FY & Q4 2025 results

Conference call and webcast for investors and analysts
Wednesday, 4 February 2026 at 11:00 GMT

Introduction | Constantin Fest

Slide 1
Conference call and webcast for investors and analysts

Slide 2 | Agenda
Ladies and gentlemen, a warm welcome to the GSK Full Year 2025 results call.

I am delighted to be joined today by Luke Miels, Nina Mojas, Deborah Waterhouse, Tony Wood and Julie Brown. And in our Q&A session we will be joined by David Redfern.

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 Luke.

Q4 2025 strong performance improves further | Luke Miels

Slide 4 | 2025 performance: Specialty Medicines growth drives strong sales and earnings delivery

Thank you and welcome everyone.

My introduction today will have two parts:

- Headline results for 2025 and
- Our key focus areas in 2026 to drive value

Starting with 2025:

- Results were strong. Sales were up 7% to more than £32bn.
- Growth was driven by Specialty Medicines which were up 17%, with Vaccines also contributing.
- Core operating profit grew 11% and EPS was up 12%.
- Cash generation was strong at £8.9bn, supporting future investment - and returns to shareholders, enabling the dividend upgrade of 2p to 66 pence declared today.
- R&D output remained very positive - with 5 FDA approvals and 7 new pivotal trial starts.
- And we maintained our high standards for being a responsible business.

Looking forwards, we expect another year of profitable growth - reflected in the guidance given today.

Next slide please.

Slide 5 | Key focus areas to drive value

In 2026, we expect momentum to continue and we'll get there by focusing on execution and operational delivery.

There are three areas where we are focused:

- The first is driving topline growth by maximising launch products like Blenrep and Exdensur and ensuring success in overall operational execution.
- Second, accelerating key assets in our late-stage portfolio like B7-H3, B7-H4, and velzatinib in oncology, and efi in MASH; and in our earlier portfolio like the ultra long-acting TSLP for respiratory diseases and regimen selection for our 6 monthly treatment for HIV.
- And third, continue to execute BD where we see a clear pathway to value creation. And our recent addition of the food allergy IgE antibody, ozureprubart, is consistent with this.

Underpinning this will be a drive to simplify how we work - with greater pace, accountability and focus.

- And this starts by matching our best people and resources to the best opportunities to create value.

- Linked to this, changes have already been made to the executive team bringing on commercial leaders with deep industry experience to increase our focus on products and execution. And this includes Nina Mojas, our new Head of Global Product Strategy, who I worked with for a number of years at AZ and Roche, who will present the Commercial update.
- And, importantly, we will have an increased focus on leveraging practical use of AI and Technology

And I'll now hand over to Nina.

Performance: growth drivers | Nina Mojas

Slide 6 | Performance: growth drivers

Thanks, Luke. Please turn to the next slide.

Slide 7 | Full year growth driven by Specialty momentum

Overall sales for the year were up 7% with strong growth driven by Specialty, up 17%, and another year of growth in all regions.

Next slide please.

Slide 8 | Specialty Medicines

In RI&I, full year sales were up 18%, driven by strong Benlysta and Nucala performance.

In the year, Benlysta grew 22%, driven by higher demand and supported by all major guidelines. 82% of US bio-naïve patients are now starting on Benlysta, driven by its differentiated profile, with organ damage prevention and more than 14 years of safety and experience.

Nucala grew 15% and delivered £2bn for the year. This is the 10th consecutive year of double-digit growth for Nucala.

Moving to Oncology, sales were up 43%.

In the year:

- Jemperli sales were up 89%, reflecting our differentiated profile in endometrial cancer.
- Ojjaara grew 60%, driven by growth in all markets following the new data at EHA emphasising the importance of early intervention and based on these data, NCCN included Ojjaara as category

one for patients with anaemia. We expect this to drive uptake in 1L although growth will be slower than what we have seen with 2L.

- Zejula sales decreased reflecting FDA labelling restrictions, and we remain focused on the potential we have for Blenrep – now approved in 15 markets globally.

Deborah will cover HIV shortly.

Given the continued strong performance and momentum across the Specialty portfolio, we are expecting sales to grow low double-digits for 2026.

Next slide, please.

Slide 9 | Strong *Nucala* COPD delivery ahead of key launches in 2026

The strong performance of Nucala in '25 was driven by our successful launch in COPD. This launch also had a halo effect on all of Nucala's indications resulting in higher market shares in Asthma and Nasal Polyps – also fueling brand growth in '26.

We are applying the lessons from the severe asthma market with Nucala to the launch of Exdensur. which is now approved in the US, UK and Japan. We know that there is a significant opportunity in the bio-naïve population as only 27% of US eligible patients are on a biologic. And market research shows that 97% of patients would prefer or likely switch to a biologic with six-monthly dosing. And Exdensur has demonstrated a 72% reduction in exacerbations leading to hospitalisations in an indication where we know lack of therapy adherence leads to worse clinical outcomes.

The second key launch this year is for Blenrep, our off-the-shelf BCMA agent for multiple myeloma, available in the community setting, where 70% of patients are treated. We've made fast progress on our launch in the UK and are applying lessons learned in the US - particularly around eye care networks.

We've now engaged around 18,000 eye care professionals in the US enabling smooth collaboration between treating physicians and eye care professionals; and have had positive feedback on the simplification of our REMS.

We continue to expect this to be a slow ramp up as we support prescribers and patients to ensure a positive first experience and robust adoption.

I will now hand over to Deborah to cover HIV.

HIV Performance | Deborah Waterhouse

Slide 10 | HIV: strong, competitive 2025 performance accelerates transition to long-acting portfolio | Deborah Waterhouse

Thank you, Nina.

We enter 2026 confident in our unique position to lead the next transformation in HIV care.

Sales growth was 11% in the year – powered by accelerated patient demand for our long-acting injectables and our foundational oral two-drug regimen, Dovato. Demand continued to increase across all regions, most notably in the US, which grew 14% in 2025, continuing to outpace competition in market share gain.

With the only commercially established long-acting HIV treatment regimen - backed by over four years of real world data - we are delivering long-acting innovation at scale and are delighted with our ongoing portfolio transition to long-acting regimens. In 2025, over 75% of our growth came from long-acting injectables – which now represent around 1/3 of US sales.

With treatment accounting for 90% of the total £22bn HIV market – we are pleased that Cabenuva grew 42% in 2025 fueled by patient demand and accelerated switches from competitor products, reaching >75% in the US this quarter.

In long-acting prevention, Apretude grew 62% in 2025, withstanding any impact from a competitor launch.

In 2026, we expect continued growth momentum and so today we are guiding mid to high single digit growth.

This quarter we also announced Pfizer will exit ViiV and Shionogi's shareholding will increase, simplifying ViiV's shareholder structure. GSK will maintain the same position. We look forward to continuing our highly successful collaboration to advance our pipeline and portfolio of long-acting HIV medicines.

Moving onto our INSTI-led long-acting pipeline. Powered by unmatched patient insight, we are set to deliver transformative launches over the next decade, enabling us to navigate the dolutegravir loss of exclusivity and accelerate long-term growth.

We believe twice-yearly treatment presents our most significant commercial opportunity and - through a combination of novel assets – presents the potential to change the HIV treatment paradigm once again.

At CROI we will share data that will help inform our regimen selection for twice-yearly HIV treatment.

Starting with VH184, a potential first-in-class third-generation INSTI with IP protection through to at least 2040. We'll present key data on its unique resistance profile (vs a competitor) and findings from an ongoing first time in human trial exploring its significant potential for up to twice-yearly dosing. We strongly believe this asset has the power to redefine the long-acting landscape and we remain extremely confident in its potential to become the backbone of our long-acting treatment regimens.

To pair with our INSTI once selected, we are evaluating two partners: VH499 and our bNAb N6LS. Data at CROI for VH499 will show potential dosing durations. For N6LS - one of the broadest and most potent bNAbs in development - we'll share more data focused on Q4M dosing, with Q6M dosing data expected this year.

This year we'll also begin CUATRO – our Ph3 registrational study – for four-monthly HIV treatment. This critical step builds on our Q2M success and we are on track to file in 2027 and launch in 2028. At launch, we still expect to have the only long-acting treatment options on the market for years to come.

Our strategy is clear and our execution is strong. We are fully confident and well-positioned to drive sustained, long-term performance and will continue to update you on our Q6M regimen selection. We look forward to introducing you to our new head of R&D Charlotte Allerton, who will succeed Kim Smith upon her retirement at the end of Q1.

I'll now hand back to Nina.

Performance: growth drivers | Nina Mojas

Slide 11 | Vaccines

Thanks, Deborah.

Turning to Vaccines, sales were £9.2bn in the year, up 2%, driven by European and International region sales of Shingrix and Bexsero.

Shingrix sales were £3.6bn, up 8%, driven by Europe and International, offset by the US.

In Europe, sales were supported by our focus on co-morbid patients. And in International, region Japan continued to grow following expanded public funding and in China we saw similar sales to 2024. In 2026, we expect market performance outside of the US and China to benefit Shingrix sales, offset by slowing US immunisation rates and our partner in China managing inventory.

In Meningitis, sales were up 12%, with strong continuous growth across Europe and International driven primarily by Bexsero up 16% for the year. Bexsero demand increased in Europe partly due to MenB outbreaks.

Ex-US represents 69% of Bexsero's global full year sales, demonstrating continued growth from national immunisation programmes and geographic expansion. In the US, we retain MenB market leadership with 74% market share and have seen positive signs for Penmenvy with initial stock building.

Turning to Arexvy, sales were up 2% for the year, also driven by ex-US growth.

We continue to monitor the evolving pediatric vaccine landscape in the US. At this time, insurance coverage remains as before and we expect the recent HHS changes to be manageable, given GSK's broad portfolio of vaccines.

For '26, we expect sales growth to be in the range of low single digit decline to stable.

Next slide please.

Slide 12 | General Medicines

Turning to GenMeds - sales were slightly down for the year. Strong growth of Trelegy was offset by other respiratory and established products.

Globally, Trelegy continues to be the top selling brand for asthma and COPD. And in the US, the SITT class is growing, with Trelegy leading in share, driven by GOLD guidelines and strong execution.

In anti-infectives, we are taking a targeted approach to align access for Blujepa in uncomplicated UTIs with positive initial insights. And for complicated UTIs we now have a PDUFA date of 18th June for Tebipenem in the US.

Looking forward, we expect sales growth to be in the range of low single digit decline to stable, reflecting pricing pressures and generic competition of our established portfolio.

And in the US, across the broader portfolio, we navigated the impact of the Medicare redesign from the Inflation Reduction Act near the upper end of our £400 to £500m range.

I will now hand over to Tony to talk to you about our progress in R&D.

Pipeline progress | Tony Wood

Slide 13

Thank you, Nina. Next slide please.

Slide 14 | Accelerating late-stage pipeline and development of early-stage assets

Starting with the pipeline, there is greater focus and opportunity than ever before. Our top priority is to accelerate development to deliver new products to patients faster.

In 2025 we secured 5 FDA regulatory approvals and started 7 new pivotal trials, three for Exdensur in COPD, two for efimosfermin in MASH, one for velzatinib in 2L GIST and ris-rez, our B7-H3 ADC in ES SCLC.

I am delighted with the progress we are making to deliver the pipeline, shorten development timelines and access world-leading innovation through BD.

Next slide please.

Slide 15 | RI&I: Leading in Respiratory with a unique COPD[1] pipeline, including ultra long-acting assets

In Respiratory, we have extended our leadership through a focus on exacerbation prevention with long-acting treatments and now have approval for Exdensur, the world's first and only 6 monthly biologic to treat patients with severe eosinophilic asthma.

Also, in Respiratory, COPD is a growing area of significant unmet need; a patient hospitalised with an exacerbation has less than a 50% chance of survival over a 5-year period alongside a cost to US Healthcare of around $7bn per year. Our work to understand the role that inflammation plays in chronic airway disease has led to an emerging and differentiated pipeline of long-acting options for COPD patients.

Starting with Exdensur, the phase III ENDURA trials recruit patients at moderate risk of exacerbations, while VIGILANT is the first ever study of an antibody for patients at an early stage of disease who are at risk of rapid progression.

Our phase II trial investigating the ultra long-acting TSLP monoclonal antibody, GSK '283, in asthma patients, is on track to generate data by the end of this year and will further guide development of a six-monthly option for patients with a low T2 phenotype.

The portfolio also includes a PDE-3/4 inhibitor with potential for DPI use in phase I development in China, complementing our leadership position with Trelegy.

Looking now to refractory chronic cough, I'm pleased to confirm that we achieved Last Patient First Visit for the CALM-2 study in December. And we are on track to report phase III data from the total programme around mid 2026 (in line with our prior guidance). We believe camlipixant will provide an effective treatment in RCC where there are no approved therapies in the US and approximately 10 million patients diagnosed globally who could benefit from this medicine.

Next slide please.

Slide 16 | RI&I: Expanding to fibro-inflammation for lung, liver and kidney disease

A focus on inflammatory pathways of disease and how this leads to fibrosis, particularly in the lung, liver and kidney, underpins our development programmes in fibro-inflammatory mechanisms.

We are pleased with the progress of efimosfermin, our potential BIC, once monthly, FGF21 analogue, which started phase III trials for MASH last year. As a reminder in phase II, efi demonstrated sustained improvement in fibrosis and resolution of MASH in patients with F2/F3 stage disease. These data supported the start of our ZENITH 1 and 2 pivotal studies.

We plan to start the NEBULA phase III studies which will recruit a more advanced F4 patient population, later this year.

Also in our hepatology pipeline is GSK'990, an siRNA therapeutic targeting HSD17B13. Consistent with human genetics of this target, preliminary data from the phase II STARLIGHT study in Alcoholic Liver Disease, demonstrate favourable trends in reduced liver enzymes despite ongoing alcohol consumption, and this with no emerging safety concerns.

These assets have the potential to reverse cirrhosis, where 20-50% of patients with associated complications die within 1 year.

Next slide please.

Slide 17 | Bepirovirsen: functional cure for patients with chronic hepatitis B

Last month we were pleased to announce positive results from the B-Well 1 and B-Well 2 studies, our phase III trials of bepirovirsen for the treatment of patients with chronic hepatitis B, a disease which affects more than 250 million people worldwide, causing over 1 million deaths each year.

We believe that bepi has the potential to transform chronic hepatitis B treatment and become the first ever fixed course of therapy with functional cure at a significantly higher rate than today's standard of care. This is important because chronic hepatitis B accounts for around 56% of liver cancer cases and real-world evidence shows that functional cure reduces this risk by around 90%.

We look forward to sharing these data with regulators during the first half of the year and at an upcoming scientific congress.

Next slide please.

Slide 18 | Oncology – portfolio momentum with further development in haematological cancers and advances into solid tumours

Our Oncology pipeline is a critical part of the portfolio.

Starting with Blenrep, we anticipate mature OS data from DREAMM 7 in early 2028, to support 2L registration in the US.

In the 1L transplant ineligible setting, DREAMM10 is recruiting well and we recently expanded the number of US sites to increase US patient participation. DREAMM 10 uses a lower dose when compared to 2L studies and evaluates dual endpoints of MRD and PFS. Interim MRD and safety data are expected early in 2028.

Also in the 1L setting – we will start a study looking at a Blenrep quad regimen in a younger, fitter population later this year.

Moving now to Ojjaara, we continue to generate data to support decision making for myelofibrosis patients with anaemia and a phase II study in myelodysplastic syndrome is currently recruiting.

We also continue to develop life cycle indications for Jemperli.

Later this year we anticipate results from a pivotal AZUR-1 trial for Jemperli in dMMR locally advanced rectal cancer. AZUR-1 was designed following the publication of transformative data which showed 100% complete clinical response rate in a single centre monotherapy study. We are excited about Jemperli's potential for patients with this disease.

Velzatinib, our KIT inhibitor, which targets all clinically relevant enzyme mutations, has started phase III in 2L GIST with 1L to start later this year. Velzatinib has the potential to replace current SOC and is designed to offer a well tolerated schedule with greater efficacy against resistant mutations.

Moving now to our other ADCs, our B7-H3 targeting molecule, which I will now call ris-rez, recently received its 5th regulatory designation with orphan drug status in SCLC.

With this transformative potential in mind, we have initiated a global programme encompassing multiple solid tumour trials for ris-rez, called EMBOLD. The first of these studies– EMBOLD SCLC-301 has started ex-US recruitment in 2 and 3L. US recruitment will start later this year and include tarlatamab exposed patients. We have extensive plans for additional ris-rez phase III starts in the next 12-18 months.

In the first half of this year, we also plan to start recruitment for pivotal phase III trials for mo-rez our B7-H4 ADC in platinum resistant ovarian cancer and in patients with recurrent endometrial cancer. We are targeting a conference this year to present interim data from our early phase BEHOLD-1 study for patients with ovarian and endometrial cancers and we anticipate further pivotal starts for this molecule during 2026.

Next slide, please.

Slide 19 | Agreement to acquire RAPT Therapeutics[1]

Business development is a core part of how we are accelerating our pipeline and accessing innovation.

2 weeks ago we announced an agreement to acquire RAPT Therapeutics whose lead asset is oz-u-rep-rubart, a potential BIC, long-acting anti-IgE monoclonal for food allergy, which is currently in phase II. Food allergy is a chronic inflammatory condition, with severe reactions leading to anaphylaxis, emergency care and persistent lifestyle disruption. In the US, severe food allergies impact over 17 million patients with an estimated $33 billion cost of economic burden, underscoring the need for more effective treatment options.

We expect the deal to close this quarter and look forward to progressing this important asset into phase III development.

Next slide please.

Slide 20 | Developing pipeline of best/first-in-class medicines and vaccines to address medical need and deliver growth

In conclusion, 2025 saw further strong momentum in the pipeline, which continues into 2026.

We have critical data readouts to come for bepi, Camli, Jemperli, Q4M PrEP and *Exdensur* for EGPA. We also have 10 pivotal starts planned for this year including more than five from our ADCs, two for advanced MASH and CUATRO our Q4M treatment phase III trial for HIV. All of which are supporting our growth in Specialty Medicines.

I am excited about our progress and our prospects.

I'll now hand over to Julie.

Q3 2025 financial performance | Julie Brown

Slide 21

Thank you Tony and good afternoon everyone.

Next slide, please.

Slide 22 | Strong performance and operational leverage delivered in FY 2025

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

As highlighted, sales grew +7%, whilst Core operating profit grew +11%.

This leverage was primarily driven by a +3% increase in SG&A, as investment in product launches was balanced with productivity improvements.

Additionally, royalty income benefitted from the RSV IP settlement, the new mRNA royalty streams and Kesimpta performance, and R&D growth of +11% reflects our acceleration of investment across multiple key Specialty assets.

Core EPS grew +12%, supported by the share buyback and lower interest expense due to strong operating cashflows.

And finally, turning to **Total results,** growth primarily reflects the impact of the Zantac charge taken in 2024.

Next slide, please.

Slide 23 | Q3 2025 core operating margin

The operating margin increased +110bps in 2025, bringing total accretion at CER to +470bps over the last 4 years.

This increase was primarily driven by SG&A margin improvement of +90bps, whilst gross margin continued to benefit from the portfolio transition towards Specialty, growing +40bps.

R&D expenditure increased as we re-invested the additional royalty income into our pipeline to support the initiation of the PhIII efimosfermin trials and prepared pivotal trials for the ADCs in multiple indications.

Incorporated within this margin improvement were core charges of £300m taken in Q4, split evenly across supply chain and SG&A to drive productivity benefits.

And currency was a headwind to margin, lowering the reported margin to 29.9% for the year.

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Slide 24 | Strong cash performance, cash generated from operations £8.9bn

Turning to the cash flow,

Cash generated from operations was £8.9bn, or more than £10bn excluding Zantac payments, up £1.6bn YoY, driven by higher operating profit, favourable RAR movements and the CureVac settlement, partially offset by increased trade receivables.

Free cash flow increased to £4bn, or more than £5bn excluding Zantac, driven by strong CGFO.

Zantac payments in 2025 were £1.2bn and the settlement process is now materially complete, with £1.9bn paid in total, drawing a line under this matter.

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Slide 25 | Capital deployment prioritises business growth and shareholder returns

Turning to **capital allocation**:

- Underlying free cash generation was strong at over £8bn before investment decisions
- £4½bn was deployed in capex and BD as we added 3 potentially BIC clinical stage Specialty assets to the pipeline, and completed multiple early stage and platform deals
- Shareholder distributions totalled £4bn through the dividend and the share buyback. With 93m shares repurchased at an average price of £14.73 and the remaining £0.6bn will be completed in H1.
- Overall, our balance sheet remains strong with ND/EBITDA relatively stable YoY at 1.3x, including the absorption of Zantac and the buyback.

Next slide, please.

Slide 26 | 2026 Guidance at CER

Now turning to guidance for 2026, with growth rates stated at CER.

Starting with our headline guidance; we expect sales growth of 3-5%, core operating profit and core EPS to both grow 7-9%. And to pay a dividend of 70p, a 6% increase.

Product area growth is once again led by Specialty, at low DD% growth, including mid-HSD growth for HIV. Vaccines and Gen Meds are both expected to be a LSD decline to stable. And we expect sales growth to be evenly phased through the year.

Turning to the P&L:

- Gross margin is expected to continue to benefit from supply chain efficiencies and the portfolio transition towards Specialty
- SG&A will grow at LSD %, benefitting from the acceleration of productivity initiatives.
- And R&D will continue to grow ahead of sales as we invest to advance the pipeline

Interest charges and the tax rate are expected to increase YoY, however these will be offset by the benefits of the share buyback to EPS.

Importantly, the phasing of operating profit growth will be heavily weighted towards the second half, reflecting the ~£300m of charges taken in Q4'25, and impacted by the annualisation of the RSV settlement in the second quarter.

Additionally, currency could be a headwind. If rates hold at the closing rates on 28th January we would expect an impact of -3% on sales and -6% on operating profit.

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Slide 27 | Step change in performance delivered 2021-2026

Before I finish I wanted to take a moment to share the continued performance of the business.

In 2021 we provided outlooks on 4 financial KPIs for the five-year period to 2026.

We have delivered consistent revenue growth and improvements in operational efficiency

We are on track to deliver against all the 4 KPIs.

Taking the mid point of our '26 guidance ranges would lead to delivery of 8% sales and 13% operating profit CAGR over this period.

Additionally, cash generation has been significantly enhanced and we are on track to reach >£10bn in 2026. This, together with SH returns, and a strengthened Balance Sheet, lay strong foundations for the next phase of growth.

Our usual IR roadmap is shown in the Appendix, signaling the major value inflections in 2026 and 2027.

Thank you and with that I'm pleased to hand back to Luke.

Summary | Luke Miels

Slide 28 | Evolving GSK to create value for shareholders

Thanks Julie.

Looking forwards, I see two clear things we need to do to create value for shareholders.

- The first one is topline. This means delivering our ambition for 2031 and addressing the loss of dolutegravir exclusivity.
- The second is the pipeline. We need to accelerate what we have and add to it via smart BD. We also need our labs to produce more competitive products.

So to do these two things we need to evolve as a company.

- Products are the key in this business, and we need to be more product-centric.
- And to accelerate the pipeline we need to have more scientific courage and be more agile to capitalise on opportunities when we see them.

Each quarter you will hear more detail about how we are going to make this happen.

Next slide please.

Slide 29 | Summary - Creating value for patients and shareholders
To conclude, 2025 was a strong year for GSK.

For 2026, we are guiding for another year of topline growth and operating leverage.

And for the long term, we know what we need to do to create value for shareholders and patients. And the focus is now on evolving the Company to do it.

Thank you, and we will now move to Q&A.

- Question & Answer Session -

Constantin Fest: Thank you, Luke. With this, we're ready for the Q&A. And the first question comes from James Gordon from Barclays. Please go ahead.

James Gordon (Barclays): Thanks for taking the questions. First one, Respiratory, can you elaborate on R&D and commercial strategy in COPD and asthma? Because you now got Nucala, Exdensur, and then IL-33 and TSLP all in development with some overlapping products. I don't want to double count. So, how do we think about segmenting this given you've got products going for the same disease? And then also, quite a lot of these mechanisms also have multiple competitors also looking at them for the same diseases. The second question was HIV, and I heard the comments on long-acting strong uptake and exciting next-generation data at CROI. And so, when could we see the six-monthly treatment and PrEP Phase III trial start now? And commercially, what is the implications of the four month and six monthly in terms of your TAM? Because I've seen before you talked about the majority of sales in HIV being long-acting in 2031, but then that might partly be just because the orals are going to go away by then. So, what's the TAM increase if this work? And maybe if I could squeeze in a clarification. The £40 billion-plus revenue target, which has been reiterated, is that the original assets or is that also including some of the recent acquisitions you were talking about and the BD you're talking about, please?

Luke Miels: Great. Thanks, James, and I appreciate the question. So, Tony, should we go into COPD and then I might add a little bit of color at the end of that in terms of how we position the assets and what our

thinking is. It's obviously always dynamic. And then, Deborah, do you want to cover HIV? I think we're in very healthy shape there. Some more color there. And then, Julie, did you want to cover the assumptions around the £40 billion. Again, I would just take this opportunity, just in case we get any other questions to reiterate the commitment to the £40 billion. And, again, I think we have a clear pathway for that, so.

Tony, over to you.

Tony Wood: Yeah. Let me start. Thanks for the question, James. First of all, I'm really pleased with the progress we're making in Respiratory. Obviously, just to mark last year, the Nucala approval in COPD in the middle of the year and then at the end of the year, Exdensur in severe eosinophilic asthma as the first ultra-long-acting entry in our pipeline. I think what's important to understand about COPD, James, obviously huge opportunity there, 300 million individuals globally and significant cost to the US healthcare system, as I outlined in the presentation, but it's a complex disease. It's a heterogeneous disease. And that's why we're placing ourselves across a range of different long-acting mechanisms. The way you can think about it is there is the high EO population. This is where IL-5 and Exdensur and Nucala are positioned. And, again, let me just emphasize there that we have a label, which covers both the bronchitic and the emphysemic and the mixed population is important when one considers the reality of a hospital admission for a COPD patient.

You can then think about the intermediate T2 population, which is the 150 to 300. We were delighted to see the Nucala label there, but that's where we see, for example, our long-acting TSLP starting to play increasingly in the future and then the low T2 population, and that's where we're positioning IL-33. So, what we have, of course, is already starting in that high T2 population, the ENDURA-1 and ENDURA-2 studies. That's the GOLD-E population that we're looking at. And the VIGILANT study, which, as I mentioned in the script, looks as a brand-new approach looking at rapid progressers in that high eosinophil population. We also have ongoing Phase I and Phase II studies for the long-acting TSLPs and IL-33 mechanisms in the context of the stratification that I described. And then, just to finish off, we'll be expecting in both of those to be starting pivotal studies over the next two to three years once we have been informed by ongoing Phase I and Phase II work and competitor insights.

And then lastly, just to finish off. Important to emphasize, we also have the HRS-9821 molecule, which is the first nominated candidate from our Hengrui collaboration that's focused on dyspnea, which is associated pain associated with breathing and fits nicely into our Trelegy portfolio given that that molecule has an opportunity to be a DPI-administered agent. And then lastly, in the low group, we have the recent deal we did with Empirico, EMPIRICO-012 and that's now called GSK '821. That's a long-acting oligo, which is aimed at a broad spectrum as I indicated. We haven't disclosed the mechanism yet, but we will in future as we gather more data.

Luke Miels: Yeah. And, James, what I will say is we're going to resist the temptation, as a company, to construct a lovely PowerPoint slide that shows how we'll carefully capture this bit and have trade-offs amongst our products. I mean, there is strategic intent here, but we also recognize there's a Darwinian dimension here in terms of the data that these targets generate, but also the competition gets a vote as well. I mean, ultimately, the long-acting is the future. The launch for Nucala COPD in the US is going very well. And I was just there on Monday. We have around – well, depending on which dataset, 43% to 46% of new patient starts already. The market research and the messaging is really resonating. But we have transferred all of our Nucala reps to Exdensur, and Nucala COPD is being promoted by the Trelegy legacy team because, again, we need to place our bets on the future, and the ultimate future with IL-5 and higher EOS is going to be long-acting Exdensur for COPD. So, thanks, James, I appreciate the question. Deborah, do you want to give an update?

Deborah Waterhouse: Thanks, Luke. So, the key thing that I want to reemphasize is that we're on track to select our Q6M treatment regimen in the middle of the year. And as I said, we're going to do a meet the management event midyear where I'll lay out a lot more detail about the pipeline. But let me just give you a top line view now.

So, let's start with treatment. The treatment market is $20 billion in value, 90% of the value of the total HIV market. As I said in my presentation, Q6M is clearly our biggest opportunity in treatment. We're very confident in the assets that we've got to choose from. And the CROI data that we'll present will show just how strong those assets are particularly VH184, which is unique third-generation, really potent integrase inhibitor. And we believe that to have a really potent regimen, you need to have an integrase inhibitor at the core. So, in terms of when studies will start - Q6M treatment, you'll see us move into Phase IIb this year. That puts us on track for our commitment, which is the 2028 to 2030 launch for our Q6M in treatment.

In terms of PrEP, it's a different pathway because with the medicine that we're developing for Q6M PrEP, it's a prodrug of cabotegravir, which we've talked about before. And that means that we'll be able to go from Phase I to Phase III relatively rapidly. And the Phase I will be starting this year where we'll then progress to dose selection. And then, we'll do a bridging study from the data that we already have from Q2M. So, our Q6M pathway is clear, and we're very confident in our ability to deliver against our milestones.

But don't underestimate Q4M. There is a huge desire for Q4M in treatment and in PrEP. And we know that many clinicians are really looking forward to opening up their clinic capacity, which will double from what they've got today with Q2M for Q4M. And I think what you're going to see is a rapid cannibalization of Q2M to Q4. And then actually, you will see a rapid cannibalization from Q4 to Q6. And as I've said before, particularly in treatment, you see the market really opening up as we progress through longer and longer durations between administrations. So, the addressable market for Q2M is about 15% of patients. When

we get to Q4, we get to 30% of patients. And then, you've got, with Q6M treatment, 50% of patients who would be very willing to take a long-acting injectable. That is a big chunk of the market, which is why we are so excited about the offering that Q6M in treatment and in PrEP, but particularly in treatment will offer.

Luke Miels: Thanks, Deborah. Julie, quick answer on the £40 billion. I think everyone knows, but let's confirm it.

Julie Brown: Yeah. Sure. Thanks, James, for the question. So, in terms of what we've included. Of the recent deals, IDRX is included, efimosfermin, together with the earlier stage Hengrui license, PDE3/4. RAPT obviously has just been announced, so it's not included at all in the LRF. And clearly, we continue, as Luke mentioned, to support our BD to build and continue to build the pipeline.

Luke Miels: Great. Thanks, Julie. Next question, please. Thanks, James.

Simon Baker (Redburn): Good morning, everyone. Thank you for taking my questions. Two if I may, please. Firstly, on Blenrep, in light of the early feedback that you've had, you talked about the response to the REMS program. Can you just update us on how we should be thinking about the launch trajectory for Blenrep?

And then secondly, slightly bigger picture question for you, Luke. You did mention some of the facets of your strategy. I just wondered if you could give us a bit more detail on how and in what forum we're going to learn more about that strategy over the course of the year. Is this something where there will be additional disclosures as we go through the quarterly calls or are you envisaging having Capital Markets Day or similar events to lay out the strategy in that sort of forum? Thanks so much.

Luke Miels: Thanks, Simon. I'll come to Nina in a second. I mean, I think, as I said earlier – and thanks for your questions. Look, what you'll get from us is a very clear communication. If it's on track, you'll hear about it. If it's not, we'll call it out. And I really want to use these forums to regularly update on our progress and where we're going to. So, I think these are very effective forum to do it, and we'll see how that evolves over time.

Nina, I mean, again, as I said in my intro, I mean, Nina and I have worked together a long time. She has huge experience in oncology and is now responsible for the whole portfolio in partnership with Tony. And also, we've had a number of other members join the team that have been in their roles during this commercial transformation. And there's a lot of history with those individuals at Aventis and Roche and AstraZeneca. So, they are people that many of you will know and they've got a very strong record. And the aim of bringing them into the team again is just to rebalance and increase their focus on the portfolio, the pipeline, and product execution.

So, with that intro, Nina, over to you on Blenrep in terms of launch uptake and initial feedback.

Nina Mojas: Great. Yeah. Simon, so you remember Blenrep was launched in the US just at the end of November, so we can't really share significant update based on the sales numbers. But what we do know, we launched in the UK middle of the year and the dynamic is opening the accounts is systematic. It's happening, but it is definitely slower because of the coordination of care with eye care professionals. By now, we have about 70% of patients covered in the accounts that are open in the UK. And based on the uptake there, we are actually extremely satisfied.

Two things. There is huge interest to try Blenrep. And then, we know that we have done good homework in guiding physicians how to use the drug. Physicians are very much aware of the need of extended dosing intervals to reduce or to avoid eye-related side effects. Now, translating that to the US, we expect similar dynamic. So, the timing of opening the accounts is going to take a bit of time, longer probably than what you would see with an asset that doesn't need that coordination of care. But what we did learn from the first launch, as an example, I think I mentioned we are actively educating 18,000 eye care professionals. As an illustration, comparing to the first launch of Blenrep, we had only about 5,000 to 6,000 eye care professionals engaged in our program, helping treaters to treat the patients.

REMS has been a big factor. I think you know that. It has been received very positively. Currently, REMS is not an issue. Physicians are very much used to REMS programs, and Blenrep REMS is very similar. Eye care professionals' scale, as we said, we are going to reach significantly higher number and then communicating to the physicians how to use the drug. That extended dosing is very relevant to enable early positive experience. And I would say that's what we see so far.

To your question, what can we expect? What we said before, it is not going to be a quick ramp-up. It's going to be a slow ramp-up. But the positive initial experience is more relevant than starting high number of patients very early and then having a negative experience.

Luke Miels: Thanks, Nina. And I would just add one other interesting data point is if we look at usage right now for Blenrep, it's about 50/50 between academic and community, which our strategy is to focus on the community. And with a product that is being relaunched and not a lot of experience in the community, I think this is an encouraging trajectory because, at this point, you'd expect volume to be dominated by the academic centers who tend to move on newer things earlier. But we can see, to Nina's point, this strategy of focusing on the community, building confidence, supporting them to dose the first five patients appears to be showing promise. And we will give you a lot more granularity at the Q1 update, including on Exdensur.

Thanks, Simon. Appreciate the questions. Next, please.

Michael Leuchten (Jefferies): Hi. Yeah. Thank you for taking the questions. Two, please. One for Luke. It's been reported that there is a reduction in R&D staff, I think about 350 people in the US and also in the UK. Just wondering is that part of a broader program, normal attrition... just wonder if you could put that into context.

And then, back to Nina on Exdensur. There's a few ways one could launch a product like this especially early on sort of go into treatment experienced patients where I guess it'd be easier to make an argument to get patients on drug more quickly or into a naïve population to broaden out the market. Can you talk about a little bit the launch curve for 2026? So, how should we think about this as the year progresses? Thank you.

Luke Miels: Thanks, Michael. So, I'll cover the first one. I mean, look, we're going to manage the business and where we see success, we'll reinforce it. If we have programs that are less promising or Tony and Nina, in managing the portfolio, decide to cull something, then we're going to be very dynamic and shift resources behind to where we can get the best return, generate assets that are most compelling. And, ultimately, in doing this we will have happy shareholders at the end of the process. So, this is very much this element of accelerating R&D and simplifying how we work, and you'll see more of that. What we can assure you is that we will run the business with great discipline. And where we can see an opportunity, we will rapidly move resources, people, head count, capital to support that. Nina, Exdensur?

Nina Mojas Thank you, Michael. Just as a reminder, Michael, and I think this information basically guides the strategy. We have about mid-20s bio penetration in severe asthma. So, about 25% of eligible patients now receive biologics, any. And of those who start on biologics, 65% will discontinue in the first 12 months. And that tells you if we would go for switch, active switch, that business wouldn't last very long because patients are dropping anyway. And I think we need to look at it in that context. Our main objective, I think, Luke mentioned that when we talk about our sales force, is going for bio naïve patients. It's very legitimate to expect there will be some switching and there will be switching very likely from Nucala, hopefully also from other agents in severe asthma as well. What is more relevant is can Exdensur gain share from patients who would have otherwise started on other agents? And six-monthly dosing, I think you have seen everything that we have seen from both physicians and patients is that there is huge level of enthusiasm for a long acting six-monthly dosing. And that will hopefully translate into preferential use of Exdensur over other agents to initiate patients, but then also to start patients who otherwise wouldn't start on biologic yet.

Luke Miels: Great. Thanks, Nina. And I think the positioning of the first and only biologic that delivers ultra-long protection in two doses, that's landing extremely well when we look at market research and perception. Thanks, Michael. Next question, please.

Sachin Jain (Bank of America): A couple of questions, please. Just firstly for Nina and congrats on the new role. Perhaps a bit more detail on Blenrep. How many physicians did have you had through the REMS certification process? And any cadence of how you think that will go through the year as a rate limiting factor?

Second one for Deborah on the HIV event midyear. Clearly, we're looking to Q6M start. But I wonder if you will be disclosing how you think about the financials of that business through the LOE. And I guess two questions. One, how do you think about the rate of decline of this business relative to where consensus sits? And, I guess, Q6M isn't in the midterm guide. So, do you plan on including it at that point if you start the Phase III?

And then, a quick one for you, Luke, just on your slide 5 and high-level objectives. You've mentioned two things. One, simplification, do you intend to have any official cost savings program? And then secondly, R&D acceleration, are there any specific programs that you can target for earlier readouts or filing? Thank you.

Luke Miels: Thanks. Sachin, I'll answer your last question then we'll go to Deborah, and then finish with Nina. I mean, we are always looking to save money because I think that it's always an opportunity cost, right? So, if we can move resources behind particular assets where we think there is a higher payoff and return and have the clinical profile to justify it, then we will do that. And we will continue that in a dynamic and disciplined fashion. Areas for acceleration, again, I think naturally the scale of B7-H3, ris-rez, is quite interesting. I think, GSK '584, B7-H4, it is a very competitive and dynamic area. But I think we're starting to see some color around the tox profile that could give us an edge. FGF21, we looked at all three of those companies. We think we've bought the best. Again, you'd expect me to say that, but I think we can back that up in time with the profile of the frequency of the dosing and some of the profile of the product that'll emerge in time. So, they're probably the key ones. TSLP as well, long-acting TSLP. Again, the target is being actively de-risked by AstraZeneca. And I think that we have a plan to move that asset forward and rapidly because it is a very attractive area. We think long-acting can really reframe, to Nina's earlier point, about how respiratory diseases are treated.

Deborah, over to you on HIV.

Deborah Waterhouse: Brilliant. Thank you, Sachin, for the question. So, if we think about Q6M first, so we are intending to set out our HIV story in the middle of the year. And at that point, once we've done a regimen selection and we then commence with Phase II, we will put that into our long-range forecast, which is how we always operate when products get to that Phase II phase. So, you'll see that happen midyear.

You then asked about the evolution of kind of the portfolio over time. So, let me just give you a top line view, and we will come back and talk more about this when we set out the HIV evolution in the middle of the year. So, we've seen a relatively rapid decline of Triumeq as the guidelines have moved away from Triumeq. And what's happened is over the last 12 months it's created dynamism in the market and Dovato was benefited significantly as has Cabenuva.

So, the amount that's sitting in Triumeq and Tivicay, as you can see, is going down quite significantly in advance of the loss of exclusivity of dolutegravir, which is, to remind you, a glide path not a cliff, starting in April 28 in the US and then July 29 in Europe with obviously Dovato and Juluca in the US having intellectual property coverage now until end of 2029 for Dovato and July 2030 for Deluca. So, the glide path is coming down. We're already seeing a move away from the old dolutegravir regimens into our newer regimens, and that is going to continue.

And then, what's going to happen is we will continue to power forward with Cabenuva, Q2M. It's doing incredibly well, growing fast. Apretude has not been dented by the launch of Yeztugo. So, that will also continue to grow 2026 and beyond. And then, what we will see is Q4M, both the treatment and PrEP coming in and powering longer-acting forward again until we reach the point at which we launch Q6M. And then, we've got two brand-new molecules with intellectual property coverage, composition of matter patents through into the 2040s.

And so, you see a dip in 2029 and 2030 for the franchise as we face into the largest erosion through the exclusivity loss. And then, we come back out into growth in 2031 and beyond. And that growth in that decade is going to be a significant contributor to GSK's success in the 2030s because we are incredibly confident in the value to patients that the Q6M will bring. So, that hopefully gives you a sort of a view as to how it's going to evolve. We will share more detail in the middle of the year. But I just want everybody to understand that HIV will be a big contributor to GSK's success this decade and into the future.

Luke Miels: Right. Thanks, Deborah. Nina, quick answer and then we'll try and squeeze one more question in because I know people have to go.

Nina Mojas: Yeah, definitely. Sachin, thank you. First of all, trying to avoid the situation where you will chase me next quarter for the same number. REMS, hundreds, hundreds and obviously that's just the start.

Luke Miels Yeah. I mean, we feel happy about where we're at. One more question?

Steve Scala (TD Cowen): Good morning. Thank you so much. Two questions. First on camlipixant. If GSK needs two positive trials to file, which is what the company has said previously, then what's the purpose of the pooled analysis? And/or has FDA confirmed it will accept filing based on pooled data even if one trial

is negative? And secondly, on Shingrix, what were sales to Zhifei in Q4 and what is your level of confidence in 2026 on this drug?

Luke Miels Tony, you want to cover?

Tony Wood: Yes, quickly. Steve, hi. Not going to get into details of regulatory strategy. But as you defined, what it's giving us is the option to take the approach, both as independent and ultimately pooled studies. So, it's worthwhile saying that we remain confident in the outcomes for both CALM-1 and CALM-2.

Luke Miels: Yes. And, Steve, there was a shipment in December. We can get you that number offline. I don't have it on top of my head. What I will say is that the underlying demand is improving in China. So, it's up six times since the start of 2025. Now, it's a low base. And we've grown the market share. So, now we have 93% market share in that population, which is an operational improvement. And what is driving this? We've shifted the strategy to the one that we launched in Australia and also drove in Germany. And now, we're employing in the US, which is also helping us get some traction there. Julie just told me it's £100 million we did at the end of the last year. So, there's still some stock in the pipe. But again, we'll give you more color on Q1, but it's heading in the right direction along with Shingrix in aggregate.

So, I think we'll stop there because I know a lot of you need to join another call and I want to respect that. Thank you again for investing the time to construct such thoughtful questions and joining the call and your interest in the company. And we look forward to updating you further next quarter. Thank you.