Zacks Small-Cap Research

November 3, 2015
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Resverlogix Corp. (RVX - TSX)

RVX: Phase 3 BETonMACE Trial of Apabetalone Begins Patient Recruitment…

Current Recommendation	**Buy**
Prior Recommendation	Hold
Date of Last Change	11/03/2015
Current Price (11/03/15)	$1.58
Target Price	**$3.25**

UPDATE

Resverlogix Corp. (RVX.TO) recently began recruiting participants for the Phase 3 BETonMACE trial of apabetalone (RVX-208) in high-risk CVD patients with diabetes, and we expect the first patient should be dosed at some point during the fourth quarter of calendar year 2015. We believe the trial will take about 3 years to complete. This puts the top-line data in 2018.

Resverlogix also presented additional data regarding the proposed multimodal mechanism of action of apabetalone in achieving Major Cardiac Adverse Event (MACE) reduction at the European Society of Cardiology (ESC) Congress 2015. The company also recently announced the commencement of an Orphan Disease Program to study apabetalone in Complement Mediated Diseases, and plans to begin a Phase 2 proof-of-concept pilot study in a small group of patients with Paroxysmal Nocturnal Hemoglobinuria (PNH) in 2016.

At the current price, we view Resverlogix shares as undervalued, and as providing long-term upside potential. We are increasing our price target to $3.25 per share, and rate the stock a 'Buy'.

SUMMARY DATA

52-Week High	**3.13**
52-Week Low	**0.41**
One-Year Return (%)	**162.90**
Beta	**4.22**
Average Daily Volume (sh)	**32,829**
Shares Outstanding (mil)	**105.1**
Market Capitalization ($mil)	**166.0**
Short Interest Ratio (days)	**N/A**
Institutional Ownership (%)	**N/A**
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 2015 Estimate	**N/A**
P/E using 2016 Estimate	**N/A**

Risk Level	**Above Average**
Type of Stock	**Small-Growth**
Industry	**Med-Biomed/Gene**

ZACKS ESTIMATES

Revenue

(In millions of $)

	Q1 (Jul)	Q2 (Oct)	Q3 (Jan)	Q4 (Apr)	Year (Apr)
2014	0 A	0 A	0 A	0 A	0 A
2015	0 A	0 A	0 A	0 A	0 A
2016	0 A	0 E	0 E	0 E	0 E
2017					0 E

Earnings per Share

(EPS is operating earnings before non-recurring items)

	Q1 (Jul)	Q2 (Oct)	Q3 (Jan)	Q4 (Apr)	Year (Apr)
2014	$0.55 A	-$0.02 A	$0.19 A	$0.00 A	$0.70 A
2015	$0.08 A	-$0.04 A	-$0.02 A	-$0.23 A	-$0.21 A
2016	$0.03 A	-$0.03 E	-$0.02 E	-$0.03 E	-$0.06 E
2017					-$0.14 E

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WHAT'S NEW

Business Update

On October 26, 2015, Resverlogix Corp. (TSX: RVX) announced commencement of the Phase 3 BETonMACE trial of apabetalone (RVX-208) in high-risk patients with coronary artery disease (CAD) and type 2 diabetes mellitus (DM). Additionally, Resverlogix recently provided a Research and Development Update on apabetalone in New York City. The presentation included analyses of diabetes and chronic kidney disease (CKD) as they relate to cardiovascular disease by BETonMACE clinical steering members. We also learned more about some recent findings from ongoing mechanistic studies focused on cardiovascular risk pathways and apabetalone's potential in reducing MACE. We will proceed to review apabetalone and share some details from the clinical progress update below.

Diabetes & Cardiovascular Disease

According to the American Diabetes Association, 29.1 million Americans, or 9.3% of the population, had diabetes in 2012. In 2012, 86 million Americans over the age of 20 had pre-diabetes, which is up from 79 million in 2010. In 2012, total costs of diagnosed diabetes in the U.S. were $245 billion, with $176 billion related to direct medical costs, and $69 billion in reduced productivity. The International Diabetes Federation estimates that there are 387 million individuals worldwide with diabetes, and this number is projected to grow to over 470 million by 2035. These statistics show that diabetes remains a huge public health challenge.

Diabetes mellitus is a group of metabolic diseases characterized by high blood glucose levels that result from defects in the body's ability to produce and/or respond to insulin. The defect usually stems from a dysfunction of the pancreas to either produce insulin, or because cells show decreased sensitivity to the insulin that is produced. The primary manifestation of the disease, high blood glucose levels, has far-reaching implications and classical symptoms, including polyuria (frequent urination), polydipsia (increased thirst) and polyphagia (increased hunger).

Diabetes is classified into three broad categories: type 1 diabetes, type 2 diabetes, and gestational diabetes. A fourth category, called pre-diabetes, is also considered important from a clinical perspective, and may be the largest patient population as indicated by the statistics above.

Type 2 Diabetes: Type 2 diabetes, once called non-insulin dependent or adult-onset diabetes, is the most common form of diabetes and accounts for approximately 90% of all diabetics worldwide. Type 2 diabetes is a metabolic disorder that is characterized by high blood glucose in the context of insulin resistance and therefore relative insulin deficiency at the level of the cell. This is in contrast to type 1 diabetes, in which there is an absolute insulin deficiency in the body due to destruction of islet cells in the pancreas. Furthermore, unlike type 1, obesity is thought to be the primary cause of insulin resistance and type 2 diabetes in people who are genetically predisposed to the disease. However, the symptoms of uncontrolled type 2 diabetes are similar, in polyuria (frequent urination), polydipsia (increased thirst), and polyphagia (increased hunger), as are the potential long term complications to nerves and blood vessels (i.e. eye disease, kidney disease, cardiovascular disease, and limb ulcers/amputations).

Type 1 Diabetes: Type 1 diabetes is usually diagnosed in children and young adults, and was previously known as juvenile onset diabetes. In type 1 diabetes, the body does not produce insulin, most commonly the result of the body's own immune system destroying the insulin-producing cells of the pancreas called beta cells.

Normally, the hormone insulin is secreted by the pancreas. When you eat a meal, carbohydrates (sugars) from food stimulate the pancreas to release insulin. Generally speaking, the amount that is released is proportional to the amount of carbohydrates in that particular meal. The overall nutrient composition of the meal also impacts insulin secretion by affecting the rate that glucose is absorbed into the body. The main role of insulin is to help move certain nutrients, mainly sugar, into the cells of the body's tissues. Cells use sugars and other nutrients from meals as a source of energy to function. In non-diabetic individuals, the pancreas is able to appropriately increase or decrease the secretion of insulin and other hormones in response to the blood glucose level to maintain a relatively constant amount of sugar in the blood. Hence, as insulin transports sugar into the cells and the glucose load diminishes, the pancreas lowers the amount of insulin secreted so that low blood sugar, called hypoglycemia, does not develop. Unfortunately, the destruction of the pancreatic beta cells that occurs in patients with type 1 diabetes disrupts this process. In people with type 1 diabetes, insulin is not available to transport sugar into the cells. The

result is that sugar builds up in the blood. A high blood sugar level is called hyperglycemia. Since sugar is not able to enter cells effectively, the cells of the body are starved for nutrients. Thus, other systems in the body must provide energy for important bodily functions.

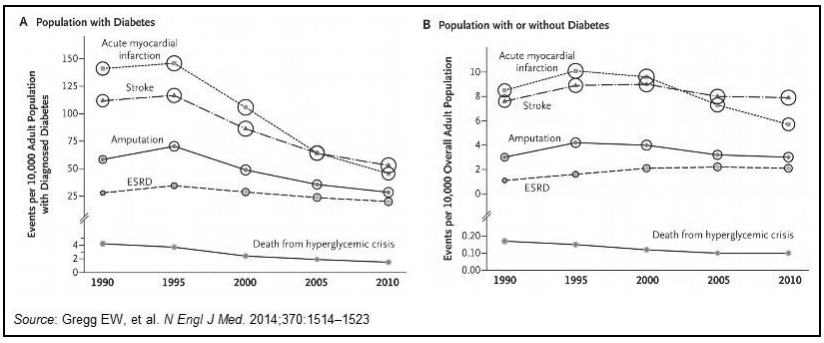
Hyperglycemia can cause dehydration due to increased urination as the kidneys are unable to handle the increased amounts of glucose in the body. This may result in weight loss due to the frequent urination (caloric wasting). In the absence of insulin, the inability of the body to take up sugar (calories) and turn it into energy may further contribute to malnutrition and weight loss. If the insulin deficiency reaches a critical point, the body breaks down fat cells for energy in the absence of the ability to turn sugar into energy. A byproduct of this metabolic pathway is the production of acidic molecules called ketones, which can be detected in the body. The production of sugar by the liver in response to these ketones and to the perception of glucose starvation leads to further hyperglycemia and. only compounds the problem. The combination of dehydration, frequent urination, and acid build-up in the body is known as Diabetic ketoacidosis (DKA). DKA is the severe manifestation of insulin deficiency but is a relatively common occurrence and cause for acute symptoms, including hospitalization, in type 1 diabetes.

Over time, hyperglycemia and ketoacidosis can create damage to the nerves and small blood vessels of the eyes, kidneys, and heart, leading to several important health complications. According to the American Diabetes Association, eye problems occur in about 80% of adults with type 1 diabetes. Kidney damage is also common, occurring in about 20-30% of type 1 diabetics over time. In the U.S., diabetes is the leading cause of blindness, and kidney failure requiring renal replacement therapy (e.g. dialysis).

Diabetics are also predisposed to atherosclerosis and hypertension (high blood pressure), two major causes of heart attack and stroke. Poor blood circulation due to hardening of the arteries and nerve damage due to high blood glucose levels causes problems in the feet. This can lead to increased risk of injury and decreased ability to heal open sores and wounds, which in turn significantly raises the risk of diabetic foot ulcers and amputations.

The Link between Diabetes and Cardiovascular Disease

Cardiovascular disease is a major complication of diabetes, and is the leading cause of premature death among diabetics. It is estimated that 65% of people with diabetes die from heart disease and stroke, and adults with diabetes are 2 to 4 times more likely to have heart disease or suffer a stroke than people without diabetes. Elevated blood glucose in adults with diabetes increases the risk for heart attack, stroke, angina, and coronary artery disease, and individuals with type 2 diabetes also have high rates of high blood pressure, lipid problems, and obesity, which also contributes to a higher risk for cardiovascular disease. Diabetics that smoke have a doubled risk of CVD.



Source: Gregg EW, et al. *N Engl J Med.* 2014;370:1514–1523

According to the American Diabetes Association, some of the complications/co-morbid conditions associated with diabetes include:

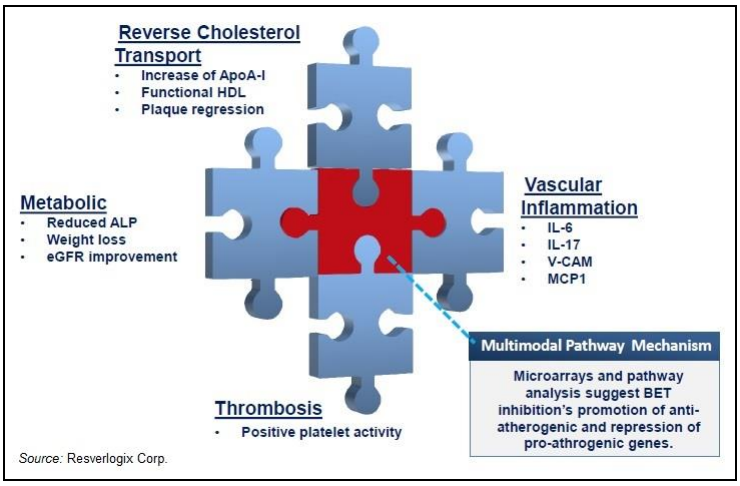
- **Hypertension**: In 2009–2012, 71% of adults aged 18 years or older with diagnosed diabetes had blood pressure greater than or equal to 140/90 mm Hg or used prescription drugs to lower high blood pressure.
- **Dyslipidemia**: In 2009–2012, 65% of adults aged 18 years or older with diagnosed diabetes had blood LDL cholesterol greater than or equal to 100 mg/dl or used cholesterol-lowering medications.
- **CVD Death Rates**: In 2003–2006, cardiovascular disease death rates were about 1.7 times higher among adults aged 18 years or older with diagnosed diabetes than among adults without diagnosed diabetes after adjusting for population age differences.

- **Heart Attack Rates**: In 2010, hospitalization rates for heart attack were 1.8 times higher among adults aged 20 years or older with diagnosed diabetes than among adults without diagnosed diabetes after adjusting for population age differences.
- **Stroke**: In 2010, hospitalization rates for stroke were 1.5 times higher among adults with diagnosed diabetes aged 20 years or older compared to those without diagnosed diabetes after adjusting for population age differences.
- **Kidney Disease**: Diabetes was listed as the primary cause of kidney failure in 44% of all new cases in 2011. In 2011, approximately 50k people of all ages began treatment for kidney failure due to diabetes. In 2011, a total of 229k people of all ages with kidney failure due to diabetes were living on chronic dialysis or with a kidney transplant.

Although the incidence rates of type 2 diabetes related cardiovascular complications have declined due to improvements in standard of care, rates still remain higher than in adults without diabetes, and the rising incidence of type 2 diabetes is expected to increase the overall burden. Therefore, there is a need for new therapeutics that target all aspects of the pathophysiology of cardiovascular disease in diabetes, and this is an area where Resverlogix believes apabetalone (RVX-208) has potential.

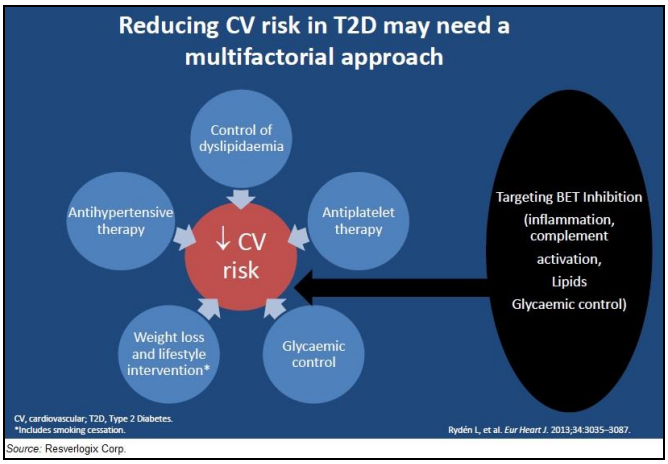
A Review of Apabetalone (RVX-208)

Resverlogix's lead candidate, apabetalone (RVX-208), is a first-in-class small molecule that inhibits BET proteins and has the potential to impact cardiovascular disease, neurodegenerative diseases, diabetes, cancer, and autoimmune diseases. By targeting BET bromodomains, apabetalone has a multimodal approach and impacts several key biological processes that play a role in vascular disease risk. First off, when apabetalone binds to the BET protein, it triggers a cascade of events. Apabetalone induces ApoA-I mRNA production in human hepatocyte cell lines leading to an increase in ApoA-I gene transcription and eventually an increase in endogenous ApoA-I protein production (McLure *et al*., 2013). This results in the subsequent synthesis of new HDL particles. In addition to ApoA-I/HDL production, apabetalone has been proposed to act on vascular inflammation processes as well as metabolic and thrombotic mediators (*below*).



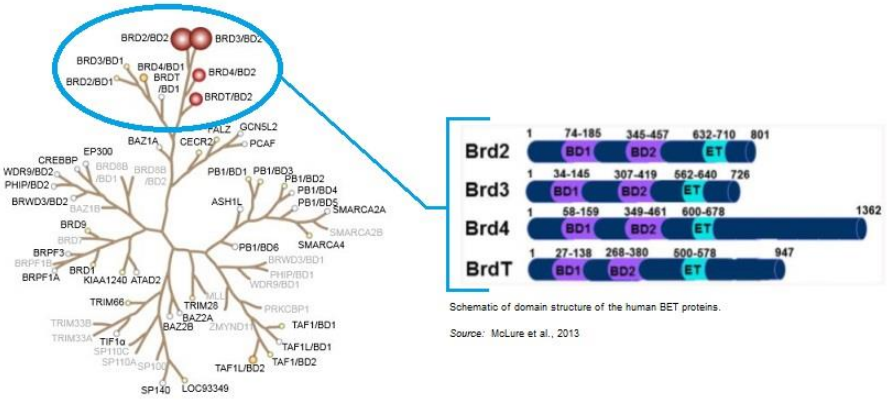
Currently, apabetalone is the first selective BET bromodomain inhibitor in clinical trials for high-risk vascular disease with patent life extending to 2033. Resverlogix is the first to test apabetalone in the reduction of major adverse cardiac events (MACE) in diabetic and chronic kidney disease (CKD) patients. Analysis of prior Phase 2 clinical trials data ("ASSURE" and "SUSTAIN") has shown that apabetalone reduces coronary atherosclerosis and major adverse cardiac events in patients with CVD who also have a low level of HDL and elevated CRP, and other select populations with unmet medical need. We have discussed the data from "ASSURE" and "SUSTAIN" in prior reports, and would like reiterate that data have been presented at the American College of Cardiology (ACC) 2014 (Puri *et al.*, 2014), the European Society of Cardiology (ESC) Congress 2014 and the ESC Congress 2015.

Because of the link between diabetes and CVD, there appears to be a need for novel therapies that target all aspects of the pathophysiology of cardiovascular disease in diabetes, as we discussed above. Resverlogix believes that the multimodal mechanism of action of apabetalone could potentially reduce cardiovascular risk through BET inhibition for high-risk patients with diabetes (*below*).



Apabetalone is a BET antagonist

Apabetalone is a first-in-class, orally active small molecule that acts on epigenetics via selective inhibition of BET proteins. Apabetalone works by binding one of two specialized areas of BET proteins known as bromodomains (BD1 and BD2). Both of these bromodomains can recognize and bind an acetylated lysine, which is a modified amino acid found on histones bound to DNA. This process is referred to as "reading", which refers to the protein-to-protein interaction of a BET protein finding and binding an acetylated lysine through the actions of the bromodomain. Apabetalone acts on BET proteins, specifically BRD4 with increased selectivity for BRD4-BD2 (*below*).



Major Adverse Cardiac Events (MACE)

Many scientists, key opinion leaders and physicians believe that of all the biomarkers that are analyzed for providing prognostic predictability for cardiovascular risk, Major Adverse Cardiac Event (MACE) is the most crucial. MACE refers to adverse events caused by cardiovascular disease (CVD) processes generally affecting the coronary arteries. MACE includes several key markers of cardiovascular risk including cardiovascular mortality, myocardial infarction, stroke, death, worsening angina, worsening of peripheral artery pain and ischemia, urgent revascularization procedures such as percutaneous stent procedures and coronary artery bypass grafting, as well as hospitalization for cardiac-related incidents. Payer groups and health systems carefully assess MACE when looking at the potential reimbursement of a novel CVD drug. It is the strongest outcome measure for providing prognostic predictability for CVD risk and efficacy and value of novel drugs in CVD.

According to the 2015 AHA Statistics report, an estimated 85.6 million American adults (greater than 1 in 3) have one or more types of CVD. Many of these CVD patients will have some type of MACE during or after they have been diagnosed with heart disease. On average, more than 2,150 Americans die of CVD daily, which is approximately 1 death every 40 seconds (Mozaffarian *et al*., 2015).

The term MACE (major adverse cardiac events) came into use in the mid-1900s in reference to complications related strictly to percutaneous coronary interventions (PCIs) in hospital settings (Hermans *et al*., 1993 and Keane *et al*., 1994). Although there is no standard definition of MACE, it has become the most commonly utilized end point in cardiovascular clinical research today, and is reported for both short and long-term outcomes involving various treatment regimens. MACE is used today as a composite of clinical events that typically include safety and effectiveness endpoints. Regulatory agencies focus on efficient reduction of three-point MACE (cardiovascular death, myocardial infarction, and stroke) for future reimbursement and value proposition. For instance, the FDA guidance document for therapies evaluating cardiovascular disease outcomes in type 2 diabetic patients states that MACE should include cardiovascular death, myocardial infarction, and stroke. Additionally, groups have asked the novel LDL modulators like the PCSK9 class that are designed to lower LDL for outcome studies based on MACE.

Clinical Overview of Apabetalone

Resverlogix has completed numerous clinical trials to date (*below*). Apabetalone has been tested in close to 1,000 patients in 12 countries, and clinical experience with apabetalone has demonstrated that BET inhibitors can be both safe and efficacious. Over the years, Resverlogix has gathered information from these studies and shifted focus to target patients with low HDL and diabetes with co-treatment of Apabetalone and rosuvastatin (Crestor®).

Summary of Apabetalone (RVX-208) Clinical Trials

Trial	Summary	Patients	Status	Initiated	Data Release
Phase 3	MACE Reduction BETonMACE	2400-4000	Enrolling Patients	1st patient expected to be dosed – Q4 2015	TBD
Phase 2	Paroxysmal Nocturnal Hemoglobinuria (PNH)	TBD	Pending	TBD	TBD
Phase 2b	Alzheimer's disease	45-60	Pending	TBD	TBD
Phase 2b	Pre-diabetes mellitus / effects of RVX-208 and ApoA-I production on glucose metabolism	20	Completed	Q4 2012	Q3 2014
Phase 2b ASSURE	26 week risk-stratified IVUS study in patients with low HDL	323	Completed	Q2 2011	Q2 2013
Phase 2b SUSTAIN	24 week single-dose safety, tolerability and efficacy in stable CVD patients with low HDL	176	Completed	Q3 2011	Q3 2012
Phase 2 ASSERT	12 week dose-ranging safety, tolerability and efficacy in stable CVD patient	299	Completed	Q4 2009	Q4 2010
Phase 1b/2a	28 day multiple dosing safety, tolerability and efficacy in healthy volunteers with low HDL	72	Completed	Q3 2008	Q3 2009
Phase 1 BE	Single dose bio-equivalency comparing capsule and tablet drug form	9	Completed	Q3 2009	N/A
Phase 1 BE	Single dose bio-equivalency	7	Completed	Q3 2009	Q4 2009
Phase 1a	First-in-man single ascending dose and 7-day multiple dosing	80	Completed	Q4 2007	Q1 2008

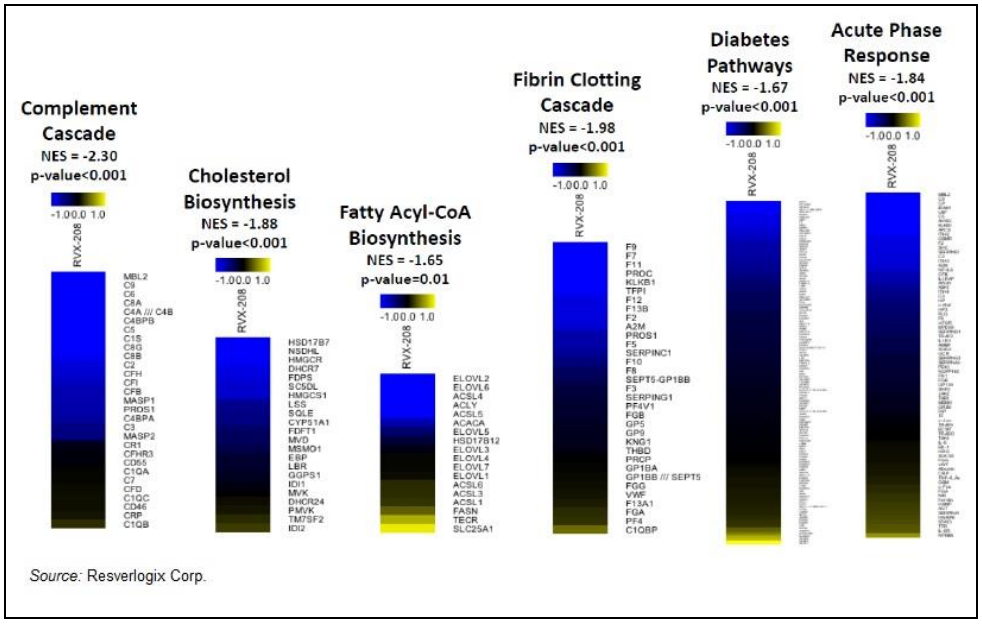
Source: Adapted from Resverlogix, Corp.

More on Apabetalone & Gene Expression…

Resverlogix presented additional data at the European Society of Cardiology (ESC) Congress 2015 in a poster presentation titled: "*RVX-208, an orally active BET inhibitor, lowers CVD risk by activities beyond raising ApoA-I/HDL*." Primary human hepatocytes and whole blood from healthy individuals were exposed to apabetalone and subsequent changes in gene expression were surveyed using micro-array technology. Plasma protein levels were measured to show dominant effects on biological pathways. Management believes that the treatment causes decreases in the expression of many genes involved in cholesterol synthesis, fatty acid synthesis, innate immunity and glucose processing which could benefit high-risk patients.

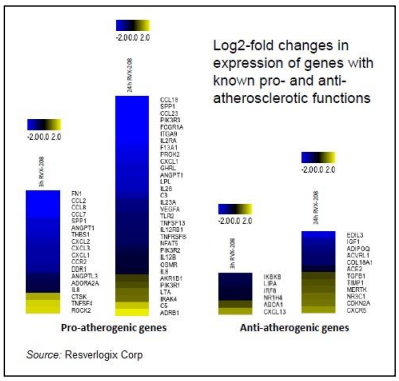
A heat map is a graphical representation of data and in this case, can portray the level of gene expression. The image below shows a heat map for various genes across six different pathways that Resverlogix has investigated, such as the complement cascade, cholesterol biosynthesis, and the coagulation cascade. The blue color indicates down regulation or "cooling down" of genes that are involved in the pathways, while yellow refers to upregulation of the genes after treatment with apabetalone. The heat map shows that apabetalone "cooled down" or attenuated

several pathways that are known to increase cardiovascular disease risk. For example, the complement cascade is an innate immune system pathway that involves a series of proteins that are made in the liver that work together most notably to kill microbial pathogens and recruit inflammatory cells. Resverlogix believes that apabetalone modulates this cascade and could be helpful in combating the inflammatory cells that are present at the site of atherosclerotic plaque build-up, and could also have a beneficial effect on MACE reduction. Resverlogix also pre-administered inflammatory mediators into cells prior to apabetalone administration, and saw decreases in these complement factors to basal levels or lower, which suggests that apabetalone could potentially work to reduce inflammation in a natural inflammatory setting. We believe the risk of infection when "cooling down" this pathway could be an issue in human subjects, but management stated that there was no impact on infection over the course of their studies and that to date, there have been no observable differences versus placebo in regards to increased infection rates. Resverlogix will monitor this moving forward but does not expect to see any increases in infection rates. We will need to keep this in mind when reviewing Phase 3 results.



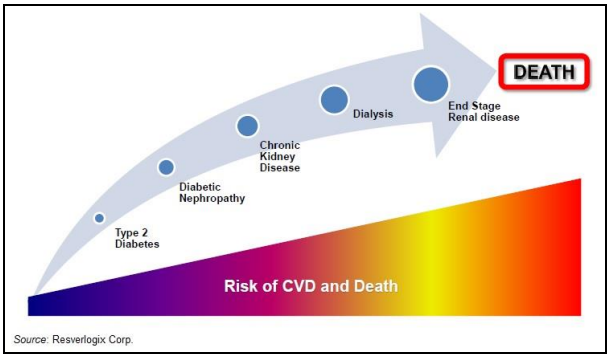
The poster showed that apabetalone decreased expression in 19 out of 26 genes that encoded components in the complement pathway, and similarly decreased expression in 20 out of 33 gene that encoded components in the coagulation cascade. Other results from the poster showed decreases ranging from 7-12% vs. baseline in complement (i.e. complement factor 3) and coagulation components. Resverlogix studied the coagulation pathway to study the effect of apabetalone on various factors that are required in the process of clot formation. In multiple donors, it was seen that clotting factors were cooled down in the liver in the primary human hepatocytes, which could potentially be beneficial for MACE reduction as well, however we believe that the risk of bleeding will need to be ruled out in the Phase 3 trial. As per management, there were no bleeding disorders observed in clinical trials following six months of treatment.

It was also noted that apabetalone lowered atherogenesis by downregulating pro-atherogenic genes while upregulating anti-atherogenic genes that control the recruitment of monocytes, migration and activation, macrophage function, inflammatory signaling and plaque stability (*right*). Resverlogix believes that the new data from both primary human hepatocytes and whole blood suggest an overall anti-atherosclerotic benefit of apabetalone that extends beyond its ApoA-I/HDL enhancing effects, and supports the multi-modal mechanism of action. Overall, we see this additional data as providing further insight into the multi-modal mechanism of action of apabetalone. It will be interesting to see if the proposed mechanism of action will translate to dramatic MACE reduction in the 2,400+ patients in the Phase 3 BETonMACE trial. We are looking forward to reviewing the data once it is available.



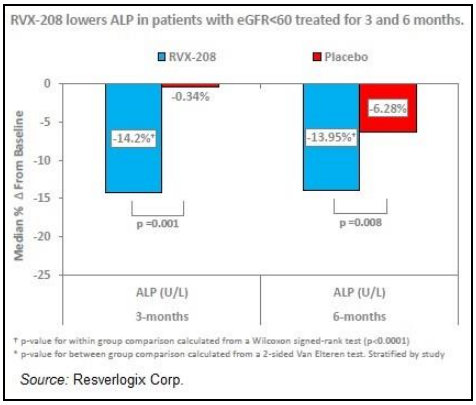
More on Chronic Kidney Disease & Alkaline Phosphatase…

In addition to focusing on type 2 diabetes patients, Resverlogix is also studying the effects of apabetalone on chronic kidney disease (CKD). According to the National Kidney Foundation, in Chronic Kidney Disease (CKD), the kidneys are damaged and kidney function is gradually lost over time. CKD is typically due to poorly controlled or uncontrolled diabetes, high blood pressure as well as other disorders. The kidneys are responsible for filtration of the blood and removal of waste products and excess fluid and sodium through the urine, as well as production of some hormones that help control blood pressure, the uptake of calcium, and red blood cell production. As the disease progresses, the kidneys gradually lose these functions, and waste products and fluid can build up, and complications such as high blood pressure, heart and vessel disease, anemia, nerve damage and bone disease can occur. Progression of the disease can lead to kidney failure and can require dialysis and/or kidney transplantation for survival. Approximately 26 million American adults have CKD, and heart disease is the major cause of death for individuals with the disease.



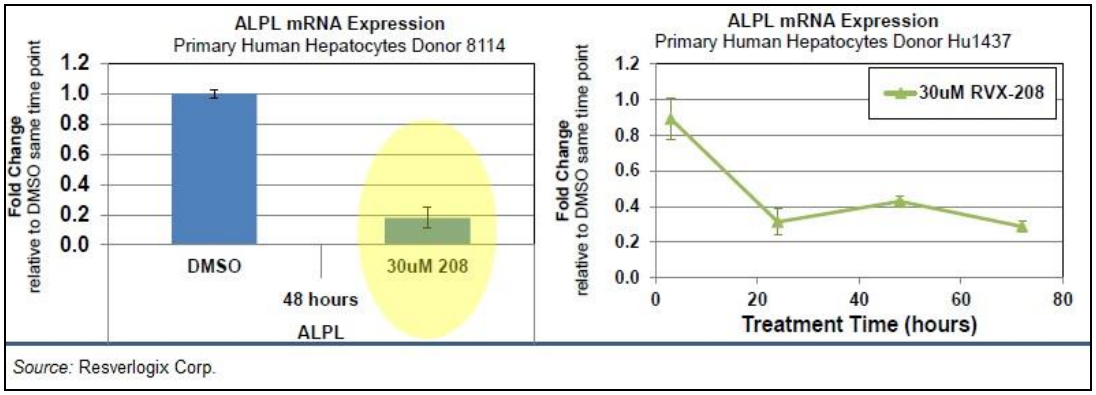
There are several studies over the last decade that have shown that higher levels of serum alkaline phosphatase (ALP) are associated with increased mortality in the general population and in survivors of myocardial infarction, and chronic kidney disease patients (Tonelli *et al*., 2009; Beddhu *et al*., 2009; Blayney *et al*., 2008; Kalantar-Zadeh *et al*., 2006; Lee *et al*., 2007; Regidor *et al*., 2008). Furthermore, a retrospective observational study of over 15,000 patients highlighted the link between elevated ALP and CVD risk in patients with diabetes (Krishnamurthy *et al*., 2011). Additionally, it has been proposed that serum ALP has an important role in calcification and has been used as a marker and therapeutic target of vascular calcification, cardiovascular diseases, or even mortality (Cheung *et al.*, 2013). Vascular calcification is thought to be a strong predictor of death in CKD patients.

ALP as a proposed risk marker for MACE in patients with diabetes and CKD is an area that Resverlogix continues to explore. Resverlogix has conducted pooled subpopulation analyses from the placebo controlled Phase 2b program in CVD in 81 patients (apabetalone n=58, placebo n=23) with CKD based on eGFR < 60 ml/min/1.73m^2, and the effect of apabetalone on renal parameters (changes from baseline for eGFR, ALP and creatinine) and lipid markers (ApoA-I, HDL) was further assessed at 3 and 6 months. The company believes that selective BET inhibition via apabetalone lowers serum alkaline phosphatase (ALP) (*below*), improves lipid parameters, lowers creatinine and appears to improve eGFR at 6 months, and these findings may have implications for patients with CKD and high cardiac risk.

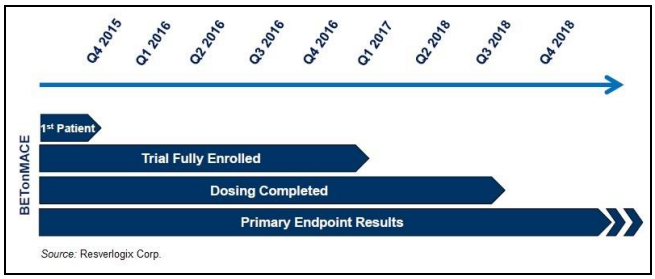


We believe that additional clinical trials in the target CKD population are warranted in order to better understand the findings from the pooled analyses, but would also like to point out that in studying primary human hepatocytes,

Resverlogix found that ALP expression was downregulated by apabetalone (*below*). Although the mechanism of ALP release into the circulation remains unclear, we believe that Resverlogix will continue to explore the relationship for apabetalone and ALP in recently commenced Phase 3 BETonMACE.



Commencement of Phase 3 BETonMACE



With regulatory confirmation from a European Regulatory Agency now in place, Resverlogix recently announced that apabetalone entered into the Phase 3 BETonMACE clinical trial. The trial is recruiting participants, and management believes that the first patient should be dosed at some point during the fourth quarter of calendar year 2015. As a reminder, the primary endpoint of the BETonMACE trial is designed to show a relative risk reduction of Major Adverse Cardiac Events (MACE) in high-risk cardiovascular type 2 diabetes mellitus patients with coronary artery disease. Resverlogix is incorporating input from Sweden, German and UK Regulatory Authorities for the trial. We expect the trial to take about 3 years to complete. This puts the top-line data in 2018, with the goal to file a new drug application (NDA) during the end of 2018 or early part of 2019. We believe the program will cost in the area of $30 million, but note that exact costs will depend on how many patients are ultimately enrolled since the trial is currently setup to be adaptive.

The main objective of the trial will be to confirm MACE reduction by apabetalone as seen in SUSTAIN and ASSURE pooled analysis and also expand safety assessment. The study will be in a larger prospective setting with high-risk patients that have diabetes mellitus and low HDL-C (< 40 mg/dL who are post events). Management also plans to further explore the potential impact that apabetalone may have on inflammation, the complement and coagulation pathways, as well as on platelet improvement in these high-risk patients in the Phase 3 trial.

Resverlogix believes that apabetalone is a BET inhibitor that has effects on pathways underlying CVD risk in high-risk patients. Reverse cholesterol transport, ApoA-I and HDL functionality are one part of the mechanism of action of apabetalone that the company will continue to look at over longer treatment durations in the upcoming Phase 3 trial. Additionally, as mentioned above, Resverlogix has come across additional pathways and biomarkers that drive vascular risk that may play a role in the reduced MACE that the company observed. A larger and longer trial would further elucidate which biomarker(s) may be the best to correlate and predict future MACE. BETonMACE will be a randomized, double-blind, placebo-controlled, 2 arm parallel-group study of apabetalone at a dose of 100 mg twice daily (total daily dose of 200 mg) or matching placebo in combination with standard of care statin therapy administered to type 2 diabetes mellitus subjects with history of recent CVD event and HDL-C level < 40 mg/dL males or < 45 mg/dL females. Standard of care statin therapy shall consist of daily dose of either atorvastatin 20-40 mg or rosuvastatin 10-20 mg. After an initial screening period of 1 to 2 weeks during which subjects will be treated with standard of care high potency statin therapy, subjects will be randomized to either apabetalone 100 mg twice daily or matching placebo with continued statin treatment. This combination treatment period will continue for up to

104 weeks. BETonMACE will be conducted in over 150 European and (potentially some U.S. sites) and will be an adaptive trial with a minimum of 2,400 patients and the ability to go up to 4,000 patients if necessary.

The primary endpoint of the trial is the time from randomization to the first occurrence of three-point MACE narrowly defined as a single composite endpoint of cardiovascular death or non-fatal myocardial infarction or stroke. The secondary endpoints of the trial includes time from randomization to the first occurrence of MACE broadly defined (including cardiovascular death, non-fatal myocardial infarction, hospitalization for cardiovascular disease events, or stroke) between treatment groups, all-cause mortality, change in lipoprotein concentration, diabetes mellitus variables, alkaline phosphatase and kidney function. Safety endpoints for the trial include incidence of adverse events (AEs), serious adverse events (SAEs), vital sign measurements, clinical laboratory evaluations, Montreal Cognitive Assessment (MOCA) (for subjects over 70 years of age) and physical examination findings. The study is an event-based trial and will continue until at least 250 MACE events have occurred. MACE will be adjudicated by an independent Endpoint Adjudication Committee and the study will be monitored by a Data Safety Monitoring Board. Resverlogix hopes to see a 25-30% MACE reduction with apabetalone as compared to the placebo and the current standard of care statin therapy.

It is also important to mention that apabetalone has the potential to expand to other indications, and Resverlogix plans on conducting parallel or subsequent Phase 3 trials in the future. For instance, Resverlogix stated that up to 15-20% of patients enrolled in BETonMACE are anticipated to have stage 3 chronic kidney disease (CKD) and up to 10% are anticipated to have PAD (peripheral artery disease). These subgroups will be analyzed as part of the statistical analysis plan (SAP), and if the data are positive in these subgroups, this could represent important additional indications the company could pursue in the future.

Resverlogix is confident that apabetalone is now well-positioned to move forward on an expedited and more affordable registration path. Resverlogix believes there are early revenue opportunities that include regional licensing deals, with discussions underway in high need areas, as well as potential through the orphan pathway. As a reminder, the company closed an equity and licensing deal with Shenzhen Hepalink Pharmaceutical Co., Ltd. for China, Hong Kong, Taiwan and Macau. By pursuing this parallel development program, Resverlogix hopes to expand and speed up revenue streams.

Apabetalone Competitive Landscape & Value Proposition

Resverlogix is addressing the major problem of the unmet need in cardiovascular disease management. Over the last several years, there has been a great movement forward in cardiovascular care with statins and other therapies, but these only take up about 30% of the market. There are some of new medications such as the novel LDL modulators like PCSK9 that are designed to lower LDL, yet they only have a small impact on the unmet need in CV management and take up only a small part of the market. Additionally, there are several new classes of drugs that are aimed at addressing MACE reduction. As Resverlogix moves forward with Phase 3 BETonMACE, it is important to examine where apabetalone may fit into the competitive landscape in comparison to other drugs that are currently in development for CVD risk management.

In May 2014, GlaxoSmithKline's darapladib, a lipoprotein-associated phospholipase A2 (Lp-PLA2) inhibitor that is in development for the treatment of atherosclerosis, failed to meet its primary endpoint of reduction of major coronary events vs. placebo when added to standard of care in its second Phase 3 study of 13,000 patients following acute coronary syndrome (ACS). The drug had previously failed to meet its primary endpoint of reduction of major adverse cardiovascular events (cardiovascular death, myocardial infarction, stroke) vs. placebo in its first Phase 3 trial of 16,000 patients with chronic coronary heart disease back in 2013. GlaxoSmithKline is also evaluating losmapimod in a Phase 3 trial in acute coronary syndrome patients. Losmapimod is an anti-inflammatory agent that works via inhibition of mitogen-activated protein (MAP) kinase p38 that is an enzyme known to be associated with acute inflammation and cell injury that occurs immediately following an acute coronary syndrome. In October 2015, GlaxoSmithKline provided an interim review of the Phase 3 data from part A of the study from approximately 3,500 patients with ACS (more specifically, heart attack). The company stated that losmapimod did not show efficacy against the primary endpoint, and the current data does not support continuing with the larger part B component of the study. We believe GlaxoSmithKline will continue to evaluate the data before announcing future development plans for the drug.

Drugs that target ApoA-I production and CETP inhibitors are the only technologies to date that were thought to effectively eliminate and regress atherosclerotic plaque from arteries in high-risk CVD patients. CETP inhibitors are a class of drugs that inhibit cholesteryl ester transfer protein (CETP) and work by reducing the risk of

atherosclerosis by increasing HDL and RCT. Several large pharma organizations have been investigating CETP inhibitors over the last decade. To date, these drugs have generally failed in trials either because of excess deaths (Pfizer's torcetrapib, 2006), or not showing clinically meaningful efficacy despite increases in HDL (Roche's dalcetrapib, 2012). Eli Lilly's evacetrapib Phase 2 study results were published in November 2011, and in October 2015, Lilly announced discontinuation of the Phase 3 program for the treatment of high-risk atherosclerotic cardiovascular disease due to insufficient efficacy. Merck's anacetrapib showed encouraging Phase 2b interim results in 2010, and is currently being evaluated in Phase 3 REVEAL, which has enrolled over 30,000 patients with data readout expected in 2017. Additionally, Amgen recently acquired privately-held Netherlands-based Dezima Pharma, and once-daily CETP inhibitor TA-8995, for $300 million upfront with the potential for milestones up to $1.25 billion. Results from a Phase 2b trial for dyslipidemia showed that TA-8995 reduced LDL-C by 45-48% as compared to baseline. We believe that TA-8995 is several years behind anacetrapib. It is believed that the compound could have high potency, but we will have to wait and see if this translates to better efficacy. We are not sure what the future holds for the CETP inhibitor class as we have yet to see the hypothesis that CETP inhibition translates into atherosclerotic disease prevention be conclusively proven.

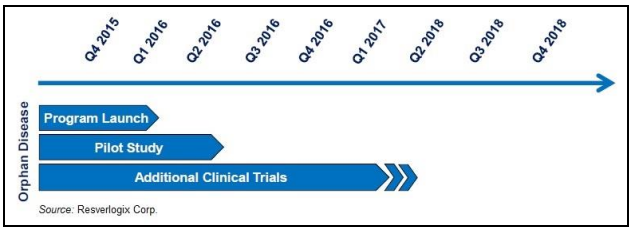
In contrast to the CETP inhibitor class which is proving to be a disappointment, there has been recent excitement surrounding newly approved drugs in the PCSK9 inhibitor class. Drugs in this class have been shown to significantly lower LDL levels, especially for patients that have struggled to control their cholesterol levels using traditional statin therapies. PCSK9 inhibitors are monoclonal antibodies (MABS) that have been shown to inactivate the liver protein proprotein convertase subtilisin kexin 9 (PCSK9), and therefore more receptors on the liver are available to remove LDL cholesterol from the blood, resulting in lower LDL-Clevels. Sanofi-Aventis/Regeneron's Praluent® (alirocumab) injection was the first cholesterol-lowering medication approved in the PCSK9 inhibitor class by the FDA in July 2015. The ODYSSEY LONG TERM trial showed that alirocumab was significant in lowering LDL cholesterol by 62% and also illustrated a 50-55% reduction in MACE. Praluent® is intended to be used in combination with diet modification and statin therapy in adult patients with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (including heart attack or stroke), who require additional lowering of LDL-C. In August 2015, the FDA approved Amgen's Repatha™ (evolocumab) as the second drug in the new PCSK9 inhibitor class. Repatha™ is an injection intended to be combined with diet modification and statin therapy to help maintain LDL cholesterol levels for adults with heterozygous familial hypercholesterolemia (HeFH), homozygous familial hypercholesterolemia (HoFH), or clinical atherosclerotic cardiovascular disease (including stroke or heart attack) who require additional LDL-C lowering. Repatha™ and Praluent® are to be injected once or twice a month. Clinical trials that are evaluating the effect of the drugs combined with statin therapy on reducing cardiovascular risk and on clinical outcomes based on MACE (such as myocardial infarction, stroke, and CVD death) are still ongoing.

How much should we be willing to pay for drugs that have the potential to prevent a heart attack or stroke? Health insurers and drug-benefit managers are voicing concerns over the pricing of PCSK9 inhibitors. The Institute for Clinical and Economic Review (ICER) recently published a draft report entitled "PCSK9 inhibitors for treatment of high cholesterol: effectiveness, value, and value-based price benchmarks." Repatha™ and Praluent® are currently priced at $14,100 and $14,600 per patient per year, respectively. The report estimates that between 3.5-15 million Americans with high cholesterol may be eligible and considered for treatment with these drugs. Since PCSK9 inhibitors are proposed to be a long-term maintenance therapy for a large and increasing population, at the current prices, we see the potential overall expenditures by payers to be enormous. According to the ICER report, the value-based price benchmark for each PCSK9 inhibitor is $2,177 per year, which equates to around an 85% reduction from the list price. We don't know if this can be achieved, and heightened concerns surrounding the pricing structure and long-term clinical effectiveness of the new PCSK9 inhibitors leads us to believe that there could be an huge opportunity for more cost-effective clinically significant treatment options for CVD management.

Resverlogix hopes that successful pharmaceutical partnerships or licensing agreements for apabetalone, similar to the one with Hepalink, will help overcome the cost burden, lengthy development time, and high attrition rates, while helping to advance the drug through clinical trials and drug development stages. Management hopes that this will ultimately lead to commercialization of the drug. Through extensive modeling and ongoing outreach to key opinion leaders (KOLs), management believes that if apabetalone shows a 20-30% relative risk reduction of MACE in the Phase 3 trial, the pharmaco-economics of apabetalone could be quite appealing for the near future. The company believes it will cost around $3,000-$4,200 per year once it hits the market depending on the specific efficacy scenario (20-30% RRR). Management believes that at this price point, the drug would be in the preferred co-pay status (Tier 2, which comes right after generics in Tier 1), and if so, there is a very strong opportunity for preferred reimbursement. Greater than $5,000 would likely put the drug in Tier 3 and require prior authorization. It's also important to remember that this is a sliding scale and that numbers needed to treat (NNT) and the cost to prevent an event must also be taken into consideration. Efficient NNT are an important assessment in the accretive value added by reimbursement and payer groups. NNT is calculated as the inverse of the ARR (Absolute Risk

Reduction): NNT = 1/ARR, where ARR = PER (Placebo Event Rate) – TER (Treatment Event Rate). For example, when looking at Praluent® (alirocumab) and Repatha™ (evolocumab) with a reported $14,600 and $14,100 per year treatment cost per patient, respectively, some would argue that the cost to prevent an event could be close to or exceeding $1 million for one year as per the analysis of the NNT, in this case 63 for alirocumab and 81 for evolocumab (vs. 21 for RVX-208 from pooled SUSTAIN and ASSURE trial data), based on annualized treatment therapy. Even if the costs of these drugs were lowered to around $10,000 annually per patient, the total cost to avoid such an event with the medications would be approximately $600,000 to $800,000 for one year. If apabetalone can illustrate a greater than 20-25% relative risk reduction over standard of care medicines, pricing will be a major advantage over agents such as PCSK9 inhibitors. If approved, and if apabetalone costs mirror what management is currently predicting, we believe this could be a game changer from the viewpoint of payer groups. While the jury is still out on RVX-208, management believes that the drug is positioned to be one of the most promising drugs in development for the prevention and reduction of atherosclerotic related CVDs.

Orphan Disease Program



On September 24, 2015, Resverlogix announced the commencement of an Orphan Disease Program for Complement Mediated Diseases.

Management believes that the new data that we discussed above suggests that apabetalone downregulates different components of the complement and coagulations pathways, which are important to cardiovascular disease as well several orphan diseases. Resverlogix would like to further explore the potential of apabetalone in humans with overactive complement pathways. We believe that apabetalone will be tested in a Phase 2 proof-of-concept pilot study in a small group of patients with Paroxysmal Nocturnal Hemoglobinuria (PNH) in 2016. We believe there is potential for Resverlogix to study other complement mediated diseases, such as atypical hemolytic uremic syndrome (aHUS), and glomerulonephritis in conjunction with apabetalone as well as other pre-clinical BET inhibitors/follow-on compounds (*below*), but we are not exactly sure the path the company plans to go down at this point. We are unsure at this point if the drug candidates will receive orphan drug designation. Resverlogix does not have any type of orphan drug designation at this point, but we are assuming that this will be the route that the company plans to pursue at some point in the future. If things go well, and apabetalone is approved for PNH, management believes that the orphan drug route will allow for the drug to get to the market sooner, potentially 2 years earlier.

Compound	Selectivity fold (BRD4(1)/BRD4(2))	IC50 uM							Fold Induction
		InfA	InfB	Comp 'A'	Comp 'B'	Fact'1'	Clot 'B'	Clot 'C'	ApoA-I
RVX-208	30	0.97	4.4	14.5	5	0.18	ND	ND	2.35 fold
1	43	2.29	ND	11.1	>50	4.4	ND	ND	ND
2	14	1.54	ND	29.6	12.9	2.14	26.5	19.9	ND
3	13	1.21	ND	18.5	17.2	1.8	ND	ND	2.27 fold
4	9	2.16	ND	13.9	13.8	0.58	ND	ND	3.55 fold
5	4	0.94	ND	29.2	21.1	7.7	38.4	20.7	2.75 fold
6	2.7	1.98	ND	15.4	17.8	4.2	ND	ND	2.01 fold
7	2	0.87	1.55	12.6	9.3	0.29	35.6	8.8	3.59 fold
8	2	ND	ND	9.5	15.6	3.22	ND	ND	3.92 fold
9	1.5	1.38	ND	20.4	17.4	0.83	37.4	21.2	2.02 fold
10	ND	0.87	1.67	5.3	13.8	3.4	ND	ND	ND

Source: Resverlogix Corp. ND = no data

Background on Orphan Diseases

Orphan diseases are rare diseases that only affect a small percentage of the population. The U.S. FDA classifies orphan diseases as those that affect less than 200,000 in the U.S. There are approximately 7,000 rare diseases characterized to date, with the list continuing to grow. It is estimated that 30 million people in the U.S. are living with rare diseases, which equates to 1 in 10 or 10% of the U.S. population. Across the world, it is estimated that 350 million people are living with some sort of rare disease. Approximately 50% of people affected by rare diseases are children (Global Genes, 2015).

Paroxysmal Nocturnal Hemoglobinuria

The National Organization for Rare Disorders (NORD) states that paroxysmal nocturnal hemoglobinuria, or PNH, is a rare yet progressive and often life-threatening acquired hematopoietic stem cell disease of the blood. Hematopoietic stem cells give rise to red blood cells. In PNH, red blood cells break down or are prematurely destroyed earlier than normal (hemolysis) by an individual's own immune system (complement system), with potentially fatal consequences. It is estimated to affect between 1 to 5 million individuals. A quick search on clinicaltrials.gov shows 42 results related to PNH, with 14 being "open studies."

In healthy individuals, RBCs and other blood cell types have specific cell surface proteins that function to inhibit the complement system and ultimately protect cells against formation of the MAC (membrane attack complex). Individuals with PNH have blood cells that are missing a gene called PIG-A. This gene normally allows a substance known as glycosyl-phosphatidylinositol (GPI) to help particular proteins to stick to cells. Without PIG-A, certain proteins are unable to stick to cell surfaces in order to offer protection to the cell against complement substances that are circulating in the blood. Due to the acquired mutation in their hematopoietic stem cells, patients with PNH do not express these host proteins and their red blood cells become subject to complement-mediated destruction. A direct link exists between excessive complement activation and the clinical manifestation of PNH. This process leads to early destruction of red blood cells, and leakage of hemoglobin into the blood, which can pass into the urine (hemoglobinuria) and can lead to renal failure, (U.S. National Library of Medicine, 2014) as well as repeated, potentially fatal blood clots (thromboses) that account for up to 40-67% of PNH mortality. Other symptoms of PNH include extreme fatigue, abdominal pain, and anemia. The resultant excessive red blood cell destruction often causes transfusion dependence in PNH patients.

Treatment Options for PNH

PNH treatment is often tailored to specific symptoms and includes many different therapeutic and supportive approaches. Treatment often involves steroids that can suppress the immune system to help slow down red blood cell destruction, as well as blood transfusions, supplemental iron and folic acid, anti-coagulation drugs to prevent clot formation, and bone marrow transplantation.

The U.S. Food and Drug Administration (FDA) approved Soliris® (eculizumab), an orphan drug, in 2007 for the treatment of PNH. It was the first drug to be approved for PNH, and although it does not cure the disease, it does block the breakdown of red blood cells, and in turn, can prevent thrombosis. Soliris® blocks the complement system of the body that is responsible for destroying blood cells in PNH individuals. Since it does block the immune system, the drug does increase the risk of meningococcal infections, and patients must be vaccinated with a meningococcal vaccine at least two weeks before receiving the first dose of the drug. Soliris® is also approved for the treatment of aHUS. The drug was developed by Alexion Pharmaceuticals and patent expiration occurs in 2021.

Soliris® has been the subject of controversy as it has been called one of the most expensive drugs in the world, and. In 2014, it had a U.S. list price of about $440,000 per patient a year. According to EvaluatePharma, worldwide sales of Soliris® in 2014 were $2.2 billion, and estimates sales to be over $2.6 billion in 2015. According to a 2014 report by the International PNH Registry, close to 75% of PNH patients are not receiving Soliris® treatment. Some believe it is only being used in severe cases of PNH due to the high cost of the drug. For these reasons, Resverlogix believes that if apabetalone is successful as a treatment for PNH, it could fill a large unmet medical need for patients with this severe disease. It is still early for us at this point, but we will wait and see approach regarding the orphan disease program.

Financial Update

Resverlogix recently filed its Certification of Filings for the first quarter fiscal year 2016 ended July 31, 2015. The company reported no revenues in the quarter, and had a net loss of $2.6 million, or $0.03 per share in first quarter ending July 31, 2015.

R&D expenses for the first quarter 2016 were $2.2 million vs. $0.7 million for the same time period in 2014. R&D expenditures in the quarter consisted of approximately $1.1 million of clinical costs (including $0.8 million related to the BETonMACE clinical trial, and $0.3 million for sample analysis, regulatory, consultants and insurance related costs), $0.3 million of chemistry costs (chemistry, manufacturing, and controls), $0.1 million of preclinical costs (research, pharmacology, toxicology, drug metabolism, and pharmacokinetics), and $0.4 million of R&D compensation and related costs associated with expansion of clinical staff in preparation for the BETonMACE.

G&A expenses for the first quarter 2016 were $1.3 million vs. $1.0 million for the same time period in 2014. G&A expenses in the first quarter 2016 reflect business development costs related to the Hepalink license, and increased compensation and related costs (excluding share-based payments).

As a reminder, on July 21, 2015, Resverlogix announced that it closed the previously-announced private placement with Shenzhen Hepalink Pharmaceutical Co., Ltd. ("Hepalink") and Eastern Capital Limited ("Eastern"). On July 8, 2015, Resverlogix had announced that it closed a license agreement with Shenzhen Hepalink Pharmaceutical Co., Ltd. According to the license agreement, should lead candidate apabetalone reach specific annual sales milestones in China, Hong Kong, Taiwan, and Macau ranging from 500 million to 10 billion Renminbi (“Chinese Yuan”) (approximately $80 million to $1.6 billion), Resverlogix will be eligible to receive sales-based milestone payments from Hepalink, each ranging from USD $5 million to $90 million. Additionally, Hepalink will pay Resverlogix an adjusted royalty of 6% of net sales of apabetalone in the territories listed above. The license agreement will expire on a region-by-region basis on the latter of either the 15th anniversary of the first commercial sale in such region or the expiration date of the last-to-expire of any licensed patent. We would like to point out that Hepalink will be responsible for all clinical and development costs in the territories mentioned above, including a patient population that will be included in the upcoming Phase 3 BETonMACE trial.

Resverlogix and Hepalink also entered into a definitive stock purchase agreement whereby Hepalink will purchase approximately 13.3 million shares of common stock at CAD $2.67 per share. Hepalink will also be granted roughly 1.0 million 5-year warrants exercisable at CAD $2.67 per share. The transaction provides gross proceeds of CAD $35 million to Resverlogix. After the transaction is completed, Hepalink will hold approximately 12.63% of Resverlogix's common shares, and the common shares and warrants issued to Hepalink will be subject to a lock-up period of three years. Hepalink will also be able to nominate one representative for election to the board of directors of Resverlogix. The Hepalink transaction is now complete, and on July 20, 2015, Eastern Capital Limited purchased 5.6 million common shares and 0.422 million common share purchase warrants, for aggregate consideration of approximately CAD $15 million (US $12 million), or CAD $2.67 per share.

Net proceeds, which we estimate to be in the area of CAD $47 million ($37 million USD) will be used to fund research and development activities including clinical development, non-clinical development, research, discovery, chemistry and regulatory costs in addition to repayment of outstanding indebtedness and/or payment of interest thereon as well as general and administrative expenses, capital expenditures, working capital needs and other general corporate purposes.

At the end of July 2015, Resverlogix had approximately $48 million in cash and cash equivalents. We believe that the cash position as of the end of July 2015 is enough to fund the activities related to Phase 3 BETonMACE trial. In our opinion, if all goes according to schedule, the first patient in the Phase 3 program will be dosed at some point in the fourth quarter of 2015. Although exact costs will be based on the total number of patients enrolled, we believe the program will cost at least $30 million and take about 3 years to complete. In our opinion, the cash raised from the Hepalink and Eastern Capital Limited will fully fund the Phase 3 BETonMACE trial.

Conclusion & Valuation Methodology

Resverlogix’s lead product candidate, apabetalone (RVX-208), is the first selective BET bromodomain inhibitor in clinical trials for high-risk vascular disease. Apabetalone is targeting a very specific patient population with low HDL, type diabetes mellitus and chronic kidney disease with a high cardiovascular risk for increased MACE. Based on pooled Phase 2 data, patients who respond best to apabetalone are also taking AstraZeneca’s Crestor® (rosuvastatin), but we do not suspect that will be included in the final label.

According to internal analysis conducted by Resverlogix, there is a minimum high-risk market for apabetalone of 18.8 million patients in the top 7 global markets. We have adjusted our model to reflect apabetalone entering Phase 3 BETonMACE. Patients are being recruited for the trial, and we expect that the first patient will be dosed at some point during the fourth quarter of calendar year 2015. Management gave us some pretty good initial inputs for our valuation model and we have slightly ticked these up to 23% probability for high-risk CVD and 16% for diabetes mellitus, and 12% probability for chronic kidney disease for the U.S. We believe these are relatively conservative figures for projecting U.S. revenues, however, we have increased the probabilities for revenues outside of the U.S. to 40% for high-risk CVD and diabetes mellitus and 20% for chronic kidney disease, given the recent news that trial sites were initiated in Europe, and that the first patient should be dosed by year end. Management believes that the product will likely launch in 2021, with sales ramping up over the next several years. We are assuming peak sales in

2027. Management also gave us a 24% discount rate assumption, which we believe is a fair and conservative estimate.

We are modeling peak sales of $6.3 billion or approximately $5.7 billion, net of royalties. We have assumed gross sales of $1.5 billion from high-risk cardiovascular disease, $2.7 billion in diabetes mellitus, and $2.1 billion in chronic kidney disease. We also compared our projected peak sales figures to the existing market for at risk CVD patients, including approved drugs like Lipitor® ($13.7 billion peak in 2006), Crestor® ($6.6 billion peak in 2011, $5.5 billion in 2014), Lovaza® ($1.1 billion peak in 2013). We are also using several peak sales estimates we found for recently approved drugs such as Amgen's and Regeneron/Sanofi's PCSK9 inhibitors, evolocumab and alirocumab, respectively. We are also including CETP inhibitors, such as Merck's Phase 3 candidate anacetrapib, on the list of comparable drugs to help us understand the peak sales potential for apabetalone. Wall Street consensus estimates, as well as independent analyst estimates from websites such as TheStreet.com, FierceBiotech, Benzinga, and Seeking-Alpha, for these drugs range between $3 billion to $10 billion. We believe apabetalone, although flying significantly below the radar of these other drugs, has similar peak sales potential, if Phase 3 BETonMACE data are positive.

We believe that strong patent position and pharmacoeconomics of apabetalone, combined with a management skill set surrounding CVD and diabetes and a novel approach to addressing the residual risk in high need CVD patients, allows for Resverlogix to be in an interesting position. The company secured access to approximately $37 million USD in new capital through licensing and stock purchase agreements with Hepalink and Eastern Capital, which we believe should fully fund the Phase 3 BETon MACE program.

On the other hand, we still believe that there are certain challenges that Reservlogix will continue to face such as proving the long-term hepatic safety of apabetalone use, and significant operating losses that are building up year after year. Additionally, we are still not sure what type of cardiovascular clinical trials the FDA and EMA will require of apabetalone, and we are still uncertain regarding the outcome of Phase 3 BETonMACE.

Currently, we believe the company is undervalued as it embarks on the Phase 3 BETonMACE trial. We do want to point out that data from this trial will not likely be available until mid-2018. The recently announced complement-mediated orphan disease program could also provide further upside to our valuation, however at this time it is too early to include in our model. After re-visiting our model, we are changing our 'Hold' rating to 'Buy' and adjusting our price target to $3.25 given the potential upside to the Resverlogix story.

PROJECTED FINANCIALS

Resverlogix Corp. - Income Statement

Resverlogix Corp.	Apr. 2015 FY-15 A	Jul. 2015 Q1 A	Oct. 2015 Q2 E	Jan. 2016 Q3 E	Apr. 2016 Q4 E	Apr. 2016 FY-16 E	Apr. 2017 FY-17 E	Apr. 2018 FY-18 E
RVX-208	$0	$0	$0	$0	$0	$0	$0	$0
Licensing & Collaborative	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
Total Revenues	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
CoGS	$0	$0	$0	$0	$0	$0	$0	$0
Product Gross Margin	-	-	-	-	-	-	-	-
R&D Expense (net)	$4.2	$2.2	$2.8	$3.0	$3.5	$11.5	$15.0	$20.0
SG&A Expense	$4.3	$1.3	$1.4	$1.5	$1.6	$5.8	$6.3	$6.8
Operating Income	($8.5)	($3.5)	($4.2)	($4.5)	($5.1)	($17.3)	($21.3)	($26.8)
Operating Margin	-	-	-	-	-	-	-	-
Net Finance Activities	($9.9)	$6.1	$1.7	$1.7	$1.7	$11.1	$6.7	$6.7
Other Gain / Loss	($1.1)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Pre-Tax Income	($19.4)	$2.6	($2.5)	($2.8)	($3.4)	($6.2)	($14.6)	($20.1)
Taxes & Other	($1.1)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Tax Rate	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*100%*
Net Income	($18.3)	$2.6	($2.5)	($2.8)	($3.4)	($6.2)	($14.6)	($20.1)
Reported EPS	**($0.21)**	**$0.03**	**($0.02)**	**($0.03)**	**($0.03)**	**($0.06)**	**($0.14)**	**($0.18)**
YOY Growth	-						-	-
Shares Outstanding	85.6	105.1	105.5	106.0	106.5	105.8	108.0	110.0

Source: Company Filing // Zacks Investment Research, Inc. Estimates



Source: Resverlogix Corp.

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