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EDITED TRANSCRIPT

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OVERVIEW:

Company Summary

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CORPORATE PARTICIPANTS

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

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

CONFERENCE CALL PARTICIPANTS

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

PRESENTATION

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

So delighted to introduce Mikael Dolsten. Mikael is President, R&D, Chief Scientific Officer. Did I miss any other title?

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

You did it very well.

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

That's it. And also Chris Stevo, the Head of IR; and then we have several other members of the Pfizer team with us today. So obviously, there's a lot of change going on -- oh, sorry, forgive me. Chris is going to make some opening comments. Then he's going to pass it to Mikael. Then I'll ask the question.

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

So this is going to be very scintillating and interesting for all of you. I can assure you of that. In the course of this presentation, Mikael might make some forward-looking statements. If we do, these forward-looking statements are limited in their validity only to today. And if you have any further questions about forward-looking statements, please see our SEC filings under Forms 10-Q and 10-K. Thank you.

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

So I just thought I'll start up by saying I think 2023 is turning out to be a very strong R&D year for Pfizer. Thus far, we have had 9 approvals and we expect another up to 6 to come. And the 9 have included some really exciting products like PCV20, the pneumococcal vaccines for pediatrics; Abrysvo, the only RSV vaccines with 2 approved indications, older adult and maternal vaccination; LITFULO, a novel TYK inhibitor with some transient JAK activity for alopecia and in the future opportunity (inaudible) so our bifunctional antibody for myeloma.

And the more to come include products that are in the later step of registration like etrasimod, a new oral agent for inflammatory bowel disease, pending final regulatory step; a pentavalent pneumococcal vaccine could also be the first one, where you consolidate vaccination of the various ACYW and the Bs; XTANDI in the most early line of prostate cancer, the nonmetastatic hormone since, the full reach to prostate cancer patients; and XBB.1.5 that we're eagerly waiting for the new updated Comirnaty 2023 to '24 approval.

In addition, we have a few really intriguing readouts that I'm looking forward to. As I spoke about vaccine, I can't resist, of course, to look forward to concluding the flu vaccine study, now ongoing in the Southern Hemisphere. I think we and other players have been seeing considerable flu, but very few, these 4 globally flu B cases. However, our immunicity thus far that we reported has been very robust, particularly for the A, which is the dominant strain. So we look forward concluding that study.

We have GBT601, a new powerful drug for sickle cell disease that are going to have a readout.

We have the oral GLP. We have our DMD gene therapy that we have said could report some interim data that could lead to acceleration year-end or otherwise finalizing the study mid of next year and our EZH2 inhibitor for prostate cancer. So I hope you got a sense. This year has had a good start and it has a good rhythm of more to come.

QUESTIONS AND ANSWERS

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

Well, thank you for those words of introduction. And thank you also for doing this panel today, because many of you may not know that Mikael endured about 2 hours of questions from me over dinner last night at an investor event. So it's very good for him to come back for a round 2. So the risk of some things we obviously touched upon last night. This is a pivotal year because obviously, you've made your first major transactions for many years with the acquisition of Seagen. There's also been a significant change in the structure of Pfizer with you separating Oncology and going straight into you and Albert.

So perhaps you could talk to how that reshapes and what you're trying to achieve with all of this. And then within that, yes, with Seagen, you want the existing approved assets, the pipeline technology as a link, as a conjugate, but also you want the people and the talent. So to what extent -- because obviously, all of us have seen transactions where the talent goes once the company is acquired. Are there lock-ins on the key talent within the organization? Or you're just reliant on individuals hoping to buy into the Pfizer culture?

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

This is a great question for the ongoing integration planning and pending close the future combined company. I think the structure that we have chosen very much sets us up for success. On one hand, we have gained a lot of experience particularly, of course, during the pandemic era where we already had a vaccine-organized end-to-end. And we could see, as you run trials, passed from early to late stage, as you have a portfolio with increasing opportunity for product combinations, as you have new platforms. And end-to-end organization gives you that oversight and opportunity to take fast decisions.

Now we thought it was time to do that in Pfizer Oncology as it has grown and become a very large pillar of our both R&D and revenues. Of course, with a view of a Seagen closing deal pending final clearance, it also adds very nice that it captures that biotech spirit of Seagen being an organization focused only on oncology and now being part of an oncology R&D group that can have that focus and allow the talent to feel that they continue their journey in that mission-driven, purpose-driven part that made Seagen so successful.

And of course, it's not like they're completely separated. Pfizer R&D will continue to provide support in designing small molecules, in designing antibodies

(technical difficulty)

which is the dominant place where Seagen has facilities. We will become next to Microsoft and Amazon, the household names. And I don't see a lot of staff going to Amazon or Microsoft. So I think that we'll really see an opportunity to even flourish more than in the past without needing to disrupt their life.

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

So maybe turning to autoimmune because we'll come back to Oncology in a second. And Pfizer, starting with Xeljanz now recently with your JAK and TL1A portfolio, has been a leader in that field. Could you talk to something which I know you're very interested in which is bispecifics or

trispecifics or you have the TL1A p40. Maybe you could talk to the potential of that project, where it is to the extent it can raise the bar whilst not showing an acceleration in safety profile compared to the naked TL1A and the existing treatment options for UC and Crohn's. So just talk to the next generation because I think there's less awareness of that than there is in your JAK portfolio.

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

Yes. I mean clearly, we spent a long time trying to design bi and trifunctional antibodies, but preserving the properties of really good antibodies, potency being recognized as fully human agents with good activities and ability to deliver them with ease in a subcutaneous formulation. And we have now been able with ELREXFIO to get the drug approved based on a bifunctional platform.

We have, for some years, been applying it also to immunology and inflammation. And we have both bifunctional, which is what you spoke about TL1A p40. I think we and Prometheus demonstrated that TL1A is another part of TNF family with really robust efficacy and good tolerability. We added on the p40 arm that has proven activity in inflammatory bowel disease. So I see that as an additional step, not necessarily need to be instead of TL1A. And I think we and Roivant and Telavant, the particular subsidiary, have developed a great way to work together. And for us, it allows us, at the same time, to pursue other programs, having them given R&D funding, and that included a reason to be launched pending final registration here for etrasimod. That will also set us up for success a few years ahead, building up our -- or expanding our presence in ulcerative colitis, where we traditionally have been present with Xeljanz.

On the trispecific, we have established ourselves in atopic dermatitis in the oral segment with CIBINQO. We have clearly noticed the success of antibodies such as dupilumab in these patients and broadening into many allergic conditions, including different respiratory condition, asthma, COPD with activity. So now we have designed more potent with more binding breadth than that type of first generation of very active molecules. So we have high potency IL-4, IL-13; and the third arm in one agent is T cell P, that has also in clinical studies shown good activity in allergic condition or IL-33 that seems to have been involved in part of the symptomology, including each in allergic conditions.

So we see this as an opportunity in the trials we are now running after having concluded favorable PK studies, now moving into patients to really replicate what we did in Oncology with ELREXFIO, move very fast with mechanisms that are likely to be highly active and to bring treatment targets to a new level in allergic or inflammatory respiratory or gut conditions.

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

And we'll see the Phase 2 data from them in which year?

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

I think we'll get some data already next year. That will set us up later for decisions into Phase 3 shortly thereafter.

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

So flipping back to elranatamab, which I've been practicing pronouncing without stuttering. Could you talk to how you intend to see share in what's an incredibly competitive market. J&J obviously has a subcutaneous BCMA approved. Yours has a slightly more favorable dosing schedule. Maybe, maybe the CRS is a little bit less. But the treatment momentarily is looking like it may be moving to combination antibodies with GPRC5D or we've got also the cell therapies and so on and so forth. So given you have a single agent, although it's a very big market, how do you manage to carve out your mind share, market share in this setting?

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

Yes. Given the drug is now approved, we think it will -- the broad class, the first 2 that are now going to be increasingly tried in the triple-class refractory or penta-agent refractory myeloma. I think the activity of bifunctional BCMA antibodies is so profound that it will be the first choice and displace cell-based therapy to a more later stage. So I think you will see long-lasting, high response rate already visible in our reported dataset for registration and approval.

And we are now running numerous studies to move into what we call double-exposed patients or patients that are in the very first line of treatment, either compatible with transplant or not. And what we can see is that a bifunctional antibody seen in general to combine very well with either CD38 or some of the other oral agents that are used.

Of course, there are 3 classes to combine already, and some of them are going off-patent, which is favorable for the patient and health care system. But there may be also novel combinations, and one that we feel intrigued about is the maplirpacept or the TTI-622 agent from Trillium that we acquired. That is the only CD47, to my knowledge, that have shown single-agent activity, and we have become increasingly confident that it can achieve a good clinical activity without causing meaningful anemia removing red blood cells, but being sparing. So we think it's a unique agent. That is one of my first on the list things when I discussed with Chris Boshoff what I'm excited about.

But I think also pending close with Seagen, it's intriguing to see how they have been successful in blood cancers with ADCETRIS. And I think there will be ability to look together on things that we could do together to become a really strong combination player here. So I'm optimistic that this drug class will be very prominent and that we will see a lot of new combinations and leverage a combination that are now starting to go off-patent to keep very favorable health economics for patients and the health care system.

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

So if anyone has a question in the room, please raise your hand. Happy to take it. Let's just segue to metabolic disease and danuglipron. Now you obviously had 2 compounds and the first one, you terminated through to have better tox -- or the second one you terminated, the first one, you are looking at reformulating as a once daily.

Could you just talk to a couple of things? So number one, if the option of reformulation for danuglipron was already on the table, why invest the time and bandwidth in prosecuting the second compound, which blew up? Was that because you didn't believe at the time it was going to be so straightforward and now you do?

And then second, in terms of the timelines in the registration and the launch strategy, it's clearly important because Lilly is somewhat ahead of you. So what exactly are you going to be taking into Phase 3? Do you bridge whilst you're doing the Phase 3 to the once daily so therefore, you can enter the market at a similar time?

And then the last question is your molecule, I think, is a full agonist. The Lilly one is a partial agonist. Could you talk to what that means in terms of either efficacy or tolerability and the evidence to support that? So whichever part of the question you want to take.

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

Well, you very skillfully put in a whole book chapter into that question. So I'll do my best to respond without being too lengthy. Well, first of all, obesity diabetes and the GLP drug class currently standing in particular on the injectable delivery system is a very large market. And I think our presence is particularly a focus in contributing to making this drug class oral and by embracing combination of the future as oral drugs as we see multi-active peptides being used for various patient segments.

So we are quite excited about that journey. And danuglipron data will read out later this year. And it's been in 1,400 patients, so we feel absolutely convinced that it does not have the type of adverse events that, unfortunately, our other oral GLP had. And it really will be to look at the overall

integrated profile of that drug. The thing we have made progress gradually and more recently, is to be able to advance our modified release capabilities. And we had really made that platform much better today than it was a few years ago.

So we have some very sophisticated modified release systems that can allow you even to incorporate starting with one molecule like danuglipron being BID and turning it QID with a sustained level rather than the peaks, which we are looking forward with intrigued eyes to see if that can also attenuate some of the nausea and vomiting that the drug class of GLPs are associated with.

And that MR once-a-day option that now has opened up for us could also be a platform for adding other drugs into it. So we will look forward to the danuglipron data end of this year or late this year and then make a decision on that. We have a significant metabolic portfolio, including obesity agents that will come over a period. Next year, we have a readout of our DGA2 in NASH.

That's an area that I think coming back a bit as the focus on obesity has increased and many of those patients are suffering from NASH. And I think for us, we see an opportunity to leverage this oral approach, obesity to NASH to diabetes in the future, because we have been a strong company in the cardiovascular arena and we're trying to transit that into metabolic. But staying more focused on oral (inaudible) work by Lilly and Novo Nordisk has been very successful with injectable.

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

So you'll be initiating all being while the Phase 3 with the twice-daily danuglipron, correct?

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

I would put it like this. We'll review the data. If we would take a decision to progress, I would see that a target profile for us would be once daily. And I'm feeling that the type of technology platform we have today, which we didn't have a while back, will allow us to make drugs of this type with high probability to once a day. And that's really some technical improvement we have done. So that would be the target profile as we would possibly conclude Phase 3 with a drug like danuglipron.

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

Skillfully answered. Partial versus full agonist and whether that pharmacologic difference translates to a different clinical profile.

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

I think it's just too early to know. We'll look at the dataset and try to have very sharp eyes to see what could be differences. But in general, we have liked to have full agonist. And now it's a real opportunity as the orforglipron data is available to learn from this and incorporate that in our plans.

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

And your GDF15 antagonist, which you know I care a lot about and we've spoken much over the last 12 months or so. It seems like the appetite of Pfizer has waxed and waned over the years. Could you just update us on the levels of internal enthusiasm, commitment to this now? And where the key focus is given there are regulatory uncertainties that need careful thought and planning?

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

Since this is a continuation of treating body weights abnormalities or deviations, treating either those with obesity or those with cachexia, it's been an area that has grown upon us. And you look at body weight curve and look at long-term impact, morbidities or life span, you actually note that whether you have too low or too high body weight, you suffer from accompanying diseases and your life expectancy will be shortened.

So clearly, enthusiasm from you and others just ignites further our interest to participate in both ends of the obesity and the cachexia spectrum. I think there has been an increasing number of publications also that cachexia contributes to a fatal outcome in about 20% of cancers. It's associated in 50% to 80% of the cancers as a major negative factor prognostic, and many patients are unable to go through treatment unless they can deal with cachexia.

We completed a study that showed our GDF15 antibody led to quite a fast improvement in body weight and also, other patients reported very favorable outcomes. So clearly, our enthusiasm because of these many factors is now quite high. And we're looking at the readout from a second cancer cachexia study earlier part of next year. And it's interesting to notice that we have seen a really good enrollment in this study. It's indicating that the whole field is starting to be recognized as increasingly important as part of supportive cancer care.

And a vision could be that a drug, if you can make it really help with nutrition, body weight, ability to go through treatment, ability to be mobile for these cancer patients, you may be seeing a product as big as the growth factors that were established erythropoietin G-CSF in cancer, but now focusing on reestablishing a healthy body weight in patients suffering from difficult-to-treat cancer. So that's a bit our vision, and we are really encouraged about the journey thus far. I should say, it's not just cancer, but other chronic conditions: heart failure and COPD, where you have a substantial number of patients that are impaired because of cachexia.

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

So related but slightly different. Can we talk about development speed, risk appetite at Pfizer and how things could be further optimized? So danuglipron, you're clearly behind Novo, you're behind Lilly. IBRANCE, it took some time before it became the drug that it was, and there was several years that we've gone there. To what extent, when I look trying to be objectively, it seems that there's still a fair degree of white space for projects which ultimately tend to be important drugs where development speed and time to market could be accelerated?

And then second, could you comment on the risk appetite and one, companies are like humans that are impacted by what were before. And obviously, torcetrapib was many years ago, but it was a pretty heavy body blow. And so one wonders whether that and other similar failures have taken away some of the risk appetite.

Now obviously, COVID talks away from that because there it was -- but how do you -- do you think those observations are fair? Do you think there is additional work that is being done or can be done on taking out the white spaces? And do you think there is still any legacy of risk appetite? And talk to ways that you're addressing that calibration of not to overdo the risk, but also not to be cautious, overly aggressive.

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

I think you asked a very important question about culture in innovation companies, and there is a spectrum from risk averse to overly risk tolerant. And I would say that we currently are risk curious. We welcome to take thoughtful risks. And like you said, COVID showed it twice, where we found a way to shorten timelines drastically. And we are embedding that culture in our go-forward strategy, both when it comes to move things in parallel, trying new technology platform as well on new internal programs.

One example was the alliance we made with Flagship, where we are able to partner with them in looking at 40 of their companies, 20 of their different technology platform with the aim to co-create 10 new companies with new science to address big medical problem and particularly pursuing new platforms. So I think what you raised is part of the new Pfizer being risk curious just right on the spectrum because you need to be careful. There is a rise of new technologies and some collapse and then they become reengineered and are on a much more healthier path.

So you want to hit the perfect inflection point. And the deal with Seagen, I think, is another one. Right now is the era where a couple of companies that specialize in a disease, Seagen and Daiichi, seems to have reached that sweet spot of being able to pursue it in many different types of programs. So I hope you will see increasingly Pfizer being risk curious.

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

So turning to some novel platforms. Obviously, Pfizer is one of the leaders in mRNA through relationship with BioNTech on COVID and now flu. An area that I don't think you are currently active in, and correct me if I'm wrong, is mRNA therapeutic vaccines for oncology. Obviously, we've seen the Moderna, Merck data and the BioNTech, Genentech data in pancreatic.

Now yes, it's early or very early in either case, but the signals are quite strong and compelling for a significant unmet medical need and a platform that could go very broad indeed. Given that you have many of these competencies, what's the appetite? And Pfizer has a history historically of interest in cancer vaccines. So is this enough to get you reengaged?

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

Well, you never say never. So we always try to have an open mind and look at data and medical advances, in this case, in the cancer field using the mRNA platform. I would say, right now, we are prioritizing higher to use our mRNA resources to expand our vaccine portfolio and to deploy it possibly in common diseases for gene editing. So I spoke briefly in my introduction of mRNA for flu vaccines, which would allow you to mount both an antibody and a T cell response and may much better deal with the variability of flu.

I see that's an intriguing path. We also see opportunity to break into other areas where you can take benefit on the potency of mRNA, like zoster treatment that has turned out to be highly active herpes zoster but is associated currently with adjuvant side effects. And with mRNA, you really don't need more adjuvant than the product itself. And we're looking at numerous other -- more increasingly common respiratory viruses as we sought to diagnose respiratory diseases increasingly.

Now in gene editing, we have a collaboration with Beam and our particularly Internal Medicine group are looking at a few different indications, including some liver targets, some non-liver targets. So I hope we'll also be able to report advances in that field. And on top of it, we are looking at ways to augment the mRNA platform by itself, which could mean in cooperation of more different antigens like the sa-mRNA platform that we put some efforts into increasing durability, possibly circular mRNA. So expect us to add 1 of those 2 likely to our toolbox, and that includes working with biotech and major academic centers.

We have been a little bit more watched in the cancer vaccine, and while I welcome some of the advances there and it should be really acknowledged, it's still more of a personalized approach and when you incorporate a collection of mutated cancer antigen or neoantigens. And the question is how broad can that be, how much of a niche vaccination will it rather be? And will it similarly to CAR T that has been initially seen with a lot of enthusiasm now maybe being displaced by a functional antibody, multifunctional. So that's just where we want to be careful.

And also looking at when you deploy ADCs and combine them with PD-1s, like data of PADCEV and KEYTRUDA, you may actually generate immune responses to new antigens, because as you bring in immuno and cell death, you take away a checkpoint blockade. So that is another way to treat cancer and strengthen the ongoing immune response that necessarily need to combine almost person-specific or subpopulation-specific cancer vaccines. We are keeping an eye on it should area break. We may jump into it. But at the moment, we see bigger drugs coming from these other approaches I alluded to.

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

So before this session, I hosted a similar type as the conversation we're doing now with a former colleague of yours, Phil Dormitzer, who is now in his new home at GSK. And they're talking about, obviously, their new strep pneumoniae drug, which is on the MAPS platform through the Affinivax transaction. And the vulnerabilities of increasing serotypes with traditional platforms, particularly for the #3 serotype, which is associated with

evasive, obviously, they are not the only competitor. You have Merck, you have Vaxcyte, you have Affinivax. To what extent do you believe that Pfizer has the technology to keep up? And do you think that the regulator has a similar understanding of the relationship between neutralization titers and incidents by the individual serotypes, which is going to translate into a differentiated label from either the FDA or recommendation from ACIP?

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

Clearly, the pneumococcal space has been a stronghold of Pfizer, and we have now 3 generations of pneumococcal vaccine from PCV7 around year 2000 to 10 years later when we started to introduce PCV13 and more recently, PCV20. And each time there were various competitors sitting with Andrew Baum or his predecessors, being optimistic, but none of them really has played a major role, whether GSK, the last time when they're working on a 10-valent or Merck with our current presence of a 15-valent.

So I feel pretty optimistic that the depth of our skills and the new approaches we're putting in place to even go beyond 20-valent for the future will allow us to be strong and prevail, whether in the infant or in the adult sector. So we have developed technologies that allow you to combine even more serotypes without paying a price on attenuation, and that includes more sophisticated conjugation chemistry, adding additional carrier to avoid carrier interference and for older adult considering mild adjuvants.

Finally, in -- when we launched PCV13 for the adult indication, it has 2 claims. One is prevention of invasive pulmonary disease and the other is for community-acquired pneumonia. And we run a large study in the Netherlands, where we basically vaccinated a whole region and were able to track cases, had unique assays to address them to each of the serotypes. And that led to a unique label for pneumonia, which is by far the dominant reasons of illness among older adults.

And that indication is transferred from Prevnar 13 to 20 based on that we have aligned conjugation experience, bridging with similar or identical assays. And so far, that has been a unique label that we have. And I think that will allow us that investment and knowledge to continue to have improved label versus others. And we continuously move new generation into the clinic. You will hear about that next year, and we are not concerned about adding more serotypes.

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

Using the existing technology.

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

Using new technologies. The ones that we'll introduce next year will be based on new technologies. The current technology did us very well up to 20 as we think about going another...

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

But it's not biosimulation, it's not like the MAPs spectrum?

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

It's not. It's based on one hand, as I said, refining the conjugation, making it even better. And on the other hand, we have seen when you do new carriers, not just [cream], you can allow the response to the -- some of the serotypes to be better and for older adult use of a mild adjuvant could allow also stronger responses. And I think what you were asking, could you get better responses also to some of the existing serotypes that maybe so far, none of the existing vaccines, some of them have been optimal. And that's something we are -- have made a lot of progress on, that to some of the existing serotype that protects but doesn't eliminate disease, we think we have cracked that nut how to address it. So that's why I feel it's

the same game, and we were victorious with PCV7, 13, and I feel convinced we can prevail with the innovation experience and bring it to new levels of protections.

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

So staying with vaccines, as you pointed out, yours is the only RSV vaccine with approval in 2 patient populations. COVID vaccinations in pregnant women turned out to be a very sensitive topic. And here, patients and their physicians have a choice. It's not an insubstantial market. It's $1 billion, $1.2 billion. I mean it's a good size opportunity. How are you thinking what the acceptance of a vaccine versus a monoclonal will be in this patient population?

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

It's a great question. First of all, I think that having successfully concluded approval for 2 indications, older adult and maternal, creates a unique dataset and acceptance of our vaccines for both indications. Now when it specifically deals with the maternal, where we're the only vaccine available, we have the opportunity for seeing the patients or the person far ahead of any antibody. So in the U.S., from week 32 to 36, where there are 2 to 3 visits in the normal practice of pregnant women to obstetrician or their offices.

In Europe, we have an even wider window. And their health care system, similar, have multiple visits between 24 and 36. There will be an opportunity for a discussion. Do you prefer to have your kid protected from day 1 when it's born? Or do you want to wait and take the risk that you get an infection before you have had a discussion with your pediatrician that you don't know, you haven't met yet? I think that gives us a fabulous voice long ahead of the antibody dialogue. And I think there is now a strong tradition emerging with flu vaccination with Tdap. And we also have reported real-world evidence that many used our COVID vaccine in the pregnant state and that was associated with very, in general, favorable tolerability and protection for the pregnant women as well as possibly a birth acquisition of disease.

So I think it's a changing landscape. And finally, I would like to say, since you brought up COVID, we saw the importance of COVID antibodies initially. But when they were more broadly used, we saw terrible resistance because they are monoclonal. And that's different with a vaccine which is polyclonal, where that you don't develop devastating resistance. I think that would be a public health burden if you extensively use monoclonal antibodies, maybe not as fast as in COVID, but already now there are circulating RSV strains that show resistance to the type of existing antibody.

So I think there are individual reasons, there are population reasons, resistance reasons. So always for us, have a good serious dialogue about vaccination of the pregnant mother. We protect day 1 rather than wait when you have a very intense period post birth. That is my perspective both as a physician and having worked with this type of prevention approaches.

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

And Mikael, as you pointed out before that as we've seen with influenza, this is seen with COVID, there is tremendous advantage to having not only a prophylactic approach via vaccines but also to have a treatment alternative available as well. So as you know, we acquired ReViral last year, and we're very excited with their fusion inhibitor and how that's going.

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

That's a really nice add-on. It's one of the projects that we're reviewing now that could be entering Phase 3, the final stage for registration. Based on our previous experience, we're making great progress with it. And similar like we have had PAXLOVID and Comirnaty, we think to have sisunatovir, the RSV drug and have a maternal vaccination gives us a real good strategy for the future.

And I think also, we and others are moving the adult vaccination against RSV to younger adults and to pediatric sector. And gradually, you will see RSV vaccines also for the first phases of life. So I think there is a lot of opportunities. But for the preventing from day 1, I think vaccinating pregnant mothers is the preferred.

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

So as you take the age down below 65 into the younger patient population, I'm assuming that coverage is going to be under what, commercial, under Medicare? How does that -- and what implication does it have for pricing?

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

Well, I think we will see the vaccine commercially be established, and we should wait and see what happens there. I think in younger adult, there are options to vaccinate those that particular have risk groups, which are increasingly many, whether obese or either respiratory disease or cardiovascular disease.

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

Sort of high-risk subgroups.

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

I think in the younger adult, that may be the place. However, for the pediatric sector, we know that RSV can be very devastating. So there, I see an opportunity over time to see RSV vaccine part of the annual vaccination recommendations. So that's part of the vision where we would like to go.

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

And Andrew, sorry, just to your point on pricing. Just to remind you, any ACIP-recommended vaccine in the U.S. is available for a $0 out-of-pocket for anyone with insurance in the U.S., including government insurance.

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

I guess I was wondering, given -- assuming it was a broad, not a selected patient population, given the burden of disease from RSV is a very different proposition from some others, whether it would get an ACIP recommendation. And therefore, it may be a sort of self-pay vaccination.

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

And that's why I said in the younger adults, at least initially, it will be particularly focused on higher risk where we would see penetrants. And we'll see how RSV evolves as a disease, and risk groups for getting viral infections are increasing as unfortunate comorbidities and use of immunosuppressive drugs. But clearly, it's the youngest patients, the newborn in the first few years where you have severe impact of RSV and the older adult and some high-risk group in between. So ample opportunity to grow beyond these 2 initial indications.

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

So that seems a perfect place to stop. So Mikael, Chris, thank you so much for joining us, and thank you for the audience for the conversation. Appreciate it.

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

Thank you very much.