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PRESENTATION

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Okay. Great. Welcome to the mid-day sessions, midday East Coast at the end of the day, London time, but it's BofA Global Healthcare Conference. My name is Geoff Meacham. I'm the senior biopharma analyst here at BofA. I also have Bill Maughan for my team on. And we're thrilled to have Pfizer with us today. And speaking on behalf of Pfizer, we have Angela Hwang, who is Group President Pfizer Biopharmaceuticals. Angela, great to see you.

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

Thanks, Geoff. Thanks for having me here.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

We also have Chris Stevo from the IR team. And I'll hand over to Chris to say a couple of things from a disclaimer perspective, then we'll get right into questions.

Christopher J. Stevo - *Pfizer Inc. - Senior VP & Chief IR Officer*

I have the fun duty of talking about the forward-looking statements. So we're going to be making some forward-looking statements during the course of this fireside chat. We undertake no duty to update those statements in the future. And if you would like more information on our forward-looking statements, you can see further commentary on our SEC Form 10-Q and 10-K.

QUESTIONS AND ANSWERS

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Okay. Perfect. Well, Angela, let's -- I know that COVID is going to be a lot of the discussion today, but I want to kick it off just at a higher level and just to say that you guys have transitioned with a lot of partnerships and divestitures and concentrated just on the innovative biopharma piece. So you look a lot more like some of your pharma peers than ever before with no -- very little other businesses. I wanted to just ask you, give us an overview of where you are with that evolution to innovative biopharma and maybe what are some of the challenges or lessons to be learned thus far. And then obviously, we'll have a little bit of a forward-looking piece to that.

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

Yes. Thanks, Geoff. And again, thanks for having me here. It's a real pleasure to be able to spend the time with you and everyone on the call today to talk a little bit more about Pfizer and sharing our story.

So you're right, we have made a very definitive pivot into being a pure-play, innovative biopharmaceutical company. That doesn't mean that we weren't innovative before, right? It was always a part of our portfolio. It's just that we had our innovative business units as well as our multisource businesses. And some of these recent decisions that we've made to spin off some of our businesses has really given us an opportunity to then double-down and singularly focus on what we've always been doing and to really focus all our resources on it. So I would say it's a continuation but a really big and significant one of a journey that we began a long time ago.

And I would say that I think it's really bearing fruit. And why? I think we have some really positive evidence of this shift in our mindset, shift in the way that we are making resource allocation decisions and investments. We've talked a lot about our 25 by 2025. That is a huge velocity of new launches to bring over the next several years, and that was only possible because of this pivot that we've had.

If you look at our Phase 2 starts, those have also improved significantly over the last 5 years, right? We are now -- our Phase 2 success rates are double what they used to be and are actually exceeding peer medians. We launched the COVID-19 vaccine COMIRNATY in record time and brought an incredible innovation to the world.

And so when I think about things like that, they are big, big, I think, demonstrations of the kind of company that we always were. But now we have the opportunity to show because this is the only thing that we're doing. And so I think that the focus is one. And even if you think about our business development, Geoff, think about the last 2 deals that we announced, Arvinas as well as Trillium, they are great examples of the kinds of technologies that we want to invest in going early, looking for technologies that have opportunities to expand, right, beyond that sort of initial indication.

So hopefully, that paints the picture are sort of like where we are in that evolution, our pride and how far we've come in the short time, but really just a setup for so much more that we can do.

And then you also asked about sort of lessons learned. I think that, honestly, the most important thing that all of us as a company, have really sort of rallied around is this notion of this risk taking and the decision-making, right? Like, the fact that if you look at the COVID-19 vaccine program, and we had to make new decisions every single day in order to advance this. And even though I use this as an example, it is an example that now permeates throughout an entire company as what good looks like. And so it's been a very powerful motivator and a really a great example of decisiveness, taking the right investment decisions as well as moving with speed. So these are the things that we're going to continue to build throughout our company. And I think that these are the right elements.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Right. No, and you're right, and COVID in particular has translated directly into faster product launches, better growth, top, bottom line stock performance. It's definitely fulfilled a lot of the void. And let's focus on that a little bit.

From a COVID perspective, with the vaccines, talk a little bit about where we are in the booster shot kind of a continuum. I know tomorrow -- obviously, we had some briefing documents that came out today, and we've had 2 prior panel meetings, and they have stopped short of broadly recommending boosters just for more narrow populations. But I want to get your perspective, Angela, on the evidence supporting it more broadly and kind of how do you think it could play out in the next 6 to 12 months?

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

Yes. Well, I think the timing is right. Because actually this week with the upcoming VRBPAC as well as that's going to be the first step towards really understanding and looking at the data on a public basis. So I think we're really looking forward to the opportunity to be able to discuss this in the public domain. But you know what? All I can focus on is what data we have and what our data says. And I think you will see throughout the week, as the data are being discussed, that our data demonstrate an effectiveness of a booster, which is the third dose against variants and specifically and very effectively against the Delta variant and that we see this benefit broadly. And so that's what our data says, and that's what we will be discussing.

And so I think if you step back from that, I think where we are, and I think that JCVI yesterday is a good example of the kinds of discussions that are going on around the world that, big picture, boosting is important. Boosting is necessary. It is the way that we need to protect individuals as well as the public. And so we agree with all of those, and we look forward to sharing our data to demonstrate why 16-plus vaccinations or boosting is going to be beneficial.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Right. Yes. I guess when you look at the recent publication by some FDA officials, one of the elements that they said against boosters was that -- one of the arguments is, is that, well, it's not necessarily antibody titers, you still have some level of protection against the virus even if antibody titers start to decline. What are your thoughts on that? Have you guys looked at T cell responses, for example, over time and other elements of immune protection outside of just pure titers against coronavirus?

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

Yes. Well, Geoff, as you know, the trial -- our Phase 3 trial will be followed for 2 years. And so I think there's an element of -- we only know what we know today and that we will continue to learn along the way. So yes, we're looking at all forms of immune response beyond just neutralizing antibodies. And we're studying all of those. And I think that our knowledge base around all of that will continue to evolve and strengthen our case.

I think though that what is really important for us to all recognize is that the pandemic has been raging. It's been going for a really long time. And that in addition to, again, providing individual protection, it's also important that we find the right mechanism to end the pandemic, what can we do on a public basis. And I think that, that's our -- that's what our studies are trying to help demonstrate, which is what is the right vaccination approach or scheme that will enable us to not just infer individual protection but also help end the pandemic sooner rather than later.

And so I think all of those things weigh into and go beyond the very specifics of the T cells, the B cells, so on and so forth. But suffice to say that boosting helps with all of that. And so it's a real solution and a very serious solution that we all need to consider.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Great. Yes. And just along those lines, maybe just give us a quick status update on where you are on some studies and more special populations, kids below 12 years of age, expectant mothers, the Delta variant specific trials, things of that nature.

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

Yes. So as you know, we are intensely focused on ensuring that we can support broad populations of people because that indeed is the way to end the pandemic, which is our goal, right? And so that's why these additional populations and the studies that we have done are very important to us. I think that Pfizer has also been unique in the fact that our program is the only one that currently is extending into these younger age groups.

And so with that, you know that we had the 12 to 15 approved earlier this summer. And right now, we are amassing the data for the 5- to 11-year olds. And we expect to submit this data at the end of this month, actually, to the FDA and to begin our discussions for an emergency use authorization there. Following that, we are also going to be submitting our data for the under 5-year old, so the 6 months to under 5-year olds. And so that submission will follow the 5 to 11s.

And then in addition, and in parallel, we're also studying data in understanding the vaccine and immune levels in pregnant women. And those data should be available early 2022. And then beyond that, we're always -- I think we're on high alert in terms of following and monitoring any of these variants. So as you know, the reason why we even came up -- we were able to have this booster data is because we have been following it. And our data will demonstrate the efficacy and the effectiveness of the current vaccine against the Delta variant.

But of course, you know that we always have to be on the lookout for new mutations and new variants. And so I'm also rest assured that if, at some point, we need a new vaccine, that's also something that we've thought about, planned for and we can do in short order. In fact, with an mRNA technology, you can produce a new vaccine in 110 days, right? So we're sort of thinking about the current vaccine and its forms, different formulations, different pack sizes, different populations and ages, as we've just discussed, but we're also keeping an eye out for, in the event that we need a whole new vaccine, what would we do.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Right, right. And just to follow on that, what would you -- so the third shot or having 1 booster is kind of the conversation today. How regular would you think that this could be? Would it be an annual? I know some companies are talking about the combination of flu and COVID. But I wasn't sure -- obviously, we won't get any science on that for a while on when we'll need it, but what would sort of be the bookends of your expectations for how frequently, over a longer term, one may need a COVID vaccine?

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

Well, as you say, only time will tell, right, because we have to follow this population for the full 2 years to really understand the entire life cycle of how all this happens. And that's exactly what we're doing. But short of that, what we think is we need to do the third booster and potentially do it seasonally, sort of on an annual basis thereafter. So that's a hypothesis to be proved out by the follow-up and the clinical trials that we're continuing to do. But that is 1 proposal and sort of directionally where we think it could go. So we do believe that we need this third booster and then to be followed by an annual thereafter. But again, as you say, we have to let the data play out.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Right, right. And then last question on COVID, I promise. When you look at the move from -- or the formal approval from an Emergency Use Authorization, is there anything commercially that you saw? What types of patients were those? Did you see a big acceleration in volume when you formally got FDA approval? Just trying to get a sense for what the tipping point is for some of those unvaccinated folks out there.

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

Yes. Well, the time that we got the approval of the BLA was also, I think, a time when sort of we saw a rise and -- a significant rise in Delta, right? So when I look at what happened in July and the number of vaccinations, like first-time vaccinations that happened in July, it was something like in the order of like 9.6 million people had their first vaccinations in July. And that jumped up to like 13.2 million in August.

So clearly, we saw a big jump between July and August. And I think that, that jump is a function of the fact that we got the BLA, the full approval and the full licensure, giving the public even greater confidence in the vaccine. But I also think that, to the point about Delta and the prevalence of Delta, it was probably both of those 2 things coming together that really drove a much greater awareness of the need to vaccinate. So I think we need to just continue to drumbeat because we still have quite a long ways to go in terms getting people vaccinated, but we have definitely seen a jump between July and August.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Okay. Great. That's helpful. Let's switch gears and talk about abrocitinib and your JAK franchise with Xeljanz. Just wanted to get -- now that you've had some time to think about the FDA new guidance for -- or the language on Xeljanz, on the label and then the step edits. What are your thoughts about maybe what commercial implications could that have for Xeljanz today and then we can talk about abrocitinib and the implication there, too.

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

Sure. Well, first of all, I mean, Xeljanz is probably one of the most well-known and well-studied drugs in the world. And its utilization in just hundreds of thousands of patients have demonstrated to us globally, around the world, a comfort level and a familiarity with this. 1133, which happened in February brought a new piece of data into the mix. By the way, that was not new data. It was -- because we've always known the absolute risk, right, of Xeljanz, 1133 was about a relative risk relative to anti-TNFs. And so that has been the analysis and the discussions to date.

And I think actually, the most -- probably the most important impact that it's had on Xeljanz is in the new patient starts because physicians were left with the uncertainty of -- without the clarity about what do I do with this information. And we just received FDA's statement, the DSC, just recently on that. But up till then, physicians are left with this uncertainty of like what do I do with this. And I think that, that is what has led to a decline -- a slight decline in our new patient starts. So if you look at our continuing patients, that didn't change. So at this point of the familiarity, the comfort, the belief in Xeljanz, that continued. It's just that when you came to be a new patient, that's where we saw a decline in what we -- the usual rates of new patient starts. So that sort of explains, right, why, because of this lack of clarity.

So I think, first and foremost, the fact that we received this DSC the other day is a helpful step. I think it was helpful because it also talked about the fact that this is not just about Xeljanz that the FDA is thinking about this as a class. And I think that that's also clarity that our physicians now have. And then the most important thing is sort of getting towards the final step, which is getting a label because once we get a label, everyone will know what to do and to whom and what are the populations that we need to be watching out for and having the conversations around.

Even with all of that, I'll just remind everyone that what you saw from the DSC the other day, which is a recommendation from the FDA to use Xeljanz after TNF, that, in fact, is what's happening today. 80% of all Xeljanz use is after TNF. There's very little in first line or in monotherapy, right, or post methotrexate. Most of it is post-TNF use. So I think that this behavior of writing Xeljanz after TNFs is, in fact, the predominant prescribing approach today. So that doesn't change. And so I think what we'll be able to do with clarity of a label is to sort of reset, have clarity around what we can say, how we can continue to educate. And I think that, that will just honestly give us the opportunity to have the right conversations with physicians and to focus on the right patients.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Right. Yes. And just to your point, you're right, this information is not new. I guess a lot of folks forget that the data at beginning of the year was the final analysis, but the interim analysis was several years before that. And so none of it's new. But I wanted to ask you, though, is there a risk that payers can somehow use the sequencing after TNFs to help dictate formulary? Or is it just pretty much a status quo impact to the market?

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

Because it's -- to your point, because it's after TNF and that is, in fact, the way people do write today Xeljanz, like 80% of all Xeljanz is written after TNF. So that formulary status isn't going to change because that is the formulary status today.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Yes. Got you. Okay. Yes. And then when you think about the potential for abrocitinib, obviously, the data looks fantastic, very clean. For a lot of the next-gen JAKs actually, you don't see -- they're both remarkably clean. But yet, to your point, FDA is sort of putting them all in the same category when it comes to class labeling. But just remind us of where we are today with the approval cycle for abrocitinib, and then how you think that could be affecting the differentiation that you guys may hope to provide between Xeljanz and abrocitinib.

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

Yes. Well, I think what's really terrific is the fact that abrocitinib is already approved. Our first approval globally was in the U.K., and it was approved at both doses, the 100 and the 200 milligrams. So I think that sets a strong tone for what we -- for all of us to really understand how do regulators

-- or how could regulators think about this, what do they see in the data. And importantly, I think it tells us a very strong story around the unmet need that exists in the atopic dermatitis space, how few options there are, how heterogeneous this disease is and the reason why you need multiple options, right? And I think the U.K. is a great example because we were also given early access by EAMS. So that's an added step of like how much do we need this medicine and how quickly do we need to get it out there. So I think that's the first thing that I want to say. I think that, that is just a huge piece of evidence.

That being said, the FDA does want to take the time to really understand what this does mean for the class. Certainly, they are looking for the Xeljanz and the RA category, that's a class, Rinvoq and the other JAKs are being put in the same bucket and being considered for some sort of like class labeling. And so we'll have to see what this means for abrocitinib.

But regardless of how this turns out, I think what is really true is the following, and we've said this all along, that they are just a -- there are a significant amount of patients that are suffering from this very difficult disease and that there are not enough systemic options out there. And all of the JAKs and, in fact, all medicines have a risk-benefit profile. And so there will be a role that abrocitinib will play in the lives of atopic dermatitis patients. And I think that the final label will then help us to understand again who are the patients, where do we target.

But the unmet need and the size of the patient population doesn't change, right? There's 60 million people suffering from atopic dermatitis. Less than half of them today or barely -- less than half are using any kind of systemic therapies. So just right there, I think you can understand why there is such an unmet need and that there is a role for multiple mechanisms and multiple products to play, and we intend to play a very important role in this regard.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Right. Yes, I wanted to go back to one of your comments about the impact of the FDA communication on Xeljanz. And you mentioned that the ongoing patients weren't affected, but new starts were. When you think about the persistence and the duration of therapy for Xeljanz, do you expect it to be shorter than abrocitinib going forward? Are they going to be more alike than different? Or I'm just trying to tease out maybe the nuances between what you'd expect the 2 JAKs to have in terms of durability of effect.

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

Yes. That's really difficult to compare for so many different reasons. I mean both are completely different diseases.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Yes, different indicators, I know.

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

And also the age groups are completely different, right? When you look at -- even if you look at Xeljanz, the rheumatoid arthritis patient compared to the psoriatic arthritis patient compared to the UC patient, even different ages in there. And so atopic derm is going to be the same. I mean atopic dermatitis spans a fairly large age group. There was a lot of younger patients in there as well. 1133, just to remind everyone, was also enriched for patients with multiple CV risk factors, right? Like, that's what that study was about. We're studying it in not all age groups and not all kinds of risk factors, specifically enriched or sicker people. So it's just really -- it's impossible to compare between the 2.

All to say that, of course, being that RA is a chronic condition, we do see good duration, meaning adherence and long adherence to Xeljanz. And we're going to have to see with atopic dermatitis like what in reality plays out, not just what happened in the trials but what in reality plays out. It is also a chronic disease. So I think that we will see the persistence and adherence play out, but it's just impossible to compare the 2 from that perspective.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Okay. I thought I'd give it a shot. Well, let's go from high volume to medium to more of the orphan opportunities for you guys. And Pfizer, I think, is the largest company to have sort of a rare disease prowess and a really robust rare disease business. I wanted to ask you more about tafamidis and where you guys are with respect to TTR identification, diagnosis rates, things of that nature. Have some of the awareness efforts borne some fruit to help identify more new patients going forward? Just catch us up with where you are in the adoption curve.

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

Well, when we launched tafamidis, we were singularly focused on finding -- suspecting who these patients were because they are being so misdiagnosed. And in doing so, we're not -- we've not been able to sort of effectively, right, target and surface who these patients are. So we've been intensely focused, as you know, on diagnosis. It's something we talk about almost every quarter from the time that we launch, what our diagnosis numbers are.

So I think through a couple of things, through the work that we've done in suspecting the patient, right, what are the risk factors, what are the red flags that might lead you to believe that this particular individual might be at risk for ATTR-CM and then through the noninvasive imaging techniques that have been applied, I think that we've been really successful in finding these patients.

So as you know, and this is written in the literature, that typically, for a rare disease to date, diagnosis rates are at best somewhere between 30% and 50%, right? And if you look at where we are right now with ATTR-CM, our last quarter, we had what we believe to be a 27% diagnosis rate of those who are suspected with this disease. So I would say that the approaches that we've taken since the time that we've launched are working well. We are finding these patients. And the imaging techniques as well as, like I said, the red flags and creating suspicion, they're all working well.

And so I think what we've learned is that this benchmark of 30% to 50% diagnosis is we aspire for more -- we aspire to be that, right, on the top end of that and if we can go beyond that. And I think we're getting there faster than we thought. So I think those are 2 good things that are stacking up for us and for VYNDAQEL.

The other thing that we've been focused on as well, and this is an epi study that we'll report out in 2022, this is also a question that I get asked all the time, which is, well, how big is this population? And everything that we've done to date empirically leads us to believe that where we were, which is what we said, we estimate that there are about 100 sufferers of ATTR-CM in the U.S. and 500 around the world. We haven't found any data to refute that. But we know that we need to continue to really understand this more. So we've seeded an epi study, which will pan out next year, and we'll be able to answer that question more definitively.

But I think the most important thing is diagnosis is going well. We're doing and we're also trying -- we've implemented innovative techniques to try and understand how to suspect and identify these patients more and using different -- just using different mechanisms and different tools. So I think this is what's all adding to our ability to find them and to get them treated.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

And just along those lines, are there successes that you've had in some pockets, say, some countries in Europe or some regions in the U.S. that were more successful than others in helping identify that you could more broadly implement globally? I just wanted to kind of at the micro or the local level, are there techniques for identification that have worked better than others?

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

Yes. Honestly, what has worked the best is these sort of -- it's the red flags. It's like who is suspected or who do we think is suspicious for ATTR-CM. And we came up with a list of 10 things that are very easy and very pragmatic to be used in any doctor office, right, in any cardiology office. And

honestly, it's been that. And once you suspect that someone is at high risk for this and you follow that up with this imaging, that's when we've been able to have the highest success rates. And so it's about getting these red flag -- it's the awareness, right, making sure that physicians or physicians that are screening or primary care physicians understand what these red flags are. It's about making sure that there's referrals, the typical things that you would need to ensure that you close the loop. If you suspect someone, you want to make sure that they get the imaging.

And then where we're just, I would say, upping our game is just sort of using technologies, right, not just here's the 10 red flags, but are there electronic -- are there algorithms that you can do, use and predictive analytics that you might apply to model out a population and people within a population and who might be at risk. So these are the kinds of new technologies, that's what I was meaning, that we're using to try and find more.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Okay. That makes sense. Sticking with rare diseases and the DMD program, just help us with -- kind of give us a status update on where you are and how you think ultimately the competitive landscape is going to shape out just because DMD is, to your point, you're looking at these big unmet needs in larger orphan markets.

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

Yes. It's certainly a significant unmet need and one that we're very focused on. Again, I'm unable to talk about other people's programs. So I'll just talk about my own. But we're really proud of the fact that we have a Phase 3 study and that this study is a global multicenter study. So we'll be following 99 boys from the age of 4 to 7 ambulatory, and we're looking at this sort of around the world. So we're really trying to expand the way and using sites around the world to be able to capture the right number of potential patients and be able to give us the learnings that we need to move fast. So I think with this sort of -- with the size of this multicenter program that we have and where we are, we have the potential to be the first to market.

Importantly, we're supporting all of this by making sure that we have the right manufacturing capabilities to be able to supply, right, and be able to commercialize this if we're successful. So we have 3 gene therapy sites that have already been set up that have the capabilities to be able to scale up to provide the therapies. So we are working hard on this. We know that this is important. There is a huge unmet need and stay tuned.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Got you. Okay. That's helpful. Let's switch gears to the cardio portfolio. And I want to get your perspective on vupanorsen. Just help us with kind of where you are with the Phase 2b. You guys have talked about this being a $3 billion peak potential opportunity. I mean you look at the total size of the population and the potential indications, obviously, it could be much larger than that. Would you just catch us up to kind of where you are with that today?

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

Yes. So as you say, this is -- it's a huge opportunity. And it's because, even though we have had so many innovations and so many treatments in cardiovascular disease, there is still significant unmet need. Beyond the LDL-C lowering, there's still at least 6 million people here in the U.S. that remain exposed to cardiovascular risk because the issues are beyond LDL-C lowering. And then there is an additional 2 million sufferers of triglyceridemia. So just there alone, you see the sort of the size of the potential patient population that could benefit from treatments in this area. And that's where vupanorsen comes in.

We're looking at trials that are going to be focused on cardiovascular risk reduction and also in trials that really look at the -- I mean how to meet the unmet needs in triglyceridemia. The trial that's coming up soon, the Phase 2b trial that probably you're thinking about, is an important one. It's the next one. That's going to be coming up. And in that trial, what we hope to demonstrate is that there is a change in baseline in the -- in LDL

-- HDLC lowering compared to baseline, right? So looking at what that is, that's our primary end point. And then there will be other secondary end points and other CV markers that we'll be measuring.

So that's sort of like the next milestone that we're looking for, which is in 2022. And that will then inform the opportunity here and what we understand of this particular program.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Got you. Okay. Well, let's wrap up with maybe a higher level question. You guys have done the 2 recent BD deals, Arvinas and Trillium. And I wanted to get maybe your perspective on external innovation BD going forward. How does Pfizer view the need for deals? I mean, obviously, there is -- bolt-ons are straightforward to do. But is there a category or is there a part of your portfolio that you would really like to enhance that you think is ripe for more value-add with the BD? Or is there something that you think is interesting out there but still a dramatic unmet need?

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

Well, we talk about this, I think, almost every quarter at our earnings calls, right? And I think that what we truly believe in is that we have an opportunity to bring in great science, and that is across our different business units. We are deeply focused on ensuring that each of our business units have the substrate, whether they're internal or external, to be able to advance their pipelines. And actually, we're in a really great place. I mean I've been here 24 years, and there was definitely a time when there were certain disease areas or businesses you would want to be in or not be in because of the number of launches, and I can truly say that every single one of our business units here at Pfizer have tremendous opportunity and are working on great breakthroughs. And so every single one of them are firing off in their own different ways. And so that's how we see our external pipeline.

We believe that we do have an opportunity and we should be enhancing our internal pipeline with external technologies. And that's what we're looking for. So I think that Trillium and Arvinas are 2 great examples of the kinds of things that we are interested in, which is that they are earlier stage, that we have the opportunity to develop them and sort of be part of their future. Being part of their future means that we see a potential for this technology beyond the sort of like immediate and the one indication perhaps that it's already being worked on and that we see additional opportunities to expand either to different populations within the same condition or different conditions. And I think that with both Arvinas and Trillium, they are examples of exactly that, right?

So let's just take Arvinas, breast cancer, like absolutely in our wheelhouse. We see this as an opportunity to play out, whether it's in monotherapy or in combination, combination with our own therapies or combination with others. And so it's a great example of sort of the expansiveness of how -- of the things that we look at when we are looking for our deals and where they can go beyond the immediate thing.

Trillium is exactly the same thing, right? We have the opportunity to first look at lymphoid malignancies. That's our initial focus but also has the opportunity to go into solid tumors. So we have a lot of spaces to explore. And when you get them earlier, yes, you have to take some risk but in that, is the ability for us to also shape the future of these molecules. So that's the role that BD plays and we see it as a very important part of complementing what we do internally.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

Okay. Well, with that, we are out of time. So Angela, thank you so much. It's been a great dialogue here and look forward to doing this face-to-face, hopefully, sooner than later.

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

Likewise, Geoff. Take care.

Geoffrey Christopher Meacham - *BofA Securities, Research Division - Research Analyst*

All right. Take care.