GSK plc

GSK plc - Q2 2024 Earnings Call

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Event Participants

Executives 7

Nick Stone, Emma Walmsley, Tony Wood, Luke Miels, Deborah Waterhouse, Julie Brown, Unknown Executive

Analysts 9

Peter Verdult, Peter Welford, James Gordon, Richard Parkes, Graham Parry, Timothy Anderson, Mark Purcell, Emily Field, Simon Baker

Nick Stone Executive

Hello, everyone. Welcome to today's call and webcast. The presentation was sent to our distribution list by e-mail today, and you can also find it on gsk.com. Please turn to Slide 2. This is the usual safe harbor statements will comment on our performance using constant exchange rates, or CR unless stated otherwise.

Please turn to Slide 3. Today's call will last approximately 1 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 to 2 questions so that everyone has a chance to participate. Turning to Slide 4.

I will now hand the call over to Emma.

Emma Walmsley Executive

Welcome to everyone joining us today. Please turn to the next slide. I am delighted to report that GSK's momentum this year continues with excellent second quarter performance. Sales grew 13% to GBP 7.9 billion. Core operating profit was up 21% to GBP 2.5 billion and core earnings per share rose 17% to 43.4p, 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 of Ojjaara in myelofibrosis, Jemperli in endometrial cancer and long-acting HIV treatments, and we also delivered a record quarter for Specialty and 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 cash flow providing funds for pipeline investments as well as returns to shareholders. Our dividend for the quarter was 15p. And on the basis of our current performance and prospects, we are again upgrading our full year guidance. Next slide, please.

We continue to invest in the pipeline and are making good progress. This quarter, GSK's long-standing expertise and leadership in respiratory will once again reinforce with positive Phase III data reported for depemokimab. In oncology, we continue 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 were at increased risk. Although ACIPs postponed vote on recommendation for this cohort are 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 of Arexvy can offer to this age group like other cohorts will be fully recognized and that this best-in-class vaccine will reach its full sales potential. I'm also delighted we've taken steps forward in clinical development for our pioneering ultra long-acting HIV medicines or potential functional cure treatment for hep B and on novel antibiotic gepotidacin. Next slide, please. Build and trust by delivering across the 6 key areas we prioritized at ESG remains a clear priority for all of us at GSK. Earlier this month, in partnership with Medicines for Malaria Venture then we launched tafenoquine in Thailand and Brazil.

This is the first single-dose radical dual medicine to prevent malaria relapse, another step forward to eliminating this disease. In May, we became a founding partner of the Fleming initiative, a new global network that proves together scientists, proxy makers and the public to fight antimicrobial resistance. And we've also started a Phase III trial for a low carbon version of our metered dose inhaler Ventolin, using a generation propellant on 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. So I am delighted with GSK's continued progress and strengthening prospects, but before reminding you of these, a quick word on Zantac, given the ruling we have 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 interest 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're all focused on delivering against all of these short, medium and long term. With our current momentum and the continued progress we're 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 79% and core operating profit growth of 11% to 13% for the short-term shift in mix that the team will comment on. For 2026, we continue to

expect more than 7% sales growth and more than 11% core operating profit growth on a 5-year CAGR basis. Until 2031, we continue to expect sales of more than GBP 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'm now going to hand over to Tony to talk you through our R&D progress in more detail.

Tony Wood Executive

Thank you, Emma, and welcome, everybody.

Next slide, please. 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 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 as well. We strengthened our respiratory pipeline with the acquisition of Aiolos Bio for their 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 2 new technology platforms the acquisition of Elsie Biotechnologies, which will help accelerate our oligonucleotide program and an agreement with Ochre Bio that will create foundational liver biology data sets deepening our understanding of disease and improving target identification. In all, we've advanced the pipeline across all our core therapeutic areas.

And importantly, we're on track with the development of the 12 scale product opportunities as well as Blenrep that we highlighted at the start of the year. These all have the potential to deliver profitable growth in the 2026 to '31 time frame and to support our 2031 ambition of more than GBP 38 billion in sales. I'll now take a closer look at a few important areas.

Next slide, please. 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 all adults aged 75 and over.

And for adults aged 60 to 74 who had increased risk from severe RSV disease. The committee unexpectedly postponed a vote in adults aged 50 to 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 and 004, assessing efficacy, immunogenicity and safety of Arexvy over 3 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 that this uniquely adjuvanted vaccine offers against RSV. Later this year, we're also looking forward to sharing more from trials in adults aged 18 to 49 who are at increased risk from RSV disease.

Next slide, please. Next, a comment on the interesting data for Shingrix. So 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 a reduced risk of dementia. Our study was prompted by a number of observations, some of which are summarized on this slide.

There's 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 data set, 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 suggests that after 3 years, Shingrix was associated with a 27% reduced risk of acquiring dementia when compared with the competitors zoster vaccination and a 24% reduced risk of dementia when compared to the Comparator pneumococcal vaccine. The potential relationship between shingles prevention and risk of neurodegeneration is an area of increasing interest to the scientific community.

These are interesting early results, which we are investigating with additional retrospective and mechanistic studies. Next slide, please. Turning now 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 engineer 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 2 weeks. This quarter, we announced the 2 pivotal Phase III trials in severe asthma with an eosinophil phenotype SWIFT-1 and SWIFT-2 met their primary endpoints demonstrating that 2 doses of depemokimab administered over a 12-month period showed a statistically significant and clinically meaningful reduction in significant exacerbations versus placebo in combination with standard of care. We're 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 program is being informed by predictive biomarkers and phenotyping, which has enabled us to progress 4 clinical indications in parallel. The pivotal ANCHOR-1 and 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 the use of Nucala and COPD this year and Phase III data for camlipixant in the treatment of refractory chronic cough in 2025. Next slide, please. You'll shortly hear from Deborah on the important advances in our HIV pipeline. So I'll conclude with a brief summary of the strong progress we've made within the oncology portfolio during the first half. We're 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 are pleased that EMA recently accepted our first filing for this indication. Additional filings are planned before the end of the year. Also stated the recent mid the management event, we plan to start a Phase III trial in the first-line setting in early 2025. For Jemperli, recent data from the RUBY trial demonstrated a statistically significant overall survival benefit in an all-comer population with primary advanced or recurrent endometrial cancer.

Jemperli is the only immuno-oncology agent to demonstrate a survival benefit in this patient population. These data have been filed with the FDA, and we anticipate a response ahead of the 23rd of August PDUFA date. Carefully targeted Phase III trials investigating these in 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 indication trial starts, including GALAXIES-301 and a Phase III trial investigating our TIGIT antibody, belrestotug, in combination with Jemperli in the treatment of first-line PD-L1 high non-small cell lung cancer. The glio-focused 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're pleased to announce the recent Japanese approval of Ojjaara with a line-agnostic label for all patients with myelofibrosis. So in summary, a productive first 6 months to 2024. I'm pleased with the progress we're making to deliver differentiated health impact for people and patients. And I'll now hand over to Luke.

Luke Miels Executive

Thanks, Tony. Please turn to the next slide. In Q2, we delivered growth across all our product areas and regions with GBP 7.9 billion of sales, up 13% versus last year, excluding private solutions. This includes another strong performance in the U.S. with growth of 17%.

Please turn to Slide 17. Vaccines 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 GBP 832 million. Outside the U.S., 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 a source of future growth for this vaccine. Q2 growth was driven by a national immunization program in Australia, expanded European public funding and supplied to China. Supply phasing to China is now expected to be delivered evenly across the second half with 40% of our grid full year supply delivered to date. In the U.S., sales decreased by 36% in the quarter due to 3 factors: the first channel inventory reductions; and secondly, important changes in retail vaccine prioritization in part due to a transition to a new CMS rule effective the 1st of January '24 that changed how pharmacies process reimbursements and payers. These 2 short-term effects are not expected to repeat in the second half of this year.

And 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 '23 based on latest census data. We've more than 70 million adults that are still unvaccinated and recommended to receive our vaccine. We're focusing our resources and marketing content on targeting these eligible potential patients. Our expectation continues to be that Shingrix' global sales will grow this year and reach more than GBP 4 billion by 2026 driven by growth outside the U.S.

Turning to RSV. Nearly 8 million people have been vaccinated with Arexvy since launch, and we are maintaining around 2/3 of the retail vaccination share. As expected, demand levels were lower in Q2 due to seasonality. Ahead of the 2024, '25 RSV season, we're well positioned in 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 U.S.

And following the ACIP recommendation, we received a universal recommendation in 75-plus roads, but now expect minimal sales in the 50 to 59 age group this year with further potential impact in those age 60 to 74 years. Preparation for launches in Europe and international are underway for 2025 and beyond with the best-in-class data profile, we're confident Arexvy will return to growth next year and longer term can achieve more than GBP 3 billion in peak year sales. The meningitis Q2 sales for Bexsero and Menveo were up 23% and 30%, respectively. Bexsero continues to demonstrate strong growth, benefiting from favorable pricing in the U.S., recommendation in Germany and increased demand from Australian immunization programs. Menveo grew due to favorable delivery timing in international markets and U.S.

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 expectation with a tough comparative for Arexvy and U.S. Shingrix in the second half, we now anticipate vaccine sales in the full year to increase by low to mid single-digit percent. Our increased 2026 CAGR outlook for vaccines of low double digits has not changed. Next slide, please.

In specialty medicines, including HIV, which Deborah will cover next, we had a very strong quarter and increased sales by 22%, excluding COVID solutions. And our expectations for the year, I'm pleased to say have increased. Nucala was up 17%, driven by higher patient demand for treatments addressing a Eosinophilic-lead disease market expansion and increased buyer penetration. Benlysta was up 20% in the quarter driven by buyer penetration growth from

early intervention in SLE and lupus nephritis. We're also seeing growing demand in the U.S.

and continued consecutive double-digit growth outside the U.S. In oncology, sales again more than doubled in the quarter. In hematology, we're continuing to see a strong update for Ojjaara, which launched in the U.S. last year and in the U.K. and Germany in Q1.

In gynecological cancers, continued momentum was primarily driven by sales in the U.S., Germany, France and the U.K. in the first line dMMR/MSI high 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 shippers, which will drive future growth. Zejula's growth continued in Q2, driven by the U.S. and volume growth globally.

As a reminder, for the next quarter, we will not benefit from the stocking of -- or the switch to the new tablet formulation as seen in Q3 '23. Given the 21% sales growth in the first half, we're increasing our full year expectations, and we now expect Specialty Medicines to grow mid- to high-teen percent with the second half growth being lower due to tougher comparisons in oncology. Please turn to Slide 19. Focusing on Nucala for a moment. The chart on the left of this slide demonstrates Nucala's continued leadership in IL-5 market share and pleased to say that Nucala continues to grow by double digits quarter-on-quarter, despite being on the market for almost 9 years.

We anticipate our IL-5 portfolio comprising depemokimab and Nucala to deliver more than GBP 4 billion in peak year sales. Next, looking at Ojjaara. We're still seeing the fastest U.S. launch uptake in value for a JAK inhibitor in myelofibrosis. The only treatment to demonstrate clinical and durable benefit on spleen response symptoms and anemia for myofibrosis patients with anemia.

We're finding anemia burden to be increasingly at the forefront of treatment decisions. We continue to improve our market share. 65% of U.S. and EU healthcare professionals expect to increase prescribing Ojjaara in the next 6 months.

Please turn to Slide 20. Finally, General Medicines grew by 12% in Q2, reflecting a record quarter for Trelegy, with sales increasing 41% to GBP 842 million. Around half the growth was driven by channel and segment mix as well as adjustments to returns and rebates, which were expected to moderate in Half 2. Trelegy also benefited 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 U.S.

had expected to impact branded versions of ADVAIR , Flovent and LAMICTAL. However, increased use of authorized 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 percent for the full year. I'll now hand over to Deborah to cover HIV.

Deborah Waterhouse Executive

Thank you, Luke. Next slide, please. We're pleased to see continued strong performance and 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 2 percentage points in global market share versus Q2 2023. Our oral 2-drug regimens and long-acting injectables continue to transform the HIV marketplace.

Dovato delivered sales of GBP 551 million in 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 randomized 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. [CASM] LATITUDE data presented at CROI and data from real-world cohorts that include over 10,000 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 and 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 0 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 10x larger than the PrEP market at about GBP 20 billion, which will have a significant impact on the sales potential for long-acting options. In the long-acting inject for 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 integrated inhibitor, VH184, demonstrating strong efficacy and a unique resistance profile.

Building on our strong legacy of developing powerful integrated inhibitors, these positive findings reinforce that integrated 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've selected rilpivirine as a 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 4 monthly treatment regimen in 2027 and 4 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 6-month dosing towards the end of the decade. Our strong

performance over the first half gives us confidence to increase our guidance to low double-digit percentage growth in 2024.

With that, I will hand to Julie.

Julie Brown Executive

Thank you, Deborah, and good afternoon, everyone. Next slide, please. 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 GBP 1.6 billion, predominantly reflecting charges arising from the CCLs, primarily due to improved longer-term prospects of our HIV business and less favorable foreign currency movements.

Next slide, please. Moving to the core operating margin. This increased 190 basis points to 31.9% year-on-year, excluding COVID. This reflected cost discipline the drive of 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 favorable impact relating to the Zejula Royalty dispute.

Next slide, please. Cash generated from operations in the first half was GBP 2.8 billion, representing an improvement of GBP 0.9 billion versus Half 1 last year. This was primarily driven by core operating profit growth and favorable working capital with the latter benefiting from higher receivable collections. Free cash flow was GBP 0.6 billion relative to an outflow last year, and therefore, improving year-on-year by almost GBP 1 billion. 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 vaccine business.

Next slide, please. Slide 26 shares our net debt position since the 31st of December and how we've actively deployed capital in the business in line with our capital allocation framework. Net debt was GBP 1.1 billion lower compared to the end of 2023 at GBP 14 billion, and this included the monetization of our remaining stake in Heleon. We have a strong balance sheet to support continued investment in future growth, including business development as we look to deploy funds to enhance growth and deliver attractive shareholder returns. And now with that, I'll turn to our latest full year expectations.

Next slide, please. 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 Specialty Care and

General Medicines more than offset our lower expectations for vaccines this year. In abrogate, for full year 2024, we now expect group sales to increase between 7% and 9% and core operating profit to increase between 11% and 13%, notwithstanding the loss of Gardasil royalties which will reduce profit growth this year by 6 percentage points.

Turning to the P&L. The gross margin 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 low single-digit percentage and we now expect R&D spend to increase slightly below sales growth and royalties for the year to be around GBP 600 million. Core EPS is expected to grow 10% to 12% due to an increase in the 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 the initial stock builds. In addition, Gardasil was stronger in Half 2 last year, 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 of our medium and longer-term outlooks.

Next slide, please. Turning to our IR road map, 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 aspirin patients with a eosinophilic phenotype.

Second, the Phase III data 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.

Emma Walmsley Executive

Thanks, Julie. So to summarize, 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're 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're confident in delivering our growth commitments and we continue to progress with development of meaningful innovation in our core therapy areas.

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

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

Nick Stone Executive

Thanks, Emma. We're going to take our first question from Peter Verdult of Citi.

Peter Verdult Analyst

Peter Verdult, Citi. Two questions, please. Just firstly, Emma and Luke, I'm sure you're 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 firstly, what you're seeing in China, when you think realistically you can return U.S.

Shingrix to growth I realize that's sort of a difficult question to answer, but I'll try. And then lastly, how are you feeling about the contracting for 2024 U.S. RSV in both the retail and non-retail channels? And then a very different and quick question for Tony. Just can you remind us why GSK still has enthusiasm for the TIGIT mechanism in light of disappointing competitor data sets?

Is there any differentiation that you want to call out on EOS-448?

Emma Walmsley Executive

Thanks very much, Peter. Well, let's go to look on all 3 of those. I just would refer you back to his introduction earlier today, we -- the update has shown some short-term impacts on our vaccines portfolio. But we remain very confident in our medium-term outlook and the strength of our products today and their prospects as well as the pipeline that continues to develop in vaccines. But Luke, both on China, U.S.

Shingrix, and I know great confidence in the contracting for the season.

Luke Miels Executive

Thanks, Peter, and I suspect you're not Robinson Crusoe with these questions. So I'll spend a bit of time on it. I mean, firstly, on contracting, very happy. Based on what we can see, we will retain market leadership. We're on track to be a blockbuster.

We can cover ACIP a little bit later on. But yes, I think we're very happy with the work that's been done by the team on the ground there. In terms of vaccines in China, Look, I mean, I think at a macro level, we're extremely happy with the partnership we've 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've already expanded from 6,000 points of vaccination that we were covering. They've already hit 19,000 and are on track for around 27,000 by the end of the year. So scale of that company and the impact that they can bring to -- for Shingrix in China is clear.

Now in terms of broader vaccine demand, we did see some softness in servers, but it's confounded by the fact that we moved resources off the product as well. We do hear some signs that some of the local CDC do have tighter budgets. And this is something we're going to watch very, very closely. But for us, the key here is that Shingrix is at a very different point

in the life cycle to HPV vaccines. We're just getting started here.

So we've got the best possible partner. We'll build the opportunity. If you look at the opportunity, it's very similar to the U.S. When you look at people in China that can pay out of pocket and that are in key cities. So the numbers are very large, but we need to build that.

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

If we get on to the U.S. and Shingrix growth I mean basically for the full year in Shingrix, we're 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 3 factors. And the first 2, let me be really clear, these are half 1 dynamics. So we've moved through them.

The first one is wholesaler, as I said in my earlier comments, that delta is about 300,000 doses. So we finished quarter 4 '23 with 700,000 in the wholesaler and that's typically what we like. As I've said on previous calls, in Q2, it went down to around 400,000. So that was -- that's something though that we expect to be rebuilt as we go into the flu season. The second factor was CMS rule changes covering direct and indirect remuneration on DIR fees.

And just as background, these are basically discounts pharmacies pay Medicare PBMs and plans spotters certain quality measures are not met. And the -- the complication has been historically the PBMs can request these retroactively for up to 6 months from the point of sale. So that's obviously a complication for the pharmacy and the pharmacy group. The new rule that was brought in remove retroactive -- the retroactive part. So basically, at the point of sale, all of these components had to be booked and visible.

And what that meant was for the 6 months, so from January to June, there was just less incentives for pharmacies to vaccinate patients. And we saw them shifting volumes between different types of vaccines to offset that. We've now moved into the second half of the year. We look at market research, tracking, et cetera. TRx trends adjusting for 4th of 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're looking at 65 plus, it's 88%. So that's the same as last year. 60 to 64 is 80%.

So again, same as last year, 50% to 59% is around 50%. So that's all where it was. If we look at patient engagement, that's also holding overall, but that leads to the third factor, and this is something I've mentioned on previous calls. As we penetrate this population. And if you look at the rate that we've penetrated with Shingrix, is double the rate of PCV.

So we've got there in 7 years, what it took PCV vaccine to get there in '14. But as I said before, the most motivated people obviously sort out the vaccine, and we've been able to penetrate those populations to a very high degree. In our #1 segment, we're 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.

So we will be looking at patients which are resident in other specialties, we're looking at COVID, we're looking at comorbid ways that we can stop leakage some account management work that we're doing as well. And then we're just really changing our marketing mix to focus on segments who on top to activate. So that's the plan. And if you put all this together, basically, we'll expect some growth in half 2. But again, we're at this evolution of really looking outside the U.S.

to Europe, Japan, Australia and China for our growth. And then ultimately, once we've moved through those cohorts, we'll get to emerging markets as we've covered on previous calls. Long story short, we can never get this and we remain confident that we could hit our GBP 4 billion target with Shingrix in 2026. So a long answer, but hopefully, that is helpful to everyone else.

Emma Walmsley Executive

Great. Thanks very much, Luke. I really want to reiterate that confidence in the broader vaccines portfolio and the maintenance of our 26 CAGRs and excitement to the pipeline ahead. but we do see the growth coming ex U.S. on Shingrix, but the decline in the U.S.

to moderate. And I would just point out Luke's presentation, that in the U.S., we absorbed about 36% decline on Shingrix and delivered whilst digesting that 17% growth in our largest country in the world. So Tony and TIGIT.

Tony Wood Executive

Yes. Thanks for the question, Peter. Your quick answer, might get a slight -- sorry, your quick question might get a slightly longer answer if you forgive in. And just to remind you, we've said our focus in oncology is very much on hematological and gynecologic book answers, and we said we'll invest outside of that in a gated way. when we see data that suggests transformational opportunities.

So with that in mind and TIGIT, what have we seen, what are we doing about it? And why do we think it's happening. So what have we seen in our Galaxy's 201 platform study, and this is with 120 patients, so a larger patient population than the initial data from the cityscape valuation of similar mechanisms. What we see is similar overall response rates, but a speed and quality of response that is differentiated from those observed previously. You'll hear more about that when we present on these preliminary data at the end of the year.

So I'll pause on that at this point. What we're doing with that data now is moving into the GALAXIES-301 Phase III study. And an important thing to bear in mind about the characteristics of that study. First of all, it's in combination with Jemperli, we're learning there from what we've seen in the PERLA lung study. It's also in a carefully biomarker-selected population, and it is with EOS-448 or by rest of those of you who haven't connected the 2 together.

What we expect to see as a consequence of it -- as a consequence of the differential profile for EOS-448. It's an IgG1 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 tumor microbe environment augmenting immunity. And also, it induces something

called ADCC, which is antibody-directed cellular cytotoxicity and that results in the killing of T regulatory cells, which are immunosuppressive in the tumor environment. We've seen that latter feature of depletion, both preclinically and clinically.

So in short differentiated data moving forward in a gated Phase III study in designed based on what we've learned from PERLA, with a molecule that we think has differential characteristics.

Emma Walmsley Executive

So more to see at the end of the year and a strong focus on making those decisions.

Nick Stone Executive

Okay. So we're going to go to Jefferies and take our next question from Peter Welford.

Peter Welford Analyst

Sorry but I want to come back to the vaccines. Can we just come back to a AREXVY for a minute and just understand, Luke, particularly on the contracting. I understand that you're very confident with the market, the intros, the share of retail, but there are 2 things, I guess. So you can you just talk about the appetite and what you've had here on contracting discussions insofar as, I mean, maybe you can talk about the extensive vaccination we've seen in that 75-plus cohort about the motivation you see in that group for greater incentive year-on-year, perhaps for those to come in versus, on the other hand, the lower obviously age where there's less of a strong recommendation. And equally, if you could just talk a little bit about then the non-retail segment.

What you're 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 the 75-plus year olds?

Emma Walmsley Executive

Thanks, Peter. So Luke, AREXVY?

Luke Miels Executive

Peter, maybe what I'll do is I'll talk through. I mean the key thing is we are confident with the AREXVY in terms of the long-term ambition of 3 billion. And you're right. I mean the G&A set was positive for 75 plus. And if you look at our immunization rate in 2023, of that population, which our numbers, that's about 26 million.

Under shared clinical decision-making, we achieved an immunization rate of around 18% overall -- all products. If you look at the 60 to 74 with ACIP, there's no way you can escape that as a negative for the class, right? We have to be realistic there. But there is some lining to the cloud, some silver lining to the cloud when we break that population down. So if you look at 60 to 74 under shed clinical decision-making in '23, the amortization of rates 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 high-risk complications, what -- is it diabetes? Or is it advanced diabetes? So it's a bit difficult. But if we just -- along the lines that you were talking about if we

just look at people with other complications in that 60 to 74 group. It's a similar number, it's about 26 million.

And if you look at the immunization rate that was under share clinical decision-making for the 60 to 74 population last year, it was about 16%. If you look then a little bit more tightly at the 65 to 74 at increased risk, it was actually higher, it was 19.5%. So I assume that's because we're a bit more mobile, easy to reach in the pharmacy versus care homes, et cetera. So there's clearly in that population areas 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 to 74 population at around 15% in the 65 to 75 cost of slightly more narrowly. So yes, I think there's going to be more momentum for 75, but you've taken a big chunk of people out in the 60 to 74. And what we don't know is the reaction of physicians with ACIP changes, whether they're going to withhold recommendation in some populations. So it's difficult to project. Obviously, Q3 is going to be a key.

And our intention is to maximize AREXVY there. We've been very, very deliberate with this product. It has been positioned from day 1 for high-risk individuals. So -- and then when you look at PCP preference and patient preference, that'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 1 you'd give you on -- and our plan is to go back, feel free to add, Tony, is to go back to ACIP with 50 to 59 data with the updated benefit risk safety data and GBS and also when we've got the full package, the 3-year data.

Emma Walmsley Executive

Tony, do you want to add?

Tony Wood Executive

Look, let me just pick up on one point of that because I suspect we're going to deal with more questions around -- as -- but just to underscore the point in the populations that detailed. We have a very strong data set, for example, in the 79-year-old, so that was a 94% vaccine efficacy in the first season and 75% across 2 seasons. See that also with A versus B coverage. So we're confident in the strength of our data and our continuing ability to add to that data centers we accrue more and sales because I'm sure we'll get more questions.

Emma Walmsley Executive

Luke, anything you want to add on the retail channel?

Luke Miels Executive

Yes. Yes. I mean historically, it's around 85%. We don't see that as changing. When you look at market research, why -- and we've obviously looked at this a lot.

-- when we show this change in Shingrix with the removal of the co-pay. And when you look at patients' reasons for going to the pharmacy, from memory, it's like 58% of them site that the process is easier, the physician prepares to do that. There's greater certainty around coverage and out-of-pocket costs. So we think that structurally will remain the same. As Tony

said, we'll be back in with the 50 to 59.

But I think ACIP is going to be very conservative about broader coverage until they've got complete clarity in terms of benefit risk. And I think that's important in the non-retail segment.

Unknown Executive Executive

Yes. And it's probably just worthwhile underscoring the 50 to 59 that we see no change in bettors proposition for the vaccine relative to season 1 in that population or indeed in the broader group.

Emma Walmsley Executive

All right. Thank you. Next question please.

Nick Stone Executive

Okay. So we're going to go to JPMorgan and James Gordon.

James Gordon Analyst

James Gordon, JPMorgan I'll stick with the vaccines team. My first question was just the vaccines guide for '24. So you know it quite significantly today. I think it's about GBP 700 million is the difference. So the question how much of the downgrades are actually being lower versus Shingrix?

Am I working out right that it looks like the guidance roughly has actually being about flat at only in the second year in the market or even not growing maybe even be slightly down or if I miscalculated that? And the other question was just AREXVY and revaccination. So we saw the 2-year revaccination in antibody titer data at ACIP. And the ACIP panelist was a bit cautious on the data, and I think I had a comment now that you're going to share some more data in the coming months. So is that the NOI clinical trial and show the waning of protection.

So are we going to in the next couple of months have all the data that relates to whether you can get this 2-year revaccination interval. And what is your confidence in getting that now we've seen some more data.

Emma Walmsley Executive

Great. Thanks, James. Well, I'll come to Julie first to give you the building blocks of the guidance of the year, remembering we are annualizing against the launch. And then Tony will come to you on data and back.

Julie Brown Executive

Thanks, Emma. Yes, so in terms of the overall position with the second half, -- you probably recall the very strong vaccine performance that we had in half 2. And the change in the guidance overall to the 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. So you'll probably recall that in Q3, we mentioned we got [2 cents] of the sales, we're actually 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 probably recall our growth rates in vaccines last year were 33% and 34% in Q3 and Q4. So this is the headwind that we face now going into this period. And I think Luke summarized it very well just in terms of the exact guidelines in terms of what they actually mean in terms of people at risk of whether it's a normal diabetic that whether it's always complications will make a big difference in the second half performance.

Emma Walmsley Executive

Great. Thanks, Julie. And just to reiterate that RSV update is purely related to ACIP nothing competitive. And as Luke said earlier, we'll be looking forward to being back to great growth in -- in '25 and confident in the long-term prospects of this vaccine. Tony, do you want to talk about the -- the data to come back this time?

Tony Wood Executive

Yes, yes, sure. And James, just quickly double up for the immuno study, but I want to describe this in the context of the entire data set since that's really the important aspect with regards to food to revaccination. We've said we have 006, which is the vaccine efficacy study, 004 the immunogenicity study and the study is looking at immunogenicity, which we started, for example, in the immunocompromised population. A decision on revaccination will depend on the trends in vaccine efficacy and the ability to boost 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'd say rather than making guesses given that we're only a few months away from the whole data package that we will be presenting at ACIP, so we wait for that. And what things stress, though, within that, for me, is what we're learning for as is a greater focus on benefit risk, and therefore, the importance, for example, offered by a longer duration vaccine, both with regards to great value and benefit risk.

Emma Walmsley Executive

Thanks, Tony. Next question please.

Nick Stone Executive

Okay. I'm going to take our next question from Richard Parkes, BNP Paribas.

Richard Parkes Analyst

Nick. So I've got one on Vaccines, one on Gen Med. On Gen Med, obviously, performance has been strong. I know that's partly driven by a strong strategy demand, but also better navigation of the AMP Cap removal. So can you just talk about how much of that performance is sustainable into 2025 versus turning to a headwind, and I'm thinking about things like stocking for authorized generics, et cetera.

So just thinking about Gen Med performance into 2025. Then secondly, just to push on Rx fee a little bit more. Could you help us just understand how much true visibility you've got on likely

second half demand based on the contracting? And I'm just trying to compare it to maybe the flu vaccine market, where generally it feels like people have got good visibility there. Obviously, with the ACIP panel recommendation happening only recently, it might take some time for retailers to digest that and predict the demand.

And obviously, that could work both ways, either additional orders for you and upside or downside through returns. So could you just talk about your visibility and where the risks lie, either to the upside or downside for RSV and guidance.

Emma Walmsley Executive

All right. Well, 2 more questions for Luke although we will guide on '25 in '25. And -- and there's no change to our midterm CAGR for Gen Med's obviously a great performance there. So Luke, you want to start with that about?

Luke Miels Executive

Yes. And thanks, Richard. Look, I think a lot of it is really a one-off effect sort of authorized generics and I'm pleased to say that we were more successful than we're expecting in terms of being able to capture those patients as they came on ADVAIR and FLOVENT. With LAMICTAL, we just took a price hit and that was very sizable. We did that because we didn't want to disrupt those patients.

So the underlying growth is lower, and it's very much along the language we used in the past with General Medicines over the longer term. I mean Trelegy itself continues to grow very strongly. But of course, it did that outside the U.S. as well. I mean, Japan was up 29%, China, 26% and the EU was up 15%.

So this is an excellent medicine. It's one that we're going to continue to back. We had 10 recent presentations, publications. So there's a lot of momentum there. But yes, again, we'll start to lap that -- those components of shifting and the movement with authorized generics in the second half of this year and '25, I won't comment on.

In terms of clarity, I mean, the key difference structurally is with flu, we do a lot of pre-booking because there's a manufacturing cycle, it's a new product every year. It's definitely softer this year. If we look at flu volumes. They were higher than normal in the first half in the U.S., but Southern Hemisphere was weak. So it's not a really good surrogate with -- with AREXVY, don't have guaranteed volumes.

We've got guaranteed percentage splits, which I won't go into, and that's why I'm quite happy about where we landed. And I think the other factor is pricing. You've got 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.

Nick Stone Executive

We're going to come to Graham Parry at Bank of America.

Graham Parry Analyst

Sorry, it's more on Vaccines. But whether actually, you said about having U.S. market

leadership in the second half on volumes, and you said you sort of have a good idea of split. So can you help us understand, I think up to this point, you've been 2/3 of the volume for this season, Pfizer started contracting a bit earlier, you've had Moderna into the market. So is 2/3 what you'd be aiming for?

Or should we be just thinking about having the majority of the market even? Or is it less than that? And then secondly, on your peak sales of GBP 3 billion and return to growth in 2025, does that assume that you are going to have some sort of best regimen in there can you get there by just rolling out globally? And if you could help us understand on the boosters with the season 3 vaccine efficacy data for a single dose that you're expecting in the second half? I think your modeling data on the all-comers population has suggested that the single administration could drop to around 40% in season 3, which would certainly warrant a booster, but in the populations you're now recommended for the over 75s and the comorbid.

It looks like those are much higher in the 70s in season -- across season 1 and 2. So do you have any sort of predictive modeling data of where vaccine efficacy on those target populations might drop to that would perhaps allow for best to be recommended?

Emma Walmsley Executive

So Luke, and then we'll come to Tony on basic.

Luke Miels Executive

Sure. 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 multiplied by price.

And that's something else that will be more visible in time to the aggregate revenue. In our forecast, we assume that a booster is required Tony, I'll hand over to you for the rest of that.

Tony Wood Executive

Yes. And look, Graham, I'd say at this stage, what I've done. It is really -- this is a matter of waiting and seeing. Otherwise, I'm drawing straight lines between 2 points to get an estimate of where season 3 is bearing in mind that the dynamics in season 1 and season 2 were very different. And as I mentioned earlier in answering Graham's question, and I think it's not just a combination of vaccine efficacy, but also the boost response to.

So we'll know more about that when we get ready for ACIP not COVID.

Nick Stone Executive

So we're going to take our next question from Tim Anderson at Wolfe Research.

Timothy Anderson Analyst

A non-vaccine question. which is an Zantac obviously, in our investors downstream of the Delaware ruling. I know Glaxo will say it will continue to depend itself it lots of studies in your paper, but in the theoretical event laxer to enter into a broad settlement to try to put all of 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?

Emma Walmsley Executive

Thanks, Tim. And as far we do absolutely recognize the impact this litigation has had on shareholders. And you're right, by I am going to start by reiterating the fact and the science here, which is total scientific consensus that there is absolutely no consistent or reliable evidence the initiating increases the risk of any cancer. And so we're going to continue to vigorously defend ourselves against all of the claims and manage the litigation in the best interest of the company and of shareholders. That's been our focus all the way along.

And we are confident that we have done so in the process. And 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 interest of shareholders and the company. And -- as I'm sure you know, there is obviously a limit towards I can say around this litigation since we need to respect the judicial process and protect the interest of the company.

Nick Stone Executive

Can we go to Mark Purcell at Morgan Stanley.

Mark Purcell Analyst

Just a few questions. Firstly, on China and vaccines, are you seeing much in the way of emerging domestic competition I think CHT has a shingles vaccine, for example. And in that respect, what's the appetite from [indiscernible] to extend the agreement to AREXVY. On AREXVY business. It's been suggested that revaccination only achieves 45% to 65% of peak neutralization titers due to immune interference from the T4 fold on trimerization [T Lac] which is used by AREXVY and rise as well.

So I just wondered if it's the factor and if we've seen this sort of before. And the last one, in terms of Nucala, ahead of the COPD vaccinate data late Q3, Q4 I think, Tony, you've described the efficacy is likely to be in the low 20s in terms of reducing exacerbations. Sanofi CSPs a GBP 5 billion peak potential across its 2 assets. So I just wondered if you could help us understand how large the opportunity you see is for your IL-5 focused medicines?

Emma Walmsley Executive

Well, we'll come to look quickly on China. I mean, we point that's quite hard really on top to come up against Shingrix with an effective vaccine, and we've got 18% efficacy for 11 years. But -- and then we'll come to Tony on both the booster question and Nucala and the broader opportunities in COPD in the pipeline, please. Tony. So Luke first.

Luke Miels Executive

Yes. Thanks, Mark. I mean there is a local competitor to Shingrix. It's a company called [indiscernible]. It's a live attenuated vaccine.

So it's Zoster vaccine its license is 40-plus. But they get around 1/4 of the volume at this point. But again, these are very different patients, the ones that we're targeting. We're targeting high out-of-pocket tolerance, willingness to pay population, which is different. In terms of Japan rand relationship there, as I said earlier, it's excellence.

It's a strategic long-term relationship. And 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 Executive

Yes. Thanks, Mark. Just quickly then 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 there's no evidence of interference.

What is a much more likely and common explanation for the boost is the relative waning in the vaccine efficacy in the first instance and it's generally understood that the greater the waning of efficacy or greater the boost. So you'll see more on the folding question when we disclose those data. In terms of COPD and IL-5 and -- let's just start by putting your comment with regards to dupilumab versus that into context, sorry, you color into context. I've mentioned this in the past, and I appreciate there's a lot of sort of comparative numbers flat -- floating around. What's important is, I said, based on the patient population that we've targeted in our Phase III study in [MaaT NA], which is a broader population and includes and for seeming patients.

These represent about 30% of the COPD population, so a significant proportion of the 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've seen in the past, that's where my prediction for sort of mid-20s, low to mid-20s percent for [MaaT NA] comes from. It is not a reflection of relative efficacies of the 2 molecules. What we -- what both matters are showing is that there is a significant response for those with COPD and high yield counts in this instance, in particular, over 300 caps.

We're very well placed in the COPD arena and evaluation of not just IL-5 but the mechanisms. I would point to, first of all, of course, we're looking forward to the progressing on epi with once every 6-month dosing. That is a significant advantage in COPD, even greater than it is in severe asthma. And in addition to that, T-slip offers a broader opportunity in the risk data from Amgen in COPD with that slippage and albeit with a much lower with a much more frequent dosing regimen, of course, [TEZI], suggests that we should also have opportunity there. I'll pause, but there are additional aspects of our COPD portfolio that I look forward to telling you about in the future.

Nick Stone Executive

We'll take the next question from Emily Field at Barclays.

Emily Field Analyst

I'll just ask 2 quick ones. One on ex-U.S. AREXVY, one of the things that Pfizer talked about

yesterday in terms of their ex U.S. contract wins was a desire to simplify the contracting between having one option for a turn on older adults. I know this year is mostly going to be U.S.

driven for AREXVY. But is that something that you see as an obstacle to ex-U.S. AREXVY. And then just on the HIV guidance, third year in a row of expecting double-digit growth in HIV. You have your CAGR target of 6% to 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?

Emma Walmsley Executive

Thank you. Well, let's get to Deborah first on HIV, and then we'll come back to get any further comments on Arexvy from Luke.

Deborah Waterhouse Executive

Yes. Thanks for the question, Emily. So I think in quarter 1 and actually reiterated on Friday when we did our update post the age conference. We are tracking towards the top of our guidance. As you say, we've had 3 years of double-digit growth.

Next year, we have the headwind of the IRA. We've stated very clearly that that's going to be around a GBP 200 million impact. And then obviously, we've set out very clearly in 2026, what we think the shape and the size of our portfolio is going to be. So we should be reaching GBP 7 billion if not slightly above, which is what we've kind of shared with you all in 2026. And then by 2027, obviously, we are moving into a world where we've got 40% of our portfolio in our -- in portfolio value and long acting.

So I think at the moment, everything that we've said '21 to '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, because obviously, we're having a very successful period with those medicines at the moment. So -- so no change in our guidance, but just I think your feeling or increased confidence because of the feedback we get from physicians and patients as to the impact that our long-acting medicines are having and the growing momentum for those medicines.

Emma Walmsley Executive

It's great to see the progress in the pipeline on you've been announcing just through into last week too. Yes. So Luke?

Luke Miels Executive

Thanks, Emily. The short answer is no. I mean, typically, the way the contracts and NIPs are constructed as they separate pediatric populations from adult populations and really what counts. And it's different to ACIP, of course, is the systems are willing to concentrate on single vaccines and separate them out more vigorously versus push them together. And so our approach is to really -- we have an excellent asset here in AREXVY.

What we want to see is the full profile, as Tony mentioned, we want to see what this product

looks like at 3 years because that is going to have a huge impact on pricing, durability, et cetera, which are all the things and particularly in European contracts that players concentrate on. So we're 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 a business based on that. And as I said before, the numbers are looking very good for AREXVY unless we have that, we will then move ahead and execute.

Nick Stone Executive

So given that we're coming up to about quarter past, I'm going to take one more question, so apologies for the 4 of you that didn't get to ask a question, but we're going to go to Simon Baker at Redburn Atalantic.

Simon Baker Analyst

I should respect from limit up to one question. It's on AREXVY, but it's one for Tony. In terms of the potential mechanism for lower incidence of dementia. I just wondered what thoughts you had on that. There's been some suggestion that it's an indirect effect caused by the vaccine suppressing reactivation of HSV 1 virus.

But any thoughts you got on why we're seeing this effect would be much appreciated.

Tony Wood Executive

Yes, Simon, I presume you mentioned AREXVY in that rather than AREXVY you know the story. Look, it's fair to say there's very little known here mechanistically. We're investing in further retrospective studies and mechanistic ones. Let me just try and 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. It's the science is better level, 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 that constant reactivation impacts microglial function. So there are a range -- and I haven't been comprehensive in that answer to avoid on spending too much time on it. It's fair to say there's a range of different mechanisms.

If you want to comprehensive summary actually, the Australian paper detailing the epidemiological retrospective outcomes has a really nice summary and it's concluding paragraph.

Emma Walmsley Executive

Thank you. I mean it's exciting science to explore still in early stages. In the meantime, this is a very effective vaccine with still a lot of opportunities to penetrate around the world. . So with that, Nick, as all asking, a big thank you to everyone.

We are really pleased with our Q2 performance and another upgrade to our outlook and even more looking forward to the ongoing progress in our pipeline and delivering on our short, medium and long-term ambitions. With thanks to everybody for joining us for the call. We

look forward to following up with you in coming days.