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OVERVIEW:

Company Summary
CORPORATE PARTICIPANTS

Dean Y. Li Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories
Eliav Barr Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories
Jannie J. Oosthuizen Merck & Co., Inc. - Senior VP & President Merck U.S. Human Health
Marjorie C. Green Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development
Peter Dannenbaum Merck & Co., Inc. - VP of IR

CONFERENCE CALL PARTICIPANTS

Chris Shibutani Goldman Sachs Group, Inc., Research Division - Research Analyst
Christopher Thomas Schott JPMorgan Chase & Co, Research Division - Senior Analyst
Conor MacKay BMO Capital Markets Equity Research - Research Associate
Louise Alesandra Chen Cantor Fitzgerald & Co., Research Division - MD & Senior Research Analyst
Luisa Caroline Hector Joh. Berenberg, Gossler & Co. KG, Research Division - Co-Head of Global Pharmaceutical Team
Stephen Michael Scala TD Cowen, Research Division - MD & Senior Research Analyst
Trung Chuong Huynh UBS, Research Division - Research Analyst
Umer Raffat Evercore ISI Institutional Equities, Research Division - Senior MD & Senior Analyst of Equity Research
Cerena Chen Wells Fargo, Research

PRESENTATION

Operator
Thank you for standing by. Welcome to the Merck & Co., Inc. ESMO Virtual Investor Event. (Operator Instructions) This call is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Mr. Peter Dannenbaum, Vice President, Investor Relations. Sir, you may begin.

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

Thank you, Jill. Good morning, afternoon and evening, everyone. Welcome to Merck's investor event coinciding with the European Society of Medical Oncology Annual Meeting. Thanks to all of you who are tuning in on a Sunday. This is a virtual call with Merck participants calling from both Madrid, Spain; and here in Rahway, New Jersey. We're excited to have this opportunity to speak to you about the substantial data Merck and our collaborators presented this weekend at ESMO and to also highlight the excitement we have around our newly announced collaboration with Daiichi Sankyo. During today's call, a slide presentation will accompany our speakers' prepared remarks, and it has been posted to the Investor Relations section of Merck's website.

Before we get started, we would like to remind you that some of the statements that we make during today's call may be considered forward-looking statements within the meaning of the Safe Harbor provision of the U.S. Private securities Litigation Reform Act of 1995. Such statements are made based on the current beliefs of Merck’s management and are subject to significant risks and uncertainties. If our underlying assumptions prove inaccurate or uncertainties materialize, actual results may differ materially from those set forth in the forward-looking statements. Please reference this slide in our presentation and our 2022 10-K, which identify certain risk factors and cautionary statements.
I would now like to introduce Dr. Dean Li, President, Merck Research Laboratories, who will outline our agenda and make a few opening remarks.

Dean?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Thank you, Peter. Thank you all for taking the time to join us. Today I will start with our new strategic collaboration with Daiichi Sankyo, announced on Thursday, and then hand over to Eliav to provide details regarding the candidates covered by the collaboration, and then Marjorie will review clinical highlights from data presented at the ESMO Congress. We are also joined by my colleague Jannie Oosthuizen, President, Human Health U.S., who is here to address questions from a commercial standpoint.

As I have previously indicated, our oncology strategy remains focused on leveraging the antitumor properties of KEYTRUDA to establish a diverse clinical pipeline of candidates with novel mechanisms and modalities. This is based on 3 strategic pillars immuno-oncology, precision oncology, and tissue targeting. In immuno-oncology, we continue to evaluate KEYTRUDA in the metastatic and increasingly in earlier-stage disease settings, while also investigating multiple novel immuno-oncology combinations and coformulations. With precision oncology, we are selectively modulating pathways to inhibit cancer cell growth and in tissue targeting, we are developing agents such as antibody-drug conjugates designed to enhance cancer cell sensitivity and increase cell killing.

Last week, we announced an important strategic collaboration with Daiichi Sankyo. Daiichi Sankyo scientists have a world-renowned reputation for their pioneering work in the design, engineering and development of antibody-drug conjugates with proven benefit for patients with cancer. This platform provides tremendous opportunity to evaluate the antitumor efficacy of promising ADC candidates targeting tumor cell surface receptors. By combining our respective strengths, we are well positioned to accelerate clinical development for 3 promising, potentially first-in-class candidates targeting multiple tumor types. Our companies share a passion for innovative medicines and for improving the lives of patients worldwide.

With that, I will turn the call over to Eliav to provide further details of the ADCs that form the basis for our agreement with our colleagues at Daiichi Sankyo. Eliav?

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

Thank you, Dean, and good afternoon, everyone. Good evening. It’s great to be here at ESMO to provide an update on our oncology development program and the significant progress we are making.

Now I will provide you with additional perspectives on our oncology strategy and our new collaboration with Daiichi Sankyo, before turning it over to Marjorie. Although we’ve made remarkable progress to date in treating cancer, we recognize that there is more work to do to help patients and their families who are dealing with this devastating disease. To address this unmet need, we have a robust oncology pipeline of 25 partnered or wholly-owned assets spanning a range of mechanisms of action. As Dean highlighted, we are pursuing an oncology strategy focused on boosting antitumor immune responses, modulating molecular pathways that inhibit cancer cell growth, and tissue-targeting strategies such as antibody-drug conjugates to increase cancer cell sensitivity to tumor-killing drugs. We’re studying multiple exciting compounds in each of these areas, many of which are being evaluated in combination with our foundational anti-PD-1 agent KEYTRUDA. And all of this is underpinned by our excellent discovery pipeline that gives us the confidence that we are going to sustain our leadership position in oncology with new and differentiated molecules that will improve outcomes for patients. In the next 3 slides, I will focus on our work to develop antibody-drug conjugate medicines to selectively deliver potent cytotoxic agents to cancer cells.

Now, we’re very excited to begin work as part of this new collaboration and to combine each company’s unique strengths for the benefit of patients. Daiichi Sankyo has a proven track record of pioneering next-generation ADCs, having been a leading innovator across 3 critical components of an optimally constructed treatment, which includes the antibody, the linker, and the payload. Merck has a proven track record in oncology clinical development, and the collaboration will benefit from the ability to leverage our clinical trial expertise and global scale. KEYTRUDA’s position as a foundational anti-PD-1 provides us with a wall of data across many tumor types and the ability to study in combination with ADCs to advance
standard of care. As Marjorie will discuss, KEYNOTE-A39 provides a prime example of the potential for regimens of KEYTRUDA in combinations with high-quality ADCs. Together, we look forward to having a meaningful impact on patients with cancer.

Now the collaboration includes 3 programs addressing novel targets and across several tumor types, each with a potential to be first in class. The first one, patritumab deruxtcan, or HER3-DXd, is an investigational fully-human anti-HER3 monoclonal antibody attached to a topoisomerase I inhibitor payload. HER3 is a member of the EGFR family of receptor tyrosine kinases that is separate and distinct from HER2. Approximately, 83% of primary non-small cell lung cancer tumors and 90% of EGFR-mutated tumors following EGFR tyrosine kinase inhibitor treatment express HER3. There is currently no HER3-directed therapy approved for the treatment of cancer. HER3-DXd is currently being evaluated as monotherapy and in combination with other agents in a global development program, which includes multiple clinical trials of patients with EGFR-mutated non-small cell lung cancer.

Recent data from the HERTHENA-Lung01 study demonstrated that HER3-DXd provided clinically meaningful and durable efficacy in patients with advanced EGFR-mutated NSCLC that progressed following EGFR TKI and platinum-based chemotherapies. HER3-DXd was granted Breakthrough Therapy designation by the FDA in December 2021 for the treatment of patients with metastatic or locally advanced EGFR-mutated non-small cell lung cancer with disease progression on or after treatment with a third-generation tyrosine kinase inhibitor and platinum-based therapies. A Phase I/II trial in patients with HER3 expressing metastatic breast cancer has also been completed. Interim results of Phase II part A, which evaluated heavily pretreated metastatic breast cancer patients were presented at ASCO in June. HER3-DXd showed acceptable safety and encouraging efficacy across the broad range of HER3 expression.

The second asset is I-DXd or ifinatamab deruxtcan, also known as DS-7300. This is an investigational humanized anti-B7-H3 or CD276 monoclonal antibody attached to a topoisomerase I inhibitor payload approved for the treatment of cancer. Now DS-7300 is being evaluated in a global development program, which includes a Phase II monotherapy trial in patients with previously treated extensive stage small cell lung cancer and a Phase I/II first-in-human trial. Phase I/II interim data were presented at ESMO 2022, which demonstrated encouraging efficacy and manageable safety in patients with several types of heavily pretreated cancers, including lung, prostate, or esophageal cancer. Further data at WCLC 2023 continued to demonstrate promising efficacy in patients with heavily pretreated small cell lung cancer. A dose optimization Phase II study for patients with small cell lung cancer started in June 2022 and data from this study are expected in 2024.

Now, the last of the 3, is R-DXd or raludotatag deruxtcan or DS-6000, an investigational humanized cadherin 6 or CDH6 targeted monoclonal antibody attached to a topoisomerase I inhibitor payload. Now, CDH6 is overexpressed in several cancer types and is associated with tumor growth and proliferation. No CDH6-directed cancer therapies are approved for the treatment of cancer. DS-6000 is being evaluated in Phase I trials for the treatment of ovarian cancer. Interim Phase I results showing early clinical activity in heavily-pretreated patients with advanced platinum-resistant ovarian cancer and renal cell cancer were presented at ASCO 2022. And in fact, just earlier today, updated results from a subgroup analysis from the Phase I study show that DS-6000 continues to demonstrate promising clinical activity in patients with heavily-pretreated, platinum-resistant advanced ovarian cancer. Along with our partner Daiichi Sankyo, we plan to rapidly advance the development of these 3 ADCs with speed and rigor, exploring their potential across a range of indications.

So now we have a broad portfolio of 6 distinct clinical ADCs targeting different tumor enriched cell surface receptors across a spectrum of tumors. So how are we going to develop all of these drugs efficiently for the benefit of cancer patients? Well, our partnerships with Daiichi Sankyo and Kelun Biotech give Merck the opportunity to create precision medicine treatment strategies that target each tumor focused on the right medicine, at the right time, and with the right enhancement of chemotherapy activity. With the extraordinary assets from Daiichi Sankyo, we are focused on a variety of thoracic malignancies, including a variety of segments of non-small cell lung cancers as well as small cell and ovarian cancers, places where either KEYTRUDA is foundational or we can now build new capabilities and a new presence.

These 3 programs complement our ongoing productive collaboration with Kelun Biotech. We are very encouraged by the progress of our TROP-2 ADC program, and we have recently posted our initial Phase III trial in patients with certain non-small cell lung cancers. In addition, MK-1200, a Claudin 18.2 ADC, is in Phase I in advanced GI tumors. This ADC has shown encouraging efficacy, and we anticipate advancing it quite rapidly. There is another clinical ADC and several other earlier ADCs with undisclosed targets that we are evaluating as well. So together, our programs in collaboration with Kelun are highly complementary to what we have added to our new collaboration with Daiichi Sankyo.
So when you think about our overall ADC strategy, I imagine a roof with really strong slate tiles, each of them unique and with slight overlap in particular areas of need. But the overall picture is 1 of really complete and sturdy coverage of the entire surface of cancer. We have what we believe to be the potentially best-in-class suite of ADCs that will complement our foundational IO platform with KEYTRUDA as well as other targeted agents. With this extensive pipeline and the strength of KEYTRUDA, we can hope to create regimens with the potential to have unparalleled efficacy for patients both early and late-stage cancers.

Now, with that, I will turn it over to Marjorie, who will provide detailed highlights of the robust data presented at ESMO. Just as a reminder, Marjorie joined Merck earlier this year. Her deep understanding of ADCs, including the linkers, the payloads, and antibodies, as well as an understanding of how ADCs are potentially combinable with other agents, such as pembrolizumab, has greatly enhanced our scientific and operational prowess. So, Marjorie?

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Thank you, Eliav. Good evening, good afternoon, everyone. It’s my pleasure to provide highlights of our important data continue to extend and deepen our reach in oncology, as evidenced by the robust data presented this weekend from 4 approved medicines and 3 pipeline candidates across the more than 15 types of cancer. The breadth and depth of datasets showcase our leadership in oncology, both in earlier stages of disease as well as our foundational position in metastatic cancers. Today, I will focus on a few featured Phase III programs from our approved medicines, KEYTRUDA and WELIREG, and also touch on data from novel pipeline molecules, including MK-2870, our TROP-2 ADC; and MK-1084, our KRAS G12C inhibitor.

Starting with our Phase III dataset. Diagnosing and treating cancer at an earlier stage may give patients a greater chance of long-term survival. That is because many cancers are considered most treatable and potentially curable in the earlier stages of the disease. Unfortunately, many patients with resectable stage II, IIa, and IIIb non-small cell lung cancer will experience recurrence even after surgical resection and chemotherapy. KEYNOTE-671 is an important trial for people with earlier stages of lung cancer, and I’m pleased to present the full dataset. In this study, KEYTRUDA in combination with chemotherapy given as neoadjuvant therapy, followed by surgery and then adjuvant single-agent KEYTRUDA, was compared with preoperative chemotherapy followed by surgery, and then placebo for patients with resectable stage II, IIa, or IIIb non-small cell lung cancer. The KEYTRUDA regimen demonstrated a clinically meaningful and statistically significant overall survival benefit, reducing the risk of death by 28%. The OS benefit was generally consistent across subgroups. KEYTRUDA as used in KEYNOTE-671 is the first and only anti-PD-1 therapy to demonstrate an overall survival as well as event-free survival benefit in the neoadjuvant or adjuvant therapy in resectable non-small cell lung cancer. KEYNOTE-671 is the 7th Phase III trial of lung cancer utilizing KEYTRUDA to demonstrate a statistically significant overall survival benefit. This data adds to the meaningful impact KEYTRUDA is having across the spectrum from the metastatic setting into earlier stages of disease. This reinforces the need for early detection through improved lung cancer screening, and with earlier diagnosis, people have an option to treat their cancer earlier.

Moving to our next potential practice-changing dataset is data from KEYNOTE-A39, otherwise known as EV-302. Note, while all the datasets presented this weekend are really important advances for patients, this trial is especially dear to my heart. During my time at Seagen, another company I worked with closely with the teams of Seagen, Astellas, and Merck, and I couldn’t be more proud to see this completion here at Merck. This data is the first ADC/IO combination to show overall survival improvement in a Phase III study and is important as there have not been advances in the first-line treatment of metastatic urothelial cancer in over 20 years. This represents a confirmatory trial to the KEYNOTE-869, EV-103 study, and forms the basis for seeking full approval for patients who are ineligible for cisplatin chemotherapy. Also forms the basis for seeking approval to extend patients eligible for cisplatin chemotherapy. When you look at the overall survival advantage with more than a 50% reduction in the risk of death from cancer, the benefit is consistent across all predefined subgroups, including PD-L1 status, type of chemotherapy given, as well as sites of disease. The combination of KEYTRUDA with enfortumab vedotin shows a manageable safety profile and reflects the individual toxicities of each of these drugs.

Moving on into women’s cancers. We remain committed to achieving better outcomes for these people who have malignancies of breast and gynecologic tumors, notably in the earlier-stage setting where we can have the most meaningful impact and improved prognosis. First, in cervical cancer, cervical cancer remains the foremost common cancer despite the availability of preventative agents such as GARDASIL.
For women with locally advanced cervical cancer, there has not been an innovation in standard-of-care therapy since 1999. Data from KEYNOTE-A18 is a tremendous leap forward for patients. KEYTRUDA in combination with concurrent chemotherapy radiation is the first and only regimen with a checkpoint inhibitor to demonstrate statistically significant and clinically meaningful improvements in progression-free survival for people with newly diagnosed, high-risk, locally-advanced cervical cancer when compared to standard-of-care therapy. The use of a KEYTRUDA-based regimen reduced the risk of disease progression or death by 30%. The data supports the potential of this regimen to become a new standard of care and again is a leap forward for women who have this locally-advanced burdensome disease.

Next, moving to breast cancer, we are generating more evidence of the benefit of treating breast cancer in earlier stages where the immune system is more robust. Hormone receptor positive, HER2 negative breast cancer is a heterogeneous disease that historically has not been considered to be immunogenic. Promising data from KEYNOTE-756 showed that adding neoadjuvant KEYTRUDA to standard-of-care chemotherapy improves the pathologic complete response or the ability to eradicate cancer in the breast and the lymph nodes at the time of surgery. This led to a statistically significant increase in pathologic complete response by an estimated 8.5 percentage points compared to chemotherapy alone, regardless of PD-L1 status. At this early time point, event-free survival results are immature and continue to be evaluated.

Finally, in triple receptor negative breast cancer, we have updated results from KEYNOTE-522. Since approval of KEYNOTE-522 regimen in triple receptor negative breast cancer in the neoadjuvant and adjuvant setting, we’ve seen the significant impact this regimen is having for people who have high-risk, early-stage, triple receptor negative breast cancer [type]. After a median follow up of more than 5 years, data from KEYNOTE-522 shows a maintained clinically meaningful improvement of event-free survival. These results provide further support for KEYTRUDA plus platinum-containing neoadjuvant chemotherapy followed by adjuvant pembro after surgery, regardless of the PCR outcome as a new standard-of-care treatment regimen for patients with high-risk, early-stage TNBC. Follow up for overall survival is ongoing.

Next moving into Belzutifan in advanced renal cell carcinoma. The treatment landscape for patients with advanced renal cell carcinoma has changed tremendously over the past few years, with many therapies such as VEGF-TKIs and IO therapies such as KEYTRUDA moving into the frontline setting, there becomes an increasing need for novel therapies for patients who have received these types of treatments in the past. LITESPARK-005 is the first positive Phase III study in patients with advanced kidney cancer following immune checkpoint and antiangiogenic therapies. In this study, Belzutifan was compared with everolimus, and Belzutifan demonstrated a 26% reduction in the risk of progression or death when compared to standard-of-care therapy. Of note, almost 23% of patients achieved an objective response rate when compared to single-digit response rates with everolimus. And for those people who obtained an objective response, the median duration of response was over 19 months. Belzutifan was well tolerated and adverse events were consistent with the known safety profile of the drug. The data from LITESPARK-005 demonstrates the potential of Belzutifan for certain previously treated patients with advanced renal cell carcinoma, and we look forward to the 3 additional ongoing Phase III studies in combination with pembrolizumab and/or lenvatinib in the advanced and adjuvant RCC setting.

Moving to important data from our pipeline assets. First, in the ADC field with MK–2870, our TROP-2 ADC that we are developing in collaboration with Kelun, and we are excited that Kelun announced a positive Phase III study of MK–2870 as the treatment of patients who have metastatic triple receptor negative breast cancer that they studied in China. It helps to demonstrate the potential of this ADC in breast cancer. At ESMO, data in the HR positive/HER2 negative metastastic breast cancer setting was presented. This data demonstrated an objective response rate of almost 37%, a duration response of 7.4 months, and a median progression-free survival of over 11 months. The safety profile was manageable with no occurrence of drug-related interstitial lung disease and treatment-related AEs which led to treatment discontinuation or death. This data supports our efforts as we look to advance the broad global clinical development program. As Eliav stated, we recently posted our first Phase III trial in previously-treated non-small cell lung cancer with EGFR mutations or other genetic aberrations, and we look forward to continuing to develop a broad development program.

Finally, moving into the KRAS inhibition space. KRAS oncogene is an important driver of abnormal cancer cell growth. MK–1084 is a highly selective oral KRAS G12C inhibitor. Early but encouraging data provides promising evidence of antitumor activity in patients with previously treated solid malignancies and previously untreated non-small cell cancer whose tumors harbored KRAS G12C mutations. Importantly, on the safety and tolerability profile, we are encouraged by the numerically low rate of high-grade toxicities reported of MK-1084 as monotherapy as well as in combination with KEYTRUDA. The efficacy is also encouraging as overall response rate noted here of April 2023 is 47%, and we have updated data which will be presented tomorrow.
Thank you for your attention, and I'll now turn it back to Dean for some closing comments.

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Thank you, Marjorie. To summarize, the data sets presented at ESMO and covered during this session provide tangible signs of progress across our broad oncology portfolio within our 3 strategic pillars: immuno-oncology, precision oncology, and tissue targeting. In immuno-oncology, we are building on our strong foundation with important progress in earlier stage disease. A special note is the recent FDA approval based on KEYNOTE-671. This approval represents the first PD-1 therapy to demonstrate an overall survival and event-free survival benefit as perioperative treatment in non-small cell lung cancer. In precision oncology, we touched on the important data and ongoing work for Belzutifan as well as for our KRAS G12C inhibitor, MK-1084. And in tissue targeting, through new and continuing collaborations with Daiichi Sankyo and Kelun Biotech, we are expanding and advancing our pipeline with 6 distinct clinical ADCs targeting different tumor-enriched cell surface receptors across a spectrum of tumors in clinical development. As you can see, we are moving with urgency to progress, augment, and diversify our oncology pipeline across multiple mechanisms, and modalities that have the potential to transform treatment paradigms as we look to treat more patients.

Now I will turn the call back to Peter to start the Q&A.

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

Thank you, Dean. And as a reminder for the Q&A session, along with Dean, Eliav, and Marjorie, we are joined by Jannie Oosthuizen, President of our U.S. Human Health Business, who can respond to any potential commercial questions. So Jill, we're now ready to take questions.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Our first question comes from Umer Raffat with Evercore.

Umer Raffat - Evercore ISI Institutional Equities, Research Division - Senior MD & Senior Analyst of Equity Research

I wanted to understand the ILD profile of your HER3 ADC and how do you compare that with your Kelun TROP-2 as well as the AstraZeneca TROP-2, as well as do you intend to study the HER3 ADC broadly in lung because it looks like the TROP-2 might have been selected as being the broad candidate?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Yes, so this is Dean. Why don't I send this first to Marjorie, who has the deepest experience and understanding of ADCs, and then ask Eliav to comment from a broader clinical development standpoint. Marjorie?

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Yes. There are no comparative studies of these agents, so all we can do is comment on the published individual datasets seen to date from each of these agents. And so with the MK-2870, there have been minimal reports of interstitial lung disease in the datasets that we have seen to date. The AEs reported have been primarily hematologic in nature, as well as some other typical side effects that you'd expect from an ADC with a cytotoxic payload. The HER3 ADC, deruxtecan ADC, does have the deruxtecan payload, which has been associated with ILD, as have many ADCs that are out currently on the market. I think it's still early days for this asset, but the AE rate is not higher than you would anticipate from a deruxtecan payload.

Thank you for your attention, and I'll now turn it back to Dean for some closing comments.
Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

Yes. And I would just add that I think that the 2 assets are again very complementary because if you think about the AE profiles, they're somewhat different, and therefore, may have interesting ability to combine in different ways. In addition, I would propose that with 2870 we're able to advance the compound now with Pembrolizumab and with monotherapy. With HER3, we're really excited by the data. You've seen the initial results. The drug has a very different AE profile than 2870, and I think we can create strategies that would make these drugs complementary just as I mentioned.

I'd point out that HER3 ADC as well as 2870 will be developed in different elements -- different parts of the lung cancer spectrum. This is a huge cancer, and again, we see great complementarity and the ability to fully develop both assets with our colleagues in Daiichi Sankyo on 1 hand and Kelun.

Operator

Your next question comes from Luisa Hector with Berenberg.

Luisa Caroline Hector - Joh. Berenberg, Gossler & Co. KG, Research Division - Co-Head of Global Pharmaceutical Team

And congratulations on ESMO today and the standing ovation. Good to see. Now, I just wanted to come in with more questions on Daiichi Sankyo, please. Why partner now on all 3 of those assets? So I guess just maybe a bit of background in the build up to that collaboration. And does Merck have any internal ADC capabilities? And then on the funding of the R&D, the first 75% rather than 50%, which I think is up to $2 billion per asset, can you talk a little bit about that split? And does that signal extension of development beyond the tumor types you listed on slide 11? And so any opportunities for broader tumors that you might mention upfront, and potential combinations with Merck assets?

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

Luisa, so this is Peter. Just to be clear, there’s 1 of the 3 assets that we will be responsible for this first 75% up to $2 billion, and that’s the CDH6. So if you look at the press release, I think it’s clearly stated there. Dean, do you want to take the...?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Yes, I think there were 2 other parts of that question. One was, do we have internal capabilities in terms of antibody drug conjugates? And the answer is absolutely yes. And then the other question was related to why now, I think that was the question. And I just want to be really clear. When we’re talking about all the ADCs that we have made public here, there are clear indications and line of sight that is publicly available. But I want to just make sure that everyone understands that those are a subset of the indications.

The second point that I would make is that these ADCs, it'll be important to see, like everything in cancer, what they do in combination. Where appropriate, it could be PD-1; where appropriate, it could be other chemos or other ADCs; where appropriate, it could be a RAS inhibitor; where appropriate, it could be a novel hormonal agent; where appropriate, it could be a PARP. And so this issue of moving from those clear indications to broader indications and thinking about combinations also have to calculate this question of we're focused on late stage, and there will come a time where we're going to have to ask ourselves similar to PD-1, similar to chemo itself, at what point do you go from later stage to earlier stage? So all those 3 considerations makes it an ideal time for us to partner with both Kelun and with Daiichi Sankyo.

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

Luisa, it was a little hard to hear all of your question. I just want to make sure that we responded to everything that you asked.
Luisa Caroline Hector - Joh. Berenberg, Gossler & Co. KG, Research Division - Co-Head of Global Pharmaceutical Team

Yes, actually, everything was covered.

Operator

Next question comes from Trung Huynh with UBS.

Trung Chuong Huynh - UBS, Research Division - Research Analyst

Trung Huynh from UBS. So, firstly, congratulations on the deal with Daiichi. With some of the data, the KEYNOTE-A39 especially, it's the first time we've seen OS advantage over chemo. And during your talk just now, you were talking about potentially combining ADCs with pembro. I'm wondering your thoughts on combination studies with some of the novel coformulations that you have in house, things like the LAG-3, the TIGIT. Mechanistically, does this have value? And do you have any plans here?

And then, second question, just wondering the possibility about creating a fixed dose combination with an ADC and an IO like KEYTRUDA. Is there any pharmacokinetic reason why you couldn't do that?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

So why don't I just hand this first to Marjorie and Eliav, and then I may make some remarks after that. And I think the question was around whether or not you could combine an ADC with IO combinations, IO combinations that have not -- where we're doing studies but they haven't read out yet. And then I think the other question was fixed dose combinations between an IO and an ADC. Marjorie and Eliav?

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Yes. Maybe I'll start first and talk a little bit about potential additional combinations. So I think ADCs have advantages over historic systemic chemotherapies, in that you're able through the targeting and the construct of the linker and the payload, to deliver more potent cytotoxic therapies to tumor cells, and with the potential to diminish the off target toxicities in the remainder of the body. And so one of the goals of ADCs is to replace chemotherapy. And so in thinking about a development plan, you can do that as a monotherapy. You also could do that potentially in combinations like you heard of earlier where they are established therapies and standard-of-care. And so, for example, KEYNOTE-189 in first line non-small cell lung cancer has set a very high bar for what efficacy can do. And so you could predict that if there is ability to combine with a PD-1 inhibitor, that might be something that you do is try to replace chemotherapy. And so, to date, the coformulations really are still in studies, as Dean stated. And so if there are data that supports that they are superior in combination with chemotherapy to current standard-of-care, it would make sense to try to replace chemotherapy with an ADC if appropriate and based upon what data you might be able to see in early studies. Eliav, did you want to add anything to that?

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

Yes, I think that 1 of the advantages of working with Daiichi Sankyo and their extraordinary ADCs is our ability to provide access to a whole set of medicines that are foundational like KEYTRUDA, but also with different kinds of other medicines that I think would be quite exciting to look at specific subsets of patients. And it's for that reason that we're definitely going to be looking at combinations. As you noted, the coformulations with KEYTRUDA are in clinical trials, and we'll have to see what the results of those trials are before we progress to doing triplets.

One of the other things you asked about is fixed dose of KEYTRUDA and ADC. That is probably not a great -- won't be something we'll be doing simply because it's important for physicians. Unlike the IO-IO drugs, it's important for physicians to be able to control the dosing and control the AE to reduce doses or to change doses with adverse experiences. So whereas coformulations of IO with IO are reasonable, I think with a chemotherapy
agent, including ADCs, we’d want to keep those 2 medicines separate so that we can have independent action on the physician side to manage the patients through those therapies.

Operator

Our next question is from Evan Seigerman with BMO Capital Markets.

Conor MacKay - BMO Capital Markets Equity Research - Research Associate

This is Conor MacKay on for Evan. Can you just please expand a bit more on your confidence in Daiichi’s platform and how it’s differentiated from peers?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

I’ll let Marjorie and Eliav answer, but I would just say that when you look at the construct of Daiichi Sankyo that are in the clinic and approved, I think that gives the field and I mean the field, not just us, but patients and providers’ confidence in their platform. But Marjorie and Eliav?

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Dean, and I would agree with that. I think their platform has already got proven activity based upon data that’s been seen within HER2, as well as with data of DXd. Antibody drug conjugates are quite complicated to manufacture. And so it’s not only the antibody structure itself and where it binds to an antigen, the linker and how the linker is cleaved, both from the antibody as well as from the payload, and the payload itself. And so the platform technology that Daiichi Sankyo has created has already proven itself in clinic. And so I think that it is differentiated that way because it already has established launch medication. So we’re very confident in our ability to work with Daiichi based upon their performance to date.

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

And I would say that from the thinking about how this platform is complementary, the platform that we currently have with Kelun. I think the Kelun Biotech platform is really robust as well. And I think that between the 2 structures, the 2 platforms, we can create different combinations with different AE profiles in different tumors. I think that the data that we currently have with the 2 ADCs we’ve now disclosed are really very encouraging. And I think that the AE profiles of each of these allow us to apply them for specific areas and specific cancers in terms of the combinations that we could contemplate. And again, I think that the tumors that we’re going to go into are in general complementary. There’s going to be a little bit of overlap, as I mentioned, just like you’d think about it with a slight roof, to use the analogy. But overall, I think that this group of 6 will give us a really broad platform that will enable us to manage different settings, different combinations, different cancers, early and late, and allow us to develop the ADC field with the same kind of intensity that we developed KEYTRUDA over the past few years.

Operator

Our next question is from Louise Chen with Cantor.

Louise Alesandra Chen - Cantor Fitzgerald & Co., Research Division - MD & Senior Research Analyst

So I wanted to ask you about the assumptions that went into your statement in your press release on the Daiichi Sankyo agreement that these programs have multibillion-dollar worldwide commercial revenue. Just curious how you’re thinking about that when you say approaching the [mid-2030]. And then if you could elaborate a little bit more on the market opportunity for KEYNOTE-671, that would be helpful.
Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

I am so thankful that someone asked me a question about KEYNOTE-671, which I think is really important. But before we'll take care of your ADC question with Jannie, and then we'll take care of your 671 question with Marjorie, Eliav, and then Jannie again. But Jannie, the first question about the ADCs.

Jannie J. Oosthuizen - Merck & Co., Inc. - Senior VP & President Merck U.S. Human Health

Yes. Louise, so in terms of the ADCs, despite the major advances we've made in the last 10 years across multiple tumors and lines of treatment, there's still significant unmet need that obviously exists within cancer treatment. So we are really excited to be part of this new modality with a total of 6 ADCs now, and these 3 from Daiichi Sankyo in particular, to continue to pursue indications and lines of therapy that will bring significant -- or that will address the significant unmet need that still exists. We view these 3 ADCs as having potential to be used across multiple tumors and at an aggregate level. We view on a risk-adjusted basis that these 3 assets will have multibillion-dollar potential. And each asset on a non-probabilized basis will have multibillion-dollar potential. So we are very bullish in terms of where we think our scientists will go with these 3 ADCs. And at the end of the day, really address significant unmet need.

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Yes. So I'll give it to Marjorie and then Eliav for KEYNOTE-671. But I just want to start off, we're talking about lung cancer, the #1 cancer killer of men and the #1 cancer killer of women in the United States and the world. So I think the 671 data is very important for the field if we're serious about really addressing cancer mortality in this country and globally. Marjorie, do you want to take it? And then Eliav, and then I'll turn it to Jannie to speak about the dynamics of the market.

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

671 is a special study. It was carefully designed and executed to really determine not only could KEYTRUDA in combination with chemotherapy prior to surgery and then adjuvant KEYTRUDA improve event-free survival, but it also was actually designed to do the coprimary test of overall survival. And the other studies haven't really been designed that way. Overall survival is a secondary endpoint. And we really are thankful that we designed the studies that way because with 36 months of median follow up, we've already demonstrated an overall survival advantage that's not only clinically meaningful but statistically significant. And I think that really is important for clinicians and patients because it gives certainty that the data that you're giving can improve overall survival. And these are people who historically they considered lung cancer a death sentence. And so having a regimen that's proven to not only keep cancer from progressing, but to help people live longer is just really, I think, a tremendous step forward in the field.

And in the sessions here at ESMO, one of the speakers talked about this as something that really is transformative in the field. There has not been a study that's shown improvement in overall survival in this perioperative space in over 30 years. And then another speaker put a gold medal next to it because there the overall survival advantage has improved. And so I think that that's very compelling for clinicians because when you're giving a regimen, you always want to make certain that the benefits are there and overall survival is the gold standard of endpoints. So when we get an event-free survival, we're very happy with that. But the overall survival is, I think, what really makes us special and resonates with both physicians and patients.

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

Yes, I think that the key here is the fact that we're the only company that has demonstrated -- only study that has demonstrated an overall survival benefit. I think that for the first time in about 30 years now, this is the first demonstration in any early-stage cancer, lung cancer, that we've been able to do that. And so I think that's why we got that gold medal or gold star or whatever it is in the discussion. I do think that there is also an enormous consistency across the different subgroups, and it's a broad population that's included, by the way, those people with [driver] mutations...
as type of cancers. So I think that's really important. Obviously, the fact that there's an overall survival benefit will, I think, stimulate organizations who are interested in improving cancer outcomes to really advocate for screening and for increasing screening among those eligible per the guidelines. And I think that all of this will really advance our ability to nip lung cancer in the bud, so to speak, in its early stages. I'll turn it over to Jannie for his comments.

**Jannie J. Oosthuizen** - Merck & Co., Inc. - Senior VP & President Merck U.S. Human Health

Yes. So from a commercial point of view, we've obviously been transforming the way that metastatic disease has been treated with KEYTRUDA over the last 9 years, with KEYNOTE-189 in particular in the metastatic setting. And it's really exciting that we can now move into the early stage in this potentially curative setting. We've been there for a while now with KEYNOTE-091 in the adjuvant setting, and now we have an opportunity to really move forward with the perioperative modality, with the evidence of overall survival that hopefully will spur physicians on to treat even more patients. We know one of the big challenges in early-stage lung cancer is that it's not just the low screening and lower diagnosis of patients in this early setting, but even patients that are diagnosed are not all treated as they could be. So with the evidence of OS and EFS in hand, hopefully, this will -- and this is how we will use it, is to really spur physicians on to treat patients before and after resection with this modality.

**Operator**

Our next question is from Chris Schott with J.P. Morgan.

**Christopher Thomas Schott** - JPMorgan Chase & Co, Research Division - Senior Analyst

Just 2 questions for me. Maybe just, first, just interested in your perspective on TROP-2 and your program in lung relative to, I guess, the ASTRO data we saw at this ESMO. I guess just have the competitor results in any way changed your enthusiasm, approach, or just views in terms of the role TROP-2 is going to play in lung here at all. And the second was just we'd love to get your latest thoughts on TIGIT and thinking on mechanism and your asset in light of some of the competitor headline data we saw about, I guess, 1.5 month ago or so.

**Dean Y. Li** - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

So, Marjorie, you want to take a first shot and then Eliav?

**Marjorie C. Green** - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Yes. I think that each of these ADCs are different, and so we always pay attention to competitor data and emerging information, but we really rely on the data we generate with our own assets and make our development decisions based upon that. And so we do have a broad development program planned in lung cancer, which we have not really fully described publicly. And so we are confident in our plans, and we'll be happy to share them with you as we get ready to roll them out.

**Eliav Barr** - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

And, again, this was a second line study that we saw, and the results are evident. I think that it’s important for us for the overall point of view here, is that there are many different settings within the lung cancer space and many different drugs with different ADCs that have somewhat different profiles. And as Marjorie points out, we’re bullish in what we see with our ADC in our hands with our data, and I think we’ll be able to demonstrate our confidence in that through the clinical trials that Marjorie and her team have developed. You asked about TIGIT as well, and I wanted to say that we remain confident in our TIGIT program. The studies are proceeding apace, and we hope to be able to read out results as interim analyses and data accrue, and we'll be sure to share those results when they arrive.
Operator

Our next question comes from Steve Scala with TD Cowen.

Stephen Michael Scala - TD Cowen, Research Division - MD & Senior Research Analyst

A few questions. Does Merck believe the ILD associated with deruxtecan can be tempered? And if yes, how are subsequent trials being designed to do so? Or is the answer that it is what it is and it can't be modified? Second, WELIREG has been a positive surprise within the Merck oncology lineup. What other opportunities are there for WELIREG beyond RCC? And then lastly, just to be clear, within the ADCs that you're collaborating on with Daiichi Sankyo, are there only certain tumors and/or settings that can be pursued, or can you pursue anything you want with each of these 3 ADCs?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Well, I'll just take the last one, first, which is we work with Daiichi Sankyo, and the ambition that we have is to advance those 3 ADCs similar to how we operate with Kelun to maximize the impact of those ADCs on medicine and on patients. So there's no limitation, except for scientific feasibility. That's the first layer that we go through. And that's Adjudicated with Marjorie and Eliav, with the equivalent leadership at those 2 respective companies. In relationship to ILD and WELIREG, I'll let Marjorie and Eliav speak about that.

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Yes. First, I'll talk about WELIREG, I think that the data from LITESPARK-005 was really tremendous to be able to show activity in a broader population of patients than our original studies looking at patients with Hippel-Lindau disease. And so it does show the promise of where you've got an angiogenesis driver potentially through HIF-2 alpha where you're able to make a difference. And so we do have ongoing studies looking in solid tumors, exploring the potential for WELIREG. And we'll be happy to discuss those as we have data and our development plans continue on.

In regards to ILD, I think Daiichi Sanko, this is their technology, and so I don't want to speak on their behalf, but I think that what you've seen in the field with the drug that's available primarily, which is in HER2 right now, is that clinicians get very good at managing toxicities when they are present. They learn to screen for them, they learn to monitor, to dose modify, to take breaks. And it has not stopped the ability to be able to fully develop and HER2 for Daiichi and AstraZeneca. And so these drugs are all distinct, they have different drug antibody ratios, and therefore will have different toxicity profiles, including different rates of ILD, if that's present. And so I think it's premature for us to really talk too much about that currently based upon where these assets sit. But these are manageable toxicity. It isn't that we don't want to do anything about them, but we're very careful looking at efficacy and toxicity when we pick the dose of a drug. And that's part of something that is considered when you're developing this kind of ADC.

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

Yes, I have to just emphasize, as Marjorie just said, each ADC is separate and has its own profiles. One of the things that I've been really impressed with, the work that we've done with the 3 ADCs so far with Daiichi Sankyo is how well they've thought about dose ranging and finding doses that are extraordinarily active with relatively minimal ILD. I think that the lessons and the experience that they gained with the first 2 ADCs has served them incredibly well, because it's impressive to us to see how well they've been able to think through both dosing strategies as well as approaches to patient management that will enable these 3 newer ADCs to have as low as possible ILD while maintaining activity that we were really quite impressed with. So I think that this may very well be somewhat of an issue of these drugs when they were newer and with the doses that may have been selected for some of the earlier ADCs. But the 3 that we have, I think, we really have quite a manageable profile, as Marjorie had pointed out.
I just wanted to make 1 comment about WELIREG because we talk about the 3 pillars of immuno-oncology, precision oncology, and tissue targeting. I just want to lay out that question about WELIREG, right? So WELIREG was first done for VHL syndrome, where there's a germline mutation. Now we've moved it into RCC where there's sporadic or somatic mutations. And you would think about that in combinations in certain places where that is important. But also you have this overarching broader physiologic question as to not just in terms of germline or somatic mutations, but its effect more broadly on angiogenic pathways. The reason I also want to emphasize it in terms of precision oncology is I want to just emphasize what Marjorie said. The data that we presented here or discussed here in terms of KRAS is one that will change. The slides will change tomorrow at 8:00 A.M. in Madrid on Monday. So the reason -- we can't preempt that data, but I would suggest that many of you who are interested in our push into precision oncology not just WELIREG, but more broadly, that someone should listen into that presentation.

Our next question comes from Chris Shibutani with Goldman Sachs.

I wanted to ask perhaps to Dean in particular about clinical development strategy in the context of IRA. I think it was immediately after ASCO that you and Merck were quite emphatic about how you felt about the potential disincentives to move into earlier lines of treatment. And just as I think about what we've learned incrementally since then about potential advantages, clearly clinically, but also potentially strategically, about Sub-Q, and then how you've continued to make decisions about prosecuting combinations, including ADCs? And as you outlined what the strategy here is, which I see a lot of relatively derisk but later-stage clinical advancement opportunities, can you refresh us on your view about the pros and cons of moving into the earlier stages, the adjuvant, what role Sub-Q in particular might make and how the ADCs fit in?

So, Chris, I think you were the one who described that my response at ASCO, or outburst at ASCO, I think, you described politely as passionate in relationship to the IRA. And I think your point is extremely well taken because the issue for us is that, as you know, when you look at 671 or -- it's not just 671, it's also many of the other people who have moved their best agents into earlier stage, where you really can make a huge impact. Those clinical trials, they don't take 3 years. In metastatic it might be 3 to 5 years. Earlier stage often takes 5 and in some cases 8 years. So one has to be very thoughtful when 1 moves an agent from late-stage to earlier stage. But I also think that 1 also has to think about the broader medical benefit for patients. If you really believe that this could really have an impact on earlier stage cancer, where the possibility of cure is there, I think you have to think really hard about how you invest.

And one of the things that I think will happen is you're going to have to take your best agents and make that decision of moving agents into earlier-stage cancers. You're going to have to make it much earlier. If you look at how KEYTRUDA was developed, we took 2013, maybe to 2017-'18 largely looking at the metastic space. And then around that time, that's when we pivoted into earlier stage. I think that development plan becomes much more challenged with the IRA, and it becomes much more challenged, especially depending on the modalities. But I want to emphasize we are committed to take clear agents with good clinical efficacy in late-stage clinical development stages or late-stage cancers, and we are committed to moving them into earlier stage. We're going to have to think about how to do it and when to do it differently than when was done just 5 to 8 years ago.

Great. I'm going to read a question that was emailed into us from Daina Graybosch from Leerink, who was unable to make today's call. The question is, what specific data or milestones are you looking at when you consider the opt-ins for both the HER3 and the CDH6, the 12 to 24 month additional opt-ins that we have on those 2 programs?
Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

So I'll give Marjorie and Eliav to talk about the important data that we think could develop. But we should also be very clear that the complete development plan and the complete decision making of that, we're not sure that we want to reveal all of this here. This is a competitive space. But Marjorie and Eliav, in terms of HER3 and CDH6, what would make you excited? And essentially for CDH6, there was recent data that was presented today. Marjorie and Eliav?

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

Yes, and I think, Dean, you really took my answer a bit, is that the development plans are going to be data dependent. And so our partners, Daiichi, have already started signal-seeking studies in a variety of solid tumors. And so the data reveals our excitement. And so to go into each tumor and what threshold it would take, I think it gives up a little too much away of what our plans are and what we're looking for. And so I think we're going to be really thrilled to be able to talk about our upcoming development plans as they emerge and as the data helps guide the way.

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

I'm going to read a second question. It comes from Andrew Baum from Citi. Will you initiate a first-line TROP-2 SKB264 trial for non-small cell lung cancer in the absence of an IHC biomarker, #1? And is an immunofluorescence biomarker a viable way to measure TROP-2 ADC internalization?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Marjorie and Eliav, do you want to take a shot at that?

Marjorie C. Green - Merck & Co., Inc. - Senior VP & Head of Late-Stage Oncology - Global Clinical Development

I love Andrew's question because it made me scratch my head for a second. And I think he's asking a great question about biomarker selection. And lung cancer, like many, many other malignancies, you're seeing more subdivision and fragmentations, and that's happening naturally in oncology. And when you've got a targeted therapy, intuitively, you would think that you would be able to use a biomarker to select which patients might benefit the most. There is, bystander effect with our TROP-2 ADC, and what that means is that you're able to affect tumor cells nearby that may not have the same level of expression. And so we haven't fully disclosed our plans, and so I think it's premature for us to discuss what we'd be doing in the first-line setting.

The second part of that question was about a particular way to look at internalization. And we do activities like that preclinically and look at in vivo models. That's not something that we necessarily do actively in the clinic, and I don't believe we've published information on that. And so I'll say that it is something that is looked at because you want to understand the internalization of the antibody as you're developing your ADC.

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

As I think we've described in our past interactions and public statements, we are very interested in looking at biomarker-driven strategies and are working very hard to develop proprietary assays in measuring -- that would correlate with TROP-2 susceptibility. We have several hypotheses around a variety of different assays for each of the assets that we have, and now we'll work together with Daiichi Sankyo and theirs, and those strategies are being evaluated in our clinical trials.

Operator

Our final question will come from Cerena Chen with Wells Fargo.
This is Cerena for Mohit Bansal. I had a 2-part question. So first on KEYNOTE-A39. Congrats on the really impressive data. Given the toxicity profile of Padcev, is there a potential to use Padcev for a shorter duration in combo and then pembro as maintenance? And then the second part of my question is the multibillion opportunity expected from the Daiichi collab, is that incremental to be over $10 billion from new mechanisms in oncology that you guys have talked about before?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Yes. So why don’t I have Marjorie and Eliav take care of that first one about Padcev and pembro, and then have Jannie take care of the second one in terms of incremental over what was said, I think in January or so at JPMorgan.

Eliav Barr - Merck & Co., Inc. - Chief Medical Officer & Head of Global Clinical Development of Merck Research Laboratories

Yes, let me take the A39 one. First of all, when you see the results, such as they are, and the ability of patients to achieve such amazing results, it’s going to be hard for physicians to feel comfortable about de-escalation in a manner without having had really good reasons to do so. That’s the whole point with the 2 drugs. And I’d point out that the chemotherapy arm and the Padcev-KEYTRUDA arm had comparable rates of grade 3 plus and serious adverse experiences. It’s just they were different. I think that the trial protocol, as well as now, physicians who are getting more and more comfortable with managing the various toxicities, were careful to provide ways in which EV can be administered and continue to be given to patients when they experience some modest toxicities so that they don’t become severe. And so I think that the overall picture here, as shown by the OS data is that this regimen is really quite important for patients. Speculating about different changes in those regimens is very difficult to say. I don’t know how that might be tested. But I do think that physicians naturally are learning how to use EV. And the clinical trials themselves will provide that guidepost about how long patients can stay and tolerate the AE profile of the combination. And obviously one drug or the other would be stopped, but probably EV. But we’ll have to follow that in real world practice. I’ll turn it back to Rahway for the rest.

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Jannie?

Jannie J. Oosthuizen - Merck & Co., Inc. - Senior VP & President Merck U.S. Human Health

Yes, so I’ll just Cerena, on your question regarding the $10 billion we spoke about before, that was really based on a suite of ADCs, including ROR1, TROP-2 and others, as well as the pipeline small molecules in terms of CYP11A1, the Orion product that we are studying, LSD1 inhibitor, KRAS inhibitor and the BTK inhibitor and others. So the Daiichi Sankyo deal really does come as an incremental on top of the $10 billion that we spoke about before.

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

Dean, a couple closing comments?

Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

Yes, I really enjoyed the discussion with all of you. I think it just highlights what we’ve been trying to do. We had conversations about KEYNOTE-671 and also earlier stage, we had conversations about Belzutifan and KRAS G12C, and we had conversations about tissue targeting with Daiichi Sankyo and Kelun Biotech, and so we’re really moving as fast as we possibly can to really diversify our oncology pipeline using the wall of data and wall of insight that we get from the assets that we already have and the multiple internal as well as external collaborations that really create an avenue
for us to think about where we need to go next. And so I think as we talk more, I think it's really important that all of us keep that in mind as we seek to diversify our oncology pipeline and really have the potential to transform treatment paradigms as we look to impact more patients.

Peter Dannenbaum - Merck & Co., Inc. - VP of IR

Great. Thanks everyone for joining us today. Please follow up if you have any outstanding questions, and we look forward to being in touch soon. Thank you.

Operator

This does conclude today's conference call. We thank you all for participating. You may now disconnect and have a great rest of your day.