Q4 2016 Earnings Call

Company Participants

- Albert Bourla, President-Pfizer Innovative Health
- Charles E. Triano, Senior Vice President, Investor Relations
- Frank A. D'Amelio, Chief Financial Officer & Executive Vice President-Business Operations
- Ian C. Read, Chairman & Chief Executive Officer
- John Young, Group President, Pfizer Essential Health
- Mikael Dolsten, President-Worldwide Research & Development

Other Participants

- Alex Arfaei, Analyst
- Andrew S. Baum, Analyst
- Christopher Schott, Analyst
- David R. Risinger, Analyst
- Geoffrey C. Meacham, Analyst
- Gregg Gilbert, Analyst
- Jami Rubin, Analyst
- John T. Boris, Analyst
- Marc Goodman, Analyst
- Mark J. Schoenebaum, Senior Managing Director, Head of Healthcare, Biotech & Pharma Analyst
- Richard J. Purkiss, Analyst
- Seamus Fernandez, Analyst
- Steve Scala, Analyst
- Timothy Minton Anderson, Analyst
- Tony Butler, Analyst
- Vamil K. Divan, Analyst

MANAGEMENT DISCUSSION SECTION

Operator

Good day, everyone, and welcome to Pfizer's Fourth Quarter 2016 Earnings Conference Call. Today's call is being recorded. At this time, I would like to turn the call over to Mr. Chuck Triano, Senior Vice President of Investor Relations. Please go ahead, sir.

Charles E. Triano {BIO 3844941 <GO>}

Good morning. And thank you for joining us today to review Pfizer's fourth quarter and full-year 2016 performance, as well as our 2017 guidance. I'm joined today by our Chairman and CEO, Ian Read; Frank D'Amelio, our CFO; Mikael Dolsten, President of Worldwide Research and Development; Albert Bourla, Group President of Pfizer Innovative Health; John Young, Group President of Pfizer Essential Health; and Doug Lankler, General Counsel.

The slides that will be presented on this call can be viewed at our home page, Pfizer.com, by clicking on the link for Pfizer Quarterly Corporate Performance – Fourth Quarter 2016, which is located in the For Investors section in the lower right-hand corner of this page.

Before we start, I'd like to remind you that our discussion during this conference call will include forward-looking statements that are subject to risks and uncertainty that could cause actual results to differ materially from those projected in the forward-looking statements. Additional information regarding these factors is discussed under the disclosure notice section in the earnings press release we issued this morning, as well as in Pfizer's 2015 Annual Report on Form 10-K, including Item 1A, Risk Factors, that is filed with the Securities and Exchange Commission and available at SEC.gov and on our website at Pfizer.com. The forward-looking statements during this conference call speak only as of the original date of this call, and we undertake no obligation to update or revise any of these statements.

Discussions during the call will also include certain financial measures that are not reported in accordance with U.S. generally accepted accounting principles. Reconciliation of those non-GAAP financial measures to the most directly comparable GAAP financial measures can be found in Pfizer's current report on Form 8-K dated today, January 31, 2017. You may obtain a copy of the Form 8-K at our website, Pfizer.com/Investors. Any non-GAAP measures presented are not and should not be viewed as substitutes for financial measures required by U.S. GAAP. They have no standardized meaning prescribed by U.S. GAAP and may not be comparable to the calculations of similar measures at other companies.

We'll now make prepared remarks, and then we'll move to a question and answer session. With that, I'll now turn the call over to Ian Read. Ian?

Ian C. Read {BIO 3358997 <GO>}

Thank you, Chuck, and thank you for joining our call this morning. During my remarks, I will make a few comments about the year and where we see the opportunities for continued growth in 2017. Frank will provide details regarding the quarter and our 2017 financial guidance.

2016 was marked by solid execution, which led to another year of operational revenue growth, both in terms of our overall portfolio, which showed an increase of 11% for the year, and on a Pfizer standalone basis excluding legacy Hospira and Medivation, where the annual growth was 5%. We saw robust revenue growth from both new and mature brands.

Pfizer Essential Health established market-leading positions in sterile injectables and biosimilars. Our sterile injectables portfolio achieved over $6 billion in revenue during the year, and in our biosimilars business we launched Inflectra, the first biosimilar monoclonal antibody available in the U.S. Globally, we had three marketed biosimilars and are the leader in total sales, as well as having a robust pipeline of biosimilar assets. We look to the sterile injectables and biosimilar portfolios to continue to generate growth for the Essential Health business and also expect continued growth of the Essential Health portfolio in emerging markets, which achieved 7% operational growth in 2016.

For Pfizer Innovative Health, Eliquis achieved 88% operational growth for the year and is the number one prescribed new oral anticoagulant by cardiologists in 12 markets around the globe. Xeljanz grew 78% operationally and is now nearly a $1 billion brand on an annual revenue basis. Chantix grew 27% operationally. In December, the FDA approved updates to Chantix's labeling, including the removal of the boxed warning regarding serious neuropsychiatric events based on the outcomes of the EAGLES study. Lyrica grew 14% operationally, and our consumer healthcare business achieved another year of solid performance with 5% operational growth. Ibrance remains a significant growth driver. Its revenue almost tripled year over year and grew 17% globally on a sequential quarterly basis, reflecting its attractive clinical profile and continued acceptance by physicians, payers, and patients. Ibrance received EU approval in November and will begin to launch across Europe during the year, resulting in incremental revenues, primarily in the second half of the year. We feel very confident about our leadership in the CDK 4/6 inhibitor class.

Our business development activities during 2016 have provided us with attractive revenue growth opportunities within both of our businesses. With the acquisitions of Medivation and Anacor to our Innovative business, we have added Xtandi for metastatic castration-resistant prostate cancer and Eucrisa for the topical treatment of mild to moderate atopic dermatitis in adults and children as young as 2 years of age. And the addition of AstraZeneca's small molecule anti-infective business to Essential Health has strengthened our anti-infectives portfolio, which is the industry's largest, with more than 60 products.

Each of these acquisitions strategically aligns with our approach to business development, which is to look for opportunities that contribute immediate and/or near-term revenue growth. As we look at the total company operational revenue growth profile, we see our current in-market products, including our recently acquired products, as having the ability to deliver an enhanced revenue growth rate over time and more than offsetting continued headwinds from product losses of exclusivity.

In 2017, on an operational basis, the midpoint of our revenue guidance reflects 4% revenue growth, excluding the Hospira Infusion Systems business, which we expect to divest next month. Improved revenue growth is an important driver of valuation and requires continued solid executions in addition to the ongoing advancement of our key pipeline assets. In 2016, we received five product approvals, achieved six regulatory submissions, and advanced 39 compounds in our pipeline. Our current pipeline contains 96 clinical programs – half biologics, half small molecules – and about two-thirds new molecular entities, and is well-positioned. And in 2017, we're expecting pivotal top line study results in oncology and biosimilars.

A few pipeline highlights include: In oncology, we a very robust life-cycle program for Ibrance. It is being studied in an additional four pivotal studies in early, advanced, or recurrent breast cancer. In addition, Ibrance is being studied in several non-breast cancer indications, including two sponsored trials in pancreatic and head and neck cancers. Xtandi has provided us with a novel treatment in metastatic prostate cancer. We see a potential opportunity to extend the type of androgen receptor blocker in Xtandi into other indications and to seek regulatory approval in non-metastatic prostate cancer.

In immuno-oncology, we're making significant progress in building a strong I-O portfolio and see avelumab as a core asset. Through our partner, Merck KGaA, in the U.S. the avelumab submission for treatment of metastatic Merkel cell carcinoma was accepted by the FDA with priority review. And we also have announced that the European Medicines Agency validated for review the marketing authorization application in the EU. We have 11 compounds in the clinic, including anti-PD-1 MAb, a T-cell retargeting P-cadherin T-DART (9:32), a small molecule IDO1 inhibitor, and the allogeneic UCART19 T-cell therapy for pediatric and adult acute lymphomic leukemia. Our avelumab program with Merck KGaA now has 30 programs ongoing, 10 of which are potentially registration enabling. And over 4,000 patients have now been enrolled in ongoing avelumab studies.

The breadth of our I-O portfolio allows us to differentiate with combinations, which is core to our strategy. For example, we are starting to deliver data with avelumab and 4-1BB. We plan to initiate by the end of the first quarter a triplet with avelumab, 4-1BB, and OX40. And we'll have studies with avelumab combined with rituximab and 4-1BB. We also have studies with avelumab with lorlatinib, our next-generation ALK inhibitor, and avelumab with Inlyta.

In biosimilars, we recently announced positive top line results for both infliximab, a potential biosimilar to Remicade, and trastuzumab, a potential biosimilar for Herceptin. And this month we announced positive top line results from the comparator REFLECTIONS study for adalimumab, a potential biosimilar to Humira. This marked the third potential biosimilar molecule from our pipeline to report positive top line data results during the past four months. This year, we expect readouts in bavituximab and filgrastim, and we have a total of 14 biosimilar molecules in various stages of development.

In inflammation and immunology, we have one of the strongest JAK franchises in the industry and have advanced four immunokinases, including three selective JAK and one IRAK4 inhibitor to clinical two studies. Our Phase 2 trials cover 10 different indications, from rheumatoid arthritis to gastrointestinal to dermatology.

And in vaccines we have a robust portfolio that continues to progress. We achieved proof of concept of our C. difficile vaccine and expect to enter Phase 3 in the coming months. Our staph aureus vaccine is currently in Phase 2, and we now have a novel pneumococcal vaccine in the clinic in Phase 1 that could potentially cover up to 20 serotypes.

Of note, during 2017 we anticipate potential U.S. decisions for our avelumab Merkel cell carcinoma, potential lorlatinib submission for non-small cell lung cancer, potential EU

decision for Xeljanz in RA, potential U.S. filing in the first half of 2017 for additional indications for Xeljanz in ulcerative colitis and geriatric arthritis.

As we look at the year ahead, Pfizer's well-positioned with our in-market portfolio and our pipeline assets. I also see our company's structure, with its two distinct businesses, as affording us the focus and sense of urgency to deliver enhanced revenue growth over time. For 2017, we look forward to working with a new administration and across the healthcare system. Our efforts will continue to be focused on developing, delivering, and providing access to innovative therapies that address areas of unmet medical need and that advance patient care. Pfizer has long held a contract with society through our business practices and culture to ensure that patients get the medicines they need.

In summary, in 2016, we created significant value for our shareholders through several initiatives, including acquisitions and partnerships that bolstered each of our businesses, share repurchases, and an increase to the dividend. We enter 2017 with strong financial position, products that are leaders in their categories, strong and emerging mid- and late-stage pipeline, and an operational structure that gives us the flexibility to differentiate our business in ways that will continue to create shareholder value.

Now I turn it over to Frank to provide more detail on the quarter.

Frank A. D'Amelio

Thanks, Ian. Good day, everyone. As always, the charts I am reviewing today are included in our webcast.

As a reminder, because we completed the acquisition of Hospira on September 3, 2015, Pfizer's financial results for the full year 2016 reflect legacy Hospira global operations for the entire period, while full year 2015 includes only four months of legacy Hospira U.S. operations and three months of legacy Hospira international operations. Our financial results for the fourth quarter 2016 and fourth quarter 2015 include legacy full Hospira global operations for both periods. In addition, Pfizer completed the acquisition of Anacor Pharmaceuticals on June 24, 2016. Consequently, our financial results for the fourth quarter and full year 2016 include three months and approximately six months of legacy Anacor operations, respectively, which were immaterial. Finally, Pfizer completed its acquisition of Medivation on September 28, 2016, so financial results for the fourth quarter and full year 2016 include three months of legacy Medivation operations.

Now moving on to the financials. Fourth quarter 2016 revenues were approximately $13.6 billion and reflect a year-over-year operational decline of $191 million or 1%. It's important to note that fourth quarter revenues were negatively impacted by four fewer selling days in the U.S. and three fewer international selling days versus the prior-year quarter, which unfavorably affected revenues by approximately $750 million. If you'll recall, in the first quarter of 2016 I pointed out that there were nine more selling days versus the prior-year quarter and that this imbalance would be primarily offset in the fourth quarter 2016, which would have seven fewer selling days. It's important to note that there are essentially the

same number of selling days in full year 2016 as in full year 2015, so they impacted the quarterly year-over-year comparisons, notably the first and fourth quarters.

Fourth quarter 2016 revenues were also unfavorably impacted by foreign exchange of $228 million or 2%. Our Innovative Health business recorded 2% operational revenue growth in the fourth quarter, driven by the strong performance of Ibrance in the U.S., Eliquis globally, Xtandi in the U.S. with the Medivation acquisition in September, and in Xeljanz and Lyrica, both in the U.S., all of which were partially offset by a 23% operational decrease in global Prevnar 13 revenues. In the U.S., Prevnar 13 declined 33% due to a decrease in revenues for the adult indication after the high initial capture rate of the eligible population following its successful fourth quarter of 2014 launch, which resulted in a smaller remaining catch-up opportunity compared to the prior-year quarter and the unfavorable impact from the timing of government purchases to the pediatric indication.

We continue to believe that Prevnar 13, both pediatric and adult indications, will remain very significant products for Pfizer, notwithstanding this decrease in the fourth quarter 2016 and the expectation that full year 2017 global Prevnar 13 revenues will remain flat to slightly down. We do expect Prevnar adult launches in international markets, as well as the potential for increased utilization in the 18 to 64 population to temper. We expect a decline in sales in the U.S.

Fourth quarter Innovative Health revenues were also negatively impacted by lower revenues for Enbrel in most developed Europe markets, primarily due to continued biosimilar competition and the loss of Rebif alliance revenue versus the year-ago quarter due to the expiration at year-end 2015 of the agreement to co-promote Rebif in the U.S.

Revenues for our Essential Health business decreased 6% operationally, driven by a 20% operational decline from Peri-LOE products and a 3% operational decline from legacy established products, which were partially offset by operational growth of 3% from the sterile injectable pharmaceuticals portfolio and 48% in biosimilars. Revenues from legacy Hospira products declined 1% operationally; however, excluding the performance of Hospira Infusion Systems, these revenues actually increased 2% operationally.

In emerging markets, Pfizer's overall Essential Health revenues grew 4% operationally, due primarily to 3% growth in the legacy established products portfolio and 9% growth in the sterile injectables portfolio.

Fourth quarter reported EPS was $0.13, compared with the loss of $0.03 in the year-ago quarter, primarily due to the non-recurrence of foreign exchange losses related to Venezuela, a Protonix-related legal matter, and pension settlements in the prior-year quarter, and a lower effective tax rate in Q4 of 2016 compared with Q4 of 2015. These were partially offset by fewer selling days, foreign exchange impacts, higher restructuring costs, and losses related to the early redemption of debt and the pending sale of Hospira Infusion Systems.

Adjusted diluted EPS for the fourth quarter was $0.47 versus $0.53 in the year-ago quarter. The decrease was primarily due to fewer selling days, the unfavorable impact of

foreign exchange, continuing product losses of exclusivity, and a higher effective tax rate, all of which were partially offset by revenue growth due to certain new inline and acquired products and fewer diluted weighted average shares outstanding, which declined by 105 million shares versus the year-ago quarter due to our share repurchase program.

As I previously mentioned, foreign exchange negatively impacted fourth quarter 2016 revenues by approximately $228 million or 2% and negatively impacted adjusted cost of sales, adjusted SI&A expenses, and adjusted R&D expenses in the aggregate by $50 million or 1%. As a result, foreign exchange negatively impacted fourth quarter adjusted diluted EPS by approximately $0.04 compared with the year-ago quarter, with approximately $0.03 related to Venezuela. On a full-year basis, foreign exchange had a $0.21 negative impact on adjusted diluted EPS, with approximately $0.10 attributable to Venezuela.

As you can see, we achieved or exceeded all elements of our 2016 financial guidance ranges. It's important to note that every major currency except the yen weakened against the U.S. dollar in 2016, which negatively impacted our full year 2016 revenues by approximately $1.5 billion, of which $778 million was attributable to the devaluation of the Venezuelan bolivar.

In full year 2016, we generated 11% operational revenue growth, and excluding legacy Hospira and legacy Medivation operations, Pfizer's standalone revenues grew 5% operationally. I also want to point out that 2016 adjusted SI&A expenses were at the top end of our guidance range as a result of spending to support new products including Ibrance, Eliquis, Prevnar adult, Xeljanz, and biosimilars.

Now I'd like to walk you through the 2017 guidance ranges for revenues and adjusted diluted EPS relative to our 2016 actual results. First, it's important to note that our 2017 financial guidance assumes the pending disposition of Hospira Infusion Systems in February 2017 and excludes its $1.2 billion contribution to 2016 revenues and its $0.03 contribution to adjusted diluted EPS in 2016.

Also, while our 2017 revenue guidance range reflects anticipated strong growth of certain new, inline, and acquired products, this growth is partially offset by an anticipated $2.4 billion negative impact due to continuing product losses of exclusivity and an anticipated $900 million negative impact due to adverse changes in foreign exchange rates. Consequently, we're absorbing a negative impact of $4.5 billion related to these three factors. In addition, I'd like to clarify for modeling purposes that while expanding revenues from the U.S. are included in alliance revenues, revenues that our generated outside the U.S. are booked as royalty and therefore included in other income.

In summary, we expect our 2017 revenues to be in the range of $52 billion to $54 billion. I also want to point out that the midpoint of this revenue range implies another year of mid-single digit operational growth, excluding the impact of the pending sale of Hospira Infusion Systems and foreign exchange.

Adjusted diluted EPS guidance, as I mentioned, excludes the contribution from the Hospira Infusion Systems and includes the negative impact of product losses of exclusivity, as well as an expected $0.05 negative impact from foreign exchange. In addition, the guidance range for adjusted diluted EPS incorporates $5 billion of anticipated share repurchases in 2017, which are expected to more than offset potential dilution related to employee compensation programs. As a result, we expect adjusted diluted EPS to be in the range of $2.50 to $2.60. The midpoint of this range implies operational growth of approximately 10%, excluding the impact of the pending sale of Hospira Infusion Systems and foreign exchange.

Moving on to key takeaways, we finished full year 2016 with 5% standalone operational revenue growth, excluding Hospira and Medivation. We issued 2017 financial guidance. Excluding the pending sale of Hospira Infusion Systems and foreign exchange, the midpoint of the revenue guidance range implies another year of mid-single digit operational growth, and the midpoint of the adjusted diluted EPS guidance range reflects approximately 10% operational growth. We accomplished several key product and pipeline milestones, including the European Commission's approval of Ibrance for the treatment of women with HR+, HER2- locally advanced or metastatic breast cancer and the FDA's approval of Eucrisa for the treatment of mild to moderate atopic dermatitis in patients 2 years of age and older. We returned $12.3 billion to shareholders through dividends and share repurchases. Finally, we remain committed to delivering attractive shareholder returns in 2017 and beyond.

Now I'll turn it back to Chuck.

Charles E. Triano {BIO 3844941 <GO>}

Thank you. Operator, at this point can we poll for questions, please?

Q&A

Operator

Your first question comes from Tim Anderson from Bernstein.

Q - Timothy Minton Anderson {BIO 3271630 <GO>}

Thank you very much. I'd like to ask you about Immuno-Oncology and just the commitment to the agreement on avelumab and with your partner, Merck KGaA. As you outlined, you've got lots of registration-enabling trials ongoing and lots of combinations. Should we interpret that as meaning that you're fully committed to that partnership and to avelumab? Or is it in the realm of possibilities that in this fast-changing world of I-O, where the landscape continues to shift, you have to be more open-minded to continually reassess the way and try to become a leader in this area? And maybe Merck KGaA and the assets that you have in development don't quite get you there.

Then a second question is on border tax. Can we just get your perspective for how you think this whole issue might play out both in the nearer and longer term? Do you think

this proposal has legs? My understanding is that it could clearly be a potential negative for multinational drug companies.

A - Ian C. Read {BIO 3358997 <GO>}

Tim, thank you for the question. Regarding avelumab and our partnership with Merck KGaA, we believe avelumab is a highly competitive molecule, and we're focused along with our partner on delivering its promise as both monotherapy and in combination with other agents.

In the I-O area, we believe that having a backbone with a PD-L1 compound is necessary but insufficient in the future competitive environment. So we see avelumab as potentially competitive in selected first-line settings but believe the true value will be in combinations, potentially with targeted agents such as Inlyta, antibody drug conjugates, analytic (27:00) vaccines, and other I-O agents such as OX40, 4-1BB, IDS1 (27:05), and drugs in Pfizer's pipeline. So I think that addresses most of the risk and concerns you have about our strategy. Everybody needs, I think, a PD-L1, but that's just the chip to the entry. After that, you need an extensive portfolio around combinations to really open up the value of immuno-oncology.

On the issue of border tax, look, the tax codes are complicated – or the tax suggestions are complicated. I think the Republican leadership has overall tax changes that are overall favorable for the pharmaceutical industry. Certainly would allow us to create more jobs in the United States. And I don't really think that we would feel that the changes as being proposed are negative for our industry – far more positive, in fact. Frank, do you want to add something to that?

A - Frank A. D'Amelio

I'd just punctuate what Ian said, which is I don't think you can look at one individual – one potential individual part of reform. You got to look at what the total package would look like. So it'll include what's going to be corporate taxes? What are going to be the impact on future foreign earnings? Base erosion, which is where border adjustability comes in. Accumulated foreign earnings, interest expense deductibility. So I think what we'll need is we need the full picture, the full puzzle, instead of just trying to comment on one individual piece of it.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Frank and Ian. Next question, please, operator.

Operator

Your next question comes from Chris Schott from JPMorgan.

Q - Christopher Schott {BIO 6299911 <GO>}

Great. Thanks very much. Just two questions here. First of all, on just appetite and priorities for business development from here. And as you're just thinking about that,

would a repatriation kind of tax holiday or broader tax reform affect any of your capital deployment or business development priorities? Basically, could that make deals that didn't make sense previously make sense given the new capital structure?

Second question was just maybe talking a little bit more about Prevnar. We had a step down in sales this quarter. You've talked about sales to be flat to maybe modestly declining in 2017. Could you just elaborate a little bit more? Where are we with regards to the in adult kind of bolus in the U.S.? And how should we think about this kind of ramp in Europe offsetting potential further erosion of the U.S. opportunity? Thanks very much.

A - Ian C. Read {BIO 3358997 <GO>}

Thank you, Chris. Well, I'll make a few comments on the BD. Frank, you may want to add something, and then we'll go over to Albert for a discussion on the Prevnar vaccines.

To the extent – I'd like to point out that the most impactful thing with tax reform will be to level the playing field between U.S. companies and foreign companies in regards of the foreign companies not having the tax advantage of acquiring companies and then taking it to a low-tax location. So that'll be a fundamental change in competitiveness. To the extent that tax changes would make it cheaper for us to access financing, then you're quite right. Some deals that previously would not have been affordable, may now be affordable.

But the lens we look at it is always from the point of view of creating value for shareholders. So per se I don't see that the tax reform alters our approach to doing BD, which is, are we going to generate above our cost of capital in making this investment, and is it, both short- and long-term, the right think for shareholders? So I hope that answers on BD, and we'll go over to Albert to talk about vaccines.

A - Albert Bourla {BIO 18495385 <GO>}

Prevnar 13 is expected to continue to be a significant program. Overall this year, we expect Prevnar 13 to be flat to declining. And this is a result of complex movements in the marketplace. As discussed previously, in the U.S. we have already vaccinated approximately 50% of the 65-plus population. So we expect to continue to see a decline here in the adult indication, as we exhaust the catch-up opportunity (31:09). This will be offset by international adult growth, and growth of adult vaccinations in the 19 to 64 age range. And we will also see a modest growth in pediatric indication.

From our perspective, moving forward in U.S. and in EU, in the U.S. we are focused on protecting the remaining 50% of the 65-plus population and expanding uses to 19-64 age range. We are aware that vaccinating the remaining 50% is more challenging than it was to vaccinate the first half. And to realize the full potential of 19-64 we need an SEP (31:53) recommendation, but we are moving forward with plans given the current situation.

In Europe, as you know, it's all about recommendations and reinvestments. We continue to advocate with vaccine technical committees for recommendations and payers for reinvestments. The timing of the success varies country by country and in some cases

region by region within the same country. Last couple of data (32:17) in 2016, we had relatively limited number of recommendations and reinvestments. We had in Denmark and we had one region in Spain, Madrid region. In 2017 we expect funding decisions in a number of important markets, like France, Italy, and Belgium.

A - Ian C. Read {BIO 3358997 <GO>}

Thank you, Albert. And, as you know, I think we've said in the release that we expect, given the pressures on the ability to get into the residual 50% of the adult markets, we expect sort of flat to slightly down for our overall Prevnar franchise next year.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you. Operator, can we move to the next question, please?

Operator

Your next question comes from Vamil Divan from Credit Suisse.

Q - Vamil K. Divan {BIO 15748296 <GO>}

Great. Thanks so much for taking my questions. So, one, again going back to the business development and some of the D.C.-related comments you made earlier. I'm just wondering, in terms of – given there's a lot of uncertainty around how everything's going to play out in terms of corporate tax and border pricing, all these issues, is it fair to say that there might be a little bit of a pause in Pfizer's desire to do larger scale business development until these issues are sorted out, presumably later this year?

And then my second question that I had just relates to Xtandi. And I'm just curious on that product sort of your expectations given how much you paid for that asset in your acquisition last year. J&J commented a little bit last week around some market contraction that they're seeing in that space. And I'm just curious if you can give a little bit more color in terms of what you're seeing in terms of volumes and pricing from Xtandi? Thanks.

A - Ian C. Read {BIO 3358997 <GO>}

On the BD, I don't see it as a pause. We're going to play the cards we get dealt. As I said, the change in the tax code may reduce competition for assets from external buyers. It may alter somewhat the overall cost to make an acquisition, but it's not dramatic in the sense of we're going to take a year pause or so while we see what the tax code's going to do. We're going to continue to do BD where we see value for our shareholders. We think we have the flexibility on the balance sheet to do that, and so I don't see a dramatic pause. Frank, do you want to add anything to that?

A - Frank A. D'Amelio

Just that since September of 2015, with the current cards we've been dealt, with the current tax laws as they're written, we've done approximately $40 billion in deals, all of which obviously we believe are or will create shareholder value. And, to Ian's point, if we

get dealt a new set of cards, a new hand, then obviously we'll play that hand. And once again the compass never changes. The compass is always creating shareholder value.

A - Ian C. Read {BIO 3358997 <GO>}

Okay. Albert, on Xtandi?

A - Albert Bourla {BIO 18495385 <GO>}

Yes. Vamil, let me provide some insight of the market dynamics and then also provide our expectations for the product. Xtandi revenues in Q4 declined 8% versus Q3 of the same year and 13% versus same quarter of last year. However, Xtandi demand, as measured by specialty pharma, was up – increased 4% in Q4 versus Q3 and over 9% versus the same quarter of last year.

The same inconsistency between revenues and demand is also observed on a full-year basis, where revenues were up by 8%, while total prescriptions were up by 15%. This inconsistency is due to changes in the demand mix, with a significant increase in patient assistance program last quarter, which impact revenue. This spike in PAP programming is unprecedented compared with prior experiences.

We remain confident in the growth potential of Xtandi in the metastatic first stage cancer market for the following reasons: We expect to continue to grow sir (36:36) with both oncologists and urologists. Urology is where the largest growth potential exists. Currently the number of oncologists prescribing the product is almost 4,000 of a universe of 6,500. The number of urologists prescribing Xtandi now grew to around 1,400 this quarter. However, there is still a great opportunity with over 5,500 urologists prescribing casodex.

The publication of the positive data from TERRAIN, which is the only study demonstrating superiority against casodex, head to head, will have a significant impact. Recent market research showed a significant increase in prescribing intent by both oncologists and urologists that were aware of current data versus those that were not aware. Beginning of January 1 this year, we put a strong commercial management team in place from Pfizer. Given our strong reputation and experience in both oncology and urology, together with partner Astellas, we expect to accelerate the Xtandi growth.

A - Charles E. Triano {BIO 3844941 <GO>}

All right. Thank you, Albert. Our next question, please, operator.

Operator

Your next question comes from Jami Rubin from Goldman Sachs.

Q - Jami Rubin {BIO 1527982 <GO>}

Thank you. My question is for you, Ian. As you know, President Trump is meeting with a group of industry executives right now as we speak, and he said he wants to bring drug pricing down. Do you think that the industry is doing enough to quell concerns out there?

And, if this comes to a head – I mean, how do you think it does come to a head? How are we going to get closure on this drug pricing issue? Will the industry have to give something up? How do you look at it? And just specifically on your price increases, which you announced January 1, are you holding to one price increase a year? Can you comment on that? I think it's just interesting that a number of the distributors this morning said that they are expecting that drug companies will raise prices again in the June and July time period. So just sort of your overall views on how this is all going to come to a head. Thanks.

A - Ian C. Read {BIO 3358997 <GO>}

Okay. Thank you, Jami. On our price increases are, I don't want to get into the will and the when we increase prices for simply competitive reasons. But we are not changing our philosophy vis-à-vis how we price our medications and when we take those price increases.

And regarding the meeting with President Trump, which I couldn't attend because I'm on this analyst call, I'd like to sort of broaden exactly and look at what he said. He said, well, number one, you need to get manufacturing back to America, so that falls squarely inside of getting a tax reform which allows us to reinvest in the United States and create jobs. So I think we can be a very positive part of the story of creating jobs in the United States if we get the tax reform.

Regulations. He's going to cut up to 80% to help streamline the approval process. That will help with drug prices, because it'll induce more competition. We have been advocating for a long time to speed up the approval of generics and remove the barriers to their approval, because that will help with drug prices.

Regulations, the way insurance is delivered. Cost to consumers, which is really, I think, what the president is talking about. Cost to patients is driven by the fact that the out-of-pocket expense on average for a patient to visit a hospital is 3%, but on his drug bill it's 15%. So we'd like to see regulations that would allow that unfair playing field to be squared up. It'd be positive to get a new FDA head and very positive if we can – if young companies (40:53) and companies can be – get to the market quicker. And that's good for us and good for the whole system.

So I think complexity of drug prices involve all of the other comments he made. And I think there are lots of ways, like changing regulations to allow value-based contracting between the industry and the health system, will also be very helpful. We have a regulation that was created for fee-for-service, and now we need regulations in a new world of value-based pricing. So I think there's lots of ways we can work with the administration to ensure that patients have affordable drugs – or more affordable drugs in the United States. I think that covered most of what you asked.

A - Charles E. Triano {BIO 3844941 <GO>}

Thanks, Jami. Thanks, Ian. Next question, please.

Operator

Your next question comes from Mark Schoenebaum from Evercore ISI.

Q - Mark J. Schoenebaum {BIO 5001077 <GO>}

Hey, guys. First of all, I'd like to thank the Pfizer organization for all the help while I was gone, especially Chuck, Ryan, and Bryan helping my team. Thank you.

I wanted to ask again about the possibility of a repatriation holiday. So maybe this is a question for Frank. But I just want to understand if I'm doing this right. Your OUS cash, I believe, is at least $14 billion, I think is what you said publicly, not updated for the 4Q. Your leverage ratio right now, total debt to EBITDA, is something around 1, 1.3, somewhere in there. I believe you said you'd be willing to go to at least 2. And I'm wondering if – my understanding is that if you're able to repatriate cash, you probably alleviate some of your needs for short term paper in the U.S. So, in the event of a tax repatriation holiday, how high, Frank, would you allow your leverage ratio to go? And would you consider maximizing your borrowing to maximize cash on hand?

And, then second of all, if you don't mind, just the 5% operational growth for the year in revenue. Can you break out price versus volume?

A - Ian C. Read {BIO 3358997 <GO>}

Mark, I know you've directed most of the questions to Frank; I think he can give you the answers you're looking for. I'd just like to say welcome back. Good to have you back on the calls.

A - Frank A. D'Amelio

Yeah, welcome back, Mark. I also wanted to also say that, too. So, listen, on capital structure, the real punchline to the question was how high would we go? Let me run a few numbers, and then I'll answer the question, which is at the end of last quarter we had about $24 billion in cash. We say at any point in time, up to $10 billion of that is in the U.S. So that $24 million minus that $10 million that disclosed is how you got to your $14 billion. At the end of last quarter, we had give or take about $44 billion in debt. So if you put the debt of $44 billion, put that on our EBITDA number, you get a number that's close to 2. If you do a net debt number, which is probably the calculation that you did, you get to a leverage ratio that's about 1, 1 and change, which is, I'm assuming how you got to the basis of your question.

In terms of how high we would go on leverage, the answer is, it depends on what we're doing. I mean, quite frankly, to lock myself in on a number really to me isn't an appropriate thing. It really depends on what is the use of capital? And the compass on capital, whether it's business development, whether it's buybacks, whether it's dividends, whether it's investing in our business, but the compass is how do we maximize capital deployment to maximize shareholder value? So that's how we think about it. To the extent we need it to lever up because we think there'd be an opportunity that made sense, we'd

lever up. But to lever up just to lever up isn't what we're all about. So that's how I'd answer that.

On price, I think the way I'll answer it is I believe for the full year our operational revenue growth all in was 11%. Then you took out – you made a couple adjustments to get to 5%. But I look at the 11%, the majority of that 11% is volume. Low single digits, approximately 2% of that, is price.

A - Charles E. Triano {BIO 3844941 <GO>}

Thanks, Frank. Next question, please, operator?

Operator

Your next question comes from David Risinger from Morgan Stanley.

Q - David R. Risinger {BIO 1504228 <GO>}

Yes. Thanks very much. I have a couple questions. First, with respect to pipeline news flow in 2017, could you just highlight what the top two or three readouts are in your mind that we should be focused on?

And then second, with respect to future business development, you've obviously commented on it in some detail, but it would be helpful to get some more perspective on what your expectations are for potential timing on large transactions. It would seem that it would be most beneficial for Pfizer to have clarity on the likelihood of tax reform and/or repatriation before pursuing a very substantial transaction. But would love to get your comments on that, Frank. Thank you.

A - Ian C. Read {BIO 3358997 <GO>}

Well, I'll ask Mikael to do the pipeline flow, and then myself and Frank will answer your BD question.

A - Mikael Dolsten {BIO 16368411 <GO>}

Yeah, thank you for the question. I think we are in a really good rhythm with the pipeline. Actually over the last six years we have had over 20 key approvals with an average of three to four approvals per year, and the pipeline, the quantity and the quality that we have of the pipeline of more than 90 programs in clinical development, we'll have a similar flow or even more. Actually in 2017 and 2018 we expect about five approvals every year.

Concerning readouts, and I'll focus mainly on pivotal studies that are registration enabling, we will have about 15 pivotal readouts in 2017 and 2018. Particularly in 2017, more near term, I can mention readouts expected for dacomitinib, lorlatinib, avelumab in certain indications, and also two of our biosimilars. And there will be a continuous flow up to 15 pivotal readouts in total, 2017 and 2018.

A - Ian C. Read {BIO 3358997 <GO>}

Thank you, Mikael. Frank, would you like to have a stab (47:37) at the BD question?

A - Frank A. D'Amelio

Sure. And, Dave, you commented specifically you mentioned large transactions. The way I'd answer the question is – and Ian and I have both said this before – we always start with we're agnostic to size when it comes to business development. Our compass is, will continue to be, shareholder value.

In terms of the other part of your question about access to overseas cash, or easier access to overseas cash, clearly that would be beneficial. That would be favorable, all other things being equal. But in terms of does that make it easier to do deals? The answer is it depends. For example, what happens to the valuations of all the companies? If it's easier to have access to overseas cash, does that drive valuations and prices up? So the compass has to continue to be shareholder value, return on capital, relative to our cost of capital. That's what we've always done. That's what we'll continue to do. But at a macro level, all other things being equal, does easier access to our global cash help us, is it more favorable? The answer is yes. But there's other factors that we'll have to understand as we work our way through business development.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Frank. Next question, please, operator.

Operator

Your next question comes from John Boris from SunTrust.

Q - John T. Boris {BIO 2563403 <GO>}

Thanks for taking the questions. First question just has to do with a very broad question on -

A - Ian C. Read {BIO 3358997 <GO>}

John, we can't hear you. You need to speak up, sorry.

Q - John T. Boris {BIO 2563403 <GO>}

Sure. Can you hear me now?

A - Frank A. D'Amelio

Much better, John. Loud and clear.

Q - John T. Boris {BIO 2563403 <GO>}

Okay. Great. Thank you. So the first question is just a very broad question on how fragmented the pharmaceutical industry is relative to other industries. Can you just give

your thoughts on consolidation, and especially in light of the pricing pressures, just your thoughts on the need for the industry to consolidate? There's a lot of manufacturing inefficiencies out there, just a lot of inefficiencies in the industry in general. So that's the first broad question.

Second question, in 2006 you made a decision to sell your consumer business. Is there any way of giving some quantification as to what kind of earnings contribution you currently get from the consumer business? And if you were to consider externally selling it, how would you offset that dilution? Would you add to that $5 billion share repurchase?

Third question, Ibrance. Was there any – obviously outperformance, great performance on the brand in the quarter. Was there any additional product put into the channel on Ibrance? Was that all sell-through?

And then lastly, Ian, applaud your highlighting the 96 clinical programs you have, but one thing I hear a lot from investors is that you haven't had an R&D meeting in a long time. Would love to see that innovation displayed in front of the investment community. Any thoughts about doing an R&D meeting?

A - Ian C. Read {BIO 3358997 <GO>}

Okay. Thank you, John. Four good questions.

So the issue of fragmentation. So if I look at it from a society point of view, society has to decide, do they want continuing – a flexible (50:45) organization with lots of shots on goal? If they do, they need to continue to support that and support it through a robust market-based system in the United States. To the extent that that would change, and we don't have a robust ability to recover our value, then I do think you'd see the fragmentation disappear and innovation would go down. So it's a sort of really macro decision that the government has to make or society has to make as to how much progress and how fast do they want to see progress and how much resources they're willing to put behind it. And that would dictate, I think, the fragmentation or infragmentation (51:19) of the industry.

Vis-à-vis the consumer business, we don't give out obviously our profits for sub-businesses, but we see it as an asset that is valuable to us, valuable to our shareholders. And just like all of our portfolio and all of our assets, if there's a better mix, we're always open to it, but it has to be for strategic reasons rather than cash.

On Ibrance, I'll ask Albert to talk a little bit about Ibrance, but before he does, you asked about the R&D portfolio.

A - Charles E. Triano {BIO 3844941 <GO>}

R&D day.

A - Ian C. Read {BIO 3358997 <GO>}

R&D day. Well, look, let's look at it. We haven't had one for some time. I haven't often found them that productive. We give you a lot of visibility by publishing on Clinical.com (sic) [ClinicalTrials.gov] (52:15). Mikael's available to analysts whenever they want to talk about the science. More than willing for you to come in and talk to Mikael, John. So I'm not sure that a big R&D day really is worth the disruption and the focus on getting it done vis-à-vis explaining what we're doing, but we'll take a look at it.

Okay, Ibrance, Albert.

A - Albert Bourla {BIO 18495385 <GO>}

It was a great performance for Ibrance, John. As we said, exceeded $2 billion this year in the second year of its launch, and it was almost 200% growth. And this excellent financial performance is driven by underlying demand, and there was no abnormal situations in inventories.

A - Ian C. Read {BIO 3358997 <GO>}

Okay. And, Frank, why don't you add some more on the consumer?

A - Frank A. D'Amelio

Yeah, so, John, just to run some numbers to help you in terms of answering your question. So for the quarter, consumer revenues, $950 million, plus 4% operationally. For the year, $3.4 billion, up 5% operationally. We don't give specific margins, but one of the things we do say about the consumer business is that the margins are lower than the pharmaceutical business because it's a less risky business. That gives you enough information, I think, to be able to really ballpark what the number is.

And, by the way, in terms of just the theory or the case of when we divest an asset, how do we deal with it from a dilution or accretive perspective? The answer is it depends, but think about Zoetis. We did a big buyback. We did a share exchange. And so even though we divested what was a very good, very profitable company, we wound up making that transaction accretive. So there's lots of ways for us to do that. You mentioned share buybacks, and, yes, that's clearly one of the ways when we divest assets that we can deal with accretion and dilution.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Frank. Our next question, please, operator.

Operator

Your next question comes from Geoff Meacham from Barclays.

Q - Geoffrey C. Meacham {BIO 21252662 <GO>}

Hey, guys. Good morning. I want to dig in a little bit on the biosimilar franchise. What can you guys tell us about the Inflectra experience so far in the U.S.? And then what's the Pfizer view of the new interchangeability guidance and what it means to speed to market?

And then, at a higher level, when your biosimilar franchise scales to add more assets, do you think about gross to net any differently? In other words, is the long-term value here biased to more margin contribution or more revenue growth? Thanks.

A - Ian C. Read {BIO 3358997 <GO>}

John, would you like to comment on that?

A - John Young {BIO 16960082 <GO>}

Yeah, so first of all, I think we obviously are very positive about the opportunity that we have with biosimilars. First of all, the commercial opportunity to provide real value to our shareholders, but also the opportunity that biosimilars represent to continue to bring some of the competition that Ian referred to, to the healthcare system and to bring efficiencies and savings. So we think the opportunities in both regards are very significant.

It's obviously very early days of Inflectra in the U.S. We're literally in the first – this is just the second month of launch, so it's early days. We anticipate that the uptake in the first few months in the U.S. will be slow. That represents our progress in Europe, where we've seen that actually after the first few months as physicians get comfortable with biosimilars, we've seen the rate of uptake really begin to accelerate.

Just to give you a data point to compare in Europe, the uptake of biosimilars overall for infliximab in Europe is something like 28%, 29% in the second year. So we're actually very satisfied with what we've seen about the progress of biosimilars can make when we begin to get information about how a high-quality biosimilar and our data can really actually deliver significant value to the healthcare system.

In regard to your second question about the portfolio, we certainly continue to have, as you've heard from Ian and Frank, a bias to shareholder value. So our compass, whether it's in BD, as Ian and Frank have talked about, or when it comes to the individual contribution of a product portfolio such as biosimilars, will always be around shareholder value. And so we certainly are very positive about the opportunities for revenue growth, but our compass is always going to be shareholder value as we determine how to invest in that portfolio going forward.

A - Charles E. Triano {BIO 3844941 <GO>}

Thanks, John. Next question, please.

Operator

Your next question comes from Steve Scala from Cowen.

Q - Steve Scala {BIO 1505201 <GO>}

Many thanks. I have two questions. First for Ian. As someone who's been in the industry for a long time, I would be interested in how you view the current potential threat from government intervention on drug pricing versus that sporadically over the last 20 or 30

years. Would you say it is now among the most significant threat you've ever seen? Would you say it's similar to past periods or not as severe?

And then a question for Dr. Dolsten on JAVELIN 100. The study is similar to KEYNOTE-024 and CheckMate 026, reads out this summer, the PD-L1 expression threshold is 1%. Is Pfizer amending the protocol to use a higher threshold? Since otherwise it seems that the study is unlikely to be successful. Thank you.

A - Ian C. Read {BIO 3358997 <GO>}

Steve, on the relative threat, it's a good question. I think the misinformation is far greater than I've ever seen before out in the marketplace. And we're seeing added onto previous price discussions the behavior of companies that work in the generics sector, who are moving to change their prices in a volatile manner, hence creating a negative perception there. But if you actually look at the price increases of the branded pharmaceutical companies as a whole for 2015, it was 2.8%. So if you separate the hysteria, frankly, in the media and often the examples are companies that are in the generic market, then I think it's really a huge amount of misinformation out there that we and the pharma as an organization needs to begin to start dealing with (58:26).

A - Mikael Dolsten {BIO 16368411 <GO>}

So great to get the question on our clinical strategies. We always carefully monitor new learning in clinical science to make sure we try and incorporate them into our studies, and this is true also for the JAVELIN first-line lung cancer study, where we are obviously incorporating the best way to define the patients concerned in PD-L1, and you can be certain that our patient population we've optimized for what is the best knowledge how to get the likely maximum response to a PD-L1 inhibitor such as avelumab.

Finally, I just wanted to add, beyond the monotherapy, which we think will be a productive profile for initial monotherapy, we worked on doublets and triplets with 4-1BB and OX40 that will over time, we think, be able to move the needle even further, including indications such as lung cancer.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Mikael. Next question, please, operator.

Operator

Your next question comes from Gregg Gilbert from Deutsche Bank.

Q - Gregg Gilbert {BIO 3565226 <GO>}

Thank you. First for John Young. John, do you think the Essential business can grow without deals and without the benefit of innovative projects coming over the wall, over time? Can you also give us a roadmap for what biosimilar launches Pfizer might have in the next two to three years? And comment on your copaxone ANDA status in light of the legal ruling?

And over to Ian and Frank. Rather than asking you to predict as to what replaces the Affordable Care Act and when, could I ask you to quantify the effect you think the ACA has had on Pfizer? Industry fee, donut hole, increased volume potentially, biotech exclusivity. These are the things that come to mind. But how do you quantify what ACA has done for Pfizer as we think about where that may go in the future? Thanks.

A - Ian C. Read {BIO 3358997 <GO>}

Please, John.

A - John Young {BIO 16960082 <GO>}

Okay. So thanks for the question, Gregg. So I think we have been fairly consistent in terms of saying that we really believe that we have a strategy and a portfolio that can return the Pfizer Essential Health business to some sustainable growth after the impact of LOEs has begun to lessen. We certainly still have an impact of some LOEs in our portfolio, as you know, but that impact will lessen over the next few years. And I think we believe that just strategically at a high level, the strength that we have in our emerging market business that would be typically in most of the large emerging markets, number one or two in most of those countries. We have the leading sterile injectable business, leading biosimilars business. And within our, what we think of as our global brand portfolio, we actually also have the largest portfolio of anti-infectives in the business. So we believe that those core areas of strength really provide an opportunity for us to really drive this business to sustainable growth.

Just to run some numbers for you. Whilst in the fourth quarter this year, the growth of the business overall was minus 6%, if you adjust for the impact of LOEs, giving you a sense of what is actually happening to the core business without that headwind, the answer is flat. But if you adjust for and equalize for the selling days, which I think Frank highlighted in his opening comments, that core business grew by 6%. So I think it hopefully gives you a sense that we are actually growing those portfolios that we believe will be the positive drivers of growth going forward. We'll continue to look at opportunities to strengthen those portfolios. And certainly our aspirations for setting (1:02:06) this business to sustainable growth remains undimmed.

In terms of biosimilar launches, as you know, we are also – we're very well-positioned to be the leader that we are today in terms of revenues, but actually a leader over the next five to 10 years given the strength of our portfolio. In the relatively near term, we anticipate that in the 2018, 2019 timeframe we'll be able to file around about five biosimilar products. I think you're aware of the products that we have in our pipeline. We certainly have potential biosimilars for trastuzumab for cancer; for bevacizumab, also for cancer; for adalimumab, which is an anti-TNF product and one of the biggest products in the world; and rituximab; as well as EPO, which we filed in response to the complete response letter that Hospira had previously received. And we filed that response in December of last year.

So when you look at all of those drivers, both combining that with the early stage pipeline that we have, we believe we're really well-positioned to have a rich pipeline of biosimilars in the marketplace over the medium term. Thanks for the question, Gregg.

A - Ian C. Read {BIO 3358997 <GO>}

Gregg, thank you. I'm going to just point out some of the – I'll get Frank to go through some of the costs of ACA first. I'd like to just make the point that there was no windfall for our industry from the expected 20 million more patients. Because mostly these patients were not treated with a type of – given the level of insurance they have, they didn't really have access to innovative drugs. So there was very little revenue growth from the exchanges for Pfizer (1:03:54) the expenses of the ACA.

A - Frank A. D'Amelio

Yeah. So the donut hole in the fee on pharma sales this year for the full year, Gregg, $722 million. Now, by the way, the thing to add to that is the Medicaid component, although it's very hard to really come up with that number now because many states have moved to managed Medicaid. But if I just ballpark that number and assume it's been roughly the same as it was a couple years ago, that number grosses up to about $1.25 billion. And you divide that by, call it, 80 million per share pre-tax to that $1.25 billion, $0.15, $0.16 a share. Thank you.

A - Charles E. Triano {BIO 3844941 <GO>}

Thanks, Frank. Can we move on to the next question, please?

Operator

Your next question comes from Marc Goodman from UBS.

Q - Marc Goodman {BIO 1853567 <GO>}

Yes. Morning. Looks like another year of flat spending. Can you talk about the push and pulls specifically on SG&A for this year? But also just more broadly, just philosophically, it looks like R&D SG&A the past couple years has been flattish. Should we be thinking flattish for the next couple years as we model? And basically however the top line drives the bottom line?

And then, second of all, just on Ibrance, you mentioned there was no unusual inventory, but you also on the quarter usually give us some metrics, how many patients were on the product and what kind of penetration rates you've got in first line and second line. That would be helpful. Thanks.

A - Ian C. Read {BIO 3358997 <GO>}

Why don't you do the Ibrance, Albert? Then we'll get back to the movement of R&D and -

A - Charles E. Triano {BIO 3844941 <GO>}

A side comment (1:05:27).

A - Albert Bourla {BIO 18495385 <GO>}

Yes. Marc, let me give you a brief overview of the performance of Ibrance. And let me start by saying how happy we are with the success. Ibrance has been prescribed in the U.S. by approximately 9,500 physicians. This is up from 8,500 that were in Q3. It's been given to approximately 50,000 patients. Our initial on strategy was to establish Ibrance as the standard of care with early adopting physicians.

Moving forward, we believe the growth will come from late adopters, many of whom have already prescribed Ibrance, but in a limited number of patients. 20% of the approximately 12,000 prescribing physicians in the U.S. have not yet prescribed the product. From those already prescribing it, approximately 30% have only one or two patients on Ibrance. With the publication of PALOMA-2, we think that this is important data for these late-adopting physicians. Let's not forget that the study demonstrated more than two years PFS, making at the first and only treatment of this population to do so in a randomized Phase 3 study.

And then last, to answer your question, our internal market shares are approximately 45% in first line for the quarter, 40% in second line, and 25% approximately in the third line.

A - Ian C. Read {BIO 3358997 <GO>}

Thank you, Albert. I'm going to make a couple of comments on your question from the sort of strategic point of view of our expenditure in R&D and SG&A, and then I'll ask Frank to give you more analysis. So we spend in SG&A and R&D according to the opportunities we see and how we can create value. So that layer is always there, and expectations of R&D and SG&A are really related to the opportunities we see in the marketplace. Underneath that, though, we have consistent programs to look for efficiencies in how we do R&D, how we deliver our SG&A. And perhaps Frank can comment upon some of those efficiencies. So right now, looking at it, I'm satisfied with the level of support we have next year for SG&A and R&D, and each budget cycle we look at it, look at the opportunities and the growth we can get from those opportunities. Frank.

A - Frank A. D'Amelio

Yeah, maybe I'll give you some of the puts and takes, Marc, to see if that helps. So – and I'll run some numbers first. So let's do SI&A. So last year, the SI&A actual number for 2016 full year was $14.7 billion. Our guidance for 2017 is $13.7 billion to $14.7 billion, with a midpoint of $14.2 billion. There's a lot going on underneath those numbers, so if you look at the $14.7 billion compared to $14.2 billion, just in terms of the midpoint of the guidance, what's going on there? One is ongoing cost reduction programs that Ian alluded to. Two is we get the benefit of the sale of Hospira Infusion Systems. Right, so that comes out. And then foreign exchange actually helped SI&A to the tune of about $200 million. We called that out.

So think about that as things that are helping the number, but then there's offsets against that. So for example, we get the full year effect of Mediviation next year – launch costs for that, launch costs for Eucrisa, which is another area. Spend on some of our other areas. But those are the kinds of things that are going on in terms of $13.7 billion, $14.7 billion, what the midpoint is relative to next year. There's items that are driving the number down. There's items that are driving the number up.

If you look at R&D, same kind of, I'll call it, puts and takes. So last year, 2016, $7.8 billion. Guidance for this year, $7.5 billion to $8 billion, so the midpoint's roughly the same as last year, which is part of the basis of your question. But once again, lots going on there. So for example, the large boco charge we had in the fourth quarter comes out. So that would reduce spending all other things equal. On the other hand, we've got the Medivation acquisition, and we're actually increasing our investment in things like Ibrance, immuno-oncology, and see (1:09:27) some of our late-stage pipeline assets. So when you put that all together, we get to that range of $7.5 billion and so just kind of the rhythm of the numbers. (1:09:46)

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Frank. Next question, please, operator.

Operator

Your next question comes from Andrew Baum from Citi.

Q - Andrew S. Baum {BIO 1540495 <GO>}

Hi. Couple of questions, please. It seems as if a new administration is proposing lower drug prices in exchange for accelerating development timelines for drugs. Do you really believe that that's the underlying issue with the economics of pharmaceutical industry? Does that represent a fair trade to you?

And then, second, in terms of the industry group highlighting other players in the healthcare value chain who may be contributing to drug price inflation, perhaps you might like to comment both on the role of the PBMs, as well as on the 340B hospital program.

And then very quickly on biosimilars. In relation to your oncology biosimilars, could you outline what you think the anticipated adoption rate and market impact will be, how fast, and in particular to which customer groups in the U.S. you think you're going to be most accessible in the initial launch period? Thank you.

A - Ian C. Read {BIO 3358997 <GO>}

So your question on the administration, I would look at it this way. I think to the extent that – and I would hope this is how the administration's thinking of it – to the extent that they can remove regulations and make it easier and faster to bring drugs to market, that will make the marketplace a lot more competitive, which will then in turn help to bring down drug prices. I believe that this is the philosophy of the administration, to ensure there's competition in the marketplace, and that would be one way of ensuring that drug prices are modified some way.

Regarding your comment about the difference between our price and the list price, I think we get – I think there's a study that recently came out indicating the percentage we get of the list price. So we have got into a marketplace, and the way the marketplace has developed, that we have list prices but then rebates negotiated that gives a net price. I

believe there are alternative systems where we could have just as an efficient system but where the list prices could be lower and the net prices would stay substantially the same or might drop slightly because of the middleman not making so much money in the middle. But that's very complex, and we need to come up with a competitive marketplace solution to that. But I do believe that's one of the problems in the market today, because people without insurance or through the deductibles are hit with the list price rather than the net price through the insurance companies. So maybe there are ways we can work with the insurance company administration to get rid of this big difference between list price and net price.

And the last question was for John on biosimilars.

A - John Young {BIO 16960082 <GO>}

So thanks for the question, Andrew. So obviously there are no currently available oncology product biosimilars, either from our portfolio or any other company's portfolio in either the U.S. or Europe or any other major market around the world. So to some extent it's very early days to conjecture what reach of uptake might be. Yet what I can say is that we are very positive about the pipeline that we have. As I mentioned earlier, we have bevacizumab, a potential biosimilar to Avastin. We have rituximab, a potential biosimilar to Rituxan, and we have a potential biosimilar, trastuzumab, to Herceptin. And we're very positive about the way that those clinical programs are unfolding.

I think in oncology, it's very likely that biosimilars will be used initially for new patients. I think it's probably unlikely that oncologists will choose to change a patient's therapy, but given the particular dynamics where patients by definition start and finish courses of therapy more often we don't see that as being an inhibition in any way to the uptake once physicians actually see the clinical data for a biosimilar and then can make an informed decision along with their patients around how to most appropriately manage their course of therapy.

A - Charles E. Triano {BIO 3844941 <GO>}

Thanks, John. Next question, please?

Operator

Your next question comes from Tony Butler from Guggenheim Securities

Q - Tony Butler {BIO 1504193 <GO>}

Yes. Thanks very much. Three very brief questions. Frank, have efficiencies in gross margins actually been totally wrung out to date?

And number two, to John Young again on biosimilars, do you believe in the U.S. that overall demand is dependent upon formulary positioning à la pushing a brand back to a higher tier for where your biosimilar may be at a lower tier as opposed to physician pull-through?

And then finally to Mikael Dolsten on first-line lung, yet once again, do you wait until JAVELIN 100 completes before moving forward with the combination studies? Or are you already underway with those? And I noticed or cannot find any trials other than in head and neck, which has radiation which may involve chemotherapy plus avelumab. So I'm curious how you and/or Pfizer think about that and combinations specifically for lung? Thanks very much.

A - Ian C. Read {BIO 3358997 <GO>}

Okay. Frank?

A - Frank A. D'Amelio

Yeah, and, Tony, I'll answer it by using cost of sales, which is basically the same thing. So think about it this way: Our cost of sales in 2016 was 22% of revenue for the full year. Our guidance for 2017 is 20% to 21%, so midpoint to that guidance 20.5%. So we're actually down from 22% to a range of 20% to 21% in 2017. Couple things going on there. One is more alliance revenue, so alliance revenue we book is – we book the revenue based on net gross profit, so there's no COGS. So that obviously helps the percentage, but also ongoing cost reduction programs taking place in our factories and throughout the company. And then there's -the offset to that is we've got 2.4 billion of LOEs next year, some of which obviously have a negative impact on the cost of sales. But when you put that together the short answer is we're going down year over year and no, the short answer is no, we haven't wrung it out completely. There's always opportunities to continue to improve in everything that we do.

A - John Young {BIO 16960082 <GO>}

Okay. Thanks for the question on biosimilars, Tony. So I'm going to, I think, just hit on a couple points I made already, which is clearly one component of ensuring appropriate uptake for biosimilars in the marketplace is physician education, making sure that they're familiar with your clinical data, the strength of your program, and we also believe actually the importance of the company profile in your experience in biosimilars. That said, plainly access is a critical component as well. And we're absolutely clear that ensuring that we can negotiate appropriate patient access and we take the steps necessary to ensure that patients can have access to high-quality biosimilars is equally important.

A - Mikael Dolsten {BIO 16368411 <GO>}

Yeah, so great to hear about your interest in how we'll evolve the I-O combinations. So as we have optimized JAVELIN 100 for PD-L1 monotherapy, and I think based on current experiences across the field of PD-1 and PD-L1 antibodies, one can assume that monotherapy may be particularly robust in the PD-L1 height (1:17:27) fraction of tumors but likely of less magnitude in PD-L lower lung cancers. We have several Phase 1 studies ongoing where we study combination of avelumab, such as JAVELIN Lung 101, which contains avelumab plus ALK inhibitors Xalkori/lorlatinib for ALK+ lung cancer, and we also have JAVELIN Medley – and so the tumor basket studies that contain avelumab with 4-1BB, avelumab with OX40, and we're planning this quarter to start a triple, avelumab, 4-1BB, OX40, which likely, to the best of my knowledge, will be the first triple with these agents.

I should say that although you cannot predict outcome of combination drugs, it has been the history of oncology to evolve to that as we learn about single-agent activity. Both 4-1BB and OX40 show some single-agent activity, whether on clinical activity or important immunoparameters (1:18:40).

Finally, I should say that we also are starting studies where we combine avelumab with our own PDE4 inhibitor for the T790 mutation, which is a growing segment. We will review those data as they emerge in the first half of the year, particularly, avelumab, 4-1BB and OX40 data will emerge, and take rapid decisions together with our partner, Merck, (1:19:08) how to leverage those data, and we will certainly not wait to see an outcome of JAVELIN 100, as we think the design of combination studies can also contribute to expand and supplement the position we can have in monotherapy.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you. Thanks, Mikael. Next question, please?

Operator

Your next question comes from Seamus Fernandez from Leerink.

Q - Seamus Fernandez {BIO 7525186 <GO>}

Oh, thanks for the question. So just a couple of quick ones. Ian, maybe you can just kind of comment on the fact that I-O investment overall seems wildly inefficient. In that context, can you just discuss the general efficiency of pharma's investments into this area? And in oncology, if you think the industry should really be looking to consolidate more of that spend over time. Or should companies really be taking these independent paths, chasing the same targets?

And then the separate question is just for Frank. On the tax rate, can you just help us understand a little bit more the – relative to your current repatriation thresholds, what would the tax rate need to be in order to maximize your free flow of capital? Obviously 15%, I think, would get us there, which is the current proposal for a territorial tax system. But would 20% get us there? Would 22% get us there relative to forecasting your current pro forma tax rate, which typically runs between 22% and 25%? Thanks.

A - Ian C. Read {BIO 3358997 <GO>}

Seamus, regarding your question, I think you can see that clearly with the way investors have treated initially BMS and Merck and those that have been the frontrunners on I-O, that they think it's a very effective investment strategy. The question you're really asking is, is there value to multiple shots on goal and multiple combinations? And there are a lot of combinations that you can try. So I think that the field is in its infancy and that implies some lack of efficiencies as we explore for leads and different ways to take these products forward, which will, over the medium term shake out. Now, whether you want people chasing – only one person chasing – only one company chasing one target, well that would be the result of not spending as much on research by not supporting prices and not supporting innovation. Okay. Taxes.

A - Frank A. D'Amelio

So, Seamus, on taxes, now let me run a few numbers, and then I'll answer the question which is, there's – really, there's kind of the proposals from the administration, there's the proposals from Paul Ryan and the rest of the Republicans. Think about it this way. You got to think of foreign earnings in terms of accumulated earnings to date and then future earnings. So on future earnings, the administration has a proposal, I believe, of 15% minimum tax, where Paul Ryan has a proposal that's basically a total territorial tax system that would bring it back at zero. Now that comes, by the way, with base erosion called border adjustability. By the way, I like that total territorial at zero. I mean that's kind of really good.

A - Ian C. Read {BIO 3358997 <GO>}

(1:22:43)

A - Frank A. D'Amelio

Puts us by the way, to Ian's point, in terms of a level playing field with our competitors. If you look at accumulated earnings, so everything that's been accumulated already to date, the administration has a proposal of 10%, Paul Ryan has a proposal of I believe it's 8.75% on the cash, 3.5% on the noncash, and then it's payable over eight years. My short answer is the lower the better. We obviously want to have easier access to our overseas cash. And in terms of maximizing shareholder value, the lower that number is for us, the better it is for our shareholders. So my threshold, though, is low.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Frank.

A - Frank A. D'Amelio

Yes, sir.

A - Charles E. Triano {BIO 3844941 <GO>}

Next question, please.

Operator

Your next question comes from Alex Arfaei from BMO Capital Markets.

A - Frank A. D'Amelio

Good morning, Alex.

Q - Alex Arfaei {BIO 15433937 <GO>}

Good morning. Thank you for taking the questions. First, Ian, thank you for prioritizing your investors and being on the call as opposed to the White House. This morning, the president said that foreign countries must pay their fair share for drug development. This

may not be a fair question to you, but do you think that is actually achievable? And if so, how could it be achieved?

And then also, forgive me, I'm not sure if I understood your earlier comments regarding the connection between U.S. manufacturing and tax reform. If you could clarify that.

And then on finally on the business, Hospira operational growth was a little bit lower than expected at 2%, given all the ex-U.S. launches. Can you provide some commentary there? Thank you.

A - Ian C. Read {BIO 3358997 <GO>}

Okay. On the – stopping free riding is the way I'd put it. The economy's free ride on innovation paid for by Americans, clearly it's trade policy. It's how we interact and how we do our trade policies and how we negotiate them, and I think the president has been clear that he thinks that they haven't been negotiated hard enough. And as regards to free riding on American innovation of pharmaceuticals, I totally agree with him. And hopefully we will get something done on that. He certainly has declared his intentions to do so. I'll hand it over, the other question to John.

A - John Young {BIO 16960082 <GO>}

Yeah, so thanks for the question. So we continue to be very positive about the contribution that Hospira has made to our business, both in terms of its strategic fit but also its operational performance. Just to run some numbers by you, our sterile injectable business for Hospira on the quarter as we printed it was flat. Our biosimilars business grew by 48%. The infusion systems business, which had some softness in the fourth quarter, declined by 9% and the total of minus 1%. But just to come back to the selling days true-up, that if you adjusted those for selling days and equalized between 2015 and 2016, the numbers become 9% growth for the sterile injectable business, 61% growth for the biosimilars business, infusion systems would be minus 2% compared to the minus 9%, and the total business would be 8% compared to the minus 1% when you adjust for selling days. So overall we remain very positive about the organic performance of that business.

A - Ian C. Read {BIO 3358997 <GO>}

So regarding the connection between tax reform, manufacturing, and bringing jobs back, we are not – as an industry, we're interested in highly qualified workforces that have been trained, and – but we're driven by the tax code today to manufacture outside of the United States. If there is no penalty by the border adjustment for manufacturing inside the United States to supply your markets outside of the United States, that will encourage us to put more jobs in the United States.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Ian. And, operator, if we could take our last question, please.

Operator

Your final question comes from Richard Purkiss from Piper Jaffray.

Q - Richard J. Purkiss {BIO 16073464 <GO>}

Thanks. I had a couple of quick product questions. Firstly, for Albert on Bosulif, do you see the results from the BFORE study allowing you to expand into the first-line setting in the face of Gleevec generics?

And then for Mikael or Albert on Ibrance, can you tell us when you expect to see the neoadjuvant breast cancer data from the PALLET study? And also, can you give us a quick update on how enrolment is going in PALLAS?

A - Charles E. Triano {BIO 3844941 <GO>}

Can you repeat the first question, Richard?

A - Ian C. Read {BIO 3358997 <GO>}

Bosulif?

Q - Richard J. Purkiss {BIO 16073464 <GO>}

Sure, yeah. It was a question for Albert on Bosulif -

A - Charles E. Triano {BIO 3844941 <GO>}

Bosulif.

Q - Richard J. Purkiss {BIO 16073464 <GO>}

– the BFORE study, allowing you to expand into first line in the face of Gleevec generics.

A - Ian C. Read {BIO 3358997 <GO>}

Yeah, I think we'll ask Mikael to make some comments on that. And the second one was on -

A - Charles E. Triano {BIO 3844941 <GO>}

Ibrance.

A - Ian C. Read {BIO 3358997 <GO>}

Ibrance. You can take those two, Mikael. Thanks.

A - Mikael Dolsten {BIO 16368411 <GO>}

Yeah, thank you for noting the very strong performance of Bosulif in the BFORE study that was run with the venture group Avillion supporting us in developing into earlier line. We were really pleased with the data that we – I think have been released on a first type of high level that showed it outperformed Gleevec and showed superiority. So we think it

will certainly give Bosulif an opportunity to be a major drug across all lines in chronic myelogenous leukemia. Thank you for noting that.

When it comes to Ibrance, we have had solid enrollment for our early breast cancer trials, which I think reflect, as Albert has alluded to, the very favorable tolerability profile for a drug like Ibrance to be used. And we have both, as you know, PALLAS and PENELOPE. PALLAS is the broader study that covers both high-risk and intermediate-risk patients that will be treated with Ibrance for two years. The smaller PALLET trial, which is a Phase 2, more of a neoadjuvant trial, may read out later this year or possibly 2018. Always difficult to have a firm projection. We anticipate data could come this year.

That's a study that in some way will give additional data from a Wash U university study that was earlier shown at ASCO, which did show on Ki-67 as a proliferative molecule estrogen receptor-positive cancer cells as well as on clinical responses that Ibrance was very active in this equivalent of early breast cancer. And these are the endpoints but in a larger trial, Phase 2 APPELLATE (1:29:38), we look forward to the data and think if we just add more aspects of Ibrance and its activity across many segments of breast cancer, whether advanced, recurrent, or, here, earlier breast cancer.

A - Charles E. Triano {BIO 3844941 <GO>}

Thank you, Mikael, and thank you, everybody, for your attention this morning.

A - Ian C. Read {BIO 3358997 <GO>}

Thank you, everybody.

A - Frank A. D'Amelio

Thank you, everybody.

Operator

Ladies and gentlemen, this does conclude Pfizer's fourth quarter 2016 earnings conference call. You may now disconnect.
