Q2 2024 results
Conference call and webcast for investors and analysts
Wednesday, 31 July 2024 at 12:00 BST

Introduction | Nick Stone

Slide 1
Hello everyone. Welcome to today's call and webcast. The presentation was sent to our distribution list by email, and you can also find it on gsk.com.

Please turn to slide 2.

Slide 2 | Cautionary statement regarding forward-looking statements
This is the usual safe-harbour statement - we will comment on our performance using constant exchange rates or CER unless stated otherwise.

Please turn to slide 3.

Slide 3 | Agenda
Today's call will last approximately one hour, with the presentation taking around 35 minutes and the remaining time for your questions.

Today, our speakers are Emma Walmsley, Tony Wood, Luke Miels, Deborah Waterhouse and Julie Brown, with David Redfern joining for Q&A.

Please ask 1-2 questions so that everyone has a chance to participate.

Turning to slide 4, I will now hand the call to Emma.

Strategic summary | Emma Walmsley

Slide 4 | H1 2024 continued momentum and R&D progress

Welcome to everyone joining us today.

Please turn to the next slide.

Slide 5 | H1 2024 momentum drives upgraded guidance

I am delighted to report that GSK's momentum this year continues with excellent second-quarter performance.

Sales grew 13% to 7.9 billion pounds, core operating profit was up 21% to 2.5 billion pounds, and core earnings per share rose 17% to 43.4 pence (all excluding COVID solutions).

This reflects our continued focus on operational execution and the strength of GSK's broad portfolio to prevent and treat disease.

Sales growth was reported across all 3 product areas for the first half. For the second quarter, Vaccine growth was driven by international expansion. Specialty medicines, in particular, were up strongly, growing over 20%, reflecting successful new launches: *Ojjaara* in myelofibrosis, *Jemperli* in endometrial cancer, and long-acting HIV treatments, and we also delivered a record quarter for *Trelegy* in General Medicines. All of this demonstrates the strength and breadth of our portfolio to deliver competitive and profitable long-term growth.

This strong sales performance has been underpinned by effective cost control - driving operating leverage and further margin improvements this year. And these benefits are also delivering improved operational cashflow - providing funds for pipeline investment, as well as returns to shareholders. Our dividend for the quarter was 15 pence.

On the basis of our current performance and prospects, we are again upgrading our full-year guidance.

Next slide, please.

Slide 6 | 2024 pipeline delivering momentum

We continue to invest in the pipeline and are making good progress.

This quarter, GSK's long-standing expertise and leadership in Respiratory was once again reinforced with positive phase III data reported for depemokimab. In Oncology, we continued to progress material growth opportunities– most notably, the presentation of positive second-line combination data for *Blenrep*, to treat multiple myeloma.

In Vaccines, *Arexvy* was first again with the approval by the FDA to prevent RSV disease in adults aged 50 to 59 who are at increased risk. Although ACIP's postponed vote on recommendation for this cohort was surprising, we have to remember this is a brand-new vaccine. We look forward to sharing the additional data requested and more, and remain very confident that the benefit *Arexvy* can offer to this age group – like other cohorts – will be fully recognised and that this best-in-class vaccine will reach its full sales potential.

I am also delighted we've taken positive steps forward in clinical development for our pioneering ultra-long-acting HIV medicines, our potential functional cure treatment for hep B, and our novel antibiotic gepotidacin.

Next slide, please.

Slide 7 | Trust: delivering health impact sustainably

Building trust by delivering across the 6 key areas we prioritise for ESG remains a clear priority for all of us at GSK.

Earlier this month, in partnership with Medicines for Malaria Venture, we launched tafenoquine in Thailand and Brazil. This is the first single-dose radical cure medicine to prevent malaria relapse—another step forward to eliminating the disease.

In May, we announced that we will become a founding partner of the Fleming Initiative, a new global network that brings together scientists, policymakers, and the public to fight antimicrobial resistance.

We have also started a phase III trial for a low-carbon version of our metered dose inhaler, *Ventolin*. Using a next-generation propellant, our new inhaler has the potential to reduce emissions by around 90% versus the current one and benefit millions of people with asthma.

Please turn to slide 8.

Slide 8 | Strong momentum underpins confidence in future profitable growth

So, I am delighted with GSKs continued progress and strengthening prospects.

But before reminding you of these, a quick word on Zantac, given the ruling we had on admissibility of evidence this quarter. This Daubert ruling in Delaware does not determine liability and our position remains unchanged. We will continue to defend against the claims being made, and our aim – as it has been all along – is to manage this in the best interests of the company and shareholders...and to stay focused on our delivery.

As many of you know, we started this year by setting out new, upgraded long-term commitments. And we are all focused on delivering against all of these. Short. Medium. And Long term.

With our current momentum, and the continued progress we are making, we have today upgraded our outlook for 2024, demonstrating the strengthening depth and breadth of our portfolio. We now expect to deliver sales growth of 7-9% and core operating profit growth of 11-13% with a short-term shift in mix the team will comment on.

For the five-year period to 2026, we continue to expect more than 7% sales growth and more than 11% core operating profit growth on a 5-year CAGR basis;

For 2031, we continue to expect sales of more than £38 billion with a broadly stable margin through the loss of exclusivity of dolutegravir.

And remember these outlooks do not yet include the launch of *Blenrep* or ongoing progress in our early-stage pipeline.

So, I'll now hand over to Tony to talk you through our R&D progress in more detail.

Positive pipeline progress | Tony Wood

Slide 9 | Performance: growth drivers

Thank you, Emma, and welcome everybody.

Next slide, please.

Slide 10 | Continued pipeline delivery

As you know, our approach in R&D is to invest for growth in new, best-in-class Vaccines and Medicines, combining our scientific focus on the immune system, with the use of advanced technologies. Today our pipeline comprises 70 assets in clinical development and my priority remains the acceleration of the delivery of new vaccines and medicines for patients and to drive future growth for GSK.

In the past 6 months, we have secured regulatory approvals, or received acceptance of submissions for 10 major medicines and vaccines and reported positive data from 7 phase III studies, clearly demonstrating the innovation and health impact that GSK is now bringing to patients.

Focused business development has continued. We strengthened our respiratory pipeline with the acquisition of Aiolos Bio for their the long acting TSLP antibody anticipated to start phase II in 2025; and we gained full control of our candidate mRNA vaccines by restructuring our collaboration with CureVac.

Accompanying these were investments in two new technology platforms: the acquisition of Elsie Biotechnologies, which will help accelerate our oligonucleotide programme, and an agreement with Ochre Bio, that will create foundational liver biology datasets, deepening our disease understanding and improving target identification.

In the past six months, we have advanced the pipeline in all our core therapeutic areas. And importantly, we are on track with development of the 12 scale product opportunities, as well as *Blenrep*, that we highlighted at the start of this year. These all have the potential to deliver profitable growth in the 2026 to 2031 timeframe, and to support our 2031 ambition of more than £38bn in sales.

I will now take a closer look at a few important areas.

Next slide, please.

Slide 11 | Infectious Diseases: Vaccines

First in vaccines, where preventing seasonal viral and high-risk bacterial diseases, remains a key focus for us

We have an extensive development plan for *Arexvy* and continue to see this exceptional vaccine as a major long-term growth opportunity.

Arexvy is the world's first RSV vaccine and has demonstrated outstanding efficacy in adults of various ages, including more than 94% during the first season for people with comorbidities; and who are at increased risk of severe RSV disease.

In June, ACIP recommended use of *Arexvy* for all adults aged 75 and over, and for adults aged 60-74 who are at increased risk from severe RSV disease. The committee unexpectedly postponed a vote in adults aged 50-

59, requesting additional data. These include evidence from vaccine surveillance databases to further support the benefit/risk profile observed during clinical trials in a real-world setting. We look forward to contributing to these data over the coming months.

I'm also looking forward to the data from studies (006/004), assessing efficacy, immunogenicity and safety of *Arexvy* over three RSV seasons. These data will be important to help answer some of the questions raised by ACIP on outcomes and duration of protection. As a reminder, season 2 data showed 75% cumulative vaccine efficacy against severe lower respiratory tract disease over 23.3 months. These data support the strong - and durable - protection this uniquely adjuvanted vaccine offers against RSV.

Later this year, we are also looking forward to sharing more from trials in adults aged 18-49 who are at increased risk from RSV disease.

Next slide please

Slide 12 | Infectious Diseases: Vaccines progress

Next, a comment on the interesting data for Shingrix that we shared yesterday at the Alzheimer's Association International Conference in Philadelphia. These data add to the growing body of evidence exploring the observed association between shingles vaccination and reduced risk of dementia.

Our study was prompted by a number of observations, some of which are summarised on this slide. There is a growing body of evidence, largely generated from retrospective case studies in very large populations, that herpes zoster vaccination is associated with a reduction in the diagnosis or onset of dementia. These data include a recent observational study in Wales, which concluded that vaccination with a live-attenuated Herpes zoster vaccine was associated with a 20% reduction in dementia diagnosis when compared to people who did not receive the vaccine.

Using an AI/ML approach and data from Optum's electronic health record dataset, we constructed a retrospective, observational study comparing matched cohorts of adults vaccinated with Shingrix, a competitor, live attenuated shingles vaccine, and a comparator Pneumococcal vaccine.

Headline data shown on the right-hand side of this slide suggest that after three years, Shingrix was associated with a 27% reduced risk of acquiring dementia when compared with a competitor zoster vaccination and a 24% reduced risk of dementia when compared to a comparator pneumococcal vaccine.

The potential relationship between shingles prevention and risk of neuro-degeneration is an area of increasing interest for the scientific community. These are interesting early results that we are investigating with additional retrospective and mechanistic studies.

Next slide, please.

Slide 13 | Preventing and treating respiratory diseases

Turning to Respiratory, we're making good progress with novel treatments that could provide more effective options for severe asthma, COPD and refractory chronic cough.

Depemokimab is the first ultra-long-acting biologic engineered to have high affinity for IL-5. It enables sustained inhibition of Type 2 inflammation with twice yearly dosing, versus current options some of which require injections every two weeks

This quarter, we announced that two pivotal phase III trials in severe asthma with an eosinophilic phenotype, SWIFT-1 and SWIFT-2, met their primary end points, demonstrating that two doses of depemokimab, administered over a 12month period showed a statistically significant and clinically meaningful reduction in significant exacerbations vs. placebo in combination with the standard of care. We are looking forward to sharing full data at the ERS conference in September, and we remain on track to file the medicine for approval later this year.

Depemokimab's development programme is being informed by predictive biomarkers and phenotyping which has enabled us to progress four clinical indications in parallel. The pivotal ANCHOR 1-2 trials in one of these - chronic rhinosinusitis with nasal polyps - are now closed for recruitment with data expected later this year.

We also expect to see phase III data on use of Nucala in COPD this year; and phase III data for camlipixant in the treatment of refractory chronic cough in 2025.

Next slide, please.

Slide 14 | Oncology

You will shortly hear from Deborah on the important advances in our HIV pipeline, so I will conclude with a brief summary here of the strong progress we have made within the oncology portfolio during the first half. We are building an emerging and high-potential portfolio of new medicines, with a growing focus on ADCs, immuno-oncology and targeted small molecules.

For *Blenrep*, pivotal data from the DREAMM-7 and DREAMM-8 studies presented at ASCO demonstrate the potential for *Blenrep* to become the new standard of care for patients with multiple myeloma in the second line setting. These trials will serve as the basis for regulatory submissions, and we were pleased that EMA recently accepted our first filing for this indication. Additional filings are planned before the end of the year.

Also as stated at the recent meet-the-management event, we plan to start a phase III trial in the 1L setting in early 2025.

For *Jemperli*, recent data from the RUBY trial demonstrate a statistically significant Overall Survival benefit in an all-comer population with primary advanced or recurrent endometrial cancer.
Jemperli is the only immune oncology agent to demonstrate a survival benefit in this patient population and these data have been filed with FDA. We anticipate a response ahead of the 23rd August PDUFA date.

Carefully targeted phase III trials investigating the use of *Jemperli* in the treatment of rectal, lung and head and neck cancers are also ongoing.
The first half of 2024 also saw a number of oncology clinical trial starts including GALAXIES-301, a phase III trial investigating our TIGIT antibody, belrestotug in combination with *Jemperli* in the treatment of first line PDL1-high non-small cell lung cancer; the Gliofocus phase III study which will investigate *Zejula* in the treatment of newly diagnosed glioblastoma, and a phase I study of our B7-H4 ADC, GSK '584, which recently entered the clinic.

We're looking forward to seeing more data from our ADCs by the end of the year, to inform pathways for accelerated registrations

Finally – we were pleased to announce the recent Japanese approval of *Omjjara* with a line-agnostic label for all patients with myelofibrosis.

So in summary – a productive first six months to 2024. I am pleased with the progress we are making to deliver differentiated health impact for people and patients.
And will now hand over to Luke.

Performance | Luke Miels

Slide 15 | Performance: growth drivers

Thanks, Tony. Please turn to the next slide.

Slide 16 | Growth across all product areas and regions

In Q2, we delivered growth across all our product areas and regions, with £7.9 billion of sales, up 13% versus last year, excluding COVID solutions. This includes another strong performance in the US, with growth of 17%.

Please turn to slide 17.

Slide 17 | Vaccines: +3%[1] driven by meningitis vaccines, *Shingrix* ex-US and *Arexvy*

I Vaccine sales grew 3% in Q2, excluding COVID solutions. This performance was impacted by short-term factors and we fully expect the underlying strength of the business to continue over the long term.

Globally, Shingrix grew 7% year-to-date but was down 4% in the quarter, delivering £832 million.

Outside the US, sales grew significantly and represented 64% of Q2 revenue. Shingrix has now launched in 45 markets, the majority with less than 5% penetration, and these markets represent our source of future growth for this vaccine. Q2 growth was driven by a national immunisation programme in Australia, expanded European public funding, and supply to China. Supply phasing to China is now expected to be delivered evenly across the second half, with 40% of our agreed full-year supply delivered to date.

In the US, sales decreased by 36% in the quarter due to three factors: the first, channel inventory reductions, and secondly, important changes in retail vaccine prioritisation in part due to a transition to a new CMS rule effective 1 Jan 2024 that changed how pharmacies process reimbursements from payers. These two short-term effects are not expected to repeat in the second half of this year. Thirdly, lower demand driven by challenges activating harder-to-reach consumers. Addressing this remains a priority, with cumulative penetration of people aged 50 and older reaching 37%, up 6 points since the same time in 2023 based on latest census data. More than 70 million adults are still unvaccinated and recommended to receive our vaccine, and we are focusing resources and marketing content on targeting these eligible consumers.

Our expectation continues to be that Shingrix global sales will grow this year and reach more than £4 billion by 2026, driven by growth outside the US.

Turning to RSV, nearly 8 million people have been vaccinated with *Arexvy* since launch and we are maintaining around two-thirds of the retail vaccination share. As expected, demand levels were lower in Q2 due to seasonality.

Ahead of the 2024-25 RSV season, we are well-positioned with our contracting and still expect blockbuster-level sales in 2024. These sales are expected to be second-half weighted, with the vast majority in the US. Following the recent ACIP recommendation, we received a universal recommendation in 75 plus year olds, but we now expect minimal sales in the 50–59 age group this year, with further potential impact in those aged 60-74.

Preparation for launches in Europe and International are underway for 2025 and beyond. With a best-in-class data profile, we are confident *Arexvy* will return to growth next year and longer term can achieve more than £3 billion in peak-year sales.

In meningitis, Q2 sales for Bexsero and Menveo were up 23% and 30%, respectively. Bexsero continues to demonstrate strong growth, benefitting from favourable pricing in the US, recommendation in Germany and increased demand from Australian immunisation programmes. Menveo grew due to favourable delivery timing in International markets and US CDC purchasing patterns. Including our candidate MenABCWY vaccine, our meningitis portfolio is expected to deliver around £2 billion in peak-year sales.

Given the first-half performance and our latest expectations with a tough comparator for Arexvy and US Shingrix in the second half, we now anticipate Vaccine sales in the full year to increase by low to mid-single-digit per cent. Our increased 2026 CAGR outlook for Vaccines of low double digits has not changed.

Next slide, please.

Slide 18 | Specialty Medicines: +22%[1] with strong performance across disease areas

In Speciality Medicines, including HIV, which Deborah will cover next, we had a very strong quarter and increased sales by 22%, excluding COVID solutions. Our expectations for the year, I am pleased to say, have increased.

Nucala was up 17%, driven by higher patient demand for treatments addressing eosinophilic-led disease, market expansion and increased biopenetration. Benlysta was up 20% in the quarter driven by biopenetration growth from earlier intervention in SLE and lupus nephritis. We're also seeing growing demand in the US and continued consecutive double-digit growth outside the US.

In oncology, sales again more than doubled in the quarter.

In haematology, we're continuing to see strong uptake for *Ojjaara* which launched in the US last year and in the UK and Germany in Q1.

In gynaecological cancers, *Jemperli*'s continued momentum was primarily driven by sales in the US, Germany, France and the UK in first-line dMMR/MSI-H primary advanced or recurrent endometrial cancer. In addition to growth from second-line and later treatment. *Jemperli* is the backbone of our immuno-oncology development, and pending regulatory decisions and development beyond dMMR-driven tumours will drive future growth.

Zejula's growth continued in Q2, driven by the US and volume growth globally. As a reminder, from next quarter we will not benefit from the stocking of, or the switch to, the new tablet formulation as seen in Q3 2023.

Given the 21% sales growth in the first half, we are increasing our full-year expectations. We now expect Specialty Medicines to grow mid to high-teens per cent, with second-half growth being lower due to the tougher comparisons in Oncology.

Please turn to slide 19.

Slide 19 | Growth drivers spotlight: *Nucala* and *Ojjaara* performance

Focusing on *Nucala* for a moment, the chart on the left of this slide demonstrates *Nucala's* continued leadership in IL-5 market share. Pleased to say, *Nucala* continues to grow by double digits quarter-on-quarter, despite being on the market for almost nine years. We anticipate our IL-5 portfolio, comprising depemokimab and *Nucala*, to deliver more than £4 billion in peak-year sales.

Next, looking at *Ojjaara*, we are still seeing the fastest US launch uptake in value for a JAK inhibitor in myelofibrosis. It's the only treatment to demonstrate clinical and durable benefit on spleen response, symptoms, and anaemia for myelofibrosis patients with anaemia. We're finding anaemia burden to be increasingly at the forefront of treatment decisions, and we continue to improve our market share. 65% of US and EU healthcare professionals expect to increase prescribing *Ojjaara* in the next six months.

Please turn to slide 20.

Slide 20 | General Medicines: +12%, driven by *Trelegy* momentum

Finally, General Medicines grew 12% in Q2, reflecting a record quarter for *Trelegy*, with sales increasing 41% to £842 million. Around half of the growth was driven by channel and segment mix as well as adjustments to returns and rebates, which are expected to moderate in H2. *Trelegy* also benefitted from share gains and remains the top-selling brand in asthma and COPD, and is the most prescribed single-inhaler triple therapy worldwide.

Removal of the AMP Cap on Medicaid drug prices in the US had the expected impact on branded versions of *Advair, Flovent* and *Lamictal*. However, increased use of authorised generic versions of *Advair* and *Flovent* offset this impact in the quarter.

Given the strong start to the year, we now expect General Medicines sales to increase low to mid-single digit per cent in the full year.

I'll now hand over to Deborah to cover HIV.

Performance | Deborah Waterhouse

Slide 21 | HIV: Growing 13% in Q2 2024, with momentum across LAI[1] portfolio

Thank you, Luke. Next slide please.

We are pleased to see continued strong performance and we sustained double-digit growth in Q2, delivering 13% revenue growth. Our growth is driven by continued strong patient demand for our industry-leading medicines, which has led to an increase of two percentage points in global market share versus Q2 2023.

Our oral two drug regimens and long-acting injectables continue to transform the HIV market.

Dovato, delivered sales of 551 million pounds for the quarter. The strong body of clinical data and real-world evidence reinforcing the efficacy and durability of this medicine continues to grow. At the International AIDS Conference last week, results of the PASO DOBLE study, a large head-to-head, randomised clinical trial of *Dovato* compared against the 3-drug regimen, Biktarvy, showed non-inferior efficacy and significantly less weight gain. This is important because we know people living with HIV are concerned about taking more medicines as they age, as well as the long-term risk of metabolic diseases that can come with weight gain.

Our long-acting portfolio also continues to perform strongly, delivering more than 50% of total HIV growth.

Cabenuva, grew 42% driven by patient preference and proven and durable efficacy. CARES and LATITUDE data presented at CROI and data from real-world cohorts that include over 10 thousand people living with HIV in diverse settings has resonated strongly with physicians and has supported increased breadth and depth of prescribing.

Apretude grew more than 100% in the quarter. This medicine has demonstrated proven superior efficacy compared with daily orals, with a positive safety profile and high patient preference. As a reminder, the registrational HPTN 084 study of PrEP in women was the first to show zero infections in participants who received injections as described per protocol.

We believe that long-acting therapies are the future of HIV care, empowering people impacted by HIV with choice and addressing the barriers standing in the way of reaching the end of the HIV epidemic.

Looking at the long-acting market, we can see that the treatment market is currently approximately 10 times larger than the PrEP market at about 20 billion pounds, which will have a significant impact on the sales potential of long-acting options. In the long-acting injectable treatment setting there are no competitor launches planned before 2028.

We continue to see strong progress across our pipeline. At the AIDS congress, we shared first-time-in-human data for our third-generation integrase inhibitor, VH184, demonstrating strong efficacy and a unique resistance profile. Building on our strong legacy of developing powerful integrase inhibitors, these positive findings reinforce that integrase inhibitors will remain the gold standard in HIV, trusted for their efficacy, long-term tolerability and high barrier to resistance and make VH184 an excellent candidate for further development for both ultra-long-acting and self-administered therapies.

In PrEP we have committed to move forward with our registrational studies for cabotegravir ultra long acting Q4M with confidence in the efficacy and safety profile. In treatment we have selected rilpivirine as the partner for cabotegravir ultra long acting Q4M. This regimen selection is based on progress in formulation studies for rilpivirine and builds on existing positive patient and physician experience with these medicines in our current portfolio. We remain on track to deliver the first ultra-long-acting four monthly treatment regimen in 2027 and four monthly dosing options for prevention in 2026. We continue to progress our ambition of extending the dosing interval of our long-acting regimens to enable every-six monthly dosing towards the end of the decade.

Our strong performance over the first half gives us confidence to increase our guidance to low double digits percentage growth in 2024.

With that, I will hand to Julie.

Q2 2024 performance and 2024 guidance | Julie Brown

Slide 22

Thank you, Deborah, and good afternoon, everyone.

Next slide, please.

Slide 23 | Continued strong momentum in Q2 2024

Starting with the income statement for the second quarter, with growth rates stated at CER.

Sales increased 13%, as Emma mentioned, reflecting continued strong business performance, particularly within Oncology, HIV and *Trelegy* within General Medicines.

Core operating profit grew 21% (excluding COVID) and 18% overall. Operating profit grew ahead of sales as we continue to focus on disciplined resource deployment and delivery of a competitive P&L.

Core EPS grew 17% excluding COVID.

Turning to the **Total results**, operating profit decreased 22% to £1.6 billion, predominantly reflecting charges arising from the CCLs, primarily due to improved longer-term prospects of our HIV business, and less favourable foreign currency movements.

Next slide, please.

Slide 24 | Q2 2024 core operating margin improved

Moving to the **Core operating margin**.

This increased 190bps to 31.9% YOY, excluding COVID. This reflected cost discipline, the drive for productivity improvements and targeting resources to the key Commercial and R&D assets in the business. In addition, the gross margin benefited from positive regional mix.

These factors were partly offset by the impact of the loss of Gardasil royalties, as guided.

In the first half, we saw a significant margin improvement of 380 basis points at CER to 32.5%, with strong operating leverage underpinned by 13% sales growth, gross margin mix benefits, and a one-off favourable impact relating to the *Zejula* royalty dispute.

Next slide, please.

Slide 25 | H1 2024 free cash flow of £0.6bn

Cash generated from Operations in the first half was £2.8bn, representing an improvement of £0.9bn versus H1 last year.

This was primarily driven by core operating profit growth and favourable working capital, with the latter benefiting from higher receivables' collections.

Free cash flow was £0.6bn, relative to an outflow last year, and therefore improving YoY by almost £1bn. As usual, we expect to generate the majority of our free cash flow in the second half of the year given the seasonality of the vaccines business.

Next slide, please.

Slide 26 | Capital deployment supports business growth and shareholder returns

Slide 26 shares our net debt position since 31 December and how we've actively deployed capital in the business in line with our Capital allocation framework.

Net debt was £1.1 billion lower compared to the end of 2023, at £14 billion. This included the monetisation of our remaining stake in Haleon.

We have a strong balance sheet to support continued investment in future growth, including BD, as we look to deploy funds to enhance growth and deliver attractive shareholder returns.

And now, with that, I'll now turn to our latest full-year expectations.

Next slide, please.

Slide 27 | 2024 guidance at CER and excl. COVID-19 solutions

Given our strong start to the year and continued momentum, we are pleased to upgrade our 2024 guidance today.

You heard Luke and Deborah refer to our updated product guidance and, in summary, the strong upgrades to Speciality Care and General Medicines more than offset our lower expectations for Vaccines this year.

In aggregate, for FY 2024, we now expect group sales to increase between 7-9%, and Core Op Profit to increase between 11-13%, notwithstanding the loss of Gardasil royalties, which will reduce profit growth this year by 6 percentage points.

Turning to the P&L, the GM has been strong in the first half. In the second half, we expect to incur costs to drive future supply chain efficiencies, as well as lower positive mix benefits given the phasing of the launches last year. In addition, we continue to expect SG&A to grow at a LSD%, and we now expect R&D spend to increase slightly below sales growth, and royalties for the year to be around £600m.

Core EPS is expected to grow 10-12 per cent due to an increase in tax rate under OECD legislation.

I am confident in our underlying business momentum, but obviously, the second-half growth rates are very different from the first, with the second half significantly impacted by the very strong launches of *Arexvy* and in Oncology last year, as well as initial stock builds. In addition, Gardasil was stronger in H2 LY, which will impact our profit growth in this upcoming second half.

In summary, we are pleased with our first-half performance and confident in achieving our upgraded full-year guidance, as well as all our medium and longer-term outlooks.

Next slide, please.

Slide 28 | IR Roadmap 2024 to 2025

Turning to our IR roadmap, which shares our progress towards major milestones and value unlock opportunities.

As you can see, we have made good progress in the first half.

In the second half, there are a number of major milestones expected notably in respiratory:

- First, the presentation of the detailed SWIFT 1 and SWIFT 2 data at the ERS congress for depemokimab in the treatment of severe asthma in patients, with an eosinophilic phenotype.
- Second, the phase III readout of depemokimab for Chronic Rhinosinusitis with Nasal Polyps
- And finally, the Phase III data for Nucala in COPD.

We also look forward to our next Meet the Management event at the end of the year, which will be the first introduction to our early-stage pipeline.

And with that I will hand back to Emma to conclude.

Summary | Emma Walmsley

Slide 29

Thanks, Julie.

So, to summarise.

GSK continues to deliver on its commitments and perform to a new standard. Our excellent performance in Q2 underpins the strong momentum across the business.
We are pleased to be upgrading guidance and expect 2024 to be another meaningful year of growth in sales, profit and earnings, as we continue to focus on prevention and changing the course of disease for millions of people.

We are confident in delivering on our growth commitments, and we continue to progress with development of meaningful innovation in our core therapy areas.

Our strong momentum underscores our confidence to sustain profitable growth through this decade, deliver scale health impact and attractive returns for shareholders, combining science, technology and the talent of GSK's people to get ahead of disease together.

With that, I will now open up the call for the Q&A with the team.

Peter Verdult (Citibank): Two questions please. Firstly, for Emma and Luke, I am sure you are going to get a lot of questions on this but let's just head it straight off. In light of the vaccine dynamics that you are calling out today, and yesterday's comments from Pfizer and Merck, can I just push you a little more on, first, what you are seeing in China; when you think realistically you can return US *Shingrix* to growth - I realise that is a difficult question to answer but I'll try - and, lastly, how are you feeling about the contracting for 2024 US RSV in both the retail and non-retail channels?

Then a very different and quick question for Tony: can you remind us why GSK still has enthusiasm for the TIGIT mechanism, in light of disappointing competitor datasets? Is there any differentiation that you want to call out on EOS-448? Thank you.

Emma Walmsley: Thanks very much, Peter. Let's go to Luke on all three of those but I would refer you back to his introduction earlier today. The update has shown some short-term impact on our Vaccines portfolio but we remain very confident in our medium-term outlooks and the strength of our products today and their prospects, as well as the pipeline that continues to develop in Vaccines. Luke, both on China, US *Shingrix* and I know great confidence in the contracting for the season.

Luke Miels: Thanks, Peter, and I suspect you are not Robinson Crusoe with these questions, so I will spend a bit of time on it. Firstly, on contracting, very happy and, based on what we can see, we will retain market leadership, we are on track to be a blockbuster. We can cover ACIP a little later on, but I think we are very happy with the work that is being done by the team on the ground there.

In terms of Vaccines in China, at the macro level we are extremely happy with the partnership we have started with Zhifei. This is a strategic partnership, this is a long-term partnership. The start-up process for *Shingrix* has been completed in Q1. We have reps on the ground as of the end of May and, if you just look at numbers, they have already expanded from 6,000 points of vaccination that we were covering and have already hit 19,000 and are on track for around 27,000 by the end of the year, so the scale of that company and the impact they can bring for *Shingrix* in China is clear.

In terms of broader vaccine demand, we did see some softness in *Cervarix* but it is confounded by the fact that we moved resources off the product as well. We do hear some signs that some of the local CDT do have tighter budgets and this is something we are going to watch very, very closely.

For us, the key here is that *Shingrix* is at a very different point in the life-cycle to HPV vaccines, we are just getting started here. We have the best possible partner, we will build the opportunity. If you look at the opportunity, it is very similar to the US when you look at people in China who can pay out of pocket and they are in key cities, so the numbers are very large but we need to build that.

We have just shipped 60% of the remaining, we will ship the rest of the order in the second half. We did have a delay of shipment, not demand-based, but we have just booked another 94 million in July, so we are on track to fill the full contract for the year, so that's China.

If we get on to the US and *Shingrix* growth, for the full year we are not going to grow versus last year but the second half, obviously, is going to be stronger than the first half. If I just expand on the three factors. On the first two, let me be really clear: these are half one dynamics, so we have moved through them. The first one is wholesaler, as I said in my earlier comments and that delta is about 300,000 doses, so we finished Q4 2023 with 700,000 wholesaler which is typically what we like, as I have said on previous calls, in Q2 it went down to around 400,000 but that is something that we expect to rebuild as we go into the 'flu season.

The second factor was CMS rule changes covering direct and indirect remunerations, or DIR fees. Just as background, these are basically discounts the pharmacies pay to Medicare PBMs and plan sponsors if certain quality measures are not met. The complication has been historically that PBMs can request these retroactively for up to six months from the point of sale, so that is obviously a complication for the pharmacy and the pharmacy group.

The new rule that was brought in removed the retro-active part, so basically at the point of sale, all of these components had to be booked and visible. What that meant was for the six months – so, from January to June – there were just less incentives for pharmacies to vaccinate patients. We saw them shifting volumes between different types of vaccines to offset that. We have now moved into the second half of the year, if we look at market research tracking et cetera, PRX trends, adjusting for 4 July, is looking very encouraging.

The key thing also – this is very much a pharmacy structural element that has expired – if we look at market research for physicians and their enthusiasm to recommend *Shingrix* either strongly or extremely strongly, if you are looking at 65-plus, it is 88%, so that is the same as last year; 60-64 is 80%, so again, the same as last year; 50-59 is around 50%. That is all where it was.

If we look at patient engagement, that is also holding overall, but that leaves the third factor, and this is something I have mentioned on previous calls. As we penetrate this population, and if you look at the rate that we have penetrated with *Shingrix*, it is double the rate of PCV. We have got there at seven years, when it took PCV vaccines to get there in 14.

But, as I said before, the most motivated people obviously sought out the vaccine and we have been able to penetrate those populations to a very high degree. In our No. 1 segment, we are around 66% penetration, so we have to work harder to get less engaged people, less motivated people. There is a huge plan to do that and so we will be looking at patients who are resident in other specialties, we are looking at co-ad, we are looking at comorbid, ways that we can stop leakage, and some account management work that we are doing as well. We are just really changing our marketing mix to focus on segments who are tougher to activate. That is the plan.

If you put all of this together, basically we will expect some growth in half-two but, again, we are at this evolution of really looking outside of the US, to Europe, Japan, Australia and China for our growth. Then ultimately, once we have moved through those cohorts, we will get to emerging markets, as we have covered on previous calls. Long story short, we can navigate this and we remain confident that we can hit our £4 billion target with *Shingrix* in 2026.

That was a long answer but, hopefully, that is helpful to everyone.

Emma Walmsley: Great – thank you so much, Luke. I really want to reiterate that confidence in the broader Vaccines portfolio and the maintenance of our '26 CAGRs and excitement for the pipeline ahead, but we see the growth coming ex-US on *Shingrix* but the decline in the US to moderate. I would just point out, per Luke's presentation, that in the US we absorbed that 36% decline on *Shingrix* and delivered – whilst digesting that – 17% growth in our largest country in the world. Tony and TIGIT?

Tony Wood: Thanks for the question, Peter. Your 'quick' question might get a slightly longer answer, if you will forgive me. Just to remind you, we have said that our focus in Oncology is very much on haematological and gynaecological cancers, and we have said that we will invest outside of that in a gated way when we see data that suggests transformational opportunities. With that in mind in TIGIT, what are we seeing, what are we doing about it and why do we think it is happening?

What have we seen in our GALAXIES 201 platform study, this is with 120 patients, so a larger patient population than the initial data from the CITYSCAPE evaluation of similar mechanisms, what we see is similar overall response rates but a speed and quality of response that it is differentiated from those observed previously. You will hear more about that when we present on these preliminary data at the end of the year, so I will pause on that at this point.

What we are doing with that data now is moving into the GALAXIES 301 Phase III study. An important thing to bear in mind about the characteristics of that study is first of all that it is in combination with *Jemperli,* and we are learning there from what we have seen in the PERLA lung study. It is also in a carefully biomarker-selected population and it is with EOS-448, or belorestotug for those of you who haven't connected the two together. What we expect to see is as a consequence of the differential profile for EOS-448, it is an IgG-1 antibody, which means it has a functional FC region, the constant region of the antibody. That means it engages macrophages, dendritic cells and natural killer cells in the tumour micro-environment, augmenting immunity. It also induces something called ADCC, which is antibody-dependent cellular cytotoxicity and results in the killing of T-regulatory cells which are immunosuppressive in a tumour environment. We've seen that latter feature of depletion both pre-clinically and clinically. So in short, differentiated data, moving forward in a gated Phase III study and designed on what we have learned from PERLA with a molecule we think has differential characteristics.

Emma Walmsley: So more to see at the end of year and a strong focus on basing those decisions, thanks Tony.

Peter Welford (Jefferies): Sorry I want to come back to the vaccine, could we just come back to *Arexvy* for a minute and just understand Luke, particularly on the contracting, I understand that you are very confident with the market which contributed to the share of the retail but two things, firstly can you just talk about the appetite and what you have heard from contracting discussions. Maybe you can talk about the extent of vaccination we have seen in that 75-plus cohort and perhaps the motivation you see in that group, so a greater incentive year-on-year perhaps for those to come in, versus on the other hand, the lower age where there was a less of a strong recommendation. And equally then if you could just a little bit about then the non-retail segment, what you are seeing there. Do you see any change to that segment going into the second half of this year, or do you still anticipate that to be a relatively minor part for RSV, given the recommendation that we've seen for 75-plus year olds.

Emma Walmsley: Thanks Peter, so Luke?

Luke Miels: Peter, maybe what I'll do is I'll just talk you through it. The key thing is we are confident with *Arexvy* in terms of the long-term ambition at £3 billion and you're right, the June ACIP was positive for 75-plus and if you look at our immunisation rate in 2023, of that population, our numbers are about 26 million. Under shared clinical decision making we achieved an immunisation rate of around 18% overall, all products.

If you look at the 60-74 with ACIP, there's no way you can escape that is a negative for the class, we have to be realistic there, but there is some silver lining to the cloud when we break that population down. If you look at 60-74 under shared clinical decision making in '23, the immunisation rate was around 13%. Now the hard part right now of course is we don't know where CDC is going to set the boundaries in terms of what's high risk and complications and is it diabetes or is it advanced diabetes? So it's a bit difficult, but along the lines of what you were talking about, if we just look at people with other complications in that 60-74 group, it's a similar number, it's about 26 million. If you look at that immunisation rate that was under shared clinical decision making for the 60-74 population, last year it was about 16%. If you look then a little bit more tightly at the 65-74 at increased risk, it was actually higher, it was 19.5%, so I assume that's because you are a bit more mobile, easy to reach in the pharmacy versus care homes etc. Clearly in that population there is engagement and it will just depend on how CDC sets the rules.

In contrast, if you look at healthy people, the penetration rates were much lower, so it was around 11% in the 60-74 population and around 15% in the 65-74, if you slice it more narrowly. So I think there's going to be more momentum for 75 but you've taken a big chuck of people out in the 60-74. What we don't know is the reaction of physicians with ACIPs changes, whether they are going to withhold a recommendation in some populations ,so it's difficult to project. Obviously Q3 is going to be key and our intention is to maximise *Arexvy* there. We've been very, very deliberate with this product, it has been positioned from day one for high-risk individuals. Then when you look at PCP preference and patient preference it's clearly the leader in the minds of physicians and patients that are aware of it and that makes sense right. Our data is the strongest as I said before, it's the one you'd give your mum. Feel free to add Tony – our plan is to go back to ACIP with the 50-59 data, with the updated benefit/risk safety data and GBS and also when we have the full package - the three-year data.

Tony Wood: Let me pick up on one point of that because I suspect we will deal with more questions around ACIP. Just to underscore Luke's point, in the populations that he detailed, we have a very strong dataset, for example in the 70-79 year olds, there was 94% vaccine efficacy in the first season, and 75% across two seasons. You see that also with A versus B coverage, so we are confident in the strength of our data and our continuing ability to add to that dataset as we accrue more and, as I said, I am sure we shall get more questions around it.

Emma Walmsley: Is there anything you want to add on the retail channel?

Luke Miels: Historically, it is around 85% and we don't see that as changing. When you look at market research, and we have obviously looked at this a lot, when we saw this change in *Shingrix* with the IRA removal of the copay, and when you look at patients' reasons for going to the pharmacy, from memory it's like 58% of them cite that the process is easier, the physician prefers to do that, there is greater certainty around coverage and out-of-pocket costs. So, we think that structure will remain the same. As Tony said, we will be back in with the 50-59

but I think ACIP will be very conservative about broader coverage until they have got complete clarity in terms of benefit/risk, and I think that is important in the non-retail segment.

Tony Wood: It is probably worthwhile underscoring the 50-59 that we see no change in the benefit/risk proposition for the vaccine relative to season one in that population or, indeed, in the broader group.

James Gordon (JP Morgan): I will stick with the Vaccines theme! My first question is: the Vaccines guide for 2024, so you lowered it quite significantly today, I think about £700 million is the difference. How much of the downgrade is *Arexvy* being lower versus *Shingrix*? Am I working it out right that it looks like the guidance roughly has *Arexvy* being about flat for only the second year in the market or even slightly down, or have I miscalculated that?

The other question is on *Arexvy* and revaccination. We saw the two-year revaccination interval antibody titre data at ACIP. The ACIP panellist was a bit cautious on the data and I think I have heard a comment now that you will share some more data in the coming months, so is that the 004 clinical trial and showing the waning of protection? Are we in the next couple of months going to have all the data that relates to whether you can get this two-year revaccination interval and what is your confidence in getting that now we have seen some more data?

Emma Walmsley: Thanks, James. I will come to Julie first to give you the building blocks of the guidance for the year, remembering that we are annualising against the launch. Then Tony will come to you on data and re-vax.

Julie Brown: Thanks Emma. In terms of the overall position with the second half, you will probably recall the very strong Vaccine performance that we had in half two, and the change in the guidance overall to low to mid-single digits is primarily relating to RSV for the reasons Luke mentioned, relating to the age groups and the ACIP decision-making.

As Emma mentioned also, the stocking impact last year was fairly significant. You will probably recall that in Q3 we mentioned we got two thirds of the sales we were stocking going into the channel, together with about 20% towards the end of last year, so there is a very significant first half/second half impact with Vaccines. You will probably recall our growth rates of Vaccines last year were 33% and 34% in Q3 and Q4, so this is the headwind that we face now going into this period.

Luke summarised it very well, just in terms of the exact guidelines in terms of what they actually mean in terms of people at risk of RSV: whether it is a normal diabetic or whether it is one with complications will make a big difference to this second half performance.

Emma Walmsley: Thanks, Julie, and just to reiterate, that RSV update is purely related to ACIP, nothing competitive, and, as Luke said earlier, we are looking forward to being back to great growth in 2025 and are confident in the long-term prospects of this vaccine. Tony, do you want to talk about the data to come on revax?

Tony Wood: James, just quickly, 004 is the immuno study but I want to describe this in the context of the entire dataset, since that is really the important aspect with regard to revaccination. We have said we have 006 which is a vaccine efficacy study, 004 is the immunogenicity study and other studies looking at immunogenicity which

we started, for example, in the immuno-compromised population. A decision on revaccination will depend on the trends in vaccine efficacy and the ability to boost, but that in itself depends on how the various aspects of the immunological profile wane over time.

I think we talked about this at the last call, with regard to our expectations on duration and, at this stage, I would say rather than making guesses – given that we are only a few months away from the whole data package that we will be presenting at ACIP, we wait for that. One thing to stress within that, though, is that what we are learning from ACIP is a greater focus on benefit/risk and therefore the importance, for example, offered by a longer duration vaccine, both with regard to greater value and benefit/risk.

Richard Parkes (BNP Paribas): I have one question on Vaccines, and one on GenMed. On GenMed, obviously the performance has been strong and I know that is partly driven by strong *Trelegy* demand but also better navigation of the AMP Cap removal. Could you just talk about how much of that performance is sustainable into 2025, versus turning to a headwind – and I am thinking here about things like stocking for authorised generics and so on, just thinking about GenMed performance into 2025.

Then secondly, just to push on *Arexvy* a little more, could you help us understand how much true visibility you have on likely second-half demand based on the contracting? I am just trying to compare it to perhaps the flu vaccine market, where generally it feels like people have good visibility there. Obviously, with the ACIP panel recommendation happening only recently, it might take some time for retailers to digest that and predict demand – and obviously that could work both ways, either with additional orders for you and upside or downside through returns. Could you just talk about your visibility and where the risks lie, either to the upside or downside for *Arexvy*, and your guidance.

Emma Walmsley: Those are two more questions for Luke, although we will guide on '25 in '25 and there is no change to our mid-term CAGRs. With GenMed, it is obviously a great performance there. Would you like to talk on that, Luke?

Luke Miels: Yes, thanks Richard. I think a lot of it is really one-off effects of authorised generics. And I am pleased to say that we were more successful than we were expecting in terms of being able to capture those patients as they came off *Advair* and *Flovent*. With *Lamictal,* we just took a price hit and that was very sizeable: we did that because we did not want to disrupt those patients. The underlying growth is lower and it is very much along the language we used in the past for General Medicines over the longer term.

Trelegy itself continues to grow very strongly but, of course, it did that outside the US as well. Japan was up 29%, China 26%, and the EU was up 15%, so this was an excellent medicine and it is one that we will continue to back. We had 10 recent presentations/publications, so there is a lot of momentum there, but yes, we will start to lap those components we're shifting and the movement with authorised generics in the second half of this year and 2025 I won't comment on.

In terms of clarity, the key difference structurally is with flu, we do a lot of pre-booking, because there is a manufacturing cycle and it is a new product every year. It is definitely softer this year if we look at flu volumes: they were higher than normal in the first half in the US but southern hemisphere was weak. It is not a really good

surrogate with *Arexvy*, where we don't have guaranteed volumes. We have guaranteed percentage splits, which I will not go into, and that is why I am quite happy about where we have landed.

The other factor is pricing. We have these contracts with good prices and that was very, very important to us when we take a long-term view on what is an excellent asset.

Graham Parry (Bank of America): Thank you for taking my questions – and I am sorry this is more on Vaccines. You said about having US market leadership in the second half on volumes, and you have said you have a good idea of splits. Could you help us understand – I think up to this point you have been two-thirds of the volume. For this season, Pfizer started contracting a bit earlier and obviously you have had Moderna enter the market. Is two-thirds what you have been aiming for, or should we just be thinking about you having the majority of the market even? Or is it less than that?

Secondly, on your peak sales of £3 billion and return to growth in 2025, does that assume that you are going to have some sort of booster regimen in there? Or can you get there by just rolling out globally?

If you could help us understand on the boosters, with the season three vaccine efficacy data for a single dose, you are expecting in the second half, I think your modelling data on the all-comers population has suggested that the single administration could drop to around 40% in season three, which would certainly warrant a booster, but in the populations you are now recommended for the over 75s and the comorbid, it looks like those are much higher, they are in the 70s across season one and two. Do you have any sort of predictive modelling data of where vaccine efficacy on those target populations might drop to that would perhaps allow for a booster to be recommended? Thanks.

Emma Walmsley: Luke and then we'll come to Tony on booster.

Luke Miels: Graham, I won't give you a percentage but it's market leadership. I think what is not visible to us yet is how much Moderna picked up relative to Pfizer, but we know how much we've picked up and that's why we're using the term, 'leadership'. I think the other thing of course one thing is volume but it has to be modelled by price and that's something that will be more visible in time to the aggregate revenue.

In our forecast we assume that our booster is required. Tony I will hand over to you for the rest of that.

Tony Wood: Yes, Graham I would say at this stage that really it is a natural waiting and seeing, otherwise I am drawing straight lines between two points to get an estimate of where season three is, bearing in mind that the dynamics in season one and season two were very different. As I mentioned earlier in answering Graham's question, I think it's not just a combination of vaccine efficacy but also the boost response, so we'll know more about that when we get ready for ACIP in October.

Tim Anderson (Wolfe Research): Thank you, a non-vaccine question which is Zantac, for investors downstream with the Delaware ruling. I know Glaxo will say it will continue to defend itself. It will cite lots of studies in your paper but in the theoretical event Glaxo were to enter into a broad settlement to try to put all this behind the company, what's realistically the earliest this could happen? Is it safe to assume that would not be possible until 2025, possibly well into 2025. Thank you.

Emma Walmsley: Thanks Tim and we do absolutely recognise the impact this litigation has had on shareholders. And you're right, I am going to start by reiterating the facts and the science here, which is total scientific consensus that there is absolutely no consistent or reliable evidence that ranitidine increases the risk of any cancer. And so we are going to continue to vigorously defend ourselves against all of the claims and manage the litigation in the best interests of the company and of shareholders.

That has been our focus all the way along and we are confident that we have done so in the process. That means no change to our growth agenda, no change to our guidance, no change to our investment plans. Our position is based on science and facts, and our focus is to address this in the interests of shareholders and the company. As I am sure you know, there is obviously a limit to what I can say around this litigation since we need to respect the judicial process and protect the interests of the company.

Mark Purcell (Morgan Stanley): Thank you very much. Just a few questions, firstly on China and vaccines. Are you seeing much in the way of emerging domestic competition and BCHT has a shingles vaccine for example, and in that respect what's the appetite from Zhifei to extend the agreement to *Arexvy*? Quick one on *Arexvy* and boosters, it's been suggested that revaccination only achieves 45-65% of peak neutralisation, tied to this due to immune interference, from the T4-foldon trimerization tag which is used by *Arexvy* and Abrysvo as well, so I just wondered if it's a factor and whether we have seen this before? And the last one in terms of *Nucala* ahead of the COPD MATINEE data, late Q3/Q4. I think Tony you've described the efficacy as likely to be in the low 20s in terms of reducing exacerbations. Sanofi see COPD as a £5 billion peak potential across its two assets, so I just wondered if you can help us understand how the large the opportunity is that you see for your IL5-focused medicines? Thank you.

Emma Walmsley: We will come to Luke quickly on China. I would point out that it is quite hard for someone to come up against *Shingrix* with an effective vaccine when we have one with 80% efficacy for 11 years. Then we will come to Tony on both the booster question and *Nucala* and the broader opportunities in COPD in the pipeline. Luke first.

Luke Miels: Thanks, Mark. There is a local competitor to *Shingrix*, it is with a company called Ganwei. It is a live attenuated vaccine, so it is Zostavax-like. Its licence is 40-plus but they get around a quarter of the volume at this point. But, again, these are very different patients to the ones we are targeting. We are targeting a high out-of-pocket-tolerant, willingness-to-pay population which is different. In terms of Zhifei and our relationship there, as I said earlier, it is excellent, it is a strategic long-term relationship. We have had some initial discussions around RSV and we would very much like to expand the collaboration to include RSV, so just watch this space.

Tony Wood: Thanks Mark. Quickly on the T4 construct, this is obviously something we spotted and were eager to understand as well. The short answer to that, although we haven't disclosed the data, is there is no evidence of interference. A much more likely and common explanation for the boost is the relative waning in the vaccine efficacy in the first instance and it is generally understood that the greater the waning of efficacy, the greater the boost. You will see more on the T4-folden question when we disclose those data.

In terms of COPD and IL5 and depe, let's start by putting your comment with regard to dupilumab versus *Nucala* into context. I have mentioned this in the past and I appreciate there are a lot of comparative numbers floating

around but what is important is that, based on the patient population that we have targeted in our Phase III study in MATINEE, which is a broader population including emphysemic patients. These represent about 30% of the COPD population, so a significant proportion of approximately 300 million individuals with COPD. That population is more difficult to treat even in the high eosinophilic setting and, because of the different patient mix and based on what we have seen in the past, that is where my prediction for low to mid-20s per cent for MATINEE comes from. It is not a reflection of relative efficacies of the two molecules. What both classes are showing is that there is a significant response to those with COPD and high eo counts and, in this instance, in particular over 300 counts. We are very well-placed in the COPD arena in evaluation of not just of IL5 but other mechanisms.

First of all, we are looking forward to progressing on depe with once every six months dosing. That is a significant advantage in COPD, even greater than it is in severe asthma. In addition to that, TSLP offers a broader opportunity in the recent data from Amgen in COPD with their TSLP agent, albeit with a much more frequent dosing regimen, of course, for teze which suggests that we should also have opportunities there. I will pause there but there are additional aspects of our COPD portfolio that I look forward to telling you about in the future.

Emily Field (Barclays): I will just ask two quick ones, one on ex-US *Arexvy*. One of the things that Pfizer talked about yesterday in terms of their ex-US contract wins was a desire to simplify the contracting between having one option for maternal and older adults. I know this year will mostly be US-driven for *Arexvy* but is that something you see as an obstacle to ex-US *Arexvy*? Then on the HIV guidance, you're in the third year in a row of expecting double-digit growth in HIV, you have your CAGR target of 6-8% still intact. Are there any reasons to expect a slowdown in the next couple of years in HIV, or why not upgrade that guidance? Thank you.

Emma Walmsley: Let's go to Deborah first on HIV and then we will come back to get any further comments on *Arexvy* from Luke.

Deborah Waterhouse: Thanks for the question, Emily. In Q1, and we reiterated on Friday when we did our update post the AIDS conference, we are tracking towards the top of our guidance. As you say, we have had three years of double-digit growth. Next year, we have the headwind of the IRA and we have stated very clearly that that will be around a £200 million impact and then, obviously, we set out very clearly in 2026 what we think the shape and size of our portfolio will be. We should be reaching £7 billion, if not slightly above, which is what we have shared with you all, in 2026. By 2027, we are obviously moving into a world where we have 40% of our portfolio value in long-acting.

At the moment, everything that we have said about 2021-26 holds firm. We are at the top end of that CAGR and then, as we move into 2027, we remain extremely confident that the long-acting medicines in our portfolio will be 40% of our total revenue, if not more. Obviously, we are having a very successful period with those medicines at the moment. So there is no change in our guidance but I think you are feeling our increased confidence because of the feedback we are getting from physicians and patients as to the impact that our long-acting medicines are having, and the growing momentum for those medicines.

Emma Walmsley: It is great to see the progress in the pipeline that quite a lot of you have been announcing just last week. Luke?

Luke Miels: Thanks, Emily. The short answer is no. Typically, the way the contracts and NIPs are constructed is that they separate out paediatric populations from adult populations and really what counts – and it is different to ACIP of course – in that the systems are willing to concentrate on single vaccines and separate them out more vigorously, versus pushing them together. Our approach is to really - we have an excellent asset here in *Arexvy* and what we want to see is the full profile, as Tony mentioned. We want to see what this product looks like at three years because that will have a huge impact on pricing, durability et cetera, which are all the things - particularly in European contracts - that payors concentrate on. We are happy to let people bid against themselves: we want to sit and wait and see what the true picture of the product is, and then build the business based on that. As I said before, the numbers are looking very good for *Arexvy* and, once we have that, we will then move ahead and execute.

Emma Walmsley: Thanks, Luke.

Simon Baker (Redburn Atlantic): Thank you very much – I will limit myself to one question. This is on *Arexvy* and it is a question for Tony. In terms of the potential mechanism for lower incidence of dementia, I wondered what thoughts you have had on that. There has been some suggestion that it is an indirect effect caused by the vaccine suppressing reactivation of HSV-1 virus. Any thoughts you have on why we are seeing this effect would be much appreciated. Thank you.

Tony Wood: Simon, I presume you meant *Shingrix* in that, rather than *Arexvy* – that is another story. It is fair to say that there is very little known here, mechanistically, and we are investing in further retrospective studies and mechanistic ones.

Let me try to do this quickly. There is some potential that the mechanism may be vascular in nature. It may even be due to, as you say, underlying – let's call it subclinical reactivation. The science is better known, although not by any means comprehensive, for HSV underlying reactivation and therefore inflammation that occurs as a result of that, leading to dementia. One can imagine a similar story in the context of shingles or one could even imagine the constant reactivation impacts microglial function. There is a range – and I haven't been comprehensive in my answer, to avoid spending too much time on it. It is fair to say that there is a range of different mechanisms. If you want a comprehensive summary, the Australian paper detailing the epidemiological retrospective outcomes has a really nice summary in its concluding paragraph.

Emma Walmsley: Thank you. It is exciting science to explore although it is still in its early stages. In the meantime, this is a very effective vaccine with still a lot of opportunities to penetrate around the world.

With that, Nick, as our last question, thank you to everyone. We are really pleased with our Q2 performance and another upgrade to our outlooks. Even more, we are looking forward to the ongoing progress in our pipeline and delivering on our short, medium and long-term ambitions.

Thank you to everyone for joining us for the call and we look forward to following up with you in the coming days.

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