

GSK enters agreement to acquire Nuvalent, Inc.

09 June 2026



Constantin Fest | Introduction

A warm welcome to this GSK call on our agreement to acquire Nuvalent. My name is Constantin Fest, Investor Relations. I am delighted to have here today with me Luke Miels, CEO, Nina Mojas, President Global Product Strategy, Tony Wood, Chief Scientific Officer, Julie Brown, our CFO. Also, for the Q&A part of this call, we will be joined by David Redfern, President Corporate Development, as well as Mondher Mahjoubi, our Chief Patient Officer. Please go with me to the next slide three for our disclosure statement. Also note our cautionary statement on slide four. With this, please turn to slide five, and I will hand over to Luke to start this presentation.

Luke Miels | Key focus areas to drive value

Thanks, Constantin. Good morning, and thanks for joining the call at short notice. Look, I will start here first. As a reminder, this is the framework that we are using to drive value for patients and shareholders. It has got three components: driving top-line growth, accelerating late-stage assets, and combining this with simplification. This deal is a disciplined continuation and acceleration of that strategy. Next slide, please.

Luke Miels | Nuvalent acquisition will drive growth and accelerate R&D

Now, we have been following Jim and the team at Nuvalent and their impressive medicinal chemistry work for some time. The deal is a consideration of \$10.6 billion U.S. It is accretive to EPS in 2029 and is expected to close in Q3 of 2026. This acquisition, critically, will bring multiple products with the two lead assets already filed and expected to launch in 2026, immediately impacting top-line growth. Next slide, please.

Luke Miels | Nuvalent meets critical strategic objectives

Here is the logic for the deal. Simply, it is on strategy and helps us deliver top-line growth and accelerate R&D. It accelerates our planned entry into lung via two well-defined subpopulations which have clear unmet needs. Both products work via validated targets and are designed to address these established unmet clinical needs. These are small molecules in oncology, the deal combined with measures to offset costs is accretive to sales and operating profit in 2027 and EPS in 2029. Through discipline, we are maintaining the 70p dividend and the progressive policy. Next slide, please.

Luke Miels | Nuvalent is an extension of proven BD strategy "Multiple assets in one deal"

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Finally, just at the start, I would add this is our type of deal. The difference is that it is a multi-product deal versus a single asset, single company deal. Zidesamtinib for ROS1 mutations and neladalkib for ALK1 driven tumours, are the types of products we like.

They are an extension of our BD strategy, which you can see on this slide, which is to acquire external innovation that works via established targets, but addresses unmet efficacy or tolerability needs. With that, I will hand over to you, Nina.

Nina Mojas | Nuvalent: precision medicine for NSCLC

Thank you, Luke. As Luke mentioned, Nuvalent is a company that has been very successful in developing precision medicine assets with its clinical-stage assets focused on specific, well-defined patient segments in lung cancer. ALK-positive and ROS1-positive mutations affect about 3%-5% of all non-small cell lung cancer patients with about 80% of patients already diagnosed at stage 3, so metastatic stage. These patients are often younger, in their 40s and 50s, unlike typical lung cancer patients who are normally diagnosed in their 70s. These patients are more frequently women and in general have high rates of central nervous system involvement, so brain metastasis. What's very characteristic about this specific defined patient population is that they are one of the most engaged lung cancer communities, they are actively shaping their treatment.

Established treatments have been transformative for these patients, they frequently remain on ALK and ROS1 tyrosine kinase inhibitor therapy for years. As an example, treatment duration in first-line non-small cell lung cancer patients treated with PD-1s, majority of cancers of patients in non-small cell lung cancer patients, they are treated for approximately 10 months. For EGFR mutated cancers, patients are treated for up to 2 years. For ALK positive first-line patients, current median PFS is longer than 7 years and hopefully further increasing. Next slide, please.

Nina Mojas | Accelerate GSK lung cancer ambition and maximise Nuvalent value through geographic expansion

Acquisition of Nuvalent is going to strengthen our overall oncology ambition, specifically it will accelerate our efforts in lung cancer, supporting both development and commercial efforts for our ongoing ris-rez program in lung cancer.

After this acquisition, we are looking at a number of milestones from 2 approvals this year, potential approval for ROS1 naive patients next year, ongoing trial in first-line ALK mutated segment, the ongoing trials for the early stage HER2 asset. On the other hand, GSK's global

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footprint will maximise the opportunity for Nuvalent portfolio of precision medicine assets. Next slide, please.

Nina Mojas | ALK+ NSCLC: Moving towards chronic therapy that preserves quality of life

We are moving to the ALK specific segment. Over the past decade, we have seen an improvement in outcome for ALK positive non-small cell lung cancer patients as innovation focused on solving unmet needs such as blood-brain barrier penetration to address CNS metastasis, which I have mentioned before are very frequent in this patient population, and then broader coverage of resistance mutations.

The current 3rd generation ALK inhibitor, lorlatinib, recently had 7-year update of its CROWN study where the median PFS still has not been reached. Despite strong efficacy, unmet need remains as tolerability issues significantly limit potential quality of life and therefore adoption in first-line. These limitations stem from the lack of selectivity for ALK and involvement of TRK kinase, which Tony will describe in details in a moment. Neladalkib is a next-generation ALK tyrosine kinase inhibitor designed to improve on lorlatinib's profile, sparing TRK engagement with first-line pivotal study ongoing. Next slide, please.

Nina Mojas | ALK+ NSCLC: treatment choices driven by efficacy and tolerability

How did this development impact the evolution of treatment practice in ALK-positive non-small cell lung cancer space? Most commonly used medicines to treat ALK-positive lung cancer are 2nd and 3rd generation ALK inhibitors. Alectinib continues to have a significant use in first-line, driven by its acceptable tolerability profile.

Despite best-in-disease efficacy, lorlatinib adoption is limited by its tolerability issues, central nervous system events impacting cognition, speech, and mood, metabolic issues like hypercholesterolemia, hypertriglyceridemia requiring co-medications, and significantly weight gain. These issues are attributable to lorlatinib's off-target activity. I'll now hand over to Tony to talk more about neladalkib's differentiation and supporting clinical data.

Tony Wood | Nuvalent: precision medicine for NSCLC

Thank you, Nina. On this slide, you can see the evolution of the ALK family inhibitors. Neladalkib is a fourth-generation inhibitor, is designed to pair third-generation ALK potency with strong CNS penetration while retaining activity against both single and compound ALK resistant mutations. This, alongside its TRK-sparing profile, underpins its potential for superior efficacy and tolerability

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compared to previous generations of inhibitors. Each of these characteristics is critical to maximizing the amount of time a patient can potentially benefit from therapy. Next slide, please.

Tony Wood | Neladalkib: ALK inhibitor with potential BIC efficacy and tolerability

Okay, taking a more detailed look, we believe that nela has the potential to be a best-in-class ALK inhibitor as it delivers strong performance against the three basic pillars of precision medicine. Firstly is, as you can see on the left-hand side of the slide, it's important to hit the driver of disease hard to control the original tumour.

Secondly, also on the left-hand side of the slide, it's important to address or prevent the emergence of key drivers of disease progression to extend the durability of response. This specifically includes designing molecules which maintain inhibition in the presence of on-target resistance mutations, as well as optimizing for brain penetration to address metastatic disease. This is illustrated on the right hand of the slide and is critical because of the high incidence of brain metastases at diagnosis for ALK-positive non-small cell lung cancer patients. Thirdly, it's important to address selectivity to avoid off-target adverse events, which can be treatment limiting. You can see this in the selectivity index calculated on the left-hand side of the slide. This is critical to minimize discontinuations and dose reductions and to maximize potential therapeutic benefit while removing barriers to adoption.

This differentiation is important as it allows nela to improve on the significant cognitive, psychiatric, and metabolic adverse events associated with lorlatinib, which severely impact patient quality of life. Next slide, please.

Tony Wood | Neladalkib: duration of response and PFS benefit indicate BIC profile

With these design principles in mind, data from the ALKOVE-1 study support a best-in-class profile for neladalkib based on cross-trial comparisons. In TKI-pretreated patients, nela produces encouraging response rates, including for intracranial disease when compared to lorlatinib. As you can see on the left-hand side of the slide, in the second-line plus setting, a median duration of response is not yet reached, and encouragingly, 60% of patients achieve a duration of response greater than 18 months, which is a meaningful improvement compared to 9.6 months for lorlatinib. Based on these data, the FDA has granted nela priority review with a target PDUFA date of November 27th, 2026.

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In TKI-naïve patients, nela produces promising response rates compared to lorlatinib, and importantly shows a 12-month duration of response for more than 90% of patients, exceeding the historical benchmark from lorlatinib in the phase III CROWN study. A phase III registrational study for nela in the first-line setting, ALKAZAR, is ongoing and recruiting well. Next slide, please.

Tony Wood | Neladalkib: TRK sparing avoids long-term metabolic and neurological adverse events

ALK-positive non-small cell lung cancer patients are typically younger non-smokers who are otherwise fit and healthy. This is a highly motivated and informed patient population, as such, a manageable safety and tolerability profile is a key consideration. Nela spares TRK binding, and this is reflected in its adverse events profile, which shows avoidance of the long-term metabolic and neurological adverse events seen with lorlatinib. Importantly, the liver enzyme elevations seen with nela are typically asymptomatic, transient, and manageable through monitoring and dose modifications, as is consistent with routine practice for TKIs.

Overall, they do not result in increased drug discontinuation rates compared to other ALK inhibitors. This is also supported by physician feedback, which highlights a more manageable safety profile for nela compared to the intensive monitoring and caregiver burden associated with lorlatinib's cognitive impairment, mood disorders, and metabolic side effects. Next slide, please.

Tony Wood | Neladalkib: 2026 2L launch with 1L ALKAZAR study rapidly recruiting

On this slide, you can see the ongoing clinical studies for Nela. ALKOVE-1 is a phase II study in ALK-positive solid tumours with several cohorts. It was designed to have registrational intent for TKI-pretreated ALK-positive non-small cell lung cancer patients. In 253 TKI-pretreated patients, Nela delivered a 31% overall response rate and a durable response was 64% and 53% of responders estimated to remain in response at 12 and 18 months, respectively.

Notably, 78% of patients had received two or more prior ALK TKIs, of which 91% had received prior lorlatinib. A heavily pretreated population for which no approved therapies have demonstrated meaningful activity. This pivotal data was presented last week in Chicago at ASCO. As mentioned, based on these data, Nela has been granted Breakthrough Therapy designation with a planned PDUFA date in November of this year. ALKAZAR is an ongoing phase III registrational trial in the first-line setting using the current standard of care, alectinib, as a control arm. This study is enrolling well. Let me hand over to Nina.



Nina Mojas | Zidesamtinib: Significantly longer PFS outcomes to transform ROS1+ NSCLC anticipated

Thank you, Tony. We are moving now to the ROS1 space. Consistent with evolution of ALK TKIs, zidesamtinib is strongly differentiated through its significant improvement on safety profile and strong efficacy compared to previous generations of ROS1 TKIs. Repotrectinib carries notable TRK-driven neurological and metabolic side effects that drive those discontinuations.

Taletrectinib, a third-generation ROS1 TKI, improves on tolerability, but still brings meaningful dizziness, GI tox, and side effects like diarrhoea, nausea, and vomiting. Based on the large clinical data sets generated across over 900 patients, zidesamtinib shows a class-leading safety profile. Its ROS1 selective and TRK-sparing design allows for a differentiated safety profile, avoiding the CNS and GI side effects historically associated with the class. Ability to stay on treatment for longer has potential to translate into improved median PFS in first-line, compared to current treatment options. Back to Tony again.

Tony Wood | Zidesamtinib: potential BIC profile for ROS1+ NSCLC

Thanks, Nina. Next slide, please. As with Nela, zidesamtinib has a compelling profile. It's a highly potent TRK-sparing ROS1 inhibitor with broad mutational coverage and improved selectivity profile. Importantly, the G2032R-resistant mutation coverage supports durable activity in heavily pretreated patients and improved outcomes in early lines of therapy, including in the TKI-naïve population. G2032R is a common resistance mutation arising following crizotinib and next-generation TKI treatment. Once more, high TRK selectivity allows for CNS activity, which is demonstrated in patients who received more than one prior brain-penetrant TKI, as well as in the naïve population. Overall, this profile translates to a low rate of serious or severe CNS events, with significant improvements in problematic adverse events associated with earlier-generation TKIs, including dizziness and GI toxicity. Next slide, please.

Tony Wood | Zidesamtinib: potential improved durability in TKI-naïve and post-TKI

Moving now to the clinical setting and looking across trial comparisons for zide, you can see a substantially improved duration and response in both heavily pretreated and TKI-naïve patients, as evaluated in the ARRIS 1 study. Based on these data, the FDA has granted zide a Breakthrough Therapy designation with a target PDUFA date of September 18th, 2026, in TKI-pretreated patients. These data support best-in-class efficacy with comparable response rates and response durations exceeding that of taletrectinib in both the TKI-pretreated and naïve settings. Next slide, please.

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Tony Wood | Zidesamtinib: ongoing clinical development programme

Finally, this slide shows a summary of the ongoing studies. The ARRIS 1 phase II study recruited patients with ROS1-positive solid tumours, with a specific cohort focused on ROS1-positive non-small cell lung cancer, including those previously treated with TKI inhibitors, as well as TKI-naïve patients.

As mentioned, clinical efficacy supports a best-in-class profile, and importantly, this extends to safety, where zide demonstrates considerable improvements in rates of dizziness, GI and liver toxicity that is seen with previous-generation TKIs. The pretreated indication carries an Orphan Drug Designation with an up-and-coming PDUFA date in September, while filing of a supplementary NDA for the TKI-naïve setting is planned in the second half of 2026. I'll now hand over to Julie.

Julie Brown | Financial highlights

Thank you, Tony. To summarize, the acquisition of Nuvalent includes two launch-ready, potential best-in-class assets with blockbuster potential, with PDUFA dates later this year, and will further strengthen our oncology portfolio, building on our exciting development pipeline, which includes risvutatug rezetecan, our ADC for lung cancer. I will now cover three main areas, and all my commentary will refer to core results at constant rates. First, the transaction details. We have agreed a purchase price of \$124 per share, a 40% premium to yesterday's closing price and a 26% premium to the 30-day VWAP, equating to an aggregate consideration of \$10.6 billion, or net of cash, \$9.4 billion, which is GBP 7.1 billion. We will commence a tender offer for the shares within the next 10 business days, and subject to regulatory approval, we anticipate closing the deal in Q3. Second, the financial impact.

We expect the acquisition to support GSK's revenue growth from 2027 onwards, and be incremental to our existing ambition for sales of more than \$40 billion by 2031, and to strengthen sales, operating profit and margin through the dolutegravir loss of exclusivity period. We expect the deal to be accretive to operating profit in 2027 and earnings per share in 2029 onwards, inclusive of synergies and reprioritization. Assuming completion in Q3, we expect a low single-digit dilution to EPS in full year 2026 to 2028, but remain confident in our current 2026 guidance range for earnings per share growth of 7%-9%. Third, capital allocation and the balance sheet. This transaction is aligned with our investor growth priorities and BD strategy. Our capital

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allocation priorities remain unchanged. Post the transaction, we will retain our strong investment-grade balance sheet with no impact expected on our credit rating.

We remain committed to our dividend of GBP 0.70 this year and our progressive dividend policy. Lastly, the transaction will be funded from existing and new debt facilities and existing cash resources. With that, I'll hand back to Luke.

Luke Miels | Nuvalent meets critical strategic objectives

Thanks, Julie. To summarize, we think this deal is a strong strategic fit for GSK, and it represents a continuation and acceleration of our strategy. We get two potential best-in-class products that can launch this year, driving growth and operating profit in 2027. As you've just heard from Julie, we have applied financial discipline to ensure that we manage the cost of the deal, and that we've recommitted to the dividend and the progressive policy. With that, let's turn it over to Q&A. Please.

Question & Answer session

Constantin Fest: Thank you. With this, we're ready for Q&A. Please use the raise your hand feature if you want to ask a question. Please limit yourselves to one question each so more of you have time to ask questions in the first place. The first question comes from Matthew Weston. Luke Hi, Matthew.

Matthew Weston, UBS: Good morning, everybody. Hope you can hear me. Thanks for taking the question. It's about the split of the value or the potential, I should say, by asset. I think consensus has 2 billion peak approximately for Nuvalent, but that's heavily skewed to ALK over ROS1. I'd be very interested in your view on the relative contribution of zide versus nela, and then also about the speed of launch. I think zide has an expanded access program with over 500 patients on it. Does that mean that we should expect a rapid launch on approval as we convert those patients to commercial drug?

Luke Miels: Thanks, Matthew. I'll answer the second one and then maybe Nina if you want to characterise that without too much colour because we'd like you to do your work on your own modelling, Matthew. Appreciate the question. The speed of launch, absolutely, and if you look at

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our heritage, working with Sierra and other biotechs that we've acquired, this is a very important component. We're already planning to pivot and execute that launch, and we're in a good place. The access program, the recruitment for the programs, the first-line ones are very strong. Again, it's a targeted population. We can ramp that up, and it was something that we were going to do for B7-H3 anyway. Thanks for that question.

Nina, the split of the asset and 2 billion, Matthew, I assume again, we won't comment on that, but it's obviously not the timeframe that we're looking at over the life of the deal.

Nina Mojas: Yeah, I was just going to mention this 2 billion. I'm not sure if that's the peak reference to peak sales, which are clearly higher than that.

Luke Miels: Yeah.

Nina Mojas: In terms of value split on sales, I would say ROS space is probably between quarter to a third of the total value.

Matthew Weston: Thank you. Very helpful.

Luke Miels: Thanks, Nina. Thanks. Appreciate the question. Next one.

Constantin Fest: Next question comes from Sarita Kapila.

Luke Miels: Hi, Sarita.

Sarita Kapila, Morgan Stanley: Hey, thanks for taking my question. Just on Nela and in the TK-naive cohort that you have in your original data, are you actively discussing with the FDA whether a frontline label expansion is possible, or will we have to wait for the ALKAZAR phase III PFS readout for approval in the earlier line setting? If I could just squeeze in another one, please. Are you sure that doing a head-to-head in the frontline setting versus Alecensa is the right comp, particularly when we've seen seven-year PFS data for Lorbrerna from the CROWN study? Thank you.

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Luke Miels: Thanks, Sarita. We certainly have looked at those questions in depth. Tony, did you want to cover the first two, and then maybe Monder, if you can comment on standard of care on the second question, and Nina, feel free to jump in.

Tony Wood: Yeah, look, I'm obviously not going to get into the details of regulatory interactions. It's a little early in terms of the phase III study. The points you raise are all ones that we have taken into consideration. We very much see this molecule as being one which has the credentials that will support a first-line indication.

Mondher Mahjoubi Just to add, actually today, the standard of care in terms of market penetration is still alectinib with almost 45% market share. It tells you about how important it is for us to pick the right control arm. Just as a reminder, lorlatinib phase III trial, the CROWN data that were presented to us, could use crizotinib as a control arm. Very low bar in the third-generation TKI. The fact that we are choosing alectinib, I think it's the right thing to do. Having said that, I believe the community will certainly look at other setting of the disease and also other option to have head-to-head data with lorlatinib to try to figure out actually the best benefit-risk ratio.

Luke Miels: Thanks Mondher, Nina, you want to add?

Nina Mojas: Yeah, I just realised that we didn't answer Matthew's question on early access program and the number of patients. Yes. Actually, Nuvalent did a great job with early access program for both assets. There are hundreds of patients on early access program, which gave us confidence for multiple reasons because feedback from the physicians who have hands-on experience with actually all TKIs in this space and were able to compare the experience of patients and the physicians was really tremendous benefit. When we launch the drug, the assets, we do expect early access patients to be transitioned to commercial source.

Luke Miels: That's an important point, Sarita. Because there's such broad experience and empirical experience with both of these products, we were able to do a massive amount of due diligence, frankly. We had over 300 interactions, quantitative, qualitative, in-person interviews, online interviews with physicians. A large proportion of whom had direct experience utilizing these drugs in these subpopulations. Again, that's what's behind the confidence and why we think there's a pathway there. We've also spent a lot of time characterizing the profile of lorlatinib in particular and have some insights there that we will disclose at a future date. Next question please.

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Constantin Fest: Next question comes from Kerry Holford.

Luke Miels: Hi, Kerry.

Kerry Holford, Berenberg: Good morning. Thank you for taking my questions. One for Julie, please, for the financials. In the context of the accretion that you cite from next year for revenues and profits and EPS from 29, you referred to synergies and reprioritization. Just intrigued to hear what that involves, both in terms of the deal but perhaps also internally. Anything additional to add there?

Julie Brown: Thank you very much, Kerry. As Luke mentioned, obviously we wanted to be very disciplined about the way we approach the deal generally, appreciating that this was going to be, on the face of it, dilutive to shareholders. Taking each of those in turn, I've worked very closely with Tony and his team on this. The first one is relating to synergies on the integration. We expect some synergies through SG&A, then we also expect synergies in R&D, including through the discovery portfolio and integration and also contracting synergies for activities such as CMC and clinical study design. This is exactly what we found with other deals that we've embarked on recently. The second thing relates to the just prioritisation in the business generally, across all areas, together within R&D.

As far as we're concerned in R&D, approximately twice a year, we do a very thorough review of the portfolio. We are constantly assessing the internal portfolio and reprioritising assets to really optimise the return on investment and the probability of technical and regulatory success. Net-net, we believe we've been very responsible in terms of exercising discipline around the dilutive impact of the deal.

Luke Miels: Thanks, Kerry. Thanks, Julie. Next question.

Constantin Fest: Next question comes from Emmanuel Papadakis.

Luke Miels: Hi, Emmanuel.

Emmanuel Papadakis, Deutsche Bank: Hey, sir, thank you for taking the question. It was just a follow-up on ALKAZAR. I'm not sure if apologies if I missed it. Is the frontline approval predicated



on the PFS readout, or is there any scenario in which you could get that approval sooner? Maybe a quick question on ROS1. Back in the day, the original commercial optimism around that landscape was predicated on better diagnosis, unlocking clinical and commercial opportunity. That hasn't really happened. Do you harbour any greater hopes for a diagnostic transformation, unlocking the patient opportunity there? Thank you.

Luke Miels: Sure. Thanks, Emmanuel. Nina, do you want to cover the second question, then Tony-

Tony Wood: It's a quick one. Yes. The frontline study is based on PFS.

Luke Miels: You hear that, Emmanuel? PFS. Nina on the ROS1 testing and opportunity.

Nina Mojas: Again, both ROS and ALK are now standard part of testing. It's part of the panels that are done on lung cancer tissue samples at the diagnosis. That's probably less of a barrier, as we have seen, the product profile so far actually had significant limitations.

Luke Miels: Nina, do you mind expanding on this? I think the more you look at these products, and particularly you look at these subpopulations with these particular mutations, what we've found is a very interesting relationship in terms of innovation price, small molecule. You've got a defined population, but you've got these very long tails, which. The better tolerated profile that you can get, you're more able to sustain these. The mathematics start to look very, very interesting. You really have to stop and look at it and just work your way through it, which is what we've spent a long time doing. Nina, do you mind expanding on that, please?

Nina Mojas: Exactly. Again, to repeat what Luke said, there are a small number of patients, that's definitely true. If you look at the totality of non-small cell lung cancer, in terms of value, it's disproportionately higher because for each patient that you start on ALK or very likely in the future on ROS1, you have multiple duration of therapy for these patients. CROWN data update 7 years, PFS rate at 7 years is still 55%, so median has not still been reached. It's very likely that that tail will continue at 50% or above 50%. These are metastatic patients. They are not stopping their treatment. It's very difficult for mutation-driven cancer to stop treatment because what we have experienced from all these TKI areas, EGFR, ALK as well, as soon as patient stops therapy, the cancer usually comes back.



In terms of value, they are proportionally significantly bigger than what the number of patients would indicate. I would just add, as Luke mentioned, we spoke to probably about 300, or had interactions with about 300 physicians. Very positive thing is that they had hands-on experience, and they could compare the effects of all these TKIs. I will share some of the comments that were made. One is lorlatinib is a drug that everybody loves to hate. Because of the efficacy, it's frequently the first drug that they will offer to their patients. What comes as with the use of lorlatinib is CNS-related side effects, serious conversations with the patient, with patient carers, because they have to be aware of these side effects that go into a psychiatric area.

One of the physicians said, "Using lorlatinib, I became both psychiatrist and metabolic expert." One of them mentioned that he became a target for sales reps that sell GLP-1s because the patients gain weight, and these are younger patients, it's very relevant for them. One of them described a patient who was a younger woman. Her income was coming from being an influencer on social media, and after gaining weight, she actually stopped therapy and progressed. These are all issues that you need to address over the years while you're treating patients. Therefore, it was a very clear feedback that tolerability is the main barrier. While we were doing due diligence, just a comment between ROS1 and ALK. While we were doing due diligence, I have to say ROS1 space was probably what physicians refer to as slam dunk.

There is no way that they would not use this drug over other inhibitors, ROS1 inhibitors. There, our confidence is actually very high that this is going to be the best in disease, best-in-class drug.

Luke Miels: Thanks, Nina. We can expand on that. Again, we've been spending a lot of time on this before breaking cover and have really been very thoughtful and rigorous in profiling these assets and the team that's developed them. Next question, please.

Constantin Fest: Next question comes from Sachin.

Luke Miels: Sachin?

Sachin Jain, Bank of America Merrill Lynch: Hi there. Can you hear me?

Luke Miels: Yes, we can.



Sachin Jain: All right. I'm on dial-in. Apologies. Two quick questions, please. One, just to get a picture for you, Luke. This is one of the largest deals Glaxo's done in a while and is focused on launch assets versus mid-stage, early-stage pipeline for 2930. Just what's driven that, in inverted commas, "strategic shift?" I know you frame it as consistent. Second one for Nina is a follow-on to prior. Thank you for giving the split on ROS versus ALK. I wonder if you could just give the bit of colour on second line versus front line across both, acknowledging that front line's bigger. Two-part question. One, how comfortable are you with consensus on the launch in later lines before front line comes through? How much of the deal valuation is front line ALK, whether some conceived risk around that data delivering differentiation? Thank you.

Luke Miels: Thanks, Sachin. I'll answer the first one. Then we'll go to Nina. I think, that's what I've tried to outline with that slide in my introduction, we have a methodology to our BD. We like validated targets because essentially the clinical scientific components are heavily de-risked. We're really reliant on our regulatory, clinical execution and commercial launch capability, which again, we have to validate at every quarter, but I think it'd be fair to say there's a high degree of, there's a strong track record there. What we had with Nuvalent was unusual. Basically, it was a little bit like London buses, Sachin. All right? Suddenly two or three come along at once. Each one of these products we would have acquired as a separate deal. We just had the attractive element of having them all embedded in a single company.

Importantly, this was very much a bottom-up driven deal. Some deals are driven top-down. I might come into the office and say, "I really like this company. Let's go for it." This was very much a deal that was driven by Chris Sheldon, who you all know from his previous time at AstraZeneca. We had the individual involved in designing TAGRISSO on the team. There was a number of other AstraZeneca and Roche escapees. I'm sitting next to Tony, who was deeply involved in the lorlatinib's design. This built momentum inside the organization over quite a long time. In the end, we reached the conclusion that this was a really smart deal to do. It was a good use of our shareholders' capital. Again, if you take the components apart, it's more consistent with what we've done before.

Also there's attraction in critical mass because essentially we're pulling forward our entry into lung, but in discrete populations to build our credibility there, which positions us very well for B7-H3. There's a method to this, but also critically, as we've said, there's financial discipline here to maintain capacity for future accretive deals. This was just too attractive to let pass by. Nina, over to you.



Nina Mojas: Yeah. Sachin, I'm not sure I fully understood your question, I will try and maybe either you need to help me or my colleagues. First and second line, ROS1 as I think we communicate, second line has been filed. PDUFA date is in September this year. In ROS space, this is a really ultra-orphan indication, so number of patients is very small. All the assets are accrued on single arm studies. Second line, the first line is filing is expected in the second half of this year, so approval next year. Again, this is extension or based on the additional data from TKI-naïve patients from the ongoing study. As I mentioned, there is a very clear feedback that this is going to be easily standard of care in the ROS space. I'm not sure, was there a question on ALK as well for second line?

Sachin Jain: Let me just reframe the question. Two parts. One, are you comfortable with consensus on launch in the later lines across both ROS and ALK in the next couple of years versus yourself framing upside to peak midterm? Then the second was how much the deal valuation is on frontline ALK for that data 2028, 2029, and how do you assess the risk around differentiation delivery?

Nina Mojas: Sachin, pretty confident, again, to previous question about number of patients on early access program and the extent of experience that physicians community had so far. I would say, again, not going to guide on the year annual sales, but we are quite confident that consensus is not too optimistic or unrealistic. The value of first-line ALK. Clearly first-line ALK carries majority of the value of the deal, no doubt. You are looking at the highest number of patients with the highest duration of therapy based on the data that we have seen and the profile of the drug. We actually have very little doubt that this would not be successful. Question is time, which also we actually have pretty good idea when it's happening because the recruitment in the study is actually going exceptionally well.

Tony Wood: Sachin, I would say, look, three things to consider in the context of confidence in the duration of response data in the first-line setting. This is not only true for Nela, but also in the ROS1 setting. If you look at the improved resistance profile, that is important in maintaining response because it prevents the emergence of compound resistant mutations as well as taking care of already existing cases. Obviously, tolerability plays into that as well, and in particular, in the context of dose reductions or dose holds. Nela has a very favourable profile in that context and also in the context of when reductions are necessary. What we see is mostly only single step-



down reductions in the case of Nela and its intrinsic properties, its PK favour a more reliable outcome in that context.

In case anyone's going to ask me the question, we've looked into the impact of dose reductions and holds on the efficacy, and we can see very little to suggest that there's any significant impact there. It's a combination of features underpinned by the profile of the molecule, which gives us confidence in duration of response.

Mondher Mahjoubi: I can't resist jumping in. Sachin, you may remember this. 10 years ago, I think a few people believed that EGFR market will become what it is today. Actually, second and third generation of drugs have turned this disease into a chronic one. I think we have with ROS1 and ALK the opportunity to turn those metastatic patient into really a patient who can live with their cancer for many years. The key word here is really tolerability. I think we know that second and, of course, third generation and this asset hit the target hard, have a broad coverage of the different driver mutation, penetrate the CNS, has definitely a very good efficacy in terms of tumour shrinkage. The key word is tolerability and durability. I think what we have seen so far in the phase I, II, and the momentum that Nina described around clinical trial and expanded access program from the community of oncologists, but also from patient, is telling us that this is the right drug for them to stay longer on treatment, even in second line, but definitely more on first line in order to live with this disease more than 10 years. Of course, everyone is excited about the CROWN, remember, half of the patients stop their treatment already, and we know what will happen for this patient when they stop the treatment.

Luke Miels: Right. Thanks, Mondher. Next question. Thanks, Sachin.

Constantin Fest: Next question comes from Victor Floch.

Luke Miels: Victor.

Victor Floch, BNP Paribas: Hey, thanks so much for taking my question, our question. Maybe starting with the commentary you've made on ALKAZAR. You've mentioned that recruitment was progressing well, and that you have good visibility on completion. Can we ask whether there is an interim analysis planned on ALKAZAR, and what would be the trigger for that potential interim analysis? On nela's hepatic toxicity signal, can you walk us through how you think about managing this signal in clinical practice and why you believe it won't ultimately undermine its

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deliverability advantage? Maybe last one for Julie. You've indicated low single-digits EPS dilution for 2026, but guidance for 7%-9% remains unchanged. Can you just help us reconcile this? Thank you very much.

Luke Miels: Great. Thanks, Victor. Tony, do you want to cover interim? Mondher, you cover clinical consequences and management of nela, which we've learned a lot about, and Julie last on that question.

Tony Wood: Yeah, look, obviously, I'm not going to get into the details of the ALKAZAR study. Yes, an interim is planned, and you can get a clue from that if you look at the landmarks from the phase III CROWN study.

Luke Miels: Right. Mondher, we've seen the full data set.

Mondher Mahjoubi: Maybe a quick reminder that one of the challenges that we have seen with third-generation ALK inhibitors is essentially the off-target side effects and the fact that inhibiting the tropomyosin receptor kinase. There are three of them, actually the A, B, and C. The B is the one that basically is driving the whole CNS side effects. Now actually, it's really disturbing because not only we have somnolence, we have cognitive effect, we have really even mood transformation that basically prompt patient and physician to stop treatment. This is the most critical actually side effects. Of course, there are other side effects, in particular, peripheral neuropathy, that occur in more than 34% of the patient that sometimes actually are of grade 3 and 4. Those type of side effects are leading to the discontinuation.

What we have seen in the 1,500 patient treated so far, both in clinical trial and expanded access program with nela, is basically no side effects of the stay-up type. The only thing that was noticed is an elevation of transaminase that is purely asymptomatic. There was no hepatic failure. There is no fatal events. It's only biochemical asymptomatic elevation of transaminase that can be monitored very easily. Physician oncologists are used to this because it's not the first time that we have this in tyrosine kinase inhibitors. The approach is to stop treatment for a while, test until it goes back, and then rechallenge with a slight dose reduction. We have seen that patient can completely be rechallenged without any compromise with the efficacy.

Luke Miels: Nina, do you want to cover?

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Nina Mojas: I will just add that other ALK inhibitors have the same monitoring for liver enzyme elevation already as part of their management clinical practice and the label. We don't expect that this is going to come as a surprise to the physicians because that's exactly what they are doing with other ALK inhibitors already.

Luke Miels: Right. Julie.

Julie Brown: Yeah, thank you very much for the question. Obviously, the EPS is affected mostly by the interest that comes through together with Nuvalent's profile in its own right, and we are assuming for 2026 that we've got a Q3 completion of the deal. Clearly, when we've guided, we've guided an EPS range of 7%-9%. It does mean that we move within that range to manage the dilution, but we stay within the range on a net basis.

Luke Miels: Thanks, Julie. Thanks, Victor. Next question, please.

Constantin Fest: Next question comes from David Evans.

Luke Miels: David.

David Evans, Kepler Cheuvreux: Hi there, hopefully you can hear me. Just a question, if you could just clarify or give us more information on the level of discontinuations that you see in the ALK space. I thought your slide said that on lorlatinib, well, only 7% discontinuations versus 5% on nela. Is that a like-for-like comparison? It doesn't quite seem to stack up with your sort of commentary about wildly different tolerability profiles. Just anything in the lorlatinib proposition, if you could just flesh out.

Luke Miels: Yeah, sure, David. Thanks for your question. These are distinctly different profiles. Tony, do you want to cover that and, Nina, add any market commentary, physician commentary?

Tony Wood: Look, the data you've picked are indeed relating to discontinuations associated with tolerance. What's important, though, is to look at the complete picture for treatment discontinuation, because as Nina mentioned earlier, with discontinuation and dose reduction, you do see disease return, and the data for lorla at 2 years, I believe, is a 38% progression rate based on the combination of those things.

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Luke Miels: Nina, anything?

Nina Mojas: Yeah. Again, David, I think if you look at the discussion that happened at this year's ASCO Post CROWN 7 years presentation, I believe there was a slide from the discussant which something along is the CROWN worth the price or something along that, where the focus of the whole discussion was exactly the tolerability profile and is the benefit that comes with such a long PFS actually worth the adverse events that patients are going to? I would probably say if there is an interest for you to talk to some of the physicians who have used the drugs and hear the experience, because that probably tells you more than the numbers in the tables.

Luke Miels: Thanks, David. We can certainly do that for anyone who's interested. Next question, please.

Constantin Fest: Next question comes from Naresh Chouhan.

Luke Miels: Hi, Naresh. You might be on mute, Naresh.

Naresh Chouhan, Intron Health: Sorry, can you hear me now?

Luke Miels: Yeah, we can.

Naresh Chouhan: Yeah. Thanks for taking my question. Just interested in the ex-U.S. development plan, please. Two thirds of Alecensa sales come from outside the U.S., and China's a big part of that. Looks like about a third of the sales. There seem to be no Chinese sites in any of the Nuvalent development program, as far as I can see. Can you just help us understand the ex-U.S. development plans, please.

Luke Miels: Sure, we can do that. Yeah.

Naresh Chouhan: Thank you.

Luke Miels: No worries. There is a plan to bring Chinese sites. Tony, do you want to come in?

Tony Wood: That's basically it. It is a global plan. They're just opening Chinese sites.

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Luke Miels: Yeah. Great. Thanks for your question, Naresh.

Naresh Chouhan: Thanks

Luke Miels: Next one please.

Constantin Fest: Next question comes from Matthew Weston.

Luke Miels: Hi, Matthew.

Matthew Weston: Hi. Oh, lots of unmute dialogues. Can you hear me?

Luke Miels: Yes, we can. Yep.

Matthew Weston: Amazing. It's a quick follow-up for Julie. Julie, in your opening comments, you said, I think, that the deal strengthens margins through dolutegravir's LOE. I think the previous comments were that margin was going to be flat through the dolutegravir LOE. Does that mean we all need to sharpen our pencils and start taking the margin up, or this just gives you incremental confidence that you'll be able to keep those margins flat, particularly because it looks like there may be some incremental pressure in HIV from guideline changes and other things?

Luke Miels: Okay. Thank you, Matthew. Just to recap for everybody, in terms of prior margin guidance, we've said that in 2026 we'll be above 31%, and then we've said we will have a stable margin through DTG LOE, which is the 2028 to 2030 period. What we're referring to when we say the deal strengthens is it will improve. Obviously, it's very accretive to sales during this period, as the team have talked about. It's high profitability assets. It brings through benefits to the profit, and we would expect the margins during that period to be higher than before the deal. We've managed the dilutive period to be a very short period with accretion quite quickly. It does give us a benefit to profit and margin through the DTG years.

Matthew Weston: Perfect. Many thanks indeed.

Luke Miels: Thanks, Matthew. Appreciate the other question. We've got time for a couple more if people have them.

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Constantin Fest: Next question comes from Zain.

Luke Miels: Zain. Hi.

Zain Ebrahim, J.P. Morgan: Hello, Zain Ebrahim, J.P. Morgan. Thanks for taking the question. It's another follow-up for Julie, just on the dilution over the next 2 years of low single-digit. I think the colour you provided earlier was helpful in terms of the expectation for synergies, and it sounds like there's an internal portfolio rationalization, but also CMC costs within Nuvalent that you can potentially unlock to manage at a low single-digit dilution. Just stepping back, I'm still struggling a little bit to fully get there, because I think Nuvalent consensus is about 100 million revenues for next year. OpEx, they've got about 400 million dollars in terms of spend. What's the key disconnect as you see it? Do you think that the maybe consensus top line is a little bit on the conservative side, given your bullishness around zidesamtinib and what the uptake could be there? Do you think that maybe there's a portion of your R&D effort rationalization that helps you get there that we might not be appreciating?

Luke Miels: Thanks, Zain. I think the short answer is it's a combination of those things, but I'm not sure we want to give too much colour at this point beyond the commitment. Julie, feel free to expand if you want.

Julie Brown: Yeah. I think we've covered it. We wouldn't go into specific projects in the R&D portfolio. I would emphasize that we're looking at prioritization across the company, not just within R&D, but across the company and driving that hard to be very disciplined, as Luke mentioned. We wouldn't normally also comment on consensus models, but in our view the R&D cost in consensus models for the target are reasonably high. I'll just leave it at that.

Luke Miels: Great. Thanks, Zain.

Zain Ebrahim: Thank you.

Luke Miels: Next question, please.

Constantin Fest: There's time for one more question. Probably also a follow-up, that is Kerry.

Luke Miels: Kerry.

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Kerry Holford: Hello. Thank you. For follow-up, just a quick one. Anything you can say on the IP for the two late-stage assets that you're acquiring here? Just to confirm, you expect both to be exempt from IRA? Thank you.

Luke Miels: Yes on IRA because they're orphan and 2040s plus, Nina?

Nina Mojas: Yeah. Early '40s.

Luke Miels: Yeah.

Kerry Holford: Thank you.

Luke Miels: Great. Thanks, Kerry. Very grateful to everyone joining at short notice. I'll conclude by saying again to reinforce, we think this deal is very much the type of transaction that we do. It's a great fit strategically for us. It's consistent with our strategy in lung cancer, and actually forms an accelerant for that. We're getting a number of very, very attractive assets, which, as you've hopefully heard today, have a deep exposure amongst the clinical community and patient exposure. I think there's a clear pathway for both of them, the late-stage ones to best in class, as well as some earlier-stage assets like the HER2 and a stable of preclinical medicinal assets, which are also very creative. Finally, I hope you've seen that we have applied financial discipline here in terms of selecting this transaction pricing and then integration of it. Thanks again for your very thoughtful questions at short notice, and look forward to following up with you.

End
