114TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
114–20

THE PRICE OF SOVALDI AND ITS IMPACT ON THE U.S. HEALTH CARE SYSTEM

PART 2 OF 2

PREPARED BY THE STAFFS OF RANKING MEMBER RON WYDEN AND COMMITTEE MEMBER CHARLES E. GRASSLEY

COMMITTEE ON FINANCE
UNITED STATES SENATE

ORRIN G. HATCH, *Chairman*
RON WYDEN, *Ranking Member*

DECEMBER 2015

Printed for the use of the Committee on Finance

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U.S. GOVERNMENT PUBLISHING OFFICE
97–329—PDF WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

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Appendix E—Continued

Exhibit 19

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Revenue / Valuation Models:
Project Harry

Investment Banking Division

Global Healthcare Group

November 13, 2011

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Confidential Presentation

Key Assumptions Validated Post 2011 AASLD

Geographies / 2011 Prevalence	▪ U.S.: Prevalence of 3.7 million ▪ EU-5: Prevalence of 3.7 million ▪ ROG [1]: Prevalence of 4.1 million ▪ Japan: Prevalence of 0.6 million
Regimen	▪ Initial: 7977 + RBV for GT2/3 and IFN-intolerant ▪ Follow-on: 7977 + Gryffindor OAV Pan Genotypic
Launch Year	▪ U.S.: 2014 (2 years to peak post launch year) ▪ EU-5: 2015 (2 years to peak post launch year) ▪ ROG [1]: 2015 (5 years to peak post launch year) ▪ Japan: 2016 (2 years to peak post launch year)
Peak Share	▪ Overall peak penetration of 50% in all markets ▸ GT1: 54%, GTnon-1: 38% ▸ Recognizes potential future competition in the market
Price	▪ $65k gross / patient / year in U.S. ▸ U.S.: Gross to net discount of 19% at launch year, grows to 25% over 8 years ▸ EU-5: 25% discount to U.S. ▸ ROG [1]: 40% discount to U.S. ▸ Japan: 43% discount to U.S.
POS	▪ 75%

1. ROG territories include developed EU countries (Austria, Denmark, Finland, Greece, Ireland, Norway, Poland, Portugal, Sweden and Switzerland), Turkey, Australia, Canada and Brazil. Note only in Brazil does Gryffindor not have a presence today.

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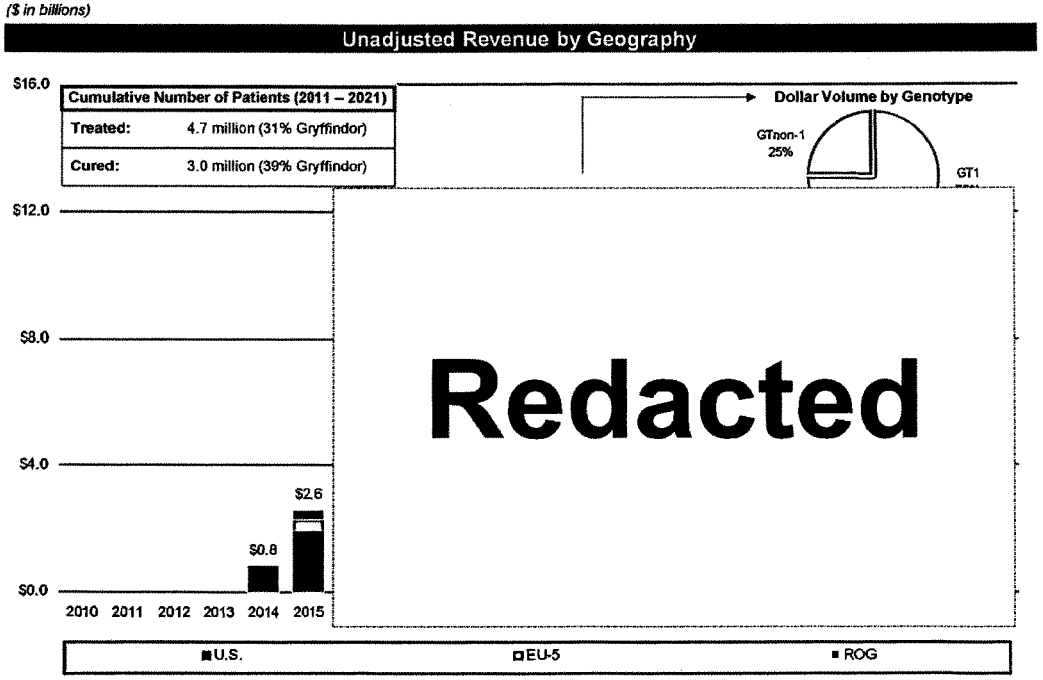
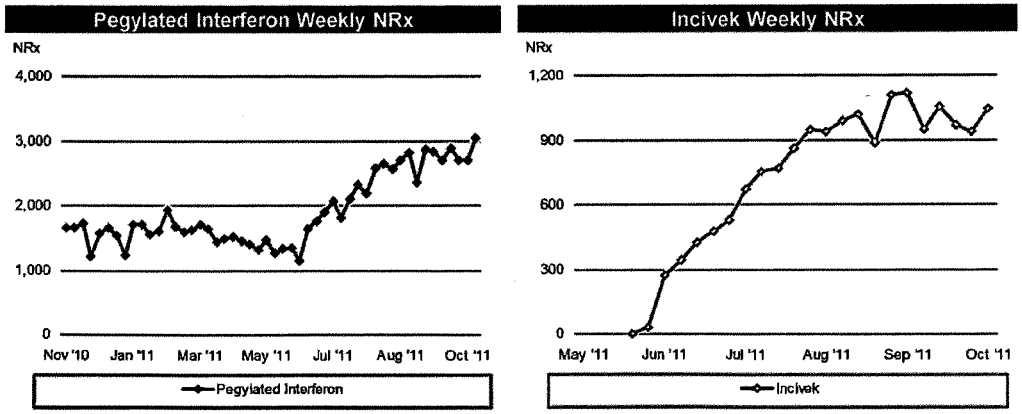
Unadjusted Revenue by Geography

($ in billions)



Incivek Uptake Has Exceeded Expectations

- At $420mm, largest first quarter launch since Viagra in 1998, far outpacing Victrelis ($31mm) and surpassing Street/our expectations
- Rapid increase in total treated patients upon launch of Incivek
- Price has not impeded adoption in U.S.
- More recent flattening of prescriptions due to warehousing:
  - Complicated treatment algorithm
  - Toxicity profile of PI-based regimen
  - Anticipation of improved, all oral therapy



Source: Wolters Kluwer Health PHAST Weekly.
Note: Atripla first quarter sales were $137mm in 4Q'06.

Price vs. Clinical Benefit Comparison

Price Comparison				
Drug	**Indication**	**U.S. WAC Price**	**Duration of Therapy**	**Clinical Benefit / Outcome**
Avastin	Oncology (colon) Oncology (lung)	$93k $54k	10.6 m 6.2 m	▪ survival increased 4.7 m (15.6 → 20.3m) ▪ survival increased 2.0 m (10.3 → 12.3m)
Gleevec	Oncology (CML)	$434k	6.8 y	▪ 3y survival increased 15% (81 → 96%)
Revlimid	Oncology (multiple myeloma)	$104k	13.9 m	▪ time to progression increased 9.2 m (4.7 → 13.9 m)
Yervoy	Oncology (metastatic melanoma)	$120k	3 m	▪ survival increased 4 m (6 → 10m)
Zytiga	Oncology (prostate)	$79k	15.8 m	▪ survival increased 4.6 m (11.2 → 15.8m)
Letairis	Cardiovascular (PAH)	$68k/y	3+ y	▪ clinical worsening 22% → 6% over 12 w ▪ 79% survival at 3y
Benlysta	Autoimmune (lupus)	$34k/y	10+ y	▪ symptom score reduced >4pts 46% → 58%
Gilenya	CNS (MS)	$48k/y	10+ y	▪ 24% less relapse over 1 y (70% → 46%)
Atripla	Antiviral (HIV)	$19k/y	10+ y	▪ 69% increased risk of death for HAART deferred until CD4 <350 vs. immediate HAART
		HCV Related		
Incivek + RBV + IFN	Antiviral (HCV)	$84-80k	3 m	▪ SVR increased from 46% → 74-79% ▪ SVR reduced 10 y mortality in HCV patients with cirrhosis 23 % → 9.8%
Liver Transplant	HCV liver disease	$300k	5+ y	▪ 70% survival at 5y
7977 + RBV / 7977 + Gryffindor OAV	Antiviral (HCV)	$65k	3 m	▪ SVR 80%+ ▪ SVR reduced 10 y mortality in HCV patients with cirrhosis 23 % → 9.8%

Overview of Valuation Methodology

Valuation Methodology

- NPV evaluated by calculating difference between Standalone and Pro Forma free cash flows
- Demonstrates economic value gain to the Gryffindor enterprise
- Evaluated using two methodologies – adjusted for probability of success and 100% probability (for illustrative purposes)
- Difference in free cash flows – 2012 through 2030
- Net cash flows discounted at 10%

Scenario Overview

NPV – Difference between Standalone and Pro Forma Free Cash Flows

NPV

Adjusted for POS	100% POS
$18.3bn	**$25.5bn**
Gryffindor Standalone	**Gryffindor Standalone**
Product / POS	Product / POS
PI/NS5A + IFN/RBV 43%	PI/NS5A + IFN/RBV 43%
All Oral Regimen 26%	All Oral Regimen 26%
Gryffindor Pro Forma	**Gryffindor Pro Forma**
Product / POS	Product / POS
Redacted	
PF Pan Genotypic[1] 75%	PF Pan Genotypic[1] 100%

1. *Represents the majority of the pro forma value. Representative of initial regimen of 7977 + RBV for GT2/3 and IFN-intolerant and follow-on regimen of 7977 + Gryffindor OAV Pan Genotypic.*

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Summary of Scenarios: NPV and IRR Analysis

- Two Gryffindor Standalone HCV scenarios evaluated
  - HCV Status Quo: Originally modified forecast of Gryffindor Standalone HCV revenues and costs
  - HCV Downside Case: Gryffindor Standalone HCV R&D continues through Phase III but a commercially viable regimen does not materialize
    - Assumes no Gryffindor standalone HCV revenue or costs from projected launch year forward (2016 for Gryffindor PI/NS5A + IFN/RBV and 2017 for Gryffindor All Oral Regimen)
- Gryffindor economic value gain from Harry shown both adjusted for probability of success and at 100% probability (for illustrative purposes)
  - NPV represents difference in free cash flows – 2012 through 2030, discounted at 10%
  - Notional value (aggregate cash flows not discounted) also shown

NPV – Difference between Standalone and Pro Forma Free Cash Flows			
		Probabilized (75% POS)	100% POS (Illustrative)
Gryffindor Standalone HCV Status Quo	NPV	$18.3bn	$25.5bn
	Notional	$44.2bn	$61.8bn
	IRR at $10.0bn purchase price	*18.1%*	*23.2%*
	IRR at $13.0bn purchase price	*14.5%*	*19.2%*
Gryffindor Standalone HCV Downside Case	NPV	$21.2bn	$28.5bn
	Notional	$51.9bn	$69.6bn
	IRR at $10.0bn purchase price	*20.2%*	*24.7%*
	IRR at $13.0bn purchase price	*16.4%*	*20.7%*

Source: Gryffindor management.

Valuation Appendix

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Price and Share Sensitivity Analysis

Price and Share Sensitivity Analysis

		Base Case $65k Price, 50% Market Share	Change Price: +/- $10k	Change Market Share: +/- 10%
2021 Unadjusted Revenue		Total: $12.0bn	Change: △ $1.8bn	Change: △ $2.3bn
NPV		75% POS: $18.3bn 100% POS: $25.5bn	75% POS: △ $3.5bn 100% POS: △ $4.6bn	75% POS: △ $4.4bn 100% POS: △ $5.9bn
IRR	**$10.0bn** (1)	75% POS: 18.1% 100% POS: 23.2%	75% POS: △ 3.0% 100% POS: △ 3.1%	75% POS: △ 3.9% 100% POS: △ 4.0%
	$13.0bn (1)	75% POS: 14.5% 100% POS: 19.2%	75% POS: △ 2.8% 100% POS: △ 2.9%	75% POS: △ 3.6% 100% POS: △ 3.8%

1. Assumed purchase prices.

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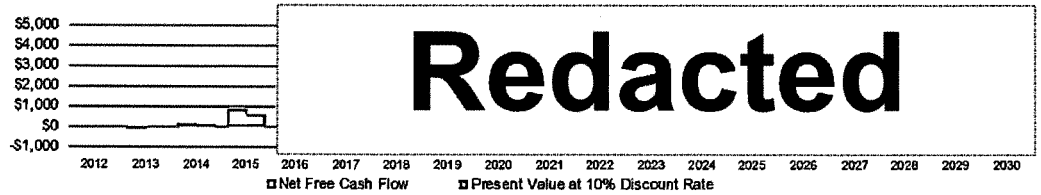
NPV and P&L Summary – Probability Adjusted ($10.0bn)

($ in millions except per share values)

Net Free Cash Flows and Present Value *(for Illustrative Purposes)*



P&L Snapshot – Standalone vs. Pro Forma *(for Illustrative Purposes)*

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Gryffindor Standalone Revenue	$9,377	$10,446	$11,522	$12,555					
Gryffindor Pro Forma Revenue	9,377	10,446	12,089	14,482					
Revenue Difference ($)	$0	$0	$567	$1,926					
Revenue Difference (%)	*0.0%*	*0.0%*	*4.9%*	*15.3%*					
Gryffindor Standalone Operating Income	$4,898	$5,775	$6,575	$7,231					
Gryffindor Pro Forma Operating Income	4,716	5,576	6,857	7,943					
Operating Income Difference ($)	($182)	($199)	$282	$712					
Operating Income Difference (%)	*(3.7%)*	*(3.4%)*	*4.3%*	*9.8%*					
Gryffindor Standalone Net Income (non-GAAP) [1]	$3,672	$4,332	$4,881	$5,356					
Gryffindor Pro Forma Net Income (non-GAAP) [1]	3,459	4,117	5,031	6,387					
Net Income Difference ($)	($213)	($215)	$150	$1,031					
Net Income Difference (%)	*(5.8%)*	*(5.0%)*	*3.1%*	*19.2%*					
Gryffindor Standalone EPS (non-GAAP) [1]	$4.96	$6.19	$7.18	$7.88					
Gryffindor Pro Forma EPS (non-GAAP) [1]	4.52	5.39	6.59	8.34					
EPS Difference ($)	($0.44)	($0.80)	($0.59)	$0.47					
EPS Difference (%)	*(8.8%)*	*(13.0%)*	*(8.2%)*	*5.9%*					

Redacted

Note: Operating income difference includes amortization.

Key Pro Forma Assumptions: Assumes dilution-only share repurchases with 81% premium to stock price of $89.07 on 11/8/11 using ~$5.0bn cash on hand and ~$5.1bn of new debt at a cost of cash of 1.0% and blended cost of debt of 2.8%. Assumes 85% of the purchase price allocated to new intangibles amortized in 10 years, with 90% allocated to IPR&D amortization starting from the product launch year.

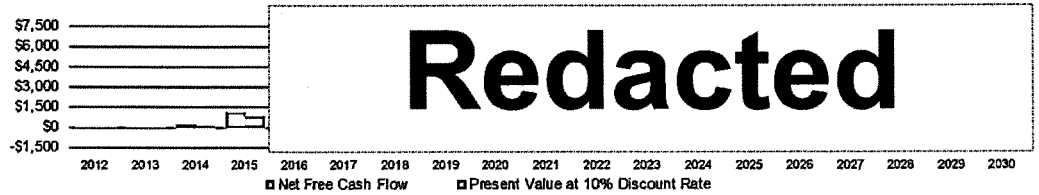
1. *Excludes amortization of intangibles.*

BARCLAYS CAPITAL

NPV and P&L Summary – 100% POS ($10.0bn)

($ in millions except per share values)

Net Free Cash Flows and Present Value *(for Illustrative Purposes)*



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P&L Snapshot – Standalone vs. Pro Forma *(for Illustrative Purposes)*

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Gryffindor Standalone Revenue	$9,377	$10,446	$11,522	$12,555					
Gryffindor Pro Forma Revenue	9,377	10,446	12,295	15,145					
Revenue Difference ($)	$0	$0	$784	$2,590					
Revenue Difference (%)	*0.0%*	*0.0%*	*6.6%*	*20.6%*					
Gryffindor Standalone Operating Income	$4,898	$5,775	$6,575	$7,231					
Gryffindor Pro Forma Operating Income	4,716	5,576	6,981	8,452					
Operating Income Difference ($)	($182)	($199)	$406	$1,221					
Operating Income Difference (%)	*(3.7%)*	*(3.4%)*	*6.2%*	*16.9%*					
Gryffindor Standalone Net Income (non-GAAP) [1]	$3,672	$4,332	$4,881	$5,356					
Gryffindor Pro Forma Net Income (non-GAAP) [1]	3,459	4,117	5,123	6,765					
Net Income Difference ($)	($213)	($215)	$242	$1,409					
Net Income Difference (%)	*(5.8%)*	*(5.0%)*	*5.0%*	*26.3%*					
Gryffindor Standalone EPS (non-GAAP) [1]	$4.98	$6.19	$7.18	$7.88					
Gryffindor Pro Forma EPS (non-GAAP) [1]	4.52	5.39	6.71	8.84					
EPS Difference ($)	($0.44)	($0.80)	($0.47)	$0.96					
EPS Difference (%)	*(8.8%)*	*(13.0%)*	*(5.5%)*	*12.2%*					

Redacted

Note: Operating income difference includes amortization.

Key Pro Forma Assumptions: Assumes dilution-only share repurchases with 81% premium to stock price of $69.07 on 11/8/11 using ~$5.0bn cash on hand and ~$5.1bn of new debt at a cost of cash of 1.0% and blended cost of debt of 2.8%. Assumes 85% of the purchase price allocated to new intangibles amortized in 10 years, with 90% allocated to IPR&D amortization starting from the product launch year.

1. *Excludes amortization of intangibles.*

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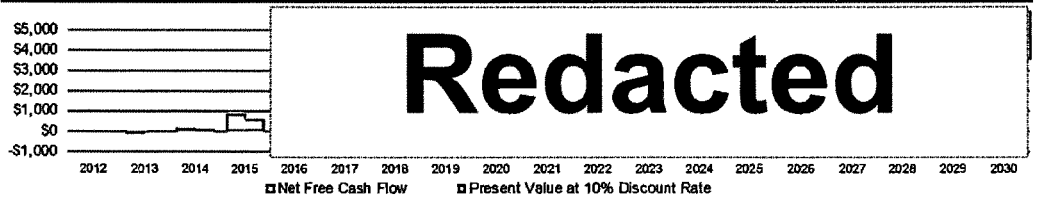
NPV and P&L Summary – Probability Adjusted ($13.0bn)

($ in millions except per share values)

Net Free Cash Flows and Present Value *(for Illustrative Purposes)*



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Revenue Difference ($)	$0	$0	$567	$1,926					
Revenue Difference (%)	*0.0%*	*0.0%*	*4.9%*	*15.3%*					
Gryffindor Standalone Operating Income	$4,888	$5,775	$6,575	$7,231					
Gryffindor Pro Forma Operating Income	4,891	5,550	6,832	7,690					
Operating Income Difference ($)	($207)	($224)	$257	$459					
Operating Income Difference (%)	*(4.2%)*	*(3.9%)*	*3.9%*	*6.3%*					
Gryffindor Standalone Net Income (non-GAAP) [1]	$3,672	$4,332	$4,881	$5,356					
Gryffindor Pro Forma Net Income (non-GAAP) [1]	3,401	4,061	4,976	6,331					
Net Income Difference ($)	($271)	($271)	$95	$975					
Net Income Difference (%)	*(7.4%)*	*(6.3%)*	*1.9%*	*18.2%*					
Gryffindor Standalone EPS (non-GAAP) [1]	$4.96	$6.19	$7.18	$7.88					
Gryffindor Pro Forma EPS (non-GAAP) [1]	4.45	5.31	6.52	8.27					
EPS Difference ($)	($0.51)	($0.88)	($0.66)	$0.39					
EPS Difference (%)	*(10.4%)*	*(14.2%)*	*(9.2%)*	*5.0%*					

Redacted

Note: Operating income difference includes amortization.

Key Pro Forma Assumptions: Assumes dilution-only share repurchases with 134% premium to stock price of $69.07 on 11/8/11 using ~$5.0bn cash on hand and ~$8.1bn of new debt at a cost of cash of 1.0% and blended cost of debt of 2.7%. Assumes 85% of the purchase price allocated to new intangibles amortized in 10 years, with 90% allocated to IPR&D amortization starting from the product launch year.

1. *Excludes amortization of intangibles*

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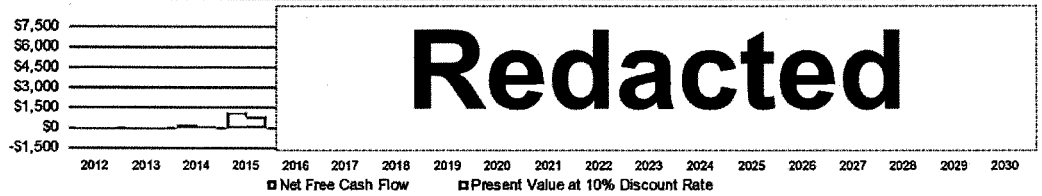
NPV and P&L Summary – 100% POS ($13.0bn)

($ in millions except per share values)

Net Free Cash Flows and Present Value *(for Illustrative Purposes)*



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Gryffindor Pro Forma Revenue	9,377	10,446	12,285	15,145					
Revenue Difference ($)	$0	$0	$764	$2,590					
Revenue Difference (%)	*0.0%*	*0.0%*	*6.6%*	*20.6%*					
Gryffindor Standalone Operating Income	$4,898	$5,775	$6,675	$7,231					
Gryffindor Pro Forma Operating Income	4,691	5,550	6,955	8,200					
Operating Income Difference ($)	($207)	($224)	$280	$968					
Operating Income Difference (%)	*(4.2%)*	*(3.9%)*	*5.8%*	*13.4%*					
Gryffindor Standalone Net Income (non-GAAP) [1]	$3,672	$4,332	$4,881	$5,356					
Gryffindor Pro Forma Net Income (non-GAAP) [1]	3,401	4,061	5,068	6,710					
Net Income Difference ($)	($271)	($271)	$187	$1,354					
Net Income Difference (%)	*(7.4%)*	*(6.3%)*	*3.8%*	*25.3%*					
Gryffindor Standalone EPS (non-GAAP) [1]	$4.96	$6.19	$7.18	$7.88					
Gryffindor Pro Forma EPS (non-GAAP) [1]	4.45	5.31	6.54	8.77					
EPS Difference ($)	($0.51)	($0.88)	($0.54)	$0.89					
EPS Difference (%)	*(10.4%)*	*(14.2%)*	*(7.5%)*	*11.3%*					

Redacted

Note: Operating income difference includes amortization.

Key Pro Forma Assumptions: Assumes dilution-only share repurchases with 134% premium to stock price of $69.07 on 11/8/11 using ~$5.0bn cash on hand and ~$8.1bn of new debt at a cost of cash of 1.0% and blended cost of debt of 2.7%. Assumes 85% of the purchase price allocated to new intangibles amortized in 10 years, with 90% allocated to IPR&D amortization starting from the product launch year.

1. *Excludes amortization of intangibles*

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Exhibit 20

From: John McHutchison
Sent: Tuesday, June 21, 2011 4:31 PM
To: 'jonathan.piazza@barclayscapital.com'
Subject: Re: Project Pyramid Assumptions

Ok

Have a call for 15 to 20 mins and will then call

Thx

John

----- Original Message -----
From: jonathan.piazza@barclayscapital.com [mailto:jonathan.piazza@barclayscapital.com]
Sent: Tuesday, June 21, 2011 02:30 PM
To: John McHutchison
Subject: RE: Project Pyramid Assumptions

Sounds good. 650-289-6046.

-----Original Message-----
From: John McHutchison [mailto:John.McHutchison@gilead.com]
Sent: Tuesday, June 21, 2011 2:30 PM
To: Piazza, Jonathan S: IBD (MLP)
Subject: Re: Project Pyramid Assumptions

Give me 15 mins Jonathan

What's the best number to get you?

John

----- Original Message -----
From: jonathan.piazza@barclayscapital.com [mailto:jonathan.piazza@barclayscapital.com]
Sent: Tuesday, June 21, 2011 02:28 PM
To: John McHutchison
Subject: RE: Project Pyramid Assumptions

Sorry - let me know if you have a moment to talk live.

-----Original Message-----
From: John McHutchison [mailto:John.McHutchison@gilead.com]
Sent: Tuesday, June 21, 2011 2:26 PM

To: Piazza, Jonathan S: IBD (MLP)
Subject: RE: Project Pyramid Assumptions

you have lost me know jonathan

john

John McHutchison MD
Senior Vice President
Liver Disease Therapeutics
Gilead Sciences Inc.
Tel (650) 522 5302

From: jonathan.piazza@barclayscapital.com [jonathan.piazza@barclayscapital.com]
Sent: Tuesday, June 21, 2011 1:48 PM
To: John McHutchison; Patrick Lamy
Cc: Chelsea.Zhang@barclayscapital.com; kristina.stumbaugh@barclayscapital.com; Muz Mansuri
Subject: RE: Project Pyramid Assumptions

The model is currently running usiug a 73% GT1, 27% GT2/3 split, and I believe you are suggesting running the model at a 78%/22% split.

If we make this change and use unchanged assumptions for treatment rates for each population, the model tells us that 21% of all patients on treatment are GT2/3. In order to hit the 24% bogey that Patrick mentions below we need to increase the 2011 treatment rate for naïve and experienced GT2/3 patients by ~12%. This compares to the 40% figure John mentioned this morning.

We should address whether the team is comfortable changing the model to reflect this 78%/22% split, which seems to be based on relatively older data in 2000.

The weighted average peak penetrations are predicated on the original 73%/27% split assumption, so if we change the split we will need to adjust the GT1 and GT2/3 individual penetrations to reach the same weighted average peak penetrations.

The other way to go is to keep the 73%/27% split and assign a GT2/3 treatment rate somewhere between the calculated 12% and John's 40%. As a reference point, assuming a 73%/27% split and identical treatment rates for GT2/3 and GT1 already gets us to 27% of all treated patients on GT2/3. So if we increase the GT2/3 treatment rate, we will go north of 27%.

Let us know what you think. We are happy to jump on the phone to discuss this afternoon if convenient.

Jonathan

-----Original Message-----
From: John McHutchison [mailto:John.McHutchison@gilead.com]
Sent: Tuesday, June 21, 2011 12:08 PM
To: Patrick Lamy; Piazza, Jonathan S: IBD (MLP)
Cc: Zhang, Chelsea: IBD (MLP); Stumbaugh, KC: IBD (MLP); Muz Mansuri
Subject: RE: Project Pyramid Assumptions

lets have a look at this in the model and see how it works out jonathan

does that sound ok

john

John McHutchison MD
Senior Vice President
Liver Disease Therapeutics
Gilead Sciences Inc.
Tel (650) 522 5302

From: Patrick Lamy
Sent: Tuesday, June 21, 2011 11:35 AM
To: John McHutchison; jonathan.piazza@barclayscapital.com
Cc: Chelsea.Zhang@barclayscapital.com; kristina.stumbaugh@barclayscapital.com; Muz Mansuri
Subject: RE: Project Pyramid Assumptions

Hi Jonathan,

I would make the following assumptions and see how that impacts your numbers:

22% of the diagnosed pool is GT 2/3 (reference Blatt (2000) J Viral Hepatitis 7:196)

24% of all patients on treatment were GT 2/3 (based upon Synovate 2007 HCV Monitor)- so you can calculate the number treated and then back-calculate your treatment rate as a percentage of the diagnosed GT2/3 pool.

Once you have your base tx rate, grow it with the dynamics as john recommends below (match the growth with assumptions around going to an all oral regimen).

Let me know how that looks and we can revisit.

We still also need to discuss the TPP assumptions- you have 0% penetration for 7977+Peg/RBV in GT2/3. I am not sure that I would agree with that assumption if they are able to take tx duration down to 12 weeks.

Patrick

-----Original Message-----
From: John McHutchison
Sent: Tuesday, June 21, 2011 10:44 AM
To: jonathan.piazza@barclayscapital.com; Patrick Lamy
Cc: Chelsea.Zhang@barclayscapital.com; kristina.stumbaugh@barclayscapital.com; Muz Mansuri
Subject: RE: Project Pyramid Assumptions

OK

i need patrick to chime in here

More patients are treated with peg and RBV with geno 2 and 3, driven by the 80% SVR currently

so i suggest we increase that 6.5% conservatively by a factor of about 40% to 9%. The ramp up through 2020 should not be as great, for the reason that the efficacy of 80% in this group currently will be hard to beat, and be offset by the premium price, until IFN is REMOVED from the GT2/3 regimen, at which stage there will be a bump in Rx rates.

how can we include these facts in the model most simply

i would not exceed the 2020 percentages you have for GT2/3 jonoathan

happy to chat if you need

patrick??

copied muz so he knows what i am thinking here

John McHutchison MD
Senior Vice President
Liver Disease Therapeutics
Gilead Sciences Inc.
Tel (650) 522 5302

From: jonathan.piazza@barclayscapital.com [jonathan.piazza@barclayscapital.com]
Sent: Tuesday, June 21, 2011 8:18 AM
To: John McHutchison; Patrick Lamy
Cc: Chelsea.Zhang@barclayscapital.com; kristina.stumbaugh@barclayscapital.com
Subject: RE: Project Pyramid Assumptions

John,

For both GT1 and GT2/3 we currently project that % of treatment-naïve patients on drug treatment grows from 6.5% in 2011 to 18% in 2020, while the % of treatment-experienced patients on drug treatment grows from 2.8% in 2011 to 17.3% in 2020.

How much do you suggest we increase the treatment rates for GT2/3?

We can keep the diagnosis rates the same as you suggest.

Thanks.

Jonathan

-----Original Message-----
From: John McHutchison [mailto:John.McHutchison@gilead.com]
Sent: Tuesday, June 21, 2011 4:25 AM
To: Patrick Lamy; Piazza, Jonathan S: IBD (MLP)

Cc: Zhang, Chelsea: IBD (MLP); Stumbaugh, KC: IBD (MLP)
Subject: RE: Project Pyramid Assumptions

I agree with patrick jonathan

essentially all diagnosed HCV GT2/3 patients are treated, docs like to Rx people who are likely to respond!!

Thats the way it is in practice, but still the relative contraindications to Rx would suggest, that like GT!, about 35% of these patients are ineligible for Rx based on co morbidities etc.

Will diagnosis rates increase for GT2/3, compared to 1, i think they would if simpler Rxs became available, you would pick up that proportion of patients and Rx them that cant recieve Rx as outlined above. I think we should apply the same increase in diagnosis rates across the board and not increase it for G12/3 further. That would be hard to defend given that Rx is effective now in 80% of those patients

john

John McHutchison MD
Senior Vice President
Liver Disease Therapeutics
Gilead Sciences Inc.
Tel (650) 522 5302

From: Patrick Lamy
Sent: Monday, June 20, 2011 8:25 PM
To: jonathan.piazza@barclayscapital.com; John McHutchison
Cc: Chelsea.Zhang@barclayscapital.com; kristina.stumbaugh@barclayscapital.com
Subject: RE: Project Pyramid Assumptions

Jonathan,

Thank you for sending. We don't have any good data on the patient dynamics broken out by genotype. It will only be guesses and I suggest putting the dynamics together and making the cut for GT1 vs 2/3 at the end. Even then, we don't know what treatment rates are for the GT2/3 vs GT1 are.

The problem is that IFN is indicated for all genotypes so there is no way to get at that data. What we have heard from MDs is that if they find a GT2/3 patient, they generally treat them suggesting high treatment rates and low diagnosis rates- so it could be different dynamics but no real data to support that position.

Let me think about it but that's my initial reaction.

Patrick

From: jonathan.piazza@barclayscapital.com [jonathan.piazza@barclayscapital.com]
Sent: Monday, June 20, 2011 6:37 PM
To: John McHutchison; Patrick Lamy
Cc: Chelsea.Zhang@barclayscapital.com; kristina.stumbaugh@barclayscapital.com
Subject: Project Pyramid Assumptions

John and Patrick,

We now have separate patient models running for GT1 and GT2/3, respectively. For simplicity as a starting point we have assumed the patient dynamics for GT2/3 patients are the same as for GT1 patients, but we know this is not the case. Please see the attached - we need your guidance on pages 4, 6 and 8 which outline the GT2/3 assumptions for each region. In particular, diagnosis and treatment rates for GT2/3 require review.

It also makes sense to confirm your view of the penetration for each product in GT1 and GT2/3, which is outlined on page 1, and to confirm your view on POS assumptions for each product on page 2. Both remain unchanged from our last review.

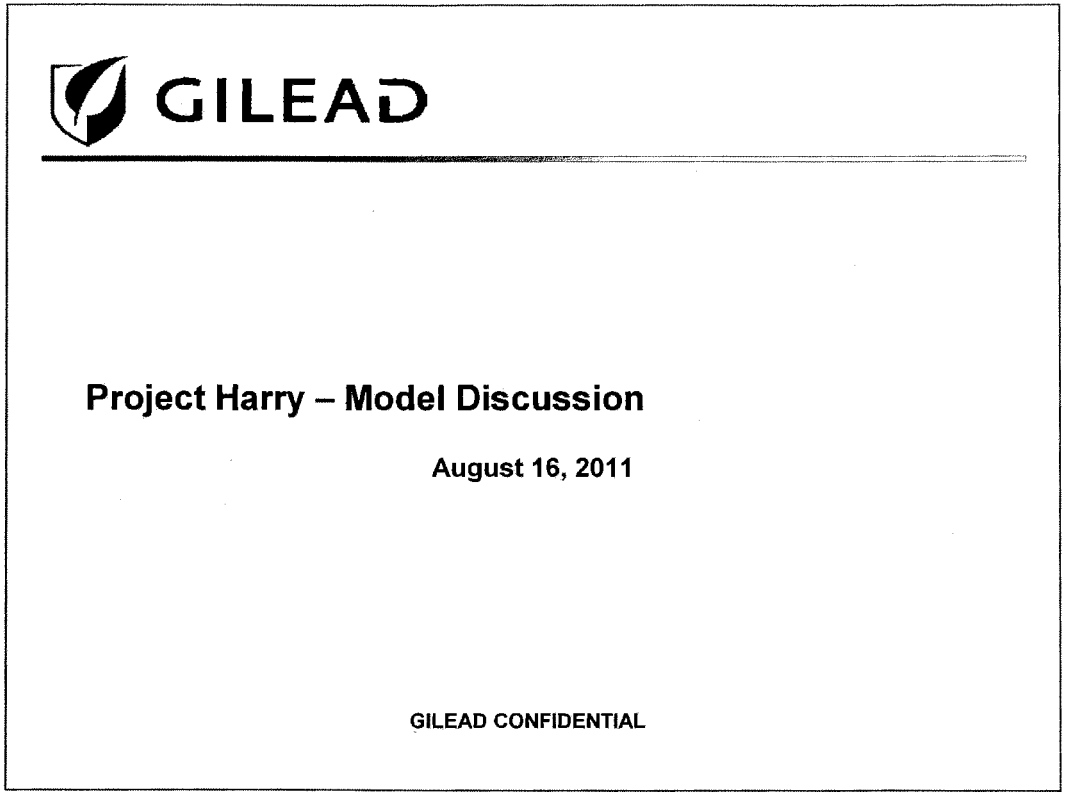
All of the individual product assumptions are shown on pages 9-16, including assumed SVR rates for GT2/3.

Thanks in advance for your help, we are happy to jump on the phone if you have any questions.

Best,
Jonathan

Jonathan S. Piazza
Vice President
BARCLAYS CAPITAL
Healthcare Investment Banking
155 Linfield Drive, Menlo Park, CA 94025
Tel: (650) 289-6046 | Cell: (415) 606-4748
jonathan.piazza@barclayscapital.com<mailto:jonathan.piazza@barclayscapital.com>

Exhibit 21


GILEAD
Project Harry – Model Discussion
August 16, 2011
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Basic Model Background

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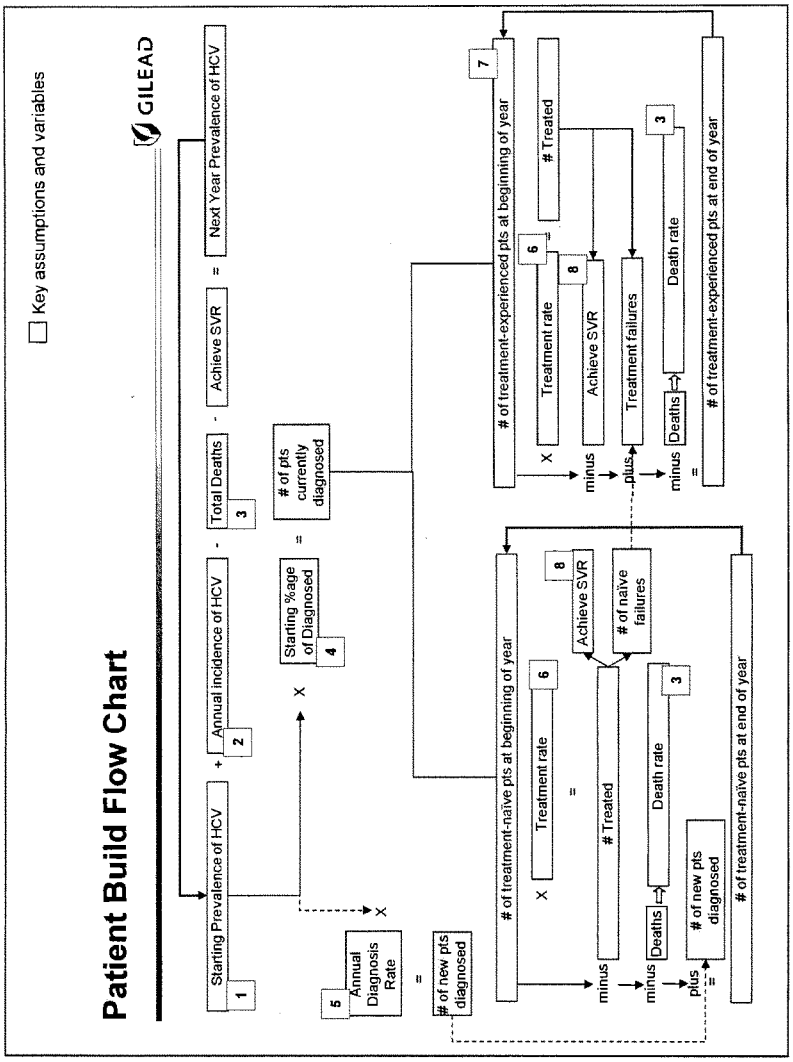

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GS-0005513

Key assumptions supporting epidemiology & patient waterfall

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	Variable	Value (2010)	Source and/or Rationale
1	HCV Prevalence	2.97 M	Prevalent population based upon published epidemiology rates from NHANES applied to the adult population (1.3%). 79% of the prevalent HCV population has chronic HCV as identified by the presence of HCV RNA Sources: NHANES, Armstrong (2006), Annals of Internal Medicine, v144, N10
2	HCV Incidence	16.5K	CDC website (as of July 1, 2009) listed estimated HCV incident cases: 2005 - 21,000, 2006 - 19,000, 2007 - 17,000
3	Mortality rate	0.7%	Age-specific all-cause mortality: 45-54 = 0.42%, 55-64 = 0.87%, 65-74=2% Current distribution of HCV+ population: <40=10%, 40-60=72%, >60=17% Sources: CDC (2007), NHANES 1999-2006 (with epidemiology modelling to project to 2010)
4	Total Diagnosed	1.27M	In 2000, ~32 – 37% of the prevalent population was aware of their HCV status based on a US national study. Sources: Armstrong (2004), Hepatology, 40(4:S1):176a, Culver (2000), Transfusion, 40:1176,
5	Annual Diagnosis Rate (of undiagnosed prevalent)	3.6%	Annual diagnosis rate: 20,000 newly diagnosed HCV patients in 2008 based upon medical claims Source: WK Claims Database (2002-2008)
6	Treated	67K	Treatment rates based on pegylated interferon + ribavirin units and average days of therapy Sources: IMS MIDAS, Synovate Chart Audits, Roche and Schering Plough annual reports
7	HCV Treatment Failure Pool	339K	Patients who did not achieve an SVR after a previous round of treatment. Patient group includes previous discontinuations, non-responders, partial responders, null responders, viral breakthroughs, and relapsers Calculated number of HCV treatment failures based on the annual number of treated patients and SVR rates Source: IMS MIDAS, Synovate Chart Audits (2007)
8	SVR (GT1 vs GT2/3) Naïve Experienced	 40%/80% 15%/80%	Ghany (2009), AASLD Practice Guidelines: Diagnosis, Management and Treatment of Hepatitis C, An Update. Hepatology 2009; 49: 1335-74

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Key assumptions supporting epidemiology & patient waterfall

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	Variable	Value (2010)	Source and/or Rationale
1	HCV Prevalence	3.8 M	Based upon country specific HCV screening. Sources: Cornberg (2011), Liver International, V31, S2, July 2011
2	HCV Incidence	20K	Assumed same ratio of incidence to prevalence as US
3	Mortality rate	2.8%	Age-specific all-cause mortality: 45-54 = 0.42%, 55-64 = 0.87%, 65-74=2%, 75-84=5% Current distribution of HCV+ population: <40=16%, 40-60=25%, >60=59% Sources: CDC (2007), , FR: Applied average EU-4 age distributions, GE: Palitzsch Eur J Gastro & Hep 1999;11:1215, IT: Guadagnino Hepatology 1997;26:1006, SP: Dominguez J Med Virol 2001;65:688, UK: Hepatitis C National Register data
4	Total Diagnosed	1.28M	No diagnosis data in EU. Assume US data applies: 32 – 37% of the prevalent population was aware of their HCV status based on a US national study. Sources: Armstrong (2004), Hepatology, 40(4:S1):176a, Culver (2000), Transfusion, 40:1176,
5	Annual Diagnosis Rate (of undiagnosed prevalent)	3.6%	Same assumption as US. Source: WK Claims Database (2002-2008)
6	Treated	52K	Same assumption as US. Sources: IMS MIDAS, Synovate Chart Audits, Roche and Schering Plough annual reports
7	HCV Treatment Failure Pool	231K	Same assumption as US. Source: IMS MIDAS, Synovate Chart Audits (2007)
8	SVR (GT1 vs GT2/3) Naïve Experienced	 40%/80% 15%/80%	Same assumption as US. Source: Ghany (2009), AASLD Practice Guidelines: Diagnosis, Management and Treatment of Hepatitis C, An Update. Hepatology 2009; 49: 1335-74

Key assumptions supporting epidemiology & patient waterfall

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	Variable	Value (2010)	Source and/or Rationale
1	HCV Prevalence	628K	Based upon country specific HCV screening. Sources: Tanaka J., et al. Intervirology 2004;47:32
2	HCV Incidence	9.1K	Reported incidence ranges from 1.8-3.4 per 100,000 or calculated incidence of 2.2k to 4.3k per year. Source: Sievert (2011), A systematic reviewof hepatitis C virus epidemiology in Asia, Australia and Egypt, Liver International
3	Mortality rate	10.1%	Current distribution of HCV+ population: <40=5%, 40-60=28%, >60=27%, >70=40% Sources: Tanaka Intervirology 2004;47:32 and epidemiology modeling to project to 2009
4	Total Diagnosed	203k	No diagnosis data in JPN. Assume 30%. Sources: Armstrong (2004), Hepatology, 40(4:S1):176a, Culver (2000), Transfusion, 40:1176,
5	Annual Diagnosis Rate (of undiagnosed prevalent)	2.5%	There are no reported diagnosis rates for JPN.
6	Treated	10K	Same assumption as US. Sources: IMS MIDAS, Synovate Chart Audits, Roche and Schering Plough annual reports
7	HCV Treatment Failure Pool	96K	Same assumption as US. Source: IMS MIDAS, Synovate Chart Audits (2007)
8	SVR (GT1 vs GT2/3) Naïve Experienced	 40%/80% 15%/80%	Same assumption as US. Source: Ghany (2009), AASLD Practice Guidelines: Diagnosis, Management and Treatment of Hepatitis C, An Update. Hepatology 2009; 49: 1335-74

Patient Populations and Demographics

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US HCV Patient Waterfall: 2010

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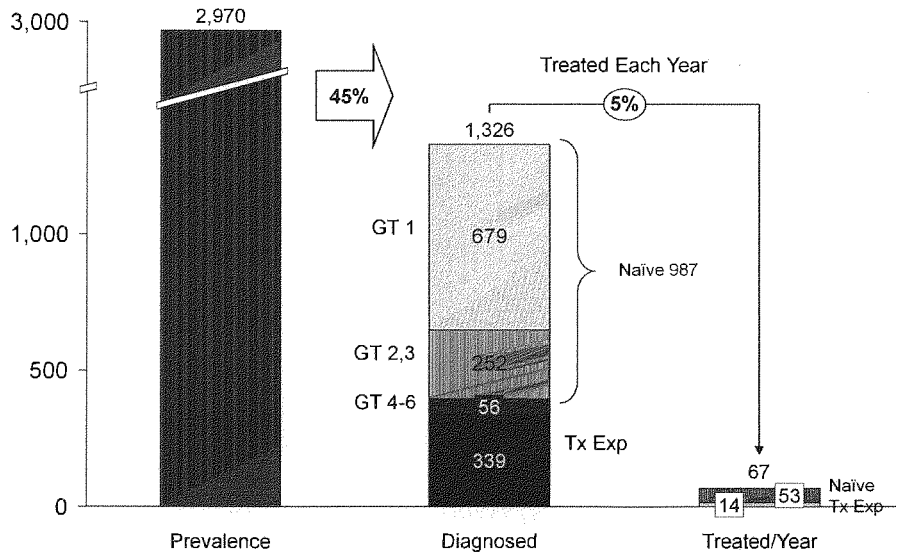
Patients in thousands



EU-Core 5 HCV Patient Waterfall: 2010

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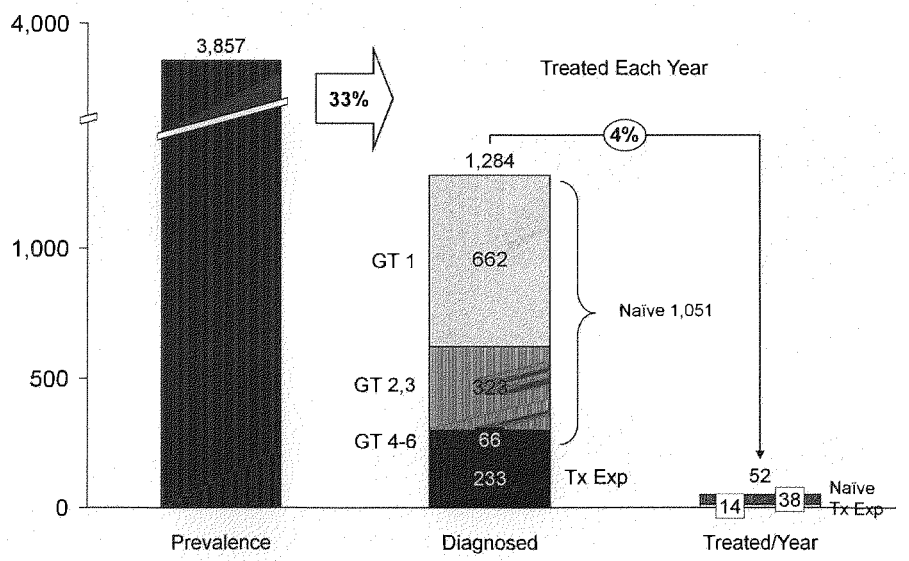
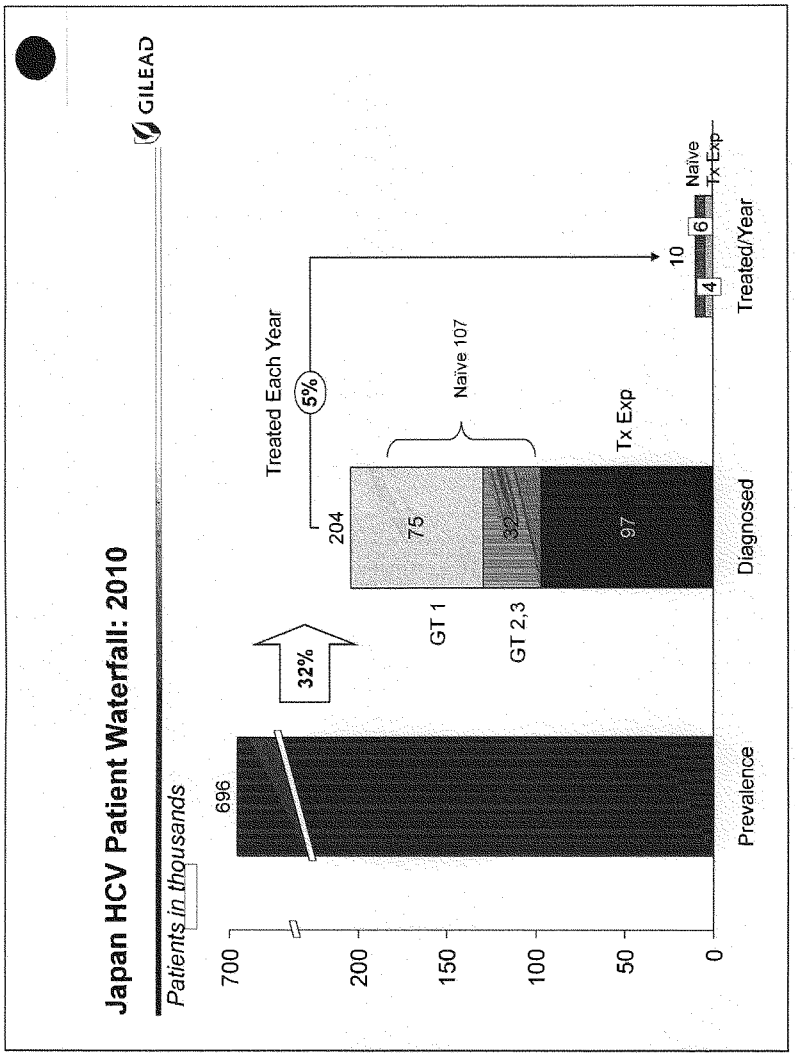
Patients in thousands





Global Prevalence of HCV is Estimated to be 160 Million Individuals[1]

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1) Lavanchy, et al. 2011. 2) Cornberg, Sievert, and Kershenobich, et al 2011.

HCV Prevalence (M) and Treatment (K) in Core and Emerging Markets

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Region	US[1]	EU-Core 5[1]	Japan[1]	Can & Australia[2]	Europe Other[2]	Asia[2]	Latin America[2]
GT1 (%)	2.1 (73%)	2.4 (63%)	0.4 (70%)	0.3 (61%)	4.4 (65%)	27.7 (39%)	3.7 (68%)
All GT	2.9	3.8	0.7	0.5	6.7	70.8	5.4
	7.4 (68% GT1)			83.4 (43% GT1)			
# Treated	67k[1]	52k[1]	10k[1]	4.3k[3]	27.9k[3]	47.1k[3]	0.6k[3]
	129k[1]			79.9k[3]			

1) Barclay's Forecast (for prevalence estimate and treated patient estimates in US, EU-Core 5 and JPN).
2) Cornberg, Sievert, and Kershenobich, et al 2011. Country pop from 2009 World Bank estimates.
3) 2010 IMS MIDAS Peg-IFN units for markets outside of US, EU-Core 5 and JPN. Converted to patients by dividing units by weighted AVG treatment duration for GT1 or GT2/3.

Background Information

Appendix
HCV Prevalence Estimates for Core and Emerging Markets

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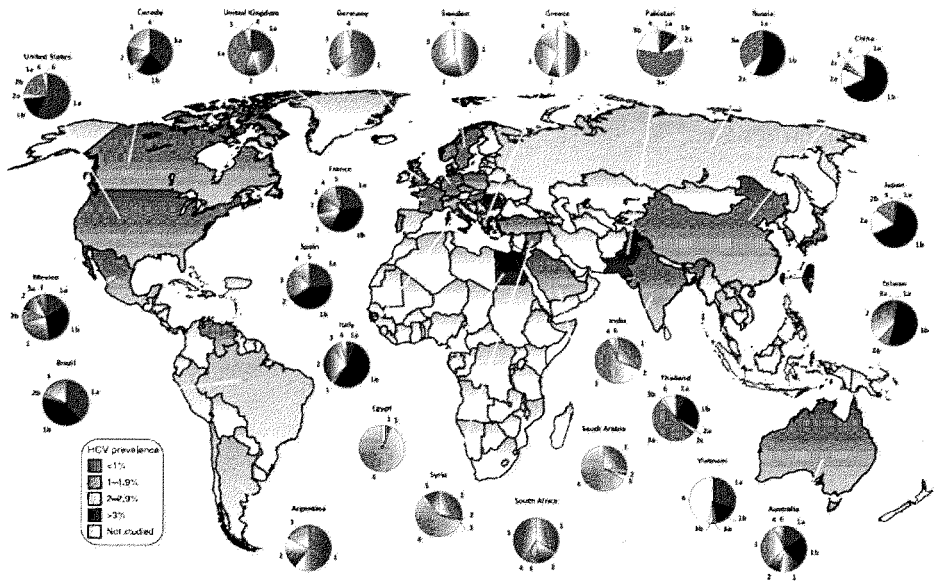
Genotype Distribution Region	Country	GT1	Non-GT1	GT1 Prev (M)	Non-GT1 Prev (M)	Prevalence (M)
Asia	China	68%	32%	17.10	8.20	25.30
Asia	Egypt	6%	94%	0.74	11.61	12.35
Asia	India	31%	69%	6.85	15.10	21.95
Asia	Korea	50%	50%	0.10	0.10	0.19
Asia	Pakistan	12%	89%	0.59	4.51	5.09
Asia	Saudi Arabia	23%	77%	0.11	0.37	0.48
Asia	Syria	29%	72%	0.11	0.29	0.40
Asia	Taiwan	48%	52%	0.48	0.52	1.00
Asia	Thailand	33%	67%	0.48	0.98	1.46
Asia	Vietnam	47%	53%	1.19	1.34	2.53
Canada, Australia	Australia	62%	38%	0.16	0.10	0.26
Canada, Australia	Canada	60%	40%	0.15	0.10	0.24
EU-Core 5	EU-Core 5	63%	37%	2.36	1.38	3.74
Europe, Other	Czech Republic	79%	21%	0.08	0.02	0.10
Europe, Other	Greece	47%	53%	0.10	0.11	0.21
Europe, Other	Hungary	94%	6%	0.06	0.00	0.06
Europe, Other	Israel	70%	30%	0.10	0.04	0.15
Europe, Other	Norway	62%	39%	0.02	0.01	0.03
Europe, Other	Poland	58%	43%	0.42	0.31	0.72
Europe, Other	Portugal	52%	48%	0.08	0.08	0.16
Europe, Other	Romania	93%	7%	0.70	0.05	0.75
Europe, Other	Russia	56%	44%	1.98	1.57	3.55
Europe, Other	Sweden	45%	55%	0.02	0.03	0.05
Europe, Other	Switzerland	51%	49%	0.07	0.07	0.14
Europe, Other	Turkey	97%	3%	0.73	0.02	0.75
Japan	Japan	70%	30%	0.44	0.19	0.63
Latin America	Argentina	59%	41%	0.36	0.25	0.60
Latin America	Brazil	65%	35%	1.89	1.02	2.91
Latin America	Mexico	70%	30%	0.72	0.30	1.02
Latin America	Puerto Rico	82%	18%	0.07	0.02	0.09
Latin America	Peru	86%	14%	0.48	0.08	0.55
Latin America	Venezuela	65%	35%	0.18	0.09	0.27
US	US	73%	27%	2.14	0.79	2.93

Global HCV Genotype Distribution



Global Genetic Distribution of IL28b

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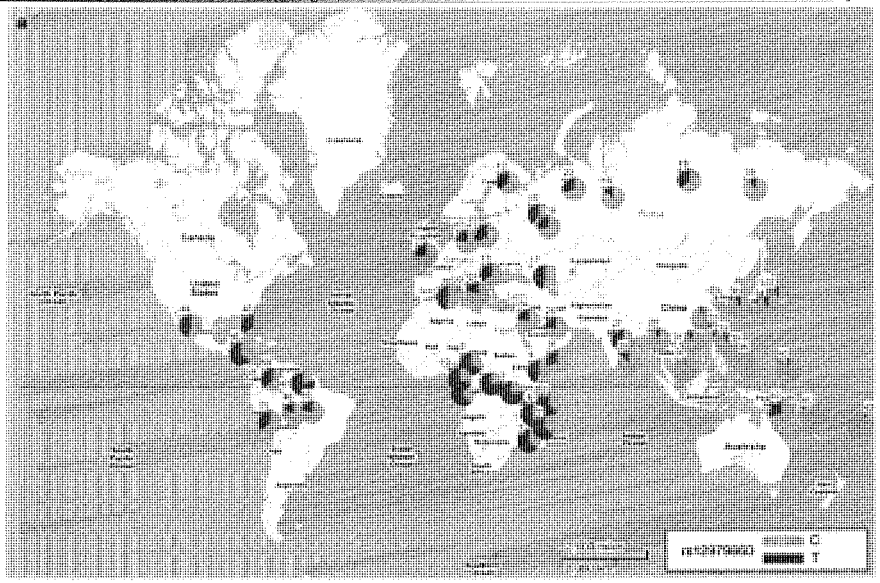

2009 US and EU HCV Age Distribution

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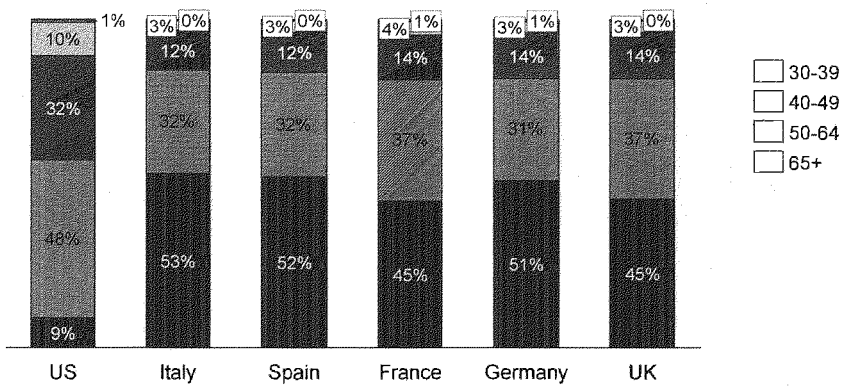
Age Distribution of HCV Population, 2009:



- US HCV population generally younger than in the EU; however, 57% > 50 years of age
- Roughly half of the EU HCV population is >65 yrs old
  - EU HCV population older than US, consistent with the hypothesis of post-WW II infection

16

Future HCV Patient Dynamics

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Patient Forecast Model Assumptions and Sensitivities

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Assumption	Future Dynamic (2010 to 2030)	Rationale
Incidence rate	Slow decline	With availability of blood screening, HCV infections are now predominantly limited to high risk populations (IVDU, HIV+) in US, EU-5 and Japan
Mortality rate	Steady increase in US/EU-5	Aging HCV prevalent population
Diagnosis rate	Significant increase	Availability of new therapies will lead to increases in disease awareness. Aging HCV+ population will experience clinical manifestations of disease
Treatment rate	Significant increase	More efficacious treatment in near term and all-oral regimens in long term will drive more MDs to treat
SVR rate	Significant increase (GT1)	PI-based regimens have set the efficacy bar

- **The epidemiology model is sensitive to changes to the following:**
  - **Incidence rate**
  - **Mortality rate**
  - **Diagnosis rate**
  - **Treatment rate**
  - **SVR rate**

Can Barclays assess the sensitivity of the model to these assumptions and highlight the drivers?

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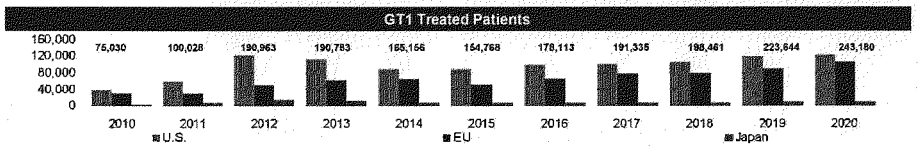
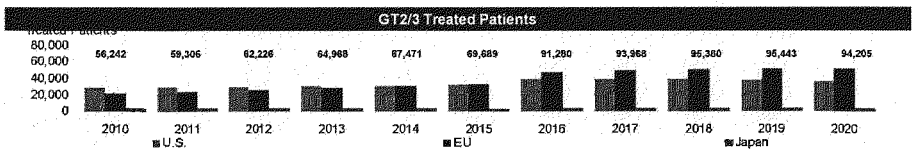
Patient Forecast Model: Key Assumpti

To be updated by Barclays

Diagnosis and Treatment Rate

	U.S.			EU					
	2010	2015	2020	2010	2015	2020	2010	2015	2020
New Diagnosis Rate	3.6%	4.7%	6.6%	3.6%	4.7%	6.6%	2.5%	4.5%	8.5%
Treatment Rate									
Naïve GT1	4.7%	10.7%	18.0%	3.4%	5.9%	13.5%	4.7%	10.7%	18.0%
Naïve GT2/3	8.5%	11.0%	18.0%	4.2%	6.7%	13.5%	8.5%	11.0%	18.0%
Experienced GT1	2.8%	9.0%	17.3%	5.7%	8.3%	16.7%	2.8%	9.0%	17.3%
Experienced GT2/3	8.0%	10.5%	17.3%	7.1%	9.6%	16.7%	8.0%	10.5%	17.3%





Note: Number of treated patients above bars represents worldwide treated patients.

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Treatment Rates: Drivers and Benchmarks

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- Total treated patients increase 2.6x from 131k (2010) to 339k (2020)
- The drivers for increased treatment include
  - Near term: more effective therapies now available for treatment naïve and treatment experienced patients, improved awareness of disease, warehoused pool of patients awaiting PI launch
  - Long term: well tolerated regimens, activity in patients who fail PI-based regimens, improved activity in GT2/3, improved awareness of disease

	2005 – 2010	2010 – 2020
Growth in Treated HCV Patients[1]		158%
Benchmark: Growth in ARV treated HIV Patients[2]	36%	
Benchmark: Growth in treated HBV Patients[3]	107%	

1. Barclays Forecast July 15, 2011
2. Synovate
3. WKH PHAST TRx, IMS LRx, and internal estimates

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Benchmark for Near-Term Growth

51% Increase in Pegasys NRx Volume 6 Weeks Post-PI Launch

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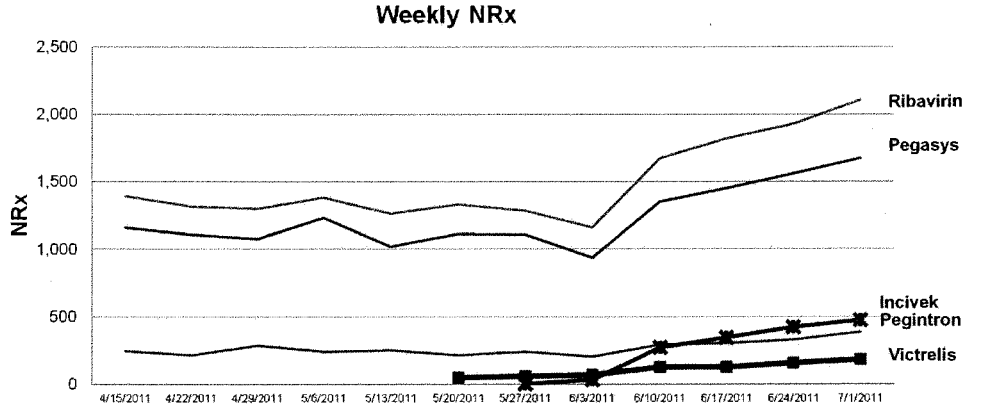

	4/15/2011	4/22/2011	4/29/2011	5/6/2011	5/13/2011	5/20/2011	5/27/2011	6/3/2011	6/10/2011	6/17/2011	6/24/2011	7/1/2011	4 Wk Avg	12 Wk Avg
RIBAVIRIN	1,396	1,316	1,302	1,383	1,263	1,334	1,285	1,163	1,676	1,823	1,930	2,107	1,884	1,498
PEGASYS	1,158	1,109	1,078	1,235	1,019	1,112	1,108	937	1,354	1,454	1,559	1,675	1,511	1,233
PEGINTRON	246	214	287	243	249	214	242	202	292	305	331	387	329	268
VICTRELIS						46	57	71	126	125	155	182	147	64
INCIVEK							2	33	272	344	425	477	380	129

Source: Wolters Kluwer Health PHAST Weekly

Commercial Planning & Operations

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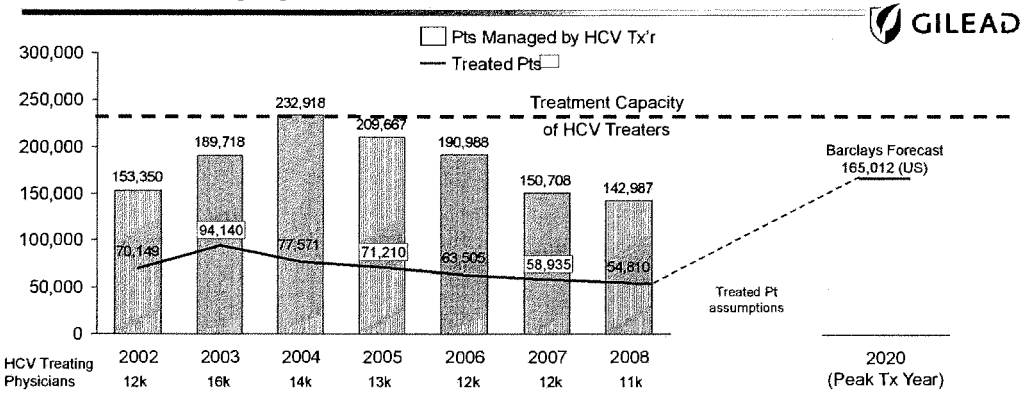
Is there health-care capacity to support forecast growth in HCV treated population?



- The historical peak #'s of HCV+ patients managed by treating MDs is 233k in 2004 and 94k treated in 2003
- If required, additional capacity does exist- only 51% of the 11.5k Hep/GEs and 11% of the 5.9k IDs prescribe HCV treatments
- Simpler, better tolerated therapies with shorter duration may allow for further expansion of treaters to ID

1. Managed patients and number of treating physicians based on Wolters Kluwer medical claims data analysis, which excluded patients treated in VA clinics/hospitals, prisons, and LTC. Scaled up Managed pts numbers by 25% based on the % of non-retail Peg-IFN units vs total Peg-IFN units in 2007-2008. Physician numbers have not been scaled up.
2. Treated patients calculated based on IMS MIDAS unit volume data which includes retail & non-retail channels.
3. Gilead estimates based upon 2014 and analysts estimates of 2012

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Milestones / Timelines / Lifecycle / Patents

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Gryffindor Pro-Forma

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Model Assumptions	OAV + IFN/RBV	All Oral
Launch year	2015 in US, 2016 in EU, 2017 in JPN	2016 in US, 2017 in EU, 2018 in JPN
Peak penetration	GT1: 34.2% in all markets	GT1: 61.5% in all markets GT2/3: 18.8% in all markets
Peak year	2017	2020
Penetration curve	Launch Yr % Peak 0 30% 1 60% 2 100% 3 50% 4 25% 5 2.5	Launch Yr % Peak 0 30% 1 60% 2 100% 3 95% 4+ 90%
Price	$50k gross/patient/year in US EU: 75% US JPN: 57% US	$64k gross/patient/year in US EU: 75% US JPN: 57% US
Price increases	US: 3%/yr to 2015 EU/JPN: -3%/yr 2015	US: 3%/yr to 2015 EU/JPN: -3%/yr 2015
Patent timing and impact	2026 patent expiry Revenues decay 20% 1st yr and 50%/yr to 2030	2026 patent expiry Revenues decay 20% 1st yr and 50%/yr to 2030
POS	80%	55%

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Product Assumptions – Harry Base Case (cont'd)

Gryffindor OAV + IFN/RBV Assumptions

Assumptions in Barcap Model			Rationale & Source / Data Range
Launch Year	GT 1: 2015 in U.S. 2016 in EU 2017 in Japan	GT 2/3: NA	
Peak Penetration	GT 1: 34.2% in U.S., EU and Japan	GT 2/3: NA	
Penetration curve	Year after Launch: 0, 1, 2, 3, 4, 5 % of Peak Penetration: 30.0%, 60.0%, 100.0%, 90.0%, 25.0%, 2.5%		▪ Quickly drop after the peak year due to superior 2+DAA cocktails launch
	GT 2/3: NA		
Peak Year	GT 1: 2017	GT 2/3: NA	▪ Modeled off of Peg-IFN
SVR (cure rate)	GT 1: 60% in treatment-naïve 75% in treatment-experienced	GT 2/3: NA NA	▪ Assume increase over PI-Peg-Ribavirin
Pricing	$50,000 gross price / patient / year in U.S. 3% annual U.S. increase and 3% annual EU/Japan decrease until 2015 EU pricing is 75% of the U.S. price and Japan pricing is 57% of the U.S. price Gross-net discount of 19%-25% in the U.S.		▪ ~$80k per cure (subtract $14k Peg-IFN/RBV cost) ‣ Victrelis average pricing of $86,700 in the U.S. ‣ Incivek average pricing of $89,600 in the U.S. ‣ Wall Street research shows 0%-22.5% discount in EU
Probability of Success	80%		▪ R&D assessment
Patent impact	Revenues decay 20% in 2026, and at 50% annually after that before disappearing in 2030		▪ Standard revenues decay curve after patent expiry ▪ Barcap assumption
COGS expense	Trial Status: 2011 Phase II, 2012 Phase II, 2013 Phase III, 2014 Phase III, 2015 Launch R&D expense: 30, 30, 90, 90, 90 3.5% additional cost burden		▪ Gryffindor R&D assumption (Project Management) ‣ Wall Street research shows 5-10%
SG&A expense	▪ Assumes total costs distributed evenly by # of products		▪ Assume one sales and marketing team dedicated to HCV franchise
R&D expense			▪ 25% greater cost than the nuc + SOC R&D expense, given potential for greater number of patients and/or more complex trials for combo drug development
	▪ 7% of product sales for year one after launch, 4% for year two after launch, and 2% for year three and thereafter until patent expires		▪ Gryffindor R&D team assumption

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Product Assumptions – Harry Base Case (cont'd)

Gryffindor Pro Forma All Oral Regimen Assumptions

Assumptions in Barcap Model			Rationale & Source / Data Range
Launch Year	GT 1: 2016 in U.S. 2017 in EU 2018 in Japan	GT 2/3: 2016 in U.S. 2017 in EU 2018 in Japan	▪ Incorporates benefit of Harry nuc
Peak Penetration	GT 1: 61.5% in U.S., EU and Japan	GT 2/3: 18.8% in U.S., EU and Japan	▪ Incorporates benefit of Harry nuc
Penetration curve	Both GT 1 and GT 2/3 0: 30%; 1: 80%; 2: 100%; 3: 85%; 4+: 90%		▪ Keep the peak penetration rate until patent expires ▪ Modeled off of Peg-IFN
Peak Year	GT 1: 2020	GT 2/3: 2020	
SVR (cure rate)	GT 1: 80% in treatment-naïve 75% in treatment-experienced	GT 2/3: 85% in treatment-naïve 85% in treatment-experienced	▪ Wall Street research shows at least 90%
Pricing	$64,000 gross price / patient / year in U.S. 3% annual U.S. increase until 2015, 3% annual EU/Japan decrease EU pricing is 75% of the U.S. price and Japan pricing is 57% of the U.S. price Gross-net discount of 19%-25% in the U.S. 8% convenience bump in 2016 in the U.S., 6% in 2017 in the EU and 2018 in Japan		▪ ~$80k per cure ‣ Victrelis average pricing of $86,700 in the U.S. ‣ Incivek average pricing of $89,600 in the U.S. ‣ Wall Street research shows 0%-22.5% discount in EU
Probability of Success	55%		▪ R&D assessment
Patent impact	Revenues decay 20% in 2026, and at 50% annually after that before disappearing in 2030		▪ Standard revenues decay curve after patent expiry ▪ Barcap assumption
COGS expense	Year % of product sales Status: 2011 Phase II; 2012 Phase II; 2013 Phase III; 2014 Phase III; 2015 Launch R&D expense: 30; 30; 90; 90; 90		▪ Wall Street research shows 5-10%
SG&A expense	▪ Assumes total costs distributed evenly by # of products		▪ Assume one sales and marketing team dedicated to HCV franchise
R&D expense	▪ 7% of product sales for year one after launch, 4% for year two after launch, and 2% for year three and thereafter until patent expires		▪ 25% greater cost than the nuc + SOC R&D expense, given potential for greater number of patients and/or more complex trials for combo drug development ▪ Gryffindor R&D team assumption
Other	▪ Gryffindor receives 100% of revenues and 100% of costs		▪ All internal development

Penetration / Competition

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U.S. Market Share Split by Genotype

GT1 Patients = 73% of Total Patient Population
GT2/3 Patients = 27% of Total Patient Population

Harry Standalone

Combo	U.S. Launch	GT1 Peak Penetration	GT2/3 Peak Penetration	Weighted Average Peak Penetration
Redacted				
Harry nuc + IFN/RBV	2015	30.8%	0.0%	22.5%
Harry nuc + nuc	2016	19.2%	50.0%	27.5%
Harry nuc + other	2016	22.6%	50.0%	30.0%

Gryffindor Standalone

Combo	U.S. Launch	GT1 Peak Penetration	GT2/3 Peak Penetration	Weighted Average Peak Penetration
Gryffindor PI/NS5A + IFN/RBV	2016	15.1%	0.0%	11.0%
Gryffindor All Oral Regimen	2017	31.5%	0.0%	23.0%

Gryffindor Pro Forma

Combo	U.S. Launch	GT1 Peak Penetration	GT2/3 Peak Penetration	Weighted Average Peak Penetration
Redacted				
OAV + IFN/RBV	2015	34.2%	0.0%	25.0%
Gryffindor PF All Oral Regimen	2016	61.5%	18.8%	50.0%

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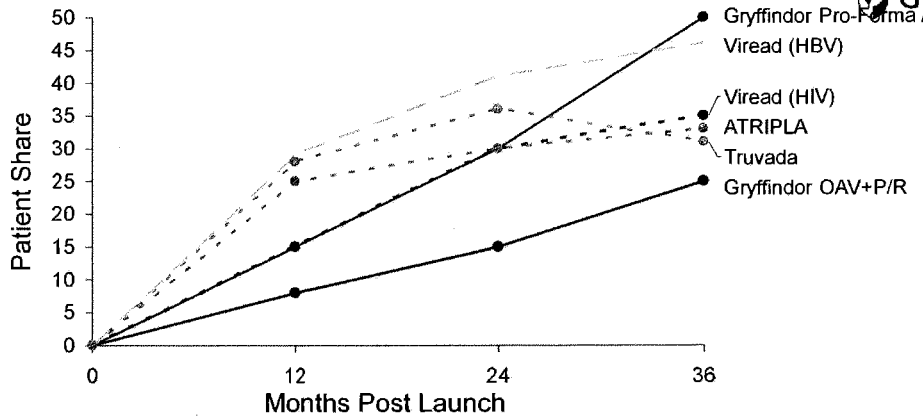
Market Share Benchmarks to HIV and HBV Franchise



Months Post Launch	12	24	36
Gryffindor OAV+P/R	8%	15%	25%
Gryffindor Pro-Forma All Oral	15%	30%	50%
Viread (HIV)	15%	30%	35%
Truvada	28%	36%	31%
ATRIPLA	25%	30%	33%
Viread (HBV)	29%	41%	46%

Greater number of HIV competitors than assumed for all oral space in HCV

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HCV patient share assumptions from Barclays Model July 15, 2011
HIV patient share from Synovate
HBV Script Share from Source® Monthly PHAST and Source Payer-Prescriber Data

Competition: Combination Development Landscape

GILEAD

- Thirteen combination clinical studies are ongoing or announced
  - 2 inter-company collaborations and 11 intra-company programs (from 8 companies)
  - Earliest possible launch is 4Q 2015 (Redacted
- Of the 5 combinations containing a NI, all are from the HARRY portfolio
- Redacted
  - Established safety: all compounds have established safety profiles from Ph2b studies
  - Potent combinations: all compounds have > 3 log reduction HCV RNA in monotherapy studies
- Of the 8 companies with internal combination programs, all have $\geq$ 1 weak link in the combination
- The two most promising combinations both involve collaborations with HARRY
  - Project HARRY offers the opportunity to have the 1st all OAV regimen with no weak links
  - The risk is that inter-company collaborations could threaten the leadership in all OAV regimens
- There is a downside for Gryffindor standalone if HARRY is acquired by another company

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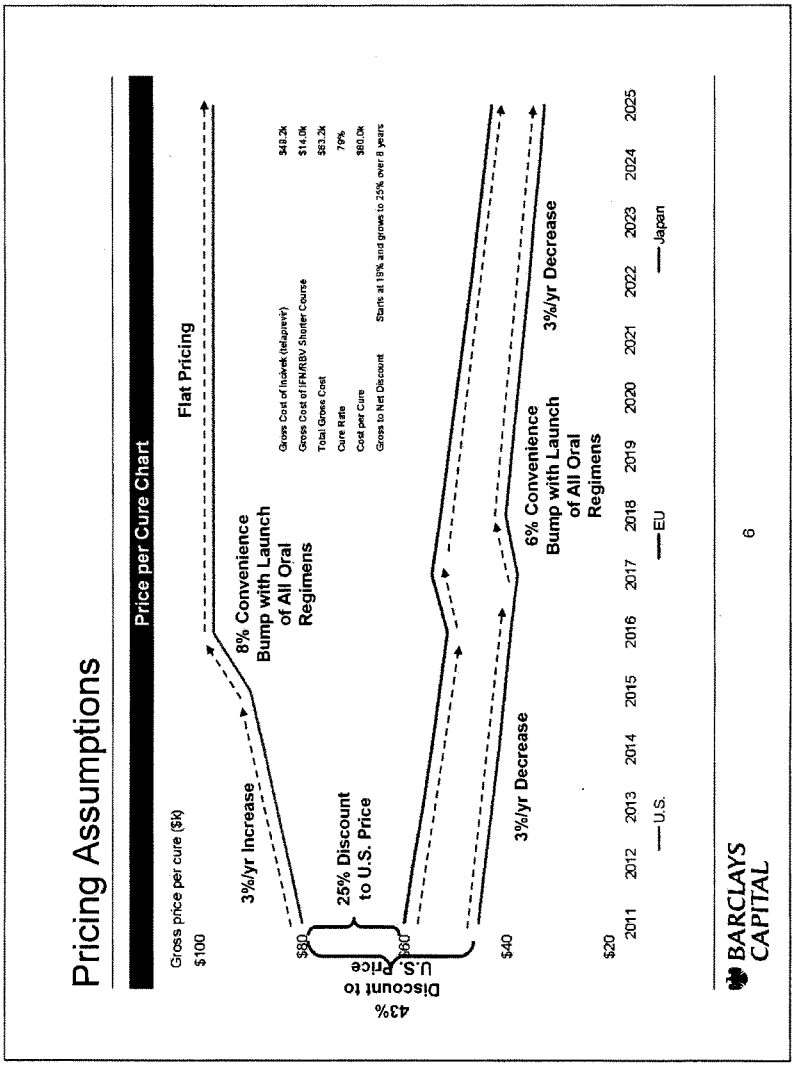
Competition: Combination Studies

Company	Compound	Compound	Class	Phase	Pts	IFN	RBV	Duration	Est. Launch	Comments
Inter-Company Collaboration										
Redacted										
Redacted										
Intra-Company Combination										
Redacted										
VRUS	PSI-7977	PSI-938	NI, NI	PhIIb	TN	-	+/-	Tbd	3Q2016	Limited safety data on PSI-938.
Redacted										
Vertex	TVR	VX-222	PI, NNI	PhIIa	TN	+/-	+	12/24 wks	2Q2017	TVR and VX-222 are poorly tolerated (rash/diarrhea)
Redacted										
Abbott	ABT-450/r	ABT-072	PI + NNI	PhIIa	TN	-	+	12 wks	3Q2017	NNI ABT-072 low potency. RTV boosted PI.
Redacted										
Abbott	ABT-450/r	ABT-333	PI + NNI	PhIIa	TN	-	+	12 wks	1Q2018	ABT-333 low potency. RTV boosted PI.
Redacted										
BI	BI-201335	BI-207127	PI, NNI	PhIb/II	TN	-	+/-	24/48 wks	4Q2019	TID and low potency NNI.

1: In GT1/2/3

Pricing

GILEAD



Business Proprietary Information – Confidential Treatment Requested

GS-0005543

Price Per Cure – Treatment Naïve Patients

52% Increase in Price Per Cure with the Addition of PIs

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Peg-IFN/Ribavirin	48 w Duration (GT1)	24 w Duration (GT2/3)
Pegasys/Ribavirin	$29,882 (48 wks)	$14,941 (24 wks)
SVR	51%	82%
Price Per Cure	$58,592	$18,220

Telaprevir	48 w Duration[3]	24 w Duration	Estimated Avg (34 w)
Telaprevir	$49,200 (12 wk)	$49,200 (12 wk)	$49,200
Pegasys/Ribavirin	$29,882 (48 wks)	$14,941 (24 wks)	$21,215
Total Regimen Cost	**$79,802**	**$64,141**	**$70,415**
SVR	60%	92%	79%
Price Per Cure	$133,000	$69,718	$89,133

Boceprevir	32 wk BOC + 48 wk P/R	28 wk course	Estimated Avg (39 w)
Boceprevir	$35,200 (32 wks)	$26,400 (24 wks)	$31,326
Pegasys/Ribavirin	$29,882 (48 wks)	$17,431 (28 wks)	$24,400
Total Regimen Cost	**$65,082**	**$43,831**	**$55,727**
SVR	40%	96%	63%
Price Per Cure	$162,705	$45,657	$88,455

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HCV Single Agent Pricing

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Country	Price Per Week[1] (% Discount to US)		
	Pegasys	Incivek[2]	Victrelis[3]
US	$576	$4,100	$1,100
France	$229 (40%)	$2,567 (63%)	$1,250 (114%)
UK	$199 (34%)		$1,148 (104%)
Germany	$315 (55%)		
Italy	$273 (47%)		
Spain	$288 (50%)		
Japan	$342 (59%)		

1. Prices from Analysource.com Accessed April 2011, unless otherwise noted
2. Incivek US price from May 23, 2011 Vertex Press Release. France price from ATU.
3. Victrelis US price from May 13, 2011 Merck Press Release. France price from ATU. UK posted price.

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Selected Pricing Analogues

Selected Pricing Analogues

Drug	Indication	Launch Date	EU Discount / (Premium) to U.S. Launch	L + 1	L + 2	L + 3	L + 4	L + 5	5-Year Price CAGR U.S.	EU
Benlysta	**Systemic Lupus Erythematosus (SLE)**	**1H'11**	**25%**	**28%**	**31%**	**33%**	**36%**	**38%**	**4%**	**0%**
Yervoy	**Metastatic Melanoma**	**1H'11**	**17%**	**24%**	**30%**	**36%**	**41%**	**46%**	**7%**	**(2%)**
Prolia	Postmenopausal Osteoporosis (PMO)	2H'10	0%	6%	6%	6%	11%	11%	2%	0%
Xgeva	Bone metastases	2H'10	NA	0%	6%	11%	16%	21%	5%	NA
Xiaflex	Dupuytren's Contracture	1H'10	NA	19%	19%	19%	19%	19%	2%	NA
Kuvan	Phenylketonuria (PKU)	2H'07	(5%)	(5%)	(0%)	(0%)	5%	5%	2%	0%
Soliris	Paroxysmal Nocturnal Hemoglobinuria (PNH)	1H'07	(10%)	(10%)	(7%)	(4%)	(4%)	(4%)	1%	0%
Revlimid	**Multiple Myeloma (MM)**	**2H'06**	**(15%)**	**(10%)**	**(7%)**	**11%**	**16%**	**19%**	**4%**	**(3%)**
	Best Fit Mean[1]		**9%**	**14%**	**18%**	**27%**	**31%**	**34%**	**5%**	**(2%)**

	EU Discount / (Premium) to U.S. L - 5	L - 4	L - 3	L - 2	L - 1	Launch	L + 1	L + 2	L + 3	L + 4	L + 5	5-Year Price CAGR U.S.	EU
Pyr. nuc + nuc - Base Case	**25%**	**29%**	**33%**	**37%**	**41%**	**47%**	**44%**	**46%**	**47%**	**49%**	**50%**	**0%**	**(1%)**

Source: Wall Street research.
1. Best fit defined by closest pricing analogues to Pyramid compounds. Includes Benlysta, Yervoy and Revlimid.

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Commercial Costs

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Summary of Key Assumptions

Patient Population

- **Genotype Breakdown:** U.S.: 73% GT1, 27% GT2/3; EU: 63% GT1, 37% GT2/3; Japan: 70% GT1, 30% GT2/3
- **Diagnosis Rate:** Increases steadily over time due to greater patient awareness and availability of treatments (see page 5 for detailed assumptions)
- **Treatment Rate:** Increases from 2011-2012 due to wave of recently launched PIs, decreases and then stays constant from 2013-2015 due to warehousing ahead of and leading into IFN sparing and then increases from 2016-2020 due to wave of all oral therapy (see page 5 for detailed assumptions)

Pricing

- **Price per cure:** $80k (see page 6 for detailed assumptions)

U.S.
- Gross to net discount: Starts at 19% at launch year, grows to 25% linearly over 8 years and stays flat thereafter (see page 9 for detailed assumptions)
- 3% ramp, 8% oral price bump, flat growth thereafter (see page 6 for detailed assumptions)

EU
- 25% discount to U.S.; -3% ramp, 6% oral price bump, -3% growth thereafter (25% discount today growing to 47% in 2016)

Japan
- 43% discount to U.S.; -3% ramp, 6% oral price bump, -3% growth thereafter (43% discount today growing to 60% in 2016)

Costs

COGS
- 11%: 7.5% COGS + 3.5% royalty

R&D
- Before launch: For all DAA+SOC products: 250, 1k and 3k pts costing ~$60k/patient for Phase I, II and III trials, respectively; for all 2+DAA products: 25% greater cost than DAA+SOC R&D expenses
- At launch year: R&D cost is equal to that of the prior year
- After launch: 7% of product sales for year one after launch, 4% for year two, and 2% for year three and thereafter until patent expires
- For Giza Pro Forma, assumes that Giza will develop four products (two DAA+SOC, two 2+DAA) in Phase I and II studies and advance the better two combos into Phase III

SG&A

	Pyramid Standalone	Giza Standalone	Giza Pro Forma
U.S. HCV Sales Force	195	195 (119 incremental)	195 (119 incremental)
Cost ($mm)	49	30	30

- U.S. managed markets and marketing & operations costs: $9mm (37 FTEs)
- Additional G&A costs: Pyramid Standalone: $17mm in 2011, grows to $40mm in 2016 and stays flat thereafter; Giza Standalone / Giza Pro Forma: 50% of Pyramid Standalone

Other

- Tax rate: 26%

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Hepatology Sales Force Benchmarks

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	Merck		Roche		Gilead	Vertex
	US	EU	US	EU	US[3]	US
Total Field Force			126		76	150-200[1]
Sales Representatives	100[1]	170[2]	92[1]	197[2]	65	100[1]
Sales Management	10[1]		6[1]		11	
MSLs			10[2]			
Clinical Consultants			18[2]			

1. Gilead CI July 2011
2. Gilead CI June 2007
3. Internal- an incremental 119 reps/sales management required for HCV launch.

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Exhibit 22

Project Harry – Barclays Deck Backgrounder

July 20, 2011

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Gilead Sciences, Inc.
Attachment 4(c)(7)
December 13, 2011

Barclays Deck – Slide 1

Disappointing Data from EASL on RG7128 PSI-7977 and PSI-938 Continue in Multiple Studies

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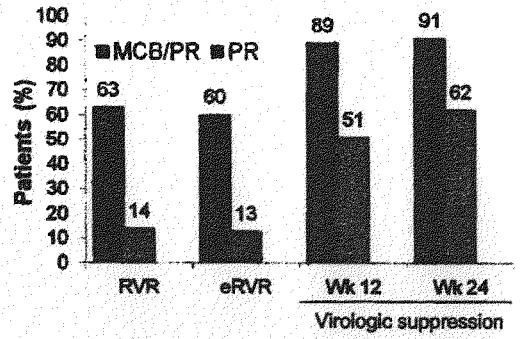
- Higher than expected relapse rate with RG7128 + P/R
  - 76% SVR rate in patients who qualified for 24 weeks for therapy
  - With TVR and BOC, ~90% SVR in same population
- PSI-7977 is in 10 studies that enroll over 700 patients
  - PSI-7977+P/R: SVR12 from Tx Naïve GT1 study PROTON as early as 4Q2011
  - PSI-938+PSI-7977: week 4 and week 12 data in GT1 study QUANTUM by 1H2012

Meracitabine (RG7128) combined with PR in G1/4: SVR12 with RGT

- Phase IIb, treatment-naive
- Meracitabine (MCB) 1000 mg BID
- RGT (n=81) (5 G4 pts):
  - MCB/PR 24 wks if eRVR
  - MCB/PR 24 wks then PR 24 wks if no eRVR
- PR 48 wks (n=85)
- No safety signals for MCB
- No resistance to MCB
- MCB modified IL28B effect



SVR12 in MCB pts with eRVR

SVR	Relapse
76% (37/49)	24% (12/49)

Pockros P, et al. EASL 2011, Berlin, O1359

Background Information

PSI-7977 Clinical Studies
(07/15/11)

GILEAD

GT1	585	Naïve 555 Nulls 10
GT2/3	127	Naïve
GT4,5,6	25	Naïve
Combined	717	Naïve 707 Nulls 10

[1]Number of patients dosed does not include pts from the planned studies, QUANTUM or PSI-7977 + TMC435. No details at this time.
Source: Clinicaltrials.gov; Citeline TrialTrove

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4

Background Information

PSI-7977 Clinical Studies: Planned (07/15/11)

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[illegible]	[illegible]	[illegible]	Study Design	Start Date	Expected Data
PSI-7977 + PSI-938 PhIIb (QUANTUM) TrialTroveID-138686	Nuc + Nuc GT1	Naïve	Planned: PSI-7977 + PSI-938, +/- R	3Q2011	SVR
PSI-7977 + TMC435 PhII TrialTroveID-149273	Nuc + PI GT1	Nulls	Study announced (07/06/11): PSI-7977 (QD) + TMC435 (QD) +/- RBV	2H2011	SVR12 1H2012

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Source: Clinicaltrials.gov, Citeline TrialTrove

[1]Assume 3 month enrollment, treatment duration, and 6 month follow-up. [2]Assume 2 month enrollment, treatment duration, and 6 month follow-up

PSI-7977 Clinical Studies: On-going (07/15/11)

GILEAD

PSI-7977/BMS-790052 Phila NCT01359644	Nuc + NS5A GT1a/1b, 2/3	Naïve (N=84)	7d PSI-7977 (400 mg); then add BMS-790052 (60 mg) for 24w total 24 w PSI-7977 (400 mg) + BMS-790052 (60 mg) 24 w PSI-7977 (400 mg) + BMS-790052 (60 mg) + R	05/2011	SVR 09/2012
PSI-7977 + P/R Phllb (ATOMIC) NCT01329978	Nuc + P/R GT1	Naïve (N=300)	(400 mg PSI-7977) (1:2:3) 12 w PSI-7977 + P/R 24 w PSI-7977 + P/R 12 w PSI-7977 + P/R; then 12 w PSI-7977 +/- R	04/2011	EVR 01/2012 SVR 06/2012
	GT4,5,6	(N=25)	24 w PSI-7977 (400 mg) + P/R		
PSI-7977 + RBV Phllb (ELECTRON) NCT01260350	Nuc + RBV GT2/3	Naïve (N=40)	Part 1: (400 mg PSI-7977) (1:1:1:1) 12 w PSI-7977 + RBV 12 w PSI-7977 + RBV + 4w Peg-IFN 12 w PSI-7977 + RBV + 8w Peg-IFN 12 w PSI-7977 + RBV + 12w Peg-IFN	10/2010	EVR 08/2011 SVR 02/2012
	GT1, 2/3	Naïve/ Nulls (N=30)	Part 2: (400 mg PSI-7977) (1:1:1) 12 w PSI-7977 monotherapy (TN, GT2/3) 8w PSI-7977 + P/R (TN, GT2/3) 12 w PSI-7977 + P/R (Nulls, GT1)	08/2011	SVR 2Q2012[1]
PSI-7977 + P/R Phllb (PROTON) NCT01188772	Nuc + P/R GT1	Naïve (N=125)	12w PSI-7977 (200 or 400 mg) + P/R; then RGT (+12w or 36w P/R) (N=100) 48w Pbo + P/R (N=25)	08/2010	SVR24 03/2012[2]
	GT2/3	Naïve (N=25)	12w PSI-7977 (400 mg) + P/R		SVR12 04/2011

Source: Clinicaltrials.gov, Citeline TrialTrove

[1]Assume 3 month enrollment, treatment duration, and 6 month follow-up. [2]Assume 2 month enrollment, treatment duration, and 6 month follow-up

PSI-7977 Clinical Studies: Completed (07/15/11)

GILEAD

PSI-7977 + P/R Phila NCT01054729	Nuc + P/R GT1	Naïve (N=63)	4 w PSI-7977 (100, 200, 400 mg) + P/R; then 44w P/R (N= 49) 4 w Pbo + P/R; then 44w P/R (N=14)	01/2011	RVR 05/2010
PSI-7977 + PSI-938 Phila (NUCLEAR) Trial Trove-137071	Nuc + Nuc GT1	Naïve (N=40)	14d PSI-938 (300 mg) (N=8) 7d PSI-938 (300 mg); then 7d PSI-938 + PSI-7977 (N=8) 7d PSI-7977 (400 mg); then 7d PSI-938 + PSI-7977 (N=8) 14d PSI-938 + PSI-7977 (N=8) Pbo (N=8)	12/2010	04/2011
PSI-7851[1] (PSI-7977/PSI-7976) Phl	Nuc GT1	Naïve (N=40)	Multiple ascending dose study in HCV-infected patients. 3d PSI-7851 QD (50,100, 200, and 400mg) (N=32) Pbo (N=8)	06/2009	4Q2009
PSI-7851[1] (PSI-7977/PSI-7976) Phl	Nuc	Healthy	Single ascending dose study: 25mg - 800mg	03/2009	

Source: Clinicaltrials.gov, Cliniine TrialTrove
[1]Company website

Barclays Deck – Slide 8 and 9

HCV Forecast Model Market Share and Pricing Information

GILEAD

- **Pro-Forma Market Share**
  - Benchmarks for HIV (TDF, TVD, ATR) range from 31-35% and for HBV (TDF) is 46% at 36 months post launch
  - Assumptions
    - OAV+P/R peak share of 25% reflects the rapidly evolving market with the all OAV regimens following only 1 year post launch
    - All OAV peak share of 50% reflects a differentiated profile, 1st to market and limited competitive set (1-2 competitors) due to the high failure rate in HCV development
- **Price-Per-Cure in Treatment Naïve Patients**
  - US assumption of $80k is in line with PI-based regimens which range from $45k to $162k for BOC and $70k to $133k for TVR
  - EU assumption of $60k is below the range of selected pricing analogs but higher than the current discount for Pegasys in the EU (relative to the US)
  - JPN assumption of $34k is in-line with the EU discount of Pegasys and higher than the Pegasys discount in JPN (relative to the US)

Barclays Deck – Slide 8 and 9

HCV Forecast Treatment Rates

GILEAD

- **Treatment rates**
  - **Total treated patients increase 2.6x from 131k (2010) to 339k (2020)**
  - **The drivers for increased treatment include**
    - **Near term: more effective therapies now available for treatment naïve and treatment experienced patients, improved awareness of disease**
    - **Long term: well tolerated regimens, activity in patients who fail PI-based regimens, improved activity in GT2/3, improved awareness of disease**
  - **Benchmarks in HIV and HBV of the growth in treated patients confirm that increased physician and patient awareness, industry investment and governmental support can all significantly drive increases in treatment rates**
  - **Additional capacity exists to treat substantially more patients within the current treater pool and in longer term to develop new treaters (IDs)**

Background Information

GILEAD

Model Assumptions
Share, Pricing, Treatment Rates, Costs

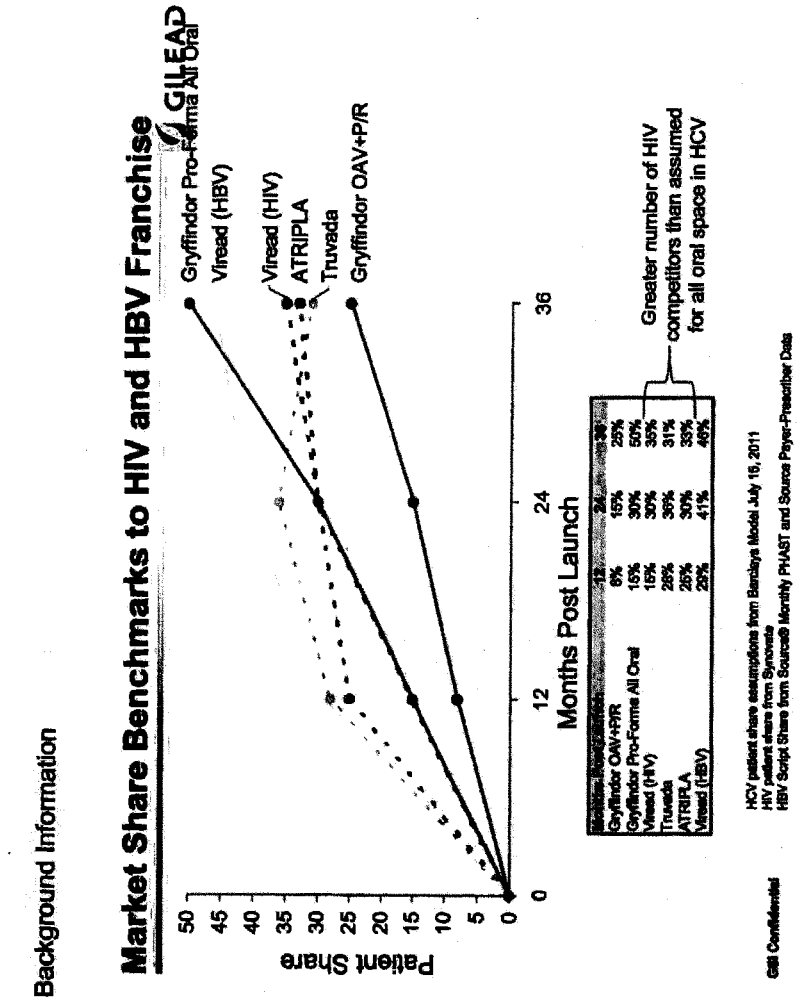
July 2011

GILEAD CONFIDENTIAL

U.S. Market Share Split by Genotype

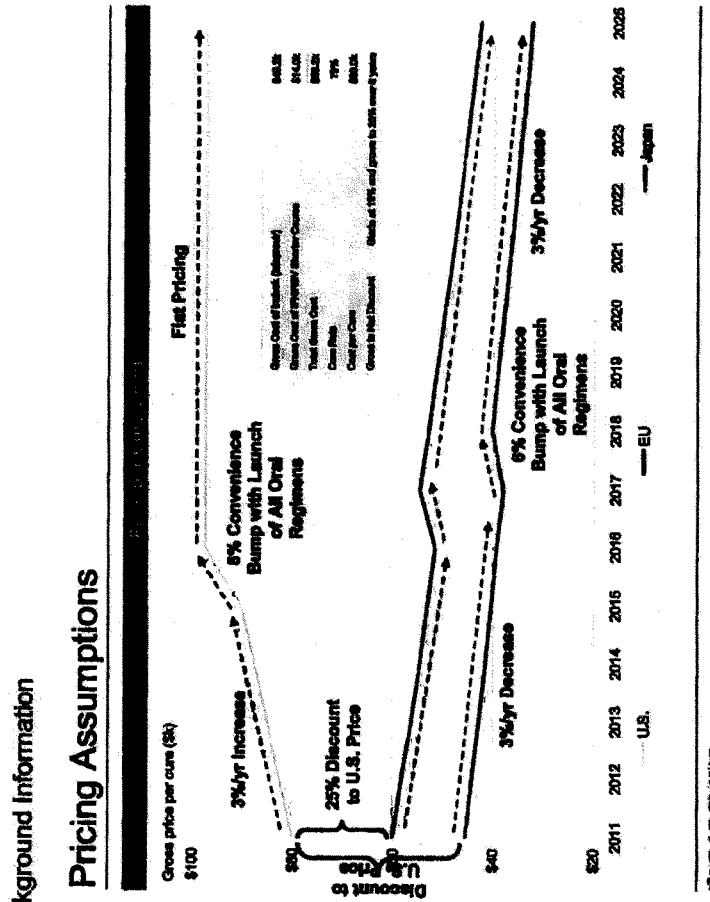
GT1 Patients = 73% of Total Patient Population
Giza Patients = 27% of total Patient Population

Pyramid Standalone				
Regimen	Year of Launch	GT1 Peak Penetration	Giza Peak Penetration	Giza Peak Penetration Adjusted for Resistance
R7128 + IFN/RBV	2014	13.7%	0.0%	10.0%
Pyramid nuc + IFN/RBV	2015	30.8%	0.0%	22.5%
Pyramid nuc + nuc	2016	19.2%	50.0%	27.5%
Pyramid nuc + other	2016	22.6%	50.0%	30.0%
Giza Standalone				
Regimen	Year of Launch	GT1 Peak Penetration	Giza Peak Penetration	Giza Peak Penetration Adjusted for Resistance
Giza PI/NS5A + IFN/RBV	2016	15.1%	0.0%	11.0%
Giza All Oral Regimen	2017	31.5%	0.0%	23.0%
Giza Pro Forma				
Regimen	Year of Launch	GT1 Peak Penetration	Giza Peak Penetration	Giza Peak Penetration Adjusted for Resistance
R7128 + IFN/RBV	2014	13.7%	0.0%	10.0%
OAV + IFN/RBV	2015	34.2%	0.0%	25.0%
Giza PF All Oral Regimen	2016	61.5%	18.8%	50.0%


Background Information
Market Share Benchmarks to HIV and HBV Franchise
GILEAD
Gryffindor Pro-Forma All Oral
Viread (HBV)
Viread (HIV)
ATRIPLA
Truvada
Gryffindor OAV+P/R
Patient Share
50
45
40
35
30
25
20
15
10
5
0
0
12
24
36
Months Post Launch
Greater number of HIV competitors than assumed for all oral space in HCV
HCV patient share assumptions from Barclays Model July 16, 2011
HIV patient share from Synovate
HBV Script Share from Source® Monthly PHAST and Source Payer-Prescriber Data
Gilt Confidential

Background Information

Pricing Assumptions



Background Information

Price Per Cure – Treatment Naïve Patients
52% Increase in Price Per Cure with the Addition of PIs

GILEAD

Pegasys/Ribavirin	$29,882 (48 wks)	$14,941 (24 wks)
SVR	51%	82%
Price Per Cure	$58,592	$18,220
Telaprevir	$49,200 (12 wk)	$49,200 (12 wk)	$49,200
Pegasys/Ribavirin	$29,882 (48 wks)	$14,941 (24 wks)	$21,215
Total Regimen Cost	$79,882	$64,141	$70,415
SVR	60%	92%	79%
Price Per Cure	$133,000	$69,718	$89,133
Boceprevir	$35,200 (32 wks)	$26,400 (24 wks)	$31,326
Pegasys/Ribavirin	$29,882 (48 wks)	$17,431 (28 wks)	$24,400
Total Regimen Cost	$65,082	$43,831	$55,727
SVR	40%	96%	63%
Price Per Cure	$162,705	$45,657	$88,455

GILEAD Comments:

Background Information

HCV Single Agent Pricing

GILEAD

Country	Price Per Week[1] (% Discount to US)		
	Pegasys	Incivek[2]	Victrelis[3]
US	$576	$4,100	$1,100
France	$229 (40%)	$2,567 (63%)	$1,250 (+114%)
UK	$199 (34%)		
Germany	$315 (55%)		
Italy	$273 (47%)		
Spain	$288 (50%)		
Japan	$342 (59%)		

1. Prices from Analysource.com Accessed April 2011, unless otherwise noted
2. Incivek US price from May 23, 2011 Vertex Press Release. France price from ATU.
3. Victrelis US price from May 13, 2011 Merck Press Release. France price from ATU.

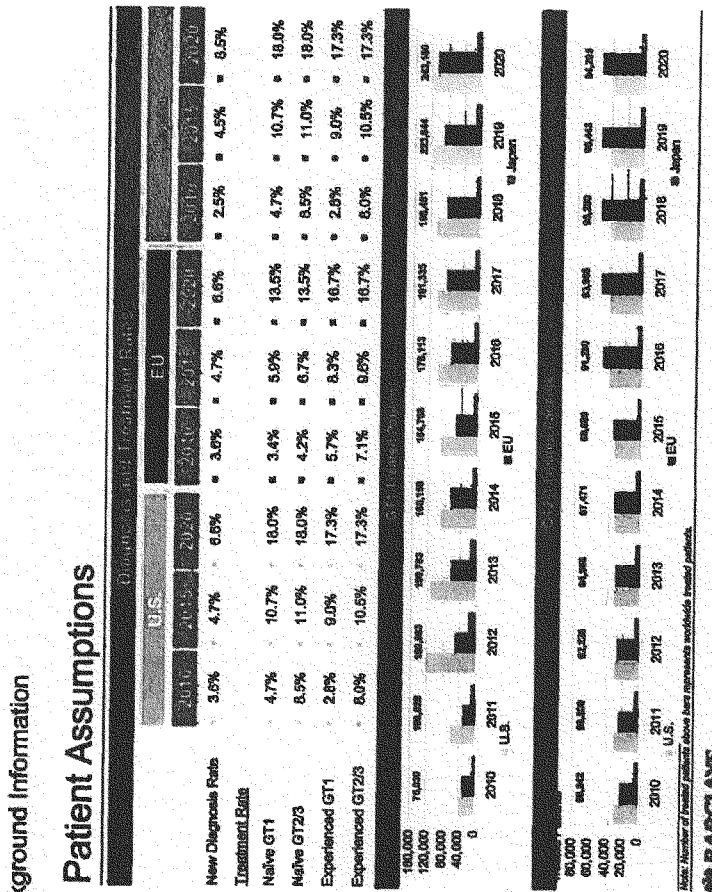
Selected Pricing Analogues

Selected Pricing Analogues

Drug	Indication	Launch Date	EU Discount / (Premium) to U.S. Launch	L + 1	L + 2	L + 3	L + 4	L + 5	5-Year Price CAGR U.S.	EU
Benlysta	Systemic Lupus Erythematosus (SLE)	1H'11	25%	28%	31%	33%	36%	39%	4%	0%
Yervoy	Metastatic Melanoma	1H'11	17%	24%	30%	36%	41%	46%	7%	(2%)
Prolia	Postmenopausal Osteoporosis (PMO)	2H'10	0%	6%	6%	6%	11%	11%	2%	0%
Xgeva	Bone metastases	2H'10	NA	0%	6%	11%	16%	21%	5%	NA
Xiaflex	Dupuytren's Contracture	1H'10	NA	19%	19%	19%	19%	19%	2%	NA
Kuvan	Phenylketonuria (PKU)	2H'07	(5%)	(5%)	(0%)	(0%)	5%	5%	2%	0%
Soliris	Paroxysmal Nocturnal Hemoglobinuria (PNH)	1H'07	(10%)	(10%)	(7%)	(4%)	(4%)	(4%)	1%	0%
Revlimid	Multiple Myeloma (MM)	2H'06	(15%)	(10%)	(7%)	11%	16%	19%	4%	(3%)
	Best Fit Basis [1]		7%	14%	18%	27%	31%	34%	5%	(2%)

	L - 5	L - 4	L - 3	L - 2	L - 1	EU Discount / (Premium) to U.S. Launch	L + 1	L + 2	L + 3	L + 4	L + 5	5-Year Price CAGR U.S.	EU
Pyr. mac + nuc - Base Case	25%	29%	33%	37%	41%	47%	44%	46%	47%	49%	50%	0%	(1%)

Source: Wall Street research.
1. Best fit defined by closest pricing analogues to Pyramid compounds. Includes Benlysta, Yervoy and Revlimid.


Background Information
Patient Assumptions
U.S.
EU
2010
2015
2020
New Diagnosis Rate
3.6%
4.7%
6.6%
3.6%
4.7%
6.6%
2.5%
4.5%
8.5%
Treatment Rate
Naïve GT1
4.7%
10.7%
18.0%
3.4%
5.9%
13.5%
4.7%
10.7%
18.0%
Naïve GT2/3
8.5%
11.0%
18.0%
4.2%
6.7%
13.5%
8.5%
11.0%
19.0%
Experienced GT1
2.6%
9.0%
17.3%
5.7%
8.3%
16.7%
2.6%
9.0%
17.3%
Experienced GT2/3
8.0%
10.5%
17.3%
7.1%
9.6%
16.7%
8.0%
10.5%
17.3%
U.S.
EU
Japan
Note: Number of treated patients above bars represents worldwide treated patients.
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5

Treatment Rates: Drivers and Benchmarks

GILEAD

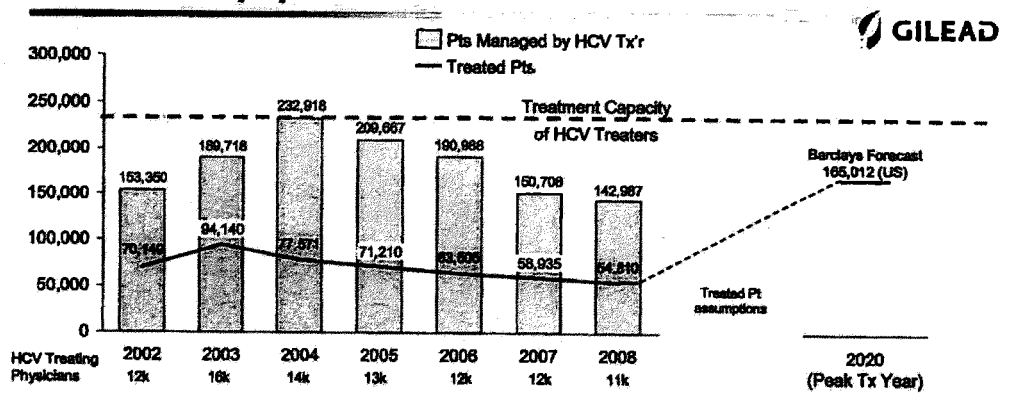
- **Total treated patients increase 2.6x from 131k (2010) to 339k (2020)**
- **The drivers for increased treatment include**
  - **Near term: more effective therapies now available for treatment naïve and treatment experienced patients, improved awareness of disease**
  - **Long term: well tolerated regimens, activity in patients who fail PI-based regimens, improved activity in GT2/3, improved awareness of disease**

	2010 – 2015	2015 – 2020
Growth in Treated HCV Patients[1]		**158%**
Benchmark: Growth in ARV treated HIV Patients[2]	**36%**	
Benchmark: Growth in treated HBV Patients[3]	**107%**	

1. Barclays Forecast July 15, 2011
2. Synovate
3. WKH PHAST TRx, IMS LRx, and internal estimates

Background Information

Is there health-care capacity to support forecast growth in HCV treated population?



- The historical peak #'s of HCV+ patients managed by treating MDs is 233k in 2004 and 94k treated in 2003
- If required, additional capacity does exist- only 51% of the 11.5k Hep/GEs and 11% of the 5.9k IDs prescribe HCV treatments
- Simpler, better tolerated therapies with shorter duration may allow for further expansion of treaters to ID

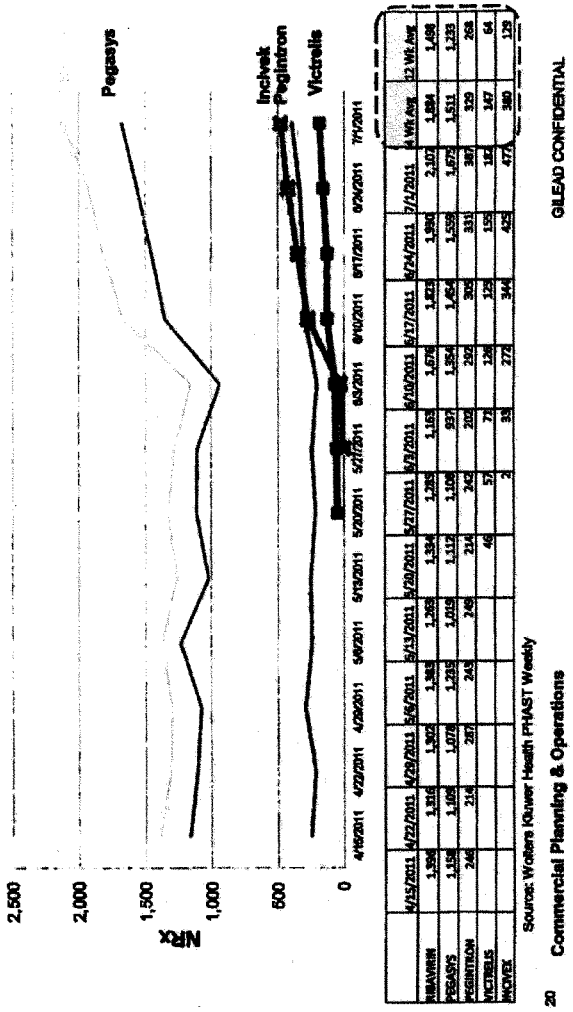
1. Managed patients and number of treating physicians based on Wolters Kluwar medical claims data analysis, which excluded patients treated in VA clinics/hospitals, prisons, and LTC. Scaled up Managed pts numbers by 25% based on the % of non-retail Peg-IFN units vs total Peg-IFN units in 2007-2008. Physician numbers have not been scaled up.
2. Treated patients calculated based on IMS MIDAS unit volume data which includes retail & non-retail channels.
3. Gilead estimates based upon 2014 and analysts estimates of 2012

Background Information

51% Increase in Pegasys NRx Volume 6 Weeks Post-PI Launch

GILEAD

Weekly NRx



	4/15/2011	4/22/2011	4/29/2011	5/6/2011	5/13/2011	5/20/2011	5/27/2011	6/3/2011	6/10/2011	6/17/2011	6/24/2011	7/1/2011	4 Wk Avg	12 Wk Avg
INCIVEK	1,356	1,316	1,302	1,383	1,268	1,334	1,285	1,163	1,676	1,453	1,390	2,107	1,884	1,498
PEGASYS	1,158	1,105	1,078	1,235	1,015	1,113	1,156	937	1,354	1,464	1,539	1,672	1,511	1,233
PEGINTRON	246	214	267	245	249	214	242	202	292	305	331	387	329	268
VICTRELIS						46	57	73	126	125	155	156	147	64
MOVER							2	33	272	344	425	477	380	129

Source: Wolters Kluwer Health PHAST Weekly

Hepatology Sales Force Benchmarks

GILEAD

	[redacted]		Roche		[redacted]	Vertex
	[redacted]	[redacted]	US	EU	[redacted]	US
Total Field Force	[redacted]	[redacted]	126		[redacted]	150-200[1]
Sales Representatives	[redacted]	[redacted]	92[1]	197[2]	[redacted]	100[1]
Sales Management	[redacted]	[redacted]	6[1]		[redacted]	
MSLs	[redacted]	[redacted]	10[2]		[redacted]	
Clinical Consultants	[redacted]	[redacted]	18[2]		[redacted]	

1. Gilead CI July 2011
2. Gilead CI June 2007
3. Internal- an incremental 119 reps/sales management required for HCV launch.

Summary of Key Assumptions

- **Genotype Breakdown:** U.S.: 73% GT1, 27% GT2/3; EU: 63% GT1, 37% GT2/3; Japan: 70% GT1, 30% GT2/3
- **Diagnosis Rate:** Increases steadily over time due to greater patient awareness and availability of treatments (see page 5 for detailed assumptions)
- **Treatment Rate:** Increases from 2011-2012 due to wave of recently launched PIs, decreases and then stays constant from 2013-2015 due to warehousing ahead of and leading into IFN sparing and then increases from 2016-2020 due to wave of all oral therapy (see page 5 for detailed assumptions)

- **Price per cure:** $80k (see page 6 for detailed assumptions)
  - Gross to net discount: Starts at 19% at launch year, grows to 25% linearly over 8 years and stays flat thereafter (see page 9 for detailed assumptions)
  - 3% ramp, 6% oral price bump, flat growth thereafter (see page 6 for detailed assumptions)
  - 25% discount to U.S.; -3% ramp, 6% oral price bump, -3% growth thereafter (25% discount today growing to 47% in 2016)
  - 43% discount to U.S.; -3% ramp, 6% oral price bump, -3% growth thereafter (43% discount today growing to 60% in 2016)

- 11%: 7.5% COGS + 3.5% royalty
- Before launch: For all DAA+SOC products: 250, 1k and 3k pts costing ~$60k/patient for Phase I, II and III trials, respectively; for all 2+DAA products: 25% greater cost than DAA+SOC R&D expenses
- At launch year: R&D cost is equal to that of the prior year
- After launch: 7% of product sales for year one after launch, 4% for year two, and 2% for year three and thereafter until patent expires
- For Giza Pro Forma, assumes that Giza will develop four products (two DAA+SOC, two 2+DAA) in Phase I and II studies and advance the better two combos into Phase III

	Pyramid Standalone	Giza Standalone	Giza Pro Forma
U.S. HCV Sales Force	195	195 (119 incremental)	195 (119 incremental)
Cost ($mm)	49	30	30

- U.S. managed markets and marketing & operations costs: $9mm (37 FTEs)
- Additional G&A costs: Pyramid Standalone: $17mm in 2011, grows to $40mm in 2016 and stays flat thereafter; Giza Standalone / Giza Pro Forma: 50% of Pyramid Standalone

- Tax rate: 26%

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Exhibit 23

Hepatitis C and GS-7977 Development Update

John McHutchison
Senior Vice President
Liver Disease Therapeutic Area

November 5, 2012

Update Summary

- Integration was completed successfully and without interruption. The timelines have shortened considerably for both GS-7977 as a single agent and GS-7977 combinations.
- GS-7977 is performing as hoped and expected. Safety (>2000 patients) and efficacy continue to perform well.
- Development plans for 2012-14 are clearer, and well underway.
- Competitors are developing alternate regimens based on safety and efficacy of their respective compounds (including segmentation and regional development). The competition is intense.
- We continue to balance the need for rapid approval with the need for new combinations to explore optimal duration of treatment in different populations

1078

Waves for Gilead HCV Development Are Now Clearer

Wave 1 2012-13 — GT 1: 3 drugs *(P/R/Protease Inhibitor)*

Wave 2 2013 — First all oral therapy GT2/3: *(GS-7977/R)*
Simplified, shorter therapy for GT1: *(GS-7977/P/R)*

Wave 3 2014-15 — GT1: First All Oral Therapy:
(GS-7977/GS-5885)

Wave 4 2015+ — All Oral Therapy for All HCV Genotypes
(GS-7977/GS-5816; GS-7977/GS-"other")

1079

Waves for Gilead HCV Development Are Now Clearer

Wave 2 2013

First all oral therapy GT2/3: *(GS-7977/R)*
Simplified, shorter therapy for GT1: *(GS-7977/P/R)*

1080

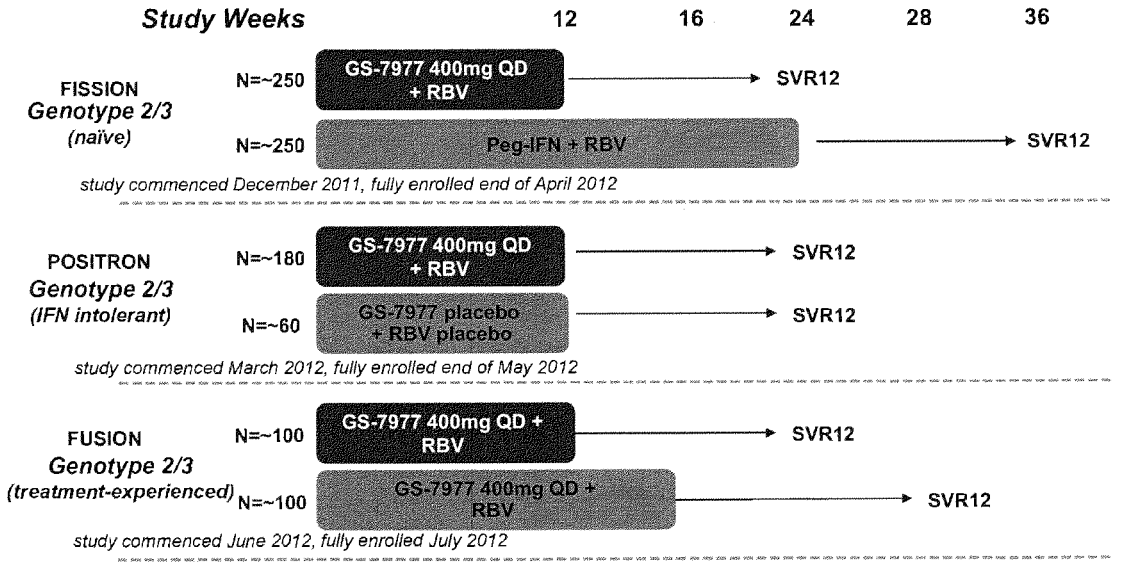
GS-7977 2012 Data

GT	Regimen	SVR
1,4,5,6	GS-7977 + RBV + PEG (12w)	>90%
2,3	GS-7977 + RBV (12w)	75-100%
1	GS-7977 + RBV (12-24w)	52-100%
1	GS-7977 + NS5a+ RBV (24w)	100%

- GS-7977 needs to be combined with another drug for high efficacy
- Ribavirin provides that "activity" for GT2/3
- Something more "potent" is required for other genotypes

  NB: SVR rates of ≥ 90% are becoming the standard

GS-7977 Phase 3 Programs: GT2/3



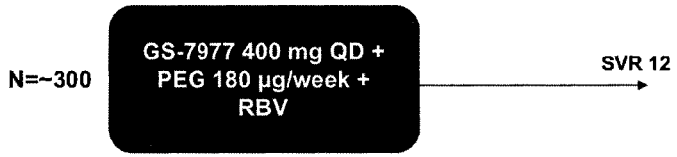
Final Data : 4Q 2012 – 1Q 2013

1082

GS-7977 Phase 3 Programs: GT 1,4,5,6

Study Weeks	12	24

NEUTRINO:
Treatment-naïve patients, multicenter, open-label study

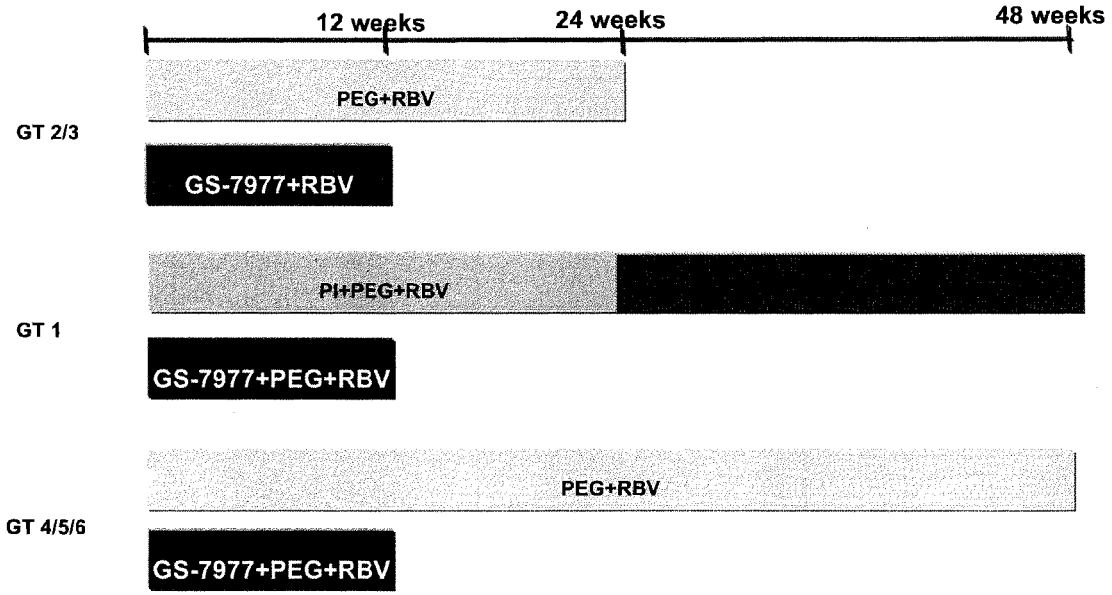


study commenced June 2012 fully enrolled early August 2012

Final Data : Q1 2013

1083

The Initial Registration Strategies provide a significant advance compared to current therapy



These two regimens provide a safe, highly effective, tolerable regimen until the STR are available.

Wave 2
2013

Initial NDA Filing

- 1240 patients
  - 4 phase 3 trials
  - 70% NA
  - 24% Asia/Pacific
  - 5% EU
- 2090 patients
  - safety database
- Filing: Q2 2013

1085

Wave 2
2013

2013: Proposed Indication and Timelines

- **GT2/3:** In combination with RBV for 12 weeks, whether previously treated or not
- **GT1** : In combination with pegIFN and RBV for 12 weeks in previously untreated patients

- **Final Results** Ph 3 Trials Nov 12-Feb 13
- **NDA filing:** April 15, 2013
- **Priority Review**
- **EASL April 2013:** Scientific Presentations with simultaneous peer-reviewed publications

1086

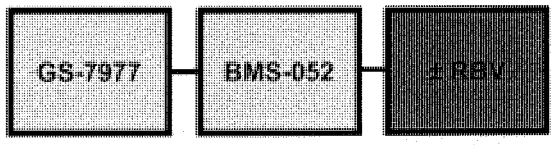
Waves for Gilead HCV Development Are Now Clearer

1087

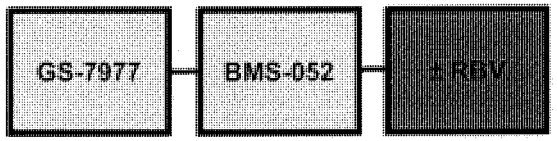
Wave 3
2014-15

GT1: First All Oral Therapy:
(GS-7977/GS-5885)

GT 1 Naïve: GS-7977 + NS5A Inhibitor



24 week duration
SVR 4 = 100%



12 week duration
SVR 4 = 96%

1088

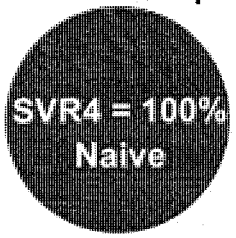
GS-5885 is very similar in activity to BMS-052.

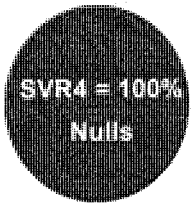
Should be able to substitute to provide Gilead tablet.

Sulkowski M et al, EASL 2012 and AASLD 2012

ELECTRON: GS-7977/GS-5885

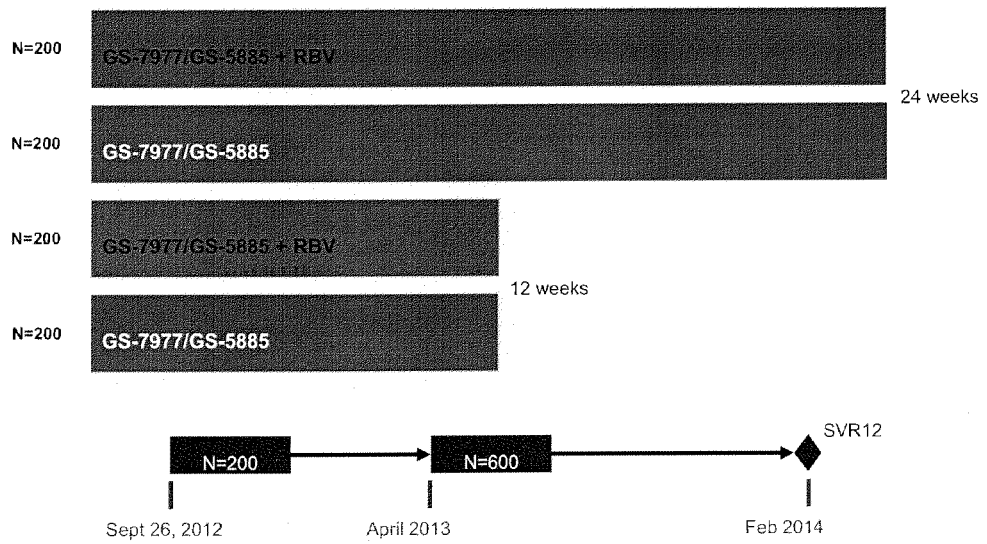
- 12 weeks
- Drugs given individually
- With RBV
- GT1 naïve (N=25) and null responders (N=10)





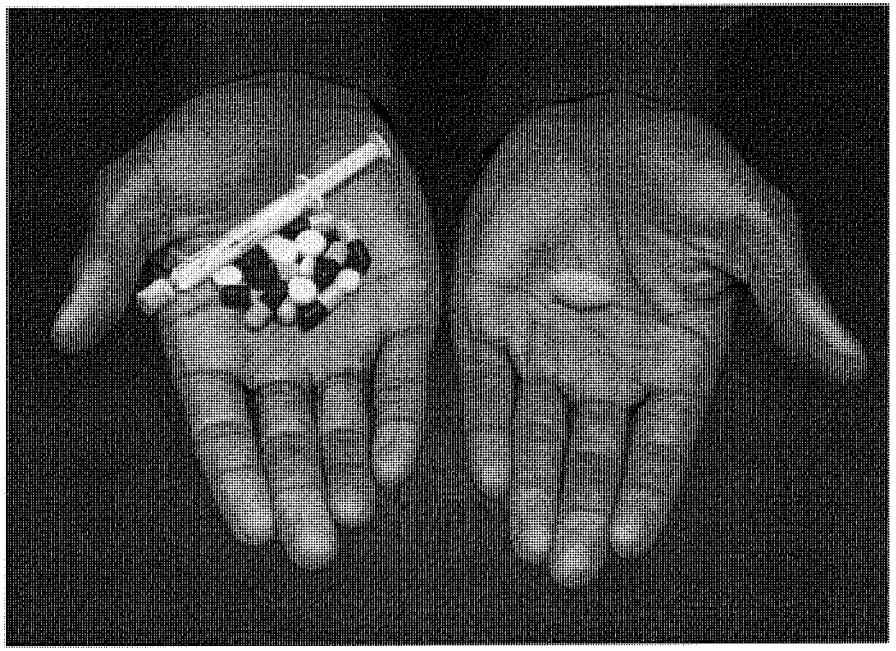
1089

GS-7977/GS-5885 (FDC):
Initial Phase 3 Trial: GT1, Treatment Naive



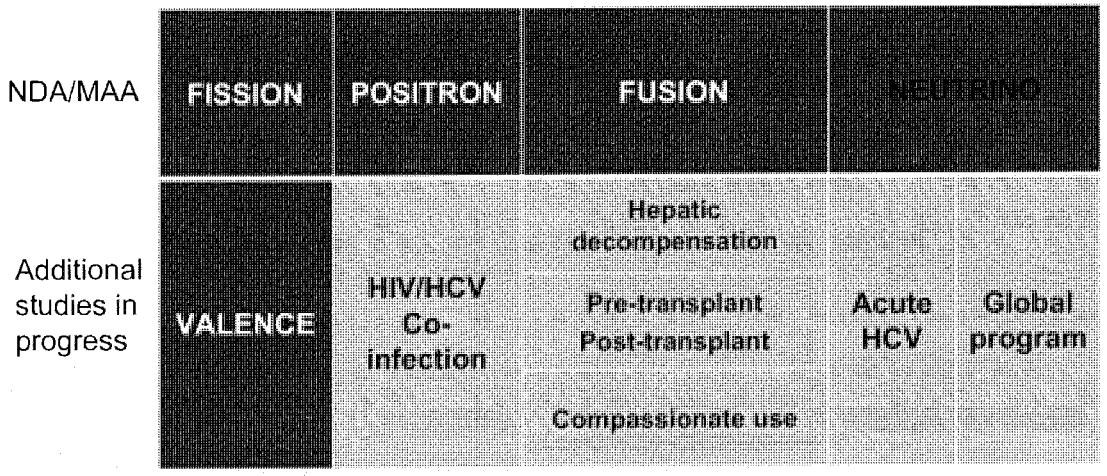
First 200 patients screened - Oct 16

FDC: Fixed-Dose Combination "7985"



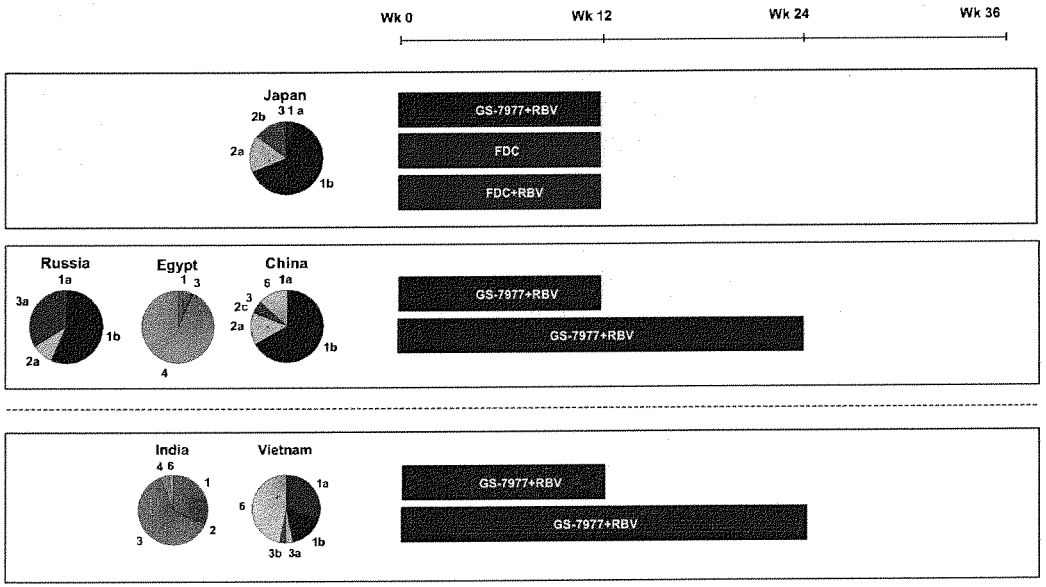
1091

GS-7977 Program: Other Key Components



Safety, convenience and activity of GS-7977 make it very important for these populations

Prioritizing Development in Other Parts of the World



48 Countries Accept US NDA or EMA MAA "paper filing"

Waves for Gilead HCV Development Are Now Clearer

Wave 1 2012-13 GT 1: 3 drugs *(P/R/Protease Inhibitor)*

Wave 2 2013 First all oral therapy GT2/3: *(GS-7977/R)*
simplified, shorter therapy for GT1: *(GS-7977/P/R)*

Wave 3 2014-15 GT1: First All Oral Therapy:
(GS-7977/GS-5885)

Wave 4 2015+ All Oral Therapy for All HCV Genotypes
(GS-7977/GS-5816; GS-7977/GS-"other")

1094

HCV Strategy Review

Kevin Young CBE
Executive Vice President
Commercial Operations

November 5, 2012

Agenda

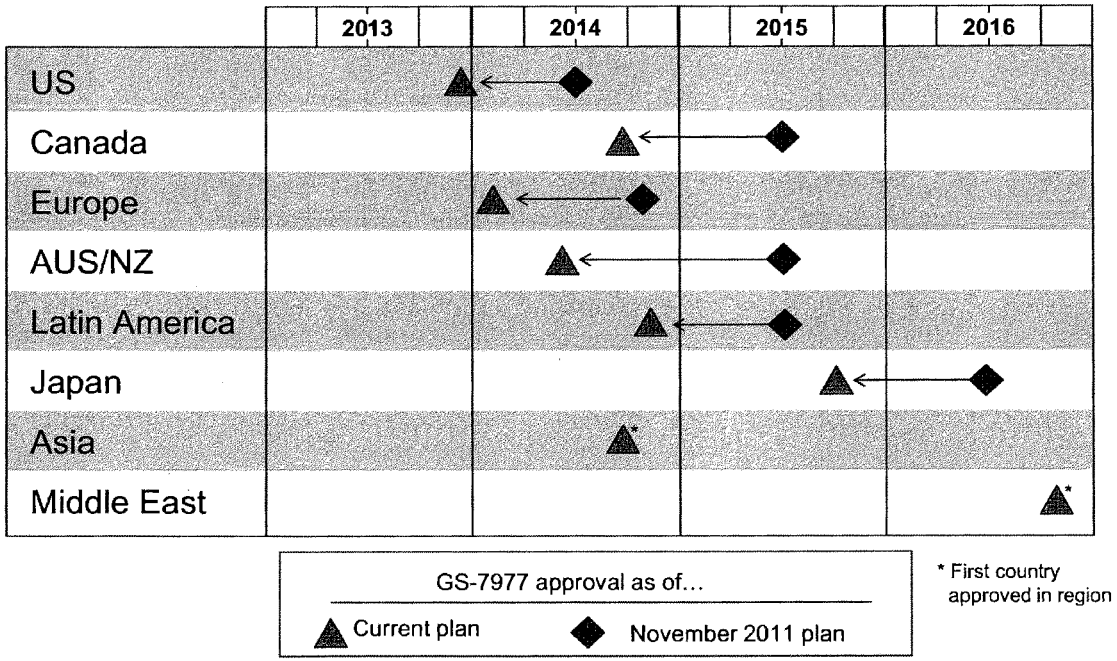
- **The HCV Opportunity: Today vs. Nov 2011**
- US Preparations for GS-7977 Launch
- European Considerations
- Expansion into Japan

1096

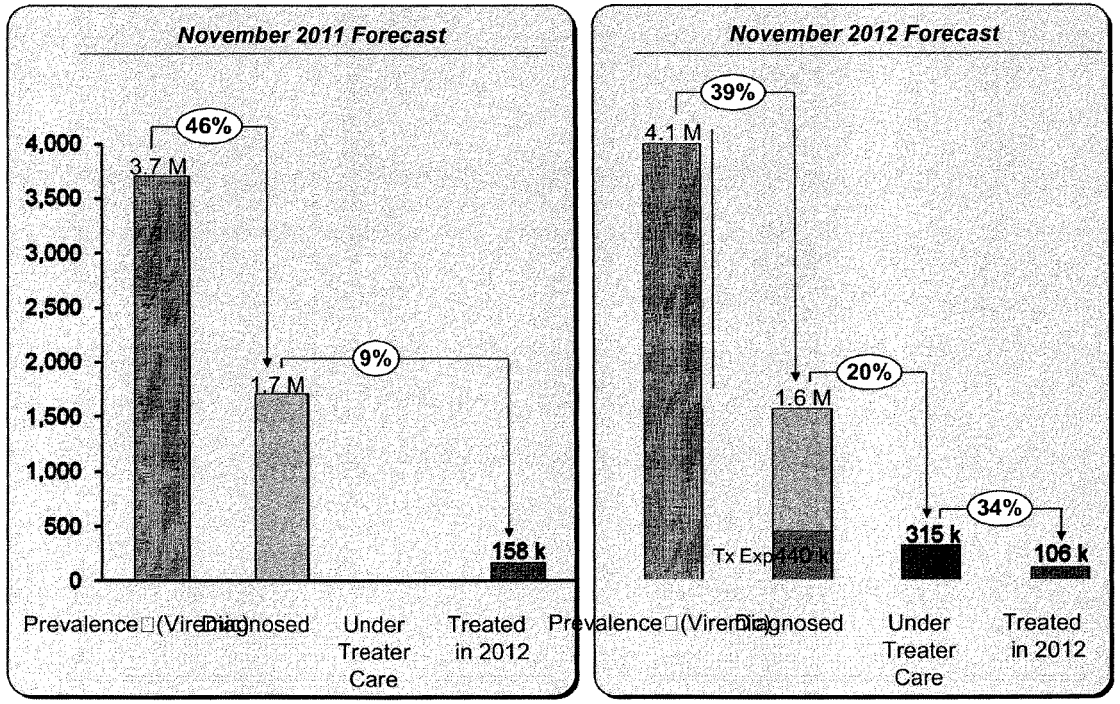
Valuation has Increased with Improved Assumptions and Favorable Trends

Timing of Launch		↑	• Accelerating launches ~ 1 year • Approval of GT 1 simultaneously with GT 2/3
Market Size	Prevalent	↔	• US, EU & Japan prevalence remains at 8M • Greater insight into regional variation
	Diagnosed	↑	• Larger pool of diagnosed ex-US • Quantified number under care of HCV treater • CDC advocates testing 45 – 65 yr olds (82M)
Patient Share	Genotype 1	↑	• US: 66% today vs. 54% • EU 5: 60% today vs. 54%
	Genotype 2/3	↑	• US: 87% today vs. 38% • EU 5: 82% today vs. 38%
Competition		↔	• Highly competitive • Leading competitors changing
Price		↔	• US: $58k vs. $65k (likely at parity for launch) • EU: discount to US ~ 25%

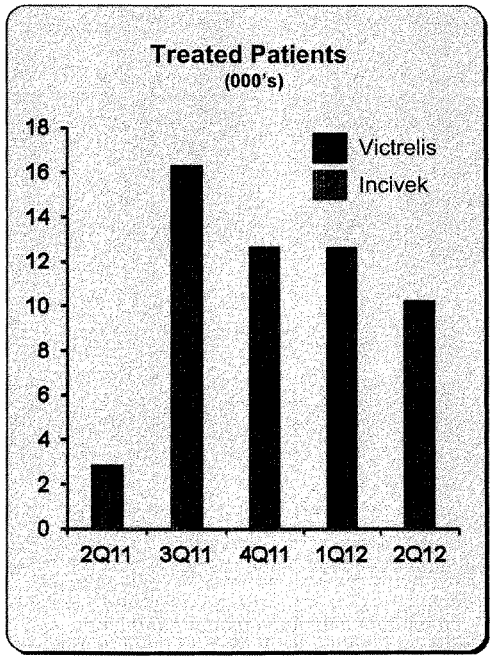
Launch Timelines Have been Brought Forward

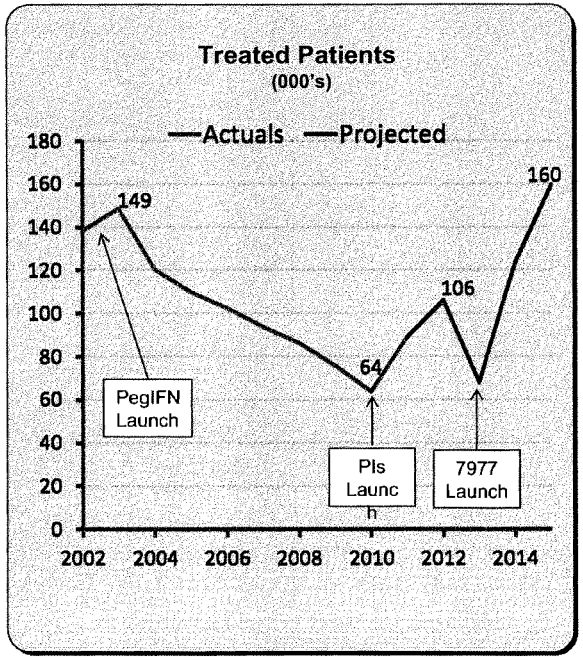


Enhanced Insight into the Market

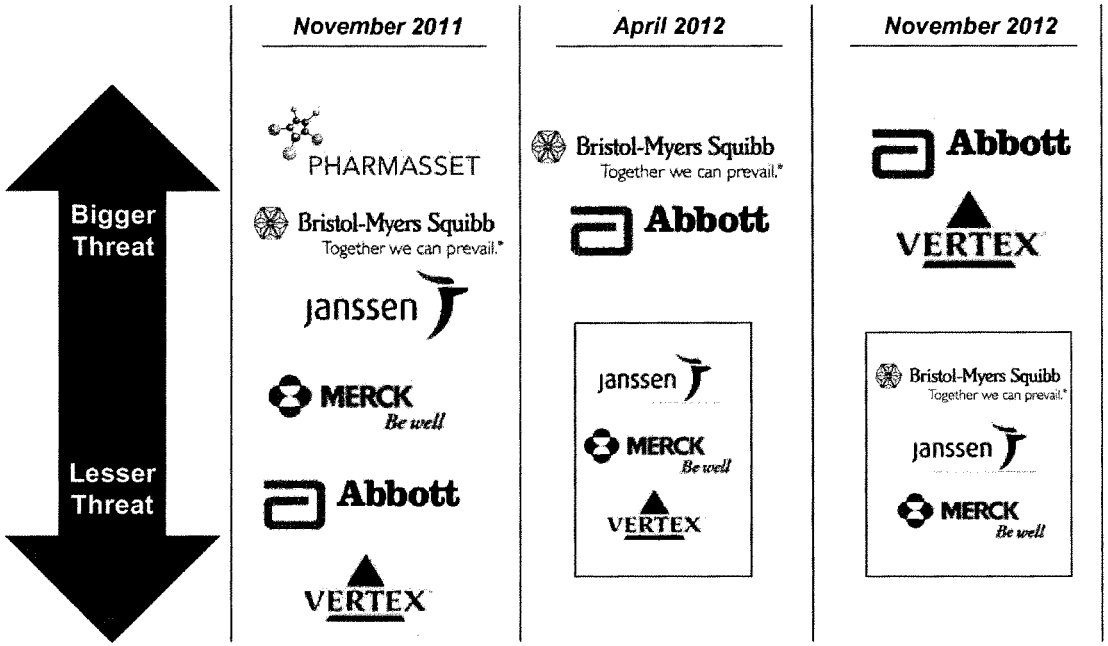


Decrease in Treatment Rates Will Reverse with 7977 Launch





Competitive Landscape Continues to Evolve



Agenda

- The HCV Opportunity: Today vs. Nov 2011
- **US Preparations for GS-7977 Launch**
- European Considerations
- Expansion into Japan

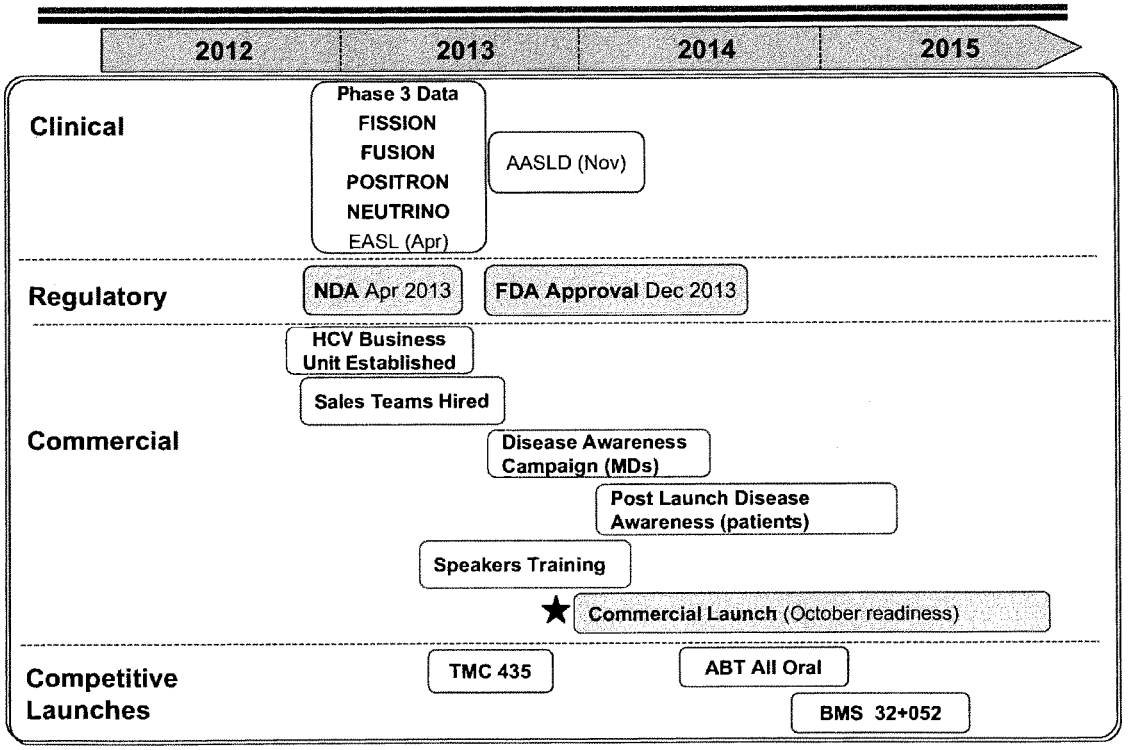
1102

Critical Success Factors at US Launch of 7977

- Quickly establish GS- 7977 as the SOC and the backbone of HCV therapy
- Achieve broad access and reimbursement across all payer segments
- Grow the pool of treated patients above historical norms
- Successfully deploy disease awareness advertising campaigns
  - Pre-launch to raise awareness about new therapies for HCV
  - Post-launch to drive diagnosed patients to an HCV treater

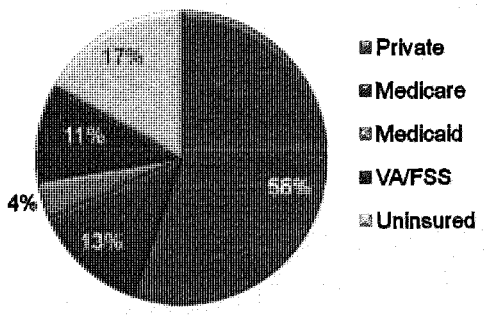
1103

Launch Readiness by October 2013

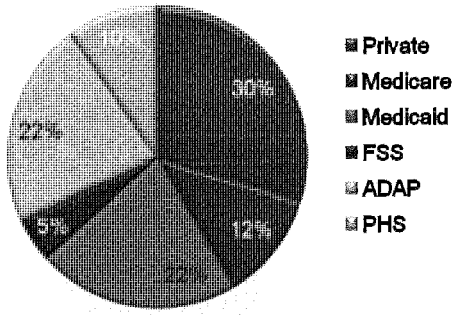


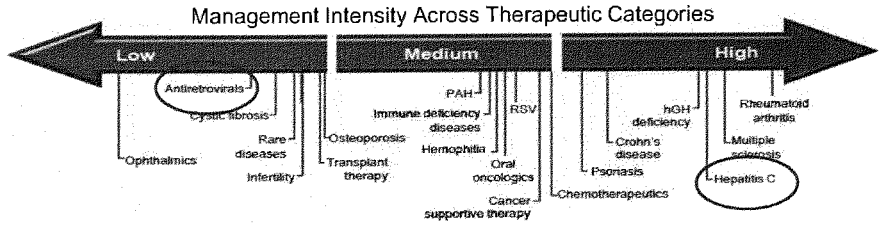
Payer Profile and Utilization Scrutiny Very Different from HIV

HCV Payer Mix

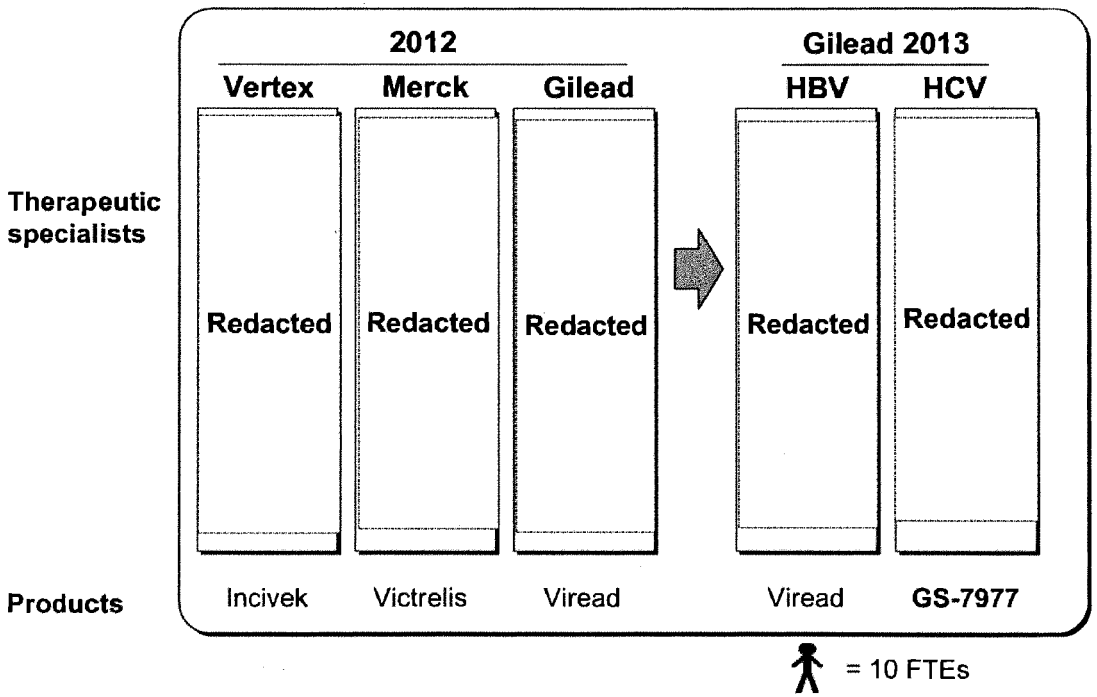


HIV Payer Mix





Field Force Sized to Expand HCV Treaters



Does not include sales management

HBV – HCV - HIV Target Overlap

HBV Targets = 1,053

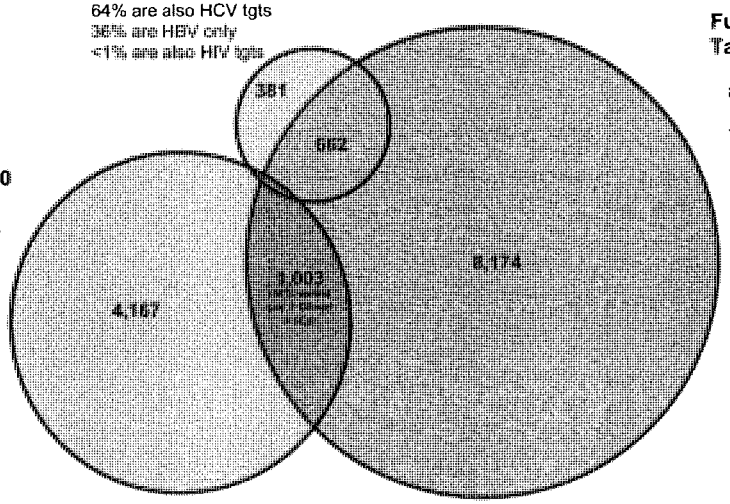
64% are also HCV tgts
36% are HBV only
<1% are also HIV tgts

Future HCV Targets = 9,847

83% are HCV only
10% are also HIV tgts
7% are also HBV tgts

HIV Targets = 5,180

80% are HIV only
20% are also HCV tgts
<1% are also HBV tgts



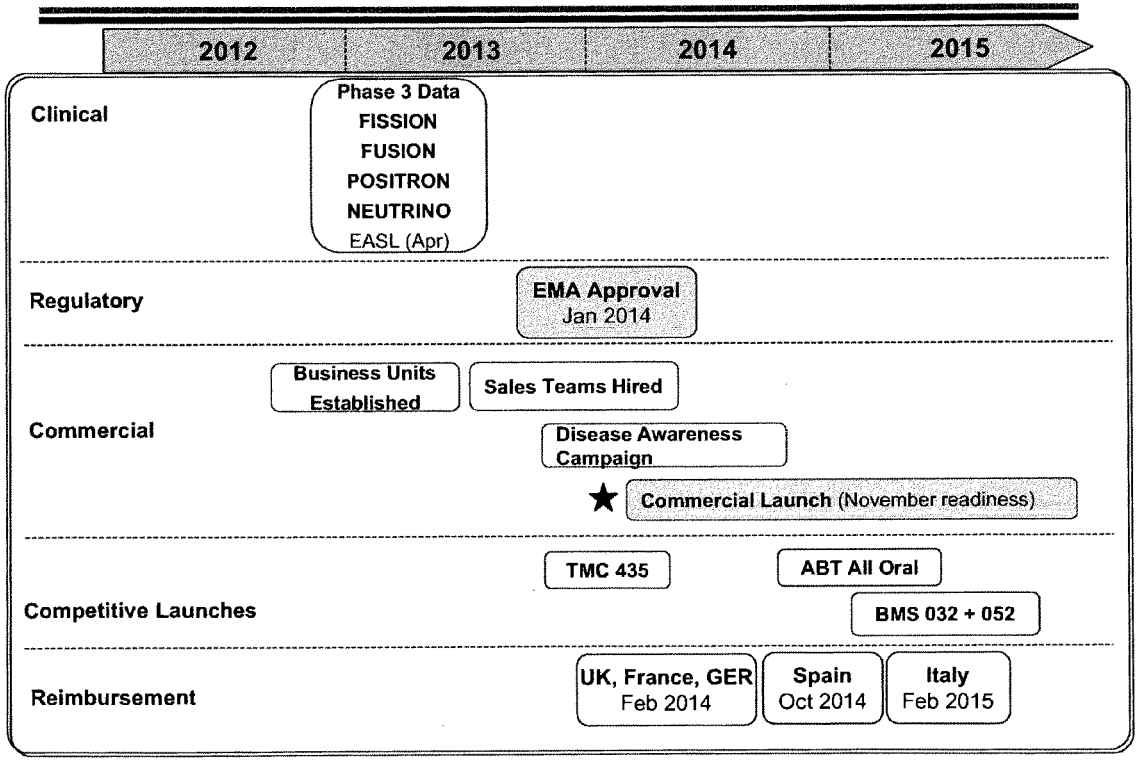
- 8 HCPs are targeted by HIV, HBV, and HCV
- 2 HCPs are targeted by HIV and HBV but not HCV
- HBV excludes "No Access" HCPs with <12 calls in last 12 months
- HIV Targets only include those with call frequency > 0 ("No Access", some Decile 99, 0s excluded)
- HCV is based on 10,365 targets discounted by 5% "No Access" assumption

Agenda

- The HCV Opportunity: Today vs. Nov 2011
- US Preparations for GS-7977 Launch
- **European Considerations**
- Expansion into Japan

1108

EU Launch Readiness by Nov 2013

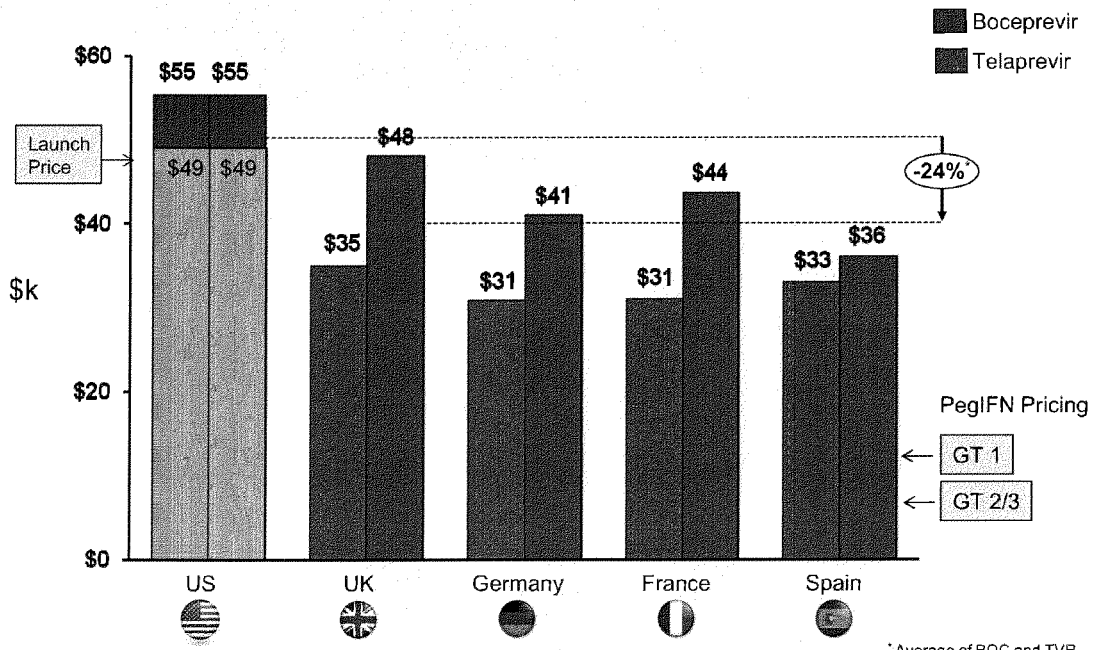


EU HCV Markets More Heterogeneous than HIV

	France	Germany	Italy	Spain	UK
Prevalence	308k	262k	1.5 M	476k	371k
% Diagnosed	48%	36%	20%	36%	34%
Treated in 2011	11k	9k	14k	9k	10k
# HCV Treaters	2,700	2,000	4,400	1,700	1,100
PI Availability	No Restrictions	No Restrictions	Not Reimbursed	Restrictions	No Restrictions

1110

Good EU Prices Established by Protease Inhibitors



*Average of BOC and TVR

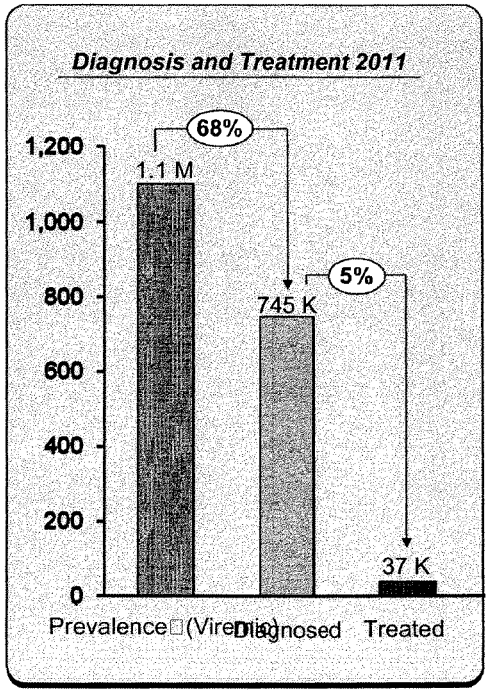
Notes: Exchange rates based on the following: 1 Euro = $1.23, 1 GBP = $1.55
Assuming maximum treatment durations: BOC 44 weeks and TVR 12 weeks.
Updated Oct 2, 2012

Agenda

- The HCV Opportunity: Today vs. Nov 2011
- US Preparations for GS-7977 Launch
- European Considerations
- **Expansion into Japan**

1112

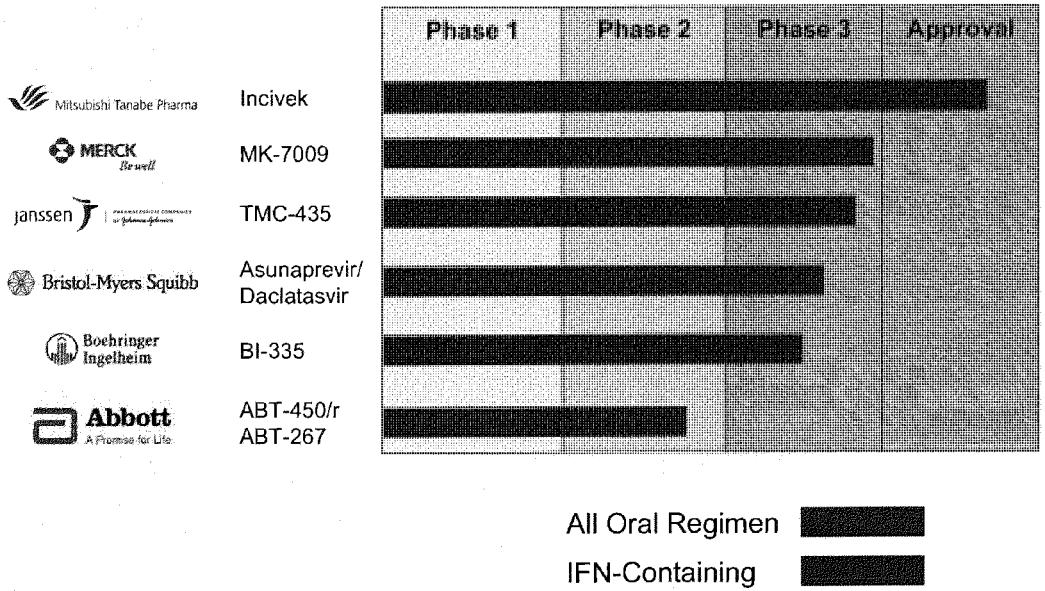
Japan: General Facts



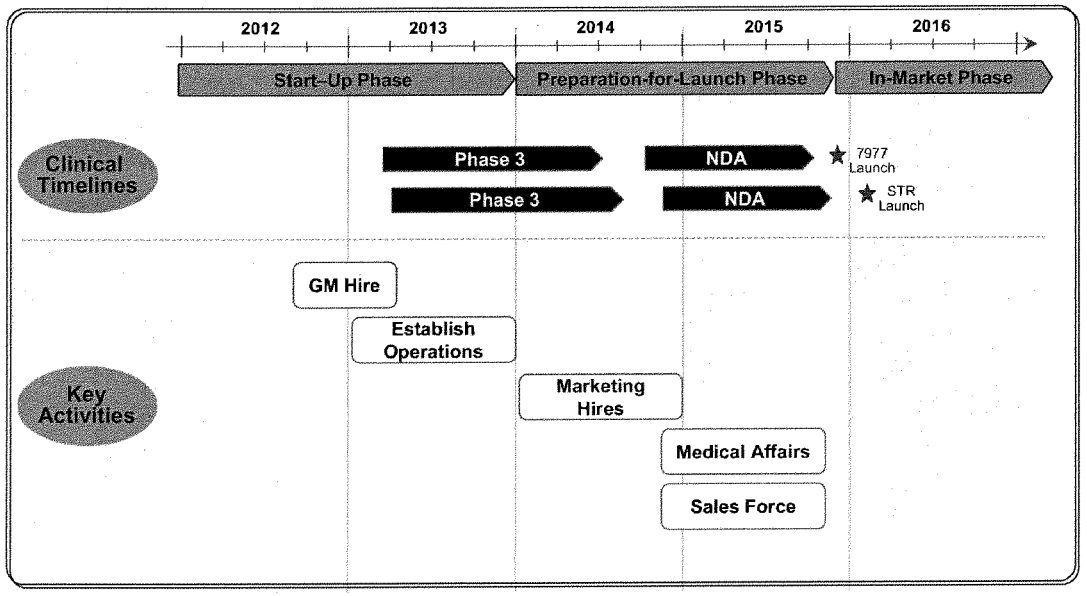
Patient Demographics

Genotype	• GT 1 = 67% (mostly 1b) • GT 2/3 = 31% • GT 4-6 = 2%
IL28B	• CC = 70% • CT = 25% • TT = 5%
Age	• 43% > 65 years • Mean age 60 years
IFN Eligibility	• 396 k (53%) IFN Eligible • 349 k (47%) IFN Ineligible

Japan: Significant Opportunity but Highly Competitive



Japan: Accelerating 7977 Timelines is an Imperative

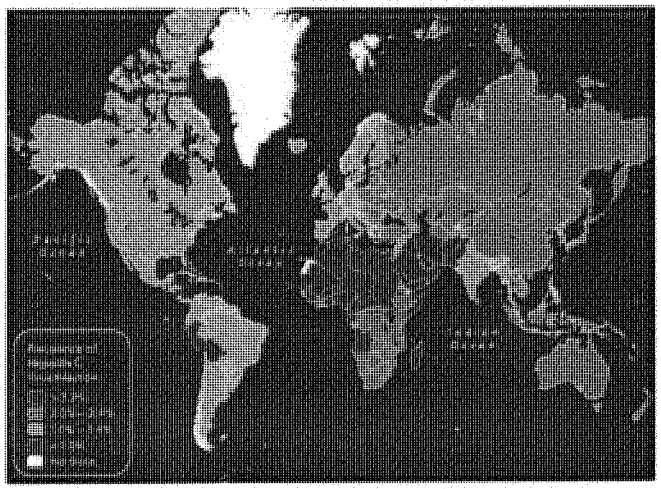


HCV Strategy Review

Gregg Alton
EVP Corporate and Medical Affairs

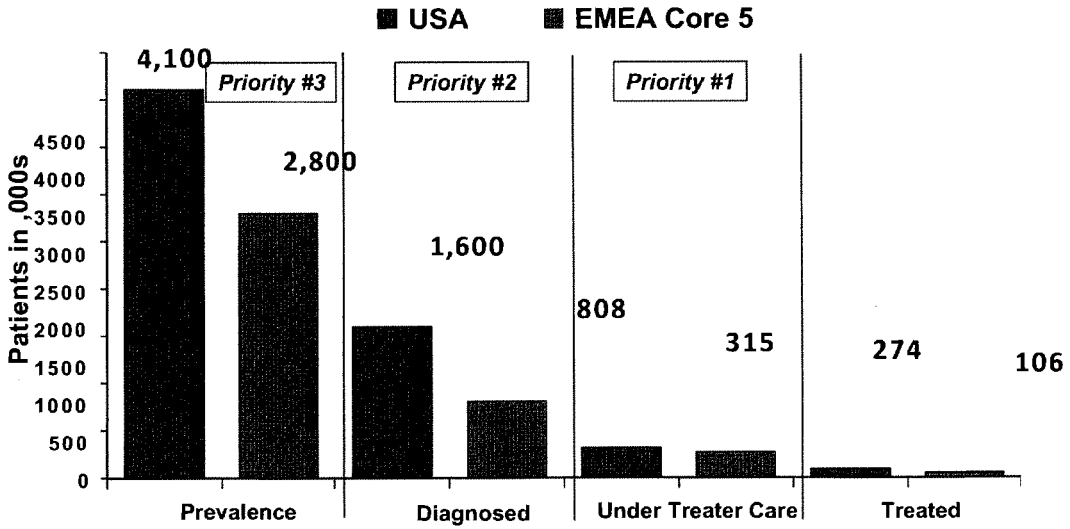
Board of Directors Meeting
November 5, 2012

Approximately 170 millions HCV patients worldwide



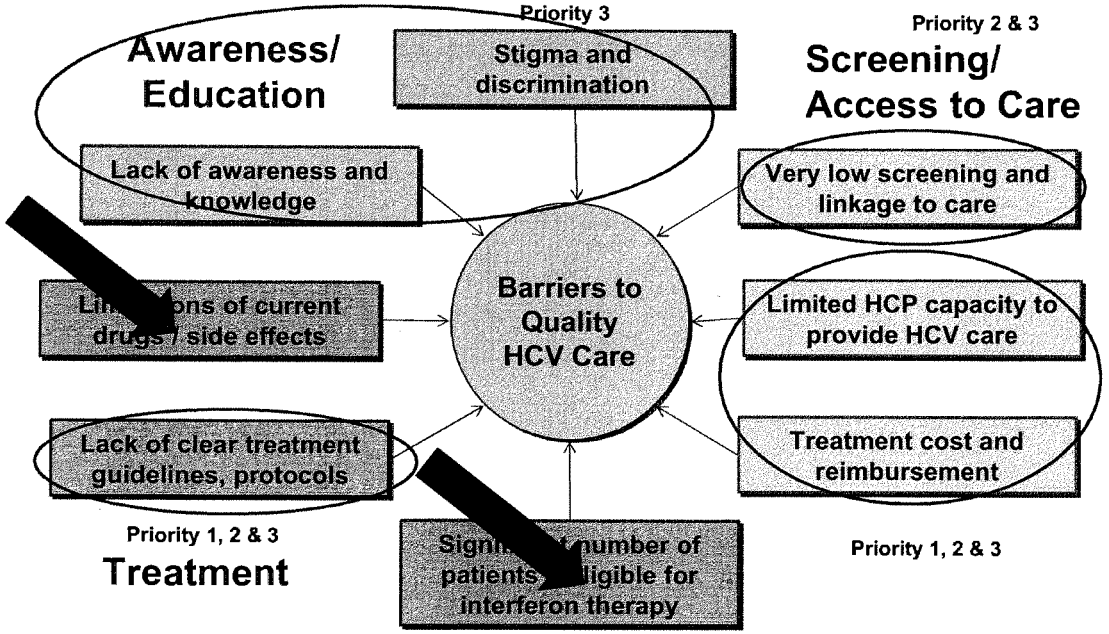
HCV Landscape in the USA and EMEA Core 5

Approximately 7 Million Infected Individuals in the US and EMEA Big 5 with Fewer than 150,000 Treated per Year



Under Treater Care = # of treated patients / treatment rate. Estimated treatment rate is based on Synovate Q2 and Q4 2011 audits.

Overcoming Current and Future Challenges to HCV Care



Challenge of Ensuring Adequate and Fair Reimbursement

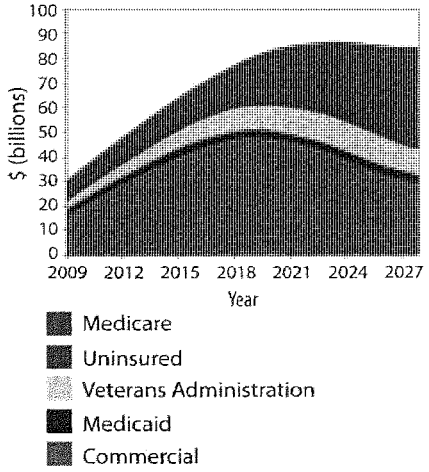
- U.S. costs of current HCV standard of care:

Component	Weekly	48 w Duration
Boceprevir	$1,100	$78,282
Telaprevir	$4,100	$79,802

Includes interferon and ribavirin
Some patients are able to take a shorter course of therapy

- Similar Challenges in Europe
- Global Challenges Greater

Medicare will be responsible for an increasing share of HCV-related medical costs



Source: Milliman, 2009

1120

HCV: Building on Our Experience

- As Gilead moves into HCV, our experience and expertise are major assets – in both the U.S. and abroad
  - Strong relationships with medical professionals and advocates
  - Collaborative efforts to collect robust medical and clinical data
  - Strong relationships with key government officials across
  - Diverse partnerships with public health and community groups
  - Productive engagement on responsible use of IP

1121

Medical Affairs
HCV Plan

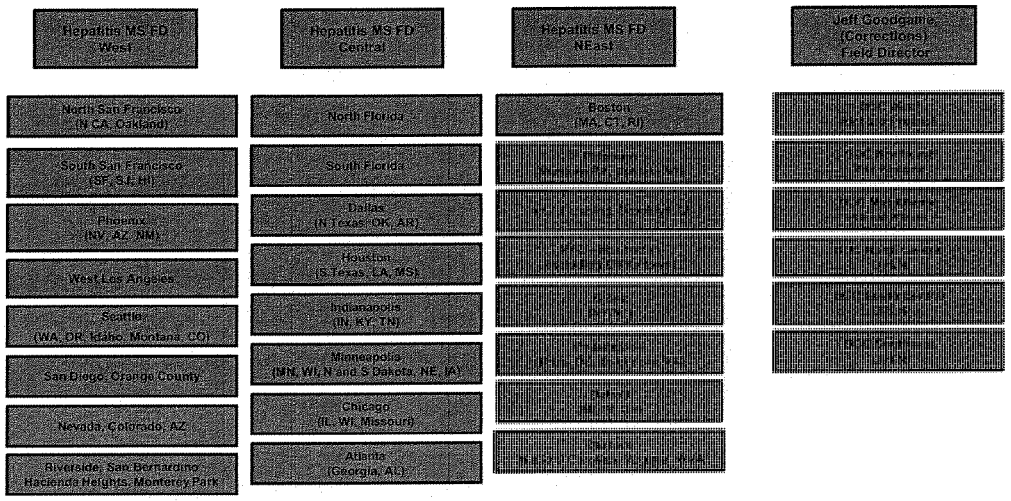
1122

HCV Medical Affairs Global Strategies (2013-2016)

1. Educate on 7977-based regimens
2. Generate additional data
   - **Determine true cost of current, PI-based SOC regimens**
   - **HEOR and QoL benefits of 7977-based regimens**
   - **Special populations**
3. Shape international and national treatment guidelines
4. Drive HCV testing and linkage to care

1123

Build out of US Hepatitis Team
3 Field Directors with 24 MSs
1 DOC Field Director with 6 Correction MSs



♦ EU build-out in progress

2013 Proposed HCV Program Timeline

Program	Education Partner	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
Simply Speaking HBV	PPC												
Expanding the HCV Provider Base	Medscape												
Clinical Course in HCV	Medscape												
Hepatology inPractice	CCO												
Changing the Paradigm for HCV Screening and Management	MedIQ												
From Conference to the Clinic	ViralEd												
Post-Conference Coverage	CCO												
Workshop on HCV Resistance & New Compounds	Virology Ed												
Managed Care Considerations for HCV	ASiM												
DDW HCV Symposium	TBD												
AASLD HCV Symposium	TBD												

Live Meeting Online Print

Phase 3b/4 Priorities

1. Establish "Real World" cohorts

2. Generate HEOR data to answer key questions: Why treat? Why treat now? Why treat with SOF?
   - **Demonstrate cost burden of illness**
   - **Demonstrate the cost of cure for current therapy**

3. Special Populations (age, race, co-morbidities)

1126

Government Affairs

U.S. HCV Policy Priorities (1)

- *Affordable Care Act* – could help increase access to new HCV treatments, although budget pressures may limit implementation
  - Address gaps in Medicaid expansion
  - Make HCV screening a required preventive service
- *Medicaid and Medicare* – ensure strong coverage and reimbursement policies on HCV screening and treatment access

1128

U.S. HCV Policy Priorities (2)

- *Veterans Administration (VA)* – work with the VA to improve screening and access to treatment
- *Making the case for improved HCV policies and funding* – demonstrate to policymakers the value of new HCV treatments
  - E.g., fewer cases of advanced liver disease; associated cost savings to government healthcare system
  - Screening in communities of color and prisons

1129

EU HCV Policy Landscape (1)

- No one approach fits governments in all EU markets – critical to engage country-by-country with locally tailored data and strategies

	France	Italy	Spain
HCV Prevalence	<1% (360,000)	>3% (1,500,000)	>1% (476,000)
Percent Diagnosed	48%	20%	30%
HCV Surveillance ?	National network	No national data	Incomplete, no database
HCV Action Plan?	Yes, 2002	No	In Madrid, but not

EU Landscape (2)

- EU Diagnostic priorities:
  - Identify political leaders who have worked on HCV, and technical leads within health ministries
  - Identify local clinicians and community groups who can serve as trustworthy advocates
  - Is there a national plan? Budget? Debate on HCV policy issues?
- Present the science-based case for government funding
  - In-language briefs on the local HCV burden, evolution of HCV therapy its impact on patients and public health
  - Interactions with government carefully timed to share what we know about the science

Emerging Markets – Policy Priorities

- Engage governments early and get ahead of activists (e.g., anti-IP advocates)
  - Engage healthcare providers and patient community
    - improving public health programs and patient access to new treatment options
    - sound IP and economic policy
  - Partner with governments on HCV especially MOH
- Address funding challenges

1132

Emerging Markets

Change to Gilead Regional Reporting Structure

- October announcement of changes to Gilead Commercial Operations and International Access Operations
- Primary tenets that drove these changes:
  - Align HCV launch priorities across existing core markets and emerging markets
  - Manage groups of markets that are closely related for political and economic reasons
  - To better coordinate and, where appropriate, consolidate distributor relationships

Details of new regional alignment

Commercial Operations

- North America (Jim Meyers)
- EAME: Europe, Asia and Middle East (Paul Carter)
- Japan (Vice President to be hired)

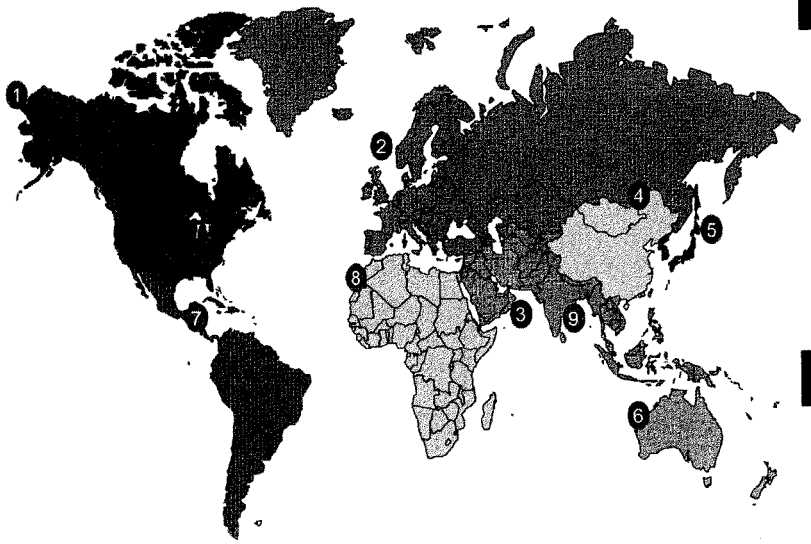
Emerging Markets

Clifford Samuel responsible for the new Emerging Markets Department

- Africa
- South and Southeast Asia
- Caribbean, Central & Latin America

Current access program for developing countries to remain intact

New regional alignment split between Commercial Operations and new department of Emerging Markets



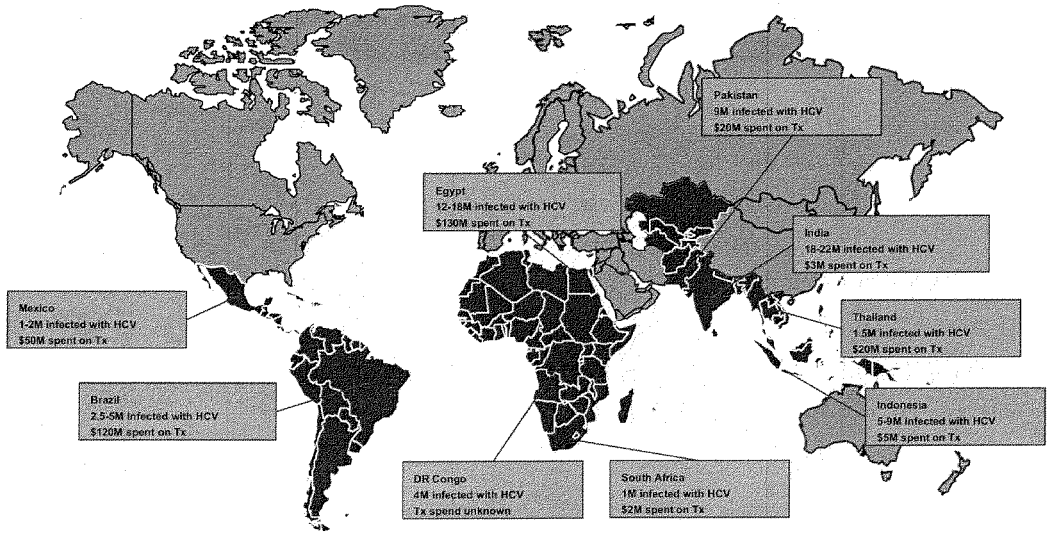
Commercial

1. North America
2. Europe
3. Middle East
4. Central Asia
5. Japan
6. Australasia

Emerging Markets

7. Central & South America
8. Africa
9. East Asia

Emerging Markets: 60% of global HCV prevalence (100M of 170M) in Latin America, Africa, and Central & SE Asia



Spend on HCV treatment is very low
All figures above based on Interferon treatment

*Source: Prevalence - Lavanchy 2010, CDA (multiple sources); Sales - IMS, MoHP Egypt, BCG analysis

Emerging Market Department Goals

- **Ensure products available for significant medical need, capturing commercial opportunity where possible**

- **Use HCV launch to initially prioritize markets, and leverage entire portfolio across markets over time**

- **Given heterogeneity of markets, tailor our business strategies within markets**

Public Affairs

Public Affairs Advocacy Engagement Plan

- Initial stakeholder meetings in U.S. and Europe
  - Key advocacy groups with an emphasis in hepatitis C
  - Specific individuals who influence and help connect these groups
- Umbrella groups identified in each region
- Critical to addressing the reimbursement landscape

1140

Conclusion

- Cross department alignment to address challenges
  - R&D
  - Medical
  - Policy
  - Commercial

1141

Exhibit 24

2012 – 2018 Financial Forecast

John Milligan, PhD
President and COO

Board of Directors Meeting
November 2012

Executive Overview: 2013-2018

- By 2018:
  - HIV
    - Over 1 million people on treatment with Gilead's products in the developed world
    - Up to 10 million people on treatment in the Access Program
      - Highly dependent upon continued public funding
  - HCV
    - Over 500,000 people cured
  - Potential breakthrough therapies
    - HBV cure
    - Hematological disorders and solid tumors
    - Fibrotic diseases

1144

Executive Overview: 2013-2018

- By 2018:

Redacted

  - Manufacturing complexity increases with 30 products
    - Seven HIV tablets with 2, 3 or 4 APIs
    - Two HCV tablets with 2 APIs
    - First biological product
  - Viread generics will become available

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Assumptions

- Scenario specific assumptions

	Base Case	Downside	Upside
Domestic Defensive	• 2012 – '14 from 3 year plan (Oct LE) • 2014 – '18 from 2012 Portfolio Review with probability adjusted revenues and expenses	• 2012 – '14 from 3 year plan (Oct LE) except downside HIV and HCV revenue • 2014 – '18 from 2012 Portfolio Review with probability adjusted revenues and expenses except domestic HIV and HCV	• 2012 – '14 from 3 year plan (Oct LE) • 2012 Portfolio Review without probability adjustment
HCV	• Same as above	• Probability adjusted downside revenue scenario ▸ Earlier launch of ABT regimens, lower GS-7977 patient share, lower rate of retreat to treated, and higher discounts in EU ▸ Cumulative revenue difference - $5.0B	• Same as above ▸ Cumulative revenue difference +$5.0B
HIV	• Same as above	• Probability adjusted downside revenue scenario ▸ No compelling strategy following loss of exclusivity ▸ Cumulative revenue difference - $4.0B	• Same as above ▸ Cumulative revenue difference +$0.7B

- Assumptions common to all scenarios

Variable	Assumption
R&D Expenses	• 2012 – '14 from 3 year plan (Oct LE) • 2014 – '18 from 2012 Portfolio Review; Assumed to be held >/= 13% of revenue
SG&A Expenses	• 2012 – '14 from 3 year plan (Oct LE) for Commercial and G&A • 2014 – '18 includes Commercial Expenses from CP&O with adjustments to align SG&A expenses at approximately 14% of revenue; G&A assumes 5% of NPR
Gross Margin	• Gross Margin for GS-7977 assumed to be 98.7% • Products launched through 2014 from 3 year plan (Oct LE), remaining pipeline products launching post 2014 from PDM
Shares	• Share repurchases: No share repurchases in 2013, Dilution + 50% free cash flow from 2014 – '18
Debt/EBITDA	• Target 1.5 x through 2018
M&A	• $1 B per year through 2018
Tax Rate	• Driven by geographic shift of revenues, peaking at 30% in 2014, declining to 26% by 2018

Product Launch Assumptions

Launch by Therapeutic Area

US	HIV	• Elvitegravir • Cobicistat		• E/C/F/TAF • TAF		
	Liver		• GS-7977	• GS-7977/GS-5885 FDC		
	Cardio			• Ranexa T2DM • Ranexa Post-PCI		
	Resp.			• Caystón (*Bronchoactive*)		
	Onc./ Inflam.		• GS-1101 (*iNHL R/R*)	• GS-1101/GS-9820 (*iNHL/CLL 1st line*) • GS-1101 (*CLL R/R*)		
EU	HIV	• Stribild • Elvitegravir • Cobicistat		• E/C/F/TAF • TAF (HIV)		
	Liver		• GS-7977	• GS-7977/GS-5885 FDC		
	Cardio					
	Resp.			• Caystón (*Bronchoactive*)		
	Onc./ Inflam.			• GS-1101 (*iNHL R/R*)		

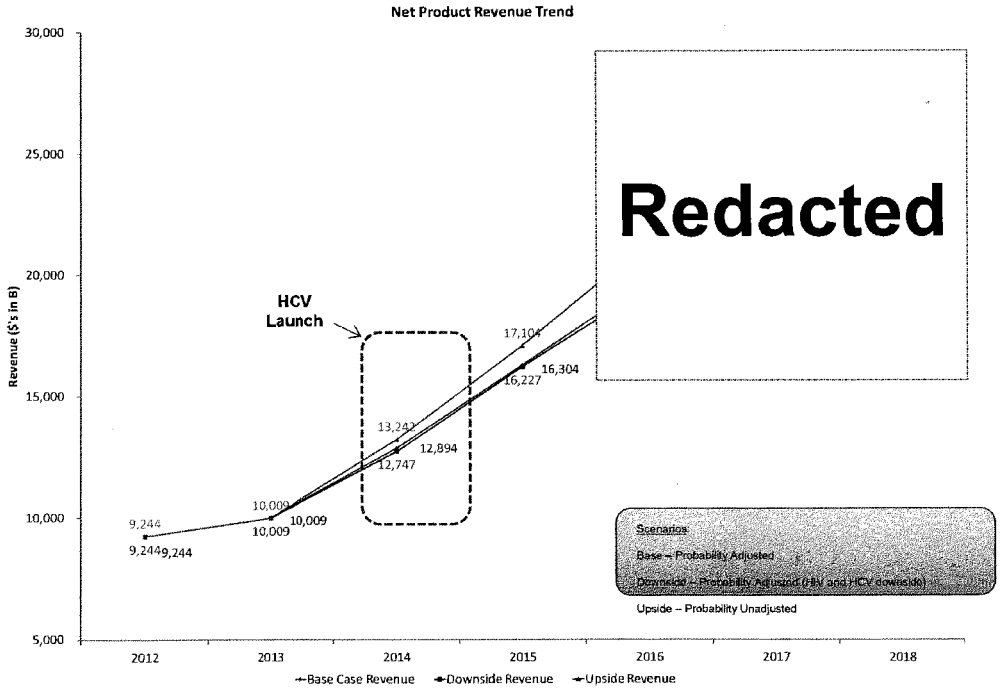
Redacted

Glossary	
Acronym	Defined
TAF	Tenofovir Alafenamide (GS-7340)
E/C/F/TAF	Elvitegravir/Cobicistat/FTC/Tenofovir Alafenamide (GS-7340)
D/C/F/TAF	Darunavir/Cobicistat/FTC/Tenofovir Alafenamide (GS-7340)
R/F/TAF	Rilpivirine/FTC/Tenofovir Alafenamide (GS-7340)
FDC	Fixed Dose Combination
iNHL	Indolent Non-Hodgkin Lymphoma
CLL	Chronic Lymphocytic Leukemia
T2DM	Type 2 Diabetes Mellitus
Post-PCI	Post-Percutaneous Coronary Intervention

Glossary	
Acronym	Defined
TLR7	Toll-Like Receptor 7
NASH	Non-Alcoholic Steatohepatitis
PSC	Primary Sclerosing Cholangitis
R/R	Relapsed/Refractory
IPF	Idiopathic Pulmonary Fibrosis
RAN/DRON	Ranolazine/Dronedarone
MMF	Methylmercaptoguitine

Descriptions in italics represent indication for which the product is approved

Revenue (All Scenarios)



2012 – '18 (Base Case)

($ in millions except per share data)	Base Case FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast	FY16 Forecast	FY17 Forecast	FY18 Forecast
Net Product Revenue	**$ 9,244**	**$ 10,009**	**$ 12,894**	**$ 16,304**			
Total Revenue	**9,533**	**10,312**	**13,227**	**16,652**			
% Change (YoY)	*14.1%*	*8.2%*	*28.3%*	*25.9%*			
Gross Margin	75.5%	75.7%	81.1%	84.3%			
Research & Development	1,472	1,787	1,782	2,165			
% of Revenue	15.4%	17.3%	13.5%	13.0%			
Sales, General & Admin	1,263	1,589	1,813	2,407			
% of Revenue	13.2%	15.4%	13.7%	14.5%			
Sales & Marketing	*773*	*986*	*1,201*	*1,578*			
% of Revenue	8.1%	9.6%	9.1%	9.5%			
General & Administrative	*490*	*602*	*612*	*829*			
% of Revenue	5.1%	5.8%	4.6%	5.0%			
Total Operating Expense	**2,735**	**3,375**	**3,595**	**4,572**			
Operating Income	**4,460**	**4,430**	**7,127**	**9,467**			
Operating Margin	46.8%	43.0%	53.9%	56.9%			
Other Income & Expense	(392)	(302)	(255)	(491)			
Tax Rate	27.3%	29.0%	30.0%	29.0%			
Net Income - Gilead	**$ 2,974**	**$ 2,946**	**$ 4,827**	**$ 6,389**			
Shares	**788.7**	**816.8**	**796.8**	**753.0**			
EPS	**$ 3.77**	**$ 3.61**	**$ 6.06**	**$ 8.48**			

Redacted

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Therapeutic Area (Base Case)

$'s in millions

Net Prod Revenue	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast	FY16 Forecast	FY17 Forecast	FY18 Forecast
HIV/HBV	$ 8,010	$ 8,646	$ 9,296	$ 9,966			
Hepatitis C	-	-	2,047	4,625			
Cardiovascular	767	876	964	1,009			
Respiratory	100	115	156	261			
Oncology			7	37			
Total	**$ 9,244**	**$ 10,009**	**$ 12,894**	**$ 16,304**			

Operating Margin	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast
HIV/HBV	57.9%	57.1%	60.5%	62.4%
Hepatitis C	-	-	63.3%	76.0%
Cardiovascular	47.6%	50.8%	52.6%	52.2%
Respiratory	-134.2%	-145.8%	-142.6%	-59.1%
Oncology	-	-	-7050.2%	-1143.6%
Total	**46.8%**	**43.0%**	**53.9%**	**56.9%**

Product EPS Contribution	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast
HIV/HBV	$ 4.32	$ 4.34	$ 4.94	$ 5.86
Hepatitis C	$ (0.51)	$ (0.68)	$ 1.14	$ 3.31
Cardiovascular	$ 0.39	$ 0.45	$ 0.45	$ 0.50
Respiratory	$ (0.12)	$ (0.15)	$ (0.19)	$ (0.15)
Oncology	$ (0.19)	$ (0.29)	$ (0.43)	$ (0.40)
Total	**$ 3.77**	**$ 3.61**	**$ 6.06**	**$ 8.48**

Redacted

Transition to positive Operating Margin & EPS contribution for the following TAs

- HCV following launch of GS-7977 in 2014

- **Redacted**

1150

Therapeutic Area (Upside)

$'s in millions

Net Prod Revenue	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast	FY16 Forecast	FY17 Forecast	FY18 Forecast
HIV/HBV	$ 8,010	$ 8,646	$ 9,349	$ 9,950			
Hepatitis C	-	-	2,274	5,370			
Cardiovascular	767	876	982	1,021			
Respiratory	100	115	162	296			
Oncology	-	-	9	61			
Total	**$ 9,244**	**$ 10,009**	**$ 13,242**	**$ 17,104**			

Operating Margin	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast
HIV/HBV	57.9%	57.1%	59.6%	60.2%
Hepatitis C	-	-	66.8%	75.7%
Cardiovascular	47.6%	50.8%	52.7%	48.0%
Respiratory	134.2%	145.8%	133.7%	89.6%
Oncology	-	-	-5438.1%	-901.7%
Total	**46.8%**	**43.0%**	**54.0%**	**57.4%**

Product EPS Contribution	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast
HIV/HBV	$ 4.32	$ 4.34	$ 4.90	$ 5.67
Hepatitis C	$ (0.51)	$ (0.68)	$ 1.34	$ 3.84
Cardiovascular	$ 0.39	$ 0.45	$ 0.45	$ 0.46
Respiratory	$ (0.12)	$ (0.15)	$ (0.19)	$ (0.19)
Oncology	$ (0.19)	$ (0.29)	$ (0.43)	$ (0.52)
Total	**$ 3.77**	**$ 3.61**	**$ 6.23**	**$ 9.01**

Redacted

Transition to positive Operating Margin & EPS contribution for the following TAs

- HCV following launch of GS-7977 in 2014
- **Redacted**

1151

HCV P&L (Base Case)

$ in millions except per share data	Base Case FY12 Forecast	FY13 Forecast	FY14 Forecast
Net Product Revenue	$ -	$ -	$ 2,047
Total Revenue	-	-	2,047
% Change (YoY)			
Gross Margin			98.7%
Research & Development	515	535	356
% of Revenue			17.4%
Sales, General & Admin	38	237	368
% of Revenue			18.0%
Sales & Marketing	*38*	*230*	359
% of Revenue			17.6%
General & Administrative	*0*	*8*	*9*
% of Revenue			0.4%
Total Operating Expense	553	772	724
Operating Income	(553)	(777)	1,296
Operating Margin			63.3%
Tax	27.3%	29.0%	30.0%
Net Income - Gilead	(402)	(554)	934
Shares	788.7	816.8	796.8
EPS	-$0.51	-$0.68	$1.17

Revenue

US Launch: Jan. 2014

EAME: France, Germany (Feb. 14), UK (Aug. 14), Spain (Dec.14)

R&D

- 2013 expenses driven by ramp up and additional studies to support GS-7977 and GS-5885 ramping down in 2014 with continuing investment in GS-7977/GS-5816
- US Medical Affairs addition of 17 FTEs in 2013 ; International Medical Affairs addition of 7 FTEs

S&M

- US: 188 FTEs in 2013, held flat in 2014
- EAME128 FTEs in 2013, 239 in 2014
- US Expenses: $108 M in 2013 increasing to $181 M in 2014 reflecting full year impact of sales force, marketing, commercial ops and managed market expenses
- EAME Expenses: $32 M in 2013 increasing to $72 M in 2014 reflecting phased launch preparation and full year impact of sales force and marketing expenses

G&A

- Addition of 5 FTE: Legal (1), Corp Affairs (2) and Finance (2) in 2013, 5 FTE for Finance in 2014
- $6.6 M for Medical Affairs grants, Corporate Affairs and HR in 2013; full year impact included in 2014

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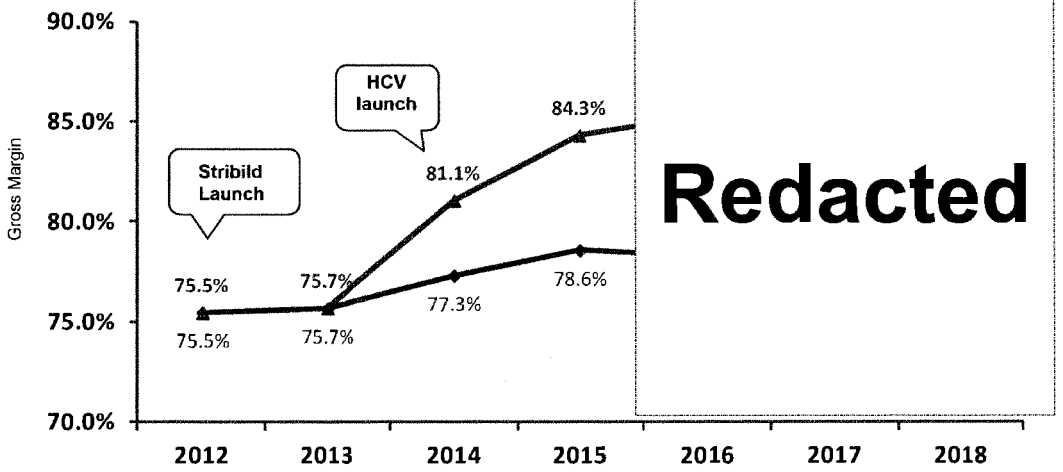
Gross Margin Trends (Base Case)

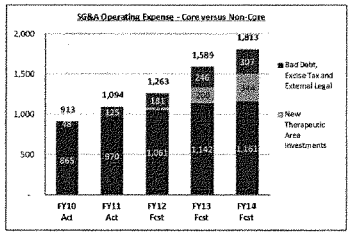


- Key assumptions driving gross margin trends
  - 7977 Gross Margin assumed to be at 98.7%
  - **Redacted**

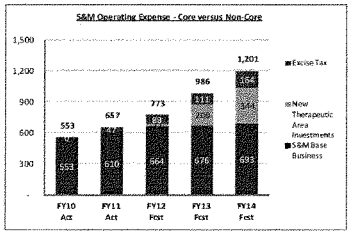
1153

All amounts are in Non-GAAP unless explicitly noted

Normalized SG&A Expense Trend (Base Case)

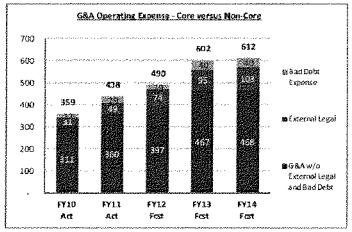


$ in millions	FY10 Act	FY11 Act	FY12 Fcst	FY13 Fcst	FY14 Fcst
SG&A Growth - Base Business	865	970	1,061	1,142	1,161
Y/Y Growth %		12.2%	9.4%	7.7%	1.7%
Total SG&A Growth	913	1,094	1,263	1,589	1,813
Y/Y Growth %		19.9%	15.4%	25.8%	14.1%



$ in millions	FY10 Act	FY11 Act	FY12 Fcst	FY13 Fcst	FY14 Fcst
S&M Base Business	553	610	664	676	693
Y/Y Growth %		10.2%	8.9%	1.8%	2.6%
HCV			21	174	280
Oncology				14	29
Ranexa (T2DM)				6	19
Cayston (BX)				5	16
New Therapeutic Area Investments	-	-	21	200	344
Excise Tax	-	47	88	111	164
Total S&M Growth	553	657	773	986	1,201
Y/Y Growth %		18.7%	17.7%	27.5%	21.8%

➢ Launch of GS-7977, Cayston BX, GS-1101 (iNHL R/R) in 2014

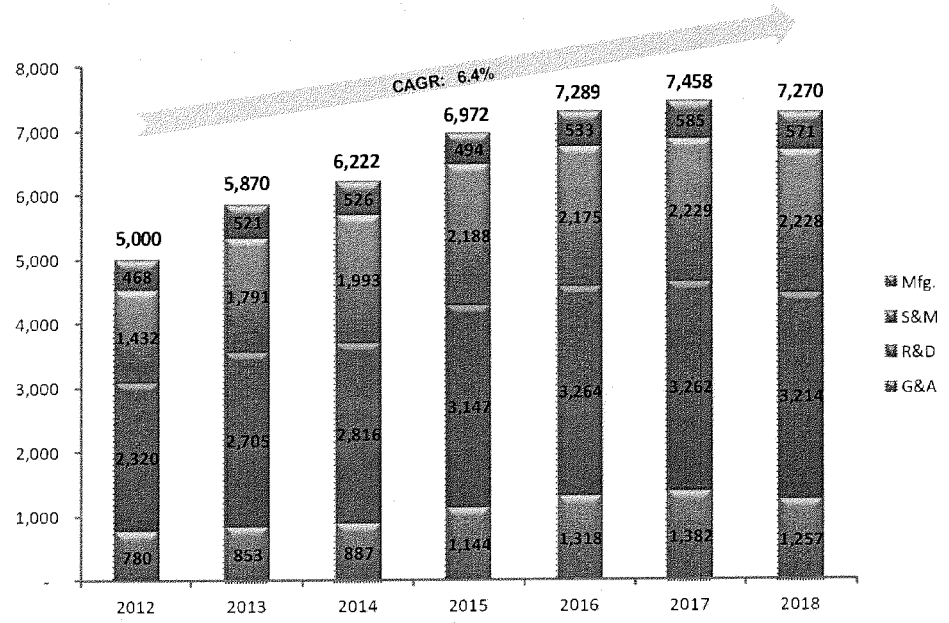


$ in millions	FY10 Act	FY11 Act	FY12 Fcst	FY13 Fcst	FY14 Fcst
G&A w/o External Legal and Bad Debt	311	360	397	467	468
Y/Y Growth %		15.7%	10.4%	17.5%	0.3%
External Legal	31	49	74	95	103
Bad Debt Expense	17	29	19	40	40
Total G&A Growth	359	438	490	602	612
Y/Y Growth %		21.8%	11.9%	23.0%	1.8%

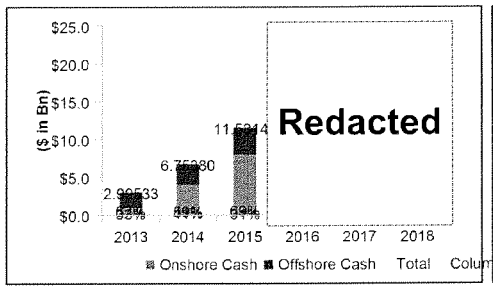
➢ Increase in external legal expenses due to patient litigation

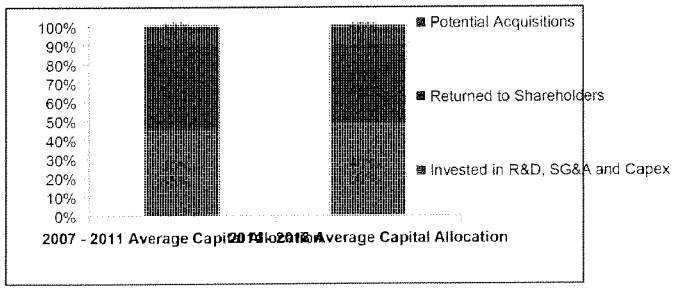
➢ 2012 adjustment to Bad Debt based on collections in Southern Europe

Headcount Projection (Base Case)



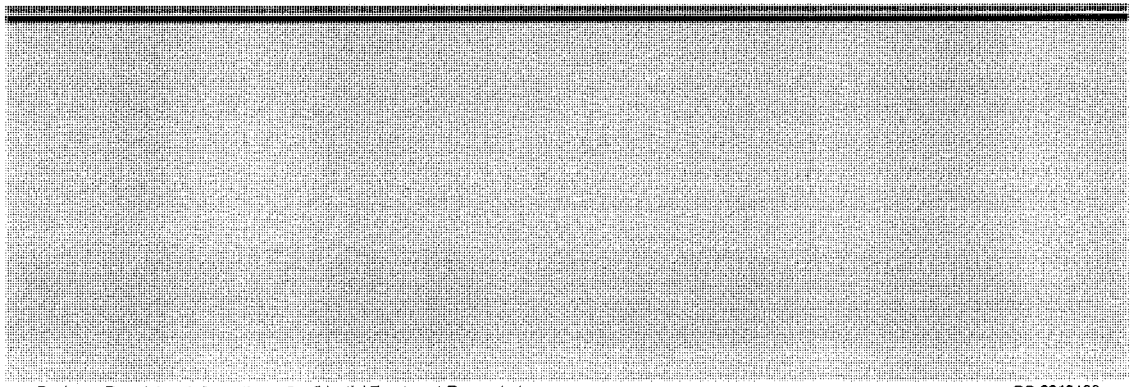
Cash (Base Case)





At 1.5x Debt/EBITDA, Gilead has additional flexibility to spend on acquisitions and/or return to shareholders

Appendix



2012 – '18 P&L (Downside)

($ in millions except per share data)	Downside FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast	FY16 Forecast	FY17 Forecast	FY18 Forecast
Net Product Revenue	**$ 9,244**	**$ 10,009**	**$ 12,747**	**$ 16,227**	Redacted		
Total Revenue	**9,533**	**10,312**	**13,081**	**16,576**			
% Change (YoY)	*14.1%*	*8.2%*	*26.8%*	*26.7%*			
Gross Margin	75.5%	75.7%	80.9%	84.3%			
Research & Development	1,472	1,787	1,782	2,155			
% of Revenue	15.4%	17.3%	13.6%	13.0%			
Sales, General & Admin	1,263	1,589	1,813	2,403			
% of Revenue	13.2%	15.4%	13.9%	14.5%			
Sales & Marketing	*773*	*986*	*1,201*	*1,578*			
% of Revenue	8.1%	9.6%	9.2%	9.5%			
General & Administrative	*490*	*602*	*612*	*825*			
% of Revenue	5.1%	5.8%	4.7%	5.0%			
Total Operating Expense	**2,735**	**3,375**	**3,595**	**4,558**			
Operating Income	**4,460**	**4,430**	**6,982**	**9,419**			
Operating Margin	46.8%	43.0%	53.4%	56.8%			
Other Income & Expense	(392)	(302)	(255)	(491)			
Tax Rate	27.3%	29.0%	30.0%	29.0%			
Net Income - Gilead	**$ 2,974**	**$ 2,946**	**$ 4,725**	**$ 6,355**			
Shares	**788.7**	**816.8**	**796.8**	**753.9**			
EPS	**$ 3.77**	**$ 3.61**	**$ 5.93**	**$ 8.43**			

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2012 – '18 P&L (Upside)

($ in millions except per share data)	Upside FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast	FY16 Forecast	FY17 Forecast	FY18 Forecast
Net Product Revenue	**$ 9,244**	**$ 10,009**	**$ 13,242**	**$ 17,104**			
Total Revenue	**9,533**	**10,312**	**13,576**	**17,452**			
% Change (YoY)	*14.1%*	*8.2%*	*31.6%*	*28.6%*			
Gross Margin	75.5%	75.7%	80.4%	84.8%			
Research & Development	1,472	1,787	1,782	2,269			
% of Revenue	15.4%	17.3%	13.1%	13.0%			
Sales, General & Admin	1,263	1,589	1,813	2,510			
% of Revenue	13.2%	15.4%	13.4%	14.4%			
Sales & Marketing	*773*	*986*	*1,201*	*1,641*			
% of Revenue	8.1%	9.6%	8.8%	9.4%			
General & Administrative	*490*	*602*	*612*	*869*			
% of Revenue	5.1%	5.8%	4.5%	5.0%			
Total Operating Expense	**2,735**	**3,375**	**3,595**	**4,779**			
Operating Income	**4,460**	**4,430**	**7,325**	**10,022**			
Operating Margin	46.8%	43.0%	54.0%	57.4%			
Other Income & Expense	(392)	(302)	(255)	(517)			
Tax Rate	27.3%	29.0%	30.0%	29.0%			
Net Income - Gilead	**$ 2,974**	**$ 2,946**	**$ 4,965**	**$ 6,764**			
Shares	**788.7**	**816.8**	**796.8**	**750.4**			
EPS	**$ 3.77**	**$ 3.61**	**$ 6.23**	**$ 9.01**			

Redacted

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Global Revenue by Product (Base Case)

			Base Case Global Revenue (Adjusted)*						
			2012	2013	2014	2015	2016	2017	2018
HIV	STR	Atripla	$ 3,489	$ 3,407	$ 3,270	$ 2,825	$		
		Complera	$ 318	$ 656	$ 889	$ 1,095	$		
		Stribild	$ 58	$ 510	$ 1,028	$ 1,812	$		
		EVG/COBI/FTC/GS-7340 (E/C/F/TAF)	$ -	$ -	$ -	$ 15	$		
		RPV/COBI/FTC/GS-7340 (R/C/F/TAF)	$ -	$ -	$ -	$ -	$		
		RPV/FTC/GS-7340 (R/F/TAF)	$ -	$ -	$ -	$ -	$		
	Other	Truvada	$ 3,056	$ 2,968	$ 3,104	$ 3,097	$		
		Viread	$ 302	$ 269	$ 253	$ 262	$		
		Emtriva	$ 37	$ 29	$ 28	$ 29	$		
		Elvitegravir	$ -	$ 16	$ 47	$ 86	$		
		Cobicistat	$ -	$ 4	$ 6	$ 13	$		
		GS-7340 single agent HIV	$ -	$ -	$ -	$ 1	$		
HIV Franchise			$ 7,260	$ 7,858	$ 8,623	$ 9,235	$		
Liver Disease	HBV	Viread HBV	$ 492	$ 550	$ 615	$ 686	$		
		Hepsera	$ 104	$ 83	$ 98	$ 45	$		
		GS-7340 single agent HBV monotherapy	$ -	$ -	$ -	$ -	$		
		GS-7340 HBV in combo w/ immunomodulator	$ -	$ -	$ -	$ -	$		
		GS-9620 TLR7 HBV	$ -	$ -	$ -	$ -	$		
		Globelmmune tarmogen HBV	$ -	$ -	$ -	$ -	$		
	HCV	GS-7977 single agent	$ -	$ -	$ 2,047	$ 3,048	$		
		GS-7977/GS-5885 STR	$ -	$ -	$ -	$ 1,578	$		
		Pan-GT STR	$ -	$ -	$ -	$ -	$		
	Fibrosis	GS-6624 NASH	$ -	$ -	$ -	$ -	$		
		GS-6624 PSC	$ -	$ -	$ -	$ -	$		
Total Liver Disease			$ 596	$ 633	$ 2,720	$ 5,357	$		
Cardiovascular	PAH	Letaris	$ 390	$ 459	$ 504	$ 511	$		
	Late Pha	Ranexa 500mg (base case angina)	$ 255	$ 276	$ 297	$ 308	$		
		Ranexa 500mg (T2DM label)	$ -	$ -	$ -	$ 11	$		
		Ranexa 500mg (post-PCI)	$ -	$ -	$ -	$ 3	$		
		Ranexa 1000mg (base case angina)	$ 110	$ 139	$ 163	$ 169	$		
		Ranexa 1000mg (T2DM label)	$ -	$ -	$ -	$ 6	$		
		Ranexa 1000mg (post-PCI)	$ -	$ -	$ -	$ 1	$		
		GS-6615	$ -	$ -	$ -	$ -	$		
		RAN/DRON FDC ARb	$ -	$ -	$ -	$ -	$		
	Other	GS-4997 ASK1 Diabtileph	$ -	$ -	$ -	$ -	$		
Total Cardiovascular			$ 755	$ 874	$ 964	$ 1,009	$		
Respiratory	CF	Cayston CF	$ 109	$ 115	$ 156	$ 172	$		
		GS-5737 CF	$ -	$ -	$ -	$ -	$		
	Other	Cayston BX	$ -	$ -	$ -	$ 89	$		
		GS-6624 IPF	$ -	$ -	$ -	$ -	$		
		GS-5806 RSV Inpatient (IV)	$ -	$ -	$ -	$ -	$		
		GS-5806 RSV Outpatient (Oral)	$ -	$ -	$ -	$ -	$		
		GS-5737 COPD	$ -	$ -	$ -	$ -	$		
Total Respiratory			$ 109	$ 115	$ 156	$ 261	$		
Oncology & Inflammation	Hematology	AmBisome	$ 318	$ 321	$ 318	$ 321	$		
		GS-1101 iNHL R/R	$ -	$ -	$ 7	$ 21	$		
		GS-1101 and/or GS-9820 rNHL 1st line	$ -	$ -	$ -	$ 3	$		
		GS-1101 CLL R/R	$ -	$ -	$ -	$ 11	$		
		GS-1101 CLL 1st line	$ -	$ -	$ -	$ 2	$		
		GS-9973 iNHL & CLL (all lines, single/sequential/mono)	$ -	$ -	$ -	$ -	$		
	Solid Tumor	GS-6624 Pancreatic	$ -	$ -	$ -	$ -	$		
		GS-6624 Colorectal	$ -	$ -	$ -	$ -	$		
	Other	GS-6624 Myelofibrosis	$ -	$ -	$ -	$ -	$		
		GS-5745 MMP Ulcerative Colitis	$ -	$ -	$ -	$ -	$		
		GS-6208 RA	$ -	$ -	$ -	$ -	$		
Total Oncology & Inflammation			$ 318	$ 321	$ 325	$ 359	$		
Other	Other	CauseXome	$ 1	$ -	$ -	$ -	$		
		Visilize	$ 18	$ 20	$ 17	$ 17	$		
Total Other			$ 19	$ 20	$ 17	$ 17	$		
Total Global			$ 9,047	$ 9,930	$ 12,805	$ 16,238	$		

Redacted

*Assumes no access, hedge or out-license revenue

Global Revenue by Product (Upside)

			Upside Global Revenue (Unadjusted)*						
			2012	2013	2014	2015	2016	2017	2018
HIV	STR	Antpla	$ 3,489	$ 3,407	$ 3,270	$ 2,825	$		
		Complera	$ 318	$ 656	$ 889	$ 1,095	$		
		Stribild	$ 58	$ 510	$ 1,028	$ 1,805	$		
		EVG/COBI/FTC/GS-7340 (E/C/F/TAF)	$ -	$ -	$ -	$ 22	$		
		DRV/COBI/FTC/GS-7340 (D/C/F/TAF)	$ -	$ -	$ -	$ -	$		
		RPV/FTC/GS-7340 (R/F/TAF)	$ -	$ -	$ -	$ -	$		
	Other	Truvada	$ 3,056	$ 2,968	$ 3,104	$ 3,097	$		
		Viread	$ 302	$ 258	$ 237	$ 245	$		
		Emtriva	$ 37	$ 29	$ 28	$ 29	$		
		Elvitegravir	$ -	$ 16	$ 47	$ 86	$		
		Cobicistat	$ -	$ 4	$ 6	$ 13	$		
		GS-7340 single agent HIV	$ -	$ -	$ -	$ 2	$		
HIV Franchise			$ 7,260	$ 7,847	$ 8,608	$ 9,219	$		
Liver Disease	HBV	Viread HBV	$ 492	$ 550	$ 615	$ 686	$		
		Hepsera	$ 104	$ 83	$ 58	$ 49	$		
		GS-7340 single agent HBV monotherapy	$ -	$ -	$ -	$ -	$		
		GS-7340 HBV in combo w/ immunomodulator	$ -	$ -	$ -	$ -	$		
		GS-9620 TLR7 HBV	$ -	$ -	$ -	$ -	$		
		Globeimmune tarmogen HBV	$ -	$ -	$ -	$ -	$		
	HCV	GS-7977 single agent	$ -	$ -	$ 2,274	$ 2,866	$		
		GS-7977/GS-5885 STR	$ -	$ -	$ -	$ 2,504	$		
		Pan-GT STR	$ -	$ -	$ -	$ -	$		
	Fibrosis	GS-6624 NASH	$ -	$ -	$ -	$ -	$		
		GS-6624 PSC	$ -	$ -	$ -	$ -	$		
Total Liver Disease			$ 596	$ 633	$ 2,947	$ 6,102	$		
Cardiovascular	PAH	Letaris	$ 390	$ 459	$ 504	$ 511	$		
	Late-Na	Ranexa 500mg (base case angina)	$ 255	$ 276	$ 297	$ 308	$		
		Ranexa 500mg (T2DM label)	$ -	$ -	$ -	$ 17	$		
		Ranexa 500mg (post-PCI)	$ -	$ -	$ -	$ 5	$		
		Ranexa 1000mg (Base case angina)	$ 110	$ 130	$ 163	$ 169	$		
		Ranexa 1000mg (T2DM label)	$ -	$ -	$ -	$ 8	$		
		Ranexa 1000mg (post-PCI)	$ -	$ -	$ -	$ 3	$		
		GS-6615	$ -	$ -	$ -	$ -	$		
		RAN/DRON FDC Mfg	$ -	$ -	$ -	$ -	$		
	Other	GS-9287 ASK1 Diashegh	$ -	$ -	$ -	$ -	$		
Total Cardiovascular			$ 755	$ 874	$ 964	$ 1,021	$		
Respiratory	CF	Cayston CF	$ 100	$ 113	$ 156	$ 172	$		
		GS-5737 CF	$ -	$ -	$ -	$ -	$		
	Other	Cayston BX	$ -	$ -	$ -	$ 124	$		
		GS-6624 IPF	$ -	$ -	$ -	$ -	$		
		GS-5806 RSV Inpatient (IV)	$ -	$ -	$ -	$ -	$		
		GS-5806 RSV Outpatient (Oral)	$ -	$ -	$ -	$ -	$		
		GS-5737 COPD	$ -	$ -	$ -	$ -	$		
Total Respiratory			$ 100	$ 113	$ 156	$ 296	$		
Oncology & Inflammation	Hematology	Ambicorna	$ 318	$ 321	$ 318	$ 321	$		
		GS-1101 INHL R/R	$ -	$ -	$ 9	$ 28	$		
		GS-1101 and/or GS-9820 INHL 1st line	$ -	$ -	$ -	$ 9	$		
		GS-1101 CLL R/R	$ -	$ -	$ -	$ 16	$		
		GS-1101 CLL 1st line	$ -	$ -	$ -	$ 7	$		
		GS-9973 rIHL & CLL (all lines, single/sequential/mono)	$ -	$ -	$ -	$ -	$		
	Solid Tumor	GS-6624 Pancreatic	$ -	$ -	$ -	$ -	$		
		GS-6624 Colorectal	$ -	$ -	$ -	$ -	$		
	Other	GS-6624 Myelofibrosis	$ -	$ -	$ -	$ -	$		
		GS-5745 MMP Ulcerative Colitis	$ -	$ -	$ -	$ -	$		
		GS-9200 RA	$ -	$ -	$ -	$ -	$		
Total Oncology & Inflammation			$ 318	$ 321	$ 325	$ 359	$		
Other	Other	Daunoxome	$ 1	$ -	$ -	$ -	$		
		Vistide	$ 18	$ 20	$ 17	$ 17	$		
Total Other			$ 19	$ 20	$ 17	$ 17	$		
Total Gilead			$ 8,937	$ 9,814	$ 13,012	$ 17,014	$		

Redacted

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*Assumes no access, hedge or out-license revenue

Probability of Success

TA	Product		Current Phase	2012 PoS % (calculated)
HIV				Redacted
	Elvitegravir (GS-9137)		Filed	
	Cobicistat (GS-9350)		Filed	
	GS-7340 single agent		P1	
	STR's containing GS-7340			
	EVG/COBI/FTC/GS-7340 (E/C/F/TAF)		P2	
	DRV/COBI/FTC/GS-7340 (D/C/F/TAF)		P2	
	RPV/FTC/GS-7340 (R/F/TAF)		P1	
Liver Disease				
	HCV	GS-7977 (single agent)	P3	
		GS-7977+GS-5885 (STR)	P2	
		GS-7977+GS-5816 (STR)	P1	
		GS-7977+GS-9813 (STR)	P1	
	HBV	GS-9620 (TLR-7 Agonist 2) + Viread/GS-7340 HBV	P1	
		GS-7340 HBV	P1	
		Tarmogen (GlobeImmune) + Viread/GS-7340	Pending IND filing	
	Other	GS-6624 (LoxL2 mAb) Liver Fibrosis	P2	
		GS-5745 (MMP9) Ulcerative Colitis	P1	
Cardiovascular				
	Ranolazine (GS-9668) T2DM		P3	
	Ranolazine (GS-9668) post-PCI		P3	
	GS-9668/GS-9670 (Ran+drone) Afib		P2	
	GS-6615 (Na Inhibitor) IHD		P1	
	GS-6637 (ALDH 2) Addiction		P1	

TA	Product		Current Phase	2012 PoS % (calculated)
Oncology/Inflammation				Redacted
	Hematology	GS-1101 P13KD CLL R/R	P3	
		GS-1101 P13KD iNHL R/R	P3	
		GS-1101 P13KD CLL 1st Line	P3	
		GS-1101 P13KD iNHL 1st Line	P3	
		GS-9973 Syk Inhibitor Oncology (single agent)	P1	
		GS-9820 P13KD iNHL 1st Line	P1	
		GS-6624 (LoxL2 mAb) Myelofibrosis	P2	
	Solid Tumor	GS-6624 (LoxL2 mAb) Pancreatic Cancer	P2	
		GS-6624 (LoxL2 mAb) Colorectal Cancer	P2	
	Inflammation	GS-4997 (ASK1) Diabetic Kidney Disease	P1	
		GS-6208 (Syk Inhibitor) RA	P1	
Respiratory				
	Aztreonam Lysine (GS-9268) BX		P3	
	GS-6624 (LoxL2 mAb) IPF		P1	
	GS-5806 RSV		P1	
	GS-5737 (ENaC Blocker #2) CF		P1	
	GS-5737 (ENaC Blocker #2) COPD		P1	

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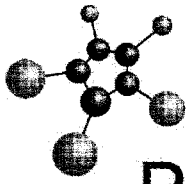
Exhibit 25



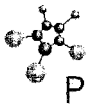
PHARMASSET

Board of Directors Meeting

New York City

October 11, 2011

Confidential



PHARMASSET

303-A College Road East
Princeton NJ 08540 USA
Office 609 613 4100
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www.pharmasset.com

WHERE INNOVATION IS VIRAL

Board of Directors Meeting

Tuesday, October 11, 2011
8:00 am – 4:00 pm (EST)

Location:
Le Parker Meridien Hotel – **Penthouse Suite**
119 West 56th Street (located between 6th & 7th Avenues)
New York, NY 10019

AGENDA

8:00 am	**Administration** – Review and approval of previous meeting minutes
8:05 am	**Report of Board Committees** – Audit Committee – Nomination/Governance Committee – Compensation Committee
10:00 am	**Clinical Development Update**
11:00 am	**Budget Presentation**
12:00 pm	**Lunch**
1:00 pm	**Morgan Stanley Update**
3:00 pm	**Executive Session – Directors Only**
4:00 pm	**Adjourn**

Board Dinner
Monday, October 11 at 7:00 pm EST
Marea Restaurant
240 Central Park South
New York, NY 10019
Phone 212-582-5100

Future Board Meetings

- January 12, 2012 - San Francisco
- March 6, 2012 – New York City
- June 20, 2012 – Princeton, NJ
- October 11, 2012 – New York

ADMINSTRATION TAB

CONFIDENTIAL DRAFT
FOR DISCUSSION PURPOSES ONLY

Minutes of the Special Meeting of the Board of Directors of Pharmasset, Inc. (via teleconference) September 15, 2011

Directors in attendance:
William J. Carney
Herbert Conrad, Chairman of the Board
Elliot F. Hahn
Michael Inouye
P. Schaefer Price, President and CEO of the Company
Robert F. Williamson, III

Others in attendance at the invitation of the Board:
From the Company—
Kurt Leutzinger, Chief Financial Officer
Bryce Roberts, Vice President, Senior Counsel & Secretary

From Morgan Stanley—
Jessica Chutter
Steven Harr
Susan Hoang
Ashwin Pai
Ari Terry

From Sullivan & Cromwell –
Matthew Hurd

The Board of Directors (the "Board") of Pharmasset, Inc. (the "Company") held a special meeting, pursuant to notice, on September 15, 2011 via teleconference commencing at 10:30 a.m. EDT. All members of the Board being present, Mr. Conrad called the meeting to order. Mr. Roberts acted as secretary for the meeting.

Mr. Conrad thanked the members for their attendance and reviewed the agenda. Mr. Conrad then asked Mr. Price to address the Board. Mr. Price provided information regarding a certain clinical study participant. Mr. Roberts then addressed the Board regarding management's vetting of the independence of each of the members of the Board and the Company's counsel, Sullivan & Cromwell, the results of such vetting being that no independence or conflict issues were found to be of concern. Mr. Leutzinger addressed the Board regarding management's vetting of the independence of Morgan Stanley, the results of which being that no independence issues were discovered.

Mr. Conrad then asked the representatives of Morgan Stanley to address the Board and present materials previously provided. Mr. Harr provided a summary of the information to be presented. Ms. Huang provided background regarding the financial information to be presented

and emphasized that the intent of today's presentation is to understand the Company's potential value and Kight's proposal in the context of several factors. Mr. Hurd provided additional information regarding the analytical process that is expected of public company boards in similar circumstances. Further discussions ensued regarding the potential for shareholder litigation in the context of a business combination transaction.

Mr. Harr directed the members to the materials previously provided regarding the current circumstances and the process and results of Morgan Stanley's valuation of the Company and proceed to lead discussions regarding same along with other Morgan Stanley representatives. The members asked questions to which Morgan Stanley representatives responded. Detailed discussions were had among the members and Morgan Stanley representatives, particularly on the assumptions and methodologies applied by Morgan Stanley to generate their materials.

Morgan Stanley representatives proceeded to present and lead discussions regarding the materials concerning the current proposal for a business combination transaction. The members asked questions to which Morgan Stanley representatives responded. Detailed discussions were had among the members and Morgan Stanley representatives, particularly concerning the assumptions applied to the financial analysis of the potentially combined company.

Detailed discussions were had among the members and the invitees regarding responding to Knight's proposal. The members also considered the potential for a tender offer and the effects thereof. The members shared their individual views regarding the Company valuation, the potential risks regarding the potential transaction and tactical considerations. After further discussions, the members of the Board reached a consensus regarding the Company's response to the proposal and authorized Mr. Price to make a verbal reply to Knight that would propose the entering into of a confidentiality agreement, including a standstill provision, and conducting a limited diligence period.

The Chairman inquired among the members regarding any further business and, there being none, the meeting was adjourned at approximately 12:15 p.m.

Respectfully submitted,

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Bryce Roberts

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CONFIDENTIAL DRAFT
FOR DISCUSSION PURPOSES ONLY

Minutes of the Special Meeting of the Board of Directors of Pharmasset, Inc. (via teleconference) September 12, 2011

Directors in attendance:
William J. Carney
Herbert Conrad, Chairman of the Board
Elliot F. Hahn
Michael Inouye
P. Schaefer Price, President and CEO of the Company
Robert F. Williamson, III

Others in attendance at the invitation of the Board:
From the Company—
Kurt Leutzinger, Chief Financial Officer
Michelle Berrey, M.D., Chief Medical Officer
Michael Rogers, Chief Development Officer
Patrick Higgins, Executive Vice President, Marketing and Sales
Bryce Roberts, Vice President, Senior Counsel & Secretary
Michael McElhaugh, Director, Market Analytics and Business Development

From Morgan Stanley—
Jessica Chutter
Steven Harr
Susan Hoang
Ashwin Pai
Ari Terry

From Sullivan & Cromwell—
Matthew Hurd

The Board of Directors (the "Board") of Pharmasset, Inc. (the "Company") held a special meeting, pursuant to notice, on September 12, 2011 via teleconference commencing at 2:30 p.m. EDT. All members of the Board being present, Mr. Conrad called the meeting to order. Mr. Roberts acted as secretary for the meeting.

Mr. Conrad thanked the members for their attendance and reviewed the agenda. Mr. Conrad then asked Mr. Price to address the Board regarding the materials to be presented and discussed. Mr. Price summarily reviewed the materials previously provided to the members and asked Ms. Chutter to present Morgan Stanley's materials. Ms. Chutter proceeded to address the Board to present such materials and responded to questions from the members.

Dr. Berrey then addressed the Board to present materials previously provided regarding clinical information concerning the Company's product candidates; Dr. Berrey also responded to questions from the members regarding same.

Dr. Rogers presented materials previously provided to the members regarding the Company's clinical development plans and responded to questions from the members regarding same.

Mr. Higgins and Mr. McElhaugh then addressed the Board regarding the current HCV market, market dynamics and the potential role of the Company's drug candidates in the market, and also presented a detailed forecast model with an explanation of the assumptions made for same.

Redacted

Mr. Terry then referred the members back to the Morgan Stanley materials and continued, along with Mr. Harr and other Morgan Stanley representatives, to present same that included, among other things, detailed financial analyses on Knight.

The Chairman inquired regarding any further business and, there being none, adjourned the meeting at approximately 4:15 p.m.

Respectfully submitted,

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Bryce Roberts

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CONFIDENTIAL DRAFT
FOR DISCUSSION PURPOSES ONLY

Minutes of the Special Meeting of the Board of Directors of Pharmasset, Inc. (via teleconference) September 6, 2011

Directors in attendance:
William J. Carney
Herbert Conrad, Chairman of the Board
Elliot F. Hahn
Michael Inouye
P. Schaefer Price, President and CEO of the Company
Robert F. Williamson, III

Others in attendance at the invitation of the Board:
From the Company—
Kurt Leutzinger, Chief Financial Officer
Bryce Roberts, Vice President, Senior Counsel & Secretary

From Morgan Stanley—
Jessica Chutter
Steven Harr
Susan Hoang
Ashwin Pai
Ari Terry

The Board of Directors (the "Board") of Pharmasset, Inc. (the "Company") held a special meeting, pursuant to notice, on September 6, 2011 via teleconference commencing at 2:00 p.m. EDT. All members of the Board being present, Mr. Conrad called the meeting to order. Mr. Roberts acted as secretary for the meeting.

Mr. Conrad thanked the members for their attendance and reviewed the agenda. Mr. Conrad then asked Mr. Price to address the Board regarding the materials to be discussed. Mr. Price provided background information regarding recent discussions with a certain pharmaceutical company and discussed details of a letter received from such company regarding a proposed business combination transaction. Discussions were had among the members and questions asked of Mr. Price regarding the proposed transaction and the other company. Mr. Price then asked Ms. Chutter to present Morgan Stanley's materials. Ms. Chutter proceeded to address the Board and, along with Mr. Harr and other Morgan Stanley representatives, responded to questions from the members regarding the materials and other items. Detailed discussions were had among the members, Company representatives and Morgan Stanley representatives.

Upon the conclusion of discussions, the Chairman inquired among the members regarding any further business and, there being none, upon motion duly made, seconded and unanimously approved, adjourned the meeting at approximately 2:30 p.m.

Respectfully submitted,

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Bryce Roberts

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CONFIDENTIAL DRAFT
FOR DISCUSSION PURPOSES ONLY

Minutes of the Regular Meeting of the Board of Directors of Pharmasset, Inc. Pharmasset, Inc., Princeton, New Jersey July 21, 2011

Directors in attendance:
William J. Carney
Herbert Conrad, Chairman of the Board
Elliot F. Hahn
Michael Inouye
P. Schaefer Price, President and CEO of the Company
Robert F. Williamson, III

Others in attendance at the invitation of the Board:
From the Company—
Kurt Leutzinger, Chief Financial Officer
Mark Meester, Chief Administrative Officer
Michael Rogers, Chief Development Officer
Patrick Higgins, Executive Vice President, Marketing and Sales
Bryce Roberts, Vice President, Senior Counsel & Secretary
Richard E.T. Smith, Vice President Investor Relations
Michael McElhaugh, Director, Market Analytics and Business Development

From Morgan Stanley—
Jessica Chutter (via teleconference)
Steven Harr

The Board of Directors (the "Board") of Pharmasset, Inc. (the "Company") held a regular meeting, pursuant to notice, on July 21, 2011 at the Company's facility in Princeton, New Jersey commencing at 8:00 a.m. EDT. All members of the Board being present, Mr. Conrad called the meeting to order. Mr. Roberts acted as secretary for the meeting.

Approval of Minutes

Subject to certain ministerial corrections provided to Mr. Roberts, upon motion duly made, seconded and unanimously carried, it was

RESOLVED, that the minutes of the meeting of the Board held on March 23, 2011 are hereby ratified and approved.

Board Committee Reports

Mr. Williamson reported that the Audit Committee met on February 4, 2011 to receive Grant Thornton's presentation of the results of the firm's review of the Company's financial

statements for the quarter ended December 31, 2010 which review noted no deficiencies or other issues.

Mr. Carney reported that the Nominating & Corporate Governance Committee has reviewed the size of the Board relative the boards of similar companies and learned that the Board is slightly undersized. Mr. Carney presented certain aspects of the Nominating and Corporate Governance Committee materials previously provided to the Board and led discussions regarding same. The Committee also reviewed the current skill sets of the members and considered desirable qualifications of additional members that would benefit the Board and the Company. The members also discussed the qualifications of several potential candidates. The members discussed the possibility of using a search firm to recruit additional members. Mr. Carney stated that the Committee will assemble a search committee to move forward on selecting a search firm and settling on the qualifications being sought in one or more additional members.

Mr. Williamson reported that the Compensation Committee met on July 20, 2011. Mr. Williamson reported that the Committee has decided to use Radford as its compensation consultant to, among other things, address the issue of selecting an appropriate compensation peer group. Moving forward, the Committee will communicate the peer group to the full Board, once the peer group is selected, Radford's process will move forward apace. Mr. Williamson led discussions regarding the difficulties in finding appropriate peer group companies. Mr. Williamson summarized the balance of the Compensation Committee materials previously provided to the Board.

Mr. Meester presented the Risk Management Update to the Board, led discussions and responded to questions regarding same.

Morgan Stanley representatives joined the meeting at approximately 9:35 a.m. and distributed materials to the members and presented and led detailed discussions regarding same. Specific discussions were had regarding the market potential for the Company's product candidates, recent share price performance, the share price performance of comparable companies, Pharmasset's relative position in the HCV space, overall value under various circumstances, and other topics. At approximately 10:35 am, the Morgan Stanley representatives departed the meeting.

Mr. Conrad asked Mr. Leutzinger to present the Company's recommendation of a stock split. Mr. Leutzinger explained the Company's rationale for a two-for-one stock split in the form of a stock dividend and led discussions regarding same. The members considered the proposed resolutions previously provided and, upon motion duly made and seconded, unanimously approved the resolutions attached hereto as Exhibit A.

Clinical Update

The Chairman then asked Dr. Rogers to present the Company's clinical update to the Board. Dr. Rogers proceeded to present materials and lead discussions, including addressing questions from the members, regarding same. Specific discussions were had regarding the

Company's plans to continue on its HCV genotype 2/3 strategy in currently planned and future clinical studies. Mr. Leutzinger addressed the Board regarding the Company's plans to finance the continued development strategy, including plans for an underwritten offering later in 2011. Upon the conclusion of such discussions and upon motion duly made, seconded and unanimously approved, it was

> RESOLVED, that the Board hereby approves the incurrence of the expenses involved in progressing the clinical development of the Company's product candidates consistent with the designs as presented, including non-material deviations from same as required by the FDA.

Pharmasset Strategy

Dr. Otto presented materials and led discussions regarding the Company's efforts to diversify its research strategy. Specific information was provided with regard to influenza virus and dengue virus, including market potentials, screening methods, collaborations in place with third parties, and certain specific data generated with Company compounds to date.

IMS Consulting Group representatives joined the meeting at approximately 11:40 a.m. and distributed detailed materials regarding its HCV Market Prioritization and Strategy prepared for the Company. The IMS representatives proceeded to present such materials and led discussions regarding same. The members and Company management actively participated during such presentation and asked questions which were addressed by the IMS representatives. The IMS representatives departed the meeting at approximately 1:45 pm.

Mr. Higgins then addressed the Board regarding the Company's US commercialization strategy. Mr. Higgins presented detailed materials, led discussions and answered the questions of the members regarding same.

Mr. Leutzinger referred members to a memorandum previously provided regarding the Company's global financial considerations and proceeded to provided background information, summarize content, lead discussions and answer questions regarding same. He noted that the next steps in this process will require hiring the appropriate experts, such as accounting and law firms, and collecting all the information needed to enable to Board to fully evaluate such considerations. Upon conclusion of discussions, and upon motion duly made, seconded and unanimously approved, it was

> RESOLVED, that the Board hereby authorizes the expenditure by Company management of up to $500,000 to continue to explore the potential for the Company to restructure in order to decrease the tax burden on future Company revenue, with the requirement that Company management report back to the Board on such activities at it's next regular meeting.

Mr. Price referred members to a memorandum previously provided regarding the Company's strategic update and proceeded to present same to the Board. Detailed discussions

were had, during which Mr. Price and other Company representatives address questions posed by the members.

The Chairman then excused Company representatives from the meeting at approximately 3:45 p.m. in order to conduct an executive session, which concluded at approximately 4:30 p.m., after which the meeting was adjourned.

Respectfully submitted,

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Bryce Roberts

CONFIDENTIAL DRAFT
FOR DISCUSSION PURPOSES ONLY

EXHIBIT A

PROPOSED RESOLUTIONS OF THE BOARD OF DIRECTORS

WHEREAS, the Board of Directors (the "***Board***") of Pharmasset, Inc. (the "***Company***") has reviewed and considered the Company's existing capital structure; and

WHEREAS, the Board has determined that it is in the best interests of the Company's stockholders to declare a two-for-one stock split in the form of a stock dividend of one share of the Company's common stock, par value $0.001 per share (the "***Common Stock***"), for each share of Common Stock outstanding on the Record Date (as defined below); and

WHEREAS, the Company's 1998 Stock Plan, as amended (the "***1998 Plan***"), and 2007 Equity Incentive Plan, as amended (the "***2007 Plan***", and together with the 1998 Plan, the "***Plans***") provide, and the Compensation Committee of the Board recommends, that such actions as are necessary shall be taken to make appropriate equitable adjustments in order to preserve the value of outstanding and future awards made pursuant to the Plans in the event of certain corporate actions such as the actions contemplated by these resolutions.

NOW, THEREFORE, BE IT RESOLVED, that the Board hereby declares a two-for-one stock split of the Common Stock in the form of a dividend of one share of Common Stock for each outstanding share of Common Stock outstanding at the close of business on August 22, 2011 (the "***Record Date***"); and be it further

RESOLVED, the Chief Executive Officer and Chief Financial Officer of the Company (each an "***Authorized Officer***," and, collectively, the "***Authorized Officers***") be, and each of them hereby is, authorized, empowered and directed to take all actions necessary such that on August 31, 2011 each shareholder of the Company as of the Record Date shall be issued one additional share of Common Stock for each share of Common Stock owned of record by such shareholder as of the Record Date; and be it further

RESOLVED, that as of the Record Date (i) the number of shares of Common Stock subject to outstanding awards made pursuant to the Plans, (ii) the number of shares of Common Stock reserved for future issuance pursuant to the Plans, (iii) the number of shares of Common Stock subject to the limitation in Section 5.2(a)(i) of the 2007 Plan and (iv) the number of shares of Common Stock that shall be issued pursuant to Section 11.1(a) of the 2007 Plan following the date hereof, are hereby doubled, and that the Authorized Officers are hereby authorized, empowered and directed, in the name and on behalf of the Company, to take any and all actions necessary or required to implement this resolution; and be it further

RESOLVED, that as of the Record Date the purchase price of outstanding options and stock appreciation rights is hereby reduced by 50%, and that the Authorized Officers are hereby authorized, empowered and directed, in the name and on behalf of the Company, to take any and all actions necessary or required to implement this resolution; and be it further

RESOLVED, that any Common Stock issued pursuant to these resolutions, upon issuance and payment therefor, shall be validly issued, fully paid and nonassessable, and upon such issuance, the sum of $0.001 per share of Common Stock shall be credited to the Company's stated capital account; and be it further

RESOLVED, that the Authorized Officers are, and each of them hereby is, authorized, empowered and directed, on behalf of the Company, to provide any and all required notices and documents on behalf of the Company to list any Common Stock issued pursuant to these resolutions on The NASDAQ Stock Market, LLC or any other market on which the Common Stock is listed (the "***Exchange***"); and be it further

Resolved, that each Authorized Officer be, and each of them hereby is, authorized, in the name and on behalf of the Company, to perform all such acts and execute, deliver and/or file all such agreements, notifications, documents and instruments (including, without limitation, any filings or notifications required by the rules and regulations of the Securities and Exchange Commission or the rules of any Exchange on which the Common Stock is listed), make any public announcements and pay any and all fees and expenses in connection therewith, as such Authorized Officer shall deem necessary, desirable or appropriate to effectuate the intent and purposes of the foregoing resolutions, including, without limitation, the payment of legal, accounting, printing and regulatory fees, such determination to be conclusively evidenced by the performance of such acts, the execution delivery or filing of such agreements, documents and instruments and the payment of any such fees; and be it further

Resolved, that all actions previously taken by any director, officer, employee or agent of the Company in connection with or related to the matters set forth in or reasonably contemplated or implied by the foregoing resolutions be, and each of them hereby is, adopted, ratified, confirmed and approved in all respects as acts and deeds of the Company.

AUDIT COMMITTEE TAB

Minutes of the Regular Meeting of the
Audit Committee of the Board of Directors of
Pharmasset, Inc.
(via teleconference)
August 5, 2011

Committee Members in attendance:
William J. Carney
Herb Conrad, Chairman of the Board
Robert F. Williamson, III, Chairman of the Audit Committee

Others in attendance at the invitation of the Committee:
From the Company—
P. Schaefer Price, President and Chief Executive Officer
Kurt Leutzinger, Chief Financial Officer
James Maguire, Vice President, Financial Reporting
Bryce A. Roberts, Vice President, Senior Counsel & Secretary

From Grant Thornton LLP—
Wayne Kaplan
James Epperson

The Audit Committee (the "Committee") of the Board of Directors of Pharmasset, Inc. (the "Company") held a regular meeting, pursuant to notice, on August 5, 2011 commencing at 8:30 a.m. EDT via teleconference. All members of the committee being present, Mr. Williamson noted that a quorum was present and called the meeting to order. Mr. Roberts served as secretary for the meeting.

Mr. Kaplan summarized the materials Grant Thornton LLP provided to the members in advance of the meeting and proceeded to present same. Mr. Kaplan reported on, among other things, Grant Thornton's review activities related to the Company's financial statements and Form 10-Q for the quarter ended June 30, 2011, including a review of the draft 10-Q and all Board and Board committee meeting minutes. Mr. Kaplan also provided background information and the results of Grant Thornton's quarterly review of the financial statements, noted that no adjustments to the disclosure or financial statements were identified, and provided all required communications to the Committee. Mr. Kaplan reported that there were no disagreements with management nor any material weaknesses or significant deficiencies noted in the Company's internal controls or financial systems. Mr. Kaplan then proceeded to provide the members with a review of upcoming accounting, SEC, audit and other changes that may impact the Company.

Mr. Williamson then provided comments to the Company's Form 10-Q and asked the other members to do the same. At approximately 8:55 a.m., the Chairman asked members of management to depart the meeting so that the Committee could conduct its executive session with Grant Thornton, upon the conclusion of which the meeting was adjourned.

Respectfully submitted,

_____
Bryce Roberts

NOMINATION/GOVERNANCE COMMITTEE TAB

COMPENSATION

COMMITTEE TAB

CONFIDENTIAL DRAFT
FOR DISCUSSION PURPOSES ONLY

Minutes of the Regular Meeting of the Compensation Committee of the Board of Directors of Pharmasset, Inc. (via teleconference) September 27, 2011

Directors in attendance:
Herbert Conrad, Chairman of the Board
Elliot F. Hahn
Michael K. Inouye
Robert F. Williamson III, Committee Chairman

Others in attendance:
From Radford:
Ed Speidel
Ram Kumar

The Compensation Committee (the "Committee") of the Board of Directors (the "Board") of Pharmasset, Inc. (the "Company") held a regular meeting, pursuant to notice, on July 20, 2011 via teleconference commencing at 11:00 a.m. PDT. Role was taken and, a quorum being present, Mr. Williamson called the meeting and acted as secretary for the meeting.

Mr. Williamson reviewed the agenda for the meeting and the materials provided to the Committee members by Radford in advance of the meeting (specifically, the reconstituted peer group and associated cash and equity compensation metrics for both executive management and the Board based on this peer group).

The Radford representatives presented their materials and led discussions regarding the reconstitution of the Company's compensation peer group and considerations for revising the Company's compensation philosophy in light of its peer group. The members engaged in extensive discussions and data review and posed questions that the Radford representatives responded to.

Upon conclusion of discussions, the members and Mr. Conrad unanimously approved a compensation philosophy to target the 50th percentile of the Company's reconstituted peer group for cash compensation and the 75th percentile for equity compensation of the executive management team, comprised of the President's and the President's direct reports, and the members of the Board. Mr. Williamson was tasked with communicating the philosophy to the President.

There being no further business, upon motion duly made, seconded and unanimously approved, Mr. Williamson adjourned the meeting at approximately 12:30 p.m. PST.

Respectfully submitted,

_____
Robert F. Williamson, III

CLINICAL DEVELOPMENT

UPDATE TAB

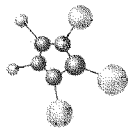
PowerPoint Presentation to be

Given by

Michelle Berrey at Board Meeting

BUDGET

PRESENTATION TAB



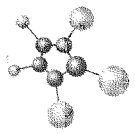
MEMORANDUM

TO: Board of Directors

FROM: Kurt Leutzinger, Jim Maguire and Mark Meester

DATE: October 4, 2011

RE: **Review of Fiscal 2012 Budget**



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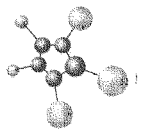


Executive Summary

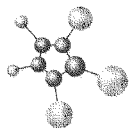
Our latest estimate of operating expenses for fiscal 2011 is $83.8 million, or $24.6 million lower than the March 2011 updated budget level of $108.4 million. The lower operating expenses were primarily within our two development programs (PSI-7977 and PSI-938) and were mainly due to timing, as we shifted $12.1 million of API purchases and $3.1 million in study costs for both programs from late fiscal 2011 to early fiscal 2012. We also incurred net savings/timing in our clin pharm studies for both programs totaling $5.3 million and incurred lower SOC costs and other savings/timing of $3.2 million in both programs. We have incorporated all of the timing-related variances into our fiscal 2012 budget. Our cash balance at September 30, 2011 is expected to be $166.6 million, or $16.4 million higher than forecasted in the March 2011 budget update. Redacted

Redacted

Our budgeted operating expenses for fiscal 2012 are $177.2 million, $93.4 million higher than the projected operating expenses for fiscal 2011. These expenses are needed to achieve our fiscal 2012 corporate objectives, which for budgeting purposes, can be summarized as follows (See Exhibit C for a complete listing of our Fiscal 2012 Proposed Corporate Objectives):

- Continue to provide funding for the development of our two development programs, PSI-7977 and PSI-938, as they advance into a series of Phase 3 studies and a Phase 2b study, respectively, during fiscal 2012,
- Add resources to our "base business" to ensure we execute on the rapid development of our two product candidates, PSI-7977 and PSI-938, and
- Begin to put in place a Sales and Marketing organization that will prepare us for the launch of our first product, PSI-7977, during May 2014.

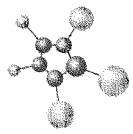
We grouped our operating expenses into two categories: base business expenses (which consist of Research, Clinical Development, G&A, and Sales and Marketing expenses that are not directly attributable to our development programs) and development program expenses (that can be specifically attributed to each of our development programs).



	Fiscal '12					Total	Diff.
	F1Q	F2Q	F3Q	F4Q	Total	Fiscal '11	Ov (Und)
Base Business							
Research	$ 3,429	$ 3,900	$ 4,022	$ 3,681	$ 15,032	$ 12,221	$ 2,811
Clinical Development	3,004	3,322	3,696	4,056	14,078	6,146	7,932
G&A	3,792	4,490	4,183	3,750	16,215	11,292	4,923
Sales & Marketing	1,077	1,952	1,741	2,084	6,854	1,841	5,013
Base Business - Total	11,302	13,664	13,642	13,571	52,179	31,500	20,679
Development Programs							
PSI-7977	18,550	19,210	25,669	27,067	90,496	37,644	52,852
PSI-938	8,310	8,672	8,323	9,236	34,541	13,397	21,144
PSI-661	-	-	-	-	-	1,289	(1,289)
Total - Dev Programs	26,860	27,882	33,992	36,303	125,037	52,330	72,707
Total - Operating expenses	$ 38,162	$ 41,546	$ 47,634	$ 49,874	$ 177,216	$ 83,830	$ 93,386

Our base business operating expenses are expected to increase to $52.2 million during fiscal 2012, an increase of $20.7 million from $31.5 million in fiscal 2011. About $11.5 million of the $20.7 million increase is from planned hirings, as we plan to add (1) 30 employees within Clinical Development to support our two development programs as they progress further into Phase 2b/Phase 3 studies, (2) 19 employees within G&A to support our growing operations, and (3) 17 employees to our Sales & Marketing team to begin to prepare for the launch of our first product in May 2014 (See Exhibits D (Justifications), E (Headcount Rollforward) and F (Proposed Organization Charts) for additional information on planned hirings for fiscal 2012). Other increases in spending in our base business include $2.4 million for product marketing initiatives, $1.8 million in consulting as we expand our operations, $1.3 million for research of non-HCV viral targets (dengue and influenza), and $1.2 million for travel and entertainment as our clinical studies go international and our newly staffed sales and marketing teams begin their messaging initiatives to HCV KOLs throughout the world.

Our budgeted development program expenses are $125.0 million for fiscal 2012, up $72.7 million from $52.3 million in fiscal 2011. The main drivers of this substantial increase in our development expenses is the advancement of PSI-7977 into four Phase 2b studies (including the Phase 2b QUANTUM study), as well as 3 Phase 3 studies, and the advancement of PSI-938 into the QUANTUM study (See Exhibits A and B for complete Development Plans for PSI-7977 and PSI-938, respectively). Included in the following table is a comparison of the clinical trial activities for each of our development programs in fiscal 2011 and 2012:



	Fiscal 2011	Fiscal 2012
PSI-7977	Is in 4 Phase 2b studies (PROTON, ELECTRON, ATOMIC, and the BMS study*), along with a handful of clin pharm studies. Also in QUANTUM study with PSI-938.	Complete Phase 2b PROTON study, continue in Phase 2b ELECTRON, ATOMIC, the BMS study, the clin pharm studies, and QUANTUM. Initiate Phase 2b study with Tibotec**, and initiate and conduct Phase 3 studies (3 separate studies)
PSI-938	Completed NUCLEAR, a Phase 1, 14-day study in combination with PSI-7977. Initiated Cohort 1 of Phase 2b study, QUANTUM along with a handful of clin pharm studies.	Conduct Cohort 1 portion of the Phase 2b QUANTUM study, and initiate and conduct Cohorts 2 (and possibly 3) of QUANTUM study
	Redacted	3

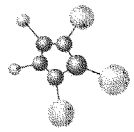
*- Collaboration study with BMS. This study is being conducted and paid for by BMS.
** - Collaboration study with Tibotec. This study is being conducted and paid for by Tibotec.
*** - Licensed to Roche. These studies are being conducted and paid for by Roche

Included in the following table are cash flow projections that assume the above fiscal 2012 operating budget of $177.2 million, along with capital equipment needs and debt repayments totaling $1.8 million and $2.6 million, respectively.

($ in millions)

	Fiscal 2012				
	Q1'12	Q2'12	Q3'12	Q4'12	Total
Cash and Investments - Beginning of quarter	$ 166.6	$ 128.4	$ 88.0	$ 40.4	$ 166.6
Changes in Cash & Investments:					
Equity Financing	-	-	-	-	-
Milestone payments to be rec'd from Roche	-	-	-	15.0	15.0
Operating expenses	(38.2)	(41.5)	(47.6)	(49.9)	(177.2)
Depreciation	0.1	0.1	0.1	0.1	0.4
Changes in W/C	2.5	1.6	0.7	1.8	6.6
Interest expense, net	(0.1)	-	-	-	(0.1)
Capital expenditures	(1.0)	(0.2)	(0.4)	(0.2)	(1.8)
Debt repayments	(1.5)	(0.4)	(0.4)	(0.4)	(2.6)
Subtotal	(38.1)	(40.4)	(47.6)	(33.6)	(159.7)
Cash and Investments - End of quarter	$ 128.4	$ 88.0	$ 40.4	$ 6.9	$ 6.9

The fiscal 2012 operating budget (without considering any financing(s)) results in a projected cash balance of $6.9 million as of September 30, 2012. Therefore, we expect to raise as much as $400.0 million during fiscal 2012 by completing one or two equity financings. The timing and size of any equity financings we complete during 2012 will be heavily dependent upon our cash on hand, our stock price and general market conditions. To prevent our cash balance from falling below $100.0 million during the quarter ended March 2012, we plan to launch an equity

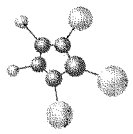


financing during late January 2012, hoping that current volatile market conditions have improved by then. Investors will thus have whatever data update we can give at the JPMorgan Healthcare Conference starting January 9, and have the incentive of buying prior to the data we expect to report at EASL April 18-22. We plan to raise at least $200.0 million and would raise as much as $400.0 million, if market conditions permitted. If we fall short of raising $400.0 million during January, we plan to raise the remainder during the quarter ended September 2012. Following is a table that presents our quarterly cash flow projections for fiscal 2012, assuming the completion of two $200.0 million equity offerings as described above.

($ in millions)

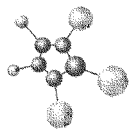
	Fiscal 2012				
	Q1'12	Q2'12	Q3'12	Q4'12	Total
Cash and Investments - Beginning of quarter	$ 166.6	$ 126.4	$ 286.0	$ 240.4	$ 166.6
Changes in Cash & Investments:					
Equity Financing	-	200.0	-	200.0	400.0
		Redacted			
Operating expenses	(38.2)	(41.5)	(47.6)	(49.9)	(177.2)
Depreciation	0.1	0.1	0.1	0.1	0.4
Changes in W/C	2.5	1.6	0.7	1.8	6.6
Interest expense, net	(0.1)	-	-	-	(0.1)
Capital expenditures	(1.0)	(0.2)	(0.4)	(0.2)	(1.8)
Debt repayments	(1.5)	(0.4)	(0.4)	(0.4)	(2.6)
Subtotal	(38.1)	159.6	(47.6)	166.4	240.3
Cash and Investments - End of quarter	$ 126.4	$ 286.0	$ 240.4	$ 406.9	$ 406.9

Assuming we are able to raise $400.0 million during fiscal 2012, we would end fiscal 2012 with over $400.0 million of cash on hand, which would fund our operations through the end of fiscal 2013.



Process Overview

Our fiscal 2012 budgeting process began in late August 2011 with project team leaders finalizing product development plans and department managers determining their resource needs to achieve these development plans (See Exhibits A and B for detailed development plans for PSI-7977 and PSI-938). Over the next four weeks, finance team members met with the project teams and department managers to develop 12-month rolling budgets for each development program and each department that included operating expenses, human and capital resources needed to achieve the 2012 corporate objectives (See Exhibit C for a complete listing of our proposed Fiscal 2012 Corporate Objectives). These budgets were aggregated and analyzed, and then reviewed with senior management. After a series of meetings between senior management and finance, the updated budget for the first half of 2012 and the budget for the second half of 2012 was prepared. The remainder of this memorandum provides an in-depth review of our proposed budget for fiscal 2012.



Review of Fiscal 2012 Budget

Brief Review of Fiscal 2011. Included in the following table are operating expense and cash flow reviews for fiscal 2011.

(in millions)

Operating Expense Review

	Fiscal '11 Actuals (1)	Fiscal '11 Budget (2)	Diff Ov. (Und.)
R&D Depts.	$ 18.4	$ 18.4	$ (0.1)
R&D Programs:			
PSI-7977	37.6	50.7	(13.1)
PSI-938	13.4	24.1	(10.7)
PSI-661	1.3	1.2	0.1
	52.3	76.0	(23.7)
G&A Depts.	13.1	14.0	(0.9)
	$ 83.8	$ 108.4	$ (24.6)

Cash Flow Review

	Fiscal '11 Actuals (1)	Fiscal '11 Budget (2)	Diff Ov. (Und.)
Balance, Beginning of period	$ 127.1	$ 127.1	$ -
Equity financing and milestone	123.4	138.4	(15.0)
Operating expenses	(83.8)	(108.4)	24.6
Proceeds from option exercises	10.5	-	10.5
Working capital changes	0.4	4.9	(4.5)
Interest expense	(0.9)	(0.9)	-
Capital expenditures	(0.9)	(1.8)	0.9
Debt repayments	(9.2)	(9.2)	-
	39.5	23.0	16.5
Balance, End of period	$ 166.6	$ 150.1	$ 16.5

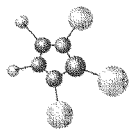
(1) - Includes latest estimates for Sept. 2011 (2) - Budget as updated in March 2011

In summary, our latest estimate of operating expenses for fiscal 2011 is $83.8 million, or $24.6 million lower than the updated budget level of $108.4 million. The lower operating expenses within our two development programs are explained in the following table:

(in millions)	PSI-7977	PSI-938	Total
Timing of API purchases (pushed out to fiscal 2012)	$ 7.6	$ 4.5	$ 12.1
Timing in Phase 2b studies	1.1	2.0	3.1
Lower SOC costs and other savings in Phase 2b studies	1.2	0.8	2.0
Net savings / timing in clin pharm studies	2.8	2.5	5.3
Other, net savings / timing	0.4	0.8	1.2
	$ 13.1	$ 10.6	$ 23.7

Our cash balance at September 30, 2011 is expected to be $166.6 million, or $16.4 million higher than forecast in the March 2011 budget update due mainly to the lower operating expenses of $24.6 million and $10.5 million of proceeds received from stock option exercises that were partially offset Redacted

Redacted



Overview of Fiscal 2012 Income Statement. The following table compares our fiscal 2012 budget to our fiscal 2011 actual results.

(in 000's)	QTRLY BUDGET - FISCAL 2012				TOTAL	TOTAL	Diff
	FQ1	FQ2	FQ3	FQ4	F2012	F2011 (1)	Ov (Und)
Net Revenue	$ 158	$ 158	$ 158	$ 15,158	$ 15,632	$ 898	$ 14,734
Operating Expenses:							
Research & Development	33,293	35,104	41,710	44,040	154,147	70,697	83,450
General & Administrative	4,869	6,442	5,924	5,834	23,069	13,133	9,936
Total Operating Expenses	38,162	41,546	47,634	49,874	177,216	83,830	93,386
Operating Income	(38,004)	(41,388)	(47,476)	(34,716)	(161,584)	(82,932)	(78,652)
Other (Income) Expense							
Interest (Income) Exp.	65	31	20	8	124	893	(769)
Income before income taxes	(38,069)	(41,419)	(47,496)	(34,724)	(161,708)	(83,825)	(77,883)
Prov. for income taxes	-	-	-	-	-	-	-
Net income (loss)	$ (38,069)	$ (41,419)	$ (47,496)	$ (34,724)	$ (161,708)	$ (83,825)	$ (77,883)

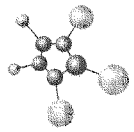
NOTE - The above operating expenses do not include non-cash stock compensation and non-cash interest expense.

(1) - Includes latest estimates for September 2011.

Redacted

Operating Expenses. Our budgeted operating expenses total $177.2 million for fiscal 2012, $93.4 million higher than the projected operating expenses of $83.8 million for fiscal 2011. The following table summarizes our operating expenses by quarter for fiscal 2012 and separates our expenses into two categories:

1. Our "base business", which mainly consists of (1) Research and Clinical Development expenses that cannot be attributed to our development programs, such as salaries, legal expenses for patents, new drug discovery expenses, lab supplies, facility and travel expenses, (2) G&A expenses, which mainly consist of salaries, legal, insurance, and travel expenses, and (3) Sales & Marketing expenses, which mainly consist of salaries, advisory board fees, seminars and symposia fees, market research fees, and travel expenses.



2. Our development program expenses, which mainly consist of clinical trial expenses, API and related expenses, standard of care drug purchases, and toxicology and clinical pharmacology study expenses, by development program.

Base Business/Program	Fiscal '12 F1Q	F2Q	F3Q	F4Q	Total	Total Fiscal '11	Diff. Ov (Und)
Base Business							
Research	$ 3,429	$ 3,900	$ 4,022	$ 3,681	$ 15,032	$ 12,221	$ 2,811
Clinical Development	3,004	3,322	3,696	4,056	14,078	6,146	7,932
G&A	3,792	4,490	4,183	3,750	16,215	11,292	4,923
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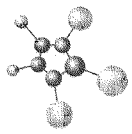
PSI-938	8,310	8,672	8,323	9,236	34,541	13,397	21,144
PSI-661	-	-	-	-	-	1,289	(1,289)
Total - Dev Programs	26,860	27,882	33,992	36,303	125,037	52,330	72,707
Total - Operating expenses	$ 38,162	$ 41,546	$ 47,634	$ 49,874	$ 177,216	$ 83,830	$ 93,386

Base Business. Our budgeted operating expenses for our base business are expected to increase $20.7 million, from $31.5 million in fiscal 2011 to $52.2 million in fiscal 2012. Following is a table that provides a line-by-line comparison between our base business expenses for fiscal 2012 and fiscal 2011:

(in 000's)	Fiscal 2012 FQ1	FQ2	FQ3	FQ4	Full Year	Fiscal 2011	Diff. Ov (Und)	Ref.
Licensing Fees and Milestones	$ 111	111	111	111	444	340	104	
Non-HCV Viral Target Research	235	462	460	221	1,378	110	1,268	(1)
Lab Supplies	308	308	308	308	1,231	1,133	98	
Other R&D Expenses	741	714	708	708	2,870	2,241	629	(2)
Pre-Marketing	866	1,374	731	620	3,590	1,192	2,398	(3)
General & Administrative Expenses	797	1,071	427	391	2,686	1,784	902	(4)
Recruiting	334	264	214	18	829	141	688	(5)
Travel & Entertainment Expense	464	413	454	682	2,014	793	1,221	(6)
Consulting	785	843	348	187	2,163	390	1,774	(7)
Legal Expenses	600	775	900	800	3,076	4,432	(1,356)	(8)
Rent	232	298	557	532	1,619	917	702	(9)
Insurance	312	267	332	332	1,243	891	352	
Facility Expenses	251	244	312	329	1,137	832	305	
Depreciation Expense	163	172	181	185	701	599	102	
Salaries and Benefits	5,028	6,259	7,509	8,057	26,853	15,382	11,470	(10)
Board Compensation	77	89	89	89	345	322	23	
Total Departmental Expenses	$ 11,303	$ 13,665	$ 13,640	$ 13,570	$ 52,179	$ 31,500	$ 20,679	



(1) The $1.4 million budgeted for Non-HCV Viral Target Research is for initiating our "hit to lead" efforts in our Dengue and Influenza research programs and beginning SAR studies with the goal of synthesizing greater than 50 compounds in each program. Funds are also budgeted for completing safety testing and for purchasing drug supply for the Dengue research program.

(2) The Other R&D Expenses of $2.9 million are primarily in support of our HCV/nucleoside research and our non-HCV viral target research (dengue and influenza). Consistent with past years, approximately two-thirds of the $2.9 million is for contract R&D services and beginning with fiscal 2012, the research work will be split somewhat evenly between HCV/nucleosides and our non-HCV viral target research programs (dengue and influenza). The remaining one-third is in support of specific nucleoside/tide research efforts, including molecular crystal structure work to help us continue to better understand what differentiates our proprietary nucleosides from naturally occurring nucleosides that will benefit our current HCV programs, as well as our dengue and influenza research programs. In the future, we plan to budget the non-HCV research portion of these expenses in the Non-HCV Viral Target Research" expense line.

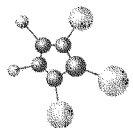
(3) The $2.4 million increase in pre-marketing expenses is primarily for the following items:
   a. $0.8 million in advisory board fees
   b. $1.0 million for seminars and symposia fees
   c. $0.5 million on market research fees, including brandname testing, messaging, and HCV market research
   d. $0.1 million for sponsorships and other product marketing expenses

(4) The $0.9 million increase in G&A expenses consists of $700K for employee relations and approximately $200K of miscellaneous G&A expenses, including computer and office supplies, and filing fees.

(5) The $0.7 million increase in recruiting fees is primarily for the senior level positions included in the hiring plan for fiscal 2012 (See Exhibits D (Justifications), E (Headcount Rollforward) and F (Proposed Organization Charts) for additional information on planned hirings for fiscal 2012).

(6) The $1.2 million increase in T&E expenses is primarily driven by the increase in travel associated with (1) the initiation and conduct of three international studies during fiscal 2012, as well as the overall expansion of our business operations, and (2) the addition of 17 sales and marketing personnel and 5 medical liasons during fiscal 2012.

(7) The $1.8 million increase in Consulting primarily consists of $533K for a manufacturing quality consultant, $500K for corporate tax structuring fees, $400K for medical consultants, $110K for manuscript development, $100K for an IS consultant, $100K for a "cost-of-illness" study to be completed by Genesis Research to be used to help us decide if we should complete a head-to-head Health Economics study with the current SOC, including telaprevir or boceprevir, and $50K for a compensation consultant.



(8) The $4.4 million of legal fees incurred in fiscal 2011 includes $1.5 million for our defense against the Emory Demand for Arbitration. No such legal fees were included in the fiscal 2012 budget.

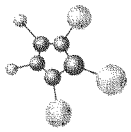
(9) The $0.7 million increase in rent consists of rent for (1) additional office space in Princeton beginning on April 1, 2012 ($72K/month), and (2) $250K for office space and related startup expenses in Europe, which if approved, the location of which would be decided upon in connection with our corporate tax structuring project beginning on February 1, 2012 ($25K/month).

(10) The $11.5 million increase in Salaries and Benefits is driven by the planned hiring of 67 heads during fiscal 2012, going from 82 heads as of 9-30-11 to 149 heads as of 9-30-12. In summary, the justifications for the 67 hires are as follows:

   a. 30 hires within Clinical Development to oversee our ongoing Phase 2b studies for PSI-7977 and PSI-938 and our upcoming Phase 3 studies of PSI-7977, to ramp up our Quality operations, to add support to our Regulatory, Project Management and Manufacturing areas, and to bring on board five medical liasons to help expand our relationships with leading KOLs in hepatology.
   b. 19 hires within G&A to support our growing operations and are spread across Finance, Legal, IT, HR, Facilities, and IR.
   c. 17 hires within Sales & Marketing to begin preparations for the launch of our first product, PSI-7977 in May 2014. These 17 hires consist of Sales Managers, Account Managers, Sales Trainers, Sales Directors, Marketing Managers, and a Head of EU Commercial Operations.
   d. 1 hire within our Virology department to provide additional genotyping/phenotyping support for our two development programs.

(See Exhibits D (Justifications), E (Headcount Rollforward) and F (Proposed Organization Charts) for additional information on planned hirings for fiscal 2012).

Development Programs: Included in the following table is a summary of the clinical trial activities for each of our development programs in fiscal 2011 and the clinical trial activities that are planned for each of these programs during fiscal 2012:

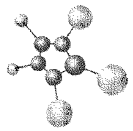


	Fiscal 2011	Fiscal 2012
PSI-7977	Is in 4 Phase 2b studies (PROTON, ELECTRON, ATOMIC, and the BMS study*), along with a handful of clin pharm studies. Also in QUANTUM study with PSI-938.	Complete Phase 2b PROTON study, continue in Phase 2b ELECTRON, ATOMIC, the BMS study, the clin pharm studies, and QUANTUM. Initiate Phase 2b study with Tibotec**, and initiate and conduct Phase 3 studies (3 separate studies)
PSI-938	Completed NUCLEAR, a Phase 1, 14-day study in combination with PSI-7977. Initiated Cohort 1 of Phase 2b study, QUANTUM along with a handful of clin pharm studies.	Conduct Cohort 1 portion of the Phase 2b QUANTUM study, and initiate and conduct Cohorts 2 (and possibly 3) of QUANTUM study
Redacted		

* - Collaboration study with BMS. This study is being conducted and paid for by BMS.
** - Collaboration study with Tibotec. This study is being conducted and paid for by Tibotec.
Redacted

In summary, during fiscal 2012 we are planning for PSI-7977 to be in multiple Phase 2b studies and to initiate and conduct 3 Phase 3 studies, and for PSI-938 to be in the Phase 2b QUANTUM study (all three cohorts). (See Exhibit A and B for Development Plans for PSI-7977 and PSI-938, respectively).

Following is a table that provides a quarterly "by phase or major study" breakdown of the clinical development expenses for the PSI-7977 and PSI-938 programs for fiscal 2012:

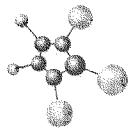


Development Programs	FQ1 '12 Budget	FQ2 '12 Budget	FQ3 '12 Budget	FQ4 '12 Budget	F '12 Budget	F '11 Actuals	Diff Ov (Und)	Total Study Costs
PSI-7977								
DMPK, Tox & Other	$ 963	$ 943	$ 766	$ 587	$ 3,259	$ 3,117	$ 142	
Phase 1 & Clin Pharm	2,339	1,101	1,288	900	5,628	4,765	863	
Phase 2b - early studies	1,185	754	534	330	2,803	9,215	(6,412)	
Phase 2b - ATOMIC	2,615	1,670	1,156	693	6,134	9,465	(3,331)	
Phase 3 - Study 1	3,769	7,102	7,492	8,094	26,457	743	25,714	$ 54,077
Phase 3 - Study 2	426	3,124	5,624	6,588	15,764	-	15,764	$ 36,286
Phase 3 - Study 3		428	3,672	7,146	11,246	-	11,246	$ 35,278
Phase 3b - Rollover				500	500	-	500	
Phase 3b - Health Economics				500	500	-	500	
API	7,251	4,088	5,137	1,729	18,205	10,339	7,866	
	18,550	19,210	25,669	27,067	90,496	37,644	52,852	
PSI-938								
DMPK, Tox & Other	792	303	418	616	2,129	2,145	(16)	
Phase 1 & Clin Pharm	2,540	2,223	3,669	2,911	11,343	5,035	6,308	
Phase 2b - QUANTUM	3,421	4,541	4,205	5,678	17,845	2,251	15,594	$ 49,480
API	1,557	1,605	31	31	3,224	3,866	(742)	
	8,310	8,672	8,323	9,236	34,541	13,397	21,144	
PSI-661	-	-	-	-	-	1,269	(1,269)	
Total	$ 26,860	$ 27,882	$ 33,992	$ 36,303	$ 125,037	$ 52,330	$ 72,707	

In summary, our budgeted development program expenses are $125.0 million for fiscal 2012, up $72.7 million from $52.3 million in fiscal 2011. In addition to the Phase 2b and Phase 3 studies already noted, we have also budgeted for two additional Phase 3b studies, "Rollover" and "Health Outcome" studies during fiscal 2012. These two studies are not expected to begin until the 4th fiscal quarter of 2012. The Rollover study is for patients who do not respond to the SOC control arm (or PSI-7977 experimental arms) in our Phase 3 – Study 1 for PSI-7977. With regard to the Health Economics study, we will wait to see the results of the Genesis Research project (a "cost-of-illness" study to be completed prior to March 2012) before we know exactly how we want to design this potential study.

Future Capital Equipment Needs

We evaluated our capital equipment needs throughout the Company. Following is a summary of the capital expenditures we need to make during fiscal 2012.



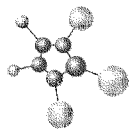
(in 000's)	Fiscal 2012				
	FQ1	FQ2	FQ3	FQ4	Total
Previously Approved Capital					
Analytical Chemistry Needs					
HPLC	76				76
	76	-	-	-	76
Other					
IT	300	-	-	-	300
Provision	100	100	-	-	200
	400	100	-	-	500
	$ 476	$ 100	$ -	$ -	$ 576
Additional Capital Requested					
1) Small Molecule Discovery					
ISCO Automated Flash Chrom System	25	-	-	-	25
	25	-	-	-	25
2) Other R&D Capital Equipment Needs					
Biology	25	-	-	-	25
Chemistry	330	-	-	-	330
	355	-	-	-	355
3) Other					
IT	116	71	82	148	417
Facilities	-	-	200	-	200
Provision	-	-	100	100	200
	116	71	382	248	817
	$ 496	$ 71	$ 382	$ 248	$ 1,197

Following are justifications for the capital items summarized above.

1) Small Molecule Discovery

ISCO Automated Flash Chromatography System ($25K)

Flash chromatography is a technique used on a daily basis by synthetic chemists to purify organic intermediates and final compounds for biological evaluation. Of the available flash chromatography systems, the older Analogix IntelliFlash 280 system has been in service since 2006 and has experienced extensive down time throughout the past year due to mechanical and electronic failures. This has led to a bottleneck in both medicinal chemistry and process research. The replacement of this unit with a technologically more advanced Teledyne-Isco CombiFlash Rf system would greatly assist the chemistry department and result in significant time savings with respect to organic purifications. The higher operating pressure of the CombiFlash Rf system (200 psi vs 100 psi for the Analogix system) provides for improved resolution and reduced run times, allowing for a greater capacity. The quaternary solvent source associated with the



CombiFlash Rf (vs binary for the Analogix system) and the radio frequency identification features also represents a time saving with regard to machine setup. The ability of the CombiFlash Rf to collect data over multiple wavelengths provides for greater versatility with respect to the nature of the compounds being purified and when used in conjunction with the Rf Gold silica cartridges, the CombiFlash Rf can reduce solvent usage by 30%, representing a cost savings with respect to both the consumption of organic solvent and the accumulation of hazardous waste.

2) Other Research and Development Capital Needs

Biology

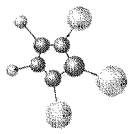
Forma Liquid Nitrogen Cell Storage System ($25K)

The storage capacity of the two liquid nitrogen cell freezers in biology has been exceeded. We are currently storing frozen samples of valuable cell cultures in the -80 freezers. The longevity of cells stored at -80 is short. Biology will continue to obtain and generate many additional cell lines from our research and from cell lines created by the Clinical Virology department. The LN2 CryoPlus 4 Storage System will have sufficient capacity for our current samples and for future increase in cell lines obtained or created.

Chemistry

Liquid Handling Automation ($160K)

Pharmasset has set two clear objectives of identifying lead compounds for the Dengue and Influenza A viruses. In order to accomplish this, a significant portion of our sample library will need to be tested against these new targets. Because the particulars for each screening assay are different, it isn't possible to create one set of plates to screen against all targets. Additionally, in order to conserve samples, compounds are being rationally selected for screening which is particular to the viral target. Thus, thousands of compounds from ordered lists will result in the generation of many screening plates, which in our current environment are very labor intensive to create since this process is done manually. The introduction of an automated liquid handler would simplify plate preparation, reducing both the time required to obtain the compounds from our liquid library and reducing the possibility of errors on the plates themselves. This will allow us to more efficiently perform our primary screening against new targets and quickly identify potential hits for follow-up studies. The research scientist who is responsible for sample archive management spends 70% of their time on archive sample prep, distribution of single samples and plates of samples to screening from medicinal chemistry efforts, and preparation of large sample set screening plates for hit identification screens. Automation of these tasks would free up the scientist to assume many more responsibilities, including the support of cheminformatics infrastructure (ChemCart), analysis of QC samples coming in from Wuxi, and registration of all information associated with Wuxi and other CRO samples. This automation would enable more



efficient and timely sample preparation for our expanded screening work and it would improve the overall efficiency and cycle time of our screening work.

In our review of potential liquid handler candidates, the Tecan EVO 150 system has emerged as a clear front-runner. It utilizes stainless steel septa-piercing tips, which allows the instrument to take solutions directly out of the microtubes in which our liquid library currently resides. In addition to the automation of plate preparation, this system is able to cherry pick targets from our library for follow-up studies and has the capability to be used in the preparation of our weekly screening plates.

ReactIR 15 ($80K)

ReactIR is a small, portable infrared spectrometer with a probe that can be inserted directly into a reaction vessel. By following certain absorption bands, the concentration of starting material, reagents and products can be followed in real time and through the included software, and the data can be plotted to create reports. This is quicker and more efficient than removing samples periodically, quenching and running numerous HPLC chromatograms. This would be a good addition to the Syrris automated reactor and will help us support the upcoming Process Development Report required for regulatory agencies.

Prep HPLC ($90K)

Chemistry has a semi-prep HPLC (from Varian) to support chiral analysis and chiral separation. This HPLC is greater than 10 years old and is currently very unstable. In addition, the service support has become very unreliable and is expected to be terminated in the near future. Therefore this purchase is required.

3) All Other Capital Equipment

IT

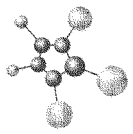
Laptops ($100K)

To support the increasing headcount new laptops will be required. Additionally, a number of older laptops currently assigned to employees will be upgraded.

Computational Chemistry Cluster Upgrade ($100K)

This upgrade will replace the blade servers in our cluster with more powerful ones capable of handling larger modeling jobs in less time. The server blades will be four years old in February 2012, and are already off of warranty.

Cisco 10G Line Card Upgrades ($51K)



With our increasing reliance on virtual server and desktop environments it has become more critical for those servers to have the fastest access possible to the back-end storage on our SAN. The 10G line card upgrades will add two 12-port 10 gigabit Ethernet line cards to our Cisco 4510 switch and add 10G cards to our VMware servers.

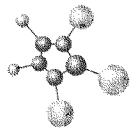
VMWare Site Recovery Manager ($50K)

Along with the NetApp SnapMirror product, the Site Recovery Manager license will allow Pharmasset the ability to easily failover operations of key IT infrastructure services (email, virtual desktops, ChemCart) to an alternate site automatically.

Other IT ($116K)

Other

We estimate approximately $100K per quarter will be needed for regular R&D equipment replacements and IT infrastructure support, including software licenses, laptop updates, and server upgrades. In addition, we estimate approximately $200K will be needed for additional facility furniture and equipment.



Financing Plan

Included in the following table are cash flow projections that assume the above fiscal 2012 operating budget of $177.2 million, along with capital equipment needs and debt repayments totaling $1.8 million and $2.6 million, respectively.

($ in millions)

	Fiscal 2012				
	Q1'12	Q2'12	Q3'12	Q4'12	Total
Cash and Investments - Beginning of quarter	$ 166.6	$ 128.4	$ 88.0	$ 40.4	$ 166.6
Changes in Cash & Investments:					
Equity Financing	-	-	-	-	-
Redacted					
Operating expenses	(38.2)	(41.5)	(47.6)	(49.9)	(177.2)
Depreciation	0.1	0.1	0.1	0.1	0.4
Changes in W/C	2.5	1.6	0.7	1.8	6.6
Interest expense, net	(0.1)	-	-	-	(0.1)
Capital expenditures	(1.0)	(0.2)	(0.4)	(0.2)	(1.8)
Debt repayments	(1.5)	(0.4)	(0.4)	(0.4)	(2.6)
Subtotal	(38.1)	(40.4)	(47.6)	(33.6)	(159.7)
Cash and Investments - End of quarter	$ 128.4	$ 88.0	$ 40.4	$ 6.9	$ 6.9

The fiscal 2012 operating budget (without considering any financing(s)) results in a projected cash balance of $6.9 million as of September 30, 2012. Therefore, we expect to raise as much as $400.0 million during fiscal 2012 by completing one or two equity financings. The timing and size of any equity financings we complete during 2012 will be heavily dependent upon our cash on hand, our stock price and general market conditions. To prevent our cash balance from falling below $100.0 million during the quarter ended March 2012, we plan to launch an equity financing during late January 2012, hoping that current volatile market conditions have improved by then. Investors will thus have whatever data update we can give at the JPMorgan Healthcare Conference starting January 9, and have the incentive of buying prior to the data we expect to report at EASL April 18-22. We plan to raise at least $200.0 million and would raise as much as $400.0 million, if market conditions permitted. If we fall short of raising $400.0 million during January, we plan to raise the remainder during the quarter ended September 2012. Following is a table that presents our quarterly cash flow projections for fiscal 2012, assuming the completion of two $200.0 million equity offerings as described above.

($ in millions)

	Fiscal 2012				
	Q1'12	Q2'12	Q3'12	Q4'12	Total
Cash and Investments - Beginning of quarter	$ 166.6	$ 128.4	$ 288.0	$ 240.4	$ 166.6
Changes in Cash & Investments:					
Equity Financing	-	200.0	-	200.0	400.0
	Redacted				
Operating expenses	(38.2)	(41.5)	(47.6)	(49.9)	(177.2)
Depreciation	0.1	0.1	0.1	0.1	0.4
Changes in W/C	2.5	1.6	0.7	1.8	6.6
Interest expense, net	(0.1)	-	-	-	(0.1)
Capital expenditures	(1.0)	(0.2)	(0.4)	(0.2)	(1.8)
Debt repayments	(1.5)	(0.4)	(0.4)	(0.4)	(2.6)
Subtotal	(38.1)	159.6	(47.6)	165.4	240.3
Cash and Investments - End of quarter	$ 128.4	$ 288.0	$ 240.4	$ 406.9	$ 406.9

Assuming we are able to raise $400.0 million during fiscal 2012, we would end fiscal 2012 with over $400.0 million of cash on hand, which could fund our operations through the end of fiscal 2013.

Exhibit A - PSI-7977 Development Plan

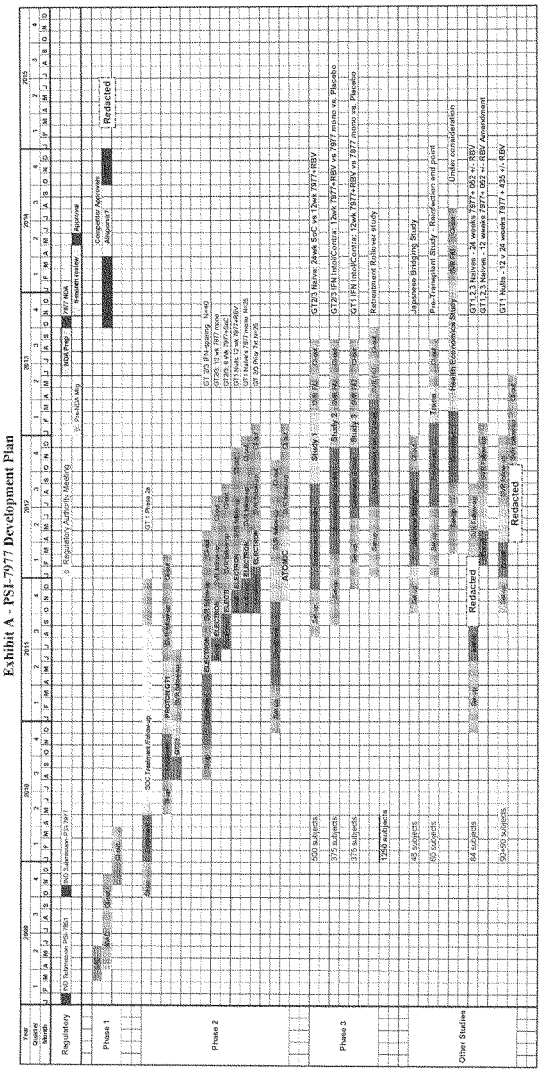


Exhibit B - PSI-938 Development Plan

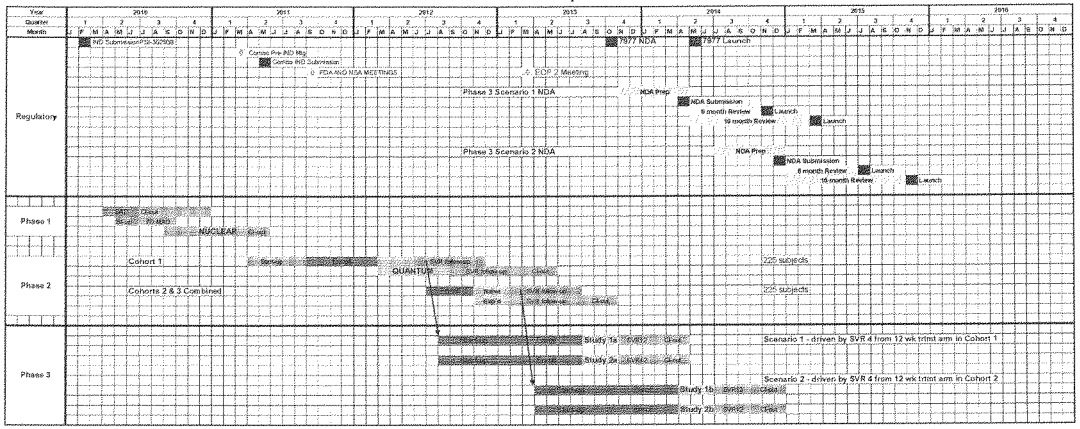


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Exhibit C

Proposed Corporate Objectives (1 of 3)

	Weight	Target Date (FY)
Clinical Development		
PSI-7977: Execute our Phase 3 and Pre-NDA Plans	30%	**All Yr**
• Initiate phase 3 FISSION study in genotype 2/3 naïve patients		1Q 12
• Initiate phase 3 POSITRON study in genotype 2/3 contraindicated/intolerant patients		2Q 12
• Complete enrollment in the remaining cohorts of the ELECTRON study		2Q 12
• Initiate phase 3 NEUTRINO study in genotype 1 contraindicated/intolerant patients		3Q12
• Initiate study in pre-transplant (liver) patients		1Q 12
• Plan and complete an EOP2 CMC meeting with FDA		1Q 12
• Plan and complete EU Central Scientific Advice meeting		1Q 12
• Initiate Clinical Pharmacology studies needed for NDA filing		All Yr
PSI-938: Commit to Phase 3 Plan	15%	**4Q 12**
• Initiate QUANTUM		1Q 12
- Complete enrollment in cohort 1		2Q 12
- Complete cohort 1 interim analysis on safety and efficacy		3Q 12
- Initiate QUANTUM cohort 2		3Q 12
• Initiate Clinical Pharmacology studies required for NDA filing		All Yr
• Agree to Phase 3 protocol synopsis		4Q 12
Research		
HCV	10%	
• Support development projects		
- Support clinical trials by geno/phenotyping patient samples		All Yr
- Support CMC submission efforts for PSI-7977 and PSI-938		4Q 12
• Reach a go/no go decision on crystal structure of ternary complex, NS5B/RNA/compound		3Q 12
• Continue lead optimization for NS4B piperazinone and indole classes and make go/no-go decision based on achieving acceptable GT 2 activity		2Q 12
• Complete in vitro and in vivo assessment of oxetane nucleotide compounds		3Q 12
Other Viruses		
• Initiate hit to lead effort in Dengue and Influenza programs. Validate hits and begin SAR studies, synthesyzing ≥150 compounds in each program.		All Yr
Technology Development	10%	
• Initiate formulation research programs for PSI-7977 monotherapy and a PSI-7977 + PSI-938 fixed dose combination		All Yr
• Hire a global head of manufacturing		2Q 12
• Initiate technology transfer activities at a secondary API manufacturer		2Q12
• Develop a technical and regulatory strategy for switching manufacturing to the chiral synthesis method post launch		1Q12
• Explore packaging requirements for commercial supply		1Q12
• Implement plan addressing Quality gap analysis findings		1Q12

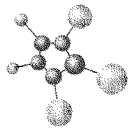


Exhibit C

Proposed Corporate Objectives (2 of 3)

	Weight	Target Date (FY)
Finance	2%	
• Maintain a cash balance that comfortably provides the Company with the cash needed to achieve its corporate objectives		All Year
Investor Relations	2%	
• Increase investor interest in trading our stock		All Year
• Revamp IR efforts to focus on messages for generalists		All Year
• Increase public relations effort		All Year
- Establish public relations strategy and plan		3Q12
Legal	Redacted	
Redacted		
Accounting	1%	
• Maintain opinion of outside auditors that Pharmasset has established and documented effective controls over financial reporting as required by SOX 404 in the 2011 10K		All Year
• Maintain effective financial systems and controls over financial reporting and use of cash		All Year
• If desired by Board, implement global tax planning efforts		All Year
Human Resources	1%	
• Recruit top-notch talent to fit within the unique culture of our organization		All Year
• Align core processes, teams and values with the structure and culture of the organization focused on shared risks and rewards		All Year
Facilities	1%	
• Develop 5 year facility master plan		2Q12
Business Development	5%	
• Support commercial's assessment of launch in EU5 and Japan and NPV analysis on remaining target countries		2Q 12
• Identify opportunities to commercialize Pharmasset products in countries where it will not build commercial infrastructure		All Year
• Assemble a scientific assessment team and create a process for the evaluation of in-bound technologies		All Year
• Manage our strategic alliances		All Year
• Assist legal department in our IP and contract defenses		All Year

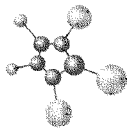


Exhibit C

Proposed Corporate Objectives (3 of 3)

	Weight	Target Date (FY)
Commercial	10%	
• Complete commercial assessment and launch requirements for EU5 and Japan and conduct NPV analysis on remaining target countries		2Q 12
• Conduct market research to prepare product messaging, understand payer dynamics, and monitor market developments		All Year
• Hire first 10 commercial headcount as per organizational launch planning		2Q 12
• Develop pre-launch marketing plan including all aspects of the Commercial rollout (branding, messaging, promotion, packaging, distribution, etc.)		3Q 12
• Develop a US and EU reimbursement plan		3Q12
Medical Affairs	5%	
• Indentify target audiences, develop and initiate educational plan for each		All Yr
• Develop HECON plan and initiate implementation		All Yr
• Develop Continuing Medical Education goals and begin plan execution		All Yr
• Recruit staff according to hiring plan		All Yr
Global Expansion	5%	
• Determine where we will establish our European Headquarters		1Q 12
• Make key hires in Europe		All Yr

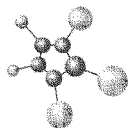


Exhibit D

MEMORANDUM

TO: Board of Directors

FROM: Mark Meester, Lisa Griffin

DATE: October 7, 2011

RE: **Justification for Requested New Positions Fiscal Year 2012**

Recommendation

Approve the requested new positions for Fiscal Year 2012 denoted on the attached proposed organizational chart.

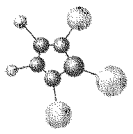
Background

Based on company objectives proposed for FY 2012, 34 new positions are requested, which are highlighted in orange on the attached proposed organizational charts. These positions are needed to successfully manage the progression of our clinical programs as we move into Phase 3 and closer to approval and building a commercial organization. Further detail regarding newly requested positions is outlined below.

An additional 33 prior approved positions for FY 2012 are highlighted in yellow on the attached proposed organizational charts. These positions are comprised of 6 positions within the Clinical Development Officer's departments, as well as 27 sales and marketing related positions that were outlined in the first phase prior to hiring initial field force of the US Commercialization Proposal approved in the July Board meeting.

The estimated hiring timeframe for each position is outlined in the Headcount– Quarterly Rollforward Analysis spreadsheet and is also denoted in each position box on the proposed organizational charts. The costs associated with each position are incorporated into the budget.

Global : European Union
As we move to expansion in the European Union, the need to develop capabilities to support EU regulations and submissions will require a global head within Clinical/Medical Affairs, Regulatory, and Manufacturing, as well as an EU Patent Attorney and an Accounting/Finance professional. Also requested is an EU Commercial Head to lead the expansion, identify the proper structure to operate in various countries and setting strategic direction for growth. These six positions are currently shown in the organizational chart under their respective functional departments.



Research & Development
One new position in clinical virology is being requested due to the increased support necessary to perform the phenotypic analysis in larger Phase 3 studies including Proton, Atomic, Quantum and Electron.

Clinical Development
Two physician positions are requested, one to direct, monitor and interpret Phase 3 studies and contribute to the NDA, and the other to provide a dedicated physician resource in support of translational studies as well as ongoing monitoring of other external studies being conducted.

Clinical Operations, Regulatory, Quality and Manufacturing
Clinical Ops - Two additional positions to support current ongoing studies and proposed global trials in line with the 7977 clinical development plan to ensure highest degree of timeliness and quality are being requested. In addition, one position to manage the accountability of all global clinical trial supplies is also requested.

Regulatory & Quality – Four positions requested in Regulatory Affairs to support ongoing 7977 regulatory functions and maintain adequate regulatory controls. Three additional positions in a new Quality group are requested in order to provide global quality expertise and ensure compliance with all GxP requirements and relevant foreign equivalents.

Manufacturing - As the global production of our manufacturing escalates and we move toward commercial development of drug product, three positions are needed within the manufacturing group to facilitate transfer of drug substance, manage supply chain, and to ensure formulation and manufacturing activities are properly integrated.

Administration
As the organizational headcount expands and moves toward global and commercial operations, a total of 13 additional resources spread throughout the Finance, Legal, Human Resources, Information Technology, Facilities, Purchasing, and Administration departments are requested to ensure alignment of resources and processes strategically focused to help facilitate the growth of the organization.

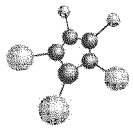


Exhibit E

Headcount Rollforward

	Annual Rollforward - Prior Approved & New Positions			
	Actual- as of end of F4Q '11	Prior Approved Positions*	New Positions Requested	Projected as of end of F4Q '12
HCV Research				
Chemistry	17	-	-	17
Biology	11	-	-	11
Clinical Virology	3	-	1	4
Research Admin	1	-	-	1
Facilities - R&D	-	-	-	-
HCV Development				
Development Admin	1	-	-	1
Clinical Development	10	7	3	20
Clinical Operations	10	1	3	14
Regulatory Affairs	4	1	5	10
Compliance / Quality	-	1	3	4
Project Management	2	2	-	4
Manufacturing	2	1	3	6
Subtotal - R&D	61	13	18	92
G&A				
Sales & Marketing	2	16	1	19
Legal Affairs	3	-	4	7
CEO	2	-	-	2
Bus Dev	1	-	-	1
Finance	7	1	5	13
IR	1	1	-	2
HR	2	1	2	5
IT	2	1	2	5
Facilities - Admin	1	-	2	3
Subtotal - G&A	21	20	16	57
Grand Total	82	33	34	149

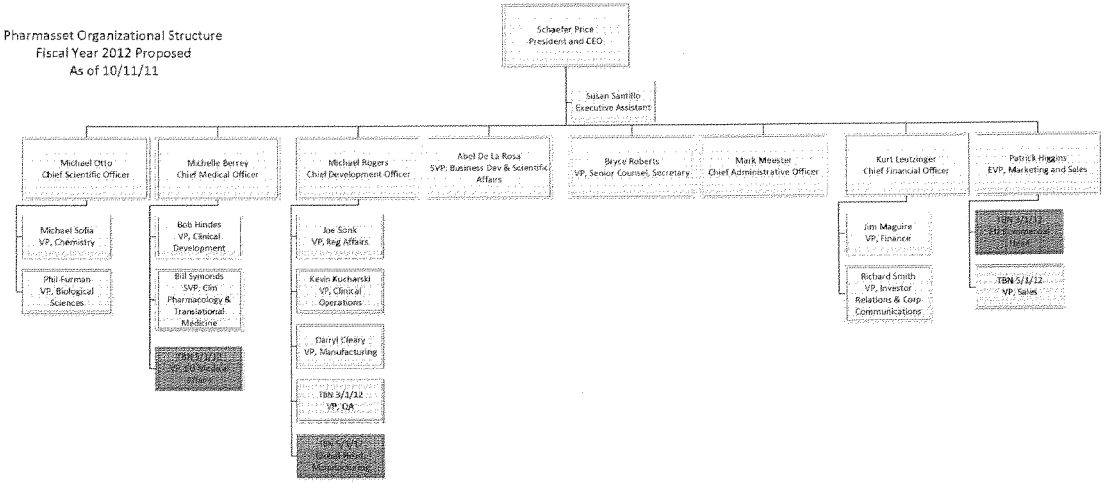
Note: The headcount includes 33 open and previously approved positions, which consists of 27 Sales & Marketing (or related) positons, along with the 6 open and previously approved positions in Regulatory Affairs, Compliance / Quality, Project Management (2), and Manufacturing.

Exhibit F

Proposed Organization Charts

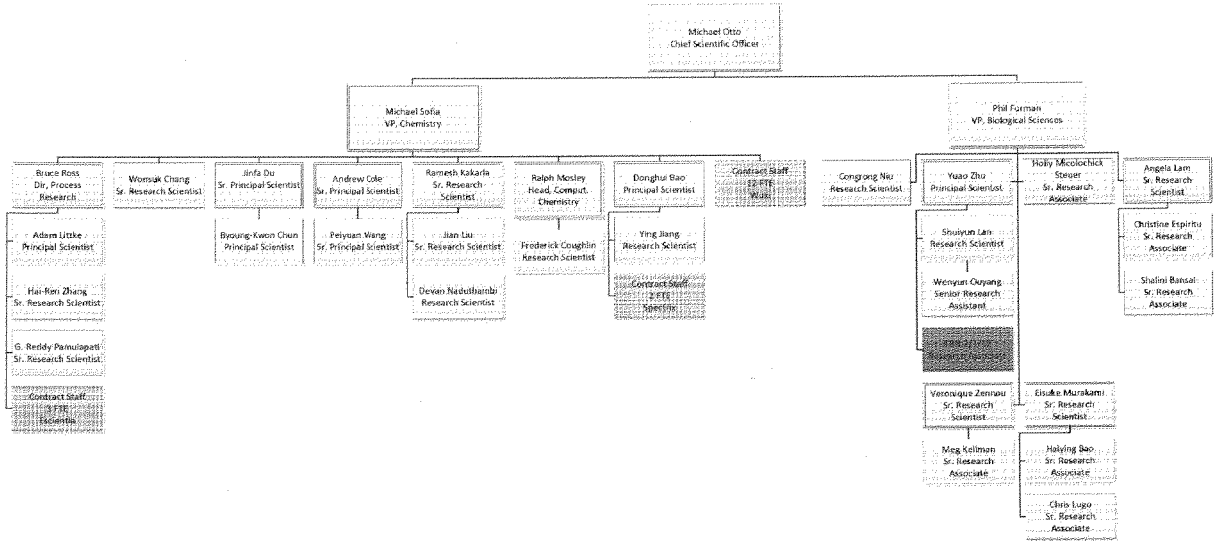
(See Next 6 Pages)

Pharmasset Organizational Structure
Fiscal Year 2012 Proposed
As of 10/11/11

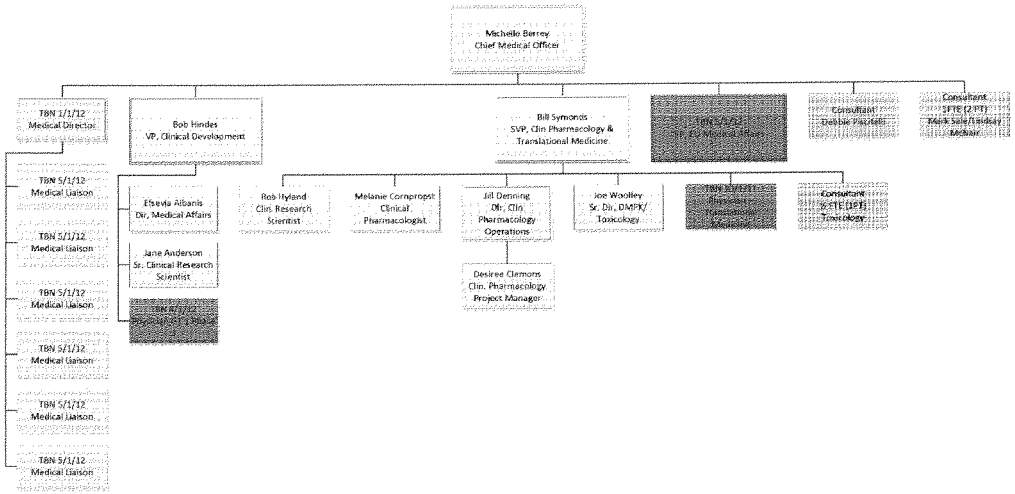


1221

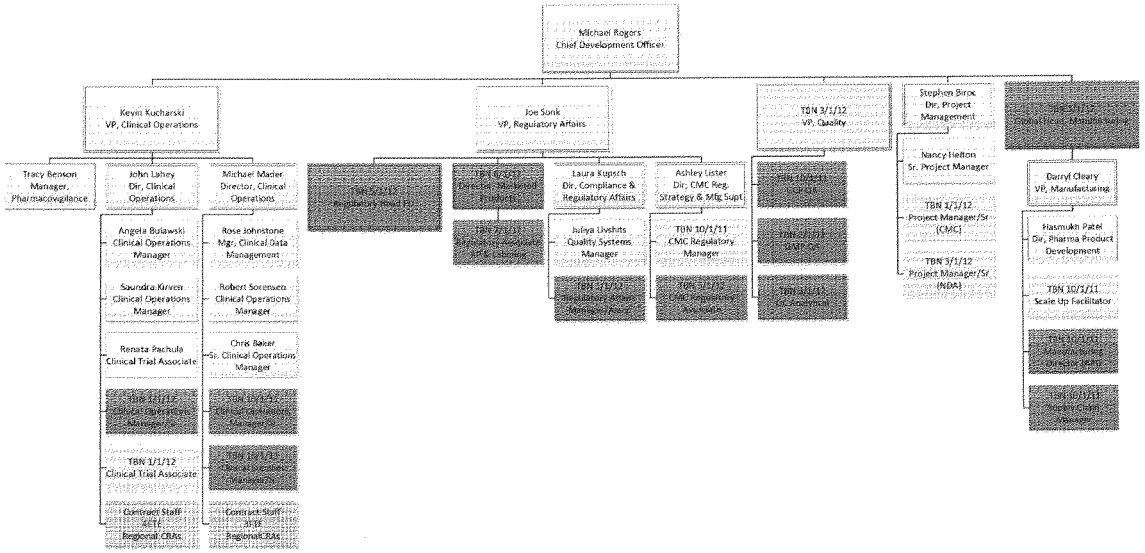
Research & Development



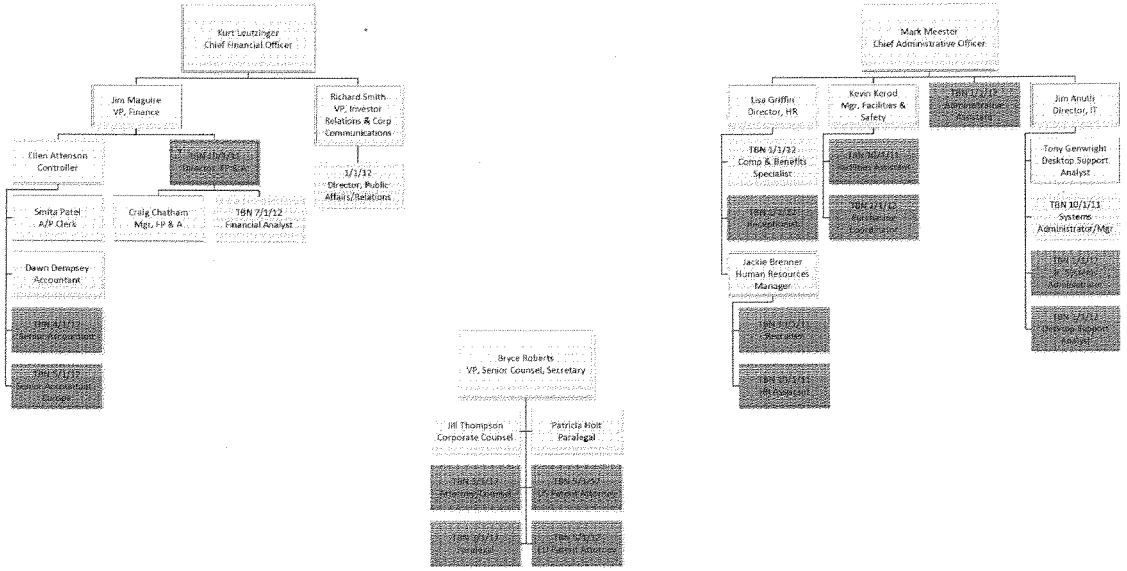
Clinical Development



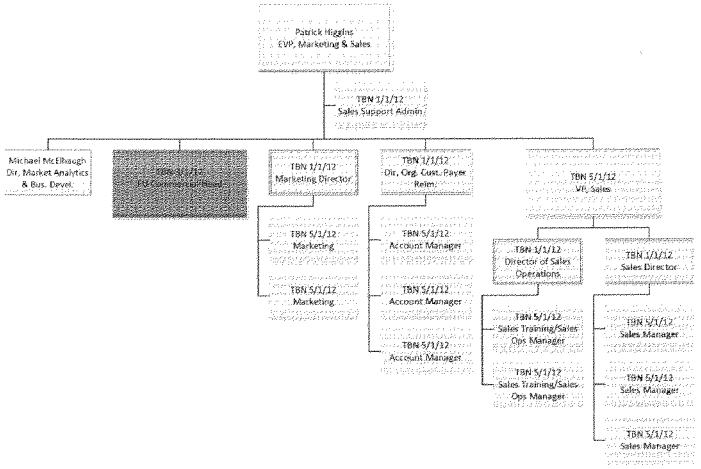
Chief Development Officer reports



Administration



Sales & Marketing



MORGAN STANLEY

UPDATE TAB

Presentation to be provided

by Morgan Stanley at Board Meeting

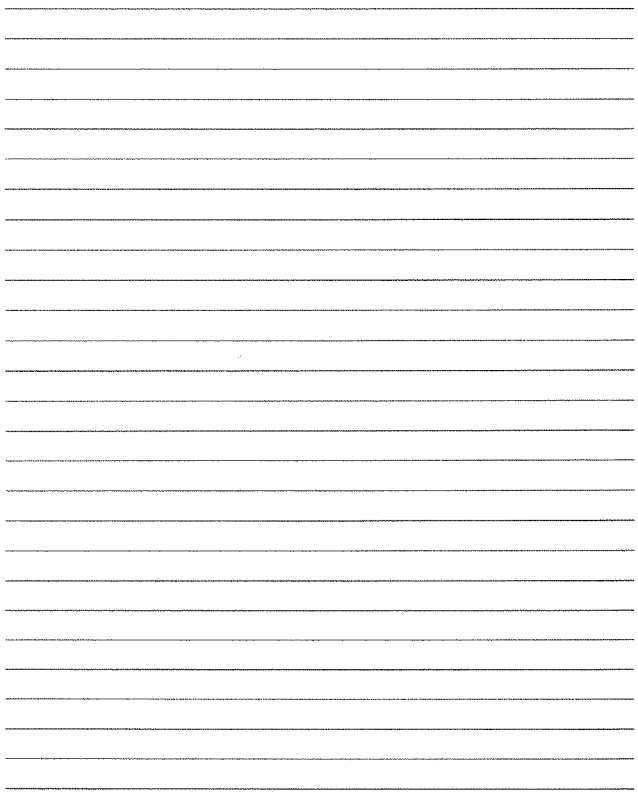


Exhibit 26

Harry Update

John Milligan

Board Meeting

October 24, 2011

Review of Recent Events

Sept. 2nd	JCM, JFM and SP meet in NJ First Offer letter sent: $100/share
Sept. 9th	Harry Board rejects offers as inadequate but allows a limited diligence process to move forward
Sept. 29th	CDA executed (six month standstill)
Oct. 3rd	Harry and Gilead management teams meet for presentations
Oct. 7th	Second offer letter sent: $125/share
Oct. 12th	Response from Harry on second offer. Harry Board will hold their response until after AASLD and a market check with other potential acquirers

1233

Diligence findings on PSI 7977

- Clinical data continue to look robust
  - High response rates in all genotypes
  - Good safety profile
    - Potential for use in broad populations
- FDA standards for filing and approval changed
  - 12 weeks treatment plus 12 weeks off
  - Placebo controlled trial acceptable
- Phase III studies simpler and faster
  - PSI 7977 +/- ribavirin
- FDA Filing by end of 2013
  - Genotypes 2 and 3 plus some genotype 1 patients

1234

Ongoing and Upcoming Harry Events

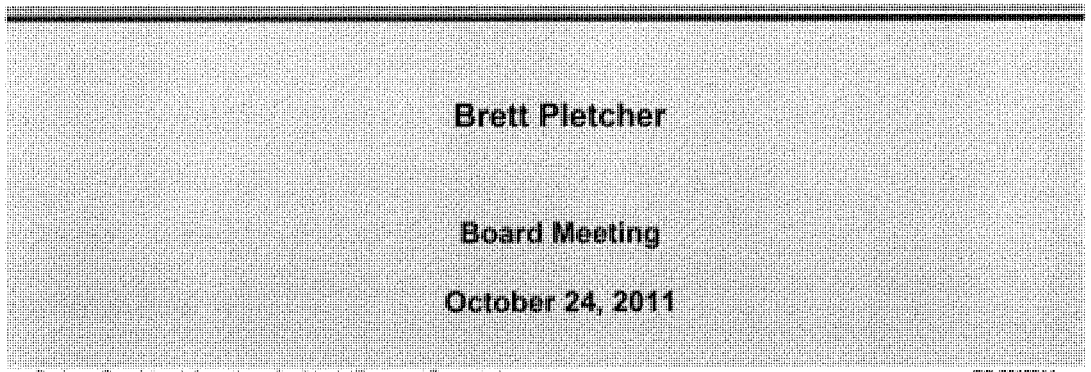
- Electronic data room opened
  - Gilead granted access on Oct. 23rd
- Merger Agreement to be sent by end of month
- Data released on Nov. 8 at AASLD
  - SVR4 results in Genotype 2/3 patients
- Announcement on new Phase III and filing timelines

1235

Remaining Items for Gilead

- Completion of diligence
  - Phone calls or meetings with Harry management
  - Final IP assessment and legal preparation (Brett)
- Pre-Financing Activities (Robin)
- Final Bids and completion of merger agreement
  - Estimated at mid-November

IP and Legal Preparation

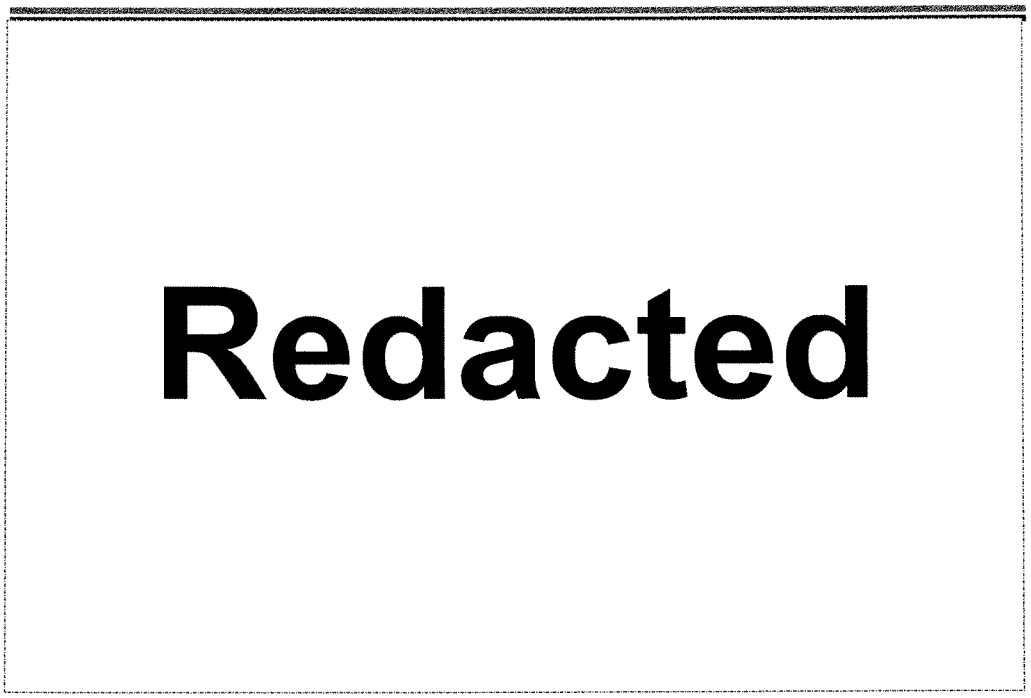


Project Harry: IP Update

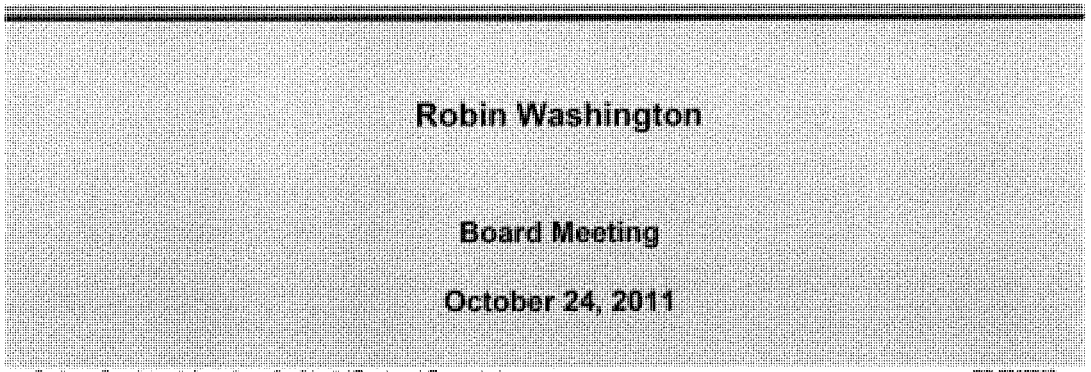
Redacted

1238

Project Harry Legal Preparation



Financing



Project Harry Financing and Timing Considerations

Pre-Transaction Announcement

- Investment Bank Selection
- Bridge Loan Agreement
- Ratings Assessment
- Financial Due Diligence
- Offshore Cash Utilization Considerations

Post-Transaction Announcement

- Audited / Pro Forma Financials
- Public Bond Offering
- Credit Facility Amendment / Refinance
- Tax Structuring

1241

Illustrative Financing Strategies: All-Cash Consideration

Acquisition Size	$8,000	$10,000		$13,000		
Assumed Rating	Baa1	Baa2		Baa3 or Better [1]		
Sources of Financing	Bond	Bank	Bond	Bank	Bond	Equity
Cash						
Domestic	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Offshore	4,000	4,000	4,000	4,000	4,000	4,000
Bank						
Term Loan / Revolver	$750	$1,000	$750	$1,000	$750	$1,000
Commercial Paper	--	1,500	--	1,750	750	1,750
High Grade Bonds (US and Foreign)	$2,250	$1,500	$3,000	$4,000	$5,500	$3,250
Short Term Convertible Debt [2]	--	$1,000	$1,250	$1,250	$1,000	$1,000
Equity	--	--	--	--	--	$1,000
Total Sources	$8,000	$10,000	$10,000	$13,000	$13,000	$13,000
Debt Bridge / Incremental Debt [3]	$3,000	$5,000	$5,000	$8,000	$8,000	$8,000
Shares Issued (millions)	--	--	--	--	--	25.000
% of Basic	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*3.3%*
PF Leverage **Status Quo**						
2011E 1.01x	1.66x	2.09x	2.09x	2.74x	2.74x	2.53x
2012E 0.94x	1.33x	1.20x	1.48x	1.80x	1.96x	1.60x
Incremental Pre-Tax Cash Interest						
2012E	$86	$69	$127	$203	$257	$155
2015E	58	29	93	154	222	110

(1) Ratings outcome and resultant market capacity will impact cost and tranching of takeout financing
(2) Can consider convertible debt based on capacity in other markets and strategy with respect to deleverage and ratings
(3) Does not include potential need for $4B cash bridge

Exhibit 27

From: Cara Miller
Sent: Friday, November 22, 2013 1:28 AM
To: gregg.alton@gilead.com
Subject: FOR REVIEW: BOD Memo

Hi Gregg,

Following is the draft board memo for John's review. Please advise of any comments/edits and if you will be sending to him directly or if I should send.

Can you confirm it was both Bill and John or should we just reference Bill Symonds?

Thank you,

Cara

***

Hello,

I am pleased to inform you that the U.S. Food and Drug Administration (FDA) has approved Sovaldi™ (sofosbuvir 400 mg) in combination with other agents for the treatment of chronic hepatitis C virus (HCV) infection in adults.

As highlighted by John McHutchison and Bill Symonds during our meeting last month/earlier this month, the FDA granted Sovaldi a Breakthrough Designation, which allowed us to submit data from two additional Phase 3 studies beyond the four Phase 3 trials submitted with the initial New Drug Application.

These data were accepted by the FDA and are reflected in the label, which allows a broad range of HCV patients to be treated with Sovaldi. Sovaldi is approved for use in hepatitis C patients with genotypes 1, 2, 3 or 4 HCV infection, including patients with HCV monoinfection and HCV/HIV co-infection. It forms the basis of the first oral treatment regimen for genotype 2 or 3 patients, and the first regimen for patients awaiting liver transplantation to prevent HCV recurrence.

The price of one bottle of Sovaldi is $XX, which means the cost of a 12-week, Sovaldi-based regimen is consistent with that of current Guidelines-recommended HCV regimens.

To help patients who are uninsured, underinsured or who otherwise need financial assistance to access Sovaldi, Gilead today launched a comprehensive patient support program in the United States. Details about Gilead's global access program will be available in the coming months.

As you may be aware, today's milestone falls on the heels of (this morning's/yesterday's/last week's) announcement that the scientific committee of the European Medicines Agency (EMA) has adopted a positive opinion on Gilead's application for Sovaldi in the European Union. A final decision from the European Commission is anticipated early next year.

I'd like to thank each of you for your ongoing support and guidance, and I'd like to acknowledge John McHutchison for his leadership in establishing such a robust viral hepatitis clinical program. I also want to thank Gayle, John and Nick for taking time out of their schedules to attend the launch preparation meeting in Phoenix and for interacting directly with the sales team that will introduce Sovaldi to hepatitis C physicians and their patients beginning today.

I look forward to keeping you updated on the progress of the Sovaldi launch and on continued advances in our HCV pipeline, including new fixed-dose regimens combining Sovaldi with other Gilead agents. In the meantime, please let me know if you have any questions.

John

Exhibit 28

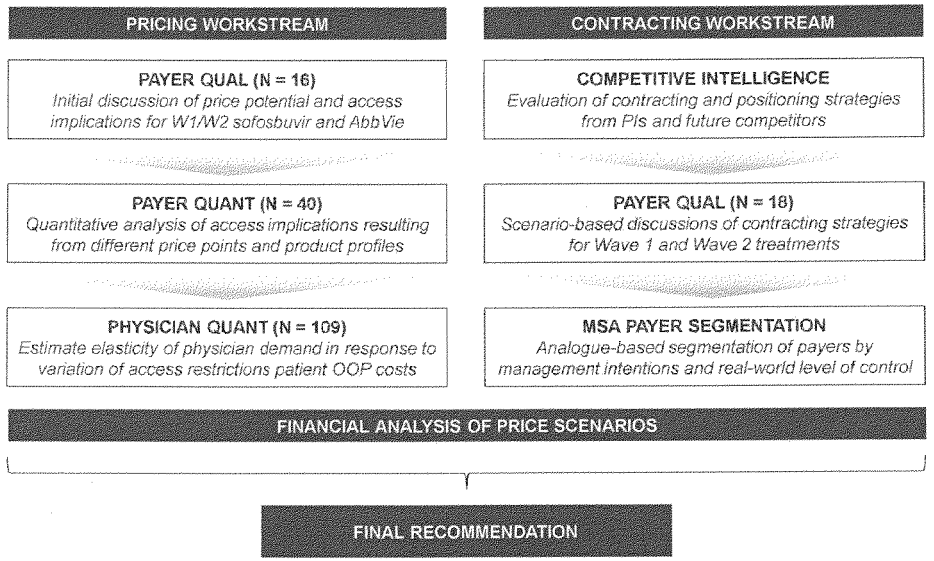
GILEAD

Sofosbuvir Pricing and Market Access Assessment

Final recommendations - July 31st, 2013

The final recommendation is based upon multiple waves of research, involving a total of over 200 HCV market stakeholders

GILEAD



Executive summary

GILEAD

CONCLUSIONS

1. Gilead has **considerable pricing potential with sofosbuvir in Wave 1** without major access consequences, but the pricing potential for future launches will be constrained by competition
2. Long term sofosbuvir franchise value will be driven by **a high price capture opportunity in Wave 1** and a **volume capture in Wave 2 and beyond**
3. The optimal range for Wave 1 pricing based on revenue / uptake trade-offs is likely $85-$95K, though other softer factors must be considered

WAVE 1 PRICING RECOMMENDATION

1. **Gilead should price sofosbuvir Wave 1 between $80K to $85K per course of therapy** and contract selectively for access at target payers where it is required for access (*after non-contracting strategies are unsuccessful at improving access*)

   Key consideration: The loss in patient starts will be more than offset by increases in revenue at the high end of this range, but softer considerations of advocacy groups and difficult conversations with payers about the price will be pronounced

This price will allow Gilead to capture value for the product without going to a price where the combination of external factors and payer dynamics could hinder patient access to uncomfortable levels

HCV is very much unlike HIV and, while exercising caution based on the Stribild launch is understandable, sofosbuvir is quite different

GILEAD

SOFOSBUVIR OPPORTUNITY RELATIVE TO STRIBILD

SOFOSBUVIR WAVE 1 IS...

1. SUBSTANTIALLY BETTER THAN STANDARD OF CARE ACROSS METRICS
2. IN A THERAPY AREA WHERE THERE IS SIGNIFICANT UNMET NEED
3. IN A THERAPY AREA WHERE PRIOR AUTHORIZATIONS ARE THE NORM
4. BEING RESEARCHED WITH MORE RIGOR THAN THE STRIBILD LAUNCH

IMPLICATIONS

- Market access in **HIV is significantly different** than market access in HCV
- Prescribing **physicians are comfortable with prior authorizations** and recognize that they are part of "standard operating procedures"
- **Stribild** is not viewed by payers as having substantially better efficacy than current products and view it largely as a **convenience value story**
- **Sofosbuvir** demonstrates substantially better data in both efficacy and convenience as well as other metrics that are important to payers and represents **significant clinical value**

Other therapy areas, especially the anti-TNFs in RA, are much better analogues

Sofosbuvir will fundamentally change the way HCV is treated and the pricing recommendation is defensible based on product value

GILEAD

SIGNIFICANT VALUE CREATION

BETTER OUTCOMES

- Clinical trials show a higher SVR than the PIs had at launch and there is an expectation that the real world SVR will be similar (unlike PIs)

DECREASED USE OF PEG/RBV

- 50% less PEG/RBV for the regimen than the best case scenario for the current products, which will make achieving SVR more likely

JUSTIFICATION FOR PRICING

PRODUCT PRICING

- A price of $80-$85K does represent >30% premium to Incivek on a molecule price, however, the product is delivering better outcomes for those dollars
- Payers are currently paying significantly more than the price of Incivek to achieve an outcome, so regimen cost is critical

REGIMEN PRICING

- At a price of $80-$85K per course of sofosbuvir, payers would not be paying any more than what they currently do for a fully adherent patient
- Cost per SVR will be substantially lower in the future with sofosbuvir relative to today's regimens, even without consideration of the lower costs of managing side effects

FUTURE MARKET CONSIDERATIONS

MARKET MIGRATION TO VALUE

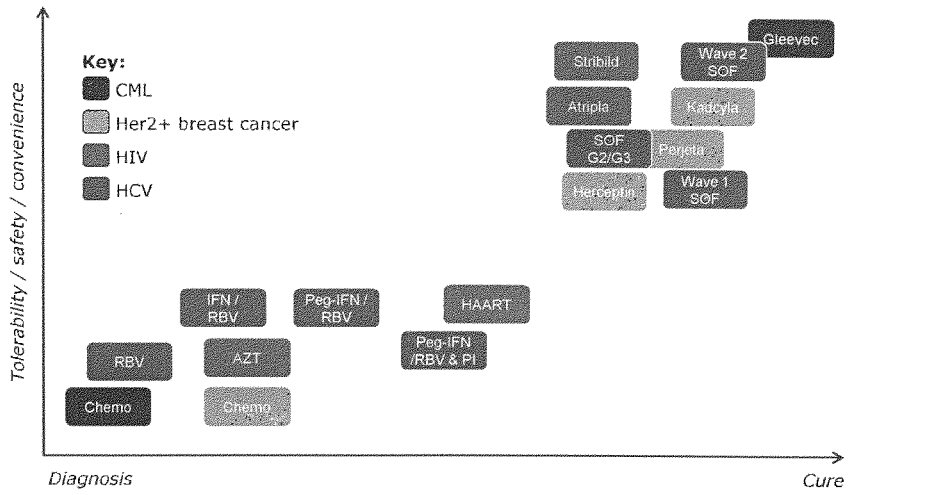
- Healthcare reform has incentives to pay for value, which aligns with what sofosbuvir will deliver (*even if it is not the least expensive agent*)

CLOSER MANAGEMENT OF COSTS

- While it is true that budgets are not infinite, higher cost products can be preferred if actually demonstrating strong real world outcomes

Major breakthrough products across analogous TAs have significantly improved both efficacy and safety like sofosbuvir

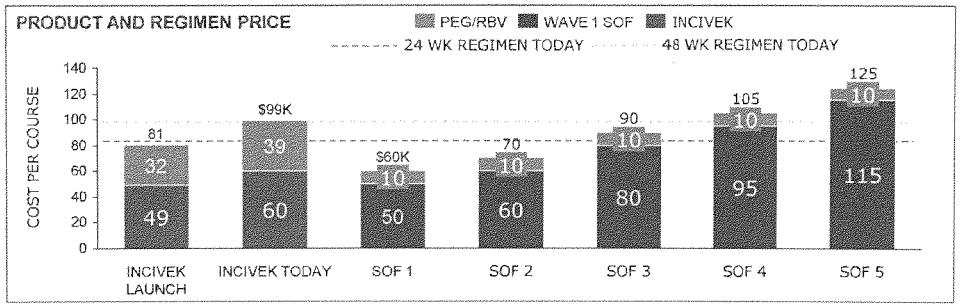
GILEAD



Relative to the current cost of Incivek, sofosbuvir would most likely provide *savings* to payers at molecule prices <$80K

GILEAD

PRICING SCENARIOS BY REGIMEN AND PRODUCT BASIS



KEY CONSIDERATIONS FOR GILEAD

- Given a potential Incivek regimen cost near $100K, payers will almost certainly be saving money if the wave 1 sofosbuvir regimen has a product price of $80K or below
- Savings are still likely at a sofosbuvir product cost of $95K, especially considering sofosbuvir's superior SVR and the significant rates of treatment failure/abandonment associated with Incivek

Note: prices graphed for Incivek are the cost of therapy for the full 48 week regimen

Pricing in the sub-WAC government channels of Medicaid, 340B and the VA is substantially lower than the Commercial market

GILEAD

GOVERNMENT PRICING DATA						
Product	Launch WAC per Bottle	Current WAC per Bottle/Pack (28 day supply)	VA and Big 4 Price per Bottle	VA and Big 4 Discount %	Medicaid Price per Bottle	Penalty Rebate %
Boceprevir	$4,400.00	$5,536.26	$2,182.22 - $3,087.72	44% - 61%	$3,225.98	18.04%
Telaprevir	$16,400.00	$20,156.95	$10,432.45 - $11,671.78	42% - 48%	$6,066.73	16.10%
Pegasys	$1,164.00	$2,883.00	$1,575.68	45%	$823.49	48.05%

Assumptions/Notes:
Estimated 1% discount at launch
Estimated 10% discount for Best Price (Under the basic rebate of 23.1%)
Estimated 1% discount for current AMP
Note: competitive pricing in these channels can be achieved selectively through contracting, without affecting best price

1254

Our findings to date have consistently emphasized the value of both products and that the value capture opportunity is in Wave 1

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WAVE 1 FINDINGS
• Expected physician uptake of SOF in GT-1 is strong, and also favorable in GT-2 and GT-3, with the all-oral regimen winning even if efficacy is not substantially improved (i.e. GT-3)
• Given the significant improvements in efficacy and tolerability and high level of physician demand, SOF enjoys substantial pricing freedom in Wave 1
• The majority of payers indicated that even at a high price differential it is unlikely they would impose step edits through inferior regimens (PIs or simeprevir)
• Majority of payers will either prefer or place sofosbuvir at parity to both simeprevir and PIs without requiring a contract; price sensitivity begins at $90k for subset of payers
WAVE 2 FINDINGS
• Payers assign significant value to the Wave 2 profile and show a willingness to provide favorable access at premium prices to the Wave 1 profile
• At any price, access for Wave 2 improves as the price for Wave 1 is increased, suggesting that Wave 1 will set a price benchmark against which Wave 2 will ultimately be evaluated
• Competitive threat from AbbVie and BMS will be critical factors for the Wave 2 market access strategy as these regimens could drive payers to disadvantage sofosbuvir under select scenarios, especially if efficacy is comparable among all the regimens and there is a large price differential
• Critically, this evidence strongly reinforces that the value capture opportunity lies in Wave 1, and that Wave 2 access will be enhanced with a high Wave 1 price

Additional learnings since last meeting include a more robust view of both competitive considerations and sub-WAC strategies

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ADDITIONAL PAYER SEGMENTATION
• Findings from the payer segmentation workstream have been integrated into the pricing recommendation, adding specific insights as to which plans present a higher risk of managing sofosbuvir and what volume those plans represent
• Plans are categorized both by intent and ability to manage, revealing that most plans have not managed and, among those who have, only a small high-control subset have been capable of enforcing preferences
COMPETITIVE CONSIDERATIONS
• Further consideration of BMS strategy has emphasized the possible risk of daclatasvir being used to break up the sofosbuvir STR if a significant value capture opportunity is presented
• Additionally, BMS has the opportunity to gain market share in wave 2 due to the reduced pill burden of ASV + DCV + 791325 relative to AbbVie; however, this regimen will still be less desirable than the sofosbuvir STR and could be a threat to Gilead depending on price
FURTHER DEVELOPMENT OF SUB-WAC STRATEGIES
• Wave 1 pricing will impact the imputed sub-WAC value of ledipasvir, therefore determining the value capture opportunity for a sofosbuvir + daclatasvir combination
• These considerations re-enforce the limitations on taking a premium in Wave 2, as a large difference between the two regimens would make NS5A substitution significantly more appealing to payers

Previous research has explored the HCV payer mix, although health reform and evolutions in demographics may shift the overall balance

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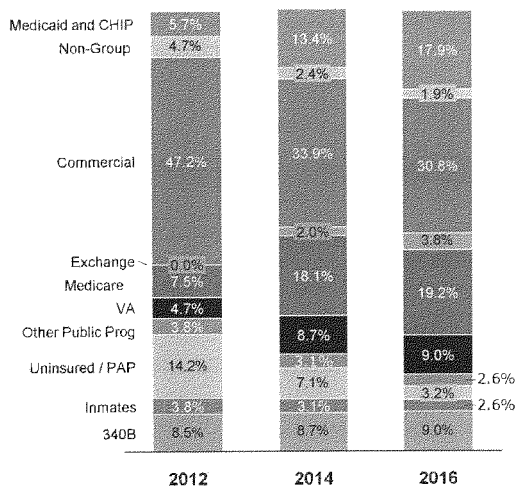
ESTIMATED PAYER MIX IN HCV BY TREATMENT SOURCE OF COVERAGE



IMPLICATIONS

- Over the near term, **expansion of Medicaid** is expected to continue and Gilead's exposure to this segment will grow over time
- Although declining over coming years, the **Commercial market is** expected to the be **the largest channel**
- Implementation of **Exchanges** will influence the overall payer mix, however, the **exposure is somewhat limited**

Importantly, a possible influx of warehoused patients will affect payer mix and these new treated patients will likely increase Medicaid exposure

Source: Avalere Enrollment Model for HCV Patients. Medicaid Optimistic Scenario; VA= Veterans Affairs; CHIP = Children's Health Insurance Program
Note: all of the uninsured patients are covered under PAP

SOF Wave 1 GT-1 access relative to the existing PIs is quite favorable and $75-$90K appears to be an access inflection point

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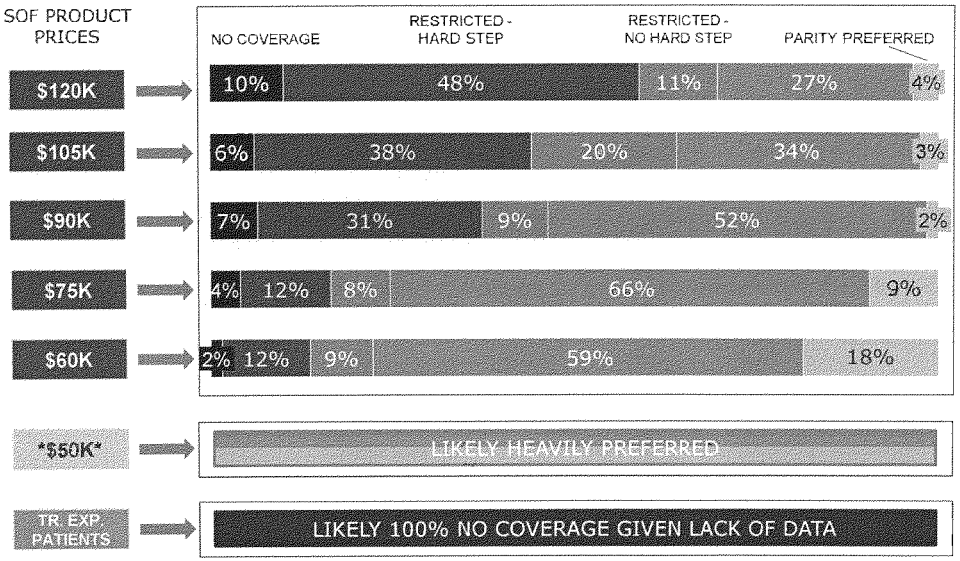

*Source: IMSCG PRIMARY RESEARCH; ALL DATA IS WEIGHTED BY NUMBER OF LIVES COVERED; **$50K PRICE NOT TESTED IN QUANT***
Note: Parity access assumes Prior Authorization to the label; raw data is shown and it has not been discounted for posturing

The access provided to GT-2 and 3 shares a similar access inflection point although GT-3 faces more restrictions overall

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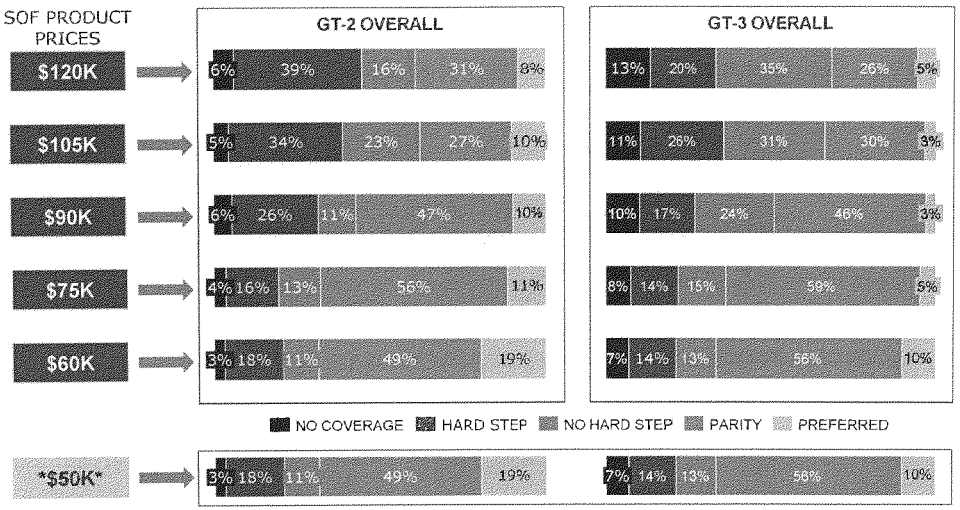

Payer sensitivity is likely equal at a $50K versus $60K price

*Source: IMSCG PRIMARY RESEARCH; ALL DATA IS WEIGHTED BY NUMBER OF LIVES COVERED; **$50K PRICE NOT TESTED IN QUANT***
Note: Parity access assumes Prior Authorization to the label; raw data is shown and it has not been discounted for posturing

We have layered on additional payer analysis in order to calibrate assumptions against the volume of scripts through each channel

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LINKING SEGMENTATION AND INTENT TO MANAGE

Using a combination of secondary data sources, we have developed an overall view of payer intent to manage using the formulary status of Incivek and Victrelis for each major payer channel

MARKET INFLUENCERS (HIGH CONTROL)	MODERATE MANAGERS (MEDIUM CONTROL)	PHYSICIAN ENABLERS (LOW CONTROL)
• Utilization management for these payers is quite strong • There is only one preferred agent or step edits are required to use a non-preferred agent	• These payers currently prefer one PI over another through differences in tiering and, therefore, through patient OOP cost	• Very limited, if any, utilization management applied to the PIs • Products are managed at parity and physicians can use either regimen without access constraint

COMBINE PRIMARY RESEARCH AND MARKET KNOWLEDGE

Payer sensitivity heat maps have been developed looking at previously presented market research results within this intent to manage framework

While soft steps begin at slightly different points for traditional payers, the tipping point for hard restrictions is quite consistent

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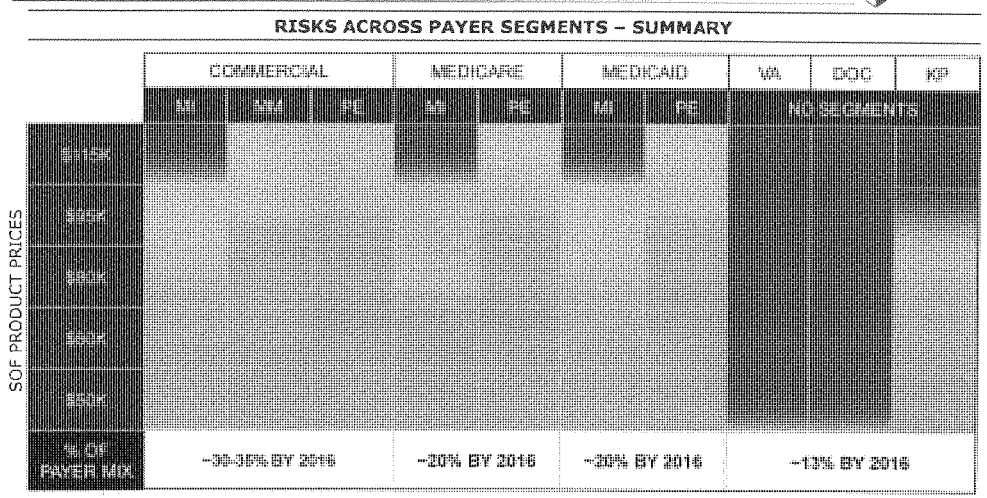

Overall, Gilead has considerable pricing flexibility with sofosbuvir that is likely to be in the $80-$100K range per course of therapy in Wave 1

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Wave 1 pricing freedom in the commercial market is strong; payers most likely to restrict represent <10% of PI volume

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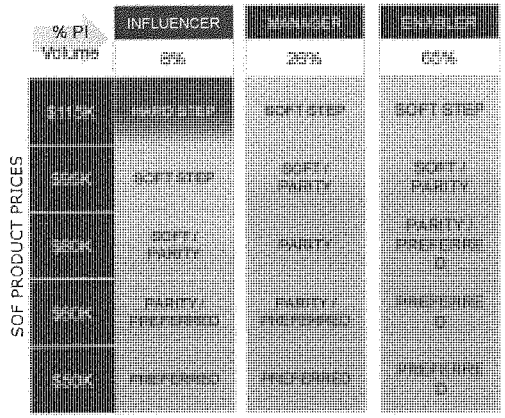
RISKS ACROSS PAYER SEGMENTS - COMMERCIAL



INFLUENCERS: BCBS MI, AETNA, REGENCE

MANAGERS: CIGNA, OPTUM RX, UNITED

ENABLERS: BLUESHIELD CA, HUMANA, WELLPOINT

KEY CONSIDERATIONS
• $115K for many of the Commercial payers would push them to introduce very strong restrictions, likely blocking GT-2/3 TN patients
• $95K is a key price sensitivity level, in which soft restrictions are often more favored than hard restrictions though some GT-2/3 is lost
• $80K for the Commercial market is a level where Gilead is unlikely to face significant restrictions and would have parity access
• Below $80K and at discount levels below the price of the current PIs, will in some cases allow sofosbuvir to gain preferred access relative to incumbents • Alternatively, some plans are likely to not grant preferred access in which case sofosbuvir would be at parity

Note: % PI volume in each payer segment is based on secondary IMS data analysis presented previously; only select plans shown

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Medicare Part D potential is comparable to that in the commercial market

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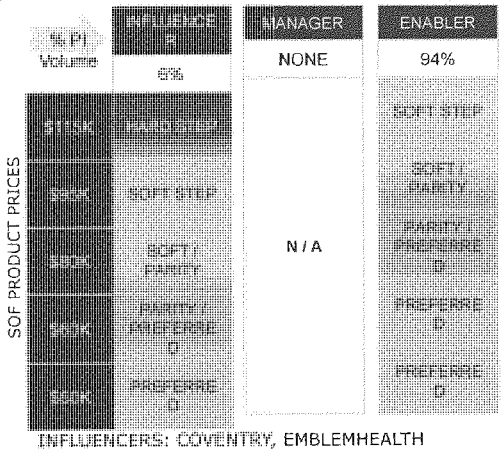
RISKS ACROSS PAYER SEGMENTS – MEDICARE PART D



INFLUENCERS: COVENTRY, EMBLEMHEALTH

MANAGERS: N/A

ENABLERS: HEALTH NET, CVS CAREMARK

KEY CONSIDERATIONS
• Many Part D payers at these levels may consider not providing access to sofosbuvir and would implement blocks across GTs
• $95K may be a challenge in high control Medicare although payers interviewed are mostly looking to implement soft edits in GT-1 and possibly limited GT-2/3 use in TN patients
• $80K represents an inflection point for the highest control Medicare plans, who would likely implement soft edits
• Parity pricing to Incivek will create preferred access for most Medicare Part D payers based on this research • While the highest control influencers are most likely to restrict at high prices, they are also most likely to grant preferred access

Note: % PI volume in each payer segment is based on secondary IMS data analysis presented previously; only select plans shown

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

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Traditionally price-sensitive Medicaid payers show a favorable reaction to the product and accept premium pricing to PIs

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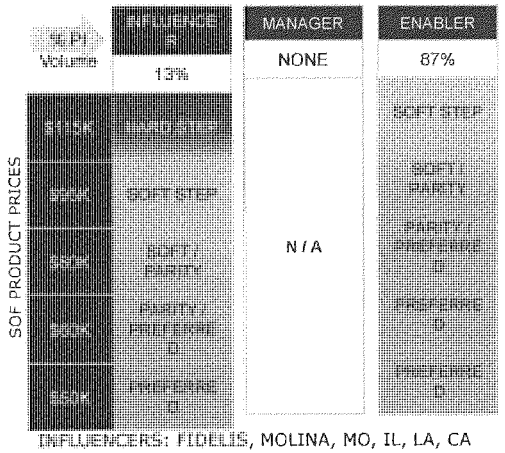
RISKS ACROSS PAYER SEGMENTS – FFS AND MANAGED MEDICAID



INFLUENCERS: FIDELIS, MOLINA, MO, IL, LA, CA

MANAGERS: N/A

ENABLERS: FL, TN, IN, OH, NY, GA

KEY CONSIDERATIONS
• A $115K price for Medicaid in Wave 1 is generally unachievable without significant supplementary rebates
• $95K may be an inflection point in high control FFS, although most payers are not looking to force hard edits at this price in any genotype
• $80K is likely below a major inflection point for the highest control Medicaid plans and for some payers SOF would be preferred to PIs
• Parity pricing to Incivek will create preferred access for the majority of Medicaid payers, including both FFS and Managed Medicaid • Discount pricing to the PIs will ensure preferred status relative to the incumbents

Note: % PI volume in each payer segment is based on secondary IMS data analysis presented previously; only select plans shown

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Non-traditional segments widely vary in price sensitivity and some degree of contracting is likely required regardless of price

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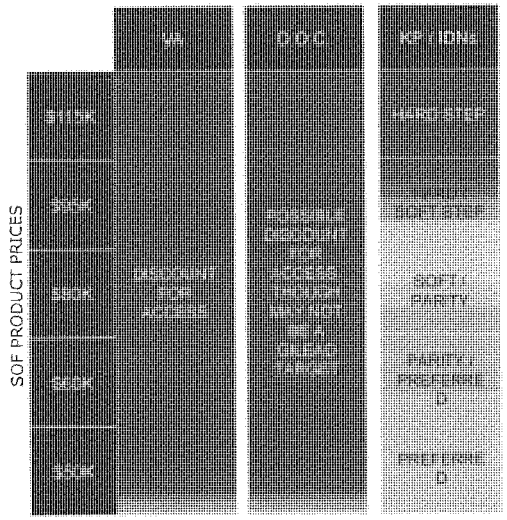
RISKS ACROSS PAYER SEGMENTS – NON-TRADITIONAL PAYERS



KEY CONSIDERATIONS
• Non-traditional payers, such as integrated delivery networks (IDNs) at these price levels will likely not provide access and demand contracts
• Generally pushing the upper comfort level for IDN payers although the recognition of improved outcomes still carries significant value at these prices • As the IDNs can directly see the cost savings in their system, they recognize decreased use of supportive care and lower cost per SVR
• Prices at parity to the protease inhibitors in the IDNs will not only result in preferred status, but some payers will remove the incumbent products from the formulary • Even at these lowest prices, other segments including VA and DOC are likely to demand lower net prices for access

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Reactive contracting with low rebates should be sufficient in many channels although proactive strategies will be required elsewhere

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SEGMENT (Total Rx lives)	SELECT PAYERS	SOFOSBUVIR WAC PRICE			APPROACH	COMMENTARY
		<$70K	$70-90K	>$90K		
COMM'L / PART D (~100M)	*MARKET INFLUENCERS*	NONE	CASE BY CASE, WITH MAX 5-8% AT HIGH CONTROL PLANS		REACTIVE	• Some plans may require low rebates and those are likely to be the payers heavily managing Incivek or Victrelis • This will likely represent less than 10% of the volume through these channels
KAISER (~9M)	KAISER	NONE	5-10%	>10%	PROACTIVE	
MANAGED MEDICAID (~25M)	*MARKET INFLUENCERS*	NONE	5-10%	>10%	REACTIVE	• Some Managed Medicaid may seek contracts, such as Fidelis or CalOptima, among others • Proactive recommended in CA FFS Medicaid, which represents ~10% of channel; high contract potential in FL, IL and MO
FFS MEDICAID (~28M)	CA ONLY	5-10% SUPPLEMENTARY AS NEEDED FOR PDL LISTING			PROACTIVE	
DOC (~1.2M)	CA ONLY	5-10%			PROACTIVE	• CA represents ~12% of overall DOC payer segment
340B	AHF, ADAP, some DOC	STATUTORY DISCOUNTS				• Statutory discounts in these settings will be required
VA (~5.6M)	N/A	0-3%	10%	>10%	PROACTIVE	• Currently in the VA, Merck total rebate is 44-61% and Vertex is 42-48%, which includes both statutory and penalty rebates

Note: Market influencers are payers currently managing PIs via differential tiering and step edit through a preferred product; there are likely to be exceptions across each payer channel where strategically Gilead may implement a contract; price protection contracts are not expected to be implemented in Wave 1 though could be valuable in Wave 2; data on covered HCV lives was sourced by Gilead

Under current assumptions, the GTN for SOF across product waves is likely to be lower than other Gilead therapy areas

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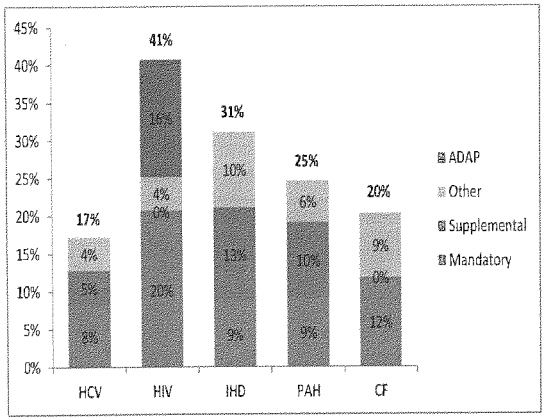
GTN ASSUMPTIONS ACROSS GILEAD THERAPY AREAS



- Total HCV GTN is lower primarily due to smaller mandatory discounts, which are driven by the Medicaid pricing penalty
- Supplemental discounting includes commercial contracting of 16% in IHD, 10% in PAH, and 2% in HCV. CP also has significant supplemental discounts for Medicare
- Other discounts are higher in CP due to higher sales returns and higher donut hole costs (which is a greater proportional hit as prices are lower)
- HIV discounts are the highest, primarily due to heavy discounting to ADAPs and high Medicaid pricing penalties which factor in the CMS line extension rule

Source: Gilead internal analysis

Simeprevir is likely to build a market in the treatment experienced population and do so at a premium price to current PIs

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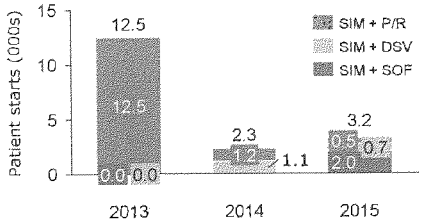
KEY COMPETITOR	WHERE COULD THEY WIN?	WHAT ARE THEY OPTIMIZING FOR?	WHAT ARE THEY LIKELY TO DO WITH PRICING?
JANSSEN SIMEPREVIR	• Likely use in prior-PEG/RBV, which represents a minority of the experienced patient population, but a broad TE label could influence uptake • Some potential use in treatment naïve patients possible despite inferior data	• Clear market opportunity in the treatment experienced population • Can be positioned as a future PI backbone of therapy going forward as multiple agents are likely to be in combination with it going forward	• Janssen can price above the current levels for Incivek and still get good access • Unlikely to price at a discount to current products as this would be value-destroying

SIMEPREVIR FORECASTED STARTS



Source: Gilead forecast

HOW DOES IT AFFECT GILEAD?

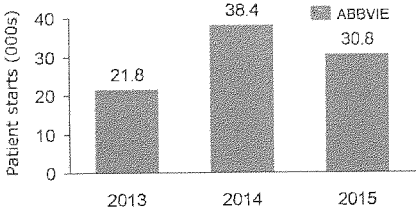
- Anticipated uptake for SIM is expected to be strong in GT-1/TE patients, where SOF lacks data at Wave 1
- With the launch of AbbVie's 3-DAA and Wave 2 SOF, SIM use will decline rapidly, reflecting its inferior SVR, P/R-associated toxicities, PI-associated side effects and longer treatment duration
- Simeprevir will be a competitor for Wave 1 although payers are not eager to prefer it over sofosbuvir

AbbVie will be the first all-oral GT-1 regimen to launch and they will seek to build a position as fast as possible before Wave 2

GILEAD

KEY COMPETITOR	WHERE COULD THEY WIN?	WHAT ARE THEY OPTIMIZING FOR?	WHAT ARE THEY LIKELY TO DO WITH PRICING?
ABBVIE 3-DAA	• Strong data in the treatment experienced and treatment naive patient populations • First to market all-oral regimen will drive demand to the product, despite the pill burden issues	• AbbVie will want to get as many patients on product as soon as possible before the Wave 2 STR launches • Over the longer term it is likely to become less favored clinically so establishing a position is key at launch	• AbbVie will certainly be able to take a premium above the Wave 1 / simeprevir price ranges • Once Wave 2 launches, AbbVie will likely consider contracting in order to maintain / build share

ABBVIE FORECASTED STARTS



HOW DOES IT AFFECT GILEAD?
• As the first all-oral, AbbVie's 3-DAA will displace SOF and SIM in GT-1 and become the new benchmark • AbbVie has a limited window, as subsequent entrants will offer improved duration and pill burden; projected revenue for 3-DAA peaks in 2015 and begins to erode after STR entry • AbbVie is likely to set a new price benchmark above the Wave 1 price upon which Wave 2 will be evaluated

Source: Gilead forecast

BMS has multiple shots on goal over the coming years according to the most recent data presented at EASL

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- **BMS has multiple strategies using all-internal regimens**
  - All-oral triple regimen (PI + NS5A + NNI): **First breakthrough designation in HCV (April 25, 2013)**
    - Phase III expected to start late 2013 - ***Potential launch by 4Q 2015***
    - BMS plans to co-formulate into one pill, twice-daily

- **Active with external collaborations; 4 studies currently planned with DCV (NS5A)**
  - Janssen's PI (simeprevir), VRTX's NI (VX-135), Merck's PI (MK-5172), and GILD's NI (SOF)

Patients		Regimen	Potential Launch
GT1/4	QUAD (null and partial responders)	DCV (NS5A) + ASV (PI) + P/R	Oct 2014
	Single agent (TN, HIV co-infection)	DCV (NS5A) + P/R	2Q 2015
	Triple, all-oral (TN and null)	DCV (NS5A) + ASV (PI) + BMS-791325 (NNI)	YE 2015
GT1b	DUAL (TN, null, IFN-ineligible)	DCV (NS5A) + ASV (PI)	Oct 2014
	DUAL (Japan)	DCV (NS5A) + ASV (PI)	YE 2014
External Collab	BMS/Janssen (GT1, TN and null)	DCV (NS5A) + simeprevir (PI)	2Q 2015
	BMS/GILD (GT1/2/3 TN, GT1 PI-failure)	DCV (NS5A) + SOF (NI)	3Q 2015
	BMS/Vertex (GT1/2/3 TN)	DCV (NS5A) + VX-135 (NI)	YE 2016
	BMS/Merck (GT1)	DCV (NS5A) + MK-5172 (PI)	YE 2016

BMS will become more competitive over the longer term and will aim to drive the payer market to "break up" the Wave 2 STR

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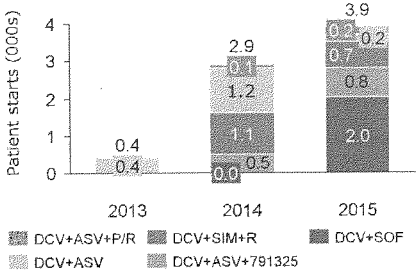
KEY COMPETITOR	WHERE COULD THEY WIN?	WHAT ARE THEY OPTIMIZING FOR?	WHAT ARE THEY LIKELY TO DO WITH PRICING?
BMS DACLATASVIR	• Possible use in GT-1b patients with the first launch although this is likely an ex-US focus (i.e. Japan with 1.5M infected, 70% GT-1b) • Reasonable potential over the longer term in GT-1 with their own triple regimen or when used in combination	• Most likely optimizing for future launches rather than the initial 24 week launch • BMS is ahead in Japan, but price referencing in Japan means US price will be a key influence (i.e. low price in US is unlikely as it will prevent high prices in Japan)	• If SOF+LDV 8 week data shows high SVRs, then DCV will most likely be less than LDV • If Gilead needs 12 weeks in Wave 2, then BMS will be in a position where they may not be comfortable with such a low price

DACLATASVIR FORECASTED STARTS



HOW DOES IT AFFECT GILEAD?

- BMS' first launch will be inferior to existing regimens, particularly outside of GT-1b
- Most subsequent regimens will match SOC on duration – 12 weeks – but are otherwise unlikely to generate significant enthusiasm
- Half of total DCV franchise use is projected to come from combination use with products from other manufacturers – **reinforcing the risk that BMS will modulate price**

Source: Gilead forecast

Preliminary findings from the financial modeling – Wave 1 only

Impact of Wave 1 Price on Demand and Net Revenues

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	Net Revenue ($ MM)			Treated Pts (000s)			
SOF PRODUCT PRICES	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	
June Forecast **W1: $60K**	2.0	0.7	0.5	46.4	15.4	12.3	*Gross to Net in June Forecast was ~22% in 2014*
Reference Case **W1: $60K**	2.21	0.86	0.66	-	-	-	
Delta from June Forecast:	*0.22*	*0.11*	*0.11*				
W1: $50K	1.82	0.71	0.54	-	-	-	*Updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or Below 60K*
Delta from Reference:	*(0.4)*	*(0.1)*	*(0.1)*				
W1: $60K	2.19	0.85	0.65	-	-	-	
Delta from Reference:	*(0.0)*	*(0.0)*	*(0.0)*				
W1: $80K	2.66	1.04	0.78	-5%	-4%	-6%	*Updated gross-to-net assumptions of ~17% in 2014 are used for all scenarios with Wave 1 pricing above 60K*
Delta from Reference:	*0.5*	*0.2*	*0.1*				
W1: $95K	2.79	1.11	0.83	-16%	-14%	-16%	
Delta from Reference:	*0.6*	*0.3*	*0.2*				
W1: $115K	3.07	1.24	0.91	-24%	-20%	-24%	
Delta from Reference:	*0.9*	*0.4*	*0.3*				

Note: this analysis assumes Gilead does not contract to win back lost patient volume

Preliminary findings from the financial modeling – Wave 1 only

Impact of Wave 1 Price on Demand and Net Revenues

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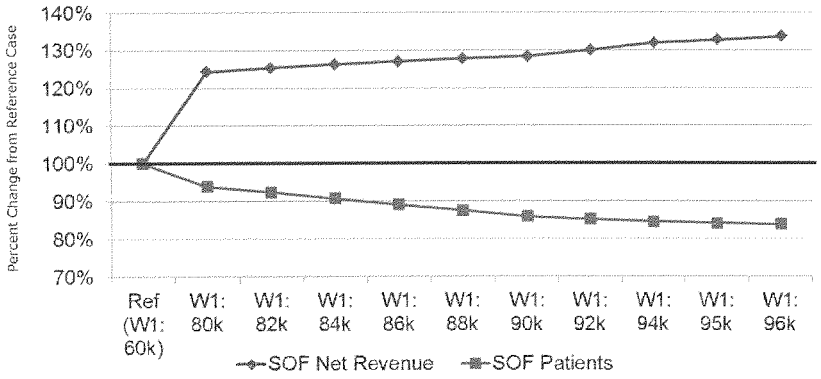
REVENUE & PATIENT ANALYSIS ACROSS SCENARIOS 2013 -2016 – WAVE 1 ONLY



The financial analysis shows that with in the $80k-$95K range patient impact increases as price is increased but not enough to offset Revenue Gains.

Preliminary findings from the financial modeling – Wave 1 and 2

Impact of Wave 1 and Wave 2 Price on Demand and Net Revenues

GILEAD

	Net Revenue ($ MM)			Treated Pts (000s)			
SOF PRODUCT PRICES	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	
June Forecast (W1: $60K / W2: $87K)	2.1	4.2	3.7	49.9	77.3	65.0	*Gross to Net in June Forecast was ~22% in 2014*
Reference Case (W1: $60K / W2: $87K)	2.29	4.80	4.45	-	-	-	*Updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or Below 60K*
Delta from June Forecast:	*0.23*	*0.63*	*0.73*				
W1: $50K / W2: $70K	1.89	3.88	3.60	-	-	-	
Delta from Reference:	*(0.4)*	*(0.9)*	*(0.9)*				
W1: $60K / W2: $80K	2.27	4.47	4.14	-	-	-	
Delta from Reference:	*(0.0)*	*(0.3)*	*(0.3)*				
W1: $80K / W2: $100K	2.76	5.42	5.00	-5%	-1%	-1%	*Updated gross-to-net assumptions of ~17% in 2014 are used for all scenarios with Wave 1 pricing above 60K*
Delta from Reference:	*0.5*	*0.6*	*0.5*				
W1: $95K / W2: $115K	2.90	5.77	5.31	-16%	-9%	-9%	
Delta from Reference:	*0.6*	*1.0*	*0.9*				
W1: $115K / W2: $135K	3.18	6.05	5.54	-24%	-19%	-19%	
Delta from Reference:	*0.9*	*1.3*	*1.1*				

Note: this analysis assumes Gilead does not contract to win back lost patient volume; TN population is 78% of patients at Wave 2 launch

Preliminary findings from the financial modeling – Wave 1, 2 and 3

Impact of Wave 1 and Wave 2 Price on Demand and Net Revenues

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	Net Revenue ($ MM)			Treated Pts (000s)			
SOF PRODUCT PRICES	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	
June Forecast (W1: $60K / W2: $87K)	2.1	4.2	5.5	49.9	77.7	98.6	*Gross to Net in June Forecast was ~22% in 2014*
Reference Case (W1: $60K / W2: $87K)	2.29	4.81	6.51	-	-	-	
Delta from June Forecast:	*0.23*	*0.63*	*0.98*				
W1: $50K / W2: $70K	1.89	3.89	5.25	-	-	-	*Updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or Below 60K*
Delta from Reference:	*(0.4)*	*(0.9)*	*(1.3)*				
W1: $60K / W2: $80K	2.27	4.48	6.03	-	-	-	
Delta from Reference:	*(0.0)*	*(0.3)*	*(0.5)*				
W1: $80K / W2: $100K	2.76	5.43	7.27	-5%	-1%	-1%	*Updated gross-to-net assumptions of ~17% in 2014 are used for all scenarios with Wave 1 pricing above 60K*
Delta from Reference:	*0.5*	*0.6*	*0.8*				
W1: $95K / W2: $115K	2.90	5.78	7.92	-16%	-9%	-6%	
Delta from Reference:	*0.6*	*1.0*	*1.4*				
W1: $115K / W2: $135K	3.18	6.07	8.61	-24%	-19%	-13%	
Delta from Reference:	*0.9*	*1.3*	*2.1*				

Note: this analysis assumes Gilead does not contract to win back lost patient volume; TN population is 78% of patients at Wave 2 launch; Wave 3 price held constant

Aside from payer access and physician demand, there are a number of softer issues that could affect Gilead's final pricing decision

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Stakeholders	Wave 1 Regimen	$60,000	$70,000	$90,000	$105,000	$125,000
	Wave 1 SOF product (12 wks)	$50,000	$60,000	$80,000	$95,000	$115,000
	Wave 2 FDC (8 wks or 12 wks?)	$70,000	$80,000	$100,000	$115,000	$135,000
Payers	Likelihood of applying directly observed therapy due to high price	Unlikely	Possible	Possible	Likely	Likely
Physicians	Likelihood of delay treatment of GT-1 TN patients due to pricing	Unlikely	Possible	Possible	Likely	Likely
	Likelihood of losing some KOL endorsement/support as price too high	Very Unlikely	Unlikely	Possible	Likely	Likely
	Likelihood of getting rejection on TE patients and delay treatment for all due to misconception of restriction for SOF	Possible	Possible	Possible	Possible	Possible
Patients and Advocacy groups	Likelihood of AHF, FPC and other advocacy groups reacting negatively to price, and affecting public opinion	Likely	Likely	Very Likely	Very Likely	Very Likely
	Higher out-of-pocket costs (not offset by patient support) could drive patient choice away from SOF, especially AbbVie has great patient support programs	Very Unlikely	Very Unlikely	Unlikely	Unlikely	Possible
	Likelihood of AHF, FPC and other advocacy groups promote AbbVie products due to the relationship and lower price	Unlikely	Unlikely	Possible	Possible	Likely
Treatment Guidelines	Likelihood of AASLD develop treatment pathway to prioritize (staging) patients (per KOLs or/and professional community request)	Possible	Possible	Possible	Possible	Possible
	Likelihood of a "price mention or asterisk" in AASLD (per KOLs or/and professional community request)	Unlikely	Unlikely	Possible	Possible	Likely
Others	Likelihood of public outcry if SOF revenue exceed $2B as government trying to control healthcare cost	Possible	Possible	Possible	Likely	Very Likely
	Likelihood of a letter from congress on SOF price	Possible	Likely	Likely	Likely	Likely
	Likelihood of a congressional hearing if SOF revenue exceed $2B	Unlikely	Unlikely	Unlikely	Unlikely	Possible

While pricing at $50-60K would promote preferred status, it will result in significant unrealized revenue

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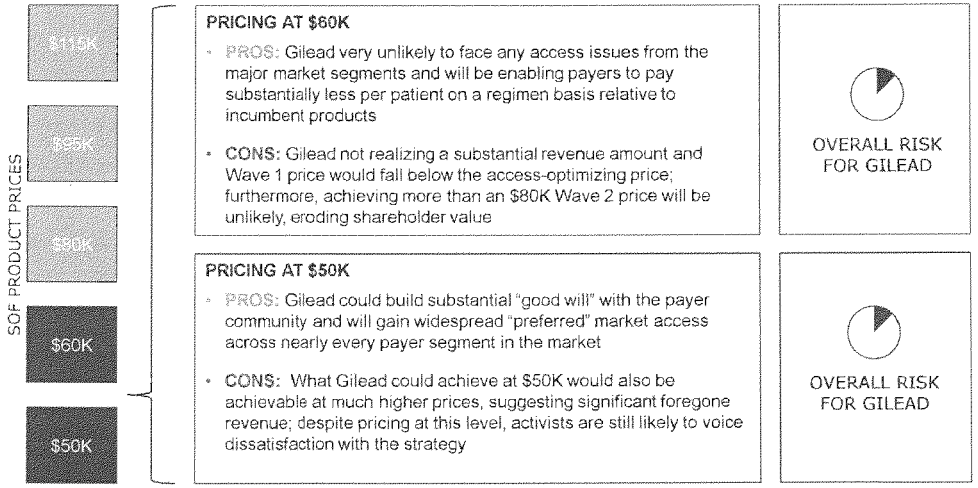

3 YEAR TOTAL REVENUE FOR WAVE 1 ONLY	$3.1B – $3.7B	% DELTA IN PATIENTS FROM JUNE FORECAST	NO CHANGE

At $80K, widespread parity access will be the norm, with strong physician and patient preferences driving significant uptake

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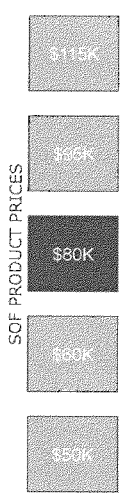

PAYER CONSIDERATIONS
- Given that SOF will be cheaper than most PIs on a regimen basis, payers are highly unlikely to manage access at $80K (beyond PA to label), instead placing it at parity to current treatments and leaving the decision to physicians

OVERALL RISK FOR GILEAD

PHYSICIAN / PATIENT CONSIDERATIONS
- SOF will be the clear favorite of physicians and patients considering its equivalent (or cheaper) total cost, significantly improved SVR, decreased duration, and reduced side effect burden relative to PIs

OVERALL RISK FOR GILEAD

COMPETITIVE CONSIDERATIONS
- An aggressive price strategy for SIM could create some challenges for SOF in some high control accounts, but a low price strategy would be value-destroying for Janssen

OVERALL RISK FOR GILEAD

EXTERNAL CONSIDERATIONS
- As with all prices, advocacy groups will criticize pricing, likely focusing on the product cost without accounting for the total regimen discount
- While a select subset of KOLs will be vocal about their concerns, a change in guidelines is highly unlikely at this price

OVERALL RISK FOR GILEAD

3 YEAR TOTAL REVENUE FOR WAVE 1 ONLY	$4.5B	% DELTA IN PATIENTS FROM JUNE FORECAST	- 4% to -6% PER YEAR

Payer pushback is more likely at $95K, but strict management will remain difficult due to the significantly improved clinical profile

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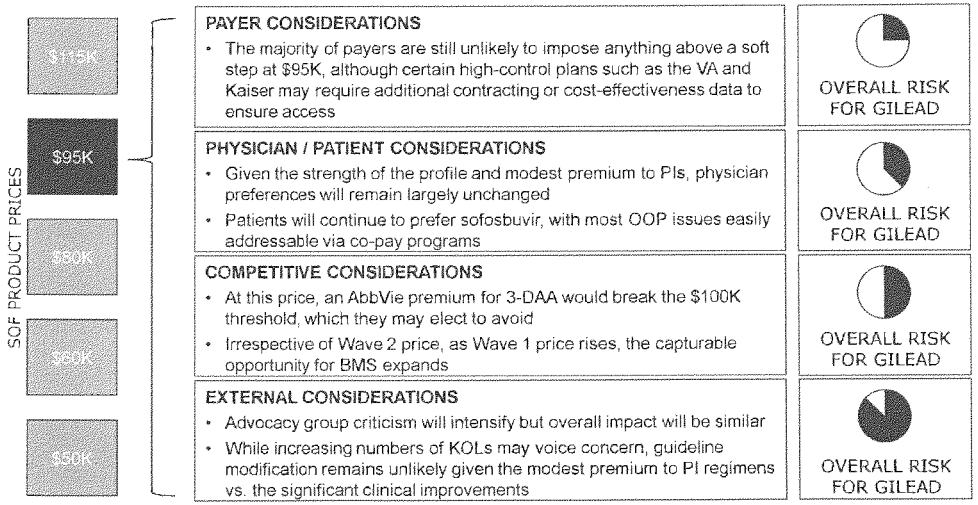

3 YEAR TOTAL REVENUE FOR WAVE 1 ONLY	$4.7B	% DELTA IN PATIENTS FROM JUNE FORECAST	- 14% to -16% PER YEAR

Strict management and guideline restrictions may appear at $115K, with usage in GT-2 and GT-3 presenting a potential target for payers

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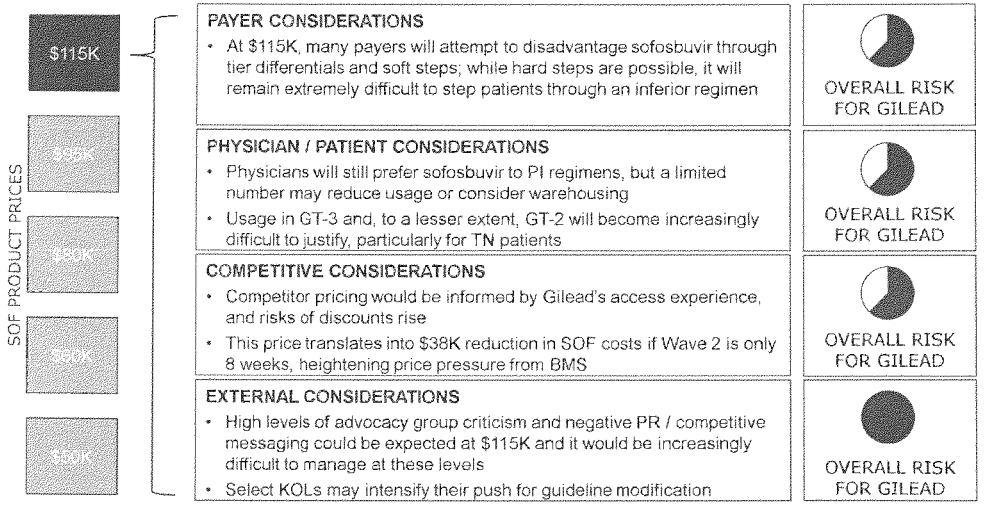

3 YEAR TOTAL REVENUE FOR WAVE 1 ONLY	$5.2B	% DELTA IN PATIENTS FROM JUNE FORECAST	- 20% to -24% PER YEAR

Pricing dynamics vary between waves; Gilead's pricing freedom will be significantly more constrained in Wave 2

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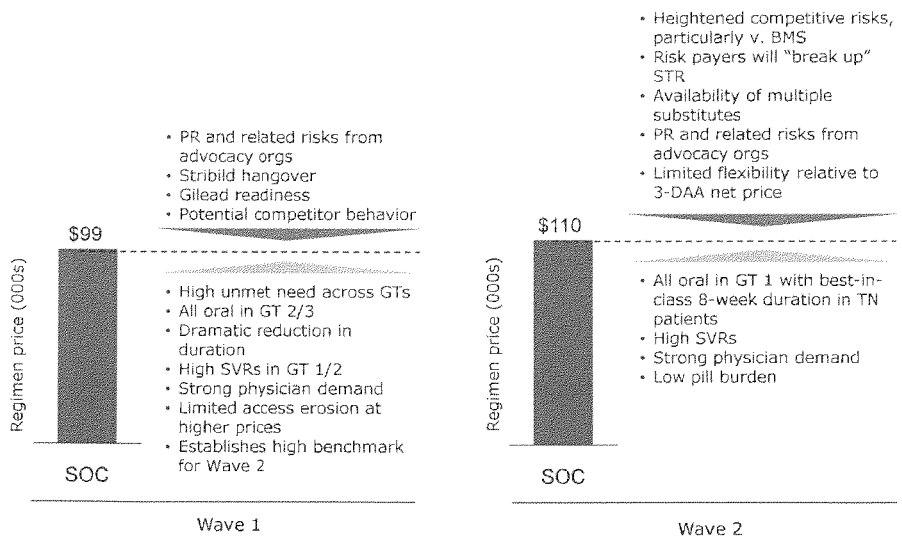
PRICING DRIVERS ACROSS WAVES



Final recommendations

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CONCLUSIONS

1. Gilead has **considerable pricing potential with sofosbuvir in Wave 1** without major access consequences, but the pricing potential for future launches will be constrained by competition
2. Long term sofosbuvir franchise value will be driven by **a high price capture opportunity in Wave 1** and a **volume capture in Wave 2 and beyond**
3. The optimal range for Wave 1 pricing based on revenue / uptake trade-offs is likely $85-$95K, though other softer factors must be considered

WAVE 1 PRICING RECOMMENDATION

1. **Gilead should price sofosbuvir Wave 1 between $80K to $85K per course of therapy** and contract selectively for access at target payers where it is required for access (*after non-contracting strategies are unsuccessful at improving access*)

   Key consideration: The loss in patient starts will be more than offset by increases in revenue at the high end of this range, but softer considerations of advocacy groups and difficult conversations with payers about the price will be pronounced

This price will allow Gilead to capture value for the product without going to a price where the combination of external factors and payer dynamics could hinder patient access to uncomfortable levels

At this price, Gilead can expect a PA to the label, some contracting and a moderate noise level from advocates and vocal KOLs

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WHAT TO EXPECT AT $80-$85K FOR SOFOSBUVIR WAVE 1	
PRIOR AUTHORIZATION	• Sofosbuvir will have a PA to the label, which will mean very limited, if any, access for treatment experienced patients; naives will be accessible
SELECT CONTRACTING	• Gilead will need to contract with the VA, Kaiser, and likely additional plans on the fringes who may restrict sofosbuvir
NOISE LEVEL	• Advocacy groups will be vocal *at any price* and a minority of KOLs may voice concern

CRITICAL ACTIVITIES FOR GILEAD GOING FORWARD	
GET AHEAD OF APPROPRIATE USE	• While restrictions based on fibrosis score are unlikely, Gilead needs to be prepared to answer questions about which patients and why
PAYER VALUE MESSAGES	• It will be critically important to communicate to payers the *clinical* value that SOF creates and to be prepared in advance to answer questions regarding in which patients SOF should be used
PAYER ACCOUNT MANAGEMENT	• Gilead should proactively identify key accounts and develop a plan for messaging to them immediately following launch to ensure access
PAYER EDUCATION	• Ensure that payers understand the population Gilead is aiming to treat and to reinforce that the population is not in the millions, as some believe

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- BACK-UP SLIDES

GSI Confidential
= IFN-free competitor

HCV Competitive Landscape:
2013 – 2017

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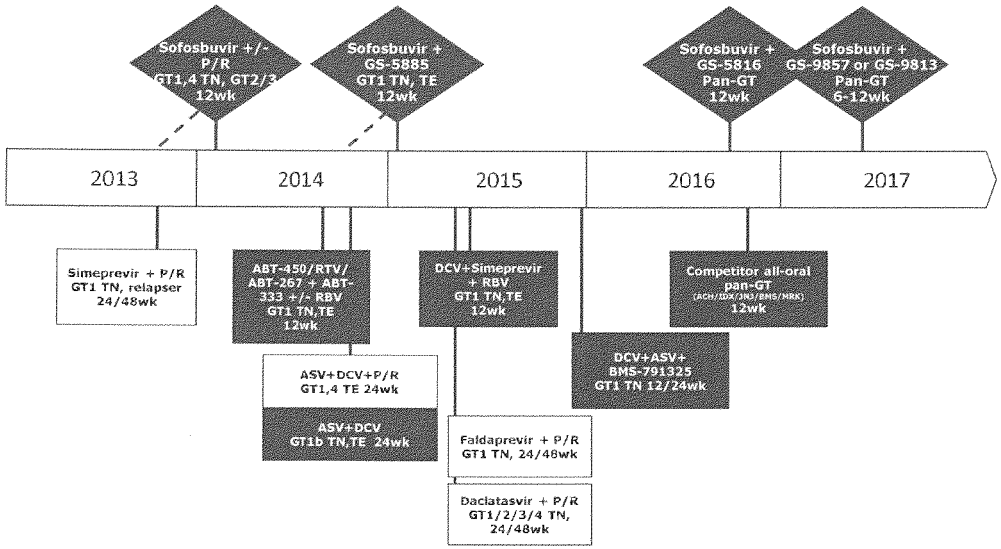

While a possible 8-week SOF+DCV combination would capture a plurality of DCV franchise starts, most volume is in 12-24 week regimens, suggesting BMS will optimize price for that

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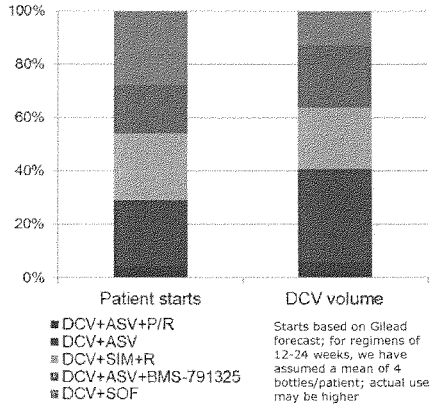
OPTIMIZING DACLATASVIR PRICE

Projected DCV starts and volume, 2014-16*



Starts based on Gilead forecast; for regimens of 12-24 weeks, we have assumed a mean of 4 bottles/patient; actual use may be higher

- The first BMS regimens to launch will be 24 weeks, and both include asuneprevir, a PI viewed as inferior to simeprevir
- Additionally, at launch, DSV+ASV+P/R will be inferior to currently available options on all important dimensions
- This presents BMS with the option of emphasizing data in GT-1b patients, though traction may be limited given duration and PI side effects
- If 12 week data is still the norm they have only a small place to play vs. LDV, but if 8 week data is good they have a strong opportunity to break up our STR

Optimizing price for subsequent 12 week DCV-based regimens necessitates pricing the initial DCV+ASV combinations at a premium to superior regimens and/or effectively pricing ASV at a deep discount to current PIs

Patient Support Programs will ensure there is no gap in coverage and impact from pricing & contracting decisions

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	Commercial % of (Type of costs covered)	Medicare % of (Type of costs covered)	Exchange % of (Type of costs covered)	Uninsured % of (Type of costs covered)	Sensitivity to SOF WAC
Copay Coupon	40% of SOF patients (deductibles, copay, coinsurance	0%	0%	0%	Yes • WAC 60K ~$10m • WAC 80K ~$12m • WAC 100K ~$15m
Foundation **(Based on estimated need & uptake; may vary materially)**	33%[a] (deductibles, copay, coinsurance) [a] Expressed as % of total treated commercial patients	70%[b] (deductibles, copay, coinsurance, "donut hole") [b] Expressed as % of total non-dual, non-LIS treated patients	70% (deductibles, copay, coinsurance)	0%	Yes • WAC 60K ~$100m • Every 10K WAC increase added ~$5m[c] [c] Impact to Medicare patients only; commercial patients could add to this amount
PAP (may include un-insured and under insured)				50% (Free product)	No, expense is COGS, Include 6,000 uninsured patients + 6,000 pre-transplant patients

Exhibit 29

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Gilead HCV US BPOA

October 2012

1289

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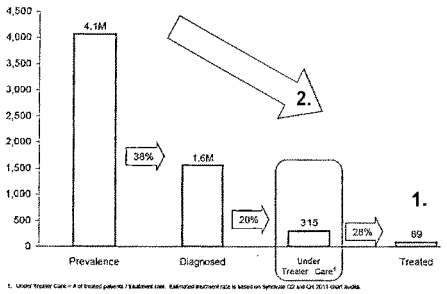
Launch Objectives for Sofosbuvir



1. **Establish SOF Regimen as Standard of Care**
   - All appropriate GT-1 and 2/3 receive sofosbuvir when treated

2. **Sustain Launch Trajectory by Growing Treated Patient Pool**
   - Treated Patients must increase by 73% beginning Nov 2013*

*By Nov 2013, Treater Patient Pool expected to decline to 56K.
Sofosbuvir and simeprivir launch must increase treated pool by 41K patients to be consistent with forecast.

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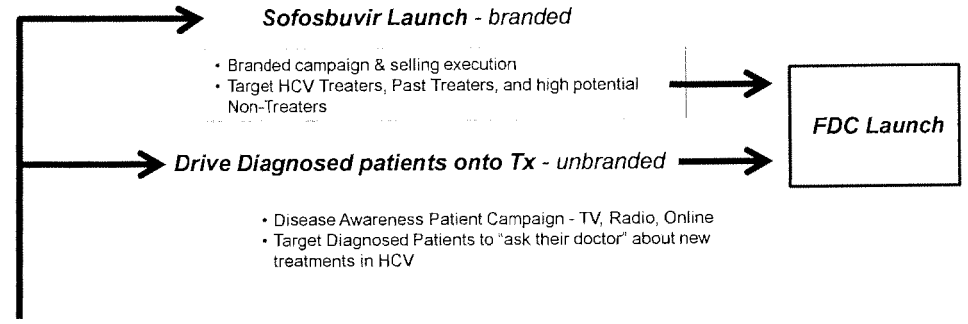
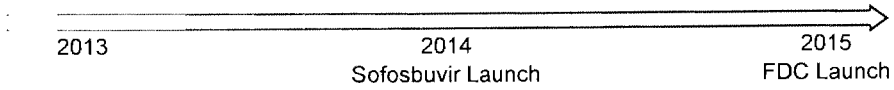
Stages of Promotional Strategy / Emphasis



Prepare Market for Sofosbuvir Launch –
focus on treaters and their patients

- Disease Awareness Pre-Launch campaign - focus on HCV treaters and patients in their care



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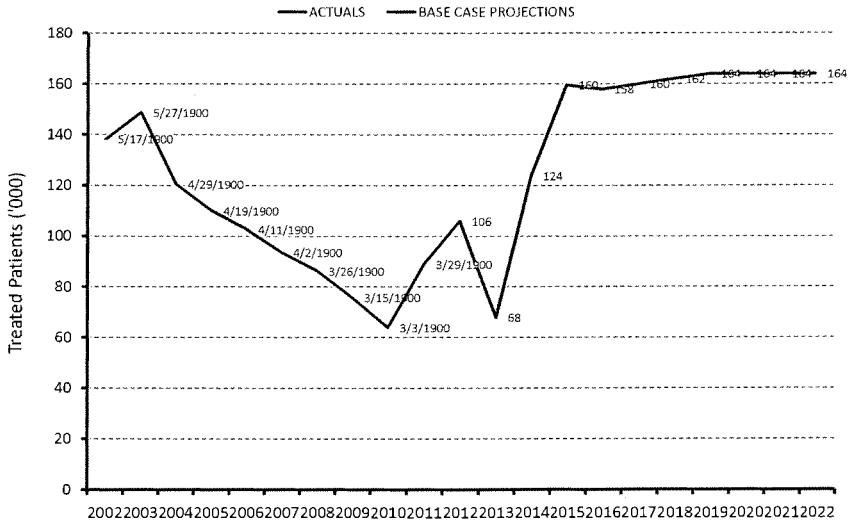
Marketing Efforts Will Need To Drive More Patients Into Care and Increase Referral Rates



[1]Treated patients in a given year include patients who continue therapy from the prior year and those who initiate treatment in the given year
Roche monthly historical IFN sales converted to yearly treated patients by calibrating 2010 IMS TRx's to Gilead's estimate of 64k IFN-treated patients in 2010 (IMS LRx Data)

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Summary of Insights and Implications - Critical Success Factors for Launch

Key Launch Drivers

- Sofosbuvir is differentiated and addresses key unmet needs
  - Willl be adopted as SOC quickly
  - Profile will motivate more patients to get Tx - grow treated population
- Access and advocacy are key to eliminating barriers to get Tx
  - Most notably market access, guidelines, KOL's

Key Launch Barriers

- Need to overcome inertia towards non-treatment
  - For all customer groups, it's easier not to treat
  - From competitor messaging (ABT/BMS)
  - From growing awareness of all-oral regimens
- Need to manage expectations
  - Absence of all oral regimen and treatment experienced indication in GT1

Sofosbuvir Launch Objectives

1. **Establish SOF Regimen as SOC**
   - Rapid uptake of sofosbuvir as the new SOC in all appropriate patients receiving treatment
2. **Grow Treated Patient Pool:**
   - a. **HCV Treaters:** Expand their definition of "treatment candidates" so that they re-engage untreated patients for SOF
   - b. **Past Treaters:** Re-engage with treating HCV or refer patients to treaters
   - c. **Patients:** Approach their HCP's for treatment

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Key Success Factors for Launch Objective (1)
Establish Sofosbuvir Regimen as SOC (Maximize Market Share)

1. **Prepare the Market – *Disease Awareness Pre-launch Campaigns***
   - Inform treaters and their patients about the promise of coming therapies
     - HCP's – in-office / journals / online
     - Patients – in-office
   - Develop KOL champions and other advocates

2. **Prepare for Product promotion**
   - Brand objective
     - Establish SOF as new SOC instead of PI's
     - Expand treatment-eligible patient pool by narrowly defining the GT-1 patient who is treatment experienced or ineligible for 12 weeks IFN
   - Tactical Execution
     - Develop and execute successful brand campaign, messaging, tactics
     - Provide clear field sales direction and strong execution
     - Targeted branded promotion to patients-in-treater-care

3. **Ensure advocacy and access at launch – *No obstacles for SOF***
   - Product access with all payors – incl VA
   - Guidelines
   - Advocacy groups
   - Policy groups
   - Distribution channel / model

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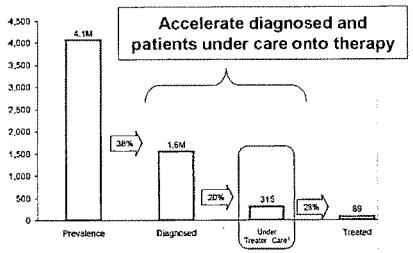
Key Success Factors for Launch Objective (2)
Growing Treated Patient Pool



For Diagnosed Patients:

- Overcome their inertia to sit-and-wait; motivate them to seek treatment
  - Target Behavior: "Ask your doctor"
- Utilize most efficient promotional channels to reach baby boomers
  - TV, radio, internet

For Non-Target Providers:

- Utilize non-personal promo to generate awareness of sofosbuvir as new SOC
- Prepare them for HCV patients coming to their office to request Tx
- Target Behavior: "Treat or Refer"

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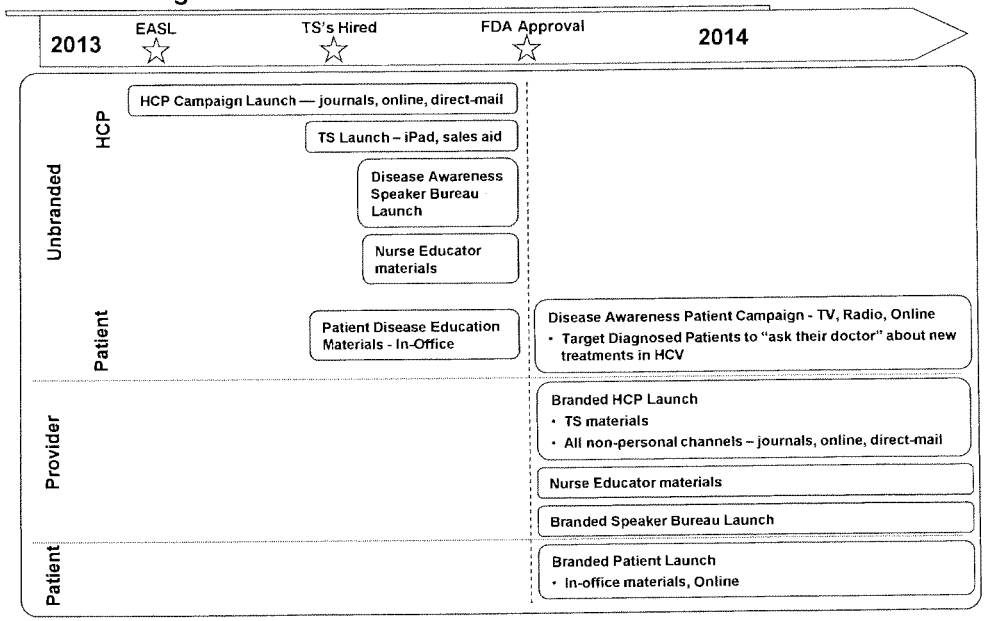
US Promotional Plan
HCV Marketing US Milestones



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HCP Customer Groups - Prioritized Based on Potential

	Priority	Customer Group	Learnings To-Date	Target Behavior Sofosbuvir Launch 2013
Current HCV Treaters	1	***High Value Current PI Treaters***	• Highest volume and most productive Rxers • Most likely to be Hepatologist and/or OL • Most likely to be aware of coming IFN sparing/free • Competitive SOV - called-on by Vertex and Merck	**Treat** • Quickly adopt sofosbuvir as SOC • Re-engage untreated patients in their practice and discuss sofosbuvir with them • Become advocates for sofosbuvir and increasing treatment rates
	2	***Community PI Rxers***	• Vast majority are GI's • Competitive SOV - called-on by Vertex and Merck	
	3	***Only Rx IFN/RBV***	• GI's remain the majority – lower volume; maybe more interested in GI procedures and/or do not want burden of PI's	
Past Treaters	4	***Past treaters – stopped Rxing IFN since April 2011***	• GI remains the majority - perhaps more interested in GI procedures, do not want burden of treating HCV, perhaps not practicing in "high endemic" communities	**Treat or Refer** • Gilead and Sales Force to profile and segment this group – identify reasons they stopped treating and unlock Tx barriers with sofosbuvir • Otherwise, screen / diagnose and refer patients to Treaters
Non-Treaters	5	***Non-treaters***	• Diagnosing/Testing HCV, but not prescribing • More ID and PCP (62%) – fewer are GI (38%) • Some overlap with HIV/HBV	

Source: Source (formerly WKH) Payer Prescriber data historical sales data through April 2012. IMS medical claims data April 2011 – March 2012.
Notes: IFN volume represents the average volume for a 12 month period. Non-treaters were identified through HBV/HIV Rx data and IMS medical claims data.

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Targeting HCP Customer Groups
Past and Non-Treaters will constantly be evaluated based on potential to treat

			Sales Force Target List			HCP Universe (for non-personal promo)		
	Priority	Customer Group	# of target MDs	IFN Volume (12 mos)	# of patients per target	# of MDs in universe - n	IFN volume (12 mos)	# of patients per HCP
Current HCV Treaters	1	*High Value Current PI Treaters*[a]	660 13% NP/PAs	157	26[c]	695	157	26[c]
	2	*Community PI Rxers*	4,452 10% NP/PAs	30	5[c]	5,330	26	4[c]
	3	*Only Rx IFN/RBV*	2,238 9% NP/PAs	14	2[c]	3,882	10	2[c]
Past Treaters	4	*Past treaters – stopped Rxing IFN since April 2011*	1,264	18	3[c]	5,617	10	2[c]
Non-Treaters	5	*Non-treaters*	1,232 (31% HIV/HBV treaters)[d]	N/A	To-Come	128,000[b]	N/A	TBD

Source: Source (formerly WKH) Payer Prescriber data historical sales data through April 2012. IMS medical claims data April 2011 – March 2012.
Notes: IFN volume represents the average volume for a 12 month period. Non-treaters were identified through HBV/HIV Rx data and IMS medical claims data.
[a] Current treaters with the following characteristics: adopted PIs in first 3 months, is D5-D10 and also is an HBV prescriber; assume 95% can be reached due to access restrictions
[b] 128,000 represents the number of HCPs who have either ordered an HCV RNA test, HCV antibody test or have seen a patient with an HCV diagnosis from April'11-Mar'12 found in IMS medical claims
[c] Assumes that a patient on PEG-interferon therapy (with or without DAA) is on for about 6 months per IMS LRx), also assumes that one TRx is equal to one bottle (28-day supply)
d Threshold for HIV/HBV treaters to be included: GE/Hep: >avg. D1 HBV; ID/PCP: >avg D1 HBV & HIV

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Diagnosed Patient Insights and Messages

Insights

- Baby Boomers (age 45-65)
- Average time since diagnosis >14 yrs
- Are content to monitor their disease
  - Slow progressing
  - Asymptomatic
- Awaiting better therapies
  - Aware of undesirable treatment experience with today's treatment options

Messages

- Remind about the seriousness of their condition, even though they have no symptoms
- Inform that new, better, more tolerable treatment is now available
  - Unbranded campaign will achieve our objective of driving patients onto SOF since SOF will quickly be adopted as SOC
- Spokesperson to be considered
  - Credible individual that baby boomers can relate-to (e.g. Sally Field for Boniva)

Target Patient Behavior: Ask their doctor about new treatment for HCV

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TV, Internet, and radio have the highest reach to Boomers

Reach By Media Channels

Age	Television	Newspaper	Radio	Magazines	Internet	Mobile Phone	Tablet
18-34	84.0	21.4	59.7	16.2	74.2	46.0	16.8
35-64	89.1	36.2	63.2	25.6	75.2	24.9	11.4
65+	93.7	61.3	44.1	37.4	64.3	4.8	4.1

20 states capture 75% of Baby Boomer population

Source: TVB Media Comparisons Study 2012. Knowledge Networks Inc. Custom Survey

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Background on Unbranded Patient Campaign - TV and Radio

- Initiate campaign post-approval to drive diagnosed patients onto treatment
  - Need to have these patients start the dialogue with their provider upon launch in order to get on therapy in 12 – 18 months
- Target baby boomers
- Plan for a 30-second public awareness TV ad – no fair balance
- Achieve most efficient reach for media $$ – target cable and local news
  - No primetime; no major network (other than local news), no sports channel

TV	**Younger Boomers (age 40's - 50's)**	**Older Boomers (age 55+)**
Characteristics	Employed Putting children through school	Working fewer hours Semi-retired, Empty nesters
Viewing Habits	Evening 6-8 pm	Daytime 12-4 pm
Examples of TV shows	Pawn Stars, Storage Wars, History Channel, local news	Judge Judy, The Dr's, local news
Examples of cable channels	A&E, TLC, USA, History, E!, TNT	
Projected Cost	$ 12.5 mil for 12 weeks	
Radio		
Listening Habits	Drive Times – morning & late afternoon	
Examples of stations	Target Local Talk, Sports Talk *Not so much music stations nor religious talk (disease ads don't work so well in these formats)*	
Projected Cost	$ 2.25 mil for 12 weeks	

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TV Campaign will be measured closely
Metrics available beginning 12 weeks post launch to assess effectiveness

Performance Criteria	*Metric*
Awareness of Campaign and Message	Ratings points Awareness Tracking for patients and HCP's
Response – seeking more information as a result of TV campaign	Website visits Internet searches Calls to 800#
Action – taking action by visiting HCP	Point of prescribing uptake study Patient Chart Audit

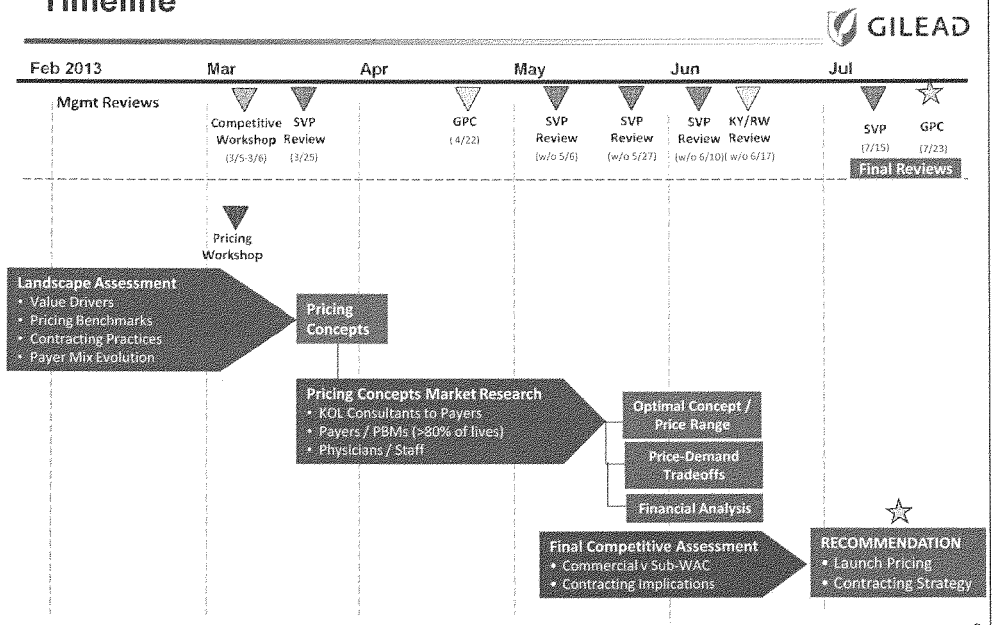
Exhibit 30

Sofosbuvir US Pricing & Contracting Strategy

SVP Briefing

March 25, 2013

Sofosbuvir US Pricing & Contracting Strategy Timeline



Objectives for Today's Meeting

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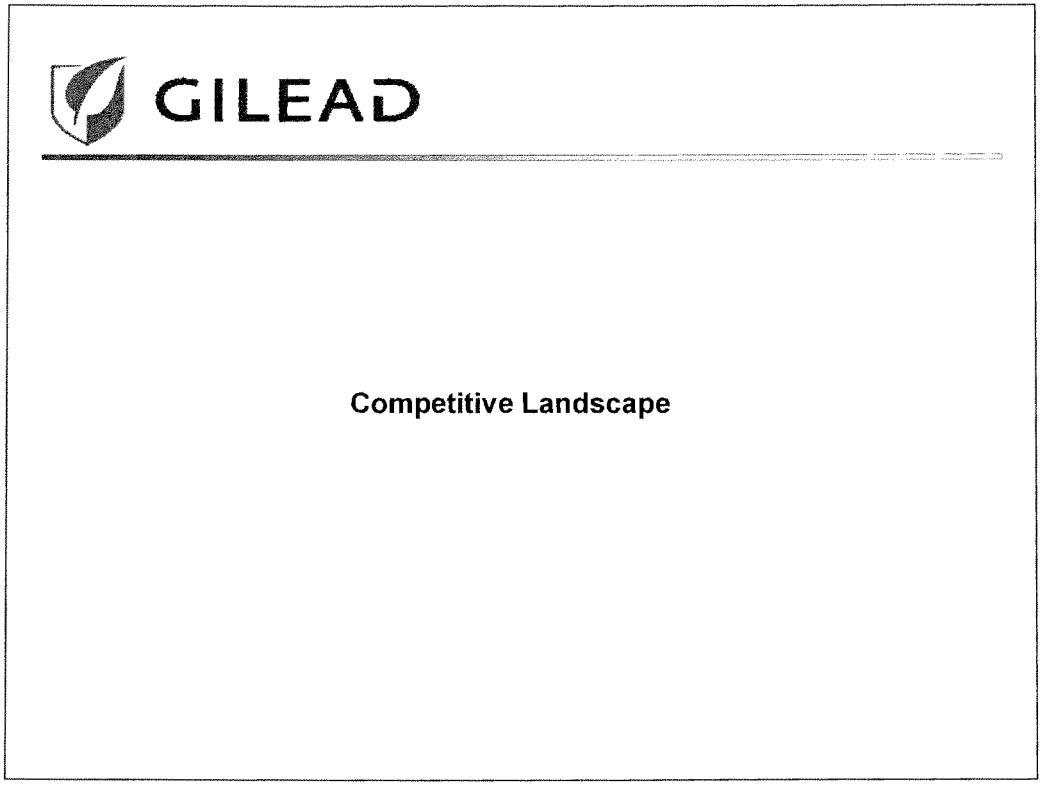
Align on key strategic questions in the context of the market environment into which sofsobuvir will be launching:

- **Competitive Landscape**
- **Economic Landscape**
- **Value 360: Payers, KOLs, Community Physicians, Patients**
- **Pricing & Contracting Concepts**



HCV Competitive Landscape:

2013 - 2017

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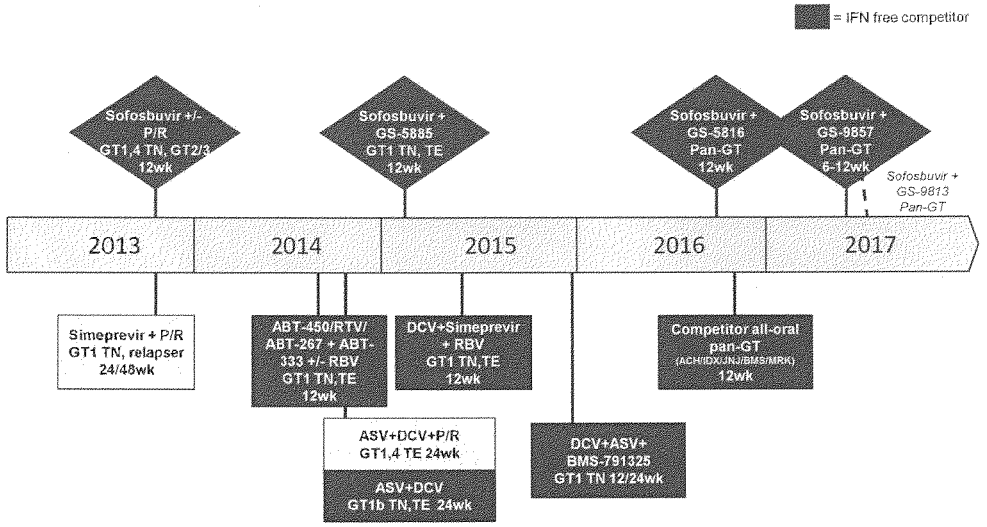

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HCV Competitive Landscape by Genotype:

2013 - 2015

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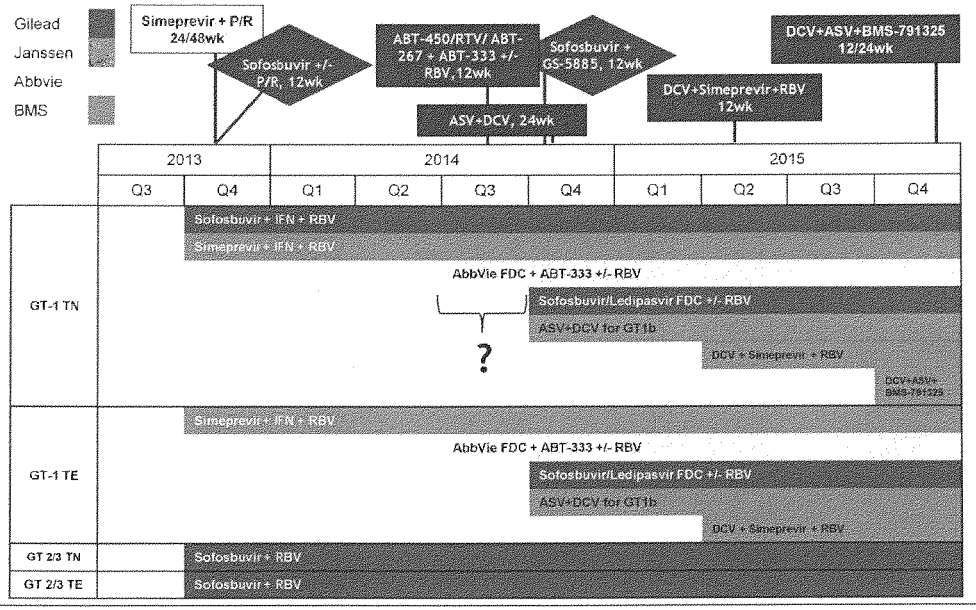

6

Sofosbuvir Positioning

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What does "the new backbone" imply in terms of Pricing?

Sofosbuvir Positioning	
For ...	HCV patients and the physicians who treat them
Sofosbuvir is ...	**The new backbone of therapy**
That ...	Lets HCPs begin to **see every patient as a candidate for a cure**
Because ...	Sofosbuvir **transforms the treatment experience** into a simple, short regimen and delivers consistently high cure rates for all patients without undue burden of treatment.

In view of their clinical profiles, price and/or contracting may be an important competitive differentiator for Simeprivir & AbbVie FDC at launch

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Wave I
Relative Advantages at Launch

Simeprevir + P/R	Sofosbuvir + P/R
First to Launch?	Novel MOA
Best in class PI/familiar MOA	Superior efficacy
Treatment-Experienced Indication	Shorter LOT (non-response guided)
Price? Contracting?	Fewer AEs
	GT 2/3 Indication

Wave II
Relative Advantages at Launch

Abbvie FDC – ABT-333 +/- RBV	Sofosbuvir/GS885 FDC +/- RBV
First all-oral to launch?	Simpler regimen
Highest SVRs?	Fewer AEs
Comprehensive Ph III program in GT 1 (TN, TE, cirrhotics, co-infected)	Less resistance with relapse
Multiple MOAs	No DDI with PI (RTV)
Price? Contracting?	

Competitive Landscape: Key Takeaways

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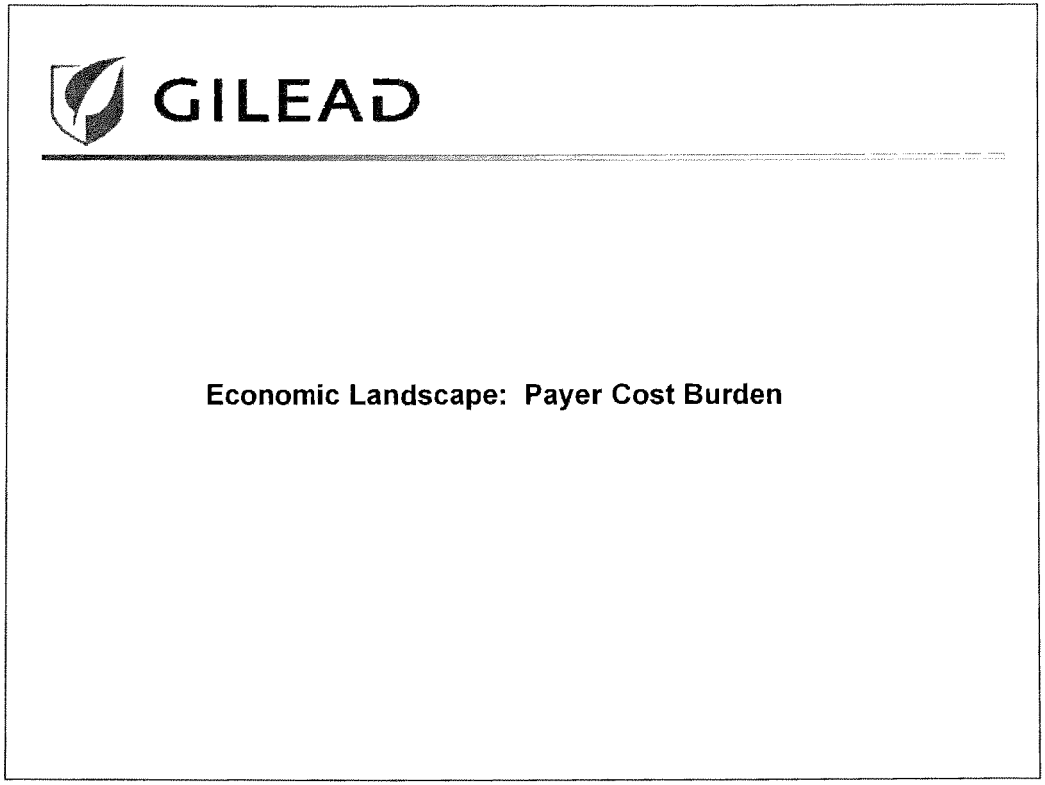
- **Timing of respective launches in both Waves I & II will influence how sofosbuvir price at launch is perceived**
- **SOF clinical strengths relative to simeprivir and SOF/5885 vs AbbVie FDC could lead Janssen and AbbVie to use price as differentiator**
  - However, order of market entry could drive their pricing strategies

Strategic Questions:

- **How much of our FDC value do we want to assign to sofosbuvir?**
- **How much weight should we give to SOF/5885 FDC pricing when evaluating our initial launch price? How about the AbbVie FDC, which could launch while SOF + P/R uptake is accelerating?**
- **What should our assumption be regarding launch timing of Wave I & II products?**
- **To what degree, if at all, should we factor potential order of launch into our pricing & contracting strategy recommendation?**
- **How much weight in our decision will we give to actual or assumed competitive pricing?**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Economic Landscape: Payer Cost Burden

US Sales in First Four Quarters of Launch

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- Incivek's first full four quarters of sales were $1,562M (US)

Fastest New US Product Launches - sales in first full 4 quarters on the market (SOURCE: EvaluatePharma, Nov 3, 2011)							
Rank	Product	Company	Pharma Class	Therapeutic Category	Launch in US	US sales in first 4 quarters ($m)	Inflation Adjusted*
1	Celebrex	Pharmacia	COX-2 inhibitor	Non-steroidal anti-inflammatory	31-Jan-99	1,553	$ 2,114
2	Vioxx	Merck & Co	COX-2 inhibitor	Non-steroidal anti-inflammatory	20-May-99	1,008	$ 1,372
3	Lipitor	Pfizer	Statin	Anti-hyperlipidaemic	28-Jan-97	990	$ 1,406
4	Neulasta	Amgen	Colony stimulating factor	Neutropaenia therapy	15-Apr-02	897	$ 1,135
5	Viagra	Pfizer	PDE5 inhibitor	Erectile dysfunction	06-Apr-98	808	$ 1,130
6	Lucentis	Roche	Anti-VEGF MAb	Macular disorders	30-Jun-06	790	$ 896
7	Atripla	Gilead Sciences	NRTI & NNRTI	HIV anti-viral	19-Jul-06	779	$ 884
8	Avastin	Roche	Anti-VEGF MAb	Anti-neoplastic MAb	26-Feb-04	714	$ 858
9	Nexium	AstraZeneca	Proton pump inhibitor (PPI)	Antacid & anti-ulcerant	19-Mar-01	669	$ 867
10	Lexapro	Forest Laboratories	SSRI	Anti-depressant	05-Sep-02	646	$ 818

* Estimate calculated by Gilead (not provided by Evaluate Pharma)

Peak & Cumulative Spend on Top-ranking Biopharma Products through 2012

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Rank	Product	Peak Year ($B)	Cumulative ($B)
1	Lipitor	$7.8 (2006)	$76.5
2	Plavix	$6.7 (2011)	$44.5
3	Nexium	$3.5 (2006)	$30.3
4	Singulair	$3.5 (2011)	$29.0
5	Enbrel	$3.9 (2012)	$28.8
6	Abilify	$4.0 (2012)	$23.6
7	Neulasta	$3.2 (2012)	$23.5
8	Avastin	$3.1 (2010)	$19.8
9	Copaxone	$2.9 (2012)	$11.0
10	Revlimid	$2.1 (2012)	$8.3

SOF US revenue could peak among the "Top 10"
Current costs per cure, however, would equal ~80-100 patient years on Lipitor

Source: Evaluate Pharma

Express Scripts 2012 data shows HCV to be the #1 specialty class for overall trend increase

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		TREND		
Therapy Class	PMPY Spend	Utilization	Unit Cost	Total
Inflammatory Conditions	$50.62	9.0%	14.0%	23.0%
Multiple Sclerosis	$37.98	0.5%	17.3%	17.8%
Cancer	$31.98	3.4%	22.3%	25.8%
HIV	$20.78	-2.1%	11.1%	9.0%
Hepatitis C	$7.82	28.9%	4.8%	33.7%
Growth Deficiency	$7.41	-1.7%	7.7%	6.5%
Anticoagulant	$6.74	1.7%	0.3%	2.1%
Pulmonary Hypertension	$5.71	5.1%	6.2%	11.3%
Respiratory Conditions	$5.56	1.5%	25.7%	27.2%
Transplant	$4.92	2.2%	-6.9%	-4.7%
Other	$27.68	-24.9%	43.7%	18.8%
Total Specialty	$207.19	-0.4%	18.7%	18.4%

Source: IMS 2013

Based on current Gilead forecast, 2014 US HCV spend projected to be ~$4.7B, over 2X spend seen in 2012 ($2.1B).

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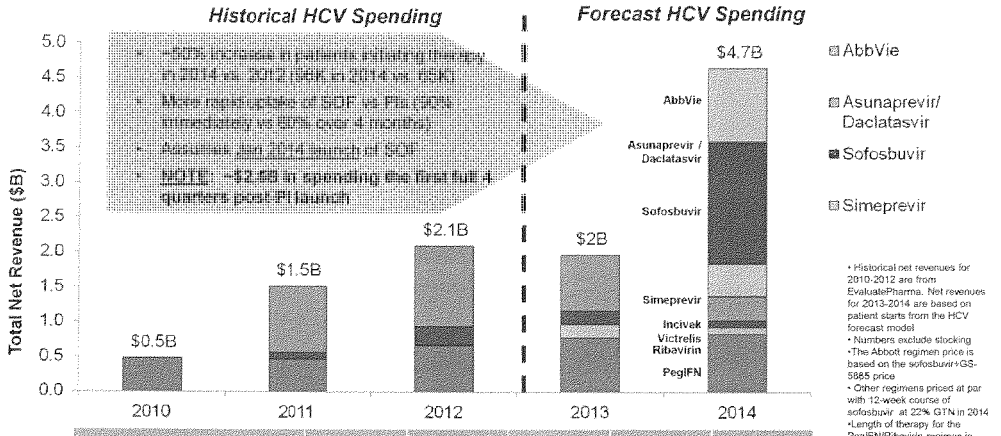

	2010	2011	2012	2013	2014
Total spending change		217%	39%	-6%	136%
Spending per treated patient (K)	$5K	$15K	$20K	$27K	$37K
Per patient spending change		211%	36%	39%	37%
Spending per patient start	$8K	$21K	$32K	$45K	$48K

- Historical net revenues for 2010-2012 are from EvaluatePharma. Net revenues for 2013-2014 are based on patient starts from the HCV forecast model
- Numbers exclude stocking
- The Abbott regimen price is based on the sofosbuvir+GS-5885 price
- Other regimens priced at par with 12-week course of sofosbuvir at 22% GTN in 2014
- Length of therapy for the PegIFN/Ribavirin regimen in 2013 and 2014 is assumed to be 36 weeks. Different lengths of therapy for the PegIFN/Ribavirin component are assumed for each respective new regimen, with averages from 12 weeks to 36 weeks
- Compliance is assumed to be 80% for current regimens and 90% for new regimens

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Economic Landscape: Product / Regimen Pricing

U.S. HCV Pricing

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Product or Regimen	Cost ($)	
Telaprevir (TVR) WAC - 28 days (4 weeks)	18,425	
Boceprevir (BOC) WAC - 28 days (4 weeks)	5,536	
Pegasys (PEG) WAC - 28 days (4 weeks)	2,695	
Generic ribavirin (RBV) WAC - 28 days (4 weeks)	330	
TVR for 12 weeks	55,275	
BOC for 24 weeks (min)	33,218	
BOC for 44 weeks (max)	60,899	
PEG/RBV for 24 weeks	18,148	
PEG/RBV for 48 weeks	36,295	
TVR for 12 weeks + PEG/RBV for 24 weeks (min) – GT-1	73,423	Average: $82,496
TVR for 12 weeks + PEG/RBV for 48 weeks (max) – GT-1	91,570	
BOC for 24 weeks + PEG/RBV for 28 weeks (min) – GT-1	54,390	Average: $75,792
BOC for 44 weeks + PEG/RBV for 48 weeks (max) – GT-1	97,194	
PEG + RBV for 24 weeks - GT-2/3	18,148	

Updated: 03/15/13

From a per patient regimen perspective, PI launches added >$40K of cost to SOC, but the cost per cure...

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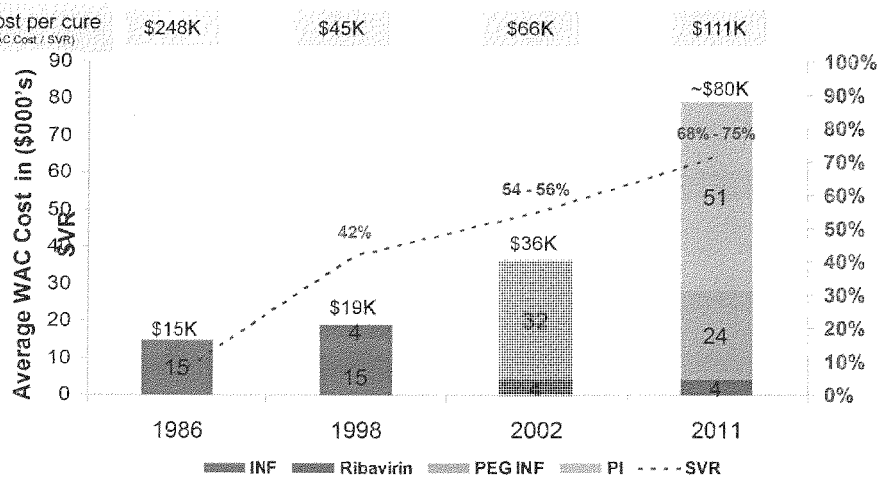

WAC Cost is based on First Data bank March 15, 2013 with average duration and regimen

SVR Adapted from Strader DB, et al. Hepatology 2004;39:1147-71. INCIVEK [PI]. Cambridge, MA: Vertex Pharmaceuticals; 2012. VICTRELIS [PI]. Whitehouse Station, NJ: Merck & Co; 2011.

The addition of PIs added ~200% to cost per regimen, a significant premium to ~30% increase in SVR

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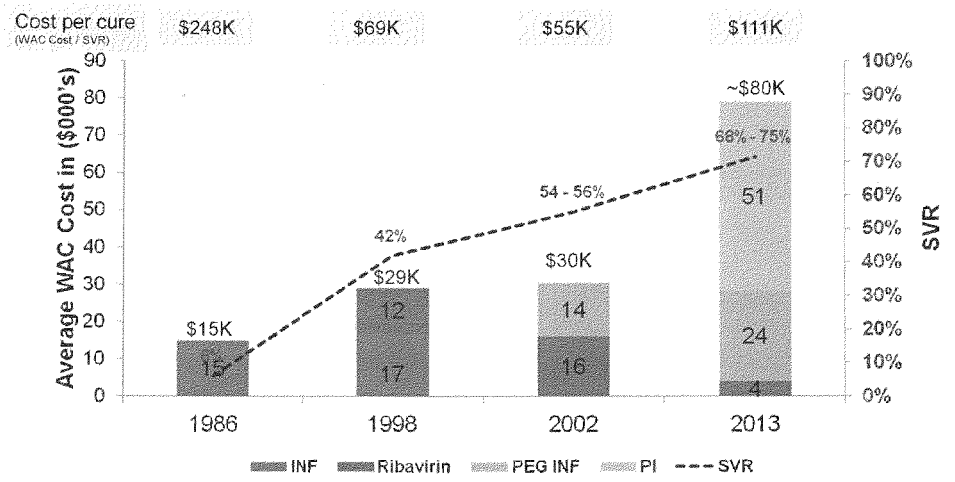

Prior years WACs are based on Analysource May 2012

2013 WAC Cost is based on First Data bank March 15, 2013 with average duration and regimen

SVR Adapted from Strader DB, et al. Hepatology 2004;39:1147-71. INCIVEK [PI]. Cambridge, MA: Vertex Pharmaceuticals; 2012. VICTRELIS [PI]. Whitehouse Station, NJ: Merck & Co; 2011.

Discontinuation rate of regimens containing TVR & BCV could cause payers to exaggerate the "real world" cost per cure for sofosbuvir

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- **Incivek patients appear to be more compliant than Victrelis patients:**
  - Incivek patients fill 10.1 weeks of supply (vs. 12 weeks per label)
  - Victrelis patients fill 16.7 weeks of supply (vs. 24 weeks, shortest duration, per label)
- **Incivek has fewer early discontinuations than Victrelis:**
  - Incivek: ~40% discontinue early
  - Victrelis: ~70% discontinue early
- **Two-thirds (65%) of patients on Incivek and Victrelis refill with no gap in therapy**

Refill Analysis	Incivek	Victrelis
Patient Sample	21.5k	11.5k
Average total supply per patient start	10.1 weeks (12 per label)	16.7 weeks (24 with 4 of PEG/Riba lead-in per label)
% Early discontinuations	38.5% of starts	67.4% of starts
% Refills with no cumulative gap in therapy	65.0%	65.3%
% Refills with > 1 week cumulative gap in therapy	14.1%	17.9%

But if payers conduct comparative effectiveness analyses as intended, this should favorably impact the perceived value of sofosbuvir-based regimens

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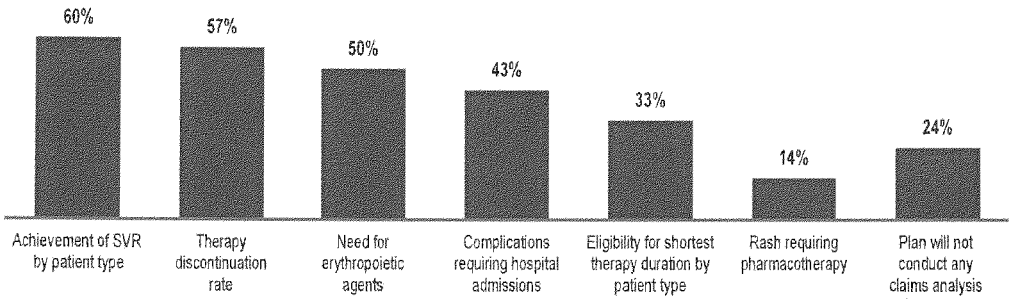
Likely Use of Data Analysis to Evaluate Effectiveness of Protease Inhibitors in the Next 12 Months

(Percentage plans)



Source: Health Strategies Group, Managed Care Complete. November 2012.

n=42

Economic Landscape: Payer Management of HCV Class

Like MS & RA, HCV business is heavily contracted

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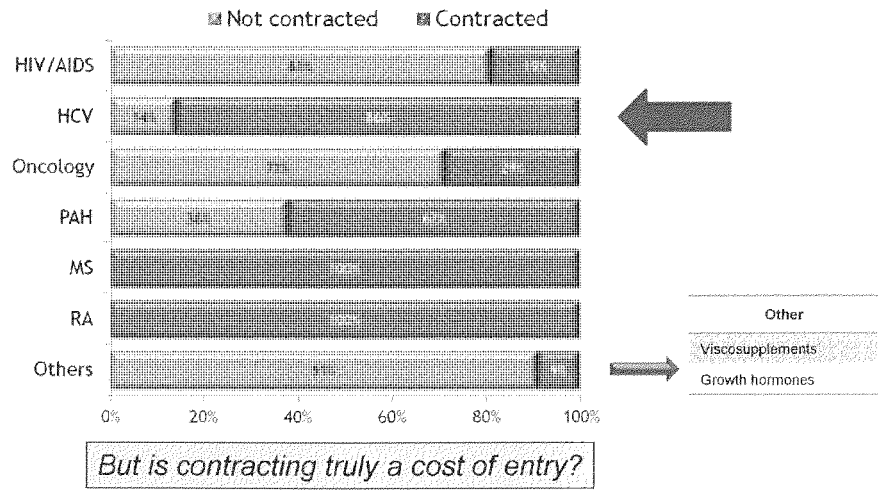
% Lives Contracted By Specialty TAs



But is contracting truly a cost of entry?

22 Source: MME Gilead QUAD Project April 2012 (n=21)

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1325

Over one-third of payers have designated preferred agents in the oral HCV therapeutic class

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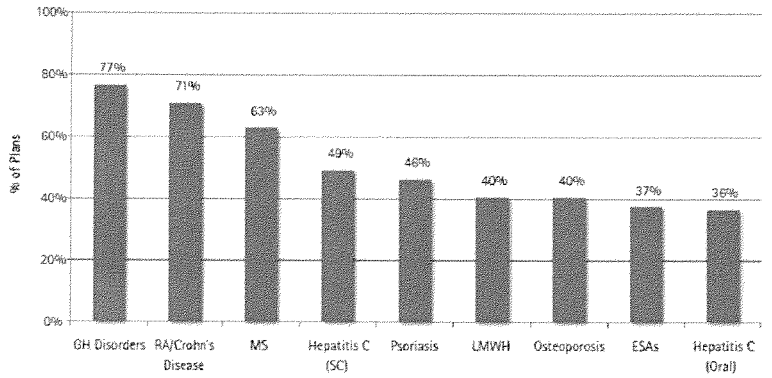
Figure 19. Therapy Categories with Preferred Products Q. Indicate whether you have preferred products in each therapy category.



Source: EMD Serono Specialty Digest, 8th Edition

NOTE: EMD Serono Specialty Digest, 8th Edition contains data gathered in December 2011 on the management of specialty pharmaceuticals by health plans in 2011. Data was collected via online survey from 102 health plans representing over 122 million covered lives

Excluding employer-specified benefits (PBM), prior authorizations are the norm across payer segments and irrespective of agent

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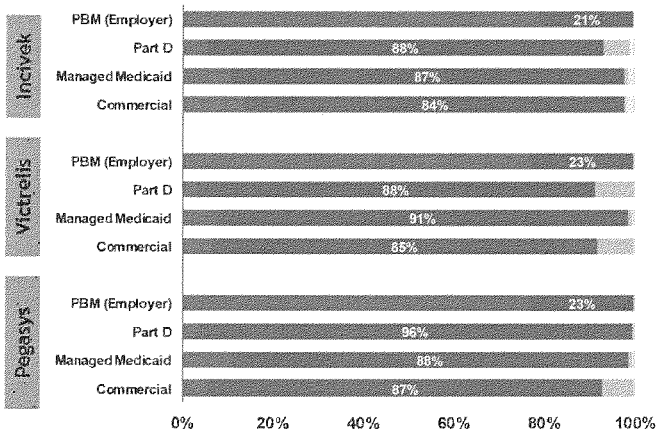
- Main reasons for PA on oral HCV agents: Verification of indication and monitoring response to therapy
- Generally high PA rate compared to other areas

Formulary Restrictions in Percentage of Lives by Segment



* EMD Serono Specialty Digest 8th edition
Source: Pathfinder Pinsonault Data accessed Jan 7, 2013, pharmacy lives represents in Commercial ~115 M, Managed Medicaid ~ 19 M, Part D ~25 M and PBM(Employer) ~54M; RBV is generic and therefore the data is not available

NOTE: EMD Serono Specialty Digest, 8th Edition contains data gathered in December 2011 on the management of specialty pharmaceuticals by health plans in 2011. Data was collected via online survey from 102 health plans representing over 122 million covered lives

Incivek and Victrelis approval rates have improved but have stablized at still relatively low levels

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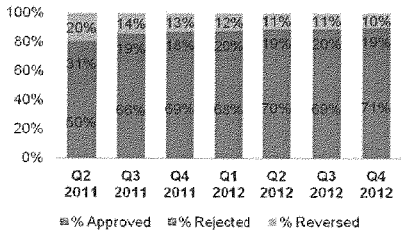
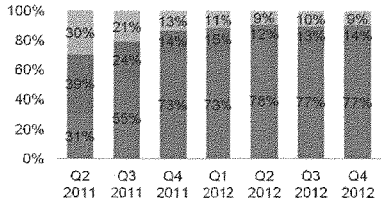
HCV PIs

Incivek

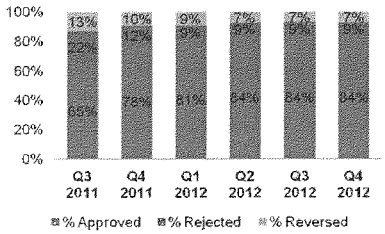


Victrelis

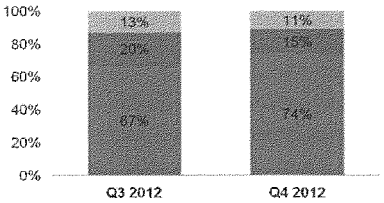


HIV STRs

Complera



Stribild



Source: % Approved % Rejected % Reversed
Incivek and Victrelis: SHA Patient Claims Data Jan 2013 Data Month
Atripla, Complera and Stribild : SHA Dynamic Claims Data Jan 2013 Data month ; Atripla Q4 2012 approved rate = 85% , rejected rate = 8% and reversed rate = 7%

Benefit Design and PAs represented over 60% Incivek and Victrelis Claim Rejections

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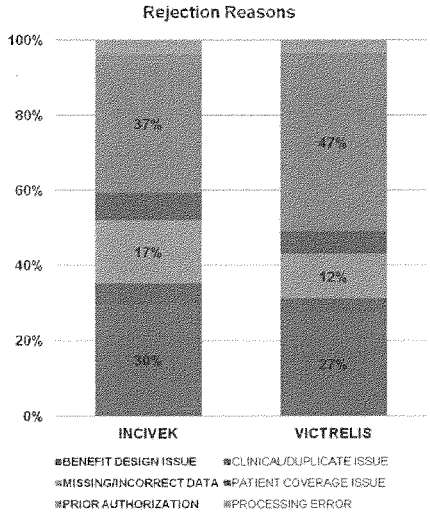
The majority of claim rejections were for the following reasons:

- **Benefit Design Issues** - Plan limitations exceeded, refills not covered, filled after coverage terminated, etc
- **Prior Authorization** – Because PAs are appealable, this does not mean the patient did not get the drug eventually



Source: SHA Health Care Patient Data Jan 2012 - Oct 2012

PI patients pay $50 or less out-of-pocket on more than 80% of claims

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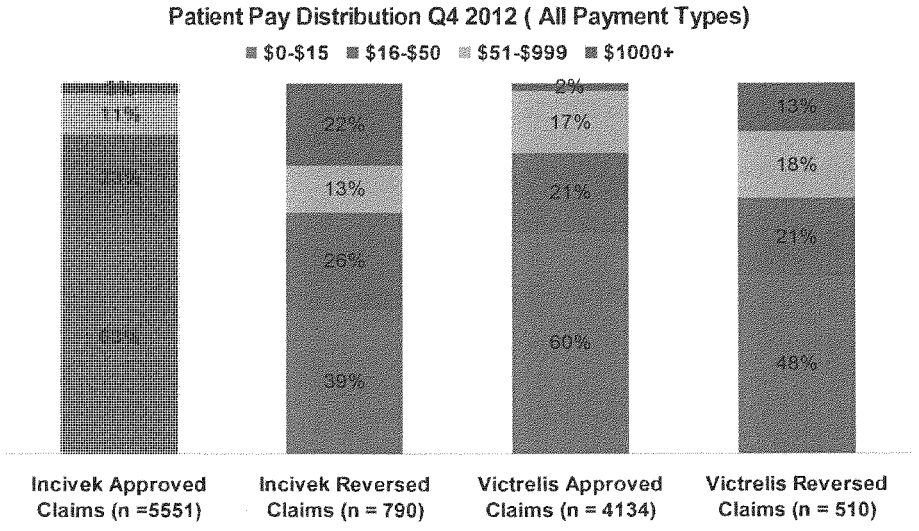

Source: SHA Claims data Patient Pay Report Q4 2012 December 2012 data month

* The estimated Coupon Utilization vs. Commercial Percentage ranged from Victrelis 43% to Incivek 75% based on SHA Claims data Jun 2011 - Sep 2012

1330

Potential Limitations by Payers / SPs on Copay Coupon Utilization?

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Example:

- **Beginning January 1, 2013, pharmacies in UnitedHealthcare's Designated Specialty Pharmacy network will no longer honor manufacturer-sponsored copay/coinsurance assistance coupons for six branded specialty drugs:**
  - Extavia® - Novartis AG
  - Gilenya® - Novartis AG
  - Cellcept® - Roche
  - Humira® - Abbott Laboratories
  - Victrelis® - Merck
  - PegIntron® - Merck
- ***Purpose*: create a financial incentive for members to choose a lower-tier, lower-cost drug alternative (does not apply to preferred Tier)**
- **UHC states that "less than 0.1% of members take an impacted drug"**

Source: Kelly, Cathy. "UnitedHealthcare Program Will Bar Copay Coupons For Six Specialty Drugs." http://consultant.uhc.com/articleView-10051

Economic Landscape: Key Takeaways

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- **Sofosbuvir will likely rank among the largest launches ever (year 1 sales), driving a doubling in payers' HCV class expenditures in 2014**
  - High discontinuation rates for PIs could cause payers to exaggerate
- **Though PIs have been widely contracted, discounts have been relatively small and geared mostly to provide access rather than preferred status**
- **Supported by distribution through SPs, payers can more easily and are actively managing the HCV class**
  - Prior authorizations before starting patients are the norm, leading to relatively high rejection rates
  - Once approved, however, patient cost burden, eased by copay coupon support, is relatively small

Economic Landscape: Strategic Questions

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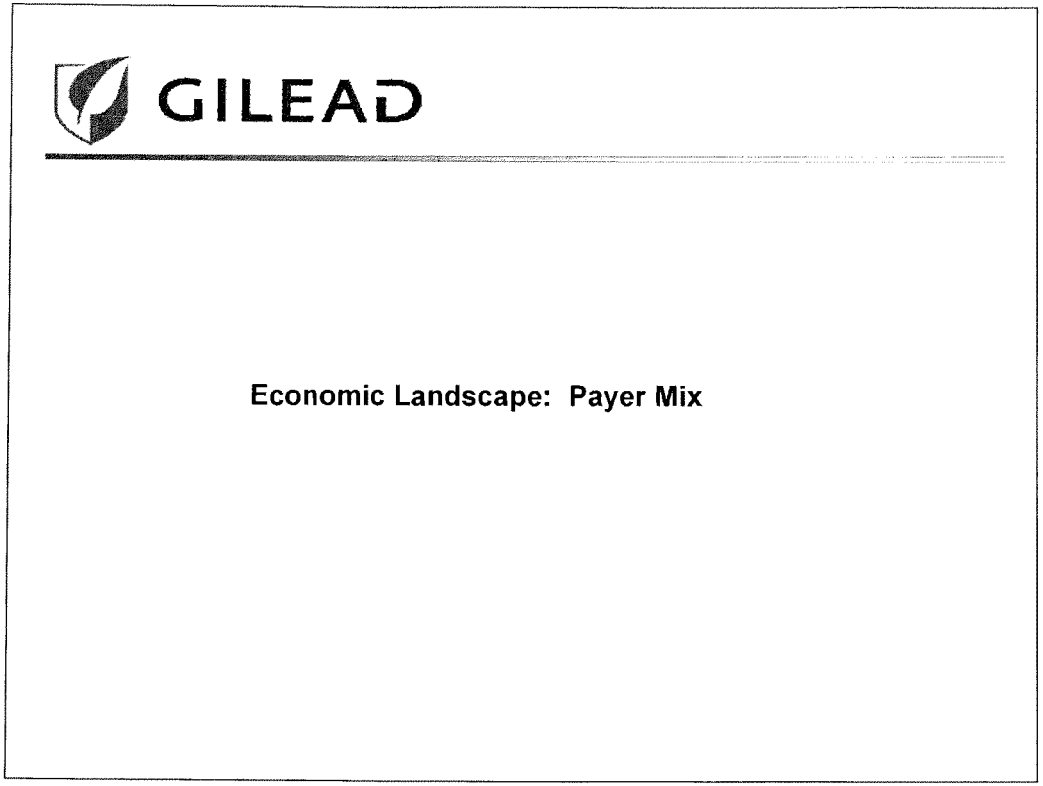
- Do payers anticipate historic increases in HCV expenditures? If so, how do they intend to control them?
- What should Gilead do to assuage payers' concerns?
- Is contracting a cost of entry in HCV? Should we contract from "day one"? Should our contracting strategy be proactive or reactive? Do we think it's going to be a nominal contract?
- Should we make any "guarantees" to create greater predictability of expenditures for payers?



Estimated Incivek and Victrelis Payer Mix in Q4 2012

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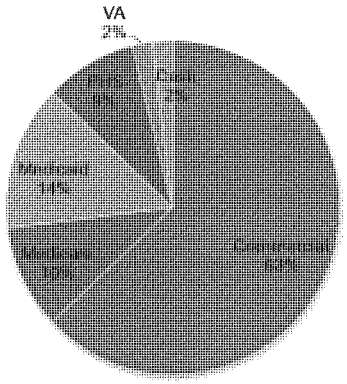
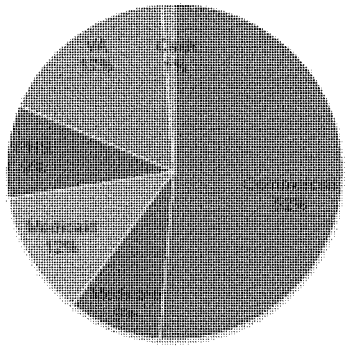
Incivek Payer Mix- Q4 2012



Victrelis Payer Mix- Q4 2012



Source: CMS.gov:
VA PBM Jan - Dec 2012 Utilization Report
Source PHAST Prescription and Institutional Monthly Data (December 2012 data month)

With the majority of claims still paid by commercial payers, PIs enjoy relatively strong G2N at 80 – 85% of WAC

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Approximation

	Average Discounted Price	WAC	Commercial	Medicare	Managed Medicaid & FSS	340 B	VA
Volume Contribution		Avg	66%	10%	14%	9%	10%
TVR +P/R	$69k $46kTVR (12 weeks)	$82.5	TVR 5 - 10% rebate	TVR 5 - 10% rebate	TVR ~25% rebate	TVR ~25% rebate	TVR discount 33%
BOC + P/R	$60k $38k TVR (Avg 36 weeks)	$75.8	BOC 5 - 10% rebate	BOC 5 - 10% rebate	BOC ~25% rebate	BOC ~25% rebate	BOC was 35% and now is 64% discount

Note:
1. Estimated average discounted PI price is the estimated weighted average price for all segments;
2. WAC assumes average cost for different treatment length
3. Medicaid and 340 B discounts do not account for CPI-U penalties. These are the mandatory discounts
4. VA (FSS) information is sourced from McKesson's on-line ordering system.
5. Commercial and Medicare rebates are preliminary internal Gilead estimation

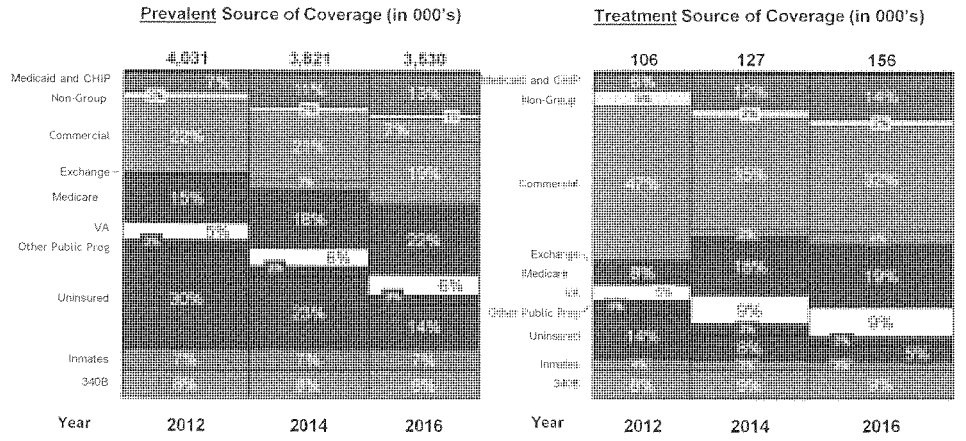
PAYER MIX EVOLUTION: How can Gilead expect its payer mix to evolve in view of ACA & projected demographic trends?

GILEAD

- As ACA is implemented and baby boomers age, the HCV treatment cost burden on public payers could grow substantially
- By the launch of sofosbuvir, the ACA will significantly expand coverage through increased Medicaid eligibility and the creation of exchanges
  - Gilead could thus see the percent of uninsured patients in its payer mix decline substantially
- In addition, the percentage of HCV-infected with public coverage, specifically Medicare and VA, will grow substantially
  - As a result, these sources of coverage could be important targets for policy engagement and contracting
- The number of individuals with other coverage sources, including ESI, non-group, and other public sources will remain relatively stable as a percent, but will decline in absolute size due to declining prevalence rates

Health Reform and Changing Patient Demographics Will Alter Gilead Payer Mix Substantially

GILEAD



Source: Avalere Enrollment Model for HCV Patients. Medicaid Optimistic Scenario
VA= Veterans Affairs
CHIP = Children's Health Insurance Program

Payer Mix Evolution: Key Takeaways & Strategic Question

GILEAD

- **While the advent of ACA will significantly expand coverage for HCV patients, the concurrent aging of the baby boomer cohort—together with ACA-driven Medicaid expansion—could place significant downward pressure on Gilead's ASP**

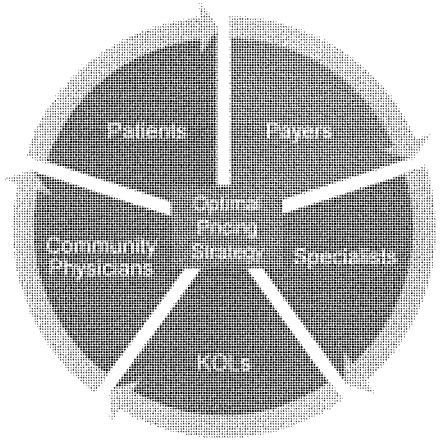
Strategic Questions

- **What are the implications of ACA for pricing and contracting of sofosbuvir at launch?**
  - Should we plan at launch to build into our WAC the fact that ACA and patient aging could place downward pressure on our ASP?
  - Does this mean we need to be more proactive in contracting with government payers?
  - What are the implications in planning for PAP and other support programs? For copay coupon support?

VALUE 360

GILEAD

Payer value perspectives will be balanced with those of other key customer segments in determining optimal pricing and contracting strategy



VALUE 360: Payers

GILEAD

- **Sustained viral response is highly valued but unlikely to drive preferred formulary access alone**
  - Potential benefit of improved SVR will not be valued at any cost
- **A substantial benefit in the total *cost to cure* may be a game-changer for payers evaluating the HCV therapeutic class**
  - While payers plan to offer continued open formulary access, the right formula of SVR, treatment cost, and tangible cost offsets from better safety/tolerability may offer incentive to re-evaluate this approach
- **To leverage improvement in treatment simplicity offered by sofosbuvir, Gilead will need to demonstrate a tangible increase in treatment success over standard of care**
  - Payers recognize that significant improvement in treatment simplicity over standard of care may lead to better treatment compliance and subsequent treatment success. This link needs to be demonstrated with post-market real-world data
- **New data supporting re-treatment of prior failures may lead to future use of strategies to encourage starting patients on lower cost treatments.**

38 SOURCE: Optum

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Payer Value Hierarchy (Optum)

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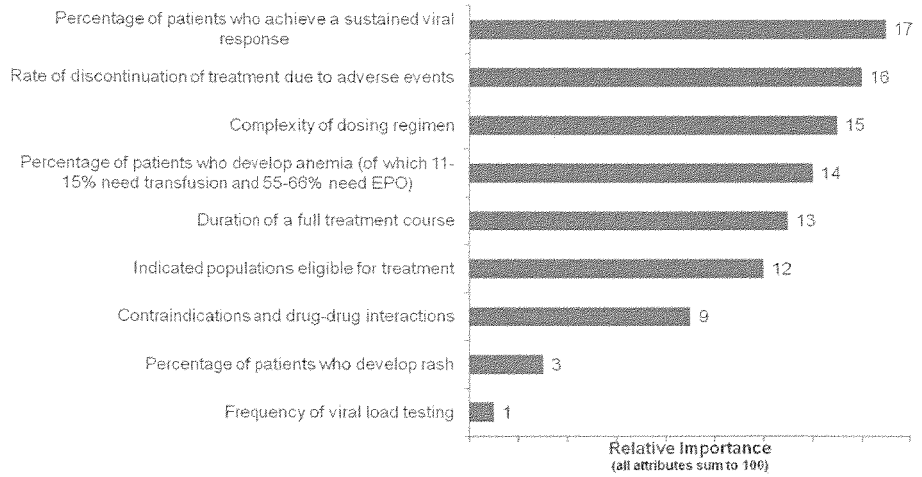
Relative importance of HCV treatment product attributes in formulary decision

(relative importance scores are in proportion to each other. For example, rate of rash is 3 times more important than viral load testing)



Source: Optum Value Corridors, Managed Markets, Q1 2013

Payer attribute importance and attribute ratings are applied to defined r...

	Genotype 1					Genotype 2, 3	
Criteria	Telaprevir / Peg+RBV	Boceprevir / Peg+RBV	Sofosbuvir / Peg+RBV	Simeprivir / Peg+RBV	ABT / RBV	PEG / RBV	Sofosbuvir / RBV
SVR (Naive)	75-79% @ 24wks GT1	63-68% @ 24wks GT1	90% @ 12 wks GT1	80% @ 12 wks GT1	90% @ 12 wks GT1	60-90% @ 24wk 60-70% GT3 80-90% GT2	67-78% @ 12 wks 56-61% GT3 93-97% GT2
Indicated Populations	Treatment Naive Prior Relapsers Prior Partial/Null Resp.	Treatment Naive Prior Relapsers Prior Partial/Null Resp.	Treatment Naive	Treatment Naive Prior Relaspers	Treatment Naive	Treatment Naive Treatment Experienced	Treatment Naive Treatment Experienced IFN-Intolerant, Ineligible
Duration of treatment	24-48 Weeks RGT (GT 1)	4 Wks PR Lead In 24-44 Wks RGT (GT 1)	12 Wks (GT 1,4,5,6)	24-48 Wks RGT (GT1)	12 Wks (GT1)	24 Wks (GT 2-3) 48 Wks (GT 4,5,6)	12 Wks (GT 2,3)
Dosing regimen	Weekly SQ PEG 3 Pills, BID RBV 2 Pills, TID TVR	Weekly SQ PEG 3 Pills, BID RBV 3 Pills, TID BOC	Weekly SQ PEG 3 Pills, BID RBV 1 Pill, QD Drug 1	Weekly SQ PEG 3 Pills, BID RBV 1 Pill, QD Drug 2	3 Pills, BID RBV 1 Pill, BID Drug 3 2 Pills, QD Drug 4	Weekly SQ PEG 3 Pills, BID RBV	3 Pills, BID RBV 1 Pill, QD Drug 5
Viral Load Testing	Week 4, 12, 24 RGT	Week 8, 12, 24 RGT	Week 12	Week 4, 12 RGT	Week 12	None	Week 12
DC due to AEs	10% (clinical) Up to 27% (post-marketing)	12% (clinical) Up to 8% (post-marketing)	2%	5%	1%	9%	1-4%
Anemia (11-15% need transfusion and 55-66% need EPO)	38% (clinical) Up to 60% (post-marketing)	48% (clinical) Up to 60% (post-marketing)	9%	30%	1%	24%	1%
Rash	56% (4% severe requiring hospitalization clinical; 7-9% severe rash post marketing)	16-17% (clinical) 0% (post-marketing)	0%	30%	0%	6-34%	0%
Contra-indications	Pregnancy Liver disease Hemoglobinopathies Coadmin with drugs dependent on CYP3A4/5 clearance	Pregnancy Liver disease Hemoglobinopathies Coadmin with drugs dependent on CYP3A clearance Ritonavir-based regimens	Pregnancy Liver disease Hemoglobinopathies	Pregnancy Liver disease Hemoglobinopathies	Pregnancy Coadmin with drugs dependent on CYP3A clearance HIV co-infection	Pregnancy Liver disease Hemoglobinopathies	Pregnancy
WAC cost per course	$73,043 to $90,810	$50,954 to $75,836	NA	NA	NA	$35,157	NA
WAC cost per week	$5,347	$2,000	NA	NA	NA	$732	NA

40 Source: Optum Value Corridors, Managed Markets, Q1 2013

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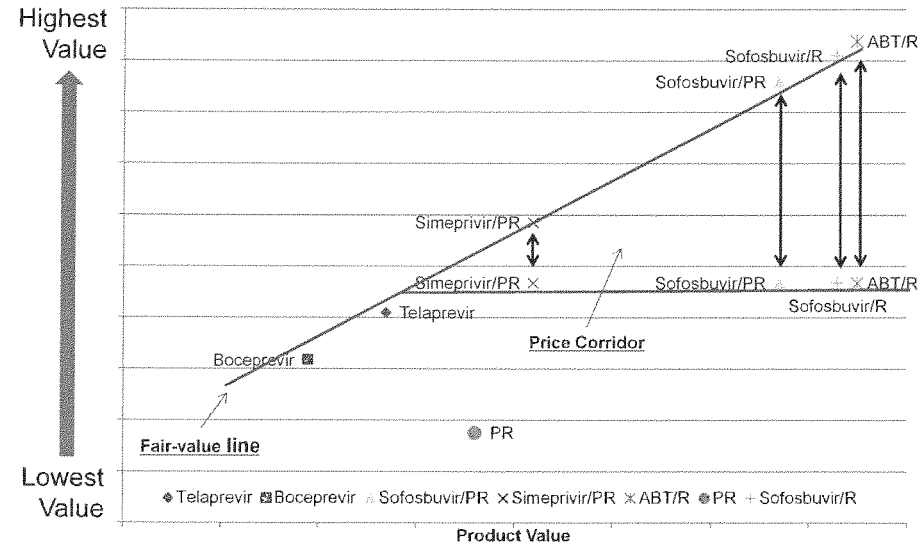
SOF + P/R profile commands a significant value premium to simeprivir, which all-oral AbbVie FDC could eclipse depending on launch timing relative to SOF/5885



41 Source: Optum Value Corridors, Managed Markets, Q1 2013

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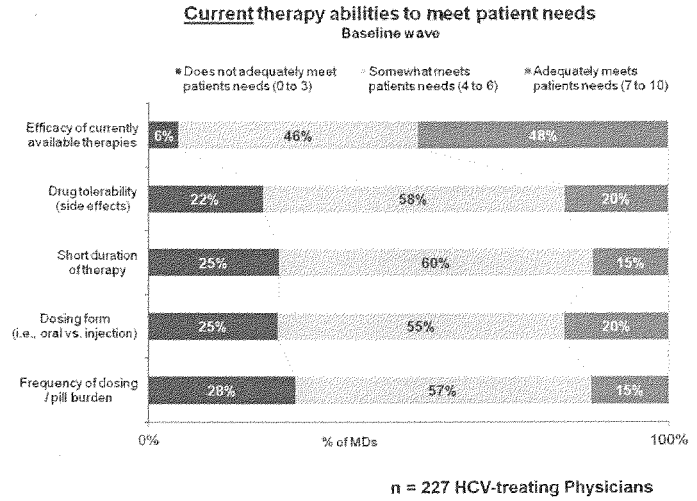
Current therapies fail adequately to meet the needs of physicians; efficacy perception is better than tolerability and dosing



Source: HCV Pre-Launch Tracker, Marketing Sciences, Q4 2012

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Pricing Concepts

Pricing Framework: How will payers assess the price : value relationship for sofosbuvir?

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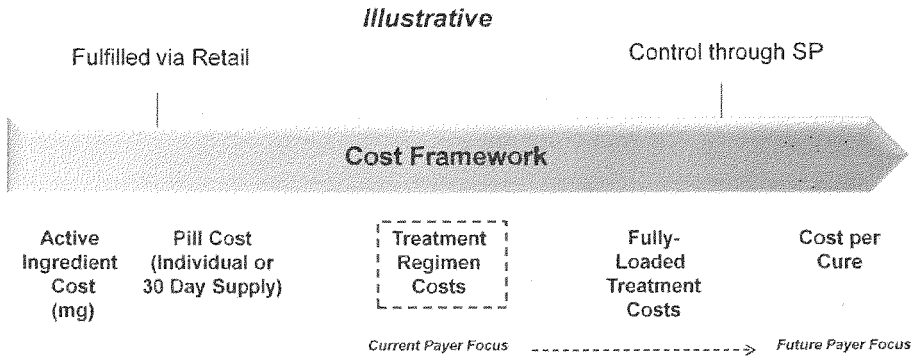

How will payers determine value on this basis as they gain experience and more treatments enter the market?

Pricing Concept

Nominal Approaches

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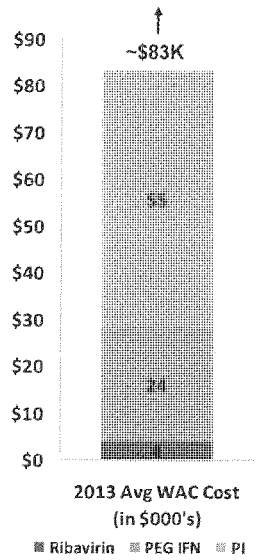

Illustration

Nominal approaches build directly on current HCV prices and regimens

- Sofosbuvir "baseline" price at PI price level
- Sofosbuvir at premium to PI price level

Sofosbuvir value premium

- Increased efficacy (higher SVR%)
- Increased tolerability
- Shorter treatment duration
- Ultimately part of an all-oral regimen

WAC Cost is based on First Data bank March 15, 2013 with average duration and regimen

Pricing Concept

Premium Based on Explicit Savings from P/R Duration

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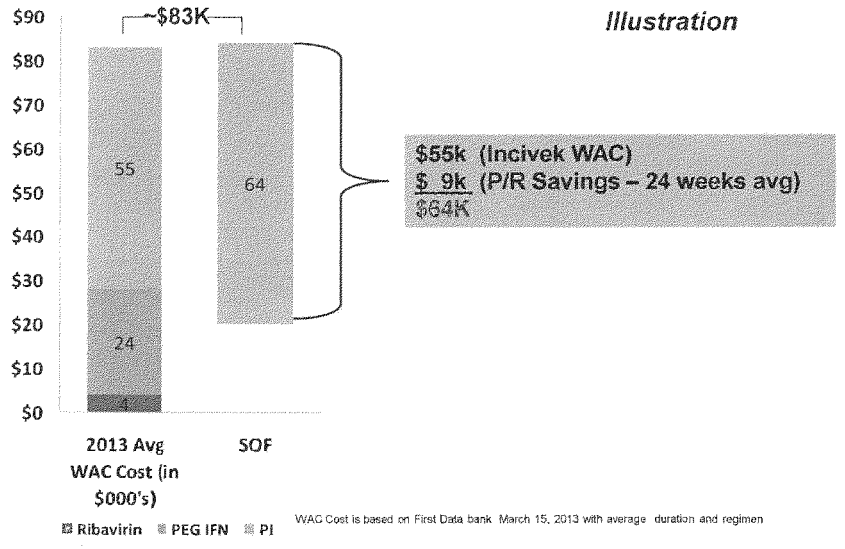


Illustration

$55k (Incivek WAC)
$ 9k (P/R Savings – 24 weeks avg)
$64K

WAC Cost is based on First Data bank March 15, 2013 with average duration and regimen

Pricing Concept

Price per Cure – Equal to Current SOC (GT1)

GILEAD

Illustration

	Cost per cure	SVR*	WAC
TVR regimen (wt-average qualifying patient duration)	$103 k	79%	$81 k
II			
SOF-based Regimen (12 wks)	$103 k	89%	$91 k (-$9,000 12 wks P/R)
SOF (12 wks)			$ 82 k

*SVR based on the highest seen phase 3
WAC source: First Data Bank as of March 15, 2013

Pricing Concept

Price per "Real World" Cure – Equal to Current SOC (GT1)

GILEAD

Illustration

	Cost per "Real-world Cure"	SVR	Real World Cure Rate*	WAC
TVR regimen (wt-average Qualifying Patient duration)	$162 k	79%	50%	$81 k
II				
SOF-based regimen (12 wks)	$162 k	89%	80%	$130 k (-$9,000 12 wks P/R)
Sofosbuvir (12 wks)				$121 k

*"Real-world cure rate would discount SVR% for discontinuations observed in the market. Assumption:
- TVR: 38% (per Gilead analysis)
- SOF: 10% (Gilead forecast assumption)

WAC source: First Data Bank as of March 15, 2013

Pricing Concept

Blended Price across Patient Types Example

GILEAD

Illustration

	Genotype 1	Genotype 2	Genotype 3
% of Diagnosed Patients	70%	20%	10%
% SVR	89%	87%	56%
Cost (assums $90K) per Cure	$101 K	$93K	$161K
Blended Price by Genotype		$105 K	

Pricing Concept

Pay for cure concept example ("Money-back guarantee")

GILEAD

Illustration

	Genotype 1	Genotype 2	Genotype 3
% of Diagnosed Patients	70%	20%	10%
% "Cured"*	89%	97%	56%
% Failure	11%	3%	44%
Weighted % of Failure = Rebate		**12.7%**	

Conceptually, it may be possible to guarantee a cure rate across an HCV population and not impact Medicaid best price

Strategic Questions

GILEAD

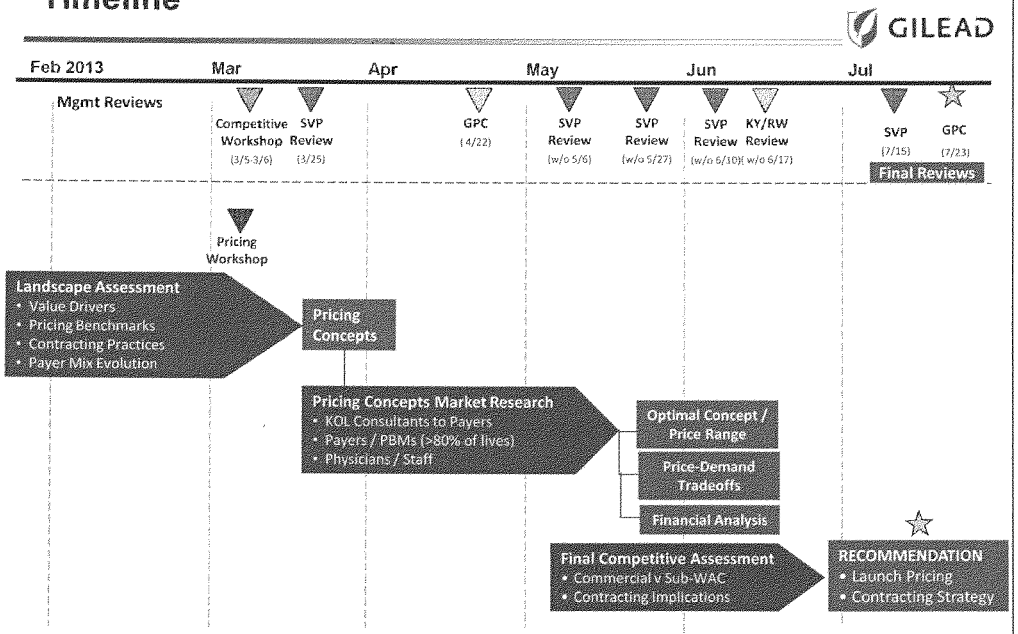
- **Is our objective to maximize revenue or volume/share?**
- **What nominal price range for sofosbuvir should we consider? Are today's PIs a valid reference point?**
- **How should we think about articulating sofosbuvir's price—in terms of price per cure? Other more or less sophisticated metrics?**
- **How can we best manage value perceptions of sofosbuvir for those patient groups for which SVR% is lower? Should we evaluate strategies that offer guarantees, e.g., price-per-cure, blended pricing maximum across genotypes?**
- **At what price does it become reasonable for a payer to force current therapy first line?**
  - To what extent might payers view current DAA therapy as a substitute for SOF-based therapies?
  - Could they convince themselves and patients that PI + P/R should be used ahead of SOF-based therapies?

Strategic Questions (continued)

GILEAD

- How should the fact that the vast majority of volume (~70% at present) will flow through specialty pharmacies, which have superior patient data capture, influence our pricing and contracting strategy, if at all?

Sofosbuvir US Pricing & Contracting Strategy Timeline



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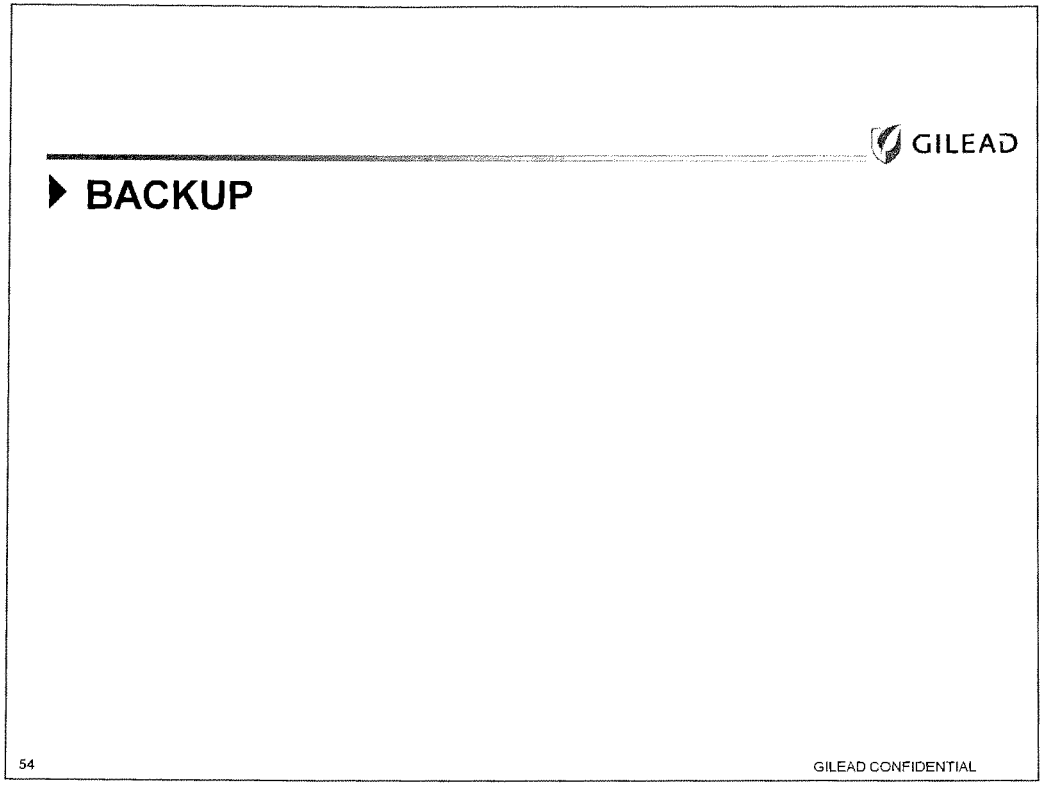
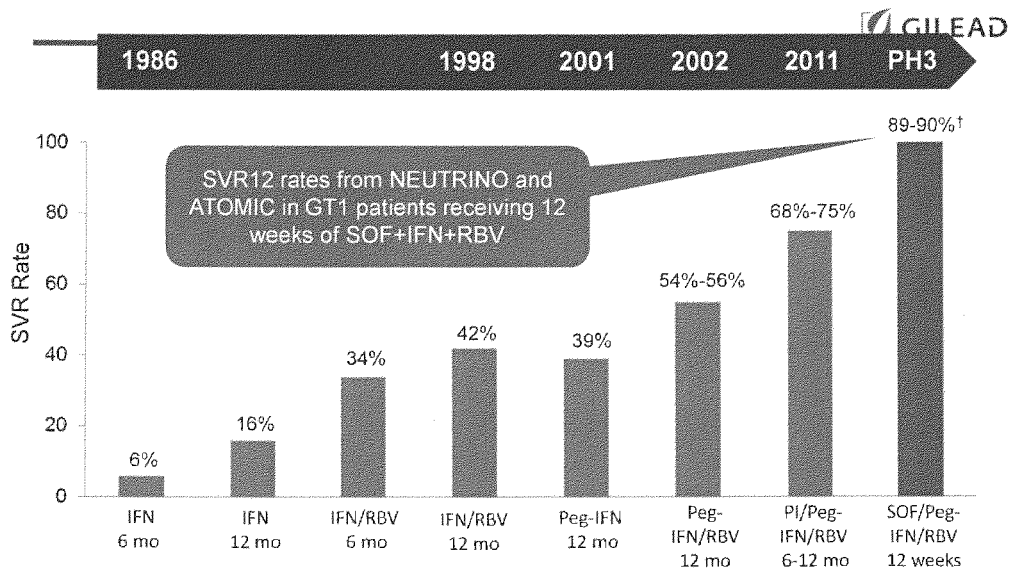


SVR Rates in Patients With Genotype 1 HCV



*SVR12 rate from patients in group A of the Phase 2 ATOMIC trial. Group A was treated with 12 weeks of SOF+Peg-IFN+RBV.
† SVR rate from patients in the Phase 3 ATOMIC and NEUTRINO trial treated with SOF+Peg-IFN+RBV at the end of 12 weeks of treatment.

Adapted from Strader DB, et al. Hepatology 2004;39:1147-71. INCIVEK [PI]. Cambridge, MA: Vertex Pharmaceuticals; 2012. VICTRELIS [PI]. Whitehouse Station, NJ: Merck & Co; 2011.

10

VALUE 360: Ad Board Findings

[redacted]	[redacted]	[redacted]	[redacted]

• Opinions and practices vary greatly
  - Some are going to aggressively utilize a SOF based regimen at approval
  - Others may wait for clinical registries
• This variation of SOF may be driven by data in special populations like cirrhotic, co-infection and transplant where patients have a more immediate need for treatment
	• Affected to a greater degree by the difficulty in managing HCV patients with complex drug regimens
	• Patients that were most receptive to future therapies leveraged the ease of use (safety, tolerability and dosing)
	  - There is generally less treatment failure within this audience and they tend to be more aggressive treating patients with less fibrosis
		• Most heavily influenced by ease of administration and tolerability
		• Tend to have a fair degree of autonomy but their treatment management preferences and style typically model that of their supervising physician
		• The group seems most impressed with the SOF data as it compares to the current SOC
			• Tend to be more aggressive in treating patients with middle degrees of fibrosis
			• However, they are much more likely to co-manage or refer a patient that has cirrhosis or substance consideration that complicates the general management of these patients beyond what they are used to
			• Many of the KOLs that are currently treating HCV have most of their experience in managing HCV through clinical trials, it is not fully known how they will embrace management of HCV once it is routinely managed in their clinical practice

Pricing Concept
Price per Cure

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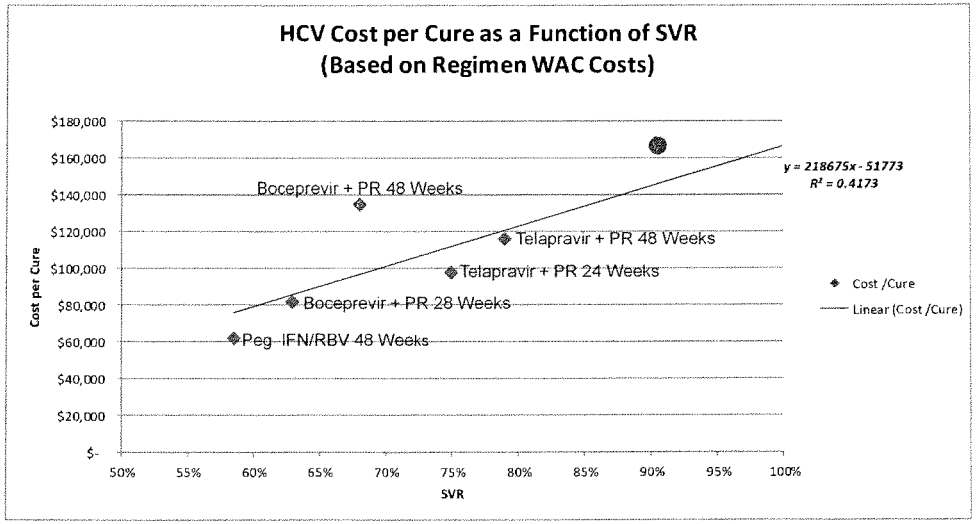

Source?

Exhibit 31

U.S. HCV Launch Update

Jim Meyers
SVP, North America Commercial Operations

Board of Directors Meeting
August 1, 2013

Agenda

- **HCV Marketplace Dynamics**
- **Commercial Operations Readiness**
- **Pricing and Access**

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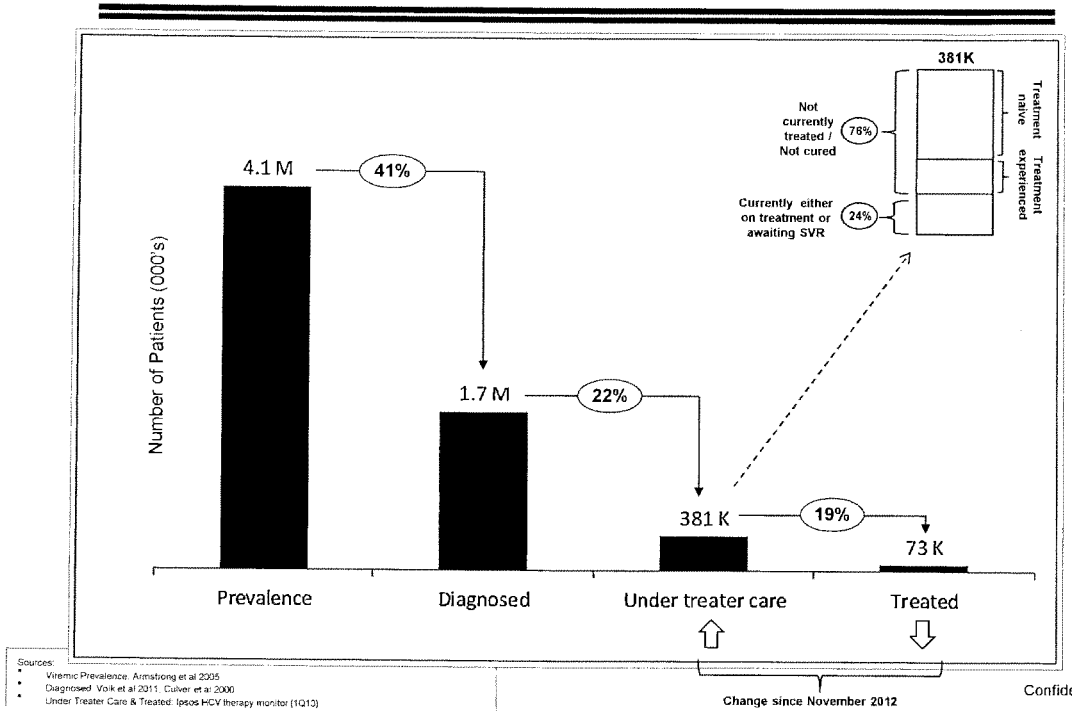
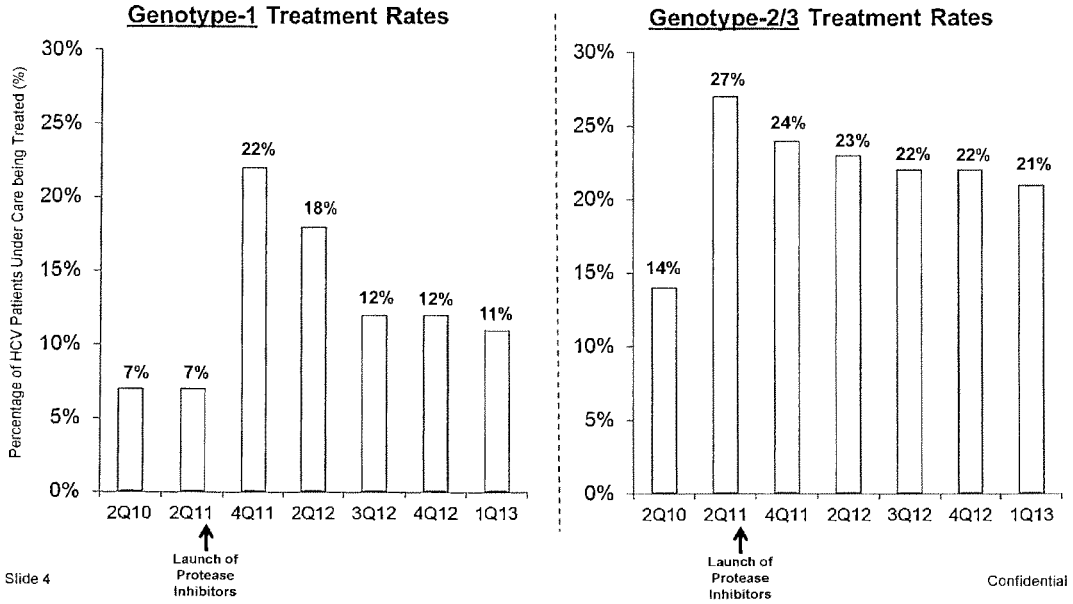
U.S. HCV Market – 1H13



Sources:
- Viremic Prevalence: Armstrong et al 2006
- Diagnosed: Volk et al 2011, Culver et al 2006
- Under Treater Care & Treated: Ipsos HCV therapy monitor (1Q13)

Confidential

Decline from Peak in Treatment Rates More Pronounced for GT-1 Patients

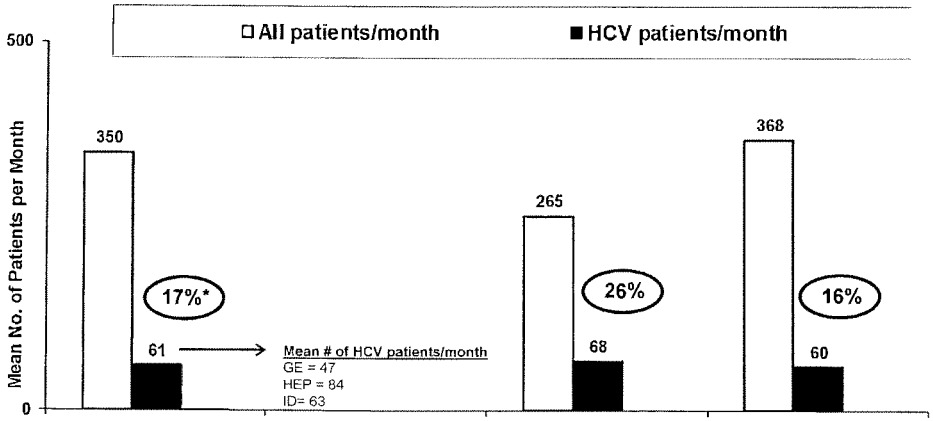


Slide 4

Confidential

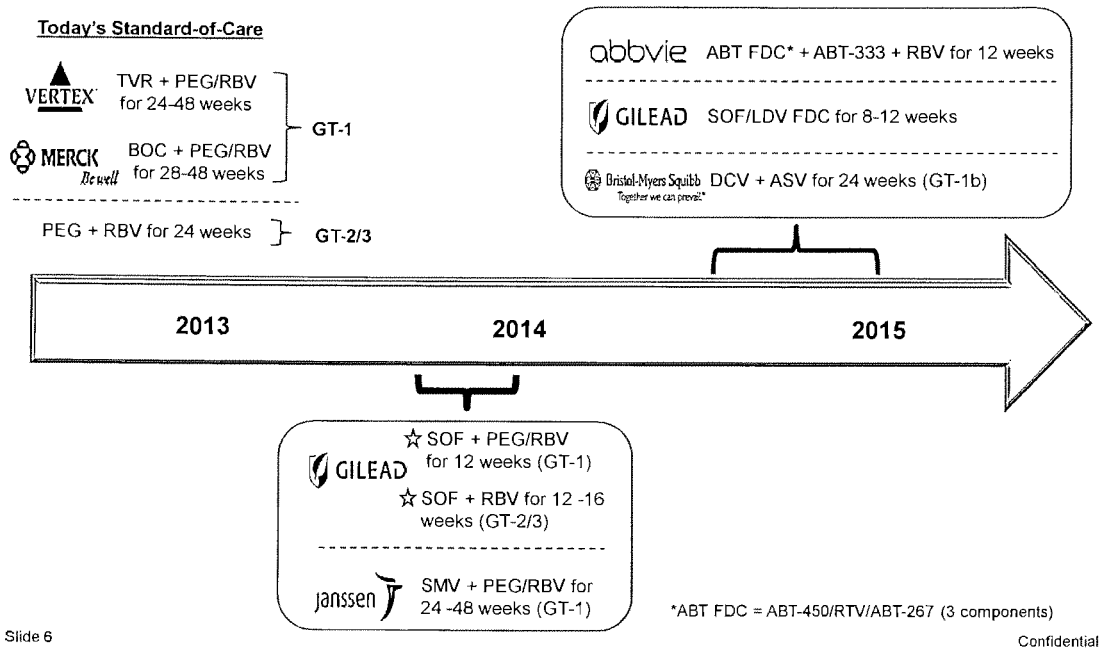
HCV-Infected Patients Account for only ~17% of the Patient Volume of HCV Treaters

- Awareness of new therapies, emerging clinical data, and changes to guidelines is much lower in HCV than in diseases like HIV, PAH, and CF
- Increases the importance of implementing a broad disease awareness/medical education platform and of increasing patient awareness of new treatment options



* Increased from ~14% prior to the launch of the PI's

HCV Competitive Landscape: 2013 - 2015



*ABT FDC = ABT-450/RTV/ABT-267 (3 components)

Slide 6

Confidential

Growing Consensus for Increased Screening

August 2012:

CDC recommends one-time HCV testing for all Americans born between 1945-1965

June 2013:

U.S. Preventive Services Task Force (USPSTF) issues final guidance with a "B" recommendation for one-time testing for all baby boomers

- Decision driven by strong advocate support
- Impact: Testing for boomers <u>will be covered by insurers at no cost to patient</u>

Agenda

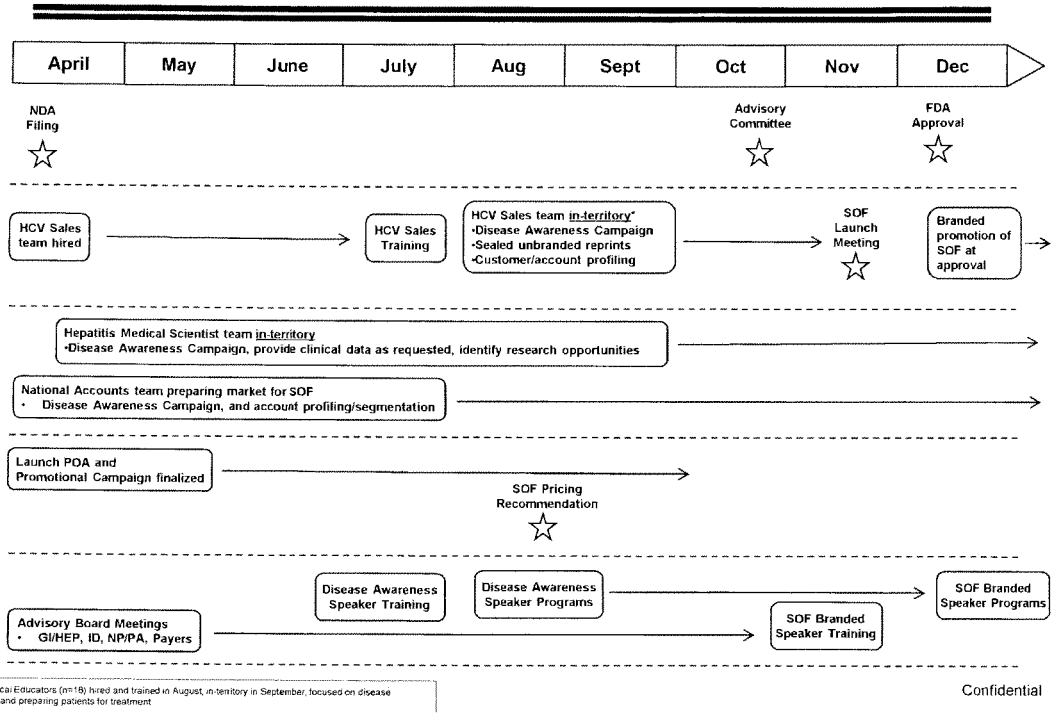
- HCV Marketplace Dynamics
- **Commercial Operations Readiness**
- Pricing and Access

1369

Critical Success Factors at Launch of Sofosbuvir

- Establish SOF as the standard-of-care and backbone of HCV therapy at initial launch
  - The more physicians wait for IFN-free GT-1 therapy, the less established SOF will be at the time of competitive IFN-free launches
- Achieve broad access and reimbursement across all payer segments
- Grow the pool of treated patients above historical norms
- Successfully deploy disease awareness advertising campaigns
  - Pre-launch to raise awareness about new therapies for HCV
  - Post-launch to drive diagnosed patients to an HCV treater

U.S. Launch Readiness



* HCV Clinical Educators (n=18) hired and trained in August, in-territory in September, focused on disease awareness and preparing patients for treatment

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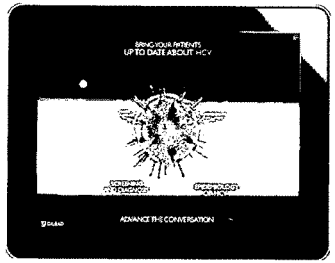
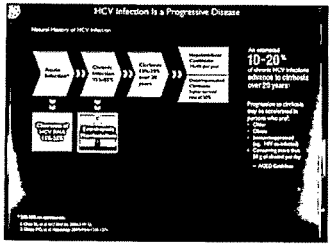
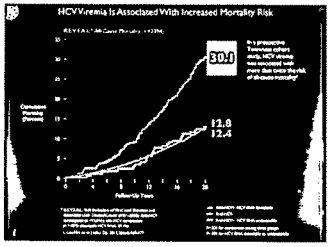
Disease Awareness Campaign

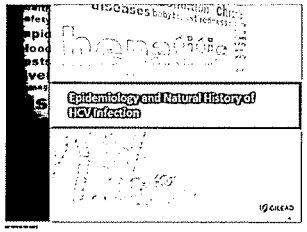
Therapeutic Specialists*

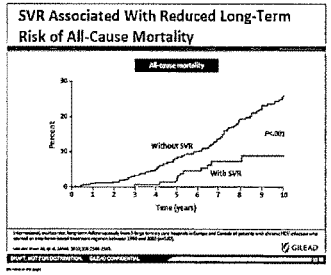






Speaker Programs





* Patient education brochures
* Sealed reprints of AASLD Guidelines, CDC Birth Cohort Testing, and the REVEAL HCV study

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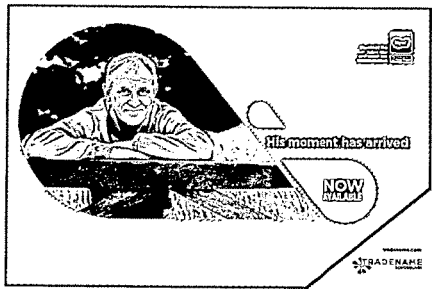
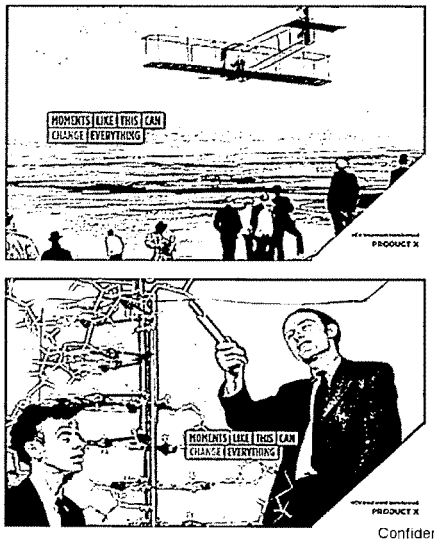
Sofosbuvir Launch Campaign

At Approval



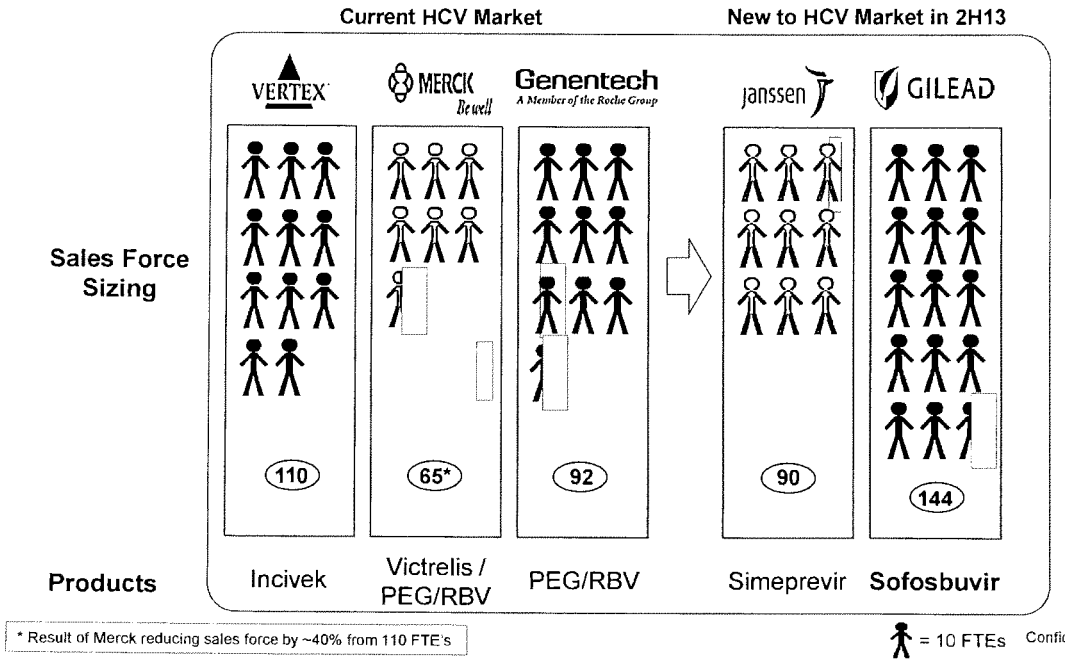
Post-Launch (~3 months)



Slide 12

Confidential

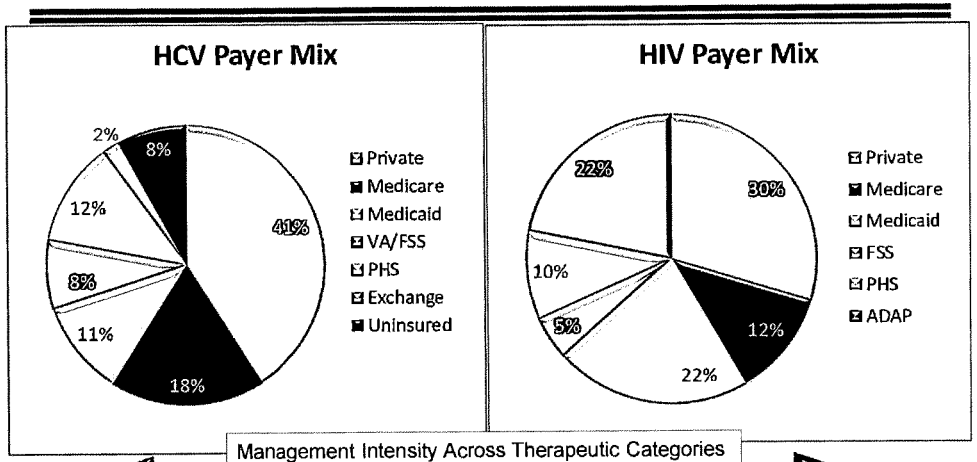
U.S. HCV Market: Sales Force Sizing

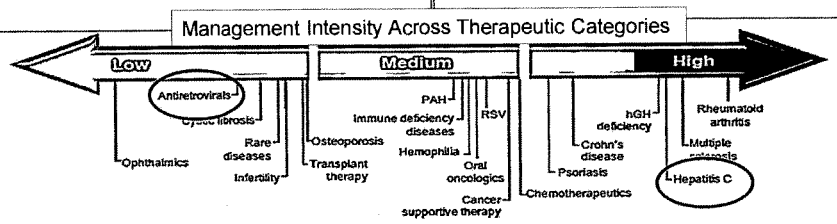


Agenda

- HCV Marketplace Dynamics
- Commercial Operations Readiness
- Pricing and Access

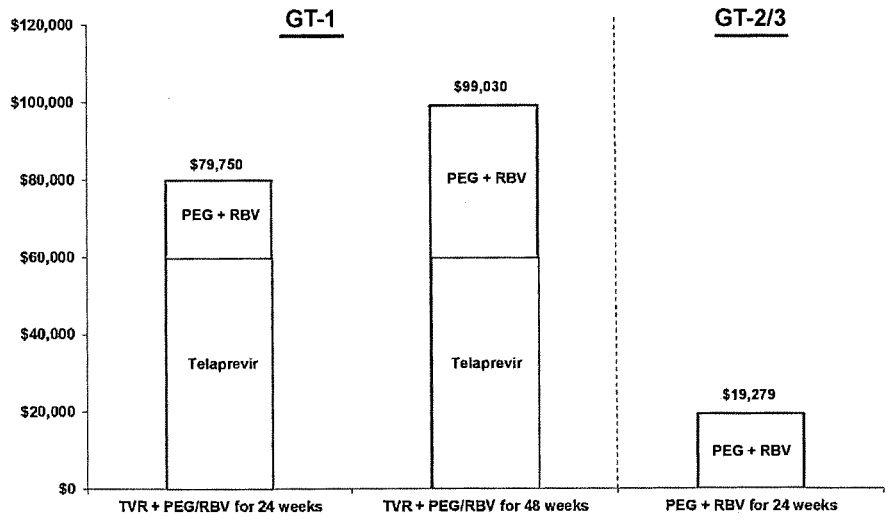
Payer Mix and Payer Intent To Manage Very Different from HIV*





* Projected payer mix in 2014

Significant difference in the pricing of standard-of-care (SOC) in GT-1 versus GT-2/3*



* U.S. wholesaler acquisition cost (WAC) pricing

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Learning's from Interactions with Payers

- Payer intent to manage HCV is on the very high end of the scale relative to other therapeutic areas
  - Less so at initial launch than when there are multiple IFN-free options capable of delivering 90+% SRV rates in GT-1 patients
- Payers value efficacy/cure rates (SVR) above all other attributes
- At launch and beyond, there will be a *Prior Authorization (PA) to label* on every prescription for SOF
- Unmet need seen as much higher for GT-1 patients than for GT-2/3 patients

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Implications for our U.S. Pricing & Access Strategy

- Better off pricing SOF at initial launch for GT-1 patients, as there will be varying degrees of access restrictions for GT-2/3 patients regardless of where we price
- Pricing strategy for SOF at initial launch must be informed by our strategy for the pricing of SOF/LDV, particularly because of the potential for differing durations of therapy
- Wherever we want to end up in terms of pricing for SOF/LDV, we have to get most of the way there in the initial pricing of SOF
  - Largest incremental gain in SVR is at initial launch, and this is what payers value
  - SOF seen as the value driver of any SOF-containing regimen
- We need to keep prescribing in the hands of physicians, not payers, and to contract for open/parity access only when necessary

SOF Pricing & Access Recommendation

- In the process of determining access trade-offs, if any, for each price point
- Final recommendation will include not only the list price, but the strategy for the VA & Corrections, and patient support programs (co-pay card, Foundation support, PAP)

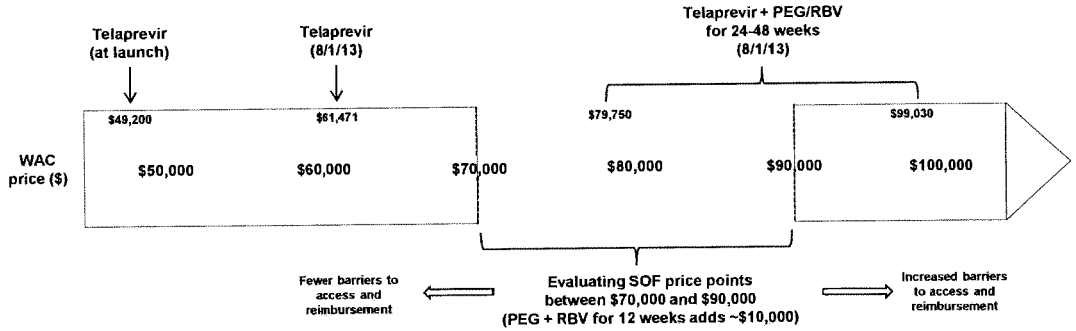

Exhibit 32

GILEAD

2013-2015 HCV Launch Commercial Plan

Final: April 4, 2013

GILEAD CONFIDENTIAL

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OPPORTUNITY

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1

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HCV Market Context

Key Trends in Market Context

- Highly prevalent, yet burden not fully appreciated
- Low Dx rate; majority diagnosed seen by PCP
- Limited number HCPs who treat today; mostly specialists who are not the diagnosing MD
- Treatment today can lead to cure, but burden of Tx limits uptake
- Premium pricing limits access in some EU markets
- Unmet needs in HCV not fully understood or appreciated
  - The societal, clinical and economic burden of untreated HCV is substantial and growing rapidly
  - HCV cure is possible, however, most patients are not suited for current therapies
  - Several barriers must be overcome to allow more patients the chance of cure
- Not currently a gov't priority despite costs associated with progression
- Highly competitive environment with all-oral regimens for GT1 launching within the next 2 years

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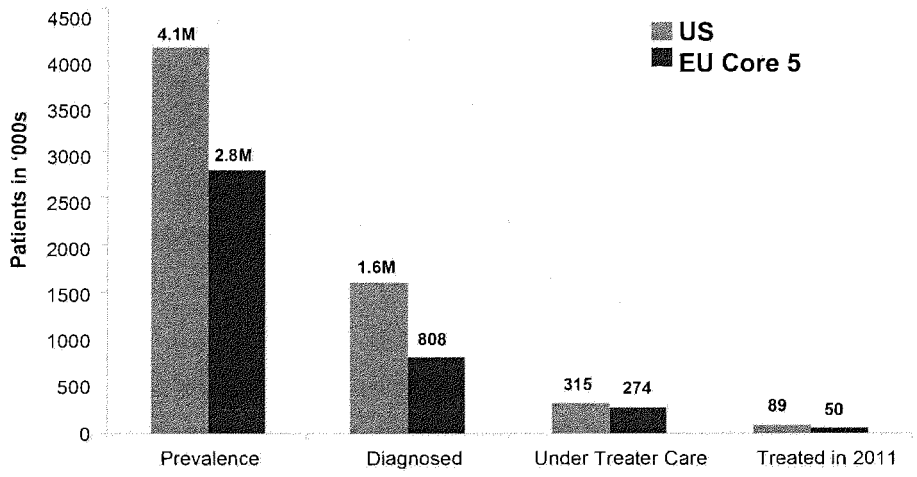
The HCV Waterfall: High prevalence, low diagnosis and the majority are not treated today

1 OPPORTUNITY

Gilead Focus



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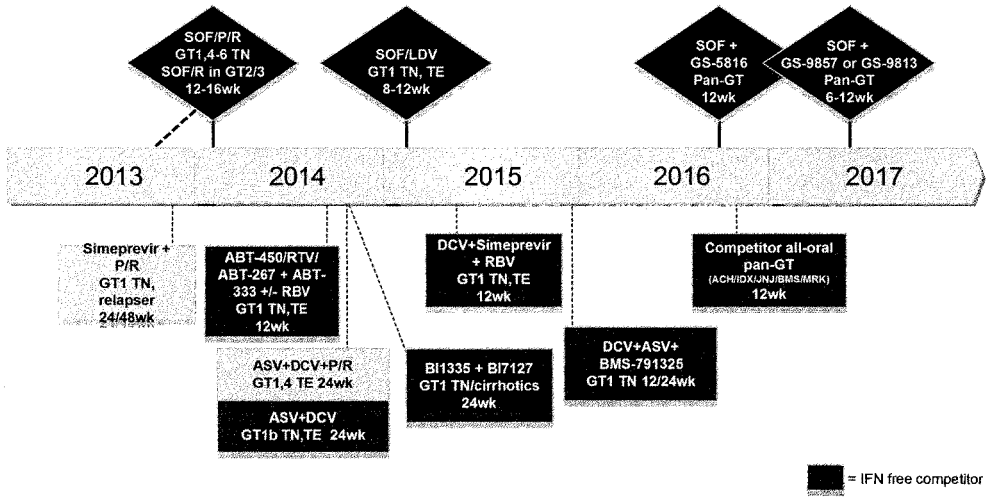
1 OPPORTUNITY

The HCV market will evolve quickly…

Market Context



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1

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Summary of sofosbuvir registration studies

	PATIENT TYPE	P3 STUDY	SOF SVR	SOC SVR
GT1	NAÏVE eligible	NEUTRINO	89%	80%* historic control
	EXPERIENCED and IFN unwilling, intolerant and ineligible	N/A	-	-
GT2	NAÏVE	FISSION	97%	78% 24 W
	EXPERIENCED	FUSION 12W	86%	No TX option
		FUSION 16W	94%	
	IFN unwilling, intolerant and ineligible	POSITRON	93%	No TX option
GT3	NAÏVE	FISSION 12W	56%	63% 24 W
	EXPERIENCED	FUSION 12 W	30%	No TX option
		FUSION 16W	62%	No TX option
	IFN unwilling, intolerant and ineligible	POSITRON 12W	61%	No TX option
GT4,5,6,	NAÏVE eligible	NEUTRINO	97%	60% (pre-defined)

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2

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Sofosbuvir Launch TPP

Criteria	Genotype 2 or 3		Genotype 1, 4, 5 and 6	
Target population	Treatment naive Treatment experienced Interferon intolerant or ineligible		Treatment naive	
Regimen	*Regimen 1* SOF + Ribavirin No response-guided therapy		*Regimen 2* SOF + Peginterferon alfa + Ribavirin No response-guided therapy	
Dosing and Administration	Sofosbuvir: 400 mg tablet, QD Ribavirin: 1000 – 1200 mg BID		Sofosbuvir: 400 mg tablet, QD Ribavirin: 1000 – 1200 mg BID Peginterferon alfa: Weekly injection	
Recommended Duration of Sofosbuvir	**GT 2**	**GT3**	**GT1, 4, 5 and 6**	
Treatment Naive	12 weeks	16 weeks	12 Weeks	
Treatment Experienced	12 weeks	16 weeks		
IFN Ineligible, Unwilling, Intolerant	12 weeks	16 weeks		
Patients awaiting liver transplantation	Treat until liver transplantation		Treat until liver transplantation	
Efficacy in Phase 3 (SVR-12)	**GT2**	**GT3**	**GT1**	**GT4,5,6**
Treatment Naive	97%	56%	89%	97%
Treatment Experienced	86%	62%	N/A	
IFN Ineligible, Unwilling, Intolerant	93%	61%	N/A	
Subpopulations included in label	• Compensated cirrhosis • Geriatric population • Methadone use • HIV/HCV Co-Infection (GT2/3 only in EU)			
Safety profile	0-2% of patients discontinued sofosbuvir-based regimens across the phase 3 studies. Mild fatigue, insomnia, anemia, headache, nausea occurred in < 10% of treated patients. *In Regimen 2*, laboratory abnormalities associated with RBV and PegIFN were observed.			

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OPPORTUNITY

Sofosbuvir Opportunities and Threats

Opportunities

- Patient and HCP dissatisfaction with current SOC
- Provide IFN-free regimen for first time to GT2/3
- Treat more patients without expanding physicians' resources
- Simplification = Expansion of treater pool
- Overlap between customers treating HCV/HBV and HCV/HIV
- Strive for rapid inclusion in guidelines
- Growing evidence of disease burden in all countries
- Closed systems that reach high risk patients (prisons, VA)

Threats

- HCPs may wait for IFN-free regimens in GT1
- Apathy to Tx early disease due to limited data on benefits of treating earlier
- Payors may limit access and force declining value
- Potential for market fragmentation with launches of competitive regimens
- Low government prioritization of HCV in many countries

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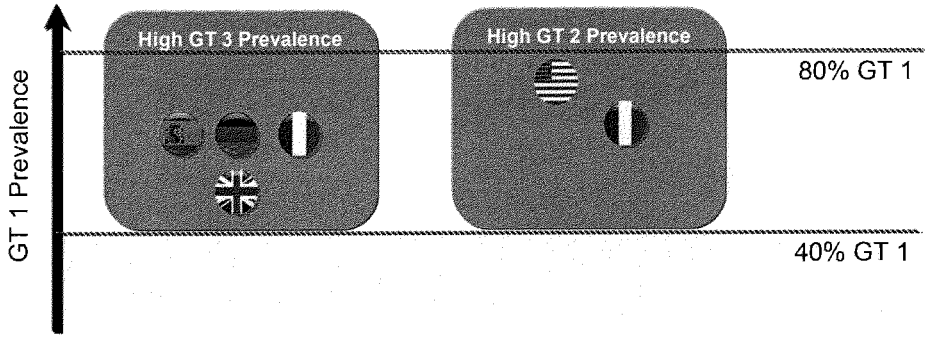
Patient Group Prioritization
Based Upon Country Level Prevalence of GT 1, 2 and 3[1,2]

- GT 1 patients are approximately 50% or greater of US and EU-5, followed by EITHER a predominance of GT 2 or GT 3.
- Each market therefore has a focus on two key genotypes:
  - GT 1 + GT 2 in US and Italy
  - GT 1 + GT 3 in ES, GE, FR and the UK
- The sofosbuvir communication flow should be determined by the genotype distribution at the local level



1. Cornberg, et al. A systematic review of the epidemiology in Europe, Canada and Isreal. Liver International (2011), 30-60.
2. Altern, et al. The prevalence of hepatitis C virus infection in the United States, 1988 through 1994. NEJM, August 19, 1999, 556-562.

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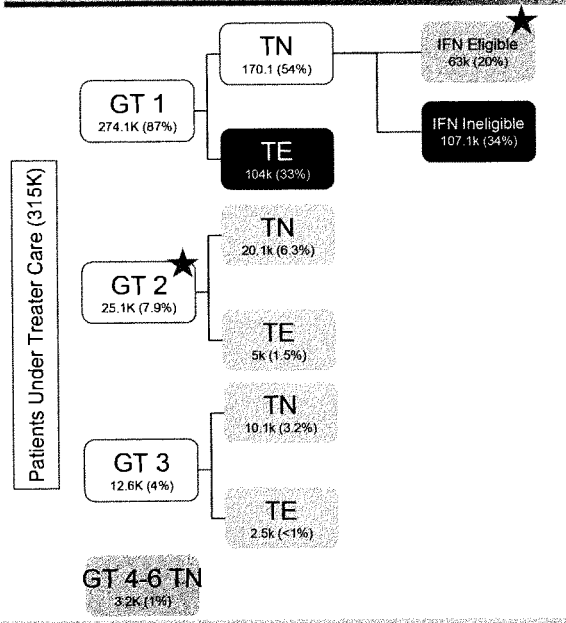
Prioritized Patient Groups in the US
Based upon the patients under treater care[1]



Implications

- The most significant patient groups in the US at launch are GT 1 IFN Eligible and GT 2 (all patients)
  - GT 1 IFN eligible is 20% of the patients under treater care
  - GT 2 is 7% of patients under care
- GT 3-6 represent 5% of the patients under treater care

Gilead Regimen

- SOF/Peg/RBV
- SOF/RBV All Oral
- SOF/LDV All Oral

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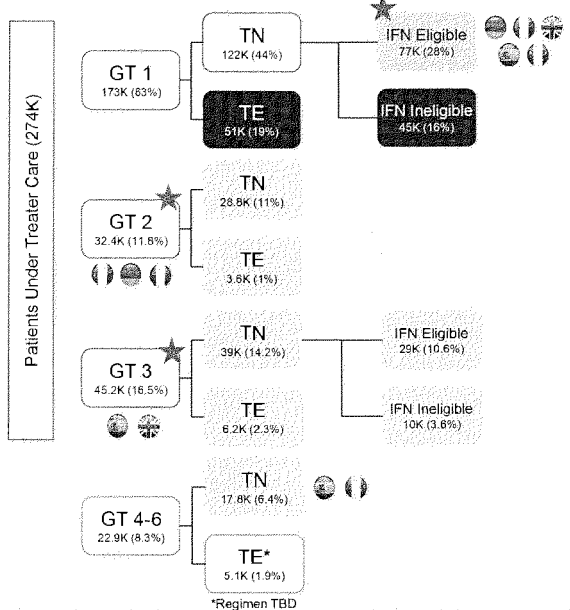
Prioritized Patient Groups in the EU Core-5
Based upon the patients under treater care[1]

2

OPPORTUNITY



*Regimen TBD

Implications

- GT 1 IFN eligible represents the largest patient group across the EU Core 5 (except the UK)
- GT 2 is the second priority opportunity for FR, GE, IT
- GT 3 is the second priority opportunity for ES and the largest opportunity for the UK
- GT 4-6 represents >10% of patients in ES and FR

Gilead Regimen

SOF/Peg/RBV

SOF/RBV
All Oral

**SOF/LDV
All Oral**

1. Combined data from Q2/3/4 2012 Ipsos EU5 HCV Therapy Monitor

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Special Populations Prioritized Patient Groups

Pre-Transplantation

- High unmet need for pre-transplantation treatment to:
  - Significantly lower risk of HCV reactivation post transplantation
- SOF + RBV will be available patients with compensated liver disease who are awaiting liver transplantation with a treatment duration up to 48 weeks
  - ~6,400 HCV patients awaiting transplantation in the US
  - ~4,800 HCV patients awaiting transplantation in the EU

HCV/HIV Co-infection (EAME Focus)

- Approximately 55,000 patients are co-infected; most are diagnosed and under specialist care[1]
- High unmet clinical need
  - HIV accelerates progression to cirrhosis
- Fewer barriers to initiating Tx vs mono-infected
- SOF + RBV is being studied in GT2/3 patients

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2

OPPORTUNITY

Priority Physician Groups at Launch

	Priority US	Priority EU Core-5	Customer Group	Learnings To-Date	Target Behavior Sofosbuvir Launch
Current HCV Treaters / Key Accounts (ex US)	1	1	*Hepatologists/ Tertiary Hospitals (EU)*	• Highest volume and most productive Rxers • Most likely to be aware of coming IFN sparing/free • Competitive SOV - called-on by all competitors	**Treat** • Quickly adopt SOF-based regimens as SOC • Re-engage untreated patients in their practice and discuss SOF-based regimens with them • Become advocates for SOF-based regimens and increasing treatment rates
	2	2	*Community Prescribers/ Teaching Hospitals (EU)*	• Vast majority are GIs (and hepatologists in EU) • Competitive SOV - called-on by all competitors	
	3	3	*Only Rx IFN/RBV/Local Hospitals (EU)*	• GIs remain the majority – lower volume • Limited PI use (EU)	
Past Treaters	4		*Past treaters*	• GI remains the majority - perhaps more interested in GI procedures • Do not want burden of treating HCV, perhaps not practicing in "high endemic" communities	
Non-Treaters	5		*Non-treaters*	• Diagnosing/Testing HCV, but not prescribing • In US: More ID and PCP (62%) – fewer are GI (38%) • Some overlap with HIV/HBV	**Treat or Refer** • Gilead to profile and segment this group – identify reasons they stopped treating and unlock Tx barriers with SOF-based regimens • Otherwise, screen / diagnose and refer patients to Treaters

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STRATEGY

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3
STRATEGY

The Beginning of a Transformation in HCV

	WAVE 1	WAVE 2	WAVE 3
Clinical advance	Sofosbuvir approval	SOF/LDV STR for GT1 patients	Pan-genotypic STR
Implication	• New standard for efficacy with just 12 weeks of therapy in treatment-naïve, GT1 patients • First and only all-oral, IFN, 12 to 16 week regimen for GT2/3 patients	• Increased simplicity with all-oral, IFN-free, single tablet regimen for GT1 patients	• Single tablet regimen for all HCV patients regardless of genotype

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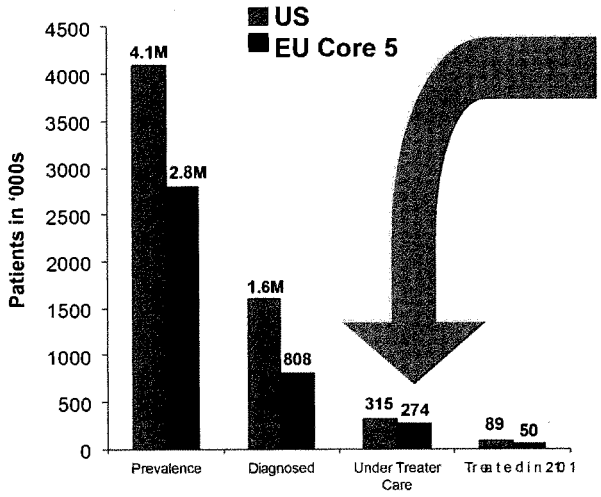
The HCV Waterfall: High prevalence, low diagnosis and the majority are not treated today

3 STRATEGY



Majority of patients under treater care are not on therapy

Barriers to Treatment	Reasons for Delaying Treatment
IFN Ineligible/Intolerant	Patient Refusal (unwilling)
Advanced age	Waiting for better treatments
Advanced liver disease (decomp)	Minimal liver damage (F0-F2 fibrosis)
Compliance/ substance abuse	
Cost affordability (US)	
Restrictions to Access (EU)	

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Priority Weighted Strategic Objectives

Strategic Objective		Priority Weighting
Pre-launch	Articulate the unmet needs and disease burden of HCV to multiple stakeholders including physicians, health policy makers, payors, and advocates. Develop evidence of HCV disease burden and a plan for raising HCV as a national health priority.	10%
At launch	Ensure payors and national health authorities are supportive of the value offered by SOF-based regimens. From the outset, SOF-based regimens should be considered first for all GT2/3 and GT1 TN patients.	60%
Post-launch	Maintain SOF value and eliminate access barriers with payors. Increase the numbers of patients accessing treatment. Engage with national health authorities to elevate HCV as a national priority.	30%

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Pre-launch Strategic Objectives

Articulate the unmet needs and disease burden of HCV

- Educate physicians on the growing burden of HCV (US)
- Educate payors, advocates and health policy makers on disease burden and SVR benefits (EU)

Develop country-level evidence of HCV disease burden and a plan for raising HCV as a national health priority

- Generate country-level evidence utilizing the Health Policy Model
- Identify options to increase budget allocated to HCV
  - Develop advocates among thought leaders

1400

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Launch Strategic Objectives

Ensure payors and national health authorities are supportive of the value offered by SOF-based regimens.

- Communicate sofosbuvir-regimen value proposition to ensure optimal pricing/reimbursement

From the outset, all appropriate HCV patients should be considered first for sofosbuvir based regimens

- Drive rapid awareness about the sofosbuvir approval
- Establish market share leadership:
  - First choice in combination with PEG/RBV for GT 1 naïve patients
  - First all oral regimen and only choice for GT2/3 treatment experienced, IFN-intolerant and ineligible
  - Best choice for GT2/3 treatment naïve as a significant improvement over current SOC

1401

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3 STRATEGY

Post-Launch Strategic Objectives

Maintain SOF value and eliminate access barriers with payors

- Protect price erosion of sofosbuvir in advance of SOF/LDV launch, and maintain value in GT2/3
- Work to ensure restrictions are not imposed in key markets

Increase the numbers of patients accessing treatment

- Encourage treating physicians to initiate SOF-based regimens in the majority of patients for whom previously no treatment was offered
- From year 1 to 3 post launch
  - Establish sofosbuvir-based regimens as SOC in "closed health care systems"
  - Increase referral of diagnosed patients to treating physicians
  - Support efforts to increase delivery of HCV care beyond specialists who treat today

Engage with national health authorities to elevate HCV as a national priority

- Near term:
  - Communicate burden of disease
  - Demonstrate investment models that enable cure strategy with predictable model of budget growth
- Long term: Change frame of mind from one of 'watch and wait' to seeking eradication

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Sofosbuvir positioning at launch

For HCV patients and the physicians who treat them…

sofosbuvir is the *new backbone of therapy* …

…that lets Health Care Providers begin to see *every patient as a candidate for a cure.*

Sofosbuvir *transforms the treatment experience* into a simple, short regimen, and delivers consistently high cure rates for all patients without undue treatment burden.

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Global Launch Message Platform;

The story communicated by the preferred messages with optimal story flow

Message	Optimal story flow
• TRADENAME establishes a new standard for HCV therapy by delivering high cure rates across all genotypes in a simple, short treatment.	Overarching Message
• TRADENAME is a first-in-class, nucleotide polymerase inhibitor that is pan-genotypic and has demonstrated a high barrier to resistance.	MOA
• The proven high cure rates of TRADENAME in combination with PegIFN/RBV set a new standard for efficacy by delivering SVR with just 12 weeks of therapy in treatment-naïve, HCV GT1 patients.	GT1 Efficacy
• TRADENAME in combination with RBV as the first and only, all-oral, interferon-free regimen represents a significant advance for both treatment-naïve and treatment-experienced GT2/3 patients – including those who are IFN-intolerant, ineligible, or unwilling.	GT2/3 Efficacy
• The highly favorable tolerability profile of TRADENAME significantly advances the HCV treatment experience with the shortest regimens available.	Safety/Tolerability
• One-tablet, once-a-day TRADENAME enables simple, short regimens to treat HCV across a broad range of patients in all genotypes without response-guided therapy.	Dosing and administration

Global Sofosbuvir Message Validation Research, April 2013

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Positioning & Communication

Recommendations to Adopt the Efficacy Messages to the Local Markets - Prioritized Messages

- Based upon the overall prevalence and the distribution of patients under treater care:
  - GT 1 treatment naïve is the most significant opportunity at launch in all markets except the UK
  - GT 2 is a substantial opportunity in the US, FR, GE and IT and an impactful way to introduce the all oral regimen
- Message flow will be refined at the affiliate level prior to launch

Country-Level Genotype Priority	Priority Themes	Behavior message is intended to drive
GT1 and GT2 	**GT1:** • The proven high cure rates of sofosbuvir in combination with PegIFN/RBV set a new standard for efficacy by delivering SVR with just 12 weeks of therapy in treatment-naïve, HCV GT1 patients • High SVR rates observed in difficult to treat patient groups including cirrhotic patients **GT2:** • Sofosbuvir in combination with RBV represents a significant step forward for HCV GT2 patients as the first and only all-oral, interferon-free regimen that consistently delivers high cure rates in just 12 weeks • Consistent response rates in difficult to treat patient groups including cirrhotic, HIV/HCV co-infection and pre-transplantation patients	**GT 1:** • Initiate SOF/PEG/RBV in all GT1 TN patients who can tolerate IFN replacing PI-based regimens at the SOC **GT 2:** • Initiate SOF/RBV in all GT2 patients as the new standard of care • Initiate SOF/RBV as the only standard of care in patients who are ineligible for IFN

1405

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Strategy

Positioning & Communication

Recommendations to Adopt the Efficacy Messages Flow to the Local Markets - Prioritized Messages

- Based upon the overall prevalence and the %age of patients under treater care:
  - GT 1 treatment naïve is the most significant opportunity at launch in all markets except the UK
  - GT 3 is a substantial opportunity in the UK and Spain and should be presented as an all oral regimen achieving efficacy consistent with PegIFN/RBV
- Message flow will be refined at the affiliate level prior to launch

Country-Level Genotype Priority	Priority Themes	Behavior message is intended to drive
GT1 and GT3 	**GT1:** • Same themes as previous slide **GT3:** • Sofosbuvir in combination with RBV represents a significant step forward for HCV GT3 patients as the first and only, all-oral, interferon-free regimen that delivers cure rates consistent with PegIFN/RBV in a short course of treatment • Sofosbuvir in combination with RBV is the first and only treatment option available for intolerant/ineligible or treatment-experienced patients with GT3, a group with no other treatment options • Consistent response rates in difficult to treat patient groups including HIV/HCV co-infection and pre-transplantation patients	**GT 1:** • Same behavior as previous slide **GT 3:** • Replace PEG/RBV with SOF/RBV for treatment naïve GT3 patients who are ineligible for IFN-based regimens • Initiate SOF/RBV in all GT3 patients with no treatment options today as the only standard of care

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INITIATIVES

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5 INITIATIVES

Publication plan/upcoming data

	Q1 2013	Q2 2013	Q3 2013	Q4 2013
Abstracts	CROI • **Resistance** • **DDI (ART)** • **Co-infection (GT1)**	EASL • **FISSION** • **FUSION** • **POSITRON** • **NEUTRINO** • **BMS Collaborative** • **Tibotec Collaborative** • **NIAID (334-0112)** • **ELECTRON** • **Cost of Cure** • **Unmet need** • Cost of Cure • Unmet Need • Multiple Treatment Comparisons • FISSION • FUSION • POSITRON • NEUTRINO • Phase III Sub • 238-0121		AASLD • **FISSION** • **FUSION** • **POSITRON** • **NEUTRINO** • **Pre-transplant** • **PHOTON-1** • **Pilot Acute Infection** • **Multiple Treatment Comparisons** • **337-0102** • **NIAID (2xDAA/3xDAA)** • **Younossi 1** • **Younossi 2** EU • Budget Impact • Cost Effective • Lit Review
Manuscripts	• **Cost of Cure (EU)** • **Literature Review (EU)**	• **Neutrino** • **FISSION** • **FUSION** • **POSITRON** • **SOF Viral Kinetics (Co-Infected)** • **Cirrhosis (GT2/3)** • **Cirrhosis (GT1)** • Budget Impact Model • Cost Effectiveness • Multiple Treatment Comp • Interim GS-5885/GS-9451/P/R	• **VALENCE** • **US Co-Infection** • **SVR Concordance** • **QUANTUM** • **GS-5885/9451/P/R: Tx Naïve** • **GS-5885/9451/P/R:** • **Tx Exp**	• **ELECTRON (Arms 12-13)** • **ELECTRON (Arm 14)**

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5 INITIATIVES

Opinion Leader Engagement and Scientific Communication

Commercial Planning and Operations	Country Level	Timing
Stakeholder Mapping ▪Partner with R&D and Medical Affairs on KOL Mapping and Engagement Plan (SP) ▪Partner with R&D and Medical Affairs on Global Advisory Board Plan roll out (FC)	**Stakeholder Mapping** ▪Coordinate with local Medical Affairs team to develop National KOL Mapping and Engagement Plan ▪Coordinate with local Medical Affairs team CP&O on preparation and roll out of National Advisory Board Plan	CP&O: complete Country level: 1 year prior to launch and L -6 update
Publication Plan ▪Deliver Global Publication Plan in Partnership with R&D and Medical Affairs and create related Reference Compendium (FC)	**Publication Plan** ▪Partner with Medical Affairs to create and execute local Publication Plan to complement Global plan	CP&O: 4Q2012 then updated quarterly Country level: Q12013 then updated quarterly
Unmet Need Campaign ▪Develop unmet need campaign highlighting unmet needs in HCV and linking to educational resources (FC,SP,US) ▪Develop appropriate metrics and track progress of campaign globally (FC,SP,US)	**Unmet Need Campaign** ▪Adapt global campaign and modify elements to local market conditions and country regulations as necessary ▪Implement campaign	CP&O: complete Country level: 3 to 6 months prior to launch depending upon tactics
Congress Plan ▪Through CCC develop key scientific themes and messages for global congresses (EASL, AASLD, APASL) (FC)	**Congress Plan** ▪Outline activity plan at congress and drive customer attendance to Gilead sponsored events (symposia, booth, etc...) ▪Deliver Local conference plan and investment for National Conferences	CP&O: 1Q2013 and updated before 3 months before each congress Country level updates local plan and communicates activity 3 month before conference

SP = EAME CP&O
FC = CP&O
US = US marketing

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5 INITIATIVES

Market Access and SOF Value Story

Commercial Planning and Operations	Country Level	Timing
Market Access Situational Analysis •Global analysis of the public health and health political environment, burden of disease, P&R competitive landscape, identification of value drivers for payers (SP) •Understanding the payer environment in each market to identify opportunities and barriers, *learning* from recent introductions of the PI's (SP, US) •Develop payer and customer archetypes (SP) •Strategic imperatives and action plan for identified Payer Value Proposition (SP)	**Market Access Situational Analysis** •Country analysis of the public health and health political environment, burden of disease, P&R competitive landscape, and identification of value drivers for payers •Identify potential hurdles, issues and requirements (e.g. reimbursement restrictions, HTA guidelines etc…)	CP&O: 2H2013 Country level: 1 year prior to launch and L-6 update
Market Access Plan •Develop and validate core value propositions that can be tailored by countries that communicates the value of SOF-based regimens in achieving SVR within a predictable growth model (SP) •Pricing and reimbursement guidance on target price and sequencing (SP) •Ensure best practice shared between regions (SP, FC)	**Market Access Plan** •Ensure local plans are developed which outline critical access timeframes •Review evidence requirements needed to ensure optimal access •Adopt Global payer value communication and advocacy plan for local market •Create local pricing and reimbursement strategy and communicate to CP&O •Strategic imperatives and local action plan for identified Payer Value Proposition •Local Payer Advisory Board Plan (US)	CP&O: 1H2013 Country level: 1 year prior to launch and L-6 update
Market Access Tools •Ensure economic models for SOF are developed early to allow for accelerated submission in all countries (SP) •Develop economic models for special populations and prisons (SP) •Deliver Value Dossier and Access Toolkit to include Budget Impact Models, Cost Effectiveness Models, Cost of Cure (SP) •Training on implementing Market Access toolkit (SP) •Pharmacoeconomic Pub Plan (SP) •Mock negotiation workshops for HTA (SP)	**Market Access Tools** •Adapt and tailor Value Dossier and models to local needs to ensure optimal access at launch	CP&O: 1-4Q2013 Country level: 12-18 months pre-launch

SP = EAME CP&O
FC = CP&O
US = US marketing

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5 INITIATIVES

Promotional Planning

Commercial Planning and Operations	Country Level	Timing
Market Context •Develop HCV market "fact files" of country level data providing details on HCV epidemiology, market, treatment flow, screening/treatment guidelines (SP) •Develop competitor assessments and continue to gain deep understanding of competitive landscape including anticipated launch dates, strength, weakness, and provide key intelligence questions framework to markets (FC,SP)	**Market Context** •Assess and validate "fact files" from CP&O and identify any gaps in market understanding •Provide rationale and plan for additional country-level market research needed to fill in any identified knowledge gaps •Execute local competitive intelligence monitoring using CP&O framework of key intelligence questions to anticipate local impact of competition	CP&O: complete Country level: 1 year prior to launch CP&O and Country level update and share CI quarterly
Brand Book •Develop positioning, core creative concept, claim, resource file, messages, core visual aid and related brand book (FC) •Create brand portal to distribute consistent branding across all markets (FC) •Establish branding guidelines and drive brand stewardship to ensure unified and consistent branding and positioning across all markets (FC)	**Brand Book** •Adapt global campaign locally and communicate any necessary deviations due to local regulatory guidance •Develop local language launch materials utilizing global branding guidelines book either regionally (SP) or at country level (US)	CP&O: 1Q2013 Country level: 6-8 months prior to launch
Trade Name •Develop trade name and logo that capitalizes on the functional and emotional attributes of sofosbuvir (FC)		CP&O: 3Q2013

SP = EAME CP&O
FC = CP&O
US = US marketing

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5 INITIATIVES

Commercial Infrastructure

Commercial Planning and Operations	Country Level	Timing
Customer Facing Organization •Provide Business Unit and sales force structural recommendations phased by launch timing (SP, US)	**Customer Facing Organization** •Hire dedicated affiliate HCV commercial team •Develop organizational structure needed to optimize launch •Be field force launch ready 90 days before expected launch date	CP&O: complete Country level: 1 year prior to launch and L-6 update FF Launch Ready 90 days prior to launch date
Learning Program •USA and EMA Create Global Training Program to support building knowledge and skills required at launch (SP, US) •US and EMA on Pre Launch Learning; e-learning modules, Web Conferences, Patients with HCV case studies, Regional Preceptorships (SP, US) •Facilitate and share best practice learnings at country launch training meetings (FC)	**Learning Program** •Execute Global Training Program and certify customer facing organization •Prepare and execute local launch meeting	CP&O: 1H2013 Country level: 6 month prior to launch and L-3 Pre-Launch Training
Performance Tracking •Establish and communicate unified launch success metrics (FC)	**Performance Tracking** •Track success metrics and communicate monthly	CP&O: 3Q2013 Country level: monthly post launch

SP = EAME CP&O
FC = CP&O
US = US marketing

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5 INITIATIVES

Government Policy and Patient Advocacy

Commercial Planning and Operations	Country Level	Timing
Policy Plan •Support Government Affairs and Public Affairs in creating tools necessary to engage policymakers in advocating and elevating HCV as a major public health issue and increase budgets accordingly (SP)	**Policy Plan** •Diagnostic of current policy environment and mapping of policymaker and community advocacy stakeholders / influencers in all core markets at national and relevant regional government levels •Establish multi-stakeholder group in each country to develop policy paper for Government which outlines potential strategies •Develop core materials for implementation by GMs and GA's including economic and health policy data that support the policy paper •Develop community advocacy plan to support broad reimbursement and government investment •Develop potential mechanisms to encourage investments and manage financial risks for governments	CP&O: 1Q2013 and 4Q2013 Country level: 1 year prior to launch and L-6 update Country level: Q12013
PR/Media Plan •Support PA as necessary to develop comprehensive media plan for key data milestones (FC)	**PR/Media plan** •Maximize major data milestones as appropriate through media channels •Utilize EAME/Global campaign development materials	CP&O: 1Q2013 and ongoing Country level: Q2 2013 then ongoing
Patient Advocacy Plan •Partner with PA to support Patient Advocacy initiatives as needed (SP, US)	**Patient Advocacy Plan** •Engage with local patient groups to support launch initiatives & global/EAME strategy	CP&O: 4Q2012 then updated quarterly Country level: Q2 2013 then ongoing

SP = EAME CP&O
FC = CP&O
US = US marketing

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5 INITIATIVES

Commercial Product and Forecasting

Commercial Planning and Operations	Country Level	Timing
Commercial Forecasting ▪Develop robust 1-3 year and 10 year HCV forecasting model (FC) ▪Train, and transition 1-3 year forecast model and assumptions to markets (FC)	**Forecasting** ▪Develop local market forecast using global model and document assumption differences to global view ▪Schedule forecast alignment meeting with Regional and Global Teams	CP&O: 1Q2013 Country level: 1 year prior to launch and L-6 update
Manufacturing Forecasting ▪Provide base case and upside demand to manufacturing based on unit forecasting (FC)	**Manufacturing Forecasting** ▪Coordinate with Medical Affairs to identify the timing and scope of local early access programs and communicate to CP&O	CP&O: complete Country level: ongoing
Packaging and Distribution ▪Partner with regulatory and manufacturing to develop global packaging that is consistent with branding guidelines (FC) ▪Define the optimal distribution strategy that protects Gilead and adds value to SOF (CP&O)	**Distribution** ▪Evaluate current and other potential distribution channels to determine optimal distribution model for HCV	CP&O: 1-3Q2013 Country level: 1 year prior to launch and L-6 update

SP = EAME CP&O
FC = CP&O
US = US marketing

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METRICS

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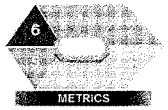

Sofosbuvir Launch Tracker – US Key Metrics 2013

Metrics	Frequency		
	Monthly	Quarterly	Dates available
HCP – Attitude Trial and Usage (Physician Brand Awareness) study		✓	
HCP point of prescribing patient profile uptake study	✓		
HCP Message testing (Pre Launch) study			
Patient Chart Audit (Ipsos-Synovate)		✓	
Managed Patient Pool (treatment rate, patient share, newly diagnosed) (Pre and Post Launch)			
DTP Unbranded (Pre & Post) Awareness study		✓	30-day lag
Unbranded HCP Adv Awareness – Norms-study (Kantar) Pre Launch		✓	30-day lag

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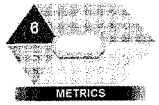

Sofosbuvir Launch Tracker – US Key Metrics 2013 (cont'd)

Metrics	Frequency		
	Monthly	Quarterly	Dates available
NBRx** (Post), NRx, TRx** (Pre and Post Launch)	✓	✓	Weekly: 10-day lag Monthly: ~15-day lag
Ex-Factory units (Post Launch)	✓	✓	
Revenues (Post Launch)	✓	✓	
Forecast Attainment (Unit, TRx, Revenues) (Post Launch)	✓	✓	
Prescriber base* (Pre and Post Launch)	✓	✓	Weekly: 14 day lag Monthly: ~45-day lag
Source of business (LRx) (Pre and Post Launch)		✓	30-day lag

**NBRx data are a subset of NRx data (~10-15%) and include only patients that are new-to-brand (naïve and switch patients) not continuing patients. It is a leading indicator for both NRx and TRx data, and particularly useful during a product launch. It is the same underlying source we use to estimate HBV naïve patient share

*In addition to "real-time", will also track launch-aligned versus other GILD & key competitor products

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6

METRICS

EAME Sofosbuvir Metrics

Metrics	Method of Measurement	Pre-launch	Post-launch	Frequency
Under treater care and treated patient pool, Tx rate and patient share	Ipsos patient chart audit	✓	✓	quarterly
Perception and performance of PIs	Ipsos patient chart audit	✓	✓	quarterly
Awareness of sofosbuvir and pipeline products	Ipsos patient chart audit	✓	✓	quarterly
Attitude, Trial, & Usage (ATU)	ATU/detail tracker	✓ (1 wave baseline)	✓	quarterly
Unbranded campaign awareness	campaign effectiveness tracking	✓		
HCV market sales and share	IMS MIDAS	✓ (national Level)	✓ (national and brick level)	quarterly
SOF launch performance	ATU/detail tracker		✓	quarterly
SOF GT1 naive, GT2/3 naive/experienced share and all patient share; source of business	Ipsos patient chart audit		✓	quarterly
Increase in treated & under treater care pool	Ipsos patient chart audit	✓	✓	quarterly
Internal alignment and effectiveness of sales execution	STEM study		✓	annually
Time between diagnosis and initiation	Ipsos patient chart audit	✓	✓	quarterly
SOF campaign recall and effectiveness	campaign effectiveness tracking		✓	biannually
Treater/prescriber expansion	treatment flow/prescriber analysis		✓	annually

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APPENDIX

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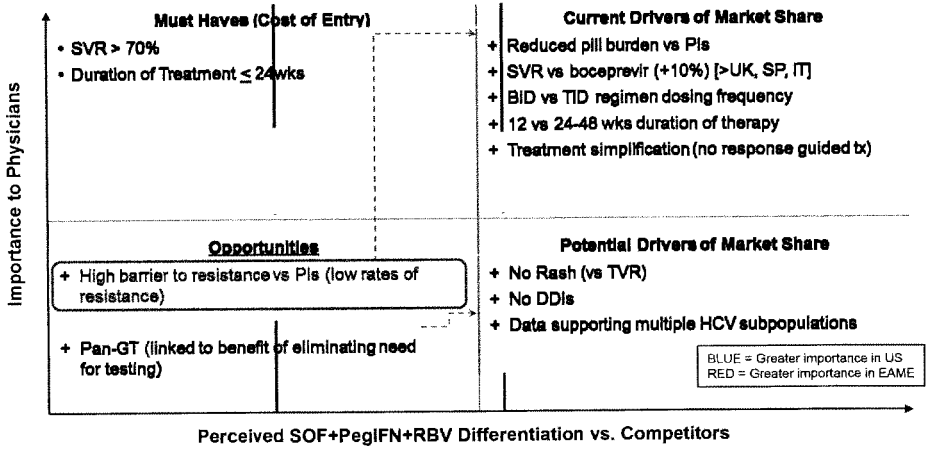
Competitive Brand Evaluation – GT1,4,5,6 Naïve
SOF + PegIFN + RBV

4 STRATEGY

Insights

- While SVR is the cost of entry for GT 1, the high SVR rate observed in the NEUTRINO study in addition to the shortened treatment duration of the SOF+Peg+RBV regimen are highly important to physicians and will drive market share in GT 1
- The high barrier to resistance (i.e. no resistance observed in Phase 3) is the leading opportunity to differentiate from future all oral regimens



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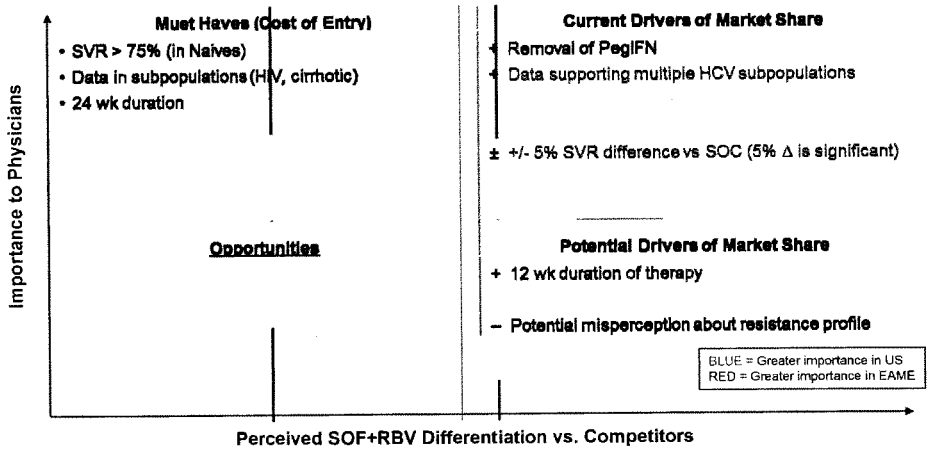
Competitive Brand Evaluation – GT 2,3
SOF + RBV

4
STRATEGY

Insights

- SVR is the key cost of entry for GT 2 and GT 3.
  - For GT 2, SOF+RBV has demonstrated SVR rates well above the current SOC of Peg/RBV with a simple, all oral IFN-free regimen. Both regimen features will drive market share for GT 2.
  - For GT 3, SOF+RBV has demonstrated SVR rates with an all oral regimen that are similar to Peg/RBV.



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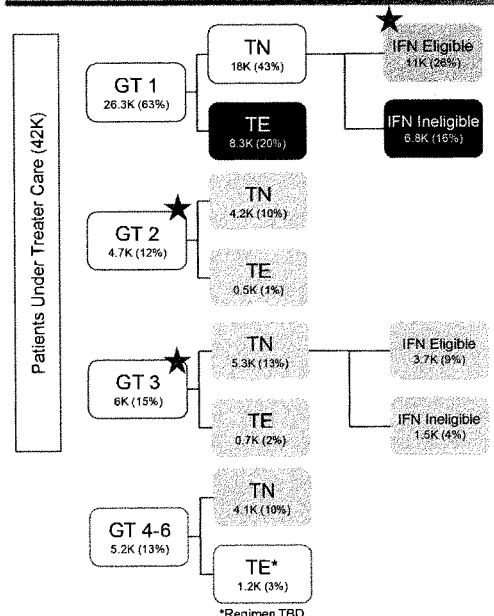
Prioritized Patient Groups in France
Based upon patients under treater care[1]

2
OPPORTUNITY



Implications

- The most significant patient group in France at launch is GT 1 IFN Eligible representing 26% of patients under treater care
- GT 2/3 patients are the second largest opportunity at launch with 27% combined
- GT 4-6 TN is the third largest opportunity at launch with 10% of patients under treater care

Gilead Regimen

- SOF/Peg/RBV
- SOF/RBV All Oral
- SOF/LDV All Oral

1. Combined data from Q2/3/4 2012 Ipsos EU5 HCV Therapy Monitor

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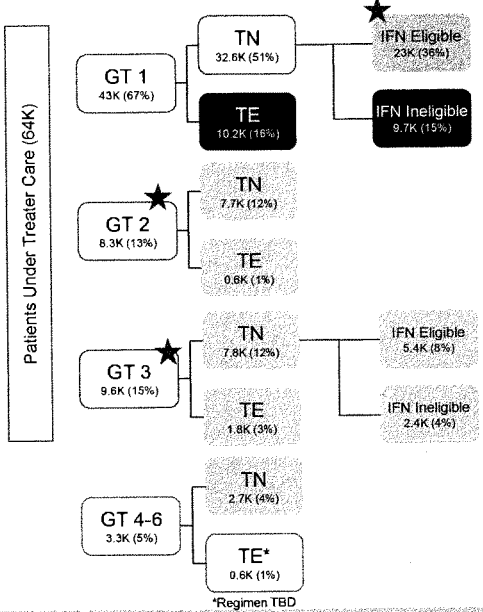
Prioritized Patient Groups in Germany
Based upon patients under treater care[1]

2

OPPORTUNITY



Implications

- The most significant patient group in Germany at launch is GT 1 IFN Eligible representing 36% of patients under treater care
- GT 2/3 patients are the second largest opportunity at launch with 28% combined

Gilead Regimen

SOF/Peg/RBV

SOF/RBV
All Oral

SOF/LDV
All Oral

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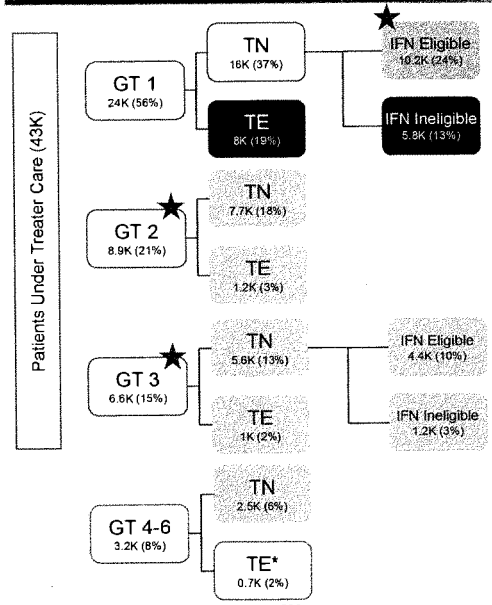
Prioritized Patient Groups in Italy
Based upon patients under treater care[1]

2

OPPORTUNITY



Implications

- The most significant patient group in Italy at launch is GT 1 IFN Eligible representing 24% of patients under treater care
- GT 2/3 patients are the second largest opportunity at launch with 26% combined

Gilead Regimen

- SOF/Peg/RBV
- SOF/RBV All Oral
- SOF/LDV All Oral

1. Combined data from Q2/3/4 2012 Ipsos EU5 HCV Therapy Monitor

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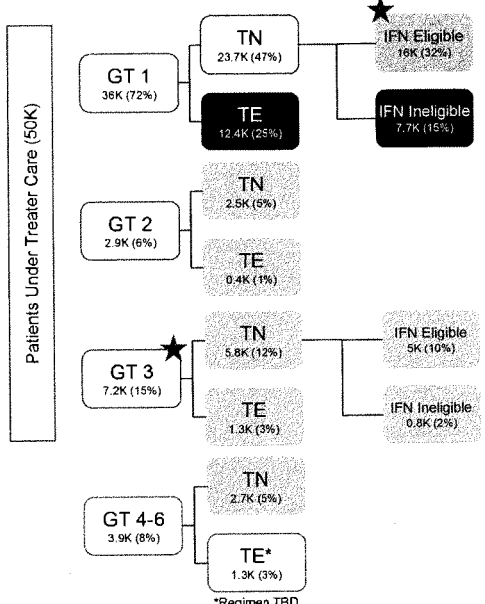
Prioritized Patient Groups in Spain
Based upon patients under treater care[1]

2

OPPORTUNITY



*Regimen TBD

Implications

- The most significant patient group in Spain at launch is GT 1 IFN Eligible representing 32% of patients under treater care
- GT 3 patients are the second largest opportunity at launch with 15% of patients under treater care

Gilead Regimen

- SOF/Peg/RBV
- SOF/RBV All Oral
- SOF/LDV All Oral

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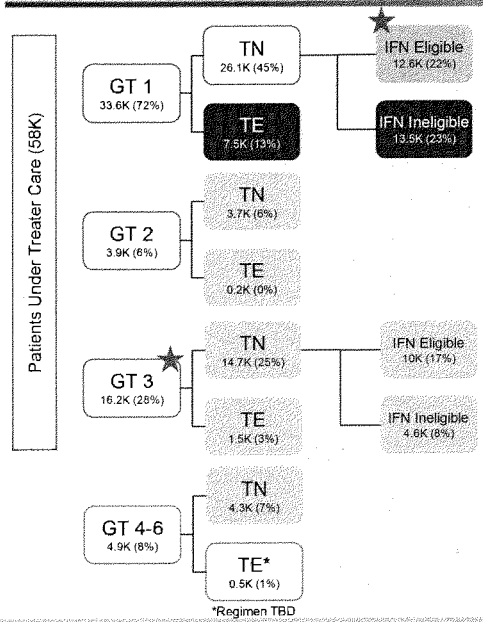
Prioritized Patient Groups in UK
Based upon patients under treater care[1]

2

OPPORTUNITY



Implications

- The most significant patient group in the UK at launch is GT 3 representing 28% of patients under treater care
  - The majority of GT 3 being TN, interferon eligible
- GT 1 treatment naive patients are the second largest opportunity at launch with 22% combined

Gilead Regimen

- SOF/Peg/RBV
- SOF/RBV All Oral
- SOF/LDV All Oral

1. Combined data from Q2/3/4 2012 Ipsos EU5 HCV Therapy Monitor

Exhibit 33

From: Kevin Young
Sent: Friday, November 08, 2013 9:51 PM
To: Jim Meyers
Subject: Re: Characterization of SOF pricing at launch

Thank you Jim

I'd like to catch you on the phone at some point to have a final pricing thoughts (I talked to Norbert)

K

From: Jim Meyers
Sent: Friday, November 08, 2013 01:45 PM
To: Kevin Young
Subject: FW: Characterization of SOF pricing at launch

Kevin - FYI

From: Jim Meyers
Sent: Friday, November 08, 2013 1:44 PM
To: David L. Johnson (US Sales & Marketing); Coy Stout; Monica Tellado; Cara Miller; Bill Guyer; Jason Levine
Subject: Characterization of SOF pricing at launch

All,

It will be important for us to have a coordinated cross-functional characterization of the price of SOF at launch, regardless of who we're speaking to (advocacy groups, physicians, payers, Wall Street, etc.). Part of that characterization (not by any means all of it) will be addressing concerns about patients who may require 24 weeks of SOF and thus be subjected to 2X the cost (GT-3 patients, HIV/HCV co-infected patients, etc.). If not handled effectively, this concern could dominate the narrative at launch.

As you know, I raised this concern proactively with some of our closest advisors at AASLD. Below was the helpful advice from Nid Afdhal (which was very similar to that of Ira Jacobson) on how to speak to the fact that some patients may need 24 weeks

SOF has been developed for a therapy duration of 12 weeks or less, now and in the future. For the first year of launch, there are some patient segments that may benefit from 24 weeks of SOF. We are hopeful that having an FDA approved indication for a longer duration of therapy in these subgroups will induce payers to cover SOF and leave a modest cost burden to the patient (that Gilead can cover)

DJ – please work with Coy, Monica, Cara, and Bill to develop the narrative that will be used, and the plan for how/when/if it will be used across teams

Thank you

Jim

Jim Meyers

Senior Vice President

North America Commercial Organization

Gilead Sciences

301 Velocity Way

Foster City, CA. 94404

(P) - 650-522-5420

(Cell) - 415-203-9235

Exhibit 34

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Sofosbuvir Pricing & Contracting Strategy Working Team

SVP Check-in II

May 10, 2013

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US- Market Research

Sofosbuvir Pricing and Contracting Strategy Working Team

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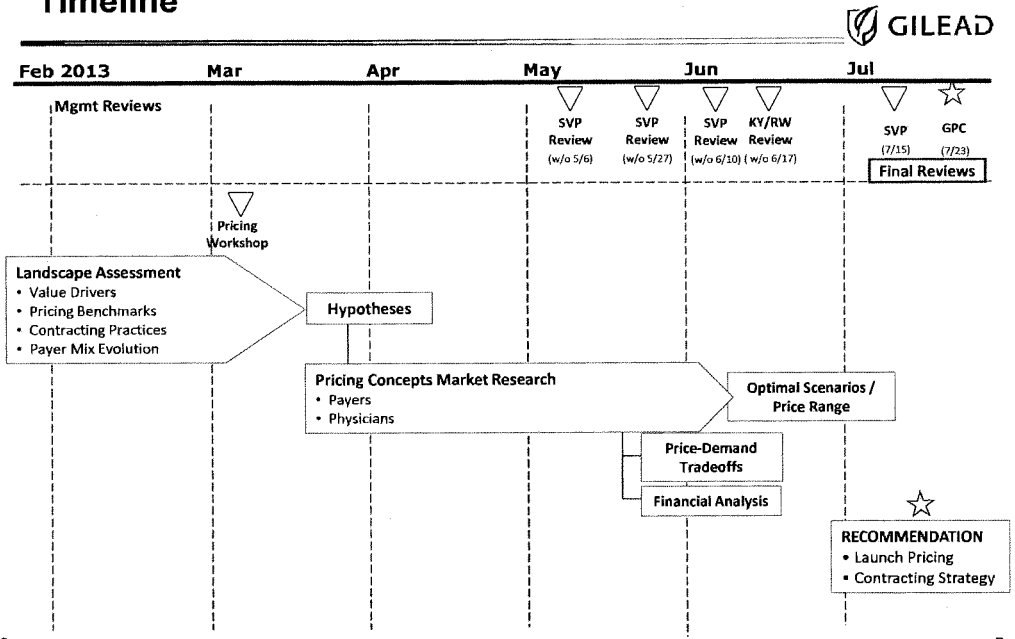
SVP Check-In II - Agenda			
1. Intro, Timelines, & Background	Abby Ginsberg	HCV Market Research	10 min
2. Qualitative Payer Market Research Findings	Steve Swanson & Tom Baker	IMS	50 min
3. Roche – Pegasys Pricing & Contracting Strategy	Kevin O'Leary	IMS	30 min

Sofosbuvir US Pricing & Contracting Strategy Timeline



3 US- Market Research GILEAD CONFIDENTIAL 3

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Sofosbuvir Pricing and Contracting Strategy Working Team
Pricing Market Research Plan

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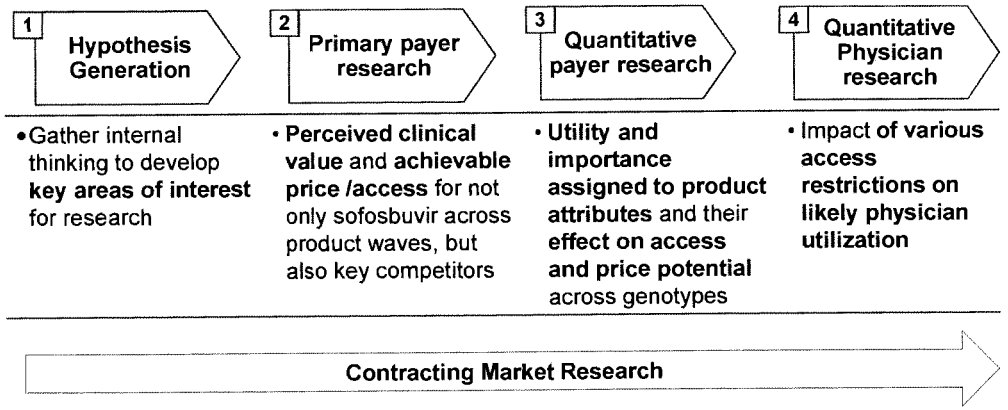

Internal partner discussions across functions yielded a fairly consistent set of results that focused on the product opportunity and expectations on premium pricing

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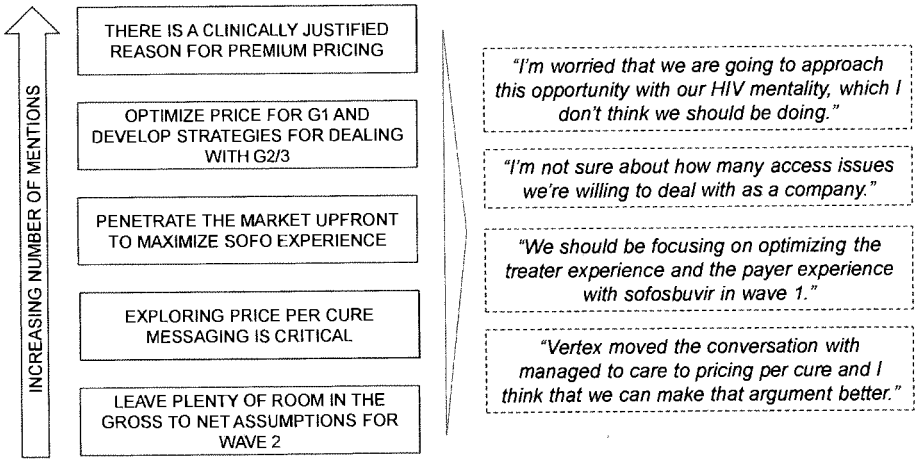
INGOING PRODUCT HYPOTHESES ACROSS FUNCTIONS



Note: quotes are adapted from conversation and do not necessarily reflect the views of any particular person or function

Sofosbuvir Pricing and Contracting Strategy Working Team
Pricing Market Research Plan

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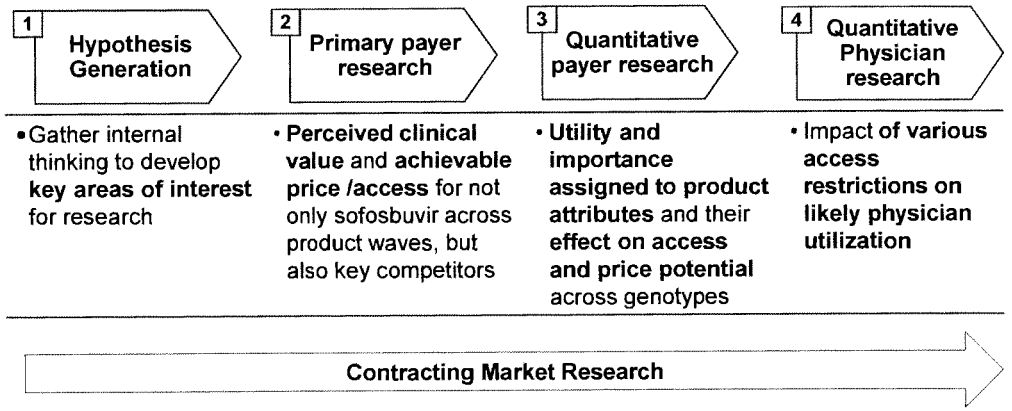


Agenda

Sofosbuvir Pricing and Market Access Assessment

- **Review of approach and initial research findings**
- Pegasys launch strategy

2012 Specialty Drug PMPY spend at Express Scripts is approximately 25% of total PMPY Drug Spend

COMPONENTS OF COMMERCIAL TREND, 2012 YEAR TO DATE AND 4TH QUARTER

	PMPY Spend		TREND					
			Utilization		Unit Cost		Total	
	2012	Q4*	2012	Q4	2012	Q4	2012	Q4
TRADITIONAL	$639.66	$642.87	0.6%	0.8%	-2.2%	-5.1%	-1.5%	-4.3%
SPECIALTY	$207.19	$215.40	-0.4%	-0.9%	18.7%	14.4%	18.4%	13.5%
TOTAL OVERALL	$846.85	$858.27	0.5%	0.3%	2.6%	-1.2%	2.7%	-0.4%

*January - December 2012 compared to same period in 2011 ** October - December 2012 compared to same period in 2011

Source: Express Scripts 2012 Drug Trend Report

ims consulting group

Express Scripts 2012 data shows HCV PMPY to be <1% of total PMPY drug spend and approximately 4% of specialty PMPY spend

SPECIALTY TREND BY THERAPY CLASS

Components of Trend for the Top 10 Commercial Specialty Therapy Classes, Ranked by PMPY Spend, 2012 Year to Date

		TREND		
Therapy Class	PMPY Spend	Utilization	Unit Cost	Total
Inflammatory Conditions	$50.62	9.0%	14.0%	23.0%
Multiple Sclerosis	$37.98	0.5%	17.3%	17.8%
Cancer	$31.98	3.4%	22.3%	25.8%
HIV	$20.78	-2.1%	11.1%	9.0%
Hepatitis C	$7.82	28.9%	4.8%	33.7%
Growth Deficiency	$7.41	1.7%	7.7%	9.5%
Anticoagulant	$6.74	1.7%	0.3%	2.1%
Pulmonary Hypertension	$5.71	5.1%	6.2%	11.3%
Respiratory Conditions	$5.56	1.5%	25.7%	27.2%
Transplant	$4.92	2.2%	-6.9%	-4.7%
Other	$27.68	-24.9%	43.7%	18.8%
Total Specialty	$207.19	-0.4%	18.7%	18.4%

Source: Express Scripts 2012 Drug Trend Report

ims consulting group™

Gilead Sciences has engaged with IMS to determine the access-optimizing price point for its novel HCV therapy sofosbuvir in support of the brand's US launch

PROJECT GOAL

The goal is to anticipate payer access and management strategies for sofosbuvir in order to determine the access-optimizing pricing strategy

KEY OBJECTIVES:

- ✓ Measure perceived value of sofosbuvir for payers, in terms of clinical efficacy as well as budget impact and cost savings (i.e., reduction in the number of hospitalizations)
- ✓ Understand how payers would manage sofosbuvir, including tier placement and management controls, in response to different pricing scenarios
- ✓ Determine physician value perceptions on sofosbuvir and willingness to prescribe under different payer access controls
- ✓ Project payer mix for HCV, especially in light of Medicaid expansion under Health Care Reform to evaluate implications on Medicaid Best Price and sofosbuvir Net Pricing
- ✓ Develop a payer segmentation list to prioritize the most important accounts for sofosbuvir market access and to be used as a basis for optima contracting strategies

As a reminder, these exploratory discussions were with a sample that represented all of the relevant payer segments and were conducted within the past week

PAYER SAMPLE FOR THE PRIMARY RESEARCH PROGRAM

STAKEHOLDER	QUAL SAMPLE	QUANT SAMPLE	RATIONALE
Commercial MCO medical and pharmacy directors	6	30-40 (*likely to be a Commercial heavy payer sample*)	• Evaluate unmet needs from payer perspective • Understand price sensitivity and establish key pricing threshold for sofosbuvir • Provide insights on potential access restrictions for different pricing scenarios
Medicare Part D PDP and MA-PDP pharmacy and medical directors	4		
Medicaid decision makers – FFS and Managed Medicaid	5		
Dept. of Corrections	1		
Total	**16**	**30-40**	

Today's focus

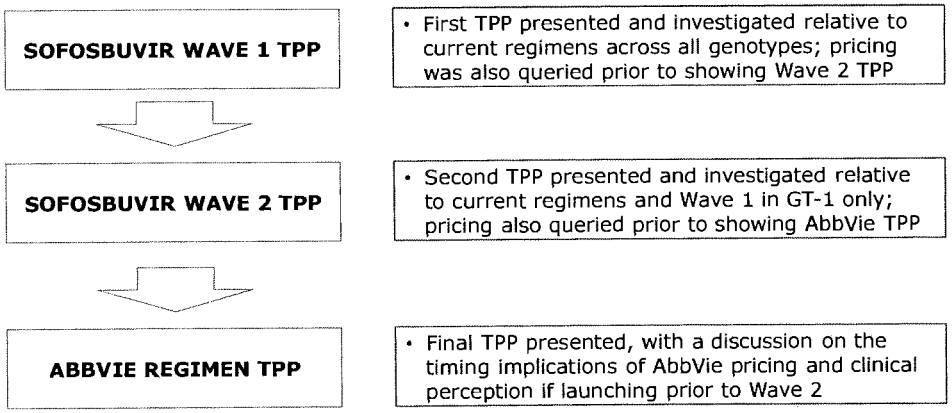
ims consulting group™

Executive summary

CLINICAL EVALUATION OF THE PRODUCTS
• Wave 1 sofosbuvir was seen to be a clear winner over the current standard of care in GT-1 and GT-2, while GT-3 was generally not well-received (at least in treatment naïve patients)
• AbbVie's regimen was highly valued, despite the complicated regimen burden, and was favored by payers over IFN-containing regimens, including sofosbuvir Wave 1
• Wave 2 was the unanimously preferred regimen over all profiles tested and was driven by a multitude of clinical factors, including co-infected data, limited side effects, once daily oral dosing, and SVR
WAVE 1 PRICING STRATEGY
• Pricing potential varied across payer segments although acceptable pricing with equal access was widely achievable at up to $80-90K; access will always have a PA to the label in HCV and a hard step through current products was seen to be quite difficult
• Gilead could feasibly influence AbbVie's pricing by capturing a high price with Wave 1, which is most likely to be the price reference for AbbVie at the time of their launch
WAVE 2 PRICING STRATEGY
• If AbbVie launches before Wave 2, it will become the new price reference and drive payer reactions to Wave 2 list prices
• Despite the significantly better clinical perception, Wave 2 will likely need to be within a 10-15% price range to AbbVie's regimen to avoid being disadvantaged on access because of equal SVR
• For Wave 2, contracting could be valuable with payers who might prefer AbbVie's 3-DAA based on a lower price; the goal would be to allow Gilead to have equal market access and compete among docs

Payers were shown profiles for both sofosbuvir regimens as well as for the AbbVie regimen and the implications of launch timing on P&MA potential was discussed at length

APPROACH FOR EVALUATING THE SOFOSBUVIR OPPORTUNITY ACROSS WAVES



NOTE: Due to timing constraints, discussion of the simeprevir profile was ultimately excluded from most discussions based on a perceived lower level of competitive threat as compared to AbbVie

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Wave 1 sofosbuvir was received positively by payers and there was a clear recognition of improvement over current products, especially on the duration and an IFN-free regimen for GT-2/3

WAVE 1 PROFILE EVALUATION

STRENGTHS	WEAKNESSES
GT-1 AND 2 SVR • Very **strong perception of GT-2** data across all payer segments; **GT-1** was also well-received to nearly all payers though **slightly less so than the GT-2 data** IMPROVED DOSING / DURATION • 12 week dosing and the reduced duration of IFN/Ribavirin were very favorable drivers of value to the payers, with many believing these would drive **improved patient compliance**	GT-3 SVR • Though payers were interested in another GT-3 option, the data was seen to be **weak relative to IFN/Ribavirin alone** TREATMENT NAÏVE ONLY IN GT-1 WITH IFN • Only mentioned by 2 payers, but **the lack of T.E. data** was seen as a major weakness • Although reduced duration of IFN was a strength, there were still payers who saw **any IFN** in the regimen **as a weakness**

ADDRESSING UNMET NEEDS

- Overall, most payers cited that Wave 1 sofosbuvir addressed a number of key unmet needs as the regimen was seen to provide better efficacy in an "easier, more tolerable" regimen
- No major differences among the major payer segments although Managed Medicaid payers did appear slightly less enthusiastic than others

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SOF/5885 in Wave 2 had a much stronger clinical value proposition to payers than Wave 1, with most believing that the many of the unmet needs were being addressed

WAVE 2 PROFILE EVALUATION

STRENGTHS	WEAKNESSES
IMPROVED DOSING / DURATION • Seen to be a **major advancement** by all payers, with many citing that the all oral regimen **will become the standard of care** • **Daily dosing** of the FDC was seen to be a **"game-changer"** by nearly all payers SUBPOPULATION DATA • Seen as a key point of differentiation, with the **HIV/HCV co-infected population** being cited most often	GT-1 SVR • Payers were **looking for higher SVR** relative to Wave 1, but generally believed it was **"acceptable" given** both T.E. data and the **dramatic improvements in regimen burden** EXPECTATION OF HIGH PRICE • Three payers immediately cited their **concerns** that **the product would be expensive** due to all the improvements relative to the current treatment options

ADDRESSING UNMET NEEDS

- Overall, most payers cited that Wave 2 sofosbuvir was a significant step for advancing HCV treatment and met nearly all unmet needs originally cited
- Interestingly, Medicaid payers (especially FFS) seemed to be the most enthusiastic about the Wave 2 profile compared to the other payer segments

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The AbbVie regimen was viewed more favorably than Wave 1 by payers although not as compelling as sofosbuvir in Wave 2; pill burden was seen to be a major weakness

ABBVIE PROFILE EVALUATION

STRENGTHS	WEAKNESSES
IMPROVED DURATION • 12 week duration was seen positively relative to the current treatment regimens and having an **all oral regimen in GT-1 was a strong point of value** STRONGER THAN SOFOSBUVIR WAVE 1 • Seen to be a **stronger profile than Wave 1 sofosbuvir** because of the IFN-free regimen and treatment experienced data with a comparable SVR	COMPLICATED REGIMEN / PILL BURDEN • 6-11 pills per day was a **significant weakness** of the profile **although** payers did believe it was **superior than having IFN** in the regimen DISCONTINUATION RATE • Higher discontinuation relative to Wave 2 (1.6% v. 1%) was a **concern for a few** payers although **others were less worried**

ADDRESSING UNMET NEEDS

- Seen to be an advancement over current regimens and perceived to be a potential new SoC depending on the launch timing relative to sofosbuvir
- If AbbVie did provide the regimen in a blister pack then payers would have fewer concerns about AbbVie dosing and would see it as a sign of the manufacturer wanting to ensure outcomes

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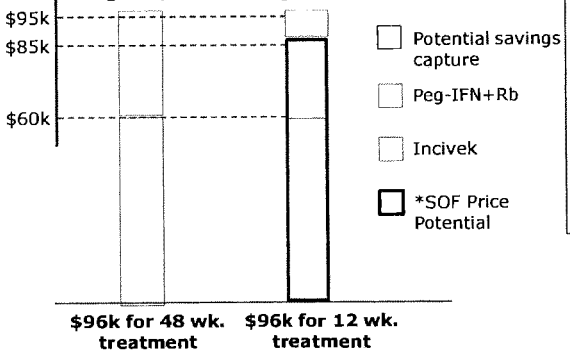
Payers consider total regimen costs when making coverage decisions, but will also be sensitive to the relative cost of single agents

SINGLE AGENT VERSUS REGIMEN PRICING

REGIMEN PRICING ARGUMENT



COMMENTARY

- Sofosbuvir will clearly benefit from **comparison to the current triple regimen cost** because of shorter duration and less INF/ribavarin
- Payer price sensitivity towards regimen costs **compels a choice** of a pricing strategy **that maximizes revenue for a single regimen**
- Generally, payers will look at the **cost of single agents** in terms of PMPM **for underwriting purposes**, but the **P&T** will certainly **consider course of therapy**

**assuming equal clinical benefits to Incivek/Peg-IFN/Rb and shorter duration

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Reactions to tested price points showed that most payers are willing to accept at least $85K for GT-1 before considering additional access restrictions over the current PIs

WAVE 1 PRICING POTENTIAL – REACTIONS TO TESTED PRICE POINTS FOR GT-1

	COMMERCIAL (n=6)	MEDICARE (n=4)	MEDICAID (n=5)
≥$120K	• 3 require a hard step and 1 requires a soft step through existing regimens in GT-1 • All others have PA only	• 3 require a hard step through existing regimens • 1 blocks access in GT-1	• All Managed Medicaid (3) block access for GT-1 • 1 FFS has PA only, while 1 has step edit in all genotypes
$100K	• 4 require a soft step through existing regimens in GT-1 • All others have PA only	• 1 requires a hard step and 1 requires a soft step in GT-1 • All others have PA only	• All FFS (2) and 2 Managed Medicaid have PA only • 1 Managed Medicaid has a block for GT-1
$85K	• 1 would prefer SOF in GT-1 • 1 requires soft step in GT-1 • All others have PA only	• 1 requires soft step in GT-1 • All others prefer the product relative to current products with a PA only in all genotypes	• PA only for both Managed Medicaid and FFS payers in GT-1
≤$67K	• 3 would prefer SOF in GT-1 • All others have PA only and most would require a step through SOF to get PIs	• Preferred agent relative to current products for all payers with a PA only • 1 requires step through SOF to get PIs	• Preferred agent relative to current products for all payers with a PA only • 2 block the PIs from GT-1 in favor of SOF

Note: Prior authorization will always be part of market access in HCV

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Generally open access | Some restrictions | Many restrictions

GT-2/3 posed more difficulties to payers at the tested price points, and GT-3 in particular pushed many payers to look for heavy restrictions or block sofosbuvir completely

WAVE 1 PRICING POTENTIAL – REACTIONS TO TESTED PRICE POINTS FOR GT-2/3

	COMMERCIAL (n=6)	MEDICARE (n=4)	MEDICAID (n=5)
≥$120K	• 3 would block access for GT-2/3 for treatment naïve • 1 would block GT-3 only for treatment naïve	• 3 have hard step for GT-2/3 at $140K, but soft step at $120K • 1 has more stringent PA every 4 weeks for GT-2/3 and hard step for GT-3	• 1 FFS has PA only for GT-2/3, while other has blocked access for GT-3 only • 2 Managed Medicaid block GT-2/3, while 1 blocks only GT-3
$100K	• 2 block access for GT-2/3 for treatment naïve • 2 would block GT-3 only for treatment naïve	• 3 have PA only in GT-2/3 • 1 has more stringent PA every 4 weeks for GT-2/3 and hard step for GT-3	• All FFS (2) and 2 Managed Medicaid have PA only for GT-2/3 • 1 Managed Medicaid blocks GT-3
$85K	• 2 block access in GT-2/3 for treatment naïve • 2 would block GT-3 only for treatment naïve	• 3 prefer SOF in GT-2 and PA only in GT-3 • 1 has hard step for GT-3	• PA only for all Managed Medicaid and FFS payers
≤$67K	• 2 would have a soft step only for GT-2 • 4 would block GT-3 only for treatment naive	• 3 prefer SOF in GT-2 and PA only in GT-3 • 1 has hard step for GT-3	• Preferred agent relative to current products for all payers with a PA only

Note: Prior authorization will always be part of market access in HCV

Generally open access | Some restrictions | Many restrictions

Sofosbuvir in Wave 2 was widely seen as achieving a $100K price point although the competitive implications of AbbVie pricing will clearly influence achievable pricing

WAVE 2 PRICING POTENTIAL – REACTIONS TO TESTED PRICE POINTS

	COMMERCIAL (n=6)	MEDICARE (n=4)	MEDICAID (n=5)
≥$120K	• 2 require soft step edit, while 1 requires hard step edit • 3 require PA only	• Soft step edit for all payers	• 1 Managed Medicaid has a block, while other 2 have soft step edits • All FFS require PA only
$100K	• 2 require soft step edit, while other 4 require PA only	• 3 require soft step edit, while other 1 requires PA only	• 1 Managed Medicaid has a block • All other payers require PA only
$85K	• 1 has SOF as preferred agent, while other 5 require PA only	• All payers require PA only	• All payers require PA only
≤$67K	• 4 have SOF as preferred agent, while other 2 require PA only	• 3 have SOF as preferred agent, while other 1 requires PA only	• 4 have SOF as preferred agent, while other 1 requires PA only (Managed Medicaid)

Note: Prior authorization will always be part of market access in HCV

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Generally open access | Some restrictions | Many restrictions

Pricing potential for AbbVie was generally in line with price responses for sofosbuvir Wave 2 although payers did clearly see less value in the more complicated regimen

ABBVIE PRICING POTENTIAL RELATIVE TO SOFOSBUVIR ACROSS PRODUCT WAVES

PRICING POTENTIAL TO SOFOSBUVIR WAVE 1	• AbbVie's 3-DAA would become SoC if entering the market before Gilead's fixed-dose combination and will likely receive equal access to sof./Peg-IFN/Rb if priced with at least a premium of 15%
PRICING POTENTIAL TO SOFOSBUVIR WAVE 2	• Most payers consider AbbVie's 3-DAA to be inferior due to complex dosing regimen, however, they expect Gilead's fixed-dose combination to be within a 10-15% price difference, assigning only slight pricing power to dosing over SVR
IMPORTANCE OF LAUNCH TIMING ON ACHIEVABLE PRICE	• Gilead's has the first mover advantage with Wave 1, which gives the possibility to set a higher price reference for the market • If AbbVie's 3-DAA comes to the market before Wave 2, it will become SoC and Wave 2 will not be able to command a premium over it if equal market access is the goal

Although only briefly touched upon in discussions, contracting was not seen to be mandatory for sofosbuvir in Wave 1 although a net price strategy in Wave 2 could be needed

CONTRACTING CONSIDERATIONS FOR SOFOSBUVIR

WAVE 1 CONTRACTING

PAYER EXPECTATIONS

- No contracting in Wave 1, unless it is to be a sign of good faith
  - Wave 1 provides significant advantages and strong access will likely be achieved without active payer engagement via contracting

POTENTIAL CONTRACTING APPROACHES

- Contract only with the high level of control payers that may block Wave 1 at high prices and only implement traditional rebate +/- performance kickers
- Engage Managed Medicaid plans that may prefer the existing triple regimens based on price

WAVE 2 CONTRACTING

PAYER EXPECTATIONS

- Payers expect significant contracting opportunities when both AbbVie and Wave 2 are on the market due to comparable SVR, which drives payers to see interchangeability
- Payers would, however, expect Gilead to have to offer less given the improved pill burden

POTENTIAL CONTRACTING APPROACHES

- Contract selectively only with payers preferring AbbVie to gain equal access and compete for physicians, who will likely prefer Gilead's easier regimen
- Simple, traditional contracts are clearly preferred and outcomes-based is discouraged

"I understand why they'd want to attempt a price per cure or outcomes-based contract, it's the holy grail, but I just think it would be remarkably dumb and risky for them to try it." – Commercial Payer

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Agenda

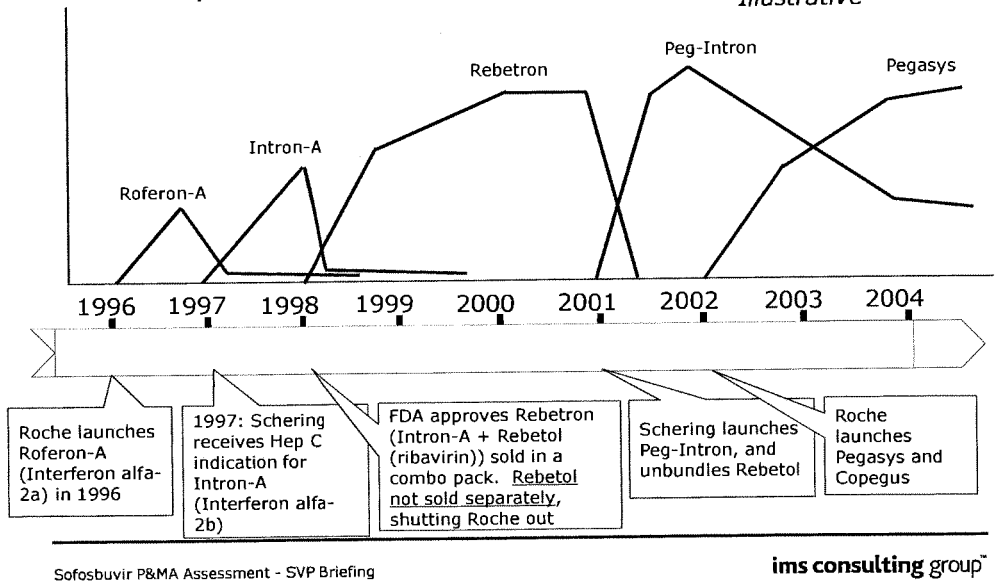
Sofosbuvir Pricing and Market Access Assessment

- Review of approach and initial research findings
- **Pegasys launch strategy**

Timeline and Results

Launching into a market owned by Schering, Pegasys overtook Peg-Intron one year after launch

Illustrative



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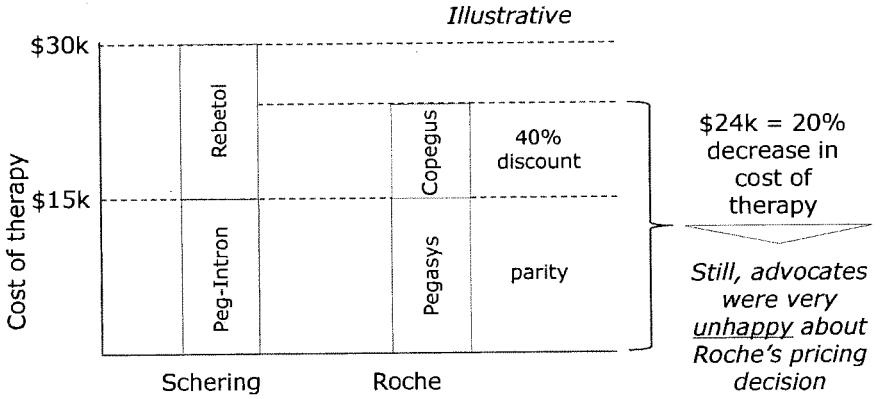
Considerations around pricing for Pegasys and Copegus

- By exclusively co-packaging interferon + ribavirin in Rebetron, Schering ensured Roferon-A could not compete against Intron-A
- Through aggressive price increases, Schering doubled the cost of HCV therapy over 3-4 years following Rebetron launch
- In preparing for Pegasys launch, Roche courted advocacy groups who were angry about Schering's pricing tactics
  - Roche had committed, implicitly or explicitly, that Pegasys would bring down cost of HCV treatment
- FDA approval process slowed Pegasys's approval, delaying it until one year after Peg-Intron's launch
- Pricing studies showed that launching Pegasys at a discount would have no effect on physician uptake, or on payer access
- Copegus would have about one year on market before Rebetol LOE, which would make cheap ribavirin available for use with either peg-interferon

Accordingly, in arriving at launch price, Roche tried to balance competing objectives of long term revenue maximization and commitment to HCV advocates



By pricing Copegus at 40% discount to Rebetol, and parity pricing its long term asset, Pegasys, Roche reduced cost of therapy by 20%, which the brand team argued was lowest "meaningful" discount

Considerations around contracting for Pegasys and Copegus

- Payers felt burned by Schering price increases, but HCV not a high spend category or priority for management
- Given lack of differentiation, aggressive payers saw opportunity to "make a market," preferring one brand through tiering and extracting rebates from manufacturer
- Most payers were reluctant to intervene with specialists in a heavy-handed way (e.g., step therapy requiring failure on preferred peg-interferon)
- At time of Pegasys launch, Peg-Intron had 100% of HCV market
  - Utilization x rebate % = Rebate Stream Value
- Roche believed physicians would prefer Pegasys over Peg-Intron, if not disadvantaged by payers or other intermediaries
- Schering contracted with SPPs and drove scripts to that channel

Roche's contracting strategy was to maintain payer neutrality, allowing the battle for share to be waged at physician level

- Contracting Objective #1
  - *Secure parity access at payer level*
    - No rebates to payers that could not demonstrate ability and willingness to prefer one peg-interferon
    - Pay low level rebates for parity access to payers that could and would differentially tier
      - Rationale: Payers would rather not incur management costs and ill will among providers if they could collect rebates from both manufacturers
- Contracting Objective #2
  - *Where payers are intent on preferring one product, play to win*
    - Given Pegasys's lack of share at launch, every effort was made to discourage and delay these decisions as long as possible
    - Significant Medicaid share in HCV was barrier to aggressive rebating that would create new best price
- Contracting Objective #3
  - *Contract with SPPs to ensure neutrality and secure high-touch services to improve compliance, persistence, and patient experience/outcomes*

- **APPENDIX: SUPPORTING SLIDES AND PRODUCT PROFILES**

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Profile A

Sofosbuvir Wave 1 TPP – Product A

	Genotype 1,4,5,6	Genotype 2	Genotype 3
MOA	NS5B Nucleotide Polymerase Inhibitor		
Target Population	Treatment naïve	Treatment naïve Treatment experienced Interferon intolerant or ineligible	Treatment naïve Treatment experienced Interferon intolerant or ineligible
Sub-populations	Cirrhotics, Pre-Transplant Patients, Geriatric Patients (65+), Pre-Transplant Patients	Cirrhotics, Geriatric Patients (65+), Pre-Transplant Patients, HIV-HCV Co-infected Patients	Cirrhotics, Geriatric Patients (65+), Pre-Transplant Patients, HIV-HCV Co-infected Patients
Regimen	**Product A:** 400mg tablet, QD **Ribavirin:** 1000 – 1200mg BID **Peginterferon alfa:** Weekly inject.	**Product A:** 400mg tablet, QD **Ribavirin:** 1000 – 1200mg BID	**Product A:** 400mg tablet, QD **Ribavirin:** 1000 – 1200mg BID
Duration of therapy	12 weeks (Until transplantation for pre-transplant patients)		16 weeks (Until transplantation for pre-transplant patients)
Side effects	No signature safety signal has been observed with Product A. All laboratory abnormalities were consistent with those expected from 12 weeks PegIFN/RBV treatment (Top 4 AEs): **Anemia:** 14% **Fatigue:** 13% **Neutropenia:** 12% **Headache:** 9% 2% of patients discontinued due to AEs in clinical trials	No signature safety signal has been observed with Product A. All laboratory abnormalities were consistent with those expected from 12 weeks RBV treatment (Top 4 AEs): **Fatigue:** 9% **Insomnia:** 6% **Headache:** 4% **Anemia:** 3% 1% of patients discontinued due to AEs in clinical trials	No signature safety signal has been observed with Product A. All laboratory abnormalities were consistent with those expected from 16 weeks RBV treatment (Top 4 AEs): **Fatigue:** 8% **Headache:** 7% **Insomnia:** 6% **Anemia:** 6% 0% of patients discontinued due to AEs in clinical trials
Estimated SVR in Phase 3	Treatment naïve: 90%	Treatment naïve: 97% Treatment experienced: 86% Interferon intolerant or ineligible: 93%	Treatment naïve: 56% Treatment experienced: 62% Interferon intolerant or ineligible: 61%

Profile D

	SOFO/LDV FDC Regimen Product C	AbbbVie FDC Regimen Profile D regimen
MOA	Fixed dose combination of NS5B Nucleotide Polymerase Inhibitor (Product A) + NS5A Inhibitor	Product D: Protease inhibitor + NS5A Inhibitor + Ritonavir Product Q: Non-Nucleotide Polymerase Inhibitor
Target Population	Treatment naïve Treatment experienced (IFN or PI experience)	Treatment naïve Treatment experienced (IFN experience only)
Subpopulations	Cirrhotics, Geriatrics, HCV/HIV co-infected	Cirrhotics, Geriatrics
Regimen	**Product C:** (400mg NS5B/90mg NS5A) 1 tablet QD **Ribavirin:** 1000-1200mg BID	**Product D** (2 x 75mg PI/12.5mg NS5A + Ritonavir): 2 tablets QD **Product Q:** 250mg 1 tablet BID **Ribavirin:** 1000-1200mg BID
Duration of therapy	12 weeks	12 weeks
Side effects	No signature safety signal has been observed with Product C. All laboratory abnormalities were consistent with those expected from 12 weeks RBV treatment (Top 4 AEs): Fatigue: 9% Insomnia: 6% Headache: 4% Anemia: 3% 1% of patients discontinued due to AEs in clinical trials	No signature safety signal has been observed with Product D or Q. All laboratory abnormalities were consistent with those expected from 12 weeks RBV & Ritonavir AEs in >10% of patients: Headache, fatigue, nausea, insomnia, and diarrhea 1.6% discontinuation rate due to AEs in clinical trials
Estimated GT-1SVR in Phase 3	Treatment naïve: 90% Treatment experienced: 85%	Treatment naïve: 90% Treatment experienced: 85%

Potential analogue for HCV: anti-TNFs

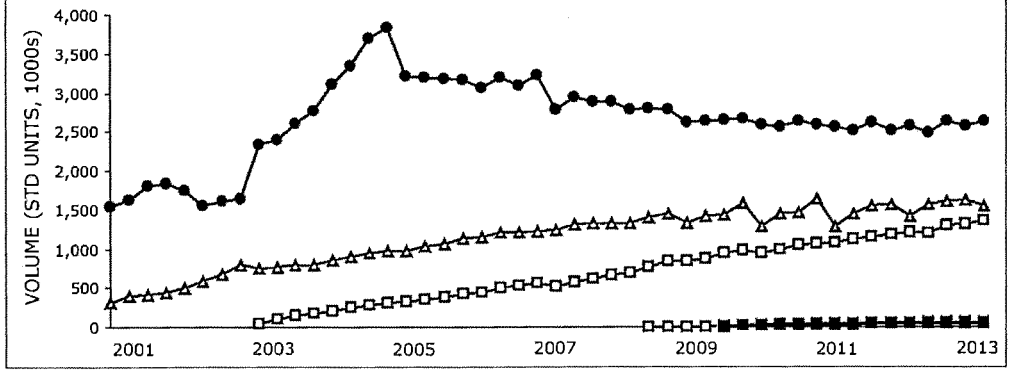
PRODUCT OVERVIEW

- Enbrel launched as the first sub-q, followed by Humira in 2003; both have been successful, adding new indications and generally holding off new competitors
- TNF inhibition represented a major breakthrough and significant clinical advance over traditional DMARDs

MARKET DYNAMICS

- Subsequent entrants, including both TNFs and other MoAs, have been less successful, largely because incremental improvements have been very modest
- Amgen and Abbott have successfully co-existed in the market for over a decade, generally comfortable with parity access

VOLUME OVER THE PAST DECADE



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Payers see unmet needs in treating HCV and many recognize that the PIs have not entirely lived up to expectations; tough treatment regimens and high costs drive current management

OVERALL HCV PHILOSOPHY AND PERSPECTIVES ON THE THERAPY AREA

PERCEPTION OF UNMET NEEDS

- Payers clearly see unmet needs in HCV and placed a particular emphasis on having a "shorter, less complicated" regimen
- Most unmet need is seen in GT-1 and to a lesser degree in GT-3 due to fewer patients

PAYER MANAGEMENT APPROACH

- Preferred PIs were seen with some plans although limited consistency was seen
- Those plans with a preferred product seemed to be largely driven by contracting terms
- All products have a PA, likely just to label

PRICE-VALUE TRADEOFF

- Regimen costs of $85K-$95K were generally seen as too expensive for the value provided given the SVR and side effect profiles
- With that said, payers recognized the better GT-1 outcomes than with PEG/RBV alone

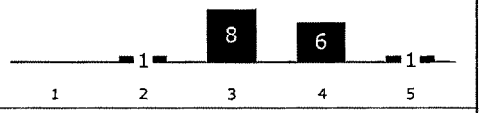
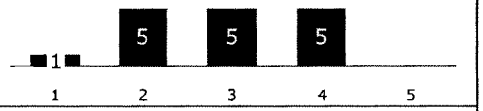
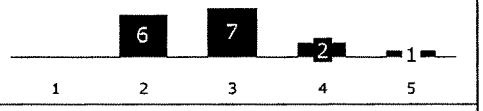
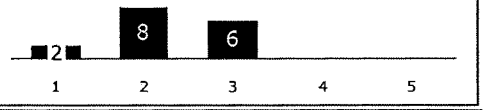
DIFFICULT PATIENT POPULATION

- At a broader level, payers recognized that the HCV patient population is hard to manage
- Co-morbid conditions and heavy pill burden raised concerns over compliance

Overall, payers agree that they would not have approached management of the PIs any differently since they represented innovation in GT-1 when launched

Modest dissatisfaction is seen with the current options and it is largely driven by the duration and SVR; while wastage concerns are present, payers see SPPs improving that situation

SATISFACTION WITH CURRENT HCV PRODUCTS

ATTRIBUTES	RATINGS (1-5, 1=UNSATISFIED, 5=SATISFIED)
SVR EFFICACY	
RX OPTIONS ACROSS GENOTYPES	
DURATION OF THERAPY	
COMPLIANCE	

"It would be great to have a high SVR for the non-responders." – Commercial payer

"I'm only really thinking about GT-1, we don't have enough GT-2/3 to worry about it." – FFS Medicaid payer

"The current regimens with a PI+Peg+Riba are a serious pain. The PIs caused problems." – DOC payer

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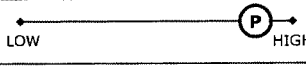
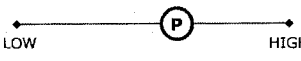
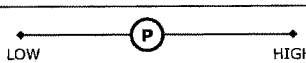
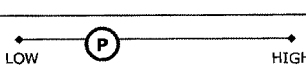
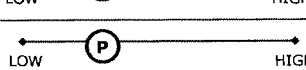
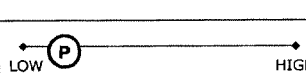
Knowledge of upcoming HCV market changes was generally high, particularly around IFN-free regimens, though few payers cited specific products of interest

AWARENESS OF FUTURE HCV MARKET CHANGES

	RELATIVE AWARENESS	COMMENTARY
ALL-ORAL / IFN-FREE REGIMENS		• Very high awareness of the market eventually shifting to INF-free regimens • Reasonable awareness of the key players, with Gilead, Janssen and AbbVie all identified
AWARENESS OF HCV MANUFACTURERS		
PRICING CHANGES OF CURRENT PRODUCTS		• Aware of the recent price increases of Incivek, but no change in management as a result
NEW LAUNCHES / SIMILAR MOA		• Mechanism was not well-identified by the payers (much more emphasis was put on efficacy and duration) • Limited differentiation across product classes (e.g. PI, NI)
NEW LAUNCHES / NEW MOA		
ACTIONS FROM SPECIFIC MANUFACTURERS		• No payer shared specific actions that manufacturers have recently taken to discuss pipeline products at their plan

"I know there are A LOT of upcoming changes, but I don't know specific products." – Commercial payer

(P) PAYER

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Sofosbuvir was perceived to show a number of improvements relative to the current standards of care in both GT-1 and 2, while GT-3 was viewed much more critically due to the SVR

WAVE 1 CLINICAL VALUE RELATIVE TO CURRENT COMPETITION

COMPARATOR	RATINGS OF WAVE 1 ATTRIBUTES RELATIVE TO COMPARATOR (--- TO +++)			
	EFFICACY	SAFETY	DURATION	COMPLIANCE
GT-1 S.O.C.	++	+	+++	++
GT-2 S.O.C.	++	-/+	++	++
GT-3 S.O.C.	-/+	-/+	++	++

[ ] BETTER THAN COMPARATOR [ ] EQUAL TO COMPARATOR [ ] WORSE THAN COMPARATOR

GT-1 COMMENTARY

- Payers believed that Wave 1 was an improvement over SoC on all tested attributes, with duration being most important
- Meaningful improvements in efficacy and compliance were also cited and many believed that the shorter duration would directly lead to better compliance and outcomes

GT-2/3 COMMENTARY

- The GT-2 profile showed clear improvements on efficacy although the safety profile was effectively neutral
- The GT-3 profile was effectively neutral relative to SoC in treatment naïve patients, although value was seen in the T.E. / IFN-ineligible populations

Overall, SOF/5885 was seen to have the strongest clinical value proposition due to a combination of the efficacy across GT-1 subpopulations and expectations of good patient compliance

WAVE 2 CLINICAL VALUE RELATIVE TO ALL CURRENT AND FUTURE PRODUCTS

COMPARATOR	RATINGS OF WAVE 2 ATTRIBUTES RELATIVE TO COMPARATOR (--- TO +++)			
	EFFICACY	SAFETY	DURATION	COMPLIANCE
GT-1 S.O.C.	+++	++	+++	++
WAVE 1 SOFOSBUVIR	++	+	-/+	++
ABBVIE REGIMEN	+	-/+	-/+	++

[ ] BETTER THAN COMPARATOR [ ] EQUAL TO COMPARATOR [ ] WORSE THAN COMPARATOR

WAVE 2 RELATIVE TO WAVE 1

- Clearly preferred relative to Wave 1 based primarily on efficacy and expected improvements in compliance as a result of the simple regimen
- Duration was seen to be fairly neutral as the two tested profiles were both at 12 weeks

WAVE 2 RELATIVE TO ABBVIE

- Strong preference for Wave 2 over AbbVie based mostly on compliance
- Although efficacy tested was identical, some payers believed that Wave 2 sofosbuvir would be much more likely to achieve this SVR in the real world because of the simpler regimen relative to AbbVie

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Clinical guidelines will also play a significant role in the way that payers manage HCV products, both within and across product classes (e.g. PIs, NIs), when differences in pricing exist

ROLE OF CLINICAL GUIDELINES ON PAYER POLICIES

PAYER PERSPECTIVES

- Payers recognize that the **severity of the disease** and **increasing** number of available **therapies** will require to pay close attention to **evidence-based guidelines** (e.g., CDC)
- Payers indicate ability to **implement step edits if** guidelines specify therapies to be **possible alternatives**
- If therapies are specifically deemed to be standard-of-care, they **will not impose step edits even at premium price points** that represent significant increases over the current standard of care

Overall, guidelines will have a significant impact on payer management in HCV, regardless of the price, for next generation products

"If the guidelines prefer something then you can't do anything about it. There is no way I could introduce a step in front of a guideline preferred product. We just wouldn't do it." – Commercial payer

"We are not in a position to argue with guidelines, so we would just accept what they say and that will be it." – Commercial payer

"If a product comes to market at a 20% premium over the PIs, and it is specified the be the new and accepted standard of care, the only thing I can do is to recommend that physicians use the PIs (via soft step edit), but I know they will never actually do it ." – Commercial payer

Payers believed that sofosbuvir in Wave 1 could command premium pricing to current products without significant access disadvantages

WAVE 1 PRICING POTENTIAL – OPEN PAYER RESPONSES

At what price would you provide...	COMMERCIAL	MEDICARE	MEDICAID
BETTER ACCESS FOR SOFOSBUVIR	<$70K	<$75K	$65K - $75K
EQUIVALENT ACCESS FOR SOFOSBUVIR	$85K - $100K	$85K - $94K	$85K - $100K
MORE RESTRICTED ACCESS FOR SOFOSBUVIR	$85K - >$170K	$95K - >$120K	$100K - >$140K
NO COVERAGE / OFF FORMULARY	Always covered	Always covered	>$140K

BETTER ACCESS
- Payers indicate that they would prefer sofosbuvir over the current standard of care only if the regimen was less expensive
- Even if they recognize higher value in sofosbuvir, they would not prefer it and comment that it would in any case become the SoC over currently used treatments

MORE RESTRICTED ACCESS
- The majority of payers appeared to be more inclined to imposing restriction on sofosbuvir once the $100K threshold was passed
- It must be noted however, that payers indicated that for price points slightly over $100k, they would impose a "soft" PA, that is, they would simply ask prescribing docs why they would not use current SoC instead

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Payers believed that sofosbuvir in Wave 2 could command significant premiums over current products, but would be impacted by both Wave 1 and AbbVie pricing levels

WAVE 2 PRICING POTENTIAL – OPEN PAYER RESPONSES

At what price would you provide...	COMMERCIAL	MEDICARE	MEDICAID
BETTER ACCESS FOR SOFOSBUVIR	10% DISCOUNT OVER PRODUCT A	15% DISCOUNT OVER PRODUCT A	10% DISCOUNT OVER PRODUCT A
EQUIVALENT ACCESS FOR SOFOSBUVIR	10-15% PREMIUM OVER PRODUCT A	SAME PRICE AS PRODUCT A	SAME PRICE AS PRODUCT A
MORE RESTRICTED ACCESS FOR SOFOSBUVIR	>20% PREMIUM OVER PRODUCT A	>20% PREMIUM OVER PRODUCT A	>20% PREMIUM OVER PRODUCT A
NO COVERAGE / OFF FORMULARY	Always covered	>20% PREMIUM OVER PRODUCT A	>20% PREMIUM OVER PRODUCT A

EQUIVALENT ACCESS
- Payers specified that Wave 1 will become the standard of care and will use its price point as reference for assessing pricing of Wave 2
- If Wave 2 launches before AbbVie's regimen, commercial payers will accept a 10-15% premium over Wave 1 for Wave 2

MORE RESTRICTED ACCESS
- Payers considered the fixed dose combination of Wave 2 to be the game changer that the market is expecting and considered possible restrictions to be imposed only if Wave 2 were priced with a >20% premium over Wave 1

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For the Department of Corrections (DoC) payer we surveyed, there are several important considerations for determining the pricing and access potential of sofosbuvir in that segment

CONSIDERATIONS FOR THE DEPARTMENT OF CORRECTIONS

FORMULARY DECISIONS • For HCV, all products, including the PIs, are excluded from the formulary – This is a form of control to make physician go through a PA process and ensure need for the expensive treatment	*"All these expensive drugs do not get added to our formulary. Docs will need to go make an off-formulary and wait for our internal committee to approve." – DOC payer*
PRICE SENSITIVITY • Limited concern over price given 340B buying and confidence in additional state funding should budget be exceeded	*"We are held to the community standard of care that is why we give PIs. We buy expensive drugs from the 340B program or via our GPO. If we still go over what is budgeted, we will recover the cost from the State." – DOC payer*
RESTRICTED ACCESS • Patients must have 18 months or more in sentence and patients cannot have chemical dependency	*"Our highest unmet need is for our drug abusive population. At least 70% of them would require HCV treatment and we cannot give it to them." – DOC payer*
VERY HIGH PERCEIVED VALUE FOR WAVE 2 • Expected to be the SoC because of the simple regimen and the expected dramatic reduction in nursing time	*"I would buy [Wave 2] over [AbbVie's 3-DAA] even if it is 50% more expensive! Making sure that the patient really swallows six pills requires a lot of nursing time!" – DOC payer*

Profile A

	Genotype 1,4,5,6	Genotype 2	Genotype 3
MOA	NS5B Nucleotide Polymerase Inhibitor		
Target Population	Treatment naïve	Treatment naïve Treatment experienced (IFN or PI) Interferon intolerant or ineligible	Treatment naïve Treatment experienced (IFN or PI) Interferon intolerant or ineligible
Sub-populations	Cirrhotics, Geriatric Patients (65+), Pre-Transplant Patients	Cirrhotics, Geriatric Patients (65+), Pre-Transplant Patients, HIV-HCV Co-infected Patients	Cirrhotics, Geriatric Patients (65+), Pre-Transplant Patients, HIV-HCV Co-infected Patients
Regimen	**Product A:** 400mg tablet, QD **Ribavirin:** 1000 – 1200mg BID **Peginterferon alfa:** Weekly inject.	**Product A:** 400mg tablet, QD **Ribavirin:** 1000 – 1200mg BID	**Product A:** 400mg tablet, QD **Ribavirin:** 1000 – 1200mg BID
Duration of therapy	12 weeks (Until transplantation for pre-transplant patients)		16 weeks (Until transplantation for pre-transplant patients)
Side effects	No signature safety signal has been observed with Product A. All laboratory abnormalities were consistent with those expected from 12 weeks PegIFN/RBV treatment (Top 4 AEs): **Anemia:** 14% **Fatigue:** 13% **Neutropenia:** 12% **Headache:** 9% 2% of patients discontinued due to AEs in clinical trials	No signature safety signal has been observed with Product A. All laboratory abnormalities were consistent with those expected from 12 weeks RBV treatment (Top 4 AEs): **Fatigue:** 9% **Insomnia:** 6% **Headache:** 4% **Anemia:** 3% 1% of patients discontinued due to AEs in clinical trials	No signature safety signal has been observed with Product A. All laboratory abnormalities were consistent with those expected from 16 weeks RBV treatment (Top 4 AEs): **Fatigue:** 8% **Headache:** 7% **Insomnia:** 6% **Anemia:** 6% 0% of patients discontinued due to AEs in clinical trials
Estimated SVR in Phase 3	Treatment naïve: 90%	Treatment naïve: 97% Treatment experienced: 86% Interferon intolerant or ineligible: 93%	Treatment naïve: 56% Treatment experienced: 62% Interferon intolerant or ineligible: 61%

Profile D

	Product C	Profile D regimen
MOA	Fixed dose combination of NS5B Nucleotide Polymerase Inhibitor (Product A) + NS5A Inhibitor	Product D: Protease inhibitor + NS5A Inhibitor + Ritonavir Product Q: Non-Nucleotide Polymerase Inhibitor
Target Population	Treatment naïve Treatment experienced (IFN or PI experience)	Treatment naïve Treatment experienced (IFN experience only)
Subpopulations	Cirrhotics, Geriatrics, HCV/HIV co-infected	Cirrhotics, Geriatrics
Regimen	**Product C:** (400mg NS5B/90mg NS5A) 1 tablet QD **Ribavirin:** 1000-1200mg BID	**Product D** (2 x 75mg PI/12.5mg NS5A + Ritonavir): 2 tablets QD **Product Q:** 250mg 1 tablet BID **Ribavirin:** 1000-1200mg BID
Duration of therapy	12 weeks	12 weeks
Side effects	No signature safety signal has been observed with Product C. All laboratory abnormalities were consistent with those expected from 12 weeks RBV treatment (Top 4 AEs): Fatigue: 9% Insomnia: 6% Headache: 4% Anemia: 3% 1% of patients discontinued due to AEs in clinical trials	No signature safety signal has been observed with Product D. All laboratory abnormalities were consistent with those expected from RBV & Ritonavir AEs in >10% of patients: Headache, fatigue, nausea, insomnia, and diarrhea 1.6% discontinuation rate due to AEs in clinical trials
Estimated GT-1SVR in Phase 3	Treatment naïve: 90% Treatment experienced: 85%	Treatment naïve: 90% Treatment experienced: 85%

Current treatment approach across genotypes

Genotype	Initial treatment			Relapse patients / non responders
	Regimen	Duration	Success rate	
G1	Ribavirin + Peg interferon a / b + Protease Inhibitor *(teleprevir / boceprevir)*	24-48 depending on patient response	TVR: 70-80% BCR: 65-70%	• Repeat treatment, (if well tolerated previously) • Give triple therapy if previously treated with mono or dual therapy • Roughly 1/3 of patients receive the 48 week course of treatment for telaprevir
G2	Ribavirin + Peg interferon a / b	24	75-90%	• Repeat treatment (if well tolerated previously), extending to 48 weeks if necessary
G3			60-70%	

- HIV/HCV patient treatment is as above but initiated earlier
- Re-treatment considerations:
  - Previous treatment type, adherence and response
  - Severity of liver disease
  - Genotype (retreatment more successful and likely for G2/3)
- Multiple re-treatments (Peg Int a/Rib only) are rare, for maintenance purposes only
- Telaprevir+peg-Int+ribavirin has been shown to cause anemia in roughly 36% of patients, versus 17% of patients on peg-Int+ribavirin alone
- Telaprevir also has a black box warning for serious and sometimes fatal skin infections

Sources: American Association for the Study of Liver Diseases

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Profile C

	Product C
MOA	Fixed dose combination of NS5B Nucleotide Polymerase Inhibitor (Product A) + NS5A Inhibitor
Target Population	Treatment naïve Treatment experienced (IFN or PI experience)
Subpopulations	Cirrhotics, Geriatrics, HCV/HIV co-infected
Regimen	**Product C:** (400mg NS5B/90mg NS5A) 1 tablet QD **Ribavirin:** 1000-1200mg BID
Duration of therapy	12 weeks
Side effects	No signature safety signal has been observed with Product C. All laboratory abnormalities were consistent with those expected from 12 weeks RBV treatment (Top 4 AEs): **Fatigue:** 9% **Insomnia:** 6% **Heachache:** 4% **Anemia:** 3% 1% of patients discontinued due to AEs in clinical trials
Estimated GT-1SVR in Phase 3	Treatment naïve: 90% Treatment experienced: 85%

Prices of current products and regimens across genotypes

Product or Regimen	Cost ($)
Telaprevir (TVR) WAC - 28 days (4 weeks)	20,157
Boceprevir (BOC) WAC - 28 days (4 weeks)	5,536
Pegasys (PEG) WAC - 28 days (4 weeks)	2,695
Generic ribavirin (RBV) WAC - 28 days (4 weeks)	330
TVR for 12 weeks	60,471
BOC for 24 weeks (min)	33,218
BOC for 44 weeks (max)	60,899
PEG/RBV for 24 weeks	18,148
PEG/RBV for 48 weeks	36,295
TVR for 12 weeks + PEG/RBV for 24 weeks (min) – GT-1	78,619
TVR for 12 weeks + PEG/RBV for 48 weeks (max) – GT-1	96,766
BOC for 24 weeks + PEG/RBV for 28 weeks (min) – GT-1	54,390
BOC for 44 weeks + PEG/RBV for 48 weeks (max) – GT-1	97,194
PEG + RBV for 24 weeks - GT-2/3	18,148

Average telaprevir regimen cost per patient is roughly $85K, considering the 24/48 week patient mix of 33%/67%, respectively

Exhibit 35

GILEAD SCIENCES, INC.

MINUTES OF REGULAR MEETING OF BOARD OF DIRECTORS

Date and Time: August 1, 2013, 11:30 a.m.

Place: Offices of Gilead Sciences, Inc. (the "Company")
333 Lakeside Drive
Foster City, CA 94404

Directors Present: John C. Martin, Chairman
John F. Cogan, Lead Independent Director
Etienne F. Davignon
Carla A. Hills
Kevin E. Lofton
John W. Madigan
Nicholas G. Moore
Richard J. Whitley
Gayle E. Wilson
Per Wold-Olsen
George P. Shultz, *Director Emeritus*

Also Present: Gregg Alton, Norbert Bischofberger, Muz Mansuri, Jim Meyers, John Milligan, Brett Pletcher, Bill Symonds, Robin Washington, Katie Watson and Kevin Young

1. Call to Order

John Martin called the meeting to order and served as Chairman and Gregg Alton served as Secretary of the meeting.

2. Executive Session; Audit Committee Report

Dr. Milligan and Mr. Pletcher joined the executive session.

Mr. Moore summarized the meeting of the Audit Committee held on July 31, 2013.

With the recommendation of the Audit Committee, upon discussion and upon motion duly made, the Board approved the changes to the Audit Committee Charter as set forth on **Exhibit A** attached hereto.

Executive Session; Compensation Committee Report

Mr. Madigan summarized the meeting of the Compensation Committee held on August 1, 2013.

Executive Session; Nominating and Corporate Governance Committee Report

Ms. Wilson summarized the meeting of the Nominating and Corporate Governance Committee held on August 1, 2013.

3. CEO's Report

Dr. Martin reviewed with the Board a written summary of developments in the biotechnology and pharmaceutical industries during the last quarter.

4. Approval of Minutes

Mr. Alton, Dr. Bischofberger, Ms. Washington, Ms. Watson and Mr. Young joined the meeting at this time.

The Board approved the minutes from the meeting held on May 8, 2013 in the form previously distributed.

5. Quarterly Update

Ms. Washington reported to the Board on the Company's financial results, progress and developments in the second quarter of 2013.

6. Corporate Development

Dr. Mansuri gave an update on the Company's business development activities.

7. Sofosbuvir Clinical Update and U.S. Launch Preparations

Mr. Symonds gave an update on the status of the clinical trials involving sofosbuvir and Mr. Meyers discussed the preparations taken for the anticipated U.S launch of sofosbuvir. The Board asked a number of questions that were answered by management. Messrs. Symonds and Meyers left the meeting and Mr. Young and the Board further discussed the anticipated launch of sofosbuvir.

8. Independent Directors' Session

The Board then met in independent directors' session.

9. Adjournment

There being no further business to come before the Board, the meeting was adjourned.

Respectfully submitted,

John C. Martin, Chairman of the Meeting

Gregg H. Alton, Secretary of the Meeting

EXHIBIT A

Exhibit 36

GILEAD

Sofosbuvir Pricing and Market Access Assessment

RESPONSE TO FOLLOW UP QUESTIONS

August 26, 2013

Topics

GILEAD

- **Incorporating the potential impact of discounting on demand into the financial modeling**

- **Additional competitor scenarios**

1484

The team has updated the financial analysis to show the potential impact of discounting on demand

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- **Including the impact of discounting does not change the overall conclusion from the financial analysis:**
  - *Within a $70k-$95K SOF price range patient impact increases as price is increased but not enough to offset revenue gains*
- **Assuming a gross SOF price between $75k and $90k the current budgeted level of mandatory and supplemental discounting could theoretically support enough contracting to regain the majority of the predicted patient losses**
- **Given the competitive timing executing these contracts in a timely manner may be challenging.**
  - *This analysis assumes supplemental discounts could be in place by Q3 2014*

The original forecast was deliberately conducted using several conservative assumptions

GILEAD

Original Forecast Methodology

- **Analysis is based on un-tempered quantitative market research**
  - *In general, payers tend to posture and over estimate the actions they will take especially when responding in web-based research*
- **Included three demand impacts**
  - MD reaction to restrictions and OOP (Quantitative research)
  - Estimated Patient OOP Elasticity (Rejection claims analysis)
  - Direct Impact of Payer Action (Team estimate*)
  - *The analysis treats these three factors separately when there is likely some over-lap between them*
  - *MDs over estimate their own sensitivity to OOP costs and Payer Restrictions*
- **Payer action is driven by gross prices**
  - No impact of mandatory or supplemental discounts on demand

Changes incorporated in the updated analysis:
- *Payer action (and thus share loss) is based on net, not gross prices*
- *Commercial, Medicare and Medicaid are segmented into the Top 1/3 most price sensitive lives and All others. Differential discounts are assumed to be offered to the top 1/3*

Changes incorporated into the updated financial analysis

*Note: For payers that indicated they would offer no coverage the team assumed 0% uptake even though MDs still indicated use. For payers that indicated they would impose a hard step edit the team applied an additional 50% cut to the use MDs predicted in the market research.

The analysis of the impact of discounts on demand assumes supplemental discounts are offered to the most price sensitive accounts

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- **The budgeted Gross to Net includes allowances for supplemental discounts with Medicare, Medicaid and Commercial payers**

SEGMENT (% of Payer Mix)	Budgeted Supplement Discount	Ave Discount For Impacted Accounts	% of Accounts Impacted	COMMENTARY
Medicare (20% in 2016)	5.0%	15%	33%	• Average discount for impacted accounts has been set to keep budgeted discounts constant
Medicaid (15% in 2016)	4.9%	15%	33%	
Commercial (37% in 2016)	2.0%	6%	33%	

Incorporating the impact of discounting on patients demand increases the forecast and reduces estimated patient loss significantly

Impact of Wave 1 SOF price on demand and net revenues

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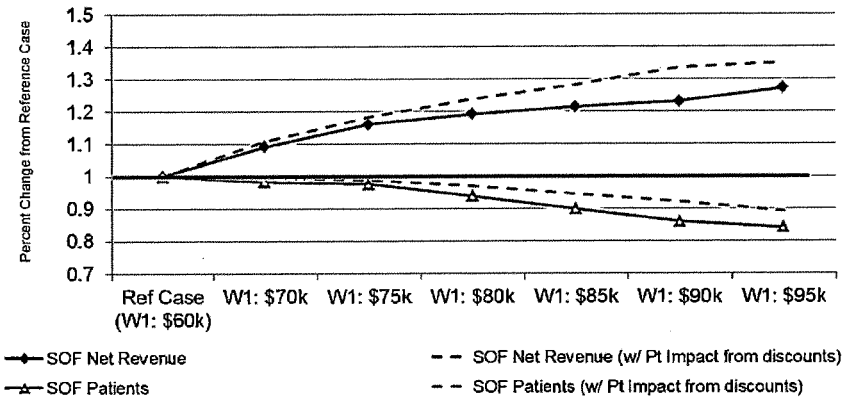
REVENUE & PATIENT ANALYSIS ACROSS SCENARIOS 2013 -2016 – WAVE 1 ONLY



Under both methodologies the financial analysis shows that within a $70k-$95K SOF price range patient impact increases as price is increased but not enough to offset revenue gains

*Note: *Gross to Net in June forecast was ~22% in 2014; updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or below $60K and ~17% for all scenarios with Wave 1 pricing above $60K*

Incorporating the impact of discounting on patients demand increases the forecast and reduces estimated patient loss significantly

Impact of Wave 1 SOF price on demand and net revenues – WAVE 1 ONLY

GILEAD

	WITHOUT PATIENT IMPACT FROM DISCOUNTING (ORGINAL)						WITH PATIENT IMPACT FROM DISCOUNTING (UPDATE)					
	Net Revenue ($ MM)			Treated Pts (000s)			Net Revenue ($ MM)			Treated Pts (000s)		
W1 SOF PRICE	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
June Forecast* ($60K)	$2.0	$0.7	$0.5	46.4	15.4	12.3						
Reference Case* ($60K)	$2.2	$0.9	$0.7	-	-	-	-- *No change for Original Forecast* --					
Delta from June:	*+$0.2*	*+$0.1*	*+$0.1*									
$75K	$2.6	$1.0	$0.8	-3%	-2%	-3%	$2.6	$1.0	$0.8	-1%	-1%	-1%
Delta from reference:	*+$0.4*	*+$0.1*	*+$0.1*				*+$0.4*	*+$0.2*	*+$0.1*			
$80K	$2.6	$1.0	$0.8	-6%	-5%	-7%	$2.7	$1.1	$0.8	-4%	-2%	-3%
Delta from reference:	*+$0.4*	*+$0.2*	*+$0.1*				*+$0.5*	*+$0.2*	*+$0.2*			
$85K	$2.7	$1.1	$0.8	-10%	-8%	-11%	$2.8	$1.1	$0.8	-6%	-4%	-5%
Delta from reference:	*+$0.5*	*+$0.2*	*+$0.1*				*+$0.6*	*+$0.3*	*+$0.2*			
$90K	$2.7	$1.1	$0.8	-15%	-12%	-15%	$2.9	$1.2	$0.9	-9%	-6%	-7%
Delta from reference:	*+$0.5*	*+$0.2*	*+$0.1*				*+$0.7*	*+$0.3*	*+$0.2*			
$95K	$2.8	$1.1	$0.8	-16%	-14%	-16%	$3.0	$1.2	$0.9	-12%	-8%	-11%
Delta from reference:	*+$0.6*	*+$0.3*	*+$0.2*				*+$0.8*	*+$0.3*	*+$0.2*			

*Note: *Gross to Net in June forecast was ~22% in 2014; updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or below $60K and ~17% for all scenarios with Wave 1 pricing above $60K*

Topics

GILEAD

- Incorporating the potential impact of discounting on demand into the financial modeling

- Additional competitor scenarios

1490

Simeprevir at $20K is highly unlikely, but it would put negative attention on SOF at the recommended price

GILEAD

WHAT WOULD JANSSEN HAVE TO BELIEVE TO PRICE SIMEPREVIR AT $20K?

PAYER ACCESS	EXPECTED UPTAKE	VALUE PERCEPTION
• Simeprevir would get disadvantaged at higher prices OR Janssen could create restrictions for others if priced low	• Decreasing price would drive additional prescribing (i.e. half the price and 2x the uptake, all else equal)	• Price relative to value of other agents is far too high and possible good will is worth foregone revenue

WHAT WOULD BE THE IMPLICATIONS FOR GILEAD UNDER CURRENT PRICE GUIDANCE?

PAYER ACCESS	EXPECTED UPTAKE	VALUE PERCEPTION
• Some payers on the margin may restrict SOF/prefer SIM • However, SOF still remains a better product and favoring an inferior agent may be difficult • Increased contracting would likely be needed	• Many physicians are unaware of price and may not be influenced unless OOP is quite different • With proper patient assistance, this effect could be minimized even if Janssen prices low	• A high price for SOF and low price for SIM would clearly create tough questions for Gilead from many different outlets • Stakeholders would likely expect Gilead to implement net price concessions

A low price strategy for SIM should only change our net price strategy for sofosbuvir in Wave 1, but overall this is not a likely competitor action

Janssen would have to dramatically increase SIM patient starts to make a low price strategy worthwhile

GILEAD

- SOF+SIM (COSMOS trial) would be off-label through 2014 and payers will block the regimen and only allow use by exception
- This will be a key constraint that will limit SIM's primary opportunity for increasing patient starts, which will likely make a low price strategy value-destroying
- At the peak in 2016, Gilead is forecasting 2,000 SOF+SIM patient starts in total, but we do not forecast any SOF+SIM in 2014

SIM PRICE	BASE CASE ASSUMPTIONS	
	TOTAL 2014 PATIENTS	GROSS REVENUE
$60K	12.5K forecasted starts in 2014 and all are SIM+P/R	$750M
$40K		$500M
$20K		$250M

- If SIM gets off-label use with SOF in 2014 in null responders and SIM is $20K, Janssen would need 25K more patients to get to the same revenue as at $60K

OPTIMISTIC ASSUMPTIONS	
TOTAL 2014 PATIENTS	GROSS REVENUE
12.5K	$750M
25K	$750M
37.5K	$750M

Achieving this increase in starts will be difficult for Janssen and should push them to de-prioritize a low-priced approach, assuming patient starts in other populations would not dramatically increase as a result of low price

AbbVie's strategy remains the same if the 3-DAA and FDC launch at the same time, but our strategy may differ

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If AbbVie 3-DAA and Wave 2 launch simultaneously

- **Wave 1 SOF will be a price benchmark for both products**
  - Theoretically AbbVie could be more aggressive at launch with payers and offer contracts to disadvantage Wave 2
  - AbbVie will be less comfortable with Wave 1 premiums in case Gilead can have 8 week duration and undercut price

Considerations for our Wave 1 strategy

- **Our Wave 1 goal of a high price remains consistent**
  - Wave 1 represents the greatest price capture opportunity across all waves of the sofosbuvir franchise
  - Wave 1 pricing is only affected if we want a specific Wave 2 price (such as >$100K), in which case Wave 1 may need to be even higher as a result of the new price comparator

Considerations for our Wave 2 strategy

- **Wave 2 strategy may require more caution**
  - If AbbVie and Wave 2 launch at the same time, then the reactive element of Wave 2 pricing decision is eliminated
  - Achievable Wave 2 price is likely lower, all else equal, due to the price comparator at launch now being Wave 1 and not AbbVie 3-DAA

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Appendix

The team recommended that reactive contracting with low rebates should be sufficient in many channels

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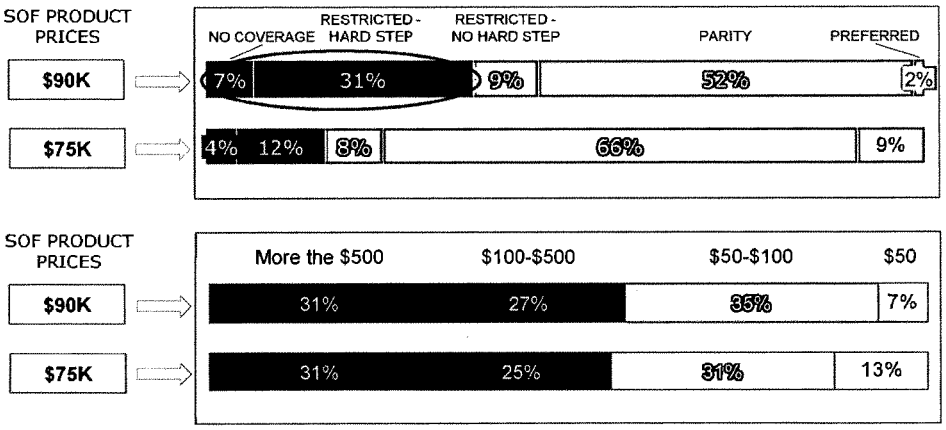
SEGMENT (Total Rx lives)	SELECT PAYERS	SOFOSBUVIR WAC PRICE			APPROACH	COMMENTARY
		<$70K	$70-90K	>$90K		
COMM'L / PART D (~100M)	*MARKET INFLUENCERS*	NONE	CASE BY CASE, WITH MAX 5-8% AT HIGH CONTROL PLANS		REACTIVE	• Some plans may require low rebates and those are likely to be the payers heavily managing Incivek or Victrelis • This will likely represent less than 10% of the volume through these channels
KAISER (~9M)	KAISER	NONE	5-10%	>10%	PROACTIVE	
MANAGED MEDICAID (~25M)	*MARKET INFLUENCERS*	NONE	5-10%	>10%	REACTIVE	• Some Managed Medicaid may seek contracts, such as Fidelis or CalOptima, among others • Proactive recommended in CA FFS Medicaid, which represents ~10% of channel; high contract potential in FL, IL and MO
FFS MEDICAID (~28M)	CA ONLY	5-10% SUPPLEMENTARY AS NEEDED FOR PDL LISTING			PROACTIVE	
DOC (~1.2M)	CA ONLY	5-10%			PROACTIVE	• CA represents ~12% of overall DOC payer segment
340B	AHF, ADAP, some DOC	STATUTORY DISCOUNTS				• Statutory discounts in these settings will be required • Currently in the VA, Merck total rebate is 44-61% and Vertex is 42-48%, which includes both statutory and penalty rebates
VA (~5.6M)	N/A	0-3%	10%	>10%	PROACTIVE	

Note: Market influencers are payers currently managing PIs via differential tiering and step edit through a preferred product; there are likely to be exceptions across each payer channel where strategically Gilead may implement a contract; price protection contracts are not expected to be implemented in Wave 1 though could be valuable in Wave 2; data on covered HCV lives was sourced by Gilead

In the quantitative research, ~1/3 of accounts indicated that at $90k for SOF Wave 1 they would impose a hard step or not cover GT-1

GILEAD



Source: IMSCG PRIMARY RESEARCH; ALL DATA IS WEIGHTED BY NUMBER OF LIVES COVERED;
Note: Parity access assumes Prior Authorization to the label; raw data is shown and it has not been discounted for posturing

We split the respondent into the 1/3 that are most price sensitive and everyone else*

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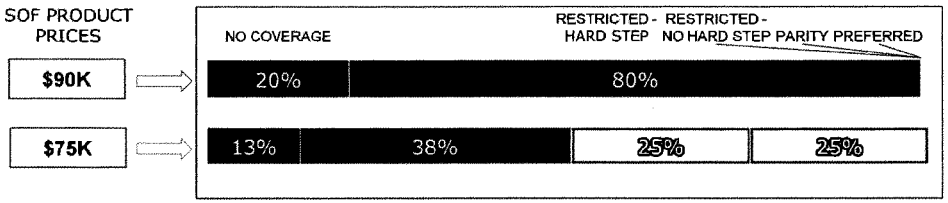
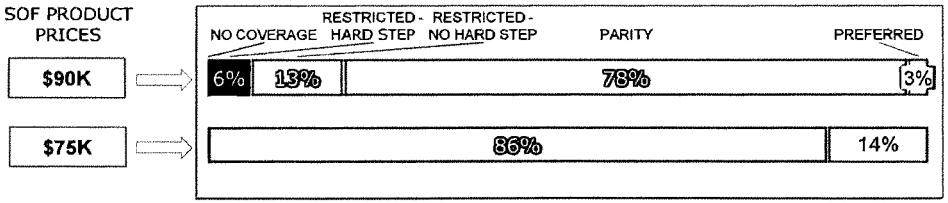
33% of Respondents most Price Sensitive



67% of Respondents least Price Sensitive



Source: IMSCG PRIMARY RESEARCH; ALL DATA IS WEIGHTED BY NUMBER OF LIVES COVERED;
Note: Parity access assumes Prior Authorization to the label; raw data is shown and it has not been discounted for posturing

*Note: Data was not analyzed longitudinally but was treated as such

Previous research has explored the HCV payer mix, although health reform and evolutions in demographics may shift the overall balance

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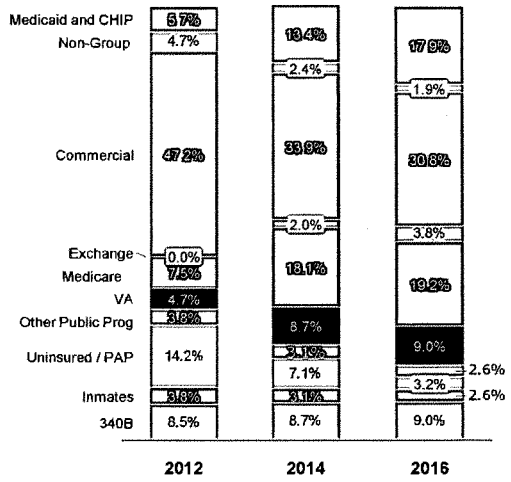
ESTIMATED PAYER MIX IN HCV BY TREATMENT SOURCE OF COVERAGE



IMPLICATIONS

- Over the near term, **expansion of Medicaid** is expected to continue and Gilead's exposure to this segment will grow over time
- Although declining over coming years, the **Commercial market is** expected to the be **the largest channel**
- Implementation of **Exchanges** will influence the overall payer mix, however, the **exposure is somewhat limited**

Importantly, a possible influx of warehoused patients will affect payer mix and these new treated patients will likely increase Medicaid exposure

Source: Avalere Enrollment Model for HCV Patients. Medicaid Optimistic Scenario; VA= Veterans Affairs; CHIP = Children's Health Insurance Program
Note: all of the uninsured patients are covered under PAP

SOF Wave 1 GT-1 access relative to the existing PIs is quite favorable and $75-$90K appears to be an access inflection point

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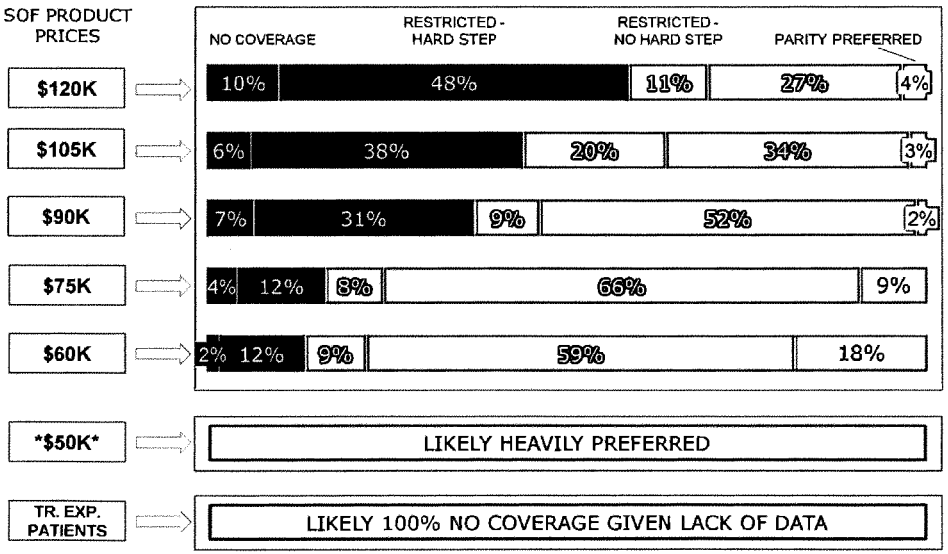

*Source: IMSCG PRIMARY RESEARCH; ALL DATA IS WEIGHTED BY NUMBER OF LIVES COVERED; **$50K PRICE NOT TESTED IN QUANT***
Note: Parity access assumes Prior Authorization to the label; raw data is shown and it has not been discounted for posturing

The access provided to GT-2 and 3 shares a similar access inflection point although GT-3 faces more restrictions overall

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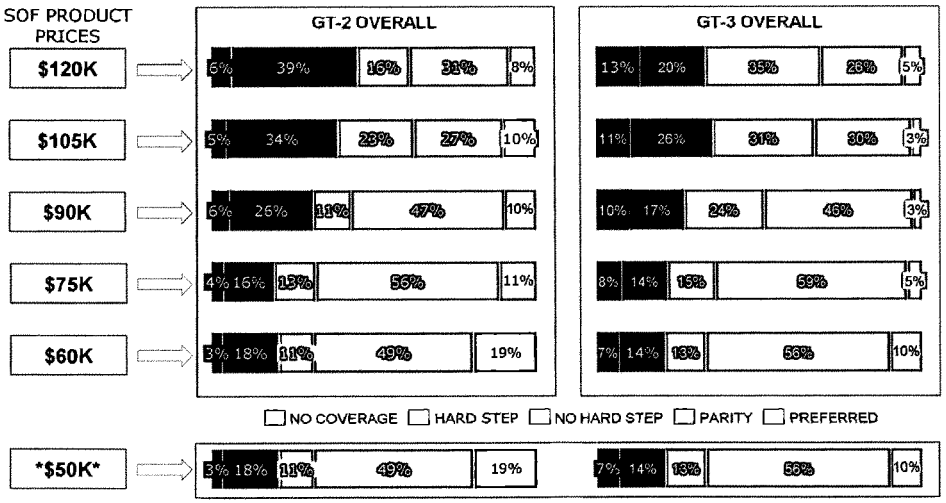

Payer sensitivity is likely equal at a $50K versus $60K price

*Source: IMSCG PRIMARY RESEARCH; ALL DATA IS WEIGHTED BY NUMBER OF LIVES COVERED; **$50K PRICE NOT TESTED IN QUANT***
Note: Parity access assumes Prior Authorization to the label; raw data is shown and it has not been discounted for posturing

While soft steps begin at slightly different points for traditional payers, the tipping point for hard restrictions is quite consistent

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RISKS ACROSS PAYER SEGMENTS – SUMMARY

SOF PRODUCT PRICES	COMMERCIAL			MEDICARE		MEDICAID		VA	DOC	KP
	MI	MM	PE	MI	PE	MI	PE	NO SEGMENTS		
$115K										
$95K										
$80K										
$60K										
$50K										
% OF PAYER MIX	~30-35% BY 2016			~20% BY 2016		~20% BY 2016		~13% BY 2016		

Overall, Gilead has considerable pricing flexibility with sofosbuvir that is likely to be in the $80-$100K range per course of therapy in Wave 1

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Wave 1 pricing freedom in the commercial market is strong; payers most likely to restrict represent <10% of PI volume

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RISKS ACROSS PAYER SEGMENTS - COMMERCIAL

SOF PRODUCT PRICES

% PI Volume	INFLUENCER 8%	MANAGER 26%	ENABLER 65%
$115K	HARD STEP	SOFT STEP	SOFT STEP
$95K	SOFT STEP	SOFT / PARITY	SOFT / PARITY
$80K	SOFT / PARITY	PARITY	PARITY / PREFERRED
$60K	PARITY / PREFERRED	PARITY / PREFERRED	PREFERRED
$50K	PREFERRED	PREFERRED	PREFERRED

Redacted

KEY CONSIDERATIONS
• $115K for many of the Commercial payers would push them to introduce very strong restrictions, likely blocking GT-2/3 TN patients
• $95K is a key price sensitivity level, in which soft restrictions are often more favored than hard restrictions though some GT-2/3 is lost
• $80K for the Commercial market is a level where Gilead is unlikely to face significant restrictions and would have parity access
• Below $80K and at discount levels below the price of the current PIs, will in some cases allow sofosbuvir to gain preferred access relative to incumbents • Alternatively, some plans are likely to not grant preferred access in which case sofosbuvir would be at parity

Note: % PI volume in each payer segment is based on secondary IMS data analysis presented previously; only select plans shown

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Medicare Part D potential is comparable to that in the commercial market

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RISKS ACROSS PAYER SEGMENTS – MEDICARE PART D

SOF PRODUCT PRICES

% PI Volume	INFLUENCER	MANAGER	ENABLER	KEY CONSIDERATIONS
	6%	NONE	94%	
$115K	HARD STEP	N/A	SOFT STEP	• Many Part D payers at these levels may consider not providing access to sofosbuvir and would implement blocks across GTs
$95K	SOFT STEP		SOFT / PARITY	• $95K may be a challenge in high control Medicare although payers interviewed are mostly looking to implement soft edits in GT-1 and possibly limited GT-2/3 use in TN patients
$80K	SOFT / PARITY		PARITY / PREFERRED	• $80K represents an inflection point for the highest control Medicare plans, who would likely implement soft edits
$60K	PARITY / PREFERRED		PREFERRED	• Parity pricing to Incivek will create preferred access for most Medicare Part D payers based on this research • While the highest control influencers are most likely to restrict at high prices, they are also most likely to grant preferred access
$50K	PREFERRED		PREFERRED	

Redacted

Note: % PI volume in each payer segment is based on secondary IMS data analysis presented previously; only select plans shown

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

21

Traditionally price-sensitive Medicaid payers show a favorable reaction to the product and accept premium pricing to PIs

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RISKS ACROSS PAYER SEGMENTS – FFS AND MANAGED MEDICAID

SOF PRODUCT PRICES

% PI Volume	INFLUENCER	MANAGER	ENABLER
	13%	NONE	87%
$115K	HARD STEP	N/A	SOFT STEP
$95K	SOFT STEP		SOFT / PARITY
$80K	SOFT / PARITY		PARITY / PREFERRED
$60K	PARITY / PREFERRED		PREFERRED
$50K	PREFERRED		PREFERRED

Redacted

KEY CONSIDERATIONS
• A $115K price for Medicaid in Wave 1 is generally unachievable without significant supplementary rebates
• $95K may be an inflection point in high control FFS, although most payers are not looking to force hard edits at this price in any genotype
• $80K is likely below a major inflection point for the highest control Medicaid plans and for some payers SOF would be preferred to PIs
• Parity pricing to Incivek will create preferred access for the majority of Medicaid payers, including both FFS and Managed Medicaid • Discount pricing to the PIs will ensure preferred status relative to the incumbents

Note: % PI volume in each payer segment is based on secondary IMS data analysis presented previously; only select plans shown

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

Non-traditional segments widely vary in price sensitivity and some degree of contracting is likely required regardless of price

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RISKS ACROSS PAYER SEGMENTS – NON-TRADITIONAL PAYERS

SOF PRODUCT PRICES

	VA	D.O.C.	KP / IDNs	KEY CONSIDERATIONS
$115K	DISCOUNT FOR ACCESS	POSSIBLE DISCOUNT FOR ACCESS, THOUGH MAY NOT BE A GILEAD TARGET	HARD STEP	• Non-traditional payers, such as integrated delivery networks (IDNs) at these price levels will likely not provide access and demand contracts
$95K			HARD / SOFT STEP	• Generally pushing the upper comfort level for IDN payers although the recognition of improved outcomes still carries significant value at these prices • As the IDNs can directly see the cost savings in their system, they recognize decreased use of supportive care and lower cost per SVR
$80K			SOFT / PARITY	
$60K			PARITY / PREFERRED	• Prices at parity to the protease inhibitors in the IDNs will not only result in preferred status, but some payers will remove the incumbent products from the formulary • Even at these lowest prices, other segments including VA and DOC are likely to demand lower net prices for access
$50K			PREFERRED	

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

23

1505

Under current assumptions, the GTN for SOF across product waves is likely to be lower than other Gilead therapy areas

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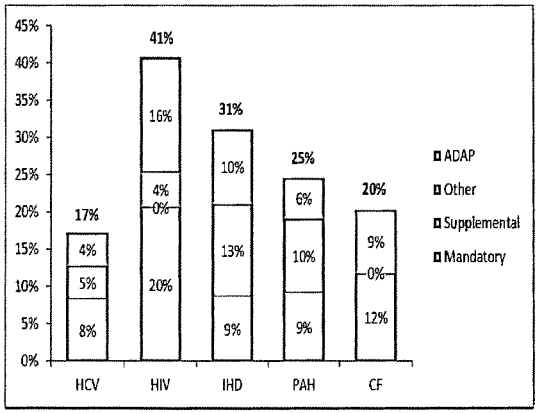
GTN ASSUMPTIONS ACROSS GILEAD THERAPY AREAS

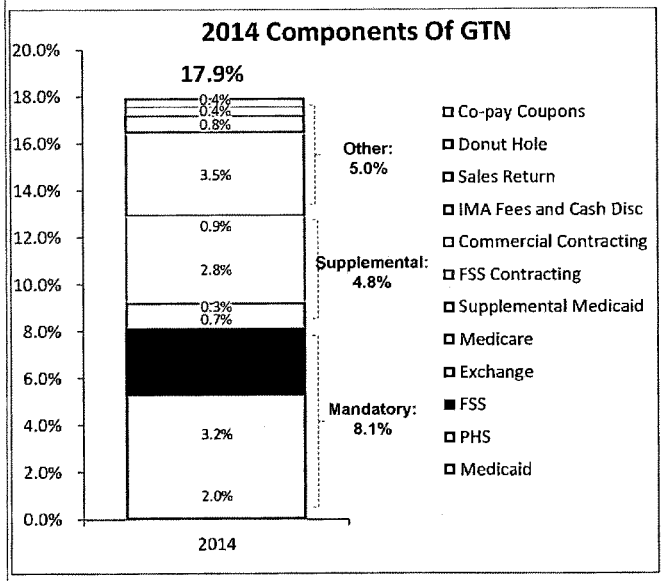


- Total HCV GTN is lower primarily due to smaller mandatory discounts, which are driven by the Medicaid pricing penalty
- Supplemental discounting includes commercial contracting of 16% in IHD, 10% in PAH, and 2% in HCV. CP also has significant supplemental discounts for Medicare
- Other discounts are higher in CP due to higher sales returns and higher donut hole costs (which is a greater proportional hit as prices are lower)
- HIV discounts are the highest, primarily due to heavy discounting to ADAPs and high Medicaid pricing penalties which factor in the CMS line extension rule

Source: Gilead internal analysis

Executive Summary

- Forecasting 17.9% GTN for 2014
  - 8.1% relates to Mandatory discounts (23% for Medicaid, etc)
  - 4.8% for Supplemental discounts (Commercial contracts, etc)
  - 5.0% for Other discounts (Cash Discounts, IMA Fees, etc)
- This is higher than our last 17% GTN model as we bumped up the VA discount to 50%



Mandatory & Supplemental Discounts

Supplemental Rationale:

- **Medicaid** – Proactive contracting to occur at launch for California with increasing supplemental beginning in Q2'14 as a result of competition from AbbVie's FDC
  - Q4'13/Q1'13 supplemental based off assumed CA population per 2012 census of 11% of total US at 10% discount = ~1% effective Medicaid Supplemental
- **Exchange** – No proactive contracting anticipated. Assumes contracting beginning in Q2'14,1 quarter in advance of AbbVie's launch
- **Medicare** – No proactive contracting anticipated. Assumes ramp-up of contracting beginning in Q1'14 and not right at launch due to timing of payer formulary reviews. Assumes slightly longer review timing than HIV since HCV is not a protected class
- **PHS** – No proactive contracting
- **Inmates** – Proactive contracting for CA DOC (12% of overall DOC population * 10% = ~1% effective discount). Assumes not effective until Q1'14 due to formulary review timing and contracting activities
- **FSS** – Proactive contracting to match total discount offered by existing PI's (Boceprávir: 44-61% and Telapravir: 42-48%)
- **Commercial** – Proactive contracting with Kaiser and increasing reactive contracting starting in Q2'14 towards "Market Influencers" in advance of competitor launches
  - Kaiser: 10% of volume at 10% discount = ~1% effective discounting on overall commercial

	Mandatory Discount	Quarterly Supplemental Discount				
		Q4'13	Q1'14	Q2'14	Q3'14	Q4'14
Medicaid	23%	1%	1%	3%	4%	5%
Exchange				5%	8%	10%
Medicare			2%	4%	5%	5%
PHS	23%					
Inmates	23%		1%	1%	1%	1%
FSS	25%	25%	25%	25%	25%	25%
Commercial		1%	1%	2%	2%	2%
Competitor Launches:		Simeprawir (GT1 TN 24/48 Wk)			AbbVie FDC (GT1 TN, TE 12 Wk)	ASV +DCV (GT1b TE 24 Wk)
						ASV + DCV + P/R (GT1,4 TE 24 Wk)

Other Discounts

Other Discounts		
Big 3 IMA Fees	Redacted average fees applied to 99% of volumes that goes through Big 3	A
Specialty Pharmacy Fees	N/A (not included since Fees are immaterial)	B
Prompt Pay	2.0%	C
Donut Hole	Assumes 19% of Total Medicare patients will hit coverage gap with GILD covering 50% while in gap	D
Copay Coupons	Applied to 40% of Commercial patients assuming copay coverage up to 20% coinsurance	E
Sales Returns	Using Q2'13 sales return provision disclosed in VRTX 10-Q as proxy	F

Rationale:

A – Based on contractual IMA agreements with Big 3 wholesalers for 2014 fees are: MCK: Redacted CAH: Redacted and ABC: Redacted

B – Current plan is to only contract with ESI for data with projected costs to be $25-35K per month with a one time setup cost of $100K. Implied GTN for specialty pharmacy fees would be <.01%

C – Based on standard prompt pay discounts offered to all customers and standard across all TA's

D – Source of percentage of Medicare patients that will hit Donut hole: http://medcitynews.com/2013/02/medicare-drug-costs-to-fall-in-2014-but-donut-hole-widens/

E – Incivek and Boceprevir copay utilization and coverage used as proxy

F – Used Q2'13 Vertex 10-Q as proxy to determine sales returns assumption (~0.8%). Incivek would be similar given short product cycle due to increased competition and impact of sofosbuvir wave 2 launch which would make wave 1 less desired

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Alt Version

Redacted

ALT VERSION - 15% Supplement Commercial

The analysis of the impact of discounts on demand assumes supplemental discounts are offered to the most price sensitive accounts

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- **The budgeted Gross to Net includes allowances for supplemental discounts with Medicare, Medicaid and Commercial payers**

SEGMENT (% of Payer Mix)	Budgeted Supplement Discount	Ave Discount For Impacted Accounts	% of Accounts Impacted	COMMENTARY
Medicare (20% in 2016)	5.0%	15%	33%	• Average discount for impacted accounts has been set to keep budgeted discounts constant
Medicaid (15% in 2016)	4.9%	15%	33%	
Commercial (37% in 2016)	5.0%*	15%	33%	

*Note: This represents a change from the finance assumptions

Redacted

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Incorporating the impact of discounting on patients demand increases the forecast and reduces estimated patient loss significantly

Impact of Wave 1 SOF price on demand and net revenues

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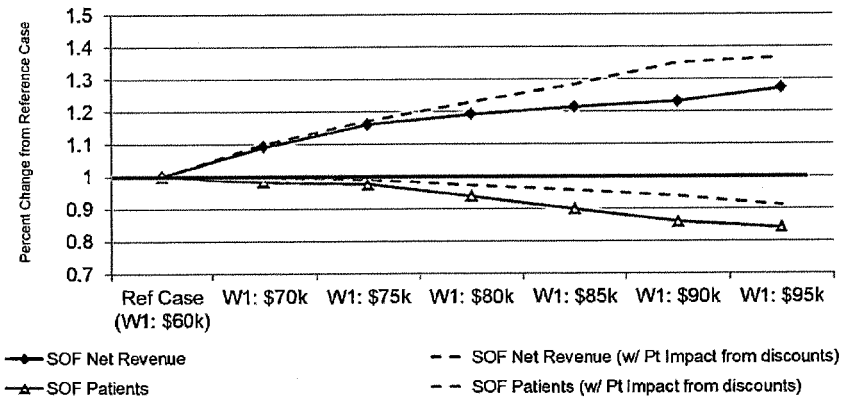
REVENUE & PATIENT ANALYSIS ACROSS SCENARIOS 2013 -2016 – WAVE 1 ONLY



Under both methodologies the financial analysis shows that within a $70k-$95K SOF price range patient impact increases as price is increased but not enough to offset revenue gains

*Note: *Gross to Net in June forecast was ~22% in 2014; updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or below $60K and ~17% for all scenarios with Wave 1 pricing above $60K*

Redacted

Incorporating the impact of discounting on patients demand increases the forecast and reduces estimated patient loss significantly

Impact of Wave 1 SOF price on demand and net revenues – WAVE 1 ONLY

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	WITHOUT PATIENT IMPACT FROM DISCOUNTING (ORGINAL)						WITH PATIENT IMPACT FROM DISCOUNTING (UPDATE)					
	Net Revenue ($ MM)			Treated Pts (000s)			Net Revenue ($ MM)			Treated Pts (000s)		
W1 SOF PRICE	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
June Forecast* ($60K)	$2.0	$0.7	$0.5	46.4	15.4	12.3						
Reference Case* ($60K)	$2.2	$0.9	$0.7	-	-	-	– *No change for Original Forecast* –					
Delta from June:	*+$0.2*	*+$0.1*	*+$0.1*									
$75K	$2.6	$1.0	$0.8	-3%	-2%	-3%	$2.6	$1.0	$0.8	-1%	-1%	-1%
Delta from reference:	*+$0.4*	*+$0.1*	*+$0.1*				*+$0.4*	*+$0.1*	*+$0.1*			
$80K	$2.6	$1.0	$0.8	-6%	-5%	-7%	$2.7	$1.1	$0.8	-3%	-1%	-2%
Delta from reference:	*+$0.4*	*+$0.2*	*+$0.1*				*+$0.5*	*+$0.2*	*+$0.1*			
$85K	$2.7	$1.1	$0.8	-10%	-8%	-11%	$2.8	$1.1	$0.8	-5%	-2%	-3%
Delta from reference:	*+$0.5*	*+$0.2*	*+$0.1*				*+$0.6*	*+$0.3*	*+$0.2*			
$90K	$2.7	$1.1	$0.8	-15%	-12%	-15%	$3.0	$1.2	$0.9	-7%	-3%	-5%
Delta from reference:	*+$0.5*	*+$0.2*	*+$0.1*				*+$0.8*	*+$0.3*	*+$0.2*			
$95K	$2.8	$1.1	$0.8	-16%	-14%	-16%	$3.0	$1.2	$0.9	-10%	-6%	-8%
Delta from reference:	*+$0.6*	*+$0.3*	*+$0.2*				*+$0.8*	*+$0.3*	*+$0.2*			

*Note: *Gross to Net in June forecast was ~22% in 2014; updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or below $60K and ~17% for all scenarios with Wave 1 pricing above $60K*

Exhibit 37

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Sofosbuvir Pricing and Market Access Recommendation

November, 2013

GSI Confidential

We recommend pricing sofosbuvir Wave 1 at $81K ($27k/bottle) per course of 12 week therapy

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Rationale

- We have **considerable pricing potential with sofosbuvir in Wave 1** without major access consequences for 12 week therapy, but the pricing potential for future launches will be constrained by competition
- Long term sofosbuvir franchise value will be driven by **a high price capture opportunity in Wave 1** due to the increase in SVR, and a **volume capture in Wave 2 and beyond**
- The optimal range for Wave 1 pricing based on revenue / uptake trade-offs is likely $85-$95K, though other softer factors must be considered
- If we price lower it opens up a window for competitors to pair up with SOF and come in at a lower regimen cost than our FDC
- Even if we priced lower, such as $70k, it would not mitigate the high cost of a 24 week regimen (message points being developed), and therefore we recommend we address this on a case by case basis on a sub-WAC level

Pricing Recommendation

- **We recommend pricing sofosbuvir Wave 1 at $81K ($27k/bottle) per course of 12 week therapy** and contract selectively for access at target payers:
  - For the VA we recommend negotiating up to a 50% discount on their volume (vs the original 40% discount) to make up for the higher cost of treating co-infected and IFN-ineligible patients which account for about 60% of their population
  - For Kaiser we recommend negotiating up to a 10% discount for access
  - Other plans will be evaluated on a one off basis

2

While soft steps begin at slightly different points for traditional payers, the tipping point for hard restrictions is quite consistent

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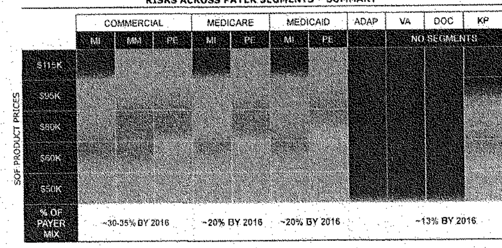
RISKS ACROSS PAYER SEGMENTS – SUMMARY



Overall, Gilead has considerable pricing flexibility with sofosbuvir that is likely to be in the $80-$100K range per course of therapy in Wave 1

PREFERRED PARITY SOFT RESTRICTIONS HARD RESTRICTIONS

3

Reactive contracting with low rebates should be sufficient in many channels although proactive strategies will be required elsewhere

SEGMENT (Total Rx lives)	SELECT PAYERS	SOFOSBUVIR WAC PRICE			APPROACH	COMMENTARY
		<$70K	$70-90K	>$90K		
COMM'L / PART D (~100M)	"MARKET INFLUENCERS"*	NONE	CASE BY CASE, WITH MAX 5-8% AT HIGH CONTROL PLANS		REACTIVE	• Some plans may require low rebates and those are likely to be the payers heavily managing Incivek or Victrelis
KAISER (~9M)	KAISER	NONE	5-10%	>10%	PROACTIVE	• This will likely represent less than 10% of the volume through these channels
MANAGED MEDICAID (~25M)	"MARKET INFLUENCERS"*	NONE	5-10%	>10%	REACTIVE	• Some Managed Medicaid may seek contracts, such as Fidelis or CalOptima, among others
FFS MEDICAID (~28M)	CA ONLY	5-10% SUPPLEMENTARY AS NEEDED FOR PDL LISTING			PROACTIVE	• Proactive recommended in CA FFS Medicaid, which represents ~10% of channel; high contract potential in FL, IL and MO
DOC (~1.2M)	CA ONLY	5-10%			PROACTIVE	• CA represents ~12% of overall DOC payer segment
340B	AHF, ADAP, some DOC	STATUTORY DISCOUNTS				• Statutory discounts in these settings will be required
VA (~5.6M)	N/A	0-3%	10%	>25%	PROACTIVE	• Currently in the VA, Merck total rebate is 44-61% and Vertex is 42-48%, which includes both statutory and penalty rebates
ADAP (~xxM)						

4

2

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Incorporating the impact of discounting on patients demand increases the forecast and reduces estimated patient loss significantly

GILEAD

	WITHOUT DISCOUNT BENEFITS						WITH DISCOUNT BENEFITS					
	Net Revenue ($ MM)			Treated Pts (000s)			Net Revenue ($ MM)			Treated Pts (000s)		
Wave 1 SOF PRICE	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016
June Forecast* ($60K)	$2.0	$0.7	$0.5	46.4	15.4	12.3	– No change for Original Forecast –					
Reference Case* ($60K)	$2.2	$0.9	$0.7	-	-	-						
Delta from June:	*+$0.2*	*+$0.1*	*+$0.1*									
$75K	$2.6	$1.0	$0.8	-3%	-2%	-3%	$2.8	$1.0	$0.8	-1%	-1%	-1%
Delta from reference:	*+$0.4*	*+$0.1*	*+$0.1*				*+$0.4*	*+$0.2*	*+$0.1*			
$80K	$2.6	$1.0	$0.8	-5%	-5%	-7%	$2.7	$1.1	$0.8	-4%	-2%	-3%
Delta from reference:	*+$0.4*	*+$0.2*	*+$0.1*				*+$0.5*	*+$0.2*	*+$0.2*			
$85K	$2.7	$1.1	$0.8	-10%	-8%	-11%	$2.8	$1.1	$0.8	-8%	-4%	-5%
Delta from reference:	*+$0.5*	*+$0.2*	*+$0.1*				*+$0.6*	*+$0.3*	*+$0.2*			
$90K	$2.7	$1.1	$0.8	-15%	-12%	-15%	$2.9	$1.2	$0.9	-9%	-6%	-7%
Delta from reference:	*+$0.5*	*+$0.2*	*+$0.1*				*+$0.7*	*+$0.3*	*+$0.2*			
$95K	$2.8	$1.1	$0.8	-18%	-14%	-16%	$3.0	$1.2	$0.9	-12%	-8%	-11%
Delta from reference:	*+$0.6*	*+$0.3*	*+$0.2*				*+$0.8*	*+$0.3*	*+$0.2*			

*Note: *Gross to Net in June forecast was ~22% in 2014; updated gross-to-net assumptions of ~13% in 2014 are used for all scenarios with Wave 1 pricing at or below $60K and ~17% for all scenarios with Wave 1 pricing above $60K*

6

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HCV Support Program

GILEAD

Programs ensure that out-of-pocket costs or lack of insurance are not a barrier for patients to receive treatment…

50k Commercial Patients
50k Other Insured Patients
12k Uninsured Patients

Copay Coupon

Preparing to help up to 40% of SOF Commercial Patients with Copay Assistance ~ 9,000 patients

- Commercial patients pay no more than $6 per Rx (capped at 25% of WAC)

Foundation

Preparing to help up to 9% of patients on HCV therapy ~ 13,000 patients

- Foundation specific eligibility criteria (patients covered by government programs such as Medicare are eligible)
- Patient should be insured with product specific coverage, and income should be less than 500% of FPL
- Maximum grant will likely range between $5k - $7k/yr

PAP Patient Assist

Preparing to help up to 50% of uninsured patients ~6,000 patients

- Program for eligible "un-insurable" and functionally un-insured patients
- Maximum Annual Income criteria is recommended to be the greater of $100,000/year or 500% of FPL (adjusted for household size)
- Patients must have HCV diagnosis, have been prescribed SOF, and meet residency requirements

11/15/2013

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Back-up

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ADD TABLE WITH SOF (single agent, plus FDCs) VOLUME BY PATIENT TYPE

GILEAD

		G1N	G1E	G2N	G2E	G3N	G3E	G4/G6	Total
2014	Single Agent	21	1	10	2	4	1	1	40
	FDC	3	1	0	0	0	0	0	4
	Total	**23**	**2**	**10**	**2**	**4**	**1**	**1**	**44**
2015	Single Agent	3	0	8	1	3	0	1	16
	FDC	47	15	0	0	0	0	0	62
	Total	**50**	**15**	**8**	**1**	**3**	**0**	**1**	**78**
2016	Single Agent	5	0	4	0	1	0	1	12
	FDC	66	14	4	0	2	0	0	86
	Total	**71**	**15**	**8**	**0**	**4**	**0**	**1**	**98**

Source: 2013 Sep LE HCV Forecast

8

Exhibit 38

From: "Kevin Young" <>
Subject: COMPANY CONFIDENTIAL

From: Kevin Young
Sent: Monday, November 18, 2013 10:37 PM
To: John Martin; John Milligan; Norbert Bischofberger; Robin Washington; Gregg Alton
Subject: COMPANY CONFIDENTIAL
Attachments: HCV Pricing Recommendation - Wave 1 - November 2013.ppt

Importance: High

John, John, Norbert, Robin & Gregg

Sofosbuvir US WAC

Our recommendation for your discussion and approval is $27,000 per 28 tablet bottle ($81,000 for 12W)

I look forward to finalizing this with you at the Off Site

Kevin

Sofosbuvir (SOF) Pricing

Target Price	SOF price per bottle ($)	SOF price per pill ($)	Cost of 12 weeks of SOF ($)	Cost of 24 weeks of SOF ($)	Cost of SOF + PEG+RBV for 12 weeks	Cost of SOF + RBV for 12 weeks	Cost of SOF + RBV for 24 weeks
$70,000	$23,333	$833	$70,000	$140,000	$79,640	$70,980	$141,960
$75,000	$25,000	$893	$75,000	$150,000	$84,640	$75,980	$151,960
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$85,000	$28,333	$1,012	$85,000	$170,000	$94,640	$85,980	$171,960
$90,000	$30,000	$1,071	$90,000	$180,000	$99,640	$90,980	$181,960

Assumes SOF priced at $80,000 for 12 weeks

Genotype / Patient type	SOF-based regimen	Cost of SOF-based regimen ($)	Cost of current SOC ($)
GT-1 (Option A)	SOF + PEG/RBV for 12 weeks	$99,640	$95,074*
GT-1 (Option B)	SOF + RBV for 24 weeks	$161,960	$95,074*
GT-2	SOF + RBV for 12 weeks	$90,980	$18,279
GT-3	SOF + RBV for 24 weeks	$161,960	$18,279
GT-4/5/6	SOF + RBV for 24 weeks	$161,960	[illegible]

* Range from $85,435 to $104,714

Exhibit 39

From: "John Martin" <>
Subject: Re: CONFIDENTIAL

From: John Martin
Sent: Sunday, November 24, 2013 11:47 PM
To: Kevin Young
Subject: Re: CONFIDENTIAL

Kevin,

Tokyo is a special place. Thanks for your comments. I'm pleased where we are too.

Enjoy your visit, John

> On Nov 24, 2013, at 2:49 PM, "Kevin Young" <Kevin.Young@gilead.com> wrote:
>
> Hi John
>
> I'm in a place you know far better than me - Tokyo. Its a wonderful city. Today and tomorrow I will be working hard with Yuji and Masa to plan for 2014. Just like our GT-2 program, our GT-1 study is running ahead of time lines. Its very exciting but a lot of pressure to be ready. But how marvelous for Japanese patients.

>
> We had some really good discussions at the Off Site. They were measured and meaningful. I thoroughly enjoyed it.
>
> I think $28,000 is right. Its where I wanted to be and I think we all collectively circled this price point. What I've really appreciated is how we have stepped carefully through this with the Board and LT over two years.

>
> So time for work.....I teased Yuji last night because the Tokyo Car Show just finished. I bet that's worth a visit!
>
> Kevin
>
>
>
> ----- Original Message -----
> From: John Martin
> Sent: Sunday, November 24, 2013 12:52 PM
> To: Kevin Young
> Subject: Re: CONFIDENTIAL
>
> Kevin
>
> Our discussion at the offsite about this was very interesting but brief compared how hard you and your team has worked on this. I would defer to whatever your team prefers within the range we discussed and want to be sure that they know the calculation will be easy from the press release, from 28 days and $28,000.

>

> It's still stunning to me that we have a product that brings so much value to patients.
>
> Thanks, John
>
>> On Nov 23, 2013, at 9:38 AM, "Kevin Young" <Kevin.Young@gilead.com> wrote:
>>
>> Cara
>>
>> The amount to drop into the US Sovaldi approval press release, when you do final review is '$28,000'
>>
>> Please add Jim to the final review list
>>
>> Thank you, Kevin

Exhibit 40

From: Kevin Young
Sent: Tuesday, November 19, 2013 12:46 PM
To: Jim Meyers; Coy Stout
CC: Kristie Banks
Subject: Re: ADAP and Sofosbuvir

Jim and Coy

Very clear. I support your position and will inform JCM/JFM

Two sincere requests....

Let's not fold to advocacy pressure in 2014. Let's hold our position whatever competitors do or whatever the headlines.

Let's monitor PAP very carefully. I do worry that people might attempt to stretch applications for PAP. We may see some strange behaviors we need to address early

Thank you, Kevin

From: Jim Meyers
Sent: Monday, November 18, 2013 04:18 PM
To: Kevin Young
Subject: FW: ADAP and Sofosbuvir

Kevin,

Below is our approach to ADAP at the launch of SOF. It has not changed from what I conveyed to the executive team at our last meeting on SOF pricing. Let me know if you have any questions or concerns

Jim

From: Coy Stout
Sent: Monday, November 18, 2013 4:07 PM
To: Jim Meyers; Monica Tellado; David L. Johnson (US Sales & Marketing); Geoff Cotton
Cc: Linda Simpson; Kristie Banks; Bruce Pfaff; Melanie Pavate
Subject: ADAP and Sofosbuvir

Jim, DJ, Monica, and Geoff:

To reduce the risk of exposure to "partial bottle rebates" our recommendation for ADAP as it relates to coverage of coinfected patients is as follows:

1. We will not seek coverage of sofosbuvir on ADAP formularies.

2. ADAPs that elect to cover sofosbuvir will be eligible for 340B pricing. Supplemental rebates will not be extended by Gilead. Sofosbuvir will not be included in our ACTF agreements.

3. Gilead is prepared to assist ADAP clients who are prescribed sofosbuvir therapy through the offerings of My Support Path, which includes:

* The TRADENAME Co-pay Coupon Program, which provides co-pay assistance for eligible patients with private insurance who need assistance paying for out-of-pocket medication costs. The Co-pay Coupon will cap co-payments at $5 per co-pay and can also be applied toward deductibles and co-insurance obligations. Most patients will pay no more than $5 per prescription.

· Gilead will provide support to the Patient Access Network (PAN) Foundation, which provides assistance for eligible federally-insured and privately-insured patients who need help covering out-of-pocket medication costs.

· The My Support Path Patient Assistance Program will provide TRADENAME at no charge for eligible patients with no other insurance options.

Regards,

Coy

Sent from my iPad

Exhibit 41

GILEAD

EAME SOF Price Recommendation

11th September 2013

Paul Carter

SVP Commercial Operations

GILEAD

Executive summary – Core 5

GILEAD

- **Pricing recommendation developed using GT1 pricing as the foundation and the highest price we can get accepted in early launch markets (UK, Germany, France).**

- **Proposed list price EU corridor for 12 weeks SOF is $64.4k to $54.2k**
  - UK forms the EU list price floor at $54.2k. The price is set at the limit of cost-effectiveness for GT1 non-cirrhotic approval at NICE.
  - Highest price is Germany $64.4k. Price set to the highest limit we estimate AMNOG will approve.

Redacted

  - Subsequent countries' list pricing set to UK price
  - Significant premium over Telaprevir (Average 60%)
  - Price corridor 16%

Redacted

Forex €1=$1.322; $54.2K= €41K; $64.4K=€48.7K

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Non Core 5 countries

GILEAD

- **Swiss price of $56.8k**
  - Price set using the average of the available prices in the reference basket (UK, Germany, Austria, Denmark)
- **All other EU countries will have list prices of $54.2k**
  - **Redacted**
- **Australian price of $54.2k**
  -
  -

Redacted

Forex €1=$1.322; $54.2K= €41K; $56.8K=€43K

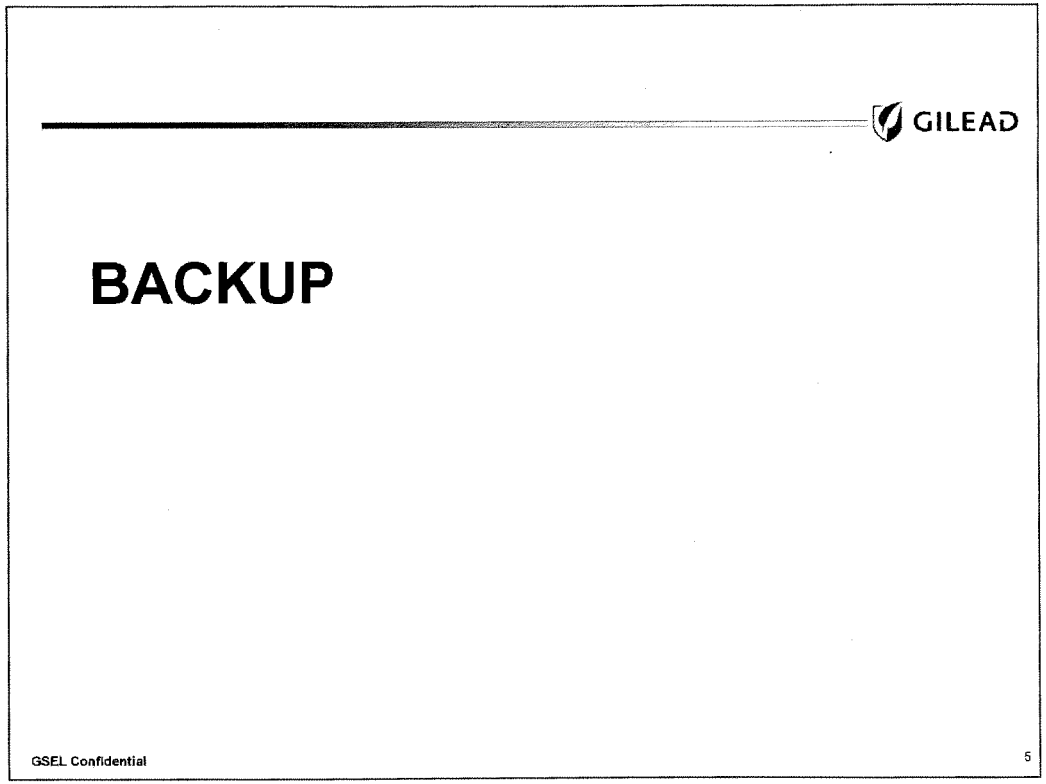
1532

Reimbursement sequence and targeted list price

GILEAD

Reimbursement	Country	List Price	Comment
Jan 2014	UK	$54.2K	Redacted
	Germany	$64.4K	
Feb 2014	Sweden	$55.5K	
	Finland	$55.5K	Price set by EU referencing available prices
Apr 2014	Denmark	$55.5K	Price set by referencing basket
Jun 2014	Netherlands	$54.2K	Price set via referencing basket and negotiation
	Switzerland	$56.8K	Average of available prices in EU basket
	Norway	$54.2K	Price set via referencing basket
Aug 2014	France	$54.2K	Redacted
	Austria	$56.8K	Negotiated price based on available EU average
Dec 2014	Greece	$54.2K	
Feb 2015	Italy	$54.2K	Redacted
	Spain	$54.2K	
Mar 2015	Belgium	$54.2K	Price set by negotiation and referencing
May 2015	Portugal	$54.2K	Price set by negotiation and referencing
Jun 2015	Australia	$54.2K	Redacted

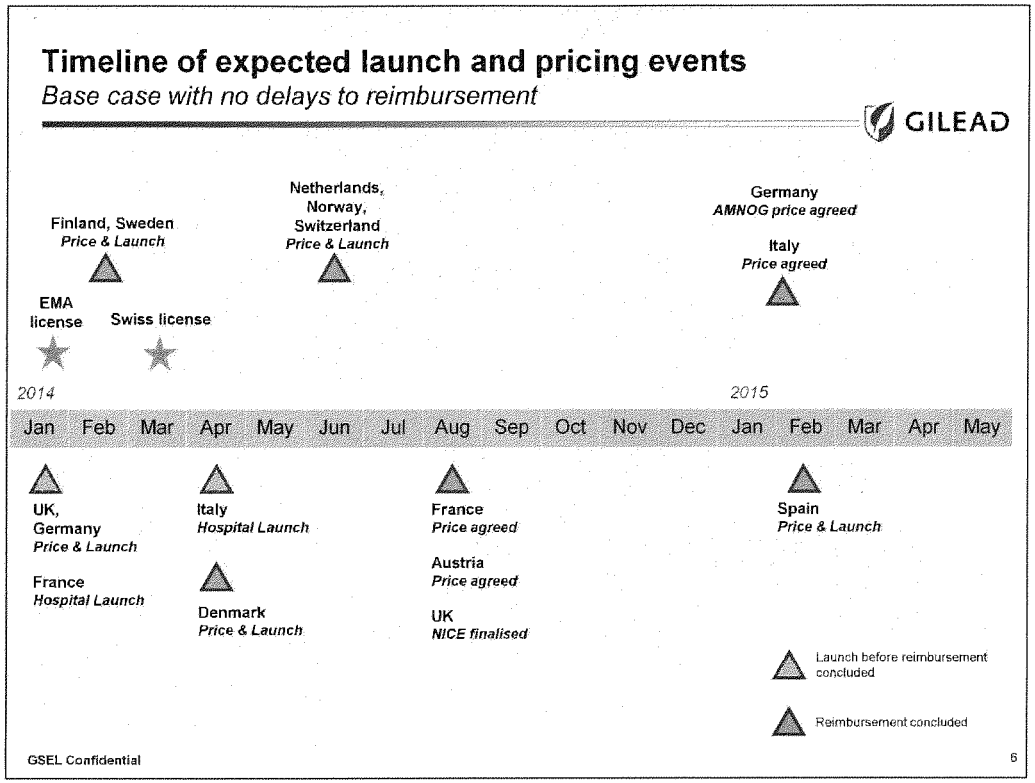
Forex
€1=$1.322;
$54.2K= €41K
$56.8K= €43K
$64.4K=€48.7K



1534

Timeline of expected launch and pricing events

Base case with no delays to reimbursement



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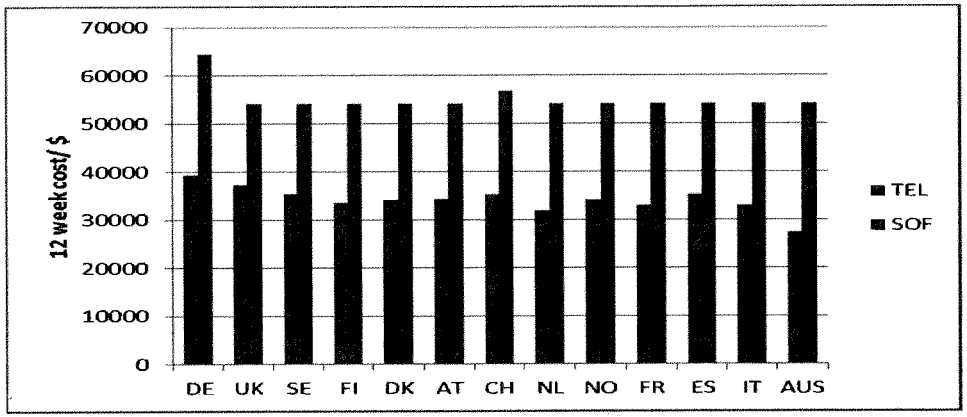
6

1535

SOF EU corridor in comparison to TEL corridor

GILEAD



- TEL ceiling price DE $39.4k, SOF ceiling $64.4k
- Floor price NL $31.8k, SOF floor $54.2k
- Average EU $34.5k, SOF average $55.3k
- Average EU premium 60%

Forex €1=$1.322

Exhibit 42

From: Kevin Young
Sent: Saturday, October 19, 2013 12:30 AM
To: Jim Meyers; Derrell Porter
Subject: Fw: Fwd: Very early customer reactions to sofosbuvir price
Attachments: image003.png

Derrell & Jim

I'm glad we pushed France to go in high for their ATU (74K)

Kevin

From: Paul Carter
Sent: Friday, October 18, 2013 12:28 PM
To: Kevin Young
Subject: Fwd: Very early customer reactions to sofosbuvir price

Kevin

FYI

Early reaction but so far so good.

Paul

Begin forwarded message:

From: Michel Joly <Michel.Joly@gilead.com>
Date: 18 October 2013 19:20:17 BST
To: Paul Carter <Paul.Carter@gilead.com>, Pat Ansell <Pat.Ansell@gilead.com>, Lisa Bright <Lisa.Bright@gilead.com>, Luc Hermans <Luc.Hermans@gilead.com>, Mark Hill <Mark.Hill@gilead.com>, Cara Miller <Cara.Miller@gilead.com>

Subject: Very early customer reactions to sofosbuvir price

Dear All,

Thanks for supporting us to communicate ATU pricing in France

Please find here very early reaction to it (56 000 € / 12 weeks)

Generally, comments are favorable or neutral so far.

You will find some quotes below.

Have a good we

Michel

Note : A lot of competitors has communicate to KOLs, during this year, on "sofosbuvir very high price to come" in relation to Pharmasset acquisition cost. Numbers between 70-85-100 K€ per cure where often publicly mentioned, which influence reaction to this ATU price.

KOL Face/Face :

- Redacted (KOL, Infectious Diseases, Paris).
  - § Immediately convert into "cost / cure for a three months duration will be around 60.000 € if you add PR for G1"
  - § "This will probably lead to a negotiated price around 45 000 € , -20% after negotiation with CEPS"
  - § "less than expected, you are in the wright direction positioning the price this way"
  - § Will include into CE modeling

- Redacted (KOL, Hepatology, Paris)
  - § Calculate also the "cost / cure" for a three months duration (i.e. adding Peg Rib for G1)
  - § Consider "reasonable" and " a fair price"

o Redacted (KOL, Hepatology, Lille).

§ No reaction

From the Com Ops/Customer Service's side

- Redacted October 14th (face/face meeting in Toulouse)

o No question regarding the price. Only if Sofosbuvir in Cohort ATU is free or not.

- Redacted October 15th (face/face meeting in Paris)

o "Will you increase the price later? "

- Redacted

o " it is expensive and we will consider the orders carefully "

- Redacted

o No reaction

- Redacted

o No reaction

- Redacted

o No reaction

Michel JOLY

General Manager France

Gilead Sciences • 65, quai Georges Gorse • 92100 • Boulogne Billancourt • France

Office : +33 (0)1 46 09 41 30 • Fax : +33 (0)1 46 09 41 34

Mail : <mailto:mjoly@gilead.com> mjoly@gilead.com

Exhibit 43

From: Paul Carter
Sent: Friday, October 11, 2013 10:17 AM
To: Cara Miller
CC: Kevin Young
Subject: RE: FOR REVIEW: French ATU Key Messages and Q&A
Attachments: image001.jpg

Cara

On Q & A point 5, I think we should be careful saying that the price is comparable with existing treatment. It's actually at a significant premium (though entirely justifiable on its merits).

Paul.

Paul Carter

SVP, Commercial Operations - Europe, Asia & Middle-East

From: Cara Miller
Sent: 11 October 2013 02:50
To: John Martin; John Milligan; Norbert Bischofberger; Kevin Young; Gregg Alton; Robin Washington; Katie Watson; Brett Pletcher; Hans Reiser; John McHutchison; Paul Carter

Cc: Amy Flood
Subject: FOR REVIEW: French ATU Key Messages and Q&A

Hi all,

I believe you are aware that information regarding the availability of sofosbuvir in France via the ATU mechanism is anticipated to be posted live on the ANSM website on Monday. Although the price of sofosbuvir through the ATU will not be posted on the website, we anticipate that word will get out via physicians and the community relatively quickly.

In preparation for any media/community questions around the ATU and pricing, we have developed the attached key message document and QA. This has been previewed by John McHutchison, Norbert and Gregg.

If possible, we would greatly appreciate receiving any comments tomorrow.

Thank you in advance,

Cara

Exhibit 44

[redacted]

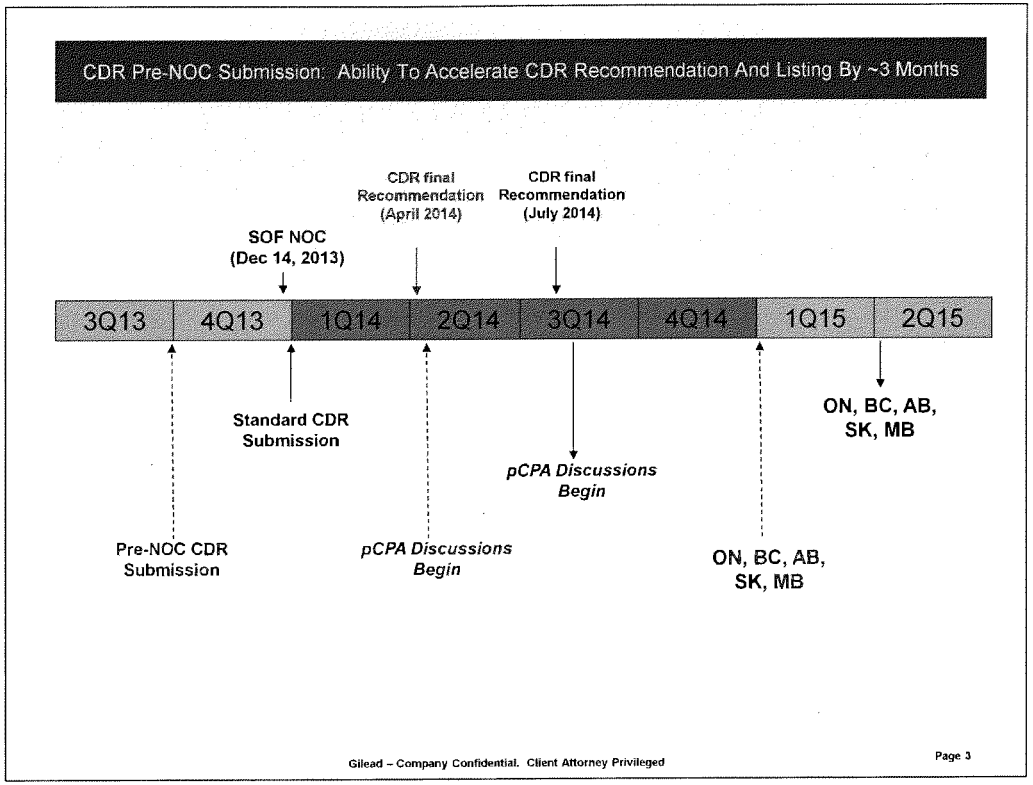
Gilead Sciences Canada Inc.
Canadian Sofosbuvir Pricing Considerations

Ed Gudaitis
Sept. 30, 2013

1546

Executive Summary

- Pre NOC submission opportunity in early October brings forward the timing of CDR decision to April 2014, resulting in earlier reimbursement approval and patient access across provinces
  - SOF price in Canada would not become public until April 2014, five months after the launch of SOF in the U.S.
- Proposed price of SOF in Canada ($55,000) matches the EU target price for SOF
  - Represents a 57% premium to the telaprevir (TVR) price in Canada
  - **Redacted**
  - U.S. price of SOF ($80,000) would be at a 45% premium to the proposed Canadian price of SOF
  - A 40-50% difference between U.S. and Canadian pricing at launch is common
- Launch price of TVR in the U.S. ($49,200) was ~41% higher than in Canada ($35,000)
  - As of September 2013, the price of TVR in the U.S. ($66,155) is approx. 90% higher than the price of TVR in Canada
- Risk of "medical tourism" and cross-border treatment seen as low, in large part due to the high price point of SOF
  - U.S. patient traveling to Canada would have to pay more than $55,000 out-of-pocket for SOF
- SOF distribution/channel strategy in both the U.S. and Canada further lowers risk of mail order arbitrage


CDR Pre-NOC Submission: Ability To Accelerate CDR Recommendation And Listing By ~3 Months
CDR final Recommendation (April 2014)
CDR final Recommendation (July 2014)
SOF NOC (Dec 14, 2013)
3Q13
4Q13
1Q14
2Q14
3Q14
4Q14
1Q15
2Q15
Standard CDR Submission
pCPA Discussions Begin
ON, BC, AB, SK, MB
Pre-NOC CDR Submission
pCPA Discussions Begin
ON, BC, AB, SK, MB
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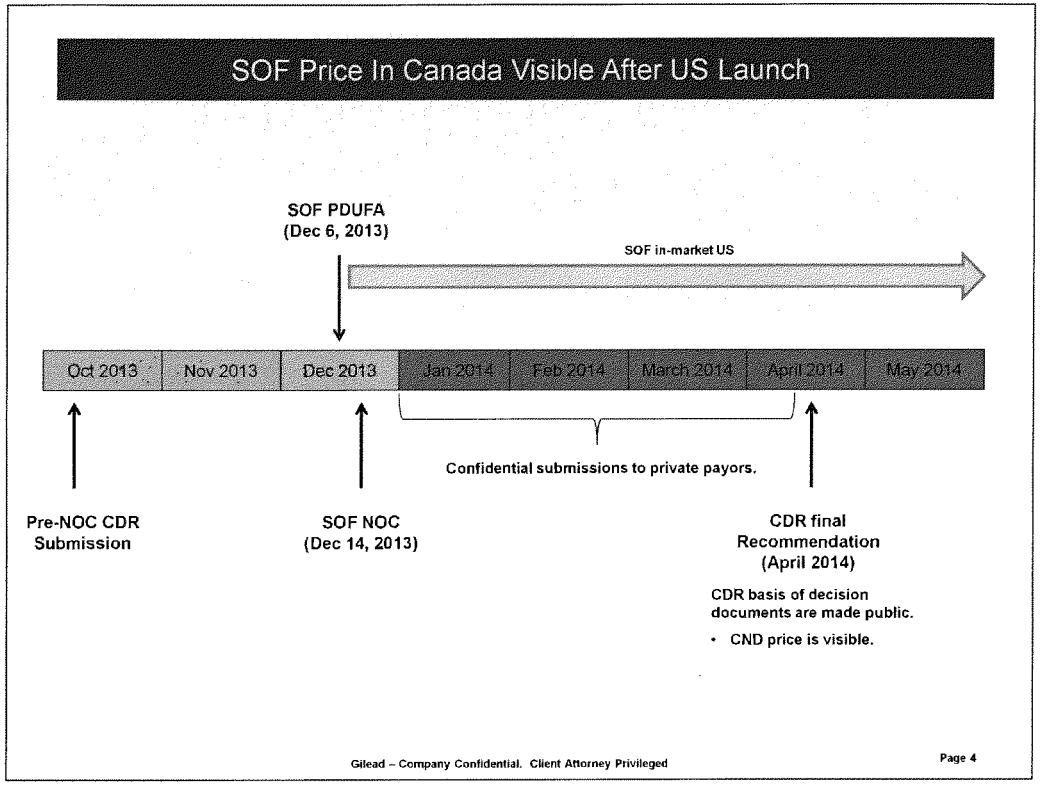
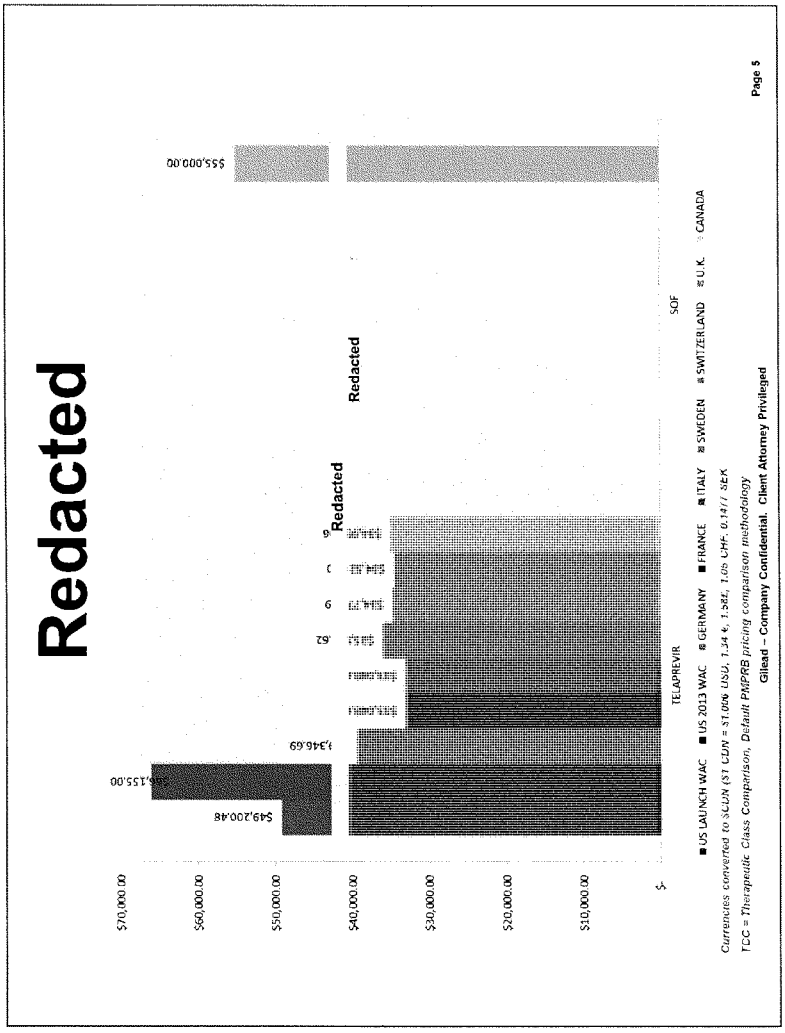
Page 3



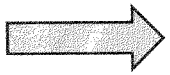


Out Of Pocket Cost For SOF - Discourages Cross Border Patients

For a US patient seeking access to SOF in Canada:

Requires a Canadian Rx for SOF

- Has to see a CND MD
  - Likely Hep or GI
  - 9-12 months waiting list
  - Requires referral from a GP



SOF Rx Fulfilled in Canada

- Charged cash by pharmacy
- Out of pocket cost (CAD$):
  - $55K SOF (12 weeks)
  - + 20% mark-up*
  - + $8.62 dispensing fee**

Total Cost $66K (CAD)

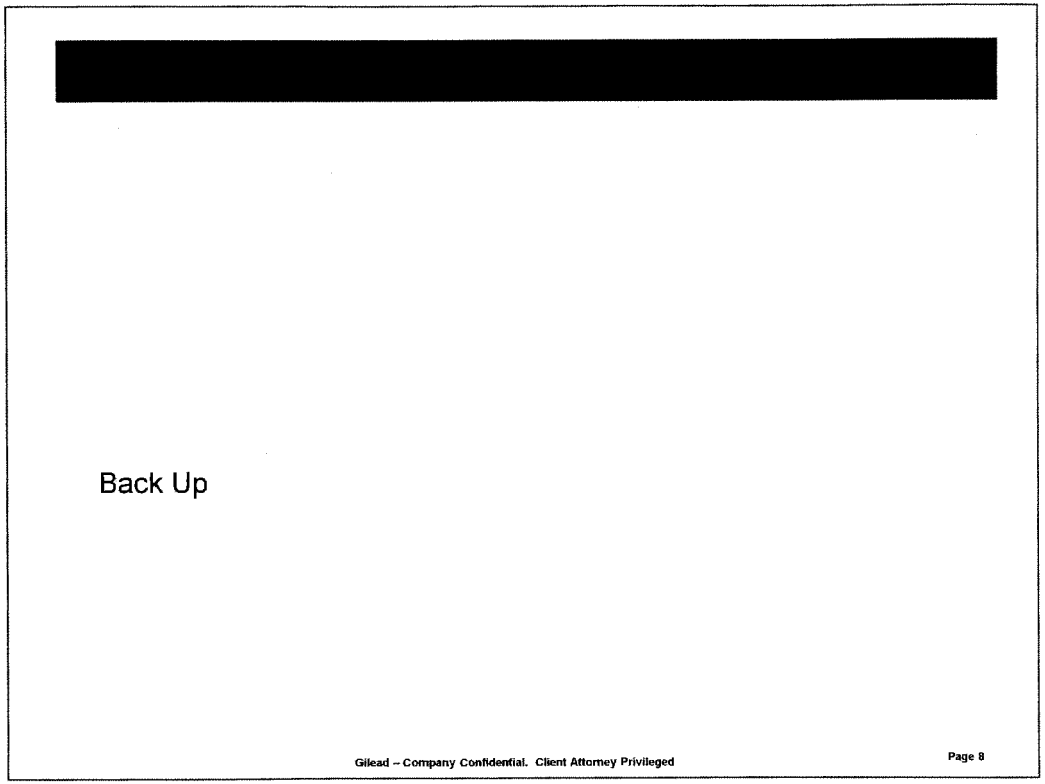
$64K (USD, fX Sept 24, 2013)

* = Lower bound of average Ontario pharmacy mark-up for cash customers. Range 20% to 50%. Pharmex Direct, personal communication.

** = Ontario ODB dispensing fee. April 2013.

SP Distribution Will Be Primary Channel For SOF In Canada

Redacted



Canadian Prices Average Approx. 50% Below US WAC

Sample of recently launched products

Product	CND Launch Date	Dose	CND List Price (CND $)	US WAC (CND $)	CND vs. US % Difference	Mfg	Indication
Jakavi	07 / 2012	5 mg	82.19	127.09	- 35.3	Novartis	Myelofibrosis
Stivarga	04 / 2013	40 mg	74.25	103.62	- 28.3	Bayer	mCRC
Tecfidera	05 / 2013	120 mg	15.77	66.05	- 76.1	Biogen Idec	MS

On average, prices of 16 new medicines introduced in Canada with recordable sales in 2012 were 47.2% below WAC.

Sample of existing branded products (as of 05 / 2013)

Product	Dose	CND List Price (CND $)	US WAC (CND $)	CND vs. US % Difference	Mfg	Indication
Enbrel	50 mg/ml	359.28	561.60	- 36	Amgen	RA+
Herceptin	440 mg	2,700.00	3,363.65	- 20	Roche-GNE	HER2+ve BRC
Avastin	400 mg	2,000.00	2,523.45	- 21	Roche-GNE	mCRC+

Prices of top 50 branded products in Canada (also available in US) were on average 48% below WAC (as of May 2013).

(31 of 50 were > 50% of WAC)

Source: IMS, Provincial Reimbursement Advisor (PRA), August 2013

Exhibit 45

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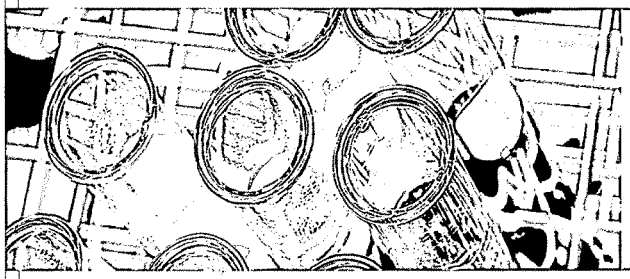

2015-2016
HCV Commercial Plan

April 22, 2014

GILEAD CONFIDENTIAL

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EXECUTIVE SUMMARY

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Executive Summary

Achieving Sustainable HCV Franchise Growth

Secure market share leadership, while growing the market

- Effective portfolio management/prioritization in wake of successive launches
- Responding to competitors' attempts to fragment the market *through scientific dialogue* with prescribers
- Ensuring parity access in a payer environment that desires market fragmentation
- Accelerating Market Development efforts to grow the market

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Executive Summary; 2015-2016 Plan Period

- **GOAL** - *Maximize Total Franchise Value*
  - Within each wave
  - Across successive waves
- **STRATEGIC OBJECTIVES** – *Four Integrated Categories*
  - BRAND
  - ACCESS
  - POLICY
  - MARKET DEVELOPMENT

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OPPORTUNITY

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Opportunity

Market Context

HCV Market Context – Key Trends and Implications

- **Significant unmet need** - high prevalence, under diagnosed, under treated
- **Growing interest in an elimination strategy** within physician community
- **Limited burden of disease data** - Growing awareness of HCV disease by policy makers, but a lack well publicized data
- **Unprecedented regulatory environment** - BMS filing on Ph2, SOF approved in GT1 TE
- **Low sense of urgency to treat now**– stakeholders underestimate the impact of early disease
- **Budget impact** – will shape reimbursement decisions in certain markets, with growing desire to prioritize care
- **Treatment Transformation** began with launch of SOVALDI
- **Highly dynamic competitive environment** – many new all-oral regimens launching within the next 2 years

Implications

- *Increased focus by all stakeholders on HCV*
- *Novel disease management approaches will likely be considered considering both elimination concepts and budget management*
- *Competitors will pair with SOF to share in the HCV market opportunity*

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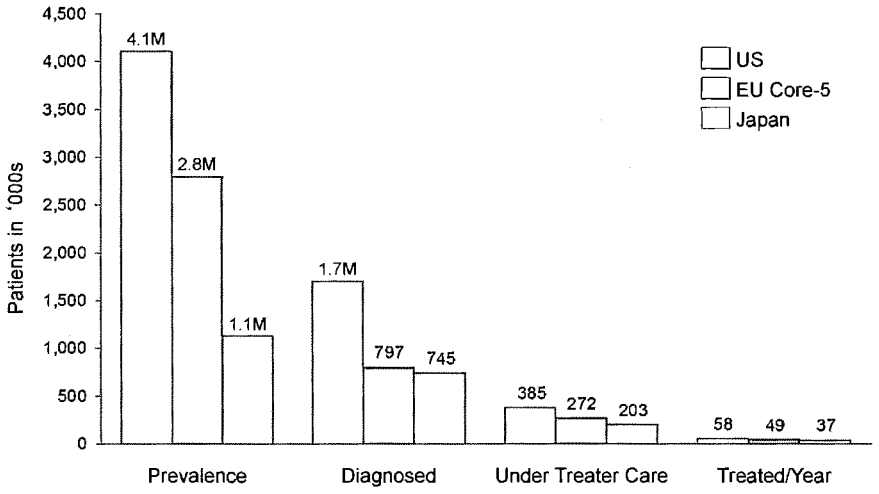
Opportunity

Market Context

The HCV Waterfall: High prevalence, low diagnosis and the majority are not being treated today



Sources
US: Armstrong et al 2006, Volk et al 2011, Culver et al 2009, Decision resources 2008, CDA AASLD 2012, NHANES 2012, Ipsos Monitor Q2 2013 and Gilead estimates.
Europe: Ipsos Healthcare EU5 HCV Monitor Q4 2012 – Q2 2013, IMS/GERS data and Gilead estimates.
Japan: Tanaka et al 2011, Ipsos HCV Monitor Q212, IMS data and Gilead estimates.

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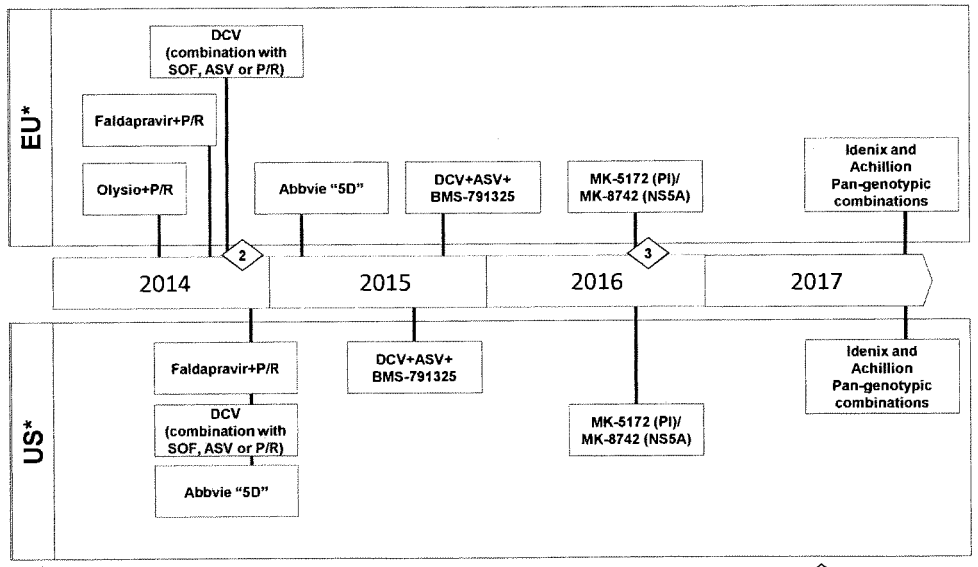
Opportunity

Market Context

Highly Dynamic and Ultra Competitive Environment…



* Assumes 10 month approval in EU and 8 month approval in US

Gilead Launch Wave

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Opportunity

Market Context

Market Environment – Key Opportunities and Threats

Opportunities

- Growing recognition on need to prioritize HCV disease by all stakeholders
- High expectations and anticipation for therapies that remove IFN and RBV
- Physician and patient motivation toward treatment is increasing with the introduction of new therapies
- Simplification of therapy will expand breadth of treatment and broaden treater base
- Multiple companies entering HCV market will help in market expansion
- Patient advocacy beginning to mobilize, especially with the co-infection community

Threats

- Low sense of urgency to proactively diagnose and treat HCV
- Country level budgets do not grow sufficiently to address treatment demands
- Budget impact forces payors to impose restrictions on broad patient access
- Low patient advocacy and influence on payors
- Potential for market fragmentation with launches of competitive regimens
- Combination IFN-free treatments used in 2014 may impact STR uptake

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STRATEGY

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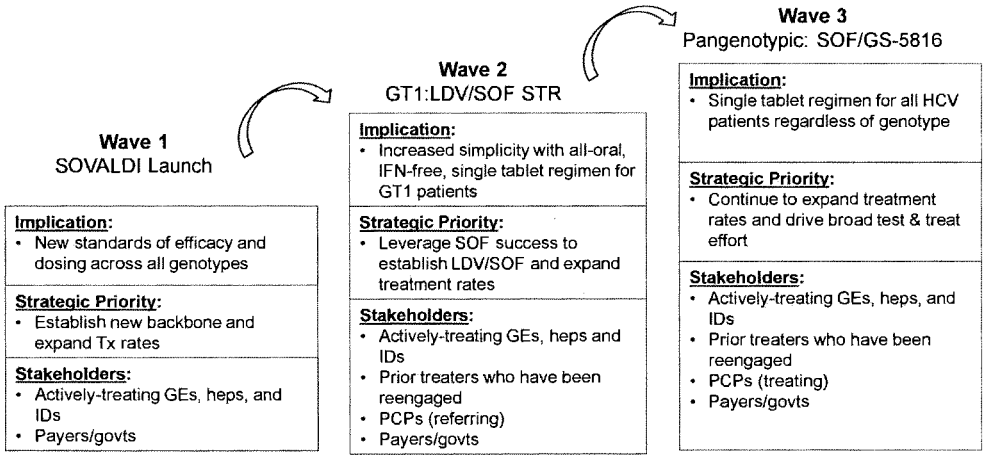
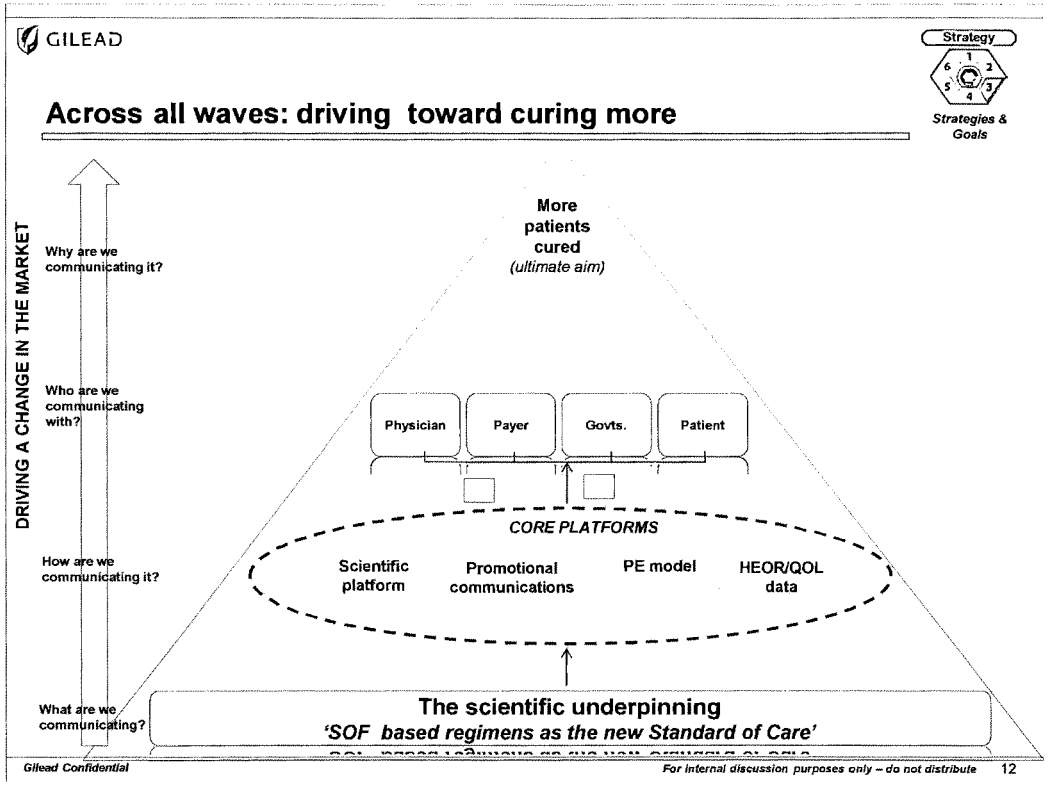
Strategy

Strategies & Goals

Maximize Total Franchise Value Within Each Wave and Across Successive Waves





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Strategy

Strategies & Goals

Priority Weighted Strategic Objectives

Strategic Objective		Priority Weighting
BRAND	Solidify SOF as the backbone of all future HCV therapy while driving sense of urgency to treat now	40%
ACCESS	Raise awareness about benefits of rapid reimbursement and maximum patient access to SOF based regimens	30%
POLICY	*Educate* governments *about economic advantages of* investments in HCV cure and of HCV budget increase in 2015-2016, supported by Government, Public, and Medical Affairs efforts to drive communication and advocacy	15%
MARKET DEVELOPMENT	Accelerate patient flow through the HCV waterfall to drive longer term sustainable growth	15%

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Strategy

Strategies & Goals

#1 Strategic Objective - BRAND

Solidify SOF as the backbone of all future HCV therapy while driving sense of urgency to treat now:

- Continue to execute Wave 1 SOVALDI launch in all markets and establish SOF as the standard of care in HCV
- Raise awareness among physicians about advantages of broadening patients treated today and not waiting for subsequent waves
- Use broad SOF label to drive depth and breadth of physician and patient experience
- Upon Wave 2 approval establish LDV/SOF as the new standard of care in Genotype 1
- Increase franchise share by responding through science to competitor efforts to fragment market
- Drive expanded advocacy for SOF based therapies amongst key influencers

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#2 Strategic Objective - ACCESS

Raise awareness about benefits of rapid reimbursement and maximum patient access to SOF based regimens:

- Ensure payers and national health authorities understand the value offered by SOF-based regimens
- Agree optimal pricing/reimbursement commensurate with the launch wave
- Anticipate and address access barriers and minimize impact of imposed restrictions
- Protect against price erosion from Wave 1→2, and 2→3

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#3 Strategic Objective – POLICY and PUBLIC AFFAIRS

Educate governments about economic advantages of investment in HCV cure and of HCV budget increase in 2015-2016:

- Optimize maximum patient access within existing budgetary constraints
- Facilitate governments to develop consensus towards elimination strategy
- Support Government Affairs and Public Affairs in engaging policymakers to elevate HCV as a major public health issue and increase budgets accordingly to address
- Public Affairs to identify and engage governmental bodies and patient advocacy groups to discuss advantages of broader HCV testing and linkage to care

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#4 Strategic Objective – MARKET DEVELOPMENT

Accelerate HCV waterfall to drive long term sustainable growth:

- Raise awareness among key stakeholders about patient benefit from earlier treatment
- Raise awareness of advantages and support initiatives to increase diagnosis rate among targeted prevalent population (i.e. Age Cohort, Military)
- Increase diagnosis rate among targeted prevalent population (i.e. Age Cohort, Military)
- Increase diagnosis rate among incident population (i.e. PWID)
- Communicate value of earlier treatment

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INITIATIVES

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Initiatives

Actions

Wave 1 and Wave 2 Launches in Select Commercial Markets

Country	Wave 1 Approval	Wave 2 Approval
US	Dec 2013	Oct 2014
EMA	Jan 2014	4Q2014
Asia		
Japan	4Q2014	1Q2015
Korea	2Q2016	1-2Q2016
Hong Kong	3Q2015	1-2Q2016
Taiwan	3Q2015	1-2Q2016
Canada	Dec 2013	4Q2014
Australia	3Q2014	1-2Q2015
Russia	4Q2015*	TBD

*Assumes 12 month review

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Initiatives

Actions

Launch Timelines and Status (US, EMA, Japan)

2014	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Commercial Plan		☆								
Brand Book	"Global" ☆	☆		Japan						
Trade Name			EMA ☆	☆ FDA						☆ PMDA
Pricing/Market Access					US/EMEA ☆		☆ Japan (SOF)			
Manufacturing					US ☆	EMEA ☆				
Key Events										
Congresses	APASL	EASL	JSH						AASLD	
Gilead Approvals								US	EAME	JPN

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BRAND Initiatives

Commercial Planning	Country Level	Timing
Market Context •Updated HCV market "fact files" of country level data providing details on HCV epidemiology, market, treatment flow, screening/treatment guidelines (SP) •Develop competitor assessments and continue to gain deep understanding of competitive landscape including anticipated launch dates, strength, weakness, and provide key intelligence questions framework to markets (FC,SP)	**Market Context** •Assess and validate "fact files" from CP&O and identify any gaps in market understanding •Provide rationale and plan for additional country-level market research needed to fill in any identified knowledge gaps •Execute local competitive intelligence monitoring using CP&O framework of key intelligence questions to anticipate local impact of competition	CP: complete Country level: Q1 2015 CP and Country level update and share CI quarterly
Branding •Develop positioning, core creative concept, claim resource file, messages, core visual aid and related brand book for SOF/LDV (FC) •Maintain brand portal to distribute consistent branding across all markets (SP/FC) •Establish branding guidelines and drive brand stewardship to ensure unified and consistent branding and positioning across all markets (FC)	**Branding** •Adapt global campaign locally and communicate any necessary deviations due to local regulatory guidance •Develop local language launch materials utilizing global branding guidelines either regionally (SP) or at country level	CP: Q1 2014 Country level: 6-8 months prior to launch
Trade Name •Develop trade name and logo that capitalizes on the functional and emotional attributes of SOF/LDV (FC)		CP: 4Q 2014

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Actions

ACCESS Initiatives

Commercial Planning	Country Level	Timing
Market Access Situational Analysis ▪Global analysis of the public health and health political environment, burden of disease, P&R competitive landscape, identification of value drivers for payers (SP) ▪Understanding the payer environment in each market to identify opportunities and barriers, *learning* from Sovaldi (SP, US) ▪Develop payer and customer archetypes (SP, US) ▪Landscape competitor mapping ▪Strategic imperatives and action plan for identified Payer Value Proposition (SP)	**Market Access Situational Analysis** ▪Country analysis of the public health and health political environment, burden of disease, P&R competitive landscape, and identification of value drivers for payers ▪Competitive landscape analysis ▪Identify potential hurdles, issues and requirements (e.g. reimbursement restrictions, HTA guidelines etc…)	CP: Ongoing Country level: 1 year prior to launch and L-3 update
Market Access Plan ▪Develop and validate core value propositions that can be tailored by countries that communicates the value of SOF-based regimens in achieving SVR within a predictable growth model (SP) ▪Pricing and reimbursement guidance on target price pre and post reimbursement and launch order sequencing (SP) ▪Negotiation strategy for P&R negotiation(SP) ▪Ensure best practice shared between regions (SP, FC)	**Market Access Plan** ▪Ensure local plans are developad which outline critical access timeframes ▪Detailed plan of evidence requirements needed to ensure optimal access ▪Adopt Global payer value communication and advocacy plan for local market ▪Create local pricing and reimbursement strategy and communicate to EMEA ▪Strategic Imperatives and local action plan for identified Payer Value Proposition ▪Local Payer Advisory Board Plan (SP, US)	CP: Ongoing Country level: 1 year prior to launch and L-3 update
Market Access Tools ▪Ensure economic models for SOF/5816 are developed early to allow for accelerated submission in all countries (SP) ▪Develop economic models for special populations and prisons (SP) ▪Deliver Value Dossier and Access Toolkit to include Budget Impact Models, Cost Effectiveness Models (SP) ▪Training on implementing Market Access toolkit (SP) ▪Pharmacoeconomic Pub Plan (SP) ▪Negotiation workshops for HTA (SP)	**Market Access Tools** ▪Adapt and tailor Value Dossier and models to local needs to ensure optimal access at launch ▪Ensure HTA dossiers are approved by EMEA prior to submission (SP, US) ▪Publication of local data to support HTA submission ▪Publication of localized economic models	CP: 3/4Q2015 – Q1 2016 Country level: 3months pre-launch Approval 1 month prior to submission Launch + 6m

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POLICY Initiatives

Commercial Planning	Country Level	Timing
Policy Plan ▪Support Government Affairs and Public Affairs in creating tools necessary to engage policymakers in advocating and elevating HCV as a major public health issue; and to educate them about economic advantages of HCV budget increase accordingly (SP)	**Policy Plan** ▪Diagnostic of current policy environment and mapping of policymaker and community advocacy stakeholders / influencers in all core markets at national and relevant regional government levels ▪Establish multi-stakeholder group in each country to develop policy paper for Government which outlines potential strategies ▪Develop core materials for implementation by GMs and GA's including economic and health policy data that support the policy paper ▪Develop community advocacy plan to support broad reimbursement and government investment ▪Develop potential mechanisms to encourage investments and manage financial risks for governments	CP: Ongoing Country level: 1 year prior to launch and L-6 update
PR/Media Plan ▪Support PA as necessary to develop comprehensive media plan for key data milestones (FC)	**PR/Media plan** ▪Maximize major data milestones as appropriate through media channels ▪Utilize EAME/Global campaign development materials	CP: Ongoing Country level: Ongoing
Patient Advocacy Plan ▪Partner with PA to support Patient Advocacy initiatives as needed (SP, US)	**Patient Advocacy Plan** ▪Engage with local patient groups to support launch initiatives & global/EAME strategy	CP: Ongoing Country level: Ongoing

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MARKET DEVELOPMENT

Commercial Planning	Country Level	Timing
Market Expansion •Support educational efforts to educate all HCPs on the need for increased HCV testing in accordance with current recommendations and on the benefits of appropriate treatment •Disseminate data on best practices for testing, pathways to linkage and sustainable care, treatment and ultimate cure	Market Expansion •Raise awareness among key stakeholders about patient benefit from earlier diagnosis and treatment to enable sustainable growth •Use SOF and LDV/SOF promotion to drive expanded treatment rates •Educate all HCPs on the advantage of increased HCV testing in accordance with current recommendations and on the benefits of appropriate treatment •Anticipate and address access barriers to market development efforts •Demonstrate the public health benefit in treating HCV to attain elimination and treatment as prevention •Collaborate with Public Affairs to identify and engage governmental bodies and patient advocacy groups to encourage support for HCV testing and linkage to care	CP: Ongoing Country level: Ongoing

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METRICS

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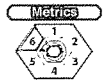

Metrics

EMEA Metrics

Metrics	Method of Measurement	Pre-launch	Post-launch	Frequency
Under treater care and treated patient pool, Tx rate and patient share	Ipsos patient chart audit	✓	✓	quarterly
Perception and performance of PIs	Ipsos patient chart audit	✓	✓	quarterly
Awareness of sofosbuvir and pipeline products	Ipsos patient chart audit	✓	✓	quarterly
Attitude, Trial, & Usage (ATU)	ATU/detail tracker	✓ (1 wave baseline)	✓	quarterly
Unbranded campaign awareness	campaign effectiveness tracking	✓		
HCV market sales and share	IMS MIDAS	✓ (national Level)	✓ (national and brick level)	quarterly
SOF launch performance	ATU/detail tracker		✓	quarterly
SOF GT1 naïve, GT2/3 naïve/experienced share and all patient share; source of business	Ipsos patient chart audit		✓	quarterly
Increase in treated & under treater care pool	Ipsos patient chart audit	✓	✓	quarterly
Internal alignment and effectiveness of sales execution	STEM study		✓	annually
Time between diagnosis and initiation	Ipsos patient chart audit	✓	✓	quarterly
SOF campaign recall and effectiveness	campaign effectiveness tracking		✓	biannually
Treater/prescriber expansion	treatment flow/prescriber analysis		✓	annually

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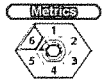

Metrics

US Metrics

Metrics	Method of Measurement	Pre-launch	Post-launch	Frequency
Attitude, Trial, & Usage (ATU)	ATU/detail tracker	✓ (1 wave baseline)	✓	3x year
Launch Initiation Tracker	Primary Market Research		✓	2x year
Message / Campaign recall and effectiveness	Primary Market Research	✓		2x year
Patient chart audit	Ipsos patient chart audit	✓	✓	quarterly
HCV market sales and share	SHA / IMS	✓	✓	Weekly/Monthly
Prescriber base analysis	SHA / IMS	✓	✓	Weekly/Monthly
Source of business	SHA / IMS	✓	✓	Quarterly
Ex-factory units	Internal		✓	Weekly/Monthly
Revenues	Internal		✓	Weekly/Monthly
Forecast attainment	Internal		✓	Weekly/Monthly

Exhibit 46

Topics for Discussion – LDV/SOF US Pricing

August 4th, 2014

Contents

GILEAD

- **Duration reconciliation**
- Wall Street expectations
- Heat map for other considerations
- SOV reversal and rejection data
- Summary at different price points
- Volume and revenue at different pricing points and competitor scenarios
- Wave 1 Impact

Reconciliation of patient population size by duration

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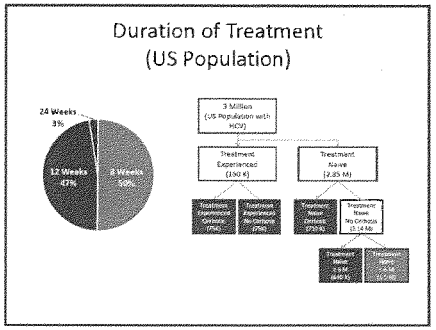
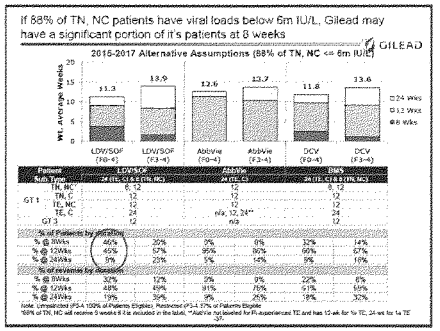
Provided by Phil Pang from Clinical Research



Provided by HCV wave 2 pricing team



Differences	Clinical Research (8wk-12wk-24 wk: 50%-47%-3%)	Pricing Team (8wk-12wk-24 wk: 46%-45%-9%)
Overall patient population	US HCV Prevalent Patient	June LE treated population, LDV/SOF GT1 and GT3
% Treatment Experienced	150K (NEJM by Holmberg ~300K treated, 50% successful, so ~150K TE)	**31%** Ipsos 2013 4QTR Average(June LE)
% of cirrhotic patients	High level estimation trying to be conservative (TE: 50%; TN: 25%)	**TE: 32%; TN: 21%** Ipsos 2013 4QTR Average(June LE)
% of TN/NC with viral load < 6M IU/mL (8 wks)	~70% based lon 1, 2, 3 (based line HCV RNA 67%, screening HCV RAN 69%)	**~88%** Ipsos Q2 2012 to Q1 2014 currently untreated patients

Reconciliation of patient population size by duration - continue

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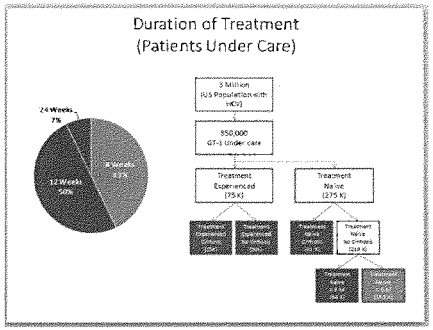
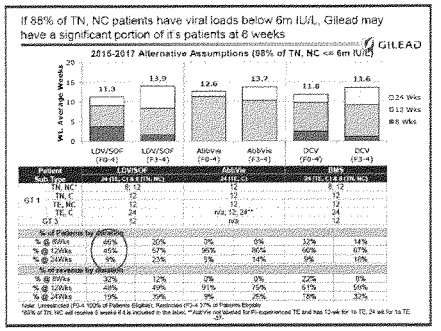
Provided by Phil Pang from Clinical Research



Provided by HCV wave 2 pricing team



Differences	Clinical Research (8wk-12wk-24 wk: 43%-50%-7%)	Pricing Team (8wk-12wk-24 wk: 46%-45%-9%)
Overall patient population	US HCV GT-1 Under care 350K	June LE treated population, LDV/SOF GT1 and GT3
% Treatment Experienced	**21%** (75k / 350k)	**31%** Ipsos 2013 4QTR Average(June LE)
% of cirrhotic patients	**TE: 33%; TN: 22%**	**TE: 32%; TN: 21%** Ipsos 2013 4QTR Average(June LE)
% of TN/NC with viral load < 6M IU/mL (8 wks)	**~70%** Ion 1, 2, 3 (based line HCV RNA 67%, screening HCV RAN 69%)	**~88%** Ipsos Q2 2012 to Q1 2014 currently untreated patients

June LE assumptions

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			USA				
			2013 Q2	2013 Q3	2013 Q4	2014 Q1	4 QTR
		Base	721	672	716	727	2836
G1	Treatment Naïve	F0	6%	4%	6%	8%	6%
		F1	18%	17%	13%	15%	16%
		F2	9%	13%	14%	13%	12%
		F3	4%	9%	6%	6%	6%
		F4	9%	11%	13%	12%	11%
	Treatment experienced	F0	1%	1%	2%	1%	1%
		F1	8%	5%	3%	3%	5%
		F2	8%	7%	6%	6%	6%
		F3	3%	2%	3%	5%	3%
		F4	7%	7%	9%	4%	7%
G2	Treatment Naïve		12%	9%	10%	9%	10%
	Treatment Experienced		2%	3%	3%	2%	2%
G3	Treatment Naïve		6%	4%	6%	9%	6%
	Treatment Experienced		4%	4%	2%	2%	3%
Other			4%	4%	5%	6%	5%

The % of TN, NC patients with an HCV viral load <-6m IU/ml is a key uncertainty

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Alternative Assumptions(88% of TN, NC <= 6m IU/ml)

Based on IPSOS data

GT1	% of GT 1*					% GT 1	Duration		
							LDV/ SOF	Abb	BMS
TN, NC	55%	<= 6m IU/L	88%			48%	8	12	8
		> 6m IU/L	12%			7%	12	12	12
TN, C	15%					15%	12	12	12
TE, NC	21%					21%	12	12	12
TE, C	10%	PI experienced	33%			3%	24	n/a	24
		Non PI exp.	67%	1a	70%	5%	24	24	24
				1b	30%	2%	24	12	24

If 88% of TN, NC patients have viral loads below 6m IU/ml, Gilead may have a significant portion of it's patients at 8 weeks

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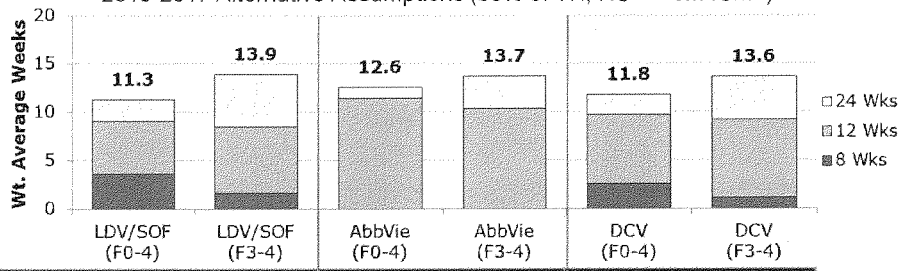

Patient Sub-Type		LDV/SOF 24 (TE, C) & 8 (TN, NC)	AbbVie 24 (TE, C)	BMS 24 (TE, C) & 8 (TN, NC)
GT 1	TN, NC*	8; 12	12	8; 12
	TN, C	12	12	12
	TE, NC	12	12	12
	TE, C	24	n/a; 12; 24**	24
GT 3		12	n/a	12

% of Patients by duration						
% @ 8Wks	46%	20%	0%	0%	32%	14%
% @ 12Wks	45%	57%	95%	86%	60%	67%
% @ 24Wks	9%	23%	5%	14%	9%	18%
% of revenue by duration						
% @ 8Wks	32%	12%	0%	0%	22%	8%
% @ 12Wks	48%	49%	91%	75%	61%	59%
% @ 24Wks	19%	39%	9%	25%	18%	32%

Note: Unrestricted (F0-4 100% of Patients Eligible); Restricted (F3-4 37% of Patients Eligible

*88% of TN, NC will receive 8 weeks if it is included in the label; **AbbVie not labeled for PI-experienced TE and has 12-wk for 1b TE, 24-wk for 1a TE

Ipsos data on viral load

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Distribution of patients latest viral load (weighted)

	Seven Quarter Average (Q3'12 – Q1 '14)	
	Naïve	Exp
Base	3,750	1,419
<= 6m IU/mL	89%	86%
	3,339	1,227
> 6m IU/mL	411	195
	11%	14%

	Q3'12		Q4'12		Q1'13		Q2'13		Q3'13		Q4'13		Q1'14	
	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp
Base	352	151	495	196	554	217	594	249	601	211	542	214	612	181
<= 6m IU/mL	328	129	427	174	499	188	518	220	534	173	489	187	544	156
	93%	85%	86%	88%	90%	87%	87%	89%	89%	82%	90%	87%	89%	86%
> 6m IU/mL	25	23	67	23	55	29	76	29	68	38	52	28	68	25
	7%	15%	14%	12%	10%	13%	13%	11%	11%	18%	10%	13%	11%	14%

Base: all naïve/experienced untreated patients with known latest viral load (weighted)

Source: Ipsos HCV TM

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While most analysts reports we reviewed did not comment on LDV/SOF price expectations, those who have show a fairly wide range of estimates

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	ANALYST	LDV/SOF PRICE EXPECTATION*	COMMENTARY
PREMIUM TO SOV	Wells Fargo	Less than $150K/course	"We believe the potential for considerably lower costs for the sofosbuvir/ledipasvir regimen [than COSMOS] as well as the likely availability of an alternative will help reduce the vociferousness of payer concerns"
PREMIUM TO SOV	Baird	$120K/12 wks	"We expect the eight-week combo regimen to be priced at $80k ($120k for the 12-week regimen)."
PREMIUM TO SOV	Bernstein	Sovaldi + 10-15% ($92-97K)	"For their coming combination, Gilead continues to suggest that most of the value of the combination will come from the Sovaldi component, which suggests that the ultimate price will be in the range of Sovaldi + 10-15%."
PREMIUM TO SOV	Cowen	$1,100/day ($92.4K/12 weeks)	"We estimate a price per day of $1,100, or $61.6K for a 56 day course."
DISCOUNT TO SOV	Nomura	$70K/patient (effective net)	"Our revised estimates are based on avg price per patient of $70k, below Sovaldi's $84k and payer expectations for combination prices of $120-150"
DISCOUNT TO SOV	Deutsche Bank	Slightly more than $65K/cure	"With shorter duration as a possibility, we think the street may be under-estimating the pricing of Gilead's all oral combo. The street is currently expecting pricing of the new pill to be $65K (~20% discount from current per cure pricing)."

Most analysts (JP Morgan, UBS, RBC, Citi, Credit Suisse, BMO, Leerink, Jeffries, Goldman Sachs, Guggenheim, William Blair, Maxim, Needham) did not identify an expected price range for LDV/SOF in the reports we reviewed.

**Note: Unless noted of the slide reports did not explicitly state whether price expectations were gross or net.*

Source: Analyst reports dated 7/17/14, 7/23/14, or 7/24/14

There are several possible ways analysts might interpret Gilead's pricing decision for LDV/SOF, with varying impact on estimated earnings

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POTENTIAL IMPACT ON ESTIMATED EARNINGS

LDV/SOF PRICED BELOW EXPECTATIONS

- Analysts may interpret a lower-than-expected LDV/SOF price in one or more ways:
  - Gilead acquiescing to payer/public push-back on Sovaldi launch pricing
  - Gilead forecasts suggest higher-than-expected demand, making up for WAC discount
- If analysts favor the former explanation, they are likely to lower earnings estimates

LDV/SOF PRICED ABOVE EXPECTATIONS

- If analysts feel that Gilead's pricing decision is designed to maximize revenue based on well-validated forecasts, earnings estimates could increase
- However, there is a risk that analysts will see LDV/SOF's price as outpacing its clinical value, creating risk

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Aside from payer access and physician demand, there are a number of issues that could affect Gilead's final pricing decision

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Stake-holders	Potential issues	Likelihood of issues across LDV/SOF prices (12 weeks)			
		$84K	$96K	$108K	$120K
Payers	Difficult payer conversations for NAMs with LDV/SOF because of Sovaldi budget concerns	Very Likely	Very Likely	Very Likely	Very Likely
	Payer scrutiny of HCV increases beyond current (very high) levels due to LDV/SOF launch price	Possible	Possible	Possible	Likely
	Payers and PBMs, such as Express Scripts, actively issue RFPs for preferred products (1 of 1)	Possible	Possible	Likely	Very Likely
	Payers request significant rebates off of WAC	Very Likely	Very Likely	Very Likely	Very Likely
	Subset of restrictive payers seek to contain HCV budget impact by limiting treatment to higher-severity subpops	Likely	Likely	Likely	Very Likely
	State Medicaid's set bundled payments for treatment of HCV	Possible	Possible	Possible	Possible
	Negative spill over to Sovaldi or other Gilead therapeutic areas	Possible	Possible	Possible	Possible
	Public and Private Payer Attribute premium increases or earnings misses to HCV	Very Likely	Very Likely	Very Likely	Very Likely
Physicians	Lost KOL support / endorsement due to price	Unlikely	Unlikely	Possible	Likely
	Public KOL outrage over LDV/SOF price	Possible	Possible	Likely	Very Likely

*Guideline changes due to price are unprecedented

Aside from payer access and physician demand, there are a number of issues that could affect Gilead's final pricing decision

Stake-holders	Potential issues	Likelihood of issues across LDV/SOF prices (12 weeks)			
		$84K	$96K	$108K	$120K
Advocacy	Pricing petitions and protests from patient advocates / advocacy groups	Very Likely	Very Likely	Very Likely	Very Likely
Guidelines	IDSA/AASLD guidelines disadvantage LDV/SOF due to price*	Unlikely	Unlikely	Unlikely	Possible
	Guidelines include a "Who and When to Treat" section to address the issue of healthcare resources and societal cost	Very Likely	Very Likely	Very Likely	Very Likely
Other	Further letters from Congress regarding LDV/SOF price	Very Likely	Very Likely	Very Likely	Very Likely
	LDV/SOF pricing is scrutinized because of expected significant differences in price between the US and rest of world	Very Likely	Very Likely	Very Likely	Very Likely
	Discussions of US government price controls gain traction	Possible	Possible	Possible	Possible
	Dollar per pill gets negative headlines (>$1000 per pill)	Very Likely	Very Likely	Very Likely	Very Likely
	Dollar per script gets negative headlines (>$28,000 per bottle)	Very Likely	Very Likely	Very Likely	Very Likely
Competitors	AbbVie launches at a significant WAC discount to LDV/SOF	Unlikely	Unlikely	Possible	Likely
	AbbVie aggressively offers discounts to try and gain preferential access at select accounts	Very Likely	Very Likely	Very Likely	Very Likely
	BMS (DCV+SOF) launches at a significant WAC discount to LDV/SOF	Not Possible	Unlikely	Unlikely	Possible
	BMS aggressively offers discounts to try and gain preferential access at select accounts	Possible	Possible	Very Likely	Very Likely

*Guideline changes due to price are unprecedented

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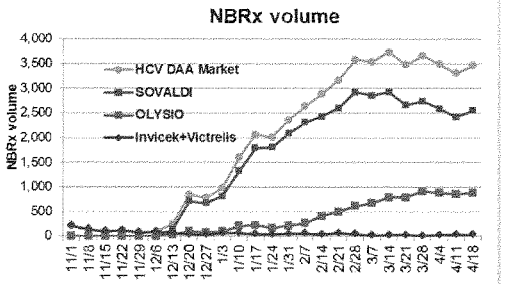
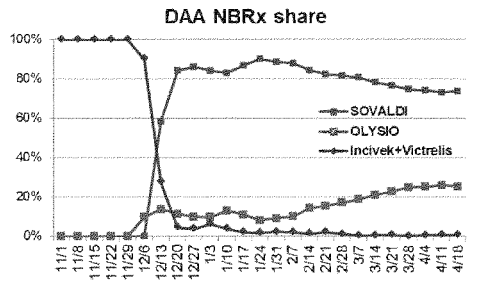
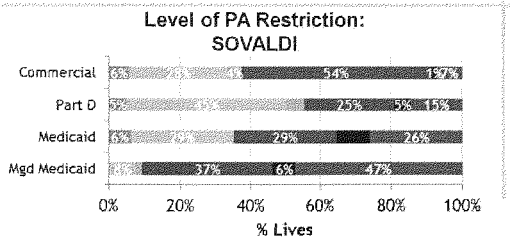
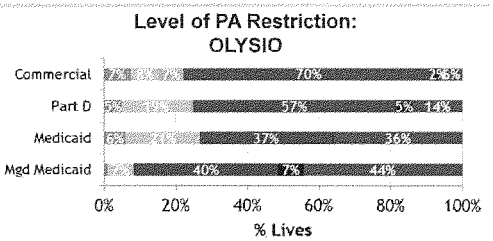
Executive Summary: National Key Performance Indicators



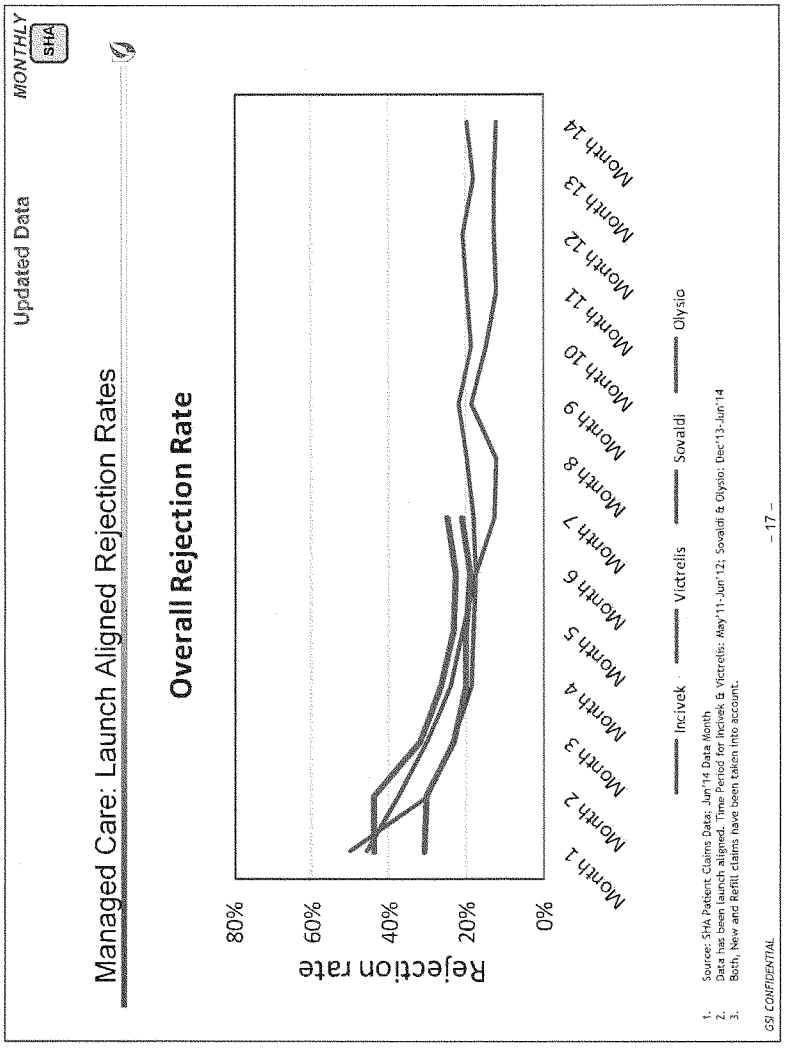






1. Source of NBRx Trends: IMS NMRx Data; week ending xx/xx/xxxx
2. Source of Level of PA Restriction Heat map: Zitter Group; week ending 06/06/2014
3. Low: PA consistent with or broader than label, little/no enforcement of preferred agents (if preferred agent specified)
4. Medium: Preferred agent specified through differential tiering, mandates specialty pharmacy distribution
5. High: Requires liver biopsy and evidence of progressed disease, fill of < 30 days or total quantity limits < duration of therapy, documentation of INF-ineligibility
6. This may include a mix of interim and final policy decisions, based on what can be validated by Zitter. This data set surveys 450 plans nationwide, both regional and national plans.

1600


Updated Data
MONTHLY
SHA
Managed Care: Launch Aligned Rejection Rates
Overall Rejection Rate
Rejection rate
80%
60%
40%
20%
0%
Month 1
Month 2
Month 3
Month 4
Month 5
Month 6
Month 7
Month 8
Month 9
Month 10
Month 11
Month 12
Month 13
Month 14
Incivek
Victrelis
Sovaldi
Olysio
1. Source: SHA Patient Claims Data; Jun'14 Data Month
2. Data has been launch aligned. Time Period for Incivek & Victrelis: May'11-Jun'12; Sovaldi & Olysio: Dec'13-Jun'14
3. Both, New and Refill claims have been taken into account.
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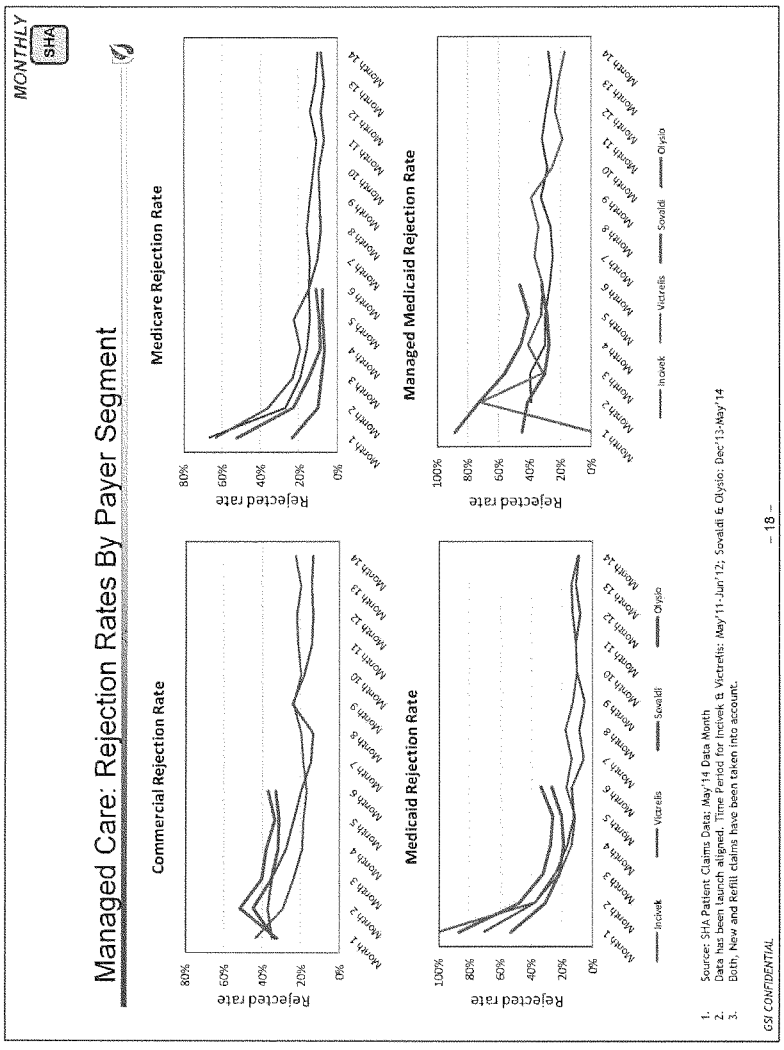
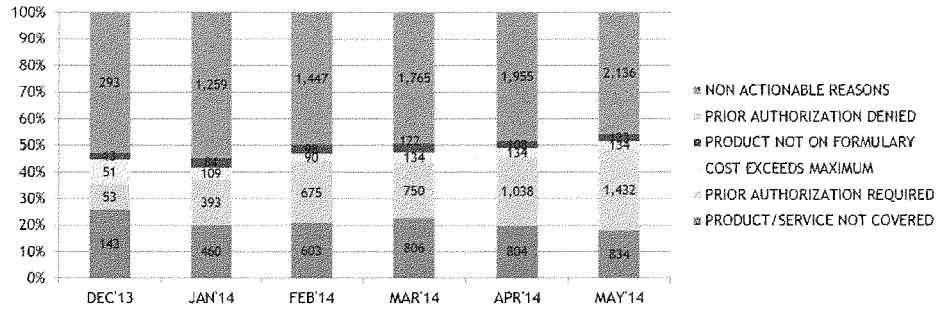


MONTHLY

SHA

Managed Care: Top Rejection Reasons

For Sovaldi, across all payer segments



REJECTION REASON	DEC'13	JAN '14	FEB '14	MAR '14	APR'14	MAY'14
Actionable Reasons	**47%**	**45%**	**50%**	**51%**	**52%**	**54%**
Prior Authorization Required	10%	17%	23%	21%	26%	31%
Product/Service Not Covered	26%	20%	21%	23%	20%	18%
Cost Exceeds Maximum	9%	5%	3%	4%	3%	3%
Product Not On Formulary	2%	4%	3%	3%	3%	3%
Non-Actionable Reasons	**53%**	**55%**	**50%**	**49%**	**48%**	**46%**
Product/Service Not Appropriate For This Location	10%	12%	11%	10%	10%	10%
Pharmacy not contracted with plan on date of service	6%	6%	4%	4%	8%	6%
Non-matched Pharmacy number	8%	11%	10%	7%	5%	5%
Must fill through specialty pharmacy	1%	9%	7%	7%	5%	5%

1. Source: SHA Patient Claims Data; May'14 Data Month
2. Direct feed claims not included. Only Final claims have been included for the analysis
3. % = Rejection due to a reason / Total rejections in a month

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1603

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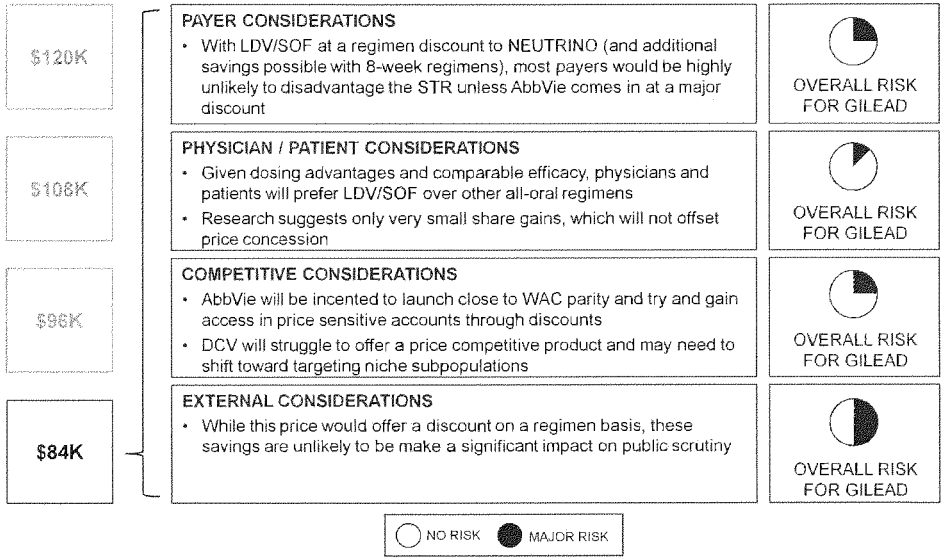
With LDV/SOF at $84K, and Abbvie at a similar WAC, some restrictive payers may seek to prefer AbbVie, but most will seek to contract for parity

GILEAD

LDV/SOF WAC (12 weeks)



At $96K, some restrictive payers may seek to prefer AbbVie, but most will seek to contract for parity

GILEAD

LDV/SOF WAC (12 weeks)

$120K

$108K

$96K

$84K

PAYER CONSIDERATIONS
- Given that 12-week LDV/SOF would be at regimen parity to NEUTRINO with potential savings at 8 weeks, most payers will not seek to restrict access, although certain high-control plans could prefer another regimen if rebates are high enough

OVERALL RISK FOR GILEAD

PHYSICIAN / PATIENT CONSIDERATIONS
- Given dosing advantages and comparable efficacy, physicians and patients will prefer LDV/SOF over other all-oral regimens
- The potential for 8-week treatment for some TN-NC patients will provide another advantage over AbbVie in this segment

OVERALL RISK FOR GILEAD

COMPETITIVE CONSIDERATIONS
- AbbVie will be incented to launch close to WAC parity and try and gain access in price sensitive accounts through discounts
- Implied value of DCV ~$12k, BMS may need to shift toward targeting niche subpopulations

OVERALL RISK FOR GILEAD

EXTERNAL CONSIDERATIONS
- Scrutiny from payers, advocacy groups, and media can be expected to continue near current levels given the premium relative to Sovaldi; payer savings from 8-week regimens or contracting will not have a major impact on public discourse

OVERALL RISK FOR GILEAD

NO RISK MAJOR RISK

At $108K, WAC competition from AbbVie may be become slightly more likely; some payers may impose hard steps against SOF/LDV

GILEAD

LDV/SOF WAC (12 weeks)

LDV/SOF WAC (12 weeks)		OVERALL RISK FOR GILEAD
$120K		
$108K	**PAYER CONSIDERATIONS** • At $108K, restrictive payers will seek to contract with AbbVie for preferred status which may be implemented via hard steps • However, lost share is unlikely to outweigh gains in revenue resulting from the increase in LDV/SOF WAC	
	PHYSICIAN / PATIENT CONSIDERATIONS • While preferences will still favor LDV/SOF, physicians will shift prescribing to AbbVie in the event of LDV/SOF restrictions • While a few LDV/SOF patients may be managed to alternative therapies, research does not suggest this impact would be significant	
$96K	**COMPETITIVE CONSIDERATIONS** • AbbVie has greater flexibility to offer net discounts • BMS has more pricing flexibility, if DCV+SOF gains in the market the resulting SOF revenue may buffer against AbbVie losses	
$84K	**EXTERNAL CONSIDERATIONS** • Public scrutiny of Gilead pricing may be prolonged if LDV/SOF crosses the $100K threshold, although the overall impact on management, uptake, and Gilead reputation is unlikely to diverge from expectations at lower price points	

NO RISK MAJOR RISK

-23-

At $120K, WAC competition from AbbVie becomes more likely; more payers may impose hard steps against SOF/LDV

GILEAD

LDV/SOF WAC (12 weeks)

$120K

$108K

$96K

$84K

PAYER CONSIDERATIONS
- At $120K, LDV/SOF will be pushing the upper limit of value for many payers, and may expand implementation of hard steps into larger, typically less cost-sensitive plans
- However, blocked access remains unlikely for most at prices <$150K

OVERALL RISK FOR GILEAD

PHYSICIAN / PATIENT CONSIDERATIONS
- While physician and patient perceptions of LDV/SOF's clinical value will remain strong, the increased frequency of hard steps may shift physician prescribing away from LDV/SOF (even in TN-NC) in order to pre-empt potential access hurdles

OVERALL RISK FOR GILEAD

COMPETITIVE CONSIDERATIONS
- AbbVie has greater flexibility to offer net discounts and may start considering significant WAC discounts based on market reaction
- BMS has more pricing flexibility, if DCV+SOF gains in the market the resulting SOF revenue may buffer against AbbVie losses

OVERALL RISK FOR GILEAD

EXTERNAL CONSIDERATIONS
- Public scrutiny may be slightly intensified at $120K, although the tone and tenor of media coverage, payer statements, and advocacy groups would not be expected to differ significantly from expectations at $108K

OVERALL RISK FOR GILEAD

NO RISK MAJOR RISK

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Base Case Assumptions have changed since the June LE (1 of 2)

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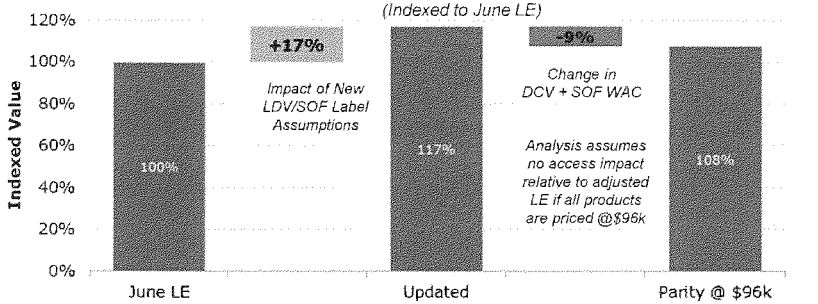
Change in Gilead HCV Franchise Net Revenue 2015 – 2017



	June LE	Updated durations	Parity @ $96k
12 Week WAC Launch Price			
LDV/SOF	106.5	106.5	96
Weighted Average WAC Launch Price			
LDV/SOF	87	109	98
2015 GT1 Share			
Other SOF	0%	0%	0%
LDV/SOF	59%	59%	59%
DCV+SOF	15%	15%	15%
Other DCV	2%	2%	2%
AbbVie	24%	24%	24%
% Patient Split by Duration (LDV/SOF)			
8 Weeks	52%	21%	21%
12 Weeks	48%	70%	70%
24 Weeks	0%	9%	9%

*Includes revised GTN assumptions updated July 2014 by Gilead finance, impact <1%

Base Case Assumptions have changed since the June LE (2 of 2)

GILEAD

The "Parity @$96k has been used as the point of comparison for alternative WAC and competitive scenarios. This case assumes no access impact relative to adjusted LE if all products are priced @$96k

	Net Revenue ($ MM)			Treated Pts (000s)		
	2015	2016	2017	2014	2015	2016
June LE Forecast		Redacted				Redacted
Sovaldi	$2,715			39	35	
LDV/SOF	$5,944			92	79	
DCV+SOF (Gilead)	$1,790			31	26	
Total	**$10,450**			**162**	**140**	
Updated Durations*	12,305			162	140	
Delta from June LE:	*1,855*			-	-	
Parity @ $96k	11,565			162	140	
Delta from New Durations:	*(739)*			-	-	

*Impact of New LDV/SOF Label Assumptions Includes revised GTN assumptions updated July 2014 by Gilead finance, impact <1%

Source: IMSCG analysis based on primary market research and Gilead March LE 2014 forecast. Note: IMSCG did not develop and has not validated Gilead patient forecast

The team examined eight competitive pricing scenarios and their impact on Gilead's Wave 2 US pricing

GILEAD

- The team created a dynamic pricing model combining the base case assumptions from June LE, the impact of changes in labeled duration, multiple price and rebate levels for Gilead, AbbVie and BMS, payers reaction to price and rebate decisions and physician reaction to payer restrictions

		LDV/SOF strategy		AbbVie strategy		AbbVie net delta to LDV/ SOF	BMS strategy	
		12 wk WAC	Rebate	12 wk WAC	Rebate		12 wk WAC *DCV / SOF+DCV*	Rebate
What if AbbVie discounts (Net vs. WAC)?	**Parity environment**	$96K	Redacted	$96K	Redacted	**Redacted**	$12K / $96K	Redacted
	AbbVie ~10% WAC discount	$96K		$84K			$12K / $96K	
	AbbVie ~10% net discount	$96K		$96K			$12K / $96K	
What if AbbVie enters at a discount?	**AbbVie discounts (WAC $72k)**	$96K		$72K			$12K / $96K	
	AbbVie 20% net discount	$96K		$96K			$12K / $96K	
	AbbVie discounts (WAC $60k)	$96K		$60K			$$12K / $96K	
What if Gilead enters higher?	**LDV/SOF @$108K**	$108K		$96K			$26K / $110K	
	LDV/SOF @$108K; AbbVie low	$108K		$60K			$26K / $110K	

Note: For consistency, in scenario names prices are quoted at 12 week durations

Impact of WAC pricing and competitive scenarios on revenue and patients

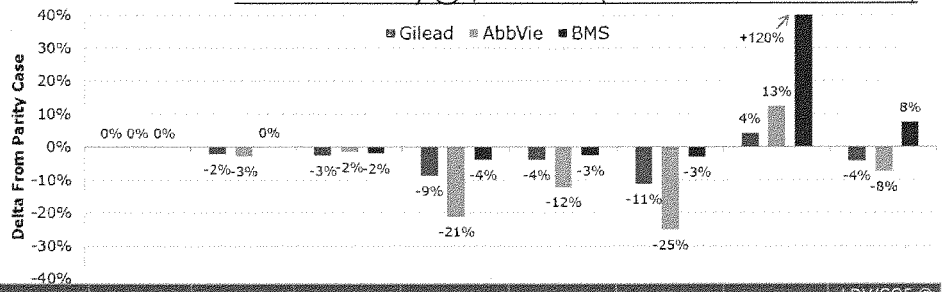
GILEAD

	Net Revenue ($ MM)			Treated Pts (000s)		
	2015	2016	2017	2014	2015	2016
Parity @ $96k	11,565	**Redacted**		162	140	Redacted
AbbVie -10% WAC	11,290			158	137	
Delta from Parity @ $96	*(275)*			*-2%*	*-2%*	
AbbVie -10% net	11,229			157	137	
Delta from Parity @ $96	*(337)*			*-3%*	*-2%*	
AbbVie @ $72k	10,564			160	139	
Delta from Parity @ $96	*(1,002)*			*-1%*	*-1%*	
AbbVie -20% net	11,065			155	135	
Delta from Parity @ $96	*(500)*			*-4%*	*-3%*	
AbbVie @ $60k	10,253			155	136	
Delta from Parity @ $96	*(1,313)*			*-4%*	*-3%*	
LDV/SOF @ $108k	12,043			157	137	
Delta from Parity @ $96	*478*			*-3%*	*-2%*	
LDV/SOF @ $108k; Abb $60k	11,011			145	128	
Delta from Parity @ $96	*(555)*			*-10%*	*-9%*	

Source: IMSCG analysis based on primary market research and Gilead March LE 2014 forecast. Note: IMSCG did not develop and has not validated Gilead patient forecast

Cross Scenario Summary
Change from Parity Case for Gilead Franchise Net Revenue

GILEAD



	Parity @ $96k	AbbVie - 10% WAC	AbbVie - 10% net	AbbVie @ $72k	AbbVie - 20% net	AbbVie @ $60k	LDV/SOF @ $108k	LDV/SOF @ $108k, Abb $60k
Weight Average WAC Launch Price								
LDV/SOF	98	98	98	98	98	98	111	111
DCV	12	12	12	12	12	12	27	12
DCV+SOF	98	98	98	98	98	98	113	98
AbbVie	101	88	101	75	101	63	101	63
Launch Contracting Assumption								
LDV/SOF	Redacted							
DCV								
AbbVie								
2015 GT1 Share								
LDV/SOF	59%	57%	56%	59%	55%	55%	56%	46%
DCV+SOF	15%	15%	14%	14%	14%	14%	15%	16%
Other DCV	2%	2%	2%	2%	2%	2%	2%	2%
AbbVie	24%	27%	27%	25%	29%	29%	27%	35%

For additional detail, please see slide 94 & 95

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Major payers have been actively adjusting forecasts and working with their state partners to prepare for expected increased HCV spend

GILEAD

PAYER	COMMENTARY
Express Scripts	• Specialty spend is forecasted to increase +63% over the next three years • HCV is expected to be a key driver of this increased spend
Humana	• EPS was lower than the second quarter of last year due to HCV drug costs • Working with states (e.g., Florida, Illinois, Virginia) to fund HCV exposures
Aetna	• Medical cost trends continue to be moderate and consistent with previous range of projections despite HCV cost pressures
WellPoint	• More than doubled HCV costs in pricing for 2014 compared to 2013 and added $100M to that outlook in Q1 2014 • Working with states to incorporate full expected HCV costs into reimbursement rates
Centene	• Net cost impact of HCV in Q2 2014 was $13.7M (compared to $4.2M in Q2 2013 and $7.3M in Q1 2014) • Working with states to include full expected HCV costs into reimbursement rates
United Health Group	• Q2 spend for HCV was "in line with" revised expectations after Q1
WellCare	• HCV drugs have had a meaningful short term budget impact ($0.30 per share in expenses) • Florida is the first state to provide a specific reimbursement agreement for the managed Medicaid lives

Source: Payers' Q2 Earnings Calls, via RBC

HCV is expected to drive a significant increase in 2015 federal Medicare Part D spending and annual individual beneficiary premiums

GILEAD

Guiding Research Question: What is the cost impact of the new HCV drug therapies on the 2015 individual Medicare Part D program?

Key Findings

Increased 2015 federal Medicare Part D spending

- New HCV drug therapies, including Sovaldi and Olysio, are estimated to increase 2015 federal spending on the individual Medicare Part D program by approximately **$2.9 billion to $5.8 billion**
  - Equivalent to a **6 to 11% increase in spending**

Increased total annual individual Medicare Part D beneficiary premiums

- New HCV drug therapies, including Sovaldi and Olysio, are estimated to increase total annual individual Medicare Part D beneficiary premiums by **$481 million to $965 million in 2015**
  - Equivalent to a **4.3% to 8.6% increase over 2014 beneficiary premiums** or an additional $17 to $33 per beneficiary per year

Key Considerations

- Assumes an average cost of $84,4000 per course of treatment, as no upcoming launch prices are known
- Assumes new HCV drug use rates of 15% to 30% of the 270,000 individual Medicare Part D enrollees estimated to have HCV
- Calculations do not reflect potential savings from reductions in other costs (e.g. treatment of chronic liver disease)

Source: The Impact of New Hepatitis C Drug Therapy on Individual Medicare Part D Spending
Prepared by Milliman for the Pharmaceutical Care Management Association

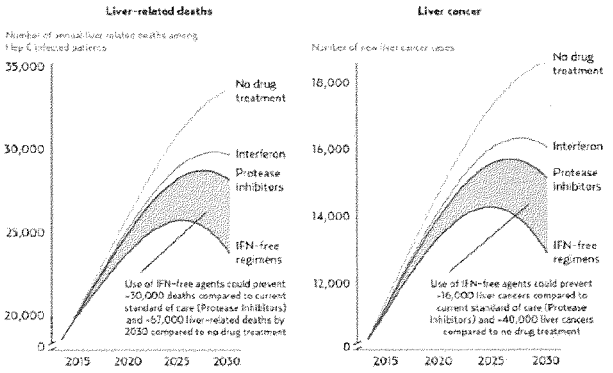
Though the debate about HCV pricing has dominated the media, key organizations have published studies highlighting Sovaldi's benefit

GILEAD

Guiding Research Question: How much better off today and tomorrow are people in the US as a result of the breakthroughs in treating HCV?

Exhibit 5: Impact of treatment innovation on human life

Methodology	Using a model created by the Center for Disease Analysis (CDA), we 'applied' different treatment regimens on today's American Hep C population. By altering SVRs, medical eligibility, and compliance rates, we can illustrate the impact of treatment innovation on morbidity and mortality



Key Takeaways

- If **no HCV drugs** were available today, mortality would rise steadily, **claiming nearly 500,000 US lives** from 2013-2030
- However, a switch to the interferon-free regimens shows a **sharp mortality decline around 2025,** such that **67,000 US lives** that would have been lost with no treatment would be saved from 2013-2030
- A switch from protease inhibitors to interferon free regimens yields more than **30,000 lives saved by 2030** (see grey shading)

Key assumptions included:

- CTAF's summary of published SVRs and discontinuation risk
- Constant diagnosis rate of 50%
- Constant treatment rate of 59,000 patients/year regardless of treatment regimen

Source: Innovation in Hepatitis C Treatment: New Opportunities for Action
Prepared by the California Healthcare Institute

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Exhibit 47

US HCV Pricing Update

SVP Update Meeting
July 21, 2014

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Executive Summary

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- **Gilead enjoys modest pricing power for the LDV/SOF, although avoiding restrictions with all accounts will be difficult to achieve**
  - Physicians still strongly prefer the Gilead regimen and research suggests demand will remain relatively robust even in the face of some restrictions
  - A majority of payers indicate that 1 of 1 arrangements are unattractive, and most seek to make at least two options available
  - A minority of payers will seek more restrictive arrangements at all prices, such as 1 of 1 access
  - Broad discounts do not offer offsetting share benefits for Gilead; however, this does not mean there are not some payers where discounting will be profitable
- **AbbVie will likely have different pricing strategies that will be driven by final label language granted by FDA**
  - In most cases, AbbVie is incented to match LDV/SOF WAC and discount modestly to gain pockets of share
  - Assuming Gilead's discounts will have a high spill-over effect on other accounts, it will likely be in Gilead's interest to cede some portion of these wins to AbbVie
  - If AbbVie is granted a very different label than Gilead, they may be incented to launch with a significantly lower WAC (on a weekly basis)[*Unlikely*]
- **BMS offers Gilead some protection against revenue loss to AbbVie**

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Executive Summary (Cont.)

GILEAD

- **NS5B is an important backbone**
  - Overall, physicians allocate between 78% and 84% of patients to a sofosbuvir-based regimen
  - As a consequence, if LDV/SOF is priced at a significant premium to the alternatives, physicians will allocate a substantial share of prescriptions to the DCV+SOF combination

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Agenda

GILEAD

- Executive Summary
- **Market Research Summary**
- Pricing Scenario Financial Analysis
- Impact of Alternative Duration Scenarios
- What If Scenarios and PR Considerations
- Other Analyses and Requests
- Appendix

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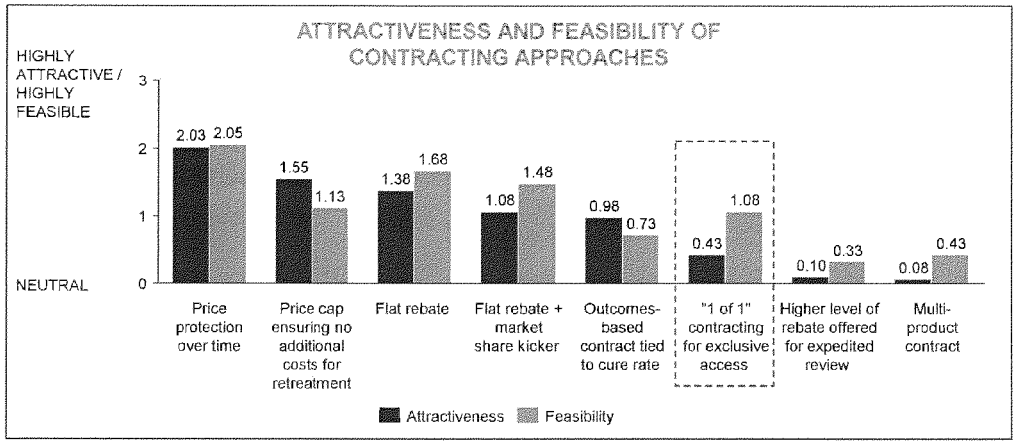
There is little interest in "1 of 1" contracting, with blocked LDV/SOF access seen as very unlikely

GILEAD



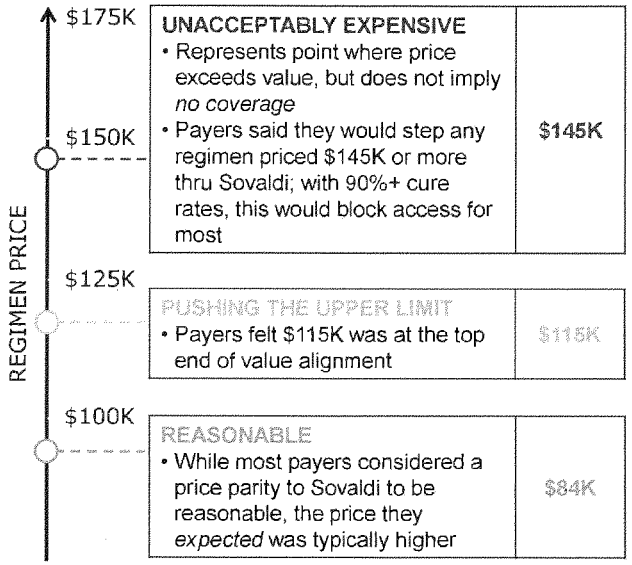
- The gap between attractiveness and feasibility for "1 of 1" strongly suggests payers have a very low level of interest in choosing a single preferred regimen
- Throughout the payer conjoint, the % of lives seeing "no coverage" for any regimen is extremely low, reinforcing the concept that payers are not eager to block access to new regimens; instead, payers may pick two "winners" and generate rebates off the volume

N = 40 payers

5

Payers' unaided expectations for Wave 2 pricing were surprisingly high, possibly due to COSMOS' influence

GILEAD



- While most payers' stated **price comparator** for Wave 2 products is **Sovaldi** (8 of 15) a notable number will benchmark against **COSMOS** (3 of 15)
- Most payers base their **initial LDV/SOF price expectations** around the **12-week** regimen, but would be interested in **further analysis** based on the distribution between **eligible TN and TE lives**

Reg. MCO

"COSMOS price would be unacceptable because this would be the second or third interferon-free regimen to the market"

*Payer price thresholds reflect a high-level assessment of expectations across both LDV/SOF and AbbVie regimens

Absolute net price does not meaningfully change payers' management of LDV/SOF when it is at a constant net premium to AbbVie*

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12-week regimen prices (WAC/rebate)			LDV/SOF management
LDV/SOF	AbbVie	DCV + SOF	
$108K/10%	$96K/10%	$12K/10% ($96K regimen)	3% 16% 34% 47%
$96K/10%	$84K/10%	$12K/10% ($96K regimen)	3% 16% 32% 49%
$84K/10%	$72K/10%	$12K/10% ($96K regimen)	3% 15% 30% 52%
$72K/10%	$60K/10%	$12K/10% ($96K regimen)	3% 15% 27% 55%

NO COVERAGE
HARD STEP
SOFT RESTRICTIONS
PA TO LABEL

*Note: Scenarios show a $10.8K net premium at different price levels representing between an 11% and 17% premium

Today, the weighted Average Cost per Treatment Regimen for HCV patients is above $100,000

GILEAD

Regimen Allocation (IMS LRx)	Regimen Price (WAC)[4]	Q1 2014[3]	Q2 2014[3]
PegIFN + RBV	$22,186	5.07%	2.10%
Incivek-Based Regimens[1]	$88,341 - $110,527	0.87%	0.30%
Victrelis-Based Regimens[1]	$66,004 - $117,926	0.67%	0.15%
Sovaldi + RBV Regimens (12 week)[2]	$85,190	61.7% → 25.48%	62.0% → 22.48%
Sovaldi + RBV Regimens (24 week)[2]	$170,380	39.57% → 38.3% → 14.09%	34.80% → 38.0% → 12.32%
Sovaldi + PegIFN/RBV Regimens	$95,093	33.80%	26.80%
Sovaldi + Olysio Regimens	$151,550	19.07%	34.25%
Olysio-Based Regimens[1]	$88,546 - $110,732	0.93%	1.60%
Average Cost per Treatment		$111,066	$120,599

Assumptions:

[1] PI + Peg-IFN/RBV regimen prices averaged across the duration range

[2] We estimate the split between 12- and 24-week SOF + RBV by calculating the ratio of total starts for each duration:

- 12-week SOF + RBV = total starts for GT2 = 27.3% (Q1), 27.8% (Q2) of total starts (June LE)
- 24-week SOF + RBV = total starts for GT3 + total starts for GT1 IFN-intolerant = 16.9% (Q1), 17.1% (Q2):
  - GT3: 10.8% (Q1), 11.0% (Q2) of total starts (June LE)
  - GT1 IFN-intolerant: 61.6% (Q1), 60.8% (Q2) GT1 (June LE) * 10% IFN-intolerant GT1 = 6.2% (Q1), 6.1% (Q2) of total starts
- Q1: 27.3% (12-wk), 16.9% (24-wk) → 61.7% / 38.3% split; Q2: 27.8% (12-wk), 17.1% (24-wk) → 62.0% / 38.0% split

[3] Quarterly allocations averaged across monthly data (Q2 does not yet include June).

[4] Prices reflect reported WAC prices from Q2 2014

Maximizing access relative to AbbVie may not be the revenue maximizing strategy for Gilead

GILEAD

LDV/SOF ACCESS RELATIVE TO ABBVIE

LDV/SOF NET PRICE RELATIVE TO ABBVIE	COMM.	MEDICARE	MEDICAID	DOC
+20%	18% ABBVIE HARD STEP	[illegible]	[illegible]	ACCESS DICTATED BY ABSOLUTE PRICE, NOT RELATIVE DELTA ACCESS FOR ANY REGIMEN ENTIRELY ABOVE [illegible] NET
+5%	SOFT STEP / PARITY	SOFT STEP / PARITY	[illegible]	
PARITY	PARITY	PARITY	PARITY	
-10%	PARITY / PREFERRED	PARITY / PREFERRED	PARITY / PREFERRED	
-20%	19% STR HARD STEP	6% STR HARD STEP	23% STR HARD STEP	

LDV/SOF Premium ↑ / LDV/SOF Discount ↓

KEY CONSIDERATIONS
• At a 20% premium to AbbVie, **~15% of lives** will see a hard step or blocked LDV/SOF (**Range 6-26%**)
• Many payers indicated that they will grant LDV/SOF parity access even with a small effective premium to AbbVie • Some portion of cost-sensitive payers will manage LDV/SOF even at parity
• Given that payers clearly prefer LDV/SOF on a clinical basis, some payers will give it preferred access if it is priced at a effective discount to AbbVie

*Note: percentages may vary slightly at different absolute prices and reflect relative LDV/SOF and AbbVie access only

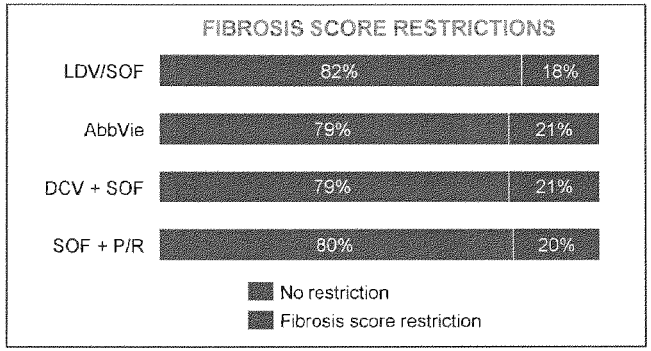
PREFERRED | PARITY | SOFT ABBVIE STEP | HARD ABBVIE STEP

Color map is intended to illustrate trends in active management only

For additional detail, please see Slide 53

The likelihood of a Fibrosis score requirement does not change across products or price scenarios

GILEAD



ATTRIBUTE	LDV/SOF	AbbVie	DCV + SOF
	12 wk*	12 wk	12 wk*
PRICE (WAC)	$96K	$96K	$96K ($12K DCV)
REBATE	10%	10%	10%
PRICE (NET)	$86.4K	$86.4K	$94.8K**

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015

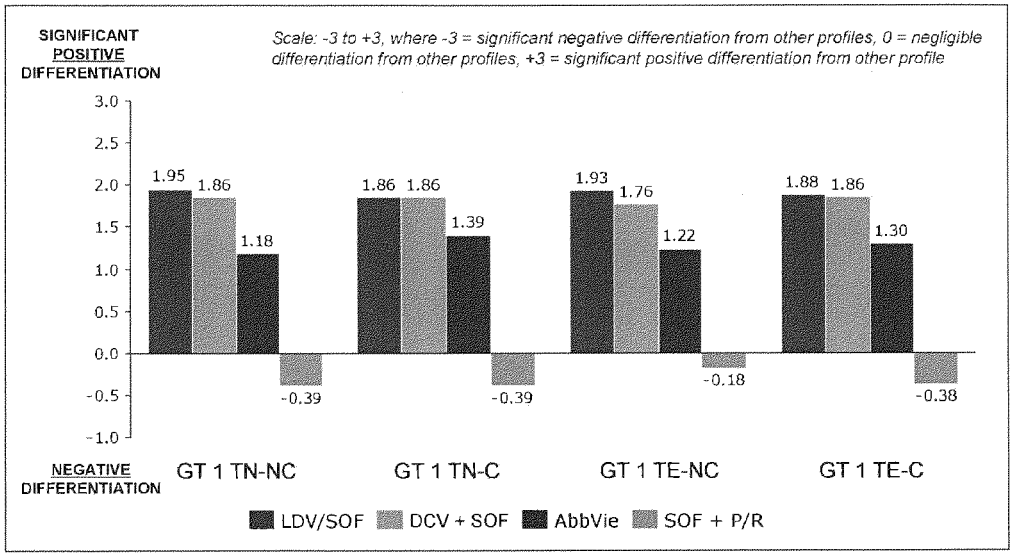
KEY TAKEAWAYS

- The percentage of lives facing a Fibrosis score restriction is equivalent for all products, indicating this may be a volume-driven decision and not a tool for differential management
- Furthermore, the likelihood of Fibrosis restriction shows minimal variation in response to competitive price scenarios
- Therefore, payers who are likely to impose a Fibrosis score restriction will apply it consistently to all HCV regimens, regardless of price

Among Wave 2 regimens, physicians see LDV/SOF as most differentiated, followed closely by BMS with AbbVie lagging behind

GILEAD

Please rate each of the following regimens on the level of clinical differentiation you perceive in its profile.



N = 76 physicians

At Wave 2 parity access, physicians allocate nearly 40% of patients to LDV/SOF regimens, with brand share consistent across subpopulations

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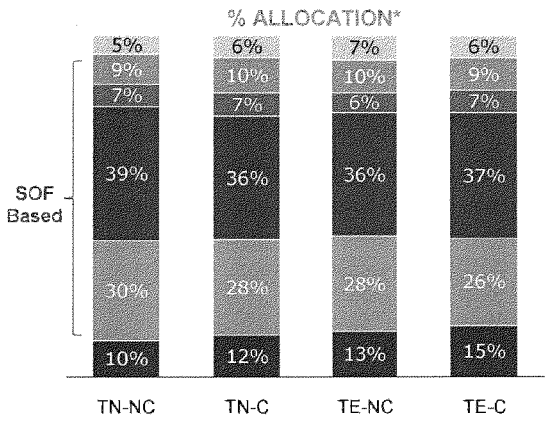

KEY TAKEAWAYS

- At **parity access and patient OOP**, Physicians exhibit a **clear preference for LDV/SOF** across all subpopulations; AbbVie share trails far behind both LDV/SOF and BMS
- Overall, physicians allocate between **78% and 84% of patients to a sofosbuvir-based regimen**
- Despite some variation in physician allocation between 8, 12, and 24-week regimen durations, **overall share for each brand remains largely consistent** across subpopulations

Peg-IFN/RBV +/- PI (incl. Olysio) | COSMOS regimen [Sovaldi + Olysio] | DCV + SOF (all durations)
Sovaldi-containing regimens (not incl. COSMOS) | LDV/SOF (all durations) | AbbVie (all durations)

ATTRIBUTE	LDV/SOF	AbbVie	BMS	Sovaldi
PA CRITERIA	PA to label	PA to label	PA to label	PA to label
PATIENT OOP**	>$75	>$75	>$75	>$75

N = 76 physicians
*Share is summed over available regimen durations for each product; shares for individual durations included in the Appendix

**Full text for >$75 OOP: patient copay greater than $75 (including some patients with 20-30% coinsurance)

AbbVie and BMS appear to be somewhat more sensitive to soft restrictions than Gilead

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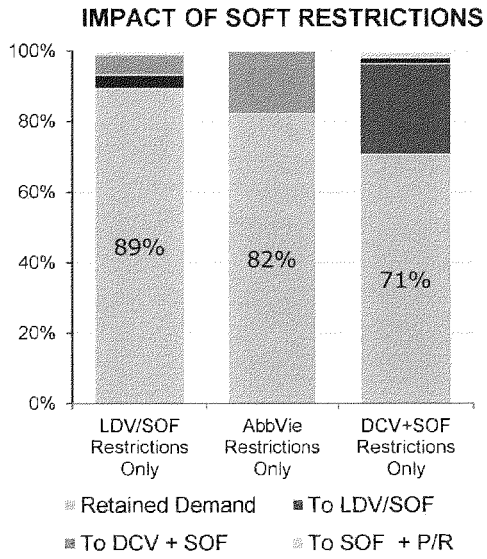


KEY TAKEAWAYS

- Physician preference share is shown relative to the original allocation if only one product is restricted and all other products are PA to Label
- LDV/SOF share loss is split between AbbVie and DCV + SOF
- AbbVie share loss tends to be captured by DCV + SOF
- DCV + SOF share loss tends to be captured by LDV/SOF

N = 76 physicians

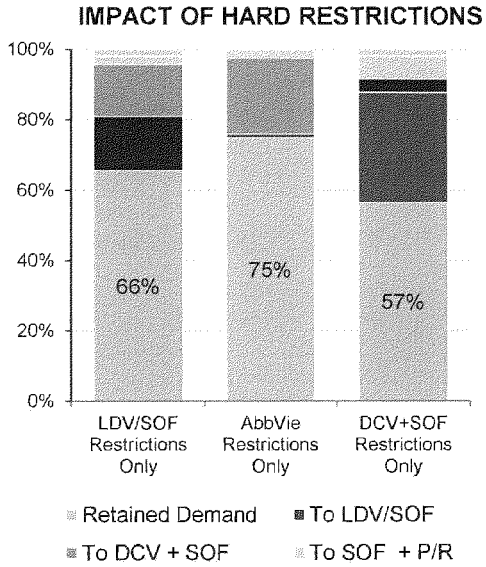
*Other than restricted product PA criteria for all other regimens held constant at PA to label

*Share is summed over available regimen durations for each product; subpopulations are consolidated by a weighted average which assumes patient population not limited by Fibrosis score

*In the raw data in the case of payer imposed soft restrictions on AbbVie, LDV/SOF also loses a few points of share.That impact seems to be noise in the data and not shown here.

Under a hard restriction for LDV/SOF, more than half the lost volume would go to another SOF based regimen

GILEAD



KEY TAKEAWAYS

- Physician preference share is shown relative to the original allocation if only one product is restricted and all other products are PA to Label
- LDV/SOF share loss is split between AbbVie and DCV + SOF
- AbbVie share loss tends to be captured by DCV + SOF
- DCV + SOF share loss is mostlycaptured by LDV/SOF

N = 76 physicians

*Other than restricted product PA criteria for all other regimens held constant at PA to label

*Share is summed over available regimen durations for each product; subpopulations are consolidated by a weighted average which assumes patient population not limited by Fibrosis score

Agenda

GILEAD

- Executive Summary
- Market Research Summary
- **Pricing Scenario Financial Analysis**
- Impact of Alternative Duration Scenarios
- What If Scenarios and PR Considerations
- Other Analyses and Requests
- Appendix

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Base Case Assumptions have changed since the June LE

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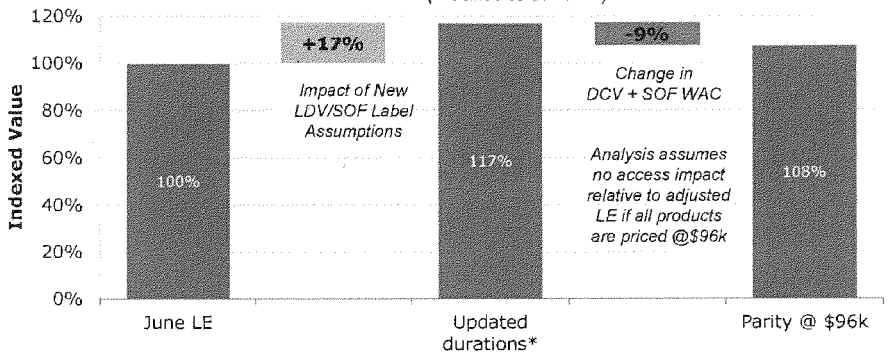
Change in Gilead HCV Franchise Net Revenue 2015 – 2017

(Indexed to June LE)



	June LE	Updated durations	Parity @ $96k
12 Week WAC Launch Price			
LDV/SOF	106.5	106.5	96
Weighted Average WAC Launch Price			
LDV/SOF	87	109	98
2015 GT1 Share			
Other SOF	0%	0%	0%
LDV/SOF	59%	59%	59%
DCV+SOF	15%	15%	15%
Other DCV	2%	2%	2%
AbbVie	24%	24%	24%
% Patient Split by Duration (LDV/SOF)			
8 Weeks	52%	21%	21%
12 Weeks	48%	70%	70%
24 Weeks	0%	9%	9%

*Includes revised GTN assumptions updated July 2014 by Gilead finance, impact <1%

The % of TN, NC patients with an HCV viral load <-6m IU/L is a key uncertainty

GILEAD

% of GT1 Patients by Sub-population

Based on Gilead Clinical Trial Results

Base Case Assumptions (40% of TN, NC <= 6m IU/L)

GT1	% of GT 1*					% GT 1	Duration LDV/SOF	Abb	BMS
TN, NC	55%	<= 6m IU/L	40%			22%	8	12	8
		> 6m IU/L	60%			33%	12	12	12
TN, C	15%					15%	12	12	12
TE, NC	21%					21%	12	12	12
TE, C	10%	PI experienced	33%			3%	24	n/a	24
		Non PI exp.	67%	1a	70%	5%	24	24	24
				1b	30%	2%	24	12	24

Based on IPSOS data

Alternative Assumptions (88% of TN, NC <= 6m IU/L)

GT1	% of GT 1*					% GT 1	Duration LDV/SOF	Abb	BMS
TN, NC	55%	<= 6m IU/L	88%			48%	8	12	8
		> 6m IU/L	12%			7%	12	12	12
TN, C	15%					15%	12	12	12
TE, NC	21%					21%	12	12	12
TE, C	10%	PI experienced	33%			3%	24	n/a	24
		Non PI exp.	67%	1a	70%	5%	24	24	24
				1b	30%	2%	24	12	24

LDV/SOF's weighted average price will vary based on the label and the fibrosis restrictions which are in place

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LDV/SOF Weighted Average Price Under Different Scenarios

	June LE	No 8wks Label			40% TN ,NC RNA < 6M IU/mL			88% TN ,NC RNA < 6M IU/mL		
% of Patients	F0-4	F0-4	F2-4	F3-4	F0-4	F2-4	F3-4	F0-4	F2-4	F3-4
% @ 8Wks	55%	0%	0%	0%	21%	12%	9%	46%	27%	20%
% @ 12Wks	45%	91%	83%	77%	70%	71%	68%	45%	56%	57%
% @ 24Wks	0%	9%	17%	23%	9%	17%	23%	9%	17%	23%
Wt Duration	9.8	13.1	14.0	14.7	12.3	13.5	14.4	11.3	12.9	13.9

12 Wk WAC ($K)	WAC per Pill	WAC per Bottle (28 Pills) ($K)	Wt Ave WAC ($K)	Wt Ave WAC ($K)			Wt Ave WAC ($K)			Wt Ave WAC ($K)		
$72	$857	$24	$59	$79	$84	$88	$74	$81	$86	$68	$78	$84
$84	$1,000	$28	$69	$92	$98	$103	$86	$95	$101	$79	$91	$97
$96	$1,143	$32	$78	$105	$112	$118	$98 "Parity"	$108	$115	$90	$104	$111
$106.5	$1,268	$36	**$87** *June LE*	$116	$124	$131	$109	$120	$128	$100	$115	$124
$108	$1,286	$36	$88	$118	$126	$133	$110	$122	$129	$101	$116	$125
$120	$1,429	$40	$98	$131	$140	$147	$123	$135	$144	$113	$129	$139

Base Case

Conclusions

- Because of the changes in the LDV/SOF duration assumptions, most of the tested price scenarios have a weighted average WAC above the June LE (scenarios which have a weighted average WAC less than the June LE are marked in Red)

The team examined eight competitive pricing scenarios and their impact on Gilead's Wave 2 US pricing

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- The team created a dynamic pricing model combining the base case assumptions from June LE, the impact of changes in labeled duration, multiple price and rebate levels for Gilead, AbbVie and BMS, payers reaction to price and rebate decisions and physician reaction to payer restrictions

		LDV/SOF strategy		AbbVie strategy		AbbVie net delta to LDV/ SOF	BMS strategy	
		12 wk WAC	Rebate	12 wk WAC	Rebate		12 wk WAC *DCV / SOF+DCV*	Rebate
	Parity environment	$96K	Redacted	$96K	Redacted	Redacted	$12K / $96K	Redacted
What if AbbVie discounts (Net vs. WAC)?	**AbbVie ~10% WAC discount**	$96K		$84K			$12K / $96K	
	AbbVie ~10% net discount	$96K		$96K			$12K / $96K	
What if AbbVie enters at a discount?	**AbbVie discounts (WAC $72k)**	$96K		$72K			$12K / $96K	
	AbbVie 20% net discount	$96K		$96K			$12K / $96K	
	AbbVie discounts (WAC $60k)	$96K		$60K			$$12K / $96K	
What if Gilead enters higher?	**LDV/SOF @$108K**	$108K		$96K			**$26K / $110K**	
	LDV/SOF @$108K; AbbVie low	$108K		$60K			**$26K / $110K**	

Note: For consistency, in scenario names prices are quoted at 12 week durations

What if AbbVie discounts (Net vs. WAC)?

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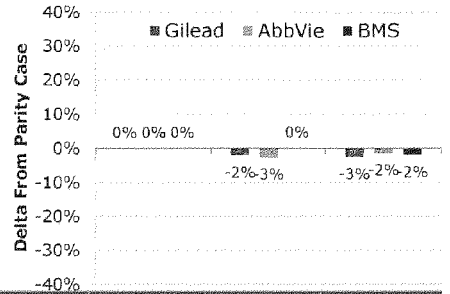
Delta from Parity @ $96k Case

(2015 – 2017 Franchise Net Revenue)



	Parity @ $96k	AbbVie - 10% WAC	AbbVie - 10% net
Weight Average WAC Launch Price			
LDV/SOF	98	98	98
DCV	12	12	12
DCV+SOF	98	98	98
AbbVie	101	88	101
Launch Contracting Assumption			
LDV/SOF	Redacted		
DCV			
AbbVie			
2015 GT1 Share			
LDV/SOF	59%	57%	56%
DCV+SOF	15%	15%	14%
Other DCV	2%	2%	2%
AbbVie	24%	27%	27%

Conclusions

- In both scenarios AbbVie does not gain enough in share to offset its discounts
- Discounting on a net rather than WAC basis is slightly superior for AbbVie
  - Gilead and BMS lose slightly more share under the net scenario than the gross scenario

Caveats and Context

- The analysis assumes that AbbVie is offering discounts to all payers. There is certainly a sub-group of payers who AbbVie could profitably offer discounts
- Gilead should assume that AbbVie will aggressively pursue such payers and should develop a clear strategy for deciding how to respond to those rebate offers

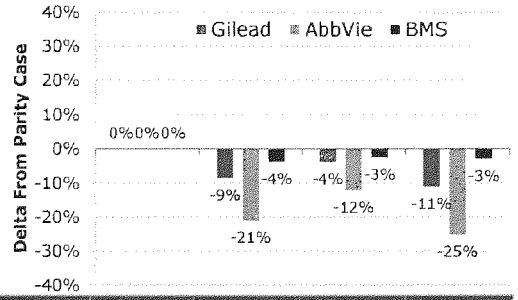
1639

What if AbbVie enters at a significant discount?

GILEAD

Delta from Parity @ $96k Case

(2015 – 2017 Franchise Net Revenue)



	Parity @ $96k	AbbVie @ $72k	AbbVie - 20% net	AbbVie @ $60k
Weight Average WAC Launch Price				
LDV/SOF	98	98	98	98
DCV	12	12	12	12
DCV+SOF	98	98	98	98
AbbVie	101	75	101	63
Launch Contracting Assumption				
LDV/SOF	Redacted			
DCV				
AbbVie				
2015 GT1 Share				
LDV/SOF	59%	59%	55%	55%
DCV+SOF	15%	14%	14%	14%
Other DCV	2%	2%	2%	2%
AbbVie	24%	25%	29%	29%

Conclusions

- In all scenarios shownAbbVie does not gain enough in share to offset its larger discounts
- The research suggests that AbbVie is incented to launch with a WAC close to Gilead's

Caveats and Context

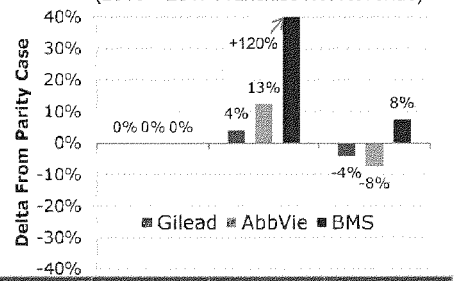
- Note effect net discounts to LDV/SOF are: Redacted
- Scenarios assume Gilead increases rebates as a reaction to the WAC differential
- If AbbVie has a significantly higher proportion of its patients at 24 weeks, AbbVie may be incented to launch at a significantly lower WAC
- The research suggests that the benefits for an AbbVie price cut are relatively stable even as Gilead's WAC price rises

What if Gilead enters higher?

GILEAD

Delta from Parity @ $96k Case

(2015 – 2017 Franchise Net Revenue)



	Parity @ $96k	LDV/SOF @ $108k	LDV/SOF @ $108k; Abb $60k
Weight Average WAC Launch Price			
LDV/SOF	98	111	111
DCV	12	27	12
DCV+SOF	98	113	98
AbbVie	101	101	63
Launch Contracting Assumption			
LDV/SOF	Redacted		
DCV			
AbbVie			
2015 GT1 Share			
LDV/SOF	59%	56%	46%
DCV+SOF	15%	15%	16%
Other DCV	2%	2%	2%
AbbVie	24%	27%	35%

Conclusions

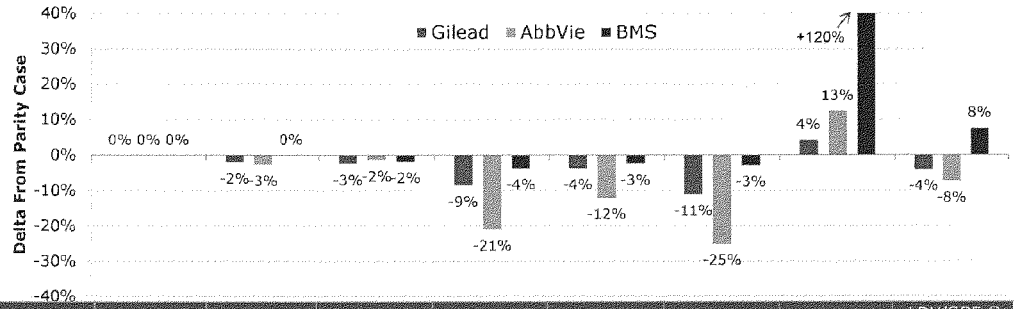
- If Gilead launches at a higher WAC price, it loses some share, but not enough to offset the gain from price
- Notably, all players (Gilead, AbbVie, and BMS) gain with a higher price

1641

Cross Scenario Summary
Change from Parity Case for Gilead Franchise Net Revenue

GILEAD

Delta from Parity @ $96k Case (2015 – 2017 Net Revenue)



	Parity @ $96k	AbbVie -10% WAC	AbbVie -10% net	AbbVie @ $72k	AbbVie - 20% net	AbbVie @ $60k	LDV/SOF @ $108k	LDV/SOF @ $108k, Abb $60k
Weight Average WAC Launch Price								
LDV/SOF	98	98	98	98	98	98	111	111
DCV	12	12	12	12	12	12	27	12
DCV+SOF	98	98	98	98	98	98	113	98
AbbVie	101	88	101	75	101	63	101	63
Launch Contracting Assumption								
LDV/SOF	Redacted							
DCV								
AbbVie								
2015 GT1 Share								
LDV/SOF	59%	57%	56%	59%	55%	55%	56%	46%
DCV+SOF	15%	15%	14%	14%	14%	14%	15%	16%
Other DCV	2%	2%	2%	2%	2%	2%	2%	2%
AbbVie	24%	27%	27%	25%	29%	29%	27%	35%

For additional detail, please see slide 91 & 92

Putting AbbVie in Context

GILEAD

- What revenue do they need from their HCV assets?
  - Humira revenues exceeded $10 billion in 2013, representing more than 50% of AbbVie's global sales
  - Analysts estimate that they need $2B+ worldwide, with at least 50% coming from US market
- Assuming similar duration in their label (12/24 weeks) – they must compete and win in the 12 week pool (relative size of 24 patient pool is too small to achieve financial goals)
  - We anticipate that they will come to market a little below LDV/SOF WAC and identify payers where they will negotiate to achieve 1 of 1 position or preferred status.Based on the quant study, they are at risk of achieving their financial goals with a parity position across payers.
  - A significant discount below WAC does not necessarily create enough volume to achieve AbbVie's financial goals.
- What can they hope to achieve with HCP targets or DTC/P efforts?

Payer	Must identify and win preferred status in a sub-set of payers without prompting Gilead to respond
HCP	Opportunity to influence HCPs with a) MOA/resistance profileb) SVRs in sub-populations c) robust clinical trials in difficult populations (perception in mkt)d) (easy) access experience e) greater number of field support
Patient	Opportunity to out-spend GILEAD and create a seamless transfer between diagnosis and treatment with Orasure

1643

Launch Excellence Implications for AbbVie

GILEAD

	Strength of value proposition/differentiation	Competitive intensity	Need to educate/change daily practice
Assessment of AbbVie position at launch	• Differentiation limited to secondary features – trial size, alternate mechanism	• Expected to be very high	• High: SOF established as backbone; complex admin requires patient training
Critical success factors	• Postulate market space and claim it • Promote secondary product benefits • Offer product services • Achieve optimal tier status/ offer co-pay card • Facilitate competition and parity access • Ensure broad sales force coverage and excellence in execution • Conduct comprehensive customer profiling to understand and address their needs • Target the optimum patient segment • Provide compelling long-term data • Create reasons to engage prescribers well before launch	• Optimize multi-stakeholder engagement model • Setup formulary access program • Conduct patient journey and ensure engagement at all leverage or possible leakage points • Achieve broad sales force coverage for high share of voice • Provide sampling • Establish brand loyalty	• Establish partnerships (scientific working groups) • Support inclusion in guidelines • Engage in public affairs • Set up unbranded physician education • Ensure strong publication strategy • Conduct patient journey to identify barriers, drivers and prescriber-influencers • Understand impact of changes to daily practice on provider/practice operations and identify ways to mitigate • Achieve high share of voice and have specialized field force in place • Provide education, services, other support to reduce barriers to trial and use
Implications for strategy	• Secondary benefits, including services, will be key	• Execution and targeted access investments	• Wrap-around services to offset VP weaknesses

Potential AbbVie Strategic Themes in Addition to Price Modulation

GILEAD

1. **Maximize secondary benefits**
   - Utility of SVR is limited, given comparable efficacy from alternatives
   - AbbVie likely to emphasize trial size, subpopulation data (1b, cirrhotics, etc.)
   - Given large installed base of SOF, AbbVie may leverage KOLs to emphasize "alternative" MOA as advantage

2. **Target strategically and ensure best-in-class execution**
   - AbbVie will struggle without payer help or, alternately, better support services
   - Targeted preferred contracts and practice-level support services can offset some competitive disadvantages, and AbbVie doesn't have to win everywhere

3. **Leverage services to compensate for weak value proposition/product complexity**
   - The complex multi-pill dosing schedule will require patient education from very busy practices so clinical support and educational services will be important differentiators
   - Patient support, pharmacy, and fulfillment services will enhance value proposition

1645

Putting BMS in Context

GILEAD

- What revenue do they need from the HCV?
  - Relative to its burgeoning oncology portfolio, HCV plays a less strategically role for BMS than for AbbVie
  - Daclatasvir represents one of several HCV compounds, and can be used in combination with several other agents, including BMS' asuneprevir
- BMS' daclatasvir is most often used with sofosbuvir:
  - Because it is used in combination with sofosbuvir, daclatasvir provides an alternative to AbbVie's regimen that still delivers revenue to Gilead
  - Moreover, combination use with daclatasvir serves to reinforce sofosbuvir's position as the "backbone" of HCV treatment
- What can they hope to achieve with HCP targets or DTC/P efforts?

Payer	Parity access is sufficient for DCV. However, low Gilead WAC pricing for the STR could result in DCV being too expensive when used atop sofosbuvir; BMS also needs to ensure that Sovaldi remains accessible
HCP	Must position DCV as an important adjunct to the newly entrenched Sovaldi backbone, particularly in situations in which AbbVie has succeeded in disadvantaging the STR
Patient	BMS will provide support services, including co-pay assistance, and will highlight the ease of use of 2 pills v. the cumbersome AbbVie regimen

1646

Launch Excellence Implications for BMS

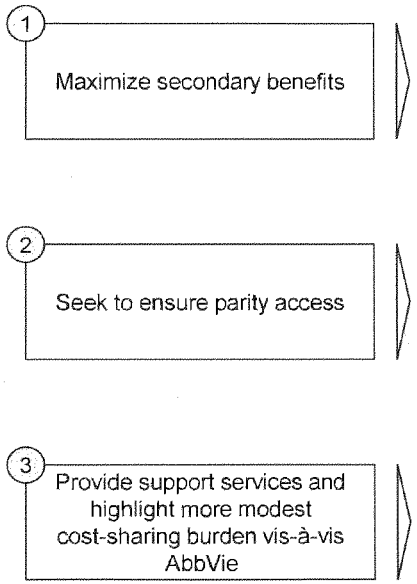
GILEAD

	Strength of value proposition/differentiation	Competitive intensity
Assessment of BMS position at launch	• Differentiation limited to; under	• Expected to be very high; BMS will seek to build on Sovaldi access
Critical success factors	• Postulate market space-- DCV as adjunctive to SOF backbone; specific subpopulations – and claim it • Promote secondary product benefits • Offer product services • Achieve optimal tier status/ offer co-pay card • Facilitate parity access for DCV *and Sovaldi* • Ensure broad sales force coverage and excellence in execution • Conduct comprehensive customer profiling to understand and address their needs • Target the optimum patient segment • Provide compelling long-term data • Create reasons to engage prescribers well before launch	• Optimize multi-stakeholder engagement model • Setup formulary access program • Conduct patient journey andensure engagement atall leverage or possible leakage points • Achieve broad sales force coverage for high share of voice • Provide sampling • Establish brand loyalty
Implications for strategy	• Secondary benefits, including services, will be key • Depending on final labeling, subpopulation data may be important in carving out specific market space	• Execution and targeted access investments; will need favorable Sovaldi access to ensure uptake

1647

Potential BMS Strategic Themes in Addition to Price Modulation

GILEAD



- Utility of SVR is limited, given comparable efficacy from alternatives
- Depending on final labeling, BMS may highlight subpopulation data
- Likely to emphasize value of an "alternative" to the STR that maintains the NS5B backbone

- BMS needs only parity access, but must ensure that Sovaldi maintains parity access
- Likely to argue that payers must maintain an NS5B-based option in at least co-preferred position

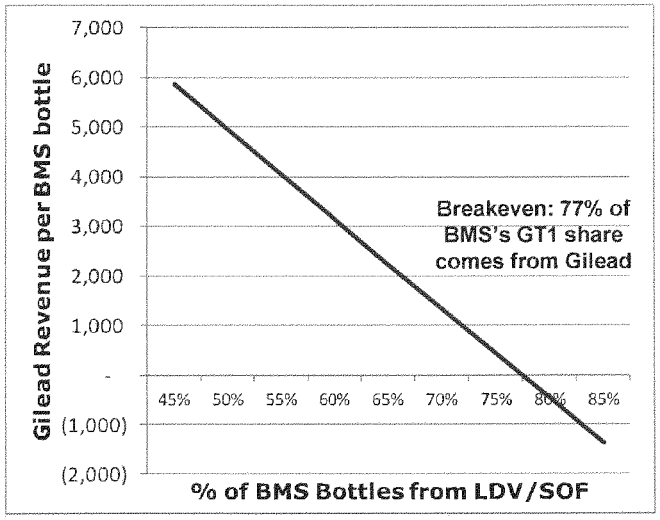
- Patient support, pharmacy, and fulfillment services will enhance value proposition
- Highlight comparative ease of administration and potential lower copay burden

1648

However, BMS's impact on Gilead will be breakeven or better if less than 77% of BMS's share comes from Gilead

GILEAD

Incremental Gilead Net Revenue per BMS bottle

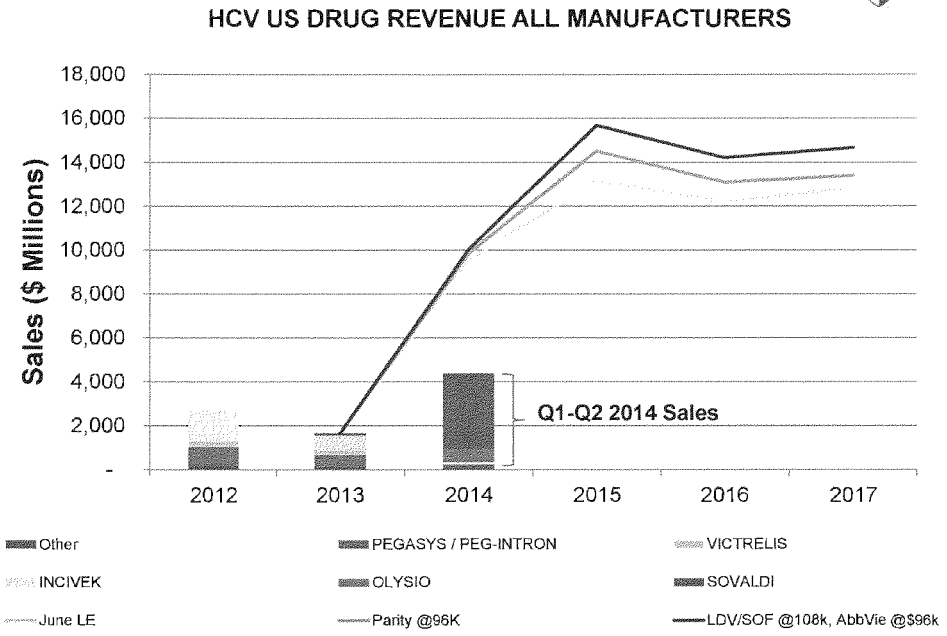


- If only 50% of BMS's GT1 share comes from Gilead; BMS's impact on Gilead would be +$400 M (~$5k per BMS bottle)
- Assumes:
  - June LE pricing
  - BMS GT1 share ~17%
  - 6% of BMS not SOF based
  - 3% of BMS's share comes from legacy regimens
  - 20% (included in the 77%) comes from other SOF based regimens
  - 31% of BMS revenue comes from GT2,3&4
  - All GT2,3&4 BMS revenue is from DCV + SOF at the expense of LDV/SOF

1649

The Wave 2 launches will add significantly to the total spend on HCV

GILEAD



Source: IMS MIDAS US HCV SALES, Note: Merck is not included in the sales figures but does impact share calculations

1650

Agenda

GILEAD

- Executive Summary
- Market Research Summary
- Pricing Scenario Financial Analysis
- **Impact of Alternative Duration Scenarios**
- What If Scenarios and PR Considerations
- Other Analyses and Requests
- Appendix

1651

Stakeholder sensitivity to % of population switched to 8 weeks and % requiring retreatment @ 12 weeks

GILEAD

- Payers will have a strong financial incentive to switch patients to lower durations
- However, without a clinical rationale or KOL/guideline support, many payers will be resistant to taking this step

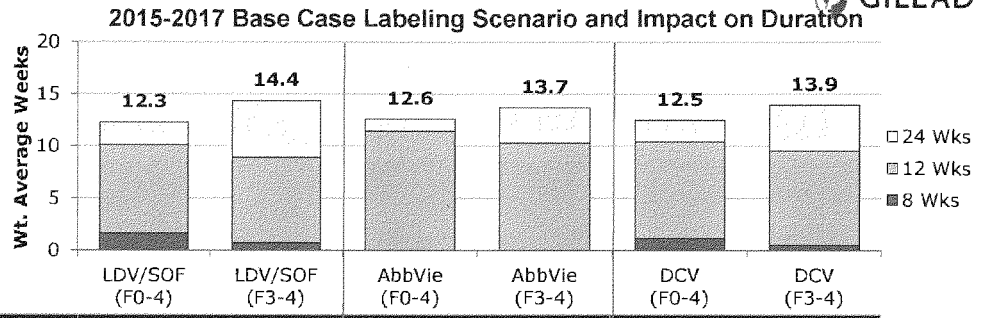
Change in Gilead Net Revenue / Payer Savings		% of LDV/SOF Population Switched from 12 to 8 weeks			
		40%	**50%**	**60%**	**70%** (~100% of BaseCase 12 WKs)
% Retreated @ 12 weeks	**0%**	-13%	-16%	-20%	-23%
	10%	-9%	-11%	-14%	-16%
	20%	-5%	-7%	-8%	-9%
	33%	0%	0%	0%	0%

Notes:
1. Assumes Wt Average Duration before switching is 12 wks (8 wks 20%; 12 wks 71%; 24 wks 9%)
2. Calculation assumes that patients failing 8 weeks would be retreatment in both cases
3. Assumes no switching for 24 week patients
4. Due to elapsed time between treatment and SVR, the net impact would span multiple years

1652

In the base case labeling scenarios, both AbbVie and BMS will have the majority of their revenue coming from 12 week regimens

GILEAD



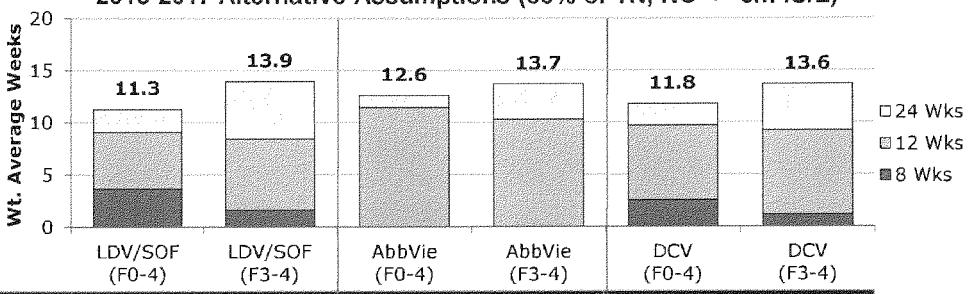
Patient Sub-Type		LDV/SOF 24 (TE, C) & 8 (TN, NC)	AbbVie 24 (TE, C)	BMS 24 (TE, C) & 8 (TN, NC)
GT 1	TN, NC*	8; 12	12	8; 12
	TN, C	12	12	12
	TE, NC	12	12	12
	TE, C	24	n/a; 12; 24**	24
GT 3		12	n/a	12

% of Patients by duration						
% @ 8Wks	21%	9%	0%	0%	14%	7%
% @ 12Wks	70%	68%	95%	86%	77%	75%
% @ 24Wks	9%	23%	5%	14%	9%	18%
% of revenue by duration						
% @ 8Wks	14%	5%	0%	0%	9%	4%
% @ 12Wks	69%	57%	91%	75%	74%	65%
% @ 24Wks	18%	38%	9%	25%	17%	32%

Note: Unrestricted (F0-4 100% of Patients Eligible); Restricted (F3-4 37% of Patients Eligible
*40% of TN, NC will receive 8 weeks if it is included in the label; **AbbVie not labeled for PI-experienced TE and has 12-wk for 1b TE, 24-wk for 1a TE

If 88% of TN, NC patients have viral loads below 6m IU/L, Gilead may have a significant portion of it's patients at 8 weeks

GILEAD



Patient Sub-Type		LDV/SOF	AbbVie	BMS
		24 (TE, C) & 8 (TN, NC)	24 (TE, C)	24 (TE, C) & 8 (TN, NC)
GT 1	TN, NC*	8; 12	12	8; 12
	TN, C	12	12	12
	TE, NC	12	12	12
	TE, C	24	n/a; 12; 24**	24
GT 3		12	n/a	12

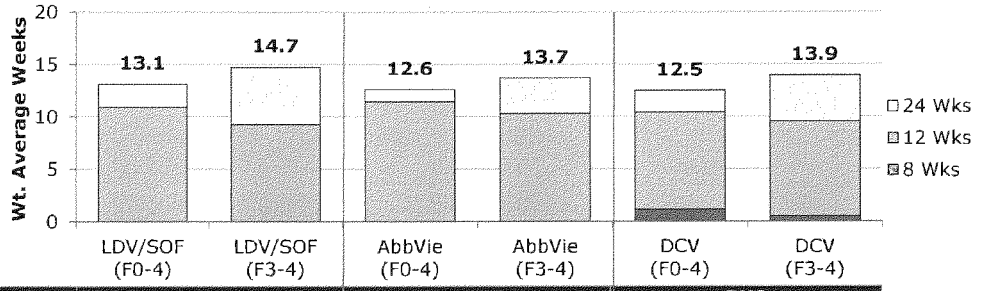
% of Patients by duration						
% @ 8Wks	46%	20%	0%	0%	32%	14%
% @ 12Wks	45%	57%	95%	86%	60%	67%
% @ 24Wks	9%	23%	5%	14%	9%	18%
% of revenue by duration						
% @ 8Wks	32%	12%	0%	0%	22%	8%
% @ 12Wks	48%	49%	91%	75%	61%	59%
% @ 24Wks	19%	39%	9%	25%	18%	32%

Note: Unrestricted (F0-4 100% of Patients Eligible); Restricted (F3-4 37% of Patients Eligible
*88% of TN, NC will receive 8 weeks if it is included in the label; **AbbVie not labeled for PI-experienced TE and has 12-wk for 1b TE, 24-wk for 1a TE

However, this will change if Gilead does not receive 8 weeks in its label

GILEAD

2015-2017 Scenario 1: No 8 Weeks for LDV/SOF



Patient Sub-Type		LDV/SOF 24 (TE, C)		AbbVie 24 (TE, C)		BMS 24 (TE, C) & 8 (TN, NC)	
GT 1	TN, NC*	12		12		8; 12	
	TN, C	12		12		12	
	TE, NC	12		12		12	
	TE, C	24		n/a; 12; 24**		24	
GT 3		12		n/a		12	
% of Patients by duration							
% @ 8Wks		0%	0%	0%	0%	14%	7%
% @ 12Wks		91%	77%	95%	86%	77%	75%
% @ 24Wks		9%	23%	5%	14%	9%	18%
% of Revenue by duration							
% @ 8Wks		0%	0%	0%	0%	9%	4%
% @ 12Wks		83%	63%	91%	75%	74%	65%
% @ 24Wks		17%	37%	9%	25%	17%	32%

Note: Unrestricted (F0-4 100% of Patients Eligible); Restricted (F3-4 37% of Patients Eligible
*All 40% of BMS's TN, NC who would have receive 8 weeks if it was included in the label receive 12 weeks; **AbbVie not labeled for PI-experienced TE and has 12-wk for 1b TE, 24-wk for 1a TE

Gilead Franchise Ave. Duration (Base Case)

Assumes 40% of TN, NC <= 6m IU/L

GILEAD

2015-2017 Base Case Labeling Scenario and Impact on Duration

GILEAD	2014	2015	2016	2017
Other SOF % of Patients by duration				
% @ 8 Wks	0%	0%	0%	0%
% @ 12 Wks	86%	100%	100%	100%
% @ 24 Wks	14%	0%	0%	0%
Wt. Ave Weeks	**13.7**	**12.0**	**12.0**	**12.0**
LDV/SOF % of Patients by duration				
% @ 8 Wks	19%	21%	21%	21%
% @ 12 Wks	72%	70%	70%	70%
% @ 24 Wks	8%	9%	9%	9%
Wt. Ave Weeks	**12.2**	**12.3**	**12.3**	**12.3**
DCV+SOF % of Patients by duration				
% @ 8 Wks	14%	16%	15%	17%
% @ 12 Wks	79%	78%	78%	75%
% @ 24 Wks	6%	7%	7%	7%
Wt. Ave Weeks	**12.2**	**12.2**	**12.2**	**12.2**
Gilead Franchise Average % of Patients by duration				
% @ 8 Wks	3%	15%	14%	16%
% @ 12 Wks	84%	79%	79%	77%
% @ 24 Wks	13%	6%	6%	7%
Wt. Ave Weeks	**13.4**	**12.2**	**12.2**	**12.2**

*40% of TN, NC will receive 8 weeks if it is included in the label

Gilead Franchise Ave. Duration (Base Case)

Assumes 88% of TN, NC <= 6m IU/L

GILEAD

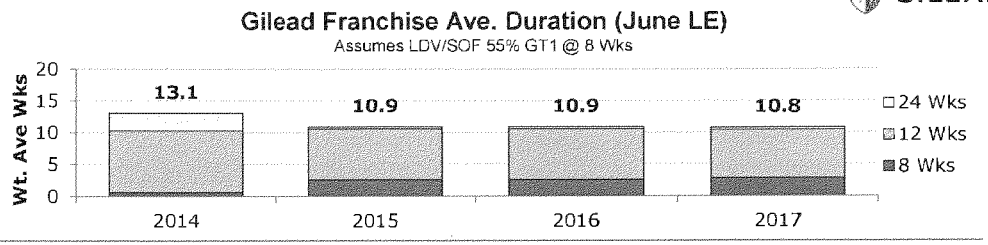
2015-2017 Base Case Labeling Scenario and Impact on Duration

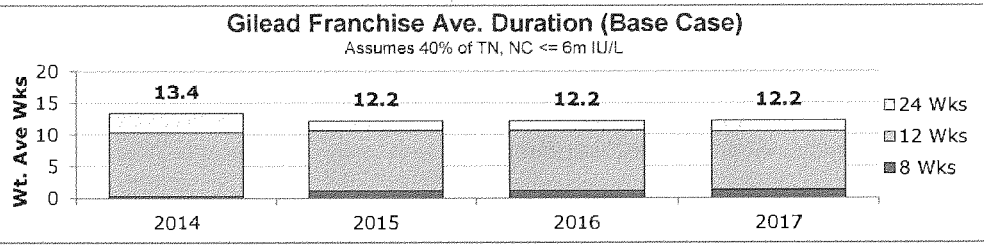
GILEAD	2014	2015	2016	2017
Other SOF % of Patients by duration				
% @ 8 Wks	0%	0%	0%	0%
% @ 12 Wks	86%	100%	100%	100%
% @ 24 Wks	14%	0%	0%	0%
Wt. Ave Weeks	**13.7**	**12.0**	**12.0**	**12.0**
LDV/SOF % of Patients by duration				
% @ 8 Wks	32%	34%	34%	38%
% @ 12 Wks	62%	59%	59%	55%
% @ 24 Wks	6%	7%	7%	7%
Wt. Ave Weeks	**11.5**	**11.5**	**11.5**	**11.4**
DCV+SOF % of Patients by duration				
% @ 8 Wks	32%	34%	34%	38%
% @ 12 Wks	62%	59%	59%	55%
% @ 24 Wks	6%	7%	7%	7%
Wt. Ave Weeks	**11.5**	**11.5**	**11.5**	**11.4**
Gilead Franchise Average % of Patients by duration				
% @ 8 Wks	7%	32%	32%	35%
% @ 12 Wks	80%	61%	62%	58%
% @ 24 Wks	13%	6%	6%	7%
Wt. Ave Weeks	**13.2**	**11.5**	**11.5**	**11.4**

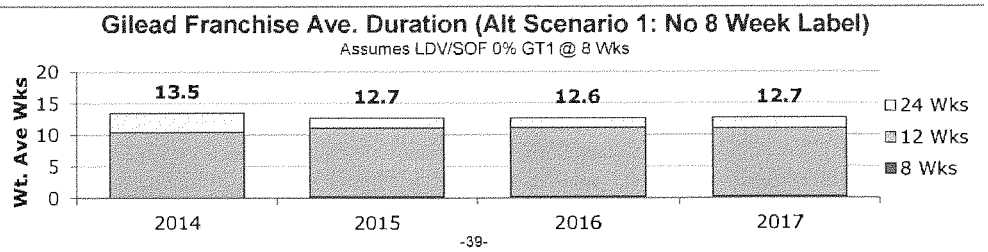
*40% of TN, NC will receive 8 weeks if it is included in the label

Gilead HCV Franchise average duration under alternative labeling scenarios for LDV/SOF

GILEAD

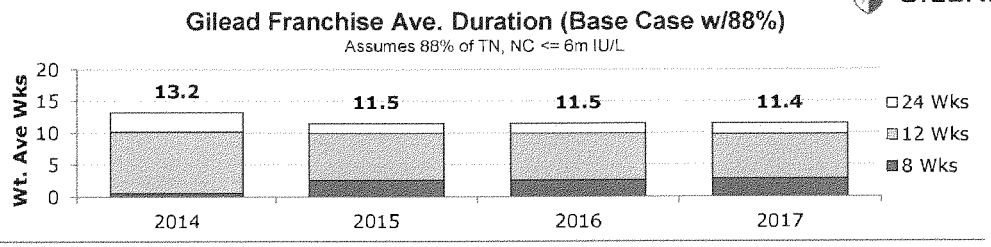


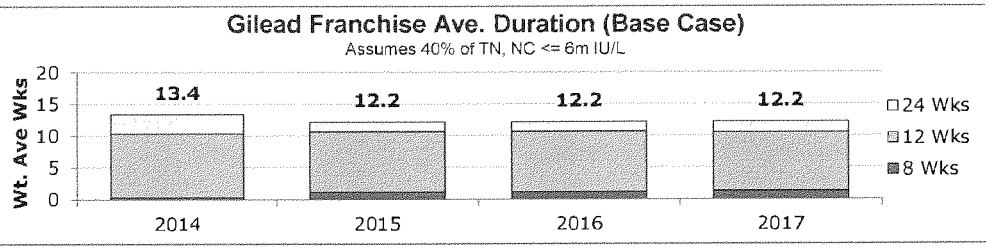


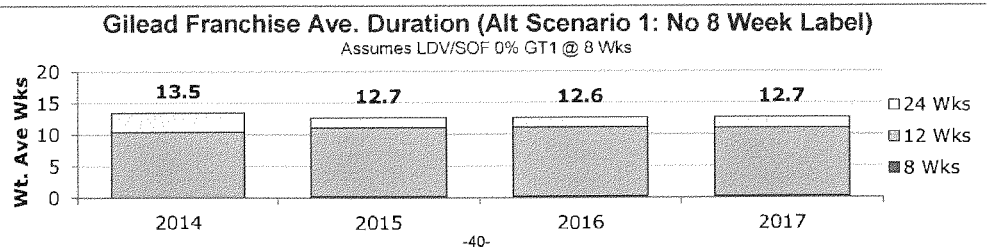


Gilead HCV Franchise average duration under alternative labeling scenarios for LDV/SOF

GILEAD

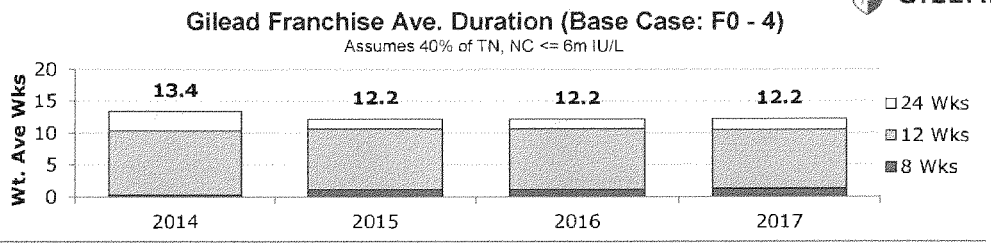


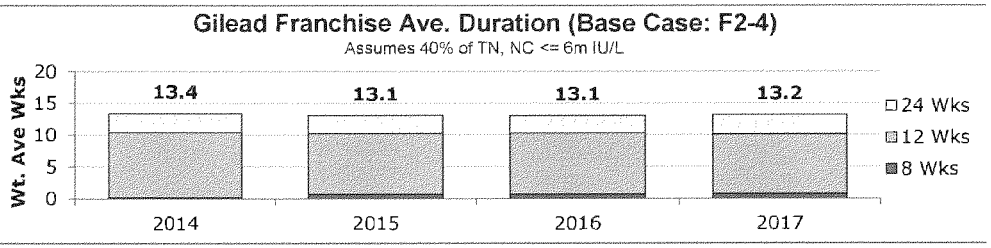


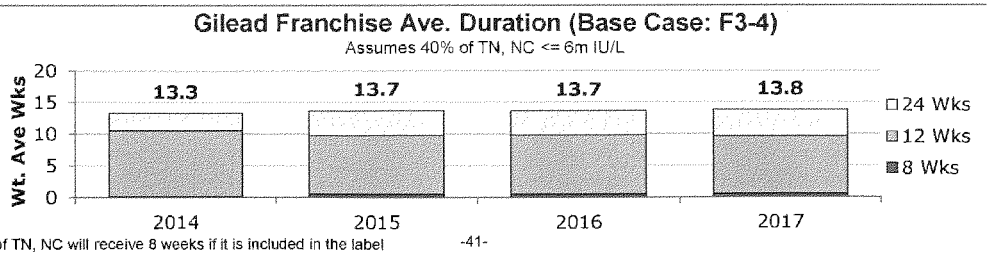


Impact of Fibrosis Score Restrictions on Gilead HCV Franchise average duration

GILEAD



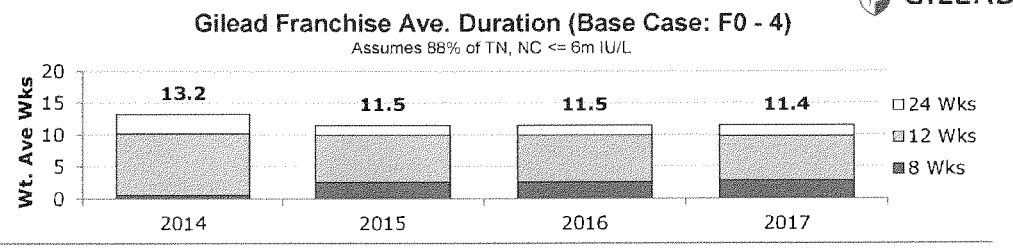


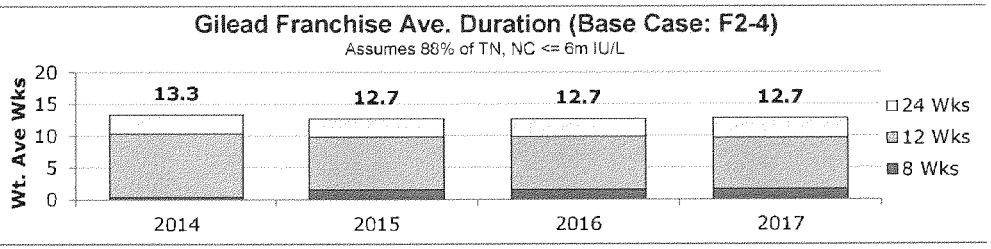


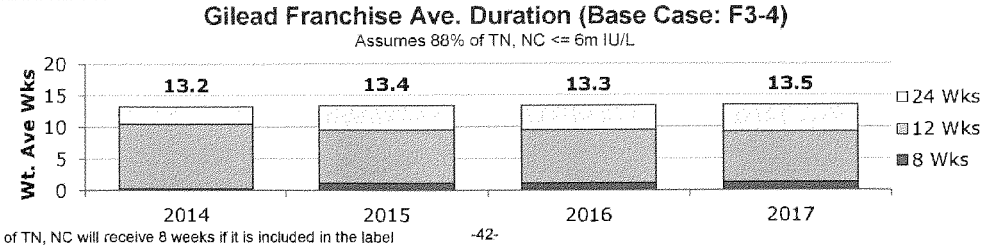
*40% of TN, NC will receive 8 weeks if it is included in the label

Impact of Fibrosis Score Restrictions on Gilead HCV Franchise average duration

GILEAD







*40% of TN, NC will receive 8 weeks if it is included in the label

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GILEAD

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High-level scenarios and potential market impact (1/2)

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SCENARIO	POSSIBLE IMPACT	LIKELIHOOD	MITIGATING STRATEGIES	
			WAC (PROACTIVE)	CONTRACTING (REACTIVE)
Gilead prices LDV/SOF significantly above expectations	• Risk - AbbVie may be tempted to come in at a WAC discount instead of competing on net	*Decision*	n/a	• Increase contracting to close the gap
AbbVie label includes greater proportion of patients on a 24-week regimen	• AbbVie may optimize for 24 weeks and cut WAC price	?	No Change	• Increase contracting to close the gap
Guidelines do not endorse fibrosis scores as a basis for treatment decisions	• Payers may look for other levers to limit patient volume		No Change	• Articulate how payers should prioritize treatment using other patient criteria
AbbVie pushes for 1:1 access	• Gilead may lose access with a limited set of highly cost-sensitive payers		No Change	• Identify target accounts for engagement • Aggressive contracting with target accounts could mitigate some losses • Gilead risks this spills over to other payers

High-level scenarios and potential market impact (2/2)

GILEAD

SCENARIO	POSSIBLE IMPACT	LIKELIHOOD	MITIGATING STRATEGIES	
			WAC (PROACTIVE)	CONTRACTING (REACTIVE)
Guidelines favor AbbVie over BMS	• AbbVie gains, decreasing SOF franchise revenue • Note: base case forecast assumes AbbVie gains a higher share than in MR		No Change	• Market may be more sensitive than predicted to differences in net • Monitor to see if increase contracting is needed
AbbVie focuses on optimizing sales force and support programs	• Physician perceptions of AbbVie improve, taking some share from BMS and / or Gilead			
AbbVie implements flat pricing across 12- and 24-week regimens	• Could increase LDV/SOF pricing scrutiny and allow AbbVie to capture TE-C share		No Change	• Reactive contracting or implementation of flat pricing if necessary

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PR Considerations

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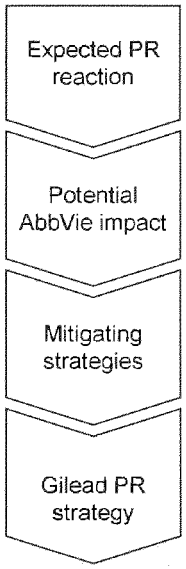

Given that the **LDV/SOF is >$1000/pill** for all scenarios under consideration, negative stakeholder reactions and media scrutiny can be expected to continue in the months prior to AbbVie's launch

If AbbVie offers a significant WAC discount, PR coverage of Gilead will intensify, with **increased pressure** to lower sofosbuvir franchise pricing

While Gilead can contract to maintain access, privately negotiated discounts will be **unlikely to have an impact on public perceptions**; furthermore, attempting to maintain access in all accounts may increase baseline expectations for contracting and **negatively impact franchise revenue**

In order to prepare for these scenarios, Gilead should formulate a unified PR strategy to **clearly articulate the clinical and economic value proposition** for LDV/SOF and Sovaldi in the face of increased competition

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  - Impact of Wave 1 on payer earnings
  - WAC vs. Net discounts
  - Financial incentives of different players
- Appendix

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Sovaldi's Effect on US Payers Spending

GILEAD

Top Payers – 2014 additional HCV spending and PMPM

- Overall additional spending on HCV treatments in the US in 2014 is estimated $10.7B*
- Reflects a 280% increase in national HCV PMPM spending from $0.87 in 2013 to $4.2 in 2014**
- Annual increases in PMPM have typically ranged from 3% to 4%***

Payer	Covered Lives	Total Medical Spending 2013	Increase in Spending On HCV* 2014	Increase in total PMPM Spending* 2014
UnitedHealth	40M	$63.4B	$1.6B	2.51%
WellPoint	35.7M	$56.2B	$1.4B	2.53%
Aetna	22.2M	$32.8B	$0.8B	2.69%
Humana	11.98M	$32.5B	$0.45B	1.47%

** Assuming 120K new patients in 2014 and a 5% discount on treatment cost-$89,300*
*** Source: Express Scripts 2013 Annual Drug Trend Report*
**** Source: Kaiser Family Foundation; state insurance commissioners of MA, ME, NH, and OR; data are from 2011*

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Sovaldi's Effect on US Payers Spending

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Top Payers – 2014 additional HCV spending and EPS

Double digit percentage decrease in EPS could drive payers to push back on cost or change coverage going forward

Payer	EPS 2013	2014 Additional spending Per share* (on HCV)	EPS 2014**
UnitedHealth	$5.5	$1.6	$4.49
WellPoint	$8.52	$4.8	$5.25
Aetna	$5.33	$2.5	$3.76
Humana	$7.73	$3.0	$5.79

** Assuming 120K new patients in 2014 and a 5% discount on treatment cost-$89,300*
*** Based on estimated tax rate from company`s 10K*

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For LDV/SOF scenarios with the same net price, access is more favorable for a high WAC/high discount approach

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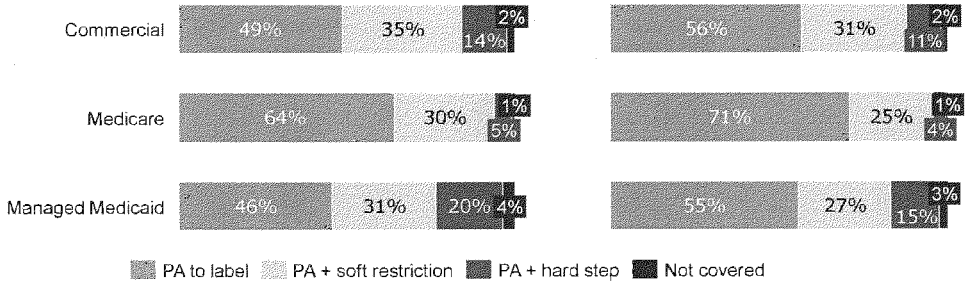
LDV/SOF PRIOR AUTH RESTRICTIONS (PBMs NOT INCLUDED)

Lower WAC / lower rebate:
- LDV/SOF: $96K w/ 10% rebate
- **Net price = $86.4K**

Higher WAC / higher rebate:
- LDV/SOF: $108K w/ 20% rebate
- **Net price = $86.4K**



- Higher WAC / higher rebate yields more favorable LDV/SOF access than lower WAC / lower rebate for all three payer types
- Medicaid weighting shows the largest change in access between the two scenarios, followed by commercial and then Medicare
- As the base WAC prices decrease, the difference between two scenarios with equivalent net becomes less significant (e.g. access is much closer for $96K/30% vs. $84K/20%)

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Market segment and business model influence account sensitivity to price and rebate

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Type	Example	Business Model	Price/Rebate Preferences	Implications
National commercial plan	Redacted	Spreads medical risk across large population and can pass higher premium costs to customers; margins subject to more regulation under MLR rules	Offering access to broad product mix is competitive priority; size may command price concessions but control is modest	Higher prices with moderate rebates can align with preferences
PBM		Spreads Rx risk across large population and can pass higher premium costs to customers	Makes money off rebates so higher prices with larger rebates can be attractive	Higher prices with moderate rebates can align with preferences
National Medicare/D plan		Spreads Rx risk across large population but premiums borne by individuals	Rebates are important in achieving desired access	Higher prices with targeted rebates to ensure access
Regional health plan		Spreads medical risk across large population and can pass higher premium costs to customers; regional dominance increases negotiating power	Locally dominant market position can increase negotiating power	Targeting truly important or dominant plans a priority
Medicare Advantage		Manages combined medical/Rx risk with hard budget constraint; only makes money if costs are below prospective payments	Price sensitivity is high due to risk model	Prefer lower prices, but deeper rebates can offset high WAC
FFS Medicaid		Holds full risk; statutory and additional discounts are often required given hard budget constraints	Very high price sensitivity; deeper discounts required as WAC rises	Discounts to compensate for high WAC trigger penalties over time
Managed Medicaid		Manages combined medical/Rx risk with hard budget constraint; only makes money if costs are below prospective payments	Very high price sensitivity; deeper discounts required as WAC rises	Discounts to compensate for high WAC trigger penalties over time

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  - **Quantitative Payer Research**
    - **Expected payer management**
    - Additional questions
  - Quantitative Physician Research
  - Additional Analysis and Supporting Documentation

1671

Maximizing access relative to AbbVie may not be the revenue maximizing strategy for Gilead

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LDV/SOF ACCESS RELATIVE TO ABBVIE

LDV/SOF NET REL. TO ABBVIE	COMM.	MEDICARE	MEDICAID	DOC	KEY CONSIDERATIONS
+20%	18% HS-ABB 21% SS-ABB 51% PARITY 9% SS-GIL 1% HS-GIL	[illegible]	[illegible]	ACCESS INDICATED BY ABSOLUTE PRICE, NOT RELATIVE DELTA ACCESS FOR ANY REGIMEN UNLIKELY ABOVE CERTAIN NET	• At a 20% premium to AbbVie, **~15% of lives** will see a hard step or blocked LDV/SOF (**Range 6-26%)**
+10%	13% HS-ABB 14% SS-ABB 55% PARITY 14% SS-GIL 3% HS-GIL	4% HS-ABB 11% SS-ABB 72% PARITY 12% SS-GIL 1% HS-GIL	[illegible]		• Many payers indicated that they will grant LDV/SOF parity access even with a small effective premium to AbbVie • Some portion of cost-sensitive payers will manage LDV/SOF even at parity
PARITY	9% HS-ABB 8% SS-ABB 57% PARITY 20% SS-GIL 6% HS-GIL	2% HS-ABB 6% SS-ABB 75% PARITY 16% SS-GIL 2% HS-GIL	1% HS-ABB 7% SS-ABB 55% PARITY 19% SS-GIL 9% HS-GIL		
-10%	5% HS-ABB 4% SS-ABB 59% PARITY 21% SS-GIL 12% HS-GIL	1% HS-ABB 3% SS-ABB 76% PARITY 17% SS-GIL 4% HS-GIL	5% HS-ABB 4% SS-ABB 57% PARITY 19% SS-GIL 15% HS-GIL		• Given that payers clearly prefer LDV/SOF on a clinical basis, some payers will give it preferred access if it is priced at a effective discount to AbbVie
-20%	2% HS-ABB 2% SS-ABB 58% PARITY 19% SS-GIL 19% HS-GIL	0% HS-ABB 1% SS-ABB 76% PARITY 17% SS-GIL 6% HS-GIL	2% HS-ABB 2% SS-ABB 57% PARITY 17% SS-GIL 23% HS-GIL		

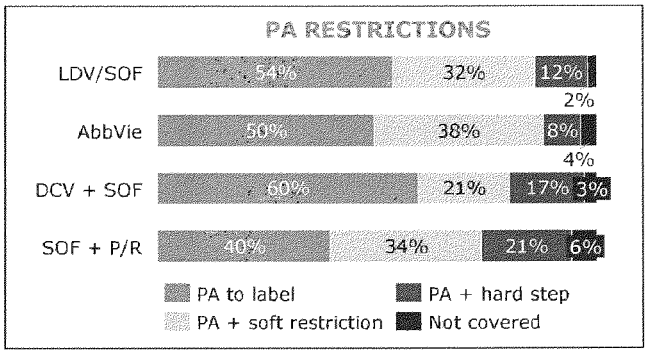
LDV/SOF Premium ↑ / LDV/SOF Discount ↓

*Note: percentages may vary slightly at different absolute prices and reflect relative LDV/SOF and AbbVie access only

PREFERRED | PARITY | SOFT ABBVIE STEP | HARD ABBVIE STEP

Color map is intended to illustrate trends in active management only

With all three regimens at parity, the likelihood of PA to label roughly tracks payer preferences among regimens



ATTRIBUTE	LDV/SOF 12 wk*	AbbVie 12 wk	DCV + SOF 12 wk*
PRICE (WAC)	$96K	$96K	$96K ($12K DCV)
REBATE	10%	10%	10%
PRICE (NET)	$86.4K	$86.4K	$94.8K**

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

KEY TAKEAWAYS

- LDV/SOF and AbbVie access is very similar at WAC/rebate parity, although more favorable perceptions of LDV/SOF's profile lead to a higher % with PA to label only
- DCV + SOF has the highest percentage of PA to label only, but also a larger share facing a hard step; the low price of DCV means it has little ability to influence net regimen price
- SOF + P/R has the least favorable access, consistent with payer expectations of a largely all-oral GT 1 market

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015

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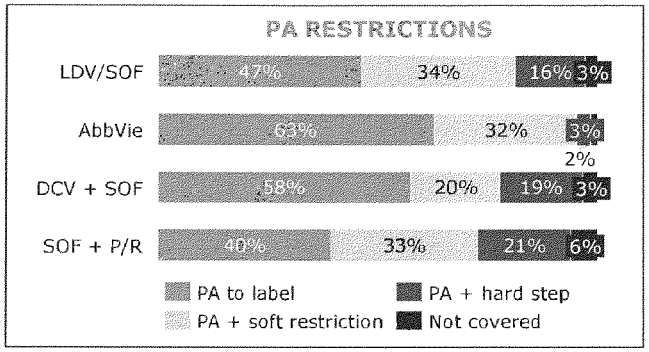
With LDV/SOF's net at a moderate 15% premium to AbbVie, favorable access shifts slightly toward AbbVie



ATTRIBUTE	LDV/SOF 12 wk*	AbbVie 12 wk	DCV + SOF 12 wk*
PRICE (WAC)	$96K	$96K	$96K ($12K DCV)
REBATE	10%	20%	10%
PRICE (NET)	$86.4K	$76.8K	$94.8K**

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

KEY TAKEAWAYS

- With LDV/SOF at a $10K premium to AbbVie, the most notable change is a large increase in % PA to label for AbbVie, and a corresponding decrease in soft/hard restrictions
- The shift in LDV/SOF access, while noticeable, is less dramatic, indicating that this discount is more likely to reduce existing AbbVie restrictions than add new LDV/SOF restrictions

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015
Launching LDV/SOF in a Dynamic HCV Market - Payer Quant Read-out
55 June 19th, 2014

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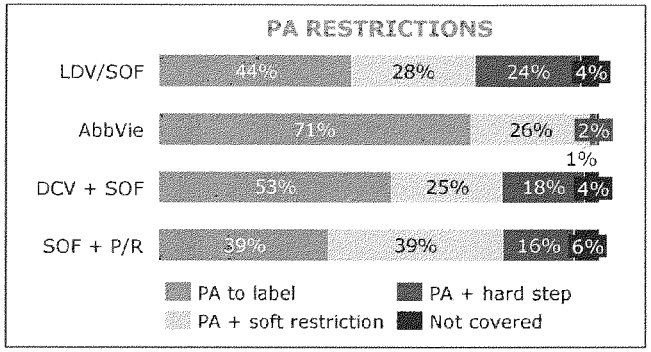
If LDV/SOF is significantly more expensive than AbbVie, the increase in hard restrictions is more noticeable



ATTRIBUTE	LDV/SOF 12 wk*	AbbVie 12 wk	DCV + SOF 12 wk*
PRICE (WAC)	$108K	$60K	$96K ($12K DCV)
REBATE	20%	10%	10%
PRICE (NET)	$86.4K	$54.0K	$94.8K**

KEY TAKEAWAYS

- With LDV/SOF at a $32K premium to AbbVie, the percentage of hard restrictions doubles from baseline
- However, 72% of lives are still expected to see LDV/SOF with a PA to label or soft restriction only
- At this point, the change in AbbVie access becomes less dramatic given that most hard restrictions were already removed at a $10K discount

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015

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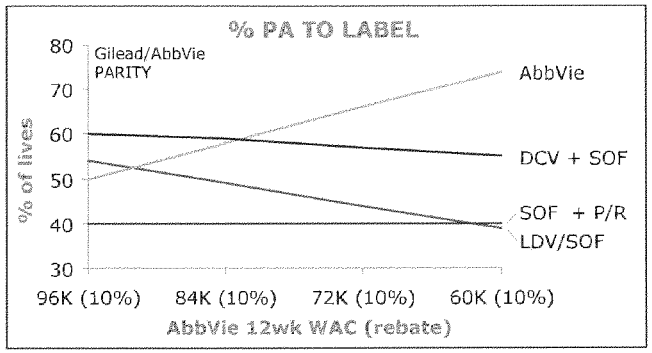
While AbbVie access is slightly less favorable at parity, it overtakes LDV/SOF once it offers a discount



ATTRIBUTE	LDV/SOF	AbbVie	DCV + SOF
	12 wk*	12 wk	12 wk*
PRICE (WAC)	$96K	Varies	$96K ($12K DCV)
REBATE	10%		10%
PRICE (NET)	$86.4K		$94.8K**

KEY TAKEAWAYS

- As the AbbVie price drops, there is a clear flow of favorable (PA to label) access from LDV/SOF to AbbVie
- DCV + SOF access also declines slightly, but the smaller change indicates that payers view the primary competitor as LDV/SOF
- The % PA to label for SOF + P/R stays constant, indicating that Wave 2 competitive scenarios do not register a major impact on Wave 1 access
- % w/ hard step and above is included in the appendix

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015
Launching LDV/SOF in a Dynamic HCV Market - Payer Quant Read-out
57 June 19th, 2014

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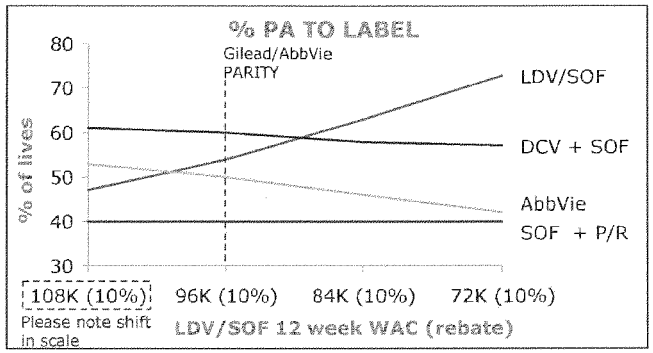
A similar trend can be seen when varying LDV/SOF price with the others held constant



ATTRIBUTE	LDV/SOF	AbbVie	DCV + SOF
	12 wk*	12 wk	12 wk*
PRICE (WAC)	Varies	$96K	$96K ($12K DCV)
REBATE		10%	10%
PRICE (NET)		$86.4K	$94.8K**

KEY TAKEAWAYS

- The same dynamic can be seen acting in Gilead's favor when LDV/SOF is lowered with others held constant
- However, the rate at which LDV/SOF picks up favorable access from AbbVie is similar to the previous case, reinforcing the perceived level of regimen interchangeability in the Wave 2 environment
- % w/ hard step and above is included in the appendix

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015

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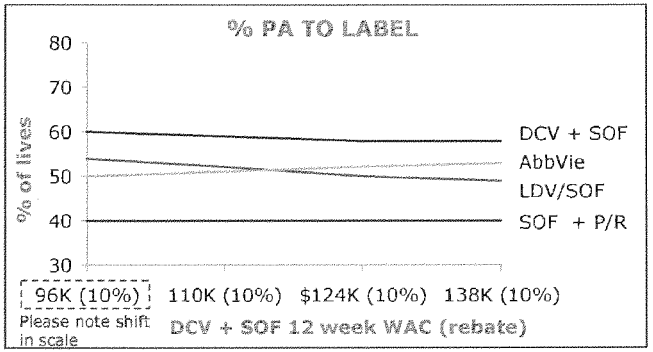
However, variation in DCV price has little impact, with BMS having little influence over the net regimen price



ATTRIBUTE	LDV/SOF 12 wk*	AbbVie 12 wk	DCV + SOF 12 wk*
PRICE (WAC)	$96K	$96K	Varies
REBATE	10%	10%	
PRICE (NET)	$86.4K	$86.4K	

KEY TAKEAWAYS

- Changes in DCV price and/or rebate have a negligible impact on access for all regimens
- It should be noted that BMS' lowest price is (necessarily) near the top of the range for LDV/SOF and AbbVie
- Therefore, the impact on management (to DCV + SOF and to the other regimens) from raising it further may not be significant if the payers are already restricting at the lowest level

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015

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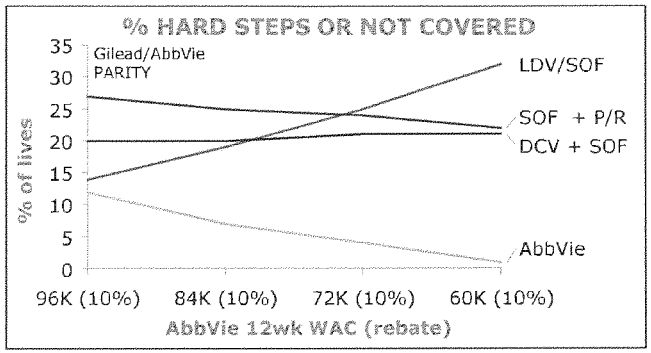
As AbbVie decreases its price from LDV/SOF parity, the likelihood of hard LDV/SOF restrictions grows



ATTRIBUTE	LDV/SOF 12 wk*	AbbVie 12 wk	DCV + SOF 12 wk*
PRICE (WAC)	$96K	Varies	$96K ($12K DCV)
REBATE	10%		10%
PRICE (NET)	$86.4K		$94.8K**

KEY TAKEAWAYS

- Similar to the trend in % PA to label only, LDV/SOF access gets significantly less favorable with AbbVie at discounts of $10K and above

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015
Launching LDV/SOF in a Dynamic HCV Market - Payer Quant Read-out
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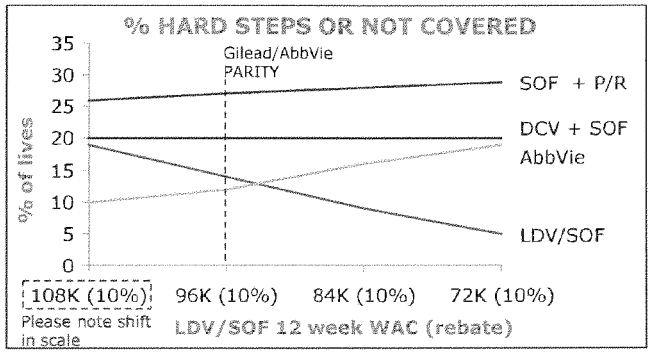
A similar trend is seen when LDV/SOF decreases its price from AbbVie parity



ATTRIBUTE	LDV/SOF 12 wk*	AbbVie 12 wk	DCV + SOF 12 wk*
PRICE (WAC)	Varies	$96K	$96K ($12K DCV)
REBATE		10%	10%
PRICE (NET)		$86.4K	$94.8K**

KEY TAKEAWAYS

- The relative speed at which hard restrictions move from LDV/SOF to AbbVie is comparable to the previous case, again indicating that net price is the primary driver of management decisions in the conjoint exercise

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015

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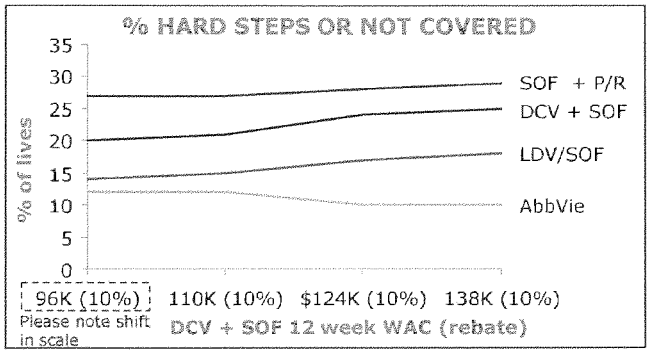
DCV + SOF premiums do not cause meaningful decreases in hard restrictions for other regimens



ATTRIBUTE	LDV/SOF	AbbVie	DCV + SOF
	12 wk*	12 wk	12 wk*
PRICE (WAC)	$96K	$96K	Varies
REBATE	10%	10%	
PRICE (NET)	$86.4K	$86.4K	

KEY TAKEAWAYS

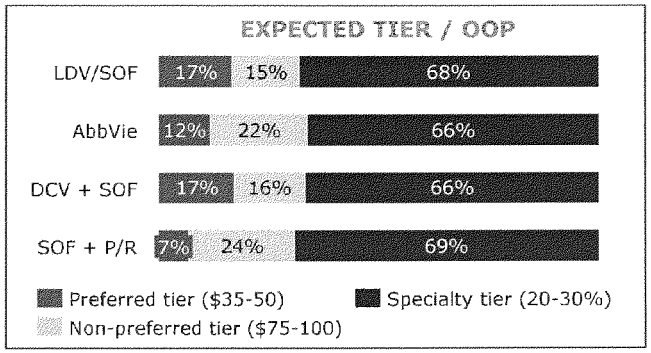
- Compared to LDV/SOF or AbbVie, lower price points for DCV + SOF did not translate to significant decreases in hard restrictions for other regimens
- This is not surprising given possible payer uncertainty on whether DCV + SOF will be an officially labeled regimen; if not, most payers would find it challenging to step other regimens through off-label DCV + SOF

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015
Launching LDV/SOF in a Dynamic HCV Market - Payer Quant Read-out
62 June 19th, 2014

ims consulting group

Near parity, expected tier/OOP is similar across regimens, but may diverge in response to competitive scenarios



ATTRIBUTE	LDV/SOF	AbbVie	DCV + SOF
	12 wk*	12 wk	12 wk*
PRICE (WAC)	$96K	$96K	$96K ($12K DCV)
REBATE	10%	10%	10%
PRICE (NET)	$86.4K	$86.4K	$94.8K**

KEY TAKEAWAYS

- For the "parity" scenario, the expected Specialty tier usage is consistent across regimens
- However, LDV/SOF and DCV + SOF both have a higher likelihood of preferred tier placement relative to AbbVie, reflecting more favorable payer perceptions
- While they are similar at parity, the tier/OOP distributions for each regimen respond differently as prices diverge in possible competitive scenarios (discussed later)

*LDV/SOF and DCV set to flat pricing for 8/12 weeks to best approximate recent profile changes
**Net price reflects DCV rebate only; payers told to assume their current levels of Sovaldi discounts

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015
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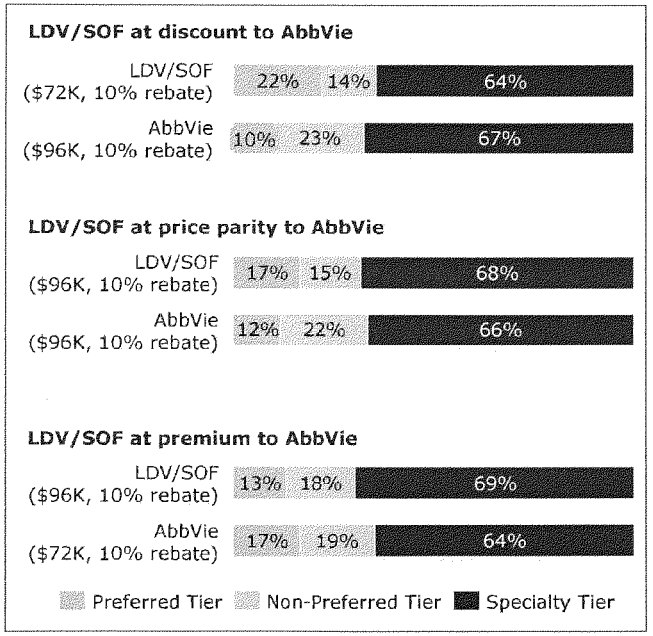
Tier placement may be used as a management tool, but to a much lesser degree than PA requirements



KEY TAKEAWAYS

- While the variation in tier / OOP is not large, payer responses do indicate some interest in using differential tiering as a way to advantage one regimen over another
- Comparing a LDV/SOF discount to a comparable AbbVie discount across scenarios show a greater likelihood of preferred tier placement for LDV/SOF, consistent with payer preference for the regimen

N = 40 payers; conjoint data weighted by lives according to expected payer mix in Q1 2015
Launching LDV/SOF in a Dynamic HCV Market - Payer Quant Read-out
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Note: DCV + SOF is at baseline for all scenarios

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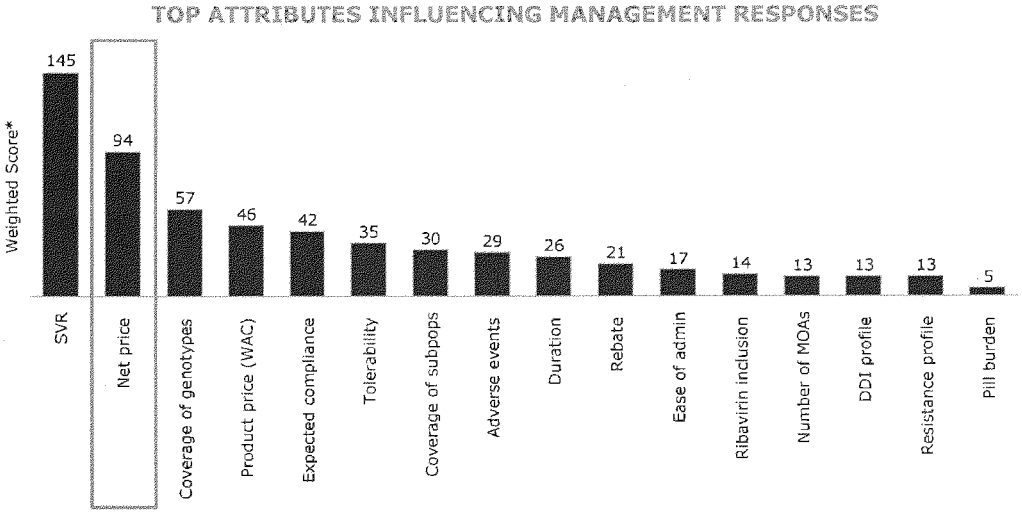
1684

Net price emerged as the most relevant financial attribute driving payer management decisions



Q: Please rank the top 5 attributes which were most influential on your management decisions in the previous exercise.

*Weighted scores were calculatedby assigning points based on ranked importance: #1 in importance = 5 pts, #2 = 4 pts, #3 = 3 pts, #4 = 2 pts, #5 = 1 pt

N = 40 payers

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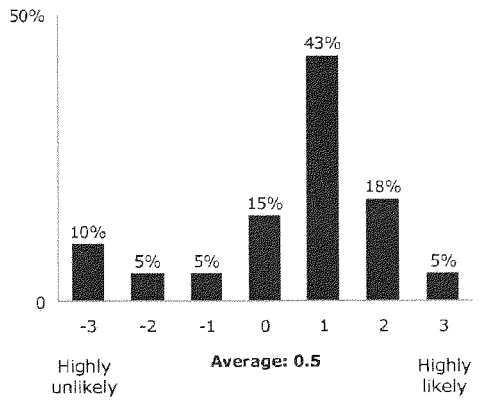
Payers show little inclination to fragment access by subpopulations

VARYING MANAGEMENT BY SUBPOP

Q: Please rate the likelihood that your management of these products would vary based on patient subpopulation (e.g. hard stepping a particular product in non-cirrhotic patients only)



KEY TAKEAWAYS

- Payers rate their likelihood of varying management by subpopulation just above neutral (0)
- Considering the typical reluctance of payers to rule out potential management options (via negative ratings), this average suggests that subpopulation fragmentation as a payer strategy is unlikely
- This also reinforces the hypothesis that payers are reluctant to stray outside of guidelines and will typically prefer to maintain broad access for multiple products in order to generate a steady flow of rebates
- However, AbbVie may still push payers toward this strategy if it optimizes pricing for a targeted subpopulation (or duration)

N = 40 payers

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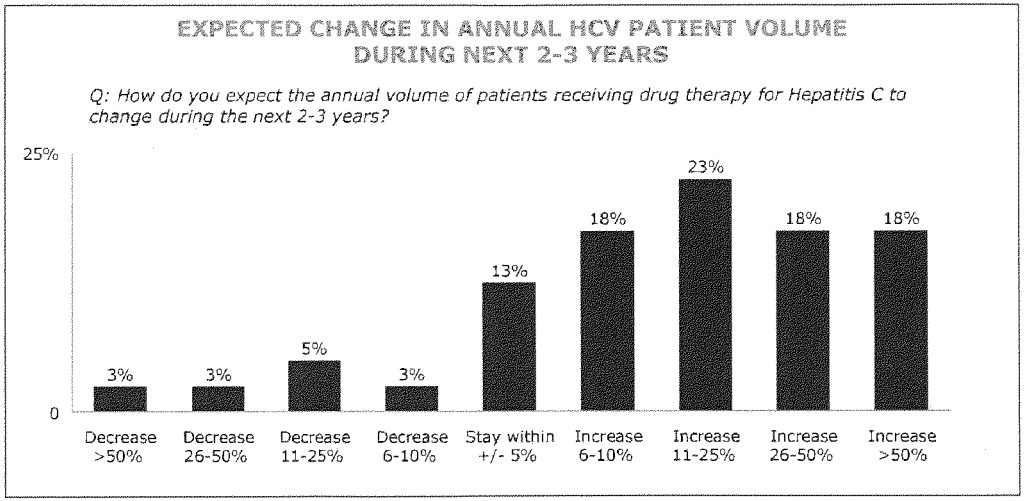
Payers feel there will be a significant growth in HCV patient volume in the near future



N = 40 payers

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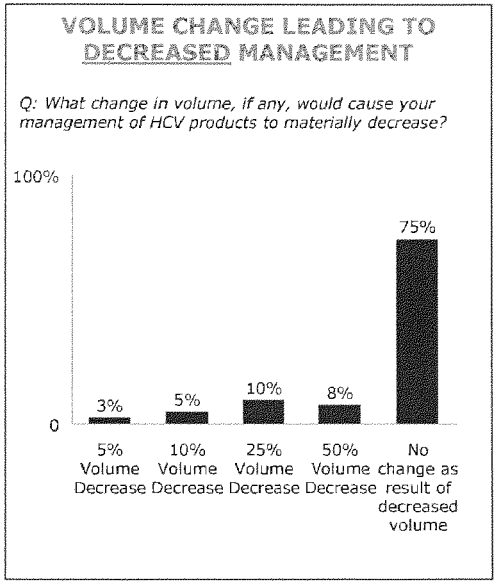
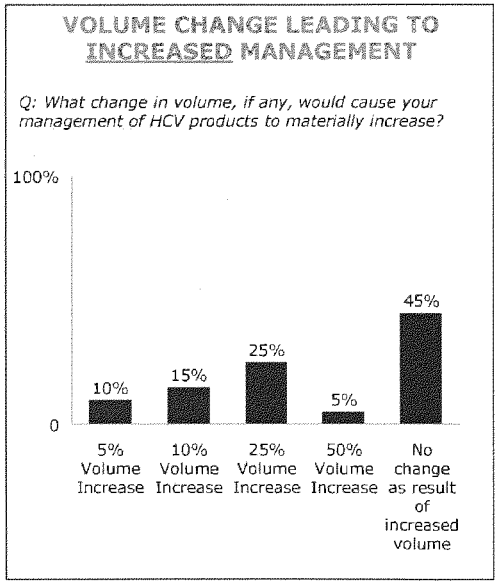
However, their management approach is unlikely to change as a result of likely volume changes





N = 40 payers

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1689

Findings from Physician Research

GILEAD

- At parity, physicians strongly prefer LDV/SOF, followed by the DCV + SOF regimen, with AbbVie a distant third
- Physician demand for LDV/SOF is likely to remain robust even in the face of soft restrictions or OOP disadvantages (LDV/SOF retains ~90% of share)
- Given hard restrictions, physician demand for LDV/SOF falls ~33%, with share going to both BMS and AbbVie; this reinforces that AbbVie will likely require help from payers to gain meaningful volume
- Despite some variation in physician allocation between 8, 12, and 24-week regimen durations, overall share for each brand remains largely consistent across subpopulations
- The access- and revenue-maximizing pricing strategies are likely to be very different price points
- At a 20% premium to AbbVie, ~18% of payers will implement a hard step or block LDV/SOF (Range 10-30%)
- AbbVie's labeled duration remains a key uncertainty

1690

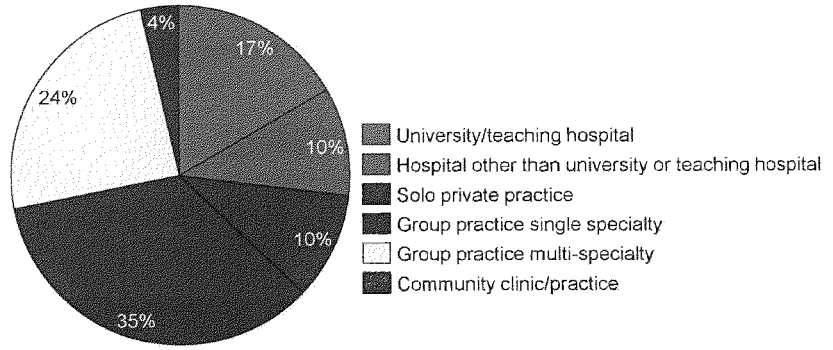
Summary of MD Market Research Sample

GILEAD

Online survey responses from 76 physicians in June 2014

SPECIALTY	# OF PHYSICIANS
Gastroenterology / Hepatology	60
Infectious Disease / Internal Medicine	16
Total	**76**

PERCENTAGE OF TIME SPENT IN EACH SETTING:



1691

At Wave 2 parity access, physicians allocate nearly 40% of patients to LDV/SOF regimens, with brand share consistent across subpopulations

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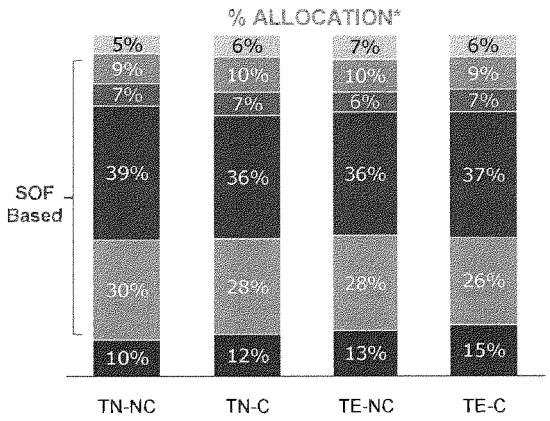


KEY TAKEAWAYS

- At **parity access and patient OOP**, Physicians exhibit a **clear preference for LDV/SOF** across all subpopulations; AbbVie share trails far behind both LDV/SOF and BMS
- Overall, physicians allocate between **78% and 84% of patients to a sofosbuvir-based regimen**
- Despite some variation in physician allocation between 8, 12, and 24-week regimen durations, **overall share for each brand remains largely consistent** across subpopulations

Peg-IFN/RBV +/- PI (incl. Olysio) | COSMOS regimen [Sovaldi + Olysio] | DCV + SOF (all durations)
Sovaldi-containing regimens (not incl. COSMOS) | LDV/SOF (all durations) | AbbVie (all durations)

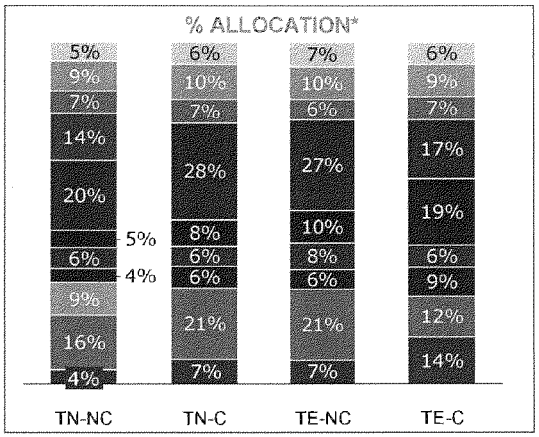
ATTRIBUTE	LDV/SOF	AbbVie	BMS	Sovaldi
PA CRITERIA	PA to label	PA to label	PA to label	PA to label
PATIENT OOP**	>$75	>$75	>$75	>$75

N = 76 physicians
*Share is summed over available regimen durations for each product; shares for individual durations included in the Appendix

**Full text for >$75 OOP: patient copay greater than $75 (including some patients with 20-30% coinsurance)

At Wave 2 parity access, physicians allocate nearly 40% of patients to LDV/SOF regimens, with brand share consistent across subpopulations

GILEAD



KEY TAKEAWAYS

- At **parity access and patient OOP**, Physicians exhibit a **clear preference for LDV/SOF** across all subpopulations; AbbVie share trails far behind both LDV/SOF and BMS
- Despite some variation in physician allocation between 8, 12, and 24-week regimen durations, **overall share for each brand remains consistent** across subpopulations

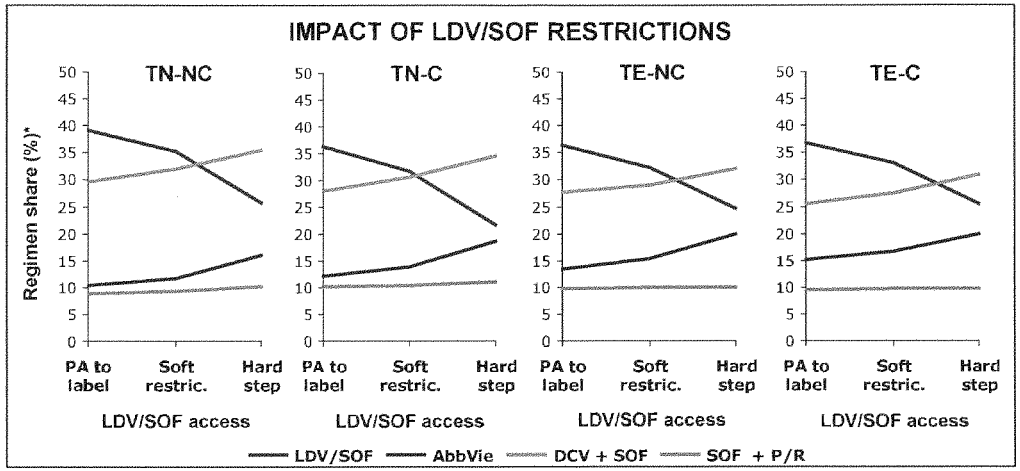
Peg-IFN/RBV +/- PI (incl. Olysio)
Sovaldi-containing regimens (not incl. COSMOS)
COSMOS regimen [Sovaldi + Olysio]
LDV/SOF 8 wk
LDV/SOF 12 wk
LDV/SOF 24 wk
AbbVie 12 wk
AbbVie 24 wk
DCV + SOF 8 wk
DCV + SOF 12 wk
DCV + SOF 24 wk

ATTRIBUTE	LDV/SOF	AbbVie	BMS	Sovaldi
PA CRITERIA	PA to label	PA to label	PA to label	PA to label
PATIENT OOP	>$75	>$75	>$75	>$75

N = 76 physicians

As restrictions on LDV/SOF increase, BMS and AbbVie both pick up share, with BMS overtaking LDV/SOF at high levels of restriction

GILEAD



KEY TAKEAWAYS

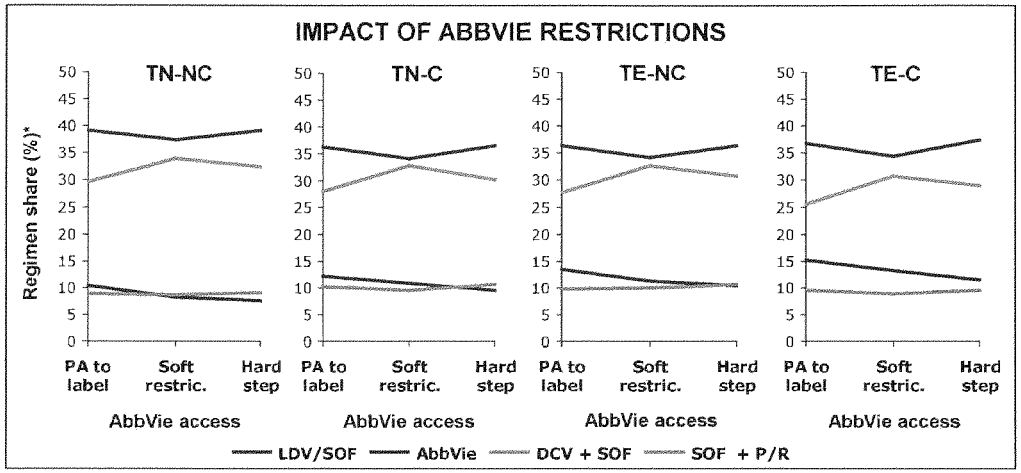
- With restrictions increasing on LDV/SOF only, physician **allocation shifts to BMS and AbbVie at approximately the same rate**; Sovaldi share remains constant throughout
- However, **LDV/SOF still maintains the greater share even with soft restrictions**

*LDV/SOF PA criteria varies; PA criteria for all other regimens held constant at PA to label
*Share is summed over available regimen durations for each product

N = 76 physicians

As restrictions on AbbVie increase, BMS allocations increase and there is little meaningful impact on LDV/SOF

GILEAD



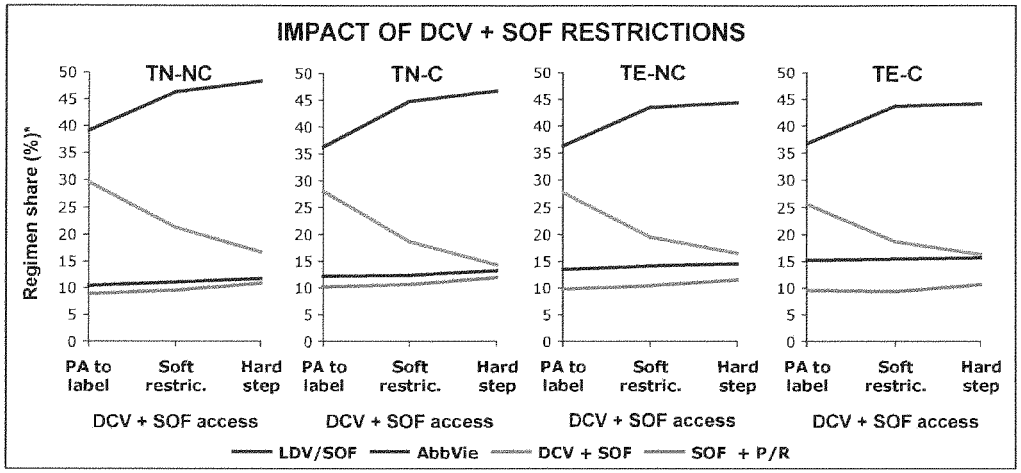
KEY TAKEAWAYS

- Given AbbVie's relatively low initial share, there **is little change to physician allocations for LDV/SOF or BMS** as restrictions increase
- Small variations shown in the data are likely caused by noise, rather than meaningful trends

*AbbVie PA criteria varies; PA criteria for all other regimens held constant at PA to label
*Share is summed over available regimen durations for each product
N = 76 physicians

As restrictions on DCV increase, LDV/SOF captures nearly all of its share and dominates the market across subpopulations

GILEAD



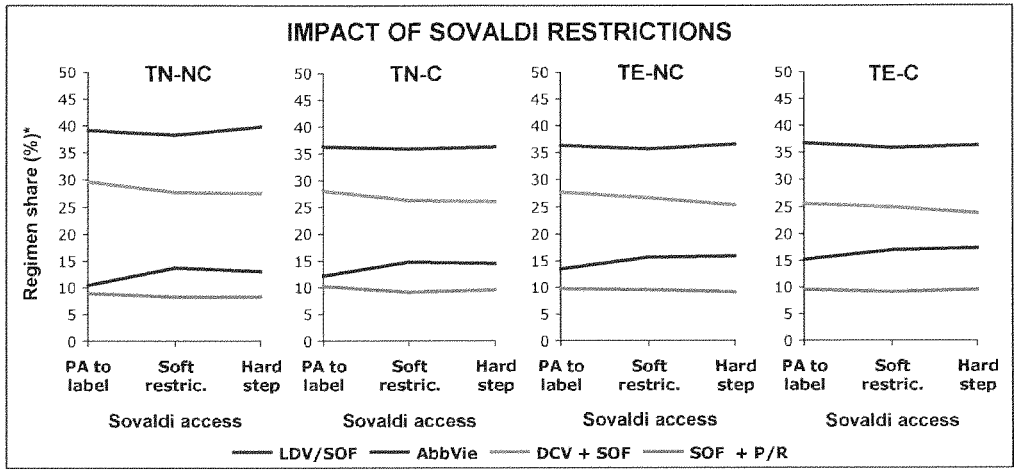
KEY TAKEAWAYS

- While DCV-only restrictions may be less likely than payer management between LDV/SOF and AbbVie, a **soft or hard DCV step would rapidly transfer share to LDV/SOF**, with AbbVie making only minimal gains, reinforcing physicians' preference for NS5B-based regimens

*DCV + SOF PA criteria varies; PA criteria for all other regimens held constant at PA to label
*Share is summed over available regimen durations for each product
N = 76 physicians

If restrictions on Sovaldi increase, there is negligible impact on prescribing across Wave 2 regimens

GILEAD



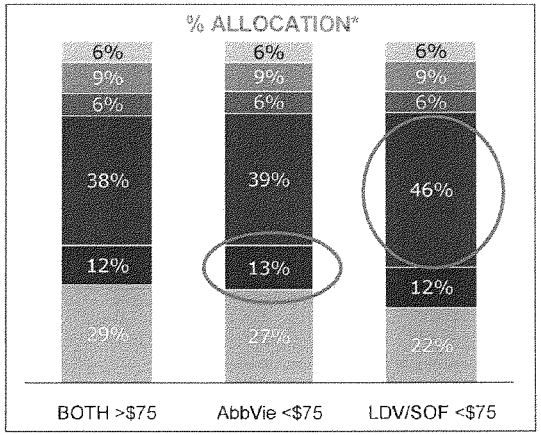
KEY TAKEAWAYS

- Physician **allocations to all regimens stay constant as Sovaldi restrictions increase**, indicating that physicians consider Wave 2 prescribing to be independent of Wave 1 access

*Sovaldi PA criteria varies; PA criteria for all other regimens held constant at PA to label
*Share is summed over available regimen durations for each product
N = 76 physicians

Advantages in patient out-of-pocket are significantly more favorable for LDV/SOF than they are for AbbVie

GILEAD



KEY TAKEAWAYS

- **AbbVie picks up only marginal share** if it has a lower OOP than LDV/SOF and BMS; furthermore, this share comes entirely from BMS
- However, a **lower LDV/SOF OOP leads to an 8% increase** in share, again taken primarily from BMS

**Full text for >$75 OOP: patient copay greater than $75 (including some patients with 20-30% coinsurance)

Peg-IFN/RBV +/- PI (incl. Olysio)
Sovaldi-containing regimens (not incl. COSMOS)
COSMOS regimen [Sovaldi + Olysio]
LDV/SOF (all durations)
AbbVie (all durations)
DCV + SOF (all durations)

ATTRIBUTE	LDV/SOF	AbbVie	BMS	Sovaldi
PA CRITERIA	PA to label	PA to label	PA to label	PA to label
PATIENT OOP	**Varies**	**Varies**	>$75	>$75

N = 76 physicians

*Share is summed over available regimen durations for each product; subpopulations are consolidated by a weighted average which assumes patient population not limited by Fibrosis score

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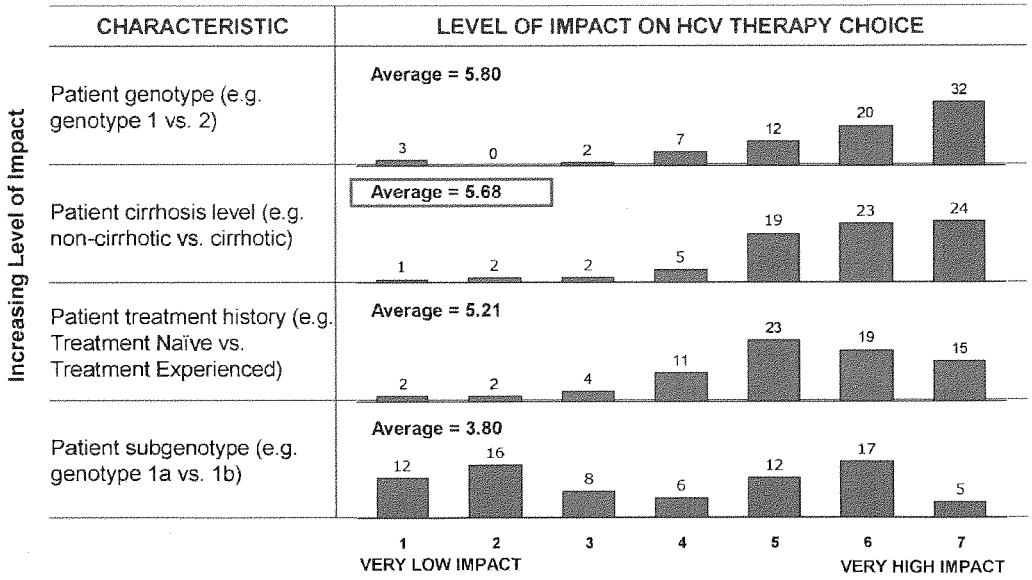
1699

Physicians assign greater importance to a patient's cirrhosis level than either treatment history or sub-genotype when selecting a regimen

GILEAD

For patients whom you treat with drug therapy, please rate the following characteristics on the level of impact they currently have on your choice of an HCV therapy.

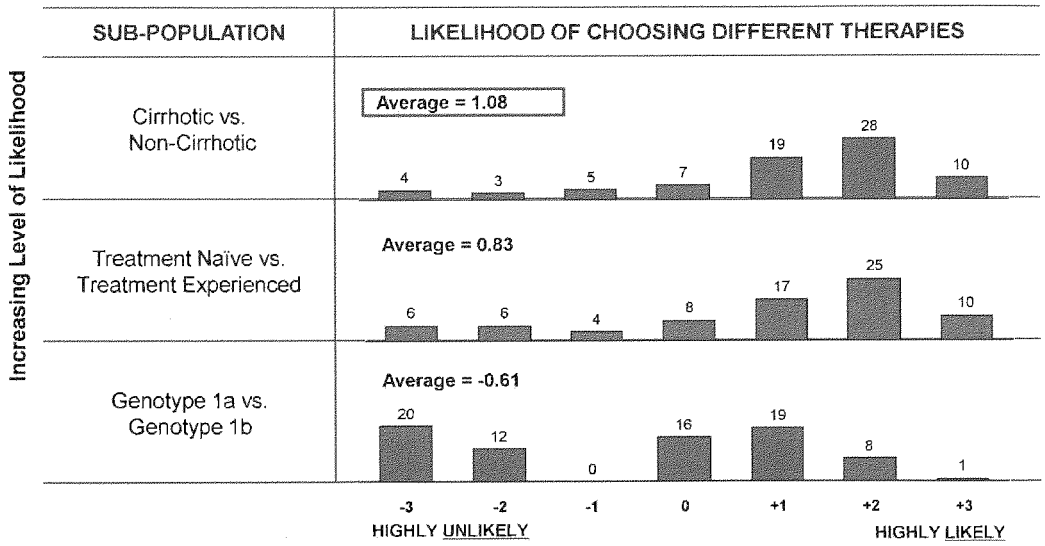


N = 76 physicians

Similarly, physicians are most likely to differentiate their prescribing decisions between cirrhotics and non-cirrhotics

GILEAD

How likely are you to choose different drug therapies within the following pairs of patient subpopulations?



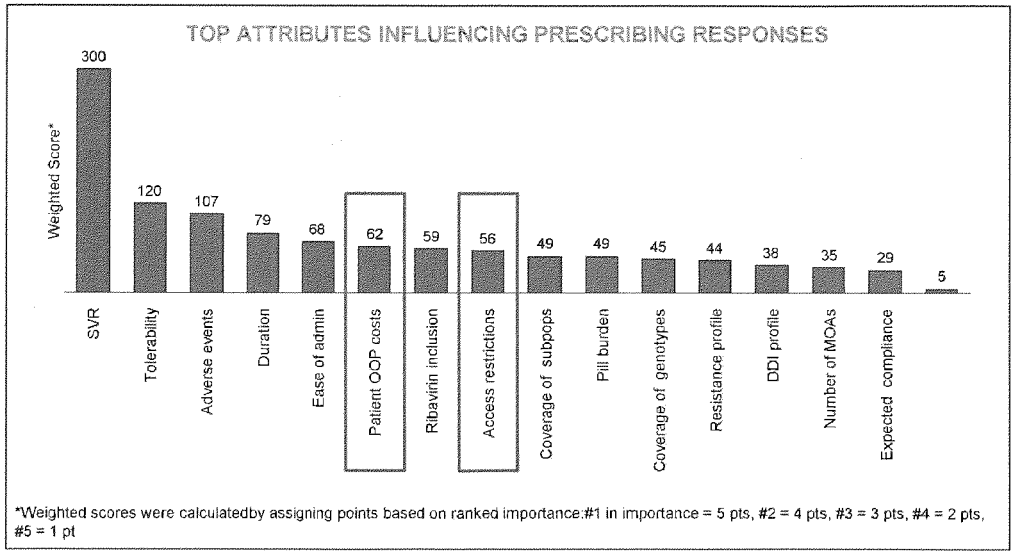
N = 76 physicians

1701

Physicians indicate that access and patient OOP concerns are less important than clinical factors

GILEAD

Rank the top 5 (in order) which were most influential on your prescribing decisions in the previous exercise. Please also select the least influential attribute to your previous prescribing decisions.



*Weighted scores were calculatedby assigning points based on ranked importance:#1 in importance = 5 pts, #2 = 4 pts, #3 = 3 pts, #4 = 2 pts, #5 = 1 pt

N = 76 physicians

Reduced duration is seen as the most significant differentiator between regimens, although RBV inclusion may also influence decisions

GILEAD

Rank which of the benefits are most meaningful to you when distinguishing between two therapeutic choices to treat your HCV patients.

TYPE OF BENEFIT	WEIGHTED SCORE*
Reducing duration of therapy from 24 to 12 weeks	447
Not having to prescribe ribavirin	324
One of the therapies involves taking at least 3 fewer pills per day	312
One of the therapies costs patients 15-20% less	300
Fewer payer restrictions	299
One of the therapies does not require Ritonavir boosting	255
Greater ease of reimbursement	191

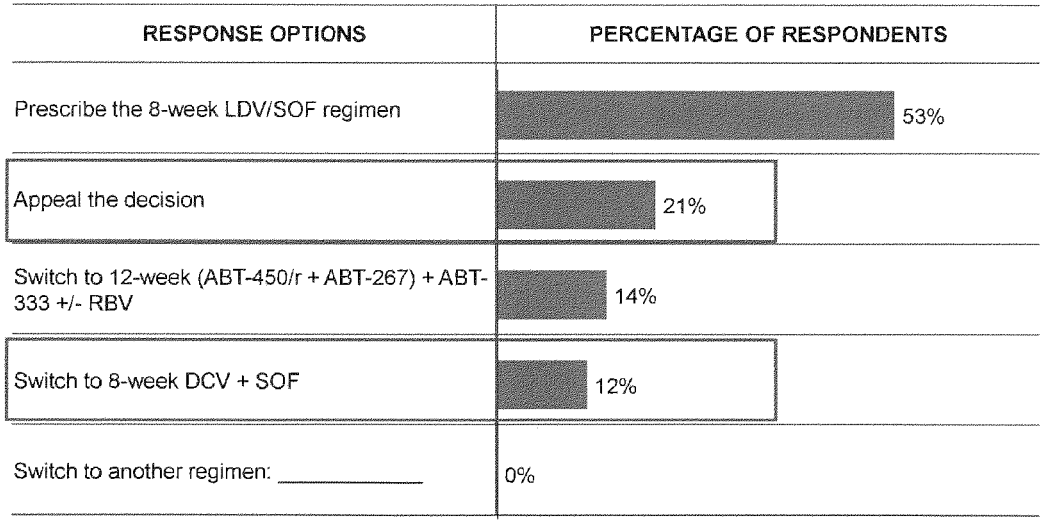
*Weighted scores were calculatedby assigning points based on ranked order:#1 (most meaningful benefit) = 7 pts, #2 = 6 pts, #3 = 5 pts, #4 = 4 pts, #5 = 3 pts, #6 = 2 pts, #7 (least meaningful benefit) = 1 pt

N = 76 physicians

If payers mandated usage of 8-week LDV/SOF, ~50% of physicians would follow suit while 21% would appeal the decision

GILEAD

Consider a scenario where you prescribed the 12-week LDV/SOF regimen for a Treatment Naïve, Non-Cirrhotic patient, but the payer mandated use of the 8-week regimen. Which of the following would be your most likely response?

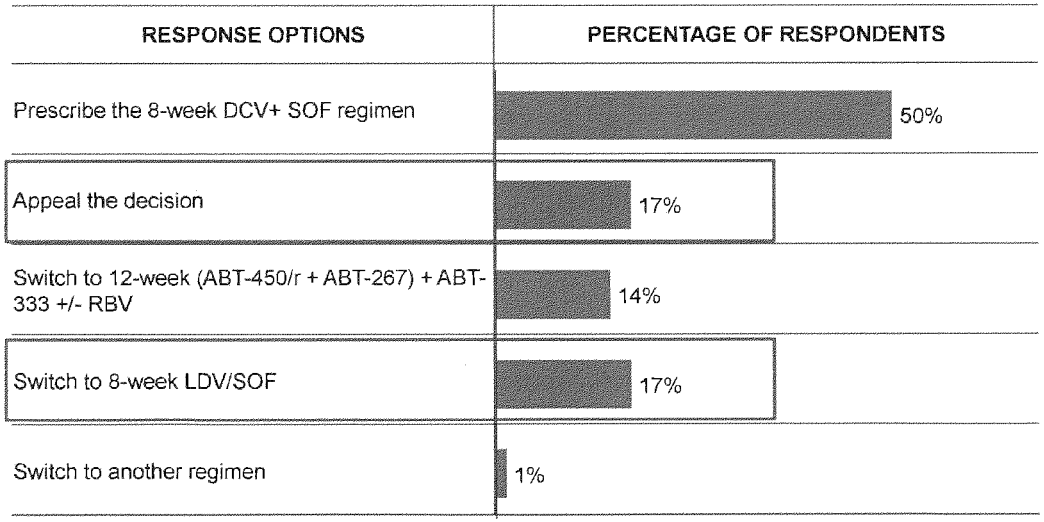


N = 76 physicians

If the payer mandate was instead for 8-week DCV + SOF, a small percentage of physicians would appeal the decision

GILEAD

Consider a scenario where you prescribed the 12-week DCV + SOF regimen for a Treatment Naïve, Non-Cirrhotic patient, but the payer mandated use of the 8-week regimen. Which of the following would be your most likely response?



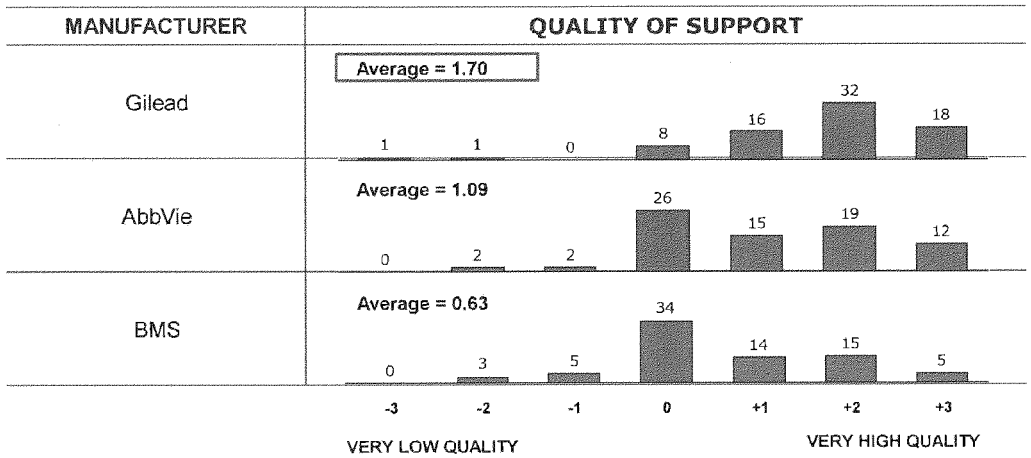
N = 76 physicians

1705

Physicians give Gilead's support programs the highest ratings among the three manufacturers

GILEAD

What is your perception of the quality of support (e.g., patient assistance programs, back-office support) from the following manufacturers?



N = 76 physicians

1706

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1707

Ipsos data on viral load

GILEAD

Distribution of patients latest viral load

	Q2'12	Q3'12	Q4'12	Q1'13	Q2'13	Q3'13	Q4'13	Q1'14
Base	499	504	691	771	842	812	756	792
<= 6m IU/L	451	456	601	687	738	707	676	700
	90%	91%	87%	89%	88%	87%	89%	88%
> 6m IU/L	48	47	90	83	104	105	80	92
	10%	9%	13%	11%	12%	13%	11%	12%

Base: all naive/experienced untreated patients with known lastest viral load (weighted)

Source: Ipsos HCV TM

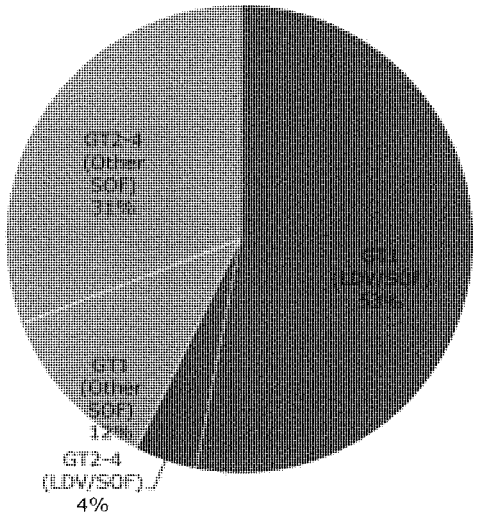
1708

Even assuming modest uptake from BMS, SOF represents about 1/3 of Gilead's near term revenue.

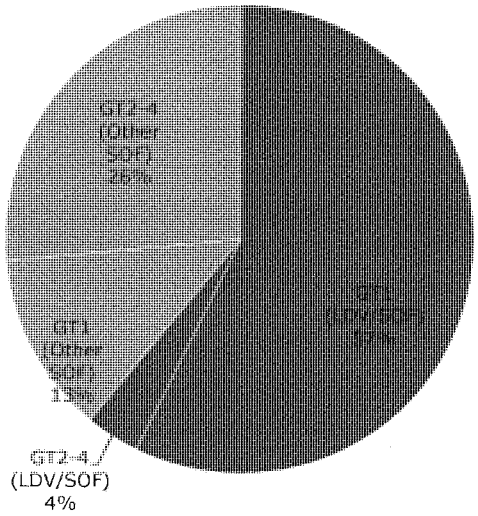
GILEAD

Gilead 2015 – 2017 Net Revenue*

Updated June LE



Est. Impact of Updated Durations



- Revenue Split Based on Gilead June LE and June LE Pricing. Note that June LE assumes BMS achieves ~15% share of GT1 in 2014 and that Gilead prices at $106.5 k for 12 weeks. 40% of TN, NC with a LVL
- Other SOF includes: PegIFN/RBV/sofosbuvir, RBV/sofosbuvir, sofosbuvir/daclatasvir and sofosbuvir/simeprevir

Cross Scenario Summary
Impact on Gilead Franchise Net Revenue

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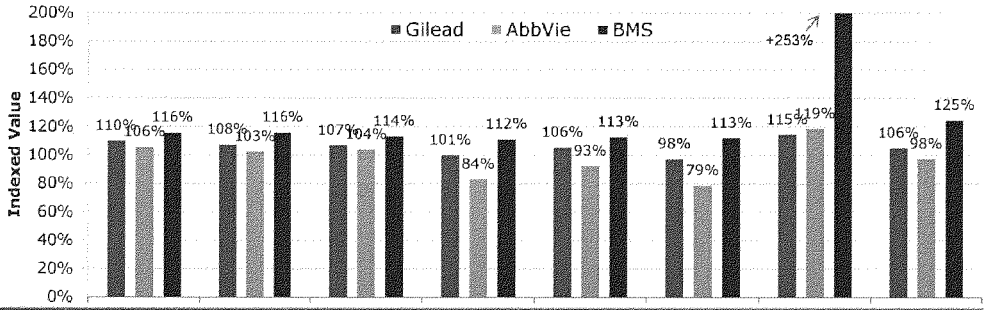
Change in 2015 – 2017 Net Revenue (Indexed to June LE)



	Parity @ $96k	AbbVie - 10% WAC	AbbVie - 10% net	AbbVie - 20% net	AbbVie @ $60k	AbbVie @ $72k	LDV/SOF @ $108k	LDV/SOF @ $108k; Abb $60k
Effective WAC Launch Price								
LDV/SOF	98	98	98	98	98	98	111	111
DCV	12	12	12	12	12	12	27	12
DCV+SOF	98	98	98	98	98	98	113	98
AbbVie	101	88	101	75	101	63	101	63
Launch Contracting Assumption								
LDV/SOF	Redacted							
DCV								
AbbVie								
2015 GT1 Share								
LDV/SOF	59%	57%	56%	59%	55%	55%	56%	46%
DCV+SOF	15%	15%	14%	14%	14%	14%	15%	16%
Other DCV	2%	2%	2%	2%	2%	2%	2%	2%
AbbVie	24%	27%	27%	25%	29%	29%	27%	35%

Summary of All Scenarios

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	June LE	New Durations	New GTN	Parity @ $96k	AbbVie -10% net	AbbVie -10% WAC	AbbVie @ $72k	AbbVie - 20% net	AbbVie @ $60k	LDV/SOF @ $108k	LDV/SOF @ $108k; Abb $60k
12 Wk Launch Price											
LDV/SOF	106.5	106.5	106.5	96	96	96	96	96	96	108	108
DCV	12	12	12	12	12	12	12	12	12	26	12
DCV+SOF	96	96	96	96	96	96	96	96	96	110	96
AbbVie	96	96	96	96	84	96	72	96	60	96	60
Contract Terms											
LDV/SOF	Redacted										
DCV											
AbbVie											
Weight Average WAC Launch Price											
LDV/SOF	87	109	109	98	98	98	98	98	98	111	111
DCV	12	12	12	12	12	12	12	12	12	27	12
DCV+SOF	98	98	98	98	98	98	98	98	98	113	98
AbbVie	101	101	101	101	88	101	75	101	63	101	63
2015 GT1 Share											
LDV/SOF	59%	59%	59%	59%	57%	56%	59%	55%	55%	56%	46%
DCV+SOF	15%	15%	15%	15%	15%	14%	14%	14%	14%	15%	16%
Other DCV	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
AbbVie	24%	24%	24%	24%	27%	27%	25%	29%	29%	27%	35%
2015-2017 GT1 Share											
LDV/SOF	47%	47%	47%	47%	45%	45%	47%	44%	44%	44%	37%
DCV+SOF	12%	12%	12%	12%	12%	11%	11%	11%	11%	12%	13%
AbbVie	16%	16%	16%	16%	18%	18%	17%	19%	19%	18%	23%

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Maximizing access relative to AbbVie may not be the revenue maximizing – or commercially optimal – strategy for Gilead

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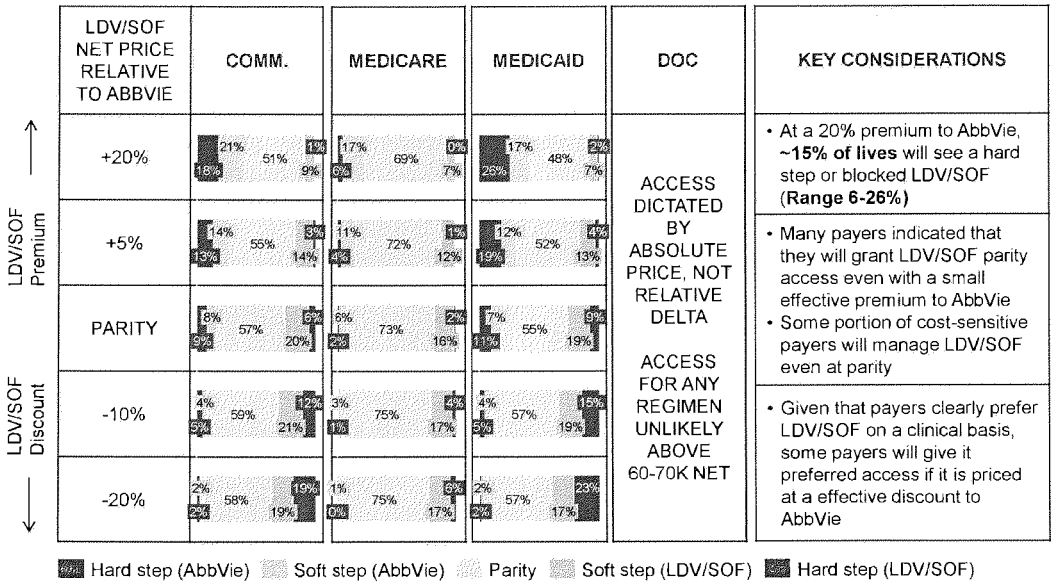
LDV/SOF ACCESS RELATIVE TO ABBVIE



*Note: management distributions are weighted to reflect percentage of lives for each payer type and may vary slightly at different absolute prices; access levels reflect relative LDV/SOF and AbbVie access only

Exhibit 48

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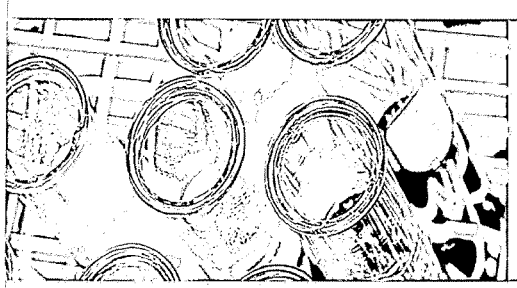

2014-2015 US HCV Franchise BPOA

Draft, June 2014

Please Note: Messages or statements contained in this document relating to Gilead products are aspirational in nature and may depend on future regulatory developments and product approvals. Specific messages for external communication and other tactics must be reviewed and approved for use in accordance with applicable regulations before they are implemented.

LDV/SOF is an investigational product until approved by the FDA. Marketing of LDV/SOF is subject to such approval, and will be in accordance with the approved labeling for the product.

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Strategy

Strategies & Goals

Commercial Plan 2015-2016 Global Strategic Objectives

Strategic Objective		Priority Weighting
BRAND	Solidify SOF as the backbone of all future HCV therapy while driving sense of urgency to treat now	40%
ACCESS	Raise awareness about benefits of rapid reimbursement and maximum patient access to SOF based regimens	30%
POLICY	Educate governments about economic advantages of investments in HCV cure and of HCV budget increase in 2015-2016, supported by Government, Public, and Medical Affairs efforts to drive communication and advocacy	15%
MARKET DEVELOPMENT	Accelerate patient flow through the HCV waterfall to drive longer term sustainable growth	15%

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2014-15 US HCV Franchise Strategic Objectives
(Brand, Access, and Policy Integrated Across Strategic Objectives)

	Strategic Objectives	2014 Focus	2015 Focus
1	Drive depth and breadth of SOVALDI adoption as the new backbone of HCV treatment	60%	10%
2	Establish LDV/SOF as the preferred "standard of cure" for GT1	30%	60%
3	Accelerate patient flow into treater care to enable sustainable growth	10%	30%*

**Scale efforts as appropriate based on market indicators*

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Key Drivers, Key Barriers, and Strategies

1 Drive depth and breadth of SOVALDI adoption as the new backbone of HCV treatment

Key Drivers

- SOF clinical profile fulfills unmet needs and enables a paradigm shift in HCV treatment (benefits >> risk)
- SOF broad label (expected to result in broad payer coverage and use)
- New AASLD/IDSA treatment guidelines validate SOF as new backbone of HCV treatment
- Patient motivation to get treated given product profile
- Provider capacity to treat given recent therapy deferral trend
- Positive real-world experience with SOF

Key Barriers

- Slower adoption due to HCP/patient inertia and established negative perceptions of IFN-based regimens
- Competitive noise and "IFN-free, all-oral" buzz results in treatment deferral and a shorten window of opportunity for SOF in GT1
- Access restrictions within cost-sensitive payer segments; potential narrowing of patients allowed to be treated
- Negative noise regarding price and potential access limitations

Strategies

- "Brand" - Drive SOF brand awareness and establish its value proposition with HCPs and patients
  - Drive HCPs to prescribe as standard of care
  - Drive patients to request brand; own "cure"
  - Position SOF as the backbone of HCV treatment
- "Experience" – Redefine treatment candidacy and drive rapid SOF uptake across all indicated patient types
  - Encourage a shift towards more patients being candidates for treatment
  - Enable a streamlined and positive treatment experience for HCPs and patients through educational, clinical, and access support
  - Validate clinical profile and benefits through real world experience
- "Access" - Optimize SOF access and reimbursement
  - Demonstrate value proposition to payers
  - Ensure optimal formulary position and PA criteria
  - Encourage use of "best" regimen based on available clinical and HEOR evidence

Post-LDV/SOF Launch: Ensure SOF remains backbone of treatment regimen for GT2/3, HCV/HIV co-infection, and pre-transplant

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Key Drivers, Key Barriers, and Strategies

2 Establish LDV/SOF as the preferred "standard of cure" for GT1

Key Drivers

- LDV/SOF clinical profile redefines expectations for HCV treatment; benefits beyond IFN-free and high SVR
- Limitations and barriers traditionally associated with treatment deferral eliminated
- Positive real-world experience with SOF
- Potential launch prior to AbbVie
- Enhanced patient awareness of treatment options and motivation to get treated given product profile
- LDV/SOF likely to be "recommended" on guidelines

Key Barriers

- Highly competitive on all fronts (HCP, DTP/DTC, payers), with AbbVie expected to deploy aggressive practices
- Competitors and payers expected to fragment (1a vs 1b)
- Continued lack of urgency amongst HCPs and patients
- AbbVie and other all-oral regimens may also be "recommended" on guidelines
- Payers expected to heavily manage access; potential narrowing of patients allowed to be treated and/or resistance to adopting new regimens
- Differences in treatment duration across patient subtypes may pose challenges to pricing
- Negative noise regarding price and potential access limitations

Strategies

- "Brand" - Drive LDV/SOF brand awareness and establish its differentiated value proposition with HCPs and patients
  - Differentiate from competitive regimens by redefining expectations for HCV treatment, with benefits beyond IFN-free and high SVR (e.g., RBV-free, STR and its implications, patient reported outcomes)
  - Leverage positive experience with SOF and build on its momentum as the backbone of HCV treatment
  - Drive HCPs to prescribe and advocate as preferred choice
  - Drive patients to request brand
- "Experience" – Redefine treatment candidacy and ensure a positive brand/Gilead experience that is differentiated from competitive offerings
  - Encourage a shift towards cure without hesitation
  - Enable an unparalleled treatment experience for HCPs and patients through educational, adherence, and access support
  - Socialize successes though HCP/patient/advocacy "champions"
  - Validate clinical profile and benefits through real world experience
- "Access" - Optimize LDV/SOF access and reimbursement
  - Establish pricing and contracting strategies towards achieving parity access for all SOF-based regimens
  - Demonstrate value proposition to payers; differentiate benefits beyond IFN-free and high SVR
  - Ensure optimal formulary position and PA criteria
  - Encourage use of "best" regimen based on available clinical and HEOR evidence

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LDV/SOF Launch Strategic Objectives

BRAND:
Establish LDV/SOF as the preferred "standard of cure" for GT1

LDV/SOF needs to be perceived as redefining expectations in HCV treatment and setting a new and preferred "standard of cure"

ACCESS:
Optimize access and reimbursement

LDV/SOF needs to have at least parity access compared to competitive regimens; ensure treatment decisions stay in the hands of HCPs and patients

EXPERIENCE:
Facilitate a positive brand experience

Customer experience with LDV/SOF and Gilead needs to be aligned with simplicity benefit and reinforce market leader position; ensure HCP and patient support programs are competitive

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Key Drivers, Key Barriers, and Strategies

3 Accelerate patient flow into treater care to enable sustainable growth

Key Drivers

- SOF and LDV/SOF provides a compelling incentive for HCPs and patients who have been on the "sidelines" to now engage
- Compelling data have emerged on short and long term impact of HCV and the benefits of early treatment
- Adoption of CDC and USPSTF screening recommendations
- Increasing public noise around HCV; enhanced engagement by PCP organizations and advocacy groups; increased patient awareness

Key Barriers

- Low relevance for PCPs and patients; HCV compete for attention with more prevalent chronic diseases
- Low overall awareness and understanding of HCV amongst PCP and patient/at-risk community
- Lack of systemic incentives, such as quality measures, to drive action; Potential of payers to limit treatment to certain HCPs and patients with advanced disease
- Payers expected to heavily manage access; potential narrowing of patients allowed to be treated

Strategies

2014: Establish foundation for market development and garner insights to inform optimal scalability in 2015 and beyond
2015: Scale efforts as appropriate based on market indicators

- Leverage SOF and LDV/SOF to drive linkage to treater care and expand treatment rates (pilots in 2014)
  - Activate diagnosed patients to seek treatment
  - Activate PCPs to provide a consistent, high quality referral of all diagnosed patients
  - Opportunistic approach in developing new treaters amongst motivated HCPs
  - Eliminate inertia and drive urgency to treat; socialize cure and treatment success
  - Convey value of early treatment
- Expand screening (potential pilots in 2015)
  - Activate at-risk population to seek testing
  - Establish a new standard for HCV screening amongst PCPs, using appropriate triggers and aligned with guideline recommendations
  - Explore partnerships to drive systemic screening and linkage to care
- Minimize payer barriers to expanding diagnosis and treatment
  - Demonstrate value of early treatment; minimize payer efforts to narrow patient population allowed to be treated
  - Reinforce broad coverage for screening
  - Encourage implementation of HCV quality measures
  - Monitor and assess opportunities to affect patient cost share within ACA environment

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Key Customer Groups

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Key Customer Groups: HCPs – HCV Treaters

Customer Group	Health Care Providers			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objective**	**Priority**
Fast Adopters – highly engaged in HCV and knowledgeable about SVD. Includes KOL's.	• Many are Hepatologists • Highly productive – at least 15 SVD TRx LTD (2x the average SVD Rxer) • n = 376 with average 36 TRx/HCP • 65% segment A	• Practice is more active in liver disease compared to community GI • Stopped treatment in anticipation of SVD; pre-scheduled their patients to return post SVD approval • High awareness of new therapies coming soon; will be the first to slow or stop treating GT 1 patients in anticipation of all-orals – EASL into Q3	• Continue to treat their pre-scheduled patients with SVD • Pro-actively offer SVD to all HCV patients in their practice • Continue to treat appropriate patients who cannot wait or are not eligible for all-orals (GT 2/3; advanced disease) • Endorse SVD as the backbone of therapy	High

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Key Customer Groups: HCPs – HCV Treaters

Customer Group	Health Care Providers			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objective**	**Priority**
Providers who are starting to adopt SVD	• Most are community GIs, some IDs • Practice is <15% HCV • Many had stopped or slowed treating HCV because of burdensome PI's (not necessarily because of anticipation/awareness of SVD approval) • n = 3,286 with average 3.5 SVD TRx/HCP	• IFN resistant or historically burned by PI's • Practice is less involved in HCV so less likely to push through managed-care hassles • Less aware of specifics related to coming all-orals	• Increase productivity - translate their initial SVD experience to be more pro-active in identifying HCV patients in their practice to be treated with SVD • Continue to treat appropriate patients through approval of LDV/SOF – no waiting	High
	• n = 5,571 with 0 SVD (March 18)	• Need to understand/appreciate transformative SVD profile in order to gain experience	• Gain initial experience w/ SVD	
NP/PA Treaters	• Follow treatment approach from MD clinician in the practice • Highest HCV patient work load • Majority are early adopters since active HCV treating offices usually leverage NP/PA's as HCV treaters • Very knowledgeable in the holistic management of HCV	• Patient-centric • Desire ongoing educational opportunities • High utilization of access support	• Sustain SVD loyalty • Increase productivity in HCV management • Encourage patients to initiate treatment	High

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Key Customer Groups: HCPs – Referrers and Potential Future Treaters

Customer Group	Health Care Providers			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objective**	**Priority**
HIV treaters who are not currently on HCV target list	• Have some HCV monoinfected in addition to co-infected patients ~25% of HIV patients are HCV co-infected	• Interested in treating HCV, but prefer to wait for IFN-free	• Initiate sales calls in Q3 to establish relationships in anticipation of all-oral • Begin treating GT 2,3 patients w/ SVD to gain experience	Medium
PCPs (IM/FP/GP/NP/PA in primary care setting)	• ~300K • Known HCV patients ~1% of practice • Low HCV awareness (1/3 aware of cure) • Low HCV engagement	• To activate PCPs, need to educate about incentive (cure, better treatments), drive urgency, and make it simple to act	• 1° Provide consistent high quality referral of all diagnosed patients • 2° Expand screening • 2° Adopt treatment (very selective and opportunistic)	Low-Medium

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Key Customer Groups: Consumers and Patients

Customer Group	*Consumers/Patients*			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objective**	**Priority**

Consumers-Diagnosed
• Core Segment
• Secondary Segment
	• 1.7 Million patients
	• Core segments represents ~1 Million patients
	• Core Segment Demos:
	  • Average age 50 yrs
	  • 50/50 male / female
	  • Employed
	  • More educated
	  • Income $60K/yr
	  • Insured
	• Secondary target represent 23% increase in opportunity ~400K patients
		• Inertia to treat
		• Despite wanting to be Hep C free- many told and believe its OK to wait
		• Tolerable and short treatment option is highly motivating
		• INF free regiments are even more motivating
		• Secondary target will need a more discrete treatment- INF free
			• Engage patients to re-think their Hep C
			• Activate urgency to treat
			• Drive linkage to treating specialist
			• Ask provider for treatment by name
				High

Patients- Starting / On Therapy	• Same Relevant Attributes as Consumers Diagnosed	• Need for higher touch education and support	• Provide education and support to access and complete treatment	High
Patients- At Risk of HCV	• Total Prevalence 4.2 Million people • CDC criteria for screening • CDC criteria for HCV risk factors for targeting • Same behavioral and demographic segmentation criteria as diagnosed population • ~75% or prevalent universe are within core targeting opportunities	• TBD	• Expand knowledge of being at risk of HCV • Increase self selection for proactive HCV screening • Link patients to appropriate testing methods and care if positive diagnosis	Medium

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Key Customer Groups: Advocates and Community

Customer Group	Advocates and Community			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objective**	**Priority**
Community KOL/Advocates	• Influential leaders in US HCV Community (~100) • Some may currently have or previously had HCV infection	• To activate Community KOLs provide access to clinical data and key Gilead staff • To activate urgency for treatment educate on evolving treatment paradigm	• Provide accurate information on evolving treatment • Generate urgency for testing, care and treatment • Shift discussion from pricing to benefits of treatment • Advocate for broad access/reimbursement to optimal care and treatment • Inspire new advocacy; identify new advocates/networks	Medium
Community Service Providers and Allied HCPs in Clinical Settings	• Community service workers in CBOs and community health centers (9,000+ CHCs)	• To activate CHWs need to educate about evolving treatment paradigm, cure, importance of linkage to HCV care	• Provide accurate information on evolving treatment • Reset urgency for HCV treatment • Link patients to testing, care and treatment • Increase awareness of HCV risk factors, need for testing • Support adherence	Low-Medium

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Key Customer Groups: Payers

Customer Group	Payers			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objectives**	**Priority**
Commercial	• ~40% of treated HCV patients will continue to fall under commercial coverage (58-65 M patients, assuming growth of overall treated population) • Low, medium, and high control access policies	• Least restrictive customer segment, more inclined to provide parity access but differential tiers can exist • Adherence and data focus predominates • Levels of control determine message emphasis	• Preserve parity access policies that minimize HCP barriers to choosing to treat HCV, and to treat with LDV/SOF (GT1) and SOF (GT 2, 3) patients • Achieve acceptable PA criteria for SOF and LDV/SOF based on label and realistic payer expectations for patient volume in majority of tier one accounts: establish an understanding of who to treat today and maintain PA criteria and policies to enable this • Achieve payer recognition of the clinical and economic advantages of LDV/SOF above and beyond SVR, including cost offsets	High
Medicare	• Will grow to ~16% of treated patient population with aging of baby boomer population • HCV population more likely to qualify for cost sharing subsidies	• Data (MAPD) and cost (PDP) focus predominates • Emerging screening and quality measures will influence this segment but no HCV measures exist today • Slower formulary review cycle	• Preserve parity access policies that minimize HCP barriers to choosing to treat HCV, and to treat with LDV/SOF (GT1) and SOF (GT 2, 3) patients • Achieve acceptable PA criteria for SOF and LDV/SOF based on label and realistic payer expectations for patient volume in majority of tier one accounts: establish an understanding of who to treat today and maintain PA criteria and policies to enable this • Achieve recognition of the real-world clinical and economic advantages of LDV/SOF and the long-term cost effectiveness of treating HCV within Medicare population • Drive meaningful uptake of metrics to support HCV screening and establish linkage to care and treatment	High
VA	• Will reflect ~10% of the treated patient pool • Significant momentum to treat	• Relatively closed system allows for strong case management of patient • Cost and data (VA-specific experience) considerations predominate	• Obtain appreciation for the real-world clinical advantages of LDV/SOF in this unique patient population • Recognize the long-term cost effectiveness of treating HCV and augment government affairs efforts for increased HCV funding • Enhance relationship between Gilead and VA to understand their needs around managing HCV; leverage insights from key VA opinion leaders into future programming	High

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Key Customer Groups: Payers

Customer Group	Payers			
Subgroups	**Relevant Attributes**	**Key Insights**	**Behavioral Objective**	**Priority**
Medicaid	• While this will grow to ~15% of the treated population, coverage may continue to be challenging based on state-level budget constraints	• Highly variable market based on state prevalence and budget considerations for access • Highly cost constrained and predominately cost-focused • May delay formulary review	• Preserve parity access policies that minimize HCP barriers to choosing to treat HCV, and to treat with LDV/SOF (GT1) and SOF (GT 2, 3) patients • Achieve acceptable PA criteria for SOF and LDV/SOF based on label and realistic payer expectations for patient volume in majority of tier one accounts: establish an understanding of who to treat today and maintain PA criteria and policies to enable this • Achieve appreciation for the real-world clinical advantages of LDV/SOF in this unique patient population and the value of achieving cure	Medium
Corrections	• Reflects only 5% of treated patient population unless impetus to treat is unlocked • Most managed and most cost conscious segment	• Significant cost considerations and very tight management controls can influence other segments • Driven by litigation • Structural challenges make all-oral regimens more attractive	• Unlock desire to treat incarcerated population • Form strong linkages to community caregivers to maintain continuity of care and enhance opportunity to treat CHC patients who are not treated in prison	Low - Med
Exchange	• Only ~6% of treated patients will come from exchange plans by 2016	• Coverage mirrors MC Medicaid or Commercial plans, but is generally more restrictive, and with higher cost-sharing. • Will continue to be a rapidly evolving landscape as patient enrollment trends emerge	• Monitor formulary coverage mandates within ACA for exchanges • Preserve open (parity) access policies for HCV products that minimize HCP barriers to treat HCV, and to treat with LDV/SOF • Achieve recognition of the clinical advantages of LDV/SOF above and beyond SVR	Low
Integrated Delivery Networks	• Most integrated systems can mine data across the health system for a comprehensive view of HCV treatment	• May view management of HCV in different terms, depending on risk (i.e. product preference, willingness to expand treater base and engagement in screening)	• Identify potential organizations to implement collaborative community-based HCV awareness initiatives for brand team consideration	Low – Med (depending on risk)

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Q2'14 – Q1'15 Tactical Plan Overview

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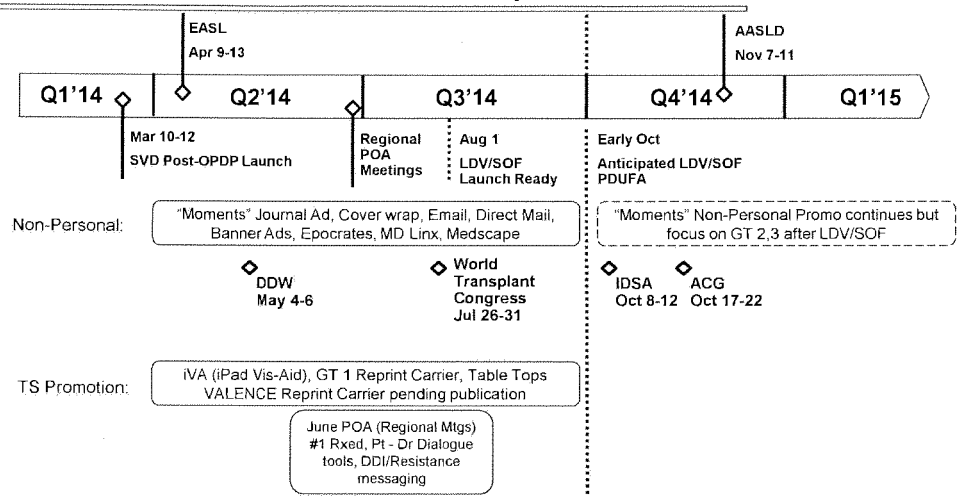
① HCP Promotion Tactical Plan Summary (SOVALDI): Drive depth and breadth of SVD adoption as new backbone



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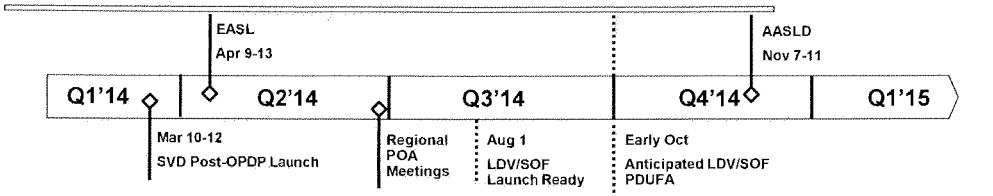
SOVALDI and LDV/SOF HCP Promotion – For Discussion



Non-Personal:	"Moments" Campaign Deliverables	LDV/SOF Now Approved "Moments" for GT 2,3
TS Promotion	SOVALDI Promotion	LDV/SOF (flexibility to incorporate SOF as needed)
	Q3 POA June Regional Mtgs	

Q3 Objective for SVD TS promotion:
- Promote SVD while maintaining credibility
  - Adapt messaging based on HCP segment
  - Evaluate re-targeting opportunities to increase R/F to community HCP's and ID's who are less likely to be waiting
- Secondary objectives:
  - Prepare for LDV/SOF and Abbvie launches

Rationale:
- LDV/SOF – larger opportunity and competitive threat; critical launch
- SVD – GT 2/3 will have no anticipated competitive threat and at least 20% IC required for meaningful TS promotion

Considerations:
- Transplant and co-infection population – only SVD is anticipated to have this indication in 2014, but like GT 2/3 still no competitive threat in these patient types

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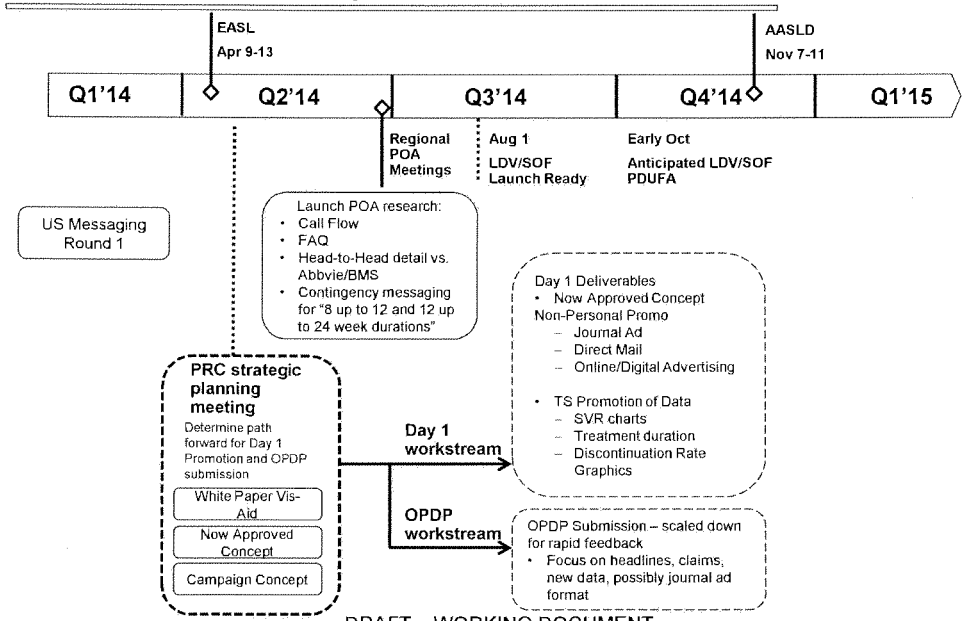
② HCP Promotion Tactical Plan Summary (LDV/SOF): Establish LDV/SOF as preferred "standard of cure" in GT 1



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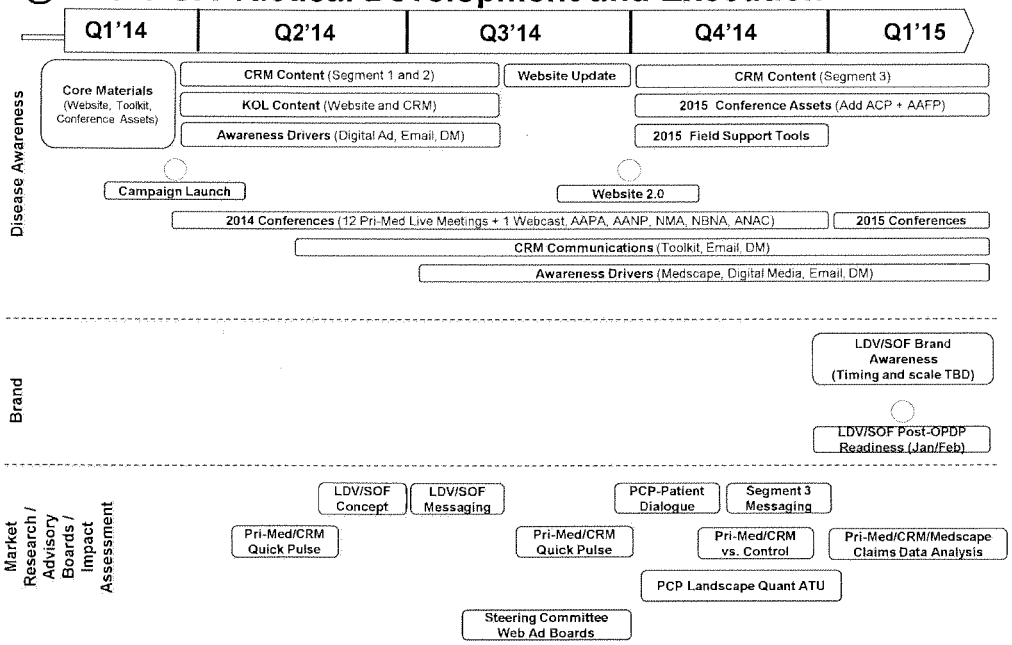
③ PCP POA Tactical Development and Execution



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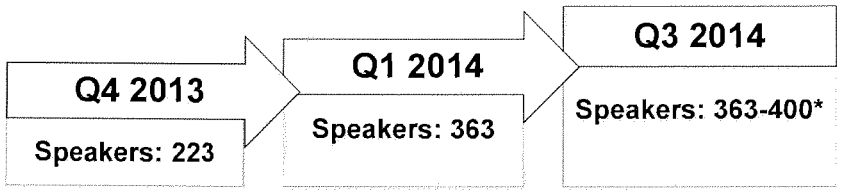
Speaker Faculty and Training



Estimated number of HCV speaker programs in 2014

Estimated # of Speaker Programs	TS's	Programs per TS	Speakers	Programs per Speaker
2,500-2,750†	144	17-19	363-400	7-8

† Does not include managed markets – estimate 250 additional programs. We are currently tracking high at 940 programs per quarter.

*Incremental addition of local and regional speakers; and to replace speakers that may no longer be able to conduct industry sponsored programs

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OLP: LDV/SOF Speaker Bureau Launch Plan

- Execute 1st LDV/SOF speaker program within 13 days of approval
  - LDV/SOF PI deck PRC approved within 2 days of approval
  - Webcast all speakers on LDV/SOF PI deck within 7 business days of approval
- LDV/SOF Satellite broadcast within 13 business days of approval
- Launch LDV/SOF PI Roundtable within 1 month of approval
- Partnership with Managed Markets to develop speaker content for payer audience

1735

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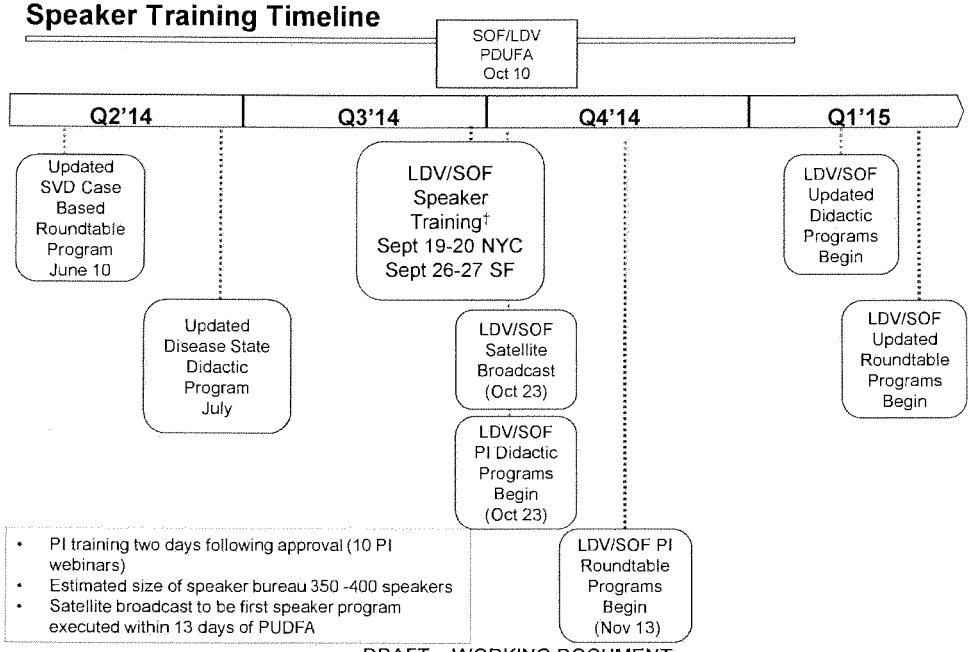
Speaker Training Timeline



- PI training two days following approval (10 PI webinars)
- Estimated size of speaker bureau 350 -400 speakers
- Satellite broadcast to be first speaker program executed within 13 days of PUDFA

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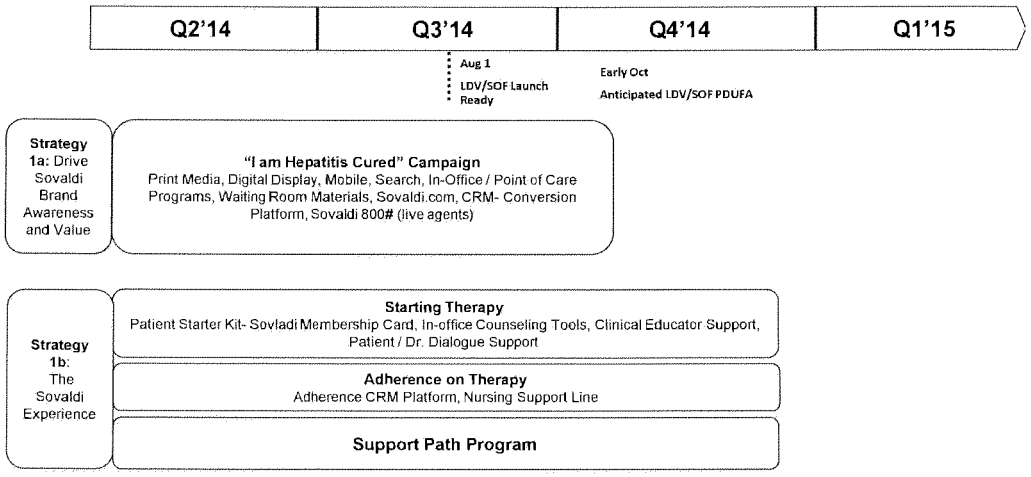
Consumer/Patient/Community Tactical Plan Summary



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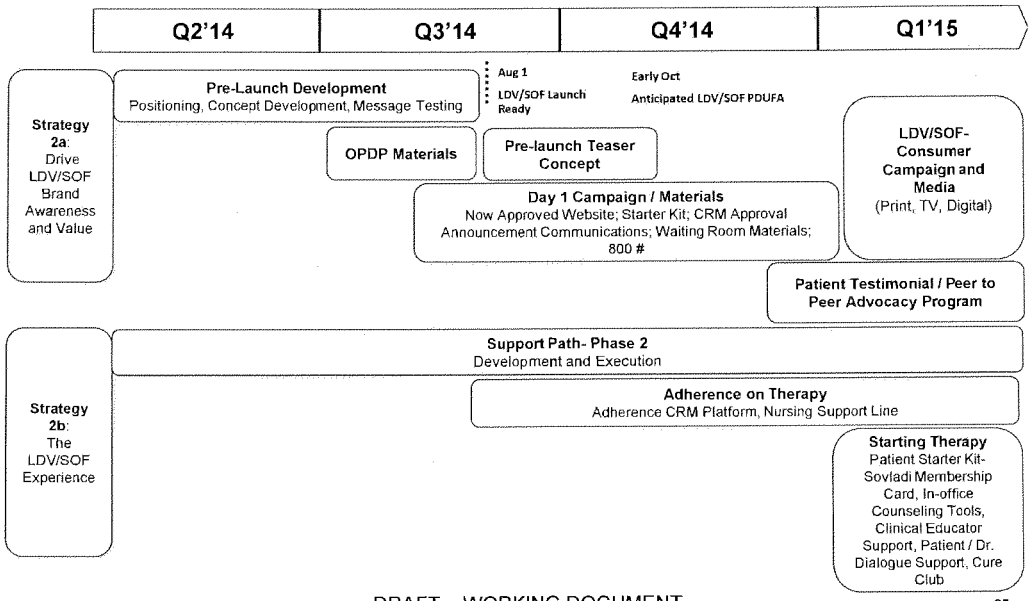
Consumer/Patient/Community Tactical Plan Summary



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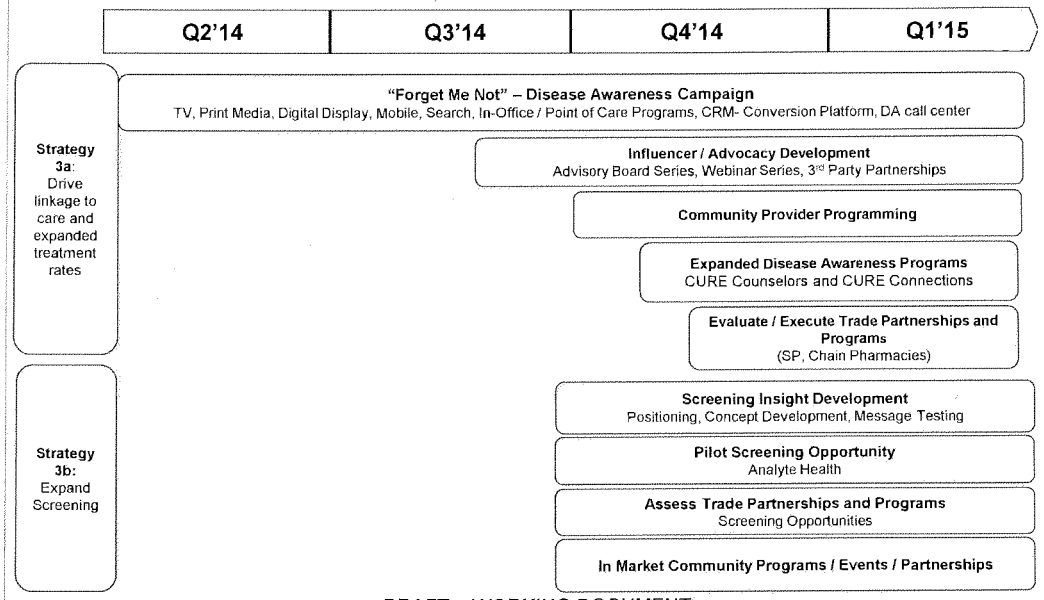
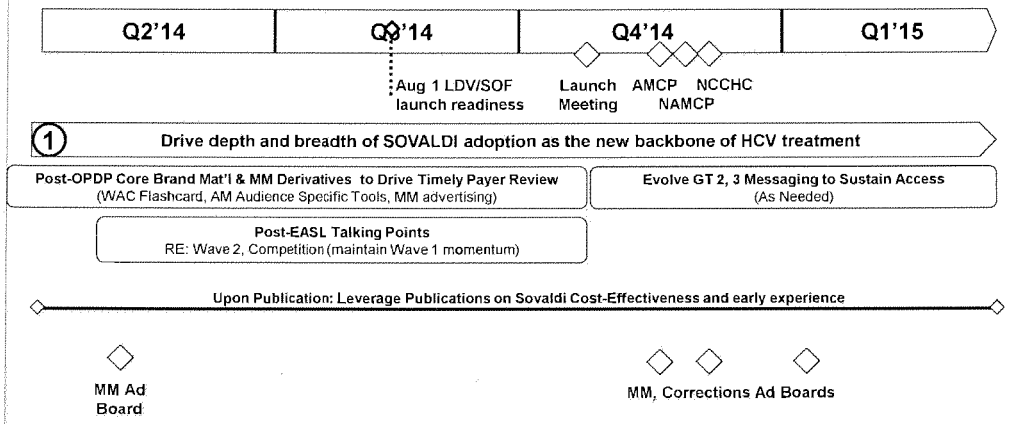
Consumer/Patient/Community Tactical Plan Summary



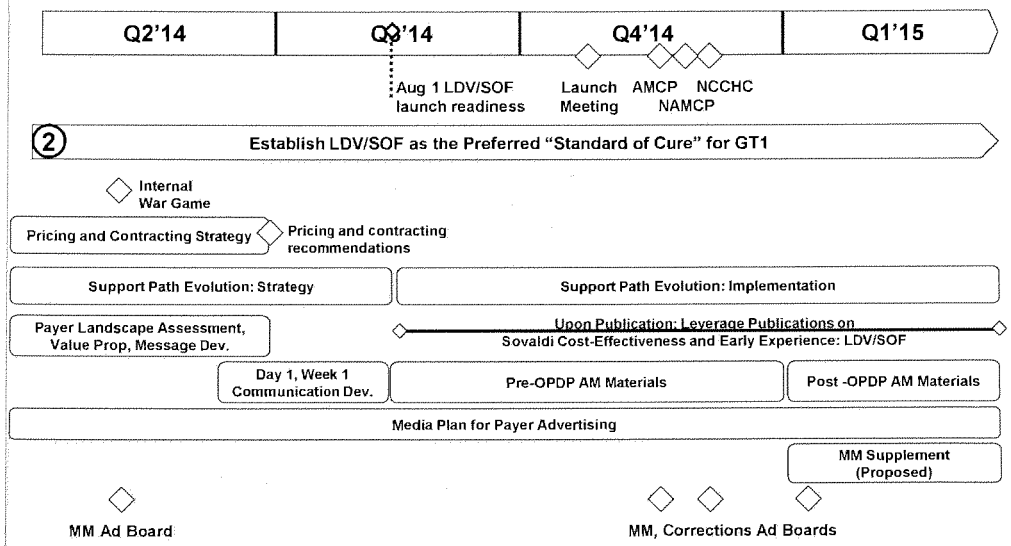
GILEAD

Managed Markets Tactical Plan Summary



GILEAD

Managed Markets Tactical Plan Summary



GILEAD

Managed Markets Tactical Plan Summary

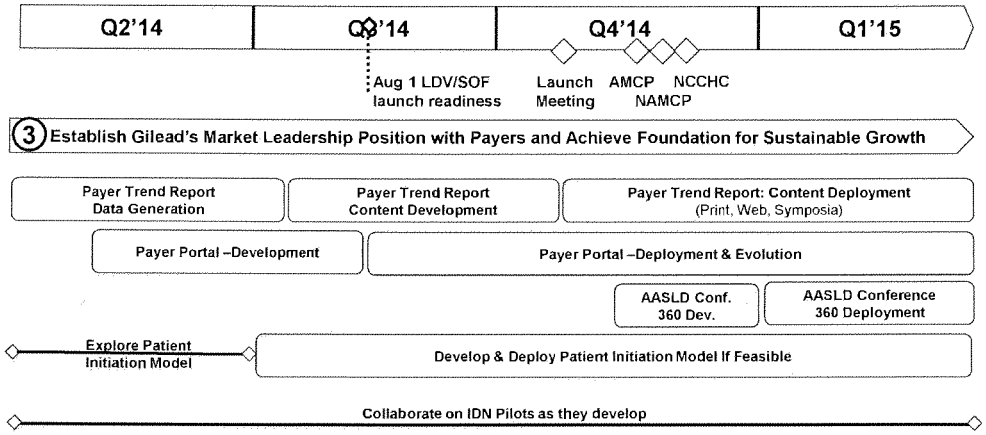


Exhibit 49

Updated Slides – Wave 2 Pricing

Contents

GILEAD

- **Wall Street expectations**
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While most analysts reports we reviewed did not comment on LDV/SOF price expectations, those who have show a fairly wide range of estimates

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	ANALYST	LDV/SOF PRICE EXPECTATION*	COMMENTARY
PREMIUM TO SOV	Wells Fargo	Less than $150K/course	"We believe the potential for considerably lower costs for the sofosbuvir/ledipasvir regimen [than COSMOS] as well as the likely availability of an alternative will help reduce the vociferousness of payer concerns"
PREMIUM TO SOV	Baird	$120K/12 wks	"We expect the eight-week combo regimen to be priced at $80k ($120k for the 12-week regimen)."
PREMIUM TO SOV	Bernstein	Sovaldi + 10-15% ($92-97K)	"For their coming combination, Gilead continues to suggest that most of the value of the combination will come from the Sovaldi component, which suggests that the ultimate price will be in the range of Sovaldi + 10-15%."
PREMIUM TO SOV	Cowen	$1,100/day ($92.4K/12 weeks)	"We estimate a price per day of $1,100, or $61.6K for a 56 day course."
DISCOUNT TO SOV	Nomura	$70K/patient (effective net)	"Our revised estimates are based on avg price per patient of $70k, below Sovaldi's $84k and payer expectations for combination prices of $120-150"
DISCOUNT TO SOV	Deutsche Bank	Slightly more than $65K/cure	"With shorter duration as a possibility, we think the street may be under-estimating the pricing of Gilead's all oral combo. The street is currently expecting pricing of the new pill to be $65K (~20% discount from current per cure pricing)."

Most analysts (JP Morgan, UBS, RBC, Citi, Credit Suisse, BMO, Leerink, Jeffries, Goldman Sachs, Guggenheim, William Blair, Maxim, Needham) did not identify an expected price range for LDV/SOF in the reports we reviewed.

**Note: Unless noted of the slide reports did not explicitly state whether price expectations were gross or net.*

Source: Analyst reports dated 7/17/14, 7/23/14, or 7/24/14

There are several possible ways analysts might interpret Gilead's pricing decision for LDV/SOF, with varying impact on estimated earnings

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POTENTIAL IMPACT ON ESTIMATED EARNINGS

LDV/SOF PRICED BELOW EXPECTATIONS

- Analysts may interpret a lower-than-expected LDV/SOF price in one or more ways:
  - Gilead acquiescing to payer/public push-back on Sovaldi launch pricing
  - Gilead forecasts suggest higher-than-expected demand, making up for WAC discount
- If analysts favor the former explanation, they are likely to lower earnings estimates

LDV/SOF PRICED ABOVE EXPECTATIONS

- If analysts feel that Gilead's pricing decision is designed to maximize revenue based on well-validated forecasts, earnings estimates could increase
- However, there is a risk that analysts will see LDV/SOF's price as outpacing its clinical value, creating risk

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Ipsos data on viral load

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Distribution of patients latest viral load (weighted)

Seven Quarter Average (Q3'12 – Q1 '14)

	Naïve	Exp
Base	3,750	1,419
<= 6m IU/mL	89%	86%
	3,339	1,227
> 6m IU/mL	411	195
	11%	14%

	Q3'12		Q4'12		Q1'13		Q2'13		Q3'13		Q4'13		Q1'14	
	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp	Naïve	Exp
Base	352	151	495	196	554	217	594	249	601	211	542	214	612	181
<= 6m IU/mL	328	129	427	174	499	188	518	220	534	173	489	187	544	156
	93%	85%	86%	88%	90%	87%	87%	89%	89%	82%	90%	87%	89%	86%
> 6m IU/mL	25	23	67	23	55	29	76	29	68	38	52	28	68	25
	7%	15%	14%	12%	10%	13%	13%	11%	11%	18%	10%	13%	11%	14%

Base: all naïve/experienced untreated patients with known latest viral load (weighted)

Source: Ipsos HCV TM

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Aside from payer access and physician demand, there are a number of issues that could affect Gilead's final pricing decision

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Stake-holders	Potential issues	Likelihood of issues across LDV/SOF prices (12 weeks)			
		$84K	$96K	$108K	$120K
Payers	Difficult payer conversations for NAMs with LDV/SOF because of Sovaldi budget concerns	Very Likely	Very Likely	Very Likely	Very Likely
	Payer scrutiny of HCV increases beyond current (very high) levels due to LDV/SOF launch price	Possible	Possible	Possible	Likely
	Payers and PBMs, such as Express Scripts, actively issue RFPs for preferred products (1 of 1)	Possible	Possible	Likely	Very Likely
	Payers request significant rebates off of WAC	Very Likely	Very Likely	Very Likely	Very Likely
	Subset of restrictive payers seek to contain HCV budget impact by limiting treatment to higher-severity subpops	Likely	Likely	Likely	Very Likely
	State Medicaid's set bundled payments for treatment of HCV	Possible	Possible	Possible	Possible
	Negative spill over to Sovalidi or other Gilead therapeutic areas	Possible	Possible	Possible	Possible
	Public and Private Payer Attribute premium increases or earnings misses to HCV	Very Likely	Very Likely	Very Likely	Very Likely
Physicians	Lost KOL support / endorsement due to price	Unlikely	Unlikely	Possible	Likely
	Public KOL outrage over LDV/SOF price	Possible	Possible	Likely	Very Likely

*Guideline changes due to price are unprecedented

Aside from payer access and physician demand, there are a number of issues that could affect Gilead's final pricing decision

Stake-holders	Potential issues	Likelihood of issues across LDV/SOF prices (12 weeks)			
		$84K	$96K	$108K	$120K
Advocacy	Pricing petitions and protests from patient advocates / advocacy groups	Very Likely	Very Likely	Very Likely	Very Likely
Guidelines	IDSA/AASLD guidelines disadvantage LDV/SOF due to price*	Unlikely	Unlikely	Unlikely	Possible
	Guidelines include a "Who and When to Treat" section to address the issue of healthcare resources and societal cost	Very Likely	Very Likely	Very Likely	Very Likely
Other	Further letters from Congress regarding LDV/SOF price	Very Likely	Very Likely	Very Likely	Very Likely
	LDV/SOF pricing is scrutinized because of expected significant differences in price between the US and rest of world	Very Likely	Very Likely	Very Likely	Very Likely
	Discussions of US government price controls gain traction	Possible	Possible	Possible	Possible
	Dollar per pill gets negative headlines (>$1000 per pill)	Very Likely	Very Likely	Very Likely	Very Likely
	Dollar per script gets negative headlines (>$28,000 per bottle)	Very Likely	Very Likely	Very Likely	Very Likely
Competitors	AbbVie launches at a significant WAC discount to LDV/SOF	Unlikely	Unlikely	Possible	Likely
	AbbVie aggressively offers discounts to try and gain preferential access at select accounts	Very Likely	Very Likely	Very Likely	Very Likely
	BMS (DCV+SOF) launches at a significant WAC discount to LDV/SOF	Not Possible	Unlikely	Unlikely	Possible
	BMS aggressively offers discounts to try and gain preferential access at select accounts	Possible	Possible	Very Likely	Very Likely

*Guideline changes due to price are unprecedented

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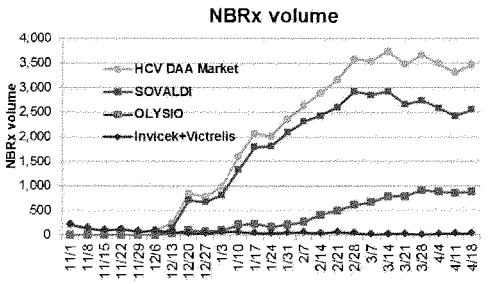
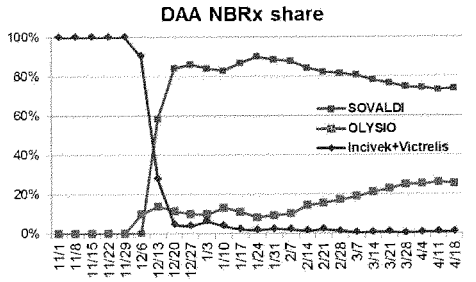
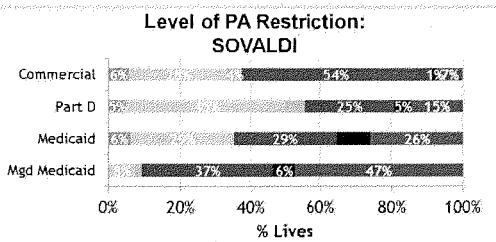
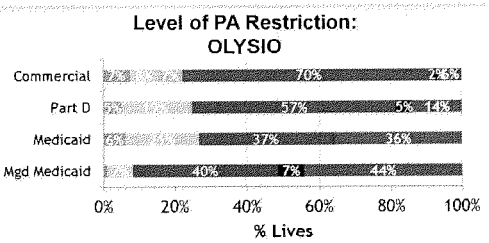
Executive Summary: National Key Performance Indicators









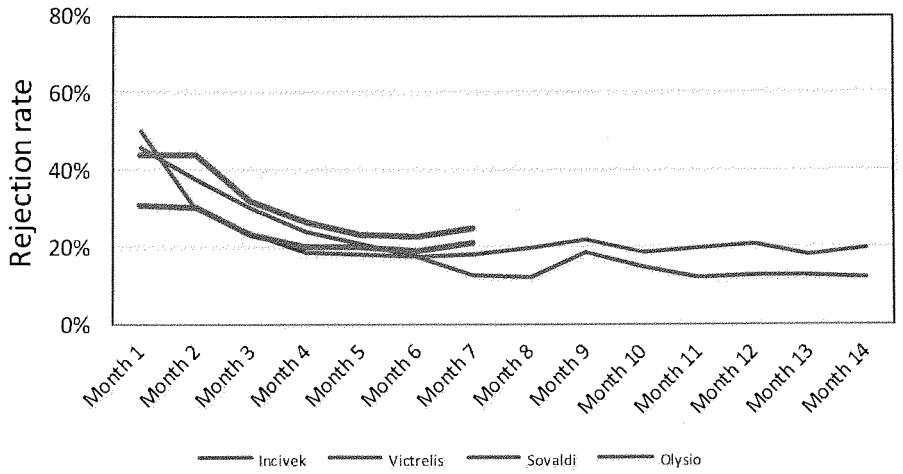
1. Source of NBRx Trends: IMS NMRx Data; week ending xx/xx/xxxx
2. Source of Level of PA Restriction Heat map: Zitter Group; week ending 06/06/2014
3. Low: PA consistent with or broader than label, little/no enforcement of preferred agents (if preferred agent specified)
4. Medium: Preferred agent specified through differential tiering, mandates specialty pharmacy distribution
5. High: Requires liver biopsy and evidence of progressed disease, fill of < 30 days or total quantity limits < duration of therapy, documentation of INF-ineligibility
6. This may include a mix of interim and final policy decisions, based on what can be validated by Zitter. This data set surveys 450 plans nationwide, both regional and national plans.

Updated Data MONTHLY

SHA

Managed Care: Launch Aligned Rejection Rates

Overall Rejection Rate



1. Source: SHA Patient Claims Data; Jun'14 Data Month
2. Data has been launch aligned. Time Period for Incivek & Victrelis: May'11-Jun'12; Sovaldi & Olysio: Dec'13-Jun'14
3. Both, New and Refill claims have been taken into account.

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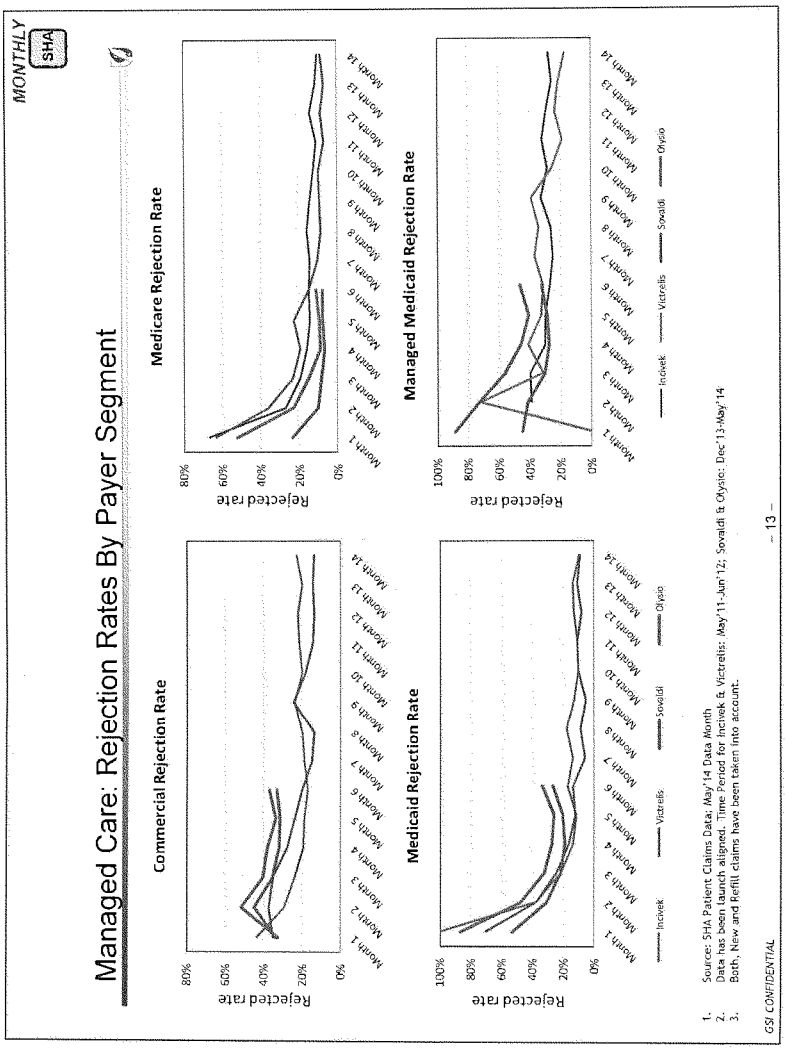
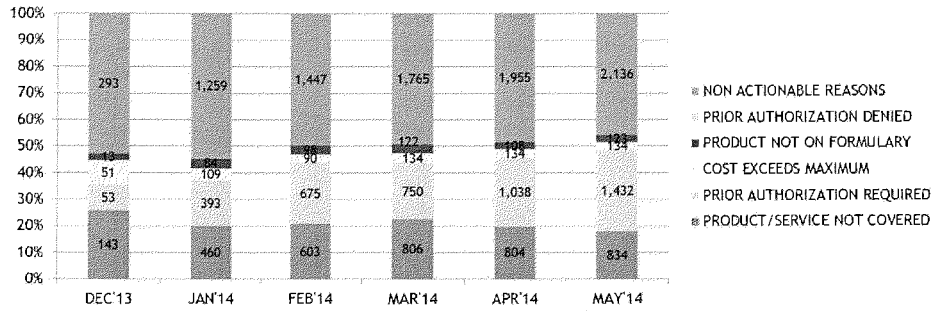


MONTHLY

SHA

Managed Care: Top Rejection Reasons

For Sovaldi, across all payer segments



REJECTION REASON	DEC'13	JAN'14	FEB'14	MAR'14	APR'14	MAY'14
Actionable Reasons	**47%**	**45%**	**50%**	**51%**	**52%**	**54%**
Prior Authorization Required	10%	17%	23%	21%	26%	31%
Product/Service Not Covered	26%	20%	21%	23%	20%	18%
Cost Exceeds Maximum	9%	5%	3%	4%	3%	3%
Product Not On Formulary	2%	4%	3%	3%	3%	3%
Non-Actionable Reasons	**53%**	**55%**	**50%**	**49%**	**48%**	**46%**
Product/Service Not Appropriate For This Location	10%	12%	11%	10%	10%	10%
Pharmacy not contracted with plan on date of service	6%	6%	4%	4%	8%	6%
Non-matched Pharmacy number	8%	11%	10%	7%	5%	5%
Must fill through specialty pharmacy	1%	9%	7%	7%	5%	5%

1. Source: SHA Patient Claims Data; May'14 Data Month
2. Direct feed claims not included. Only Final claims have been included for the analysis
3. % = Rejection due to a reason / Total rejections in a month

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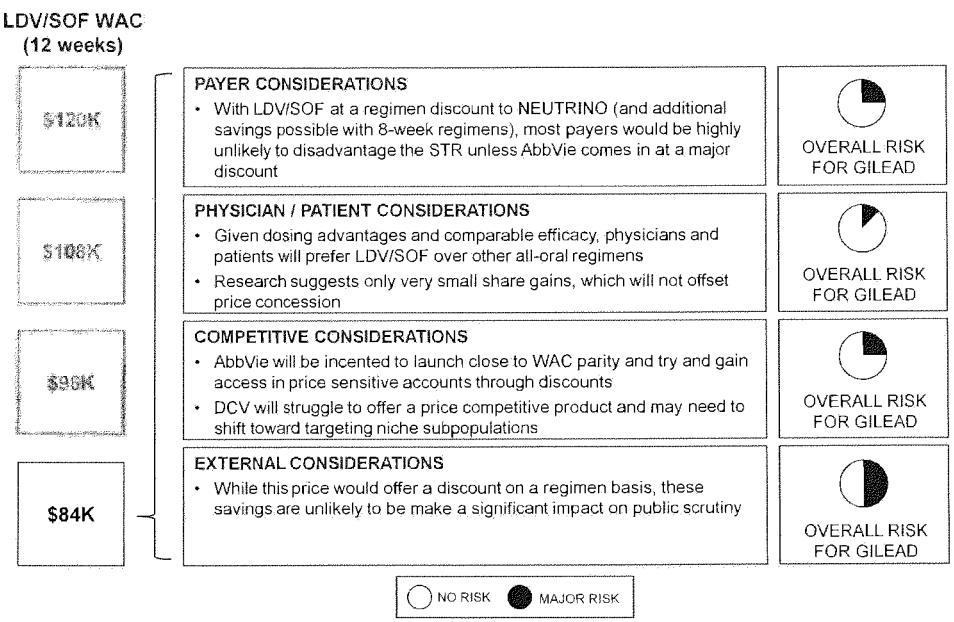
With LDV/SOF at $84K, and Abbvie at a similar WAC, some restrictive payers may seek to prefer AbbVie, but most will seek to contract for parity

GILEAD



At $96K, some restrictive payers may seek to prefer AbbVie, but most will seek to contract for parity

GILEAD

LDV/SOF WAC (12 weeks)

- $120K
- $108K
- **$96K**
- $84K

PAYER CONSIDERATIONS
- Given that 12-week LDV/SOF would be at regimen parity to NEUTRINO with potential savings at 8 weeks, most payers will not seek to restrict access, although certain high-control plans could prefer another regimen if rebates are high enough

OVERALL RISK FOR GILEAD

PHYSICIAN / PATIENT CONSIDERATIONS
- Given dosing advantages and comparable efficacy, physicians and patients will prefer LDV/SOF over other all-oral regimens
- The potential for 8-week treatment for some TN-NC patients will provide another advantage over AbbVie in this segment

OVERALL RISK FOR GILEAD

COMPETITIVE CONSIDERATIONS
- AbbVie will be incented to launch close to WAC parity and try and gain access in price sensitive accounts through discounts
- Implied value of DCV ~$12k, BMS may need to shift toward targeting niche subpopulations

OVERALL RISK FOR GILEAD

EXTERNAL CONSIDERATIONS
- Scrutiny from payers, advocacy groups, and media can be expected to continue near current levels given the premium relative to Sovaldi; payer savings from 8-week regimens or contracting will not have a major impact on public discourse

OVERALL RISK FOR GILEAD

○ NO RISK ● MAJOR RISK

At $108K, WAC competition from AbbVie may be become slightly more likely; some payers may impose hard steps against SOF/LDV

GILEAD

LDV/SOF WAC (12 weeks)

- $120K
- **$108K**
- $96K
- $84K

PAYER CONSIDERATIONS
- At $108K, restrictive payers will seek to contract with AbbVie for preferred status which may be implemented via hard steps
- However, lost share is unlikely to outweigh gains in revenue resulting from the increase in LDV/SOF WAC

OVERALL RISK FOR GILEAD

PHYSICIAN / PATIENT CONSIDERATIONS
- While preferences will still favor LDV/SOF, physicians will shift prescribing to AbbVie in the event of LDV/SOF restrictions
- While a few LDV/SOF patients may be managed to alternative therapies, research does not suggest this impact would be significant

OVERALL RISK FOR GILEAD

COMPETITIVE CONSIDERATIONS
- AbbVie has greater flexibility to offer net discounts
- BMS has more pricing flexibility, if DCV+SOF gains in the market the resulting SOF revenue may buffer against AbbVie losses

OVERALL RISK FOR GILEAD

EXTERNAL CONSIDERATIONS
- Public scrutiny of Gilead pricing may be prolonged if LDV/SOF crosses the $100K threshold, although the overall impact on management, uptake, and Gilead reputation is unlikely to diverge from expectations at lower price points

OVERALL RISK FOR GILEAD

NO RISK MAJOR RISK

At $120K, WAC competition from AbbVie becomes more likely; more payers may impose hard steps against SOF/LDV

GILEAD

LDV/SOF WAC (12 weeks)

$120K

PAYER CONSIDERATIONS
- At $120K, LDV/SOF will be pushing the upper limit of value for many payers, and may expand implementation of hard steps into larger, typically less cost-sensitive plans
- However, blocked access remains unlikely for most at prices <$150K

OVERALL RISK FOR GILEAD

$108K

PHYSICIAN / PATIENT CONSIDERATIONS
- While physician and patient perceptions of LDV/SOF's clinical value will remain strong, the increased frequency of hard steps may shift physician prescribing away from LDV/SOF (even in TN-NC) in order to pre-empt potential access hurdles

OVERALL RISK FOR GILEAD

$96K

COMPETITIVE CONSIDERATIONS
- AbbVie has greater flexibility to offer net discounts and may start considering significant WAC discounts based on market reaction
- BMS has more pricing flexibility, if DCV+SOF gains in the market the resulting SOF revenue may buffer against AbbVie losses

OVERALL RISK FOR GILEAD

$84K

EXTERNAL CONSIDERATIONS
- Public scrutiny may be slightly intensified at $120K, although the tone and tenor of media coverage, payer statements, and advocacy groups would not be expected to differ significantly from expectations at $108K

OVERALL RISK FOR GILEAD

NO RISK MAJOR RISK

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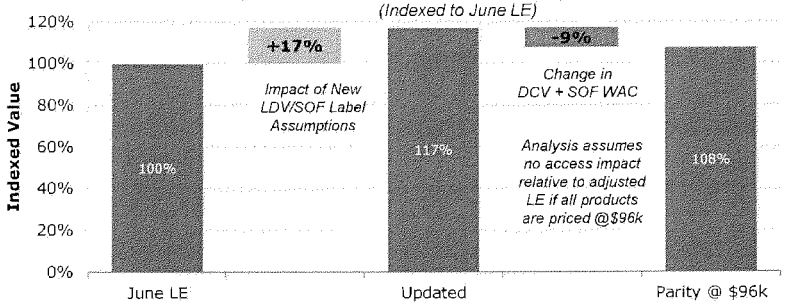
Base Case Assumptions have changed since the June LE (1 of 2)

GILEAD

Change in Gilead HCV Franchise Net Revenue 2015 – 2017



	June LE	Updated durations	Parity @ $96k
12 Week WAC Launch Price			
LDV/SOF	106.5	106.5	96
Weighted Average WAC Launch Price			
LDV/SOF	87	109	98
2015 GT1 Share			
Other SOF	0%	0%	0%
LDV/SOF	59%	59%	59%
DCV+SOF	15%	15%	15%
Other DCV	2%	2%	2%
AbbVie	24%	24%	24%
% Patient Split by Duration (LDV/SOF)			
8 Weeks	52%	21%	21%
12 Weeks	48%	70%	70%
24 Weeks	0%	9%	9%

*Includes revised GTN assumptions updated July 2014 by Gilead finance, impact <1%

Base Case Assumptions have changed since the June LE (2 of 2)

GILEAD

The "Parity @$96k has been used as the point of comparison for alternative WAC and competitive scenarios. This case assumes no access impact relative to adjusted LE if all products are priced @$96k

	Net Revenue ($ MM)			Treated Pts (000s)		
	2015	2016	2017	2014	2015	2016
June LE Forecast		**Redacted**				Redacted
Sovaldi	$2,715			39	35	
LDV/SOF	$5,944			92	79	
DCV+SOF (Gilead)	$1,790			31	26	
Total	**$10,450**			**162**	**140**	
Updated Durations*	12,305			162	140	
Delta from June LE:	*1,855*			-	-	
Parity @ $96k	11,565			162	140	
Delta from New Durations:	*(739)*			-	-	

*Impact of New LDV/SOF Label Assumptions includes revised GTN assumptions updated July 2014 by Gilead finance, impact <1%

Source: IMSCG analysis based on primary market research and Gilead March LE 2014 forecast. Note: IMSCG did not develop and has not validated Gilead patient forecast

The team examined eight competitive pricing scenarios and their impact on Gilead's Wave 2 US pricing

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- The team created a dynamic pricing model combining the base case assumptions from June LE, the impact of changes in labeled duration, multiple price and rebate levels for Gilead, AbbVie and BMS, payers reaction to price and rebate decisions and physician reaction to payer restrictions

		LDV/SOF strategy		AbbVie strategy		AbbVie net delta to LDV/ SOF	BMS strategy	
		12 wk WAC	Rebate	12 wk WAC	Rebate		12 wk WAC *DCV / SOF+DCV*	Rebate
	Parity environment	$96K	Redacted	$96K	Redacted	Redacted	$12K / $96K	Redacted
What if AbbVie discounts (Net vs. WAC)?	**AbbVie ~10% WAC discount**	$96K		$84K			$12K / $96K	
	AbbVie ~10% net discount	$96K		$96K			$12K / $96K	
What if AbbVie enters at a discount?	**AbbVie discounts (WAC $72k)**	$96K		$72K			$12K / $96K	
	AbbVie 20% net discount	$96K		$96K			$12K / $96K	
	AbbVie discounts (WAC $60k)	$96K		$60K			$$12K / $96K	
What if Gilead enters higher?	**LDV/SOF @$108K**	$108K		$96K			$26K / $110K	
	LDV/SOF @$108K; AbbVie low	$108K		$60K			$26K / $110K	

Note: For consistency, in scenario names prices are quoted at 12 week durations

Impact of WAC pricing and competitive scenarios on revenue and patients

GILEAD

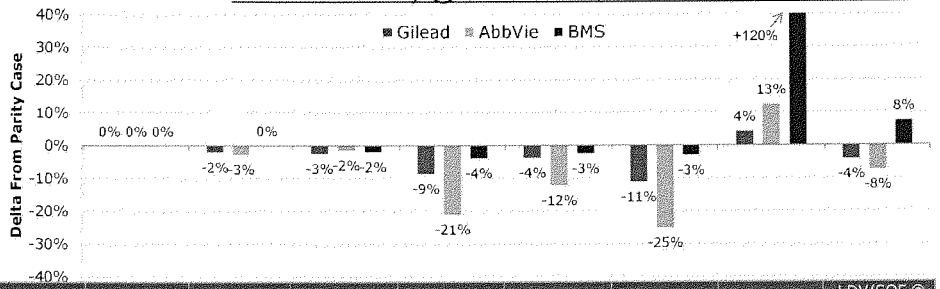
	Net Revenue ($ MM)			Treated Pts (000s)		
	2015	2016	2017	2014	2015	2016
Parity @ $96k	11,565	**Redacted**		162	140	Redacted
AbbVie -10% WAC	11,290			158	137	
Delta from Parity @ $96	*(275)*			*-2%*	*-2%*	
AbbVie -10% net	11,229			157	137	
Delta from Parity @ $96	*(337)*			*-3%*	*-2%*	
AbbVie @ $72k	10,564			160	139	
Delta from Parity @ $96	*(1,002)*			*-1%*	*-1%*	
AbbVie -20% net	11,065			155	135	
Delta from Parity @ $96	*(500)*			*-4%*	*-3%*	
AbbVie @ $60k	10,253			155	136	
Delta from Parity @ $96	*(1,313)*			*-4%*	*-3%*	
LDV/SOF @ $108k	12,043			157	137	
Delta from Parity @ $96	*478*			*-3%*	*-2%*	
LDV/SOF @ $108k; Abb $60k	11,011			145	128	
Delta from Parity @ $96	*(555)*			*-10%*	*-9%*	

Source: IMSCG analysis based on primary market research and Gilead March LE 2014 forecast. Note: IMSCG did not develop and has not validated Gilead patient forecast

Cross Scenario Summary
Change from Parity Case for Gilead Franchise Net Revenue

GILEAD

Delta from Parity @ $96k Case (2015 – 2017 Net Revenue)



	Parity @ $96k	AbbVie -10% WAC	AbbVie -10% net	AbbVie @ $72k	AbbVie - 20% net	AbbVie @ $60k	LDV/SOF @ $108k	LDV/SOF @ $108k; Abb $60k
Weight Average WAC Launch Price								
LDV/SOF	98	98	98	98	98	98	111	111
DCV	12	12	12	12	12	12	27	12
DCV+SOF	98	98	98	98	98	98	113	98
AbbVie	101	88	101	75	101	63	101	63
Launch Contracting Assumption								
LDV/SOF	**Redacted**							
DCV								
AbbVie								
2015 GT1 Share								
LDV/SOF	59%	57%	56%	59%	55%	55%	56%	46%
DCV+SOF	15%	15%	14%	14%	14%	14%	15%	16%
Other DCV	2%	2%	2%	2%	2%	2%	2%	2%
AbbVie	24%	27%	27%	25%	29%	29%	27%	35%

For additional detail, please see slide 94 & 95

Contents

GILEAD

- Wall Street expectations
- 8wk use patient size (break out 88% for TE and TN)
- Heat map for other considerations
- SOV reversal and rejection data
- Summary at different price points
- Volume and revenue at different pricing points and competitor scenarios
- Wave 1 Impact
- Duration reconciliation

Major payers have been actively adjusting forecasts and working with their state partners to prepare for expected increased HCV spend

GILEAD

PAYER	COMMENTARY
Express Scripts	• Specialty spend is forecasted to increase +63% over the next three years • HCV is expected to be a key driver of this increased spend
Humana	• EPS was lower than the second quarter of last year due to HCV drug costs • Working with states (e.g., Florida, Illinois, Virginia) to fund HCV exposures
Aetna	• Medical cost trends continue to be moderate and consistent with previous range of projections despite HCV cost pressures
WellPoint	• More than doubled HCV costs in pricing for 2014 compared to 2013 and added $100M to that outlook in Q1 2014 • Working with states to incorporate full expected HCV costs into reimbursement rates
Centene	• Net cost impact of HCV in Q2 2014 was $13.7M (compared to $4.2M in Q2 2013 and $7.3M in Q1 2014) • Working with states to include full expected HCV costs into reimbursement rates
United Health Group	• Q2 spend for HCV was "in line with" revised expectations after Q1
WellCare	• HCV drugs have had a meaningful short term budget impact ($0.30 per share in expenses) • Florida is the first state to provide a specific reimbursement agreement for the managed Medicaid lives

Source: Payers' Q2 Earnings Calls, via RBC

HCV is expected to drive a significant increase in 2015 federal Medicare Part D spending and annual individual beneficiary premiums

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Guiding Research Question: What is the cost impact of the new HCV drug therapies on the 2015 individual Medicare Part D program?

Key Findings

Increased 2015 federal Medicare Part D spending

- New HCV drug therapies, including Sovaldi and Olysio, are estimated to increase 2015 federal spending on the individual Medicare Part D program by approximately **$2.9 billion to $5.8 billion**
  - Equivalent to a **6 to 11% increase in spending**

Increased total annual individual Medicare Part D beneficiary premiums

- New HCV drug therapies, including Sovaldi and Olysio, are estimated to increase total annual individual Medicare Part D beneficiary premiums by **$481 million to $965 million in 2015**
  - Equivalent to a **4.3% to 8.6% increase over 2014 beneficiary premiums** or an additional $17 to $33 per beneficiary per year

Key Considerations

- Assumes an average cost of $84,4000 per course of treatment, as no upcoming launch prices are known
- Assumes new HCV drug use rates of 15% to 30% of the 270,000 individual Medicare Part D enrollees estimated to have HCV
- Calculations do not reflect potential savings from reductions in other costs (e.g. treatment of chronic liver disease)

Source: The Impact of New Hepatitis C Drug Therapy on Individual Medicare Part D Spending
Prepared by Milliman for the Pharmaceutical Care Management Association

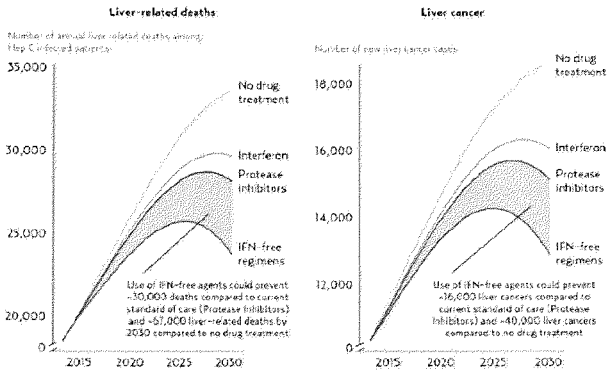
Though the debate about HCV pricing has dominated the media, key organizations have published studies highlighting Sovaldi's benefit

GILEAD

Guiding Research Question: How much better off today and tomorrow are people in the US as a result of the breakthroughs in treating HCV?

Exhibit 5: Impact of treatment innovation on human life

Methodology | Using a model created by the Center for Disease Analysis (CDA), we 'applied' different treatment regimens on today's American Hep C population. By altering SVRs, medical eligibility, and compliance rates, we can illustrate the impact of treatment innovation on morbidity and mortality.



Key assumptions included:
- CTAF's summary of published SVRs and discontinuation risk
- Constant diagnosis rate of 50%
- Constant treatment rate of 59,000 patients/year regardless of treatment regimen

Source: Innovation in Hepatitis C Treatment: New Opportunities for Action
Prepared by the California Healthcare Institute

Key Takeaways

- If **no HCV drugs** were available today, mortality would rise steadily, **claiming nearly 500,000 US lives** from 2013-2030
- However, a switch to the interferon-free regimens shows a **sharp mortality decline around 2025,** such that **67,000 US lives** that would have been lost with no treatment would be saved from 2013-2030
- A switch from protease inhibitors to interferon free regimens yields more than **30,000 lives saved by 2030** (see grey shading)

Contents

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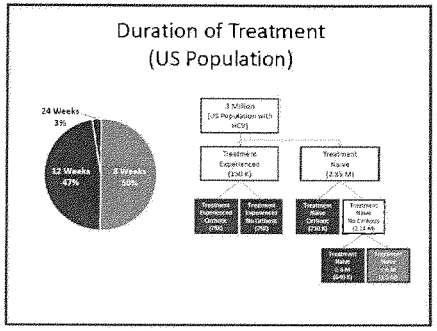
- Wave 1 Impact
- **Duration reconciliation**

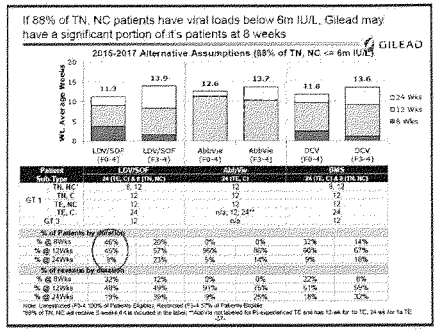
Reconciliation of patient population size by duration 1

GILEAD

Provided by Phil Pang from Clinical Research



Provided by HCV wave 2 pricing team

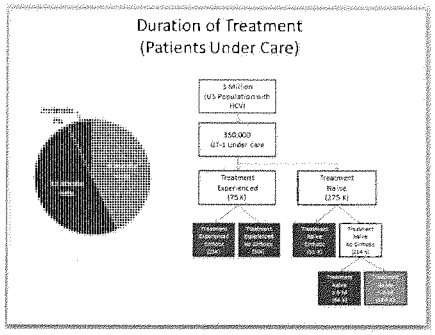


Differences	Clinical Research (8wk-12wk-24 wk: 50%-47%-3%)	Pricing Team (8wk-12wk-24 wk: 46%-45%-9%)
Overall patient population	US HCV Prevalent Patient	June LE treated population, LDV/SOF GT1 and GT3
% Treatment Experienced	150K (NEJM by Holmberg ~300K treated, 50% successful, so ~150K TE)	**31%** Ipsos 2013 4QTR Average(June LE)
% of cirrhotic patients	High level estimation trying to be conservative (TE: 50%; TN: 25%)	**TE: 32%; TN: 21%** Ipsos 2013 4QTR Average(June LE)
% of TN/NC with viral load < 6M IU/mL (8 wks)	~70% based lon 1, 2, 3 (based line HCV RNA 67%, screening HCV RAN 69%)	**~88%** Ipsos Q2 2012 to Q1 2014 currently untreated patients

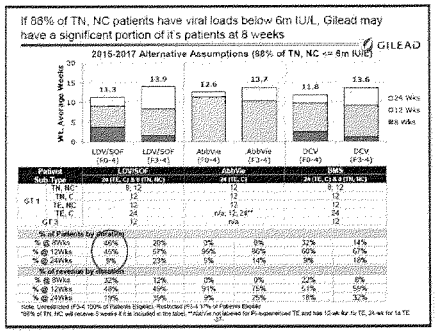
Reconciliation of patient population size by duration 2

GILEAD

Provided by Phil Pang from Clinical Research



Provided by HCV wave 2 pricing team



Differences	Clinical Research (8wk-12wk-24 wk: 43%-50%-7%)	Pricing Team (8wk-12wk-24 wk: 46%-45%-9%)
Overall patient population	US HCV GT-1 Under care 350K	June LE treated population, LDV/SOF GT1 and GT3
% Treatment Experienced	**21%** (75k / 350k)	**31%** Ipsos 2013 4QTR Average(June LE)
% of cirrhotic patients	**TE: 33%; TN: 22%**	**TE: 32%; TN: 21%** Ipsos 2013 4QTR Average(June LE)
% of TN/NC with viral load < 6M IU/mL (8 wks)	**~70%** Ion 1, 2, 3 (based line HCV RNA 67%, screening HCV RAN 69%)	**~88%** Ipsos Q2 2012 to Q1 2014 currently untreated patients

June LE assumptions

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			USA				
			2013 Q2	2013 Q3	2013 Q4	2014 Q1	4 QTR
		Base	721	672	716	727	2836
G1	Treatment Naïve	F0	6%	4%	6%	8%	6%
		F1	18%	17%	13%	15%	16%
		F2	9%	13%	14%	13%	12%
		F3	4%	9%	6%	6%	6%
		F4	9%	11%	13%	12%	11%
	Treatment experienced	F0	1%	1%	2%	1%	1%
		F1	8%	5%	3%	3%	5%
		F2	8%	7%	6%	6%	6%
		F3	3%	2%	3%	5%	3%
		F4	7%	7%	9%	4%	7%
G2	Treatment Naïve		12%	9%	10%	9%	10%
	Treatment Experienced		2%	3%	3%	2%	2%
G3	Treatment Naïve		6%	4%	6%	9%	6%
	Treatment Experienced		4%	4%	2%	2%	3%
Other			4%	4%	5%	6%	5%

The % of TN, NC patients with an HCV viral load <-6m IU/ml is a key uncertainty

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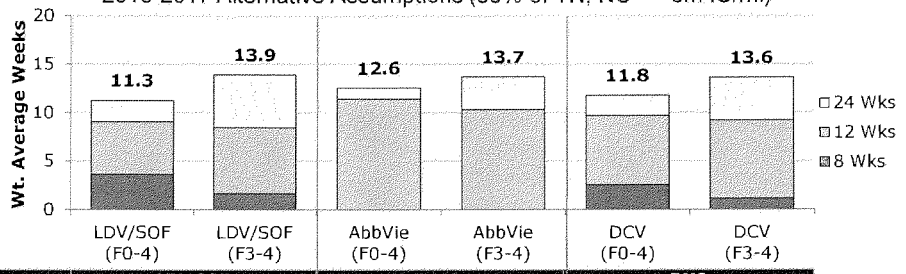
Alternative Assumptions(88% of TN, NC <= 6m IU/ml)

Based on IPSOS data

GT1	% of GT 1*					% GT 1	Duration LDV/SOF	Abb	BMS
TN, NC	55%	<= 6m IU/L	88%			48%	8	12	8
		> 6m IU/L	12%			7%	12	12	12
TN, C	15%					15%	12	12	12
TE, NC	21%					21%	12	12	12
TE, C	10%	PI experienced	33%			3%	24	n/a	24
		Non PI exp.	67%	1a	70%	5%	24	24	24
				1b	30%	2%	24	12	24

If 88% of TN, NC patients have viral loads below 6m IU/ml, Gilead may have a significant portion of it's patients at 8 weeks

GILEAD



Patient Sub-Type		LDV/SOF		AbbVie		BMS	
		24 (TE, C) & 8 (TN, NC)		24 (TE, C)		24 (TE, C) & 8 (TN, NC)	
GT 1	TN, NC*	8; 12		12		8; 12	
	TN, C	12		12		12	
	TE, NC	12		12		12	
	TE, C	24		n/a; 12; 24**		24	
GT 3		12		n/a		12	
% of Patients by duration							
% @ 8Wks		46%	20%	0%	0%	32%	14%
% @ 12Wks		45%	57%	95%	86%	60%	67%
% @ 24Wks		9%	23%	5%	14%	9%	18%
% of revenue by duration							
% @ 8Wks		32%	12%	0%	0%	22%	8%
% @ 12Wks		48%	49%	91%	75%	61%	59%
% @ 24Wks		19%	39%	9%	25%	18%	32%

Note: Unrestricted (F0-4 100% of Patients Eligible); Restricted (F3-4 37% of Patients Eligible
*88% of TN, NC will receive 8 weeks if it is included in the label; **AbbVie not labeled for PI-experienced TE and has 12-wk for 1b TE, 24-wk for 1a TE

-35-

Exhibit 50

Managed Markets
Hepatitis C Virus (HCV)
Payer Advisory Board
Final Report

October 14, 2014

GILEAD Managed Markets Advisory Board

Report Outline

Managed Markets Advisory Board

- Program Overview
- Topline Summary
- Detailed Findings
  - Sovaldi Product Overview and Early Experience
  - AASLD/IDSA Treatment Guidance
  - Economic Burden of HCV, Economics of HCV Treatment, HCV Population Model
  - HCV Treatment Landscape: Emerging Therapies
    - Pricing Worksheet Results
- Evaluations

Program Overview

GILEAD Managed Markets Advisory Board

Gilead Sciences – Confidential and Proprietary

Program Overview
Methodology

Managed Markets Advisory Board

- Unblinded advisory board meeting
- Conducted on:
  - May 2, 2014 at the Westin Michigan Avenue Chicago
- A mix of 12 pharmacy and medical directors were recruited from a targeted list of health plans, specialty pharmacies, integrated health delivery systems, and pharmacy benefit managers

Plan Type	# of Participants
Managed care organization (MCO)	6
Integrated health delivery system (IHDS) / independent physician association (IPA)	3
Pharmacy benefit manager (PBM) / specialty pharmacy provider (SPP)	3

Program Overview
Methodology (cont.)

Managed Markets Advisory Board

- HCV clinical data were presented to gather advisor feedback and facilitate discussion
- Advisors were also provided 2 pre-meeting reading materials
  - Sovaldi PI
  - Excerpts of the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) Treatment Guidelines for HCV

Gilead's Objectives

Managed Markets Advisory Board

- The objectives of this advisory board were for Gilead to receive input in order to:
  - Better understand specific issues affecting payer management of HCV and to gain insight into key points of interest for payers and emerging trends
  - Better understand how Sovaldi is being managed given that it has been on the market for approximately 5 months
  - Gain a more thorough understanding of how Sovaldi will be reviewed and what data are most salient in the process
  - Provide an opportunity for Gilead to pose a series of key questions about competitor data, as well as Gilead's own data, on emerging products in the HCV arena, including new datasets from the European Association for the Study of the Liver (EASL) that provide a more comprehensive view of Gilead's and competitor's profiles
  - Learn how our account management and managed care teams can best serve the needs of payers

Agenda

Managed Markets Advisory Board

Time	Title	Presenter
8:00 AM – 8:30 AM	Program Welcome and Gilead Corporate Overview	Coy Stout
8:30 AM – 9:45 AM	Sovaldi Product Overview and Early Experience	Zobair Younossi Louisa Leung
9:45 AM – 10:15 AM	AASLD/IDSA Treatment Guidance	Zobair Younossi Louisa Leung
10:30 AM – 10:45 AM	Break	
10:30 AM – 12:00 PM	Economic Burden of HCV Economics of HCV Treatment HCV Population Model	Zobair Younossi Ray Lancaster Louisa Leung
12:00 PM – 1:00 PM	Lunch	
1:00 PM – 1:45 PM	HCV Treatment Landscape: Emerging Therapies	Chris Lahart Louisa Leung
1:45 PM – 2:00 PM	Break	
2:00 PM – 2:45 PM	HCV Treatment Landscape: Emerging Therapies (cont.)	Chris Lahart Louisa Leung
2:45 PM – 3:00 PM	Wrap-up and Close	Coy Stout

Advisory Board
Presenters

Managed Markets Advisory Board

Moderator

Zobair Younossi, MD, MPH, FACP, FACG, AGAF
Chairman, Department of Medicine, Inova Fairfax Hospital
Vice President for Research, Inova Health System
Professor of Medicine, VCU-Inova Campus

Gilead Presenters

Chris Lahart, MD
Director, Medical Sciences

Ray Lancaster, BS, PharmD
Associate Director, Medical Sciences

Louisa Leung
Associate Director, Market Access & Reimbursement

Coy Stout
Vice President, Managed Markets

Advisory Board
Advisor Profiles

Managed Markets Advisory Board

Name	Title	Plan	Plan Type	Covered Lives		
				Commercial	Managed Medicaid	Managed Medicare
Sherry Andes, PharmD	Drug Intelligence Supervisor	Catamaran	National PBM	9,000,000	4,800,000	5,000,000
Donald Balfour, MD	President and Medical Director	Sharp Rees-Stealy Medical Group	Regional IHDS	143,000	0	14,000
Allen Becker, RPh	Director, Clinical Account Services	CVS/Caremark	National PBM with SPP	65,000,000	2,000,000	5,000,000
James Bowerman, MD	Medical Director	Molina Healthcare	National MCO	0	1,800,000	75,000
Joel Brill, MD	Chief Executive Officer	Predictive Health, LLC	Regional MCO	720,000	0	30,000
William Cardarelli, PharmD	Director of Pharmacy	Atrius Health	Regional IHDS	842,000	114,000	0

Advisory Board
Advisor Profiles (cont.)

Managed Markets Advisory Board

Name	Title	Plan	Plan Type	Covered Lives		
				Commercial	Managed Medicaid	Managed Medicare
Gary Johnson, MD, MBA	Medical Director	Humana	National MCO	4,000,000	150,000	2,000,000
Ross Miller, MD, MPH	Medical Director	CA Medicaid	Regional MCO	0	4,300,000	0
John Pacey, PharmD	Regional Director of Pharmacy	United Healthcare	Regional – West MCO	0	600,000	40,000
Glen Pietrandoni, RPh	Senior Director, Specialty Products and Services, Virology	Walgreens	National PBM with SPP	155,000,000		
Mark Shinmoto, PharmD	Director, Pharmacy Services	HealthCare Partners	Regional IHDS	490,000	2,000	110,000
Michael Strampel, PharmD	Clinical Program Manager	BCBS of Michigan	Regional MCO	4,300,000	0	50,000

Topline Summary

GILEAD Managed Markets Advisory Board

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Key Findings

Managed Markets Advisory Board

- Advisors are very interested in patient stratification and would like more guidance on who to treat first in order to allocate their resources
- For most plans, it is still too early to quantify the managed care experience with Sovaldi, so advisors are looking elsewhere for real-world validation of clinical outcomes
- While most advisors respect the AASLD treatment guidance, some advisors feel that it has pressured them to cover what are perceived as expensive regimens without providing patient stratification data that could inform utilization management strategies
- Advisors find Sovaldi and LDV/SOF's clinical profile compelling, but the potential economic burden of treating the entire eligible population remains a major concern
- Advisors found value in educational materials regarding the economic impact of HCV (eg, population model, cost per sustained virologic response [SVR], price flashcard) to help with decision making

Key Findings

Managed Markets Advisory Board

- Although advisors initially responded negatively to the cost of the regimen, most advisors responded positively to data presented as cost per SVR
- When given the opportunity to independently set treatment regimen prices, most advisors priced future treatments close to parity with Sovaldi's current standalone price
- Advisors did not immediately identify essential clinical differentiators among HCV treatments in the pipeline and were not interested in patient-reported outcomes
- Single-tablet regimens are mostly viewed as a "nice-to-have," but at this point, advisors do not expect that single-tablet regimens will play a major role in formulary decision making; however, with so many expensive treatments in the pipeline, advisors are focusing on regimen simplicity and increased adherence as a differentiator between the treatment options

Most Common Overall Concepts

Managed Markets Advisory Board

- After removing cost, the most frequent topics of discussion for advisors were about identifying appropriate treatment regimens and narrowing which patients to treat to find an optimal balance between patient care and healthcare costs

"The best thing you can do is help us figure out who gets treated and not position yourselves as treating everyone at diagnosis. This too will pass, the hysteria will die down; there's something new every year. The government has the attention of a 2-year-old." — William Candarelli, Aetius Health

Key Similarities and Differences Between Previous Advisory Boards

Managed Markets Advisory Board

Similarities

- Most advisors still do not have a clear idea of who to treat
- Advisors would like manufacturers to provide assistance to payers/stakeholders by offering continuing education
- Advisors found Sovaldi and LDV/SOF's clinical profile compelling; however, the cost per population and impact on the plan's budget are large concerns for advisors

Differences

- Payers in the first advisory board responded very positively toward treatment guidelines, but Department of Corrections advisors and payers from the second advisory board were a little more skeptical about them
- When seeking price discounts and creative contracting strategies, this current group of payers offered the first concrete strategy for a creative contracting opportunity

Detailed Findings

GILEAD Managed Markets Advisory Board

Sovaldi Product Overview
Early Managed Care Experience

GILEAD Managed Markets Advisory Board

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With an increase in patients being treated for HCV, advisors are looking for mechanisms to help prioritize patients for treatment to help sustain FY14 budgets

Managed Markets Advisory Board

There was concern over budget sustainability given the number of patients eligible for treatment per the guidelines; advisors repeatedly asked, "Who needs to be treated first?"

- *"We need to know who needs treatment the most and triage from there; we do not want to be treating everyone from the get-go; it is unsustainable."* – Mark Shinmoto, HealthCare Partners
- *"There is a need to narrow the patient population, because if you tell us that all patients need to be treated, our budgets cannot afford that."* – Joel Brill, Predictive Health

Advisors caution against advertising

- *"We know the data and the economic impact, but if you're thinking you should broadcast more of the disease state to justify the price of your drug, that is more difficult to accept rather than if you are doing it for awareness and public health reasons."* – Ross Miller, CA Medicaid
- *"We take serious consideration when people are saying that we should treat patients with HCV; it becomes a societal issue, where we as a society say we can't treat all patients because it is too expensive."* – Gary Johnson, Humana

Opportunities exist for Gilead to develop positive relationships with their stakeholders

Managed Markets Advisory Board

Advisors are looking for more information to stratify patients

- "Clinical progression of disease and resources determine who to treat, but we would also see information about cost per SVR based on GT, relapsers, and subpopulation" – Ross Miller, CA Medicaid
- "The more you help managed care operationalize treatment, the better mission you will be in because you're partnering to help the patient." – Joel Brill, Predictive Health

Advisors would like to see Gilead provide data from real-world treatment experience

- "I would like to see the completion rate of PEG+RBV+SOF and SVR in the real world. We are not tracking, so we would like to see the data from [Gilead]." – James Bowerman, Molina Healthcare

Address specialty pharmacy dispensing and reimbursement issues related to the 12-week requirement

- "We do not dispense 12 weeks of therapy for other patients." – Michael Stamper, BCBS of Michigan
- "[Payers] are requesting 8 or 12s but we are conflicted." – Geri Pierardoni, Walgreens

Help educate mid-level practitioners

- *"Now we're seeing mid-levels running HCV clinics and doing all the day-to-day patient interface."* – Joel Brill, Predictive Health

AASLD/IDSA Treatment Guidance

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Although advisors agree that treatment guidance is important for utilization management, advisors have mixed opinions about the available treatment guidance

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Advisors agreed that AASLD/IDSA guidelines were more impactful for decision making than the EASL and Veterans Affairs (VA) guidelines

- Most advisors were already familiar with the AASLD/IDSA guidelines and reported that the EASL guidelines are more complicated

Some advisors struggled with the implied societal obligations to cover treatment options

- "*Prior to the guidelines coming out, we were not required to cover, but from a CMS regulatory standpoint, we feel obligated to cover, which makes a difference in policies.*" – Gary Johnson, Humana

Although AASLD/IDSA has promised frequent updates to treatment guidance, advisors are conflicted about the role that treatment guidance will play in plan reviews of newly approved HCV agents

- "*We will probably look at other management strategies when new drugs come in for coverage. As time goes on, we will most likely re-evaluate new agents and have 1 to 2 agents on formulary, while excluding high-cost newer drugs.*" – Allen Becker, CVS/Caremark
- "*It does not affect our review of drugs; we are going to see utilization management and update those. We will change to what guidelines recommend.*" – Sherry Andes, Catamaran

Advisors agreed that treatment guidance is still missing one important component

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Who to treat?

- While advisors appreciate that current treatment guidance assists with definitive treatment plans for patients, most advisors are still unsure who should be treated and when

"After determination of treatment is made, the continued conversation between plans and physicians will be on who gets treated." – Michael Stramel, BCBS of Michigan

"The issue is not so much when to treat, but who to treat. AASLD should come up with more information about that. I thought they put out a statement that they were striving to find a better way to stratify those patients." – Mark Shinnick, HealthCare Partners

Economic Burden of HCV

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Advisors hope to track outcomes and understand the economic burden in context

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While many advisors are not equipped to properly track SVR, some are getting up to or attempting to track outcomes

- *"One of the protocols we're working on is tracking SVR in addition to adherence. There's no reason to continue if we're not getting a good clinical response."* – Allen Becker, CVS/Caremark
- *"We're monitoring the trends and our specialty pharmacy will have more access to these data in the future."* – Sherry Andes, Catamaran
- *"Our specialty pharmacy has been given orders to track these patients and to keep up with the offices to see if it's really working and if they are getting the same levels of cure. They're doing a lot more work on data in this class than I've seen in the past because it's really important to them due to the cost."* – John Pacey, UnitedHealthcare

Some advisors recommend framing cost in terms of big picture cost offsets in the context of clinical pathways

- *"Can you frame your cost in terms of a bundled payment with a self-defined period that would include the costs associated with pharmacy, medical, facility, diagnosis, office visits, and monitoring?"* – Joel Brill, Predictive Health
- *"I think it's important to look at the initial cost of the medications in the context of clinical pathways. Some aspects of this are unsustainable, so we need to find the most effective pathway to get to the goal."* – Allen Becker, CVS/Caremark
- *"You need to look at the whole picture and how much Sovaldi costs and the length of therapy required."* – Sherry Andes, Catamaran

Some advisors are closely investigating length of therapy and possible relapses

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Some advisors are looking at length of therapy and possibly split fills as a potential cost-saving tactic

- *"Can you address payers looking for split fills in order to track adherence?"* – Glen Pietrandoni, Walgreens
- *"I see our criteria evolving a bit, and tracking responses could lead to shortening therapy if it's possible to save money."* – Allen Becker, CVS/Caremark

Concerned about the cost impact of relapsed patients, advisors sought data directly linked to new DAAs

- *"The graph with SVR and mortality showed that most relapses occur within 6 months, but I didn't think that was with new drugs. When are we going to get updated information with these new regimens? How do we know if the virus won't come back in 3 years?"* – Donald Balfour, Sharp Rees-Stealy Medical Group

While advisors are looking for immediate budget relief, the future is considered similarly bleak economically

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Hoping to spread the economic burden over time, some advisors are seeking data to stage patients

- *"So maybe it's important for us to understand who we treat this year and who we treat in 5 years."* – William Canterell, Atrius Health
- *"If we can stage it and not take this big hit all at once, that would be much appreciated."* – Mark Shinnick, HealthCare Partners
- *"Maybe waiting for fibrotic changes isn't the best thing for the patient, but we need to capture that data and show why."* – Mike Strampel, BCBS Michigan

Looking beyond immediate budget concerns, many advisors fear the imminent impact of screening baby boomers who are aging into Medicare

- *"The problem is not today, it's at the end of the decade when the baby boomers reach Medicare age."* – Joel Bril, Predictive Health
- *"I heard from our CIS that the tsunami is coming with the baby boomers, and we agree it's a major concern. Employers are also concerned."* – Donald Balfour, Sharp Rees-Stealy Medical Group

Opportunities to Frame the Economic Story

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Cost Education

- There is a knowledge gap about various treatment costs, and most advisors found the cost education tools Gilead provided supportive for decision making
  - Population model
  - Cost per SVR data
  - Pricing flashcard

Patient Stratification

- Advisors believe there is an opportunity for Gilead to develop guidance for patient stratification
  - *"Opportunity for Gilead: identify the subpopulation who really needs treatment."*
    - Ross Miller, CA Medicaid

Creative Contracting

- With so many treatments in the pipeline, advisors are interested in creative contracting opportunities
  - *"You'd be the first company to guarantee effectiveness with little financial risk, and it would be a huge public relations boost."*
    - Gary Johnson, Humana

HCV Population Model

Overall, advisors have varied pre-set perceptions of population-based models, but with increasing interest in new DAAs, most are open to reviewing

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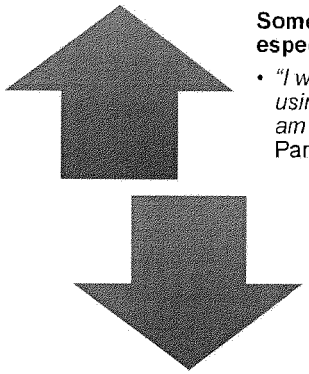

Some advisors consider population-based models useful, especially to assist with forecasting

- *"I would certainly love to have something like this… I am using this model to help provide guidance [for projections], I am confident about that."* – Mark Shinmoto, HealthCare Partners

Some advisors are skeptical of population-based models because there is perceived bias leading to likelihood of missing information pertinent to decision making

- *"There are still some moving parts that may not be captured in the model: [for example] who is going to get treated, which is the driver for determination of cost."* – Michael Strampel, BCBS of Michigan

Given heightened interest in the HCV market, advisors expressed interest in evaluating the model with cautious optimism that it may offer an additional data source when considering HCV management decision making

"I don't think anyone will take [the model] as gospel and most people will say this is just one approach to modeling, but we use these and we may consider this in our budget and forecast." – Gary Johnson, Humana

Advisors agreed that Gilead should continue developing a population-based model as a short-term solution before a cost-effectiveness model can be finalized

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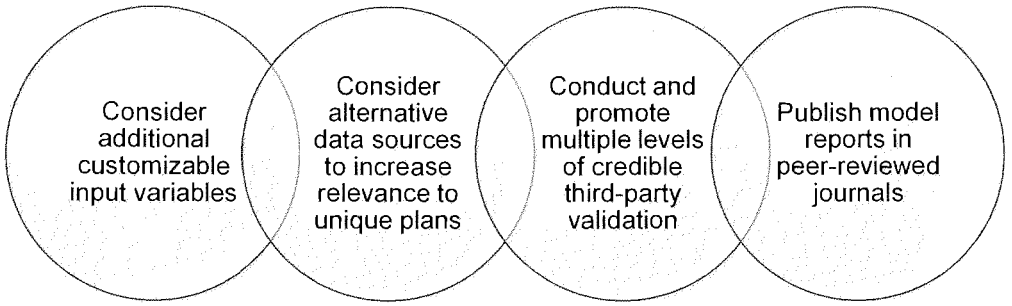
Create more confidence in the population model by improving the transparency of model assumptions and inputs



- Patient population
- Membership demographics (eg, ethnic origin)

- Plan type (eg, MCO/IHDN, PBM)
- Book of business (eg, commercial, Medicare)

- Corporate validation
- Academic validation

- JMCP and AJMC were recently rated the most frequently read peer-reviewed journals by MCN members

HCV Treatment Landscape: Emerging Therapies

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The LDF/SOV clinical profile was well received, but more information is desired on viral load at 4 weeks and over the long term

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- Advisors were impressed by LDV/SOF's strong clinical profile but were unable to appropriately evaluate all pipeline regimens
  - Most advisors were looking for more clinical trial data (eg, phase 3) with more information on SVR before making an evaluation of each regimen
- 4-week viral load is still considered by payers to be an important criteria of response likelihood
  - One medical director specifically asked if 4-week viral load was being considered a benchmark or standard for LDV/SOF response
  - Advisors appear to be looking for "stopping rules" based on early response criteria, since the current guidelines do not provide this information
- Additionally, several advisors wanted to see long-term SVR maintenance data (at 1 year and beyond) before assigning value to different regimens
  - Concern exists among payers that relapse could occur in some patients, even after achieving SVR

Interferon- and ribavirin-free regimens are an exciting option for advisors—provided that the efficacy holds

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- Interferon-free and ribavirin-free regimens present an opportunity to treat patients who were previously warehoused due to poor efficacy and adverse event profiles
  - Advisors were also looking for indicators of efficacy for new interferon-free regimens
  - *"Communicate information about the efficacy without using interferon and there will be no problem getting on the formulary; it may replace other therapies, but we just don't want to be surprised by price."* – John Pacey, UnitedHealthcare

Given strong efficacy across the board for the new treatments for genotype 1, differentiation must be achieved to avoid formulary decisions based on price

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- Advisors also brought up the idea of the proverbial "ceiling" on efficacy of treatments for genotype 1
  - Since new treatment options have extremely high (95%+) rates of SVR, several advisors considered them all to be approximately equal, thus opening up opportunities to contract for preferred positioning
    - *"If patients had their choice, its clear what they'll pick, so it's really a pricing and coverage type of decision."* – Gary Johnson, Humana
- Additionally, advisors were looking for treatment options and guidance for treatment of genotypes 2 through 6 given the lack of information for non-genotype 1 HCV for new regimens

Class review is likely in the future; creative contracting is important to achieve preferred status on formulary

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- When the current group of pipeline HCV regimens becomes available, a class review of medications is likely
  - Several advisors mentioned the possibility of either an HCV full clinical class review or a contracting class review, although advisors are still unsure of how the classes will be defined

- Advisors are looking for creative contracting—including guarantees and/or warranties of SVR—in order to choose preferred regimens for their formularies
  - *"Offer a warranty or guarantee that would say 'I'm so confident in my medication, I'd offer it for free for relapsers.'"* – Joel Brill, Predictive Health

All-oral treatments are considered a step forward for adherence, but they could lead to many warehoused patients seeking treatment

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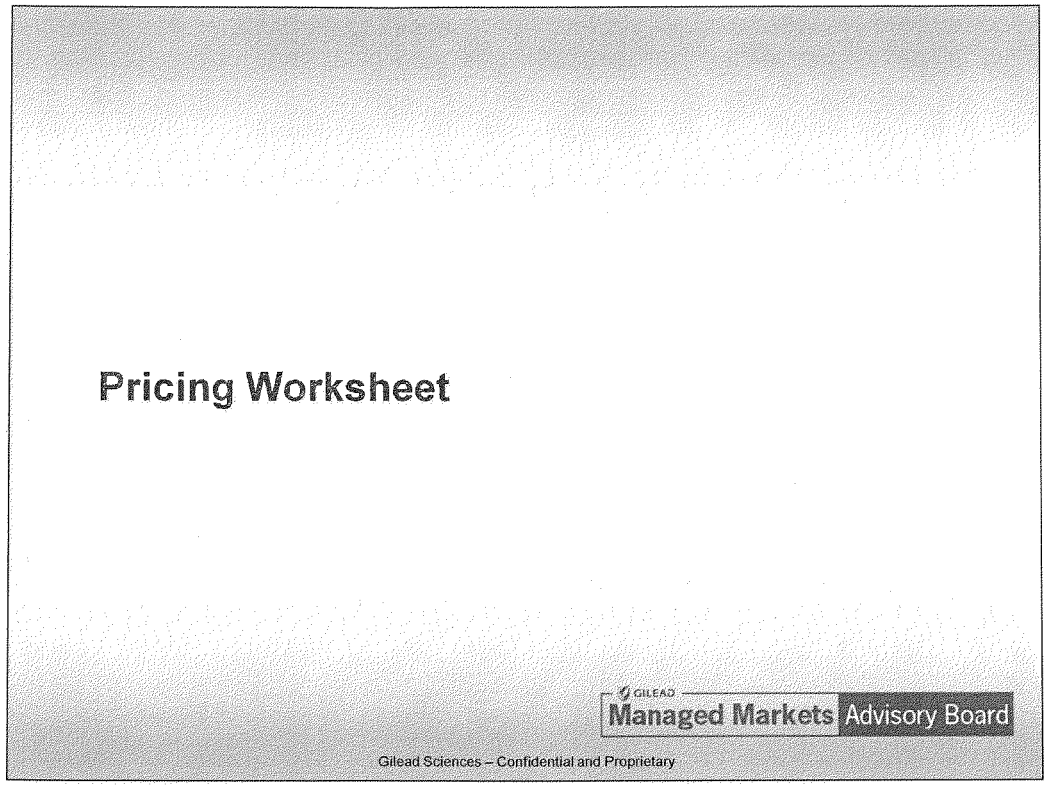
- Advisors were generally optimistic about all-oral treatment options for patients, believing that they could lead to better adherence and better side effect profiles (vs interferon-containing regimens), which could ultimately lead to better outcomes

- Payers believe that all-oral treatment options are likely to lead to many patients seeking treatment who previously refused interferon-containing therapies
  - *"It's about who to treat…patients have been waiting for oral treatment, the real question is who should we treat."* – Donald Balfour, Sharp Rees-Stealy Medical Group



Future Treatment Options for HCV: Cost Per Regimen

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	Daclatasvir + Asunaprevir + RBV Pricing	Daclatasvir Pricing	Olysio Pricing
	$108,000	$42,000	$89,040
Advisors were instructed to price each regimen based on the clinical profile as if they were the manufacturer	$70,000	$70,000	$42,000
	$84,000	$60,000	$84,000
	$84,000	$84,000	$66,000
	$134,000	$100,000	$86,516
	$84,000	30,000	$64,887
	$95,000	$45,000	$50,000
	$100,000	--	$45,000
	$75,000	--	$86,516
	--	--	--
	--	--	--
AVERAGE	**$98,900**	**$61,571**	**$68,218**

Advisors reported pricing with variable denominators: $/tablet, $/day, $/regimen, $/SVR. All pricing was normalized to $/regimen. When advisors reported $/tablet, it was assumed advisors meant $/dose per day. Pricing was calculated as such. One advisor reported pricing in $/SVR; it was excluded from the table.

If advisors were the manufacturer, they would price LDV/SOF and daclatasvir + asunaprevir + RBV highest

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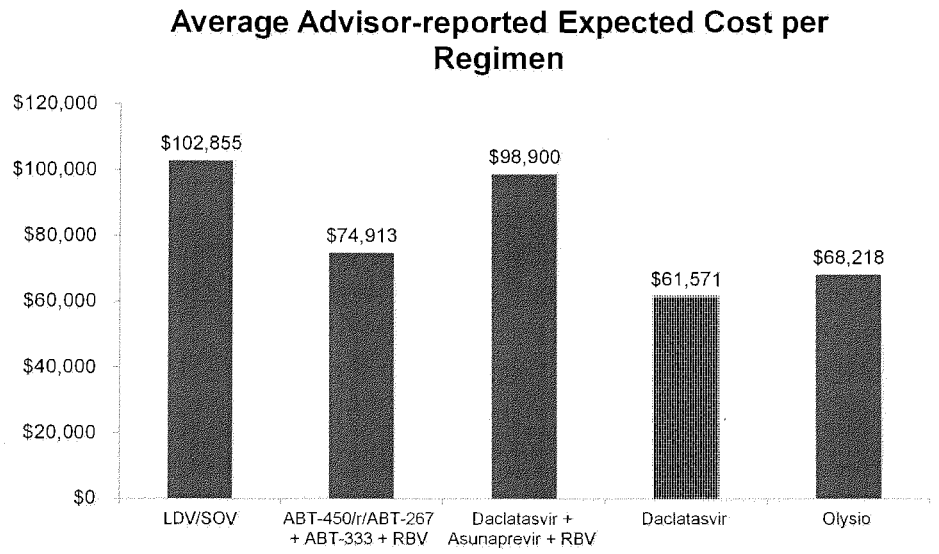

Advisors expected rebates on LDV/SOF ranging from 10% to 30% and some expect a guarantee or warranty of treatment success

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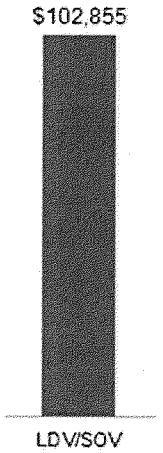

Price protection and free treatments for failures were also expected

Verbatim LDV/SOF Contracting Expectations
"Price protection; free treatment for failure"
"10% rebate and pay for failure"
"15% rebates"
"Rebates or price protection for preferred status"
"30% rebate"
"Money-back warranty"
"Incremental increase in SVR"

Advisors expected rebates on the AbbVie regimen ranging from 0% to 15%

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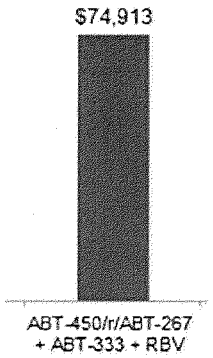

Advisors offered disparate expectations for contracting of the AbbVie regimen

Verbatim AbbVie Contracting Expectations
"Price protection"
"15% rebate"
"No rebate"
"Rebates"
"Rebates or price protection for preferred status"
"10% to 15% rebate"
"Capture market share; complicated regimen"

1820

Advisors expected rebates on daclatasvir-containing treatments ranging from 10% to 15%

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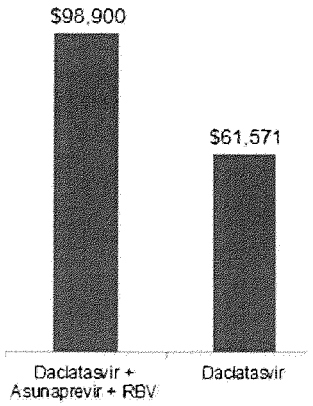

Exclusivity and price protection were also mentioned as expectations for contracting

Verbatim Daclatasvir Contracting Expectations
"(1) Exclusivity; (2) price protection"
"15% rebate"
"Rebate ≥15%"
"Rebates"
"Rebates or price protection for preferred status"
"10% to 15% rebates"
"More complicated; longer duration"

Advisors expected rebates on Olysio ranging from 10% to 20%

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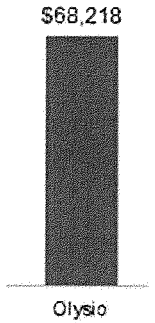

Price protection and tier 2 status were also mentioned as contracting expectations

Verbatim Olysio Contracting Expectations
"Tier 2; price protection"
"15% rebate"
"Rebate ≥20%"
"Rebates or price protection for preferred status"
"10% to 15% rebates"

Advisor Education Opportunities:
Price per dose/day vs price per regimen

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- Several advisors made comments during the advisory board that the current prices of DAAs are too high
- However, prices per dose or per day were listed on the pricing worksheet that, when calculated into price per regimen, far exceeded the prices previously considered to be too high
  - Example: One advisor listed a per-dose price for daclatasvir-containing regimens as $1,000/day, which calculates to $168,000 for the full regimen
- Education opportunity: Inform payers of the effect of regimen length (ie, 8, 12, 24, and 48 weeks) in determining total cost of HCV treatment
  - Advisors responded well to the wholesale acquisition cost pricing sheet and bar chart of cost per regimen

Advisor Education Opportunities:
Cost per SVR

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- During the advisory board, several advisors responded positively to the concept of cost per SVR as opposed to price per regimen
  - This highlights the value of Sovaldi and LDV/SOF given their high rates of SVR
- Additionally, after presentation of advisory board materials, one medical director incorporated cost per SVR into his answers on the pricing worksheet
- Education strategy: Present cost per SVR as part of the value proposition for Sovaldi and LDV/SOF, especially in the context of a higher cost per SVR for other treatment options that have lower SVR rates

Strategic Recommendations

Overall Strategic Recommendations

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- Show payers you're listening
  - Consider sharing recommendations heard from payers in advisory boards, market research, conferences, and account management meetings in an aggregated and blinded format
  - Show how Gilead took action on recommendations
- Partner with an industry-leading health plan to visibly help them prioritize which members should be treated first
  - Continue the strategy of pursuing patients already identified as HCV-positive for treatment with Sovaldi
- Continue to promote manufacturer-provided value-added services
  - Consider supporting SPPs by:
    - Providing benefit investigation and claims assistance (eg, assistance with 12-week fill vs standard 30/60-day fill)
    - Helping to establish adherence programs to track and support adherence
- Continue to monitor payers' perceptions of the treatment pipeline
  - Conduct further market research to probe differences between treatment regimens with future audiences to collect qualitative and quantitative data on the importance and impact of trial design on decision making

Overall Strategic Recommendations (cont.)

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- Consider piloting an outcomes-based contracting strategy with a large health plan that has an established analytical presence to:
  - Collect data and validate Sovaldi and LDV/SOF's real-world clinical value
  - Support improved healthcare by offering incentives for health plans to treat their patients (eg, offer warranty-like guarantee for relapsing patients)
  - Clearly promote Gilead as an HCV industry leader and an advocate for patient care
- Continue framing the picture of the economic impact of HCV
  - Payers need to be educated about the impact of cost per SVR vs cost per treatment regimen for their patient population
  - Continue to pursue publications in peer-reviewed journals, especially with regard to Sovaldi's cost-effectiveness, to support the validity of real-world cost-effectiveness
  - Leverage the pricing flashcard and pricing graph with payers to mitigate negative views about treatment price
- Consider providing large-scale real-world outcomes data from databases that will resonate with the majority of health plans

Program Evaluations

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Program Evaluations
Most Compelling Topic/Dataset

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Verbatim Recommendation: Most Compelling Topic/Dataset Discussed
Pipeline information; what we need to prepare for
Treatment costs, low relapse rate, effectiveness vs other agents
Effectiveness
Ray Lancaster's data
Chris Lahart's presentation on LDV/SOF
Pipeline and how the landscape will be changing when the next wave of products is available
Pricing and clinical information
SVR results for LDV/SOF
Efficacy data. I'm not compelled by PRO data
Efficacy and tolerability of LDV/SOF; treating HCV improves insulin resistance
Association between hep C and diabetes
F2 vs F3 cut-off for treatment

Program Evaluations
HCV Access Strategy

Managed Markets Advisory Board

- Advisors requested assistance in identifying which patient population to treat and recommended education about cost per SVR for HCV treatments to improve the HCV access strategy to maximize payer receptivity

Verbatim Recommendation: HCV Market Access Strategy
Get the cost/SVR out
Identify target population (who should be treated)
Bring out the slide deck Ray had presented regarding relative costs of Sovaldi vs others
Bring down cost
Better define which patients should be treated now while awaiting guidance
Disseminate the total cost of treatment info to payers, and help us determine who will benefit most from treatment
Keep pricing competitive
Help us identify the right patient cohort
Share the slide (Ray's first slide) about the cost comparisons with established treatments
Focus on sub-population that really needs treatment (eg, fibrosis 3+, symptoms, etc)
Show cost per SVR value message slides

Program Evaluations
Overall Meeting

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- Overall, mean score results indicate participants **"agree" that the program achieved its key objectives**
  - Advisors rate "The meeting stimulated participation and interaction among presenters and advisors" most favorably, based on mean score values

Overall Meeting	Mean Score n=11
The meeting stimulated participation and interaction among presenters and advisors	4.8
I had adequate opportunity to express my thoughts relative to the topics discussed	4.7
The topics discussed were relevant to my plan's policies around hepatitis C testing and treatment	4.6
The meeting was well organized	4.6
The goals and objectives of the meeting as an advisory board were clear	4.5

On a scale of 1 to 5, where 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Program Evaluations
Logistics

Managed Markets Advisory Board

- Overall, advisors reacted **positively to the program logistics**
  - Advisors rated "Helpfulness of the Xcenda team" most favorably, based on mean score values
  - "Hotel accommodations" was rated least favorably, based on mean score values

Logistics	Mean Score
Helpfulness of the Xcenda team	4.7 (n=11)
Ease of registration and confirmation process	4.5 (n=11)
Coordination of travel arrangements	4.5 (n=10)
Hotel accommodations	4.1 (n=11)

On a scale of 1 to 5, where 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent

Program Evaluations
Additional Comments and Suggestions for Improvement

Managed Markets Advisory Board

- While advisors were mostly satisfied with their ad board experience, they would like more information from Gilead regarding how to stratify patient populations and had mixed opinions on the KOL perspective

Verbatim Additional Comments and Suggestions for Improvement
Very well prepared
Little longer
Use a hotel right at the airport
Excellent format
Saturday preference
Great meeting. Great discussion/interaction
Offer sure guarantee on combo product and Sovaldi; great value-added component, and this sets Gilead apart from the competitors
State Medicaid with small FFS populations are dragging their feet on guidelines or helping with coverage due to ACA guaranteed rebates, forcing managed Medicaid companies to assume all risk for HCV patients
Gilead didn't answer the most important question: How do we stratify patients; who gets treated first and who can wait?
Still need more information on who to treat and when
Consider covering cost of failures/relapses
Dr. Younossi—was awesome to have clinician here
Don't have clinical KOL present economic data without first validating his experience
Needed KOL perspective

Thank You

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Jasmine Knight, PharmD, MS
Health Outcomes & Managed Markets Fellow, Xcenda
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Exhibit 51

From: "Mark Schoenebaum" <mschoenebaum@isigrp.com>
Subject: FINAL data from gild/bmy (and sort of MRK/ROG) buy-side survey

From: Mark Schoenebaum [mschoenebaum@isigrp.com]
Sent: Thursday, October 31, 2013 8:12 PM
To: Robin Washington
Subject: FINAL data from gild/bmy (and sort of MRK/ROG) buy-side survey

final . . . 203 responders . . . ~40% specialists/~60% generalists . . . . ~25% hedge funds . . .

Please don't forward to the evil non-responders J

Where do you think GILD will price 12 weeks of single agent sofosbuvir (hep C)? [gross price]

$85.4k

What do you think total WW sales of GILD's hep C drugs will be in 2014?

$2.6B

What do you think total WW sales of GILD's hep C drugs will be in 2015?

$5.8B

What do you think total WW sales of GILD's hep C drugs will be around 2021/2022?

$5.1B

When GILD gets approval for a combination pill of sofosbuvir plus an NS5A, where do you think the company will price this pill per G1 patient? (for this question, it doesn't matter if u think the regimen will be 8 or 12 weeks . . . Assume GILD will know whether the regimen will be 8 or 12 weeks at the time of pricing)

$94k

What share of the G1 market do you think GILD will take in 2015 versus competing all oral regimens (mainly ABBV)?

72.3%

What do you think think PEAK (~2021) WW combined sales of BMY's PD-1 antibody (Nivo) plus Yervoy will be?

$6.9B

At peak (~2021) what SHARE of the PD-1 market do you think BMY's Nivo will have?

62.4%

What do u think WW peak (~2021) sales of MRK's PD-1 antibody (Lambro) will be?

$2.9B

What do u think WW peak (~2021) sales of Roche's PD-L1 antibody will be?

$2.9B

Imagine it is October of 2016, not October of 2013. What forward PE (i.e. on 2017 EPS) do you think GILD will trade at in Oct 2016?

13.1x

Do you think GILD's market cap will be bigger than MRK's in 1-2 years? (MRK is ~$132B; GILD is now ~$110B)

YES: 82%

ONLY ANSWER IF U OWN GILD: In the next 12 months, what is the lowest price at which you would SELL most of your GILD?

$89.6

ONLY ANSWER IF U OWN BMY: In the next 12 months, what is the lowest price at which you would SELL most of your BMY?

$59.3

WHAT IS YOUR SUMMARY OPINION OF GILD AND BMY HERE? IS THE SELL SIDE OVERLY BULLISH OR BEARISH ON EITHER NAME? IF SO, WHY?

Think sell-side is overly bullish on BMY, appropriately bullish on GILD. IO will be a huge area and BMY has a headstart; but, there's uncertainty on who the ultimate winner will be.

Buy both.

sellside is cautious on taking estimates too high, because they never had to deal with such paradigm shifts before or fathom numbers (revs and eps gettign to those levels). That's fine though because it leaves room for upside.

overly bullish on GILD, esp relative to BMY...PD-1 must longer tail and less risk in pricing/sustainability

Overly bullish on BMY. About right on GILD.

PDI plus immunotherapy combos for BMY are still dramatically higher than expectations . If anti-TNF is a $20b market, and growing, why won't cancer immunotherapy sales exceed TNF? Bristol portfolio is far more than Nivo + Yervoy. On GILD, can't imagine peak, per years sales will exceed consensus given capacity constraints. There is no dire rush to treat patients who have not been infected for long periods of time.

What happens when MRK, BMY and JNJ all can cure HCV with a cheaper regimen? Wont it be akin to Januvia now with lots of DPP4s out there (i.e. cheapest wins)? The exception is that this isn't a chronic disease, so there is not a recurring revenue stream unlike diabetes.

both are buys, not enough bulls out there.

GILD-launch should exceed sell-side, BMY - think sell side is overly bullish given level of competition.

GILD is a buy...very little risk. Tough to see regulatory or conmpetive risk. BMY seems overvalued as a stock. Still lots of risk ahead. Many other competitors in IO.

Byu them both. GILD cheap. BMY will acquire CLDX and crush MRK, unless MRK buys CDLX first

Buy gilead here. The sell-side revenue estimates for HepC are way too low but the buy-side probably has it right, which is governing where the stock is trading. Even then, the stock is undervalued on a DCF basis, which you can't say for most of the other large and mid caps. And you get the pipeline largely for free, which is maturing in the background. The sell-side is obviously extremely bullish but it is justified. Near-term catalysts will be positive and estimates need to revised upward. There is no reason to get off this one yet. Fundamentals haven't peaked nor is the stock overvalued.

right on target

Peak sales in gild are going to come faster than expected - market not as big as people think - bmy competition going to take a lot of share which doesnt seem factored in

Crowded longs, but probably good stocks to own.

two great growth stories, both widely held, GILD and BMY both went through rough patches, so i have no issue with the sell side cheer leading a bit here.

Will focus many analysts on these stocks. May provide opporunities in other bioteeh /drug securities. Hep C is happening soon, and that always brings excessive upmanship .

need to participate

sentiment is about right for GILD, too bullish on BMY PD1 is going to be competitive and all drugs look comparable, if you are a PD1 bull you should own MRK as its not in the stock whereas TOO MUCH pd1 is in BMY

GILD pricey until you apply valuation on future earnings. BMY getting streetched . Need more data. Probably BMY. Only growth name in the group.

Very positive on both. Sell side is about right but waiting with bated breath on upside data/scenarios.

overly bullish. but, i'll enjoy it while i can

PD-1 bullishness is way premature c/w sofos bullishness, and thus less valuable.

Sell Side is overly bullish on BMY as they are extrapolating PD-1 across numerous tumor types; bearish on GILD, specially on pricing.

Overly bullish on BMY. 2nd or 3rd inning of immunotherapy, with high probability that superior products to Nivo emerge.

short BMY / long GILD

I believe the Sell Side may be light on GILD and about right on BMY

gild is a buy

GILD much more upside with multiple legs beyond HCV

both are shorts

*You need a don't own option in the drop down of the last two questions. Everybody is looking for the top in biotech names and trying to figure out if it is a bubble . I will tell you when the top will come. It will be when GILD reports their first quarter of HCV revenue outperformance will be gone from these names and multiple near term

patent cliffs will be a focus. Generalists will flee, mid and small cap valuations will suffer, IPOs won't go up 100% on first trade, dogs and cats will live together in harmony, Mark will again wax poetic about covering Genentech.

Sell side is overly bullish on GILD

Bristol - reminds me of Genentech with Avastin, when some were thinking of it as a $10 billion drug. Think the stock works because there are greater fools. The fact that you have this survey out suggests that we're above fundamental value for both companies. Gilead - reminds me of Apple. No doubt will shoot way above fundamental value and round trip itself. Question is whether this is like Apple at $200 or Apple at $700.

I think the debate on GILD is still around the tail and what the true DCF value is. This will catch up to the stock soon unless they produce or buy another blockbuster . I'm not convinced that Idelalisib is that asset (more bullish on Ibrutinib and ABT-199). On BMY the key is what other tumor types PD1 will work in.

positive on gild

still room to run on both; can still be more broadly owned

GILD has more to go though that doesn't rule out waves profit taking along the way. The street is appropriately bullish on GIULD

GILD - If GILD CURES HepC, I feel like there will be a rush to the exit AT SOME POINT. But I don't know when. I don't think its in 2014. BMY - This stock will carry me through ther end of my career (15+ years)

buy gild; hold bmy

I love GILD, but a year from now, when everyone owns it... and I worry about its sheer market cap size BMY still has a lot of fat to cut.

Sell side is fair and balanced on both. Why do you keep bringing up MRK? The company is a disaster, remember the Titanic was also the largest in terms of market cap ...oops I mean size. Stop trying to make MRK happen. Signed, Contact #89,025 on your distribution list

GILD just needs to be in portfolio. Too much earnings power potential over next few years. Still plenty of upside.

gild is a buy, bmy is a hold. sell side a bit too optimistic on bmy

Both still a buy. Think GILD more upside.

fair

GILD nearing pricing to perfection - too many bullish folks, no one bearish. It is the opposite of when they bought the HCV assets. BMY still a bit of upside to go.

GILD is still woth +50% from here. BMY tougher to justify.

pipeline pipeline pipeline. Now let the future unfold and reveal the truth....

Best stories in healthcare. Stocks should continue to work.

to infinity and beyond....

GILD too tough to call, wouldn't make a bet either way. BMY overly bullish, some upside, but more downside risk at current levels.

overly bullish on BMY, GILD has room to run

Both stocks are cheap now based on prospects as they stand today. Question is how long drug pricing can be maintained.

overly bullish? not POSSIBLE

Euphoria

BUY GILD on pullback. Sell-side analysts will be tripping over each other to raise numbers.

Gilead is a buy - great things outside of Hep C not reflected in the stock. BMY is overdone - PD1 will be very competitive and BMY won't see $10 bil in peak sales .

Have to own GILD through approval and launch (see BIIB). BMY is also a BUY.

Gilead has far better management than BMY... not sure strategically where BMY is going to

continue to buy GILD

Bristol should be valued in the context of biotech companies. Gilead numbers are still way too low. Buy them both

FILL YOUR BOOTS

Gild still has upside, but bmy has more risk with their PD-1, less data. and higher valuation on 2015

GILD is expensive but it's so hard to sell it when #'s still are 2 STD too low for 2014/15

GILD still a buy into firrst quarter or two of launch. After that, fahgettaboudit . BMY is longer-term hold

Best products = best companies = best share price performance

GILD Hep C ramp seems overly bullish. Street only looking at upside for BMY pipeline .

Overly bullish on the sustainability of Hep C sales for GILD, but tch stock still has room to go, whereas on BMY the market is too bullish too early - one has to assume PD1 is used chronically, in all tumours and all combo's to justify the price. It's simply way too early to call this.

buy blockbusters

gilead continues to keep pulling a rabbit out of their hat. stock will go up each Q in 2014 if they continue to hit numbers. if bmy's PD-1 starts to get the love that sofo does for GILD, BMY will continue to go up.

GILD gross to net will be wide to get VA and jail patients

is there upside to pricing?

The GILD story is easier due to immediacy of revenues and easier pharmacoeconome math for pricing. PD-1 only gets the big pricing power upside if it works without chemo in certain tumor types.

Is there a space in bandwagon?

Estimates need to go way higher for GILD and it is still cheap on '17 earnings, BMY is too expensive at this point as the story has yet to be de-risked. Something could still go wrong.

sellside very bullish on gild, as is buyside, but w/ consensus beats stock should drift higher. bmy the opposite, overly optimistic pd1 estimates w/ competition on the horizon.

Overly bullish on BMY, especially considering the multiple. Getting bullish but not overly bullish on GILD

overly bearish on GILD. Market is still conditioned to short the launch. think tecfidera x10. reasonably cautious on BMY because Nivo is so novel. feels like mkt is still trying to get its arms around the science.

Foaming at the mouth Love Fest. Good until... well, whenever.

solid

Very hard to predict given the profitability of each product and the vast market sizes without knowing ultimate competitive landscape.

Likes GILD into the launch. BMY looks fully priced as Roche and MRK will fight for market share. No differentiation within PD1 class so far.

GILD - Valuation seems stretched. Need to pull forward HCV revenues into 14 and 15 to make it work BMY - GILD has a 10bn drug and that gets most of GILD's 100bn market cap. Why shouldn't BMY get a similiar valuation for something that won't go generic

too bullish - everyone expects aggressive pricing of these drugs. This can't be sustainable.

BMY best cancer story GILD best hep C story with upside in cancer and Hep B

a little too bullish on both but that will only matter in risk off

Overly bullish on GILD but for good reasons. Catalyst rich year approaching in 2014 , accelerating top and bottom lines, strong core business with newer oncology assets under appreciate

both will grind higher

EVERYBODY LOVES BOTH MORE THAN RAYMOND

Gild should do well due to the global hep c market size; Bmy may work too but harder to see a clear path to upside via PD-1 from here

wish I owned them this year

nivolumab cures cancer, so it's better.

gild buy through at least 1st quarter of launch, bearish on bmy

If you aren't fillin' your boots, then you are missin' the boat.

BMY is a little bullish, is some safety issue shows up to delay the drug the stock has a lot of room to fall. GILD is a good buy at these levels. Nobody seems to really have a good handle on the size of the Hep C market and oncology is not reflected yet.

I think the sell side is overly bullish on bristol, due to scarcity value - it is the only US pharma stock, with an interseting pipeline.

IF Mark likes them how can you go wrong...

It feels toppy--but so did BIIB @ 140-150, and of course BIIB just broke 250 and is trading at 2015 19x, vs 15.3x 2015 for GILD

Both are buys, but I think the sell-side is overly bullish on GILD. I am skeptical that they are going to be able to grab and maintain this entire market. Remember that they were not first with Viread/Atripla; the potential for someone else to put together and move forward with an equivalent regimen is underestimated by the street. In the current environment, in such a situation, pricing pressure is not impossible.

Isn't the sell side always overly bullish on everything?

GILD - not bullish enough BMY - Too bullish -

Both are fully valued at best and BMY may be overvalued In both cases, potential competition is not adequately reflected which has sell side and buy side overly bullish for this time and status of info re competive products.

high risk

I think people will get more and more fixated on the size of the HCV market starting now and continue through the all oral G1 approval. I think people are overly bullish on PD-1 given the most recent data set. I don't think you look good with more hair , esprecially blonde hair. Maybe if you buy a Ron Cohen wig I'll change my mind.

GILD: Game, Set, Match

Am bullish on both GILD and BMY

GILD still works from here...sustainability on HCV and HIV is underestimated, oncology moving along nicely. Not a fan of BMY as valuation is not attractive to me at all .

BUY GILD.....no opinion on BMY, but looking at most large cap global pharma stocks ....point-to-point EPS (2013 - 2017) are likely to be virtually flat. Unless you trade frequently large cap pharma could prove to be a hard way to make a dollar .

BMY and GILD, if nothing goes wrong they both can work

GILD has strongest late stage data and still EPS upside in 2014-2015 so GILD is a must own here. BMY's early stage data - you have to wait 8 months for more/next data that can support the stock? BMY looks over-hyped here.

THIS SHT IS BANANAS!!!! B-A-N-A-N-A-S!!!

both are over owned

love GILD concerned about BMY

Mo is your friend - everytime that I have trimmed my GILD position it has been wrong so far but you have to wonder when will investors start to discount the eventual slowdown in earnings growth and run for the exits.

Should i just send my entire model?

GILD: hard to be overly bullish here BMY: not a PD-1 true believer yet, so seems punchy

Neither OVERLY bullish/bearish on eith GILD/BMY. BMY slightly overvalued. GILD still slightly undervalued.

Let the good times keep rolling

GILD sentiment is well placed in bullishness with a couple hold outs. BMY sentiment probably also well placed.

very high expectations for launches now may make it difficult for either stock to outperform from here

GILD is 5x in the out years, BMY is 24x in the out years; very different value propositions here

Bearish

GILD is on a positive momentum with great clinical data, material catalysts and a market that is under-penetrated BMY PNL looks unimpressive, is stretched and the Co is a one-way bet on one product - Nivo - does not mean it might not work , but its a cachet stock

BMY will have 2014 like GILD's 2013

BMY is ridiculous. Discounts over $6B in PD-1 sales. Could fall 20 points and still not be very cheap.

BMY will still go up as you get incremental data on PD1 GILD will be dependent on launch / pricing. Whisper seems high. DCF seems challenging

GILD: going to mid-$80s BMY: going higher to. roughly comparable in street appreciation for magnitude of the company's revenue opp to where GILD was at start of year.

sellside is about right on both names. what else am i going to buy in large cap land?

neutral

overly bearish

GILD still has plenty to run, BMY less so

GILD: Bullish on HCV (rightfully so), not bullish enough on the cancer pipeline. BMY: Very bullish overall.

ridiculously overbullish on BMY... thin data, huge expectations

Sellside needs to catch up to Buyside on GILD's hep-c sales.

Buy both today! nothng quite like them in biopharma today!

Not overly bullish on either as long as investors are willing to wait a few years for significant EPS growth. Expecting both of these stocks to plateau fairly soon .

Both have one core asset that will dominate its therapeutic area for the next decade .

Sell side bearish/neutral on GILD; Overly bullish on BMY

Rachel Mcminn - 20x current year for drugs with patent expiries. DCFs are for finance professors.

Hard to argue the sell-side (or buy-side, for that matter) is overly bearish on either name

I think GILD is undervalued - will find out when sofo pricing comes out post Dec 8. Cats Meow! Also you are now only just hearing about the pipeline! WIll become the largest drug company because of cash flow and I believe management is very very good. MRK? Needs to start to be successful with its pipeline.

Sellside consensus is appropriately bullish on both names. Drugs move drug stocks . Period.

Hold on both

too bullish. not enough data yet in PD1 to make $10bn revenue calls. HepC launch /uptake if slower than people think would just kill the momentum

Sell side is bearish on the name as multiple should expand for both of the names .

overly bullish on both, even more on GILD. concept stories on PD-1 and Hep-C respectively , but both the areas are becoming more crowded

Hep C is a bubble. Telaprevir doubled cure rates and look how that drug did...

BMY is not GILD and sellside way too bullish on BMY. GILD is the AAPL of health care for the next few years.

Bullish on GILD although competitor pricing may be a bigger issue going forward than is today to sentiment. MRK HepC drug needs to be watched. Bullish on BMY PD1 but always dangerous when a large pharma acts like a developmental biotech!

Both should continue to run as expectations creep upward into a launch. In the case of GILD, there is the possibility that the launch could exceed expecations. For BMY, it is unlikely that Nivo will meaningfully exceed expectations upon launch , but near-term estimate increases and data at ASCO should continue to move shares upward.

the base business matters and it's strong for GILD, BMY is weak. Therefore the SS about right on GILD, too bullish on BMY

GILD short the 2nd Q post launch. BMY really not that different from MRK, and not a massive gamechanger that valuation seems to indicate

BMY has room to move higher than GILD. Still think this HCV market is a bubble. Patients can wait to receive treatment after sofosbuvir goes generic in 2020s!

Positive on both names, solid fundamentals, promising pipelines, and strong momentum behind each stock

GILD & BMY will keep going

Can never be too bullish. Both will dominate very large markets.

gild should be a 85 dollar stock today.....bmy is probably due for a pause.

Don't think sentiment is overly bullish on GILD - think the stock will keep running . Neutral opinion on BMY.

GILD some frothiness, BMY too bearish.

Gild - shows consensus can work; bmy overvalued but less sure on a downside catalyst

overly bullish on both, but moreso BMY. at some point the beat+raise story will stop working at these valuations.

I really like both names and the potential of both pipelines. I lean a little more in GILD's direction only because of how many big catalysts we have in the NT, but I need to stress "little bit." Think both company's have a bright future.

Bullish on both. GILD - HIV on solid ground, one not getting too much credit yet , HCV expectations high but likely to be met.

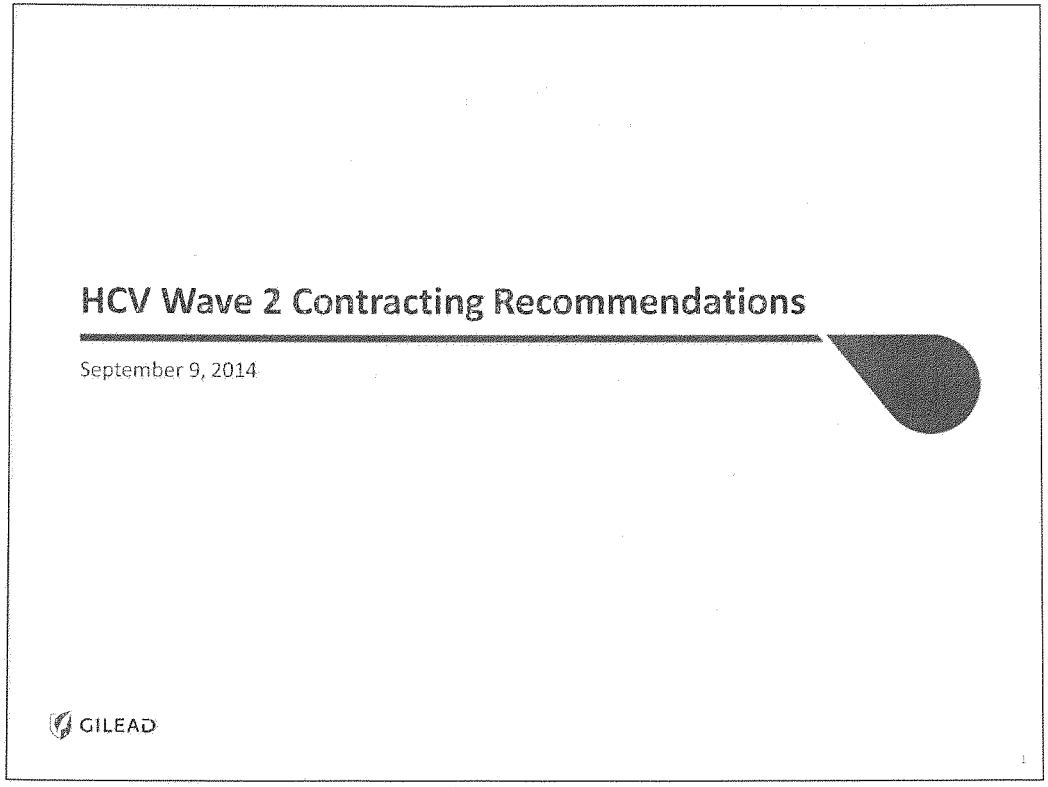
Gild is clearly a momentum stock right now with a key near term catalyst. Believe is is set up for unrealistic launch assumptions.

Can buy both but more upside in GILD

Bullish but doesn't matter - buy the theme

GILD numbers still seem conservative. BMY estimates for Yervoy+Nivolumab peak revenue and share are very low.

Exhibit 52


HCV Wave 2 Contracting Recommendations
September 9, 2014
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SOF/LDV Contracting Recommendations

Summary Contracting Guideline

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SOF/LDV Contracting Guidelines

SEGMENT	SELECT PAYER	SOF/LDV WAC PRICE VS. DISCOUNT $94.5K	APPROACH	COMMENTARY
Kaiser	Kaiser Only	20%	PROACTIVE	
IDN	Geisinger, UPMC, SelectHealth, Henry Ford	8-10%	PROACTIVE	• Henry Ford is reactive only
DOC	CA, FL, NY, OH, MI, AZ State DOC's + UTMB (TX)	10-20%	PROACTIVE	• Contract with listed State DOC's at a discount of 10-20%. UTMB will receive 340B pricing and a 10-15% supplemental discount on eligible utilization (10% on Commercial utilization)

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SOF/LDV Contracting Guidelines (Continued)

SEGMENT	SELECT PAYER	SOF/LDV WAC PRICE VS. DISCOUNT $94.5K	APPROACH	COMMENTARY
FFS Medicaid	Medicaid Pools Magellan and SSDC Independent States: Magellan Independent States: FL, MO, TN, TX, VA All other independent states: CA, CO, GA, IL, IN, MA, OH	4-10%	PROACTIVE	• Independent states will be negotiated if they are listed as "select payers" or reactive, as needed • Discounts will be tiered based on the coverage levels (fibrosis level) • Listed on PDL (4%) • F2-F4 (8%) • PA to Label (10%)

Contracting Guidelines

SEGMENT	SELECT PAYER	SOF/LDV WAC PRICE VS. DISCOUNT $94.5K	APPROACH	COMMENTARY
Managed Medicaid	All	See Commentary	• PROACTIVE FOR PerformRx And Envision Rx • REACTIVE FOR ALL OTHER MMCO ACCOUNTS ACCORDING TO GUIDELINE CRITERIA	• At launch, for Type A accounts, proactively extend rebates for SOF/LDV at 4% - 5% • At formulary review/competitor launch, rebates for the Type A accounts in 5% - 7% range • For Type B accounts, either half of rebate available to account capped at 7% or rebate range of 5% - 7% • For Type C accounts, discounts will be considered based on guideline criteria

*Type A: SOF/LDV Targets **Type B: Letter offers but no current account ***Type C: All other accounts

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SOF/LDV Contracting Guidelines (Continued)

SEGMENT	SELECT PAYER	SOF/LDV WAC PRICE VS. DISCOUNT $94.5K	APPROACH	COMMENTARY
VA	VA/DOD	10% (plus 26% statutory discount)	PROACTIVE	• VA discount will be proactively submitted at launch via TPR
340B	All	Statutory Discounts	PROACTIVE	• All 340B accounts will receive statutory discount with the exception of UTMB and PR DOH (10%)
Healthcare Exchanges	All	Equal to Commercial Discounts	PROACTIVE	• Exchange utilization will be included in commercial account contracts at the commercial discount rate

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HCV Wave 2 Contracting Recommendations

Commercial and Part D

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Contracting Objective

Develop a profitable discount/contract model for all channels to ensure treatment decisions remain in physicians' hands by minimizing the use of formulary restrictions (especially relative to competing treatment regimens)

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Contracting Guiding Principles

- We anticipate that payers will continue to use formulary restrictions (e.g., PA to label including treatment duration, PA to F2-F4, prescribing limited to specialists, genotype) to segment and prioritize patients to manage the aggregate cost of treatment
  - Non-invasive techniques (e.g., FibroScan and platelet count) are preferred to determine a patient's disease progression/ severity; liver biopsies are invasive and viewed as restrictive
- SOF/LDV contracting should not disadvantage SOF - maintain SOF access
- Payer contracts should support broad/appropriate access and should not encourage patient segmentation, prioritization, or reduced treatment durations that are outside the label
- Parity access is the targeted level of access and will be sought proactively with targeted accounts
  - Preferred access (1:1) will be evaluated when a payer intends to offer only one preferred position option, when it will likely be more profitable than parity access, and/or on the basis of specific strategic rationale to limit price erosion
  - Clear operating principles must be provided for parity and/or preferred access scenarios that are likely to be unprofitable
- Contracting guidelines (rebate ranges, exceptions processes) are required at launch to support ongoing negotiations
  - New competitive entrants may drive changes to the contracting principles

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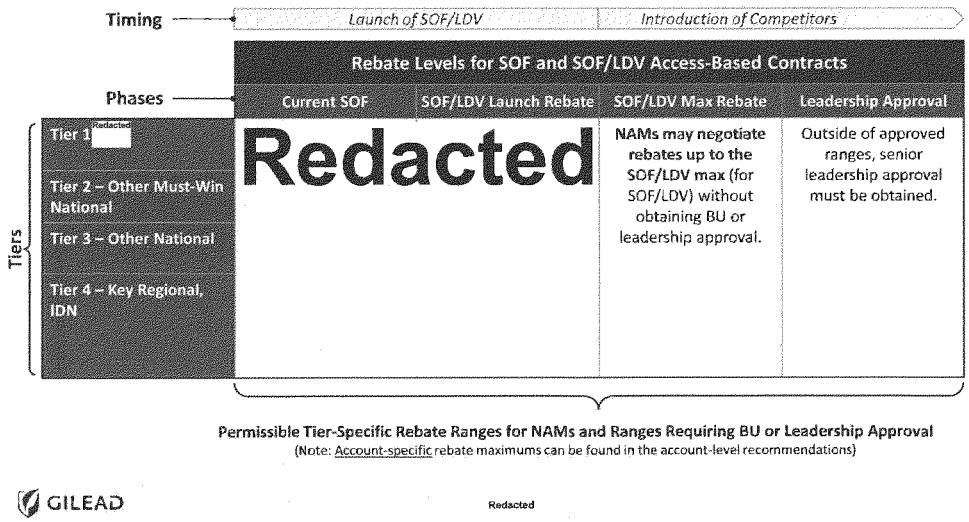
Contracting Recommendations and Rationale
Overview of Phased Rebate Approach

Framework for Phased Rebate Approach



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Contracting Recommendations and Rationale
Overview of Tiered Rebate Approach

Below are the rebate recommendations for each account tier. Due to their size and influence, ESI, CVS Caremark, Humana, UnitedHealthcare, and WellPoint are considered "must win" accounts.

		Accounts	Max Rebate (594.5K WAC for 12 wk regimen)
Tier 1	National	EXPRESS SCRIPTS®	8% - 12%
Tier 2	National	Humana. OPTUMRx WELLPOINT	8% - 12% (Humana: 12% - 15%)
Tier 3	National	aetna CVS CAREMARK PRIME WellCare	8% - 12%
Tier 4	Key Regionals	blue of california Harvard Pilgrim HealthCare ...and others	10%
Tier 4	Kaiser	KAISER PERMANENTE	20%
Tier 4	Other IDNs	selecthealth GEISINGER UPMC	8-10%
Tier 5	High Potential, High Control	Rebate 5%	5%
Aggregate Rebate			7% - 10%

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Contracting Recommendations and Rationale
Detailed Rebate Levels: Must-Win National Accounts (1 of 2)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 1	Express Scripts (Commercial)	210,450	▪ Lowest preferred brand co-pay position ▪ Parity ▪ PA to label	5%	5%	8% - 12%
Tier 1	Express Scripts (Part D)	23,450		5%	5%	8% - 12%
Tier 2	Humana (Commercial)	11,000	▪ Lowest preferred brand co-pay position for DAAs ▪ Parity ▪ PA to label	10%	5%	10% - 12%
Tier 2	Humana (Part D)	31,700		15%	5%	15%
Tier 2	Optum Rx (Commercial)	75,240	▪ Lowest preferred brand co-pay position for DAAs ▪ Parity ▪ PA to label	10%	5%	10% - 12%
Tier 2	Optum Rx (Part D)	3,660		10%	5%	10% - 12%

- Price protection is part of current Humana SOF contract. Price protection will not be offered for SOF/LDV at launch, but may be negotiated
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa
- Health Insurance Exchange (HIX) business is included in listed rates.

GILEAD Sources: Gilead Account Manager Survey, July 2014; Zitter PATT data, May 2014; Payer Segmentation analysis.

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Contracting Recommendations and Rationale
Detailed Rebate Levels: Must-Win National Accounts (2 of 2)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 2	WellPoint (Commercial)	71,250	▪ Lowest preferred brand or specialty co-pay position ▪ Parity ▪ PA to label	10%	5%	10% - 12%
Tier 2	WellPoint (Part D)	5,270		10%	5%	10% - 12%
Tier 3	CVS Caremark (Commercial)	22,035	▪ Parity ▪ PA to label	8%	5%	8% - 12%
Tier 3	CVS Caremark (Part D)			10%	5%	10% - 12%

- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

GILEAD Sources: Gilead Account Manager Survey, July 2014; Xantus PATT data, May 2014; payer segmentation analysis;

Contracting Recommendations and Rationale
Detailed Rebate Levels: Tier 3 (Other National Accounts 1/2)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 3	**Aetna (Commercial)**	41,300	▪ Lowest brand or specialty co-pay position within the defined basket (Olysio, Incivek, Victrelis) ▪ PA to label ▪ Parity	10%	5%	10% - 12%
	Aetna (Part D)	4,840		10%	5%	10% - 12%
	Catamaran (Commercial)	22,900	▪ Lowest preferred brand co-pay position ▪ Parity ▪ PA to label	5%	5%	8% - 12%
	Catamaran – Cigna (Commercial)	33,690	▪ Lowest preferred brand co-pay position ▪ Parity ▪ PA to label	5%	5%	8% - 12%
	Catamaran – Cigna (Part D)	9,085		5%	5%	8% - 12%
	Catamaran –Health Spring (Part D)	1,600	▪ Lowest preferred brand co-pay position ▪ Parity ▪ PA to label	5%	5%	8% - 12%

- Price protection is part of current Aetna and Catamaran SOF contracts. Price protection will not be offered for SOF/LDV at launch, but may be used in negotiating upon formulary review of Wave 2 regimens.
- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

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Source: [illegible] Survey, July 2014; Elixir PATT Data, May 2014; Payer Segmentation analysis.

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Contracting Recommendations and Rationale
Detailed Rebate Levels: Tier 3 (Other National Accounts 2/2)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 3	Coventry (Commercial)	6,965	▪ Lowest brand or specialty tier co-pay position within the defined basket (Olysio, Incivek, Victrelis) ▪ Parity ▪ PA to label	10%	5%	10% - 12%
	Coventry (Part D)	7,800		10%	5%	10% - 12%
	Prime Therapeutics (Commercial)	71,150	▪ Lowest preferred brand co-pay position for DAAs ▪ Parity ▪ PA to label	10%	5%	10% - 12%
	Prime Therapeutics (Part D)	5,590		10%	5%	10% - 12%
	WellCare (Part D)	8,280	▪ Lowest specialty tier with respect to branded DAAs ▪ Parity ▪ F2-F4 fibrosis scores using METAVIR scoring and imposed on other DAAs	10%	5%	10% - 12%

- Price protection is part of current Prime SOF contract. Price protection will not be offered for SOF/LDV at launch, but may be used for negotiating leverage upon formulary review of Wave 2 regimens.
- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

GILEAD Sources: Gilead Account Manager Survey, July 2014; Zirbe PATT data, May 2014; Payer Segmentation analysis.

Contracting Recommendations and Rationale
Detailed Rebate Levels: Tier 4 (East Region)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 4	EnvisionRx Options (Commercial)	12,540	▪ Lowest preferred brand co-pay position ▪ Parity ▪ PA to label	5%	5%	10%
	EnvisionRx Options (Part D)	5,700		5%	5%	10%
	EnvisionRx Options (Medicaid)	3,420		5%	5%	5% - 7%
	PerformRx (Commercial)	114	▪ Lowest preferred brand co-pay position ▪ Parity ▪ PA to label	4%	5%	10%
	PerformRx (Medicaid)	6,270		4%	5%	5% - 7%
	PerformRx (Part D)	143		4%	5%	10%

- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

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Sources: Gilead Account Manager Survey, July 2014; Zitter PATT data, May 2014; Payer Segmentation analysis.
*Current formulary information not available; listed are NAM survey results for intended Wave 2 management.

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Contracting Recommendations and Rationale
Detailed Rebate Levels: Tier 4 (Central Region 1/2)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 4	**BCBS MI (Commercial)[1]**	324 (est. starts)	▪ Tier 2 ▪ PA to Label plus specialist, IFN unwilling, patient readiness, F score, ST, QL	None	Highmark	
	BCBS MI (Part D)[1]	75 (est. starts)	▪ Specialty Tier ▪ PA to Label plus specialist, IFN unwilling, patient readiness, F score, ST, QL	None	Highmark	
	Health Alliance (Commercial)[1]	57 (est. starts)	▪ Specialty Tier ▪ PA to label plus specialist, IFN unwilling, patient readiness, F score, ST, QL	None	None	None

- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

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Sources: Gilead Account Manager Survey, July 2014; Zitter PATT data, May 2014; Payer Segmentation Analysis.
[1]Current formulary information not available; listed are NAM survey results for intended Wave 2 management.

Contracting Recommendations and Rationale
Detailed Rebate Levels: Tier 4 (Central Region 2/2)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 4	Priority Health (Commercial)[1]	13 (est. starts)	▪ Specialty Tier ▪ PA to label plus IFN unwilling, ST, QL	None	None	None
	Priority Health (Part D)[1]	N/A		None	None	None
	Scott & White (Commercial)[1]	10 (est. starts)	▪ Specialty Tier ▪ PA to label plus IFN unwilling, patient readiness, F score, ST	None	None	None
	Scott & White (Part D)[1]	N/A		None	None	None
	Wellmark BCBS (Commercial)[1]	104 (est. starts)	▪ Specialty Tier ▪ PA to label plus ST	None	Catamaran	

- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

GILEAD Sources: Gilead Account Manager Survey, July 2014; Optum PATT data, May 2014; Payer Segmentation analysis;
[1]Current formulary information not available; listed are NAM survey results for intended Wave 2 managements.

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Contracting Recommendations and Rationale
Detailed Rebate Levels: Tier 4 (West Region)

		HCV Lives	Current Formulary Management	SOF Rebate	SOF/LDV Rebate	
					Launch	Max
Tier 4	**BCBS AZ (Commercial)[1]**	292 (est. starts)	▪ Tier 2 ▪ PA to label plus specialist, IFN unwilling, patient readiness, QL	5%	5%	10%
	BS of CA (Commercial)	8,550	▪ Specialty tier position for branded DAAs ▪ Parity	5%	5%	10%
	BS of CA (Part D)	855		5%	5%	10%
	Health Net (Commercial)	6,000	▪ Lowest preferred brand co-pay position for DAAs ▪ Parity	5%	5%	10%
	Health Net (Part D)	1,150	▪ Lowest preferred brand co-pay position for DAAs ▪ Parity	10%	5%	10%
	Regence BlueShield (Commercial)[1]	131 (est. starts)	▪ Preferred Tier ▪ PA to label plus specialist, F score, ST, QL	None	Catamaran	

- Health Insurance Exchange (HIX) business is included in listed rates.
- Rebates for Commercial and Medicare Part D plans will be negotiated separately. Rebates for Commercial would not be contingent on rebates for Part D, and vice versa

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Sources: Gilead Account Manager Survey, July 2014; Zitter PATT data, May 2014; Payer Segmentation analysis.
[1]Current formulary information not available; Rated are NAM survey results for intended Wave 2 management.

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Contracting Recommendations and Rationale
Wave 2 LOIs, No Current Sovaldi Contracts (1/2)

The accounts listed below have received letters of intent for Wave 2, but do not have current SOF contracts.

	Segment	LOI	SOF/LDV Rebate	
			Launch	Max
Arkansas Blue Cross Blue Shield	T4	▪ Unsigned	0%-5%	10%
Emblem Health (Commercial)	T4	▪ Signed	0%-5%	10%
Emblem Health (Part D)	T4	▪ Signed	0%-5%	10%
Gateway (Managed Medicaid)	T4	▪ Unsigned	0%-5%	5%
Gateway (Part D)	T4	▪ Unsigned	0%-5%	10%
Harvard Pilgrim (Commercial)	T4	▪ Unsigned	0%-5%	10%
HealthPartners (Commercial)	T4	▪ Unsigned	0%-5%	10%
HealthPartners (Part D)	T4	▪ Unsigned	0%-5%	10%
Health Partners of PA (Commercial)	T4	▪ Signed	0%-5%	10%
Health Partners of PA (Part D)	T4	▪ Signed	0%-5%	10%
Highmark (Commercial)	T4	▪ Signed	0%-5%	10%
Highmark (Part D)	T4	▪ Signed	0%-5%	10%

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Contracting Recommendations and Rationale
Wave 2 LOIs, No Current Sovaldi Contracts (1/2)

The accounts listed below have received letters of intent for Wave 2, but do not have current SOF contracts.

	Segment	LOI	SOF/LDV Rebate	
			Launch	Max
MedImpact (Commercial)	T4	▪ Unsigned	0%-5%	10%
MedImpact (Part D)	T4	▪ Unsigned	0%-5%	10%
Navitus (Commercial)	T4	▪ Unsigned	0%-5%	10%
Navitus (Part D)	T4	▪ Unsigned	0%-5%	10%
Pharmaceutical Technologies (Commercial)	T4	▪ Unsigned	0%-5%	10%
Pharmaceutical Technologies (Part D)	T4	▪ Unsigned	0%-5%	10%
Presbyterian (Commercial)	T4	▪ Unsigned	0%-5%	10%
Presbyterian (Part D)	T4	▪ Unsigned	0%-5%	10%
SelectHealth (Commercial)	T4	▪ Unsigned	0%-5%	10%
SelectHealth (Part D)	T4	▪ Unsigned	0%-5%	10%
UPMC (Commercial)	IDN	▪ Signed	0%-5%	8%
UPMC (Part D)	IDN	▪ Signed	0%-5%	8%

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HCV GTN: June LE vs. Current Scenario

Changes from June LE:

1) Redacted

2) Assumes SP fee's of 1% to 70% of population (0.7% GTN impact) for LDV/SOF and 5816/SOF

3) Lowered sales return assumptions from 0.8% overall to 0.1% and ramping up to 0.8% by 2017 for all products

Redacted

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GTN % June LE vs. Current Bridge

Redacted

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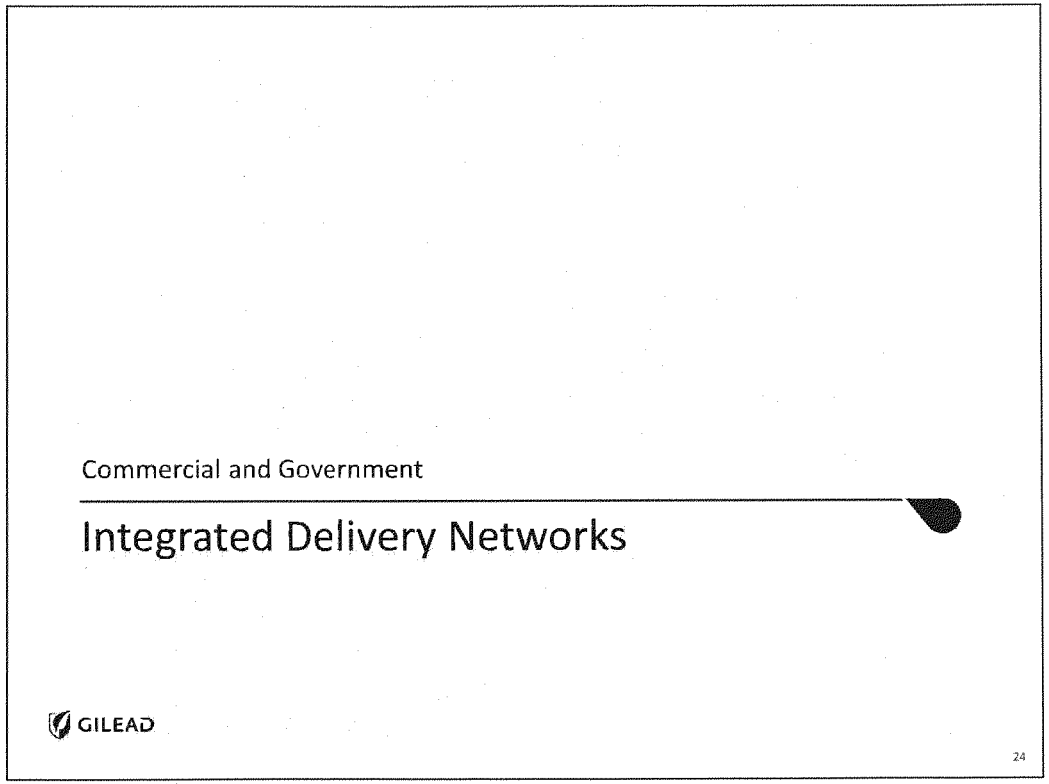

Executive Summary

Current IDN Landscape

- **High control** organizations with the **ability to move market share** within regional markets
  - Typically have a high level of physician buy-in for formulary decisions
  - Physicians are often incentivized via shared pharmacy and medical savings
- Sophisticated **data capabilities** to understand trends and inform patient programs

Current Contracting Relationships

- In Wave 1, SOF contracts were extended to Kaiser and Geisinger
- Additionally, Wave 2 LOIs have been extended to SelectHealth (Intermountain) and UPMC

SOF/LDV Contracting Approach

- **Proactively contract with Kaiser** at an account-specific rebate of up to 20%
  - Kaiser controls ~3% of the HCV market and has articulated expectations of a rebate as high as 30%-49%
  - The rebate may be extended by BU and Executive Leadership above 20%
- **Proactively contract with other regionally important IDNs** at a rebate of up to 10%
  - Current recommendations include **Geisinger, SelectHealth** (Intermountain), and UPMC
  - Rebate range may be extended by BU and Executive Leadership above 10%
- **Reactively contract with other IDNs** identified to be strategically important (e.g., Henry Ford Health System) at a rebate up to 8%

IDNs are high control organizations with significant local market influence and may be a segment of interest for future HCV program partnerships.

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General Overview of Integrated Delivery Networks

Business Model

Current Business Model

- Organizations include **clinics, pharmacies, hospitals, and health plan(s)**
- The majority of covered lives are commercial; also cover managed Medicaid, MAPD, and PDP
- Some have opted into the **CMS Pioneer ACO program** with the goal of greater coordination of care across settings for Medicare beneficiaries (e.g., Sharp Healthcare, Presbyterian Healthcare Services)
- IDN plans usually feature **capitated payments** for hospitals/providers

Anticipated Evolution

- While the number of IDNs is anticipated to grow in the future, **no major evolution** in the model is expected, with the exception of **technology enhancements** and more patient outreach programs.

Payment Model

General Description

- If the health plan or hospital are successful, **typically savings are shared with physicians**; losses are generally assumed across the medical group
- Physicians may be **salaried employees**, or **private providers** who assume some risk under contract with local hospitals
- Physician performance is based on all medical and pharmacy utilization and is usually a peer-based comparison

Incentive and Penalty Structures

- Shared savings based on efficiencies
- **Bonus structure** typically based on performance metrics for overall clinical goals (e.g., to address general treatment issues), as well as specific goals for specialty areas
- Some IDNs closely **monitor/manage high risk and high cost patients** through various programs, including Medication Treatment Management (MTM)

Metrics and Progress

Key Metrics

- **Internally driven metrics vary between TAs** and may include: admissions and medical utilization by physician, length of stay, mortality, medication compliance, hospital readmissions, and/or patient management

Performance and Challenges

- Generally strong performance against internal and external performance metrics
- **Expect increased scrutiny** of treatment options/new drugs unless clear cost savings
- Open to long-term value vs. price arguments (excluding HCV and transplants)
- Value patient adherence

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IDN Segment Dynamics and Overview

Individual providers have significantly less power and influence in IDNs. To achieve economies of scale and improve outcomes, IDNs have centralized control over a number of treatment parameters.

Formulary Decisions	Formularies are typically closed. Prescribing physicians often sit on P&T Committees, which drives prescriber buy-in, utilization, and experience with specific treatments.
"No-Call" Restrictions	Many IDNs have a "no-call" and/or restrictive policies to limit manufacturer access (includes reps, educators, and reimbursement specialists).
Sophisticated Technology	Functional integration and sophisticated data capabilities with a strong focus on EMR management characterize most IDNs.
HCV Treatment	IDNs are informed by external guidelines, but independently develop internal treatment protocols with a high degree of physician buy-in. HCV case management and MTM are likely.

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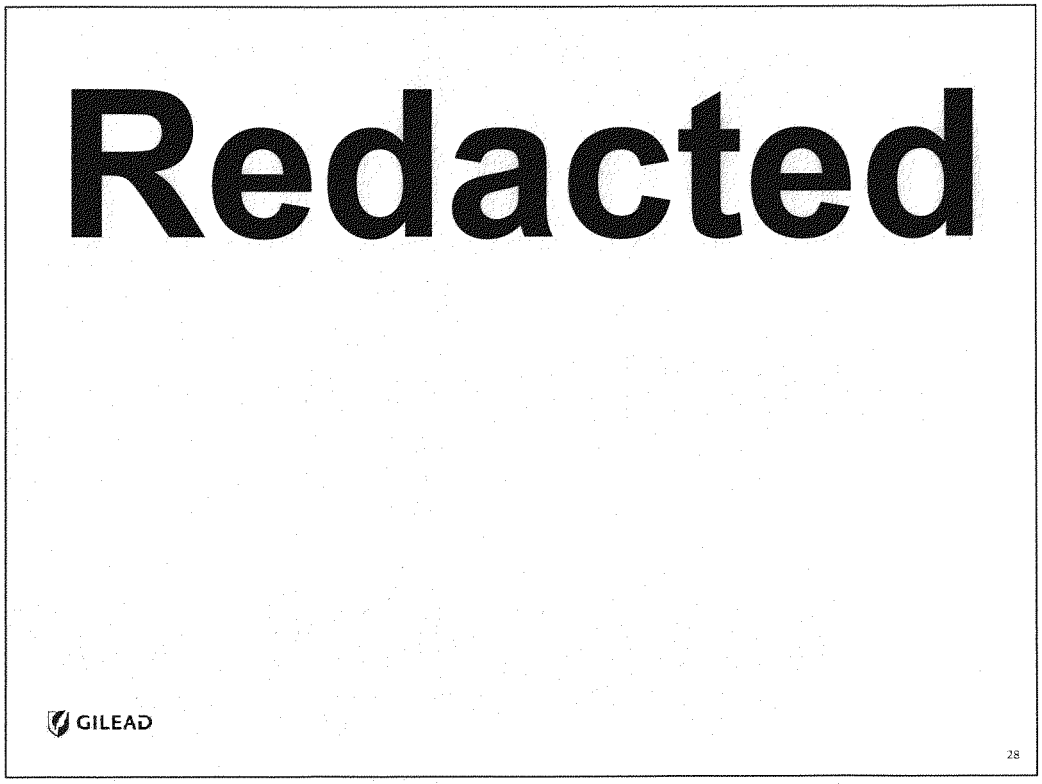

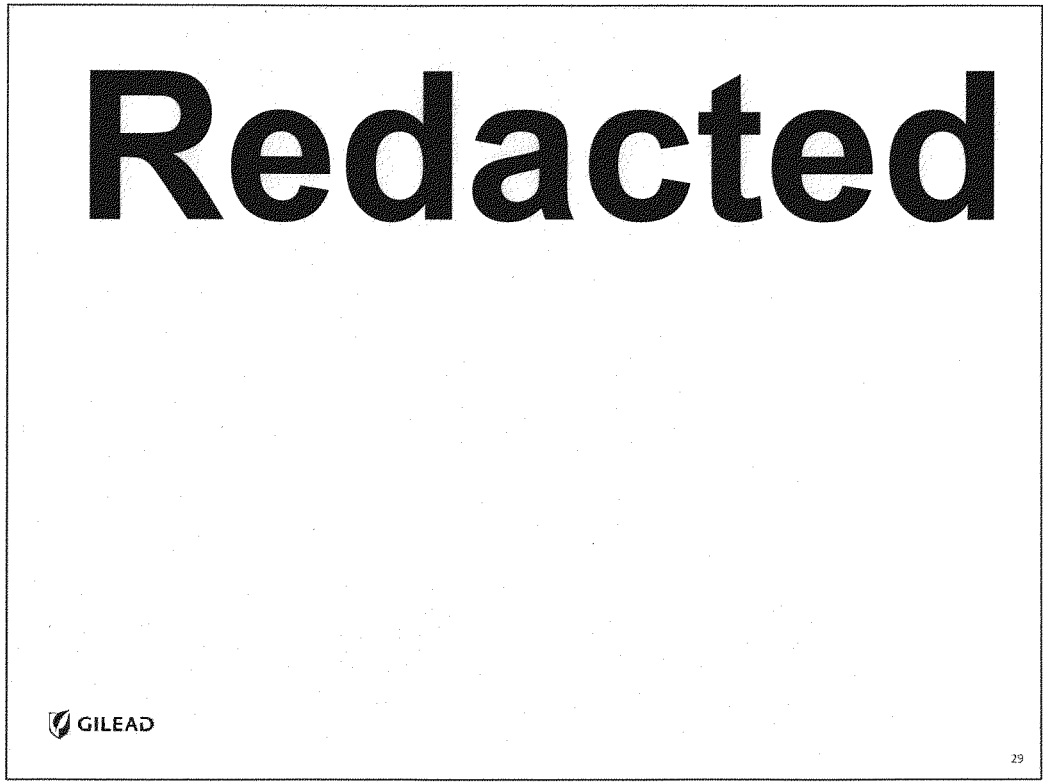

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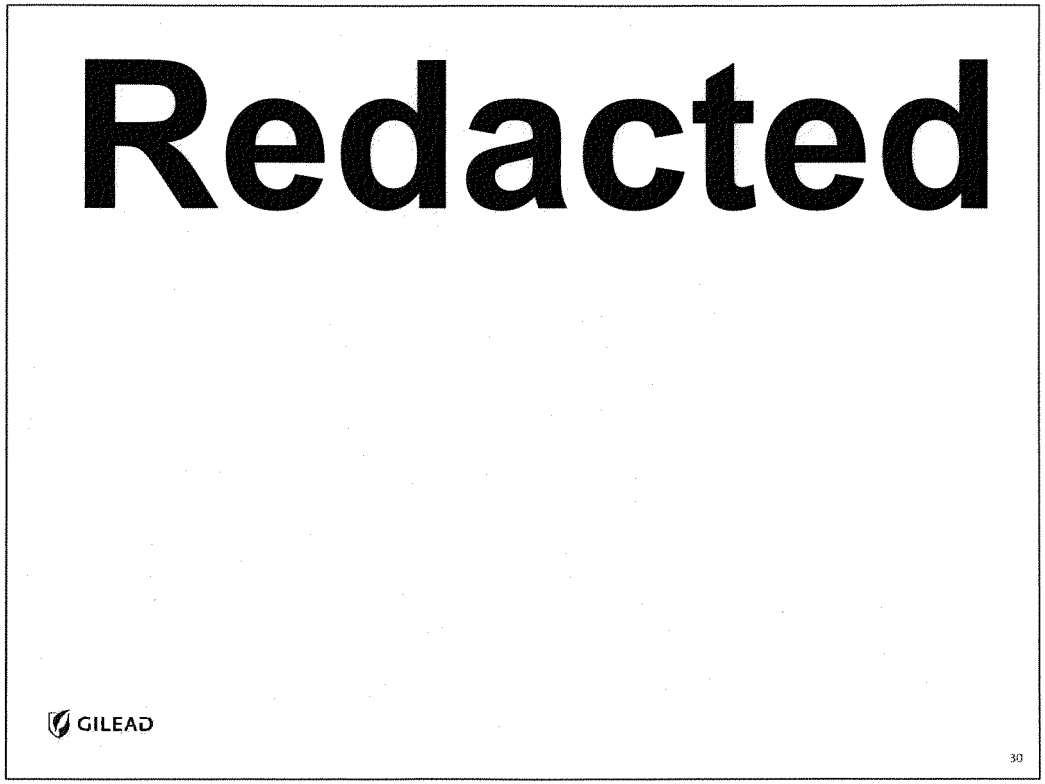

Commercial and Government

Department of Corrections

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Executive Summary
Department of Corrections ("DoC")

Current Landscape

- Budget restrictions severely handicap testing and treatment
- Oral regimens are attractive in the DOC but will not alone increase treatment
- Untreated inmates will return to community and will likely receive treatment under Medicaid at a substantial discount or free PAP
- Limited existing contracts (CA DGS and UTMB contracts)

Market Size

- High HCV prevalence rate in the DoCs (est. 360k patients)
- State DoCs pay commercial prices except for a limited few with 340B pricing
  - State DoCs are not Best Price exempt (except for where they utilize 340B structure)
- Patient treatment rates vary across states (range from 25-400 patients/year) based on budget constraints / other limitations

SOF/LDV Contracting Approach

- Proactively contract with CA DGS and the top 5 non-contracted state DoCs with high prevalence rates and inmate population (propose one-year contract)
- No contract with MCOs or jails
- Target an initial discount of 10% - 15% (with a 20% max) to position SOF/LDV on formulary and potentially remove treatment barriers
  - Solidify positioning of SOF/LDV in preparation for future policy changes
  - Demonstrate support for treatment of more patients

Testing and treatment continue to be access barriers. Offer select discounts on SOF/LDV to support patients access and future policy changes for HCV treatment.

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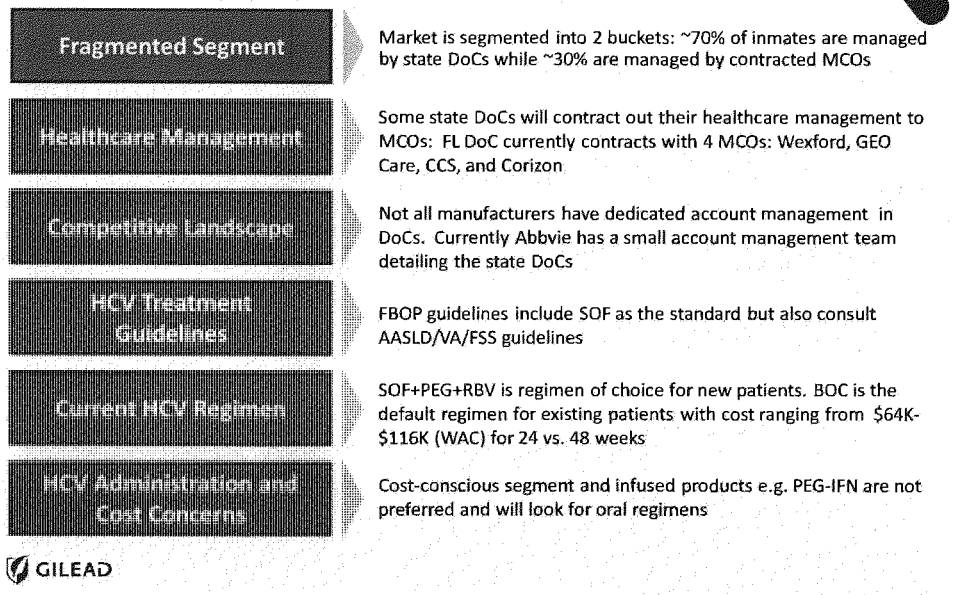
DoC Segment Dynamics and Overview



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Sovaldi Regimens for GT 1 and 4 Recommended in the FBOP Interim Guidance (selected information)

HCV Mono-infected and HCV/HIV-1 Co-infected Patients		Recommended Regimen
GT 1	Treatment-naïve and prior Peg-IFN + RBV relapsers	SOVALDI + Peg-IFN + RBV 12 weeks
GT 4	Treatment-naïve and prior Peg-IFN + RBV non-responders and prior relapsers	SOVALDI + Peg-IFN + RBV 12 weeks

- According to the FBOP interim guidance:
  - The following clinical scenarios involving chronic HCV infection should be prioritized for treatment:
    - Advanced hepatic fibrosis/cirrhosis
    - HIV co-infection
    - Continuity of care for newly-incarcerated inmates who were being treated at the time of incarceration
  - In addition to the above, inmates being considered for treatment of HCV should:
    - Not be pregnant nor have contraindications to any components of the treatment regimen
    - Have sufficient time remaining on their sentence to complete therapy
    - Have demonstrated willingness and ability to adhere to treatment regimen and abstain from high-risk activities while incarcerated

FBOP = Federal Bureau of Prisons.

Federal Bureau of Prisons. http://www.bop.gov/resources/pdfs/hepatitis_c_current.pdf. May 2014. Accessed June 11, 2014.

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Sovaldi Regimens for GT 2 and 3 Recommended in the FBOP Interim Guidance (selected information)

HCV Mono-infected and HCV/HIV-1 Co-infected Patients		Recommended Regimen
GT 2	Treatment-naïve and prior Peg-IFN + RBV nonresponders* and prior relapsers	SOVALDI + RBV 12 weeks
GT 3	Treatment-naïve and prior Peg-IFN + RBV nonresponders and prior relapsers	SOVALDI + RBV 24 weeks

*Without cirrhosis.

- According to the FBOP interim guidance:
  - The following clinical scenarios involving chronic HCV infection should be prioritized for treatment:
    - Advanced hepatic fibrosis/cirrhosis
    - HIV co-infection
    - Continuity of care for newly-incarcerated inmates who were being treated at the time of incarceration
  - In addition to the above, inmates being considered for treatment of HCV should:
    - Not be pregnant nor have contraindications to any components of the treatment regimen
    - Have sufficient time remaining on their sentence to complete therapy
    - Have demonstrated willingness and ability to adhere to treatment regimen and abstain from high-risk activities while incarcerated

FBOP = Federal Bureau of Prisons.

Federal Bureau of Prisons. http://www.bop.gov/resources/pdfs/hepatitis_c_current.pdf. May 2014. Accessed June 11, 2014.

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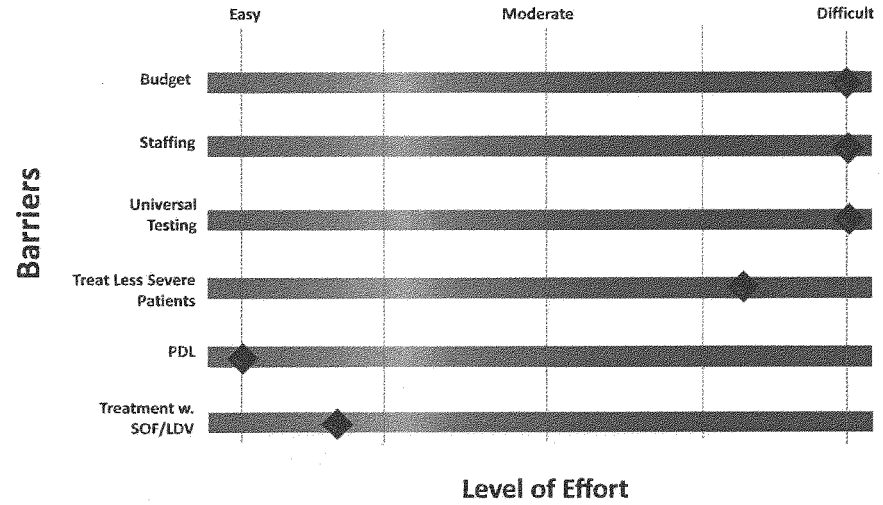
What Are the Institutional Barriers and Can We Potentially Reduce Them Through Contracting?



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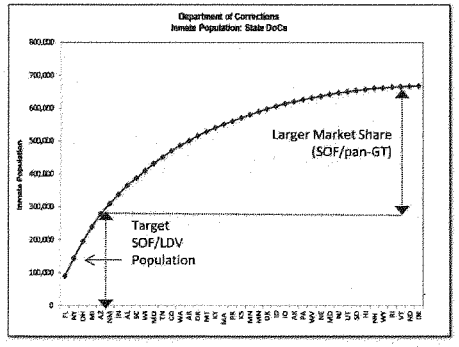
Whom Do We Contract With?

We recommend top 5 commercial state DoCs which represents ~42% of non-contracted inmate lives



Sources: KAS Survey, DoC Websites

- Total estimated inmate population is ~1.2M, with an estimated prevalence rate of 30%, 360,000 inmates in need of treatment for HCV
- 57% of ~1.2M inmate lives reside in state DoCs without Sovaldi contracts
- Consider a phased approach for contracting
  - SOF/LDV – Top 5 DoCs
  - SOF/pan-GT – Broader contract strategy

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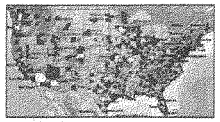
We propose using selection criteria to contract based on prevalence rates and inmate population



Commercial				
Payer	State DoCs	Inmate Pop	Map of HCV cases	SOF/LDV Contract
DoC	CA DOC	118,000	7,046 or Greater	Existing Contract (SOF)
Prioritized Contract*	FL	102,000	2,675-7,045	✓
DoC	NY	54,000	7,046 or Greater	✓
DoC	GA	50,000	1,750-2,674	✓
Centene*	MI	44,000	2,675-7,045	✓
Centene*	AZ	42,000	1,750-1,674	✓

340B Pricing Recipients				
Payer	Prime Recipient 340B Pricing	Inmate Pop	Map of HCV cases	SOF/LDV Contract
UTMB	TX	135,000	2,675-7,045	Existing Contract (SOF)
DoC	CA	118,000	2,675-7,045	No Contract
DoC	IL	50,000	2,675-7,045	No Contract
DoC	LA	34,000	1,750-2,674	No Contract

Proactively contract with top 5 key state DoCs plus those with existing contracts CA and UTMB

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*Only contract with state DoCs and not MCOs

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Recommendation of Select Contracts

State DoCs	MCO/Jails	340B Pricing Entities (23% off WAC)
Option: • Contract with top 5 non-contracted state DoCs for 10% - 15% (with a 20% max) off WAC at formulary position (possibly preferred) • Proactive approach Benefits: • Monitor contract performance to determine if patient treatment rates increase • Access to DoC data (poor coverage of this segment currently) Risks: • Spillover to other non-contracted state DoCs • If SOF/LDV is not covered, we may miss out on treatment opportunities arising from public policy changes	• Contracts with MCOs are difficult to manage as the accounts change frequently and expose discounts more broadly • Jails – inmates short length of stay does not make treating HCV ideal. – Volume of patients appears to be low	Option: • No contracting with 340B entities since they are already receiving a reduced price

Agreements continue to support treatment within the DoC. Upon release patients may be eligible to Medicaid, PAP or be lost to care

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NOTE: UTMB's non-340B population is recommend at 10% off WAC

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Other Recommended Contracts

UTMB (340B)	UTMB (non-340B)	CA DGS (DoC)
Contract Offered: PENDING (+10%) Proposed offer: (340B +10-15%) Overview: • Support for treatment in DoC within available budget. • Discounts will support more treatment for diagnosed patients Risks: • Requesting discounts on non-340B utilization	No current contract on non-340B utilization, however it has been requested for Wave 2 - One entity (Texas Tech) is not collecting 340B price, recommend offer of 10% discount on commercial business	Contract signed May 2014 (10%) Overview: • Utilization appears to be increasing (low rebates) • Agreement can be amended for SOF/LDV

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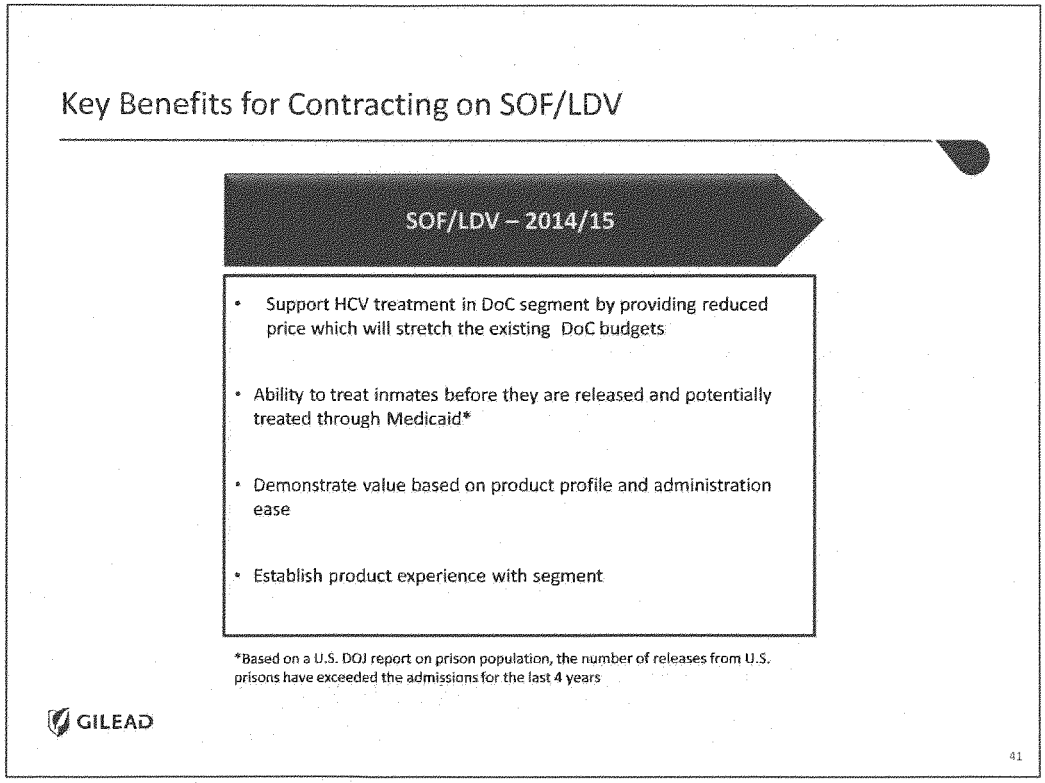

HCV Wave 2 Contracting Recommendations

Public Health Service (PHS) 340B Sub-WAC Discounts

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Executive Summary
Public Health Service ("PHS") (excludes UTMB)

Current Landscape

- The program was created in 1992 with the passage of the Veterans Health Care Act ("VHCA")
- The VHCA requires manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price
- The 340B program is intended to support entities that serve the "uninsured, isolated or medically vulnerable"
- Covered entities can use money saved on drugs for other patient services & increasing access to care

Market Size

- The Program aims to limit cost of drugs to safety net providers. A safety net provider:
  - Has an open door policy, patient treatment is not dependent on patient ability to pay for services
  - Serves a population that is largely "uninsured, under-insured and/or otherwise vulnerable"

Redacted

Goal of gaining parity access by offering discounts to a growing 340B/PHS and Medicaid population

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Puerto Rico Department of Health Overview

Healthcare Management

- US territory with the highest prevalence of HCV (~10-12%)
- Very low Federal funding compared to US (20%)
- Countrywide initiative for HCV testing began May 19th
- Medicaid population only testing for HCV

HCV Cost Concerns

- PR Department of Health is requesting a sub-ceiling 340B discount
- 340B eligible (~23% discount)
- **Redacted**
- No Best Price Implication

Redacted

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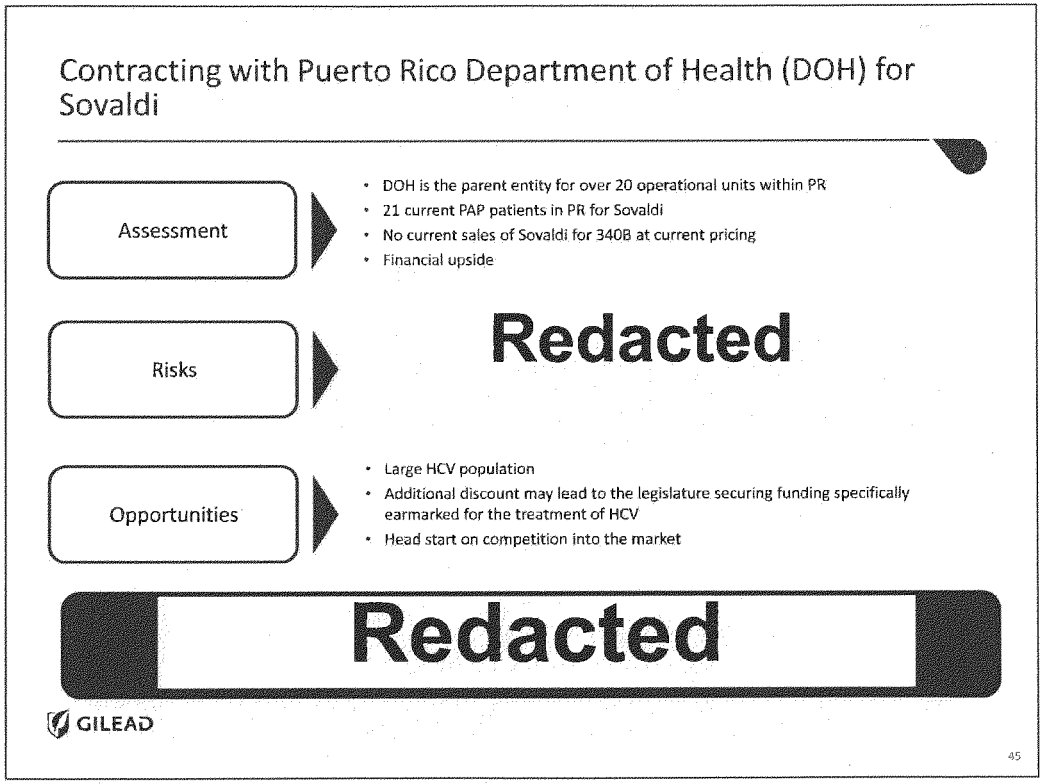

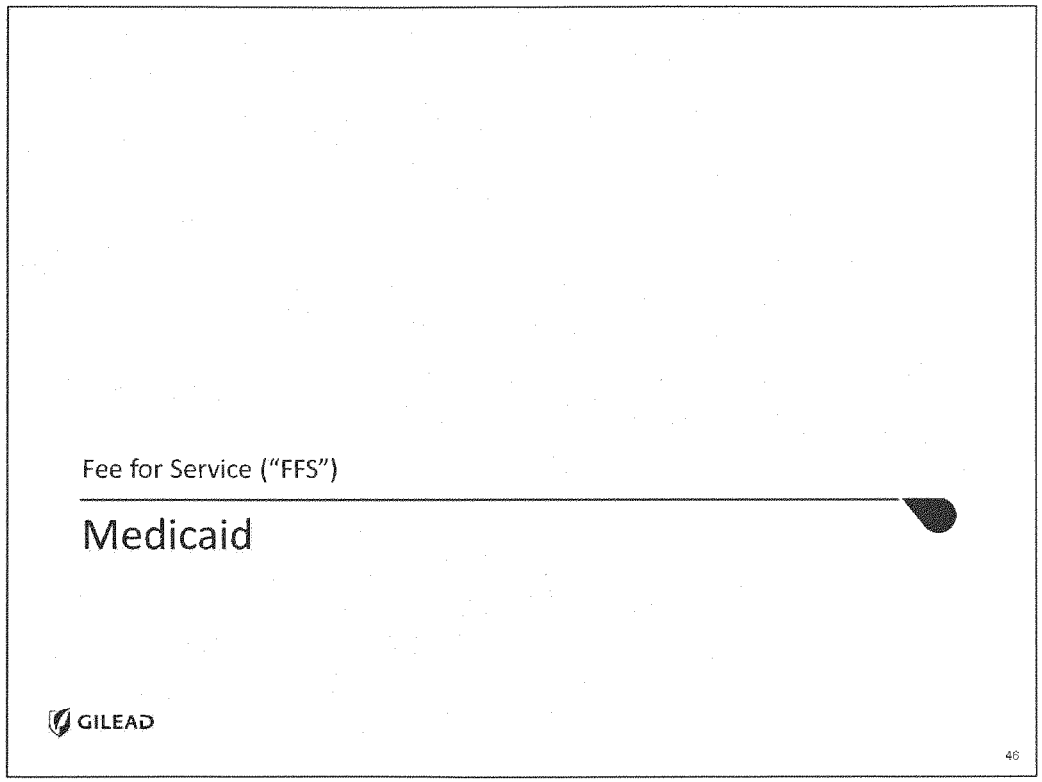

Executive Summary
Medicaid Fee For Service ("FFS")

Current Landscape

- There are 3 market segments – independent states, pools, and non-contracting states
- Given State level budget constraints, cost is a significant barrier
- Continued trend of States moving to Managed Medicaid
- No confidentiality within pools or across states
- Majority of states are managing HCV with strict criteria
  - 953 unique patients on Support Path
- No future use of Cosmos required in Wave 2
- Unit cost is the basis for a cost measure comparison
- Only one executed agreement (NMPI) and over 30 bids

Market Size

- Medicaid is the single largest source of health care coverage in the United States serving ~66 million people
- 22.8 million FFS lives with estimated ~130k HCV diagnosed lives
- 27 states implementing Medicaid expansion in 2014
- 1 in 5 Americans will be on Medicaid in any given year

SOF/LDV Launch Approach

- Independent and pool states get the same net pricing structure
- 4%-10% additional discounts
- Independent states: Wave 1 states
  - identified based on prevalence rates, restriction criteria, and influence factors
- Net Price and Best Price calculations will drive the final discount/rebate

Goal of gaining parity access by offering discounts to a growing Medicaid population

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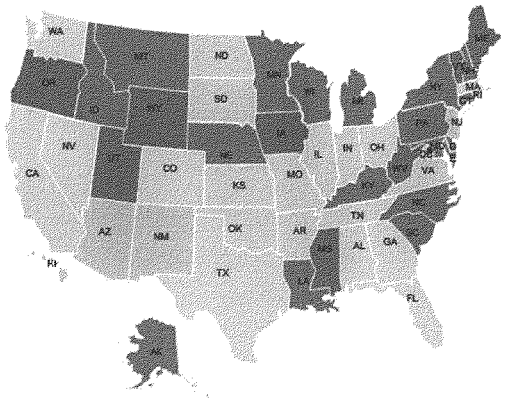
Distribution of Medicaid Segments is Unique and Complex

State Supplemental Landscape, July 2014



Independent States
- Formulary for 7 of the independent states are controlled by MMCO
- Supplemental FFS rebates required for MMCO in a few states, potentially leading to double/triple discounts

Pools
- Magellan interacts with 26 states – TOP$, NMPI and 4 independent states
- SSDC influences 8 states
- States share information within and across pools

No Contract States
- AZ, NM, ND, SD, and NJ do not contract and don't have a PDL
- AR, HI, and OK: do not manage HCV currently

Supplemental Consortium
Supplemental No Consortium
No Supplemental

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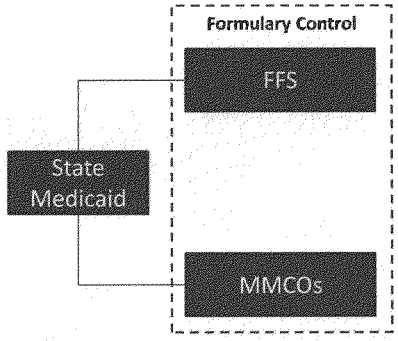
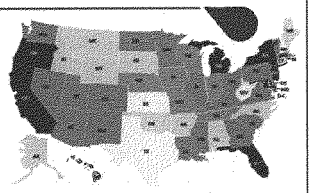
Commercial discounts could have broad impact across states, regardless of PDL criteria or formulary listing

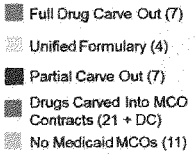
States Are Split in How the Drug Benefit is Managed Between FFS and MMCOs

States Medicaid MCO Formulary Status



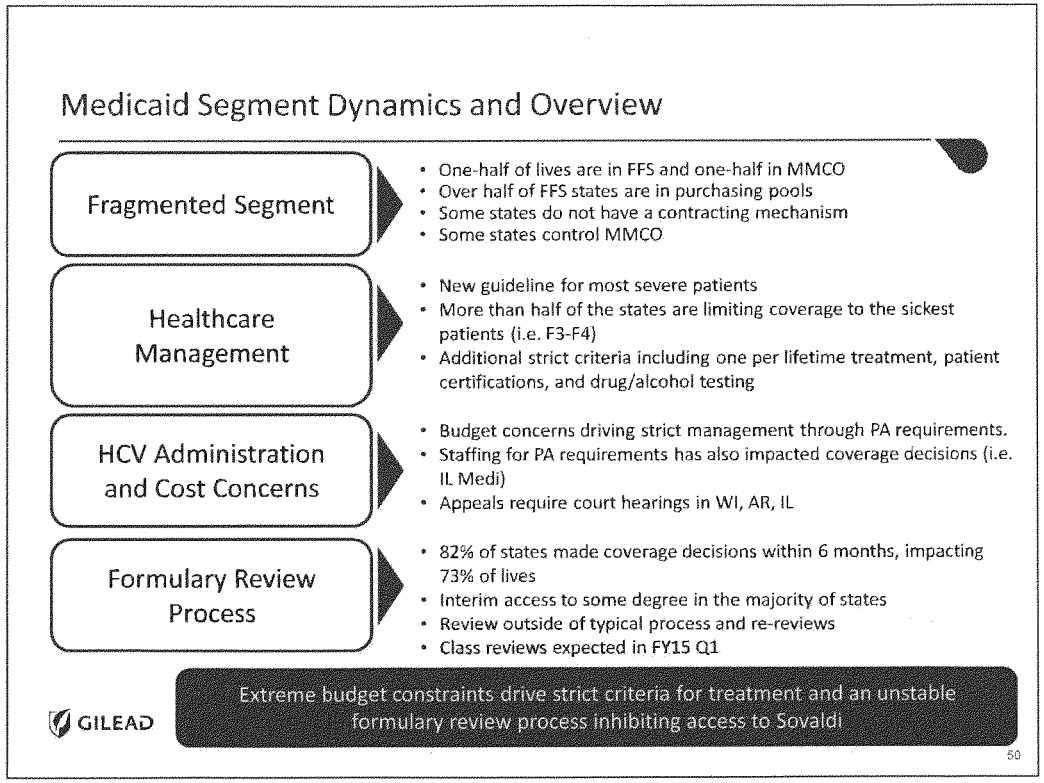
- 11 States have no MCO presence
- 7 States have full drug carve-out
- 7 States have partial drug carve-out
- 4 States have unified FFS and MCOs formulary
- 21 States+ D.C. have drugs carved into MCO contracts





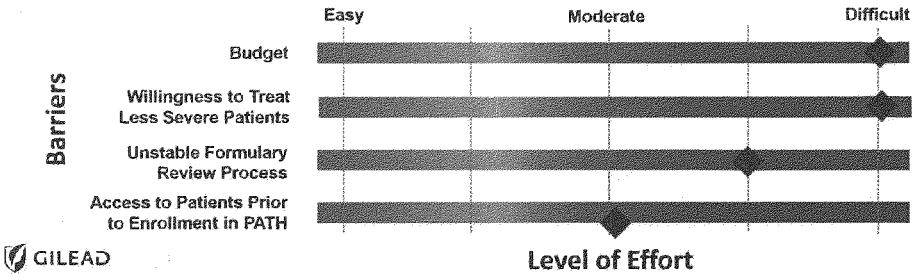
Within State Medicaid, contract strategy is driven by formulary control which can be with FFS, MCOs, or shared resulting in potential double or triple discounting

GILEAD Source: Avalere analysis, July 2013; updated to include ad hoc updates through March 2014
MCO: Managed Care Organization; FFS: Fee-for-service. *CA and FL's current programs are partial carve-outs; CA is considering moving to a unified formulary and FL will use a unified formulary for MCOs in its statewide MCO program, which begins in 2014 in four phases



What are the Barriers to Access and Can We Influence Them?

- **Budget concerns driving a delayed and unstable formulary review process**
  - States wait for competitors to hit the market before reviewing
  - Delayed reviews or re-reviews
  - Some states are handling patient requests on a case-by-case basis until they get a handle on the cost
- **Highly restrictive criteria to control costs and F3-F4 restrictions will likely remain**
- **Rapid landscape changes expected with new therapies coming soon**



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Medicaid FFS
Key Accounts/States

Pools	No. of States	HCV Lives	PAP Patients
NMPI	11	16,874	137
TOP$	8	19,044	38
SSDC	8	10,840	61

High Prevalence of Diagnosed HCV Lives

State influence over MMCO formulary decisions

Key Independent States	HCV FFS Lives	Impact on MMCO	Current Restrictions	PAP Patients	Sovaldi Utilization [illegible]
Illinois	13,771	Some	case-by-case	59	102
Florida	7,869	Some	F4	20	288
Tennessee	[illegible]	No	F3-F4	2	384
Alabama	5,478	n/a	New Review	0	46
Indiana	[illegible]	n/a	PA to Label	3	241
Colorado	5,351	n/a	F3-F4 and more	48	71
California	[illegible]	Yes	case-by-case	168	135
Massachusetts	3,309	n/a	PA to Label	5	150
Missouri	[illegible]	n/a	F3-F4	4	319
Georgia	2,648	n/a	PA to Label	4	173
Ohio	[illegible]	Influence	PA to Label	22	24
Texas	1,804	Yes	Not Covered	242	0

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We Identify the Following Contract Options
Covers over 80% of HCV FSS Lives

Redacted

Contracting risks include:
- Competitor Contracting Strategy:
  - Sets net competitive pricing lower due to BP and/or contracting strategy
- Typically, one bid and no counters

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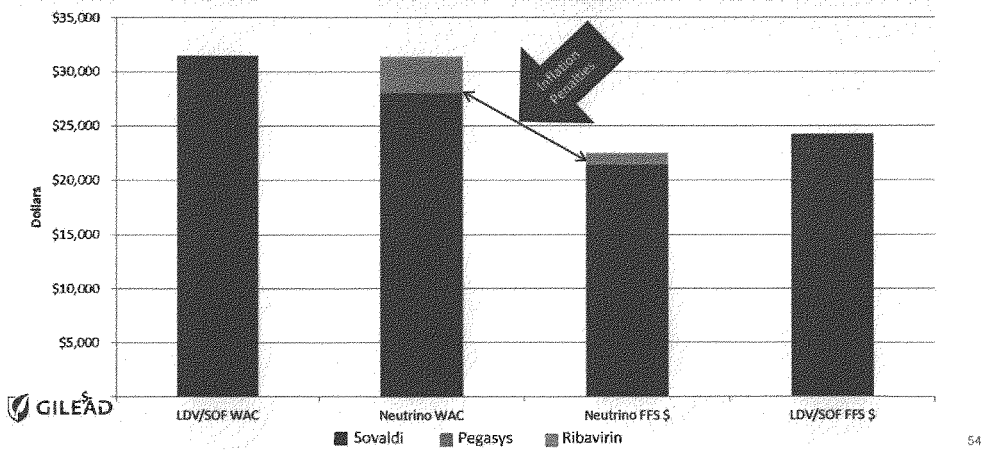
While WAC and LDV/SOF are in line, penalty discounts give a 6% price advantage for Neutrino



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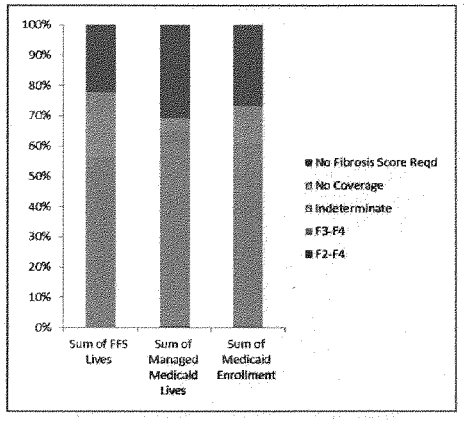
Proactive Contracting for State Medicaid's



Contracting Scenarios
$31,500

***Listed on PDL**
- 4% supplemental discount
- 27% total discount off WAC
- Note: The Medicaid Drug Rebate statute requires states to cover all FDA approved indications

F2-F4 Criteria
- ~8% supplemental discount
- 31% total discount off WAC

PA to Label
- ~10% supplemental discount
- 33% total discount off WAC
- CA, IL, NY and TX may require higher discounts

Unstable and fragmented healthcare system with extreme budgetary constraints supports targeted contracting

GILEAD - Business Case and coverage levels to be reviewed and approved prior to offer

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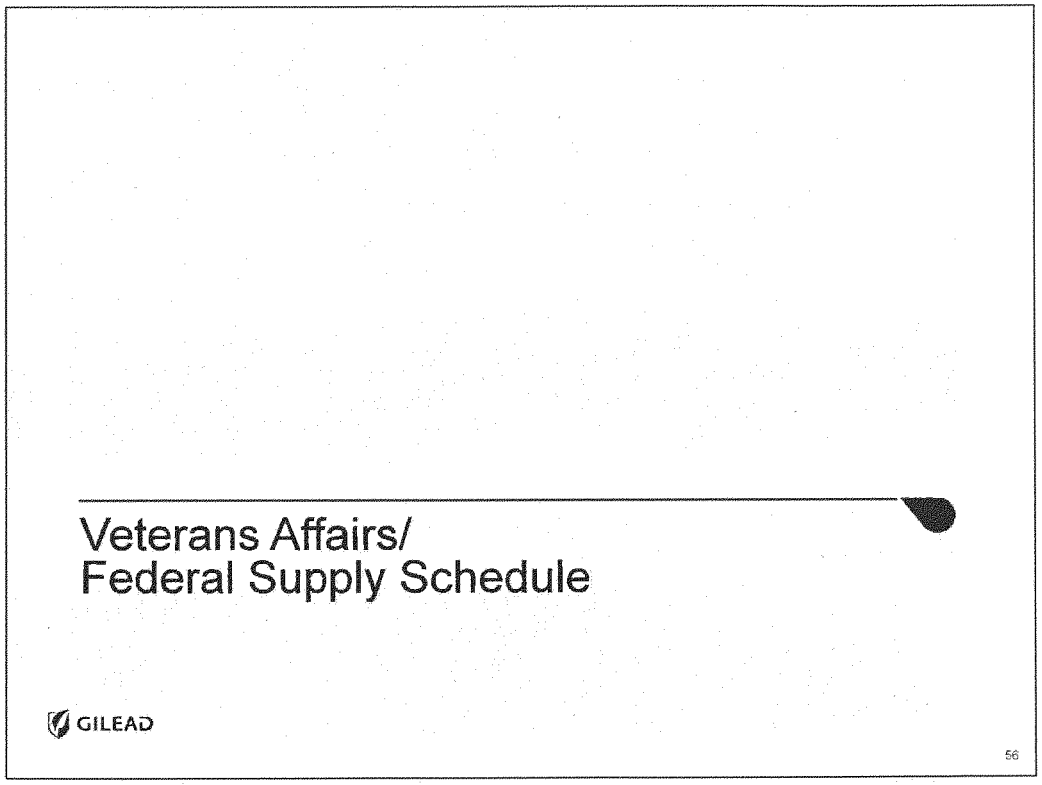

Executive Summary
Federal Contracting

Current landscape

- There are three segments: VA/FSS, DOD, and Tricare
- Generally Sovaldi is being covered with Criteria for Use ("CFU")
  - Budget constraints are driving some VAMCs to be very restrictive in treating patients
  - VA is concerned about patient adherence and implementing 7 day fills
- Pressure to designate more drugs as Non-Formulary with CFU to reduce pharmacy spend
- VA messaging that cost should not determine treatment

Market size

- ~ 8M patients enrolled with the VA of which ~6M are active
- ~ 4M pharmacy beneficiaries with a $4B Pharmacy Drug Procurement Budget in FY 2013
- The VA estimates treatment of approximately 11k patients in the first twelve months
  - An estimated 2,233 patients were started on Sovaldi in the VA
  - Budget relief expected in FY 2015 leading to more patients treated

SOF/LDV launch approach

FSS/VA/DOD:

- Proactively offer Temporary Price Reduction (TPR) below the mandatory price
- Recommend 33% off WAC total discount as the starting discount
  - Request approval up to 36% off WAC

Tricare:

- Proactively offer 10% off WAC on top of the mandatory discount

Contracting can provide access to significant VA patient population

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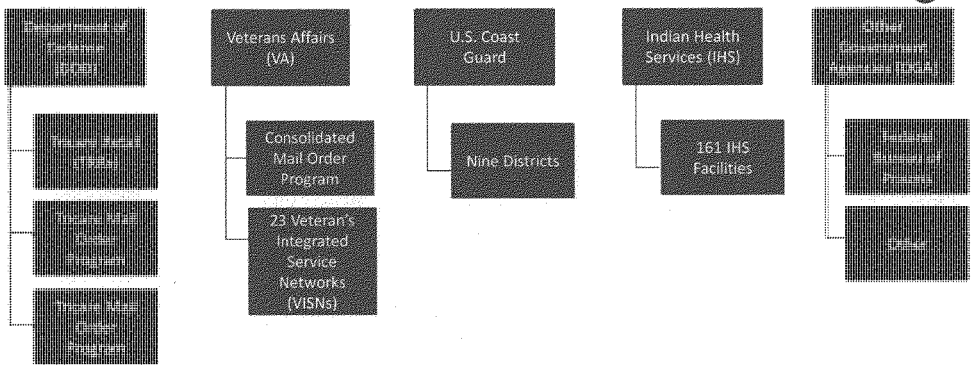
Federal Supply Schedule – Overview



Who is eligible to purchase off Gilead's contract?

- Big Four: DOD, VA, U.S. Coast Guard, and IHS
  - Federal Ceiling Price: 24% discount from the net prices wholesalers pay to manufacturers for covered drugs
- Other Government Agencies: Federal Bureau of Prisons
  - Negotiated Pricing
- Can extend additional discounts via Temporary Price Reductions (TPRs)

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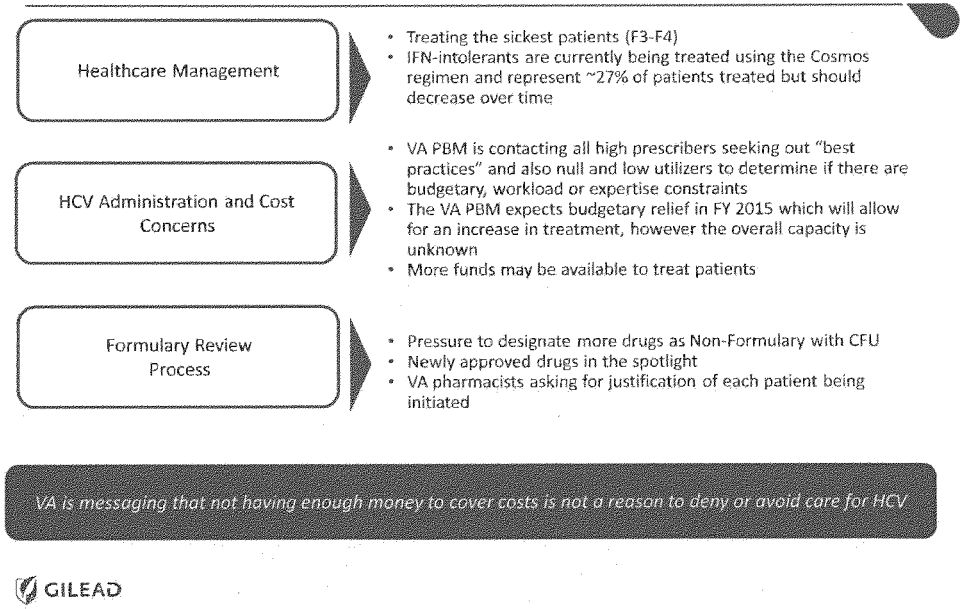
VA/FSS Segment Dynamics and Overview



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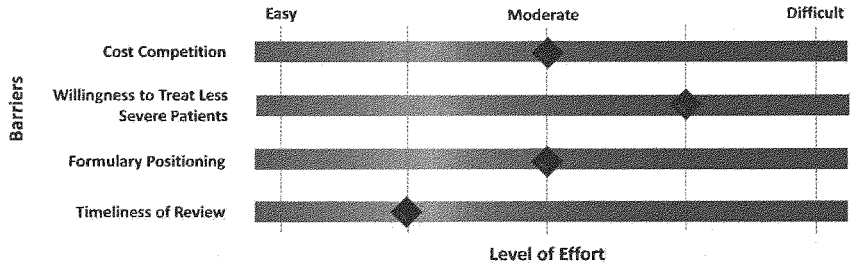
What are the Barriers to Access and Can We Influence Them?

- Control costs through increased management/restrictions
- Willingness to treat only the sickest patients
- Pressure to designate more drugs as Non-Formulary with CFU
  - Competitive pricing is key to position SOF/LDV on the formulary



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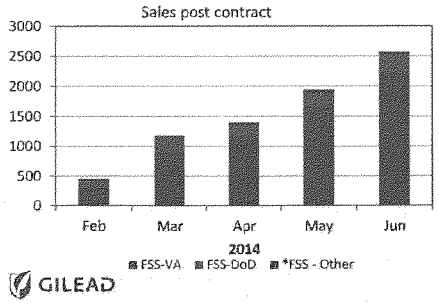
Wave 1 Federal Pricing and Sales Volume

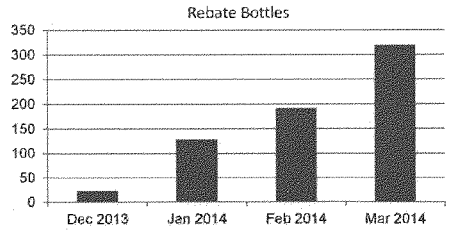
VA/FSS

- Neutrino Regimen: $ 19,216
- 24% Discount off Non-FAMP + Inflation Controls
- TPR (Sovaldi: 41% total discount)
- Sales have increased since contracting, sales through June 30th:
  - ~7,538 bottles
  - $ 85 M in chargeback

Tricare

- Neutrino Regimen: $ 21,496
- 24% Discount off Non-FAMP + Inflation Controls
- Additional 10% Discount (Sovaldi: 34% total discount)
- Sales through March 31st:
  - ~659 bottles
  - $ 4.3 M in chargebacks





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Contract and Pricing Recommendations

VA/FSS/DOD

Proactively offer Temporary Price Reduction ("TPR")

- Consistent with Neutrino Regimen
- DOD: 6 month blanket purchase agreement
- Approval up to 36% off WAC total discount for $31,500/bottle:
  - Recommend starting discount at 33%
- Approval up to 41% off WAC total discount for $35,000/bottle
  - Recommend starting discount at 40%

Tricare

Proactively offer 10% off WAC in addition to mandatory pricing

- Consistent with historical discount levels for HCV and Sovaldi
- Demonstrates commitment to partnership by Gilead for the long-term
- Can access DOD pricing through mail order, as well

Contracting risks include:

- Competitor contracting strategy sets competitive Net Price Lower

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GTN % June LE vs. Current Bridge

LDV/SOF	2015
June LE	24.9%
Sales Return	(0.7%)
LDV/SOF: Medicare Discount (12% to 10%)	(0.3%)
LDV/SOF: Commercial Discount (12% to 10%)	(0.9%)
LDV/SOF: Medicaid Discount (FFS: 15% to 10% and MM: 10% to 5%)	(0.7%)
LDV/SOF: Lower VA discount (50% to 39%)	(1.0%)
SP Fee's (1% to 70% of population)	0.7%
Current GTN %	**22.1%**

Sovaldi GTN Bridge	2015
Sovaldi June LE GTN %	22.7%
Sales Return Impact (0.8% to 0.1%)	(0.7%)
Other	(0.1%)
Sovaldi Current GTN %	**21.9%**

Total HCV	2015
June LE GTN %	24.0%
Sales Return	(0.7%)
LDV/SOF: Medicare Discount (12% to 10%)	(0.2%)
LDV/SOF: Commercial Discount (12% to 10%)	(0.5%)
LDV/SOF: Medicaid Discount (FFS: 15% to 10% and MM: 10% to 5%)	(0.4%)
LDV/SOF: Lower VA discount (50% to 39%)	(0.6%)
SP Fee's (1% to 70% of population)	0.4%
Current GTN %	**22.0%**

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HCV Wave 2 Contracting Recommendations

Managed Medicaid

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Types of Accounts

- Type A – Target Managed Medicaid Accounts

Redacted

- Type B - Accounts with letter offers for SOF/LDV (no HCV Contracts)

Redacted

- Type C - All other accounts
  - No current contracts with Gilead
  - No letter offers

Accounts in any of these groups may have other commercial lives or may have only managed Medicaid lives

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Executive Summary

Current Managed Medicaid (MMCO) Landscape

- MMCOs represent ~6-10% of overall HCV payer mix and 50% of Medicaid lives
- States receive 23.1% for their MMCO utilization
- FL and CA are considering "kick payments" to the MMCOs
- Fragmented market: 86+ accounts; 10 largest parent accounts representing about 50% of overall market
- MMCOs are the most cost-conscious among commercial payers
  - Formulary management is highly restrictive (F3/F4) and often includes extensive case management

Current Contracting Relationships

- Little contracting for SOF; nominal discounts are extended in two commercial accounts:
  - Redacted
  -
- Some Medicaid states have duplicate discounts: CA (pending), FL, KS, MS, NH, NY (pending), TX, WV , GA (pending), OR , MS (effective Q4 2014), DE (pending)

SOF/LDV Contracting Approach

Redacted

MMCOs are anticipated to be highly restrictive with Wave 2 regimens, which will require a disciplined contracting strategy

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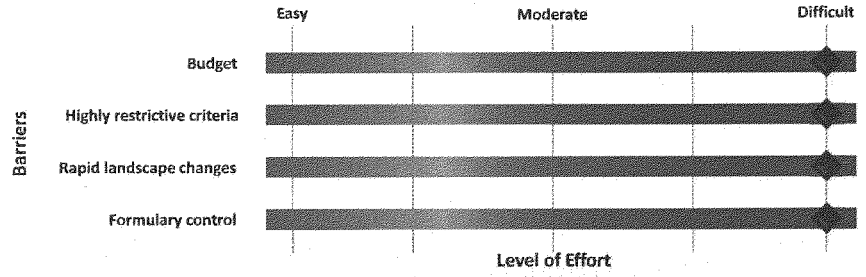
Barriers to Access

- **Budget concerns driving a delayed review process**
  - Plans wait for competitors to hit the market before reviewing
  - Some plans are handling patient requests on a case-by-case basis until they understand the cost
- **Highly restrictive criteria to control costs** including fibrosis score, treatment history, viral load, etc.
- **Rapid landscape changes** expected with new therapies coming soon



Aggressive contracting with MMCOs is unlikely to lower access barriers. We may influence select criteria with targeted rebates e.g. remove F3/F4 restrictions and contract at PA to label for PerformRx and EnvisionRx

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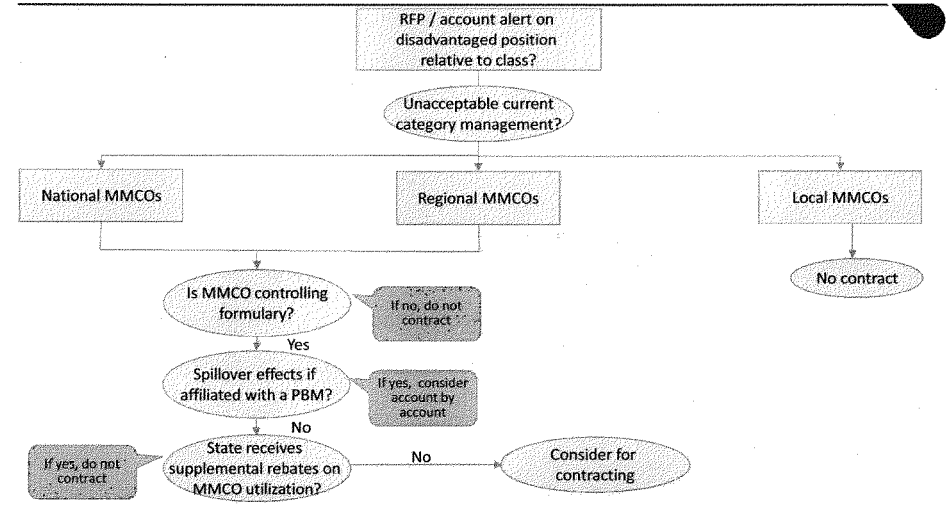
Guideline Criteria For Contracting With MMCOs



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Net cost of duplicate rebates should not be greater than account access gain (defend or gain in market share). Contract for a PA to label and parity with other DAAs.

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MMCOs Contracting Recommendation

- Contract reactively for the MMCO segment due to its relatively small segment size and significant barriers to access
  - Currently paying 23.1% rebate to states for MMCO utilization
  - Some states require supplemental rebates be paid on both FFS utilization and MMCO utilization
  - Some states require MMCOs to use the FFS formulary rather than the MMCO's formulary
  - Only 9% of surveyed payers expressed a willingness to implement contracts for F2 access*
- Redacted

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*Campbell Alliance survey July 2014 as part of SOF/LDV payer strategy

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Contracting Guidelines

SEGMENT	SELECT PAYER	SOF/LDV WAC PRICE VS. DISCOUNT	APPROACH	COMMENTARY
		$94.5K		
Redacted	All	See Commentary	Redacted	

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Exhibit 53

From: Cara Miller
Sent: Friday, October 04, 2013 6:30 PM
To: Gregg Alton
CC: Amy Flood
Subject: FW: FPC Ad Board Feedback

FYI.

From: David L. Johnson (US Sales & Marketing)
Sent: Friday, October 04, 2013 10:21 AM
To: Kevin Young; Jim Meyers; Hans Reiser; Andrew Cheng (HIV Therapeutics & Dev Ops)
Cc: Amy Flood; Cara Miller; Bill Guyer; Coy Stout
Subject: FPC Ad Board Feedback

All,

Following is a brief overview of our meeting yesterday with the HCV Fair Pricing Coalition (FPC) and key questions/points they would like Gilead to consider. Attendees from Gilead included Cara, Bill, Coy, Kristie, Jim Drew, and myself.

Overall, the dialogue was collaborative. Members were pleased to hear our emphasis on patient access and the type of patient assistance elements we are considering. They also were pleased to hear that Gilead has added Health Care Reform information to our call center.

However, they also emphasized that they want both a reasonable price and a comprehensive patient support program. We plan to maintain an ongoing (general) dialogue with them leading up to approval and launch and provide them with a specific update with regard to pricing/patient assistance at the time of approval.

Please let me know if you have any immediate questions. Otherwise, following are a few specific comments from the group.

Thanks,

DJ

***

Environmentally:

· While they understand the clinical value of sofosbuvir (and believe it is a "very good drug"), they feel the cost-effectiveness argument will not matter in the current environment as states, insurers, physicians and patients are focused on the "right now" costs and not what the potential cost-savings may be down the road. This will be particularly true as more new compounds become available.

· They also are focused on the potential impact of a high price on VA/Correctional formularies – particularly as they expect Merck and Vertex to significantly lower the price for boceprevir/telaprevir in advance of our launch.

· It's possible that when a patient hears a high price, they may immediately assume they can't afford treatment and not pursue any further dialogue with their physicians regarding treatment. Similarly, a physician may make a value judgment as to whether it is worth putting a patient with high-risk behaviors on treatment.

· Education of both physicians and patients is critical. Patients have to advocate for themselves so educating them on how to/what to ask for will be key. Currently, patients are getting majority of their information from media, not from their doctors.

· Additional barriers to care include a lack of federal leadership and policy, and routine testing for HCV.

With regard to pricing:

* They hope Gilead will price sofosbuvir at or below current SOC (~60K)
* We did not engage in any price point discussions with this group. Instead we redirected the conversation to the outcomes work being done in HCV and the patient access programs.

With regard to the patient assistance programs:

· They want us to support a Patient Assistance Foundation with maximum patient benefit and make a "significant" contribution. If we confirm our plans to support, they would be happy to use that information as leverage to press other companies to support, as well.

· Be as clear and transparent as possible in our description of the program and exactly how patients can apply, qualify, etc.

· Consider what more we could do to support "underinsured" patients

· Make the system (and Website) easy to navigate – ensure live telephone transfers of patients if we need to refer them outside the call center

· In their minds, the Vertex program is a best practice and they would like us to consider similar elements, e.g. the following:

o $100K PAP

- o $10K maximum co-pay benefit
- o No income limit

David Johnson

Vice President, Sales & Marketing

Liver Disease Business Unit

Gilead Sciences, Inc.

(650) 522-5080 (office)

(650) 619-9621 (cell)

Exhibit 54

From: Jim Meyers
Sent: Thursday, November 14, 2013 6:25 PM
To: John Martin
Subject: FW: Synopsis of feedback from top HCV advisors at AASLD

John,

Not sure if this made its way to you, but I thought I'd forward a synopsis of my discussions with HCV advisors at AASLD. The feedback is collectively supportive of the approach we're taking across the company

Jim

From: Jim Meyers
Sent: Tuesday, November 05, 2013 6:15 PM
To: David L. Johnson (US Sales & Marketing); Jason Levine; Rob Adamoski; Edward Gudaitis; Coy Stout; Monica Tellado; Bill Guyer; Bruce Kreter; Joe Steele; Patrick Lamy; Thomas Russo; Jack Gomm; Melanie Pavate; John Wolf; Kathy Dong; Marc Aquino

Subject: Synopsis of feedback from top HCV advisors at AASLD

All,

Below is a synopsis of feedback from some top HCV advisors at AASLD, for inclusion in broader re-caps that follow the U.S. KOL Debrief. It reflects the feedback of our top U.S. KOL's, which does not always mirror the views of the broader treating community. As always, please keep this confidential within the company as there is a lot of very specific information shared by our advisors, and they would not be pleased to hear it played back. Top-line overview below, followed by additional detail in five specific areas of inquiry:

- To a person, our advisors are extremely positive on sofosbuvir (SOF) and anticipate rapidly adopting it in their practice. Just about all of the questions they've ever had specific to our Wave 1 launch (optimal regimen for GT-3 patients, the best regimen for HIV/HCV co-infected patients, etc.) have been answered with the clinical data that continues to emerge

- Late-breaking clinical data that identifies patients who would benefit from >12 weeks of SOF at Wave 1 (VALENCE, PHOTON) is important information that will inform how the advisors use SOF at initial launch, but it also has the potential to dent the aura of simplicity surrounding SOF and could create barriers to access

- Important for initial use of SOF to be in patients where the access experience is likely to be the most favorable (NEUTRINO regimen for GT-1, SOF + RBV for GT-2). If a physician's first several attempts to start a patient on SOF are greeted by all sorts of barriers, it has the potential to frame their overall perception of access to SOF in a less-than-optimal manner, impacting both their prescribing of SOF at Wave 1 and their susceptibility to the rhetoric of advocacy (related to pricing)

- Most advisors view the recent actions by Vertex as a sign that there is not a viable path forward for VX-135 and that Vertex will soon leave the HCV space. They cannot believe that Vertex would do what they did if they hoped to re-enter HCV 2-3 years from now

- Most of our advisors, while favoring SOF-based regimens over the AbbVie regimen when comparing all features and attributes, believe that Wave 2 will be a highly competitive battle, that may now expand beyond AbbVie to include Merck. Some feel that Wall Street analysts have already tried to "decide" a battle before it's been fought

- Several advisors felt that the sudden availability of seasoned Vertex personnel in Sales and Medical Affairs was a "big win" for AbbVie, as they assumed that those who are able to will move to AbbVie. "AbbVie was seen as an hepatitis outsider compared to Gilead, Vertex, Merck, and BMS…now the faces of their company to the outside world will be familiar ones"

- Not surprisingly, the Fair Pricing Coalition (FPC) is proactively trying to "agitate" physicians to align with them on their advocacy against HCV pricing (with Gilead in the bulls eye)

- Any overt highlighting of pending Wave 2 Phase 3 results (ION-1/2/3) will have a detrimental impact on SOF uptake at Wave 1 among those physicians close to emerging data, and will complement the efforts of our competitors who will be communicating a mantra of "WAIT" to an audience used to waiting (physicians and patients)

- Advisors perceive Gilead to be on a nearly identical timeline with AbbVie for Wave 2 filing and approval

1. How the advisors view access to regimens requiring more than 12 weeks of SOF (other than transplant patients):

- Several of the advisors are close to Gilead and the data and generally aware that there are a growing percentage of patients who they'll want to treat with >12 weeks of SOF (whether or not it's indicated in the label): 1) GT-3 patients (standard-of-care/labeled indication will be SOF + RBV for 24 weeks), 2) HIV/HCV co-infected patients (based upon the results of PHOTON), and 3) advanced GT-1 patients who cannot take IFN but are in dire need of therapy. They consider transplant patients as a separate category that will generally be treated for whatever duration is necessary

- Most of the advisors differentiated GT-3 and HIV/HCV co-infected patients from advanced GT-1 patients who cannot take IFN but are in dire need of therapy. For GT-3 and HIV/HCV co-infected patients, SOF + RBV for 24 weeks will be the standard-of-care (if not in the label, then in Treatment Guidelines), the best option based upon available clinical data. As such, if access for these patients were to be blocked, they would react very negatively. For advanced GT-1 patients who cannot take IFN but are in dire need of therapy, while they certainly hope to have access for these types of patients, they wouldn't expect it, because it's at best a "fallback option", and not the best option for GT-1 patients, which is clearly the NEUTRINO regimen

- The advisors urged us to develop a narrative to deal with this. Ira Jacobson advised "you need to communicate the scientific rationale for why SOF + RBV for 24 weeks for GT-1 patients is just a fallback option and not what most patients should receive (and hence not what you should price the product for). There's a reason you didn't do a registration-enabling Phase 3 study of SOF + RBV, for any duration, in GT-1 patients (ELECTRON results in nulls, etc.), you need to remind people of that. NEUTRINO (SOF + PEG/RBV for 12 weeks) is the best option for GT-1 patients at your initial launch, especially for those patients with advanced disease. There were no cirrhotics or decompensated patients in your studies of SOF + RBV in GT-1, we have no idea how it would work in those patients. If I were speaking to a group of physicians, that's what I would say, that's all I could say, because that's what the data supports"

- Bob Brown felt the same way. "You need to set expectations up-front that SOF + PEG/RBV for 12 weeks is the best regimen for GT-1 patients at initial launch, and that SOF + RBV for 24 weeks is a secondary option that will be more difficult to access due to payer restrictions. In reality, some patients who can afford to wait may need to wait for the next wave (IFN-ineligible GT-1 patients)".

- Nid Afghal feels strongly that SOF + PEG/RBV for 12 weeks (NEUTRINO and LONESTAR II) is a "more robust" regimen than SOF + RBV for 24 weeks for both GT-1 patients and GT-3 patients (based on the results of LONESTAR II, he would prescribe SOF + PEG/RBV for 12 weeks

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1933

Exhibit 55

From: John Milligan
Sent: Friday, November 08, 2013 5:06 PM
To: Jim Meyers
Subject: Re: Synopsis of feedback from top HCV advisors at AASLD

Thanks Jim, I had not yet seen this.

Sent from my iPhone

On Nov 8, 2013, at 8:31 AM, "Jim Meyers" <Jim.Meyers@gilead.com> wrote:

John,

No sure if this made its way to you, but in follow-up to our discussion yesterday, I wanted to forward the synopsis of my discussions with advisors at AASLD.

I agree that Merck has (potentially) the most competitive regimen; their challenge is that they won't launch until 4Q15/1Q16 at the earliest, meaning both SOF/LDV and the AbbVie regimen will have been on the market for at least a year

Jim

From: Jim Meyers
Sent: Tuesday, November 05, 2013 6:15 PM
To: David L. Johnson (US Sales & Marketing), Jason Levine; Rob Adamoski; Edward Gudaitis; Coy Stout; Monica Tellado; Bill Guyer; Bruce Kreter; Joe Steele; Patrick Lamy; Thomas Russo; Jack Gomm; Melanie Pavale; John Wolf; Kathy Dong; Marc Aquino

Subject: Synopsis of feedback from top HCV advisors at AASLD

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- To a person, our advisors are extremely positive on sofosbuvir (SOF) and anticipate rapidly adopting it in their practice. Just about all of the questions they've ever had specific to our Wave 1 launch (optimal regimen for GT-3 patients, the best regimen for HIV/HCV co-infected patients, etc.) have been answered with the clinical data that continues to emerge

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- Most of the advisors differentiated GT-3 and HIV/HCV co-infected patients from advanced GT-1 patients who cannot take IFN but are in dire need of therapy. For GT-3 and HIV/HCV co-infected patients, SOF + RBV for 24 weeks will be the standard-of-care (if not in the label, then in Treatment Guidelines), the best option based upon available clinical data. As such, if access for these patients were to be blocked, they would react very negatively. For advanced GT-1 patients who cannot take IFN but are in dire need of therapy, while they certainly hope to have access for these types of patients, they wouldn't expect it, because it's at best a "fallback option", and not the best option for GT-1 patients, which is clearly the NEUTRINO regimen

- The advisors urged us to develop a narrative to deal with this. Ira Jacobson advised "you need to communicate the scientific rationale for why SOF + RBV for 24 weeks for GT-1 patients is just a fallback option and not what most patients should receive (and hence not what you should price the product for). There's a reason you didn't do a registration-enabling Phase 3 study of SOF + RBV, for any duration, in GT-1 patients (ELECTRON results in nulls, etc.), you need to remind people of that. NEUTRINO (SOF + PEG/RBV for 12 weeks) is the best option for GT-1 patients at your initial launch, especially for those patients with advanced disease. There were no cirrhotics or decompensated patients in your studies of SOF + RBV in GT-1, we have no idea how it would work in those patients. If I were speaking to a group of physicians, that's what I would say, that's all I could say, because that's what the data supports"

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Exhibit 56

From: Norbert Bischofberger
Sent: Thursday, November 07, 2013 5:16 PM
To: Jim Meyers
Subject: RE: Synopsis of feedback from top HCV advisors at AASLD

Many thanks, very useful.

N

From: Jim Meyers
Sent: Thursday, November 07, 2013 9:15 AM
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Subject: FW: Synopsis of feedback from top HCV advisors at AASLD

Norbert - FYI

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1. How the advisors view access to regimens requiring more than 12 weeks of SOF (other than transplant patients):

- Several of the advisors are close to Gilead and the data and generally aware that there are a growing percentage of patients who they'll want to treat with >12 weeks of SOF (whether or not it's indicated in the label): 1) GT-3 patients (standard-of-care/labeled indication will be SOF + RBV for 24 weeks), 2) HIV/HCV co-infected patients (based upon the results of PHOTON), and 3) advanced GT-1 patients who cannot take IFN but are in dire need of therapy. They consider transplant patients as a separate category that will generally be treated for whatever duration is necessary

- Most of the advisors differentiated GT-3 and HIV/HCV co-infected patients from advanced GT-1 patients who cannot take IFN but are in dire need of therapy. For GT-3 and HIV/HCV co-infected patients, SOF + RBV for 24 weeks will be the standard-of-care (if not in the label, then in Treatment Guidelines), the best option based upon available clinical data. As such, if access for these patients were to be blocked, they would react very negatively. For advanced GT-1 patients who cannot take IFN bnt are in dire need of therapy, while they certainly hope to have access for these types of patients, they wouldn't expect it, because it's at best a "fallback option", and not the best option for GT-1 patients, which is clearly the NEUTRINO regimen

- The advisors urged us to develop a narrative to deal with this. Ira Jacobson advised "you need to communicate the scientific rationale for why SOF + RBV for 24 weeks for GT-1 patients is just a fallback option and not what most patients should receive (and hence not what you should price the product for). There's a reason you didn't do a registration-enabling Phase 3 study of SOF + RBV, for any duration, in GT-1 patients (ELECTRON results in nulls, etc.), you need to remind people of that. NEUTRINO (SOF + PEG/RBV for 12 weeks) is the best option for GT-1 patients at your initial launch, especially for those patients with advanced disease. There were no cirrhotics or decompensated patients in your studies of SOF + RBV in GT-1, we have no idea how it would work in those patients. If I were speaking to a group of physicians, that's what I would say, that's all I could say, because that's what the data supports"

- Bob Brown felt the same way. "You need to set expectations up-front that SOF + PEG/RBV for 12 weeks is the best regimen for GT-1 patients at initial launch, and that SOF + RBV for 24 weeks is a secondary option that will be more difficult to access due to payer restrictions. In reality, some patients who can afford to wait may need to wait for the next wave (IFN-ineligible GT-1 patients)".

- Nid Afdhal feels strongly that SOF + PEG/RBV for 12 weeks (NEUTRINO and LONESTAR II) is a "more robust" regimen than SOF + RBV for 24 weeks for both GT-1 patients and GT-3 patients (based on the results of LONESTAR II, he would prescribe SOF + PEG/RBV for 12 weeks for GT-3 patients over the labeled indication of SOF + RBV for 24 weeks). In terms of physician/advocacy reaction to a 2X cost for 24 weeks of SOF for certain patients, he advised us to be communicate clearly that "SOF has been developed for a therapy duration of 12 weeks or less, now and in the future. For the first year of launch, there are some patient segments that may benefit from 24 weeks of SOF. We are hopeful that having an FDA approved indication for a longer duration of therapy in these

subgroups will induce payers to cover SOF and leave a modest cost burden to the patient (that Gilead can cover)". He felt we would not be well served trying to explain or justify each segment

2. Payer management of SOF / Advocacy related to the pricing of SOF / ACA-related shifts in the HCV marketplace

- Understandably low awareness among our advisors of the considerations that go into pricing. Many assumed we could just cap the cost paid by each patient (e.g., no patient/insurer pays for more than 12 weeks), or just take a 50 to 100% price increase on single agent SOF at Wave 2. They understand why that's not practical or operational when it's explained, but we should assume others will have the same disconnect

- Doug Dieterich indicated that the New York Department of Health has asked to bring along the FPC to the next meeting of Doug/Ira/Bob's non-profit CME organization on November 20. These meetings typically include 40-50 NYC-area physicians who treat HCV. The goal of the FPC is to get this key group of Hep/GI's "agitated" and aligned with them on speaking out against pricing in HCV. Doug feels that the FPC will have a much harder time getting Hep/GI's to align with this than was the case with HIV treaters. He will update us on the outcome after the meeting

- Ira Jacobson was approached after the Gilead Symposium by a physician (GI) who works with Empire Blue Cross Blue Shield whom told him that Empire is "scared to death" by the pending launch of SOF. He indicated they put aside $500 million for the PI's and ended up spending $1.1 billion. When Ira asked the payer representative what they'd do with a decompensated cirrhotic who was prescribed 24-48 weeks of SOF + RBV, he replied "we'd cover it for 12 weeks, it's on the patient after that". Ira was very concerned with this response. He went on to say that he was happy to help us in our efforts with payers in any way that he could.

- Mark Sulkowski volunteered that the buzz at AASLD is that SOF will be the highest priced pill in the history of the pharmaceutical industry. "Everyone is speculating"

- Doug Dieterich indicated the Mount Sinai Accountable Care Organization (ACO) is moving forward, and that they'll assume "full risk" in 1-2 years (i.e., they'll be the payer, incentivized to reduce overall costs including hospitalizations, etc.). Doug's intention is to "put the payers out of business", and they're in the process of hiring the individuals who would then negotiate with the manufacturers, suppliers, and employers. The Mount Sinai ACO "system" will include Beth Israel and St. Lukes-Roosevelt, and will have ~1 million patients (~80,000 HCV-infected patients, ~10,000 HIV-infected individuals). They are partnering with Trio Health (Nid Afdhal) to help them optimize the data they'll be able to collect and sell (claims, outcomes, etc.)

- Doug Dieterich felt that if GT-3 and HIV/HCV co-infection "have labeled indications for SOF + RBV for 24 weeks, it will be difficult for payers to give us too much of a hassle". He also noted that he'd expect support from the AASLD-IAS Treatment Guidelines that would help with these two patient groups. Others (Ira Jacobson, Mark Sulkowski) were not so optimistic on payers reimbursing for 24 weeks of SOF (outside of the transplant setting)

- HIV KOL Rick Elion indicated that they recently had telaprevir and boceprevir added to the Washington DC ADAP formulary just for the purpose of facilitating "a swap-out" once SOF and simeprevir (SMV) are approved. Having HCV compounds already on formulary will speed-up the process of ADAP approval

- Most advisors said that their perception of access to SOF will be framed by two things: 1) the first several patients they try it on (how easy or how difficult it is to prescribe), and 2) ease of access in the patients they most need to treat (advanced patients, many of whom may require more than 12 weeks or multiple DAA's). In the words of Bob Brown, "if a physician tries to use SOF + SMV early on (without promotion) and is greeted by all sorts of barriers, it has the potential to frame their overall perception of access to SOF in a negative manner. It's in your best interest for physicians to stick to the NEUTRINO regimen and the approved GT-2/3 regimens early on, as their access experience will be better" (we agree). Ira Jacobson agrees, and worried that all the good will that is being conveyed toward Gilead at the moment could turn if physicians perceives their access to SOF to be adversely impacted by how Gilead priced the product

3. Impact of Vertex decision to get rid of their sales force and Medical Scientists:

- To a person, each KOL thought the fact that Vertex prohibited their people from going to competing companies and then fired them was "reprehensible and would be remembered". Many thought the decision to let them go was the right decision at this point from a business perspective, but that employees should have been free to go to competing companies at any point. Several thought that Vertex CEO Jeff Leiden made the decision to make the cuts in headcount the day that VX-135 was put on partial clinical hold, and that he should have cut the team loose at that point as it would have given the employees more options (including being considered by Gilead)

- Mark Sulkowski felt that AbbVie was the big winner in the Vertex drama. "Most of the Vertex people will go to AbbVie – sales rep's and Medical Scientists – which is a big boost for AbbVie. They were trying to bring in a team of HIV people that didn't know HCV as well as they should; the Vertex people – at least the good ones – know HCV. The face of AbbVie, the people who interact with customers, will now be familiar, and comparable to the Gilead team". Mark also felt there could be some sympathy for the Vertex sales rep's due to the position they were put in that could play in their favor when they go head-to-head against Gilead

- Consensus on VX-135 was that it is permanently crippled, and that its path to market – if there is one – would be as part of a regimen with one or more other potent DAA's. There is no path forward for VX-135 + RBV alone, which by definition implies it lacks the potency of SOF at the 200mg dose. Mark Sulkowski reiterated his belief that one of the biggest hurdles for VX-135 is the ability to convince the FDA that certain patients receiving the 200mg

dose would never be exposed to 400mg, which is known to be toxic to the liver (e.g., elderly patients with impaired renal function). "It's one thing if this was a PI, but VX-135 is cleared through the kidneys". Each KOL also noted that the FDA has no incentive to do anything other than move very slowly with any future nucleoside/nucleotide, including VX-135, as they feel some culpability for what happened with the BMS/Inhibitex compound as they allowed the studies to proceed despite some hints of cardio-toxicity

- Nid Afdhal felt the Vertex decision means that "there is no path forward for VX-135…it's dead. It's inconceivable to me that they would make this move if there was any chance of them coming back to HCV 2-3 years from now. They are exiting HCV."

4. Gilead versus AbbVie in Wave 2:

- Mark Sulkowski indicated that Gilead and AbbVie timelines are "nearly identical" and should result in back-to-back Advisory Committee Meetings and near simultaneous approval. He acknowledged that this assumes that AbbVie's internal machinery works more quickly than it has in the past, but he's assuming it will as "this is a huge priority for them"

- Mark also felt that contrary to what he hears from many analysts, "SOF/LDV versus the AbbVie regimen is going to be a dog fight (we agree)". His personal choice is SOF/LDV, but he doesn't feel that the AbbVie regimen "will disappoint on efficacy or even on safety/tolerability….when everything is lined up, there are more reasons to use SOF/LDV, but it's close enough that pricing/contracting/access will matter (we agree)"

- Nid Afdhal had similar views to Mark. He feels the AbbVie regimen, and perhaps the Merck regimen, will deliver "90+% SVR's with good tolerability", leading to a highly competitive market at Wave 2 and beyond

- Rick Elion has enrolled many patients in SOF clinical trials and AbbVie clinical trials. He considers SOF the best individual compound, but notes that the AbbVie regimen "is very well tolerated by patients, and the drug-drug interactions are manageable". He sees an very competitive battle ahead

5. Impact of Wave 2 launches on Wave 1 uptake

- To a person, each KOL felt the more that is communicated about what's coming next (SOF/LDV, AbbVie regimen, etc.), the greater the negative impact would be on Wave 1 prescribing (reducing uptake at Wave 1). In the words of Bob Brown, "making a big deal about the ION data as it emerges is the equivalent of flashing a big WAIT sign in the offices of physicians, and will play right in to the strategies of AbbVie and BMS, who will be telling physicians on every call to wait". It also play into the overall mindset of inertia that permeates HCV. Ira and Mark felt the same way. They understand we have disclosure obligations as a publicly traded company, but wanted us to understand the potential impact.

- Ira Jacobson's thinking on who he would treat at Wave 1 versus hold for Wave 2 has ebbed and flowed over the past few years as data have emerged. His current thinking is that he'll hold back F0-F1 patients, and the less severe F2 patients, as well as those who are IFN-ineligible or unwilling. He'll treat everyone else, largely with the NEUTRINO regimen (GT-1's)

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Appendix F

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 6

In its final annual financial filing with the Securities and Exchange Commission (SEC), Pharmasset reported that its research and development costs totaled $176.7 million for the fiscal years ending 2009, 2010 and 2011, the period during which PSI-7977 was being developed. Of that total, Pharmasset attributed $62.4 million directly to the development of PSI-7977.

a. *Please provide an itemized accounting of Pharmasset's total research and development costs prior to the completion of the merger with Gilead on January 17, 2012.*

	2008	2009	2010	2011*
*CLINICAL***				
Pre-Clinical Studies	665,453	2,028,632	2,379,467	303,068
Drug Compound/ Standard of Care	3,117,719	5,454,685	11,046,959	18,046,848
Clinical Operations	24,150,102	27,469,911	17,129,537	34,998,888
Total	*27,933,274*	*34,953,228*	*30,555,963*	*53,348,804*
NON-CLINICAL				
Non-Cash comp	2,110,048	2,494,413	3,154,152	4,527,020
Licensing/permits (incl. GRI)	865,956	755,521	266,477	336,808
Labs supplies	864,804	930,491	1,007,367	1,117,723
Recruiting & relocation	71,307	-	-	-
Legal – Patents	1,549,448	1,656,510	1,661,738	2,254,405
Depreciation expense	843,072	851,311	732,751	462,373
Salaries (incl. bonuses, SAB, Social Security taxes, 401k exp., vacation, & SUTA)	6,386,283	8,013,680	7,966,029	10,312,143
BEIP Grant	(126,557)	-	-	-
Consulting (7290)	443,196	116,888	141,278	105,044
Other, net	210,591	916,718	834,123	1,145,781
Contract drug discovery services	1,844,036	1,863,020	1,940,837	2,239,980
Total	*15,062,184*	*17,598,552*	*17,704,752*	*22,501,277*
TOTAL	***42,995,458***	***52,551,780***	***48,260,715***	***75,850,081***
TOTAL, 2008 - 2011				***$219,658,034***

* Data unavailable from November 2011 to January 2012 due to merger activity.
** Note that detailed R&D categories differ pursuant to accounting and reporting conventions for respective companies

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 6 (cont.)

b. *Please provide an itemized accounting of Pharmasset's research and development costs directly attributable to the development of PSI-7977 prior to the completion of the merger with Gilead on January 17, 2012.*

	2008	2009	2010	2011*
Pre-Clinical Studies**	665,453	1,251,034	34,496	-
Drug Compound/ Standard of Care	95,000	1,165,974	6,471,055	14,039,821
Clinical Operations	9,825	4,474,151	9,925,310	24,292,074
Total	*770,278*	*6,891,159*	*16,430,861*	*38,331,895*
TOTAL, 2008 - 2011				***$62,424,193***

* Data unavailable from November 2011 to January 2012 due to merger activity.
** Note that detailed R&D categories differ pursuant to accounting and reporting conventions for respective companies.

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 12

Please provide an itemized accounting of research and development costs related directly to the development of sofosbuvir that was incurred by Gilead after the completion of the Pharmasset merger on January 17, 2012. This accounting should include separate line items for personnel costs, clinical studies, materials and supplies, licenses and fees, milestone payments under collaboration arrangements, overhead allocations, facilities costs and the value contracts with contract research organizations (CROs) related directly to the development of sofosbuvir.

R&D Expenses for Sofosbuvir-Based Regimens*

	2012	2013	2014 (est.)
Personnel Costs**	45,195,000	51,770,600	74,765,423
Clinical Studies/ CRO Costs	136,942,698	238,986,739	242,830,400
Milestones/ Licenses	-	4,117,281	(2,907,678)
Overhead Allocations/ Facilities Costs/ Materials and Supplies	27,859,182	29,339,061	31,367,638
TOTAL	*209,996,871*	*324,213,681*	*346,055,782*
TOTAL, 2012 - 2014			***$880,266,334***

* Sofosbuvir-based regimen is defined as any compound in R&D that uses sofosbuvir or is combined in development with sofosbuvir. Note that these figures do not reflect Gilead's significant R&D investment in HCV prior to the acquisition of Pharmasset, which enabled Gilead's later work with sofosbuvir. Additionally, Gilead's R&D expenses related to sofosbuvir are significant and ongoing; post-approval R&D investments in sofosbuvir are expected to exceed pre-Sovaldi approval costs due to ongoing clinical research and work exploring future combination therapies.

** As outlined in Gilead's securities filings, Gilead does not track expenses related to personnel costs, overhead allocations, facilities costs, and materials and supplies by therapeutic product candidate. To respond to the Committee's request, Gilead estimated expenses by allocating based on a percentage of total employee headcount.

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 17

Looking forward, what are Gilead's expected changes in the treatment cost-per-patient and the cost-per-cure of Sovaldi-based treatment over the next five years for each of the FDA approved regimens for the U.S. HCV populations?

In general terms, Gilead anticipates that the cost-per-patient and the cost-per-cure of HCV treatment regimens will go down over time due to both shortened durations of therapy and higher cure rates.

Most immediately, we will see this cost reduction upon the launch of sofosbuvir/ledipasvir (SOF/LDV) later this year. Today, every patient on a Sovaldi-based regimen receives at least 12 weeks of therapy, and some receive 24 weeks of therapy. Upon the launch of SOF/LDV, we estimate that only a minority of patients will require 24 weeks of therapy with Sovaldi, and up to 50% of patients over time may be candidates for an eight-week duration of therapy, since Gilead's current draft product labeling allows an eight-week therapy duration for patients who are treatment-naïve, non-cirrhotic, and have a baseline viral load of less than six million IU/mL.

Because Gilead will price any Sovaldi-based regimen in a manner that reflects that most of its value is the result of the unique properties of sofosbuvir, Gilead anticipates that the average cost-per-patient will come down from where it has been over the last several quarters. The average cost of treating an HCV patient in 2Q14 was approximately $120,000,* in part because of physician desire to use the regimen of Sovaldi + Olysio (approximately $150,000). Upon the launch of SOF/LDV, we expect the use of Sovaldi + Olysio to substantially decrease because SOF/LDV will offer a more favorable clinical profile and a shorter duration of therapy that will cost significantly less. Due to the reduced use of Sovaldi + Olysio, the shortened duration of therapy for a substantive subset of patients, and Gilead's pricing philosophy for SOF/LDV as outlined above, Gilead anticipates that the average cost of treating an HCV patient will come down well below $100,000. For those patients able to take eight weeks of therapy, the cost-per-patient will be the lowest since the introduction of direct-acting antivirals in May 2011 (e.g., a per-patient cost of less than $65,000). Additionally, Gilead and many other manufacturers have clinical development programs focused on even shorter durations of therapy (perhaps as short as 4-6 weeks), meaning it is likely that the treatment cost-per-patient will continue to decrease over time.

** Average prices cited are Wholesale Acquisition Cost ("WAC") prices, and do not include discounts, rebates or reductions in price.*

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 18(a)

Please provide an itemized accounting of all payments from 2009 to present between Gilead and/or Pharmasset and the following organizations:

i. AASLD
ii. IDSA
iii. IAS-USA

Payments Identified Between Gilead and AASLD, IDSA, and IAS-USA

AASLD (American Association for the Study of Liver Diseases)		
Date	**Amount**	**Description**
2009	$25,000.00	Support for conference
2009	$225,000.00	Grant supporting Liver Scholar Award
2009	$650.00	Registration fees for attendance at conference
2009	$44,800.00	Costs related to exhibit at conference
2009	$113,406.50	Costs related to exhibit at conference
2009	$150,000.00	Registration fees for attendance at conference
2009	$50,000.00	Support for conference
2009	$31,650.00	Costs related to exhibit at conference
Subtotal	*$640,506.50*	
2010	$100,000.00	Support for conference
2010	$150,000.00	Registration fees for attendance at conference
2010	$50,000.00	Registration fees for attendance at conference
2010	$10,000.00	Grant supporting medical education program
Subtotal	*$310,000.00*	
2011	$49,050.00	Costs related to exhibit at conference
2011	$60,000.00	Grant supporting fellowship
2011	$260,000.00	Registration fees for attendance at conference
2011	$60,000.00	Grant supporting fellowship
2011	$52,000.00	Registration fees for attendance at conference
2011	$225,000.00	Grant supporting Liver Scholar Award
Subtotal	*$706,050.00*	
2012	$30,000.00	Costs related to exhibit at conference
2012	$50,950.00	Costs related to exhibit at conference
2012	$290,100.00	Registration fees for attendance at conference
2012	$60,000.00	Grant supporting fellowship
2012	$3,500.00	Promotional materials for conference
Subtotal	*$434,550.00*	
2013	$15,000.00	Sponsorship of conference

AASLD (American Association for the Study of Liver Diseases)		
Date	**Amount**	**Description**
2013	$318,250.00	Registration fees for attendance at conference
2013	$5,000.00	Promotional materials for conference
2013	$53,700.00	Costs related to exhibit at conference
2013	$60,000.00	Sponsorship of conference
2013	$225,000.00	Grant supporting Liver Scholar Award
Subtotal	*$676,950.00*	
2014	$400,000.00	Grant supporting fellowship and research award
Subtotal	*$400,000.00*	
Total	***$3,168,056.50***	

IDSA (Infectious Diseases Society of America)		
Date	**Amount**	**Description**
2009	$11,600.00	Costs related to exhibit at conference
2009	$99,972.00	Support for conference
2009	$5,000.00	Sponsorship of workshop
2009	$300.00	Membership fee
2009	$300.00	Membership fee
2009	$110,000.00	Grant supporting fellowship
2009	$10,000.00	Grant supporting publication
Subtotal	*$237,172.00*	
2010	$100,000.00	Grant supporting fellowship
2010	$10,000.00	Grant supporting publication
2010	$100,000.00	Support for conference
2010	$200,000.00	Grant supporting CME program
2010	$12,000.00	Costs related to exhibit at conference
2010	$200,000.00	Support for meeting
Subtotal	*$622,000.00*	
2011	$48,000.00	Costs related to exhibit at conference
2011	$100,000.00	Grant supporting fellowship
2011	$100,925.00	Support for conference
2011	$1,000.00	Sponsorship of conference
2011	$51,200.00	Costs related to exhibit at conference
2011	$325.00	Membership fee
Subtotal	*$301,450.00*	
2012	$15,000.00	Grant supporting fellowship
2012	$95,000.00	Grant supporting fellowship
Subtotal	*$110,000.00*	
2013	$12,800.00	Costs related to exhibit at conference
2013	$51,200.00	Costs related to exhibit at conference
2013	$17,500.00	Registration fees for attendance at conference
2013	$3,000.00	Honoraria for speaker
2013	$95,000.00	Grant supporting fellowship

IDSA (Infectious Diseases Society of America)		
Date	**Amount**	**Description**
2013	$7,800.00	Registration fees for attendance at conference
2013	$62,148.00	Grant supporting CME program
2013	$100,000.00	Support for conference
Subtotal	*$349,448.00*	
2014	$60,090.00	Support for conference
2014	$18,200.00	Costs related to exhibit at conference
2014	$5,000.00	Grant supporting fellowship
2014	$5,101.00	Grant supporting fellowship
2014	$100,000.00	Support for conference
Subtotal	*$188,391.00*	
Total	***$1,808,461.00***	

IAS-USA (International Antiviral Society-USA, formerly known as the International AIDS Society-USA)		
Date	**Amount**	**Description**
2009	$220,000.00	Grant supporting CME program
Subtotal	*$220,000.00*	
2010	$231,084.00	Grant supporting CME program
Subtotal	*$231,084.00*	
2011	$300,411.00	Grant supporting CME program
2011	$25,200.00	Fees for exhibit booth at conference
2011	$33,320.00	Costs related to meeting held at conference
Subtotal	*$358,931.00*	
2012	$136,000.00	Registration fees for attendance at conference
2012	$231,575.00	Registration fees for attendance at conference
2012	$7,000.00	Registration fees for attendance at conference
2012	$125,550.00	Sponsorship of conference
2012	$7,073.38	Costs related to meeting held at conference
2012	$284.08	Costs related to meeting held at conference
2012	$300,000.00	Grant supporting CME program
2012	$100,000.00	Grant supporting CME program
2012	$157,250.00	Corporate sponsorship fee (three years)
Subtotal	*$1,064,732.46*	
2013	$43,690.00	Costs related to meeting held at conference
2013	$18,360.00	Fees for exhibit booth at conference
2013	$2,414.00	Costs related to meeting held at conference
2013	$2,984.00	Costs related to meeting held at conference
2013	$104.00	Costs related to meeting held at conference
2013	$225,000.00	Grant supporting CME program
2013	$100,000.00	Grant supporting CME program
Subtotal	*$392,552.00*	

IAS-USA (International Antiviral Society-USA, formerly known as the International AIDS Society-USA)		
Date	**Amount**	**Description**
2014	$157,250.00	Sponsorship of conference
2014	$34,000.00	Costs related to meeting held at conference
2014	$130,625.00	Registration fees for attendance at conference
2014	$20,196.00	Fees for exhibit booth at conference
2014	$55,000.00	Grant supporting medical education program
2014	$17,000.00	Costs related to meeting held at conference
2014	$175.00	Registration fees for attendance at conference
2014	$100,000.00	Support for conference
2014	$150,000.00	Grant supporting CME program
2014	$200,000.00	Grant supporting CME program
Subtotal	*$864,246.00*	
Total	***$3,131,545.46***	

Payments Identified Between Pharmasset and AASLD, IDSA, and IAS-USA

No records found.

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 18(b)

Please provide an itemized accounting of all payments from 2009 to present between Gilead and/or Pharmasset and the expert panel members that developed the AASLD/IDSA treatment guidelines for HCV.

Payments Identified Between Gilead and AASLD/ISDA Treatment Guidelines Panelists**

Name	Date	Amount	Description
Andrew Aronsohn	05/09/2011	$113.42	Meals
	11/07/2011	$119.87	Meals
	Subtotal	*$233.29*	
	Total	***$233.29***	
Michael Charlton	02/26/2011	$1,273.31	Meals/ Travel
	05/05/2011	$297.25	Meals/ Travel
	05/23/2011	$3,000.00	Honoraria
	06/23/2011	$14.97	Meals
	06/24/2011	$904.90	Travel
	Subtotal	*$5,490.43*	
	08/26/2013	$92.36	Meals
	08/26/2013	$607.68	Travel
	08/26/2013	$220.00	Travel
	08/26/2013	$84.00	Travel
	11/01/2013	$124.50	Meals
	12/05/2013	$378.28	Travel
	12/05/2013	$104.08	Travel
	12/06/2013	$71.78	Meals
	12/06/2013	$201.48	Travel
	12/17/2013	$5,000.00	Honoraria
	12/31/2013	$5,000.00	Honoraria
	Subtotal	*$11,884.16*	
	04/30/2014	$993.96	Travel
	05/01/2014	$48.72	Meals
	05/01/2014	$212.68	Travel
	05/13/2014	$4,000.00	Honoraria
	05/20/2014	$52.21	Meals
	05/20/2014	$108.45	Travel
	Subtotal	*$5,416.02*	
	Total	***$22,790.61***	
Raymond Chung	06/18/2009	$164.31	Meals
	06/18/2009	$1,500.00	Honoraria
	10/09/2009	$2,500.00	Honoraria
	Subtotal	*$4,164.31*	
	Total	***$4,164.31***	

Name	Date	Amount	Description
Gary Davis	02/09/2010	$27.82	Meals
	03/22/2010	$22.78	Meals
	05/11/2010	$12.73	Meals
	06/16/2010	$16.20	Meals
	07/21/2010	$16.85	Meals
	08/17/2010	$19.75	Meals
	09/14/2010	$20.25	Meals
	10/20/2010	$16.99	Meals
	10/26/2010	$13.72	Meals
	12/08/2010	$16.28	Meals
	Subtotal	*$183.37*	
	01/12/2011	$6.19	Meals
	02/10/2011	$11.40	Meals
	03/10/2011	$20.99	Meals
	03/25/2011	$20.55	Meals
	04/05/2011	$15.61	Meals
	05/11/2011	$24.30	Meals
	05/11/2011	$2.16	Meals
	06/16/2011	$15.18	Meals
	06/30/2011	$24.35	Meals
	08/10/2011	$21.03	Meals
	09/06/2011	$23.56	Meals
	12/06/2011	$21.85	Meals
	Subtotal	*$207.17*	
	01/19/2012	$13.96	Meals
	02/06/2012	$9.99	Meals
	05/23/2012	$10.41	Meals
	06/15/2012	$13.96	Meals
	07/11/2012	$13.96	Meals
	08/07/2012	$2.84	Meals
	08/14/2012	$10.61	Meals
	08/31/2012	$63.16	Meals
	09/06/2012	$4.55	Meals
	09/12/2012	$11.61	Meals
	09/25/2012	$11.61	Meals
	10/09/2012	$12.91	Meals
	10/24/2012	$11.91	Meals
	11/07/2012	$12.61	Meals
	11/27/2012	$11.61	Meals
	12/10/2012	$11.61	Meals
	Subtotal	*$227.31*	
	05/09/2013	$11.00	Meals
	Subtotal	*$11.00*	
	Total	***$628.85***	
Jordan Feld	03/16/2009	$1,965.02	Unknown (likely honoraria)
	Subtotal	*$1,965.02*	

Name	Date	Amount	Description
	07/07/2010	$945.75	Honoraria
	Subtotal	*$945.75*	
	04/14/2011	$1,558.90	Honoraria
	10/22/2011	$1,464.27	Honoraria
	11/25/2011	$286.81	Travel
	Subtotal	*$3,309.98*	
	01/29/2013	$1,511.41	Honoraria
	03/20/2013	$1,460.85	Honoraria
	08/30/2013	$2,436.96	Honoraria
	Subtotal	*$5,409.22*	
	05/01/2014	$1,314.34	Travel
	05/01/2014	$83.79	Meals
	05/01/2014	$4,000.00	Honoraria*
	05/12/2014	$24.98	Meals
	05/12/2014	$120.00	Travel
	07/09/2014	$2,333.90	Honoraria
	Subtotal	*$7,877.01*	
	Total	***$19,506.97***	
		**** Paid to Toronto General & Western Hospital Foundation***	
Robert Fontana	04/22/2009	$202.43	Meals
	04/22/2009	$2,000.00	Honoraria
	05/20/2009	$95.42	Meals
	05/20/2009	$2,000.00	Honoraria
	05/20/2009	$137.50	Travel
	Subtotal	*$4,435.35*	
	11/08/2010	$98.83	Meals
	11/08/2010	$1,500.00	Honoraria
	11/08/2010	$55.00	Travel
	11/08/2010	$98.83	Meals
	11/08/2010	$1,500.00	Honoraria
	11/08/2010	$55.00	Travel
	12/21/2010	$39.80	Meals
	12/21/2010	$1,500.00	Honoraria
	12/21/2010	$40.00	Travel
	12/21/2010	$23.29	Meals
	12/21/2010	$39.80	Meals
	12/21/2010	$1,500.00	Honoraria
	12/21/2010	$40.00	Travel
	Subtotal	*$6,490.55*	
	08/16/2013	$51.24	Meals
	08/16/2013	$61.00	Meals
	08/16/2013	$73.20	Meals
	08/16/2013	$832.68	Travel
	Subtotal	*$1,018.12*	

Name	Date	Amount	Description
	Total	***$11,944.02***	
Eliot Godofsky	02/17/2010	$15.01	Meals
	04/21/2010	$14.95	Meals
	05/26/2010	$15.59	Meals
	08/25/2010	$16.36	Meals
	Subtotal	*$61.91*	
	02/13/2012	$17.13	Meals
	07/18/2012	$17.07	Meals
	Subtotal	*$34.20*	
	11/01/2013	$8.85	Meals
	12/04/2013	$17.59	Meals
	12/18/2013	$77.98	Meals
	12/20/2013	$9.37	Meals
	Subtotal	*$113.79*	
	05/21/2014	$11.76	Meals
	Subtotal	*$11.76*	
	Total	***$221.66***	
Donald Jensen	03/26/2010	$7.68	Meals
	Subtotal	*$7.68*	
	04/21/2012	$2,500.00	Honoraria
	04/21/2012	$120.35	Meals
	07/24/2012	$116.91	Meals
	10/16/2012	$3,180.00	Honoraria
	10/16/2012	$109.44	Meals
	10/16/2012	$25.61	Meals
	10/16/2012	$220.00	Travel
	10/17/2012	$125.00	Meals
	Subtotal	*$6,397.31*	
	Total	***$6,404.99***	
Arthur Kim	01/13/2011	$9.49	Meals
	01/13/2011	$911.48	Travel
	01/13/2011	$6.78	Meals
	01/14/2011	$50.00	Meals
	01/14/2011	$60.00	Meals
	01/14/2011	$70.00	Meals
	01/15/2011	$60.00	Meals
	01/15/2011	$70.00	Meals
	01/13/2011	$130.00	Meals
	Subtotal	*$1,367.75*	
	08/01/2013	$26.29	Meals
	08/01/2013	$30.79	Meals
	08/01/2013	$12.06	Meals
	08/01/2013	$550.00	Consulting fee
	08/01/2013	$7,700.00	Consulting fee
	07/08/2013	$752.30	Travel

Name	Date	Amount	Description
	Subtotal	*$9,071.44*	
	06/23/2014	$22.84	Meals
	Subtotal	*$22.84*	
	Total	***$10,462.03***	
Kristen Marks	12/16/2013	**$14.44**	Meals
	Subtotal	*$14.44*	
	Total	***$14.44***	
Paul Martin	02/18/2009	$2,500.00	Honoraria
	02/18/2009	$2,500.00	Honoraria
	05/26/2009	$2,500.00	Honoraria
	06/29/2009	$237.30	Travel
	Subtotal	*$7,737.30*	
	10/21/2010	$2,500.00	Honoraria
	11/02/2010	$40.00	Travel
	11/11/2010	$13.69	Meals
	Subtotal	*$2,553.69*	
	04/02/2011	$2,500.00	Honoraria
	04/02/2011	$84.51	Meals
	04/07/2011	$11.28	Meals
	04/07/2011	$12.22	Meals
	09/22/2011	$4,000.00	Honoraria
	09/22/2011	$45.18	Meals
	09/23/2011	$43.77	Meals
	09/23/2011	$23.40	Meals
	09/23/2011	$1,219.79	Travel
	12/07/2011	$89.37	Meals
	12/07/2011	$5.91	Meals
	Subtotal	*$8,035.43*	
	05/12/2012	$1,500.00	Honoraria
	05/12/2012	$768.96	Travel
	05/12/2012	$79.05	Meals
	05/12/2012	$97.42	Meals
	07/11/2012	$122.82	Meals
	07/11/2012	$15.56	Meals
	07/12/2012	$22.44	Meals
	11/28/2012	$6.61	Meals
	11/29/2012	$19.01	Meals
	12/01/2012	$2,500.00	Honoraria
	12/01/2012	$111.65	Meals
	12/01/2012	$43.50	Meals
	12/01/2012	$49.81	Meals
	12/01/2012	$67.35	Meals
	12/01/2012	$846.54	Travel
	Subtotal	*$6,250.72*	
	04/27/2013	$152.81	Meals

Name	Date	Amount	Description
	11/19/2013	$1,221.44	Travel
	11/19/2013	$60.86	Meals
	11/19/2013	$47.40	Travel
	Subtotal	*$1,482.51*	
	Total	***$26,059.65***	
Henry Masur	11/05/2012	$108.00	Travel
	11/05/2012	$108.00	Travel
	11/06/2012	$112.00	Travel
	Subtotal	*$328.00*	
	Total	***$328.00***	
Timothy Morgan	11/05/2009	$2,000.00	Consulting fee
	Subtotal	*$2,000.00*	
	09/15/2012	$19.88	Meals
	Subtotal	*$19.88*	
	05/10/2013	$42.70	Meals
	05/10/2013	$115.90	Meals
	05/10/2013	$61.00	Meals
	05/10/2013	$241.60	Travel
	12/18/2013	$26.78	Meals
	Subtotal	*$487.98*	
	Total	***$2,507.86***	
Susanna Naggie	09/30/2010	$50.00	Travel
	Subtotal	*$50.00*	
	11/07/2011	$123.95	Meals
	Subtotal	*$123.95*	
	06/27/2012	$1,103.75	Travel
	06/27/2012	$35.00	Meals
	06/27/2012	$50.00	Meals
	06/27/2012	$50.00	Meals
	06/27/2012	$10.69	Meals
	06/27/2012	$15.00	Meals
	Subtotal	*$1,264.44*	
	07/27/2013	$3,000.00	Honoraria
	07/27/2013	$1,606.40	Travel
	07/27/2013	$131.85	Meals
	10/03/2013	$34.82	Meals
	Subtotal	*$4,773.07*	
	Total	***$6,211.46***	
Nancy Reau	05/26/2009	$2,500.00	Honoraria
	08/06/2009	$72.32	Unknown (likely travel)
	Subtotal	*$2,572.32*	
	03/23/2010	$2,500.00	Honoraria

Name	Date	Amount	Description
	08/07/2010	$2,000.00	Honoraria
	08/07/2010	$481.44	Meals
	08/07/2010	$962.05	Travel
	Subtotal	*$5,943.49*	
	01/13/2011	$1,179.44	Travel
	01/13/2011	$130.00	Meals
	01/14/2011	$60.00	Meals
	01/14/2011	$70.00	Meals
	01/18/2011	$250.00	Honoraria
	04/02/2011	$2,500.00	Honoraria
	04/02/2011	$84.51	Meals
	11/03/2011	$50.00	Meals
	11/03/2011	$522.47	Travel
	11/07/2011	$119.87	Meals
	12/01/2011	$1,500.00	Honoraria
	Subtotal	*$6,466.29*	
	06/20/2012	$131.33	Meals
	07/24/2012	$116.91	Meals
	Subtotal	*$248.24*	
	05/11/2013	$1,500.00	Honoraria
	05/11/2013	$77.83	Meals
	05/11/2013	$52.46	Meals
	05/11/2013	$28.17	Meals
	05/11/2013	$57.22	Meals
	05/11/2013	$16.91	Travel
	07/13/2013	$2,500.00	Honoraria
	07/13/2013	$105.73	Meals
	07/13/2013	$50.27	Meals
	07/13/2013	$65.23	Meals
	07/13/2013	$1,672.35	Travel
	11/19/2013	$3,500.00	Honoraria
	11/19/2013	$1,274.38	Travel
	11/19/2013	$60.86	Meals
	11/19/2013	$50.37	Meals
	Subtotal	*$11,011.78*	
	04/17/2014	$3,500.00	Honoraria
	04/17/2014	$13.17	Meals
	04/17/2014	$1,050.68	Travel
	Subtotal	*$4,563.85*	
	Total	***$30,805.97***	
Michael Saag	04/08/2010	$2,500.00	Honoraria
	Subtotal	*$2,500.00*	
	03/20/2011	$956.58	Travel
	03/20/2011	$229.29	Meals
	03/20/2011	$617.18	Travel
	03/20/2011	$83.63	Meals

Name	Date	Amount	Description
	12/13/2011	$3,625.00	Honoraria
	12/04/2011	$459.96	Travel
	Subtotal	*$5,971.64*	
	08/24/2012	$10,410.30	Honoraria
	08/24/2012	$8,999.73	Travel
	08/24/2012	$1,245.07	Travel
	08/24/2012	$435.32	Meals
	12/11/2012	$3,625.00	Honoraria
	11/16/2012	$592.50	Travel
	11/16/2012	$43.00	Meals
	11/16/2012	$77.71	Meals
	11/16/2012	$6,527.00	Travel
	11/16/2012	$436.04	Travel
	Subtotal	*$32,391.67*	
	01/17/2013	$183.76	Travel
	01/18/2013	$708.20	Travel
	01/18/2013	$35.00	Meals
	01/18/2013	$35.00	Meals
	01/18/2013	$75.00	Meals
	01/18/2013	$35.00	Meals
	01/18/2013	$35.00	Meals
	01/18/2013	$75.00	Meals
	01/18/2013	$708.20	Travel
	Subtotal	*$1,890.16*	
	Total	***$42,753.47***	
Robert Schooley	01/21/2009	$2,000.00	Consulting fee*
	02/17/2009	$2,000.00	Consulting fee*
	04/01/2009	$2,000.00	Consulting fee*
	04/21/2009	$2,000.00	Consulting fee*
	05/22/2009	$2,000.00	Consulting fee*
	06/22/2009	$2,000.00	Consulting fee*
	07/30/2009	$2,000.00	Consulting fee*
	08/05/2009	$133.00	Travel
	08/18/2009	$2,000.00	Consulting fee*
	09/18/2009	$2,000.00	Consulting fee*
	10/20/2009	$2,000.00	Consulting fee*
	11/16/2009	$2,000.00	Consulting fee*
	12/14/2009	$2,000.00	Consulting fee*
	Subtotal	*$24,133.00*	
	01/01/2010	$2,000.00	Consulting fee*
	02/01/2010	$2,000.00	Consulting fee*
	03/01/2010	$2,000.00	Consulting fee*
	03/04/2010	$88.08	Meals
	03/08/2010	$82.75	Meals
	03/08/2010	$93.33	Travel
	03/09/2010	$47.00	Travel
	03/09/2010	$20.00	Travel
	03/09/2010	$129.70	Travel

Name	Date	Amount	Description
	03/09/2010	$91.33	Travel
	03/09/2010	$101.62	Travel
	04/01/2010	$2,000.00	Consulting fee*
	05/01/2010	$2,000.00	Consulting fee*
	06/01/2010	$2,000.00	Consulting fee*
	07/01/2010	$2,000.00	Consulting fee*
	07/21/2010	$17.95	Meals
	07/21/2010	$21.95	Meals
	07/21/2010	$47.60	Meals
	07/21/2010	$40.49	Travel
	07/21/2010	$273.84	Travel
	07/22/2010	$21.75	Meals
	07/22/2010	$16.95	Meals
	07/22/2010	$37.79	Travel
	07/23/2010	$465.52	Travel
	08/01/2010	$2,000.00	Consulting fee*
	09/01/2010	$2,000.00	Consulting fee*
	10/15/2010	$2,000.00	Consulting fee*
	11/15/2010	$2,000.00	Consulting fee*
	12/15/2010	$2,000.00	Consulting fee*
	Subtotal	*$25,597.65*	
	01/20/2011	$2,000.00	Consulting fee*
	02/17/2011	$2,000.00	Consulting fee*
	03/24/2011	$2,000.00	Consulting fee*
	04/15/2011	$2,000.00	Consulting fee*
	05/15/2011	$2,000.00	Consulting fee*
	06/15/2011	$2,000.00	Consulting fee*
	07/20/2011	$17.95	Meals
	07/20/2011	$21.95	Meals
	07/20/2011	$51.20	Meals
	07/20/2011	$38.24	Travel
	07/20/2011	$126.34	Travel
	07/21/2011	$16.95	Meals
	07/21/2011	$21.75	Meals
	07/21/2011	$38.24	Travel
	07/22/2011	$53.00	Meals
	07/22/2011	$119.00	Travel
	07/22/2011	$327.80	Travel
	08/01/2011	$2,000.00	Consulting fee*
	09/01/2011	$2,000.00	Consulting fee*
	10/01/2011	$2,000.00	Consulting fee*
	11/01/2011	$2,000.00	Consulting fee*
	11/07/2011	$123.95	Meals
	12/01/2011	$2,000.00	Consulting fee*
	Subtotal	*$22,956.37*	
	01/15/2012	$2,000.00	Consulting fee*
	01/26/2012	$151.20	Meals
	02/01/2012	$2,000.00	Consulting fee*
	03/01/2012	$2,000.00	Consulting fee*
	04/01/2012	$2,000.00	Consulting fee*

Name	Date	Amount	Description
	04/01/2012	$2,000.00	Consulting fee*
	04/01/2012	$2,000.00	Consulting fee*
	07/01/2012	$2,000.00	Consulting fee*
	07/17/2012	$98.49	Meals
	07/30/2012	$98.49	Meals
	07/31/2012	$17.95	Meals
	07/31/2012	$18.95	Meals
	07/31/2012	$62.50	Meals
	07/31/2012	$16.45	Travel
	07/31/2012	$196.02	Travel
	07/31/2012	$384.25	Travel
	08/01/2012	$13.95	Meals
	08/01/2012	$2,000.00	Consulting fee*
	08/01/2012	$16.45	Travel
	08/01/2012	$15.00	Travel
	08/07/2012	$145.00	Travel
	09/01/2012	$2,000.00	Consulting fee*
	10/01/2012	$2,000.00	Consulting fee*
	10/11/2012	$167.62	Travel
	11/01/2012	$2,000.00	Consulting fee*
	12/01/2012	$2,000.00	Consulting fee*
	Subtotal	*$25,402.32*	
	07/30/2013	$83.40	Travel
	07/31/2013	$17.95	Meals
	07/31/2013	$14.40	Travel
	08/01/2013	$31.95	Meals
	08/01/2013	$62.00	Meals
	08/01/2013	$14.40	Travel
	08/01/2013	$761.16	Travel
	08/05/2013	$24,000.00	Consulting fee*
	12/11/2013	$38.73	Meals
	12/11/2013	$572.58	Travel
	12/11/2013	$35.67	Travel
	12/11/2013	$15.75	Travel
	12/11/2013	$129.25	Travel
	12/12/2013	$41.42	Meals
	12/12/2013	$49.94	Meals
	12/12/2013	$129.25	Travel
	12/13/2013	$38.64	Meals
	12/13/2013	$129.25	Travel
	Subtotal	*$26,165.74*	
	Total	***$124,255.08***	
			**** Paid to University of California, San Diego***
Kenneth Sherman	05/03/2010	$109.41	Meals
	Subtotal	*$109.41*	
	01/13/2011	$1,309.68	Travel
	01/14/2011	$36.48	Meals
	01/14/2011	$60.00	Meals

Name	Date	Amount	Description
	01/15/2011	$60.00	Meals
	01/14/2011	$70.00	Meals
	01/15/2011	$70.00	Meals
	01/13/2011	$130.00	Meals
	02/28/2011	$112.63	Meals
	Subtotal	*$1,848.79*	
	Total	***$1,958.20***	
Mark Sulkowski	03/17/2009	$2,500.00	Honoraria
	04/30/2009	$595.16	Travel
	05/26/2009	$2,500.00	Honoraria
	10/09/2009	$2,500.00	Honoraria
	11/12/2009	$429.01	Meals/ Travel
	Subtotal	*$8,524.17*	
	03/23/2010	$2,500.00	Honoraria
	04/16/2010	$110.85	Meals
	05/25/2010	$3,000.00	Honoraria
	06/28/2010	$28.00	Travel
	Subtotal	*$5,638.85*	
	02/05/2011	$3,000.00	Honoraria
	02/05/2011	$658.66	Travel
	02/19/2011	$30.00	Travel
	05/03/2011	$50.00	Meals
	05/03/2011	$288.50	Travel
	05/05/2011	$35.00	Meals
	05/06/2011	$20.00	Meals
	06/24/2011	$116.79	Meals
	09/19/2011	$4,000.00	Honoraria
	12/08/2011	$121.75	Travel
	Subtotal	*$8,320.70*	
	02/02/2012	$42.14	Travel
	03/07/2012	$27.07	Meals
	04/21/2012	$120.35	Meals
	04/21/2012	$2,500.00	Honoraria
	05/24/2012	$9,750.00	Consulting fee
	05/24/2012	$430.76	Travel
	06/28/2012	$2,000.00	Consulting fee
	06/29/2012	$135.28	Meals
	06/29/2012	$4,000.00	Honoraria
	06/29/2012	$125.75	Travel
	07/31/2012	$54.00	Travel
	09/28/2012	$75.95	Meals
	09/28/2012	$4,000.00	Honoraria
	09/28/2012	$647.16	Travel
	09/28/2012	$772.86	Travel
	09/28/2012	$266.56	Travel
	09/29/2012	$20.29	Meals
	09/29/2012	$27.23	Meals

Name	Date	Amount	Description
	09/29/2012	$73.11	Meals
	09/29/2012	$36.45	Meals
	09/29/2012	$24.52	Meals
	10/16/2012	$109.44	Meals
	10/16/2012	$25.61	Meals
	10/16/2012	$3,180.00	Honoraria
	10/16/2012	$220.00	Travel
	11/09/2012	$48.16	Meals
	Subtotal	*$28,712.69*	
	07/27/2013	$131.85	Meals
	07/27/2013	$3,000.00	Honoraria
	07/27/2013	$61.50	Travel
	08/01/2013	$11.21	Meals
	08/01/2013	$9,000.00	Consulting fee
	08/01/2013	$311.19	Travel
	08/26/2013	$92.36	Meals
	08/26/2013	$340.80	Travel
	09/06/2013	$77.34	Meals
	09/06/2013	$40.00	Meals
	09/06/2013	$36.96	Meals
	09/06/2013	$85.60	Meals
	09/06/2013	$40.13	Meals
	09/06/2013	$649.96	Travel
	09/06/2013	$643.01	Travel
	09/06/2013	$235.44	Travel
	10/03/2013	$4,000.00	Honoraria
	11/01/2013	$124.50	Meals
	12/06/2013	$2,000.00	Consulting fee
	12/09/2013	$107.37	Meals
	12/31/2013	$5,000.00	Honoraria
	Subtotal	*$25,989.22*	
	01/17/2014	$116.92	Meals
	01/17/2014	$227.68	Travel
	01/18/2014	$3,500.00	Honoraria
	01/18/2014	$867.00	Travel
	01/18/2014	$215.68	Travel
	01/18/2014	$303.97	Travel
	02/18/2014	$3,500.00	Honoraria
	04/12/2014	$2,000.00	Honoraria
	Subtotal	*$10,731.25*	
	Total	***$87,916.88***	
David Thomas	12/03/2012	$36.80	Meals
	12/03/2012	$206.21	Travel
	12/03/2012	$406.31	Travel
	Subtotal	*$649.32*	
	01/15/2013	$68.53	Meals
	01/15/2013	$288.50	Travel
	01/17/2013	$3,750.00	Honoraria

Name	Date	Amount	Description
	Subtotal	*$4,107.03*	
	Total	***$4,756.35***	
Hugo Vargas	08/16/2013	$51.24	Meals
	08/16/2013	$61.00	Meals
	08/16/2013	$73.20	Meals
	08/16/2013	$986.30	Travel
	Subtotal	*$1,171.74*	
	Total	***$1,171.74***	
John Ward	01/14/2010	$121.32	Meals
	01/14/2010	$52.58	Meals
	01/15/2010	$28.39	Meals
	01/25/2010	$1,522.59	Travel
	Subtotal	*$1,724.88*	
	Total	***$1,724.88***	
David Wyles	05/03/2011	$20.00	Meals
	05/05/2011	$1,316.69	Travel
	05/05/2011	$50.00	Meals
	05/06/2011	$35.00	Meals
	05/06/2011	$26.44	Meals
	Subtotal	*$1,448.13*	
	11/10/2012	$69.29	Meals
	11/11/2012	$34.36	Meals
	Subtotal	*$103.65*	
	11/19/2013	$7,975.00	Consulting fee
	11/19/2013	$28.00	Travel
	Subtotal	*$8,003.00*	
	05/08/2014	$123.66	Meals
	Subtotal	*$123.66*	
	Total	***$9,678.44***	

*** No records of payments between Gilead and Marc Ghany, Shyam Kottilil, Kiren Mitruka, and Daniel Raymond.*

Payments Identified Between Pharmasset and AASLD/ISDA Treatment Guidelines Panelists**

Name	Date	Amount	Description
Donald Jensen	07/21/2011	$2,000.00	Unknown
	Subtotal	*$2,000.00*	
	Total	***$2,000.00***	

*** No additional records found.*

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 18(d)

Describe any communications between employees of Gilead and the organizations and individuals identified in (a) and (b) regarding the AASLD/IDSA treatment guidelines for HCV. Please provide all supporting documents related to those communications.

There were two conversations, both with Bill Guyer, Vice President of Medical Affairs and HIV Global Medical Director at Gilead. The two conversations occurred before the approval of Sovaldi (likely in October and November 2013) and were with panelists Donald Jensen and Mark Sulkowski, respectively. Dr. Jensen called Dr. Guyer directly, while Dr. Sulkowski and Dr. Guyer were speaking generally after encountering one another at the annual AASLD conference. Both discussions related to the combination of sofosbuvir + simeprevir (SOF/SMV). Dr. Jensen called to ask whether Gilead believed it would get FDA approval for the regimen, while Dr. Sulkowski and Dr. Guyer discussed in passing the relative merits of various HCV treatment regimens. In both cases, Dr. Guyer noted that SOF/SMV was supported only by Phase II data and that Gilead did not recommend the combination, and stated that he would not include the combination in any guidelines. Dr. Jensen was noncommittal in response, while Dr. Sulkowski disagreed on the merits of the clinical data and expressed support for the SOF/SMV regimen.

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 20

Gilead has included Sovaldi in its patient assistance program, which includes coupons for reducing the cost of patient copays. Gilead estimated that 30,000 patients were treated with Sovaldi during the first quarter of 2014.

Gilead operates a robust set of patient support programs for patients with HCV. These programs include:

- MySupportPath – Gilead's patient support programs are accessible via MySupportPath, which is available through a website (www.mysupportpath.com) and a call center staffed with associates trained to help patients, caregivers, and health care professionals who need assistance (1-855-7-MYPATH – 9-8 PM EST). Services accessible via MySupportPath are free, and include:
    - *General guidance.* Patients who call SupportPath can receive 24/7 information about HCV from trained nurses. Patients can also enroll in email updates from MySupportPath providing disease-related information.
    - *Insurance counseling.* Patients who have been prescribed or are considering Sovaldi can also receive guidance on possible public and private insurance options.
    - *Coverage and access support.* Patients who have been prescribed or are considering Sovaldi who have questions regarding their health care insurance and coverage can receive assistance, including research into their health insurance benefits and information regarding payer-specific prior authorization requirements.
    - *Financial support information.* Finally, patients facing financial barriers to access can learn about and enroll in various financial support programs (described below).
- Gilead financial support programs – To reduce financial barriers to access Sovaldi, Gilead invests significant resources in financial support programs:
    - *Copay coupons.* Patients with commercial insurance – regardless of income – are eligible for copay coupons to subsidize their out-of-pocket cost-sharing obligations for Sovaldi, including deductibles, co-insurance, and copayments. Each copay coupon is valid for up to $16,800 and can be used at any point in a patient's treatment.
    - *Patient assistance program (PAP).* Uninsured patients and underinsured patients meeting pre-defined income limits may be eligible for free product through Gilead's PAP.
- Foundation support – Gilead also makes arms-length donations to two independent non-profit patient assistance foundations ("the Foundations"), which assist patients across many different disease states, including HCV. The Foundations' HCV funds provide cost-sharing support to government-insured and commercially insured patients who have been prescribed HCV therapy by their physician and who meet certain income requirements. Foundation assistance is open to HCV-infected individuals regardless whether they have been prescribed Sovaldi or another HCV treatment. The Foundations do not disclose to Gilead how many of the individuals they assist are prescribed Sovaldi, and Gilead has no information about other Foundation donors and their funding levels.

a. *How many patients have been treated in the United States with Sovaldi to date?*

As of the first week of July, 2014, an estimated 66,212 patients had been treated in the United States with Sovaldi.

b. *How many patients in the United States have been assisted by Gilead's patient assistance program to date?*

As outlined above, Gilead's patient support program includes multiple components. As of the first week of July, 2014, the estimated number of patients* assisted by Gilead's program include –

- *MySupportPath call center* – 117,462 inbound and outbound calls to assist 15,673 unique patients
- *Copay coupon financial support* – used by 18,618 unique patients
- *PAP (free product for uninsured and underinsured patients)* – 3,568 unique patients served, which represents 5.4% of all patients who have been treated with Sovaldi
- *Foundation support* – The Foundations do not disclose to Gilead how many of the individuals they assist are prescribed Sovaldi

* *Note that the unique patients listed above are not cumulative because a single unique patient may access multiple offerings through the MySupportPath program.*

c. *What percentage of patients does Gilead expect to be covered under this program?*

As of the first week of July, 2014, approximately 50% of commercially insured patients received financial support through Gilead's copay coupon program and an estimated 5.4% of patients treated with Sovaldi received free product through Gilead's PAP.

d. *What is the average outlay-per-patient in the patient assistance program?*

As of the first week of July, 2014:

- Patients using Gilead's copay coupons offset an average of $919 per prescription (i.e., per each bottle dispensed*), and as a result, 99% of these patients paid less than $25 per prescription.
- Gilead provided over $225 million (based on the Wholesale Acquisition Cost (WAC)) in free product through its PAP.

* *Bottles hold 28 pills, or the equivalent of four weeks of therapy.*

e. *What percentage of the patient's cost for Sovaldi will the payment assistance program cover for each of the FDA-approved treatment regimens?*

The copay coupon benefit equals up to 20% of the WAC value of Sovaldi for a 12-week regimen, and can be used at any point during a patient's treatment (including all on the first fill). The current wholesale acquisition cost for a 12-week regimen is $84,000, so eligible patients can currently receive up to $16,800 of financial assistance from Gilead through the copay coupon benefit. As of the first week in July, 2014, 99% of commercially insured patients who used copay coupons paid less than $25 per prescription (i.e., per each bottle dispensed).

Additionally, as noted above, as of early July, 2014, 3,568 uninsured or underinsured patients (or approximately 5.4% of patients treated with Sovaldi) had received free product through the Gilead PAP; as of early August 2014, this number increased to 4,430.

f. What patients are eligible for this assistance? What patients are ineligible for this assistance?

Eligibility requirements differ across Gilead's patient support programs:

- *Copay assistance.* Open to all U.S. patients with commercial insurance who have been prescribed Sovaldi, regardless of income. Patients are limited to one copay coupon per six-month period. Reenrollment is required after six months.
- *PAP.* Open to U.S. uninsured and underinsured patients who meet pre-defined U.S. residency and income limits. The current income threshold for the PAP is less than $100,000 for patients with a household size of 1-3 and under 500% of the federal poverty line (FPL) for patients with larger households.

g. There are a number of HCV-infected populations, such as those exposed through intravenous drug use, contaminated blood and those born to someone infected with the virus. Describe the patient populations expected to be covered by the Sovaldi patient assistance program.

All patients who have been prescribed Sovaldi can use Gilead's patient support programs. In addition, general information regarding HCV is available through MySupportPath, even for patients not prescribed Sovaldi. Gilead does not collect data about how patients contracted the disease.

h. How are the costs of the assistance accounted for within Gilead's financials, e.g. are they deducted as part of the company's Selling, General, and Administrative (SG&A) expenses?

Costs related to operating MySupportPath, Gilead's PAP, and the copay coupon program, as well as the manufacturing cost of the free product provided through the PAP, are accounted for as operating expenses (S&M Opex). The value of the copay coupon assistance is accounted for in a contra revenue account that offsets Gilead's product revenue.

Response to Chairman Wyden/Senator Grassley request dated July 11, 2014: Request No. 21

Sovaldi is and will be sold in multiple countries, many of which are expected to receive significant discounts compared to the price in the U.S.

a. *Please provide a list of all countries where Sovaldi is or will be sold, and the corresponding price or planned price for each country. Describe how the company reached the price for each country.*

b. *How are the revenue, costs and any discounts associated with international sales, such as Egypt, accounted for within Gilead's financials, e.g. are they deducted as part of the company's Selling, General, and Administrative (SG&A) expenses?*

21(a)

Gilead is working in partnership with governments, health care systems and providers, and public health entities to help ensure broad access to Sovaldi worldwide. Our goal is to make Sovaldi accessible in as many places as possible, as quickly as possible.

In developed countries, Gilead considers several value and market-based factors in pricing its medicines. Gilead compares the drug's effectiveness, safety, and tolerability to the current standard of care. Gilead also considers the drug's cost effectiveness, including any potential savings or "offsets" to a country's overall health care system in terms of reducing the cost of disease and/or in comparison to other treatment options. Gilead negotiates with individual countries and payers pursuant to the governing laws, regulations, and customs, with prices being determined on a country-by-country basis.

In less developed countries, ranging from the least developed countries to lower- and upper-middle income countries, Gilead applies a tiered pricing structure based on a country's health care and other resources and the severity of the HCV prevalence within the country. Gilead has employed this approach to its HIV program, and the number of people in developing countries receiving Gilead antiretroviral therapy has increased from fewer than 30,000 in 2006 to six million in 2014. As with its HIV program, Gilead is in the process of entering into licensing agreements with a number of generic manufacturers to broaden the reach, access, and affordability of sofosbuvir in even the poorest of countries. This is a humanitarian program offering drugs at little to no profit.

Gilead is prioritizing treatment expansion first in those developing countries with the highest burden of HCV. For Sovaldi, Gilead has set three basic pricing bands that serve as the basis for negotiations with national governments. Countries are categorized within the bands according to gross national income (GNI) per capita (a reflection of the average income of a country's citizens) and HCV prevalence. Final prices are determined on a country-by-country basis. Attached is a slide deck, already produced to the Committee, that provides an overview of our access pricing approach.

Your letter referenced Gilead's agreement with the Egyptian government. Consistent with our philosophy described above, Gilead began working to register and provide access to Sovaldi in resource-poor countries immediately following the U.S. approval of Sovaldi in December 2013. In July 2014, Gilead signed its first HCV treatment expansion agreement with the Egyptian government. HCV prevalence is higher in Egypt than in any other country in the world – around 12 million Egyptians are infected (15% of the population) – following the use of poorly sterilized needles in campaigns dating back to the 1970s to eliminate the parasitic disease

schistosomiasis. Due to the heavy disease burden, low gross national income, and the government's strong commitment to address the epidemic, the country is in Gilead's lowest pricing tier for HCV at 2,200 Egyptian pounds per bottle.

To better shape Egyptian HCV treatment strategies, Gilead is conducting a Phase III clinical trial in the country evaluating the safety and efficacy of Sovaldi and ribavirin in adults with genotype 4 HCV, the most prevalent strain of the virus in the country. Sovaldi was approved by regulators in Egypt in July 2014. Gilead expects distribution to begin in September 2014. Sovaldi will be available to treat qualified patients endorsed by the Ministry of Health through government programs (through 26 national treatment centers). Gilead will also support medical education, prevention, screening, and patient awareness initiatives.

21(b)

Gilead accounts for revenue and expenses in accordance with U.S. Generally Accepted Accounting Principles. Gilead recognizes revenues from product sales when there is persuasive evidence that an arrangement exists, delivery to the customer has occurred, the price is fixed or determinable, and collectability is reasonably assured. Gilead records estimated reductions to revenues for government rebates, distributor incentives such as cash discounts for prompt payment, distributor fees, and expected returns of expired products. These estimates are deducted from gross product sales at the time such revenues are recognized.

Any costs associated with the production, directly or indirectly, of inventory is recognized as cost of sales in the financial statements.

Selling, general and administrative expenses relate to the sales and marketing, finance, human resources, legal and administrative activities. Expenses are primarily comprised of facilities and overhead costs, outside marketing advertising and legal expenses, and other administrative costs.

Response to Chairman Wyden and Senator Grassley request dated July 11, 2014:
Request No. 21(a)

Please provide a list of all countries where Sovaldi is or will be sold, and the corresponding price or planned price for each country.

Country	List Price*	Comments
Albania	TBD	
Argentina	TBD	
Armenia	TBD	
Australia	TBD	
Austria	€ 48,810.00 ($63,198.70 USD)	Interim Price
Azerbaijan	TBD	
Bahrain	TBD	
Belgium	TBD	
Bolivia	TBD	
Bosnia and Herzegovina	TBD	
Brazil	TBD	
Bulgaria	TBD	
Cameroon	TBD	
Canada	CAD $55,000.00 ($50,525.00 USD)	
Chile	TBD	
China IND	TBD	
China NDA	TBD	
Colombia	TBD	
Croatia	TBD	
Cuba	TBD	
Cyprus	TBD	

Country	List Price*	Comments
Czech Republic	TBD	
Denmark	DKK 324,510.00 ($56,449.40 USD)	
Dominican Republic	TBD	
Ecuador	TBD	
Egypt	EGP 6,600.00 ($908.04 USD)	
El Salvador	TBD	
Estonia	TBD	
Finland	€ 42,000.00 ($54,381.20 USD)	
France	€ 56,000.00 ($72,508.20 USD)	Interim Price
GCC	TBD	
Georgia	TBD	
Germany	€ 48,810.00 ($63,198.70 USD)	Interim Price
Greece	TBD	
Guatemala	TBD	
Haiti	TBD	
Hong Kong	TBD	
Hungary	TBD	
Iceland	TBD	
India	TBD	
Indonesia	TBD	
Iran, Islamic Republic of	TBD	
Iraq	TBD	
Ireland	TBD	
Israel	TBD	
Italy	TBD	
Jordan	TBD	
Kazakhstan	TBD	

Country	List Price*	Comments
Kenya	TBD	
Korea, Republic of	TBD	
Kosovo	TBD	
Kuwait	TBD	
Latvia	TBD	
Lebanon	TBD	
Lithuania	TBD	
Luxembourg	€ 48,000.00 ($62,149.90 USD)	Interim Price
Macao	TBD	
Macedonia, The Former Yugoslav Republic of	TBD	
Malta	TBD	
Mexico	TBD	
Moldova, Republic of	TBD	
Mongolia	TBD	
Netherlands	TBD	
New Zealand	TBD	
Nigeria	TBD	
Norway	NOK 333,480.00 ($53,043.90 USD)	
Oman	TBD	
Pakistan	TBD	
Paraguay	TBD	
Peru	TBD	
Philippines	TBD	
Poland	TBD	
Portugal	TBD	
Qatar	TBD	

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Country	List Price*	Comments
Romania	TBD	
Saudi Arabia	TBD	
Serbia	TBD	
Singapore	TBD	
Slovakia	TBD	
Slovenia	TBD	
South Africa	TBD	
Spain	TBD	
Sweden	SEK 365,400.00 ($51,453.60 USD)	
Switzerland	CHF 55,500.00 ($59,594.80 USD)	
Syrian Arab Republic	TBD	
Taiwan	TBD	
Taiwan, Republic of China	TBD	
Tanzania, United Republic of	TBD	
Thailand	TBD	
Tunisia	TBD	
Turkey	TBD	
Uganda	TBD	
United Kingdom	£34,982.94 ($57,100.20 USD)	
Ukraine	TBD	
United Arab Emirates	TBD	
Uzbekistan	TBD	
Venezuela	TBD	
Vietnam	TBD	
Yemen	TBD	

** Please note that all pricing is in reference to a 12-week regimen. Exchange rate information as of 9/8/14.*