

NEUROCRINE BIOSCIENCES INC

Form 10-K

February 11, 2014

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2013

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission file number: 0-22705

NEUROCRINE BIOSCIENCES, INC.

(Exact name of registrant as specified in its charter)

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Delaware
(State or other jurisdiction of
incorporation or organization)

33-0525145
(I.R.S. Employer
Identification Number)

12780 El Camino Real, San Diego, CA
(Address of principal executive offices)

92130
(Zip Code)

Registrant's telephone number, including area code:

(858) 617-7600

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, \$0.001 par value	The NASDAQ Stock Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes No

The aggregate market value of the common equity held by non-affiliates of the registrant as of June 30, 2013 totaled approximately \$646,990,582 based on the closing price for the registrant's Common Stock on that day as reported by the NASDAQ Stock Market. Such value excludes Common Stock held by executive officers, directors and 10% or greater stockholders as of June 30, 2013. The identification of 10% or

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greater stockholders as of June 30, 2013 is based on Schedule 13G and amended Schedule 13G reports publicly filed before June 30, 2013. This calculation does not reflect a determination that such parties are affiliates for any other purposes.

As of January 24, 2014, there were 67,793,709 shares of the registrant's Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Document Description	10-K Part
Portions of the registrant's notice of annual meeting of stockholders and proxy statement to be filed pursuant to Regulation 14A within 120 days after registrant's fiscal year end of December 31, 2013 are incorporated by reference into Part III of this report	III

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PART I

FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K and the information incorporated herein by reference contain forward-looking statements that involve a number of risks and uncertainties. Although our forward-looking statements reflect the good faith judgment of our management, these statements can only be based on facts and factors currently known by us. Consequently, these forward-looking statements are inherently subject to risks and uncertainties, and actual results and outcomes may differ materially from results and outcomes discussed in the forward-looking statements.

Forward-looking statements can be identified by the use of forward-looking words such as believes, expects, hopes, may, will, plan, estimates, could, should, would, continue, seeks, pro forma, or anticipates, or other similar words (including their use in the discussions of future matters such as the development of new products, technology enhancements, possible changes in legislation and other statements that are not historical. These statements include but are not limited to statements under the captions Risk Factors, Management's Discussion and Analysis of Financial Condition and Results of Operations and Business, as well as other sections in this report. You should be aware that the occurrence of any of the events discussed under the heading Item 1A. Risk Factors and elsewhere in this report could substantially harm our business, results of operations and financial condition and that if any of these events occurs, the trading price of our common stock could decline and you could lose all or a part of the value of your shares of our common stock.

The cautionary statements made in this report are intended to be applicable to all related forward-looking statements wherever they may appear in this report. We urge you not to place undue reliance on these forward-looking statements, which speak only as of the date of this report. Except as required by law, we assume no obligation to update our forward-looking statements, even if new information becomes available in the future.

ITEM 1. BUSINESS

We were originally incorporated in California in January 1992 and were reincorporated in Delaware in May 1996.

We discover and develop innovative and life-changing pharmaceuticals, in diseases with high unmet medical needs, through our novel R&D platform, focused on neurological and endocrine based diseases and disorders. Our two lead late-stage clinical programs are elagolix, a gonadotropin-releasing hormone (GnRH) antagonist for women's health that is partnered with AbbVie Inc. (AbbVie), and a wholly owned vesicular monoamine transporter 2 (VMAT2) inhibitor for the treatment of movement disorders. We intend to maintain certain commercial rights to our VMAT2 inhibitor and evolve into a fully-integrated pharmaceutical company.

Table of Contents**Our Product Pipeline**

The following table summarizes our most advanced product candidates currently in clinical development and those currently in research and is followed by detailed descriptions of each program:

Program	Target Indication(s)	Status	Rights
Product candidates in clinical development:			
Elagolix	Endometriosis	Phase III	AbbVie
VMAT2 (NBI-98854)	Movement Disorders	Phase II	Neurocrine
CRF ¹ Antagonist (NBI-77860)	Stress-related Disorders	Phase II	Neurocrine
Elagolix	Uterine Fibroids	Phase II	AbbVie
Research programs:			
G Protein-Coupled Receptor 119 (GPR119)	Type II Diabetes	Research	Boehringer Ingelheim
VMAT2	Tourette Syndrome Schizophrenia	Research	Neurocrine
GnRH Antagonists	Men's and Women's Health, Oncology	Research	AbbVie
Antiepileptic Drugs	Epilepsy, Essential Tremor, Pain	Research	Neurocrine
G Protein-Coupled Receptors	Other Conditions	Research	Neurocrine

Phase III indicates that we or our collaborators are conducting large-scale, multicenter comparative clinical trials on patients afflicted with a target disease in order to provide substantial evidence for efficacy and safety.

Phase II indicates that we or our collaborators are conducting clinical trials on groups of patients afflicted with a specific disease in order to determine preliminary efficacy, optimal dosages and expanded evidence of safety.

Research indicates identification and evaluation of compound(s) in laboratory and preclinical models.

Product Candidates In Clinical Development**Elagolix – Gonadotropin-Releasing Hormone (GnRH) Antagonist**

GnRH is a peptide that stimulates the secretion of the pituitary hormones that are responsible for sex steroid production and normal reproductive function. Researchers have found that chronic administration of GnRH agonists, after initial stimulation, reversibly shuts down this transmitter pathway and is clinically useful in treating hormone-dependent diseases such as endometriosis and uterine fibroids. Several companies have developed peptide GnRH agonists on this principle, such as Lupron[®] and Zoladex[®]. However, since they are peptides, they must be injected via a depot formulation rather than the preferred oral route of administration. In addition, GnRH agonists can take up to several weeks to exert their desired effect once the initial stimulation has occurred, a factor not seen with the use of GnRH antagonists. Upon administration, GnRH agonists have shown a tendency to exacerbate the condition via a hormonal flare. More importantly, the profound suppression effect observed with GnRH agonists is similar to that seen after menopause and can be associated with hot flashes and the loss of bone mineral density.

Orally active, nonpeptide GnRH antagonists potentially offer several advantages over injectable GnRH peptide drugs, including rapid onset of hormone suppression without a hormonal flare. Also, injection site

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reactions commonly observed in peptide depots are avoided and dosing can be rapidly discontinued if necessary a clinical management option not available with long-acting depot injections. Additionally, by using GnRH antagonists, it may be possible to alter the level of pituitary GnRH suppression thereby titrating circulating estrogen levels. Using this approach, an oral GnRH antagonist may provide patients relief from the painful symptoms of endometriosis while avoiding the need for the active management of bone loss.

Endometriosis. Endometriosis is associated with a multitude of symptoms, some of the most common of which include pain related both to menstruation (dysmenorrhea) and sexual intercourse (dyspareunia) as well as chronic pelvic pain throughout the menstrual cycle, infertility, and menorrhagia, among many others. The wide range of symptoms associated with endometriosis serves to complicate and delay diagnosis due to the significant overlap of symptoms with the disease profiles of other conditions. The World Endometriosis Research Foundation estimates that there are over 170 million women worldwide who suffer from endometriosis, including approximately 7.5 million women in the United States alone. We believe that the availability of an oral treatment, lacking the side effect profile of the currently available peptide GnRH agonists, may be a desirable alternative to current pharmaceutical therapies and ultimately encourage a significantly higher treatment rate.

During 2008, we completed the first Phase IIb study of elagolix (PETAL or 603 study) in which 252 patients, with a laparoscopic diagnosis of endometriosis, were treated over the initial six-month period. This multi-center, randomized, double-blind, double-dummy study consisted of three treatment groups, elagolix 150mg once a day, elagolix 75mg twice daily, and an active control, DMPA-SC. The primary purpose of this study was to assess the impact of six months of treatment of elagolix on bone mineral density as measured by a dual energy x-ray absorptiometry (DXA) scan at the conclusion of treatment and at six and 12 months post treatment. This study also assessed, as secondary endpoints, the impact of treatment on endometriosis symptoms as measured by Composite Pelvic Signs and Symptoms Scale (CPSSS), a monthly recall scale that measures dysmenorrhea, non-menstrual pelvic pain, dyspareunia, pelvic tenderness and induration (all elements of endometriosis pain). Top-line results showed that elagolix met the primary endpoint by having minimal impact on bone mineral density at the conclusion of treatment. This study also showed that elagolix had both a statistical and clinically meaningful reduction in endometriosis symptoms as measured by CPSSS with an 86% responder rate in the 150mg once daily elagolix arm of the study. Additionally, elagolix was shown to be non-inferior to DMPA-SC under the CPSSS. Patient follow up both six and 12 months post treatment showed elagolix did not result in a significant reduction in bone mineral density as measured by DXA scan, with a mean time of return to ovulation of 24 days for elagolix subjects.

Toward the conclusion of the 603 study, the U.S. Food and Drug Administration (FDA) requested that the endpoints for dysmenorrhea and non-menstrual pelvic pain be assessed on a daily basis rather than utilizing the CPSSS monthly recall scale. In addition, the FDA also provided modified wording to assess the dysmenorrhea and non-menstrual pelvic pain scores on a daily basis. Given these new independent co-primary endpoints, we conducted two additional Phase IIb trials of elagolix to evaluate these modified endpoints as proposed by the FDA, to fully explore the elagolix dose range utilizing both 150mg and 250mg doses. These two trials were designed to assess elagolix for an initial three months, with the non-elagolix treatment arms re-randomized after three months into treatment groups of either 150mg or 250mg of elagolix once daily for an additional three months.

The first additional Phase IIb trial (Lilac PETAL or 702 study) consisted of three arms, elagolix 150mg once daily, elagolix 250mg once daily and placebo. We randomized 155 subjects with a laparoscopic diagnosis of endometriosis in this trial. The three-month placebo-controlled portion of the 702 study showed that elagolix provided endometriosis sufferers with clinical improvement of symptoms, coupled with an excellent safety and tolerability profile. However, the FDA-proposed non-menstrual pelvic pain daily scale had a low baseline score and was relatively insensitive to treatment effects. There were no treatment related serious adverse events in the 702 study and the two most common adverse events were headache and nausea, which were typically mild and transient and consistent with our previous studies.

The second additional Phase IIb trial (Tulip PETAL or 703 study) consisted of four arms, elagolix 150mg once daily, elagolix 250mg once daily, Prostag[®] SR 3.75mg (leuprorelin) and placebo. We enrolled 174 subjects

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with a laparoscopic diagnosis of endometriosis in this trial. The three-month placebo-controlled portion of the 703 study confirmed that elagolix and leuprorelin are associated with reductions in dysmenorrhea and non-menstrual pelvic pain daily scores when compared to placebo. However, the FDA-proposed non-menstrual pelvic pain daily scale numeric changes and dynamic range were both small. Although the adverse events reported in the 703 study as occurring more often with elagolix than with placebo were nausea and headache ($\leq 12\%$), consistent with previous clinical studies of elagolix, these events were generally mild or moderate, transient and not generally associated with study discontinuation. There were no treatment related serious adverse events.

In August 2009, we held a Type C meeting with the FDA to discuss the non-menstrual pelvic pain scale as proposed by the FDA and used in the 702 and 703 studies. Based on this meeting, we modified the wording of the non-menstrual pelvic pain and dysmenorrhea daily scales and launched a new clinical trial, the Daisy PETAL Study (901 study). This parallel, double-blind, placebo-controlled clinical trial was designed to provide an assessment of the modified scales over an eight-week treatment period of 150mg elagolix, followed by sixteen weeks of open-label treatment. This trial commenced in September 2009 and randomized approximately 130 subjects. In May 2010, we announced the results of this trial which showed the symptoms of dysmenorrhea and non-menstrual pelvic pain, as measured by the modified daily scales, both improved significantly in the elagolix treated arms (p-value<0.001 and p-value<0.01, respectively). Daily dysmenorrhea pain scores were a 2.1 at baseline (0-3 scale) with a 1.13 reduction in the elagolix arm compared to a 0.37 reduction in the placebo arm at eight weeks. Daily non-menstrual pelvic pain scores were a 1.4 at baseline (0-3 scale) with a 0.47 reduction in the elagolix arm compared to a 0.19 reduction in the placebo arm at eight weeks. There were no treatment related serious adverse events in the 901 study and the two most common adverse events were headache and nausea, which were typically mild and transient and consistent with our previous studies.

We have a worldwide collaboration with AbbVie to develop and commercialize elagolix and all next-generation non-peptide GnRH antagonists for women's and men's health indications. AbbVie has primary responsibility for all regulatory interactions with the FDA related to elagolix and the next-generation GnRH antagonists covered by the collaboration.

The endometriosis Phase III program is assessing two separate doses of elagolix (150mg once-daily and another dose) over a 24-week treatment period. The initial randomized, parallel, double-blind, placebo-controlled pivotal trial (Violet PETAL) is expected to enroll 875 women in approximately 160 clinical sites throughout the United States, Canada and Puerto Rico. The co-primary endpoints are a comparison of the daily non-menstrual pelvic pain and daily dysmenorrhea scores during the third month of treatment to the respective daily baseline scores utilizing a responder analysis. Additional efficacy and safety endpoints include assessing persistence of pain reduction at month six and the impact on bone mineral density after one year of continuous dosing.

The second Phase III study of elagolix was initiated by AbbVie during 2013. This study is similar in design to the Violet PETAL study with the same co-primary endpoints of daily non-menstrual pelvic pain and daily dysmenorrhea, comparing the third month of treatment to the respective daily baseline scores utilizing a responder analysis. This trial is anticipated to enroll 788 women with moderate to severe endometriosis-associated pain at more than 200 sites globally. AbbVie initiated the elagolix endometriosis Phase III program during the second quarter of 2012, with a new drug application (NDA) filing expected in 2016.

Uterine Fibroids. Uterine fibroids are benign hormonally responsive tumors that form in the wall of the uterus. They are the most common solid tumor in women with a prevalence rate of at least 25% (American College of Obstetricians and Gynecologists). While many women do not have symptoms, depending on the size, location and number, uterine fibroids can cause pelvic pain, reproductive problems, and severe bleeding that can lead to anemia. Due to the severity of symptoms, treatment sometimes requires surgery, including the removal of the uterus. In fact, uterine fibroids is a leading indication for hysterectomy in the United States, with approximately 250,000 hysterectomies performed each year related to uterine fibroids (Whiteman *et al AJOG* 2008, 198, e1). We believe that a safe and effective oral therapy would be a preferred treatment regimen rather than surgical intervention.

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During 2011, AbbVie initiated a randomized, double-blind, placebo-controlled, Phase IIa study of approximately 300 women to assess the safety and efficacy of elagolix in the treatment of uterine fibroids. The primary endpoint in this study was an assessment of blood loss after three months of treatment with elagolix. The dose ranging study evaluated various doses of elagolix compared to placebo. Additional efficacy endpoints were also evaluated including change in uterine volume, fibroid volume, and change in menstrual patterns. Based on the results of this study, AbbVie launched a Phase IIb uterine fibroids study for elagolix in early 2013. This Phase IIb clinical trial will enroll 520 women with heavy uterine bleeding due to uterine fibroids and assess uterine blood loss after six months of treatment across various dosing regimens of elagolix, utilizing a quantitative assessment tool for blood loss, alkaline hematin. Secondary efficacy endpoints include change in uterine volume, fibroid volume, and change in menstrual patterns. Safety assessments of bone mineral density, comparing baseline to month six, will be performed via DXA scan. Patients will also be followed off drug for up to six months. This study is expected to be completed in 2015.

Vesicular Monoamine Transporter 2 Inhibitor (VMAT2)

VMAT2 is a protein concentrated in the human brain that is essential for the transmission of nerve impulses between neurons. VMAT2 is primarily responsible for re-packaging and transporting monoamines (dopamine, norepinephrine, serotonin, and histamine) among nerve cells. Specifically, dopamine enables neurotransmission among nerve cells that are involved in voluntary and involuntary motor control. Disease states such as tardive dyskinesia, Huntington's chorea, schizophrenia, Tourette syndrome and tardive dystonia are characterized in part by a hyperdopaminergic state in the brain, and modulation of neuronal dopamine levels may provide symptomatic benefits for patients with these conditions.

Tardive dyskinesia (TD) is defined by hyperkinetic involuntary movements which arise after months or years of treatment with dopamine receptor blocking agents, e.g. antipsychotics for schizophrenia, bipolar disorder, and depression, and Reglan® (metoclopramide) for nausea and vomiting and gastric emptying in patients with gastroparesis. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing of the lips, and rapid eye blinking. Rapid movements of the extremities may also occur. The impact on daily function and the quality of life for individuals suffering from TD can be substantial. While the prevalence rates of TD can vary greatly in accordance with the population being studied, it is estimated that nearly 500,000 individuals are affected by TD in the United States alone (Kantar Health).

To address the unmet medical needs of patients suffering from TD, we are developing NBI-98854. NBI-98854 is a potent, highly selective, VMAT2 inhibitor that is effective in regulating pre-synaptic release of dopamine. This selectivity should reduce the likelihood of off target side effects. Additionally, we have designed this novel compound to provide low, sustained, plasma and brain concentrations of the active drug to minimize the potential side effects associated with excessive dopamine depletion, while at the same time having minimal impact on the other monoamines, e.g. norepinephrine and serotonin. With these features, NBI-98854 should be well tolerated in patients. NBI-98854 has been evaluated in several Phase I studies and four Phase II studies to assess its safety, tolerability and efficacy and to establish a treatment regimen to be used in future clinical trials. We believe that the potential efficacy and safety profile of NBI-98854 will address many of the shortcomings of current off-label treatments. Finally, NBI-98854 may be useful in the treatment of other disorders, such as Huntington's chorea, schizophrenia, Tourette syndrome and tardive dystonia.

During 2009, a Phase I single ascending dose clinical trial of NBI-98854 was completed in healthy male volunteers in Canada under an approved Clinical Trial Application with Health Canada. This trial showed NBI-98854 to be generally safe and well tolerated. There were no serious adverse events, clinically significant drug-related laboratory abnormalities or clinically significant electrocardiogram (ECG) findings. The characteristics of NBI-98854 met the pre-specified pharmacokinetic requirements for the trial: dose proportionality, low maximum concentration with adequate area-under-curve for drug exposure, low variability and a half-life which supports once per day dosing.

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During 2010, we completed a multiple, repeated dose Phase I study of NBI-98854 in healthy male volunteers. This trial also showed NBI-98854 to be generally safe and well tolerated, and again displayed the desired pharmacokinetic requirements. There were no serious adverse events, clinically significant drug-related laboratory abnormalities or clinically significant ECG findings.

Based on the successful completion of this second Phase I study, we initiated a Phase IIa open label dose exploration study of NBI-98854 in six patients with TD in late 2010. This study was designed to assess, over a twelve-day dosing period, the efficacy, safety and tolerability of NBI-98854 in schizophrenia patients who have moderate to severe TD. The impact on the dyskinesia was assessed utilizing the Abnormal Involuntary Movement Scale (AIMS). The study inclusion criteria included a baseline total score of at least nine on the first seven physical components of AIMS, with at least two body regions receiving scores of moderate (3) or severe (4). For the study the mean baseline score was 14.3 (AIMS total items 1-7, possible total score of 28). The dosing regimen consisted of three, four-day periods of NBI-98854, at increasing doses of 12.5mg, 25mg, and 50mg administered once daily. After discontinuation of NBI-98854, a seven-day washout period was followed by a final assessment. After the twelve days of dosing, the mean AIMS score decreased to 8.4, a reduction of 41.3%. Reduction in abnormal involuntary movements was shown across multiple assessment points. After the seven-day washout period, most patients' AIMS scores returned to their baseline levels. The adverse events reported during administration of NBI-98854 were transient and mild or moderate including one subject with dizziness and one with restlessness. One subject became anxious and agitated seven days after study medication due to the patient's return to baseline-intensity TD.

Upon successful completion of this open-label Phase IIa study, we filed an Investigational New Drug (IND) Application with the FDA to permit the initiation of larger Phase II studies in patients with TD in the United States.

In September 2011, we began a second Phase II study in TD patients. This 32 patient placebo-controlled, double-blind, randomized, cross-over study, used a within-subject comparison for safety and efficacy evaluation. Patients were randomized to either 12.5mg or 50mg doses of NBI-98854 for a two-week dosing period, and each patient also had a two-week placebo dosing period. The primary efficacy endpoint of the study was a comparison of placebo versus active AIMS scores at the end of the two dosing periods.

After database lock and unblinding of study data, an inconsistent pattern of AIMS scores emerged at one of the eight sites that was not evident during the blinded data review. Based on these findings, the AIMS data from this single site was removed and a post-hoc analysis was completed which demonstrated a clinically meaningful and statistically significant improvement in TD symptoms for the subjects receiving the 50mg once-daily dose. These subjects had a significant reduction in TD symptoms at the end of two weeks of active treatment versus the end of two weeks of placebo (difference in LS mean of 4.2 for the 50mg period versus the placebo period, p-value=0.002). As expected, the 12.5mg dosing group was not statistically better during the active treatment period than during the placebo period (difference in LS mean of 0.4 for the 12.5mg period versus placebo period, p-value=0.68).

When including the data from the site in question, this study did not meet the pre-specified primary endpoint of reducing the AIMS scores during active treatment periods. The efficacy results from the entire study population showed a non-significant reduction in TD at the end of two weeks of active treatment versus the end of two weeks of placebo (difference in LS mean of 1.1 for the 50mg period versus the placebo period (n=15), p-value=0.42) (difference in LS mean of 0.7 for the 12.5mg period versus placebo period (n=17), p-value=0.59).

We also performed a second post-hoc analysis, engaging a single, independent, blinded AIMS assessor to review the videotaped AIMS assessments at all of the eight sites that participated in the trial. This AIMS assessor scored, in a blinded fashion, the videotaped baseline, day fifteen and day twenty-nine AIMS assessments. This independent secondary post-hoc analysis demonstrated a clinically meaningful and statistically significant improvement in TD symptoms for the subjects receiving the 50mg once-daily dose. These subjects had a

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significant reduction in TD symptoms at the end of two weeks of active treatment versus the end of two weeks of placebo (difference in LS mean of 3.0 for the 50mg period versus the placebo period, p-value=0.008). As expected, the 12.5mg dosing group was not statistically better during the active treatment period than during the placebo period (difference in LS mean of 0.7 for the 12.5mg period versus placebo period, p-value=0.54).

NBI-98854 was generally safe and well tolerated during the fourteen days of treatment. The frequency of treatment-emergent adverse events was 17% during the placebo period and 24% and 32% in the 12.5mg and 50mg treatment periods, respectively. There were no serious adverse events during the treatment period. The most common adverse event was headache and one subject in the 50mg group discontinued due to akathisia.

The larger Phase IIb TD program began in 2012. The initial Phase IIb study (Kinect Study) was a randomized, parallel, double-blind, placebo-controlled, clinical trial utilizing the capsule formulation of NBI-98854 in moderate to severe TD patients with underlying schizophrenia or schizoaffective disorder. This 109 subject study assessed two doses of once-daily NBI-98854 over a six-week placebo-controlled dosing period. Approximately half of the randomized subjects received placebo and half received one of two doses of NBI-98854. The two NBI-98854 dosing groups consisted of a 50mg group for six weeks and a group that began at 100mg for the initial two weeks and then converted to 50mg for the final four weeks of placebo-controlled dosing period. Subsequent to the placebo-controlled dosing, all subjects were eligible to enter a six-week open label safety extension, whereby 50mg of NBI-98854 was administered once daily with additional AIMS assessments. The primary endpoint of the study was a comparison of placebo versus active scores utilizing the AIMS at the end of week six as assessed by the on-site AIMS assessors.

The 50mg dose of NBI-98854 did not reach statistical significance for the primary endpoint at week six; however, the 100mg dose, utilizing a blinded central video AIMS assessment, showed a statistically significant and clinically meaningful reduction in TD symptoms at week two (the end of the 100mg dose interval).

NBI-98854 was generally safe and well tolerated during the twelve weeks of the Kinect Study. During the six-week placebo-controlled treatment period the frequency of treatment-emergent adverse events was 37% for placebo and 26% for NBI-98854. There were no drug-related serious adverse events. The most common treatment emergent adverse event was mild and transient somnolence during the placebo-controlled portion of the study.

In November 2013, we convened a Scientific Advisory Board (SAB) to review the results of the Kinect Study. The SAB was formed to specifically focus on the dose levels and the AIMS assessment tool. Based on the results of the Kinect Study and the advice from the SAB, the protocol for the second Phase IIb study (Kinect 2 Study) was amended to change the primary endpoint from on-site AIMS assessments to a blinded central video assessment conducted by two movement disorder specialists who would review the AIMS videos in a scrambled fashion and concur on a final AIMS score for each video.

The Kinect 2 Study, was a randomized, parallel, double-blind, placebo-controlled, clinical trial utilizing the capsule formulation of NBI-98854 in moderate to severe TD patients with underlying mood disorders, schizophrenia and schizoaffective disorders, and gastrointestinal disorders. This study randomized 102 patients into a six-week placebo-controlled dosing period where half of the subjects received placebo and half received NBI-98854. The study began with all subjects on once-daily 25mg of NBI-98854, or placebo. The treating physician was then permitted to escalate the dose at two-week intervals, at the end of week two and at the end of week four, to a maximum dose of once-daily 75mg. The dose escalation was determined by the treating physician based on week two and week four on-site AIMS assessments coupled with safety and tolerability assessments at these same time points. The primary endpoint of the study was a comparison of placebo versus active scores utilizing the AIMS at the end of week six as assessed by scrambled blinded central video assessment conducted by two movement disorder specialists.

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At week six, AIMS scores, as assessed by blinded central video, were reduced by 2.6 points in the NBI-98854 intention-to-treat (ITT) group (n=45) compared to a reduction of 0.2 points in the placebo arm (n=44) (p<0.001). Additionally, the responder rate (>= 50% improvement from baseline) was 49% in the NBI-98854 ITT group compared to 18% in placebo (p=0.002). In the per-protocol (PP) group (n=78) AIMS scores were reduced by 3.3 points for those subjects taking NBI-98854 (p<0.001), with a corresponding responder rate of 59% (p<0.001). The improvement in week six AIMS was also corroborated by on-site treating physicians utilizing the Clinical Global Impression Tardive Dyskinesia (CGI-TD) scale scores. Treating clinicians determined that approximately 67% of the subjects taking NBI-98854 were much improved or very much improved at week six compared to only 16% of the placebo subjects (p<0.001) in this pre-specified key secondary efficacy endpoint.

The data from the Kinect Study and Kinect 2 Study, along with the other Phase I and Phase II clinical studies, preclinical work, and drug manufacturing data will form the basis for an end of Phase II meeting request that we expect will be filed with the FDA during the first half of 2014.

Tourette syndrome. Tourette syndrome is a neurological disorder that manifests in early childhood or adolescence, consisting of involuntary motor and vocal tics. Tourette syndrome is more commonly diagnosed in males than females and may be associated with attention deficit hyperactivity disorder and obsessive compulsive disorder. There are approximately 400,000 people with Tourette syndrome in the United States.

We are currently completing preclinical studies of NBI-98854 to permit a single dose pharmacokinetic study in 16-18 year old Tourette syndrome patients. We expect that this study will begin and be completed during the first half of 2014. Upon successful completion of this study, we intend to approach the FDA to open an IND in Tourette syndrome and broaden NBI-98854 into clinical development for this indication.

Corticotropin-Releasing Factor (CRF) Receptor₁ Antagonist

CRF is a central nervous system-based, hypothalamic hormone that acts on specific CRF receptors to stimulate the release of adrenocorticotropin hormone (ACTH). The primary role of ACTH is the stimulation of synthesis and release of adrenal steroids including cortisol. Blockade of CRF receptors on the pituitary has been shown to decrease the release of ACTH and subsequently attenuate the production and release of adrenal steroids and potentially alleviate the symptoms associated with clinical depression as well as anxiety and stress related disorders.

We have a strategic position in the CRF field through our intellectual property portfolio and relationship with experts in the neuropsychiatric field. We have patents covering two receptor subtypes termed CRF₁ and CRF₂, and we have pending patent applications on small molecule organic compounds modulating the CRF receptors. Our compound, NBI-77860, is a potent, selective, non-peptide CRF₁ receptor antagonist as demonstrated in a range of in vitro and in vivo assays as well as human clinical studies.

Post-Traumatic Stress Disorder. Research indicates that clinically depressed patients and patients with anxiety experience dysfunction of the hypothalamic-pituitary-adrenal axis, the system that manages the body's overall response to stress. This dysfunction amplifies production of CRF, and induces the physical effects that are associated with stress that can lead to stress-related disorders such as post-traumatic stress disorder and acute stress disorder. According to National Institute of Mental Health there are approximately eight million post-traumatic stress disorder sufferers in the United States.

Emory University of Atlanta, Mt. Sinai Medical Center in New York, Baylor College of Medicine in Texas and University of California San Francisco, VA Medical Center through a grant from the National Institute of Mental Health, have been conducting a multi-site Phase II clinical trial evaluating NBI-77860 in women with post-traumatic stress disorder. This randomized, double-blind, placebo-controlled trial is expected to enroll approximately 150 patients for a six-week treatment period. This study began in late 2009 and is expected to take

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several years to complete. Additionally, the National Institute on Alcohol Abuse and Alcoholism is currently enrolling subjects in a Phase II clinical trial evaluating NBI-77860 in stress-induced craving in alcoholic women with high anxiety. This randomized, double-blind, placebo-controlled trial is expected to enroll 60 patients for a four-week treatment period. This study is also expected to take several years to complete.

Research Programs

Our research and development focus is on addressing diseases and disorders of the central nervous and endocrine systems, which include therapeutic categories ranging from diabetes to stress-related disorders and neurodegenerative diseases. Central nervous system and endocrinology drug therapies are among the largest therapeutic categories, accounting for over \$140 billion in worldwide drug sales according to GlobalData (2013).

G Protein-Coupled Receptor 119 (GPR119)

Type II diabetes is growing at epidemic proportions world-wide. This disease is characterized by reduced ability to secrete and respond to insulin. Drugs which can enhance the secretion of insulin in response to rising blood glucose levels can improve blood glucose control without increased risk of hypoglycemia. Nearly 26 million people suffer from diabetes in the United States alone with a worldwide prevalence in excess of 340 million. Recent estimates put the total direct and indirect costs of diabetes at \$174 billion.

GPR119 has been identified as a novel target for the treatment of Type II diabetes. GPR119 is expressed predominantly in the pancreas and gastrointestinal tract. The activation of GPR119 receptors located in the gastrointestinal tract stimulates incretins, resulting in increased insulin production, while activation of GPR119 receptors located on pancreatic islet beta cells can stimulate insulin secretion directly.

In June 2010, we entered into a worldwide collaboration with Boehringer Ingelheim International GmbH (Boehringer Ingelheim) to research and develop small molecule GPR119 agonists for the treatment of Type II diabetes and other indications. We worked jointly with Boehringer Ingelheim to identify and advance candidates into preclinical development during the collaborative research period which concluded in June 2012. Boehringer Ingelheim is now responsible for the global development and commercialization of potential GPR119 agonist products.

VMAT2

VMAT2 inhibition results in the modulation of dopamine pathways which may also be useful for patients suffering from schizophrenia. Approximately 2.2 million people in the United States suffer from schizophrenia at an estimated annual cost of \$62 billion. Our discovery efforts around VMAT2 inhibitors also focus on developing novel therapies for schizophrenia sufferers.

Antiepileptic Drugs

Antiepileptic drugs are utilized in the treatment of epileptic seizures by suppressing the rapid firing of neurons that initiate a seizure. Antiepileptics also have additional effects within the central nervous system that have proven beneficial in bipolar disease, neuropathic pain and essential tremor. According to Datamonitor, in 2011, worldwide sales of branded anticonvulsants totaled approximately \$6 billion.

G Protein-Coupled Receptors (GPCR)

GPCRs are the largest known gene superfamily of the human genome. Greater than thirty percent of all marketed prescription drugs act on GPCRs; which makes this class of proteins historically the most successful therapeutic target family. However, only a small fraction of the GPCR gene superfamily has been exploited. Next

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generation therapies derived from targeting GPCRs will be discovered through the understanding of the complex relationships of drug/receptor interactions and their subsequent impact on efficacy, downstream signaling networks and regulation.

Our GPCR research platform has met this requirement by integrating drug discovery research efforts with a suite of assays and assay systems and automated analytical techniques. This process provides a profile of GPCR pharmacological receptor/ligand interactions capable of predicting in vivo efficacy allowing for rapid discovery of initial leads and advancement into preclinical and clinical development. Importantly, this design cycle is not limited to GPCR targets, but can be utilized for other proteins that play a role in human disease where current treatments or therapies are either inadequate or nonexistent.

Our Business Strategy

Our goal is to become the leading biopharmaceutical company focused on neurological and endocrine-related diseases and disorders. The following are the key elements of our business strategy:

Continuing to Advance and Build Our Product Portfolio Focused on Neurological and Endocrine-Related Diseases and Disorders. We believe that by continuing to advance and build our product pipeline, we can mitigate some of the clinical development risks associated with drug development. We currently have multiple programs in various stages of research and development. Our two lead late-stage clinical programs are elagolix, a GnRH antagonist in Phase III development for endometriosis and Phase II clinical studies of uterine fibroids that is partnered with AbbVie, and a wholly owned VMAT2 inhibitor for the treatment of movement disorders that is currently in Phase II development. We take a portfolio approach to managing our pipeline that balances the size of the market opportunities with clear and defined clinical and regulatory paths to approval. We do this to ensure that we focus our internal development resources on innovative therapies with improved probabilities of technical and commercial success.

Identifying Novel Drugs to Address Unmet Market Opportunities. We seek to identify and validate novel drugs on characterized targets for internal development or collaboration. For example, GnRH antagonists, compounds designed to reduce the secretions of sex steroids, may represent the first novel non-peptide, non-injectible means of treatment of endometriosis. We believe the creativity and productivity of our discovery research group will continue to be a critical component for our continued success. Research and development costs were \$39.2 million, \$37.2 million and \$31.0 million for the years ended December 31, 2013, 2012 and 2011, respectively.

Selectively Establishing Corporate Collaborations with Global Pharmaceutical Companies to Assist in the Development of Our Products and Mitigate Financial Risk while Retaining Significant Commercial Upside. We leverage the development, regulatory and commercialization expertise of our corporate collaborators to accelerate the development of certain of our potential products, while typically retaining co-promotional rights, and at times commercial rights, in North America. We intend to further leverage our resources by selectively entering into additional strategic alliances to enhance our internal development and commercialization capabilities by licensing our technology.

Acquiring Rights to Complementary Drug Candidates and Technologies. We plan to continue to selectively acquire rights to products in various stages of development to take advantage of our drug development capabilities.

Our Corporate Collaborations and Strategic Alliances

One of our business strategies is to utilize strategic alliances to enhance our development and commercialization capabilities. The following is a summary of our significant collaborations/alliances:

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AbbVie Inc. (AbbVie). In June 2010, we announced an exclusive worldwide collaboration with AbbVie to develop and commercialize elagolix and all next-generation GnRH antagonists (collectively, GnRH Compounds) for women's and men's health. AbbVie made an upfront payment of \$75 million and has agreed to make additional development and regulatory event based payments of up to \$480 million and up to an additional \$50 million in commercial event based payments. Under the terms of the agreement, AbbVie is responsible for all development, marketing and commercialization costs. We received funding for certain internal collaboration expenses which included reimbursement from AbbVie for internal and external expenses related to the GnRH Compounds and personnel funding through the end of 2012. We will be entitled to a percentage of worldwide sales of GnRH Compounds for the longer of ten years or the life of the related patent rights. Under the terms of our agreement with AbbVie, the collaborative development effort between the parties to advance GnRH compounds towards commercialization was governed by a joint development committee with representatives from both us and AbbVie. The collaborative development portion of the agreement concluded, as scheduled, on December 31, 2012. AbbVie may terminate the collaboration at its discretion upon 180 days written notice to us. In such event, we would be entitled to specified payments for ongoing clinical development and related activities and all GnRH Compound product rights would revert to us. Since the inception of the agreement, we have recorded revenues of \$75.0 million related to the amortization of up-front license fees, \$30.0 million in milestone revenue, and \$37.0 million of sponsored development revenue.

Boehringer Ingelheim International GmbH (Boehringer Ingelheim). In June 2010, we announced a worldwide collaboration with Boehringer Ingelheim to research, develop and commercialize small molecule GPR119 agonists for the treatment of Type II diabetes and other indications. Under the terms of the agreement, we and Boehringer Ingelheim are working jointly to identify and advance GPR119 agonist candidates into preclinical development. Boehringer Ingelheim will then be responsible for the global development and commercialization of potential GPR119 agonist products. We received a \$10 million upfront payment and received research funding to support discovery efforts. We are eligible to receive up to approximately \$3 million in additional preclinical milestone payments and payments of up to approximately \$223 million in clinical development and commercial event based payments. We will be entitled to a percentage of any future worldwide sales of GPR119 agonists resulting from the collaboration. Under the terms of the agreement, the collaboration effort between the parties to identify and advance GPR119 agonist candidates into preclinical development is governed by a steering committee with representatives from both us and Boehringer Ingelheim; provided, however, that the final decision making authority rests with Boehringer Ingelheim. The collaborative research portion of the agreement concluded, as scheduled, on June 15, 2012. Boehringer Ingelheim may terminate the agreement at its discretion upon prior written notice to us. In such event, we may be entitled to specified payments and product rights would revert to us. Since the inception of the agreement, we have recorded revenues of \$10.0 million related to amortization of up-front license fees and \$3.0 million of sponsored research revenue.

The Mount Sinai School of Medicine of the City University of New York (Mt. Sinai). In August 1999, we entered into an agreement with Mt. Sinai pursuant to which we acquired a nonexclusive license to certain patents and patent applications related to GnRH, to develop and commercialize licensed products worldwide. Pursuant to the terms of the agreement, we have the right to grant sublicenses to third parties only with the prior written consent of Mt. Sinai. Upon entering into the agreement, we paid a \$50,000 upfront fee and are required to pay an additional \$10,000 annual license fee on each anniversary of the agreement. In addition, we are obligated to pay Mt. Sinai a royalty equal to 1% of net sales of licensed products. The agreement will remain in effect until the later of 15 years after the date of the first commercial sale of the first licensed product or the expiration of the last to expire of the licensed patents, unless terminated earlier at our election or for material breach by either party. Mt. Sinai also has the right to terminate the agreement if we become insolvent or bankrupt or have suspended our business operations. Pursuant to the terms of the agreement, in the event that Mt. Sinai grants a third party a license to the GnRH patents and patent applications on economic terms and conditions less favorable to Mt. Sinai than those in our agreement, we have the right to substitute the terms and conditions of the other third party license for those currently set forth in our agreement.

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Intellectual Property

We seek to protect our lead compounds, compound libraries, expressed proteins, synthetic organic processes, formulations, assays, cloned targets, screening technology and other technologies by filing, or by causing to be filed on our behalf, patent applications in the United States and abroad. Additionally, we have licensed from institutions the rights to issued United States patents, pending United States patent applications, and issued and pending foreign filings. We face the risk that one or more of the above patent applications may be denied. We also face the risk that issued patents that we own or license may be challenged or circumvented or may otherwise not provide protection for any commercially viable products we develop.

The technologies we use in our research, as well as the drug targets we select, may infringe the patents or violate the proprietary rights of third parties. If this occurs, we may be required to obtain licenses to patents or proprietary rights of others in order to continue with the commercialization of our products.

In addition to the granted and potential patent protection, the United States, the European Union and Japan all provide data and marketing exclusivity for new medicinal compounds. If this protection is available, no competitor may use the original applicant's data as the basis of a generic marketing application during the period of data and marketing exclusivity. This period of exclusivity is generally five years in the United States, six years in Japan and ten years in the European Union, measured from the date of FDA, or corresponding foreign, approval.

Elagolix, our small molecule GnRH antagonist currently in clinical trials for the treatment of endometriosis and uterine fibroids, is covered by six issued U.S. patents relating to composition of matter, pharmaceutical compositions, and methods of use. U.S. Patent Nos. 6,872,728, 7,179,815 and 7,462,625 are due to expire in 2021 (not including potential patent term extensions of up to five years) while U.S. Patent Nos. 7,056,927, 7,176,211 and 7,419,983 are due to expire in 2024 (not including potential patent term extensions of up to five years).

NBI-98854, our highly selective VMAT2 inhibitor, currently in clinical trials for the treatment of tardive dyskinesia, is covered by U.S. Patent No. 8,039,627 which expires in 2029 and U.S. Patent No. 8,357,697 which expires in 2027 (not including a potential patent term extension of up to five years). NBI-98854 is also covered by European Patent No. 2,081,929 which expires in 2027.

Our CRF antagonist NBI-77860 is currently in clinical trials for the treatment of stress-related disorders and is covered by U.S. Patent No. 7,879,862 which expires in 2026 (not including potential patent term extensions of up to five years).

Manufacturing and Distribution

We currently rely on, and expect to continue to rely on, contract manufacturers to produce sufficient quantities of our product candidates for use in our preclinical and anticipated clinical trials. In addition, we intend to rely on third parties to manufacture any products that we may commercialize in the future. We have established an internal pharmaceutical development group to develop manufacturing methods for our product candidates, to optimize manufacturing processes, and to select and transfer these manufacturing technologies to our suppliers. We contract with multiple manufacturers to ensure adequate product supply and to mitigate risk.

There currently are a limited number of these manufacturers. Furthermore, some of the contract manufacturers that we have identified to date only have limited experience at manufacturing, formulating, analyzing and packaging our product candidates in quantities sufficient for conducting clinical trials or for commercialization.

We currently have no distribution capabilities. In order to independently commercialize any of our product candidates, we must either internally develop distribution capabilities or make arrangements with third parties to perform these services.

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Marketing and Sales

We currently have limited experience in marketing or selling pharmaceutical products. To market any of our products independently would require us to develop a sales force with technical expertise along with establishing commercial infrastructure and capabilities.

Government Regulation

Regulation by government authorities in the United States and foreign countries is a significant factor in the development, manufacture, distribution, marketing and sale of our proposed products and in our ongoing research and product development activities. All of our products will require regulatory approval by government agencies prior to commercialization. In particular, human therapeutic products are subject to rigorous preclinical studies and clinical trials and other approval procedures of the FDA and similar regulatory authorities in foreign countries. The process of obtaining these approvals and the subsequent compliance with appropriate federal and state statutes and regulations require the expenditure of substantial time and financial resources. In the United States, various federal and state statutes and regulation also govern or influence testing, manufacturing, safety, labeling, storage, and record-keeping of human therapeutic products and their marketing. Recent federal legislation imposes additional obligations on pharmaceutical manufacturers regarding product tracking and tracing. In addition, federal and state healthcare laws restrict business practices in the pharmaceutical industry. These laws include, without limitation, federal and state fraud and abuse laws, false claims laws, data privacy and security laws, as well as transparency laws regarding payments or other items of value provided to healthcare providers.

Preclinical studies generally are conducted in laboratory animals to evaluate the potential safety and efficacy of a product. Drug developers submit the results of preclinical studies to the FDA as a part of an IND application before clinical trials can begin in humans. Typically, clinical evaluation involves a time consuming and costly three-phase process.

Phase I Clinical trials are conducted with a small number of subjects to determine the early safety profile, maximum tolerated dose and pharmacological properties of the product in human volunteers.

Phase II Clinical trials are conducted with groups of patients afflicted with a specific disease in order to determine preliminary efficacy, optimal dosages and expanded evidence of safety.

Phase III Large-scale, multi-center, comparative clinical trials are conducted with patients afflicted with a specific disease in order to determine safety and efficacy as primary support for regulatory approval by the FDA to market a product candidate for a specific disease.

The FDA closely monitors the progress of each of the three phases of clinical trials that are conducted in the United States and may, at its discretion, re-evaluate, alter, suspend or terminate the testing based upon the data accumulated to that point and the FDA's assessment of the risk/benefit ratio to the patient. To date, we have also conducted some of our clinical trials in Europe, Canada, Oceania and South Africa. Clinical trials conducted in foreign countries are also subject to oversight by regulatory authorities in those countries.

Once Phase III trials are completed, drug developers submit the results of preclinical studies and clinical trials to the FDA in the form of an NDA or a biologics licensing application for approval to commence commercial sales. The FDA may also convene an advisory committee to provide input on critical review issues associated with an NDA. The FDA is not bound by the recommendation of an advisory committee, but it considers such recommendations carefully when making decisions.

Before approving an NDA, the FDA typically will inspect the facility or facilities where the product is manufactured. The FDA will not approve an application unless it determines that the manufacturing processes and facilities are in compliance with current Good Manufacturing Practice requirements and adequate to assure consistent production of the product within required specifications. Additionally, before approving an NDA, the FDA will typically inspect one or more clinical sites to assure compliance with Good Clinical Practices.

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At the conclusion of its review, the FDA may grant marketing approval or may issue a complete response letter requesting additional information if the FDA determines that the application does not meet regulatory approval criteria. FDA approvals may not be granted on a timely basis, or at all. Furthermore, the FDA may prevent a drug developer from marketing a product under a label for its desired indications, which may impair commercialization of the product.

If the FDA approves the NDA, the drug becomes available for physicians to prescribe in the United States. After approval, the drug developer must submit periodic reports to the FDA, including descriptions of any adverse reactions reported. The FDA may request additional studies, known as Phase IV, to evaluate long-term effects. The FDA may also require a Risk Evaluation and Mitigation Strategy (REMS) safety plan upon approval.

We will also have to complete an approval process similar to that in the United States in virtually every foreign target market for our products in order to commercialize our product candidates in those countries. The approval procedure and the time required for approval vary from country to country and may involve additional testing. Foreign approvals may not be granted on a timely basis, or at all. In addition, regulatory approval of prices is required in most countries other than the United States. The resulting prices may not be sufficient to generate an acceptable return to us or our corporate collaborators.

Competition

The biotechnology and pharmaceutical industries are subject to rapid and intense technological change. We face, and will continue to face, competition in the development and marketing of our product candidates from biotechnology and pharmaceutical companies, research institutions, government agencies and academic institutions. Competition may also arise from, among other things:

other drug development technologies;

methods of preventing or reducing the incidence of disease, including vaccines; and

new small molecule or other classes of therapeutic agents.

Developments by others may render our product candidates or technologies obsolete or noncompetitive. We are performing research on or developing products for the treatment of several disorders including endometriosis, tardive dyskinesia, uterine fibroids, stress-related disorders, pain, diabetes, insomnia, and other neurological and endocrine-related diseases and disorders.

Lupron Depot[®], marketed by AbbVie, and Synarel[®] and depo-subQ provera104[®], marketed by Pfizer, are products that have been approved for the treatment of endometriosis, infertility, and central precocious puberty. These drugs, and any generic alternatives, may compete with any small molecule non-peptide GnRH antagonists we, in conjunction with our collaborative partner AbbVie, develop for these indications. Approximately 130,000 hysterectomies are performed annually in the United States as a direct result of endometriosis, as well as a significant number of laparoscopic procedures to ablate endometrial explants. Our oral small molecule pharmaceutical agent, elagolix, would also compete directly with these current invasive standards of care.

We, in conjunction with our collaborative partner AbbVie, are developing elagolix for the treatment of uterine fibroids. There are no current pharmaceutical therapies approved in the United States for the chronic treatment of uterine fibroids. Lupron Depot[®] is approved for short-term use to improve the outcome of uterine fibroid surgery. However, approximately 250,000 hysterectomies are performed annually in the United States as a direct result of uterine fibroids, as well as myomectomies (surgery) to remove the fibroids. Our oral small molecule pharmaceutical agent, elagolix, would compete directly with these current invasive standards of care.

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