Medivation (MDVN) Earnings Report: Q1 2015 Conference Call Transcript

The following Medivation conference call took place on May 7, 2015, 04:30 PM ET. This is a transcript of that earnings call:

Company Participants

- Anne Bowdidge; Medivation; Senior Director of Investor Relations
- David Hung; Medivation; Founder, CEO, President and Executive Director
- Ridhard Bierly; Medivation; CFO
- Lynn Seely; Medivation; Chief Medical Officer
- Joseph Lobacki; Medivation; Chief Commercial Officer

Other Participants

- Geoffrey Meacham; Barclays Capital; Analyst
- Catherine Hu; Barclays Capital; Analyst
- Yaron Werber; Citigroup; Analyst
- Richard Goss; Leerink Swann; Analyst
- John Newman; Canaccord Genuity; Analyst
- Geoffrey Porges; Sanford C. Bernstein; Analyst
- Matthew Roden; UBS Investment Bank; Analyst
- Brian Klein; Stifel, Nicolaus & Company; Analyst
- Jeremiah Shepard; Credit Suisse; Analyst
- Biren Amin; Jefferies; Analyst
- Michael King; JMP Securities; Analyst
- Anupam Rama; JP Morgan Chase; Analyst

MANAGEMENT DISCUSSION SECTION

Operator:

Good afternoon, everyone, and welcome to the Medivation First Quarter 2015 Financial Results Conference Call. This call is being recorded. (Operator Instructions) I will now turn the call over to Anne Bowdidge, Senior Director of Investor Relations. Please go ahead.

Anne Bowdidge (Senior Director of Investor Relations):

Thank you. And thank you, all, for joining us. On the call today from Medivation are Dr. David Hung, President and CEO; Rick Bierly, Chief Financial Officer; Joe Lobacki, Chief Commercial Officer; and Dr. Lynn Seely, Chief Medical Officer. We issued a press release today that you can find on our website at www.medivation.com.

Before we begin, I'd like to remind you that various remarks that we make on this call contain forward-looking statements that are made under the Safe Harbor provisions of the securities laws. Forward-looking statements involve risks and uncertainties that could cause Medivation's actual results to differ significantly from those projected or included in Medivation's guidance, including without limitation: risks relating to the timing, progress and results of Medivation's clinical trials, including the risk that adverse clinical trial results could alone or together with other factors, result in a delay or discontinuation of the

commercialization of XTANDI or some or all of Medivation's product development activities, including with respect to MDV9300; Medivation's dependence on the effort of and funding by Astellas for the development, manufacturing and commercialization of XTANDI; the risk of unanticipated expenditures or liabilities and other risks detailed on Medivation's filings with the SEC, including our quarterly report on Form 10-Q for the quarter ended March 31, 2015, which was filed today.

In addition to our prepared remarks, we may make forward-looking statements in response to questions, including, for example, statements regarding our current or potential future collaboration, potential in-licensing opportunities and our future financial position and results.

Any statements made in this call that are not statements of historical fact, may be deemed to be forward-looking statements. All forward-looking statements made during this call are based on information available to us as of today, and we assume no obligation to update these statements as a result of future events or otherwise.

This call is a property of Medivation , and any replay of this conference call cannot be made without Medivation's expressed written permission.

We'll also be using non-GAAP financial measures to help you understand underlying business performance. The non-GAAP to GAAP reconciliations are provided in our press release.

With that, I'll turn the call over to Dr. David Hung, President and CEO of Medivation . David?

David Hung (Founder, CEO, President and Executive Director):

Thanks, Anne. Thank you, all, for joining us today. We appreciate the opportunity to discuss Medivation's financial performance during the first quarter and the excellent operational progress we've made across our businesses. 2015 is off to an exciting start, highlighted by the statistically significant readouts from the STRIVE and TERRAIN trials. These Phase II trials were designed to evaluate enzalutamide head-to-head versus bicalutamide, the most commonly used antiandrogen.

We were extremely pleased with the results from the trials, which exceeded even our own internal expectations. I'll talk about STRIVE and TERRAIN in a bit as well as other ongoing trials evaluating enzalutamide in the prostate cancer continuum and also in breast cancer.

The first quarter also marked our second full quarter of sales in the U.S. with our expanded metastatic CRPC label. We're pleased with the positive demand growth we saw in the quarter, which was consistent with our previous guidance as a result of the strong chemo-naive mCRPC launch.

Worldwide, Astellas has made significant strides to expand access to XTANDI. Currently, XTANDI is approved in over 50 countries for the treatment of metastatic CRPC patients. Just last month, Canada was added to the growing list of countries as it approved XTANDI for mCRPC. Astellas continues to work with the relevant regulatory and reimbursement authorities in additional markets to ensure XTANDI becomes available to appropriate patients as soon as possible.

With that introduction, I'll turn the call over to Rick to discuss our financial results for the first quarter of 2015, and then I'll update you on our clinical and research program. Rick?

Ridhard Bierly (CFO):

Thanks, David. Good afternoon, everyone. I'll begin with XTANDI net sales worldwide at the level reported by Astellas, which were $357 million in the first quarter, more than double the $175 million reported in the 2014 first quarter.

In the U.S., XTANDI net sales were $224 million in the first quarter 2015, which is 80% growth versus a year ago 2014 first quarter. You will recall that in our February 25 year-end call, we said U.S. XTANDI net sales in the first quarter may be at or below the $230 million of net sales reported by Astellas in the fourth quarter 2014 due to several factors.

I'd like to break down those factors a bit for you now to assist your understanding. First, based on units, the March 31 quarter's XTANDI net sales included robust sequential quarter demand growth in the low-teens as a percentage of fourth quarter demand. We're pleased with this growth, following the greater-than-20% sequential quarter growth seen last quarter, which was the first full quarter after the PREVAIL label update in September.

Second, as is typical with oncology Part D therapies early in the year and as referenced in our February call, the first quarter gross-to-net accrual rate utilized by Astellas was higher than the rate used in the fourth quarter. This is primarily due to the annual reset of the so-called doughnut hole associated with Medicare Part D coverage. This higher accrual rate in the quarter was mostly offset by a $5.2 million favorable gross-to-net adjustment in the quarter related to true-up of prior period gross-to-net.

Finally, and as also discussed in February, the December 31 quarter's reported net sales of $230 million included an increase in channel partner inventory of approximately 1 week as well as a favorable gross-to-net adjustment of $3.8 million.

Based on information from Astellas, the channel partner inventory at the end of the first quarter is within a range seen as normal.

First quarter 2015 gross-to-net accrual rate utilized by Astellas is higher than the mid-teens percentage rate that we expect Astellas will average for full year 2015 gross-to-net.

In the U.S., we estimate there were between 31,000 and 32,000 prescriptions written for XTANDI in the first quarter compared with just under 28,000 in the fourth quarter. Since the U.S. launch of XTANDI in September of 2012, prescriptions have been written by more than 8,500 individual prescribers in the U.S. We continue to be pleased with growth in new prescribers of XTANDI and new patient starts were, again, an important contributor to sequential quarter demand growth.

Our ongoing market research shows a growing preference for XTANDI by urologists and oncologists among the novel hormonal agents.

XTANDI enjoys broad coverage across all lines of therapy in metastatic CRPC and virtually all U.S. Medicare and commercial payer prescription plans.

Ex-U.S. net sales of XTANDI reported by Astellas were approximately $133 million in the first quarter of, which is 161% growth over the prior year. Contributing to this growth, XTANDI received a number of ex-U.S. initial or supplemental marketing approvals in the past 12 to 18 months, and we're pleased with the early commercial progress made by our partner, Astellas, in these markets.

On a constant currency basis, growth was 15% compared with the fourth quarter. Without adjusting for currency rate changes, sequential quarter ex-U.S. net sales were approximately 6% higher than the fourth quarter 2014.

Turning now to Medivation's income statement. Collaboration revenue was $129.2 million for the first quarter on a GAAP basis compared with $87.2 million for the same period in 2014 or 48% growth versus prior year. Non-GAAP collaboration revenue, which excludes $1.4 million related to upfront and milestone payments in 2015, was $127.8 million for the first quarter compared with $68 million for the same period in 2014, which is 88% growth versus the prior year.

Medivation's total GAAP basis collaboration revenue from XTANDI consists of 3 components: revenue related to U.S. sales; revenue related to ex-U.S. net sales in the form of a royalty; and finally, revenue from upfront and milestone payments.

In the U.S., we share XTANDI net sales costs, profits and losses with Astellas. Our collaboration revenue related to U.S. net sales in each period is equal to 1/2 of the net sales reported by Astellas.

For the first quarter 2015, collaboration revenue related to U.S. net sales was $112 million compared with $62.2 million in the year-ago quarter, an increase of 80%.

Outside the U.S., Astellas handles commercial activities and bears all XTANDI costs, retains the related profits and losses and pays Medivation tiered royalties, ranging from the low-teens to low-20s as a percentage of ex-U.S. net sales.

For the first quarter of 2015, royalty revenue related to ex-U.S. XTANDI net sales was $15.8 million compared with $5.7 million in the year-ago quarter. Collaboration revenue related to upfront and milestone payments was $1.4 million in the first quarter of 2015 compared with $19.2 million in the year-ago quarter.

First quarter non-GAAP operating expenses were $105.3 million compared with $72.5 million for the same period in 2014, an increase of $32.8 million. Non-GAAP SG&A expenses for the first quarter of 2015 were $67.4 million compared with $44.2 million for the same period in 2014. The increase in non-GAAP SG&A expenses primarily relates to higher sales and marketing and medical affairs expenses, higher collaboration expense from Astellas and higher personnel-related costs, excluding stock-based compensation that we adjust out for non-GAAP purposes.

Some first quarter SG&A expense is not expected to recur in subsequent quarters, and we are maintaining full year non-GAAP SG&A operating expense guidance at $230 million to $250 million.

Non-GAAP R&D expenses for the first quarter of 2015 were $37.9 million compared with $28.3 million for the same period in 2014. The increase in non-GAAP R&D expenses primarily relates to higher MDV9300 or pidilizumab costs and XTANDI clinical costs, higher preclinical expenses for other programs and higher personnel-related costs, excluding stock-based compensation.

In the first quarter 2015, non-GAAP collaboration revenue increased 88% over the prior-year period, while non-GAAP operating expenses increased by 45%. Medivation reported non-GAAP net income of $13.4 million or $0.17 per diluted share for the first quarter of 2015 compared with a non-GAAP net loss of $4 million or $0.05 per diluted share in the year-ago first quarter.

At March 31, 2015, we had cash and equivalents of nearly $569 million. Cash increased by $66 million in the quarter from the level on hand at year-end 2014. In the second quarter of 2015, we received approximately $90 million at face value of convertible note redemptions. We expect to settle the face value of these in cash and the premium in shares in the second quarter as disclosed in our Form 10-Q.

Turning to guidance. We are maintaining our full year 2015 non-GAAP collaboration revenue and operating expense guidance that we provided in our year-end conference call in February. With regard to XTANDI net sales in the U.S. at the Astellas level, that full year guidance is a range from $1.05 billion to $1.25 billion. I won't repeat the other guidance information here as it's included in the press release filed today.

I will point out, the one relatively minor change we are making to reduce full year 2015 interest expense guidance from $7 million to $5 million. This is a result of the previously mentioned convertible note redemptions that we received in the past several weeks after the end of the quarter.

Just a few further comments regarding income taxes. We expect our cash taxes payable in 2015 will be well below that calculated from the GAAP basis effective tax rate in the range of 36% to 37%. This is due to expected use of available net operating losses and tax credits. To illustrate, if we were to achieve the midpoint of 2015 non-GAAP collaboration revenue and expense guidance ranges and also achieve both remaining sales milestones, we'd expect to pay full year 2015 federal and state cash taxes in the range of $30 million to $50 million. In this scenario, we would also expect to utilize most, if not all, of our roughly $300 million of gross federal tax losses and tax credit carryforwards, all expressed on a pretax basis.

With that, I'll hand the call back over to David.

David Hung (Founder, CEO, President and Executive Director):

Thanks, Rick. I'd now like to update you on our progress to further develop enzalutamide in the prostate cancer disease continuum and also in breast cancer. As I mentioned earlier, we were extremely pleased with the results from the STRIVE and TERRAIN trials, comparing enzalutamide head-to-head versus bicalutamide.

In total, these trials enrolled nearly 800 men. The TERRAIN trial enrolled patients from Europe and the U.S. with metastatic disease. The STRIVE trial enrolled men with metastatic and non-metastatic disease. Both trials met their primary endpoint, demonstrating robust statistical significance with P values less than 0.0001.

In March, at EAU, Dr. Axel Heidenreich presented additional results from TERRAIN, including data from the prespecified secondary endpoint, PSA response and time to PSA progression, which were both met and statistically significant.

The safety profile of the enzalutamide-treated patients in TERRAIN was consistent with the known safety profile of enzalutamide.

I'm pleased to report that new data from STRIVE and TERRAIN will be presented on Sunday, May 17 at AUA. Dr. Celestia Higano from the University of Washington, will present the results from STRIVE and Dr. Arnauld Villers from the University of Lille in France, will present the results from TERRAIN.

We look forward to making additional data available in the public domain through future scientific publications and presentations.

Also at EAU in Madrid, Dr. Bertrand Tombal presented an updated overall survival endpoint analysis from the Phase III PREVAIL study in which enzalutamide confirmed a significant overall survival benefit despite patients receiving -- despite many patients receiving subsequent treatments.

I'd now like to update you on progress in our ongoing trials to develop enzalutamide earlier in the prostate cancer spectrum and also in breast cancer. Just 4 months ago, our first patient was enrolled in our EMBARK study, our global Phase III registrational study to evaluate approximately 1,860 patients with high-risk, hormone-sensitive, non-metastatic prostate cancer that has biochemically recurred as defined by a rise in PSA following surgery and/or radiation.

The primary endpoint of the trial is metastasis-free survival. The purpose of the trial is to determine if enzalutamide can delay the development of metastatic prostate cancer in high-risk men with a rapidly rising PSA.

The trial will have 3 arms, including enzalutamide in combination with leuprolide, enzalutamide alone and leuprolide alone. So in essence, this will be our first combination and head-to-head comparison of enzalutamide against the most widely-used prostate cancer drug, Lupron.

Our Phase III PROSPER trial has been enrolling for over a year. As a reminder, PROSPER is enrolling a high-risk subgroup of approximately 1,560 pre-chemotherapy, non-metastatic CRPC patients whose disease is progressing despite androgen deprivation therapy and are asymptomatic. The primary endpoint of the trial is metastasis-free survival.

In addition to our efforts with enzalutamide in prostate cancer, we're evaluating enzalutamide in 3 subsets of breast cancer. I'll start with our program in triple negative breast cancer known as TNBC. TNBC is a type of breast cancer that is not driven by the 3 most commonly targeted receptors of breast cancer: estrogen, progesterone and human epidermal growth factor receptor 2 or HER2.

It is estimated that about 20% of all metastatic breast cancers are triple-negative. We initiated our Phase II trial in this indication nearly 2 years ago. The trial is evaluating enzalutamide as a single agent for the treatment of advanced androgen receptor-positive TNBC. In just 1 year, we enrolled 118 women, exceeding our original enrollment target of 80. The rapid enrollments of this trial speak to the urgent need for new therapies in this area.

We are pleased to report that Dr. Tiffany Traina from Memorial Sloan-Kettering Cancer Center, will be presenting the mature Phase II result from these 118 women on Monday, June 1 in an oral presentation at ASCO. We are currently discussing a development plan with Astellas.

We are also studying XTANDI in other populations of breast cancer. Based on our preclinical data, XTANDI appears to inhibit not only AR signaling, but may also inhibit estrogen signaling.

In March, we completed enrollment in our second Phase II trial, evaluating enzalutamide in combination with exemestane versus exemestane alone in women with advanced breast cancer that is ER-receptor positive and/or PR-receptor positive and HER2 normal. The trial enrolled 247 women. The primary endpoint is PFS in all patients and the subset of patients whose tumor expresses the androgen receptor. We are continuing to enroll patients in our third breast cancer trial evaluating enzalutamide in a population of patients that are HER2-amplified and AR+. The goal of the study is to determine whether adding enzalutamide to trastuzumab will provide any incremental benefit for women who have progressed on trastuzumab, otherwise known as Herceptin.

In the future, we look to drive additional value through our proprietary research and development programs, which are focused among other areas in oncology and neurology. One important area of emphasis for Medivation is immuno-oncology.

In December, we licensed the worldwide rights to a monoclonal antibody, pidilizumab, which we will advance into development as MDV9300. We currently anticipate initiating a Phase III clinical trial in at least one hematologic malignancy as early as in 2015. We are also considering evaluating MDV9300 in other indications, including, but not limited to, breast and prostate cancer.

There is also encouraging preclinical data showing that enzalutamide improves thymic function, suggesting that it may have a role in combination with other agents in other cancers in the immuno-oncology setting. We will continue to evaluate potential uses of enzalutamide.

We expect to announce another internal development program in 2015, and we'll continue to actively pursue other external opportunities.

In closing, we're pleased with our financial performance for the first quarter as well as the ongoing clinical progress of enzalutamide and the strides we made in our proprietary research and development programs.

We believe these initiatives will continue to support our short- and long-term growth strategy, while

staying focused on our ultimate mission: to develop medically innovative therapies to treat serious diseases for which there are limited treatment options.

With that, we thank you for your continued support and look forward to updating you on our progress. I'll now turn the call over to the conference coordinator to open the call up to Q&A.

QUESTIONS & ANSWERS

Operator:

(Operator Instructions) First question comes from Geoff Meacham from Barclays.

Geoffrey Meacham (Analyst - Barclays Capital):

David, a question on STRIVE and TERRAIN. I guess, when you look at the -- just curious how much of a role publication and compendia listing plays on the ability to drive demand versus just greater awareness of the data. I guess, I'm asking because a physician can formally write a script today for an M1 patient and that is the STRIVE and the -- mostly STRIVE and the TERRAIN population. So I'm just trying to get a better sense for how much of an impact these studies could have going forward.

Lynn Seely (Chief Medical Officer):

So this is Lynn. Why don't I start. So obviously, we're extremely excited about these studies and they're going to be presented. I think the field is also extremely excited about these studies, and that's why be they're both being presented at the plenary at the upcoming AUA meeting. So I think that getting those data out there are going to be an incredibly part of -- important part of our strategy and high-caliber peer review, scientific publication is going to be critically important. I think after the data are both presented publicly, we'll be in a position to submit to the NCCN for consideration. And I think, ultimately, as we always do, we'll be submitting these data to the health authorities. And so these data, we think, are very important for physicians to be aware of and we're going to do everything we can to ensure that, that happens.

Joseph Lobacki (Chief Commercial Officer):

And Geoff, this is Joe. You are correct in saying that the mCRPC patient is within our label. So if a physician writes a prescription for mCRPC, that is reimbursed by payers.

Geoffrey Meacham (Analyst - Barclays Capital):

Got you. And just real quick commercial question just from a -- I don't know if you can help sort of quantify just the puts and takes with regard to the sequential trends for 1Q. If you had to ranks sort of what would be the biggest sort of impact factor from 4Q to 1Q, is it the gross-to-net? Is it inventory drawdown? Is it Medicare Part D sign-ups, things of that nature?

Joseph Lobacki (Chief Commercial Officer):

This is Joe again. So I think what we've seen on the commercial side is we've seen growth in the active writers of XTANDI. We've seen growth in new patient starts as well as preference, so that's driving a lot of the growth that we've seen in Q1 from a demand perspective.

Operator:

Our next question comes from Catherine Hu.

Catherine Hu (Analyst - Barclays Capital):

I was just curious about the anti-PD-1 antibody. There are a number of hem-onc studies ongoing with various anti-PD-1 and anti-PD-L1 antibodies and there's a bunch of combinations as well. Most common was with Imbruvica. So I'm just curious, how are you devising your strategy for your anti-PD-1 antibody (inaudible) and how do you differentiate yourself from a strategic perspective?

Lynn Seely (Chief Medical Officer):

Thanks, Catherine. Yes. No, we are extremely excited about MDV9300, which, I think most of you are aware, we brought into Medivation at the end of last year. This antibody is an immunomodulatory antibody and it has really nice clinical activity, which was then published by the group out of Dana-Farber in the Journal of Clinical Oncology in patients with Relapsed/Refractory Diffuse Large B-Cell Lymphoma. It also has clinical activity that's been published in the Lancet Oncology by MD Anderson Group, and relapsed follicular lymphoma in combination with Rituxan. So this is an antibody that has a lot of clinical activity in Phase II studies and key malignancies, and we're very excited about moving it forward. And we said that we'll be an at least one Phase III study in hematologic malignancies as early as this year, and we're very excited to get that moving. And I think at that point -- at this point, that's all we're going to say about it for very obvious competitive reasons.

Operator:

Next question comes from Yaron Werber from Citi.

Yaron Werber (Analyst - Citigroup):

Quick question, can you guys help us in terms of gross-to-net? Was there everything perhaps a little bit more disproportional this quarter relative to previous quarter? And then, if you don't mind, I just have a follow-up as well.

Ridhard Bierly (CFO):

Yes, Yaron. This is Rick, I'll take that. Of course, we had the first quarter situation that I mentioned in my comments where we -- Astellas supplied us a higher gross-to-net rate, really related to doughnut hole. And so that's pretty typical as you know. And so that was several points of gross-to-net in the first quarter that we won't see in subsequent quarters. In fact, as I mentioned, I think the full year average will be probably mid-teens.

Yaron Werber (Analyst - Citigroup):

Okay. And then just -- I don't know what you can or can't say about the upcoming data coming at ASCO, but help us understand, from what you know so far of XTANDI, where do you think it would fit in? Is this ultimately going to be a combination agent in your view? Or is it going to be a single agent in breast cancer?

Lynn Seely (Chief Medical Officer):

That's a great question. Obviously, women with triple negative breast cancer are in great need of new therapies, whether in -- single agent would be exceptional, and that's where our data are today and even in combination. What's really interesting about this program is we are having an opportunity to sort of redefine what's known about triple negative breast cancer. This is currently a very deadly disease without a target. It's what we talk about what it isn't. And now we sort of are finding that there may well be a target for triple negative breast cancer, or at least some percentage of women, a rather large percentage of women, which is the androgen receptor. And so we're very excited about showing the data and getting this moving forward.

Yaron Werber (Analyst - Citigroup):

Okay. And do you think -- and maybe final question, do you think is stable disease enough in that setting? Or do you really need to see sort of a CRPR in excess of 20% to really be able to get traction and approval?

Lynn Seely (Chief Medical Officer):

Yes. So typically, the registration endpoint in a trial like this is, again, progression-free survival. And I think obviously, stable disease is a very important part of delaying progression. And CRs and PRs are, of course, always highly desirable, but a progression-free survival would be the typical endpoint here.

Operator:

Next question comes from Howard Liang from Leerink Partners.

Richard Goss (Analyst - Leerink Swann):

This is Rich Goss calling in for Howard. Do you have a sense as to how much XTANDI use there is currently in the non-metastatic CRPC setting?

Joseph Lobacki (Chief Commercial Officer):

So Rich, this is Joe. So we follow the metastatic study. That's the market that we're focused on. So -- and that's where we look at in our data. So we -- our label covers mCRPC and that's what we focus on.

Richard Goss (Analyst - Leerink Swann):

Okay. And when do you expect the PROSPER trial to read out?

Lynn Seely (Chief Medical Officer):

Yes. The PROSPER is a Phase III registration trial in the non-metastatic CRPC population. It's a large trial of 1,560 patients. We're actively enrolling that trial, and we haven't given guidance yet on when we'd be bringing out the top line results.

Operator:

Next question comes from John Newman from Canaccord.

John Newman (Analyst - Canaccord Genuity):

Just have a question for David in terms of the STRIVE and TERRAIN data that will presented at AUA. David, do you think that urologists may interpret these data differently than they did the PREVAIL data? I'm just curious as to what your thoughts are on these data presentations, given that you've got an active agent in the studies that urologists have used and how they might sort of compare and contrast the data sets with regard to PREVAIL.

David Hung (Founder, CEO, President and Executive Director):

So John, I think that there's certainly that potential. I think that PREVAIL, although it showed a very robust overall survival and progressive re-survival benefit, wasn't compared to an agent that urologists are very accustomed to using, which is bicalutamide. I think that, as you know, there are -- bicalutamide has never demonstrated a survival benefit to any well-controlled study. I think that having now 2 trials, which show that head-to-head, against an agent that they not only are very familiar with, but used, at least in the United States. There are 600,000 scripts written every year by, primarily, urologists for the treatment of

prostate cancer with bicalutamide. So I think that having direct head-to-head data showing the benefit of XTANDI over bicalutamide is probably going to be pretty meaningful and of interest to that segment of physicians.

So yes, we do think that these data are very significant. I think they're going to be very noteworthy because of familiarity of urologists with bicalutamide, and the fact that this is the first head-to-head study ever done against bicalutamide showing superiority to bicalutamide.

John Newman (Analyst - Canaccord Genuity):

Okay. And then, on the work that you're doing in triple negative breast cancer -- it's the follow-up to one of the prior questions. Can you talk about what's currently seen in triple negative breast cancer? It seems that people have been pretty focused on the magnitude of response that's seen with some of the chemotherapy agents. But my impression is that you can get a response, but it's very short. And I'm just wondering how you might be able to differentiate there if you're able to keep patients from progressing even though you don't have this sort of big response upfront?

David Hung (Founder, CEO, President and Executive Director):

I think that, that's an important fact that you cite. So when our San Antonio data came out, some people were a little critical of the response rates compared to other agents. There was a very small study of a PD-1 inhibitor showing an objective response rate that appeared to be higher than ours.

If you look at actual comparison of the 6-month PFS, the results of XTANDI were actually very favorable compared to the PD-1 agents. So I think that it doesn't really matter what your objective response rate is if it's -- the durability of that response is a [must]. But I think what is much more meaningful to these patients are the longest durability that can be achieved, and that -- at least in this case that we presented at San Antonio with the limited follow-up we had at the time, our 6-month PFS was almost 50%. So our PFS was almost 50%.

So I think that's going to be significant. And now what you'll have the chance to see with our more mature data set is a little bit of longer-term follow-up, and you'll see what that data shows.

So I think that we're on the right track. I think that these are exciting data because when you consider that right now, the gold standard of care for this patient population is chemotherapy, given how well-tolerated XTANDI is and given now at least the preliminary data that you've already seen at San Antonio and more data you're going to see at ASCO, I think that we're going to pretty well positioned in this space.

Operator:

Our next question comes from Geoffrey Porges from Bernstein.

Geoffrey Porges (Analyst - Sanford C. Bernstein):

Look, my question, David, is one I've asked before which is one of duration, which is could you comment on how your duration is increasing and how much of your revenue growth is coming from duration versus patient number? And secondly, the duration was somewhat shorter than we anticipated in both STRIVE and TERRAIN. And do you think that those results approximate what you'll see in the real world? Or do you think the patients will stay on treatment for a shorter duration or a longer duration than we saw in STRIVE and TERRAIN?

David Hung (Founder, CEO, President and Executive Director):

So Geoff, I think that the -- we haven't commented on duration because that's a changing number. Clearly, as we get farther and farther upstream, we hope that duration will increase. The differences between STRIVE and TERRAIN and PREVAIL probably can be attributed to the fact that in PREVAIL, you have a well-controlled Phase III study with an RPFS endpoint as we had a lot of fight and PI, principal investigator, and education to try to convince them to keep patients on the study as long as possible, and I think we were pretty successful in PREVAIL.

STRIVE and TERRAIN were Phase II studies and they were conducted primarily by urologists, which are clearly a different type of physician, I think. And also given the fact that there were composite endpoints in the STRIVE and TERRAIN trials, which included more than just PFS. It included PSA, as an example, as an endpoint [retaining] therapy. I think that, that could account for some of the differences. But we do believe that the drug has greater benefit farther upstream than it does downstream. We've shown that in PREVAIL compared to AFFIRM. And even if you looked at the data in STRIVE and TERRAIN in terms of benefit, we believe that the benefits accrue even more as the farther upstream you get.

So I think it's a matter of educating physicians and also, eventually, at some point, teaching patients that if a drug is well-tolerated, we believe that there are compelling arguments to be made biologically as to why patients should stay on a drug that they're getting benefit from as long as possible. So I think that we're going to have to educate a lot of people to keep them on therapy, but I think that -- we believe that those -- that duration will increase as we move farther upstream in the disease cycle.

Operator:

Our next question comes from Matt Roden from UBS.

Matthew Roden (Analyst - UBS Investment Bank):

First one, a commercial question, if I may, a follow-up on the pipeline. So for Rick or Joe, looks like if third party data are correct, you took a price increase on April 2? And I'm just wondering that -- if that increase would have been known to buyers ahead of time in the first quarter, such that the $224 million that you reported here may have actually reflected buying ahead of that increase. Now, if I look back to the timing of your prior price increases, it seems to be maybe irregularly timed. So I just don't know if that would have been known to buyers ahead of time. I wonder if you can comment as to whether or not that may have -- if that was in or not in the 1Q number.

Ridhard Bierly (CFO):

Yes. Matt, this is Rick. Thanks for the question. I think, as you know, Astellas manages the sort of price increase process. And to my knowledge, there wasn't any announcement of any kind ahead of time. I can't say that it didn't get out in some fashion, but to my knowledge, there's was no pre-announcement.

Matthew Roden (Analyst - UBS Investment Bank):

Okay, great. And then maybe for Lynn, you alluded to speaking with Astellas about development options in triple negative. And just curious if that suggests Phase II data that you're going to show at ASCO are good enough to justify pivotals?

Lynn Seely (Chief Medical Officer):

Well, I think, everybody will have to judge that for themselves, but I think the companies are quite excited about these data. I think that's very clear. I think this is something very important for triple negative breast cancer for the field and particularly for the women. We're learning more and more about the disease and potentially, ways that can benefit them. And I think we're very interested in continuing that exploration. So yes, I think stay tuned. We're really [excited].

Matthew Roden (Analyst - UBS Investment Bank):

Nice. Okay. And then I guess just related, in HR-positive breast cancer, you give hormone agents in the adjuvant setting. And in HER2-positive disease, you give HER2 inhibitors. So if your data are good here in triple-negative, does that create a path for developing XTANDI into triple-negative adjuvant setting? And if so, what would that path look like?

Lynn Seely (Chief Medical Officer):

Great question. And the adjuvant setting in triple negative breast cancer is absolutely something that we need to be thinking about very seriously. And it's very standard when you show the benefit in an advanced breast cancer sub-type that you think about the adjuvant setting, and there's a huge need here. So we would be remiss if we were not thinking about that as well.

Operator:

Our next question comes from Brian Klein from Stifel.

Brian Klein (Analyst - Stifel, Nicolaus & Company):

Just a quick strategy question. Can you talk a little bit about the pipeline and whether you think you need to add additional candidates here to develop outside of XTANDI and pidilizumab?

David Hung (Founder, CEO, President and Executive Director):

The answer is yes. I think that, as always, we try to achieve a diversified pipeline of agents that we believe are likely to have a reasonable probability of success and always to balance that with the constraints of our budget.

So we're very excited about XTANDI. As we've said many times, we intend to grow that franchise by expanding XTANDI upstream in prostate cancer, moving to the front of the line in treatment, expanding XTANDI across other indications. I think breast cancer is just the first example of that. There are others that we can consider.

We've also spoken about the possibility of XTANDI, at some point, being a foundation for immunotherapy, given the specs on immune function and the possibility of synergistic effects with other immuno-oncology agents.

That said, our second late-stage asset is pidilizumab, and we've already said that we intend to be in at least one Phase III trial and at least one heme-malignancy as early as 2015. And I think that we're excited about that franchise -- about that opportunity because we believe that there are some things about pidilizumab that have the potential to differentiate it from other PD-1 or PD-L1 agents.

We made the point several times that pidilizumab was not generated against single purified PD-1 protein. It's actually generated against a lymphocyte line -- cell line. And as a result, we believe that the immunomodulatory effects of pidilizumab may differ from some of the other agents.

And in fact, there will be a -- there's been several groups that have produced some data suggesting that that may indeed be the case. So I think that if indeed that is the case and the profile of pidilizumab differs from other immunomodulatory agents, I think that could really change the complexion of that program. And in that case, we would clearly want to expand that into as many indications as we could justify. So that's certainly something that's very, very high up on our priority list.

And then, on top of that, we have said that we intend to announce at least one new internal Medivation program this year. And since we only have like 7 months left in the year, I guess, the next 7 months, you're

going to hear about at least one new internal program. And I think that, that will also give you a little bit of an idea about where else we're going and how we're filling out our pipeline. And then, as we've also said on the call today, we continue to look at external opportunities. We've had a history in the company of being pretty successful in identifying other external opportunities and bringing them in-house, and so we will continue to do that.

So I think that we intend to achieve a very robust and balanced portfolio. So we intend to do that with some -- with fiscal rigor, I guess, I would say. We're going to do it responsibly. We're going to pick opportunities that we think are going to give us a higher return on our investments. And we tend to go into areas of great unmet medical need and therefore, that are likely to reflect great commercial opportunities. I think we're well positioned to achieve that.

Operator:

Our next question comes from Jeremiah Shepard from Credit Suisse.

Jeremiah Shepard (Analyst - Credit Suisse):

Just a quick follow-up to one -- to Matt's question. In terms of that price increase you did take, how long does it take for that price increase to actually work through the channel and you actually see a benefit on the terms of your sales?

Ridhard Bierly (CFO):

Well, I think the benefit should be obviously all sales from April 2 forward will reflect the new price. And as I've mentioned, we consider the inventory that's in the channel to be at a range that's normal at the end of Q1. So I wouldn't anticipate much delay at all.

Jeremiah Shepard (Analyst - Credit Suisse):

Okay. And in regards to EMBARK for the entry criteria, you mentioned that you're looking at high-risk patients. But is it strictly this -- in terms of like rapidly rising PSA, are you including Gleason scores as well to further characterize these patients?

Lynn Seely (Chief Medical Officer):

So certainly, there are number of ways to identify high-risk men. And in our particular case, we've selected a rapid PSA doubling time. There is a set PSA level that you have to achieve as well. So it's -- you've got to reach a certain PSA level and then a rapid PSA doubling time. We're not -- the additive benefit of Gleason is pretty small. It overlaps very much with a rapid PSA doubling time. So we look at both of those extensively and take the rapid PSA doubling time.

Jeremiah Shepard (Analyst - Credit Suisse):

And just one quick follow-up to that is I've heard the numbers like 15% to 20% of like the earlier-stage patients, like I'm assuming it might be in the M0 setting, are actually high risk. And then, I wonder how many of those patients actually are the patients that actually succumb to the disease eventually. Is that roughly like 1/2 of the patients? Because what I was wondering about is if you're treating patients upstream, are you essentially drawing patients away from later-stream use? Because I -- and also, do you expect that you might have patients -- or do you anticipate patients actually also receive XTANDI twice, potentially?

Lynn Seely (Chief Medical Officer):

I think that the way that we're thinking about this is it's certainly possible, but what we want to do is treat

these men early upstream. And what we find is if you can treat them early, you can stabilize their disease for quite some period of time. And so I think this study is really attractive because of the 3-arm design. It allows us to look at the combination of enzalutamide with leuprolide upfront and early and potentially give us this really long duration, which can be very beneficial to men. It allows us to look at enzalutamide alone, which is the very first time we're studying the monotherapy, which may again be particularly beneficial and maybe even giving them a more attractive safety profile. It's something we're looking at. And so I think that this is an opportunity to treat them aggressively upfront and change the course of their disease.

David Hung (Founder, CEO, President and Executive Director):

And I guess, I would add that, although we would treat them twice, I think the idea preferably would be -- we treat them once and continue them on therapy. So if you look at the way urologists currently manage prostate cancer, most men who are started on Lupron, given how well-tolerated Lupron is, continue on Lupron for the course of their disease. And as you might be aware, we started dosing patients with XTANDI in our Phase I study in July '07. So that's almost 8 years ago. And some of those patients are still on XTANDI today. So we believe that if -- as long as the drug is well tolerated, which XTANDI appears to be, we would hope that patients would -- if they derive -- especially if they derive benefits from the drug, would not be treated twice but be treated once, just continue on their therapy. And there's already a paradigm for that among urologists with Lupron.

Operator:

Next question comes from Simos Simeonidis from RBC Capital.

Unidentified Participant:

This is [David] in for Simos. I was wondering about the upcoming internal program. Would that be related to the bromodomain program? Or do you have any updates from that particular program?

David Hung (Founder, CEO, President and Executive Director):

We don't discuss our preclinical programs. So I would just say stay tuned and you're going to hear about -- you're going to hear about this soon enough and I'm not going to give a preview on that.

Unidentified Participant:

Okay. And could you also comment on any plans, I think you said in the past, for perhaps combination therapy for pmab with XTANDI?

David Hung (Founder, CEO, President and Executive Director):

So we have said that we believe that there is strong rationale for combining XTANDI with a number of immunomodulatory agents. As we've made the point several times and at the conferences, it's pretty well established in the literature that when you inhibit AR signaling, that alone potentiates a process called thymopoiesis, which is an increase in the size and function of your thymus. The thymus is an important organ for your white cells to go to become immunocompetent and recognize cell from non-cell.

So clearly, in terms of being able to potentially enhance the efficacy of immunological agents as well perhaps potentially improving their therapeutic index, it would really make the agent recognize cell versus non-cell better. If those were to do that, that could be potentially quite interesting.

So we've said that pmab is a very interesting immunomodulatory antibody. And we believe that it may have activities that are really differentiated from other PD-1 or PD-L1 inhibitors. And so I think it would

make a lot of sense for us to make the combination. But we also believe that the combination of XTANDI with other agents, be it besides this class, I mean, I think that if you look at all immunotherapies, whether it's IDO or TDO or CAR-T or TGFbeta, any of those immunomodulatory agents could potentially benefit in combination with an agent that improves thymic function.

So I think we would be pretty open-minded to potential combinations. And also, if I didn't mention, vaccines, another clear class of drugs where an improvement of thymic function could also be very beneficial.

Operator:

And our next question comes from Biren Amin from Jefferies.

Biren Amin (Analyst - Jefferies):

On the triple-negative data at ASCO, I just want to clarify on your comments, David, that PFS-6, so 50% is your goal? Is this for your diagnostic positive patient population? Or in all valuable patients in the trial?

David Hung (Founder, CEO, President and Executive Director):

I didn't say that was our goal. I just said that in the data we presented at San Antonio, the PFS -- 6-month PFS we presented was approaching 50%. I think the number was like 45%. So I didn't say that was our goal. That's just what the data showed. And now you're going to see longer, more mature data at ASCO. So I didn't say that was our goal. I just said that our -- the effect that we saw at San Antonio that we presented was approaching 50%. I think the number was actually 45%.

Lynn Seely (Chief Medical Officer):

And one of the things that I think that we have shown is that the novel diagnostic is something which we think really enables us to select the women that have AR-driven disease and that are going to be the most likely to benefit. So we do believe that novel diagnostic is an important component of this program. So that will be where you'll want to focus.

Biren Amin (Analyst - Jefferies):

Got it. And then, just on the XTANDI prescriptions for this quarter. It seems that when I calculate Q1 prescriptions written in the quarter, it seems to be somewhere between 3,000 to 4,000 compared to 6,500 the last quarter. Why do you think we observed this trend?

Ridhard Bierly (CFO):

Yes. I'm not -- this is Rick. I'm not sure I understand those numbers. I think we said 31,000 to 32,000 prescriptions in total for Q1 versus just under 28,000 in Q4. Was the question around something else?

Biren Amin (Analyst - Jefferies):

Yes. I mean -- so in Q3, you had 21,500 so it grew about 6,500 prescriptions in Q4.

Ridhard Bierly (CFO):

Yes, yes, yes. Yes, absolutely. So you're right. We had -- in the first quarter after -- first full quarter after the PREVAIL launch, there was greater growth. I think, perhaps, there were physicians that were waiting for that approval to treat patients with XTANDI. I don't know, Joe, if you've got another perspective on that. But that would be mine, I suppose.

Joseph Lobacki (Chief Commercial Officer):

So yes, we do know that there were physicians waiting for the label in the fourth quarter. So we saw an uptick, but we still continue to see growth in Q1 that I think sets us up nicely for the remainder of the year. Saw about a 40% increase in active writers for urology increase in Q1. So again, that's our key focus is with urologists and we continue to expand in that setting.

Biren Amin (Analyst - Jefferies):

And maybe if I could just have one follow-up, in that urology subsegment, how many our community-based versus large academic or LUGPA centers?

David Hung (Founder, CEO, President and Executive Director):

Yes, we don't break it down into that for you, so I don't have those numbers to provide. But we're seeing it across all segments, so we see it throughout the academia as well as community and the larger LUGPAs.

Operator:

Our next question comes from Mike King from JMP Securities.

Michael King (Analyst - JMP Securities):

Just a couple of follow-ups on a number of matters. Just wanted to ask about the gross-to-net, following up on a previous question. I thought, Rick, you said that going forward, we're going to be somewhere in the mid-teens. The way we did our work, I thought your gross in that was quite a bit lower last year, and I just wondered maybe if we're wrong or if there has been a fairly big change in the gross-to-net and perhaps what factors contributed to that.

Ridhard Bierly (CFO):

Yes. That's a good question, Mike. So I was careful to say in my remarks the accrual rate, which is sort of the rate at which Astellas provides gross-to-net initially when the sale occurs. And so that accrual rate for sales occurring in 2015 should average mid-teens for the year. It was higher than that in Q1. Last year, if you were to look at all in, as you may recall, there were a number of favorable gross-to-net adjustments that Astellas had during the year in addition to the accrual rate that they originally provided. So that brought that average down in 2014. I know your next question is apt to be will that happen again in '15? And we did see an adjustment in Q1, and I really can't predict the future.

Michael King (Analyst - JMP Securities):

Okay. I don't know if you can talk about what the contributors are, though, to the changes to the gross-to-net. Is it the type of account? Do you have more Part D that might influence that? Or maybe help us think about the blend of business that would contribute to the higher gross-to-net.

Ridhard Bierly (CFO):

No. I don't think there's any blend of business change in particular. I think with respect to the first quarter, it was the doughnut hole effect which, in fact, we would have also seen in the [year].

Michael King (Analyst - JMP Securities):

Right. Okay. All right. Fair enough. And then with regard to triple negative, just can you tell us -- talk a little bit about the state-of-the-art for assays for androgen receptor? Are they as sensitive and specific as things for -- such as HER2?

Lynn Seely (Chief Medical Officer):

So one of the things that we have learned as we've been studying this is that a lot of what's been put in the literature is sort of using standard androgen receptor assays that were developed for prostate cancer. And prostate cancer, as you might imagine, is very -- has got lots and lots of androgen receptor and so they may not have been as perfectly developed. We've now optimized our assays for breast cancer and are seeing a much higher percentage of women having the androgen receptor expressed in their breast cancer. So I think that was a surprise when we actually did this study and that we learned that the assays off the shelf for prostate cancer weren't that good once we optimized and we found a much higher percentage of breast cancers expressing the androgen receptor.

David Hung (Founder, CEO, President and Executive Director):

In fact, just to refresh your memory, what we presented at San Antonio was that 79% of tissues from TNBC patients expressed some AR and 55% were actually high AR, which would be significantly higher than the literature would have suggested based on prostate cancer or prostate AR tests. And as Lynn said, when we optimized this for breast tissue, we got a pretty different number. So we think that the numbers that we have are much more relevant and solid numbers that should be -- that should be used to kind of back-of-the-envelope calculate what kind of size of opportunity this could be.

Lynn Seely (Chief Medical Officer):

And this wasn't just a single effort. This was using 2 different antibodies, and they gave very comparable results. So we're quite confident in that.

Michael King (Analyst - JMP Securities):

Great. That's extremely helpful. All right. And then just on XTANDI, maybe to weigh this into the discussion about duration. Can you talk about how docs are managing patients currently either in the pre- or post-chemo setting? Just wondering are they managing PSA? Are they managing symptoms perhaps in the post-chemo setting? Maybe a little bit of color on that. And are they -- are you encouraging them, the docs, to treat patients through progression? Or are they pretty much stopping at whatever they deem to be progression?

Joseph Lobacki (Chief Commercial Officer):

So this is Joe. We see a kind of variety of how physicians are treating, from urologists to oncologists in both pre- and post-chemo of what they follow. Based on our studies, we'd like them to follow through more of a radiographic progression to look at that. But they also -- they follow PSA and other endpoints. So we work with them to try to put out the information that we have on XTANDI according to label. But a lot of it becomes up to the physician on how they follow that and when they decide to start or to stop therapy. But we do try to educate them on that. And actually, we see a lot of the patients -- as we look at the mCRP population, which is fairly large, we also see that there's probably a lot of men that still need to be diagnosed correctly with mCRPC. So that's another education of when do you start these patients as well. But again, that's all left up to the physicians. It's their choice to how they manage those patients.

Operator:

Okay. This will be the last question. It comes from Anupam Rama from JPMorgan .

Anupam Rama (Analyst - JP Morgan Chase):

Just a little bit of a follow-on question to something previously asked. You noted the growth in prescribers here in the U.S. Could you provide a little bit more granularity on the growth between oncologists versus urologists? I think in a previous question, you said 40% growth in the quarter for the urology segment. And what level of inflection do you expect with AUA and ASCO around the corner, particularly around

AUA and urologists?

Joseph Lobacki (Chief Commercial Officer):

So thanks, again, one of our folks is in the urology sector because they are moving farther up in therapy. That's where those patients are, the mCRPC patients further up in treatment. And we did see an increase in active prescribers in the urology study to that 40%.

So we continue to see active prescribers come in, in both the urology and oncology setting. And we have many writers already in the oncology setting, so we grow faster in the urology setting. Right now, urology is about 15% of our business as we look at the urology sector.

So both have opportunities for growth, urology just because it hasn't been an area that's been penetrated that much by other agents. And XTANDI's very favorable risk-benefit profile is exciting to the urologists, so we've got a great team out there working with the urologists to deliver the message. So we've seen a good uptake in urology's growth across both segments. So we continue to expect growth across both segments.

Operator:

Ladies and gentlemen, this does conclude today's conference. Thank you for participating. All have a great day.