**COMPANY NOTE**

Initiating Coverage

USA | Healthcare | Pharmaceuticals/Specialty

January 26, 2012

Jefferies

# Pacira Pharmaceuticals (PCRX)

## Initiating at Buy; No Pleasure Without Pain

**BUY**

Price target $18.00

Price $9.06

EQUITY RESEARCH AMERICAS

### Key Takeaway

**We are initiating on PCRX with a BUY and an $18 target. Although investors are sour on new launches, we find tremendous value in Exparel: 1) no competition, 2) unlikely generics, 3) low fixed cost infrastructure and 100% economics, 4) not changing the practice of medicine, and 5) experienced commercial management team. Last, expectations are low, valuation is cheap, and $15M in 2012 sales seems beatable.**

*In Nov '11, Jefferies acted as joint book-runner on PCRX's follow-on offering, which was priced at $6.50/share and raised $49M net proceeds.*

**Exparel Is One of a Kind**. Unlike other recent new drug launches where estimates were too high, we think sell- and buy-side expectations are low and that our $15M in 2012 Exparel sales is beatable, and an enterprise value of only $130M seems to more than discount this.

**72 hours vs. 8 hours Is a No Brainer**. Exparel was approved in Oct 2011 and will be launched in April. Efficacy improves pain scores up to 72 hours after surgery -- beating both placebo and IR bupivicaine (lasts only 8 hours). Because IR bupivicaine is already injected post surgically about 24M times per year, Pacira does not need to change the practice of surgical medicine - just *the* medicine. Pacira has also shown a dramatic 45-50% reduction in opioid use to treat the pain. This leads directly to fewer side effects and related costs.

**Worth the Price**. Since approval, Pacira has been working with hospital formularies (using their own data) to demonstrate that the side effects from opioid use leads to longer stays and higher costs. A recent Barnabas study found that 2.7% of 3,654 hysterectomy patients were "outliers" due to an extended length of stay due to twice the opioid consumption; these had costs of $14,275 vs. controls of only $5,745. As Pacira continues to show that Exparel can actually help hospitals *make* money by lowering opioid use and preventing costly complications, the uptake should be strong.

### Valuation/Risks

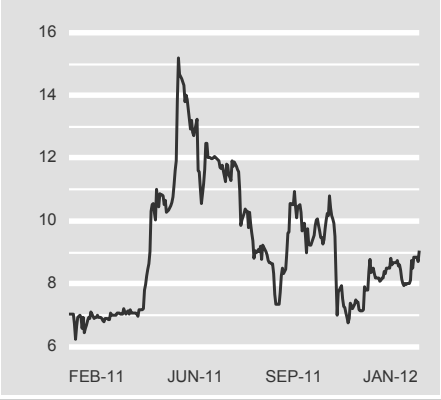
We have Exparel growing from $15M in 2012 to $210M in 2015 and this drives EPS in the same years from a loss of $2.07 to a profit of $2.86. This seems easily achievable given the small fraction of the market it needs to obtain. We use a DCF methodology to derive our $18 PT with $12/sh. from cash flows through 2021, a $4/sh. terminal value, and $2 cash/sh. The biggest risk is an even slower than expected uptake for Exparel since this is truly the only driver for the company.

| USD | Prev. | 2011E | Prev. | 2012E | Prev. | 2013E | Prev. | 2014E |
|---|---|---|---|---|---|---|---|---|
| Rev. (MM) | -- | 15.3 | -- | 31.5 | -- | 92.7 | -- | 154.7 |
| Consensus | -- | (2.44) | -- | (1.72) | -- | 0.04 | -- | 1.86 |
| **EPS** | | | | | | | | |
| Mar | -- | (0.98)A | -- | (0.49) | -- | -- | -- | -- |
| Jun | -- | (0.51)A | -- | (0.64) | -- | -- | -- | -- |
| Sep | -- | (0.55)A | -- | (0.53) | -- | -- | -- | -- |
| Dec | -- | (0.57) | -- | (0.41) | -- | -- | -- | -- |
| FY Dec | -- | (2.44) | -- | (2.07) | -- | (0.68) | -- | 1.26 |
| FY P/E | | NM | | NM | | NM | | 7.2x |

| Financial Summary | |
|---|---|
| Book Value/Share: | $3.00 |
| Net Debt (MM): | ($44.0) |
| **Market Data** | |
| 52 Week Range: | $15.34 - $6.16 |
| Total Entprs. Value (MM): | $175.3 |
| Market Cap. (MM): | $219.3 |
| Insider Ownership: | 63.0% |
| Institutional Ownership: | 12.2% |
| Shares Out. (MM): | 24.2 |
| Float (MM): | 16.1 |
| Avg. Daily Vol.: | 292,753 |

**Corey Davis, Ph.D.** *
Equity Analyst
(212) 336-7187 cdavis@jefferies.com
**Oren G. Livnat, CFA** *
Equity Associate
(212) 284-2214 olivnat@jefferies.com
**Matthew Weiss, CFA** *
Equity Associate
(212) 707-6446 mweiss@jefferies.com
**Graig Suvannavejh, Ph.D.** *
Equity Analyst
(212) 284-2170 gsuvannavejh@jefferies.com
* Jefferies & Company, Inc.

**Price Performance**



# Pacira Pharmaceuticals

## Buy: $18 Price Target

THE LONG VIEW

### Scenarios

#### Target Investment Thesis

- Exparel represents an ideal drug for a small company to launch on its own:
  - Highly differentiated
  - Cost effective
  - No competition
  - Huge market
  - Small cost structure
  - Unlikely generics
- $18 PT – based on Exparel cash flows through 2021, discounted at 15% (terminal value @ 20%).

#### Upside Scenario

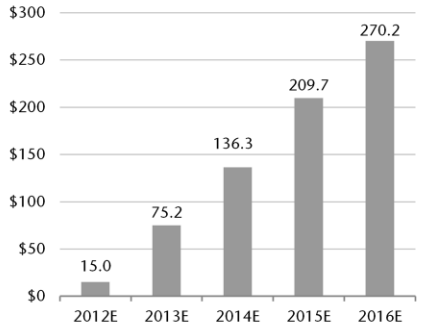
- If Exparel sells more than $15M in 2012, it would be upside to our projections.
- Faster than expected formulary adoption at hospitals would lower the discount rate with higher conviction that peak sales of $400M are beatable.
- Attractive as a take-out since PCRX owns 100% economics on Exparel.
- $30 stock – using a lower 10% discount rate and a faster ramp of Exparel sales.

#### Downside Scenario

- If it takes longer than expected to secure formulary access and sales ramp slower than our modest expectations, peak potential would be questioned.
- If the company fails to secure an upfront payment from outlicensing ex-US rights, it would likely create a financing overhang and the need to issue more equity in 2013.
- A $4 stock would likely result from a sales ramp that generates <$10M in 2012 sales.

### Long Term Analysis

#### Exparel End User Sales ($M)




Source: Jefferies estimates

#### Long Term Financial Model Drivers

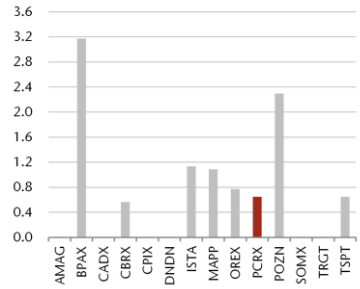
| | |
|---|---|
| '12-'16 Revenue CAGR | 74% |
| '14-'16 EPS CAGR | 77% |

GM Expansion:
8.6% in '12 to 77% in '16

#### Other Considerations

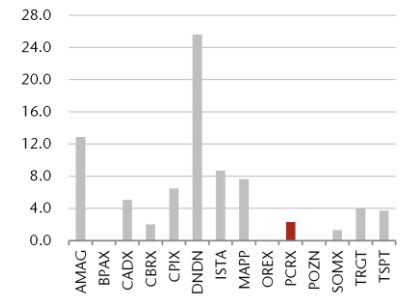
There are ~45M annual surgeries in the U.S., and ~24M wound infiltration oppy's. About 16M of these are soft-tissue procedures that are the immediate target for Exparel. At a cost of $285/procedure, it equates to a ~$4.5B *branded* market. PCRX has 63 sales reps, that can cover ~80% of the hospital targets but only 100 hospitals generate 20% of the volume.

#### 2015 EV/Revenue




Source: Capital IQ

#### 2015 P/E




Source: Capital IQ

Recommendation / Price Target

| Ticker | Rec. | PT |
|---|---|---|
| AMAG | Underperform | $12 |
| BPAX | Hold | $0.70 |
| CADX | NC | - |
| CPIX | NC | - |
| DNDN | NC | - |
| ISTA | NC | - |
| MAPP | NC | - |
| OREX | Hold | $3 |
| PCRX | Buy | $18 |
| POZN | Hold | $4 |
| SOMX | Buy | $2 |

### Catalysts

- April '12: Full U.S. launch of Exparel
- 2H:12: Evidence that launch is gaining traction from sales/Rx data
- 2012: Potential ex-U.S. partnering
- 2013: Completion of C Suite Buildout
- 2013/'14: Advancement of trials for add'l indications/potential sNDA filings
- 2013+: Potential advancement of DepoMethotrexatae/DepoNSAID

### Company Description

Pacira Pharmaceuticals, Inc. engages in the development, commercialization, and manufacture of pharmaceutical products for hospitals and ambulatory surgery centers. It provides its pharmaceutical products based on DepoFoam drug delivery technology. The company's product portfolio consists of EXPAREL, an FDA-approved, long-acting bupivacaine product for postsurgical pain management; DepoCyt for the treatment of lymphomatous meningitis; DepoDur for controlling post-operative pain; DepoNSAID, which is in preclinical trials for the acute pain; and DepoMethotrexate that is in preclinical trials for the treatment of rheumatoid arthritis oncology. Pacira is based in Parsippany, New Jersey.



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

# Executive Summary

Exparel could be the "Holy Grail" of post-surgical pain management.

**We initiate coverage on Pacira Pharmaceuticals with a Buy rating and $18 price target.** Pacira Pharmaceuticals is an integrated commercial-stage specialty pharmaceutical company leveraging its validated DepoFoam manufacturing technology to soon launch a differentiated controlled-release non-opioid product for post-surgical pain management. Pacira is currently collecting (minimal) royalties on two approved products, but the primary value driver is the commercialization of recently approved Exparel (bupivacaine liposome injectable suspension), PCRX's long-acting bupivacaine for post-surgical analgesia that we believe could eventually be a game-changer in the treatment paradigm.

**It's All About Exparel: FDA Approved and Launching in April.** The FDA approved Exparel – long acting bupivacaine – on October 28 with a broad label for post-surgical single-dose wound "infiltration." Long-acting injectable bupivacaine has been considered by many a "Holy Grail" target given that generic IR 'caines are so widely used yet have a disappointingly short duration of action (<8 hours). That short-lived efficacy requires that patients receive additional pain management, most often opioids (e.g., morphine) which are associated with adverse events and increased length of hospital stay, hence worse patient experience and a higher cost of care. Exparel, with up to 72 hours of pain relief, provides an obvious efficacy advantage vs. IR, clear opioid sparing, and safety/ convenience/cost advantages vs. alternatives such as PCA (patient controlled analgesia) pumps and elastomeric bags. Importantly, Exparel is administered in the same fashion as current IR bupivacaine, so it doesn't require any change in physician practice.

**Large Concentrated Market**. There are ~45M annual surgeries in the U.S., and ~24M wound infiltration opportunities. Pacira will target ~16M soft-tissue procedures as the most relevant target market for the current indication. At a cost of $285/procedure, it equates to a ~$4.5B *branded* market. The top-100 facilities perform about 20% of target procedures, the top-100 >50%, and the top-4 GPO's cover >70%. Pacira already has its 63 sales reps in the filed working on obtaining payer acceptance and covering ~80% of market. *We model a modest initial ramp ($15M in '12) climbing to $270M in 2016, representing ~1M procedures/year. We see peak U.S. sales ~$400M.* This disregards potential label expansion to nerve block & epidurals.

**Why PCRX Can Break the Formulary Glass Ceiling: Preparation & Differentiation.** Investors have rightfully taken a 'short-the-launch' perspective in general – especially for smaller pharmaceutical companies launching their own products. The market is particularly skeptical given recent disappointing launches by small companies into the hospital markets, namely Cumberland (CPIX, $5.94, NC) with Caldolor and Cadence (CADX, $4.27, NC) with Ofirmev. Even Forest's (FRX, $31.80, Buy) launch of its antibiotic, Teflaro, has been very weak. However, we believe Exparel is a much more differentiated product that those, with a much more obvious value proposition to physicians and payers. At launch, PCRX will have already meaningfully "primed-the-pump" with ~50 publications & 2,000 customer interactions, high-profile industry exposure, and most importantly impressive pharmacoeconomic data showing that Exparel saves money by preventing opioid side effects. Pacira has what we believe is unprecedented pre-launch GPO buy-in for a small company, partnering with Premier and VHA, which should help expedite formulary adoption. Pacira already has internal champions at key target institutions, and has already been meeting the key hospital gatekeepers – pharmacy & therapeutics committees (P&T). Note that PCRX is attempting to sell savings, rather than incremental spend, particularly in this era of *capitation* (contracted fixed procedure reimbursement). Current ineffective or labor-intensive pain treatments and AE-causing opioids drive up hospital costs, and Exparel should present a



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

tantalizing alternative. Even many hospitals were not aware of their own high costs from opioid side effects until Pacira began suggesting studies to examine the effects.

**Management Has Done It Before**. Pacira management previously launched Angiomax at the Medicines Company (MDCO, $19.31, Hold) in 2001. That too was a launch into the hospital surgical market aiming to replace an extremely cheap yet less-than-ideal generic heparin with a relatively expensive (>$400) product with a different profile. In that case, using the same contract sales organization as for Exparel now, and in a market with ~1M annual relevant annual procedures, Angiomax has developed into what is now a ~$450M product. While we are certainly in a tighter cost containment environment now (vs. 2001) Exparel targets a *much* larger volume market (~25M procedures).

We expect the Exparel launch to be extremely slow in 2012 as hospital formulary acceptance will take time.

**Modest Initial Ramp, But Low Hanging 'Plastic' Fruit**. Hospital formulary adoption will take time (6-12 months). Hence we see many of the earliest adopters in "cash-pay" plastic surgery markets for elective procedures. There are ~500K patients (~1M applications; largely breast implants and liposuctions), with PCRX reps covering 83% of the market. Exparel already received substantial interest at ASPS (American Society of Plastic Surgeons; September, 2011), and given the likely advantage in patient satisfaction with 72-hour bupivacaine, and the relatively minor incremental patient cost, surgeons should be eager. In hospitals, the likely earliest utilization will be in replacing elastomeric bags, the only current means to deliver long-acting non-opioid analgesia (usually bupivacaine). Elastomeric bags require patient catheterization at the surgical site, which 1) tethers the patient, limiting ambulation and prevents discharge, and 2) raises infection risk. Further, these infusion devices have a history of malfunction and misuse. There are >1M elastomeric bag uses annually and they cost about the same per patient as Exparel.

**No Competition In Sight: We Don't Expect Generics, Ever.** Pacira has issued patents (recently allowed Exparel patent with composition claims to Sept 2018) and pending patents (to 2022) on DepoFoam and Exparel, but in our view, the nature of the product and its manufacture alone present an *extremely* high generic hurdle. First, we believe it unlikely FDA would grant bioequivalence to any generic with a significantly different delivery mechanism without *clinical* trials. Second, the DepoFoam manufacturing process is highly complex/difficult, involving aseptic procedures, intermediate emulsions, cold-chain distribution, etc. PCRX's DepoFoam scale up has been a long road, and we estimate a generic challenger would require seven years and $100M to duplicate it. Pacira's DepoCyt(e) has had no generic challenge despite lacking U.S. patent protection for >5 years. On the brand competition front, the only other ER bupivacaine in late-stage development, Durect's (DRRX, $0.79, NC) Posidur, failed in Phase 3, and we assume its development will be terminated.

## Valuation

Given what we see as a low risk of Exparel genericization, we believe an extended DCF based valuation is appropriate – yielding an $18 target.

**Our 12-month price target is $18.** Given what we see as extremely low risk of Exparel genericization, we believe an extended DCF based valuation is appropriate. We model Exparel sales reaching $270M by 2016 and ~$400M peak (just U.S. and just wound infiltration), and gross margins increasing significantly with scale (large fixed overhead component). We model full-year profitability and positive free-cash-flow in 2014. Discounted cash flows through 2021 yield present value of ~$12/share using a conservative 15% discount rate, and we ascribe $4/share terminal value using more conservative assumptions of -10% terminal growth and a higher 20% discount rate, plus ~$2/share net cash. We believe conservative terminal growth and discounts are appropriate given the current context of an as yet un-launched drug driving the entire valuation. Further, even after the most recent financing, we estimate that PCRX will still scrape the bottom of the cash barrel in 2013, potentially necessitating additional modest


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

financing (perhaps from ex-U.S. partnering and not necessarily from further equity issuance).

**Exhibit 1: PCRX DCF Yields $18 Valuation**

| | 2011E | 2012E | 2013E | 2014E | 2015E | 2016E | 2017E | 2018E | 2019E | 2020E | 2021E |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Revenue | 15.3 | 31.5 | 92.7 | 154.7 | 228.3 | 288.8 | 346.5 | 388.1 | 426.9 | 461.1 | 484.2 |
| Gross Profit | 2.0 | 2.7 | 46.6 | 105.0 | 168.5 | 222.2 | 275.4 | 314.2 | 345.6 | 373.3 | 392.0 |
| Adj. Operating Profit | (34.9) | (49.4) | (14.8) | 39.3 | 101.3 | 152.2 | 199.3 | 234.8 | 262.6 | 285.9 | 300.2 |
| *op margin* | | | *-16%* | *25%* | *44%* | *53%* | *58%* | *61%* | *62%* | *62%* | *62%* |
| - Taxes | 0.0 | 0.0 | 0.0 | 0.0 | (12.4) | (27.6) | (48.7) | (84.5) | (94.5) | (102.9) | (108.1) |
| NOPAT | (34.9) | (49.4) | (14.8) | 39.3 | 88.9 | 124.6 | 150.5 | 150.3 | 168.0 | 183.0 | 192.1 |
| +D&A | 3.6 | 4.4 | 6.7 | 8.1 | 10.6 | 13.1 | 15.4 | 16.9 | 18.1 | 19.1 | 19.6 |
| -Capital Expenditures | (4.8) | (21.8) | (4.6) | (4.6) | (5.7) | (7.8) | (8.7) | (9.3) | (9.8) | (10.1) | (10.2) |
| -Change in working capital | (2.8) | 4.0 | (1.0) | (13.4) | (17.1) | (8.9) | 20.8 | 23.3 | 0.0 | 0.0 | 0.0 |
| **Free Cash Flow Firm** | **($39)** | **($63)** | **($14)** | **$29** | **$77** | **$121** | **$178** | **$181** | **$176** | **$192** | **$202** |

| | | Disc. Rate | | |
|---|---|---|---|---|
| **NPV of Cash Flows 2011 - 2021** | **$352** | 15.0% | Terminal Growth Rate | -10.0% |
| Plus: NPV of Terminal Value | **$117** | 20.0% | **Terminal Value** | 726 |
| Enterprise Value | $469 | | Implied FCF Multiple | 3.6x |
| Plus: Excess Cash, Securities & Other | $37 | | | |
| Plus: Cash from Secondary | $49 | | | |
| Firm Value | $556 | | | |
| Less: MV of Debt | $29 | | | |
| Less: MV of Preferred Stock | $0 | | | |
| **Equity Value** | **527** | | | |
| # Of Shares Outstanding | 29.1 | including 3.5M FD anti-dilutive shares | | |
| **DCF Value per Share** | **$18** | | | |

**Source: Company reports, Jefferies & Co. estimates**

From a comparable multiples perspective, our $18 target implies 2014 EV/REV multiple of 3x, which is approximately in-line with the'14 average for mature integrated specialty pharmaceuticals companies. On a P/E basis, applying the current spec pharma '13 average ~11x P/E to our PCRX 2015 (2nd full-year of profitability) EPS of $2.86 then discounting back 4 years at 15% also yields our current $18 target.

**Exhibit 2: Mature Specialty Pharma Multiples (consensus ests.)**

| | | | 1/25/2012 | ($MM) | | EV / REVENUE | | | EV / EBITDA | | | P/E | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Company | Ticker | Rating | Price ($) | Mcap | EV | 2011E | 2012E | 2013E | 2011E | 2012E | 2013E | 2011E | 2012E | 2013E |
| **Allergan** | **AGN** | HOLD | **$ 89.30** | 27,239 | 26,579 | 4.9x | 4.5x | 4.2x | 14.1x | 13.0x | 11.5x | 24.5x | 21.2x | 18.7x |
| **Alkermes** | **ALKS** | BUY | **$ 19.05** | 2,469 | 2,697 | 9.0x | 5.4x | 4.8x | nm | nm | nm | nm | nm | nm |
| **Endo** | **ENDP** | BUY | **$ 37.36** | 4,365 | 7,607 | 2.8x | 2.4x | 2.3x | 7.5x | 6.0x | 5.8x | 8.1x | 6.8x | 6.4x |
| **Forest** | **FRX** | BUY | **$ 31.80** | 8,495 | 6,291 | 1.4x | 1.8x | 1.8x | 4.1x | 9.2x | 10.3x | 7.7x | nm | nm |
| **Jazz** | **JAZZ** | BUY | **$ 45.96** | 2,583 | 2,470 | 9.2x | 5.2x | 4.4x | nm | nm | nm | 14.3x | 11.1x | 9.3x |
| **Medicis** | **MRX** | BUY | **$ 32.35** | 2,041 | 1,436 | 2.0x | 1.7x | 1.5x | 5.4x | 4.8x | 4.2x | 14.0x | 12.4x | 11.0x |
| **Salix** | **SLXP** | BUY | **$ 46.00** | 2,720 | 2,558 | 4.8x | 3.5x | 2.7x | 14.2x | 9.3x | 6.4x | 18.9x | 17.7x | 12.9x |
| **Shire** | **SHP.LN** | HOLD | **$ 32.91** | 18,554 | 19,377 | 4.6x | 4.1x | 3.7x | 13.0x | 11.2x | 9.9x | 18.7x | 16.3x | 14.2x |
| **Valeant** | **VRX** | BUY | **$ 50.72** | 16,788 | 21,758 | 8.9x | 6.6x | 6.1x | nm | 12.6x | 11.4x | 17.9x | 12.5x | 11.1x |
| **Warner Chilcott** | **WCRX** | BUY | **$ 16.85** | 4,282 | 7,857 | 2.9x | 2.9x | 2.8x | 5.7x | 5.5x | 5.3x | 4.5x | 4.2x | 3.9x |
| | | | | | **Average** | **5.0x** | **3.8x** | **3.4x** | **9.1x** | **9.0x** | **8.1x** | **14.3x** | **12.8x** | **10.9x** |

**Source: Jefferies & Co., Capital IQ**



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

## Risks

- **Commercialization Risk.** Ultimately, Pacira's success will depend on its ability to successfully commercialize Exparel. This is the single biggest risk to the Pacira story. While we believe there is a clear market opportunity for the drug, should the company be unable to implement effective strategies to support sales and marketing efforts for Exparel, future revenues and profits are likely to be materially and adversely impacted.
- **Financing Risk.** We estimate that Pacira has >$70M cash entering 2012 (after recent net $49M follow-on proceeds). We estimate that Pacira will burn >$50M in 2012 (assuming further CAPEX investment for capacity growth), hence will need more cash in 2013. This could come from partnering Exparel rights outside the U.S. and does not necessarily need to involve issuing more equity. However, should Exparel fail to ramp as fast as expected to cover launch costs and ongoing overhead, the company could be forced to pursue more dilutive financing that we don't currently model.
- **Manufacturing Risk.** Pacira manufactures Exparel in-house in its San Diego facility. We are not aware of a realistic back-up option should that facility fail to fully comply with cGMP regulations. Further, we assume the company successfully expands its capacity to meet our out-year Exparel sales projections and at lower variable cost than the current set-up. If Pacira is unable to manufacture Exparel in sufficient quantities and/or at low enough cost, there would be downside risk to our earnings estimates.
- **Regulatory and Development Risk.** Since Exparel is already an FDA-approved product, regulatory risk is not our chief concern, though bears mentioning since Pacira will still clearly fall under the purview of the FDA (as well as other regulatory agencies) on manufacturing processes, safety issues, etc. The company will also face ongoing regulatory risk related to its current early stage pipeline of products, as well as associated development risk should respective clinical trials fail to show statistically significant / clinically meaningful results.
- **Intellectual Property/Patent Risk.** Exparel has patent protection out to 2018, but we believe its shelf-life extends beyond that since generics would have a nearly impossible (at the least, very costly) time proving equivalence and scaling up. While we are confident about Exparel's IP protection for the foreseeable future, any negative developments on the IP front would create a significant overhang on a stock's valuation.

# Financial Overview

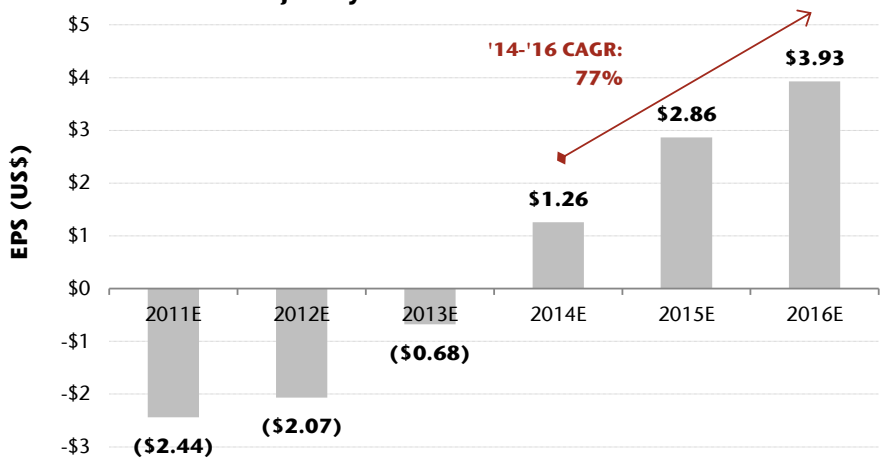
## Breakeven Late'13; Explosive EPS Growth Thereafter

The breakeven point for Pacira is Exparel sales of $100M.

We estimate that the breakeven point for Pacira is when Exparel sales exceed $100M. We expect that $25M/Q run-rate to be achieved in 2H 2013, and 2014 to be the first full-year of net profitability at $1.26 EPS. After that we project extremely strong earnings growth, with '15 and '16 EPS estimates of $2.86 and $3.93, respectively. That's a 77% CAGR on 2014.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exhibit 3: Pacira EPS Trajectory**



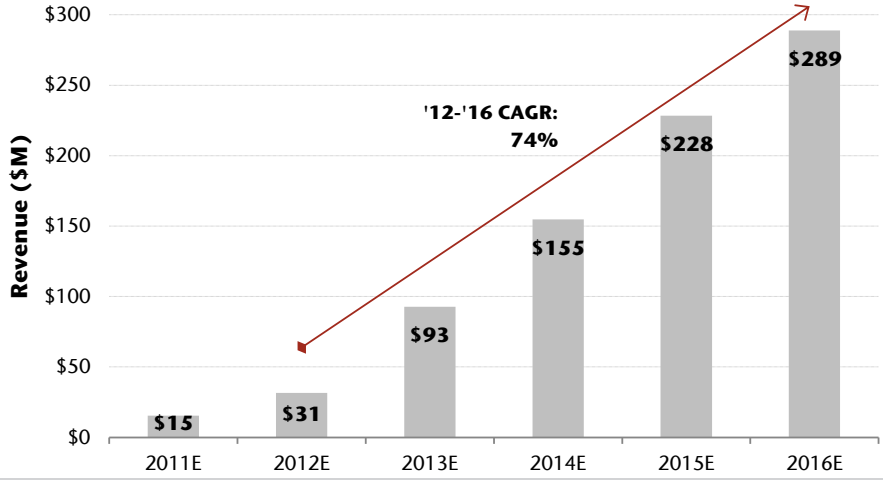

**Source: Jefferies estimates**

## Revenue: U.S. Exparel only Current Driver

While Pacira currently books ~$15M annual sales (pre-Exparel), that stream is not growing and not materially profitable. There is ~$10-$11M "supply revenue" and royalties associated with the two approved DepoFoam products marketed by 3rd parties (DepoCyte and DepoDur; the latter a small minority and partnership recently terminated). Essentially PCRX books those sales at cost-plus. There is also $4-5M "contract/development" revenue representing reimbursement for R&D work for 3rd parties working with the DepoFoam delivery platform). U.S. Exparel growth is the only revenue and profit driver in our estimates. We currently do not model any contribution from potential EU or ROW Exparel partnerships, nor do we include any additional Exparel indications (i.e., nerve block or epidurals).

Driven by Exparel sales of $15M in 2012, climbing to $270M in 2016, our total PCRX revenue is projected to climb from $31M in 2011 to $289M in 2016. That represents a 4-year '12-'16 revenue CAGR of 74%

**Exhibit 4: Projected Revenue Ramp**




**Source: Company reports, Jefferies & Co. estimates**



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

## COGS: Fixed Cost = Delayed Gratification

Gross margins on Exparel will be low initially because of the fixed cost overhead of manufacturing – at $50M, product GM would be <50%.

Pacira will not realize immediate pharmaceutical-like gross profitability on Exparel because of the fixed cost overhead of manufacturing. In the long-run, Exparel should deliver 75-80% or higher GM, but earlier and at lower sales levels we'll see the impact of effective amortization of fixed costs; in addition, lowering variable costs will also take time and further investment.

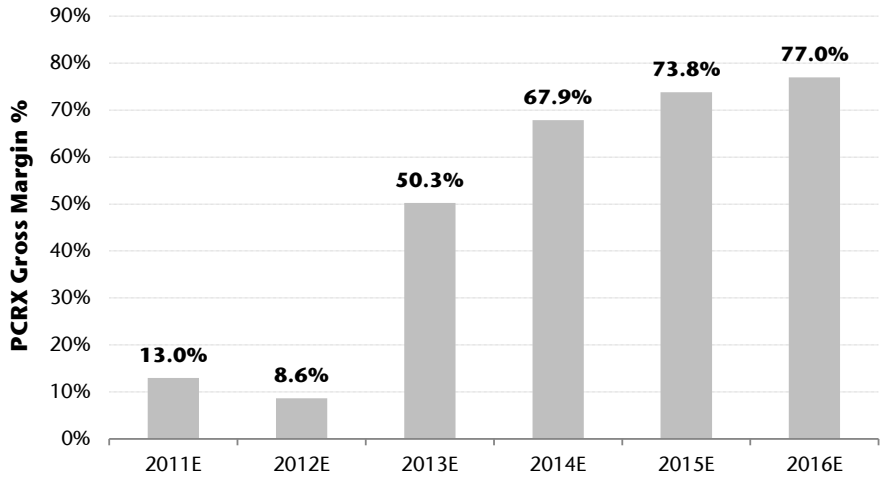
Currently, Pacira manufactures Exparel in "Suite A," a semi-automated site capable of producing $60M finished product now, or $108M/year with an additional shift. The variable cost associated with Suite A is ~15%, but PCRX also has a fixed cost infrastructure of ~$17M/year allocated to Exparel (*incremental* to the current COGS being reported for the non-Exparel base-business). Plus, PCRX pays out an aggregate ~5.5% sales royalty. Thus, *Pacira won't book any gross profit on Exparel until sales exceed $20M*; at $50M Exparel would generate a ~50% GM. At that level, total corporate GM would still be lower given the current ~$15M non-profitable base-business. In 2012, we model total GM of just 8.6% on $31M revenue, and in 2013 50.3% GM on $93M revenue. As sales climb, GM will as well.

By 2015, Exparel sales of $210M would translate to a corporate GM of 74%.

About $10M in cash is earmarked for the build-out of a higher capacity/efficiency "Suite C" production site. This automated facility should have variable costs ~50% lower than Suite A (we estimate 8%) and we believe it will have capacity to produce ~$175M on each of two lines, or $350M/year total product. Suite C should be complete in 2013, and we conservatively assume that lower cost is realized starting in 2014. Our projected 2014 & 2015 GM is 67.9% and 73.8%. In the longer run, PCRX plans to move to a completely different manufacturing process that is more of an order-of-magnitude improvement in efficiency/capacity. This would require time/investment and validation, but should allow higher GM and important scale necessary to exceed our conservative peak sales targets. Further, the innovative manufacturing method would potentially be patent protected to April 2031.

**Clearly, as scale and revenue increase, PCRX *profitability* should grow even faster.**

**Exhibit *5*: Pacira Gross Margin – GM Will Climb with Scale**




**Source: Jefferies estimates**

**SG&A.** The Exparel launch should require only a modest spend by pharmaceutical standards because promotion is limited to hospitals. Sixty-three Reps at launch at ~200K/year (climbing perhaps to 80 reps in 2013), plus promotion, plus maybe $5M in



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

"gift certificates" for the plastic surgery markets, plus only $12M base G&A should bring 2012 SG&A in at ~$45M. Given the highly concentrated nature of the market, we don't believe SG&A would have to *step-up* meaningfully with the large sales increase beyond 2012. We only model SG&A of <$60M in 2016. That is the beauty of the hospital market: *if* you can get in the door and get usage, the operating profitability becomes exceptionally high.

**R&D.** With the Exparel main clinical program complete, R&D should decline meaningfully in 2012 (<$10M). We expect PCRX to invest $4M-$5M/year through 2013 and 2014 on an sNDA and a Phase 3 program for Nerve Block, but again, don't expect any truly *meaningful* increase going forward.

We model zero taxes through 2014, then an effective 12% and 18% tax rate in 2015 & 2016, respectively.

**Taxes.** When the company was purchased from SkyePharma (SKP:LN, 34.50p, NC) in March 2007, no NOLs were acquired. The accumulated deficit from 2007 through 2011 – approximately $175M – is likely *not* immediately fully 1:1 redeemable due to the recent financing and a probably Rule 382 'change of ownership' trigger. For now, we assume they provide only a 50% tax-offset until exhausted. On the other hand, any net losses from Q1'12 onward *should* be immediately redeemable as tax offsets. We project another $71M losses before breakeven in 2014. Hence, we model zero taxes through 2014, then an effective 12% and 18% tax rate in '15 & '16, respectively. We assume a fully-loaded ~36% tax rate beginning in 2018.

# Need Better Post-Surgical Pain Drugs

There are tens of millions of surgical procedures in the U.S. each year, and surgery hurts. Almost all patients experience post-surgical acute pain of varying intensity and duration typically depending on the type, length, and tissue damage caused in during surgery. Pain is not surprisingly usually most severe in the first days immediately following the procedure. According to epidemiological studies ~50% of patients self-report inadequate pain relief with current treatments. Current surgical pain management uses a multimodal approach including:

Pain relief from bupivacaine only lasts 8 hours, but the pain from surgery lasts much longer. Despite this limitation, there are >20 million procedures with it each year.

**Wound Infiltration with local anesthetics**: Prior to *completing* surgery, a local anesthetic – sodium channel blockers including bupivacaine, ropivacaine, & other 'caines – is injected directly into and around the wound itself. This treatment has the advantages of providing: 1) an immediate post-surgical base for pain relief onto which other pain treatments can be layered, and 2) a non-systemic method of action, limiting side-effects and allowing more combination therapy. 'Cains, particularly bupivacaine, are so widely used by surgeons and anesthesiologists primarily because of their familiarity and a decades-long record of safety and predictability. Unfortunately, the *limitation of local anesthetics for wound infiltration is their short half-life and short duration of analgesia. Bupivacaine is longest-acting yet its efficacy generally only lasts up to 8 hours*. After surgery, repeat infiltration (injection into the wound site), is not practical for a recovering patient. Thus, the vast majority of patients are put on additional systemic treatments for longer duration pain management (primarily opioids and NSAIDs). There are approximately **24 million** wound infiltration procedures in the U.S. annually.

Side effects from opioids are not only troublesome, but very costly for hospitals.

**Opioids: Ubiquitous, Effective, & Extremely Problematic**. Opioids (most commonly IV morphine in the hospital) are the standard of care for post-surgical pain. The potency and multiple modes of administration for opioids make them the easiest choice for consistent efficacy. However, opioids are also consistently associated with a broad array of side effects from irritating to life threatening. Adverse events (AEs) could be as mild as headache, sedation, and pruritus (itching), but very commonly include more severe nausea, vomiting, constipation, urinary retention, and cognitive impairment. Most


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

dangerously, opioids can cause respiratory depression and death, particularly in more vulnerable populations including the elderly, and hepatic or renally impaired, or obese. These opioid-related adverse events (ORAE's) have clear negative implications for patient healing/recovery, risk of complications, requirement for concomitant meds, **length of stay in ICU and/or the facility in general, and overall *cost* of patient care**. Practical opioid-sparing is a nearly universal objective.

**NSAIDs: Opioid Alternative, but Less Potent and not without Complications**. Non-steroidal anti-inflammatories (NSAIDs) including ketorolac, diclofenac, or ibuprofen, do not have the same risk of constipation or respiratory depression. However, besides being less potent analgesics, NSAIDs cause GI complications including diarrhea and ulceration/bleeding and renal dysfunction.

## Current Long-Acting Approaches

In the immediate post-surgical setting, oral administration of opioids (like Percocet or Vicodin) is limited by a slower onset of action and less efficacy than intravenous (IV) administration. The most common post-surgical IV opioid administration modality is Patient Controlled Analgesia (PCA) pumps. Where opioids are being avoided, many hospitals attempt to get long-acting analgesia from short-acting local anesthetics (primarily bupivacaine) by elastomeric bag systems.

**PCA Pumps: Still Opioids (AE's), Expensive, Resource Intensive, and Error Prone.**

*There are >15M PCA uses annually in the U.S.* While PCA opioid administration will likely never go away, there is plenty of room for improvement. First, and most important, regardless of the route of administration, it is still an opioid (morphine) with all the risks, complications, and costs accompanying that. Also, patients are necessarily tethered to an IV post, which postpones ambulation and likely slows recovery/discharge. Further, despite PCA by definition being 'patient controlled' and thus apparently requiring less hospital/nurse resources, these devices still consume plenty of staff time to setup and monitor. Nurses must program the devices, set up IV line access, educate patients and frequently monitor the pump usage. There has been considerable attention on misprogramming of devices and design flaws.

All in, opioid IV PCA *can cost >$500 for 3-days therapy*, excluding any impact of potential opioid-related adverse events. Data published in 2006 reviewing opioid PCA usage showed 48% of morphine PCA patients had opioid-related AE's (including 8% suffering respiratory depression). Two published studies showed ORAE's led to >1/2 day longer hospital length of stay, and they also resulted in $499 and $862 higher hospital cost per patient in the respective studies.

**Elastomeric Bag Infusion Systems: MacGyver'ing a Long-Acting Bupivacaine**

*There are ~1M Elastomeric Bag uses annually in the U.S.* In the interest of opioid-sparing, many hospitals extend the duration of local analgesia with bupivacaine through the use of elastomeric bag infusion systems. These are essentially drug-filled 'balloons' that feed bupivacaine over a 2-5 day period *directly* to the surgical incision site via a catheter.

Elastomeric bags can preempt opioid PCA usage, but they carry their own baggage. First, unlike a single wound-infiltration injection with Exparel, elastomeric bags require intra-operative catheterization, leaving the patient tethered to the infusion system while drug drips to the site for 2-5 days, which must then be removed again by the surgeon. Certainly these carry catheter infection risk, detachment risk, device failure and/or incorrect dosing risk. There have been several product recalls due to incorrect infusion rates (too fast or slow), misassembly, etc. Like PCA, elastomeric bags limit ambulation,


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

potentially slowing recovery and patient discharge, and consume significant hospital/nursing resources. All in, elastomeric infusions *can cost >$450 per patient.*

**Exhibit 6: Elastomeric Bag Infusion System: Complicated and Riskier.**


Source: I-FLOW ON-Q® product website

**Exhibit 7: EXPAREL for direct wound infiltration. Single injection at site.**


Source: Pacira company presentations

# Exparel: Superior Yet Familiar Post-Surgical Pain Management

Exparel is Pacira's long-acting bupivacaine formulation for post-surgical acute pain management. It is bupivacaine in PCRX's proprietary "DepoFoam" (extended-release multivesicular liposomal) delivery technology. Exparel was approved by the FDA on October 28, 2011 with a very broad labeled indication: "single-dose infiltration into the surgical site to produce postsurgical analgesia." That indication squarely targets – without any obvious limitations – the existing high-volume wound infiltration market (~24M annual procedures in which a surgeon injects local anesthetic directly in/around the wound at end of surgery). Exparel's 72-hour efficacy offers clear advantages over existing immediate-release bupivacaine (or other short-acting local anesthetics like lidocaine), and should reduce the dependence on alternative or additional forms of long-acting pain treatments which are associated with higher risks, adverse events, slower recovery, and increased healthcare costs. Importantly, Exparel does not require surgeons "re-learn" or alter their current method of wound infiltration treatment, so there should be minimal push-back from practitioners.

## Key Advantages vs. Existing Treatments:

**Only Long-Acting injectable local anesthetic.** Exparel, with up to 3-days efficacy offers dramatically longer pain management than current short-acting local anesthetics (bupivacaine, ropivacaine, etc.) which last <8 hours. This has obvious positive implications for patient quality of life and recovery.

**Risk Reduction: Less opioid use and less elastomeric bag use.** Opioids (morphine) are nearly ubiquitous for post-surgical pain management, but they are



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

associated with myriad AE's (nausea, vomiting, constipation, cognitive impairment, or even respiratory depression and death). Reducing, or sometimes even eliminating the need for post-surgical opioid administration could reduce adverse events, improve patient outcomes, hasten recover/discharge, and lower hospital costs. Exparel could entirely replace the use of elastomeric bags which are the only current method to extend the -caines' duration of efficacy but are riskier and less convenient. Although it is not extensive, Pacira was able to get one sentence into the Exparel label that allows it to promote the ability of Exparel to reduce opioid consumption:

> ***In the Phase 3 Hemorrhoidectomy trial, "…there was an attendant decrease in opioid consumption…"***

**Potential Cost Savings Despite "Generic" Alternatives**. Though bupivacaine is generic and costs pennies, ~1M elastomeric bags infusions are now used annually to extend its efficacy beyond the 8 hours allowed by immediate post-surgical infiltration. All-in cost of elastomeric bags infusion procedures can be >$450 per patient. All-in cost of opioid IV PCA (15M annual uses) can be >$500 for 3 days of therapy. Exparel's sticker price is $285/procedure, so despite competing with generic *molecules* it is cheaper than other treatment modalities that it should replace or reduce. Beyond the direct cost of pain-management treatment, Exparel's lower risk-profile than elastomeric bags and opioid PCAs could lead to indirect hospital costs savings with lower complication rates and shorter patient length-of-stays.

## Exparel Data: Better Efficacy, Opioid Sparing, and Implied Reduced Costs

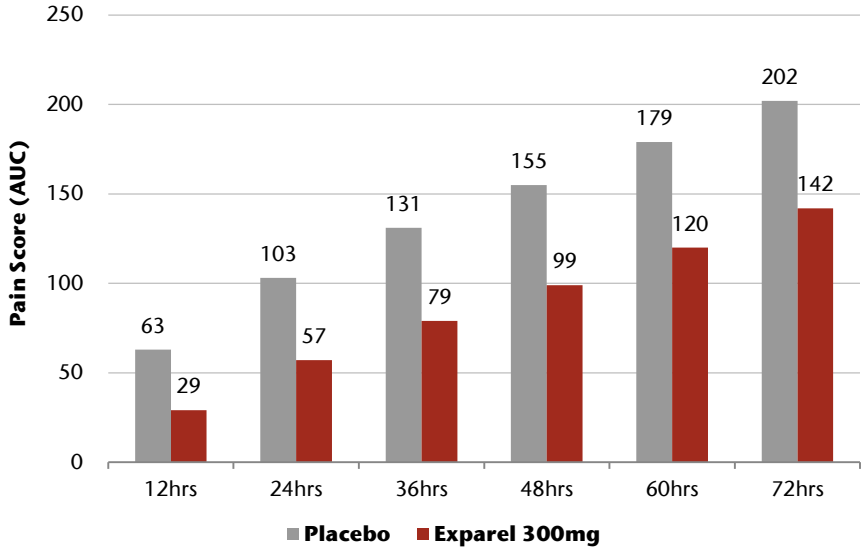
**Phase 3 Placebo-controlled Data: Less Pain & Less Opioids Necessary**

Exparel outperforms placebo (though placebo response rates are typically very high in pain studies). There were two Phase 3 trials – one in bunionectomies and one in hemorrhoidectomies.

In the Phase 3 hemorrhoidectomy registration trial, 95 patients received 300mg Exparel and 94 received placebo (sham injection), both injected to the local site (wound infiltration) at the end of surgery. The primary efficacy endpoint was the difference in pain (AUC on NRS-R pain scale). As can be seen below, Exparel clearly beat placebo at all-time points. At 72-hours, Exparel had a 30% pain reduction with a highly statistically significant p-value <0.0001.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

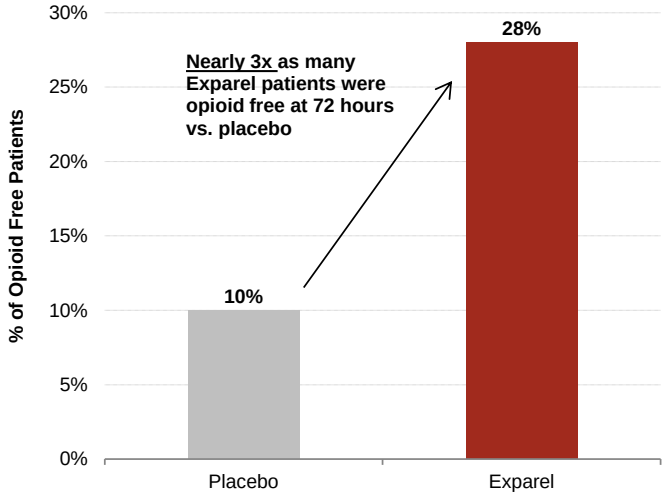
**Exhibit 8: Exparel Ph.3 – Reduced Pain at all-time points vs. placebo**




Source: Company reports

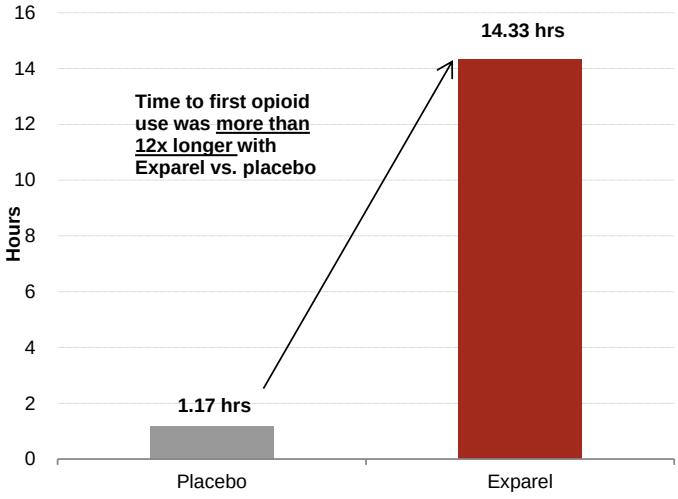
Important secondary endpoints in the Phase 3 included measures of opioid use. At 72 hours, 28% of Exparel patients totally avoided opioid rescue treatment, ~3x the 10% on placebo (p=0.0007). Also, the median time-to-first-opioid use for Exparel patients was 14.33 hours, which was >12x the 1.17 hours for placebo patients (p<0.0001). Last, the adjusted mean total post-surgical supplemental opioid consumption (morphine-equivalent basis) for Exparel was 45% lower than placebo.

**Exhibit 9: 3x as many Exparel patients vs. Placebo avoid opioids altogether**




Source: Company reports

**Exhibit 10: Of patients needing opioid rescue, Exparel patients can hold out >12x longer than placebo patients**

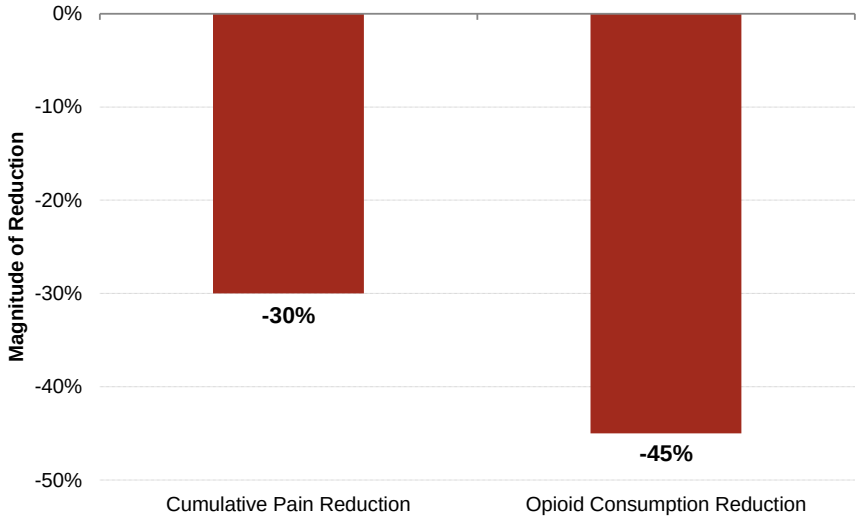



Source: Company reports



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exhibit 11: Exparel vs. Placebo at 72-hrs: 30% Pain reduction & 45% Opioid Consumption reduction**




**Source: Company reports**

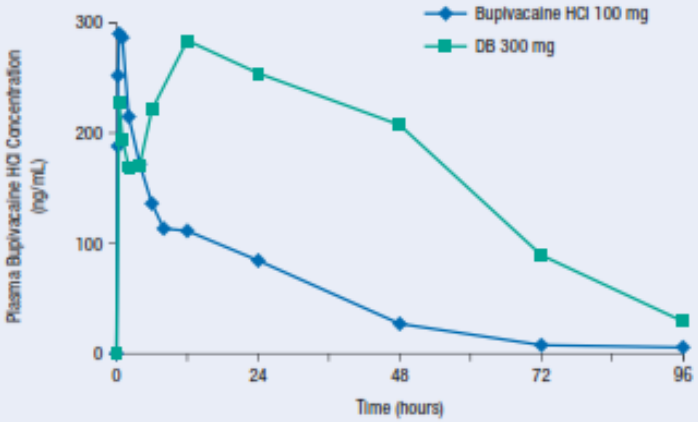
**Exparel vs. IR Bupivacaine: Lasts Longer**

While placebo-controlled data was necessary for approval, clinicians, hospital pharmacies, and managed care will be more interested in data for Exparel data vs. IR bupivacaine. For this, Pacira has relied on all of the work that was performed with Exparel prior to Phase 3. To start, Exparel demonstrates a vastly different pharmacokinetic (pK) profile than generic injectable bupivacaine – it simply lasts much longer. In this cross-study analysis involving 446 patients across several different routes of administration (wound infiltration, subcutaneous, epidural, & nerve block) and surgical models (hemorrhoidectomy, herniorraphy, bunionectomy, & total knee arthroplasty), Exparel *delivered an elongated Tmax and similar Cmax vs. IR bupivacaine.* Exparel has a "bimodal" peak concentration (both 0.25-2 hours, and 12-24 hours), versus IR bupivacaine's single onset-peak (0.25-2 hours) then rapid decline. Exparel showed a long half-life of 34.1 hours, yet even at the highest 600mg dose (2x the approved Exparel dose), its Cmax was only 935mg/mL (2x to 4x below bupivacaine's respective CNS toxicity and cardio-toxicity thresholds). As can be seen below, over the course of 72 hours, DepoFoam bupivacaine has dramatically higher plasma concentration than IR bupivacaine.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exhibit 12: Pooled pK data for Exparel (DB300mg) vs. 100mg IR Bupivacaine**

| | Time to Onset | Peak | Duration |
|---|---|---|---|
| Bupivacaine HCl 100 mg | 5 minutes | 0–1 hour | 8 hours |
| DB 300 mg | 5 minutes | P1: 0–2 hours<br>P2: 12–24 hours | 72 hours |




**Source: Company data**

Exparel provides better pain relief with less opioids compared to IR bupivacaine.

**Exparel vs. IR Bupivacaine: Better Pain and Less Opioids**

As shown in a poster from the October ACCP (American College of Clinical Pharmacy) meeting, Pacira conducted a meta-analysis of 5 active-controlled studies it had performed prior to the two pivotal placebo-controlled Phase 3 studies that formed the basis of its approval. Exparel used up to 300mg (n=313) was compared to IR bupivacaine up to 150mg (n=409) in various surgeries that included: hemorrhoidectomy, total knee arthroplasty, and herniorrhaphy. There were four takehome messages from this poster:

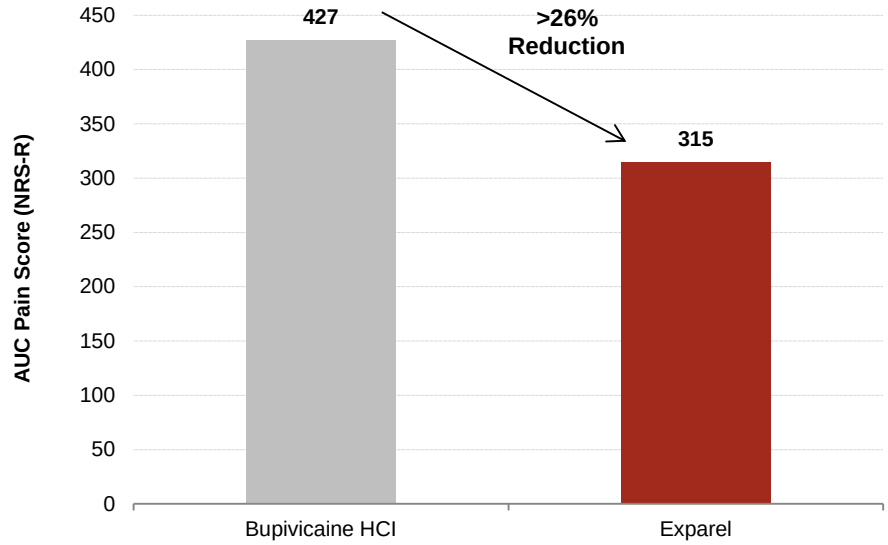
1. Exparel provided a 26% improvement in pain scores compared to IR bupivacaine at 72 hours.
2. The median time to first oral opioid use was 3.5-times longer (9.9 hrs. vs. 2.7 hrs.) for Exparel compared to IR bupivacaine.
3. Patients on Exparel used 50% less opioids than patients on IR bupivacaine (7.9 mg vs. 15.8 mg).
4. The average number of opioid-related adverse events was 2x higher for IR bupivacaine than Exparel (0.46 vs. 0.25).

In terms of efficacy Exparel demonstrated similarly highly statistically significant advantages vs. IR bupivacaine as it did vs. placebo on pain reduction and opioid sparing. At 72 hours, Exparel had a 26% less pain vs. IR bupivacaine patients ($p<0.0001$), which is similar to the 30% advantage vs. placebo in Phase 3.



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

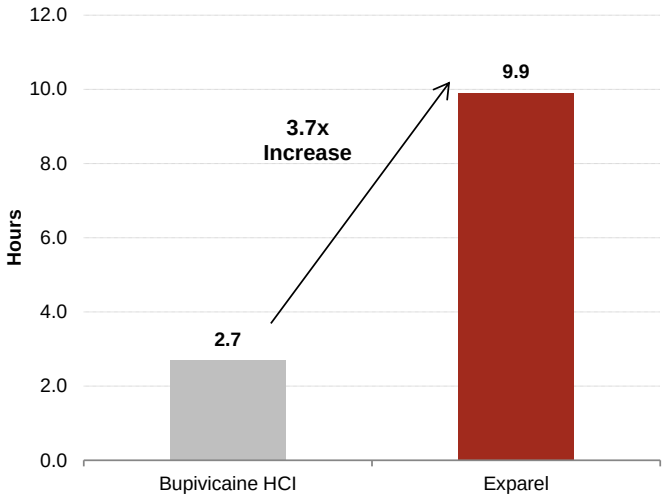
**Exhibit 13: Exparel >26% pain reduction vs. IR bupivacaine at 72 hours**




**Source: Dasta, et.al.; October 16-19, 2011, Pittsburgh; Poster 198**

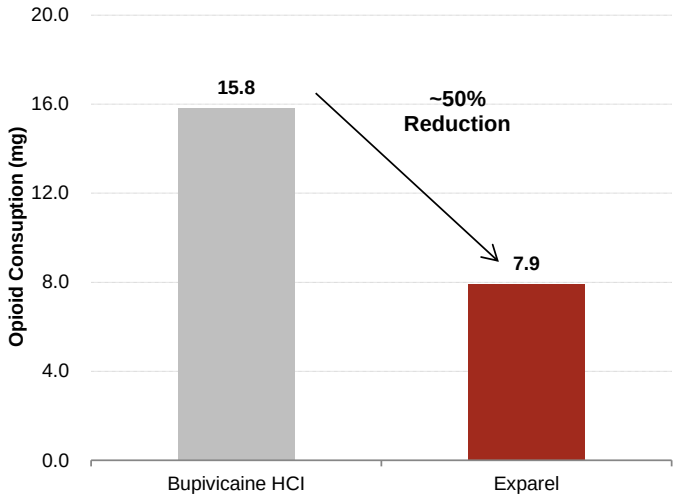
On opioid-sparing endpoints, Exparel also had clear advantages. The median time-to-first-opioid for Exparel was 9.9 hours vs. 2.7 hours for IR bupivacaine (>3.5x difference; p<0.0001). The mean total morphine-equivalent opioids consumed was 7.9mg for Exparel vs. 15.8mg for IR bupivacaine (50% reduction; p<0.0001).

**Exhibit 14: Of patients needing opioid rescue, Exparel patients held out 3.7x longer than IR bupivacaine patients**




**Source: Dasta, et.al.; October 16-19, 2011, Pittsburgh; Poster 198**

**Exhibit 15: Exparel patients had 50% lower total opioid consumption vs. IR bupivacaine**



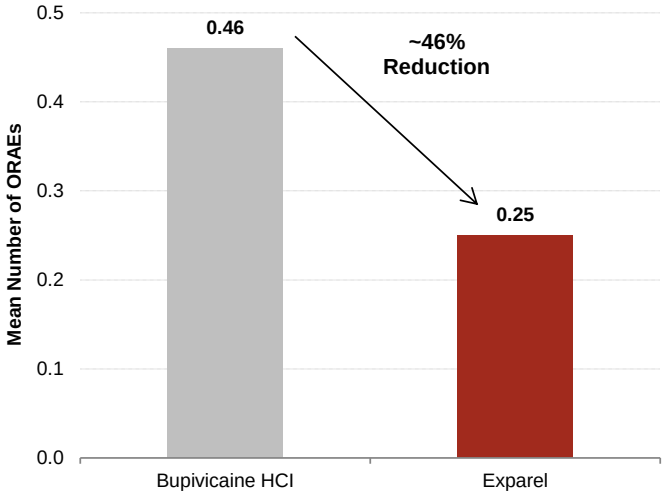

**Source: Dasta, et.al.; October 16-19, 2011, Pittsburgh; Poster 198**

The opioid-sparing advantages of Exparel, translated to all-important evidence of decreased opioid-related adverse event rates (ORAEs). The mean number of ORAEs per patient was 0.25 on Exparel vs. 0.46 on IR bupivacaine (46% reduction; p<0.0001). The total % of patients reporting ≥1 ORAE was only 24.6% in Exparel vs. 45.1% in IR bupivacaine patients (45% reduction).



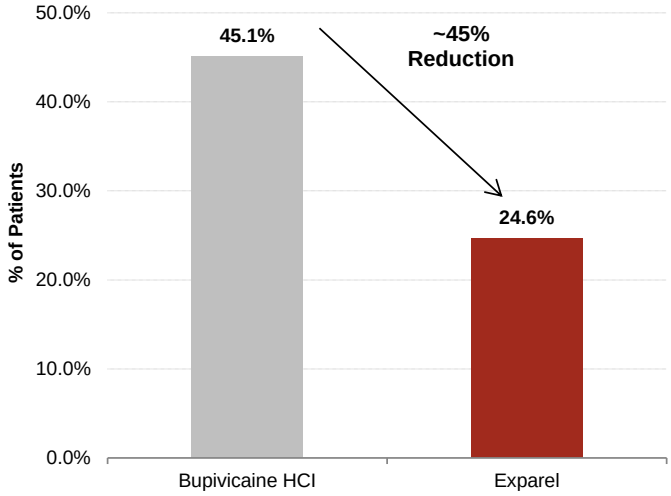
**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exhibit 16: 46% reduction in Opioid AE rate for Exparel vs. IR Bupivacaine**




Source: Dasta, et.al.; October 16-19, 2011, Pittsburgh; Poster 198

**Exhibit 17: 45% fewer Exparel patients reported ≥1 ORAE vs. IR bupivacaine**




Source: Dasta, et.al.; October 16-19, 2011, Pittsburgh; Poster 198

## The Hidden Costs of Opioid AEs: The Value Proposition of Opioid Sparing

The 1st step was to prove that Exparel reduces opioid use. The 2nd step is to prove to hospitals how much opioid side effects are costing them.

Although this data is not in the label, Pacira is able to use it in its pitch to hospital administrators for showing the cost effectiveness of Exparel. We believe the data above show Exparel provides obvious advantages in terms of opioid-sparing (in % who avoid opioids entirely, time-to-first-use, and total opioids consumed). While we believe clinicians and payers clearly recognize a need to reduce opioid use in general, Pacira is using actual data to support its contention. The next step is to prove to the hospitals just how expensive the side effects from opioids are by utilizing hospitals' own databases.

**Opioid Related AEs => Increased Hospital Stay and Increased Costs**

Pacira sponsored a retrospective analysis using Premier's (a leading GPO) national hospital databases. The data covered 381 hospitals, and looked at patients undergoing common soft-tissue and orthopedic surgeries who received opioid for post-surgical pain (from Sept'08 to Aug'10). Key findings were presented in a poster at the ASPH (American Society for Health-System Pharmacists) meeting in December 2011:

- ~20% of patients who received opioids experienced a opioid-related adverse events (ORAEs)
- Patients with ORAEs had **1.1 days increase in mean length of stay**. (p<0.0001)
- Patients with ORAEs had **$1,028 mean increase hospitalization cost** vs. patients with no ORAEs. (p<0.0001)

**Outliers use More Opioids, Have More ORAEs, and Much Higher LOS/Costs**

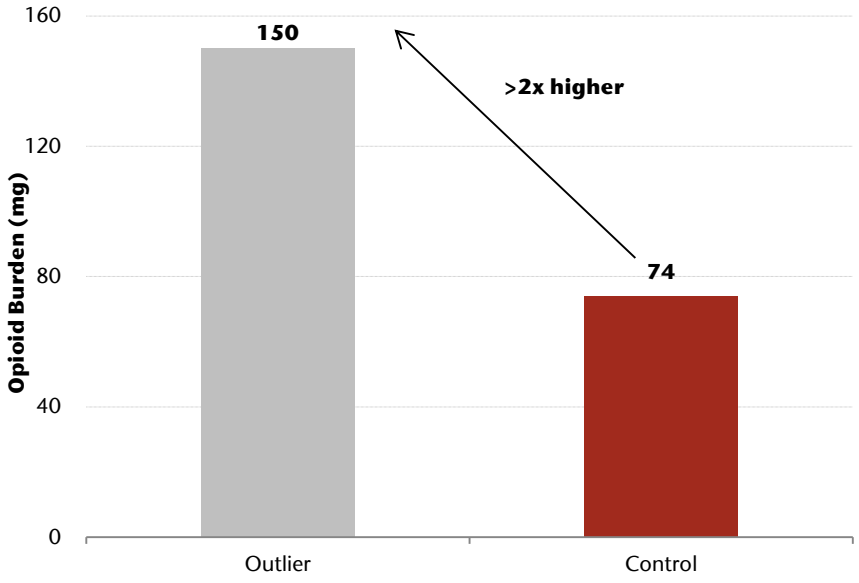
Pacira also sponsored a smaller study using data from a regional health system (Barnabas Health, in one of their hospitals) looking to determine if there was a relationship between opioid use and increased length of stay (LOS) and overall cost in patients undergoing total abdominal hysterectomy (TAH). The results were also presented in a separate poster at the ASHP (American Society for Health-System Pharmacists) meeting in December 2011.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

This study focused on "outlier" patients – those minority of patients that are especially problematic in terms of LOS and cost of care – and sought to determine if the use of opioids and experiencing of ORAEs was related to higher LOS/cost even among those outlier patients that drive much of the cost overage. Of 3,654 TAH patients, the 100 with longest LOS were selected, then matched with a control group of remaining TAH patients (matching age range, BMI, race, diabetes status, etc.). 97 pairs of outliers & controls were matched.

The total morphine-equivalent opioid burden in outliers was 2x the controls, 150mg vs. 74mg ($p<0.01$). The associated ORAE rates were not surprisingly much higher in the outliers: gastrointestinal AEs in 44% of outliers vs. 19% of controls (2.3x; $p<0.01$), and respiratory AEs in 12% of outliers vs. just 1% in controls (12x; $p<0.01$). Note that 11 of the 12 respiratory AEs occurred within 72 hours of surgery.

**Exhibit 18: Hospital LOS/Cost outliers had 2x higher opioid burden**

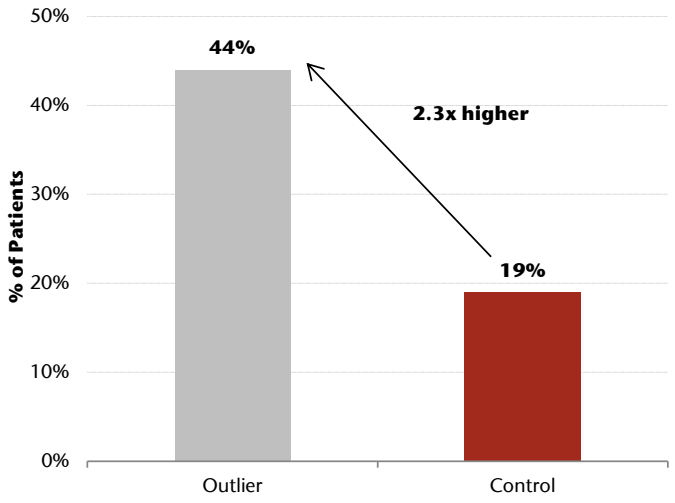



**Source: Adamson, et.al.; ASHP December 2011; Poster 3-192**



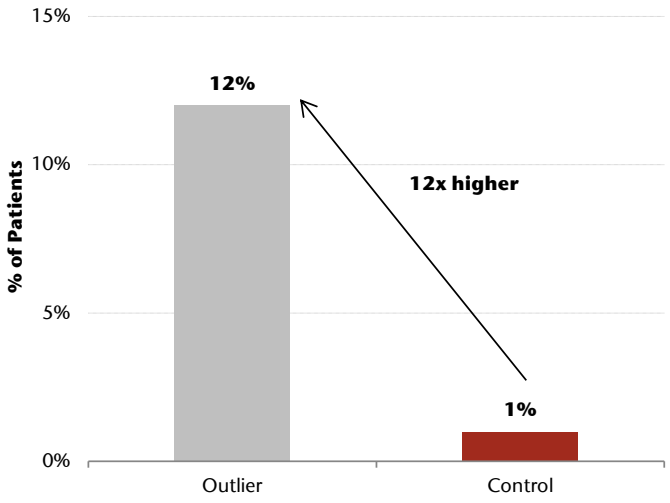
**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exhibit 19: >2x Higher GI AE's in LOS/Cost Outliers**




Source: Adamson, et.al.; ASHP December 2011; Poster 3-192

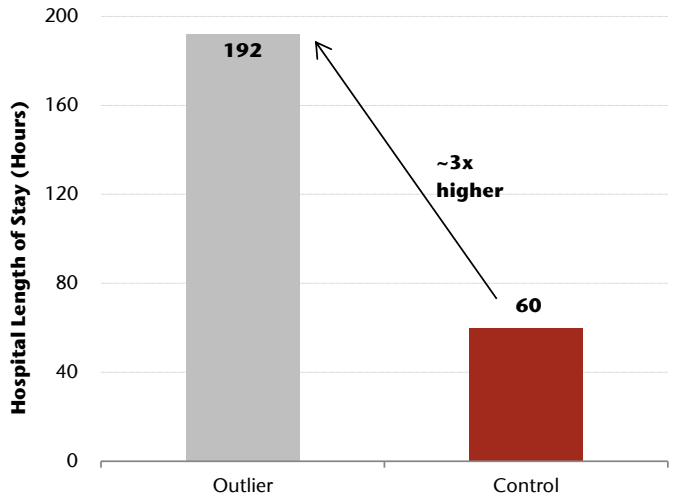
**Exhibit 20: 12x Higher Respiratory AEs in LOS/Cost Outliers**




Source: Adamson, et.al.; ASHP December 2011; Poster 3-192

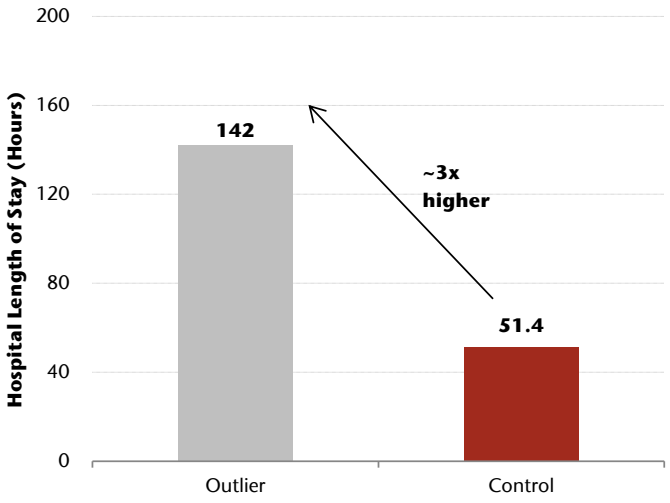
The length of stay for outliers vs. controls was 192 hours (8 days) vs. 60 hours (2.5 days), and >3x difference ($p<0.01$). Of that total LOS difference, most was from a difference in time from post-anesthesia care unit discharge to hospital discharge: 142 hours vs. 51.4 hours ($p<0.01$)

**Exhibit 21: >3x total Hospital LOS in Outliers**




Source: Adamson, et.al.; ASHP December 2011; Poster 3-192

**Exhibit 22: Almost 3x postsurgical LOS in Outliers**



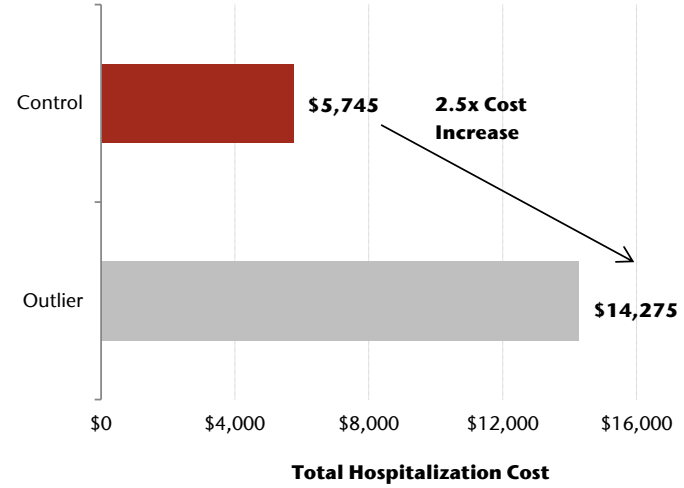

Source: Adamson, et.al.; ASHP December 2011; Poster 3-192

Consequently, the hospitalization cost for outliers was substantially higher than for controls. *Total* costs (including indirect costs and/or overhead) for outliers was $14,430 – 2.5x or $8,530 higher than the controls' total cost of $5,745. The *direct* hospitalization costs (excluding indirect/overhead) for outliers was $9,372 – 2.4x or $5,517 higher than the controls' direct cost of $3,855.



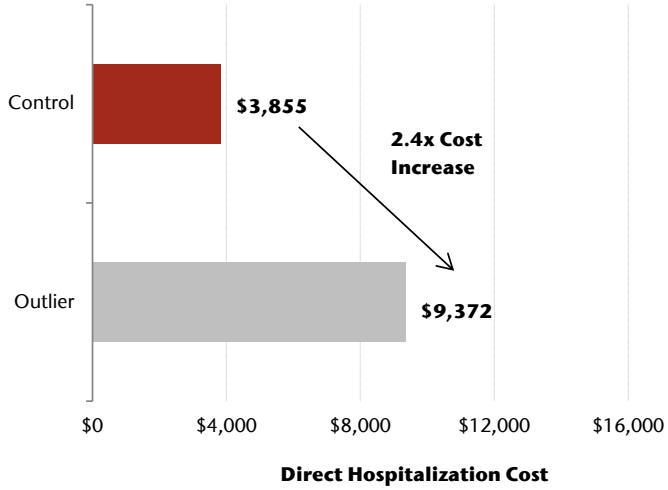
**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exhibit 23: 2.5x Higher Total Hospitalization Cost for Outliers**




Source: Adamson, et.al.; ASHP December 2011; Poster 3-192

**Exhibit 24: 2.4x Higher Direct Hospitalization Cost for Outliers**




Source: Adamson, et.al.; ASHP December 2011; Poster 3-192

This is the sort of data showing the implied large potential cost/resource savings from opioid sparing options like Exparel, that Pacira expects will make the value apparent to hospital Pharmacy and Therapeutic (P&T) Committees, GPOs, etc. The outlier approach is useful to institutions which are always looking to identify the costliest and most appropriate patients in whom to use new treatments like Exparel. This is the same approach PCRX management took with Angiomax at Medicine's Company; they helped hospitals identify the most expensive patients, which then led to Angiomax being used in ALL of those patients. Pacira is already working with GPOs whose analytical and best-practice transfer teams could expedite the acceptance at the hospital formulary level.

In addition to retrospective analyses, Pacira plans to conduct small Phase 4 prospective *outcomes* studies. These will aim to show Exparel can improve patient outcomes with less cost/resources. Pacira has already started a program of prospective trials at 15 key institutions focusing on open and laparoscopic colectomies and ileostomy reversals to show Exparel + rescue vs. morphine PCA + rescue results in significantly less total opioid consumption, and hence fewer ORAEs and shorter length of stay. This data should start to be available in April.

In a capitated reimbursement environment (fixed total procedure reimbursement by 3rd party payers no matter what actual costs are incurred by the hospital), hospitals should be very interested in the data generated by PCRX and partners that highlight certain populations (e.g., obese, opioid tolerant, elderly, sleep apnea sufferers, and those with BPH) which are at higher risk for ORAEs and driving higher costs/LOS.

## Exparel Commercialization

Pacira has already begun promotion of Exparel even before product availability.

Pacira has already soft-launched Exparel ahead of product availability in April. Prior to first shipment, the sales force is already in the field (national sales meeting was mid-January), aggressive formulary negotiations are already underway, internal champions at the top-50 hospitals, and speakers are being trained. In our view, Pacira is better positioned than any other "small company" hospital launch in recent memory, with the pump primed and likely much better early access and demand than others. The company is already getting multi-hospital formulary wins months ahead of availability with no signs of any restrictions.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**The target market is extremely large yet concentrated**. There are approximately 45M U.S. surgeries annually, and Pacira estimates that ~24M of those are wound-infiltration opportunities. Further, ~16M of those are ideal targets in soft-tissue procedures. At Exparel's $285/procedure WAC (wholesale acquisition cost), that equates to a full brand-equivalent opportunity of >$4.5B. There are also an additional 1M target annual plastic surgery procedures. This only represents the market for the current wound infiltration indication. Nerve Block represents another 8M procedures/year, and Epidural another potential 6M.

The market is very concentrated with only 100 hospitals performing 20% of the 16M direct target procedures.

Despite there being ~6,000 U.S. hospitals, almost 20% of procedures are at only the top-100 facilities, 52% at the top-500, and >80% and less than 1,300 facilities. Further, the top-4 group purchasing organizations (GPOs) cover >70% of the market.

**63 Rep Contract Sales Force + 20 in-house marketing/formulary specialists**. Pacira is launching with 63 Quintiles contract sales representatives, which can cover ~80% of target procedures, but will primarily focus on the top deciles. That may expand to 80-100 reps over 3 years. PCRX mgmt. has a long/close history with Quintiles, having launched Angiomax with the Innovex CSO (became Quintiles). Pacira CEO David Stack, prior to helming MDCO, was actually the President of Innovex.

In the first 6-months, PCRX will focus on the top-50 formularies, and lower hanging fruit. The plastic surgery market, particularly for breast augmentations represents likely early adopters given cash-pay (no formulary), an obvious focus on patient experience/satisfaction, and the clear value of longer-duration non-opioid pain control for a relatively small incremental cash expense. PCRX believes it can cover with the same 63 reps >80% of relevant the plastic surgery markets, focusing on breast augmentation procedures and liposuction. The hospitals/ORs and plastics/ambulatory care centers can be separately detailed by the same reps with mornings spent in the former, and afternoons in the latter. PCRX has already had significant plastic surgeon exposure, receiving high interest ("Best of Hot Topics") at the American Society of Plastic Surgeons (ASPS) this past fall, and already conducting ongoing Webinars and promotion.

On the formulary-gated side, PCRX should have the easiest/earliest success attempting to replace elastomeric bags (1M/year) before more general acceptance in all wound infiltration opportunities and morphine PCA (15M/year) replacement. We'd expect the majority of hospital business (>80%) in the first year to come from more favorable formulary environments (Texas and Southeast U.S.).

**Don't Paint All Launches with the Same Brush.** Recent disappointing small-company launches into hospital markets have spooked most investors. In particular are Cumberland's Caldolor launch, and Cadence's Ofirmev launch. We believe it's fundamentally unjustified to lump Exparel in with these. Besides what we view as more comprehensive pre-launch preparation and demand generation, we believe Exparel has a *much* stronger case for in terms of differentiation and value vs. those two products. Caldolor – IV Advil (ibuprofen) – has limited differentiation from dirt cheap IV ketorolac, and Ofirmev – IV Tylenol (acetaminophen) – has limited value beyond alternative oral acetaminophen. As we've stated above, Exparel has what should be an obvious advantage over short-acting bupivacaine, a clear safety advantages over opioids, and no current reasonable alternative for long-acting non-opioid postsurgical pain management.

**Exparel Revenue Projections**

Like any formulary-gated launch, we do not expect a meaningful immediate ramp. Early adopters in cash-pay and lower formulary-hurdle territories should drive initial sales while wider spread adoption should take more than a year.



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

As can be seen below, for the current wound infiltration indication, we model a market of ~24M annual procedures, growing at 1.5%/year. Since the most likely source of Exparel use would be in replacing current IR bupivacaine and elastomeric bag uses (~6M procedures), we model penetration into that ~25% of the market. This is a conservative approach since Exparel presents value for opioid-sparing across *most* of the wound infiltration market, not just where bupivacaine is being used now. Further, it does not yet account for label expansion to nerve block or epidural use.

For 2012, we model 1% share capture of the current IR bupivacaine/elastomeric bag submarket, or just 0.3% of the wound infiltration market. At an assumed net $250/procedure, that equates to *$15M Exparel sales in 2012* (we model $2M in Q2'12, $5M in Q3'12, and $8M in Q4'12).

We model Exparel sales of $15M in 2012, with $2M in Q2 (first quarter of launch) and exiting the year at a >$32M run-rate. We model steady share gains going forward, with Exparel capturing 4.8% of bupiv./elasto. in 2013, climbing to 15.6% in 2016. That only represents 3.9% of the total wound infiltration market by 2016, or ~1M Exparel procedures. That underpins our Exparel sales estimates of $75M in 2013 climbing to $270M in 2016. Again, this doesn't include label expansion.

**Exhibit 25: Exparel Volume and Revenue Projections**

| *(in thousands except $ amounts)* | 2012E | 2013E | 2014E | 2015E | 2016E |
|---|---|---|---|---|---|
| Approx. # Wound Infiltration Oppy's | 24,000 | 24,360 | 24,725 | 25,096 | 25,473 |
| *y/y growth* | | *1.5%* | *1.5%* | *1.5%* | *1.5%* |
| *Total Bupivacaine + Elastomeric Bag Use* | *25.2%* | *25.2%* | *25.2%* | *25.2%* | *25.2%* |
| EXPAREL Share Capture | *1.0%* | *4.8%* | *8.4%* | *12.5%* | *15.6%* |
| EXPAREL Total Utilization Rate | ***0.3%*** | ***1.2%*** | ***2.1%*** | ***3.2%*** | ***3.9%*** |
| EXPAREL Procedure Volume | 60 | 295 | 524 | 791 | 999 |
| EXPAREL net cost/use (gross $285) | $250 | $255 | $260 | $265 | $271 |
| **EXPAREL net sales (mil)** | **$15.0** | **$75.2** | **$136.3** | **$209.7** | **$270.2** |
| *y/y growth* | | *401.1%* | *81.4%* | *53.8%* | *28.8%* |

**Source: Company reports**

# Pipeline / Label Expansion

Pacira is devoting the vast majority of its current financial resources to the launch of Exparel for the approved wound infiltration indication (you only get to launch a drug once). However, it does have two additional Exparel indications in the works, as well as a couple early-stage (preclinical) DepoFoam based drug candidates. Also, Pacira is already working with partners to develop potential DepoFoam based formulations of undisclosed 3rd-party molecules. We currently give zero credit for pipeline development, though a nerve block expansion could be approved by 2015.

**Exparel for Nerve Block**. Nerve block is just local anesthetic injection at a nerve site for pain management. Like the current wound infiltration indication, current therapies are limited by short duration of action or problematic longer duration alternatives. There are ~8M nerve block procedures in the U.S. annually, with about 50% of them already using IR bupivacaine. Thus this represents a meaningful opportunity on top of the 24M wound infiltrations. PCRX has completed two Ph.3 trials (40 patients on drug) and is ready for Ph.3, but given the focus on the current launch, it will wait until it has better revenue visibility before proceeding (likely start Ph.3 in 2013). The company estimates development will only require $4M - $5M in each of 2013 and 2014, and we would imagine it's a relatively low-risk proposition given Exparel's proven dynamics and the current use of bupivacaine for nerve block.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Exparel for Epidural Administration**. Epidurals are *regional* anesthesia via an injection into the epidural space (outer spinal canal). Again, current therapies are limited by short duration of action or problematic longer duration alternatives. There are ~6M annual epidurals in the U.S., though only ~10% currently use local anesthetics like bupivacaine. Pacira has completed a proof of concept Ph.1 trial (24 patients on drug). We do not yet model specific further investment in this indication. Note that the DepoFoam delivery technology has *already* been approved for epidural administration with DepoCyte (cytarabine liposome injection for lymphomatous meningitis).

**Preclinical DepoFoam Targets**. Pacira is in early preclinical development with DepoNSAID and DepoMethotrexate. Pacira has experimented with several NSAIDs in the DepoFoam delivery for local infiltration for acute pain and will select a lead candidate going forward. DepoMethotrexate would be an extended release methotrexate formulation for rheumatoid arthritis and/or oncology indications. Pacira has 1-year stability data for its DepoMethotrexate formulation. We currently model no specific investment or value contribution for these early candidates.

**Exhibit 26: Pipeline**

| Candidate | Indication | Ownership | Stage | Comment |
|---|---|---|---|---|
| **EXPAREL** | Wound Infiltration | Pacira (WW) | FDA approved | By utilizing the DepoFoam platform, a single dose of Exparel delivers bupivacaine for an extended period of time, providing analgesia with reduced opioid requirements for up to 72 hours |
| | Nerve Block | Pacira (WW) | Phase II (complete) | |
| | Epidural | Pacira (WW) | Phase I (complete) | |
| **DepoNSAID** | Acute pain | Pacira (WW) | Preclinical | PCRX has DepoFoam formulations for several local infiltration NSAIDs, and expects to select a lead product candidateby in 2012. |
| **DepoMethotrexate** | Rheumatoid Arthritis / Oncology | Pacira (WW) | Preclinical | An extended release formulation of methotrexate; PCRX currently has one year of stability data for its desired product formulation. |

**Source: Company data, Jefferies**


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

# Management and Director Profiles

**Exhibit 27: Pacira Leadership Team**

| Name | Position | Joined |
|---|---|---|
| **Management Team** | | |
| David Stack | President and CEO | November 2007 |
| James Scibetta | CFO | August 2008 |
| Gary Patou, M.D. | Chief Medical Officer | March 2009 |
| Mark Walters | SVP, Technical Operations | February 2008 |
| **Board of Directors** | | |
| Fred Middleton | Chairman | December 2006 |
| David Stack | President and CEO | November 2007 |
| Luke Evnin, Ph.D. | Board Member | December 2006 |
| John Longenecker, Ph.D. | Board Member | July 2007 |
| Gary Pace, Ph.D. | Board Member | June 2008 |
| Andreas Wicki, Ph.D. | Board Member | December 2006 |
| Paul Hastings | Board Member | June 2011 |
| Laura Brege | Board Member | June 2011 |

**Source: Company Data, Jefferies**

## Executive Management

We see Pacira's management team as a key asset, with deep domain expertise in the hospital setting and a successful track record of launching acute care products. Notably, management is part of the same group that launched Angiomax at the Medicines Company, which is now a ~$450M drug. In particular, we believe that Dave Stack, CEO has an extremely good handle on the pulse of the hospital market given the amount of time he spends in ERs/ORs, and view him as an instrumental force in the eventual commercialization of Exparel.

- ***David Stack – President and Chief Executive Officer.*** Mr. Stack has served as the company's President, CEO and as a member of its Board of Directors since November 2007. Mr. Stack has been a managing director of MPM Capital since 2005 and a managing partner of Stack Pharmaceuticals, Inc. since 1998. From 2001 to 2004, he was President and CEO of The Medicines Company. Previously, Mr. Stack was President and General Manager at Innovex. He was VP, Business Development/Marketing at Immunomedics from 1993 until 1995. Prior to that, he was with Roche Laboratories in positions of increasing responsibility from 1981 until 1993.

- ***James Scibetta – Chief Financial Officer.*** Mr. Scibetta has served as the company's CFO since August 2008. Prior to that, Mr. Scibetta was CFO of Bioenvision from 2006 until its acquisition by Genzyme in 2007. From 2001 to 2006, Mr. Scibetta was EVP and CFO of Merrimack Pharmaceuticals and a member of its Board of Directors from 1998 to 2004. Mr. Scibetta formerly served as a senior investment banker at Shattuck Hammond Partners, LLC and PaineWebber Inc. He currently serves as Chairman of the Board of Nephros (NEPH, $0.88, NC) and heads its Audit Committee.

- ***Gary Patou, M.D – Chief Medical Officer.*** Dr. Patou has served as the company's Chief Medical Officer since March 2009. Dr. Patou has been a managing director of MPM Capital since 2005 and has served as Chief Medical Officer of MPM Capital portfolio companies at varying points including Peplin Ltd., Cerimon Pharmaceuticals, and Oscient Pharmaceuticals. Dr. Patou currently spends part of his


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

time as the acting CEO of Cerimon. From 2001 to 2004, he was President of Genesoft and from 1995 to 2000, Dr. Patou worked at SmithKline Beecham, now a unit of GlaxoSmithKline (GSK:LN, 1,425p, Buy), where he held positions of increasing responsibility including SVP and director, project and portfolio management. From 1991 to 1995, he held increasing senior, director level positions at Vernalis (VER:LN, 19.90p, NC). He currently serves as a member of the Board of Directors of Xenon Pharmaceuticals.

- ***Mark Walters – Senior Vice President, Technical Operations.*** Mr. Walters has served as SVP, Technical Operations since February 2008, and as VP of business and commercial development since March 2007. From January 2001 until March 2007, Mr. Walters was with SkyePharma Inc. serving as the VP of business and commercial development and as Director of both strategic sourcing and product management. From 1989 until 2001 Mr. Walters worked for Alliance Pharmaceutical Corp.


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Pacira (PCRX) – Income Statement**

*(In millions except per share amount)*

| | TOTAL REVS | COGS | Gross Profit | Margin % rev | R&D | % rev | SG&A | % rev | Other | Total OPEX | Op Income | % rev | Non-Op. Total | Pretax Inc | % rev | Inc. Tax Rate | Net Income | % rev | EPS (basic) | **EPS (diluted)** | Basic shares | Diluted shares |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2009** | **15.0** | 12.3 | 2.7 | 18.0% | 26.2 | 175% | 5.0 | 33% | 0.0 | 43.6 | (28.5) | | (3.2) | (31.7) | | 0.0 | (31.7) | | ($55.32) | **($3.71)** | 0.6 | 8.5 |
| 1Q | **4.8** | 3.7 | 1.0 | 21.7% | 4.6 | 97% | 1.0 | 21% | 0.0 | 9.4 | (4.6) | | (0.8) | (5.4) | | 0.0 | (5.4) | | ($9.39) | **($9.39)** | 0.6 | 0.6 |
| 2Q | **3.1** | 2.8 | 0.2 | 6.7% | 4.6 | 150% | 1.2 | 41% | 0.0 | 8.7 | (5.6) | | (1.2) | (6.8) | | 0.0 | (6.8) | | ($11.86) | **($11.86)** | 0.6 | 0.6 |
| 3Q | **4.5** | 3.6 | 1.0 | 21.2% | 5.7 | 126% | 1.7 | 37% | 0.0 | 11.0 | (6.5) | | (1.4) | (7.9) | | 0.0 | (7.9) | | ($13.76) | **($13.76)** | 0.6 | 0.6 |
| 4Q | **2.2** | 2.1 | 0.1 | 3.8% | 3.7 | 168% | 2.1 | 95% | 0.0 | 7.9 | (5.7) | | (1.4) | (7.0) | | 0.0 | (7.0) | | ($12.27) | **($12.27)** | 0.6 | 0.6 |
| **2010** | **14.6** | 12.3 | 2.3 | 15.7% | 18.6 | 128% | 6.0 | 41% | 0.0 | 36.9 | (22.4) | | (4.8) | (27.1) | | 0.0 | (27.1) | | ($47.28) | **($2.40)** | 0.6 | 11.3 |
| 1Q | **3.9** | 3.7 | 0.2 | 5.1% | 3.5 | 91% | 3.8 | 98% | 0.0 | 11.0 | (7.1) | | (2.7) | (9.8) | | 0.0 | (9.8) | | ($0.98) | **($0.98)** | 10.0 | 10.0 |
| 2Q | **3.6** | 3.1 | 0.5 | 14.3% | 4.4 | 120% | 4.7 | 128% | 0.0 | 12.2 | (8.5) | | (0.2) | (8.8) | | 0.0 | (8.8) | | ($0.51) | **($0.51)** | 17.2 | 17.2 |
| 3Q | **4.0** | 3.4 | 0.6 | 15.1% | 4.3 | 110% | 5.0 | 126% | 0.0 | 12.7 | (8.7) | | (0.8) | (9.5) | | 0.0 | (9.5) | | ($0.55) | **($0.55)** | 17.2 | 17.2 |
| 4QE | **3.9** | 3.2 | 0.7 | 17.4% | 3.7 | 96% | 7.5 | 194% | 0.0 | 14.4 | (10.5) | | (1.4) | (11.9) | | 0.0 | (11.9) | | ($0.57) | **($0.57)** | 21.0 | 21.0 |
| **2011E** | **15.3** | 13.3 | 2.0 | 13.0% | 15.9 | 104% | 21.0 | 137% | | 50.2 | (34.9) | | (5.0) | (39.9) | | 0.0 | (39.9) | | ($2.44) | **($2.44)** | 16.4 | 16.4 |
| 1QE | **4.2** | 3.3 | 0.9 | 21.7% | 2.5 | 59% | 10.0 | 238% | | 15.8 | (11.6) | | (1.0) | (12.5) | | 0.0 | (12.5) | | ($0.49) | **($0.49)** | 25.6 | 25.6 |
| 2QE | **5.8** | 7.7 | (1.9) | | 2.0 | 35% | 11.5 | 199% | | 21.2 | (15.4) | | (1.0) | (16.3) | | 0.0 | (16.3) | | ($0.64) | **($0.64)** | 25.7 | 25.7 |
| 3QE | **9.1** | 8.5 | 0.6 | 6.8% | 1.8 | 20% | 11.5 | 126% | | 21.8 | (12.7) | | (1.0) | (13.6) | | 0.0 | (13.6) | | ($0.53) | **($0.53)** | 25.8 | 25.8 |
| 4QE | **12.3** | 9.3 | 3.1 | 24.9% | 1.8 | 15% | 11.0 | 89% | | 22.1 | (9.7) | | (1.0) | (10.7) | | 0.0 | (10.7) | | ($0.41) | **($0.41)** | 25.9 | 25.9 |
| **2012E** | **31.5** | 28.8 | 2.7 | 8.6% | 8.1 | 26% | 44.0 | 140% | | 80.9 | (49.4) | | (3.8) | (53.2) | | 0.0 | (53.2) | | ($2.07) | **($2.07)** | 25.7 | 25.7 |
| **2013E** | **92.7** | 46.1 | 46.6 | 50.3% | 13.0 | 14% | 48.4 | 52% | | 107.5 | (14.8) | | (3.0) | (17.8) | | 0.0 | (17.8) | | ($0.68) | **($0.68)** | 26.3 | 26.3 |
| **2014E** | **154.7** | 49.7 | 105.0 | 67.9% | 13.4 | 9% | 52.3 | 34% | | 115.4 | 39.3 | 25.4% | (1.2) | 38.1 | 24.6% | 0.0 | 38.1 | 24.6% | $1.42 | **$1.26** | 26.8 | 30.3 |
| **2015E** | **228.3** | 59.8 | 168.5 | 73.8% | 10.7 | 5% | 56.5 | 25% | | 127.0 | 101.3 | 44.4% | 0.5 | 101.8 | 44.6% | 12.4 | 89.4 | 39.2% | $3.27 | **$2.86** | 27.3 | 31.2 |
| **2016E** | **288.8** | 66.5 | 222.2 | 77.0% | 10.7 | 4% | 59.3 | 21% | | 136.6 | 152.2 | 52.7% | 1.0 | 153.2 | 53.1% | 27.6 | 125.6 | 43.5% | $4.51 | **$3.93** | 27.9 | 32.0 |
| ***Growth*** | | | | | | | | | | | | | | | | | | | | | | |
| **09/08** | 8% | | nm | | -21% | | -42% | | | -27% | nm | | | nm | | | | | | nm | | |
| **10/09** | -3% | | nm | | -29% | | 20% | | | -15% | nm | | | nm | | | | | | nm | | |
| **11E/10** | 5% | | nm | | -14% | | 248% | | | 36% | nm | | | nm | | | | | | nm | | |
| **12E/11E** | **105%** | | nm | | -49% | | 110% | | | 61% | nm | | | nm | | | | | | nm | | |
| **13E/14E** | **194%** | | nm | | 61% | | 10% | | | 33% | nm | | | nm | | | | | | nm | | |
| **14E/13E** | **67%** | | 125% | | 3% | | 8% | | | 7% | nm | | | nm | | | | | | nm | | |
| **15E/14E** | **48%** | | 61% | | -20% | | 8% | | | 10% | 158% | | | 168% | | | 135% | | 130% | **128%** | | |
| **16E/15E** | **26%** | | 32% | | 0% | | 5% | | | 8% | 50% | | | 50% | | | 40% | | 38% | **37%** | | |

**Source: Company reports, Jefferies & Co. estimates**



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Pacira (PCRX) – Segment Revenues**

*(In millions)*

| | Exparel | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | U.S. Sales (infiltration) | (nerve blk) | U.S. | EU Sales Royalty | ROW Sales Royalty | **Exparel Total** | Supply Revenue Total | Other Product | **PRODUCT SALES** | Royalties Exparel | Other | Contract/ Development | Other | **TOTAL REVENUE** |
| **2007** | 0.0 | 0.0 | 0.0 | | | **0.0** | 5.4 | | **5.4** | 0.0 | 2.4 | 0.5 | | **8.3** |
| **2008** | 0.0 | 0.0 | 0.0 | | | **0.0** | 6.9 | | **6.9** | 0.0 | 3.6 | 3.4 | | **13.9** |
| **2009** | 0.0 | 0.0 | 0.0 | | | **0.0** | 6.3 | | **6.3** | 0.0 | 4.0 | 4.6 | | **15.0** |
| **2010** | 0.0 | 0.0 | 0.0 | | | **0.0** | 7.6 | | **7.6** | 0.0 | 3.7 | 3.2 | | **14.6** |
| 1Q | 0.0 | 0.0 | 0.0 | | | **0.0** | 1.7 | | **1.7** | 0.0 | 0.9 | 1.2 | | **3.9** |
| 2Q | 0.0 | 0.0 | 0.0 | | | **0.0** | 1.5 | | **1.5** | 0.0 | 0.9 | 1.3 | | **3.6** |
| 3Q | 0.0 | 0.0 | 0.0 | | | **0.0** | 1.7 | | **1.7** | 0.0 | 0.9 | 1.4 | | **4.0** |
| 4QE | 0.0 | 0.0 | 0.0 | | | **0.0** | 1.8 | | **1.8** | 0.0 | 1.0 | 1.1 | | **3.9** |
| **2011E** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **0.0** | 6.7 | | **6.7** | 0.0 | 3.7 | 4.9 | | **15.3** |
| 1QE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **0.0** | 1.9 | | **1.9** | 0.0 | 1.0 | 1.3 | | **4.2** |
| 2QE | 2.0 | 0.0 | 2.0 | 0.0 | 0.0 | **2.0** | 1.6 | | **3.6** | 0.0 | 0.9 | 1.3 | | **5.8** |
| 3QE | 5.0 | 0.0 | 5.0 | 0.0 | 0.0 | **5.0** | 1.9 | | **6.9** | 0.0 | 1.0 | 1.3 | | **9.1** |
| 4QE | 8.0 | 0.0 | 8.0 | 0.0 | 0.0 | **8.0** | 2.0 | | **10.0** | 0.0 | 1.1 | 1.3 | | **12.3** |
| **2012E** | 15.0 | 0.0 | 15.0 | 0.0 | 0.0 | **15.0** | 7.3 | | **22.3** | 0.0 | 4.0 | 5.2 | | **31.5** |
| **2013E** | 75.2 | 0.0 | 75.2 | 0.0 | 0.0 | **75.2** | 7.9 | | **83.1** | 0.0 | 4.3 | 5.4 | | **92.7** |
| **2014E** | 136.3 | 0.0 | 136.3 | 0.0 | 0.0 | **136.3** | 8.3 | | **144.7** | 0.0 | 4.5 | 5.5 | | **154.7** |
| **2015E** | 209.7 | 0.0 | 209.7 | 0.0 | 0.0 | **209.7** | 8.5 | | **218.2** | 0.0 | 4.6 | 5.5 | | **228.3** |
| **2016E** | 270.2 | 0.0 | 270.2 | 0.0 | 0.0 | **270.2** | 8.5 | | **278.7** | 0.0 | 4.6 | 5.5 | | **288.8** |
| ***% Growth*** | | | | | | | | | | | | | | |
| **10/09** | | | | | | | 20.8% | | **20.8%** | | -8.4% | -30.6% | | **-3.0%** |
| **11E/10** | | | | | | | -12.7% | | **-12.7%** | | 0.3% | 53.7% | | **5.3%** |
| **12E/11E** | | | | | | | 10.0% | | **235.0%** | | 6.6% | 5.2% | | **105.5%** |
| **13E/14E** | 401.1% | | 401.1% | | | 401.1% | 8.0% | | **272.0%** | | 8.0% | 3.0% | | **194.4%** |
| **14E/13E** | 81.4% | | 81.4% | | | 81.4% | 5.0% | | **74.1%** | | 5.0% | 3.0% | | **66.8%** |
| **15E/14E** | 53.8% | | 53.8% | | | 53.8% | 2.0% | | **50.9%** | | 2.0% | 0.0% | | **47.6%** |
| **16E/15E** | 28.8% | | 28.8% | | | 28.8% | 0.0% | | **27.7%** | | 0.0% | 0.0% | | **26.5%** |

**Source: Company reports, Jefferies & Co. estimates**



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Pacira (PCRX) – Cash Flow Statement**

| (In millions except per share amount) | Dec-08 | Dec-09 | Dec-10 | Mar-11 | Jun-11 | Sep-11 | Dec-11 | Dec-12 | Dec-13 | Dec-14 | Dec-15 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 12 mo | 12 mo | 12 mo | 3 mo | 6 mo | 9 mo | 12 mo | 12 mo | 12 mo | 12 mo | 12 mo | 12 mo |
| CASH FLOWS FROM OPERATING ACTIVITIES | | | | | | | | | | | | |
| Net income (loss) | (41.9) | (31.7) | (27.1) | (9.8) | (18.5) | (28.0) | (39.9) | (53.2) | (17.8) | 38.1 | 89.4 | 125.6 |
| Depreciation & Amortization | 4.2 | 4.1 | 4.1 | 1.0 | 2.0 | 3.0 | 3.6 | 4.4 | 6.7 | 8.1 | 10.6 | 13.1 |
| Other non-cash adjustments | (4.9) | 2.7 | (0.5) | 2.2 | 1.9 | 2.0 | 1.2 | 3.8 | 6.0 | 7.4 | 9.1 | 10.8 |
| Change in opearing assets & liabilities | 13.4 | 4.0 | (1.3) | 2.6 | (0.3) | (0.4) | (2.8) | 4.0 | (1.0) | (13.4) | (17.1) | (8.9) |
| **Net Cash from Operations** | **(29.2)** | **(20.8)** | **(24.9)** | **(4.0)** | **(14.9)** | **(23.4)** | **(37.8)** | **(41.0)** | **(6.2)** | **40.2** | **92.0** | **140.7** |
| CASH FLOWS FROM INVESTING ACTIVITIES | | | | | | | | | | | | |
| Purchases of fixed assets, net | (5.8) | (5.5) | (6.8) | (0.8) | (2.0) | (3.7) | (4.8) | **(11.8)** | (4.6) | (4.6) | (5.7) | (7.8) |
| Purchase of short-term investments, net | | | | | (19.8) | (20.7) | (0.0) | | | | | |
| Acquisition of intangible assets, business and other invests. | | | | | | | **2.0** | **(10.0)** | | | | |
| Net Cash from Investing | (5.8) | (5.5) | (6.8) | (0.8) | (21.8) | (24.4) | (2.9) | (21.8) | (4.6) | (4.6) | (5.7) | (7.8) |
| CASH FLOWS FROM FINANCING ACTIVITIES | | | | | | | | | | | | |
| Proceeds from issuance of preferred stock | 40.0 | | | | | | | | | | | |
| Proceeds from issuance of common stock and options excercises | 0.2 | 0.0 | 0.0 | 38.0 | 38.0 | 38.0 | **90.4** | | | | | |
| Purchase of treasury stock | | | (0.0) | | | | | | | | | |
| Proceeds from convertible notes | | 10.6 | 7.5 | | | | | | | | | |
| Proceeds from secured promissory notes & credit facility | | 10.6 | 56.3 | | | | | | | | | |
| Other credit/debt financing | | | | | | | | 10.0 | | | | |
| Payoff of credit facility | | | (11.3) | | | | | | | (10.0) | | |
| Financing Costs | | (0.2) | (1.8) | | | | (3.1) | | | | | |
| Net Cash from Financing | 40.2 | 21.0 | 50.7 | 38.0 | 38.0 | 38.0 | 87.2 | 10.0 | 0.0 | (10.0) | 0.0 | 0.0 |
| Foreign exchange rate effect | | | | | | | | | | | | |
| **Net Increase in Net Cash** | 5.1 | (5.3) | 19.1 | 33.2 | 1.3 | (9.7) | 46.5 | (52.8) | (10.8) | 25.6 | 86.3 | 132.9 |
| Net Cash at beginning of year | 7.2 | 12.4 | 7.1 | 26.1 | 26.1 | 26.1 | 26.1 | 72.7 | 19.9 | 9.1 | 34.7 | 121.0 |
| **Net Cash, End of Period** | **12.4** | **7.1** | **26.1** | **59.3** | **27.5** | **16.4** | **72.7** | **19.9** | **9.1** | **34.7** | **121.0** | **253.9** |

**Source: Company reports, Jefferies & Co. estimates**



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

**Pacira (PCRX) – Balance Sheet**

| (In millions) | Dec-09 | Dec-10 | Mar-11 | Jun-11 | Sep-11 | Dec-11 | Dec-12 | Dec-13 | Dec-14 | Dec-15 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ASSETS** | | | | | | | | | | | |
| **Current Assets:** | | | | | | | | | | | |
| Cash & cash equivalents | 7.1 | 26.1 | 59.3 | 27.5 | 16.4 | 72.7 | 19.9 | 9.1 | 34.7 | 121.0 | 253.9 |
| Restricted cash | 1.2 | 1.3 | | 2.1 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 |
| Short-term investments | | | | 19.8 | 20.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Accounts receivables | 1.5 | 1.2 | 1.8 | 1.1 | 1.5 | 1.5 | 5.2 | 16.0 | 26.7 | 39.4 | 49.8 |
| Inventory | 1.7 | 1.6 | 1.8 | 1.9 | 1.7 | 2.0 | 9.5 | 22.7 | 24.5 | 29.5 | 32.8 |
| Prepaid expenses & other current assets | 1.1 | 0.8 | 1.1 | 1.4 | 1.5 | 1.5 | 3.8 | 13.0 | 23.2 | 34.2 | 43.3 |
| Total Current Assets | 12.5 | 31.1 | 64.0 | 53.6 | 43.4 | 79.3 | 40.0 | 62.5 | 110.8 | 225.9 | 381.6 |
| Property, Plant, & Equipment, net | 19.6 | 24.0 | 24.4 | 24.6 | 25.8 | 26.5 | 27.2 | 27.6 | 27.6 | 27.6 | 28.5 |
| Intangibles, net | 11.2 | 8.9 | 8.3 | 7.8 | 7.2 | 7.2 | 7.2 | 7.2 | 7.2 | 7.2 | 7.2 |
| Other assets, net | 0.7 | 2.6 | 1.1 | 1.1 | 1.2 | 1.2 | 2.4 | 9.3 | 15.5 | 22.8 | 28.9 |
| **TOTAL ASSETS** | **44.0** | **66.6** | **97.9** | **87.1** | **77.6** | **114.2** | **76.7** | **106.6** | **161.1** | **283.5** | **446.2** |
| **Working Capital** | **-1.9** | **14.7** | **44.4** | **36.1** | **25.6** | **62.4** | **5.6** | **-4.2** | **34.8** | **138.3** | **280.1** |
| **LIABILITIES & STOCKHOLDERS EQUITY** | | | | | | | | | | | |
| **Current Liabilities** | | | | | | | | | | | |
| Accounts Payable | 7.0 | 6.0 | 6.1 | 5.1 | 4.3 | 5.8 | 17.3 | 32.9 | 31.3 | 39.3 | 43.8 |
| Accrued expenses | 3.5 | 3.3 | 3.8 | 3.6 | 5.0 | 6.2 | 11.0 | 27.8 | 38.7 | 45.7 | 57.8 |
| Current portion of royalty interest obligation | 1.6 | 1.6 | 1.6 | 1.5 | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Current portion of deferred revenue | 2.3 | 2.3 | 2.6 | 2.5 | 2.4 | | | | | | |
| Current portion of long-term debt | 0.0 | 3.2 | 5.6 | 4.9 | 4.9 | 4.9 | 6.0 | 6.0 | 6.0 | 2.6 | 0.0 |
| Total current liabilities | 14.4 | 16.3 | 19.7 | 17.5 | 17.8 | 16.9 | 34.4 | 66.7 | 76.0 | 87.6 | 101.5 |
| **Long-term Liabilities** | | | | | | | | | | | |
| Related party debt, including accrued interest | 22.2 | 49.8 | | | | | | | | | |
| Long-term debt | | 21.9 | 19.6 | 20.4 | 20.6 | 20.6 | 14.6 | 8.6 | 2.6 | 0.0 | 0.0 |
| Royalty interest obligation | 3.6 | 3.0 | 2.9 | 2.2 | 1.8 | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Deferred revenue | 20.4 | 18.1 | 18.9 | 18.4 | 17.8 | 17.8 | 17.8 | 17.8 | 17.8 | 17.8 | 17.8 |
| Contingent purchase liability | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| Deferred rent | 1.2 | 1.3 | 1.3 | 1.4 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Other liabilities | 3.1 | 2.5 | 2.4 | 2.3 | 3.6 | 3.6 | 3.6 | 3.6 | 3.6 | 3.6 | 3.6 |
| **Total Liabilities** | 66.9 | 114.9 | 66.7 | 64.2 | 63.7 | 61.5 | 72.4 | 98.7 | 102.0 | 111.0 | 125.0 |
| **Stockholders' Equity** | | | | | | | | | | | |
| Total stockholders' equity | -22.9 | -48.4 | 31.1 | 22.9 | 13.9 | 73.4 | 15.6 | 18.6 | 79.8 | 193.3 | 342.0 |
| **TOTAL LIABILITITES AND EQUITY** | **44.0** | **66.6** | **97.9** | **87.1** | **77.6** | **134.9** | **88.0** | **117.4** | **181.8** | **304.3** | **466.9** |

**Source: Company reports, Jefferies & Co. estimates**



**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

## Company Description

**Pacira Pharmaceuticals, Inc. is a specialty pharmaceutical company focused on the development, commercialization and manufacture of pharmaceutical products, based on its DepoFoam drug delivery technology, for use in hospitals and ambulatory surgery centers. Its leading product candidate is EXPAREL (approved by FDA in October 2011), a long-acting bupivacaine (anesthetic/analgesic) product for postsurgical pain management. EXPAREL provides analgesia for up to 72 hours post-surgery. EXPAREL consists of bupivacaine encapsulated in DepoFoam. DepoFoam, its extended release drug delivery technology, is the basis for its commercial products: DepoCyt(e) and DepoDur, which it manufactures for its commercial partners. Its product portfolio and product candidate pipeline include EXPAREL, DepoCyt, DepoDur, DepoNSAID and DepoMethotrexate.**

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The brother of the analyst is the Head of Investor Relations for Endo Pharmaceuticals.

An individual involved in the preparation of this report owns shares of GlaxoSmithKline common stock.

An individual involved in the preparation of this report owns shares of GlaxoSmithKline Plc common stock

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**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

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5. Once a month, analysts are invited to recommend their best ideas. Analysts' stock selection can be based on one or more of the following: non-Consensus investment view, difference in earnings relative to Consensus, valuation methodology, target upside/downside % relative to the current stock price. These are then assessed against existing holdings to ensure consistency. Stocks that have either reached their target price, been downgraded over the course of the month or where a more suitable candidate has been found are removed.
6. All stocks are inserted at the last closing price and removed at the last closing price. There are no changes to the conviction list during the month.
7. Performance is calculated in US dollars on an equally weighted basis and is compared to MSCI World AC US$.
8. The conviction list is published once a month whilst global equity markets are closed.
9. Transaction fees are not included.
10. All corporate actions are taken into account.

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- Alkermes, Inc. (ALKS: $19.05, BUY)
- Allergan, Inc. (AGN: $89.30, HOLD)
- AMAG Pharmaceuticals, Inc. (AMAG: $16.68, UNDERPERFORM)
- BioSante Pharmaceuticals (BPAX: $0.68, HOLD)
- Endo Pharmaceuticals Holdings, Inc. (ENDP: $37.36, BUY)
- Forest Laboratories, Inc. (FRX: $31.80, BUY)
- GlaxoSmithKline Plc (GSK LN: p1,441.00, BUY)
- Jazz Pharmaceuticals (JAZZ: $45.96, BUY)
- Medicis (MRX: $32.35, BUY)
- Orexigen Therapeutics, Inc. (OREX: $2.58, HOLD)
- Pacira Pharmaceuticals, Inc. (PCRX: $9.06, BUY)
- POZEN Inc. (POZN: $4.25, HOLD)
- Salix Pharmaceuticals, Ltd. (SLXP: $46.00, BUY)
- Shire (SHPGY: $100.14, HOLD)
- Somaxon Pharmaceuticals, Inc. (SOMX: $0.64, BUY)
- The Medicines Company (MDCO: $19.31, HOLD)
- Valeant Pharmaceuticals International (VRX: $50.72, BUY)


**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

• Warner Chilcott Ltd. (WCRX: $16.85, BUY)


## Distribution of Ratings

| Rating | Count | Percent | IB Serv./Past 12 Mos. Count | IB Serv./Past 12 Mos. Percent |
|---|---|---|---|---|
| BUY | 740 | 51.90% | 106 | 14.32% |
| HOLD | 585 | 41.00% | 62 | 10.60% |
| UNDERPERFORM | 101 | 7.10% | 3 | 2.97% |

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**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com

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**Corey Davis, Ph.D.**, Equity Analyst, (212) 336-7187, cdavis@jefferies.com