Alimera Sciences (ALIM)

INITIATION

Don't Turn a Blind Eye

Rating	**OUTPERFORM* [V]**
Price (01 June 10, US$)	9.34
Target price (US$)	16.00¹
52-week price range	11.06 - 7.93
Market cap. (US$ m)	308.22
Enterprise value (US$ m)	286.69

**Stock ratings are relative to the relevant country benchmark.*
¹Target price is for 12 months.
[V] = Stock considered volatile (see Disclosure Appendix).

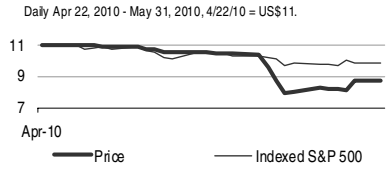
Research Analysts

Michael Faerm
212 538 1771
michael.faerm@credit-suisse.com

Arti Sanganeria
212 538 5206
arti.sanganeria@credit-suisse.com

- **We initiated coverage of Alimera Sciences with an Outperform rating and a $16 target price**.
- **Investment Case:** We expect share price appreciation in Alimera to be driven by three factors: (1) Alimera seeks to address a large, underserved market in diabetic macular edema (DME); (2) Alimera's lead product, Iluvien, has a differentiated product profile with demonstrated clinical advantages in sustained vision improvement, based on Phase III data in DME; and (3) Alimera can employ an attractive commercial model for Iluvien that is leverageable and can achieve high margins and rapid profitability. Furthermore, Alimera's 15% stock price decline since its IPO is not warranted by fundamentals.
- **Catalysts:** The primary catalysts in 2010 will pertain to the FDA approval of Iluvien. Alimera intends to file for approval around June 28, should find out in late August if Iluvien received priority review, and should receive an FDA approval decision in late December if priority review is granted. This timeline would enable a January launch, which we expect and assume in our model.
- **Valuation:** Our target price of $16 is based on a discounted cash flow analysis (DCF). Since the vast majority of the stock's value is attributable to a single product (Iluvien) with a finite commercial life, we believe DCF analysis is more appropriate than a multiples-based methodology. Our DCF analysis assumes a 12% discount rate; and a 75% probability of success and 15% peak U.S. penetration for Iluvien.

Share price performance



On 05/31/10 the S&P 500 index closed at 1089.41

Quarterly EPS	Q1	Q2	Q3	Q4
2009A	—	—	—	—
2010E	-4.58	-0.41	-0.28	-0.36
2011E	-0.03	0.01	0.12	0.15

Financial and valuation metrics

Year	12/09A	12/10E	12/11E	12/12E
EPS (CS adj.) (US$)	-34.55	-1.61	0.26	1.51
Prev. EPS (US$)	—	—	—	—
P/E (x)	NM	NM	35.6	6.2
P/E rel. (%)	NM	NM	323.3	63.6
Revenue (US$ m)	—	—	96.5	197.7
EBITDA (US$ m)	-18.1	-31.2	17.3	87.6
OCFPS (US$)	-11.6	-2.0	-0.2	2.1
P/OCF (x)	—	-4.7	-46.9	4.5
EV/EBITDA (current)	-17.6	-9.2	17.0	2.5
Net debt (US$ m)	10	-22	-15	-87
ROIC (%)	—	—	—	—

Number of shares (m)	33.00	IC (12/09A, US$ m)	—
BV/share (current, US$)	1.7	EV/IC (x)	—
Net debt (current, US$ m)	-63.1	Dividend (12/09A, US$)	—
Net debt/tot. cap. (%)(12/09A,	—	Dividend yield (%)	—

Source: Company data, Credit Suisse estimates.

Table of Contents

Investment Summary

We initiated coverage of Alimera Sciences (ALIM) with an Outperform rating and a 12-month target price of $16.

Alimera Sciences is preparing to file an NDA for its lead product, Iluvien, a potential treatment for diabetic macular edema (DME) consisting of an insert placed into the back of the eye to deliver a corticosteroid over a 2-3 year period. The company's time line calls for a filing around June 28 with a request for priority review, a December FDA decision, and a January 2011 launch. We believe that Iluvien represents a substantial new opportunity in a large and growing market that, coupled with recent weakness in Alimera shares that is not warranted by fundamentals, provides investors with the opportunity to realize attractive returns.

We expect share price appreciation in Alimera to be driven by three factors:

(1) A large, underserved market opportunity in DME;

(2) A differentiated product profile for Iluvien, with clinical advantages in sustained vision improvement, based on Phase III data in DME; and

(3) An attractive commercial model that is leverageable and can achieve high margins and rapid profitability.

Alimera Seeks to Address a Large, Underserved Market Opportunity in Diabetic Macular Edema (DME)

DME is a condition among diabetics caused by swelling in the center of the retina (the macula), which can result in mild to profound loss of vision. The diabetes epidemic in the U.S., combined with the aging population, creates a favorable demographic backdrop. We estimate that there are about 340,000 new cases of DME each year, derived from the U.S. diabetic population of approximately 18 million, creating a $3-4 billion market opportunity annually.

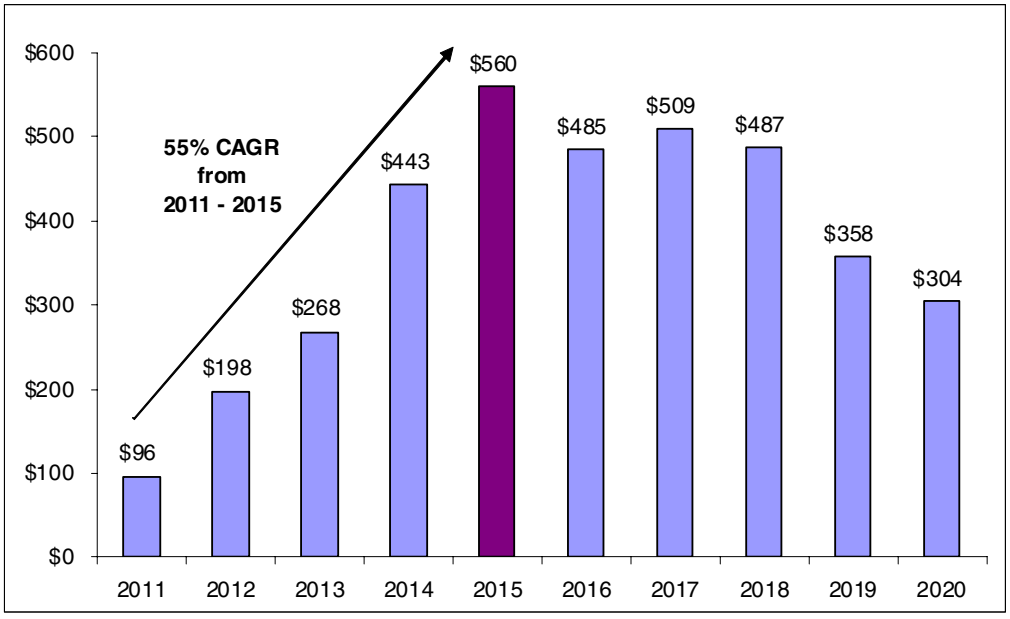
There are currently no approved drugs for DME. Laser photocoagulation is the gold standard treatment and is well accepted by physicians, but it often must be repeated and is recognized more for slowing vision decay than providing gains.

There are a number of competing treatments that are used off-label in DME, some of which are pursuing approval in the indication, but each of them has weaknesses that can be improved upon.

We estimate peak revenues of $560 million in 2015

Based on our estimates of the market opportunity and Iluvien's potential market share (15% at peak), we forecast peak global sales of approximately $560 million in 2015 (Exhibit 1).

Exhibit 1: Credit Suisse Forecast for Global Iluvien Sales—$560 Million Peak in 2015
in millions, unless otherwise stated



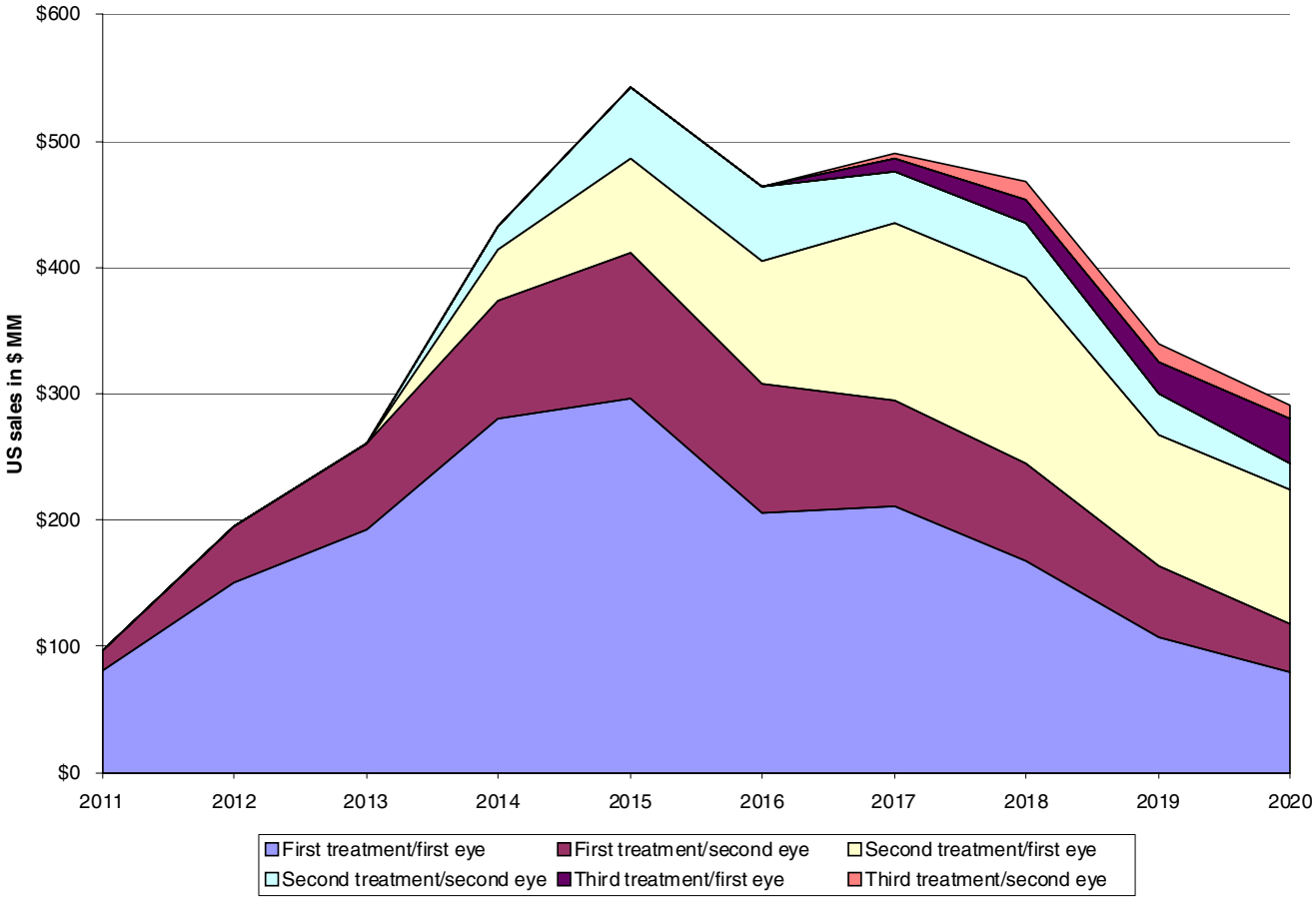
Source: Company data, Credit Suisse estimates.

Revenue profile is similar to a vaccine with boosters

In our model, Iluvien's revenue profile is similar to that of a vaccine with boosters (Exhibit 2). Since the product has the potential for a durable efficacy profile of 2-3 years, its revenue uptake does not behave like a chronic medication such as statins. On the other hand, Iluvien is not necessarily a one-time only proposition like some vaccines, since the efficacy is not indefinite and retreatments are possible.

Thus, revenue uptake has attributes of a vaccine—with a large unaddressed pool of "catch-up" patients available at launch for initial treatments. The uptake in initial treatments is projected to be relatively rapid in the first several years, as penetration and the diabetic population grow; however, this uptake plateaus and declines as share flattens and later declines. Additional layers in the revenue model are derived from bilateral treatments (second eyes) and from retreatments—akin to "boosters."

Exhibit 2: Iluvien's Revenue Profile is Similar to a Vaccine with Boosters
in millions, unless otherwise stated



Source: Company data, Credit Suisse estimates.

Iluvien Has a Differentiated Product Profile with Demonstrated Clinical Advantages in Sustained Vision Improvement

Alimera has reported two-year results from its Phase III trial in DME (the FAME Study), which will form the basis for its upcoming NDA filing. Based on these data, Iluvien appears to offer important advantages over existing DME treatments in terms of speed of efficacy (vision improvement as measured by percentage of patients achieving at least three lines of improvement on the ETDRS, or Early Treatment Diabetic Retinopathy Study, eye chart), magnitude of efficacy, and durability of efficacy, with a safety profile that suggests an acceptable risk-benefit trade-off.

Iluvien's efficacy appears to be equal to or better than other DME treatments, and Iluvien's potential for 2-3 year efficacy from a single administration is a unique attribute. This durability could provide a substantial competitive advantage versus other DME treatments, particularly anti-VEGF (vascular endothelial growth factor) therapies such as Lucentis (ranibizumab) and Avastin (bevacizumab), which are injected on an approximately monthly basis, creating a significant inconvenience for many patients.

In Exhibit 3, we show a comparison of Iluvien to other treatments that are currently used for DME, both on- and off-label. We compare the treatments along a number of criteria, broadly grouped into three categories: clinical, practical, and economic, with shaded circles indicating more favorable attributes, in our view, than unshaded circles.

Exhibit 3: **Iluvien Has a Differentiated Profile versus Competing DME Treatments**

	CLINICAL			PRACTICAL	ECONOMIC	
	Immediate Vision Improvement	Durability of Vision Improvement	Side Effect Profile	Convenience & Compliance	Profitability to Physician	Cost to Payors
Iluvien	Excellent	Excellent	Average	Excellent	Poor	Poor
Laser	Average	Poor	Average	Average	Excellent	Average
IVTA	Poor	Poor	Average	Poor	Average	Excellent
Lucentis	Excellent	Very Poor	Excellent	Very Poor	Poor	Poor
Avastin	Excellent	Very Poor	Poor	Very Poor	Average	Poor
Ozurdex	Excellent	Average	Average	Average	Poor	Average

Very Poor · Poor · Average · Good · Excellent

Source: Company data, Credit Suisse estimates.

Alimera Can Employ an Attractive Commercial Model for Iluvien That Is Leverageable and Can Achieve High Margins and Rapid Profitability

Alimera plans to focus its sales and marketing efforts on retinal specialists, a relatively small, concentrated audience of approximately 1,600 physicians in 900 centers in the U.S. The company should be able to cover this audience with a small sales force of 30 representatives.

Coupled with rapid revenue uptake, this modest, fixed infrastructure creates a high degree of operating leverage for Alimera. Along with low COGS and R&D expense burdens, this drives high operating margins of up to 60%, after a 20% profit split payment to its partner pSivida, and should enable the company to turn profitable in 3Q:2011 and to begin consistently producing positive operating cash flow in 4Q:2011 (assuming an Iluvien launch in January 2011).

Target Price of $16 Based on DCF Analysis

Our target price of $16 per share is based on a discounted cash flow analysis (DCF), summarized in Exhibit 4. In our view, the vast majority of the stock's value is attributable to a single product, Iluvien, with a finite commercial life. Therefore, we believe that valuing the company's cash flows over a fixed period of time, with no terminal value, is most appropriate as it best mirrors the cash flows with sufficient visibility.

Our assumptions for our DCF are as folllows:

- **Time horizon:** we have modeled cash flows through 2030. This horizon includes the period through the company's main patent expiries (2019-2020), followed by an assumed fading of annual cash flows to zero by 2030.

- **Probability adjustment:** we have assumed a 75% probability of success for Iluvien, and our annual cash flows are adjusted accordingly, before discounting to the present. This adjustment factor is based on our assessment of Iluvien's probability of approval by FDA and launch.
- **Discount rate:** We have assumed a discount rate of 12% per year, applied to the probability-adjusted cash flows, for use as Alimera's cost of capital.

Exhibit 4: $16 Target Price Based on Discounted Cash Flow Analysis

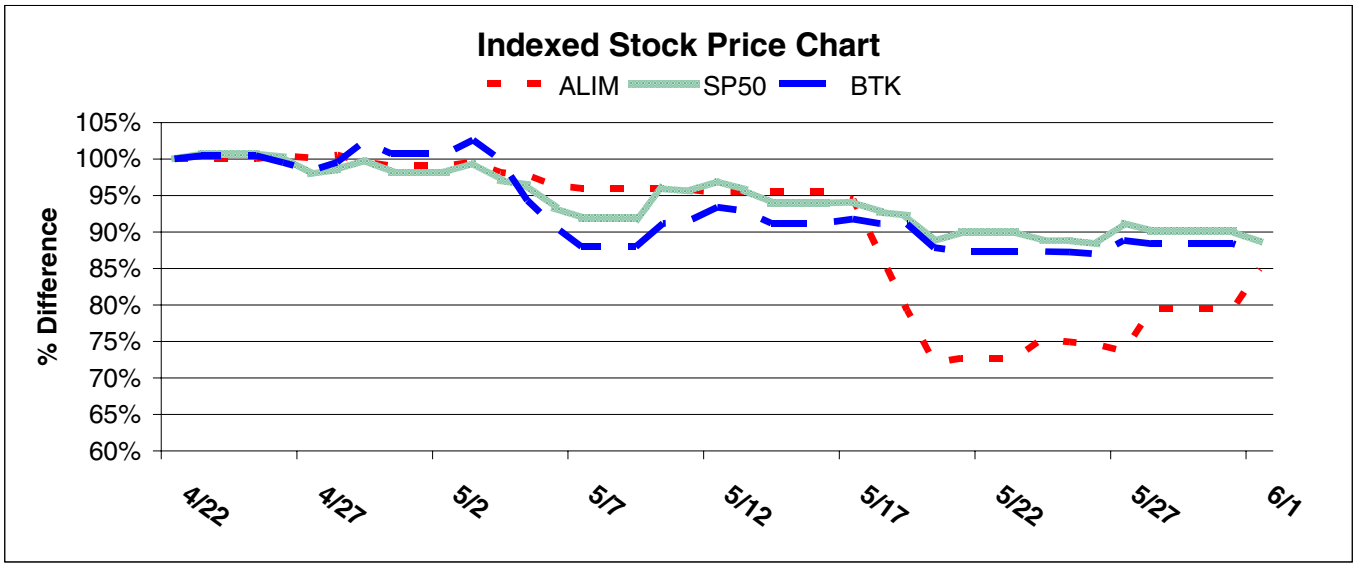
Risk-Adjusted DCF Valution Summary				
Disount Rate	Enterprise Value	Net Debt/(Cash)	Equity Value	Equity Value Per Share
11%	$507,929	($63,067)	$570,996	$17.37
12%	$474,353	($63,067)	$537,420	**$16.34**
13%	$443,538	($63,067)	$506,605	$15.41

Source: Company data, Credit Suisse estimates

Alimera's 15% Stock Price Decline Since IPO Is Unwarranted by Fundamentals

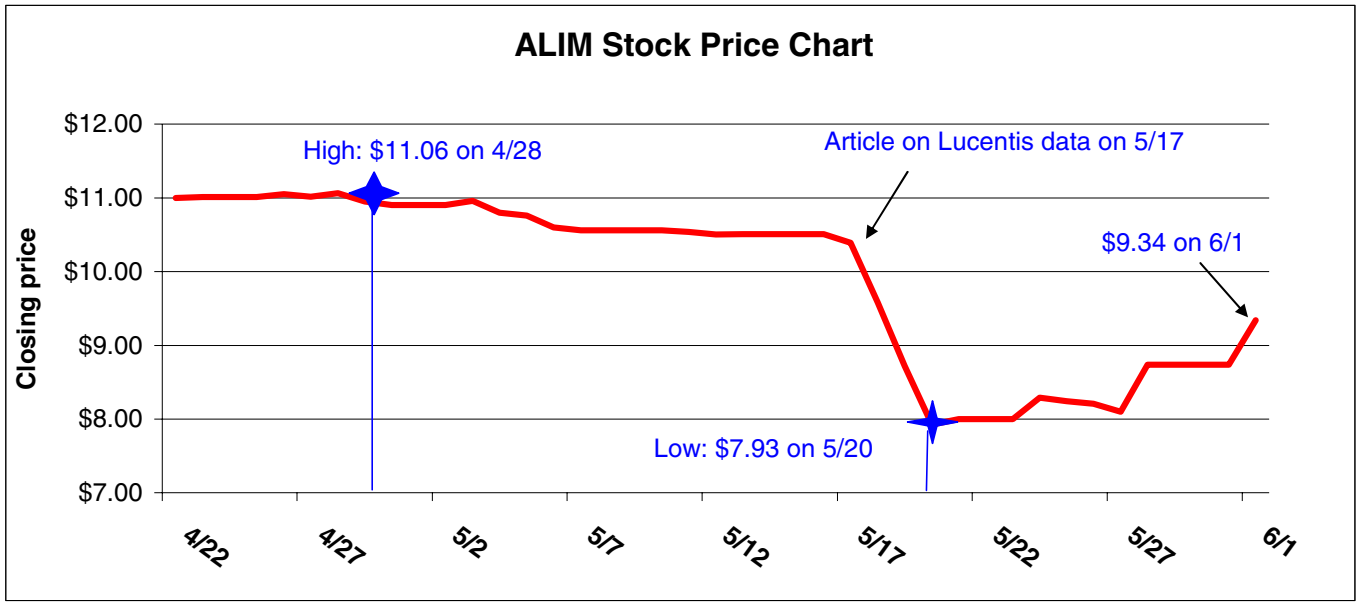
Since it commenced trading on April 22, Alimera's stock price has underperformed the market (Exhibit 5), returning -15%, compared with -11% for the S&P 500 and -13% for the NASDAQ Biotech Index (BTK).

Exhibit 5: Alimera Has Underperformed the Market



Source: FactSet, Credit Suisse estimates.

Exhibit 6: Alimera Stock Is Down 15% from Its $11.00 IPO Price



Source: Company data, Credit Suisse estimates.

Alimera's stock price began a sharp descent on May 18, dropping from 6% below the IPO price (at $10.39 on May 17) to the current 15% below ($9.35) (Exhibit 6). We don't believe that the decline was related to any fundamental changes with Iluvien or Alimera. The company continues to work toward an anticipated NDA filing around June 28, and there have been no reports of new data for Iluvien, or strategic or financial changes with Alimera.

Instead, we see two potential factors that may have contributed to the fall in the stock price.

(1) **Macroeconomic issues and low Alimera liquidity.** As investors are well aware, the broader stock market has been buffeted by recent macroeconomic concerns including sovereign debt default in Europe and negative pressures on the euro. As investors search for liquidity, smaller, less liquid names like Alimera can be disproportionately affected by selling pressure.

(2) **Recent data from the DRCR study of Lucentis in DME in combination with laser.** These data were first published on April 27 in the journal *Ophthalmology*, but were featured in a *Biocentury* article on May 16. The data showed promising efficacy for Lucentis, but the study had factors in its design that aided the demonstrated efficacy in comparison with Alimera's FAME study. When FAME data are analyzed on a comparable basis with DRCR data (observed cases only), Iluvien's efficacy is greater than Lucentis+laser.

Investment Risks

(1) Single product risk

(2) Regulatory risk to timely Iluvien approval (partly highlighted below)

(3) Commercial risk

(4) Liquidity and financing risk (summarized below)

(5) Reimbursement risk

Statistical Analysis of FAME Study Creates Risk to Iluvien Approval, but We Expect Approval

The FAME study utilized 2 noteworthy methods of statistical analysis, the full data set (including all 956 patients randomized) and the modified all randomized and treated (MART) dataset (with 953 patients, excluding 3 who were randomized but treated), for which in instances where a patient received a treatment prohibited by the FAME protocol (such as Lucentis, Avastin or triamcinolone), the last observation prior to the protocol violation was imputed forward to month 24 using the LOCF (last observation carried forward) method.

The primary efficacy measure of FAME met statistical significance under the full data set analysis, but narrowly missed significance under the MART analysis. This adds risk to the chances of Iluvien approval, which we have considered by using a 75% probability of success in our valuation, which is somewhat higher discount than the 80-85% more commonly used for post-Phase III products.

Moreover, we believe that despite the missed statistical significance of the MART data set, the FDA will consider the totality of the FAME data, including the full data set, and will approve Iluvien, for the following reasons, discussed in this report.

(1) Strong efficacy with statistical significance in the broadest patient group (the full data set);

(2) Full data set is consistent with ICH E9 guidelines;

(3) Our diligence checks with experts;

(4) The Ozurdex precedent; and

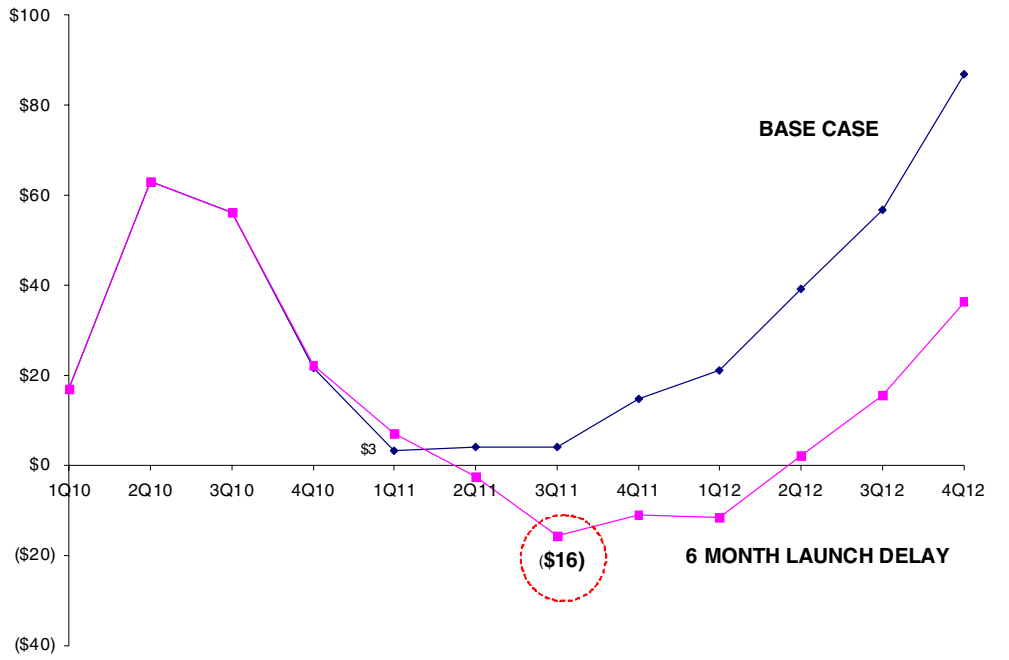
(5) Alimera's uneventful pre-NDA meeting with FDA

Iluvien Approval Delay Could Create Short-term Financing Need in 2011

We assume in our model that Alimera files the Iluvien NDA in late June 2010, receives approval in late December under a priority review, and launches the product in January 2011. Under this scenario, Alimera should have sufficient cash flow to reach profitability.

However in the event of a delay to Iluvien approval, for example of 6 months, Alimera may face the need to raise additional financing of a cash shortfall that we estimate at $16 million in 3Q:2011 (Exhibit 7). This estimate excludes any potential deal payments, such as for ex-US rights to Iluvien. Alimera could seek financing through equity issuance, however the short-term cash need would likely dictate a short-term funding source, such as accounts receivable financing or an Iluvien ex-US collaboration sought at an earlier time than otherwise.

Exhibit 7: Alimera Could Require Additional Financing in 3Q11 If Iluvien Launch is Delayed (cash shortfall in $MM shown) – Excluding Potential Deals
in millions, unless otherwise stated



Source: Company data, Credit Suisse estimates

Iluvien Filing and Approval Headline the List of Upcoming Catalysts

The primary potential catalysts for the rest of 2010 will pertain to the FDA approval of Iluvien. Alimera intends to file for approval around June 28 and seek priority review. The company should find out about two months after filing if its request for priority review has been granted. Last and most important, if Alimera receives priority review for Iluvien, then the FDA would be expected to render an approval decision in December, potentially enabling Alimera to launch Iluvien in January 2011, as is assumed in our model.

Exhibit 8: Summary of Upcoming Catalysts

Timing	Catalyst/Event	Fundamentals
approx. June 28, 2010	**Iluvien:** ALIM plans to file with FDA for US approval	ALIM must file in June and receive priority review in order to meet launch goal of early 2011
approx. August 28, 2010	**Iluvien:** ALIM likely will find out whether approved for priority review	Priority review request normally decided 60 days after filing
approx. December 28, 2010	**Iluvien:** FDA approval decision if priority review	Priority review decisions are typically made 6 months after filing; a Dec. approval would enable a Jan. 2011 launch

Source: Company data, Credit Suisse estimates.

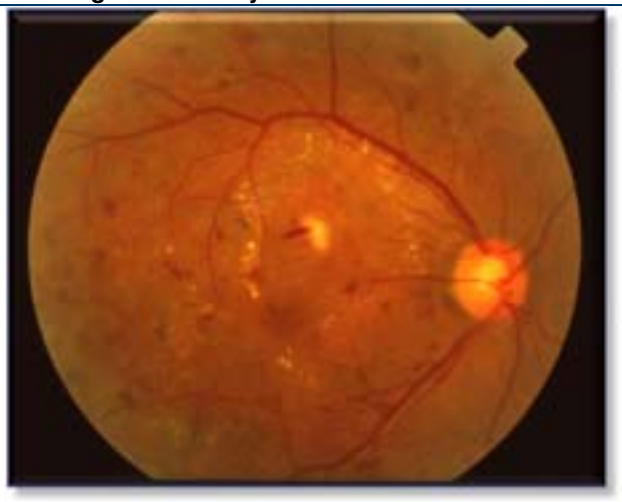
Diabetic Macular Edema Market

What Is Diabetic Macular Edema (DME)?

Diabetic Macular Edema (DME) is swelling in the center of the retina (Exhibit 9), known as the macula, which provides detailed vision for activities such as reading, driving, or distinguishing faces. DME is caused by retinal microvasculature changes that occur in diabetics after years of elevated blood sugar levels. These changes cause swelling of the macula due to leakage and abnormal growth of blood vessels in the diabetic retina, which are symptoms associated with an ophthalmic complication of diabetes called diabetic retinopathy.

The onset of DME is painless and often unnoticed in the initial stages of the disease. Patients tend to realize they are suffering from the disease in the latter stages of the disease when they experience blurring or acute loss of central vision. The severity of blurring may range from mild to profound loss of vision.

Exhibit 9: Retinal Swelling Due to Leaky Blood Vessels in the Macula of the Human Eye



Source: Company data, Marinel Casiano CRA and Sanford Chen MD of Orange County Retina.

Diabetes and Diabetic Retinopathy

The leading cause of blindness among working-age adults in the United States is **diabetic retinopathy**, a devastating optic complication of diabetes mellitus and a serious health problem throughout the world. It is estimated that more than 12,000 patients each year become blind owing to diabetic retinopathy.

Diabetic retinopathy can be divided into **early, middle,** and **advanced stages,** with the first two stages being nonproliferative and the last stage being proliferative retinopathy.

Early pathology is considered mildly nonproliferative (also called background retinopathy) and is characterized by retinal vascular microaneurysms, blot hemorrhages, and cottonwool spots.

Middle stage includes moderate, severe, and very severe nonproliferative diabetic retinopathies with venous changes, retinal capillary loss, retinal ischemia, increased capillary permeability, exudates, and extensive intraretinal hemorrhages.

Advanced stage of the disease is called **proliferative diabetic retinopathy,** which is marked by growth of new blood vessels in addition to the various changes observed in nonproliferative retinopathy. These fragile new blood vessels grow in two locations, along the retina and along the surface of the clear, vitreous gel filling the inside of the eye. The presence of additional blood vessels does not cause the disease. It is the suppleness and

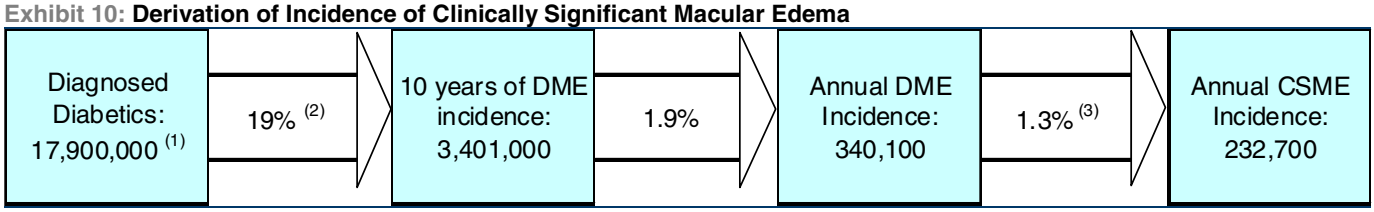
fragility of the weak, tender walls of the blood vessels that are prone to leakage and hemorrhage. Increased permeability of these vessels results in leakage of fluid and proteinaceuous material, which clinically appears as retinal thickening and exudation. Neovascularization, preretinal and vitreous hemorrhages, fibro-vascular proliferation, and retinal detachment are some of the clinical manifestations of advanced diabetic retinopathy.

How Many People Suffer from Diabetic Macular Edema?

Diabetes Mellitus has been declared an epidemic in the U.S. by Centers for Disease Control and Prevention. According to the CDC, the number of diagnosed diabetics has grown to 17.9 million in 2007. Despite the increased awareness and diagnosis rate, of the nearly 24 million people suffering from diabetes in 2007, about 24% remain undiagnosed. Diabetes Mellitus represents an enormous public health threat in the United States.

Per the American Diabetes Association, diabetes is the leading cause of blindness incidence in adults aged 20 to 74, with about 12,000 to 24,000 new cases of blindness annually. Over a ten-year period, about 19% of diabetics evaluated were diagnosed with DME, according to the Wisconsin Epidemiological Study of Diabetic Retinopathy XV. Using the same penetration rate, about 340,000 diabetics patients suffer from DME annually, equating to an incidence rate of 1.9% per year.

Exhibit 10: Derivation of Incidence of Clinically Significant Macular Edema



Source: (1) Total diagnosed diabetics in 2007 per CDC, (2) 10 year incidence rate per Wisconsin Epidemiological Study of Diabetic Retinopathy XV, (3) Derived from 10 year incidence rate of 13% in Wisconsin Epidemiological Study of Diabetic Retinopathy XV

What Are the Current Treatment Options?

There are currently no approved drugs for DME. Patients are treated with laser photocoagulation and several drugs that are used off-label for DME. Current treatments include the following.

Laser Photocoagulation- the Gold Standard, But Modest Vision Improvement

Laser photocoagulation is the gold standard treatment for DME. It is well accepted and widely used by retinal specialists, as it decreases retinal thickening, lowers the risk of vision loss, and provides some chance of vision improvement, without systemic side effects. However, laser is recognized more for slowing vision loss than providing gains and can cause thermal injury to the retina with repeated use, which is often required. In addition, laser is mainly effective in focal DME, rather than diffuse DME, leaving the latter patient group with a particularly unmet need.

In 1985, the Early Treatment Diabetic Retinopathy Study (ETDRS), a landmark study for laser photocoagulation, showed that laser can be reasonably effective in reducing vision loss but did not measure vision improvement. The study showed that immediate laser treatment made it about half as likely for patients to lose 15 or more letters on the ETDRS eye chart compared with deferred laser treatment (deferred until development of high-risk proliferative diabetic retinopathy). For example, among patients with macular edema and mild to moderate retinopathy, 12% of those treated with immediate laser had 15 lines or more of vision loss, versus 24% of those for whom laser was deferred. This benefit was more pronounced in patients with clinically significant macular edema, for whom the risk of a vision loss of 15 or more letters was cut by 59% (from 29% to 12%).

Exhibit 11: Early Treatment Diabetic Retinopathy Study (ETDRS)—Immediate Laser Treatment Showed Less Vision Loss, but Vision Improvement Not Measured

	Efficacy					
Trial Arm	% eyes with vision loss of 15 letters or more in eyes with macular edema and mild to moderate diabetic retinopathy			% eyes with vision loss of 15 letters or more in eyes with clinically significant macular edema		
	12 months	24 months	36 months	12 months	24 months	36 months
Deferral Laser until high-risk proliferative retinopathy developed, n = 1490	8%	16%	24%	11%	20%	29%
Immediate Laser n=754	5%	7%	12%	5%	7%	12%

Source: ETDRS Research Group, Photocoagulation for Diabetic Macular Edema, Archives of Ophthalmology 1985.

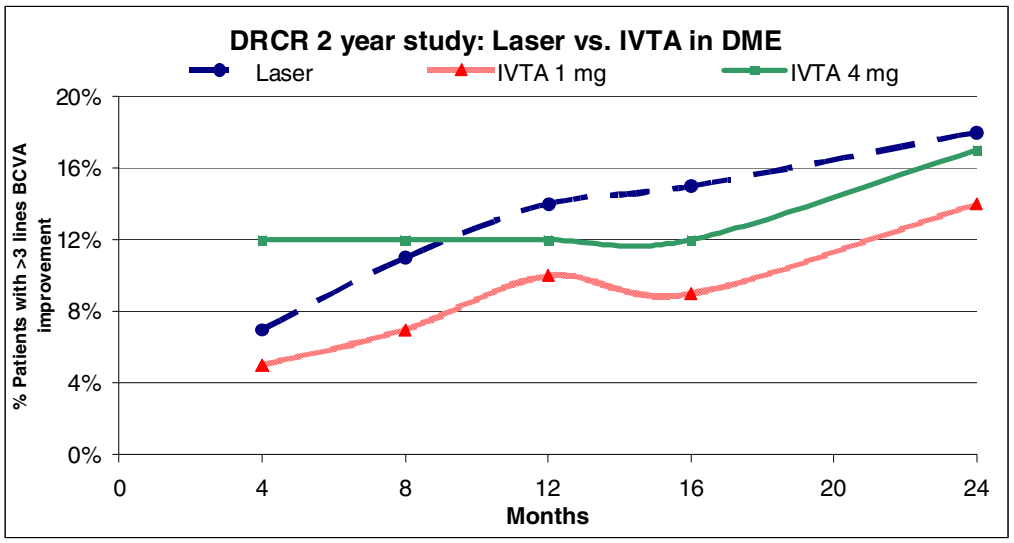
In many retinal practices, laser is widely used as first-line therapy for DME patients owing to its longstanding status as the standard of care, and the fact that it can be lucrative for practices. Laser is most beneficial in patients with focal DME, but its widespread use across DME patients coupled with laser's inherent limitations results in many cases of suboptimal efficacy.

Intravitreal Corticosteroid Injections – Short-term Vision Improvement, But Durability and Safety Are Suboptimal

Often abbreviated as **IVTA,** (for intravitreal triamcinolone acetonide, one of the corticosteroids used intravitreally), these drugs are marketed as brands and generics by several companies. They are known for providing relatively rapid efficacy, but not durability, and can come with significant side effects, including elevated intraocular pressure (IOP) and cataract surgeries.

The Diabetic Retinopathy Clinical Research (DRCR) Network study highlights that although IVTA provides modest efficacy in the short term, the response is not very durable and can actually be inferior to laser's efficacy by month 24 (Exhibit 12). Patients in this study were given the randomized treatment at the onset of the study and every four months at the time of a follow-up visit if needed after clinical evaluation of edema.

Exhibit 12: Two-Year DRCR Phase Study Comparing Laser vs. IVTA in DME



Source: DRCRN, Randomized Trial Comparing Intravitreal Triamcinolone Acetonide and Focal/Grid Photocoagulation for Diabetic Macular Edema, Ophthalmology 2008.

In the DRCR study, the efficacy comparison between laser and IVTA, based on percentage of patients with 3 or more lines of improvement in visual acuity, did not reach statistical significance at 24 months (Exhibit 13), but is directionally interesting. During the early stages of the study, at month 4 and month 8 of the study, IVTA 4 mg seems to have better efficacy than laser. However, between months 8 and 12, laser's efficacy surpasses 4 mg IVTA. This gap persists but narrows by month 24. The 1 mg IVTA dose remains inferior at all times. Based on mean change in number of letters improvement, laser showed statistically significant superiority to IVTA, though more showed noteworthy impairment.

Not surprisingly, IVTA showed higher incidence of IOP elevation and cataract than laser. However, the incidence of trabulectomy was insignificant for all arms.

Exhibit 13: Two-Year DRCR Phase Study Comparing Laser vs. IVTA in DME (additional details)

	Efficacy						Safety		
Trial Arm	% patients with ≥ 3 lines VA improvement					Mean Δ in BCVA, # of letters	IOP > 30 mmHg	Cataract Surgery (% of Phakic Eyes)	% Requiring Trabulectomy
	4 months	8 months	12 months	16 months	24 months	24 months	24 months	24 months	24 months
Laser n=330, t=0, every 4 months if needed	7%	11%	14%	15%	18% p = 0.10	1	1%	13%	0%
IVTA 1 mg n=256, t=0, every 4 months if needed	5%	7%	10%	9%	14% p = 0.48	(2) p = 0.02	9%	23%	0%
IVTA 4 mg n=254, t=0, every 4 months if needed	12%	12%	12%	12%	17% p = 0.36	(3) p = 0.002	21%	51%	1%

Source: DRCRN, Randomized Trial Comparing Intravitreal Triamcinolone Acetonide and Focal/Grid Photocoagulation for Diabetic Macular Edema, Ophthalmology 2008.

Anti-VEGF Injections – Safe and Efficacious, But Require Persistent Injections

Studies have shown that levels of VEGF (vascular endothelial growth factor) are increased in the retina and the vitreous of eyes with diabetic retinopathy. Consequently, therapies that inhibit VEGF have been studied and used as a means to target the pathogenesis of DME.

Lucentis (ranibizumab) and Avastin (bevacizumab) are injectable anti-VEGF antibodies marketed by Roche/Genentech (with Lucentis ex-U.S. marketed by Novartis). Lucentis is approved for age-related macular degeneration (AMD), and is in Phase III trials for DME in the U.S. and has been filed in the EU. Avastin is approved for several cancers, but due to its similarity to Lucentis and its much lower unit cost, it is used off-label for AMD and DME.

Currently, Avastin claims the bulk of anti-VEGF use in DME. Lucentis is significantly more expensive ($2,000 per dose for the drug, versus $20-100 per dose for Avastin) and is not approved, nor generally reimbursed in DME. Furthermore, Avastin has started to receive reimbursement from government and some private payors. Lucentis is used in DME in a small minority of practices that get it free for clinical trials or through patient access programs.

The 2 drugs are considered by many physicians to have similar efficacy, although some say that Lucentis works better but that Avastin can often be used less frequently in real-world use (e.g., every 6 weeks versus every 4 weeks).

In terms of safety, Avastin and Lucentis are seen by many physicians as having similar effects, particularly with ocular events (very few). Some physicians have concerns about long-term systemic side effects with Avastin, which in oncology studies has shown kidney and hypertension side effects.

Lucentis has shown in clinical studies to work rapidly in DME, and also to have a relatively clean safety profile. The unanswered question is, how will it fare as a long-term treatment? The recently reported DRCR study (below) begins to address this, and the RISE and RIDE Phase III trials will answer it more fully, with 2-year data expected in 1H11, and potential launch (and 3-year data) in 2012.

A recent NIH-funded study by DRCR Network has garnered significant attention for demonstrating Lucentis' efficacy in DME for longer periods, and in greater patient numbers, than the READ-2 study (discussed below). The DRCR study was for 2 years, evaluating the efficacy and safety of 0.5 mg Lucentis or 4 mg triamcinolone combined with laser, or laser alone, for treating DME. (Exhibit 14.) While Lucentis with prompt or deferred laser showed it was successful in increasing visual acuity by 3 lines or more in 26% and 29% of patients, respectively, with a relatively low risk of adverse events, it is worth noting two factors that likely contributed meaningfully to the results: (1) the study evaluates Lucentis in combination with laser only, not as a monotherapy; and (2) the results include observed patients only and could be favorably biased when compared to trials measuring all patients and using last observations carried forward.

Exhibit 14: Design of DRCR Study Comparing Lucentis with Laser

Trial Arm	Design
Lucentis + Prompt Laser (n =187)	0.5 mg intravitreal ranibizumab injection + focal/grid photocoagulation within 3-10 weeks after injection
Lucentis + Deferred Laser (n = 188)	0.5 mg intravitreal ranibizumab injection + focal/grid photocoagulation after 24 weeks since injection
Triamcinolone + Prompt Laser (n = 186)	4 mg intravitreal triamcinolone injection + focal/grid photocoagulation within 3-10 weeks fter injection
Sham + Prompt Laser (n = 293)	sham injection + focal/grid photocoagulation within 3-10 weeks after injection

Source: DRCRN, Randomized Trial Evaluating Ranibizumab Plus Prompt or Deferred Laser of Triamcinolone Plus Prompt Laser for Diabetic Macular Edema, American Academy of Ophthalmology 2010.

The primary endpoint was best-corrected visual acuity (BCVA) and safety at 1 year. In addition, the study measured BCVA at 2 years, and the percentage of patients witnessing

three or more lines visual acuity improvement (Exhibit 15). Both Lucentis+laser groups demonstrated statistically signficant improvement in mean change in number of letters, while triamcinolone+laser did not. In terms of 3-line improvement, both Lucentis+laser groups exceeded trimcinolone+laser and sham+laser, with Lucentis+prompt laser scoring highest at 1 year (30%) and Lucentis+deferred laser highest at 2 years (29%).

Exhibit 15:Lucentis + Laser Demonstrated Superior Efficacy in DME (DRCR Study)

	Efficacy					
Trial Arm	% patients with ≥ 3 lines VA improvement		Mean Δ in BCVA, # of letters		Median Δ in BCVA, # of letters	
	1 year	2 year	1 year	2 year	1 year	2 year
Lucentis + Prompt Laser (n =187)	30%	26%	9 p < 0.001	7 p = 0.01	10	8
Lucentis + Deferred Laser (n = 188)	28%	29%	9 p < 0.001	10 p < 0.001	9	10
Triamcinolone + Prompt Laser (n = 186)	21%	19%	4 p = 0.33	0 p < 0.001	5	6
Sham + Prompt Laser (n = 293)	15%	17%	3	2	5	5

Source: DRCRN, Randomized Trial Evaluating Ranibizumab Plus Prompt or Deferred Laser of Triamcinolone Plus Prompt Laser for Diabetic Macular Edema, American Academy of Ophthalmology 2010.

The incidence of adverse events was higher in patients treated with triamcinolone than in patients treated with Lucentis. (Exhibit 16.) While 25-27% of patients treated with triamcinolone experienced IOP greater than 30 mmHg, only 1-3% of patients treated with Lucentis recorded IOP greater than 30 mmHg. At the end of year 2, 55% of patients treated with triamcinolone had undergone cataract surgery as compared to 12-13% patients treated with Lucentis. The safety profile associated with laser was benign with 1-3% of patients experiencing IOP greater than 30 mmHg and 6-12% patients undergoing cataract surgery.

Exhibit 16:Lucentis + Laser Demonstrated Better Safety in DME (DRCR Study)

	Safety					
Trial Arm	IOP > 30 mmHg		Cataract Surgery (% of Phakic Eyes)		Trabulectomy	
	1 year	2 year	1 year	2 year	1 year	2 year
Lucentis + Prompt Laser (n =187)	1%	2%	5%	12%	0%	1%
Lucentis + Deferred Laser (n = 188)	2%	3%	6%	13%	0%	0%
Triamcinolone + Prompt Laser (n = 186)	25%	27%	15%	55%	0%	1%
Sham + Prompt Laser (n = 293)	1%	3%	6%	12%	0%	<1%

Source: DRCRN, Randomized Trial Evaluating Ranibizumab Plus Prompt or Deferred Laser of Triamcinolone Plus Prompt Laser for Diabetic Macular Edema, American Academy of Ophthalmology 2010.

The READ-2 study (Exhibit 17) demonstrated Lucentis' potential for efficacious improvement in visual acuity though the study was short (6 months, with some 12-month

data) and had small patient numbers (n=126). The 6-month study of **r**anibizumab (Lucentis) for **e**dema of the m**a**cula in **d**iabetes compared the safety and efficacy of Lucentis with laser or a combination of both in DME. After completion of the study at 6 months, Lucentis alone was the most efficacious therapy with 46% of patients experiencing 2 or more lines visual acuity improvement and 22% of patients achieving 3 or more lines visual acuity improvement; as well as higher mean change in number of letters. In addition, it is important to note that the mean gain in BCVA letters with Lucentis and laser was not statistically significant.

Exhibit 17: Lucentis Demonstrated Superior Efficacy in DME (READ-2 Study)

	Efficacy			
	6 Months		6 Months	12 months
Trial Arm	% patients with ≥ 2 lines VA improvement	% patients with ≥ 3 lines VA improvement	Mean Δ in BCVA, # of letters	Mean Δ in BCVA, # of letters
0.5 mg Lucentis n = 42, (t = months 0,1,3,5)	46% p = 0.00004	22% p = 0.002	7.24 p = 0.0003	6.70
0.5 mg Lucentis+Laser n = 42, (months 0,3)	30% p = 0.007	8%	3.80 not stat sig	4.50
Laser n = 42, (months 0; 3 if needed)	5%	0%	(0.43)	2.53

Source: Nguyen, Primary End Point (6 months) Results of the Ranibizumab for Edema of the mAcula in Diabetes Study, American Academy of Ophthalmology 2009.

Recent data from the RESTORE Phase III study in DME (presented May 22, 2010 at the EASD meeting), shown in Exhibit 18, provide further evidence of Lucentis' efficacy but only to 12 months, and the study does not give data for 3 lines or more improvement in visual acuity.

The study highlighted that Lucentis with or without laser is effective in treatment of DME patients. 37% of patients on 0.5 mg ranibizumab alone and 43% patients being treated with ranibizumab + laser achieved 2 lines or more of visual acuity improvement. The mean gain in BCVA letters was 6.1 and 5.9 for the patients getting ranibizumab alone or with laser, respectively. The safety profile appeared benign, with incidence of IOP (metric not disclosed) among patients less than 1%. Systemic adverse events were also relatively low with 5-8% patients reporting hypertension and 3-4% patients reporting arterial thromboembolic events.

Exhibit 18: RESTORE Demonstrates Lucentis Effective in DME, but only shown to 12 months

	Efficacy	
	12 Months	12 Months
Trial Arm (n=345)	% patients with ≥ 2 lines VA improvement	Mean Δ in BCVA, # of letters
0.5 mg Lucentis	37%	6.1
0.5 mg Lucentis+Laser	43%	5.9
Laser	16%	0.8

Source: Novartis Company data, Credit Suisse estimates

Ozurdex (corticosteroid implant) – Falling Short in Providing Durable Efficacy

Ozurdex, approved in treatment of macular edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO), is also being studied in DME. A six-month study in DME (see Exhibit 19) has shown modest efficacy, in terms of magnitude (14% of patients receiving the high dose reaching greater than 3 lines or more of improvement), and durability (studied only to 6 months), and did not achieve statistical significance (p=0.22 at 6 months in the high dose). Phase III DME trials are in progress, which will provide data to 3 years.

Exhibit 19: **Ozurdex Has Demonstrated Modest Efficacy in DME**

	Efficacy						Safety		
Trial Arm	% patients with ≥ 3 lines VA improvement			% patients with ≥ 2 lines VA improvement			IOP > 25 mmHg		Cataract
	2 months	3 months	6 months	2 months	3 months	6 months	3 months	6 months	6 months
Observation n = 57	0%	2%	7%	9%	12%	23%	0%	0%	No significant difference among trial arms
350 µg dexamethasone p - value n = 57, (1 injection at t=0)	7% 0.04	6% 0.30	10% 0.30	23% 0.04	21% > 0.31	18% > 0.31	13%	16%	
700 µg dexamethasone p - value n = 57, (1 injection at t=0)	10% 0.01	10% 0.05	14% 0.22	26% 0.10	33% 0.007	30% 0.40	8%	13%	

Source: Haller, Randomized Controlled Trial of an Intravitreous Dexamethasone Drug Delivery System in Patients with Diabetic Macular Edema, Archives of Ophthalmology 2010, Credit Suisse estimates.

The data that supported Ozurdex's approval in CRVO and BRVO are shown in Exhibit 20 and Exhibit 21, respectively. These data show the relatively modest efficacy magnitude, and the 6 month trial design does not measure longer-term durability. Each data set shows efficacy peaking at 2 months, then falling to 6 months and in some instances not demonstrating statistical significance.

The product's label is in-line with physician comments we have heard about Ozurdex's limited durability. The label implies 3-5 months of efficacy, stating that "the duration of effect persists approximately one to three months after onset of this effect," the effect being 3 line improvement in vision, which occurs within two months for approximately 20-30% of subjects per the label.

In the Ozurdex data in CRVO, it was observed that over the six months of the study, 0.7 mg Ozurdex was efficacious in treating the disease but the magnitude of efficacy was neither sustained nor statistically significant at 3-6 months (3-line impairment) nor at 6 months (mean change in letters), (Exhibit 20.)

Exhibit 20: Ozurdex Efficacy Declined After 2 months in CRVO

Trial Arm	Efficacy							
	% patients with ≥ 3 lines VA improvement				Mean Δ in BCVA, # of letters			
CRVO	1 month	2 months	3 months	6 months	1 month	2 months	3 months	6 months
0.7 mg dexamethasone p - value n = 136, (1 injection at t=0)	21.3% p <0.001	28.7% p <0.001	17.6% ns	18.4% ns	7.2 p <0.001	8.7 p <0.001	4.2 p=0.005	0.1 ns
Observation n=147	6.8%	8.8%	10.2%	12.2%	0.4	(0.5)	(0.4)	(1.8)

Source: Ozurdex Prescribing Information, Allergan Company Data.

In the BRVO data, 0.7 mg Ozurdex was efficacious in treating the disease but over time a drop in efficacy was observed. (See Exhibit 21.) At month 1, 21.3% of patients on Ozurdex attained 3 or more lines of visual acuity improvement peaking at 29.6% at month 2. However, at month 3, the percentage dropped to 23.7% and fell to 23.0% at month 6. Moreover, the result at month 6 was not statistically significant. The mean change in BCVA letters demonstrated a similar trend, falling after 2 months.

Exhibit 21: Ozurdex Efficacy Declined After 2 months in BRVO

Trial Arm	Efficacy							
	% patients with ≥ 3 lines VA improvement				Mean Δ in BCVA, # of letters			
BRVO	1 month	2 months	3 months	6 months	1 month	2 months	3 months	6 months
0.7 mg dexamethasone p - value n = 291, (1 injection at t=0)	21.3% p <0.001	29.6% p <0.001	23.7% p=0.006	23.0% ns	8.5 p <0.001	10.3 p <0.001	8.7 p <0.001	4.9 p=0.008
Observation n=279	7.9%	12.5%	14.7%	20.4%	3.8	5.1	5.0	7.4

Source: Ozurdex Prescribing Information, Allergan Company Data.

The primary adverse event associated with patients treated with 0.7 mg Ozurdex was increase in IOP. (See Exhibit 22.) At month 2, the incidence of patients with IOP greater than 25 mmHg peaked to 15.7% and declined to 1.2% by the end of 6 months. Although no significant cataract incidence was observed, cataracts often require more than 6 months to appear in patients.

Exhibit 22: **Safety of Ozurdex in BRVO+CRVO Combined**

	Safety						
Trial Arm	**% patients with IOP > 25 mmHg**						
CRVO and BRVO combined	**Base-line**	**1 day**	**7 days**	**30 days**	**2 months**	**3 months**	**6 months**
0.7 mg dexamethasone p - value n = 421, (1 injection at t=0)	0.2%	0.7%	3.6%	11.4%	15.7%	6.1%	1.2%
Observation n=423	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.3%

Source: Ozurdex Prescribing Information, Allergan Company Data.

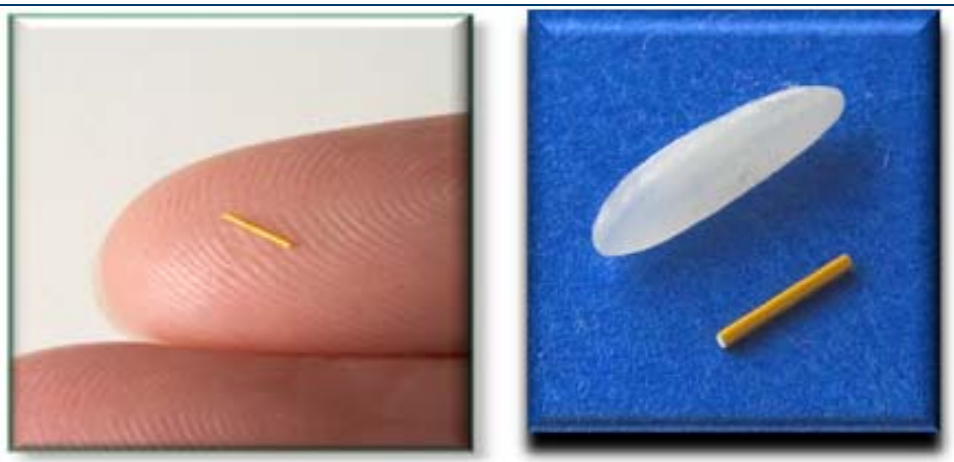
Iluvien Overview and Opportunity

Iluvien (Exhibit 23), Alimera's lead product candidate, is in phase III clinical trials for the treatment of DME. Alimera is preparing to file a NDA for Iluvien based on the 24-month data from the FAME study while Alimera continues to manage the study toward its 36-month completion in 4Q 2010 (with data expected to report in 1Q 2011).

An intravitreal (floating in the jelly-like substance called vitreous filling the back of the eye behind the lens) insert, Iluvien delivers 0.24-microgram (µg) per day levels of fluocinolone acetonide (FA) to provide a therapeutic effect for up to 36 months. Inserted in the posterior of the eye with the Iluvien inserter using a 25-gauge needle, Iluvien insertion is intended to be performed in a retinal specialist's office, as is currently done with injections of anti-VEGF therapies and steroids. The Iluvien inserter consists of a transparent window to visually confirm the presence of Iluvien and markings to guide retinal specialists to the proper insertion point, and the procedure creates a self-healing wound.

Iluvien is made of a tiny polyimide tube with membrane caps filled with 190 µg of FA in a polyvinyl alcohol matrix, and is licensed from pSivida (PSDV). While Iluvien is non-bioerodable, both polyimide and polyvinyl alcohol matrix are biocompatible with ocular tissues and have a safe usage history with the eye.

Exhibit 23: **The Iluvien Device**

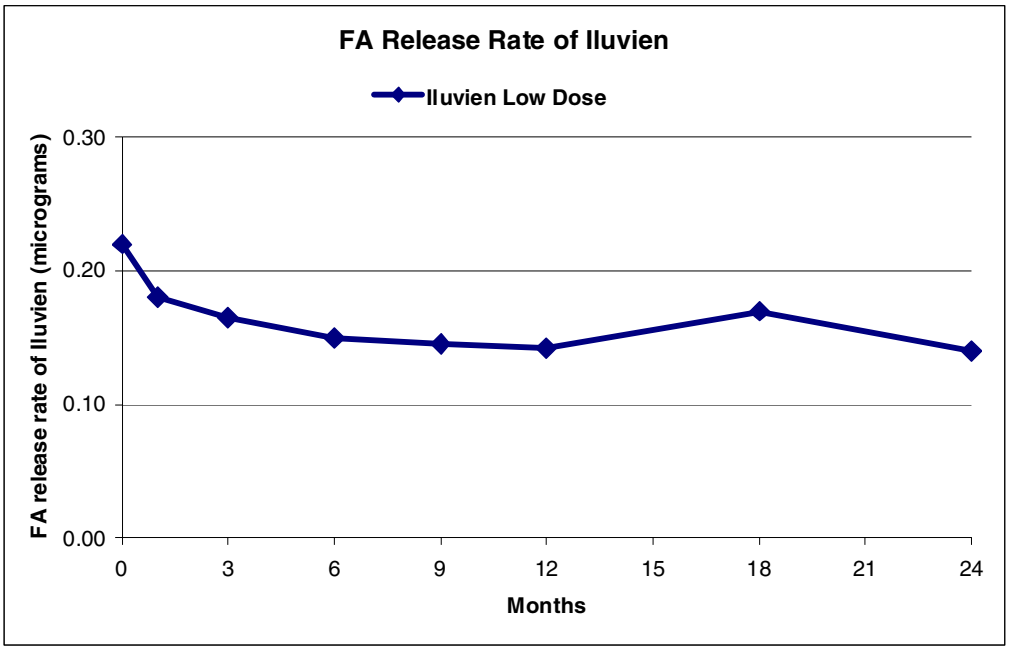


Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

Key Attributes of Iluvien:

- **Proven active ingredient, fluocinolone acetonide:** A corticosteroid by classification, FA is the active pharmaceutical compound of Iluvien and has demonstrated efficacy in the FAME study. FA is a nonproprietary corticosteroid that has previously been used in treating ocular disease as the active compound in Bausch and Lomb Inc.'s Retisert (a surgically implanted intravitreal drug delivery device approved for the treatment of chronic noninfectious posterior uveitis). While corticosteroids have known to be efficacious in treating DME, they are not without side effects, including glaucoma and cataract.
- **Sustained delivery of sub-microgram levels of steroid to the eye:** The low dosage levels of Iluvien in the clinical trials, 0.45 µg per day and 0.23 µg per day (high dose and low dose, respectively), provide lower exposure to corticosteroids than other intraocular dosage forms currently available, and are delivered in a sustained, steady manner as shown per in vitro data. (See Exhibit 24.) This has the potential of significantly mitigating the incidence of intraocular pressure elevations and cataract formation commonly associated with the intraocular use of corticosteroids.

Exhibit 24: Slow , Steady Fluocinolone Acetonide Release Rate of Iluvien



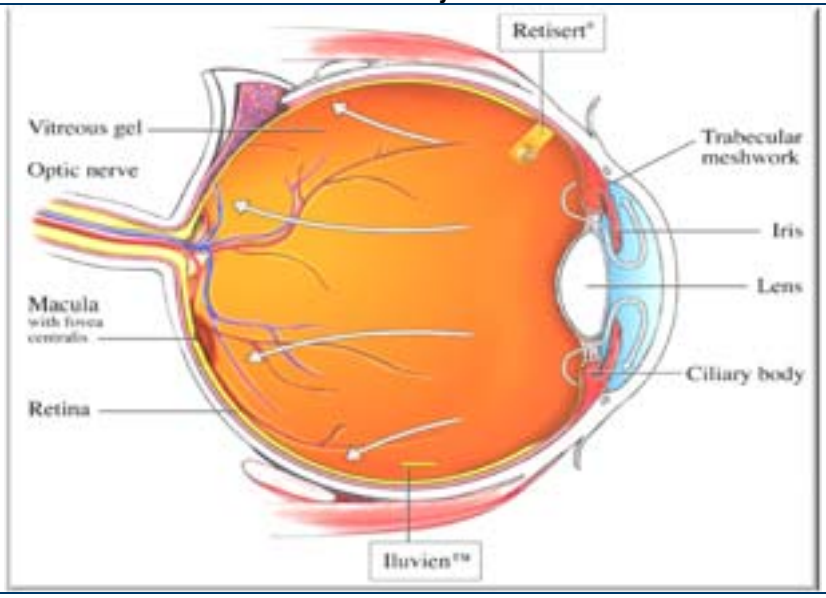
Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

- **Durability of efficacy for up to 24-36 months:** The 24-month readout from the FAME study demonstrates Iluvien's efficacy with 28.7% and 28.5% for the patients on low dose and high dose, respectively, reporting an improvement in best corrected visual acuity (BCVA) of at least 15 letters or 3 lines on the ETDRS eye chart. In a subset analysis of patients completing 30 month follow up visits, 39.8% of low-dose patients reported greater than or equal to 15 letter BCVA and a 10.2 mean change in letter score.

- **Strategic location with unique position at the back of eye:** Being stationed in the back of the eye (see Exhibit 25), Iluvien is able to use the natural currents in the eye to its advantage. There are two currents of fluid within the eye; one anterior directed toward the front of the eye and the other posterior directed toward the back of the eye, or retina. The company believes that Iluvien's position in the back of the eye optimizes delivery of fluocinolone acetonide, maximizing efficacy and minimizing possible side effects. The FAME 24 month data provide evidence of this and the 36-month results for the full population will provide a more definitive indication of Iluvien's durability of efficacy.

  The company believes that the posterior chamber location of Iluvien minimizes anterior chamber exposure to FA, mitigating the incidence of IOP elevations and cataract formation commonly associated with the intraocular use of corticosteroids. IOP is directly related to the interaction of corticosteroids with the cells of the trabecular meshwork, a specialized tissue that acts as a filter located in the front of the eye. In some individuals, corticosteroids are known to cause a buildup of debris in this area, increasing resistance to outflow and thus increasing pressure inside the eye. However, with the positioning of Iluvien enables it to leverage the posterior flow of fluid away from the trabecular meshwork, potentially reducing the chance of IOP.

Exhibit 25: Iluvien Inserted at the Back of the Eye



Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

- **Simple administration with 25-gauge needle in a physician's office:** Iluvien is inserted into the back of the eye in a retinal specialist's office using a 25-gauge needle (see Exhibit 26), creating a self-healing wound, with no additional procedure or intervention required after piercing.

Exhibit 26: Iluvien Injectable Pen with 25-Gauge Needle

Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

FAME Study Demonstrates Potential for Durable Efficacy

The FAME study involves 956 patients in sites across the United States, Canada, Europe and India in two Phase III, randomized, double-blinded, dose comparison (trials A and B)

to evaluate the efficacy and safety of Iluvien to treat DME. As part of the study, investigators were able to retreat each patient with Iluvien following their month-12 follow-up visit. Each trial had three arms—low dose of Iluvien (0.23 µg/day), high dose of Iluvien (0.45 µg/day), and control. The patients in the control arm received a sham injection. In December 2009, Alimera reported 24-month data from the study. While both the high dose and low dose were efficacious, the safety profile of the lower dose is more benign and the company plans to file the NDA with the lower dose of Iluvien.

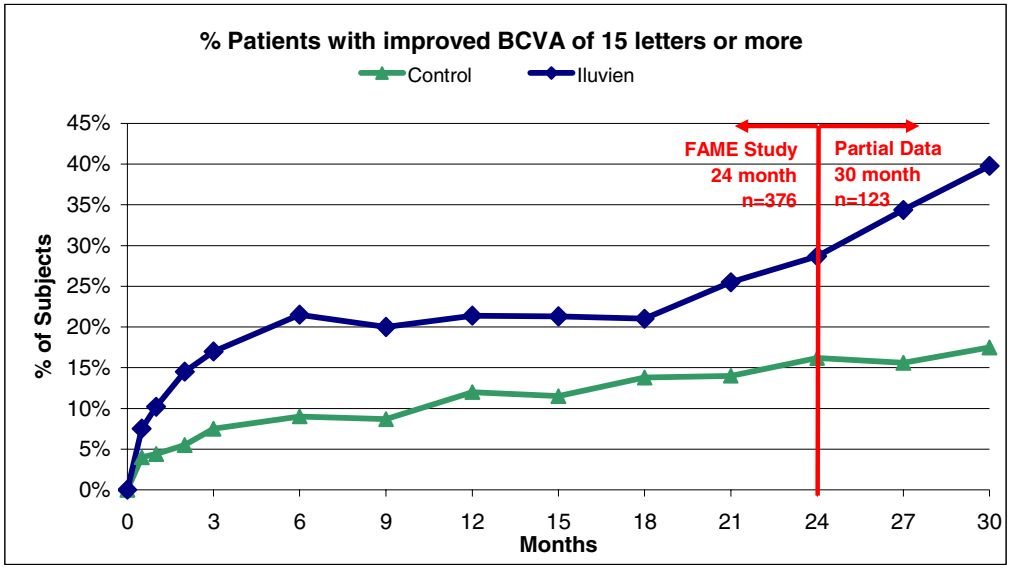
Primary Endpoint—Percentage of Patients Showing Improvement in BCVA of 15 Letters or More

The primary efficacy endpoint in FAME, per FDA requirement for drugs being developed for diabetic retinopathy, including DME, is the difference in the percentage of patients whose best corrected visual acuity (BCVA) improved from baseline by 15 or more letters on the Early Treatment Diabetic Retinopathy Study (ETDRS) eye chart between the treatment and control groups at month 24.

Both the high-dose arm and the low dose arms met the primary endpoint on a combined basis of trial A and B. Specifically, the 24 month clinical data, on a combined basis of trial A & trial B, showed that 28.7% patients of the 376 on the low dose of Iluvien witnessed improved BCVA of at least 15 letters as compared to only 16.2% in the control group (see Exhibit 27). A significant improvement was noticed in as early as third week of therapy with Iluvien. While the percentage of patients experiencing improved BCVA of 15 letters or more seems to remain constant at around the 20-22% range from month 6 to month 18, there is a steady rise from the eighteenth month onwards, rising to 28.7% patients by month 24.

About 33% of patients on the low-dose had completed 30 months in the study and demonstrated increasing efficacy. Notably, 34.4% and 39.8% of patients witnessed 15 letters or more of BCVA improvement at 27 months and 30 months, respectively. While this upward trend in efficacy is promising, we look to complete data at 36 months to confirm this observation.

Exhibit 27: % Patients Meeting Primary Endpoint of >= 15 Letters of Improved BCVA



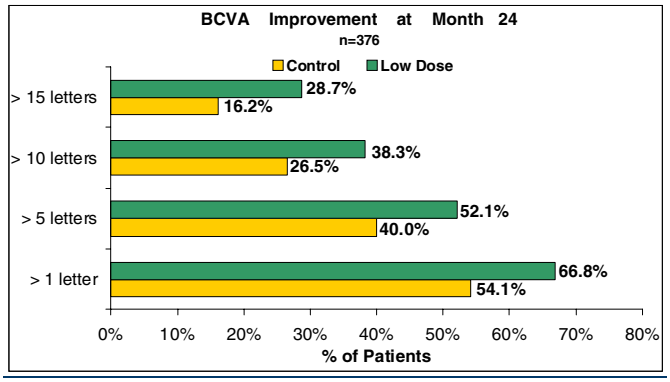
Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

BCVA Improvement at Month 24 Consistently Better in Low-Dose Patients than in Control

Further analyzing the clinical data results, BCVA improvement of various letter levels at month 24 (see Exhibit 28) was higher in patients receiving the low dose of Iluvien than

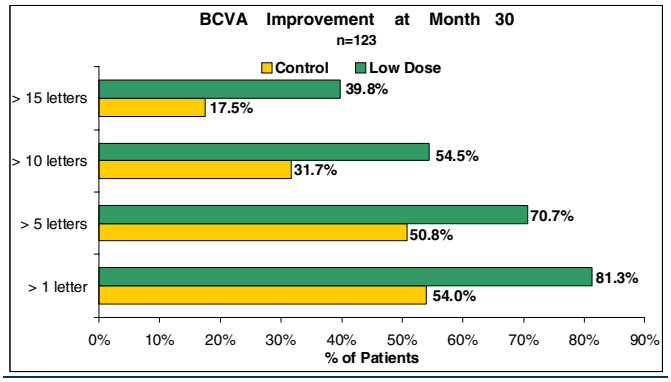
patients in the control arm. The control-adjusted gain ranged from 11.8% for 10 letters or more to 12.7% for more than 1 letter improvement. While the FDA designated trial endpoint is at least 15 letters, lesser degrees of improvement are still clinically relevant and considered by retinal specialists. At month 30, 39.8% patients of the 123 had more than 15 letters of BCVA improvement implying a 22.3% control-adjusted gain. (See Exhibit 29.)

Exhibit 28: BCVA Improvement at Month 24



Source: Company data, Credit Suisse estimates

Exhibit 29: BCVA Improvement at Month 30

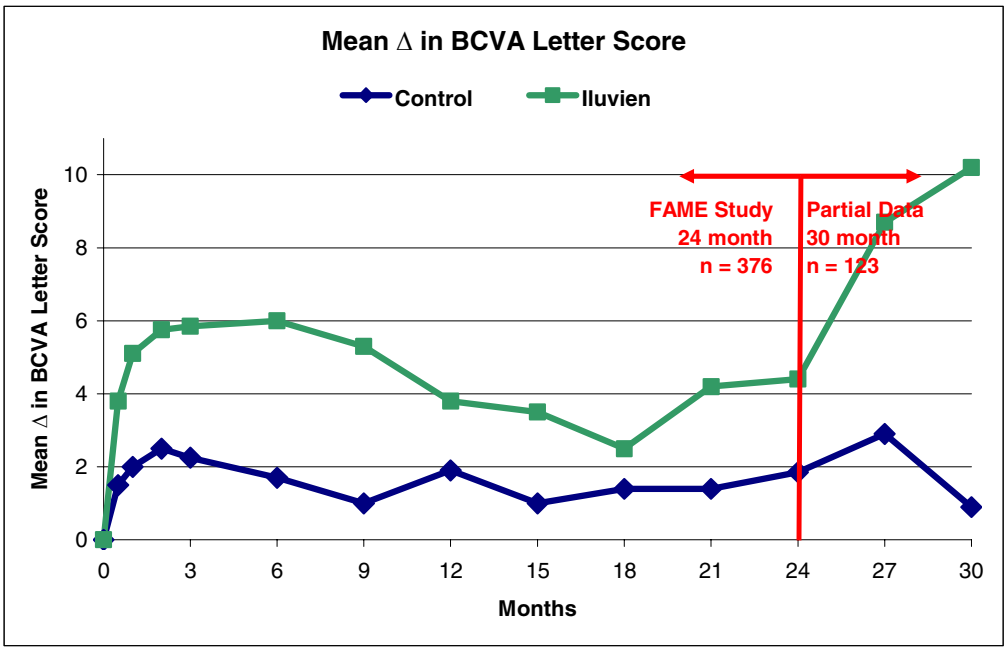


Source: Company data, Credit Suisse estimates

Mean Change in BCVA Letter Score

Another metric evaluated in DME patients is mean change in BCVA letter score. In the 24-month follow-up visit period, patients on the low dose of Iluvien showed rapid improvement leading to a peak 6.0 letters at month 6 compared with a peak of 2.6 letters at week 6. (See Exhibit 30.) A dip is observed in mean change from month 6 to month 18 in patients on the low dose of Iluvien. From the 18th month the improvement reaccelerates, eventually reaching a mean change of BCVA letter score of 4.4 at month 24 implying a 2.55 control-adjusted improvement. Interestingly, in the 125 and 123 patients who completed their 27- and 30-month visits, mean letter changes of 8.7 and 10.2 were recorded while the control dropped to 2.9 and 0.9 in month 27 and 30. Analysis of additional patients data will further bolster post-24 month data.

Exhibit 30: Greater Mean Change in BCVA Letter Score over time

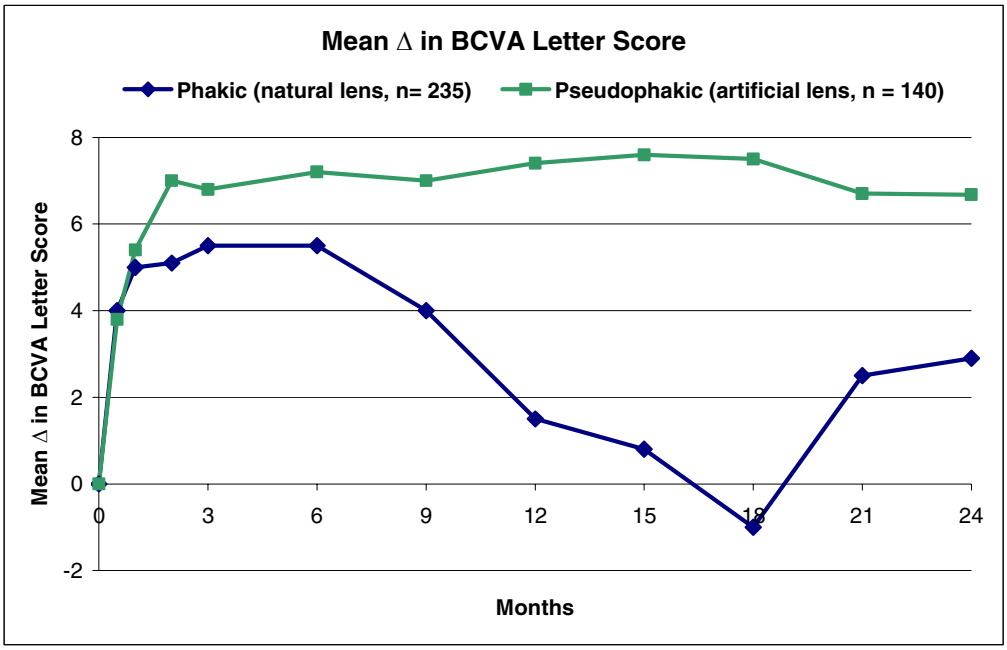


Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

Cataract Formation Could Explain the Low Efficacy through the Month 6 to Month 18 Period

Teasing out the data for phakic (natural lens and no prior cataract) and pseudophakic (have had cataract previously) lens at baseline, it is observed that the pseudophakic subset, who have had prior cataract surgery and would not have affected vision due to a cataract during the study, recorded a mean change in BCVA of more than 7 letters by month 6 and maintained the gain through month 24. (See Exhibit 31.) However, the phakic study eyes experienced a decrease in the mean change in BCVA from month 6 to month 18.

Exhibit 31: Difference in Mean Change in BCVA Letter Score due to Cataract



Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

The downward trend in BCVA letter score improvement from month 6 to month 18 (Exhibit 30), and the plateau in 3-line improvement (Exhibit 27) can possibly be attributed to cataracts. About 77.4% of the phakic eye population receiving the low dose of Iluvien had reported cataract formation through month 24, with median time to reporting cataract formation as an adverse event of approximately 12 months from randomization into the study. About 155 patients of the 182 low-dose Iluvien-treated phakic patients who developed cataract during the study underwent cataract surgery through month 24. The median time to cataract surgery was 18 months.

Laser Treatments Used More Often in Control than the Active Arms

As part of the protocol, patients in all three arms were allowed to receive laser. Specifically, 51.9% of patients in the control arm got 208 treatments, 34.9% of patients in the low-dose arm got 256 treatments, and 33.6% patients in the high-dose arm got 229 treatments. (See Exhibit 32.)

Exhibit 32: **Laser Treatment as Part of FAME Protocol**

Laser Treatments	Control	Low Dose	High Dose
n =	185	375	393
Number of Treatments	**208**	**256**	**229**
% of patients	**51.9%**	**34.9%**	**33.6%**
Received by Subject, %			
No treatment	**48.1%**	**65.1%**	**66.4%**
1 treatment	24.8%	18.2%	20.1%
2 treatments	14.1%	8.3%	7.4%
3 treatments	2.1%	4.2%	3.8%
4 treatments	4.9%	1.6%	0.7%
5 treatments	2.7%	1.9%	0.8%
6 treatments	2.7%	0.5%	0.5%
7 treatments	0.6%	0.3%	0.0%
8 treatments	0.0%	0.0%	0.2%

Source: Company data, Credit Suisse estimates.

Iluvien's Side-Effect Profile Appears Acceptable in the Context of its Efficacy

An analysis of Iluvien's safety profile at the 24 month clinical readout indicates **no apparent risk of systemic adverse events**. The safety profile of the low dose is superior to that of the high dose (see Exhibit 33), and Alimera plans to file an NDA with the lower dose.

Two of the more commonly occurring side effects in patients taking corticosteroids, **elevated intraocular pressure (IOP) and cataracts**, were seen with Iluvien in both the high and low dose arms of the FAME study. In the low dose group, 16.3% of patients experienced IOP greater than 30mmHg, and 3.7% required at least one IOP-lowering surgery. Although elevated IOP was the primary safety concern associated with corticosteroids cited in our conversations with physicians, most physicians found the 3.7% figure acceptable, particularly when balanced with Iluvien's efficacy profile. Some cited Iluvien's 2.1% incidence of trabulectomy (filtration) as the more important metric, and they were generally comfortable with this data point in the context of Iluvien's overall profile.

Cataract incidence is often high with corticosteroids, and Iluvien demonstrated a 74.9% rate of cataract surgery among phakic eyes (those with natural lenses). The consistent feedback from our physician conversations was that cataracts are not a significant issue for DME patients, as many of these patients would have eventually developed cataracts eventually in any event, and the tradeoff of improved vision (particularly of the magnitude and durability shown by Iluvien) for earlier and/or more certain cataracts is one that most physicians seemed willing to make.

Exhibit 33: **Low Dose Safety Profile Superior to High Dose in FAME Study**

Adverse Events	Control	Low Dose	High Dose
n =	185	375	393
IOP > 30 mmHg	2.7%	16.3%	21.6%
Trabeculoplasty	0.0%	1.3%	2.5%
IOP-Lowering Surgeries	0.5%	4.0%	8.1%
Trabeculectomy	0.0%	2.1%	5.1%
Vitrectomy	0.0%	0.3%	0.5%
Other Surgery Performed	0.5%	1.6%	2.5%
% of Patients requiring 1 or more IOP-lowering surgeries	0.5%	3.7%	7.4%
Cataract in Phakic Eye*			
Cataract Formation in Phakic Eye	46.3%	80.0%	87.5%
Cataract Surgery in Phakic Eye	23.1%	74.9%	84.5%
** 65.2% study eyes are phakic*			

Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

Statistical Analysis of FAME Study Creates Risk to Iluvien Approval, but We Expect Approval

Full Data Set Met Statistical Significance While MART Data Set Did Not

For the FAME study, Alimera used 2 noteworthy methods of data analysis, the **full data set** and the **modified all randomized and treated, or MART, data set**. The FAME study results met statistical significance per the analysis of the full data set, but narrowly missed significance in one of the two trials within FAME (Trial A) per the MART analysis. Although the FAME study protocol provides that the primary efficacy assessment is based on the MART data set, both analyses will be included in the NDA and we believe that the FDA will consider the totality of the data presented, including the full data set, and will approve Iluvien. However, there is risk that FDA relies primarily or solely on the MART analysis, and rejects Iluvien due to the missed statistical significance.

Exhibit 34: **Results Not Statistically Significant in Trial A of Modified ART Data Set**

	Full Data Set				Modified ART Data Set			
% improvement in BCVA of 15 letters or more	Control	Low		High	Control	Low		High
	%	%	p value	% p value	%	%	p value	% p value
Trial A	14.7% n=95	26.8% n=190	0.029	26.0% n=196	0.03	12.6%	22.6%	0.057	24.1%	0.026
Trial B	17.8% n=90	30.6% n=186	0.034	31.2% n=199	0.027	13.3%	29.7%	0.004	29.3%	0.005
Combined	16.2% n=185	28.7% n=376	0.002	28.6% n=395	0.002	n/a	n/a		n/a	

Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

The **full data set** includes all 956 patients enrolled and randomized into the FAME study, with data imputation using "last observation carried forward" (LOCF) for missing data because of patients who discontinued the trial or were unavailable for follow-up.

Both Trials A and B, in the full data set analysis, met the primary endpoint and were statistically significant at month 24, with 26.8% and 30.6% of patients who received low dose of Iluvien demonstrating an improvement of more than 15 letters in trial A and trial B respectively. (See Exhibit 34.)

The **MART data set** includes the 953 patients who were randomized and treated in the FAME study (the 956 in the full dataset, less 3 patients who were randomized but not treated). In the MART data set, in instances where a treatment prohibited by the FAME protocol was used (such as Lucentis, Avastin or triamcinolone), the last observation prior to the protocol violation was imputed forward to month 24 using the LOCF method. The extent to which off-protocol treatments were used is shown in Exhibit 35: 28.6% of patients in the control, 12.5% patients in the low dose arm, and 14.0% of patients in the high dose arm received off-protocol treatments. (See Exhibit 35.)

Exhibit 35: Off-Protocol Treatments in FAME

Off-Protocol Treatments	Control	Low Dose	High Dose
n =	185	375	393
Number of Treatments	**137**	**70**	**95**
% of patients	**28.6%**	**12.5%**	**14.0%**
Received by Subject, %			
No treatment	**71.3%**	**87.5%**	**86.0%**
1 treatment	9.7%	7.5%	9.7%
2 treatments	9.2%	4.0%	2.5%
3 treatments	4.4%	1.1%	0.5%
4 treatments	1.1%	0.0%	0.7%
5 treatments	1.1%	0.0%	0.3%
6 treatments	1.1%	0.0%	0.0%
7 treatments	1.1%	0.0%	0.0%
8 treatments	0.6%	0.0%	0.0%
> 8 treatments	0.5%	0.0%	0.5%

Source: Company data, Credit Suisse estimates.

Upon analysis of the MART data set, it was found that while patients in the Iluvien low dose arm showed vision improvement versus control, this improvement was statistically significant in Trial B, but not Trial A. (Exhibit 34) The study design required a p-value of 0.0491 or lower for each of the arms but the p-value of the low dose arm in Trial B was 0.057. As a result of the low dose not meeting statistical significance, the high dose arm was required to achieve a p-value of 0.02455 or lower to demonstrate statistical significance. However, the p-value of the high dose arm in Trial B was 0.026, again slightly higher than the p-value required for significance.

We Believe FDA Will Approve Iluvien Based on the Totality of the FAME Data

The fact that the primary analysis method (MART) missed statistical significance certainly adds risk to Iluvien's approval. We have accounted for that risk by using a 75% probability of success in our valuation, which is a somewhat higher discount than the 80-85% more commonly used for post-Phase III products.

We believe that despite the missed statistical significance of the MART data set, the FDA will consider the totality of the FAME data, including the full data set, and will approve Iluvien. Our view is based on the following:

(1) **Strong efficacy with statistical significance in the broadest patient group (the full data set).** There are no approved drugs in DME, and physicians treat patients with a range of therapies in clinical practice, including laser, anti-VEGF agents, and intravitreal steroids. Iluvien demonstrated statistically significant efficacy across this broad group of patients that represents the wide range of clinical practice.

(2) **Full data set is consistent with ICH E9 guidelines.** ICH (International Conference on Harmonization) is a joint initiative involving regulatory authorities and

pharmaceutical industry representatives from Europe, Japan and the US States who discuss scientific and technical aspects of product registration. FDA has adopted ICH's Topic E9, Statistical Principles for Clinical Trials. While ICH E9 does not seek to establish specific rules or doctrines, FDA has adopted it as a set of guidelines. Alimera's analysis of the full data set of the FAME study is consistent with the recommendations regarding the appropriate population for primary analysis as described in ICH E9, including ICH E9's suggestions that the primary analysis of a clinical trial should include all randomized subjects, and that in most respects it is appropriate to include the data from subjects with whom protocol violations have occurred.

(3) **Our diligence checks with experts.** We spoke with a former senior official in the FDA's ophthalmic division, as well as several key opinion leaders who are retinal specialists involved in clinical trials and in practice, and gained additional comfort on Iluvien's approval prospects. The former FDA official expressed the views that FDA is likely to view the full data set as the primary measure of Iluvien's efficacy and safety, as the full data set gives a more complete picture and using it would be consistent with typical FDA practice; and that FDA will likely give little consideration to the MART analysis. Furthermore, other key opinion leaders with whom we spoke expressed the view that use of the full data set has the stronger scientific rationale, and that the FDA's ophthalmic division is likely to weigh that factor more heavily than the fact that the MART set was specified in the FAME protocol as the primary analysis method.

(4) **The Ozurdex precedent.** Allergan's experience with the FDA review and approval of Ozurdex (for macular edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)) provides an interesting precedent. Ozurdex's primary endpoint was initially change in BCVA from baseline to day 180. The results of the first study to be locked (206207-009) did not meet this endpoint. However, 1.5 months after locking and unblinding the data in study '009 (and seeing the missed endpoint) in the '009 study, FDA allowed a change in the primary endpoint, to time to improvement of 15 letters or more in BCVA, in the second study (206207-008) a day before the database on the '008 study was locked. Ozurdex met the new primary endpoint and was approved by FDA, despite comments from the statistical review in the FDA's summary basis of approval that "there was no scientific rationale provided for this post hoc change, which could introduce serious issues with interpreting the results and potential biases."

We do not view the situation with Ilvien's full and MART data sets as being precisely comparable. Alimera is not proposing a change in the primary endpoint, nor a change in the measure of efficacy used. However, the Ozurdex approval is an interesting example of the FDA's Ophthalmic division's flexibility, and we think it's reasonable to expect FDA to consider the totality of the FAME data, including the full data set, in making its decision.

(5) **Alimera's uneventful pre-NDA meeting with FDA.** In March, Alimera had a planned meeting with FDA in advance of filing the Iluvien NDA. According to the company, the meeting was uneventful and proceeded smoothly. The discussion centered primarily on CMC (chemistry, manufacturing and control) details, and no questions or concerns were raised about the statistical analyses of the FAME study data.

Background on the MART Analysis and Possible Factors in the Results

Alimera proposed the use of the MART analysis to FDA before filing the NDA. The company hypothesized that off-protocol treatments might be used more frequently in the sham arm of the study, and tried to design an analysis that would mitigate this potential bias.

However, the efficacy data using the MART analysis missed statistical significance and was directionally lower in magnitude than the data using the full analysis. A possible contributing factor to this unexpected difference is cataracts. As suggested by Exhibit 31,

Iluvien's efficacy begins to decline in phakic patients after month 6, before later increasing, which could be explained by cataracts. It is possible that in the Iluvien arms of FAME, after month 6 when some patients experienced lower or flattening growth in efficacy, some patients dropped out or began use of other treatments. In either case, these patients' data from that point in time would have been carried forward, thus excluding any potential vision gains that may have occurred later, after cataract surgery, thereby lowering average vision improvement versus the full data set analysis.

Unmet Need and Historical Precedents Bode Well for Priority Review

Alimera plans to request priority review for its Iluvien NDA. Therefore a filing on or about June 28 could result in an approval by the end of 2010, should the standard 6 month priority review timeline hold. We believe that Iluvien will likely qualify for priority review for two reasons:

(1) Iluvien's strong efficacy in an area of high unmet need: there are no approved drugs for DME, and Iluvien has demonstrated significant vision improvement in the FAME study.

(2) Historical precedent: 5 products which were approved by FDA for retinal diseases all received priority review, with 4 of 5 approved within about 6 months, and the 5th (Visudyne) approved in 8 months (Exhibit 36).

Exhibit 36: Historical Precedents Bode Well for Iluvien Priority Review

Product	Indication	Filing Date	Time to Approval (months)	Approval Date	Company
Visudyne	Wet AMD	August 14, 1999	8.07	April 12, 2000	QLT
Retisert	Posterior uveitis	October 7, 2004	6.10	April 8, 2005	Bausch and Lomb
Macugen	Wet AMD	June 17, 2004	6.10	December 17, 2004	Eyetech
Lucentis	Wet AMD	December 30, 2005	6.07	June 30, 2006	Genentech
Ozurdex	BRVO, CRVO	December 23, 2008	5.87	June 17, 2009	Allergan

Source: Company data, Credit Suisse estimates

Competitive Landscape Presents Opportunity for Differentiation

Below in Exhibit 37, we show a comparison of Iluvien with other treatments that are currently used for DME, both on- and off-label. We compare the treatments along a number of criteria, broadly grouped into three categories: clinical, practical and economic, with shaded circles indicating more favorable attributes, in our view, than unshaded circles.

Exhibit 37: **Iluvien Has a Differentiated Profile versus Competing DME Treatments**

	CLINICAL			PRACTICAL	ECONOMIC	
	Immediate Vision Improvement	Durability of Vision Improvement	Side Effect Profile	Convenience & Compliance	Profitability to Physician	Cost to Payors
Iluvien						
Laser						
IVTA						
Lucentis						
Avastin						
Ozurdex						

Source: Company data, Credit Suisse estimates.

Iluvien Could Offer a Differentiated Clinical Profile with Superior Durability of Efficacy

The first 2 columns show the efficacy differentiation among the products. Other than laser, all provide very good immediacy of vision improvement, but Iluvien stands out in terms of its durability of action. One insert has the potential to provide 2-3 years of stable or increasing vision improvement, and has shown evidence of vision improvement for up to 30 months in a subset of patients in the FAME study.

The long intervals between treatments could also make Iluvien very convenient for patients compared to other treatments, as shown in the 4th column. Iluvien's 24-36 months between dosing gives patients greater convenience, and therefore the potential for better compliance, especially compared with Lucentis and Avastin, for which patients need to visit their physicians for approximately monthly injections. This difference is especially important given the relatively younger, working population of DME. We believe that Ozurdex will likely be seen as an inferior product, because like Iluvien its primary selling point is duration of action, yet it only works for about 3-5 months in BRVO and CRVO. As discussed previously, Ozurdex has shown modest (and statistically insignificant) efficacy at 6 months in DME.

In Exhibit 38, we have summarized some of the major efficacy and safety parameters across several clinical trials involving DME therapies. As usual, cross-comparison of trials is fraught with inaccuracies for many reasons including differing trial designs and patient inclusion criteria, however such comparison can be directionally interesting.

Exhibit 38: Comparison of Key Data: Iluvien, Lucentis, IVTA, and Laser

		Efficacy		Safety		
Trial Arm	Study	% patients with ≥ 3 lines VA improvement		IOP > 30 mmHg	% Requiring Trabulectomy	Cataract Surgery (% of Phakic Eyes)
		24 months	30 months	24 months	24 months	24 months
Iluvien	FAME	28.7%	39.8%	16.3%	2.1%	74.9%
Lucentis + Prompt Laser n =187	DRCR September 2008	26%		2%	1%	12%
Lucentis + Deferred Laser n = 188		29%		3%	0%	13%
Triamcinolone + Prompt Laser n = 186		19%		27%	1%	55%
Sham + Prompt Laser n = 293		17%		3%	<1%	12%
Laser n = 188	DRCR April 2010	18%		1%	0%	13%
IVTA 1 mg n = 188		14%		9%	0%	23%
IVTA 4 mg n = 293		17%		21%	1%	51%

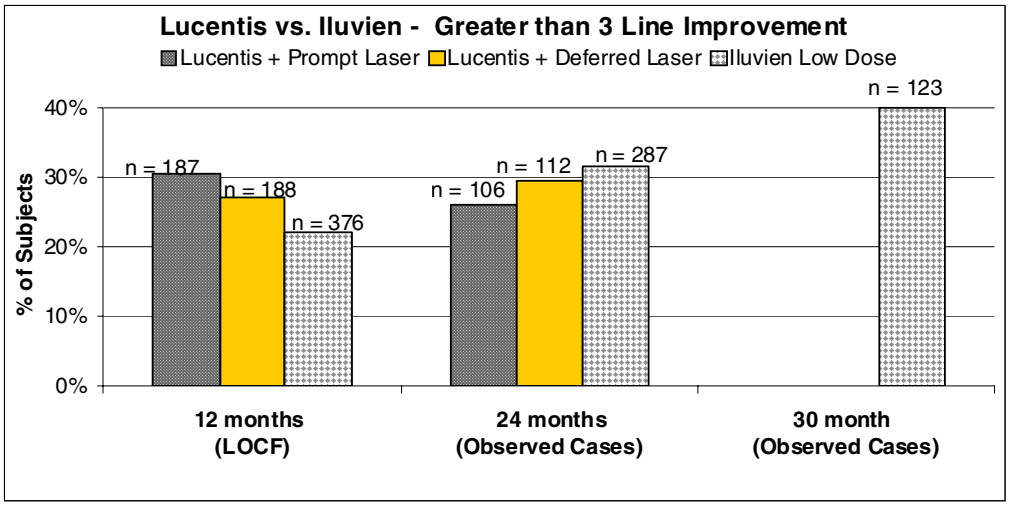
Source: Company data, Credit Suisse estimates.

Iluvien and Lucentis have been shown to be substantially more effective in providing 3-line visions gains than laser or IVTA. Both have shown 2-year benefit to 26-29% of patients. However, in the DRCR trial, two trial design attributes may have benefited Lucentis relative to Iluvien:

(1) Lucentis was studied only in combination with laser, while Iluvien was studied as monotherapy in FAME, with the option for augmentation with laser, which was used by 35% of patients in the low-dose Iluvien arm.

(2) DRCR study measured only observed patients, that is, patients who reported for data observations at month 24, whereas the 24-month data for FAME used the common last observation carried forward (LOCF) technique to impute data at month 24 for patients not observed at that time. LOCF is generally more conservative. The method used by DRCR is more analogous to that used for Iluvien's 30 month data for a subset of FAME patients, in which Iluvien showed greater efficacy than either Lucentis arm in DRCR. Furthermore, in an analysis of observed patients at 24 months released by Alimera on May 27, 31% of low-dose Iluvien patients showed 3-line improvement, based on observed cases, versus 26-29% with Lucentis + Laser in the DRCR study (Exhibit 39).

Exhibit 39: Iluvien Showed a Greater % of 3 Line Improvement than Lucentis+laser, in Observed Cases



Source: Company data, Iluvien data from FAME study, Lucentis + Laser data from DRCR study, Credit Suisse estimates

Lucentis and laser have shown the cleanest safety profile with low IOP elevation, trabulectomy, and cataract surgeries. The most common adverse event associated with Iluvien is the high incidence of cataract surgeries (74.9% of phakic eyes in FAME); however, we believe from our conversations with specialists that cataracts are largely regarded as an acceptable side effect in exchange for improved vision in DME patients.

Iluvien's IOP elevation is substantially lower than that of IVTA, which is not surprising given the low, stable dose of steroid delivered with Iluvien.

An important question raised by the data is whether specialists will accept Iluvien's higher incidence of IOP elevation and trabulectomy (filtration surgery to relieve elevated IOP), relative to Lucentis, to achieve more durable, and potentially higher, efficacy. Our impressions from conversations with specialists are that many will make this trade-off, and many see Iluvien's 2.1% incidence of trabulectomy as an acceptable level.

Iluvien Not Likely a Leader on Economics, but Probably Adequate to Obtain Usage in Light of Clinical Profile

The two "economic" columns on the far right of Exhibit 37 compare the treatments in terms of profitability to physicians and cost to the healthcare system. A more detailed analysis is shown in Exhibit 40. Laser is the clear leader in providing the best economic incentives to physicians, while IVTA provides the lowest cost to the system, though with its relative safety and efficacy weaknesses compared to some of the other treatments.

Iluvien could compare favorably on cost to the system, but faces a challenge in competing with the more attractive physician economics of other therapies. This will be an important marketing challenge for Alimera to overcome, but it could be mitigated to some degree by the relative openness of retinal specialists to promising new technologies and Iluvien's strong clinical data. In addition, there are opportunities for combination treatment, and not all DME patients are well suited for laser (e.g., diffuse edema).

Exhibit 40: Comparative Analysis of DME Treatments: Physician Revenues and Cost to Healthcare System, Annually

	Iluvien	Laser	IVTA	Lucentis	Avastin	Ozurdex
For Physicians						
Drug cost/treatment	$7,500		$20	$2,000	$50	$1,300
Treatments/year	0.33		8	12	12	3
Annual drug cost	$2,475		$160	$24,000	$600	$3,900
Markup %	6%		6%	6%	6%	6%
Markup revenue	$149		$10	$1,440	$36	$234
Procedure fees	$180	$2,000	$180	$180	$180	$180
Treatments/yr (incl follow up visits)	3	3	8	12	12	3
Procedure revenue	$540	$6,000	$1,440	$2,160	$2,160	$540
Total annual physician revenue	**$689**	**$6,000**	**$1,450**	**$3,600**	**$2,196**	**$774**
Cost to System						
Drug cost	$7,500		$20	$2,000	$50	$1,300
Treatments/yr	0.33		8	12	12	3
Drug cost	$2,475		$160	$24,000	$600	$3,900
Procedure fees	$180	$2,000	$180	$180	$180	$180
Treatments/yr	3	3	8	12	12	3
Procedure revenue	$540	$6,000	$1,440	$2,160	$2,160	$540
Total annual cost to system	**$3,015**	**$6,000**	**$1,600**	**$26,160**	**$2,760**	**$4,440**

Source: Company data, Credit Suisse estimates

Physicians collect revenues on these treatments from markups on the drug, and from per procedure fees.

Markups on drug: We understand from our conversations with specialists that they generally collect a 6% markup on the cost of Lucentis, and we have assumed a similar level for the other drugs for purposes of this analysis. Lucentis is little used in DME currently, but if it receives FDA approval and subsequently reimbursement in this indication, then these forces will join with the better physician economics and may drive more usage from Avastin to Lucentis.

Procedure fees: the frequent injections of Lucentis and Avastin, though very inconvenient for many patients and burdensome for some specialist practices, can provide attractive economics for some practices. Conversely, Iluvien's competitive advantage of durability comes with a concurrent weakness in this area (with respect to practice revenues), although it is offset to some extent by ongoing follow up visits, which would likely be more frequent upfront and reduce in frequency over time, and which we have estimated at an average of 3 per year.

Costs to the healthcare system are composed of the drug costs, as well as the aforementioned procedure fees on these treatments.

Lucentis is by a wide margin the most costly treatment in this group, and its lack of approval in DME and therefore lack of reimbursement has made this cost a very high barrier to adoption in DME thus far. FDA approval could change this to some degree.

Iluvien is in the middle of the pack in this regard, with its durable efficacy providing a longer period over which to amortize the relatively high upfront cost of the product. These dynamics could minimize Iluvien's cost disadvantage to Avastin.

Evolution of DME Treatment Paradigm

Based on our conversations with specialists, we expect that laser will continue to the first line therapy for many patients, especially those with focal DME. It will likely be given

increasingly with combinations of IVTA and anti-VEGF therapies. The economic incentives for physicians to use laser are significant, and we expect that they will continue to have an impact.

We expect that anti-VEGF use will grow in the near term, and will be helped by approval of Lucentis, and by increased use in combination with laser. However, growth may be slowed somewhat by patient dissatisfaction with ongoing frequent injections

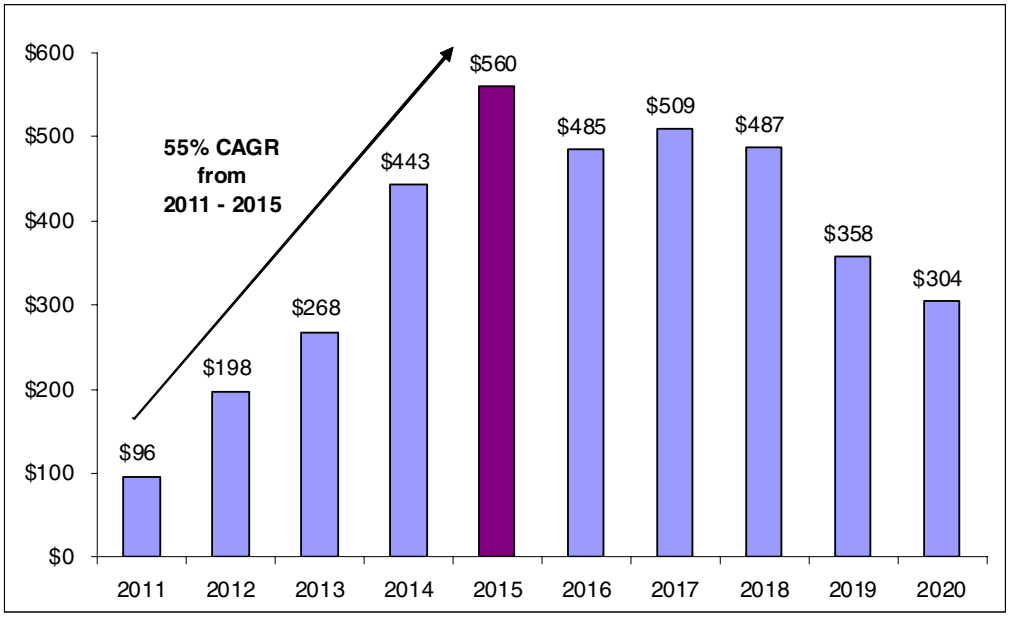
Iluvien could enter the market with a differentiated profile of strong efficacy, durability, and lack of frequent injections. Iluvien use will likely be primarily a mix of second line to laser, anti-VEGF, and combinations of these. It may get some first-line use for patients for whom frequent injections are particularly unsuitable. We expect that its market share growth will come mainly at the expense of IVTA, and will also contribute to decelerating market share growth of anti-VEGF. With the advent of implanted steroid treatments like Iluvien and Ozurdex, the role of IVTA will be reduced.

Revenue Model—Like a Vaccine with Boosters

Uptake Profile Driven by Initial Share Gains and Subsequent Retreatments

Based on our estimates of the market opportunity and Iluvien's potential market share (15% at peak), we forecast peak global sales of approximately $560 million in 2015 (Exhibit 41).

Exhibit 41: Credit Suisse Forecast for Global Iluvien Sales—$560 Million Peak in 2015
in millions, unless otherwise stated

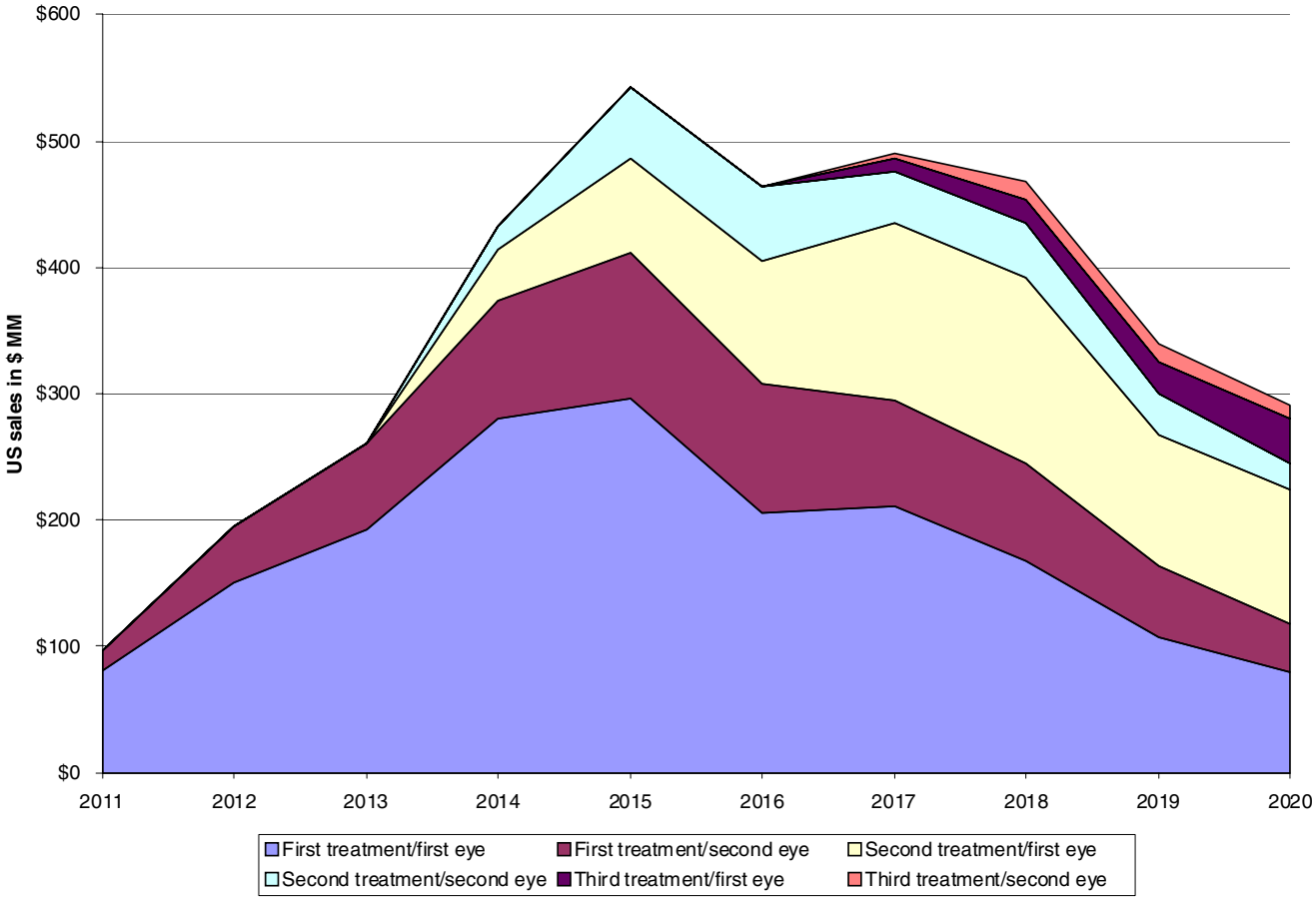


Source: Company data, Credit Suisse estimates.

In our model, Iluvien's revenue profile is similar to that of a vaccine with boosters (Exhibit 42). Since the product has the potential for a durable efficacy profile of 2-3 years, its revenue uptake does not behave like a chronic medication such as statins. On the other hand, Iluvien is not necessarily a one-time only proposition like some vaccines, since the efficacy is not indefinite and retreatments are possible.

Thus, revenue uptake has attributes of a vaccine—with a large unaddressed pool of "catch-up" patients available at launch for initial treatments. The uptake in initial treatments is projected to be relatively rapid in the first several years, as penetration and the diabetic population grow; however, this uptake plateaus and declines as share flattens and later declines. Additional layers in the revenue model are derived from bilateral treatments (second eyes) and from retreatments—akin to "boosters."

Exhibit 42: Revenue Build for Iluvien – Like a Vaccine with Boosters
in millions, unless otherwise stated



Source: Company data, Credit Suisse estimates.

Our Revenue Model Is Patient-Based with Global Peak Sales Forecast of $560 Million in 2015

A summary of our US revenue projections for Iluvien is shown in Exhibit 43. **We estimate peak U.S. revenues of $542 million, in 2015.**

Our model for US revenues is patient-based. In our estimates, we have sized the potential patient pool, estimated Iluvien's market share, made assumptions about retreatment rates, and estimated pricing. Our assumptions are as follows:

- **Treatable population of about 500,000 patients:** We assume the treatable population is equivalent to 3 years of incidence (consistent estimates of DME prevalence are not readily available); that annual incidence is 1.3% of diagnosed diabetics (clinically significant macular edema incidence per the Wisconsin Epidemiological Study of Diabetic Retinopathy XV); and that 30% of patients are effectively treated by first-line laser therapy, thus driving an estimated treatable population of about 500,000 in 2009.
- **Iluvien market share peaking at 15% in 2015:** This is based on the our views on the competitive landscape and potential future treatment paradigm, augmented with our discussions with retinal specialists.
- **Retreatment rates:** We assume that 40% of initially treated patients will receive treatments for bilateral disease (second eyes). For retreatments, we assume 3-year

efficacy, and that 50% of initially treated eyes will receive a second treatment, and 25% will receive a third treatment.

- **Pricing:** We assume a price of $7,500 (gross), and $6,750 (net of discounts and rebates). This price should allow Iluvien to compete on the basis of total cost to the system, as shown above in Exhibit 40.
- **Revenues included only for Iluvien in DME:** Alimera is pursuing other indications for Iluvien and other compounds, however, we have not included revenues for these development projects in our model at this time owing to a lack of clinical data. These projects include:
  - Iluvien in other indications: dry AMD, wet AMD, and RVO (all in Phase II); and
  - NADPH oxidase inhibitors (in preclinical development).
- **International revenues:** We expect that Alimera will seek a partner for ex-US marketing of Iluvien. In our model we assume that Alimera will receive international revenues amounting to a 20% royalty on sales, with ex-US sales estimated at 20% of U.S. sales.

Exhibit 43: Summary of CS Revenue Projections for Iluvien in U.S.—$542 MM Peak in 2015
in thousands, unless otherwise stated

	FY 2007	FY 2008	FY 2009	FY 2010E	FY 2011E	FY 2012E	FY 2013E	FY 2014E	FY 2015E
Treatable Population									
Diagnosed diabetic population	17,900,000	18,347,500	18,806,188	19,276,342	19,758,251	20,252,207	20,758,512	21,277,475	21,809,412
Growth rate									
Annual incidence of DME (CSME)	232,700	238,518	244,480	250,592	256,857	263,279	269,861	276,607	283,522
% of diagnosed diabetics	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*
Effectively treated by laser	(69,810)	(71,555)	(73,344)	(75,178)	(77,057)	(78,984)	(80,958)	(82,982)	(85,057)
percentage	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*
New patients available	162,890	166,962	171,136	175,415	179,800	184,295	188,902	193,625	198,466
Treatable population, year end			**500,989**	**513,513**	**526,351**	**539,510**	**552,998**	**566,823**	**580,993**
(assumed = trailing 3 yrs incidence)									
Iluvien									
Market share					2.0%	5.0%	8.0%	12.0%	15.0%
Total patients					10,527	26,975	44,240	68,019	87,149
Total units sold					14,276	28,977	38,574	64,048	80,327
Price per unit (net)					$6,750	$6,750	$6,750	$6,750	$6,750
Net US sales					**$96,366**	**$195,596**	**$260,374**	**$432,321**	**$542,210**
Assumed retreatment rates									
Bilateral disease (second eye)					40%	40%	40%	40%	40%
Second treatment					50%	50%	50%	50%	50%
Third treatment					25%	25%	25%	25%	25%

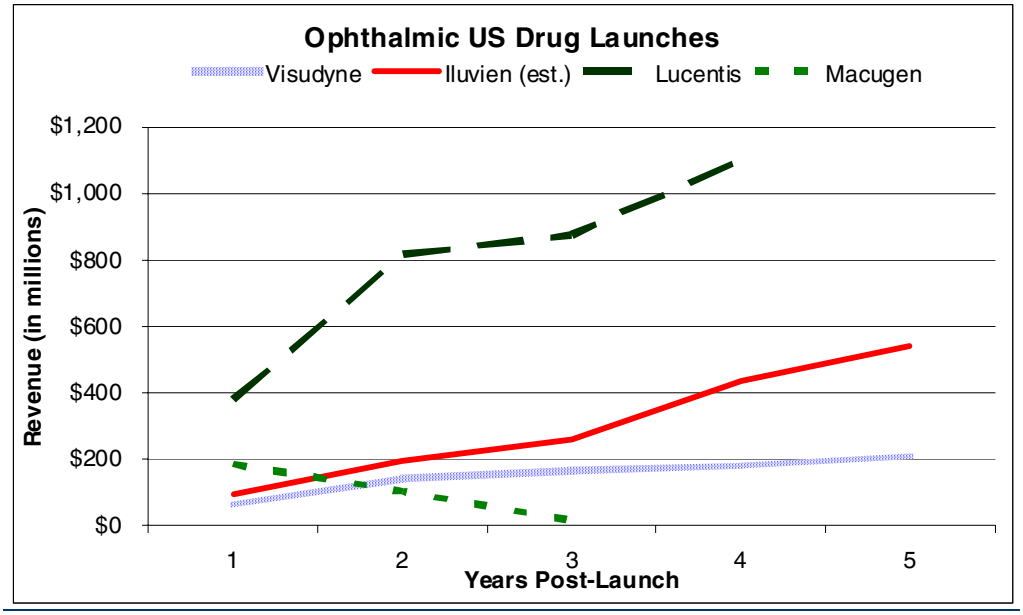
Source: Company data, Credit Suisse estimates. Diagnosed diabetic population in 2007 per CDC. Annual growth rate of diabetic population per study in Diabetes Care, Dec. 2009. Annual incidence of CSME per Wisconsin Epidemiological Study of Diabetic Retinopathy XV.

Our Projected Iluvien Uptake Is in the Middle of the Pack of Prior Comparable Launches

We project Iluvien U.S. revenues of $542 million in 2015, which is year 5 after an assumed 2011 launch. Comparing this forecast to historical performance of launches of other drugs in the retinal disease space (AMD, since there are no approved DME drugs), we see that our ramp over these 5 years is above the sales ramps of Visudyne and Macugen, but below that of Lucentis. A units-based comparison would be ideal, but reliable volume data are not available for these drugs, so we have used reported sales data to provide some historical context for our Iluvien revenue ramp.

As with any comparison of this sort, product-specific factors color the comparisons. Macugen is an unusual case in that it was nearly immediately beaten decisively by Lucentis. Lucentis' steep uptake was in large part driven by its high price.

Exhibit 44: Ophthalmic US Drug Launches, First 5 Calendar Years Post-Launch



Source: Company data, Credit Suisse estimates.

Attractive Commercial Model for Iluvien That Is Leverageable and Can Achieve High Margins and Rapid Profitability

Alimera plans to focus its sales and marketing efforts on retinal specialists, a relatively small, concentrated audience of approximately 1,600 physicians in 900 centers in the U.S. The company should be able to cover this audience with a small salesforce of 30 representatives.

Coupled with rapid revenue uptake, this modest, fixed infrastructure creates a high degree of operating leverage for Alimera. Along with low COGS and R&D expense burdens, this drives high operating margins of up to 60%, after a 20% profit split payment to Alimera's partner pSivida, and should enable the company to turn profitable in 3Q11 and to begin consistently producing positive operating cash flow in 4Q11 (assuming Iluvien launch in January 2011).

pSivida Partnership

Alimera licenses Iluvien from pSivida (see Exhibit 45), an Australian company and leader in developing miniature ophthalmic injectable drug delivery systems.

With two FDA approved products on the market, Iluvien could be pSivida's third marketed product, with Alimera expected to file with the FDA for Iluvien approval on or about June 28. Upon approval, pSivida will receive a $25 million milestone payment from Alimera. pSivida is responsible for 20% of the commercialization costs of the product and will receive a 20% share of the profits. After its IPO, Alimera repaid the outstanding $15 million promissory note in full to pSivida, along with $225,000 in accrued interest on April 28, 2010. (See Exhibit 45.) This promissory note was part of an amended agreement between the two companies signed in March 2008.

Exhibit 45: Terms of Alimera–pSivida Partnership
$ in 000s

Product	
	Iluvien
Device	Non-erodable tiny polyimide tube with membrane caps
Drug	Fluocinolone acetonide (FA) in a polyvinyl alcohol matrix
Placement	Intravitreal implant injected into the back of the eye
Durability	Up to 24-36 months
Administration	A 25-guage needle that creates a self-sealing wound

Development Terms		
Device	**Iluvien**	**Proprietary drug delivery device**
Drug	Flucinolone acetonide	Other corticosteroids
Geographic	Worldwide Exclusive license	Worldwide Non-exclusive license
Indications	Treatment and Prevention of eye diseases except Uveitis	

Intellectual Property	
Issued Patents	3 US and 1 EU patents related to Iluvien
Expiration	Between March 2019 and March 2010
Alimera has licensed these patents from pSivida	

Financial Terms					
Commercialization	**ALIM**	**pSivida**	**Reason**	**Year**	**Amount**
Profit Sharing	80%	20%	Initial License Fees	2004	$750
Cost Sharing	80%	20%	Initiation of P III trials	2005	$750
			Amended Agreement Execution	2008	$12,000
			Promissory Note Payment	2010	$15,000
			Accrued Interest	2010	$225
			Payments received to date	**TD**	**$28,725**
			FDA approval	***2010E***	***$25,000***

Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

Intellectual Property

Alimera has licensed several patents from pSivida related to Iluvien. The key patents, which are summarized in Exhibit 46, expire in 2019-2020. After the expiration of the '895 and '078 patents in 2019, but before the expiration of the '972 in 2020, a competitor could potentially have the ability to sell a different device to provide a similar type of delivery. However, the specific device used for Iluvien is projected until 2020.

We consider the patent expirations to be of secondary importance to the potential for competing products and technologies, and consider the threat of a generic in the classic pharmaceutical sense to be modest. As a result, we model market share erosion beginning in 2018, independent of the patent dates, driven by the assumption of competition from new entrants. We forecast somewhat greater erosion after 2020, to allow for greater probability of new entrants, as well as the expiring patents.

We believe that the likelihood of a traditional generic pharmaceutical is unlikely because since bioequivalence to Iluvien in the eye is not readily demonstrable, the maker of a generic Iluvien would need to perform clinical trials likely costing in the tens of millions of dollars, which we see as a relatively unlikely occurrence.

Exhibit 46: Summary of Key Iluvien Intellectual Property

Patent No.	Expiration Date	Patent Type	Patent Coverage	Limits of Alimera License from Psivida
US				
1) # 6375972	April 1, 2020	Utility	Covers the Iluvien sustained release device, has claims to device methods and device use with any drug	Exclusive rights to use Iluvien (Psivida's device with fluocinolone acetonide), and nonexclusive rights to use Psivida's device to deliver other corticosteroids; all for delivery to the back of the eye, for treatment and prevention of eye diseases in humans, excluding uveitis
2) # 6217895	March 1, 2019	Utility	Covers the methods of delivering a corticosteroid with an implantable sustained delivery device to deliver the corticosteroid in the vitreous substance in the posterior of the eye, where the result is that concentration in the vitreous is greater than in the aqueous during release	
3) # 6548078	March 1, 2019	Utility		
Europe				
1) # 1276462	April 1, 2020	Utility	Covers the Iluvien sustained release device, has claims to device methods and device use with any drug	Same as above

Source: Company data, Credit Suisse estimates.

Value Chain

Several parties have been involved in the effort to bring Iluvien to market.

Discovery at pSivida: pSivida innovated Iluvien, and licensed rights to Alimera.

Clinical development at Alimera: Alimera licensed Iluvien from pSivida to clinically develop the drug and is currently evaluating Iluvien in phase III trials with an imminent filing around June 28, 2010.

Manufacturing at Alliance Medical Products: Manufacturing and packaging of Iluvien has been outsourced to Alliance Medical Products, based in Irvine, California. Alimera loaned Alliance the necessary equipment to manufacture and package Iluvien. According to the terms of the agreement, the Iluvien inserter and the active pharmaceutical ingredient FA are supplied by Alimera and at least 80% of the total requirements for new units of Iluvien in the U.S., Canada and Europe in a calendar year must be ordered from Alliance. The agreed-upon per unit price for each unit of Iluvien may be altered one time during each subsequent calendar year but must be in-line with the proportionate increases in the Producer Price Index for Pharmaceutical Preparations by Rx and OTC product. The agreement was signed in February 2010 for a period of six years with automatic renewal for successive one-year periods unless either party delivers written notice of nonrenewal to the other at least 12 months prior to the end of the current term.

Commercialization by Alimera (U.S.) and a potential partner (ex-U.S.): Alimera plans to commercialize Iluvien in the U.S. on its own. For commercialization outside the U.S., Alimera will likely seek a partner with international commercialization capabilities and collect a royalty on sales from this partner.

Valuation and Cash Flow

Target Price of $16 Based on DCF Analysis

Our target price of $16 per share is based on a discounted cash flow analysis (DCF), summarized in Exhibit 47. In our view, the vast majority of the stock's value is attributable to a single product, Iluvien, with a finite commercial life. Therefore, we believe that valuing the company's cash flows over a fixed period of time, with no terminal value, is most appropriate as it best mirrors the cash flows with sufficient visibility. Due to the same rationale, we have not relied upon multiples-based valuation techniques, as they inherently assume the existence of a terminal value.

Our assumptions for our DCF are as folllows:

- **Time horizon:** we have modeled cash flows through 2030. This horizon includes the period through the company's main patent expiries (2019-2020), followed by an assumed fading of annual cash flows to zero by 2030.
- **Probability adjustment:** we have assumed a 75% probability of success for Iluvien, and our annual cash flows are adjusted accordingly, before discounting to the present. This adjustment factor is based on our assessment of Iluvien's probability of approval by FDA and launch. We discuss this in more detail herein, but in brief our rationale is that the product faces somewhat greater approval risk than the average product with Phase III data (to which we would often apply a rate in the area of 80-85%), due to the fact that different statistical analysis methods were used for the primary FAME endpoint (a full data set and a modified all randomized and treated data set, or MART), and a portion of the data under the MART analysis missed statistical significance.
- **Discount rate:** We have assumed a discount rate of 12% per year, applied to the probability-adjusted cash flows, for use as Alimera's cost of capital.

Exhibit 47: $16 Target Price Based on Discounted Cash Flow Analysis
in millions, unless otherwise stated

	Jul.-Dec. FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Net sales		**$96,466**	**$197,669**	**$268,197**	**$442,736**	**$559,503**	**$485,219**	**$508,910**	**$486,966**	**$357,906**	**$303,877**
EBITDA	($19,844)	$17,314	$87,642	$136,167	$261,826	$341,427	$282,783	$294,415	$272,740	$173,117	$127,013
D&A	(42)	(2,604)	(2,626)	(2,637)	(2,653)	(2,665)	(2,673)	(2,680)	(2,685)	(2,689)	(2,692)
EBIT	($19,886)	$14,710	$85,016	$133,530	$259,174	$338,762	$280,109	$291,735	$270,055	$170,429	$124,321
less: taxes	0	5,678	32,816	51,543	100,041	130,762	108,122	112,610	104,241	65,785	47,988
tax rate	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*	*38.6%*
EBIT tax-effected	**($19,886)**	**$9,032**	**$52,200**	**$81,987**	**$159,133**	**$208,000**	**$171,987**	**$179,125**	**$165,814**	**$104,643**	**$76,333**
Plus: D&A	$42	$2,604	$2,626	$2,637	$2,653	$2,665	$2,673	$2,680	$2,685	$2,689	$2,692
Less: Capex	(100)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)	(200)
Less: changes in WC	(21,679)	(15,479)	20,005	5,454	(31,605)	(17,808)	25,423	(766)	4,591	28,952	14,329
Free cash flow	**($41,623)**	**($4,043)**	**$74,631**	**$89,879**	**$129,980**	**$192,656**	**$199,884**	**$180,839**	**$172,889**	**$136,084**	**$93,153**
Growth after patent expiration											
Stage	FDA	Launch	Launch	Launch	Launch	Launch	Launch	Launch	Launch	Launch	Launch
Probability adjustment	100%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Probability Adj. FCF	**($41,623)**	**($3,032)**	**$55,973**	**$67,409**	**$97,485**	**$144,492**	**$149,913**	**$135,629**	**$129,667**	**$102,063**	**$69,865**

Risk-Adjusted DCF Valution Summary				
Disount Rate	Enterprise Value	Net Debt/(Cash)	Equity Value	Equity Value Per Share
11%	$507,929	($63,067)	$570,996	$17.37
12%	**$474,353**	**($63,067)**	**$537,420**	**$16.34**
13%	$443,538	($63,067)	$506,605	$15.41

Source: Company data, Credit Suisse estimates. Valuation includes declining cash flows from 2021-2030, not shown in this summary.

Sensitivity Analyses on Valuation and Cash Flow

We have performed valuation sensitivity analyses around several variables and scenarios. These include varying outcomes for Iluvien regarding:

(1) Peak sales (and market penetration);

(2) Probability of FDA approval; and

(3) Delays in launch from the planned early 2011.

Alimera's Valuation is Very Sensitive to Peak Sales and Probability of Approval

Under our base case assumptions of 15% peak U.S. penetration and a 75% probability of success, we derive our $16 DCF valuation. However, this valuation can be quite sensitive to the values used for these assumptions (Exhibit 48). For example, under a scenario of 20% penetration and 90% success probability, our valuation is $28; with 10% penetration and 60% probability, it is approximately $7.

Exhibit 48: Valuation Is Very Sensitive to Penetration and Probability of Success
in millions, unless otherwise stated

Sensitivity of Alimera Valuation per Share to Peak US Penetration and Global Net Sales ($MM) and Probability of Success				
	Penetration:	**10%**	**15%**	**20%**
	Sales:	**$375**	**$560**	**$730**
Probability of Success	**60%**	$6.59	**$13.22**	$19.08
	75%	$8.06	**$16.34**	$23.68
	90%	$9.52	**$19.47**	$28.27

Note: assumes peak occurs in 2015; 12% discount rate

Source: Company data, Credit Suisse estimates

The sensitivity to penetration, and thus sales levels, is not surprising given Alimera's high degree of operating leverage, due largely to its small, largely fixed sales and marketing costs, which are attributable to the small, focused retinal specialist audience on whom Alimera is focusing its marketing efforts.

Alimera's current stock price of $9.34 could be seen as implying many possible combinations of penetration and probability of success. For example:

- **Lower penetration:** 11% U.S. penetration and 75% probability of success; or
- **Lower probability of success:** 15% U.S. penetration and 41% probability of success; or
- **A combination of both lower penetration and probability of success:** 12% U.S. penetration and 60% probability of success.

Valuation Is Only Modestly Sensitive to Approval Delays, but Cash Flow Liquidity Is More Sensitive

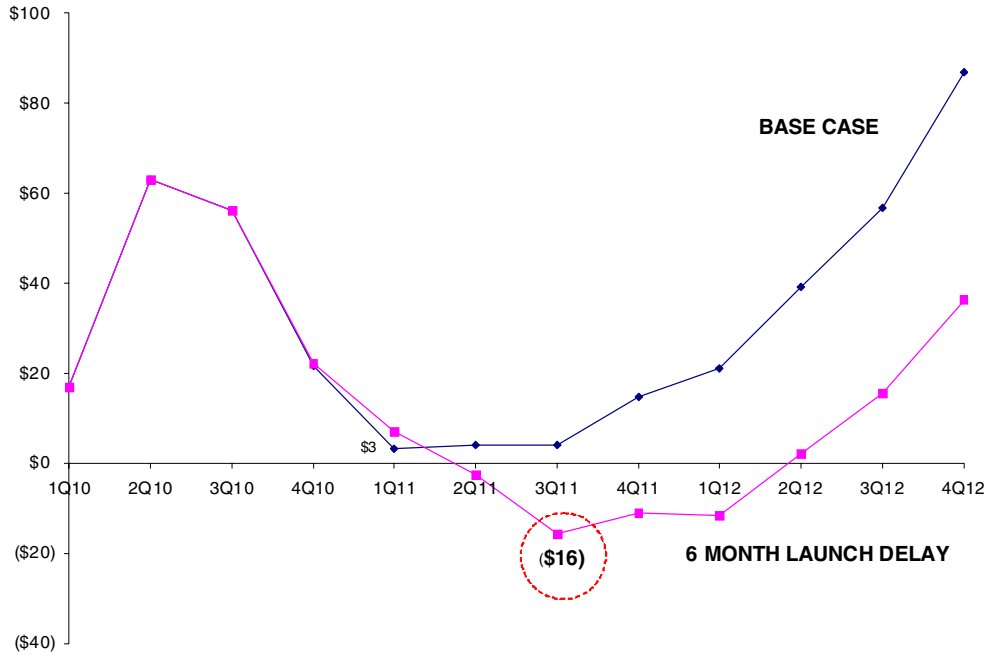
We analyzed the impact on Alimera's valuation and cash flows in the event of a regulatory delay creating a launch later than the January 2011 assumed in our base case. Two possibilities are that (1) Alimera is granted a standard review (10 months) rather than the priority review (6 months) that they will seek, or (2) FDA decides to defer a decision until 3-year data from the FAME study are available. In either case, it's likely that the delay to launch would not be greater than six months, and could be less. Therefore, we ran our model with a launch in July 2011, six months later than our base case.

Alimera's valuation is not greatly impacted with a six-month launch delay to Iluvien launch—we believe the negative impact is approximately $0.50 per share. However, a delay due to either of the two regulatory reasons discussed below could have a larger impact on the company's stock price, since investors could interpret either of these events as implying greater risk to ultimate approval, and therefore could reduce their estimated success probabilities.

However, a six-month delay could require the company to raise additional financing, of a cash shortfall that we estimate at $16 million in 3Q:2011 (excluding any potential deals) (Exhibit 49). These funds could come from any of a number of sources, such as equity issuance, consummation of a collaboration for international rights to Iluvien (possibly earlier than otherwise, with potentially less advantageous terms as a result), or short-term debt financing such as financing of accounts receivable. We assume the use of short-term debt in this analysis, which would be repaid by 2Q:2012. Our analysis presumes that Alimera would make some reductions in operating expenses.

It is important to note that these estimates exclude a potential deal for Iluvien ex-US rights. If Alimera consummates a deal with at least a $20 million upfront payment, a conservative assumption, the company should have adequate cash to weather a 6 month delay.

Exhibit 49: Alimera Could Require Additional Financing in 3Q11 If Iluvien Launch is Delayed (cash shorfall in $MM shown) – Excluding Potential Deals
in millions, unless otherwise stated



Source: Company data, Credit Suisse estimates

Alimera's Valuation Is Discounted Relative to Peers

Although we do not utilize trading multiples of comparable companies as a primary valuation method, it is illustrative for context to compare the multiples implied by Alimera's current price, as well as by our target price (Exhibit 50), to the multiples of peer companies. We have used a basket of biopharma companies that are nearing launch of a key product for this analysis. Based on sales in 2012-2014, Alimera currently trades at a 64-70% discount to peers, and our $16 target price implies a discount for Alimera of 32-42%.

Exhibit 50: Alimera's Implied Sales Multiples (current and CS target price) Are at a Discount to Other Late-Stage Biopharma Companies

in millions, unless otherwise stated

	Company	Partner	Current Price	Market Cap ($ Mn)	Enterprise Value ($ Mn)	Sales 2010 Sales Est.	Sales 2011 Sales Est.	Sales 2012 Sales Est.	Sales 2013 Sales Est.	Sales 2014 Sales Est.	Multiples 2010 EV/Sales	Multiples 2011 EV/Sales	Multiples 2012 EV/Sales	Multiples 2013 EV/Sales	Multiples 2014 EV/Sales
IRWD	Ironwood	Forest, Almirall, Astellas	$11.23	$1,064	$769	$37	$81	$114	$150	N/A	N/M	9.5x	6.7x	5.1x	NM
CADX	Cadence	Bristol-Myers Squibb	$7.28	$368	$303	$3	$55	$139	$251	$325	N/M	5.5x	2.2x	1.2x	0.9x
CLDA	Clinical Data	Santen Pharmaceuticals	$16.09	$413	$392	$22	$100	$238	$460	N/A	N/M	3.9x	1.6x	0.9x	NM
OPTR	Optimer	None	$10.07	$352	$271	$5	$44	$112	$179	$178	N/M	6.1x	2.4x	1.5x	1.5x
VVUS	Vivus	None	$12.20	$985	$810	$21	$81	$130	$207	$269	N/M	10.0x	6.2x	3.9x	3.0x
AFFY	Affymax	Takeda, Nektar	$19.83	$475	$346	$140	$166	$231	$334	$447	2.5x	2.1x	1.5x	1.0x	0.8x
SVNT	Savient	None	$12.00	$796	$701	$7	$103	$171	$247	$312	N/M	6.8x	4.1x	2.8x	2.2x
						$34	**$90**	**$162**	**$261**	**$306**	**2.5x**	**6.3x**	**3.5x**	**2.4x**	**1.7x**
ALIM	Alimera- as is	None	$9.34	$290	$227	$0	$96	$198	$268	$443	NM	2.3x	1.1x	0.8x	0.5x
	discount to peers										*NM*	*63%*	*68%*	*64%*	*70%*
ALIM	Alimera- CS target	None	$16.00	$496	$433	$0	$96	$198	$268	$443	NM	4.5x	2.2x	1.6x	1.0x
	discount to peers										*NM*	*29%*	*38%*	*32%*	*42%*

Source: Company data, Credit Suisse estimates

Possible Upsides to Our Valuation

There are several possible areas of upside to our model that could be driven by Alimera's execution. These include:

(1) **Higher, and more rapidly growing, U.S. penetration rates:** We assume peak penetration of 15% of patients, after deducting 30% of patients assumed to be satisfied by laser. This penetration could well prove higher, particularly if Iluvien is used extensively in combination with other treatments such as anti-VEGF therapies and laser. Our conversations with retinal specialists indicate broad interest in combination uses of DME therapies including Iluvien. Furthermore, our model has a fairly gradual ramp in U.S. penetration in 2011-2015 of 2%, 5%, 8%, 12%, 15%. If Iluvien's 3-year data are appreciably more attractive than the 2-year data—as hinted by the strong efficacy in limited patient numbers at 30 months—then this uptake could be more rapid.

(2) **Greater ex-U.S. revenues:** We have modeled ex-U.S. revenues as 20% of U.S. revenues (and then assumed Alimera will receive a royalty from an eventual partner, as Alimera's ex-U.S. revenue).

(3) **Better terms on an ex-U.S. partnership:** We have assumed that Alimera will receive a 20% royalty on ex-U.S. sales. This is a reasonable yet possibly conservative assumption. For example, in a deal that should probably represent the upper end of expectations for an Alimera deal, Regeneron negotiated a 50% share of ex-U.S. profits for VEGF-trap (eye) with Bayer.

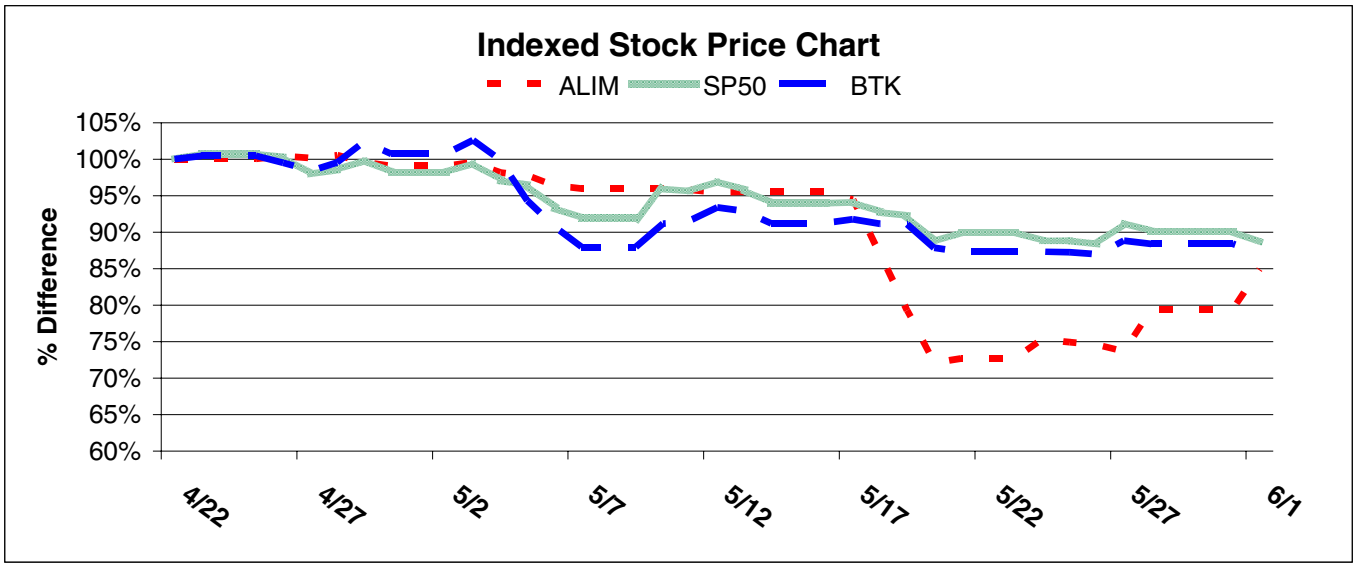
(4) **Additional indications for Iluvien:** Our model includes revenues in DME only. Alimera is in Phase II studies for dry AMD, wet AMD, and macular edema associated with non-ischemic retinal vein occlusion (RVO).

(5) **Pipeline:** Alimera is studying NADPH oxidase inhibitors, which could have applicability in a range of ocular diseases. Alimera's studies are only in the preclinical stage currently, thus we have not attributed any value to them in our model. However, specialists we spoke with are intrigued with the potential of this class, and it could represent future long-term value for Alimera.

Alimera's 15% Stock Price Decline since IPO Is Unwarranted by Fundamentals

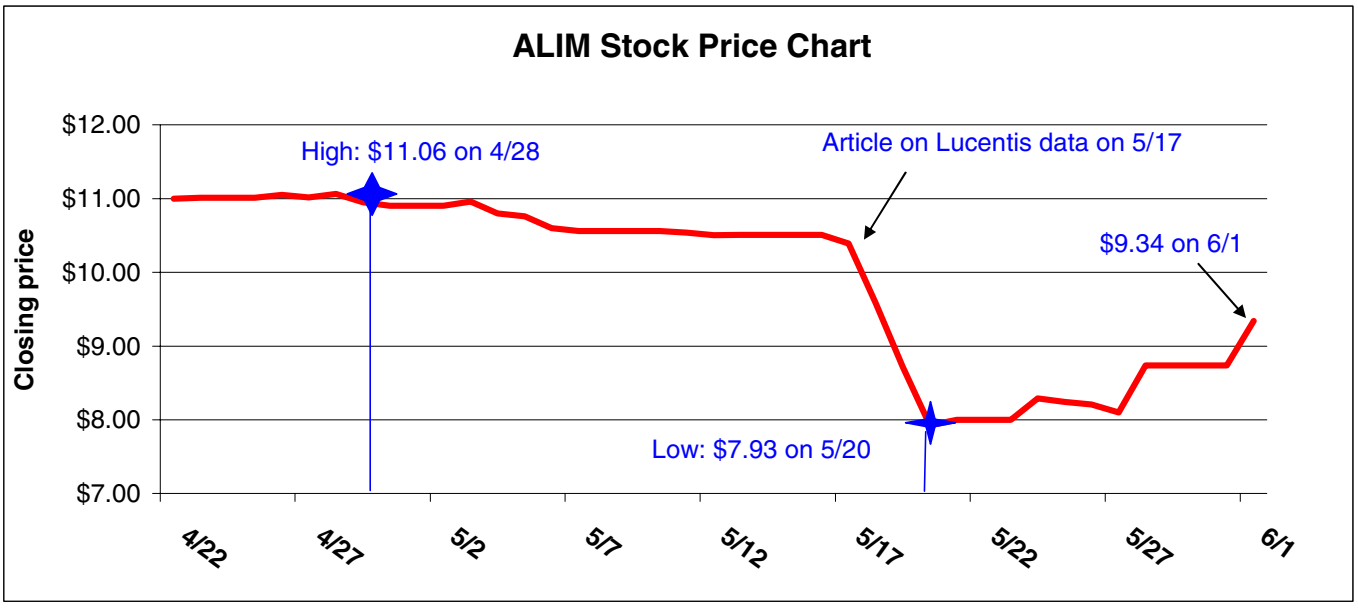
Since its initial public offering, Alimera's stock price has underperformed the market (Exhibit 51), returning -15%, compared with -11%% for the S&P 500 and -13% for the NASDAQ Biotech Index (BTK). Alimera began trading on April 22, 2010, after pricing its IPO at $11 the previous day.

Exhibit 51: Alimera Has Underperformed the Market



Source: FactSet, Credit Suisse estimates.

Exhibit 52: Alimera Stock Is Down 15% from Its $11.00 IPO Price



Source: Company data, Credit Suisse estimates.

We don't believe that the decline in Alimera's stock price since IPO (Exhibit 52) was related to any fundamental changes with Iluvien or Alimera. The company continues to work toward an anticipated NDA filing around June 28, and there have been no reports of new data for Iluvien, or strategic or financial changes with Alimera.

Instead, we see two factors that may have contributed to the fall in the stock price.

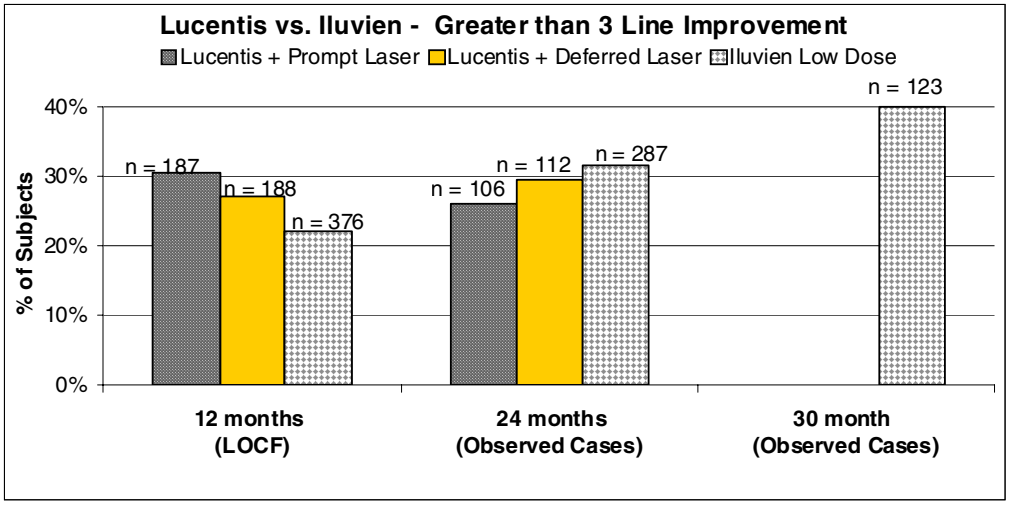
1. **Macroeconomic issues and low Alimera liquidity:** As investors are well aware, the broader stock market has been buffeted by recent macroeconomic concerns including sovereign debt default in Europe and negative pressures on the euro. As investors search for liquidity, smaller, less liquid names like Alimera can be disproportionately affected by selling pressure.

2. **Recent data from the DRCR study of Lucentis in DME** in combination with laser: these data were first published on April 27 in the journal *Ophthalmology*, but were featured in a *Biocentury* article on May 16. The data showed promising efficacy for Lucentis, over a longer term (2 years) and with higher patient numbers (n=691) than had been shown previously. However, we do not see these data as being directly comparable to the FAME study. DRCR had two factors in its trial design that likely aided the demonstrated efficacy relative to the FAME study:

   a. Lucentis was studied only in combination with laser, while Iluvien was studied as monotherapy in FAME, with the option for augmentation with laser, which was used by 35%% of patients in the low dose Iluvien arm.

   b. The DRCR study measured only observed patients, that is, patients who reported for data observations at month 24, whereas the 24 month data for FAME used the common last observation carried forward (LOCF) technique to impute data at month 24 for patients not observed at that time. LOCF is generally more conservative. When the data from DRCR and FAME are reviewed on a comparable basis (Exhibit 53), one see that Lucentis plus laser showed better efficacy at 12 months using LOCF, but Iluvien demonstrated superior efficacy at 24 months in observed cases, and Iluvien's efficacy in a subset of FAME patients increased markedly by month 30.

Exhibit 53: Iluvien Showed a Greater % of 3 Line Improvement than Lucentis+laser, in Observed Cases



Source: Company data, Credit Suisse estimates

PharmaValues NPV Analysis

PharmaValues, a Credit Suisse proprietary valuation tool for the global pharmaceutical and biotechnology industry, suggests a net present value (NPV) of $18.87 per share (Exhibit 54). This value is entirely from Iluvien, with 90% of it derived from the DME indication.

There are several factors contributing to the difference between the PharmaValues NPV and our DCF valuation driving our target price, each of which is due to the nature of the PharmaValues algorithm (please see our note, *Credit Suisse PharmaValues: PharmaValues – Now Online*, dated January 19, 2010 for a full description of the PharmaValues methodology):

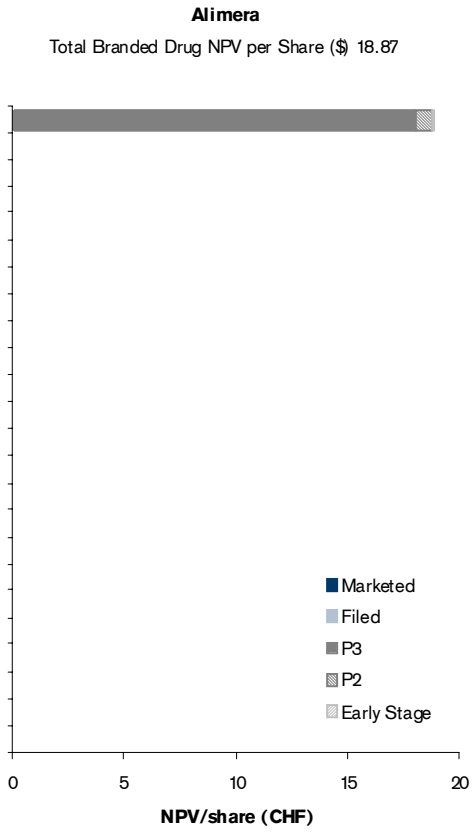
- PharmaValues uses a number of proprietary assumptions that are applied across the pharmaceutical and biotechnology sectors, to evaluate over 4,000 products; as a

result the assumptions can be necessarily crude relative to the more customized analyses possible with individual company DCF analyses.

- PharmaValues uses a 10% discount rate, while we use 12% in our DCF analysis.
- PharmaValues excludes R&D expenses, as these are not readily allocatable to individual products.
- PharmaValues includes modest value contributions from Iluvien's development indications.

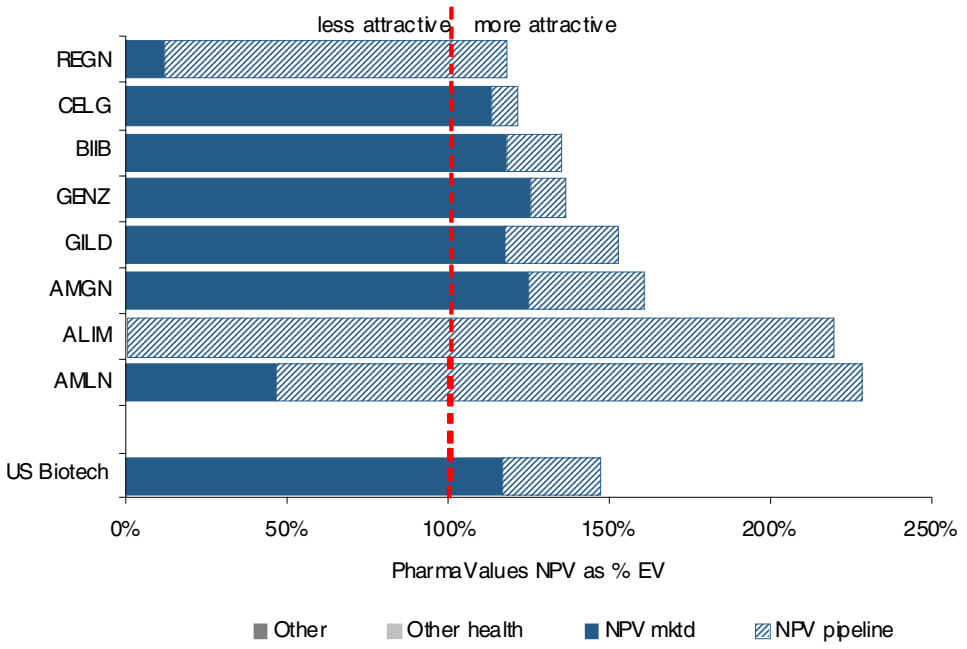
On an NPV/EV basis, Alimera trades at 219% (ratio of PharmaValues NPV to market-implied enterprise value) versus the US biotechnology sector average of 148% (Exhibit 55).

Exhibit 54: Alimera PharmaValues NPV Breakdown



Source: Company data, Credit Suisse estimates

Exhibit 55: Alimera – PharmaValues NPV/EV Relative to US Biotechnology Companies



Source: Company data, Credit Suisse estimates

Investment Risks

Single Product Risk

Alimera's value is virtually entirely attributable to Iluvien. There is little visibility on additional indications for Iluvien or on the new product pipeline. The company's near to medium term revenues, profits and value depend on the FDA's approval and Alimera's successful commercialization of Iluvien in DME.

The company plans to submit the NDA for Iluvien around June 28, 2010 and request priority review. Any substantial delays in filing or approval could have a materially negative impact on Alimera's financial performance and valuation. Alimera's FDA filing could face a range of outcomes, but if FDA requires additional trials, or issues an outright non-approval, Alimera's stock price could decline rapidly and substantially. However, a modestly delayed approval, due to a standard review (instead of priority) or an FDA decision to wait for 3 year data (rather than the 2 year data that will be the basis of the filing) would be less impactful on valuation. We estimate a 6 month delay would have an impact of approximately $0.50 per share, however the stock price could be greater if investors interpret a delay as implying a lower probability of approval.

In addition to the Phase III FAME study in AMD, the company is conducting proof of concept trials to evaluate Iluvien in geographic atrophy, wet AMD, and RVO. However, all these trials are presently in phase II with minimal clinical data to provide insight into the likelihood of successful development in these indications.

Two classes of NADPH oxidase inhibitors licensed from Emory University are in early stage pre-clinical development for treating wet AMD, and thus there is no clinical data available to evaluate the success prospects of these potential product candidates.

Regulatory Risk to Timely Iluvien Approval

There is inherent risk involved in the approval of Iluvien because the ultimate decision power resides with the FDA. Apart from the typical regulatory risk, there are several regulatory risks specific to Iluvien and the FAME study including the modified ART dataset, 3 year trial data and priority review.

First, there are approval concerns due to the missed statistical significance in the MART (modified all randomized and treated) data set, defined as the primary assessment of efficacy in the FAME study protocol. However, we believe that the totality of the FAME data, including the full data set, will be considered by the FDA and that the product will be approved. Furthermore, FDA's approval of Allergan's Ozurdex despite a change in primary endpoint creates a precedent that adds comfort to our view that Iluvien will be approved (see section "Statistical Analysis of FAME Study Creates Risk to Iluvien Approval, but We Expect Approval" for additional details).

Second, there is the possibility that the FDA will wait for the complete 3 year trial data (expected in 1Q11) before issuing a decision. Some retinal specialists we have spoken with have suggested that glaucoma is known to present itself later in the disease, and given that 3.7% patients required IOP-lowering surgery at the end of 24 months, the FDA might be cautious and wait until they see the entire dataset.

Lastly, there is some risk to the company's plan to seek priority review. Historically, the FDA has granted priority review to retinal disease products like Visudyne, Retisert, Macugen, Lucentis and Ozurdex and our conversations with experts have led us to believe that it is more likely that Iluvien will be granted priority review than not, due to the high unmet need in DME and the efficacy demonstrated in FAME.

Commercial Risk

Alimera will face challenges in successfully marketing and launching Iluvien. The company needs to hire and build a commercial sales force in the US. In the rest of the world, Alimera needs to find a partner to commercialize the drug.

Iluvien will compete against several established treatments in DME. Laser photocoagulation, the current gold standard for treatment for DME, is well-established with, and lucrative for, retinal specialists, and has modest efficacy. Off-label use of anti-VEGF therapies like Avastin and Lucentis is also common due to the molecules' attractive efficacy and clean safety. Breaking into a market where current therapies have attributes, though varying by product, of reasonable efficacy and safety will be challenging.

Furthermore, Alimera will compete against companies that are better-capitalized and have a longer-standing presence in the ophthalmology community. However, we believe that the small, focused specialist audience for Iluvien, Alimera management's experience with this audience, and the modest commercial infrastructure needed will mitigate this challenge.

Liquidity and Financing Risk

The company may need to raise additional funds if the Iluvien approval and/or launch are delayed because Iluvien is the only visible source of revenue for Alimera. We model a 1Q11 launch with profitability in 3Q11 and positive operating cash flow in 4Q11. Under this scenario, additional financing is likely not needed.

However, if the launch were to be delayed by six months, for example, due to approval delays, then Alimera would need to raise additional funds of approximately $16 million to avoid running out of cash in 3Q11 (see section titled "Valuation and Cash Flow" for more detail." These funds could come from any of a number of sources, such as equity issuance, consummation of a collaboration for international rights to Iluvien (possibly earlier than otherwise, with potentially less advantageous terms as a result), or short-term debt financing such as financing of accounts receivable.

Reimbursement Risk

Securing reimbursement is crucial to the success of Iluvien. Iluvien will contend against some inexpensive therapies like IVTA and Avastin. Due to Iluvien's high upfront cost relative to other treatments, it is important for Iluvien uptake that Alimera secure reimbursement for Iluvien.

We believe that the unmet need in DME, along with Iluvien's differentiated clinical profile demonstrated in Phase III studies, particularly the degree and durability of efficacy, will enable Alimera to secure reimbursement for the product.

Pipeline

Alimera has a pipeline that includes Iluvien phase II studies in other ophthalmic indications, and various preclinical projects related to NADPH oxidase inhibitors. Given that the pipeline portfolio is at an early stage, and there are very little data available for these studies, we have not included these projects into our model.

Iluvien—Pipeline within a Product

Apart from the DME indication, for which the NDA is expected to be filed around June 28 this year, Alimera is investigating Iluvien for the treatment of various diseases affecting the back of the eye, including wet AMD, retinal vein occlusion (RVO) and geographic atrophy (GA). (See Exhibit 56.) Clinical studies are currently in Phase II.

Exhibit 56: Clinical-Stage Portion of Pipeline Depends on Iluvien

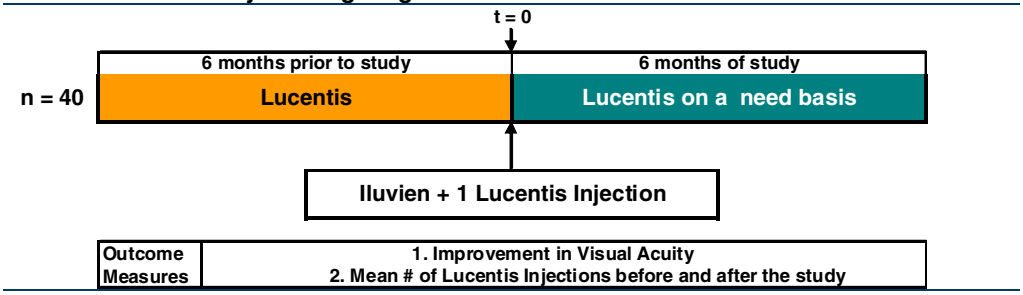
Candidate	Stage	Indication	Comment	Development Phase
Iluvien	Filing	**DME**	Completed FAME study, Expected NDA filing	
Iluvien	P II	**Wet AMD**	Recruiting for MAP Study: Single masked, randomized comparison of the safety and efficacy of 0.2 and 0.5 µg/Day FA in patients suffering from Wet AMD who have received Lucentis	P IIb
Iluvien	P II	**Retinal Vein Occlusion**	Recruiting 20 patients in randomized, double-masked, pilot study of the safety and efficacy of 0.5 µg/Day and 0.2 µg/Day Iluvien in subjects with macular edema secondary to RVO	PII
Iluvien	P II	**Geographic Atrophy - Dry AMD**	Recruiting - 40 patients with AMD-related Bilateral geographic Atrophy for randomized, double-masked, fellow-eye safety and efficacy comparison of 0.2 And 0.5 µg/Day Iluvien To Sham Injection	PII
NADPH Oxidase Inhibitor	Pre-clinical	**Geographic Atrophy - Dry AMD**		Pre-clinical
NADPH Oxidase Inhibitor	Pre-clinical	**Wet AMD**		Pre-clinical
NADPH Oxidase Inhibitor	Pre-clinical	**Diabetic Retinopathy**		Pre-clinical
NADPH Oxidase Inhibitor	Pre-clinical	**Posterior Uveitis**		Pre-clinical

Source: Alimera IPO Prospectus dated April 22, 2010, Clinicaltrials.gov, Credit Suisse estimates.

- **Wet AMD:** Caused by blood and fluid leaking from the abnormal blood vessels growing under the macula, wet AMD is one of the leading causes of severe vision loss in people over 50. According to Visiongain, an independent competitive intelligence organization, the wet AMD market was worth $2 billion in 2008.

  Iluvien is currently in a Phase II clinical trial called the MAP Trial to evaluate Iluvien in conjunction with Lucentis in wet AMD (Exhibit 57). Patients will be enrolled who have been treated with Lucentis for at least 6 months and whose visual acuity has plateaued. After initial Iluvien and Lucentis injections at baseline, patients are given additional Lucentis injections if retinal fluid persists. In addition to measuring improvement in baseline visual acuity at six months, the mean number of Lucentis injections in the 6 months before and after study entry will also be assessed.

Exhibit 57: **MAP Study Investigating Iluvien in Wet AMD**



Source: Alimera IPO Prospectus dated April 22, 2010, Credit Suisse estimates.

- **Dry AMD:** Dry AMD, which is responsible for 90% of AMD cases, is characterized by slow breakdown of light-sensitive cells in the macula. As the disease progresses, vision worsens and localized yellow deposits of extracellular deposits accumulate, usually concentrated in the macula. Geographic atrophy, the most severe form of dry AMD, where cells die, leads to blindness and is currently not treatable. Alimera is investigating safety and efficacy of Iluvien in the MAP GA Trial in patients with bilateral GA secondary to AMD, after promising preclinical results in rat models.

- **Retinal Vein Occlusion:** Alimera is conducting the FAVOR study, a Phase II study to evaluate safety and efficacy of Iluvien in patients with macular edema due to non-eschmic retinal vein occlusion. Currently, Ozurdex, a dexamethasone intravitreal implant, is approved for macular edema due to branching or retinal vein occlusion. While Ozurdex is more durable (three to five months) than the off-label triamcinolone acetonide injections, Iluvien holds the promise of being a longer-term solution with sustained release of low levels of FA for up to three years.

NADPH Oxidase Inhibitors

Under agreements with Emory University, Alimera has gained the exclusive, worldwide licenses of rights under patent applications covering two classes of NADPH oxidase inhibitors, fulvene and triphenylmethane, in July and August 2009, respectively. NADPH oxidase inhibitors limit the formation of reactive oxygen species (ROS) that appear to contribute to certain pathological conditions including ophthalmic diseases like dry AMD and wet AMD.

Alimera can develop, manufacture, market, and sell pharmaceutical products using these compounds for therapeutic and prophylactic uses in eye diseases and disorders. The company stated its intent to evaluate NADPH oxidase inhibitors in geographic atrophy, and believes these compounds have potential use in treating wet AMD, diabetic retinopathy and posterior uveitis.

As an upfront license fee, Alimera issued to Emory and the molecule's inventors common stock worth $150,000 for each of the two classes of NADPH oxidase inhibitors. If Alimera is able to successfully develop therapies with these molecules, then Emory will receive royalties (in low-single digit percentages of net sales of products pertaining to the agreement), with minimum annual amounts as shown in Exhibit 58. Furthermore, Alimera will have to make payments of up to $5.8 million under the fulvene license agreement and up to $5.9 billion under the triphenylmethane license agreement depending on which regulatory milestones have been achieved at the time. If no milestone payments are made prior to the third anniversary of the license and the agreement is still effective, then Alimera will pay Emory annual license maintenance fees of $500,000 to $2 million depending on the timing of payment, until a milestone payment is made or contract terminated.

Exhibit 58: Key Elements of Alimera-Emory University Partnership for NADPH Oxidase Inhibitors

Product		
NADPH Oxidase Inhibitors		
July 2009 Agreement	Fulvene class of NADPH oxidase inhibitors	
August 2009 Agreement	Triphenylmethane class of NADPH oxidase inhibitors	
Indications for Development		
Alimera may investigate the NADPH oxidase inhibitors in treating		
Geographic Atrophy	**Wet Age-related Macular Degeneration**	
Posterior Uveitis	**Diabetic Retinopathy**	
Development Terms		
Alimera holds exclusive worldwide license for ophthalmic indications Exclusive right to sublicense in ophthalmology Exclusive option for non-ophthalmic use Alimera is responsible for development and commercialization		
Financial Terms		
Upfront Fees		
Emory and the inventors were issued common stock worth $150,000 fair market value each for the Fulvene contract and Triphenylmethane contract.		
Annual License Maintenance Fees	**Minimum Annual Royalties (based on low-single digit % of net sales)**	**Amount**
If no milestone payments are made prior to 3rd anniversary of the license and agreement is still effective, then Emory will receive annual license agreement fees of $500,000 to $2 million depending on the timing of payment, until a milestone payment is made or contract terminated.	**Year after Regulatory Approval***	
	1st year	$250
	2nd year	$500
	3rd year	$1,000
	4th year	$2,500
	Milestones	
	Up to $5.8 million (fulvene agreement) and up to $5.9 million (triphenylmethane agreement)	
** after regulatory approval in a major market & country (US, China, Japan, India, or any European country)*		

Source: Alimera IPO Prospectus dated April 22, 2010, Company Data, Credit Suisse estimates.

Catalysts

We summarize upcoming potential catalysts for Alimera in Exhibit 59.

Exhibit 59: Potential Alimera Catalysts

Timing	Catalyst/Event	Fundamentals
June 3, 2010	**ALIM Earnings Call**	Reported financials are a relative non-event; any updates on NDA filing plans would be of greater interest.
approx. June 28, 2010	**Iluvien:** ALIM plans to file with FDA for US approval	ALIM must file in June and receive priority review in order to meet launch goal of early 2011
approx. August 28, 2010	**Iluvien:** ALIM likely will find out whether approved for priority review	Priority review request normally decided 60 days after filing
2H 2010	**Lucentis:** Approval decision for DME in EU	Novartis filed for approval in December 2009 based on the RESOLVE phase 2 trial; RESTORE data will be filed in support of the application
3Q 2010	**Iluvien:** ALIM plans to file in EU	ALIM is filing in EU via decentralized procedure; UK has agreed to be reference member state
3Q 2010	**Iluvien:** ALIM plans to file for approval in Canada	
approx. December 28, 2010	**Iluvien:** FDA approval decision if priority review	Priority review decisions are typically made 6 months after filing; a Dec. approval would enable a Jan. 2011 launch
4Q 2010	**VEGF trap (REGN):** report Phase 2 52 week data in DME (DA VINCI trial)	REGN reported positive 6 month data in Feb. 2010; 1 year data will be important to see durability of efficacy and efficacy with every 2 month dosing
1Q 2011	**Iluvien:** Report 3 year FAME data	Data will be important to substantiate potential 3 year efficacy claim. Potential risk that FDA may await 3 year data before approving product.
1Q 2011	**Lucentis/Avastin:** first data from CATT trial expected	2 year NEI-sponsored study comparing Avastin and Lucentis in AMD. Enrollment completed in early 2010. Important milestone in the Avastin-Lucentis debate, and a favorable outcome for Avastin could impact other competitors due to Avastin's low cost.
1H 2011	**Lucentis:** 2 year data from RISE and RIDE Phase 3 trials in DME expected	Roche plans to file for approval based on the 2 year data when data is available, in advance of availability of 3 year data
3Q 2011	**Iluvien:** potential EU approval	12 month review expected; UK is reference member state for ALIM (decentralized EU filing procedure)
3Q 2011	**Lucentis:** FDA filing for DME	File with 24 month data
2011	**Ozurdex:** 2 year Phase 3 data in DME	Trial completed enrollment in 2009, thus 2 year data, which is the primary endpoint, could be available in 2011
2012	**Lucentis:** Potential FDA approval in DME in US	Currently approved in AMD
2012	**Ozurdex:** Potential FDA approval in DME in US	2012 approval would follow a 2011 filing based on 2 year data, and an FDA decision, in advance of completion and review of the 3 year portion of the study

Source: Company data, Credit Suisse estimates.

The first key event is Alimera's expected FDA filing for Iluvien in DME around June 28, 2010. Management has indicated that they will ask the regulatory authorities for a priority review of Iluvien. Typically, the FDA takes about 60 days to respond to a priority review request. Given this trend, we expect Alimera to learn of the FDA's decision on granting

Iluvien priority review in approx. late August 2010. If priority review is granted, then we expect the FDA to make a decision around December 28, 2010 and Alimera to subsequently launch the drug in January 2011 in the U.S.

In Canada and the EU, we expect Alimera to file for approval in 3Q10. We expect the EU to make the approval decision on Iluvien by 3Q11.

The news flow on the competitive landscape for branded ophthalmic therapies will be important to monitor, including REGN's Phase 2 52 week data from the DA VINCI trial in 4Q10 and study results from Lucentis/Avastin for AMD in the first half of 2011.

The pivotal two-year data from the Phase III Rise and Ride study evaluating Lucentis' safety and efficacy in DME is expected in 1H11. This 24-month study will form the basis of Roche's U.S. FDA filing for Lucentis' approval for treatment of DME. While Lucentis is currently used off-label to treat DME, the quality of the efficacy and durability could drive Lucentis' reimbursement and determine share uptake.

The National Eye Institute (NEI) is sponsoring the **C**omparison of **A**ge-related Macular Degeneration **T**reatments **T**rials: The Lucentis-Avastin (CATT) trial which is investigating Avastin and Lucentis' efficacy and safety in treating AMD. Two-year data from this study are expected in 1Q11. Favorable data for Avastin in this head-to-head trial with Lucentis could drive higher Avastin usage in AMD and potentially DME owing to Avastin's low cost. This could potentially affect the share of other competitors.

Company Background

Alimera is a specialty pharmaceutical company specializing in research, drug development, and commercialization of prescription ophthalmic pharmaceuticals. The company is preparing to file for FDA approval of its lead product candidate, Iluvien, for the treatment of diabetic macular edema (DME), a retinal disorder in diabetics that can lead to loss of vision and potentially blindness. DME is a currently underserved disease market with no approved drug therapy, and where opportunity exists to improve upon the standard of care (laser photocoagulation) and upon drugs used off-label (injectable steroids and anti-VEGF agents). Furthermore, DME is well-aligned with the management's development strategy to focus on therapeutic needs associated with the retina of the eye.

The company's near term goals for 2010 are successfully obtaining FDA approval for Iluvien in Q410, followed by commercializing Iluvien in 1Q11. The company's long-term goals include developing its early-stage pipeline, which includes additional indications for Iluvien and two potential compounds in the treatment of dry age-related macular degeneration (AMD), and acquiring and in-licensing ophthalmic drugs and compounds.

Management and Board of Directors

Management Team

Headed by Daniel Myers, president and CEO, the management team at Alimera has deep experience in branded ophthalmic drug development and commercialization. Along with his former Novartis Ophthalmics colleagues now at Alimera, Kenneth Green, Ph.D., Susan Caballa, and David Holland, Mr. Myers was responsible for Visudyne, the first successful branded ophthalmic drug for the treatment of a form of wet AMD, called predominantly classic wet AMD in 2000. At its peak in 2004, Visudyne, the fastest ophthalmology drug to reach $100 million in sales, generated $209 million in US sales.

Exhibit 60: Alimera's Management Team – Collectively over 100 Years in Ophthalmology

Name	Principal Position	Comments
C. Daniel Myers	President, Chief Executive Officer	28 Years in ophthalmology including tenures with Novartis, Allergan and Johnson & Johnson; founding member of Novartis Ophthalmics (formerly CIBA Vision Ophthalmics)
Richard S. Eiswirth, Jr	Chief Financial Officer	19 Years in accounting and finance including tenures with Brand Ignition Group, Black River Holdings, Netzee and Arthur Anderson; Chairman: Jones Soda Co.
Kenneth Green, Ph.D.	Senior Vice President, Scientific Affairs & Chief Scientific Officer	25 Years in drug development, including tenures with Novartis Ophthalmics, Bausch and Lomb, Lederle Laboratories and Storz Ophthalmics; involved with the development of Visudyne, Rescula and Zaditor
Susan Caballa	Senior Vice President, Regulatory & Medical Affairs	27 Years in ophthalmic regulatory management including tenures with Novartis, Allergan, Iolab Corporation and Alcon Laboratories
David Holland	Vice President, Marketing	25 Years in marketing and brand management (21 in ophthalmology) including tenures at Novartis and Procter and Gamble

Source: Alimera IPO Prospectus dated April 22, 2010, Credit Suisse estimates.

C. Daniel Myers is a co-founder of the company and has been president and CEO since 2003. Mr. Meyers has 27 years of ophthalmic experience, was a founding member of Novartis Ophthalmics, now CIBA Vision Ophthalmics, serving as president from 1997 to 2003 and vice president of sales and marketing from 1991 to 1997. Previously, he held executive responsibilities in sales, marketing and management in the ophthalmic sectors at Allergan and Johnson & Johnson. Mr. Myers has a B.S. in Industrial Management from Georgia Tech.

Richard S. Eiswirth, Jr., has been CFO of Alimera since October 2005. Mr. Eiswirth founded two consulting practices, Brand Ignition Group and Black River Holdings, and was CFO of Netzee Inc. A certified public accountant and graduate from Wake Forest University with an accounting degree, he began his career as senior manager in Arthur Andersen's audit and business advisory practice. He is Chairman of the board of directors of Jones Soda Co.

Kenneth Green, Ph.D. joined the company as vice president of scientific affairs in 2004 and has been the senior vice president and chief scientific officer of Alimera since 2007. He is responsible for all preclinical and clinical development activities of the company. Before joining Alimera, Dr. Green was the global head of clinical sciences at Novartis Ophthalmics. Prior to that, he managed ophthalmic clinical development at Storz Ophthalmics, Bausch & Lomb, and CIBA Vision. He started his career in 1984 as a basic research scientist in drug discovery at Lederle Laboratories. Dr. Green holds a B.A. in Chemistry from Southern Illinois University and a Ph.D. in Organic Chemistry from Ohio State University.

Susan Caballa has been the senior vice president of regulatory and medical affairs of Alimera since 2004. Prior to that, she held the same position at Novartis Ophthalmics from

1999. Ms. Caballa various regulatory management positions at Allergan, Iolab Corporation, and Alcon. Ms. Caballa holds a B.S. and M.S. in Chemistry from the University of Santo Tomas and University of the Philippines, respectively.

David Holland co-founded the company in 2003 and has served as the vice president of marketing since that time. Before joining Alimera, Mr. Holland was the vice president of marketing at Novartis Ophthalmics from 1998 to 2003. Prior to Novartis Ophthalmics, he held various marketing and sales executive positions at CIBA Vision from 1989-2003, including global head of the lens business since in 1996, and director of marketing from 1992 to 1995. At Procter and Gamble, he was Brand Assistant and Assistant Brand Manager from 1985 to 1989. Mr. Holland graduated from Princeton University with a B.A. in Politics.

Management Compensation

At Alimera, an executive's compensation is composed of three main components:

(1) *Base Salaries:* Industry-competitive salaries are based on the individual's expertise, title, and experience.

(2) *Annual Incentive Compensation:* This component is assessed based on successfully achieving individual, corporate and strategic objectives. Individual performance goals are weighted 50%, corporate performance and strategic objectives are assigned 25% each. Management's 2010 goals are not finalized but are related to a successful IPO, FDA filing of Iluvien, Iluvien approval and commercialization.

(3) *Long-Term Incentive Compensation:* To ensure that members of management are incentivized to act in the long-term interest of the company, they are given a stake in the Alimera through stock options.

Exhibit 61 summarizes the management compensation in 2009 and Exhibit 62 shows management termination agreements including compensation in the event of a change in control.

Exhibit 61:Alimera Management Compensation in 2009

Name	Position	Salary	Bonus	Option Awards	Non-Equity Incentive Plan	All other Compensation	Total	% Share Beneficial Ownership
C. Daniel Myers	President, Chief Executive Officer	$353,600	$35,360	$365,380	$108,909	$1,721	$864,970	1.47%
Richard S. Eiswirth, Jr	Chief Financial Officer	$249,600	$15,600	$97,690	$48,048	$6,221	$417,159	0.67%
Kenneth Green, Ph.D.	Senior Vice President, Scientific Affairs and Chief Scientific Officer	$260,000	$16,250	$126,652	$50,050	$6,221	$459,173	0.92%
Susan Caballa	Senior Vice President, Regulatory and Medical Affairs	$228,800	$14,300	$83,995	$43,186	$6,174	$376,455	0.66%
David Holland	Vice President, Marketing	$218,400	$13,650	$94,513	$42,042	$6,128	$374,733	0.76%

Source: Alimera IPO Prospectus dated April 22, 2010.

Exhibit 62: Management Termination Agreements

Name	Designation	Voluntary Resignation or Termination for Cause	Termination without Cause or for Good Reason Prior to Change in Control	Termination without Cause or for the Good Reason after Change in Control
C. Daniel Myers	President & CEO			
	Salary	$0	$353,600	$353,600
	Bonus	0	144,269	144,269
	Benefit Continuation	0	5,174	5,174
	Accelerated Vesting	0	0	3,232,570
	Total Value	**$0**	**$503,043**	**$3,735,613**
Richard S. Eiswirth, Jr.	CFO			
	Salary	$0	$249,600	$249,600
	Bonus	0	63,648	63,648
	Benefit Continuation	0	15,593	15,593
	Accelerated Vesting	0	0	1,347,816
	Total Value	**$0**	**$328,841**	**$1,676,657**
Kenneth Green, Ph.D.	SVP			
	Salary	$0	$260,000	$260,000
	Bonus	0	66,300	66,300
	Benefit Continuation	0	10,220	10,220
	Accelerated Vesting	0	0	1,496,179
	Total Value	**$0**	**$336,520**	**$1,832,699**
Susan Caballa	SVP			
	Salary	$0	$228,800	$228,800
	Bonus	0	57,486	57,486
	Benefit Continuation	0	10,470	10,470
	Accelerated Vesting	0	0	742,236
	Total Value	**$0**	**$296,756**	**$1,038,992**
David Holland	VP			
	Salary	$0	$218,400	$218,400
	Bonus	0	55,692	55,692
	Benefit Continuation	0	15,593	15,593
	Accelerated Vesting	0	0	731,501
	Total Value	**$0**	**$289,685**	**$1,021,186**
Total, 5 named executives		**$0**	**$1,754,845**	**$9,305,147**

Source: Alimera IPO Prospectus dated April 22, 2010.

Board of Directors

The board of directors is listed in Exhibit 63. Polaris Venture Partners, Intersouth Partners, and Domain Associates, each own 15.71% of Alimera's shares post-IPO. Scale Venture Management I owns 15.66% and Venrock Associates holds 12.72%.

Exhibit 63: Alimera Board of Directors

Name	Affiliation	% Share Benificial Ownership*	Position	Class	Independent	Annual Retainer (including committees)	Option Awards
C. Daniel Myers	Alimera	1.47%	Board of Director	Class I	No		
Calvin W. Roberts	Ophthalmology Expert	1.04%	Audit Committee	Class I	Yes	$22,000	7,500
Bryce Youngren	Polaris Venture Partners	15.71%	Nominating/Corporate Governance Committee	Class I	Yes	$22,000	7,500
Anders D. Hove	Venrock Associates	12.72%	Audit Committee, Compensation Committee	Class II	Yes	$24,000	7,500
Philip R. Tracy	Intersouth Partners	15.71%	Chairman of the Board and Nominating/Corporate Governance Committee	Class II	Yes	$28,500	7,500
Brian K. Halak	Domain Associates	15.71%	Chairman of Compensation Committee, Nominating/Corporate Governance Committee	Class III	Yes	$25,500	7,500
Mark J. Brooks	Scale Venture Management I	15.66%	Compensation Committee	Class III	Yes	$22,000	7,500
Peter J. Pizzo, III	Healthcare Industry Expert	0.00%	Chairman of Audit Committee, Financial Expert	Class III	Yes	$27,500	7,500

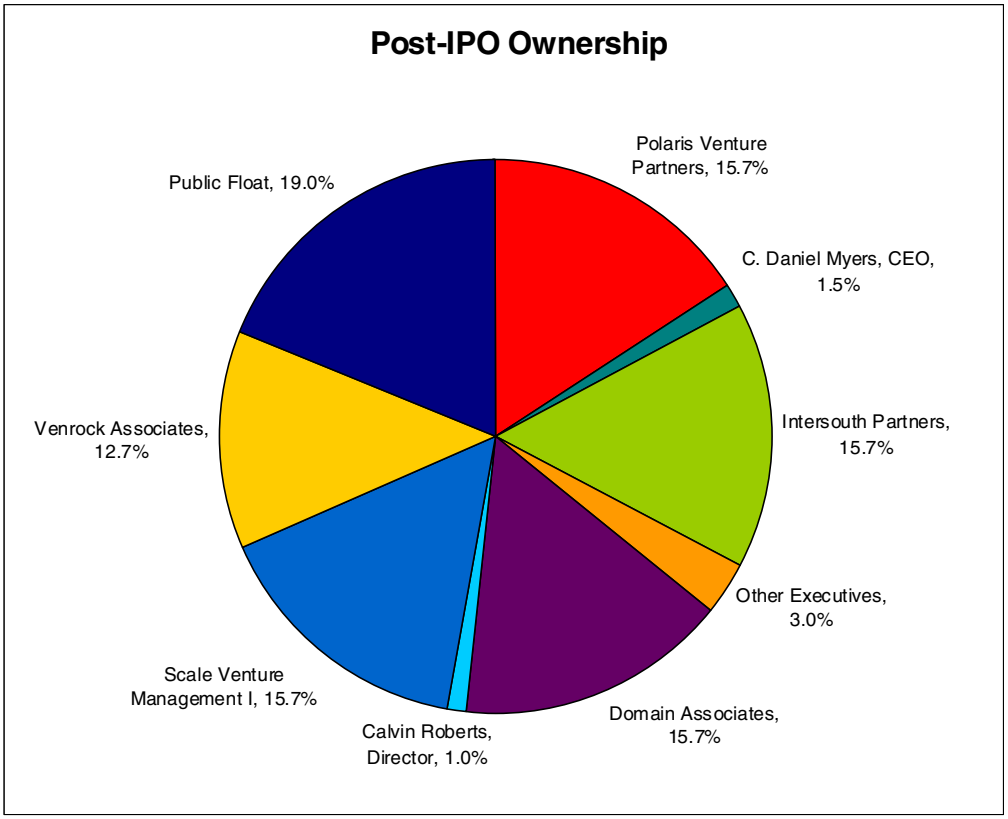
** post-IPO*

Source: Alimera IPO Prospectus dated April 22, 2010, Company data.

Insiders Own 81% Post-IPO

As shown in Exhibit 64, Alimera stock is largely held by Alimera's venture capital firms.

Exhibit 64: Alimera Post-IPO Ownership



Source: Alimera IPO Prospectus dated April 22, 2010, Credit Suisse estimates

Financial Models

See following pages for model

Exhibit 65: Alimera Summary of U.S. Revenue Model
in millions, unless otherwise stated

	FY 2007	FY 2008	FY 2009	FY 2010E	FY 2011E	FY 2012E	FY 2013E	FY 2014E	FY 2015E
Treatable Population									
Diagnosed diabetic population	17,900,000	18,347,500	18,806,188	19,276,342	19,758,251	20,252,207	20,758,512	21,277,475	21,809,412
Growth rate									
Annual incidence of DME (CSME)	232,700	238,518	244,480	250,592	256,857	263,279	269,861	276,607	283,522
% of diagnosed diabetics	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*	*1.30%*
Effectively treated by laser	(69,810)	(71,555)	(73,344)	(75,178)	(77,057)	(78,984)	(80,958)	(82,982)	(85,057)
percentage	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*	*30.0%*
New patients available	162,890	166,962	171,136	175,415	179,800	184,295	188,902	193,625	198,466
Treatable population, year end			**500,989**	**513,513**	**526,351**	**539,510**	**552,998**	**566,823**	**580,993**
(assumed = trailing 3 yrs incidence)									
Iluvien									
Market share					2.0%	5.0%	8.0%	12.0%	15.0%
Total patients					10,527	26,975	44,240	68,019	87,149
Total units sold					14,276	28,977	38,574	64,048	80,327
Price per unit (net)					$6,750	$6,750	$6,750	$6,750	$6,750
Net US sales					**$96,366**	**$195,596**	**$260,374**	**$432,321**	**$542,210**
Assumed retreatment rates									
Bilateral disease (second eye)					40%	40%	40%	40%	40%
Second treatment					50%	50%	50%	50%	50%
Third treatment					25%	25%	25%	25%	25%

Source: Company data, Credit Suisse estimates

Exhibit 66: **Alimera Income Statement Forecast**

in millions, unless otherwise stated

	FY 2007	FY 2008	FY 2009	1Q10E	2Q10E	3Q10E	4Q10E	2010E FY 2010E	FY 2011E	FY 2012E	FY 2013E	FY 2014E	FY 2015E
Iluvien - US				0					$96,366	$195,596	$260,374	$432,321	$542,210
Iluvien - ROW royalty (based on below sales)									$100	$2,074	$7,824	$10,415	$17,293
Total net sales									**$96,466**	**$197,669**	**$268,197**	**$442,736**	**$559,503**
Iluvien - ROW sales										$10,368	$39,119	$52,075	$86,464
% of prior year's US sales										11%	20%	20%	20%
COGS									3,569	7,244	9,643	16,012	20,082
Profit Sharing									10,102	28,307	41,186	73,410	94,218
Gross margin									**82,795**	**162,118**	**217,368**	**353,314**	**445,204**
R&D Expense	8,363	13,964	15,057	3,200	4,800	4,600	4,500	17,100	21,200	22,815	24,847	27,081	29,539
Marketing Expense	969	1,259	752	1,000	1,000	3,000	5,000	10,000	24,000	23,800	22,640	18,522	19,448
Sales Force Expense	0	0	0	0	0	975	2,025	3,000	12,600	13,230	13,892	14,586	15,315
Logistics	0	0	0	0	0	0	0	0	5,788	11,860	16,092	26,564	33,570
G&A	3,184	3,758	3,407	862	899	974	1,012	3,748	4,497	5,397	6,368	7,387	8,569
Psivida Expense Reimbursement	0	0	0	(200)	(200)	(795)	(1,405)	(2,600)					
Total SG&A	4,153	5,017	4,159	1,662	1,699	4,154	6,632	14,148	46,885	54,287	58,991	67,059	76,903
Total expenses	12,516	18,981	19,216	4,862	6,499	8,754	11,132	31,248	68,085	77,102	83,838	94,140	106,442
Operating Income/EBIT	**(12,516)**	**(18,981)**	**(19,216)**	**(4,862)**	**(6,499)**	**(8,754)**	**(11,132)**	**($31,248)**	**$14,710**	**$85,016**	**$133,530**	**$259,174**	**$338,762**
Interest Income	1,079	585	37	$4	$13	$47	$42	106	41	165	435	873	1,513
Interest Expense	(2)	(1,514)	(1,897)	(332)	(111)	0	0	(442)	0	0	0	0	0
Chg in Fair Value of Pfd Stk Conv Feature	1	(10,454)	(23,142)										
Pretax Income/(Loss)	($11,438)	($30,364)	($44,218)	($5,190)	($6,597)	($8,707)	($11,090)	($31,584)	$14,751	$85,181	$133,965	$260,047	$340,275
Tax Expense/(benefit), fully taxed				0	0	0	0	0	6,009	32,880	51,710	100,378	131,346
Net income from continuing operations	**($11,438)**	**($30,364)**	**($44,218)**	**($5,190)**	**($6,597)**	**($8,707)**	**($11,090)**	**($31,584)**	**$8,742**	**$52,301**	**$82,254**	**$159,669**	**$208,929**
Series A Preferred Dividends & Accretion				(534)	(534)	0	0	(1,068)	0	0	0	0	0
Series B Preferred Dividends & Accretion				(637)	(637)	0	0	(1,274)	0	0	0	0	0
Series C Preferred Dividends & Accretion				(600)	(600)	0	0	(1,200)	0	0	0	0	0
Beneficial Conversion Feature			(355)										
Preferred stock accretion	(248)	(718)	(623)	(156)				(156)					
Preferred stock dividends	(4,685)	(6,573)	(7,225)	(2,071)	(2,071)	0	0	(4,143)	0	0	0	0	0
Net income to common	**($16,371)**	**($37,655)**	**($52,421)**	**($7,417)**	**($8,669)**	**($8,707)**	**($11,090)**	**($35,882)**	**$8,742**	**$52,301**	**$82,254**	**$159,669**	**$208,929**
Wtd Avg Shares (diluted)	*1,500*	*1,510*	*1,517*	*1,618*	*21,251*	*31,061*	*31,068*	*22,220*	*33,285*	*34,575*	*35,412*	*36,199*	*37,126*
Earnings per Share (diluted)	**($10.91)**	**($24.93)**	**($34.55)**	**($4.58)**	**($0.41)**	**($0.28)**	**($0.36)**	**($1.61)**	**$0.26**	**$1.51**	**$2.32**	**$4.41**	**$5.63**
Margins & Growth													
Margin Analysis													
ROW royalty, % of sales										20.0%	20.0%	20.0%	20.0%
Gross margin, excl profit share									96.3%	96.3%	96.4%	96.4%	96.4%
Gross margin									**85.8%**	**82.0%**	**81.0%**	**79.8%**	**79.6%**
Rsch & Devel. % sales									22.0%	11.5%	9.3%	6.1%	5.3%
Marketing % sales									24.9%	12.0%	8.4%	4.2%	3.5%
Sales force % sales									13.1%	6.7%	5.2%	3.3%	2.7%
Logistics % sales									6.0%	6.0%	6.0%	6.0%	6.0%
G&A % sales									4.7%	2.7%	2.4%	1.7%	1.5%
Other % sales									0.0%	0.0%	0.0%	0.0%	0.0%
Total SG&A % sales									48.6%	27.5%	22.0%	15.1%	13.7%
EBIT margin									**15.2%**	**43.0%**	**49.8%**	**58.5%**	**60.5%**
Effective tax rate									38.6%	38.6%	38.6%	38.6%	38.6%
Net margin									9.1%	26.5%	30.7%	36.1%	37.3%
Growth Analysis													
Net sales										**104.9%**	**35.7%**	**65.1%**	**26.4%**
Gross margin										95.8%	34.1%	62.5%	26.0%
Research & Development									24.0%	7.6%	10.0%	10.0%	10.0%
Marketing									140.0%	(0.8%)	(4.9%)	(18.2%)	5.0%
Sales force									320.0%	5.0%	5.0%	5.0%	5.0%
Logistics										104.9%	35.7%	65.1%	26.4%
G&A		18.0%						10.0%	20.0%	20.0%	18.0%	16.0%	16.0%
Total SG&A									231.4%	15.8%	8.7%	13.7%	14.7%
EBIT									**(147.1%)**	**478.0%**	**57.1%**	**94.1%**	**30.7%**
Net income									(124.4%)	498.3%	57.3%	94.1%	30.9%
Earnings per Share										**475.9%**	**53.6%**	**89.9%**	**27.6%**

Source: Company data, Credit Suisse estimates

Exhibit 67: **Alimera Balance Sheet Forecast**

in millions, unless otherwise stated

	FY 2008	FY 2009	2010 1Q10	2Q10	3Q10	4Q10	FY 2010E	FY 2011E	FY 2012E	FY 2013E	FY 2014E	FY 2015E
ASSETS												
Current Assets												
Cash & cash equivalents	$17,875	$4,858	$17,014	$63,067	$56,280	$21,533	$21,533	$14,700	$86,932	$174,578	$302,594	$493,679
Accounts receivable								30,699	56,978	67,049	110,684	139,876
Inventory			0	0	0	663	663	1,564	2,411	4,003	5,020	4,292
Prepaid Expenses	1,593	634	650	665	680	697	697	767	844	928	1,021	1,123
Prelaunch Costs Receivable - pSivida								1,538	0	0	0	0
Other current assets		815	815									
Total current assets	$19,468	$6,307	$18,479	$63,732	$56,960	$22,894	$22,894	$49,268	$147,164	$246,558	$419,319	$638,970
Long-term Assets												
Property and Equipment, net	796	254	288	320	350	378	378	474	548	611	658	694
Deferred tax assets			0	0	0	0	0	46,704	13,824	0	0	0
Other assets						25,000	25,000	$22,500	$20,000	$17,500	$15,000	$12,500
TOTAL ASSETS	**$20,264**	**$6,561**	**$18,767**	**$64,052**	**$57,310**	**$48,272**	**$48,272**	**$118,946**	**$181,537**	**$264,670**	**$434,978**	**$652,163**
LIABILITIES AND EQUITY												
Current Liabilities												
Accounts Payable	$1,575	$1,758	$5,062	$6,699	$8,574	$10,512	$10,512	$14,181	$16,376	$17,487	$19,889	$22,782
Accrued Expenses	2,308	3,314	3,400	3,480	3,550	3,645	3,645	5,833	9,332	6,582	6,737	6,873
Outsourced Services Payable	1,024	1,157	1,157									
Note Payable		4,500	4,500	0	0	0	0	0	0	0	0	0
Capital Lease Obligations	10	6										
Total Current Liabilities	$4,917	$10,735	$14,119	$10,179	$12,124	$14,157	$14,157	$20,014	$25,708	$24,069	$26,626	$29,654
Long-term Liabilities												
Note Payable, less Current Portion	15,000	10,500	10,500	0	0	0	0	0	0	0	0	0
Capital Lease Obligations	6											
Profit Share Payable to pSivida								3,285	7,795	10,297	18,353	23,554
Fair Value of Pfd Stk Conv Feature	12,656	36,701	36,701	0	0	0	0	0	0	0	0	0
Other Long-term Liabilities	555	708	720	740	760	779	779	857	942	958	985	1,012
Total Long-term Liabilities	28,217	47,909	47,921	740	760	779	779	4,142	8,737	11,255	19,338	24,566
Preferred Stock												
Series A Redeemable Preferred Stock	34,199	36,467	37,053	0								
Series B Redeemable Preferred Stock	37,963	40,617	41,306	0								
Series C Redeemable Preferred Stock	30,855	33,452	34,104	0								
Series C-1 Redeemable Preferred Stock		2,853	14,625	0								
Total Preferred Stock	103,017	113,389	127,088	0								
Shareholders' Equity												
Common Stock	51	54	54	2,355	2,355	2,355	2,355	2,355	2,355	2,355	2,355	2,355
Add'l Paid-in Capital	3,474	4,836	4,836	234,697	234,697	234,697	234,697	234,697	234,697	234,697	234,697	234,697
Series C-1 Preferred Warrants		1,472	0	0	0	0	0	0	0	0	0	0
Common Stock Warrants	58	57	57	57	57	57	57	57	57	57	57	57
Retained Earnings/(deficit)	(119,470)	(171,891)	(175,308)	(183,977)	(192,684)	(203,773)	(203,773)	(142,319)	(90,018)	(7,764)	151,905	360,834
Total shareholders' equity	(115,887)	(165,472)	(170,361)	53,133	44,425	33,336	33,336	94,790	147,091	229,346	389,014	597,943
TOTAL LIABILITIES & EQUITY	**$20,264**	**$6,561**	**$18,767**	**$64,052**	**$57,310**	**$48,272**	**$48,272**	**$118,946**	**$181,537**	**$264,670**	**$434,978**	**$652,163**

Source: Company data, Credit Suisse estimates

Exhibit 68: **Alimera Cash Flow Statement Forecast**

in millions, unless otherwise stated

	FY 2008	FY 2009	2010 1Q10	2Q10	3Q10	4Q10	FY 2010E	FY 2011E	FY 2012E	FY 2013E	FY 2014E	FY 2015E
STATEMENT OF CASH FLOWS												
Net income/(loss)	($61,464)	($44,218)	($1,190)	($6,597)	($8,707)	($11,090)	($27,584)	$61,455	$52,301	$82,254	$159,669	$208,929
Depreciation & Amortization	241	1,098	$16	$18	$20	$22	$76	104	126	137	153	165
Change in Fair Value of Pfd Stk Conv Feature	10,454	23,142	0									
Stock Compensation Expense	750	551										
Noncash R&D Expense	17,809	300										
Change in Current Assets:												
Decr/(Incr) in Accounts Receivable			0	0	0	0	0	(30,699)	(26,279)	(10,072)	(43,635)	(29,192)
Decr/(Incr) in Inventory			0	0	0	(663)	(663)	(900)	(847)	(1,592)	(1,017)	729
Decr/(Incr) in Prepaid Expenses	(1,213)	591	(16)	(15)	(15)	(17)	(63)	(70)	(77)	(84)	(93)	(102)
Decr/(Incr) in Prelaunch Costs Recvbl			0	0	0	0	0	(1,538)	1,538	0	0	0
Decr/(Incr) in Other Curr. Assets			0	815	0	0	815	0	0	0	0	0
Change in Current Liabilities:												
Incr/(decr) in Accounts Payable	615	183	3,304	1,637	1,875	1,937	8,754	3,669	2,195	1,111	2,402	2,893
Incr/(decr) in Accr. Exps. & Other Curr. Liabs.	85	705	80	(1,077)	70	95	(832)	2,187	3,500	(2,750)	155	136
Change in Other Assets & Liabilities:												
Decr/(Incr) in defd tax assets			0	0	0	0	0	(46,704)	32,880	13,824	0	0
Decr/(Incr) in other long-term assets	24		0	0	0	(25,000)	(25,000)	2,500	2,500	2,500	2,500	2,500
Incr/(Decr) in other long-term liabs.	540	153	12	20	20	19	71	78	86	16	27	27
Incr/(decr) in profit split payable			0	0	0	0	0	3,285	4,510	2,501	8,056	5,202
Cash from Discontinued Operations	43	(43)										
Cash from Operating Activities	**($32,116)**	**($17,538)**	**$2,206**	**($5,199)**	**($6,737)**	**($34,697)**	**($44,427)**	**($6,633)**	**$72,432**	**$87,846**	**$128,216**	**$191,285**
Purchase of PP&E	(640)	(65)	($50)	($50)	($50)	($50)	($200)	(200)	(200)	(200)	(200)	(200)
Other												
Cash from Investing Activities	**(640)**	**(65)**	**($50)**	**($50)**	**($50)**	**($50)**	**($200)**	**($200)**	**($200)**	**($200)**	**($200)**	**($200)**
Increase/(Decr.) in Note Payable			0	(15,000)	0	0	(15,000)	0	0	0	0	0
Proceeds from Series C Stock Offering	29,938											
Proceeds from Series C-1 Stock Offering		4,897										
Proceeds from Exercise of Stock Options		7										
Repurchase of Common Stock	(150)											
Proceeds from Common Stock Offering				$66,302			$66,302					
Proceeds from Exercise of Warrants	6	31	$10,000				$10,000					
Deferred Offering Costs		(339)										
Payments on Capital Lease Obligations	(10)	(10)										
Cash from Financing Activities	**$29,784**	**$4,586**	**$10,000**	**$51,302**	**$0**	**$0**	**$61,302**	**$0**	**$0**	**$0**	**$0**	**$0**
Net Increase/(Decrease) in Cash	**($2,972)**	**($13,017)**	**$12,156**	**$46,053**	**($6,787)**	**($34,747)**	**$16,675**	**($6,833)**	**$72,232**	**$87,646**	**$128,016**	**$191,085**
Cash at beginning of year	20,847	17,875	$4,858	$17,014	$63,067	$56,280	$4,858	21,533	14,700	86,932	174,578	302,594
Cash at end of year	**$17,875**	**$4,858**	**$17,014**	**$63,067**	**$56,280**	**$21,533**	**$21,533**	**$14,700**	**$86,932**	**$174,578**	**$302,594**	**$493,679**

Source: Company data, Credit Suisse estimates

Companies Mentioned *(Price as of 01 Jun 10)*
Affymax, Inc. (AFFY, $19.83)
Alimera Sciences (ALIM, $9.34, OUTPERFORM, TP $16.00)
Allergan Inc (AGN, $58.65)
Bayer (BAYGn.DE, Eu45.82, NEUTRAL, TP Eu52.00, OVERWEIGHT)
Cadence Pharmaceuticals (CADX, $7.28)
Clinical Data, Inc. (CLDA, $16.09)
Ironwood Pharmaceuticals (IRWD, $11.23)
Novartis (NOVN.VX, SFr51.91, NEUTRAL, TP SFr59.00, OVERWEIGHT)
Optimer Pharmaceuticals (OPTR, $10.07)
pSivida Corp. (PSDV, $3.65)
Regeneron Pharmaceutical (REGN, $27.66, OUTPERFORM [V], TP $32.00)
Roche (ROG.VX, SFr158.60, OUTPERFORM, TP SFr200.00, OVERWEIGHT)
Savient Pharmaceuticals, Inc. (SVNT, $12.00)
Vivus, Inc. (VVUS, $12.20)

Disclosure Appendix

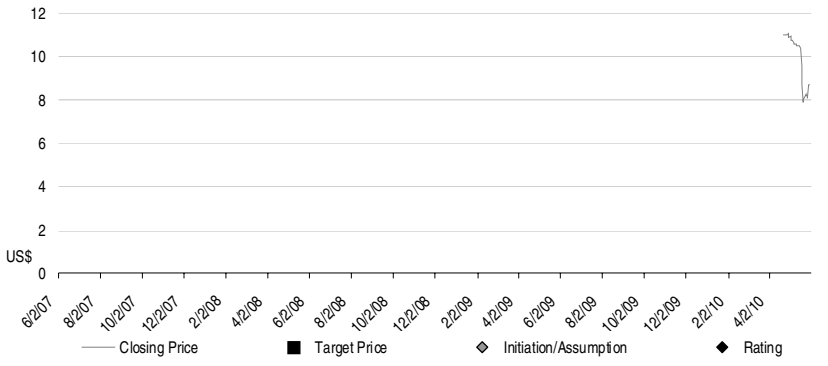
Important Global Disclosures

I, Michael Faerm, certify that (1) the views expressed in this report accurately reflect my personal views about all of the subject companies and securities and (2) no part of my compensation was, is or will be directly or indirectly related to the specific recommendations or views expressed in this report.

See the Companies Mentioned section for full company names.

3-Year Price, Target Price and Rating Change History Chart for ALIM

ALIM Date	Closing Price (US$)	Target Price (US$)	Rating	Initiation/ Assumption



O=Outperform; N=Neutral; U=Underperform; R=Restricted; NR=Not Rated; NC=Not Covered

The analyst(s) responsible for preparing this research report received compensation that is based upon various factors including Credit Suisse's total revenues, a portion of which are generated by Credit Suisse's investment banking activities.

Analysts' stock ratings are defined as follows:

Outperform (O): The stock's total return is expected to outperform the relevant benchmark* by at least 10-15% (or more, depending on perceived risk) over the next 12 months.
Neutral (N): The stock's total return is expected to be in line with the relevant benchmark* (range of ±10-15%) over the next 12 months.

Underperform (U): The stock's total return is expected to underperform the relevant benchmark* by 10-15% or more over the next 12 months.
Relevant benchmark by region: As of 29th May 2009, Australia, New Zealand, U.S. and Canadian ratings are based on (1) a stock's absolute total return potential to its current share price and (2) the relative attractiveness of a stock's total return potential within an analyst's coverage universe, with Outperforms representing the most attractive, Neutrals the less attractive, and Underperforms the least attractive investment opportunities. Some U.S. and Canadian ratings may fall outside the absolute total return ranges defined above, depending on market conditions and industry factors. For Latin American, Japanese, and non-Japan Asia stocks, ratings are based on a stock's total return relative to the average total return of the relevant country or regional benchmark; for European stocks, ratings are based on a stock's total return relative to the analyst's coverage universe**. For Australian and New Zealand stocks a 22% and a 12% threshold replace the 10-15% level in the Outperform and Underperform stock rating definitions, respectively, subject to analysts' perceived risk. The 22% and 12% thresholds replace the +10-15% and -10-15% levels in the Neutral stock rating definition, respectively, subject to analysts' perceived risk.*
***An analyst's coverage universe consists of all companies covered by the analyst within the relevant sector.*
Restricted (R): In certain circumstances, Credit Suisse policy and/or applicable law and regulations preclude certain types of communications, including an investment recommendation, during the course of Credit Suisse's engagement in an investment banking transaction and in certain other circumstances.

Volatility Indicator [V]: A stock is defined as volatile if the stock price has moved up or down by 20% or more in a month in at least 8 of the past 24 months or the analyst expects significant volatility going forward.

Analysts' coverage universe weightings are distinct from analysts' stock ratings and are based on the expected performance of an analyst's coverage universe* versus the relevant broad market benchmark:**
Overweight: Industry expected to outperform the relevant broad market benchmark over the next 12 months.
Market Weight: Industry expected to perform in-line with the relevant broad market benchmark over the next 12 months.
Underweight: Industry expected to underperform the relevant broad market benchmark over the next 12 months.
**An analyst's coverage universe consists of all companies covered by the analyst within the relevant sector.*
***The broad market benchmark is based on the expected return of the local market index (e.g., the S&P 500 in the U.S.) over the next 12 months.*

Credit Suisse's distribution of stock ratings (and banking clients) is:

	Global Ratings Distribution	
Outperform/Buy*	45%	(62% banking clients)
Neutral/Hold*	40%	(60% banking clients)
Underperform/Sell*	13%	(55% banking clients)
Restricted	2%	

**For purposes of the NYSE and NASD ratings distribution disclosure requirements, our stock ratings of Outperform, Neutral, and Underperform most closely correspond to Buy, Hold, and Sell, respectively; however, the meanings are not the same, as our stock ratings are determined on a relative basis. (Please refer to definitions above.) An investor's decision to buy or sell a security should be based on investment objectives, current holdings, and other individual factors.*

Credit Suisse's policy is to update research reports as it deems appropriate, based on developments with the subject company, the sector or the market that may have a material impact on the research views or opinions stated herein.

Credit Suisse's policy is only to publish investment research that is impartial, independent, clear, fair and not misleading. For more detail please refer to Credit Suisse's Policies for Managing Conflicts of Interest in connection with Investment Research: http://www.csfb.com/research-and-analytics/disclaimer/managing_conflicts_disclaimer.html

Credit Suisse does not provide any tax advice. Any statement herein regarding any US federal tax is not intended or written to be used, and cannot be used, by any taxpayer for the purposes of avoiding any penalties.

See the Companies Mentioned section for full company names.
Price Target: (12 months) for (ALIM)
Method: Our $16 target price for ALIM is based on a discounted cash flow analysis (DCF). We have estimated ALIM's future cash flows by forecasting the company's income statement, balance sheet and cash flows through 2020 (the year of patent expiration), and by assuming a fading of cash flows to zero by 2030, with no terminal value. We have used this methodology because we believe that the vast majority of ALIM's value is attributable to a a single product, Iluvien, with a finite commercial life. We have applied a 75% probability of success adjustment to our cash flow estimates to account for the risks to approval and launch of the Iluvien. We have used a 12% discount rate for our DCF, applied to the probability-adjusted cash flows. Our ALIM revenue forecast is based on our estimates for the addressable patient population in diabetic macular edema, and our assumption that Iluvien will achieve a peak penetration rate of 15%.
Risks: Risks to our $16 target price include: (1) single product risk (ALIM's value is virtually entirely attributable to Iluvien, and the company's near to medium term revenues, profits and value depend on the FDA's approval and Alimera's successful commercialization of Iluvien in diabetic macular edema. There is little visibility on additional indications for Iluvien or on the new product pipeline; (2) regulatory risk to timely Iluvien approval, due to missed statistical significance on the MART data set, the possibility that the FDA may wait for 3 year FAME data before issuing an approval decision, and the the possibility that FDA may not grant priority review; (3) commercial risk, due to the presence of several established treatments for DME and competing companies that are better-capitalized and have a longer-standing presence in the ophthalmology community than ALIM; (4) liquidity and financing risk, due to the potential need for ALIM to raise additional funds, particularly if Iluvien approval is delayed beyond the expected

December 2010; and (5) reimbursement risk, as securing reimbursement from payors is crucial to Iluvien's success and the fact that Iluvien will compete against some relatively inexpensive products.

Please refer to the firm's disclosure website at www.credit-suisse.com/researchdisclosures for the definitions of abbreviations typically used in the target price method and risk sections.

See the Companies Mentioned section for full company names.
The subject company (ALIM) currently is, or was during the 12-month period preceding the date of distribution of this report, a client of Credit Suisse.
Credit Suisse provided investment banking services to the subject company (ALIM) within the past 12 months.
Credit Suisse provided non-investment banking services, which may include Sales and Trading services, to the subject company (ALIM) within the past 12 months.
Credit Suisse has managed or co-managed a public offering of securities for the subject company (ALIM) within the past 12 months.
Credit Suisse has received investment banking related compensation from the subject company (ALIM) within the past 12 months.
Credit Suisse expects to receive or intends to seek investment banking related compensation from the subject company (ALIM) within the next 3 months.
Credit Suisse has received compensation for products and services other than investment banking services from the subject company (ALIM) within the past 12 months.
As of the date of this report, Credit Suisse Securities (USA) LLC makes a market in the securities of the subject company (ALIM).

Important Regional Disclosures

Singapore recipients should contact a Singapore financial adviser for any matters arising from this research report.

The analyst(s) involved in the preparation of this report have not visited the material operations of the subject company (ALIM) within the past 12 months.

Restrictions on certain Canadian securities are indicated by the following abbreviations: NVS--Non-Voting shares; RVS--Restricted Voting Shares; SVS--Subordinate Voting Shares.
Individuals receiving this report from a Canadian investment dealer that is not affiliated with Credit Suisse should be advised that this report may not contain regulatory disclosures the non-affiliated Canadian investment dealer would be required to make if this were its own report.
For Credit Suisse Securities (Canada), Inc.'s policies and procedures regarding the dissemination of equity research, please visit http://www.csfb.com/legal_terms/canada_research_policy.shtml.

As of the date of this report, Credit Suisse acts as a market maker or liquidity provider in the equities securities that are the subject of this report.

Principal is not guaranteed in the case of equities because equity prices are variable.

Commission is the commission rate or the amount agreed with a customer when setting up an account or at anytime after that.

CS may have issued a Trade Alert regarding this security. Trade Alerts are short term trading opportunities identified by an analyst on the basis of market events and catalysts, while stock ratings reflect an analyst's investment recommendations based on expected total return over a 12-month period relative to the relevant coverage universe. Because Trade Alerts and stock ratings reflect different assumptions and analytical methods, Trade Alerts may differ directionally from the analyst's stock rating.
The author(s) of this report maintains a CS Model Portfolio that he/she regularly adjusts. The security or securities discussed in this report may be a component of the CS Model Portfolio and subject to such adjustments (which, given the composition of the CS Model Portfolio as a whole, may differ from the recommendation in this report, as well as opportunities or strategies identified in Trading Alerts concerning the same security). The CS Model Portfolio and important disclosures about it are available at www.credit-suisse.com/ti.

To the extent this is a report authored in whole or in part by a non-U.S. analyst and is made available in the U.S., the following are important disclosures regarding any non-U.S. analyst contributors:
The non-U.S. research analysts listed below (if any) are not registered/qualified as research analysts with FINRA. The non-U.S. research analysts listed below may not be associated persons of CSSU and therefore may not be subject to the NASD Rule 2711 and NYSE Rule 472 restrictions on communications with a subject company, public appearances and trading securities held by a research analyst account.

For Credit Suisse disclosure information on other companies mentioned in this report, please visit the website at www.credit-suisse.com/researchdisclosures or call +1 (877) 291-2683.
Disclaimers continue on next page.

CREDIT SUISSE SECURITIES (USA) LLC
United States of America: +1 (212) 325-2000