Investor Relations

Q3 2026 results

Conference call and webcast for investors and analysts
Wednesday, 28 October 2026 at 12:00 GMT

Introduction | Jeff McLaughlin/Luke Miels

Slide 1

Welcome everyone and thanks for joining GSK's Q3 2026 results.

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

Slide 2 | Cautionary statement regarding forward-looking statements

Before we begin, this slide is our 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 Miels, CEO.

Slide 3 | Agenda

Thanks, Jeff.

I'm joined today by Tony Wood who will give an update on the pipeline, Nina Mojas who will cover growth drivers, Julie Brown who will cover financial performance and David Redfern will join for Q&A.

First, let's review the company performance.

Next slide please.

Q3 2026 performance: strong sales performance and core operating profit delivery | Luke Miels

Slide 4 | Q3 2026: strong sales performance and core operating profit delivery

Q3 was strong. And, we have continued operational momentum with sales up 5% to £8.9 billion pounds.

As expected, Specialty is driving our momentum including launches in Respiratory and Oncology.

Core operating profit grew 5% and core earnings per share were up 1%.

Our cash generation remains very positive at £7.4 billion pounds YTD, our Q3 dividend is 17 pence and we are on track with our responsible business rating.

Given our operating momentum and launch progress we are pleased to reconfirm 2026 guidance today.

Next slide please.

Slide 5 | Key priorities to drive value

This slide is a reminder of our key priorities to drive value for the business and our shareholders.

To start – we're focused on maximising launches. This quarter we've made good progress on Blenrep, where repeat prescribers are growing as physicians and patients get comfortable using the medicine and Exdensur, where we see momentum building with prescribers, patients and access - all increasing in the quarter

We've also now had our first launch in non-small cell lung cancer with Jideytro for TKI pre-treated ROS-1 positive patients – which has already delivered £3m. And our oncology portfolio continues to grow with approval for a further indication for Jemperli in locally advanced rectal cancer.

We also received approval for Hibsago in the US and Japan--- the first finite treatment to offer a functional cure for patients with Chronic hepatitis B.

Each of these products will meaningfully contribute to near-term growth as we continue to build momentum in our specialty business.

At quarter 2, we outlined clear plans to accelerate R&D and are now delivering on those plans:
We are recruiting in 18 of the 22 phase three trial starts for 2026, including two new phase three studies for flu and the rest on track to start recruiting before the end of the year.

We also presented data for several of these assets including for Jideytro, Ris-Rez, Mo-Rez and Jemperli, demonstrating significant progress in our oncology pipeline and proof points for our approach to BD.

Finally, on simplification, we made progress on the Accelerate Growth programme, helping to reallocate resources to invest in R&D and accelerate our late-stage development pipeline. Fundamentally, this will align our cost base with our evolving portfolio and help us accelerate growth and deliver value for patients and shareholders. With that, I'll now hand to Tony to cover our pipeline momentum in more detail.

Pipeline Progress | Tony Wood

Slide 6 | Growth drivers

Thanks Luke.

Slide 7 | Pipeline highlights

It's been a busy period for R&D, with a number of recent approvals and pivotal data readouts.

Jideytro and Hibsago approvals were received ahead of their FDA PDUFA dates and Jemperli received accelerated approval for rectal cancer.

These, together with the strength of the data presented at recent medical congresses, demonstrate the value of assets in our late-stage pipeline, where the majority have potential to be best-in-class; and where we have added 12 new phase 3 study starts this quarter, to bringing us to 18 for the year.

Next slide please.

Slide 8 | New products and indications to address significant unmet need and drive value

Moving to new products and indications. Jideytro for ROS1+ and neladalkib for ALK+ mutations in non small cell lung cancer have the potential to meaningfully improve on standard of care.

These mutations represent 3-5% of all NSCLC. Here patients are often younger, in their 40s and 50s and remain on therapy for years while experiencing high rates of central nervous system side effects and often developing brain metastases.

Importantly, Jideytro is the first and only ROS1 TKI to address both selective targeting of ROS1 resistance mutations and CNS activity, thus aiming to improve treatment for patients with brain metastases while minimising TRK-related CNS adverse events.

Similarly neladalkib is a once a day medicine designed to avoid off-target adverse events which can be treatment limiting for patients. We anticipate FDA approval in November, supported by the ALKOVE study which showed a median progression free survival of 14.5 months in previously TKI-treated patients.

Also in Oncology, approval for Jemperli in locally advanced rectal cancer is based on the AZUR-1 data which shows 68% of participants with no detectable signs of cancer one year or more after treatment. Current standard of care, achieves complete clinical response in around 20-25% of cases and can have lasting consequences, including bowel and urinary dysfunction and secondary cancers.

And finally, for Hibsago; Nina will cover our launch plans for this important medicine in a moment, but I want to reiterate how transformational Hibsago will be for those living with chronic hepatitis B. These patients are at an increased risk of death from cirrhosis and liver cancer and current treatment options involve lifelong therapy. Hibsago is the first finite treatment for chronic hepatitis B which provides the potential for a functional cure. We plan to share additional data from the development programme at AASLD in November.

Slide 9 | Precision medicines for NSCLC: Emerging data support potential best-in-class profiles

Now moving to our development plans for Jideytro and neladalkib in TKI naïve patients.

Jideytro data were presented at the recent World Lung congress. The ARROS-1 response rates are among the highest response rates ever reported in this patient population with a 94% Overall Response rate, and a 15% Complete Response rate. The median duration of response has not yet been reached, but 86% of patients have a duration of response greater than 12 months.

Data on brain metastases in this TKI naive population showed no CNS progression events observed in patients without metastases at baseline, and a 100% response rate in those with brain metastases at study entry.

The emerging clinical profile for Jideytro suggests it has the potential to deliver meaningful outcomes as a best in class therapy for TKI naive patients.

Neladalkib is also in development for a TKI naïve population. And here the phase 1/2 ALKOVE study shows an 86% Overall Response. Median duration of response has not yet been reached, however 91% of patients have a duration greater than 12 months, as you can see on this slide.

The corresponding phase three TKI naive study ALKAZAR, is more than 50% recruited. And based upon available data today, we believe neladalkib could have the potential to drive years of progression free survival. Next slide please.

Slide 10 | Ris-Rez: First phase 3 OS data in 2L SCLC; GSK global trials ongoing

Next, for Ris-Rez, where emerging data demonstrate robust and consistent outcomes across a range of solid tumour types.

In Small Cell Lung cancer, the Chinese phase 3 ARTEMIS-008 data presented at World Lung by Hansoh showed a 54% reduction in risk of death and a median Overall Survival of 18.5 months.

The global pan-tumour phase I/2 EMBOLD 101 study has now enrolled with more than 550 patients. Data from the small cell lung cancer cohort of this study were presented last weekend at ESMO and showed a 61% response rate, consistent with the 58% overall response observed in ARTEMIS-008.

The global phase 3 trial, EMBOLD SCLC 301, is also recruiting well and we anticipate preliminary data by the end of 2027.

Next slide please.

Slide 11 | Ris-Rez: Impressive phase 3 osteosarcoma data at presidential symposium

Also, for Ris-Rez, data from the Hansoh phase 3 ARTEMIS 011 study which looked at Ris-Rez vs standard of care in Chinese patients with relapsed/refractory osteosarcoma was selected for the Presidential Symposium at ESMO last weekend.

Osteosarcoma is a rare tumour, and relapsed patients have few treatment options. The current standard of care delivers around 2% response rate and 1.5 months of median progression free survival.

In this trial, Ris-Rez demonstrated a 67% reduction in risk of disease progression or death in patients with relapsed disease.

A global GSK phase 2 trial, EMBOLD-Sarcoma 202, started earlier this year and is recruiting well.

The global EMBOLD programme, now has over 1000 patients who have received Ris-Rez, with more than half of these enrolled in the last 8 months.

Over the next 12 months, we anticipate data read outs across multiple indications, and we look forward to sharing these as they mature.

Next slide please.

Slide 12 | Mo-Rez: Emerging data confirm potential for best-in-class PROC activity

For Mo-Rez, new data presented at ESMO from the global phase 1 BEHOLD-1 trial confirms the potential for best-in-class activity in ovarian cancer with median progression free survival of around 11 months in a non-biomarker selected population. These data compare favourably with current standard of care which delivers around 6-8 months of PFS.

As promised at the Accelerate Growth event in July, we have now started recruitment for five phase 3 trials in ovarian and endometrial cancer.

Over the next 12 months, alongside Hansoh, we will continue to generate longer term data to demonstrate the durability, response and safety profile of this novel ADC.

Next slide please.

Slide 13 | *Jemperli*: Accelerated approval for locally advanced rectal cancer, supported by outstanding clinical response data

Also at ESMO, we presented interim pivotal results from AZUR-1, which looked at Jemperli in the treatment of patients with dMMR locally advanced rectal cancer.

The current standard of care for these patients achieves a complete clinical response in around 20-25% of cases but involves chemotherapy, radiotherapy and surgery and is associated with significant morbidity.

In AZUR-1 over two thirds of patients achieved a complete clinical response and after a two year follow up period, no disease recurrences were reported amongst patients who responded. The study continues to generate data and offers an important, potentially curative option for patients with locally advanced rectal cancer.

Next slide please.

Slide 14 | mRNA flu: Phase 2 data suggest potential for best-in-class protection

Turning now to vaccines.

Last season over 700,000 people mostly older adults, were hospitalised with flu in the US.

Current flu vaccines, which generally focus on haemagluttinin, protect unevenly.

Our mRNA flu vaccine candidate, which has achieved fast track designation from the FDA, targets both haemagglutinins and neuraminidase. Neuraminidase changes more slowly, so protection may be more durable when haemagglutinin mismatched strains.

Targeting both has the potential to offer broader immunity and better, more consistent protection. In phase 2 our candidate produced stronger immune responses against both targets than a high-dose comparator, supporting our decision to start a large phase 3 study in more than 50,000 adults aged 65 and over.

The study started in September and more than two thirds of this season's enrolment target has already been recruited. The study will run over two seasons and we anticipate preliminary data next year, pending a sufficient number of cases.

Next slide please.

Slide 15 | Accelerate R&D: 2026 phase 3 starts

Across R&D, we continue to make fantastic progress in accelerating our late-stage pipeline. At Q2 we described our plans to start 20+ phase 3 studies in 2026.

We have now started 18 phase 3 studies with a further 4 on track to start before the end of the year.

These studies have been accelerated based on our confidence in the differentiation and benefit to patients of our late-stage assets. I am pleased with the continued hard work of our teams to deliver this previously unmatched pace of acceleration across a broad and growing portfolio.

Next slide please.

Slide 16 | Accelerate R&D: Late-stage pipeline momentum

Before I close, I momentarily want share this slide which we presented in July. It demonstrates the expansion of the late-stage portfolio. And, from 2028 onwards we expect to build further as we progress phase 1/2 studies and continue to pursue external opportunities.

I will now hand over to Nina to cover Commercial performance.

Growth Drivers | Nina Mojas

Slide 17

Thanks Tony.

Slide 18 | Q3 growth driven by Specialty Medicines

Commercial momentum continued in the third quarter driven mainly by Specialty Medicines, up 15%. Our top performing product was Cabenuva which grew 35% in the quarter.

More than 75% of switches continue to come from competitors in the US and Cabenuva remains the only long-acting injectable regimen for HIV treatment -- establishing a strong foundation with patients who prefer to take medicine less frequently.

This is setting us up for success as we move closer to 2027 when we will have data for our three times a year formulation for HIV treatment.

In Prevention, Apretude is performing strongly with 21% growth in the quarter and holding market share.

Nucala was also a very strong contributor up 18% driven by the successful launch into COPD while Exdensur continues to expand the biologic opportunity in severe asthma.

In Oncology, we've also now launched our first medicine in non-small cell lung cancer – Jideytro. Blenrep is continuing to build as expected whilst Ojjaara and Jemperli again delivered strong double-digit growth for the quarter.

Vaccine performance was down 2% with a drag from Shingrix China de-stocking partly offset by growth in the US. We had significant growth in our meningitis portfolio - up 12%. This was driven by strong growth from our meningitis B containing portfolio in the US, including new contributions from the first full back to school season for Penmenvy. And we now have over 90% share of the Men B market, globally.

General Medicines was flat in the quarter with Trelegy performance offsetting the decline of the established portfolio. In the US, Trelegy returned to growth, up 8% as patients reached their Medicare deductibles and adjusted to coinsurance. In the triple inhaler class, we maintained market leadership in COPD and asthma however, the overall US inhaler market and SITT class continues to face pricing pressure. Globally, the SITT class remains the fastest growing inhaler class and Trelegy continues to grow double digits internationally – up 11% in the quarter. Next slide please.

Slide 19 | *Blenrep*: HCP experience increasing with reimbursement building globally

Starting with Blenrep, now approved in 52 markets, we continue to launch globally.

As we're launching more broadly, we continue to see that the hands-on experience is the clearest predictor of future use, frequently changing the pre-existing beliefs.

In the UK, Blenrep is now the market leader in 2L for NICE approved regimens.

And in the US, HCPs are getting more comfortable with Blenrep and repeat prescribers account for 1/3 of sales so far and are building.

Recently updated NCCN guidelines recognise the full breadth of Blenrep data and include both DREAMM7 and DREAMM8 data in the second line plus patient population, significantly beyond the US label.

Prescribers are getting more familiar with dosing. This is leading to an improved experience with Blenrep – whilst also extending the period between prescriptions.

This extended dosing is similar to what we have in DREAM10 1L study – expected to have MRD data in 2028.

Next slide please.

Slide 20 | Leaders in IL-5 with *Nucala* growth and *Exdensur* launch

Moving to Respiratory, we have two key launches that have enabled GSK to gain IL-5 market leadership in a class that's up 12% versus last year.

- The importance of reducing exacerbations that lead to hospitalisations is the highest unmet need amongst physicians. And the success we're having with Nucala in COPD continues to have a halo effect across all five of its indications.
- 'New to brand patients' in the US is up 19% with COPD driving a majority of the growth and significant room to continue growing as only 6% of COPD patients are on a biologic.
- International growth continues, up 21% in the quarter with now achieved, market leadership in China.
- The success we've had with Nucala and the relationships we've established with these providers has been key as we launch Exdensur.

Exdensur sales were £27m in the quarter, with a majority of sales coming from bio-naïve patients.

- Third quarter was a pivot point, following the availability of the J-code in July and the roll-out of the average selling price as of October.

- As a result, new prescribers in the US were up 68% in Q3 and new patients starts were up 74% when we include those who received a free first dose through our Fast Start programme.
- Access continues to build with more than 2/3 of insured patients now being covered
- And significant growth opportunity remains as around 70% of patients who could be on a biologic for severe asthma still are not.

Next slide please.

Slide 21 | *Hibsago*: first significant development in chronic hepatitis B in over 40 years

Finally, I wanted to share further details on our launch plans for Hibsago.

In Japan, chronic hepatitis B is a government priority and there are already established processes in place and guidelines that support functional cure. Since approval, we have received a very positive reimbursement decision and physicians have already identified patients to receive therapy.
In the US, chronic hepatitis B is very concentrated with a majority of patients in five states. We have launched with a focus on patients with surface antigen level lower than 1000, where the opportunity to have a positive experience leading to function cure is the highest.

The US, Japan and China represent around 80% of the potential value for Hibsago. Following the approvals in Japan and the US, we look forward to hearing from regulators in China where managing chronic hepatitis B is a national priority and where we have established a strategic collaboration with Sino Biopharmaceutical, a recognised leader in hepatology in China.

I'll now hand over to Julie.

Financial Performance | Julie Brown

Slide 22

Thank you, Nina, I will now cover financial performance, with growth rates at CER, unless otherwise stated.

Slide 23 | Disciplined capital allocation supports accelerated R&D investment

Starting with the income statement for the quarter:

- Sales grew +5%
- Gross profit was up +7% supported by product mix and efficiencies
- SG&A increased +1% including Nuvalent costs, demonstrating smart resource allocation and improved ROI

- and R&D grew 22% in line with our Accelerate Growth agenda outlined at Q2, with a further 12 Ph3 trials initiated this quarter. Growth was driven primarily by accelerated oncology spend on ris-rez, mo-rez and velzatinib, as well as further investment in felcorekibart and efimosfermin.

Operating profit grew 5%, with the margin broadly stable, as increased R&D investment was broadly offset by COGs and SG&A productivity as we further match our cost base to the evolving portfolio.

EPS was up +1%, with the differential due to increased interest costs following the Nuvalent acquisition and a higher tax rate in the quarter.

Turning to Total results the quarter was impacted by £0.3bn Accelerate Growth charge, with the programme to simplify and reallocate spend towards R&D now well underway.

We are moving at pace and ahead of schedule and since July we have initiated a series of changes across the organisation to streamline support services, simplify our supply chain and reallocate resources. And we now expect charges of up to £1bn in 2026.

Next slide please.

Slide 24 | Strong cash generation driven by operational performance

Moving to cash generation, YTD performance has been strong:

- CGFO was £1.1bn ahead of last year underpinned by business performance with increased operating profit and favourable working capital movements.
- And, as a reminder, the YoY comparison was impacted by £0.7bn Zantac cash outflow in 2025 and a net headwind of £0.2bn from the CureVac settlements.
- Turning to free cash flow, it was up £1.8bn YTD, including $650m from the out licence of linerixibat and the special dividend received due to the ViiV shareholding change.

Looking forward to the FY, we remain on track to deliver our target of ~£10bn CGFO at CER.

Next slide please.

Slide 25 | Capital deployment to accelerate growth and shareholder returns

Over the past years we have significantly improved cash generation, conversion of profit to cash and the strength of the balance sheet. This has enabled targeted business development to strengthen our late-stage pipeline, and most recently with the acquisition of Nuvalent, whilst retaining capacity within a strong balance sheet with Net Debt to Core EBITDA at 1.8x.

Next slide please.

Slide 26 | 2026 guidance

Looking ahead, we remain on track to deliver our full year 2026 guidance.

Sales are expected in the upper half of the range, driven by Specialty performance.

Core operating profit is also expected in the upper half of the range and margin remains on track to be >31% at CER.

This is enabled by:

- SG&A, which is projected to be broadly stable,
- COGS benefits from product mix and efficiencies, and
- Royalties which are now upgraded to around £900m for the year

Whilst R&D is expected to grow significantly ahead of sales for the year as we more than double the number of Ph3 starts from the 10 expected at the start of the year to now 22.

EPS growth is expected to be in the lower half of the range, with FY interest expected to be £700-750m, including ~£160m related to the acquisition of Nuvalent.

With respect to currency, we now expect foreign exchange headwinds of -1% on sales and -3% on operating profit.

And finally, looking ahead, we remain committed to our long-term outlook and in the appendix you can find modelling considerations to the end of this year and into next.

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

Summary | Luke Miels

Slide 27 | Critical components of growth strategy are in place and delivering

Thanks, Julie.

To close – we remain focused on executing our strategy which is built on driving topline growth, building and accelerating the late stage portfolio and actively reallocating resources to where they can create the largest value for patients and shareholders.

We'll now open for Q&A.

- Question & Answer Session -

Jeff McLaughlin: We will go with James Gordon from Barclays for the first question.

James Gordon (Barclays): Hello. Hi. James Gordon from Barclays. Thanks for taking two questions. First question was on HIV and next-generation injectables and also more broadly, what's going on in HIV at ViiV.

So I read there was an update about Cabo four-monthly PrEP and that you've got the data in-house and PK analysis is still underway. But how should we read that? Does that mean you've got to do a bit more work on the PK equivalence? Are there questions there? And could that delay the launch? I think there was a comment about the data next year. But do you still think you could launch on the same timelines? And is there any read-through? Because I believe it's the same tech for four-monthly Apretude as four-monthly Cabenuva. So could there be a delay or any extra work you've got to do there?

And the broader question in HIV, there's been quite a few management changes. So ViiV CEO and CFO and fairly recent R&D head changed. So is this at all connected? Is there a trend there, any implications? Is there any sort of reboot going on in HIV since Luke became CEO?

And then the second question was just on new launches, so Exdensur and Blenrep, and I've heard comments about you've now got the J-code. I think it was from the beginning of July. Was that the key thing that was holding up the launches? And do you now think we're going to see a big acceleration, a big inflection into next year, or might we need to wait a little bit longer because there's some other things you also need to really see those products accelerate?

Luke Miels: Right. Thanks, James. I think you've done your colleagues a favor because I suspect we'll be able to capture a number of themes there. So why don't we do the ViiV questions first? I'll just say something quickly, then we'll go to David, and then Nina, if you can cover Exdensur and Blenrep.

Look, I think firstly, no connection to management changes. I mean, the fact is that Deborah got a promotion to be the CEO of CSL. These things don't come along every day, and I think that's great news for Deborah. And actually, I just want to personally thank her for her years as GSK, as a peer and a team member. And as an Australian, I hope she does very well at CSL, just not too well on the vaccine side.

Lynn ran the, just as background, Lynn Baxter, who stepped in. So it was a very quick process. Pretty much as soon as I got the phone call, Deborah, I called Lynn. Lynn ran the U.S ViiV business and she launched

the long acting products and she has been on the ViiV Board during this time. So, she's very much up to date. It was an easy decision. And I've known Lynn for a long time, since my Roche days.

Kim retired, remember, and Charlotte stepped in. She remains the head of ViiV R&D. Charlotte worked with Tony at Pfizer. As I think you all saw at Q2, she knows what she is doing. So, feel very comfortable there. I think more broadly, operationally, I want ViiV to be closer. So there will be more intensive interaction and supervision there, but that is not a bad thing.

Secondly, before I hand to you, David, I just wanted to make a broader point about how we want to communicate with the owners of the company and you, as analysts, and I guess the market more broadly. Look, we are going to call things as we see them. We are not going to park crap on page 41 of a press release and hope none of you notice it. So, we will tell you as much as we can. We will have a plan to address it, but please just adjust your parameters on that because that is how we want to operate. All right? So with that, David, over to you.

David Redfern: Thanks, Luke. The first thing I want to do, actually, is just echo what Luke said around Deborah. She led ViiV incredibly strongly through almost 10 years. Obviously drove a huge amount of growth through that time. Not least this year, where ViiV is up 10% in the quarter and for the year. As Luke said, Lynn Baxter may not be particularly well-known to the investment community, but she's very well-known inside GSK. Very distinguished leader with experience on both sides of the Atlantic. Led ViiV North America for six years, so very connected in the HIV community in America. Obviously, during that time, introduced the long-acting medicines to the U.S. market. As Luke said, Lynn plus Charlotte Allerton plus Jean van Wyk, who's the Chief Medical Officer and very well-known in the HIV community. I'm very confident in the strength right through the ViiV management team.

James, in terms of the pipeline, not much more to say at this point on EXTEND 4M. We have the data in-house. The analysis is ongoing. We look forward to sharing with the regulators. Obviously, we will update the market once that analysis is complete.

What I would say is we're very pleased with the progress we're making with the treatment pipeline in parallel. So the first thing I'd call out, actually, for Cabenuva is the phase III-B CROWN study, where we've shown the headline that showed superiority of Cabenuva in an unsuppressed viraemic population compared to daily oral standard of care. That's important because in the U.S., there's probably about 40% of the market is unsuppressed, so over 400,000 people. So that's just people living with HIV. So that's a

significant growth opportunity. We will show that data at the future congress, and we will also update the regulators and apply for a label expansion on that. Just to remind you, that's actually the second superiority study of Cabenuva. We had LATITUDE earlier in patients, people living with HIV with adherence challenges. So great progress with Cabenuva.

Then with the four monthly formulations of cabotegravir and rilpivirine, I'm pleased to say the CUATRO study recruited very fast over the summer ahead of our expectations. It's been fully recruited now for a number of weeks. The readout is at month 11. Just to remind you, it is an efficacy study comparing four months with two-monthly Cabenuva, but that's obviously now very much on track to read out next year.

We continue to make progress with the six monthlies VH-184 and VH-499 that are progressing as planned through phase II. We still intend to start a pivotal study with that combination with six monthly, which we are very excited about in 2028.

Tony Wood: Just a couple of very quick points. First of all, Charlotte is a very experienced pharmacokineticist and R&D leader. You saw that at 3Q, and I just want to underscore, we see no read-through to the treatment portfolio.

Nina Mojas: Exdensur and Blenrep. Exdensur very specific question, J-code, has that been a milestone or a change? For Exdensur, I am actually pretty confident --- yes. Just for background, we got the J-code the 1st of July. Maybe a little bit more technical. Usually with J-code, the team gets something that we call the ASP document, which is average selling price document that can be shared with the physician, so they are aware of what is the price that will be reimbursed to them. That document became available only on the 1st of October. All of that said, the numbers that we shared in Q3, we have seen significant increase in the new prescribers. 68% new prescribers, and then 74% new patient starts. That includes the totality of both sold volume and the free goods volume that is part of our Fast Start.

Another piece to remember, Q3, because of the summer, tends to be the quarter that has the lowest number of patient visits. As that ASP document became available as of 1st October, obviously you do not see the sales after that. I can just maybe mention every week since then has been the highest week of sales for Exdensur one after another, with the last week being the high sales. So, yes, definitely for Exdensur this has been a milestone kind of moment, and we do expect to see a change in trend from now on. All of that said, it still remains the first long-acting and there has to be adjustment to that. But definitely very positive moments. Maybe just to add, this is the time when we start seeing patients coming back.It is six monthly, so we would start seeing patients after six months receiving again another shot, which is our whole benefit of Exdensur that patients remain on therapy for a long time. It is a very small number of

patients that is reaching that point, but the numbers that we see are actually very encouraging. Let us see if that holds as more and more patients get to six monthly mark.

Blenrep, the way I would describe Blenrep, you have seen now that about half of the sales are coming from ex-U.S., and that reflects again that more experience, existing ex-U.S., both in the clinical setting and in the commercial setting. The previous experience is the most relevant factor when it comes to prescribing Blenrep, and that is reflected ex-U.S. A lot of learnings ex-U.S., that can be moved to the U.S.

We are intensifying peer-to-peer exchange in the U.S., so those who have experience to potentially impact the perceptions. I would probably say that the preexisting perception of Blenrep is the biggest challenge rather than anything else. We have a number of activities that are hopefully going to work to change that.

Simon Baker (Redburn): Good afternoon, everyone. Hi, Luke. Thank you for taking my questions. Two, if I may, please. Firstly, on Shingrix, I wonder if you could just dig down a little bit into the pushes and pulls within the various regions. We do see quite a divergent performance across the world. Related to that, perhaps you could give us an update also on the potential accelerants for Shingrix growth going forward. Firstly, the MACE opportunity, and then beyond that, the dementia potential indication.

Then second question on Hibsago. Given this is the first treatment for a very long time in that indication, perhaps, Nina, you could give us an idea of how we should think about the trajectory and also the initial prescriber reaction to the profile of the product and the label. We've had a few people questioning the monitoring. I'm wondering in the real world, how much of that really, is that really a barrier to adoption? Thanks so much.

Luke Miels: Yeah. Thanks, Simon. What we'll do Thank you. I'll cover the Shingrix component, and then Tony, you can cover the acceleration. Sorry. Yeah, the acceleration and basically MACE dementia. Then Nina, after that, we'll come back to Hibsago.

Simon, how about I go region by region and call out if I confuse you? For the U.S., the IZ rate's 46%, which is up 3% points, which is in the middle of the 2%-4% range that we said that we would get in a year. TRX is okay, and we've got slightly stronger NBRX. The key thing is we're seeing stronger penetration now in the healthcare system. So, this is the comorbid population, we're getting some traction there. But we do need to balance that with the fact that the adult market overall, adult vaccines market overall is still challenging.

Shingrix is doing a little bit better in relative terms. The adult market's down about 18% versus this time last year, but Shingrix is down about 14%. Inventory is usually a question we get. Wholesalers are steady at 0.4, same as last year. But the pharmacists have been buying. So the stock level is higher right now in pharmacy. It's around 2.3, versus 1.7 million doses this time last year. That's likely driven by the fact that we've got a later flu season. So we'll get a clearer picture in Q4. So that's the U.S.

China is, I think it's steady improvement, is how I would describe it. The key is in-arm demand. So we're doing about 300,000 shots a month. That's up 60% versus last year. So I would say that's steady growth over time. It seems to be pretty resilient despite the structural CDC ordering stock management challenges. Remember, we called this early when it was slowing down in 2024. We're basically doing what we said we would do, which is to work off the volume in the pipe. The inventory has dropped. There was, summer last year was around 4.3 million doses. Now we're down to 1.4 million doses as of August. That's about 1.5 Months of demand. That's about as low as you would want it. I would expect, ideally next year we do a reorder. But again, we're not doing mass shipments. We want to sort of match the demand, knowing we've got quite a long timeframe between shipping and actually being distributed in China that we also need to manage.

The rest of the world is, again, it's about nearly, well, it's about 60% of sales. Again, solid. For the E.U., it's really expansion in new countries, broader coverage. Private demand also is starting to increase, which is encouraging. We did have a bit of a softer time in Germany and France in summer. We think that's partly due to the heat, but also there's some parallel trade impact. On the rest of international, it's very much expansion, and really driving access in markets like Brazil, Turkey, other markets like that, and Saudi.

Tony Wood: Thanks for the question, Simon. Look, we've got a broad range of work going on looking at both the MACE and dementia aspects for Shingrix, including mechanistic studies and pragmatic RCTs. There are two of those going on, Simon, in Finland and Denmark, looking to enroll about 200,000 adults. We're expecting initial results from those two studies in 2029. We'll have a first readout on the CVD data at the end of 2027. These are in Finland, where we're evaluating the effect of Shingrix on dementia in greater than 76-year-olds. That's with a registry-based diagnosis in Denmark, where we're evaluating the effect on risk of MACE and in dementia, in that case, in +65 population. For MACE standalone, we're at the moment, expecting to be able to start a study by the end of the year. We have ongoing discussions with regulators at this point in time, but this will be a very broad study in 28 countries, and we've selected already 750 sites. Well underway.

Nina Mojas: Hibsago. Hibsago was approved in Japan and the U.S. Regulatory discussions are ongoing very intensely in China. That's the next one to come.

Japan, we got the reimbursement. I think one of the testaments to Hibsago uniqueness is reimbursement in Japan was justified by the regulators with 50% usefulness premium, which is a number that you hardly see in Japan. Then additional 10% premium for SENKU designation. Very, very happy with that conversation. In the U.S., and again in Japan, we have actually patients already on therapy. Physicians have actively asked for it as we were going through the pricing discussions.

In the U.S., we got the approval. The price is available. Product is going to be on the market, I think available actually within the next, I think 10 days or something like that. Very soon.

Questions on monitoring. Did we expect it? Yes, because that monitoring exactly as described was part of the study protocol. We couldn't expect anything different. Monitoring is there for two reasons. One is ALT elevation, so liver enzyme elevation, and the other one is thrombocytopenia. Both of those happen relatively quickly. Thrombocytopenia, specifically, I think it's even quoted in the USPI. There were two cases of severe thrombocytopenia. It happens quite quickly after the initiation of therapy. The ALT elevation is also, as described in the label, linked actually to the reduction of the surface antigen. Patients who see the reduction are definitely more likely to see ALT elevation.

Now, how that monitoring is going to evolve, as I mentioned, it's quite important in the initial periods. We do expect that physicians will monitor early, seeing if their patients are, by any chance, one of those who have early elevation of ALT or severe thrombocytopenia. Following that, we expect that physicians and patients will find some kind of balance of when and how frequently they do monitoring.

Luke Miels: Thanks, Nina. I think also the feedback that we're getting from experts is they're sort of mentally gating the first 12 weeks, then reassessing it. Essentially, the language to the patient is, "Look, okay, there are frequent blood draws," and we said that to you guys in past meetings. "But look, if we can get to 12 weeks, we'll reassess where you are, then continue on from that point.

Nina Mojas: Yeah. Maybe it's important just for you to think how it's going to work. The first dose is administered in the physician's office. Then patient gets a pack of four doses that they will self-administer at home, and they will need to obviously arrange the monitoring within that period.

Tony Wood: Just worth just underscoring a few things. In terms of thrombocytopenia, as Nina mentioned, only two patients with severe cases, 8% had lower platelet counts. That is easily managed through dose holding. On the ALT flares, more than half of the functional cure patients had a flare, so it is a really

important sign of potential response. You are going to hear more from us on Hibsago at AASLD, so I might as well just give you a quick summary of that now, which is the long-term sustained data out to 48 weeks. The surface antigen measurements at 12 weeks is a predictor of functional cure. Retreatment modeling for future approaches. Lastly, continued description of surface antigen loss versus health outcome. Worth emphasizing that this is a disease with significant morbid and mortality outcomes.

Luke Miels: Yeah, and I think from memory, Tony, it was over 60% of patients who are below 1,000 at baseline could get to below 100 of surface antigen for at least a year post-treatment.

Tony Wood: That is right. More on that analysis at AASLD.

Michael Leuchten (Jefferies): Hey, thanks for taking the questions. Two, please. One for Julie. It sounds like there was inventory in the top line around Shingrix. Were there any other items in the third quarter we should take into consideration? Then as we think about the guidance for the full year, you beat very nicely on SG&A, in particular in the third quarter, but the guidance doesn't go up. So just the pushes and pulls on why not, given you do have some slight help from the royalty income and also lower net financials into the end of the year.

Then a question on, I guess, for Luke, or maybe Tony and/or David. I understand there's limited amount you can say about Q4 treatment, as in CAB treatment, and the read across from the PrEP dose, but it's the same tech, it's the same product. You clearly had an outcome with the PrEP data, the PK/PD study, that didn't exactly tell you what you were hoping for. You're saying there is no read across into treatment. How can you make that statement? How can you give us confidence that there isn't any read across? Thank you.

Julie Brown: Specifically on Shingrix, I think Luke's covered some of this, but in terms of quantifying the U.S. inventory build in the third quarter, in the quarter, it amounts to about 2% points of global growth. We do get these swings, as you know. Very confident, though, in the overall picture for Shingrix. I think China, Luke has touched on this, it's all about injections in arms, and we anticipate shipping again in 2027. I think that covers Shingrix.

In terms of the third quarter and the beat, versus consensus, first of all, we appreciate it was difficult to forecast Q3. Many moving parts, including the acquisition of Nuvalent. There are a few things to flag about the Q3. Sales were higher than our original expectations, and this included some phasing between Q3 and Q4.

As we mentioned, we had the U.S. Shingrix inventory build, meningitis ordering patterns, and we also had Ventolin impacting the quarter. The operating profit in Q3 was impacted by SG&A phasing, better royalties, as you mentioned, partially offset by the phasing of R&D, which was a very high, it was a peak growth in R&D in the third quarter of 22%.

So if we move now, obviously we are comfortable with the overall guidance for the full year. We do expect sales growth to moderate slightly. Partly HIV pricing, partly we have talked about Shingrix, because last year we had a shipment going out in the Q4 to China. Then we are also lapping some of the French and Japanese launches outside the U.S.

Then I think finally, when you think about SG&A, we are going to have the launches to support for Hibsago and Nuvalent. At the same time, there was a charge last year in SG&A of about GBP 0.2 billion that will not repeat in the fourth quarter of this year.

David Redfern: I think what I can say, Michael, is EXTEND, which is the PrEP study, and CUATRO, which is the treatment study, are very different studies. So EXTEND is a PK bridging study where we are looking at drug substance levels at steady state, no earlier than month 13, as well as safety and tolerability. The CUATRO study is an efficacy study comparing the four-monthly formulation of cabotegravir and rilpivirine with two-monthly Cabenuva. So they are very different studies. We are very confident in the formulation that we have got. I will probably leave it at that.

Luke Miels: Yeah. I think the key thing here, Michael, we do not want to front-run discussions with a regulator. That tends to backfire. So again, as I said earlier, we are telling you as much as we can at this point, but in the interest of long-term value creation, I will limit it to that at this point, and appreciate your understanding. The second we can update you, we will. Next question please.

Kerry Holford (Berenberg): Hello all, thank you for taking my questions. I am sorry, just a very quick follow-up on Apretude Q4M. Just interested to know whether you do have a date scheduled to review that data with the FDA, whether you can share that with us? Ultimately, when can we expect more clarity on the issues here in the next steps?

Then if we think into next year, and I appreciate you won't be wanting to give guidance at this point, but just given the commentary you made, Julie, on the OpEx in Q4, in the context of those phase three starts this year, and at least I think you highlighted six additional phase III starting next year, how confident are you that the necessary incremental R&D spend moving into next year can be offset by SG&A savings and COG savings in 2027? Thank you.

David Redfern: I think what I can tell you, Kerry, is we have reached steady state for the last patient only a few weeks ago, not very long ago. So the analysis, as we have said, is ongoing. I think we are confident we will be sharing the data with the regulator before the end of the year, and obviously, post-regulatory discussions, we will update appropriately. So that sort of timing, but I cannot be more specific than that.

Julie Brown: Thanks, Kerry, for the question. So as you know, we have got a really good track record of delivering margin accretion and at the same time investing more and more in R&D, and this is part of the program around Accelerate Growth. So we have also got, as the business pivots more towards specialty, you do get a natural margin lift because the SG&A cost associated with a specialty sell is considerably lower than it would be if you were in primary care. So both of these are major factors. So we do expect R&D to continue to grow ahead of sales. You will be pleased to know not to the extent of Q3, which was obviously very high. But as demonstrated, we can deliver profitable growth through the efficiency in both the cost of goods, and we have talked about the specialty pivot together with the SG&A. The Accelerate Growth program is all about removing cost from what you may call support services and some of the manufacturing network, and it is moving it towards the front line of R&D.

Sachin Jain (Bank of America): Hi there. Thanks for taking my questions. A couple on some drivers into next year if I could. First, I wonder if you could just comment on the Trelegy IRA impact you call out on the 2027 driver slide, Julie. I am assuming this is already heavily rebated. Is there any color on additional IRA pressure? The second I wonder if you can just touch on is Dovato. You talk about DTG tender impact in the quarter. Should we expect that to grow into next year? Then just one follow-up for Nina on Hibsago China. Very clear on approval timelines. Can you just run us through timeline to reimbursement? I assume this requires NRDL listing, etc. Just any colour there. Thank you.

David Redfern: I think Dovato, there are some international markets, notably Brazil, where the patents on dolutegravir expire this year. That has had some marginal impact. Although obviously overall, we are very pleased with the commercial performance of ViiV growing double digits and dolutegravir overall, but there was some impact in Brazil. Actually, as you know, the composition of matter for dolutegravir in the U.S. is 2028. Next year, we do not really have any other significant markets where we lose patents, so expect most of the trends to continue.

Nina Mojas: Yeah. Hibsago, China, as I said, discussions are ongoing. I am not sure I want to commit to a specific timeline because what we have seen is a huge desire from the Chinese authorities to make the drug available. I expect it is going to be sooner than what we planned, but let us leave it with that.

We are going to launch immediately. We will launch in the private market in China as it becomes available. Then with the next round of NRDL discussions, it will be included. I hope by the end of next year, we should be there.

Luke Miels: Yeah, and I think on Trelegy, we just have to rebase it. As you know, it was added to the list for CMS in, I think, November 2025. So the negotiated price for 30 days is now $175, which is a 73% discount to the 2024 list price. So there will be a one-off impact in the U.S. We will rebase that, and then position beyond on that. Again, we are being thoughtful in terms of how we resource this product in the U.S. Julie, anything you want to add on that?

Julie Brown: Thanks, Luke. The price reduction, clearly this is a product in its more mature phase, so there are rebates and returns associated with it. So net-net, not quite as significant as Luke's indicated. Totally included in our guidance. We judged it fairly well a number of years ago, and it was built into the long-term forecast. We have also got Breo alongside Trelegy impacting in 2027, together with the Biktarvy royalty stream that comes off in October in 2027, which is a headwind of around £70 million a quarter. Those are the main things. We have actually included a slide to help. We know you will be focused more and more on 2027. We have included a slide on modeling considerations in the appendix for those who have not seen it just yet.

Zain Ebrahim (J.P. Morgan): Hello. Thanks for taking the questions. Just to follow up on the previous question in terms of if we think about the totality of the IRA headwind for both Breo and Trelegy, is the consensus outlook for general medicines in the right sort of place for next year? I know you said it is broadly in line with your forecast, but just if you could clarify that would be helpful.

Then on Hibsago, I noticed you mentioned that you have got some clarity on the pricing. So how does that compare versus your initial expectations for HepC-like pricing, in the U.S. that is, and just remind us on what proportion of the population here is Part D and when we can expect Part D inclusion.

Luke Miels: Yep. Sure. So, on pricing, it is about £50,000 in Japan, just over £100,000 in the U.S. So, I will give you some epi because I think it would be helpful. So, U.S. is about 1.7 million patients, 400,000 diagnosed, 120,000 treated. Japan is 0.9 million. Of those, 600,000 are diagnosed and 120,000 are treated, so sort of similar. China, about 6 million treated. So it is in a category of its own, but obviously, access and pricing is different there. Julie, did you want to cover anything beyond what we can say on that?

Julie Brown: No, I think at this stage, we'll concentrate on giving you comprehensive guidance at the end of the year, certainly by product area or product category. We'll come back to that.

Luke Miels: Anything you wanted to add on Hibsago, Part D split, on commercial, Nina?

Nina Mojas: Most of these patients do have commercial coverage. There is no competition, which is relevant for this. To which extent the pricing, the discounts go, there is just no alternative, which definitely helps.

Luke Miels: Yeah. The cost of these patients, obviously, as the disease progresses. Looking at the market research, it makes sense to think physicians are going to concentrate on the younger patients initially, and build that experience there with them. As Nina said, I think 2031 is the earliest entrant, excluding China, that we would expect there. Of course, there's a history of combinations and failure in this area. Let's see how these combinations evolve over time.

Matthew Weston (UBS): Hi, Luke. Thank you. Two questions, please. I hear your confidence in Exdensur, but Nucala was also weak in 3Q as well. Can I understand if you've offered rebates on Nucala in the additional access you're talking about on Exdensur or whether or not it's pressure overall in the IL-5 category as physicians prefer TSLP? Secondly, Julie, it's a Jo Walton pro memoria question. On 2027 net financial charge, you've highlighted the strong cash flow, but obviously the cash out for Nuvalent and for the restructuring program. Do you think that consensus has next year's net financial charge modeled correctly or we need to sharpen our pencils?

Luke Miels: No worries. Thanks, Matthew. Just quickly on Nucala. If you look at the numbers in the U.S., volume I think was up nearly 40%, 39%, prices down 15%. So there is some pressure there. I would be cautious about reading that across to Exdensur.

So one of the things we have been quite deliberate on, which is holding the line on Exdensur pricing. We want to take a long-term view here. We have got a long-acting TSLP, we have got a long-acting IgE, we have a long-acting IL-33. So, if you look at coverage, in terms of commercial parity to say Nucala or benralizumab, we have gone from 18% in Q2 to 43% in Q3. And overall, we have got 71% of lives covered, with the difference being some step through. So that has been deliberate there.

I think there is clearly competitive pressure from TSLP overall on the class, but that is also being offset to a degree with COPD, and COPD is helping us within the IL-5 class capture business. Nina, anything that you want to add on that?

Nina Mojas: Again, just remember Q3 for patient visits is the weakest quarter

Julie Brown: So, just in terms of the interest charges that are coming through, and you are right, obviously we have had some considerable cash outflow, particularly in the second half of the year with the Nuvalent acquisition and Accelerate Growth. The good news is it is moving at pace, so we are anticipating charges this year. We originally guided GBP 0.7 billion. We are expecting now charges in the order of £1 billion - this is P&L, and obviously that is going to affect the cash flow going into next year.

So in terms of the financial charge, we have guided for the second half of this year that Nuvalent will be £160 million, so it gives you an idea about how much it will cost us next year in terms of interest. It is going to be over GBP 300 million.

In terms of the overall interest charge, we will guide this at the end of the year, but it is going to be in the order of £900 million to maybe £1 billion. Rates are adverse at the moment as well. The team did a great job of financing Nuvalent when we did, but the rates are getting harder.

Luke Miels: I guess with the topic of Nuvalent, can I make a request? If people have got questions on oncology, we have just had, I think a remarkable ESMO.

Graham Parry (Citi): I asked my oncology questions yesterday, I'm afraid. Just going to go back to the EXTEND 4M, and just if you can help us understand what it is that needs fully characterizing about the new formulation. Can you just remind us, I think this was the study for monthly dosing was actually determined from PK simulations from the phase I Cab-ULA study that you presented at CROI in 2024. Is really this just that the PK isn't matching what your simulations were showing? Or is this an issue of tolerability? Because I think you just had single administration tolerability data on that. Then, can you also clarify that it is the same formulation in CUATRO? I think there's a bit of confusion about that based on your comments that this doesn't read through to CUATRO. So, although they are different studies and one's an efficacy study, if there's a PK or tolerability issue with EXTEND 4M, why wouldn't that then translate to CUATRO?

Then my final question is just thoughts on an AanptysBio litigation update. You've now had the post-trial hearing. Are we heading towards a negotiated settlement here, or are you waiting for a ruling? Thank you.

Luke Miels: Thanks, Graham. Well, I think on the second question, I would direct you to their share price on the day. I can't say much more than that at this point. David, again, I'm not sure you can add too much more. We would love to tell you more, but again, we don't want to prejudice our discussions with regulators.

David Redfern: Yeah. I think that's right. I think we need to do the analysis, and then we need to talk to the regulators. So I'm not going to go into much detail. What I can say, Graham, is you're right on the PK levels were set based on the pivotal study that we did for two monthly. You're right that it's the same formulation in both EXTEND and CUATRO. We are very confident in that formulation.

Luke Miels: I think we've said it several times, there's no read across.

Trung Huynh (RBC): Unfortunately, no oncology question here either. You answered them all yesterday. We did have a couple pipelines questions... On food allergy, you have the ozureprubart phase II data next year. How are you thinking about the opportunity here? The competitive landscape does seem like it is evolving somewhat. There is perhaps more Xolair generic entry. Remi is moving into phase III, so just what is your view on how that market develops and where ozureprubart can differentiate there?

The second one is just on the agreement with Hengrui. One of those assets is a PDE3/4 in COPD. Can you provide a bit more detail on some of the other targets that you are evaluating in this collaboration? When can we expect the next programs to be optioned? How can we think about milestones economics as these progress? Thank you.

Luke Miels: In 2027, we will get a 2B readout for food allergy. The aim is to start the phase III in the second half of next year. Look, this is a huge opportunity. There are about 17 million people in the U.S. that have some form of food allergy, and about 1.6 million of them have what we term as clinically relevant disease.

You are all very familiar with the growth that Roche has seen. When we did this deal, we actually modeled that there would be up to four biosimilars entering in our calculations. Again, there are some structural limits. It is about a quarter of patients on Xolair, where, essentially, the maximum approved Xolair dose just cannot bind enough IgE to be effective in these heavier, larger individuals. We have a product that is essentially twice the potency of Xolair and could be a three-monthly shot with either three doses or an upside scenario of one dose.

Look, I think we have covered the BTK. It is two tablets a day. You have the tox heritage of BTKs. XL111, it is phase I, it is due at the end of the year. I think you need to risk adjust that, and it is really a long way behind. I think we have a very nice asset here. We have a very deliberate development plan. Its properties, t behaves the same way, binds the same way as Xolair. So, factor that in, and that again is part of our BD strategy. I think we are encouraged with the profile that we see. Anything you want to add on that, Tony, before we go to Hansoh/Hengrui?

Tony Wood: No, I think you have covered it well. Xolair was all about the nomogram simplification and getting to the higher weight patients as well, as Luke said. On Hengrui, the PDE3/4 is in early clinical development. This is very much looking for metered dose inhaler opportunity for that particular approach. You will be aware of the early clinical data in the area from competitors that suggest that it is an effective mechanism. We were very careful to look for a molecule that had a similar profile. We have 11 other targets in the collaboration. They have not been disclosed, but it is fair to say that we are engaged very actively with Hengrui on selecting the next range of those for disclosure. I am very pleased with the options that we have in front of us.

Luke Miels: Great. Thanks, Tony. I think we should conclude. We are 11 minutes over. Thank you everyone again for very thoughtful questions, and I appreciate you dialling in.