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PRESENTATION

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Hi, everybody. Thanks for joining us this afternoon. I'm Terence Flynn, the U.S. biopharma analyst here at Morgan Stanley. We're very pleased to be hosting Merck this afternoon. We have Dean Li, who is President of Merck Research Labs; and Caroline Litchfield, who is the company's CFO.

Before we get started, for important disclosures, please see the Morgan Stanley research disclosure website at www.morganstanley.com/researchdisclosures. If you have any questions, please reach out to your Morgan Stanley sales representative.

Well, thanks both so much for being here today. Really appreciate it. A pleasure to be hosting the company today.

QUESTIONS AND ANSWERS

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Maybe Caroline, I thought we'd start off with the business. Obviously, it's been performing exceptionally well here. Maybe just help us think about the puts and takes as we go into the back half of 2023 here.

Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

Very good. So thank you for having us here. It's a pleasure to be with you all. We've started 2023 extremely strong with great performance over the last quarters. And as we look to the full year and as we guided at the second quarter, we're expecting underlying double-digit growth. And that growth is really a result of the significant products we have in Oncology, in Vaccines and in Animal Health. So as we look forward to the remainder of the year, we're expecting continued strong performance across our portfolio.

We're also seeing great performance from our pipeline and in how we're progressing our pipeline, and we're augmenting that pipeline with scientifically focused, financially disciplined business development. And so as we look forward to the rest of the year, and indeed, Rob said this in our second quarter call, we're increasingly confident on our opportunities for growth, not only as we exit 2023 but also into the future, which maybe gives Dean an opportunity to talk about some of the areas we're very excited about.

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

Yes. I mean just quickly speaking, Rob, myself, Caroline, have been in the seat around for 2.5 years, and the issue for us was to diversify in oncology, leveraging KEYTRUDA. I think you see that. You see especially the trend or earlier-stage cancers. We're going to have KEYNOTE-671 in lung. If that gets approved and has impressive approaches, that will be important for the field. But it's also moving into the neoantigen therapy with Moderna as well as the TROP2-ADCs and others.
But also, we also said we needed to expand outside of oncology quickly. And you see the conversation. The conversations is about V114, but now increasingly about V116, what we hope to be the first adult-specific pneumococcal vaccine strategy as well as sotatercept and also as the advancement of what we view not as a PCSK9 medicine, but the most potent LDL-lowering cholesterol medicine pill in a pill form moving into Phase III. So those are the movements that we're very interested in continuing.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Great. Maybe just to dig in a little bit deeper here. KEYTRUDA obviously has been a strong growth driver for the company. The newest indication set is in the adjuvant setting, some earlier-stage cancers. And so maybe specifically, you just talk about what you’re seeing now in terms of the dynamics and how to think about that as we roll into ’24. Again, my perception is maybe ’24 is more of an ex-U.S. growth story given kind of the timing of reimbursement there. But just help us think through that as a driver as we head into ’24.

Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

Yes. So KEYTRUDA really has had and continues to have significant impact in the metastatic setting and indeed is still driving growth in the metastatic setting, and we expect that to continue. But increasingly, our focus has been to try and help patients earlier in their cancer journey. And we have a number of indications in the earlier-stage setting.

Now not every cancer is the same. And what we’ve seen with cancers such as melanoma or breast cancer, there’s robust screening processes that are identifying patients and there’s processes to then treat those patients. So we’ve seen great uptake, fast uptake in the support of cancer patients in especially indications such as melanoma and also in breast.

But there’s other cancer types, such as lung, where today in the United States, less than 6% of eligible people are getting screened. The majority of patients, when they’re diagnosed with lung cancer, they are metastatic. They’re not in the early-stage setting. And as Dean just noted, we’ve got great data with KEYNOTE-091 but now with 671 with a PDUFA in the end of this year, where we think we’ll have a real impact for patients in that setting.

So as we look at growth going forward, we’ve seen great growth with the current indications in early-stage in the United States. And as you rightly note, we will have that growth now in the ex-U.S. markets as we gain approval and reimbursement.

Lung will be an opportunity for growth, but it will be on a likely lower – excuse me, slower growth trajectory just based on the patients being seen later in their disease. But we do expect early-stage to be a significant part of the story for KEYTRUDA. Indeed, we expect early-stage to represent about 20% of our sales this year. It’s the majority of our growth, and we expect it to be about 25% of our total sales for KEYTRUDA in the year ’25 and grow thereafter.

And this is really important because the earlier we can treat patients, the better the prognosis. And we’re not stopping there. It’s an important part of why our subcutaneous KEYTRUDA program is underway to ensure we can provide improved access for patients and for that broader patient segment as we see a younger, earlier-stage cancer patient moving forward.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. Great. Maybe one follow-up there is that 20% this year, that's on a global basis? Or that’s...
Okay. Okay. Perfect. Maybe just, again, in the interest of time, pivoting to GARDASIL. Obviously, another strong growth franchise for the company. And again, the story here has been the global rollout. I think more recently, the company has brought on new capacity recently. So maybe just help us think about the pacing of that new capacity coming on board. And is there any incremental opportunity in the U.S.? Or is it still the kind of ex-U.S. story?

Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

So GARDASIL, as we all know, is a wonderful vaccine that it is helping prevent HPV-related cancers. We have worked really hard within our organization to improve the productivity of our existing manufacturing capabilities while at the same time build out new bulk manufacturing facilities. Those bulk manufacturing facilities are here in the United States and will come online progressively during this year, ’24 and ’25. And by the end of ’25, we’ll be fully unconstrained to continue to protect more lives across the globe.

As we think about where the demand may come from, we have an opportunity to increase vaccination rates for adolescents in the United States and in the Western world. Vaccination rates are in the 70% here. For a vaccine that’s preventing cancers, one could argue that should be in the 90s. So that’s an opportunity for growth. We have an opportunity for growth by vaccinating more males, and that’s especially in our ex-U.S. markets as we gain regulatory approval, and we’ll be driving for people to get that vaccine.

We have an opportunity in the mid-adult segment both here in the United States and outside of the U.S., but we also have an opportunity to increase vaccinations in the lower-income and middle-income markets, which will obviously be at a lower price point. So our goal as a company is to protect as many lives as we can across the globe.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. And maybe one on margins before you go over to a kind of two-parter for both of you. Just in our model, we see the gross margin expanding by about 9% in 2027 as some of the royalties roll off. And so that should provide the company with increased cash flow for either business development, share repurchase or dividends. So just maybe remind us how you’re thinking through the capital allocation priorities, that mark.

Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

Yes. So I’ll say bottom line, we’ve seen great margin progression in our company. And we expect that as we go forward for the reasons Terence has alluded to: mix of revenue and some royalty roll-off, productivity in our business, but while at the same time, we will invest in our rich and broad pipeline.

As we think about capital allocation priorities for our company, first and foremost is to invest in our business, invest in our pipeline, invest for future products to make a difference in this world that will drive growth. We are committed to our dividend and growing that dividend over time. We will augment our pipeline with scientifically focused, disciplined business development. And to the extent there’s any excess cash, we will return that to our shareholders. At this stage, we expect a modest level of share buybacks.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. So the two-part question, and again, I know Dean has passionate views about this, but just as you think about changes the company is making in a post-IRA world, maybe just from your seat, Caroline, and then from your seat, Dean, how are you adapting the company to kind of enter that new world in a post-IRA setting?
Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

I'll start with the big picture and then Dean can take on. The IRA is obviously impacting all companies in how we're looking at our resource allocation choices, our business development, evaluation and, of course, how we progress our pipeline.

For Merck, as we sit here today, we've had no significant change in our strategy or in the programs that we're executing. We will continue to focus on innovation, focus on trying to solve the many different unmet medical needs there are in this world to drive impact for patients and to drive growth. So that's what we'll continue to do.

As we look at the coming years, we are confident in our company's ability to grow given the volume growth we expect for our innovative portfolio, which more than offset the impact that IRA will have on the price points here in the United States. So we're confident in growth. It will have an impact, and we are being very focused and disciplined in our resource allocation decisions and the view of our clinical portfolio.

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

Yes. In relationship to the Inflation Reduction Act, I would just emphasize that I worry that there's some unintended consequences that those who are very interested in advancing new medicines that there's great unmet needs might not have totally taken into account.

I look at small molecules and I sit there, I said, if you want to affect the broadest patient population, not just within the U.S. but throughout the world, it's small molecule. Why would you want to disadvantage that, especially when small molecules, when they come off patent, they come off patent fast. So that's an interesting sort of point of view that I'm not sure that those who wrote the legislation understood.

But I actually -- just goes back to the earlier-stage cancer issues. Everyone knows in cancer, for example, that you prove the benefit-risk of your molecule in metastatic. You're comfortable with that kit, and then you move your best drugs into earlier-stage cancers. Those earlier-stage cancers, whether it's from our company, whether we're talking about KEYNOTE-671 or recent data at ASCO by other people, they take 5 to 8 years, right? They take longer.

So you're in a situation where you've created an environment where people will take their medicines into, for example, metastatic cancer, but they will be very thoughtful as to whether or not they're going to put in earlier-stage cancer exactly at that time. We're curious within reach at that earlier stage.

And I would say that it was an unintended consequences of the IRA that I thought might not have been thought through. But where I get a little bit tripped off is, I wonder if it was unintended when you have prominent individuals talking about making it 5 years. That will make it impossible to drive the treatments that cure cancer.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Understood. Would Merck ever rethink the amount of R&D investment as a result of IRA like down the road, depending on how that evolves?

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

So we're going to do it by where we can have the biggest impact. It will -- it has to be viewed in relationship to the modalities that you think about. But in relationship, for example, of how you step-wise do things, I think you're going to have to take on more risk.

So for example, you look at KEYTRUDA and how it was developed. You prove it in melanoma, you prove it in lung, you do this, you have that basis from 2015 to 2018, and only then do you start it in earlier-stage cancers. Only then do you start it. I think we're going to have to make some of those decisions sooner and in doing it, take more risk in relationship to that.
But if you ask, are we not going to do these things that can change the trajectory of medicine, we're not going to walk away from that. Our risk profile of how we think about it will have to change, but we will take the risk.

**Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst**

Okay. Understood. That's a good segue to the next topic I wanted to go into is obviously, Merck has been a leader in immuno-oncology. And as we think about -- we talked about adjuvant already as kind of the next area, but then there's the immuno-oncology-immuno-oncology combination approach, which again Merck has invested significant amount of R&D dollars. Many programs going on here.

I think the one that is kind of emerging to the forefront more recently is TIGIT as a target, and you have a program in Phase III. So Roche had some data that was leaked out recently. So maybe just, Dean, help us think through implications of that data for your program and then where your confidence stands as you think about TIGIT as a target that can move the bar even higher here beyond where KEYTRUDA already is.

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

So I'll answer the second question first then the first, because I would ask this. Don't worry about what I say. Watch what I do. So this past year, we actually started another Phase III PD-1 plus TIGIT in earlier stages in melanoma. I think IO-IO strategies and IO by itself is especially, especially useful in the earlier stages. So that demonstrates our confidence in continuing to invest in IO and IO-IO.

I would also emphasize our commitment to the individualized neoantigen therapy is, again, IO plus IO. But where are we deploying it? We're deploying it in earlier-stage cancer. So there's a theme there.

In relationship to the data that you spoke about, that data suggests that TIGIT on top of a PD-L1 that there is clear potential benefit of TIGIT on top of a PD-L1. The bull case is that differential, if you now add it to a very high-performing PD-1 like KEYTRUDA, that would be substantial.

The bear case is if you look at that PD-L1 plus TIGIT and compare it to our PD-1, which is largely the state of the art, that's when people sit there and say, is that a bull case or a bear case? So we'll have to see with the data as it rolls out, but I just want to emphasize IO and IO plus IO in that earlier-stage cancer, I think, is an important concept that we continue to reevaluate and we continue to double down on.

**Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst**

Yes. Okay. Great. What -- and maybe just remind us, Dean, of your lung cancer program, kind of the key trials and what you've said regarding timing of any data from this.

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

I always forget because I know what the different dates is. I think it's '25, I'm going to say there is -- in relationship to the Phase III readout. That's when they'll be getting out.

**Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst**

Okay. Understood. I think the other question is on the TROP2 space. Obviously, there's been a lot of movement across the industry here. Merck has a program that you license from Kelun-Biotech, and there was some interesting data at ASCO this year. And you're moving aggressively.

So as we think about -- maybe first question is just remind us of your program kind of next steps and then differentiation, because I think that's the other thing investors are trying to kind of work through here. As we look at data from Astra, Gilead and then Merck-Kelun, what are the key areas of differentiation that you see at this point based on the data we've seen?
Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

So I would just take a broader view. The minute you saw pembro plus chemo change how many for cancers, that changed night into day. That essentially changed night into day. And the issue is whether next-gen chemo as in antibody drug conjugates could do the same. I would emphasize that, that was an open question until this past year. And the readout was the collaboration we did with Seagen in relationship to pembro plus PADCEV. So that really solidified this concept that, that pembro plus chemo could be applied to pembro plus next-generation chemo or the antibody drug conjugate.

In relationship to Kelun and TROP2, we have a long-standing relationship with Kelun longer than what has been publicly revealed. And so it's not just a deal about TROP2. It’s a whole series of pipelines. In relationship to the TROP2 itself, I think the issue that the field has to ask, especially in relationship to lung cancer, is can a TROP2-ADC do something more than a PD-1 or a PD-1 plus chemo? We believe that it can but we believe that the TROP2-ADC deployed in the broad patient population with which pembro plus chemo might work may not be the best way to differentiate it.

We believe that, for example, you may want to subsegment the patient population so you maximize the advantage of having a TROP2-ADC. So we're not of the school of thought that the TROP2-ADC is going to have a broad impact in the breadth with which a pembro-chemo can work. But it may -- we may need to test whether it does have that broader impact but also be open to the fact that it may not and it may require subsegmentation.

When you specifically look at lung, one of the things that you think about in a lung patient is that their lungs aren't normal. And you also have to understand that PD-1 is highly [seen] by so many individuals. It’s a safe drug. It’s a good drug, but there are adverse effects with pembrolizumab, and that’s interstitial lung disease.

When you talk about a TROP2-ADC and a pembro, what you don't want is overlapping toxicity. So we scour our data with the TROP2-ADC with our partners, Kelun, especially in relationship to lung to see is there any evidence of severe interstitial lung disease, either in monotherapy or in combination, whether deployed in lung and any other tissue. And so far, we haven't seen that. So that gives us the ability to sit there and go, well, we should test this right off the bat in first line. We should go directly to that pembro plus ADCs in non-small cell lung cancer in first line.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. And one follow-up. So can I take from your comments regarding the subsegment that, that's your preference, is to go with a biomarker-driven approach in Phase III? Or was your comment about we need to understand the breadth, too, meaning you’re going to do a broad trial and then you’re going to have an enriched cohort as well?

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

So I would love for a TROP2-ADC or any ADC to be able to have in such a broad population. I think we want to open up that possibility that, that could be true. But if we -- if you only rely on that, I would be very concerned if [that’s your only rise]. So of your 2 options, the option 2, I think, is something we have to think carefully about.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. Understood. And would that be true beyond lung cancer as well?
Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

I would say that, in my view, essentially what you’re trying to do with antibody drug conjugates is you’re trying to move chemotherapy into a precision medicine approach. I mean that’s the tissue targeting where if we’re going to do that, then we should think about the appropriate segmentation of the population, if that was the whole rationale that you did ADCs in the first place.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Yes. Okay. Understood. And again, I think you touched on this a little bit, Dean, but the INT or the -- what I used to call a personalized cancer vaccine moving into the adjuvant setting here with Moderna. Maybe just help us think about -- we've seen melanoma data, which obviously a lot of IO agents generate activity there, but you're also moving in parallel into colder tumors such as lung.

So what drives that confidence level? And again, like what you spoke to, kind of moving to -- moving rather than speaking, you're already moving into adjuvant setting. And so should we read that as you have a high degree of confidence here on the lung side as well? I'm just trying to kind of understand what...

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

Yes. So I should just emphasize this has been a partnership with Moderna for 6, 7 years. We've been working on this for 6, 7 years. That data just came out last year, but this has been a long process. So that's number one.

The number 2 issue is there was a debate as to how we would develop it. There was one debate to say we should make a cold tumor hot. We should put it where KEYTRUDA didn't work or where there was no evidence of IO. And we chose not to do it. We put it in melanoma.

And the interesting thing is I think most people recognize that PD-1 or KEYTRUDA, specifically, in adjuvant melanoma, has a profound effect. And so there was a debate as to is that where you would put a vaccine or individual neoantigen because the bar is already high. And the data that came out a year ago is there is a substantial improvement with that.

[That immediately] sat there and go, wow, there's 2 different ways: kind of go into cold place or go where you can show that earlier stage works with a PD-1. If there's a place that you could do those experiments, it's at Merck, given how many approvals we have and we can advance that. So our concept is we're going to focus on earlier-stage cancers where there is evidence. There is clear evidence of immunosensitivity. And that immune sensitivity, by definition, in some sense, is did your PD-1 work there?

Other companies are going the other direction, and we watch their data like hawks, as you might imagine. And if they get more traction in this, it may change our strategy. But we are going to play where we can contribute to the field most, which is an immune-sensitive, early-stage cancer.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. Understood. And kind of the derivative question is on melanoma. What’s the latest in terms of thinking about filing for an accelerated approval on that melanoma dataset versus waiting for the full Phase III trial?

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

We're focused on doing the Phase III trial. One way or the other, you're going to need that Phase III trial. So to me, that's just critical. In relationship to other optionalities and all of this sort of thing, those are -- I think our partners at Moderna have expressed some interest in exploring those. But at least for me, one way or the other, you're going to need to prove it in a solid Phase III. So that's where our focus is.
Okay. Understood. The next area I wanted to touch on a little bit, and again, this is more of a mid-stage program. You have a GLP-1 glucagon receptor dual agonist. And obviously, there’s a tremendous amount of excitement right now around GLP in general and metabolic diseases given the data that’s been emerging from a lot of the data from Lilly and Novo.

So maybe just at a high level, remind us kind of your historical interest in this space. And then does this asset that, again, I can’t pronounce the name now, but you have the full name out there. Does this asset...

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

You and me both.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Does this asset trigger a kind of broader move into the metabolic space for the company? And then maybe, Caroline, you can comment on business development interest in -- on that front.

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

So as you’re talking about the historic interest, the historic interest is JANUVIA is the first medicine that was built to actually increase endogenous levels of GLP. Unfortunately, that’s coming off patent. But the GLP pathway as the work done by Novo and Lilly has advanced. They have focused initially in diabetes and obesity and now with cardiovascular outcomes.

Our focus has been in terms of NASH and liver fat. We look at this compound as something that can give you weight loss, but that’s not the driving force. The driving force is it’s extremely tolerable and we can drive liver fat reduction greater than 70%. And the question is if it can drive it down for 70%, would it be really important for those patients with NAFLD and NASH to prevent liver failure? So that’s a subsegment. There will be weight loss with it, but that’s not the driving force. That’s where we’re focused.

In terms of taking that molecule into the broader sort of field of obesity or something like that, I don’t think that’s where we would put that compound. We should put the compound where we have a differentiated potential advantage in an important disease, and NASH is that for us.

Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

And so from a scientific focus perspective, Dean has a broad portfolio that we are working through in discovery. We augment that with business development. And at this stage, we look at BD in oncology and outside of oncology. And we really are following the science in where we see that innovation matched with value align, we’ll act as you’ve seen us do so. So expect more in that space, but we’ll continue to look at all different therapeutic areas.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. One, I guess, follow-up, Dean, is just on -- it seems like there’s a clear path now in NASH to kind of what FDA wants to see. Is that Merck’s view too, that it’s going to be pretty easy to reach alignment on what’s going to be required from a regulatory standpoint?

And then the other question. I know, historically, there have been questions around kind of the commercial build-out given the need -- historically diagnosed with a liver biopsy. And so now there are, I think, less invasive ways to do that. So has the field evolved such that there’s a commercial opportunity here, I guess, is the...
Dean Y. Li - Merck & Co., Inc. - Executive VP & President of Merck Research Laboratories

I think there's a commercial opportunity in NASH. But as you said, it's the regulatory and it's also the practical clinical definition, and that has evolved. And the FDA's position has evolved. But part of it is, at the end of the day, you have to show an outcome that's meaningful. That's what they're most interested.

But also technology has changed in relationship to how to measure liver fat and the progression. And I would imagine over the next 3 to 5 years, there will be more advances, and those advances will create opportunities for the FDA to think carefully about how to do this more non-invasively.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Okay. And then maybe just in the interest of time, the other area that, again, Merck is diversifying into is immunology with the Prometheus acquisition. And I know you’re moving into Phase III for -- with the TL1A. So maybe just anything more to share on that design or when we might learn more about the patient population? It’s kind of similar to TROP2 question. There’s a biomarker strategy that’s embedded in there.

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

Yes. I would emphasize that the data that you see for the TL1A pathway, either from our collaboration or partnership or acquisition of Prometheus, but also there’s other TL1As. There’s a theme that, that antibody and interdicting that TL1A gives you substantial clinical benefit in all comers without, for example, a black box warning sort of thing.

I think one needs to advance that, and one needs to advance it for inflammatory bowel disease. The issue with the biomarker is that the biomarker may give you something more. But I would answer, it’s more like TROP2 than it is, for example, I said to someone, PD-L1. In PD-L1, we just raced to that initially.

So in relationship to the TL1A, I would imagine that we want to test in the all comers because it’s the totality of the data through all the different programs suggest it is a very effective drug with not -- with a very favorable adverse effect profile. You’re going to want to test that. There is biomarkers you may be able to enrich, but I wouldn't just enrich and not test the broader hypothesis.

Terence C. Flynn - Morgan Stanley, Research Division - Equity Analyst

Great. Well, I think we’re up against time. But thank you so much, Caroline, Dean. Really appreciate the time today.

Caroline Litchfield - Merck & Co., Inc. - Executive VP & CFO

Thank you.

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

Thank you very much.