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Zacks Small-Cap Research

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EyeGate Pharmaceuticals (EYEG-NASDAQ)

EYEG: Cataract Surgery Study Completes Enrollment, Topline Data Expected Q1 '18

The detailed assumptions in our Valuation section 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 $5.00/share.

Current Price (11/27/17)	$1.08
Valuation	**$5.00**

OUTLOOK

EYEG's 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 continues to enroll, although has been plagued by delays. Topline data now expected in Q2 2018. If phase 3 is positive, launch could happen by 2019. Clinicals in post-cataract surgery also progressing with positive data recently announced Phase IIb just completed enrollment with topline data expected in Q1 2018. Phase 3 study could start shortly afterwards.

Recent Jade acquisition brought complementary, de-risked pipeline. First Jade candidate (OBG) showed promising data in pilot study. Waiting IDE approval to begin 2nd pilot study. If efficacy is confirmed, we think eventual commercialization could be reasonably high. Our DCF model, which incorporates indication-specific risk adjustments to account for potential clinical or regulatory failure for each of the programs, currently values the shares at approximately $5.00. 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	**$3.90**
52-Week Low	**$0.90**
One-Year Return (%)	**-35.71**
Beta	**3.26**
Average Daily Volume (sh)	**212,548**
Shares Outstanding (mil)	**17**
Market Capitalization ($mil)	**$19**
Short Interest Ratio (days)	**N/A**
Institutional Ownership (%)	**12**
Insider Ownership (%)	**25**
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 2017 Estimate	**N/A**
P/E using 2018 Estimate	**N/A**
Zacks Rank	**N/A**

Risk Level	**Above Avg.,**
Type of Stock	**Small-Growth**
Industry	**Med-Drugs**

ZACKS ESTIMATES

Revenue
(in 000s of $)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2016	0 A	235 A	274 A	160 A	669 A
2017	185 A	148 A	75 A	0 E	408 E
2018					6980 E
2019					8394 E

Earnings per Share

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2016	-$0.31 A	-$0.46 A	-$0.36 A	-$0.38 A	-$1.51 A
2017	-$0.28 A	-$0.28 A	-$0.24 A	-$0.26 E	-$1.05 E
2018					-$0.61 E
2019					-$0.42 E

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

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Q3 Financial Results, Operating Update…

EYEG reported Q3 financial results and provided a business update. There continue to be no significant surprises in the financials. Operating expenses continue to trend higher on progression of several development programs including EDP-437, which is in clinical trials for indications related to anterior uveitis and post-cataract surgery. EYEG also has their CMHA-S compound, which came from the Jade acquisition last year, under development for an initial Ocular Bandage Gel indication.

Q3 revenue was $75k, which (per the 10-Q) represents final funding of the Jade-related government grants. Operating expenses increased to $4.2M from $3.5M in Q2 of this year and from $3.7M in the comparable prior-year period.

And while EYEG has yet to recognize as revenue any of the upfront and subsequent cash milestones received from Valeant related to licensing agreements for EGP-437 in the uveitis and (more recent) cataract surgery indications, that could soon change. Through September 30th EYEG received $9.653M from Valeant. This includes $5.428M (i.e. $4.0M upfront and $1.428M in development-related milestones, including $792k received during Q3) for the cataract surgery contract, and $4.225M related to the uveitis contract (no additional payments were received related to the uveitis indication through the first nine months of 2017). As a reminder, these payments are initially booked as deferred revenue on the balance sheet and then brought over to the income statement as revenue when the requisite milestones are completed (or in the case of upfront payments, is recognized as revenue ratably based on the proportional share that each milestone represents of the total).

So while recognizing these milestones as revenue has no cash effect, it is important as it represents development progress of EGP-437 in these indications. While progression of the uveitis program has been significantly slower than previously anticipated, data read out from the phase III study for that indication could come before the end of 1H 2018. Meanwhile the receipt of milestones in both Q2 and Q3 for the cataract surgery indication along with recent notice that the phase IIb completed enrollment implies that that program is moving along. EYEG now anticipates recognizing initial revenue from the cataract surgery and uveitis indications during Q1 2018 and Q2 2018, respectively, corresponding to the respective expected timing of release of topline data from the cataract surgery phase IIb and uveitis phase III trials.

Q3 net loss and EPS were $4.1M and ($0.24), compared to our $3.8M and ($0.22) estimates.

Cash: As a reminder, during Q2 EYEG raised ~$8.8M net ($10M gross) via the sale of 5.3M common shares (@ $1.50/share) and 1,995 Series B preferred (convertible into 1.33M common shares), along immediately exercisable warrants (@ $1.50) to purchase 6.67M shares (i.e. 100% warrant coverage). Cash balance, which also benefitted from $5.4M in upfront and development milestone payments from Valeant during 2017 (including $792k during Q3), was $9.2M at Q3 quarter-end. EYEG mentions in the 10-Q that they believe the current cash balance, in addition to cash that they expect to receive through the remainder of 2017, is sufficient to fund operations for approximately eight months.

Additional funding is expected to come from milestone payments from Valeant related to the uveitis and cataract surgery licensing agreements as well as potentially from the sale of equity and/or debt. As a reminder, the EGP-437 ocular surgery licensing agreement calls for up to $99M in cash payments from Valeant upon achievement of specific development/commercialization milestones.

Meanwhile, terms of the June 2017 $10M securities transaction restricts future sale of common shares under the ATM program for 24 months (i.e. until June 2019) unless executed at more than $3/share.

On the operational front, while EYEG continues to make progress in all of their major development programs, including completing enrollment of the phase IIb ocular surgery study, timelines continue to drag longer than previous forecasts have anticipated. This includes guidance for;

- **EGP-437 in uveitis**:
    - EYEG noted in their Q2 10-Q (filed 8/4/17) that they were aiming for topline data from their ongoing phase III study to be available in Q1 2018 and were hoping to be able to file an NDA during 1H 2018. Those anticipated respective timelines, per the Q3 10-Q (filed 11/14/2017), have been pushed back to

Q2 2018 and 2H 2018. They still expect to begin recognizing revenue (i.e. booking deferred revenue as revenue on the income statement) from this contract in 1H 2018 – while unchanged from the Q2 10-Q, it is delayed from prior expectations (i.e. as of the Q1 10-Q) of initial revenue recognition happening sometime in 2017. Eyegate has indicated that the delays relate to study enrollment taking longer than they had expected.

- **OBG**:
  - the OBG program has experienced some ongoing delays as EYEG continues to work to get IDE approval to commence a second pilot study. Earlier this year EYEG noted that they were aiming to begin a second pilot study in PRK surgery patients sometime in Q2 2017 and for topline data to be available in 2H 2017. Assuming positive results from the second pilot study, EYEG would then hope to commence a pivotal study in 2H 2017, report topline data in Q1 2018 and make 510(k) and CE Mark filings in 1H 2018.
    These timelines have now been updated to;
    - Q4 2017 for commencement of the second study
    - Q1 2018 topline data
    - Q4 2018 pivotal study
    - Q3 2018 pivotal study topline data
    - Q4 2018 CE Mark, 510(k)
    - 2019 launch

    As we noted in our recent updates, we believed the rate of development progression implied by this timeline was somewhat aggressive. Clearly the forecasted start date was too optimistic. As a reminder EYEG announced in early May 2017 that they submitted an IDE seeking FDA approval to commence this second pilot study. However, in their Q2 earnings release the company noted that, "We received FDA feedback on the application in June and anticipate refiling the IDE to address the Agency's comments later this quarter." FDA's inquiry, per EYEG's recent investor presentation, were requests for microbiology and chemistry validation work related to manufacturing. While EYEG has not provided a detailed public update as to the status of their response, hopefully the fact that they are targeting a Q4 2017 start for the study indicates that substantive progress was made on that deliverable.

    While the latest update to expected timelines equates to ~6 to 9 months (vs. initial forecast), it has only minimal influence on our model or price target. Additionally, we continue to believe that based on earlier positive clinical trial data and the de-risked nature of OBG that, if efficacy is confirmed in this follow-up study, we think the likelihood of eventual commercialization could be reasonably high.

In Summary, EYEG's Anticipated (Updated) Near-Term Milestones Include:

- **OBG**
  - Initiate second pilot study in Q4 2017, topline data Q1 2018
  - Initiate pivotal study Q4 2018, topline data in Q3 2018
  - De Novo 510(k) and CE Mark filings for corneal re-epithelization post-PRK surgery in Q4 2018
  - Launch in 2019
- **EGP-437**
  - Uveitis
    - Topline data from phase III uveitis confirmatory study in Q2 2018
    - NDA filing for uveitis by 2H 2018
  - Cataract surgery
    - On 8/1 EYEG announced that the first patient enrolled in phase IIb study
    - On 11/8 EYEG announced enrollment completed
    - Topline data expected Q1 2018
    - Assuming positive phase II results, would follow with a phase III study
    - Possible future supplementary NDA related to pain and inflammation

Readying For Launch, Includes Hiring of Chief Commercial Officer…

But, despite some delays to certain of the development programs, EYEG appears to be readying for eventual commercialization of one or more of their products. Preparations during Q3 in that regard including the hiring of a chief commercial officer as well as the appointment of two additional members to its scientific advisory board. Mike Garanzini was brought on in early November to guide EYEG's product launch and commercialization strategies. He brings a 25-year career in marketing within the pharma industry including leading glaucoma-related marketing at

Santen and acting as the Senior Director of Global Marketing for Merck's ophthalmology business. He has also held sales and marketing roles in Pharmacia's ophthalmology division where he was involved in the roll out of Xalatan (eye drops for IOP).

SUMMARY OF KEY DEVELOPMENT PROGRAMS…

EGP-437: Cataract Surgery

As a reminder, Valeant picked up their option for a cataract surgery indication. In February 2017 EYEG announced that in return for $4M upfront cash (received in Q1 2017) and up to an additional potential $99M in development and commercialization milestones, they licensed rights to their EGP-437/delivery combination product candidate for the treatment of post-operative pain and inflammation in ocular surgery patients.

Unlike the anterior uveitis program, which seems to have been stuck in neutral over the last few months, the cataract surgery program has made regular development progress. In August 2017 the first patient enrolled in the phase IIb study and just three months later, in November, enrollment completed. In May that EYEG received from Valeant the first development milestone ($636k) related to the EGP-437 in ocular surgery. The second development milestone for this program was received in Q3 ($792k).

Phase IIb Now Fully Enrolled
On November 8th EYEG announced that their recently initiated phase IIb study completed enrollment (n=100). The study design: double-masked, randomized, placebo-controlled, enrollment = 100 subjects at eight trial sites in the United States. It is designed to evaluate the safety and efficacy of EGP-437 in patients having undergone cataract surgery with implantation of a monofocal posterior chamber intra-ocular lens (IOL). Primary efficacy endpoint is the proportion of subjects with an anterior chamber (AC) cell count of zero at day 7 and the proportion of subjects with pain score of zero at day 1. Given the positive data to-date (below) including reduction in AC cell count and reduced pain favoring the EGP-437 treatment arms (versus placebo), we are optimistic for the success of this ongoing phase IIb study. Assuming positive results, EYEG hopes to move directly to a phase III study for support of an eventual FDA filing. Topline data is expected in Q1 2018.

Positive Phase Ib/IIa Data
In December 2015 EYEG announced additional positive clinical data from their phase Ib/IIa post-cataract surgery dose-ranging clinical trial. As a reminder, the study was designed to **enroll up to 80 patients** which have undergone unilateral cataract extraction and implantation of a monofocal intraocular lens.

Patients were separated into cohorts of 10 patients each with each cohort treated at different doses and/or treatment regimens. Subjects were evaluated on days 1 (i.e. 1 day following cataract surgery), 14 and 28. Primary endpoint was the proportion of subjects with ACC count of zero on day 14. Secondary efficacy endpoint was the proportion of subjects with a pain score of zero on Day 7.

In August 2016 EYEG announced top-line data from 40 patients (4 cohorts) which were administered iontophoretic EGP-437 at either 9.0 mA-min or 14.0 mA-min on day 0, day 1 and day 2 or day 0, day 1 and day 4, with potential for an additional treatment at day 7 in all cohorts. Results showed patients receiving the 14.0 mA-min dose on days 0, 1 and 4 had the most significant improvement in ACC - with 40% of patients in this group achieving an ACC count of 0 at day 14 (i.e. the primary endpoint) and this increased to 88% on day 28.

In addition, all patients receiving the iontophoretic treatment reported reduced pain at all time points with 90% having no pain as early as day 1 and increasing to 100% on day 14. In addition, there was no steroid-related increase in intraocular pressure reported.

Concurrent with the top-line data release in August, the company noted that they would enroll three additional cohorts at other doses and dosing regimens with the expectation of further improving on the efficacy data to-date.

In December 2016, EYEG announced additional positive data. Dosing and treatment regimen were modified slightly from that of the cohorts represented in the August data and included 30 patients (3 cohorts) which were administered iontophoretic EGP-437 at either 4.5mA-min on day 0 (post-operative), day 1 and day 4 or at 14mA-

min on day 0 (pre-operative), day 1 and day 4. The third cohort was dosed with placebo on day 0 (post-operative), day 1 and day 4. An optional treatment (at physician's discretion) on day 7 was available for all three cohorts.

Results indicated that subjects in the lowest dose cohort (i.e. 4.5mA-min) exhibited the greatest response, with 30% of those patients reaching an ACC count of zero by day 14 and 80% by day 28. While there was limited other data released, EYEG's press release (http://bit.ly/2ma3fli) did provide other indications of a positive EGP-437 treatment response including that; ACC count reduction was observed in both EGP-437 treatment arms, only 10% of placebo patients reached an ACC count of zero by day 28 and 80% of placebo patients required rescue prior to day 14.

In addition, and related to the pain outcome measure, it was noted that all EGP-437 patients experienced less pain at all time points and 70% had pain score of zero by day 1 whereas only 10% of placebo patients had pain score of zero at day 1.

See our table below summarizing the results disclosed in August (4 cohorts) and December (3 cohorts) 2016 and the respective dosing and treatment regimens. Perhaps interesting, and maybe arguably confounding, is that ACC count reduction was most profound in one of the two highest dose cohorts in the August data but the December data showed the opposite – that is, the lowest dose cohort had the greatest number of subjects reaching an ACC count of zero.

Although not mentioned in EYEG's data announcement, one potential factor that could relate to this seeming counter-dose effect is that the higher dose cohort (i.e. 14mA-min) in the December data was treated on day 0 pre-operatively while the lower dose cohort (i.e. 4.5mA-min) was treated post-operatively on day 0. Treating pre-operatively was found to be problematic in EYEG's earlier cataract surgery (completed in 2013) study as the surgical procedure washed out the drug, thereby eliminating any potential therapeutic benefit. This "wash-out" effect is what prompted the change in trial design to where EGP-437 is administered immediately following surgery.

We characterize this data as highly promising given that it provides additional evidence of a positive treatment response to EGP-437. Assuming positive results from the ongoing phase IIb study, a subsequent single phase III study is expected to be sufficient to support an FDA filing. If all goes well, an FDA filing for a post-cataract surgery indication (reduction of pain/inflammation) could be made sometime next year. The recent licensing agreement with Valeant should aid in funding development.

				ACC Count of Zero at Day		
Date	**N =**	**EGP-437 Dose**	**Days Dosed**	**14**	**28**	**Additional Outcomes**
8/1/2016	10	9mA-min	0,1,2, (7)*	N/A	N/A	Subjects in the 14MA-min on days 0,1 and 4 showed greatest reduction in ACC count. All patients receiving EGP-437 iontophoretic treatment experienced reduction in pain at all time points with 90% having no pain at day 1, increasing to 100% on day 14.
	10	9mA-min	0,1,4, (7)*	N/A	N/A	
	10	14mA-min	0,1,2, (7)*	N/A	N/A	
	10	14mA-min	0,1,4, (7)*	40%	88%	
12/5/2016	10	4.5mA-min	0 post-op,1,4, (7)*	30%	80%	A positive response, as determined by reduction in ACC count, was observed in both EGP-437 treatment arms with 4.5mA-min (3.0 ma for 1.5 mins) showing greatest response. 80% of patients in placebo cohort required rescue prior to Day 14 and only 10% had ACC of zero at Day 28. All EGP-437 patients experienced less pain at all time points and 70% had pain score of zero by Day 1 whereas only 10% of placebo patients had pain score of zero at Day 1.
	10	14mA-min	0 pre-op,1,4, (7)*	N/A	N/A	
	10	Placebo 14mA	0 post-op,1,4, (7)*	N/A	10%	
		(7)* = optional dosing on day 7				
		N/A = change in ACC not disclosed				

EGP-437: Anterior Uveitis

While EYEG has not provided an update on the anterior uveitis (or macular edema) studies in the last several of months, they do note in their recent public filings and PRs that their phase III anterior uveitis clinical trial continues to enroll patients. Most recent guidance includes for topline data to be available in Q2 2018 (although this timeline continues to be pushed back). If all goes well EYEG now believes they may be in a position to make an NDA filing for this indication in 2H 2018. Below is a refresher of the ongoing phase III study.

New, Pivotal Phase III Study..
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 (see Appendix for development background), will be sufficient to support an 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). Study details are listed on clinicaltrials.gov, trial ID NCT02517619

Patients are 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. The latest update on clinicaltrials.gov, on 7/26/17, lists anticipated primary completion date (i.e. final data collection) and estimated study completion date of December 2017 and February 2018, respectively. While EYEG has not provided an update on this study in the last several months, they do note in their Q3 10-Q (filed November 11, 2017) that it continues to enroll patients and they hope to have top-line data sometime in Q2 2018. If all goes well EYEG thinks they may be in a position to make an NDA filing for this indication in 2H 2018.

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 an 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."[1] 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.

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

CMHA-S: Ocular Bandage Gel (OBG) Positive Initial Clinical Data, 2nd Pilot Study Could Initiate Q2 2017

In late January 2017 EyeGate announced encouraging top-line results of its human pilot study of its Ocular Bandage Gel (OBG). While the study was small, results indicate that OBG may be associated with faster corneal healing following eye surgery as compared to standard of care. We view this as meaningfully positive as it sets the stage to move OBG into a second pilot study – assuming IDE approval, could kick off in Q4. In May 2017 EYEG submitted an IDE application to FDA. They subsequently announced that the FDA provided feedback in June and that they expect to refile the IDE (status of resubmission of the IDE was not provided in the Q3 10-Q).

As a reminder, OBG is the lead CMHA-S candidate which came from the Jade Therapeutics acquisition and is being developed for corneal repair indications. Given the strong safety profile of the compound and expected (relatively streamlined) de novo 510(k) FDA pathway (in November 2016 FDA confirmed de novo 510(k) is an appropriate pathway for OBG to pursue in seeking U.S. regulatory clearance), we think OBG may represent one of EYEG's most near-term commercialization opportunities. See our Appendix for more background on the compound and the Jade acquisition.

The pilot study compared OBG to artificial tears with bandage contact lens (BCL) in patients undergoing bilateral photorefractive keratectomy ("PRK"). PRK is a type of vision-correction laser eye surgery - recovery from which includes regrowth of the epithelium (i.e. thin outer layer of the cornea).

Ocular Bandage Gel photoreactive keratectomy pilot study

- Objective: evaluate safety and performance of OBG eye drop administered 4x/day for 14 days with or without a BCL as compared to artificial tears and a BCL in healing of corneal epithelial defects
- Primary efficacy endpoint: complete wound closure by Day 3
- Design: prospective, randomized, controlled study in up to 39 subjects undergoing bilateral PRK surgery. Subjects randomized to one of three cohorts;
  - Arm 1 (n=12): EyeGate Ocular Bandage Gel 4x/day for 2 weeks after surgery without a BCL
  - Arm 2 (n=14): EyeGate Ocular Bandage Gel 4x/day for 2 weeks after surgery in combination with a BCL
  - Arm 3 (n=13): Artificial tears 4x/day and BCL

Topline results of the pilot study, which was the first in-human study of OBG, showed a greater proportion of OBG-treated patients versus those treated with standard of care met the **primary endpoint** of complete wound closure by Day 3. Top-line results were initially announced in January but in EYEG's 2016 10-K (filed Feb 23, 2017) additional data was provided. The updated data showed that 10 of the 12 (83%) patients treated with OBG alone (i.e. no BCL) met the primary endpoint, compared to 9 of the 14 (64.3%) OBG+BCL patients and just 7 of the 13 (53.8%) artificial tears+BCL patients.

Remaining wound surface area on Days 1 (24 hours following surgery) and 3 were also assessed and similarly favored the OBG-alone cohort which had an average wound size of just 18.5mm on Day 1 and 0.02mm on Day 3. This compares to 39.5mm and 0.37mm in the SOC patients at Days 1 and 3, respectively.

	Treatment	Day 3 Wound Closure %	Surface Area Day 1	Surface Area Day 3
Arm 1 (n=12)	OBG	83.3%	18.5mm	0.02mm
Arm 2 (n=14)	OBG + BCL	64.3%	40.7mm	0.10mm
Arm 3 (n=13)	SOC*	53.8%	39.5mm	0.37mm
Delta favoring OBG		39.4%	53.2%	94.4%

* standard-of-care: artificial tears w / BCL

While specifics were not provided relative to adverse events, EYEG did note in their PR that the study demonstrated safety and tolerability.

Given the positive results of the pilot study, EYEG plans to move into a second pilot study. We look forward to hearing details about the planned design and size of this study and note that given the de-risked nature of OBG, if efficacy is confirmed in this follow-up study, we think the likelihood of eventual commercialization could at that point be reasonably high. We do note, however, that EYEG has indicated that they do expect that an eventual regulatory filing will need to be supported by a pivotal study which would follow this second pilot study. Assuming success of the pilot and eventual pivotal studies, EYEG thinks they could make a De Novo 510(k) and CE Mark filing in Q4 2018 and launch sometime in 2019.

We also think that, assuming continued success in the PRK/ re-epithelialization studies, that CMHA-S programs could reasonably be expanded to include other indications given its safety profile and potential broad applications related to corneal wound healing. And as a reminder, in addition to Ocular Bandage Gel, Jade had already initiated development programs for CMHA-S in other applications including as an ocular surface shield and for treatment of bacterial keratitis – both of which have been funded by federal grants.

VALUATION

Our model incorporates the following assumptions:

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
- EYEG begins to book revenue related to AU milestones in 2018
- Receipt of FDA approval/clearance and launch in 2019 or 2020 and receipt of regulatory milestones as well as additional development milestones up until then
- $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 2020, mid-single digit penetration by 2023/2024 and 10% in 2026/2027 (the out-year in our 10-yr DCF model)

Cataract Surgery Indication:
- Following the announcement that Valeant will license rights for the cataract surgery indication we moved our probability of successful FDA approval/clearance and launch for cataract surgery indication up from 15% to 30%. All modeled milestones and royalties related to cataract surgery are initially discounted by 70% to account for risk of regulatory or commercialization failure
- As we had noted in prior updates, we felt that the cataract surgery could be the indication which the risk discount could be reduced the most significantly in the near term. Additional positive clinical data could prompt another reduction to the haircut
- Receipt of development milestones began in 2017
- Receipt of FDA approval/clearance and launch in 2019 or 2020 and receipt of regulatory milestones as well as additional development milestones up until then
- $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 2019/2020, mid-single digit penetration by 2022/2023 and 15% in 2026/2027

Jade's Pipeline
- 50% probability of successful FDA approval/clearance of OBG
- Out-licenses to major ophthalmology-focused company such as Allergan, Novartis or Bausch+Lomb for 20% of net revenues
- U.S. launch in 2019, single digit penetration through 2022/2023
- Annual U.S. market for initial indication of ~$125M
- Currently do not model other indications for OBG or for other of Jade's candidates. This will be updated with news flow

DCF Currently Values EYEG at $5.00/Share, Progression Through Clinicals Should Push Value Higher…

The slight delays to the EGP-437 AU program as well as to refiling of the IDE for OBG have resulted in correspondingly incremental delays to our forecasted initial revenue contribution. 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 $5.00/share (updated from $5.50/share). While our $5.00/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.

FINANCIAL MODEL

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

	2016 A	Q1A	Q2A	Q3A	Q4E	2017 E	2018 E	2019 E
Milestones & Royalties	$0	$0	$0	$0	$0	$0	$6,980	$8,394
Collaboration Revenue (Jade, Gov't grants)	$669	$185	$148	$75	$0	$408	$0	$0
Total Revenues	$669.2	$184.5	$148.3	$74.7	$0.0	$407.5	$6,979.8	$8,393.6
YOY Growth	-	-	-36.8%	-72.8%	-100.0%	-39.1%	1612.8%	20.3%
Cost of Revenues	$0.0	$0.0	$0.0	$0.0	$0.0	$0.00	$0.0	$0.0
Gross Income	$669.2	$184.5	$148.3	$74.7	$0.0	$407.5	$6,979.8	$8,393.6
Gross Margin	-	-	-	-	-	-	-	-
R&D	$8,422.5	$1,815.0	$2,262.2	$3,176.0	$3,262.0	$10,515.2	$13,105.0	$11,339.0
% R&D	1258.5%	983.6%	1525.5%	4251.9%	#DIV/0!	2580.3%	187.8%	135.1%
SG&A	$5,593.6	$1,289.1	$1,212.9	$1,038.8	$1,248.0	$4,788.9	$6,216.0	$6,958.0
% SG&A	835.8%	698.6%	817.9%	1390.7%	#DIV/0!	1175.1%	89.1%	82.9%
Operating Income	($13,346.8)	($2,919.6)	($3,326.8)	($4,140.1)	($4,510.0)	($14,896.5)	($12,341.2)	($9,903.4)
Operating Margin	-1994.3%	-1582.2%	-2243.4%	-5542.6%	#DIV/0!	-3655.4%	-176.8%	-118.0%
Total, other income (exp)	$3.4	($0.0)	($0.1)	($0.3)	$0.0	($0.4)	$0.0	$0.0
Pre-Tax Income	($13,343.4)	($2,919.7)	($3,326.9)	($4,140.4)	($4,510.0)	($14,896.9)	($12,341.2)	($9,903.4)
Taxes	$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%
Net Income	($13,343.4)	($2,919.7)	($3,326.9)	($4,140.4)	($4,510.0)	($14,896.9)	($12,341.2)	($9,903.4)
YOY Growth	-	-	-	-	-	-	-	-19.8%
Net Margin	-	-	-	-	-	-	-	-
EPS	($1.51)	($0.28)	($0.28)	($0.24)	($0.26)	($1.05)	($0.61)	($0.42)
YOY Growth	-44.0%	-10.3%	-39.6%	-33.9%	-30.3%	-30.7%	-41.8%	-30.9%
Diluted Shares O/S	8,834	10,456	12,067	17,205	17,205	14,233	20,250	23,500

Brian Marckx, CFA

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APPENDIX

ANTERIOR UVEITIS

Anterior Uveitis Development Background:

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^2, 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

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

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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 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

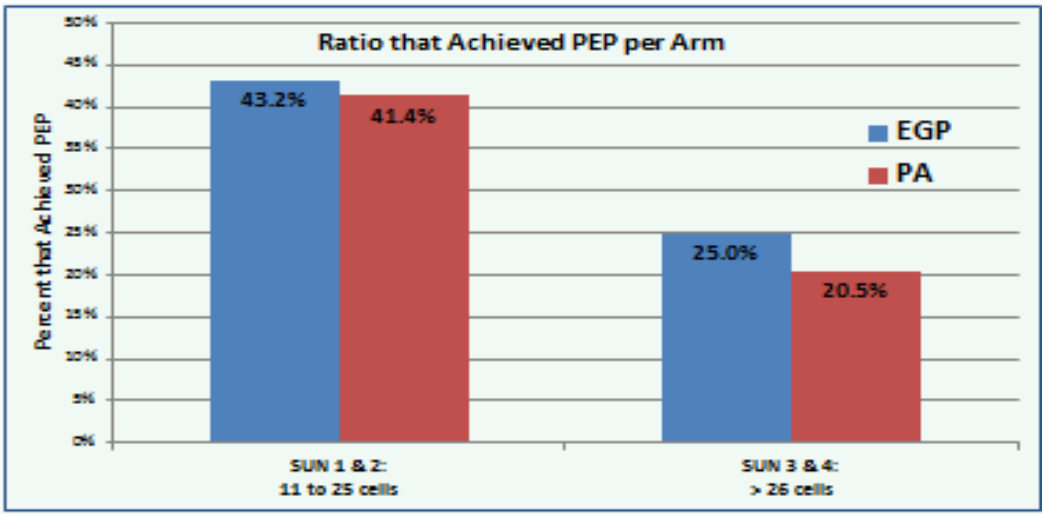
Results: (per information contained in company public filings) While response rates were similar in both the ITT and PP populations, non-inferiority (as pre-defined in the study protocol) was just missed.

- 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;

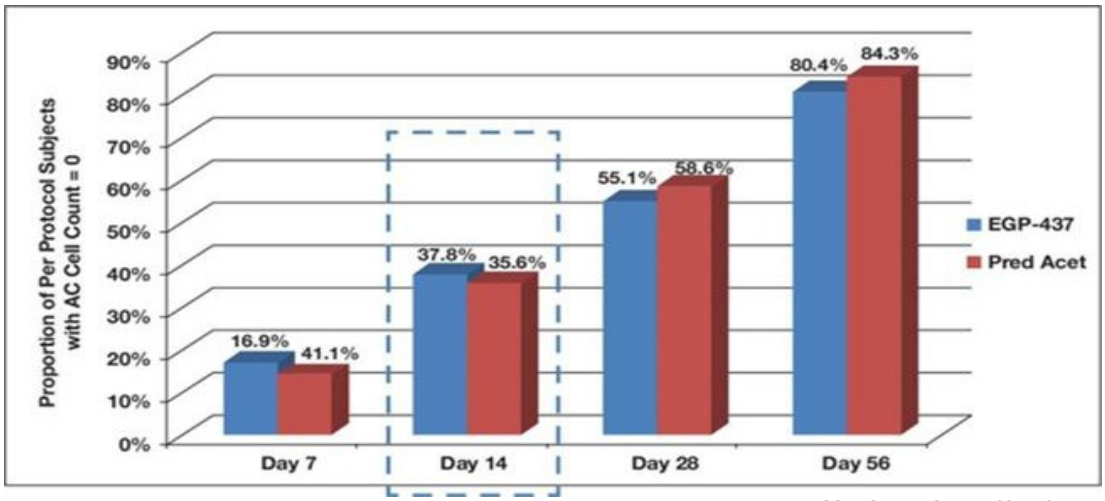
- Greater Proportion of High ACC Count Patients in EGP-437 Arm: a higher proportion of EGP-437 patients (52 of 96, or 54%) had baseline ACC counts greater than 25 as compared to those in the PA arm (40 of 97, or 41%). A post-hoc analysis was done on these high ACC count (i.e. potentially harder to treat)

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

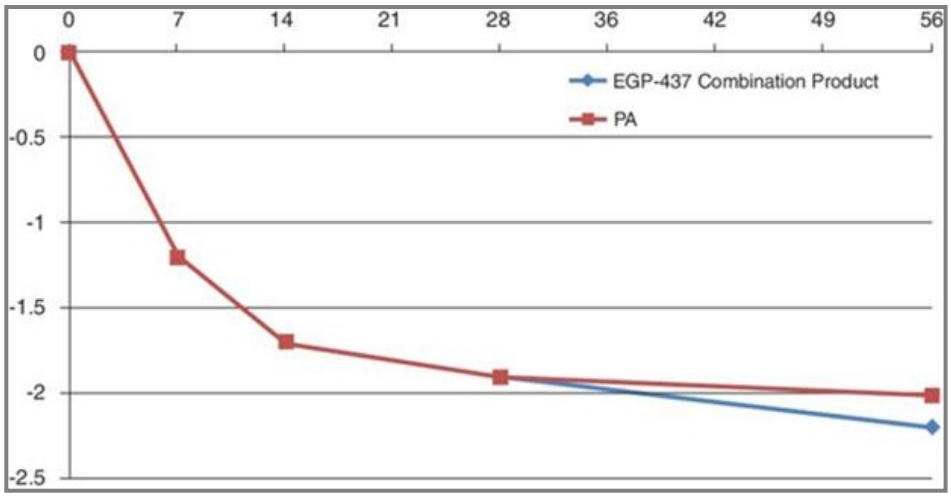
- Similar Complete Response Timeframes: "Time to anterior chamber cell count and score of zero" was a secondary endpoint. Despite the baseline difference in severity of disease (as measured by ACC count), the time to reach ACC count of zero was generally similar in both arms throughout the study (chart 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

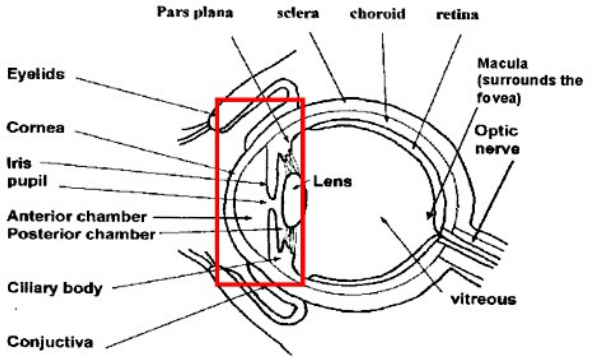
Key Takeaways:

- 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

Non-Infectious Anterior Uveitis Background

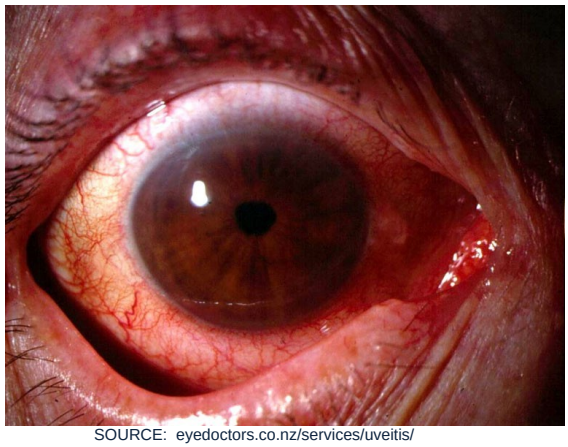
Uveitis is a generic term used to describe inflammation of the uvea. It can occur either in isolation or be the result of an underlying medical condition in other parts of the body. The uvea is the middle layer of the eye, below the white of the eye, and consists of the iris (colored portion), choroid 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



Eye Structures Involved in "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

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,

[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.

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.

Valeant Licensing Agreement for EGP-437 in Anterior Uveitis:

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. 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.

Under the agreement, as EYEG makes certain predetermined development progress they receive additional progress payments from Valeant. The upfront and progress payments are initially booked as deferred revenue on EYEG's balance sheet and will be recognize these as revenue as respective milestones are completed.

CMHA-S

Jade Therapeutics

In March 2016 EyeGate announced the acquisition of 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 naturally

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

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 paid up to $300k of Jade's liabilities
- EYEG issued ~766k common shares to Jade, 90% which were issued at closing with the other 10% to be issued 18 months later
- An additional $2.2M in cash is payable upon receiving FDA approval of a Jade product candidate

EYEG assumed Jade's Salt Lake City based R&D facility. Jade's co-founders as well as its research team also migrated over to EyeGate. This includes their Chief Medical Officer (who assumed 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 was 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 bolts on several potential ophthalmic indications at a reasonable purchase price. And we think EyeGate OBG 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. 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 an identical composition 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. As such, this provides an almost unprecedented level of confidence in the potential for positive results of EYEG's upcoming clinical studies.

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.[8] 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).

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 with EyeGate Ocular Bandage Gel', or OBG (initially JDE-003) for populations such as;

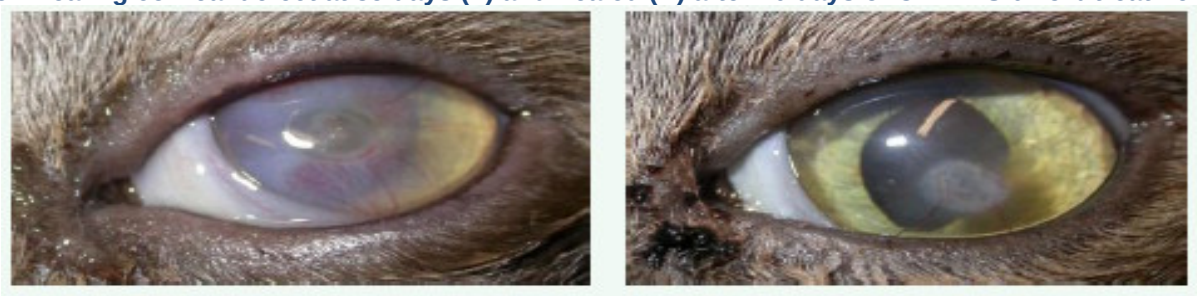
- Persistent corneal epithelial defects (PCED)
- Following photoreactive keratectomy (or PRK, which is similar to LASIK)

[8] 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.

- 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[9]



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



De Novo 510(k) Pathway Confirmed…
In November 2016 EYEG announced that, following a pre-submission meeting with FDA, that the agency confirmed de novo 510(k) was an appropriate pathway for OBG to pursue in seeking U.S. regulatory clearance. While it had been our expectation that a medical device pathway would be deemed appropriate given that a similar cross-linked formulation had already followed a 510(k) route towards FDA clearance (for dermal wound management), we still view this as positive news as it confirms that EYEG will avoid having to pursue PMA. It also speaks to the validated safety profile of CMHA-S.

De Novo 510(k) was created by FDA in an effort to help streamline approval of novel, low-to-moderate risk medical devices. Prior to de novo the only route for new devices and for which there was not an acceptable predicate, regardless of their risk profile, was the relatively long, arduous and costly PMA process. The other benefit of De Novo is an expected shorter FDA review time following submission FDA s stated goal for De Novo submissions is to make a determination within 120 days while their goal with PMA is 180 days.

For reference, 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 or gel. This, combined with the strong safety data to-date, may play in EYEG's favor.

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.

[9] Jade Therapeutics, Eyegate Pharmaceuticals

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.

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