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PFIZER INC TO HOST PFIZER PFLASH A SPOTLIGHT ON IRA PART D REDESIGN AND ITS IMPACT IN 2025

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PRESENTATION

Operator

Good day, everyone, and welcome to Pfizer Pflash, a Spotlight on IRA Part D Redesign and its Impact in 2025. Today's call is being recorded.

At this time, I would like to turn the call over to Francesca DeMartino, Chief Investor Relations Officer and Senior Vice President. Please go ahead, ma'am.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Thank you, and good morning, everyone. I'm Francesca DeMartino, Chief Investor Relations Officer. On behalf of the Pfizer team, thank you for joining us for our fourth Pfizer PFlash webcast. Today's call will be recorded and will be available for replay on our IR website at pfizer.com.

As a reminder, our Pfizer Pflash series is intended to serve as an educational deep dive into our pipeline, products, and people. Each call will give you an opportunity to hear from and interact with our business leaders. Today's session will begin with a short conversation, followed by a live Q&A.

As a reminder, this call is intended for the investment community, including our sell-side analysts and institutional investors. If you're unable to join the entirety of the event, you can find the replay available on our website.

I want to note that on today's call, we will be making forward-looking statements. I encourage you to view slide 2 in our presentation and the disclosures in our SEC filings which are available on our IR website at pfizer.com.

Forward-looking statements on the call are subject to substantial risks and uncertainties, speak only as of the call's original date, and we undertake no obligation to update or revise any of the statements. With that, let's get started.

As you know, the Inflation Reduction Act, or IRA, has different core aspects that are expected to impact Pfizer's business performance. And as a reminder, in 2025, Medicare Part D redesign is expected to have a net unfavorable impact of approximately $1 billion on Pfizer's top-line revenue versus the prior year, which is already included in our 2025 guidance which we reaffirmed at Q4 2024 earnings on February 4 of this year.

Our primary focus today is to expound on the core underlying IRA Part D redesign changes impacting our business this year. We will outline the building blocks as we see them to bolster awareness around how we expect Part D redesign to impact our net revenues in 2025 versus the prior year.

But note that we will not be providing specific quarterly projections during today's presentation nor in the Q&A. However, as we have previously shared, the net unfavorable impact is expected to be more pronounced in the first quarter of 2025 and the second quarter of 2025 versus the prior year.

This is the second Pfizer Pflash broadcast of 2025. Before we move to the main discussion, let me take a moment to introduce our speaker and my colleague, Cecile Guegan, Senior Vice President and Head of Biopharma Group Finance.

Cecile, who reports directly to our Chief Financial Officer, is at the epicenter of our commercial product portfolio and the organization's ongoing efforts to navigate the intricacies of the IRA and other legislation on our business.

Cecile, welcome and thank you so much for joining today. Can you please start by introducing yourself and giving a brief overview of your current role and experience?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Good morning, and thanks for the opportunity to participate in today's Pfizer Pflash. For your introduction, my name is Cecile Guegan. I have been at Pfizer for over 25 years, which includes about 10 years at Wyeth before the acquisition.

I'm currently Senior Vice President, Finance, for commercial, both US and international. I have held this role for about three years, in charge of the commercial finance team globally, working very closely with Aamir and Alexandre to deliver on our business and financial priorities. I spent my career mostly in regional and divisional head of finance roles, including Senior Vice President, Finance, for R&D; as well as Global Finance Lead for Oncology.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Thanks, Cecile. To kick us off, can you remind us how the IRA is expected to impact our industry and then more specifically, the expected impact on Pfizer's 2025 financials?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yes. First, let me start by quickly summarizing the different components of the IRA to clarify what our discussion will be focused on today.

The objective of the IRA, as we know, are to reduce Medicare costs and improve patient access. The three key measures of the IRA impacting pharma companies are Medicare drug price negotiation, which in our case, will apply to ELIQUIS starting in 2026.

And as a reminder, IBRANCE and XTANDI are included in the IPAY 2027 list and are subject to pricing negotiations this year. New prices would only take effect on January 1, 2027.

Inflation-based rebates, which apply only when prices for certain drugs increase faster than the rate of inflation and for Pfizer is not expected to be material compared to 2024. And finally, IRA Part D redesign, which introduces a new manufacturer discount program and replaces a past coverage gap discount program, this is the measure we will focus on today.

Regarding our 2025 financial impact, as we have communicated as part of our 2025 guidance, with a Medicare Part D redesign, we estimate the net unfavorable impact to the company revenue to be approximately $1 billion across our product portfolio, dampening growth by about 1.6% versus 2024.

This expected $1 billion negative year-over-year impact represents a net amount between the expected unfavorable revenue impact of approximately $1.5 billion related to our annual manufacturer mandatory discount, partially offset by the expected volume benefit estimated at $500 million for the reduction of the patient out-of-pocket cap, resulting in increased affordability.

It is worthwhile to mention that we have calculated the estimated 2025 impact based on third-party actuarial analysis, leveraging historical patient drug utilization data. Overall, Part D redesign is expected to more acutely impact our higher-priced innovative medicine portfolio in specialty and oncology, such as VYNDAQEL, IBRANCE, XTANDI, and XELJANZ.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

You also noted that we should expect a higher negative impact on revenues beginning early in the year. Could you confirm?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yes. We expect not only an impact on the annual amount, but also on a phasing of our growth to net, with a higher gross-to-net impact on our revenue for most of our drugs in the first half of 2025 when compared to 2024, impacting our year-on-year and quarter -on-quarter comparison.

But it is then expected to moderate in the second half of 2025, and the volume and patient affordability benefit is expected then to materialize more fully in the second half of 2025 and partially offset the negative manufacturer discount impact. We can look into more details through a couple of examples to explain those dynamics.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Could you walk us through the changes from 2024 and why they are expected to have an impact on our revenues?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yes. What these charts are showing is how the contribution from the different stakeholders -- you note the colors with the manufacturer in darker blue -- have changed significantly from 2024 to 2025. I want to note that the phases as shown graphically do not represent the magnitude of drug costs. The chart is for illustrative purposes only.

It is important to consider the percentage noted on the charts are applied to WACC price, or wholesaler acquisition price. It applies to the cumulative patient branded medicine cost, not to each individual script or medicine.

Of note also, regarding the low-income subsidy or LIS beneficiaries. The chart in 2024 reflects the cost sharing dynamics for non-LIS patients, while 2025 captures all patients given that there is no discount distinction anymore with regard to the manufacturing rebates for LIS and non-LIS patients.

What those charts highlight is a shift in material in financial responsibility from patients and government to payers and manufacturers who are covering a greater share of the cost in 2025, especially for higher priced medicine. So let's start with 2024.

There were four brackets or phases, and the contribution was different in each of them. Out-of-pocket costs for the patient were approximately $3,200. Manufacturers were paying 70% during the coverage gap phase, but not paying anything before or after that in the catastrophic phase. And higher priced medicine were progressing quickly from the coverage gap to the catastrophic phase, where there was no manufacturer discount.

When we look at 2025, there are now three brackets, and the contribution has significantly changed. The out-of-pocket cap is reduced to $2,000. We will come back to that topic later in the presentation. But this out-of-pocket cap reduction, along with the option for the patient to spread or smooth cost over the year to as low as $160 per month via the Medicare prescription payment plan, is expected to enhance affordability.

As noted earlier, the other important change in 2025 is that the program is including LIS patients, which expands the pool of patients covered under the manufacturer discount program. You see the contribution from the government is dramatically reduced from 80% of all drug costs after the patient has reached the out-of-pocket cap of $3,200 to only 20% after the patient reaches the $2,000 out-of-pocket cap. This shifts more coverage to payer as well as manufacturer like Pfizer.

Pharma companies are now required to pay 10% of the allowed cost of branded drug during the initial coverage phase and 20% during the catastrophic phase. You can then see why higher-priced drugs are disproportionately impacted.

Conversely, manufacturers of lower-priced drugs may benefit from the elimination of the coverage gap as they will no longer be responsible for the 70% discount on spending on branded drugs in the coverage gap. However, for those branded drugs, other factors may come into play, such as patients taking multiple medications which can accelerate the manufacturer's mandatory discount contribution.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

While this helps provide a better understanding of the changes this year, this is quite complex to translate in financial terms. Could you show us some practical illustrative examples to make it easier to understand the full year and also the phasing impact of those changes?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Certainly. I have prepared two illustrative examples of hypothetical drugs showing how those changes are impacting differently higher-priced, for example, $10,000-per-month prescription; and lower-priced, an example of $1,000-per-month prescription cost. You will see it can get even more complicated when the patient is taking more than one medicine from one or multiple manufacturers.

Let's start with the example of the $10,000 prescription scenario, which is relatively straightforward. For a Medicare patient, in this example, the expected manufacturer mandatory discount, or in other words, the percentage of rebate payment calculated on gross sales under Medicare Part D, is expected to increase from 3% in 2024 to 19% in 2025. And to clarify, this results in a negative year-over-year impact on net revenues.

You see on the illustrative chart how, in the case of a higher-priced medicine, the percentage manufacturer discount, or rebate, is now relatively consistent at about 20% all year, with the unfavorable year-over-year impact starting in Q1 and reaching a high-sustained impact in each of the following quarter in 2025.

And this is not impacted by how many scripts of this medicine or other medicines the patient is taking. The first script is triggered all future scripts for this patient to be in the catastrophic phase where the manufacturer discount is 20%.

Let's do the same with an illustrative $1,000 prescription scenario, which is much more complex and also requires us to make a few assumptions. For such drugs, in this example, assuming the first script occurs in month one or January, the patient covers a deductible and costs up to the $2,000 out-of-pocket cap.

Following the deductible phase, in the first part of the year, the manufacturer pays a 10% rebate during the initial coverage phase. Once hitting the catastrophic phase, the manufacturer discount increases to 20%, again calculated on gross sales under Part D.

If this is the only drug the patient takes, this switch to 20% will likely occur around the middle of the year after the patient reaches the out-of-pocket cap of $2,000. However, this is where the expansion of the scope to include LIS patients in 2025 could be impactful.

You will recall that in 2024, the LIS patient did not enter into the calculation under the coverage gap discount program; only the cost for the non-LIS patient worked. In 2025, the prescription costs for both the LIS and non-LIS patients are entering into the calculation under the new manufacturer discount program.

Given that the distinction between LIS and non-LIS does not apply in 2025 and to be able to make a simpler comparison of the impact from 2024 to 2025, in this example, we are assuming that the Medicare patient population was split equally in 2024, 50% non -LIS and 50% LIS. Thus, in this illustrative example, on a full-year basis, the manufacturer mandatory discount averages to 17% for 2024 and is then reduced to 14% in 2025.

Though this is slightly favorable on an annual basis year over year, it is clearly unfavorable earlier in the year. This, combined with a negative year-over-year impact in Q1 from higher-priced medicine, creates a significant headwind.

Again, this example is true assuming that the patient only takes this single medicine, while in reality, the patient may be taking more than one medication that accelerates the pace at which the manufacturer is going to reach the 20% discount level, which, as a result, would raise the average percentage of the mandatory discount on annual sales.

Now from a revenue phasing standpoint, on a year-over-year basis, we expect a higher manufacturer discount in the first half of the year and lower discount in the second half of the year. Obviously, there is a higher level of confidence with a calculated impact associated with the higher-priced medicine, simply given the magnitude of the year-on-year delta in the annual manufacturing mandatory discount where there is less certainty on the lower-priced medicine impact, given the low magnitude of the delta, amongst other uncertainties.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Cecile, thanks for those practical examples. We now have a better understanding of how the price level of a medicine is expected to impact both the phasing and the overall manufacturer discount, which clearly shows that product mix, amongst other factors like the number of medicines a patient is taking, will determine the net impact on a year-over-year basis. Can you provide a few examples?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

It may be helpful to see which categories the major Pfizer products fall into. The grouping on this slide is based on the WACC, or wholesale acquisition cost, price.

They are defining higher-priced medicine as those with a monthly WACC price of $5,000 or more, expected to hit the catastrophic phase in the first one or two scripts. Those will generally behave more like the $10,000 example I gave earlier. And the lower-priced products generally will behave more like the $1,000 example I gave earlier.

This slide is showing the major contributor to the estimated $1.5 billion negative year-over-year rebating impact that we are expecting to see in 2025. The innovative medicine in oral oncology and specialty drugs are expected to see a significant impact due to the manufacturer discount during the catastrophic phase starting in 2025, which was previously zero. I also want to note on this slide that ABRYSVO, specifically for older adults, is the only Part D vaccine in our portfolio and will also be impacted from a rebating perspective.

Again, I want to reinforce the point that while a medicine may be in the lower-priced category, the total out-of-pocket costs for the patient must be taken into consideration. So the impact will vary based on the total drug spend and the number of medications a patient is taking.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

In the beginning of our conversation, you also mentioned other factors that need to be considered in the overall manufacturer discount calculation for medicine. Beyond price, can you elaborate a bit more on other factors impacting net revenues?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yes, of course. To summarize the variables, one, the total net revenue impact on a product will depend on the rebate level of the product and its exposure to Medicare Part D. Part D includes individuals age of 65 plus, making up the large majority of eligible patients; as well as under 65 of age with disabilities or end-stage renal disease. Those are the patients taking products like VYNDAQEL, ELIQUIS, XTANDI, and ABRYSVO older adults.

Within Medicare Part D, the portion of LIS patients taking the product is another variable that would affect the overall net revenue calculation for each product. As I mentioned earlier, we were not paying discounts on scripts for LIS patients in 2024, but they are now part of our base in 2025.

Low-income subsidy beneficiaries are those below 150% of the federal poverty level with modest assets. Persistence and debilitating disease can lead to disability status and low income, which means both XELJANZ and Nurtec, which treat such diseases, are examples of products with a directionally higher LIS patient pool as a percentage of their overall Part D volume.

But then, a greater unknown is how many other medications a patient is taking. The more medicine the patient is taking, the faster they will progress through the phases and the higher the manufacturing discounts will be on all the drugs they are taking, regardless of their individual pricing.

For example, using the lower-priced example we discussed earlier, if a patient is taking two medications at $1,000, the annual manufacturing rebate discount increases from 14% that we saw in the example annually to 17%. And as another example, if a patient who is already taking a high-priced oral oncology treatment is prescribed a PAXLOVID script, then this script will be at the 20% manufacturer discount level, regardless of the time of the year it's written.

Our estimates of the 2025 impact, in particular estimating the total patient cost and percentage discount, are built on a third-party actuarial modeling which leverages data from millions of Medicare Part D patients.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Thank you, Cecile. There are several variables that will ultimately determine a drug's annual manufacturer mandatory discount percentage and net revenues in 2025. Now, pivoting to the partial offset, can you provide more color on the $500 million favorable volume impact we expect to materialize across the portfolio this year?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yes. On this slide, we will discuss the expected favorable volume impact from a potential increase in patient utilization due to the changes brought by the IRA Part D redesign. We will spend less time describing it as a methodology to estimate the favorable impact is based on third-party actuarial modeling, which, by leveraging Medicare Part D large patient datasets, is helping us to predict patient behavior and potential increase in volume as affordability is improving.

Firstly, we anticipate the reduced out-of-pocket costs for Medicare beneficiaries, capping their spending at $2,000 annually. In addition, patients have the option to spread their out-of-pocket expenses evenly through the year, a concept known as smoothing.

This increased affordability is expected to lead to higher utilization and fail rates, as well as better medication adherence and outcomes and to positively impact their ability to adhere to longer treatments. We expect to see benefits from increased patient utilization later in the year, as earlier in the year, patients will still experience deductible and co-pay burdens in the first months of the year as patients also are expected to become, over time, more familiar with the modality of the new manufacturer discount program.

However, there are some uncertainties associated with those changes. Potential formulary strategy changes and higher hurdles for high-cost products may arise. There could be pressure for more discounts to offset increased payer contributions.

And patient awareness of new modalities, including smoothing, will ultimately determine the rate of adoption. Furthermore, increased out-of-pocket costs, such as co-pay versus co-insurance, and higher deductibles may impact affordability negatively.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Thank you so much, Cecile. This was really informative. Let me summarize the key points of our discussion before we move to Q&A.

Pfizer expects an estimated $1 billion unfavorable overall net impact on Medicare US sales in 2025, combining the rebating headwind and volume tailwind from the out-of-pocket cap. We expect a higher gross-to-net impact in the beginning of 2025, expected to moderate through the remainder of the year when compared to 2024.

And again, the year-over-year impact on each product will depend on a number of variables such as price, exposure to Medicare Part D, and the portion of LIS patients within a drug's Part D script exposure. Further, the IRA Part D redesign impact is measured

on a per-patient basis based on the patient's individual medication regimen, which introduces additional uncertainties.

The estimates for the headwinds and partially offsetting tailwinds that we provided are based on assumptions built on third-party actuarial modeling, which leverages data from millions of Medicare Part D patients. We will continue to monitor and refine our estimates of the impact on our financials as the year progresses. And lastly, the IRA Part D redesign impact is only one component of our gross-to-net revenue calculation.

And now, I'd like to open the discussion for the Q&A. And to assure we make the best use of time, I ask that all questions focus solely on IRA Part D redesign and its impact in 2025. Operator, please assemble the queue, and let's start with the first question.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Timothy Anderson, Bank of America.

Timothy Anderson *BofA Global Research - Analyst*

Thank you. A question on commercial spillover. So different companies have different points of view on whether negotiated prices will spill over to the commercial book. And I know that's not relevant to 2025 because it's just the impact of redesign that you're primarily talking about, but I'm wondering if you can comment on that and Pfizer's views, whether you think there's going to be some commercial spillover.

And then just a second question, formulary changes. Have you seen any formulary changes in 2025 related to IRA ahead of the first products going into that negotiated price bucket in 2026? Thank you.

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Thanks for your question, Tim. As it relates to those commercial spillovers that you were referencing, I think you were probably referencing to the price negotiation that we are having today. As we said, we were going to focus mostly on the IRA Part D. But at this point of time, nothing to comment on it anyway.

Same thing as it relates to the formulary changes. Obviously, as every single year, we are in discussion with our payers associated with access for our medicine. We have not seen any different behaviors or input into the negotiation that would be associated with the IRA Part D redesign modalities.

Operator

Anastasia Parafestas, Jefferies.

Anastasia Parafestas *Jefferies - Analyst*

Hi, this is Anastasia on for Akash Tewari. Good to speak with you guys again. I think the last time we spoke, you talked about potentially flatlining at 15% instead of recognizing the 10% and 20% in the movement. Are you still anticipating flatlining 15% for 2025 or are you doing something similar to Bristol, where you're closer to the actual rule change?

And then just on the volume benefit, is that anticipated for every single drug or is it more so on your low or your high price drugs? Thanks.

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yeah. So as it relates to the first question, which is how are we going to record the impact of IRA -- so as you note, BMS for ELIQUIS is recording as it's expected to come, which will be the case as well for us in 2025. So we would expect to reflect on a quarterly basis the impact of the IRA on our revenues.

And then as it relates to the second part of the question, may I ask you to repeat your question, please?

Anastasia Parafestas *Jefferies - Analyst*

Yeah. So for the volume benefits, do you anticipate that for every single drug or is that more on a composite or more towards like higher or lower price drugs?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yeah. So we do expect to have an impact on all the products. Each of them is having a different favorability. As we know, most likely, the benefit would impact the lower price product. Because if you recall from 2024, in the catastrophic phase, the patient was also not paying any contribution. So you would expect probably to have that benefit, again, across the portfolio, but most likely on the lower price drug.

Operator

Geoff Meacham, Citi.

Nishant Gandhi *Citi - Analyst*

Hey, guys. This is Nishant on for Geoff. Thanks for taking the question. Just a couple from us.

I know you mentioned the distribution, like the impact is about $1 billion for the whole year. But can you provide color as to what the proportion of that between the first and second half? I know you mentioned it's more first half heavy.

And in terms of your analysis for this, I know you mentioned you use the third party. But can you really talk about your confidence level in this analysis and -- considering the various uncertainties that you highlighted today? Thank you.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Okay. So on the first part of the question, we actually are not able to make a further distinction of how to spread it between the first half and second half other than we see a greater impact in the first half. As we mentioned in the second half, when you start to take in the affordability, that starts to impact the headwind.

But further breakout, we just -- Nishant, we can't do. And then we had a little bit of trouble hearing you on the second part, if you wouldn't -- if you could just repeat it.

Nishant Gandhi *Citi - Analyst*

Yeah, it's regarding this overall impact. Maybe in terms of your analysis of this overall $1 billion impact in 2025, can you maybe talk about your confidence level, considering the various uncertainties you highlighted today, like regarding the various aspects of this Part D redesign?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

So I think as it relates to our confidence level -- so as I mentioned earlier, one, if you look at the $1.5 billion, the calculation of the $1.5 billion for higher price medicine, it's very clear. You see very quickly, we are going to fall under the 20% contribution. So this

one, the portion on the higher price medicine is clearly relatively straightforward.

As it relates to the lower price medicine and as it relates to affordability, this is where we've been working with third-party vendor, that vendor having access to millions of patient data under Medicare Part D which allows us to understand how many other drugs they are taking associated specifically with our medicine and also potentially anticipate how they are going to -- how increased affordability or improved affordability is going to lead into increased utilization, such as not skipping a script or staying longer on treatment.

So again, actuarial basis based on a very large and solid database. Obviously, we'll continue to monitor during the course of the year and adjust as needed. But as mentioned, relatively high level of confidence in terms of the estimate that we have at the moment that we will continue to monitor and adjust as needed.

Operator

Evan Seigerman, BMO Capital Markets.

Conor MacKay *BMO Capital Markets - Analyst*

Hello. This is Conor on for Evan. Thanks for taking our question.

I guess maybe just taking a step back here, as you look at consensus today, can you maybe highlight for us where you see the biggest disconnects between what the Street is modeling now and what we discussed on the call today? Thank you.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Conor, I've got to be really careful to comment directly on your question. But what I would encourage everybody to do is to consider the dynamics that we reviewed today of when the impact starts to occur on a per script basis as we progress through the year and how that compares if you look at -- I think it was when we started on slide 6 and 7 to look at that progression of 2025 versus '24 and have that be your guide as to how you may need to model the impacts in '24 versus '25.

And I just lost my train of thought. But that would be one thing. Oh, and then just the reminder, sorry, that the overall impact, we continue to say that it's more heavily weighted to the first half. And that's been a message we've been repeating for about a couple weeks now. But I don't want to comment directly on consensus.

Operator

Steve Scala, TD Cowen.

Steve Scala *TD Cowen - Analyst*

Thank you very much. Thank you for doing this call. It's very helpful. I have two questions which are related.

First, once a generic of a product enters the market, are you still subject to the Part D redesigned discount program on your branded version? And once MFP goes into effect, is it correct that the product is no longer subject to the discount program? Thank you.

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yeah. So thanks for your question. As it relates to the -- first question is whether when a generic enters the brand, it is still subject to the manufacturer discounts. The answer is going to be yes.

And as it relates to when -- and let's take the case of ELIQUIS next year, potentially, as part of the manufacturer negotiated -- new negotiated price. I believe, yes, that it would not be then subject to the Part D redesigned or manufacturer discounts. But as it relates to 2025, it's obviously not applicable because none of our products are falling under MFP.

Operator

Courtney Breen, Bernstein.

Courtney Breen *Bernstein - Analyst*

Hi, Francesca and Cecile. Thanks for taking the question. You spoke a little bit about the lower price scripts and specifically called out that shift in contribution from 17% to 14%. And noting that you then also made the statement that patients may be taking more than one medication which accelerates the rate at which they achieve that relative catastrophic phase.

As we're thinking about perhaps the older patients that tend to be taking more than one medication, can you talk about how much that changes the 2024 scenario versus the 2025 scenario, i.e., does the delta get bigger or smaller between '24 and '25 if a patient on a lower price product is taking more medications that push them into catastrophic earlier?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yeah, thanks for your question. So as I mentioned earlier, right, the more lower price medicine you're taking -- assuming they are branded, right? So a patient who would take a generic wouldn't -- the price of the generic would not enter into calculation. But you see, the more prescription you take, the faster you're progressing through the phases and therefore, the faster you're getting into the catastrophic phase.

And the catastrophic phase last year, we were not paying anything. This year, we pay 20% on every script. So the idea is that it will be negatively impacting our financials because we'll be paying 20% on every single script when they fall under that catastrophic phase.

And this is why we needed to collaborate with that third-party vendor in order to be able to anticipate how fast that patient is going to progress. And this is what we have reflected in our $1.5 billion estimate.

Operator

Vamil Divan, Guggenheim Securities.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Vamil, are you there? Operator, I think we may have lost --

Operator

I think Vamil has disconnected.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Okay. Hopefully, he'll reconnect. We'll go to the next one in the meantime, please.

Operator

Trung Nguyen, UBS.

Trung Nguyen *UBS - Analyst*

Hi, guys. Thanks for putting this on. So just one question for me. I appreciate you can't go through every drug. But for your highest revenue products in the portfolio, can you just give us the revenue Part D split for those? Thank you.

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

As you know, we're not providing any information that would be specifically on each of the products. But you may recall in prior communication, we've said that our portfolio is exposed to about 35% of our portfolio being Medicare Part D.

So as you can imagine and as we noted, a large portion of our portfolio is also not subject to Medicare. And that would be all of the vaccine, with the exception of ABRYSVO older adults which falls under Part D, as I had mentioned earlier.

Operator

Dave Risinger, Leerink Partners.

Dave Risinger *Leerink Partners - Analyst*

Yes. Thank you. And thanks, Francesca, for hosting this call. So there was a comment that there could be increased rebate demands from Part D plan managers due to their own financial pressures. Was this already factored into the guidance? And when will you learn more, since you said there could be increased demands from the insurers?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yes. Thanks for your question. So what I would note is we have not noticed any increase or heightened pressure as it relates to our negotiation with the payer. As part of every year, the competitive environment or other pressure are leading us to negotiating, but nothing that's specifically associated with that shift of cost to the payers that would drive either more restriction or more ask for rebate at this point of time.

So that's a risk. And for 2025, most of our contracts are now negotiated. So we're not expecting anything beyond the $1.5 billion that we have discussed that would be associated specifically to our negotiation.

Operator

Kerry Holford, Berenberg.

Kerry Holford *Berenberg - Analyst*

Oh, hi there. Thank you for taking my questions and for hosting the call. A couple. Firstly, can you confirm the payers split across your US portfolio today if we're thinking about the channels, commercial, Medicare Part B, Part D, Medicaid?

And then just following on from Steve's earlier question, will you confirm that once MFP takes place for a drug, it's no longer subject to this new party structure? Could you indicate even more than that? Could it ever be a positive for a drug in the year that MFP effectively takes place, and that core share element did not apply? Thank you.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Kerry, I apologize. We had a tough time understanding the question. Also, your phone was breaking up. I unfortunately have to ask you to repeat the questions.

Kerry Holford *Berenberg - Analyst*

Okay. Let me see. Is this better quality? Can you hear me?

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Yeah, it sounds a little bit better.

Kerry Holford *Berenberg - Analyst*

Okay, let's try. Can you confirm the payer split across your US portfolio today, thinking about the channels, commercial, Medicare Part B, Part D, Medicaid?

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Okay, let's take one at a time. So Cecile, she's asking for the payer mix across commercial, Medicare, Medicaid.

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

Yeah. So as I had mentioned earlier, overall for portfolio, about 35% of our revenues are falling under Medicare Part D.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Kerry, does that answer the question?

Kerry Holford *Berenberg - Analyst*

Yeah. I wonder if you have the split for the other channels, if you could comment on those.

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

So this is not something that we have provided in the past.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

So Kerry, we'll get back to you. Let us follow up with you and get you the split. But yeah, the 35% is -- Cecile, that's a number that we've given before on the Medicare portion. And then, if you wouldn't mind -- apologies for this, but if you can repeat the second question again.

Kerry Holford *Berenberg - Analyst*

Sure. And apologies for the line here. So the question was following on from Steve's earlier question with regard to once MFP takes place, no longer being subject to the Part D cost share, is it theoretically possible that in the year that MFP takes place for a drug, that could ever be a positive when you lose that cost share element?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

So I understand that your question is related to when we are entering into the MFP phase, whereby the product is subject to MFP, then how does it change the cost share was the question.

I think as I answered earlier, my understanding is when we enter into the MFP, then the drug is not subject to the manufacturer discount anymore. So I don't know if this is exactly the question that you are asking. Sorry, I'm having difficulties hearing.

Kerry Holford *Berenberg - Analyst*

Okay, don't worry. I'll follow up with an email, maybe, Francesca. Thank you, and apologies for the line.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

No worries, Keery. It's on both ends here. Thank you. Okay. I believe Vamil's back. So Vamil will -- Operator, if we can go to Vamil's question, that'd be great.

Operator

Vamil Divan.

Vamil Divan *Guggenheim Securities LLC - Analyst*

Great. Thanks for taking the questions again. Sorry, my line dropped because I was trying to ask what's then (inaudible)

But my question is, I think, two. So one, obviously, it seems like this first quarter -- second quarter, in fact, being more pronounced in the second half of the year is part of the issue here. And so while you're hosting the call, I'm trying to get everything aligned before the quarter.

I understand other companies, I think Johnson & Johnson, for example, are smoothing out the impact on their own end from an accounting perspective, so they're not feeling this quarterly dynamic shift, so a more smooth quarterly impact throughout the four quarters.

I'm wondering if Pfizer thought about this and for some reason, Pfizer decided not to do that just to make things maybe a little easier this first time through this process.

And then the second question is -- I know you can't get too specific on a product-by-product basis. But that $1.5 billion net negative number that you have goes into the $1 billion net number. Can you just quantify how much of that's coming from a high-priced product basket and how much is coming from a low-priced basket, just percentage-wise, directionally, just to have a sense of where the impact is being most pronounced?

Cecile Guegan *Pfizer Inc - Senior Vice President, Head, Biopharma Group Finance*

So I think as it relates to the first question -- and I think that was a question that came earlier as well, is how are we going to record the discount in our books, whether it's going to be smoothened also by quarter or whether we're going to recognize a liability as it comes, base. On the information that we are having, the objective will be to reflect every quarter the actual estimated impact of the IRA Part D redesign.

As I mentioned earlier and as you've seen, the difference for the higher-priced medicine is relatively small, but we would expect on the lower-priced medicine to definitely have a more pronounced negative impact as you come to the first quarter. So that was the first question.

The second question, as I mentioned earlier, unfortunately, we are not able to really provide details on it. But if you look at the examples that I have given, you can see that the larger -- you could expect that the larger impact for drugs under Medicare Part D is

going to come with the higher-priced drug. Because they basically are going to be spending most of the time into the catastrophic phase.

And as you saw, the impact was 3% versus the 19% when we go to 2025. And you see also that in that list are medicines that are big medicines, so our oncology portfolio as well as VYNDAQEL, just to name those, so that you would be also looking at. And those are also, as I mentioned earlier, VYNAQEL being an example, are Part D product because of the patient population that we are addressing being 65+.

So without giving you the specific impact, you can -- hopefully, with the assumption that we have provided today and the clarity we have provided -- be able to make some of those estimates.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

I just want to take an opportunity to come back to Kerry's question and give everyone a sense for our historical share of revenues by channel for the US business that we have given historically. I'll give you a set of ranges.

On the commercial side, it's about 30% to 40%; Part D, 30% to 35%; Part B, under 5%; Medicaid, also under 5%; and then there's a catch-all for other, including cash pay and other things like that, about 15% to 20%. So that's to close out on Kerry's question.

Operator, are there any remaining questions?

Operator

We have no additional questions at this time.

Francesca DeMartino *Pfizer Inc - Chief Investor Relations Officer*

Okay. So with that, Cecile, I just want to thank you again for your time and also for everybody that has logged in. I hope you found this to be informative and educational.

And if there are any follow-up questions, the IR team is around either today or next week. We're certainly happy to talk to you before we go into our quiet period in a couple weeks. And thank you for joining, and have a wonderful weekend, everyone.

Operator

This does conclude today's program. Thank you for your participation. You may disconnect at any time.

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