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EDITED TRANSCRIPT

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OVERVIEW:

Company Summary

LSEG DATA & ANALYTICS

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Editor

PRESENTATION

Terence Flynn - *Morgan Stanley - Analyst*

Great. Thanks so much, everybody. Good afternoon. I'm Terence Flynn, Morgan Stanley's US biopharma analyst.

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So I'm very pleased to be hosting Johnson & Johnson this afternoon. Joining us from the company, we have Joaquin Duato, the company's CEO and Chairman; and John Reed, Executive Vice President, Innovative Medicine, R&D. But thank you both so much for taking time out of your busy schedules to join us, really appreciate it.

QUESTIONS AND ANSWERS

Terence Flynn - *Morgan Stanley - Analyst*

Maybe we'd start, I thought high level, Joaquin. The company laid out some long-term growth targets at the December 2023 Enterprise Business Review meeting. And so maybe you could just level set us in terms of the progress you've made there, but also the rationale for providing those targets when you did?

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Yeah. Thank you. There's been a lot of progress in Johnson & Johnson since 2023. First, we have a more focused portfolio today. We have three focus areas in Innovative Medicine: Oncology, Immunology, and Neuroscience; and then three focus areas also in Medical Technology: Vision, Surgery, and Cardiovascular. So I think we have a very well-balanced portfolio that has a mix of innovation and growth that is driving a new cycle of accelerated growth for Johnson & Johnson.

Since 2023, we have done what we said we were going to do. We said we were going to be able to grow through the STELARA biosimilar entry, and that's what we are doing. We did it in '25, and we are also doing it in '26.

In both quarters, in Q1 and Q2, we were able to beat analyst expectations in top and bottom line, and also to raise our guidance. Our guidance [we shared during our Q2 earnings call] for '26 is 6.5% adjusted operational sales growth [at the midpoint] and 7.3% adjusted EPS growth [at the midpoint](added by company after the call). And for the first time for the company, we're going to be ahead of $100 billion in total revenue.

We also have said, and we said that in '23, that this was going to be the beginning of a cycle of growth, and we see 2027 being a better year than 2026, and we have line of sight to double-digit growth by the end of the decade for total Johnson & Johnson. So together,

combined, due to our existing portfolio, the new product launches, our pipeline, I believe today, Johnson & Johnson has one of the cleanest growth stories in our sector.

Terence Flynn - *Morgan Stanley - Analyst*

Great. Perfect place to start the conversation. You're hosting another enterprise business review here in early December. And so I know you're not going to get into a lot of the specifics because you want to save that for the day, but maybe just high-level preview of some of the themes that you guys are focused on as we look ahead to December?

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Thank you. So we are looking forward to that. We do it every three years, so it is an important event. There are two main topics that we plan to cover there. One is providing more granularity to double-digit growth by the end of the decade, which is a frequent question that we get from investors. We will provide more granularity on the state of our portfolio, our new product launches, and also our pipeline.

The second one is going to be to give you more confidence on the durability of our growth beyond 2030. So we will provide more information on our earlier-stage pipeline in order to be able to give you more confidence that this cycle of growth is going to continue, is going to be durable into the next decade.

Terence Flynn - *Morgan Stanley - Analyst*

Okay. Looking forward.

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Maybe the preview on that, if you just look at our pipeline with molecules that have achieved POC, they are now in Phase 3, de-risked, and moving forward. There are 12 molecules that have those criteria in the pipeline today. So we will give some insights into what we see as the opportunities there. On top of right now, in addition to DARZALEX, our top medicine right now, we have 10 in-market medicines that are still pretty early in their life cycle journeys and growing robustly.

Terence Flynn - *Morgan Stanley - Analyst*

Okay. Great. Looking forward to it. The other area I wanted to talk about at a high level is the policy front. Just anything that is on your radar as we head into the midterms here, Joaquin. I know you guys are very plugged into D.C.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Yeah. Compared to 2025, 2026 has been a more stable year from a policy perspective. I think we will agree all in that. It is likely that things may come up before or after the midterms, although I do not see pharmaceutical pricing as the core theme of this election. I think all of you know that there are other topics that are more discussed than pharmaceutical pricing.

I believe the things connected with affordability of medicines have been well-addressed with some of the changes that have been done in Medicare Part D that have addressed some of the tension that existed before. So I do not anticipate that the midterms are going to create significant noise from a policy perspective, although there is always something going on in this space, but I do not think there is going to be anything that is going to constitute a major change.

Things may change again into 2028, as we may have different changes there. But as far as the midterms go, I think that you may see some different ideas, but I do not believe that pharmaceutical pricing and affordability is going to be one of the main topics going into this election.

Terence Flynn - *Morgan Stanley - Analyst*

Okay. Great. The other one I want to touch on is just capital allocation, business development. And so I think high level, again, the company has become more streamlined, spun off the consumer business several years ago. Orthopedics, we saw some headlines over the weekend there. So maybe just talk to us about the shape of the business and as you think about divesting assets but also layering in additional assets where we are in that journey on that front.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

So a number of factors there. First, we have a strong balance sheet. We are only of one or two companies that have AAA credit rating, and we are proud of that because it's a reflection of our financial discipline. We are not married to that, but it's a reflection of the strength of our balance sheet and our financial discipline.

Our cash flow generation is strong, and we foresee that cash flow generation even becoming stronger as we accelerate growth into the rest of the decade, because that will come with also improved margins. So we are optimistic at our cash flow generation, which is at the basis of us being able to do M&A.

When it comes to our capital allocation priorities, number one now is to fund our new product launches. We are at the early innings of a number of new product launches, both in MedTech, and in Innovative Medicine. Some of them, I'm sure we will discuss. Some of them are ICOTYDE, our oral IL-23 peptide.

We are launching also INLEXZO, our intravesical drug release system for bladder cancer. We are launching RYBREVANT in lung cancer and pretty soon in head and neck cancer. We are planning to launch IMAAVY, our FcRn inhibitor, also in some rheumatological indications.

We just had the approval of our soft tissue robotic system, OTTAVA. We have a number of new catheters in electrophysiology that we plan to launch, in the US and globally. So the number one goal is to actually resource our new product launches, which are core to the cycle of growth that we want to deliver.

Number two is to resource our pipeline. John will talk about our pipeline, but we have a large number of assets in Phase 3. As you know, most of the expense in R&D is when you get into later stage. We have a number of things that we have to fund in our pipeline, and we are trying to do also parallel development, multiple indications at the same time, multiple Phase 3s. So we are in the better position when we launch the product to maximize that opportunity.

The second one is to identify external opportunities. The sweet spot for us is to identify opportunities that are earlier on, so we can create significant value using our scale in R&D, in manufacturing, and commercialization. Best examples of that are ICOTYDE or INLEXZO, which were opportunities that we identified earlier on that were very capital-sparing, if you want.

So we'll continue to look into these opportunities, and the priority there in BD is to fortify our position vis-a-vis the next decade. We can achieve double-digit growth this decade without M&A. Our goal with M&A is to fortify our position to provide you the confidence that our growth is durable into the next decade. That's the second priority, and that's what guides our M&A approach.

Then finally, return cash to our shareholders via dividends, and that's our goal, to continue to deliver a strong dividend to our shareholders. We have been, I think, decades of continuous dividend growth. We are a dividend aristocrat, and we plan to continue to give that to our shareholders.

We've done a number of transactions this year, which some of them are very promising. We acquired Halda Therapeutics. We have a new platform called RIPTAC that I would like John to talk about. We acquired Firefly Bio, which an antibody-degraded conjugate, which is a platform that we think has a lot of legs. We also did a deal with Sail in non-integrated in vivo CAR-T, which is a platform that we think could have a lot of expansion into autoimmune diseases.

I will let John talk about these new ideas that we have in our pipeline.

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. Maybe starting with the RIPTAC. These are oral drugs that stimulate what is called induced proximity, where you bring two proteins together, where one face of the molecule binds a target of interest. In this configuration, the other binds to an essential protein that the cell must have to survive. The compound then sequesters that protein in this complex. As a result of it, the cell perishes because it does not have access.

So the first iteration of this is a molecule targeting the androgen receptor in prostate cancer. Prostate cancers have very high levels of androgen receptors. With these compounds, you are able to sequester, to scarf up this essential protein. It happens to be an epigenetic protein called BRD4. As a result of it, the cell dies.

What we have seen in the early going is that the molecules are extremely active and selective at killing prostate cancer cells, regardless of what their genomic profile is, if they have TP53 mutations, RB mutations, even mutations in the androgen receptor, it does not matter.

And with its efficacy, including visceral lesions, which are sometimes hard to treat in prostate cancer, very well tolerated. Extremely well tolerated. That is moving into Phase 3. We think it could be a real practice-changing new mechanism for prostate cancer.

Early in clinical development, we have the same thing with an estrogen receptor, trying to do the same thing for breast cancer. Behind that, a pipeline of 14 more projects at various stages of lead optimization, where starting in oncology, we hope to tackle a number of ways of a new approach to how you can selectively kill cancer cells but then moving from there into certain immunological applications too, where that might make sense. So that is a great new platform, both a product and a platform for us.

With the Firefly acquisition, that is a new concept, degrader-antibody conjugates. You have all heard of ADCs, where you put a chemotherapy drug conjugated onto an antibody. In this case, it is a targeted therapy that is brought into the cancer cells by the antibody, sparing normal cells. Our lead program there is a pan-KRAS degrader.

Everyone has been hearing a lot about KRAS these days. That's the most common genetic mutation in all of human cancers are KRAS mutations that activate that oncogenic driver. So with a small molecule delivered through the antibody selectively in the cancer cells, we hope we'll get a much better therapeutic index. That's the first iterations, but there are lots of other things we can do with that platform down the road.

Terence Flynn - *Morgan Stanley - Analyst*

Is that in the clinic already?

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

That one is not in the clinic yet. That one's pre-clinical, should be in the clinic early next year.

Then another pre-clinical one was as we're getting into in vivo CAR-T, we were interested in both viral and non-viral approaches. So we have a collaboration with Kelonia in viral lentivirus, but then since then have created our own lentivirus platform, kind of leveraging our

know-how from the CARVYKTI days where we make the lentivirus for CARVYKTI, and in that case, we're infecting the cells ex vivo in the factory. But now we've engineered that so we can infect them in vivo and have selective infection of T cells. That will be in the clinic early next year.

With Sail, where we have a collaboration with an option to buy at a pre-negotiated rate, that's an mRNA platform using an engineered lipid nanoparticle that only enters into T cells, and that'll be in the clinic later this year.

Terence Flynn - *Morgan Stanley - Analyst*

Great. Just to clarify, the in vivo, that was the Kelonia approach you were talking about?

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. Well, that and Sail, they are both. They are different ways to do it. One viral, one non-viral. We are biasing viral towards oncology and non-viral towards immunology. But we have to generate clinical data, and we'll end up seeing whether both of those platforms work or do we end up pivoting and using one of the platforms for both applications to be determined.

Terence Flynn - *Morgan Stanley - Analyst*

Great. I want to focus on your myeloma franchise. I feel like every year I host you, Joaquin, and you guys have some new data that's very exciting to talk about. I know you guys have been focused on the functional cure for some time now in myeloma, and congratulations on all the progress here.

Before we talk about some of the newer targets, maybe just one question I had is just on DARZALEX FASPRO. I know you guys have had a lot of success with that launch and converting people over to the new subcutaneous formulation. How should we think about the shape of that business when you have IV biosimilars coming in? Because that's a question we get from investors sometimes. Then we'll talk about some of the newer drugs that you're bringing to market, too.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Absolutely. DARZALEX is now standard of care and a backbone in first-line therapy, and it is the number one drug used in any clinical trial. You always have DARZALEX as the backbone. So we continue to see DARZALEX as a backbone of multiple myeloma, and as John will explain later, I am sure, it has been also combined with our bispecifics and multispecifics in order to remain a backbone of therapy.

The results with DARZALEX are spectacular. When you look at progression free survival in treatment in transplant-eligible patients, it is 17 years, so it is a fantastic medicine. 90% of the patients today are already in DARZALEX FASPRO, and it is simple because you go from hours of infusion to minutes. You have less infusion-related reactions, less time, it is much easier for the patient and ultimately save resources of the healthcare system because you do not have to go there and spend six hours in the hospital, right?

We anticipate that by the time the IV biosimilars will come, close to 100% of the patients would be already in DARZALEX FASPRO, so we do not see that as a real challenge. It is very difficult to tell a patient for going from a subcutaneous to a six-hour infusion. So I think that that is going to be something that would be clearly not an issue for us down the road.

As far as our multiple myeloma franchise and the different combinations and permutations that we are going, our goal now is to be able to bring our advanced therapies earlier on. Perhaps the area which is more important for us today that is already coming into fruition is second line. About half of the patients in multiple myeloma are in second line, and we are bringing our multispecifics and cell therapy CARVYKTI into second line. We have great data in second line, both with CARVYKTI and the bispecifics, and that is the strategy that we have today.

We are not going to stop there, and we plan to bring advanced therapies into first line, but we already have approval to go into second line with both therapies. John can talk about the data we have generated and how impressive that data is. We're close to be able to achieve in multiple myeloma what you would call a functional cure.

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. The recent data in second line were, first of all, when patients begin to progress from the first-line regimen, about 70%, in the current market, have either not had DARA or they've had it, but they're still sensitive to it. So in that population, we showed in our MajesTEC-3 study that if you have DARA plus TECVAYLI, that's our BCMA, first-in-class BCMA bispecific, that compared to standard of care, which was often DARA plus other things, that we had unprecedented efficacy, progression-free survival. Hazard ratio, I think, was [0.17, so it's like a 83% reduction in progression or death](corrected by company after the call).

So impressive were the data that when we published our abstract for the ASH meeting, the FDA called us and said, can we please give you a national priority review voucher so we can get this new regimen to American patients as fast as possible? And from submission to approval was [55 days](corrected by company after the call), so the FDA did a great job with that.

Now, for the patient, the roughly 30% that are truly DARA refractory, we showed in our MajesTEC-6 study that if you have TECVAYLI combined with TALVEY, that's our other first-in-class T-cell engager, that one targeting GPRC5D, a target that was discovered in our own labs. That, again, led to hazard ratios like 0.1 in this second-line setting, showing that we have incredible solutions there for patients.

Now, thinking ahead to front line, where we're going there is with our trispecific, ramantamig. That has got the features of Tec and Tal in one molecule, both BCMA and GPRC5D, plus a third arm that binds the T-cell, the CD3, to get the T-cell to attack.

And what we'd seen in the early going there in newly diagnosed patients, if you combine ramantamig, our trispecific, with DARA, 100% MRD negativity, so minimal residual disease negativity. MRD is even recognized by the FDA as a valid surrogate in myeloma because it correlates so well with progression-free survival and overall survival. So we feel that that's where the front line will go. It'll be ramantamig plus DARA, and that's a steroid-free regimen, two drugs that you're going to get very high levels of progression-free survival that'll last for five years plus probably.

Then if the patient does relapse at that point, this is where then we have a CAR-T solution for them. We've got in hand CARVYKTI, obviously. But down the road, probably, if things go well, some in vivo CAR-T solutions as well.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

So even today, physicians have the option in second line to go an interval-free treatment like CARVYKTI with exceptional data in second line, or going into one of our bispecifics, TECVAYLI or TALVEY, with great data, so in order to have an off-the-shelf option. I think that's great for the patients, and it's great for doctors that have this optionality today.

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. CARVYKTI is the only CAR-T that has overall survival data, so really strong data, showing about half the patients many years out, alive, well, no further treatment. It's a one and done. So some patients opt for that. They're, okay, I can be several years on therapies, or I can do a one and done, and it's been very effective.

Now we are trying to bring CARVYKTI into the front line, too, in replacing bone marrow transplant. So those data will start to flow next year, I think, if I'm not mistaken, or maybe the year after. My colleagues are guiding me. But that's after patients have had the traditional induction and maintenance, and then rather than going on to an autologous stem cell transplant seeing if CARVYKTI could be the solution for them

Terence Flynn - *Morgan Stanley - Analyst*

Just one question on the positioning. So you mentioned TECVAYLI and TALVEY moving into second line. It sounds like the plan is the tri-specific is going to kind of leapfrog those and go to first line. What's the reason for that? Does it have to do with the ability to dose TECVAYLI and TALVEY where there's CRS, and this tri-specific has a cleaner safety profile? Does that make it easier or more amenable to first line?

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. It turns out the tri-specific is better tolerated. We didn't necessarily expect this, but the observation has been that the side effects associated with those two targets are actually reduced, and we think it may be because you're just getting maybe a different biodistribution where because the tri-specific has two binders that latch very tightly onto the myeloma cell, you're maybe getting less distribution to other types of cells. But that's been the observation. It's got the efficacy of as if you combine TEC and TAL, but with a better tolerability profile and the convenience that it's in a single molecule.

Terence Flynn - *Morgan Stanley - Analyst*

When will we see the next update for the tri-specific? Just remind us, like?

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

In late line, we're doing a head-to-head against our own TECVAYLI. I think we're still a couple of years off from those data.

Terence Flynn - *Morgan Stanley - Analyst*

Okay. Great. One more just before we go to immunology is just on the, mentioned CARVYKTI, and this is an ex vivo approach. There are some in vivo approaches. How do you think about the competitive dynamics? This is years in the future, but of an in vivo CAR-T in that space versus --

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Well, that's why we've also been investing and participating in that space. To be determined how well it works, right? There's some tantalizing data from a couple of companies. But handfuls of patients and the durability to be determined. We know the ex vivo approach can be highly successful, and we've demonstrated that with CARVYKTI, but we're going to try with in vivo, and we'll see how it goes.

As I said, we've established in-house a lentivirus platform so we can do that approach, and then through the recent deal and the option to acquire Sail, we'll have an mRNA platform. We think both of these are probably going to require some trial and error, and there'll be a journey to optimize. And they're both -- all these platforms are very quintessential examples of the process is the product. So the manufacturing piece of this will be critical to success, not just the design, but then the actual manufacturing, and that's a journey in and of itself. But we're going to be playing in that space too and seeing where it leads.

Terence Flynn - *Morgan Stanley - Analyst*

Okay. Great. Maybe just pivoting over to immunology. Obviously, another long, rich history at the company here, going back to REMICADE, and again now, STELARA, TREMFYA, ICOTYDE. Maybe just in the interest of time, we'll focus on ICOTYDE here in terms of the launch.

Joaquin, maybe just frame for us your view of how the launch is going and how to think about the forward opportunity here in psoriasis, and then also would just be curious, the IBD opportunity, how you guys are thinking about that, because that's probably the next wave of growth for that asset, potentially.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Thank you. With TREMFYA, [71% growth in the second quarter](corrected by company after the call), leading shares in initiation in IBD, both in ulcerative colitis and in Crohn's disease versus the other IL-23. So ICOTYDE, the launch is doing really well. The latest numbers are about 17,000 patients treated and about 7,000 writers. 60% of the patients were systemic naive, so that is where the majority of patients are coming, and the prescriber base is varied. We have dermatologists, obviously, but also APPs and primary care physicians showing that this is a medicine that is perceived having great safety profile, easy to use.

Importantly, we have now full commercial coverage in the US. So you should expect our sales to continue to improve as we go to the next quarters, as the coverage materialize into paid product.

Before the end of the year, we will show some data on psoriatic arthritis that could be the basis for a filing. We should expect having data in psoriatic arthritis and a filing that would have an impact into 2027. Our studies in IBD, both in ulcerative colitis and in Crohn's disease, are progressing well. We are in Phase 3, and John can tell you that they are recruiting at a good pace, right?

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. We noticed this with all the studies, psoriasis, psoriatic arthritis as well now IBD, that the recruitment rates exceeded our expectations. While some of that we would like to think is because we are good at clinical operations, more likely is this, there is patients really are hungry for an oral option. We have had no trouble getting. With the psoriasis studies, the studies recruited about one-third the pace that it normally takes us to do those studies. So indication that there is demand out there.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

And we anticipate that in IBD, which is the largest indication as you know, the entrance of an effective oral medicine will also expand the market as it is doing in psoriasis.

Terence Flynn - *Morgan Stanley - Analyst*

Yes. Okay. Great. Any early comments on persistence, adherence that you can say on ICOTYDE yet or still too early?

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

It's too early. We don't hear anything one way or another. Everything seems to be going in the right direction.

Terence Flynn - *Morgan Stanley - Analyst*

Okay. The other thing on immunology, you guys have been a leader here, is combination approaches. That's something the company's worked on a long time. I know you had the DUET data recently, but maybe just stepping back more broadly, how are you thinking about other novel combinations? I think that's a question we get a lot from investors, is there seems like there's more and more targets out there that are available now. So what's the latest on the combination strategy?

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

I would tell you that the market for combinations, which is the refractory patients, which is very common in IBD, is one of the most attractive markets today because there is a real patient need there. We have the one and only combination, which is our co-antibody therapeutic that combines TNF and IL-23 with an unprecedented efficacy there, and we continue to progress there in Phase 3, both in ulcerative colitis and in Crohn's disease, and also in psoriatic arthritis that we plan to develop. There are other combinations that we can think about.

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Yeah. I think this is becoming. Frankly, I think thanks to the trailblazing work that our colleagues at J&J did, where we were the first to demonstrate that bringing two biologics together could break through the efficacy ceilings.

Just to remind people, in inflammatory bowel disease, even with the best therapies, often only about a third of patients really get a sustained complete remission. So there was room for improvement. What we saw with bringing golimumab and guselkumab, TNF and IL-23 together, was we were able to break through that efficacy ceiling in the phase II studies. The Phase 2 studies also showed us that really the sweet spot for this is patients that are in that refractory bucket who failed two or more prior lines. So that is where we are really targeting it. Those are the patients for whom monotherapy is just not getting the job done.

We are marching on with that. Down the road, we see opportunities for other combo partners, starting with the biologics, but then now that we have ICOTYDE as another anchor, we are working on orals that could complement that. You will start to see coming in our pipeline examples of that, where we are starting to crack some of the well-known targets that had previously been the domain of biologics now with oral. We see the opportunity down the road for those refractory patients to have oral/oral combinations, and so we are very much in the thick of that as we speak.

Terence Flynn - *Morgan Stanley - Analyst*

Great. Maybe just one minute on MedTech and how to think about the outlook for back half of the year.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Yeah. So back half of the year, we continue to see our MedTech growing at a similar pace than in the first half. We are very focused now in two areas. One is the launch of our OTTAVA surgical soft tissue robotic system. We are going to start with a limited market release. Investors shouldn't be focused initially on placements, but more on how the system is working, how the customer experience is, how we continue to develop evidence and expand the number of indications. But this is going to be a major growth driver for Johnson & Johnson, and we are fully committed to compete and to lead in surgical robotics.

The other area of focus for us there is electrophysiology. We have the best ecosystem in electrophysiology with our mapping system, our clinical support specialist, and we plan to continue to launch new therapeutic catheters with a good pace. We just had the approval in the US of a dual energy catheter, and we plan to have the approval of VARIPULSE Pro, which is the short sequence therapeutic catheter PFA, by the end of the year here in the US. And we have a number of catheters in our pipeline that we plan to launch in the coming years. So that's in our cardiovascular space.

Then on vision, we continue to gain market share in contact lenses and also in intraocular lenses with the launch of our premium intraocular lenses here in the US with PureSee. So we see a good outlook for our MedTech business, not only for the end of the year, but also to be an enterprise double-digit growth driver by the end of the decade when our soft tissue robotic surgical system sales start to kick in and create a significant contribution to our revenue in MedTech system sales start to kick in and create a significant contribution to our revenue in MedTech.

Terence Flynn - *Morgan Stanley - Analyst*

Great. Well, thank you so much, gentlemen. Really appreciate the time.

John Reed - *Johnson & Johnson - Executive Vice President - Pharmaceuticals, R&D*

Thanks.

Joaquin Duato - *Johnson & Johnson - Chairman of the Board, Chief Executive Officer*

Thank you.

Editor

Please see the company's July 29, 2026 Form 8-K for updated guidance, including the impacts of the acquisition of Firefly Bio, Inc. and the entry into strategic agreements and collaboration with Sail Biomedicines.