Investor Relations
Q2 2025 results presentation

Wednesday, 30 July 2025 at 12:00 BST

Introduction | Constantin Fest

Slide 1 | Q2 2025 Results

Slide 2 | Agenda
Ladies and gentlemen, a very warm welcome to the GSK Q2 2025 results call.

I am delighted to be joined today by Emma Walmsley, Tony Wood, Luke Miels, Deborah Waterhouse and Julie Brown, with David Redfern joining for Q&A.

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

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

Before we start, please turn to slide 3.

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

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

I will now hand over to Emma on slide 4.

Q2 2025 Performance Momentum | Emma Walmsley

Slide 4 | Q2 2025 Performance Momentum
Thank you and welcome to everybody joining us today.

Please turn to the next slide.

Slide 5 | 2025 performance momentum: Q2 Highlights
Our second quarter results once again demonstrate GSK's strong performance momentum - and the quality and strength of our portfolio.
Group sales were up 6% for the quarter, core operating profit was up 12%, and core earnings per share grew 15% to 46.5 pence.

Sales growth was driven by our largest business, Specialty Medicines, up 15%. And Vaccine sales also contributed with sales up 9% in the quarter. This led to increases in profits and earnings, which also benefitted from a strong focus on SG&A.

Alongside operating performance, we continue to make good progress in R&D, with 3 FDA approvals achieved so far this year.

Cash generation also remains very positive with £3.7 billion generated in the first half to support further investments in growth and returns to shareholders.

The dividend for the quarter was 16p; and we have now completed more than £800m of the share buy-back programme initiated in February.

All of this is underscored by our commitment to operating as a responsible business. Our most recent action being to expand our voluntary licence agreement with the Medicines Patent Pool to now include long-acting cabotegravir for treatment of HIV as well as prevention.

And finally - driven by our strong performance - we are confirming today that we now expect to be towards the top end of the financial guidance given for 2025.

Next slide, please.

Slide 6 | Consistent operational performance and sustained momentum

Following the demerger of Haleon, we made a commitment to drive a "step-change" in performance at GSK.

This quarter has again shown that GSK is delivering consistent sales growth, operating leverage and positive financial performance.

The investments and development choices we made in our portfolio – notably to launch new specialty medicines – have really helped to drive these new performance levels.

In the last 3 years we have launched innovations in respiratory, immunology, oncology, and HIV. And we have a lot more to come.

Alongside our new vaccine to prevent meningitis and an antibiotic to treat urinary tract infections, three of the five product approvals we expect this year are Specialty Medicines. Tony will talk to each of them in more detail shortly.

But let me touch just briefly on Blenrep.

As you will have seen, the FDA has extended the review period for Blenrep with a new target action date of 23 October. We remain very confident that Blenrep can bring significant benefits to patients with multiple myeloma in the US, and are in constructive discussions with the agency.

Meanwhile, we continue to receive approvals and prepare for launches of Blenrep in many other countries, including across Europe, Japan, Canada, the UK and Switzerland.

So, with the portfolio we have - and the launches to come - we expect Specialty to be a major driver of growth for GSK. Our Specialty business accounts for around 40% of sales today and we expect this to be well over 50% by 2031.

Next slide please.

Slide 7 | Investing for growth remains top capital allocation priority

As we've consistently said and demonstrated, our number one priority for capital allocation is to invest for growth.

We are doing this by:

- Focusing strongly on the delivery of the 14 scale opportunities we've previously highlighted – all of them with peak year sales above £2bn.
- By ensuring we have appropriate resources for priority launches.
- And by prioritising capital in R&D to RII and Oncology – both organically and with targeted business development.

Our BD has real momentum and is a key driver of pipeline expansion.

We will be adding four high-potential assets to late-stage development this year. Three, starting phase 3, were sourced through disciplined BD - IDRX, efimosfermin, and our ADC targeting B7-H3, and we will also begin a pivotal trial to support our 4-monthly long-acting injectable regimen for HIV treatment.

And, we continue to add high value innovation at earlier stages of development too. The pioneering strategic collaboration announced with Hengrui this week, is another excellent example of this.

Lastly, and very importantly, we continue to optimise our Supply chain, with significant investment in US manufacturing, and scaling up of capacity for our new modalities and technology platforms. And as we said last quarter, our overall planned investment in the USA is in the tens of billions of dollars over the next 5 years.

Next slide, please.

Slide 8 | Confident in outlook for sales of >£40bn in 2031

With the breadth of our current business, and the growth opportunities we have in our pipeline, we are highly confident in our outlook for sales of more than £40 billion by 2031.

And, as we have repeatedly demonstrated with our pipeline development, this long-term outlook has consistently improved, and we are ambitious and committed to do more.

Next slide please.

Slide 9 | Strong commitment to growth

So, overall, with the momentum we have, and the progress we are making, we are very confident we can deliver the targets we have set for growth in the short – medium - and longer–term.

Let me now hand over to Tony to talk to you in more depth about our great R&D progress.

Next slide please.

Positive Pipeline Progress | Tony Wood

Slide 10 | Positive Pipeline Progress

Thank you, Emma.

Next slide, please.

Slide 11 | Developing a pipeline of best/first-in-class medicines and vaccines to address medical need and deliver growth to 2031 and beyond

Our number one priority in R&D is to develop transformational specialty medicines and vaccines - in areas of high unmet need - that positively impact health and deliver significant growth.

This is evident in the 14 scale opportunities we have for launch before 2031, and in the progress we are making to expand and accelerate our early-stage pipeline of first and best-in-class assets.

We remain focused on 4 core therapy areas – enabled by advanced technologies, talent and a network of world-class partnerships – and we continue to deepen our expertise in the science of the immune system.

This is most recently exemplified with our work to develop IL5 medicines for lung diseases which is providing us with a better understanding of the role of the immune system in fibro-inflammation – leading us to target diseases beyond the lung, towards kidney, liver, and with the potential future application in neuro-immunology.

Next slide, please.

Slide 12 | RI&I: Our understanding of inflammation in airway disease and portfolio to strengthen leadership in asthma and COPD

Based on decades of research, we have a unique understanding of the role that inflammation plays in chronic airway disease.

Our focus on the underlying biology of inflammation, notably in COPD, has led to a differentiated pipeline of long-acting options – each strongly supported by human genetics, disease phenotyping and insights from our own scaled clinical trials.

In May, we received FDA approval for Nucala for the treatment of COPD. This is the fifth indication for Nucala in the US.

We have also filed depemokimab, our novel ultra-long acting IL5 antagonist, for the treatment of asthma and chronic rhinosinusitis with nasal polyps with regulators – and we have a PDUFA date of 16 December.

I'm also pleased to report, for the first time today, positive results from the AGILE continuation study which further underscore the sustained efficacy and safety over a two-year period of twice-yearly depemokimab.

AGILE is an open-label 12-month extension study in severe asthma patients who completed either SWIFT-1 or 2.

The results show that patients who continued to receive depemokimab maintained the efficacy achieved in the prior trials. Importantly, patients who crossed over from placebo also saw a reduction in exacerbation rates consistent with results in SWIFT.

As a reminder, the SWIFT studies demonstrated a 72% reduction in exacerbations requiring hospitalisation for patients who received depe.

I am also pleased to confirm today that we have started an extensive development programme for depe as an add-on treatment in COPD. The ENDURA trials are now recruiting - and the VIGILANT trial designed to evaluate efficacy in earlier stage disease is planned to start later this year.

As the only company with a range of ultra-long-acting mechanisms, specifically IL-5, IL-33 and TSLP, we are competitively placed to lead in this disease.

And, through our licence agreement with Hengrui, we are adding a novel potentially Best in Class PDE3/4 inhibitor, addressing gaps in the treatment of patients who face continued dyspnoea or who are unlikely to receive inhaled corticosteroids or biologics because of their disease profile.

Last – but not least – the camlipixant CALM-1 and CALM-2 trials remain on track and will be reported together in 2026.

Next slide please

Slide 13 | RI&I: Deeper understanding of inflammatory-fibrosis mechanisms to target disease of the liver
In Immunology, we are extending our expertise in inflammation to understand how it leads to fibrosis in the lung, liver and kidneys to treat, prevent and stop disease progression.

Fibrotic diseases are thought to account for 45% of all deaths worldwide so there is major unmet need here. These conditions are typically seen as difficult to treat. But our work in human genetics and phenotyping combined with emerging platform technologies, including oligonucleotides which have a unique ability to modulate gene expression in the liver, is showing real promise.

As a result, we now have a growing hepatology pipeline, with assets to treat chronic hepatitis B as well as steatotic liver disease (SLD), starting in metabolic dysfunction-associated steatohepatitis (or MASH) and alcohol-associated liver disease (or ALD).

Let's start with hepatitis B, a considerable market opportunity, with large unmet need and limited standard of care.

With bepirovirsen, an oligonucleotide, we have an exciting opportunity for functional cure.

Promising data from the phase II B-CLEAR and B-SURE studies demonstrate sustained loss of hep B surface antigen below the level of quantification. Importantly, new insights from recent epidemiological studies have shown that loss of surface antigen reduces all-cause mortality by up to 62% and the risk of developing liver cancer by up to 89% in HBV patients.

We expect to present additional follow-up data from B-SURE at AASLD later this year. Our phase III B-WELL trial continues at pace with data expected in the first half of 2026.

I'm also delighted to share that the B-UNITED phase II study has completed recruitment 4 months ahead of schedule. This trial is looking at sequential administration of dap-lu-si-ran and tom-li-gi-si-ran, followed by bepi, and will read out in 2027. If positive, it will significantly expand the patient population who could benefit from treatment.

As already highlighted, we were also excited to complete the acquisition of efimosfermin, or efi. This adds another phase III ready, potential best-in-class medicine to our pipeline.

Efi is a once monthly FGF21 analog with phase II data which demonstrates its potential to reverse liver fibrosis in MASH. We plan to start phase III trials in MASH later this year, with plans for further development in ALD.

And of course, development of GSK'990, our siRNA therapeutic continues for other subsets of patients with SLD.

We see these two assets as complementary, providing options to develop both monotherapies and combinations.

Let's turn to Oncology now.

Next slide, please.

Slide 14 | Oncology: expanding beyond haematological and gynaecological cancers to additional solid tumours

Here, our momentum continues and we are rapidly expanding beyond our current focus in haematological and gynaecological cancers to treat additional solid tumours.

On Blenrep, as Emma has said, the new PDUFA date is 23 October 2025, providing the FDA with time to review additional information provided in support of the application. We are in constructive discussions with the FDA and whilst I know you will want more details, the review process remains confidential and so I will update you when we can.

Outside the US, we have already received regulatory approvals from Europe, Japan, Canada, the UK and Switzerland – all pointing to the positive impact this medicine can have for patients with multiple myeloma.

Elsewhere, in the portfolio, we are progressing multiple development programmes.

Last year, Jemperli was expanded to all adult patients with primary advanced or recurrent endometrial cancer as the first and only immuno-oncology-based treatment to show an overall survival benefit in these indications. Initial results from the AZUR-1 trial in rectal cancer are expected in 2026, with the phase III JADE study in locally advanced head and neck cancer also ongoing.

For Ojjaara, studies are underway to expand the label into MDS. And additional indications are also in planning.

We have a high ambition for our new ADC portfolio, and, given the significant potential we see here, we are prioritising investment.

We are developing GSK 227, our B7-H3 ADC, in lung cancer and evaluating other solid tumours.

We have already received two breakthrough designations from the FDA, in relapsed or refractory extensive-stage small-cell lung cancer; and in late-line relapsed or refractory osteosarcoma.

Early combination data with PDL1 indicates the potential for a chemo-free regimen in 1L small cell lung cancer, with more mature data expected in November. And we are on track to start a pivotal study before the end of the year.

For GSK'584, our B7-H4 ADC, we will start pivotal studies early next year.

Lastly, earlier this year, we entered into an agreement to acquire IDRX-42, a highly selective KIT inhibitor being developed as a first- and second-line therapy for the treatment of Gastrointestinal Stromal Tumours (or GIST).

IDRX-42, now GSK'981, has demonstrated activity against all key primary and secondary KIT mutations, observed in GIST. This breadth of coverage, in addition to high selectivity which could provide improved tolerability, offers a potential best-in-class profile. We will start recruitment for a pivotal study in second line before year end.

Next slide, please.

Slide 15 | Continued leadership in Infectious Disease

Within infectious disease, we are developing prevention and treatment options with broad coverage.

Two of our recent FDA approvals exemplify this.

Penmenvy, our pentavalent meningococcal vaccine – offers more strain coverage – enabling higher protection from the serious consequences of infection to more teens and young adults; and Blujepa – is the first new class of antibiotic in over 30 years, for the treatment of uncomplicated UTIs, a condition that affects 50% of all women.

We are also making progress with other ID assets:

Our phase III trial for tebipenem in treatment for complicated UTIs was stopped early for efficacy;

Arexvy received a positive ACIP recommendation, expanding its use to adults aged 50-59;

And, with Shingrix, we are now researching this vaccine's potential for use beyond shingles. Given the increasing number of real world evidence studies showing a potential protective effect in dementia, we

have initiated several research collaborations to explore this effect prospectively. These include a first-of-its-kind, large scale linkage study with the UK Dementia Research Institute and Health Data Research UK.

Of course, development work in HIV is also a clear priority and you will hear more from Deborah on this shortly.

Next slide please.

Slide 16 | Strong momentum and material progress in R&D

I am pleased with the strong momentum and material progress we are making in R&D.

I believe we have more – and better – opportunities with 66 assets in full clinical development, 16 currently in the late-stage and 8 regulatory breakthrough designations already this year.

Our deepening expertise in immunology, use of advanced technologies and world-class partnerships are delivering results.

We have had 3 FDA approvals so far this year and remain on track for two more.

Adding to a record 13 positive phase III readouts in 2024, we expect another 15 readouts through 2025 and 2026.

And, for the remainder of this year, we will start pivotal studies for four assets. Two of these are in oncology with our B7-H3 ADC, in extensive-stage small cell lung cancer and IDRX-42, in second line GIST. In hepatology, we will start efimosfermin in MASH, and in HIV our Q4M ultra-long-acting treatment regimen.

Overall, we have a clear path to extend our leadership in Respiratory, exciting new prospects in Immunology and Inflammation, and momentum in Oncology alongside major pipeline opportunities to come in Infectious Disease and HIV.

Next slide please.

Slide 17 | Developing a pipeline of best/first-in-class medicines and vaccines to address medical need and deliver growth to 2031 and beyond

To finish, I will go back to where I started...with our focus on a best-in-class pipeline, in areas of huge unmet need – which you can see here – and where we are making an important difference to the health of billions of people.

With that, I'll hand over to Luke.

Performance: Growth Drivers | Luke Miels

Slide 18 | Performance: growth drivers

Thanks, Tony. Please turn to the next slide.

Slide 19 | Q2 growth demonstrates strong Specialty performance

In Q2, we delivered £8billion in sales, up 6% versus last year - demonstrating strong execution and demand driven growth.

Growth in the quarter was driven by Specialty Medicines, up 15%, and strong Shingrix and Meningitis demand in Europe, with some offset driven by the expected impact of the Medicare Part D redesign across the portfolio, which is tracking as expected.

Next slide please.

Slide 20 | Specialty Medicines: Continued momentum across all therapy areas

Specialty Medicines continues to be the most important driver of our diversified business with double digit growth, once again, in all therapy areas.

Starting with RI&I, sales were up 10% even with the expected tough comparators for Nucala and Benlysta and this was driven by strong demand.
Benlysta, our treatment for lupus, grew 13% and is now positioned as a preferred therapy in all global guidelines. In the quarter, EULAR also updated their recommendation for use of Benlysta up to three years following remission.
Nucala, our anti-IL5 biologic, grew 7%, in line with expectations following an inventory build in Q2 2024 and the impact of the Medicare Part D redesign, both offset by strong performance in Europe and International. We are very pleased with the label we have in COPD, which I will cover in a minute.

Moving to our growing oncology portfolio, which was up 42%:
Jemperli, for endometrial cancer, continues to see increasing patient demand and growing market share in both dMMR and MMRp populations following our all-comers approval in the US and Europe – up 91% in the quarter and
Ojjaara sales were up 69% driven by strong US volume growth including growing demand from moderate anaemic patients that represent 65% of the market opportunity
And Blenrep had its first sales in second line multiple myeloma following early launch days in the UK, and more on that in a minute.

With this strong momentum, and the great performance from ViiV that Deborah will cover, we are increasing our full year Specialty guidance, now expected to grow in the low teens %.

Next slide, please.

Slide 21 | Specialty Medicines: Positive progress on new respiratory and oncology growth engines

In respiratory, we were very pleased with the strong label we received for Nucala in COPD. We now have an important opportunity to reach a wide spectrum of patients with a blood eosinophil count starting at 150 cells per microlitre - a key differentiator for our monthly biologic. The label also includes important data showing a 35% reduction in hospitalisations from severe exacerbations – a high-quality data point as we know that 1 in 2 patients hospitalised from COPD will die within five years and that these hospitalisations are responsible for 70% of all COPD related costs.

We continue to look forward to the significant opportunity we have with depemokimab, our twice-yearly IL-5, which has been filed in all major markets for approval in severe asthma and nasal polyps. Both are opportunities we expect will expand the market for biologics in this space. We've had very positive market

research which shows 86% of pulmonologists think depe could become standard of care and 87% of patients said they would be likely to use depe if supported by an HCP. We look forward to a US FDA decision towards the end of the year.

On Blenrep, we are very confident in the opportunity for this important medicine and continue to emphasise the projected overall survival benefit of 33 months compared to standard of care from DREAMM7. Our premium coordination of care service has already been well received in the UK following approval and launch in April. We are also pleased to have received approval in Europe, Japan, Canada, the UK and Switzerland. As you have heard from both Emma and Tony, we are continuing to work with the FDA to bring this important medicine to American patients.

I'll now handover to Deborah to cover HIV.

Performance: Growth Drivers (Cont'd) | Deborah Waterhouse

Slide 22 | HIV: strong, sustained commercial execution in Q2 for long-acting

Thank you, Luke.

Our HIV portfolio continues to deliver exceptional growth, up 12% in the quarter. 9 points of growth came from strong patient demand for our long-acting injectables and Dovato. and 3 points came from customer stocking patterns and tender phasing. We saw demand grow across all regions and major markets, particularly the US, which grew 14% through double-digit demand growth and where we saw not only total share gain outpacing the competition but Cabenuva consistently gaining at least 70% of product switches from competitors.

Dovato continued to deliver strong performance, up 23%, and our long-acting injectables - Cabenuva and Apretude - delivered robust growth, up 46% and 50% respectively. With treatment accounting for 90% of the total £22bn HIV market - we continue to drive the shift to long-acting injectables. In Q2, Cabenuva and Apretude delivered more than 70% of our total growth, driven by the US - where they now account for one third of sales.

Focusing on long acting injectables for treatment, strong patient preference is reinforced by VOLITION, a phase IIIb study shared at the IAS conference this month, showing nearly 90% of newly diagnosed people chose to switch to Cabenuva from daily pills after achieving viral suppression. This medicine continues to transform the lives of more than 90,000 people living with HIV.

Apretude saw strong growth in the quarter, and we expect it to continue to grow in H2 in the US – bolstered by over three years of real-world data demonstrating more than 99% effectiveness, along with excellent safety and tolerability across broad populations. We have set a high bar for tolerability with Apretude - given by one shot, intramuscularly. This quarter we initiated the phase 1 CLARITY study in healthy volunteers to evaluate the tolerability of a competitor long-acting injectable against Apretude's robust profile. We are very optimistic about the outcome and look forward to sharing data at an autumn conference.

Given our strong and sustained performance, today we are adjusting our 2025 HIV guidance upwards to mid-to-high single digit percentage growth.

Next slide please.

Slide 23 | HIV pipeline momentum: VH184 has potential to become backbone of next-generation of HIV treatment regimens

We continue to progress our industry-leading pipeline with integrase inhibitors at the core and have multiple long-acting options with strong profiles for Q4M, Q6M and self-administered.

Building on our established two-monthly injectable regimens, we believe four-monthly dosing in PrEP and treatment will be important options - delivering longer dosing intervals and ensuring continuity of care. Our Q4M PrEP trial has recruited rapidly and is going well. The FDA have asked for an extra 4 months of data, which means the study will read out in H2 2026 and we look forward to launching in H1 2027. At the launch of Q4M treatment, we expect to have the only complete long-acting injectable treatment regimens on the market for many years to come.

Looking ahead to our twice-yearly injectables – we're on track to confirm the dosing regimen for Q6M treatment in 2026 and expect to file and launch both Q6M for treatment and PrEP between 2028 and 2030. For treatment, we are particularly excited about VH184 - our third generation INSTI which has the best resistance profile seen to date and has the potential to be the backbone of our next generation of HIV treatment regimens with IP cover through at least the end of the next decade.

We also continue to pursue potential cures for HIV. In July we initiated ENTRANCE - a first-time in human study featuring our bNAb N6LS, with or without fostemsavir (currently marketed as Rukobia). This work is at an early stage, and we are pleased to bring our scientific expertise to this notoriously difficult area.

With a 10-year head start in long-acting treatment, we are focused on the next-generation of HIV innovation. We remain confident that our pipeline - including five planned launches by 2030 - will continue to drive performance over the coming decade and beyond.

With that, I will hand back to Luke.

Performance: Growth Drivers (Cont'd) | Luke Miels

Slide 24 | Vaccines: Global expansion: Europe and International demand, leading growth

Thanks, Deborah.

Turning to Vaccines, sales for Q2 were £2.1 billion, up 9%, primarily driven by strong demand in Europe for Shingrix and our meningitis vaccines.

Shingrix sales grew 6% in total as our global expansion strategy is delivering with 72% of our sales now coming from outside the US. Growth was driven by launches and national immunisation approvals in countries like France and Japan. We remain confident in the ex-US opportunity.

- Starting in Europe, Shingrix sales were up 48% led by a swift uptake in France and strong demand across several countries including Spain, the Netherlands, Italy and Greece.

- In the US, penetration is now 42% of the eligible older adult population – achieved in about half the time it took for older adult pneumococcal vaccines. With harder to reach patients, the immunisation rates have slowed, as expected.
- And in International, accelerated uptake in Japan following expanded public funding in April, was offset by tough Q2 2024 comparators which included supply to our co-promotion partner in China and a rapid uptake in Australia.

In Meningitis, our portfolio was up 22% with strong double-digit growth across Europe and International driven primarily by Bexsero, the only MenB indicated for infants. In the US, where we have dominant leadership in the MenB adolescent market, we are excited to introduce our pentavalent vaccine, Penmenvy. We expect this vaccine to simplify immunisation schedules and contribute to increasing coverage and protection against serious life-threatening illness.

Turning to RSV, obviously we are pre-season, but Arexvy sales increased 13%, maintaining market leadership in the US older adult segment and benefiting from strong uptake in Germany. In the US, we were pleased to see that earlier this month the CDC confirmed the ACIP recommendation for adults aged 50–59 at increased risk. In the current vaccines environment, we continue to expect this market will take time to build, but with our strong clinical profile in the most vulnerable populations, we remain confident long term in the importance of this vaccine.

And finally, our broad portfolio of Established Vaccines grew 6% primarily due to favourable CDC stockpile movements for Infanrix/Pediarix in the US.

Overall, our vaccines business is performing well amidst a challenging external environment. Driven by the good H1 performance we are increasing our outlook for vaccine sales today to "decline low single digit to stable" and we remain confident in the medium and long term prospects of this business and pipeline.

Next slide please.

Slide 25 | General Medicines: *Trelegy* growth partially offsetting portfolio pressure from generics

Turning to General Medicines which was down 6% as expected, following a very tough comparator for Trelegy in Q2 of last year.

- As you may remember, Trelegy was up 41% in Q2 2024 due, in large part, to significant adjustments in returns and rebates. This quarter, Trelegy grew 1% in the US and 4% globally despite the tough comp and pricing headwinds from Medicare Part D redesign.
- Trelegy is now in its eighth year on the market and we are continuing to see all time high shares – with room to grow.

Beyond Trelegy, the rest of the General Medicines portfolio was down reflecting continued generic competition across the portfolio and adjustments in rebates and returns as expected.

We continue to expect sales to be broadly stable in 2025 and look forward to the opportunity we have in adding anti-infectives into this part of our business with the approval of Blujepa for uncomplicated urinary tract infections in the US, which we will launch later this year. We have also seen progress on tebipenem as Tony highlighted, an important oral option to keep complicated urinary tract infection patients out of hospital.

I'll now hand over to Julie.

Q2 2025 Financial Performance | Julie Brown

Slide 26 | Q2 2025 financial performance

Thank you, Luke and good afternoon everyone.

Next slide, please.

Slide 27 | Momentum continues to build in Q2 2025

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

GSK continues to build momentum in 2025, with **sales** increasing 6% driven by continued strong Specialty performance, complemented by growth in Vaccines.

Cost of sales for the quarter grew 7%, ahead of sales, due to pricing impacts and supply chain optimisation charges.

Core operating profit grew 12%, with strong leverage in the quarter delivered through:

- A 1% reduction in SG&A, demonstrating our disciplined returns-based approach,
- And a 70% increase in royalties due to the upfront receipt from the IP settlement announced in April

Core EPS grew 15%, continuing to demonstrate our track record of delivering margin leverage and enhanced by lower interest charges as well as the share buyback.

Turning to **Total results**, growth of 33% was largely driven by a favourable ViiV CCL movement, predominantly due to currency, partially offset by intangible asset impairments.

Next slide, please.

Slide 28 | Q2 2025 core operating margin

This chart illustrates the margin improvement year on year.

The operating margin improved in the quarter by 180 basis points, driven by SG&A and royalties:

- Whilst we continue to invest competitively behind product launches, SG&A improved the margin by 190bps, due to phasing between the quarters and accelerated productivity improvements.
- As I mentioned, royalties were driven by the RSV IP settlement, the income from which is being re-invested in R&D this year, with priority projects accelerating this quarter.
- Finally, whilst the portfolio and margin continue to benefit from the transition towards Specialty, the Q2 fall in the gross margin was predominantly driven by lower RAR benefits YoY and by charges associated with supply chain optimisation.

Next slide, please.

Slide 29 | Strong H1 2025 cash performance, free cash flow up £1.2bn YoY

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

Cash generated from operations was £3.9bn at the half, improving by more than £1bn, and demonstrating our continued focus on cash discipline as we remain on track for more than £10bn CGFO in 2026.

The improvement year to date is driven by increased operating profit and favourable movements in RAR, partially offset by increased working capital, driven by higher Arexvy and Shingrix collections last year.

Free cash flow improved by £1.3bn driven by strong CGFO and the favourable phasing of tax payments.

Zantac payments so far this year have totalled £124m and we expect the remaining £1.1bn to be paid through the second half.

Next slide, please.

Slide 30 | Capital deployment prioritises business growth and shareholder returns

Turning to capital allocation, we continue to deploy cash in a disciplined manner and underpinned by a strong balance sheet, in line with our framework. Our Net Debt to Core EBITDA remains broadly aligned with this time last year.

Our priority is always to invest for growth, evidenced by the increasing investment in R&D, together with ongoing BD. In H1 we had outflows relating to a number of deals, including the acquisition of IDRX and we will continue to look for opportunities, particularly in Specialty, consistent with the size and frequency of recent deals.

We have also made over £2bn in shareholder distributions in the first half through the dividend and share buyback programme, which is progressing at pace with more than £800m executed so far and with a total of ~£1.3bn expected to be completed by the end of the year.

Please note, in the second half net debt is expected to include almost £3bn of outflows relating to the settlement of Zantac, the completion of the efimosfermin, and the Hengrui collaboration together with the ongoing SBB.

Next slide, please.

Slide 31 | FY 2025 guidance: Delivery expected towards the top end of guidance and long-term ambitions maintained

GSK's momentum continues to build and we are pleased with the performance this year. We now expect to deliver towards the top end of our guidance ranges on sales, operating profit and EPS and we are adjusting our full year guidance for Specialty, HIV and Vaccines upwards.

Regarding our 2025 P&L guidance. In line with our capital allocation priorities:

- We expect gross margin benefit from product mix in the full year
- We are accelerating investment in the pipeline and now expect R&D to grow ahead of sales

- We also remain committed to LSD % growth in SG&A for the full year, whilst there will be a step up in investment in Q3 behind our upcoming launches we will also see an acceleration of SG&A productivity initiatives, with the associated charges and benefits, in the remainder of the year.
- And, finally, net interest expense is now expected to be lower than previously guided at £550-600m due to the later phasing of Zantac payments.

Our guidance is inclusive of tariffs enacted thus far and the European tariffs indicated this week. Obviously more details are set to follow but as we have said previously, we are positioned to respond, with mitigation actions identified, and confirm our guidance towards the top end of the range this year.

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

Next slide, please.

Slide 32 | IR Roadmap 2025 to 2026

Moving to our roadmap, which illustrates our progress towards major milestones and upcoming value unlocks.

We have made good progress through the first half on our priority assets. Looking forward we expect this momentum to accelerate:

- We continue to plan for launches in H2 with Blenrep, Blujepa and Penmenvy, adding to Nucala COPD
- The FDA regulatory decision for depemokimab is due in December this year
- And, of the 14 scale opportunities that Emma mentioned, we will have pivotal trial readouts related to 6 of these over the next 18 months

With that I will hand back to Emma to close.

Summary and Q&A | Emma Walmsley

Slide 33 | Delivering strong and sustained momentum for patients and shareholders

Thanks, Julie.

To summarise, our results today confirm GSK's continued strong momentum and meaningful R&D progress- for patients and for shareholders.

Our portfolio is demonstrating quality and strength - and we now expect to be towards the top end of our financial guidance for 2025. Looking beyond, we are excited by the prospects in our pipeline - and remain highly confident in our long-term outlooks.

With that I will now open up the call for Q&A with the team.

Q&A

Constantin Fest: Thank you, Emma. I would like to remind everyone to please raise the hand to ask a question. First question comes from Simon Baker of Redburn. Please go ahead, Simon.

Simon, you have been unmuted. And you can speak.

Simon Baker (Redburn): Can you hear me now, Constantin?

Constantin Fest: Yeah, we can hear you. Go ahead, Simon.

Simon Baker (Redburn) : Thank you. Apologies for that. Yes. Two questions if I may, please. Firstly, just a clarification on camlipixant. Tony, you said they would both report in 2026. Slide 32 is still showing CALM 1 readout in H2 2025. So, when you said report, do you mean the full data, and we will still get a CALM-1 headline press release in 2025.

And then the second question was related to Blenrep. We, like you are assuming this is simply a potential delay rather than anything else. So, I just wanted to get your thoughts on what impact that has, firstly, on 2031 and the composition of the £40 billion if those Blenrep revenues are pushed out slightly. And also, what it means for 2028, where the contribution from Blenrep now looks like it will be smaller, and therefore, the impact from the dolutegravir patent expiry will be greater. Just how that -- what the magnitude of that is? And also, how that influences your M&A plans going forward? Thanks so much.

Emma Walmsley: Thanks. Well, I'll ask Tony in a second, just to comment quickly on camlipixant. But be really clear, Simon. We are very pleased to have an updated PDUFA date in October. There is absolutely no change to our expectations around the ramp of Blenrep, we're really pleased with the -- we're hoping to get into more than 10 markets actually by the end of this year, we're working hard and constructively with the FDA to be able to bring this to American patients too. So, no change. I'm fully confident whether it's our 2028 outlooks or 2031 outlook. And as you know, we keep adding to them with new prospects and ongoing BD.

And specifically on your question on BD, it's quite exciting to me that three of the four pivotal trials that are starting later this year whether it's on EFI or IDRx, or our next gen of ADCs are from a great BD that we brought in. Of course, we announced Hengrui this week, which is a really strategic play to accelerate early-stage research and with a headline asset, which might be best in class on the PDE 3-4 for COPD as well. So, lots going on in BD and we'll continue at the kind of pace and scale we have been -- no update at all except for reiterated confidence in terms of our outlook and plans to add to them. Tony, anything you want to say on Camli?

Tony Wood: Yeah and Simon, thanks for the question. And just as an update and to clarify here, as I said before, CALM-2 is still recruiting. We're anticipating data in mid-year 2026. You'll also appreciate that typically we only disclose Phase 3 studies involving two studies once both are completed. And so the formal disclosure associated with CALM-1 and CALM-2 will be in line with the CALM-2 schedule.

Right. Thank you. Next question please.

Constantin Fest: Next question comes from James Gordon from J.P. Morgan. James, please go ahead.

James Gordon (J.P. Morgan): Hello, James Gordon, J.P. Morgan. Thanks for taking the questions.
First question was also on Blenrep. So a busy few weeks with the ODAC then it sounds like subsequent data added after the ODAC and then some personnel changes at FDA with Vinay Prasad leaving. But -- so without asking what the extra data is, just what is GSK's latest confidence in getting Blenrep approved in the US this year?

And also how important is Blenrep US in keeping the margin flat through HIV LA starting in 2028? If you didn't have US Blenrep, would you still be able to keep the margin flat? That's the first question, please.

And then the second question the PDE3-4 looks interesting from the Hengrui deal. So I think based on like $10 billion to get Verona's PDE3-4, but that is already in the market, and you're paying about £500 million, but it's quite a bit earlier. So is the key differentiation that yours is DPI and there's this nebulizer or were other areas where it's differentiated and you're only paying about 5% what Merck did? Is it just how far you are in the market? It looks like a very good deal, but it depends how differentiated it is.

Emma Walmsley: Well, we definitely agree that it's a very good deal. And yes, the mark of deals is not how much you spend, it's the kind of returns you can get. And we do believe we have a potentially best-in-class asset here in a field we know a lot about and adding to the COPD portfolio.

I think there are about 7 questions in that but in your first point on Blenrep, and just for everybody, as Tony said, we know you've got a lot of questions about that, but we hope everybody on the call understands how much we are committed to respecting the confidentiality of this process.
We are in constructive dialogue. We have high confidence in our data. We're answering questions and adding more to that. And we will update you when we can. And just to reiterate we don't subsegment peak year sales by country, obviously. The US is important. But we are really pleased to have added, by the way, since the ODAC across-the-board Europe approval, the Canada approval to the UK, to Japan, and you can rest assured that Luke is ramping up the launch preparations, of course, going slow to go big.

And Blenrep is without doubt an important medicine. We are working towards the US approval. We want to bring this for American patients. When you think of this overall survival data in a head-to-head study against the standard of care. When you think that 70% of myeloma of patients are in communities, and this is a medicine that allows people to be treated in communities. So, it will keep the conversation going there. I'll see whether Tony wants to add anything at all. He's shaking his head, anything you want to say?

Tony Wood: Just simply, again, to emphasize that obviously we're in constructive dialog, but we want to respect the confidentiality of that interaction. I'll update you as soon as I can.

Emma Walmsley: Great. Thanks. And just because we want to get through as many questions as possible, I would respectfully suggest that we're not going to go much further than that on Blenrep today.

Tony Wood: I'll start with why I like the collaboration for start because as the £500 million is also dedicated towards options to the other 11 innovative potential medicines that we have covering our RI&I and Oncology.

Let me just describe the profile of the molecule itself. I would describe it in terms of its PD3-4 balance as being similar to Verona. That's important because it means that we can be confident in the efficacy and safety profile of the molecule. Whilst it's similar in balance, it's about two-fold more potent across that and has demonstrated both clinically and preclinically, both bronchodilation and anti-inflammatory effects. That reduction in dose is important when one considers the optionality for DPI. And as Emma said, we have an extensive experience there based on our own DPI portfolio. And I'm looking forward to developing that Molecule in partnership. And we see potential across the gold framework as an add-on therapy. Luke, do you want to add a bit more to that?

Luke Miels: Yeah. I mean we've obviously looked at this class for a while for a couple of years now. We like it. I think the initial uptake is pretty clear. I think about 50% of the use is in very severe patients on top of standard care triple etc. But I think there will be a threshold where nebulization and the price start to retard. That's our hypothesis anyway - starts to retard things.
So an alternative, classical delivery approach, which is very synergistic with the rest of the portfolio, is exciting. And then the final thing I'd say it's a good sign for COPD, and Nucala and COPD because clearly, there's an appetite for new mechanisms in particularly the more severe COPD population.

Emma Walmsley: We're really pleased with the agility, in fact, the aggression we've been showing on partnering for BD as of assets out of China, whether it's the ADC deal we did or the long-acting TSLP or now adding this. And of course, some great science, we all know what's happening in the biotech industry there, but then we can pick up partnering and then rolling through Internet or global ex-China clinical network and of course, manufacturing, if that's successful. Next question please.

Constantin Fest: The next question comes from Michael Leuchten from Jefferies. Please go ahead, Michael.

Michael Leuchten (Jefferies): Thank you for taking my questions. Two please, one for Julie and one for Luke.

Julie, your talk to the supply chain costs hitting COGS in the second quarter and then your slides say you expect the gross margin to benefit from product mix, but it does say the gross margin is going to go up. Can you just clarify what those costs might mean for the second half? Are they relevant or not?

And a question for Luke. Nucala COPD, you've got £500 million peak sales on the slide now. I thought in the past, you talked to £500 million to £1 billion that might be wrong, but have your expectations come down for that relative to previous communication? Thank you.

Emma Walmsley: Definitely not. I'll say before Luke answers your question. And Julie, do you want to work out our gross margin recognizing -- remember that we have included in our guidance, not only those enacted, but those indicated in terms of tariffs. So as that settles out with a bit more details to come, we'll have more specificity. But Julie, do you want to pick up on gross margin and then Luke.

Julie Brown: Yeah, sure. Thank you very much for the question. In terms of gross margin, we do anticipate some accretion this year. As you know, we took a charge for supply chain efficiencies in Q4 of last year of £150 million. We will be comping that coming up with the fourth quarter. But nevertheless, the big point is that Specialty growth, which is very considerable, is driving an improvement in our gross margin if, all else was equal, you would see that coming through.

What you see is causing some turbulence in the gross margin is one supply chain optimization charges are going through. And then the second one, as Emma just alluded to, is tariffs.

Obviously, we haven't had any tariffs in first half. We are anticipating some coming in the second half, and that will lower the gross margin slightly. But even with the ones that have either been announced or indicated, we still see the opportunity for gross margin accretion coming through mix.

Emma Walmsley: Great, thanks. Luke, COPD.

Luke Miels: Yeah. Thanks, Michael. Look, I think £500 is fair. But of course, we are going to and above that. If I look at initial signs, we're already ahead of where Dupixent was at the same point in its launch with new patient starts. So it's a good sign. We don't -- I mean the lead indicators are positive, so physicians clearly like the reduction in hospitalization and ED department visits and that certainly resonates with them.

We're also interestingly winning in terms of the perception in the lower EOS patient as well, which is naturally historically dupi's hunting ground, which is encouraging. And if you look at the market research, you've got, again, early days, but 67% of pulmonologists say they're likely to prescribe Nucala and COPD and prefer it versus only 30% with Dupixent. And really good execution. So far, we've seen 91% of our key customers with a really good frequency. So bang on there. I think balancing that back to your question, pulmonologists historically have not been, as aggressive as maybe the evidence would support in terms of biologic penetration.

So once we get more robust numbers, which will be, IQVIA, the quant, the lag indicators, we'll have a better picture. But I think it's a good start. And we'll give you a fuller update at Q3 when we've got data, which of course is you know what counts quant over qual.

Emma Walmsley: And the only other thing I'd say on this one is what we're aiming to do is be, indisputable leaders in COPD medicines. That is the strategy that Tony has laid out with a comprehensive portfolio that we've added to be able to sub-segment and treat this enormous burden of disease. More than 300 million people, third leading cause of death, 70% as Luke said of the costs related to COPD are hospitalization. Nucala is the only medicine with a demonstrated 35% reduction in hospitalization.

Tony confirmed the start of the depe COPD trial. One of the things that might contain, over time, the peak year sales of Nucala is bringing a six-monthly IL-5 to COPD and then of course, we've got the whole portfolio of assets that we've already started talking about. So exciting start. I think we've confirmed and reiterated that half a billion for this one. But let's see how it goes. Next question, please.

Constantin Fest: Next question comes from Sachin Jain from Bank of America. Sachin, please go ahead.

Sachin Jain (Bank of America): Hi, I've got two or three product ones please. So firstly, on the same vein on depe, Luke, one of you just gave us a better sense of launch. So you think about market expansion, new Nucala cannibalization switches from competition, and I guess specifically consensus is only 200 million for next year, which seems conservative relative to the launch you potentially describe?

And secondly, on Shingrix, I wonder if you could talk about continuation of the ex-US trends and how much of those European launches potentially boluses versus continuing?

And thirdly, I will apologize, but I will try my arm once on Blenrep. I just want to understand why the data you've submitted, you wouldn't have used as part of the adcom debate if it was material enough to shift the debate you knew was coming. Thank you.

Emma Walmsley: Sorry I didn't. It wasn't on purpose, but I didn't actually hear the third question on Blenrep. Could you repeat it?

Sachin Jain (Bank of America): Why data that you've submitted you wouldn't have used as part of the adcom debate if it's material enough to shift the FDA's view on a debate that you knew was coming, given you get the briefing documents well ahead of the actual adcom. Thanks.

Emma Walmsley: Yeah. We're not going to comment on that. So good try. Luke, would you like to answer the first two questions on ambitions around depe and Shingrix curves? Thanks.

Luke Miels: Thanks, and welcome back Sachin. Yeah. Look, I think on depe, you know a lot of excitement I think for anyone that's attended an academic meeting with the data has been presented, there's a lot of enthusiasm here. And I'll quote some numbers for the market research. Inside, of course, the track record of this team with Nucala and execution full stop is very good. There's a high excitement there with physicians there's also high anticipation. We've got really robust data here in controlled studies. And I think most people can see that efficacy, but also have the imagination to understand, in a real environment with less supervision, that data hopefully should improve, and we've got a program to capture that.

Look, I won't go into the strategy and positioning, but the testing response is really clear. When we've taken that profile and that strategy to pulmonologists and allergists, 94% were motivated to prescribe the product. 70% think it's more compelling than competitors and 87% of patients I cited earlier prefer it if the HTP would recommend it.

We've done other forms of market research – Again, 86% of HCPs say it will be the standard of care, and 82% would consider prescribing it. And that's before the launch, right? I mean, we don't have field force out there. This is very organic.

Look, bio pen is 27 right now in severe aspirin around 12% nasal polyps. And I've cited this before, but if you look at biologics, at the end of 12 months, you've lost about 65% of those patients.
So a combination of in-office administration, lower frequency of administration, validated non-target, excellent benefit-risk profile, I think it's going to be very exciting. We've also shown historically with Trelegy that we can target the competition without disrupting our own business too extensively.

So the hierarchy will be Dupixent first, and then Fasenra, which makes sense, and the incentive scheme in organization, obviously, will drive that, and there'll be limited points for switching Nucala, so yes, very exciting there.

If I go to Shingrix, so a continuation of ex-U.S. trend and if you look at what's going on there, we like to do what we say we're going to do, and I think this is an example of that. It's not apples-to-apples, but because the U.S. has a much broader coverage.

You've got coverage with 50 years plus, versus EU markets, in Japan and others, where they have a higher age cutoff and, even within countries and provinces, that can vary greatly. The U.S. is a steady client still. We've got 42% -- that's in line with what we've said, 3% to 5% penetration a year.

Germany, we're about 26%. We had a bit of a soft August last year, and we had a lot of work there, but we've worked out what happened there, and we're now back on a good growth trajectory, using a strategy that we're now employing in the U.S. and Japan.

And this was based on the success we had in Australia, where we're approaching 40% penetration in that market. And it was really targeting comorbid patients, promoting directly to specialists like cardiologists, pathologists, rather than just a broad approach.

If you look structurally, typically, if you've got heavy funding, full funding, you've got penetrations which are changing and growing between 8% and 29% -- not including the U.S. and growing. If there's limited funding, like the U.K., Spain, Italy, China, then you've got a penetration range of around 4% to 8%, but also growing.

And there is the opportunity, of course, to change that, as we've seen in Japan. So Japan had limited funding -- it's now got much broader funding. And actually, it's a key driver for Shingrix, over and above France.

Then, if it's out of pocket, you've got penetration range of 3% to 4%. So something to keep in mind for emerging markets. So yes, I think there's remaining potential outside the U.S. We're still very focused on the U.S., but hopefully, those numbers are a helpful session and answer your question.

Emma Walmsley: Thanks. Next question please.

Constantin Fest: Next question comes from Kerry Holford from Berenberg. Kerry, please go ahead.

Kerry Holford (Berenberg): Thank you for taking my questions. And just maybe a broad U.S. question here. On any commentary you can give us more broadly on the discussions you've been having with the US administration on tariffs, but also in the context of MFN. How have those discussions evolved? And how do you think the administration intends to balance those two items, introducing tariffs, offset and balancing that with the proposed plans to lower drug prices in the US. Any directional commentary you would be prepared to make at this point would be very helpful.

And then secondly, also on this -- on the focus here in the US, the Trump administration has indicated support for DTC cash-pay options for US patients. Clearly, this is being utilized with obesity today. Is the DTC route to market a route that you would consider in the US? And if so, which drugs within your portfolio might best fit that approach? Thank you.

Emma Walmsley: Yeah. Thanks. So look, first, in terms of tariffs, as we've said, we've included in our outlooks, not only those that are enacted, but those indicated. But it is important to reiterate that we're waiting on the 232 investigation and the sort of specifics of that still need to become clearer. I think it would be fair to say that you always have to separate from the headlines to the reality of what's delivered. And whilst on the one hand, we're now seeing numbers and indications that perhaps are not as high as in

the first run of this. On the other hand, it is very, very real in terms of focused on US manufacturing and sourcing.

Now the really good news for GSK, as I said last quarter is we are well positioned on this. It's -- since I started in this job, we prioritized together as a leadership team in the US. We've taken the business from being less than 40% to being more than 50% of the company now. And in fact, our specialty business, which is where the pipeline is focused and the innovations focus and the growth focus is two-thirds of that so far this year is in the US.

So we're well positioned for that. We're well positioned on manufacturing. We broke ground on another new factory. Some of the supply chain optimizations Julie referred to is also setting up some certain shifts of some of our production. So we'll continue to be agile around it. But whilst we'd rather spend any incremental costs more on the pipeline. And as you know, we prioritize spending on R&D, and we're pleased to be increasing that ahead of top line again this year. We think we're positioned well to find solutions as this evolves.

On MFN, still very much moving around. But I think alongside others, yes, we're in discussions. Yes, we really want to prioritize keeping the US as the best market for innovation and also to deploy access to innovation and to make sure that we're passing on discounts given to patients so that medicines are sustainably affordable. We also would like to see more countries investing in medicines, which is such a small fraction of the total cost of healthcare.

And that's why our pipeline is really important here because so many of the examples we've talked to you about are cost sparing, whether it is COPD or frankly, the fact that BLENREP can be community administered rather than long stays in hospital, whether it is the adherence of depe with that over 70% reduction, or of course, the best way to stop disease before it starts being vaccination. So, we continue to have that dialogue and we will update you alongside others, no doubt, as it becomes clearer. And yes, I do think they are all interlinked alongside trade discussions.

And on DTC, that's definitely part of the things we're being open to. But maybe I'll ask Luke to comment on how we see some differences in the portfolio around that.

Luke Miels: Yes. Thanks, Kerry. I mean, I think the first thing is the price has to be lower than someone can get it through their own program, their own insurance program. And then secondly, I mean, there are some products like Blujepa that could be amenable to that.

We're looking more broadly at products like Trelegy, and we've got an open mind. There's clearly an opportunity in certain subpatient segments. We've seen that, as you mentioned with GLP-1s. But I think it's very much, as Emma said, a watching brief at this point. But we can move very quickly once things settle out. We know what the rules are.

Emma Walmsley: Thank you. Next question please.

Constantin Fest: Next question comes from Matthew Weston from UBS. Matthew, please go ahead.

Matthew Weston (UBS): Thank you. Hopefully you can hear me. One quick comment and then two questions if I can. The quick comment is just to actually say Michael's right. The GSK Respiratory Investor

deep dive event Nucala COPD peak year sales was 500 million to 1 billion. But anyway, we take your comments.

Two product questions if I can. Camlipixant, Tony, the CALM-1 program does seem to be rolling back in terms of timeline now second half of 2026. If we've got such unmet need in chronic cough clear efficacy, what's holding patients and physicians back from signing up to the trial? Or are we wrong? We just had the timing too early. And then secondly, I am going to chance my arm Blenrep.

Emma Walmsley: Go for it.

Matthew Weston (UBS): It's just on study design of the existing studies, which are still ongoing. Have you decided to change any protocols, recruit more US patients or optimize anything in light of what you heard at the adcom?

Emma Walmsley: So I'm not sure there is going to be much to add on Blenrep for the reasons we've said. But Tony, if you want to add anything at all, please go ahead and then perhaps you can answer on camlipixant. I will just say there is no change to our level of ambition on Nucala COPD, but Tony, do you want to comment on the other.

Tony Wood: Yes. Just simply in general on recruitment in forward looking oncology studies where enacting extensive plans to ensure that we have greater U.S. representation going forward.
In the case of the studies we have conducted, they were not atypical with representation in myeloma studies, and we were careful to ensure that the outcomes and demographics we felt were consistent in European patients. But more importantly, going forward, we have an extensive focus on U.S. representation. Then just do you mind if I just run straight into camlipixant?

Emma Walmsley: Yes, I think it's worth clarifying this to people.

Tony Wood: Yes. And look, so first of all there is nothing proving difficult about the camlipixant studies. We are -- you will remember earlier I identified that in column two we'd been given the opportunity to add a larger proportion of higher frequency coffers into the study. That is the group for which we feel the pharmacology is more likely to be representative.

And in addition, you'll also recall that because of the difficulties that Merck encountered in the design, recruitment and other features of the study, we are taking careful action to ensure that we have covered all of that, both in terms of pre-screening and other features associated with, for example, the cough counter, as I said, CALM-2 is proceeding on track as we planned. We are recruiting into the study right now. It is a six-month completion. When we get closer to full recruitment into that, I will know more about the precise date, but we are on track for middle of next year.

And as I said to Simon, we will, as we will as we typically do with our Phase III studies where we have two studies ongoing combined, both results into the analysis before the submission.
So, there is nothing behind that in terms of any difficulties associated with the study other than the plan that we've already described, which is ensuring that what we see as being the unique profile that camlipixant offers both in terms of its efficacy and I remind you in the SOOTHE study, we saw 34% reduction in cough frequency relative to placebo and in terms of its selectivity profile, which in simple terms

is about 10 times better than gefapixant and is therefore likely to result in fewer dropouts and will certainly not unblind the study.

Emma Walmsley: Right. Next question please.

Constantin Fest: Next question comes from Peter Verdult from BNP Paribas. Peter, please go ahead.

Peter Verdult (BNP Paribas): Yes. Thanks Constantin. Pete Verdult, BNP. Just two quick ones for you, Tony. Just following up from Matt's. I hear your comments about adequate U.S. trial representation in your key programs. But just a factual question. When we checked DREAMM-10 first line study, there are no U.S. sites.

Now, I know we can't talk about Blenrep. I respect that, but it's a factual question, am I correct in that assumption that there are no U.S. sites currently for DREAMM-10?
And then secondly, on the Hengrui deal after PD3/4, is there any other assets you can call out at this stage that might be entering the clinic in the next 12 to 18 months, or do we need to be a little more patient? Thank you.

Tony Wood: Yeah. Let me just quickly deal with DREAMM-10. You're right on ClinicalTrials.gov. It doesn't show our activities to recruit U.S. patients at this current point in time. But as I said, we have extensive studies that we're enacting that will increase U.S. patient recruitment, not just for DREAMM-10, but more broadly across the portfolio, including the new ADCs.
And then, sorry, secondly, remind me of the second question.

Emma Walmsley: Hengrui.

Tony Wood: Yes. Look, we in signing the deal, we contemplated the first four or five of potential options. There is -- I'm not going to disclose those in any more detail at this stage.

Emma Walmsley: The key is they're all in areas that are core to -- the core therapy areas for expansion for us. And we'll keep you updated as we roll those through.

Peter Verdult (BNP Paribas): Some of them will definitely be in the clinic next year.

Emma Walmsley: Definitely.

Constantin Fest: Next question comes from Rajan Sharma from Goldman Sachs. Rajan, please go ahead.

Rajan Sharma (Goldman Sachs): Hi. Thanks for taking my questions. So, just wanted to get an update on Blujepa's launch. So, I think it was approved back in March, but it doesn't look like it's launched yet, so it'd be helpful to just understand timelines there?

And then expectations in terms of the launch trajectory given that you've, I think, previously guided to more than 2 billion peak sales for that new anti-infectives portfolio?

And then obviously based on the commentary, it looks like R&D expenses will be higher than previous guidance. Could you just help us understand what the drivers are? It doesn't look like there's any kind of

materially large new trials that are kicking off in the second half of the year and maybe a couple of rolling off, so that would be helpful there. Thank you.

Emma Walmsley: Yes, maybe I'll do that. We do have four big ones -- big pivotals kicking off second half. And then Luke -- I mean we'll comment on Blujepa. We did say at the last quarter that because of formulary timing, we're going to be a bit later with that launch. And it is a full portfolio of Anti-infectives, but one we're very ambitious for – it's been a long time since anyone brought any new antibiotics. But so Julie first and then Luke, please.

Julie Brown: Yeah. Thank you. So the main R&D areas, we sat down as a team and looked at the areas we wanted to accelerate. And clearly one of the main areas is the ADC portfolio. I think as Tony's covered, we've got a large number of solid tumour opportunities with B7H3, which we are looking into to accelerate considerably this year and into next year.

And then, as Emma mentioned, we've got 4 pivotals now going through, three of which are BD orientated or outsourced and one is our own. So those are the main areas. Tony, do you want to add to that?

Tony Wood: No that's complete. It's for new phase 3 studies in the ADC portfolio expansion.

Emma Walmsley: Luke?

Luke Miels: Yeah. Thanks, Rajan. So as Emma said, we're talking to payers right now. Things should be more visible in Q3 with a full launch push in Q1 next year. If you just look at patients, there's around 15 million episodes of uncomplicated UTIs in the U.S., of which 3 million are individuals that are resistant to multiple classes or allergic to three or more antibiotics. That's the targeting population that we've got there. We just wanted to do a little bit more work on the pricing.

And also we've had positive phase 3 results with tebipenem, which I think is also very attractive initially in complicated UTI patients who typically are admitted for ceftriaxone treatment. So this is the option of keeping those patients off the pump, keep them at home with patient benefits as well as cost benefits in the US healthcare system.

Emma Walmsley: Yeah, and another trial stop for efficacy there. So, excited to see what comes on. Next question please.

Constantin Fest: The next question comes from Steve Scala from TD Cowen. Go ahead Steve, please.

Steve Scala (TD Cowen): Thank you so much. A few questions. First, I'm curious about trends of Shingrix in China through the distributor. Are things improving, getting worse or somewhat or somewhere in between? Yesterday, Merck implied that there were no signs of improvement for Gardasil, and issues could extend to 2026. Is the same true for Shingrix?

Secondly, can we have an update on the pneumococcal vaccine program? Will you initiate phase 3 in the 30 valent vaccine in adults? When do you intend to do that? Secondly, have you addressed the manufacturing issues for the paediatric vaccine? And when does GSK expect data readout for the 24 valent in infants?

And then lastly, apologies. Blenrep. Does the recent FDA CBER leadership change alter the outlook in any way the proximity of the news is quite curious? Thank you.

Emma Walmsley: So on the last one, there's no read across from that. And let's go to Luke, please first on Shingrix in China and then Tony or an update on pneumococcal overall.

Luke Miels: Thanks, Steve. Look, it's still challenging for all the reasons we explained in quarter 3 of 2024. However, there are some small, they're very small green shoots. So if you look at in-market sales, CDC, market sales to CDC from Zhifei and the movement from CDC to the point of vaccination, there is a trend upwards for the last three months, from memory. But it's off a very low base. So you know, heavy caution there. The other thing is the CDC stock levels are declining and they've been declining since about February of this year. So it's not enough for us to trigger a major shipment to Zhifei. But it is -- it's at least pointing in the right direction.

The other point I'd make is, look, we've done a lot of work on the strategy on the way forward here. It's very clear, and we've got good alignment with Zhifei, and the focus on the co-morbid chronic disease subpopulation who are clearly high risk, we seem to get better traction there. The competitions pulled back, which has created a bit of room for us. And we've actually increased our share of voice to take advantage of that. All the other parameters like ATP perception, patient perception are pretty stable.

So again, I won't say anything about 2026, but I would say we remain confident of the mid to longer term opportunity in China and we just need to stick at it. And finally we're also doing some life cycle, Tony mentioned this before, in terms of a dementia experiment in within China itself. So yeah, we'll keep moving forwards.

Tony Wood: Great. And then just quickly on that Steve, as far as the 2024 valent platforms are concerned, both in adults and infants, we've learned enough from those platforms to move now to strategically prioritize the 30 plus vaccine, we feel that the characteristics of the MAPS platform are better expressed there, and I'm sure you'll follow that the field in general is going in that direction.

And Merck's more tailored approach is also encountering some issues associated with concerns with regards to the evolution of new serotypes like serotype 4. We are on track with regards to starting our first in-human for a 30 plus vaccine study at the end of this year, so you should expect readouts on that really, in the first half of 2026.

I'd say when you consider the progress we're making with regards to the 30-plus format and the competitive environment, we remain very much on track and competitive with 30-plus vaccine. But that, of course, will be towards the end of the decade.

Emma Walmsley: Right. Thank you. I think we have one more question.

Constantin Fest: Yes. Time for one last short question. Justin Smith from Bernstein. Please go ahead.

Yeah, I think you should be able to speak. Justin. Okay. That's not working. Then we can also close the call.

Emma Walmsley: Okay. Well, listen, thanks very much, everyone, for joining, delighted to be reporting another strong quarter and this consists delivery of the consistent step up of GSK since the separation, and most excitingly the R&D progress we continue to deliver.

We're pleased to update our guidance for the year to being at the top end of the range and continue to be highly confident together of our not only our short, but our medium and our long-term outlooks.

Look forward to talking to you over the coming days. Thanks. Bye.

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