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CORPORATE PARTICIPANTS

Andy Schmeltz *Pfizer Inc. - Global President, Oncology*

Chris Boshoff *Pfizer Inc. - Chief Development Officer, Oncology*

CONFERENCE CALL PARTICIPANTS

Stephen Michael Scala *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Kathleen Miner *Cowen and Company, LLC, Research Division - Security Analyst*

PRESENTATION

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

We'll get started. Very happy to have Pfizer with us this year at the Cowen conference. Representing the company, Chris Boshoff, who's Senior Vice President and Chief Development Officer in the Oncology business; as well as Andy Schmeltz, who is Global President of Oncology.

Oncology is such an important business to Pfizer, and it's one part of what we think is an emerging new product story. So it's great to have you here to walk us through the many exciting developments in the company.

So they're going to present just a few slides to set the stage, and then we'll dive right into questions.

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Great. Thanks, Steve. Chris and I are very happy to be here. if you want to cue the slides up, perhaps?

Okay. So maybe make a few opening remarks and then jump in.

We're very proud in Pfizer Oncology of the strong growth trajectory over the past several years. In fact, our compound annual growth rate from 2013 to 2018 has been 31%, driven by the uptake of Ibrance approved and launched in the U.S. in 2015 and then our acquisition of Medivation in 2016, bringing us Xtandi that we're actually promoting in the U.S. in partnership with Astellas.

We're very proud of our growth. We've got 18 medicines now, a portfolio spanning 14 innovative medicines and 4 biosimilars. And we have 20 -- anticipate 20-plus approvals anticipated over the coming years.

Most importantly, our Pfizer Oncology medicines have had the opportunity to provide hope to 1.2 million cancer patients since 2006.

Looking forward, our strategy is focused on 3 areas: one, to continue to expand our leadership in breast cancer and prostate cancer. So just to comment for a moment, breast cancer is certainly the core is Ibrance. In prostate cancer, Xtandi, both core indications in the metastatic setting. We have active clinical studies; life cycle programs in non-metastatic settings; adjuvant use in both breast cancer, prostate cancer that could, in both settings, double the overall population that could benefit -- eligible to benefit from these medicines. And then we have robust substrate early in the pipeline in breast cancer CDK programs and prostate, the VBIR program.

Our second area of focus is to advance our portfolio with precision immunotherapy approaches. Lots going on beyond breast and prostate. We have a growing hematology portfolio with BOSULIF in chronic myeloid leukemia, BESPONSA in acute lymphoblastic leukemia. In renal cell carcinoma, kidney cancer, our history, our heritage here, very excited by the prospects of the combination of BAVENCIO avelumab with Inlyta, potentially a new standard of care for first-line metastatic RCC. And then in lung cancer, very excited about the prospects for LORBRENA, lorlatinib, our ALK-inhibitor designed specifically to overcome resistance to first-generation ALK-inhibitors that's recently been approved and has early strong uptake.

The third strategy, our area of focus of our strategy, is pursuing the next wave of innovation. Maybe, Chris, if you want to comment on that.

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

Thanks, Andy. We currently have 14 medicines in Phase 1, some of those we can maybe expand on is our HER2 ADC potentially best in class next-generation HER2 ADC to complement our breast cancer program. CDK2/4/6, again, a next-generation medicine to potentially complement our Ibrance portfolio, CDK2/4/6, CDK2 specifically targeting cancers, which are dependent on cyclin E-CDK2. We also have a vaccine-based immunotherapy regimen, which includes a PD-1 as well as a CTLA 4. The PD-1 is actually a Pfizer molecule that's currently in Phase 1. We concluded expansion studies in breast -- sorry, in lung cancer and in bladder cancer. It's a subcutaneous medicine, so it's being developed as a differentiated administration, once every 4 weeks, potentially once every 6 weeks as a subcutaneous medicine and then as well as a very specific small molecule against TGF and beta receptor 1. VBIR program I mentioned, which is a vaccine -- the current vaccine is in prostate cancer, but it's also currently being developed in other cancer types. It includes a CTLA-4 as well as a subcutaneous PD-1. I only show here 18 of -- not all, only 18 of our ongoing registration studies -- Phase 3 studies. Included there is some of the studies Andy alluded to, the earliest-stage breast cancer studies in the adjuvant setting, like and PENELOPE B and PALLAS; the large program with Xtandi with a number of ongoing Phase 3 studies, including combination studies in partnership with Roche with Tecentriq, the IMbassador250 study as well as in collaboration with Merck, the KEYTRUDA study KN-641 both for the metastatic castrate-resistant prostate cancer setting as well as a study in combination with talazoparib. Perhaps, also just to point out, in the hematology and renal portfolio, the RCC studies Andy alluded to, these are 2 Inlyta studies that read out positive, one with BAVENCIO, the study we conducted and the study conducted by Merck with Inlyta plus pembrolizumab. And we're looking forward to working with the FDA and other health authorities now for the registration of those.

QUESTIONS AND ANSWERS

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Maybe we should, just before you start asking questions, acknowledge because I didn't have the slide that we're making forward-looking statements, and we want to make sure that you're aware of our disclosures.

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

This is the most important slide.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

All right. So lots of important drugs to chat about. You mentioned lorlatinib, let's start there. So a variety of competitors are on the market, but a varying -- varying degrees of profile, some not compelling, some very compelling. So how does -- do you -- how do you see lorlatinib fitting into this treatment armamentarium?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Lorlatinib was specifically developed to overcome resistance to crizotinib and other first-generation ALK inhibitors. So the early indication now is after patient has progressed, either on crizotinib or alectinib. And as those medicines have been on the market for several years now, there's lots of patients with unmet needs, and so lorlatinib is specifically set up to fulfill that need. We also have ongoing program in first line ALK-positive non-small cell lung cancer, the CROWN study. So we could see, over time, the utility of lorlatinib potentially expanding. Chris, if you want to comment on CROWN?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

The CROWN study is now fully recruited. That's a first-line study with Xalkori versus lorlatinib. Lorlatinib, very brain-penetrant, highly effective in brain metastases. One of the few medicines that work in tumors that progress on other ALK inhibitors, including alectinib, brigatinib or ceritinib. So we believe this potentially best-in-class ALK inhibitor, and we're looking forward to the updates in the second-line setting and then, obviously, the readout for the first-line study.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

So let's assume that CROWN study is a positive study, how would lorlatinib compare to, say, alectinib in the first-line study? You mentioned best in class. What makes it best in class?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

Well, best in class in terms of the fact that it overcomes all resistant mutations that has been described, which means that those mechanisms that provide resistance to other ALK inhibitors can be overcome and maybe further delay for the recurrence with lorlatinib. I think, in general, we believe this is probably the best medicine also to use in tumors that progress on alectinib. We still get a significant progression-free survival. In fact, progression-free survival in second line in some settings is longer than it is in first line with crizotinib.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

So let's touch upon 2 more recent oncology launches, maybe of smaller magnitude, but maybe you can just tell us how they're doing. So let's start out with dacomitinib. What is the -- where does this fit within the EGFR treatment armamentarium?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

So dacomitinib's trademark is VIZIMPRO, approved in September in the U.S. and more recently in Europe for EGFR-positive non-small cell lung cancer. Certainly, lots of unmet need here. The 5-year survival rate is still only about 12%. And while it is a competitive space, we see VIZIMPRO kind of really carving out a niche. And there's an opportunity for patients to be on VIZIMPRO first line and then subsequently on another targeted EGFR positive therapy. So we're still early days, but we think that it's going to carve out a nice niche.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

And what is that niche? Can you describe it?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Well, first-line EGFR positive for patients where it's appropriate to think about the mindset of sequencing and as a -- you would want to reserve some of the other agents for following.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Okay. And also glasdegib, tell us an update on that. How's the launch going? Where is it fitting into the AML treatment armamentarium?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

So glasdegib DAURISMO is the tradename, recently approved late in 2018 in the U.S. and still timing TBD outside the U.S. This is a smoothened inhibitor for a subset of elderly AML, acute myeloid leukemia, patients for which chemotherapy is not appropriate. Certainly, the acute myeloid leukemia space is evolving and is very dynamic. And we look forward to -- in that segment that DAURISMO has an appropriate place. It's in combination with other therapies. That being said, we know the environment is getting very competitive. And we have other clinical studies underway to further refine and add to the utility of DAURISMO. I don't know, Chris, if you want to add.

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

Perhaps just to add, remember with LDAC, we did achieve -- it was a randomized study and we did achieve a significant overall survival benefit, which is not being shown yet with other medicines in that setting. And the first-line study is both in combination with azacitidine for patients that are not fit or not eligible to receive high-dose chemotherapy. And it's also in combination with standard 7 + 3 chemotherapy.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Perhaps, one of the most important chemotherapies or oncology agents ever approved is Ibrance. I have to admit some degree of being perplexed that the other 50% of women who aren't benefiting is -- from this drug are not benefiting from the drug. So what is it about that 50% that makes them a more difficult cohort of patients to penetrate?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

So Ibrance, we're very proud of Ibrance and its leadership position in metastatic breast cancer based on the totality of data, the benefit risk profile, the significant first-mover advantage we've had in the patient and physician experience with Ibrance today. In the U.S., this is really year 5 post approval in early 2015. In Europe and international markets, we're really year 2 in many markets post reimbursement. We're now approved in 90-plus countries reimbursement, reimbursed in the EU5, in Japan as well as China and now Brazil. So the growth trajectory outside the U.S. is going to be more robust, given it's still earlier in the uptake and the life cycle. So your comment is really about in the dynamics in the U.S. where, in metastatic breast cancer, about 50% of eligible patients are now utilizing a CDK-based regimen, about 20% are utilizing chemotherapy still and about 30% are utilizing hormone monotherapy. First, the chemotherapy segment, we believe this is a little bit more of a red herring. Someone is put on chemotherapy, perhaps, to debulk the tumor, perhaps because of a visceral crisis are on a cycle of chemotherapy and then initiated on a CDK-based regimen. And we know the duration of therapy for someone that's put on Ibrance first or Ibrance after chemotherapy is still generally the same duration. So we think we're okay there. But hormone monotherapy is certainly an area that we are focusing our efforts. This is where we have robust data. PALOMA-1, PALOMA-2 showing the progression-free survival on Ibrance plus hormone therapy is double that of hormone monotherapy. And we're working on increasing the level of Ibrance use there. Interestingly, we look at accounts in the U.S., about the top 300 accounts, and about 25% of them still are using 40%-plus hormone monotherapy, and that's the segment that we're working on. Why kind of late adopters, whether it's an account base? Is there a physician basis? And we're chiseling away to increase CDK penetration. We're confident that we're going to get there and continue to grow. Also now with 3 CDK inhibitors available, you have the kind of halo effect of all 3 out there, both in promotion, in medical education and direct to consumer as well.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

And how does the use of chemo and hormone therapy differ in U.S. versus -- differ in Europe versus the U.S.?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

In Europe, it is more variable in different markets where chemotherapy is more robust than others where it's not. And we're seeing, generally, when you look at the EU5, overall, a decline in chemotherapy used in first line as there's kind of availability of Ibrance and uptake of Ibrance. Really, we're quite pleased with the robust uptake so far outside the U.S.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

So -- yes, Kathy?

Kathleen Miner - *Cowen and Company, LLC, Research Division - Security Analyst*

I have a question to follow up here. When you talk about this 25% that are still using hormone monotherapy, are the reason they are doing that patient specific, if it's hair reason or (inaudible) reason?

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Yes. So let me repeat the question. So the question is why do those patients remain on hormone therapy? What is the treatment armamentarium that's leading to that?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Certainly, there's a range of areas -- of issues. One is habit and comfort. These hormonal agents are generally well tolerated, and there's comfort. The duration of therapy is relatively long. And there's this mindset that they are going to progress and so I want to save the CDK-based regimen for afterwards. But this is where the data, the facts are our friends. We know that using Ibrance with a CDK is going to be a better option based on the data, and so we just have to continue to work on that.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

So you've done a phenomenal job at keeping the 2 CDK 4/6 competitors at very low penetration. Are there any CDK 4/6 inhibitors in development other than maybe your own that you view as a potential threat to Ibrance?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

No, not CDK 4/6-specific. For our molecules, the (inaudible) PCR [CDK2/4/6], which we are excited about it and some other medicines currently preclinically that will go into the clinic as well in the cell cycle space. But I think with the entrenchment of Ibrance, we're not really concerned about other CDK 4/6 inhibitors.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

What makes a CDK2/4/6 different from the CDK 4/6 other than the obvious?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

So one of the mechanisms of resistance is cyclin E overexpression. And we've also seen in the -- one of the PALOMA studies that in patients where the tumors are overexpressing cyclin E that they are more resistant to Ibrance. So that's one of the mechanisms of resistance. Cyclin E binds to

CDK2, so targeting CDK2 is one mechanism drug that would calm that. But completely independently, there's a large number of tumors that's actually dependent on cyclin E, so there's oncogene addiction almost to cyclin E, including some pancreatic cancers, lung cancers, breast cancers, triple-negative breast cancers. And in those settings, targeting CDK2 could be very attractive way to tackle those cancers. Why only now a CDK2/4/6? Because it's always been very difficult for the medicinal chemist to develop a medicine that specifically targets CDK2 and not CDK1, so targeting away from CDK1, CDK1 with the associated side effects. So this important medicine for us is currently in dose escalation.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Questions from the audience? So you have 2 studies in the adjuvant and neoadjuvant setting, PALLAS and PENELOPE B. How -- what is your level of confidence in a positive readout? So is this like a layup? Is it a shot from the 3-point range? Or is it a mid-court piece at the buzzer?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

Yes. We're not going to quantify that. I think we're confident in the medicine and in the mechanism in blocking CDK 4/6 across the whole continuum of treating ER-positive breast cancer. We were encouraged by the data we presented at San Antonio last year, the so-called PALLET study. The PALLET study was a biomarker driven study with 14 weeks of letrozole, plus palbociclib vs letrozole. And in that 14 weeks, we're measuring the downregulation of Ki67, a biomarker that's measuring proliferation of cancer cells. And if there was a significant downregulation of Ki67 by the combination, why that's important to us is because Ki67 downregulation is considered a robust surrogate for benefit to endocrine therapy in the adjuvant setting. So though that doesn't make us necessarily more or less confident in PENELOPE B and PALLAS, it is -- those are clearly very encouraging data for us in the early setting of breast cancer showing the potential of palbo in early setting.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Okay. So let's move to BAVENCIO. So there's been a few setbacks in the clinical trials. What do you think is the single biggest reason for this? Is it trial designs, which were too aggressive? Is it patient selection? Could it be the molecule? What it -- what do you attribute these setbacks to?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

So I think it is a combination of that. I won't say trial design is too aggressive, but we did start the ovarian cancer program based on more limited and early data. We had very strong preclinical data to indicate that immunogenic cell that can be elicited by chemotherapy and combining that with an immune checkpoint blocker could potentially be a benefit. And that played out in lung cancer, the combination of chemotherapy plus an immune checkpoint blocker. In ovarian cancer, when we started those studies was much less known about tumor mutational burden, new antigen presentation. We now know, of course, that ovarian cancer is a cold tumor, and it's certainly more challenging. And although we've seen some signals within those studies of subgroups that did benefit from the combination, which we will present in the coming months, in the overall population, it was disappointing, especially in the platinum resistant/refractory disease setting, which is a very difficult disease to treat. And there's very few medicines that actually make a difference for patients with late-stage platinum-resistant or refractory ovarian cancer. And we now -- I mean, we're very -- it's very positive for us in light of BAVENCIO data. The data is comparable to the best we've seen. We're doubling the response rate, doubling progression-free survival as well as the endpoints being positive in all different risk groups, including poor, intermediate and favorable risk groups of renal cancer. So those data are clearly very encouraging for us. We're looking forward to 2 of the next big readouts, first in first-line bladder cancer, urothelial carcinoma first line as well as the readout in locally advanced head and neck cancer, which is a combination of radiotherapy and chemotherapy. And we could potentially be the first to read out in that setting, which is the biggest opportunity in head and neck cancer.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

There may be a few skeptics in the room about your ability to be successful in first-line renal, given the data that Merck has presented and the fact that they have already achieved OS and to the best of my recollection, you haven't yet.

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

We haven't yet, yes.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

So -- and of course, Bristol now dominates. So how -- what is the path that Pfizer becomes a leader in first-line renal?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

So -- yes. So first of all, we have a rich heritage in kidney cancer with SUTENT first line, with Inlyta second line. And now clearly, Inlyta becomes a TKI backbone in combination with checkpoint inhibitors as a standard of care going forward in first-line renal cell carcinoma. We're commercializing BAVENCIO plus Inlyta. We believe that, over time, that these regimens, the KEYTRUDA, Inlyta, the BAVENCIO, Inlyta will generally be comparable. We don't have OS yet. We look forward to that readout over time. And with the kind of confidence in Inlyta as well as the Pfizer capabilities over the past decade in partnering with Merck Serono that we'll be successful in first-line RCC. We're very sensitive that this is a competitive space with the IO-IO combinations, with other IO targeted therapy combinations, but we're not deterred. We've -- RCC has always been a competitive space. Back in the day, it was in SUTENT and Votrient in first line. It was Inlyta and with the Novartis compound in second line, Afinitor. And we navigated it, so we're confident going forward.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

We don't want to talk about price in a session like this, but because you alone, both components of BAVENCIO plus Inlyta, could price be a lever that you can pull to combat KEYTRUDA plus Inlyta? Or is that not something that you would ever contemplate?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Certainly, we're thinking holistically and we're thinking about all considerations, different geographies, different dynamics from reimbursement. In the U.S., we just want to be mindful that an IV is for a medical benefit, small molecules through a pharmacy benefit, in general. That being said, there might be certain situations where we would contemplate this. So it's something in the mix. It remains to be seen if it's going to be a driver or not.

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

But we have 2 positive readouts with Inlyta. So Inlyta being a backbone is very important for us as well and establishing our TKI is the backbone in first-line RCC.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Okay. So how do you view the Allogene spinout in hindsight? Is this a good value-creation mechanism that you would now entertain for other internal assets? Or was this a one-off that you would contemplate again?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

So overall, we wanted to create a vehicle to accelerate and to focus the developing -- and the development of allogeneic CAR-T cells. i think it's been highly successful because we have a company now that we have a 25% stake in, that a very successful IPO and we're looking forward to then

now accelerating and focusing and also being -- having the capability and the leadership for the manufacturing and the delivery of CAR-T cells. It's a differentiated product. It's an allogeneic project -- product off the shelf potentially, so it could potentially transform the market especially for hematological malignancies. So overall, I think it was very successful for us, especially with our continuous involvement and stake in Allogene.

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Yes. I think that, so far, we're quite pleased with the way things have moved quickly. Having the right expertise, having the right capabilities and the access to capital is -- has been very effective. I think it's a case-by-case basis if this is a strategy that we'll employ going forward. We have quite robust R&D capabilities within Pfizer, so we have to be very thoughtful.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Okay. Questions for the audience? So let's move to talazoparib. What is the opportunity for Pfizer in the PARP space? The PARPs other than LYNPARZA haven't exactly been killing it. So can -- how can Pfizer kill it?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

We're very excited with talazoparib TALZENNA now approved in the U.S. for BRCA positive metastatic breast cancer. That's just the first indication. We have ongoing programs in prostate cancer TALAPRO-1, Phase 2 monotherapy for talazoparib; and then TALAPRO-2, a Phase 3 in combination with Xtandi in prostate cancer. We also have a basket study looking at multiple potential in tumors from talazoparib. And so we believe that -- look, it's a competitive space with PARP inhibitors. It remains to play out if there are big drivers of differentiation in -- from a benefit risk or it's really the micro attributes. And at the end of the day, it might be combinations for PARP inhibitors and generating the right data in the right areas. And so it's going to play out over time, but we're still bullish on the prospects for talazoparib.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Maybe we can move to Xtandi. And what -- so the product has clearly turned a corner, and it's starting to grow nicely again. So what have been the most important elements or attributes that have led to that?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Xtandi, core indication in metastatic castrate-resistant prostate cancer, the expanded indication last year -- mid last year in non-metastatic castrate-resistant prostate cancer, the PROSPER study, and that's really enabling us to move further. And patient population with clinicians that have been using Xtandi since 2012 now able to use it in additional segment. We are very excited by the prospects of our ARCHES data in metastatic hormone-sensitive prostate cancer that just read out and then, going forward, the EMBARK study, which is non-metastatic hormone-sensitive prostate cancer. So when you look at these castrate-resistant, hormone-sensitive prostate cancer, metastatic, non-metastatic that there's a lot of opportunity for expanded use of Xtandi over time and, not to mention, increased duration of therapy as you move into early settings.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Can you each name one early-stage oncology asset within the Pfizer pipeline that you have not talked about today that's most interesting early-stage asset you have not mentioned today?

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

Are we not allowed to mention again the HER2 IDC or CDK2/4/6? So I think, perhaps, one of the other medicines to mention, although it's currently in Phase 1, it's our easy H2 inhibitor. It's again a highly specific molecule and it's currently in dose escalation. There's a potential to combine with a number of our internal medicines as well, especially our targeted medicines, including in prostate cancer and in breast cancer with some very nice early preclinical data being generated with it. So I think we -- yes, it's one of the medicines we're interested in.

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Yes, I'll just add, VBIR, our cancer vaccine being studied in prostate cancer, it's very early. It's high-risk, but potentially could be a game changer.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Okay. And then our last few seconds, what is the one thing that you think investors are not fully appreciating about Pfizer Oncology?

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Pfizer Oncology basically came out of nowhere over the last 10 years from being a really niche part of Pfizer to being our largest innovative therapeutic area. We've got robust R&D productivity and track record. And we've got great expertise and capabilities. And we're committed to sustaining and building on this leadership over the coming years. We're committed to changing the trajectory of cancer.

Stephen Michael Scala - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Well, thank you very much. That does conclude our session. So that's been a great rundown of an important business at Pfizer. So thank you so much.

Andy Schmeltz - *Pfizer Inc. - Global President, Oncology*

Thank you.

Chris Boshoff - *Pfizer Inc. - Chief Development Officer, Oncology*

Thank you.
