

EXHIBIT 12

FEBRUARY 3, 2006 ROCHE PHARMACEUTICALS

BREAKOUT SESSION I TRANSCRIPT ¹

W.M. Burns:² Do we need a microphone for the questions? Are we supposed to be recording? Is this all due legal process or whatever?

Male Voice: Two questions Bill. One relates to your sort of switching between TNF failures as defined obviously in the Rituxan program and the ACR 70 as being a defining sort of clinical barrier. I mean where do you see the key definition for the use of Rituxan? Is it ACR 70 or is it the clinical data or on the entry criteria or the programs?

The second question relates to the cost buildup in Europe in the Roche business. I think you mentioned on the call two days ago that there was a cost buildup, you were taking a full year of those costs in 2006. Can you give us some idea here of the type of gearing or return you get on those investments because obviously the timing of that return is different in Europe than it will be in the U.S. You know we're used to exploding sales, quick returns, I mean perhaps they're slower in Europe in terms of gearing.

Burns: [inaudible] of a marketing invest point of view [inaudible]?

Male Voice: [inaudible]

Burns: Fine. So first of all for Rituxan MabThera for Rheumatoid Arthritis. I was tending to cite just to the interest of time in the main whole the ACR 70 as

¹ Audio Recording for Roche's Presentation for 2005 Annual Results in New York, Feb. 3, 2006, Pharmaceuticals Breakout Session, available at http://www.roche.com/home/investors/inv_news_pres/inv_news_pres_annual_060201.htm#inv_news_pres_annual_060201_text-Anchor-us.

² W.M. Burns is the CEO of F. Hoffman-La Roche Ltd.'s Pharmaceutical Division.

one of the key clinical markers. There's clearly a range of clinical data points and the net result is the physicians global scores and all the rest of it. It's the clinical data that will, I think, determine how the doctors will use it. Usually good medicines find their way and I think the data set that we have is pretty good coming into this sector. So I feel that there is enough clinical dissatisfaction. The clinical results are going to lead and we'll find our way into significant revenues in this area.

Marketing invests or cost blocks. What I think we were describing on the conference call the other day while people were saying, "well what about the year 2006 and what is it we should expect?" You saw me summarize in the whole that we're going from 31 Phase 3 programs to 41, so there's a significant invest in under the R&D bucket on late state D. That has to be paid for.

For marketing, there is I think 5 products effectively in launch rollout. We'll have a full year of marketing invests now for Tarceva. We'll have a full year of Avastin marketing invest. We only had in 2005 about 9 months in the U.S. of Boniva launch costs. We're going to a full year in the U.S. and a full year Rest of World as a first full year. So there's a number of those areas that are times of invest.

Product takeoff in Europe versus U.S. I'm not seeing a profound difference. If I just take the Avastin charts that we showed, but we're on the same trajectory in Germany to be rapid takeoff. Usually the difference is that launching here in the U.S., although it may be 51 member states in of the union effectively, it happens across the country in one sort of timing rollout, whereas in Europe we

usually have to wait step by step for the pricing and the price approvals. As I've evidenced with Avastin and Herceptin, at least we're seeing some rapid acceptance on the pricing.

So that time delay—Belgium will still be two years before we get the price. Belgium is always there. Small market. But for the big markets, it seems to be more tightly clustered in terms of the timing for the rollout and therefore the benefits should come accordingly. So I think that's what we've got to do for the year 2006 and maybe also if you're on the other cost blocks, we are embarking on a major program on the cost side.

In Europe, we've got 13 SAP systems. We want to end up with 1. Probably with a Financial Services Center and an HR Services Center for the 26, 27 countries that would come into that. That will take us a 2 to 3 year period. But the burning desire to do this is to keep chipping away at back office costs and also in the factories to get to, it's no longer acceptable. . . you say, "well, you do things differently in France or in the U.S. or in Germany or whatever." When the FDA or the EMDA come to call, they want one company, one invoice, one rhythm and that's the step change that we're looking for out of that. That's coming.

We've already harmonized SAP in Latin America from 4 to 1. We've consolidated our data centers around the world into Madrid and Spain. We've set up new development centers in Warsaw and got in some very bright people and they're helping in some of the computer programs. None of these is an inflection point on a margin, but they are all chipping away at a much tighter global model

over time. And we feel we have to do that because it doesn't matter where you are. There is pricing pressure almost in all societies, on all companies. And therefore if there's a dime repressure, I think in the last 2 or 3 years in Europe, we've probably lost 1.5-2 percentages points from the summation of the pricing dime repressures in the European arena. You have to offset that with operating efficiencies. So that's R&D, M&D.

Cost of Sales, we've got an operation Lex List program that's underway tying cost, quality. Some interesting examples there. We've been transforming the supply chain. We no longer ask our operating companies for orders. We ask them to give a demand for cost. This is principally in Europe and just towards the end of last year now in the United States. It's then up to the supply chain to arrange Just In Time deliveries so they don't go out of stock in the market. And by doing that, we're able to reduce inventories. That's also another way of an operational efficiency improvement.

So you can see here in the various cost buckets there are some where if you took a mid-term view, not just a 2006, there are areas where you need invest and there are other areas where you look at getting more efficient. And if this is subtitled, again back to the margin, which very often is subtitled here, what we've I hope demonstrated over the last 4 to 5 years is that by having given guidance on a number of strings of our activities, that has been helpful as we transition.

But let me also put on the table, every time I've had a one on one with folk, in this room and beyond, and I've said, "you're measuring us now -trying to get to the 25% operating margin." What we're saying, "On or by this point you

should be at this stage in the second decimal place. Are you there yet?" When you put on the table and say, "What do you want me to do? Meet the second decimal tracking half year by half year?" Or if we had some really interesting things to invest in and face three or licensing or whatever you want us to do. And of course, everybody says, "You've got to invest in the mid-term."

By going to an earnings per share, we still are pulling on the various levers, operational, non-operational tacks and so forth, but we've got more management freedom to do what is right. So that's one of the reasons why we feel having come this far of the way, we will not move to earnings per share.

And if I share one personal frustration out of maybe the last 2 days that's seeing on a number of the write-ups, people are saying, "Well it looks like the margins are going to be flat, but the achievement this year was 2 percentage points higher than I had in my forecast." And you say, "Wait a minute. This is . . . how can you square this? If we're at the operating profit level that a number of people had us at for next year already, and then they start to whip us and say, "Why isn't the margin increasing that?" There are some disconnects in the thought processes. So go with us.

Andy: Hi. Thanks. The marketing distribution costs were up 18 percent for the year and in the second half at least on a reported basis were up about 25 percent. I understand there are a lot of launches but that's an \$800 Million increase year after year. Can you talk about what into that. Are there any one time expenses there?

Burns: Interestingly enough I think you'll find that almost every year if you look at Roche in the 2 half years, the second half year is dramatically higher than the first half year. And although we advocate commitment to counting, defer to Ivan who is with us here.

Ivan 809 year in year.

Burns: Even in a year in year basis, yes, the advent of Boliva going on to direct consumer from about July, these are inflection points. If we look at the launch of Tarceva and a lot of the Congress activity for the launches were in the second half year. When you've Congresses for 1000 doctors in Europe in the launch of Bonviva, there is a cost faction. So they were inflection points, but when I look at it, I always see the second half year higher than the first half year. Some of it even comes down to the incentive programs for the field forces which only get paid out at the year end, but of course it's got a full year of involvement and in some countries they're more effective in making provisions against those payments than in some of the other operations. There's nothing trend-like or show-stopper. Am I missing anything here? There are no one-offs to identify there.

Andy: And one other question about CERA. You mentioned that you had built a sales force this year.

Burns: Yup.

Andy: Can you give us a sense of how large a sales force you need for that market?

Burns: George?

George: I can't be specific, but I can tell you there will be different component to the sales force. We have different target audiences to call on as a part of chronic kidney disease and in-stage renal disease. And so we will have multiple segments of a new sales force and we will be building it. We're not in that arena at this moment in time. And we will be building it in time for them to get the lay of the land so to speak before the product is approved. And that starts this year and we're in full launch mode.

Male Voice: I may be confused by the rumors or have misunderstood the launches I've seen over the years, but it strikes me that I have seen very very few where product introduction has been delayed for two years in order to have a better marketing portfolio. If it's not safety and these products are not incredibly dissimilar in some way that no one has figured out yet, I'm surprised at the decision to await outcome data. Can you help us?

Burns: I'm not awaiting the outcome data. What I said was, we set up the studies powered so that we can continue to run them and ultimately have the outcome data. But we don't wait for that for being in with the submission. And on the front end, there is still a bit of tweaking to be done on the dosage before we go into the big numbers. There is still a bit of fine tuning that we need to do in dosage and it's nothing to do with safety. It's all to do with profile.

Male Voice: So the 2 year delay doesn't have to do with outcome data? It does have to do with safety data?

Burns: It's not safety. This is the rumor that's been circulating and been driving me nuts because it's nothing to do with safety.

Male Voice: Well then it's got to be disease prevention in some way and you're saying that it's not outcome. I'm not understanding. Two years of tweaking seems like a lot.

Burns: If you need to do a bit more work on refinement before you go into the large scale numbers, then you can lose favoritive time, not necessarily the full 2 years, but there is a bit of time to be spent there. Just getting. . . there's a very nice profiling –we just need to do a little more optimizing on that before we do any sort of major Phase III. So it's a bit more like a Phase III, Stroke II start. That's what it is. Really there is no concern.

Female Voice: Another but much simpler question on CERA. So when we look at this molecule and think this is a superior molecule to what's available in the market currently, is it based primarily on the PK and the extended dosing –the smooth hemoglobin maintenance. Or are there structural changes over and above the PEGylation.

Burns: There are structural changes to the way it operates, the way it acts. There are observations in the way that . . . that's why we used in the expression "CERA continuous erythropoietin receptor activator". It's like a tickling. It's not a permanent binding. It's a tickling and a constant action there.

Now how that truly plays out in the clinic, that's what we also need to see, but there are elements to the start of the journey that was not obvious. And that's part of the basis of the patent. The Roche patents that are published in the United States on which we will come into the market with. Our patents.

Male Voice: My question is about Pegasys which is hugely successful. My question is you lost a few years and many of your competitors has been developing direct antiviral drugs and Roche has been quiet in that area. I'm just wondering what is the strategy in that area and how do you keep your competitor advantage?

And second question is about Anti-CD-20? Can you come under the competitor lens cap of Anti-CD-20, actually if I remember correctly, Genentech is not developing the second generation Anti-CD-20 for non-oncology indications. What's the rationale behind it?

Burns: Okay. So first of all on hepatitis, what we have is almost 2 lines of interest that I see coming through in science. One is pre-microarrays and the other is microarrays for action in hepatitis. Largely oral products that have been used just on top of interferon. So in that area, we have a pre-microarrays program in Palo Alto, we have a lead candidate that's moving into Phase II, and also we've tried to enrich the choice we could make in some of the follow on molecules by accessing libraries from the University of Whales. Also working with PharmaAsset and that's the stream of activity for us.

The other area is partnering with a number of people that are developing these products and making sure that Pegasys as the market leader and as the preferred product is in the clinical trial programs of the various people working on some of these products. So that's the twin part of the strategy. Whether that's with Valiant or Vertex or whoever you like to think of that are working into that space.

Also in hepatitis we have partnered with Maxagen in Palo Alto looking at--is there a way of using their shuffling technology to further improve on a new generation interferon, particularly focusing on genotype I which is still the more difficult one to handle. And it's at a much earlier stage, but we've just taken one of the molecules forward into a sort of Phase 0 activity that we're looking at there. So we're still pretty active in hepatitis. And if through some of the interactions we have with some of the emerging companies that we could see and that they're prepared for in some form of co-marketing, co-promotion, whatever, then we'd be interested to go forward with it. And we've have discussions with some people. We haven't reached a conclusion yet, but we are active. So that's maybe in that area.

For Anti-CD-20, here clearly with Rituxan as a principal star who we have in the background, Biogen Genentech Roche, ocrelizumab formerly known as 2H7, which is in Phase II and we're looking at this in, at the moment, at some of the non-NHL areas, primarily because it's a fully humanized version and we're trying to see--does that have a differentiation--can that help us profile a successor product there. Also as another candidate, but a slightly earlier stage in the journey, you saw us last year acquire a company called GlycArt. This. . . if you want to start the journey, this was started by a group of people who came out of Cal. Tech and where the head of the section was taking up a new Professorship at AT HA in Zurich and then it became a spin-off as GlycArt. They have a very interesting technology which allows to try and get a more potent binding on ADCC which may have a relevance. This is just a potency of the molecule which

the theory is, that also may have a benefit of a second generation in Anti-CD-20. So we would look to bring and profile that and bring it as another candidate into the joint activities into the CD-20 world. There's another molecule in there that could be an improved [inaudible] tox and so forth. The technology we had worked with before and one of the future molecules of the collaboration between Roche, Genentech, OXO 40 was also using this technology. So we knew and understand that we knew and understood the Glycart technology and we brought that into the party as well. So we think that we're working on this but it's a rather complex area. And Rituxan MabThera has set an incredibly high hurdle from a clinical point of view to find what should be the dimensions of an even better molecule. Okay?

Ed: I recall in the past that you had a sort of a back in the pipeline other anemia efforts before CERA and I think in the past you've described that as if there is a situation where there is a risk to the CERA patent position, you had a much strong conviction in that prior generation, or that earlier stage project. And I think that was dropped at some point. Does that indicate a greater confidence in your CERA position?

Burns: Yes. I think there's 2 things there Ed that . . . The position of our development of CERA has got stronger and stronger and also that that other molecule which was more of a chemical approach to creating an erythropoietin-- we worked on it in Boulder, Colorado --good group of people there, but we just couldn't see the molecule getting to where it needed to get to. So we transitioned it back to the owners.

Ed: And then an unrelated question on Boniva, what are your expectations for the subcutaneous form? How much of a hurdle is the. . . I think there's some sort of kidney safety test associated with that. . . and what are you seeing in terms of the marketing landscape for the oral product. What is the sort of counter detail you're hearing?

Male Voice: Let me take the last question first. For Boniva, the marketing landscape, it's an extremely competitive marketplace. High noise level, high stakes, big market, growing fast. With Merck, Fosamax is about it in terms of big brands that are growing. It's very important to Sanofi-Aventis, Actonel. So you know it's a sub-fest out there and we expect it to be and that's why we have GSK as a partner, but we're pleased with the performance, we're pleased with the uptake. We're running on all cylinders. There is receptivity to once a month dosing. There is receptivity to our efficacy data. We have great efficacy data and highly competitive BMD – bone mineral density increases with the oral. Now the injection which is an every 3 month injection which was just approved by the FDA and should be available in the March timeframe adds an option that simply doesn't exist in the marketplace. There are patients today who just simply can not tolerate or do not like taking an oral disphosphonate. There are patients in this age group which is predominantly post-menopausal women, the large majority 65 and older, who see their family physician routinely every 3 or 4 months. So going in for a very quick injection every 3 months or so fits with their schedule to see a physician. So we think that the IV offers a commercial opportunity for a subsegment of patients. It's not going to be as big as the oral, but it certainly is a

new interim. And we think it's going to add to the whole aura of the convenience of Boniva and the efficacy, the building of bone density.

Burns: What's interesting is this is the same molecule ibandronate down the osteoporosis line as we're also developing down the cancer line. And Bondronat we've launched in Europe and to your Kidney point, Ed, the label that we have Europe is a clear differentiation between our product and the 2 other disphosphonates that are injectable in the cancer area. Clearly we have a differentiator on a much kinder tolerance in the kidney and we don't have anything like the warnings that are on either Panidronate or Zaledronate.

Male Voice: And in the U.S. the reference is to check serum creatinine and it's based on a class issue. It's not at all based on any data we've seen with Boniva and you know it's not a big deal. It's a simple blood test and boom that's it—for the injection.

The recommendation is before every dose, yes.

Male Voice: Could you give us an update on the GenMap antibodies and what indications are you thinking about.

Burns: From the data I'm seeing, I'm not seeing a true differentiation. I'm seeing a product that maybe has a similar profile, but I'm not seeing a clearly differentiating molecule. Okay?

Female Voice: Yes, on CERA, could you discuss any safety issues, particularly like any injection site reactions or at one time I believe there might have been a signal of some cardiac events related to the half life?

Burns: Nope. Nothing for . . . In fact one of the things that we – I believe we have a certain skill and expertise on is built out of our NeoRecormon experience, is understanding the Galenic formulations here. Because with NeoRecormon as a first generation product, one of the differentiators in Europe is less anon injection. It's a smaller fill volume. The way it's just been formulated, it's kinder, so it has less anon injection.

 We've tried to take a lot of that knowledge and understanding on the Galenical forms into CERA. So it was not an issue there. There had been questions on the whole erythropoietin class, positive and negative, on its use in congestive heart failure and general heart. We see absolutely no signals so far in anything that we've done in CERA. It's pretty clean. Whose got the mike?

Male Voice: Getting back maybe to John's question. Can you take us through the progression from when CERA entered the clinic and specifically when Phase I for oncology occurred and Phase II. I'm just trying to understand the timeline up to now and why oncology originally was behind Nephrology.

Burns: I don't have the . . . honestly don't have the dates in my mind for either of those points. If underlying this is trying to say, "Is there something that I'm not telling you?" Then the answer is no. I'm giving you the honest answer. There is not anything –I'm not being Machiavellian. I'm telling it the way it is and I – forgive me but I sat in this room over the years being equally quizzed on Pegasys versus PegIntron. On Ribavirin and whether Roche could ever enter. And we are not a patent buster. We are not somebody that hides data. I'm telling you the way it is. Okay?

Male Voice: Sure. Just on the patent, it says that it's having a second life on outside transplantation and is pretty significant franchise for you. The bad news is the patent is off in '09 but you are developing ways on the other indication. The other indications and maybe the orphan stat would be after you extend the patent or do you have a plan in place to do something to extend the formulations of something else?

Burns: It's interesting. While we're still trying to define and we're working here with us, Grevia, as you know on the non-transplantations, we will get some data exclusivity. We will get orphan status as far as Myastin gravis is concerned. But what we need to see out of the clinicals is whether that allows either a dosage form or a Galenical form that would allow that protected status to actually play out. And George you may have to comment. I think the most likelihood is that if it's a standard dosage –standard form—we may see it substituted over rather quickly after the patent expires. Is that. . .

George: I think you're right. If it is the same formulation as today for transplant, I think we have to expect generic competition.

Burns: But it's fascinating how the data is looking good.

George: But, you know, having said that, it's not at all obvious that the rate of erosion in markets like transplant or even autoimmune would be what you see in other typical markets. You know when you have a transplant patient who is stable, no organ rejection. . . you don't want to tinker around with that so I'm not sure we've seen a good model for what erosion might be and it will be less than I think you see typically with an anti-hypertensive . . .

Burns: . . . model is about as good as we've got for the moment. Isn't it?

Male Voice: Yeah, I hate to keep peppering you with CERA questions, but I'm not going to go there, I'm not going to hold off either. Perhaps you could comment on the legal action that Amgen has launched and if you have any sense of what timelines might look like or milestones between now and when you might get an FDA approval?

Burns: So Pro-memoria [sic] Amgen serve notice in November. Our U.S. lawyers advise us that they have until March before the actual documentation arrives. And we haven't received anything as yet, but they do have until March. There are then various options after that comes in that we can consider. Either that we go ahead with the legal action as is now and get started or that we take use of the Safe Harbor position and say, "Fine, see you in court when we actually come to market."

And our lawyers, once we've seen their data, we will weigh up which is the best route for us. And given that that's the legal process that is happening and again just Pro-memoria [sic] because some people in following this have taken a view that because of the TKT experience, that they expect that this is a difficult area for litigation.

The profound difference between the two court cases is that TKT was using a different methodology of manufacture to get to the same clinical end point with the same product. And it never had its patents published in America. We have a different mechanism of action, a different product, a different molecule

and our own patents that have now been published in the U.S. And we think that that's a significant difference for this moving forward.

Male Voice: What are you looking for in that product in order to sort of move. How does that differentiate from Xanatide and just explain the economics going forward if you do license it to move on.

FADING OUT

Burns: So this is on the Ipson product where we have an option to come in on a Glip I and here Ipson have . . . there's two streams running. In Phase II there is a molecule that is a short acting molecule so more similar to what Lilly have on the market right now. Our other interest is in a longer acting product and there is some very interesting technology that Ipson has applied and we've got data that should be with us by about the mid year. And that's when we all take our views whether we opt in or not.

 What is it that one would look for here? There seem to be 2 clear areas. Given that the, as a baseline, that the mechanism of action is good, we're seeing weight loss, we're seeing good correction, so it's an interesting mode of action.

 Two things that I think one would look for: much less nausea. The nausea seems to be a troublesome element of the Bietta and of a lesser frequency of administration without compromising in any way of the efficacy. I think those are the two criteria that we look for. That may not be a huge amount of data, but we need to be sufficiently encouraged in some proof of concept to step in and move forward. So far I'm pretty encouraged by what I see.

We don't usually release the term sheets of the relationship between the companies, sorry. And that's also partly because of Ipson itself may not want to release science. We're respectful of both sides.

Maybe just to broaden on that just so that we're all on the same page. We've actually got between that molecule and 3 Phase II programs that are running within Roche, there's different mechanisms that have been looked at in diabetes. So our 483, the one that many of you have heard me talk about before, the insulin sensitizer, that we've got the rat carcinogenicity data which we needed to know –the whole class needs that before you go to 6 month treatments. It's not squeaky clean. It does need some interpretation. That's why we need some time in front of the FDA, both to share that data to make sure that's in the data set with which the FDA look at all the candidates, but at the same time we hope to get some clarity that says, "Can we create the Phase III a differentiated molecule or is that mission impossible?" So after we've had that, we'll give some advice on what we plan to do with our '483.

Then there's a DPP4. We're probably No. 2, No. 3, No. 4 in the market. It depends on where you take a view. That's in Phase II and once we've got some data, that will give us some sense we're onto something there.

And the final molecule in diabetes is a GK2, our terminology. This is a new mechanism of action –I'm not a scientist –I couldn't begin to explain to you probably the way that it works, but I'm told that we're in the lead as far as this mechanism is concerned. So it's my hope that out of these 4 different mechanisms in the series of Phase II's, we could be on to at least one of those that

would make a significant Phase III type program. So that would be just covering the diabetes area.

Female Voice: When you were talking about your GLP I use, you said that one of the features that you would look for was extended dosing. Is that compared to Biata [sic] or is that compared to LER [sic]?

Burns: We're taking both into account, yes. There's a combination also. I'm not fixated on a timespan yet. I want to see what the data supports and then we can take a view, how does that then look against the competition. But that alongside what we understand of the tolerances, there are hypothesis there. Because I'm not sure that whether it's once every week or 2 weeks or 4 weeks or whatever, is the profound driver if one of them has a higher instance of nausea than the other. I think a combination will probably be . . . of the experience is what will determine, "Does this look marketable?"

GEORGE LEAVES

Male Voice: Just a quick question on the Phase II program. Is there any update on your oral VLA4 program?

Burns: The VLA4?

Male Voice: Yes.

Burns: So this is known also as an integrin antagonist and was one of 4 Phase II programs that indirectly got hit or part by the Tesavri [sic] case where with Desavri [sic] also as an integrenin antagonist, but with a monochrome antibody and the experience that they had, FDA, and we understand why, said, "Look, let's wait a minute." So that's where we are. That is still on hold.

My understanding is that the Tesavri [sic] review is March and we're having some internal discussions that would say, "If that is cleared for Desavri [sic], then we need to say, "On what basis is it cleared." Does that open the way for the Asma work—the Phase IIB program that we had planned that was on hold. Or given what may be on there and hard to define as a class effect, should we look at one of the other programs we were planning to start which was itself in multiple sclerosis. Because if there is a way forward for Tesavri [sic] coming back on the market, that may be the more recognized acceptable way of getting proof of concept of whether our oral products actually have some of that clinically utility that the monochrome antibody demonstrated. So it could be either avenue that we go down, but we need to hear the Tesavri [sic] results first. Okay.

Male Voice: Roche has done a wonderful job in transitioning from primary care focus to specialty focus. I noticed that in terms of the projects in research as opposed to development, a large number are either in narrow psych or in cardiovascular metabolic—areas that tend to be more primary care, at least partially primary care.

What does that pretend—a few years down the road you won't need as large a primary care sales force because more decisions are made centrally or because of the options of partnering or just because of the high drop out rates in those area?

Burns: Well if we take the journey one step earlier, the challenge to the researchers is, "How do we build that clinical differentiation." So there are some, I agree with you, it looks more obvious at the start that this could end up in

primary care. We're pretty agnostic as to whether it goes primary care or specialty. What's more important is there was enough differentiators to get into the market. The days of "Me too" or "Me marginally different" marketed like hell, I think are really struggling as you go down the line here. That has to be to justify in terms of pricing, reimbursement and all the rest of it. There needs to be something in there for society, rather than just "We're the same guys on the block", unless you just want o to pay a price.

So what is the clinical differentiation that should be there. Then we should follow it through. If we're the VCaminasra—I don't know at the moment if that could end up as add-on therapy with a specialist initiation or whether it ends up as a primary care displacement for Singular or something else. It's difficult to know at an earlier stage of the journey. We have to be prepared to say, "We create the differentiation." Then if it needs a primary care field for us, I still characterize that in 2 ways. There's a real share of voice type market where there is plenty of hungry primary care companies around and we can just partner or if it's a build market area and it's education and build. That takes 1000 people, 1500 people, 1, 2 or 3 field forces in the U.S. It's not a big show stopper. So we could build that. We could put that in place in time. I'm not seeing a requirement for that this side of 2010 from the way the pipeline's looking. We're probably in a rather sweet place I think for this country, for this market with 600-700 primary care people on Boniva, with Panaflu—it's more than enough than we need.

And because of a noisy share voice market, we've partnered with GSK and that's fine. So, but we're not in a position where some of the companies are,

of having to say, "How do we create enough food for a 5 or a 7 or a 10,000 man-field force?" And I do think we can adjust the size of that. That's almost a tactical response later on as to who we need to see and how we need to see it. In a similar way you should expect us to build a field force for rheumatology as we come down the track with both Rituxan and Actemra.

In the U.S. Rituxan will be with Genentech and Actemra will be with the Roche side. So Roche will need a field force for rheumatology. In Europe, we got Roche field forces, but there's also some Chugai field forces in France and Germany and in the U.K. So there we can also either build that or expand our own activities. They're not show stoppers because it's not a huge field forces. So I think we're in a pretty decent place to be nimble. And not to just say, "Oh, we might need..." I think by the time we get there in 2010, you will have seen a dramatic reduction in the U.S. field forces.

The intriguing part I've always felt about primary care in this country is at what point does a sample lose its economic value? Because if you look at the sheer coverage and call rate in this country, and I think the average now is down to about 2 minutes per doctor, and something like 60% of the calls are made with the sample covered, rather than with a warm human being. So you've got a tremendous churn that's in there. And that's primarily because the sample has an economic value.

In many other countries of the world, there isn't that economic value for the sample and we maybe see doctors 4 to 10 times per year on a planned basis. And the doctors say, "Come when there's something new." Your legal entity can

have 4 calls or 8 calls a year and we don't care what the name of the marketing force is that you think you're putting in place. Your legal entity can have those calls. Use it to come to something that's a different model—a different business model.

But you could argue as the Medicare provisions come down, as average net selling price is more visible, and then that says to some customers, "Hey, wait a minute. Why am I paying above average?" It also says to competition, "Wait a minute. If my competitor's average books of business are at this actual selling price, rather than wholesale acquisition costs, then a new level of intensity of competition takes place. If you have a 6 month time lag and price increases, there are price decreases you can put in place through Medicare and the average selling price. This may temper some of the pricing. Now this may be an outsider's view looking in, but I do see that some of the dynamics of the market are changing and that's maybe why we also see some of the other companies addressing their size of the structure and shape.

Ed: On Erythropoietin and market in Europe, what are your expectations for the number of players and follow on biologics? Do you have any thoughts – expectations of timing? And then second question, I'll wait.

Burns: I'll go for the first one first then. So for biosimilars in Europe, or follow-on biologics, there is now and has been a draft. If you take as a slight different position in U.S./Europe. In the U.S. we don't expect any provisions in biosimilars and follow-on biologics until about 2007/2008.

In Europe, the authorities have said, “We’ll take it almost product area or by product area.” So the first one that we’ve taken a view on is growth hormone and we now have a first biosimilar from Sondo [sic] called Omnitrope and into the growth hormone area. The draft advice notes on EPO have been out for discussion and I think they’re just about to be ratified. Now these do require clinical trials to establish the safety and efficacy. Some of the elements that we asked for as an industry saying, “You can’t just assume that this should come in with simple data.”

Given particularly as many of you know the Eprex experience in Europe, changed the stabilizer potential interaction of the new stabilizer with the molecule and the rubber [inaudible] and you had an aggregation of protein and PRCA. So this told them from a regulatory point of view, “Be cautious; make sure there’s good clinical data.” And of course the fundamental of all of this is that the cell line is unique to the originator. The end process controls are unique to the indicator. So anyone else coming along has to have their own cell line, should then have their own in process controls and therefore perform clinicals to show the safety efficacy and quality dimensions. So a little bit closer to the new molecule.

Now having said that, what do we see playing out? Probably this will be in place. There’s been quite a number of companies working on a biosimilar for Europe. Maybe some of them have done the clinical trial work at risk and maybe can satisfy with what they have. Let’s say some of them come in with a dossier.

That's probably right at the end of this year or into early next year before the next ones make it through.

And the only other wild card which I view more like a biosimilar could be the former TKT product which is now with Shire and which given the way that they're battle took place, they could no longer produce it in the U.S. So Aventis at the time was preparing for a production in Europe and ultimately that may come through. But of course it's not been an active clinical trial build up so it's not gotten nearly the same dimensions for claims that we have or the other 2 guys have. But it may come in towards the end of the year. That would be our best estimate.

Male Voice: Just a minor, or less significant product, or an earlier stage product I should say. The CTP inhibitor that you have filing after 09, does that assume that you need outcomes data in order to file?

Burns: It is likely, but I think at the moment our preoccupation with this CETP, the product that increases his HDL that we licensed in from Japan Tobacco, as we shared with many of you, we've been on a de-risking program first of all.

Given that the clear profile here, why was Roche attracted to Japan Tobacco? It was because we didn't have Avastin. And this was the reason why they wanted to see somebody who would develop it, but it could be used with multiple staffings, rather than a fixed dose combination. Or it could even be used with monotherapy for a relatively smaller subset who just have low HDL. So we've first of all been on a de-risking strategy and then if it jumps those hurdles, yes, we recognize it will probably have to go into fairly large trials.

Also for completeness we do have one of our own molecules, that's just one step behind that. And there is also a potential access to a backup molecule from Japan Tobacco. So out of that whole range of interventions, we hope again to find something that will in time be a good clear market entry. I wouldn't like to say which one of them is ultimately going to jump the hurdles right now. More to go.

Okay, so apparently we're 5 minutes before you can either stay with me or you can change . . .

Male Voice: In terms of biological biogenerics, what is your sense of the competitive landscape of the Indian biogeneric company like Biocon and Orca [sic], for example?

Burns: There is a considerable focus obviously by the Indian government and by one or two players like Biocon—Mr. Shaw is very active in the area. First of all I think in producing recompetent insulin for India, that has been the first focus. Then it's interesting—we visited a number of the facilities in India. What you see play out here is—yes, a focus and some companies paying particular attention, but it's the same capital invest. It tends to be the same vessels from the German or the American manufacturers. So the actual cost of the plant, it's really only the cost of the land that may be less, but the actual physical cost of the equipment and all the rest of it is not so far away from the costs that one, we would have in Europe or that people have in America. So I don't see that the cost of the plant is going to make a profound difference to the cost of goods.

Everyone is entitled to their own opinion in this world. It's still a free world, thank God. But of course, given the margins on biologicals, yes of course they've got plenty of margin to play with—no debate—this is not the most critical element. Nor indeed are labor costs the most critical element—these tend to be fully automated or almost fully automated sites. So I do see them as a serious contender from the manufacturing point of view. And then the question is, “Are those companies going to build up the clinical development capability to take them into highly regulated markets or are they going to be satisfied by going into lesser regulated markets for entry?” In a similar way to some of the Argentinian companies or the Cuban companies that are active today.

Male Voice: To focus a bit more on the longer term looking at the U.S. market, you spoke of wanting to be on parity when CERA does come to market. Currently Amgen is enrolling two very large studies looking at not only pre-dialysis and cardiovascular outcomes in regard to that as a CHS study. Do you have plans to begin enrolling or . . .

Burns: In the areas that we focused on—pre-dialysis, dialysis and oncology—yes, expect us to participate fully. We have not started in some of the other more peripheral areas of use of EPO which I do see and recognize that with Amgen and with Johnson & Johnson have embarked on.

For example in – we've had discussions with Johnson & Johnson –this was about a year or two years ago, in looking at the role of EPO, alongside Ribavirin and the hepatitis studies because Ribavirin can cause anemia. So there are some of these sorts of more peripheral uses which tend to be also with other

prescribing physicians than the prescribing physicians in oncology and dialysis and pre-dialysis. So we'll concentrate at the beginning on competitive noise and share a voice in the areas we choose to enter.

Male Voice: Do you have a timeframe for follow-on indications at this point?

Burns: At this point, no. Okay.

Okay, anyone that wants to move to one of the other sessions, thank you very much for the interest. If you want to stay, you're very welcome.