

GlaxoSmithKline Plc
Investor Update
Wednesday, 23 June 2021
Questions & Answer Session

Emma Walmsley: Welcome back. I will start with some questions that I can read on the screen. I will read them out and then, of course, we will go to the line.

First of all: what factors did you consider when deciding the mechanism for Consumer separation? Why have you decided to retain a stake and why up to 20%? As a follow-up, when will you sell down this stake and what are the tax implications? I will ask Iain in just a second to pick up on some more of the details but I will just remind you what we stated earlier.

The Board obviously looked into and put an enormous amount of thought into the different options that we had around the mechanism for separation. There were three really clear criteria: first of all, to unlock the value of two businesses; secondly, to strengthen the balance sheet of New GSK, which we do of course through the improvements in our operating cash flow, both through the separation and through the up to £8 billion dividend and the short-term retention; and then, thirdly, and with absolute primacy, is shareholder value creation. On that basis, that is why we decided to go for demerger and retention of this specific stake.

We know it was one of the questions that shareholders wanted us to answer today, to be clear exactly about the mechanism. As Iain stated in his presentation, this was a stated preference for many of our long-term shareholders.

Iain, perhaps you could give a little more detail on the other supplementary points.

Iain Mackay: Absolutely. As it relates to the 20% retention, that is our stake, so you will recall that our stake in the joint venture with Pfizer is 68% and so 20% of that, broadly speaking, is somewhere around 12% to 13%, which would be the maximum amount that we would expect to retain. The expectation is that that will be a short-term financial investment. It will be sold down on a timely basis after the separation, once New Consumer Healthcare is a premium listing on the London Stock Exchange with almost certainly ADRs listed in the US also. We would expect to sell that down in a timely basis.

In terms of tax implications, this is structured in a way that is intended to be efficient for our US and UK shareholders. When we demerge and those shareholders would receive a

share in the New Consumer Healthcare business, that should be – and is clearly subject to approval from both HMRC and IRS – a tax-free event, up to the point when those shareholders might choose to monetise that stake, which would then obviously trigger tax. This should be an efficient approach for certainly a significant number of our shareholders.

Emma Walmsley: Thanks Iain.

The next question is: you refer to Pharma and Vaccine synergies frequently but, apart from COVID, I am not clear on where these exist. Do you have tangible examples?’

Again, Iain, I will come to you in just a second on the way we approach capital allocation and the financial synergies, and then it will be over to you, Hal, on R&D and science.

Let me first of all say that both Vaccines and Specialty Medicines are absolutely core to the strategy of New GSK and, as you have seen today, to the growth of New GSK. Our purpose is to get ahead of disease and that means being about both prevention and treatment. Our R&D strategies are all around the science of the immune system, which is obviously relevant both across Vaccines but also across all four of our core TAs.

In terms of operating synergies, I will just point out that our Chief Commercial Officer here runs all of the general managers, with the exception of our ViiV business which obviously Deborah leads. A general manager in every country is accountable for both our Vaccines and our Specialty and General Medicines business. In fact, right at this moment, I think we have some *Trelegy* sales reps who are supporting in the US our drive for *Shingrix* uptake post- the success of the COVID vaccination programme.

Iain, you also referred in the cost review through the Future Ready programme that we have been ‘de-duplicating’, if I can say that, where we do not need to have separate structures, but in our corporate and back offices there are many synergies there which we have been increasing as we come together through the catalyst of the separation.

Iain, perhaps you could talk about the really critical capital allocation point.

Iain Mackay: Certainly, Emma, the operational efficiencies that you talk to go to the one development organisation that Hal is leading the development of with Roger. It goes into our corporate functions and our supply chains as well at a certain level.

When you come back to the capital allocation aspect, allocating our capital which is focused on the development and strengthening of our pipeline gives us a breadth of opportunities in terms of putting the capital where the greatest opportunity is for GSK, across

our therapeutic areas, through Vaccines and our Specialty businesses. Hal has put a really strong discipline around that and Hal can probably go into much more detail about what this really means from a capital allocation perspective across the portfolio.

Hal Barron: Thanks, Iain. Yes, there are so many different ways that the Vaccines and Pharma groups can come together for synergies. The capital allocation, just to add a little more colour on that, at the PIB when we are faced with these interesting decisions about which assets to back and how much capital to put behind them, we have very robust efficiency frontiers that allow us to evaluate, within Pharma, which assets are more attractive from how many patients we can help, and commercial value. We use the probability of success and the revenue curve generated by Luke, but having the opportunity to allocate capital across both Pharma and Vaccines allows us to move money to where the great projects are. I am sure that we will optimise the portfolio just by having that incremental opportunity, so it is an important one.

The one development organisation, clearly, is going to add synergies. When you think about the convergence that is occurring in Pharma and Vaccines – we used to think of diseases either needing prevention or needing treatment, but they are really converging. COVID is a great example but we have others – particularly when vaccines, like in flu, aren't working at above 90%, which we would love to have. There is an opportunity to use a vaccine in conjunction with an antibody and that is what we are doing with the Vir antibody and the flu vaccine – potentially a multi-valent with the mRNA. There are lots of interesting ways to think about that.

Hepatitis B is another great example because another opportunity in vaccinology is to develop what is called therapeutic vaccines so that we can actually use it in patients with the disease to treat them. Therapeutic vaccines are often very attractive and, when you think about the fact that we have – and Luke talked about this – the HBV antisense oligonucleotide for hepatitis B, now you are seeing that we have two different approaches in the same disease. The synergy is there in terms of a development plan, with unique endpoints and operational efficiency for sure.

There is an enormous amount of synergy on the science side that I will take a minute to talk about. We can think about our focus on immunology, which is essentially what vaccinology is – it is a focus on the immune system. Our deep focus on immunology on the Pharma side, really complements what we are learning on the Vaccine side. An example of this, when you think about it, our focus on immuno-oncology – what is that doing? It is waking up the immune

system to allow our endogenous immune system to see foreign antigens, called cancer cells – that is what an adjuvant is for vaccinology.

We are actually contemplating maybe some of the agents we are developing in immunoncology, like STING – a STING agonist – might be a very effective adjuvant. We are learning from vaccine trials which of the polyclonal responses, which monoclonal, might be driving that vaccine response – and well, that monoclonal, if we figure it out, could be a therapeutic. Learning from trials, learning preclinically, from the bioassays we are developing to get a sense of whether a vaccine is working. There are so many different things that I could talk about but there is an enormous amount of scientific synergy as well. It is very exciting.

Emma Walmsley: Fantastic. The next question: what led you to set the dividend at this new level? It seems generous, given the focus we heard about today on investing in the pipeline?

It is absolutely right to reiterate – as shared by both myself and Iain in our capital allocation priorities – that our No. 1 priority continues to be to invest in our future growth in the pipeline, both organically and inorganically. That is clearly our priority and we are really pleased to be able to use this separation as a catalyst to keep strengthening the balance sheet so that we can invest in that growth and, at the same time with this new policy, provide competitive and progressive returns.

I will ask Iain again to give a little more specificity on how we and the Board came to this policy, and how we thought about it.

Iain Mackay: Absolutely. There is a very strong focus around the investment and strengthening the pipeline but also setting the dividend at a level that is both sustainable but, importantly, progressive. The opportunity to grow this dividend as earnings improve over the coming years is a really important aspect of this policy. I wouldn't say that 40 or 60 is a target but it is a corridor within which we would expect to operate, and that certainly will allow us to grow the dividend over the coming years as earnings improve. It will also sustain it in the longer term, when you would naturally expect in some years to see EPS variability.

I think this strikes a very appropriate balance between setting an attractive return – which, by the way, we think compares very well with our peer group in the industry – and allows us to strike the right balance between investing in R&D and long-term growth, improving the overall flexibility and strength of the balance sheet over time, and setting an attractive policy of returns for shareholders with the potential to progress it and grow it over time.

Emma Walmsley: Exactly. Again, we know that this was a key question for investors and so we wanted to be very specific and very clear on it today, right down to the penny. Hopefully that is helpful for everybody.

We will now go to the phone line.

Graham Parry (Bank of America): Thanks for taking my questions and thanks for the meeting and presentations today.

Firstly, for Roger, on *Shingrix*, talking about doubling sales in five years is actually broadly what the street is expecting at the moment, but does that take you to capacity? Will growth then become capacity constrained beyond that and perhaps flat-line relative to expectations?

Secondly, for Iain, on the gearing less than two-times net debt to EBITDA post spin – how are you treating the ViiV put and the pension liabilities within that? Are you treating those as debt? What leverage would you be happy to stretch that back up to for the right deal or deals?

Thirdly, on HIV for Deborah or Kimberly, on the IP protection on the Halozyme cabotegravir products, do you expect these to have longer-dated protection than the cabotegravir 2031? Is there any possibility to apply that technology to any other novel molecules coming through the pipe, or are we just really pushing the dolutegravir cliff from '28/29 to a cabotegravir cliff in 2031 in the HIV franchise? Thank you.

Emma Walmsley: Fantastic, Graham. Thank you. Let's take those in order. Roger?

Roger Connor: Graham, thanks very much for the question. The simple answer is that we will not be capacity constrained, going forward. We will not hit a ceiling. We have done incredible work in the whole manufacturing side to accelerate that capacity expansion on a number of different fronts, so supply will not be a constraint for us.

What I would say on *Shingrix* is that obviously it is a massive brand for us and a huge opportunity. It will contribute to growth for a long period of time. At some stage in the US we will maximise in terms of the catch-up cohort, and Luke also then shared the geographic expansion plans which, again, are significant, with 35 additional countries in terms of the number that will be launched in the next three years. Geographic expansion and further

indication expansion for *Shingrix* will be a key driver for us going forward, but supply is something that we should not be concerned about.

Iain Mackay: That was a great question, Graham, thank you. On leverage, we expect less than two times net debt to EBITDA. Our contingent liabilities as related to Shionogi and the like are not an integral part of that calculation.

In terms of what we think the overall strengthening of our balance sheet means, where I think you are going from a business development perspective, is on the focus and whether it comes from the stronger cash flows with clearly some guidance set in that regard today. This is coming from obviously growing sales; improving operating profits; expanding margins; the de-leverage of the balance sheet on the back of the dividend from before the split of Consumer Healthcare – these all help to strengthen the balance sheet, inform a much lower leverage point and then obviously inform the strategic flexibility and the strength of that balance sheet to continue to do business development along the lines that we have done. We are very focused on bolt-on acquisitions and in-licensing agreements – those have worked very well for us over the last couple of years. Clearly, as we strengthen the balance sheet, it increases our capacity and capability to continue to pursue the strengthening the pipeline as we have done over the last few years.

I am very happy with where that takes us and the opportunity to move forward from here.

Emma Walmsley: Just to remind everybody, when we say ‘more than £33 billion’ that does not include any contribution from any further business development, or very little from the early pipeline. Of course, we expect all of that to continue to accelerate, considering the recent momentum.

One of our most recent deals, of course, was Halozyme and so, Deborah, I don’t know how you and Kim want to do this.

Deborah Waterhouse: I’ll start, then pass to Kim. Just on the opportunity and the question that Graham asked. Where we are today is that we have cabotegravir for prevention, which hopefully will be approved by the end of this year and launched next year, and then we have cab/rilpivirine, brand name *Cabenuva*, which was launched at the beginning of this year and offers long-acting opportunities for people living with HIV. Obviously, we are playing in the prevention space in the near future, so that is great news.

The Halozyme deal, which Kim will talk about in a minute, gives us more shots on goal. It gives us the opportunity to aim for an ultra-long-acting prevention and treatment opportunity

for people living with HIV, but also it really gives us an opportunity to bring extra time in terms of ultra-long-acting to our pipeline of medications. We don't get any additional IP, Graham, from the Halozyme deal itself, but what we do get is from the medicines that we can add to cabotegravir we basically have a sort-of second generation of long-acting medications and the medicines that you put with cabotegravir have patent life into the 2030s. So that is where you see the portfolio moving beyond the 2020s and into the 2030s. That is how you generate long-term value from having cabotegravir at the core. In the last 10 years, we have had dolutegravir, which we built a franchise around with *Tivicay* and *Triumeq*, then moving into *Juluca* and *Dovato*. Now, what we are going to do is exactly the same over the next 10 to 15 years and beyond, where we have cabotegravir at the core, with *Cabenuva* today and CAB PrEP now just about to come. Then you add these additional medicines, with new mechanisms of action, onto cabotegravir and that takes you into the next decade and past the 2031 patent date for cabotegravir alone. That is the IP landscape. Kim, maybe you would like to say a few words about the Halozyme deal.

Kimberly Smith: The Halozyme deal is extremely exciting because of the possibility of what it can do for each of the products. The one that is right in front is obviously cabotegravir. We already have cabotegravir out to every two months and the combination with Halozyme could potentially get it out to every three months and beyond, but that is the same thing for every one of the other mechanisms of action that I mentioned in the pipeline for our future combinations with cabotegravir. Each one of those mechanisms of action was already selected because of its potential as a long-acting agent.

What the Halozyme deal does is to take it to be an ultra-long-acting. Instead of thinking about whether it can be a month, or can it be two months, we are starting to be confident that we can get at least one, if not several of those products, to three months or more. What this really does is increase our shots on goal to get to that ultra-long-acting combination and that is really what patients are telling us: the longer the better, and that is what we are intending to deliver.

Emma Walmsley: Thanks, Kim. I have to say that it has been fantastic to see the way that you have led the pioneering innovation in our HIV business: first with dolutegravir; first with two-drug regimens, and first with long-acting. There are completely pioneering data in terms of the CAB/PrEP, and it will be exciting to see what we do with the longer-acting long-acting. Fantastic.

Next question, please.

Seamus Fernandez (Guggenheim Securities): [*Technical difficulty: caller not connected*]

Emma Walmsley: Seamus, we can't hear you. Perhaps we can come back to Seamus and go to the next caller on the line?

Laura Sutcliffe (UBS): Thanks for the detailed update today. My first question is on core operating margin progression. Is it achieved largely via shifting product mix? Should we assume that the bulk of that improvement is back-weighted towards the end of the 2021-26 time period? My second question is on BD and strategy. I think you talk about your BD strategy being directed towards bolt-ons and in-licensing. Does that signal more of a desire to own your opportunities outright, rather than partnering or further JVs? Lastly, on the mRNA vaccines programme, can you do multi-antigen mRNA vaccines and make the economics work cost-of-goods wise, or in other words what conditions would need to be met for them to be viable commercially? Thanks.

Emma Walmsley: Let's go to Iain first on the progression of core operating margin, although I think you will get guidance in year, and then I would like Hal to talk about our overall approach to BD because we have had this huge acceleration recently but also looking forward. Again, it is not included in our outlook, any future BD yet. Then we will come to Roger on mRNA including that factoring into COGs - in that order.

Iain Mackay: Laura, margins. Mix is clearly an important component of this but so is the continued focus around cost management, productivity and efficiency. As we set out today, we have delivered today already £500 million of savings from programmes that we have executed between 2018 and now, and we will deliver another £1 billion of savings between now and the end of 2023 with most of those programmes completed in 2022. Then there is an ongoing focus on what we do in terms of productivity and efficiency day to day. We expect to see improving margins coming through from 2022 and we will continue to build from there.

We have set out an operating profit CAGR of more than 10% and an operating margin of more than 30% by 2026 but we are going to start moving in that direction from 2022. It is just continuous progression, I am not going to give you a totally linear set out year by year but, clearly, when we get to setting our annual guidance, we will set out our expectations in each year.

Hal Barron: Thanks for the question, Laura. Just to back up, our focus in business development, which we think is a very important way of augmenting our organic pipeline, is to really focus on the strategy that we laid out in the middle of 2018 which is to look for opportunities that leverage our focus on the science of the immune system, as well as opportunities that leverage our understanding and focus on human genetics, functional genomics and machine learning. To be more specific, we look for opportunities in immunology if we can see some unique opportunities that would fit strategically with what we have. With the focus on the immune system in immuno-oncology, as you have seen we have done deals that have bolstered our focus on the CD226 axis, so for instance we did a deal with iTEOS recently for the TIGIT antibody and we had done part of that deal with surface oncology on the PV RIG. We had advanced CD96 into the clinic with 23andMe, the first of that collaboration to get into the clinic and, of course, with the Tesaro acquisition, the PD1. So, that is a good example of how we are using our focus on the science of the immune system, our focus on oncology as a therapeutic area to then craft a number of business development deals to result in what we believe is a very impressive CD226 strategy.

We also have opportunities with human genetics to pursue everything from novel genetic targets that we have insights to from, say, 23andMe databases, or Open Targets or Fingert or the UK Biobank that we think are unique knowledge that we have that others don't, so that is another area that we are going to focus on.

Also human genetics, functional genomics allow us to do a lot of interesting business development with companies that might be having synthetic lethal targets. For instance, the opportunity that we had to do a deal with IDEAYA where we now have in the clinic a first-in-class MAT2A inhibitor in Phase I which, as I mentioned earlier, is going to potentially be very synergistic in patients whose tumours have the MTAP deleted. We also have the Pol Theta and Werner Helicase as well, so you can see how our business development strategy is really complementing our research focus as well as our TA focus.

As far as types of deals, of course, we are open to bolt-ons, we are open to product deals and you asked whether collaborations would be an option and, of course, they are, so we are open to a lot of different things.

Emma Walmsley: One of the things, Hal, that you have brought a lot for us is the gated risk in some of these partnerships and collaborations which has made quite a big difference as far as our capacity management, so we will continue to pursue all of that. Roger, over to you on mRNA.

Roger Connor: Thanks very much for the question. On mRNA we are incredibly excited by the technology. Obviously, there is a major opportunity for GSK here and it is one in that we are investing significantly and adding it to our portfolio of technologies that we have.

Specifically on multi-valent mRNA vaccines, I think that is going to be an area of opportunity for us as well.

On our second generation CureVac partnership, one thing that attracted us to that technology is the potential for lower dose, which allows you to add more antigens potentially and avoid increased reactogenicity because of that lower dose as well. You will see us doing this in both our COVID multi-valent approach and our flu strategy that we talked about today, bringing a multi-antigen flu vaccine to the marketplace to ensure that it creates a differentiated broader coverage.

When you have that opportunity from this second generation technology, we also think that we will get combinations with potentially other disease areas: we could look at a flu combination with COVID, we could also be looking at combinations with RSV. Those are all things that we want to do and utilise this opportunity of the lower dose.

Cost of goods I am not worried about. Obviously, it is high at the start of a technology's lifecycle but particularly because the dose is smaller, as I mentioned, it is again an opportunity for us. The other benefit of mRNA is the capital flexibility that you get when you start to create multi-purpose factories and reduce your capital bill as a result, so I think that we will start to see that cost of goods come down over time. If you have a differentiated product, I believe that the market will pay for that as well, and we believe that we will have differentiation particularly in flu.

Emma Walmsley: Thanks, Roger, next question please.

Seamus Fernandez (Guggenheim Securities): *[No sound]*

Emma Walmsley: I am afraid we still can't hear you. Let's go to the next caller and try again.

Keyur Parekh (Goldman Sachs): Good evening and thank you for taking my questions. I have two please if I may. First, Hal, Luke and Iain, you have given us a lot of details today but, as I look at that 2031 target you have set out for greater than £33 billion in

revenues, how much of that comes from the pipeline? I know you have given us details to 2026 but I am just wondering if you are able to give that to us towards 2031 as well?

Secondly, on the mRNA vaccines, Roger, I wonder how confident you are feeling about the CureVac partnership given the data we have seen for the first-generation vaccines and, secondly, any alternating optionalities you might have in-house. Can you reiterate and give us reasons for why you think the naked mRNA technology from CureVac may not be a problem here? Thank you.

Emma Walmsley: Thank you. Iain, perhaps you could frame overall the contributions and then we will ask Hal, as it will be very interesting for people to understand the methodology we have around our forecasting and our asset builds there, remembering it is all late stage that is contributing at this moment.

Iain Mackay: Thanks for the question. To go back to the waterfall, reflecting on 2021 to 2026, it is very much driven by in-market assets and the contribution from late stage pipeline. When you move to 2027-31, it is very much driven by the late stage pipeline with very little being contributed by early stage pipeline and nothing from BD that is not already completed. Therefore, at a high level, those are the key contributors.

As you move into 2027-31, the late stage pipeline plays a more important role as far as how we grow revenues through the latter part of the decade. Getting into some of how we inform, how we put that outlook of more than £33 billion by 2031 together, Hal, in terms of how we think about risk adjustment within the portfolio overall as we see assets move through the clinic, it might be helpful if you could provide a little colour in that regard?

Hal Barron: Sure. We do it in a pretty straightforward and, I believe, systematic and rigorous way. Basically, each asset we treat uniquely because each asset in the pipeline has a different probability of success based on a number of factors. First of all, the most important is the phase: Phase 1 assets typically have about a 10% chance of working; Phase 2 assets typically have about a 25% chance of working, and Phase 3 assets typically 65-70%. Any given asset will be above or below that depending on the data generated, the preclinical data, the robustness of the target product profile and so on.

For example, when we are looking at certain things like daprodustat where we have pretty compelling Phase 2 data and we are pretty confident that it is raising haemoglobin levels from that, we might have a higher than average probability of success when in Phase 3. However, there might be opportunities like bintrafusp or ICOS that are in the therapeutic area of

immuno-oncology which is higher risk, they are in Phase 2 so, of course, where that probability of success is typically about 25% and IO would be lower, so we would put a much lower probability of success on that. Again, each asset is treated individually and we then aggregate all those probability-adjusted numbers with revenues, as I mentioned earlier, generated by Luke and the commercial teams and we use that for a lot of different things but that is how we get to the risk-adjusted number that results in the 2031 revenue that you heard.

Emma Walmsley: Thank you and then let's come to Roger on the CureVac assets and, Hal, you may or may not want to add to Roger's comments.

Roger Connor: Thanks very much for the question. On the CureVac data that was shared last week, that is a technology that we are not involved in as GSK in terms of that development. We are very comfortable though with the second-generation technology that we have done our deal based on. The way to think of this is that it is an enhanced technology, a technology, as I have just mentioned, that gives us this opportunity with lower dose for multi-valent combination.

Why are we so comfortable? When Hal shared the data, you saw some of the preclinical information, times 10 in terms of immune response versus first technology, faster response after the first dose. Obviously, we have to prove this in the clinic so we have work to do but that is a major part of our mRNA play. However, there is optionality here and we want to make sure that we are looking at modified bases as well. Longer term, we have our in-house self-amplifying messenger RNA, which I think about as a longer-term option as far as mRNA. Where we are putting our absolute focus at the minute is in that second generation technology and bringing it to the clinic efficiently and fast, so we want to bring two assets through to the clinic in the next 12 months and we want to put six assets through in the next four years. I believe that mRNA is a big part of vaccine development going forward and we intend to be at the forefront of it, so we are investing significantly.

Hal, would you add anything to that?

Hal Barron: Let me just emphasise a couple of things, Keyur. The key thing to remember is that, at least in our view, the future for mRNA vaccines will be multi-valent. Multi-valency requires a lower dose because you can't give a certain amount of mRNA without creating reactogenicity, so if you are going to use multi-valent vaccines, you have to get the number of micrograms per valent down.

What CureVac's second generation is telling us is that, when you optimise the untranslated regions on each side, the 5 prime and 3 prime, you get more efficient translation, more protein produced. Importantly, in the long term with that combined with the modification of the uridines to reduce reactivity, because the total dose of mRNA with multi-valency might start going back up for each valent being low, you really can imagine a next generation of mRNA where we can safely and highly effectively give multi-valent vaccines with this combination of optimisation of 5 prime and 3 prime as well as the uridine modification.

Emma Walmsley: Thank you, Hal. Next question please?

Tim Anderson (Wolfe Research): I have a couple of questions. The timeline for bringing an mRNA flu vaccine to market. One big pharma company with perhaps the deepest experience in mRNA at this point made a comment to us recently that they thought it could be as short as two to three years - I would be curious to get your opinion?

Then on HIV, you talk about the value of two drug regimens and the value of long-acting regimens. What worries me here is that the competition in the form of Merck and Gilead that have not only two drug regimens but theirs will be oral, and the crux of your long-acting approach is injectable with cabotegravir which I think is even intra-muscular and not subQ. If their Phase 2 trials go as planned, they will have a once-weekly pill for treatment and a once-monthly pill for PrEP. I know you will say that they lack an integrase but studies are under way possibly to show that you possibly don't need an integrase and you can get rid of some of the weight gain that integrases cause. How is this not a reasonable threat to GSK from mid-2020s onwards?

Emma Walmsley: Thank you very much, Tim, and we will come to Deborah and Kim in a second. First of all, Roger, do you want to make any comments on timelines for flu?

Roger Connor: I won't comment on what others have said as far as their timeline but what I can tell you is the focus we have as GSK on this flu asset in terms of our mRNA second generation play. I mentioned and Hal has explained the need for a multi-valent approach and that is exactly what we are expecting to do in this vaccine. We don't want to come in and meet the current standard of care, we want to beat that standard of care and we think that we have an opportunity with that platform.

As far as our timeline, as we mentioned in the presentation we want to get into the clinic in the next 12 months and we would want to get Phase 3 data in the second half of 2025, which

would be a realistic timeline in getting there but this will be the start of it. I mentioned combinations and the opportunity to add flu to COVID could be something we are looking at as well and I do believe that, with the backbone that we have, there is a real opportunity for a universal flu play with this mRNA platform as well. Those are probably the key headlines.

Deborah Waterhouse: Thanks for the question, Tim. Over the last eight or nine years, we have really established dolutegravir as the gold standard integrase inhibitor, eight superiority studies versus competitors, and one in two people treated across the globe taking a dolutegravir-based regimen at the moment. So, I think we have built an incredibly powerful franchise based around integrase inhibitors which have an incredibly high barrier to resistance and that is the class that others will have to beat.

Now we are moving into cabotegravir and the era of cabotegravir, again an integrase inhibitor at the heart of our future franchise, and we have talked today about how we are really focused on that proven technology with *Cabenuva* for treatment and cabotegravir for PrEP as sort of the starting point of our franchise. Then, over time, using the Halozyme technology and adding that to cabotegravir both in prevention and treatment, and then adding that to our other pipeline medicines gives an incredible opportunity for people living with HIV to have ultra-long-acting treatments or treatments that they are able to administer at home. Therefore, we think that we have a very powerful value proposition not to mention that at the moment we have *Cabenuva* on the market, so a five-year head-start versus our competitors in the treatment space and in PrEP, if we are successful in securing FDA approval at the end of the year, we will have at least a three-year head-start on our competitors in the prevention space as well, so we feel very confident about our ability to compete.

Kim, do you want to add anything?

Kimberly Smith: You said a lot but let me add to emphasise why is an integrase important here. As you have already said, it is established but it is established because it has a high barrier to resistance, it has durability in its efficacy, it has durability in its safety and tolerability profile. There is a reason why every guideline around the world is that an integrase inhibitor is preferred, so that is an established place that we are building on, which I believe is a really important point. In comparison, our competitors are looking to establish new regimens with new mechanisms of action without that foundation, and we believe that foundation is particularly important.

Let me get to the other question around oral versus injectable and so the idea that an oral is preferred over an injectable I think is really subject to some debate. When you ask a patient they basically tell you that 70% of them would like a long-acting regimen, and what they tell you is that the longer the better, and so what is being again proposed by our competitors is a once-a-week oral option, again, combining two novel mechanisms of action that haven't been proven to work well together, and haven't been proven to have the capability to hold up as a two-drug regimen, and once a week still has some of the challenges that we described long-acting as actually responding to. This issue of being reminded of living with HIV, how frequently you need to take the medications, that is not improved by going from once a day to once a week; this issue of privacy and the potential of disclosure if you still have pills at home, so it doesn't address a lot of those issues.

There may be some patients who are interested in an oral once weekly, there is no question, but those are more likely patients who don't want to have an injection because if you put the choice of can you be dosed once a week, versus being dosed every two months or every three months, or beyond, patients tell us over and over the longer the better, and so we are not the least bit intimidated by the idea of oral versus injectable. We know patients want to be able to decrease the impact of HIV treatment on their lives, and that means minimising the frequency of dosing, and that is what we are trying to do with our ultra-long-acting options.

Emma Walmsley: Thank you, Kim.

We have now questions in on the screen from Seamus, thank you. One quick one for Iain to clarify the definition of peak sales guidance, which is standard across the portfolio: is that potential sustained annual peak sales or peak sales in a particular year?

Then, two for Hal. Firstly: when do you expect that we will have data sufficient to know that if your approach to HBV will result in potential functional cure similar to what we have seen in HCV?

Then, secondly: what is your conviction based on for TIGIT and what triggered the iTeos deal ASCO data, and what's the view of differentiation of our assets in competitive positioning versus other TIGITs?

Hal, quite a lot for you in that, but, Iain, perhaps –

Iain Mackay: This is where it would help to have Seamus on the line, because I have to be honest, I am not sure I entirely understand his question, but in terms of, if you like, what I would call an industry definition of peak year sales, it's the year in which you achieve

peak year sales, but if I go back to the outlooks that we talked to, that Roger talked to, is the growth rate that we would expect to see come from our Vaccines portfolio over the coming five years where we stake high single-digit CAGR over the period from now through to 2026.

I've got a sneaky feeling, Seamus, that might not entirely answer your question, but if you go to a classic industry definition of peak year sales, to the extent that we have referred to that in Vaccines, then I would apply the same definition, but I would keep taking us back to the growth rate that we have set out, that we expect to achieve for Vaccines over the coming five years, which is high single-digit percentage growth.

Emma Walmsley: Yes, and on the non-risk adjusted 20, that's obviously aggregated peak single year sales, not achieved in a year.

Hal, over to you, two questions, one on HBV and one on your excitement about

Hal Barron: Yes, two good questions, Seamus, so thank you, I understand both!

For HBV, a couple of things to remember. The antisense oligonucleotide study is really intended to do a few things. First of all, we had a very small number of patients in the Phase 2a, so we are hoping to confirm that treatment effect was real. We are hoping to determine what incremental efficacy we gained by increasing the duration, so as Luke highlighted, it was a relatively short course in the 2a. We are extending out that, looking at different ideas about whether you need to go for three months or six months, things like that, but probably most importantly in terms of the timing is that we really do believe after suppression you need to see how long it takes for the HBV surface antigen to reappear, and that requires a 48-week endpoint, so upon conclusion of the randomisation you have another 48 weeks of follow-up to get that endpoint, so we will get a lot of data from that.

What we won't know at the end of that, at least in theory, is whether that is the correct duration or do we need less, do we need more? Also importantly, because the whole hypothesis is that the elevated hepatitis B surface antigen might be inducing a type of immune suppression or a T-cell fatigue concept, and, therefore, the next question that we will have for this is does this need to be combined with an interferon, for instance? There are a lot of people in the literature that suggest that that might be a viable way, since it does seem to be somewhat active in hepatitis B.

There is also some really pretty interesting pre-clinical data on the utility of suppressing the hepatitis B surface antigen with a PD1. These are questions that will have to be answered following that data, but the short answer, just to get back to that is that we should have data in

the second half of next year because the trial is enrolling very well, we should actually finish it probably ahead of schedule, but it will require a 48-week follow-up, and so that is when it is going to take to see that data, but a very, very exciting programme and one I think Luke mentioned, there are 250 million people and the morbidity associated with this is just terrible. I have seen many of these patients in the hospital, and not only do they have cirrhosis and all the complications, but in addition, hepatocellular carcinoma is not uncommon, and so really can make a big, big difference for patients if this works, so very exciting.

TIGIT, why do we get so excited about TIGIT? There are a number of reasons, let me go into a few.

First of all, like all opportunities we first look at the pre-clinical data, and it is pretty compelling, particularly when you think about the opportunity to add the doublet of a TIGIT and a PD1, like dostarlimab, *JEMPERLI*, and we were also tantalised – it is not an enormous amount of data, but very tantalised by the study I showed you where the triplet looks like that might be even synergistic and we have biologic rationale for that, so that pre-clinical data made us very excited about the whole axis, and that's not only did we in-licence, as you point out, TIGIT, but also that whole axis, so CD96 with 23andMe, and PVRIG with Surface Oncology, so we have that entire pathway to clamp down on, which oftentimes will be incremental efficacy.

The other piece that is really to us very important too is that it is interesting that you can use human genetics sometimes to identify pathways or targets that you are particularly excited about, and, again, using this proprietary dataset with 23andMe we did genetically validate the 226 axis, so that gave us incremental confidence, and, to be honest, very important was the randomised Phase 2 designed anti-TIGIT from Roche where the treatment effect was very robust, so those three things together give us confidence, they are all triangulating on the likelihood that this pathway is active.

Now, the specific asset for iTeos we liked because of a number of things. First of all, it was one of the more advanced ones relative to other opportunities. Second, we do think that the FC portion has to be enabled. There has to be a competent FC portion, we believe. There is debate out there and we will be getting data from FC enabled and FC super-enhanced, and FC inactivated, and that will clarify that, but we do think FC activation is important.

We see that pre-clinically with this iTeos antibody. We also see it clinically where the Treg cells are profoundly reduced, which is actually unique compared to other anti-TIGITs, so that is a particularly attractive aspect, and it was only one patient, but we did see monotherapy,

which was unique for this monoclonal antibody, so when you put all that together and the cultural fit with iTeos and the desire to be aggressive and the unique opportunity for this triple we were very excited about it.

Luke, I don't know if you want to add anything to that?

Luke Miels: Yes, I will just say, Hal, it also gives us strategic flexibility. We can get insights into CD36 or 96 combos. We have flexibility in terms of pricing, so there are a lot of elements here. If you think about a triplet in future, the cost of that, if you put that in a coformulation it becomes very compelling for payers and patients alike.

Emma Walmsley: Thank you, next question, please.

Kerry Holford (Berenberg): Thank you very much. Firstly, a question for Hal, just following up on this CD226 strategy, so, clearly, you have a number of bases covered here with a number of trials at your disposal. I guess, when are the key data read outs that we should look forward to, and when can investors better assess whether your focus on that pathway has been a successful strategy or not? Just give us some ideas on timelines looking forward here.

In terms of divestment, I wonder if you could talk, how your broader appetite, your opportunity to monetise brands under the New GSK non-core products in future, are there any brands or portfolios that perhaps reside within General Medicines that could be candidates for a divestment going forward?

Then, lastly, just going back to Graham's question on the leverage ratio for New GSK, it is clear that the pensions and contingent liabilities are not in your calculation, but what is the definition that the rating agencies consider, and how might that influence your future BD strategy if you wish to maintain your A-1, P-1 rating?

Emma Walmsley: Thanks, so much, Kerry, and I am going to ask so that we can keep getting through everybody's questions, Luke, perhaps you could comment a bit on the General Medicines' portfolio because you have done a lot of work to clean that work, and then we will come quickly to Hal on data timings around the CD96/226 pathway, and then start with you, Iain.

Iain Mackay: Start with me, okay, excellent, very good. Kerry, thanks for your question.

One of the things that we set out today was the target from our ratings' perspective, so focused short-term ratings A-1, P-1 commensurate long-term ratings, and as you can imagine, we stay in very close contact with our rating agencies, S&P and Moody's, and so when we think about leverage, and, clearly, this is an incredibly important aspect of the financial strategy is that we maintain strong ratings, improve the overall strength and flexibility of the balance sheet, ensure that we have the capacity to continue to invest in R&D and the growth of the company. In terms of how we think about net debt to EBITDA, we always think about it in the context of how the rating agencies think about it, because that is going to define how we access the capital markets over the longer term, so that conversation, which is an on-going exercise with rating agencies plays an important part of how we think about leverage for the company.

I don't want to really get into the detail of how rating agencies calculate it, but we are very closely aligned in terms of how we think of that leverage.

Emma Walmsley: Luke, over to you on Gen Meds.

Luke Miels: Thanks, Emma. I think in the General Medicine's portfolio there are a lot of synergies, it is largely primary care, but we are very, very disciplined in terms of looking at this portfolio and turning it over.

I mentioned earlier that we have dropped from 400 down to 200. If you look at markets, we have shrunk from, say, 140 down to 70, so we are very disciplined in terms of whether that asset, whether that collection of products is best in our hands.

We have communicated in the past in areas like Derms. I think right now things are a little bit flat because of COVID, but in the future you can imagine we would be quite active there. We are looking around a billion, also in terms of monetising some of these equity stakes and some deals as well.

Emma Walmsley: Thank you, Luke, and Hal –

Hal Barron: Yes, thanks, Kerry, for the question.

We can't give specific timelines on a lot of things, but let me outline how to think about how we are approaching the un-gating concept.

First of all, I think there is the anti-CD96 in the clinic for us and we are uniquely positioned by it being first in class, and if this pathway is important, this should be active, not necessarily as monotherapy, which is the current design, but once we get dose escalation and

PD data and safety we will be moving to combinations with a PD1 inhibitor with *JEMPERLI*, so that could provide us with data if we start seeing activity.

Like with a lot of IO things, the timing depends on how much data you see.

I think the second thing is for our TIGIT antibody, which we are in Phase 1 with, we will be informed, not only by our own data, but I think, importantly, by competitor data, both, as I mentioned, whether or not this FC competency issue is going to end up differentiating, and possibly, importantly, whether the Phase 2 data from Roche is actually confirmed in a Phase 3 trial.

Now, it is also important to remember our concept that I think sometimes gets lost. There's first to approval, but there is also first in disease, and I want to really highlight that we have a really robust set of studies that we are anticipating doing, where we think while we might not be first to market in lung, where Roche and Merck are probably both ahead, we have some particularly interesting insights about other diseases that we might want to pursue, and we can use some data from external sources to un-gate those trials. We are pretty confident with that, as well as we are doing a lot of biomarker work, which I think can help us find PDL1 and MSI, to some extent, were used for the PD1 inhibitor class to optimise their development.

We are also looking at whether various biomarkers I won't get into could be useful for optimising our focus on the pathway.

Finally, PVRIG, which will be in the clinic later. We think that could also be an opportunity to play around with these combinations, not just triplets, but doublets with that and you can imagine all the different combinations.

It is going to be complicated, but we are really excited because we think this very well could be TIGIT plus a PD1 could be IO version 2.0 and may be analogous to what we saw with PD1, pembrolizumab in that evolution, and if the triplet should work, whether it be CD96, TIGIT and *JEMPERLI*, or even PVRIG and any combination of a triplet should work, we think that is IO version 3.0, which we think if that's to materialise, we would clearly be leaders.

Very exciting next year or two with data unravelling, but a very, very exciting pathway. I think this could be future of IO.

Emma Walmsley: Wonderful, thank you, Hal. Next question, please.

Mark Purcell (Morgan Stanley): Yes, thank you very much, and thanks for all the work put into the Capital Markets Day today.

The first question on life beyond dolutegravir, you have previously talked to CAB400 being the cornerstone with every one to potentially every three months subcutaneous dosing.

In terms of gaining confidence in this strategy, when shall we expect the first proof of concept data with CAB400, and then the first of the two combination partners that you mentioned today, the long-acting maturation inhibitor, and the broadly neutralising antibody?

Then, just a point for clarification, will the ultra-long-acting options be self-administered with the PH20, or will they be physician administered?

Secondly, in terms of vaccine manufacturing capacity, could you help us understand where you are in terms of building capacity behind RSV for older adults and RSV for the maternal side of things, where you will be at launch and the timelines to expanding that capacity, and given Roger's comments in terms of unconstrained supply now on *Shingrix*, could you remind us of the size of the ex-US target opportunity for *Shingrix* in terms of patient numbers? I think in the US it's 115 million people.

Then, the last one for Hal, in terms of probability of clinical and commercial success, if you take the 11 key assets you have outlined with over £20 billion worth of non-risk adjusted sales potential, where would you consider the aggregate risk adjustment probability today for those assets, and taking a specific one in *Blenrep*, what are the gating factors to getting above £3 billion in peak sales in terms of confidence?

I guess there is obviously pivotal data, but also you mentioned the gamma secretase proof of concept data, and it is a very competitive landscape, so how are you thinking about competitors in the ADCs, as well as bispecific space? Thank you very much.

Emma Walmsley: There are a lot of questions in that, Mark, so we will go to Roger first, but just before that, on the question to Hal, we are obviously not going to put a specific number on the risk adjustment to that late-stage pipeline. I think Hal has outlined quite clearly how we look at the assets individually, but I will come to you, Hal, to pick up on the specific gamma secretase questions, but first let's go to Roger, then Kim, three questions in there for you on HIV and then we will finish with Hal, so Roger –

Roger Connor: Yes, thanks very much for the question.

On RSV we are allocating capital and actually building capacity for RSV now.

Just so you understand the antigen for RSV maternal and for older adults is the same, so that's great, it is one supply chain for both.

The good news is it is also building off our chill-based platform which *Shingrix* is supplied on, so all of the expansion that we have done on *Shingrix*, and all of the improvement that we have done on *Shingrix* yield, which is unconstrained, this is being applied to RSV as well, so from our perspective, we've allocated capital. We are going to be ready for this launch, and as I said during the presentation, we are absolutely going to maximise it.

On *Shingrix* outside rest of the world, we are being thoughtful in terms of where we go to. We want to make sure that we protect the value of the vaccine as well, so our markets are focused in on the private areas, so I don't think it is appropriate to take all over-50s and apply that to the market globally, but there is significant opportunity. Luke particularly mentioned this in China, where we know in that private market we can achieve the same price as we are seeing in the US as well, so lots of opportunity for *Shingrix* going forward, but RSV capacity I would not be concerned about.

Luke Miels: Just one clarification, it's 115 million people in the US above 50, but around 67 million of those get a regular adult vaccination, so can we stretch beyond that? I think Roger's point also, we have different strata in the markets of course in Europe. Pricing is very much aligned with the US as it is in China. As we get deeper into the lifecycle, the question is can we go for UMs in emerging markets and fully extract the potential that this product has.

Emma Walmsley: Thanks, Luke. Hal, briefly?

Hal Barron: *Blenrep* I think you can think of as having some sort of three unguating events if you will. The first will be efficacy as it relates to how it compares to active comparator trials like in DREAMM 7 and 8 as well as DREAMM 3, so we have ongoing Phase 3 opportunities to move more proximally in the disease. That is from an efficacy perspective. We also have a whole series of studies looking at dose optimisation, both seeing if we can reduce the dose, the duration, we are playing with a lot of different things to reduce the safety concerns with the ocular tox that I mentioned, and then third, where I think is very exciting is based on this functional genomics data, and some pretty compelling biology, whether gamma secretase could be synergistic by allowing us to lower the dose to reduce ocular toxicity while maintaining the significant efficacy. That data we should actually hopefully – it's a stretch call for us to have that

by the end of the year, but I'm cautiously optimistic we'll have that data, and that could be also very un gating. So three different ways to think about how we unlock value there.

Kimberley Smith: There were a lot of questions there but let me quickly try to answer around Cab 400.

Cab 400 is a reformulation of Cab 200, it makes it more concentrated, it gives us the opportunity to give a bigger dose with a smaller volume. It really unlocks the potential for self-administration more than we had with Cab 200. But what we have now with the Halozyme deal is actually even more opportunity to give bigger doses subcutaneously, and so Cab 400/Cab 200, whatever formulation of Cab we are using, it's basically the foundation of how we build the self-administered regimen as well as the ultra long-acting regimen.

Around the timing of when we will see some data on Cab 400, we did have a little bit of delay related to COVID so that would be around mid-year next year which is when we will have those cohorts delivering that data.

I think the second question was around the BnAb, so 109 which in N6LS, that proof of concept study is open and now enrolling and so we expect to share proof of concept data for that in the first half of next year.

Then the last question was around the Halozyme and the ultra long-acting and whether or not they will be clinic-administered or self-administered. Really, when we get to these ultra long-acting timeframes, we actually think that probably is doing to be clinic-administered because that's around the timing that you would be bringing the patient into the clinic anyway, every three months, every four months, every six months, and so if we can do it in the clinic, then again that gives more convenience to the patient, it gives that privacy piece so that they don't have to worry about having products at home. They would have the potential for disclosure. That's about as quick as I can go.

Emma Walmsley: Thank you so much, Kim!

Deborah Waterhouse: Can I just ask one more? Kim said it was fantastic that we are going to have the Cab 400 data towards the middle of next year. Not just Cab 400 on its own, but Cab 400 as well, with Halozyme, so we've actually fast-tracked that to have both pieces of data.

Emma Walmsley: That is a key point, thank you. We are going to extend the Q&A session, we want to get to as many of your questions as possible. We will try and answer

them as succinctly as possible, but it will help if we don't get seven questions in one. With that point made, can we go to the next question, please.

James Gordon (JP Morgan): Thanks for taking the questions. One about HIV outlook and one about vaccines. On HIV, I saw the projection of the third injectable by 2026, but what about some further conversions beyond 2026 or 2027, once you have oral generic. I ask particularly in Europe and ex-US. Do you see that Europe is going to keep on funding the transition to injectables once there are generic orals? A few years back there were comments, and it sounds much more like this is a US opportunity. Do you think you are going to get a similar geographic split to the orals, or is Europe going to get tough once there are all these generic options?

Then to vaccines, RSV, the older adults is clearly a really big opportunity because you have that big bolus of catch-up potential, but in terms of maternal and paediatric vaccines RSV where there's not a catch-up, it just a burst opportunity, as I understand it, if there are eight million annual western births and you price at \$150 a dose, my maths says you would need about 100% of pregnancies in the west and GSK is taking 100% market share to get even to the bottom end of the range. In that range, assuming a very big ex-US/ex-EU uptake, or have I done the maths a bit wrong?

The final one, on *Shingrix*, doubling to 2026, I hear you are not capacity-constrained post-2026, I think you have probably exhausted a good chunk of the US catch-up bolus, so what has led the US steady state once you have exhausted the bolus and you're just doing that year's birth cohort for *Shingrix* in the US? Are we a long way off that already, or are we getting near that?

Emma Walmsley: Roger, do you want to cover briefly the two ends of the vaccines points and Luke if you want to add that, please do, then we'll come to Deborah.

Roger Connor: Thanks very much for the question. On the RSV maternal, we actually do see an opportunity. As I mentioned, there is a real chance to make sure that we build off the current marketplace that exists for maternal vaccination, which is established with in GSK where we could build off the DTP and flu vaccines that are already given.

We do think again that what's not fully understood is that this is a polyclonal approach and gives that potential differentiation versus a monoclonal approach going forward as well. So we do think that this could be a very impactful vaccine, not only in the US and EU that we

mentioned as well, but then globally. RSV is something we see occurring across the world, so we do think there is an opportunity here, but you're right, it's not as big an opportunity as the RSV older adults base. There is more competition in maternal as well.

However, this is where I would point to the combination that we talked about today. RSV being combined with pertussis we think, again, could be a game-changing opportunity. It's early, it's going to be going into the clinic next year, but we have access to a pertussis antigen currently. If we combine those, we will address those two key pathogens, because the maternal vaccination that's currently given in DTP really only protects the child against pertussis. That's why we think that is critical.

In terms of *Shingrix* going forward, again there is a global opportunity. Luke will build on this as well. The US cohort will be caught up at some point in time, but as we've said we have a long way to go to reach that point going forward, and then there are further opportunities in geographic expansion, particularly in China as I referenced.

Maybe, Luke, you will want to build on that.

Luke Miels: Sure. I think you are absolutely right, James. You have similar numbers that you have with PCV. Older adults is where the main effort needs to be with RSV.

If you look at maternal, from memory, penetration rates, around 60% at best in the US. There are lots of synergies in terms of paediatric purchasing within offices in the US that we can take advantage of.

In terms of the US, it's around 25 million patients who have been dosed with *Shingrix* so far. Contrast that with Zostavax over all those years of 22 million, but that's the advantage here of being free in terms of capacity.

Our aim in the short-term is to preserve pricing power with *Shingrix* in the private payor market. Once we exhaust that opportunity, then we have that flexibility to expand into emerging markets at different points through UMVs as I mentioned earlier.

There is a lot of optionality for us going forwards, but we will exhaust that cohort in the US at some point, but similar numbers, if you look at urban numbers in China, it's actually just over 100 million people who are urban-based, above 50 years of age, who have the capacity to pay for out-of-pocket *Shingrix*.

Deborah Waterhouse: To answer James' question, I'm going to split it into two different parts. I'm going to talk about treatment, I'm going to talk about prevention.

In terms of prevention, we obviously see this as a market that is going to grow rapidly. Most of the value will sit in the US and for us, about 90% of the value by the time we get to 2031 in the prevention space will actually be in the US. Prevention is going to be very dominated by the US, so generics coming into Europe or the US is not going to really impact that because we believe that the long-acting has such a strong value proposition in prevention that payors will be willing to pay because what we have today in terms of orals is not necessarily working, and more tools are needed. You only have 200,000 people taking PrEP at the moment in the US, and 1.2 million people probably should be taking PrEP, so actually more tools are needed.

We have a fantastic medicine with superiority data in cabotegravir and 90% of the value in terms of our business in prevention will actually be in the US, so that's that part of the market.

When you look at treatment, basically we have very strong data supporting our long-acting portfolio, and we have very, very strong patient preference for our long-acting treatments, so we believe that, despite oral generic competition, both in Europe and the US, we still have got a strong value proposition. It will be more skewed towards the US than where we are at the moment with dolutegravir where the split is more balanced, but we do believe that, given in the US only 50% of people who are taking medication are actually virally suppressed in the US, again there is a need for more tools, and we believe that our long-acting medications are important tools which prescribers are very keen on, and there is a strong patient preference for.

Emma Walmsley: Thanks, Deborah. Next question, please.

Matthew Weston (Credit Suisse): Three quick ones, please, largely points of clarification.

The first on your non-risk adjusted peak year sales, for the opportunities which would cannibalise your own products, 5 MenABCWY and depemokimab, are those peak sales numbers incremental, so your current revenue, or do we have to assume cannibalisation as part of that?

The second question on the flu aspirational target, I think I heard Roger say that both plants and MRNA approaches were upside to your 2031 ambition. Can you confirm I heard that right, and is that because you don't actually have commercial rights yet from Medicago and MRNA isn't in the clinic. I'd be very interested.

Then finally, just a quick one, I'd be very interested in your assumptions that *Benlysta* biosimilar entry within your 2031 aspirational target? Many thanks.

Emma Walmsley: Okay. We'll come to Roger first on Medicago, and then Luke perhaps, to give you some questions, if you could comment on any assumptions on the *Benlysta* biosimilar, and then also the non-risk adjusted sales cannibalisation. But first, quickly to Roger, because I'd like to get one more question in before we close out.

Roger Connor: I can be very quick. Just to confirm that that's exactly what I said, that our flu ambition is not included in the GSK long-term number that we've shared today. Why? Because we believe that there is still some activity to go to close out the Medicago commercialisation I mentioned, but also the mRNA piece as well. It is an early asset which will go into the clinic, as I said, in the next 12 months, but we are allocating resources and are very serious about the ambition, but it is not included in the GSK number that we quoted earlier.

Luke Miels: The ABCWY is incremental. If you look at depemokimab, really interesting. When we looked at patient surveys – and I remember this number very clearly – it was 87% of patients on a biologic would prefer to have a six month regimen, which I think is quite intuitive. A lot of opportunity there.

Again, we know the target really well. The development programme is very, very cleverly created, particularly the switching dimension, so you have patients who are stabilised on IL-5s. We can transition them, so we can target Fasenra, for example, and move patients from two months to six months.

Emma Walmsley: Thank you. Just to reiterate, that target of more than £33 billion doesn't include the vast majority of that early stage pipeline. What we wanted to do today was make sure that we reassure on growth through the decade, despite the dolutegravir loss of exclusivity. That was our goal with that. Obviously we will keep updating you as data reads out, the pipeline progresses. There will be some failures and hopefully lots of extremely exciting successes, but this is just to answer that key question which, again, was one of the points we wanted to address today.

Sorry, Luke.

Luke Miels: Just to follow up on your first question around *Benlysta*, we have no intelligence right now in terms of biosimilars for *Benlysta*. I think structurally if you think about

replicating those results, lupus is an incredibly challenging environment to operate, so the threshold for biosimilars is quite challenging.

Emma Walmsley: Thank you. Right! Last question for today, although I know we will have lots of chances to follow up with you tomorrow and in the weeks and quarters ahead, but last question, please.

Steve Scala (Cowen): Two questions. GSK believes it is the leader in adult RSV vaccines, but J&J has a very good vaccine that appears to be at a similar stage of development, so why does GSK believe it is in the lead?

The second question is – and I apologise for ending the call with a devil’s advocate question that goes back to the basics – but today GSK stated its commercial execution is industry-leading, R&D productivity is top quartile, it has a leading HIV and vaccines portfolio, it has a differentiated strategy in immunoncology which I assume could be a \$50 billion opportunity, and the guidance implies assets are ‘inhouse now, that could drive pure average growth at least so business development shouldn’t be the highest priority’, but the dividend is still being cut, a leading consumer business is being divested and management believes there is a need for a new GSK.

These are extreme measures, although everything that was said today implies the former GSK was doing just fine. In this industry, extreme measures typically are not pursued when things are going well. What is the disconnect, what am I missing? Any help would be appreciated. Thank you.

Emma Walmsley: Let me take that multi-dimensional conclusion question first, Steve, with thanks. I would refer you to one of my slides in my introduction.

What we have been working on over the last four years has been a transformational level of change in GSK. A switch in strategy to shift our portfolio from around 40%, I think in 2017, of our business in Vaccines and Specialty, to being three-quarters Vaccines and Specialty by 2026. We have been addressing long-term legacy challenges. We know this has been a company that has perennially disappointed when you look at the first half of the last decade.

In the last four years, we’ve been able to reverse the decline in top-line, we have increased, very much necessarily increased, our spend in R&D, seen a real shift in our R&D productivity, demonstrated in the last four years under the leadership of Luke and Deborah a definite step-change in the competitiveness of our commercial execution. We are addressing

questions of Group structure precisely to create value for shareholders, and unlock the strengthening of the GSK balance sheet, and set us up for a step-change in performance.

That is the key commitment that we are making today, a step-change versus our history and a commitment to competitive growth when you look at the five-year outlook, and we've really aimed to answer some very specific questions that shareholders wanted. What is this investment over the last few years, this significant amount of change, what does that translate in in terms of commitment to growth, to commitments to profit? The answer is more than 5%, more than 10%, more than 30% margin, and more than £33 billion worth of sales by the end of the decade.

With that, you had a very specific question on RSV competitiveness in vaccines. Roger, would you like to close us out with that one, please?

Roger Connor: Steve, thanks very much for the question. Just very quickly, why we're confident is the technology and the proven technology. The J&J vaccine is a viral vector vaccine. The GSK RSV, which is the most progressed in terms of an RSV older adult vaccine, is built off our adjuvant platform. It is a pre-F antigen which we know well. It is also using AS01, that is the adjuvant we use in *Shingrix*. We have seen the Phase 2 data, we are excited by it. Not only have we seen the immune response, but we have seen the T-cell response which we know is so important in this elderly population in terms of addressing age-related decline in immunity. That is why we're excited, that we're building off a platform technology that GSK has used to disrupt markets in the past, and we believe that we have a real opportunity to come in and set the bar here in terms of RSV older adults. It is a big opportunity and it's one that we're going to absolutely maximise.

Emma Walmsley: Thank you, Roger. Thank you to everybody for joining us on this call today. I hope you have seen that we have laid out for you a clear vision for the future of new GSK.

As you have seen, we have big ambitions for patients and for shareholders, and we are very confident in our ability to deliver.

Thank you very much for joining us. We are looking forward to catching up with more of your questions in coming days, quarters, and demonstrating this delivery in the years ahead.

[Ends]

