Pfizer’s LORBRENA® CROWN Study Shows Majority of Patients with ALK-Positive Advanced Lung Cancer Living Beyond Five Years Without Disease Progression

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An unprecedented 60% of patients remain alive without disease progression after five yearsUpdated results show continued 81% reduction in risk of progression or death and 94% reduction in progression of brain metastases compared to XALKORI®

NEW YORK--(BUSINESS WIRE)-- Pfizer Inc. (NYSE: PFE) today announced longer-term follow-up results from the Phase 3 CROWN trial evaluating LORBRENA® (lorlatinib, a third-generation ALK inhibitor, available in Europe under the brand name LORVIQUA®) versus XALKORI® (crizotinib) in people with previously untreated, anaplastic lymphoma kinase (ALK)-positive advanced non-small cell lung cancer (NSCLC). After five years of median follow-up, median progression-free survival (PFS) based on investigator assessment was not reached with LORBRENA, with an observed Hazard Ratio (HR) of 0.19 (95% Confidence Interval [CI], 0.13-0.27), representing an 81% reduction in the rate of disease progression or death compared to XALKORI. Further, 60% of patients treated with LORBRENA (95% CI, 51-68) were alive without disease progression after five years compared to 8% (3-14) on the XALKORI treatment arm. These data will be presented

today in an oral presentation at the 2024 American Society of Clinical Oncology (ASCO) Annual Meeting (Abstract LBA8503) and have been simultaneously published in the *Journal of Clinical Oncology* .

“These results from the CROWN trial are unprecedented, as the majority of patients on LORBRENA are living beyond five years without disease progression,” said Roger Dansey, M.D., Chief Development Officer, Oncology, Pfizer. “These results are an excellent example of Pfizer’s long-standing commitment to discovering and developing scientific breakthroughs for patients, and support LORBRENA as a standard of care for the first-line treatment of people with ALK-positive advanced NSCLC.”

Lung cancer is the number one cause of cancer-related death around the world,i and an estimated 234,580 new cases of lung cancer are expected to be diagnosed in the U.S. in 2024.ii NSCLC accounts for approximately 80-85% of lung cancers,iii with ALK-positive tumors occurring in about 3-5% of NSCLC cases.iv Approximately 25-40% of people with ALK-positive advanced NSCLC may develop brain metastases within two years from initial diagnosis.v LORBRENA was specifically designed and developed by Pfizer to inhibit tumor mutations that drive resistance to other ALK inhibitors and to penetrate the blood-brain barrier.

“ALK-positive advanced NSCLC is typically aggressive and often impacts younger people in the prime of their lives,” said Benjamin Solomon, MBBS, Ph.D., Department of Medical Oncology, Peter MacCallum Cancer Centre, and Principal Investigator of the CROWN trial. “This updated analysis shows that LORBRENA helped patients live longer without disease progression, with the majority of patients experiencing sustained benefit for over five years, including nearly all patients having protection from progression of disease in the brain. These improvements in outcomes for patients with ALK-positive NSCLC represent a remarkable advancement in lung cancer.”

In this updated analysis, LORBRENA showed a 94% reduction in the risk of developing intracranial (IC) progression (HR, 0.06; 95% CI, 0.03-0.12). The median time to IC progression was not reached (95% CI, NR-NR) with LORBRENA and was 16.4 months (12.7-21.9) with XALKORI. In people without brain metastases at baseline receiving LORBRENA, only 4 of 114 developed brain metastases within the first 16 months of treatment, compared to 39 of 109 patients who received XALKORI. At the time of analysis, 50% of patients in the CROWN trial were still receiving LORBRENA compared to 5% of patients receiving XALKORI.

“Although ALK-positive advanced NSCLC accounts for only approximately five percent of all NSCLC cases, this translates to 72,000 people who are diagnosed worldwide each year,” said Kenneth Culver, M.D., Director of Research and Clinical Affairs at the non-profit organization ALK Positive. “These new results of the CROWN trial symbolize significant progress in the first-line setting for the targeted treatment of ALK-positive lung cancer, which has led to notable improvements for the patient community.”

The safety profiles of LORBRENA and XALKORI in the five-year follow-up were consistent with previous findings, with no new safety signals reported for LORBRENA. In this analysis, the most frequent (≥20%) adverse events (AEs) reported in patients treated with LORBRENA were consistent with the 2020 analysis of the CROWN trial, which included edema, weight gain, peripheral neuropathy, cognitive effects, mood effects, diarrhea, dyspnea, arthralgia, hypertension, headache, cough, pyrexia, hypercholesterolemia, and hypertriglyceridemia. Grade 3/4 AEs occurred in 77% of patients with LORBRENA and in 57% of patients with XALKORI. Treatment-related AEs led to permanent treatment discontinuation in 5% and 6% of patients in the LORBRENA and XALKORI arms, respectively.

Pfizer is continuing its commitment to help non-scientists understand the latest findings with the development of abstract plain language summaries (APLS) for company-sponsored research being presented at ASCO, which are written in non-technical language. Those interested in learning more can visit www.Pfizer.com/apls to access the summaries.

About the CROWN Trial

CROWN is a Phase 3, randomized, open-label, parallel 2-arm trial in which 296 people with previously untreated ALK-positive advanced NSCLC were randomized 1:1 to receive LORBRENA monotherapy (n=149) or XALKORI monotherapy (n=147). The primary endpoint of the CROWN trial is PFS based on Blinded Independent Central Review (BICR). Secondary endpoints include PFS based on investigator’s assessment, overall survival (OS), objective response rate (ORR), intracranial objective response (IOR), and safety. Given that median PFS was not reached after three years of follow-up, an unplanned post hoc analysis was executed with the intent to further quantify long-term outcomes based on investigator tumor assessment from this study at a clinically meaningful landmark follow-up of five years.

About LORBRENA® (lorlatinib)

LORBRENA is approved in the U.S. for the treatment of adults with metastatic NSCLC whose tumors are ALK-positive as detected by an FDA-approved test.

Please see Full Prescribing Information for LORBRENA® (lorlatinib) or visit https://www.lorbrena.com.

IMPORTANT LORBRENA® (lorlatinib) SAFETY INFORMATION FROM THE U.S. PRESCRIBING INFORMATION

Contraindications: LORBRENA is contraindicated in patients taking strong CYP3A inducers, due to the potential for serious hepatotoxicity.

Risk of Serious Hepatotoxicity with Concomitant Use of Strong CYP3A Inducers: Severe hepatotoxicity occurred in 10 of 12 healthy subjects receiving a single dose of LORBRENA with multiple daily doses of rifampin, a strong CYP3A inducer. Grade 4 ALT or AST elevations occurred in 50% of subjects, Grade 3 in 33% of subjects, and Grade 2 in 8% of subjects. ALT or AST elevations occurred within 3 days and returned to within normal limits after a median of 15 days (7 to 34 days); median time to recovery in subjects with Grade 3 or 4 or Grade 2 ALT or AST elevations was 18 days and 7 days, respectively. LORBRENA is contraindicated in patients taking strong CYP3A inducers. Discontinue strong CYP3A inducers for 3 plasma half-lives of the strong CYP3A inducer prior to initiating LORBRENA.

Central Nervous System (CNS) Effects: A broad spectrum of CNS effects can occur; overall, CNS effects occurred in 52% of the 476 patients receiving LORBRENA. These included seizures (1.9%, sometimes in conjunction with other neurologic findings), psychotic effects (7%; 0.6% severe [Grade 3 or 4]), and changes in cognitive function (28%; 2.9% severe), mood (including suicidal ideation) (21%; 1.7% severe), speech (11%; 0.6% severe), mental status (1.3%; 1.1% severe), and sleep (12%). Median time to first onset of any CNS effect was 1.4 months (1 day to 3.4 years). Overall, 2.1% and 10% of patients required permanent or temporary discontinuation of LORBRENA, respectively, for a CNS effect; 8% required dose reduction. Withhold and resume at same or reduced dose or permanently discontinue based on severity.

Hyperlipidemia: Increases in serum cholesterol and triglycerides can occur. Grade 3 or 4 elevations in total cholesterol occurred in 18% and Grade 3 or 4 elevations in triglycerides occurred in 19% of the 476 patients who received LORBRENA. Median time to onset was 15 days for both hypercholesterolemia and hypertriglyceridemia. Approximately 4% and 7% of patients required temporary discontinuation and 1% and 3% of patients required dose reduction of LORBRENA for elevations in cholesterol and in

triglycerides in Study B7461001 and Study B7461006, respectively. Eighty-three percent of patients required initiation of lipid-lowering medications, with a median time to onset of start of such medications of 17 days. Initiate or increase the dose of lipid-lowering agents in patients with hyperlipidemia. Monitor serum cholesterol and triglycerides before initiating LORBRENA, 1 and 2 months after initiating LORBRENA, and periodically thereafter. Withhold and resume at same dose for the first occurrence; resume at same or reduced dose of LORBRENA for recurrence based on severity.

Atrioventricular (AV) Block: PR interval prolongation and AV block can occur. In 476 patients who received LORBRENA at a dose of 100 mg orally once daily and who had a baseline electrocardiography (ECG), 1.9% experienced AV block and 0.2% experienced Grade 3 AV block and underwent pacemaker placement. Monitor ECG prior to initiating LORBRENA and periodically thereafter. Withhold and resume at reduced or same dose in patients who undergo pacemaker placement. Permanently discontinue for recurrence in patients without a pacemaker.

Interstitial Lung Disease (ILD)/Pneumonitis: Severe or life-threatening pulmonary adverse reactions consistent with ILD/pneumonitis can occur. ILD/pneumonitis occurred in 1.9% of patients, including Grade 3 or 4 ILD/pneumonitis in 0.6% of patients. Four patients (0.8%) discontinued LORBRENA for ILD/pneumonitis. Promptly investigate for ILD/pneumonitis in any patient who presents with worsening of respiratory symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, and fever). Immediately withhold LORBRENA in patients with suspected ILD/pneumonitis. Permanently discontinue LORBRENA for treatment-related ILD/pneumonitis of any severity.

Hypertension: Hypertension can occur. Hypertension occurred in 13% of patients, including Grade 3 or 4 in 6% of patients. Median time to onset of hypertension was 6.4 months (1 day to 2.8 years), and 2.3% of patients temporarily discontinued LORBRENA for hypertension. Control blood pressure prior to initiating LORBRENA. Monitor blood pressure after 2 weeks and at least monthly thereafter. Withhold and resume at reduced dose or permanently discontinue based on severity.

Hyperglycemia: Hyperglycemia can occur. Hyperglycemia occurred in 9% of patients, including Grade 3 or 4 in 3.2% of patients. Median time to onset of hyperglycemia was 4.8 months (1 day to 2.9 years), and 0.8% of patients temporarily discontinued LORBRENA for hyperglycemia. Assess fasting serum glucose prior to initiating LORBRENA and monitor periodically thereafter. Withhold and resume at reduced dose or permanently discontinue based on severity.

Embryo-fetal Toxicity: LORBRENA can cause fetal harm. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use an effective non-hormonal method of contraception, since LORBRENA can render hormonal contraceptives ineffective, during treatment with LORBRENA and for at least 6 months after the final dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with LORBRENA and for 3 months after the final dose.

Adverse Reactions: In the pooled safety population of 476 patients who received 100 mg LORBRENA once daily, the most frequent (≥ 20%) adverse reactions were edema (56%), peripheral neuropathy (44%), weight gain (31%), cognitive effects (28%), fatigue (27%), dyspnea (27%), arthralgia (24%), diarrhea (23%), mood effects (21%), and cough (21%). The most frequent (≥ 20%) Grade 3-4 laboratory abnormalities in patients receiving LORBRENA were hypercholesterolemia (21%) and hypertriglyceridemia (21%).

In previously untreated patients, serious adverse reactions occurred in 34% of the 149 patients treated with LORBRENA; the most frequently reported serious adverse reactions were pneumonia (4.7%), dyspnea (2.7%), respiratory failure (2.7%), cognitive effects (2.0%), and pyrexia (2.0%). Fatal adverse reactions occurred in 3.4% of patients and included pneumonia (0.7%), respiratory failure (0.7%), cardiac failure acute (0.7%), pulmonary embolism (0.7%), and sudden death (0.7%). In the Phase 1/2 study, serious adverse reactions occurred in 32% of the 295 patients; the most frequently reported serious adverse reactions were pneumonia (3.4%), dyspnea (2.7%), pyrexia (2%), mental status changes (1.4%), and respiratory failure (1.4%). Fatal adverse reactions occurred in 2.7% of patients and included pneumonia (0.7%), myocardial infarction (0.7%), acute pulmonary edema (0.3%), embolism (0.3%), peripheral artery occlusion (0.3%), and respiratory distress (0.3%).

Drug Interactions: LORBRENA is contraindicated in patients taking strong CYP3A inducers. Avoid concomitant use with moderate CYP3A inducers, strong CYP3A inhibitors, and fluconazole. If concomitant use of moderate CYP3A inducers cannot be avoided, increase the LORBRENA dose as recommended. If concomitant use with a strong CYP3A inhibitor or fluconazole cannot be avoided, reduce the LORBRENA dose as recommended. Avoid concomitant use of LORBRENA with CYP3A substrates and P-gp substrates, which may reduce the efficacy of these substrates.

Lactation: Because of the potential for serious adverse reactions in breastfed infants, instruct women not to breastfeed during treatment with LORBRENA and for 7 days after the final dose.

Hepatic Impairment: No dose adjustment is recommended for patients with mild hepatic impairment. The recommended dose of LORBRENA has not been established for patients with moderate or severe hepatic impairment.

Renal Impairment: Reduce the dose of LORBRENA for patients with severe renal impairment. No dose adjustment is recommended for patients with mild or moderate renal impairment.

About XALKORI® (crizotinib)

XALKORI is a tyrosine kinase inhibitor (TKI) indicated for the treatment of patients with metastatic NSCLC whose tumors are ALK- or ROS1-positive as detected by an FDA-approved test. XALKORI has received approval for patients with ALK-positive NSCLC in more than 90 countries including Australia, Canada, China, Japan, South Korea and the European Union. XALKORI is also approved for ROS1-positive NSCLC in more than 60 countries.

The full prescribing information for XALKORI can be found here.

IMPORTANT XALKORI® (crizotinib) SAFETY INFORMATION FROM THE U.S. PRESCRIBING INFORMATION

Hepatotoxicity: Drug-induced hepatotoxicity with fatal outcome occurred in 0.1% of patients treated with XALKORI across clinical trials (n=1719). Increased transaminases generally occurred within the first 2 months. Monitor liver function tests, including ALT, AST, and total bilirubin, every 2 weeks during the first 2 months of treatment, then once a month, and as clinically indicated, with more frequent repeat testing for increased liver transaminases, alkaline phosphatase, or total bilirubin in patients who develop increased transaminases. Permanently discontinue for ALT/AST elevation >3 times ULN with concurrent total bilirubin elevation >1.5 times ULN (in the absence of cholestasis or hemolysis); otherwise, temporarily suspend and dose-reduce XALKORI as indicated.

Interstitial Lung Disease/Pneumonitis: Severe, life-threatening, or fatal interstitial lung disease (ILD)/pneumonitis can occur. Across clinical trials (n=1719), 2.9% of XALKORI-treated patients had any grade ILD, 1.0% had Grade 3/4, and 0.5% had fatal ILD. ILD generally occurred within 3 months after initiation of treatment. Monitor for pulmonary symptoms indicative of ILD/pneumonitis. Exclude other potential causes and permanently discontinue XALKORI in patients with drug-related ILD/pneumonitis.

QT Interval Prolongation: QTc prolongation can occur. Across clinical trials (n=1616), 2.1% of patients had QTcF (corrected QT by the Fridericia method) ≥500 ms and 5% of 1582 patients had an increase from baseline QTcF ≥60 ms by automated machine-read evaluation of ECGs. Avoid use in patients with congenital long QT syndrome. Monitor ECGs and electrolytes in patients with congestive heart failure, bradyarrhythmias, electrolyte abnormalities, or who are taking medications that prolong the QT interval. Permanently discontinue XALKORI in patients who develop QTc >500 ms or ≥60 ms change from baseline with Torsade de pointes, polymorphic ventricular tachycardia, or signs/symptoms of serious arrhythmia. Withhold XALKORI in patients who develop QTc >500 ms on at least 2 separate ECGs until recovery to a QTc ≤480 ms, then resume at next lower dosage.

Bradycardia: Symptomatic bradycardia can occur. Across clinical trials, bradycardia occurred in 13% of patients treated with XALKORI (n=1719). Avoid use in combination with other medications known to cause bradycardia. Monitor heart rate and blood pressure regularly. If bradycardia occurs, re-evaluate for the use of concomitant medications known to cause bradycardia. Permanently discontinue for life-threatening bradycardia due to XALKORI; however, if associated with concomitant medications known to cause bradycardia or hypotension, hold XALKORI until recovery to asymptomatic bradycardia or to a heart rate of ≥60 bpm. If concomitant medications can be adjusted or discontinued, restart XALKORI at 250 mg once daily with frequent monitoring.

Severe Visual Loss: Across clinical trials, the incidence of Grade 4 visual field defect with vision loss was 0.2% of 1719 patients. Discontinue XALKORI in patients with new onset of severe visual loss (best corrected vision less than 20/200 in one or both eyes). Perform an ophthalmological evaluation. There is insufficient information to characterize the risks of resumption of XALKORI in patients with a severe visual loss; a decision to resume should consider the potential benefits to the patient.

Vision Disorders: Most commonly visual impairment, photopsia, blurred vision or vitreous floaters, occurred in 63% of 1719 patients. The majority (95%) of these patients had Grade 1 visual adverse reactions. 0.8% of patients had Grade 3 and 0.2% had Grade 4 visual impairment. The majority of patients on the XALKORI arms in Studies 1 and 2 (>50%) reported visual disturbances which occurred at a frequency of 4-7 days each week, lasted up to 1 minute, and had mild or no impact on daily activities.

Embryo-Fetal Toxicity: XALKORI can cause fetal harm when administered to a pregnant woman. Advise of the potential risk to the fetus. Advise females of reproductive potential and males with female partners of reproductive potential to use effective

contraception during treatment and for at least 45 days (females) or 90 days (males) respectively, following the final dose of XALKORI.

ROS1-positive Metastatic NSCLC: Safety was evaluated in 50 patients with ROS1-positive metastatic NSCLC from a single-arm study and was generally consistent with the safety profile of XALKORI evaluated in patients with ALK-positive metastatic NSCLC. Vision disorders occurred in 92% of patients in the ROS1 study; 90% of patients had Grade 1 vision disorders and 2% had Grade 2.

Adverse Reactions: Safety was evaluated in a phase 3 study in previously untreated patients with ALK-positive metastatic NSCLC randomized to XALKORI (n=171) or chemotherapy (n=169). Serious adverse events were reported in 34% of patients treated with XALKORI, the most frequent were dyspnea (4.1%) and pulmonary embolism (2.9%). Fatal adverse events in XALKORI-treated patients occurred in 2.3% of patients, consisting of septic shock, acute respiratory failure, and diabetic ketoacidosis. Common adverse reactions (all grades) occurring in ≥25% and more commonly (≥5%) in patients treated with XALKORI vs chemotherapy were vision disorder (71% vs 10%), diarrhea (61% vs 13%), edema (49% vs 12%), vomiting (46% vs 36%), constipation (43% vs 30%), upper respiratory infection (32% vs 12%), dysgeusia (26% vs 5%), and abdominal pain (26% vs 12%). Grade 3/4 reactions occurring at a ≥2% higher incidence with XALKORI vs chemotherapy were QT prolongation (2% vs 0%), esophagitis (2% vs 0%), and constipation (2% vs 0%). In patients treated with XALKORI vs chemotherapy, the following occurred: elevation of ALT (any grade [79% vs 33%] or Grade 3/4 [15% vs 2%]); elevation of AST (any grade [66% vs 28%] or Grade 3/4 [8% vs 1%]); neutropenia (any grade [52% vs 59%] or Grade 3/4 [11% vs 16%]); lymphopenia (any grade [48% vs 53%] or Grade 3/4 [7% vs 13%]); hypophosphatemia (any grade [32% vs 21%] or Grade 3/4 [10% vs 6%]). In patients treated with XALKORI vs chemotherapy, renal cysts occurred (5% vs 1%). Nausea (56%), decreased appetite (30%), fatigue (29%), and neuropathy (21%) also occurred in patients taking XALKORI.

Drug Interactions: Use caution with concomitant use of moderate CYP3A inhibitors. Avoid grapefruit or grapefruit juice which may increase plasma concentrations of crizotinib. Avoid concomitant use of strong CYP3A inducers and inhibitors. Avoid concomitant use of CYP3A substrates where minimal concentration changes may lead to serious adverse reactions. If concomitant use of XALKORI is unavoidable, decrease the CYP3A substrate dosage in accordance with approved product labeling.

Lactation: Because of the potential for adverse reactions in breastfed children, advise women not to breastfeed during treatment with XALKORI and for 45 days after the final

dose.

Hepatic Impairment: Crizotinib concentrations increased in patients with pre-existing moderate (any AST and total bilirubin >1.5x ULN and ≤3x ULN) or severe (any AST and total bilirubin >3x ULN) hepatic impairment. Reduce XALKORI dosage in patients with moderate or severe hepatic impairment. The recommended dose of XALKORI in patients with pre-existing moderate hepatic impairment is 200 mg orally twice daily or with pre-existing severe hepatic impairment is 250 mg orally once daily.

Renal Impairment: Decreases in estimated glomerular filtration rate occurred in patients treated with XALKORI. Administer XALKORI at a starting dose of 250 mg taken orally once daily in patients with severe renal impairment (CLcr <30 mL/min) not requiring dialysis.

About Pfizer Oncology

At Pfizer Oncology, we are at the forefront of a new era in cancer care. Our industry-leading portfolio and extensive pipeline includes three core mechanisms of action to attack cancer from multiple angles, including small molecules, antibody-drug conjugates (ADCs), and bispecific antibodies, including other immune-oncology biologics. We are focused on delivering transformative therapies in some of the world’s most common cancers, including breast cancer, genitourinary cancer, hematology-oncology, and thoracic cancers, which includes lung cancer. Driven by science, we are committed to accelerating breakthroughs to help people with cancer live better and longer lives.

About Pfizer: Breakthroughs That Change Patients’ Lives

At Pfizer, we apply science and our global resources to bring therapies to people that extend and significantly improve their lives. We strive to set the standard for quality, safety and value in the discovery, development, and manufacture of health care products, including innovative medicines and vaccines. Every day, Pfizer colleagues work across developed and emerging markets to advance wellness, prevention, treatments, and cures that challenge the most feared diseases of our time. Consistent with our responsibility as one of the world’s premier innovative biopharmaceutical companies, we collaborate with health care providers, governments, and local communities to support and expand access to reliable, affordable health care around the world. For more than 175 years, we have worked to make a difference for all who rely on us. We routinely post information that may be important to investors on our website at www.Pfizer.com. In addition, to learn more, please visit us on www.Pfizer.com and follow us on X at @Pfizer and @Pfizer News, LinkedIn, YouTube and like us on Facebook at Facebook.com/Pfizer.

Disclosure Notice

The information contained in this release is as of May 31, 2024. Pfizer assumes no obligation to update forward-looking statements contained in this release as the result of new information or future events or developments.

This release contains forward-looking information about LORBRENA® (lorlatinib) and Pfizer Oncology, including their potential benefits, that involves substantial risks and uncertainties that could cause actual results to differ materially from those expressed or implied by such statements. Risks and uncertainties include, among other things, uncertainties regarding the commercial success of LORBRENA; the uncertainties inherent in research and development, including the ability to meet anticipated clinical endpoints, commencement and/or completion dates for our clinical trials, regulatory submission dates, regulatory approval dates and/or launch dates, as well as the possibility of unfavorable new clinical data and further analyses of existing clinical data; the risk that clinical trial data are subject to differing interpretations and assessments by regulatory authorities; whether regulatory authorities will be satisfied with the design of and results from our clinical studies; whether and when any drug applications may be filed in any additional jurisdictions for LORBRENA for the treatment of patients with ALK-positive advanced NSCLC or in any jurisdictions for any other potential indications for LORBRENA; whether and when any such other applications may be approved by regulatory authorities, which will depend on a myriad factors, including making a determination as to whether the product's benefits outweigh its known risks and determination of the product's efficacy and, if approved, whether LORBRENA will be commercially successful; decisions by regulatory authorities impacting labeling, manufacturing processes, safety and/or other matters that could affect the availability or commercial potential of LORBRENA; uncertainties regarding the impact of COVID-19 on Pfizer’s business, operations and financial results; and competitive developments.

A further description of risks and uncertainties can be found in Pfizer’s Annual Report on Form 10-K for the fiscal year ended December 31, 2023, and in its subsequent reports on Form 10-Q, including in the sections thereof captioned “Risk Factors” and “Forward-Looking Information and Factors That May Affect Future Results”, as well as in its subsequent reports on Form 8-K, all of which are filed with the U.S. Securities and Exchange Commission and available at www.sec.gov and www.pfizer.com.

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