LAIDLAW & COMPANY
Est. 1842
London
New York
San Francisco
Boston

EQUITY RESEARCH
Company Report

July 16, 2018

Clearside Biomedical (CLSD - $10.28)

Healthcare / Biotechnology

Initiating Coverage – Impressive Novel Proprietary Technology for the Back of the Eye

Ticker:	CLSD
Rating:	**Buy**
Price Target:	**$18.00**

We are initiating coverage of Clearside Biomedical (CLSD) with a Buy rating and $18 price target. CLSD's proprietary microinjector enables drug delivery to the back of the eye through the suprachoroidal space (SCS) to more directly administer drugs to the retina and choroid.

CLSD's lead product candidate is CLS-TA for Macular Edema (ME) due to NonInfectious Uveitis (NIU). On 3/5/18, CLSD announced strong Phase 3 PEACHTREE trial topline results. The study met its primary endpoint: 47% of patients treated with CLS-TA gained ≥ 15 letters in best corrected visual acuity (BCVA) vs. 16% in the sham procedure arm ($p < 0.001$). Mean reduction from baseline was an impressive 157 microns in central subfield thickness (CST) vs. 19 microns in the sham arm ($p < 0.001$). These highly statistically significant primary and secondary endpoints de-risk their SCS injection platform in our view, and we expect an NDA filing in 4Q18 followed by a US launch in 1Q20.

Trading Data:

Last Price (07/13/2018)	$10.28
52–Week High (05/30/2018)	$15.33
52–Week Low (02/09/2018)	$5.30
Market Cap. (MM)	$328.4
Shares Out. (MM)	32.8

Their second value driver is CLS-TA for ME due to Retinal Vein Occlusion (RVO). The Phase 2 TANZANITE trial showed potential for a reduced treatment burden as 60% fewer additional Eylea treatments were needed in the treatment arm (CLS-TA+Eylea) vs. Eylea alone. Visual acuity also improved (statistically significant at month 2), a positive indication for their two Phase 3 trials expected to readout by 4Q18 and 2H19, respectively. Finally, CLSD is also targeting diabetic macular edema (DME), for which they have recently hit on all endpoints in a Phase 2 trial. With a relatively de-risked proprietary technology and a quickly progressing pipeline, we see CLSD as undervalued and initiate coverage with a Buy rating and an $18 price target.

- **Successful clinical trials in uveitis, a testament to SCS injections.** Following the results in their Phase 3 PEACHTREE trial, we view CLSD's proprietary microinjector through the SCS as relatively de-risked.
- **CLS-TA in RVO, a potential treatment paradigm changer.** With reduced treatment burdens and visual acuity gains from Phase 2 results, we believe CLS-TA + anti-VEGF could transform the current RVO treatment paradigm.
- **Growing pipeline based on proprietary technology to look forward to.** Off a successful Phase 2 trial in DME and potential growth in wet-AMD, we believe SCS injections could serve many more ophthalmology markets.
- **Initiate with a Buy rating, $18.00 PT.** Our PT is based on CLS-TA for US uveitis at $8/share, US RVO at $6.5/share and $3.5/share for cash and tech.

Earnings Estimates: (per share)

(Dec)	1Q	2Q	3Q	4Q	FY	P/E
FY19E	(0.65)	(0.67)	(0.69)	(0.66)	(2.67)	NA
FY18E	(0.62)A	(0.64)	(0.66)	(0.61)	(2.53)	NA
FY17A	(0.41)	(0.54)	(0.72)	(0.65)	(2.33)	NA
FY16A	(2.05)	(0.62)	(0.28)	(0.46)	(1.97)	NA

Source: Laidlaw & Company estimates

Analyst
Francois Brisebois, MSc/ Specialty Pharma & Biotech
(857) 317-5362
fbrisebois@laidlawltd.com

FOR ANALYST CERTIFICATION AND DISCLOSURES, PLEASE SEE DISCLOSURES SECTION AT THE END OF THIS REPORT. This report has been prepared by Laidlaw & Co (UK), Ltd. Investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report. Investors should consider this report as only a single factor in making their investment decision. All prices are those current at the end of the previous trading session unless otherwise indicated. Prices and consensus estimates are sourced from a reliable market source

5 Key Reasons to own Clearside Biomedical

1. **Successful clinical trials in uveitis, a testament to SCS injections.** CLSD's fairly recent (3/5/18) positive Phase 3 PEACHTREE data demonstrated highly statistically significant results on both primary and secondary endpoints in patients treated for ME due to NIU. This attests to the strength of their proprietary SCS microinjector technology, in our opinion. With 47% of patients treated with CLS-TA gaining ≥ 15 letters in BCVA vs. 16% in sham ($p < 0.001$), as well as 157 microns mean reduction in CST vs. 19 microns in sham ($p < 0.001$), we believe CLSD has favorable chances of FDA approval as they intend to file their NDA in 4Q18.

2. **CLS-TA in RVO, a potential treatment paradigm changer.** We were particularly impressed with CLSD's potential to reduce the treatment burden due to RVO. Their Phase 2 TANZANITE trial was able to show 60% fewer additional Eylea treatments in the treatment arm (CLS-TA + Eylea) vs. Eylea alone. We also view as noteworthy their improvements in visual acuity and sustained CST reductions at months 1, 2, 3 vs. Eylea. While improvements in BCVA were only statistically significant at month 2, we want to remind investors that the trial wasn't powered to show statistical significance.

3. **Growing pipeline with impressive market potentials brewing.** In addition to uveitis and RVO, CLSD is already well on their way in DME. CLSD recently announced positive data in their Phase 2 TYBEE trial, which showed similar efficacy in CLS-TA + Eylea arm vs. Eylea alone ($p=0.664$). This is especially encouraging since we anticipate real-world data to reward CLSD as we believe a potential reduction in treatment frequency could be quite beneficial for this patient population. With >1M DME patients in the US, it is hard to overstate the potential opportunity in this disease.

4. **Important catalysts around the corner throughout pipeline.** While 2018 is off to a strong start marked by CLSD's impressive PEACHTREE results, we expect important value inflection points before YE18. We expect an NDA filing for uveitis in 4Q18, Phase 3 data readout in RVO of SAPPHIRE in 4Q18, as well as additional data from TYBEE to readout.

5. **Well protected platform with strong scientific validation.** CLSD's IP situation provides them with exclusivity for drug administration through the SCS until at minimum 2027, which and could allow them to continue growing their pipeline.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 1: Upcoming Potential Catalysts

Event	Expected Timing
NDA filing in ME associated with NIU	4Q18
Phase 3 SAPPHIRE trial readout in ME associated with RVO	4Q18
Phase 3 TOPAZ trial readout in ME associated with RVO	2H19
Additional phase 2 TYBEE data readout in DME	2H18

Source: Company Reports; Laidlaw and Company estimates

Valuation

We value CLSD at $18/share based on a sum-of-the-parts valuation. CLS-TA US sales for uveitis is valued at $8/share based on a 3.5x multiple of 2024 sales of $169M, discounted back 6 years at a 15% discount rate. CLS-TA US sales in RVO is valued at $6.5/share based on a 3.5x multiple of 2025 sales of $205M, discounted back 7 years at a 20% discount rate. We value net cash (end 2018) and technology at $3.5/share.

Figure 2: Sum-of-the-Parts Analysis

Sum-of-the-parts valuation		
Segment	Valuation (000's)	Per share value
CLS-TA uveitis US	$255,553	$8.00
CLS-TA RVO US	$200,318	$6.50
Cash (end '18) & tech value	$110,370	$3.50
	$566,241	**$18.00**
2018 fully diluted shares out (000)		30,964

Source: Company Reports; Laidlaw and Company estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Company Description

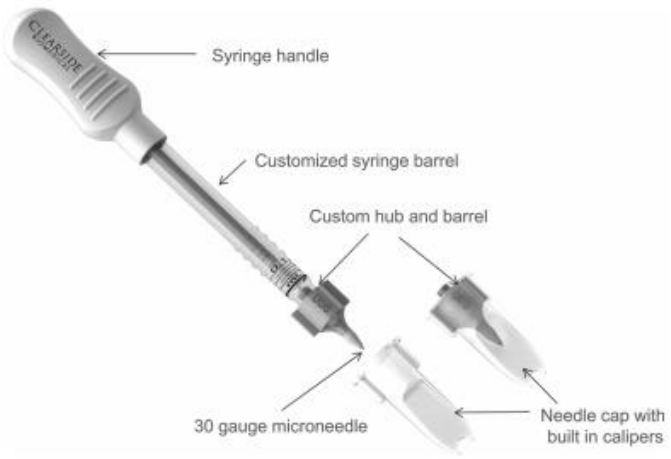
CLSD is a late-stage clinical biopharmaceutical company developing first-in-class pharmacological therapies to treat blinding diseases of the eye. Their current product candidates focus on diseases affecting the retina, which is the tissue that lines the inside of the eye and is primarily responsible for vision, and the choroid, which is the layer adjacent to the retina that supplies the retina with blood, oxygen and nourishment. With their proprietary microinjector, drugs are injected into and spread through the suprachoroidal space (SCS), which is the space located between the choroid and the outer protective layer of the eye known as the sclera. With the suprachoroidal injection, their product candidates seem to be more directly administered to the retina and choroid as compared to other ocular drug administration techniques such as injections of drug into the vitreous, a jelly- like substance that occupies the central portion of the eye. Intravitreal injections rely on diffusion of drug outward from the vitreous to the retina and choroid. This diffusion can result in lower concentrations of drug in these targeted areas. At the same time, this diffusion can also result in drug spreading to unintended parts of the eye, where, for some drugs, it can cause significant side effects. CLSD believes treatment of eye disease via suprachoroidal injection of product candidates may provide lower frequency of administration and faster onset of therapeutic effect. Through a 505(b)(2) approach, they have programs in uveitis (macular edema due to non-infectious uveitis), retinal vein occlusion (RVO) as well as diabetic macular edema (DME).

Francois Brisebois
fbrisebois@laidlawltd.com

Technology – Injection in the Suprachoroidal Space (SCS)

As mentioned previously, CLSD is developing advanced clinical and preclinical product candidates using their proprietary suprachoroidal treatment approach. Retinal diseases affect ~5M patients in the US with target indications treated by ~1,900 uveitis and retinal specialists. Although local therapy is important, many current approaches have limitations.

Figure 3: Proprietary Micro Injector for injection through the SCS

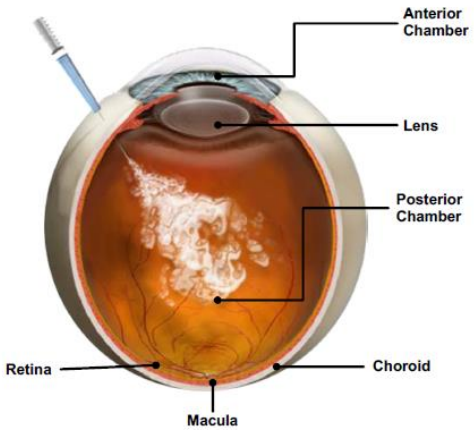


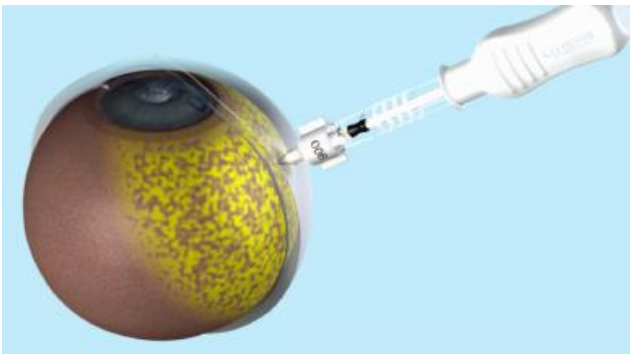
Source: Company Reports 10K16

For instance, corticosteroids can reach non-target tissues, potentially causing cataracts and glaucoma; multi-kinase inhibitors and gene therapies require precise placement at diseased tissue and finally, certain drugs like complement inhibitors require additional exposure to the choroid. While intravitreal (IVT) injections enable the drug to diffuse to all areas of the eye (the anterior chamber and lens) and periocular injections have highly variable drug diffusion across the sclera into the eye, suprachoroidal space (SCS) injections allow fluid to flow rapidly in a consistent manner as drug is absorbed into the choroid, retinal pigment epithelial (RPE) and retina.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 4: IVT vs. CLSD's Microinjector through SCS

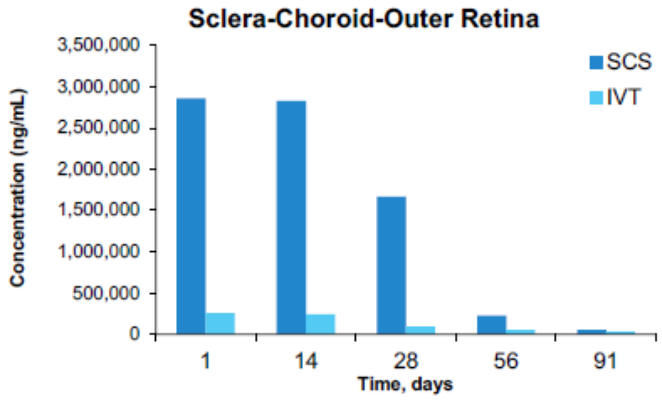




Source: Company presentation

CLSD's suprachoroidal CLS-TA is designed to improve ocular distribution of Triamcinolone Acetonide (TA). In fact, there was > 10X the amount of TA remaining in the choroid and RPE following suprachoroidal administration vs. IVT injection.

Figure 5: SCS vs. IVT - >10X TA concentration to sclera, choroid and outer retina

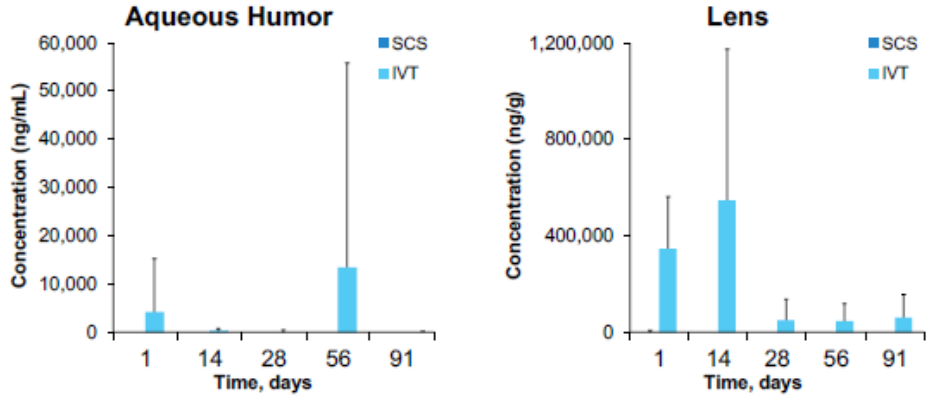


Source: Company reports

Additionally, the anterior segment is relatively spared following suprachoroidal dosing when compared to intravitreal dosing, which could ultimately lead to improved visual outcomes, increased durability and reduced treatment burden.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 6: SCS vs. IVT – Anterior Segment relatively spared



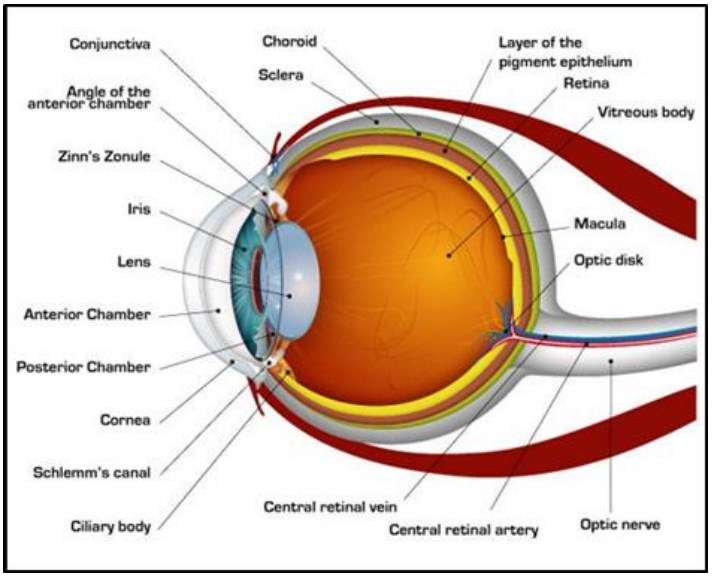
Source: Company reports

CLS-TA in Uveitis (ME due to NIU)

Uveitis is a collection of inflammatory conditions affecting the eye as ~30 disease-causing inflammations in the eye are considered uveitis. Uveitis is classified as noninfectious (NIU) (~80% of cases) or infectious (~20% of cases) in the US and is identified as by the dominant location of the inflammation in the eye as anterior, intermediate, posterior, or pan uveitis (Curr Ophtalmol, 2015). Interestingly, CLSD seems to be the first company to approach all forms of uveitis. Approximately 350,000 people in the US have uveitis and most patients are aged 20-50 years. Although uveitis does not cause mortality, morbidity results from chronic swelling in the retina, called macular edema (ME), which may lead to vision loss. ME may be found with any geographic location of uveitis, and affects ~30% of all uveitis patients (Br J Opthalmol, 2004). Even though ME is the dominant cause of vision loss in uveitis patients, there are no approved treatments for ME associated with uveitis.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 7: Diagram of the human eye



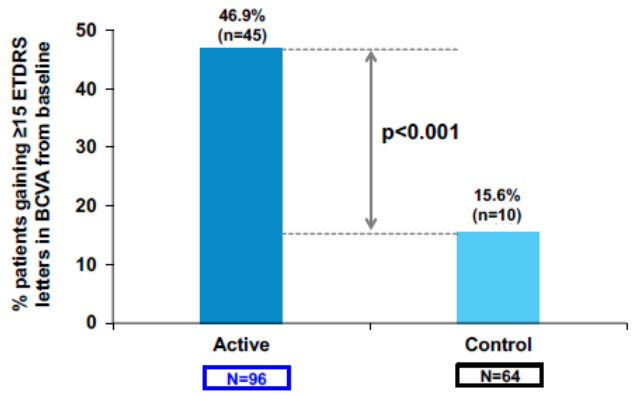
Source: National Keratoconus Foundation

Current treatments for NIU are either systemic or local to the eye, if not both. Systemic treatments include corticosteroids such as TA and other immunomodulatory therapies. Local therapies are most commonly corticosteroids that are used in and around the eye, either topically as drops or injected peri-ocularly (sub-Tenons) or intra-ocularly (IVT injections or implants).

On 3/5/18, CLSD announced positive topline results from their PEACHTREE Phase 3 clinical trial of CLS- TA for the treatment of ME associated with NIU. The trial met the primary endpoint as 47% of patients who received suprachoroidal CLS- TA every 12 weeks gained ≥15 letters in best corrected visual acuity (BCVA), as measured using the Early Treatment of Diabetic Retinopathy Study (ETDRS) scale, from baseline at week 24, compared to 16% in the sham arm ($p < 0.001$). Additionally, the improvements in BCVA from baseline were better in the treatment arm than the sham arm at each monthly evaluation.

Francois Brisebois
fbrisebois@laidlawltd.com

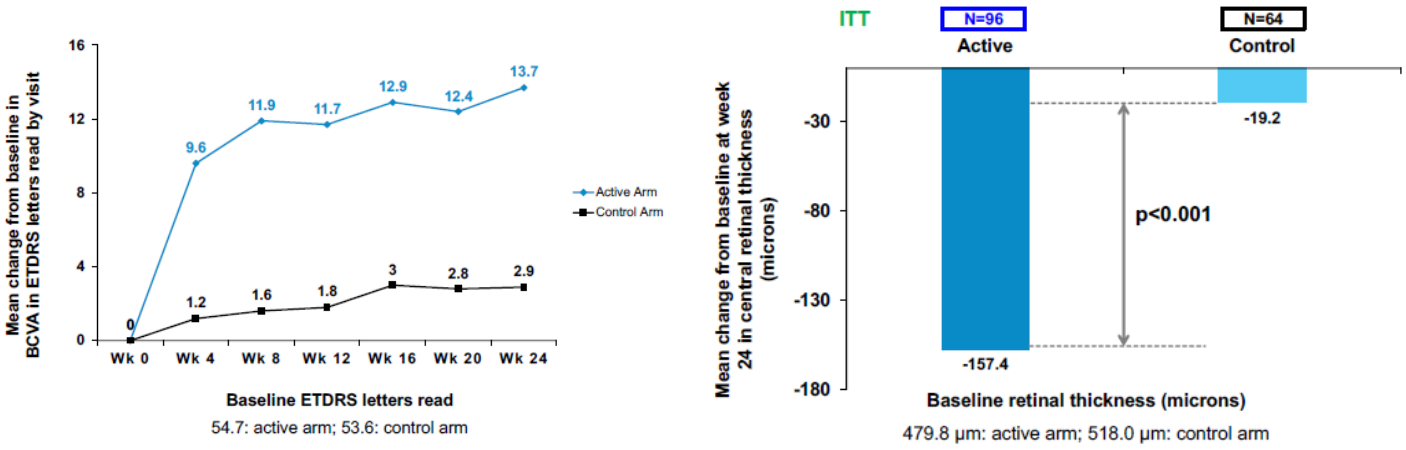
Figure 8: Primary Endpoint – Patients gaining ≥ 15 ETDRS letters in BCVA at Week 24



Source: Company presentation

The mean improvement from baseline was maintained throughout the evaluation period, with 9.6 letters gained at week 4 and 13.7 letters gained at week 24 in the active arm, compared to 1.2 letters gained at week 4 and 2.9 letters gained at week 24 in the control arm. Administration of suprachoroidal CLS- TA also resulted in a mean reduction from baseline of 157 microns in central subfield thickness at week 24 in the active arm compared to a 19 micron mean reduction in the sham arm ($p < 0.001$).

Figure 9: Secondary Endpoint – Mean Change in CRT at Week 24 and in BCVA in ETDRS Letters by Visit

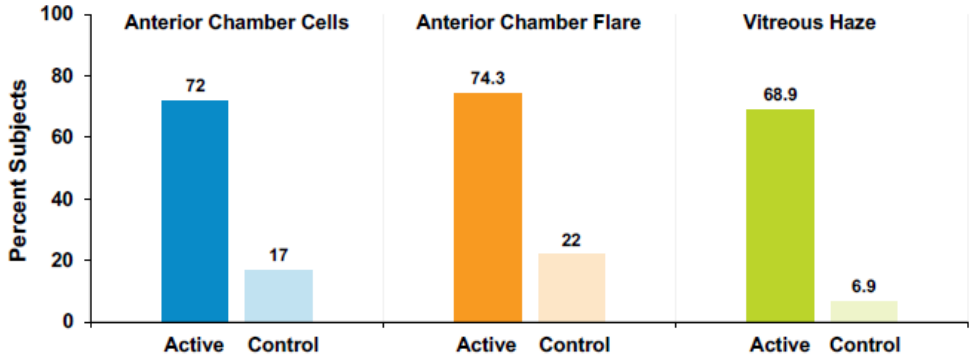


Source: Company presentation

Francois Brisebois
fbrisebois@laidlawltd.com

CLSD also demonstrated significant improvement in signs of uveitis such as accumulation of white blood cells in the anterior chamber. They were able to show that both the cells and proteins left behind (flare) showed resolution in 72% of patients and 74.3%, respectively. Additionally, 69% of vitreous haze was resolved down to 0. Data showed that ≥ 50% difference in each of these measures vs. control.

Figure 10: Resolution of Signs of Uveitis (% Subjects with Change to Zero at Week 24) - ≥ 50% difference in each measure



Source: Company Presentation

In terms of safety, suprachoroidal CLS- TA was generally well tolerated, with no treatment-related serious adverse events reported in the trial. Through 24 weeks, steroid-related elevated intraocular pressure (IOP) were reported for ~11.5% of patients in the CLS- TA treatment group vs. no patients in the sham group. Based in part on the results from PEACHTREE, they intend to submit an NDA by 2H18.

Figure 11: Clinical Trial Design

Phase 3: PEACHTREE Trial	
Aim	Evaluate safety and efficacy of suprachoroidally administered TA, CLS-TA, in subjects with ME associated with NIU.
Design	2-armed randomized, controlled, double-masked, multi-center trial at about 60 clinical sites
Dosing	3:2 randomization of suprachoroidal 4 mg CLS-TA vs sham injection. Injections at weeks 0 and 12
Endpoints	1) at week 24: superiority of best corrected visual acuity from treatment. Proportion of patients in each arm gaining ≥ 15 ETDRS letters in BCVA from baseline. 2) Mean change from baseline in CRT at week 24 in microns; Mean change from baseline in BCVA in ETDRS letters by visit
Patients	n=160
Safety	Elevated IOP: 11.5% in CLS-TA and 0% in Sham group; Cataracts: 8.3% in CLS-TA and 7.8% in Sham; No SAEs related to treatment. 97% of the randomized patients completed the trial
Results	1) 47% of patients who received suprachoroidal CLS-TA every 12 weeks gained at least 15 letters in BCVA from baseline at week 24 vs 16% of patients who underwent sham procedure (p<0.001). Mean improvement in BCVA from baseline was better in treatment arm vs sham at each monthly evaluation. Mean improvement maintained hroughout evaluation period with 9.6 letters gained at week 4 and 13.7 letters at week 24 in active arm vs 1.2 letters at week 4 and 2.9 letters at week 24 in control arm, respectively. 2) Treatment resulted in mean reduction from baseline of 157 microns in central subfield thickness at week 24 vs 19 micron mean reduction in sham (p<0.001).

Source: Company Documents and Laidlaw and Company estimates

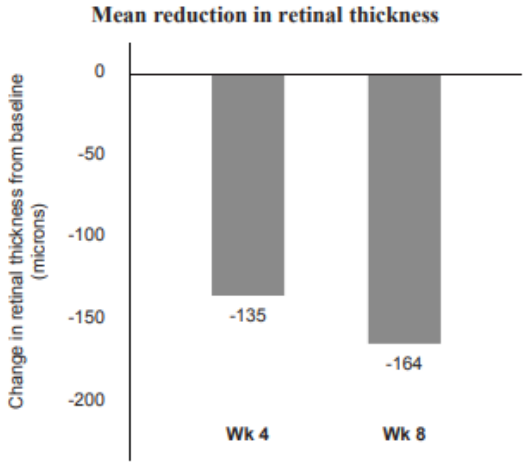
Francois Brisebois
fbrisebois@laidlawltd.com

Patients from PEACHTREE are followed in an extension trial to obtain information on the duration of action. Since the last treatment in the Phase 3 trial would have occurred at week 12 following the initial treatment, they expect to enroll patients starting at their week 24 exit visit and to follow patients for an additional 24 weeks or until they receive additional treatment (at the decision of the evaluating physician). An additional 38 patients, with a diagnosis of NIU, were enrolled in a separate clinical trial in order to collect additional safety information for their NDA submission. These additional patients will be administered suprachoroidal CLS- TA at baseline and at week 12, and they will be observed and evaluated at visits every four weeks after initial treatment, with a final evaluation at week 24.

Previously, they have also completed a Phase 2 clinical trial and a Phase 1/2 clinical trial for this indication that they conducted with CLS- TA. CLSD believes that CLS-TA will be at least as effective as commonly used local treatments with corticosteroids. However, they believe their suprachoroidal based local treatment may provide improved bioavailability of drug at the diseased retina and choroid, which may result in faster onset of therapeutic effect, a similar efficacy profile with lower drug amounts required, and longer duration of therapeutic effect, potentially resulting in a reduced frequency of necessary injections. They also believe that CLS-TA may result in fewer side effects compared to commonly used corticosteroid treatments.

On 1/5/16, CLSD announced that their Phase 2 trial achieved statistical significance on their primary endpoint. The study demonstrated statistically significant mean change from baseline in central subfield thickness at 8 weeks after 1 treatment (p=0.0018).

Figure 12: Phase 2 CLS-TA in uveitis Reduction of CST @ 8 weeks after injection (p=0.0018)

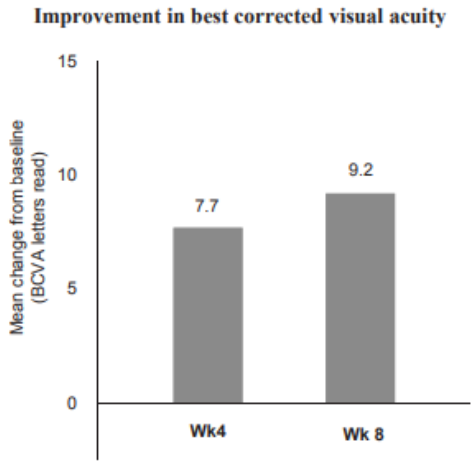


Source: Company reports 10K16

CLSD also attained statistical significance in the mean increase from baseline in BCVA, which was the secondary endpoint (p=0.0004) and there were no treatment related serious adverse events reported in the trial (no steroid-related rise in IOP).

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 13: Phase 2 CLS-TA in uveitis – Increase in BCVA (p=0.0004)



Source: Company reports 10K16

Figure 14: Clinical Trial Design

Phase 2	
Aim	Evaluate safety and efficacy of TA, CLS-TA, in subjects with macular edema following non-infectious uveitis
Design	randomized, masked, multicenter study at 14 sites. Only 17 patients on 4mg were evaluated for endpoints. 0.8mg were exploratory
Dosing	17 patients received 4mg: single unilateral injection of 40mg/mL and 5 patients received 0.8mg single unilateral suprachoroidal injection. Return for follow up examinations between 7-11 days at 4 weeks and at 8 weeks following dosing. Of the 17 patients:2 had anterior uveitis, 5 had intermediate uveitis, one had choroid posterior uveitis and 9 had pan-uveitis
Endpoints	1) change from baseline in central subfield thickness, measured using optical coherence tomography, after treatment with CLS-TA in subjects with ME following uveitis 2)changes in BCVA.
Patients	n=22
Safety	All 22 patients completed full observation and generally well-tolerated. 1 patients experienced atrial fibrillation, a condition that resolved in one day. PI considered it unrelated to treatment, which was approved by independent medical monitor. No corticosteroid related increases in IOP and no cataracts.
Results	16 of the 17 were evaluated for retinal thickness. At 4 and 8 weeks, average reduction in retinal thickness was 135 and 164 microns, respectively with p values of 0.0056 and 0.0017, respectively. Of these 16 , 9 achieved a reduction in retinal thickness to below 310 microns, which represents maximum retinal thickness for about 95% of population with normal retinas, at both week 4 and 8. Also, 9 patients had reductions in thickness of at least 20% from baseline at week 4, while 11 achieved this level of reduction at week 8. At 4 weeks and 8 weeks, average improvement in BCVA was 7.7 and 9.2 letters, respectively, with p values of 0.0001 and 0.0004, respectively. Of the 12 patients with worse than 20/40 vision, 92% improved by at least 5 letters, 50% of patients improved by at least 10 letters, 33% of patients improved by at least 15 letters and 8% improved by more than 25 letters.

Source: Company Documents and Laidlaw and Company Estimates

The previously mentioned Phase 1/2 trial was able to improvement in BCVA ranging between 1 and 5 lines (or up to 25 letters). At week 12, the average improvement in BCVA was greater than 2 lines while at week 26, the mean was close to 3 lines of improvement. Additionally, at weeks 12 and 26 of the trial, the average reduction in retinal thickness was greater than 100 microns vs. baseline (considered meaningful). Again, we were particularly encouraged by its safety profile as the injections seemed well tolerated and no patient in the trial experienced any meaningful increase in intraocular pressure (IOP) at any time point following CLS-TA injections.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 15: Clinical Trial Design

Phase 1/2	
Aim	Evaluate safety and efficacy of TA, CLS-TA, in subjects with ME following NIU
Design	3 US centers,
Dosing	single suprachoroidal injection of TA
Endpoints	IOP, changes in BCVA and retinal thickness
Patients	n=8
Safety	generally safe and well tolerated. No patients experienced meaningful increase in IOP at any time point so no patients needed IOP lowering medications
Results	During trial, patients showed impovement in BCVA ranging between 1 and 5 lines (or up to 25 letters). At week 12, average improvement average improvement in BCVA exceeded 2 lines of improvement while at week 26, average was close to 3 lines. At weeks 12 and 26, average reduction in retinal thickness was greater than 100 microns from respective baselines (considered meaningful)

Source: Company reports and Laidlaw estimates

CLS-TA for ME associated with RVO

Retinal vein occlusion (RVO) is a severe condition, which consists of blockage of the veins that drain the retina and is a common cause of vision loss, affecting ~16M people WW (Opthalmol, 2010). It is the leading cause of blindness from retinal vascular disease after diabetic retinopathy (DR) and is most often caused by atherosclerosis and the formation of a blood clot. It can lead to further eye problems such as glaucoma and ME. There are two types of RVO: central retinal vein occlusion (CRVO), which comes as a result of the main retinal vein becoming blocked; and branch retinal vein occlusion (BRVO), which occurs when one or more branches of the main retinal vein become blocked (much more common).

The goal of treatment is to reduce morbidity and prevent complications. Current treatments usually consists of anti-VEGF agents (1st line therapy) such as Genentech's Eylea, Lucentis followed by Avastin corticosteroids (dexamethasone and triamcinolone acetonide lasers).

Francois Brisebois
fbrisebois@laidlawltd.com

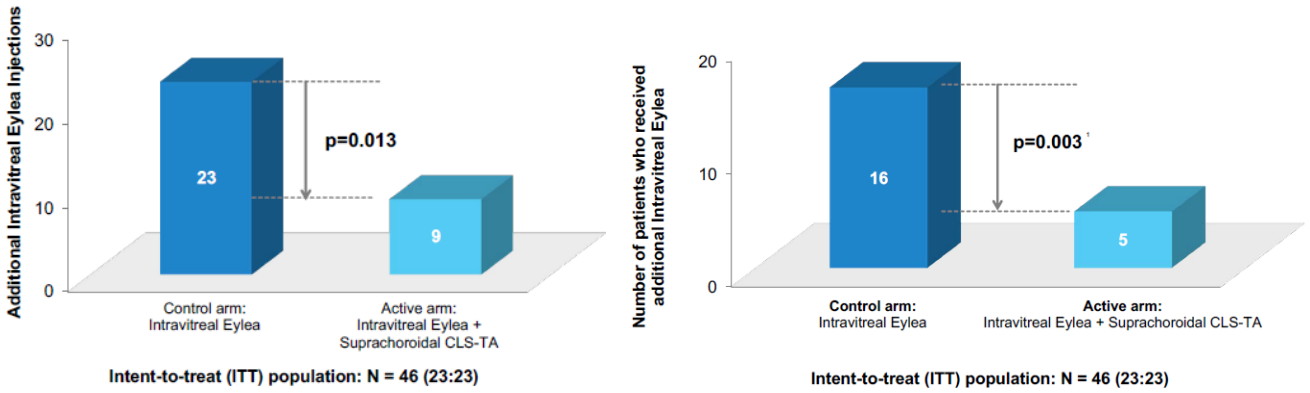
Figure 16: Retinal Vein Occlusion (RVO), CRVO vs. BRVO

Source: Regeneron, 2015

In this program, CLSD is using suprachoroidal CLS-TA together with IVT Eylea. They believe it may provide a differentiated therapeutic benefit for RVO patients with their combination treatment, potentially coupling the advantages of visual acuity gain, and ME and treatment burden reduction (quarterly rather than monthly dosing schedule). They have completed a Phase 2 (n=46) clinical trial with suprachoroidal CLS- TA together with intravitreal Eylea.

In their Phase 2 TANZANITE trial, the primary endpoint was met as patients in the active arm required an aggregate of 60% fewer additional Eylea treatments than patients in the control arm over 3 months (p=0.013). In addition, based on a post- hoc analysis, 18 of the 23 patients (78%), in the active arm of the trial did not require additional treatments during the 3-month trial vs. 7 of the 23 patients (30%), in the control arm, a result that was also statistically significant (p=0.003).

Figure 17: Number of additional injections – 60% less in CLS-TA+Eylea vs. control (3 months) and number of patients requiring additional treatments – 69% fewer patients required additional Eylea

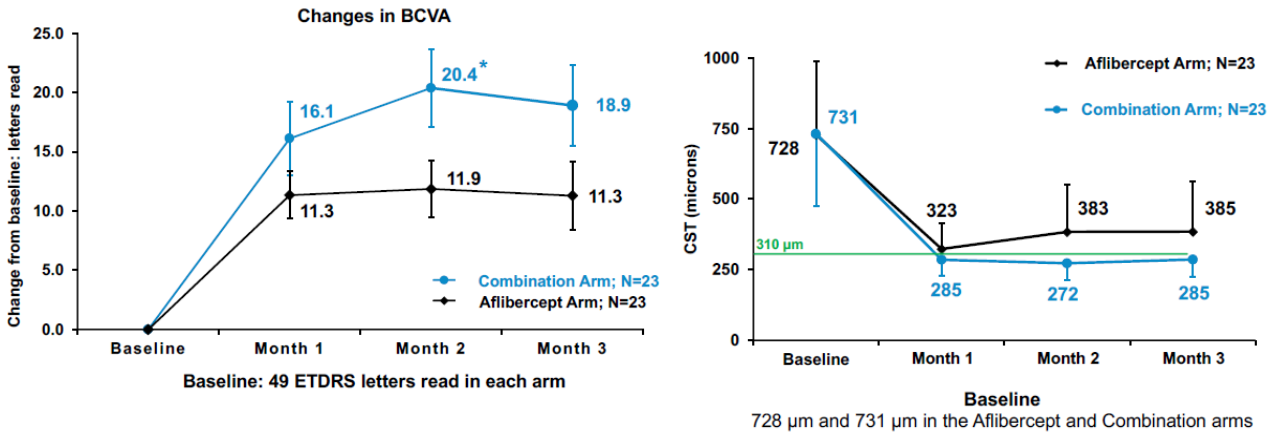


Source: Company Presentation

Francois Brisebois
fbrisebois@laidlawltd.com

In that same Phase 2 trial, patients in the active arm showed greater improvement in visual acuity than those in the control arm. Patients in the active arm experienced mean BCVA improvements at months 1, 2, and 3 of 16, 20, and 19 letters, respectively. This is compared to improvements of 11, 12, and 11 letters, respectively, in the control arm at the same time points. The greater improvement in BCVA observed in the active arm vs. the control arm was statistically significant at month 2, but was not statistically significant at months 1 or 3. It is noteworthy however, that the trial wasn't powered to show statistical significance on the secondary endpoints.

Figure 18: CLS-TA+Eylea resulted in improved visual acuity and sustained retinal thickness reductions at months 1,2,3 vs. Eylea



Source: Company Presentation

The company also extended their evaluation of the patients who participated in the trial and did not receive any additional Eylea treatment during the initial 3-month evaluation period. This was to further assess the durability of suprachoroidal CLS- TA in combination with intravitreal Eylea for an additional 6 months following completion of the trial. Of the 32 eligible patients, the medical records of 31 patients were obtained for review. Based on combined data from the initial and extended evaluation periods, 17 of the 23 patients in the combination arm did not receive any additional treatment over the 9-month period, compared to only 4 of 23 patients in the control arm. Based on these results, they believe that the combination of suprachoroidal CLS-TA and intravitreal Eylea may provide the benefits of improved visual acuity, reduced ME and reduced injection frequency.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 19: Clinical Trial Design

Phase 2: TANZANITE Trial	
Aim	Evaluate safety and efficacy of suprachoroidal CLS-TA in combination with intravitreal aflibercept in subjects with ME following RVO.
Design	phase 2, multicenter, randomized, active-controlled, masked, parallel arm
Dosing	experimental: CLS-TA + IVT aflibercept, single unilateral injection of 40mg/mL of CLS-TA following a 2mg intravitreal injection of aflibercept. Active comparator: suprachoroidal sham + IVT aflibercept
Endpoints	1) Total number of times a subject qualifies to be administered IVT aflibercept in each arm (timeframe: 3 months). 2) Mean change from baseline in BCVA and central subfield thickness
Patients	n=46
Safety	No SAEs and treatment generally well tolerated
Results	1) patients in active arm (suprata + eylea) qualified for ~60% fewer eylea treatments than control arm who initially reveiced eylea alone (p=0.013). 2) At 1 month, patients in active arm had mean improvement of ~ 16 letters in BCVA, or over 3 lines on a standard eye chart vs ~ 11 letters of improvement (just over 2 lines), for control arm (each from their respective baseline measurements. At end of 3 months, patients in active arm had average imrovement of ~ 19 letters vs control arm maintained same level of improvement at ~ 11 letters. Patients in both arms showed mean reduction of >400um. patients in active arm maintained level of reduction throughout three month trial vs control arm had smaller levels of reduction as trial progressed, with mean redution of ~340um for control arm beginning in month 2.

Source: Clinicaltrials.gov

Based on the results of TANZANITE, and after incorporating feedback from an end-of-Phase 2 meeting with the FDA held in late 2016, the company began to enroll patients in 1Q17 for a Phase 3 clinical trial, which they refer to as SAPPHIRE (readout expected 4Q18). Additionally, they initiated a second Phase 3 trial in 1Q18 called TOPAZ (readout expected 2H19).

Figure 20: Clinical Trial Design

Phase 3: SAPPHIRE Trial	
Aim	Evaluate safety and efficacy of supreachoroidal CLS-TA in conjunction with intravitreal aflibercept in subjects with RVO
Design	multicenter, randomized, masked, controlled, parrallel group study of 12 months duration
Dosing	Active: IVT aflibercept (2mg/0.05mL) + CLS_TA (4mg/100uL) SC injections. Control: IVT aflibercept (2mg/0.05mL) + sham
Endpoints	1) Proportion of subjects demonstrating ≥ 15 letter improvement from baseline in ETDRS (time frame: 2 months). 2) Mean change from baseline in BCVA based on ETDRS and mean change from baseline in central subfield thickness (timeframe : 6 months) based on spectral domain optical coherence tomography
Patients	n=460
Safety	
Results	

Source: Clinicaltrials.gov

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 21: Clinical Trial Design

Phase 3: TOPAZ	
Aim	Evaluate safety and efficacy of suprachoroidal CLS-TA in combination with an intravirteal anti-VEGF agent in subjects with
Design	multicenter, randomized, masked, controlled, parrallel group
Dosing	Active: Lucentis (0.5mg/0.05mL)+CLS-TA (4mg/0.10mL), SC injection or Avastin (1.25mg/0.05mL)+CLS-TA (4mg/0.10mL), SC injection. Sham Comparator: Control: Lucentis (0.5mg/0.05mL) + sham SC procedure or Avastin (1.25mg/0.05mL) + sham SC procedure
Endpoints	1) Proportion of subjects demonstrating ≥ 15 letter improvement from baseline in ETDRS (time frame: 2months) based on BCVA 2)Mean change from baseline in BCVA (time frame: 6 months) based on ETDRS and mean change from baseline in central sbfield thickness (time frame: 6 months) based on spectral domain optical coherence tomography.
Patients	n=460
Safety	
Results	

Source: Clinicaltrials.gov

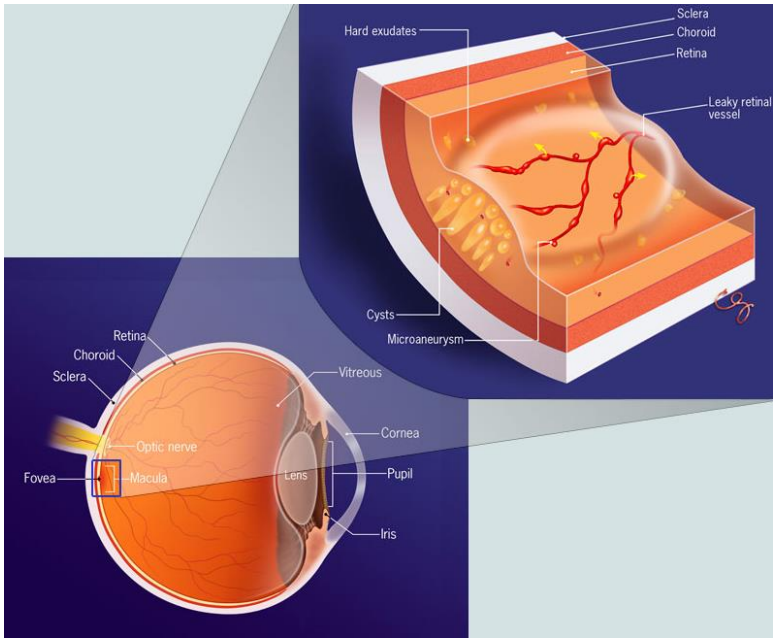
If the primary endpoint is met in SAPPHIRE and TOPAZ, where CLS-TA has been used in combination with one of three anti-VEGF agents – Eylea, Lucentis and Avastin – their objective will be to seek a class label in the US where suprachoroidal CLS-TA can be used with any intravitreal anti-VEGF agent.

Diabetic Macular Edema (DME)

DME is an accumulation of fluid in the macula caused by leaky blood vessels as a consequence of diabetes mellitus. It is defined as retinal thickening within 2 disc diameters of the macula center and DME is the most common complication of diabetes in patients with diabetes retinopathy (DR), affecting >150M people worldwide. It may cause images to appear blurry or wavy and colors that seem "washed out". Prevention of vision loss is crucial and visual improvement would be preferable.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 22: Diabetic Macular Edema (DME)



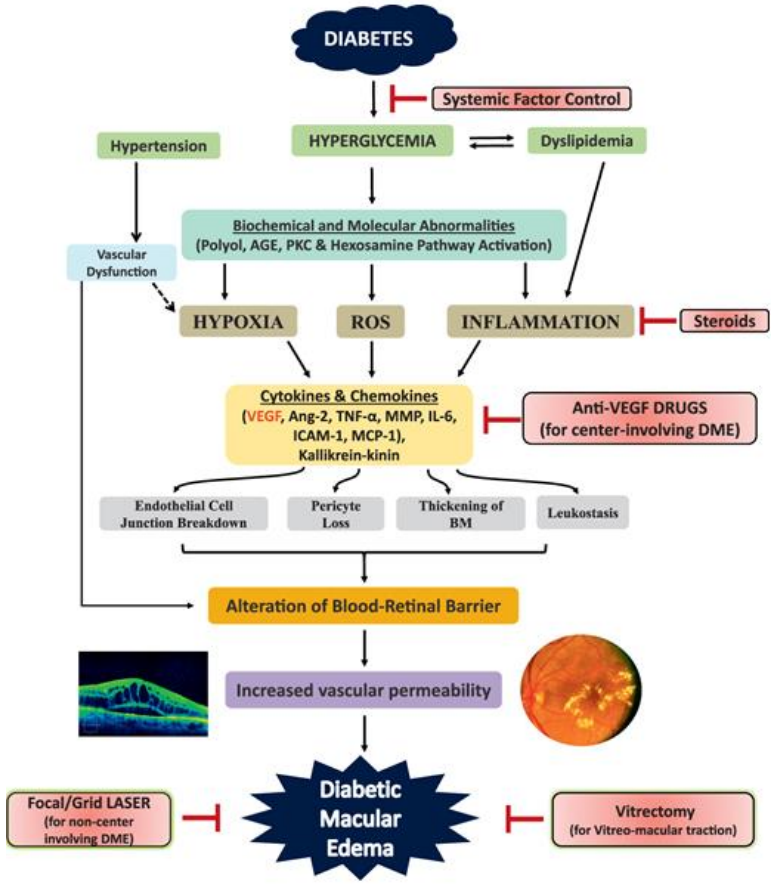
Source: Iridex, 2013

The current treatment paradigm consists of corticosteroid implants, intravitreal injections corticosteroid implants, anti VEGF therapy used off-label, and laser treatments.

In the US alone, ~21M people suffer from diabetes, with ~3% of them developing DME (600,000-700,000 patients). Approximately 30% of DME patients are unresponsive to the standard of care (lasers, anti-VEGF therapy), with some estimates putting the refractory patient percentage as high as 40-50% of DME patients. Additionally some patients don't respond well to anti-VEGF. Lucentis and Eylea are approved for treatment of patients with DME while Avastin is used off-label. In terms of corticosteroid therapy, ALIM's Iluvien (3 years) and AGN's Ozurdex (3 months) are approved.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 23: DME mechanism of action (MOA)



Source: IOVS, 2016

On 5/31/18, CLSD announced positive topline results from their Phase 2 trial (started in July 2017) using CLS-TA with Eylea vs. Eylea alone. This trial, referred to as TYBEE, met its primary and secondary endpoints in a 6-month trial. Patients in the combination arm gained an average of 12.3 ETDRS letters vs. 13.5 ETDRS in the Eylea alone (p=0.664). CLSD believes CLS-TA + anti-VEGF could provide a longer response and ultimately reduce the treatment frequency and burden of DME. Additionally, combination treatment reduced central subfield thickness by 208 microns at 6 months vs. 177 microns in the control arm (p=0.156). Treatment was generally well tolerated. Elevated IOP was reported for 8.3% of patients in the combination arm vs. 2.9% in the control. About 5.6% of patients in the combination arm vs. 2.9% in the control developed cataracts. Although the stock was cut by ~30% following the data readout, we believe the dip wasn't warranted and created an interesting buying opportunity. As patients aren't necessarily as prone to attend their appointments

Francois Brisebois
fbrisebois@laidlawltd.com

in the real world setting, we believe a reduction in treatment burden could be a significant advantage for CLSD. We believe investors were betting on superiority as opposed to equivalence. CLSD will continue to analyze their data before guiding to future developments.

Figure 24: Clinical Trial Design

Phase 2: TYBEE	
Aim	Evaluate safety and efficacy of suprachoroidal CLS-TA used with intravitreal aflibercept in subjects with DME
Design	multicenter, randomized, double-masked, controlled, parallel-group study of 6 months duration in treatment-naïve subjects.
Dosing	active: IVT injection of aflibercept followed by an SC injection of CLS-TA vs control: IVT aflibercept followed by a sham SC
Endpoints	1) mean change from baseline in BCVA (timeframe: 6 months) based on EDTRS. 2) mean change from baseline in central subfield thickness (timeframe: 6 months) based on spectral domain optical coherence tomography
Patients	n=71
Safety	CLS-TA + Eylea was generally well tolerated with no treatment related serious adverse events through 24 weeks. Elevated IOP were reported for 8.3% of patients in combination arm vs 2.9% in control arm. Both combination arm and control arms reported cataract adverse events in with about 5.6% in combo arm vs 2.9% in control arm developing cataracts.
Results	1) Patients in combination arm gained an average of 12.3 ETDRS letters vs 13.5 ETDRS letters in Eylea alone control arm (p=0.664). CLS-TA with Eylea met key secondary endpoint with a mean reduction from baseline of 208 microns in CST at 6 months vs 177 micron in control arm (p=0.156). Also 93% of patients in combination arm had > 50% reduction in excess CST at 6 months vs 73% of patients in control arm.

Source: Clinicaltrials.gov

In April 2017, CLSD completed enrollment of 20 patients with DME in an open- label, multi- center Phase 1/2 clinical trial, HULK, to obtain safety data and to observe efficacy outcomes from administering a combination of IVT Eylea + suprachoroidal CLS-TA, as well as suprachoroidal CLS- TA alone. On 11/10/17, CLSD announced preliminary results from the HULK trial. Visual benefits were established in patients receiving CLS-TA (especially in treatment naïve eyes) and anatomic improvements were observed in all treated eyes (more than 2/3 of those eyes achieving > 50% reduction in excess central retinal thickness based on monthly measurements through 6 months).

Figure 25: Clinical Trial Design

Phase 1/2 HULK	
Aim	Evaluate safety and tolerability of CLS-TA alone or in combination with Eylea for patients with DME.
Design	multicenter, open-label, non-randomized, parralel assignment.
Dosing	2mg(50uL) Eylea + SC CLS-TA 4mg(100uL) or only SC CLS-TA. Arms: TX naïve vs previous treatment arm.
Endpoints	1) Number of participants with treatment emergent Aes and serious Aes during 6 months. 2) mean change in IOP, mean change in central subfield thickness, BCVA, number of injections administered
Patients	n=20
Safety	CLS-TA with patients who received as many as 5 injections, was well tolerated, with low incidence rate of ocular side effects, including IOP elevations
Results	Visual benefit for patients receiving CLS-TA, with a greater benefit in treatment naïve eyes. Anatomic improvement observed in all treated eyes, with more than 2/3 of those eyes achieving a greater than 50% reduction in excess central retinal thickness based on monthly measurements through 6 months after initial treatment. In treatment naive group, 40% of patients didn't require retreatment with additional 20% requiring only one retreatment.

Source: Clinicaltrials.gov and Laidlaw Estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Competition

The key competitive factors affecting the success of their product candidates, if approved for marketing, are likely to be their efficacy, safety, method of administration, convenience, price and the availability of coverage and reimbursement from government and other third- party payors.

Figure 26: Competitive Landscape

Product/Disease	Competition
CLS-TA	Other commercially available forms of TA and other injectable and implantable corticosteroids. Bristol-Myers Squibb (BMS) markets TA under brand name Kenalog (indicated for intramuscular or intraarticular injection but used off-label for intraocular inflammation. Generic equivalents are also available. Also, Alcon (ACL)'s injectable TA, Triesense is approved in US for uveitis and other inflammatory conditions unresponsive to topical corticosteroids (not indicated for ME associated with uveitis, RVO or DME).
NIU	AGN's Ozurdex is a bioerodible extended releaseimplant that delivers corticosteroid dexamethasone and approved for NIU affecting posterior segment of the eye. Baush + Lomb markets Retisert, intravitreal implant of the corticosteroid FA for NIU.
RVO	AGN's Ozurdex is approved for ME due to RVO in US and EU. Anti-VEGFs (Genentech's Lucentis approved in US and EU and Avastin off-label) are current standard of care for RVO. In US, Regeneron (REGN)'s Eylea approved for ME following RVO and in EU for RVO.
DME	AGN's Ozurdex approved in US. Alimera (ALIM)'s Iluvien, injectable for of FA, approved in US and EU for DME. Anti-VEGFs (Genentech's Lucentis approved in US and EU and Avastin used off-label) current standard of care for DME. In US and EU, Regeneron (REGN)'s Eylea is approved for DME

Source: Laidlaw and Company Estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Major Risks

Exogenous events could impact our outlook. We believe pharmaceutical companies have the least control over competitive, political, and regulatory risks. Although we have incorporated competitive assumptions into our forecasts, there may be other risks beyond the scope of our analysis. Changes in the drug reimbursement system, as well as any political or regulatory amendments, may significantly influence the earnings power of these companies.

Actual clinical results and the FDA's conclusions may deviate from expectations. Many of our assumptions are based on a review of incomplete clinical trial data available in the public domain. Often, our conclusions are drawn from early stage data, which may not be reflected by pivotal studies. Furthermore, the FDA's conclusions may not coincide with our own, materially changing our revenue and earnings assumptions.

Compliance issues, product recalls, and other mandates by regulatory authorities could materially change our expectations. Regulatory compliance issues, ranging from accounting irregularities to defective manufacturing practices, could materially change our assumptions and earnings outlook. Unanticipated product recalls and labeling changes could also have adverse consequences on our earnings assumptions.

Legal risks could lead to additional liabilities and revenue loss. In addition to the expenses incurred by patent challenges, product liability and other legal suits could occur and lead to additional liabilities and revenue loss, which could substantially change our financial assumptions.

Francois Brisebois
fbrisebois@laidlawltd.com

Management

Daniel White, President and CEO. Daniel White is the founder of the company and has served as President and CEO and as a member of the board of directors since inception in May 2011. From 2008 to 2011, he served as Executive Director, Global Corporate Development, for Stiefel Laboratories, a dermatology pharmaceutical company acquired by GSK in 2009. From 2007 to 2008, he co-founded and served as President and CEO of Percept BioScience, a biotechnology company. In 2003, Daniel co-founded, and until 2007 served as VP of Finance and Corporate Development of Alimera Sciences (ALIM) a biopharmaceutical company focused on ophthalmology. He was Head of Business Development and Licensing for CIBA Vision, a Novartis company, and Director of Licensing and Business Development for AAIPharma. He holds an MBA from Wake Forest University and a Bachelor of Science in Molecular Biology from Auburn University.

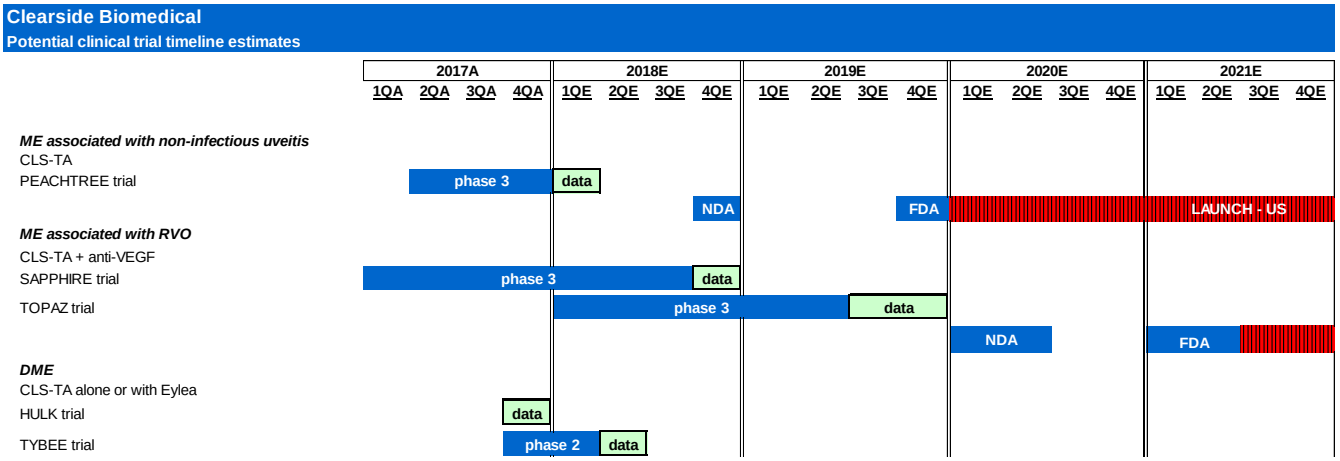
Charles Deignan, CFO. Charles Deignan has served as CFO since January 2012. From 2009 to December 2011, he was VP of Finance and Administration for Salutria Pharmaceuticals. From 1999 to 2009, Charles served in a number of roles with AtheroGenics, a publicly held biopharmaceutical company, including as VP of Finance and Administration. His career has included management positions at AAIPharma, and Schering-Plough. He received his Bachelor of Science in Business Administration from Boston University.

Glen Noronha, Chief Scientific Officer. Dr. Noronha was promoted to CSO in August 2016 after having served as their Executive VP, Research and Development since August 2013. Dr. Noronha plays a critical role in all strategic, developmental and regulatory efforts at Clearside. From 2012 to 2013, he served as VP, Research and Development, at Sucampo Pharma Americas. From 2011 to 2012, Dr. Noronha was CSO for JW Theriac, a pharmaceutical company focused on new drug research and development in oncology. From 2008 to 2011, Dr. Noronha was Global Project Lead for developmental efforts in retinal diseases at Alcon Laboratories, a Novartis company. From 2002 to 2008, Dr. Noronha held several positions with increasing levels of leadership and responsibility at TargeGen, a pharmaceutical company, including as co-lead for its ophthalmology programs. He received his education and training in Chicago and Irvine.

Brion Raymond, Chief Commercial Officer. Brion Raymond brings a wealth of ophthalmic experience and an extensive stakeholder network to Clearside. He has a track record of success building out commercial capabilities, leading marketing and sales teams, and cultivating strong thought leader relationships across multiple specialties. Prior to joining Clearside, Brion managed a consulting firm that led multiple strategy projects for clinical-stage biotechnology companies. His 16 years of progressive healthcare experience includes commercial leadership roles with Genentech, Dynavax Technologies Corporation, XOMA Corporation, and Carl Zeiss Meditec. He earned a B.S. in Optics at the University of Rochester's College of Engineering and an M.B.A. from The Amos Tuck School at Dartmouth College.

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 27: Potential Clinical Trials Timeline



Source: Company Reports; Laidlaw & Company estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 28: Quarterly Income Statement

Clearside Biomedical
Quarterly income statement

	2017A				2017A	2018E				2018E
($000 except per share)	1QA	2QA	3QA	4QA	Year	1QA	2QE	3QE	4QE	Year
Revenues										
CLS-TA uveitis US										
CLS-TA RVO US										
Total Revenue	**$5**	**$130**	**$155**	**$55**	**$345**	**$0**	**$0**	**$0**	**$0**	**$0**
Expenses:										
COGS (% of US Revenue)										
Gross Margin	**5**	**130**	**155**	**55**	**345**					
G&A	2,671	2,290	2,298	2,441	9,700	3,074	3,250	3,500	3,500	13,324
R&D	7,590	11,478	16,050	13,935	49,053	13,379	14,000	14,500	15,000	56,879
Total operating expenses	**10,261**	**13,768**	**18,348**	**16,376**	**58,753**	**16,453**	**17,250**	**18,000**	**18,500**	**70,203**
Operating income	**(10,256)**	**(13,638)**	**(18,193)**	**(16,321)**	**(58,408)**	**(16,453)**	**(17,250)**	**(18,000)**	**(18,500)**	**(70,203)**
other income (expense)	(117)	(135)	(143)	(172)	(567)	(154)	(125)	(125)	(125)	(500)
Net loss	**(10,373)**	**(13,773)**	**(18,336)**	**(16,493)**	**(58,975)**	**(16,607)**	**(17,375)**	**(18,125)**	**(18,625)**	**(70,703)**
Interest expense										
Provision (benefit) for income tax										
Adj. NI/(loss)	**(10,373)**	**(13,773)**	**(18,336)**	**(16,493)**	**(58,975)**	**(16,607)**	**(17,375)**	**(18,125)**	**(18,625)**	**(70,703)**
NI/(loss) as reported	**(10,373)**	**(13,773)**	**(18,336)**	**(16,493)**	**(58,975)**	**(16,607)**				
Earning per Share (EPS)	**($0.41)**	**($0.54)**	**($0.72)**	**($0.65)**	**($2.33)**	**($0.62)**				
Adj EPS ex-1x & non-cash	**($0.41)**	**($0.54)**	**($0.72)**	**($0.65)**	**($2.33)**	**($0.62)**	**($0.64)**	**($0.66)**	**($0.61)**	**($2.53)**
Weighted avg. shares (000)	25,250	25,310	25,338	25,348	25,312	26,818	27,068	27,318	30,651	27,964
Fully diluted shares (000)	27,459	27,575	27,643	30,990	28,417	29,984	30,068	30,318	33,651	30,964

Source: Company Reports; Laidlaw & Company estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 29: Annual Income Statement

Clearside Biomedical
Annual income statement

($000's except per share)	2016A	2017E	2018E	2019E	2020E
Revenues					
CLS-TA uveitis US	$0	$0	$0	$0	$10,697
CLS-TA RVO US	$0	$0	$0	$0	$0
License	$520	$345	$0	$0	$0
Total sales	**$520**	**$345**	**$0**	**$0**	**$10,697**
COGS	0	0	0	0	2,006
Gross margin	**520**	**345**	**0**	**0**	**8,691**
R&D	19,455	49,053	56,879	67,000	80,500
SG&A	6,263	9,700	13,324	18,100	25,700
Adj. Net Income	**(25,882)**	**(58,975)**	**(70,703)**	**(85,600)**	**(98,009)**
NI/(loss) as reported	**(25,882)**				
Adj-EPS ex-non-cash	**($1.97)**	**($2.33)**	**($2.53)**	**($2.67)**	**($2.71)**
EPS as reported	**($1.97)**	**($2.33)**			

Source: Company Reports; Laidlaw & Company estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 30: Balance Sheet Statement

Clearside Biomedical
Balance sheet

($000's except per share)	2016	2017	1Q18A	2018	2019	2020
ASSETS:						
Current assets						
Cash and cash equivalents	$34,824	$9,224	$84,834	$90,370	$105,720	$91,511
Short-term investments	$48,807	$28,416	$16,221			
Prepaid Expenses	396	1,445	2,168			
Other current assets	290	116	6			
Total current assets	**84,317**	**39,201**	**103,229**	**90,370**	**105,720**	**91,511**
PP&E	94	885	838	1,000	1,000	1,000
Restricted Cash	360	360	360			
other assets	42	47	35			
Total Assets	**84,813**	**40,493**	**104,462**	**91,370**	**106,720**	**92,511**
LIABILITIES						
Current liabilities:						
accounts payable	2,594	5,384	6,744	7,000	8,500	10,000
accrued liabilities	2,791	4,716	3,697	6,000	7,000	8,000
current portion of LT debt		3,200	3,200	4,000	5,000	6,000
Total current liabilities	**5,408**	**13,519**	**13,843**	**17,000**	**20,500**	**24,000**
deferred revenue	160	140		150	200	250
deferred rent		610	581	700	800	900
LTD	7,586	4,809	4,107	3,000	2,500	2,000
other						
Total liabilities	**13,154**	**19,078**	**18,531**	**20,850**	**24,000**	**27,150**
Shareholder's equity						
Common stock	25	25	32	25	25	25
Additional paid-in-capital	136,892	145,618	226,567	265,428	363,228	443,878
Accumulated deficit	(65,245)	(124,220)	(140,667)	(194,923)	(280,523)	(378,532)
Accumulated other comprehensive	(13)	(8)	(1)	(10)	(10)	(10)
Total shareholders' equity	**71,659**	**21,415**	**85,931**	**70,520**	**82,720**	**65,361**
Total liabilites & net worth	**84,813**	**40,493**	**104,462**	**91,370**	**106,720**	**92,511**

Source: Company Reports; Laidlaw & Company estimates

Francois Brisebois
fbrisebois@laidlawltd.com

Figure 31: Cash Flow Statement

Clearside Biomedical
Statement of cash flows

($000's except per share)	2016A	2017A	1Q18A	2018E	2019E	2020E
Operating Cash Flow						
Net Income/Loss	(25,882)	(58,975)	(16,607)	(70,703)	(85,600)	(98,009)
Depreciation	65	182	47	200	250	300
share-based comp	1,314	3,364	1,138	4,000	4,500	5,000
non-cash interest expense	283	211	49	200	200	200
accretion of debt discount	108	212	49	200	250	300
change in fair value of warrant liability	156					
Amortization and accretion on available-for-sale inv	(43)	(31)	(43)			
Loss on sale of fixed assets						
Changes in Assets & Liabilites	1,290	3,954	(286)	1,699	1,000	1,500
Cash from operations	**(22,709)**	**(51,083)**	**(15,653)**	**(64,404)**	**(79,400)**	**(90,709)**
Investing Activities						
Purchase of available for sale investment	(54,485)	(48,116)	(8,725)	(50,000)	(50,000)	(50,000)
Acquisition of PE	(3)	(306)				
Maturities of available for sale investments	5,708	68,543	20,970	70,000	75,000	80,000
Change in restricted cash	(360)					
Proceeds from the sale of fixed assets						
Cash from investing	**(49,140)**	**20,121**	**12,245**	**20,000**	**25,000**	**30,000**
Financing Activities						
Proceeds from IPO, net of issuance cost	51,376					
Proceeds from LTD	7,857					
Proceeds from follow-on offering, net of costs	33,456	5,057	79,581	125,550	69,750	46,500
Principal payments made on LTD	(6,330)		(800)			
Proceeds from share ussued under employee stock		66				
Proceeds from exercise of stock options	31	239	237			
Cash from financing	**86,390**	**5,362**	**79,018**	**125,550**	**69,750**	**46,500**
Change in cash	**14,541**	**(25,600)**	**75,610**	**81,146**	**15,350**	**(14,209)**
Cash, start of period	20,283	34,824	9,584	9,224	90,370	105,720
Cash, end of period	**34,824**	**9,224**	**85,194**	**90,370**	**105,720**	**91,511**

Source: Company Reports; Laidlaw & Company estimates

Francois Brisebois
fbrisebois@laidlawltd.com

DISCLOSURES:

ANALYST CERTIFICATION

The analyst responsible for the content of this report hereby certifies that the views expressed regarding the company or companies and their securities accurately represent his personal views and that no direct or indirect compensation is to be received by the analyst for any specific recommendation or views contained in this report. Neither the author of this report nor any member of his immediate family or household maintains a position in the securities mentioned in this report.

EQUITY DISCLOSURES

For the purpose of ratings distributions, regulatory rules require the firm to assign ratings to one of three rating categories (i.e. Strong Buy/Buy-Overweight, Hold, or Underweight/Sell) regardless of a firm's own rating categories. Although the firm's ratings of Buy/Overweight, Hold, or Underweight/Sell most closely correspond to Buy, Hold and Sell, respectively, the meanings are not the same because our ratings are determined on a relative basis against the analyst sector universe of stocks. An analyst's coverage sector is comprised of companies that are engaged in similar business or share similar operating characteristics as the subject company. The analysis sector universe is a sub-sector to the analyst's coverage sector, and is compiled to assist the analyst in determining relative valuations of subject companies. The composition of an analyst's sector universe is subject to change over time as various factors, including changing market conditions occur. Accordingly, the rating assigned to a particular stock represents solely the analyst's view of how that stock will perform over the next 12-months relative to the analyst's sector universe.

Additional information available upon request.

Laidlaw & Co (UK) Ltd. has not provided any investment banking services for the company (ies) mentioned in this report over the last 12 months.

RATINGS INFORMATION

Rating and Price Target Change History

3 Year Rating Change History

Date	Rating	Closing Price ($)
07/16/2018	Buy (B)	10.28*

3 Year Price Change History

Date	Target Price ($)	Closing Price, ($)
07/16/2018	18.00	10.28*

** Previous Close7/13/2018*

Source: Laidlaw & Company **Created by: Blue-Compass.net**

Laidlaw & Company Rating System*		% of Companies Under Coverage With This Rating	% of Companies for which Laidlaw & Company has performed services for in the last 12 months	
			Investment Banking	Brokerage
Strong Buy (SB)	Expected to significantly outperform the sector over 12 months.	0.00%	0.00%	0.00%
Buy (B)	Expected to outperform the sector average over 12 months.	67.27%	25.45%	3.64%
Hold (H)	Expected returns to be in line with the sector average over 12 months.	0.00%	0.00%	0.00%
Sell (S)	Returns expected to significantly underperform the sector average over 12 months.	0.00%	0.00%	0.00%

ADDITIONAL COMPANIES MENTIONED

Accelerate Diagnostics (AXDX– Not Rated)
Aetna (AET – Not Rated)
Alcon (ACL – Not Rated)
Alimera (ALIM – Buy)
Allergan (AGN – Not Rated)
Bausch & Lomb (BOL – Not Rated)
Bristol-Myers Squibb (BMS – Not Rated)
Cancer Genetics (CGIX– Not Rated)
Cigna Corporation (CI – Not Rated)
Genomic Health (GHDX– Not Rated)

Francois Brisebois
fbrisebois@laidlawltd.com

NeoGenomics (NEO– Not Rated)
Oxford Health Plans (OHP – Not Rated)
Quest Diagnostics (DGX– Not Rated)
Rosetta Genomics Ltd (ROSG– Not Rated)
Trovagene Inc (TROV– Not Rated)
UnitedHealthGroup Inc. (UNH – Not Rated)
Veracyte Inc. (VCYT – Not Rated)

Francois Brisebois
fbrisebois@laidlawltd.com

NOTES:

Francois Brisebois
fbrisebois@laidlawltd.com