Zacks Small-Cap Research

September 18, 2015
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Neurocrine Biosciences, Inc. (NBIX-NASDAQ)

NBIX: Elagolix Moves to Phase 3 for Uterine Fibroids; Raising Price Target to $65…

Current Recommendation	**Buy**
Prior Recommendation	Neutral
Date of Last Change	06/16/2010
Current Price (09/18/15)	$54.93
Target Price	**$65.00**

UPDATE

Neurocrine Biosciences and AbbVie recently announced positive results from a Phase 2b trial of elagolix in uterine fibroids (UF). AbbVie also announced that a Phase 3 program for elagolix will be initiated in UF in the first quarter of 2016. It will consist of two replicate, pivotal, six-month efficacy and safety studies followed by a six-month safety and efficacy extension study.

The positive news about elagolix in UF adds to the positive news flow that Neurocrine has enjoyed in 2015. Upcoming catalysts include data from the Phase 3 trial of NBI-98854 in TD and the Phase 1b trial of NBI-98854 in TS in 4Q15, while data from the second Phase 3 elagolix trial in endometriosis is expected in 1Q16. Our updated price target is $65.

SUMMARY DATA

52-Week High	**$54.93**
52-Week Low	**$15.10**
One-Year Return (%)	**235.14**
Beta	**0.25**
Average Daily Volume (sh)	**908,030**
Shares Outstanding (mil)	**86**
Market Capitalization ($mil)	**$4,717**
Short Interest Ratio (days)	**6.55**
Institutional Ownership (%)	**97**
Insider Ownership (%)	**4**
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/M**
P/E using 2015 Estimate	**N/A**
P/E using 2016 Estimate	**N/A**

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

ZACKS ESTIMATES

Revenue
(in millions of $)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2014	0 A	0 A	0 A	0 A	0 A
2015	19.8 A	0 A	0 E	0 E	19.8 E
2016					50.0 E
2017					50.0 E

Earnings per Share
(EPS is operating earnings before non recurring items)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2014	-$0.17 A	-$0.18 A	-$0.21 A	-$0.26 A	-$0.81 A
2015	-$0.01 A	-$0.28 A	-$0.30 E	-$0.34 E	-$0.95 E
2016					-$0.64 E
2017					-$0.73 E

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WHAT'S NEW

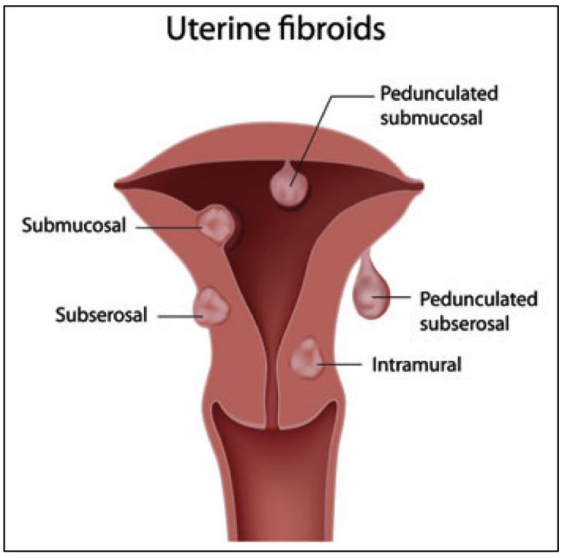
Positive Results From Phase 2b Study of Elagolix in Women with Uterine Fibroids

On September 16, 2015, AbbVie (ABBV) and Neurocrine Biosciences (NBIX) announced the successful completion of the Phase 2b safety and efficacy study of elagolix either alone or in combination with add-back therapy in patients with uterine fibroids (UF). Based upon these results, AbbVie will be initiating a Phase 3 clinical trial program of elagolix in patients with uterine fibroids (UF), which is scheduled to begin in the first quarter of 2016.

Background on Uterine Fibroids

Uterine fibroids, also called leiomyomas, are the most common type of benign tumors in women of reproductive age (Ryan *et al*., 2005). While their pathogenesis is not entirely known, they do appear to be contingent on estrogens and progestogens, as they rarely occur before menarche and typically shrink during menopause (Fields *et al*., 1996; Cramer *et al*., 1990). Women can have one or more fibroids at a time, and they are classified based upon their location:

Subserous: These type of fibroids typically develop on the outer uterine wall and then continue to grow outward thus putting additional pressure on surrounding organs. Thus, symptoms usually do not include abnormal or excessive menstrual bleeding but rather cause pelvic pain and pressure.
Intramural: These are the most common type of fibroids, which develop within the uterine wall. As they grow, intramural fibroids can sometimes be mistaken for pregnancy, as they make the uterus expand in size. In addition, these fibroids can result in excessive menstrual bleeding, which can cause prolonged menstrual cycles along with clot passing and pelvic pain.
Submucous: These are the least common type of fibroids, which develop just under the lining of the uterine cavity. Large submucosal fibroids can potentially block the fallopian tubes and cause fertility issues. They typically cause very heavy, excessive menstrual bleeding and prolonged menstruation, which can lead to other complications such as anemia and/or fatigue.
Pedunculated: These fibroids are a subset of subserous or submucous fibroids that grow on a stalk, resulting in their growth into the uterus (in the case of submucous) or into the abdominal cavity (in the case of subserous). These fibroids are more associated with pain and pressure, as they can get twisted on the stalk.



Source: ask4ufe.com

Prevalence of UF

The following epidemiological studies have been identified in order to better understand the prevalence of UF in premenopausal women. There appears to be a significant difference in the prevalence of UF based on race, with the prevalence also increasing in older women.

Borgfeldt *et al*., 2000: This study randomly sampled 335 women in Sweden between the ages of 25-40 with transvaginal ultrasonigraphic examination. UF were detected in 3.3% of women in the 25-32 years age group and 7.8% in the 33-40 years age group with an average prevalence of 5.4%.

Chen *et al*., 2001: This study was conducted to examine risk factors for UF among women in the U.S. undergoing tubal sterilization. A total of 3,174 women were included in the study, which reported an overall prevalence of UF of 10%.

Day Baird *et al*., 2003: This study examined randomly selected women (n=1,364) from an urban health plan in the U.S. who were between the ages of 35-49. The results showed a significant difference in the prevalence of UF between black women (30-40%) and white women (10-15%).

Marino *et al*., 2004: This study utilized data from a population-based cohort in Italy and included 341 premenopausal women between the ages of 30-60. UF were detected in 21.4% of the participants, however there was no correlation between the presence of UF and menstrual characteristics.

Laughlin *et al*., 2009: This study was conducted to determine the prevalence of UF in pregnant women in the U.S. A total of 4,271 women took part in the study, with UF detected in 10.7% of trial participants. UF were more common in black women (18%) than in white women (8%), with the prevalence increasing with age much more steeply for black women than for white women.

While these studies would indicate that UF are found in approximately 10-15% of the population, the Office of Woman's Health states that 20-80% of women will develop UF by the age of 50. For modeling purposes, we are estimating that 13% of women of childbearing age will develop UF, which equates to approximately 9 million women.

Treatment Options for UF

Most women with UF do not experience symptoms that require treatment, and we estimate that only 25% of women with fibroids will have symptoms that require treatment. The symptoms caused by UF will typically guide treatment, depending upon whether the fibroids are causing heavy menstrual bleeding or "bulk symptoms", i.e. pelvic pain and frequent urination. Additional factors that will influence the type of treatment include whether the woman would like to have children, her age, and how close she is to menopause (as mentioned previously fibroids typically shrink or disappear altogether in menopause). There are three groups of treatments available: watchful waiting (for those with few or no symptoms), drug therapy, and surgery.

Drug Therapy

Pain Relievers: For women who experience minor to moderate pain, pain relievers such as acetominophen, ibuprofen, or naproxen are typically utilized.

Hormonal Therapy: Oral contraceptives are sometimes used to control heavy menstrual bleeding associated with fibroids, however they do not have any effect on fibroid growth. Intrauterine devices (such as Mirena®) are inserted into the uterus and release a small amount of progestin to help reduce excessive bleeding, and have shown excellent results for this indication.

Gonadotropin-releasing hormone (GnRH) agonists: These agents work by blocking the release of the reproductive hormones LH (leutinizing hormone) and FSH (follicile-stimulating hormone). This causes the ovaries to stop releasing estrogen, thus inducing a "menopause-like" condition. Side effects from these medications include hot flashes, night sweats, vaginal dryness, weight gain, and depression. In addition, long-term use of these agents can cause bone loss, thus they are only utilized for a maximum of six months. The leading GnRH agonist is Lupron®, which had estimated 2014 worldwide sales in UF of $250 million (EvaluatePharma).

Progesterone receptor modulator: Esmya® is a first-in-class, once daily, selective progesterone receptor modulator that reversibly blocks the progesterone receptors in target tissues. The drug is approved in the E.U. and is administered in two three-month cycles to shrink fibroids in preparation for surgery. In addition, the drug was shown to stop uterine bleeding and correct anemia, while providing fewer "menopause-like" side effects such as hot flashes. According to EvaluatePharma, Esmya® is projected to produce $380 million in revenues in UF in 2020.

Surgical Treatment Options

Myomectomy: This procedure surgically removes the fibroids but leaves the uterus intact, helping to preserve fertility. Women with fewer, smaller fibroids are the best candidates for this procedure, as larger fibroids can lead to an increase in blood loss. Myomectomy can be performed either through a standard surgical approach (laparotomy) or a less invasive procedure (hysteroscopy or laparascopy). This procedure is not necessarily considered curative, as fibroids can grow back.

Uterine Artery Embolization: In this procedure, a catheter is placed in the femoral artery and threads the catheter to the uterine artery. Small plastic particles are then injected into the uterine artery, restricting blood flow in the tiny arteries that feed the fibroids. This decreases blood supply to the fibroids, which eventually die. This is a relatively new procedure, thus the long-term effects on fertility are currently unknown.

Endometrial Ablation: This procedure destroys the lining of the uterus and is typically used for women who experience heavy menstrual flow due to fibroids, as the procedure as little to no effect on large fibroids or fibroids that are growing outside of the uterus. This procedure drastically reduces a women's fertility, thus is only recommended for those who longer wish to have children and who are committed to not getting pregnant.

Magnetic Resonance Guided Focal Ultrasound: This is a non-invasive procedure uses high-intensity ultrasound waves to heat and destroy UF. The patient is in an MRI machine during the three hour procedure, while a radiologist uses the MRI to pinpoint the location of the fibroids and direct the ultrasound beam to the proper location. The procedure is relatively new, thus long-term results are not available, however it is only recommended for women who do not wish to become pregnant.

Hysterectomy: This procedure is the surgical removal of the uterus. The ovaries may also be removed, however this is usually unnecessary for treatment of UF. Hysterectomy is typically recommended for patients with very large fibroids who have not responded to other types of treatment. Since it involves removal of the uterus, women cannot get pregnant after a hysterectomy. UF is the most frequent indication for hysterectomy in the U.S., with one-third of the 600,000 hysterectomies performed each year due to UF.

Elagolix for the Treatment of UF

Elagolix is a non-peptide GnRH receptor antagonist, which has a number of advantages over currently available GnRH agonists. Like GnRH agonists, elagolix decreases the release of LH and FSH, thereby decreasing production of estrogen and progesterone, however this decrease is not as pronounced as with GnRH agonists, thus alleviating some of the "menopause-like" sympstoms. Since elagolix is not a peptide, it can be administered orally, unlike GnRH agonists, which are peptides and must be administered through injection. Chronic administration of GnRH agonists results in an initial flare of activity, which can make symptoms worse for a short period of time, before reversibly shutting down the GnRH receptor pathway. As a GnRH receptor antagonist, elagolix begins to work immediately and dosing can be discontinued immediately if necessary, something that is not available for long-acting injectable GnRH receptor antagonists.

Neurocrine is partnered with AbbVie for the development of elagolix in treating endometriosis and UF. The collaboration initially began in 2010, and includes up to $295 million in regulatory and $55 million in commercial milestone payments. AbbVie initially tested elagolix for the treatment of UF in a Phase 2a clinical trial of women age 20-49. Based upon successful results in that study, AbbVie launched a Phase 2b clinical trial in 2013 (NCT01817530). The study enrolled 561 premenopausal women, age 18-51, at approximately 100 sites around the world. Patients were administered elagolix in two dosing cohorts: 300 mg BID or 600 mg QD either alone or in combination with two different strengths of add-back therapy (estradiol/norethindrone acetate). The primary endpoint of the trial was a composite design where subjects had to achieve a menstrual blood loss volume of less than 80 mL as well as a 50% or greater reduction in menstrual blood loss volume at the final study month as measured by alkaline hematin method.

Although AbbVie did not release many details in the press release, they did indicate that preliminary results showed that all of the elagolix treatment arms, with and with-out add-back therapy, reduced heavy menstrual bleeding compared to placebo (P<0.001). The most common adverse events (AEs) were hot flush, headache, nausea, and vomiting, with some AEs such as hot flush being more frequent in the elagolix only cohort compared to placebo and elagolix treatment with add-back therapy. Importantly, it was noted that reduction in bone mineral density associated with elagolix alone was attenuated when elagolix was combined with add-back therapy. Full results from the trial will be presented at an upcoming medical conference.

AbbVie also reported that it will begin a Phase 3 program for elagolix in UF beginning in the first quarter of 2016. The Phase 3 program will include two replicate, pivotal, six-month efficacy and safety studies followed by a six-month safety and efficacy extension study. The primary endpoint of the Phase 3 studies will be the same as for the Phase 2b study, the percentage of patients with reduced uterine blood flow as measured by the alkaline hematin method. The total number of patients is not yet known as AbbVie is still working on finalizing the clinical protocol.

Market Opportunity in UF

We have recently made adjustments to our model to better account for the likely target population in UF. We estimate that of the 65 million women age 14-49 in the U.S., 13% of those will have UF. We then presume that 25% of those with UF will seek treatment due to severity of menstrual bleeding or other symptoms. Of those that begin treatment with hormone therapy, we estimate that approximately 50% will be refractory and require another treatment option, thus putting the target patient population in the U.S. at approximately 1.1 million. The prevalence

of UF appears to vary considerably in different countries in the E.U., and we are using a composite prevalence of approximately 10%, with similar numbers of women seeking treatment and failing first-line drug therapy as that found in the U.S. This puts the target patient population in the E.U. at approximately 1.3 million.

We estimate that the Phase 3 program will take approximately two years to complete, based on the two years it took for the Phase 2b study, thus an NDA filing would most likely not occur until the end of 2018, putting approval for elagolix in UF in 2019. While the data from the Phase 2b study was limited, based on the fact that bone mineral density loss could be abrogated with add-back therapy, we believe this removes some of the regulatory risk associated with the drug. Thus, we are assigning a 75% chance of approval. We now estimate that peak sales of elagolix in UF could top $2.6 billion worldwide. Using a composite 20% royalty rate, we estimate peak royalties to Neurocrine of over $500 million from sales in UF.

Update on Elagolix in Endometriosis

On January 8, 2015, AbbVie Inc. reported positive top-line data from a Phase 3 trial evaluating the safety and efficacy of elagolix in the treatment of endometriosis in premenopausal women. Violet Petal (NCT01620528) was a 24-week, multinational, randomized, double-blind, placebo-controlled study designed to evaluate the safety and efficacy of elagolix in 872 women, age 18 to 49, with moderate-to-severe endometriosis-associated pain. The trial was conducted at approximately 160 sites in the United States, Puerto Rico and Canada.

According to the AbbVie press release, results from the Phase 3 trial, dubbed Violet Petal (NCT01620528), show that after three and six months of treatment, both doses of elagolix (150 mg once daily and 200 mg twice daily) met the study's co-primary endpoints ($p<0.001$) of reducing scores of non-menstrual pelvic pain (NMPP) and menstrual pain (or dysmenorrhea), associated with endometriosis as measured by the Daily Assessment of Endometriosis Pain scale. If you're scoring at home, that's eight total endpoints that all hit statistical significance.

Unfortunately, no actual figures on efficacy were reported in the press release, protecting the data we suspect from competitors' eyes and so that AbbVie can present full results at a medical meeting later this year. However, a brief summary of the safety data and adverse event profile was presented in the release. According to AbbVie, the observed safety profile of elagolix in this Phase 3 trial was consistent with observations from prior studies (which we discuss below). The most common adverse events (AEs) were hot flush, headache, nausea and fatigue. Adverse events, particularly hot flush, were dose-dependent. No DXA scan data was presented in the press release, only the mention that bone mineral density (BMD) loss was dose-dependent and the 150 mg results were similar to the results for the 150 mg cohort seen in the previous Phase 2b studies (< 0.5% change).

During Abbvie's second quarter 2015 conference call, management indicated that they had seen data from the six-month extension trial of the Violet Petal study and "the results were consistent with the previously reported efficacy and safety findings." This is very encouraging news, as it likely indicates that the drug's efficacy does not wane over time and that no additional safety issues are likely with extended use of the compound.

Discontinuation rates specifically due to AEs for the Violet Petal trial are presented below:

Discontinuation Rates Phase 3 Violet Petal	
Placebo	*5.9%*
150 mg QD	*6.4%*
200 mg BID	*9.7%*

A second Phase 3 trial, Solstice (NCT01931670), is ongoing. This study is similar in design to the Violet Petal study and will assess 788 women, age 18 to 49, with moderate to severe endometriosis-associated pain at more than 200 sites globally. Data from Solstice is expected in the first quarter of 2016.

Market Opportunity in Endometriosis

Of the 65 million women age 14-49 in the U.S., approximately 10% of those will suffer from endometriosis. We further estimate that 35% of those with endometriosis will seek treatment and that of those who initiate treatment, 30% will fail first-line therapy. This represents a target population of approximately 0.7 million in the U.S. We estimate the initial opportunity in the E.U. to be only 20% of that in the U.S. due to a lack of diagnosing

endometriosis, however we believe this will increase to 50% through greater awareness through programs that are being put into place in various countries in the E.U. where endometriosis is under-diagnosed.

NBI-98854 (VMAT-2) Update

The Phase 3 Kinect 3 (NCT02274558) study of NBI-98854 for the treatment of tardive dyskinesia (TD) continues on plan, with top-line data expected in the fourth quarter 2015. As a reminder, the trial opened for enrollment in October 2014, with a target of 240 patients with moderate to severe TD and an underlying diagnosis of mood disorder, schizophrenia, or schizoaffective disorder. The Phase 3 trial is a randomized, parallel-group, double-blind, placebo-controlled study assessing either 40 mg or 80 mg of NBI-98854 dosed once daily against placebo.

The primary endpoint for the Kinect 3 study is change from baseline in the Abnormal Involuntary Movement Score (AIMS) as measured by blinded central raters, just as was done in Neurocrine's previous and successful Kinect 2 study (see our analysis of Kinect 2 here) at six weeks. During the second quarter conference call, management indicated that the final patients first visit is scheduled for the first week of August 2015, with the final visit likely to occur toward the end of September. Topline data would then be released approximately 4-6 weeks later. As a reminder, patients completing Kinect 3 will be eligible to enroll in an open-label, 48-week, long-term safety assessment study called Kinect 4, where all study subjects will be randomized in a blinded fashion to either 40 mg or 80 mg NBI-98854.

The Kinect 3 study, along with the previous efficacy studies of NBI-98854, is designed to complete the clinical efficacy evaluation of the drug in TD. Alongside the Kinect 3 pivotal trial and open-label Kinect 4 assessment, Neurocrine is planning to perform additional Phase 1 work that includes a QTc study, a study involving patients with renal impairment, and another drug interaction study. Assuming the Kinect 3 study is successful, we believe the company will be in position to file the NDA in TD in 2016.

Phase 1 Tourette Syndrome Study

On October 2, 2014, Neurocrine announced the initiation of a Phase 1b clinical trial called T-FORCE (NCT02256475) of NBI-98854 in both children and adolescents with Tourette syndrome (TS). The T-FORCE study is an open-label, multiple ascending dose, two-week study of 36 subjects with TS. The study participants will receive once-daily dosing of NBI-98854 during a two-week treatment period to assess both the safety and tolerability of NBI-98854 in Tourette patients followed by seven days off-drug. The study is taking place at approximately 10 centers in the U.S.

The study is divided into two dosing groups: children (ages 6-11) and adolescents (ages 12-18). Each group is divided into three dosing cohorts of six patients each. Following the initial two weeks of dosing with the first adolescent cohort, an independent review of both safety and pharmacokinetic results will occur prior to escalating the dose level for the second cohort of adolescents. Concurrently, when the second group of adolescents is dosed the first group of children will be administered NBI-98854. Continued dose escalations for both children and adolescents will be contingent upon the pharmacokinetic and safety data from the previous cohort in each age group. Lastly, each patient's Tourette symptoms will be evaluated weekly using the Yale Global Tic Severity Scale, the Premonitory Urge for Tics Scale, and the Clinical Global Impression in Tourette syndrome Scale. We remind investors that this study is not powered to show efficacy in treating TS, but is rather a pharmacokinetic and pharmacodynamics focused study. Data from the T-FORCE study should be available in the fourth quarter of 2015.

Conclusion and Recommendation

The news that AbbVie is moving elagolix into a Phase 3 program was certainly good news for Neurocrine, and it follows positive news earlier in the year when AbbVie reported positive data from the first Phase 3 elagolix trial in endometriosis in January 2015, which was then followed with the announcement that data from the six-month extension trial showed results consistent with the previously reported efficacy and safety findings. Neurocrine has taken advantage of all this good news by strengthening the balance sheet through raising $270+ million in cash in February 2015 at $36 per share. So far, 2015 has been a fantastic year for Neurocrine!

As a reminder, data from the second Phase 3 elagolix trial in endometriosis is expected in the first quarter of 2016. We expect that AbbVie will be in position to file the New Drug Application (NDA) on elagolix in late 2016. Our model assumes commercial launch for endometriosis in the U.S. in early 2018, and we believe this to be a $1.5 billion worldwide opportunity.

As far as NBI-98854 is concerned, Neurocrine's management is guiding for data from the Phase 3 Kinect 3 study to be available in the fourth quarter of 2015. In parallel, the company is conducting the open-label study Kinect 4, as well as some Phase 1 safety and drug-drug interaction studies. We continue to believe that the company will file the NDA on NBI-98854 for TD during the second half of 2016.

The treatment of TD is a very meaningful market opportunity for Neurocrine. There are an estimated 500,000 TD patients in the U.S. with no real treatment options besides tetrabenazine. For valuation purposes, we assume U.S. approval of NBI-98854 in TD will target roughly 150,000 of the total patients in the U.S. that are moderate-to-severe in disease state. We assume Neurocrine will charge pricing comparable to atypical antipsychotics, or around $15,000 per year. If Neurocrine can capture 33% market share, which we believe is reasonable given the superior characteristics of NBI-98854 (valbenazine) vs. generic tetrabenazine, then peak sales estimates are approximately $1.0 billion in this indication in the U.S. alone. We remind investors that NBI-98854 has received breakthrough designation from the U.S. FDA for the treatment of TD. Neurocrine is also pursuing development of NBI-98854 in TS. Phase 1b data are expected in the fourth quarter of 2015. We believe the opportunity for NBI-98854 in TS is another billion-dollar opportunity.

We continue to be positive on the Neurocrine story. Near term catalysts over the next six months include the Phase 3 Kinect 3 data for NBI-98854 in TD, the Phase 1b clinical data from the T-FORCE trial for NBI-98854 in TS, and the data from the second Phase 3 elagolix trial in endometriosis in the first quarter of 2016. Based upon the changes to our model, we believe the shares are fairly valued at $65 per share. Given Teva's acquisition of Auspex for a potential competitor to NBI-98854 and elagolix looking like a blockbuster for AbbVie, we continue to believe that Neurocrine will be a potential acquisition target at some point in the future.

PROJECTED FINANCIALS

Neurocrine Biosciences Inc.
Income Statement

Neurocrine Bio	2014 A	Q1 A	Q2 A	Q3 E	Q4 E	2015 E	2016 E	2017 E
R&D / Milestones & Fees	**$0**	**$19.8**	**$0**	**$0**	**$0**	**$19.8**	**$50.0**	**$50.0**
YOY Growth	-	-	-	-	-	-	-	-
elagolix Royalties	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth	-	-	-	-	-	-	-	-
NBI-77860 (CRF1)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth	-					-	-	-
NBI-98854 (VMAT2)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth	-	-	-	-	-	-	-	-
Total Revenues	**$0**	**$19.8**	**$0**	**$0**	**$0**	**$19.8**	**$50.0**	**$50.0**
YOY Growth	-	-	-	-	-	-	-	*0.0%*
CoGS / Royalties	$0	$0	$0	$0	$0	$0	$0	$0
Gross Margin	-	-	-	-	-	-	-	-
SG&A	$18.0	$5.5	$6.6	$6.8	$7.0	$25.9	$35.0	$45.0
R&D	$46.4	$16.6	$18.7	$20.0	$23.5	$78.8	$75.0	$75.0
Operating Income	($64.4)	($2.3)	($25.3)	($26.8)	($30.5)	($84.9)	($60.0)	($70.0)
Operating Margin	-	-	-	-	-	-	-	-
Interest / Other Income	$3.9	$1.1	$1.3	$1.3	$1.4	$5.1	$4.0	$4.0
Pre-Tax Income	($60.5)	($1.2)	($24.0)	($25.5)	($29.1)	($79.8)	($56.0)	($66.0)
Taxes	$0	$0	$0	$0	$0	$0	$0	$0
Tax Rate	*15%*	*0%*	*0%*	*0%*	*0%*	*30%*	*30.0%*	*30.0%*
Net Income	($60.5)	($1.2)	($24.0)	($25.5)	($29.1)	($79.8)	($56.0)	($66.0)
YOY Growth	-	-	-	-	-	-	-	-
Net Margin	-	-	-	-	-	-	-	-
Reported EPS	**($0.81)**	**($0.01)**	**($0.28)**	**($0.30)**	**($0.34)**	**($0.95)**	**($0.64)**	**($0.73)**
YOY Growth	-	-	-	-	-	-	-	-
Shares Outstanding	74.6	80.3	85.5	85.7	85.8	84.3	87.5	90.0

Source: Zacks Investment Research, Inc. *David Bautz, PhD*

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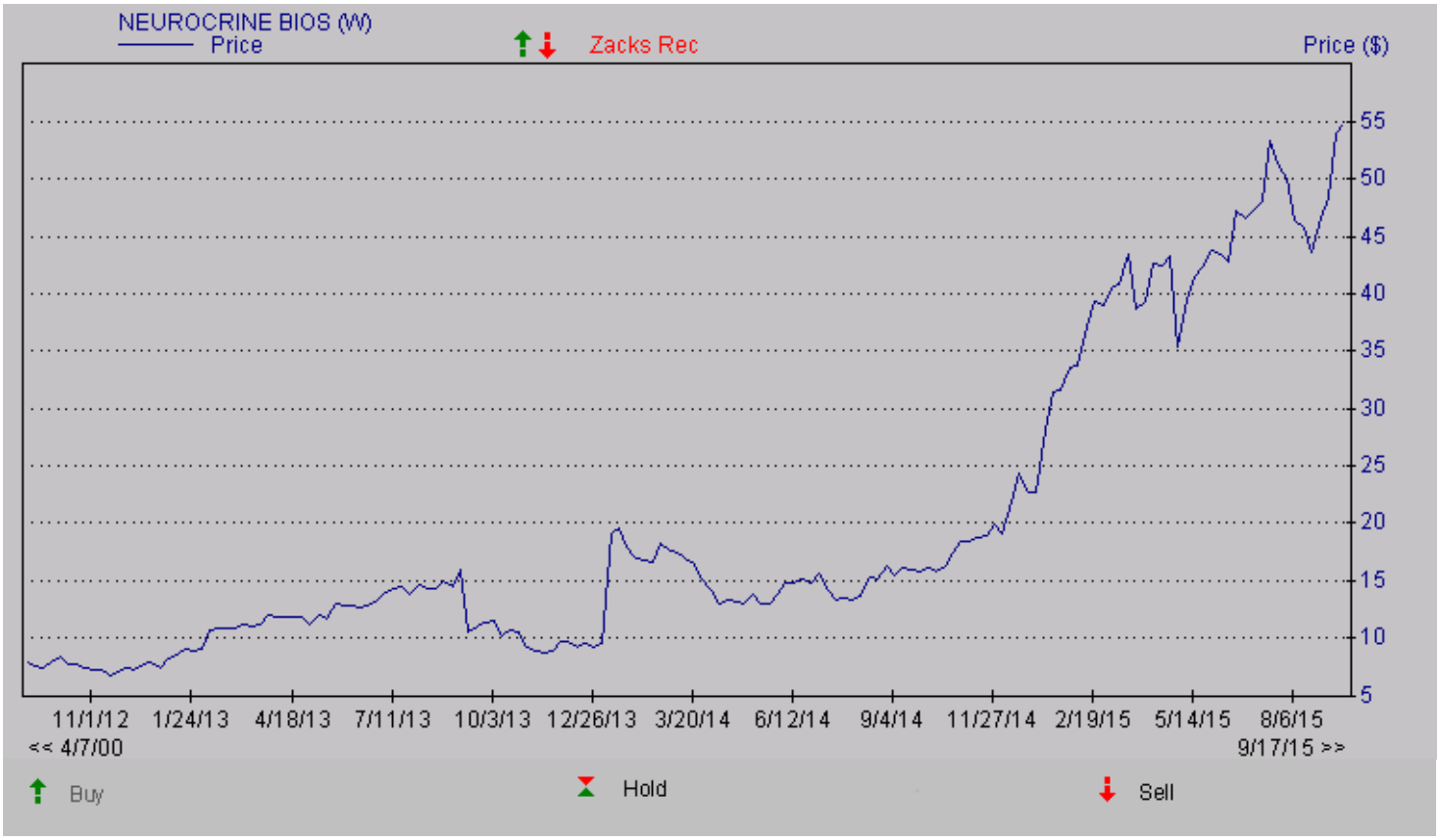
HISTORICAL ZACKS RECOMMENDATIONS



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