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PFE.N - Pfizer Inc at Wolfe Research Healthcare Conference (Virtual)

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PRESENTATION

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Okay. Good morning. Thanks for joining us. I'm Tim Anderson, the large-cap pharma and large-cap biotech analyst at Wolfe Research. And for the next 45 minutes, we'll be talking with Pfizer's Angela Hwang, who is President of Pfizer's Biopharmaceutical business, which is basically the entire business now. She's been in this role for about the last 2 years, but she's been with Pfizer for 23 years working across lots of geographies and therapeutic areas and business functions. So thank you, Angela, for joining us.

QUESTIONS AND ANSWERS

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

We're going to just jump into questions here. I thought maybe we could start with the Upjohn separation. So it officially occurred just this week. Viatris began trading, I think it was yesterday. You ran that division at one point back when it was called Essential Health. Now it was called Upjohn, and now it's part of Viatris. What will finally splitting that out allow the remaining Pfizer to do differently? And just remind listeners why that decision was made to spin out Upjohn.

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Thank you. Thank you, Tim, and thank you for having me here today. So great question on a very important week, as you say, signifying the spin-off of Upjohn.

So the reason we did that was in order to enable us to focus, to enable us to focus on innovation, to be a -- and to pivot to a science-based company. As all of you know, Upjohn, or the division that I used to run, which was called Pfizer Essential Health, was a division that was really focused on multi -- often multi-sourced molecules, molecules that had lost its patent life but still continues to create a tremendous amount of value in the marketplace. And so there was real value in doing that.

But when you brought that together and juxtapose that with an innovation-based business and a pipeline that needed to be funded and needed focus in a different way, it really led to the conclusion that more value can be created for that portfolio if it was in a different context, in a different company compared to within Pfizer.

And so that was really the decision that led to us spinning and looking for partners for Upjohn or the previous PEH business. And it led to the creation of Biopharma group, which began around the end of 2017. And as you said, I've led it, I've been leading that since its inception.

Our focus is purely on innovation-based molecules, first-in-class, best-in-class, and we know that the only way we can really fuel this kind of innovation is that if we can focus. So we're focused around just 6 business units. And we're focused about -- around making sure that both our inline as well as our pipeline can thrive in this environment.

And so we've been operating pretty separately from Upjohn since, actually even when we were Pfizer Essential Health and Pfizer Innovative Health. Those were very separate units anyway with its own infrastructure, and that certainly has been the case through this transition with Upjohn. So in

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terms of the day to day and in terms of operational elements, nothing changes for Biopharma because we've been operating this way for the last couple of years anyway and we were built this way.

But in terms of continued relationships with Upjohn, we have some transitional services that we're going to be providing over the course of the next several years to support the transition. And of course, we have also a couple of manufacturing contracts that we have with them to support them as well. But from a biopharma perspective, we have been operating as if we were a stand-alone pretty much since the inception of Biopharma a couple of years ago.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

This is kind of a crystal ball question. Pfizer is not the only one to have had a collection of mature brands, but you are the only company that seems to have monetized it in a sizable way, all of a sudden, with one large part of the business essentially carving the company up into 2 pieces.

Do you think Pfizer will be a one-off in this regard? Or do you think this is -- you're kind of the leading-edge and that other pharma companies will kind of do the same sort of thing?

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Well, I think -- I mean, listen, we -- as Pfizer, we have existed in both forms, right? So you see the value in both. I think, really, it's a statement around what does the company want to be and where does it want to create value and how does it want to create value. And for us, having spent the last 10 years with Ian Read, our previous CEO, his mission to return us to an innovation-based company, we got to a point where it was just difficult to be both and to do both.

And so I think my answer to that is you can exist in the previous world because we certainly did and we created a lot of value with different kinds of value and now we're becoming something else. And I think it really just depends on what is the company wanting to do and how does it want to create value for its shareholders and for its colleagues. And we made a very clear and purposeful decision that we wanted to be innovation-based. And so that's what led us to where it is -- where we are today.

And I think that for those of you who participated in our R&D Day and saw the excitement that we have lined up in our pipeline, those things are only possible and we can only do more of that beyond -- and beyond if we're focused because that's what it takes to be science-based and innovation-based.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

So I just want to bring it back around to that question. Do you think other companies will do what Pfizer is doing and kind of carving themselves up in a similar way? And I know it's anyone's guess, but at a high level at the organization, I'm sure you talk to high-level people in other peer companies, why don't we see this sort of thing happen more often? Because it makes sense, it shrinks your base and it kind of refocuses you on the innovative side. So I'm trying to figure out why Pfizer is the only one that is doing that.

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

I mean, I think it's -- Tim, it's back to you, what is it that you want to do with your company? For us, we want to make sure that we're focusing our investments, our profits on creating greater pipelines rather than having a diversified portfolio that could give you growth and opportunities in a wider array of products. So I think it's just -- it can work both ways. We just -- one just needs to decide who do you want to be.

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Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Okay. Let's shift to something that's very timely, which is the COVID vaccine that you've codeveloped with BioNTech. I just want to say congratulations on that effort and that great data. It's obviously quite meaningful to the world. That must feel pretty special for Pfizer.

So a handful of questions here. We have 2 data sets now. We have your data on your vaccine, and then we have the Moderna data, and they're highly efficacious product, both of them. Does that set, in your opinion, the necessary bar for efficacy and safety for other vaccines? I'm trying to figure out, if other vaccines come in with, I don't know, let's say, efficacy at 80%, are they going to be relevant at all? Or is that going to be a market that only the high-efficacy vaccines of...

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Yes. So we are so pleased and so proud of our accomplishments and also congratulate Moderna on their accomplishments as well because, certainly, in a time like this pandemic, it takes all of us to be able to get to the other side of this.

I think that this efficacy bar of 90-plus percent, 95% is a real one. And I think that when you have a product that is as efficacious as this and that this efficacy is important because this is what we need to create the herd immunity around the world so that we can end this pandemic, I do think it sets a bar that will raise questions around, what if you're not 90% or what if you're substantially less, what is the role that you can play?

So it's really terrific that 2 companies with similar technologies have come out the gates so strong and set a very high bar for what the -- what humanity can anticipate and can receive. And I think that we all deserve this kind of efficacy because this is what it's going to take to end the pandemic.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Do you think the high efficacy you're seeing with your product and the Moderna product speak to the characteristic of the virus? Or do you think that speaks to the mRNA vaccine technology? Basically trying to ask you if you think other vaccines that maybe rely on viral vectors will show similar efficacy? So what's the thinking internally at Pfizer among all the vaccine experts there?

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Well, it's the first time that we have created an mRNA vaccine in the world for us as well as Moderna, so I think that there's a lot to learn about this mechanism of action. But there are some things that are very specific about this mechanism of action that you won't see in other technologies.

The first is that in the way that it is created, which is using a gene sequence, we're going to be able to replicate and to be able to remake it if the virus changes, right? So -- and because we're so early in the inception of this virus and what it really means, I think having the ability to be able to change and to make or remake a vaccine as the virus, the genetic sequence changes, if it changes, is a real benefit. And to be able to do that at speed, only an mRNA technology can do that.

The second thing that is really beneficial about this technology is the ability to boost, right? So there's been lots of questions asked around the duration of this effect. How long will it be? When will we have to reinoculate if we have to? All of these things are still unknowns to us today because we're still also following patients in the trial and following the trends around this virus.

So again, having a technology that will allow us to boost is critical in a time when there are so many uncertainties around what the virus looks like. So that's the second benefit that is unique to the mRNA technology, that it is boostable.

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And the third, which probably speaks most directly to your question, is that what we have seen with this mRNA vaccine is that it elicits T cell responses. And these T cell responses are critical because this is what gives us sort of the memory and the ability to drive the efficacy that we're seeing in the vaccine response. And that is also a unique feature of the mRNA technology.

So I think all in all, there is a lot going for this particular technology that lends itself very well to the time that we're in and for this technology to be a real solution for this pandemic. And I think that a lot of these 3 attributes are unique to mRNA and are difficult to replicate in other kinds of technologies.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

There's a lot of focus on the logistics or distribution, you can see it everywhere. You can see it in the lay press, trade publications, by companies, by analysts like me. How much of a concern is that? Do you think that's overblown or not?

And then specific to these kind of cold chain requirements, there is a difference, of course, between Pfizer's product and Moderna's. In terms of Pfizer, you need to store it at minus 70. Moderna, you can store it at minus 4. Does that make a difference? I know I'm sure in places like emerging markets, that could make an important difference.

In developed markets like the U.S. and let's say Europe, does that create a real logistical problem? And apart from cold chain, what are the other biggest logistical challenges that you see in terms of getting what's a very good product, it looks like, to the actual end user?

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

So another great question and a very topical one because I know that everywhere in the media, we are now pivoting from the excitement around the possibility of vaccines now, how we actually get out to the public and into the arms of people.

So first and foremost, I'm going to say that we are not concerned at all about the cold storage and we're very confident about it, and so you may ask why. We have to date 152 sites around the world who are receiving this vaccine as part of our clinical trial. So we know that the distribution and the logistics system that we have created to date for our clinical trials work. And so we have proof-of-concept that the logistics and the distribution are not insurmountable. In fact, they're doable. We're doing it every day now.

And our sites are everywhere around the world. Yes, many of them are here in the U.S., but they're also spread across the emerging markets, in Africa, in Latin America, everywhere in the developed and the emerging world. So we're getting a lot of practice already in terms of what does it take, and we have not experienced any issues at all. All of our sites have been able to conduct their trials effectively, on time and with no issues. So we already know that this works.

But to more of your question around concerns and what does this mean then, the minus 80, I think the way to think about it and the practical way to think about it is that the minus 80 is important because of the lipid nanoparticle components that we chose compared to what Moderna chose. We just chose different things. And the stability of the lipid nanoparticle that we chose is one that requires the minus 80.

But the onus of the minus 80, I think, falls a lot on -- more to us, because once we manufacture it, we need to be able to store it before we transport it and distribute it out to the various vaccination sites. And so that's why you've seen in the news, the freezer farms that we have created in our own facilities to be able to store them.

But for the administrator of the vaccine or to the sites that will receive the vaccine, a minus 80 storage is not necessary, and that's because we have created the thermal shippers. So the thermal shippers that we have designed specifically are storage units onto themselves. And they are -- they leave our facilities with dry ice, and they arrive at other facilities or the points of vaccination, where, if one chooses, one can replenish those shippers with dry ice and continue to store the vaccine at minus 80.

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Alternatively, if the point of vaccination does not want to do that, they are able to store the vaccine in a regular refrigerator for 5 days.

So I think there are a range of options that are available here for the -- for anyone at the points of vaccination and for the administrators and for them to choose which way they want to go. If they want to store the vaccine for longer, you certainly do not need a minus 80 freezer that gives you the option to store it for 6 months.

But in the time when we're doing such large amounts of vaccinations, it's probably unlikely that anyone would need, other than us, to be storing it for 6 months, right? What you want is a very agile distribution and logistics network that allows you to get the product when you need it. And that's what we're really focused on.

So really, practically at the site of vaccination, the shipper can be used as storage, and that's probably all you need depending on the volumes of people that you are vaccinating. And then in addition to that, you may not even need the shipper for all that long, if you're, again, vaccinating at high volumes where you can store the vaccine in the fridge for 5 days.

So yes, lots of options. But I think the critical thing here is, where do we need this vaccine to go so that we can plan the best route so that it minimizes any kind of -- it minimizes the storage facilities or storage considerations that the sites of vaccination need to have. And that's what we're doing right now, working with each of the states to develop their vaccination plans and where it is that they want the vaccines to be administered.

You may have seen that on October 16, a number of states provided their draft plans for what they believe to be their vaccination plan. And so Operation Warp Speed and the CDC are reviewing all of that. But in addition to that, you may have seen the press release that we made, where we're also conducting -- at least to date, we have pilots going on with 4 states to really support and partner with them to design these vaccination plans so that we can really minimize the logistics on the side of the receiver.

So over the next several weeks, this is really the focus now, to really build out the distribution and the logistics plans. But we have excellent partners who are working with us from a transportation and a distribution and a delivery perspective. And I think that, coupled with thoughtful and careful planning at the site of the vaccination center, will allow us to get the right amount of doses to the right places at the right time, minimizing the need for any prolonged storage.

And again, we are in a time of a pandemic where we expect for many, many people to be vaccinated, right, high volumes of vaccinations. And so any kind of prolonged storage really probably is not really going to be happening because you're going to be moving through it so fast.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Last question. Common average person, when can I expect that I would be able to get a vaccine in your opinion? So someone who sits at the top of the organization in that regard, what's your answer for the average person like me in terms of being able to get vaccinated?

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Yes. So as you know, with the data that we have now, we will be applying for an Emergency Use Authorization. And the Emergency Use Authorization is, by definition of what it is, is going to have -- is going to define what we suspect specific populations that will be prioritized first to receive this. And then we will also be continuing to collect our data to submit for a full approval of what we call a BLA, which is what you do typically for any vaccine.

And so I think the way to think about how people are going to receive the vaccine, it's that if you are in one of these high-risk groups that the CDC defines to be important and a priority group to get vaccinated first as part of this Emergency Use Authorization, then you will be part of that group.

And for people who do not follow into that group, then we -- the remainder of the population will be able to receive the vaccine when we have the full approval, the full approval from the FDA, which is the BLA. So that will ensue and that will follow over the course of the next several months.

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So depending on your risk group or people's risk groups, you could fall into the first category of Emergency Use Authorization or you could fall into the second category, which is the full approval.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

I'm in the second category. So could I expect to get a shot in first quarter?

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

We will have to wait to see what the FDA says. And they are obviously -- I think what's clear is that there is -- everyone knows that there's tremendous urgency around this. And the FDA has been incredibly just collaborative in working with us and with us sharing our data.

But we have to work through the formal mechanisms, as we always would. We want to make sure that we have an approval that is high quality and meets all the standards that it typically would. So we await for further instruction from the FDA as to how this will happen.

But all to say and to be rest assured that we're working as fast as we can. The data that we are collecting are being provided in all the ways that the FDA expects of us. And we're following all of the appropriate guidance and guardrails to ensure that we have a high-quality submission, both with the authorization as well as for the final approval.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Okay, thank you and congrats again on that.

All right. Let's shift to other parts of the Pfizer story because it's certainly not all about COVID. I wanted to talk about one of your lead brands, which is IBRANCE, a breast cancer product that stands fantastically well, a $5 billion product today. It's about 12% of revenues. It's one of the top 3 products within the company. And you're the market leader, by far, relative to the 2 other products in that market.

You're approved in metastatic. Obviously, there was a recentness in the adjuvant early breast cancer setting for Pfizer, whereas one of your competitors, Lilly, managed to hit on their data set. So it kind of begs the question, and this is really important, are all CDK4/6s the same? Your trial didn't hit, Lilly did, is that baseline patient characteristics? Is that clinical trial conduct? Or are there molecular differences between the drugs that gives them a different clinical profile?

Lilly would say, for example, that they think that the drugs are not all the same. My guess is Pfizer believes that the drugs are the same and that there are probably reasons to explain why adjuvant failed. So in your opinion, where does Pfizer net out? But almost more importantly, what's your perception of what physicians think? Because those are going to be the stakeholders writing the prescription.

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

All right. So I think -- let's start with what you said about the physicians and share a little bit of what it is that they think. I think, first and foremost, we have to separate our early disease from metastatic disease. And the first thing I'll say is that all our physicians and our KOLs believe that there is a difference in terms of the treatment goals and also what it is that you're really -- what you're trying to do in your treatment objectives when it comes to early disease and late disease, metastatic disease.

And this has -- this has been a consistent point of view that has been shared. So the reason this is important is because the findings that we had in early disease, therefore, do not necessarily translate and they don't translate into late disease because how they think about early treatment and what they're trying to do there and what they're using there, they don't believe has relationship with the way that they would prescribe and their choices for prescribing in metastatic disease. So that has been a consistent point of view from the beginning.

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And so when we think about, therefore, the -- what we saw in PALLAS and PENELOPE, which is in early disease, compared to our core businesses, which is metastatic disease, we don't think that the connection there -- we don't think that there is a connection there, too. From the perspective of the fact that we did not achieve the outcomes that we had hoped for in early disease does not necessarily mean that we are any less effective or that there is something that we -- that there are outcomes that we have not demonstrated yet in late disease.

Because certainly, we feel and we know, just through the 5 years of experience that we've had, the clinical trials and the data that we have published, both from pivotal trials as well as from our real-world databases, that what we have in IBRANCE in metastatic disease is a molecule that has demonstrated both its efficacy, its benefits to patients and even in the real world setting, which is a unique database that we have because we are the only ones that have been in the market for long enough to be able to generate real-world data, that we had a 42% reduction in death from IBRANCE in metastatic disease. So I think that, that really is an important thing, too, when we talk about the difference with the CDK4/6 inhibitors and how they behave.

I cannot comment on a competitor molecule and their compound and what it does and doesn't do. But I think what is very clear for us is that we have a winner in IBRANCE. And beyond what we've heard from KOLs in terms of how they think about IBRANCE and what you've heard now both early as well as late disease, they see IBRANCE as a leader in metastatic disease. That's been validated through, as I said, our real-world data. But importantly, too, when you think about the prescribers, right, like the proof and the demonstration is in their prescribing.

And if you look at the market share data that we have seen consistently over the last -- throughout the year and even including the publication of the monarchE data, IBRANCE is still the leading CDK4 inhibitor for first-line treatment for patients, both new and continuing. We've carried the same share, the same market share of 86%, consistently throughout the year despite the introduction or despite the readout of monarchE.

So I think that there are just a whole host of indicators that demonstrate that IBRANCE can and will continue its leadership in the metastatic setting and that what we have here is a lot of focus, frankly, on the metastatic setting because only 52% of the entire class of drugs being used in the metastatic setting are attributed to CDK4 inhibitors today, which means with all of this great data and all of the benefits to patients, whether it's from IBRANCE or other CDK4 inhibitors, we still have a long way to go in terms of really getting this message out to patients and helping patients be on it, right?

So only 52% of all patients are on CDK inhibitors from the outset. And what we know is that there is benefit there. So I think what we're really focused on is driving that class growth and ensuring that we can continue to get as many metastatic patients as possible on the CDK4 inhibitor.

I'll also add, because I know that this is a question that often comes up and is one that you've brought up, which is sort of like how do we stack up vis-à-vis competitors. And while that obviously is a very important question, and we have every reason to believe, and I've shared all the reasons why we believe we are a leading product in this class, what we also know is that class growth is important, and so we've got to do both.

Actually, we did some analysis looking at the value of a 1 percentage point growth in the CDK class. And that is, according to our calculations, worth $40 million, right? So our ability to grow the CDK class is going to create value and it's going to create opportunities, both for patients but also for companies. And so we've got to look at defending our share in metastatic, but we also have to look into growing the class because that is going to create far more opportunities in the long run.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Let's shift to Prevnar, another important product. It's the world's biggest vaccine, $6 billion a year roughly. That's what it likely does this year. 14% of total Pfizer sales, one of your top 3 products. We have new generations coming to market. Pfizer has one, which is a 20-valent versus the current formulation which covers 13 different strands. And we also have Merck trying to bring to market a 15-valent. So Merck falls somewhere in the middle.

Pfizer has said in the past, this is a winner-take-all market when thinking about next-generation products. Merck says that's not the case. If Merck is right, and that's not the case, what would be the reason for that? Is it by virtue of just the fact that they're one of the big global manufacturing companies and maybe in certain markets, they have a commercial edge? Or is there bundling with other vaccines that Merck can do?

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To me, it would seem intuitive and to a lot of people that a 20-valent vaccine, by offering more strain coverage, would really make it a single company type of market where a winner does take all. But where could we be wrong or where could Pfizer be wrong in that logic?

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Yes. Well, I think what you said about the ability of the additional serotypes to confer benefit is really the crux of the matter. The fact that we have 5 additional serotypes, but not just any 5 serotypes, the 5 serotypes that are attributed to the deadliest infections, mortality, so we're really focused on the right 5. And we know that the 5 additional serotypes that we have give us 33% more coverage against the strains that cause IBD in adults and 42% more in peds. So these are very compelling numbers and a very compelling benefit.

So that's why in -- we are firm believers in the fact that whatever the market looks like, PCV20 is going to be a dominant leader in this market. And that -- and we've seen that before, right? And if you look at around the world and in our history, if you look back on PCV7 versus PCV10 or PCV10 versus PCV13 and how those dynamics played out, having a greater number of serotypes that matter in the end is how -- is what we've seen in the market and that those were the products that won.

And so that -- we have obviously a huge history in pneumococcal disease and in pneumococcal vaccines, and we've seen this play out before between PCV7, 10 and 13. And now that we know what we know about PCV20 and the importance of those serotypes and the benefit that, that infers, we believe the same, that we are going to be a dominant leader in this market.

Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

We have time for one last question and just a short answer from you if we can because we've got to end the call. Abrocitinib, a pipeline product, you guys will be launching it in atopic dermatitis in 2021 hopefully. There's a kind of a bear case out there that the JAK inhibitors aren't going to get usage in this market from a risk/benefit perspective relative to the major competitor out there.

Just quickly, one of the talking points that helped deflate that bear case that says that this will be a product that gets used as a first-line agent in atopic derm.

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

I think the quick points and the facts supporting the use of abro are the following. That -- first and foremost, it is a huge market, there's 60 million patients suffering from atopic dermatitis today. And only a very small percentage of them are being treated with systemic agents. And even with the current agents, the current biologic that's on the market, there are still patients that are not fully served by that and are -- still many patients that are untreated. So that's the first thing is that there are huge numbers of patients that are really in need of this medication.

The second is that moderate to severe disease is a very serious disease. It is extremely debilitating, both physically as well as mentally. And so the unmet need in this regard and the risk/benefit profile of what we're going to have to assess for all of these patients is one that really is going to put the JAKs and abrocitinib in a positive light.

What you have is a drug that is going to be -- that has incredible efficacy, and we have demonstrated that head to head as well as in placebo-controlled trials. So what we know is that the benefit that abro can bring is something that is very much needed. And that when you put that against the risk/benefit profile and you sort of bring all of that together, I think what we have here is unequivocally a compelling case for an important drug that is much needed in a highly underserved market.

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Timothy Minton Anderson - *Wolfe Research, LLC - MD of Equity Research*

Okay. Well, with that, we're going to conclude the call, Angela. I want to thank you, Chuck as well from Investor Relations. Thank you. It's been a good discussion, and thanks for participating today. Goodbye.

Angela Hwang - *Pfizer Inc. - Group President of Biopharmaceuticals Group*

Thanks, Tim.

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