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OVERVIEW:

Company Summary

LSEG DATA & ANALYTICS

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PRESENTATION

Operator

Good day everyone, and welcome to Pfizer Flash Live from ADA, spotlighting berobenatide, an investigational potential first-in-class monthly GLP-1 receptor agonist peptide. Today's event 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 and Senior Vice President*

Thank you and good morning, everyone, both here in New Orleans and on the web. I'm Francesca DeMartino, Senior Vice President and Chief Investor Relations Officer. On behalf of the Pfizer team, thank you so much for joining us. Today's event will be recorded and 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 event spotlights a specific product, therapeutic, or growth initiative and gives you an opportunity to hear directly from our business leaders.

Today's session will begin with a presentation followed by live Q&A.

As a reminder, this call is intended only for the investment community, including our sell-side analysts and institutional investors. I want to note that on today's call, we'll be making forward-looking statements. I encourage you to view slide 2 in our presentation and the disclosures in our SEC filings, all of 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. Obesity is a key area of focus for Pfizer. Last November, we completed our acquisition of Metsera and are now advancing a differentiated, diverse pipeline anchored by the investigational ultra-long acting GLP-1 receptor agonist berobenatide, formerly known as MET-097i or PF-08653944 also referred to as PF'3944.

Earlier today, key opinion leaders presented new data from three Phase 2b trials of berobenatide at the American Diabetes Association 86th Scientific Sessions. Today's presentation will build off of that symposium.

In the room, I'm joined by Pfizer R&D leader, Jim List, MD, PhD. Jim, who is our Chief Internal Medicine Officer, will review highlights of the new data as well as berobenatide's development plan and target profile.

I'm also joined by Navin Katyal, who leads US Primary Care including responsibility for translating Pfizer's global obesity commercial opportunity from strategy to launch. In addition to obesity, his portfolio also includes Eliquis, Nurtec, Paxlovid, and vaccines. From Navin, you'll hear about what berobenatide's projected profile could mean for its market potential. With that, I will hand it over to Jim.

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

Thank you, Francesca. It's a pleasure to be here. Let me start with the key takeaways from the ADA expert symposium that you just saw. We believe berobenatide has the potential to be the first monthly GLP-1 peptide approved for obesity and related comorbidities. Based on our Phase 2b data, berobenatide has the potential to combine efficacy on par with tirzepatide with favorable GI tolerability in a patient-friendly presentation that provides convenience and scalability advantages.

Informed by these Phase 2b data, we're executing an extensive pivotal program. 10 active and planned Phase 3 studies are expected to advance in 2026, and I'm going to review these later in the presentation. Through these, we aim to develop berobenatide into a foundational metabolic medicine, both as a monotherapy and as the backbone for combination peptide therapy.

Now, a reminder of the purpose of Phase 2b. The objectives in Phase 2b were to identify the right doses for Phase 3, to test titration schemes, and to test both weekly and monthly dosing. And we have positive results across all three of these objectives.

I'm going to go over the efficacy and the tolerability before handing it to Navin to highlight berobenatide's positioning, if approved, with our target profile of a first-in-class monthly peptide delivered with a simple subcutaneous auto-injector. Then I'll go over next steps and our development strategy before we open it up for Q&A.

Given that we just came from the ADA symposium, I won't rehash the entire Phase 2b data package. For anyone interested or who missed the symposium, on-demand viewing will be available through ADA's website starting on June 10th, and details from VESPER-1, VESPER-2, and VESPER-3 will be available as an appendix to our Pfizer Pflash slides.

Turning to efficacy, we believe monthly berobenatide can deliver weight loss that is on par with weekly tirzepatide and potentially superior to semaglutide. Supporting that belief are our Phase 2b results viewed alongside data from approved weekly therapies, with the caveat that cross-trial comparisons have inherent limitations that preclude one from drawing definitive conclusions.

A key point to make before discussing the comparisons is that it's critical that these be made at matched time points and across relevant doses. So when we look at 4.8 milligrams of monthly berobenatide, which is our medium Phase 3 dose, it's viewed alongside the approved doses of semaglutide and tirzepatide, which are 2.4 milligrams and 10 milligrams respectively.

And even there, it's not quite apples-to-apples because we're talking about half of our top Phase 3 dose compared to two-thirds of the top tirzepatide dose. When we do this, here's what we see.

For placebo-corrected weight change at week 28, berobenatide at the medium Phase 3 monthly dose of 4.8 milligrams delivered up to 12.3% weight loss in the VESPER-3 trial. Semaglutide 2.4 milligrams weekly in STEP-1 gave approximately 9%, while tirzepatide 10 milligrams weekly in SURMOUNT-1 gave approximately 12.5%.

And again, that's looking at half the top Phase 3 dose of berobenatide, but two-thirds of the top dose of tirzepatide. In just a moment, I'll show you the first clinical data at our top Phase 3 dose. VESPER-2 is our Phase 2b trial of weekly berobenatide in participants with obesity or overweight and with type 2 diabetes. In the trial, we observed placebo-corrected reductions in weight of up to 9.5% and placebo-corrected reductions of HbA1c of up to 2.2% both at week 28.

Those results were achieved with a maintenance dose of 1.6 milligrams weekly. This time we're talking about two-thirds of our top Phase 3 dose. So again, there's potential headroom above this dose where the results were generated, and we look forward to seeing our Phase 3 results.

On a cross-trial basis, this compares well to both the 10 and 15-milligram doses of tirzepatide when you look at the same time point within their pivotal SURMOUNT-2 trial in the type 2 diabetes population, and those results are noted on this slide.VESPER-2 and VESPER-3 were only partially up the dose-response curve for efficacy, and neither study went up to the high Phase 3 dose of berobenatide, which is 2.4 milligrams weekly or 9.6 milligrams monthly.

Our first clinical data with the high dose came in the extension of our Phase 2b VESPER-1 study. As shown here, participants who escalated from placebo to the high dose of 2.4 milligrams of berobenatide weekly had substantial weight loss, with a mean change of approximately 16% at 32 weeks.

And the curve continued its steep downward trajectory throughout the entire time period, suggesting, as you would expect, that a greater magnitude of weight loss will be seen with a higher dose. This first glimpse of high-dose data conforms to our expectations. Based on modeling, we expect the high dose to drive meaningfully greater weight loss than the mid or low doses.

Now perhaps the best way to make cross-trial comparisons in light of their limitations is to leverage as much data as are available and build a model-based meta-analysis. And that's exactly what we've done here. We integrated a dataset of 69 weight-loss trials incorporating aggregated data from over 32,000 patients. This approach integrates all the available data using a mathematical model that accounts for pharmacology and describes the weight loss trajectory over time and the dose-response relationship.

Now, using this approach, we predicted weight loss at 72 weeks for berobenatide's high monthly Phase 3 dose compared to the highest approved doses of tirzepatide and semaglutide. The modeling suggests berobenatide can deliver weight loss similar to tirzepatide, with point estimates less than 1% apart, and potentially better than semaglutide. And that prediction holds whether we're talking about weekly or monthly dosing, which generate equivalent average exposure over the dosing interval.

At the bottom of the chart, you'll see we also predicted 72-week weight loss for monthly MariTide, and it's honestly very hard to say very much there because there's limited data publicly available, and that's reflected in the wide confidence interval. What gives us a lot of confidence is that the data we generated with the 2.4-milligram high dose in the VESPER-1 extension align extremely well with the model's predictions. It validates our approach and it validates our expectations for Phase 3.

Turning now to tolerability -- and remember, one of the purposes of Phase 2b is to understand the relationship between tolerability, dose, and titration. That's the lens to keep in mind through the next few slides.

We're quite pleased with what we've seen. In the VESPER-1 extension, evaluating weekly, every-other-week, and monthly dosing intervals, we observed excellent GI tolerability. 96% of participants reported no key GI treatment-emergent adverse events or only mild ones. And that's nausea, vomiting, diarrhea, and constipation.

And in the arm that went from placebo up to our high dose in the extension, the vomiting rate was under 20%. And notably in the extension, there were no treatment discontinuations due to treatment-emergent GI adverse events in any of the arms. In VESPER-3, berobenatide was also well tolerated. 83% of participants experienced no or only mild key GI treatment-emergent adverse events, with vomiting rates in the low-to-mid 20s across active arms.

Fewer than 10% of participants in the berobenatide groups discontinued treatment due to treatment-emergent adverse events, and that's across the 215 participants who were randomized to berobenatide.

Now importantly, really importantly, these results were achieved in trials where down-titration was not permitted. So if a patient experienced GI tolerability issues, they couldn't lower their dose. They had to muscle through it or they had to discontinue. So even though the data show a good tolerability profile here, in Phase 3, because we allow for down-titration, we expect to see an even better tolerability profile.

And with our learnings from Phase 2b, we expect our Phase 3 titration scheme again should yield an even better tolerability profile than the already very good profile that we've seen in Phase 2b.Now, this slide breaks down vomiting events in the VESPER-1 extension.

All the events are shown here by week with severity color-coded: mild events in green, moderate in yellow, and severe in red. The top two rows are participants who entered the extension after receiving berobenatide weekly for 28 weeks in Part A of the study.

They continued at the same weekly dose for the first eight weeks of the extension and then transitioned to monthly dosing for 24 weeks. The data shown here are for the 3.2 and 4.8-milligram dose groups, again, our low and medium Phase 3 doses.

So this gives us insight into the expected tolerability profile of monthly berobenatide in participants switching from weekly to monthly treatment.

The vast majority of events were mild, none were severe, and while there was a mild transient increase at the point of the monthly transition, it rapidly improved with continued dosing. This, along with the VESPER-3 data, provides the critical insight that guides our Phase 3 strategy for the transition to monthly dosing.

Specifically, smaller increments in dose than were used in Phase 2b should help address any tolerability concerns that happen at the weekly-to-monthly transition. At the bottom, we see the placebo switch group escalating to the high dose. Again, the vast majority of events were mild and none were severe.

Similarly, for our placebo-controlled VESPER-3 trial, which evaluated the switch from weekly to monthly maintenance dosing, we saw a slight transient increase in events at the monthly transition, which rapidly improved with continued dosing.

And as we look ahead to Phase 3, as I said, we learned from Phase 2b and implemented designs for Phase 3 that should help ensure a smooth dose and PK transition to optimize tolerability at the point of the switch from weekly to monthly dosing.

I'll talk more about Phase 3 shortly. But first, let me hand it to Navin to talk about what berobenatide's projected profile could mean in the obesity landscape. Navin?

Navin Katyal - *Pfizer Inc - US Primary Care President*

Thank you, Jim. So as Jim has covered, we've seen a competitive efficacy and tolerability profile with berobenatide. And combined with its convenient monthly dosing, we're very excited about the commercial opportunity this sets up for us.

I'm now going to spend a few minutes on what signals we have about the desire for a monthly product, where we think it could fit in a patient's journey, and the commercial principles guiding our build. So starting with the market, it's clear that the prevailing focus in this category is on who's leading, but I think what gets less attention is how much of it has yet to be served. And the fact is that most eligible patients still are not on therapy at all, and most who are starting don't stay on.

And that's why we believe the commercial opportunity for berobenatide is so significant. It has a highly competitive profile, as Jim just outlined, and it's designed for a large and growing monthly market. It's well positioned across the full patient journey, and we have the commercial capabilities to serve this market from day one.

And starting with the molecule itself, simply put, berobenatide is built to be supplied at scale with notable COGS advantages. The API requirements, as you can see here, are 125 milligrams per patient per year, which is significantly lower than the other monthly programs in development.

Monthly dosing also means a lot less device, a lot less packaging, a lot less cold chain, and a lot less waste than weekly therapies. And so ultimately, that means we need a lot less manufacturing capacity to serve the same patient population and that we can distribute it more efficiently.

And I think importantly, the 0.5 mL injection volume lets us deliver it in a familiar auto-injector that patients and providers are very familiar with and very much trust. So taken together, berobenatide is expected to be available in formats people already know and already trust. It's highly scalable, and that, of course, is really crucial in a massive, growing category.

Now, turning to the market, we've actually done a lot of research with both providers and patients to understand what a profile like berobenatide's, with competitive efficacy and tolerability but in a monthly regimen, would mean for them.

And I think what's clear is that upon seeing that profile, that value proposition becomes super intuitive to them. We see that 51% of treatment-naive patients prefer monthly as their long-term destination when comparing it against the existing injectable and oral options.

And on the provider side, 86% of those surveyed said they would be more likely to switch their patients to monthly berobenatide when shown hypothetical positive switch trial data, and that projected switching intent rises 1.7 times. So ultimately, we believe berobenatide is going to have two distinct shots on goal.

First, for new patients who want a highly effective therapy and who know these therapies are not a one and done and want something with less long-term burden.

And then second, for existing patients on weekly GLPs who want something that feels more sustainable than dosing every single week or every single day, for example, on the orals -- to maintain what they've achieved. And we've built Phase 3 trials designed to generate evidence to serve both. And Jim is going to walk through that shortly.

So in addition to starting or switching, another substantial part of this opportunity -- and a critical need, I would add -- is keeping people on therapy for the long term. Today, about 65% of people without type 2 diabetes who initiate a weekly GLP discontinue within a year. And there are real consequences of that, as we all know.

In fact, two-thirds of the weight patients lost in the pivotal semaglutide trial was regained within a year of stopping. And then we also know about this market, and are encouraged by it, that the vast majority of lapsed users say they would consider coming back.

But I think what is missing right now is a regimen built for sustainable long-term use. And that's exactly what we believe monthly is built for. Because what we've seen time and time again is that less frequent dosing has driven adherence improvements across multiple chronic conditions. And so when we put all of this together, we expect berobenatide to compete across the entire patient journey.

And in a market expected to reach well over $100 billion, where there's fewer than 10% of eligible adults on therapy today, we're super excited about the potential to unlock real growth by bringing more patients in who haven't been willing to start, by serving those who want to switch to something more sustainable, and of course keeping people on therapy longer.

And finally, just a note about our commercial model. There's a number of principles that guide how we're approaching this. There's three that I'm going to pull out today.

First is our integrated direct-to-consumer experience, which will be in-market and ready from the start, building on our PfizerForAll platform that today connects patients with treatments for migraine, vaccines, appointments, and more. And second, we're building a model that serves both reimbursed and cash channels, and importantly, we're going to be set up to compete in cash from day one.

Third, we're designing for persistence, building for the long-term patient experience, not just for initiation. And behind all of this is, of course, the Pfizer primary care engine: a primary care field force has been ranked number one for seven years running in the industry, existing relationships across more than two-thirds of the providers writing meaningful prescriptions today in the GLP-1 class, and of course, deep experience engaging hundreds of millions of people in large-audience primary care markets.

And finally, I'm going to note that we've been here before. We didn't invent the statin; Lipitor was not the first. Eliquis was not the first oral anticoagulant. Prevnar was not the first pneumococcal vaccine. But in each case, we built the evidence, we built the commercial model, and we built the franchise that came to set a new standard. And we're really confident in our ability to make a significant impact in the market with our berobenatide franchise as well.

So with that, Jim, I'll turn it back to you to discuss our next steps. Thank you.

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

Thanks, Navin. Let's talk about the Phase 3 program now. We have two Phase 3 studies of weekly berobenatide already underway, randomizing patients and recruiting really well: VESPER-4 and VESPER-5. Both enroll participants with overweight or obesity.

VESPER-4 excludes participants with type 2 diabetes, while VESPER-5 enrolls participants with type 2 diabetes. The primary endpoint for both is the percent change from baseline in body weight at week 64.

One design point worth flagging: VESPER-4 and VESPER-5 use a simple dose-escalation scheme with one, two, or three titration steps to reach the low, medium, or high maintenance dose. That compares favorably to currently approved weekly chronic weight management therapies, which require five steps to reach the top maintenance dose.

So we're evaluating a streamlined path for getting to the maintenance dose, making it easier for patients while, as I said, incorporating the option to de-escalate for GI adverse events. VESPER-6 is the pivotal trial for monthly berobenatide.

The study is now up on clinicaltrials.gov and open for enrollment. VESPER-6 includes two cohorts: a main cohort without type 2 diabetes and a parallel cohort with type 2 diabetes. And the primary endpoint is the percentage change in body weight at week 72 in the main cohort.The initiation of monthly dosing in VESPER-6 incorporates the learnings from Phase 2b. So going back to Phase 2b and VESPER-3, participants moved directly from a weekly dose to a fourfold higher monthly dose.

For example, they moved from a 1.2-milligram weekly dose directly to a 4.8-milligram monthly dose. And we saw good tolerability with that approach, but a detailed analysis of the data suggests that we can potentially do better. We can expect to decrease that small and transient increment in GI adverse events that we saw at the weekly-to-monthly transition point by decreasing the size of the dose step-up.

So in VESPER-6, the evaluated weekly-to-monthly step-ups will range from 2- to 2.7-fold as opposed to fourfold. So that's a much more gradual transition by design. And you'll notice it's three simple titration steps to get to monthly dosing and five steps in total to reach the top monthly dose of 9.6 milligrams, with flexibility in how you get there.

And again, in Phase 3, we're allowing dose de-escalation in response to GI adverse events. We expect this combination smaller upward titration steps plus allowing for down-titration if needed will make our really good tolerability profile that we saw in Phase 2b even better in Phase 3.

Now, as you can see, VESPER-4, VESPER-5, and VESPER-6 are just the start. We're planning to advance a total of 10 berobenatide Phase 3 trials in 2026, and that includes a switch study to look at transitioning patients from approved weekly therapies directly to monthly berobenatide. We're targeting a series of potential approvals beginning with weekly dosing in 2028, with an approval for monthly berobenatide as a fast follow to that.

Our pivotal program also targets obstructive sleep apnea and knee osteoarthritis, two comorbidities where other GLP-1s have shown clinical success, and where berobenatide has the potential to uniquely bring a monthly dosing option for patients.

As we've shown you, berobenatide has a potentially compelling profile as a single agent by itself, and it's the driver behind which we're building out our research and development pipeline in metabolism. We're also really excited about berobenatide as a foundational partner to evaluate combination therapy with other monthly peptides that we're developing.

The most advanced of these combinations is berobenatide plus our investigational ultra-long-acting amylin analog PF-08653945, formerly known as MET-233i. PF-08653945 has a very similar half-life to berobenatide, and its solubility profile supports combining it with berobenatide.

We expect to report early data on our ultra-long-acting amylin analog and on the combination with berobenatide in 2026.We see the potential for this combination to deliver category-leading weight loss with the convenience of well-tolerated monthly dosing. The Phase 2b study evaluating this combination, SOLIS-1, is open for enrollment and it's up on clinicaltrials.gov.

Looking beyond berobenatide programs, we recognize that not every obesity medicine will be right for every patient. And that's why we're building a differentiated pipeline with multiple mechanisms and modalities: injectables with the potential for monthly or even longer dosing intervals, oral agents, and combinations. Our goal is to address the many needs of patients across weight management profiles and dosing preferences with our long-term commitment to obesity and to metabolic health.

With that, I will turn it back to Francesca.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Thanks, Jim, and thanks, Navin. To summarize, our Phase 2b data provide proof of concept for berobenatide as a potential first-in-class monthly GLP-1 receptor agonist peptide that we believe can deliver weight loss similar to tirzepatide and potentially better than semaglutide.

Alongside robust efficacy, we aim to pair favorable tolerability and convenient monthly delivery to develop a foundational metabolic medicine as a single agent and backbone for future combination therapies. And with berobenatide's scalability, Pfizer's leading primary care field force, and a carefully designed commercial model, we believe we are well-positioned to have a substantial impact on obesity and metabolic health, subject to clinical success and regulatory approval.

With that, we will begin the Q&A session with Jim and Navin.

As a reminder, our Pfizer Pflash series is designed as an educational deep dive into our pipeline programs. I'll therefore kindly ask that participants keep questions focused only on berobenatide's program covered today. Please avoid questions that would require us to provide forward-looking financial projections. While we're happy to clarify any information shared during the presentation, we will not be offering estimates beyond what has already been communicated.

And I appreciate your understanding on that. With that, we're ready to take the first question, starting with those in the room. (Operator Instructions)

QUESTIONS AND ANSWERS

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Chris Schott, JP Morgan.

Christopher Schott - *JPMorgan Chase & Co - Analyst*

Great, thanks so much. I just wanted to talk a little bit about the higher dose that you're going to be looking at in the Phase 3. How do you think about the tolerability profile there? It seems -- I know you're trying to improve on the lower doses but we're in kind of that low 20% vomiting rate. I'm just wondering, with that bigger step-up to that higher dose, what is your modeling suggesting that profile could look like?

And maybe just more holistically, it seems like one of the themes from this conference is this idea of not necessarily fully maximizing weight loss, but getting kind of this balance of tolerability and acceptable weight loss. And I'm just looking to think about the three kind of doses you're moving forward: how important is that to the program versus some of the ones we already are seeing at the lower side? Thank you.

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

So why don't I start with that? But I think it's also in part a question about the need for flexibility with multiple doses on the market, too. So maybe Navin can follow me.So from a tolerability standpoint, the data are the data. The data that we have are from going up to 2.4 milligrams weekly. We don't have data right now in the 9.6-milligram monthly.

What we did see in the 2.4 milligrams weekly is there really was great tolerability there. So it doesn't seem that the dose per se is what drives tolerability, and that might actually be because once you get up to a certain dose with a GLP-1 this potent, with this long a half-life and these pharmacokinetic properties, you might be essentially tonically saturating the GLP-1 receptor so that it doesn't really give you any more tolerability issues once your body has gotten used to that.

So then the question is how do you get up there? And I will say just as a note, having a dose that's four times the weekly dose in a monthly regimen isn't just by multiplying by four. It is actually based on very complex pharmacokinetic calculations to get the same average exposure over the time duration. It turns out to be exactly four times the dose, which is convenient for us.

So then the trick is what we have realized through both VESPER-1 extension and VESPER-3 is that when you make the step-up to monthly, if you're making that step-up as a big jump, a fourfold jump, you get some tolerability signal. It's not terrible, but you do get a little bit of a signal there. And so that's where, going up to that 9.6, it's a gradual titration scheme.

And there are two different schemes depending on if you already titrated up to 2.4 milligrams and you're happy at that high dose and you decide, Hey, I want to switch to monthly. There's one titration scheme for that.

There's another one if you say, I want to get to monthly as fast as I can, and we'll see how high I want to go with that, and you can titrate up to 9.6 that way. But in both cases, it's a gradual titration scheme. So the Phase 3 data will tell the answer, but from what we know now and the data we have, I think it is very promising to be very well tolerated.

And very well tolerated. Now, do patients need all of this weight loss? As the drugs on the market stand now, most patients don't get to 15 milligrams of tirzepatide. Part of that is probably because they don't tolerate it, and part of that is probably because they don't want or need that much weight loss.

We may see a very different dynamic when it's more convenient to give it monthly and when it's very well tolerated. However, there are a lot of different needs for different patients, and so I think the low and medium doses are going to be very important as well when this asset hits the market.

Navin Katyal - *Pfizer Inc - US Primary Care President*

I mean, I think that's spot on. I think the thing I would add is, to your point, there's efficacy and there's tolerability. The two things I would also add in terms of dimensions that are part of the considerations are convenience and flexibility. And so if you think about the profile that's kind of emerging here from a clinical standpoint, as Jim highlighted, we've got a very competitive efficacy and obviously tolerability profile

that we described today, that's just as good as the leading agent. But on the sort of flexibility and on the convenience front, what you get with berobenatide is the flexibility to sort of choose your own adventure, right?

So you can do, if you want to stay on weekly, you can stay on weekly. If you want to escalate up to monthly, you get to escalate up onto monthly, and then there are multiple doses you can do that with. And I think when we look at the research, both with consumers and the provider base, what you hear sort of over and over again in spades is they want flexibility and control, right?

So they can optimize that tolerability and that efficacy. And when we actually put the titration schedule in front of KOLs, HCPs, et cetera, that was sort of the theme that we got over and over again is, olkay, I'm getting flexibility, I'm getting control, and now I can optimize this for my patient and sort of get them to the right sweet spot for efficacy and also for tolerability.

And I think the sort of three themes that came out from that are, okay, I have now control over strength. I have control over titration schedule options, and I also have control over the frequency of the dosing. So that resonates, I think, really well with both consumers and with providers.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Dave Risinger, Leerink.

David Risinger - *Leerink Partners LLC - Analyst*

Thanks, Francesca, and thanks for hosting this session. So I have two questions, and the second one is quick. Could you just talk a little bit about -- sorry, could you talk a little a you just talk a little bit about your vision for a commercial launch as a weekly therapy and the messaging to consumers at that time? And then, with respect to China only -- switch study, why is it China only and can that be added to the US label? Thank you.

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

So I'll take the second one, then Navin. The switch study is global. We are running a China study and a China program, as well as a Japan program, but the switch study itself is a core component of a global program. We see that as really important for patients because, as Navin said, 65% of patients don't make it a year on current therapies. There are going to be people who feel like, I can't do this every week, and they are going to want to have that option to switch. Because of that, we want to bring that clinical data package and that option broadly worldwide.

Navin Katyal - *Pfizer Inc - US Primary Care President*

Yeah. And then just to address your question around the commercial model and the weekly launch, maybe I'll just start with the overall timeline rhythm. As Jim described earlier, we're going to launch with the weekly regimen, and the monthly comes as a fast follow.

The weekly on its own, as Jim described earlier, we see as competitive in its own right, offering leading efficacy aligned with the top agent in the market today, and the exact same on the tolerability front. I think the important thing about that weekly launch, though, is it gives early experience to both consumers and providers regarding the molecule, berobenatide. Then, all of those individuals who get onto the weekly product are now eligible with the fast-follow launch of the monthly option, right?

That initial installed patient base becomes an immediately eligible base to now make that transition decision and utilize that flexibility and that option to switch over. And then I go back to my point earlier, which is that for anyone who is on this product, it's a highly differentiated asset in the sense that you now have an option of doing this on a weekly basis or on a monthly basis.

We expect most will move over to monthly because, again, that value proposition is so incredibly intuitive the minute you put the profile in front of both consumers and providers and you show what the existing profiles look like from an oral perspective or from a weekly perspective.

From an injectable perspective, there's sort of a very intuitive light bulb that goes off because you think about the fact that this is a long-term chronic condition. If you fall off of it, you're going to regain the weight. And that sort of notion arises: do I want to be tethered to something 52 times a year in perpetuity?

Do I want to be tethered to something 365 days a year in perpetuity? Or can I do this in a sustainable way just 13 times a year? That light bulb goes off and then they develop a clear preference. So that's how we think about the rhythm and the launch of this product, and how it will evolve over time.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Dave, I don't know if it was confusing that on the slide you might have looked at the switch trial and China was next to it, but just as a point of clarification, each box is its own trial. So you'll see that represents the 10 Phase 3 studies, just for clarification. Okay.

All right, Vamil Divan, Guggenheim.

Vamil Divan - *Guggenheim Securities LLC - Equity Analyst*

Thank you, Vamil Divan from Guggenheim. So maybe just to appreciate getting your insights here today and building on the market research that you've done, I am curious if you can share how you think the market is going to evolve from here, thinking about injectables but also the orals. What percentage of the market do you think will actually be injectables five years from now?

And then related to that, obviously you talked about your primary care field force and its number-one ranking for seven years running. How do you think about the commercial model from a field force perspective versus more of a direct-to-consumer digital approach, like the PfizerForAll model that we see emerging in this space?

Navin Katyal - *Pfizer Inc - US Primary Care President*

Absolutely. So in terms of the evolution of the market mix, it's hard to have a crystal ball and predict exactly what's going to happen. I do think it's broadly believed that injectables will remain a larger part of the market. What we've observed about the marketplace so far, though, is a few things. The first is we know that ultimately people want flexibility and they want control. That's the sweet spot and the big strong suit that we have here.

Obviously, you want to have a great tolerability and efficacy profile, which is also what's emerging here with berobenatide. And then there's this very big differentiation, which is that I now have a sustainable option where I don't have to be tethered to something 52 times a year or 365 days a year. So that serves as the foundation of this opportunity.

I think that the other thing when we look at our research, the light bulb that goes off is, yes, there is convenience with orals. And by the way, that convenience with orals has unlocked more patients. We've seen that a big bulk of the patients who have come into this market are not switchers from injectables; they're sort of naive to GLPs. So that has become a step-change in market unlock.

We expect the same with a monthly injectable, but I think the key here is the light bulb that also goes off is that patients can now get even more convenience because they just have to do this once a month. And by the way, they don't have to make a trade-off on efficacy like they do with the orals, or a trade-off on fasting requirements like they have to do with certain oral alternatives as well.

So that becomes another unlock and I think becomes a core part of the value proposition. It's hard to say exactly what percent of the segment will be oral versus injectable, but as more innovations like this come along where the dosing burden sees a big step-change reduction, we see that persisting in the market. Just in terms of where we believe berobenatide is well positioned in terms of the patient journey, I think we have a lot of conviction that this is going to unlock more initiation, just like the orals did because of what I just described.

We think it's going to unlock a switch when people see the value proposition from that data. We think it's going to unlock maintenance because there is this existential dread, a bit, of being tethered to injecting yourself every single week for the long term. So it's going to unlock that maintenance and perhaps even, it stands to reason, those who have lapsed.

As I mentioned earlier, there are about 74% of lapsed users who are no longer on these therapies who have indicated that they're likely to jump back in. And if you can think about a product where you don't have to do this again every single day or every single week, that becomes super interesting to people.

So we think that's also going to happen. I think one last thing I'll just say on the commercial model relates to your question about our field force and our consumer engagement. As I said, the advantage of the Pfizer primary care field force, in addition to it being ranked so highly, is that we have a really long and deep relationship with these prescribers.

Two-thirds of the prescribers who are writing meaningful GLP-1 volume we already know, we know them well, and we call on them all the time with assets like Eliquis. If you think about the average tenure of our representatives in the primary care field force, it is 15 to 20 years. These are professional representatives who have seen the entirety of the lifecycle of Eliquis.

These are individuals who engineered the shift from Eliquis being a cardiologist-specific play to a broad primary care play, so they really know this space. They have also carried legacy blockbusters like Lipitor, meaning they are true experts in cardiometabolic health.

We think they're going to bring a lot to the table. And then on the consumer side, we are a powerhouse as well. If you look at the ROI on our advertising, it's double the industry benchmarks. Beyond just simple share of voice when engaging consumers, the key is how you bridge intent to action. We've made great progress over the last few years in terms of how we engage consumers.

You obviously have to have your DTC and all your traditional levers, but you also have to be able to intervene to not just drive awareness, but actually move and bridge people from intent to action. If you look at what we have done with PfizerForAll, which is the digital front door that we built for migraine, vaccines, and other indications, it has been incredibly successful.

Not only have we had over 30 million visitors to that site, but we've built specific, high-engagement interactions there. In the vaccine space, for example, we built an eligibility tool so people can figure out exactly what vaccines they need, alongside an end-to-end booking mechanism.

What we've seen from that is a huge lift in terms of conversion; patients move from simply researching things to bridging their intent to action. We plan to deploy that exact same integrated digital engagement model in obesity with PfizerForAll and the other corporate front doors that we build.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Let's go to Geoff from Citi.

Geoffrey Meacham - *Citi - Analyst*

Awesome. Thank you guys for doing this. A couple questions. It's good to see some new indications in the mix on your developmental slide. How are you thinking about combinations even beyond that, such as in inflammation, oncology, or neuropsychiatry? Can you take advantage of monthly dosing in those arenas?

And then, I have another commercial question. The argument here is that you have to compete with the weeklies to at least get people to start. So how do you anticipate the differentiation on the weeklies? And, what is your assumption of the percent of people who will move to monthly?

Is the reason purely because they want to, or is it pure convenience? If they lose, for example, 15% of their weight, is it just that they don't want to lose any more and simply want to maintain? I just don't know if there is a lot of data on the individuals who are averse to weekly injections.

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

Well, let me just take the first part very quickly. What we've disclosed here obviously isn't our entire Phase 3 program because some of these trials are listed as undisclosed, but we have our eye on all of these possible additional indications. There are over 200 diseases that are driven by obesity.

We certainly have a great interest in some of the areas you mentioned, such as oncology and immunology, and whether that involves combination approaches or even berobenatide as a monotherapy for improving these outcomes.

We're looking at them all, but we can't do everything, obviously, and we need to be very thoughtful about where we bring differentiation. But as you pointed out, the monthly dosing is a big differentiator because, just like obesity, most of these diseases are also chronic diseases that need chronic treatment. And so we have to find ways to keep patients on longer than just a year.

Navin Katyal - *Pfizer Inc - US Primary Care President*

And then to your point about the differentiation on the weekly piece, first and foremost, as we talked about earlier, we see the efficacy and tolerability profile being as good as the best agent in the marketplace. In terms of the differentiation, you can choose to initiate on a weekly product where you have no option to go to monthly like the incumbents, the products that exist today or you can choose to initiate on a weekly that gives you the optionality to go onto a monthly.

And I think even for that short window of time where the weekly is on the market before the monthly fast-follows, it's going to be very enticing for a consumer or for a provider to say, I think I'm going to try this weekly because in just a little bit of time, I can potentially escalate you to a monthly dose. You don't get that optionality if you start a patient on a weekly product that doesn't have this schedule.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

The Conor, Malcolm duo? Let's go over to BMO.

Conor MacKay - *BMO Capital Markets - Analyst*

Hi there. Yeah, this is Conor here from Evan's team at BMO.

You guys made a few comparisons today in your slides to some of the other leading agents in the space. And we were just wondering, from a strategic perspective, as you think about competing with some of these assets, what are your views on potential head-to-head studies? And then thinking longer-term for your combination approach, how would you think about potentially including an active comparator arm in some of those later Phase 3 studies? Thank you.

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

So again, we haven't disclosed the entire Phase 3 program here. And for the combination the next combination coming along, which is our combination with our ultra-long-acting amylin analog we're just entering Phase 2b. So it's still early days there. We do anticipate that that's going to have additive efficacy because that's what we saw in Phase 1, alongside a really good tolerability profile in monthly dosing.

So then the question is, what's the advantage of doing head-to-head trials? And I'll tell you part of the thinking here is that we have really great potential drugs here. And with showing very good efficacy and very good tolerability, I'm not sure that there's going to necessarily be a need to do head-to-head studies.

It might be the other people's need to do head-to-head trials against us because we've got, in some ways, bigger fish to fry to go after other indications where chronic treatment with a monthly offering can really make a difference again, across these many other diseases that are driven by obesity.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Time for maybe one more. Michael, you're here to represent Cowen, right? Okay, over to you.

Michael Nedelcovych - *Cowen and Company LLC - Equity Analyst*

Thanks so much for the question. Michael Nedelcovych from TD Cowen. I have two, if that's all right. My first actually dovetails on something you just mentioned about the long-acting amylin. To what extent does Pfizer view amylin monotherapy as an important future category?

I think the field is kind of excited about the possibility of perhaps lower efficacy but better tolerability. And then, on the comments made about weekly titration and transitioning to monthly, is there a potential path to monthly dosing from the start for berobenatide or perhaps for your prodrug? And if so, is that compelling, or would that not be enough of an advantage to pursue?

Jim List - *Pfizer Inc - Chief Internal Medicine Officer*

So first of all, on amylin monotherapy, it's early days in the sense that we're starting our Phase 2b trial where we will look at weekly and monthly dosing of monotherapy and combination therapy with berobenatide, and we're going to learn a lot there.

I'm not sure I would characterize it as less efficacious because what we saw in Phase 1 with our particular amylin analog which again is ultra-long-acting was an incredibly high degree of efficacy for the duration that we dosed. So the question is, will it fulfill a need as a monotherapy in the market? We're going to learn more about what exactly it does through Phase 2b, and we'll make those choices.

These, again, are investment decisions of where this embarrassment of riches within this very large pipeline that we now have meets the actual needs in the marketplace. And then, regarding your question about starting directly with monthly dosing, I'll let Navin answer that from a commercial attractiveness perspective.

From the standpoint of berobenatide itself, I think what we've worked out through Phase 2b is that it's optimal to do weekly dosing initially for the first 12 weeks. Again, this has to do with managing the size of the dose jump that you're making before you get to monthly, as you accumulate drug and exposure over time. For the prodrug, it's an interesting question. The prodrug is in Phase 1. For those who aren't aware of it, it's an ultra-long-acting version of berobenatide. Again, it's in Phase 1, so we need to learn a lot more about it, but there are a lot of potential advantages there to stretching out beyond monthly dosing. How you titrate there will be determined entirely by the incoming clinical data.

Francesca DeMartino - *Pfizer Inc - Chief Investor Relations Officer and Senior Vice President*

Okay. So, in conclusion, I just want to thank my colleagues Jim and Navin for their contributions today. And also, there are numerous Pfizer employees in the room who really helped bring this all to fruition, so thank you to all of you. And then last but not least, thank you so much for joining us live and on the web. We really appreciate it, and the IR team is always available for any follow-up questions you may have. And with that, I'll just ask the operator to conclude the call. Thank you.

Operator

Thank you ladies and gentlemen. This brings us to the end of today's program and we appreciate your time and participation. You may now disconnect.
