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AZN.L - Q1 2017 AstraZeneca PLC Earnings Call

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PRESENTATION

Operator

Good afternoon, ladies and gentlemen, and welcome to AstraZeneca's Q1 Results Analyst Conference Call. Before I hand over the call to Pascal Soriot, AstraZeneca, I would like to read the safe harbor statement.

The company intends to utilize the safe harbor provisions of the United States Private Securities Litigation Reform Act of 1995. Participants on this call may make forward-looking statements with respect to the operations and financial performance of AstraZeneca. By their vary nature, forward-looking statements involve risk and uncertainty, and results may differ materially from those expressed or implied by these forward-looking statements. The company undertakes no obligation to update forward-looking statements. (Operator Instructions)

We will now hand you over to AstraZeneca, where the call is about to start.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Hello, everyone. I'm Pascal Soriot. Welcome to the first quarter results conference call and our webcast presentation for the investors and analysts. We're in London today where we are also hosting the Annual General Meeting this afternoon. We have people on the phone and on the webcast. The presentation is available online for all of you to download.

Please turn to Slide 2. This is the safe harbor statement.

So moving on to Slide 3. We plan today to spend about 30 minutes on the presentation, and then leave 30 minutes for Q&A. In total, we have exactly 1 hour together, and we need to end on time as another company has a conference call starting in 1 hour. (Operator Instructions) Thank you for your collaboration with that.

As usual, I'm joined by Marc Dunoyer, CFO; Mark Mallon, our VP for Global Portfolio and Product Strategy, Global Medical Affairs and Corporate Affairs; and Sean Bohen, our EVP for Global Medicines Development and our Chief Medical Officer. We also have on the line, Jamie Freedman, who is our Business Unit Head for Oncology.

Please turn to Slide 4. So this is the agenda today.

I move to Slide 5. So before we get started on financials, just a reminder that we made refinements in our results announcement this morning, emphasizing actual growth rate alongside growth rate at constant exchange rates.

On our conference call today, we would be making comments on our financial performance at CER, which is a non-GAAP measure. With the formalities behind me, I will now kick off.

So in summary, we had a good start to 2017. Total revenue declined in the quarter, primarily reflecting the tail of the loss of U.S. exclusivity for Crestor. New AstraZeneca, which we defined as the 3 main therapy areas and the established medicines in the emerging markets, grew by 6% in the first quarter. The emerging markets were really a highlight, and they were up 9% and they are now the biggest sales region in AstraZeneca. Within this region, China continued to perform well and saw regulatory approval and launch for Tagrisso and approval for Forxiga.

Our respiratory business delivered a stable performance despite the ongoing challenges in the U.S. and Symbicort remained the global leader by volume market share.

In diabetes, another competitive field, Farxiga continued to grow in all markets despite subdued U.S. growth due to affordability programs and managed-care access. Brilinta continued to excel.

Tagrisso has expanded on its impressive launches in the U.S., in Europe and in Japan. And now we are also accessing the private market in China. The core earnings per share decline, was limited to 4%, given the continued cost focus, but also due to the continued transformation of the new AstraZeneca.

Now we'll turn to Slide 6. Our pipeline delivered very strong results since the last results announcement. This is the most extensive set of highlights for a long time. Let me cover a handful of new news items.

First of all, Tagrisso news included the conversion from accelerated to full approval in the U.S. and the EU, and the important approval in China, that followed the very accelerated regulatory review. In the meantime, we also launched Tagrisso in China with a very good start.

Lynparza received the regulatory submission acceptance and priority review in the U.S. for the second-line application in ovarian cancer as well as an Orphan Designation for the same cancer in Japan. As the first ever PARP inhibitor, Lynparza met a Phase III primary endpoint in BRCA-mutated metastatic breast cancer.

Forxiga received approval in China and the SGLT2 class, including Forxiga, showed encouraging CV outcomes data in the CVD-REAL real-world study. Further in diabetes, the new Bydureon autoinjector was accepted for U.S. regulatory review.

The disappointing news was that we received the Complete Response Letter for ZS-9 in the U.S. However, there are more milestones that Sean will speak to later on and a good start to 2017 should bode well for the rest of the year.

Please turn to Slide 7.

So when we look at new AstraZeneca, it was another strong quarter where product sales grew by 6%. All therapy areas contributed and so did the established medicines in the emerging markets. As we move forward, these areas will be the key growth drivers as we exit the major patent cliff for Crestor in the U.S. By July this year, comparisons will ease, and we look forward to keeping you updated on our return to growth in product sales. This graph in the light gray shading shows you that we are reaching the end of this -- the impact of this large patent expiry.

Please turn to Slide 8. As we begin returning to growth, our focus is increasingly on commercial execution, and we've already launched Bevespi in Q2 of this year. At the end of the year, we anticipate the launch of benralizumab, our first biologic to treat severe uncontrolled asthma. In bladder cancer, Durvalumab's, U.S. PDUFA date remains this quarter.

We were also encouraged by the positive Phase III data for Lynparza in metastatic breast cancer. There's a lot morepipeline news flow expected over the next few quarters with MYSTIC and FLAURA as 2 important highlights. With the opportunity in first-line lung cancer, shared between Tagrisso and our 2 IO medicines, we have the chance to become a leader in the treatment of lung cancer. And so far, we remaine very confident in the MYSTIC trial refinements.

With this, I will now hand over to Mark Mallon.

Mark Mallon - *AstraZeneca PLC - Executive Vice-President of Global Product & Portfolio Strategy, Global Medical Affairs & Corporate Affairs and Executive Vice-President of International West*

Thanks, Pascal. I'm pleased to be with -- here with all of you today to talk about our performance of the growth platforms, and we'll get started by moving to Slide #10.

So our growth platforms continued to demonstrate overall growth in the quarter despite a stable performance in Respiratory. The combined revenue of our 5 growth platforms represented almost 2/3 of our total revenue in Q1. And momentum was clearly seen in Emerging Markets and the New Oncology. I'll touch on the performance of Emerging Markets and Japan, but I'm going to focus most of my remarks on Respiratory, New Oncology and our cardiovascular and metabolic platform, which we'll refer to as new CVMD, this groups together Brilinta and our, of course, diabetes products and medicines.

Slide 11, please. So first, turning to Emerging Markets. We continue to remain on track to deliver our long-term performance goal of product sales in the mid- to high single digit range. Emerging Markets, as Pascal mentioned, is now AstraZeneca's largest sales region, with the growth being driven by the growth products: Brilinta, Farxiga and Respiratory. China continues to be a key driver where we recently received, as Pascal mentioned, approvals for Forxiga and Tagrisso.

Turning to the Slide 12. Taking a look at Respiratory -- our Respiratory franchise. Sales stabilized in the quarter after a challenging second half of 2016. The downward pressure in the U.S. being offset by strong Emerging Markets performance. Symbicort continued to grow unit volume, up a few percent, and continues to lead the ICS/LABA class globally. Product sales were down by 8%, reflecting pricing headwinds in the U.S. and competitive dynamics in Europe. This was offset by the positive Emerging Markets and established rest of world growth.

In the U.S., Symbicort product sales declined by 21%, with slight volume growth. We continue to see significant price rebasing. And as previously mentioned, we expect the pricing pressure to be strongest in the first half of the year.

In Europe, Symbicort product sales were down by 9%, with continued pressure on both branded and analog competition. Emerging Markets delivered growth of 10%, with Symbicort sales in China up by 24% in the quarter. And Pulmicort continues to grow for us, up to 14% in the quarter, with strong Emerging Markets growth up 28%, mainly driven by China. Bevespi launched successfully in January in the U.S., performing in line with the previous launched products in the class and early feedback from physicians has been positive. We plan to make a regulatory submission for Bevespi in the EU soon.

Turn to Slide 13. Just taking out a step back for a moment from sales in Respiratory, we wanted -- I want to, we really believe our overall respiratory strategy is well positioned to take advantage of the expected market expansion over the next 10 years. Significant unmet need still exists with

asthma and COPD currently affecting 600 million individuals worldwide. The inhaled market is forecast to grow in volume, particularly in the Emerging Markets, with new treatment approaches driving further expansion. Biologics are forecast to accelerate growth further to increase penetration in earlier use of biologics. And our respiratory portfolio is well positioned for this evolving market. With benralizumab, which has been accepted for regulatory review in the U.S., the EU and Japan; Tralokinumab, the Phase III data read-out in the second half of this year; and Tezepelumab, which met its primary endpoint in the Phase IIb trial PATHWAY. Our ambitions in Respiratory go beyond our current inhaled and biologics portfolio. We will continue to push the boundaries of science in our early pipeline with the goal of early intervention and ultimately, impacting disease modification.

Slide 14, please. And turning to new CVMD, which represents our on-patent medicines in CV metabolic diseases that support our return to growth strategy. The new CVMD sales were up by 6% despite intense competition, with strong performance in emerging markets, offsetting a weaker U.S. performance. We continue to focus on Brilinta and in diabetes, Farxiga and Bydureon. Brilinta delivered product sales of $244 million in the quarter, with 27% growth. Notable performance was seen in the U.S., in China and emerging markets. We remain confident that Brilinta will become a $1 billion blockbuster product this year.

Brilinta emerging market sales grew by 54% to $60 million, with China sales increasing by 68%. U.S. sales increased by 24%, reflecting updated guideline. And in Europe, sales were up 12%. And Brilique continues to outperform the OAP market in this region.

In diabetes, we continue to focus on the 2 medicines that have the potential to offer a CV benefit, Farxiga and Bydureon. Our diabetes franchise exhibited a softer quarter with minus 1% sales growth. Product sales in the U.S. declined by 7%, result of intense pricing pressure and competition for market there.

Europe exhibited a growth of 1%, with Farxiga offsetting losses in Onglyza. Farxiga maintained a 40% share globally, with product sales of $207 million in the quarter and 25% growth. We expect growth will be supported by the broader knowledge in the medical community of the CVD-REAL data, confirming the morbidity and mortality benefits of this class of medicine.

In the U.S., Farxiga outgrew the SGLT2 class, and product sales were up 2%, subdued due to affordability programs and managed-care access. Farxiga delivered strong growth in Europe and emerging markets, with sales up 24% and 90%, respectively.

In Bydureon, we returned to growth in the first quarter with 14% growth driven by the U.S. and established rest of the world with sales of $153 million in the quarter. We're also very excited to announce that the FDA has accepted the autoinjector for regulatory review in the U.S.

Please turn to Slide 15. In Japan, we returned to growth. Product sales were up 3% in the first quarter, driven by Tagrisso, Farxiga and Nexium. And this included a 6% decline in pricing as a result of national price cuts in April 2016. Tagrisso sales continue to grow, and the Japanese yen sequential quarterly growth was 7%. T790 testing levels are now at 85%, of which about 1/4 is from the new blood-based test with the T790 mutation. In March Lynparza was awarded the Orphan Drug Designation for ovarian cancer, which ensures a shorter regulatory review for it. We anticipate our second new oncology launch in Japan in 2018.

Slide 16, please. Finally, turning to New Oncology. 2017 continues to be an exciting year for us. New Oncology product sales of Tagrisso, Lynparza in the U.S. and rest of the world were $236 million in the quarter. Tagrisso continued to demonstrate strong uptake in the U.S., Europe and Japan, with global product sales of $171 million and 48 regulatory approvals.

In China, we have launched Tagrisso in April, which is a few months ahead of industry benchmarks, just after a few weeks between the approval and the first sale, really remarkable performance by our teams across the globe and in China to make this happen, and this included obtaining the import license.

Lynparza Q1 product sales were $57 million, up 32%. We continue to see growth driven by higher testing rates and market penetration. We also saw an increase in competitive pressure in the U.S. We will look to expand the current use based on strong SOLO-2 trial data in second-line maintenance treatment of ovarian cancer. And we look forward to further label expansion for us outside of ovarian cancer, like breast cancer where we have new data now.

So to conclude. Overall, we saw a solid performance from our growth platforms. We're looking forward to the next wave of launches and together, they will drive the emergence of the new AstraZeneca.

Thank you for listening, and I'm happy now to turn it over to Marc.

Marc Dunoyer - *AstraZeneca PLC - CFO and Executive Director*

Thank you, Mark, and hello, everyone. I'm going to spend the next few minutes taking you through our financial performance in the first quarter. So please turn to Slide 18.

As usual, I will begin by showing the reported P&L numbers before turning to the core numbers. Total revenue declined by 10% in the quarter, impacted by the entry in the U.S. multiple generics for Crestor in July of last year. Externalization revenue increased by 3%. As previously highlighted, we expect the sustainable and ongoing part of the Externalization revenue to increase over time. And in the first quarter, this increased to 32% of total externalization revenue from 21% in the whole of 2016.

Please turn to Slide 19. If we now turn to the core performance, we can look further down the P&L and see that our gross margin in the quarter was down at constant exchange rates by 1 percentage point to 83.6%, reflecting a changing mix of sales, including the impact of patent expiries, partly offset by the resilience of some legacy medicines in established markets and the growing influence of specialty-care medicines. The absolute gross margin benefited from foreign exchange.

It is important to note that we do not anticipate such a high gross margin to continue over the full year, however. I would like to make an additional remark. There was no real change in gross margin from the emerging markets now being our largest sales region.

Core R&D costs declined by 3% in the quarter, and core SG&A costs declined by 12%. These declines reflect our focus on cost control and support the full year commitment of keeping core R&D costs broadly stable as well as reducing core SG&A costs. Again, we do not anticipate such a similar reduction in core SG&A costs over the full year.

Core other operating income increased to $333 million, including a gain on disposal of short-term investments, as well as a milestone receipt from Pfizer. The core tax rate in the quarter was 17%, which was within the 16% to 20% range we have indicated for the full year. As Pascal mentioned a moment ago, the core EPS decline of 4% was limited by the favorable sales progression of new AstraZeneca in our relentless focus on cost.

Please turn to Slide 20. This slide, which is now familiar to you. It illustrates the important progress we have made towards taking costs out of the business. I'll just mention, core R&D decreased by 3%, whereas core SG&A cost decreased by 12%. The SG&A decline, equivalent to 1 percentage point of total revenue, was partly driven by the simplification and aligned standards for the centralization of shared services including back and mid-office activities.

We recently launched the Global Business Service organization, which over time, will increase the level of integration and allow us to focus on costs further. We remain committed to continue reducing our cost base thisyear.

Please turn to Slide 21. To conclude, I want to reiterate the 2017 guidance which is at constant exchange rate. I expect a low- to mid-single digit percentage decline in total revenue. Core EPS is anticipated to decline by low to mid-teens percentage.

Outside of guidance, the total of externalization revenue and other operating income is still expected to be ahead of that in 2016. Sustainable and ongoing income is expected to increase as a proportion of externalization revenue in 2017 and beyond. We anticipate that core R&D costs will be broadly in line with 2016. And as I just mentioned now, we plan to make further reduction in core SG&A costs. As I highlighted before, variation in performance between quarters can be expected to continue, with year-on-year comparisons beginning to ease in the second half, as we begin to lap the impact from the loss of Crestor in the United States.

Our capital allocation priorities remain unchanged. We will continue to strike a balance between the interest of the business, our financial creditors and our shareholders. After providing for investment in the business, supporting the progressive dividend policy and maintaining a strong investment-grade credit ratings, we will keep under review any potential investments in value enhancing and immediately earnings accretive opportunities.

With that, I will hand over to Sean.

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

Thank you, Marc. I would now like to run through the late-stage pipeline events since the last results announcement, the highlights of recent data presentations and then wrap up with a look at our upcoming news flow.

Please turn to Slide 23. As you can see here, it was quite a busy quarter with progress in all therapy areas. And as you will see through my presentation, we anticipate this pace to continue through the year. The highlights achieved include the conversion to full approval for Tagrisso in the United States and EU. Approvals for Tagrisso and Forxiga in China, Qtern was approved in United States for a Type 2 diabetes. And the approval for Siliq for psoriasis by our partner.

For regulatory submissions accepted, Lynparza was accepted in the United States for second-line ovarian cancer, supported by data from the SOLO-2 trial and Study 19 trial. This submission was granted priority review. The Bydureon autoinjector in the U.S. was accepted. This approval -- anticipated approval makes the medicine more convenient for patients to administer. The Symbicort, specifically for exacerbations in COPD and benralizumab in China for severe, uncontrolled asthma.

We received the second complete response letter for ZS-9 related to manufacturing issues. We remain committed to bringing this important medicine to patients with hyperkalemia and are currently working with global regulatory agencies to accomplish this goal.

To complete the picture, we had the positive Phase III trial for Lynparza OlympiAD, and this compared Lynparza to chemotherapy in metastatic breast cancer. As many of you know, we will have these data to present at ASCO in June.

Please turn to the next slide. At recent oncology medical meetings, we have kept up the positive momentum with data presentations. We have presented updated bladder cancer data from study 1108. As a reminder, we are under regulatory review in the U.S., following our mid-December announcement of submission acceptance with the PDUFA date in this quarter. We had additional concordance data on PD-L1 diagnostic assays, with an effort to reconcile the various existing tests for PD-L1.

We have Lynparza's SOLO-2 data at the Society of Gynecologic Oncology Meeting presented in March. And early data at the AACR Meeting on a number of our medicines and innovative biomarkers, including more advanced data on our TLR7/8, agonist in solid tumors and Lynparza combined with temozolomide in second-line small cell lung cancer.

You can turn now to Slide 25. With this slide, I'll conclude oncology. I know this slide will be familiar to you demonstrating our commitment and expected upcoming immuno-oncology data readouts from Phase III trials ongoing.

First, a few updates. We had a last patient begin dosing in KESTREL since the last update on the pipeline as well as in DANUBE for the global trial, which excludes China. We had first patient dosed in PEARL, which is a first-line I/O trial specifically in Asian patients. And we also had a first patient dosed in CASPIAN. CASPIAN is not listed on this slide, it is a Phase III trial in small cell lung cancer.

For data in mid-2017, as you all know, we'll have the first data from MYSTIC. This will be the final PFS analysis. We're confident in our recent trial refinement that we discussed last quarter and shared with you. You'll also note that some of these refinements have found their way into other programs and other indications, namely the NEPTUNE and KESTREL trials.

In the second half of 2017, we will have the first data for ARCTIC in the third-line PD-L1 low negative non-small cell lung cancer patients. This has pushed out from our expectations in the first half of 2017 because of a slower accrual of events, as we described in the results announcement that we circulated this morning.

Further, in lung, we expect data from PACIFIC in Stage 3 un-resectable non-small cell lung cancer. We'll also see KESTREL data in first-line head and neck cancer. Next year again will be a busy year with final overall survival data from both MYSTIC and NEPTUNE for non-small cell lung cancer.

Of course, there are interims for overall survival before that in this trial. Further, we expect readout from DANUBE in bladder and EAGLE in head and neck cancer.

We have also added our new POSEIDON trial to the overview now. It's our durva + treme combo with chemotherapy, also durva with chemotherapy and compared to standard of care chemotherapy. This is based on the encouraging Phase I data, we shared with you late last year at the World Lung Cancer meeting. We look forward to keeping you updated on our progress and our upcoming announcements in our I/O portfolio.

The slide 27, please. Moving on to data from our CVMD portfolio. At the ACC meeting in March, we shared the results of an exciting real-world evidence study called CVD-REAL. This is the first large real-world evidence study of it's kind,evaluating the rate of hospitalization for heart failure and of death from any cause in patients with Type 2 diabetes on SGLT2 inhibitors compared to other medicines and the treatment of diabetes. The study included more than 300,000 patients with Type 2 diabetes from around the world, and approximately 87% of these patients did not have existing cardiovascular disease. The CVD-REAL results are robust, consistent and confirmatory data set, showing that treatment with the SGLT2 class cuts the rate of hospitalization for heart failure and death from any cause by approximately 50%. This is the first of several comparative analyses of CVD-REAL. The study is ongoing, and there will be future analyses conducted and presented with this data set.

On the right-hand panel of the slide, other outcomes trials are underway, including EXSCEL with Bydureon, with data expected in the second half of this year, which is earlier than previously expected. Again, the change in expectation for data readout is due to a faster-than-expected event rate.

We also have DECLARE with Farxiga with data in 2019 at the latest. We have 2 additional Farxiga outcomes trial started this year. One of those in heart failure and one in chronic kidney disease, both in patientswith and , without diabetes.

And I can also share with you today that we recruited the last patient into the STRENGTH study for Epanova. This is an outcomes trial in combination with statins conducted in 22 countries worldwide with data expected in 2019.

In summary, our goal in CVMD is to reduce morbidity, mortality and organ damage by addressing multiple risk factors of cardiovascular and metabolic diseases for the long-term benefit of patients.

If we now go on to Slide 28. This is our news flow that is expected in 2017 and 2018. And you can see from this slide, these are both very busy and very exciting years for AstraZeneca.

By the end of 2017, we expect to have received 6 additional regulatory decisions and will have had first data readout from MYSTIC, PACIFIC, ARCTIC and KESTREL as well as for SOLO-1 first-line ovarian cancer with Lynparza and FLAURA first-line EGFR mutated non-small cell lung cancer with Tagrisso. We will see the potential for a fast-to-market opportunity with the acalabrutinib reading out and anticipate submitting this year as well.

Outside of oncology, we'll see data from the Bydureon outcomes trial, as Pascal has mentioned and the first Phase III data for tralokinumab in severe, uncontrolled asthma. In 2018, we will have additional regulatory decisions based on ongoing reviews and additional first data readouts, including for NEPTUNE, DANUBE and EAGLE. We'll also see data on roxadustat for anemia, benralizumab and PT010 in COPD and anifrolumab in lupus.

With this much going on, you will likely appreciate that we are busy moving the pipeline forward to bring benefit to patients worldwide and as well to benefit our shareholders.

And with that, I will hand back to Pascal for closing comments.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thank you, Sean. Please turn to Slide 30. Before we end, let me quickly summarize. First of all, we had a good start to 2017. In particular, the emerging markets now became our largest sales region. New AstraZeneca grew product sales by 6%, and our financials are on track and we reconfirmed our guidance. More importantly, the pipeline is advancing at pace with 12 new potential medicines in Phase III or under registration. The oncology pipeline in particular is progressing ahead of our expectations, with Tagrisso, Lynparza and immuno-oncology programs progressing quite nicely. We are looking forward to sharing further news flow that we think has the potential to mark a meaningful step change for AstraZeneca. In particular, the first-line data for Tagrisso and, of course, the MYSTIC trial data in lung cancer.

We'll now go to Q&A. (Operator Instructions). And I'd like to thank you in advance and we'll take the first question from Sachin Jain of Bank of America. Sachin, over to you.

QUESTIONS AND ANSWERS

Sachin Jain - *BofA Merrill Lynch, Research Division - MD*

Sachin Jain, Bank of America. One question for Sean on POSEIDON. I wonder if you could just briefly review your perspective of the data you presented at World Lung? And where you have additional data in house, in particular focusing on your perspective in the safety of the triple given that suggestions and feedback seems to be some concern around toxin isolation. And then if you could just touch on what chemo sequencing you're looking at in POSEIDON, given that study at World Lung, I think investigated concurrent chemotherapy.

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

Thank you for the question, Sachin. So we do have a little more data than was presented at World Lung, and that's just because you have a cut-off time from when you submit an abstract and actually do the presentation and prepare it, then we have more follow up. I will say it's Phase I data, so it is limited. But what we felt, we saw and what we presented and what has borne out so far is that we get the toxicity of the combo and the toxicity of the chemo, but we don't really see an enhancement of the 2 when combined, that we're able to tolerate giving them together. And we are giving them together concurrently. I guess, that was the other question about what does POSEIDON do. It's very similar to what you saw at World Lung in terms of how they are given, because as we said, we felt that, that was a manageable toxicity profile.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thank you, Sean. Tim Anderson at Bernstein. You can go ahead.

Tim Anderson - *Bernstein - Analyst*

A question on ARCTIC and the delay. You said that events are occurring more slowly, but this is a third-line lung cancer trial, which is a fast progressing disease and chemo doesn't work very well in third line. So it's a pretty low bar to cross. The expected events would actually come in quite fast. I'm wondering if you can say whether you changed any aspect of the statistical design of ARCTIC here in recent months such that it would delay the readout? And then second question. On the ELCC abstracts from yesterday for the upcoming European Lung meeting. There's an abstract from the Lung-MAP study which shows quite weak response rate with durva monotherapy even in PD-L1 positive patients, which is kind of surprising. And I'm wondering if you can give us your thoughts here?

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

So the first question is did we -- I'm going to try to simplify it. The question is did we change the analysis plan or level of maturity we ask for out of ARCTIC in order to do the analysis? The answer to that is no. We have made no changes to the analysis plan. The maturity required was prespecified in order to demonstrate the treatment effect. We were anticipating and looking at the number of patients that we had on the trial, reminding you that ARCTIC is a bit complicated. It has a 3 to 2 to 2 to 1 randomization with different arms. We had forecast that we would be getting you data sooner. So obviously, the event rate is slower than we anticipated as well, but that's the reality of it. It's not something that we changed or manipulated. It's prespecified and it's taking that long for the events to accumulate. That could be because our treatment effect is good. Or to be honest, it could be that we got more favorable prognosis patients than we had anticipated and so they're just doing better independent of treatment. With regard to the question on ELCC, the small data set, it's absolutely true that the point estimate bounces around, when we look at our data in aggregate, we remain confident. 1108 is probably the thing we've presented most on and shared most with regard to PD-L1 positive and durvalumab. And we feel that durvalumab is quite consistent with the class. So we have confidence in our program.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Sean. Matt Weston at Credit Suisse.

Matthew Weston - *Credit Suisse AG, Research Division - MD and Co-Head of European Pharmaceutical Equity Research*

It's a follow-up question on ARCTIC. Sean, you've previously said that you require the tremelimumab arm within ARCTIC to basically justify or satisfy the FDA requirements on contribution of components to MYSTIC. And so now I'd like to understand the filing strategy. Assuming we get a positive outcome for MYSTIC in the middle of the year, whether you will have to delay filing until you get that tremelimumab out of ARCTIC? Or whether or not you would anticipate filing MYSTIC with that data pending and then add it to the file once ARCTIC matured?

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

We don't anticipate any delay to the filing of MYSTIC. If MYSTIC turns out to be positive and enables the filing of the Mono. In this case, the question is, of course, of the combo. We remain very confident in our contribution of component strategy and I feel, we'll have ample data to enable that, should the outcome of the trial support it.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Sean. James Gordon, JPMorgan.

James Daniel Gordon - *JP Morgan Chase & Co, Research Division - Senior Analyst*

A question on the POSEIDON study. So as I understand, it's got the two oncology ingredients and the chemo and will be an arm that's chemo plus PD-L1. Is the -- is there a possibility of getting a chemo PD-L1 label on the basis of the study if the tripletherapy approach wasn't successful? And in that case, is this in a way an insurance policy around MYSTIC as well?

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

So let me deal with the insurance policy one first, and then I'll go back and talk about how the trial -- what positive result would look like in that trial. So it really isn't an insurance policy. We don't -- we have not lost our confidence in MYSTIC. What we have, and I've mentioned this before, what we have seen and gotten feedback from treating physicians is that there are -- there's a perception that immuno-oncology treatments are slower onset than chemotherapy. And there is subgroup of patients that progress very, very quickly, and they do not feel with that subgroup of patients that they can deny them chemotherapy. So what we're doing is we're giving them a complete data set to enable them to decide what

does chemo I/O look like versus the chemo that is given as standard of care still in many places in the world and also obviously in the first line in PD-L1 low expressers. The trial is designed to compare chemo I/O or chemo I/O plus I/O versus standard of care chemotherapy. So if you beat standard of care chemotherapy, you have a positive trial. It will then be a judgment call on benefit and risk if both arms were to be positive, whether you felt like the chemo, chemo or that I/O, I/O chemo was superior to I/O only with chemotherapy, and that will be a judgment that we would make and also that regulators would want to look at, too.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thank you, Sean. Jack Scannell, UBS.

Jack Scannell - *UBS Investment Bank, Research Division - Co-Head of Pharmaceuticals Equity Research and MD*

Just one on the diabetes franchise. We've been doing some work on formularystatus. It looks like Onglyza is probably losing a bit of formulary coverage in the last 2 or 3 years. And Tradjenta gaining and Januvia slightly down. Then in the SGLT2s, Farxiga holding with Jardiance going up and Invocana probably losing a bit. And I'm just trying to reconcile that because some of the light diabetes sales we saw in Q1. Does this reflect any particular change to the contracting dynamics that we're seeing? Or there's something else going on?

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Okay. That's a question for you Mark, Mark Mallon.

Mark Mallon - *AstraZeneca PLC - Executive Vice-President of Global Product & Portfolio Strategy, Global Medical Affairs & Corporate Affairs and Executive Vice-President of International West*

Yes. I think this is both certainly DPP-4s and also the SGLT2s are are very competitive markets. And so the contracting challenges and pricing pressures have been strong and continue to have some amount of that going forward. I wouldn't say that -- and that's had an impression -- impact on the sales growth for all of the companies and the products. We believe that this is the class that is going to be a key factor, really the foundation of diabetes therapy in the future. We're really focused on continuing growth of the class and of course Farxiga and then maintaining good access is the key part of that priority and we're going to continue to support the strong access that we have for Farxiga.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Mark. Remember that we are in the early days of this class. It's still quite small, right? It is still pretty small comparedto other classes of oral anti diabetic medicines. So the key is, which drive the long term benefit. Today, we can't really promote that, of course, but over time, this is whether -- what's going to drive the class.

Simon Baker at Exane.

Simon P. Baker - *Exane BNP Paribas, Research Division - Analyst*

Just moving on to Respiratory. I noticed that the filing time lines for PT010appears to have shifted from 2018 to 2019. I wonder if you could give us some color on the reasons for that delay?

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

Yes, it really has to do -- it has to do with -- in the United States, primarily the rate of enrollment and how long we will have follow-up in order to enable filing in COPD. And so it just -- it is an adjustment based on actual data as we enroll the trial versus what we had forecast.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Sean. There's an online question here, maybe I should take one of those webcast question, sorry. From Matias Haeggblomat Swed Bank. And the question is given the fact that MYSTIC, as most other I/O trial have an open-label trial design, investors may have concerns that some of the obviously recent amendments to the trial design of MYSTIC include amendment of core primary endpoint, but also the fact that a decision to start an IO triplet study -- I'm sorry, that includes chemo -- sorry, they are being a common study includes chemo as announced today.

So the question is becoming longer.

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

Sorry, you want me to just go ahead and...

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Yes, why don't you try it?

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

All right. So yes, MYSTIC is an open-label trial design. For a second, I want to explain when you compare I/O to chemo, you will be unblinded, the investigator will be unblinded. And the reason is that if you look at, for instance, the blood count in the patient you will know that if you get myelodysplastic suppression the patient is receiving chemo versus I/O. So it's not really possible to blind. So how do we solve that? So the way we solve that for the PFS primary endpoint is that we have the response and progression called by an independent radiographic review center, a blinded independent radiographic review center. So they don't know the treatment of assignment to the patient. They just get the scan and read that over time. So that's for PFS, how you create the blind. For overall survival, this is not an endpoint that's really sensitive to knowing the treatment assignment or not knowing the treatment assignment. So there it is less important. That's how the study of design incorporates that. That, by the way, has nothing to do with the recent amendment. That was the design of the trial from the very beginning. And what was the other -- and then a decision to start an I/O triplet and that includes chemotherapy. I think I addressed this already. That's more a pragmatic decision. We believe that there will be a place for chemotherapy in some patients with non-small cell lung cancer regardless of where I/O comes in because physicians do see these rapid progressors, they do see that the standard of care in chemo was approved and used based on a survival benefit. So some patients will probably get chemotherapy and we just wanted to really establish for physicians what is the benefit of using the 2 together and what is the safety profile.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thank you, Sean. I would just like to remind everybody actually that this I/O chemo strategy, we mentioned a long time ago that we would explore that combination for the reasons that Sean just highlighted. But we also said that we wanted to explore I/O, I/O chemo. And as a result, did this Phase I study that, of course, we had to wait for. But it's not a new event. It's not a knee jerk reaction to any new development. It was part of our strategy from sort of day one, really.

So there's Vincent Meunier at Morgan Stanley. You want to go ahead, Vincent?

Vincent Meunier - *Morgan Stanley, Research Division - Research Analyst*

A question on Lynparza. So what should we expect in terms of sales dynamic for Lynparza? Does that mean the context of the 4% decline in the U.S. in Q1? I mean, should we expect sales to grow before the SOLO-2 label update? And also would you anticipate off-label use in breast based on OlympiAD?

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Vincent. Jamie, do you want to cover this question?

Jamie Freedman - *AstraZeneca PLC - Head of Oncology*

Yes, sure. Thanks for the question. So we have seen competitive pressure in marketplace in the U.S., and that's due to early entry of competitors. But we're optimistic because we've had positive news. So for the SOLO-2 results and second-line maintenance was presented in SGO, they were positive and we filed in the U.S. and it's going to go in priority review. We hope with SOLO-2 will be introduced in a tablet formulation, which is important in the third quarter. In Japan, we've received Orphan Drug Designation, and that will accelerate the approval time line. And then as was mentioned previously with the positive OlympiAD results that we've reported, that will be actually presented at ASCO in metastatic breast cancer. We will be the first PARPinhibitor in that new indication. So overall, we do expect an uptick in sales, particularly in the third quarter, and then at the end of the year, SOLO -- the SOLO-1 readout in first-line maintenance, which should also help as well.

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

Vincent, I think I just want to add. This is Sean. I just want to add to you that, as Jamie mentioned, with the presentation of the OlympiAD data at ASCO, that does also give us the opportunity to seek a guideline recommendation for Lynparza in metastatic breast cancer, and at least in the United States, if that is granted, that does sometime -- drive some use ahead of regulatory approval.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Sean. His real first name is Vincent, by the way. But today, we'll call him Vincent. So Seamus Fernandez at Leerink.

Seamus Christopher Fernandez - *Leerink Partners LLC, Research Division - MD, Major Pharmaceuticals and Biotechnology*

Yes. Hello. Can you hear me?

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Yes.

Seamus Christopher Fernandez - *Leerink Partners LLC, Research Division - MD, Major Pharmaceuticals and Biotechnology*

Okay. So I just have 2 questions. The first one really is on the quality of the earnings and statements that you -- your views that this was a good quarter. We're seeing more externalization build into the P&L, and I'm increasingly challenged to think about the quality of the earnings after, say, in the next couple of years. Can you talk a little bit about where we should be seeing SG&A going? In preliminary comments, I think you said that 12% down on SG&A this quarter is not sustainable for this year. And I'm just trying to understand why that's the case as the arms race globally

continues to come down? And the second question is the enthusiasm around the emerging markets. Can you help us better understand why you're so enthusiastic about the growth in the emerging markets when China was such a slow grower in the mix?

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Okay, so first question. I'll ask Marc to cover it. But let me just say as far as externalization, as we mentioned before, we have an overall target and a guidance for the year. But this is going to bounce around a little bit from quarter-to-quarter. So it's not because we have a large quarter that you should think, okay, we -- this is becoming very, very, very large. It's going to vary from quarter-to-quarter because, of course, the timing of this deal varies a little bit. As far as the specific, as Jamie question, Marc, do you want to cover this?

Marc Dunoyer - *AstraZeneca PLC - CFO and Executive Director*

Yes. Just relatively -- briefly, the minus 12% in reduction of SG&A in the first quarter. You need to remember, we initiated the program of productivity increase starting second quarter of 2016. So we have, as a comparative base, the first quarter of '16 and therefore, the 12% is more impressive than the rate that we'll have for the end of the year. I don't want to give you a precise number, but I can only repeat today that we will have a further reduction on our SG&A costs base for the full year.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Marc. And in term of midterm outlook, we've always said, we don't typically guide. But on top of it, in this instance, it would be really difficult to guide before we have a better view of what kind of clinical news flow we will get. I mean, we have such a number of new clinical trials that we'll readout, and that will define the type of portfolio of products we have. And as a result, it will shape, to some extent, the SG&A ratio moving forward. So we really could not give any sort of guidance even if we wanted to at this stage in term of midterm and beyond 2017. We have 2017 guidance, of course, beyond that what would be hard. Emerging markets, Mark Mallon this time, do you want to cover it?

Mark Mallon - *AstraZeneca PLC - Executive Vice-President of Global Product & Portfolio Strategy, Global Medical Affairs & Corporate Affairs and Executive Vice-President of International West*

Yes. So first of all, actually we -- our growth in the first quarter in China has been solid. Now in the actual, it was a low single digit number but in constant exchange rate, actually we had a high single digit growth. And keep in mind, we do have some impact of the deals that we've done in China. For example, we had a couple of different partnerships in anesthesia, cardiovascular. And so actually, kind of business continues to achieve double-digit growth. And so that specifically China, very confident, we continue to outgrow the market. We're the #2 company there. So our position in China remains very strong. Overall, we're positive about emerging markets because the unmet need is so substantial across the region. And I think, of course, there are going to be ups and downs in the emerging market economy because there's volatility. But long term and overall, we definitely are -- we're very confident on that.

Seamus Christopher Fernandez - *Leerink Partners LLC, Research Division - MD, Major Pharmaceuticals and Biotechnology*

If I can follow up, just a quick question. Can you just give us a sense of when perhaps we might start to see leverage in the P&L of those market spend? Because I think that's another key question.

Mark Mallon - *AstraZeneca PLC - Executive Vice-President of Global Product & Portfolio Strategy, Global Medical Affairs & Corporate Affairs and Executive Vice-President of International West*

There was also a question on line about the difference in margin between emerging markets and the group as a whole. Our emerging markets business is definitely profitable. It's not as profitable as the whole group as U.S. or Europe. What we said in the past is that it's a bit less profitable than Europe, but this is not just growth. This is a very -- it is a profitable business for us, and it is very stable.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

All right. Thanks very much, Mark. Moving onto the next question, Andrew Baum at Citi. Andrew, do you want to go ahead?

Andrew Simon Baum - *Citigroup Inc, Research Division - Global Head of Healthcare Research and MD*

A couple of questions, please. On strategies for executing your PD-L1. You refer to the rationale for looking at chemo combinations as one to address a subgroup of patients who urgently need treatment or are symptomatic and require shrinkage. Should I interpret this as indicating that you view the role of chemo as an additive one rather than necessarily showing benefit through the immuno potentiation? That's the first question. And then the second question is I'd be interested in Sean and the team's view on the reported phenomenon of hyperprogression with some of the PD-1 and PD-L1 assets. And indeed, especially in your head and neck trials, given some of the recent literature, where do you think you are, maybe seeing hyperprogression in some of the patients in the other arm of that trial?

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

So the -- with regard to immuno potentiation question, I mean, that's a theoretical possibility, but we really take a pragmatic view, as I described. That this is chemo and the benefit you get from that plus I/O and you get time to get that started. With regard to the progression, we haven't seen evidence of it. We would say in aggregate, we don't really see hightened progression, a convincing story for hightened progression. In regards to the trial you're referring to, they're blinded now. So we don't know anything about the data, and I can't really answer the question in context of a blinded trial.

Andrew Simon Baum - *Citigroup Inc, Research Division - Global Head of Healthcare Research and MD*

But I guess that at least your lung trials, they're open label. And if you're having a patient who's rapidly falling off the cliff, you may get some medical liaisons being approached in relation to the particular patient? That's what I was referring to.

Sean Bohen - *AstraZeneca PLC - Chief Medical Officer and EVP of Global Medicines Development*

Some lung cancer patients do very badly and progress very quickly. That happens on all other therapies and we've seen nothing that is apparently specific to I/O.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Sean. So we'll come back again later on, if we have time. Just trying to keep one question per person.

Emmanuel Papadakis at Barclays. Emmanuel, do you want to go ahead?

Emmanuel Papadakis - *Barclays PLC, Research Division - MD*

Just a quick one -- quick question for Marc on cash flow, had a relatively large negative working capital movement in the first quarter. I was wondering if you could give us a little bit more color on that. And also maybe a bit of color on expectations for pricing and free cash flow for the full year in terms of comparability to last year. Should we expect to be in line or perhaps slightly ahead?

Marc Dunoyer - *AstraZeneca PLC - CFO and Executive Director*

So thank you for the question. First of all, the -- we'll address the variation quarter 1 '17 versus quarter 1 '16. So the variation, as you point out, is mostly on working capital. There are several factors, but one of them is the increase of inventories that we need to have to prepare for the new launches. There's reduction of managed markets rebates payable in the United States as we have had reductions -- sales reductions on product like Crestor, for instance, which was carrying very high rebates last year. Also an overall reduction of payables because we have reduced on overall cost base and therefore, the payables on the SG&A has reduced. There's also another factor that the factoring that we did, we had increased of factoring in the quarter 1 '16 so that's the -- which did not happen in 2017. So these 4 elements explaining the large variation in the need of working capital. Regarding the outlook for the year. Obviously, we're going to continue our effort on cash generation. We are putting pressures on receivable as well as on payable. A bit more difficult to do on inventories, which we won't be able to contend so much because we are launching new products and in particular, biologics, which require longer -- larger inventory.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Thanks, Marc. Let's take a webcast question from Marietta Miemietz. The question's for you, Mark, Mark Mallon. Can you give us an update of the patient flows between categories in diabetes? Are physicians becoming more comfortable with the SGLT2 class? Or is the class, many getting from DDP-4 due to additional benefits? Any indicators that these SGLT2s are delaying the start of injectable therapy? Any color on how patient flow into and between the categories is changing, as the SGLT2 class gains attraction? Any indication will be great.

Mark Mallon - *AstraZeneca PLC - Executive Vice-President of Global Product & Portfolio Strategy, Global Medical Affairs & Corporate Affairs and Executive Vice-President of International West*

So physicians are definitely getting more comfortable with the class. And I think the best way to describe how that's evolving is earlier use of SGLT2. So we're seeing more use in type-2 patients. We're seeing more use immediately after metformin, ahead of DPP-4s. And we're seeing physicians adding it in onto the other therapies sooner and more early in the process. So far, I can't say that we've got a strong indication of a big change in when injectable therapy is starting. I think both -- that all of this is going to head towards SGLT2s as people better appreciate the cardiovascular benefit of the class, and we're certainly doing our part to educate around the overall benefits in glucose control and weight loss of SGLT2.

Pascal Soriot - *AstraZeneca PLC - CEO and Executive Director*

Good. Thanks very much, Mark. We'll have to stop here. We are just getting to almost 1:00 p.m. So thank you very much again for your great interest in AstraZeneca, and I wish you all a great day. Thank you. Bye-bye.
