Investor Relations
Q1 2025 results presentation

Introduction | Constantin Fest

Slide 1 | Q1 2025 Results

Slide 2 | Agenda
Ladies and gentlemen, a very warm welcome to this GSK Q1 2025 results call.

My name is Constantin Fest, new Head of IR at GSK and I am delighted to be joined today by Emma Walmsley, Luke Miels and Julie Brown. I am pleased to say Deborah Waterhouse, CEO of ViiV, returned this week full time but David Redfern- Chairman of ViiV, will be covering HIV today.

Tony Wood, our CSO, will also be joining us for Q&A.

Today's call will last approximately one hour with the presentation taking around 30 minutes and the remaining time for your questions.

Please ask only 1-2 questions so that everyone has a chance to participate.

Before we start, please turn to slide 3

Slide 3 | Cautionary statement regarding forward-looking statements
This is the usual safe-harbour statement.

We will comment on our performance using constant exchange rates or CER unless otherwise stated.

I will now hand over to Emma on slide 4

Q1 2025 performance on track | Emma Walmsley

Slide 4 | Q1 2025 performance on track
Thank you, Constantin, and it's great to have you on board. And welcome to everybody joining us today.

Please turn to the next slide.

Slide 5 | 2025 performance on track
GSK continues to make strong progress. Group sales were up 4% this quarter, core operating profit grew 5%, and core earnings per share rose 5% to 44.9 pence. This performance was in line

with our expectations and again demonstrates the quality, strength and resilience of GSK's portfolio.

Sales growth was driven by Specialty Medicines, our largest business, up 17%, with strong contributions from Respiratory Immunology & Inflammation, Oncology, and HIV. As expected, Vaccine sales were down 6% and General Medicines sales were broadly stable.

R&D delivery has continued - with 2 out of the 5 FDA product approvals we expect in 2025 - now secured; and we completed the acquisition of IDRx - which adds another very promising oncology asset to our pipeline.

Cash generated from operations was over £1 billion, providing further funds to invest in growth and to deliver returns to shareholders. Our dividend for the quarter was 16p and we have commenced the £2 billion share buy back programme announced in February.

Alongside this, we are proud to have sustained progress with our Trust goals and estimate that in the last 4 years GSK has reached at least 2 billion people with our vaccines and medicines, including through our global health work.

Finally, we are confirming the financial guidance previously given for 2025.

Next slide, please.

Slide 6 | Pipeline progress delivering future growth opportunities

We continue to make good progress on delivering R&D productivity improvements and future growth opportunities.

As we said at the full year, R&D is very focused on delivering the potential of 14 key pipeline opportunities, all of which are expected to launch between 2025 and 2031 and all of which have peak year sales potential of more than £2 billion. This portfolio demonstrates the strategic shift we have made to develop more specialty medicines, many of which offer long-acting, preventative type care and better adherence for patients.

Along with the recent approvals for Penmenvy and Blujepa, we continue to expect FDA approvals for Nucala COPD imminently; Blenrep in July; and depemokimab by the end of the year.

Innovation in our pipeline also continues to be recognised. We received another breakthrough designation for our novel ADC targeting B7H3. And, we look forward to sharing more data from our ADC programmes later this year. This quarter we also presented data from our high-potential, HIV injectable portfolio at CROI including positive data from our third generation INSTI, which

advances our leadership position in the development of long acting agents to treat as well as prevent HIV infection.

Our number one priority for investment remains growth through innovation – organically in R&D and with continued targeted Business Development - and we are specifically prioritising investment to key assets in RI&I and Oncology – alongside long-acting HIV and core Vaccine opportunities.

On a broader investment front, we were also very pleased to "break-ground" in our new state-of-the art manufacturing facility in Marietta, Pennsylvania this quarter – this is squarely targeted on increasing manufacturing capacity for new pipeline products in the US - and means that GSK will have 6 manufacturing sites in America.

Next slide please

Slide 7 | Confident in commitments to growth

We remain highly confident in our commitments to growth. Whilst there are clearly elevated levels of uncertainty in the macro-environment right now, including from possible sector tariffs, we start from a position of strength. Our momentum, together with the strength of our portfolio, the resilience we have built in our supply chain and our proven capability to drive operating leverage, mean we have the ability - and options - to navigate and mitigate this.

This underscores our confidence that 2025 will be another year of profitable growth; and why we remain on track to deliver our guidance and our outlooks.

With that, I will hand over to Luke.

Performance | Luke Miels

Slide 8 | Performance: growth drivers

Thanks, Emma. Please turn to the next slide.

Slide 9 | Q1 growth led by Specialty Medicines momentum

In Q1 we delivered £7.5 billion of sales, up 4% versus last year demonstrating the resilience of our diverse medicines and vaccines portfolio.

As Emma mentioned, growth in the quarter was driven by Specialty Medicines, which continued to more than offset anticipated headwinds in our Vaccines business.

By region, growth was driven by Europe up 11% with the US up 4% impacted by a challenging comparator base and the introduction of the IRA, which, as previously stated, we anticipate to be a £400-500 million headwind through the year.

Next slide please.

Slide 10 | Specialty Medicines - Continued momentum across all therapy areas

Specialty Medicines continued its excellent momentum, growing 17% in Q1, with strong performances across all therapy areas. In addition, three of the five product approvals we expect this year are in Specialty Medicines – Blenrep, Nucala in COPD and depemokimab – and I will talk about them shortly.

RI&I was up 28% in the quarter.

Benlysta, our treatment for lupus, grew 39% and Nucala, our anti-IL5 biologic treatment, grew 21% with both benefiting from strong demand, as well as the comparator, which saw US channel inventory reductions in Q1 last year – a benefit which will not repeat in the remainder of the year.

In Oncology, Q1 sales were up 53%, with sales of Jemperli and Ojjaara both more than doubling.

Jemperli, the only immuno-oncology-based treatment to show an overall survival benefit in endometrial cancer, continues to see increased patient uptake in the US and Europe following all-comers approval for primary advanced or recurrent endometrial cancer.

Ojjaara sales were driven by higher US volumes and strong uptake following new market launches in Europe and International. Market expansion continued in Q1 with launches in Spain and Italy.

We expect excellent momentum in our Specialty Medicines portfolio to continue and reconfirm our 2025 sales guidance of low double-digit per cent increase.

Next slide please.

Slide 11 | Specialty Medicines - Three new growth engines in oncology and respiratory this year

Innovation is our priority, and we have three exciting approvals expected in Specialty Medicines this year.

Blenrep was approved in the UK earlier this month, and has an FDA PDUFA date in July. With a projected overall survival benefit of 33 months in DREAMM-7 compared to standard of care, a manageable safety profile and low treatment burden, feedback from physicians is that Blenrep could redefine second-line multiple myeloma treatment. Dose interruptions enable them to

manage ocular side effects, and it's an immediate 30-minute infusion administered in a community setting, which is where 70% of patients are treated in the US.

We are being very thoughtful about the launch, which will be staged. We'll work hand in hand with individual physicians and small numbers of patients, to ensure dose management is understood and the ophthalmic support network is in place. Laying this groundwork will help to firmly establish Blenrep in the second-line multiple myeloma market – and demonstrate the benefits of this transformative medicine.

Turning to respiratory, GSK has been a leader in the prevention and treatment of respiratory disease for more than five decades. In 2015, we launched Nucala for severe asthma, the first monoclonal antibody to target IL-5. Next week, we are expecting FDA approval for a major new indication for Nucala – to treat COPD, the third leading cause of death worldwide, affecting more than 300 million people globally. We have an experienced field force in place and are ready to launch, and we expect to share the full phase III MATINEE trial results very soon, including data on the reduction of most serious exacerbations which lead to hospital presentations, which are known to be the strongest indicator of disease progression and death.

Also in respiratory is depemokimab, our exciting new anti-IL-5 medicine with 6 monthly dosing, which has been filed in all major markets for approval in both severe asthma and chronic rhinosinusitis with nasal polyps, with a US FDA decision expected towards the end of the year.

In a pooled analysis of the SWIFT pivotal studies in asthma with type 2 inflammation characterised by blood eosinophil count, depemokimab demonstrated a 72% reduction in exacerbations requiring hospitalisation, and feedback from the asthma community on these data has been very positive. In a poll of pulmonologists, 86% think depemokimab could become a new standard of care and 82% said they would consider prescribing depemokimab ahead of alternative biologics.

There is a significant opportunity to increase uptake in bio-naive patients, given rates in asthma remain low. We estimate only 21% of eligible asthma patients currently receive a biologic. With patients potentially benefiting from increased adherence from a twice-yearly dosing schedule and we anticipate depemokimab will also capture share from shorter-acting alternatives. This underpins our confidence in depemokimab's multi-billion pound peak year sales potential.

I'll now handover to David to cover HIV.

Performance | David Redfern

Slide 12 | HIV: 7% growth in Q1 2025 fueled by gold-standard INSTI1-led innovation

Thank you, Luke.

We continue to deliver strong growth and momentum in HIV treatment and prevention, with sales growing +7%, driven by competitive execution and strong patient demand for our industry leading innovative portfolio in Dovato, Cabenuva and Apretude – all with gold-standard integrase inhibitors (INSTIs) at the core. In the US we saw strong double-digit volume growth, driven by long-acting, partially offset by some impact from the implementation of the IRA and from channel mix.

Our leading oral 2-drug regimen Dovato continued to grow strongly in all regions at +19%, while our long-acting injectables Cabenuva and Apretude grew 38% and 63% respectively. We remain delighted with the strong and continued momentum of our long-acting portfolio.

Cabenuva is the first and only approved long-acting injectable regimen for the treatment of HIV with 77,000 patients globally now benefiting from this transformative medicine. We shared data at the CROI conference in March, demonstrating Cabenuva's high, long-term effectiveness in real-world studies including almost 15,000 people living with HIV. These data underline the high patient preference and treatment satisfaction for Cabenuva compared to daily pills.

Apretude - the first and only approved long-acting option for HIV prevention - is now benefiting 21,000 individuals in the US. We remain confident in the competitive profile and growth of Apretude with strong efficacy - at more than 99%, safety and importantly, overall tolerability across broad populations. At CROI, we also shared implementation study data, showing zero cases of HIV acquisition, as well as high persistence addressing adherence challenges some face with orals.

The potential for the long-acting market remains significant with the total HIV market today worth more than £22bn and with treatment accounting for 90% of this. We expect the use of long-acting injectables to continue to rise significantly through strong patient demand, physician belief in the unique benefits and increased infrastructure to support their administration.

Given the strong start to the year, we remain confident in our 2025 guidance of mid-single digit percentage growth, driven by strong volume growth partly offset by pricing dynamics through the IRA and channel mix.

Next slide please.

Slide 13 | HIV: Strong progress across next-generation INSTI1-led treatment pipeline

At CROI we shared exciting data highlighting our great HIV pipeline progress, including three high potential assets in our treatment pipeline.

Delivering the best resistance profile of any INSTI we've seen to date – we were delighted with the phase IIa data for our third generation INSTI, VH184. Results demonstrated rapid and high potency, positive safety results and no drug resistance mutations. This promising early data supports further development of VH184 as the backbone of our next generation of HIV treatment regimens with IP cover through to 2039.

We also shared phase IIb data showing that our bNAb, N6LS achieved high efficacy and tolerability. These results combined with pharmacokinetics (PK) data support progressing this asset to explore six-monthly dosing. We look forward to seeing Q6M data in the next phase of this study.

Moving on to VH499 – our investigational capsid inhibitor. Data from a phase IIa study also showed potent antiviral activity and favourable safety, again supporting further development of this asset.

With these multiple data read outs, we remain on track to confirm the assets that will deliver six-monthly dosing for treatment in 2026, with our Q6M registrational study start planned in 2027. As you can see on the slide, we expect our Q6M regimen to contain a combination of one of three long-acting INSTIs – CAB ULA, VH184 or VH310 - with either our bNAb N6LS or VH499, our capsid inhibitor.

And then, turning to Q4M - our PrEP bridging study is fully recruited, we expect data in mid-2026 and anticipate starting our Q4M treatment registrational study by the end of this year.

As pioneers in long-acting injectables, we are focused on the next-generation of HIV innovation with integrase inhibitors – the gold standard for HIV treatment and prevention – at the core. We remain confident that our pipeline - including three new INSTIs in development and five planned launches - will continue to drive performance over the coming decade and we will share more at a meet the management event in Q2 2026.

With that, I will hand back to Luke.

Performance | Luke Miels

Slide 14 | Vaccines

Thanks David.

Turning to Vaccines, sales for Q1 were over £2 billion, down 6% on last year, in line with expectations.

Shingrix sales declined 7%, with growth in Europe partially offsetting lower sales in the US and International. As anticipated, the pace of penetration in the US is slowing, with the cumulative immunization rate reaching 41% at the end of 2024.

Sales in International were impacted by the annualization of rapid uptake from the national immunisation programme in Australia in Q1 2024 and the agreed lower supply to our co-promotion partner in China. In Europe, strong growth was driven by the excellent launch in France and good performances in other European markets including Spain, the Netherlands, Italy and Greece.

Shingrix has now launched in 54 markets, with recommendations in more than 40 markets and national reimbursement programmes in 24. Growth outside the US this year will be supported by expanded funding, the launch in France and a new Japanese national subsidy for shingles vaccination. The average immunisation rate across the top 10 markets outside the US is now around 8%, so there is still a significant opportunity for Shingrix ahead.

In Meningitis, our portfolio was up 20% in Q1 with strong double-digit growth across Europe and International driven primarily by Bexsero. In February, we received US FDA approval of our new pentavalent vaccine, Penmenvy and were pleased to have also received a unanimous recommendation from the Advisory Committee on Immunization Practices, or ACIP to the CDC. In time, we expect this vaccine to simplify immunisation schedules - increasing coverage and protection against a serious life-threatening illness.

Turning to RSV, Arexvy sales were down 57% in the quarter, against a challenging comparator and the impact of restricted ACIP recommendations. However, Arexvy continues to be the US market leader, retaining 55% of the older adult vaccination share.

Two weeks ago, ACIP voted unanimously to recommend adults aged 50–59 at increased risk to receive an RSV vaccine. We welcome the expanded recommendation, which opens up access to a cohort of around 13 million people. Although in the current vaccines environment we don't expect a significant upside this year and this market will take time to build, we remain confident long term in the importance of this vaccine.

We also presented 36-month immune response data from our 004 study. The data provided evidence to support future revaccination with Arexvy underpinning our strong belief that a revaccination will be required with our base case at 5 years. We expect more data on this in 2026.

Outside the US, Arexvy has launched in 37 markets, with recommendations in 18 markets and national reimbursement programmes in 6 with more to come. Although it's pre-season, we are seeing some early access momentum outside the US and particularly in Germany following recommendation and reimbursement.

As expected, Established Vaccines sales were impacted by non-repeating prior year sales partially offset by higher US demand for our Measles, Mumps, and Rubella vaccine.

Overall, we continue to expect vaccine sales to decrease low single digit per cent in 2025 while remaining confident in the medium to long term prospects of this business and pipeline.

Next slide please.

Slide 15 | General Medicines

Turning to General Medicines, Respiratory sales were up 1% driven by Trelegy up 15%, which benefited from continued patient demand, SITT class growth, and increased market share.

Trelegy is the number one brand in asthma and COPD worldwide. It is the cornerstone of our COPD treatment portfolio and is soon to be complemented by our new biologics that are an add-on to Trelegy as standard of care, cementing our leadership in the COPD space and reflecting our long legacy of leadership in respiratory health.

Overall, General Medicines sales were stable in the quarter, with Other General Medicines down 3% owing to continued generic competition, as expected.

In March we received FDA approval of Blujepa – a new antibiotic to treat uncomplicated urinary tract infections. We are on track to launch in the second half and we will focus on building access over time. Later this year we will be pursuing a regulatory decision for the second indication in urogenital gonorrhoea and we plan to build on our anti-infectives portfolio in coming years.

Overall, for the Gen Meds portfolio, we continue to anticipate sales to be broadly stable in 2025.

I'll now hand over to Julie.

Q1 2025 performance | Julie Brown

Slide 16 | Q1 2025 performance

Thank you, Luke, and good afternoon everyone.

Next slide, please

Slide 17 | Operational leverage continues to be delivered through the P&L

Starting with the income statement for the quarter, with growth rates stated at CER.

GSK has started 2025 well, carrying momentum through from 2024, with sales increasing 4% and Core operating profit growing 5%, against a very strong comparator base of 35% growth last year.

Sales benefited from the continued strength of Specialty, up 17%, more than offsetting the expected decline in Vaccines. Volume growth more than offset price erosion stemming from the Medicare Part D redesign implemented at the start of the year, and as Luke mentioned, the impact of this through the first quarter was in line with our expectations.

Turning to the income statement, we have delivered another quarter of operating leverage:
Gross profit benefited from product mix as our portfolio continues to transition towards higher margin Specialty Medicines
SG&A increased 8% YOY, but +4% excluding the Zejula royalty credit
Royalty growth was 21% driven by prior year true ups

These factors have supported the delivery of 5% operating profit and EPS growth, or, 8% operating profit growth excluding the Zejula credit.

Turning to the Total results, the significant growth in operating profit predominantly resulted from lower CCL charges compared to last year and foreign currency movements.

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Slide 18 | Q1 2025 core operating margin

This chart illustrates the substantial margin progression we have continued to deliver on an underlying basis, driven by benefits from the transition to Specialty Medicines, as well as our ongoing, disciplined, returns based approach to investment.

Core operating margin improved to 33.5%, up 130bps excluding the prior year Zejula credit, or 30bps YoY in total.

Accretion was driven by mix as gross margin benefitted from the strong growth of higher margin Specialty Medicines, including one-off benefits from Nucala & Benlysta comparator bases, as Luke mentioned.

We continue to invest in our key products, including Blenrep, depemokimab & Ojjarra, with underlying SG&A rising broadly in line with sales. For the full year we expect SG&A to grow low single digits as we allocate resources to support our launches over the coming 12 months.
R&D grew marginally below sales this quarter and is expected to accelerate as we progress through 2025, driven by investment in our next wave of key specialty pipeline assets.

Next slide, please.

Slide 19 | Q1 2025 free cash flow up £0.4bn

Turning to cash flow with commentary before the one-off impact of Zantac payments.

Cash generated from operations was £1.4bn.

CGFO improved £0.2bn, reflecting higher operating profit and favourable movements in RAR, partially offset by adverse movements in receivables driven by higher Arexvy and Shingrix collections last year.

Free cash flow improved by £0.5bn, excluding Zantac, supported by a favourable Capex comparator that included upfront BD payments last year to Hansoh.

Zantac payments this quarter totalled £62m and we now expect £1.2bn of payments to be phased over the remainder of 2025, with ~£0.5bn expected in Q2.

Next slide, please.

Slide 20 | Capital deployment prioritises business growth and shareholder returns

Through the quarter we have continued to deploy cash in line with our capital allocation framework, whilst ensuring this remains underpinned by a strong balance sheet.

Free cash generation pre-capex was over £1bn which supported:

Investment in our oncology pipeline through the purchase of IDRx as Emma mentioned earlier
And our continuing commitment to shareholder returns
We have returned over £0.8bn to shareholders through both the dividend and SBB, where we completed nearly a quarter of a billion pounds in Q1

We remain committed to investing for growth and providing attractive and growing shareholder returns.

Next slide, please.

Slide 21 | FY 2025 guidance confirmed

We are very pleased with the business' performance, which as outlined, was driven by strong growth of key products and higher than anticipated royalties.

These results reinforce our confidence in the delivery of our full year 2025 guidance of 3-5% sales growth and 6-8% operating profit and EPS growth.

Royalty income for the year is now expected to be higher than previously guided at £750-800 million, including an IP settlement relating to RSV, agreed in April; comprising of an upfront to be credited in Q2 and a future royalty stream. This additional income will be reinvested in the pipeline this year, with R&D investment growth now expected to be slightly ahead of sales.

In terms of phasing, we continue to expect profit growth to be second half weighted, albeit to a lesser extent than previously anticipated, with Q2 now benefiting from the IP settlement. More details around phasing and the modelling assumptions are contained within the appendix.

Looking beyond, we remain confident in our medium and longer-term outlooks to '26 and '31.

Should tariffs be imposed, as Emma mentioned we are well prepared and start from a strong position. We have identified potential mitigation options in supply chain and increased productivity initiatives; and we remain committed to sustained investment in our pipeline and launches.

Next slide, please

Slide 22 | IR Roadmap 2025 to 2026

Turning to our roadmap, on the back of thirteen positive phase 3 readouts last year, GSK has carried pipeline momentum into Q1 with the two new US approvals previously highlighted.

Looking ahead, we expect 3 more approvals for Nucala COPD, Blenrep, and depemokimab this year, with PDUFA dates in May, July & December respectively. We expect all three to be important growth drivers for GSK. Over the next two years we expect this momentum to continue as our pipeline delivers new growth drivers and we look forward to 15 phase 3 and pivotal study readouts in respiratory, hepatitis, LA HIV and oncology.

And with that I will hand back to Emma for closing remarks.

Summary | Emma Walmsley

Slide 23 | Delivering strong and sustained momentum

Thanks, Julie.

So, to summarise, GSK is delivering with a good start to the year. Momentum in our portfolio is supporting our ability to continue to deliver mix improvement, operating leverage and cashflow.

Despite the environmental uncertainty, we continue to expect 2025 to be another year of profitable growth and we remain very focused on investing in the pipeline, targeted business development and successful launches to fuel further growth– to achieve our potential - and more – for patients, shareholders and our people

Thank you very much, and with that I will now open up the call for Q&A with the team.

Q&A

James Gordon (JP Morgan): Thank you for taking two questions. My first question would be about new launch expectations. There are two important approval decisions coming up - *Nucala* COPD on 7 May, and *Blenrep* on 23 July. Assuming things are still operating as normal with FDA and you get timely approvals, what are your latest thoughts in terms of how those launches go? What are the gating factors and best precedents for how they go? And could we strong uptake already in H2, or are these more 2026 stories? I guess a negative for *Blenrep*, could ocular tox and education around that, or would other things you need to do around that, be a barrier to a fast launch? For *Nucala*, is Dupi COPD the precedent?

That is the first question. The second question is on tariffs. I have heard the comments about being well-positioned and also that there could be some mitigating options and productivity offsets. Can you elaborate on what the impact would be? Let's say there is a 25% tariff on bringing products from outside the US into the US: what would the impact be on GSK and how quickly could you have these offsets or productivity benefits? Would it be that you would actually move US manufacturing or something else? Is there an inventory, or other cushion – is that what you are referring to?

Emma Walmsley: There is quite a lot in there, but let's start with what matters most, which is the exciting new launches we are bringing across that portfolio. Luke, perhaps you would like to kick off there, and then I will come back on tariffs.

Luke Miels: Thanks, James, yes, there is a lot there. I will cover it in order and Tony can jump in if I miss anything. I will go through *Nucala* first. I think I'll touch on *Penmenvy*, because we will have questions on that, depemokimab and *Blenrep*. I won't cover *Blujepa*, because I covered that in the opening intro.

First, with *Nucala* COPD, yes, the main PDUFA is on track. The MATINEE data is going to be published very soon, and so this limits what I can say but, in big picture terms, in terms of an apples-to-apples comparison to Dupi, I think we are very competitive. We also have a wide spectrum of patients with emphysema, combined emphysema and chronic bronchitis patients, and then singular chronic bronchitis patients as well. From a physician point of view, that is very appealing because it can be difficult to stratify these patients at times, so that is simpler for their practice.

The important thing when the results are released – the trial was designed to look at hospitalisation and emergency department visits, which the Dupi studies didn't in their protocol design, so that is an important measure when you look at pulmonologists and what they consider to be critical when they are employing a biologic in these refractory patients.

If you look at market research, it's very supportive and that has grown over time. About 83% of pulmonologists, when we showed them the profile of the product, are very motivated to use *Nucala* in COPD.

I would counter this by saying that pulmonologists are generally pretty conservative in their usage of biologics - as I said earlier, about 21%. That needs to be, in terms of your ramp, factored in. The other thing with that of course, then, we are looking very, very closely at Dupi – where their access, the user base and why people are using it. We are very much looking forward to the launch. We have had a whole successful series of indications and expansions with *Nucala* and so the capacity for doing this is that we have a good track record. We are looking forward to having fun with competing against Sanofi there.

In terms of *Penmenvy* –

Tony Wood: Sorry, Luke – there is an additional point to stress for the study. As you say, we are looking forward to presenting the data very soon now. It is important to recognise that the study was conducted over a two-year period and that is critical for a disease whose survival rate at five years is only 50%.

Luke Miels: Yes, absolutely – and I think 11% mortality, which, again, is why, when we do these surveys with physicians, they cite hospitalisations as a key parameter.

In terms of *Penmenvy*, which is our pentavalent meningitis vaccine, just to remind you that we have a very strong position as a global leader in meningitis. With *Bexsero*, our MenB vaccine, we get about 75% market share in the US, and that is really driven by its 110-strain coverage and it's really perceived to be the stronger of the two MenB vaccines. That's important because when you deploy or use a pentavalent vaccine you then need to use - with a subsequent B follow-up that I'll explain in a minute - you need to use the B vaccine that was embedded in that pentavalent, which we believe gives us a good position.

We've passed the first of two steps – FDA approval and then the ACIP recommendation on April 16 - the schedule that's signed off is the same as Pfizer's and it is more complex. ACIP has signalled that they intend to evolve this - which I'll come back to in a minute – but basically, if you look at the numbers today, first shot is with ACWY, which is stipulated as a routine vaccine by ACIP in the US, so about 90% of kids in the US actually get that vaccine.

Then when you have these kids progress to 16-18 years of age - adolescence, the schedule is that they should have ACWY as a routine, and today about 60% of those kids get that vaccine, so quite a big drop-off. Now the physician at that point, based on shared clinical decision-making, can either use a B-shot, and around 32% of kids get that shot in the US, then there's a subsequent follow-up second booster shot with meningitis B, but only about 13% of adolescents or children in the US get that one, so quite a substantial drop-off from 90% down to 13%, despite the fact that B is a very, very challenging and potentially lethal strain.

What ACIP signed off on the other day was that instead of that ACWY and B combo, after that initial ACWY shot, using shared clinical decision-making the paediatrician can elect to use a penta vaccine like *Penmenvy*, and then follow that up with a B.

If you're confused at this point - a lot of paediatricians are confused - they have to stock four vaccines. Where ACIP has indicated they want to go – and that's the third step – it's a simpler regime where basically it would be ACWY initially, but the penta and then the B follow-up would be risk-based. That's an important shift because with risk-based, that supports a broader use, it enables physicians to look specifically into who should be vaccinated. For example, an 18 year-old going off to college would be a classic there, and it's an opportunity for us to expand coverage, so again, initial, the launch now with *Penmenvy* will be relatively small because of this change that paediatricians and payors are waiting for, and the aim is ACIP has signalled that they will look at that in October or early next year, so hopefully they cover that in October.

Third one – anything on that one, Tony? [*No*] Depemokimab, very, very exciting: I think the more that this product is profiled - remember we can't promote these products, they are not approved – physicians get access to the data through academic congresses, publications, etc. Again, I think the main problem when you look at biologics is just the lack of penetration despite excellent insurance coverage, and yet really high burden for these patients in terms of severe disease, exacerbations, hospital admission, but still, as I've said earlier, only 21% of patients get a biologic.

What's interesting is that if they do get a biologic, about 65% of them across biologics discontinue in the first 12 months. To me, that's very, very attractive for an effective, long-acting - two shots a year - which really reduces the patient burden, it gives the physician confidence that the patient has coverage, and the shot will be in the US given within the clinic, so the physician has total control of efficacy in that patient.

When we look at market research, it continues to strengthen. I think this is a great test: if we ask HCPs in Europe and the US, in the US, 45% say they'd use it in bio-naïve immediately, around

54% in Europe – again, that's without education, promotion, etc. – and then 66% of them, in both the US and EU would consider switching established patients on biologics across to depemokimab.

Then when we look at patients, six out of ten patients say that's clearly easier for them versus every two weeks that they have with dupilumab right now, going to twice a year, and nine out of ten said they'd switch if their doctor recommended it.

I think we have an evolving, very, very competitive product here. We have established success in severe eosinophilic asthma, the target is well-known, the profile is established, so again, I think with that one we should see an encouraging launch.

In terms of the source of patients, we are targeting about half of them, that is what we want to target initially is to get naive patients who don't have complicated histories on the product but again, I think the difference, the other 50%, some will come from *Nucala*, some will come from other products and then finally anything on that one, Tony, I missed?

Tony Wood: No, all good.

Luke Miels: Finally on *Blenrep*, again, on track in terms of the July approval date. The DREAMM-7 data is when we look at market research is incredibly compelling. I think one note of caution when you do see other surveys, we are not out there promoting the product yet, so we are limited obviously on what we can go beyond publications and presentations. Clearly I think the progression of daratumumab into the first-line opens up a big opportunity for *Blenrep* in that second line but some caution in terms of how we introduce it. If you look at the options that they have in second-line right now, particularly if you are community based haemo-oncologist who treats 70% of these patients and clearly want to retain these patients in their practice for as long as they can, then *Blenrep* really is the compelling option. They are not really seeing CAR-T as an option in the community because of the complexity of CAR-T, and I think as CAR-T has evolved the benefit/risk profile continues to become more complex.

If you at bi-specifics then again a very rigorous induction process, hospital admissions, complicated dosing, highly frequent dosing and I think what is increasingly emerging is this

infection risk. When we look at market research, it seems like community based haema-oncs are under representing that versus what the data has been published so far, so I think as they start to use those products and get experience with them, that will increase.

In contrast with *Blenrep*, we have a very, very well-known benefit/risk profile with 7000 patients being exposed. Clearly we know the focus needs to be on managing the ocular side effects which are reversible, and I think the stats, Tony if you want to cover that in terms of just how many patients are impacted, how quickly it reverses and maybe give some colour on that.

Tony Wood: Let me talk just on some data before I get into a reminder for everyone that we have a 42% reduction in risk of death from the DREAMM-7 study that is a projected 33 months of additional life. Then just to quickly cover the numbers on the ocular side effects, they are important, 66% of the individuals on the DREAMM-7 study had no vision changes, 32% had blurred vision but that was for only 11% of the total time on treatment and only 2% had serious side effects which were all reversible.

Emma Walmsley: At a headline level, James, these are important launches with meaningful data for patients and prescribers. I think we are cautious in terms of materiality of contribution this year, Luke has often described the *Blenrep* launch as 'go slow to go very big' and we know that whether it be there or our ongoing emergence of oncology or indeed in respiratory, these are very material contributors to the next chapter of growth on the 2026 and 2026-31.

Quickly on tariffs, I am not going to add a huge amount to what's already been said. First of all, what is in our guidance for this year is obviously the tariffs that have already been announced but I refer you to our press release where we are very specific that in the face of potential sector specific tariffs and we obviously have been very focused on preparation in a lot of detail and we look carefully at other 232 reviews, we think we have multiple levers and we see we have multiple levers at our disposal to both navigate and mitigate this. The three main ways we think about this are first of all, already through the enormous amount of deliberate work that was done through the separation to create regionally resilient supply chains, it was good to see, as I said, us break ground

on the sixth manufacturing site and most of our US products in some way touch the US supply chain as well and we have dual sourcing when we look across other regions.

Obviously we were delighted secondly with the shift in the gross margin through our own deliberate intent on more specialty products. Then thirdly, it's about delivering and accelerating already identified productivity improvements across various areas in the P&L, but we definitely believe we have further opportunity there.

We are prepared. We have a lot of agility and detailed work underpinning this. We think we can navigate and mitigate in the interests of patients and GSK shareholders which is where we are confident in our reaffirmation of outlooks.

Next question, please. I'm hoping we have covered an enormous amount on the launches already which may shorten some of the others.

Kerry Holford (Berenberg): Thank you very much, a couple from me please. Firstly, on vaccines, I wonder if you can talk to your experience so far with the new US Administration, vaccine business, demand, I guess, given the negative rhetoric. Are you seeing a negative impact on the demand of your vaccines in the US, particularly within the paediatric space? I would love to hear your views on whether there is a risk now that RFK Jr makes it more difficult to secure true approvals, perhaps here indeed at some point a booster for *Arexvy* in future. Just your feedback and your views on the US vaccines market as is stands today.

Then, secondly, on Medicare Part D Redesign, I think you did reiterate the £400-500 million headwind for the year, and you did say, Julie, that it was within your expectations in Q1. I wonder if you can quantify that. And also, do we expect around half of it still to be centred on HIV? Thank you.

Emma Walmsley: Julie may add to that, but I would say we are absolutely spot on, on where we thought we would be around the Part D impact and including by product area, so HIV. You're right. Anything else on that?

Julie Brown: I think it's a good summary, Kerry. We were bang on expectations. HIV is the largest part with £150-200 million, Speciality is the next one, because they tend to be the more expensive medicines. Then the balance is across vaccines and GenMed. We have treated it on a straight-line basis over the quarters so the cost obviously it is evenly spread throughout the year.

Emma Walmsley: Luke may want to add to this, but, as you know, we gave a cautious outlook on the year on vaccines. We are exactly where we thought we would be at this stage, and remember, with a really challenging comparator versus last year on our vaccines business. None of this takes away from our fundamental confidence in the field, and our ambition for our pipeline over the medium term, and we seek to separate between speculation and actual experience. Obviously it has been good to get the approval of *Penmenvy* away and a double unanimous vote at ACIP. We have to see where CDC comes out.

Luke, in terms of what we're seeing, in terms of consumer behaviour – you commented on paediatrics.

Luke Miels: Thanks, Emma. Yes, Kerry, there are a couple of ways I can cover this. Firstly, the facts are that ACIP has just given the green light to the paediatric vaccine with *Penmenvy*, so I think that's encouraging. Of course, it needs a signature, but I think that's a good directional sense.

If you look at our established vaccines overall, which include a lot of paediatric vaccines like MMRV, they were down a little bit but that's really due to phasing, so ASO3 phasing in Canada, Rabipur and some of the EU clawbacks where the MMRV vaccine in the US rolls up 25%. I think that's also encouraging.

If you look more broadly, we do track vaccine hesitancy and attitudes to vaccines. One of the numbers I was looking at the other day, within *Arexvy*, if someone declines *Arexvy*, it is strongly recommended by physicians, particularly the 75-plus age group. When we look at why does someone decline and not do that, it is only 17% of the cases that say they are against a vaccine. Let's see in time, but so far, so good.

With *Arexvy*, the impact is more predating the current Administration. It was really ACIP's decision at the end of 2024 which no doubt we'll get back to later on. Overall, to Emma's point, cautiously optimistic in terms of the direction that we set.

Emma Walmsley: In terms of your specific question on re-vax – as you know, our base case for that is five years. The data that will be presented on that will be coming through in 2026 and the earliest – if it is a five-year base case – let's see, but that isn't until 2028. Honestly, I think the current – if I can say – environmental uncertainty will have settled down pretty clearly by then. Obviously, ongoing questions around Covid vaccination are pertinent for us.

Next question, please.

Jo Walton (UBS): My two questions are both for Julie. Looking at SG&A, 4% excluding the base comparison, you have such a lot of new products to launch. Even allowing for the fact that, in Respiratory, you've already got people there, as it comes to the antibiotics, as it comes to camlipixant and so on, could you tell us how long you think you can keep that SG&A growth so low, and still be utterly confident that you are giving the very best support that is required for those new products coming through?

Secondly – and this is tariff-ish related – could you just explain or confirm for us that, when you ship product around, and you ship stuff into the US, it is largely at a sort of API type price, so that any tariffs that were put on would presumably be relatively absorbable? We note that in your Annual report, you do take quite a big benefit from intellectual property regime elements and that is presumably an ability to do that in the UK and, in particular, in Belgium for vaccines. I think there

is some concern that, perhaps, when you ship your vaccines across to the US, perhaps they go off at a high price, including some element of royalty and that would be more difficult to absorb. It is just the tax, and confirmation as to how you move your stuff around, so that we can do our own work on what broader tariffs might mean to your business initially. Thank you.

Julie Brown: Thank you very much for the questions, Jo. In terms of SG&A, obviously I am working very closely with Luke and the team on this and I will invite him to comment as well. We feel that we have an opportunity. The areas in which we are launching products are the areas where we have a very strong position already, possibly with the exception of Oncology, which we are still building. We are very strong, as you know, in Respiratory, and you have referred to it already. There is a real synergy we have found between *Arexvy* and *Trelegy*, as an example, in terms of the launch of *Arexvy*, and the benefit also on *Trelegy*.

We work this through very carefully. We do a multi-year plan. We look at the launches and we look at how we can reallocate resources from the more mature lines and we use marketing mix models and various other tools to understand the response rate to the marketing investment we are making and the field force investment we are making. Our basis is driving continued productivity and you have seen us drive the P&L quite strongly in terms of the leverage we generated last year – 8 on the top and 13 on the bottom. It is the same this year – we continue to do this. We are very committed to doing that. Luke, do you want to add anything?

Luke Miels: If we were having this conversation five or six years ago, we would be talking about a primary care structure etc., whereas the reality is that we have evolved it extensively. The products I just covered before are dramatically more concentrated resourcing events, with smaller sales forces and less DTC, so we are very confident we can support these products and evolve it. That is really our core bread and butter day job, to do that. Again, as the mix moves to more specialty dominated, that gets easier, of course, because of the factors that Julie has just outlined.

Emma Walmsley: And just on the tariff point?

Julie Brown: In terms of the supply chain, our supply chains are inherently complex. As Emma mentioned, as a result of the demerger, we often have dual sourcing. The majority of our products are touching the US in some way through the supply chain.

Emma Walmsley: Including vaccines.

Julie Brown: Including vaccines, yes, absolutely, and therefore we wouldn't be in a position of obviously when we're calculating the value of the tariff, if it came it would all be based on the customs value, therefore the API is actually not that relevant in terms of the pricing of this.

As Emma mentioned at the beginning, we have done a lot of work on this, we have looked at multiple scenarios, we're very confident in our position, which really stems from the supply chain dual sourcing, and it also stems from the productivity initiatives which are well under way in the company, that we're totally committed to delivering.

Emma Walmsley: Right, thank you. Next question, please?

Graham Parry (Bank of America): I just wanted to follow up on that point on tariffs: if you have productivity initiatives there, what's incremental in those? Is R&D, for example, a target, and why wouldn't you have just been doing these before? Secondly, just wondered on *Shingrix* if you could quantify the sales into China, where's Zhifei with inventory, and actually, do you think you could see some sales this year through the course of the remainder of the year?

Then last one was just on *Arexvy*: the 36-month booster data that was shown at ACIP and the ISIRV conference in Brazil actually showed a lower antibody boost than you saw at the 24-month data, so what gives you the confidence that the vaccine is boost-able at all, because that's staying low and is at the sort of level that saw no incremental efficacy benefit at the second season? Thank you.

Emma Walmsley: Thanks. I'll come to Tony to talk about revax, where we still have high confidence that's the most likely scenario, and Luke might want a sentence or two on *Shingrix*.

Just to be clear in terms of productivity, of course this is about our ongoing, continuous work to improve the productivity, and I would say primarily in SG&A, where we do have sufficient spending, Luke and Julie have really emphasised – of course we all know, the best way to drive leverage is by the top line, and that's going to be through focusing wholly efficiently and effectively on our growth-driving products, but there is always opportunity to do more, and by the way, technology is advancing all the time to enable us to do more.

Now, there is ongoing work in terms of continually improving the productivity of R&D, and likewise we're going as fast as possible, but as Julie said, our first priority is to continue to increase investment behind the acceleration of the pipeline, whether that be the delivery of the current wave, or arguably just as importantly, making sure we set ourselves robustly for ADCs, for the next wave of COPD, for further lifecycle innovation, for the accelerated delivery of the BD we're doing, which is why we want to use the settlement we've delivered to increase investment in R&D later this year.

So we're going at all of it as hard and fast as we can, and we see that as one of the levers to pull as we navigate through potential scenarios which we absolutely do take into account with our modelling forward.

Tony, do you want to quickly comment on revax?

Tony Wood: Just a couple of quick ones – Graham, as you appreciate, there is no vaccine efficacy correlate established yet. Just to remind everyone, in terms of the three-season vaccine efficacy data that we have in the lower respiratory tract population, we go from 83% efficacy in season 1 to 48 in season 3, so we are seeing waning. The immunogenicity point that you raise is a baseline effect, and if you stratify individuals within that study by their baseline you see a greater boost with lower baseline.

Luke Miels: Thanks, Graham. On China, I'd described it as a work in progress, we are making progress but it takes time. I think we have the right strategic partner, we reshaped the arrangement, but I think the macro and POV, point of vaccination, dynamics we're watching very closely, but we are seeing encouraging trends. We had around £54 million sales in China in Q1, and

we're maintaining a market share of about two-thirds versus Ganwei, which is good because I think the one third of Ganwei patients are not our target business, because of their out-of-pocket sensitivity. If we have deliveries, and we're watching this closely, they'll be for the second half.

Emma Walmsley: Yes, I think we were pretty cautious in our outlook for China for this year because of the broader macro, as you would all understand. Next question please.

Simon Baker (Redburn): Thank you for taking my questions, two if I may please. Firstly on the PrEP market, it was a strong performance by *Apretude*, Gilead reported strong numbers for Descovy and they sighted broader awareness of prevention and actually cited your promotional activity. I wondered if you could just give us an update on the dynamics within the PrEP market, in terms of switches versus new to prevention? Related to PrEP and the US, is there any impact from the shutdown of USAID on clinical trial recruitment? I was thinking of studies like the Palisade Study which is still showing as ongoing recruiting and others have suggested that USAID is quite handy in terms of trial enrolment and coordination, so any thoughts on that would be helpful.

One for Tony on camlipixant, we have the CALM-1 study coming up in the second half of this year. I just wonder what a good result looks like there and how relevant is the data that was recently published on the SOOTHE study as a road map for the likely outcome of Phase 3 and what constitutes a good result? Thanks so much.

David Redfern: Thanks Simon, on the clinical trial side, there has been some reduction in funding from the Federal Government to different investigators and different clinical trial networks, that hasn't specifically affected us, it has had some impact across paediatric studies that have been going on. Obviously we are working with the community to do what we can there but there has been no direct impact on GSK or ViiV.

I think on the PrEP market, through Q1 it has definitely continued the trend we are very pleased with the performance of *Apretude*, as I said in my remarks, over 21,000 patients now on *Apretude*. We continue to build this market and we know that firstly, it is an underdeveloped market,

only a third of Americans that could potentially benefit for PrEP are getting PrEP, so there is a huge market development opportunity and we recognise obviously competition will go up in the second half of the year. I think that competition could help expand the market and there's definitely an opportunity to switch more of the oral patients into long-acting because we know that the assistance and therefore the efficacy is much greater. We are very pleased to have two real world evidence studies at CROI that I think demonstrated that very clearly in the US and Brazil with the PILLAR and ImPrEP studies which showed 100% efficacy but importantly a very strong and long persistence. It's always work in progress and it's a big change for sexual health clinics and physicians to move from oral PrEP to long-acting PrEP and there's setup and a whole number of more complex administrative procedures but progressing well.

Tony Wood: Just on camlipixant and Simon I am not going to disclose what we set as the clinically significant baselines for the CALM studies, other than to say that both studies were designed with an objective of showing a clinically significant effect on cough. CALM-1 will read out this year, CALM-2 will read out next year and of course we won't be disclosing the broader data across those two studies until we pool them, this is typical for our Phase 3 studies.

Just a quick reminder for everyone about why we are interested in camlipixant, this is a molecule whose selectivity profile is many orders of magnitude is in excess of related agents and Simon to pick up on that, that is very clearly seen in the SOOTHE study, in which in the taste disturbance which has been a challenge for others was tenfold lower than that for comparator agents. Just a quick reminder about SOOTHE for you, that was a Phase 2 study looking at individuals with 25 coughs per hour and what we were able to show with camlipixant in that study of both the 50mg and 200mg is that a BID regimen achieved a 34% placebo adjusted reduction in the 24 hour cough frequency.

Rajan Sharma (Goldman Sachs): Thanks for taking my question, just a couple left actually, just ahead of the *Blenrep* PDUFA, have you had any interactions with the agency on the

potential REMS requirement and if not, could you potentially just talk to your base case assumption for a REMS and how potential scenarios here could influence uptake.

Then secondly just one on capital allocation priorities. Given that valuations are significantly lower than perhaps a year or so ago, is there a potential for you to be more active on the BD front? Or is the macro backdrop likely to be a limiting factor? Thank you.

Emma Walmsley: Very quickly, you are absolutely right – our appetite for BD remains high. We think there may be some opportunities in this environment. Obviously, we have to be cautious about assumptions on the macro but that is a question of discipline and returns. We continue to be busy reviewing and connecting and so that is still definitely a priority for us.

On the scale and pace of what you have seen us doing, we were pleased to get IDRx away but, certainly, it is a key priority of capital allocation going forward.

Let's go to Tony first, just in terms of FDA. We will not get ahead of ourselves on that, considering that it is not very far away but, on your comments on REMS. Luke, perhaps you could say just very briefly how you see that in terms of uptake, because I know that it is something you really want to invest the time in getting right.

Tony Wood: I might just bridge that with the UK approval that we have. Obviously, our regulatory interactions are confidential, so I won't get into the details of those but it is worthwhile stressing, as I am sure you are aware, that REMS are not uncommon for new oncology medicines. You have, for example, for Herceptin the need for cardiac scans, for enhertu in the management of interstitial lung disease, in doxorubicin on cardiomyopathy. Within that, it is useful to take a look at the UK approval, which requires eye examination for each of the first four doses associated with *Blenrep* – I'll let Luke speak to that and the opportunity for us to set up relationships with high street providers to complete that.

I won't repeat what I said earlier but the important point is really an understanding of the data in terms of efficacy and resolution of side effects, and their severity in the ocular events.

Luke Miels: Thanks, Tony. REMS are obviously something that are familiar to haem-oncologists as a number of agents used in multiple myeloma have REMS. I won't break down our assumptions on various REMS designs but I think commonsense would say that the less burdensome - more supportive, versus the more complicated, but we are spending a great deal of time and this goes back to my earlier point, which is that it is really about supporting the physicians. We understand much more about the dosing of this product and dose hold, etc, so the behaviour of the product and how the ocular dimension can be managed through dose hold, and really accessing that overall survival is an important component.

We are also spending a lot of time on the nuts and bolts of how the patients go through the system. How do you make it as easy as possible for haem-oncologists when they have their patient in front of them, who has just progressed on daratumumab? How do you make it as easy as possible that they can put their practice machinery in place in a community setting, to get that patient onto *Blenrep*?

We have also looked at a lot of things like collaborations with optometry groups. We know that 90% of patients in the US, or potential patients in the US with multiple myeloma, live within half an hour of an eye care professional – which is not surprising, because most of them are older and need some form of glasses, like probably a lot of the people on this call! Again, we are being very thoughtful about how we navigate that, and that is all we can say at this point beyond what Tony has covered with the UK.

Emma Walmsley: Brilliant, thanks, and for the reference to our aging profile!

We have time for one more last question.

Sarita Kapila (Morgan Stanley): Hello, thanks for taking my questions. I have a quick one on your long-term HIV strategy. Do you have any plans to develop longer-acting orals as we have seen from some of your competitors? If these long-acting orals are successful, how do you

see that impacting your competitive positioning, given the double-down on injectable pipeline. Thank you.

David Redfern: Thanks for the question. I think we are primarily focused on generating longer acting injectables. We are very pleased with both the progress with *Cabenuva*, which obviously is the first mover in long-acting injectable treatment. It is great to see the growing momentum there, both in the US and in Europe. We are focused around taking that forward, both four-month options and then potentially longer options, six months and so forth. I'm very excited with the data we presented at CROI on 184, which really showed rapid and very potent anti-viral activity, and very importantly, a very broad resistance profile. We'll have more to say on that next year, but I think we're getting increasingly excited about 184 as being a significant potential medicine.

In terms of the weekly orals and so forth, we're obviously monitoring that. I think they will likely largely cannibalise daily orals, and we'll have to see how that goes. There are different views and different levels of market research on patient preference and compliance, and so forth. Our focus at this point is really building on the first mover long-acting treatment advantage we have, and we see very clear patient preference to go there.

Emma Walmsley: Great. Thanks David, and thank you everyone for joining the call. We are only at Q1, but it's great to have a strong start for GSK, we're very much on track to deliver our 2025 outlooks, despite the weather, with strong growth in our biggest business in Specialty Medicines, and of course, most importantly, really exciting, continued pipeline progress. We look forward to catching up with you in coming days and months, and thanks for joining the call.

[*Ends*]