

FINAL TRANSCRIPT

Thomson StreetEventsSM

PFE - Pfizer Analyst Meeting

Event Date/Time: Mar. 05. 2008 / 8:30AM ET

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PRESENTATION**Unidentified Company Representative**

Ladies and gentlemen, Senior Vice President, Worldwide Investor Development & Strategy, Mr. Amal Naj.

Amal Naj - Pfizer - SVP - Worldwide Investor Development & Strategy

Good morning. It's my great pleasure to welcome you to our Investor Day. Today our senior management will present to you our path forward as we manage through many challenges facing Pfizer and the industry. Our presentation this morning and this afternoon are divided into two parts. The first section will focus on research and development and the second on operations and finance. After each section you'll have an opportunity to ask questions. When we get to the Q&A section and if you want to ask a question, please kindly identify yourself by name and your affiliation.

Those of you who are in this conference room will find in your binder our slides in front of you, our press release, updated pipeline information, as well as scientific bibliography. Those of you who are listening on the phone and on the webcast, the slides are available on our website, pfizer.com, and they can also be downloaded from the tab marked Investors.

Now before we begin I would like to draw your attention to our cautionary language on this slide -- can we have the slide please -- as well as to our regulatory notice. Both these slides, the cautionary language and the regulatory notice, are included in your binders, as well as they are available on our website. Now it's my pleasure to invite our Chairman and CEO, Jeff Kindler. Thank you.

Jeff Kindler - Pfizer - Chairman and CEO

Thanks, Amal. Good morning everyone, thanks so much for joining us today. We've made real changes in how we're operating this Company, in our structure, culture, and leadership, so that we have a much stronger foundation in place for pursuing the many opportunities before us. We're realistic about the challenges that we face, but we're also optimistic about the growth strategies that you'll hear about today and the opportunities that we see now, through, and beyond the Lipitor loss of exclusivity.

Now it's fair for you to ask, why are you so optimistic. Looked at one way, we haven't done any transformative mega-deals, we're largely selling the same products in the same markets, fixing the pipeline takes time, and Lipitor's loss of exclusivity is getting closer. But in my view this misses the bigger picture of the absolutely essential work we've been doing at the foundation of our

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business, not all of it glamorous to be sure, so that as a Company we have what we need in place to actually go forward and pursue our global opportunities.

In all candor, while Pfizer has many strengths and many talented experienced people, I believe if you go back two years ago, this was not a company that was ready to be opportunistic in the fullest sense of the word. We needed to create a new Pfizer. And today you'll see from our team, across-the-board, actions that quite honestly wouldn't have happened until very recently because they just weren't part of our culture.

We're in a different and much better position to drive our business forward today. Our DNA has changed. We're moving faster, we're identifying diverse new ways to grow, we're making smarter decisions in employing your capital and we're diversifying the risk profile of this Company. We see opportunities in growing markets around the world where we already have a strong presence and decades of experience, in therapeutic areas where we have important competitive advantages and across our broad and deep product portfolio.

Now over the next several years, to be sure, we'll have to deal with one of the realities of being in the branded pharmaceuticals business, which is losses of exclusivity on some of our products. In many cases these are similar in size and timing to those we've been managing through the past few years, but of course we all know the one-time loss of exclusivity for Lipitor is of a different magnitude. In the immediate aftermath of the Lipitor LOE our revenues and earnings will obviously be meaningfully impacted.

While we're not in a position today to say with absolute precision what that impact will be, we can say two things that go to the heart of our commitments to our shareholders. First, we have and we will continue to pursue, now, through, and beyond the Lipitor LOE, a wide range of opportunities that we believe will provide us many sources of sustainable revenue growth.

Second, we will do what is necessary to size the Company appropriately for our revenues and opportunities, whatever they are, so that we deliver growing profitability after Lipitor. In short, after the Lipitor LOE we expect to be a strong, profitable, growing company. And, I think that bears repeating, strong, profitable, growing -- an industry leader.

Now to deliver on these commitments we will execute our growth strategies, as well as proactively establish a lower more flexible cost structure, so that we're better able to quickly adjust the size of the Company when we need to. While you'll see a range of activities today, each of them rests on two important principles.

First we're aggressively finding new opportunities for growth. We're doing this by taking full advantage of our global scale and capabilities, while at the same time establishing a series of smaller operating units within our worldwide pharmaceutical operation that give us more flexibility, speed, and customer focus in a fast-changing marketplace. And second, we're ensuring as much as we possibly can that we make the right investment choices when we allocate your capital across these opportunities.

Now on the first point, it's clear that the changes in our marketplace, including an information explosion, the rising middle class in emerging markets, and the increasing fragmentation of our customer base, these all point to one important fact. One size does not fit all and cannot fit all for the world we live in. In recent years we haven't always acted on that fact. We often took a monolithic approach in which those of us in U.S.-based headquarters functioned as command and control for our global operations. Well, what you'll see today is we've moved away from that model, so that we can run the business with much more agility. The key to making this happen is accountable business units where decisions are made locally and by the people closest to the action.

So here are some examples of how this plays out across our business. Internationally we're continuing to drive decision making down to the level of execution so that our Country Managers are now essentially running their own business units and making quicker decisions without undue layers of oversight. In the U.S. pharmaceutical organization, as you know, we divided our business into five separate accountable units whose seasoned leaders, while leveraging those activities that benefit from scale, are acting quickly to seize the opportunities unique to their customers and their markets.

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In research we've not only consolidated each of our therapeutic areas of single sights, but we've also put world-class scientists in charge of each one. And those scientists will themselves pick the targets that we're going to pursue in our labs without further review by committees or supervisors. This is a significant departure from our previous practice.

In addition, as you'll hear today, we have for the first time adopted a company-wide strategy for Asia that involves all of the commercial manufacturing and research leadership in the region. These are people that are focused full-time on identifying and seizing new opportunities in that growing part of the world. Among other things, this focus will allow us to meet patient needs that are unique to Asia, particularly in oncology as you'll hear today.

And you'll also hear today that we've created two new separate business units, one of our established products and one for our very promising oncology franchise. Again, empowered accountable leaders driving for growth in their areas of focus. In these and many other ways we're stepping up innovation in our operating model, so that we can build out solutions that are tailored to our many opportunities and keenly focus on the many different customer needs that we seek to serve around the world.

Now as we keep driving down decision making and accountability in this Company, we also need to make the right investment choices to fund our growth and deliver total shareholder return. We know we have an obligation to use our owner's capital productively and we take that obligation very seriously. We intend to focus our capital with focus and discipline in the therapeutic areas, products, and geographies that offer us the best opportunities for long-term growth. We're also applying specific, measurable, systematic criteria and active oversight, so that we constantly monitor and assess the performance of our investments and make interim adjustments, including adding to something that's working and stopping something that's not.

So for example, we've put a new process in place for evaluating research candidates and focusing our R&D efforts and this has resulted in the expansion and acceleration of key programs, as our head of R&D, Martin Mackay, will highlight this morning. We looked at every disease area and every compound that we have to determine whether it's in an area of unmet medical need and anticipated growth, whether the science is promising, and whether we have or we can obtain the capability to be a leader in that particular area. And for those disease areas and compounds that met those criteria, we will invest to win. For those that do not we will look at other options, including exiting.

For external business development we'll be very active in pursuing the most promising areas of science and technology, consistent with our overall strategies. We're committed to paying close attention to the price risk equation in looking at any particular opportunity, especially in this very pricey market. Purchasing growth for us, it has to make sense both from a value and a risk perspective and we will evaluate the tradeoffs carefully, while staying opportunistic.

We remain open to everything. But as we meet today, I do not see anything that would meet the definition of a mega-deal with a large cap biopharma company where the strategic value to our shareholders would outweigh the potential concentration of risk, the inevitable disruption it would bring, and its price. Our intention is to drive the strategies that you'll hear about today, and others, by maximizing our internal assets and supplementing them with focused business development.

Now doing all of this requires that we have a very strong leadership team and I believe that is exactly what we now have. We have a good balance between leaders who have deep experience in global pharmaceuticals and those who bring valuable perspectives from other industries. Just this week we've added Bill Ringo to lead our Strategic Planning and Business Development activities and to join our executive leadership team.

Bill is a senior biopharmaceutical executive with more than 28 years of experience at Eli Lilly in virtually every facet of the business. More recently Bill's been a leader in biotechnology and in venture capital. Ed Harrigan who runs our Worldwide Business Development; Jonathan White, head of Innovation; and Kristin Peck who is head of Strategic Planning will all report directly to Bill.

We're putting the right leadership and talent together with a powerful set of assets and capabilities for the opportunities that we are now in a position to pursue. And those assets and capabilities are considerable. Our global sales and marketing footprint

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is exceptional and we are already a leader today in many of the markets that will drive our growth tomorrow. Plus, we have a diversified product portfolio with some of the world's great brands. We have integrated R&D and manufacturing capabilities, a strong presence in key therapeutic areas with high unmet medical need, a deep and experienced team of leaders, and significant financial flexibility.

We will look at every asset we have to maximize its contribution. And where we see an asset that we don't believe justifies its investment, we will exit. We'll innovate from the developed world across all of the emerging markets, from the early stages of our pipeline to the those products that have come off patent. This is about an attitude, the attitude of our leadership to look at everything we have from new perspectives and to invest to win. Whether it's opportunities for product line extensions like new dosage forms and indications or new promotional and commercial strategies for our in-line products or any of a number of other initiatives that we can take to do more with what we have, we're convinced that applying innovation and new business models to our existing assets will unlock value and deliver incremental growth.

As we look toward the Lipitor LOE and plan for various contingencies including the result of the pending Presidential election, it bears repeating that there is no single magic bullet. In fact, by pursuing a range of opportunities across global geographies, different customers, and multiple therapeutic areas, we are meaningfully diversifying our risk. And that's going to be a significant advantage to us as we move up to and beyond the Lipitor LOE.

We have five specific strategies for growth during this period. First, to refocus and optimize the patent-protected portfolio, both the research pipeline and the in-line products. Second, to seize new revenues opportunities in the fast-growing markets for established products around the world where we have significant sales of post-LOE brands. Third, to accelerate our growth in emerging markets. Fourth, to relentlessly focus on continuous improvement and innovation. And fifth, to invest in complementary businesses that leverage our capabilities and provide attractive financial returns.

Now today we're going to focus primarily on the first three of those, although you'll see evidence of the fourth in every presentation. So I'd like to give you an overview of how we'll address them in the balance of our presentations today. Now delivering our pipeline is of course critically important. Martin is going to tell you how we expect to increase the number of compounds in our Phase III portfolio by 50% to 75% by the end of next year, with a group of compounds that are largely first in class, best in class, and/or fill a significant unmet medical need. We expect this to be the foundation for a flow of valuable new products starting around the time Lipitor goes off patent and continuing in the following years.

As I mentioned, Martin will also tell you about the comprehensive review that we conducted of all of our programs and how we identified those disease areas and those compounds in which we will invest to win. Today we'll highlight two of those areas where we already have broad franchises of novel therapies, oncology, and pain.

Briggs Morrison, in addition to reviewing our late stage development plans in detail, will focus on a number of compounds including some exciting oncology agents. And then two of our highly respected scientists in the Pain Therapeutic Group, Ken Verburg and Gillian Burgess, will review our pain portfolio with a number of first-time disclosures on promising compounds. We'll also hear from the head of our new Biotherapeutics and Bioinnovations Center, Corey Goodman, on early progress there in support of our goal of being a top-tier biotherapeutics company.

Now while we work aggressively on our pipeline, we're also optimizing the value of our in-line products, including products that we will have long after Lipitor. At the same time we're also moving quickly to change our business models to respond to the new realities of our marketplace. Ian Reid, our President of Worldwide Pharmaceutical Operations, will give you an in depth look at our experimentation and implementation of multiple new go-to-market approaches that enable us to add more value to our customers by focusing locally, while we spend less money to do so. This is a strategy that Ian successfully developed and implemented as the head of our European Pharmaceuticals business and he's now applying it worldwide.

Then we'll go in depth on our emerging market strategy as it applies to Asia where we have a strong position now, but a really significant opportunity to grow as those economies and the demand for healthcare keep expanding. The head of our Asia

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business, Dudley Schleier, has decades of experience in emerging markets, especially in Asia. Our goals there include being the number one company in China, having \$1 billion in Korea, and becoming one of the top three oncology companies in the region.

We'll then hear from the leader of our new established Products business, David Simmons, on why this strategy plays to our strengths and exploits an enormous set of opportunities that David has seen first-hand in those markets. Our new comprehensive focus on established products will enable us to meaningfully participate in a large and rapidly growing segment of the global pharmaceutical market while leveraging our existing organizational assets. Ian will wrap up the commercial presentations by updating you on our in-line product portfolio, highlighting our commercial priorities in pain and explaining why our new oncology business unit is such an important step for that growing business.

And finally Frank D'Amelio will review our financials in the context of our continuing focus on total shareholder return. We're making excellent progress on creating a lower, more flexible cost base, which will be a key advantage for us up to and well beyond the Lipitor LOE. Frank will also review with you our commitment to size the Company to align with revenues, now, through, and after Lipitor, so that we can maintain industry-leading margins.

To sum it up, we're taking a much more focused and comprehensive approach to growth. We have an R&D organization that's fully focused on and committed to delivering our pipeline. We have new leadership in place, as well as changed operating models that reflect the profound changes in our global marketplace. We will show you today a specific, diversified, attractive set of opportunities to grow worldwide and to capitalize on our unique set of assets and capabilities.

We'll pursue those in new innovative ways while maintaining our relentless focus on meeting our near-term commitments. We intend to deliver top- and bottom-line growth after Lipitor loses exclusivity and we will size the Company to maintain industry-leading margins and continuing growth and profits. We're becoming over time a very different company, ready to meet the future and capitalize on opportunities anywhere in the world. And now it gives me great pleasure to introduce Martin Mackay.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

I'm going to get right into the presentation and summarize the key points that we will be giving out today. First we have an aggressive goal to rebuild our Phase III portfolio and this means 15 to 20 Phase III starts in the 2008 to 2009 period, which will include both new molecular entities and new indications for existing compounds. That will lead to a Phase III portfolio of some 24 to 28 programs in that same timeframe and that will lead to 15 to 20, a projection of submissions in the time period 2010 to 2012.

Secondly and as Jeff mentioned, we have made comprehensive decisions on both the disease areas that we work in and the compounds that we develop. Third, we're going to give 15 new disclosures today, that's 15, which really reflects the progress that we're making on our late stage portfolio. And lastly I want to discuss briefly some early indicators of delivery in action and why I'm confident that we can meet those goals that we've set out for this organization.

Disease area priorities, now even with the terrific resources that we have in Pfizer, it was clear that we couldn't prosecute all the programs that we had in development and we had to make some critical decisions on those to concentrate on. Towards the end of last year and working with our commercial organization, people like Susan Silverman and others in Ian Reid's organization, we looked across every disease area we worked in. And we set up a number of criteria, including obvious things like critical unmet medical need, large market growth, and did we have the potential to be first in class or best in class in those areas.

This led to a group of compounds and a guiding principal that we set around invest to win. And those disease areas are oncology, pain, inflammation and immunology, diabetes and obesity, Alzheimer's disease, and schizophrenia. Now we are already prominent in many of those areas, but we felt a strong desire to reallocate resources and accelerate many of the programs in these invest

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to win areas. This also led to the exit of 11 disease areas that we were currently working in. And although we saw value in those areas, we wanted to come out so we could reallocate the resources. There's another group of disease areas which we believe have more limited growth potential, but nevertheless are valuable to our organization and we will maintain those disease areas around the resources that we have on them today.

In parallel to this exercise we did a comprehensive review of our portfolio and this was really a first at Pfizer. Of course we do compound reviews and disease area reviews and reviews of certain parts of the portfolio, but never in my experience did we look at every single compound from late-stage preclinical all the way through Phase III and make some significant decisions on that portfolio. We've terminated 24 compounds. Of the 24 compounds 10 are in late-stage preclinical, 14 were in development, and of the 14, nine were in Phase II, five were in Phase I.

This has allowed us to reallocate resources into those areas that we wanted to accelerate and I show some examples on this slide. Our JAK-3 inhibitor, very promising compound, rheumatoid arthritis and transplant, we wanted to expand the number of indications with this compound. Our IGF-1R antibody which is showing very promising results in oncology, we wanted to start simultaneous trials across a number of other tumor types. Our NGF antibody that Ken Verburg will say more about later, again an extremely good looking compound and again we wanted to expand the clinical indications quickly. We wanted to broaden the neuroscience areas for Chantix and we wanted to push our DPP-IV inhibitor through as quickly as we could. In all we had 20 programs that we wanted to accelerate.

Now combining the disease area work with the work that we did with the compounds leads to the pipeline that's published today and I'll just say a little bit about this pipeline. Whilst interestingly it's numerically very similar to what we published the last time out, I believe this portfolio has more value to patients and more potential to create revenues for Pfizer. In terms of Phase III you see us starting to build this area, we know this is critical for our success. As you also know, the Phase II part of the pipeline is highly dynamic. Compounds come into that point from Phase I, they move into Phase III, they're terminated for natural attrition. And added to that this time the strategic decisions we made to terminate some of those programs.

Lastly, our Phase I portfolio is rich in promise. The research organization with the consolidation of the therapeutic areas, having single points of accountability to push compounds through, is pushing not only the quantity of compounds we need into development, but also the quality of those compounds. As we stand today, I believe that this pipeline will serve us well in our future needs.

Let's go to some specifics of the Phase III portfolio. Up here I have both new molecular entities and new indications. Briggs Morrison and Ken Verburg will give you much more detail on the compounds that are on this list and some other compounds. But let me say briefly we're very excited about Axitinib and Tremelimumab, the latter being easily the hardest to pronounce antibody that we have in the pipeline.

Apixaban is our landmark collaboration with Bristol Myers and I can't say enough about how well that collaboration is going with that organization. CP-945598 is our obesity compound and again we're pushing that ahead with some vigor. Two new entries to Phase III, PD-332334, and I've spoken to you about this compound before, is from our alpha-2-delta class of compounds which we firmly believe in, and this is for General Anxiety Disorder. The last time we spoke it was in Phase II, we had a very good meeting with the FDA at the end of Phase IIb and that compound has now progressed into Phase III. And SS-Reboxetine for Fibromyalgia and again Ken's going to show you some interesting clinical data on this clinical compound, again progressed into Phase III.

In terms of new indications, I feel strongly that this has been an area that we have underestimated within the R&D organization. If you think about what it takes to have an idea, move a compound into research, take it through to development and then launch the product, this truly is a miracle and those are golden assets. And it's incumbent upon an R&D organization to maximize the potential of each and every one of those golden assets, compounds such as Sutent, Geodon, Lyrica.

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Sutent is a perfect example of a golden asset. As you know, we gained approval in renal cell carcinoma and gastrointestinal stromal tumor. Today in Phase III we're running studies breast cancer, lung cancer, colorectal and poised in Phase II we have this compound and we're looking at hepatocellular carcinoma and hormone refractory prostate cancer. Truly a golden asset. The addition of these additional indications will serve both patients and Pfizer well.

We project to add a further 15 to 20 Phase III starts into that portfolio by the end of 2009. The majority of the compounds in this cadre are in our invest to win areas, so again we're poised to deliver in the correct areas. Briggs will say more about some of those compounds as we progress them.

We know that rebuilding the Phase III portfolio is critical to our success. By moving 15 to 20 compounds into Phase III in that timeline, we will have some 24 to 28 products in Phase III with a very good balance between new molecular entities and new indications for existing compounds. Of course during that time period we'll also be progressing to the submission stage some of those compounds that we have in Phase III already, so Tremelimumab that I mentioned before for malignant melanoma and a number of good indications for Sutent, Selzentry, Geodon, and Lyrica.

Now whilst a healthy Phase III portfolio is good, just as a healthy Phase II portfolio is good, it's essential that we translate those compounds into submissions. And therefore we project 15 to 20 submissions over the period of 2010 to 2012. And again, we'll talk about some of the specifics as we go through the presentation.

This is a tall order for R&D. In fact I do believe it's the R&D challenge of a lifetime. On the first day that I assumed this position we launched the five-point plan for PGRD and I must and I must say it has gone down very well in the organization, I believe for two reasons really. First it's very simple and secondly it really concentrates on the business that we came to Pfizer to do and that is discover and develop new medicines.

The five-point plan is to aggressively deliver our late-stage portfolio, number one. Number two, to make sure that we're working in the highest value areas. Number three, to become a top-tier company in biotherapeutics and again, Corey will take you through this in some detail. Number four, to dramatically raise the bar on productivity within our organization. We know we haven't been productive enough over the last periods. And number five, to make sure that we are accessing the very best science out there in academia and biotech, and again you'll see some examples of this.

There's no question that the change we've been through in the last few year at Pfizer, the major acquisitions, the consolidations of therapeutic areas, the reduction in sites, the reductions in headcount, they have made us a more efficient organization. But they've also taken a toll on an R&D organization. I believe that we're all but through these major changes.

Of course we'll look for continuous improvement and of course we'll make other progressive changes as we move along, but I strongly feel a renewed confidence within the R&D organization to deliver the promises and the projections that we make today. I do feel a renewed confidence, we are a competitive group of people, the will to win is striking amongst our scientists, we want to work in hard areas, we want to deliver the best compounds and I feel that you'll see that over the next period.

Now talking about competitive, let me move to the end of my presentation and -- sorry just one last point. So those are the words, some of the deliverables that we've had since the last time we published the pipeline as shown on this slide. And I won't go through this in detail, but let me just say we have approvals, we have submissions, I'd pay particular attention to a really great job by our Japanese organization. We've moved compounds into Phase III, we have new indications for existing compounds and in business development we've been active with the acquisition or potential acquisition of companies such as Encysive, CovX, Serenex, and the Coley organization.

But for me a true reflection of the health of an R&D organization is what's happening within that group. And since that time we've had three proof-of-concept studies, we've had 11 first-in-patient studies, and 17 first-in-humans. And if you think about the time scale involved here, it means that approximately every week we go into either a new volunteer study, or more importantly, a new group of patients with a Pfizer compound, every single week.

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Now as I said, a competitive group. Let me introduce you to the four leaders that will take you through the rest of the R&D presentation. First of all Briggs Morrison, I think you know that Briggs joined us around five months ago from the Merck organization. And I have to say I've never known anybody to come into an organization at this level and have such a profound impact so quickly. It's been marvelous and a lot of Briggs' ideas we're already putting in place to accelerate key programs within the development arena.

We're going to talk about pain today, one of our therapeutic areas. In the past we've spoken about neuroscience, cardiovascular, oncology, and infectious diseases, but I believe that pain is a hidden gem in our portfolio. Great potential for success in this area and you'll hear about some of the exciting programs that we have. Ken Verburg leads the development part of that organization. Ken is the consummate seasoned professional. I don't know anybody, certainly not in pain, that has the track record of delivery that Ken has.

More recently with Lyrica in Fibromyalgia, you don't have to go back very long, Ken was responsible for delivering the coxibs, notably compounds such as Celebrex. When Ken walks in your office and says, Martin you've got to look at this data, you sit up and take notice. A few months Ken came into my office with just exactly that. This was data around the NGF antibody that he will say some more about. So I sat up and took notice and when he said that he has never seen pain relief from a compound at such an early stage in development, it's meaningful.

Gillian Burgess leads our research organization in pain. I remember when we hired Gillian, and I'm somewhat biased because I was involved in that hiring, from the Novartis organization and thinking what an outstanding scientist. Gillian has been able to translate that outstanding science into a steady stream of new compounds moving from research into development. She also has an uncanny knack of being able to work outside of Pfizer with many academics, with many biotech companies, and that's really important in an area where the science is burgeoning.

And last and certainly not least my good friend and colleague, Corey Goodman. Again, Corey joined Pfizer around five months ago and it was so heartening when Corey and I sat down and started to work out how we'd become a top tier in biotherapeutics and how the Biotherapeutics and Bioinnovation Center and PGRD would work together. And it was clear our philosophies were completely aligned. We weren't going to let boundaries get in the way, there was going to be seamless transitions, we've cared less about hierarchy we moved around.

And as you know, Corey is a terrific scientist, great entrepreneur, and again has really hit the ground running and he'll show you some very exciting programs as we move along. So lastly and briefly I'd like to thank you for your attention and introduce Briggs Morrison, our head of Clinical Development.

Briggs Morrison - Pfizer - SVP - Clinical Development

Thank you very much. Is the microphone on, everybody can hear me okay? Good morning, everybody. So as Martin said, I'm new to Pfizer, I've only been here five months, today is actually my five-month anniversary. So I thought what I would do at the beginning is just to give you my impressions of the place as somebody who comes into the organization having been at another pharma company previously. And I have to say I feel really, really fortunate to be at Pfizer at this time, it's really, really exciting and you'll see as we go through my presentation why I'm so excited about being here.

You know the last week in January we brought the top 200 scientists in the R&D organization to a meeting to get them aligned around our 2008 objectives and what we're going to do. And at that meeting we reviewed nine of our late-phase programs. There were more programs that we could have reviewed but we didn't have enough time, and that tells you a lot right there. We went through nine programs. We went through four programs in oncology, as Martin has said, an invest to win for us, Sutent, Axitinib, the IGF-1R antibody, and Tremelimumab, which I agree is one of the hardest ones to say.

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Four really exciting compounds in oncology and I can tell you as an oncologist coming into Pfizer, I really do believe that Pfizer has the best oncology pipeline of anybody of the industry. These are four very exciting molecules and there are a lot of molecules behind it. So we went through those four. We went through three molecules in pain and inflammation, the NGF antibody and Reboxetine, as well as the JAK-3 program. We talked about Apixaban and we talked about Chantix, the [pregalem] awarding winning medication for smoking cessation.

Nine programs, and as I said, we could have talked about more. At the end of that day I went back to my room and I said, wow, this is just fabulous, I'm so fortunate to be here and I'm very grateful that Martin has given me this opportunity.

Now on the other side of things as I come into the organization, people in the organization told me within the first month or two that I was here that there are some issues around the operations of development, how they execute on their trials. And the people in the organization have expressed some frustration about not being able to go as fast as they want. And the good news is I have experience with that, I've worked in that area before, I understand how to improve that, and I'm very excited about doing that here at Pfizer.

So again I'm very excited to be here. Wonderful pipeline, yes we may need some issues we have to tune up on the operations side, but I'd much rather be in that situation than the converse where you have great operations, but you don't have a pipeline. So I'm really, really glad to be here.

The outline of my talk today, I'm going to primarily focus on the compounds that are moving from Phase II to Phase III over the next 12 months. Both new molecular entities and the compounds that are new indications for things that are already in Phase III or already on the market. And I will talk a bit about this execution issue and what's going well and where are there opportunities to improve that. As Martin said, there are 15 new disclosures today, these are the programs that will be touched on either in my presentation or Ken's or Gillian's. The ones that are in bold with the asterisks are the ones where there's new disclosures.

So let's get right into it. The top line on this slide is really the takeaway that I want you to focus on. We anticipate that between now and this time next year we will move between 10 to 12 programs into Phase III. That will be a combination of new molecular entities as well as new indications for existing molecules. So let me say that again to make sure everybody has it clear.

About 10 to 12 programs will move from Phase II into Phase III, about four of those will come from new molecular entities and about six will come from new indications for existing molecules. The four that we project will come from new molecular entities come from this cadre here, but more specifically from this list. So these are the six programs that are poised to move into Phase III by this time next year, and I'll just say a couple of words about a couple of them.

The first one is the nitric oxide-donating prostaglandin agonist for Glaucoma, our collaboration with NicOx. This compound is in a proof-of-concept trial now and we anticipate getting that proof-of-concept data by the middle of this year. If we get proof-of-concept, the team is well poised to take that molecule into Phase III by this time next year. So that's the first one.

The second one is a combination of an IV form of Sulopenem, an oral pro-drug for bacterial infections. Having both an IV and an oral form we think allows [fastful] transfer of patients from IV in the hospital to oral medications. We haven't had our interactions with regulatory agencies on that program yet so there is clearly some risk there. But from a scientific point of view and a development point of view, we're poised to move that program into Phase III by this time next year as well.

The IGF-1R antibody, the JAK-3 inhibitor, and the DPP-IV inhibitor I'll say more about and Ken will talk about the NGF antibody. So let's first start with the IGF-1R antibody. What you'll see on my slides and Ken's slides when we talk about specific molecules, up in the far right hand side there is our current assessment, and I'm going to emphasize, our current assessment of whether we think the molecule can be first in class or best in class, is it focused on the area of high market growth and addresses high unmet medical need.

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The IGF-1R antibody we put a check in each one of those three boxes, we do think that it can be first in class and best in class actually for this molecule. Studying it in patients with cancer, clearly an area of high market growth and an area of high unmet need. So this is a highly specific human antibody against the IGF-1R receptor, it's been well tolerated in studies to date and that gives us reasonable confidence that we should be able to combine this agent with a number of different chemotherapies. And as Martin alluded to, we've already heavily invested and developed a broad program in a number of different cancers.

We have proof-of-concept in non-small cell lung cancer and this data was presented last year at ASCO and at another scientific conference in the fall. What's shown here is the response rate. So the way the study was done is you take patients with newly diagnosed lung cancer, you randomize them to get either standard of care, which is Carboplatin/Paclitaxel or standard care plus the antibody, and you ask what percent of patients have their tumor shrink. Okay that's what's the response rate in the oncology field. And if you compare the height of the two blue bars, when you add the antibody you see that you get a higher response rate showing us clearly biologically something is going on when we add this agent to standard of care.

What's interesting in this data is that the two other bars, the yellow and the green, are the different subtypes of non-small cell lung cancer and it appears that the treatment affect seems to be greater than those who do not have adenocarcinoma. So for those of you who follow the lung cancer field you'll know that Avastin is really indicated for the adenocarcinoma side of the equation, it's the squamous and the non-adenos where there have been some issues with that class. And so here's a class molecule that we think actually can address, if you will, that other half of the non-small lung cancer population.

So we're very, very excited about this molecule and are poised to move this into Phase III actually quite quickly. Now clearly the data I've shown you here is response rate, this is does the tumor shrink. We know from a regulatory point of view the critical endpoint is survival and we don't have overall survival data from this trial yet, or from others, so we'll have to watch that as we go through. But we're very excited about this molecule.

I'm sure all of you know ASCO at the May, beginning of June where there's typically a lot of new information, there will be a lot of new information from Pfizer Oncology this year. We are anticipating that somewhere around 100 abstracts will be either presented in oral sessions or posters from Pfizer Oncology. That's really quite a lot of information that's coming out on what's, again, a very important invest to win area for us.

This is some of the data you might want to look for at ASCO. We can't say for certain this will be presented, but these are the abstracts that teams have put together. And I'll focus you on the last bullet, which is because this molecule can be dosed every three or four weeks, we think that's one of the characteristics that potentially makes this a best-in-class molecule. That other antibodies going after this target are dosed every week or every two weeks and the ability to extend the dosing interval, we think, does make this potentially a best-in-class molecule.

The JAK-3 inhibitor again I think you've probably heard about before. So again, starting with the box up on the top, we do think that this is a first-in-class molecule. Based upon what we know today about competitors in this field we think this will be a best-in-class molecule. It's an area of high market growth. Clearly RA is not quite as unsatisfied as it was before the TNF antibodies, the TNF antibodies are quite effective. But we do think having an oral agent, an oral [D-mark] that has activity similar to the TNF antibodies will be an important medical advance.

You see on the left hand side the proof-of-concept data using this molecule in rheumatoid arthritis, a six-week trial showing efficacy. There's no head-to-head comparison against the TNF antibodies, but the treatment effect looks to be the same. We now have a Phase IIIb dose ranging trial ongoing, longer duration of treatment, so we should get more data on both efficacy and safety. We'll have a first look at the information over the summer and if that reads out the way we're anticipating then we believe we can quickly have interactions with regulatory agencies to get approval for our Phase III program and move this into Phase III by this time next year in rheumatoid arthritis.

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As Martin indicated, there is a lot of other investments in this compound in other areas of inflammation. So in psoriasis, in asthma, transplant rejection, and Crohn's disease. A heavy investment in this molecule, not just in RA but in a wide spectrum of inflammatory conditions.

734200 is our DPP-IV inhibitor. Again if we go to the box up on the upper right we know we're not first in class, no question about that. I think it's a little bit early to know with this molecule whether it's going to be best in class or not, we just don't have enough clinical data to be able to answer that one. Clearly it's an area of high unmet need and high market growth. Now we're aware there's a lot of competition here, we are aware that we are behind some others and we keep our eye on that competition to see how their molecules are progressing and how our molecule is progressing.

Thus far this molecule has met all of our expectations. Preclinically there have been issues with this class in skin toxicity in certain species and tox studies. We have made a pass that have not seen that, so again the molecule is meeting our expectations. Pfizer, again coming into the organization, the PK-PD modeling that's done here is really, I think, state-of-the-art. And because of that nice PK-PD modeling we can pick the dose, we know what dose will give us a pharmacodynamic effect comparable to the 100 milligrams of Sitagliptin and we can rapidly move this molecule forward. So again, this molecule is poised to go into Phase III trials by this time next year and we're pretty excited about it.

So those are the six programs from which we anticipate four new molecular entities will go into Phase III by this time next year. So now let me move to the new indications, the other six in the 10 to 12. So the six for new indications will come from this cohort and more specifically from this cohort. I'm not going to go through all of these, you have them in your binder, we can take questions later, let me just talk about a couple of them.

So the first one is Axitinib. Again as an oncologist coming into Pfizer, I think Axitinib is an extremely fascinating molecule. And what gets me so excited about Axitinib is the data that was presented last year in pancreatic cancer. Pancreas cancer is probably one of the hardest cancers to treat. Every chemotherapy, every targeted therapy has tried to see if they have activity in pancreas cancer and invariably they have come up negative. It's really a very frustrating disease.

We're very excited about it because of the data in a trial of Axitinib added to Gemcitabine in a small randomized Phase II trial. It looks like there's a treatment effect here in terms of overall survival. Now what's particularly exciting about this is, remember that Avastin was also tested in this exact clinical scenario and did not have any clinical benefit. And we think there are reasons why Axitinib actually gives you better anti-angiogenesis activity than Avastin does.

This data suggests that that may be the case. There's indirect comparisons to renal cell that suggest that's the case. If the Phase III program in pancreas cancer comes out positive, I think that really fuels our enthusiasm for this compound to say we can expand now into breast cancer, lung cancer, colorectal cancer, the other places where Avastin has shown activity. There will be data on this at ASCO, again both in pancreas and renal cell. And again, the important point, we expect two new Phase III programs for Axitinib, one in renal cell and one in non-small cell lung cancer. We expect those programs will start by this time next year.

Sutent is sort of the leader in building the oncology franchise. Multi-kinase inhibitor already approved for Imatinib-resistant gastrointestinal stromal tumors and for renal cell cancer. We have a number of Phase III programs ongoing now in breast, non-small cell, and colorectal. Last count I think there's probably about 50 abstracts that you can look for at ASCO this year related to Sutent. There should be a lot of new information on a lot of diseases.

And again importantly, we expect to start two new Phase III programs, one in hormone-refractory prostate cancer and one in hepatocellular carcinoma. Now Dudley is going to talk later about the Asia strategy and particularly oncology in Asia. We know that Serafinib has activity in hepatocellular carcinoma, we have general believed in seeing that Sutent looks better than Serafinib in almost every indication so we're excited about putting Sutent into hepatocellular carcinoma in a Phase III program. And that starts that leading edge of what we're going to be doing for cancers that are prevalent Asia that maybe less prevalent here in the west.

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Apixaban you probably know very well, I assume my colleagues at BMS reviewed a lot of this with you. This is data that was published in the Journal of Thrombosis and Haemostasis at the end of last year, the Phase II data for Apixaban. I think the important point here is that in this study was compared both a dose given once a day and the same dose cut in half given twice a day. And we do believe that the twice-a-day dosing is an advantage here. So you'll see we have marked best in class, we do believe this could be a best-in-class molecule and clearly an area of high market growth and high unmet medical need.

There are six ongoing Phase III programs, four in the prevention of thromboembolic disease and two for [extremity] atrial fibrillation. There is new data that you can look for coming out this year, both the Phase III data on the prevention of thromboembolic disease and some Phase II data on acute coronary syndrome, and again importantly, new Phase III program in the treatment of thromboembolic disease as opposed to the prevention.

So as Martin said, if you add this all up, you take what looks a very nice growing Phase III pipeline. And this again is a slide he showed of the number of programs that will be in Phase III at various time points over the ensuing period. I think what's interesting is if you take all of those and line them up and again go through and ask are they potentially first or best in class, is it an area of high market growth, high unmet need, again our current estimations, you see a lot of checks on this list, we think this is a very valuable cadre of molecules and indications. And the highlighted in green are the invest to win areas that Martin and Jeff have talked to you about. So really putting our effort into those invest to win areas.

So now let me turn to the second half of my talk which has to do with what I said, when I first came into the organization people said to me there are some things they think that we need to improve. So when it comes to delivering the pipeline, I'm going to break this up into two themes. The first is are we focusing our resources on the best opportunities.

And Martin talked about disease areas, he also talked about that going through the whole portfolio and saying, on a compound basis, are we really focused on the right compounds, these golden assets as he referred to them. And once you do that, just improving clinical trial execution. Designing really good trials, so that if the medicine has a benefit you can show it, and to improve the speed with which you conduct these clinical trials. So I'll talk about both of these topics.

So the first one has to do with focusing resources on your best opportunities. I would argue that one of the best ways to know are you focusing your resources on your best molecules is to look at your Phase III success rate. So on the right hand side here the bars are the industry average Phase III success rates and the blue line is a rolling five-year average of Pfizer's Phase III success rates. And you can see that over the last period it's been roughly the same as the rest of the industry.

Now you can say, well why isn't it 100%, why don't you always succeed when you go into Phase III. That would be wonderful and we'd all love to do that. I think theoretically just understanding how we design trials and some of the new information you get in Phase III, I don't think we'll ever really get above that 90% point, but we're not even there, nor is the industry as a whole. So there's room for us to get better, but I think overall Pfizer has done a good job of saying these are the molecules we should invest in, let's move them into Phase III.

Now on the other side is the Phase II success rate. One important point I want to make about the Phase II success rate, you don't want to raise your Phase II success rate and drop your Phase III success rate. That would be a very poor use of our resources. So I think the choices are being made well in Phase II so that only the best assets are being moved into Phase III.

Would we like the Phase II success rate to be higher? Absolutely. We'd love to have it be higher. There's many, many reasons why it is where it is and over the next period we hope that it'll trend up. But from a development point of view the real important thing for us to be able to separate these two. What are the ones that are good assets that we should invest heavily in and move them into Phase III and what are the ones that aren't going to make it and let's not put any more investment into that.

And again, coming into Pfizer I have been extremely impressed with the scholarship that gets done within the Company to understand what they've done well and what they haven't, and how they can improve things. So they've gone back and looked when do we know whether a molecule is going to make it or not. And not surprisingly to many of you, molecules declare

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themselves very early. Early in development and in fact early in trials you can tell is a molecule going to be a golden asset or is it not.

And so here I show you two examples. One is the proof-of-concept trial, this is within a trial for Varenicline to ask if it's useful for smoking cessation. Very early in the trial, when you look at the accumulating data, you can see it's a positive trial. And as you go forward and collect more patients and more data, you end up showing it's even more positive. But very early on you can tell it's a positive trial. The same thing for the negative example on the bottom. Pretty early on you can see it's a negative trial. We don't need to keep enrolling more and more patients to show with more and more certainty that it's a negative trial, it was pretty clear at the beginning that it was a negative trial.

And so this idea of what's called early signs of efficacy, very early in the proof-of-concept trials, do we know it's going to work, do we know it's not going to work, has been built in to the way that Pfizer runs their early programs. And this has literally saved thousands of patients from participating trials and has saved tens of millions of dollars not being invested in assets that aren't going to return any value. This is really, I think, very, very well done, built into the organization and I was very pleased when I came in and saw how well they do this.

The second piece that they looked at, again very good scholarship, is why do programs fail in Phase III. Programs, as I said, you should have 80%, 90% success rate in Phase III programs, this is a Phase III trial. Why do Phase III trials fail? And when they went back and looked and said why do some of our Phase III trials fail, what you could see is they didn't actually have really rigorous proof of mechanism, they didn't really have really rigorous proof of concept, they moved the molecule into Phase III on occasion without having these things. And they looked at that and they said, this is not the way to properly invest in our resources and they've changed that.

And they now have this enhanced clinical trial design that's really built into all the therapeutic areas in development. And all of these things that you see in the box, we really make sure we have those before we move the compound into a Phase III study, which should drive that Phase III success rate high. Again it should be around 90% and you can see in 2006 the Phase III programs around 90% of the trials were positive.

In 2007 it dropped off and I can tell you, of the eight that were negative, six of those were Torcetrapib. And you say well wasn't Torcetrapib a 2006 story? The way we count these is when the actual reports are written and we put them into our database. So they were counted in 2007 and most of that drop off was Torcetrapib. Our goal is to make sure we have all these things so that, if the molecule works, we show it and we have a positive trial.

The thing I have on the bottom is work that we're doing with Ian's group to again, when you design these Phase III programs, make sure that we understand what the customer really wants. I think many companies have done a good job of understanding what regulators want, but the regulatory isn't necessarily the customer. And so working with Ian's group on understanding really what do the customers want out of that program, what endpoints do they want, what kind of patients do they want us to study, we've got to build those into our Phase III programs.

So now the last piece is cycle time and if you look at Pfizer's overall development speed, from the time they go first in human until the drug is submitted, the top bar is for the industry median performance and then Pfizer's performance in a similar time frame and more recently. Overall the organization actually moves things along pretty fast. And one nice example is Chantix, if you look at how long it normally takes, again industry median performance for a [count] on the neurosciences area, that's shown on the top, and on the bottom is the time it Chantix to do its program. And you can see it moved faster than the average.

Martin alluded to it and, again, I'm incredibly impressed at how well Pfizer Japan is working. The colleagues in Japan are doing a fabulous job and that Chantix was approved in Japan only 17 months after it was approved in the U.S. That's really, really remarkable. And from first in human until the submission in Japan was only five years. So Japan for Pfizer is doing a fabulous job and I encourage you to keep your eyes open for more approvals coming out of Japan.

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But there is one area where the organization does need some help and, again, I have experience here and I'm delighted to help improve this. And this is really the blocking and tackling of doing clinical trials, finding investigators, opening up sites, enrolling patients, collecting the data, writing the reports, it's sort of that core blocking and tackling. And you can see on the top here sort of the Pfizer median performance for these things, the industry median and the best in class. The best in class is not one Company, it's just the best for each one of those intervals. But you can see, there are best-in-class companies during each interval better than we are today and I'm committed to working with my team to improve these.

So in summary, I've told you a little bit about delivering on the Phase II and III portfolio. As I said at the beginning, the key takeaway is we do anticipate moving between 10 to 12 programs into Phase III by this time next year, a combination of about four new molecular entities and about six new indications for existing molecules. By the end of 2003, Martin showed you this slide, we really think that we will have a very robust, not just in numbers but in value, Phase III programs. And again working with my team to increase the operational efficiency and the execution so that as we get these molecules we move them along as quickly as we can.

So now it's my pleasure to turn things over to Ken Verburg. You know I've known about Ken, Ken and I actually competed against each other in the pain area a number of years ago and, to be honest, Ken's team won. So when I came to the organization and I found out that Ken was running the pain therapeutic area, I was relieved and I was delighted. And so I'd like to turn things over to Ken Verburg who will talk to you about the pain portfolio.

Ken Verburg - Pfizer - VP, Development Head - Pain

Good morning. Thanks Briggs, for those very gracious comments, it sounds like you're actually going to let go of this COX-2 Celebrex thing now after all these years and maybe now you'll finally start signing my expense reports. Okay. So Gillian and I are really pleased to be here to share the progress that we've made in pain therapeutics over the past two years here at Pfizer. We really have been a stealth therapeutic area, if you will, over shadowed by some of the other larger ones.

So here are the important points we'd like you to remember today from our presentation. First, pain therapeutics is a Pfizer growth franchise. We have already market-leading therapies in this area and they have further growth potential through new indications. Second, we have a portfolio that shows sustained growth potential. And finally, we have a leadership position in the emerging science of pain targets.

So we believe that invest to win is the appropriate strategy for pain therapeutics based on two converging reasons. The first is market potential for the factors that you see here on the slide. But equally important and perhaps even more important is our Pfizer's internal advantages, which include first our strong track record to develop new analgesics, our near-term additional growth from our in-line products Lyrica and Celebrex, and our valuable and expanding pipeline. And finally it's our ability to capitalize on really the explosion of new potentially drugable targets.

So the global prescription pain market is large, it's on the order of \$45 billion in 2007. And this is really an interesting market, there are many, many individual products in this category or formulations of the same product. But when it comes down to it, there are really very few therapeutic classes, as shown on this slide. In addition most of the existing analgesic classes have been around for years and some of them hundreds of years.

Much of the product development work ongoing here today, and there's really a lot of it, is still within these established classes. However, when you go back and you ask patients, over half of them are not receiving adequate pain relief from these existing therapies. So in our view this market will really only measurably expand through the introduction of innovative therapies that improve upon the efficacy and the safety of the existing therapeutic classes. In other words, go beyond those existing therapeutic classes.

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Okay so this is Pfizer's pain portfolio. Inside the dotted box are the current mid to late stage compounds, which I will focus on, and in a moment Gillian will discuss the earlier stage of the portfolio. So we currently have five new molecular entities against different targets in either Phase II or Phase III clinical testing for pain. In addition, we now have sufficient data in hand to project that two compounds will advance in 2008. The advance of PF-4383119 would be our second Phase III candidate in two years and we think we're in a good position to find another Phase III candidate in the 2009/2010 time period.

So the number of compounds and the number of novel mechanisms is amazing compared to what we've had in the past. And if another organization on this planet has a better pain portfolio, I haven't seen it. So let's go through some of these projects in detail, beginning with the lifecycle activities of Celebrex and Lyrica.

We have a large clinical program ongoing to further support the benefit risk of Celebrex in terms of gastrointestinal safety with the CONDOR trial and cardiovascular safety with both the PRECISION and the SCOT trials. In terms of other key Celebrex milestones for 2008 I would highlight the following. First the start of the Phase III program for gouty arthritis, second a submission for juvenile rheumatoid arthritis in Europe and third we are also projecting approval for low back pain in Japan this year.

Near-term milestones for Lyrica are summarized on this slide. And just to highlight a few of these related to pain specifically, we have ongoing programs to broaden the neuropathic pain indication in the U.S. and to add a post-operative pain indication. We expect to initiate a Phase II pain study in 2008, looking at the combination of PF-4480682 with Lyrica. And most importantly, we expect to have a submission for Fibromyalgia in Europe and a new drug application submission in Japan for post-herpetic neuralgia this year.

So we have really a remarkable position in the industry in alpha-2-delta ligand technology. And what really makes this remarkable is that we've had highly successful products in Lyrica, before that in Neurontin, and they're relatively free and clear in terms of the competition around this mechanism. In my view we don't complain too much about that. In addition to Lyrica we have three more alpha-2-delta ligands in clinical development. Two of these compounds are being pursued by Pfizer's neuroscience area. And PF-2393296 is a peripherally restricted alpha-2-delta compound for pain indications that is in Phase I.

So the Lyrica Fibromyalgia program is really an excellent example of rapid execution to capture significant value quickly. It took us only two years from the start of the first Phase III study to submission of the sNDA. And mind you, this was no small program, we studied well over 3,000 patients. In addition, we received U.S. approval for Lyrica well in advance than programs from companies.

We advanced SS-Reboxetine into Phase III clinical trials last year as a follow on to Lyrica. Now SS-Reboxetine is a highly selective norepinephrine reuptake inhibitor in contrast to the compounds that are on the market that are in development that inhibit both Serotonin and norepinephrine reuptake. For those of you who are familiar with Racemic Reboxetine, which is marketed in Europe under the trade name Edronax for depression, please take note that SS-Reboxetine is not your father's Racemic Reboxetine. The high selectivity for norepinephrine resides all in the S-stereoisomer.

so the key development objectives for SS-Reboxetine in Fibromyalgia are to show benefits in fatigue and cognition, as shown on this slide. To further maximize the value of SS-Reboxetine we will plan to seek an indication for the use of this drug in combination with Lyrica. And finally we are currently also looking at painful diabetic neuropathy as a follow-on indication to Fibromyalgia.

So PF-4383119 is a fully humanized monoclonal antibody directed to nerve growth factor, which has an important role in the generation of pain. This biotherapeutic came to us through the Rinat acquisition and you may also know the compound as RN-624. So we've completed Phase II clinical testing for osteoarthritis pain with the compound and this is a discussion that Martin and I had in his office when the data came out. Martin immediately wanted to use it as an anecdote for his soccer playing. So we're encouraged for the long-term safety data that we've accumulated on Phase II already and we've treated well over 600 patients in this Phase.

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So the data shown on this slide now are from the Phase I study, so an earlier study, conducted in patients with osteoarthritis of the knee and these data have been previously disclosed. The study was conducted in two panels, the first panel was a dose ranging view and the second panel was confirmatory efficacy assessment. So I had really never seen analgesic effects in osteoarthritis pain like this before in terms of really a clear cut signal pain relief in really a small number of patients. Not only that but just a single dose of the NGF antibody produced significant analgesia over an entire two month period.

So I have to admit that when I first saw these data they were almost too good to be true. Well it turns out that they might be even better. So we've completed now a Phase II study of osteoarthritis pain last year and we plan to disclose those results at two meetings that are upcoming. You will not want to miss those presentations and if there is any attractiveness to it, the first meeting is in Paris. So we're going to go fast. We're moving quickly now to initiate the Phase III program in osteoarthritis pain this year.

And in addition to hitting the ground running in osteoarthritis pain, we're going to simultaneously pursue a broader indication for pain to maximize the value of this compound. We've got Phase II studies ongoing in chronic low back pain and a post-herpetic neuralgia as well as visceral pain. And if these studies are successful we'll project to move into Phase III for a broader pain indication in 2009.

So PH-797804 is a selective inhibitor of p38 kinase. It is in Phase II treatment for rheumatoid arthritis as the lead indication and in fact we've nearly completed that study. It's a 300-patient study over 12 weeks and the emerging safety profile that we've seen from this study so far has really been quite encouraging. p38 kinase is an enzyme that regulates proinflammatory cytokines such as tumor necrosis factor or TNF. And the data that you see on this slide shows a well behaved dose-related inhibition of the TNF response endotoxin challenge in human volunteers.

We have a real strong interest in PH-797804 as a pain drug and we plan to initiate Phase II study in post-herpetic neuralgia patients yet this year. And Briggs, we may even get this done this year. So the slide I will leave you with now for pain for the mid- to late-stage pain portfolio is here. These are the leading indicators of our progress to date and our potential going forward. I'll wrap up just by saying that I have never been in a better position to deliver new medicines for pain.

And so with that I will not turn the presentation over to Gillian who leads the Pfizer pain research team. And she is really in a great position to talk about our scientific advances and how we can further grow our leadership position in pain research. Gillian?

Gillian Burgess - Pfizer - Executive Director - Biology

So thank you, Ken, and good morning everyone. It's a real pleasure to be here today and to be able to talk to you about how the opportunity for growth in our pain franchise is matched by our commitment and investment to increase our understanding of pain pathophysiology and how this is driving the continued growth of our portfolio.

So you've seen this slide before and apart from Celebrex and Lyrica we currently have 11 compounds in clinical testing with a further seven in hand which we predict will enter Phase I in the next 24 months. Now what I would like you to take from this slide is that these compound represent exciting new science, new molecular entities with the potential to become transformational new medicines for patients. And I'd like to talk to you now about some of the things that we're doing to try to build depth and innovation into our portfolio.

So you heard from Martin about his five-point plan and one of the points was pursue the best external science. And Martin, I think you stole this one from us because this is something that we're really passionate about in the pain therapeutic area. So our confidence in this area has grown, we've chosen not just to invest internally but also to invest externally in people, technology and science so that we can pick and then pursue the very best targets.

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So for example, over the past few years we have collaborated with the Scripps Institute and the University of Cambridge on pain genetics and on University College around preclinical models. And we also have a number of excellent collaborations with some biotechs including, for example, Incyte, Renovis, Adolor, and Rinat which is now part of Corey Goodman's organization, where we're working on target families and biotherapeutics. And I'd now like to highlight a couple of these to show how effective partnership can really drive cross fertilization that can help enrich our portfolio.

So a couple of years ago we set up a collaboration with Incyte who are scientific leaders in the area of the chemokine receptor 2. And this is a very valuable target for pain because when activated this target causes inflammation and insensitization that can lead to chronic pain states. So we have worked with Incyte to develop very potent small molecule blockers of this receptor and we've shown that these have excellent efficacy in preclinical models of nociceptive and neuropathic pain. And our lead compound, PF-4136309, has just completed Phase I studies. I'm very encouraged by these results, we are predicting that we'll enter Phase II for osteoarthritis later this year.

Now innovation drives many of our very early discovery programs and that's certainly two of the voltage-gated sodium ion channels. And these channels are absolutely critical for the conduction of pain signals. And you may have seen this article which was published in Nature just over a year ago by Pfizer scientists in my group working with external academic scientists, including from the University of Cambridge. And this was a genetic study on families with a condition called congenital insensitivity to pain.

And individuals with this condition are otherwise completely normal apart from the fact that they don't feel pain. So they can feel touch, they can feel heat, they can feel cold, they have normal autonomic nervous systems but they are unable to sense even very intense pain such as a scald or a fracture. And the root cause of this condition was not known until we showed in this paper that it was due to a mutation in the gene coding for the NaV 1.7 voltage-gated ion channel. And this was the cause of their inability to perceive pain and really has provided a compelling rationale for NaV 1.7 as a fantastic new pain target and we're moving forward from there to develop and invent selective NaV 1.7 modulators.

Now there are really too many very exciting early programs and great collaborations for me to tell you about them all today. But I hope that in this presentation I've been able to give you a good insight into the depth and the innovation that we're building into our portfolio. And personally I would like to say that I am really proud that we are leading the science in the emerging new pain targets. So to summarize, I think pain is really in great shape. We have a strong portfolio from preclinical to Phase III and beyond with the potential for sustained growth in that portfolio. And crucially, you've heard from Ken that we have the internal expertise to develop analgesic drugs.

So thank you for your attention and it's my pleasure to introduce Corey Goodman, the President of our Biotherapeutics and Bioinnovation Center. Corey?

Corey Goodman - Pfizer - SVP, President - Biotherapeutics & Bioinnovation Center

Thank you. Good morning and thank you all for being here. It's my pleasure as head of the Biotherapeutics and Bioinnovation Center to introduce you this morning to our strategy, to the work in progress, all the progress we've made and what we plan to do in the next few years. Now clearly our strategy is to make Pfizer a top-tier player, a top-tier leader in biotherapeutics. And I have to admit, today it's not a leader. So how are we going to do this?

Well, first Martin and Briggs, earlier this morning, told you about delivering on the late-stage portfolio, taking the Phase II moving it into Phase III and moving Phase III into the marketplace. Briggs also told you about some earlier things, Ken and Gillian just told you the beautiful work they're doing in the pain area, all the way from preclinical to clinical and moving things into the marketplace. What I want to do is focus on biotherapeutics. Clearly this is a major area and I want to tell you how we're going to continue to fill that pipeline in biotherapeutics, how we're going to make Pfizer a leader in that area.

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Now when Jeff hired me and like Briggs, I started within a day or two of him, Jeff gave me two challenges and those two challenges were very simple. The first challenge was he said, Corey, this is nice and simple, make us a top-tier leader. Thanks, Jeff. Make us a top-tier leader and second he said, look, we never want to play catch up again. We've had to play catch up in biotherapeutics, there are all sorts of new innovative areas coming out of the biology space, make strategic decisions, make sure we're never playing catch up again, make sure Pfizer has a clear leadership position.

And that's we established the Biotherapeutics and Bioinnovation Center, which I'll call BBC. It's a very exciting and new innovative model and in a few minutes I'll introduce you to the model. And the model really was devised by Jeff and myself and Martin. And Martin and I are completely unified on how to make this model work, how to let my unit be both independent and interdependent, and I'll tell you about this in just a moment.

But there's really a two-fold mission to the BBC. First of all, to take those existing proven technologies, the things that we already know work in human beings, things that have been validated, antibodies, peptides, proteins, vaccines and to make sure Pfizer is second to none. And secondly, and maybe this is the slightly trickier one, to take those less well validated technologies, the things you often hear or read about coming out of academia or biotech. We can't invest in every one of them, whether they're new areas with nucleic acids or stem cells, whatever it may be, our goal is to take and to make very strategic decisions of where we want to place bets, where we want to invest and to be the best.

Now clearly today we have a modest market position in biotherapeutics. Shown on this slide here there are five products, about \$1.4 billion in revenue per year. But when I came in I was very pleasantly surprised. Surprised to find that although one may have focused on just those five, that actually Pfizer's been in stealth mode for a number of years building a very strong biotherapeutics foundation. I hope you realized in the previous talks just how many biotherapeutics you've heard mentioned, just how many monoclonal antibodies. In fact what I've found is that it's the best kept secret but that really the best is yet to come. And let me just give some numbers.

There are 86 biotherapeutics in the pipeline today 26 of those are in preclinical or clinical development, they span over eight therapeutic areas, 53 of them are monoclonal antibodies, eight are vaccines and some of the others are in other modalities, nucleic acids for example. Now that's a great pipeline, but neither Martin nor I are satisfied with it because if we're going to be a top-tier leader we have to do even better. We want to make sure that the pipeline in the years to come, the 20%, perhaps even more than that, 20% to 25% of the pipeline is biotherapeutics and ultimately that 20% of what we're doing in the marketplace is biotherapeutics.

So how are we going to do that? You could say that's a pretty big goal. How is Pfizer going to become the leader? Well the way we're going to become the leader is the following way. And first let me tell you what others are doing. No surprise, many of the other large pharma companies are making major investments in biotherapeutics, it's a clear reason, it's a major area, it's a growth area. But they're using different models and let me tell you those models and then contrast it with what we're doing.

On the one hand what some companies are doing is building their large molecule capability just like they've been building their small molecule capability, within the same large organizations. That's fine. I sometimes think though that's a little cumbersome, it stifles innovation, it's not a very entrepreneurial approach. Now there's another extreme. Other companies are either building or buying completely independent units, large molecule organizations. Those are often a little more entrepreneurial, but I think they miss some of the opportunities for synergism, some of the ways the two organizations could work together.

Neither one of those models, we think, harnesses the best features. And what I mean by the best features is what Martin and I want to build is an organization that takes the best of the small biotech entrepreneurial style, fast, nimble, high productivity, high creativity and yet combines it with the best of big pharma because each of those models has strengths and weaknesses.

Now how are we going to do that? Well what we're doing at the Biotherapeutics and Bioinnovation Center is we're building a hybrid model. This is a model that acts and looks a lot like small biotechs, it's very independent but yet it's also interdependent

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because what we want to do is we want to take the very best features that big pharma has and combine them in this hybrid way with the very best features of biotech. It's really an exciting new model and we hope that you'll find this an exciting model to watch over the years to come.

What we want to do, for example, is take small units, it's a federated model, small biotech units, in fact if you walked into some of them today you wouldn't even see the name Pfizer, you would think you were walking into a small biotech Company. In fact, some of them were until very recently small biotech companies and we want to set them loose and let them thrive. But we want to leverage that with what big pharma has to offer.

So what are some of those things? Well let's take for example PharmScience. The PharmScience group in St. Louis run by [Rick Webber], the biologics group that reports to Calvin Cooper I think is second to none, and I've seen what a lot of the big biotech companies have to offer. It's a superb group. We shouldn't have to recreate that, we're going to leverage that. Similarly the clerical capability.

When I sit back and listen to what Briggs is talking about and what Ken's talking about, I don't want to duplicate that, I want to leverage that capability and simply make things faster, more efficient. And so what we're building is a model that we think thrives, that brings together the best in terms of talent, strong incentives and lets those people loose in a very efficient way. It's a very innovative environment that's going to be built on these small units.

Now you might say that's a great dream, Corey, but what I'm going to tell you about in the next few minutes is not a dream. Already in the last few months we've done it, we've been building it and let me tell you how it works. Now first of all the BBC is our commitment to establish ourselves with a leadership position. And remember in two places, biotherapeutics in general, where we ultimately want to have our pipeline and then our revenues be greater than 20%. That's quite a goal.

Secondly, we want to make sure that we have leadership ability in all those other new technologies and not in every one, we want to pick carefully, whether it's in some area of nucleic acids or stem cells. Many times these things become fads, we want to pick in a very reasonable way where should we make our investments.

We want to be competitive across all these cutting edge technologies. And what that means is that we need to be working with the academic world and with the biotech world. And those are the worlds I come from. Now you could say, well fine, how are you going to do that. It winds up my phone is ringing off the hook. The biotech companies, the entrepreneurs, the academics want to work with us. they like the model we're building, they like this unit because we're based on research units that are just like them, small independent units. We're very fast and nimble in our decision making, we're very decentralized in this federated model and it's working.

Now I'll show you in a moment that each one of these units is based on a particular technology, very much as biotech companies are. Each one is based on becoming the best in the world at doing some particular technology and keeping us at the forefront. But we don't just stop there. Scientists work at their best when they're making drugs and putting them in the clinic and ultimately seeing they're going to help patients. So each one of our units are also focused on making drugs, getting those drugs in the clinic and ultimately handing them off to Briggs' unit.

So let's just take a look at that federated model and here it is. Right now there are three major units, Rinat which is in South San Francisco in the Bay area, CovX in San Diego and RTC, Research Technology Center, which actually has been a unit of Pfizer, it's been a very entrepreneurial unit and now it's part of BBC, it's in Boston. You notice those aren't three random locations. Those are the three major hubs in the biotech world and three major hubs of the academic world.

But we're not just stopping there. We also have outreach in terms of collaborations, we already have a small unit became this part of Coley that's in Europe. We're looking at Europe and at Asia and you're going to hear in a little while from Dudley about the Asia strategy, we plan to be a big part of that with him to look at that entrepreneurial spirit in Asia. So our units are small, they're focused on technologies and they're also focused on moving drugs into the clinic.

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We also oversee the academic collaborations. Now we oversee a lot of major collaborations, I think you'll hear about more in the future, those academics want to work with us. We also have oversee Pfizer's incubator program. This is a way that Pfizer is able to get entrepreneurs, nurture them, help them found small start-up companies that of course we have major rights in a collaborative way. Let me give you just a little more information about these in just a snapshot.

Now Rinat is our hub in the San Francisco Bay area. It was a spin out of Genentech a number of years ago, it was acquired by Pfizer in the year 2006. Rinat's a great success story. And by the way, you've already heard of part of that success this morning. A few minutes ago Ken told you about the antibody for NGF, I'll come back to that in just a second. That tells you just how effective this unit is.

But this unit is really our window into the whole monoclonal antibody world and what we've given them as their mission is make sure that Pfizer is a leader and never falls behind. Whatever is the technology for the way you're going to make antibodies, stage display, you're going to do things in niche, however the heck you're going to do it, this unit is going to be right at the forefront. But they're going to be doing more than simply taking technology for it as they are, they're going to be making drugs. And they've got quite a few that are coming along, several key ones in the clinic already. Now that's one unit.

Just recently we acquired a unit in San Diego in La Jolla called CovX. CovX was a spinout of Scripps Institute. It came from really very important work on catalytic antibodies from [Paralis Barbus] and Richard Lerner at Scripps Institute. And it goes as follows. You know many small peptides, you have lots of small peptides in your body, neuropeptides, peptides that are working in your hormonal system for example, your endocrine system. But small peptides don't make very good drugs because they turn over very quickly.

What CovX figured out was how to take a human antibody, a very neutral antibody and by some very special chemistry I wish I had time to go into but I don't to figure out how to combine peptides to that and to make something that has the properties of a peptide in terms of efficacy but the properties of the antibody in terms of PH, which means you perhaps only need to give it once a week, once a month, once every two months. Very exciting work and it works.

These guys are going to continue to push this technology forward, this technology for peptides, small proteins, aptamers, nucleic acids even for organic small molecules, ways to be able to change the PK and yet at the same time have efficacy. They've already got two drugs in the clinic and there will be more coming along. And those scientists are working on pushing their drugs in the clinic.

Finally the Research and Technology Center in Boston, now this has been a very innovative unit doing a lot of ground breaking work for Pfizer. What we're doing with this new head, [Art Creeg], is we're taking and reconfiguring it and saying to these folks, and if you walked in it looks just like a biotech Company today, and saying to them there are merging areas, we picked a number of them and we said to them be the best in the world at these areas, in certain areas with nucleic acids and stem cells and other areas, be the best, take Pfizer technology forward.

Now we're going to be making additional investments in the months and years to come, both from our organic growth and when we look at external opportunities. Obviously I can't share those with you today, but we're going to keep looking, keep looking at what's going on in academia, what's going on in biotech and trying to make sure that Pfizer makes the wisest investments. We're also going to continue to strengthen the technology and in this way, given the incredible foundation and the pipeline you've heard about this morning, we want to supercharge it. Supercharge it in terms of biotherapeutics, supercharge it in terms of all the new technologies.

Now at the same time we're pushing forward in the vaccine in the vaccine space. Today clearly vaccines are a rapidly growing area, projected to be \$18 billion in a number of years. And also equally you know Pfizer is not a player. How do we make Pfizer one of the top-tier players? Well I think you see the ground plan, the roadmap right now. The way we're going to make Pfizer a top-tier player is to build best-in-class capability, top-tier leadership in a small entrepreneurial unit that acts very much like a

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biotech. And that's what's happened. In sandwich, England is the vaccine research unit, looks just like all the other BBC units, very small and entrepreneurial, also interacts with the small group in La Jolla.

Now they're building vaccine technology based on the latest technology and it's really blending different levels of risk. Because they're taking some technologies, which have already been validated in humans that we know work and that simply have to be exploited and pursued, with other technologies and really trying to spread it amongst a number of different opportunities, things that work beautifully in animals, perhaps haven't yet been validated in humans and we're going to mix and match.

And there are really three areas we're focusing on here in vaccines to be right at the cutting edge. We don't want to make vaccines like people were doing a couple of years ago, we want to make vaccines like they're going to be made in the future. And that means focusing on delivery, focusing on adjuvants and focusing on immune modulators. Now let me tell you what I mean.

As you'll know, in 2006 Pfizer acquired PowderMed and what PowderMed gives us the capability for is a whole new way of injecting and producing the vaccine using DNA technology. Instead of sticking a needle into you and injecting some protein as an antigen, what they do instead, and this is quite painless, we don't need one of Ken or Gillian's drugs for this, you take a DNA gun and what you do is you shoot DNA into the epidermal cells. You let those cells produce the protein in the right immune context. We think much more effective as a way of, in your body, producing the antigens for immune response. That's the PowderMed technology.

Now how [adjuvants]? Well we became convinced that Coley had the best adjuvants, we just recently acquired Coley and we're keeping that alive and thriving. Part of it is in my unit, part of it's in the vaccine unit. We're really taking best advantage of those Coley scientists because what they had was a set of nucleic acids called CPGs, interact with a special receptor, one of the toll receptors, toll receptor 9, which produced dramatic immune responses, very effective as adjuvants for both B-cells and T-cells. We're going to continue to expand that.

And finally, I don't have time to tell you about the immune modulators, some of the antibodies, some of the other things going on, some of our academic collaborations, we want to leverage that to be the best in class, to be a top-tier vaccine maker.

And here's the way the model works. And I don't have the time to take you through all the details, but just to say as you look up here, those horizontal lines, each of our units is focused on a technology, antibodies, peptides, RNAi vaccines. But they're making not just developing technology, they're taking drugs into the clinic. Ultimately either at Phase I or Phase IIa, there will be a seamless hand off between our units and Briggs' units and we move things forward and move them into advanced clinical trials.

Now we're going to be interacting with the various centers and sites of PGRD. There's absolutely no reason for us to duplicate what they have. Our units focus on technology. All those units like you just heard from Ken and Gillian, they focus and we think they're completely world-class when it comes to particular disease areas, particular therapeutic areas. We want to look at the intersection of that. And what Martin and I are creating is organizations that interact in a seamless way without boundaries to get synergism out of that expertise in disease and therapeutic areas with expertise in technology. And we think that's really going to supercharge the pipeline.

Finally you might say well where are we going to get targets? Where is the future going to come from? Well it's going to come from our academic collaborations that we're expanding, from our incubators, from the biotechs that we're looking at and working with and from our own internal scientists. And we're really excited about this for the future.

Now you've already heard about some of this excitement. Here's a key example. Now I'm not going to duplicate what you've already heard from Ken, but when he was telling you about the NGF antibody, the one where he walked into Martin's office and said, Martin, I've got something pretty exciting to show you. That was an antibody that came out of Rinat and there's more still to come out of Rinat, some really great antibodies coming forward. We're looking forward to that antibody entering Phase

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III this year and hopefully some time in the near future being a very important therapeutic as an analgesic for people with osteoarthritic pain and other kinds of pain.

Now Martin told you and you've also heard from Gillian about looking at external science. Well we need to look at what's going on in academia, what's going on in biotech. And let me just say briefly, when you look on this slide, this just shows you what's been happening over the last couple of years. There have been well over in this last year I think 14 major deals, six of them were in the area of biotherapeutics. We're making major investments in biotherapeutics to really expand the portfolio.

And this just takes you through some of the deals in biotherapeutics alone. I'm not going to go through the details but we're open to all business models and all ways of doing it, even some of the areas in between here, from incubators, helping entrepreneurs start companies to research alliances with academia or biotech, licenses, mergers, acquisitions. I think it's a very exciting model. And when you look at that, and I've highlighted Rinat a bit, keep your eye on CovX. I haven't said much about it today but that platform we think is very exciting, there are two drugs in the clinic, another one should go in this year, it's something we're particularly excited about.

So let me just summarize what I've told you about today. We think Pfizer is poised in the coming years to be a top-tier player in biotherapeutics. Martin and I are convinced of it because we think we're doing it the right way. What we're doing is we're building this very innovative and unique model called the BBC or Biotherapeutics and Bioinnovations Center. It's based on building units that are very biotech-like, in fact some of them were biotech companies.

And instead of bringing them into PGRD, we're letting them stay with their own independents, their own culture, their own incentives and we're letting those scientists thrive. We're building a collaborative spirit, a seamless spirit between them and PGRD to make sure we use the best of PGRD, PharmScience, clinical science, that we hand things off and move it into the clinic. It's kind of a biotech dream. How to have a small entrepreneurial unit and how you have to access all of those incredible resources and scale of Big Pharma. It also is something that we think the academic world and the biotech world finds particularly attractive and as I say, we're just getting incredible requests saying, Corey, can we work with you? Can we work with you?

So we think the model works. We think it's going to thrive. And we think we've already built a very strong federation between Rinat, CovX, RTC, and Coley. And I hope you'll find that the best is yet to come, we think this is really going to help to supercharge the pipeline in the future. And with that, I'll hand it back over to Martin.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you, Corey. Well very briefly, you've heard about our aggressive goals, some promising data on our late-stage pipeline and our hidden gem, the pain therapeutic area from Ken and Gillian. Furthermore, you heard from Corey how we do aim to be a top-tier company in biotherapeutics. And with that brief summary, I'd like to open up now for questions.

Thank you. It's David here. We've got some mic runners. Right down here. Thank you.

QUESTIONS AND ANSWERS

Steve Scala - Cowen & Co. - Analyst

Thank you very much. Steve Scala from Cowen and Company. I have three research related questions that relate to two existing products. First, when in 2008 should we anticipate the Spiriva uplift data and how important do you view them to the franchise going forward?

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Secondly, I believe Lipitor's lead E trial in Alzheimer's disease completed in 2007. But to my knowledge, the results have never been revealed. What were the results, if you have them? And thirdly, do you have any thoughts as to why Lipitor led to progression of plaque in Dr. Nissen's IVUS trial illustrate? Was this a function of the study design, the type of patients or is that what happens in surrogate end-point trials? Thank you.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you Steve. Let me go in reverse order and some of the colleagues may speak about some of those later in the day. In terms of your last study, there's both good news and bad news here in terms of that study. The good news is we have a lot of pre-clinical and clinical data to look through. The bad news is, we've got a lot of pre-clinical and clinical data to look through. And we're still working hard to understand exactly what's going on there. Interestingly, Briggs and I met with Steve only last week to look at some more data in this trial and try and understand exactly what's going on.

In terms of the Lipitor Alzheimer's trial, I don't believe we have any dates that we're going to publish those results to date. And in terms of Spiriva, and again maybe that will be taken up in the later presentation, but we've not given the date on when we'll announce those results.

Dave Risinger - Merrill Lynch - Analyst

Thank you. Dave Reisinger --

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Could you -- David, could you stand please, so we can see you?

Dave Risinger - Merrill Lynch - Analyst

Sure.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you very much.

Dave Risinger - Merrill Lynch - Analyst

I guess. I guess you like my tie. Dave Reisinger from Merrill Lynch. I have two questions. First, just in terms of the total pipeline numbers, you had mentioned back in, I think, July that you had 96 total programs and you stated today that you killed 24 of them, so that's 25%. But you've also mentioned that you have 103 total programs today. So if you could just connect the dots there, that seemed a bit baffling.

And then second, if you could talk about compensation and recruiting of talent in the Bioinnovation center, just wondering how you recruit those out-of-the-box thinkers and compensate them relative to the people in the traditional small molecule R&D organization? Thank you.

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Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you Dave. I'll pass the second question on to Corey to prepare on. In terms of the first, Dave, it's as you say, exactly right, the figures that you gave. Of course what we have on a constant basis are compounds moving into the development pipeline. So from research, and last year we had over 20 first-in-human studies started, moving into that space.

Secondly, by dint of our collaborations and acquisitions we have got compounds moving in from those organizations. So that makes up the number that are either terminated by dint of attrition, technical reasons, or by dint of the strategic decisions that we made. Does that help, Dave? And Corey?

Corey Goodman - Pfizer - SVP, President - Biotherapeutics & Bioinnovation Center

Yes. It is a good question. And first of all, we are establishing a more entrepreneurial compensation incentive system in the BBC. But I just want to remind you for attracting, recruiting and retaining the very best scientists, compensation is only a small part of it. It is also the culture and the spirit and the work environment you give them and we think that these units are really thriving. And I can say, we are not losing people, and we are able to attract the people we want to. So I think that is the proof.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thanks, Corey. I would only add, Dave, within PGRD also, we have recruited some top talent in the last period. And I will take one therapeutic area as an example, in both the research phase where Neil Gibson has come in to run that organization and also in clinical development. And I was part of the recruitment campaigns for all of those folks. And I would ask the question, why would you want to come to Pfizer? And in every case, people spoke about our pipeline and our portfolio. And as Briggs alluded to at the start of his discussion, in many therapeutic areas, we have really a very promising portfolio and that attracts top talent.

Craig Baskin - Putnam Investment Management - Analyst

Hi, I am Craig Baskin at Putnam. I have two simple questions for you. Reboxetine, my memory is not complete -- so reboxetine, I think was the old [upjohn] compound, had lots of problems. Maybe you can tell me what the problems were and why the SS molecule doesn't have those problems? That is my first question.

And my second question revolves around nerve growth factor. And it seems like I can't count the number of companies that have had nerve growth factor on their R&D pipelines, but I don't think one has made it to market yet. So what's new and different about your molecule and why is yours going to work when all the other candidates have failed? Thank you.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Sure, those were the simple questions. I will take both questions and then invite Ken up to say a few words, who knows both of those molecules very well. In terms of the SS-Reboxetine, Ken alluded to this fact that this is the specific [inaneumur] and that will make a difference just by dint of its specificity. But again, Ken can say a little more about that. In terms of the NFG antibody, you are absolutely right and I go back to actually late '80s and early '90s working in this area to try at that time to come up with a low molecular weight drug, because we knew there was activity there.

The pharmacology has always been of great interest to us. I think the most marked thing we have here is the fact that it's an antibody and whilst we have the strong desire to be a top tier company in biotherapeutics, it isn't because we really like working with big molecules. In fact, they are more expensive to make, they are more expensive to produce and they have some downsides in terms of delivery. But the great upside they have is their specificity and their opening up of target space in biology. And I think we may have just hit this with this particular NGF antibody. But, Ken, would you like to add a couple of points?

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Ken Verburg - Pfizer - VP, Development Head - Pain

Sure. I'll start with the NGF antibody. First, we need to separate blocking NGF for pain indications versus approaches that are using nerve growth factor to restimulate nerve growth in certain [arapathy] settings. There are two approaches and there are very limited approaches on blocking the molecule for pain and there are several approaches on the growth side. So we will just leave it at that and I think Martin has articulated the rest of the story very well.

On reboxetine, the product is marketed as I mentioned in roughly 30 European countries that have seen a form of that. And the reasons that it was never marketed in the U.S. were purely based on insufficient demonstration of efficacy in Phase III trials to the satisfaction of FDA. It is certainly not a failed molecule in any sense of the word. And I do believe, as Martin has mentioned, we have extracted the best out of the [recinic] mixture, if you will, and put it with the SS in antimer or stereoisomer. And the data that we have in Phase II in fibromyalgia, pretty spectacular.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thanks, Ken. Corey, you've had a real chance to look at the NGF antibody. Thoughts?

Corey Goodman - Pfizer - SVP, President - Biotherapeutics & Bioinnovation Center

Yes. First, when you say that others have worked with NGF, you are right. But just to amplify what Ken said, in the early days and it wasn't just NGF, it was a class of molecules called neurotrophins, NGF, CNTF, a number of them, BDNF. But companies like Genentech, Regeneron and others are probably ones you are thinking of, they were using them as agonists, hoping to connect the dots between a neurotrophin and some particular major disease, like ALS for example, and there were others, when actually the biology, there was no direct connection between them. One was hoping that if one kept or stimulated growth of certain nerve cells, that that would work. And to my knowledge, none of those trials historically have really been successful. This is uniquely different.

In fact, this came out of that work because the Rinat scientists were clever enough to notice that back in their Genentech days, that when you injected NGF, that what you found in those patients some days and weeks were very prolonged, was you got hypersensitivity in terms of pain. You got increased pain. And that is really what led to the insight. And so here we were dealing with an antagonist, very different than what historically has been done, and very potent, as Ken said, blocking pain, in some of these cases for up to two months.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thanks, Corey. More questions, here down front. Thank you.

Tim Anderson - Sanford Bernstein - Analyst

Thank you. Tim Anderson of Sanford Bernstein. You spent a lot of time talking about neurosciences and I think when you bought Rinat a few years ago, one of the key assets of that Company was the monoclonal antibody to Alzheimer's. But you haven't really mentioned that compound in today's discussion. So I am wondering if you can give us an update on your thinking on that approach and maybe frame out some timelines for when we might see some sort of decision or data flow on that compound?

Then on your JAK-3 product for RA, if I look at the Phase II dose ranging, it looked at one set of doses and the Phase IIb now looks at a lower set of doses. And my understanding is that maybe you are trying to mitigate some of the off-target toxicities. So if you could just talk about what some of those toxicities and some of the safety challenges that you see are with that product?

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Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you very much, Tim. I will kick off with both questions and then look to Corey to talk about the amyloid antibody and Briggs to say a wee bit more about JAK-3. The amyloid antibody was in fact the reason that we acquired Rinat. In the first instance, we were very keen to get into the Alzheimer's area with an antibody and we saw this as being a really good potential way of getting in. That antibody is firmly in Phase I. It is moving through the process. There is nothing untoward at all with the progression of the antibody.

Interestingly though and highlighted by the fact that we spoke about the NGF today rather than amyloid was, whilst we acquired that Company for amyloid, when we looked at and met the scientists, we just saw a lot more in there. The pain compound was already in Phase II and that was something whilst we had looked it, we were more interested in analoid. You saw from the data today just how marvelous that is. But we saw a whole crowd of other antibodies either late three clinical or earlier than that, the Rinat scientists had used this technology, the antibody technology to go after many neuroscience targets that were based from the neuroscience group in Genentech as Cory alluded to.

But most interestingly and I think where it is the most positive is those scientists, many of them were not wedded to neuroscience. They were biotherapeutic technologists and when they joined Pfizer and could open up to all the therapeutic areas we have and open up to all the experts, either cardiovascular, allergy and respiratory, we have been able to employ that technology across many therapeutic areas that was developed there. Again, I will look to Corey to speak specifically about amyloid and I will come back to JAK-3.

Corey Goodman - Pfizer - SVP, President - Biotherapeutics & Bioinnovation Center

Yes, just very briefly, I am as enthusiastic about that antibody as ever. And just to say historically, another Company did have an antibody against amyloid which seemed to be showing some positive results but had a side effect. And the beauty of what the Rinat folks did is that they engineered their antibody to try to avoid that particular side effect. Now the clinical trials will ultimately tell us if that is the case. But we think it has a chance to be best in class. There is some competition that is in the clinic. We are not saying how ours is going to progress. But we remain as enthusiastic as ever about that particular monoclonal antibody and its ultimate potential for patients.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thanks, Corey. The reason that we are looking at several [dulses] with JAK-3 is actually very normal and whilst it is not specifically to mitigate against any particular toxicology, it is really just trying to find the best dose. As you will remember, the data that we published on the 264-patient study in rheumatoid arthritis was a four-week study, relatively short, really speaks to the enhanced clinical trial design that Briggs mentioned. And now that this has moved into Phase IIb, we are doing classic dose-ranging studies, longer time scales within those indication areas. But, Briggs?

Briggs Morrison - Pfizer - SVP - Clinical Development

Yes, so I agree completely that the dose ranging is just typical dose ranging. You saw the three doses were roughly the same, so now you have got to go lower and find the dose, the lowest dose that gives you maximal efficacy. And in terms of in that short trial and what we are seeing so far, it is sort of what you would expect for a potent immunosuppressive in terms of the toxicity.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you, Tim. There is one here just behind Tim on the right.

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Seamus Fernandez - *Leerink Swann - Analyst*

Thank you, Seamus Fernandez from Leerink Swann. Just a -- one big picture question and something to, I guess drill down a little bit on the JAK-3 questions. You have projected 15 to 20 submissions, which seems to basically float with the 60% to 70% failure rate. But I think it is still tough to evaluate your expectations for regulatory success at that point. What is your definition for success? I mean, you are talking about Phase III success. That would be defined as efficacy in my mind. But I guess I struggle a little bit because it seems like this FDA is focused on safety. So maybe you can help us get an expectation in terms of what your expectations for likelihood of approval, rather than success on Phase III actually would be?

And then the second question on the JAK-3, I am a little bit confused by the explanation about the dose finding. It does appear that escalating doses in psoriasis, you are actually seeing increasing efficacy but also increasing toxicity, these data were presented at [UR] last year. So I am just a little bit confused on that explanation. Can you flush it out for me a little bit more.

Martin Mackay - *Pfizer - SVP, President - Global Research & Development*

Surely. In terms of the second question, again, I will go to Briggs for some comment. In terms of the submissions, it is a very good point, Seamus, that we have used historical attrition rates at Pfizer to come up with the figures that I have shown today. That is both in terms of those progressing into Phase III and then moving through to submissions. And as you correctly say, the environment with the regulatory authorities is why we have given our belief on submissions rather than approvals.

What I do know is that with each and every one of those compounds, we are having very interactive discussions with the agency, as you would imagine, at all stages, to make sure that we are doing the right studies, that we are in accord with their expectations, so that we can translate those submissions into approvals. As you also know, the attrition rate in Phase III has changed quite significantly over the last period and we need to watch that very carefully. In terms of the JAK-3 piece, Briggs? And I can always come back.

Briggs Morrison - *Pfizer - SVP - Clinical Development*

Yes, so again, the efficacy and the toxicity are both mechanism-based, right? So you are doing dose ranging to find out where's the dose that gives you the lowest dose to give you maximal efficacy and then characterizing the toxicity at that dose. And there is dose ranging as you note in different indications as well. So -- but those two things will map together and you are trying to find the sweet spot there where you get the maximal efficacy at the lowest dose to minimize the toxicity.

Martin Mackay - *Pfizer - SVP, President - Global Research & Development*

Okay, Seamus. Let's move across to this side again, please. Thank you.

Michael Castor - *SIO Capital - Analyst*

Thank you. Michael Castor with SIO Capital. A couple of questions. First, what is the doxylamine toxicity with the IGF-1 antibody? Second, can you provide additional clarity on the HCV molecule that is slated to enter Phase III development in the near future? Third, Pfizer has spoken about vaccines quite a bit in the recent past. What are the newest term or most advanced vaccines in development and the timeline for commercialization of the most promising commercial vaccines?

And then finally, \$7.5 billion is a significant amount that is being spent on R&D. There are definitely some promising compounds, but as an investor, I am not certain that I see really the full return that that amount spends. As you look out over time, what is an appropriate amount of spend, both in the near future and as Pfizer has to reset its spending to maintain operating margins over the next couple of years?

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Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you, Michael. I counted four questions in there, so let me just go back through them in reverse order, the way that I memorized them. And again, I will call on some colleagues. The \$7.5 billion, I kind of live with this every day and I am reminded by colleagues across here about the investment that is made in R&D. And as I alluded to during the talk, I am not happy with the productivity over a number of years with that extensive spend on R&D, hence, our renewed focus on really delivering this pipeline. But there is no God-given right to the \$7.5 billion.

I don't expect that on a yearly basis. And certainly know that if we don't deliver on the commitments that we have made, that as I say, my colleagues and myself will look very hard at what that looks like. We don't have a right to that money. It is very precious investment that we feel that we have over this next period.

In terms of other things you mentioned, the vaccines. The furthest advanced is actually the additional reason that we acquired the Powder Med Company and that is the seasonal flu piece of that. And that is proceeding through development now. It is really quite far advanced compared to other programs that we have. Powder Med had some other programs in infectious diseases and we are continuing with those. Where you really see the spirit of this group, though, is pre-clinically.

And as you know, we have moved back into this area after literally decades of being out of it in human health or animal health, group have really some very good vaccines for animal health. So we are playing catch up in that arena. How we said that we would catch up is not by going into conventional vaccines, lot commodity, high volume markets, but rather look at where technologies would give us that leap ahead. And Corey mentioned the Powder Med technology. It is one of those technologies that I believe will give us a leap ahead.

And the other recent acquisition and again, both Corey and I alluded to it, was the Coley organization. And Rod McKenzie, Head of Research, and I visited the Dasselendorf site, that again Corey mentioned a few weeks ago, and we are really very impressed with the technology there and really impressed with the work that they are doing around [toll light] receptor, that particular class and also their Angivent work, which ties up. So in a nutshell, Powder Med's seasonal flu is the furthest advanced, some infectious agencies earlier and then much earlier, a whole slew of what we term therapeutic vaccines.

The HCV molecule continues to progress in development. There is not really anything to report there today except to say we are very interested in the area. We believe a good molecule, it is a high unmet medical need and we are progressing that at some pace. And did you also have a question -- on the IGF antibody, Ken, you can talk to this firsthand, or Briggs?

Briggs Morrison - Pfizer - SVP - Clinical Development

The doxylamine toxicity question, from an oncology point of view, is typically grade three and four toxicities, I would say get doxylamine toxicity. My understanding, and I don't know all the insight, is it actually didn't get a doxylamine toxicity in that classic definition of how you establish one.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Sorry about that, Ken. Does that answer your questions, Michael? Thank you. Over here? We'll move to the back shortly. Tony, next.

Chris Schott - Banc of America Securities - Analyst

Great, thanks. Chris Schott at Banc of America. Quick question on Sutent, when you look at the Phase III programs in breast, lung, and colorectal, talk about enrollments going with Avastin increasingly becoming a standard of care in most settings?

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Second, when we look at Axitinib as compared to Sutent, can you just talk about, remind us again in terms of the more aggressive program with Sutent, is that just a timing issue or is there something you see with the profile of one versus the other that leads you there? And then finally on the DPP-4, just can you elaborate a little bit more on the data still coming on, what you hope to differentiate as compared to Januvia? Is this a selectivity issue and an efficacy issue? Thanks.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you, Chris. I will take those in the order that you asked them and then again, move to Briggs to make some comment. Recruitment has gone well in our trials with Sutent. As mentioned, we have got breast, colorectal and lung in Phase III. The patocellular, which is going to be very important for the Asian market and Dudley will touch on that later, this Harmon refractory prostate cancer. So we have a lot of trials running just now and so far, recruitment is up to par.

In terms of the Sutent Axitinib question, I really think it is a great question and how I would frame it is, we call these molecules vascular endothelial growth factor inhibitors and yet, we know they are different, okay? They have different receptor types that they are hitting and they have different modalities. And what we are looking to see here is just what is the difference as we are progressing both of these molecules through? Clearly, we are looking at different indications, that is one piece of it, because we sit today, I believe we have got a lot to learn about these particular molecules across a range of tumor types.

Moreover, I think there is going to be a real benefit in this area, the way that we combine the molecules that we have. And this is such a positive advantage when you have a large portfolio. We can start to think about combinations of vascular endothelial growth factor inhibitor and that is the IGF-1R antibody and look at that. It makes it more complicated in terms of the trials that we have to run. I would rather have that problem than have one or two molecules in development where we don't know exactly how we are going to position those.

And then in DPP-4 and I think Briggs mentioned, I think it is just early to say where we will see that differentiation. It is, we believe we have got a very sound molecule there. It is a well behaved molecule. It is clearly moving through the development pipeline. But you know, we have been used to working in mechanisms for many years where there is more than one entry into the mechanism. And I think particularly in this area, where again, I think combinations at least in the early days are going to be important in the way we treat this condition, for us to have a DPP-4 inhibitor is going to be very important as part of that treatment. But, Briggs.

Briggs Morrison - Pfizer - SVP - Clinical Development

Nothing to add.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you, Chris. Tony?

Tony Butler - Lehman Brothers - Analyst

Yes, thanks, Martin. Tony Butler at Lehman Brothers. Many companies really talk about this notion of proof of concept and how they have -- they believe that they can move products through at a fairly rapid rate because they have more or less better or worse proof of concept opportunities in front of them. I am interested to know if Pfizer has actually changed the way they look at how they can address proof of concept principally through some novel way that they have determined biomarkers, some novel way that they have determined genotypes, et cetera, for some disease association.

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And the reason I ask this is because, I suspect that in the past there have been very -- that trials have been much easier to attest. You may have had very easy markers to address the proof of concept. Moving forward, much more complicated diseases. I would argue that you would have to come up with more and new innovative opportunities to actually test those proof of concepts. And it really leads to how you would need to change your probabilities of success, I think, later on as opposed to the programs that you currently have in late stage trials. So anything you can address on that front would be helpful. Thanks.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

That is a really terrific question, Tony. I will mention some things and touch on some others that Briggs mentioned during his presentation. You are absolutely right, this is our battleground. This Phase II battleground of proving particularly [Ananara], where our portfolio is largely unprecedented now. We have been through different times where we have worked on [president] in molecules, particularly in an era where the range of modalities that is opening up to us now adds a pulse to the small molecular weight drugs that we loved so dearly. They will still be a very important part of the portfolio but when we start to think about all the biotherapeutics and even going into areas that Corey mentioned of eucleic acids and stem cells, the battleground is still going to be in this place.

Briggs mentioned something that came across as quite profound as he mentioned this scientist at Pfizer, [Leon Ratcliffe], who did a study. We've studied our failures for many years and as various companies have come together to form Pfizer, we have the biggest database of failure in the industry, I'd like to think just by dint of the size of the cohort that we've pushed through. But we've spent a lot of time looking at the reason for failure and set up this attrition task force to try and address that. But actually I think the most profound piece of work from an efficacy point of view wasn't looking at the failures but looking at the successes. Not only Pfizer's successes, but successes across the industry.

And what Leon found and not too surprisingly, Briggs mentioned this, the great compounds declare themselves early and big. And if you go into the clinical trials and particularly the proof of concept stage with that in mind, you will win different clinical trials. I would give one, I think really good example of it is the JAK-3 trial that we ran on the 264 patients relatively short time and that gave us real steel that we had a molecule that cleared itself big and early. I could also talk about the NGF antibody and others in that line.

Just briefly, you mentioned some other critical areas, though. Biomarkers and the way that we use these, we have a very large and aggressive group working in this space. Patient stratification and again we are doing more and more studies with exactly that in mind. Another piece that Briggs touched on which has been very important for us is to make sure that when we go into the clinic, we are actually proving the mechanism, far less proving the concept that we are actually hitting the enzyme or the receptor that we aim to in the amounts that we need to elicit the clinical response, and that is also very important for us. Briggs?

Briggs Morrison - Pfizer - SVP - Clinical Development

The only thing I would add, as I think Martin has covered it well, is it varies by therapeutic area. So in diabetes, your proof of concept is showing you lower hemoglobin A1C maybe more straightforward. In oncology, where the real registration endpoint is survival, then I think it is proof of mechanism and surrogate markers of what is going to happen there. I mean, Ken can talk about pain, again, and pain, it may be easier to get proof of concept in the appropriate models. So I think it varies depending on the therapeutic area and some are going to be easier, some of them are going to be much harder.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

I just had one other thing, Tony, and then I will check that we answered your question. And this is again, Briggs referred to our pharmacokinetic and pharmacodynamic modeling that we are doing in [Silico] is having a profound effect on the way that we are looking for the correct dose to test proof of concept. Does that get to your question?

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So Jamie, and then we will go up the back. I am conscious of the fact that we've missed out in the back there. Sorry, right in the middle, fourth row.

Jamie Reuben - Morgan Stanley - Analyst

Thank you. Jamie Reuben with Morgan Stanley. You didn't highlight your CD-1 receptor antagonist as part of your Phase II moving into Phase III or Phase III pipeline. And I am wondering if you could talk about how that profile is starting to evolve, how it looks, how it compares to [Ramaniban]. It sounds like Merck is moving forward with [Tronaban] this year. I thought you were both neck and neck, but it looks like now Merck has accelerated their program. And secondly, it seems that the path for approval for these compounds is through pursuing a diabetes claim first, so maybe if you could talk about that as well? Thanks.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thanks, Jamie. I will kick off with the answer and then pass onto Briggs. So actually, our CD-1 is moving along. It is one of those areas that unusually for us, it's actually quite nice to not be in first place here, particularly with the results from Ramaniban and how that is moving along. But our compound, we are moving along with some pace for sure. We are looking for differences, there is no question. We are very aware of where the competition are in terms of their compounds. And again, CD-1 is going to be an important mechanism here. We want to have a very good agent in here. And again, thinking about combinations, whether it be to treat diabetes or larger claims around obesity, it is going to be very important for us. But, Briggs?

Briggs Morrison - Pfizer - SVP - Clinical Development

So I think the concept around the diabetes claim, there has been sort of back and forth guidance there. It has got to be -- treatment of diabetes independent of the weight loss. But then the agency recently changed and said it doesn't have to be independent of the weight loss. So there are parts of the ongoing CD-1 program in obese patients with diabetes, treated for diabetes where we can look at both of those things. So there has been, I think your characterization of what the regulatory pathway is actually still evolving.

I think in terms of the data that is accumulating, it is, as Martin said, we are being very, very careful to look at the CNS effects. I think that has been the -- the team is really characterizing that very well. They have worked with the agency, they have worked with the consultants and the experts in this area to make sure we have the kind of information, the quality of information the agency is going to want on those endpoints.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Yes, just to reinforce, the notion of one agent working in this area would be excellent. But again, because of the pharmacology here, to have -- if this is going to be an important mechanism, we want a good compound in it. Please, up the back, you have been very patient.

Bert Hazlett - BMO Capital Markets - Analyst

Hi, it is Bert Hazlett from BMO Capital Markets. I have three questions. First, just broadly in the area of oral therapies for Type II diabetes, other companies are materially ahead of you with both follow on compounds and DPP-4s and in novel therapies. How much of a commitment is there by Pfizer to this high-growth area?

Secondly, specifically on a NAV 1.7, you discussed broader effects in humans. What did you see when you ran the animal knockout studies? Are there safety considerations that manifested themselves? And last, could you comment on the status of any

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anti-CPLA-4 monoclonal antibodies? I see that the 2006 program is listed in Phase III, but it is not listed as a filing through 2012. Could you just comment, is there still enthusiasm in that area? Thank you.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

Yes, I will take those questions and then pass on for some comment on NAV 1.7. In terms of -- I agree with you in terms of DPP-4 that companies are further ahead in diabetes. But we'd challenge your premise that earlier on that we are not at the forefront of some very exciting mechanisms in this area. We are very committed to diabetes. We are building the group up significantly now but we also have early clinical programs and also late preclinical of what we believe to be the very best targets in this area.

I will go to the third question, first on the CTLA-4 or the [tremulininab]. The only reason is not in the projections for 2010 to 2012 as we believe we will come earlier than that with this compound. As you know, we are running it for malignant melanoma at the moment and seeing some really excellent results with this particular modality. But we also have in Phase II with the same molecule opening up the range of indications of tumor types that we have. And as you know from this particular mechanism, it does have at least the potential to work in a broad array of tumors because of this mechanism of action. But Ken, would you comment on the NAV 1.7? Gillian?

Ken Verburg - Pfizer - VP, Development Head - Pain

Gillian is probably best.

Gillian Burgess - Pfizer - Executive Director - Biology

Well, I think the fantastic thing about the NAV 1.7 is that we actually have a human [knockout]. So we don't really need to go to animal models. And I think you can remember that I said from the studying, the fee for workers for condition, they are pretty normal. They don't have any other condition apart from the fact that they don't feel pain. So we are very excited about this program. Thanks.

Martin Mackay - Pfizer - SVP, President - Global Research & Development

I am going to call a halt to the question time here. We are going to take a 20-minute break and we will certainly all be available for further questions before restarting the program. So thank you very much.

(BREAK)

PRESENTATION

Unidentified Company Representative

Ladies and gentlemen, please welcome President - Worldwide Pharmaceutical Operations, Mr. Ian Read.

Ian Read - Pfizer - SVP, President - Worldwide Pharmaceutical Operations

Thank you. Good morning everyone. Change, opportunity and value. Three words that represent the path forward for Pfizer. Change in a thoughtful, dynamic way, so that we not only respond to our changing environment, but anticipate it. Opportunity,

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capitalizing on the many opportunities we have to grow our business in a significant way. And value, delivering real value to our customers in a way that sets us apart from our competition.

So, what is impacting healthcare today? Information explosion, tough questions on affordability, demand for evidence and better quality care, and several other factors. Perhaps most importantly, customers are gaining control and insight into their data. I believe when you look at that and you think about that and understand what that means for those at the commercial end and the way that moves back into our development and our research and our view of value, that has profound impacts on the way we evolve our model.

Given this situation, I know, the commercial organization knows, it needs to change. We need to be in the right geographies with the right products and with the right business models. And we must make the right investment choices. We must and we will sustain long term customer relationships and partnerships and this will lead to increased market share, sales and growth.

So on these three points, geographies, products, business model, how do we stack up? Actually, I believe that powerful forces of globalization play to our strengths. We are strong in the U.S., but with more than half our revenues from international markets, we are a force to be reckoned with worldwide. Name almost any market and we are well positioned.

Take for example, Japan. Number one in the market, \$3.7 billion of revenue at IMS level, market share of over 6%. This year, we will fuel the business in Japan with three new products, Celebrex, Chantix, Revatio. And depending on approvals, we will add Sutent and Caduet. So geographic strength is one of our core long term assets that will be with us long after the LOE of Lipitor.

Having the right products is critical. A large diversified portfolio, treating a wide range of diseases, will be a key success factor in the years ahead. While in the U.S. and Western Europe, a strong product is a golden asset until IP protection ends. In Latin America and Asia, emerging markets, the brand has value well beyond the LOE. But these assets won't reach their full potential without the right business models to sell them. And let's be frank, no one has the answer for what is the right model. There is no silver bullet.

Our ultimate goal is to radically change the business model. Let's call it game changing, shifting how we invest, deploy our resources, use different channels to reach customers on their terms, not our terms. This means moving away from a focus on reach, frequency, share of voice, to the quality of our engagement. We have done a lot in the past years and we have a wide range of pilots underway, many significant in scale, enabling us to see what works in this changing marketplace.

In the category of what we have done, let's talk about product development. We have continued to evolve our approach. We now have a seamless product development team that integrates research, development, medical, commercial to ensure that the value proposition that I have talked about, that Briggs talked about, that Martin talked about, is at the heart of our planning. As a result, we now get early agreement on the value proposition and the depth of data we need to support access in the marketplace. We've also increased our attention and resources on comprehensive life cycle management.

In Europe, we've done a radical redesign of our organization. As a result, we are more effective in deploying our resources and we have substantially reduced our spend. We now manage our brands with regional brand teams, removing duplication from the markets and improving the quality of our marketing. This has also enabled us to focus even more intensely on customer directed activities. I see our local country organizations as customer facing organizations.

In addition, we are changing our selling model. Germany is an excellent point in case. We've put an end to the conventional share of voice model in Germany by redesigning our 900-person field force that called on around 50,000 GPs. Our new model is based on looking at the value of each and every customer. For GPs, we have four segments based on value.

The highest value customers are served by account managers responsible for the total portfolio, while the middle tier is serviced with a more focused and tailored field force. And to better serve and align with regional health care structures and local physician

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networks, we also established regional teams with full accountability for the business and integrated customer management, and you will see this theme come back later on in my presentation.

All this has enabled us to reduce the GP field force by 25% while maintaining sales, improving productivity and more importantly, getting early positive responses from customers. Additionally in Sweden, we were first movers, changing from a traditional field force to a total key account management model, with similar results.

In the U.S., we are moving with just as much urgency. We have taken three major steps. First, we now have a dedicated customer unit focused on creating value through collaboration with customers, fundamentally understanding our customers' business model. Second, the focus of the business unit has sharpened our analytics, enabling us to better optimize our resources both in the BU and across the BU. And third, we have reduced the size of our traditional field force by 20% while maintaining productivity. We have also increased our flexibility by de-mirroring our field forces. And despite all of these changes in the U.S., our field force was just voted number one by physicians for the 13th year in a row. That is an incredible track record.

All of this is setting the stage for some major moves that meet the definition of game changes. In my view, to be game changes, we must be able to operate more flexibly in a world where we collaborate with our customers in developing valuable new products and services, where we take full advantage of new marketing channels, and where we operate more and more in networks as we see our customers doing. And where we have much deeper relationships with patients who are taking more and more control over healthcare spend.

So key enablers of this will be a pipeline that has been co-developed with our customers, where data meets not only regulatory requirements, but customer requirements. Internally when I talk with our research colleagues, I say, the FDA is sort of one step in the road. Customers define access. And a marketplace that facilitates meaningful communication on adherence, safety and benefits.

So to get there, we are exploring, experimenting and innovating across a wide range to see what actually works and makes sense for our customers. We are for example rethinking how we approach our customer base. We are working with communication channels such as our collaboration with Sermo, the largest online physician community in the U.S. We are invading around closed loop marketing, regionalization and with large institutions.

Let me use the U.S. to illustrate a few of these. Take a look at the map. The U.S. in fact is becoming less and less homogenous. We see a complex mix of public and private forces, big national customers, state by state markets, wide differences in physician access. Employers and academic medical centers playing more of a role in shaping the market.

So let me go through some of the pilots we are running in the United States. This is about empowerment, giving the people closest to the customer what they need. I see them with a toolbox, if you will, three or four different models that can be used with different customer segments. Regionalization, why is it important? It is important because we need to understand how to resource, respond and respond quickly and execute against local market dynamics. We are doing this across all 50 states. This is fundamental to our evolving model.

We are shifting more accountability and control from headquarters to the field and significantly changing the role and capabilities of our regional managers, something, frankly, they have been asking for. As this evolves, I see headquarters covering strategies and interactions that are nationwide in providing core product materials and positioning. I see an open dialogue between headquarters and the people closest to the action working on analytics and market drivers. And finally, the business plan, resources and execution done locally, owned locally, which in my view is where it should be.

Now let's turn to physician practice models. We have pilots in several states looking at this. These pilots turn the traditional brand-focused push promotion model on its head and move us to look at the customer base differently and how we deploy our resources. We will gain a deeper understanding of our customers' business model and from that, gain insights on collaboration.

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As a result, this will lead to reducing the mutual cost of doing business while generating opportunities for revenue growth. In many ways, this parallels what we have already successfully implemented in Germany, Sweden and the U.K.

What about big institutional customers? More and more, Big Pharma is being shut out of academic medical centers and big integrated hospitals. Given the roles these institutions play in shaping medical practice and training the next generation of physicians, we are putting account managers in place to rebuild these critical relationships. And when it comes to employers, we are focused on engaging with them on cost benefits of pharmaceuticals and health plans. We are doing this in two significant ways: one, doubling the size of our employee account managers; and secondly, involving the role or evolving the role of the customer regional manager as an integrated business partner with payors across the United States and employers.

Clearly, business model is important. And when combined with the right geographies and products, we see three significant ways to grow -- by optimizing the patented portfolio, by unlocking the value of our established products and by accelerating growth in emerging markets. Our position and capabilities in emerging markets, that is those markets aside from the U.S., Western Europe, Japan, and Australia, is very strong. The business is already robust with double digit growth, and this is where I see the power of our scale combined with the focus of our country organizations, which frankly are basically quick and nimble mini business units with a real depth of talent and knowledge of their customers.

As you can see from this slide, while the developed world of the U.S., Western Europe and Japan remain important to us and will continue to drive the growth of our innovative portfolio, the real point is the expected growth of emerging economies like China, Turkey, Brazil, Russia. China alone has incremental GDP growth of close to \$13 trillion and Russia, \$2.2 trillion forecast for the coming decade. And as you think about these markets, keep in mind, spending on healthcare is closely related to GDP.

Now, we are going to go in depth on these three major growth opportunities. First, in emerging markets we are highlighting Asia today, where we see a wide variety of ways to take advantage of growing demand for healthcare. Dudley Schleier is the head of our Asian business. His experience with Pfizer spans the U.S., Puerto Rico, the Caribbean, Turkey, Australia, China, where he was our country manager in China, and he brings a deep understanding of emerging markets and cultures and an aggressive set of targets for Asia.

Then we will hear from David Simmons, who has a diverse background in manufacturing, information technology, marketing and country management. David did an outstanding job running our central and Eastern European business and he is now leading our new established products business unit, which is a part of worldwide pharmaceutical operations. Then, I will come back and talk about how we are optimizing our patented portfolio and growing our key in line products. Dudley? Thank you.

Dudley Schleier - *Pfizer - VP, President - Pfizer Asia & Japan*

Well, thank you, Ian, and good morning everyone. I am very bullish on Pfizer's future in Asia and pleased to have this opportunity to present Pfizer's Asia strategy to you today. We have a decades-long commercial presence in Asia that has been highly successful. It is a place where I have spent a significant portion of my 35-year Pfizer career.

While we are the number one pharma company in the region today, there is great opportunity for significant growth for many years to come. I say that because emerging markets in Asia, which excludes Japan, Australia, and New Zealand, contains some of the world's fastest-growing economies, populations and healthcare markets and have a vast market of middle-income patients not currently receiving Pfizer products.

Today, we have a market share in Asia of 4% and a market valued at \$47 billion. That market is projected to grow to over \$100 billion by 2017. And I am here today to tell you that I am determined to capture between 7% and 9% of that sizeable market.

Let me take a few minutes to tell you about our operations today. 2007, sales in Asia emerging markets was \$1.7 billion on growth of 11%, making us the number one pharmaceutical company in these markets. We have created over the past decade

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a sizeable footprint in Asia to support these emerging markets. We have boots on the ground in Hong Kong to provide cross-functional regional support in marketing, sales, medical, public affairs, finance, legal and human resources, and we have made a significant investment in talent development and more importantly, retention of that key talent.

We have a strong cadre of experienced country managers in Asia, with over 75% of those country managers being local. And we have a regional management team between New York, Hong Kong and the countries that has almost 10 years of working together. And add another key element is Pfizer's strong reputation in Asia as a good partner, as a good corporate citizen and a good employer. Pfizer has received consistently high rankings in employer surveys. Our philanthropic activities in China for SARS relief and in Thailand and Indonesia for tsunami relief have created a valuable base of goodwill.

Now let's look at the highlights of the Asia strategy. A strong commercial, research and development and manufacturing collaboration led to the development of the Asia strategy and its four drivers: first, geographic expansion; second, building leadership in oncology; third, tailoring portfolio offerings; and finally, capturing global advantage in manufacturing and in research and development.

These four drivers are all integrated due to Jeff's strong support. He went to Asia soon after becoming CEO. Within six months, he had everyone at Pfizer working together on the Asia strategy and that was a real cultural change for Pfizer. This continued collaboration will be fundamental to ensure our success going forward.

Now let's focus on a country where I have a great deal of experience, where I became the country manager back in 1993. Over those 15 years, I have seen considerable change, change that is very positive for the country, for the industry, and for Pfizer. And now let me talk about our biggest opportunity, China.

Last year, China's GDP grew by more than 11%, the strongest performance in 13 years. China currently is a \$15 billion market and will become a top five pharmaceutical market as early as 2010. Pfizer has a leading presence and last year's revenue growth was 31% net of foreign exchange. Norvasc is our top selling product. It grew 17% last year and particularly important, is still the number one anti-hypertensive in China, while being off patent for over five years. Let me emphasize this once again. Because the success of Norvasc is directly related to Pfizer's marketing strategies and our ability to establish the power of the Norvasc brand. In a similar fashion, we will continue to grow all our established brands.

Moving forward, we plan to significantly expand our business. First as I mentioned, by growing our established products, namely Lipitor and Norvasc; second, by extending our reach to the rapidly growing middle income segment; and third, by launching new products such as Chantix and doing it faster. Chantix is a win-win product. It's a win for Pfizer, it's a win for the Chinese government in addressing the financial burden inherent with treating smoking related disease. And more importantly, it will help patients live longer and healthier lives. We plan to do all of this by expanding our sales force presence from 110 cities today to the largest 650 cities in China, thereby growing the population we reach by over 500 million people and capitalizing on a significant market opportunity projected to be \$31 billion.

We also see opportunities beyond China. Korea is another fast growing market and we expect to be a \$1 billion business by 2012. We will do this by driving the oncology portfolio, maximizing the long term potential of products such as Lyrica, while also leveraging the same win-win scenario for Chantix as in China. In India, we will continue to grow our portfolio. But more importantly, we will leverage India as a low-cost skills and capabilities platform for Pfizer globally.

Across Asia, we will also look to offer product channel distribution and technology innovation. We will increase our investment to further develop the cardiovascular treatment and prevention segments in all of these emerging markets. We will also drive channel innovation to increase patient access and strengthen physician relationships. As an example, we have been testing an electronic discount program in the Philippines that has been highly successful. It delivers disease education, it improves adherence, and it gets medicines into the hands of patients that would otherwise not have access to our products. That program named E-Card is also being rolled out in other Asian markets.

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Now let's talk about oncology. A lot of people have spoke about oncology today. It is a key driver of the Asia strategy. Oncology is a major opportunity with 45% of all cancer mortality worldwide seen in Asia. Over 3.5 million people die every year of cancer in Asia, nearly five times, five times as in the United States of America. As you can see from this slide, with Asia in the red and North America in the blue, we have opportunities to both better treat Western cancers such as breast and lung, but more importantly, as you can see on the right hand side of this slide, there is huge opportunity to develop compounds that can address Asia-specific cancers, which currently have few treatment options.

Pfizer with Sutent and our extensive oncology pipeline is perfectly positioned to meet this significant unmet need in Asian cancers. The potential is staggering. For patients, essential. All will be accomplished by conducting more clinical trials in Asia and increasing our development efforts with key opinion leaders.

Having spent some time discussing our geographic expansion and our oncology strategies, let me also touch upon capturing global advantage. First, let's talk about research and development. We are investing \$300 million in South Korea to conduct early phase programs. We have an existing research and development facility and a capability that we are continuing to grow in China and as Corey mentioned earlier, we plan to extend Pfizer's incubator initiatives to eight start-ups in Asia and leverage local innovation. To bring this large effort to fruition, Pfizer has created a new leadership position based in Shanghai, responsible for all Asia research and development activities and reporting directly to Martin Mackay.

In manufacturing, we have experienced throughout Asia with plants in China, Singapore, Indonesia and Pakistan. First, we will leverage partnership opportunities in Asia to lower our cost of sales and to help make our medicines more affordable. Second, we will improve our skills and speed of execution on reformulations to customize our products to meet local market needs.

Finally, we see significant potential in business development activities throughout Asia to supplement our portfolio. While the Asia strategy is organic, and internally driven, success on the business development front can provide additional upsides while hedging against any unexpected risks. To capture this opportunity, Pfizer has appointed a senior executive to lead regional business development activities and that person will be based in Hong Kong.

You have now seen the four drivers of our Asia strategy. Our goals are considerable and as I said earlier, we expect to grow our market share of 4% today to 6% by 2012 and between 7 and 9% by 2017. Grow our share in China from 2% today to between 8% and 11% by 2017, take Korea to a \$1 billion business by 2012, become a top three oncology Company in this fast-growing segment by 2017, and finally, we plan to capture global advantage by leveraging low cost infrastructure in Asia, thus making our products more affordable.

In closing, we have a plan and we are already executing on that plan. The Asia projections that I mentioned earlier include a contribution from the established products strategy. To tell you more about our global platform for tailoring our portfolio, while maximizing our established brands, I would now like to introduce David Simmons, Senior Vice President and General Manager of our newly created Established Products Business Unit.

David Simmons - Pfizer - U.S. Medical Director

Thank you, Dudley, and good morning everyone. All of you are familiar with the commercial life of a medicine. It is born when it is approved by regulators. It grows ideally under patent protection and it declines, often very rapidly as is the case in the U.S., when it loses exclusivity and faces generic competition. But this picture is too simplistic. Great branded medicines don't just go out of sight and out of mind. In many markets, we recast this life cycle, we can extend it and we can derive additional income from it, through the creative use of our strengths, our creativity and our experience.

For the next few minutes, I want to talk about the growth opportunities we see in a market segment we refer to as established products. More to the point, I want to share our strategies for gaining a larger share of this fast growing market.

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Here is a picture of the established segment of the pharmaceutical market. This is the market for medicines that have either lost exclusivity or are on the verge of doing so. The segment is big. It was \$271 billion in 2006 and is expected to grow to \$523 billion in 2012. It is growing fast, double digit rates year-over-year. There are two main drivers of this growth. First is a market shift of products that lose exclusivity over this time period. This represents about two-thirds of the growth in that green bar. The other one-third is pure organic growth, coming from increasing volume consumption worldwide. This represents about \$80 billion of growth over that time period. The strategy I discussed today primarily targets this part of the market.

I would add that this market has good operating margins. We do not incur large R&D expenses in this segment and we leverage our existing strengths here. It is a market where we can be and will be a much stronger force. Right now, we have about 3.5% of the market with room to grow. But it is not a homogenous global market and let me tell you why. We see the global established products market as three distinct markets, each with its own set of customer dynamics and each requires a different strategic approach. The Kellers have not been picked randomly on this screen. Some markets are more attractive than others. Green, which is my favorite segment, represents branded emerging markets. You just heard a little bit about Asia. Yellow represents branded traditional markets and red represents what we refer to as IP-driven markets.

Let's start with green. The largest and most dynamic segment is the branded emerging markets covering Latin America, Eastern Europe, Africa Middle East and most of Asia. It includes 5 billion and that is with a 'b', 5 billion potential customers. And it fits nearly hand-in-glove with Pfizer's strengths. This is the segment I am most excited about.

I used to have a U.S.-centric view. I thought these markets would be just like the U.S. But after living and working in countries like Greece and Russia and Turkey, it became clear to me that these markets are different. I have seen traditional generic companies try to penetrate these markets with a low cost offering. And I have seen them struggle. So why do they struggle? Why are these markets so radically different than the U.S. and what makes Pfizer's strengths matter here? Here is why. These are physician, pharmacy and patient driven countries where payor influences are not as dominant and strong brands matter. This is our model. It requires a significant commercial footprint to succeed.

Already in many markets, we compete, often very effectively, against early and unauthorized generic copies of our medicines. In fact, Lipitor competes against generic Atorvastatin in many countries already. Despite this, we are growing and maintaining a leading share in diverse countries such as Turkey, Czech Republic and India with Lipitor. Not only does this segment play to Pfizer's strengths, it is the largest of the three segments. We expect this segment to reach \$235 billion in 2012. That's nearly 45% of the entire established product segment. This segment is a major reason why I took the job I have now. I know this segment, I am confident Pfizer can do more business here and I am committed to this.

The second market segment we refer to is branded traditional markets. These are countries in Western Europe, Japan and South Korea, as an example. I have also worked in these markets. These are pharmacy channel driven markets that drives the dispensing decisions. But physicians and payors retain a lot of influence here. Brand still matters. Price erosion is not as steep as what we see in the U.S. We expect this market to reach \$130 billion by 2012. There are opportunities here that play to Pfizer's strengths.

An example is Fragmin, our biologic medicine for deep vein thrombosis. We see upside opportunity for Fragmin in many markets around the world. We have leading physicians in Germany, Sweden and Switzerland and we are applying what we have learned in these markets to other countries to drive further growth in Fragmin.

The third segment we refer to as IP-driven markets. These are markets such as the United States, Canada, South Africa, Australia and the United Kingdom. I think all of you know this segment very well, since you are in the U.S. These are tough commodity style markets where payors in the pharmacy channel drive what products are dispensed and there is little or no brand preference among generics. This is the market where sales of a branded product fall dramatically with steep erosion curves once a patent expires. While this market is large and growing, it is not a primary driver of our strategy. However, we will seek to capture collateral benefits in this market segment. For example, we will continue to do this in the U.S. through our Greenstone operation, one of the leading generic companies in the U.S.

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Now I want to share with you our strengths, Pfizer's unique strengths and how they will help us deliver against four streams of value creation. As I go through this slide, I would like you to keep in mind the branded emerging markets and branded traditional markets when you think of Pfizer's strengths. We compete so well for a number of reasons, starting with the strength of the Pfizer brand. Around the world, Pfizer's brand means a proven record of efficacy, quality, safety and reliability. We are already a leading player in established products. We have a large base from which we can grow.

As Ian and Dudley mentioned earlier, we also have a deep and broad commercial footprint. We have been in regions such as Latin America, China, India and Eastern Europe for decades. This is a real differentiator for us. We also have best in class capabilities in pharmaceutical science and we can apply these to the needs of customers wherever they may be. Here is a great example. We have a project underway to deliver Xanax in an oral dissolving tablet form. In this particular case, we designed the enhancement in Pfizer based on patient needs. We then found an external partner who could develop and manufacture this formulation very fast and at a very low cost. We envision having an ongoing portfolio of these kinds of projects, delivering a steady stream of innovation to patients.

Our manufacturing is also state of the art, with a lot of flexibility to keep driving costs down. We can genuinely aspire to be a cost complete provider of all of our top selling medicines worldwide. Without question to thrive in this established products market, we will have to develop new capabilities and new offerings. But we have a strong platform for growth, a platform that makes us vastly different when compared to a typical generics Company.

Across the board, we could apply our strengths to at least four streams of value creation. First, we can leverage our product portfolio to drive cost reductions and to promote select products. Again, strong brands are valuable in this market, even after LOE. Second, we can become a world leader in product enhancements and reformulations, innovative packaging, delivery devices, combination therapies, dosing enhancements, moderately priced value adds that can make our product stand out no matter how ferocious the competition. Third, we can find and fill the needs of niche markets that have barriers to entry for competitors, like the markets for Fragmin I talked about earlier. And lastly, we can add value by intensifying our efforts to navigate the products through the transition from patent protected product to branded medicine.

Lipitor is already a key focus here. We will fight for every unit share of Lipitor and every one of our products after LOE. Jeff has emphasized to you and to us the importance of changing how Pfizer does business to capture new opportunities. Given that we must meet the needs of three distinct market segments, we need to be a lot better to succeed. Our competitors are not weak and they are not sitting idle.

In order to ensure Pfizer's success in this area, I need to keep this established products group small, flexible and very focused on value creation. I need to quickly build a new team that capitalizes on Pfizer's strengths, spreads best practices from market to market and actively engages our regional marketers. We need to adapt to local markets, being willing to change our approach to meet the needs of customers. And we need to be willing to partner, partner with external groups and companies around the world to meet the market's needs.

This is exactly how I am going to lead this business unit. We are going to be focused. We are going to make smart bets and we will run our business like an entrepreneurial venture. Speed, speed, speed will have to be embedded in the culture of this business unit to succeed.

The established products segment is expected to grow around 11% over the coming years. Our goal is to outpace the overall market. So how are we going to do this? First, by increasing the emphasis on our current established products portfolio; second, by broadening the geographic reach of our offerings and third, by seeking out partnership opportunities to outpace the competition. By delivering better value to patients wherever they live, we can deliver more value to shareholders more effectively and capitalize on a great heritage of innovation, science and patient care that is Pfizer. Thank you very much for your time. At this point, I would like to pass the stage to Ian Read.

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Ian Read - Pfizer - SVP, President - Worldwide Pharmaceutical Operations

Thank you, David. You just heard the plans for two of our three growth opportunities, incredible opportunities in my opinion. Now let's look at how we are optimizing the value of our patent protected portfolio that remains the core strength of our Company. Let's discuss Lipitor. Despite intense competition, Lipitor continues to be a great medicine and our largest product. We are fighting hard everywhere against generics and Atorvastatin and we will continue to focus on the lack of outcomes data from the branded competition, most importantly, just reinforced by the enhanced results.

While the U.S. is important, it is actually just one part of the Lipitor story. Look at this global brand. You see a bigger picture where Lipitor is not only holding its own in Europe but actually growing in high single digits in Canada and emerging markets. This is the power of having the right geographies. During 2008, you will see us reinforce differentiation with a compelling body of clinical and outcomes evidence, drive activities targeting both new and continuing patients, maintain and leverage access.

Now, let's look at pain. You've heard a lot about our pain franchise from Ken and Gillian earlier today. The pain market is a \$45 billion opportunity with a variety of treatment options. Lyrica is one of our anchor products in this category with a very promising long term outlook. In 2007, Lyrica was approved by the FDA as the first ever treatment for fibromyalgia, which Time Magazine named one of the top ten medical breakthroughs. And Lyrica is backed by strong data. As shown here, 53% of Lyrica patients experienced rapid and sustained pain relief that continued through the six month trial. This clinical evidence will set Lyrica apart from the competition.

Lyrica has demonstrated rapid and sustained uptake. 2007 U.S. sales were up 46% with international sales growing 78% to \$781 million. On this slide, you can see how the product positively responded to the launch of the fibromyalgia indication in the third quarter of last year in the U.S. More importantly, we know of those fibromyalgia patients who are diagnosed, 90% are dissatisfied with their current treatment. And as pain is a cornerstone of fibromyalgia, we see Lyrica as the foundation of its treatment.

To accomplish this, we are using a broad-based, multi-channel campaign to build awareness, e-newsletters, webcasts, in pharmacy adherence programs and a call center for patients, to mention a few of the examples you see on the screen. To maximize the value of Lyrica to patients, we have a robust life cycle plan in place. We expect to strength the core NEP business with new indications in both spinal cord and post traumatic neuropathic pain. We also plan to broaden the Lyrica label over time through areas such as post stroke pain, cancer pain, restless legs syndrome and post operative pain.

Celebrex is a key in line component of our pain portfolio, delivering 12% growth to \$2.3 billion in global revenues, up 9% in the U.S. and 24% internationally. Our strategy for Celebrex is to defend and preserve the brand in the near term by doing three things: strengthening the understanding of efficacy and safety; repairing the patient-physician dialogue and lastly, optimizing execution. This will set the stage for the completion of the CONDOR and PRECISION studies, which are anticipated to read out over the next 24 to 36 months. We hope these new data will renew momentum for Celebrex and growth in this category.

So to summarize this, as you have seen from Ken, Gillian and me, we are in pain. It represents both a significant opportunity to address unmet patient needs and a critically important disease area for us. We continue to drive Lyrica and Celebrex performance and we are committed to accelerating our emerging pipeline.

And now, Chantix. The hope for millions of smokers around the globe who want to quit. First, I would like to comment on the recent U.S. label change. In mid-January, we added a warning that patients should be observed for serious neuro-psychiatric symptoms. This change was not tied to any new data beyond that included in the last label update in November. But we see this information as important to encourage an active patient-physician dialogue, so that these events, which are not sudden in nature, can be best managed and put into perspective.

I want to emphasize the real overriding issue here is the absolutely devastating health effects of smoking. For smokers ready to quit, representing more than half of the 45 million plus smokers in the U.S. today, Chantix is a new option. And we know from

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our recent interactions with physicians that the risk benefit proposition for Chantix is sound. They continue to see clear value in Chantix.

From a global perspective, the U.S. is really just the tip of the iceberg in a world with 1.3 billion smokers. We believe Chantix will have a major role in addressing the smoking epidemic worldwide and we will continue to expand our partnerships with organizations dedicated to reducing the terrible toll of smoking in society.

Turning to oncology, we are poised to take advantage of an oncology market that is expected to grow significantly by the middle of the next decade. Market growth is being driven by breaking science, the rapid uptake of new agents meeting high unmet medical needs and treatment to our cancer patients to live longer. Let me show you how we are going to become a major force in oncology, from a portfolio product and business model standpoint. This snapshot shows how portfolio strategy builds directly on the market opportunities. We are focusing our assets on tumors with high prevalence such as breast, colorectal and lung as well as those of high unmet medical need in Asia.

Sutent is the bedrock of our oncology portfolio with global sales of \$581 million last year. It is the market leader in its core indications, with a 55% share in first line RCC and 86% patient share in second line GIST. During 2008, we will continue to drive first line RCC leadership and address barriers such as treatment duration. We have a comprehensive life cycle plan for valuable new indications as Martin mentioned, with Phase III programs in breast, colorectal, non small cell lung and a Phase III start in prostate cancer expected later this year. Oncology is an invest to win disease area for Pfizer.

To maximize our opportunities and build our presence, we are taking up a series of actions, including maximizing new product development, enhancing the ways we interact with customers, engaging with payors, and embracing our global opportunities. In addition, we clearly must adapt our business model to the unique dynamics of the oncology market. To do this, we are announcing today that formation of an oncology business unit that will enable us to focus resources, move quickly and importantly, stay connected with customers.

The leader of this unit, who we are in the process of appointing, will serve as the single point of accountability for Pfizer's oncology presence, working across global development, medical, commercial, the leader will work in a matrix relationship with these functions. The unit, which is a part of worldwide pharmaceutical business, will have direct responsibility for product development, life cycle planning, the U.S. business and a shared P&L responsibility for the international business.

Beyond what I have just covered, our portfolio has numerous other brands growing double digits in 2007, such as Zalatan at 10%, Geodon at 13%, Zyvox and VFend, 21% and 23%, and Caduet growing at 54%. We also see continued strong growth in our alliance brands, including Spiriva and Aricept. Those are our plans. By being in the right geographies with the right products and the right business models, we will drive change, seize opportunities and create value. Thank you. And I would now like to turn the podium over to Frank D'Amelio, our Chief Financial Officer.

Frank D'Amelio - Pfizer - SVP, CFO

Thank you, Ian. Good day everybody. I am going to wrap up the presentations with a financial overview and I will talk about 2007, 2008 and I will provide some information that goes beyond 2008. Just let me move onto the charts.

So this first chart compares 2007 actuals to 2006. One point to make here about 2007, these numbers now reflect the rebate accrual adjustment that we discussed last week when we filed our 10-K, so just to make sure that everyone understands we've adjusted these numbers to reflect that. So let's just run through the line items.

If you look at revenues year-over-year, they were essentially flat. A lot going on in those revenue numbers. We had Norvasc was down \$1.9 billion year-over-year, Zolofit was down \$1.6 billion, so \$3.5 billion down on a year-over-year basis due to LOE impacts.

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We were able to offset that with a combination of new product revenues, Chantix, Lyrica, and Sutent, which were up \$1.8 billion year-over-year.

Animal health was up a couple of hundred million and we had benefit from foreign exchange, which we called out, which is about \$1.5 billion. But all in, those numbers basically netted out. Cost of sales was up 7%, that was really two things there, some mix and foreign exchange, which offsets some of our cost reduction initiatives in those areas.

On SI&A and R&D, SI&A was down 1%, R&D was essentially flat. Once again, combination there of cost reduction work that we were doing being offset by foreign exchange, with the benefit of foreign exchange on revenue and earnings to detriment of foreign exchange on our spending line items.

Adjusted income was up a percentage point, several items there. The cost reduction initiatives that I mentioned and we had some interest income that was higher year-over-year. The adjusted tax rate was also down year-over-year. All of that contributed to our adjusted income improvement and the adjusted diluted EPS was up 6% from 206 to 218. The real difference there between the income number and the EPS number is the share repurchases that we did last year. We bought back, as you all know, about \$10 billion worth of our shares. Let me move on.

This next chart just shows cash flow from operations. If you look at the numbers, in terms of 2007, the number is \$13.4 billion. On our earnings call, we had basically estimated this number, we said it would be at or above the guidance we had put out there. The actual number is \$13.4 billion. A couple of comments on that number, then I will talk about 2008. The number is down from 2006. The big driver of that was the cash payment that we made on the gain of the consumer healthcare business in 2006. So we booked the gain in 2006 but actually made the majority of the cash tax payments in 2007, which is why you see the number down year-over-year.

In terms of 2008, our guidance is \$17 billion to \$18 billion, which is very similar to what we generated in 2006. I think the key message to this chart is, we've generated a lot of cash from operations in the past. We expect to continue to generate a lot of cash from operations going forward, and you see that reflected in our 2008 guidance.

All right, this next chart is the financial 2007 guidance chart and shows the guidance that we had given versus actuals. The way I look at this chart is, check marks are good. So basically, what the check marks say is, we did what we said we were going to do. The one place we missed is in cost of sales where it was 16%, and we had guided to 15.5%. A couple of comments on that, and then I'll talk to the chart.

The miss was really driven by a combination of foreign exchange and business mix. In 2006, our cost of sales was 14.9%, 2007, 16%. And I'm just pointing it out to when I get to the '08 guidance chart, where we actually have a lower cost of sales number versus the '07 result, and I'll explain why that is. Now, just to balance the chart out, checkmarks are good. But just to be clear, we gave this guidance in October and these are the numbers that we printed in January.

So in that three-month period, we should have mostly checkmarks. Basically, we did. So, once again, we want to do what we said we were going to do, but I want to balance it out with this was guidance based on October.

Okay, a little bit about our dividend growth. We clearly have a long and proven track record of providing a strong dividend, and you can see that on the chart. In 2008, we said we would moderate the dividend growth. Compared to some recent prior-year increases, we did that. In 2008, the growth was 10%. If you look back to 2007 and 2006, we increased the dividend by 21% and 26%, respectively. And you can see obviously the strong yield that the dividend has right now, based on our stock closing price at the end of February. Let me spend a minute on the dividend relative to some comments going forward.

So the way I'll say this is significant unforeseen risks and opportunities aside, so significant unforeseen events aside, we expect to continue to generate sufficient cash flow from operations to fund the dividend at least at current levels -- at least at current levels.

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We will continue to remain very focused on total shareholder return and we understand the importance of the dividend in the total shareholder return equation. Okay, let's talk about share purchases and share repurchases. We've done a lot of share repurchasing over the last several years.

If you look over the last six years, from 2002 to 2007, we've repurchased about \$45 billion worth of our shares. That translates to 1.6 billion shares. You can see that on the chart. In January, on our earnings call, we announced a new program. We said we would repurchase up to \$5 billion of our shares, but that was an open-ended program, so there's no specific timeframe for completion. Once again, in terms of share repurchases, as we think about that as part of the overall total shareholder return equation with dividends, and obviously with revenue and earnings.

2008 guidance, we basically provided guidance in January. These were the line items that we provided the guidance on. Let me just run through them quickly. On revenues, \$47 billion to \$49 billion, compared to '07 of \$48.2 billion. So think about that as plus or minus 2%. Adjusted total cost, \$1.5 billion to \$2 billion, down in '08, versus 2006 in terms of actual spending levels on a constant currency basis.

The cost of sales percentage of 14.5% to 15.5%, so let me spend a minute on that. We said the number in 2007 was 16%, and we're providing guidance in '08 of 14.5% to 15.5%. So why is that? There are several items there, let me call out three.

One is we had six manufacturing site exits in 2007. We'll get the full-year benefit of those in 2008. Two, we're doing lots of things to lower our sourcing cost by establishing some strategic relationships with various vendors where we're leveraging some of their capabilities and some of their -- I'll call it lower-cost capabilities. And then third, we have lots of activities, lots of initiatives on the way throughout the Company in areas like finance and IT, and all of those areas have impacts on multiple line items, including COGS.

So those are just some of the examples of what we're doing that will result in a cost-of-sales number in 2008 that's lower than the 2007 number. We have R&D at \$7.3 billion to \$7.6 billion. Last year, it was \$7.5 billion. Adjusted SI&A at \$14.4 billion to \$14.9 billion, compared to \$15.2 billion in 2007. You can see the adjusted and reported diluted EPS numbers with the adjusted number at 235 to 245. Think about that as a range of plus 8% to 12% in terms of the bottom to the top end of the range, an effective tax rate of 22% to 22.5%, and our cash flow from operations of \$17 billion to \$18 billion.

And the key message to the chart is we are reaffirming our 2008 financial guidance. We provided this guidance in January. We're once again reaffirming it today.

Okay, let's move a little bit now onto some other items. We've talked about these strategies today, the five strategies. This chart lays out all of the five strategies for growth, and let me just talk through them quickly. One is optimizing our patent-protected portfolio. The second is finding new opportunities for established products. The third is growing in emerging markets, using innovation and continuous improvement and investing in complementary businesses. And you've heard us talk to some of these today.

The next item on here talks about strategies, include business development activities. Let me spend a minute on this. So, clearly, we have factored into each of these strategies assumptions around business development, but I want to just refer back to something that Jeff said, which is while we remain open to anything, right now we don't see anything that meets the definition of a mega-deal where the strategic value outweighs the concentration risk of such a deal, the disruption that such a deal would cause and the price of a deal.

Financial requirements regarding the execution of the strategies has been incorporated to our 2008 guidance, and then the last item is we expect to help mitigate revenue impacted by Lipitor's loss of U.S. exclusivity and establish that foundation for revenue and earnings growth shortly thereafter. So I view these strategies as opportunities to create new sources of revenue for the Company, and obviously to have that revenue mitigate as much of the impact of Lipitor's LOE in the U.S. as it can.

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All right, let's talk a little bit about targeted operating margin. So by managing the mix of business -- and I'll come back to that explain what I mean by managing the mix of business, and managing the total cost structure -- and obviously that includes our cost of sales, our SI&A and our R&D, we expect to maintain our overall operating margins in the mid to high 30% range. By the way, in 2007, our operating margins were 37%. An operating margin here is basically revenue, less cost of sales, R&D and SI&A.

In terms of managing the mix of business, let me just spend a minute on that. When you listen to the strategies that we've talked about today and creating these potential new sources of revenue, some of these revenues could have margins that are different than our overall margins today. And by margins I mean gross margins.

However, they should have less expense needs. So on an overall basis, the overall operating margins should be essentially the same, fairly consistent to where they are today. So that's what I mean there when I talk about managing the mix of the business.

All right, let's segue now to a couple of charts that talk about what we've been doing on cost, so things that we've done to date and then I'll lay out a couple of charts on what we'll be doing going forward. So this is a summary of some of the cost reductions that we've made to date. It's a three-year summary, so 12/31/04 to 12/31/07 and we've adjusted the numbers to remove the consumer healthcare business.

Our manufacturing sites, we've gone from 78 sites over the period to 57, from an outsourced manufacturing perspective, we've gone from 9% of our COGS to 17%. Think about that, by the way, in absolute dollars, about \$500 million to \$1 billion. We've reduced R&D sites from 15 to 10. We've reduced our overall real estate square footage from 80 million to 54 million. We've taken the sales force from 36,300 to 28,000 and the overall headcount has been reduced from 110,000 to 86,600, a 21% reduction.

So let's talk a little bit now about in addition to what's been achieved to date, what else we'll be doing. So in manufacturing, we're looking to increase the amount of manufacturing to be outsourced from that 17% to about 30%. That's -- think about that, once again, in terms of the rhythm of the numbers from what was \$500 million to \$1 billion to approximately \$2 billion, relative to our overall cost structure. Continuing to reduce the manufacturing network, so 78 to 57 to 45 by the end of 2009 and then going further than that, beyond 2009.

Implementing strategic sourcing arrangements and I alluded to that in some of my comments previously. On the research and development side, Martin and Briggs and the team talked about some of these, so let me just spend a minute or two, utilizing enhanced clinical trial design.

Think about this as really leveraging state-of-the-art statistical modeling to better size clinical trials. It's kind of one of the benefits of that. And the second is using that same statistical modeling to be able to identify earlier on in the trial, at the earliest stage, if the trial is not going to have the desired outcomes that we're looking for.

And, if that's the case, then we can actually move faster, sooner, relative to how we're going to spend or not spend money going forward in that area. Applying the biotech investment paradigm. Think about that as we're in a program and really investing to the extent necessary to get to the next decision point, and not assuming automatically that it's going to be successful, so therefore when you're in Phase I, you're building Phase II supplies for a phase that you're not in yet. So we're doing things like that, and then using centers of excellence to deliver operational efficiencies and centers of emphasis.

Think about that as certain functions, certain services, we've got these various R&D sites. Not having them at every site, but having them in one site or two sites and having that be almost a hub that serves multiple sites. High-throughput screening is an example of one of those areas. Just, once again, not intended to cover everything that we're doing, but once again, to give you all a flavor for some of the things that we're doing, in the area of kind of the corporate centers, corporate support, continuing to leverage our purchasing power. We buy a lot of stuff, we spend a lot of money. There's lots of opportunity here to continue to leverage our purchasing power with suppliers.

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We have and we will continue to do that. And we can do a lot more in the area of real estate. I talked about going from 80 million to 54 million. We believe we can do better. Continuing to centralize shared services and outsourcing. We've been doing that in finance, for example, with a lot of our transactional work. We believe there's more we can do and we actually think we can work further up in the value chain there to leverage that, and then the area of IT, really looking at everything in IT, the server rooms, data centers, servers, consumables, applications, and really just continuing to leverage that as best as we can.

And then sales and marketing -- Ian touched on some of these relative to implying the tiered customer engagement model, utilizing alternative customer channels and today we're basically a direct channel delivery system and then, finally, regionalizing resources and executing rapidly against local markets. And the way I think about that is taking the regional resources that we have and optimizing those to the local markets and local opportunities that come from those local markets, as we customize products and service offerings into those customers, into the markets that are within those customers.

And, once again, what is this all about? It's really about creating a lower, more flexible cost base and sizing the cost structure to align with our revenues. So let me wrap this up in terms of just key takeaways. I've hit on each of these, but this chart is intended to just summarize everything.

First, we'll continue to deliver on our near-term commitments. We've provided '08 guidance. We've reaffirmed our '08 guidance. Our intent is obviously to deliver on that '08 guidance.

We've talked about strategies that are expected to help mitigate the revenue that's impacted by Lipitor's loss of U.S. exclusivity and establish a foundation for revenue and earnings growth shortly thereafter. Continue to establish a lower, more flexible cost base and maintain industry-leading operating margins. We talked on one of my charts about we want to essentially maintain our industry-leading operating margins in the mid to high 30s, and I said in 2007 our actual operating margin was 37%.

We want to stay in that range. We want to proactively size the Company as appropriate to align with revenues. Obviously, we talked today about producing new potential sources of revenues with these growth strategies, but we will align the size of the Company with the revenues, and we expect to continue to generate strong operating cash flow, and I had a chart that showed that.

And, clearly, all said and done, we are, we will continue to be, very focused on delivering improved total shareholder return to our shareholders. So thank you all for your time. Now I'll turn it back to Jeff. Thanks, everybody.

Jeff Kindler - Pfizer - Chairman and CEO

Thank you very much, and while everybody's coming on up here, you've been very patient, listening to us talk all this time, and I want to be sure we leave you plenty of time for questions, so why don't we just get right into it. So who has a question? Dave?

QUESTIONS AND ANSWERS

Dave Risinger - Merrill Lynch - Analyst

Yes, Dave Risinger from Merrill Lynch. I have two questions that are tied together. The first relates to the cash flow in the United States. The short-term borrowings have been rising, I'm assuming to fund the U.S. cash needs, including the dividend and the stock buyback, and just wondering what the outlook is for that and whether there's a point in time where you're going to need to repatriate more money from markets ex-U.S., which would then potentially have implications for the tax rate.

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And then, second, it's great to get your outlook for the longer-term operating margin. Could you comment on the longer-term tax rate in light of my first question and also in light of the manufacturing of Lipitor and other mega products in very low-tax regions in the world? Thank you.

Jeff Kindler - Pfizer - Chairman and CEO

Dave, thanks. Frank, why don't you take both of those questions.

Frank D'Amelio - Pfizer - SVP, CFO

Let me take the second one first. So, in terms of the tax rate, let me run the numbers on the tax rate, and then I'll answer the question. So in 2007, our adjusted effective tax rate was 21%. In 2008, we've provided guidance that says the adjusted effective tax rate will be 22% to 22.5%, so a slight increase year to year.

I don't want to go beyond 2008 on the tax rate simply because there are just too many variables right now, including, by the way, I'll call it the political environment that we're basically doing business in. That said, I think we have done a very nice job as a Company of very effectively managing our effective tax rate. We will continue to do a very effective job of managing our effective tax rate, and that's the way I think about that.

But in 2008, it is increasing slightly over 2007. In terms of the cash flow situation, the way I think about this is -- let me frame it and then I'll peel the answer down. We continue to generate a significant amount of operating cash flow. That's a good thing.

So in 2008, \$17 billion to \$18 billion. If you start to peel the onion there in terms of uses and sources of cash in the U.S., which was your question, to outside the U.S., we believe we can fund our U.S. cash flow operations on a going-forward basis without any material detrimental impact on our earnings. Because you were asking me about borrowing and you were asking me about the tax rate. So in my mind, what you're really trying to do is work through the operating margin to the EPS number and the line items that get in between that.

We believe we can work through funding our U.S. cash flow operations without having a detrimental impact on the EPS number, so in factoring and everything is part of the question.

Jeff Kindler - Pfizer - Chairman and CEO

Okay, Dave. Thank you. Steve?

Steve Scala - Cowen & Co. - Analyst

Thank you. Steve Scala from Cowen and Company. Regarding the Lipitor patent situation, is it clear to Pfizer whether or not Ranbaxy has exclusivity? And, if they do not have exclusivity, how would Pfizer react to a novel risk, the limited at-risk lost, particularly by Teva, when their exclusivity lapses in early 2010, similar to what they did with Protonix?

And then lastly, Jeff, perhaps as an attorney, can you educate us as to how treble damages would be calculated in the pharmaceutical industry? Could they be multi billion, \$5 billion, \$10 billion, or would they be much less than that?

Jeff Kindler - Pfizer - Chairman and CEO

Okay, Steve, I have given up practicing law, so I'm going to turn that over to our General Counsel, Allen Waxman.

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Allen Waxman - Pfizer - SVP, General Counsel

Is this working? So were there to be -- I do think Ranbaxy has the 180-day exclusivity. Were there to be an at-risk launch by Teva, we would respond to that very aggressively and we do believe that treble damages would be in the billions of dollars in such an instance. So these are all hypotheticals, were they to occur, but that would be our going forward outlook.

Jeff Kindler - Pfizer - Chairman and CEO

The only thing I'll add to that, Steve, is we are in litigation with Teva right now regarding their at-risk launch of Neurontin. Watch that space. Next question, Tim.

Tim Anderson - Sanford Bernstein - Analyst

Thank you. Tim Anderson at Sanford Bernstein. On your discussion about China, I was trying to do the math to figure out what your absolute sales in China were in 2007, maybe. And if I did that math right, it still looks like it's maybe \$300 million, so I'm wondering if I did it right, because I had to triangulate from a few numbers, in which case that's still a pretty small percentage of the overall book of business.

And then Frank's question about the dividend, you said maintain it at least at current levels, and I'm just wondering what time period you're referring to and specifically I'm alluding to the period at which Lipitor goes away and are you suggesting that it stays all the way through that cliff period?

Jeff Kindler - Pfizer - Chairman and CEO

I'll let Frank answer the second question. On the first question, Tim, we don't break out those country sales, but I'm not going to quarrel with your math. But I think the thing to look at are the charts that Dudley put up there that showed the overall size of the Asian pie, our current market share and our projected market share as soon as 2007. Regarding the dividend, Frank?

Frank D'Amelio - Pfizer - SVP, CFO

So on the dividend, the way I framed it was, I'll call it significant unforeseen events aside. So what's a significant unforeseen event? Something that's significant that I'll call it has a big impact on our operating cash flow, so that aside, our intention is to continue to fund the dividend at least at current levels, and that's going forward. I said that was going forward in my comments.

Jeff Kindler - Pfizer - Chairman and CEO

Okay, Tim. Yes, Craig. Right here, Craig, up here.

Craig Baskin - Putnam Investment Management - Analyst

Thank you. This is Craig Baskin at Putnam. So you recently restated your financials from last year because you were under-accruing rebates. And one interpretation of this under-accrual is that your rebating has been pretty aggressive on important product lines in order to get near-term revenues. So my first question is, what are the implications of these high rebates on long-term margins. And my second question is, how can you feel secure that you are now properly recording rebates?

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Jeff Kindler - Pfizer - Chairman and CEO

So, Craig, let me kind of divide that. There's sort of a financial question and a commercial question in there. So I'll let Ian address the commercial implications that you're raising and, Frank, if you could talk through the financial questions that Craig asked.

Frank D'Amelio - Pfizer - SVP, CFO

So just I think the first comment I'd make, if it's okay, is you used the word restatement, and it really wasn't technically a restatement. I'm splitting hairs, but it wasn't a restatement, right? We basically changed the numbers before we filed the K, so I just felt the need to -- I felt compelled to mention that. Now, that aside, in terms of the accounting itself, what really happens with the rebate accrual is I call it -- it's the timing. The word I like to use is the interval that's involved. So what do I mean?

From the time we record the accrual to the time that the liability is ultimately settled can take up to a year, literally up to a year. So by definition there'll always be adjustments to the estimated accruals. I mean, there's just no way to nail them when you've that kind of an interval, point one. Point two, in terms of the implications of that on our margins, and you sued the term aggressive rebating. Quite frankly, when I looked over all of the rebates in '07 versus '06, there really wasn't any material change in the level of rebating.

So in terms of the '08 guidance, we basically factored rebates into the '08 guidance, but this notion of aggressive rebating, I just want to dispel. I didn't see that at all in our '07 results. Ian, do you want to comment on it?

Ian Read - Pfizer - SVP, President - Worldwide Pharmaceutical Operations

I would just reinforce it. I think the rebate adjustment was small in respect to the total reserve for rebates and the total charge for rebates to the P&L. And the only extra comment I would make on that, I think we have discussed during '07 that I do expect to see rebates increasing on Lipitor, given our approach to being flexible and maintaining two-tier access and we've signaled that. And I think you'll see that in '08.

Jeff Kindler - Pfizer - Chairman and CEO

Okay, great. Jamie.

Jamie Reuben - Morgan Stanley - Analyst

Thank you. Frank, just wanted to address again the question on your target to maintain operating margins in the mid to upper 30% range. My first question, I just want clarity on the timeframe. Did that include the period between now through Lipitor's patent expiration, 2011, 2012? And my second question is, it would appear to me, and I want clarification from your part, that in order to maintain those margins, most of the pipeline opportunities that you discussed today are opportunities which may not be commercialized until after Lipitor goes generic.

So that would imply that in order to maintain operating margins, you're going to have to find opportunities for further cost reductions. And, based on our math, it's in the sort of \$4 billion to \$5 billion range, on top of the \$1.5 billion to \$2 billion cost reduction program that you have in place today.

So my question is, am I thinking about this correctly? And then I have a question for you, Ian. According to the New York Times, there is no market for fibromyalgia. So I'm wondering if you can address -- obviously, LYRICA has enjoyed very strong growth and I'm wondering if you could talk about how much of that is coming from the fibromyalgia market, how big is that market in absolute terms? And, as you know, there are two other products on the markets in Cymbalta and [milnazepan], directed towards fibromyalgia. So if you could just talk about that opportunity, thanks.

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Frank D'Amelio - Pfizer - SVP, CFO

So I'll go first. So, Jamie, in terms of the timeframe part of your question, so kind of the first part of your question, those mid to high 30s in terms of overall operating margins, I view that as now, through Lipitor and beyond, which is how I think you asked the question. So I view that as now, through Lipitor and beyond, and, as I said, our '07 operating margin was 37%. And if you look at the range I gave, so mid to high, 34% to 39%, so there can be some -- I'll call it some variability in there, but the 37% is pretty much in the middle of that range, so that's kind of the answer to question one.

In terms of question two, you've asked about clarification in terms of the number and you put a number out there. I'm going to come at it a little bit differently. I'm not going to give a number, but here's how I do think about it.

You basically reverse-engineered the number, I assume, with some assumptions on the pipeline. And, to me, it's not just about revenues coming from the pipeline, although we want that. But it's also about some of the other things we're doing with what we have to sell relative to creating new sources of revenue, so the discussions you heard today for example from Dudley and from Dave are things where I believe we can get incremental revenue, new sources of revenue. That's the intention now, through Lipitor and beyond. So I think that helps us relative to, I'll call it, our overall cost structure.

Now, that said, I showed some of the things that we've done to date on cost. We're clearly doing more as we speak, and I tried to give you a flavor for some of that on those two charts. We're not waiting, for example, for the Lipitor LOE to hit us before we get going on cost. We're proactively all over it. And the way I'll answer the question is by saying, given everything I just said, we will size the Company as appropriately to align with revenues.

Now, we want to mitigate as much of the revenue impact of Lipitor LOE as we can, but that said, and doing all the things we're doing, we will take the actions we need to take to mitigate that impact. And, by the way, to maintain those overall operating margins.

Jeff Kindler Okay, Ian, fibromyalgia?

Ian Read - Pfizer - SVP, President - Worldwide Pharmaceutical Operations

So, Jamie, the FDA obviously has given us the indication, fibromyalgia is a disease, it's clinically identified, it's a serious pain condition. And most of the sufferers have battled for this to be recognized over many years, and I think there's a lot of support in the marketplace for this real condition that's based on pain. Now, vis- -vis LYRICA, most of LYRICA's present business of course is in DPN and PHN, and that is by far the largest segment of its prescriptions.

We've only just launched fibromyalgia in the U.S. It will be launched, or we intend to submit in Europe later this year, so I would say that I see the fibromyalgia part of growth part of the market. It's important, I believe, and Andreas can correct me if I'm wrong, there's about 6 million patients with fibromyalgia in the U.S. and half of them are diagnosed. Our market share in fibromyalgia, the best we can calculate right now, is relatively small, at around 12%, and we expect to see rapid growth in that segment. Andreas, is that right? Okay.

Jeff Kindler - Pfizer - Chairman and CEO

Okay, Jamie? Yes.

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Seamus Fernandez - *Leerink Swann - Analyst*

Thank you. Seamus Fernandez from Leerink Swann. I guess a question for both Jeff and Ian. Could you tell us in detail what you think went wrong with Exubera and what the marketing organization is doing to avoid this in the future? And then, separately, can you just help us understand this a little bit better, which is now Pfizer is about as highly levered to pharma or biopharma, which appears as risky as ever from the overall operating environment. How important would you really view non-pharma business diversity within the scope of the going-forward expectations, i.e., would you be willing to consider other non-biopharma business opportunities if they present themselves?

Jeff Kindler - *Pfizer - Chairman and CEO*

Okay, let me take these in reverse order and answer the second question. And then I'll let Ian comment on Exubera and I might add a few thoughts about that. We want to leverage our existing capabilities and we don't want to go too far afield with that. In fact, we don't want to go very far afield of that at all.

I actually believe that the practice of medicine is evolving in such a way that there are many opportunities to leverage our core capabilities, still be in the science space, the innovation space, in the space of providing medicines that require the intervention of physicians and still find complementary opportunities to our core products and services. So that's the way we're thinking about that general subject, and I wouldn't stray terribly far from that. Why don't you start on Exubera, and then I might add a comment or two?

Ian Read - *Pfizer - SVP, President - Worldwide Pharmaceutical Operations*

So I think part of the reason for Exubera was, number one, the length of the development time that we took to bring it to market. Second was the -- where the FDA introduced the need for lung function testing and the issue of safety, it was something that I don't think we reflected that appropriately in the demands on the management of the product with GPs.

I think in reflection, when we looked at our market research and understanding the implications of device, which we've never been in before, and the interaction of the device and the drug and the management of the practice, that was another barrier that we didn't appropriately quantify.

But, fundamentally, it was the length of time that it took to get to market, the fact the market evolved and passed us by with Lantus coming in. The burden and the time factor and the burden on the practice by physicians and, lastly, it was a different risk proposition for us, in the sense that we had to create an infrastructure and a manufacturing that was solely dedicated to inhaled insulin. And I think the risk factor wasn't appropriately reflected in our models, that it was different from a small-molecule business.

Jeff Kindler - *Pfizer - Chairman and CEO*

So let me, if I could, Seamus, use this example to make what I think is a broader and very fundamental point that I would really like to get across today if I get nothing else across. This Company had the characteristic, as I said at the beginning, of driving decision-making from those of us in corporate headquarters in a fairly monolithic, one-size-fits-all way. And rightly or wrongly, that was effective at different points in our history, but it's not effective today. And culturally we have to get -- and I believe we are getting, decision-making in the hands of people that are closest to the action and the customers.

And these decisions have to be made whether they're in research and development and whether they're in commercial by the people that are actually interfacing with the marketplace. And if there's nothing else that I've gotten across today, I hope you would consider that everything you heard today, every presentation, reflected that point of view. And, quite candidly, the things you heard today would not have occurred two years ago in our culture. They just wouldn't have.

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Martin went through every compound in every disease area in our pipeline and did something very un-Pfizer like. He terminated programs. He terminated programs so that we could take those costs and those investments and accelerate the ones that could win. We hired Briggs Morrison from Merck to run our clinical development. That's not exactly something consistent with our historical culture.

You heard from Dudley and from Dave what can happen when you say to somebody -- let me use Dave as an example, because I really think this is a great example. We have billions of dollars of established products that we sell around the world. Nobody was in charge of them. They were second-class citizens. There was nobody accountable for driving that business.

So we say to Dave, you're accountable for this. This is your complete job, 100%, you've got nothing else to think about, and, frankly, your success will rise or fail on what you do, and then we give him the resources, and he comes up with stuff. Ideas, creativity is unleashed that would not otherwise have occurred. And we're going to find every opportunity we can find along those lines across our business, and so I think there's just all these hidden assets in our Company which, if we put the right people and give them the right accountability, give them the responsibilities and then more or less leave them alone to make decisions quickly in the marketplace that they're in, we're going to unleash tremendous opportunities for this Company.

And I think every presentation today is consistent with that. And in the case of Exubera, just to bring it back to your question, that decision, those decisions along the line, had they been made by somebody who was in charge of the Exubera business, had nothing else to do but focus on that business, who knew that their team's success depended on that business, we might have made different decisions along the way.

And that's why we have really created a model for this Company, and this stuff doesn't happen overnight. We had to change the DNA of this Company pretty profoundly, but I'm here to tell you, today, we have done this, and we're ready to go. Way back there, is that Catherine? It looks like Catherine from here.

Catherine Arnold - *Credit Suisse - Analyst*

Thank you. It is Catherine. I was wondering if you -- in light of the fact that we expect a change in policy on biosimilars, considering your push to the emerging markets, and, lastly, considering your BDC strategy that you laid out today, have you and the Board considered biosimilars as a strategy and could you give us some color on that?

And then my second question is, if I could just go back to Frank one more time on Craig's question on rebates, I have great appreciation for the difficulty in predicting such rebates, but I'm wondering if you could just give us a little bit more explanation on how the 200 million difference came about sort of in five-weeks' time. Was it a difference in auditors' opinion? Was it sort of final invoices that really you used to close the books?

Jeff Kindler - *Pfizer - Chairman and CEO*

On biosimilars, Catherine, I do think that's an opportunity for us. I'm not ready to tell you today that we've got in place all the plans necessary to make that happen, but I think regardless of how the legislative or the regulatory pathway may evolve, and there certainly will be a regulatory pathway for biosimilars -- I think we can count on that. I think there's always going to be an advantage, a competitive advantage, in that space maybe a little bit differently than in small molecules for pharmaceutical sciences and manufacturing.

Cory mentioned that one of our sort of hidden jewels that most people don't know about is that in St. Louis, and we acquired this through the Pharmacia transaction, we have a pharmaceutical sciences organization which people tell me, people from outside the Company, tell me is the best in the industry, or certainly one of the top two or three. I think that'll be an advantage for us, and I do think, Catherine, it is consistent in general with what we have talked about with regard to established products, as well as innovative biotherapeutics for us to extend ourselves into that area.

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But, having said all that, we're not ready today to say exactly what that'll look like and when it will happen, but it certainly strikes me as being very much in the sweet spot of our capabilities. Frank, I think the number was 195, not to split hairs --

Frank D'Amelio - Pfizer - SVP, CFO

Right, I was going to mention that. It was 195 pre-tax and 154 million after tax, but roughly 200 million on a pretax basis to Catherine's point. So that's the numbers. In terms of how we found or how it was detected, it was really detected when we were completing our financial analysis in preparation for the filing of the 10-K. And then to your point, Catherine, clearly it was found subsequent to our earnings release on January the 23rd and prior to the filing of the 10-K, which we did last Friday.

The one additional thing I'll say here is, we are clearly addressing the timing of when the understatement was detected, so that's something we're all over right now, in terms of the timing of it.

Jeff Kindler - Pfizer - Chairman and CEO

Okay. Yes.

Roopesh Patel - UBS - Analyst

Thanks, Roopesh Patel from UBS. I've got a couple of questions. First, I'm curious if you expect the pipeline, based on today's update, to offset the sales erosion from LOEs for Lipitor and six other drugs by 2012. If not, roughly what's the gap that still needs to be filled? And then, to follow-up on that, Jeff, I was wondering if you could reflect back on the product inlicensing and acquisitions over the past one and a half years.

While interesting, it appears that most of these opportunities are still very early stage and I'm curious as to how might the focus be different as you look ahead, approaching some of these patent cliffs? And just related to that, under what scenario will you consider a mega-deal? Thanks.

Jeff Kindler - Pfizer - Chairman and CEO

Okay, sure. First of all, Roopesh, regarding the gap, I said at the outset that when you lose a product, and I think the appropriate focus here is the \$7 billion in the U.S., because as Dave Simmons was explaining, that's where you would experience the sharpest cliff. When you lose that, it's going to have a meaningful impact, and I'm not here to tell you that we have offset that or we'll grow right through that. The extent of the impact of that and the extent to which we will mitigate it or offset it remains to be seen.

We're still a couple of years away and it will depend a lot on our execution of the strategies that we have today. I think what we've been trying to convey today is that all of these strategies, including the pipeline, but not limited to the pipeline, and I again would not understate the potential value of some of the things we've talked about, are all oriented toward mitigating that one-year impacts, but, frankly, more importantly, setting the foundation for revenue and profit growth after that. And that's what we're all about and that's what we are very, very optimistic we're going to achieve.

Regarding business development, the deals that we did the past year, you're absolutely right, mostly early stage. I think they have about seven candidates that are actually in the clinics, in the clinic, rather. And, to be sure, they're all early and they're not likely to move the needle in the very short term. I would go back to what I said before. I think that we are in a much better position today to be very opportunistic and to do it in a focused way across the different strategies you've heard about today.

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So I would encourage you to keep an eye on what we might do in supporting each of these strategies, and that frankly leads me to your last point. I just want to reiterate what I said before about a mega-deal. Look, Warner-Lambert and Pharmacia transactions brought us a lot of things, including a lot of great people, there's no doubt about it. But they took a long time to integrate, they were extremely disruptive.

And I will tell you that whatever else you can say about our R&D productivity and what it might have otherwise been, you can't get around the fact that it impacted our R&D productivity. When I have gone around and visited our R&D sites around the world, it's very obvious to me that over the last six, seven years, the leadership of that organization has spent an undue amount of time thinking about reorganizing, integrating, site closures and the rest of it. And I think Martin will testify that that was extremely distracting and that's certainly impacted productivity. The great news now is that, as I think Briggs might have mentioned, I visited the year beginning meeting that R&D had this year, and they're actually talking about drugs.

They're not talking about what site they're going to close and how they're going to reorganize. They're talking about moving those drugs to the pipeline. So these big deals have an impact, and they can be very expensive and they can be very disruptive. And so I can only repeat what I said before, never say never. The world can change, opportunities can present themselves. But as I sit here today, I don't see a combination with another big biopharma Company where the strategic value and the long term to our shareholders is good enough to offset these considerations that I've described.

I guess I'm giving too long an answer, because it says we have time for one more question, but I'll cheat and take two, if there are two. Yes, way back there.

Harry Duke - *Promethean Fund - Shareholder*

Hi, I'm Harry Duke from Promethean Fund. We're a Pfizer shareholder, patient. I've got a very basic question for Jeff, Martin, and I think Dudley, too. Can you give us a sense of longer-term growth for animal health and how animal health fits in and complements your research organization.

Now, we've asked this tangentially before. Dudley, from what we've seen from our travels to your region, your numbers to us may be low. We'd love to see what happens for animal health, as well, if the people have to eat. Thank you in advance, and enjoy your day.

Jeff Kindler - *Pfizer - Chairman and CEO*

Thank you, Harry. So let me start, and I'm going to see if Martin and Dudley want to add some things. First of all, I'm really glad you asked this, because we often neglect to mention animal health. Animal health is a strategic asset for us. We do believe, and I'll let Martin, and perhaps Nat Ricciardi, our Head of Manufacturing, elaborate a little bit about this, that animal health really does leverage our existing assets in some very important ways, and it is a growing business. Maybe, Frank, I don't know if you have the numbers off the top of your head. Care to share those?

Frank D'Amelio - *Pfizer - SVP, CFO*

Sure. The revenue numbers for animal health went from about \$2.3 billion in '06 to about \$2.6 billion in '07, so it's roughly 14% of top-line growth. Some benefit from foreign exchange, but, all in, about 14% growth.

Jeff Kindler - *Pfizer - Chairman and CEO*

So let me very briefly, if I could, ask first Martin, and then Matt, and then Dudley, if you want to add anything. Explain why animal health benefits from its association with our R&D and manufacturing groups.

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Martin Mackay - Pfizer - SVP, President - Global Research & Development

Thank you for the question, Harry. I'll sum this up just in three areas. The head of R&D in animal health can help the human health organization. Cathy Knupp came from my organization. We have a terrific relationship. We meet regularly to compare our portfolios, to compare our technologies and actually, Jeff, it's a two-way process, although we are clearly much larger and that group takes in compounds from us, they recently launched a very nice compound for dog emesis which came out of the human health laboratories.

And, as I say, it's a two-way process. And if I think about vaccines, where we have a very good animal health group working in vaccines, we've learned a lot from them and leveraged their technology as we've moved into human health vaccines. So suffice it to say, Harry, a great relationship, very integrated for both humans and our favorite companions.

Jeff Kindler - Pfizer - Chairman and CEO

Could you send the mic down to Nat, please?

Nat Ricciardi - Pfizer - SVP, President - Global Manufacturing

So we too leverage the presence of animal health as part of Pfizer in leveraging our unit costs, managing our capacity much more effectively. But it goes beyond unit cost and capacity. We leverage our technology. Our vaccine business, as Martin said, it is a spectacular unit that we don't talk quite a bit, but it is a source of knowledge and talent, as it is in small molecules, as well as large molecules. So leverage technology, leverage unit costs.

Jeff Kindler - Pfizer - Chairman and CEO

Thank you. Ian is actually going to respond, because it goes beyond Asia.

Ian Read - Pfizer - SVP, President - Worldwide Pharmaceutical Operations

Yes, well, it's animal health is important from a perspective of talent, as well. We do move talent between the divisions and the present head of animal health was working in pharmaceuticals. Vis- -vis the opportunity in Asia, it's a consequence of both the dietary patents in Asia, where a large vegetarian population in India. There are opportunities in swine and poultry.

What we see is that the food production isn't yet -- the chain isn't industrialized. So there is a large opportunity as the production of food and proteins becomes industrialized in Asia, and it's something we're focused on and have the footprint to leverage.

Jeff Kindler - Pfizer - Chairman and CEO

Okay, we'll take one more. Yes.

John Levinson - Westway Capital - Analyst

John Levinson, Westway Capital. As a follow-up to David Risinger's question, is the U.S. in a negative cash flow situation today, given the dividend and other things that you really run out of the U.S.?

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Jeff Kindler - Pfizer - Chairman and CEO

Frank?

Frank D'Amelio - Pfizer - SVP, CFO

Yes. The U.S. clearly uses lots of cash. If you look at the various uses of cash in the U.S., the dividend is clearly one of those uses of cash. However, we believe there's things we can do to basically mitigate or fund those needs for cash in the U.S. And as I said before, to Dave's question, you step back and kind of bump it up a level, we generate lots of cash from operations, that's a very good thing.

When you peel it down a layer and you look at where we generated versus where we used it, clearly we use cash in the U.S. and one of the big uses of cash in the U.S. is the dividend. We believe we can fund the U.S. cash flow needs -- so within the overall cash flow, we can fund those U.S. cash flow needs with various options that are available to us without having a detrimental impact on the EPS number going forward.

When Dave asked his questions, one of the things that he said was repatriation. Well, the fact of the matter is, we've done repatriation in the past and we'll continue to do repatriation. I call it not all repatriation is created equally. It really depends on where you're taking the money from. So if it's a high-tax jurisdiction to begin with and you're bringing it to a high-tax jurisdiction, minimal impact on the tax rate and on earnings.

If it's a low-tax jurisdiction and you're bringing it to a high-tax jurisdiction, then much more of a significant impact on earnings, right? Because you've got a much bigger spread and so you're creating a big negative spread relative to the impact on the effective tax rate. All that said and done, and me factoring all that in to my answer, I believe we clearly have opportunities to clearly fund the U.S. cash flow needs and not have a detrimental impact on your earnings per share number.

Jeff Kindler - Pfizer - Chairman and CEO

Yes, thank you, Frank. Thanks for your questions. Everyone's invited to have lunch in Metropolitan West. Thanks for joining us today.

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