Novartis AG

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Richard Vosser Analyst

Welcome to the Novartis presentation at the 43rd JPMorgan Healthcare Conference. I'm Richard Vosser, European pharma analyst with JPMorgan. It's my great pleasure to introduce Vas Narasimhan, the CEO of Novartis. Before I hand over to Vas, I'd just remind you that there is a Q&A period after Vas's presentation. So you can either put up your hand or you can submit through the portal, and then we'll take your questions.

Vas, a great welcome to the conference.

Vasant Narasimhan Executive

Thank you. Thank you, Richard, and great to be with all of you as every January. I'm excited to give you an overview of where Novartis is this year, where we're headed, particularly from a pipeline standpoint and hopefully get some great insights and have a good dialogue with Richard.

Now I think as many of you who have followed us know, we've had quite a transformation over the last decade. Moving from a really diversified health care conglomerate to a pure-play company, along the way creating really out of 1 company, 4 excellent companies, Haleon Consumer Health with GSK; Alcon, a leading medical device company; Sandoz, a leading generics company; and now today 100% focused Novartis. And along that journey, what I think is often lost is the strong underlying performance we've had within our Innovative Medicines business.

When you look at it over that period, our Innovative Medicines sales has grown 7%. Our core op inc has grown 14%. Our margin is up 990 basis points on our way to our goal of a 40%-plus core margin. So we've been able to -- while making all of these transformations,

redesigning our company, continuing to build on the core strength of Novartis, which is our Innovative Medicines business.

Now along the way as well, we've really generated a tremendous machine or created a tremendous machine for cash flow generation. When you look at the chart here, you can see that we have already surpassed the cash flow in the first 3 quarters of this year that we had in 2020 when we had Alcon and Sandoz. So we're well on our way to a $15 billion-plus free cash flow, hopefully quite a bit higher than that. That gives us tremendous flexibility to not only continue to have a strong and growing dividend in Swiss francs but continued share buybacks and regular M&A in BD. We have full flexibility, a strong balance sheet, and also an improving return on invested capital.

Our forecast suggested by the end of this 5-year period, we should be up in the upper quartile of invested capital -- return on invested capital amongst the peer set. So looking ahead, we remain committed to the strategy. We set out 4 core therapeutic areas, which I'll go through in more detail. Our technology platforms where we continue to invest in these advanced technology platforms, which we think will shape the industry 2030 and beyond. And a continued belief to be a leader outside the United States, Novartis, one of the largest, if not the largest pharma company outside the U.S.

and a growing presence within the U.S.

Now I want to come back to capital allocation. It's so important for a conference like JPMorgan. We have the capital and flexibility to both fully invest in our organic business. So we're fully open for M&A, BD&L, finding the right partnerships with the right companies to strengthen our pipeline and long-term growth profile with value-creating bolt-on deals or BD&L as appropriate, strong and growing dividend in Swiss francs. And I still get the question, we are not rebasing that dividend.

That dividend has not been rebased through Alcon, not rebased through Sandoz. So it's a growing dividend that has grown consistently over 28 years. And continued share buybacks where we still have $5.4 billion of share buybacks available ongoing right now and the firepower to do more as appropriate. Now when you look at the profile of the company today, I think some important points to highlight. One, we have 13 in-market blockbuster medicines, and importantly, 8 medicines that we believe can generate over $3 billion in peak sales, and I'll go through those in a bit more detail.

We have limited binary risk. Only 13% of our overall sales come from any 1 product. So that, of course, while we always have to deal with patent expiries, and I'm sure Richard and I will talk more about that, we're never heavily exposed and can grow through patent expiries as we have in the past, whether that was Diovan, Gleevec or other expiries. I mentioned our technology platforms. And then when you look at our growth profile outside the United States, in addition to wanting to grow that U.S.

business, we have a 20%-plus growth rate in China, now 1 of the top 3 companies in China. We're #1 in Germany and continue a very steady growth rate there. And slowly moving up the ranks in Japan, a market we think that is getting more and more attractive as reforms continue to happen there, and really now 1 of the top 3 or 4 companies in the Japanese

market. #1 outside the United States and working to be a bigger player in the U.S. over time.

Now in R&D, we've also made a lot of efforts to streamline and focus the portfolio with all of the changes that we've made. We've reduced our clinical stage pipeline by 40%, so 155 projects down to 94 projects, which allows us to increase the resources that we put on any one of the projects now that we prioritize. You can see a 50% increase over the last years on resources for project and development spend per project up 5%. That allows us to really accelerate those key projects, go deeper on key assets. And in addition to that, we make strategic investments, which I'll talk about in a bit more on data science, AI, technologies that we think could accelerate the portfolio over time.

And lastly, critical for our long-term success, and I'll talk about this in a few more times over the course of the day, is our technology platforms. In addition to being a 100-year leader in the world of small molecule chemistry, emerging and growing presence in biotherapeutics. We have a long-term commitment to RNA therapeutics, RLT cell therapies and gene therapies. Not easy treading, always many challenges to overcome. We continue to believe having a consistent focus on these areas will give us the ability to grow consistently for the decades to come.

Now when we guide for the long run, we have a very clear goal in our mind. We've guided to 5% CAGR, which I still need to convince Richard of but I will by the end of this conference. A 5% CAGR out to 2029 and then a mid-single-digit growth beyond, into the 2030s. This is driven both by derisked in-market brands. You can see them here on the chart as well as, I think, emerging set of growth brands that we have with recent approvals as well as emerging pipeline assets.

And this is really what I'll spend the rest of my time going through over the course of this presentation.

So let's start through 2029, where we've guided to that 5% and the 40% margin. When you look at the dynamics there, a lot of energy this year is going to be focused on this red bar, where we expect midyear this year, Entresto generics for forecasting purposes, Promacta and Tasigna, so these GXs will happen over the forecast period. We assume that, and we are very confident we'll be able to outgrow those based on a really robust set of in-market brands that you see in the middle box here, as well as a probabilized pipeline that if successful and unprobabilized also gives us the opportunity to outperform that 5% CAGR. And that's what we'll be hoping to demonstrate over the next 18 to 24 months. When you look at why we have that conviction, a lot of it is around our commercial execution.

We have some of the leaders here in the room, and they've done an absolutely outstanding job. We have Kisqali right now, 50% NBRx share is the leader in metastatic breast cancer. I can say now that based on the data that we have 3 months into our early breast cancer launch, we have a 52% NBRx so the market leader in early breast cancer. When you look at Cosentyx recent launch in HS, a 60% NBRx share. Pluvicto, steadily growing 35% post-taxane, setting us up well for the pre-taxane setting later this year.

And then in Scemblix, we don't have the first-line data yet but we're already at 50% NBRx in the third-line setting, and that gives us real confidence that this drug can reach that

significant $3 billion-plus potential that I've guided towards. And I mentioned the rankings that we have. China, we hope to get to #3 by this year, in Japan as well. So we have, I think, really that geographic diversity and consistency in performance. We did upgrade some of our peak guidances at the recent Meet the Management meeting that we had in London.

You can see in addition to Entresto and Cosentyx, Cosentyx $8 billion, Entresto $7 billion but that's been well studied, I think, by the market. Kesimpta now, we believe, can be a $6 billion brand in MS. Pluvicto, across all lines, a $5 billion-plus product. Scemblix, a $3 billion medicine. Kisqali now, given the trajectory that we're seeing in early breast cancer, we believe can be an $8 billion-plus medicine in the breast cancer setting.

Leqvio now took some time but that RNA therapeutics consistent approach to commitment to tackling cardiovascular disease with these RNA-based therapies, $4 billion-plus peak sales. And then Fabhalta across a range of more ultra-rare indications stacking up to a $3 billion medicine. This is all within our hands. It's our ability to execute and drive these launches. But based on everything we're seeing in our sales and our momentum in the markets, we're confident that we can get to these numbers.

But what I think is now most important for our story is the next 4 medicines, which will help us hopefully drive the growth into the 2030s and beyond. Remibrutinib, we do expect to get the approval this year in chronic spontaneous urticaria. We think this is an underestimated market. We think it's a best-in-class medicine, and as I'll show, has the opportunity to go into multiple other disease areas. OAV, which is our Zolgensma follow-on for adult -- children and young adults, positive Phase III readout.

We believe a multibillion dollar potential there. Pelacarsen, which is our medicine to tackle Lp(a) cardiovascular risk reduction, also an exciting opportunity. And then ianalumab, which is our anti-BAFF receptor antagonist, which has the ability to tackle a range of diseases both in autoimmune disease and in oncology, we think a significant potential there that if we can get the first win this year in Sjogren's, followed by some additional wins in '26 and '27, can stack into a very significant medicine.

We expect 15 submission-enabling readouts over the next few years on those core assets. I won't go through them all in detail. But I think after the middle part of this year, we're back into a space where we'll have pretty regular news flow on these late-stage assets. And alongside that, an emerging set of mid-stage assets, which I'll spend some time on in a moment. I did want to say a study -- a few comments on the recent readout of OAV-101.

This is our medicine, intrathecal gene therapy for spinal muscular atrophy. The study was designed versus placebo in children 2 years and up with a crossover at 52 weeks. We use the industry standard, HFMSE, which is the industry standard approach to actually measuring the efficacy in these patients. I mean, we are very pleased with the results on the primary endpoint. We think it shows really a robust medicine that has significant potential and can compete successfully with the orals and the intrathecal medicines that are out there today.

So we'll be excited to now move this into the regulatory filings and then hopefully get a launch going later this year. Now going to beyond 2029 because a lot of the questions around Novartis from certain parts of the investor community is how will we grow post-2031,

post-2032. I think it's an honor as a CEO sitting in 2025 to have to worry about 2032. But I think we have, we believe, the assets to actually enable us to do that successfully. Now here is a kind of snapshot of the 30 potential high-value NME assets that we have in our pipeline in Phase II/III or entering into Phase I.

Obviously, many of these will not work but we believe enough of them will work and be able to enable us to drive that mid-single-digit growth into the 2030s. And I think that's the real upside opportunity you have now investing in Novartis. And in fact, you have a very, I think, sure opportunity out to -- at 2030. And then you basically have the option to one of the most exciting pipelines in the industry. And I'd like to walk you through why that pipeline is so exciting.

So first, in immunology, you can see here we have 10 Phase II readouts in the next 5 years. I'd like to start with remibrutinib and building off of that CSU expected approval. We'll be moving into chronic inducible urticaria, another immune-related illness that we think also could be a bigger market than maybe realized. We're moving remibrutinib into HS and also into food allergy. So that will give us a nice portfolio.

And in addition, remibrutinib will later be in MS. Ianalumab, as I mentioned, Sjogren's but in lupus nephritis, SLE, HS, and systemic sclerosis. And we have a major effort ongoing in immune reset for cell therapy. So YTB is our rapid CAR-T therapy that takes 2 days in the manufacturing site. Our goal is to be vein-to-vein in 8 to 10 days.

And you can see here, we're now entering Phase II studies in a range of indications, both in immunology and as I'll allude to in a moment, also in neuroscience. So some really exciting things happening in the immunology space. And then early on, we -- earlier on in our portfolio, a big effort in bispecifics and T cell engagers to see, can we build on the success of current generation of antibodies in areas like atopic dermatitis. Very high bar but obviously, if we can get there, a significant opportunity. In cardiovascular, in addition to, of course, Entresto and Leqvio, we continue to have a consistent effort on siRNAs for long-acting approaches.

So we have follow-on medicines to pelacarsen in the clinic, multiple siRNA assets targeting various HMG-CoA reductase and related targets to really enable us to hopefully cover the full range of cardiovascular risk. In addition to those efforts on cardiovascular risk reduction, we've really built out a broad portfolio within renal disease, building on the back of the approval of Fabhalta in C3G in igaN. We shortly expect the approval of atrasentan in IgAN. We take Fabhalta into additional indications. And then you can see here a range of earlier efforts.

We think the opportunity in rare renal disease and more severe renal disease is substantial. And given that we now have a field force on the ground around the world, the opportunity to bring more and more medicines into that portfolio is very exciting. So we're very excited as well to learn on the biotech community what's out there to help us build out our renal portfolio. Now moving to neuroscience. Here, in addition to building on the long legacy we have in MS with Kesimpta, remibrutinib in MS, we also are now taking Fabhalta into myasthenia gravis to give another option for those patients, and as I mentioned, immune reset as well in this space.

So we have ongoing studies here in RMS, in PPMS, and in myasthenia gravis to see can you get immune reset in severe patients with these illnesses, hopefully get them to close to remission. In addition, we continue the long road, I would say, in trafficking gene therapies as well as siRNAs into the brand. I mentioned OAV-101 but we recently acquired a company Kate Biotherapeutics. Their gene therapies are targeting FSHD and DM1, so I think a good opportunity here to use gene therapies to tackle the various muscular dystrophies, hopefully with more success than the first generation assets that are out there. In addition, we made an acquisition last year as well to give us a lipid technology to allow us to traffic siRNAs into the brain.

So there's EDK060, Charcot-Marie-Tooth disease, a more prevalent disease maybe than is appreciated. These are all programs that if we're successful, we think, can get to the regulatory approval much faster, of course, because it's a huge unmet need, need for high efficacy therapies. So again an area of continued focus. We're going to stay really stay the long game here in gene therapies. And then lastly in oncology, where RLT has clearly been our major focus area.

And in this chart, what we tried to do is look at RLT from the perspective of the various tumor types where we want to lead. So in breast cancer, building off of Kisqali's leadership, a number of combination studies with Kisqali, but now we move into later-stage studies or into the clinic, FXX489, which is one of our RLTs targeting breast cancer. We have a number of other emerging RLTs, including a HER2 RLT, which we now move into the clinic in 2025. That's consistent with our approach, both to look at radioligand therapy for novel targets, which we think can only be addressed by RLT as well as targets that have been traditionally addressed by antibody drug conjugates, where we think we can get a better therapeutic index potentially with a radioligand therapy. Similarly, in prostate cancer, building on Pluvicto and mCRPC, mHSPC, we now move into our actinium-based PSMA program.

So we have 2 actinium-based PSMA programs, one rapidly moving into Phase III, one moving as well into the mid-stage studies. And then follow-on products -- follow-on projects beyond that, an AR degrader program and an EZH1/2. And then lastly, within this bottom category, a number of other solid tumor RLTs we're advancing rapidly into the clinic. You can see, again, FXX, GIZ, which is our folate receptor, and a number of others, DLL3, B7H3. We estimate we should have around 10 to 12 programs in the clinic in 2025, and then hopefully moving those rapidly through the pipeline so that they can launch towards the end of the decade.

So in order for all of this to happen, huge focus on R&D productivity. I mean, clearly, our industry needs to do more. AI might help but sometimes just getting the basic rights is going to help a lot. So we're working on a fast IND strategy. Also looking at where we can combine Phase IIa and Phase IIb.

Really working on enhanced operations, and I mentioned as well, AI enabling the pipeline. Now just to show you the scale that we have in each one of these advanced technology platforms, this is in a single chart showing you in xRNA, 7 clinical programs, 19 preclinical programs. Two manufacturing sites. We're the largest producer of RNA therapeutics in the world. Leqvio now trending to be over a $1 billion asset.

We think a $30 billion potential if we can really capitalize on siRNA from a market standpoint.

In RLT, 17 clinical stage programs, 18 preclinical programs. We now have 6 manufacturing sites. We are able to deliver on time in full over 99% of the doses that a patient needs for RLT anywhere in the globe. That includes from an East Coast site to California, from Italy to Japan.

We were able to deliver those doses on time to the doctor in less than 5 days consistently. That's taken us years to build up and I think gives us a significant advantage over any competitors that scale in the operational side of RLT. And lastly, in cell and gene therapy, as I mentioned, 11 clinical programs, 16 preclinical programs. Maybe underappreciated, one of the best gene therapy manufacturing capabilities in the world. Three sites, we think a huge opportunity as well in cell and gene therapy, including the immune reset.

Importantly, that manufacturing capability allows us to also be a leading CMO. We use many -- much of our excess capacity actually to support the biotech sector by enabling clinical stage production as well. So if any of you need that, you can certainly let us know. And then when you look at our activity now from a BD standpoint, I think last year, I read a report that we led the industry in the number of strategic deals. Now many of these are not the flashy M&A but it's really the deals that I think impacted people at this conference.

Over 30 strategic deals that we did over the last 2 years. You can see a lot of them in the preclinical and Phase I space. We're going to continue to do that. We think the best ideas are likely outside of our walls, so we need to be able to access that innovation to be successful. I did want to say a word, though I know it goes in and out of fashion.

We are the leader in ESG in our sector. We do it because it's the right thing to do. We're #1 in the Access to Medicines Index, industry leader in Sustainalytics. We're in the leaders group at MSCI. Regardless of how the winds change, we're just going to keep doing those things because it's the right thing to do for, I think, a large company that has a role to play on this planet.

So in closing, I think we present a very attractive opportunity for shareholders. Strategy is delivering results. We've got our clear strategy. We showed we could deliver 7% sales CAGR to 14% core op inc CAGR. Attractive growth profile in the midterm.

Really an exciting pipeline in the long run, which gives us confidence that we'll be able to grow well into the 2030s and really an industry leader and being a responsible company to support humanity around the world. So I'll stop there, and I look forward to having a discussion with Richard. Thank you very much.

Richard Vosser Analyst

Fantastic, Vas. Any questions in the room? Maybe we can start then on some of the growth drivers that you talked about. And maybe just high level, of those ones, which is the most important to contribute to that growth that you outlined to '29?

Vasant Narasimhan Executive

I think the one we have to get right is Kisqali. I mean, Kisqali has the opportunity to be one of, if not our biggest, I mean, think about Diovan was in that $7 billion to $8 billion range. But this is a medicine, $8 billion assumes, I think, a reasonable uptake in the node 0/node 1

population. If we were to go even higher, obviously, there's even more possibilities here. So getting Kisqali right is going to be probably the 1 thing we have to do and all signs are that we're in the right direction.

Richard Vosser Analyst

And in Kisqali, what are you seeing in the market? I mean, that NBRx is pretty spectacular after 3 months with an incumbent in the market. Maybe break it down by those node zeros as well. But how are you doing?

Vasant Narasimhan Executive

Richard, we don't have great data yet in terms of how the split is happening. But I think one of the things that helped was having an NCCN guideline recommendation across both the Stage II and Stage III patients at launch. And so that immediately, I think, gave a lot of energy. I think having a really strong position in the metastatic setting means all of those established physicians are naturally going to gravitate to Kisqali for the early breast cancer, so they're very, very comfortable with that. So I think we have a lot of things going our way.

And I think it's definitely exceeded our expectations in the early days. I mean, the hard work is still to come. We have the launches in Europe. We have the launches in other parts of the world. But I think all the early signs would suggest this is going to be a really great launch.

Richard Vosser Analyst

Any questions? And building on that franchise, that oncology franchise, obviously, that's got a relatively long patent life and a long runway for growth. But how do you think about the next stages within breast cancer but also wider in oncology?

Vasant Narasimhan Executive

Right now, it's on our minds to make sure that we have, both from a small molecule and as I mentioned, in an RLT standpoint, the ability to extend the breast cancer enterprise. So we do have entering the clinic, both the CDK2 and the CDK2/4. I don't yet know -- I mean, it's a high bar, I think Kisqali and Verzenio set a very high bar. And so it's not easy to beat. But nonetheless, I think it's important for patients that either progress or in certain settings where CDK2 or CDK2/4 might be better, need to have that option.

As I mentioned, a big effort in RLT, in breast cancer. We do see a lot of enthusiasm. Some of that is existing targets like HER2 and some of that is novel targets like FAP. But we'll see. And I think that could give us a whole other space where we continue to build on that strength in breast cancer.

And then, of course, we have -- often, we get the question on the degrader space. We do have partnerships to have the data generated with Kisqali in the degrader space as well.

Richard Vosser Analyst

Do you think if the degraders are successful, well, they're not first generation but the ones that are closest to market, does that have any impact on Kisqali? Or as the data you've generated, they're not trialed with Kisqali but the data you generated, do you think it has an

effect?

Vasant Narasimhan Executive

I don't think so. I mean, when you look at the history here, look at the PD-1 space, no matter which PD-1 people ultimately did their clinical trials with, physicians use KEYTRUDA. And so I think establishing Kisqali as the standard of care across these various segments of the breast cancer population means whoever anyone did their study with, the physician is going to want to combine the degrader that they're choosing with Kisqali is our view.

Richard Vosser Analyst

Makes sense. On RLTs, there was a very fast uptake of Pluvicto, and you've got demand outstripping supply to start with. Maybe you could talk about building that market and expanding it beyond some of the key centers.

Vasant Narasimhan Executive

I mean, that's really now the huge focus for us from a commercial standpoint. I mean, for Pluvicto now, the next inflection point will come, we expect, from the PSMA4 approval, which should triple the number of patients available. And then we should get the readout on PSMA addition at least on the RPFS later this year. But a lot of this now comes down to how can we move this from an academic and large hospital setting further and further into the community. We've learned a lot about that.

I mean, our teams are working very hard locally to figure that out. In some cases, that's building stronger referral networks to radiation oncology. In other cases, it's even just enabling community oncologists to be able to give RLT, which is not -- sounds complicated but actually is relatively straightforward to put into place in the clinic. And if you play the long game here, I mean, we're going to have this bumpy ride in the initial years. But the way I look at it is, can you get RLT, given the number of places where it could have a role, to be like chemo, right, where chemo is just given in the community?

If you play that game and you're willing to think long term, obviously, then post 2030, I would expect us to solve these issues. And then, of course, you'd have a big market ahead of you.

Richard Vosser Analyst

Do you think Actinium and alpha sort of accelerates that move into the community? Is it easier to give? Do you think that could...

Vasant Narasimhan Executive

I mean, I think on Actinium and I know -- and it's wonderful to see the explosion in biotech now in RLT, but I think it's important to note that with beta emitters, we have a lot of data, right, with Pluvicto and Lutathera around the world. A lot of clinical data, a lot of in-market data. I think we're learning now with Actinium because it is a higher energy nuclear particle, what is the right dosing frequency? What are the right tumor types? Where are we going to learn that in prostate cancer?

Actually, I think our lead asset on DLL3 is in Actinium as well. We have, with HER2, we're

looking both at lutetium and actinium. So I think we're going to figure out what the right settings are. But I think what will ultimately happen is you're going to have a mix of lutetium and beta and alpha emitters. And it's going to be dependent on the cancer setting.

It's going to depend on the patient type, and we're going to get more and more sophisticated in using these.

Richard Vosser Analyst

Radiation has been used upfront when it's delivered by beam radiation. Where do you think the setting -- best setting is for an RLT? I mean, you're moving -- traditionally, we start late and move forward. Do you think that it is in the earlier settings?

Vasant Narasimhan Executive

I mean, the science would suggest going earlier, you'll get a better response, right? When you -- I mean, just taking both with SSTR in the neuroendocrine tumor space or PSMA in the prostate cancer space, we know that earlier stage patients have higher rates of expression, and so you should get a deeper response. I think it's much more of the psychology of physicians we now have to tackle, where there is a tendency to want to reserve therapies that are perceived as very high-powered for later lines, right? And let's save this therapy. And I think we've got to convince physicians through data and education that going earlier in eradicating a tumor or at least knocking it down significantly is actually better for the patients in the long run.

Richard Vosser Analyst

Any questions in the room? I wanted to pivot to Kesimpta, one of the other assets where you increased the peak sales. The CD20s have just dominated, I would say, the multiple sclerosis or the RMS space. Is there any pressure from more competitors or more competitor data like Roche going into subcutaneous? How do you see that growth?

Vasant Narasimhan Executive

I mean, to date, I think any of the life cycle management that happens on physician administration or a physician/nurse administration that doesn't materially change steroid pretreatment and post-treatment monitoring has no effect on Kesimpta. I mean, that just seems now pretty clear to us that we have had a new entrant come in. We've had the leader come in and do various things to make -- go from a 6-hour infusion or 1-hour infusion. It doesn't seem to affect Kesimpta's strength. I mean, Kesimpta right now, NBRx in the U.S.

is 28% to 30%. Overall B-cell class of the overall MS market is trending towards 60%. As the B-cell market continues to take more and more away from the legacy BRACE therapies, I would expect Kesimpta to just grow with the market. We would love to get higher share, of course, but I think that gives us the momentum. And so we look at can we life cycle manage Kesimpta?

Can we get to less frequent dosing? Are there other things we might do? We do have remibrutinib in MS. I think let's see. I mean, I think the class has not done so well in RMS, as you know.

And then we have the immune reset as well as the other approach in MS along with it.

Richard Vosser Analyst

Maybe pivoting to the pipeline, and let's start with remi. It's maybe not the most important but it's probably quite derisked. How do you see the potential there and broadening out from the CSU data that we've seen?

Vasant Narasimhan Executive

So first, I think CSU, similar to what we've seen in areas like HS, will surprise people. I mean, I think there -- we have to remember, patients with CSU have a very symptomatic disease. I mean, generally speaking, these patients, the itch makes it difficult to sleep at night. So that creates a very motivated patient base. Most of the therapies, including Xolair, but even the competitor antibodies, take 12 to 16 weeks to work.

And now you have a drug that gives you relief in 2 weeks. And I think there's going to be much more demand for this maybe. You should actually do a research project on it. I think JPM should look and model it out. You've got to have an inside track versus your competitors.

And then you'll see that this market is actually quite a bit bigger than people think. And then that builds into chronic inducible urticaria. Maybe, as I said, we're doing HS, food allergy. And so there's a lot of opportunity then to take that medicine forward.

Richard Vosser Analyst

Maybe on food allergy, I mean we've seen data from Xolair, remibrutinib data versus Xolair is indistinguishable on the longer term, so pretty good data. And Xolair had pretty good data in food allergy. So that -- and it's accelerating Xolair quite a lot now. So just thoughts on that?

Vasant Narasimhan Executive

I mean, we're -- we've had a lot of debate on food allergy because, of course, in the end, for these patients, you still have to avoid the allergen so it's not like a real cure. But on the flip side, the Xolair data has, I think, changed our perspective. I mean, clearly, it's caught us by surprise, and as you know, we participate in that, that food allergy and Xolair seems to be a driver. So then certainly for remibrutinib, this could be a significant opportunity.

Richard Vosser Analyst

I mean, just -- are you seeing that have an effect on Xolair in Europe as well?

Vasant Narasimhan Executive

Looking at my colleagues, I'm not sure. Getting a no.

Richard Vosser Analyst

Clearly not. Maybe then on the pipeline, and a similar question before. I mean, you outlined a few assets that are coming. We've seen IT Zolgensma or OAV or whatever. But what's the most important that you see of those ones you listed?

Vasant Narasimhan Executive

And just by the way, just as a nuance, the reason we call it OAV, it'll be a separate BLA, and that's important for a variety of reasons as you can imagine. I think clearly, we talked about remibrutinib. I would say ianalumab, I mean, the opportunity to address both Sjogren's disease, potentially other autoimmune diseases and then to life cycle manage and affect the Promacta business, first and second-line ITP. I think that's a very attractive medicine. We understand the mechanism while data looks good.

And so that could rapidly stack into something significant. I mean, pelacarsen is, of course, gets a lot of attention. It's very exciting but I think the reality is that will be a slow build market because the overall Lp(a) diagnostic rates are relatively low. And it's going to take us time to convince, I think, physicians, patients. A lot of work will have to happen to build that market up.

And in many ways, that's like a first generation. We work on an siRNA for Lp(a) that could be every 6 months, every 9 months. So maybe building over time to something -- a point in time when this could be a much bigger market. But I think we have to be realistic on that.

Richard Vosser Analyst

Is that the physicians adopt at the index event? And then is it testing-based where someone has a heart attack, then they have the index event and then they're tested? Is that how you think the market will evolve?

Vasant Narasimhan Executive

I mean, that's -- I mean, right now, of course, it is in patients who have elevated risk in a prior event. So we hope that will motivate patients. But we still -- I mean, look, we know that patients who have had a prior event and should be on a statin, only 30% of those patients take their statin, right? So now we have to convince all of these patients who had a prior event to go get this test done. I mean, it's going to just take time.

It's going to take time.

Richard Vosser Analyst

So something like Leqvio and something like...

Vasant Narasimhan Executive

Look, our long run is we would love to combine a PCSK9 and an Lp(a) for an siRNA. We have that ongoing. We look at, can we combine a PCSK9 and an HMG-CoA reductase? That's a statin pathway. So can we get to infrequently administered, very high efficacy lipid-lowering or a cardiovascular risk reduction opportunities.

Richard Vosser Analyst

We mentioned Leqvio and it's not the pipeline, of course, but I mean, there is a cardiovascular outcome study. And maybe we can ask 2 questions here. I mean, it has accelerated and Europe or ex U.S. has really adopted this a little bit better than the U.S. So what's going on and

how do we see it?

Vasant Narasimhan Executive

Yes, some important insights, learnings for us. We've seen very robust uptake in the China private market, which continues to actually still surprise us every month. Very robust uptake in Japan, where I think there is always a need, interest in better technologies and novel technologies to have a significant health benefit. Very good uptick in the German market, even in the private market. And so actually, Leqvio is selling more ex U.S.

than in the U.S., which is not a typical profile for a cardiovascular drug. So that's important insights on that side. In the U.S., we see steady build, buy and bill, cardiovascular physicians are understanding it. The key switch we made in our strategy there is to focus more on interventional cardiologists, hospitalists, lipidologists, so people who are much more motivated to test and get to goal on cholesterol lowering. So the next big unlocks for that, one will be the outcomes trial for Europe and for many parts of the world.

This is a reminder, that's a study where unlike the studies that were done on the monoclonal antibodies with 2 years of follow-up. We did 5 years of follow-up. And the opportunity there is we hope to get to a much higher cardiovascular risk reduction. They were in the high teens. Maybe we can be in the high 20s.

That gives us a very strong position in Europe. Potentially gives us another accelerator in the U.S. Then we have an outcome study as well in primary prevention as well. So in the long run, we are tracking a little bit ahead of the Entresto line, step by step. You'll remember well the Entresto early days.

There weren't a lot of believers. Now it's setting to be an $8 billion drug or a $7 billion drug. So we'll play the long game.

Richard Vosser Analyst

And you touched on China. China has been an important growth driver for you. What are we seeing today? There's been some concern over the health of the Chinese market maybe because of macroeconomic conditions, maybe because of governmental intervention but...

Vasant Narasimhan Executive

I mean, we continue to see a robust performance in China. We remain excited and we think the opportunity there is substantial. I would say that given the economic situation, we do see more cost pressures in the regional governments. So I do think that will have an effect. Hopefully, that's cyclical and when the growth comes back, there will be that interest to invest in health.

We maintain our ambitions there. We're building a $100 million radioligand therapy facility there. We've expanded our manufacturing site in Beijing. Our R&D programs continue to be heavily -- we always run now in China and the U.S., single global programs. So we remain quite ambitious in China.

Richard Vosser Analyst

Maybe 1 last question, just thinking about health care reform. We've got some of the adoptions of the IRA coming through this year. How do you see it affecting Novartis?

Vasant Narasimhan Executive

I mean, I think we've guided to be a modest negative. In many ways, there's a lot we're going to learn. I think clearly, what's for sure is our exposure in patients beyond the $2,000 out-of-pocket cap is for sure. We do think we can optimize many of our patient support programs and that will help us balance that out. Big unknown is demand uplift.

I personally believe in the medium term, the $2,000 out-of-pocket cap will lead to more fulfillment of prescriptions and more compliance. I think in the short run, given that we need to educate seniors across the United States that one, there is a $2,000 out-of-pocket cap. Many of them will learn when they go to the pharmacy. Second, they've got to opt in for the smoothing to know that they can actually do this month to month. So that's going to take time.

I mean, as that unfolds, you'll see, I think, hopefully better and better uptick, but it won't happen overnight. I am cautiously optimistic we have a chance to fix 9 and 13. I mean, that's a huge focus of the whole industry. And I think we have to take the opportunity maybe with one of these reconciliation bills that are being considered to really tackle that.

Richard Vosser Analyst

Fantastic. Thanks, Vas. We're right on time.

Vasant Narasimhan Executive

Thank you. Thank you very much. Thank you, everyone.