CLOSER LOOK

MEMORANDUM

Amgen 2Q26 – Repatha nears $1.0 billion in revenue (+37% YoY, +9% sequentially); MariTide development continues in nine phase 3 trials; phase 1 obesity candidate discontinued – August 4, 2026

Executive Highlights

- **Amgen reported 2Q26 results in a call led by CEO Mr. Robert Bradway, R&D Head Dr. James Bradner, and EVP of Global Commercial Operations Mr. Murdo Gordon**. See the webcast, presentation slides, and press release.
- **Amgen emphasized that once-monthly MariTide's Phase 3 program has rapidly expanded its obesity and T2D development programs**, with nine ongoing and three planned Phase 3 studies spanning obesity and obesity-related cardiometabolic diseases. Beyond chronic weight management, the program now includes dedicated studies in T2D, ASCVD, heart failure, obstructive sleep apnea (OSA), weight-loss maintenance, and patients switching from weekly GLP-1 RA therapies. Amgen framed this broad clinical strategy as an effort to establish MariTide as a long-term cardiometabolic therapy rather than solely a weight-loss drug.
- **Sales of the PCSK9 inhibitor Repatha (evolocumab) totaled $953 million in 2Q26, up 37% from 2Q25 and up 9% sequentially.** US sales totaled $510 million, up 41% from 2Q25 and up 10% sequentially. OUS sales totaled $443 million, up 32% from 2Q25 and up 8% sequentially. Sales were driven by volume growth and new-to-brand prescriptions, which grew more than 50% from 2Q25 according to Mr. Murdo Gordon (EVP, Global Commercial Operations). Mr. Gordon explained that these trends are supported by increased urgency to treat in secondary prevention and in high-risk primary prevention patients.
    - **During Q&A,** management described Repatha growth to be driven by two dynamics: (i) the increased prescribing of Repatha in cardiology clinics for secondary prevention or very-high-risk patients; and (ii) primary care physician use in high-risk primary prevention.
    - **Mr. Bradway underscored Repatha's growing leadership in primary prevention with multiple new subgroup analyses from the phase 3 VESALIUS-CV trial (n=12,257).** Excitingly in 2Q26, these data supported a positive CHMP opinion supporting Repatha's label expansion for primary prevention.
- **Amgen announced that it will discontinue future development of AMG 513**, its Phase 1 obesity candidate with an undisclosed mechanism of action, while allowing the ongoing Phase 1 trial (n=80) to continue through completion.
- **Revenue for Pavblu, a biosimilar to Bayer/Regeneron's anti-VEGF drug Eylea for retinal diseases, totaled $287 million in 2Q26, up a striking 121% from 2Q25 and up 3% sequentially.** Sales growth was primarily driven by volume growth as the only commercially available biosimilar to EYLEA in the US during 2Q26.
- **In 2Q26, management characterized Lp(a)-lowering olpasiran as a potentially best-in-class siRNA designed to reduce lipoprotein(a) synthesis in the liver.** Dr. James Bradner emphasized that elevated Lp(a) remains a serious, genetically defined cardiovascular risk factor affecting approximately one in five people. Olpasiran is part of Amgen's broader effort to target residual risk beyond LDL-c.

Table of Contents

1. Financial Highlights

1. Repatha (evolocumab) revenue totals $953 million (+37% YoY; +9% sequentially), driven by increased urgency in secondary prevention and high-risk primary prevention

2. Pipeline Highlights
    1. MariTide phase 3 program expands across obesity, cardiometabolic disease, and long-term weight maintenance
    2. Repatha expands VESALIUS-CV evidence base with high-risk diabetes and prior PCI subgroup analyses; positive CHMP opinion for primary prevention
    3. Amgen discontinues AMG 513 for obesity
    4. ABP 938 (8 mg) biosimilar to EYLEA HD advances into Phase 3 as Amgen continues expanding ophthalmology biosimilar portfolio
    5. Phase 3 studies continue for Olpasiran in Lp(a)-lowering

3. Analyst Q&A
    1. On Lp(a)
    2. On MariTide
    3. On Repatha

4. Close Concerns' Questions

Financial Highlights

1. Repatha (evolocumab) revenue totals $953 million (+37% YoY; +9% sequentially), driven by increased urgency in secondary prevention and high-risk primary prevention

Sales of the PCSK9 inhibitor Repatha (evolocumab) totaled $953 million in 2Q26, up 37% from 2Q25 and up 9% sequentially. US sales totaled $510 million, up 41% from 2Q25 and up 10% sequentially. OUS sales totaled $443 million, up 32% from 2Q25 and up 8% sequentially. Sales were driven by volume growth and new-to-brand prescriptions, which grew more than 50% from 2Q25 according to Mr. Murdo Gordon (EVP, Global Commercial Operations). Mr. Gordon explained that these trends are supported by increased urgency to treat in secondary prevention and in high-risk primary prevention patients. Management reiterated Repatha's potential today, suggesting the therapy should be central to "an aggressive LDL-lowering strategy" for 100 million patients estimated to have not met their LDL-c goals. In Q&A, Mr. Gordon reminded his audience that Repatha may be used as a monotherapy or in combination with statins.

- **During Q&A, management described Repatha growth to be driven by two dynamics:** (i) the increased prescribing of Repatha in cardiology clinics for secondary prevention or very-high-risk patients; and (ii) primary care physician use in high-risk primary prevention. Mr. Gordon particularly highlighted PWD as having experienced increased prescribing of Repatha for primary prevention in primary care, citing findings from the phase 3 VESALIUS-CV study (n=12,257) and a subsequent diabetes-specific sub-study.
- **Since October 2025,** Repatha is available at $239/month through AmgenNow – the company's direct-to-patient program in the US. This price is nearly 60% below the current US list price, although management has previously stated that over 95% of American patients have coverage for Repatha and pay less than $50/month out of pocket.

Repatha was again spotlighted by Amgen CEO, Mr. Robert Bradway, as one of Amgen's six key growth drivers. Repatha, Evenity (romosozumab-aqqg) for osteoporosis, Tezspire (tezepelumab-ekko) for severe asthma, and the company's businesses for rare disease, innovative oncology, and biosimilars totaled around 70% of Amgen's near $10 billion total 2Q26 sales – a 9% increase from 2Q25.

Pipeline Highlights

1. MariTide phase 3 program expands across obesity, cardiometabolic disease, and long-term weight maintenance

Amgen emphasized that once-monthly MariTide's phase 3 program has rapidly expanded into one of the broadest obesity and T2D development programs in the industry, with nine ongoing and three planned phase 3 studies spanning obesity and obesity-related cardiometabolic diseases. Beyond chronic weight management, the program now includes dedicated studies in T2D, ASCVD, heart failure, obstructive sleep apnea (OSA), weight-loss maintenance, and patients switching from weekly GLP-1 RA therapies. Amgen framed this broad clinical strategy as an effort to establish MariTide as a long-term cardiometabolic therapy rather than solely a weight-loss drug.

Management also reiterated continued progress on nine global phase 3 studies of MariTide:

- **MARITIME-1** (n=3,853) has completed enrollment in adults living with obesity or overweight, without T2D, and is expected to complete in January 2027;
- **MARITIME-2** (n=1,105) has completed enrollment in adults with obesity or overweight, with T2D and is expected to complete in April 2027;
- **MARITIME-CV** (n=12,800 estimand) continues to enroll adults living with established ASCVD and obesity or overweight and is expected to complete in September 2030;
- **MARITIME-HF** (n=5,056 estimand) continues to enroll adults with heart failure with preserved or mildly reduced ejection fraction and obesity and is expected to complete in September 2030;
- **MARITIME-OSA-1** (n=250) continues to enroll adults with overweight or obesity and obstructive sleep apnea (OSA) who are receiving positive airway pressure (PAP) therapy and is expected to complete in September 2028;
- **MARITIME-OSA-2** (n=250) continues to enroll adults with overweight or obesity and OSA who are not PAP therapy and is expected to complete in September 2028;
- **MARITIME-SWITCH** (n=300 estimand) is enrolling adults living with obesity or overweight who will be switching from weekly tirzepatide or weekly semaglutide to MariTide on an every eight-week or quarterly dosing schedule;
- **MARITIME-1 EXTENSION** (n=3,200 estimand) is enrolling adults living with obesity or overweight without T2D who completed the MARITIME-1 study. This study aims to evaluate the maintenance of weight loss with monthly, every eight-week or quarterly dosing;
- **MARITIME-2 EXTENSION** (n=900 estimand) is enrolling adults living with obesity or overweight with T2D who completed the MARITIME-2 study. This study aims to evaluate the maintenance of weight loss with monthly and every eight-week dosing.

As background, MariTide (maridebart cafraglutide/AMG 133) is Amgen's investigational GLP-1 RA/GIP RA antibody-peptide conjugate designed for extended-duration dosing. The company also noted that manufacturing investments in 2026 include expanding capacity in preparation for a potential MariTide launch.

A key differentiator remains MariTide's infrequent dosing schedule. Amgen reiterated that MariTide is designed to begin with monthly dosing using a simple three-step dose escalation over two months before transitioning to maintenance dosing. Phase 3 extension studies will evaluate whether patients can successfully maintain weight loss while reducing dosing frequency to every eight weeks or as few as four to six injections per year. This represents a significant potential advantage over currently available weekly incretin therapies.

- **Amgen also highlighted its dedication to the "next chapter"** in obesity treatment, which the company believes will focus not only on achieving weight loss but also on helping patients remain on therapy long term. The MARITIME-SWITCH phase 3 trial will evaluate patients transitioning from weekly semaglutide or tirzepatide to MariTide with the goal of reducing injection frequency.
- **Compared to 1Q26, management shifted from announcing new MARITIME studies to emphasizing execution and long-term differentiation**. Rather than focusing primarily on weight loss efficacy, Amgen repeatedly highlighted maintenance dosing, treatment persistence, and switching from weekly GLP-1 therapies. Amgen suggested that their view is focused on reducing treatment burden and increasing long-term adherence, rather than targeting weight loss alone, positioning this as MariTide's primary competitive advantages.

2. Repatha expands VESALIUS-CV evidence base with high-risk diabetes and prior PCI subgroup analyses; positive CHMP opinion for primary prevention

Mr. Bradway underscored Repatha's growing leadership in primary prevention with multiple new subgroup analyses from the phase 3 VESALIUS-CV trial (n=12,257). In 2Q26, Amgen conducted subgroup analyses on patients at particularly high risk, including: (i) PWD with or without known atherosclerosis; and (ii) patients with prior percutaneous coronary intervention (PCI). These data were presented at ADA 2026 and EuroPCR 2026, respectively, and published concurrently in *Diabetes Care* and *Circulation*. Excitingly in 2Q26, these data supported a positive CHMP opinion supporting Repatha's label expansion for primary prevention.

- **In the high-risk diabetes cohort (n=6,002),** Repatha achieved robust LDL-c lowering and clinically meaningful reductions in major adverse cardiovascular events (MACE). Specifically, Repatha reduced 3-point MACE (coronary heart disease-related death, MI, or ischemic stroke) by 29% and 4-point MACE (including ischemia-driven revascularization) by 21%, with a 21% reduction in all-cause mortality. These findings extend a high-risk primary prevention signal first reported at AHA 2025 and reinforce that intensive LDL-c lowering in PWD – before overt atherosclerotic disease is documented – translates into fewer adverse cardiovascular events. In its corresponding *Diabetes Care* publication, this benefit was observed across patients with and without known atherosclerosis, supporting a risk-based approach to intensification of lipid-lowering therapies.
- **The EuroPCR analysis (n=3,627) examined VESALIUS-CV participants with prior PCI** – a group with substantial residual risk despite guideline-directed statin use and revascularization. In this subgroup, Repatha reduced 3-point MACE by 30% and 4-point MACE by 18%. Repatha also halved the risk of MI (50% relative risk reduction), with treatment effects emerging as early as six months after randomization. Repatha was associated with 34% and 24% reductions in cardiovascular and all-cause death, respectively. These data support the use of Repatha for sustained, aggressive LDL-c lowering to reduce the likelihood of future adverse cardiovascular events in patients treated with PCI.
- **Alongside VESALIUS-CV's initial readout,** which reported a 20% reduction in all-cause mortality and a 25% reduction in MACE over five years in patients with early CVD or diabetes without prior MI or stroke, Amgen's subgroup analyses expand evidence for Repatha in risk reduction across the cardiometabolic spectrum. To date, Repatha has demonstrated benefit in patients with high-risk diabetes with and without atherosclerosis, in patients post-PCI, and across multiple composite endpoints. Consistent with VESALIUS-CV results, Repatha's greatest risk reduction was seen for MI, while benefits were broadly consistent across age, sex, and baseline lipid therapy.

Clinically, these data support early, intensive lipid-lowering therapy beyond statins for primary prevention in high-risk patients who remain above their LDL-c goals. In 2Q26 commentary, management repeatedly emphasized Repatha as the only PSCK9 inhibitor with phase 3 outcomes data in primary and secondary prevention, supported by 51 clinical trials that involve over 57,000 patients and 100,000 patient years of exposure.

3. Amgen discontinues AMG 513 for obesity

Amgen announced that it will discontinue future development of AMG 513, its phase 1 obesity candidate with an undisclosed mechanism of action, while allowing the ongoing phase 1 trial (n=80) to continue through completion. This

marks a notable shift from the company's earlier stance: after the FDA placed the trial on clinical hold in 4Q24, Amgen resumed the study, reaffirming that AMG 513 was "still expected to be in development." Chief Technology Officer Dr. James Bradner said that "the bar is high at Amgen for obesity medicines," emphasizing that the company will continue advancing differentiated next-generation obesity programs. The decision appears to reflect Amgen's increasing focus on MariTide.

4. ABP 938 (8 mg) biosimilar to EYLEA HD advances into Phase 3 as Amgen continues expanding ophthalmology biosimilar portfolio

Amgen continues to expand its late-stage biosimilar pipeline with ABP 938 (8 mg), an investigational biosimilar to Regeneron's high-dose anti-VEGF therapy Eylea HD. During 2Q26, Amgen announced the initiation of a randomized, double-blind phase 3 comparative clinical study evaluating ABP 938 in patients with neovascular age-related macular degeneration (nAMD). The trial is currently enrolling participants and joins Amgen's growing late-stage biosimilar portfolio, which also includes candidates such as Opdivo, Keytruda, and Ocrevus.

- **As background,** ABP 938 targets the rapidly growing high-dose anti-VEGF segment. If approved, ABP 938 would broaden Amgen's ophthalmology biosimilar portfolio and strengthen the company's strategy of following successful biosimilar launches.
- **The program builds on Amgen's growing presence in ophthalmology** following the successful launch of Pavblu, the company's biosimilar to standard-dose Eylea. During the quarter, Pavblu sales increased 121% year-over-year to $287 million, driven by expanding adoption among retina specialists. Amgen highlighted how retina specialists appreciate the product's prefilled syringe format, reliable supply, and manufacturing expertise.

5. Phase 3 studies continue for Olpasiran in Lp(a)-lowering

In 2Q26, management characterized Lp(a)-lowering olpasiran to be a potentially best-in-class siRNA designed to reduce lipoprotein(a) synthesis in the liver. In today's remarks, Dr. James Bradner emphasized that elevated Lp(a) remains a serious, genetically defined cardiovascular risk factor affecting approximately one in five people. Olpasiran is part of Amgen's broader effort to target residual risk beyond LDL-c.

- Dr. James Bradner noted that olpasiran demonstrated greater than 95% Lp(a) reduction in Phase 2, supporting its advancement into three ongoing phase 3 outcomes trials: (i) OCEAN(a)-Outcomes in established atherosclerotic cardiovascular disease; (ii) OCEAN(a)-PreEvent in high-risk primary prevention; and (iii) OCEAN(a)-CCTA plaque study in adults with atherosclerotic CVD and elevated Lp(a).

Clinically, Amgen continues to frame olpasiran as a late-stage asset with potential best-in-class potential. 2Q26 commentary underscored confidence in the molecule's profile but demonstrated measured optimism in phase 3. The therapy's value proposition will depend on whether intense Lp(a)-lowering translates into clinical outcomes benefit.

Analyst Q&A

On Lp(a)

Q (Michael Yee, UBS): Just a quick question on the Lp(a). Just thinking about how you design the protocol. Is that involving an interim? I know that you guys are doing a mace three endpoint opposed to Novartis who's doing mace four, do you see that the exclusion of strokes to be affecting the time of your study versus having a mace four endpoint?

A (Robert Bradway, CEO Amgen): As you note, our development of Olpasiran, which is a potentially best in class siRNA for modifying the risk of cardiovascular disease attributable to LP little a elevations affect 1 in 5 patients. It's a serious and profound unmet need. And it's terrific to see so much attention for what is one of the last known and well defined, genetically modifiable risk factors. We have a terrific study design with ocean A. This is a double blind, randomized controlled trial. As you asked. 7297 patients have been enrolled in record time. And there are distinguishing features of our design. One is the requirement for elevations of LP little a above 200 Nanomoles per liter. And with this

every 12 week dosing in an event driven study, we'll read out a primary event. We focus on three point mace. After extensive, human genetics and population science analysis indicated to us that the association of Ischemic Stroke and LP little elevation was not as compelling as other cardiac specific cardiovascular endpoints. And this is therefore a potentially important distinction between this study and others.

Q (Chris Shot, JP Morgan): We had a follow up on Lp(a). So, there's competitor Lp(a) data that's expected shortly. What will you be looking for when this data set reads out? And specifically, if we do see a 13 to 15% type benefit from that study, how would you think about the potential read to El Paso?

A (Mr. Bradway): Again, with the huge unmet need affecting so many humans globally and the American heart Association recommending testing, it's understandable that there would be so much attention on Lp(a) and we quite like our chances with Little Passeren, and its profile. What can we expect from the data? We're following it with interest. We can expect perhaps directional insight, but not decisional perspective owing to the superior properties of our molecule that delivers 95% Lp(a) reduction compared to say 70% with that molecule. And also, some differences in the study design, which we've, we've just described.

Q (Manoj Eradath, Jefferies): Hey, this is Manoj for Akash. Just one from our end. One of the concerns around the HORIZON Lp(a) trial is around the extent of LPA effect, independent of LDL-C. In HORIZON trial, we see the baseline LDL-C is around like 65 milligram per deciliter. What's the baseline LDL-C in the OCEAN trial you are planning? Or like is it in the same levels? And also, is there a possibility that Lp(a) effects manifest only in presence of a relatively higher baseline LDL-C effect? Just trying to understand that point. Thanks.

A (Mr. Bradway): Well, thank you for the question. As I shared moments ago, we're enrolling the OCEAN-(a) a study, to target an Lp(a) that's a little bit higher than the HORIZON study by targeting 200, or higher in OCEAN(a), we bias towards a slightly higher risk group of patients. We believe and have seen data from population studies that Lp(a) elevation to this extent is firmly independent as a risk factor of LDL-C. And if I understand all aspects of your question, correct me, forgive me if I did not. The reduction of LDL-C, even with no improving standard of cardiovascular care, a two which Repatha contributes meaningfully, would not be sufficient to drop LP(a) meaningfully from this elevation to protect patients adequately. So LP(a) directed therapy, we believe is urgently needed and we're conducting the studies to assess that.

On MariTide

Q (Umer Raffat, Evercore ISI): Based on everything you know, right now and all the titration that's been put into place, how confident are you that the vomiting rates in phase three trials of maritime will be mid 20s or better? Are you tracking malignancies on a blinded basis in the ongoing Cd40 trial?

A (Mr. Bradway): First regarding the maritime clinical development program, you know we are noses down delivering a very compelling, phase three data package right now, 2026 is a year of very disciplined data generation. Trial enrollment is strong. I think a clear sign of the remaining unmet need and also an interest in the maritime profile. We're executing a broad therapeutic program very well. And we are very confident in the profile of this medicine. Second, around as appropriate for any medicine in phase three clinical investigation, especially immunomodulatory medicines, we have data safety monitoring committee associated with these studies. That is just doing their job perfectly. As we would expect, they're capturing all high and potentially associated as well.

Q (Dave Risinger, Leerink Partners): Thanks very much, and thanks for all of the details today and all the commentary on the pipeline. So my question is for Jay, please. Regarding MariTide's construct. So it's a GLP-1 peptides conjugated to a GIP antagonist antibody of course. Could you discuss the duration of effect of each mechanism and potential implications for duration of efficacy. Obviously, since the peptide component will last a lot shorter than the antibody? And then if you could also comment on whether you expect real world patient LED dosing selection for every one, two, or three months maintenance dosing based upon individual experience, is that the right way that we should be thinking about it? Thanks so much.

A (Mr. Bradner): I wish, only we had more time in a whiteboard to take you through the answer, I'll be succinct. MariTide is truly a singularity. It's the only of its kind antibody peptide conjugate. And because of the antibody design, unlike peptides that through miracles of chemistry last maybe a week in the bloodstream, the antibody design affords a half life of approximately 21 days. And that's the half life of the intact molecule of MariTide. MariTide, a pending

peptides were designed and appended in order to maximize stability to tissue proteinases and to serum esterases and other xenobiotic metabolizing enzymes in tissues and in circulation. And because of this, the duration of effect of the GIPR inhibitory variable chains of the antibody, and the GLP-1 receptor agonizing peptides on MariTide is preserved through this long period of exposure. And what that means is that with monthly dosing as used with starting MariTide and with the transition to less frequent dosing, maybe four to six doses per year, as you start and stay on MariTide or as you switch from another medicine and then stay on MariTide, that the, GLP-1 agonist and GIPR receptor antagonism is quite persistent as the molecule is quite persistent. Why is this important? Because we're that to say burn off with metabolism or elimination of the drug then rechallenge with a therapeutic dose of the drug will be very hard. And that's not what we're seeing on our clinical studies as we've shared with less frequent dosing, MariTide at target doses proves very, very well-tolerated. And so this design is reading through to truly differentiating clinical activity and a different experience for patients. Your second question is a little harder. I can't predict the way in which MariTide in the fullness of time, will be utilized by prescribing physicians and by patients. But what we're seeing is activity in our Phase 2 for chronic weight management as for diabetes is observed at multiple different doses. And as we've shared that maintenance MariTide can be administered on different schedules. And so this would, you know, I can say as a physician, this would seem to imply real flexibility in approaching how best to take MariTide.

On Repatha

Q (Terence Flynn, Morgan Stanley): Just a two-part question on PCSK9. Merck's oral PCKS9 recently got approved. Can you compare and contrast the key label language differences from that of process? And also, can you comment on the contracted dynamics now that there's an oral option?

A (Mr. Murdo Gordon, Executive Vice President-Global Commercial Operations Amgen): Yeah, let me take that one. Obviously, the two labels really just don't compare. You have, Repatha as Jay mentioned, over 50,000 patients on clinical trial experience reflected in a broad label that includes primary and secondary prevention. Repatha can be used as monotherapy or in combination with statins, 10 years of real world experience reflected in data that we've presented at recent scientific meetings. So, as we say, the data behind Repatha are unrivaled. It is the category leader and indeed the data are unrivaled. I think though, what's important to remember is that this is a huge market with a lot of patients that are still not at their LDL cholesterol goal and additional therapies, much like when Inclisiran entered the market, are treating other patients, they're not necessarily competing for share with Repatha. And so, we think there's a lot of education that still needs to be done. We think that the guidelines are important in this market, and we think that we are able to drive utilization in this market more effectively, given the compelling data that we generated on VESALIUS. The other thing that we've experienced with Repatha is we look at persistency data in the market and the real world analysis, is an every two-week injection is a really easy regimen for patients to adhere to. We've seen limitations with orals, including with statins where, daily oral therapy does have some compliance and some adherence challenges to it. We're also seeing in the label with the new PCSK9 approval that there, there are indeed food restrictions that you have to be, careful with what you eat in the first 30 minutes after you take that medicine. So, I think this oral versus injectable is too simplistic a compare and you really have to look at why do you take an LDL cholesterol medicine in the first place? And is to prevent a first or second heart attack and we've demonstrated that with very clear evidence for Repatha.

Q (Mohit Bansal, Wells Fargo): Quick question on Repatha and then a longer one on dazodalibep. On Repatha, what portion of growth is coming from broader primary care adoption versus existing prescribers, and how do you see that changing over time?

A (Mr. Gordon): We are pleased to see that Repatha is growing very nicely, particularly in new to brand prescriptions. So new patient starts, we grew about 50% year-over-year in the quarter in new to brand prescriptions. And is being driven by two dynamics, one, cardiologists who already use Repatha for some patients are broadening their use of Repatha. So they're increasing the number of prescriptions they generate on a per physician basis treating more patient's mostly in secondary prevention or in very high risk primary prevention, so that's roughly about half of our growth. And then the other half of our growth is coming from primary care physicians. And expansion in the number of primary care physicians in particular, who are prescribing Repatha for their high risk primary prevention patients. And there I would highlight one specific patient type, and that's those patients who have diabetes. The primary care community see that as a patient that they should manage for their cardiovascular risk and given the Basileus data and then the subsequent diabetes sub-study, the data there for adding Repatha for intensifying LDL cholesterol lowering are pretty compelling. And we're not just developing MariTide for weight loss. We're developing it for diabetes and for heart failure. For

ASCVD, we're looking at all of the different independent metabolic risk factors that travel with losing weight we're seeing more and more primary care physicians adopt Repatha for those patients, in particular for primary prevention.

Q (Mr. Jay Olson, Oppenheimer): Our question is about your cardiovascular portfolio. As you look across Repatha, Olpasiran, and maritime, Amgen is building a comprehensive cardiovascular risk reduction franchise. So, how are you thinking about leveraging those three assets with a coordinated strategy? And what are the advantages that creates versus competitors who might be pursuing only one or two components of cardiovascular risk?

A (Mr. Gordon): I think it's, it's obviously, a nice opportunity given the foundational strength we have in the LDL cholesterol lowering market and cardiovascular risk reduction market with the leadership position we've established with Repatha. I think what you heard even on today's call, you've heard from us prior to this is the experience that we've gained from Repatha has been applied to the clinical development and the design of the clinical programs behind Olpasiran and behind MariTide. We're not just developing Olpasiran for secondary prevention, we're looking at primary prevention. We're not just developing maritime for weight loss. We're developing it for diabetes and for heart failure. And for ASCVD, we're looking at all of the different independent metabolic risk factors that travel with losing weight. And so it's our intent to fully explore, each of these unique medicines, these best-in-class Potentially first in class of their kind molecules. As well as potential combinations thereof. So, this is an exciting time for us. We continue to develop additional molecules in the clinic and we continue to look outside for additional external innovation that could be brought in. It's an important part of our long-term growth strategy and one that we expect to be durable well into the next decade.

A (Mr. Bradway): I hope you can see that our business is in strong shape. And that is indeed a fitting way for Pete to pass the baton to Thomas Dittrich, who will be in the CFO role for our next call. Recall that Thomas returns is a veteran of the Amgen finance team. We're delighted to have him back and grateful to Pete for ensuring another smooth transition of responsibilities at Amgen. I know many of you have worked closely with Pete since he joined us at the end of 2019, and we've all had fun working with him in his role here and are grateful to him for the many ways in which he has strengthened our financial foundations. His disciplined financial leadership has enabled our largest ever investments in research and development, acquisitions and manufacturing capacity expansion. And he's also helped prepare Amgen for the future through our investments in technology, cybersecurity, and data capabilities that will serve us well in the years to come.

Close Concerns' Questions

1. Might Amgen consider allowing another company to develop AMG 513 for obesity?
2. When does Amgen anticipate its first submission of MariTide for regulatory approval?
3. Which indication will Amgen pursue first for MariTide?
4. Might Amgen pursue a combination approach to Lp(a) and LDL-c lowering with Repatha and olpasiran?

-- by Caroline Metz, Elizabeth Rose, Kayla Mathieu, and Kelly Close