

Neurocrine Biosciences, Inc.

(NBIX-NASDAQ)

NBIX: Elagolix Partnership Nearing...

OUTLOOK

Current Recommendation	Hold
Prior Recommendation	Buy
Date of Last Change	12/13/2007
 Current Price (07/30/09)	 \$3.39
Target Price	\$5.00

Neurocrine's stock has been stuck in a tight trading range over the past year as investors are waiting for an update on both elagolix and indiplon. We think indiplon is dead, but that elagolix has real potential. An attractive early-stage pipeline, plenty of cash, and likelihood of a partnership later in the year position Neurocrine well for the future. The biggest near-term catalyst remains the signing of a lucrative partnership for elagolix. This could occur before year-end 2009.

Long-term, we like the upside that elagolix offers. We see \$5 as fair value.

SUMMARY DATA

52-Week High	\$5.95
52-Week Low	\$2.22
One-Year Return (%)	-26.14
Beta	0.66
Average Daily Volume (sh)	105,519

Shares Outstanding (mil)	39
Market Capitalization (\$mil)	\$132
Short Interest Ratio (days)	23.51
Institutional Ownership (%)	70
Insider Ownership (%)	7

Annual Cash Dividend	\$0.00
Dividend Yield (%)	0.00

5-Yr. Historical Growth Rates	
Sales (%)	-62.0
Earnings Per Share (%)	N/A
Dividend (%)	N/A

P/E using TTM EPS	N/A
P/E using 2009 Estimate	N/A
P/E using 2010 Estimate	N/A

Zacks Rank	2
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Risk Level	Average
Type of Stock	Small-Value
Industry	Med-Drugs
Zacks Rank in Industry	of 107

ZACKS ESTIMATES

Revenue

(in millions of \$)

	Q1	Q2	Q3	Q4	Year
	(Mar)	(Jun)	(Sep)	(Dec)	(Dec)
2008	1.8 A	0.7 A	0.8 A	0.7 A	4.0 A
2009	0.7 A	0.7 A	0.7 E	0.8 E	2.9 E
2010					5.0 E
2011					7.5 E

Earnings per Share

(EPS is operating earnings before non recurring items)

	Q1	Q2	Q3	Q4	Year
	(Mar)	(Jun)	(Sep)	(Dec)	(Dec)
2008	-\$0.55 A	-\$0.55 A	-\$0.46 A	-\$0.75 A	-\$2.30 A
2009	-\$0.51 A	-\$0.39 A	-\$0.38 E	-\$0.38 E	-\$1.65 E
2010					-\$1.11 E
2011					-\$1.10 E

Zacks Projected EPS Growth Rate - Next 5 Years %	N/A
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WHAT'S NEW

Second Quarter Financials...

Neurocrine Biosciences reported financial results for the second quarter 2009 on July 30, 2009. The company reported total revenues for the quarter of \$0.7 million, consisting of collaborative under the collaboration agreement with GlaxoSmithKline relating to the CRF program. This was dead-on with our forecast. Net loss for the quarter totaled \$15.3 million, or \$0.39 per share. This was \$0.02 better than expected on slightly lower operating expenses. Results include a \$0.9 million cease-use charge associated with the vacancy of one of the company's buildings at its San Diego campus. Neurocrine exited the second quarter with approximately \$74.0 million in cash and equivalents. According to our financial model, this is a cash runway of just under two years.

COMPANY OVERVIEW

Neurocrine Biosciences, Inc. (NBIX) is a biopharmaceutical company that develops drugs primarily for neurological and endocrine diseases and disorders. The company's lead drug candidate is an oral GnRH small-molecule for endometriosis called elagolix. Other candidates include, Urocortin-2 for congestive heart failure, a CRF antagonist compound with GlaxoSmithKline for IBS and anxiety/depression, and early-stage molecules for insomnia and neuropathic pain. The company earns revenues primarily through sponsored research and development (R&D) collaborations, milestone payments, and licensing fees. Neurocrine Biosciences is based in San Diego, CA.



Elagolix at the Forefront

The leading pipeline candidate is now **elagolix**, an oral, small molecule GnRH (gonadotropin-releasing hormone) antagonist under development for the treatment of endometriosis. Elagolix is currently in a large-scale phase II program consisting of three separate trials, Petal-603, Lilac-702, and Tulip-703.

...Petal-603...

Neurocrine initiated the phase IIb study (Petal, Study-603) in the fourth quarter of 2006 in which 252 patients with endometriosis were studied over a 6-month treatment period. The trial included three treatment groups, with two doses of elagolix, 150 mg once a day (QD) and 75 mg twice daily (BID), and an active comparator (DMPA / Depo-Provera). The trial offered top-line data from the six month treatment portion in September 2008. The design of the Petal Study was to assess the impact of elagolix treatment on bone mineral density (BMD) as the primary endpoint using Dual Energy X-ray Absorptiometry (DXA) scans to document any change from baseline. In addition, efficacy assessments of endometriosis symptoms using Composite Pelvic Sign and Symptoms Score (CPSSS) and Visual Analog Scale (VAS) were tested as secondary endpoints.

A pre-specified statistical analysis established that the primary endpoint would be deemed a success if the lower-bound of the 95% confidence interval for mean change in BMD did not exceed -2.2%. We present the primary endpoint below for both the mean and lower-bound DXA data.

Change in BMD at Month 6 (per DXA)	Elagolix 150mg QD	Elagolix 75mg BID
Mean Results	-0.11% Spine -0.47% Femur	-1.30% Spine -0.99% Femur
Lower-bound (95% CI)	-0.70% Spine -0.96% Femur	-1.86% Spine -1.46% Femur

The data show that neither the 150mg once daily nor 75mg twice daily elagolix resulted in greater than 2.2% bone mineral density loss after six month for the lower-bound at 95% confidence. Several secondary endpoints demonstrated encouraging initial signs of efficacy, as presented below:

	Baseline	Elagolix 150mg QD	Elagolix 75mg BID	DMPA (+ control)
CPSSS	9.1			
– week 4		-3.9	-3.7	-3.8
– week 24		-5.5	-5.2	-5.3
Dysmenorrhea	2.4			
– week 24		-1.5	-1.4	-1.7
– response rate		86%	74%	86%
Non-Menstrual Pelvic Pain	2.2			
– week 24		-1.2	-1.2	-1.1
– response rate		86%	77%	77%
VAS	78.7			
– week 24		-31.8	-33.4	-35.5

The results show a very favorable comparison efficacy wise to DMPA (Depo-Provera) on all major subjective secondary endpoints, including two key endometriosis measures in dysmenorrhea (heavy or painful menstrual bleeding) and non-menstrual pelvic pain. Given the similar efficacy of 150mg once daily (QD) oral elagolix to intramuscular DMPA, the safety and tolerability profile of elagolix should make the drug a significant market share gainer. We note that the discontinuation rate for the DMPA cohort totaled 16%, compared to only 5% for 150mg elagolix. A higher incidence of headache (23% for the 150mg elagolix vs. 14% for DMPA) was the only concern. However, there were no serious adverse events in either elagolix arms vs. 2 reported in the DMPA arm.

The Petal-602 study also allowed for management to follow patients for 6 months post-treatment. This six-month follow-up data was released in mid-May 2009. The data was also presented at the 91st Annual Meeting of the Endocrine Society (ENDO) in June 2009. Key findings from the 150mg QD program with respect to:

- Bone Safety – demonstrate no apparent effect after the first 24 weeks of treatment, or no cumulative effect on bone mineral density (BMD) after the full 48 weeks. Mean change from baseline for the elagolix 150mg QD remained close to the 0% mark at week 48, with n-telopeptide values within the normal range of between 6 and 19 nM BCE for the tested age group.
- Pain Reduction – demonstrate a sustained improvement at week 48 compared to baseline in the Composite Pelvic Signs and Symptoms Score (CPSSS), with similar results on the ITT (n=252) and completers (n=131) analysis. Sub-components of the CPSSS demonstrate a "responder rate" on dysmenorrhea (heavy menstrual bleeding) of 77% at week 24 and 64% at week 48, and on non-menstrual pelvic pain were 86% at week 24 and 67% at week 48 (both p<0.0001).
- Quality of Life – based on the Endometriosis Health Profile (EHP-5) scale, which assessed the impact of endometriosis symptoms on five core domains, improved from baseline 80% of subjects reported that they suffered difficulties across all domains "sometimes," "often" or "always" to 60-80% of subjects saying "never" or "rarely" to these same EHP-5 questions at week 48.
- Safety and Tolerability – demonstrated adverse events that were generally mild and transient in nature, and included things such as headache and nausea. No serious adverse events, including no pattern of excessive estradiol suppression, were observed at a rate that would prohibit future development of the candidate.

...Lilac-702...

On March 25, 2009, Neurocrine Bio reported results from the Lilac Petal -702 study. Lilac Petal randomized 155 women with confirmed diagnosis of endometriosis into three treatment arms: placebo, 150mg elagolix, and 250mg elagolix – both once daily – for three months of treatment. After the first three months, the placebo group was randomized into the elagolix cohorts. Understanding the three month data from the Lilac-702 study is complex, and starts with first understanding the endpoints and why each was selected. There were five endpoints in the study, two clinically validated endometriosis endpoints and three exploratory endpoints. These endpoints include:

- 1) Patient Global Impression of Change (PGI-C): A clinically validated endometriosis endpoint that is an assessment of the changes in endometriosis-related pain on a scale of 1 to 7, with 1 meaning "very much improved, 4 meaning "no change" and 7 meaning "very much worsened".

- 2) Endometriosis Health Profile (EHP): A clinically validated endometriosis endpoint that is an assessment of disease specific quality of life on a scale of 0 to 100.
- 3) Numeric Rating Scale (NRS): An exploratory endpoint requested by the National Institutes of Health (NIH) and the American Society of Reproductive Medicine (ASRP) that is an assessment of pain on a scale of 0 to 10, with 0 meaning "no pain" and 10 meaning "severe pain".
- 4) Dysmenorrhea (DYS): An exploratory endpoint requested by the FDA that is an assessment of dysmenorrhea pain on a scale of 0 to 3, with 0 meaning "no pain" and 3 meaning "severe pain".
- 5) Non-Menstrual Pelvic Pain (NMPP): An exploratory endpoint requested by the FDA that is an assessment of non-menstrual pelvic pain on a scale of 0 to 3, with 0 meaning "no pain" and 3 meaning "severe pain".

The data from the first three months (placebo-controlled portion of the study) is presented below:

3-Month Treatment Data	placebo	150mg 1x Daily	250mg 1x Daily
Change in Baseline of...			
...NRS (mean, 0-10)	-0.90	-1.19	-1.25
...NRS (peak, 0-10)	-1.33	-2.45`	-2.75``
NMPP (mean, 0-3)	-0.24	-0.27	-0.25
...DYS (mean, 0-3)	-0.27	-0.68``	-0.76``
...EHP-5 (pain, 0-100)	-11	-23`	-20
Efficacy Endpoints...			
...PGI-C (mean, 1-7)	3.2	2.2``	2.3``
...PGI-C (% < 2)	33%	67%``	62%``
Safety & Tolerability...			
...Adverse Event Rate	8%	14%	15%
` p<0.05 `` p<0.01			

Elagolix met the primary efficacy goal for both the 150mg and 250mg on the clinically validated PGI-C scale for both overall lower PGI-C score and percent of women with a score below 2. The 150mg dose was also statistically significant for the clinically validated EHP scale. Management was also able to show a statistically significant reduction in baseline for the NRS-peak scale and dysmenorrhea (DYS). The trial failed to show a significant reduction in NMPP or the NRS-mean scale, both which management hypothesized were measuring the same thing – non-menstrual pelvic pain on a daily basis – to a correlation of 0.9, and both which started with baseline values that were relatively low on the scale to begin with and did not change much over the course of the program. Management has been referring to this as a "statistical floor effect".

The six month data was released in late July 2009. This data includes results from a total of 125 subjects that continued into the second three months of the trial; 38 subjects were re-randomized from their initial assignment of placebo to elagolix 150 mg (n=18) or elagolix 250 mg (n=20) once daily in a double-blind fashion. Those subjects who were initially randomized to elagolix continued under double-blind conditions. The outcome of primary interest at month six was the impact of the elagolix 250 mg dose on bone mineral density (BMD) as measured by DXA scan. Results are presented below.

	Elagolix 150mg QD	Elagolix 250mg QD
Mean Change in BMD (per DXA) Results	-0.8% Spine -0.7% Femur	-1.0% Spine -1.6% Femur
Median Value Serum Estradiol Levels	41 pg/ml	21 pg/ml

As expected, the 250 mg once daily dose had slightly greater percentage change from baseline in BMD. Management has now shown both dose-response curve and an upper limit bounding threshold for bone impact. From an efficacy standpoint, the exploratory daily pain scales for DYS and NMPP demonstrated that women had minimal endometriosis pain symptoms at month six. The overall assessment of benefit using the PGI-C revealed that 80% of elagolix 150 mg and 79% of elagolix 250 mg were "Much Improved" or "Very Much Improved" after six months of treatment. There were no signals of dose limiting adverse events for either dose of elagolix. Discontinuation due to adverse events was 2.9% for 150 mg, 5.6% for 250 mg. There were no drug-related serious adverse events (SAEs).

Overall we believe the results of the Lilac Petal (-702) study are positive. It is clear that the FDA is interested in assessing non-menstrual pelvic pain as a key component for approving an endometriosis drug. However, this is the first time a clinical program looked at non-menstrual pelvic pain on a daily basis. The original Lupron and Depo-Provera studies all assess non-menstrual pelvic pain on a monthly basis. We already know that elagolix works on monthly basis from the Petal-602 study. Women tend to remember or recall the worst days of pain over a monthly period as opposed to daily fluctuations in pain. This hypothesis is backed up by the fact that the NRS-peak did show a statistically significant reduction for elagolix vs. placebo whereas the NRS-mean did not. What it comes down to is management believes that assessing mean non-menstrual pelvic pain on a daily basis was non-applicable or sensitive enough for a population with mild-to-moderate disease (the target market). Plus, safety and tolerability in the program was excellent. The most common adverse events were headache and nausea, and none of these events were deemed to be serious.

...Tulip-703...

In December 2009, management should released data from the Tulip-703 program. This trial has a similar design to the Lilac-702 program, only with an active comparator in leuprolide depot (Abbott's Lupron).

In the meantime, management will hold an end-of-phase II meeting with the FDA to take place in the first quarter 2010. Management has been meeting with outside consultants to better understand the "statistical floor effect" observed in the Lilac-702 study. At that meeting, management and the FDA will outline a pivotal phase III program for elagolix. We expect that the pivotal phase III program will include two large-scale (n~500) patient programs with some modified NRS / NMPP / DYS endpoint. There will also be a long-term (n~400) safety program. One of the two phase III programs will include a head-to-head non-inferiority program vs. Lupron for the European submission. Neurocrine may seek a special protocol assessment (SPA) for the phase III trials. The company may also conduct one additional phase II program prior to the phase III trials depending on what endpoint is agreed upon for the phase III. Nevertheless, management believes the phase III trials should start during the first half of 2010.

...Partnership Talks Likely To Heat Up...

In the meantime, management remains in late-stage discussions with potential partners for elagolix. The data left to present is starting to run out. We stated in 2008 that no partnership on elagolix was likely until the full data from Petal-603 and the six month data on Lilac-702 were released. Well, here we are! There still remains the three month data from Tulip-703 in early December 2009, followed by the six month data and the end of phase II meeting in the first quarter of 2010. Still, partners should now be in a position where if they are interested in elagolix it's time to pony up. We believe elagolix is a highly attractive molecule. A lucrative partnership will eventually be secured. Management is looking for a worldwide distribution partner in return for upfront cash plus backend milestone and royalties. Potential partners are firms that have strong Women's health focus, including market leader Wyeth, or perhaps J&J. We estimate a small specialty OB/GYN sales force of 200 to 250 representatives can effectively target greater than 80% of the market.

...Background Info on Endometriosis...

Endometriosis is a medical condition characterized by growth of the endometrium (uterine tissue) outside of the uterus, most usually on the pelvis, that affects an estimated 89 million women of reproductive age worldwide, or about 5-10% of the female population. There are an estimated 8 million women affected by endometriosis in the U.S. Endometriosis also occurs in a small percentage (2-4%) of postmenopausal women. Symptoms of endometriosis are severe recurring pain that can include dysmenorrhea (menstrual pain), dyspareunia (painful sex), dyschezia (painful bowel movements) and dysuria (painful urination). Endometriosis is caused by an excess of the hormone estrogen, and thus can manifest during peak reproductive years. Hereditary and environmental factors, as well as associated infections (such as HPV), can increase incidence and severity.

The disease is often treated, ineffectively, by a number of medications. NSAIDs are used to treat mild-to-moderate pain associated with endometriosis. Progesterone or progestin and hormonal contraceptives are used to regulate estrogen levels when appropriate. Steroids and aromatase inhibitors are used to block estrogen levels and endometrium growth. However, these have significant negative side-effects. Lupron, a gonadotropin depo shot, is used to lower estrogen levels and slow endometrium growth. However, Lupron shuts down estradiol production and puts the body into "medicated menopause", resulting in significant side effects such as hot flashes and a reduction in bone mineral density. In the most severe cases, a hysterectomy is performed.

Elagolix, a gonadotropin-releasing hormone (GnRH) antagonist has efficacy characteristics similar to Lupron for the treatment of endometriosis, but with less potential for bone mineral density loss. The drug works by blocking the action of GnRH and suppressing luteinizing hormone and follicle-stimulating hormone. There are a few other GnRH molecules on the market, but none that are oral in dosing or have amassed the clinical data of elagolix. Therefore, we believe that Neurocrine can achieve significant market share gains with elagolix upon commercialization. Most women shy away from Lupron due to side-effects. Market research so far has been encouraging. Management noted that they are beginning to receive requests from physicians to prescribe elagolix on a compassionate basis. It is possible the FDA will allow elagolix compassionate use once phase III trials begin in 2010. Peak market sales opportunity is roughly \$500 million.

Indiplon Most Likely Dead

In mid December 2007, Neurocrine Biosciences received another approvable letter from the U.S. Food and Drug Administration (FDA) regarding insomnia drug indiplon. This second approvable letter follows the first letter received in May 2006 on the immediate release (IR) capsule formulation. Unfortunately, this letter listed new requirements that in our view kill the future development of the drug. The three requests outlined in the letter are:

- An objective / subjective clinical trial in the elderly.
- A safety study assessing the rates of adverse events occurring with indiplon when compared to a marketed product.
- A preclinical study to evaluate indiplon administration during the third trimester of pregnancy.

Management met face to face with the FDA for an end of review meeting in July 2008. They are current waiting for the minutes from that meeting before they make a final decision on the drug. However, given all the necessary work above, we expect discontinuation in the U.S. shortly.

CRF Progressing Slowly At Glaxo

Neurocrine is also developing novel corticotrophin releasing factor (CRF) small molecule antagonists for various mood disorders, including anxiety, depression, and irritable bowel syndrome (IBS). The company has teamed up with GlaxoSmithKline for development of these agents. The previous lead candidate was NBI-876008. Management initiated two phase II "proof-of-concept" trials that began in late December 2006 – one with 130 patients in IBS and another with 200 patients in SAD. Both trials failed to show a statistically significant improvement vs. placebo. We expect no future work with this candidate.

NBI-561679 is now the leading candidate. Glaxo recently completed a multi-dose phase I program and is now advancing this agent into phase II trials for major depression disorder (MDD). Information learned throughout the program about receptor binding pharmacology point to encouraging signs for NBI-561679. We would expect data read-out from this phase II program around mid-2010. There is also an additional "back-up candidate", dubbed NBI-586529, which recently completed a phase I dose-escalation program. NBI-586529 offers potential in depression and anxiety disorders.

VMAT-2 Moving Into Phase I

The next clinical stage candidate at Neurocrine is a vesicular monoamine transport 2 (VMAT-2) inhibitor, dubbed NBI-98854, that could play an important role in treating or preventing hyperkinetic movement disorders. Targeted dyskinesia is characterized by involuntary bodily movements as seen in patients suffering from Huntington's disease, Parkinson's disease, or as a side effect of dopamine modulation in patients suffering from schizophrenia. VMAT-2 is a protein concentrated in the human brain that is essential for the transmission of nerve impulses between neurons. Neurocrine identified a highly selective VMAT2 inhibitor that is effective in regulating the levels of dopamine release during nerve communication, while at the same time having minimal impact on the other monoamines thereby reducing the likelihood of "off target" side effects.

A clinical trial application has been approved by Health Canada for single ascending dose phase I study in August 2009. Doing a phase I pK study in Canada is a quick and cost-effective way to allow for a U.S. IND filing and initiation of a phase II study in 2010.

Looking to Monetize Urocortin-2

Another important mid-stage program is the Urocortin-2 program for mild to moderate congestive heart failure (CHF). Previous phase II data with Urocortin-2 has demonstrated the candidate to be generally well tolerated and that the predicted hemodynamic effects on systolic and diastolic blood pressure, heart rate, cardiac work and, most importantly, cardiac output occurs over the entire 4-hour infusion. Management recently completed some preclinical formulation, toxicology and safety work to support a longer-term duration infusion – potentially up to 14 days. Neurocrine has partnered with academic laboratories to move Urocortin-2 forward.

Most recently, Neurocrine formed a collaboration with the Christchurch Cardioendocrine Research Group (CCRG) at the University of Otago, New Zealand, Christchurch School of Medicine and Health Sciences. CCRG has submitted a proposal to initiate a 50-person pilot study with Urocortin-2 in patients with acute decompensated heart failure (ADHF). Neurocrine will supply drug and logistical support to CCRG. Neurocrine has always been focus on drugs primarily for neurological and endocrine diseases and disorders. We believe that management will look to out-license Urocortin-2 to a pharmaceutical partner focused on cardiovascular disease. This could bring upfront cash perhaps later in 2009 or in 2010.

VALUATION & RECOMMENDATION

Neurocrine's stock was punished hard on the second approvable letter in December 2007, down 50% on the surprising news. It is amazing to think that since the first approvable letter in May 2006, Neurocrine's stock is down over 95%. The FDA request seems to go far above and beyond what was originally asked of Neurocrine after the first letter. It is also unprecedented with respect to what was asked of Sanofi for Ambien and Sepracor for Lunesta. In our view, indiplon is most likely to be discontinued here in the next few months.

Investor focus has now squarely turned to elagolix. The company has conducted a total of five phase II programs on the molecule in nearly 900 total patients. Over the past two years we have seen positive six and twelve month data from the PETAL Study (study-603) and positive three and six month data from the Lilac-PETAL (study-702). Both trials confirmed the safety and tolerability of elagolix in the endometriosis population. One more phase II program, Tulip-PETAL (study-703) is ongoing, with data expected in early December 2009.

Management remains in discussions with multiple pharmaceutical companies on a potential development partnership. We stated in 2008 that no partnership on elagolix was likely until the full data from Petal-603 and the six month data on Lilac-702 were released. Well, here we are! There still remains the three month data from Tulip-703 in early December 2009, followed by the six month data and the end of phase II meeting in the first quarter of 2010. Still, partners should now be in a position where if they are interested in elagolix it's time to pony up. We believe elagolix is a highly attractive molecule. A lucrative partnership will eventually be secured. Management is looking for a worldwide distribution partner in return for upfront cash plus backend milestone and royalties. Potential partners are firms that have strong Women's health focus, including market leader Wyeth, or perhaps J&J. We estimate a small specialty OB/GYN sales force of 200 to 250 representatives can effectively target greater than 80% of the market.

The company exited the second quarter with \$74.0 million in cash and investments. This is \$1.90 per share. Based on DCF analysis, elagolix is worth \$3-4 per share. The rest of the pipeline, including the three CRF agents with Glaxo, Urocortin-2, and a few early-stage candidates are worth another \$2+ in total. Our sum of parts analysis, including cash, yields a price of \$8+ per share. However, Neurocrine will burn an estimated \$50 – 60 million in 2009. Therefore, we expect the stock to remain selling at a discount to fair value. That being said, the name is attractive from a long-term stand point, and we expect that the shares will receive a nice pop on the day the elagolix partnership is secured. We would be buyers of the stock below \$3.

PROJECTED FINANCIALS

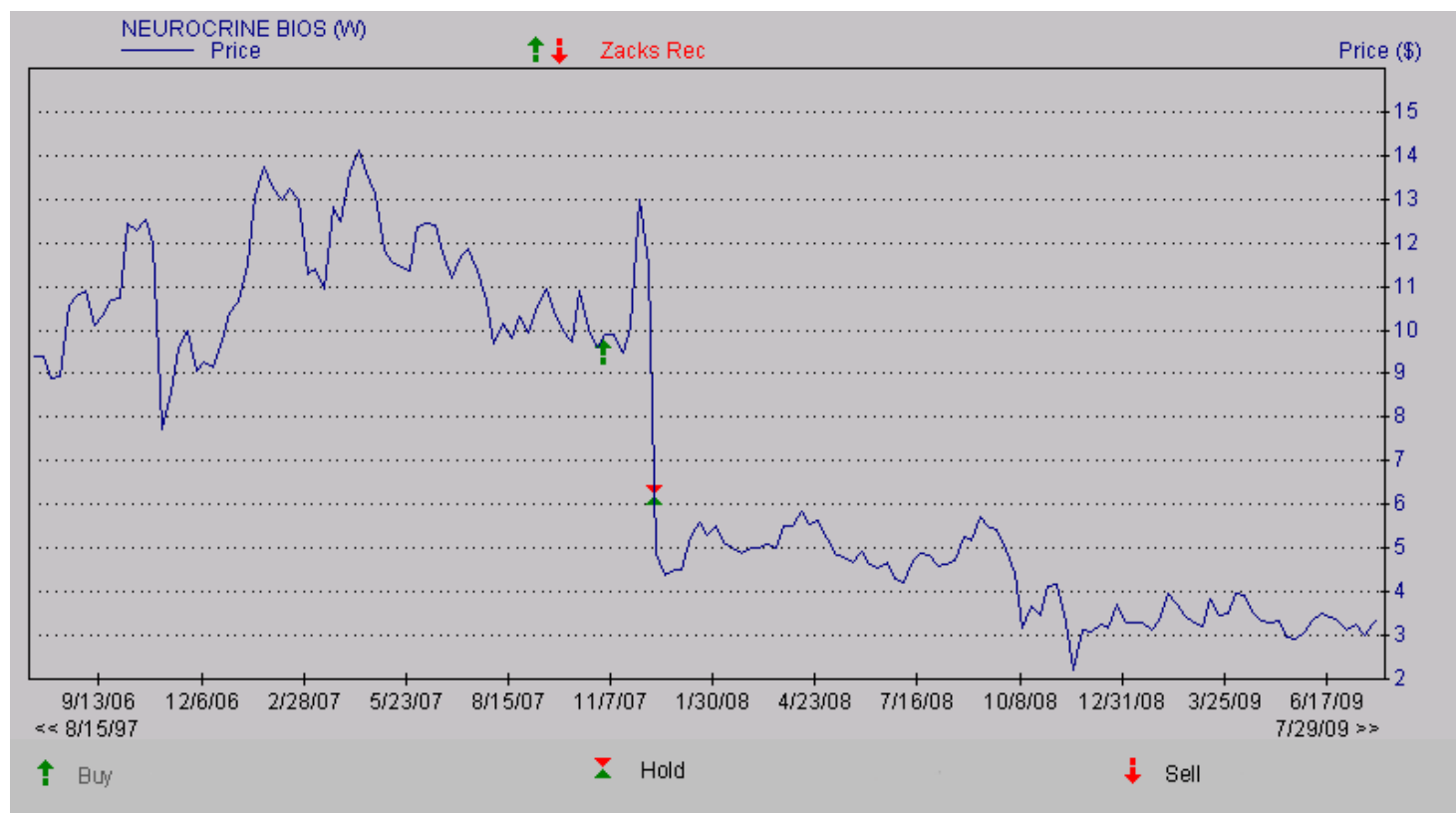
Neurocrine Biosciences Inc. Income Statement

	2008 A	Q1A	Q2A	Q3E	Q4E	2009 E	2010 E	2011 E	2012 E	2013 E
R&D / Milestones & Fees	\$4.0	\$0.7	\$0.7	\$0.7	\$0.8	\$3.0	\$5.0	\$7.5	\$10.0	\$10.0
YOY Growth	224.8%	-57.3%	-0.1%	-8.0%	9.7%	-25.0%	67.8%	50.0%	33.3%	0.0%
indiplon Royalties	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
YOY Growth	-	-	-	-	-	-	-	-	-	-
elagolix Royalties	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
YOY Growth	-	-	-	-	-	-	-	-	-	-
CRF Receptor Antagonists	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
YOY Growth	-	-	-	-	-	-	-	-	-	-
Urocortin 2	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
YOY Growth	-	-	-	-	-	-	-	-	-	-
VMAT-2	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
YOY Growth	-	-	-	-	-	-	-	-	-	-
Total Revenues	\$4.0	\$0.7	\$0.7	\$0.7	\$0.8	\$3.0	\$5.0	\$7.5	\$10.0	\$10.0
YOY Growth	224.8%	-57.3%	-0.1%	-8.0%	9.7%	-25.0%	67.8%	50.0%	33.3%	0.0%
CoGS / Royalties	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Gross Margin	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
SG&A	\$20.2	\$4.2	\$4.8	\$3.8	\$3.5	\$16.3	\$14.0	\$14.5	\$15.5	\$16.5
% SG&A	509.2%	561.6%	658.5%	542.9%	437.5%	547.7%	280.0%	193.3%	155.0%	165.0%
R&D	\$55.3	\$10.8	\$10.8	\$11.2	\$11.8	\$44.7	\$42.5	\$45.0	\$48.0	\$50.0
% R&D	1391.0%	1452.2%	1474.5%	1600.0%	1475.0%	1498.5%	850.0%	600.0%	480.0%	500.0%
Operating Income	(\$87.3)	(\$14.3)	(\$14.9)	(\$14.3)	(\$14.5)	(\$58.0)	(\$51.5)	(\$52.0)	(\$53.5)	(\$56.5)
Operating Margin	-	-31.1%	-25.9%	-8.9%	-52.8%	-	-	-	-	-
Interest / Other Income	(\$1.3)	(\$5.4)	(\$0.4)	(\$0.4)	(\$0.4)	(\$6.5)	(\$1.1)	(\$1.4)	(\$1.8)	(\$2.1)
Pre-Tax Income	(\$88.6)	(\$19.7)	(\$15.3)	(\$14.7)	(\$14.9)	(\$64.5)	(\$52.6)	(\$53.4)	(\$55.3)	(\$58.6)
Taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Tax Rate	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Net Income	(\$88.6)	(\$19.7)	(\$15.3)	(\$14.7)	(\$14.9)	(\$64.5)	(\$52.6)	(\$53.4)	(\$55.3)	(\$58.6)
YOY Growth	-	-6.7%	-27.1%	-17.0%	-48.4%	-	-	-	-	-
Net Margin	-2229.3%	-2632.5%	-2084.6%	-2100.0%	-1862.5%	-2165.9%	-1052.0%	-712.0%	-553.0%	-586.0%
Reported EPS	(\$2.30)	(\$0.51)	(\$0.39)	(\$0.38)	(\$0.38)	(\$1.65)	(\$1.11)	(\$1.10)	(\$0.98)	(\$1.04)
YOY Growth	-	-7.5%	-28.3%	-18.6%	-49.5%	-	-	-	-	-
Stock Options	\$8.2	\$1.9	\$1.5	\$1.6	\$1.3	\$6.3	\$7.0	\$7.5	\$8.0	\$8.0
EPS Impact of FAS-123R	\$0.21	\$0.05	\$0.04	\$0.04	\$0.03	\$0.16	\$0.15	\$0.15	\$0.14	\$0.14
Shares Outstanding	38.4	38.7	39.0	39.2	39.5	39.1	47.5	48.5	56.5	56.5

Source: Zacks Investment Research, Inc.

Jason Napodano, CFA

HISTORICAL ZACKS RECOMMENDATIONS



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