
# EQRx

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**Chris Schott:** Good afternoon, everybody. I'm Chris Schott at J.P. Morgan. It's my pleasure to be introducing EQRx today in their first presentation as a public company at this year's J.P. Morgan Healthcare Conference. From the company, we have CEO, Melanie Nallicheri.

Before I turn it over to Melanie, I just want to remind people. If you want to ask a question, please feel free to use the Ask a Question feature on the website, and I'll work those into the Q&A post the presentation. With that, Melanie, happy New Year's, and thanks for joining us. We look forward to the presentation.

**Melanie Nallicheri:** Thank you, Chris, and thank you, J.P. Morgan, for inviting us. Hello, everyone who is watching or listening in today. It was two years ago at the J.P. Morgan conference that we launched EQRx. We are particularly excited to be back today, two years in, as a newly public company.

Today, we would like to introduce you to a new pharma and to how we are intending to remake medicine. If you followed our progress in the past, today we'll be talking about some of our most recent advances with our payer partners, we will be talking about new studies we're going to initiate, and for the first time, we will be providing guidance for 2022.

Here are disclaimers which you can read in our filings.

When we launched EQRx, we launched with a bold mission -- a mission to improve health for all with great, innovative, affordable medicines such that patients with chronic and life-threatening diseases can access those innovative medicines regardless of their socioeconomic status, their health insurance status, or where in the world they are and such that payers and health systems can offer these innovative medicines in a financially sustainable way.

But first, what is EQRx? At EQRx, we are building a platform at scale, a platform where payers

and health system partners, who we call our Global Buyers' Club, can drive the adoption of these innovative medicines and create population-level access to a large selection of high-quality, innovative branded medicines -- what we at EQRx call our catalog of medicines -- at radically lower prices.

How can we do this? By fundamentally re-engineering how we create, how we develop, and how we deliver innovative medicines and by rethinking how we are partnering throughout the health ecosystem, in short, by creating new pharma.

Today, pharma and payers are caught in a vicious cycle, a cycle where ever-increasing prices are offset by rebates and by discounts. The spectators on the sidelines and the losers of this game are the patients.

At EQRx, we believe that we can align the incentives between the innovator and the payer. By offering radically lower prices, we enable our partners to take the brakes off.

By using the levers that they have at their disposal -- and those are powerful levers -- to create the pull-through for their populations, by doing so, they are creating savings for themselves and they're able to increase and expand access to these innovative medicines.

This is also good for EQRx because it increases volume. That in turn allows us to reinvest in expanding our catalog, but it has to be done at scale. This is why we're intending to partner with public and private payers from across the OECD countries. These come in many different shapes, and sizes, and forms, but together, they provide some form of insurance coverage to about 1.3 billion people.

I want to give you a few examples of how we are changing the relationship with our partners into a true partnership. Offering a rebate for preferred formulary access, that's not a partnership. That's a transaction. Let's go get a couple of examples.

Blue Cross of North Carolina and Horizon, the leading Blue plan in New Jersey, they are examples of regional payer partners. What we are doing with them is we're helping them lower the out-of-pocket burden on their members. We are working with them to achieve their stated goal of saving their employer customers $100 million in the coming years.

These regional payers have a really deep reach and connectivity into the local and regional provider network. They are working with us to connect us to those providers. Together, we can

change reimbursement to eliminate any of the disincentives, the economic barriers that might stand in the way of adopting lower-cost medicines.

Blue Cross of North Carolina has publicly commented on what they're doing with EQRx and what they're doing differently with us. A very different example is the National Health Service in the UK. We've entered into an MOU with the NHS. This is their first population health partnership for cancer medicines.

Population health is not just defined by creating and developing new innovative medicines for many different conditions and ailments, but it is ultimately defined on whether we do or do not have access to those innovative medicines.

What we are doing with the NHS is we've mapped out how we can create that population health access to UK citizens by working with physicians, with hospital leaderships, with pharmacists, with advocates, and with NHS leadership. This allows us to help the NHS and the UK Office of Life Sciences to achieve their stated goal of expanding cancer care and of extending cancer survival.

These are just examples of partnerships that we've put in place. Together, to this date, we had 70 million lives covered by our payer and health system partners. Today, we would like to share with you three incredibly exciting new partnerships.

The first, Geisinger, renowned for its quality of care delivery and also well known as being one of the most comprehensive integrated delivery systems in the United States, inclusive of a hospital system, a health plan, and a provider business. Geisinger is a great example of a partner where we don't just have a commercial arrangement but a partnership that goes well beyond that.

Of course, we are also working with Geisinger to make sure that our economic value proposition works in all parts of their system. This is what the recent MOU was about, but we've also been working together, leveraging Geisinger's data to supplement our development efforts, progress our pipeline, and ultimately generate evidence from the real-world use of EQRx medicines.

Blue Shield of California, a leader amongst the Blues plans, we are working together to reimagine how we're delivering pharmacy care in new innovative ways. We're also working together to streamline the supply chain such that it can be more efficient and less costly.

Last but certainly not least, we've just announced that we've entered into an MOU with CVS

Health, the leading health solutions company. This is really exciting because the goal is to be working with CVS across their pharmacy, PBM, and their health plan business. We have a shared goal of creating greater access and lower cost.

If you've read Alan Lotvin's statement about our partnership, what it says is this is an opportunity to help them from changing the focus on rebates to a focus on managing spend and trend.

Given how far CVS reaches into American communities, this is a great opportunity for EQRx to expand what we're doing with a partner. CVS has also built compelling capabilities in oncology, including how to streamline prescribing, how to expand cancer diagnostic testing, and how we can identify patients for new studies that we want to create.

Together, these three new partnerships add another 110 million covered lives to our partnered lives for a total of 180 million now. This is important. Of course, once approved and launched, our medicines will be broadly available, but it is different with the members of our global buyers' club.

Not only does our value proposition allow them to our true financial impact, but it's a different level of engagement. Not only are we creating transparency to our pricing strategy, and our development and adoption plans, and ultimately our future pipeline, but importantly, they are active participants in our business model. They are helping to drive adoption that create savings for them.

That pull-through also allows us to lower our commercial spent. By helping us in the generation of evidence, they are also helping us be more efficient in development and have lower cost. That, in the long run, will continue to allow us to offer low prices.

We expect that we will see more patients on an EQRx medicine from among the covered lives of our partners. That's why we're expecting to have a greater market share from those partners. That's the reason why we want to share our lives with you and why we want you to track lives.

In some geographies around the world, we will choose to partner with a distributional commercial partner where that connectivity into those regions is important. An example is our partnership with Abdul Latif Jameel Health, a leader in those regions, and our partner to bring the first couple of EQRx medicines to the Middle East, all of Africa, and Turkey.

These different partnerships that I just described are an example for how our model resonates broadly and how we're truly mission-aligned.

What are we putting on our platform that these partners are partnering with us well before we have a launched medicine? In the middle of this decade, we expect that we're going to reach a trillion dollars in global brand of drugs spent. We are expecting that 500 billion, half of that, will be driven by oncology and immune-inflammatory diseases, such as rheumatoid arthritis and psoriasis.

What we've done at EQRx is we have built a portfolio where we are addressing these large categories. We've already assembled a portfolio of over 10 programs that address 100 billion of that 500 billion. Half of those, five, are clinical stage. The remainder are an earlier stage of development. Let's take a look at our two lead assets.

Aumolertinib is our third-generation EGFR inhibitor for EGFR-driven non-small cell lung cancer. Our phase III data in the first-line setting has shown truly encouraging efficacy and a very attractive safety profile.

Expanding options in this category, one of the largest categories in lung cancer, and offering an option where we could potentially mitigate the EGFR wild-type mediated toxicities, that's an important patient need.

A testament to the clinical profile of aumolertinib is that others have begun to use it in combination with their drug candidates, such as Turning Point Therapeutics, but also generating additional data such as in the adjuvant setting or in diverse patient populations.

What we would like to share today is that we are going to generate additional evidence with a randomized multicentered US trial where we are achieving two important goals. First, we're going to ask an important question. Is it better to use aumo alone or aumo plus chemo for patients?

Secondarily, we also want to create the reference to osimertinib with Tagrisso, which we know many physicians would want to know. Let's take a look at our PD-L1 inhibitor, sugemalimab.

What's exciting about sugemalimab is that we have generated phase III data in both the stage III and the stage IV non-small cell lung cancer setting. That is across different pathologic subtypes, and in stage IV, also different PD-L1 status.

We are the first PD-L1 that actually has demonstrated a benefit in stage III after either concurred or sequential treatment with chemoradiotherapy. The sequential treatment with

chemoradiotherapy option, that's a really important need for the frailest of cancer patients.

We're also studying sugemalimab and other indications, such as gastric and esophageal cancer. We have breakthrough designation in a rare form of lymphoma and KTL. Q2, we would like to share with you that today, we would like to let you know that we will generate evidence with a randomized multicenter US trial where we are comparing sugemalimab against other approved PDFs.

We know that that is data that many in our health ecosystem would want to see. This year, we are intending to double our portfolio to over 20 programs that will be addressing over $200 billion in global branded drug spend.

We are sourcing these medicines from in-licensing from eastern and western biotech and pharma companies at the clinical and preclinical stages of development. What we want to see is that we can create an equally good or better molecule and treatment option in each of its respective classes while also creating new molecules from scratch.

If you look at these five partners that we have set up drug engineering and drug discovery collaborations with, these are some of the best-of-breed drug discoverers. What we're doing together is we're building and creating new molecules against prespecified targets.

What these partnerships show is that it's not just on the payer and the health system side that we can be mission-aligned, but what this shows is that there are others from throughout the life sciences community that want to be on our platform.

What enables this unique platform that we're building at EQRx? When we got started, we said from the very beginning that we have to have a laser-sharp focus on designing an incredibly efficient model. We're doing this in three ways.

First, we're expecting that we're going to succeed more often than not. We know that putting success rates of 50 percent or more out there, that's a high number, but we believe that that's not crazy. It is possible today. By way of example, a recent Nature Discovery article looked at all kinases that have entered the clinic. Their collective success rate was 44 percent.

50 percent or more is higher, but again, we think it's possible. That higher success rate translates directly into pricing because it means that we do not need to burden our prices with the cost of failures.

Second, one of the few positives that has come out of the last two years is that we now have greater acceptance that we can do drug development differently. For instance, we can use telemedicine visits. We can remotely monitor patients.

Another example of how we are building a truly modern drug development organization is by combining real-world data with the data from studies for much greater insights into how our medicines work overtime.

Third, as I mentioned earlier, by creating a very different commercial model, by having the pull-through from our payer partners, we do not need to invest in costly promotion in setting up and having a large sales force. That is often one of the largest categories on a biopharma company's P&L. Ours will look very different.

These sources of efficiencies allow us to offer radically lower prices and truly improve health for all, such that we create financial health for our payer and health systems partners, better outcomes for patients because of greater access, and ultimately, a thriving business for EQRx.

In the last two years, we've accomplished a lot. We're still a young company, but we've already built a sizable portfolio addressing $100 billion in global drug spend. We are on our way to partnerships with payers and health systems that cover 180 million lives. We've raised over $2 billion since inception, and we've hired over 250 passionate EQRxers.

This year is going to be our most dynamic year yet.

On the Global Buyers' Club side, we will not announce every single one of our partnerships, but we will be sure to let you know when there's something unique or special about them. We want to expand our partnerships so that by the end of this year, we have partners that together provide some form of insurance coverage to 350 million partner lives.

On the catalog side, it's the same. We're not going to announce every program that we are going to be working on but we will be sharing with you when there's something big that we're bringing in or that we're working on. Our goal is to double our portfolio and to address $200 billion in global brand and direct spend.

We also anticipate our first regulatory filings in the second half of this year. At the end of last year, we had $1.7 billion of cash on our balance sheet. This year, we're anticipating operating

expenses in the range of $350 to $500 million.

I know that's a very large range, but we are a young company. There are a lot of moving parts. If we bring in a larger asset at a later clinical stage, it could very well be that we are the top end of that range or even just blow over it.

We are also doubling the size of our organization because what we're doing is we're building at scale. We're growing the organization very rapidly. In the long term, we anticipate three growth horizons for EQRx. We're already building scale into our pipeline and our payer partnerships. We will continue to do that in the second horizon, from '23 roughly to '27.

It's at that time that we will start to launch medicines. We will start delivering revenue. Of course, that will be smaller at the earlier part of that range, of that time frame, and more meaningful as we progress.

By the end of this decade, we intend to have a platform at true scale. What that means is that through our partnerships we're going to be able to create true population-level access to a large selection of innovative therapies.

Not only that, we anticipate, because we've already had other companies approach us and say, "Can we use your platform as an innovator so we don't need to build our own?" Anticipate that we will be adding content to this platform. That's what we mean when we say a platform at scale.

When we launched EQRx two years ago we asked a really important question. What if the system could work for everyone? We at EQRx believe the answer is unequivocally, "Yes, it can." It can work for the innovator, for the patient, for the physician, for the payer, for the health system.

This is what we mean when we're saying, "Remaking medicine." This is new pharma. Thank you.

**Chris:** Why don't we open it up to the Q&A session. Maybe one question, first, on the filing pathway side from my end.

Thinking about your two lead assets, how do you think about the filing pathway and maybe put that into context with some of the recent commentary from paths, including "The New England Journal" editorial and then some comments from Lily and others as they're thinking about similar Chinese data sets and filing in the US.

Just a little bit about how you see that evolving, assessing about getting filings this year.

**Melanie:** Yeah, Chris.

First of all, when we brought in some of our first medicines, including from Chinese partners like Hansoh and CStone and others from other places like G1, we've never thought that this is just about flipping Chinese data.

I want to be really clear. That was never the intention. We actually agree with many of Dr. Pastor's comments. I want to hone in on that little bit, Chris.

First of all, when you think about additional data generation and generating comparative data, I just talked about a couple of examples. We know our health ecosystem wants to see some of that data. We're willing to generate some of that.

Second, he laments, and we think rightly so, that there hasn't been any price competition despite the fact that we have so many options in the immunotherapy class.

Again, we agree. That's what EQRx is founded on. Thirdly, he laments the fact that everybody has created their proprietary immunotherapy. Our partnership, for instance, with TP Therapeutics is an example of what we're intending to do broadly with the EQRx medicines.

We are going to make them available. We anticipate that they're going to be great combination partners, both because of a positive or encouraging side effect profile which, of course, is good for combination therapies, but also because we're going to make it really easy for others to come to us and say, "Well, I need an EGFR inhibitor," or, "I need a PD-L1," or, "I need a PD-1."

We're making that possible. I would say, number one, we have never anticipated that we can just flip data, and we're committed to generating additional evidence. Some of that evidence clearly will be for adoption for physician decision-making. We agree with many of his comments. We think we are aligned.

Then lastly, to answer your question o what's the filing strategy, and how do we think about the upcoming ODAC, we think that that's, of course, an important data point. I also want to remind us all, that's Lily's ODAC. It's not EQRx's ODAC. We are creating data for our programs.

Then I want to add, we're committed to diversity and inclusivity. In fact, that's one of the reasons

why we named the company EQRx. EQ stands for equally good or better, equitable pricing, equal access. We are committed to creating data in diverse patient populations.

To come back to your question on filing strategy for aumolertinib, for instance, in addition to the phase III data that we already have in hand, we are in the process of creating additional data in a diverse patient population that proves that in this class, it's truly generalizable. We're generating that kind of data.

As I said, we anticipate that we're going to start filing in the second half of this year. That isn't just in the United States. That's, of course, with other regulatory agencies as well. Their perspective on these questions may not necessarily be exactly the same.

**Chris:** Sure. On that point, do you expect that, as we think about the UK or broader EU markets, that they might be more willing to look at the price part of the equation versus purely just the data piece? I'm trying to understand a little bit about the...I think there's a lot of focus on the US filing strategy. Thinking more globally, how do you think about that?

**Melanie:** I want to bring home a really important point. It is an absolutely necessary condition for an EQRx medicine to be equally good or better in the class. We are not going to ask anyone ever to make a trade-off and to say, "Well, it's not quite as good, but it's much lower cost."

What we're saying is these medicines need to stand on their own two feet based on the data that we're generating. On top of that, we're going to make it financially incredibly attractive. Aumolertinib and sugemalimab are two great examples of what we're talking about.

Number one, no, we would never ask someone to make that trade-off. Number two, in the UK, for instance, we receive the innovation passport designation from MHRA and NICE, from the ILAP organization. That's the Innovative Licensing and Approval Pathway. That gives us the opportunity to use some of the tools of that toolkit, including different types of approval pathways, rolling, accelerated, etc.

Think of this as similar to a BTD designation in the US. Yes, we're not asking anybody to make a trade-off. We think both need to be a given.

**Chris:** You talked about today some head-to-head studies that you're looking at for these lead assets. Talk a little bit about the size and the timelines we should be thinking about for those programs.

**Melanie:** We're initiating those this year in the coming months. It's a little bit too early to go fully into the design, but we will certainly share some of those updates. What we believe is important here is this is additional evidence that we believe our health community wants to see. We're not just doing this with one single goal in mind, which is regulatory approval.

That's, of course, something that we will need, but we are very much committed to generating what we call evidence to adoption, evidence that our payer partners will want to see, evidence that physicians will want to see.

Chris, all the partnerships that we've talked about, we've shared data with them ahead of actually setting up these MOUs. That's a testament to how we're going about this. The clinical quality needs to come first. The pricing comes second.

**Chris:** OK, that makes sense. Then as we look for the broader pipeline over time, do you expect [inaudible] every program will have some sort of head-to-head component to it going forward so you can show that evidence of that's directly comparable so that it eliminates any question about the equivalence of data versus a study that isn't head-to-head against the market leader?

**Melanie:** Here's an interesting question. At what point in time, how much time of the first medicine launch and a class do you actually need that or do you want to have that? The way we think about the portfolio is that it will comprise classes where we have launched medicines today, but their targets we're working on where nobody has launched a medicine yet.

We will be right there with them. We may not be the first to market, but we will be -- if you want to use that word -- much faster following. In those cases, I'm not sure we need comparative data. I think it depends. It will be on a case-to-case basis where that's warranted and where it isn't.

**Chris:** Yeah, that makes sense if you got an established market where these clear metrics to look after may be head to head. If you're shortly on the heels of an innovator, that's a different story. OK, that makes sense.

Another question is, what percent of the US market do you think can be incentivized by a lower drug pricing? Is this question of giving the payer system we have? [inaudible] of the market just doesn't make sense for? Have you guys done any sense of framing what percent of market this type of model is going to resonate with?

**Melanie:** We believe, and this is, by the way, one of the reasons why we shared these specific examples. Again, I want to highlight, these are not all the partnerships we have. We wanted to give very different examples. What have we shared?

A regional payer, right? Very, very different than a large single-payer system like the NHS, an integrated delivery network that has a health systems component. Then one of the largest, if not the largest PBN.

You see in each of these how the economics work is very different. The reason we wanted to share this is to show that if you really put your heart and your mind to it there is a way to ensure that you can create a true partnership both so that you can align the economic incentives...

Again, I want to reemphasize what I mentioned earlier. There is so much more to a partnership. It is, of course, essential that you have the economic component, but you also want to make sure that you truly create a partnership where you leverage everything that both sides can bring to bear.

My answer to your question is I think it can work everywhere.

**Chris:** Interesting.

In the course of...When you're announcing these MOUs or pre-commercial contracts, what's contained in these? I know you're probably not going to share all the details with us. Does this layout very specific pricing? Does this give you volume minimums?

I'm trying to get a sense of what visibility you're able to get from these contracts and what comfort investors should have when we see an announcement of...How that translates to share and revenue for EQRx over time.

**Melanie:** As you just said, Chris, we can't share the details. I can say the following. A MOU contains some of the commercial terms, but most importantly the way I look at it is it contains commitments. Ultimately, that is what both sides do. We're trying to solve a problem together. We're saying, "What if we were on the same side? What if we had the same shared goal?"

If you're willing to go to the place that we're willing to go -- to radically lower prices -- you create enough headroom that you can do a lot of things together.

How does that translate into market share? The way we think about it is that we will get more market share from those partners because ultimately, they will use some of the important levers that they have. There will be probably a larger proportion of patients for each of these respective indications on an EQRx medicine than perhaps outside.

Ultimately, what I believe what this means is when you track lives, it should give everybody comfort that it A, can work broadly, that B, we know how we can align the incentives, and that C, ultimately that does translate in true market share.

**Chris:** Excellent. I think we're just about out of time here. I really enjoyed the presentation and the conversation. Congrats on all the progress in a very short period of time. Melanie, thanks again for joining us. Have a happy New Year and best of luck for '22.

**Melanie:** Happy New Year to you, and thank you so much again for having us.

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