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EDITED TRANSCRIPT

MRK - Merck & Co Inc at Deutsche Bank Health Care Conference

EVENT DATE/TIME: MAY 09, 2018 / 3:20PM GMT

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PRESENTATION

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

At last, good morning folks. Welcome back. Greg Gilbert here. I cover Pharma for Deutsche Bank. Thank you all for attending or listening in. I'll be reading this transcript later. We're very pleased and fortunate to have Merck here; Frank Clyburn, who is President of Global Oncology; Teri Loxam, runs the very capable IR team. We're going to go ahead and get started with a sort of informal format and certainly happy to take your questions if you have them towards the end. I thought Frank, welcome back. Maybe we could kick it off with looking at (inaudible) just a little bit in getting us up-to-date on the organization that you run. It's quite a bit different now than it was a couple of years ago. So may be just kind of size and structure of the organization and what the key priorities are today and over the next year or so? And we'll take it from there.

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Sure, Greg. Thank you, and it's great to be here this morning. And at Merck, it's a lot of excitement taking place in particular within the oncology business unit. We had a chance to form this unit, back prior to the launch of KEYTRUDA as we started to see the promise. And I've had the chance to work in the industry now for about 30 years and worked in oncology at an another company. But what we did, we had the opportunity to build this out from the ground up. We went and hired some of the top oncology experienced professionals in the industry, folks that have worked on a number of key oncology brands around the world. The organization now is several thousand people. We have now launched in over 80 countries, KEYTRUDA and have reimbursement in approximately 50 countries around the world. So it's a global business unit, with I would say, top talent from oncology experience folks in the industry as well as some of our top internal talent. And we actually think that really helps us especially with the global nature of this business. So we're very excited about the team that we've assembled. And obviously we're focused on launching KEYTRUDA right now around the world.

QUESTIONS AND ANSWERS

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

It seems like years ago where we're asking companies, how many reps you have and now it's sort of the end of it, but maybe you could put a little more color around the types of folks you have? Whether it's straight up reps or medical science liaisons are much bigger access team than in the past. So what's today's version of that question of 5, 10 years ago?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Sure. So the commercial models around the world have evolved in many markets, you still obviously have what we have is our sales professional, sales representatives. However, we have a very strong medical sales liaison team, so our medical affairs team is of a very strong significance and markets around the world. We also have 3 account managers, which are roles that are in place to engage with some of the top oncology key account manager -- or key accounts around the world. We also have a very strong market access presence. So outside the U.S., because of reimbursement,

we have, at Merck, not only a strong market access function, we have a core function that focuses on observational research. And we obviously work very closely with our managing directors around the world as well. So the model has evolved, and we have top talent in each one of those positions and rolls around the world.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

And to what degree do you and your team interact with Roger's team from an R&D standpoint? And how is that from trial design or what you need to do a better effort commercially, and what he needs to do a better job? From an R&D standpoint, I'm sure he loves taking advice from you.

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

So it's very well integrated. We have actually, what is called product development teams. And for instance on KEYTRUDA, we have product development teams, they are set up by tumor type. So on the product development teams, you have someone that is from the clinical development organization, someone from the commercial organization, someone from the regulatory organization. So we're very well integrated with our research colleagues. And each one of those PGT, is looking at the landscape within that cancer type to think about what are the clinical trials that we need to do, what is happening in the marketplace today, how is standard of care evolving within that cancer type. So we have a very integrated approach between our commercial and clinical organizations.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

I remember when Bristol was first out at melanoma and you were sort of behind, folks were skeptical about your ability to kind of field in oncology efforts, today we have history of melanoma. And I'm sure you don't get the question anymore, but can you talk about what's changed since the melanoma, early days of KEYTRUDA launch to now. Is it just the number of bodies required to scale up and go after along, or were there other fundamental changes that have occurred as the business has gotten much larger?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Sure. So when we first launched in melanoma, it was our initial indication, and I do remember those questions. And we had the opportunity to establish KEYTRUDA very quickly as the standard of care in melanoma and actually in many markets around the world, we still lead in market share with regards to melanoma. Obviously with the expansion of lung and now 11 different indications, in the U.S., we've had to expand our sales force present. So we went from a single team of approximately 100 representatives in the U.S. as an example, and now we have several hundred representatives in the U.S. that are now supporting not only melanoma but supporting lungs, supporting head and neck, supporting our bladder indication, or MSI high indication as well as our gastric indication. So we've expanded out our teams around the world. And I feel as though we have very strong presence, good share of voice in just about every major market around the world.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

So let's jump into that some of the issues. Let's talk about KEYNOTE-189 and maybe give us a flavor for how quickly do you think the use of that regimen will ramp up? We can obviously look at IQVIA data, but you have some better data sources I suspect. So how quickly do you expect that to ramp?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

So with regards to KEYNOTE-189, we're extremely excited. The feedback that we are receiving from key opinion leaders, not only in the U.S. but around the world, I think has been extraordinary. We left ACR, and we very rapidly had a chance to communicate the results of 189 and the New England General Medicine Publication. So KOL feedback has been -- they believe now within the nonsquamous, non-small cell lung cancer patient

population. Remember 189 is an all-comer trial. So across all nonsquamous, non-small lung cancer patients. They believe that this is the new standard of care. So what we are seeing now happened in the marketplace based on that encouragement, we do think we will start to see broad adoption over time. There is not a bolus of first-line non-small cell lung cancer patients. However, if you take a step back and look at what's been happening in lung cancer, we establish KEYTRUDA already in the high PD-L1 expression patient population based off a KEYNOTE-024. We start to see use, and we're getting use with our combination. Remember, this combination was actually approved last year in May of '17. We started to see the combination used in PD-L1 positive patients. However, we have been saying that the opportunity really was in the PD-L1, negative patient population as well as the untested patient population. And based off of KEYNOTE-189, one of the most important aspects of that trial was not only that we reduced the risk of death in half compared to chemotherapy as a standard of care overall, which is outstanding results. It also was the importance of the subgroups. And when they had a chance to see the different subgroups, especially the PD-L1 negative patient population and saw that it has the ratio of 0.59% or reducing the risk of death by almost 40%, we think that actually really helps with regards to the adoption of this combination. Because that was one of the questions that some oncologists had, as they wanted to see that data set from 189. So we feel very excited, we feel we're very well positioned. And I think over time, we do expect broad adoption in nonsquamous, non-small cell lung cancer patients.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

To what extent do you think updated NCCN Guidelines will be an important event driving that? In this case, is there really just coincident with what you already expect?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Yes, we're already, so the combination of KEYTRUDA, ALIMTA, carboplatin is already on the NCCN Guidelines. It actually was put on the guidelines last year, and it's on as a category 2A. We do anticipate with the overall survival benefit that we now have with 189 that we are hopeful that the guideline committee would update and make this a category one with regards to NCCN. However, from a reimbursement perspective, being on NCCN from last year, it's not really a significant change, but it obviously, would be good if we were upgraded to a category one.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

When do you expect the second line market for PD-1 to sort of melt away, when does that start to really show up?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Well if you look at what's happening right now, clearly KEYTRUDA is being used today in the first line setting as I mentioned in both monotherapy and combination. And as we start to see broad adoption of 189, we do anticipate that the second line market will start to decline. We have to see how it plays out from an overall timing perspective, but we do anticipate second line will decline.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

Okay, great. So your key competitor, one of them Bristol is confident that there will be an important role for chemo-sparing regimen, and that's the term they use quite a bit in non-small cell lung. So what is your view today on how I-O plus I-O will fit into the lung cancer treatment paradigm? I know from an R&D standpoint, you're positioned to catch up. It maybe in that regard and are exploring all possible options but as you sit here today, how do you think I-O/I-O will fit in?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Well with regards to currently, we have to -- I think keep coming back that overall survival is the overall gold standard, especially in treating lung cancer patients. So we feel very confident with 189, we feel as though the overall combination should be used for all nonsquamous patients and

all appropriate patients. So as far as the chemo-sparing option, I think even if you look at the high expressed patient population, where some people are looking at and saying would you use KEYTRUDA monotherapy versus the chemo combination. That's something that we think is going to be more of a physician-patient choice. But I really now don't see a chemo-sparing option, at least as we see the data today. As things evolve, we've always set our combination strategy. We've been agnostic to modality, so we have a very broad combination program. We are exploring I-O/I-O combinations in lung. So it's something that we're clearly exploring. But for right now, we believe that with 189, the bar honestly has been raised pretty high. To have the overall survival benefit that we showed, we think that sets the bar high, both, not only from a commercial perspective, but as competitors as well as ourselves think about new trials that will need to come to actually show better magnitude of effect for those combinations. We think that something that clearly is going to be a challenge in the future, so we feel like we're positioned right now very well.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

So regardless of whether the survival data is good or bad relative to your I-O/I-O combos, do you and your folks think there is a subset of folks that would prefer I-O/I-O over I-O chemo? Is there sort of an acknowledgment that there's some folks that would care? It's just a question how large that niche is?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Yes, I actually think that you're going to have to have a magnitude of effect size from the new combination that would at least have to be close to what we're seeing with chemo plus KEYTRUDA. There are oncologists that -- for patients that have a certain performance status or comorbid disease that they may want to not use chemotherapy, but what's really nice in that option is that we have monotherapy KEYTRUDA. We have monotherapy KEYTRUDA in the high expressed patient population, we did mention, we'll be sharing some additional data with our monotherapy KEYNOTE-042 trial as well as we also have our keynote combination and squamous patient population as well. So when we look at, how the marketplace is currently treating -- or how oncologists are currently treating lung cancer patients, we feel as though we're very well positioned. I also think it's very important that we do put in the context that ALIMTA, carboplatin and KEYTRUDA are very common regimens in treating lung cancer patients. So while there may be some oncologists that want to move to new regimens, the fact of the matter is that they're very comfortable with the toxicity profile of these regimens today. And I think that is very, very important. And while there may be new combinations coming, there are often -- they're always going to balance the efficacy get with the additional tox profile and then how do they best manage that for patients. So I think that is also an important consideration as we think about, how things are going to evolve in the future.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

In the last couple of months, especially following ACR, there's been a lot more questions around this concept of TMB and its potential role in lung and other cancers. So can you talk about Merck's work around TMB? And how important you think that biomarker is or could be?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

I think: one, we feel as though TMB is important scientifically. It is something that we are going to continue to evaluate. However, with regards to lung cancer, obviously with our KEYNOTE-189 trial, where biomarker testing is not required, it's an all-comer trial, we feel as though that positions us very well. And a couple of things that came out of ACR from the discussion that, I think, were really important that actually, I think, kind of summarize our position, very important scientifically. However, TMB has not been predictive or associated to this point with overall survival. It's just with progression through survival. In addition, TMB is not standardized, and I think that's very important. If you think about what Merck has done over the last couple of years, we establish PD-L1 testing in lung cancer. But PD-L1 testing was correlated with overall survival. And also it's a very simple test to administer a simple IAC test, and it's very easy to use. The other thing that TMB requires is significant amount of more tissue, which I think as you think about in the community setting, that is going to be a challenge, as this gets rolled out broadly potentially. And then lastly, the cost of the actual biomarker is 5x to 10x, the cost of an IAC based test. And the turnaround time, I mean if you think about lung cancer patients, they have to wait for several weeks for the results of a tumor mutational burden test. We think that also can be a challenge in the

marketplace. So our position is -- we think it's important scientifically, it's something that we're exploring. However, we at this point in time do not believe that it is ready for broad use from a patient perspective in lung cancer patients.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

Are there any signs yet that payers are looking for you and other companies to sort of define patients that are unlikely to benefit and therefore not get reimbursement? To some degree that's part of the Bristol going around TMB is that over time, the system will look for better definition around who was likely to benefit? My counter to that as if, someone benefits that's PD-L1 negative or TMB negative then they're still going to get the drug, right? So your thoughts on how payers would like you to sort of segment the market into responders versus non?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Well actually, I'll take it from 2 different points. Payers in the U.S. right now, we have very broad reimbursement for KEYTRUDA, monotherapy and also KEYTRUDA contribution in the U.S. And right now, we do not see any segmentation taking place from a payer perspective in the U.S. Outside the U.S., clearly payers really look towards the benefit of the product compared to standard of care and they really look at overall survival. And we feel like we're very well positioned with regards to our monotherapy, overall survival benefit that we've now shown not only within lung, but within bladder cancer and within a number of other cancer types, melanoma et cetera. And then if you look at with -- KEYNOTE-189, with the magnitude of the effect of that trial, we feel like we're very well positioned with discussions with payers as well. So we don't see payers necessarily segmenting out certain patient populations. If you think about what we've done around the world with KEYNOTE-24, which is our monotherapy indication, that is in the high expressed PD-L1 patient population, where we had a significant overall survival benefit versus standard of care. And payers are reimbursing that product pretty widely now, based on the magnitude of that effect. So we don't anticipate that they will go into sub-segment to try to identify, they really look at overall survival benefit. And what that brings to the overall treatment regimens that are available in their countries or markets around the world.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

I want to take a pause and see if anyone has questions before I shift into some of the combinations. And you can raise your hand at any time, I'll notice you. Just a little bit off the big track, I know Roger would have a view scientifically, about this question, but I'm curious about your commercial colleagues and your customers view on, whether there are actual differences between PD-1. And whether there are differences between PD-1s and PD-L1s? So you think there's a perception growing out there on either of those fronts?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Well, we believe that -- what we're hearing is that some customers and some opinion leaders did even started to mention that there may be a difference between the PD-1 and the PD-L1 antibody and that's something that we are starting here with some customers, at least bring up. I do believe that the way in which we have executed our clinical program for KEYTRUDA and the benefit that we have seen in showing overall survival now with 24, with 189, with 42, in bladder now in second line with KEYNOTE-045 where we showed an overall survival benefit. I think that many of the oncologists I engage with are basically saying that they're not sure if there's a difference between the antibodies, but they clearly see the benefit of KEYTRUDA and are very comfortable with using KEYTRUDA and are very clear on significant overall survival advantages we now have shown across multiple different cancer types . I think, it's now 7 different cancer types what we that he has shown overall survival benefit. Also in monotherapy in lung, we are the only, right now PD-1 that has shown an overall survival benefit in lung cancer, even as monotherapy. So we'll have to see how things evolve with regards to the marketplace and the differentiation over the next couple of years. But we feel as though KEYTRUDA based on its very clear overall survival benefits across multiple cancer types are giving people a lot of comfort with using the product. I think Roger and I also talked a lot about this wall of data. And I think that's probably as important, because as oncologists get comfortable with using a regimen across many different cancer types, we believe that actually is what helps the differentiation. And clearly they are becoming very comfortable in using KEYTRUDA, not only in lung cancer, but in lung and many different cancer types and with a breath of our overall program, now at over 700 clinical trials and 400 combinations, we think that the data that we are now building, both in monotherapy combinations with targeted therapies,

combinations with the I/O agents, we feel that that actually is going to be what important differentiates up in the future as well as our first mover advantage in many of these different cancer types.

Unidentified Analyst

And just to clarify, we show an overall survival across 4 different types, which we've got indications across 7 to 15 types.

Roger Dansey - *Merck & Co., Inc. - SVP of Clinical Research - Oncology*

7 to 15 types, yes.

Unidentified Participant

I just wanted to clarify that.

Roger Dansey - *Merck & Co., Inc. - SVP of Clinical Research - Oncology*

Yes.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

So let's talk about which of the combination regimen you're most excited about involving KEYTRUDA.

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Well clearly, we talked a lot about our KEYNOTE combination with regards to 189, our KEYNOTE combination with regards to KEYNOTE-407, which is our squamous lung cancer trial that we will be sharing data in ASCO. We have other KEYNOTE combinations that we're very excited about in head and neck with KEYNOTE-048, with our gastric cancer trial in KEYNOTE-062. So we're very excited about those combinations. We also have a number of assets that we're building within the Merck internal pipeline. Our LAG-3, our STING agonist, we're very excited about. We also have done a number of different deals with regards to recently Cavatak in an oncolytic virus. We think that's important. And also we are very excited about the opportunities that we have with Primavera, which is our recent collaboration with ASA. So we have one of the broadest combination programs I think in the industry. And we've always been agnostic to modality. See we're excited about a lot of different combinations as we move forward.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

So let's take a little bit deeper into KEYTRUDA/LYNPARZA, maybe just what's the rationale for a PD-1 in part combo, any different tumor types. What -- where would it make the most sense?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Yes. We're still right now in discussions with AstraZeneca, and there'll be more to come with regards to our specific trials that we will be initiating KEYTRUDA plus LYNPARZA soon. I think it's important now that we do highlight why we were excited to do the AstraZeneca deal, because we're very excited about LYNPARZA, even in monotherapy. We've seen obviously now the expansion of LYNPARZA as we broaden out in second line ovarian cancer. We are the first part that has been approved in a germline BRCA-mutated breast cancer patient population, and we're seeing that launch start to go very well. We also are expanding into other cancer types with LYNPARZA plus selumetinib and other combination. So when

while on LYNPARZA, it has I think over 150 clinical trials in place. So we feel very good about the near term of our program working with AstraZeneca just with LYNPARZA. And then as I mentioned, we're excited about future opportunities to combine LYNPARZA with KEYTRUDA that we'll be sharing more details later on.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

Any color you can provide at this point in terms of areas of interest where KEYTRUDA and LENVIMA.

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

I think LENVIMA and KEYTRUDA right now, we actually have a basket trail across multiple different cancer types, I think it's in the neck endometrial. We are excited about our renal cell carcinoma data. And I think there will be additional data that we'll be sharing in ASCO and we have breakthrough designation in the U.S., for that combination. And then LENVIMA also, we think is an important asset for us near term, because of its current position and approval in differentiated thyroid cancer. As well as we've recently received approval in Japan for HCC. And then obviously, LENVIMA is approved in renal cell carcinoma in second line in combination with the Afinitor. So when we take a look at the both of those assets, we see a tremendous opportunity with their current indications and near term indications. And are obviously very excited about the potential future in combinations with KEYTRUDA.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

Before any questions out there? Before I ask about -- ask on other future things, let me just talk about a broader question about PD-1, sometimes investors grow worried when they see how many companies are developing PD-1 inhibitors or PD-L1 inhibitors and there is this notion that you need to have one in regards to what combination wins in the end. What's your view on how many PD-1 or PD-L1 inhibitors there can be in a given setting? How will competition proliferate in your view in this space? Obviously, oncology is quite a bit different than if there were ACE inhibitor or statin?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

I think as we know, there's a lots PD-1s and PD-L1s that are in different pipelines and in development. I think for us -- and it goes back to our strategy, if you think about what we communicated many years ago. And I think it's played out very well for us. We took a very broad-based approach to really understand KEYTRUDA in a mono-therapy setting across many different cancer types. And that rep and approach I think has played out very well for how we're positioned today. We then wanted to identify segments of patients where you could enhance or improve the management of effect i.e. that's why we introduced KEYTRUDA with a PD-L1 patient population, for instance in lung cancer. And then we said we wanted to then go broaden out and see combinations and see how KEYTRUDA could be used in many different combinations with chemotherapy, with other I/O agents and also with other modalities and targeted therapies. And the reason why I say that is, because while there maybe many PD-1s or PD-L1s in development, I do believe because of where we are positioned today, as well as the breadth and depth of our overall program, positions us extremely well if there ends up being multiple PD-1s or PD-L1s in the future that come out into the marketplace because having that depth of data, along with oncologists getting very comfortable in using the regimens in either monotherapy in combination, I actually believe helps to differentiate us, not only today, but its' really going to help to differentiate us for the long-term.

So I think our strategy is playing out very well. We used to get a lot of questions with regards to what is the combination strategy that Merck is implying. And I think you can see an example with regards to KEYNOTE-189, an example with regards to we'll be sharing data with KEYNOTE-407 that our combination strategy we think has positioned us very well for the future.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

What have you learned in terms of potential future differentiators, what have you learned about the importance of things like dosing frequency?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Dosing is never one of the top attributes or reasons why oncologists choose a regimen. They start with the overall survival benefit, they then look at what is the toxicity profile of that regimen, they then may consider dosing as one of the things they consider. But from a Q3 week regimen of what we have, they're very comfortable with that regimen. I also think it's very important for us to understand that many of the combinations that we're using KEYTRUDA with, for instance, ALIMTA as an example, is on a Q3 regimen. So it's not only the monotherapy they're looking at, they're looking at the other regimen that may be used with KEYTRUDA. And we think Q3 is a very good regimen for us.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

So there's obviously a lot of investor and science focus on long, but can you outline a couple of the other tumor areas for KEYTRUDA that you see coming in the next year to 18 months that we should be on the lookout for that could materially affect the business?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Sure. So we're excited about moving into earlier lines of therapy and several different cancer types. Head and neck is one that we're excited about as we think about. We provided some updated data at ACR on our second line trial, but moving into first line into head and neck, moving into first line into gastric cancer, we think that's important, and an important cancer type, not only for U.S. but if you think about the prevalence of gastric cancer outside the U.S. is very significant. We are also excited about some of the data we showed even at ACR KEYNOTE-054, which was our adjuvant melanoma trial. So that obviously we think is important as we look at patients getting I/O therapies even earlier. And then we have a host of other additional cancer types, triple-negative breast cancer will be an important cancer type we believe for the future. We have data in cervical cancer for KEYTRUDA. And then if you think about LYNPARZA, as a as an example, we do have, I think study 8, which we will be sharing at ASCO where we combine LYNPARZA with abiraterone in patients with metastatic prostate cancer. We think that's important data for the future. And then I've already mentioned, we think renal cell carcinoma becomes an important cancer type for us as well, as we think about combining that with targeted therapy.

David Reed Risinger - *Morgan Stanley, Research Division - MD in Equity Research and United States Pharmaceuticals Analyst*

Well 2 minutes left on the shock clock. I'm going to ask you to preview what's the most important at ASCO that you haven't touched on yet? And maybe any other cancer pipeline developments or modalities that you would plant the seed on for us in terms of longer-term drivers for your business?

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Sure. So we've spoken about it today briefly, but KEYNOTE-407, our squamous cell lung cancer trial obviously will be important in ASCO. We believe KEYNOTE-042 will be important, which is our monotherapy lung cancer trial. We do have a KEYNOTE-427, which is an advanced clear cell renal carcinoma from one of our Cohort A trials KEYNOTE and as I mentioned 427. We also have our cervical cancer trial that will be presented, which is KEYNOTE-158. We have the KEYNOTE-146 trial, which is lenvatinib plus KEYTRUDA in patients with renal cell carcinoma, those are going to be updated results. And I mentioned there will be at ASCO and then also we have KEYNOTE-158, which is a Phase II study of KEYTRUDA in advanced small cell lung cancer, which we obviously think is important data as well. So we will have a very strong presence at ASCO. As I mentioned, we have 20 internal pipeline assets that we're building in oncology. We feel very good about our internal pipeline and how that is evolving, in particular, our LAG-3 as I mentioned, our intertumoral STING agonist as well as some of our other I/O pipeline agents. And then lastly, as we've mentioned before, I think the spoken size of both LENVIMA and LYNPARZA's development program. So there'll be a lot of data coming out from those programs as well. So when you look at what we're building in oncology, KEYTRUDA being foundational in many different cancer types, you look at us building out our internal pipeline. And then you look at LYNPARZA and LENVIMA and our overall combination program, we feel as though we have a tremendous opportunity in front of us with regards to oncology at Merck.

Gregory B. Gilbert - *Deutsche Bank AG, Research Division - MD and Senior Analyst*

Frank and Terry, thank you so much for your time. And thank you all to our clients who are attending or listening in. So off to lunch, and we'll continue after that. Thank you.

Robert M. Davis - *Merck & Co., Inc. - CFO & Executive VP of Global Services*

Thank you.