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OVERVIEW:

Company Summary

LSEG DATA & ANALYTICS

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PRESENTATION

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Great. Thank you for joining us for the afternoon session today. We have team Merck with us. So with us, we have Caroline Litchfield, the CFO of the company. We have Dean Li, the Head of R&D, president of Merck Research and everything.

So thank you very much for joining us today.

Caroline Litchfield - *Merck & Co Inc - Executive Vice President, Chief Financial Officer*

Thank you for having us.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

So I will turn it over to you, Caroline, to give us the overview of all the great things you are doing at Merck. And yeah, let's just start there.

Caroline Litchfield - *Merck & Co Inc - Executive Vice President, Chief Financial Officer*

So thank you all for being here today and thank you for your interest in and support of Merck. Since we were here a year ago, we've made tremendous progress. And that progress is all anchored towards driving our long-term growth ambition. This time last year, we were talking about 20-or-so human health products that had the promise of delivering impact for patients and more than $50 billion in non-risk-adjusted revenues by the mid-2030s.

At the start of this year, we announced at the JPMorgan conference, we see more than $70 billion of non-risk-adjusted revenues from this suite of human health products. So the transformation of Merck's portfolio is underway. We've launched several new products. We've seen progress across our clinical book of business, and that's across oncology, cardiometabolic, ophthalmology, immunology, HIV.

On top of that, we continue to augment our pipeline with value, creating scientifically focused business development. That includes the acquisitions in this last year of both Cidara and Terns. And we've got an animal health business that continues to exhibit strong growth. So we're excited and confident in our future.

And we're going to fully invest behind the opportunities we have with our expansive pipeline and our launches to drive growth into the future. We've got many clinical readouts coming, and I'm sure we'll talk a lot about that. But overall, we are confident in the execution of our strategy and we're confident in our future.

So we look forward now to your questions.

QUESTIONS AND ANSWERS

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Awesome. We are also looking forward to it right now. So last year, we have Eliav here, and I kept asking him about sac-TMT, that you have all these trials going on. What gives you confidence to make such investments?

And his response was that we appreciate that you have not seen what we have seen with Kelun data that are generated in China. Now we are seeing some glimpses of that. So talk a little bit about -- in the last one year or so, what we have learned with sac-TMT, and what is still underappreciated for the asset at this point.

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Yeah, so for sac-TMT itself, you could argue it's the third TROP2 ADCs. Whenever you're coming in with a third TROP2 ADC, the minute you say it, they're like, why are you doing that? And the concept for us is that we had already seen some data just from preclinical that made us think that this ADC, the linker payload, was going to be a cornerstone and would have a different benefit-risk ratio, especially in combinations.

The other sort of thing that was really important is that we've had a close relationship with Kelun, and so we trust them implicitly in relationship to how they conduct their trials in China. And the reason why that's important is we almost use it as a reconnaissance force to figure out where we should play. So our initial focus was, when we looked at everyone else's TROP2 ADC, we're actually very surprised how focused they were on breast and lung and how not focused they were in other indications.

So we put in 17, and [8](corrected by company after the call) of them were not in breast and lung. But we said in breast and lung, we would be thoughtful, and we would strike when the time was right. And what you've seen in the last year is that strategy coming out, our endometrial is likely to be the first TROP2 ADC, and those [8](corrected by company after the call) trials are moving.

But in lung and breast, those data are coming through. You saw in Kelun, in China data, in Phase 3 data, very compelling data across the PD-L1 standard. And so I think that gives us great confidence in moving our sac-TMT into lung and being more aggressive about it.

You'll probably see data about breast cancer that will allow people to do a comparison. But the other sort of thing is, we think the data for sac-TMT is substantially differentiated. That not only does it give us an opportunity to be in lung and breast with sac-TMT, but it has us be in a differentiated position to consider things like PD-1 VEGF.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

And a lot of us are actually seeing sac-TMT as a replacement for KEYTRUDA, but it does seem like -- it's like a targeted chemo, basically. So it could go much further than that. So how do you internally see this as an asset, in terms of just protecting lung cancer versus broadening?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Yes. I mean essentially, our initial strategy was not to protect lung and breast and to go everywhere else because we were a little bit surprised that other people hadn't done that. And you've seen, let's say, where the growth of KEYTRUDA and other agents have been outside of lung and breast. It's in women's cancer. I've been in those sort of places.

So we thought that, that was ideal. More recently, we're now the Eye of Sauron is moving back into lung and breast. And that's where we're focused on. And I think people have asked, are you going to try to do the whole KEYNOTE-189 with sac-TMT and the bottom line is we intend to go with sac-TMT in the breadth of PD-L1 indications.

But one of the things that's available to us is that -- we believe in many of those indications. We just need to use pembro. But in some of those indications, we may have a unique position to drive a PD-1 VEGF. And so we're being very thoughtful in relationship to that. So it's -- actually, we went outside of lung and breast, and now we're moving back in.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Now, it's funny, right? I mean, like, the discussion has moved from, why are you running 14 trials to, why are you only running 14 trials?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Right. I mean, we want to strike when the time is right, and it's to our advantage.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. Completely makes sense. So, I mean, you have an event of ESMO as well. You'll see a lot more data there. How far are we from seeing a VEGF PD-1 plus sac-TMT kind of those combination trials starting at this point?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

So I think in the clinical trial side of the on ClinicalTrials.gov, it becomes very clear to people that we are exploring indications of a PD-1 VEGF with sac-TMT, and that we are clearly exploring PD-1 VEGF with WELIREG. And I think people can immediately calculate, okay, there's 50 plus indications for PD-1s and PDL-1s. There's maybe six to seven indications with VEGF. And then of those, the question is, does Merck have a third arm, which truly distinguish that they can go in in combination.

And so what we've said is those two agents, our sac-TMT and our WELIREG, look different than other people's agents. And so that's a place where we're wondering, hey, can we use it to really amplify what PD-1 VEGF can do.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. Got it. So some of that, I mean, I think as you talked about it. In due course, you'll have --

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Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Yeah, I mean, those trials in the clinical trial, I mean, they're posted.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Right, okay. Got it. Right. Helpful. Thank you. So going to the strategy side of things, and then looking at the, I mean -- like all the success that the group has had in the last 12 to 18 months here, and then M&As and all, when you look at the model, like four or five years down the line -- like how do you see the pattern playing out in your internal model? Because a few years ago, Rob had this ambitious goal of growing through the LOE. So how close are you to realize this team?

Caroline Litchfield - *Merck & Co Inc - Executive Vice President, Chief Financial Officer*

So our ambition over the last several years has been to diversify within oncology and diversify outside of oncology. And as you've just discussed in oncology, we're feeling very good about the progress we're making with a number of great assets. And similarly, outside of oncology, we feel extremely good. As Rob has described, as we look forward to the LOE period of KEYTRUDA, we do not see a cliff in terms of how revenues may evolve Instead, we see more of a hill with a quick return to strong growth.

Now that's on a risk-adjusted basis. If we were to look at our own numbers on a non-risk-adjusted basis, the path to growing through the KEYTRUDA LOE is something we continue to aspire to and could become a reality. But the reality is we're not running our business to achieve a certain profile in a single year. What we're doing is we are prosecuting this expensive pipeline in a way to enable us to have sustainable growth into the future, and that remains the priority of our company.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. Very, very helpful. Thank you. So going back to oncology, so INT. So success we have seen in Melanoma. Again, I think Phase 2, it does look like, I don't know, data will reveal themselves. But with the early success in melanoma, how comfortable should we feel about the other indications you are also pursuing here?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

So all in all, even though INT is not a conservative program, the way that we've actually prosecuted is reasonably conservative. We have focused INT where KEYTRUDA works and works in early stage. So that's where we've focused. And then the other place we focused is in a span of tumors that have varying tumor mutation burdens, we've done that.

So in the situation with Melanoma, it's highly sensitive to IO agents and has a high tumor mutation burden. I think that when people see the data, when it gets presented, hopefully at a meeting this fall, they will study the Phase 2 and ask how close is this to the Phase 2.

Because if you can replicate something close to the Phase 2, which is a sort of oversimplified way of looking at it, what you have is you almost double the number of people who are cancer free on top of KEYTRUDA. And it isn't like KEYTRUDA doesn't do, it does do something. So that's pretty good.

But the also important sort of thing is you know from the Phase 2 that if you look year one, year three, year five, those people responded, stay responding. So when people see the Phase 3, I think it's not unreasonable to sit there and say, how close is it to Phase 2? And they may extrapolate and say, this probably will look like this in phase, in five years, seven years maybe. So I think that will be an important point.

The stronger that data is, it's no different than when KEYTRUDA and Opdivo came out. The stronger the data was for Opdivo and KEYTRUDA and Melanoma, the more likely you thought it was going to work in lung, which would make it more likely. So I think it wouldn't be unreasonable that if you saw something close to Phase 2 versus not seeing something close to Phase 2, if you saw something close to Phase 2, your pre-test probability, at least in some of these IO-sensitive and higher tumor mutations, I think many people will calculate in their brain, that becomes more likely.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. So I think you talked about Melanoma is probably more immune sensitive, IO-sensitive tumor versus RCC is probably on the other spectrum. In an event that it works in Phase 2 RCC trial, how big an opportunity does it open up for you?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Well, I think what people will do is they'll consider them as bookends. They'll sit there and say Melanoma, okay, RCC is IO-sensitive, but it's a lower tumor mutation. So they'll go everywhere between Melanoma and RCC and say -- okay, non-small cell lung cancer becomes more likely, head and neck becomes more likely.

That's how they'll calculate it. They'll sit there and say, well, RCC has around the same tumor mutation as MSS-CRC, but MSS-CRC doesn't have it. So I think what someone will do is they'll look at that bookend, and they'll do the KEYTRUDA story over and probably probabilize that bookend. And I think that's how people will interpret the data. And to be very honest, that's probably how some of us would interpret the data.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. Makes sense. With all that clinical success, you are creating a good problem for your CFO. So in terms of like, so obviously with the success, you have to invest heavily in R&D as well, which is the right thing to do.

So this is a question we get from investors a lot, that now that the pipeline is really vibrant and growing, you did some deals as well, what are the puts and takes when you think about the guidance for next year? How should we think about expenses and revenues for next year? And I don't want you to give me guidance, but obviously, like, can you help us understand that?

Caroline Litchfield - *Merck & Co Inc - Executive Vice President, Chief Financial Officer*

Of course. So we're not giving guidance at this stage, but to give some themes as we look at our business in 2027. 2027 will be another year of investment for our company because we will, as we've noted, invest in this expansive pipeline and we will invest in our launches so that we are successful in the marketplace.

As you look at the P&L, on the top line, we would expect modest growth. We'll have increasing contributions coming from our launch products. They will be partially offset by some headwinds we anticipate on products that face generic competition or will face generic competition.

Notably, we have Bridion, we have Januvia, and we have Adempas that loses LOE at the end of this year. KEYTRUDA remains such an important product for our company, for the world, but growth is slowing, as you would expect, given its current phase in its lifecycle. We are looking for some pricing pressures in the world, specifically in Germany, where we've seen some policy changes that will impact -- I think, growth for KEYTRUDA next year. We expect our animal health business to continue to have strong growth.

As we look at gross margin, we're expecting some improvement in gross margin as there's the roll-off of a royalty on KEYTRUDA. From an expense perspective, as you rightly note, we are in a fortunate position that, in a disciplined way, we will invest fully behind our business. We would expect our investments to grow at a similar rate as what we've seen in 2026, when you normalize for any of the BD upfronts or the funding we received for Sac-TMT.

So we're expecting expense growth of around mid- to high single digit. And then the only other line to call out would be on other income expense. We'll see interest expense tick up a little, given the debt that we issued during this year for the business development that we've done. But in summary, a year of modest top-line growth, driving expenses to support our pipeline to enable long-term growth for our company.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Very helpful. Thank you very much for that. Now I want to move beyond oncology, because you have a lot going on beyond oncology as well. Maybe starting with the EyeBio asset. We'll have data this year in one of the trials. So the question here is, it's a non-inferiority trial versus Lucentis.

However, do you internally believe that you have potential to demonstrate superiority there? Because the argument is that you are going after the weakest drug there, but it's a little bit refractory setting, so you're going after a different market there. How should we think about -- how did you think about the commercial opportunity when you designed the trial?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

So we had the fortunate concept that when we're designing the trial for MK-3000, we also know that we have MK-8748. So the two of them together, although we're prosecuting each one independently, makes us think about the field a little bit differently.

So all the anti-VEGFs, whether you go from Lucentis to Eylea to Vabysmo, they've all been non-inferiority trials. And so what we're hoping is with 8748, which is not MK-3000, but it's an anti-VEGF Tie2 Agonist, we are hoping that that one will be a best-in-class anti-VEGF. So that to us is like going right down in the belly of the beast and saying, of all of these molecules, this one will be the best.

In relationship to this Wnt Agonist, all of the other major medicines have been VEGFs. There haven't been -- another sort of non-anti-VEGF. And people recognize, and ophthalmologists recognize, that anti-VEGF is really important, but anywhere between 30% to 40% of people don't respond or stop responding. So what we wanted to do is create an option for them. So all of a sudden, they have two hands to fight. They have the best anti-VEGF, and they have the first non-VEGF pathway.

And we believe that in true practice, what will happen is ophthalmologists will begin to mix and match them on their own. So for us, it was just really important to have a really clear signal that if -- no one's had a new mechanism of action, and we're hoping that MK-3000, [Remigromig], is that first non-VEGF pathway. And if we can do that and also come up with 8748, I think we could really create a situation where ophthalmologists will think about their field for diabetic macular edema and for neovascular AMD, the two of the major places, very differently, with both agents in their hands.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Is there a reason to believe Wnt would also work in AMD?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

I think you would say that there is a chance that Wnt would be it, and it's more from the anti-VEGF sort of field. In general, things that have worked in neovascular AMD have worked in DME, and DME in neovascular AMD. I think for 8748, you'd be very, very strong because there's so much precedent. What people would push back is, well, that's great. You have a new mechanism of action. Prove it to me. So the issue is that whenever you have a new mechanism of action, I do think that you have a high standard to convince people, and it behooves us to prove that to people.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Completely makes sense. So tied to the data on OCT and drying the eye, they are pretty strong, actually, compared to anti-VEGFs as well. So how do you envision this playing out? Is that the reason you believe it is probably the best in class like what --

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Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Well, you just see the different VEGFs, and you see Vabysmo, right? Vabysmo is essentially non-inferiority, but there's a sense that it dries the eye faster. We're hoping that whatever that spot number is, our ambition is to be superior to it, and that's what that data suggests.

And it's not how dry it is, it's how fast. What the ophthalmologists, they want to dry you out fast, because it's that wet-dry, wet-dry, that thing, that's what disrupts things. So it'll be how dry we can get them, but also how fast we can get them. And so when you look at this, the OCT is how they start thinking about it. So for them, OCT is not just a biomarker, it's how they actually think about treating. They actually use that number.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Yeah, I mean, they treat based on the basis of --

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

That's what they treat. We may talk about heme malignancy, heme malignancy starts talking about MMR and DMR, right? In some of our trials. People will treat to that number. People are beginning to treat, in practice, to OCT. So we think that is an important readout.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Very helpful. Thank you for that. Moving to TL1A. So, I mean, congrats on the success of ulcerative colitis trial. How -- so there are two schools of thought there. One is that TL1A, it doesn't have to be superior. It doesn't have to be numerically better than IL-23 or anything, because it is a super clean drug. This has a place, and it's a new mechanism of action, so it should have a place.

And then there's the other one, because IL-23 is FD and all, these guys are going in combinations and all. So maybe the bar to move into first line will be higher, so it becomes a second line drug, or combination will be important. How do you envision the market in the next four, five years?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

So I would separate the different places. So in our mind, we're trying to make TL1A a really important node. Other important nodes are TNF and IL-23 and IL-17, and they dominate in different indications. So we'll have to sort of play this out. I think for GI, which is ulcerative colitis and Crohn's disease, I think people start thinking of drugs like IL-23 as highly effective and reasonably safe. I think some people start talking about other mechanisms like integrins that some people believe are maybe not as effective as the IL-23s, but they're extremely tolerable. Those people stay on.

Our ambition for whether we're talking about GI or Derm or rheum is that among the biologics, we are the best, if not the best, but we are the safest as well. And that in each different indication will be important, and it will also be important because it gives us a degree of flexibility. Because if you have one of the most effective, if not the most effective, and you're extremely safe, should you do a combination strategy, you're in a very good position than if you don't have that profile. So that's the profile we're looking, whether it be GI, whether it be DERM, whether it be rheum.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. Very helpful. Another question I have is the asset which you have an expertise in, PCSK9, Oral PCSK9 here. So Amgen, Regeneron, they all try to get into primary care market, and statin is pretty much a primary care market right now.

So to get into that segment -- so this is an oral, so primary care should be using it, but how important it is to have an outcome data, not only in secondary prevention, but Amgen now has data with the VESALIUS-CV trial in primary prevention as well. And you've got a really good label actually there. So talk a little bit about how do you make inroads into that market?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

So I'll have Caroline talk about the commercial push and pull. I'll talk scientifically from it. So just to be really clear, not all PCSK9s are the same. The antibodies, I think in general people think of LDL cholesterol lowering of 60%. If you look at the sRNA or other things that affected PCSK9, I think the number is more in the 50%.

So not all PCSKs are the same. I think the field and the FDA was very clear. They understood that this was designed to do something very similar to the antibody. And essentially was designed with the concept of can I do the same thing that a biologic does, but do it in a pill. And what people saw from the biomarker data, which is LDL and ApoB and this, the profile looks surprisingly similar in a biomarker sense to the antibody.

We still need to do the outcome trial, but I think many people in the field sit there and go, okay, this was designed to interdict PCSK9 LDL like the antibodies. It gives you a biomarker profile that looks similar. They're going to have to do the outcomes trial, but I think the FDA recognized it and you saw how they recognized it because they didn't make any comment in terms of not having cardiovascular outcomes in the label. What they emphasized is this should be as an add-on in statins. And they reminded everyone that statins has outcomes trial. And they also reminded everyone that the monoclonal antibodies, which this was designed to mimic, was also in the label.

But we do have to do the outcomes because we have to prove that. But I think for many cardiologists and many people, seeing the profile of the LDL and knowing the history of PCSK9, I think many people will be very comfortable prescribing it, especially if it's extremely accessible.

And then from commercial, I'll have you speak about it.

Caroline Litchfield - *Merck & Co Inc - Executive Vice President, Chief Financial Officer*

So we're very excited about the opportunity we have to bring an oral PCSK9 to really address this epidemic that exists. What we have with LIPFENDRA is we're entering a market that now has guidelines in place after many years where those guidelines did not exist on treating to a target level of LDL.

And so those guidelines will really help unlock some of the inertia that exists in this marketplace. In the US, there's 30 million people who are taking statins who are not at goal. About half of those are secondary prevention, about half are primary. And we think initially we expect utilization to be more in that secondary group, those who have established ASCVD. We're getting really strong feedback at this stage from those who have seen the data, understand the data, understand the accessibility of this oral product and see the pricing strategy that we've had as a company.

And initial scripts are looking good. So our confidence in LIPFENDRA and its ability to be multi-billion dollars in peak revenue is high. We're working hard to break that inertia. And we expect to see good uptake ahead of the CVOT study.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

We did a survey. Primary care doctors really like it, actually. So that'll be interesting.

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Maybe this is too personal. I actually tested the system because I had a non-cardiologist write me a prescription. I got it.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

So that's interesting. Awesome. Thank you for that. So the last asset on the pipeline side I want to talk about is CD388. So now you're running two seasons in the northern hemisphere, one season in the southern hemisphere.

Just walk us through any change in conviction and confidence in the trial so far. And it does seem like you do see Europe also as a market now, opportunity as well. So talk a little bit about how your thought process has evolved since you bought CD --

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Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

To be honest, it hasn't really evolved that much. The critical piece of information for me is the way that you give this medicine. So it's essentially an antibody drug conjugate. That's the simplest way to explain it, where the drug is an antiviral. And the issue that comes up is that you go to your physician and you get three jabs.

And there was a view that was held throughout the field that you really shouldn't launch it with three jabs. You should launch it with two jabs. At one time, you come in, someone gives a leg and they do your bum or something. So they really thought that two was really important. So the minute that we do this, that means we have to change three jabs into two jabs. That immediately creates a time of when we can launch.

So the concept for me is until that time comes, I'm going to get as much data as possible because it's not just that I get a label. Remember, this is not going to be sold at the price of the influenza vaccine that I just got from the drugstore. It's going to be more expensive.

And so the question that comes up is we think that this is a really important product for the US, but also with MFN, we can't have a 10-fold discount in Europe. And so we need to find patient populations where we can hold that price in a situation where we have robust subpopulations. For example, it's not just immunosuppressed. If someone has cardiovascular risk, is a non-LIPFENDRA, should they get it?

That's the type of data because it's one thing for the label, which is really important, but especially outside the US, how you deal with the HTA agencies will become really important. And the more strain, the more data, the more different subpopulations that we have, whether they're statistically pre-specified or not, will be important for those situations.

So we're not delaying the launch in any way. The minute you decide that you're going to do three jabs into two jabs, you create this issue. So my concept is let me play it out all the way to the end and get the maximum amount of patients.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Got it. Very helpful. There's no Merck discussion without talking about BD. And there was a time last year or so, like we were waking up every Monday waiting for a press release to hit, Merck bought something. So you have been very active. And it shows in pipeline now. Now, where you sit right now, how do you think about, one, the need for BD?

Number two, if you do see it, like how do you think about what would be the asset, what kind of asset or profile of asset would you be interested in?

Caroline Litchfield - *Merck & Co Inc - Executive Vice President, Chief Financial Officer*

We're proud of the BD that we've done thus far. We've brought some great assets into our company that have the opportunity for patient care and drive growth for our company in the future. As we look forward, that strategy is unchanged. We will continue to look for the best science externally that when brought into Merck that will create value, address areas of unmet need, and drive growth for the company.

We're not desperate to do any deal, but we will continue to do the right types of deals for our company. What we've talked about in the past, and that's consistent today, is a sweet spot has been deals that are in the $10 billion to $15 billion range.

And we've also talked about, as we look at areas of unmet need, that including oncology, including cardiometabolic, but we also see immunology as an opportunity space. So BD will remain an area of focus for any cash that we have at our disposal that's science-led to drive patient impact and growth.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Do you have anything to add?

Dean Li - *Merck & Co Inc - Executive Vice President and President, Merck Research Laboratories*

Whatever money she has. I know how to use it.

Mohit Bansal - *Wells Fargo Securities LLC - Analyst*

Thank you very much. On that high note, I really appreciate you joining us today. Thank you.
