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PRESENTATION

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Great. Thank you very much for joining us today in post-learn session. We'll keep it entertaining so that we don't -- yes. Thank you very much. And my name is Mohit Bansal. I'm one of the biopharma analysts here at Wells Fargo, and we have Pfizer management team today with us. We have Annaliesa Anderson, she's SVP and CSO, Vaccine R&D; and Rodrigo Puga, he's the U.S. Commercial and Global Business Lead of Internal Medicine; and we also have Chris Stevo, Head of IR at Pfizer. Thank you all for joining us today.

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

And Mohit, if I can just make -- briefly make a forward-looking statement and I'll let you all get to it. So I just wanted to inform you that we're going to be making forward-looking statements or may be making forward-looking statements today and anything we say is only valid as of today. And if you have any more questions on forward-looking statements, please see the relevant sections in our SEC filings under Forms 10-Q and 10-K.

QUESTIONS AND ANSWERS

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Great. Thank you very much. A lot of questions on like -- I think we are really lucky to have both of you because I have 2 pages full of questions. But if you have any questions, please feel free to let me know. Yes. I mean Chris has set me up so that I don't ask questions to him.

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

We can always send them over though.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Yes. He does that (inaudible). So maybe with RSV, look, now that the data are out and we know the competitive profile of different assets that are out there, what has been the feedback from the payers and prescribers so far when they compare Abrysvo versus GSK's product at this point? I mean how -- what are you hearing?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

So we're very confident about Abrysvo, our vaccine. It's a vaccine that's now broadly approved across older adults and the maternal population. And we had extremely powerful efficacy results. The efficacy study was conducted in over 35,000 individuals, and we looked at very objective endpoints that really showed that someone had severe RSV disease, and we saw very good efficacy. We continue to see efficacy as we go through the second season. First of all, very efficacious vaccine from that clinical study. Also, a large safety database and very safe. We haven't seen any kind of -- when you compare it to other vaccines, the reactogenicity profile is very straightforward. There's no adjuvant or anything else that might cause the vaccine to cause more discomfort.

And then the other piece is, which is obviously important for providers, that it's very easy to administer. It is a lyophilized vaccine, which means that it's made as a powder and then you reconstitute it with a liquid to administer it. And the way that we do it is we have a special adapter that we've used for other Pfizer products and works well to link the 2 pieces together so that you can then reconstitute it. So there's none of this kind of playing around, stabbing things with needles and pulling things up and down with needles. So it's much, much simpler than the traditional reconstitution approaches. So we think that, that makes it a much more user-friendly vaccine as well.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

So when you think about the drivers for a vaccine adoption, I mean, this is a newer market for vaccines, what is more important? I mean, like, there's physician and patient preference as well, but how much contracting plays a role here? Because I mean, contracting is one area where, we saw with Pfizer COVID vaccine as well, you really did well. So how much does this play a role here?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

So -- and I'm not in the commercial organization, but obviously, we have a very strong commercial organization. A lot of the COVID contracting was done through governments, but -- and we certainly have experience with global contracting of vaccines and other products. We've had Prevnar in doctors' offices for over 23 years now.

And with the RSV vaccine, it provides further obviously opportunities to expand our footprint in pharmacies as well, and we're currently distributing the vaccine across different pharmacies in the U.S. It's being taken, and we're looking forward to seeing the effect that RSV vaccination has on reducing severe RSV disease.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. This is helpful. Maybe moving on to flu -- I'm sorry, I have a lot of questions here to go through. Sorry about that. Thanks.

So moving to flu vaccine here. I mean -- so Moderna ran into an issue with their Phase 3 studies, and they talked about differences in prior immunization history in southern hemisphere that led to not meeting the noninferiority against the B strain. What -- like, how are you thinking about that? What can you do to mitigate that? And what is the difficulty in driving the responses to B strains?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

So there's two ways to license a vaccine. So I'll start with that for flu. One is to show noninferiority against an existing vaccine, and I think that might be what you're referring to. The other is to do an efficacy study. So when we looked at our early-stage results for our flu vaccine, what we saw was very, very strong A responses that were improved from the standard of care. Our B responses were kind of similar, maybe a bit lower than the standard of care from the B cell perspective.

But from the T cell perspective, we saw extremely high and robust T cell responses. T cells are associated with protection against severe disease and also memory. And so rather than go into an immunogenicity study to look for noninferiority, which other companies may have done, we then went and did an efficacy study so that we could really determine whether or not those T cell responses were going to have a contribution towards efficacy.

So we started that study last fall, and we conducted it in the U.S. The U.S. had a very low incidence of B strain disease. And so we continued it into the southern hemisphere. The study is ongoing. It's blinded, so I can't tell you how it's doing. But later this year, we should have more news that we can certainly share.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. And when you think about the efficacy of flu vaccine with an mRNA approach, how do you think about what is the bar? Should it be similar to other protein-based vaccines or should it be higher because a new modality?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

So current flu vaccine efficacy isn't very good. You're looking at between 20% and 60%, and that's overall. So if you look into certain populations such as the elderly, the efficacy some years may go down. And there's a number of reasons for that. Most flu vaccines are made in eggs. It's a long, slow production process. So if you're in a situation where a vaccine's -- infectious strain changes during the year, you can't keep up with it, yes. So essentially, the flu vaccines declared in February, and essentially, after that, they're then made ready for the winter season. So it's a long process.

RNA vaccines have the ability to be made in 100 days. Yes, we've shown that with COVID. And so there's more flexibility. You can wait until you actually pick a flu strain as opposed to having to do it early. So if you see changes, you can maybe adapt with that pending WHO and other authorities making that decision.

Also, flu vaccines are made in eggs. And so think about a virus, yes? So virus made in an egg will look different to a virus that is made during infection. And so by making and using an RNA vaccine, you have a much higher likelihood of having a vaccine that's displayed in a much more similar way to how it's displayed during infection, so you can get better antibodies. So there's a number of reasons why an RNA vaccine could be superior to a traditional vaccine before you even look at efficacy. So I think there are ways that the technologies differentiate.

And when you think at the end of the day, a lot of people don't take flu vaccines. You have 50% of the population take flu vaccines and the rest are like, well, flu is not that bad or the vaccines don't work or it's okay if I got flu.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

(inaudible).

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

Yes.

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

Sorry, just -- Mohit, maybe to add to what Liesa is saying because I think this is a key point that sometimes people miss, is that she talked about the benefit of being able to choose the strains later, perhaps more accurately as a result. But the key point here is in both the northern hemisphere and the southern hemisphere, the strains we used in the mRNA construct were exactly the same strains that were chosen back in February, for example, for the northern hemisphere and the southern hemisphere at the appropriate time. So we -- this is not going to test that advantage. So any advantage from that would, of course, hopefully be additive to that.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. This is helpful. Maybe moving on to pneumococcal vaccine, actually. Where do you go from Prevnar 20 here? And I know Merck is talking about their 116 program as well. How much benefit that one provides? And how does Pfizer continue its competitive advantage going forward?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

So thank you for the question, Mohit. So we've been in the pneumococcal conjugate vaccine business now for 23 years, and we've led the field, yes? So we started with a 7-valent vaccine. There was competition at the time, but we were the only ones that came through and really set the stage for not only pneumococcal vaccines but also kind of the concept of premium pricing for vaccines.

We then went on and did the 13-valent vaccine, again, heavy competition, which we were able to again maintain dominance in the market. And now we have the 20-valent vaccine. And we're not certainly saying, okay, we're done. And we haven't said, oh, we're not done. Maybe we need to do something.

We've spent many years looking at what are our next steps after the 20-valent vaccine. And so we're actively working on our next reiteration of the pneumococcal vaccines. We're not ready to talk about it today, but we certainly will be talking about it later this year. But needless to say, we're the leaders in pneumococcal conjugate vaccines. We have vaccines that provide the broadest coverage against devastating disease for both older adults and the very young. And we're looking forward to maintaining our leadership, bringing new innovative vaccines that are going to provide protection to the most vulnerable of our populations.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. So again, one question we get a lot is like, I mean, right now, you are selecting -- for flu vaccine, you're selecting 6 months in advance. How important it would be -- like, how differentiated it could -- how big a differentiator it could be that you're choosing a strain only 90 days in advance of the flu season? I mean how -- can you help us understand that advantage?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

Yes. So it's not so much that we would be choosing to change the flu strain. So I think about it in terms of the WHO makes a decision on the flu strain very early. It gets ratified by different countries and governments. But then sometimes, there's a strain change, and there's nothing that can be done about it. Yes. So by having technologies where you can actually change the vaccine and implement new vaccines, that's where the advantage is and the fact that if the WHO were then to see that the choice was wrong, which sometimes unfortunately, it is, there's an option to introduce another vaccine later on in the flu season.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. This is super helpful. Maybe moving on to the Internal Medicine side of it. So let's just start with migraine here. So when Pfizer acquired Biohaven -- or Biohaven is still there. But Biohaven is a migraine program. The idea was $6 billion peak sales. I mean that was the -- like have you talked about how you think about splitting -- split of that $6 billion between NURTEC and Zavzpret spray? And how do you see that growth coming? I mean it's just like the market itself is growing? Or how do you think about that?

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

Thank you, Mohit. So maybe I can start by answering your last question, and then I go to the first one. We do see that this market can grow 6x between now and the end of the decade. And the reasons why we believe that are basically 3. The number one is we believe that there is going to be more and more penetration of oral CGRPs, and oral CGRPs will challenge generics, meaning triptans and topiramate, as the standard of care. When you see the efficacy profile, when you see the really, really positive tolerability profile, we see more and more physicians and patients adopting that.

We think that, that is going to be discussed more and more in medical societies. When you see the balance of what patients get today with a triptan, which have good efficacy, but for many patients have to deal with a lot of side effects. And you compare that to oral CGRPs, we think that we have a fundamental advantage basically for patients. That's one source of growth.

The second one is coming from PCPs' engagement and penetration. And I think that the fact, the data point there is today, 60% of the triptans prescriptions are coming from PCPs. Only 30% is -- of oral CGRPs is coming from that same group. And we are working -- and a big part of our strategy was to actually double the size of our reps and the educational effort on those physicians because we think that, specifically, NURTEC ODT has a clear competitive advantage being the only oral CGRP that has both acute and prevention indication. It's very simple. The drug is very clean if you want, and it's very easy to adopt for a PCP. So that's the second source of growth. And we are currently investing heavily on that.

And the third one is, basically, we'll continue to invest in allocating and creating more awareness. And we know that there's 1 billion people suffering migraine. And we also know, based on research, that there are many, many patients on the sidelines. For many years, they have dealt with this disease, and they basically think that they need to live with that. They have tried some of the available standard of care, and it hasn't worked very well for them, and they're in the sidelines. And we -- a big part of our mission is to go and tell that there is hope, and I always talk about that because I am a patient myself, and I was in that situation. I suffer migraine and for, like, 5 years, I said there's nothing to be done until I discovered this new drug and this new medicine, and it was life-changing. So these are the 3 sources of growth.

Your first question was NURTEC versus Zavzpret and how do we see that. We think that NURTEC ODT will continue to be the foundational treatment. It's the only CGRP with both acute and prevention. It's very simple to use, and it has a broad range of uses. So we'll continue to promote that. We'll continue to allocate, as I was mentioning.

And we think that Zavzpret can be a perfect complement to NURTEC. If you remember, migraine can be treated acutely to abort an attack or you can prevent that to reduce the number of migraine days. The only molecule that is approved for both is NURTEC. Zavzpret is only approved for acute, but it's very suitable for patients that cannot swallow, they cannot take a medicine because it's the only intranasal CGRP. And that's a big benefit. And also, it has been seen that it has a very rapid onset. So if you wake up with a migraine, Zavzpret could be a very, very good treatment for that type of patient.

And when you style a little bit the profile of the migraine patients, many of them unfortunately need to work with what we call a toolbox. Sometimes not only one medication is enough. And that's why we think that Zavzpret can be a perfect complement to NURTEC for so many patients and also a perfect complement to many other migraine treatments available in the market.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. Got it. This is very helpful. That actually -- you answered like 3 or 4 questions in one shot. Thank you for that.

Maybe moving on to the obesity franchise, obviously, slash diabetes franchise for you. Danu has shown really interesting data, at this point, like mid-single-digit percentage growth. So how do you think about the competitive profile of this oral? And then like if you compare it to Lilly's oral, orforglipron, it's kind of like close to 15% at the highest dose and it's once a daily pill. So just think -- like, let us discuss a little bit about the competitive profile of the drug compared to what is out there in the same time frame?

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

Sure. So I cannot comment on orforglipron because there's no head-to-head study, but we have the data and we see it. So what I can share with you is that what we know as of today for danuglipron is only based on type 2 diabetes Phase 2 trials. And as we speak, we are running our Phase 2 in obesity. So our main strategy is to wait until we see that obesity trial that will read out by the end of the year. And once we have the totality of the data of the 3 trials, we'll be able to inform, hopefully, our Phase 3 decision and strategy moving forward.

A couple of comments about how we designed and how are we pursuing this obesity trial in comparison to what we know today with the type 2 diabetes for danuglipron. There are 2 fundamental differences, which are in the dosing schedule and also in the duration of the trial. For diabetes, for type 2 diabetes, we went up to 120 milligrams. And in this study, we are going up to 200 milligrams.

The other thing is on the type 2 diabetes side, the duration was between 12 and 16 weeks. Now we are going between 26 and 32 weeks. When you add more doses more time, it is likely to expect that we should be seeing some impact on efficacy in terms of weight loss, HbA1c reduction and so on and so forth. So that's an important thing to consider. I think that the other factor that it's important to consider is that this oral treatment can be taken with food, and the available treatment today has significant fasting restrictions.

And finally, one thing that we are doing with this obesity trial is we are testing very different titration schedules because -- and that's why we want to wait until the end of the year when we have the data. We are expecting that by phasing out and having more time for the patient to adopt the medicine and titrate up, we can see more tolerability with good level of efficacy. And we think that, that -- again, totality of the data will allow us to inform us, together with the already finalized type 2 diabetes trials, the best decision moving forward.

The last thing that I want to comment is we are also exploring the opportunity to develop a modified release formulation. And pending the results of the readout by the end of the year, should we decide to do that, we are very confident that we can progress that into the clinic.

Why we are trying to -- or exploring to do that is we don't know about this specific drug, but we have seen in other molecules that when you do that, you reduce the impact of that drug in terms of the gastrointestinal effect. And we know that particularly for this class, that is a big issue. So that's why we are exploring the possibility of having a modified release formulation.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. And from a manufacturing point of view, is this easier to -- is it a pure small molecule? Is it still peptide-based drug?

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

Nonpeptidic, it's a true small molecule.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Okay. Got it. Got it. Do you have any thoughts on developing a portfolio of these medicines in diabetes, obesity? Or this is the...

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

Again?

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

A portfolio of multiple drugs because, I mean, there are other companies like Amgen, like people who are not known and Lilly they're trying to develop a portfolio rather than just one asset. I mean you had 2, but again, one had safety issue. But how are you thinking about developing a portfolio there?

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

Yes. We can clearly see some companies that have a portfolio. In the end, I think that it will depend on the clinical benefit of each drug. And we do see that this is going to be a very sizable market, and there's going to be opportunity for many different types of drugs. We don't believe in the one-size-fits-all because when you think about, there are so many different types of patients, so many different needs in terms of weight loss reduction, in terms of the different tolerability profiles from the patient. So we celebrate and we know that it's going to be a highly competitive market. But at the same time, we believe that there is going to be space for many different types of treatments.

And we have seen that there are good news recently in terms of having cardiovascular outcomes, different levels of efficacy from different combinations, monotherapy. We think that, that is good because it's going to be good for the patients.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Do you think having those data helps with the reimbursement? Because we are hearing both sides, we know payers are still even more skeptical or more -- like, challenging it more that, we don't want to cover it, versus -- because now they are worried that it will be even bigger market than they thought before.

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

Well, we definitely think that it's great news for the patient because for many years, there was this conversation between, is this a lifestyle issue or this is a real health care issue? This study that was recently published demonstrated a 20% relative risk reduction. That is amazing. It's showing that these patients are dying less from cardiovascular disease, heart attack, stroke, so it's great news.

We definitely think that this will create some new pathways in terms of access, accessibility and will shape the conversation. I think that you cannot hide the data. And at Pfizer, we follow the science. In this case, the science is there. So in any case, we believe it's a very positive event in this marketplace.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. One question we get a lot is like regarding anticoagulants. So you obviously have Eliquis there. All the other players in this space, they're all continuing with something else, like factor XI. So Bayer is there, J&J is there, Bristol is there. Pfizer decided to scale back. I mean can you -- like do you have a plan to continuing that in a year? Or like what is the thought process there to not do anything in that space?

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

So the way that I would respond to that question is we are constantly evaluating every development in this area and specialty. We have a huge legacy in the cardiovascular and metabolic area. So definitely, we are interested, and we are following, again, the science.

I think that the main driver for us to pursue factor XI, factor XIa, it's how breakthrough can that drug be. And I think that until we don't see that breakthrough component, we are waiting and seeing and hopefully expecting that, that will come. So far, the projects that we have assessed, we didn't see that breakthrough potential. And that's why -- the reality is that the NOACs or OACs came to really solve a big, big part of the problem. And we are still seeing how many, many more patients are being prescribed for the first time on Eliquis. Actually 7 out of 10, every new prescription is going to Eliquis. We keep growing market share, getting patients from warfarin. So definitely, apixaban is the standard of care in the category, and we expect to continue to grow.

And even after LOE, we have seen for other molecules, and we expect the same in this case because we are already facing LOE in some emerging markets and what we call solo markets where we have exclusivity, where Pfizer is alone. And those markets continue to grow after LOE, and that represents around $1 billion. So we expect that to be a significant revenue contributor even after LOE.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. Got it. This is helpful. Maybe going back to the vaccine/COVID part of it. So at the earnings call, it was mentioned that if COVID sales do not -- or come below expectations, there could be some cost cuts to think about at some point. Do you -- so like how would you think of it -- it'll be -- if it happens, would it be specific to COVID? How are you thinking about it?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

I think we're a large company, and we're always looking for ways that we can do our work most efficiently. We're coming up to the next COVID season. In fact, some people would say it already started. We're looking forward to a potential approval of the next vaccine, the XBB.1.5. There's an ACIP coming up very soon, which hopefully indicates when we'll get that approval and we'll be able to start rolling that vaccine out. We presented data at the VRBPAC earlier this year, just to show how the vaccine did preclinically against XBB.1.5 and other variants. And it was much better than the bivalent vaccine, and we continue to monitor variants and show that the vaccine, the XBB.1.5 vaccine is the better vaccine to neutralize some of these new variants such as the 2.86 and others as far as the neutralizing capacity. So we're very excited about the data that we're generating with our vaccine, and we're looking forward to a potential approval and recommendation so that we can make sure that the vaccine is available to those who need it in the coming season.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. That's helpful.

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

With regards to cost cuts, Mohit, as Dave and Albert alluded to on the last call, let's see where the fall COVID revenue realization comes out to and what that implies for future seasons. And then we'll be in a better position to talk about what kind of cost cuts would be appropriate as a result of that.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

One question I want to ask about the BCMA bispecific. So I know Pfizer last year, December, you guided for $4 billion opportunity there. The field is very competitive. So how do you think about the competitive positioning versus the other BCMA bispecifics and then eventually CAR T as well because, obviously, CAR T is going to be a big player later on.

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

Yes. So I'll take that question. So we're very pleased that ELREXFIO got approved a few weeks ago. We think it's an excellent product, not just within the BCMA bispecific space but in general, in the multiple myeloma space. So we're very excited by the attributes of the product. So for example, it only has 3 days of hospitalization versus the other BCMA bispecific, which has 6 days of hospitalization in its label.

As you know, the majority of multiple myeloma patients are treated for -- are treated in community centers, nonacademic myeloma specialist centers. So they're not transplant centers. So this is a very binding constraint for them, hospital bed time. So reducing it in half is a big advantage.

We have fixed dosing. We have very simple dosing. We have weekly administration that goes to every other week administration after 26 weeks. And we hope in other trials to get that potentially to even longer dosage windows. So you see there are a number of ways that make the product very friendly for the users and for the patients.

And then in terms of the efficacy as well, we see very, very low rates of side effects, including severe ones like CRS or ICAN, which is very important for a whole host of reasons. So those are very well controlled there.

And the part you don't see yet, which is the part that will be evolving, is how this can be used in combination. Obviously, multiple

myeloma has a number of different backbone regimens, and we've started to generate data already with some of those different regimens. And the data we've seen so far suggest that it can be used very successfully with them. We've already started our frontline trials. We are going to have trials in transplant-eligible and transplant-ineligible patients using common backbones there. So that's an important part of it.

And then there will be more work that we'll be talking about increasingly with novel backbones with ELREXFIO. So stay tuned. There's a lot to come there. So you've only seen basically the tip of the iceberg above the water for that $4 billion. You haven't seen most of the story yet of how we're going to get there.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Got it. So one last question for both of you. Fast forward one year, September 2024, I hope you're all here. I hope I'm here. What would make you very happy looking back one year and you'll be like, this was a great year for us?

Annaliesa Anderson ***Pfizer Inc. - Senior VP & Head of Vaccine Research & Development (R&D)***

So if I can start. So for vaccines, by the end of the year, we're expecting to have a total of 5 approvals. No vaccine company has ever done that in recent history. And these vaccines are all targeting severe infections with high medical impact. And so from my perspective, this time last year -- next year, rather, we have the maternal vaccine now for RSV, thousands of patients die every year globally from this disease. And so to have an impact on that, I think, will be very exciting.

As well as our end of the year, we're looking at approval potentially of our pentavalent meningococcal vaccine. Many people take -- children have meningococcal vaccines. And often, parents don't fully understand that there's different types of meningococcal disease. And so there's a lot of confusion around whether or not the child has had all the right ones or not. And so to have a single vaccine with the ACWY and the B together should have prospects of reducing that confusion. And when often sadly, you hear that someone has died, for example, of meningitis B, the mother is like, but I thought my child was vaccinated. And so to remove that from society, I think, would be very, very important as well.

Rodrigo Puga ***Pfizer Inc. - U.S. Commercial and Global Business Lead for Internal Medicine***

In my case, I'll briefly talk about 3 things. For Eliquis, I think it's one of the most successful medicines in recent history in terms of small molecules, and we have been able to help 10 million patients in 10 years. But the mission is not yet accomplished. We know that only in the U.S., there are around 3 million patients that have nonvalvular atrial fibrillation and are either undiagnosed or untreated. And we have a commitment to find every patient because they deserve it. Many of those patients discover their disease once they face their first stroke, and that is not acceptable. So I would be very happy if we can find a big, big proportion of them next year.

I think that regarding migraine, it's so incredibly positive to have the opportunity to bring hope to patients that are on the sidelines, and we are working on that. We have a new campaign with real patient stories, and Lady Gaga is a true patient talking about migraine. And we are sure and confident that, that will bring many, many more patients to start treatment with NURTEC ODT.

And then September next year, I would like to see that we have a very robust Phase 3 program for our danuglipron GLP-1. So that will be my answer.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Awesome. On that high note, thank you very much. Really appreciate you joining us.

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

Thank you, Mohit.

Mohit Bansal ***Wells Fargo Securities, LLC, Research Division - Senior Equity Analyst***

Thank you, Chris.