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Speakers: Dr Patrik De Haes, CEO, Mr Paul G Howes, Executive Chairman US and Mr Dominique Vanfleteren, CFO

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HATIM KAGHAT: Good evening, good morning. My name is Hatim Kaghat, and I will be hosting this ThromboGenics 2014 Full Year results conference call.

On today's call we have Dr Patrik De Haes, Chief Executive Officer of ThromboGenics, Paul Howes, Executive Chairman of ThromboGenics US and Dominique Vanfleteren, Chief Financial Officer.

Today's presentation part will take about 20 minutes before opening the call for a Q&A session. The presentation and transcript of this call will be made available on the investors section of the ThromboGenics website.

Before handing the call over, I would like to remind you that the matters we will discuss during this call include certain statements relating to future results or statements of our intentions, beliefs and expectations for the future which are forward-looking statements. For this purpose, these forward-looking statements are subject to certain risks and uncertainties that could cause actual results to differ materially from anticipated results.

With this introduction, I will hand over to Dr Patrik De Haes. Sir, please begin.

PATRIK DE HAES: Thank you.

Good evening to those listening in Europe and good morning to those listening in the US. I am Patrik De Haes, the CEO of ThromboGenics and I would like to welcome you to this conference call covering our 2104 results.

Slide 3. I would like to start by running through the highlights of what has been another challenging year for ThromboGenics.

We delivered revenues of €13.8 million, of which €8.8 million came from the US sales of JETREA® as we saw sales decline due to a number of factors, which we

will explain later on. We ended the year with €127.1 million in cash and as many of you know we conducted in early 2014 a strategic review and after careful consideration of a range of options the board decided to move ahead with a standalone strategy.

As a result we have adapted the organisational structure so that we are focused on ensuring we can deliver the potential of JETREA®.

In the US we have made important changes to our commercial organisation, including recruiting a new leadership team, in order to build the sales of this novel medicine by focusing especially on strategic accounts.

During the year our partner Alcon has continued to roll out JETREA® in the rest of the world, gaining the product's first approvals in Asia and South America.

This year, in February we reached an important target with JETREA® gaining its 50th approval globally and that was in the Philippines.

In 2014 we received royalty income of about €3 million as a result of Alcon's sales in the rest of the world.

2015 will be a key year for ThromboGenics as we believe our stabilised organisation and new long-awaited real-world data will enable the community to focus on the clinical outcomes that JETREA® is able to deliver for patients with symptomatic VMA.

By using this real-world data we are confident that the community will be able to build the right level of experience and trust in JETREA® leading to greater use of the product.

We have seen this take place in our strategic accounts and we are confident that by the latter part of 2015, helped by our medical education and marketing initiatives, we will see this coming through in terms of revenues.

The challenges that we have faced in 2014 and for 2015 in the US have led us to provide new financial guidance.

We now anticipate selling between 3,500 to 4,000 vials of JETREA® in 2015 in the US and this compares to the 3,200 US patients that were treated with the medication in 2014.

Looking to create longer term value, we remain committed to developing JETREA® for other important indications and plan to start a Phase II study later this year in patients with diabetic retinopathy.

This indication could be a significant commercial opportunity for JETREA® based on its ability to create a posterior vitreous detachment.

By creating a PVD we hope to prevent the growth of new blood vessels in the back of the eye that are responsible for the sight-threatening part of this condition.

We will also continue to selectively invest in our pipeline as we look to develop more innovative medicines for the treatment of vitreo-retinal diseases.

Our earlier announced plans to spin out our oncology assets into a new venture with VIB are materialising. Further announcements will follow in the near term.

I would now like to pass you to Paul who will cover the developments in the US market.

PAUL HOWES: Thank you, Patrik, and we'll now move over to slide 4. In the next several slides I intend to give you some background on what has been happening in the US and the measures that we have taken to ensure we can deliver JETREA®'s significant commercial potential.

Slide 5. As Patrik outlined 2014 has been a challenging year for ThromboGenics in the US. Sales of JETREA® fell from just over €20 million in 2013 to just below €9 million in 2014. This reduction in the number of patients treated was the result of several discrete factors. Firstly, a decreasing adoption rate within the retinal community due to perceived safety concerns following a small number of published case reports. Second, some impact both from external and internal uncertainties following the announcement of our strategic review earlier in 2014 and the

subsequent organisational changes that we made, and finally, number 3, a retinal community that clearly needed more and new real-world data before starting or re-initiating the treatment of patients with JETREA®.

Before going into further details on these challenges, I would like to say a word about the important insights regarding the use of JETREA® that we have gained during the last 12 months. These findings have not only reinforced our confidence in this novel medicine but have also been critical in shaping the changes we have made to our commercial approach in recent months.

It is clear that retina specialists can deliver better patient outcomes as their experience with JETREA® grows. This is largely driven by the fact that as they use JETREA® more often they are able to better identify those patients who will benefit most from this novel medicine.

We have been encouraged by the growing number of publications from leading retina centres both in the United States and in the rest of the world, outlining how better patient selection can be achieved by using a number of prognostic criteria including the absence of an epiretinal membrane or ERM, small areas of vitreomacular adhesion - called focal adhesion - of 1,500 microns or less and if there is a full thickness macular hole that it be of a diameter of 400 microns or less. By using these criteria these centres have seen success, measured by resolution of the vitreomacular adhesion, in over 50 per cent of the patients treated with a single injection. In some centres success rates of up to 80 per cent have been achieved.

Another important finding is that with greater understanding of the drug, retina specialists are much better placed to set patient expectations in terms of efficacy and the potential side effects that they may experience in the period immediately post-injection and during the recovery process.

The feedback we have received from the retina community has also made it clear that more real-world data is needed in order to give many retinal physicians the

confidence they need to use JETREA® on a regular basis. This need to deliver more real-world data is something we will address during the course of 2015.

I would like now to go back to the challenges that we have faced in 2014, and more importantly, how we have addressed them. The most important issue which negatively impacted JETREA® sales in 2014, was related to the perceived safety issues surrounding our drug. These safety concerns arose during the first half of the year following publication of a few case reports, based on a very small number of patients who had experienced specific side effects following an ocriplasmin injection. Because it's a relatively small community, these reports led to a decline in the number of retina physicians using JETREA® and to many physicians delaying their decision to use JETREA® for the first time.

We responded to these concerns by undertaking a number of initiatives to evaluate and confirm the safety profile of JETREA®. These included new studies, as well an external review of the complete patient safety database from our Phase III programme, as well as the first 10,000 patients treated in the marketplace.

We are happy to confirm that these studies and reviews have raised no new concerns and confirmed that the product's post-marketing safety profile was and is very much in line with the approved label

Meanwhile, real-world clinical data being published by retinal centres who have been treating patients with JETREA® over a longer period have also confirmed the product's post-marketing safety profile is in line with its approved label.

We have used all of the above findings to support our medical education efforts over the last 12 months and we can confirm that our efforts, based on this real-world data, has led to a significant reduction in the concerns surrounding the safety of JETREA® and much more balanced discussions about the drug's side effect profile.

A further important factor in helping improve the perceived safety of JETREA® is the growing awareness that the post-injection effects seen with JETREA® are

related to the drug's activity, and they are very similar to those experienced by patients who have undergone a surgical vitrectomy.

On slide 7, the second factor that hit the sales of JETREA® was the turnover of staff in our US organisation in 2014, particularly in the second half of the year. This was due to a number of factors including the company's decision to initiate a strategic review, the reorganisation that followed the decision to pursue a standalone strategy, changes in the commercial leadership team and our new focus on strategic accounts.

Given the shift in focus to key accounts we made the important decision in Q4 2014 to move away from working with a contracted sales force to one comprised solely of ThromboGenics employees.

Today, we have completed this recruitment process and we believe we have a stronger sales team as a result. This new organisation is now well-placed to leverage the growing body of real-world data that will be released over the course of 2015, and to re-build the sales of JETREA® in the US.

2015 will bring us a lot of new real-world data. On this slide we have summarised the three key real-world studies with JETREA® that are currently ongoing:

First, and perhaps most importantly, is OASIS, for which we expect to report top line results in the coming weeks. This sham-controlled double-masked study recruited a total of 220 patients and is designed to assess anatomical and functional outcomes following a single intravitreal injection of ocriplasmin 0.125 mg in subjects with symptomatic VMA, also known as VMT, including macular hole.

This is an important study in terms of generating real-world efficacy and safety data with JETREA® as the patients in the study are being followed up for a 24-month period post-injection. The retinal community is very interested in seeing both the safety and efficacy results which are coming soon.

The next study is ORBIT, an acronym for Ocriplasmin Research to Better Inform Treatment, and that is a prospective, observational study that is designed to assess

clinical outcomes and the safety of JETREA® administered in a real-world setting for the treatment of symptomatic VMA by assessing both anatomical and functional outcomes.

It's actually a patient registry-type study. ORBIT is looking at a number of parameters including resolution of VMA and also monitors adverse drug reactions and changes from baseline in ocular signs and symptoms, such as metamorphopsia. We expect to provide data on a number of occasions during 2015, with respect to ORBIT, at various retinal conferences during the course of the year.

A first intermediate batch of data was presented by the Orbit Steering Committee during the Macula Society Meeting last week. As confirmed by the representative of the committee, this interim analysis in the ORBIT study has shown that the safety and efficacy profiles are consistent with the product's label and the data from the Phase III clinical trials. Further analysis is ongoing to assess these rates compared with the Phase III results.

Also, we were very happy to see the committee confirming that their findings of the interim analysis are also a confirmation that our medical education activities are beginning to deliver results. A growing number of retina centres are gaining the understanding they need, to select the patients most suited for this novel pharmacological treatment option for symptomatic VMA.

Lastly, the OZONE study, which is an acronym for Ocriplasmin Ellipsoid Zone Retrospective Data Collection Study, which is a retrospective patient study designed to capture more data to characterise the anatomic and symptomatic changes that potentially occur in the six months immediately after treatment with JETREA® for symptomatic VMA. This study is designed in particular to provide more data on the relationship between the disappearance of the outer segment of the ellipsoid zone and positive anatomic outcomes. Results from this study are expected during the first half of 2015.

We trust that the above data will allow further education of the retina community allowing those members who have been sitting on the fence for a long time to start use or to reconsider, or for those long-time users to improve their practice management when fitting JETREA® into their everyday management of patients with symptomatic VMA.

I believe that ThromboGenics can look forward to the remainder of 2015 with a greater level of confidence. We have the right organisation in place and are now clearly focused on the key retina physicians who we believe can catalyse the use of JETREA® by the broader community

The safety concerns that impacted JETREA® in 2014 have been addressed, and will be further addressed, with more data and medical education efforts.

With the real data that is due to emerge in the coming months we anticipate having the information we need to build greater confidence amongst existing users of JETREA® and to persuade the "wait and see" retina physicians to start to integrate this novel medicine into their everyday treatment approach to symptomatic VMA.

Given this platform I am confident that we can achieve the 2015 sales target that Patrik outlined earlier and I would now like to turn the presentation over to our CFO, Dominique.

DOMINIQUE VANFLETEREN: Yes, thank you Paul. Let me run you through the highlights of the P&L. If we look at the total sales in comparison to 2013 where we were showing €112.8 million of sales, we have achieved €13.8 million of sales in 2014. Obviously the difference comes from a milestone that we got in 2013. That is not repeating this year. Now we are comparing €13.8 million of sales in 2014 versus €22.8 million comparable in 2013. What we have here, and has been said, is that we have made €8.8 million sales in the US versus €20 million last year. We have €3.4 million in royalties this year versus €1 million last year, which is a nice upside and we have the same level of goods and material sales as last year.

If we come to the R&D expenses in 2014 we have reduced the R&D expenses to €22.6 million, and that includes €6.8 million of amortisation of the JETREA® Phase III study programme. This figure compares to last year €31.7 million which also includes a similar level of amortisation. This reduced spending is due to a real decrease in expenditure, but also results from some development being invoiced to external partners as well as increased use of grant funding.

When it comes to sales and marketing we have also reduced our expenses to €29.9 million from €37.6 million in 2013. This is due to changed strategic priorities as well as organisational changes. In addition the 2013 figure reflects costs of launching JETREA® in the US.

So as a result we made this year an overall loss of €51 million compared to a profit of €26.4 million in 2013. Obviously the 2013 good result is due to the €90 million milestone, and if we have to go to the earnings per share, we show effectively a loss of €-1.42 versus €0.71 in 2013.

In the next slide I would like to shortly talk about the cash at end of this year, and what is going to happen next year.

So this year we have cash remaining of €127.1 million. That compares to €170.4 million in December 2013. It is our intention this year that we are going to manage our cash very tightly, and we foresee that we are going to have an average cash-out of €11 million per quarter for 2015.

With this, I would like to hand back to you, Patrik.

PATRIK DE HAES: Thank you.

So I would now like to turn to the activities of our partner, Alcon. As we have previously communicated Alcon remains very committed to building the sales of JETREA® outside the US as is evidenced by the growing number of approvals we are seeing around the world. Recently the 50th approval globally was gained in the Philippines.

Now, in Europe the rollout of JETREA® is largely complete in terms of market introductions. Good progress has also been made in terms of gaining reimbursement in the major European markets. 2014 also saw the first approvals in Asia and Latin America

In parallel with our own efforts Alcon is working to generate more real-world data with JETREA®. As it is in the US, reports from selected centres continue to highlight the improved level of efficacy that can be delivered with appropriate patient selection.

The first data from the Alcon INJECT study, which is the equivalent of our ORBIT study in the US, is due during the first half of 2015.

Alcon is making good progress with its plans to gain approval for JETREA® in Japan. The bridging clinical study is now complete and the regulatory filing remains on track for 2015.

In both Asia and South America we expect further approvals in the coming months.

The next indication we will be targeting with JETREA® is the prevention of diabetic retinopathy. We plan to start a Phase II trial with JETREA® in diabetic retinopathy and expect to recruit our first patient in the second half of 2015.

We have decided to move ahead with this potential indication as creating a total PVD, posterior vitreous detachment, which can be achieved with JETREA®, is accepted as an important step in preventing further growth of blood vessels in the back of the eye. This indication could represent a large opportunity for JETREA® as a recent report of the American Academy of Ophthalmology indicated the prevalence by 2020 will be that 6 million people in the US will have diabetic retinopathy of whom 1.34 million will have vision threatening diabetic retinopathy.

Now, on the next slide I would like to conclude with a few key takeaways. It is clear that 2014 has been a very challenging period for ThromboGenics. However, I believe our new management team in the US has addressed most of the issues we have faced over there.

We now have a commercial organisation focused on strategic accounts and this team is well placed to leverage the real-world data that will emerge over the course of 2015

Based on these changes we are guiding towards selling 3,500 and 4,000 vials of JETREA® in the US in 2015 as we expect to see the adoption of the product to improve during the course of the year.

Given we are in a turnaround situation we believe it is prudent not to provide guidance beyond 2015.

Our partner Alcon continues to grow JETREA®'s rest of the world footprint and as a result we expect the level of royalty income that we receive to grow.

We believe that by investing in a US Phase II diabetic retinopathy study we will be able to broaden the clinical utility of the drug and generate important value for our shareholders.

We have cash of €127 million which we intend to manage carefully. Based on these cash resources and the reshaped organisation we have in place, I am confident that we can rebuild the sales of JETREA® in the States, while at the same time investing in Phase II to evaluate the potential of this novel medicine to treat diabetic retinopathy.

With that, I would now like to open the call for any questions that you may have.

OPERATOR: Ladies & gentlemen, we will now begin our Q&A session. If you wish to ask a question, please press the code 01 on your telephone keypad and you will enter a queue. After you are announced, please ask your question. So once again, please press the code 01 on your telephone keypad. You can also use the Q&A code on your webcast to submit your questions. Thank you.

And our first question is from Roderick Verhelst from Petercam. Please go ahead. Sir, your line is open.

RODERICK VERHELST: Good evening, gentlemen. Thank you for taking my questions. The first one on diabetic retinopathy, can you give us some insight on the trial set-up, so how many patients you anticipate to recruit, and a bit more details on the timelines of when we should expect the first data?

Second, you indicate on the cash burn that you will burn around €11 million per quarter. Is that going to be evenly spread over the coming quarter, so is it going to be more front-end loaded for the cash burn? Lastly, I know that you don't give a quarterly split on the sales, but just to give me insight on how you reached your guidance for 2015, because sales in the US in the second half has declined. I can understand because of all the changes you are going through, but do you really see a pick-up in the fourth quarter, after you did all the restructuring, or is it too early to tell? Thank you.

PATRIK DE HAES: Thank you, Roderick. First of all, on the DR, that's a study that we plan to start in the second half of 2015. It is a study that we plan to do with multiple-dose injections. At this stage we are running talks for multiple-dose injections that will be available by mid-year, and so then we can start including the patients afterwards. So more details with regard to the number of patients will come later.

One of the primary endpoints of that study is clearly to induce PVD because in general it is scientifically accepted that the moment that you create a PVD, a posterior vitreous detachment, that at that stage you stabilise your diabetic retinopathy and that you don't progress from non-proliferative to proliferative, but more details to come later.

Secondly, with regard to the cash and such, and Dominique over the quarters last year?

DOMINIQUE VANFLETEREN: Yes, it would be hazardous to say that it is going to be equally over each quarter. Obviously we have the sales that need to increase, but we will tightly manage to ensure that the impact is not too hefty.

PATRIK DE HAES: So in regard to the progress in 2015 maybe Paul could shed some light on that?

PAUL HOWES: Sure. Our indication is that we will be seeing a turnaround as our new data enters the marketplace, which will really be at the start of Q2 and over the course of the year, so we see progressively increasing sales over the four quarters of 2015.

OPERATOR: Thank you very much. So, next question is from Peter Welford, from Jefferies. Please go ahead. Your line is open.

PETER WELFORD: Hello. Yes, thank you for taking my questions. So a couple, firstly in regards to the financial outlook with regards to the 3,500, 4,000 vials. Just curious with the way you keep referring to 3,200 patients in the US, but 3,500 to 4,000 vials is the target. Is there something that we should be reading into this? I guess I'm kind of curious as to the difference in the words that have been chosen.

Secondly, then, the comment, "It's prudent not to provide guidance beyond 2015" do we take that to mean that the previous US profitability in 2016, cash flow positive in 2017 and long-term target of €100 million in 2019 have now been withdrawn, or can you just update us on the status or the exact standing of those targets? Then thirdly, just on the decision to hire your own sales force, and recruitment now complete, can you give us some sort of idea how many reps are we talking about here that have been recruited and that will be recruited by the end of the process? Thank you.

PAUL HOWES: Okay, so this is Paul Howes. On the vials versus patient it's really one and the same thing. It is one vial per patient, so the two terms are interchangeable. With respect to future progressions, I guess what I would say is that our guidance for 2015 of 3,500 to 4,000 contemplates a modest level of growth, and we could ultimately see more growth than that, or potentially less. The reason we're not commenting beyond 2015 right now is primarily because we want to get this new data into the marketplace, gauge the impact of it, and when we see that we'll be able to tell and project a whole lot more accurately what 2016 and 2017 will look like. We are anticipating growth and we expect that to start with 2015. So I think by the time we get deeper into this year we'll be in a better position to comment on future projections.

Lastly, you asked about the sales organisation. Initially we downsized slightly in 2014. We had a sales force of around 28 retina specialist representatives. We're currently at about 18, which for the time being is an appropriate amount, given our level of activity today, and again we're going to see how well the community responds to the new data that we can bring into the market place in 2015. If we believe that we can drive additional growth by adding more people we are absolutely prepared to do that. We will be making that determination probably by mid- to third quarter in 2015.

PETER WELLFORD: That's great. Thank you.

OPERATOR: Our next question is from Jan de Kerpel from KBC Securities. Please go ahead. Your line is open.

JAN DE KERPEL: Okay. Thank you for taking my question. Patrik, if you could just remind us what the sales expectation was for 2015, in terms of number of vials? Also, could you, Paul, indicate to us how you are trying to get early stage patients into the retinal

specialist's office? What kind of actions are you taking there? Then some financial questions, if I may. What's the estimated cost for the Phase II study and what kind of operating expenses are you expecting going forward, so R&D lines, sales and marketing lines, are they expected to be the same as they were in 2014? Regarding the royalties of €3.4 million are they exclusively coming from the Alcon JETREA® sales, if you could confirm that? And then finally a small question on the new indication in DR. Given the primary endpoint will be PVD do you expect you will be needing a Phase III trial as the product already has the label for PVD induction? Thank you.

PATRIK DE HAES: Quite a few questions, Jan, so we're going to have to divvy them up here. With regard to 2015, I mean you are referring to the previous projection for the year 2015?

JAN DE KERPEL: I believe in the start of the conversation you said that the guidance was up to 3,500 to 4,000 vials versus previous, but I might have missed that.

PATRIK DE HAES: Yes, the current guidance is between 3,500 and 4,000, yes.

JAN DE KERPEL: So let me phrase it like this. When you provided the guidance for 2016 what were the assumptions you had for 2015?

PATRIK DE HAES: I don't think we gave them, but that was 6,000 vials.

JAN DE KERPEL: Okay, thank you.

PATRIK DE HAES: So then there was the question with regards to early stage, and let's say at a very early stage, quite clearly, if we look at all the recommendations we got from the

authorities with regard to the use of this product it's like everything guided towards the use of that product in early therapy. Whether it's now Europe or whether it's the US currently that is really not happening to a big extent, and yet we know that's where the big opportunity lies. That's where we got in the UK a very high price, as well as in Germany, that we can intervene early and basically prevent people from going into a macular hole. Right now we're being positioned as "competition" to vitrectomy which is not the reason why this drug was developed. This drug was developed to prevent vitrectomy and to intervene early in the disease process so that you don't have to develop a macular hole. So between what the drug can do and how it's currently used there's a clear delta.

In our medical education we always keep that in the back of our minds, but once again the medical community is not there yet. Do you want to add something to that, Paul?

PAUL HOWES: Yes, I would only just add that the safety concerns that we were dealing with in 2014 we hope will be well addressed with the increased data that we have coming into the market in 2015. With any kind of an interventional product if there is a safety concern you will find a lot of physicians really sitting on the sidelines, when they have other choices, and clearly in the case of SVMA they do have another choice. They can do a vitrectomy, so until you satisfy their need for more information, particularly on safety, I think our efficacy is well understood, but if they have concerns about safety or about the patient experience post-injection they will generally stay on the sidelines. That's what we have found, and that's why we have a degree of confidence that when we can bring this new data, particularly from OASIS into the market in 2015 we hope it will provide the answers that they need. Once we can satisfy the safety concerns they're likely to be much more willing to intervene early but having the discussion on early intervention is for the most part a non-starter with any specialist who has concerns about safety.

PATRIK DE HAES: With regard to the cost of Phase II, Jan, that is currently at the €10 million over three years. Then the question on R&D, perhaps you want to take that?

DOMINIQUE VANFLETEREN: Yes, on the operating costs, you were asking were they on the same level, so for the R&D expenses and the Belgian expenses they are expected to be at the same level at 2015. At comparable rates for the US, the US expenses are going to be below, and that is benefiting from the reorganisation and the restructuring and new strategy that has taken place last year. So as a whole we are expecting to be at a comparable rate, certainly at the same level or a bit below.

PATRIK DE HAES: Then on the specific question regarding the royalties. The €3.9 million are Alcon royalties.

DOMINIQUE VANFLETEREN: Yes, exactly, so royalties is only with Alcon, yes.

JAN DE KERPEL: Okay, thank you.

OPERATOR: Thank you very much, and before we go to the last question we have, let me remind you that you can ask a question by pressing the code 01 on your telephone keypad. You can also use the option Q&A on your webcast to submit your questions.
The next question is from Samir Devani, RX Securities. Please go ahead. Your line is open.

SAMIR DEVANI: Thanks for taking my questions. I've got a few. Some simple ones to begin with. Can you just tell me whether the price of JETREA® changed at all in the US over the last 12 months?

PATRIK DE HAES: The price evolution of JETREA® in the US over the last 12 months?

PAUL HOWES: It's stayed the same, USD 3,950 per vial.

SAMIR DEVANI: And then just on the cost of goods in the second half, can you just explain what's happened there?

DOMINIQUE VANFLETEREN: Yes, we have had to write off a few of the batches that we had in stock, so that's the main impact. Now, this is only for the cost of goods. If you look at the total year the cost of goods goes down, but that's because last year we had to base some licences on the milestone, so that affects the comparison.

SAMIR DEVANI: And I note your inventories have gone up a little bit. Is there any chance of you having to write off any of those inventories?

DOMINIQUE VANFLETEREN: For 2015, you mean?

SAMIR DEVANI: Yes.

DOMINIQUE VANFLETEREN: Well, we have to see how the sales are going. Because we have had a promulgation of the shelf life of the -- I would say the raw material, but the finished product which is not yet into the vials so, yes, there is no expectation for that.

SAMIR DEVANI: Okay, and then just really for Patrik, just a strategic question. You're obviously bringing down guidance again today, and just on my model certainly it doesn't look like the US business is going to be profitable probably until earliest 2017, if you're lucky. At what point do you make a decision that it's not economic to market this product in the US yourself?

PATRIK DE HAES: Every time we have a board meeting, we review the progress we make, and we decide on what is the best way to proceed with the business.

SAMIR DEVANI: I suppose the question is if I'm right it would be five years of trying to sell the product you would have been selling the product unprofitably, and I can't think of any other pharmaceutical that has been launched for five years and not done so profitably. Have you got any examples that you could give of doing that, that creates shareholder value?

PATRIK DE HAES: As you know, we launched in 2013 in the US. We look forward in 2015 to making the turnaround needed. At the end of 2015 we will see whether we have changed the form of the curve, so the end of 2015 will be very important.

SAMIR DEVANI: Okay, thanks very much.

OPERATOR: Thank you very much, and next question is from Mick Cooper from Edison. Please go ahead. Your line is open.

MICK COOPER: Good evening. Thank you for taking my question. Two questions. Firstly, talking about surgeons being able to better identify those that are more likely to respond well to JETREA®, can you give us a feeling with optimal patients what proportion do benefit from JETREA® treatment and what proportion of the market and how that affects the market opportunity for you of good responders? Secondly, regarding your reps, I'm assuming that all 18 are fully trained up at the moment, but if you do decide to grow your sales force, how long does it take to train a rep?

PAUL HOWES: Yes. Let me answer the second question first. There is like two ways of looking at it. One is having somebody sufficiently trained to initiate their work on a given piece of geography or a territory, and the other is at what point are they fully functional? It really depends on your ability to recruit people for this indication that have prior retinal experience. The good news is there are now a lot of companies offering products in the retinal space, so there are people with experience, whereas if you go back a few years there really wasn't much but now with the anti-VEGF products, with a few more steroid implants on the market, there are several companies and so you can access reasonably well-suited people, and if they are hired in the same geography that they used to work in they are also familiar with the practices around that geography.

Having said all that, if you can recruit people that have experience in retina, as opposed to general ophthalmology or non-ophthalmology backgrounds you can have somebody fully functional within a matter of a couple of months from their start date.

I think your earlier question was on patient selection. This is also somewhat related to market size, and this might have been one of the factors that was not well understood at the time of launch and that we're getting clearer indications of now, which is what is the size of the market for symptomatic VMA. It's really hard to pin that down, particularly because given the safety concerns we have a lot of retinal physicians that aren't using the product today. That's one of the major sources of potential upside for us, if we can solve those safety concerns we will get a better look at what the size of this particular market is. Symptomatic VMA is a relatively small indication and is literally dwarfed in size by the diabetic retinopathy market and other potential indications for this product, so that's another one of the reasons why we see a lot of potential upside for JETREA® beyond SVMA and that's why we're initiating this work in diabetic retinopathy at the same time.

MICK COOPER: Okay, thank you.

OPERATOR: Thank you very much. There are no more questions. Do you wish to begin closing comments? I am sorry, in between we have another new question from Jan De Kerpel again, I see, so please go ahead. Your line is open.

JAN DE KERPEL: Yes, thank you. I just wanted to have follow-up and then one of my previous questions was not answered, being do you expect that you will have to do a Phase III study for the DR indication as the primary endpoint will be a PVD induction which is already on the label of the product? Secondly, regarding coming back to the early stage patient, do we have to understand that your primary physician focus is still the retina specialist and not trying to broaden it to general ophthalmologists?

PATRIK DE HAES: Okay. So you maybe take the second part.

PAUL HOWES: We are focused on the retinal physician right now, and primarily because focusing on a broader community if the result of that ever ends up with them sending a patient to a retinal physician that isn't comfortable using our product today that doesn't really accomplish anything. So in the short term our focus is very clearly on the retinal specialist but we are working with them to engage broader audiences, including general ophthalmology and optometry to make them aware of the condition, how they recognise it and how they potentially identify patients with the right anatomic characteristics to suggest for referral to a retinal specialist for potential treatment of their VMA.

PATRIK DE HAES: So with regard to the first question, Jan, yes, we do plan a Phase III. No, PVD is not on our label, but we think that with that study we could get that on the label. That study would not just be looking at PVD but it would also be looking at progress

of vision, so not purely an anatomical endpoint, it would also have a clinical endpoint.

JAN DE KERPEL: Okay, thank you.

PATRIK DE HAES: If no further questions, you know, one comment that I want to make here, you have heard today a lot about safety perception and I think we have to underline the word perception. Why is that? Because having analysed over 10,000 patients and having submitted that to the FDA and to EMA It is clear that the safety profile by which we got the approval on less than 1,000 patients is still the safety profile that we have with over 10,000 patients. As Paul said, the safety perception by some anecdotal reports, by a small group of physicians in the US, has had an important impact on the market. Again, that data is available for all people who want to see it. The safety data by which we got approval is still the same as we have with over 10,000 patients.

That would be my final remark.

OPERATOR: Do you want to conclude the conference?

PATRIK DE HAES: Yes, it is I think the end of the conference. We want to thank all participants for joining us.

OPERATOR: Thank you Dr Patrik de Haes, Mr Paul Howes and Mr Dominique Vanfleteren. This concludes today's conference. Thank you all for attending. You may now disconnect your lines.