THOMSON REUTERS STREETEVENTS

EDITED TRANSCRIPT

MRK - Q1 2015 Merck & Co Inc Earnings Call

EVENT DATE/TIME: APRIL 28, 2015 / 12:00PM GMT

OVERVIEW:

MRK reported 1Q15 revenues of $9.4b. Expects 2015 sales to be $38.3-39.8b and non-GAAP EPS to be $3.35-3.48.

THOMSON REUTERS

CORPORATE PARTICIPANTS

Joseph Romanelli *Merck & Co., Inc. - VP, IR*

Ken Frazier *Merck & Co., Inc. - Chairman & CEO*

Adam Schechter *Merck & Co., Inc. - EVP & President, Global Human Health*

Rob Davis *Merck & Co., Inc. - EVP & CFO*

Roger Perlmutter *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

CONFERENCE CALL PARTICIPANTS

Tim Anderson *Sanford Bernstein - Analyst*

Chris Schott *JPMorgan Chase - Analyst*

Mark Schoenebaum *Evercore ISI - Analyst*

Jami Rubin *Goldman Sachs - Analyst*

Marc Goodman *UBS - Analyst*

Gregg Gilbert *Deutsche Bank - Analyst*

Alex Arfaei *BMO Capital Markets - Analyst*

David Risinger *Morgan Stanley - Analyst*

John Boris *SunTrust Robinson Humphrey - Analyst*

Seamus Fernandez *Leerink Partners - Analyst*

Colin Bristow *Bank of America Merrill Lynch - Analyst*

PRESENTATION

Operator

Good day, everyone and welcome to Merck's first-quarter 2015 earnings conference call. Today's call is being recorded. At this time, I'd like to turn the call over to Joseph Romanelli, Vice President of Investor Relations. Please go ahead.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thank you, Darla and good morning, everyone. We would also like to say good afternoon and good evening to everyone listening outside the United States. Welcome to Merck's first-quarter 2015 conference call. Before I turn the call over to Ken, I just want to point out a couple of items. First, you will see that we have items in our GAAP results such as the acquisition-related charges, restructuring costs and certain other items. You should note that we have excluded those items from our non-GAAP results. There are reconciliation tables available in our press release so you can get a better understanding of the underlying performance.

We've also provided tables to help you understand the sales results in the quarter for the business units, as well as for products. This can be found in table 3 of our press release and the reconciliation table I mentioned earlier is in table 2 of the release.

During the call, we will be referring to table 2 for the P&L and table 3 as it relates to revenue. Second, I would like to remind you that some of the statements we make during today's call may be considered forward-looking statements within the meaning of the Safe Harbor provision of the US Private Securities Litigation Reform Act of 1995. Such statements are made based on the current belief of Merck's management 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.

Our SEC filings, including item 1A in the 2014 10-K, identify certain risk factors and cautionary statements that could cause the Company's actual results to differ materially from those projected in any of our forward-looking statements made this morning. Merck undertakes no obligation to publicly update any forward-looking statements and you can see our SEC filings, as well as today's earnings release on Merck.com.

So with that, this morning, I'm joined by Ken Frazier, our Chairman and Chief Executive Officer; Adam Schechter, President of Global Human Health; Rob Davis, our Chief Financial Officer; and Dr. Roger Perlmutter, President of Merck Research Labs. Now I would like to turn the call over to Ken.

Ken Frazier - *Merck & Co., Inc. - Chairman & CEO*

Thank you, Joe. Good morning, everyone and thank you all for joining our call today. We are off to a very promising start this year in 2015 and we are seeing additional confirmation that Merck's scientific and business strategies, together with our focused investments, are paying off. In the first quarter, we saw strong top-line growth from our core human health therapeutic areas and our animal health business. At the same time, our late-stage pipeline and the product approvals we gained last year are now coming to fruition with launches like KEYTRUDA, BELSOMRA and ZERBAXA.

It's an exciting time at Merck because we believe that our pipeline will continue to deliver medically important products over the coming months and years. And by bringing greater focus and discipline to all aspects of our business, we will continue to transform Merck into a more competitive, more innovative company built on a platform for sustainable future growth. Adam will discuss the quarter's product performance in greater detail later in the call.

Looking to the future, what we at Merck find most energizing is the progress we're making across our pipeline, progress evidenced by strong data presented during several recent major medical meetings. For example, last week at AACR, Merck presented KEYTRUDA data in three tumor types. It was both inspiring and encouraging to see and hear the impact KEYTRUDA is having in patients with lung cancer, melanoma and mesothelioma, which is a particularly challenging cancer with limited treatment options. Not surprisingly, the feedback we have received from physicians has been overwhelmingly positive.

We also announced new filings for KEYTRUDA in lung cancer and melanoma, which brings us another step closer to reaching more patients with this life-saving medicine. Additionally, we presented new Phase 3 data from our HCV doublet program at EASL last week. We are seeing robust responses to the doublet with significant cure rates across all patient types, including harder to treat patients. As you know, we also received breakthrough therapy designation from the FDA for some of these patients who have a clear unmet need.

Finally, this past week at ECCMID, we continued to reinforce our long-standing commitment to the global fight against infectious diseases, including antibiotic-resistant infections. This is another area where Merck will continue to lead the charge to address an unmet global need. Roger will discuss the progress of our pipeline in greater detail later in the call.

Immuno-oncology, hepatitis C and cardiometabolic disease are just a few examples of our most promising late-stage programs. Programs that are predicated upon what has long-defined Merck, our ability to generate innovative and medically important products that address global unmet medical need. In the evolving healthcare environment, commercial success will accrue to those who develop medicines and vaccines that help patients to live healthier and more productive lives and reduce overall healthcare expenditures.

We will remain focused on bringing forward the best scientific and medical innovations sourced both internally and externally because we believe that this is the best path to intrinsic long-term value creation. By capitalizing on the significant and exciting scientific and clinical opportunities that lie ahead, Merck intends to play a major role in transforming healthcare for the benefit of patients, payers and shareholders alike.

The advances in immuno-oncology, hepatitis C and anti-infectives I've mentioned earlier are just the beginning. There are numerous other examples ranging from chronic and debilitating neurodegenerative diseases like Alzheimer's to urgent and pressing global threats like Ebola. These remind

us both of the immensity of unmet global medical need and the unprecedented opportunity we have to address that need with transformational medicine. It is an exciting time to be at Merck on both the research and commercial fronts and with that, I will now turn the call over to Adam Schechter.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

Thank you, Ken. Good morning, everyone. This morning, I will discuss the first-quarter results for Global Human Health. My comments will be on a constant currency basis. We are off to a strong start in 2015. We continue to drive growth within the core portfolio while entering a phase of important launches. Sales in the first quarter grew 5% reflecting the following -- growth in all four core areas of diabetes, hospital acute care, vaccines and oncology, the integration of the Cubist portfolio and product divestitures.

Now I'll review performance of several key products followed by a brief update by region and then commentary on a few of our most important launches, so I will start with Januvia. The Januvia franchise reached approximately $1.4 billion in sales and grew 10% in the quarter. In the United States, sales grew 4%. Strong performance this quarter was driven by continued focus and investment to defend our 75% marketshare and to grow the DPP-4 class. As you may recall, TRx volume was declining during the first quarter of last year, also allowing for a favorable comparison.

In the international markets, sales grew 17%. Europe grew as a result of market events last year, which led to share gains, particularly in Germany. Emerging Markets continued to show strong demand. We are off to a strong start to deliver global growth for Januvia in 2015.

Next, in hospital and specialty care, sales of Isentress grew 6% to approximately $390 million primarily as a result of tenders in certain Emerging Markets. In immunology, sales of Remicade and Simponi were approximately $660 million, growing 1%. Continued strong growth in Simponi was mostly offset by a 3% decline in Remicade. All remaining European markets lost patent protection for Remicade in February. We are still in the early stages of biosimilar competition in core EU markets, but the discounts offered by biosimilars are higher than our original expectations of 30%. Discounts are closer to 45%. However, we have yet to see many of the initial tender results to understand what the net prices may become over time.

We continue to maintain the vast majority of patients who are already well-controlled on Remicade. We anticipate that the impact of biosimilar competition, particularly for new patients, will accelerate throughout the year as more tenders occur in the core European markets.

In hospital acute care, sales grew to approximately $800 million. Strong double-digit growth from a broad portfolio, coupled with the addition of sales from Cubist products, solidifies our position as a global leader in hospital acute care. With important in-line brands and new product launches such as ZERBAXA, we continue to expect that this segment will be a core contributor of growth for Merck.

Now turning to the vaccine business. In the first quarter, vaccine sales grew 9% to approximately $1.3 billion. Growth was driven by pediatric vaccines given the recent public attention to measles, which has now subsided and also by Zostavax. Sales of Zostavax were $175 million in the quarter reflecting growth of 25%. Sales in the United States grew as a result of continued DTC efforts. Globally, we also saw positive contributions from Canada, as well as in markets in Asia, which are continuing to launch.

Combined sales of Gardasil and Gardasil 9 reached approximately $360 million in the first quarter, a decline of 5%. Growth in the United States, which reflects higher public sector purchases of about $30 million, was more than offset by timing of government purchases in Brazil. In February, the ACIP recommended Gardasil 9 for routine use in line with Gardasil recommendations. Managed care coverage continued to build following the ACIP meeting and coverage is rapidly approaching that of Gardasil. Physicians currently are transitioning to this new vaccine that offers increased protection from cervical cancer-causing HPV.

Now I'll provide some geographic commentary for the quarter. In the United States, sales increased 10%, excluding Cubist. There was growth across primary care, oncology, vaccines and hospital acute care. Sales in Europe decreased 5%. Growth from the Januvia franchise and Simponi was offset by ophthalmology product divestitures and declines in HCV and Remicade. Japan sales declined 13% as growth in Pneumovax was offset by ophthalmology product divestitures and the bi-annual price decreases that took effect in April of last year. Emerging market sales grew 7%, including 16% growth in China.

Now I'll spend a few moments speaking to several important launches and I'll start with BELSOMRA. We are pleased with the initial months of the BELSOMRA launch in the United States. As of the end of March, there were about 4000 total weekly prescriptions. To date, we have achieved positive coverage decisions for nearly 50 million commercial lives and half of those lives require no step edit. Our teams are continuing to drive awareness for this exciting, first-in-class treatment for patients suffering with insomnia.

Moving to ZERBAXA, following the acquisition of Cubist in January, we have rapidly began working with our new colleagues in the launch of ZERBAXA, a new treatment for certain complicated gram-negative infections. We are just beginning to see formulary additions. As expected in this market, formulary access is critical before use occurs. The growing resistance issue with gram-negative pathogens is driving positive discussions and positive formulary uptake for ZERBAXA.

In oncology, we saw strong performance in the continuing launch of KEYTRUDA. Sales reached $83 million in the quarter. We have achieved rapid penetration of the on-label indication in advanced melanoma. Additionally, NCCN guidelines recommend reimbursement in the first-line treatment of melanoma. Importantly, physicians continue to gain comfort and experience treating patients with KEYTRUDA, a product that will become foundational in the treatment of melanoma and potentially in a number of other cancers. We continue to believe that the immuno-oncology area holds great promise for patients and that it will be a very large and significant market.

Lastly, we are excited about the future opportunities we see, particularly with our hepatitis C portfolio. This is a market where we have succeeded in the past and we are excited for what the launch could mean for patients and for Merck.

In summary, Global Human Health is off to a strong start in 2015. We drove growth as a result of strong performance in focused areas of diabetes, hospital acute care, vaccines and oncology. Furthermore, the integration of Cubist is fortifying our growth platform in hospital acute care. The strength of our underlying business, our focused commercial strategy and the launch opportunities in our hands positions us well for the remainder of 2015 and for future growth. Now I'd like to turn the call over to my colleague, Rob Davis.

Rob Davis - *Merck & Co., Inc. - EVP & CFO*

Thanks, Adam and good morning, everyone. As Ken and Adam shared with you, our results this quarter demonstrate our ability to simultaneously grow our businesses and effectively reduce our cost base. We continue to remain focused on transforming our operating model, achieving our cost-reduction targets and ensuring we have a leveraged P&L. This morning, I will provide some additional detail on the quarter and comment on our outlook for the rest of the year. My remarks will focus on our non-GAAP financials.

Total Company revenues were $9.4 billion for the quarter, a decrease of 8% year-over-year, which includes a negative 5 percentage point impact from foreign exchange. The 5% impact from exchange is net of a 2% hedging benefit we realized in the quarter. Our sales decline reflects approximately $700 million of lower revenue from divestitures, including the sale of our consumer care business to Bayer, as well as $379 million in decline in other revenue in the quarter due to the termination of the AstraZeneca JV and the sale of US Saphris rights.

The overall top-line decline was partially offset by the $208 million increase in revenue from the integration of the Cubist portfolio following the close of the transaction in late January. Excluding these items, and the impact of foreign exchange, the underlying base business grew 6% in the quarter. As Adam stated, our sales growth in the pharmaceutical business was driven by growth across our core therapeutic areas of diabetes, hospital acute care, oncology and vaccines.

Our Animal Health business delivered another strong quarter of growth with revenue of $829 million, an increase of 13% year-over-year, excluding exchange. The growth this quarter was primarily driven by our companion animal business, reflecting the continued strong launch of BRAVECTO. We are excited about the progress we've made in this first full year of BRAVECTO's launch.

Now moving to expenses. Gross margin was 76.5% in the quarter, which represents a 240 basis point increase year-over-year driven by product mix, including the impact of acquisitions and divestitures and foreign exchange. We now expect full-year gross margin to be approximately 100 basis points higher versus 2014. Marketing and administrative expenses were $354 million lower in the quarter driven by declines in direct selling

costs and net favorability from acquisitions and divestitures. We remain focused on funding opportunities for growth while reducing our overall cost base. Overall, we continue to expect a decline in marketing and administrative expenses compared to 2014.

Research and development expenses were $1.7 billion in the quarter, $149 million higher than prior year driven primarily by licensing costs incurred in the quarter. We continue to expect a modest increase in R&D expense versus prior year. We expect total Company operating expenses to be lower versus last year and we remain on track to reduce our operating expense by $2.5 billion compared to 2012 by the end of this year. Other income and expense was $69 million of expense in the quarter compared with income in the prior year primarily due to a nonrecurring gain from the divesture of Sirna in 2014.

Finally, regarding our tax rate, our non-GAAP effective tax rate this quarter was 22.4%. We continue to anticipate the tax rate for the full year to be between 22% and 23%. Taken together, we earned $0.85 per share in the first quarter, which reflects strong operational performance, as well as $0.06 benefit due to higher equity income from our research investment fund, revenue hedging gains and other one-time items. This compares to $0.88 per share in the prior year, which included $0.11 of gains from the sale of US Saphris rights and the divestiture of Sirna.

Turning to our outlook for the year, we now expect the strengthening of the US dollar to have a roughly $2.8 billion impact on our full-year sales results. Despite additional FX pressure, we are maintaining our sales guidance of $38.3 billion to $39.8 billion.

Now regarding EPS, we continue to expect FX to have a $0.27 impact in 2015. We anticipate that most of that impact will occur in the remainder of the year. In light of our strong first-quarter performance, tempered by our non-operational gains this quarter and the anticipated incremental negative impact of FX, we now expect non-GAAP EPS to be in the range of $3.35 to $3.48, which reflects an increase from our prior guidance.

In summary, we are off to a strong start in 2015. As we continue to focus on execution, we are seeing the benefit of our efforts in revenue growth in core products and markets, a lower cost base and this first wave of innovation and new product launches. Lastly, as I previously mentioned, we remain on track to achieve our cost reduction goals by the end of 2015. Now I'll turn the call over to Roger.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

Thanks, Rob. We had a very busy first quarter in research and development culminating in several important regulatory filings and research presentations. Turning first to KEYTRUDA, our PD1 directed monoclonal antibody designed to promote activation of pre-existing tumor directed immune responses. We previously announced that the Data Monitoring Committee recommended early conclusion of our KEYNOTE-006 study, which compared KEYTRUDA to ipilimumab in the first and second-line treatment of patients with advanced melanoma. Details of this study, including the favorable outcomes observed for response rates, progression-free survival and overall survival were presented at the American Association for Cancer Research meeting in Philadelphia last week and published in the New England Journal of Medicine. Also presented at the AACR meeting and simultaneously published in the New England Journal of Medicine were the results of KEYNOTE-001 cohorts, including patients with advanced non-small cell lung cancer treated with KEYTRUDA following progression after systemic chemotherapy.

In these studies, we observed that expression of PD-L1, one of the two ligands for PD1, the target of KEYTRUDA, in greater than 50% of tumor cells was associated with substantially higher response rates than what was seen in patients whose tumors did not express PD-L1. These responses occurred irrespective of the underlying histologic classification of the presenting non-small cell lung cancer. These data were included in our recent submission to the FDA seeking approval for KEYTRUDA in the treatment of non-small cell lung cancer that has progressed despite platinum-based chemotherapy and where EGF receptor or ALK-directed therapy is not indicated.

This filing joins another filing based on our earlier KEYNOTE-002 study, which is now under review at the FDA, demonstrating that, in a randomized comparison, KEYTRUDA therapy is superior to conventional chemotherapy in patients with advanced melanoma as judged by progression-free survival. We expect to file the results of our KEYNOTE-006 study, which I mentioned earlier, by the middle of the year.

Data from our melanoma studies is also under review by the Committee on Human Medicinal Products at the European Medicines Agency. I should note that, during the first quarter, KEYTRUDA was approved for the treatment of advanced melanoma in Canada and Australia, among other

jurisdictions. We are particularly gratified that melanoma patients in Australia will now be able to benefit from KEYTRUDA treatment since this is the region of the world with the highest incidence of this life-threatening disease.

I also wish to emphasize that although we have studied a range of KEYTRUDA doses in our clinical trials, our data are persuasive that 2 milligrams per kilogram given every three weeks is as efficacious as higher doses across all tumor types studied. Indeed, we are advancing a unit dose of 200 milligrams every three weeks, which we hope to show is equally effective. This will simplify dosing for the vast majority of patients for whom KEYTRUDA is an appropriate therapy.

Finally, I will mention again that, during 2014, we provided data indicating that KEYTRUDA has activity in seven different tumor types -- head and neck cancer, bladder cancer, gastric cancer, triple negative breast cancer and Hodgkin's lymphoma, as well as melanoma and non-small cell lung cancer. And we are pursuing registration-enabling studies in each of these indications. At the AACR meeting, we presented the first data from our signal detection study called KEYNOTE-028 demonstrating tumor shrinkage in patients with malignant pleural mesothelioma following KEYTRUDA administration. This represents an eighth malignancy for which data supporting further potentially registration-enabling studies can be pursued.

During the upcoming American Society for Clinical Oncology meetings in June, we will present 33 abstracts, including nine oral presentations describing the activity of KEYTRUDA in different settings, which can potentially be used to sharpen treatment algorithms for malignant disease. In all, we now have more than 14,000 patients enrolled in clinical trials aimed at defining the attributes of KEYTRUDA therapy.

Also during the first quarter, we completed Phase 3 studies of grazoprevir/elbasvir treatment for patients suffering from chronic hepatitis C virus infection. Some of these data were presented last week at the European Association for the Study of the Liver meetings in Vienna, demonstrating that our doublet regimen produced 95% sustained virologic responses at 12 weeks in patients suffering from genotypes 1, 4 or 6 infection with hepatitis C virus.

In addition, data presented at the meeting showed responses in patients simultaneously infected with human immunodeficiency virus or suffering from renal insufficiency, including those on hemodialysis. Summarizing across this very large data set, much of which was also published in the Annals of Internal Medicine, we conclude that combined treatment with grazoprevir/elbasvir presented together in a single oral dosage form given once daily permits control of hepatitis C infection in a broad range of patients. I will remind you that we have received breakthrough designation for this doublet therapy in the treatment of patients with genotype 4 infection and for the treatment of chronic HCV genotype 1 infection in patients receiving hemodialysis, an important subset of the total HCV-infected population. We plan to file for approval of this combination with the FDA by midyear.

Yesterday, we announced the results from our TECOS study in patients with type II diabetes. The study compared treatment with Januvia as a means of maintaining lower levels of glycated hemoglobin, a measure of diabetic control, with alternative standard regimens and was designed to collect data regarding the cardiovascular safety of Januvia treatment as compared to these other regimens. The TECOS study conducted under the sponsorship of the University of Oxford Diabetes Trials Unit and the Duke Clinical Research Center is the largest one of its type enrolling almost 15,000 patients from 38 countries and with a median follow-up of more than three years.

As I've indicated previously, the study investigators will present their data at the June American Diabetes Association Forum in just a few weeks and hence, I will not describe the results in detail. I will say, however, that the study met its primary endpoint. Januvia therapy was non-inferior to treatment with alternative regimens with respect to the composite cardiovascular endpoint. Observed adverse experiences were generally consistent with what has been previously reported in post-approval studies of Januvia. I should note that, during the month of April, the FDA convened an advisory committee to examine the safety of two other DPP4 inhibitors for which cardiovascular outcomes data had previously been made available as a result of the SAVOR-TIMI and EXAMINE trials.

Of special interest to the FDA and to committee members were results suggesting that DPP4 inhibitors might be associated with an increased risk of hospitalization for heart failure. This was an explicit endpoint of the TECOS study and I can report that there was no imbalance in heart failure hospitalization comparing the Januvia treatment arm with the treatment group receiving other therapies designed to reduce hyperglycemia.

Beyond TECOS, I will remind you that we are also engaged in a 30,000 patient outcome study called REVEAL testing whether anacetrapib, our novel CETP inhibitor, can, when added to standard therapy, reduce the frequency of major cardiovascular events in patients with significant risk for such events. Earlier this month, we received a proposal from the steering committee of the trial to change the study protocol to include ischemic stroke as a component of the primary composite endpoint. This proposal is based in part on data that emerged last year from the IMPROVE-IT study, which documented a reduced risk of ischemic stroke associated with LDL cholesterol lowering. With this in mind, and in advance of any interim analyses of REVEAL, it was proposed that ischemic stroke rather than revascularization would prove to be a more appropriate measurement for the cardiovascular composite endpoint.

The letter from the steering committee should not be taken to mean that investigators are aware of any outcomes from the REVEAL trial itself. The study remains blinded. However, given the proposed change in endpoint, they also wish to adjust the timing of the proposed interim analyses. Their proposal must be fully vetted by governance committees and regulatory agencies and I expect that they will publish the proposed modifications. The steering committee estimates that the first interim analysis with this new protocol would take place towards the end of this year. In the meantime, the study is proceeding as planned in a fully blinded fashion.

A few final notes on regulatory activity. We have received a complete response letter from the FDA regarding our submission of Bridion, which is approved in more than 60 countries for the reversal of certain types of neuromuscular blockade during anesthesia. The agency has asked for additional sensitivity analyses regarding the data that we have submitted. We expect to be able to respond to these requests in the very near future. And now I will turn the call over to Joe.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Great. Thank you, Roger. And Darla, I think we are getting ready for the Q&A segment of the call. For callers, I will ask that you ask only one or two questions so that we can get through as many colors as possible. Darla, can you turn it over to the Q&A segment? Thanks.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions). Tim Anderson, Sanford Bernstein.

Tim Anderson - *Sanford Bernstein - Analyst*

Congratulations on TECOS. I'm not going to ask any questions; I am imagining you won't say much. On KEYTRUDA in lung, the debate continues to rage on about the utility of a biomarker and you filed your product. Are you willing to say that you have asked for a label that is specific to high expressers of PD-L1, or is the data set you submitted really broader than that and you did not explicitly ask for a biomarker limitation?

And then you raised guidance for the year on earnings. Is part of that related to hep C specifically? What is baked into your 2015 guidance about a potential launch before year-end? Would that not make a difference anyway and your breakthrough therapy designation was limited in terms of what that status applies to. Can you talk about when the drug does get approved, is it likely to be a broad label?

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

First of all, with respect to KEYTRUDA in lung, of course, the entire data set, the totality of our data has been filed with the FDA. And in those data, as I have said previously, what we know is that patients who have a high proportion of tumor cells expressing PD-L1 experience a higher likelihood of response and in fact, the response rates for those who are above the 50% representation are really very significant. But that doesn't mean that patients with low or even no visible PD-L1 expression failed to respond inevitably. There are responses in this patient populations as well and I

would expect that the labeling would want to capture that information to best advise physicians as they make decisions about how to treat their patients.

Rob Davis - *Merck & Co., Inc. - EVP & CFO*

Maybe I'll take the other question with regards to the hepatitis C. I just remind you that, as we look to file in the first half of 2015, our guidance really has multiple scenarios around how this will play out, but it's not material this year given the timing of the launch.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

And finally, Tim, with respect to HCV and our breakthrough designation, the breakthrough designation provides a mechanism whereby we can work closely with the FDA to design studies and our filing because the FDA recognizes, we believe, and the FDA recognizes that our therapy, our HCV therapy, has the potential to provide meaningful and important benefits to an underserved population. However, the data set that we submit is the entire data set and it is that entire data set that they will review and that data set, as you know, from the EASL meetings and from what we have published and from other presentations, spans the entire range of HCV infection.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Great. Thank you, Roger. Thank you, Tim. And Darla, our next caller.

Operator

Chris Schott, JPMorgan.

Chris Schott - *JPMorgan Chase - Analyst*

Congrats on the quarter. Just two questions here. First, maybe just more broadly on KEYTRUDA in non-small cell lung cancer. Can you just talk a little bit more about your product's relative competitive position in this market and how you are thinking about the commercial rollout here? I know you just mentioned you are filing basically your entire data set, but commercially how do you think about your initial data versus your competitor, which has OS data from a controlled study and how that plays out in the market?

The second question was on the BACE program in Alzheimer's and just updated thoughts there following the recent Biogen data. I guess I would be interested in your views of how you think about BACE versus [block-specific] antibodies and just how the treatment paradigm in Alzheimer's ultimately shapes up. Thanks very much.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

I'll answer the question on the lung cancer market readiness. So we have been building our oncology business unit to make sure we maximize the potential of KEYTRUDA over time and just like we were ready to launch in melanoma, we see lung cancer as a very significant opportunity for KEYTRUDA and we will be ready to launch. Of course, you'd prefer to have overall survival data to promote, but these data are maturing in our broad clinical program. We've been building our lung cancer capabilities, adding sales representatives and customer-facing teams who have been working with key scientific leaders and we are just getting ready for the launch.

In terms of competitiveness, we feel really good about the data we have showed and if you look at the value in the PD-L1 diagnostic, I think that can really help identify patients who will have an enhanced likelihood for improved efficacy and benefit most from KEYTRUDA. And when I talk to opinion leaders, but also when I have talked to governments, they see this as a way of allowing physicians to potentially have a different conversation

with patients, depending on their PD-L1 expression. Particularly, we can see such a large effect of 45% in the high expressers, but it also allows physicians to prioritize treatment options, which they are looking for. Payers around the world, particularly in Europe, have noted their interest in the potential health economics and those that could be associated with identifying patients who could benefit most from KEYTRUDA and thinking about algorithms of treatment. So we feel very good about the data we have and our competitive position at this time.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

And Chris, with respect to BACE, as you know, of course, our BACE-inhibitor is currently under study in two large Phase 3 trials, one in patients with mild to moderate cognitive impairment and the other in patients with prodromal disease. The data set from Biogen, which, as you know and as they characterize, is a small data set, is intriguing because it appears to show that there can be a dose response curve for plaque reduction using an antibody directed against A beta. The data with respect to cognitive improvement, of course, are, as everyone has commented, immature.

I think what we would say is, to the extent that one believes that actually reducing A beta and plaque has an effect on cognitive function, we feel very good about our clinical trials. However, the trials are the trials. We wait to see how they develop and we are eager to understand whether we can have an impact on this horrible disease.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Great. Thank you, Roger. And Darla, our next caller, please.

Operator

Mark Schoenebaum, Evercore ISI.

Mark Schoenebaum - *Evercore ISI - Analyst*

Maybe I could just double down on Tim's question. At the risk of annoying you, but, Roger, is it your expectation that the FDA will write a label for KEYTRUDA in lung cancer that will allow for broad use irrespective of PD-L1 status in the commercial setting? Yes or no.

And then perhaps for Adam, if the answer is yes, how do you think physicians are going to choose between KEYTRUDA in OPDIVO given that, at least for a while, OPDIVO will be the only one with a -- presumably the only one with an overall survival benefit actually described in label?

And then also, Roger, you mentioned -- this is what everyone on Wall Street wants to hear you say, so I'll just ask it, I don't know what you will say, but you mentioned no quote in balance in hospitalizations for heart failure. I assume that that clearly means no statistical difference between the arms. What everyone is asking though in our world is can you also give us some comfort that there wasn't some sort of numerical difference that just optically is going to frighten us when we see the data? Thank you.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

Mark, so, first of all, there is no yes or no answer to your question about FDA labeling. The FDA will make its own decision based on the data, which you have seen and which we have presented. I think that the data with respect to KEYTRUDA in lung cancer speaks for itself and FDA will want to inform physicians of the actual information that is available so that they can make their best judgments and we will see how that turns out. I can't predict yes or no what exactly that labeling language will look like, so that's the first thing.

With respect to the issue of TECOS, just to take that off the table, again, with respect to heart failure hospitalization, the results in the two arms were balanced. They were completely balanced and that is I think all you need to know.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

Mark, what I would say with regard to the marketplace, the first thing I'd like to say is that this is a very large market and it is not just looking at KEYTRUDA for one indication. If you look at KEYTRUDA, we are studying it over many, many different indications. I believe that this market can handle several competitors, so I don't think it should be looked at as one company versus the other. I think it should be looked at these companies, including Merck, versus cancer and trying to change the way the world thinks about treating cancer.

If you look specifically at lung, I think that having the data we have is good. I think having high expressers and understanding what the benefit is in those patient types will allow not only physicians, but payers to start to think about the treatment algorithms that they want to utilize to best treat patients. But I would look at this class more like the anti-TNFs where you have multiple competitors, they all do very well, they all have strong growth, some do a little bit better in one indication than another indication, but over time there's room for multiple, multiple competitors.

Mark Schoenebaum - *Evercore ISI - Analyst*

Thanks, I really appreciate it.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thanks, Mark. Thanks for the questions. Darla, next caller, please.

Operator

Jami Rubin, Goldman Sachs.

Jami Rubin - *Goldman Sachs - Analyst*

Just to follow up, Roger, what gives you confidence that the FDA will approve KEYTRUDA without a survival benefit just given that Bristol has now proven overall survival, both squamous, non-squamous in both PD-L1 positive and negative-express patients? So just if you can share your level of confidence in that issue. And secondly, when do you plan to file in lung in Europe? And then, thirdly, a question for you, Rob. I noticed that you highlighted a revenue hedging benefit and based on my math, that would seem to be around $200 million, or about $0.06 to earnings. Is that how we should look at that and is that something that is going to continue for the rest of the year? Thanks.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

I have confidence that the data that we have provided to FDA are registration worthy. We have identified a population of patients for whom we've received breakthrough designation. We've had lots of discussions with the FDA. I think we recognize the benefit that [endures] to these patients from treatment with KEYTRUDA and we will move forward on that basis.

With respect to the European filing, of course, as I mentioned and as you know, KEYTRUDA is under review in Europe for melanoma and while that review process continues, we will wait and sit back and once we know what that answer is we will be in a position to file with respect to non-small cell lung cancer.

Rob Davis - *Merck & Co., Inc. - EVP & CFO*

With your question on the hedging, it's a little less than the number you quoted, but generally you understand it correctly. It flows pretty consistently from the revenue down to earnings and as you look for the rest of the year, obviously, it will depend on where currency rates end up, but assuming

they continue where they are today, you should expect to see a proportion of benefits similar to what you saw in Q1 for the remainder of the quarters.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thank you, Jami. Darla, next caller.

Operator

Marc Goodman, UBS.

Marc Goodman - *UBS - Analyst*

I guess first question is if you could just give us some more detail on KEYTRUDA and what has happened so far; number of patients on drug, how is it being used, mono versus combo, first line, second line, that kind of thing. Second question is on hep C. Can you talk about the potential here that there is some limitations just in the experienced patients, just given the data we saw. And third, just on Bridion, we keep hearing the same thing on Bridion. Is this ever going to make it through the US FDA? Is there something new that they are bringing up, or is this just the same old stuff and we're going to have to go back and do more data? What is happening here? Thanks.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

So Adam, do you want to take the KEYTRUDA mix of patients?

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

Yes, absolutely. So first of all, what I would say is we had rapid penetration of our on-label indication and if you look, we had sales of about $83 million. The US was $66 million of that. Most of the patients that we have been treating are on label. So we think about 75% of the patients are in the approved indication and this is where we promote KEYTRUDA. The NCCN coverage takes some time for physicians to become aware of and for them to adapt. I think that that will increase over time, but it is still early.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

And Marc, with respect to -- you had two questions. The first with regard to our doublet treatment of HCV, and you spoke of limitations, I actually think the data are extremely strong and they are especially strong, actually, in patients that are difficult to treat who have, for a variety of reasons, fit into the category where it is difficult to get therapy to result in sustained virologic response. So I actually think that the totality of the data set, and it's a very large data set, is really quite strong. I don't see it as limited in that way.

With respect to Bridion, we think our data set well characterizes the hypersensitivity reactions that can occur with Bridion administration. FDA is eager to get additional information about that study in particular, which they have asked for sensitivity analyses about and they also intend to scrutinize the data from each individual site and as soon as we can get that done, I am hopeful that we and they will agree that Bridion is appropriate for the US market, but it is important that they have their questions answered and we are doing everything we can to get those answers to them.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Great. Thanks for the questions, Marc. Darla, next caller.

Operator

Gregg Gilbert, Deutsche Bank.

Gregg Gilbert - *Deutsche Bank - Analyst*

First for Adam, a KEYTRUDA commercial question. In the PD1 space, so far, I assume that the price is the price from the two companies, but my question is about whether you see these products moving into a contracting environment in lung cancer, or perhaps not until there are more players or perhaps never in this class. Want your views on that and how it evolves over time.

And then for Roger, where do you see the field settling on first-line melanoma treatment, monotherapy PD1 or combo therapy with Ipi? Obviously some data out in both of those cases recently. And lastly, Roger, beyond CETP, are there any sweet spots in cardiovascular research that you think make sense for Merck internally or externally given your current portfolio and heritage in the area? Thanks.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

The first thing is that if you look at KEYTRUDA, the vast majority of formularies have put both products on formulary and they are looking at this as a way to allow physicians to have choice. In this class, obviously, reimbursement is different, so the way in which you can contract is different than in other classes and how you might think about it, but I would also say, with so many different tumor types being developed with so much different data by indication being developed, I think that, over time, there will be multiple products that will continue to be available so physicians can choose which product they want for which indication, which tumor type and I don't see that necessarily changing right now over time.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

And Gregg, with respect to therapy for melanoma, just to elevate a little bit, the good news is that more and more profound results are being obtained in patients who previously had no hope of treatment and the results that we saw with KEYTRUDA monotherapy versus ipilimumab, previously the best available therapy for people with advanced disease, were so impressive that the Data Monitoring Committee had to stop the study early for a difference that emerged very early with respect to overall survival. So that is very good news.

The question is can we get beyond what we see with monotherapy in combination therapies and do better yet and for there, first of all, we need to see direct comparisons between the combination of a PD1 directed therapy plus let's say a CTLA-4 directed therapy versus a PD1 directed therapy alone. We are doing such studies. Bristol-Myers is doing such studies. We'll have an opportunity to see what those kinds of data look like and that will be important. And beyond that, there are other combinations which may prove to be attractive and we and others are pursuing those as well. I see a very bright future for this and I think we're going to continue to make strides. The platform of PD1 directed therapy is I believe foundational for the treatment of this malignancy and for many others and we are going to see further advances over the next few years, all good news.

With respect to cardiovascular disease, obviously, we are doing a great deal and one of the things that we have been working on is the soluble guanylate cyclase activators as a result of our recent interaction. We now have access to Adempas and in addition, we have a set of other compounds which come from Bayer and from us too, which address a whole family of interesting potential indications in that area. So we are doing quite a lot of work in cardiovascular research and we are quite encouraged by it.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thank you, Gregg. Darla, our next caller.

Operator

Alex Arfaei, BMO Capital Markets.

Alex Arfaei - *BMO Capital Markets - Analyst*

Thank you for taking the questions and congratulations on the quarter. Roger, do you anticipate having difficulty recruiting for the KEYNOTE-024 study in PD-L1 positive lung cancer patients given what you showed at AACR? If a patient has greater than 50% PD-L1 expression, why would they agree to go on chemo?

And then a follow-up for Rob. How much of the gross margin was driven by FX versus product mix? Thank you.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

I should say it is a changing environment; indeed, coming in very, very rapidly. I think it is important to recognize that these studies are conducted around the world in a whole variety of jurisdictions where we are at different stages in terms of the availability of PD1 directed therapies. And as is typical in such cases, there are opportunities to do studies directly comparing the therapies that exist locally. There are important questions that are being asked in KEYNOTE-024 and so we are eager to see those studies completed and to be able to present those data.

Rob Davis - *Merck & Co., Inc. - EVP & CFO*

With your question to product gross margin, if you look at the gross margin in the quarter, it grew about 240 basis points. And one of the major impacts was the fact that we had the divestitures of MCC and some of the other products, so the change in product mix. But if you look at it, a little less than half would have been coming from the benefit of FX.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thanks, Rob. Thanks, Alex. Darla, our next caller.

Operator

David Risinger, Morgan Stanley.

David Risinger - *Morgan Stanley - Analyst*

I have had a number of my questions asked and answered already, but I guess I have a few more. First, could you just comment on the expected EPS accretion from Cubist in 2015? And then could you provide a little bit more color -- I know that you commented on the hedging benefit, but other revenues stepped up dramatically in the first quarter of 2015 relative to the fourth quarter of 2014. Could you provide any more quantification of the hedging benefit? And then as we look to modeling the second quarter of 2015, how should we model other revenue sequentially versus what you just reported in the first quarter of 2015? Thanks very much.

Rob Davis - *Merck & Co., Inc. - EVP & CFO*

Maybe I'll take the second question first and then we can jump into the Cubist question as well. So if you look at other revenue in the quarter, and it's really probably worth unpacking it a little bit because, while in some ways it looks like it declined year-on-year, I would have you recall that in the first quarter of last year, we did have the gain from the sale of the US Saphris rights, as well as the fact that we do have AstraZeneca joint venture revenues that were in that line that no longer repeat. So in reality, we did see year-on-year an increase of about $250 million in that line.

And if you look at it from that perspective, the vast majority of that was FX hedging gains we had in the quarter, as well as we did have third-party manufacturing sales as a result of the MCC divestiture. We still are supplying Bayer in that system, that line and then we had Alliance revenue. So those really are what drive the change in other revenue, but the single biggest piece of it, if you look at it year-on-year or frankly sequentially, is going to be the foreign currency hedge gains we had.

And then with regard to the Cubist accretion, recall when we gave the guidance on this deal earlier we said we would expect it to be modestly accretive in 2015 and that continues to be the case.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thank you, Rob and thank you Dave. And Darla, our next caller.

Operator

John Boris, SunTrust Robinson.

John Boris - *SunTrust Robinson Humphrey - Analyst*

Thanks for taking the questions. First one on KEYTRUDA. There certainly has been a lot written in the trade publications, especially from the head of the FDA oncology division. He certainly has put his pen to approving products. We saw CYRAMZA approved in 9 weeks, OPDIVO approved materially earlier than anticipated. Just your thoughts on is this a new paradigm out of the FDA, and could we see potentially earlier than expected approval of KEYTRUDA in lung? And if so, are you ready commercially to match share of voice within the marketplace?

On HCV, just reiteration of your filing timeline there; and then, Adam, any comments about Europe and Japan growth dynamics. It certainly would appear that a lot of the growth is coming from ex-US relative to US, but your commercial readiness to potentially launch HCV before the end of the year. And then just lastly, can we anticipate Zilmax back in the model before the end of this year, or back in the market? Thanks.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Okay, do you want to start, Roger, with KEYTRUDA and timing; and Adam, go to share of voice?

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

Yes. So for KEYTRUDA in the KEYTRUDA review, I just would say that Dr. Pazdur speaks for himself. He is the head of the oncology review division and he has made plain that he is eager to advance these programs as best he can working with his colleagues. He spoke at the AACR meeting directly to this point. We have tried to provide the Agency with the information that they need to make their decision, but it is their decision and I really can't speculate on timing. With HCV with respect to filing, again, we will file by midyear.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

With regard to lung, so we are ready. As soon as we have approval, as soon as the FDA provides that to us, we are ready to launch. We have been building our lung capabilities. We have added sales representatives. We already have sale representatives selling EMEND in many of those offices already. But we have built the customer-facing teams. We have begun working on our scientific platform with key scientific leaders. So we are ready as soon as Roger and the team can work with the FDA to get us approval.

In terms of HCV, so we have been in this market for a long time. And if you look at our success when we launched our protease inhibitor, we did very well everywhere around the world. And if you look at markets in Europe, our market share was very high, I think higher than most people would've expected. When we no longer promoted our PI in those markets, we kept a commercial presence because we knew at some point, we would be launching again into the marketplace.

So we never left the market for HCV in Europe or Japan. In fact, in Japan we continue to promote PI in that market. So we are ready for HCV. We are very excited about that opportunity. And frankly, as soon as Roger and team work with the FDA to get us approval, we will be off to the races. We think this is a very exciting opportunity for Merck. It's an exciting opportunity for patients, and we are certainly ready.

Rob Davis - *Merck & Co., Inc. - EVP & CFO*

John, with your question regarding Zilmax, recall that we voluntarily withdrew that product. Right now, we are in the midst of trying to work through an infield study working with our industry partners. And given the timing of that, we really can't speculate when we will be back in the market. We are continuing to work through that, but right now for purposes of how we would look at the year, I would not assume any Zilmax.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thanks, John. Thanks for the call, the questions. Darla, next caller.

Operator

Seamus Fernandez, Leerink.

Seamus Fernandez - *Leerink Partners - Analyst*

Just a couple of quick ones on KEYTRUDA. I know it is short-lived, but maybe, Adam, if you could help us with the percent of sales in the community versus academics and if you can't give us that number, maybe you could just help us in terms of the increased penetration of oncology physician practices before the on-label indication?

And then separately for the on-label indications, can you just give us a sense of where you see the duration of therapy evolving at least in the melanoma setting? And then my last question, as we think forward to your update on anacetrapib, can you just remind us how that fits in terms of what your expectations were in terms of timing previously, what is the anacetrapib update coming towards the end of this year, a little bit of a delay implying that events are coming in just a little bit more slowly? Thanks a lot.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

So first of all, with regard to KEYTRUDA, if you look at our sales, right now, the vast majority of those, we believe greater than 75%, are for the approved indication in melanoma and if you look at the breakout between community-based versus non-community-based physicians, the majority of sales still are from the non-community-based physicians and the big institutions. But you should know we are in all the offices of not only the large institutions, but the community practices as well and we continue to have a strong presence covering over 90% of the prescriptions of physicians prescribing for melanoma.

In terms of duration, it is just too early. In this market, data is hard to find, so it's very difficult for us to tell you how long people in the marketplace that have started a product have continued taking the product. So it's just very early for us to have that type of data. The data in oncology is a little bit harder to get than in primary care.

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

And just to follow up on that, Seamus, as you know, the duration of therapy in our clinical trials is two years because there is no marker that we can follow in responding patients that would tell us that it is essential to maintain the drug in order to keep the response. And that is one of the questions that is continuing to be explored in additional studies across the entire program.

And then with respect to anacetrapib, the protocol revision that has been proposed by the steering committee, assuming that it is accepted by governing bodies, will delay by a few months the first interim analysis, but it is not going to affect the conduct of this study at all, which is proceeding exactly as planned and is, of course, end-point-driven.

Seamus Fernandez - *Leerink Partners - Analyst*

Okay, great. Thank you.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thanks, Seamus. Darla, I think we have time for one more call.

Operator

Colin Bristow, Bank of America.

Colin Bristow - *Bank of America Merrill Lynch - Analyst*

On hep C, could you talk about your level of confidence in developing a shorter regimen with one of the triplet combinations? And when will we first see data from that C-CREST trial? Also on hep C, can you talk about how you see the pricing environment evolving in 2016 given the market is going to become increasingly crowded? And then just a quick one on odanacatib. Could you provide us an update on this program? Thanks.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Roger, do you want to talk a bit about --?

Roger Perlmutter - *Merck & Co., Inc. - EVP & President, Merck Research Laboratories*

So for the hep C program, the question is, of course, can we -- we have a terrific set of data that we presented with respect to doublet and we've talked previously about developing triplet therapy, which would be pan-genotypic, shorter duration and could be used irrespective of comorbidities and we continue to work on that. Our triplet with 3682 is under study in Phase 2. We hope to be able to begin Phase 3 sometime perhaps in the beginning of next year or so. Data from the Phase 2 studies should be available sometime around the end of this year and once those data are available, that will help us to understand what we can do. Of course, we have already previously published data demonstrating that we can use a shorter regimen by using Sofosbuvir as a nucleoside inhibitor in combination with the doublet therapy. So we have some confidence that one could do that, but it needs to be explored, of course, with 3682 and that we will do.

With respect to odanacatib, the program continues. As we indicated before, we are working to adjudicate this set of adverse events that were scored in the study. It's a large study and the adjudication process is proceeding in an independent and blinded fashion. We worked with the FDA to create that adjudication process. We hope it will be done soon and then we will be in a position to file the drug.

Adam Schechter - *Merck & Co., Inc. - EVP & President, Global Human Health*

And Colin, in regard to the hepatitis C market, first, this is a very large market. There are more than 3 million patients in the US alone and there's more than 100 million patients worldwide, so we think that this will be a very big, a very important market over time. We have seen some of the pricing and contracting occur in the market, but we believe that with our product and that we are developing a highly effective, well-tolerated ribavirin-free pan-genotypic regimen that has a minimal treatment duration for a broad variety of patients that we can be successful in this market and we believe that despite what has happened in the past with some of the pricing that it will still be a very big important market for us. So we remain very excited about coming back into the hepatitis C market in the United States, but also globally.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thank you, Adam and I will turn it over to Ken.

Ken Frazier - *Merck & Co., Inc. - Chairman & CEO*

Okay, just to close the call, we are seeing steady progress as you heard in our pipeline and we are also experiencing solid growth in our underlying business. We are pleased with the momentum of the business and we look forward to speaking to you again. Thanks.

Joseph Romanelli - *Merck & Co., Inc. - VP, IR*

Thanks, everyone.

Operator

Ladies and gentlemen, this concludes Merck's first-quarter 2015 earnings conference call. You may now disconnect.
