EXHIBIT 5

RBC Capital Markets Global Healthcare Conference

Company Participants

- Chuck Triano, Vice President, Investor Relations

Other Participants

- Randall Stanicky, Analyst

Presentation

Randall Stanicky {BIO 6967011 <GO>}

Great. Thanks everybody for joining us for our next virtual fireside chat here. We're kicking things off again with our next company. I'm Randall Stanicky, the pharmaceuticals analyst here at RBC Capital Markets. And next up, we have Pfizer. The stock has proven resilient in the current pandemic. It's one of the names that we've been highlighting as defensive and wanting to own in this environment.

So with us to chat on the company current dynamics and outlook here, Senior Vice President of Investor Relations, Chuck Triano. And so Chuck, first, I just want to say thanks for joining us. It's great to have Pfizer at our conference. So thank you for that.

And then to start off, let's jump into DMD and the market opportunity. This was something that you guys sounded pretty excited about on Friday, relative to the data, you're pushing into Phase III early second half. To me, there seems to be more debate with investors around the competitive dynamics with Sarepta. So I have two questions. The first one, how do you think about the DMD market opportunity for Pfizer.

And again, I mean, you guys talk about scaling up here on a presumption of success, so maybe touch on that and then I have a follow-up.

Chuck Triano {BIO 3844941 <GO>}

Yeah, sure, sure. Yeah. And thanks for hosting the conference. So pleasure to be here. If we look at the prevalence, we see about 40,000 individuals effected with DMD in the developed countries. So within that 40,000 there is probably 10,000 to 12,000 affected in the US markets here, so certainly a significant market. Obviously very dire unmet medical need on that front and I'll maybe just add quickly that sometimes, one of the first questions that we get is just about gene therapy in general and whether it is a focus area for Pfizer or is it more just a one-off and I just want to really emphasize that the whole rare disease business inclusive of gene therapy is a very high priority for Pfizer. Right, as you're probably aware, we are stepping to therapeutic area business units, rare disease has its

own business unit, right, its own zone Chief Scientific Officer, Chief Development Officer, President.

So rare disease inclusive of gene therapy is a very high focus area for Pfizer. And even with DMD, we've talked about spending around $800 million of investment in manufacturing capacity down in North Carolina, so not just for the DMD program, but for some hemophilia programs as well. So this is a big area of focus for Pfizer and an important area. And I guess -- I just wanted to add that sometimes the first question I get is why is Pfizer in gene therapy? We are here, because we think -- we think we can -- we have a very comprehensive and a very competitive end-to-end capability between manufacturing, clinical trial development and then marketing, right. So we've been in rare disease for quite some time, have a lot of experience here, and this is one area where we think we are absolutely playing to one of our (Technical Difficulty). So I'll stop there and go onto your next questions and the topic.

Randall Stanicky {BIO 6967011 <GO>}

Yeah, I mean you're clearly committed and so there's a lot of focus on this program as the big driver within gene therapy and rare disease in general. So if you look at what we've heard coming out of Pfizer there is some debate around efficacy as you and Sarepta have used different study measures, you developed an LCMS method or mass spectrometry. Sarepta uses Western blot. But I thought you said probably you looked at both and I also think your patient age was slightly older which matters. How do you characterize your data versus Sarepta's understanding that they're not totally comparable?

Chuck Triano {BIO 3844941 <GO>}

Yeah and right. There's always the danger of cross-trial comparison. Right. So our mean age was a bit over 8-years-old and I think the first facts to point out is when you get into the older age group. This is where you're going to see some natural regression right. So you're going to see natural decline in the boys at that age as opposed to maybe in the 4 to 6-year-old age group, you're seeing natural improvement. Right. Regardless of any intervention. So as you have older boys, you are showing improvement in a cohort that you would expect to decline as opposed to showing improvement in an area where you would expect some improvement. So there is one difference there in terms of just the bandwidth of the ages that we looked at. For us, we have seen right now, we've shown the most comprehensive efficacy data for either program out there, very encouraging consistency in the results is what we've seen. And that's one big point I would stress for us is that consistency of the results.

Well we've used some different measurements, we mentioned -- we're using LCMS, which we view as more modern, more predictable, more accurate approach than Western blot. We did mention on the call that when we looked at Western -- looked at Western blot with some of our data in some instances, the readings exceeded 100% of the normal value of the CR [ph] assays.

So in terms of LCMS, we show it to be a much more qualitative measure of dystrophin levels -- higher -- more highly sensitive with good reproducibility and a wider dynamic

range. So we mentioned that we're talking with the agency and has been very encouraged. We're showing them our data and how we're measuring it, but we do see differences there. We have runs as we pointed out in the call, we have runs in Western blot, so we'll see what we do with that data, but that is also a difference in terms of how we're measuring.

So couple of apples versus oranges in a sense in terms of the comparability. But the encouraging consistency in the results is what we are happy to have. No need for high steroid use there and when we talk about the adverse events, we've had three that we reported, right, they happened early, they all rectified and once we saw those, we made some amendments to the protocol, where the protocol now is to look for complement activation and platelet reduction in the first two weeks with instructions to treat with an anti-complement drug as necessary. Right.

So the patients always don't need to be inpatient for this, since they are going to be monitored for liver function, they're not going to be too far away from a medical center anyhow and then I know -- we showed data on the nine boys, where we had the three SAEs that resolved. We've dosed an additional three, so we've got 12 boys dosed. We have not seen any additional SAEs at this point in the -- in the Phase 1b study.

So I think as we look at the view that this may be decades, if not a lifetime treatment versus the initial lead-in period of 14 days with with adverse events that were manageable on a benefit risk profile. That's why, we're very encouraged. Right. So again consistency in the results, manage and understand adverse events and the benefit that we can potentially provide these boys has us very bullish on the program. And as we mentioned, we're looking over the next several months that will start in the Phase 3 program that is planning to enroll 99 boys.

Again, this is the Phase 1b data more to come here, but in terms of what's out there to look at clearly the most comprehensive efficacy data of either of the studies, is that the data that we just showed.

Randall Stanicky {BIO 6967011 <GO>}

So that may stay in the under-appreciated pipeline bucket for now. And when launched in January, one of the biggest push backs was 2026 LOE and now 2026 and the current pandemic seems really, really far away, but one of the themes that did stick was you do have some under-appreciated pipeline and you guys have been wanting to discuss that. You push the Analyst Meeting for September for obvious reasons, given that the pandemic, but as you think about some of the things that Pfizer thinks that the Street is missing, what are those? You file tanezumab, you belt [ph] the PALLAS for citinib soon in atopic derm. The Street deals look warm on those, if you were to step back and say, okay, here are programs that Pfizer is most excited about, what would those be?

Chuck Triano {BIO 3844941 <GO>}

Yeah, sure, sure. Thanks. Yeah, it's interesting. Right the LOEs which start probably second half of 2026 and it's not that all of LOEs happen in 2026. Right, it's spread out between '26 and really '29. Paragraph one, sentence one is that if you are launching drugs on a regular basis. That's part of the business, right. So that's not a surprise. The fact that we don't have big efficacy for the next few years is more a reflection of (Technical Difficulty) R&D productivity 12 years ago, right, because we didn't have products to launch.

So for us having LOEs is not something that we say well that's really peculiar how are we going to manage that. And I'd also add, when we look at sell side models generally, the LOE cliff in totality, in the back half of the decade (Technical Difficulty) between $18 and $20 billion. I think we'd probably agree with that. But I'd also say, when we take a snapshot of our pipeline today and to your question, Randall. When we take a snapshot of the pipeline today. Again this is ignoring any future business development and just take a risk adjusted view of our pipeline. We have significantly more in terms of revenue generation from the pipeline, than what the projections are in terms of revenue lost.

And so if you look at the R&D Day, how we're and this goes right to your question, how we are determining what to focus with the shareholder base and investors and analysts with rather than saying we've got 70, 80, 90 programs look how many we have. This is about quality and so we made a couple of different cuts. We looked at compounds that we thought would be of most interest because one in almost all cases what we want to discuss launching by 2025 or at the end of 2025 or sooner. Right so this way, you can bring in compounds that would start to immuliarate LOEs. Two, we took a look at compounds -- again, this won't be all of them, but for many where we can show some new data, always easier to talk about why you're excited when you've got some data to show.

And then the third cut, we looked at our internal risk adjusted revenue projections for the -- for those compounds. And then we took a look at sell side models and we took the ones where there were the biggest gaps in terms of what we think on a risk adjusted basis and many of the sell-side models. And that we fully understand that from some compounds at NLSA [ph]. I haven't -- I'm aware of it, but I've seen no data. I haven't heard you talk about it, we don't expect that they're necessarily going to be modeling revenue. But just to run down if we've got, I don't know, 18 analysts or so, you mentioned abrocitinib right so.

Phase 3 data going to be filing I think about a third of the models have any revenue at all for abro. If I stick with the I&I, we've got our JAK3 TEC for alopecia. Right, this is post proof of concept in Phase 3 maybe a quarter of the sell-side models have any revenue at all there. If I look at our internal medicine area, which is probably an area in terms of the revenue potential, where we might see the biggest -- biggest potential in terms of single product, we have a post-proof of concept.

If you look at NASH a DGAT2 within ACC. Again, it's post proof of concept is -- are there any revenue in any models out there? No. We have the Akcea program right for high triglycerides, which is going to start a Phase -- moving toward Phase 3, not being modeled. If I look at gene therapy, right our hemophilia A, hemophilia B, again both programs that already have proof of concept, two or three models showing revenue at all

there. And then looking at our RSV maternal vaccine where on our earnings call, we mentioned, we just got positive Phase 2 data there that's not modeled at all.

And then the pentavalent meningococcal vaccine also post proof of concept, not being model. So a lot of companies like to talk about everything in their pipeline and I saw one analyst note that said. But most of the compounds these companies talk about are all pre-proof of concept highly risky. The ones I just listed are have proof of concept already.

So the thought is that we want to show you our work. We want to show the community why we're excited. We have up to the investment community to do their own homework and see if they agree,disagree, but we find it's always easier to -- to pick a meaningful and manageable number of compounds, show our work with some data, with some patient analytics, market sizes and then talk about how we see ourselves fitting in but that's usually the question that you just asked, what is Pfizer excited about, what is Pfizer focused on and why?

So I think when we get to the Analyst Day, we'll have a good -- a manageable number of compounds that we can deep dive and move there, but the short answer is right now, there is a lot that we have internally with -- with good risk adjusted profiles that are not yet being included in analyst models. So when people look at the quote cliff, it becomes a one-sided story externally. But that's why I say internally, we don't see it at all as a one-sided story. In fact, if anything, we see it more one-sided toward. We have more -- more than enough to replace with cell therapy [ph] and again that does not include any future business development.

So I'll stop there on that question.

Randall Stanicky {BIO 6967011 <GO>}

Yeah. And then if we pivot to what's probably definitely not in Street models. You can look at COVID-19 therapy or vaccine obviously with Moderna's update. A lot of focus around vaccines right now, but as we step back. There is also a lot of focus on where Pfizer is at. I think, Albert was recently quoted as saying, you guys could be in a position to deliver millions of vaccine doses of Bn1 sticks [ph] to by October and so just in light of some of the news flows the last couple of days, how are you guys thinking about COVID-19 from either a therapy or vaccine perspective.

Chuck Triano {BIO 3844941 <GO>}

Yeah. So we we've got both. We're in the clinics now with our partner BioNTech, right. And so we've got an mRNA vaccine and I'll say plural vaccines. We're testing four different variants of an mRNA vaccine. So we're testing, not just the spike protein, which we are testing, but we're not just testing that -- that's Moderna's approach, and I'm not saying that that's a bad approach at all, but in addition, we're testing, both the spike and the receptor binding domain. So which offers a different hypothesis and allows us then to select based on clinical data, the best one or two hypotheses to move forward here.

Right. So as we look at that, we are looking to dose just under 400 patients with each of the four variants of the vaccine. One is a self-amplifying version of that. We have two modified RNA and one with unmodified RNA. So we're looking at those and the plan would be -- as we move forward and I expect, we'll probably be in a position, and we've got our partnership here, so I can't commit to everything. But I would think by June sometime, we should be in a position to have some early antibody data there and presuming that one or two of the programs starts to show itself and emerge as probably a best hypothesis. We would look to move to sort of a Stage 2 of testing, where we'd get into now closer to 2500 patients and continue to add on the database.

And so that would run really through the summer time. And then after that, again, presuming things continue to go well and we're seeing a good profile emerge. We've said in the fall, we have probably close to 8,000 total participants on vaccine. We'd be manufacturing the lead-- lead candidate, we'd be manufacturing at risk. We'd be in a position to have tens of millions of doses if successful this year. And then hundreds of millions next year.

So really kind of growing the clinical study, reporting data maybe not quite real-time, but more of a back and forth with regulatory agencies in terms of as we get data in to supply them with data and we can do a much -- we think quicker analysis of the data. But I think our view having the four different variants of the MRNA vaccine, both the spike in the RBD, may be an advantage here. As we look to move quickly toward a vaccination.

We've got manufacturing capacity at our existing facilities there. So we're very, very hopeful that one of the four programs will look good. And then on antiviral, while we have screened out a lead compound. We've had some antivirals in our library back from SARS. They had not been in -- in preclinical tests at that point, but we had with the third party screened out and have looked to -- look and have identified a lead candidate that we'll start looking -- looking at that.

We're also looking at Xeljanz. There is a study going to occur in Italy at Xeljanz looking if there may be some impact on the cytokine storm that we're seeing, as part of the ramifications of COVID-19. So several irons in the fire here, Pfizer in terms of decision-making and resource allocation moving very, very quickly. And this is led from the top down from -- from the CEO level down doing everything we can to as safely and as quickly, look for vaccines or therapies here.

So the company is moving very, very quickly. The whole leadership team and clinical development team highly, highly focused here which is -- which is what you need, right.

You need a company and not just Pfizer but you need other companies, large companies that can make the investment that have the resources in terms of clinical studies manufacturing and look and if it doesn't work, we're not going to go out of business. Right. But we're able to put our best -- our best effort forward and just given the experience we have. We're very hopeful that we can -- we can get a therapy here.

Randall Stanicky {BIO 6967011 <GO>}

So a good case scenario has you in the market on a vaccine with millions of doses in October. At what point, would you be in scale up mode by a good part of the country?

Chuck Triano {BIO 3844941 <GO>}

So I think -- we thought -- we think if it's -- we'd have tens of millions, probably more and more in emergency use utilization and then we would look to see where is the (Technical Difficulty) and exposure there. And then as we look at next year, without giving exact numbers, we have said hundreds of millions of doses as we move into -- into 2021, so it's going to be interesting -- it's also, interesting indeed the one version, the one variant the self amplified some of the pre-clinical studies show that you could need up to maybe 50 times less dosing material for that compound. So that would really expand the ability.

But I think for us manufacturing into hundreds of millions is clearly a -- easily a 2021 event for us.

Randall Stanicky {BIO 6967011 <GO>}

Got it. We're in the last couple of minutes. But I did want to ask you just on business development outlook, look as you get past this Upjohn closing, you're going to have $12 billion in proceeds from Beatrice, you'll pay down debt with that that's going to bring debt down to net leverage of closer to call it 1.5 to sub 2 times and you're generating close to $10 billion in cash flow year. So the argument or the support to go do deals is there and I understand Pfizer's messaging right. There's no need to run out and do a big deal. That's only going to add to that the LOE issues in late 2020s when you could do mid to late-stage pipeline deals that can help you grow through that 2026 LOE.

How are you thinking now about deploying capital. I mean, should we be looking at Pfizer getting more aggressive coming out of this pandemic and are you seeing deals currently?

Chuck Triano {BIO 3844941 <GO>}

So I think we're -- I mean, we always see deals and I guess, there is no necessarily pattern that you have to follow meaning steady deals one a quarter or what have you, sometimes they seem to come in flurries as well. We just brought in a Lyme disease vaccine that's in Phase 2, right. So we've been doing -- we've done things in rare disease in vaccines. So we've been steadily building on what we know best. So when we look at deals, we are, for the most part, sticking to our key therapeutic areas because you are less likely to make mistakes. If you've got a real talented team in the rare disease with the vaccine or the I&I space, where you really know what to look for when you're looking to source externally. So again less likely to make mistakes as opposed to buying into an area that you don't know. So I think as when we focus on what we're looking at. Revenue now is not our issue, right.

We've said at least 6% on the top line, in terms of a revenue CAGAR, right. We were saying about 6, now we're saying at least 6% through the end of 2025. So it's not about bolting on revenue, now, right. That was more in the Hospira, the Medivation deals. It's

really looking to what your earlier question was about supplementing the internal pipeline for this back half of the decade. So that almost lends itself more often to doing licensing deals and maybe one-off deals for compounds that are in Phase II or so, that we can add a lot of value to given the expertise, if we stick with the areas that we have.

Look, we never say never. Right.

There is no upside to saying, we will never do something because you never know when the facts change or opportunities present themselves. But right now, our focus really is on the back half of the decade. And as a pure play biopharma company post Upjohn, right, it's all about the pipeline and you really want to -- you want to be carve yourself out as a real winner in a manageable number of therapeutic areas.

I think the old Pfizer way back right was in a lot of different therapeutic areas. But -- but didn't really commad many of them. So I think that's how we look at, look at BD. When I look at the $10 billion to $11 billion in cash flow, capital allocation and dividend, I'd say is very -- will remain an important part of the Pfizer story and a growing dividend. Right.

So that takes a big chunk of that cash flow, CapEx is probably a little less than $2 billion a year.

So that leaves you in terms of cash flow that's not allocated to either the dividend or CapEx. It leaves you know 1 billion to 2 billion leftover to redeploy in the business, now we can always borrow for opportunities, but if it is a bit of a different story as opposed to having $5 billion or $6 billion or $8 billion in cash flow, kind of left over after your dividend and CapEx every year.

So it's a different story. So, I think to our view, we're always looking, I think we do see a lot of interestings. I know we see a lot of interesting signs out there that we're -- that we're pursuing. And we've got a reputation now is becoming a very good partner is I'd say as opposed to a decade or 2 ago, where it was a different story here.

So again, we never say never to anything but again with our, I would echo what we've been saying, generally is that our main focus is to bolster the areas, where we already believe we have the right people, the right platform and we want to add more compounds into those areas.

Randall Stanicky {BIO 6967011 <GO>}

That's helpful color and probably a good place to end as well. We're a couple of minutes over. So I want Chuck -- thanks for joining us. We're glad we have Pfizer at our conference. And for those on the line. Our next session starts in three minutes, and that's the keynote with Dr. Scott Gottlieb, who coincidentally Chuck is also on the Pfizer board. So thanks, everyone.

Chuck Triano {BIO 3844941 <GO>}

Thanks, Randall. Thanks everybody for your attention. So long.

Randall Stanicky {BIO 6967011 <GO>}

Take care.