Versartis

Biotechnology

US Equity Research
17 February 2015

BUY
unchanged

PRICE TARGET US$45.00
unchanged

Price (16-Feb)	US$18.04
Ticker	VSAR-NASDAQ

52-Week Range (US$):	16.15 - 36.86
Avg Daily Vol (M) :	148.3
Shares Out. (M) :	23.3
Market Cap (US$M):	420

FYE Dec	2013A	2014A	2015E
Revenue (US$M)	0.0	0.0	0.0
EPS Adj&Dil (US$)	(1.99)	(3.03)↓	(2.37)↓
Previous	*(1.99)*	*(2.65)*	*(2.34)*

Quarterly Revenue	Q1	Q2	Q3	Q4
2013A	0.0	0.0	0.0	0.0
2014A	0.0	0.0	0.0	0.0
2015E	0.0	0.0	0.0	0.0

Quarterly EPS Adj&Dil	Q1	Q2	Q3	Q4
2013A	-	-	-	-
2014A	(16.13)	(0.36)	(0.57)	(0.65)
2015E	(0.49)	(0.55)	(0.65)	(0.69)

Source: FactSet

Versartis is a biotechnology company focused on development and commercialization of VRS-317 for human growth hormone deficiency.

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Estimates Revised

VRS-317 in favorable competitive position vs. Ascendis, Opko

Ascendis and Opko height velocity related to severe growth hormone (GH) deficient patients

Patients in the non-US based Ascendis and Opko clinical trials had more severe growth deficiency than the US-based Versartis study, likely resulting in higher growth velocities for Ascendis and Opko. Particularly, Ascendis (A) and Opko (O) had lower height standard deviations (A: -3.0, O: -3.9, V: -2.5), IGF-1 levels (A: -2.3, O: -2.1, V: -1.7), and bone age (A: 4.85 yrs; V: 6.4 yrs), which may contribute to the higher annualized HV seen in their trials at 6 months. We expect that FDA will require a US-based study to secure approval for pediatric growth hormone deficiency.

VSAR safety clean, long-term Ascendis PEG safety unknown

VRS-317 demonstrated a clean safety profile with their 3.5 mg/kg semi-monthly dose, and has safety data out to >12 months, a major positive. Ascendis safety appears reasonable to date, but details have not been disclosed. Also, the pegylated formulation in Ascendis' technology could be a concern since we do not know the long-term safety effects of this formulation in pediatrics, especially since the drug is given for 5-10 years. Additionally, because the pegylated carrier is renally eliminated, we do not yet have data to determine whether the drug accumulates in the kidney. We suspect FDA may require long-term follow-up safety data for Ascendis' technology that may delay regulatory approval.

Ascendis has active comparator, Versartis trends also positive

Ascendis included a standard of care comparator Norditropin arm in their phase 2 study, which may ease interpretation of efficacy, but Versartis performance at one year is in-line with historical once daily data. Importantly, Versartis has produced 12-month height velocity data, whereas Ascendis and Opko have data at 6 months only. Importantly, height velocity for Ascendis may be lower at 12 months versus 6 months, in-line with historical performance of daily human growth hormone. Versartis has not seen a drop-off in height velocity at 12 months vs. 6 months.

Versartis 18 months ahead of Ascendis, 2x vs 4x month dose

Versartis has an ~18 month lead in development over Ascendis, which we believe may offer an important commercial advantage. Ascendis may ultimately be successful in gaining FDA approval and commercializing their drug in the US for pediatric growth hormone deficiency. However, we believe that Versartis' semi-monthly formulation may be more attractive than Ascendis' weekly formulation.

Maintain BUY rating, $45 PT

We maintain our BUY rating and $45 PT based on continued confidence in VRS-317. We decrease our 2015 EPS estimates based on company's 4Q14 earnings update.

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For important information, please see the Important Disclosures beginning on page 13 of this document.

Baseline demographic differences reason for difference in height velocity between trials

We believe the larger magnitude height velocity seen for Ascendis and Opko's long-acting human growth hormone drugs vs. VSAR-317 is related to more severe growth hormone deficiency at baseline. The patient demographics in the Ascendis and Opko clinical trials included highly growth deficient patients likely to show a higher magnitude height velocity that is not representative of US patients. Importantly, both the Opko and Ascendis studies had more severe baseline bone age, height standard deviation (SDS), IGF-1 SDS, and GH stimulation test values. In countries where growth hormone is not approved or reimbursed, specifically eastern European nations, the patient demographic may have more severe GH deficiency compared to Western European countries or the US. Therefore, treatment with GH in these patients will show a significantly higher response than the US and Western European population, making it difficult to compare the three products from an efficacy standpoint.

The figure below shows the differences in baseline demographics between VSAR's semi-monthly formulation vs. Ascendis' and Opko's weekly formulation. In general, the average height velocity of healthy children decreases as they approach puberty, which means that direct numerical comparisons between height velocities in children of different ages are not possible (Ranke et al. *J Clin Endocrinol Metab*. 2010). In terms of age, Opko's trial had the youngest patients (6.1 years old) vs. VSAR (7.8 years old) and Ascendis (7.9 years old), which is important to note since younger patients grow faster than older patients and falsely demonstrate a greater response in annualized height velocity with the drug. This difference is also seen in the baseline bone age, where VSAR patients had an initial bone age of 6.4 years vs. Ascendis of 4.85 years. We believe the differences are closely tied to the higher height velocity seen in Opko's and Ascendis' trials versus VSAR's study.

US study for Versartis, Eastern European patients for Ascendis, Opko

Ascendis and Opko also had patients with lower height standard deviations than VSAR, demonstrating that these patients are further away from the normal growth chart, allowing them to grow faster with GH treatment. VSAR had patients with an average height SDS of -2.5, which is typical of US and Western European clinics. Ascendis and Opko had height SDS of -3.0 and -3.9, respectively, which again shows that these patients suffer from severe growth deficiency. Finally, IGF-1 (a hormone required for growth) SDS were also farther away from the norm in the Ascendis (-2.3) and Opko (-2.1) patient population compared to VSAR (-1.7), which may contribute to the higher annualized height velocities seen in their trials. We believe physicians will carefully take these differences into consideration when looking at the full results from each study and may feel that the trials from Opko and Ascendis may not represent the patient demographic that they treat.

Finally, from a FDA approval perspective, we do not know if the agency will look favorably to the results of clinical trials that do not fully represent the US patient population. Average height SDS below -2.5 is very uncommon, and clinical studies have demonstrated that the mean US height SDS for GH patients is only -2.7 (Hintz RL et al. NEJM. 1999; Deodati A et al. BMJ. 2011). Importantly, SDS below -3.0 is even rarer in the US, which we believe the agency may require another trial with US patient demographics in order to receive approval, a concern going forward with both Opko and Ascendis' trials.

Figure 1: Baseline patient demographics in GH trials

	VSAR	Ascendis	Opko	Norditropin
	Xten technology reduce receptor mediated clearance and kidney filtration	TransCon carrier - long acting produg with predicatable release of unmodified parent drug	CTP technology - pegylation	Endogenous GH
Demographics	US	Europe and Eastern Europe	Eastern Europe	US
Formulation	Semi-monthly	Weekly	Once weekly	Daily
Patients (n)	64	49	50	104
Age (yrs)	7.8	7.9	6.1	7.8
Bone age (yrs)	6.4	4.85		
Height SDS	-2.5	-3.0	-3.9	-3.0
GH stimulation test	5.4	4.7	3.9	4.9
IGF-1 SDS	-1.7	-2.3	-2.1	-2.8

Source: Company Reports, Canaccord Genuity estimates

Patients with severe GH deficiency have higher responses to therapy

The concept of patients with severe GH deficiency resulting in a more robust increase in annual height velocity after exogenous growth hormones was validated by Ranke and colleagues. The group examined patient data from the KIGS-Pfizer International Growth Database, and noted that patients with severe GH deficiency (measured by max GH levels <5 ug/L) had a higher height velocity at one year of 10.39 cm vs. 8.58 cm for patients with less severe GH deficiency (max GH levels 5 -10 ug/L) when treated with daily gonadotropin hormones. Although baseline GH levels were not checked in any of the three trials, we believe Ascendis and Opko had more patients with severe GH deficiency vs. VSAR, which can contribute to higher height velocities at one year that was reported.

Figure 2: Height velocity with daily Gonadotropin: Severe vs. moderate GH deficiency

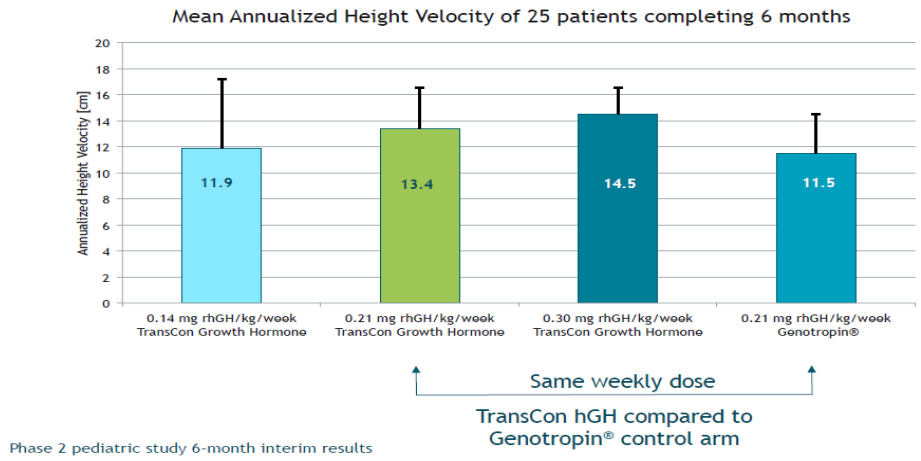
Growth disorder	GHD (maxGH <5 μg/liter) (n = 2129) Mean	SD	GHD (maxGH = 5–10 μg/liter) (n = 3075) Mean	SD
At start of (before) GH therapy				
Age (yr)	6.44	3.12	6.86	2.54
Ht SDS	−3.61	1.26	−3.19	0.89
HV (cm/yr)	5.00	2.19	5.07	1.79
ΔHt SDS	−0.22	0.72	−0.08	0.47
GH dose at start (mg/kg/wk)	0.22	0.07	0.22	0.07
After the first year of GH therapy				
HV (cm/yr)	10.39	3.08	8.58	2.07
ΔHt SDS	1.11	0.69	0.74	0.43
SR	−0.37	1.44	−0.09	1.03

Source: Ranke et al. J Clin Endocrinol Metab. 2010

Ascendis and Opko demonstrate higher height velocity but in severe GH patient population

Ascendis and Opko's formulation both showed higher annualized height velocity vs. VSAR, although we believe it is difficult to compare the results between the trials since the baseline characteristics in the former two studies had more severe GH deficient patients. At 6 months, the mean annualized height velocity was 11.9 – 14.5 cm in the Ascendis trial (0.14 – 0.3 mg/kg/week TransCon hGH) and 12.25 – 14.37 cm in the Opko trial (0.25 – 0.66 mg/kg/week Lagova) (Figure 2 and 3). VSAR's VRS-317 reported a lower 8.7 cm in mean annualized height velocity at 6 months with the 2.5 mg/kg semi-monthly dose and a dose response increase to 9.3 cm at 12 months when 20 patients on the 1.15 mg/kg dose switched to the higher 3.5 mg/kg semi-monthly dose.

Figure 3: Ascendis: TransCon hGH vs. Daily hGH

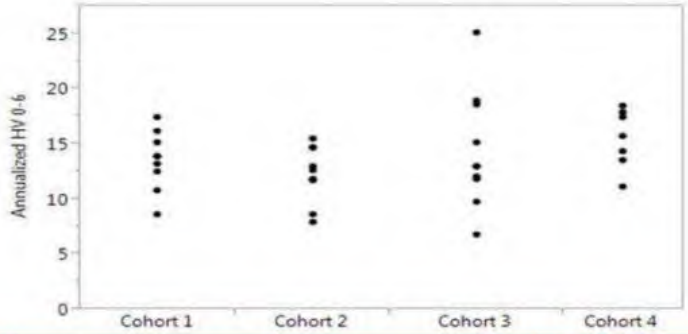


Source: Ascendis Corporate Presentation

Lack of dose response for height velocity problematic for Opko

Opko's Lagova did not show a dose-proportional response for increased height velocity, which we view as problematic. The dose response actually appeared to be inversely dose proportional for the 0.25 and 0.35 mg/kg/wk dose, and also for the 0.40 mg/kg/wk dose when excluding outliers. Importantly, the standard deviation for the highest dose of 0.48 mg/kg/wk was 5.26 versus 2.71, 2.64, and 2.68 for the 0.18 and 0.35 mg.kg.wk Lagova doses, and the 0.034 mg/kg/day Genotropin control dose. Although the number of patients in each group was small, we believe that the trends to suggest a lack of dose response, which we believe will be a serious problem for the drug going forward.

Figure 4: Opko: Lagova vs. Daily hGH

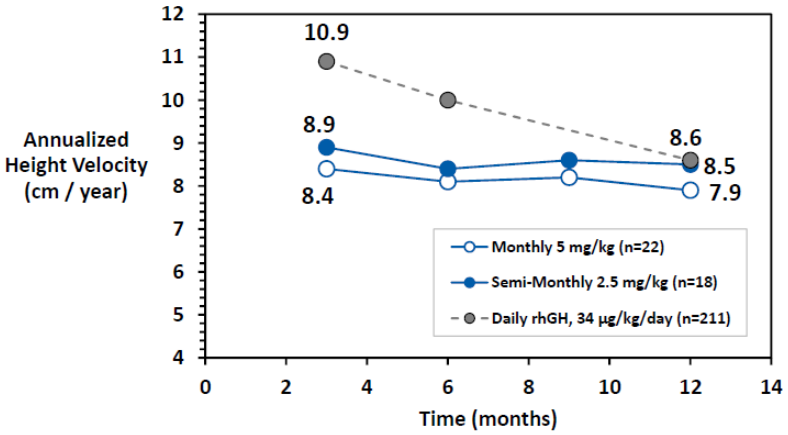


Cohort	Dose	hGH Content	N	Mean (cm/year)	Std Dev
Cohort 1	0.25 mg/kg/w Lagova™	0.18 mg/kg/week	9	13.48	2.71
Cohort 2	0.48 mg/kg/w Lagova™	0.35 mg/kg/week	9	12.25	2.64
Cohort 3	0.66 mg/kg/w Lagova™	0.48 mg/kg/week	10	14.37	5.26
Cohort 4	0.034 mg/kg/d Genotropin	0.24 mg/kg/week	7	15.46	2.68

Source: Opko Corporate Presentation

Importantly, Ascendis and Opko both have a standard of care comparator Norditropin arm in their phase 2 study, which may allow easier efficacy interpretation versus once daily drugs. TransCon hGH and Lagova both demonstrated similar annualized height velocity vs. daily norditropin, but 12 month data for Ascendis and Opko are not yet available. Importantly, height velocity may decrease at 12 months vs. 6 months for Ascendis and Opko's drugs as seen for daily historical rhGH (Figure 5).

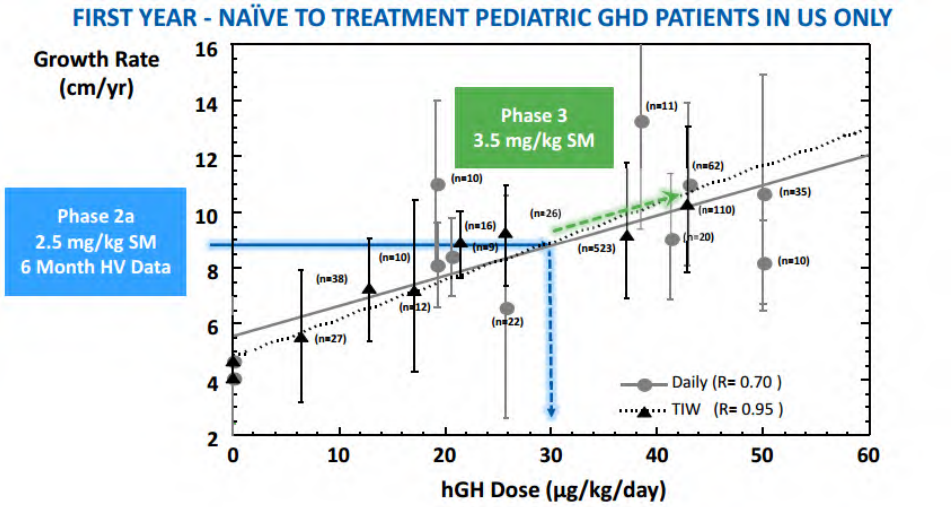
Figure 5: Versartis: VRS-317 vs. historical daily growth hormone



Source: Versartis Corporate Presentation

Although VSAR's phase 2a data did not have a 1x daily comparator arm, comparison to age-matched historical control with high dose daily Genotropin and Norditropin show comparable 6 month height velocity results, which we view as a positive (Figure 6). However, interim 6-month height velocity in Phase 3 expected during 2016 will be critical for VRS-317, in our view.

Figure 6: VRS-317 vs. daily rhGH: decline in annualized height velocity with daily rhGH

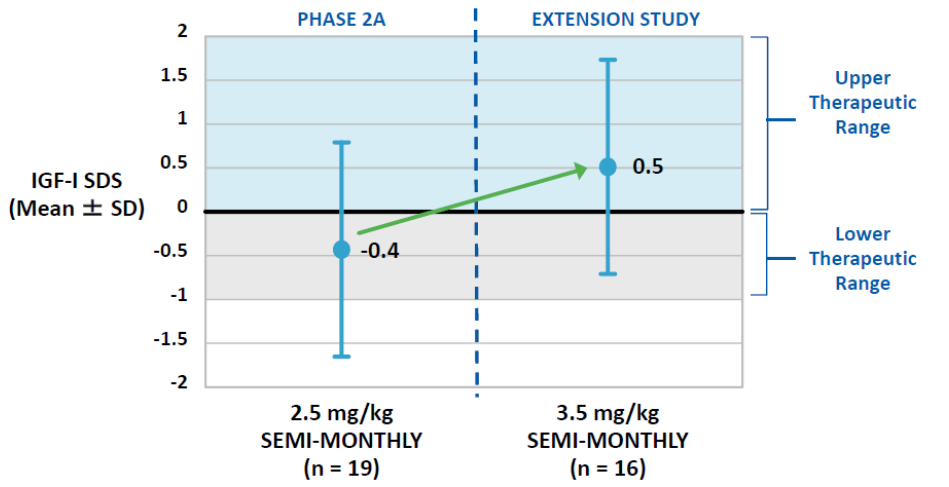


Source: Versartis Corporate Presentation

VSAR and Ascendis demonstrate dose proportional IGF-1 elevations, no correlation for Opko

Both VSAR and Ascendis reported positive IGF-1 dose proportional IGF-1 elevations after dose administration vs. Opko, which mildly elevated IGF-1 levels without much correlation to the dose. Compared to the 2.5 mg/kg semi-monthly dose in the VSAR trial, the 3.5 mg/kg dose resulted in a full one SD higher mean IGF-I SDS (0.5 vs. -0.4), which we believe is significant as this correlates with positive increases in height velocity. Additionally, we believe the increase in IGF-I SDS confirms the PK/PD model of the higher dose. Although there were two transient overexposure of IGF-I levels above 2, we do not find this clinically relevant, since negative events, like acromegaly, are only seen chronic IGF-I exposures above 3 SDS.

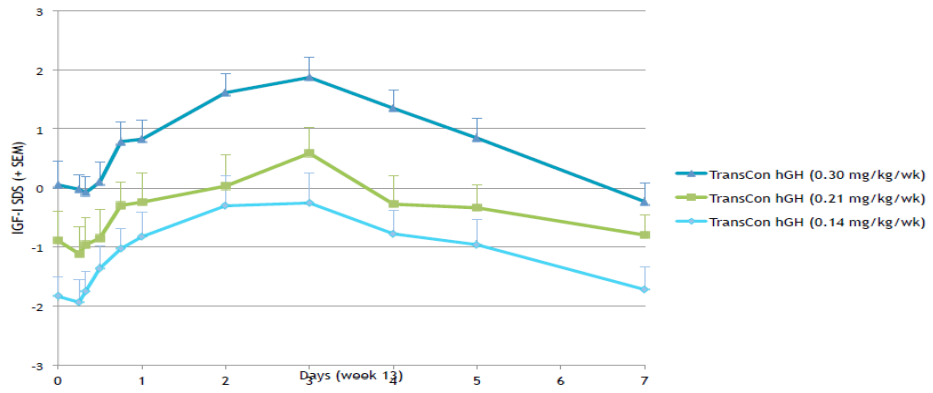
Figure 7: Dose response in IGF-I standard deviations



Source: VSAR corporate presentation

Ascendis also reported positive IGF-1 elevations at 6 months that appeared to be dose dependent, as seen in the figure below. Both VSAR and Ascendis had some IGF-1 excursions above 2 SDS, which we do not find meaningful since FDA is only concerned with chronic IGF-1 exposure above 2 SDS. The company reported data on the first 25 patients at 6 months and we await complete data with the final 49 patients to see if the curves remain elevated. We suspect that Ascendis may opt to take the lowest dose tested in Phase 2 into Phase 3 as we expect a non-inferiority study design.

Figure 8: Ascendis: IGF-1 dose proportional levels

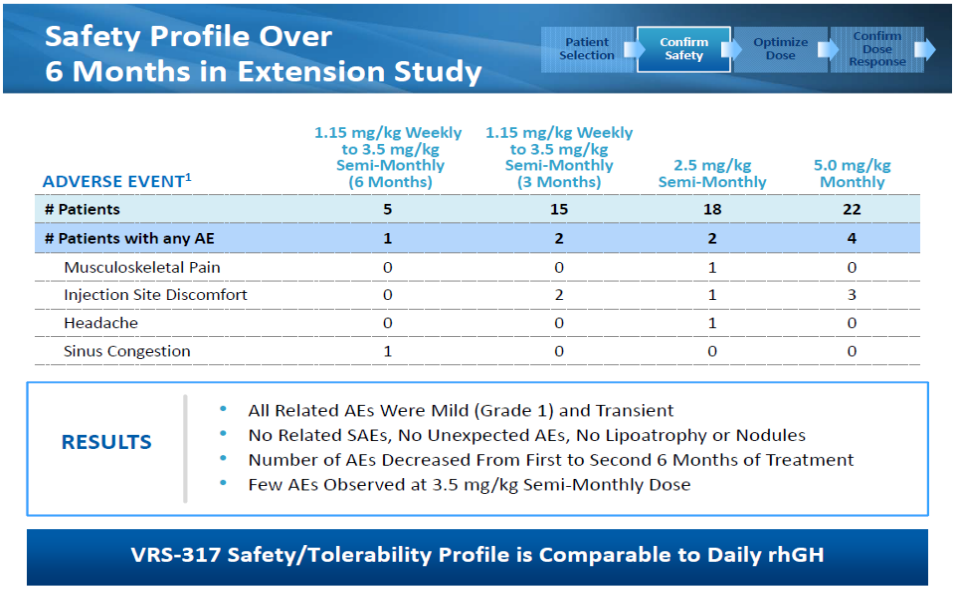


Source: Company Reports, Canaccord Genuity estimates

VSAR demonstrates clean safety profile, long term effects with Ascendis pegylated formulation unknown

VRS-317 demonstrated a clean safety profile with their 3.5 mg/kg semi-monthly dose, with only a few injection site reactions that were grade 1. Interestingly, when patients were switched from 1.5 mg/kg weekly to 3.5 mg/kg semi-monthly dose, adverse events actually decreased over the next 6 months, demonstrating the positive tolerability of this dose.

Figure 9: Safety profile in 6 month extension study



Source: VSAR corporate presentation

Ascendis also reported low safety side effects, with minor AEs including some musculoskeletal pain and headache, similar to daily rhGH. However, details have not yet been disclosed, and data are only available at 6 months. Importantly, because Ascendis' technology involves a pegylated carrier for the rhGH that has a longer circulating half-life than the active rhGH, we do not know the long-term safety effects of this formulation in pediatrics, especially since these drugs are often given for 5-10 years. Additionally, because the pegylated carrier is renally eliminated, we do not have data regarding whether or not the drug can accumulate in the kidneys to cause any systemic damage. Because these human growth hormone drugs are given chronically in children, FDA is likely to have a higher safety bar for approval then for other PEGylated drugs, in our view.

Figure 10: Ascendis Transcon Technology

Source: Ascendis Corporate Presentation

The figure below shows twelve FDA approved pegylated medications currently on the market. However, only 3 of the drugs are approved for pediatric use, including Pegasys, Oncaspar, and Adagen, demonstrating the fact that the agency does not have a lot of experience in approving pegylated formulations of drugs in pediatrics, especially for chronic use. Both Oncaspar and Adagen are approved for very serious diseases, including acute lymphoblastic leukemia and SCID, which we believe the benefit of the treatment outweighs the unknown side effects of long term use of the pegylated formulation. Pegasys is approved in the pediatric population for hepatitis B and C, although the maximum duration is only 48 weeks vs. the 5-10 years of growth hormone treatment in GH deficient patients. GH deficiency does not fall into either category of severe disease or short-term treatment duration. Therefore, we believe the agency may require long-term safety data with Ascendis' pegylated formulation, especially since the current standard of care daily rhGH is already deemed safe for chronic use.

Figure 11: FDA approved Pegylated drugs

Generic name	Brand name	Use	Pediatric approved
Naloxegol	Movantik	PEGylated naloxol for the treatment of opioid-induced constipation in adults patients with chronic non-cancer pain	
Peginesatide	Omontys	once-monthly medication to treat anemia associated with chronic kidney disease in adult patients on dialysis	
Pegloticase	Krystexxa	PEGylated uricase for the treatment of gout	
Certolizumab pegol	Cimzia	monoclonal antibody for treatment of moderate to severe rheumatoid arthritis and Crohn's disease, an inflammatory gastrointestinal disorder	
Methoxy polyethylene glycol-epoetin beta	Mircera	PEGylated form of erythropoetin to combat anemia associated with chronic kidney disease	
Pegaptanib	Macugen	used to treat neovascular age-related macular degeneration	
Pegfilgrastim	Neulasta	PEGylated recombinant methionyl human granulocyte colony-stimulating factor for severe cancer chemotherapy-induced neutropenia	
Pegvisomant	Somavert	PEG-human growth hormone mutein antagonist for treatment of Acromegaly	
Peginterferon alfa-2a	Pegasys	PEGylated interferon alpha for use in the treatment of chronic hepatitis C and hepatitis B	X
Doxorubicin HCl liposome	Doxil/Caelyx	PEGylated liposome containing doxorubicin for the treatment of cancer	
Pegasparagase	Oncaspar	PEGylated L-asparaginase for the treatment of acute lymphoblastic leukemia	X
Pegademase bovine	Adagen	PEG-adenosine deaminase for the treatment of Severe Combined Immunodeficiency Disease (SCID)	X

Source: FDA.gov, Canaccord Genuity estimates

Semi-monthly dose easier to use vs. weekly formulation

We continue to believe that the semi-monthly dose is the main advantage for VRS-317 vs. weekly competitors in terms of patient compliance and physician acceptance. We remind investors that the point of long acting growth hormones is to increase compliance, since compliance with daily dosing gonadotropin is only 67% by the first year of use. Parents may find it cumbersome to go into clinic every week for an injection when they can do it only twice a month. We acknowledge the fact that two injections may be needed in older patients with the VSAR formulation since it is weight based, although we believe parents will still find the less traveling time to be significant. When evaluating the different products, we continue to believe that physicians and patients will find the idea of taking half the required number of shots per month quite favorably.

Second product could boost shares, important mid-2015 event

Versartis may announce a second clinical program by mid-2015, which could move shares higher, given the large commercial opportunity for some of its proof-of-concept programs. Versartis works with Amunix to take proof-of-concept data into clinical development. Versartis and Amunix have published proof-of-concept data for long-acting Gattex, glucagon, and GLP-1, although the company has made no indication of the identity of the potential second program. We do suspect that the second program will also be in endocrinology, similar to VRS-317. Importantly, a second clinical program could lead to additional upside to the share price during 2015, and also diversify risk, both of which we view as positive.

Figure 12: VSAR Catalysts

Drug	Description	Timing	Effect	Importance	Notes
VRS-317	Initiation of phase 2/3 pediatric trial in Japan	Early 2015	↑	High	Note: japan uses 25 ug/day vs. 34 ug/d in US
VRS-317	Phase 2/3 registration study in adults	2H15	↑	High	Dose escalation trial, IGF-1 level dosing
VRS-317	6-month Phase 3 results pediatric growth hormone deficiency	mid-2016	↑	Critical	Commence phase 3 trial early 2015 @ higher dose of 3.5 mg/kg semi-monthly
VRS-317	Top line data with 12 month height velocity	Early 2017	↑	Critical	BLA submission in 2017, FDA approval mid-2018

Source: Company Reports, Canaccord Genuity estimates

Figure 13: VSAR Income Statement

Income Statement ($000's)	2012A	2013A	Mar-14A	Jun-14A	Sep-14A	Dec-14A	2014E	2015E	2016E	2017E	2018E	2019E	2020E	2021E	2022E
Total revenues									-	17,859	273,992	635,385	924,102	1,066,948	1,174,795
Cost of goods sold								-	-	1,429	21,919	50,831	73,928	85,356	93,984
Gross profit	-	-	-	-	-	-	-	-	-	16,430	252,073	584,554	850,173	981,592	1,080,811
Operating expenses															
R&D	10,963	14,855	4,869	5,622	10,515	11,602	32,608	40,950	42,000	37,000	30,879	69,892	101,651	117,364	129,227
SG&A	1,936	4,428	2,714	2,877	3,577	4,338	13,506	17,550	19,000	31,500	54,798	101,662	147,856	170,712	187,967
Total expenses	12,899	19,283	7,583	8,499	14,092	15,940	45,000	58,500	61,000	68,500	85,677	171,554	249,507	288,076	317,195
Depreciation & amortization							1,114								
EBITDA	(12,899)	(19,283)	(7,583)	(8,499)	(14,092)	(15,940)	(45,000)	(58,500)	(61,000)	(52,070)	166,395	413,000	600,666	693,516	763,617
Operating income	(12,899)	(19,283)	(7,583)	(8,499)	(14,092)	(15,940)	(46,114)	(58,500)	(61,000)	(52,070)	166,395	413,000	600,666	693,516	763,617
							(46,114)								
Interest income		1		40	50	43									
Interest expense	393	128	-	-	-	-	-	-	-	-	-	-	-	-	-
Other (expense) / income, net	(75)	(913)	(11,843)	(141)	208	244	(11,532)	-	-	-	-	-	-	-	-
Interest & other	318	(786)	(11,843)	(101)	258	287	(11,532)	-	-	-	-	-	-	-	-
Taxes								-	-	-	58,238	140,420	198,220	221,925	236,721
Tax rate			37%	37%	37%	37%		37%	37%	37%	35%	34%	33%	32%	31%
Equity in earnings / (losses) of investees, net															
Loss from discontinued operations															
Net loss attributable to noncontrolling interest															
Net income - GAAP	(13,217)	(18,497)	(19,426)	(8,600)	(13,834)	(15,653)	(57,513)	(58,500)	(61,000)	(52,070)	108,157	272,580	402,446	471,591	526,895
Deemed dividend			(25,559)												
Net loss attributable to common shareholders			(44,985)												
Adjustments to net income			(36,902)	500	-	500	(35,902)	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Foreign Currency Adjustment		-													
Net income - Adjusted	(13,217)	(18,497)	(8,083)	(8,100)	(13,834)	(15,153)	(45,170)	(56,500)	(59,000)	(50,070)	110,157	274,580	404,446	473,591	528,895
GAAP EPS	($9.97)	($1.99)	($16.13)	($0.36)	($0.57)	($0.65)	($3.03)	($2.37)	($2.42)	($1.93)	$3.93	$9.72	$14.07	$16.17	$17.71
Adjusted EPS excl. options expense	($9.97)	($1.99)	($2.90)	($0.33)	($0.57)	($0.63)	($2.38)	($2.29)	($2.34)	($1.86)	$4.01	$9.79	$14.14	$16.24	$17.78
Diluted shares outstanding - GAAP															
Diluted shares outstanding	1,325	9,300	2,788	24,194	24,195	24,215	19,000	24,703	25,197	26,947	27,486	28,036	28,596	29,168	29,752

Source: Company Reports, Canaccord Genuity estimates

Figure 14: VSAR Valuation

Product	Peak Sales ($MM)	Peak Year	Current Value ($MM)	Probability Adjustment	Value / Share
US					
Pediatrics - GHD	$ 443	2027	$356	65%	$10
Adults - GHD	$ 108	2027	$92	65%	$2
Turner Syndrome	$ 83	2027	$69	65%	$2
ISS + Other	$ 464	2027	$389	65%	$10
Total	**$ 1,099**		**$906**		**$24**
EU - Co-Promote					
Pediatrics - GHD	$ 203	2027	$258	65%	$7
Adults - GHD	$ 60	2027	$74	65%	$2
Turner Syndrome	$ 37	2027	$46	65%	$1
Other	$ 80	2027	$99	65%	$3
Total	**$ 381**		**$478**		**$13**
Japan - Royalties					
Pediatrics - GHD	$ 60	2027	$79	65%	$2
Adults - GHD	$ 3	2027	$23	65%	$1
Other	$ 13	2027	$18	65%	$0
Total	**$ 75**		**$120**		**$3**
Net Cash					$100
Total Equity Value					$978
Shares Outstanding					24
Value Per Share					$45

Risk-Free	2.0%
Beta	1.5
Risk premium	8%
Total discount rate	14%
Effective Discount Rate	22%
Date	Feb-15

Source: Company Reports, Canaccord Genuity estimates

Appendix: Important Disclosures

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Target Price / Valuation Methodology:

Versartis - VSAR

Our $45 PT is based on a probability-adjusted NPV valuation.

Risks to achieving Target Price / Valuation:

Versartis - VSAR

Primary risks to our rating and price target include the following: VRS-317 may not produce positive Phase 2a data at its six-month readout for monthly, semi-monthly, or weekly dosing, even if positive data is produced Phase 3 data may not be positive and the FDA may not approve VRS-317 for any indication, future litigation may delay or reduce revenues, and increased competition may reduce revenues below our current estimates. VRS-317 may not show positive Phase 2a data at its six-month readout in June 2014, and even if it does, weekly or semi-monthly dosing may prove to be a more viable treatment option. If dosing is reduced from a monthly treatment to semi-monthly or weekly, VRS-317's competitive advantage versus current and future competitors will be reduced. We see the strength of VRS-317 in its monthly dosing and do not believe patients and doctors will view a semi-monthly treatment option as a very meaningful difference from weekly dosing, should currently in development products be approved. Litigation from Novo, Roche, or Pfizer may delay VRS-317's entry onto the market, assuming positive data and FDA approval. Depending on the extent of the delay, revenues may be greatly reduced and future cash flows diminished as we expect Versartis' VRS-317 patents will expire in 2030. Future competition in the growth hormone market may increase, lowering estimated market share for VRS-317 and reducing revenues for Versartis. Should another long-acting growth hormone product be introduced, we expect revenues could be negatively impacted. Growth hormone treatment is a field dominated by several players and new entrants could result in strong competition.

Distribution of Ratings:

Global Stock Ratings (as of 02/17/15)

Rating	Coverage Universe		IB Clients
	#	%	%
Buy	585	58.27%	33.68%
Hold	321	31.97%	14.95%
Sell	44	4.38%	2.27%
Speculative Buy	54	5.38%	57.41%
	1004*	100.0%	

*Total includes stocks that are Under Review

Canaccord Genuity Ratings System

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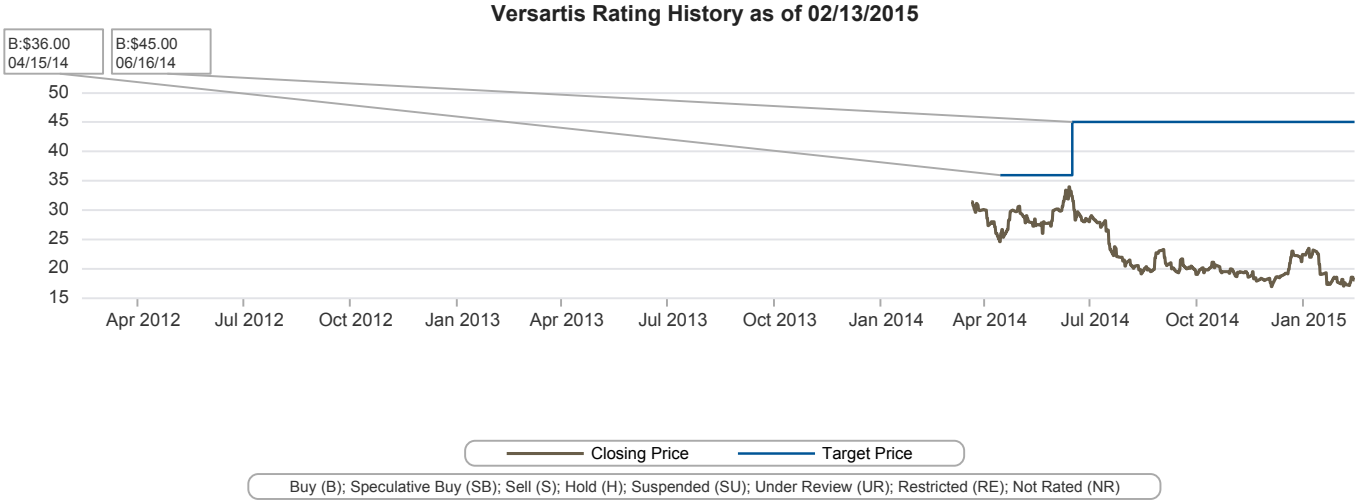
Versartis Rating History as of 02/13/2015



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