Graham Parry (Bank of America): Great, thanks for taking my questions. I’ll start with Arexvy; the question on the level of discounting in the initial launch, so two-thirds of your £709 million was inventory and you have administered somewhere between 1.4-1.5 million doses. That means underlying sales are in the 230-240 range and that would imply a net price probably more than 30% below the list price, so can I just check that is the right ballpark? Is that mostly wholesaler discounting or retail pharmacy discounting to drive the initially inventory build and something which we might see ameliorate a little bit over time, or is that just kind of where the competitive nature of the market is at the moment?

And then secondly, I know Julie touched on this, but the dynamics into next year, I would just be interested in what you are internally planning at the moment for 2024. You obviously won’t have the initial inventory build, but how much of that inventory do you think is just seasonal inventory build as opposed to initial inventory build. Of course you don’t have the return of the people who have been vaccinated this year, so any thoughts you have so far on how far penetrated you are into the easy wins of the more elderly, comorbid, etc., and how much tougher it might be to get return or new people to get vaccinated next year.

Emma Walmsley: Thanks, Graham. We will come to Julie in a minute on guidance and thoughts around next year, although obviously we will mainly be giving you thoughts around next year when we come to February 2024. I would just remind everybody that whilst we are absolutely delighted with the fast and competitive start here on RSV, it is just the start. It is the first season and we remain very ambitious for the £3 billion, at least, that we expect this asset to represent.

Now let’s go to Luke first, noting, Graham, you will fully understand that we are not going to be declaring all our commercial details on this call, but Luke, do you want to comment more broadly?

Luke Miels: Yes, Graham, thank you. I think we have been quite disciplined taking a longer-term around pricing and contracting, and it’s landed quite well. I won’t give you any more colour than that in terms of the stages at this point because I am sure our friends in New York have probably got up a little bit earlier this morning, but what I would say
is to build on Emma’s point, in the short-term things are uncertain. We are very happy with the launch. In the long-term we are very certain. I think so far if we look at some of the metrics which I can try and help you with, it’s about 50% co-administration with flu. There is a very large overlap with that population and, interestingly, around 15% of people are getting three shots when they come into the pharmacy. 85% is that 65 to 84 age population, so again very similar to high dose flu and, yes, I think for the rest of the year in terms of demand, you are still seeing good market research in terms of HCPs recommending it, so it’s about 64% based on our latest market research which is encouraging, and of course the CDC is advising doctors to keep going, so that’s on the positive side of the ledger.

But the fact is our working hypothesis is this is more of a flu-like trajectory, and as people start coming into pharmacies and we see a reduction in staffing levels in pharmacies who actually deliver these vaccines, then we are going to see a drop off in demand. That’s our hypothesis at this point. We will obviously have a lot more colour in Q4 and will give you an update and as Emma said, I think we are very, very confident in terms of the £3 billion number that we have outlined in the past.

Emma Walmsley: And obviously looking forward to running forward with that with that 50 to 59 data too which is another potentially meaningful cohort.

Julie, anything else you want to add?

Julie Brown: No, I think actually Luke has covered it extremely well. We have obviously looked at the levels of stock in the channel, we have looked at the rate of immunisations, we have seen the correlation with flu, as Luke mentioned, very, very close, and that has really informed our guidance.

And in terms of 2024, as we come through the US flu season we are going to have a much clearer view of 2024 when we give our full year results, so we will definitely update you at that stage more fully.

Emma Walmsley: Thanks.

Kerry Holford (Berenberg): Thank you. I have a couple of questions for Tony, please, within R&D. Firstly on the bepivirosvin, now you have the full suite of your Phase II data and you have recently signed that deal with J&J to look at sequential therapy, do you still remain confident you can offer Hep B patients a functional cure, at least a proportion of them, and what do you expect that J&J siRNA to add here? And do you stand by your more £2 billion sterling peak sales target for that asset?
And then secondly a broader question on R&D budget. Here we have seen significant growth in your budget over the past 18 months or so and, based on the guideline you have ahead of you, are you broadly happy with the annual budget that you have effectively been given this year - the run rate looks to be about £5.5 billion, or should we expect that R&D budget to continue to grow in the low double-digit range that we have seen, year-to-date, going forward?

**Tony Woods:** Thanks, Kerry. Let's get started with HBV and then I will comment on the pipeline and perhaps, Emma, you might want to make a comment on the R&D budget.

First of all, I am really pleased with this deal, Kerry. Let me just remind you because I am going to anchor this in what we know about bepi and becoming increasingly confident about, and that is in the context of monotherapy on top of nucleoside treatment, that we achieve a durable, functional cure for a significant proportion of the chronic HBV patient population. That is for individuals who have a surface antigen count of less than 3,000, just as a reminder, that is about 40% of the 300 million individuals who are living chronic Hepatitis B.

To put it in a nutshell, what the new deal with J&J siRNA does is that it takes the broader population down to that target population of about 3,000 and below. You should expect – and we are excited about the prospects therefore – of seeing increased both an increased coverage in an ITT population and also a deepening of the therapeutic effect. This is important, if you look at the mechanism of action of the J&J siRNA: it works in a complementary fashion to bepi, further lowering viral DNA and the consequences of that, as I mentioned in the presentation.

The other important thing is that we have built a complex PK/PD model around response, which this will add to. In addition, using AIML and some really deep phenotyping on the 500 patients, established an understanding of the immune status required at the beginning of treatment for response.

We will continue to add that with the deal in question, we get a number of ongoing Phase II studies. I am really very pleased about where we are with that particular deal: for me, it strengthens my expectations in terms of our ability to deliver a functional cure for a broader population of patients living with this disease.

In terms of the question about R&D budget and growth, perhaps I could just say a few brief things about the portfolio and then hand over to Emma. I am really very pleased with where we are in the portfolio. Emma mentioned the strength that we have in our growing vaccines portfolio, particularly next year as you will see more data coming from our
mRNA platform, from MAPS. We have a number of important studies, like, for example, the therapeutic arm of the herpes simplex vaccine readout on POC, that will again continue hopefully to deepen the importance of our adjuvant technology that is underscoring the fantastic clinical performance that we see for Shingrix and for Arexvy.

Luke and I will say more at the meet the management about the cornerstones of depemokimab, Nucala and camlipixant in our Respiratory portfolio – of course, I just mentioned bepi - and moving just briefly into Oncology, Jemperli most recently through the OS data that I mentioned earlier, continues to show its credentials as a very highly effective PD-1 inhibitor. With all of that in place, I think we are well set with regard to our future ambitions and the budget required for that ambition. We’re in good shape with that.

Emma Walmsley: Thanks, Kerry. There are two important things to emphasise strongly here. First of all, we have been very clear in our capital allocation framework that the No. 1 priority for the company is to invest in the pipeline – organically and inorganically. That is why, over the last five years, you have seen a significant step-up in our R&D spending. What matters is not how much you spend but that you spend it super-smartly, and that is ever improving, and that we continue to fuel competitive, profitable growth for our shareholders.

The first thing is that it is a priority, but it is about how we spend it. I think we are broadly at more industry-norm levels in terms of spending, but very much focused on the returns of that.

The second point is that we are absolutely committed to profitable growth. We are in that chapter now: we are in seven consecutive quarters of competitive growth and glad to upgrade guidance for the year. We are very confident about our ‘26 outlooks and our double-digit profit CAGR. This year, we expect R&D spend to increase slightly below our turnover levels: we are not going to set an explicit target around that but you can be very confident that the outlooks we previously laid out we are completely committed to, and delighted about our progress against those.

Simon Baker (Redburn): Thank you for taking my questions – I have two, if I may please, both on the pipeline. Apologies if I missed this, but I lost sound at one point.

It looks like depemokimab is running slightly ahead of previous expectations: perhaps you could give us update there on the shift in the SWIFT-2 study timeline?

And then secondly on the Hansoh ADC, I wondered if you could just elaborate a bit on what attracted you to that asset. Obviously we have not seen much data, you will have
seen more than us, and I was wondering if it was data-driven or whether it was driven by the fact that the payload and the link of one or two carbons is identical to Dato-DXd and therefore gives you a high level of confidence in the potential of that ADC. Thanks so much.

**Emma Walmsley:** Thanks. I will come to Tony on both of those, but just to flag, please do join us, or at least Tony and Luke I should say, on 30 November when they will update you on the very exciting scale assets we have in Respiratory, obviously our homeland and our heartland, including depe and camlipixant as well, but Tony might want to comment a bit more on the trials that are ongoing and then also on the ADC, which is obviously completely in line with our Onc strategy.

**Tony Wood:** Sure, thanks, Emma. Hi, Simon. Yes, I am pleased with the progress we are making on SWIFT-1 and 2. As you have spotted, we have seen a slight acceleration in that. That was associated with also an acceleration in the ANCHOR study for nasal polyps. What that means is that the safety database that we need to end up in the file is now complete. You should expect though that we will stay on schedule with regards to the analysis and publication of the data, and I won’t be doing that until we get the results for the second SWIFT analysis which still places us in the first half of next year.

As far as the ADC deal is concerned, Simon, yes, as you quite rightly point out in terms of link and payload, there are similarities to Dato-DXd and therefore we derive confidence from the improved profile that you see for ADCs carrying that link of payload.

Two important things though to stress in the context of this deal. One, the antigen, B7-H4, is selectively expressed on gynaecological cancers. That’s why we went after the mechanism in line with our strategy to focus on women’s cancers and haem. And lastly in that area as well, there is ample evidence of the use of topoisomerase inhibitors, so standard of care for chemotherapy. That’s related in part probably to the fact that you see a lot of DNA instability in those cancers and as I am sure you are aware, topoisomerases work on that mechanism.

**Andrew Baum (Citi):** Two questions please, one for Luke and the other one for Tony. For Luke, could you talk to the impact of the removal of the Medicaid cap, the AMP cap, on your Gen Med business, particularly Respiratory next year in terms of quantifying the impact on revenue and earnings?

And then for Tony, or I guess Kim if she’s on, there was recently reported the ATHENA cohort with cabotegravir with rilpivirine, there was a number of cases of viral rebound resistance, particularly in patients with high BMI or weight gain.
Should we expect any label change as a function of observations in that cohort? It was a limited number, but still it was notable and remarked upon. Thank you.

**Emma Walmsley:** We will come to Deborah on the HIV pipeline first and then Luke, back to you.

**Deborah Waterhouse:** Thanks Andrew, the ATHENA is a cohort study, it was presented at the ACS eight to ten days ago. Actually the finding is exactly in line with our clinical studies, so as you know there are three characterised things that give you a higher likelihood of failing with cab plus rilpivirine. Weight is one, so high BMI is one, and then obviously A6, A1 subtypes, and then lastly, if you are resistant to rilpivirine, so we clearly guide that those patients - if you have two of those risk factors you are more likely to fail.

We guide that and that's exactly what we saw in the ATHENA study in terms of the characteristics of those that failed and it was in proportion with what we saw in the clinical study which is obviously less than 1%, so no surprises whatsoever. Exactly what you would expect, and it just makes it more important that we continue to communicate through our multivariate analysis data for whom **Cabenuva** is right and who probably shouldn't be taking the medicine, but it's a tiny proportion of the overall patient base that will get benefit from this medicine.

**Emma Walmsley:** And nothing new. Luke.

**Luke Miels:** Thanks, Andrew. As I said at Q2, the exposure is US$700 million, but of course we have had notice so we have authorised generics in place, we have done some withdrawals that we have announced, we have done WAC adjustment with **Lamictal**. The other products impacted of course are **Advair** and **Flovent** and **Serevent**.

I think the impact is going to be sizeable. We have started to reflect that in our adjustments now but we need to judge to see what level of returns ultimately come back. There is also some variables in terms of the percentage of switch to authorised generics but we do have competitive generics, for example, with **Flovent**, so they may pick up more volume and make it hard to forecast. Long story short, we have been prepared for this and we have been working on it for a couple of years and I think we are in the strongest position possible, but there will be a material impact on that $700 million and that is why it is reflected in the outlook for General Medicines next year.

**Emma Walmsley:** That is a really important point. It is a 24-hit, but it is all included in our medium-term guidance, and then broadly flat in this business where we have
obviously seen a nice uptick in performance, not least as Trelegy continues to power forward and lead the way. It is all factored in and planned for.

**Richard Bath (BNP Paribas):** I just have a couple of questions, firstly on Arexvy. Can you talk about the unmet need in terms of severe disease in the 50 to 60-year old patient population, just so that we can have a sense of that, and also what you would expect in terms of ACIP recommendations so that we can have a sense of how that label update might impact the opportunity going into next year?

My second question is on Jemperli. Could you talk about your confidence in expanding the approval into the MMR proficient population? Obviously, I think there are two options there: one is the overall survival data from Part 1 of the studies. Could you talk about consistency of that benefit across those subgroups? And then the PARP inhibitor arm of Part 2 of the trial – I notice you don’t include Zejula when you talk about Part 2 as an opportunity, so I just wondered about your confidence in the PARP inhibitor maintenance arm of that study as well. Thank you.

**Emma Walmsley:** Thank you. We will come to Tony in a minute on Oncology but Luke, perhaps you could talk about the 50-59 opportunity – which is another 40 million people by the way in the USA.

**Luke Miels:** There are two advantages. One is just the access to the 40 million people, and, again, that lines up nicely with the overall Shingrix cohort, so there are lots of synergies there that we can achieve. And then there is the broader advantage when we are contracting in the retail and non-retail settings, because we will be the only one there. Our expectation at this point is that it will be shared clinical decision-making but, as we speculated before the launch, and I think so far that is holding up, that has not been a barrier during this initial phase of adoption.

If you look at the 50 to 60-plus population, there is a sizeable proportion within that who also have one or more co-morbidities, so it is attractive and certainly resonates well with primary care doctors in terms of their support for the brand, which is around 71% in terms of their preference overall for Arexvy.

**Tony Wood:** Okay. In terms then of RUBY and particularly RUBY-Part 2, and indeed the MMR-P population from the results that we described earlier this week, it is important to recognise that the RUBY-Part 1 study was not powered to look at OS in the MMR-P population, but rather OS for the overall population. The way to think about this in the context of both Part 1 and Part 2 is definitely isolating out the MMR-P population and
asking under what circumstances are we likely to see the most meaningful therapeutic effect for those. There are, for example, genotype considerations associated with part response in the Part 2 population that are important. I don’t want to get into the details of that at this point in time because we are still waiting for the read-outs, but it is fair to say that the filing strategy that we will put around Jemperli in first-line EC will take account of all the factors that I have just described, as well as the competitor position.

Luke Miels: Yes, and I think to build on that competitive position, we are optimistic in terms of how the NCCN may read that. Of course, as you know, GY18 is not designed around an overall survival signal, and it is very interesting that since that initial label we have gone from 300 to 900 accounts now stocking Jemperli in the US, so that has a flow-on effect, and sales are 10 times up after SGO. It is intriguing, just looking at the market shares, if you look at that first-line setting where it was obviously non-promoted initially, Keytruda was picking up around 40% of that business. Chemo had dropped from 40% down to 27% and we had around 13% of that market, so I think there is an opportunity now to start to make the case versus GY18, with the elements of the design and the survival signal, to try to expand the use of Jemperli in that setting. This is something we are quite excited about, and then of course DUO-E helps to inform the thinking around RUBY-2.

Tony Wood: There are just a couple of things to underscore, to Luke’s point, to remind you about GY18, different patient populations. We had a larger degree of carcinosarcoma patients, which are harder to treat and, importantly as well, the RESIST sampling frequency for our study was smaller, which will obviously be going to pick up failures more quickly than the GY18 case does. It is important to bear those two things in mind when you consider the comparison of the two studies.

I think Luke has guided you correctly in thinking about DUO-E as being informative, as regards to how we might interpret the Part 2.

Emma Walmsley: Thank you.

James Gordon (JP Morgan): Thank you for taking the questions. I will stick to Arexvy for my two.

The first one is about Arexvy and stocking. It looks as though £460 million of Arexvy was stock in this quarter and the guide for this year implies about £200 to £300 million of sales in Q4. What does this assume in terms of stocking unwind in Q4? How much stock do you need to keep in the market to support the product as an ongoing run rate?
And also, what are you thinking about ex-US stocking in Q4? Could there be a US sized stock up that we saw in Q3 in Q4?

And the second question links into that which is Arexvy and the ex-US launch, so ex-US sales were only around £9 million in this quarter but the product was approved in the EU back in June and my understanding is you are not capacity constrained, so could ex-US stocks ramp in Q4 this year and, looking into next year, could we see a big launch for ex-US Arexvy? Could that be a big growth driver for next year or is it going to take a bit longer in Europe to get this going and what are the gating factors to get ex-US Arexvy ramp like what we have seen this quarter in the US?

Emma Walmsley: Okay, we will go to Julie first just to deconstruct the guidance for Q4, and then Luke around the globalisation, but you are absolutely right, this is a global opportunity and I will even include in that the recent commercial deals we have been doing in the second biggest market in the world. There could be an option on that for the future. Just to repeat, we are very ambitious for this being a multi-billion asset as we’ve committed before, but in terms of the very short-term in its first season, Julie, do you want to comment on the guidance?

Julie Brown: Yes, thanks very much, Emma. What we have definitely found so far is of the sales of £709 million in terms of immunisations into people’s arms we have around the equivalent of about 230 million to 250 million. The launch has been massively successful. We were expecting a stock-in at this point because it’s very, very analogous to what is happening with flu, so I think I will hand over to Luke in terms of the amount of inventory we expect to carry. The figure for Q4, by the way, was absolutely spot on in terms of the level of sales we expect to see in the remainder, 200 to 300, and it’s all to do with the stocking, so over to Luke.

Luke Miels: Yes, if you look at the total market it’s about 2.71 and we have 1.7 of that in arm. Yes, I won’t give too much more colour. As Julie says, it’s two-thirds of sales so far and we will obviously try and burn through that towards the end of the year to position ourselves well. What we don’t want is empty shelves or any window where Pfizer can get in there. That’s why I am being a little bit cute with the numbers here because it’s very dynamic at this point.

In terms of EU, look, it’s very early days, it’s private, we have kept the price in a very tight collar with the US like we have done with Shingrix, and our expectation is that we need to now navigate access. We have early wins in Canada, we have some very encouraging signs coming in in Europe and other markets, so we will see the full effect of that in 2024. Of course, the advantage in the European, much like Japan, and other international markets is
once we get the NIP, then the level of resourcing we need to do to drive patients is significantly lower, and so from a P&L point of view it’s also very attractive, so 2024 for rest of world for Arexvy and a quick start in the US.

**Emma Walmsley:** And just to repeat, we are definitely seeing increased openness and recognition of the value, literally, financial value of investing in prevention, and so that is definitely in part why we are seeing this faster rate, even if currently in the private market of approvals, because it’s just a lot cheaper and there isn’t a healthcare system or budget that isn’t burdened at the moment, and they have more infrastructure in place, not least through pharmacy channels for distribution in many countries.

All of this underpins this broader confidence, but with phenomenally tight discipline from Luke and his team, as he has alluded to, around the shape of the financial contribution.

**Mark Purcell (Morgan Stanley):** Thank you, and thanks for taking my question. On Arexvy, a little bit more colour. I just wondered if there was any early indications of how the seasonal demand for RSV vaccination is doing and there may be more of a sort of Prevnar/flu-type of model. I know you will know more by the end of the year but any early indications there?

And in pharmacies where Pfizer is fully stocked alongside you, given that they talk about how they are not fully launched yet, what is your market share in those pharmacies where both products are present?

And then a quick one for Tony. In terms of the IRA considerations on R&D, where you have assets such as like your IL-18 where you could run parallel trials across a multiple number of indications, do you see the sort of pressure to do that, and on IL-5, could you do a bridge study or would you have to do a separate study in COPD?

**Luke Miels:** Thanks, Mark. We are beating them everywhere so far. The aim is to keep that happening. It’s interesting, when you look at pharmacists’ prioritisation, RSV is up there with flu and COVID, but you are seeing COVID volumes drop off, and last week we still kept growing with Arexvy which is encouraging. I was wondering whether it would start to slow down, so this next couple of weeks, scrip data will really be interesting. It is more than 90% in the retail setting and that is another critical component in your assumptions and we do not expect that to change materially. We think vaccines for maternal, in OBGYN and PCP offices, will occur, which is something we will have to back up for future calculations, but we think the older adults market will be very much like flu, very
much like Shingrix, heading in the direction of retail. We will just have to see what people’s enthusiasm is over the next couple of weeks.

Clearly, awareness is very high and the intention to recommend is very high, and so, again, I am very happy to back the truck up with everything we know in Q4 and give you much more colour around the market research that we will have at that point.

Emma Walmsley: Great, thanks. Tony, is there anything to add?

Tony Wood: Yes, just two very quick points in terms of the IL-18 question. The key question we are asking with IL-18 is at the moment is about its efficacy relative to dupi in atopic dermatitis. For the medium-term, as we build out our biomarker strategy and look for markers of efficacy at Phase I – that is exactly the underpinnings that I would then want, to have the confidence to go forward into multiple indications.

You probably have in mind that, in the case of IL-18, the Mendelian randomisation also points to inflammatory bowel disease. There is obviously a range of other considerations there, beyond just IRA, in terms of whether or not that is a path to go.

Lastly, for MATINEE and a bridge for deppe, let’s see where we go when we get the MATINEE results. Obviously, we are focusing very much on the role of EOs in driving the morbidity and mortality associated with COPD, so that will be part of our strategy, but I am focused at the moment on making sure that we get the results out of MATINEE and delivering success for Nucala there.

Emma Walmsley: Yes, and of course any allocation of capital is a combination of progress and success and the assumed forecast, and that assumed forecast now has to take into account the area under the curve, or the format, or anything else.

Stephen Scala (TD Cowen): Thank you very much. I am curious if Arexvy shipments in October support your conservative guide for the full year. Were they essentially zero? I would note that in the first quarter of 2018, GSK called out stocking for Shingrix and then went on to beat in 10 of the next 12 quarters in the US.

Second, I know that you are beating Pfizer in RSV everywhere, but to what should we attribute the success they have had? Previously, you have said you have a better vaccine and you are stronger in the commercial setting, and yet they put up a big number as well. To what do we attribute that?

Emma Walmsley: I will ask Luke to overlay, Steve, but thanks for the questions. This is the first season that we have been through. We have our guidance for
reasons that I will not repeat, since we are under some timing pressure, but we will know a
great deal more at Q4. Obviously, we remain extremely ambitious for this and our
competitive focus is to make sure that not only the size of the market is big, which is why we
welcome competition, but that we are able to effectively reach the patients who need us,
which is this more vulnerable hospitalisation cohort.

Luke, is there anything you would like to add?

**Luke Miels:** I think *Shingrix* is a different case. I was in the middle of that: we cancelled the global launch and we redirected all of the volumes to the US and we also in
the middle of the later year had some synergies in manufacturing, which were a surprising upside, in terms of loss rent and packaging. That is why we were able to get that volume ahead for *Shingrix*.

In terms of us versus Pfizer, first, it is great that two companies are out there driving volume, because this is an awareness game. No-one had heard of RSV – it was the first in the population before that – and so having two companies promote is good. We have enormous respect for Pfizer; we like competing with them and they are a strategic competitor for us, if you look across PCV, meningitis, RSV and potentially shingles at some point. It is nice to have this strong start and, again, we want to keep this going.

**Peter Welford (Jefferies):** I am afraid that I am sticking with *Arexvy*. You mentioned that retail was over 90% of volume so far. I am curious as to why you are so confident that that mix will continue. Obviously with *Shingrix* it has varied over time. I think your competitor made some comments that they think that potentially, in the 4th quarter in the back half of the season, it will switch more towards the non-retail segment, where they see perhaps a greater competitive advantage. I wondered if you could comment on both of those – both from the competitor advantage point of view, and also how potentially this could change during the course of the season.

Secondly, I wanted to stick with vaccines but wondered whether Tony could possibly give us an update on how you are thinking about mRNA. I know we come back to this almost every quarter, but there have obviously been some competitive developments in this, so could you give us a quick update on how you are looking at your strategy and give an update on the news flow we could get for your mRNA portfolio in 2024?

**Emma Walmsley:** Yes, we are very excited about mRNA so I will come to Tony first. Remember, the 90% is older asset adult, but we will come back to Luke on that in a minute. Tony, mRNA?
Tony Wood: Just very quickly, we are very pleased about the platform and how it is moving forward. We are now moving into Phase II, in both COVID and flu, and our Phase II programme for flu includes a range of options and doses that we have deduced from our Phase I study, looking at up to eight antigen components, which we feel is the path forward to, I presume, resolving the B-strain coverage question that exists. It is also worthwhile pointing out that that is likely to become a slightly simplified proposition as the B and the garter strain is probably going to be removed in ’24, but more on this when I have the readout from the Phase II data.

Emma Walmsley: Luke, anything to add on?

Luke Miels: Yes, I just look at it at a macro level. You have 83 million who are over 60, you add the 50-59ers, that’s another 40 million, so that’s 120 million. We think 90% of those are going to still come through. If you look at a typical birth cohort, it’s four million a year, so if I look at between now and the end of the year, that’s about a million pregnant women and then it’s unknown how many of those will get a vaccine. Then there is the influence of the antibody as well.

I think the other thing to keep in mind and we are seeing this with Shingrix is there are a lot of practices that are driving patients to a pharmacy because they don’t want to navigate the IRA dimensions and then have a separate track for the commercial patients, so they are actually sending patients through to the pharmacy rather than persisting with that themselves, so that’s a bit unknown but definitely those maternal vaccines will be given in OB-GYN offices where we don’t have the label there so we will need to exclude that from our market share calculations going forwards.

Emma Walmsley: Thank you. We have time for one more.

Emily Field (Barclays): Thank you so much for fitting me in and maybe I will just ask one last one about Ojjaara. I was wondering if you could provide some context about how you are thinking about the speed of uptake of this launch, particularly now that you did get the line-agnostic label and if you are expecting more upfront usage versus second-line usage and any early indicators you could give us. Thank you.

Luke Miels: Thanks, Emily. We have about 132 patients on so far. The bulk of those are JAK failures, highly anaemic, so pretty severe cases so that initial bolus will work through.

Our working assumption is that between 40% and 50% of patients presenting are anaemic at diagnosis and as you know, we have an outstanding recommendation there in
terms of 2A and the most competitive profile in that subgroup and we also know that around 46\% of patients require a transfusion within one year of diagnosis, so that’s our target market.

We think right now, yes, third-line is a couple of months but we will work our way up. Second-line typical treatment length is 18 months but we should be able to start to penetrate in 2024 that first-line where typical treatment is around 26 months of duration. We got the NCCN data into the two hours approval and we were very happy with the recommendation.

So far so good, a lot of academic interest, it’s about 55\% of the volume right now, 45\% in the community. Of course we expect that to change in time, but a lot of excitement and this is clearly a visible problem for haematologists and they are very supportive of momelotinib, so, so far so good.

**Emma Walmsley:** Wonderful, thanks Luke. We will look forward to coming to more of your questions over coming days and weeks. I just want to leave you with the recap that we are delivering strong and sustained performance momentum with another quarter of double-digit sales and earnings growth.

This is broadly based performance but of course benefitting specifically from the very fast start of Arexvy which we are looking forward to seeing its progress ahead.

Pleased to have an upgrade, but also really delighted with momentum as we look ahead to delivering our ’26 results and continue to strengthen that longer-term outlook as we keep progressing the Vaccines pipeline, longer acting HIV and exciting prospects in Respiratory, so thank you to everybody and look forward to catching up soon.

*Ends*