Zacks Small-Cap Research

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Eyegate Pharmaceuticals (EYEG-NASDAQ)

EYEG: Jade Brings De-Risked, Complementary Pipeline

Current Recommendation	**Buy**
Prior Recommendation	N/A
Date of Last Change	02/18/2016
Current Price (04/04/16)	$3.07
Target Price	**$6.00**

OUTLOOK

EYEG is a pre-revenue stage company engaged in the development of drugs and drug delivery devices for diseases of the eyes. Their novel iontophoresis drug delivery platform offers a much less burdensome and non-invasive solution to current standard of care for diseases of the eye. Phase 3 pivotal study in anterior uveitis now enrolling – if positive will support NDA filing. Launch could happen by 2018. Out-licensing agreement recently consummated with Valeant/Bausch+Lomb. Clinicals in other indications also enrolling, which could eventually expand the label and respective target market size. Recent Jade acquisition brings complementary, de-risked pipeline. Our DCF model, which incorporates indication-specific risk adjustments to account for potential clinical or regulatory failure for each of the three programs, currently values the shares at approximately $6. While representing attractive upside to the current share price, our calculated value should appreciate further on progression through clinical trials of EGP-437 as well as Jade's pipeline.

SUMMARY DATA

52-Week High	**$20.00**
52-Week Low	**$1.59**
One-Year Return (%)	**0.00**
Beta	**2.73**
Average Daily Volume (sh)	**257,421**
Shares Outstanding (mil)	**8**
Market Capitalization ($mil)	**$26**
Short Interest Ratio (days)	**N/A**
Institutional Ownership (%)	**5**
Insider Ownership (%)	**N/A**
Annual Cash Dividend	**$0.00**
Dividend Yield (%)	**0.00**
5-Yr. Historical Growth Rates	
Sales (%)	**N/A**
Earnings Per Share (%)	**N/A**
Dividend (%)	**N/A**
P/E using TTM EPS	**N/A**
P/E using 2016 Estimate	**N/A**
P/E using 2017 Estimate	**N/A**
Zacks Rank	**N/A**

Risk Level	**High,**
Type of Stock	**Small-Growth**
Industry	**Med-Drugs**

ZACKS ESTIMATES

Revenue
(in 000s of $)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2015	0 A	0 A	0 A	0 A	0 A
2016	0 E	0 E	0 E	0 E	0 E
2017					5.6 E
2018					7.6 E

Earnings per Share

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2015	-$3.23 A	-$0.24 A	-$0.19 A	-$0.35 A	-$2.70 A
2016	-$0.32 E	-$0.33 E	-$0.34 E	-$0.35 E	-$1.35 E
2017					-$0.68 E
2018					-$0.49 E

Zacks Projected EPS Growth Rate - Next 5 Years % **N/A**

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WHAT'S NEW…

Q4 Financial Results, Operating Update…
EYEG reported fourth quarter financial results on March 29th. Operating expenses jumped fairly substantially from both the prior year and prior quarter periods. R&D expense was $1.4M in Q4, up from just $109k in the comparable year-earlier period and from $407k in Q3. The increase relates to ramping of activities in the phase 3 anterior uveitis and macular edema clinical studies as well as some additional staffing and scientific advisory board expenses. Meanwhile, SG&A came in at $1.3M in Q4, compared to $284k and $946k in prior year and quarter periods with additional personnel expenses accounting for the majority of the increase. Excluding non-cash charges related to conversion of notes to common stock and warrant liability revaluation as well as deemed dividends on preferred stock (non-cash related to conversion of preferred to common in connection with IPO), net income and EPS were ($7.0)M and ($1.13).

EYEG acquires ophthalmic therapy company, Jade Therapeutics…
The significant operational update since we initiated coverage of EYEG in mid-February was the announcement on March 7th that EyeGate acquired Jade Therapeutics, a Utah-based, privately-held specialty pharma developing locally administered, polymer-based ophthalmic therapies. Their lead technology, CMHA-S, is a proprietary cross-linked, thiolated (with carboxymethyl groups) version of hyaluronic acid (HA). HA is a naturally occurring in the human body and is a primary contributor of cell proliferation with wound-healing, tissue repair and anti-inflammatory properties. BioTime Inc. granted Jade a worldwide exclusive license to CMHA-S for delivery of any and all therapeutic molecules related to the human eye. BioTime retains rights for non-ophthalmic indications.

Terms of the deal:

- EYEG will pay up to $300k of Jade's liabilities
- EYEG will issue ~766k common shares to Jade, 90% which were issued at closing with the other 10% to be issued 18 months later (EYEG shares closed at ~$3.80 prior to the announcement = ~$2.9M)
- An additional $2.2M in cash is payable upon receiving FDA approval of a Jade product candidate

EYEG will assume Jade's Salt Lake City based R&D facility. Jade's co-founders as well as its research team will also migrate over to EyeGate. This includes their Chief Medical Officer (who will assume the same role at EYEG) and co-founder, a board certified ophthalmologist with a strong research background and who at a previous role as Pfizer's Senior Medical Director led the successful European regulatory filing for pediatric Xalatan (eye drop for open-angle glaucoma). Also coming from Jade is their head of R&D who has extensive experience in hydrogels for wound healing and drug delivery as well as another of Jade's co-founders.

EYEG pulled the trigger on Jade given the complementary product portfolios. We think this is about as good of a marriage in terms of fit for products and customer-channels that could be hoped for. And both companies' products address the shortcomings of the way that ophthalmic medications are administrated – that is, a rigorous dosing regimen and ineffective penetration.

EYEG will bolt on several potential ophthalmic indications at a reasonable purchase price. The pipeline is also re-risked to a degree in that the active ingredient (HA) is already widely used in human ophthalmic (as well as non-eye) applications, a similar cross-linked formulation is already 510(k)-cleared for dermal wound management (BioTime's product), CMHA-S has been vigorously and successfully tested in animals and a version is marketed by BayerDVM (animal health) in the U.S. and Europe under the Remend brand for corneal wound repair which has sold over 600k units.

Jades Technology…
The average person has about 15 to 20 grams of hyaluronic acid in their body. It is a main component in synovial fluid, which reduces friction between joints, is found in connective tissue and is also a major component of skin where it is involved in tissue repair. It has been used since the 1970s during intraocular surgery to protect the corneal endothelium where it is still considered standard of care. Hyaluronic acid's efficacy in protecting the corneal endothelium during cataract surgery has been well established.[1] It is also used in Europe as a first-line treatment for dry eye disease. HA is also an active ingredient in many of the "artificial tears" products sold in the U.S. and internationally. HA is also used in other applications, including as an injectable to treat osteoarthritis. Safety of HA, therefore, has already been well-established (particularly in ophthalmic applications).

[1] Goa KL, Benfield P. Hyaluronic acid. A review of its pharmacology and use as a surgical aid in ophthalmology, and its therapeutic potential in joint disease and wound healing. Drugs. 1994 Mar;47(3):536-66.

One issue that HA suffers from, however, is that it has short half-life with approximately one-third of it degraded (and replenished) in the body each day. But by cross-linking it, it stabilizes the molecule and forms into a hydrogel with a very high molecular weight and viscosity which resists degradation and allows it to adhere to the surface of the eye much longer. Unlike typical eye drops, which quickly run down the side of user's face, a hydrogel will stay in place and provide the benefit of sustained release, thereby improving efficacy. It also means a much less rigorous dosing regimen. And it remains biocompatible, will thin with blinking and a user's vision will not be compromised immediately following administration (despite its gel-like properties).

The compound starts with HA from Novosymes (bacterial fermentation). Carboxymethyl groups at then added to produce CMHA which are then thiolated using a proprietary method to produce CMHA-S. Depending on the intended application, it can be formulated into a relatively low viscosity liquid or higher viscosity gel or film.

Initial Indication…

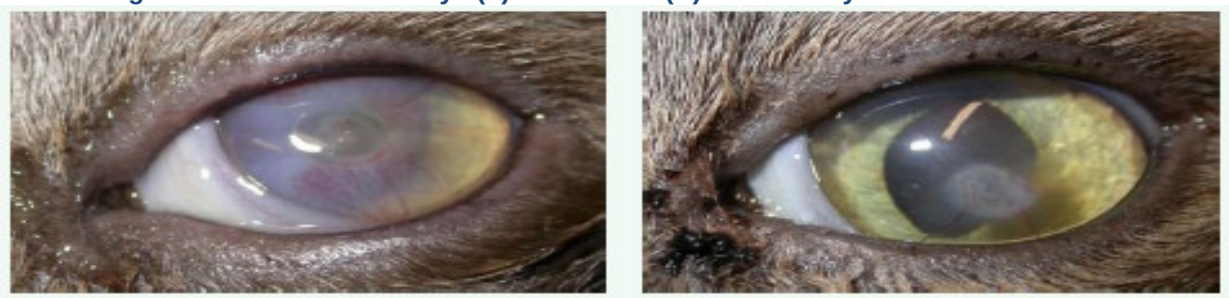
The initial indication EYEG expects to seek is for corneal repair (currently dubbed JDE-003) for populations such as;

- Persistent corneal epithelial defects (PCED)
- Following photoreactive keratectomy (similar to LASIK)
- Moderate-to-severe dry eye
- Following diabetic vitrectomy (eye surgery to remove vitreous gel)

JDE-003 uses cross-linked 0.75% HA solution. A non-healing corneal defect is considered persistent, or non-healing, if it persists for more than two weeks. PCED's can result in corneal ulcers, scarring, infection and, eventually, blindness if not effectively treated.

A masked, randomized study in 29 cats with superficial, mid-stromal and deep stromal (i.e. non-healing) corneal defects showed superior efficacy of CMHA-S (0.75% concentration) as compared to non-cross-linked 0.25% eye drops. Both arms received their respective eye drops 3x/day and were evaluated weekly. Primary endpoint was lack of staining with fluorescein (i.e. healed ulcer). Results showed eyes treated with CMHA-S 0.75% took an average of 21 days (± 11 days) to heal while those treated with non-cross-linked 0.25% HA concentration took an average of 32 days (± 10 days) to heal.

Non-healing corneal defect at 35 days (L) and healed (R) after 10 days of CMHA-S 0.75% treatment[2]



Non-healing corneal defect at 42 days (L) and healing (R) after 12 days of CMHA-S 0.75% treatment



FDA Meeting Upcoming…

EYEG believes JDE-003 will be able to follow an FDA medical device pathway (as opposed to drug pathway) and expects to meet with the agency in Q3 of this year for confirmation. We note that AmbioDisk and Prokera, both

[2] Jade Therapeutics, Eyegate Pharmaceuticals

amniotic membranes (i.e. disks placed on the eye by clinicians) indicated for use of non-healing epithelial defects also did not follow NDA pathways. Prokera followed 510(k) as a Class II device while AmbioDisk is regulated under Section 361 of the Public Health Service Act by FDA with no clearance required. These are more invasive and require much greater skill to administer than eye drops (i.e. JDE-003). This, combined with the strong safety data to-date, may play in EYEG's favor. Assuming they get confirmation of the device pathway, EYEG expects to initiate clinical studies for corneal repair in Q4.

Pipeline Indications…
In addition to corneal repair, the pipeline includes JDE-002, an ocular surface shield and JDE-004, for treatment of bacterial keratitis. Both of these programs have been funded by federal government grants.

The ocular shield candidate consists of a thin film, shaped to surface of the eye which will remain in place up to 7 days to promote healing. Department of Defense funding has funded over $1M for Phase 1 and 2 (through August 2017).

JDE-004 utilizes the Jade technology to deliver antibiotics to the eye to treat bacterial keratitis (infectious corneal ulcers), which is most common due to wearing contact lenses overnight. Typical treatment is antibiotics delivered via drops such as Bausch+Lomb's Besivance (besifloxacin 0.6%). JDE-004 would deliver a medication via a CHMA film with a 7 – 8 day release window, thereby eliminating the need of the rigorous 3x/day for 7 days dosing schedule recommended with Besivance. Jade has demonstrated safety and tolerability of the sustained release film in rabbit models.

Product #	Product	Type of Product	Indication	Formulation	Preclinical Development	IND/IDE
JDE-003	Device	Thiolated-HA Topical Drop (0.75%)	Corneal Repair	US-IDE/PMA Regulatory Pathway		
JDE-001	Drug	Thiolated-HA Topical Drop (0.4%)	Dry Eye Disease (DED)	US-IND Regulatory Pathway		
JDE-002*	Device	Thiolated-HA Ocular Surface Shield	Corneal Protection / Repair	US-IDE/PMA		
JDE-004*	Drug	Antibacterial Film	Bacterial Keratitis	IND Pathway		
JDE-005*	Drug	rHGH Film	Persistent Corneal Epithelial Defects	Orphan Drug Designation		
JDE-006	Drug	Anti-angiogenic	Corneal Neovascularization, AMD/DME	Drug Delivery Program		

*These programs are fully funded by Federal Government Grants (Department of Defense and National Science Foundation)

SOURCE: Eyegate Pharm

Market Opportunity…
JDE-003 is considered the lead Jade candidate with PCED potentially being the most near-term opportunity. EYEG estimates PCED encompasses an annual U.S. market of approximately 125k people. Incorporating an estimated $300 per treatment cost and an average of two (i.e. one to three) treatments per patient, results in a U.S. market opportunity worth roughly $75M (i.e. - ~$40M - $115M). Other indications for JDE-003 could include post photoreactive keratectomy, moderate-to-severe dry eye and following diabetic vitrectomy which, in aggregate, could balloon the total market opportunity to over $1B – the vast majority of which would relate to dry eye, given the relatively high incidence (3 – 5 million Americans) of the condition.

Comments
Jade's pipeline looks like it could be a seamless fit to that of EYEG's – not only does it target similar customer channels but also addresses the drawbacks of current ophthalmic drug administration. JDE-003, the lead candidate, is already de-risked to an extent given the long history of HA being used in human eyes and its broad use and extensive successful testing for corneal repair in animals.

Standard of care for corneal repair, including liquid eye drops, bandage soft contact lenses, pressure patching and debridement sometimes fail or require onerous dosing/administration regimens. Newer therapies, including

amniotic membranes, offer the potential for greater efficacy and more rapid healing but come with drawbacks – including that some of these must be sewn in place or glued and all require a skilled clinician. These are also relatively costly ($1k - $2k per treatment).

Jade also comes with an existing R&D facility, highly experience staff and existing government grants to help fund other of the pipeline candidates. The purchase price equates to approximately $3.2M (~$2.9M worth of stock plus $300k assumed liabilities) and EYEG will pay another $2.2M (cash) upon FDA approval/clearance of a Jade candidate. All in, this equates to approximately 4% of the annual estimated U.S. market of just the PCED indication. And this implies a no-cost option for all of the other potential indications ($1B plus market, ~$200M of which might be lower-hanging fruit) of JDE-003 as well as for the other pipeline candidates (i.e. corneal protection, bacterial keratitis) and the opportunity to expand into other areas.

We think the JDE-003 program could be fairly fast moving given the existing safety data and that the FDA regulatory pathway is expected to follow that of a device. While it may be a PMA pathway (as opposed to 510(k)), the FDA clinical program could potentially be a relatively small Phase 2 study, followed by a larger (n = 100 or 200) Phase 3 study. While this is just speculation on our part, we should know more following the anticipated FDA meeting in Q3.

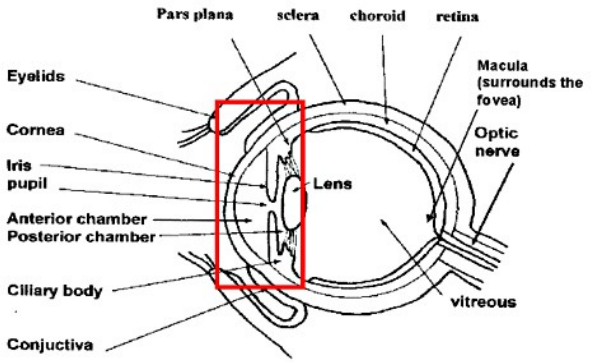
We have incorporated JDE-003 into our model and using similar methodology of that for EYEG's legacy product candidates. If all goes well we think JDE-003 could reach the market sometime in 2018. We use a 50% probability of successful launch in the U.S. and, similar to the deal with Valeant for EGP-437 for the anterior uveitis indication, assume EYEG out-licenses marketing rights. But, given that we are modeling that EYEG assumes all R&D risk, we assume a much higher royalty rate of 20% (versus "high single digits" with Valeant for EGP-437). We think there could be several interested licensors, which could include Valeant but also Allergan and Novartis. We are modeling single-digit penetration through 2022. These, however, are early assumptions and very likely to change as more information becomes available – with the most significant near-term information expected to relate to the FDA pathway and scope of requisite clinical studies.

BACKGROUND

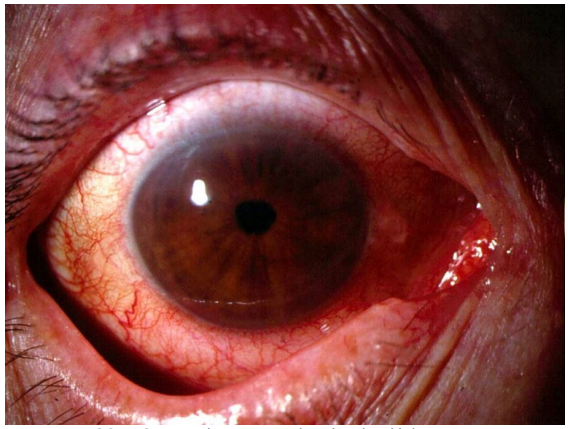
Non-Infectious Anterior Uveitis

Uveitis is a generic term used to describe inflammation of the uvea. It can occur either in isolation or be the result of an underlying medical condition in other parts of the body. The uvea is the middle layer of the eye, below the white of the eye, and consists of the iris (colored portion), choroid layer (connective tissue) and ciliary body (secretes liquid). Infectious uveitis is caused by a virus or bacteria in the eye while non-infectious uveitis is endogenous, or the result of a disease elsewhere in the body.

Non-Infectious Anterior Uveitis



SOURCE: uveitis.net



SOURCE: eyedoctors.co.nz/services/uveitis/

Symptoms include redness, inflammation and pain in the eye, photophobia (extreme sensitivity to light), blurred vision and change in shape or size of the pupil. If left untreated, anterior uveitis can result in development of other complications including glaucoma, formation of synechiae, cataracts, macular edema, retinal detachment and, eventually, even blindness.

Prevalence of uveitis in the U.S. is roughly (estimates vary depending on source) 50 people per 100k population, or approximately 165k. U.S. incidence estimates also vary by study – the most cited study estimates range from a low of about 17 to a high of about 52 people per 100k population[3,4,5,6] - an average of ~35 per 100k, or approximately 115k incidents per year. Non-infectious uveitis, which is the initial indication that EYEG is pursuing, is the most common form of uveitis, accounting for about 75% of all cases and about 90% of these are located at the anterior of the eye (i.e. non-infectious anterior uveitis).

Estimated U.S. Incidence and Prevalence

	Uveitis	Non-Infectious	Non-Infectious Anterior
Incidence	115,000	86,250	77,625
Prevalance	165,000	123,750	111,375

[3] Acharya NR, Tham VM, Esterberg E, et al. Incidence and Prevalence of Uveitis: Results From the Pacific Ocular Inflammation Study. JAMA Ophthalmol. 2013;131(11):1405-1412. doi:10.1001/jamaophthalmol.2013.4237

[4] Darrell RW, Wagener HP, Kurland LT. Epidemiology of uveitis: incidence and prevalence in a small urban community. Arch Ophthalmol. 1962;68:502-514

[5] Gritz DC, Wong IG. Incidence and prevalence of uveitis in Northern California: the Northern California Epidemiology of Uveitis Study. Ophthalmology. 2004;111(3):491-500, discussion 500

[6] Suhler EB, Lloyd MJ, Choi D, Rosenbaum JT, Austin DF. Incidence and prevalence of uveitis in Veterans Affairs Medical Centers of the Pacific Northwest. Am J Ophthalmol.

Uveitis treatment involves arduous dosing regimen…

Dexamethasone phosphate is a corticosteroid, administered either orally in pill form or as an injection, which has anti-inflammatory and immune-response modifying effects. It is used for rheumatic diseases as well as other conditions such as allergies, intestinal disorders, eye diseases and other ailments. Topical corticosteroids are considered the first line of treatment for uveitis with dexamethasone and prednisolone acetate being the most widely used. Corticosteroids are used to reduce inflammation which is caused by the build-up of white blood cells in the anterior chamber (see diagram above) of the eye. The primary endpoints of EYEG's clinical trials evaluating EGP-437 and Eyegate Delivery System for the treatment of anterior uveitis are reduction of anterior chamber white blood cell count.

Diagnosis and evaluation, which includes patient history and ocular examination, are done to rule out other possible causes and to determine severity of the disease. Anterior uveitis is classified as either mild, moderate or severe which determines the initial dosing regimen as well as frequency of follow up visits to an ophthalmologist. The follow-up schedule and prednisolone acetate dosing regimen in the table below are adapted from the reference guide, *Primary Care of the Anterior Segment*, by Louis Catania.[7]

Anterior Uveitis Dosing and Follow-Up Schedules

	Severity		
	Mild	Moderate	Severe
Frequency of follow-up visits	Every 4 to 7 days	Every 2 to 4 days	Every 1 to 2 days
Recommended dosing	Two to four times per day	Four times per day	Every 2 to 4 hours

The above table lists the recommended initial dosing. The total regimen can last four to six weeks and include 150 or more drops. Regular follow-up visits are necessary to ascertain response and determine if and when to begin tapering dosage as **regular use of corticosteroids is associated with certain adverse side effects including immune suppression, accelerating cataract formation and increased ocular pressure**. Eye drops are an inherently inefficient route of administration and, depending on how much of the drop gets in the eye (versus runs down the face) and penetrates protective tissue (eyes are adept at keeping out foreign substances), the amount of active ingredient that reaches its intended target can vary widely. This is another reason as to why drops must be dosed so frequently and regular check-ups are so important.

The burdensome dosing schedule results in patient compliance issues. When patients fail to complete the recommended dosing regimen, the risk of treatment failure increases. In fact, lack of compliance is the most common cause of treatment failure. As noted above, significant complications can result if uveitis is not effectively treated.

Iontophoresis *is defined as the transfer of ions. It is the use of a weak electrical current to deliver drugs through or across tissue and other biologic substances. An ionic therapeutic substance is placed under an electrode of like-charge (i.e. ion and electrode are both of either positive or negative polarity). The like-charges create electropropulsion as two substances of similar charge repel, pushing the therapeutic substance into the tissue.*

EYEG's Treatment Solution: Eyegate II Delivery System and EGP-437

The Eyegate II Delivery System delivers a precise dose of EGP-437, a proprietary and reformulated version of (generic) dexamethasone phosphate, to the eye through the use of iontophoresis. The procedure is relatively fast, is non-invasive and is efficient in delivering drugs to their intended target within the ocular tissue. It has been used in over 1,700 treatments to-date.

As opposed to the rigorous dosing schedule of eye drops for conditions such as anterior uveitis, treatment with EYEG's combination product can be completed in only one to four minutes over just two or three visits to an eye doctor. It has also been shown to effectively deliver drugs to the posterior of the eye, offering a non-invasive approach to traditional eyeball needle injections for treatment of conditions such as macular edema. As such, Eyegate believes their combination therapy provides a

[7] Catania, L. J. (1995). Primary care of the anterior segment. Norwalk, CT: Appleton & Lange

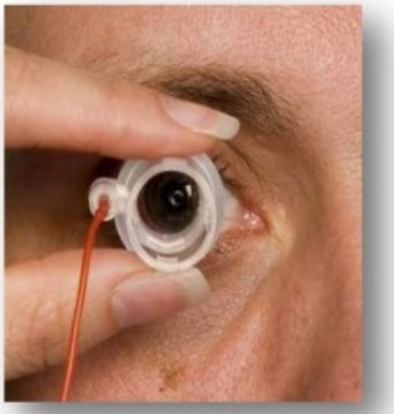
solution to the patient burden, non-compliance and invasiveness issues associated with conventional therapy.

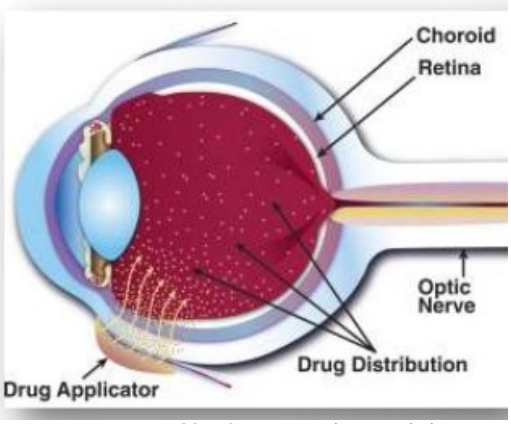
Eyegate II Delivery System consists of a small handheld generator, a return electrode and an ocular applicator. The generator produces and delivers the iontophoresis-inducing current. It is easily programmed through an LED screen for the correct dosage and current. The screen displays delivery of the current in real-time, the amount of the drug delivered and the treatment time remaining. The generator is the only portion of the delivery system and drug that is not a single-use disposable.

The return electrode, which is placed on the patient's forehead, is used to create a continuous current. The ocular applicator is filled with EGP-437, topical anesthesia is applied to the surface of the eye and the applicator is then placed over the sclera of the eye. A soft foam pad on the applicator makes contact with the eye – EYEG's instructional video (https://youtu.be/v7oSLe-bLWo) on their website notes that the applicator is as comfortable as a contact lens. Drug delivery commences when the generator is turned on, delivering a low electrical current to an electrode within the applicator and initiating iontophoresis.

The electrode electrolyzes water molecules within the applicator, converting them into either hydronium or hydroxide molecules, depending on whether positive (cathodic) or negative (anodic) polarity is used. Electropropulsion, created by the like-charged ions and molecules, pushes the drug molecules into the tissues of the eye until they reach their intended target. The drug delivery takes about one to four minutes, after which the applicator is removed and the procedure is completed. Dose can be changed by adjusting the current and application time.







SOURCE: Eyegate Pharmaceuticals

Issues of Traditional Ophthalmic Drug Delivery Address by Eyegate's System

Anterior Eye Conditions	Posterior Eye Conditions
• Rigorous dosing regimen	• Needle-in-the eye patient anxiety
• Biological barriers in eye inhibit drug penetration	• Several injections over multiple weeks required
• Patient non-compliance	• Risk of inflammation and infection
• Side effects; IOP, cataracts and others	• Requires experienced clinician & companion
	• Complications such as IOP, retinal detachment

Patents

Eyegate's technology is protected by eight patent families including 13 U.S. patents, 3 pending U.S. patent applications, 59 international patents and 15 pending international patents. The existing and pending (if issued) patents will expire between 2018 and 2029.

Below is the (16) results of our search (link: http://1.usa.gov/1NWFSnI) of the USPTO database using "Eyegate" as the Assignee Name. Patents 9,149,525 and 9,180,292 are held by Eyegate Pharmaceuticals while the others are held by their subsidiary EyeGate Pharma S.A.S.

Refine Search | AN/eyegate

	PAT. NO.	Title
1	9,238,131	Ocular iontophoresis device
2	9,192,512	Device for delivering medicines by transpalpebral electrophoresis
3	9,180,292	System and method for ocular iontophoresis with buffering
4	9,149,525	Delivery of corticosteroids through iontophoresis
5	8,771,256	Device delivering medicines by transpalpebral electrophoresis
6	8,611,994	Irritation-reducing ocular iontophoresis device
7	8,452,391	Ocular iontophoresis device
8	8,306,613	Irritation-reducing ocular iontophoresis device
9	8,099,162	Ocular iontophoresis device
10	7,937,142	Irritation-reducing ocular iontophoresis device
11	7,848,800	Device for delivering medicines by transpalpebral electrophoresis
12	7,771,403	Uniform feed connector for devices for the delivery of active principles
13	7,684,857	Device for medicine delivery by intraocular iontophoresis or electroporation
14	7,628,781	Medical usage connector assembly for the transfer of fluids
15	7,548,778	Irritation-reducing ocular iontophoresis device
16	7,164,943	Irritation-reducing ocular iontophoresis device

SOURCE: US Patent & Trademark Office, Patent Full Text and Image Database

Specific to EGP-437, U.S. patent # 9,149,525 "Delivery of corticosteroids through iontophoresis", which was granted in October 2015, covers a method of treating eye conditions using EGP-437 delivered by ocular iontophoresis and is not limited to a particular eye condition.

Specifically the patent claims are[8]:,

1. A method for iontophoretically delivering dexamethasone phosphate into the eye of a subject in need of such treatment, comprising: a) administering a formulation of dexamethasone phosphate to the eye of the subject; wherein the formulation comprises: i) 40 mg/mL of a dexamethasone phosphate solution; and ii) wherein the pH of the formulation has been adjusted to between 5.7 and 6.1 with a buffering agent; and b) performing ocular iontophoresis to the eye of the subject.
2. The method of claim 1, wherein the subject is being treated for an ophthalmic condition selected from uveitis, dry eye, post-operative inflammation, diabetic macula edema and corneal graft rejection.
3. The method of claim 1, wherein the subject is being treated for an inflammatory ophthalmic condition.
4. The method of claim 1, wherein the subject is being treated for uveitis.
5. The method of claim 1, wherein the subject is being treated for anterior segment uveitis or dry eye.
6. The method of claim 1, wherein the step of ocular iontophoresis is carried out prior to, during or after the step of administering the dexamethasone phosphate.
7. The method of claim 1, wherein the dexamethasone phosphate is delivered by an iontophoretic dose of about 0.5 mAmin to about 50 mAmin.

And another application related to the Eyegate II Delivery System has also been filed covering (per EYEG 10/15/15 P.R.) "claims for a delivery device containing a hydrogel applicator used to transport therapeutic substance across and / or through the eye." In October 2015 EYEG announced that they received a Notice of Allowance from the USPTO related to this application.

[8] USPTO. United States Patent 9,149,525. Jaffe, et al. October 6, 2015

Clinical Data in Non-Infectious Anterior Uveitis: EYEG has completed two non-infectious anterior uveitis clinical studies. The first, which completed in 2009, was a phase I/II dose-ranging study which demonstrated the combination product produced inflammation lowering effects with no corticosteroid mediated effects and found the most effective dose to be the lowest one tested. The second study, a phase III trial which used the dose found to be most effective in the prior dose-ranging study, just missed the primary efficacy endpoint of non-inferiority to standard of care. However, FDA recently communicated to EYEG that if a planned new phase III study demonstrates non-inferiority, that that data, along with results of the completed phase III study, will be sufficient to support a New Drug Application (NDA) filing.

- ***Phase I/II dose-ranging study: lowest dose deemed most effective…***

EYEG's first non-infectious anterior uveitis clinical trial was a phase I/II, single-arm dose-ranging study (clinicaltrials.gov ID:NCT00694135) to determine a safe and effective dose of EGP-437. Non-infectious anterior uveitis was defined as having anterior chamber cell (ACC) scores of ≥1.5 (on a scale of 0 – 4, lowest – highest), which corresponds to a cell count of ≥11. Enrollment of the multi-site, double-blind study consisted of 40 patients (40 eyes), all of which received treatment with EGP-437 delivered by iontophoresis via the Eyegate II Delivery System. Patients were randomized to receive one of four EGP-437 doses (dexamethasone phosphate ophthalmic solution 40mg/mL) with 10 patients in each arm; 1.6 mA-min @ 0.4 mA[9], 4.8 mA-min @ 1.2 mA, 10 mA @ 2.5 mA and 14 mA @ 3.5 mA. Each dose was administered only once and for approximately four minutes. Treatment was administered on Day 0, follow-up exams were conducted on Days 1, 7, 14 and 28.

Results (table below): 19 of the 40 patients (48%) and 24 of the 40 patients (60%) achieved an ACC score of zero within 14 days and 28 days, respectively. Interestingly, the greatest proportion of patients achieving both ACC scores and ACC cell counts of zero at both the 14 day and 28 day follow-up were in the lowest dose (i.e. 1.6 mA) cohort. The lowest dose group also had the highest proportion of patients (80% vs. 60% of the other three groups) which experienced an ACC score reduction of 0.5 or more at Day 28. The mean change in ACC score from baseline to Day 28 ranged from a maximum of -2.25 in the 1.6 mA dose group to a minimum of -2.00 in the 14.0 mA dose group. The 1.6mA dose was chosen as the most effective dose. Achievement of an ACC score of zero by Day 14 was considered statistically significant (p=0.032) at a 95% CI. Treatment was well tolerated with no corticosteroid mediated effects.

		Treatment Group				
Characteristic	Statistic or Category	1.6 mA-min (N = 10)	4.8 mA-min (N = 10)	10.0 mA-min (N = 10)	14.0 mA-min (N = 10)	Total (N = 40)
ACC Score of Zero	Day 14	8 (80%)	6 (60%)	2 (20%)	3 (30%)	19 (48%)
	Day 28	8 (80%)	6 (60%)	5 (50%)	5 (50%)	24 (60%)
ACC Count of Zero	Day 14	4 (40%)	1 (10%)	1 (10%)	1 (10%)	7 (18%)
	Day 28	6 (60%)	2 (20%)	1 (10%)	5 (50%)	14 (35%)

SOURCE: Eyegate YE 2015 10-K

- ***Initial Phase III Study; Similar Clinical Response as PA Although Endpoint (Barely) Missed…***

The phase III randomized, double-blind, placebo-controlled study (clinicaltrials.gov ID:NCT01505088) that followed the dose-ranging trial was powered as non-inferiority to standard of care. The study was conducted at 45 U.S. sites and included 193 patients with non-infectious anterior uveitis (ACC count ≥ 11) which were randomized to treatment, consisting of Eyegate combination treatment of 4.0 mA-min @ 1.5mA on Day 0 and Day 7 (in addition to placebo drops for 28 days), or control, consisting of prednisolone acetate 1% eyedrops for 28 days (in addition to sham Eyegate treatment (sodium buffer solution) on Day 0 and Day 7).

While dexamethasone is one of the most potent of all corticosteroids and has anti-inflammatory effects that are as much as 10x greater than that of prednisolone, it does not penetrate the anterior chamber of the eye nearly as well as prednisolone. This is the reason that prednisolone is considered standard of care for anterior uveitis and why it was used as the control in these clinical studies. And while absorption of dexamethasone dosed as drops is inhibited by corneal and conjunctival barriers, these challenges are at least partially overcome with the use of iontophoresis which propels the drug into the tissue. And the drug's

[9] mA is abbreviation for milliampere (one thousandth of an ampere)

accommodating chemical profile make it highly water soluble which also adds to its attractiveness with iontophoresis delivery.

Per pre-study communications with FDA, prednisolone acetate (PA) administered at least 4x per day was the recommended standard of care (i.e. control). However, EYEG chose to use a more aggressive control regimen, administering PA 8x per day in week one, 6x per day in week two and 4x per day in weeks three and four (for a total of 154 drops over 28 days).

Primary endpoint was proportion of patients with ACC count of zero at Day 14 (i.e. complete response). Several **secondary** efficacy outcomes were also measured including proportion of patients with ACC counts at Days 7, 28 and 56, mean change from baseline in ACC count and score at Days 7, 14, 28 and 56 and proportion of patients with ACC count and score reduction from baseline of one or more units at Days 7, 14, 28 and 56, and time to anterior chamber cell count and score of zero.

Results were presented on two separate patient populations; intent to treat (ITT) and per protocol (PP). ITT is generally used in clinical trials to account for non-compliance of trial design, protocol deviations drop-outs or anything after randomization. ITT results are generally considered conservative to treatment effect. PP is typically considered the population that remained in the study through the measurement endpoints and did not violate any of the trial protocol

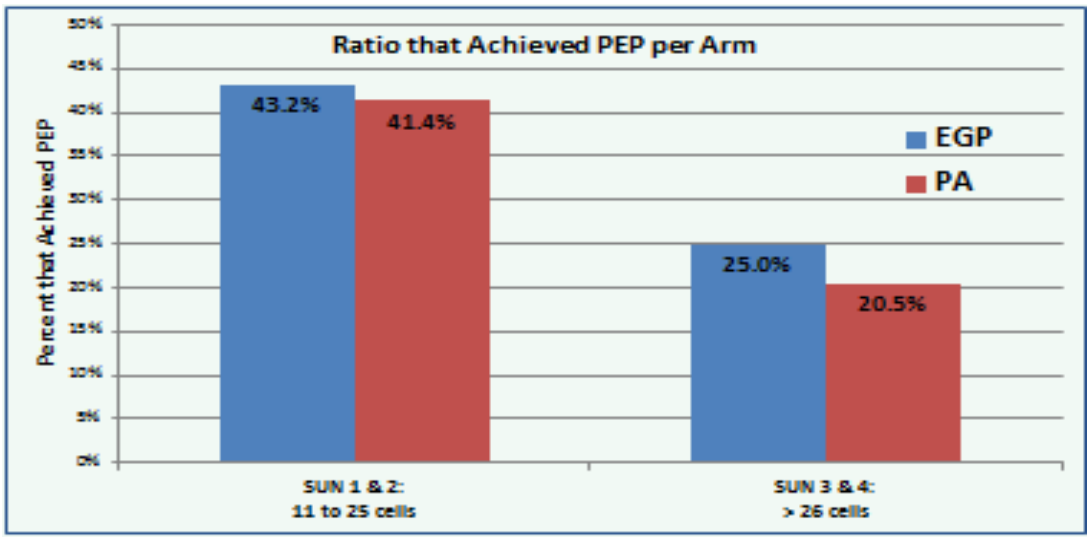
- **ITT**: defined as all randomized patients (193) who were treated with at least one dose of study medication, have a valid baseline efficacy and at least one valid post-randomization efficacy measurement and all data associated with these subjects, until the visit following initiation of any rescue therapy.
- **PP**: 169 patients met the PP population parameters which included those that had a Day 14 ACC count and without any significant protocol deviations. Of the ITT population, 24 patients had protocol violations prior to Day 14 including;
    - 14 in Eyegate treatment arm, 10 of which either needed to be rescued and/or did not receive the second (of two) iontophoresis treatments, 1 which needed non-ocular surgery, 2 which were unable to continue with follow-up visits and 1 which withdrew consent
    - 10 in the PA arm, 8 of which either needed to be rescued and/or did not receive the full amount of PA and 2 which had their Day 14 visit twelve and thirty days later than that visit timeframe

Results: (per information contained in company public filings) While response rates were similar in both the ITT and PP populations, non-inferiority (as pre-defined in the study protocol) was just missed.

- IIT: EGP-437 treatment arm had 32 (out of 96) patients with complete response (i.e. ACC count of zero at Day 14) while PA arm had 32 (of 97) with complete response. There was no difference in response rates between the two arms at a 95% C.I., however, the non-inferiority margin, at -12.94%, just missed statistical significance of the pre-determined non-inferiority margin of -10%
- PP: EGP-437 treatment arm had 31 (of 82) patients, or 37.8%, with complete response while PA arm had 31 (of 87), or 35.6%, with complete response. Again, while there was no difference in response rates, the non-inferiority margin (-12.37%) just missed the pre-determined non-inferiority margin (-10%) at a 95% C.I.

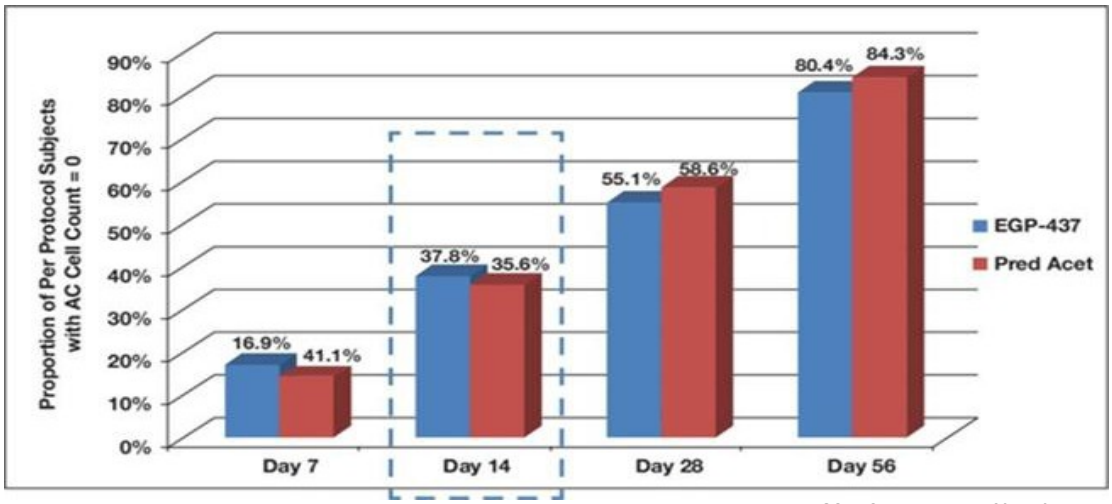
Additional Observations: Along with no difference in response rates between both arms on the primary endpoint, secondary measures and other observations also support the efficacy of EGP-437 combination therapy;

- Greater Proportion of High ACC Count Patients in EGP-437 Arm: a higher proportion of EGP-437 patients (52 of 96, or 54%) had baseline ACC counts greater than 25 as compared to those in the PA arm (40 of 97, or 41%). A post-hoc analysis was done on these high ACC count (i.e. potentially harder to treat) patients with better efficacy favoring the EGP-437 arm. Among the patients with baseline ACC of 11 to 25 cells, 43.2% of EGP-437 patients met the primary endpoint (i.e. ACC count of zero at Day 14) while only 41.4% of PA patients did. Among the patients with baseline ACC > 26 (i.e. – more severe cases), 25% of EGP-437 patients met the primary endpoint while only 20.5% of PA patients did (chart below).



SOURCE: Eyegate

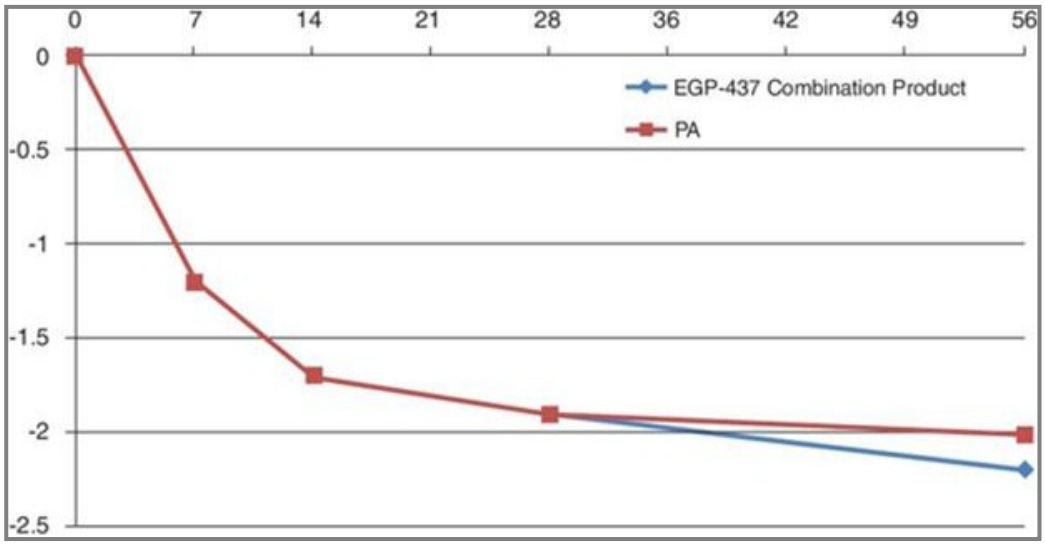
- Similar Complete Response Timeframes: "Time to anterior chamber cell count and score of zero" was a secondary endpoint. Despite the baseline difference in severity of disease (as measured by ACC count), the time to reach ACC count of zero was generally similar in both arms throughout the study (chart below). However, at Day 7, after just one iontophoresis treatment, the EGP-437 arm showed a statically significant superior response with 16.9% of patients achieving complete response, compared to just 14.1% of PA patients. This non-inferiority margin was -7.82%, within the pre-determined margin of -10% at 95% C.I.



SOURCE: Eyegate YE 2015 10-K

- Similar Reduction in ACC Count of One or More Units: "Proportion of subjects with ACC count and score reduction from baseline of one or more units" was another secondary endpoint. On this measure the two arms were similar, although the non-inferiority margin (-13.97%) was just outside the non-inferiority margin at 95% C.I.

- Similar Change from Baseline ACC Score: "Mean change from baseline in ACC count and score" at Days 7, 14, 28 and 56 was another secondary endpoint. This was similar between both arms throughout the study (chart below) with an incremental benefit to the EGP-437 treatment group at Day 56



SOURCE: Eyegate YE 2015 10-K

- Safety: Lower Incidence of IOP in EGP-437 Arm: corticosteroid use is associate with an increase in intraocular pressure (IOC), which can eventually result in permanent damage to the eye. IOC measurements were taken at Days 7, 14, 28 and 56 and compared to baseline.
    - There were 2.4x more incidents of increase in IOP in the PA arm as compared to the EGP-437 arm. 17 incidents of an increase in IOP among 14 patients (of 96, or ~15%) were recorded in the EGP-437, compared to 41 incidents among 24 subjects (of 97, or ~25%) in the PA arm
    - No patients in the EGP-437 therapy arm experienced any significant increase (i.e. over 20mmHg) in IOP while one subject in the PA arm reported an IOP increase of 27mmHg. In terms of IOP-related adverse events, one patient in the EGP-437 arm reported an adverse event (~3 weeks following rescue) and six patients in the PA arm reported IOP-related adverse events. NOTE: EYEG's 10-K, where we sourced this trial data and information, did not provides specifics of the nature or severity of the adverse events, only that they were related to IOP

Key Takeaways:

- While the primary endpoint was (barely) missed, EGP-437 combination therapy appeared to be similarly effective as standard of care (i.e. PA)
- There was a trend in the data favoring EGP-437 combination therapy in patients with higher ACC counts (i.e. generally considered more difficult to treat)
- EGP-437 combination therapy consisted of two treatments at Days 0 and 7 with administration taking ~5 minutes each session. This compares to PA therapy which consisted of 4 – 8 eye drops every day over the course of four weeks, aggregating to a total of 154 drops. While the PA regimen was perhaps more aggressive than that recommended by FDA (of "at least four drops per day"), this highlights how much more burdensome conventional therapy is
- Safety was at least comparable, or perhaps favoring EGP-437 combination therapy particularly in lower IOP

❖ ***New, Pivotal Phase III Study Initiating..***

In May 2015 EYEG announced that FDA communicated that if a planned new phase III study demonstrates non-inferiority, that that data, along with results of the earlier phase III study (discussed above), will be sufficient to support a New Drug Application (NDA) filing.

This non-infectious anterior uveitis "confirmatory study" is randomized, double-blind, placebo-controlled and designed to demonstrate non-inferiority of EGP-437 combination therapy to PA 1%. Up to 250 patients (~125 each arm) with anterior segment uveitis (ACC count $\geq$ 11) are expected to enroll at approximately 60 U.S. sites. Primary efficacy endpoint is the same as the initial phase III study (i.e. ACC count of zero at Day 14).

Patients will be randomized to either three treatments of EGP-437 combination therapy (Days 0, 4 and 9) plus placebo eye drops or PA 1% plus sham EGP-437 combination therapy. The design of this confirmatory study, while similar to the initial phase III anterior uveitis trial, has some important differences which should improve the chances

of meeting the primary efficacy endpoint. This includes its larger size (greater chance of fleshing out statistical significance), three EGP-437 combination treatments (1.5 mA-min @ 2.7mA) instead of two (4.0 mA-min @ 1.5mA) and randomization based on severity of the disease (to eliminate the potential bias of more severe patients which was seen in the AGP-437 arm in the initial study).

	First Phase 3	Confirmatory Trial
Number of Subjects	193	250
Number of Treatments	2 (Day 0 and Day 7)	3 (Day 0, Day 4 and Day 9)
Randomization	1:1	1:1 and SUN scale severity
Primary Endpoint	ACC Count= 0 at Day 14	

SOURCE: Eyegate

Timelines: The first patient was enrolled in the confirmatory study in January 2016. Per EYEG's most recent public communications regarding timelines, they expect the study to be fully enrolled by current year-end and to have top-line data in Q1 2017. Those timelines may be do-able depending on the rate of enrollment. For comparison, per clinicaltrials.gov, the initial phase III study started in December 2011 and had a primary completion date (final data collection date for primary outcome measure) of February 2013 – or ~14 – 15 months. This ~14 months included 12 months of enrollment and 2-month follow-up period. While the confirmatory study will enroll ~23% more patients, the pace of enrollment should benefit from presumed use of some of the same clinical sites and investigators.

U.S. Regulatory Pathway: Assuming positive results (i.e. primary efficacy endpoint met and acceptable safety profile), EYEG expects to file for U.S. regulatory approval/clearance of both the Eyegate II Delivery system and EGP-437 simultaneously. Eyegate has already received confirmation from FDA that their delivery system is considered a Class II device but can pursue clearance through the (relatively simple) 510(k) clearance pathway. For EGP-437, which must be approved through a New Drug Application (NDA), Eyegate intends to file a 505(b)(2) NDA.

Relative to the device. EYEG's 510(k) will cite two existing iontophoresis devices which deliver drugs through the skin, one of which is DJO Global's (Empi's) Dupel II Buffered iontophoresis electrode for use of delivery of lidocaine and epinephrine. FDA has agreed that these are acceptable to use as predicates.

The 505(b)(2) NDA relates to, "an application that contains full reports of investigations of safety and effectiveness but where at least some of the information required for approval comes from studies not conducted by or for the applicant and for which the applicant has not obtained a right of reference." It "permits FDA to rely, for approval of an NDA, on data not developed by the applicant."[10] FDA allows 505(b)(2) applications in circumstances where there are changes to an approved drug such as, formulation, dosage form, strength and route of administration, among others. EYEG has referenced Decadron, a topical dexamethasone formulation, which they believe they may be able to use the existing safety and efficacy literature of for filing of EGP-437 under the 505(b)(2) pathway.

Based on our communication with Eyegate, management is comfortable, based on their interaction and communication with FDA including the agency accepting a preclinical and clinical data protocol based on the 505(b)(2) NDA route, that this is an acceptable pathway. And importantly, EGP-437 has demonstrated what appears to be an acceptable safety profile in the five clinical studies in which it has been used. The initial phase I/II non-infectious anterior uveitis trial was conducted under the initial IND, submitted to FDA in April 2008. The IND was then subsequently amended for additional studies.

Follow-On Indications: Macular Edema and Cataract Surgery

While EYEG expects to enter the market with a non-infectious anterior uveitis indication, they have had their sights on a broader label and one that includes more prevalent ophthalmic diseases (i.e. larger market sizes) and harder to treat (i.e. potential for rapid market penetration) back-of-the-eye conditions. Macular edema, which is a swelling of the macula (center portion of the retina) due to a build-up of fluid leaking from blood vessels, is traditionally treated with drug injections, laser therapy or intravitreal implants. EYEG has initiated a phase Ib/IIa study in

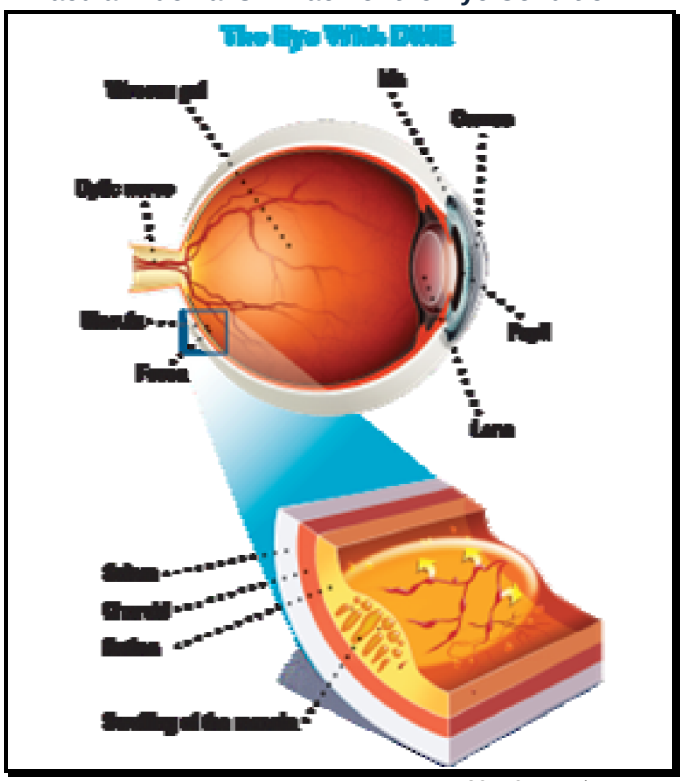
[10] Guidance for Industry. Applications Covered by Section 505(b)(2). US Dept of HHS/FDA/CDER. Oct 1999

macular edema. Cataract, the leading cause of blindness, results in over 3 million cataract surgeries per year in the U.S. and may represent an attractive market for Eyegate's combination therapy.

- **Macular Edema:** ***EGP-437 can treat back of the eye, initial clinical data is positive…***
  Formation of macular edema can be the result of a variety of conditions and circumstances. While it is most commonly associated with type 2 diabetes, age-related macular degeneration can be a direct cause. Chronic uveitis or blockage of a vein (retinal vein occlusion) can also be contributors as can complications following cataract surgery such as cystoid macular edema (cyst-like fluid build-up in macula).

  Diabetic macular edema affects up to 7% of people with diabetes[11], or ~2M Americans. Estimated incidence of cystoid macular edema varies widely depending on the source, examination technique and definition of the condition but is believed to be ~1% - 14% of cataract surgery patients, or ~30k – 400K Americans. Standard of care of macular edema includes NSAID and cortisone drops, laser retinal photocoagulation, intravitreal injections (corticosteroids and anti-VEGF drugs) and intravitreal implants. These all have drawbacks; NSAID's can cause burning, stinging and even "corneal melting", laser retinal photocoagulation often damages nerve cells in the retina causing some vision loss, drops not only must be dosed continuously but they are highly inefficient in reaching the back of the eye and can have adverse side effect, injections are highly invasive, cause patient skittishness, risk infection and eye damage and require a trained ophthalmologist to administer, intravitreal implants can migrate within the eye which can cause permanent eye damage.

Macular Edema Is A Back-of-the-Eye Condition



SOURCE: ozurdex.com

EYEG's phase Ib/IIa multi-site, open label proof-of-concept clinical study (clinicaltrials.gov ID: NCT02485249) **of EGP-437 therapy in patients with macular edema** associated with retinal vein occlusion (RVE), diabetic macular edema (DME) or post-surgical (cystoid) macular edema (CME) is ongoing. Subjects received three treatments of EGP-437 iontophoresis therapy at 14mA-min (3.5mA) on days 0, 4 and 9. Primary outcome was reduction in mean central subfield thickness on day 4, day, 9 and day 14. Ozurdex, a dexamethasone intravitreal implant marketed by Allergan (NYSE: AGN) and indicated for treatment of macular edema, retinal vein occlusion and non-infectious posterior uveitis, was administered as control to patients that did not respond to EGP-437 combination therapy at day 14 and were re-evaluated at day 28.

[11] Curr Diab Rep. 2012 Aug;12(4):346-54. doi: 10.1007/s11892-012-0283-6. *Current epidemiology of diabetic retinopathy and diabetic macular edema.* Ding J1, Wong TY.

In November 2015 EYEG announced results of the first-leg of the study, which included 19 patients (results on 18). Nine patients with pseudophakic eyes (i.e. those with implanted intraocular lens) were enrolled with the following conditions; six with DME, three with RVO. Nine patients with phakic eyes (i.e. those with natural lens) were enrolled with the following conditions; four with DME, three with RVO and two with CME. **Safety profile was considered excellent** with no increase in IOP – which is particularly noteworthy given that the dose in this study was three times that of the dose in the initial phase III anterior uveitis study.

There was a clear efficacy signal, demonstrating that EGP-437 combination therapy can deliver drugs to the back of the eye. The study also showed that pseudophakic eyes responded better than phakic eyes. Nine patients with pseudophakic eyes and nine phakic eyes were in the study.

- While **phakic eyes** responded relatively poorly, with just an 8% mean thickness reduction observed in only 2 of 9 patients and minimal or no response in the remaining seven, pseudophakic eyes showed a relatively strong response.
- Seven of nine **pseudophakic eye** patients had a positive response including three with greater than 25% reduction in edema at day 14, one of which showed a 67% reduction. Just three patients were given Ozurdex and only two of which showed minimal or no response to EGP-437 therapy.

Edema (µ)	V1 Day 0	V2 Day 4	V3 Day 9	V4 Day 14
Phakic	451	461 (-1.6%)	455 (-0.2%)	470 (-3.6%)
Pseudophakic	540	448 (17%)	416 (23%)	427 (21%)

7 of 9 Pseudophakic Showed Positive Response Incl. 3 >25% and 1 = 67%

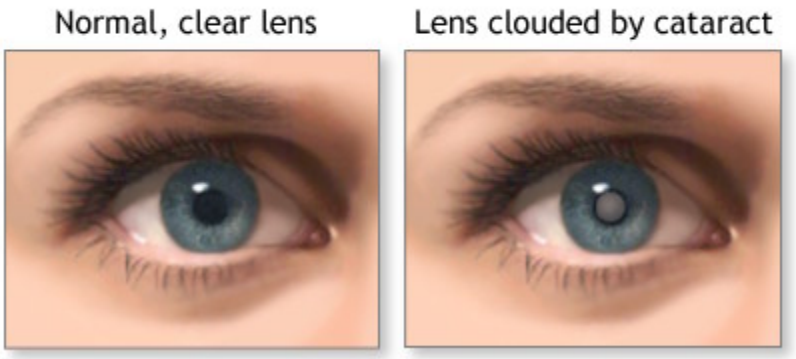
Patient Information				OCT Measurements				IOP			
	ME DX	Gender	DOB	Visit 1 Day 0	Visit 2 Day 4	Visit 3 Day 9	Visit 4 Day 14	Visit 1	Visit 2	Visit 3	Visit 4
PSEUDOPHAKIC SUBJECTS											
1	DME	Male	21-Dec-58	694	615	614	616	12	15	15	14
					11.4%	11.5%	11.2%				
2	CME	Female	23-May-54	623	569	512	566	14	15	12	10
					8.7%	17.8%	9.1%				
3	BRVO	Female	25-Dec-50	558	531	522	503	14	13	15	18
					4.8%	6.5%	9.9%				
4	pCME	Female	6-Dec-48	500	325	304	298	10	10	12	10
					35.0%	39.2%	40.4%				
5	DME	Male	21-Sep-52	758	392	249	273	16	14	13	17
					48.3%	67.2%	64.0%				
6	BRVO	Male	20-Sep-51	318	317	294	291	11	11	11	11
					0.3%	7.5%	8.5%				
7	DME	Female	2-Nov-53	521	496	515	523	18	18	20	20
					4.8%	1.2%	-0.4%				
8	BRVO	Female	24-Dec-26	502	413	358	368	12	14	13	16
					17.7%	28.7%	26.7%				
9	DME	Female	13-Feb-44	390	372	380	408	13	14	14	12
					4.6%	2.6%	-4.6%				
Mean				**540**	**448**	**416**	**427**	**15**	**14**	**14**	**14**
					17.1%	22.9%	20.9%				

The **second leg** will enroll an additional 15 patients; 5 with phakic eyes and 10 with pseudophakic eyes. Five (three with phakic, two with pseudophakic) of the patients in the first trial which had minimal or no response to EGP-437 therapy but did respond well to Ozurdex will continue in the second leg. As it was observed that edema comes back when the drug clears the tissues, this extension study will use a modified dosing regimen; three consecutive days of EGP-437 iontophoresis treatments at the same dose. And as data from the first leg demonstrated some patients with pseudophakic eyes responded better than those with phakic eyes, this second leg will also evaluate the efficacy of EGP-437 combination therapy in phakic versus pseudophakic eyes to collect additional data on the differences in the responses of both groups. Interim data is expected to be available in 1H 2016. Data from this study, assuming positive, will then be used to design a larger, later-stage clinical trial.

Our comments: Macular edema represents a potentially receptive and large market for EYEG given the seriousness and high incidence of the disease as well as the lack of conventional, effective non-invasive methods to treat it. EYEG's early stage studies have shown the ability to deliver EGP-437 to the back of the eye to treat conditions such as macular edema. As back-of-the eye conditions are more difficult to treat than, for example anterior uveitis, if effectiveness of EGP-437 combination treatment in macular edema is confirmed in larger studies, we think this indication could offer significant opportunity for EYEG.

- **Post Cataract Surgery:** ***EGP-437 can treat back of the eye, initial clinical data is positive…***

Cataract, or a clouding of lens, is most commonly the result of ageing and is the leading cause of blindness across the globe. Approximately 21 million people in the U.S. over the age of 40 have cataract in at least one eye, ~6 million of which have undergone surgery to have their lens removed. About 3.6 million cataract surgeries are performed in the U.S. each year and about 20 million worldwide.



SOURCE: A.D.A.M. / umm.edu

Standard of care to manage post-operative cataract surgery inflammation are NSAIDs and corticosteroids. EYEG conducted a phase II study (clinicaltrials.gov ID: NCT01602068) with EGP-437 combination treatment in cataract surgery which completed in 2013. They decided to apply EGP-437 treatment prior to (4.0 mA-min at 1.5 mA one day prior to surgery) surgery in order to avoid putting the delivery device directly on a post-surgery open wound. Primary endpoint was proportion of subjects with ACC count of zero on day 7. While we were unable to find the detailed results in the public domain, EYEG has noted that "the surgical procedure eliminates or washes out any remaining drug product from the ocular tissue that becomes inflamed post-surgery" - presumably indicating that the study failed to meet the efficacy endpoint.

EYEG has revised the trial design and expects to initiate another cataract surgery study. This open label, multi-site phase Ib/IIa clinical trial (clinicaltrials.gov ID: NCT02571556) will enroll up to 20 patients which have undergone unilateral cataract extraction and implantation of a monofocal intraocular lens. Patients will undergo EGP-437 combination treatment (4.0 mA-min at 1.5 mA) on days 0 (i.e. immediately after surgery) and 7. Follow-up will occur on days 1, 14 and 28. Primary endpoint is the same as the initial study (i.e. proportion of subjects with ACC count of zero on day 7). EYEG believes they will have top-line data in 1H 2016.

There are some therapeutic similarities between the uveitis and post cataract surgery indications in that both involve the same tissues, those being of the iris and ciliary body. As such, we think the positive outcomes of EYEG's anterior uveitis studies may bode well for the same result in post cataract surgery – although we acknowledge the differences of both indications including possible influences or difficulties related to surgery. That relationship along with the potential for positive outcomes from this cataract surgery pilot study means that later stage/pivotal studies in post cataract surgery could be fairly swift moving. We will be keeping a close on this 'eye' on this.

Similar to macular edema, we view cataract surgery as a considerably attractive market than that of anterior uveitis given its relatively large size (i.e. ~3 million U.S. surgeries each year). We expect the upcoming interim data to provide more insight into the potential utility of EGP-437 combination treatment in a potential cataract surgery indication.

Dry Eye: Shelved, at least for the time being

EYEG had, at one time, also been pursuing a dry eye indication, although has since shelved that program due to the difficulties associated with enrolling clinical trials for a condition that has different and varying etiologies. While EYEG has already completed a phase II and III clinical trial in the treatment of dry eye which showed EGP-437 combination therapy was associated with significant improvement in certain signs (such as corneal staining , tear film break-up and conjunctival redness) and symptoms (such as ocular discomfort) of dry eye, results were mixed with some efficacy endpoints met, while others were not. These studies used a "controlled adverse environmental system" (CAE) to reproduce the signs and symptoms of dry eye although EYEG has noted that if they were to conduct future dry eye clinical trials that they would use an alternative way to enroll the trial, without the use of CAE. While dry eye represents a large market (~5 million Americans over the age of 50 have it), given the difficulty in finding and enrolling a homogenous patient group for dry eye and the other indications (such as anterior uveitis, macular edema and cataract surgery) that may be more straightforward, EYEG has decided to put dry eye on the back burner.

Investment Considerations

Valeant (Bausch+Lomb)

The ophthalmic therapy market is fairly concentrated with only three major companies; Alcon, Allergan plc and Valeant Pharmaceuticals' Bausch+Lomb division dominating the space. In July 2015 EYEG announced a licensing agreement, granting Valeant worldwide rights to manufacture and commercialize the Eyegate II Delivery System and EGP-437 for the uveitis indication as well as right of last refusal in other applications. In return, EYEG received upfront cash ($1 million) and is eligible for up to $32.5 million in development, regulatory and sales milestones. EYEG will also receive ("high single digit") royalties on sales. We note that neither Eyegate or Valeant has disclosed how the milestones are structured. EYEG is responsible for product development and related costs for the anterior uveitis indication in the U.S. Valeant has the right to develop the product outside of the U.S. and will be responsible for associated development costs.

This deal not only affords EYEG entry into the difficult-to-penetrate ophthalmic therapy market, but does so with some mitigated financial and product development risk. We also view this partnership with one of the ophthalmology "majors" as a meaningful vote of confidence in the product. In a deal valued at $8.7 billion, Valeant acquired Bausch + Lomb in 2013 in order to bolt on capabilities in the growing ophthalmology market. Bausch & Lomb, which is the largest worldwide provider of contact lenses, has a broad product line that also includes ophthalmic pharmaceuticals and ophthalmic surgical products.

Low-Hanging Fruit is Anterior Uveitis

While the market size of non-infectious anterior uveitis is much smaller than that of potential follow-on indications, it is the one that is furthest along in development, is already licensed to Valeant and has the clearest regulatory path. As such, we view this as the low-hanging fruit opportunity. If all goes to plan, we think reasonable expectations relative to anterior uveitis are;

- Top-line data from phase III confirmatory study in Q1 2017
- Full data analysis completed, regulatory packages (505(b)(2) NDA for EGP-437, 510(k) for device) prepared and submitted 2H 2017
- FDA approval / clearance of EGP-437 and delivery device 1H 2018
- Launch in U.S. by Valeant in 2H 2018. At which point EYEG would have received development and regulatory approval milestones
- EYEG has not disclosed the specific royalty rate on sales for the uveitis indication only noting that it is in the 'high single digits'. Our model uses 8% as the assumed rate
- U.S. prevalence of anterior uveitis is ~110k, much smaller than either macular edema or cataract surgery. Penetration / adoption of EYEG's therapy in anterior uveitis may be somewhat measured, even over the long-term, given the headwinds of corticosteroid market saturation. Despite their burdensome dosing regimen and adverse risk profile, steroids are well entrenched, are effective and patients/clinicians may be more forgiving of their drawbacks than they might be of injections

- As such, while we view anterior uveitis as the most near-term opportunity and one which EYEG may be able to clip sizeable development and regulatory milestones, we think macular edema and cataract surgery may hold much more sales royalty potential, particularly over a longer duration

Macular Edema, Cataract Surgery Are Bigger, and Maybe More Receptive, Markets
While macular edema and cataract surgery are at earlier stages of development than is the anterior uveitis indication, these other indications represent much larger market opportunities. Points of interest relative to these indications;

❖ **Macular Edema**
- Eyegate therapy response observed, particularly in pseudophakic eyes. Second leg of study will look closer at difference in phakic vs. pseudophakic response. Top-line data could be available 1H 2016
- Full-data set and analysis could be late 2016/1H 2017
- Assuming second leg data is positive, ME will move to larger clinicals – potentially directly to pivotal phase III
- Anticipate pivotal study timelines could be as long as two years from start (late 2017?) to completion (late 2019?)
- Expect interest from Valeant to license for ME indication potentially as early as entry into late-stage clinical trials or possibly earlier depending on strength of data sets
- Analysis, regulatory package, filing and FDA response/approval happen by late 2020 and launch late 2020/early 2021?
- We ballpark the U.S. ME market at approximately 2.2 million people but think EYEG's target market may be restricted to pseudophakic eyes, which comprise account for about 30%[12] (or ~660k) of the total ME market. This still represents a sizeable market and one that is about 6x the size of that of anterior uveitis (~110k)

❖ **Post Cataract Surgery**
- Cataract surgery is at somewhat of a similar (i.e. early) stage as macular edema. And while we think the evidence to-date of ME is more supportive of efficacy in that indication, given that targeted tissues with post cataract surgery are similar to those with anterior uveitis (which has the most supporting evidence of efficacy to-date), cataract surgery may be able to move through later stage/pivotal studies fairly swiftly. However, the differences of anterior uveitis and post cataract surgery patients (most noteworthy of which is surgical intervention) could result in differences in efficacy. So, given the early clinical stage of post cataract surgery as well as the potential that surgical intervention may confound an efficacy signal that may otherwise be expected to be similar to that of anterior uveitis, our model (as explained in more detail below) incorporates a relatively low probability of success for cardiac surgery. This could be updated if the pilot study shows positive results
- Phase II study which completed in 2013, used Eyegate therapy prior to cataract surgery. Failed to meet endpoint as was found that the surgical procedure washed the drug out of the eye
- New phase II clinical study will use Eyegate therapy post-surgery
- If the pilot study results are positive, EYEG may be able to move directly to phase 3 – which could initiate as early as later this year or early next. Assuming that happens, pivotal studies could wrap up in late 2017/early 2018 and, if all goes well, FDA approval and entry into the U.S. commercial market possibly happening in 2018 – 2019
- ~3.6 million cataract surgeries are performed in the U.S. every year. Target market for Eyegate's therapy may more likely be a sub-segment of this. Inclusion criteria of the upcoming phase II study requires implantation of monofocal intraocular lens. This represents ~30% of the aggregate cataract surgery market or ~1.1 million people, making it the largest market (by far) of EYEG's current focused programs and approximately 10x as large as anterior uveitis

Home Use
Eyegate has indicated that they may also pursue regulatory approval for home use for certain chronic conditions such as macular degeneration and note in their January 2016 investor presentation that they have initiated a collaboration for that purpose. Home use, in our opinion, would significantly broaden the size of the overall target markets and likely accelerate adoption for eye-drop related conditions as patients would be able to perform the treatment in the comfort of their home. However, as FDA approval specific to home use would be required and will likely necessitate additional clinical studies demonstrating that individuals (i.e. non-

[12] Congdon N1, Vingerling JR, Klein BE, West S, Friedman DS, Kempen J, O'Colmain B, Wu SY, Taylor HR; Prevalence of cataract and pseudophakia/aphakia among adults in the United States. Arch Ophthalmol. 2004 Apr;122(4):487-94.

clinicians) can correctly and safely perform the procedure (and these studies could be lengthy and require substantially more resources), given the lack of foresight relative to timing or feasibility, we do not currently incorporate any assumptions in our outlook or model related to an at-home indication.

Jade Therapeutics

The significant operational update since we initiated coverage of EYEG in mid-February was the announcement on March 7th that EyeGate acquired Jade Therapeutics, a Utah-based, privately-held specialty pharma developing locally administered, polymer-based ophthalmic therapies. Their lead technology, CMHA-S, is a proprietary cross-linked, thiolated (with carboxymethyl groups) version of hyaluronic acid (HA). HA is a naturally occurring in the human body and is a primary contributor of cell proliferation with wound-healing, tissue repair and anti-inflammatory properties. BioTime Inc. granted Jade (EYEG) a worldwide exclusive license to CMHA-S for delivery of any and all therapeutic molecules related to the human eye. BioTime retains rights for non-ophthalmic indications.

Terms of the deal:

- EYEG will pay up to $300k of Jade's liabilities
- EYEG will issue ~766k common shares to Jade, 90% which were issued at closing with the other 10% to be issued 18 months later (EYEG shares closed at ~$3.80 prior to the announcement = ~$2.9M)
- An additional $2.2M in cash is payable upon receiving FDA approval of a Jade product candidate

EYEG will assume Jade's Salt Lake City based R&D facility. Jade's co-founders as well as its research team will also migrate over to EyeGate. This includes their Chief Medical Officer (who will assume the same role at EYEG) and co-founder, a board certified ophthalmologist with a strong research background and who at a previous role as Pfizer's Senior Medical Director led the successful European regulatory filing for pediatric Xalatan (eye drop for open-angle glaucoma). Also coming from Jade is their head of R&D who has extensive experience in hydrogels for wound healing and drug delivery as well as another of Jade's co-founders.

EYEG pulled the trigger on Jade given the complementary product portfolios. We think this is about as good of a marriage in terms of fit for products and customer-channels that could be hoped for. And both companies' products address the shortcomings of the way that ophthalmic medications are administrated – that is, a rigorous dosing regimen and ineffective penetration.

EYEG will bolt on several potential ophthalmic indications at a reasonable purchase price. The pipeline is also re-risked to a degree in that the active ingredient (HA) is already widely used in human ophthalmic (as well as non-eye) applications, a similar cross-linked formulation is already 510(k)-cleared for dermal wound management (BioTime's product), CMHA-S has been vigorously and successfully tested in animals and a version is marketed by BayerDVM (animal health) in the U.S. and Europe under the Remend brand for corneal wound repair which has sold over 600k units.

Jades Technology…

The average person has about 15 to 20 grams of hyaluronic acid in their body. It is a main component in synovial fluid, which reduces friction between joints, is found in connective tissue and is also a major component of skin where it is involved in tissue repair. It has been used since the 1970s during intraocular surgery to protect the corneal endothelium where it is still considered standard of care. Hyaluronic acid's efficacy in protecting the corneal endothelium during cataract surgery has been well established.[13] It is also used in Europe as a first-line treatment for dry eye disease. HA is also an active ingredient in many of the "artificial tears" products sold in the U.S. and internationally. HA is also used in other applications, including as an injectable to treat osteoarthritis. Safety of HA, therefore, has already been well-established (particularly in ophthalmic applications).

One issue that HA suffers from, however, is that it has short half-life with approximately one-third of it degraded (and replenished) in the body each day. But by cross-linking it, it stabilizes the molecule and forms into a hydrogel with a very high molecular weight and viscosity which resists degradation and allows it to adhere to the surface of the eye much longer. Unlike typical eye drops, which quickly run down the side of user's face, a hydrogel will stay in place and provide the benefit of sustained release, thereby improving efficacy. It also means a much less rigorous dosing regimen. And it remains biocompatible, will thin with blinking and a user's vision will not be compromised immediately following administration (despite its gel-like properties).

[13] Goa KL, Benfield P. Hyaluronic acid. A review of its pharmacology and use as a surgical aid in ophthalmology, and its therapeutic potential in joint disease and wound healing. Drugs. 1994 Mar;47(3):536-66.

The compound starts with HA from Novosymes (bacterial fermentation). Carboxymethyl groups at then added to produce CMHA which are then thiolated using a proprietary method to produce CMHA-S. Depending on the intended application, it can be formulated into a relatively low viscosity liquid or higher viscosity gel or film.

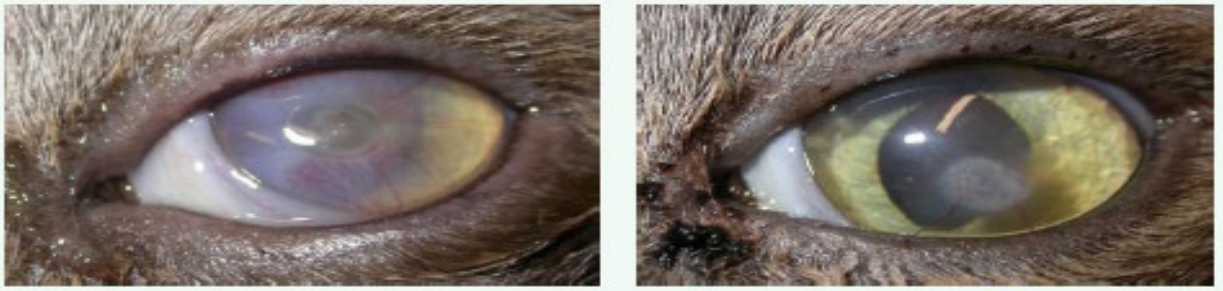
Initial Indication…

The initial indication EYEG expects to seek is for corneal repair (currently dubbed JDE-003) for populations such as;

- Persistent corneal epithelial defects (PCED)
- Following photoreactive keratectomy (similar to LASIK)
- Moderate-to-severe dry eye
- Following diabetic vitrectomy (eye surgery to remove vitreous gel)

JDE-003 uses cross-linked 0.75% HA solution. A non-healing corneal defect is considered persistent, or non-healing, if it persists for more than two weeks. PCED's can result in corneal ulcers, scarring, infection and, eventually, blindness if not effectively treated. A masked, randomized study in 29 cats with superficial, mid-stromal and deep stromal (i.e. non-healing) corneal defects showed superior efficacy of CMHA-S (0.75% concentration) as compared to non-cross-linked 0.25% eye drops. Both arms received their respective eye drops 3x/day and were evaluated weekly. Primary endpoint was lack of staining with fluorescein (i.e. healed ulcer). Results showed eyes treated with CMHA-S 0.75% took an average of 21 days (± 11 days) to heal while those treated with non-cross-linked 0.25% HA concentration took an average of 32 days (± 10 days) to heal.

Non-healing corneal defect at 35 days (L) and healed (R) after 10 days of CMHA-S 0.75% treatment[14]



Non-healing corneal defect at 42 days (L) and healing (R) after 12 days of CMHA-S 0.75% treatment



FDA Meeting Upcoming…

EYEG believes JDE-003 will be able to follow an FDA medical device pathway (as opposed to drug pathway) and expects to meet with the agency in Q3 of this year for confirmation. We note that AmbioDisk and Prokera, both amniotic membranes (i.e. disks placed on the eye by clinicians) indicated for use of non-healing epithelial defects also did not follow NDA pathways. Prokera followed 510(k) as a Class II device while AmbioDisk is regulated under Section 361 of the Public Health Service Act by FDA with no clearance required. These are more invasive and require much greater skill to administer than eye drops (i.e. JDE-003). This, combined with the strong safety data to-date, may play in EYEG's favor. Assuming they get confirmation of the device pathway, EYEG expects to initiate clinical studies for corneal repair in Q4.

Pipeline Indications…

In addition to corneal repair, the pipeline includes JDE-002, an ocular surface shield and JDE-004, for treatment of bacterial keratitis. Both of these programs have been funded by federal government grants.

[14] Jade Therapeutics, Eyegate Pharmaceuticals

The ocular shield candidate consists of a thin film, shaped to surface of the eye which will remain in place up to 7 days to promote healing. Department of Defense funding has funded over $1M for Phase 1 and 2 (through August 2017).

JDE-004 utilizes the Jade technology to deliver antibiotics to the eye to treat bacterial keratitis (infectious corneal ulcers), which is most common due to wearing contact lenses overnight. Typical treatment is antibiotics delivered via drops such as Bausch+Lomb's Besivance (besifloxacin 0.6%). JDE-004 would deliver the medication via a CHMA film with a 7 – 8 day release window, thereby eliminating the need of the rigorous 3x/day for 7 days dosing schedule recommended with Besivance. Jade has demonstrated safety and tolerability of the sustained release film in rabbit models.

Product #	Product	Type of Product	Indication	Formulation	Preclinical Development	IND/IDE
JDE-003	Device	Thiolated-HA Topical Drop (0.75%)	Corneal Repair	US-IDE/PMA Regulatory Pathway		
JDE-001	Drug	Thiolated-HA Topical Drop (0.4%)	Dry Eye Disease (DED)	US-IND Regulatory Pathway		
JDE-002*	Device	Thiolated-HA Ocular Surface Shield	Corneal Protection / Repair	US-IDE/PMA		
JDE-004*	Drug	Antibacterial Film	Bacterial Keratitis	IND Pathway		
JDE-005*	Drug	rHGH Film	Persistent Corneal Epithelial Defects	Orphan Drug Designation		
JDE-006	Drug	Anti-angiogenic	Corneal Neovascularization, AMD/DME	Drug Delivery Program		

*These programs are fully funded by Federal Government Grants (Department of Defense and National Science Foundation)

SOURCE: Eyegate Pharm

Market Opportunity…

JDE-003 is considered the lead Jade candidate with PCED potentially being the most near-term opportunity. EYEG estimates PCED encompasses an annual U.S. market of approximately 125k people. Incorporating an estimated $300 per treatment cost and an average of two (i.e. one to three) treatments per patient, results in a U.S. market opportunity worth roughly $75M (i.e. - ~$40M - $115M). Other indications for JDE-003 could include post photoreactive keratectomy, moderate-to-severe dry eye and following diabetic vitrectomy which, in aggregate, could balloon the total market opportunity to over $1B – the vast majority of which would relate to dry eye, given the relatively high incidence (3 – 5 million Americans) of the condition.

Comments

Jade's pipeline looks like it could be a seamless fit to that of EYEG's – not only does it target similar customer channels but also addresses the drawbacks of current ophthalmic drug administration. JDE-003, the lead candidate, is already de-risked to an extent given the long history of HA being used in human eyes and its broad use and extensive successful testing for corneal repair in animals.

Standard of care for corneal repair, including liquid eye drops, bandage soft contact lenses, pressure patching and debridement sometimes fail or require onerous dosing/administration regimens. Newer therapies, including amniotic membranes, offer the potential for greater efficacy and more rapid healing but come with drawbacks – including that some of these must be sewn in place or glued and all require a skilled clinician. These are also relatively costly ($1k - $2k per treatment).

Jade also comes with an existing R&D facility, highly experience staff and existing government grants to help fund other of the pipeline candidates. The purchase price equates to approximately $3.2M (~$2.9M worth of stock plus $300k assumed liabilities) and EYEG will pay another $2.2M (cash) upon FDA approval/clearance of a Jade candidate. All in, this equates to approximately 4% of the annual estimated U.S. market of just the PCED indication. And this implies a no-cost option for all of the other potential indications ($1B plus market, ~$200M of which might be lower-hanging fruit) of JDE-003 as well as for the other pipeline candidates (i.e. corneal protection, bacterial keratitis) and the opportunity to expand into other areas.

We think the JDE-003 program could be fairly fast moving given the existing safety data and that the FDA regulatory pathway is expected to follow that of a device. While it may be a PMA pathway (as opposed to 510(k)), the FDA clinical program could potentially be a relatively small Phase 2 study, followed by a larger (n = 100 or 200) Phase 3 study. While this is just speculation on our part, we should know more following the anticipated FDA meeting in Q3.

We have incorporated JDE-003 into our model and using similar methodology of that for EYEG's legacy product candidates. If all goes well we think JDE-003 could reach the market sometime in 2018. We use a 50% probability of successful launch in the U.S. and, similar to the deal with Valeant for EGP-437 for the anterior uveitis indication, assume EYEG out-licenses marketing rights. But, given that we are modeling that EYEG assumes all R&D risk, we assume a much higher royalty rate of 20% (versus "high single digits" with Valeant for EGP-437). We think there could be several interested licensors, which could include Valeant but also Allergan and Novartis. We are modeling single-digit penetration through 2022. These, however, are early assumptions and very likely to change as more information becomes available – with the most significant near-term information expected to relate to the FDA pathway and scope of requisite clinical studies.

VALUATION / RECOMMENDATION

Given the pre-revenue stage of Eyegate, typical valuation methodologies such as P/E, P/EG, P/S and others which require financial metrics as components are unsuitable. As such, we believe the most appropriate valuation methodology is discounted cash flow.

Regarding milestones that EYEG is eligible to receive from Valeant. As milestones could be a significant portion of any revenue that EYEG recognizes, we think it is relevant to provide a comment. It is unclear how the milestones are structured as neither EYEG or Valeant has disclosed this information. EYEG's prospectus dated November 11, 2015 notes that, "The Company is eligible to receive milestone payments totaling up to $32.5 million, upon and subject to the achievement of certain specified developmental and commercial milestones. In addition, the Company is eligible to receive royalties based on a specified percent of net sales of the Product throughout the world, subject to adjustment in certain circumstances."

The language in the July 10, 2015 press release announcing the licensing agreement is somewhat different and reads, "Under the agreement, EyeGate will receive an upfront cash payment, development-based milestone payments related to the completion of development for the indication of anterior uveitis and an approval-based milestone payment upon receipt of FDA approval of the Product. Additionally, the Company would receive royalties based on net sales, as well as additional milestone payments based on the achievement of certain cumulative sales milestones."

So there is no information that relates to timing/triggers/deliverables of potential payments and it is also unclear whether the $32.5M is related only to development and FDA approval or if it also relates to commercialization and sales. We are taking a conservative approach and assuming that not only is the $32.5M also related to commercialization/sales, but that the majority of it is back-weighted (i.e. – not related to development and FDA approval). This, like all of our assumptions, is subject to updating if and when new information becomes available that is at odds with our inputs.

Our model incorporates the following assumptions:

General assumptions:

- we have discounted all modeled milestones and royalties related to each indication to account for risk of regulatory and/or commercialization failure. These respective risk discounts are subject to change based on change in risk profile (i.e. decreasing with clinical trial and regulatory progression)
- while Valeant has currently only licensed rights for the anterior uveitis indication, we assume that if and when macular edema and cataract surgery demonstrate positive results in later stage clinical trials, that Valeant will also license rights to these indications. For consistency purposes, we assume the aggregate milestones and royalty rates are the same as for anterior uveitis
- assume all sales royalties are at 8% (EYEG has disclosed the anterior uveitis indication will pay "high single digits")
- operating expenses trend higher with progression of each indication through later-stage clinical trials and related regulatory activities. Following launch, operating expenses fall as Valeant is responsible for sales and marketing and EYEG's R&D activities temper

Anterior Uveitis Indication:

- 80% probability of successful FDA approval/clearance and launch for anterior uveitis indication. All modeled milestones and royalties related to anterior uveitis are initially discounted by 20% (i.e. 1 – 0.80) to account for risk of regulatory or commercialization failure
- Receipt of development milestones begins in 2017
- Receipt of FDA approval/clearance and launch in 2018 and receipt of regulatory milestones as well as additional development milestones in that same year
- $300 cost per application x 3 applications (per clinical trial protocol) = $900/patient. Cost increases at rate of inflation
- U.S. market size of ~110k, increasing at the rate of population growth. Less than 1% penetration through 2019, mid-single digit penetration by 2023 and 10% in 2026 (the out-year in our 10-yr DCF model)

Macular Edema Indication:

- 50% probability of successful FDA approval/clearance and launch for macular edema indication. All modeled milestones and royalties related to macular edema are initially discounted by 50% to account for risk of regulatory or commercialization failure
- Receipt of development milestones begins in 2017
- Receipt of FDA approval/clearance and launch in 2020 and receipt of regulatory milestones as well as additional development milestones in that same year
- $300 cost per application x 3 applications (per clinical trial protocol) = $900/patient. Cost increases at rate of inflation
- U.S. market size of ~660k, increasing at the rate of population growth. Less than 1% penetration in 2020, mid-single digit penetration by 2023 and 12% in 2026

Cataract Surgery Indication:

- 15% probability of successful FDA approval/clearance and launch for cataract surgery indication. All modeled milestones and royalties related to cataract surgery are initially discounted by 85% to account for risk of regulatory or commercialization failure
- Cataract surgery may be the indication which the risk discount could be reduced the most significantly in the near term. Positive results from the pilot study (top-line expected ~mid-2016) could prompt this haircut reduction, which could positively influence our valuation of the company
- Receipt of development milestones begins in 2017
- Receipt of FDA approval/clearance and launch in 2018 and receipt of regulatory milestones as well as additional development milestones in that same year
- $300 cost per application x 2 applications (per clinical trial protocol) = $600/patient. Cost increases at rate of inflation
- U.S. market size of ~1.1M, increasing at the rate of population growth. Less than 1% penetration in 2018, mid-single digit penetration by 2021/2022 and 15% in 2026

Key Initial Assumptions

	Probability of success	Year of launch	Treatment cost	Market size ('000s)	Penetration		
					< 1%	Mid-Single	Yr 2026
Anterior Uveitis	80%	2018	$900	110	2019	2023	10%
Macular Edema	50%	2020	$900	660	2020	2023	12%
Cataract Surgery	15%	2018	$600	1,100	2018	2021/2022	15%

Jade's Pipeline

- 50% probability of successful FDA approval/clearance of JDE-003 and launch for - Persistent corneal epithelial defects
- Out-licenses to major ophthalmology-focused company such as Allergan, Novartis or Bausch+Lomb for 20% of net revenues
- U.S. launch in 2018, single digit penetration through 2022
- Annual U.S. market for PCED of ~$125M
- Currently do not model other indications for JDE-003 or for other of Jade's candidates. This will be updated with news flow

DCF Currently Values EYEG at $6/Share, Progression Through Clinicals Should Push Value Higher…

The above assumptions along with other inputs in our DCF including a 10% discount rate and 2% terminal growth rate, results in a current DCF-generated valuation of approximately $6/share. While we have incorporated some assumed revenue from Jade's pipeline, we have also incorporated assumed expenses from combining the two companies as well as R&D expenses related to the pipeline (as well as additional outstanding shares). While our $6/share target represents attractive upside to the current share price, our calculated value should appreciate further on progression of EGP-437 and Jade's pipeline through clinical trials in any of the indications as this would positively affect (i.e. decrease) our risk discounts. We are maintaining our Buy recommendation.

FINANCIAL MODEL

Eyegate Pharmaceuticals Inc. (figures in 000s of $)

	2015 A	Q4E	Q4E	Q4E	Q4E	2016 E	2017 E	2018 E	2019 E
Legacy Eyegate									
Anterior Uveitis									
Probability reaches market	-	-	-	-	-	80%	80%	80%	80%
U.S. Market Size	-	-	-	-	-	110,000	112,200	114,444	116,733
Penetration %	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.7%
Number of patients	-	-	-	-	-	**0**	**0**	**343**	**817**
EYEG Royalty rate	-	-	-	-	-	8%	8%	8%	8%
Cost per procedure	-	-	-	-	-	$900	$923	$946	$969
Revenue (millions) w/haircut	-	-	-	-	-	**$0.00**	**$0.00**	**$20.78**	**$50.69**
Milestones w/ haircut	-	-	-	-	-	**$0.00**	**$4,000.00**	**$5,600.00**	**$2,800.00**
AU Total Revenue	-	-	-	-	-	**$0.0**	**$4,000.0**	**$5,620.8**	**$2,850.7**
Macular Edema									
Probability reaches market	-	-	-	-	-	50%	50%	50%	50%
U.S. Market Size	-	-	-	-	-	660,000	673,200	686,664	700,397
Penetration %	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Number of patients	-	-	-	-	-	**0**	**0**	**0**	**0**
EYEG Royalty rate	-	-	-	-	-	8%	8%	8%	8%
Cost per procedure	-	-	-	-	-	$900	$923	$946	$969
Revenue (millions) w/haircut	-	-	-	-	-	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Milestones w/ haircut	-	-	-	-	-	**$0.00**	**$1,250.00**	**$1,250.00**	**$2,500.00**
ME Total Revenue	-	-	-	-	-	**$0.0**	**$1,250.0**	**$1,250.0**	**$2,500.0**
Cataract Surgery									
Probability reaches market	-	-	-	-	-	15%	15%	15%	15%
U.S. Market Size	-	-	-	-	-	1,100,000	1,122,000	1,144,440	1,167,329
Penetration %	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	1.7%
Number of patients	-	-	-	-	-	**0**	**0**	**2,289**	**19,845**
EYEG Royalty rate	-	-	-	-	-	8%	8%	8%	8%
Cost per procedure	-	-	-	-	-	$600	$615	$630	$646
Revenue (millions) w/haircut	-	-	-	-	-	**$0.00**	**$0.00**	**$17.31**	**$153.87**
Milestones w/ haircut	-	-	-	-	-	**$0.00**	**$375.00**	**$750.00**	**$525.00**
CS Total Revenue	-	-	-	-	-	**$0.0**	**$375.0**	**$767.3**	**$678.9**
Product Sales/Royalites	-	-	-	-	-	$0.0	$0.0	$38.1	$204.6
Dvlpmnt / Reg Milestones	-	-	-	-	-	$0.0	$5,625.0	$7,600.0	$5,625.0
Jade's Pipeline									
JDE-003 (Corneal Repair)									
Probability reaches market	-	-	-	-	-	50%	50%	50%	50%
U.S. Market Size	-	-	-	-	-	125,000	127,500	130,050	132,651
Penetration %	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	3.0%
Number of patients	-	-	-	-	-	**0**	**0**	**1,301**	**3,980**
EYEG Royalty rate	-	-	-	-	-	20%	20%	20%	20%
Cost per procedure	-	-	-	-	-	$450	$461	$473	$485
Revenue (millions) w/haircut	-	-	-	-	-	**$0.00**	**$0.00**	**$61.49**	**$192.85**
Milestones w/ haircut	-	-	-	-	-	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Corneal Repair Total Revenue	-	-	-	-	-	**$0.0**	**$0.0**	**$61.5**	**$192.8**
Total Revenues	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$5,625.0	$7,699.6	$6,222.4
YOY Growth	-	-	-	-	-	-	-	*36.9%*	*-19.2%*
Cost of Revenues	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.00	$0.0	$0.0
Gross Income	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$5,625.0	$7,699.6	$6,222.4
Gross Margin	-	-	-	-	-	-	-	-	-
R&D	$2,717.1	$1,244.0	$1,467.0	$1,515.0	$1,748.0	$5,974.0	$6,320.0	$6,555.0	$6,880.0
%R&D	-	-	-	-	-	-	*112.4%*	*85.1%*	*110.6%*
SG&A	$3,960.5	$1,288.0	$1,315.0	$1,322.0	$1,294.0	$5,219.0	$5,540.0	$5,884.0	$6,108.0
%SG&A	-	-	-	-	-	-	*98.5%*	*76.4%*	*98.2%*
Operating Income	($6,677.6)	($2,532.0)	($2,782.0)	($2,837.0)	($3,042.0)	($11,193.0)	($6,235.0)	($4,739.4)	($6,765.6)
Operating Margin	-	-	-	-	-	-	-	-	-
Total, other income (exp)	($1,710.4)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Pre-Tax Income	($8,388.0)	($2,532.0)	($2,782.0)	($2,837.0)	($3,042.0)	($11,193.0)	($6,235.0)	($4,739.4)	($6,765.6)
Taxes	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Tax Rate	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Net Income	($16,615.2)	($2,532.0)	($2,782.0)	($2,837.0)	($3,042.0)	($11,193.0)	($6,235.0)	($4,739.4)	($6,765.6)
YOY Growth	-	-	-	-	-	-	-	-	*42.8%*
Net Margin	-	-	-	-	-	-	-	-	-
EPS	($2.70)	($0.32)	($0.33)	($0.34)	($0.35)	($1.35)	($0.68)	($0.49)	($0.67)
YOY Growth	*-70.7%*	*-90.1%*	*37.5%*	*78.4%*	*1.4%*	*-50.1%*	*-49.6%*	*-27.9%*	*37.1%*
Diluted Shares O/S	6,164	7,930	8,350	8,400	8,600	8,320	9,200	9,700	10,100

Brian Marckx, CFA

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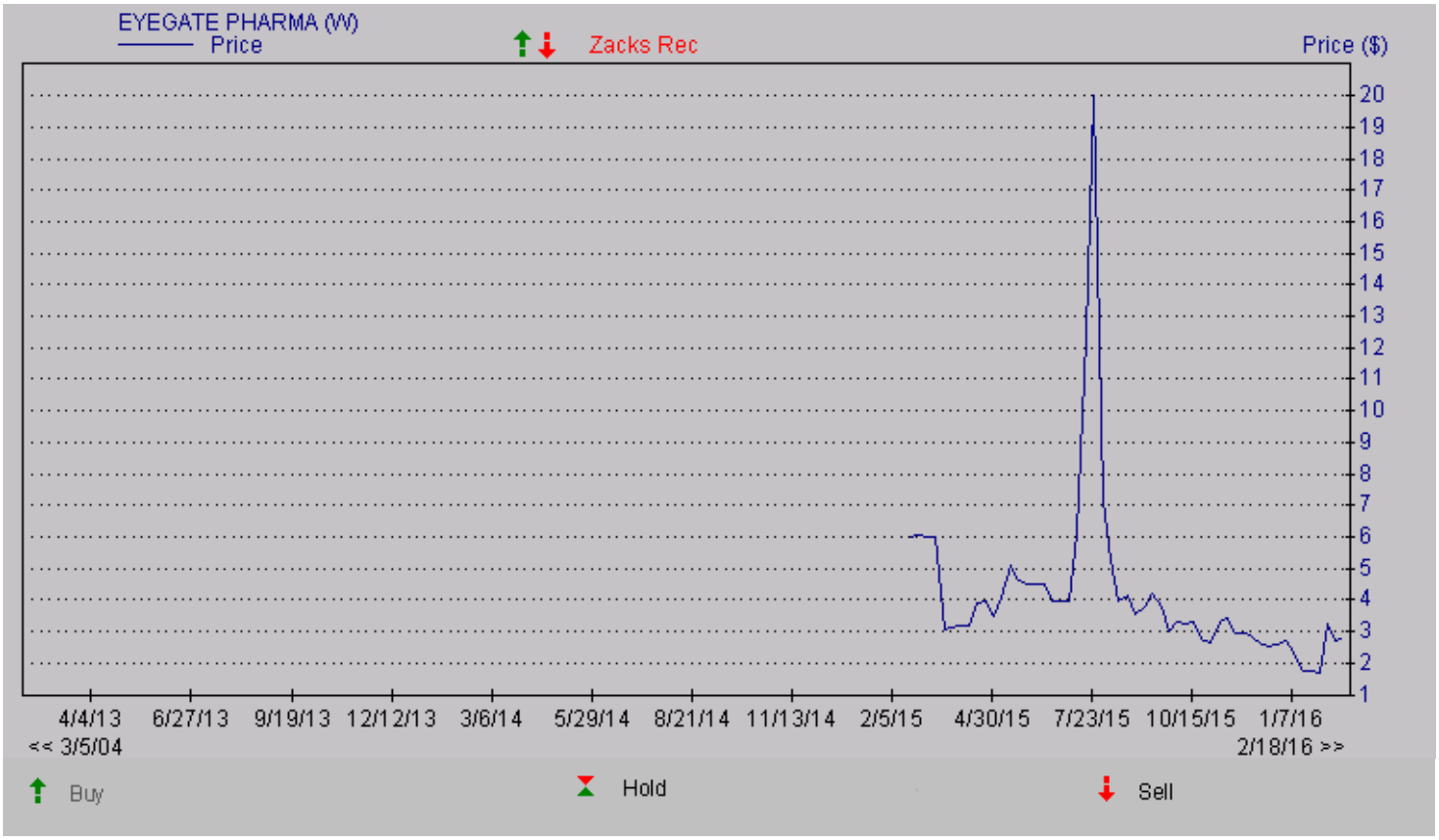

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