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PRESENTATION

Gregg Gilbert

Well, another good morning everyone. Good morning everyone, we're going to go ahead and get restarted. Very pleased to have Merck's Head of R&D Roger Perlmutter here sitting by the fire. Would you like a scotch, a wine, or a beer?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Coffee is fine, thanks.

Gregg Gilbert

Coffee is fine. Okay, thank you all for coming and listening in. Gregg Gilbert here. I cover especially pharma and major pharma here at Deutsche Bank in the U.S. Welcome to day 2. We have a great line-up with Merck and beyond here.

QUESTIONS AND ANSWERS

Gregg Gilbert

So Roger, I'd love to just kick it off with a little bit of a journey. I guess it's been about 3 years since you rejoined the company. Can you talk about what you came back to do and what progress you've made sort of at a high level, R&D strategy, R&D structure, before we dig into some inevitable specific questions about the pipeline?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes, sure, great, thanks. So 4 years and my view of Merck is the same as that it has been ever since I first came to know the company which goes back close to 40 years. To my mind Merck has always been the premier research-intensive pharmaceutical company and over the years Merck has introduced more drugs and vaccines than any other organization obviously in history and has had a bigger effect on human health through the introduction of therapeutics and vaccines than any organization in history. And to me that's a proud legacy and one which I'd like to see continued for ever. And my view of what needed to be done at Merck was to return the primacy of research-directed thinking to the company. Why that needed to be done is a much longer story and not really terribly important for today, but I would simply say that it was necessary to go into the organization and establish a governance axis that made it plain that fundamental research is at the center of what we do. It's very simple, it's a simple statement that there is a social architecture associated with the company, my view. And that is that we have a mission which is to translate breakthrough research into medicines that make a difference. I will stipulate that great medicines change the world, period, and our job is to introduce those. We have a mission, we have an aspiration to do this better than it's ever been done before, and we have a set of guiding principles to enable us to get that done. And I've tried to drive those through the organization. To be honest, it's something I really learned at Merck many years ago and had the opportunity to develop while I was at Amgen, so it's a privilege to have had the chance to bring it back to Merck.

Gregg Gilbert

Could you give some sort of practical examples of some things that have changed, whether it's bureaucracy or dialing up a capability that wasn't resourced appropriately, or adding a capability that --

Roger M. Perlmutter - *Merck Research Laboratories - President*

Sure.

Gregg Gilbert

-- had been lost in the past?

Roger M. Perlmutter - *Merck Research Laboratories - President*

So I've been fortunate over the years to have worked in a lot of different environments and I often say to people that I am in no sense a scholar of organizational structure, but I'm a pretty good student and I've gone to some good schools and have had the chance to look at R&D organizations not only in the for-profit sector and the non-profit sector, but across different kinds of industries. And one of the things that I learned is that there is no perfect way to govern an R&D organization, but it is essential that you have an axis of governance. So for example, in the pharmaceutical industry, you can choose to have a franchise-based governance system. You say, well, we're in oncology for example, so we have oncology sales reps and we're going to have there for oncology clinical development and we'll have oncology research right down to having oncology chemists and will be organized in a very columnar sort of way. On the other hand, you can say instead we have multiple sites which we act, and so we're going to have site-based governance within R&D. Or alternatively you could say we're going to govern R&D based on functional expertise. You can always tell a functionally governed organization because everyone puts global in front of their title, I'm global clinical development, I'm global chemistry, we're big, we're powerful -- or functionally organized. And the reality is you can organize yourself along any of those axis, but you do have to choose one. At Merck when I returned in 2013 I found that in some sort of orgy of egalitarianism, the attempt had been made to introduce all of those simultaneously, so we had franchise-based governance, but there was also functional governance which was site-based so that there were experts on individual sites. And they also had done the trick of trying to break down into smaller units. This is the old GSK CEDD DPU kind of model. So all of those were running simultaneously and it was necessary within the first few weeks of my arriving in 2013 to break that out and to choose a governance axis. And for a variety of reasons, not because it's necessarily my preference, the axis that made sense was a functional axis which is what we've implemented. As a result unfortunately many good people no longer had positions in the company because there was a superstructure of organization that supported all these different governance axis that had to be eliminated. Fortunately those people can find other places to work and have done extremely well, but we had to reorganize a lot of the company in order to make it more fleet, more powerful, more nimble.

Gregg Gilbert

For the person reading the transcript, it was an orgy of what that led to that situation?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Well, I think I said orgy of egalitarianism, but if you â€¦

Gregg Gilbert

Yes, that's right. Big word. I went to (inaudible), not Harvard.

Roger M. Perlmutter - *Merck Research Laboratories - President*

If you would prefer -- if you would prefer ecumenicalism, we can do that too.

Gregg Gilbert

So one former industry CEO who is no longer in the industry talked about bet on management, not R&D. Now, I assume you fundamentally disagree with that statement, but let me ask the question this way. There are lot of folks that believe R&D success can be somewhat random and that basic research discoveries often happen in academia and biotech and not at big pharma regardless how much big pharma spends on R&D, or how it staffs itself. What's your fundamental view on that I guess very big subject in a couple of minutes?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Well, first of all, let's just -- let's be realistic. I have a terrific neuroscience organization at Merck, just as an example, and my entire research organization in neuroscience might be 60 or 70 people. Last time I looked, the Society for Neuroscience had about a 120,000 members, let's see 60-70, 120,000, who do you think is going to make all the important discoveries? The odds that we will be making the important discoveries versus those who are toiling away for example in this city, pretty small. There are many more neuroscience researchers here, in fact at a single institution here in Boston, Cambridge, than there are at Merck. But the reason why we maintain a very strong commitment to fundamental research is because if you don't continue to do that work, if you're not contemporary, if you're not doing the problem sets you will not recognize it when others make important discoveries, and you will not be able to translate them. And I agree (inaudible) on management, than on R&D management.

Gregg Gilbert

Can you talk about how that sort of R&D sort of knowledge at Merck has helped inform either BD or licensing deals in the last 3 or 4 years?

Roger M. Perlmutter - *Merck Research Laboratories - President*

I think we like many other companies have always had a system in which the experts within the research organization are held to be responsible not only for what goes on internally, but for understanding what goes on in the outside world as well. And that's -- as I say that's a key part of the job. So business development has -- first of all has a search and evaluation feature and then it has a transactional piece. The transactional piece has to be, my view of the world, very close to the search and evaluation group and needs to be run out of R&D because in the current world, things move too quickly to pass transactions off from one group to another. You can't sit down with a -- as I would sit down with a small company I do all the time, we begin talking about a scientific issue. Within 30 seconds, we're talking about terms and the way in which collaboration structure would be orchestrated, it becomes transactional very quickly. And so those things need to be very close one to the other. I'm eager to have finance looking over my shoulder. I'm eager to have legal looking over my shoulder, but we need our own attorneys as well. And so we've built that into the structure of business development now because the race is to the swift, there's no question.

Gregg Gilbert

Let's talk a little about [Petruda] and for a moment let's skip lung because you know that's going to be asked about. Talk about some of the key readouts or findings around Petruda and other tumor types over the next year or two before we circle back to lung.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Well, as you know to start at the higher altitude, everyone should recognize, everyone does, that Petruda is the first truly broad-spectrum antineoplastic agent ever introduced into clinical practice. And we are currently conducting -- it's getting, what, close to 500 clinical trials across the entire spectrum

of tumors. This became very clear now within the first couple of years after I returned to Merck, it was obvious early on that there was activity in a number of places where one didn't expect immune recognition of tumor cells to be terribly meaningful. There was a long history of immune recognition of tumor cells in melanoma, also in renal cell carcinoma, but to see activity in lung and other solid tumors was surprising and that led to us add additional cohorts to the original study. At the time when I came to Merck we had only study going on, the 001 study, which is actually the study that we used for registration in melanoma which we achieved in September 2014. The -- but we added additional cohorts and then built up other studies that enabled us to look at a broad spectrum of different tumors. Now of course we have registration in first and second line lung cancer, in head and neck cancer, in melanoma of course. We also have classical Hodgkin lymphoma, but there'll be many others coming forward. We currently have bladder under review and we have a broad spectrum of tumors with microsatellite instability. Going forward we're going to see data some of which will be presented at ASCO and at other meetings. We're going to seeing additional data supporting the use in gastric cancer, there has been some early data in multiple myeloma, we'll see more of that, we'll see many more data points in hematological malignancy, we'll see a variety of studies done at hepatocellular carcinoma and across a very broad of spectrum of solid tumors. In essence, as we know, KEYTRUDA is treating the host, it's not treating the tumor. The activity of the agent is directed against host cells and it permits immune cells -- it permits the most remarkable thing that is it reveals the preexisting immunity directed against the tumor, that's what it does. It permits those cells that are already activated to actually engage the tumor and participate in destroying it. That's a remarkable thing and every morning I wake up and say this is unbelievable, it's amazing.

Gregg Gilbert

How are you directing Merck's IO strategy in terms of the different combinations that either you are partnered with or have chosen to own --

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Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes.

Gregg Gilbert

-- what's the importance of owning versus simply partnering until making a decision later?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes. Yes. It's a complicated environment and first all --

Gregg Gilbert

I'm envisioning a big whiteboard in your office with a major of all these things.

Roger M. Perlmutter - *Merck Research Laboratories - President*

I wish, yes. There'll be a big whiteboard. The initial attempt was to say, look, we need to have mechanistic insight in order to understand how to proceed with combinations. What exactly are we doing? Let's look at it this way; melanoma is a very responsive tumor, if not the most responsive tumor, on a response-rate basis Hodgkin lymphoma is the most responsive tumor that we've seen, but melanoma is a very responsive tumor, and yet even in the most favorable setting something on the order of above 75% of patients will see some effect on tumor, tumor regression may not be resist criteria, but about 75% will in a first line setting for advanced melanoma. But what's wrong with the other ones, and why don't we see it there? And more or less there are three possibilities. The first possibility is that that particular tumor is just not recognizable by an immune system. It's just -- there's no way that immune system could see it. That could be for a variety reasons. As an example, in principle if the tumor is incapable of putting antigen on its surface, if it lacks HLA presentation molecules, it's invisible, nobody can see it, it could be that kind of thing. So that's the

first possibility. The second possibility is that yes, this is a recognizable tumor, but not by that individual that could be for example because there's really -- there's something to recognize, but there is a hole in the repertoire of that individual and their immune cells just can't see it. These things -- this may be -- seem like sort of philosophy, but they have treatment implications, in other words if a tumor is incapable of being seen, it might be pretty hard to figure out how to get it to be seen, you might have to introduce something into it so it becomes visible. The other end of the tumor could be seen by some immune system, jut not by that person's immune system, you could imagine making that tumor more visible through immunogenesis, radiation, DNA directed toxic chemotherapy, other kinds of things that would make it more visible. Third possibility is that, yes, the tumor is visible and it's visible by that patient's immune system, but for some reason other than PD-1/PD-L1 interaction for some reason the immune cells can't be activated. Well, that gets you to different checkpoints, whether those checkpoints are four, like three (inaudible) take it, whatever it is, it could be other checkpoints. So let's try and explore those different ideas pre-clinically and what we found fairly quickly was pre-clinically we could develop systems that would more or less demonstrate that anything worked. So KEYTRUDA or PD-1 rodent equivalent will work in combination with cytotoxic chemotherapy with radiation, with targeted chemotherapy, with oncolytic viruses, with other checkpoint inhibitors, all of those things can be made to work. And that made us feel right at the beginning that there was probably not going to be one answer, that we were going to end up in a clinical setting where we'd really have a personalized this therapy. That seems to be playing out. We have clinical data from our various different collaborations that demonstrate activity in combination with oncolytic viruses, that demonstrate activity in combination with toll-like receptor agonists, with various activating cytokines which is directed intratumorally, combinations with radiotherapy, combinations of course with cytotoxic chemotherapy and some of those have produced registration-worthy data as you know. So all of those things can be made to work and in addition there is data for various checkpoint combinations which is at various levels of strain. So as we're moving forward in these, we're trying to understand what's special about which tumors and how do we address them. And to do that we've developed a lot of expertise in analyzing tumor samples and we're taking advantage of particularly what you get from neoadjuvant studies in order to be able to get material that we can actually look at from biopsy and then post-section enables us to understand the interaction between the patient's immune system and the tumor that we're trying to control.

Gregg Gilbert

So back to the question of sort of being intellectually promiscuous and partnering with everyone versus making some bets and ownership or discovery?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes. I don't, at this level of understanding I think it's very difficult to just say, okay, I'm going to make it bad. I do believe that you reach a point where you have enough understanding to move forward and we certainly don't -- will never get to the point where fully understand what's going on. So you get to a point, a tipping point. But it's worth remembering that there are only certain kinds of combinations that are going to be worth owning and there are several ways to think about that. First is combinations where you can actually co-formulate, co-administer, co-package, those things have a lot of trenchancy in the marketplace, and in particular I do think that we have to consider it very seriously what the pricing environment is. Realistically speaking how much more can this system bear. My preference is to be able to bring forward always new treatment regimens that are much more effective which have a better safety profile and which are not more costly. And to do that you have to increase volume. That means you just have to work a lot better so that people will use them more and they have to be used together, that's the best combination. It is the case that a lot of the combination products that we are talking about are either combinations with parentally administered KEYTRUDA and oral agents, can't co-formulate, can't co-package, can't do anything with those or combinations with intratumoral injection for example, or -- and KEYTRUDA. And there the arguments for ownership are really based on how much -- how much you believe in that particular therapy for a large group of patients in the marketplace and those are issues that we wrestle with every day.

Gregg Gilbert

I believe a couple of folks asked about KEYTRUDA plus CTLA-4 and where you stood in lung. I'm not sure we got a clear answer as to exactly where you are or what the specific [gating] factor is. I know you mentioned it's complicated, if we fast-forward and MYSTIC unequivocally shows that there's a robust sort of effect with tolerable side effects. What would you then say how long it would take to start that trial or am I asking the wrong question, it's really not about that?

Roger M. Perlmutter - *Merck Research Laboratories - President*

No, it's a fine question. I think within -- ready to initiate a registration enabling study for a long time and could embark upon a study with ipilimumab plus KEYTRUDA. We have data from ipilimumab plus KEYTRUDA. In melanoma we've done some work in lung as well. We wanted to make sure that we were getting the dose of schedule because of course as you mentioned a key consideration is the relative safety profile of CTLA-4 directed agents. And so in the meantime, we've also been developing our own CTLA-4 directed agents to ask is there something special that we could engineer that would give us perhaps a leg up from a benefit risk point of view. We are still analyzing all of these data before we pull the trigger but we could do that very quickly and we will be influenced of course by outside events. As I've mentioned the recent final data from Bristol-Myers with respect to their melanoma studies are in some sense a cautionary tale in terms of overall survival comparing the OPDIVO plus ipilimumab versus OPDIVO alone, there's no doubt that CTLA-4 added -- CTLA-4 directed therapy blockade of CTLA-4 does affect PD-1 directed therapy. The question is how to do it right and so we continue to ponder that.

Gregg Gilbert

So the idea is ponder and then potentially move in combo with available agents while discovering and developing your own CTLA-4 therapies, it could be better that are preclinical tests?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Depending on how we feel about it, we might end up pulling the trigger with our own sooner with the idea in mind that we could advance that compound. If we thought it was good enough, if we thought it was better, and if we imagine that we could introduce those -- in the best possible world if you could co-formulate such molecules and administer them as a single injection imagining that you don't need to provide blockade of both all the time, that might turn out to be a good strategy. So that's one that we've been looking at too.

Gregg Gilbert

How far along is your most advanced CTLA-4?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Pretty far along.

Gregg Gilbert

A very common question again, but have to ask, did KEYTRUDA (inaudible) read out or FDA action soon, your confidence is supported by, fill in the blank?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Great data. We have great data. If we look at those data. And we could at the margins quibble about the -- where exactly the point estimates fall in the confidence of those. But there's no question that from a standpoint of response rate and progression for survival, there's a large impact in the first line setting (inaudible) non-small cell lung cancer for the combination of KEYTRUDA plus ALIMTA and (inaudible). That's supported by, as I mentioned on the earnings call, supported by the original cohort which was a single arm cohort using the same chemotherapy regimen. So there's a lot of reason to believe that those -- that that is the kind of result that you'll see. We will have additional readouts over time and it will be studied over time in a whole variety of different settings and surely patient selection can matter, but it's going to change dramatically I wouldn't think. Just

look at the strength of the data. And that's certainly what we have presented to the FDA. The FDA will make their own decision. We've had good discussions with them back and forth. The date is not far away, so you'll learn when we do or just after.

Gregg Gilbert

Hopefully within minutes.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes, very â€¦

Gregg Gilbert

I want to take a pause and see if there are any burning questions in the audience, to my colleague from across the pond. Can you turn his mic on please?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes, we can't hear you.

Richard John Purkiss - *Piper Jaffray Companies, Research Division - MD and Senior Research Analyst*

Okay. Richard Purkiss from the European Pharmacy Deutsche Bank.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes.

Richard John Purkiss - *Piper Jaffray Companies, Research Division - MD and Senior Research Analyst*

So couple of questions on IO. We're obviously going to start to see more and more data from second generation IO combination at the upcoming ASCO conference, and I know you've just made the decision to go to registration studies with insights, I don't (inaudible). So I'm just wondering about your kind of optimism about that particular combination in lung cancer. And then as an addendum to that, just strategically how do you balance the pressure to move very quickly with some of these new combinations with the risk that maybe you move forward with a false positive signal?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes, great question. So first of all we are enthusiastic about the IDO-1 access IDO1, TDO1, and maybe the combination, for a number of reasons. The promise of it frankly based on the clinical data thus far is you'll get an efficacy benefit like that which we believe we could see with ideal CTLA-4 introduction plus KEYTRUDA, but it's without a safety penalty, without a meaningful safety penalty. So if you look at the data from ourselves and insight, what you see is that the combination really looks very similar to KEYTRUDA alone, and there is really very little safety penalty associated with administration of epacadostat which I like very much. The question is how much efficacy do you get out of that. And none of the studies are large enough now to let us know. When we thought about that at the end of last year, my conclusion finally was that the only way we were going to find out was to do the studies in a large enough setting so that we would really know. It's a risk, but there was enough signal there that I felt it

was worth pursuing and that's what we've done. We like the profile so well that we acquired our own molecules and it built up other molecules with the idea in mind that we could dial in additional properties. Epacadostat has wonderful characteristics, but there might be other properties one would want such molecule.

Gregg Gilbert

You have another one before we hand the mic back? Good.

Richard John Purkiss - *Piper Jaffray Companies, Research Division - MD and Senior Research Analyst*

Since the subject of ASCO came up, can you frame for us what most important learnings come from that as it is relates to Merck at ASCO? I know you're going to have a session there for investors.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Well, the most important learnings will actually emerge at ASCO in the context of the discussions and what people see and what presentations are made, not only by us, but by the many others who are engaged in looking at new cancer therapies. We have some pretty interesting data coming up. We have more than 50 abstracts, more than a dozen different presentations including a clinical science symposium and you'll have the opportunity to see some additional data on the combination of KEYTRUDA plus epacadostat, and in addition there is a lot of interesting data on breast cancer, the results from (inaudible) which will be interesting, which will be presented orally and number of other things. The titles are out. I know the abstracts will be out soon and you will have a chance to look at them. There will be a lot to see.

Gregg Gilbert

Coming back to the KEYTRUDA plus chemo, the first action I guess relates specifically to ALIMTA, but tell us what you're doing to explore other chemo regimens, other chemo compounds, how sort of (inaudible) you're exploring the way to optimize KEYTRUDA plus chemo?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes.

Gregg Gilbert

Your competitors will help answer that question as well.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes, there is -- there are a lot of studies in combination with chemotherapy that are being done in different tumor types. You're driven to a substantial extent by what oncologists have already become accustomed to in the marketplace. And when I say that I recognize that we again stand on the shoulders of giants over a period of 30 to 40 years combination chemotherapy has actually being refined through the efforts of the various cooperative groups CTAB, [E-cogs], [Swag]. There's an enormous amount of data that has emerged that has answered important questions about which chemotherapeutic regimens perform best in patients with which malignancies and that drives a lot of what we do. There is the underlying theory about how this works, not terribly well-developed, let's be clear is that chemotherapy -- cytotoxic chemotherapy releases sufficient antigen from tumors, sufficient stuff that the immune system can recognize that that material that's released is presented to immune cells which then become more activated. So if you're using KEYTRUDA release the breaks as is often said on the immune system and provide more antigenic stimulation, then things work better. It goes back to the work which we did years ago on T-Vec, the oncolytic herpes virus. In that setting the

argument always was from Rob Coffin who was the person who engineered that virus at BioVex, the argument always was, well, gee, this is an oncolytic virus, and the virus will spread. It will preferentially infect tumor cells for reasons that have to do with the way in which it was engineered and then it will kill those tumor cells and that's how it will work. And my feeling always was the reason why, Rob, you put a GM-CSF cassette into that oncolytic virus was because you wanted to attract immune cells, in that case myeloid cells. And the way in which that oncolytic retrovirus works is, yes, it does kill tumor cells, but more importantly it exposes the products of having (inaudible) those tumor cells and having a breakup and exposes them to the immune system, and the reason why you inject in one side and you see the tumor regression in another side is not because the virus spread, but because immune cells were activated and they went and found the tumor, that's the so-called abscopal effect. I think that's exactly the same thing that happens with cytotoxic chemotherapy. You kill cells, immune cells become activated and then they move to other places. I think one of the surprises for everyone has been that the killing is more directed at the tumor than it is at the immune cells. But in a way that's what we've selected for over the last 40 years through all the chemotherapy studies. We've been looking for agents that were more likely to kill the tumor cell than host cells. And in combination with things that permit host immune cells to become activated seems to work better.

Gregg Gilbert

Sure. I wonder how may abstracts to that score focused on new chemo agents to sort of build on that 40-year experience, but maybe a discussion for another time.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes.

Gregg Gilbert

Let's wrap up on another subject. Soon enough we'll hear about death of the fourth CETP inhibitor or the unexpected finding that one can work. I say it that would sort of provoke you into -- to framing for us how and why yours could work, when three other did not.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Yes. Well, so let's be clear. Anacetrapib is being studied in a very large cardiovascular outcome study. And it was designed many years ago, a decade ago, to test the question of whether or not elevation of HDL cholesterol would permit reverse cholesterol transport and protect the vessel wall and reduce cardiovascular events. That whole idea seems now a little less supported by data than it did 10 years ago, but it takes a long time to answer these questions. I think the fact that you've had many other CETP inhibitors fail, they sort of need to be taken one at time, but that's certainly not a positive for anacetrapib. It can only be viewed as a negative. I think in particular the evacetrapib data are disquieting because evacetrapib is a potent molecule that really dramatically lowers LDL cholesterol and one would have guessed would have an effect on major cardiovascular events. The reason why anacetrapib might work is because the study design is different. First of all, it's a much larger study with 30,000 patients. Secondly, it was designed with the idea in mind that after all things that lower LDL cholesterol, and this was something which I paid quite a bit of attention to, study it was always underway when I came back to Merck. But to me the important issue was if you lower LDL cholesterol, it doesn't act to reduce your risk of cardiovascular events immediately, it takes time before you have the (inaudible) changes in the vessel wall that reduce myocardial events. And so if that's true, longer study is better, longer run-in period is better and you want to have the average time on therapy be longer in order to see whatever effect you can see from lowering LDL cholesterol. In every other setting, whether it's by blocking cholesterol absorption with the ezetimibe by increasing the expression of LDL receptor through Repatha or by Statins which affects LDL receptor as well. In every setting, you lower LDL cholesterol and there is a nomogram that associates that LDL cholesterol lowering with cardiovascular outcomes. Anacetrapib lowers LDL cholesterol by average 30% or so even in the presence of Statins. From that perspective it ought to work.

Gregg Gilbert

Maybe a last follow-up to that, does the future of research in cardiovascular at Merck pivot on this event at all?

Roger M. Perlmutter - *Merck Research Laboratories - President*

Not really. We have other cardiovascular research going on. In particular our collaboration with Bayer in pulmonary hypertension using soluble guanylate cyclase activators and other kinds of things. We're doing a lot of work in the cardiovascular space. We're very interested in it.

Gregg Gilbert

Well, thanks so much. We just barely scratched the surface of the last 4 years, but we really appreciate your insights, Roger and Merck. And thank you all for attending.

Roger M. Perlmutter - *Merck Research Laboratories - President*

Great. Thank you. I enjoyed.