this patient assistance program and that things will gradually resolve by early next year. I know Albert's team have made good progress when it comes to accessibility of the drugs through payers and removing step edits. And there is also tremendous growth opportunity in existing indication for XTANDI of metastatic. It's used by both oncologists and urologists. But there's a large number of urologists that are not yet -- gotten experience to use XTANDI. And I think the really important data for many of them were the TERRAIN data, where XTANDI showed significant superiority over CASODEX, the older type of drugs that were used by many of these physicians. So we think that will be very important within the metastatic setting, further growth. Now in the non-metastatic, we are very excited about the opportunity to accelerate the PROSPER readout by about 2 years. And we will have data this year that will allow us to, hopefully pending conclusion of the data, to have a drug that can have a great impact for patients in the non-metastatic setting. And I think that will be a tremendously important growth opportunity. Over time, we do see XTANDI to be able to combine with the other assets in our portfolio. We're looking at combination with our immuno-oncology drugs, including BAVENCIO. We see opportunities with a few other of our targeted agents, including new NMEs in the clinic and coming to the clinic to deal also with the resistance as it emerges, similar as I alluded to how we're

dealing with IBRANCE. And it's that kind of experience, how we grow a brand across many indications, deal with the cancer resistance, that we think will sustain and enhance our leadership in this space. I have no doubt that XTANDI and IBRANCE will be healthy-growing drugs in metastatic and non-metastatic.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

But not look for that in the next second quarter is what you're saying. Don't look for that in the second quarter.

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Well, I think we should look with a great emphasis for the PROSPER data as well as see further prescription rates in the metastatic setting, as I alluded to.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

And I just have one last question. Is your R&D organization ready for a large transaction, i.e., a mega deal?

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Well, Pfizer is a company that is always very active in reviewing small, medium or large transactions because we are here to create maximum shareholder value based on opportunities to do drug development and commercialization of new treatments in the most effective way. So it's a company that has shown tremendous capability to do anything from small to large transactions. So I think there are few other companies that have that breadth of experience. And I hope that just shows that we never say no to anything. We are constantly reviewing things where we can see good shareholder value.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

So you're ready? Is that what you're...

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

We will always be ready when good BD opportunities emerge. That's how we are. That's the genetic code of Pfizer, always be ready and act forcefully.

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**Jamilu E. Rubin** - *Goldman Sachs Group Inc., Research Division - Equity Analyst*

Okay, great. Thank you very much.

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**Mikael Dolsten** - *Pfizer Inc. - President of Worldwide Research & Development & Executive VP*

Thank you very much. Thank you.

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