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PRESENTATION

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Thanks for joining us, everybody. I'm Terence Flynn, the U.S. biopharma analyst here at Morgan Stanley. And this morning, I'm very pleased to be hosting Johnson & Johnson. Today from the company, we have Joaquin Duato, who is the company's Chairman and CEO; and John Reed, who is Executive Vice President of Pharma, R&D. Thank you both so much for joining us. Really appreciate the time today.

Before we get started, for important disclosures, please see the Morgan Stanley Research disclosure website at www.morganstanley.com/researchdisclosures. If you have any questions, please reach out to your Morgan Stanley sales representative.

QUESTIONS AND ANSWERS

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Well, maybe I thought we'd get started, Joaquin, you've been in the role as CEO now for almost a year. And so maybe you could provide us an update kind of first on your strategic priorities and capital allocation strategy. And the other big change of the company is the consumer separation. So now J&J is a Pharma Medtech company following the separation of Kenvue a few weeks ago.

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Thank you, and thank you for joining this fireside chat. The -- we are very pleased of having completed the consumer separation. It was a 2.5-year process. And at this point, the consumer company, Kenvue, is an independent company. And we are enthusiastic about the Johnson & Johnson that has come out of that, exclusively focused on R&D and innovation, on Medtech and Pharmaceuticals. This increased focus is going to help us be more productive and, at the same time, have higher margins, higher growth rates because consumer had lower margins and lower growth rates compared to Medtech and Pharma.

So I firmly believe that this positions us especially well to be a multi-decade company and to bring success not only in the coming couple of years, but into the future. When I think about Johnson & Johnson, there are things that remain the same. It's our mission around healthcare and difficult-to-treat diseases with medical technology or with pharmaceuticals. It's our principles of our credo. This is the 80th anniversary of our credo. It was written in 1943, and those are things that are not going to change.

Looking at the priorities for this decade. I have stated two when I started to be a CEO. One is to drive our MedTech group to be a best-in-class group, a top-tier grower. And we are clearly moving into that direction. Our first half of the year growth for MedTech was 8%. And the second one is to continue to deliver growth, competitive growth in our Pharmaceutical side, not only in the short term of '24, '25 period overcoming the STELARA patent expiration, but also in the second half of the decade and to continue to deliver significant growth during that period. So I'm sure we will discuss about these two aspects later, but those are the two goals: top-tier growth in Medtech, increased profile of our growth in the second half of the decade in the Pharmaceutical group.

When I think about Johnson & Johnson now and in the future and when I think about where medicine is going, I firmly believe that having a company -- the only company that has MedTech and Pharmaceutical capabilities, it's going to be important for us to be successful where medicine is going. Most of the diseases do have a component of treatment of surgery and pharmaceutical, and we are going to be the only company that we have both capabilities so we can do things that no other company can do.

Now the proof it's going to be in our results. And when I look at the first half of the year, I think we are delivering on that promise. Our total Johnson & Johnson growth in the first half of the year was 8%. We have provided updated guidance post the consumer separation for full year 2023. And the midpoint of our guidance for the combined company is $84 billion, 8% operational growth and north of 12% of EPS increase. So I'm pleased with that trajectory that we're having in 2023, and it delivers on the promise of being a top-tier company.

When I think about capital allocation priorities, which is your second question, we aim to be a very disciplined financial company. We have an excellent credit profile, we have a very robust free cash flow generation, and we want to maintain that solid financial profile for Johnson & Johnson. Our priorities are clear and have not changed. The first thing is to continue to invest in our business in -- especially in R&D, and I'm sure you'll have opportunities to discuss with John how we are doing that. Second one is to continue to pay a competitive dividend. We have had 61 consecutive years of dividend increases, and we don't plan to change that.

The other one is to use part of that for M&A, for value-creating acquisitions, expanding into markets that we are today or adjacencies and, if appropriate, for share repurchases. If I tell you the numbers in the last 5 years, we invested $64 billion in R&D in the last 5 years. We used $60 billion for dividends and share repurchases, so about 60% of our free cash flow and $33 billion for M&A. So that gives you a picture of what are our capital allocation priorities. And this is something that we don't plan to change. We want to maintain our robust financial position.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Okay. Great. Well, it sets the stage perfectly. The one, I guess, segue question just relates to M&A. I know you and I have talked in the past, and you've been very proud of some of the deals you've done on the pharma side where you guys have gone very early stage. When I think of the IMBRUVICA deal, DARZALEX deals, those are kind of early-stage assets and you've generated a great return on those given the success of those assets.

And so my question is, I guess, is that your preference on the pharma side? And then in MedTech, should we think about more of kind of Abiomed-type deal is kind of the preference? How do you think about just kind of stage of deal in Pharma and MedTech?

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Yes. So I know there's a lot of focus on M&A, but I also would like to underline that the majority of the growth of Johnson & Johnson, the overwhelming majority of the growth is going to come from our existing R&D and our existing portfolio. So M&A thus is important, it's important in creating future growth. But the majority of the growth, if you look at the 5-year period, it's going to come from our existing portfolio and our R&D efforts. So our preferred way, and that reads both for MedTech and for Pharma, is to be able to go earlier on in order to do deals that can be licenses, partnerships or acquisitions, to be able to leverage our scale in development, in manufacturing, in commercialization and to capture the most value we can.

So clearly, if we could, it would be all these type of deals. And we have a great track record in Pharma in being able to do that. You mentioned some of them. And we also have a good track record in MedTech to do that. It does take longer to maturate these deals in MedTech. That's clear. So with that differentiation, our preferred way in Pharma remains the same. We have a tried and true formula. We have not departed from that formula. And in MedTech, we want to be able to go earlier on too and to increase the number of shots on goals that we have there. And sometimes if we see the right opportunity, expand into markets that are faster growing that are adjacency where we are. For example, what we did with Abiomed. That would be an example of that.

How is Abiomed is doing? Abiomed is doing really well. I mean it's growing around 20%. And we think that the Abiomed deal is very prototypical of what Johnson & Johnson should do, which is platforms that are going to have a multi-decade growth profile. And that's what we are trying to

do. And Abiomed has a number of opportunities in different products and indication expansions that are going to make it a core part of our cardiovascular business there.

But I want to underline that we remain disciplined, and the same way that I was describing our capital allocation priorities, that plays in our M&A strategy. And that while we are open for M&A as we have deal with Abiomed, we remain focused on making sure that we do very well with our existing business because that's the core of the growth that we'll deliver to investors in the coming years.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Okay. Great. So maybe just moving on to the Pharma business. Obviously, this is going to be on a percentage basis, a much higher percentage of the company now post the consumer separation. The company has provided 2025 pharma guidance of $57 billion on an FX-adjusted basis. I think consensus stands around $55 billion despite the recent STELARA settlement. So maybe just walk us through what you see as the biggest disconnect, and this goes back to some of your earlier point on just the underlying franchises driving that of your growth.

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Absolutely. I have to tell you that the consensus is moving closer to the $57 billion now.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

I didn't look this morning.

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Yes. So the consensus has moved closer to the $57 billion. And I see in the investor side an increased confidence on the $57 billion, and I will explain to you that. We have always been confident on getting into $57 billion in 2025, and we are very confident that we are going to be able to do that, just to be clear. So why are we confident of the $57 billion? There's a number of factors that I'll go one by one, and then I will go at the end to the disconnects, which are not as wide as we had before.

So what are the factors? First, we have a very strong marketed portfolio of products that are growing well, TREMFYA, our IL-23; ERLEADA, our prostate cancer medication; our long-acting therapy, our long-acting antipsychotic franchise with INVEGA SUSTENNA; our pulmonary arterial hypertension franchise; and our biggest asset today, which is DARZALEX, which is doing really well being standard of care, now in first-line in newly diagnosed multiple myeloma patients. So those ones that we have identified as core products of our existing portfolio, that do have legs during the second half of the decade, are doing really well, all of them growing north of double digit.

Then at the same time, I think we have provided increased visibility to our new product launches, four: one is CARVYKTI, our BCMA cell therapy, which has had best-in-class results, and I'm sure John will talk about CARTITUDE-4 later and what it means to be able to go to earlier lines; TECVAYLI, which is teclistamab, our BCMA CD3 bispecific; and then our recent approval of talquetamab, TALVEY, our GPRC5D CD3 bispecific, which was approved a couple of weeks ago. So those are 3 new products, with the addition also of SPRAVATO, which is our medication for treatment-resistant depression, which we are now disclosing in our sales tables. And you're going to be able to see the progression of these 4 new drugs.

So all these new products are going to be substantial contributors. And then on top of that, because those products are marketed, I think there's more visibility to some of the late-stage products in our pipeline that will have some important role in this coming couple of years. One, you have more visibility on amivantamab and the combination of amivantamab plus lazertinib with the PAPILLON data and the MARIPOSA-2 data that I'm sure we're going to get a question, and I'll let John talk about that. You have more visibility on nipocalimab, in which we are going to have upcoming data. We also have presented data on our oral IL-23 receptor antagonist peptide, which creates an additional avenue for growth. And we also have

presented data on our drug-eluting device, TARIS, that is implanted in the bladder for earlier-stage bladder cancer which was very promising. So I think there's more visibility into some of the key assets of our pipeline. And I think that gives enhanced confidence to the investor.

There are other elements of our pipeline that we have more visibility, for example, milvexian, that we have started all the 3 Phase III studies. So we are executing well on our pipeline, and that gives increased visibility. So I think that is -- the combination of our existing products, our new product launches, the visibility in our pipeline has increased the confidence on the $57 billion.

What are the disconnects that still exist? One is with TREMFYA. I think that TREMFYA and the impact that the IBD indications are going to have in TREMFYA is not yet well recognized, right? And we are going to present data on the studies both in UC and in CD very soon. And that's going to be a new leg of growth in TREMFYA, which is not yet well recognized. For background, on STELARA, that could be a good proxy, 75% of the sales of STELARA are in IBD. So when you look at TREMFYA today, you have to think about the potential because 75% of the sales of STELARA are in IBD. TREMFYA, it's only in psoriasis and in psoriatic arthritis. So I don't think that's well captured yet.

ERLEADA is not yet well captured because we are in the process also of having results of a study on highly localized -- in localized prostate cancer, high-risk localized prostate cancer, 2 studies there. And that would be a new level of growth for ERLEADA, our prostate cancer medication. And then finally, I don't think that SPRAVATO, our treatment-resistant medication rapid-acting antidepressant is still well captured in its potential. SPRAVATO was the first medication with a different mechanism of action in treatment-resistant depression. It got 2 breakthrough designations by the FDA. And while it takes longer to introduce new antidepressants because the psychiatry group is more conservative, it's building up very well, and you're going to see strong progression quarter-over-quarter.

So these 3 products, I believe, are the ones that may have more of a disconnect versus what The Street is projecting in $57 billion. But again, I believe that the confidence of the $57 billion has increased. Now our goal is to provide more reasons to believe in our growth profile in the second half of the decade.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Yes. So does that mean we should expect 2030 guidance at the R&D Day that's coming up later?

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

I mean, we have an upcoming enterprise business review at the end of this year. And what we -- our goal there would be to provide more conviction around the next couple of years both in MedTech and in Pharmaceuticals and at the same time, give you more visibility, both in MedTech and Pharmaceuticals to our pipeline so as to be able to have a better view of the growth profile in the second half of the decade. The same way that it took some time to get into the $57 billion, I think that we have some work to do in showing investors what is our growth profile in the second half of the decade. So our main goal in that reading would be to give you more visibility so you are in a better position to model and to profile what is going to be our growth in the second half of the decade.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Okay. Understood. I want to get to myeloma because that's one of the important franchises. But first, I just thought I'd ask one on RYBREVANT and lazertinib. You mentioned this, Joaquin, MARIPOSA-2, but also we're waiting on the MARIPOSA-1 study which again would open up the frontline opportunity. So maybe, John, this is more for you, in terms of weighing the importance of efficacy versus tolerability here in that first-line setting, because I think that's one of the debates is we get physician feedback as it's an IV plus an oral. But where does efficacy -- how do you weigh efficacy versus the tolerability of the infusion reactions, et cetera, as you think about first-line setting?

John C. Reed - *Johnson & Johnson - Executive VP of Pharmaceuticals R&D*

Yes. No, thanks. Well, first, I just want to say, while Joaquin has been the CEO for 1 year, I've been the Head of R&D now for 5 months. But I have to say it's just been great to join the J&J team. Great pipeline, great people, great purpose-driven culture. The RYBREVANT program is one of the exciting gems of the portfolio and really giving us now an anchor in lung cancer. As you know, we're #1 in hematologic malignancies, and you referenced some of the groundbreaking products that we've brought to market there, But solid tumors now is an area where we're starting to build momentum beyond prostate where we've had a strong track record, but now in lung and bladder.

The ongoing study, I think it really comes down to efficacy and whether we can move the needle on that, preferably showing disease-free survival improvements of at least 6 months to offset. There will be additional EGF-driven side effect profile. In terms of convenience, I would say we're making rapid progress with a subq formulation of RYBREVANT, which actually is better tolerated as well. So I think once we've got that and that part of the argument around convenience becomes moot, that will be quite easy then for patients and healthcare providers. So that really comes down to the efficacy, and the data will be the data.

But in the pilot study we did in frontline with ami and laz, the -- we recently -- the so-called CHRYSALIS study, we recently reported progression-free survivals of around 33 months. And if you look at the historical same context, single-arm pilot data that was done with osimertinib back in the day, that was around 18, 19 months. So not a trivial difference, really almost a doubling of progression-free survival was seen. So we're going to have the data any day now. Then -- and I think it really -- it all comes down, do we move the needle on the efficacy for patients that make a little bit extra side effects worth it?

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Yes. One, I guess, segue because there's some data that was presented at World Lung and from the FLAURA study, I think it was with osimertinib plus chemo versus osimertinib. And it looked like that PFS in the control group was a little bit lower than the 18 to 19 months. And I think they attributed it to maybe some like slightly later-stage patients. Anything you can comment there about how to think about your population in your trial versus that study that came out?

John C. Reed - *Johnson & Johnson - Executive VP of Pharmaceuticals R&D*

No. I mean the eligibility requirements certainly not that different. But I would just say I would -- if you look at those data, notice a discontinuation rate, it's not a very well-tolerated regimen. And then let's also understand that what really matters is, in the lung cancer patients' journey, how long are they actually going to live? And chemo, we tend to reserve for when they failed everything else. And so to use that upfront with a lot of dropouts for side effects and really, I think, raises the question, what will the overall survival be for patients that go that route versus what we're proposing, which is to use the 2 targeted agents, RYBREVANT, lazertinib and then in a second-line setting, go to chemo at that point. So let's see what the data are. I can't wait any day now.

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Certainly, we're going to do it. Yes.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

All right. Looking forward to it. We'll stay tuned. Now maybe going back to myeloma, Joaquin, we've been talking about this for a decade. You guys have a long history going back to VELCADE innovating in this space; DARZALEX, as you mentioned, standard of care in frontline, has been a transformative drug; and now CARVYKTI and 2 bispecifics. So I guess the big-picture question I have is just how do you guys position for the next 5 years? We know right now, a lot of these drugs are being used in late-line patients because there aren't any options, unfortunately. But as you think about the medium to longer term in myeloma, how do you think this will play out in terms of segmenting the market because you have so many different options for patients now?

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Thank you. And I will let John elaborate on the studies that we have there. I mean as a headline, multiple myeloma is the best example of our disease-centric approach and the combination of internal and external innovation that we have done there. We have internal assets, partner assets. We've been able to develop 5 major assets in multiple myeloma starting with VELCADE, DARZALEX, CARVYKTI, TECVAYLI and now TALVEY. So really a good example. And our aim here, as I have commented, and I said that humbly, is to change the paradigm from treating to progression to treating to cure. And we think that acute in multiple myeloma is something that is reachable with the existing therapies.

We have now 4 products like DARZALEX, which we believe will remain a backbone of therapy. Every single time that DARZALEX has been combined with any regimen, it has improved the results. And it's today, as you mentioned, standard of care in newly diagnosed multiple myeloma patients. CARVYKTI, that we plan to move into earlier lines. CARTITUDE-4 is an example of that, but we have other studies there. And I'm sure when we talk about CARVYKTI, you think about supply of CARVYKTI, you're going to see improvement quarter-over-quarter in CARVYKTI. So the proof will be in our improvement there. We are expanding capacity internal and externally. We have in-sourced the lentivirus production. So we are in a better position to supply the demand, and you're going to see progress in our supply of CARVYKTI, as you saw when you look at the quarter-over-quarter sales of CARVYKTI this time.

TECVAYLI and TALVEY, which just been approved in later lines, and we have a number of studies combining both and moving them also into earlier lines that John can comment. So overall, it's a very strong portfolio, one that we believe is going to be the major growth driver in absolute terms for our Pharmaceutical group now and also in the second half of the decade. So this is a situation where we believe we have a clear position of leadership. So I'll let John comment on the different studies that we have in order to try to sequence and combine all these.

John C. Reed - *Johnson & Johnson - Executive VP of Pharmaceuticals R&D*

Yes. I think it's what it's all about. It's sequencing, the mining. And for example, in the frontline, of course, we've been really focusing on DARZALEX as a combination for the more standard of care kind of regimens, and the readouts are coming shortly on one of the more popular ones, the BRD, the VELCADE, one of our molecules, REVLIMID, dexamethasone in combo. But then, as you know, patients if they're eligible, go on to a stem cell transplant, so here's where we are doing studies to look at whether CARVYKTI could substitute for that. And this is where you can really start to think about cure, might that be the road to cure where you get people into a very deep remission, we can do these minimal residual disease testing after the initial therapy and then see them go into a CAR-T therapy rather than an autologous stem cell, and the same thing in transplant ineligible.

So that's just one example. And then with the 2 bispecifics, and these -- we had the -- we were the first to bring a bispecific into the myeloma market. The most recent one, TALVEY, is exciting because our scientists actually discovered that target. So it just shows how deep our expertise goes in myeloma. There, we're looking at combos of the 2 bispecifics. And at ASCO last -- this year, earlier this year, we showed tantalizing data, small number of patients, but it really looked like bringing those 2 T cell engagers together was giving you CAR-T-like activity with a pair of biologics. So we're digging deeper into that.

But we're also running combos with DARZALEX plus tec, DARZALEX plus tal, working out dose schedules so we get tolerability well nailed. And then we'll be looking at how we bring those combos in further into the frontline product possibly. So I think the takeout message is we'll be able to cover all lines of therapy essentially for myeloma patients. And we -- really, with some of these new regimens, I think we can really start thinking about how do we get from decades of successive therapies to one of might we actually come up with a curative therapy for this disease? And wouldn't that be wonderful?

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Our goal would be that the vast majority of the newly diagnosed multiple myeloma patients would be treated with a Johnson & Johnson regimen.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Yes. I think you guys said on the earnings call, 3 out of 4 patients by the end of the decade, yes.

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Yes.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Yes. What -- can I just ask one question about the kind of current dynamics? Because you mentioned the supply constraints around some of the CAR-Ts, including CARVYKTI. Are the bispecifics being used as kind of a bridge to CAR-T therapy currently? Is that what's -- part of what's happening right now? Or is it just there's not enough supply, so patients are really embracing the bispecifics?

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

I mean there's 2 cell therapies in the market and the bispecifics now are used, I mean, in a similar setting than the cell therapies are given the current indication. They are all BCMA, right? So it's more the patient's preference of using cell therapy or a bispecific, and it depends also on how quickly and the type of patients they are using. But there's not really -- I cannot tell you an answer there. I mean I have yet to see how TALVEY as a GPRC5D and a different antigen is going to be positioned, right?

Because TALVEY may open a new line of therapy, but also offers possibilities of convenability that John was describing, and we have yet to see -- it's been only 3 weeks since we launched TALVEY. We already have commercial patients of TALVEY in the U.S., and there's significant enthusiasm for a modality like that. But I would say that the vast majority of the patients that are receiving these therapies today are patients which are relapsed refractory, that have gone through multiple lines of therapy, both in cell therapy and in bispecific.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Okay. Maybe just in the last 30 seconds, another asset, I think maybe somewhat underappreciated is nipocalimab FcRn. Obviously, there's a competitor out there who's ahead of you. You guys have talked about your broad strategy. But maybe just remind us what data are you expecting near term.

John C. Reed - *Johnson & Johnson - Executive VP of Pharmaceuticals R&D*

Well, we see this as kind of a universal solution to auto antibody-driven diseases, and there are about 80, 8-0, different ones out there. We're in parallel development in 10 different indications. But I guess the one I'm personally most excited about is what we're doing in rheumatoid arthritis, where we're going to have some data that we'll disclose later this year. And just I think a day or 2 ago, we also disclosed on clinicaltrials.gov that the next chapter too, we'll be looking at combos with TNF therapies, TNRA, where we hope by combining these mechanisms, we might break through efficacy ceilings and get a higher percentage of RA patients into complete remissions and keep them in remission and really allow them to enjoy a pain-free, inflammation-free lifestyle.

So very excited about where we can take that molecule. We've got proof of concept now in 3 different big segments, sort of demonstrating the broad utility. The epitope we're using drives the lowest levels of IgG, so we think it's the most potent. We also have what appears to be the best safety profile in terms of not having much effect on albumin and lipids. And we've even taken into pregnant women who are having autoimmune-driven hemolytic anemia, but their babies have shown safety in a context like that. And a lot of these autoimmune diseases do strike disproportionately women and in their childbearing years. And so to have that kind of safety profile there along with the efficacy in 9 out of -- on

an average of 9 out of 10 cases, we were able to save babies and they were born, whereas the results would have not been very good otherwise. So that safety profile in the right population, potency, very excited about where we can take nipocalimab.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Could I add, and we're out of time. Just one follow-up on the RA side. I know in the past, you guys talked about the kind of biomarker strategy there. Is that still the plan?

John C. Reed - *Johnson & Johnson - Executive VP of Pharmaceuticals R&D*

It's part of the studies. So we'll be sharing some of those data as they unfold. And of course, a precision medicine strategy in the autoimmune diseases has always been a Holy Grail. Many attempts, few successes, but we are going at it there. And we'll see how that pans out for us.

Terence C. Flynn - *Morgan Stanley, Research Division - Equity Analyst*

Great. Well, Joaquin, John, thank you so much. Appreciate it.

Joaquin Duato - *Johnson & Johnson - CEO & Chairman*

Thank you. Thank you.
